Payment Schedule For Yukon

April 1, 2006

INSURED HEALTH SERVICES

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PREAMBLE

Complete understanding of the following paragraphs is essential to proper interpretation of the Guide

1. SETTING OF FEES

(a) Yukon Health Care Insurance Plan: Fees payable by the Yukon Health Care Insurance Plan (YHCIP) are subject to negotiation between the Government of Yukon and the Yukon Medical Association. The description of fee items and their respective dollar values form part of the Yukon Health Care Insurance Plan Act regulations. The YHCIP/YMA Liaison Committee is responsible for resolving issues of interpretation and making recommendations regarding new fee items, amendments to existing items and re-evaluation of existing items.

No fee above or in addition to this prescribed schedule may be charged to either YHCIP or to the patient in the case of insured services provided to insured persons.

If there is not a fee included in this schedule for a particular service, the account may be submitted to YHCIP with a copy of the operative report or a letter outlining the reason for the charge. In such cases a Fee Item Number may be designated by taking the first digit of item in the applicable section, and adding the digits 999 (i.e. General Surgery 7999 - Obstetrics 4999).

Individual medical practitioners have the right to communicate directly with the Medical Advisor to the YHCIP or the President of the YMA on any fee matter, giving details of the reason for their method of billing or dispute.

Information in respect to the submission of physicians' accounts to YHCIP forms an appendix to this manual.

(b) Yukon Workers' Compensation Health & Safety Board: Fees payable by Workers' Compensation Board (YWCHSB) are subject to separate negotiations between the YWCHSB and the YMA. Specific items directly related to YWCHSB are found in the Non-Insured Fee Guide. Disputed fees and fees not found in the fee book will be handled by direct communication with the Executive Director of YWCHSB and/or President of the YMA.

(c) Private Billing: All fees in the attached guide shall be used in private practice. If the doctor intends to charge a higher fee because of unusual circumstances, this fee should, whenever possible, be arranged with the patient before the service is rendered.

If smaller charges are required because of the patient's reduced circumstances, the listed fee should be quoted, followed by the charge actually being made. This will prevent the public from gaining a false impression of the necessary level of professional charges from these exceptional cases.

If the patient's financial circumstances are unusual, and other doctors have been called in attendance, it is the responsibility of the attending physician to acquaint his/her colleagues of such circumstances. Each doctor concerned in the care of the patient shall give or send to the patient or their agent a statement showing his/her own professional services. An itemized statement should be supplied on request.

2. GROUP PRACTICE

If fees are collected by an organized clinic or medical partnership, then the total itemized fee should be submitted to the patient or his agent. Members of such a group shall be considered as individual physicians, each charging for his/her own services.

3. INCLUSIVE FEES

(a) Inclusive fees (e.g. surgical operations) are intended to provide for the planning and carrying out of operative procedures and cover pre-operative care, operation and postoperative care. (See also paragraphs 10 and 11.)

(b) When services other than those above can be shown to have been required, because of serious, complications or coincidental illness, the doctor rendering the service, whether he/she is charging the inclusive fee or not, may charge an additional sum commensurate with the extra service rendered.

4. CONSULTATION

This is defined as a request by a doctor for a second opinion on a case he/she has examined and with which he/she has encountered some difficulty. It includes the initial services of a consultant and additional visits necessary to enable him/her to prepare and render his/her report. Subsequent consultations may be sought by the original doctor from the same or other consultants. No consultation should be charged to the patient or their payment agency unless it was requested by the attending doctor.

5. CONTINUING CARE BY CONSULTANT

This may follow consultation at the request of the referring doctor if the complexities of the case are such that its management should remain for a time in the hands of the consultant. In such circumstances, the consultant will charge for his/her consultation and continuing care according to the Fees pertaining to his/her specialty.

Should the referring doctor consider that continuing consultant care of his/her patient is still necessary after six months, he/she should review the case and re-refer for continuing care only. (NOTE: Otherwise future services will be paid at general practitioner rates. Also see Fee 3333 on Page 13). When a referral takes place, it must be made clear by the referring doctor to all concerned that the major responsibility for the case has been transferred, and the referring doctor may not charge for the case until, or unless, the full responsibility is returned to him/her, except that for a patient in hospital, he/she may charge supportive care where the patient's condition warrants it. (See Preamble 10 (b)(i)).

6. DIRECTIVE OR CONCURRENT CARE BY A CONSULTANT

For those medical cases where the medical indications are of such complexity that concurrent services of more than one physician are required for the adequate care of a patient, subsequent visits should be claimed by each physician as required for that care. To facilitate payment, relevant clinic records should accompany claims, and independent consideration will be given.

7. MULTIPLE SERVICE

(a) When the performance of a minor therapeutic or diagnostic procedure (e.g. intramuscular or intravenous injection or taking a specimen from the patient) is the purpose of the doctors' attendance in the office, hospital or on a house call, the charge made will be that listed for the procedure only.

(b) Therapeutic and diagnostic procedures performed consequent to a visit or consultation shall be billed in addition to the visit or consultation (see paragraph 13).

8. MISCELLANEOUS FEES NOT INCLUDED IN THE GUIDE AND DISPUTED FEES

See Preamble 1.

9. HOSPITAL CARE

Routine in-patient care can be billed at the rate of one visit per day. Exceptions to this protocol are consultations, ICU care, concurrent care, long-term care, supportive care, procedural fees and new conditions requiring immediate assessment. (See Preamble 5, 6, 10(a), 10(b), 14, 15 & 20). Another exception is admission to hospital prior to 0800 hours when a second visit that day can be billed.

10. OPERATIVE SURGICAL BILLING

(a) General

The surgeon's responsibility for any case under his/her care, referred or not, includes usual preoperative preparation of up to one month's duration, operation, and routine postoperative follow-up, including removal of sutures and care of the operative wound. These services are included in the surgical fee. The normal post operative period is considered to be 42 days for all surgical procedures. Management of serious or unusual post-operative complications may be billed as separate items.

When a surgical assistant is necessary, surgical assistant's fees are to be billed as separate items.

(b) Referred Surgical Cases

If a requested consultation is followed by a surgical or diagnostic procedure performed by the same physician, the consultation charges are in addition to the scheduled operative fee.
The family or referring doctor may charge for necessary care for a referred case quite apart from the surgical fee as follows:

(i) Supportive Care – non-surgical care including liaison with the family, reassurance of the patient, etc. while the patient is hospitalized. The referring doctor may charge one hospital visit for every two- (2) days hospitalized during the first ten- (10) days of hospitalization and, thereafter, one visit every five- (5) days hospitalized.
(ii) Convalescent Care – visits by the patient to the family doctor following discharge from hospital. Up to one visit a week until convalescence is completed may be billed.
(iii) Concurrent Care – see Preamble 6.

(c) Surgery by a Visiting Doctor

The surgical fee will be indivisible at all times. If a surgeon operates outside his/her geographical areas, and because of this he/she is unable to carry out the post-operative care, the physician who performs this service for the patient should make a separate charge to the patient. The charges may be made on the basis of daily care while in hospital up to fourteen (14) days postoperatively and thereafter on the basis of the supportive care formula. No charge should be made for patients in a metropolitan area or within 20 miles of the surgeons office or usual hospital.

(d) Operation Only

When billing YHCIP or YWCB fee items marked "operation only", the pre and post-operative calls can be charged. If the procedure is the sole reason for the visit, the visit fee should not be charged in addition to the procedural fee. Fee items classified "operation only" do not preclude proper referral of the patient.

(e) Cosmetic Surgery

Cosmetic Surgery is defined as any procedure done primarily to change the external appearance of an anatomically and physiologically normal person aged 19 and over. The surgeon must obtain prior authorization for such procedures in ANY case when dealing with a payment agency.

11. OPERATIVE SURGICAL FEES

(a) When two similar procedures (e.g. bilateral herniorrhaphy) are done at the same time, the charge for the second procedure should be 50% of the listed fee. When done under separate anaesthetics at staged intervals, the full fee should be charged for each operation.

(b) When two different elective procedures are done through separate incisions at the same time (e.g. herniorrhaphy and varicose veins), the charge for the lesser procedure should be 50% of the fee.

(c) When two procedures are done through the same incision the lesser procedure should be charged at 50%. (NOTE: Incidental appendectomy is not to be billed in addition to the abdominal surgery)

(d) When two different emergency procedures are done through separate incisions under the same anaesthetic, each procedure shall be charged at the full listed fee.

(e) An emergency operation followed by a definite surgical procedure (e.g. cholecystotomy followed by cholecystectomy at a later date) should be charged as the full listed fee in each instance.

(f) When two procedures are done by two physicians in different fields utilizing the same anaesthetic, each procedure shall be charged for at the full listed fee, except as stated for team procedures (e.g. laminectomy and fusion).

(g) Certified surgical assistant: Where an operative assistant is required, he/she would ordinarily be a non-specialist. However, in certain selective instances of unusual technical difficulties, the services of a certified surgical assistant may be necessary. In only these instances should the fee for specialist assistant be applied.

(h) Where two surgeons, specialists in different fields, perform major surgical procedures under the same anaesthetic, except where 7019 is indicated, each surgeon may charge an assistant fee for assisting the other.

(i) Where the completion of two or more different procedures are required and could be completed by one physician, but two physicians of the same speciality complete the procedures, the total surgical fee billed may not exceed the equivalent if done by one physician and one assistant.

12. FRACTURES, ETC.

(a) When multiple procedures for multiple fractures and/or soft tissue injuries are done by the same surgeon, the full fee for the major procedure shall be charged and 50% for all subsequent procedures. In cases of dissociated injuries of which the presence of one impedes the progress of another, or in the cases of multiple major fractures (e.g. a fractured femur and tibia in the same limb), a full fee for each may be charged provided that adequate clinical evidence to support this charge is rendered with the account.

(b) Compound fracture - up to 50% extra may be charged.

(c) Open reduction of fracture or dislocation when necessary - 50% extra may be charged except when a special fee is listed.

(d) Where a closed reduction of a fracture is followed within (4) four weeks by an open reduction the greater fee will be paid in full and the lesser fee at 50%.

(e) Inclusive fees for fractures include the necessary application of casting, when applied before the expiry of the post-operative period (See paragraph 10(a)).

(f) Open reduction of old malunited fracture - 25% extra may be added to the fee for open reduction of the equivalent new fracture.

(g) External Skeletal Fixation with closed reduction - 25% above closed reduction fee may charged. External fixation of an open fracture 25% above the open reduction fee (see Preamble)

(h) Any secondary amputation, excision or disarticulation may be charged at 50% of the listed fee for the primary procedure, whenever performed.

(i) Failed Procedure Requiring Remanipulation

(i) Remanipulation by same surgeon within four weeks, no charge.
(ii) Remanipulation by a consultant surgeon should be charged at the full fee for the procedure.
(iii) Where a patient is referred to a consultant and remanipulation is required, the attending physician who performed the initial or original attempt to reduce the fracture should charge 50% of the fee for the procedure he performed.

13. DIAGNOSTIC PROCEDURES

Special fees are listed for Diagnostic Procedures when performed in conjunction with another service. These fees are procedural fees only, and the fee for opinion, whether given as a consultation or as an office visit, will be charged in addition to the procedural fee. If the procedure augments a consultation, the consultant will indicate whether it was a major or limited consultation. If the procedure is done at a time different than the original visit, no fee other than the procedure fee should be billed for the second visit.

Diagnostic procedural fees may be charged in addition to fees for surgical procedures. The surgical fee includes only those services detailed in Paragraph 10.
If two diagnostic procedures are done at the same time, whether in office or in hospital, the lesser should be billed at 50% of the listed fee. Repeat procedures done at separate times will be listed as separate procedural fees.

14. LONG-STAY HOSPITAL AND NURSING HOME CARE

Accounts for long-stay, serious illness in acute care hospitals may be charged in full for a period up to thirty days. Care beyond this period may be charged up to two hospital visits per week, when such visits are necessary.

Accounts for long-term nursing home(or other similar institutions) cases may be charged up to one visit every two weeks. When patient is acutely ill charge fee-for service, when such visits are necessary. Charges in excess of these should be accompanied by an explanatory letter.

15. PREMATURE CARE IN HOSPITAL

Charge in accordance with clause 14. Payment agencies shall pay accounts for supportive or directive care as outlined in clauses 5 and 6 in addition to one attending physician while newborn is hospitalized and considered premature as defined in clause 17.

16. DIAGNOSTIC ROENTGENOLOGY

(a) Multiple examinations of areas on the same side of the body may be charged as the sum total of the individual items.

17. AGE CATEGORIES

Age categories are defined as follows:

Premature baby: under 2,500 grams
Neonate: under 28 days
Infant: 28 days to 1 year
Child: 1 year to 16 years

18. EXPERIMENTAL MEDICINE

Costs of medical services (such as examinations by physicians, laboratory procedures, other diagnostic procedures, etc.) which are primarily related to research or experimentation are not the responsibility of the patient or the Yukon Health Care Insurance Plan. Only those reasonable costs customarily related to routine and accepted care of a patient's problem are considered to be insured services by the Yukon Health Care Insurance Plan.

Grants are available from a number of funding agencies to defray the extra costs associated with clinical research and experimentation.

19. COUNSELLING

The following definitions apply:

(i) Counselling is the lengthy discussion (minimum of 20 minutes) with the patient, parent or relative about a difficult and complex medical condition. Routine advice, for example birth control advice or explaining pathophysiology, is a normal part of therapeutic intervention and, as such, is part of the visit or service fee and should not be billed as counselling regardless of duration of visit.

(ii) Psychotherapy is a medical act by which a physician, through sessions of verbal or other communication, explores and attempts to influence the behaviour of a psychiatrically disordered patient with the objective of reducing his disability.

NOTE: YHCIP and YWCHSB have agreed to pay item 0120 on the basis of a limit of four (4) visits per twelve month period per patient. Subsequent visits should be billed at the appropriate office visit fee. The twelve month period starts April 1st each year. One of the 0120's may be billed for Life Style reasons.

20. INTENSIVE AND CORONARY CARE UNITS

(a) The responsibility for a patient in an I.C.U. or C.C.U. lies with the patient's attending physician unless he/she specifically requests continuing consultative care.

(b) When there is a doctor in charge of an I.C.U.or C.C.U., he/she is entitled to charge a patient or their agent for those services which he/she is specifically requested to provide by the attending physician or consultant in charge.

(c) When a patient requires multiple consultations, a consultation fee may be charged by each consultant. Continuing care by a consultant or consultants must be clearly requested by the attending physician in charge. Any patient admitted to an I.C.U. or C.C.U. is considered to be critically ill and therefore the attending physician who is coordinating the consultative services is entitled to charge up to three visits daily. Payments for additional visits will be considered when detailed case summary is provided.

(d) Where a consultant or consultants are requested to see a patient or provide continuing care, the fee shall relate the responsibility each consultant bears to the patient's treatment.

(e) Intensive Care billings (0138) may apply for care on wards other than in formal Intensive Care Units, eg. newborn nursery, paediatric ward, outpost hospitals prior to transfer, etc.

21. BALANCE BILL

Means the amount of the difference between the payment made by Yukon Health Care Insurance Plan for an insured service and the fee for that service listed under the heading "ALL OTHERS".

22. DIFFERENTIAL BILLING FOR NON-REFERRED PATIENTS

Means the difference between the fee payable to the general practitioner and the fee payable to the specialist for YHCIP insured services. This amount may be billed by the specialist directly to the patient.

23. EXTRA BILL

Means an amount for an insured service over the fee for that service listed herein under "YHCIP and YWCHSB fees."

24. FEES FOR INDIVIDUAL PRACTITIONERS

After review, by the appropriate Committee, the Association may recommend to the Yukon Health Care Insurance Plan adjustments in fees to be paid to individual practitioners.

25. VENEPUNCTURE AND DISPATCH

(Fee Item 0012) - this is the only fee applicable for taking blood specimens and is to apply to those situations where a single service is provided by an unassociated facility or person. Where a specimen is taken by a laboratory and dispatched to another unassociated laboratory, the original laboratory may charge fee item 0012 only when it does not perform another laboratory procedure using that specimen.

26. ACCOMPANYING PATIENTS

When it is medically essential that a physician accompanies a patient to a distant hospital, charges should be made under fee item 0095, plus travel expenses, meals, accommodation and incidentals at the prevailing government rates.

27. PREFIXED FEE ITEMS

B designates services included in visit fee. For an isolated service see clause 7 preamble.
T designates fee items approved on a temporary basis awaiting further information.

28. MISSED APPOINTMENTS

The charging for missed appointments is at the discretion of each physician. Such charges should not be submitted to the Yukon Health Care Insurance Plan.

29. MICROSURGERY

Means operating with the use of an operating microscope.

30. STATUTORY HOLIDAYS

New Year's Day
Heritage Day
Good Friday
Easter Monday
Victoria Day
Canada Day
Discovery Day
Labour Day
Thanksgiving Day
Remembrance Day
Christmas Day
Boxing Day

FOR BILLING PURPOSES ONLY

The next working day will be used when the stat falls on a Saturday or Sunday.

GENERAL SERVICES

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY

These fees cannot be correctly interpreted without reference to the Preamble. No additional visit fee should be charged unless extra service is rendered. Letter B designates services included in visit fee.

INJECTIONS

B 0010	Intramuscular medications	13.00
B 0011	Intravenous medications	17.50
B 0012	Venepuncture and dispatch of specimen to laboratory, when no other charge is made (see Preamble Clause 25)	13.00
B 0013	Intra-arterial medications	25.90
0014	Intra-articular medications by injection - hip (initial injection)	36.10
0015	- tendons, bursae and all other joints	25.80
0016	Intrathecal medications by injection	44.30
0020	Trigger point injection (maximum 2 per sitting)	12.10

BLOOD TRANSFUSIONS

0017	Venesection of central venous catheter	43.70
0018	Insertion of indwelling arterial line	43.70
0019	Venesection of polycythemia for phlebotomy	43.70
0024	Vein dissection for intravenous therapy (not paid in the immediate pre and post-operative phase of surgery)	66.10

DIALYSIS FEES

Acute Renal Failure (Hemodialysis)

0350	Blood Dialysis - physician in charge	898.50
0351	Repeat Blood Dialysis - physician in charge NOTE: Maximum number of repeat dialysis on one patient is four (4). Thereafter, bill as chronic renal failure under fee code 0358.	337.00
0352	Blood Dialysis - fee for cut down by surgeon to be charged in addition to fee code 0350 or 351. NOTE: When fee code 0350 or 0351 are charged there should be no charge under fee code 0310, 0308 or 0081.	224.40

Acute Renal Failure (Peritoneal Dialysis)

0355	Dialysis (initial) to include consultation and two (2) weeks care	671.40
0308	Subsequent hospital visits (paragraph 15 applies)	33.00

GENERAL SERVICES

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
0356	Re-insertion of peritoneal catheter after 10 days from initial insertion NOTE: fee code 0081 not to be charged in addition to fee code 0355. Where an initial peritoneal dialysis is performed and for various reasons hemodialysis initiated within next forty eight (48) hours, the subsequent service should be charged under fee code 0358 plus fee code 0356 for the inserton of catheter.		88.20
Chronic Renal Failure (a) Hemodialysis:			
7239	Insertion of new A.V. Bypass (no consultation charged)	2+T	427.60
0358	Performance of Hemodialysis - fee to include supervision of the procedure, history, physical examination, appropriate adjustment of solutions, and other problems during dialysis for each dialysis.		88.20
7598	Removal of Hemodialysis shunt		106.90
0360	Cannula declotting when performed by attending physician		66.10
Chronic Renal Failure (b) Peritoneal Dialysis:			
7599	Insertion of permanent catheter, procedural fee only	2+T	319.20
0323	Performance of initial peritoneal dialysis to include consultation and two (2) weeks care		677.20
0359	Performance of each Peritoneal Dialysis thereafter - fee to include supervision of procedure, history, physical examination, appropriate adjustments of solutions and any other problem that may arise during dialysis. NOTE: (i) Other situations requiring medical care such as bacteremias, etc. to be covered by fee code 0081 and always to be accompanied by a letter of explanation. (ii) If a period greaeter than three (3) months elapses since last dialysis, then charge as an initial fee code 0355.		88.20
0361	Supervision of home dialysis - per week NOTE: fee code 0361 covers all services per week necessary for home or limited care dialysis and includes consultations and visits of all types. Should a patient take ill with a condition totally unrelated to renal care or require hospitlaization for any reason, then other appropriate fee codes may be charged in lieu of fee code 0361.		113.30

IMMUNIZATION, SKIN TESTS

B 0030	Diagnostic skin tests (Schick, Dick, T.B., and Frei)	8.70
B 0034	Subcutaneous injections, including desensitization treatments, immunization, oral polio vaccine, etc. (maximum per sitting 3)	8.70

MISCELLANEOUS

0040	Stomach Lavage and Gavage	43.70
B 0041	Ultrasound treatments	9.30
B 0045	Manipulation therapy without anaesthesia	19.90
3333	Referral to Specialist when patient not seen	

GENERAL SERVICES

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
0050	Nurse initiated home care calls to a maximum of one call per patient per day. *Calls must be initiated by the homecare worker and direction received from the physician must be incorporated in the patient's chart. Calls handled by physicians' staff are not billable. Calls to renew prescriptions are not billable. Premiums not payable in conjunction with this fee.		30.60
0049	Telephone calls initiated by Community Nurse Practitioners to Physicians providing scheduled emergency coverage in the Hospital. Physicians resident in communities outside Whitehorse are eligible for those calls received from Nurse Practitioners in communities other than the physician's community of residence. Premiums not payable in conjunction with this fee.		31.10

EMERGENCY CARE

Prolonged emergency procedures requiring bedside attention. When surgery is performed by the same physician, after prolonged emergency care, he/she may charge both the emergency care fee and the surgical fee.

When a second or third physician is required for the emergency care of an acutely ill patient requiring continuous bedside care item 0081 is applicable.

A) Fee item 0081 to be used for billing for the active treatment of acutely ill patients whom one cannot leave. The fee is not for standby time such as waiting for laboratory results nor is it for detention care such as repeat examinations of a patient on the same day or treatment of extensive lacerations.

B) Fee item 0081 may be billed in addition to a consultation, but where a consultation fee is charged, this consultation fee will constitute the fee for the first half hour.

In excess of 2 units will be assessed by the Medical Advisor on the basis of a written report.

0081	Per half hour or major portion thereof	107.00

ACUTE CARE DETENTION FEE

To be billed when, as the result of an acute medical circumstance, the lack of a physician in attendance would likely result in a significant risk to the patient's health. This fee is for services when emergency care is not required yet the physician should not leave the patient unattended. This is not to cover time waiting for lab or xray results, consultations, etc. In excess of 2 units will be assessed by the Medical Advisor on the basis of a written report. This fee is inclusive of all other services.

0082	Per half hour or major portion thereof	85.30

PERSONAL OR FAMILY CRISIS INTERVENTION FEE

Applies to situations where the attending physician is called upon to provide continuous medical assistance at the exclusion of all other services in periods of personal or family crisis caused by rape, sudden bereavement, suicidal behaviour or acute psychosis. In excess of 2 units will be assessed by the Medical Advisor on the basis of a written report.

0083	Per half hour or major portion thereof	77.40

GENERAL SERVICES

	Anaes. Proc. Unit	YHCIP and YWCHSB ONLY

IN-TERRITORY MEDIVAC ON-CALL

To be billed by the scheduled physician on call to provide medical services to patients who require transportation by air ambulance within the territory. To be billed when the scheduled physician is on call in a 24-hour period. The first and second Medivac performed within the territory constitutes one unit. If the physician is on call but is not required to provide services one unit is payable. When the scheduled physician performes a third in-territory medivac in a 24-hour period then 2 x 0084 is to be billed. The third unit shall be sent with an accompanying letter of explanation to Insured Health Services. When submitting a claim for payment the physician shall include the patient's name and the destination on the diagnosis line if a medivac is performed.

0084 Per Unit 682.00

OUT-OF-TERRITORY MEDICAL EVACUATION

To be billed by the family physician (if available) to provide medical services to patients who require transportation by air ambulance out of the territory. South bound Medivac - two units. If returning from out of territory necessitates loss of scheduled work time - one additional unit. Physicians can apply for .5 of a unit for second patient on the same medivac with supporting documentation to the Medical Advisor.

0095 Per Unit 846.80

DIAGNOSTIC PROCEDURES

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY

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

PROCEDURES INVOLVING VISUALIZATION BY INSTRUMENTATION

0700	Bronchoscopy or bronchofibroscopy	4+T	130.40
0701	Direct laryngoscopy	5+T	65.40
0702	Bronchoscopy with biopsy	4+T	216.40
0703	Culdoscopy or Open Colpotomy	1+T	216.60
0704	Cystoscopy to include dilatation and panendoscopy	1+T	118.90
0705	Cystoscopy with catheterization of ureters (with kidney function test and injection of solution for pyelogram to include dilation and panendoscopy)	1+T	130.40
0706	Esophagoscopy with biopsy	3+T	216.40
0707	Gastroscopy including esophagoscopy	3+T	173.50
0709	Esophagoscopy	3+T	130.40
0710	Mediastinoscopy or anterior mediastinotomy (combined 50% extra)	4+T	216.60
0711	Gastric biopsy	3+T	54.70
0713	Arthroscopic examination under general anaesthetic	2+T	216.40
0713	-hip joint NOTE: 50% if followed by surgery under the same anaesthetic	3+T	216.40
0714	Sigmoidoscopy	1+T	54.70
0715	Sigmoidoscopy with biopsy	1+T	65.40
0716	Flexible sigmoidoscopy	1+T	108.40
0718	Gonioscopy	1+T	21.90

PROCEDURES UTILIZING RADIOLOGICAL EQUIPMENT

The following fees are separate from the fees for the radiological part of this examination and should be charged by the attending physician or by the radiologist who performs the procedure, e.g. instrumentation or injection of contrast material.

0720	Air encephalogram	3+T	151.50
0721	Myelogram	2+T	65.40
0723	Sialogram - per duct	2+T	65.40
0724	Presacral air insufflation	2+T	65.40
0725	Perirenal air insufflation	2+T	65.40

DIAGNOSTIC PROCEDURES

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
0726	Arthrogram	2+T	65.40
0727	Salpingogram	2+T	108.40
0728	Orthodiagram	2+T	21.90
0729	Fluoroscopy of chest by Internist or Paediatrician	1+T	21.90
0730	Catheterization of bronchi for bronchogram. NOTE: When performed in conjunction with a Bronchoscopy (fee code 0700 or 0701) both fees are to be paid in full	4+T	43.10
0731	Duodenal Biopsy	3+T	151.50
0732	Voiding cysto-urethrogram	1+T	21.90
0733	Venogram, Intraosseous or Intravenous	2+T	43.10
0734	Lymphangiography or Lymphography - surgical component (see fee code 8614)	1+T	216.60
0735	Laryngogram	1+T	43.10
0736	Bronchial brushing in conjunction with Bronchoscopy (Bronchoscopy extra)	4+T	130.40
0737	Bronchial brushing in conjunction with bronchogram (bronchogram extra)	4+T	65.40

THERAPUTIC PROCEDURES UTILIZING RADIOLOGICAL EQUIPMENT

0738	Removal of biliary calculi by Burhenne technique	4+T	303.70
0980	Trans-hepatic biliary drainage procedure	3+T	445.30
0983	Percutaneous abdominal abscess drainage by catheter insertion	2+T	302.20
0984	Exchange of previously inserted catheter for percutaneous or biliary drainage	1+T	105.60

NEEDLE BIOPSY PROCEDURES

These biopsies include only those done by needle. Biopsies involving the incision of skin or mucous membrane or involving total or partial removal of a lesion are regarded as surgical procedures, i.e. biopsy of breast, brain, larynx, skin, facial skin, lymph nodes, prostate, etc.

0739	Percutaneous lung or mediastinal biopsy	2+T	151.50
0740	Liver biopsy	2+T	108.40
0741	Splenic biopsy	2+T	108.40
0742	Renal biopsy	2+T	151.50
0744	Thyroid biopsy	1+T	86.80
0745	Peripheral or subcutaneous lymph node biopsy	1+T	21.90

DIAGNOSTIC PROCEDURES

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
0747	Prostate biopsy	1+T	43.10
0748	Bone biopsy	1+T	65.40
0749	Parietal pleural, including thoracentesis	1+T	86.80
0766	Breast biopsy	1+T	86.80

PUNCTURE PROCEDURES FOR OBTAINING BODY FLUIDS

(when performed for diagnostic purposes)

0750	Lumbar puncture	1+T	43.10
0751	Pericardial puncture	3+T	86.80
0752	Cisternal puncture	2+T	65.40
0753	Marrow aspiration	1+T	65.40
0754	Subdural tapping in infant	2+T	45.60
0755	Artery puncture	1+T	12.80
0756	Joint aspiration - hip	1+T	32.40
0757	- other joints	1+T	21.90
0758	Pneumoperitoneum	1+T	43.10
0759	Paracentesis (thoracic) or transtracheal aspiration	2+T	43.10
0760	Paracentesis (abdominal)	1+T	43.10
0761	Cyst or bursa aspiration (to include breast)	1+T	21.90

ALLERGY, PATCH AND PHOTOPATCH TESTS

0762	Scratch test - per antigen		2.30
0763	- Children under 5 years of age - per antigen		4.30
0764	Intracutaneous test - per test		4.30
0767	Patch testing (extra) (annual maximum, 30 tests) per test		2.30
0768	Photopatch test - per test		8.70

EXAMINATION UNDER ANAESTHESIA

(when done as independent procedure)

0770	Pelvic examination under anaesthesia	1+T	43.10

DIAGNOSTIC PROCEDURES

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
0771	Retinal examination under anaesthesia	3+T	43.10
0772	Nasopharyngeal examination under anaesthesia	3+T	43.10

GYNAECOLOGICAL

0775	Hydrotubation		108.30
0776	Fetal scalp sampling - initial sample		43.10
0777	- subsequent samples		21.90
0778	Laparoscopy	4+T	216.60
0779	Amnioscopy		43.10
0781	Rubin's Test		43.10
0782	Needle aspiration of Pouch of Douglas	1+T	43.10
0783	Huhner's Test		43.10
0784	Cervix punch biopsy	1+T	21.90
0785	Endometrial biopsy	1+T	65.40
0786	Pelvic examination with needle aspiration of Pouch of Douglas under anaesthesia when not followed by a surgical procedure by the same surgeon	1+T	86.80
0787	Transabdominal amniocentesis (assessment of multi-gestation can be billed at 50% for each additional fetus)	2+T	65.40
0788	Colposcopy with biopsy and curettage	1+T	55.90
0789	Colposcopy		37.30
0790	Hysteroscopy (simple)	2+T	109.70

UROLOGICAL

0795	Biopsy of penis	2+T	43.10
0796	Cystometrogram		43.10
0773	Sphincterometry (in addition to cystometrogram)		43.10
0802	Urethrogram	2+T	107.80
0792	Cysto-ureterogram - technical fee	2+T	21.90
0793	professional fee		10.50

DIAGNOSTIC PROCEDURES

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
0794	Peritoneal lavage	1+T	173.50

MISCELLANEOUS

CARDIOVASCULAR PROCEDURES

0801	Intra-arterial cannulation (with multiple aspirations)		43.10
0831	Swans-Ganz catheter insertion NOTE: When catheter is inserted as part of anaesthetic procedure the fee code 0831 would be payable at 50%	5+T	216.40

ELECTRODIAGNOSIS

Items under Intensity duration Curve-each muscle.
Electromyograph - each muscle.
Motor nerve conduction study - each nerve.
Sensory nerve conduction study - each nerve.
Tetanic stimulation test - each muscle.

0904	Schedule A-extensive examination (8 or more)		181.80
0905	Schedule B-limited examination (4 - 7 items)		121.30
0906	Schedule C-short examination (1-3 items)		67.00
0907	Endoscopic flexible or rigid examinations of the nose and nasopharnx (procedure only)	3+T	39.80
0908	procedure and biopsy	3+T	68.50
0909	Flexible fiberoptic nasopharyngolaryngoscopy	3+T	50.40
0922	Electrodiagnostic component of the decamethonium edrophonium test for myasthenia gravis, inclusive of tetanic stimulation tests.		61.50
0923	Technical fee for electrodiagnostic testing		30.60

PULMONARY INVESTIGATIVE AND FUNCTION STUDIES

0928	Simple Screening Spirometry with FVC, FEV(i) and FEV(i)/FVC ratio using a portable apparatus without bronchodilators		22.40
0929	- before and after bronchodilators. Exercise Studies: NOTE: No more than one exercise study item may be billed for a single patient on any one day without written explanation		35.20
0950	Progressive Exercise Test with at least three workloads, measuring ventilation and electrocardiographic monitoring -professional fee		42.40
0951	- technical fee		63.90

DIAGNOSTIC PROCEDURES

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
0952	Ventilation at rest and exercise with blood gas analysis but without expired gas analysis -professional fee		52.90
0953	- technical fee		84.70
0954	Exercise in a steady state at two or more workloads with measurements of ventilation, 02 and CO2 exchange, and electrocardiographic monitoring - professional fee		88.40
0955	- technical fee		88.40
0956	Exercise in a steady state at two or more workloads with measurements of ventilation, 02 and CO2 exchange, electrocardiographic monitoring, arterial blood gases, measurement of Aa gradients and physiological dead space - professional fee		105.80
0957	- technical fee		105.80
0958	Testing for exercise induced asthma by serial flow measurements - professional fee		42.40
0959	- technical fee		63.90
0962	Expired gas analysis to measure mixed venous C02 - professional fee		6.40

GENERAL PRACTICE

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
These fees cannot be correctly interpreted without reference to the Preamble.			
1100	Visit (in emergency department at Whitehorse General Hospital)		36.70
0100	Visit (in or out of office): For any condition(s) requiring partial or regional examination and history to include pronouncement of death and health supervision of infant up to and including one year of age		36.70
1101	Complete examination (in emergency department at Whitehorse General Hospital)		80.60
0101	Complete examination (in and out of office): For any condition requiring a complete physical examination and detailed history NOTE: A complete physical examination shall include a complete and detailed history and detailed physical examination with special attention to local examination where clinically indicated, adequate recording of findings and, if necessary, discussion with patient. The above should include complaints, history of the present and past illness, family history, personal history, functional inquiry, physicial examination, differential diagnosis, and provisional diagnosis. A minimun of 20 minutes in patient contact is considered necessary to use this fee.		80.60
1109	Second extensive examination (in emergency department at Whitehorse General Hospital)		46.70
0109	For a situation when a second extensive examination is required, the second complaint should be more than passing significance. Both complaints or diagnoses should be recorded on the claim card. Can also be used for "well woman" annual check ie; blood pressure, pap, breast exam and related health counselling.		46.70
0110	Consultation (in and out of office): To include history and physical examination, review of x-rays and laboratory findings and written report		118.60
0112	Limited General Practitioner Consult (in or out of office): To include a brief history and focused examination, review of xrays and laboratory findings with a written report		59.40
0116	Admission to ICU for critically ill patients (not routine or post anaesthetic) requiring immediate complete examination, investigation and close monitoring of condition		139.70

HOME VISITS

0103	First patient		77.10
0104	Extra patients seen during same house call NOTE: Home visits can also be used when a non emergency visit is provided at a place other than the normal health care facility (i.e. place of work, sporting event, etc.).		41.20

HOSPITAL VISITS

0108	Visit (see Preamble 14)		47.10
0128	Supportive Care (see Preamble 10 (B) (i) and 5)		47.10
0138	ICU Visit (see Preamble 20 (C)		52.30
0148	Long Stay Hospital and Nursing Home care (see Preamble 14). To be billed when seeing a patient while already at nursing home or on regular rounds.		52.70

GENERAL PRACTICE

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY

NURSING HOME VISITS

0114	To be billed when the physician is called by the nursing home to see patient.	62.60

EMERGENCY VISIT PREMIUM

*NOTE: To be charged in addition to visit or procedural fee. * Based on time seen by physician.*

0150	Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	37.20
0151	Evening (1800 - 2259)premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	110.20
0152	Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	127.80

Hospital Emergency Department Premium (When located in hospital and called to emergency)

0153	Evening (1800 - 2259) premium when located at or called to the hospital emergency department from within the hospital NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	17.70
0154	Night (2300 - 0759) premium when located at or called to the hospital emergency department from within the hospital	77.50

LEVEL I ON-CALL COVERAGE

**Physicians must meet the criteria as per section 6 of the Memorandum of Understanding to bill for on-call remuneration.*

0240	GENERAL SURGERY, OBSTETRICS/GYNAECOLOGY ON-CALL: To be charged by a certified specialist when the specialist is available to provide services as required at Whitehorse General Hospital. Per 24 hour period 8 am to 8 am	424.11
0540	ANAESTHETIST ON-CALL: (Certified or non-certified) To be charged by the scheduled anaesthetist on-call when the anaesthetist is available to provide anaesthetic services as requires at Whitehorse General Hospital. Per Hour.	17.66
0140	SECOND ON-CALL AT WHITEHORSE GENERAL HOSPITAL EMERGENCY DEPARTMENT: To be charged by the scheduled second on-call physician when the physician is available to provide emergency services as required. Per Hour.	17.66
0440	COMMUNITY (WATSON LAKE) PHYSICIAN ON-CALL: To be charged when the scheduled physician on-call is available to provide services as required. Per 24 hour period 8 am to 8 pm.	424.11

GENERAL PRACTICE

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
LEVEL II ON-CALL COVERAGE			
0270	PAEDIATRICIAN, INTERNAL MEDICINE, PSYCHIATRY, DAWSON CITY ON-CALL: To be charged when the scheduled on-call physician is available to provide services as required at Whitehorse General Hospital. Monday to Friday, 8 am to 8 am (Dawson City Monday to Friday 6 pm to 8 am)		300.00
0280	PAEDIATRICIAN, INTERNAL MEDICINE, PSYCHIATRY, DAWSON CITY ON-CALL: To be charged when the scheduled on-call physician is available to provide services as required at Whitehorse General Hospital Saturday, Sunday and Statutory Holidays		470.00
MISCELLANEOUS			
0115	Complex laboratory or x-ray studies performed by physician when such studies are beyond the scope of a local available support staff (e.g. skull or spine xrays taken by outpost physician)		38.00
0117	Interpretation of electrocardiogram by non-internist		4.60
0118	Attendance at birth if specifically requested by surgeon for care of baby only		67.10
0119	Routine care of newborn in hospital. NOTE: If a newborn becomes ill and requires care beyond routine then the physician shall bill routine hospital visits from day of birth and not bill 0119. Physiologic jaundice requiring only phototherapy is considered routine newborn care.		67.10
0120	Prolonged visit for counselling a complex medical condition (minimum time per visit - 20 minutes) NOTE: Payment agencies will pay up to (4) visits per patient per fiscal year (starting April 01). One visit per year for discussion of smoking cessation and/or weight management is permitted.		80.50
0121	Psychotherapy - up to 30 minutes		61.10
0122	Psychotherapy - 31 to 45 minutes		92.00
0123	Psychotherapy - over 45 minutes		122.60
0124	Nurse Referred G.P. Consultation: This fee item is for the referral from an outpost nurse to a Whitehorse physician for in depth consultation. The GP must, by way of return letter, outline the results of a complete history and physical, a tentative diagnosis, all laboratory investigations undertaken, with results if available, and all therapeutic measures advised. In addition the GP should outline several alternatives of treatment to be attempted before re-evacuation for assessment if indicated.		118.60
T 0125	New Patient Program - Pilot Project: Payment for accepting patients into practice retroactive to April 01, 2004. One time payment for each new patient that a family physician accepts into his/her practice. Completion of New Patient Form with signatures from both the family physician and patient are required for payment. A copy of this form is required with the claim for payment. Payable once for each YHCIP health care number.		200.00

GENERAL PRACTICE

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
0126	Stand-By Service: To be paid when a physician is requested to stand-by to possibly provide an immediate service pending the results of another service by another physician (i.e. possible surgical assist pending arthroscopy or gastroscopy results, or possible general anaesthesia pending failed local or regional anaesthetic, etc.). In excess of 2 units will be assessed by the Medical Advisor on the basis of a written report. Per half hour or major portion thereof		35.00
0129	Cancer Chemotherapy Visit: To include the administration of multiple parenteral chemotherapeutic agents, history and physical examination as necessary to document disease status, counselling of patient and/or family, review of pertinent laboratory and radiologic data, venesection and institution of an intravenous line. This service not to be billed more than once every 28 days (time taken must be in excess of 1 hour).		143.60
0130	Limited Cancer Chemotherapy Visit: To include the administration of single or multiple parenteral chemotherapeutic agents, history and physical examination as necessary to document disease status, counselling of patient and/or family, review of pertinent laboratory and radiological data, venesection and institution of an intra-venous line. NOTE: This item is not to be billed more than once every 7 days. Neither is it to be billed for routine administration of 5 Flourouracil as a single agent.		71.70

TELEMEDICINE

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY

Physicians should submit billings to Insured Health Services using the telemedicine codes listed below for any conditions requiring preparations of a telemedicine transmission.

In addition to the patient exam a family practitioner may charge an additional equivalency to an office visit if they are actually sending the transmission.

Specialists will be paid the regular major or minor consultation fee (as if the patient were physically present with the specialist.) Consult letter to follow in each instance.

2600	Telemedicine Transmission or Review: For any condition(s) requiring partial or regional examination and history. (2600 to be billed when sending or replying to a telemedicine transmission.)	36.90
2601	Detailed Telemedicine Transmission or Review and Reply: For any condition requiring a complete review of examination and detailed history. NOTE: A complete review of examination shall include complaints, history of the present and past illness, pertinent family history, functional inquiry, differential diagnosis, and provisional diagnosis. A minimum of 20 minutes of the physicians time should be spent for review and reply of transmission.	73.60
2602	Telemedicine Consultation: To include review of history, review applicable x-rays and laboratory findings and a written report. A minimum of 30 minutes of the physicians time should be spent for review and reply of transmission.	119.20
2603	Dermatology Consultation Review and Reply	91.40
2699	In circumstances where an inordinate amount of time is required of any physician in management of a clinical problem utilizing the telemedicine modality, that physician may claim by billing under fee code 2699. A brief explanation should accompany the billing. In the rare event emergency consultations via telemedicine are required, they will be paid as per the current administrative guidelines for premium fees, etc.	

ANAESTHESIA

These fees cannot be correctly interpreted without reference to the Preamble

ANAESTHESIA PREAMBLE

1. The tariff is for all types of anaesthesia. The fee is for the professional services, including ordering pre-anaesthetic medication, administering anaesthesia, immediate post-anaesthetic supportive measures to include necessary post-anaesthetic visits and follow-up; but does not include cost of material used.

2. Total anaesthetic fee is determined by multiplying a unit value of $28.10 for YHCIP and YWCHSB billings ($56.20 for ALL OTHERS) by the number of units applicable and totaling the dollar value.
   Units are divided into three categories:
   a) Anaesthetic evaluation unit
   b) Procedural fee unit
   c) Time unit

The anaesthetic evaluation unit compensates for the professional assessment of a patient and will be applied when a pre-operative assessment has been done whether or not an anaesthetic is administered.

The procedural unit is listed opposite many diagnostic and surgical procedures. It is a modifying factor to compensate for the anaesthetic service rendered. When presenting accounts to a payment agency, the code number and description for the diagnostic or surgical fee item should be stated on the claim card.

The time unit compensates for the time involvement in the total anaesthetic service. Anaesthesia time begins when the anaesthetists is first in attendance with the patient for the purpose of creating the anaesthetic state and ends when he/she is no longer in personal attendance (when the patient may be safely placed under customary post-operative supervision). When presenting accounts to a payment agency the time the anaesthetic commenced and the time it ended should be stated on the claim card. One additional unit may be charged at the beginning of each daily slate to allow for in-depth security check on anaesthetic machines.

3. When multiple or bilateral procedures are done during the same anaesthetic, the procedural units shall be the number listed for the procedure carrying the greatest number of units; e.g. thoracic approach to hiatus hernia repair – procedural units as limited for thoracotomy, i.e. 10.

4. When the following modifying factors are utilized by a Certified Anaesthetist in the administration of an anaesthetic, charge additional for:
   a) Induced hypothermia
   b) Controlled hypotension
   c) Pump oxygenator
   d) Prone position
   e) Sitting position for intracranial or vertebral surgery

5. Where unusual detention with the patient before or after anaesthesia is essential for the safety and welfare of such patient, the necessary time will be compensated on the same basis as indicated for the anaesthetic time.

6. Where the attendance of the anaesthetist is requested by the patient's other medical attendants for the sole purpose of monitoring or special supportive care, and where the anaesthetist is in constant attendance, the fee shall be 4 units plus time.

7. Anaesthetist's continuous attendance by request at any procedure for possible resuscitation and/or complementary anaesthesia, will be charged for the time of such attendance at the same rate as for administration of anaesthesia for the procedure.

8. Payment of Two Anaesthetists:
   Where two anaesthetists are medically required in the interest of the patient both may charge a full fee. When billing a payment agency support need for charges with a written statement.

9. Payment of Anaesthesia when performed by the Surgeons:
   When a surgeon is required to administer an anaesthetic in addition to performing a surgical procedure it is recommended that a charge NOT be made for the anaesthesia in addition to the procedure performed. In emergency situations it may be necessary for the surgeon to act as the anaesthetist; a charge for such service should be accompanied by a written explanation of the circumstance by the surgeon concerned when billing payment agencies.

10. Anaesthetic Fees Not Included in the Schedule:
    Such fees shall be computed in equity with the procedures of similar anaesthetic responsibility, difficulty, and skill. When submitting an account to a payment agency use fee item 1999 and state the reason for the charge.

    The foregoing also applies to anaesthetic procedural units for surgical or diagnostic procedures charged under a miscellaneous 999 number (see Clause 8, page 2 of the Preamble).

11. Epidural Anaesthesia for Obstetrics:
    a) Evaluation unit
    b) Procedural unit
    c) Time units

12. For consideration of premiums, the time of the anaesthetic shall correspond to the beginning of the first procedure.

13. Anaesthesia for CT Scan
    a) Evaluation unit
    b) Procedural unit x 2
    c) Time units

ANAESTHESIA

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY

EMERGENCY VISIT PREMIUM

**Based on time seen by physician*

0250	Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care		47.80
0251	Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays.		131.10
0252	Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: The above fees to be charged by certified specialist only. Premiums for non-certified anaesthestist are listed under General Practice (fee code 0150, 0151, and 0152)		153.50
1015	Consultation by a Certified Specialist in Anaesthesia: To include complete history and physical examination for a systemic disturbance which is a threat to life, either by itself or in association with proposed anaesthesia and surgery, review of x-ray and laboratory findings and written report. If followed by an anaesthetic, the consultation is to be charged in addition to the total anaesthetic fee.	7	28.10
1014	Repeat or Limited Consultation: To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant or where in the judgment of the consultant the consultative service does not warrant a full consultative fee.	4	28.10
1017	Assessment and initiation of treatment of a non-anaesthetic complication when such services are requested and a degree of urgency exists	3	28.10
1009	Dental Anaesthesia (certified anaesthetists) (anaesthetic evaluation, extra)	2	28.10
1010	Non-certified Dental anaesthesia (anaesthetic evaluation, extra)	1+T	28.10
1051	Routine anaesthetic evaluation - certified anaesthetist	3	28.10
1025	Complicated Pre-Anaesthetic Check (non-certified): To include complete history and physical examination for systemic disturbance which is a threat to life, either by itself or in association with proposed anaesthesia fee code includes complete exam, history, review of xray and laboratory findings. If the anaesthetic is administered by the same anaesthetist fee code 1052 does not apply.	3	28.10
1052	Non-certified anaesthetist	2	28.10
1053	Procedural fee (units as listed opposite diagnostic or surgical procedure)		28.10
1054	Time, for each 15 minutes or fraction thereof (Less than 2 hour duration)	1	28.10
1063	Time, 2 hours or more duration for each 10 minutes or fraction thereof	1	28.10

ANAESTHESIA

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
1055	Monitoring or special supportive care (neither anaesthetic evaluation units nor resuscitative care apply) - applies to cadaverous kidney donor	4+T	28.10

MODIFYING FACTORS

1056	Induced hypothermia	5	28.10
1057	Controlled hypotension	5	28.10
1058	Pump oxygenator	5	28.10
1059	Prone position	1	28.10
1064	Patient over 70 years of age	1	28.10
1065	Patient under 1 year of age	1	28.10
1066	Sitting position for intracranial or vertebral surgery	8	28.10
1068	Neonates (under 28 days)	5	28.10

DIAGNOSTIC AND THERAPEUTIC ANAESTHESIA FEE ITEMS

The anaesthetic fee is for professional services (excluding cost of materials). Anaesthetic evaluation units to be charged in addition to procedural units as listed. No time units will be charged, except for Epidurals. Consultations, when requested, will be charged in addition. Nerve block fees are also for diagnostic or therapeutic anaesthetic techniques when surgery is not involved. When surgical, obstetrical or diagnostic procedures are involved the nerve block anaesthetic procedural units do not apply except for Epidurals.

NERVE BLOCKS

Somatic Nerves

1020	Nerve roots (maximum 4 units per sitting) per root	1	28.10
1022	Nerve plexus	3	28.10
1023	Peripheral nerves - (maximum 3 units per sitting) per nerve	1	28.10
1030	Epidural or Caudal Block - lumbar	5+T	28.10
1038	Nerve root and facet blocks - cervical (maximum 12 units per sitting)	4	28.10
1039	Nerve root and facet blocks - thoracic (maximum 9 units per sitting)	3	28.10
1031	Repeat injections of Caudal or Epidural Block (if via previously inserted catheter, anaesthetic evaluation applies to fee code 1030 only). Remuneration of time only payable after 30 minutes. Time spent up to and including 30 minutes is inclusive of anaesthetic units.	2	28.10
1032	Subdural (spinal) Block	3	28.10

ANAESTHESIA

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
1033	Repeat injections of Subdural (spinal) Block (if via previously inserted catheter, anaesthetic evaluation applies to fee code 1032 only)	2	28.10
Sympathetic Nerves			
1036	Thoracic Epidural Block	6+T	28.10
1040	Stellate Ganglion	2	28.10
1042	Paravertebral	3	28.10
1044	Coeliac Ganglion Block	5	28.10
1045	Injection of Alcohol, Phenol, or other Sclerosing Agent into: Nerve Sheath, Plexus, Ganglion	9	28.10

INTRAVENOUS PROCEDURES

Injection intravenously of procaine, vasodilators, curare, decamethonium, or other drugs, for diagnostic or therapeutic indications.

1060	- First injection	2	28.10
1061	- Subsequent injections (anaesthetic evaluation applies to fee code 1060 only)	2	28.10

RESUSCITATIVE PROCEDURES BY ANAESTHETIST

(a) When followed by an anaesthetic, include in anaesthetic time.
(b) When an isolated service, apply fee item 0081.
(c) Prolonged resuscitation or respiratory control or assistance with or without apnoeic technique (asthmatics, crushed chests, respiratory failure or infection, etc.) Anaesthetic evaluation does NOT apply.
(d) Resuscitative procedures by Anaesthetist to include both ventilator care and By-Level Positive Airway Pressure (BYPAP).

1078	- first day	6+T	28.10
1079	- second and third day	4+T	28.10
1081	- fourth to twenty-first day, per day	2+T	28.10
1083	- twenty-second to forty-second day, per day	1+T	28.10
1085	- seventh to fourteenth week, per day	3+T	28.10
1087	- thereafter, per month	5+T	28.10
1089	Resuscitation of a seriously depressed neonate at the request of the attending physician (anaesthetic evaluation does NOT apply)	4	28.10
1091	Intubation	5	28.10
1092	Awake fibre-optic intubation	3	28.10

ANAESTHESIA

ACUTE PAIN MANAGEMENT

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
1016	Consultation by a certified specialist in anaesthesia for assessment of the patient for chronic pain, to include review of relevant history and physical examination, x-ray and laboratory findings, and a written report	6	28.10
1013	Consultation by a certified specialist in anaesthesia: Assessment of the patient for post operative acute pain management within 24 hours following the end of surgery, to include review of the relevant history and physical examination, x-ray and laboratory findings, and a written report	4	28.10
1011	Follow-up visit for chronic pain control in the office by a certified specialist in anaesthesia	2	28.10
1012	Pain management acute or chronic in the hospital by non-certified anaesthetist (maximum of two visits per day or letter of explanation)	1.5	28.10
1019	Pain management acute or chronic in the hospital by certified anaesthetist (maximum of two visits per day or letter of explanation)	2.5	28.10

DERMATOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY

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

REFERRED CASES

0210	Consultation: To include history, and dermatological examination, with review of any previous x-ray and laboratory findings and written report	93.30
0211	Treatment, as under fee code 0216, other than excision, with consultation	26.20
0214	Repeat or Limited Consultation: To apply where a consultation is repeated for the same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee (laboratory test and biopsy, when necessary, extra)	65.10
0215	Dermatological Biopsy	34.30

Continuing Care by Consultant:

0204	Directive care	26.20
0207	Subsequent office visit	26.20
0208	Subsequent hospital visit	26.20
0209	Subsequent home visit	64.40

EMERGENCY VISIT PREMIUM

**Based on time seen by physician*

0250	Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	47.80
0251	Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	131.10
0252	Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	153.50

SPECIAL EXAMINATIONS

0206	For primary systemic diseases with cutaneous manifestations, to include complete history and physical examination, review of x-ray and laboratory findings, and a written report	216.20

SPECIAL THERAPY

0216	Forms of treatment other than excision, such as removal of haemangiomas and warts with electrosurgery, cryotherapy initial visit	52.10
0217	- subsequent visit	26.20
0218	Curettage and electrosurgery of skin carcinoma proven histopathologically	151.70

DERMATOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
0219	- each additional lesion (maximum charge $147.60)		75.60

OPHTHALMOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY

These fees cannot be correctly interpreted without reference to the Preamble

* See fee code 2012

REFERRED CASES

2010	Consultation: To include history, eye examination, review of previous x-rays and laboratory findings and any or all of measurement for refractive error, ophthalmoscopy, biomicroscopy, tonometry, eye balance test keratometry where indicated and necessary to prepare a written report.	116.90
2011	Repeat or Limited Consultation: To apply where a consultation is repeated for the same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	64.00
2012	Special Consultation: To apply when an ophthalmologist, neurologist, paediatric neurologist or neurosurgeon refers a patient to an ophthalmologist for special examination, or when an ophthalmologist refers a patient to another ophthalmologist where a decision regarding medical or surgical treatment is complicated and requires extra consideration, judgment and implementation of specialized knowledge and experience. This item should include any or all eye examinations marked with an asterisk when indicated and necessary to prepare a written note. NOTE: Where referred for emergency surgery and surgery is performed within 3 days from date consultation is requested - charge fee code 2010	150.00

Continuing Care by Consultant:

2007	Subsequent office visit	40.90
2008	Subsequent hospital visit	21.40
2009	Subsequent home visit	64.40

EMERGENCY VISIT PREMIUM

**Based on time seen by physician*

0250	Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	47.80
0251	Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	131.10
0252	Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	153.50

OPHTHALMOLOGY

			Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
		EYE EXAMINATIONS		
		Included in consultation or visit fee when applicable.		
		NOTE: When two or more examinations are performed by specialist ophthalmologist on the same subsequent visit, the major examination is to be charged in full and the lesser examinations to be charged at 50% UP TO A MAXIMUM OF THREE EXAMINATIONS. Do not bill professional or technical fee to Insured Health Services bill TOTAL FEE only.		
	2015	Eye examination to include measurement of refractive error, ophthalmoscopy, and any or all biomicroscopy, tonometry, eye balance test, keratometry, where indicated. NOTE: May be charged by non-specialist, or by an Optometrist under the supervision of an Opthalmologist.		75.00
*	**2020**	Opthalmo-dynamometry		52.80
	2041	Limited visual field examination, ie. tangent screen, autoplot, arc perimeter, or single level automated test such as octopus program 3 or 7 or equivalent - may be billed by Optometrist		52.80
	2639	Ophthalmic ultrasound A scan for determination of axial length (to be billed only if patient proceeds to lens implant surgery)		84.60
	2042	Quantitative perimetry examination: one of: (a) full field manual perimetry such as 2 or 3 isopters on Goldman perimeter or equivalent, with spot checks between isopters and kinetic plotting of scotomata; or (b) limited area manual static threshold perimetry such as 2 or 3 half-meridians at 2 degrees intervals to 30 degrees from fixation or 30 to 50 static threshold points in any arrangement; or (c) automated testing at 2 or 3 threshold related luminance levels (such as OCTOPUS program 33 or 34 or equivalent); or (d) automated testing of periphery only (such as OCTOPUS program 41 or equivalent NOTE: Item 2042 includes 2041		50.80
*	**2017**	Oculo-motor function tests		34.30
*	**2018**	Biomicroscopy (inclusive of visit)		25.70
*	**2019**	Tonometry		25.70
*	**2022**	Provocative test for glaucoma		34.30
	2025	Fluorescein angiography of retina with interpretation		170.20
	2026	- professional fee		41.00
	2027	- technical fee		129.20
*	**2029**	Dynamic Fluorescein Angioscopy		64.40
	2035	Colour vision assessment (anomaloscope, Farnsworth Hue)		64.40
	2036	- professional fee		41.70
	2037	- technical fee		22.80
*	**2038**	Keratometry		21.40

OPHTHALMOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
2039	Fundus photography (limitations-glaucomatous disc changes, tumor progression and potentially progressive retinal disease) - may be billed by Optometrist		21.40
2040	Retinoscopy, keratometry, tonometry,indirect fundoscopy,fundus photography and prosthetic fitting under general anaesthetic	3+T	178.00
2048	Exophthalmometry		17.70
2046	Gonioscopy (for one or both eyes)		16.20
2047	Dacryocystogram		85.70
2049	Potentiometry		41.40

SPECIAL THERAPY

2109	Injections - subconjunctival		38.60

LACRIMAL APPARATUS

2120	Punctum dilation and syringing sac (operation only)	3+T	41.60
2118	Two or three snip procedure	3+T	81.60
2121	Duct probing - under general anaesthesia (operation only)	3+T	154.30
2122	- under local anaesthesia (operation only)	3+T	38.60
2123	Insertion of Quickert tube	3+T	183.50
2129	Insertion of Lester Jones tube	3+T	488.10
2124	Dacryocystostomy -under general anaesthesia (operation only)	3+T	135.30
2119	- under local anaesthesia (operation only)		38.80
2125	Dacryocystectomy - under local anaesthesia	3+T	482.40
2126	Dacryocystorhinostomy	3+T	964.80
2127	Repair of canaliculi	3+T	624.60
2128	Surgical excision of lacrimal gland	3+T	482.40

ORBIT

2132	Retrobulbar injection of alcohol	2+T	154.20
2133	Enucleation or evisceration	4+T	624.60
2134	Complicated implant (Allan or Iowa)	4+T	772.90
2136	Exploration and/or biopsy of orbit	4+T	385.70

OPHTHALMOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
2137	Exploration and decompression (Kronlein)	4+T	964.80
2139	- anterior orbital tumor	4+T	386.50
2141	Excision of posterior orbital tumor by anterolateral approach	6+T	1,225.70
2143	Lateral orbitotomy with decompression, fat dissection and down-fracture into maxillary sinus	4+T	1,251.40

EYE LIDS

2130	Blepharoplasty, simple, non-cosmetic	3+T	240.60
2131	Blepharoplasty, complicated, non-cosmetic	3+T	520.90
2146	Trichiasis - epilation - forceps	3+T	38.60
2147	- electric	3+T	41.60
2148	Cryotherapy of eyelids for trichiasis or tumor	3+T	153.10
2149	Meibomian gland evacuation	1+T	38.60
2150	Chalazion excision	3+T	96.50
2151	Repair of conjunctiva	1+T	104.60
2152	Tarsorrhaphy	3+T	214.20
2153	Ectropion, Entropion, Ziegler or simple procedure	3+T	104.60
2154	- complicated, including neoplasms and plastic repair	3+T	578.50
2155	Ptosis repair - orbicularis sling - using synthetic material	3+T	729.90
2156	Excision of tumors of lid margins or conjunctiva - benign	3+T	107.20
2157	Excision of benign tumor of lids	3+T	62.70
2158	Fasanella Servat	3+T	344.40
2159	- orbicularis sling - using autologous fascia lata	3+T	833.20
2160	- levator resection	3+T	833.20
2166	Lid elevation and scleral graft for lower lid retraction	3+T	569.20
2100	Graded muellerectomy with levator recession under local anaesthesia	3+T	569.20

EYE MUSCLES

2161	Strabismus - one or two muscles	3+T	642.70

OPHTHALMOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
2162	- three or more muscles	3+T	833.20
2163	- complicated re-operation	4+T	964.80
2164	- adjustable suture surgery		964.80

CORNEA AND SCLERA

2167	Cautery or cryotherapy of corneal ulcer	3+T	62.40
2170	Removal of imbedded corneal foreign body (operation only)		30.40
2171	Pterygium or limbus tumor excision	3+T	214.20
2172	Gunderson type flap	3+T	624.40
2173	Keratoplasty - lamellar	3+T	1,200.90
2175	- penetrating	4+T	1,447.10
2168	- Complicated re-operation NOTE: Fee code 2168, 2173, 2175 includes all suture removals after 42 days	4+T	1,693.60
2174	Suture of cornea and/or sclera with or without iridectomy - simple	4+T	749.90
2169	- complicated	4+T	1,200.90
2176	Posterior sclerotomy with or without insufflation of anterior chamber	4+T	240.60
2165	Sclerokeratectomy with mucous membrane graft	4+T	890.60

INTRAOCULAR

2181	Foreign body intraocular-magnetic extraction	4+T	964.80
2182	non-magnetic (including enucleation, if necessary)	4+T	1,249.70
2177	Glaucoma - peripheral iridectomy	4+T	642.90
2178	- filtering procedures	4+T	857.40
2179	- combined (complicated)	4+T	964.80
2180	- goniotomy	4+T	771.90
2183	- repeat within 3 months	4+T	624.70
2184	- cyclodialysis	4+T	578.80
2185	- cyclodiathermy or cryotherapy	4+T	502.40
2186	- repeat within 3 months	4+T	240.60

OPHTHALMOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
2187	- microsurgical (trabeculectomy or trabeculotomy)	4+T	964.80
2189	Iridocyclectomy via scleral flap dissection	4+T	1,003.50
2188	Cataract - linear extraction, congenital, traumatic or senile	4+T	653.50
2191	- capsulotomy, needling or discission - initial	4+T	386.50
2193	- subsequent	4+T	128.80
2190	Primary intraocular lens implant to include repositioning of lens within the 42 day post-operative period - extra	4+T	210.10
2192	secondary intraocular lens implant to include repositioning of lens within the 42 day post-operative period	4+T	821.90
2196	Surgical repositioning of implant lens NOTE: For non-surgical repositioning, use visit fees	4+T	331.70
2197	Surgical evacuation of hyphema	4+T	893.10
2198	Anterior vitrectomy NOTE: fee code 2198 is intended for cases of vast complication requiring removal of membranes from the anterior segment as a result of prior surgery or injury. It is not intended in conjunction with elective cataract removal and/or primary lens implantation.	4+T	512.90
2090	Vitreous paracentesis	4+T	256.70
2091	Anterior chamber paracentesis	4+T	213.60
2092	Vitreous biopsy	4+T	341.90

RETINAL DETACHMENT

2195	Diathermy or cryopexy	5+T	833.20
2194	Buckling procedure NOTE: Repeat procedures full fee	5+T	1,447.40

PHOTOCOAGULATION OR CRYOPEXY FOR TREATMENT OF OCULAR PROBLEMS OTHER THAN RETINAL DETACHMENT USING PORTABLE YAG LASER

2114	Yag laser, per eye - professional fee		233.80
2115	Yag laser, per eye - technical fee		147.10
2116	Panretinal photocoagulation - defined as greater than 700 burns. Maximum fee for one eye for any 6 month period	4+T	1,245.30
2117	Photocoagulation of second eye during course of treatment of first eye	4+T	334.80

OPTOMETRY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY

These fees cannot be correctly interpreted without reference to the Preamble
** Note: These fees have been established in the absence of a resident Ophthalmologist.

EYE TESTING

These fees are only billable by Optometrist

2215	Problem based eye testing that may include measurment of refractive error, opthalmoscopy, and any or all biomicroscopy, tonometry, eye balance test, keratometry where indicated. NOTE: This fee is billable for medically required testing including ocular disease, trauma or injury; systemic diseases associated with significant ocular risk including but not limited to diabetes, wet macular degeneration and glaucoma; and medications associated with significant risk. *Submissions for payment require a referring physician/Optometrist.	73.20
2216	Surgical follow up monocular	30.00
2217	Surgical follow up binocular	60.00
2218	Binocular Indirect Ophthalmoscopy	30.00
2219	Non surgical follow up	36.60
2019	Tonometry	25.70
2041	Limited visual field examination .i.e. tangent screen, autoplot, arc perimeter, or single level automated test such as octopus program 3 or 7 equivalent	52.80
2039	Fundus photography (limitations – glaucomatous disc changes, tumor progression and potentially progressive retinal disease)	21.40

OTOLARYNGOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

2510	Consultation: To include history, detailed examination of the ear, nose and throat, review of x-ray and laboratory findings and written report	81.60
2511	Consultation including Audiogram (AC and BC), when performed in conjunction with consultation	103.30
2514	Repeat or Limited Consultation: To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	64.40

Continuing Care by Consultant:

2507	Subsequent office visit	21.40
2508	Subsequent hospital visit	21.40
2509	Subsequent home visit	64.40

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250	Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	47.80
0251	Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	131.10
0252	Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	153.50

SPECIAL EXAMINATIONS

The following fees, except for fee codes 9520 and 2521, apply when these special otolaryngological examinations are carried out by/or under the supervision of a certified otolaryngologist.
NOTE: When two or more special examinations are performed by a specialist otolaryngologist on the same subsequent visit, the major examination is to be charged in full and the lesser examinations to be charged at 50% UP TO A MAXIMUM OF THREE EXAMINATIONS, (not to include an audiogram (AB or BC) if done as part of a consultation). No charge will be made for an office visit in addition to these special examinations when examination is done as an adjunct to a consultation.

Hearing Tests

9520	Audiogram - pure tone (AC and BC)	29.80
2521	Audiogram - speech (SRT, PB, MCL)	29.80
2522	Audiogram - SISI	29.80
2523	Audiogram - tone decay	29.80

OTOLARYNGOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
9525	Tympanogram (Impedance test)		29.80
2531	Impedance test, including contralateral reflex		42.80
2533	Play audiometry		42.80
2534	Fee field audiometry		42.80
2536	Brain stem evoked response audiometry		92.30
Vestibular Tests			
2526	Cold Calorics Test		21.40
2527	Bithermal Test		42.80
2528	E.N.G. (Electronystagmography) NOTE: To control the total cost involved in extensive patient investigation the following recommendation applies: Vestibular tests performed on a subsequent visit should have a maximum fee limitation equal to the value of fee code 2528 to be paid directly in lieu of return visit.		86.10
Functional Tests:			
2529	Lombard		29.80
2530	Stenger		42.80
2537	Alternate binaural loudness balance test		31.30
Miscellaneous Tests:			
2535	Maxillary Sinus Endoscopy via canine fossa, with or without biopsy	3+T	162.00

EAR

	Removal of foreign body or aerating tubes from ear - simple		Per Visit
2201	- requiring general anaesthetic (operation only)	1+T	107.00
2208	Mastoid antrotomy (infants)	3+T	432.20
2206	Removal of ear canal osteoma (operation only)	1+T	107.00
2209	Removal of obstructing exostosis of ear canal	3+T	642.90
2210	Paracentesis of the ear drum (operation only)	1+T	64.40
2220	Removal of aural polyp (operation only)	1+T	107.00
2232	Facial nerve decompression involving vertical portion only	4+T	1,071.60
2240	Labyrinthectomy - destructive (any type)	4+T	642.90
2243	Repair bony atresia external ear canal - complete atresia	3+T	1,286.40

OTOLARYNGOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
2244	- partial atresia	3+T	642.90
2247	Simple mastoidectomy	3+T	642.90
2248	Radical mastoidectomy	4+T	1,042.00
2249	Stapes - reconstruction	3+T	937.60
2250	Stapes - mobilization of	3+T	642.90
2251	Myringoplasty repair of drum without exploration of middle ear	3+T	321.90
2252	Tympanoplasty - without ossicular chain reconstruction (repair of ear drum as well as inspection of middle ear by means of a tympanotomy)	3+T	750.70
2264	- with ossicular chain reconstruction	3+T	859.00
2253	- with complete exenteration	3+T	1,288.40
2265	- with partial mastoid exenteration	3+T	964.80
2263	Trans-tympanic polyneurectomy	3+T	642.90
2257	Homograft tympanic membrane - tympanoplasty	3+T	1,213.60
2254	Myringotomy with insertion of aerating tube (operation only)	1+T	107.00
2255	Exploratory tympanotomy	2+T	416.60
2266	Paper patch application to TM perforation	1+T	65.80
2256	Subarachnoid endolymphatic shunt (any procedure)	6+T	1,288.40
2259	Excision of glomus by tympanotomy approach	3+T	859.00
2260	Excision of glomus (where extensive dissection is required)	4+T	1,288.40
2267	Conchal cartilage graft	3+T	750.70

NOSE AND SINUS

	Removal of foreign body from nose - simple		Per Visit
2298	Cryosurgical treatments of turbinates- unilateral	3+T	227.60
2299	Cryosurgical treatments of turbinates- bilateral	3+T	311.80
2301	- Complicated with anaesthetic	2+T	107.00
2303	Cauterization of septum - electric	3+T	42.80
2304	Turbinectomy - unilateral	3+T	146.10
2305	- bilateral	3+T	219.10

OTOLARYNGOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
2306	Submucous resection of septum	3+T	429.70
2307	Nasal antral window - single	3+T	217.50
2308	- double	3+T	311.80
2309	Radical antrostomy	3+T	624.10
2310	- with closure of alveolar fistula	4+T	833.20
2311	Intranasal ethmoidectomy to include polypectomy - complete one side	3+T	624.10
2312	- complete two sides	3+T	833.20
2313	Partial ethmoidectomy to include polypectomy - anterior and middle	3+T	315.40
2314	- bilateral	3+T	415.30
2315	External radical fronto-ethmoidectomy	4+T	935.90
2316	External radical frontal operation	3+T	833.20
2317	Electrocoagulation of turbinates - one side	3+T	86.10
2318	- both sides	3+T	128.80
2319	Trephining frontal sinus	3+T	321.70
2320	Sphenoidectomy (intranasal)	3+T	429.70
2322	Removal of nasal polypi - unilateral	3+T	150.00
2323	- bilateral	3+T	225.00
2324	Antral lavage - unilateral	3+T	32.20
2325	- bilateral Choanal atresia - definitive repair of	3+T	48.40
2326	- unilateral	3+T	642.70
2327	- bilateral Choanal atresia - perforation of	4+T	964.80
2328	- unilateral	3+T	214.50
2329	- bilateral	4+T	320.70
2330	Submucous turbinectomy - unilateral	3+T	214.50
2331	- bilateral	3+T	320.70
Lateral rhinotomy and excision of tumour			
2332	- benign	3+T	749.90

OTOLARYNGOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
2333	- malignant	3+T	964.80
2334	Transantral ethmoidectomy	3+T	859.00
2335	Transantral ligation, internal maxillary artery	6+T	749.90
2337	Ligation of anterior and posterior ethmoid arteries	6+T	535.50
2338	Removal of angiofibroma - nasal pharynx	6+T	1,288.40
2342	Maxillectomy with exenteration of ethmoid	5+T	1,288.40
2339	Palatal fenestration	3+T	429.70
2343	Septal reconstruction	3+T	644.00
2344	Posterior nasal packing (operation only)	3+T	107.40
2345	Drainage of abscess or haematoma of septum (operation only)	3+T	107.40
6121	Nasal fracture - simple reduction	3+T	107.40
6122	- reduction and external splinting	3+T	214.50
6123	- comminuted nasal fractures - transosseous wire plate fixation	3+T	429.70
2348	Operative closure of oral nasal fistula	3+T	644.00
2349	Operative closure of nasal septal perforation	3+T	644.00

RHINOPLASTY

2350	Removal of hump	3+T	320.70
2351	Nasal refracture requiring lateral osteotomies	3+T	644.00
2352	Reconstruction of nasal tip, ala and columella	3+T	749.90
2354	Complete rhinoplasty with SMR to include nasal hump removal, nasal refracture and reconstruction of nasal tip without skin grafting	3+T	1,073.60

THROAT

2400	Incision of peritonsillar abscess (operation only)	4+T	64.40
2401	Tonsils and adenoids - child (to include neonate)	4+T	214.50
2402	- adult	4+T	300.40
2403	Tonsillectomy under local anaesthesia	4+T	320.70
2404	Adenoidectomy - office visits extra, apart from usual one pre and one post-operative visit	4+T	107.40

OTOLARYNGOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
2405	Retropharyngeal abscess	4+T	107.40
2406	- requiring lateral pharyngotomy	4+T	429.70
2407	Tracheostomy (operation only)	5+T	275.70
2408	Removal of tumor from larynx or trachea	5+T	415.30
2409	Uvulo-palato-pharyngoplasty for severe obstructive sleep apnea confirmed by polysomnogram, with or without tonsillectomy	5+T	520.10
2412	Biopsy of larynx and/or cauterization (including laryngoscopy)	5+T	214.50
2413	Operative control of post-tonsillectomy or post-adenoidectomy hemorrhage requiring local or general anaesthetic	6+T	171.80
2415	Esophagoscopy with removal of foreign body	3+T	300.40
2416	Dilation of oesophagus	2+T	107.40
2417	- repeat within one month	2+T	64.40
2420	Dilation of trachea	5+T	107.40
2421	- repeat within one month	5+T	64.40
2422	Tracheostomy Tube Change (operation only) to be billed in addition to office visit		12.60
2425	Arytenoidectomy	5+T	859.00
2426	Bronchoscopy with removal of foreign body	6+T	520.90
2427	Microlaryngoscopy	5+T	128.80
2428	Microlaryngoscopy with biopsy of larynx and/or cauterization	5+T	279.20
2429	Microlaryngoscopy and removal of tumor from larynx or trachea	5+T	478.20
2433	Vocal cord implant - injection	5+T	535.50
2434	- external approach	5+T	965.20
2438	Trans-oral cricopharyngeal myotomy	5+T	715.70

INTERNAL MEDICINE

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

0310	Consultation: To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report		216.20
0312	Repeat or Limited Consultation: Where a consultation for same illness is repeated within six (6) months of the last visit by the consultant or where in the judgment of the consultant the consultative service does not warrant a full consultative fee		108.00
0314	Prolonged visit for counselling (maximum four (4) per year applies to Insured Health Services and YWCHSB only)		77.20

Continuing Care by Consultant

0306	Directive care		42.80
0307	Subsequent office visit		42.80
0308	Subsequent hospital visit		33.00
0309	Subsequent home visit		64.40

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250	Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care		47.80
0251	Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays		131.10
0252	Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care		153.50

EXAMINATIONS BY CERTIFIED INTERNIST

9316	Electrocardiogram and interpretation- in office by internist - each		42.70
9317	Electrocardiogram and interpretation - in home by internist - each		65.20
0318	Electrocardiogram - professional fee		21.40
9401	- technical fee		27.30
0322	Internists' part in cardioangiogram, per hour or fraction thereof		86.10
0325	Cardioversion NOTE: The procedural fee does not include the consultation fee or follow-up daily visits. If more than one cardioversion is performed on any patient in a single day, this is to be treated as a special case and a written report should accompany the account	6+T	151.80

INTERNAL MEDICINE

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
Polarcardiography and interpretation			
0327	- professional fee		72.70
9427	- technical fee		78.20
0330	Temporary right ventricular pacemaker catheter placement, using external battery pack - internist or other qualified physicians	4+T	303.40
0332	Pacemaker standby and/or placement of the endocardial catheter	4+T	151.80
0333	Generator placement and venous cutdown	4+T	498.00
0334	Graded exercise test (performance and interpretation)		130.30
0335	- professional fee		83.70
0336	- technical fee NOTE: This test involves controlled graduated exercise levels by the use of either a bicycle or treadmill ergometer with continuous electrocardiographic monitoring during and after exercise. At least two exercise work levels must be measured, exclusive of a warm-up period, and reproducible exercise and post-exercise records must be obtained. When only one level of exercise testing is performed, then the same fee as for a Master Two-Step should apply. When a 23 lead cardiogram is done on the same day as the graded exercise test, it is included in fee code 0334. A graded exercise tolerance test may be repeated once within one year to assess functional capacity of patient after recovery from coronary by-pass surgery and to assess the affect of therapy where exercise has produced a serious ventricular rhythm disturbance. In all other circumstances, where graded exercise tests are repeated within one year a letter of explanation for the need will accompany the account to the payment agency except in conjunction with thallium myocardial scans where a graded exercise test may be performed and charged with each scan.		46.40
0337	Replacement transfusion - hepatic failure to include two weeks care after transfusion NOTE: Consultation and necessary hospital visits prior to initial transfusion, extra		541.00
0338	Plasmapheresis - therapeutic		214.50
0340	Scanning of 8 hour electrocardiogram		128.80
0341	- professional fee		82.90
0342	- technical fee		45.90
0343	Cardiac Screening (maximum 3 a month within manufacturer's guarantee and one a week beyond manufacturer's guarantee)		8.70
0344	- professional fee		4.30
0345	- technical fee		4.30

INTERNAL MEDICINE

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
Scanning of 24 hour electrocardiogram			
0347	- professional fee		126.80
0348	- technical fee for ECG		47.80
0349	- technical fee for scanning Level I: Requires a recorder capable of recording all beats and transmitting this information to a scanner which is capable of analyzing and printing every beat and also performing edited trend analysis, and/or edited graphic or alpha-numeric hourly summary of data		85.90
0363	Level II: Requires a recorder capable of recording all beats and transmitting this information to a scanner which is capable of analyzing and printing every beat and also performing unedited trend analysis, and/or unedited graphic or alpha-numeric hourly summary of data		64.60
0364	Level III: Requires a recorder capable of recording only a portion of each minute, or a pre-determined time period after an abnormal complex is sensed The scanner of this record is capable of analyzing the data and printing all beats in the pre-determined time period and analyzing the ST segment, heart rate and ectopic beat frequency		42.80
0365	Level IIII: a) Requires a recorder capable of recording beats for only a portion of a minute and feeding this information into a scanner through an adaptor that feeds the information to the standard ECG machine b) Requires a recorder capable of recording all beats and feeding the information into an alpha-numeric device which prints an hourly maximim R-R intervals, premature beats, and ventricular complexes of abnormal width		21.50
0372	Measurement of Bone Mineral content in vivo using photon absorptiometry		72.90
Intracardiac Electrophysiological Mapping			
0366	- initial study		1,229.60
0367	- restudy		246.40
0368	Esophageal or intra-atrial electrophysiological study		184.00
Chemotherapy			
0382	Cancer Chemotherapy visit: To include the administration of multiple parenteral chemotherapeutic agents, history and physical examination as necessary to document disease status, counselling of patient and/or family, review of pertinent laboratory and radiologic data, venesection and institution of an intravenous line. This service will not be billed more than once every twenty-eight days (time taken must be in excess of 1 hour).		147.20

INTERNAL MEDICINE

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
0383	Limited Cancer Chemotherapy visit: To include the administration of single or multiple parenteral chemotherapeutic agents, history and physical examination as necessary to document disease status, counselling patient and/or family, review of pertinent laboratory and radiologic data, venesection and institution of an intravenous line. NOTE: This item is not to be billed more than once every seven days. Neither is it to be billed for routine administration of 5-fluorouracil as a single agent.		73.50

RHEUMATOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

3310	Consultation: To consist of examination, review of history, laboratory, x-ray findings and additional visit necessary to render a written report	223.60
3312	Repeat Limited Consultation: Where a consultation for same illness is repeated within six months of the last visist by the consultant, or where in the judgement of the consultant, the consultative services do not warrant a full consultative fee	111.90
3314	Prolonged visit for counselling	79.80

Continuing Care By Consultant

3307	Subsequent office visit	44.40

NEUROLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

0410	Consultation: To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report	216.20
0411	Repeat or Limited Consultation: Where a consultation for the same illness is repeated within six (6) months of the last service by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	108.20

Continuing Care by Consultant:

0406	Directive care	42.80
0407	Subsequent office visit	42.80
0408	Subsequent hospital visit	32.80
0409	Subsequent home visit	64.40

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250	Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	47.80
0251	Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hour of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	131.10
0252	Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	153.50

BOTULINUM TOXIN INJECTIONS

**These fees are only billable by Neurologist*

0473	Botulinum Toxin Injection for Blepharospasm associated with dystonia (including benign essential blepharospasm) or VII nerve disorders -unilateral or bilateral	176.50
0424	Botulinum Toxin Injection only applicable to Cervical Dystonia (spasmodic torticollis); adductor spasmodic dysphonia, jaw-closing oro-mandibular dystonia or hemifacial spasm, dynamic equines foot deformity due to spasticity in paediatric cerebral palsy patients, focal spasticity including the treatment of upper limb spasticity associated with strokes in adults	206.00

NEUROSURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

3010	Consultation: To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report		128.80
3011	Repeat or Limited Consultation: Where a consultation for the same illness is repeated within six (6) months of the last service by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee		64.40

Continuing Care by Consultant:

3007	Subsequent office visit		21.40
3008	Subsequent hospital visit		32.20
3009	Subsequent home visit		64.40

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250	Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care		47.80
0251	Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays		131.10
0252	Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care		153.50

CRANIAL NERVES

3101	Supra or intra orbital nerve avulsion	3+T	147.40

TRAUMA

3111	Elevation of simple depressed skull fracture	5+T	822.10
3112	Elevation of compound depressed skull fracture	6+T	1,351.40
3113	Elevation of compound depressed skull fracture with repair of dura, debridement of cerebral laceration and sinuses	6+T	1,500.20
3115	Exploration of subdural space for chronic subdural hematoma - unilateral or bilateral	6+T	964.80
3116	Craniotomy for evacuation of intracranial hematoma (cerebral sub-dural, extradural or abscess)	8+T	1,579.30
3118	Craniotomy for repair of CSF leak	8+T	1,503.20
3119	Craniotomy for microvascular decompression of cranial nerve	8+T	1,928.80

NEUROSURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
CEREBRAL PROCEDURES			
3126	Re-opening or removal of bone flap	6+T	616.90
EXTRA-CRANIAL VASCULAR PROCEDURES			
7237	Carotid endarterectomy	8+T	1,145.30
SPINAL			
3165	Insertion of intracranial pressure monitoring device (operation only)	6+T	441.80
3167	Insertion of skull tongs (operation only)	4+T	214.50
3173	- in conjunction with orthopaedic surgeon (operation only)	6+T	959.00
PERIPHERAL NERVE			
3191	Minor, digital, primary suture or secondary	2+T	320.70
3192	Repair of palmar nerve	2+T	320.70
3193	Major, primary suture	2+T	644.00
3195	Exploration of peripheral nerve and neurolysis	2+T	429.70
3196	Exploration, mobilization and transposition	2+T	529.90
3198	Neurectomy of major nerve	2+T	320.70
3200	Secondary suture including transposition	3+T	859.00
3201	Secondary suture of major nerve	3+T	744.60
3204	Hypoglossal facial anastomosis	4+T	744.60
3205	Nerve graft	3+T	644.00
7751	Cervical or dorsal sympathectomy	5+T	787.40
7753	Lumbo-dorsal sympathectomy and splanchnic neurectomy - unilateral	7+T	787.40
MISCELLANEOUS			
3211	Muscle biopsy		107.40

OBSTETRICS AND GYNAECOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

4010	Consultation: To include complete history and gynaecological examination, review of x-ray and laboratory findings, if required, and written report or consultation during labour		151.80
4012	Repeat or Limited Consultation: To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee		70.20

Continuing Care by Consultant:

4007	Subsequent office visit		46.00
4008	Subsequent hospital visit		42.40
4009	Subsequent home visit		70.20

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250	Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care		47.80
0251	Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays		131.10
0252	Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care		153.50

OBSTETRICAL PROCEDURES

4020	Emergency obstetric consultation including complicated vaginal surgery	4+T	323.20
4021	Emergency obstetric consultation including complicated delivery NOTE: This is the maximum fee for emergency obstetric consultation	4+T	500.20
4022	Repair of complete separation of external sphincter (operation only) (Third degree tear)	3+T	170.30
4023	Repair of extensive cervical and/or vaginal lacerations (operation only)	3+T	170.30
4090	Prenatal visit - complete examination		81.00
4091	- subsequent examination		37.60
4092	Initial Pregnancy Counselling minimum time per visit 20 mins (1 per pregnancy)		82.50

OBSTETRICS AND GYNAECOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
4100	Extraordinary events during labor (eg. fetal distress, antepartum hemorrhage, maternal fever) where immediate assessment of the patient by the physician is required and the physician is specifically called by the nurse. This is not to be billed for routine monitoring of the laboring patient and must include call back time.		37.60
4108	Delivery only (50% extra for each additional neonate delivery) NOTE: For consideration of premiums, the time of delivery shall be the time of the birth of the newborn		582.10
4109	Post-natal care of mother in hospital		86.30
4110	Six weeks post-partum check of mother plus pap smear NOTE: (If IUD is inserted, 50% of fee code 4540 may be charged in addition)		71.40
4105	Caesarean section	5+T	646.30
4106	Caesarean hysterectomy	8+T	729.70
4111	Therapeutic abortion (vaginal) - by whatever means - less than 12 weeks gestation (operation only)	1+T	214.50
4112	- 12 weeks gestation or over	1+T	415.30
4113	Obstetrical assist - to be billed in complicated delivery by the family physician who supervised the labour when the neonate was delivered by a consultant. *This shall cover the first stage and 2 hours of the second stage of labour		449.40
4117	Curettage for post-partum hemorrhage or retained placenta	3+T	214.20
4118	Induction or stimulation of labour by oxytocin intravenous drip, where constant attendance by the physician in attendance is required - per half hour; maximum 10 hours		87.40
4119	Inpatient or outpatient insertion of prostaglandin vaginal gel for ripening and/or induction of labor		37.60
4120	External cephalic version		55.20
4199	MANAGEMENT OF PROLONGED SECOND STAGE: This item is billable in addition to fee code 4108 or 4113 after the second stage of labour exceeds 2 hours (may begin at transitional stage of 8 cm). The physician must be in personal attendance for duration of second stage. Both start and end time is required on the claim submission. In excess of 2 units will be assessed by the Medical Advisor on the basis of a written report. Per half hour or major portion thereof		87.40
4299	MANAGEMENT OF PROLONGED THIRD STAGE: This item is billable after the third stage exceeds 45 minutes for such reasons as postpartum hemorrhage, manual removal of retained placenta or extensive vaginal laceration. It is not payable if fee code 4022, 4023 or 4428 is billed. The physician must be in personal attendance for the duration of the third stage. Both start and end time is required on the claim submission. In excess of 2 units will be assessed by the Medical Advisor on the basis of a written report. Per half hour or major portion thereof		87.40

OBSTETRICS AND GYNAECOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
ABDOMINAL OPERATIONS			
4200	Hysterectomy - subtotal	5+T	750.10
4201	- total	5+T	859.00
4202	- vaginal	4+T	859.00
4203	- Myomectomy	5+T	643.90
4204	Abdominal hysterotomy with or without sterilization	5+T	643.90
4205	Removal of ectopic pregnancy, abdominal or vaginal route	5+T	643.90
4206	Suspension of uterus	4+T	535.50
4207	Removal of ovarian cysts and/or salpingectomy	5+T	535.50
4208	Removal of complicated pelvic disease	6+T	1,073.60
4209	Abdominal excision of cervical stump	3+T	859.00
4213	Sterilization by abdominal or vaginal route	4+T	415.30
4215	Wedge resection of ovaries	5+T	643.90
4217	Post-operative hemorrhage (intra-abdominal management)	6+T	429.70
OPERATIONS ON THE VULVA			
4300	Incision of hymen (operation only)	1+T	64.40
4301	Excision or marsupialization of a Bartholin's cyst	1+T	214.50
4302	Incision and drainage of Bartholin's abscess (operation only)	1+T	64.40
4303	Excision of hydrocele or canal of Nuck	1+T	320.70
4304	Urethral caruncle - cautery or excision in hospital	1+T	107.40
4305	Venereal warts, cautery or excision (not for application of phodophyllin) (operation only)		42.80
4306	Excision of venereal warts under general anaesthesia in hospital	1+T	214.50
4309	Varicocele of labium	1+T	214.50
4312	Resection of labia minora	1+T	214.50
4315	Biopsy of vulva	1+T	64.40

OBSTETRICS AND GYNAECOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
OPERATIONS ON THE VAGINA			
4401	Repair of recto-vaginal fistula	3+T	858.50
4403	Colpotomy - open	1+T	107.40
4402	Colpotomy with drainage pelvic abscess	1+T	214.50
4404	Removal of vaginal inclusion cyst	1+T	64.40
4405	Removal of other vaginal cyst	1+T	320.70
4406	Operation for removal of vaginal septum	1+T	214.50
4408	Vault prolapse following hysterectomy	4+T	859.00
4409	Excision of cervical stump with anterior and posterior repair	3+T	750.10
4410	Post-operative hemorrhage - vaginal management requiring anaesthesia	5+T	214.50
PLASTIC OPERATIONS OF GENITAL PROLAPSE			
4420	Repair of cystocele	2+T	535.50
4421	Repair of rectocele	2+T	535.50
4422	Repair of enterocele	2+T	750.10
4423	Repair of cystocele and rectocele combined	2+T	750.10
4425	Vaginal hysterectomy with complete repair	4+T	1,179.70
4426	Repair of cystocele or rectocele with abdominal hysterectomy or laparotomy	4+T	1,179.70
4427	LeFort's operation	2+T	535.50
4428	Primary repair of fourth degree perineal laceration	2+T	204.30
4429	Repair of old third degree perineal laceration	2+T	643.90
4432	Repeat vaginal plastic procedure (additional fee)	2+T	214.50
4431	Retropubic operation for urinary incontinence (Burch Procedure)	2+T	750.10
VAGINAL OPERATIONS ON THE CERVIX AND UTERUS			
4500	Dilation of cervix and curettage (prenatal and pre-operative visits extra)	1+T	171.80
4502	Repair of cervix	1+T	214.50
4503	Cryosurgery of cervix	1+T	174.50
4505	Removal of cervical polyp in office		42.80

OBSTETRICS AND GYNAECOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
4506	Removal of cervical polyp with dilation and curettage (pre-operative visits extra)	1+T	171.80
4508	Biopsy of cervix under general anaesthesia	1+T	107.40
4510	Biopsy of cervix with dilation and curettage - total (pre-operative visits extra)	1+T	171.80
4513	Vaginal repair of vesico-vaginal fistula	3+T	858.50
4514	Repair of incompetent cervical os	2+T	429.70
4515	Removal of buried cervical ligature under anaesthesia	2+T	107.40
4218	Hysteroscopic endometrial resection and ablation	2+T	413.30
4528	Laparoscopic excision of endometriosis to include transection of uterosacral liagaments. This fee is not to be billed in addition to fee code 4529	4+T	415.30
4529	Cauterization of endometriosis at laparoscopy or laparotomy		64.40
4530	Cauterization of cervix under general anaesthesia	1+T	86.10
4531	Cauterization of cervix with dilation and curettage (pre-operative visits extra)	1+T	171.80
4533	Electric cauterization of cervix in office		33.50
4536	Dilation and curettage with cone biopsy of cervix for abnormal cytology under general anaesthesia	2+T	300.40
4540	Insertion of intrauterine contraceptive device (IUD) or Laminaria tent(s) (operation only)	1+T	38.10
4541	Retrieval of lost or retained IUD via intrauterine hook, curettage or forceps (operation only)		62.20
4545	Artificial insemination (operation only)		64.40
4550	Vaginal removal of cervical stump - open peritoneum	3+T	429.70

MISCELLANEOUS

4610	Obstetric/Gynaecology ultrasound (professional fee) (assessment of multi-gestation can be billed at 50% for each additional fetus)		70.20

ORTHOPAEDICS

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

5010	Consultation: (In office or hospital) To include a history and physical examination, review of x-ray and laboratory findings, and a written report		117.30
5012	Repeat or Limited Consultation: To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee		64.40
5015	Orthopaedic special consultation: Extended consult for complex problems (ie., oncology, complex trauma, adult cerebral palsy etc.), when requested by another Orthopaedic Surgeon, Neurosurgeon, Plastic Surgeon or Rehabilitation Physician. Includes history, physical examination, review of x-rays and written report		234.70

Continuing Care by Consultant:

5007	Subsequent office visit		33.50
5008	Subsequent hospital visit		21.40
5009	Subsequent home visit		64.40

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250	Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care		47.80
0251	Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emeregency care NOTE: This fee to be charged during the hourse of 0800 and 2259 on Saturday, Sunday and Statutory Holidays		131.10
0252	Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care		153.50

FRACTURES

Upper Extremity

	Finger phalanx or metacarpal - not requiring reduction		Per Visit
5201	Finger phalanx, requiring reduction	1+T	171.70
5203	Metacarpal, requiring reduction	1+T	171.70
5225	Distal phalanges - open reduction and wiring - first	2+T	320.70
5226	- each additional (extra)	2+T	171.70
5227	Other than distal phalanges - open reduction and wiring - first	2+T	535.50

ORTHOPAEDICS

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
5228	- each additional (extra)	2+T	257.70
5229	Crush injury of hand with multiple fractures - closed reduction	2+T	320.70
5206	- open reduction NOTE: To include wiring if applicable	2+T	535.50
5205	Base of 1st metacarpal (Bennett's)	2+T	257.70
5207	Scaphoid (intra-articular)	2+T	314.90
5209	Radius and/or ulna at wrist - requiring reduction	2+T	277.70
5210	- greenstick requiring reduction	1+T	148.90
5211	Radius or ulna shaft, closed reduction	2+T	257.70
5212	Radius and ulna shaft, complete displacement requiring closed reduction	2+T	535.50
5213	Head of radius - closed reduction	2+T	214.50
5214	Resection head of radius	2+T	429.70
5215	Olecranon - closed reduction	2+T	214.50
5216	Olecranon and humeral epicondyles	2+T	320.70
5217	Humerus shaft - requiring reduction	2+T	320.70
5219	- open reduction	2+T	320.70
5220	Supracondylar (humerus)	2+T	535.50
5221	Surgical neck of humerus - requiring reduction	2+T	320.70
5222	Clavicle - child		Per Visit
5224	- adult	1+T	171.70
5223	- open reduction	2+T	257.70
5231	Intercondylar (humerus)	2+T	750.00
5232	Intercondylar (humerus) - not requiring reduction		Per Visit
Chest			
	Sternum		Per Visit
	Ribs - single or multiple		Per Visit
Spine			
5233	Spine - non-operative management of unstable fracture	4+T	643.90

ORTHOPAEDICS

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
5230	Coccyx - operative	4+T	257.70
Pelvis			
5235	Simple - without displacement		Per Visit
5236	Non-operative management of unstable and complicated fracture	4+T	643.90
Lower Extremity			
5238	Femur - neck or intertrochanteric (including slipped epiphysis) - closed reduction with fixation	4+T	429.70
5239	Femur - neck or intertrochanteric-operative	5+T	1,073.60
5240	Femur - shaft or supracondylar - closed reduction with or without anaesthetic - infant	4+T	320.70
5241	- child	4+T	535.50
5242	- adult	2+T	750.00
5243	Femur - shaft - open reduction	5+T	1,073.60
5249	- supracondylar - open reduction	5+T	1,073.60
5246	Vastus medialis advancement	4+T	429.70
5247	Patella - simple - closed reduction	2+T	214.50
5248	- excision or open reduction, including wiring	2+T	429.70
5250	Stapling of proximal tibial and distal femoral epiphyses	2+T	750.10
5251	Tibial condyles - (plateau) not requiring reduction		214.50
5252	- (plateau) requiring reduction	2+T	429.70
5253	Tibia shaft closed reduction	2+T	535.50
5244	- open reduction	3+T	859.00
5254	Tibia - medial malleolus	2+T	214.50
5255	Tibia and fibula bimalleolar or trimalleolar	2+T	429.70
5256	Surgery for dislocating patella - involving plication of medial capsule plus transposition of patellar tendon	2+T	643.90
5257	Quadriceps myoplasty	3+T	643.90
5266	Crush injury of foot with multiple fractures - closed reduction	2+T	320.70
5267	- open reduction	2+T	535.50
5270	Fibula - malleolus - closed reduction	2+T	320.70

ORTHOPAEDICS

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
5271	Fibula - shaft or malleolus - not requiring reduction		148.90
5272	Os calcis - closed reduction	2+T	320.70
5273	Fracture - neck of talus	2+T	320.70
5274	Tarsal bones - closed reduction	2+T	214.50
5275	Metatarsal bone - closed reduction - one	2+T	148.90
5276	- two or more	2+T	214.50

DISLOCATIONS

5300	Reduction of dislocation other than shoulder without anaesthetic		42.70
5301	Temporo-mandibular joint - dislocation - closed reduction	1+T	107.40
5303	Clavicle - acromio-clavicular - requiring open reduction	2+T	643.90
5304	Shoulder - closed initial reduction	1+T	148.90
5305	- closed recurring reduction	1+T	107.40
5306	- open reduction to recurrent - Bankart	3+T	1,089.70
5307	Elbow - closed reduction	1+T	148.90
5308	Carpal bones - closed reduction (Lunate)	1+T	148.90
5309	- open reduction	2+T	429.70
5310	Metacarpophalangeal or interphalangeal joint - closed reduction	1+T	64.60
5311	- open reduction	2+T	257.70
5312	Hip - closed reduction	2+T	429.70
5313	Patella - closed reduction	1+T	107.40
5314	Knee - open primary repair of ruptured ligaments (with or without meniscectomy)	3+T	750.00
5315	Ankle - closed reduction	2+T	214.50
5316	Astragalus - closed reduction	2+T	214.50
5317	Metatarsal bone - closed reduction	1+T	64.60
5318	Toe - closed reduction	1+T	64.60
5319	Vertebra - closed reduction	4+T	429.70
5320	Congenital dislocation of hip - closed reduction	4+T	535.50

ORTHOPAEDICS

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
5321	- open reduction	6+T	964.80

FRACTURE-DISLOCATIONS

5400	Hip - central, anterior or posterior: - closed reduction	2+T	643.90
5401	- open reduction	4+T	1,073.60
5402	Vertebra - closed reduction	4+T	643.90
5403	- open reduction with internal fixation or fusion	6+T	1,288.40
5404	Astragalus - closed reduction	2+T	429.70
5405	- open reduction	2+T	643.90
5406	Carpus - closed reduction	1+T	320.70
5407	- open reduction	2+T	429.70
5408	Monteggia fracture - dislocation of elbow - closed reduction	2+T	535.50
5409	- open reduction	2+T	750.00
5410	Head of humerus - closed reduction	2+T	535.50
5411	- open reduction	2+T	750.00
5412	Dislocated elbow with fractured epicondyles - closed reduction	1+T	352.40
5413	- open reduction	2+T	484.10
5414	Ankle - closed reduction	2+T	429.70
5415	- open reduction	2+T	643.90

AMPUTATIONS

Upper Extremity

5420	Disarticulation - interscapulo-thoracic	5+T	1,073.60
5421	Shoulder disarticulation	4+T	859.00
5422	Upper arm	3+T	535.50
5423	Forearm	3+T	535.50
5424	Hand	2+T	535.50
5425	Transmetacarpal	2+T	320.70

ORTHOPAEDICS

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
5426	Finger - any joint or phalanx	2+T	214.50
Lower Extremity			
5430	Disarticulation - interpelvic-abdominal	6+T	1,643.20
5431	Disarticulation - hip	6+T	1,073.60
5432	Thigh (all levels) including knee	4+T	643.90
5433	Leg	4+T	535.50
5434	Ankle - Syme, Pirogoff	2+T	643.90
5435	Foot - mid or trans-metatarsal	2+T	429.70
5436	Metatarsal - with toe	2+T	214.50
5437	Toe - any joint or phalanx	2+T	86.10
5438	Secondary closure for amputations up to 50% of original fee not to exceed	2+T	320.70

OSTEOTOMY AND EXCISION

5460	Minor bones, eg. phalanges, metatarsals	2+T	214.50
5461	Major bones, eg. tibia, humerus	2+T	643.90
5462	Subtrochanteric of femur (McMurray)	4+T	1,288.40
5473	Innominate osteotomy (Salter)	6+T	854.80
5463	Phalangectomy - Hammer Toe	2+T	150.40
5464	Osteomyelitis - Saucerization, muscle flap or bone graft	3+T	859.00
5465	- saucerization and sequestrectomy	3+T	643.90
5467	- incision subperiosteal abscess	2+T	107.40
5474	Decompression of acute osteomyelitis	3+T	640.80
5468	Local excision of bone tumor - benign Local excision of bone tumor - malignant - bill under fee code 5999	3+T	429.70
5469	Local excision of bone spur	1+T	107.40
5470	Excision of acromion or outer end of clavicle	2+T	535.50
5471	Excision of clavicle	3+T	535.50
5472	Excision accessory tarsal scaphoid (Kidner)	2+T	429.70

ORTHOPAEDICS

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
ARTHROTOMY			
(including removal of loose or foreign bodies, including osteochondritic disease, if necessary).			
5501	Wrist, elbow, ankle or tarsal	2+T	320.70
5502	Hip	4+T	429.70
5508	Shoulder	2+T	429.70
5503	Knee	3+T	320.70
5504	Knee, transarthroscopic meniscectomy	3+T	683.80
5505	Knee (meniscectomy)	3+T	429.70
5506	Stripping of lateral epicondyle for tennis elbow	2+T	320.70
5507	Pes anserinus transfer	2+T	429.70
5511	Fixation of osteochondral fragments with bone graft peg	3+T	535.50
ARTHROPLASTY			
5522	Interphalangeal or metacarpophalangeal - capsulotomy, arthroplasty and arthrodesis	2+T	320.70
5514	Metatarsal phalangeal joint - silastic	2+T	429.70
5528	Obliteration nail bed - great toe (Zadic)	2+T	214.50
5529	Total hip prosthesis	6+T	1,932.40
5525	Metatarso-phalangeal (Keller, McBride)	2+T	320.70
5526	Mitchell osteotomy - unilateral	2+T	429.70
5527	- bilateral	2+T	643.90
5513	Glenohumeral - total shoulder	7+T	1,387.50
5524	Total knee joint replacement	5+T	1,600.50
ARTHRODESIS			
5530	Knee, shoulder, elbow, ankle	3+T	1,177.00
5531	Hip	6+T	1,502.90
5532	Sacroiliac	6+T	744.60
5533	Wrist	2+T	744.60
5538	Foot - subtalar, mid-tarsal, triple, Grice-Green	2+T	744.60

ORTHOPAEDICS

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
5539	Interphalangeal or metacarpophalangeal	2+T	320.70

FASCIAL REPAIRS

5544	Meniscal Reattachment	2+T	439.60
5554	Major knee ligament reconstruction - medial or lateral sides	3+T	1,089.70
5555	- medial and lateral sides	3+T	1,632.50
5553	Patellar shaving	2+T	429.70

TENODESIS BONE GRAFTING

5560	Femur - neck	4+T	859.00
5561	Shaft	3+T	1,073.60
5562	Tibia	3+T	859.00
5563	Humerus	2+T	859.00
5564	Radius and ulna	2+T	859.00
5565	Radius or ulna	2+T	535.50
5566	Metacarpal, Phalanx	2+T	429.70
5568	Tibial or fibular malleolus	2+T	535.50
5572	Scaphoid	2+T	535.50
5571	Bone graft-clavicle	2+T	859.00
5573	Harvesting of live bone for grafting (in conjunction with open reduction), extra	2+T	413.20

PLASTER CASTS IN NON-FRACTURE CASES AND FOR FRACTURES NOT REDUCED

Initial application of cast to be charged in addition to visit fee. If assessment including x-ray are required for subsequent recasting, then visit and cast fee allowed. If only minimal reassessment prior to recasting is required, cast fee only should apply. See also clause 12 (C) of Preamble.

5580	Finger or toe	21.40
5581	Short arm (elbow to hand)	32.50
5583	Long arm (axilla to hand)	42.80
5584	Shoulder spica	107.40
5585	Ankle (foot to midleg)	42.80

ORTHOPAEDICS

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
5586	Knee (foot to thigh)		42.80
5587	Walking cast		42.80
5588	Hip spica - unilateral		107.40
5589	- bilateral		128.80
5590	Body - shoulder to hips	2+T	107.40
5591	Body - including head (Minerva)	2+T	150.40
5592	Petrie abduction cast		128.80
5593	Cast brace for fractured femur		396.40

MISCELLANEOUS

5600	Manipulation of any joint under general anaesthetic other than for dislocation or fracture (operation only) - Casting extra at 100%	2+T	107.40
5601	Irrigation of joint	1+T	42.80
5604	Application of Denis-Browne Splint with adhesive tape		42.80
5607	Removal pins and screws (operation only)	2+T	209.10
5608	Removal of plates, intramedullary rods	2+T	320.70
5612	Bone biopsy - open	2+T	150.40
5613	Reconstruction of rheumatoid hand joints multiple eg. synovectomy, intrinsic release, repositioning of extensor tendons, each hand: Fee for service at any one operative session - up to	3+T	1,717.70
5614	Forefoot reconstruction - per individual items up to maximum of	3+T	750.10
5615	Finger joint prosthesis - first joint	2+T	320.70
5616	- subsequent joints same sitting	2+T	157.40
5620	Synovectomy of hand joint	2+T	429.70
5621	Intrinsic release	2+T	429.70
5625	Orthopaedic interpretation of submitted x-ray films		42.60
5626	Synovectomy of flexor or extensor tendons in wrist or hand for rheumatoid disease	2+T	643.90
5627	Iliopsoas transplant	4+T	1,173.90
5629	Synovectomy of knee joint	3+T	859.00

ORTHOPAEDICS

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
5630	Closed digital tenotomy - first	1+T	150.40
5631	- each additional	1+T	21.40
5632	Digital neuroma excision	1+T	214.50
5633	Epiphyseal arrest, femur and/or tibia	2+T	643.90
5634	Jones tenosuspension	2+T	429.70
5635	Tendon achilles	2+T	399.10
5637	Proximal hamstring release Resection volar carpal ligament - see fee code 3195	2+T	429.70
5640	Rotator cuff tear repair	3+T	1,089.70
5642	Skeletal traction	1+T	128.80
5646	Reconstruction lateral ligaments of ankle	2+T	643.90
5643	Halo skeletal traction	4+T	429.70

PAEDIATRICS

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

0510	Consultation: To consist of an examination, review of history, laboratory, x-ray findings and additional visits necessary to render a written report	214.50
0512	Repeat or Limited Consultation: Where a formal consultation for the same illness is repeated within six (6) months of the last visit by the consultant or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	107.40
0514	Prolonged visit for counselling NOTE: Insured Health Services and YWCHSB will pay up to four such visits per year (see clause 19 of the Preamble)	107.40

Continuing Care by Consultant

0506	Directive care	47.50
0507	Subsequent office visit	58.60
0508	Subsequent hospital visit	47.00
0509	Subsequent home visit	64.60

NOTE: For premature care or intensive care of a newborn see clause 15 and 20 of the preamble.

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250	Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	47.80
0251	Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	131.10
0252	Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent emergency care	153.50

SPECIAL PROCEDURES

0522	Emotionally disturbed child and/or FAS reporting: Diagnostic interviews or examination, including mental status and treatment recommendation, assessment of parents, guardian or other relatives and written report	372.10
0525	Insertion of intra-arterial infusion line in infants - extra to consultation	88.70

PAEDIATRICS

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
0524	Exchange transfusion - procedural fee NOTE: (i)Charge full fee for all repeat transfusions (ii) Normally an assistant for exchange transfusion is not required. However, in those exceptional cases when one is required, a letter of explanation of need must accompany the account to the payment agency.		552.90
0526	Insertion of intravenous infusion line in children under 5 years - extra to consultation		66.70
0527	Electrocardiogram and interpretation in office by a paediatrician - each		44.20
0528	Electrocardiogram and interpretation in home by a paediatrician - each		66.70
0529	Electrocardiogram - professional fee		17.30
9401	- technical fee		27.30
0530	Graded exercise test - technical fee		32.20
0535	- professional fee NOTE: The note following fee codes 0335 and 0336 in the Internal Medicine Section of this guide applies to fee codes 0530 and 0535		61.00
Electrocardiogram and interpretation for children under 2 years of age:			
0533	- professional fee Paediatrician only		17.30
0534	- technical fee Paediatrician only		49.10
Chemotherapy:			
0582	Cancer Chemotherapy visit: To include the administration of multiple parenteral chemotherapeutic agents, history and physical examination as necessary to document disease status, counselling of patient and/or family, review of pertinent laboratory and radioloigic data, venesection and institution of an intravenous line. This service not to be billed more than once every twenty-eight days (time taken must be in excess of 1 hour)		147.20
0583	Limited Cancer Chemotherapy visit: To include the administration of single or multiple parenteral chemotherapeutic agents, history and physical examination as necessary to document disease status, counselling patient and/or family, review of pertinent laboratory and radiologic data, venesection and institution of an intravenous line. NOTE: This item is not to be billed more than once every seven days. Neither is it to be billed for routine administration of 5-fluorouracil as a single agent		73.50

PSYCHIATRY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

Consultations: (office, home or hospital)

0610	Individual: Diagnostic interviews or examination, including history, mental status and treatment recommendation,with written report	228.30
0622	Emotionally disturbed child: Diagnostic interviews or examination, including mental status and treatment recommendation, assessment of parents, guardian or other relatives and written report	372.10
0623	Multiple disturbed family (3 or more members) simultaneous diagnostic interviews or examination, including mental status of the members, their interactions and written report	372.10
0624	Evaluation interview with family member or guardian without presence of patient - per 1/2 hour session	82.50

Repeat or Limited Consultation: (If a formal consultation for same illness is repeated within six (6) months of the last visit by the consultant, or in the judgment of the consultant the consultative service does not warrant a full consult).

0625	Individual (see fee code 0610)	102.70
0626	Emotionally disturbed child (see fee code 0622)	186.00
0627	Multiple disturbed family (see fee code 0623)	186.00

Continuing Care by Consultant

0607	Office visit to include services such as chemotherapy management and/or minimal psychotherapy	46.20
0608	Hospital visit	47.80
0609	Home visit	72.40

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250	Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	47.80
0251	Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	131.10
0252	Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent emergency care	153.50

PSYCHOTHERAPY

0630	Individual per 1/2 hour	88.80

PSYCHIATRY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
0631	Individual per 3/4 hour		129.00
0632	Individual per 1 hour		170.90
0633	Family - two or more family members (conjoint therapy) per 1/2 hour		100.90
0635	Family - two or more family members (conjoint therapy) per 3/4 hour		151.50
0636	Family - two or more family members (conjoint therapy) per 1 hour NOTE: Where a psychotherapy session extends beyond one (1) hour in a day, a written explanation of need is required by the payment agencies such as out-of-town patient, emergency or like situations		201.70
0637	Group therapy (session runs from 1 1/2 to 2 hours) per patient		38.70

PLASTIC SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

6010	Consultation: To include complete history and physical examination, review of x-ray and laboratory findings, if required, and a written report		127.60
6012	Repeat or Limited Consultation: To apply where a consultation is repeated for same condition within six (6) months of last visit by the consultant or where in the judgment of the consultant the consultative service does not warrant a full consultative fee		64.60

Continuing Care by Consultant:

6007	Subsequent office visit		33.50
6008	Subsequent hospital visit		21.40
6009	Subsequent home visit		64.60

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250	Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care		47.80
0251	Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays		131.10
0252	Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care		153.50

SKIN GRAFTS

NOTE: Additional procedures, other than skin grafts are extra; e.g. bone or tendon grafts, inlay grafts, etc.

Local Tissue Shifts: (Advancements, rotations, transpositions "Z" plasty, etc.)

6019	Single or multiple flaps under 2 cm. in diameter used in repair of a defect(except for special areas as in fee code 6024)	1+T	211.80
6020	Single	2+T	423.70
6021	- with free skin graft to secondary defect	2+T	529.90
6022	Multiple	2+T	844.80
6023	- with free skin graft to secondary defect	2+T	944.90
6024	Eyebrow, eyelid, lip, ear, nose - single	3+T	529.90
6025	- two stages	3+T	844.80
6026	Arterial Island Flap	2+T	630.00

PLASTIC SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
Flaps from a Distance: Direct (2 stages)			
6030	Upper extremity	2+T	844.80
6031	- with free skin graft to secondary defect	2+T	1,059.30
6032	Lower extremity (plaster cast included) NOTE: Further stages at 50% of appropriate fee	2+T	1,274.10
Indirect - tubes, jumps:			
6033	Major stage - per operation	4+T	630.00
6034	Minor stage - per operation	3+T	415.30
6036	Minor stage with free skin graft - per operation	3+T	630.00
6035	Delaying tube or pedicle	3+T	127.60

FREE SKIN GRAFTS: (including mucosa)

Note: In the case of a free skin graft, where a donor is necessary - plastic surgeon -additional 25% of appropriate grafting fee.

Full thickness grafts			
6041	Eyelid, nose, lips, ear	2+T	630.00
6043	Finger tip	2+T	171.70
6040	Finger more than one phalanx	2+T	529.90
6044	Sole or palm	2+T	529.90
6045	Toe pulp graft	2+T	214.50
Split thickness grafts: Non-functional areas: (total area treated, whether at one operation or at staged intervals).			
6046	- less than 6.5 square cm.	2+T	105.80
6047	- 6.5 square cm. to 65 square cm.	2+T	214.50
6048	- 65 square cm. to 650 square cm.	2+T	423.70
6049	For each 6.5 square cm. over 650 square cm. Refrigerated graft - 50% of appropriate fee	3+T	8.80
Split thickness grafts: Functional Areas: NOTE: Multiple operations to functional areas - see Preamble paragraph 11(a)			
6051	Finger tip	2+T	168.60
6050	Regions of - Major joints and hands - early	2+T	630.00
6058	Regions of - Major joints and hands - late with scar excision graft	2+T	859.00

PLASTIC SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
6052	Head and neck - 65 square cm. or less	3+T	423.70
6053	- in excess of 65 square cm.	3+T	630.00
6054	- in excess of 195 square cm.	3+T	1,488.70
Cavity Grafting:			
6055	Eye socket	3+T	715.70
6056	- with mucosa	3+T	1,059.30
6057	Nose	3+T	630.00
6060	Mouth	3+T	859.00
6061	Lining pedicle flaps	3+T	423.70
6062	Bone cavity over 7.4 cm. or more in diameter in large bone eg. Femur	4+T	630.00
6065	- up to 7.5 cm. in diameter in large bone	3+T	429.70
6064	- in small bone, eg. hand or foot	2+T	317.90
Tumors of Skin - removal requiring skin graft:			
6070	If area involved less than 6.5 square cm.	2+T	105.80
6071	- 6.5 square cm. to 65 square cm.	2+T	211.90
6072	- 65 square cm. to 650 square cm.	3+T	423.70
6073	- for each 6.5 square cm.over 650 square cm.	3+T	4.30
Tumors of skin - removal not requiring skin graft:			
6069	Excision of benign tumor of skin or subcutaneous tissue or small scar - face	3+T	105.80
7034	- additional lesions removed at the same sitting (maximum per sitting - five) each		21.40
7035	Excision of benign tumor of skin or subcutaneous tissue or small scar	1+T	71.80
7036	Localized carcinoma of skin, proven histopathologically	1+T	107.40
7037	Excision of large (over 7.5 cm.) benign tumor of skin or subcutaneous tissue where general anaesthetic or regional block is necessary	2+T	150.40
7038	Removal of major benign tumor requiring extensive dissection (accompanied by written report to payment agencies)	2+T	644.00

INJURIES

Wounds - simple:

7030	Minor laceration or foreign body requiring local anaesthesia (operation only)		66.00

PLASTIC SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
7031	Minor laceration or foreign body requiring general anaesthesia (operation only)	1+T	66.00
7032	Extensive laceration (bill if total length of all skin lacerations exceed 15 cm.)	2+T	153.80
Wounds - avulsed and complicated:			
6075	Lips and eyelids	3+T	429.70
6076	Nose and ear	3+T	429.70
6077	Complicated lacerations of the scalp, cheek and neck	3+T	429.70

BURNS

(with or without general anaesthesia - per operation)

General Care - severe only:			
6083	- first hour	2+T	105.80
6084	- subsequent hour (per hour)	2+T	63.60
Local Care			
	- Minor burns		Per Visit
6078	- dressing (in hospital care only)	4+T	42.80
6079	- surgical debridement - for each 5% of body surface	5+T	63.60
6080	- subsequent debridements - for each 5% of body surface (includes dressing)	5+T	31.70
Surgical excision of burnt tissue prior to immediate skin grafting:			
6081	- for first 5% of body surface	5+T	211.80
6082	- for each subsequent 5% of body surface	5+T	105.80

OSTEOMYELITIS

5464	Saucerization, muscle flap or bone graft	2+T	859.00
5465	Saucerization and sequestrectomy	2+T	643.90
5467	Incision subperiosteal abscess	2+T	107.40

BIOPSY

7021	Biopsy of skin or mucosa		64.60
7022	Biopsy of facial area Note: Punch or shave biopsies not to be charged under fee code 7021, 7022		64.60

PLASTIC SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
REGIONAL MANDIBULO-FACIAL			
Fracture-Mandible			
6240	Interdental and intermaxillary wiring	6+T	535.50
6241	Wiring and Gunning splints	6+T	643.90
6242	Open reduction - unilateral	6+T	643.90
6243	- bilateral	6+T	964.80
6244	Open reduction and intermaxillary wiring - unilateral	6+T	750.00
6245	- bilateral	6+T	1,073.60
6246	Removal of sutures, intra-oral splints, etc. under general anaesthesia	4+T	150.40
Fracture-Maxilla (Central mid-third):			
6250	Le Fort I - (Horizontal fractures)	6+T	1,073.60
6251	Le Fort II - (Pyramidal fractures)	6+T	1,073.60
6252	Le Fort III - (Cranio-facial disjunction)	6+T	1,073.60
6253	Open reduction and internal or external craniomaxillary wire suspension with or without intermaxillary fixation	6+T	1,073.60
Fracture-Zygomatic (Lateral mid-third): Zygomatico-maxillary (including Orbital Floor)			
6260	Temporal elevation	3+T	214.50
6261	Open reduction and interosseous wiring (to include antral packing where necessary)	4+T	859.10
6262	Reduction via transantral approach and antral packing	4+T	214.50
Zygomatic Arch:			
6265	Temporal elevation	3+T	214.50
6266	Open reduction and interosseous wiring	4+T	535.50
Orbital Floor Fractures: (Blow-out fractures)			
6270	Open reduction (to include antral packing where necessary)	4+T	750.00
Fracture - Alveolus:			
6271	Alveolar fracture with one tooth extraction	3+T	150.40
6272	- each additional tooth	3+T	42.70
6273	Arch bar fixation of teeth	3+T	429.70

PLASTIC SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
Temporo-Mandibular Joint:			
5301	Dislocation - closed reduction	3+T	107.40
Mandibular Resection:			
6291	Tumors - enucleation, partial or complete resection	4+T	635.50
6292	- with bone graft	4+T	956.30
7500	Resection of mandible	5+T	644.00
6293	Bone graft to jaw or face - autologous	4+T	859.10
6294	- non-autologous	4+T	643.90
Osteotomies:			
6314	Canthopexy	3+T	859.10
6304	Malar Maxillary	6+T	1,460.20
6305	Mandibular - for prognathism, micrognathism, malocclusion, etc. - unilateral with intermaxillary fixation	6+T	830.10
6306	- bilateral with intermaxillary fixation	6+T	1,259.90
6307	Premaxillary set back	6+T	1,044.90
6308	Mandibular osteotomy with rigid internal fixation - unilateral	6+T	1,044.90
6309	- bilateral	6+T	1,460.20
CHEEKS			
6111	Facial paralysis-static stings - unilateral	3+T	936.30
6112	Abrasive surgery - less than one quarter of face	3+T	105.80
6113	- between one quarter and one half of face	3+T	317.90
6114	- full face	3+T	629.80
7525	Salivary fistula - plastic to Stenson's duct	4+T	643.90
NOSE			
Rhinoplasty:			
2350	Removal of hump	3+T	320.70
2351	Nasal refracture requiring lateral osteotomies	3+T	644.00
2352	Reconstruction of nasal tip, ala and columella	3+T	749.90
6118	Bone graft to nose - autologous	3+T	859.10

PLASTIC SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
6119	- non-autologous	3+T	635.50
2354	Complete rhinoplasty with submucous resection to include nasal hump removal, nasal refracture and reconstruction of nasal tip - without skin grafting	3+T	1,073.60
6115	Forehead rhinoplasty - 2 operations NOTE: Partial forehead rhinoplasties charge under fee code 6020 and 6021	3+T	1,274.10
6116	Composite graft	3+T	529.90
6117	Rhinophyma	3+T	423.70
Fractures:			
6121	Simple reduction	3+T	107.40
6122	Reduction and splinting	3+T	214.50
6123	Comminuted nasal fractures - transosseous wire plate fixation	3+T	429.70
6124	Naso-orbital fractures - open reduction and interosseous wiring or transosseous wire plate fixation	3+T	643.90

EARS

6131	Outstanding ears - unilateral otoplasty	3+T	423.70
6132	Microtia or loss of ear-partial - per stage	3+T	423.70
6133	- total - major stage	3+T	635.50
6134	- total - minor stage	3+T	423.70
6130	Accessory auricle	3+T	211.80
6135	Preauricular sinus - simple	3+T	254.90
6180	- complicated	3+T	423.70

MOUTH

7720	Lip shave - vermilionectomy	3+T	429.70
6137	Full lip thickness transfer by rotation flap	4+T	859.00
6140	Wedge resection of lip, vermilion	3+T	148.90
6141	Wedge resection of lip - to sulcus	3+T	317.90
6142	Pharyngoplasty of pharyngeal flap	6+T	744.60

PLASTIC SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
ORBIT			
6153	Bone graft to orbit - autologous	4+T	859.00
6154	- non-autologous implant	4+T	635.50
2153	Ectropion-Entropion-Ziegler or simple procedure	3+T	104.60
2154	- complicated, including neoplasms and plastic repair	3+T	578.50
2159	Ptosis repair - orbicularis sling - using autologous fascia lata	3+T	833.20
2160	- levator resection	3+T	833.20
6148	Direct flat to eyebrow - first stage	3+T	635.50
6149	- Second stage	3+T	317.90
GENITALIA			
Hypospadias, excluding urethrostomy			
8274	- First stage, chordee	2+T	429.70
8275	- Second stage, (penile)	2+T	643.90
8276	- penoscrotal	2+T	859.00
8277	Epispadias - plastic repair	2+T	859.00
TRUNK			
Note: See Preamble regarding cosmetic surgery			
6151	Decubitus ulcers - excision and treatment of bone, rotation flaps and skin grafts to secondary defect	4+T	959.00
6155	- with flap procedure, mobilization of umbilicus and repair of umbilical hernia NOTE: Only medically required procedures should be billed to the payment agency (accompanied by an explanation of the medical requirement)	4+T	856.40
6157	Nipple-areolar reconstruction	2+T	598.30
6158	Myocutaneous flap - involving major muscle rotated on its neurovascular pedicle	5+T	1,175.40
6164	Prosthetic breast replacement in unilateral agenesis or following mastectomy -unilateral	3+T	529.90
6165	- bilateral	3+T	856.40
LEG			
7216	Lymphedema of limbs - excision and grafting - entire leg	3+T	1,288.40
7217	- entire lower extremity	3+T	1,932.60

PLASTIC SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
6167	Treatment of lymphedema using the Thompson procedure - upper extremity forearm	4+T	635.50
6168	- arm (Total of $1,033.50 whether one or two stages)	4+T	423.70
6169	- lower extremity leg	4+T	1,059.30
6170	- thigh (Total of $2,067.00 whether one or two stages)	4+T	1,059.30

HAND

6171	Syndactyly - local flaps - first cleft	2+T	423.70
6172	- with skin graft, first cleft	2+T	635.50
6173	Direct flap to finger - 2 stages	2+T	529.50

Amputations:

5425	Transmetacarpal	2+T	320.70
5426	Finger, any joint or phalanx	2+T	214.50

Bone Grafting:

5566	Metacarpal, phalanx	2+T	429.70

Fractures:

5203	Metacarpal, requiring reduction	1+T	171.70
5225	Distal phalanges - open reduction and wiring - first	1+T	320.70
5226	- each additional (extra)	1+T	171.70
5227	Other than distal phalanges - open reduction and wiring - first	1+T	535.50
5228	- each additional (extra)	1+T	257.70

Joints - Inter or Metacarpophalangeal:

5522	Capsulotomy, arthroplasty and arthrodesis	2+T	320.70
5613	Reconstruction of rheumatoid hand joints - multiple eg. synovectomy, intrinsic release repositioning of extensor tendons, each hand - fee for service, at any one operative session - up to	3+T	1,717.70
5615	Finger joint prosthesis - first joint	2+T	320.70
5616	- subsequent joints same sitting - each	2+T	157.40
5620	Synovectomy of hand joint	2+T	429.70
5621	Intrinsic release	2+T	429.70
5626	Synovectomy of flexor or extensor tendons in wrist and hand for rheumatoid disease	2+T	643.90

PLASTIC SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
5629	Synovectomy of knee joint	2+T	859.00
Hand Infections:			
6197	Acute tenosynovitis-finger (operation only)	2+T	214.50
6198	- ulnar or radial bursa (operation only)	2+T	214.50
7046	Web space abscess (operation only)	2+T	64.40
7047	- under general anaesthetic (operation only)	2+T	107.40
7049	Mid palmar, thenar and dorsal subaponeurotic space abscess (operation only)	2+T	107.40
Nerves:			
3191	Peripheral nerve - minor, digital, primary suture or secondary	2+T	320.70
3192	- repair of palmar nerve	2+T	320.70
3193	- major, primary suture	3+T	644.00
3195	- exploration of peripheral nerve and neurolysis	2+T	429.70
6156	Transplant of neuroma	2+T	317.90

MISCELLANEOUS

Meningocele:			
6166	Excision of axillary sweat glands for hyperhydrosis - unilateral	4+T	635.50

GENERAL SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

7010	Consultation: To include complete history and physical examination, review of x-ray and laboratory findings, if required, and a written report	149.00
7012	Repeat or Limited Consultation: To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	82.30

Continuing Care by Consultant:

7007	Subsequent office visit	33.50
7008	Subsequent hospital visit	42.40
7009	Subsequent home visit	70.20

EMERGENCY VISIT PREMIUM

**Based on time seen by physician*

0250	Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	47.80
0251	Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	131.10
0252	Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	153.50

SURGICAL ASSISTANT

**Payment will be based upon the total dollars billed by the surgeon, excluding diagnostics.*
NOTE: For consideration of premiums, the time of the surgical assist shall correspond to that of the start time of the first procedure.

7015	Operation fee - less than $179.30	93.60
7016	- $179.31 to $550.60 inclusive	162.20
7017	- $550.61 to $928.70 inclusive	209.80
7018	- over $928.71	282.80

GENERAL SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
7014	Time, after 2 hours or more of continuous surgical assistance for one patient, each 15 minutes or fraction thereof NOTE: (i)When a second assistant in surgery is requested by the Surgeon-in-Chief there should be adequate written explanation on the claim card and the charge should be in accordance with the fee for the first assistant. (ii)In those rare situations where an assistant is required for minor surgery, a detailed explanation of need must accompany the claim to the payment agency. (iii)Where an assistant at surgery assists at two operations in different areas performed by the same or different surgeon(s) under one anaesthetic, he/she may charge a separate assistant fee for each operation, except for bilateral procedures.		30.50
7019	Certified Surgical Assistant - where it is necessary for one certified surgeon to assist another certified surgeon		364.70
7020	Surgeon's part in cardioangiogram - per hour or fraction thereof		86.10

GENERAL

Biopsy:

7021	Biopsy of skin or mucosa NOTE: Punch or shave biopsies not to be charged under fee code 7021, 7022 (see fee code 0215)	1+T	64.60
7022	Biopsy of facial area	2+T	64.60
7023	Excision biopsy of lymph glands for malignancy under general anaesthetic	1+T	107.40
7024	Scalene gland biopsy	3+T	214.50
7025	Temporal artery biopsy	2+T	107.40

Abscess:

7026	Opening superficial abscess, including furuncle (operation only)	1+T	36.10
7027	Deep abscess, including carbuncle requiring general anaesthesia (operation only)	1+T	107.40

Lacerations or foreign bodies:

7030	Minor laceration or foreign body requiring local anaesthesia (operation only)		66.00
7031	Minor laceration or foreign body requiring general anaesthesia (operation only)	1+T	66.00
7032	Extensive laceration (bill if total length of all skin lacerations exceed 15 c.m.) NOTE: For very extensive lacerations of face see Plastic Surgery Section	2+T	153.80

Skin:

7035	Excision of benign tumor of skin or subcutaneous tissue or small scar	1+T	71.80
7034	- additional lesions removed at the same sitting (maximum five per sitting) each	1+T	21.40
7036	Localized carcinoma of skin, proven histopathologically	1+T	107.40

GENERAL SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
Soft Tissue Tumor:			
7037	Excision of large (over 7.5 cm.) benign tumor of skin or subcutaneous tissue where general anaesthesia or regional block is necessary	2+T	150.40
7038	Removal of major benign tumor requiring extensive dissection (accompanied by written report to payment agency)	2+T	644.00
INFECTIONS OF HAND AND FOOT			
7044	Paronychia (operation only)	1+T	42.80
7045	Anterior closed space abscess (operation only)	1+T	42.80
7046	Web space abscess (operation only)	2+T	64.40
7047	- under general anaesthetic (operation only)	2+T	107.40
7049	Mid palmar, thenar and dorsal subaponeurotic space abscess (operation only)	1+T	107.40
7050	Removal of nail - simple (operation only)	1+T	42.80
7052	- with destruction of nail bed	1+T	86.10
7053	- complete with shortening of phalanx	2+T	214.60
7051	Wedge excision of one nail	1+T	64.60
BURSAE, SYNOVIAL CYSTS AND GANGLIA			
7054	Excision of prepatellar, olecranon or trochanteric	2+T	214.60
7055	Ganglia - of the wrist	1+T	214.60
7056	- of tendon sheath joint	1+T	320.70
7057	- compound	1+T	643.90
7058	- popliteal cyst - radical removal	2+T	429.70
TENDONS			
7060	Flexor - primary or secondary repair	2+T	535.50
7061	- each additional	2+T	214.50
7062	Tendon achilles	2+T	320.70
7063	Extensor - primary or secondary repair	2+T	320.70
7064	- each additional	2+T	150.40
7065	Silastic Rod prior to Tendon Grafting	1+T	643.90

GENERAL SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
7066	Silastic Pulley and Underlay	1+T	107.40
7067	Tendon graft	2+T	964.80
7068	Tenoplasty - tenodesis, tenovaginitis, shortening or lengthening, stenosing tenosynovitis - 1 tendon any location	2+T	320.70
7069	- 2 or more tendons	2+T	535.50
7070	Tendon transplant - single	3+T	429.70
7071	- each additional (extra) Section of transverse carpal ligament (bill under fee code 3195)	2+T	279.20
7077	Plantar fasciectomy	2+T	535.50
7078	Extensive palmar fasciectomy involving one or more digits (Dupuytren's)	2+T	643.90
7084	- with skin grafting NOTE: Localized charge under fee code 7037	2+T	870.30
7085	Tenolysis	2+T	535.50
7086	-each additional to a maximum of three extra	2+T	214.50

TENOTOMY

7073	Tenotomy - congenital torticollis	3+T	214.60
7074	- resection Section of transverse carpal ligament (bill under fee code 3195)	3+T	429.70
7081	Anterior scalenotomy	2+T	320.70

VENOUS SYSTEM

7100	Vein Eraser - first vein		42.70
7101	- each subsequent vein		21.40
7102	Varicose veins, injection, each visit		21.40
7104	- injection with elevation, sponge rubber compression and bandaging (operation only)	1+T	71.80

Varicose Veins and Perforators:

7107	High ligation, long saphenous	2+T	265.40
7108	Stripping long saphenous	2+T	441.30
7109	Stripping short saphenous	2+T	242.90
7110	Multiple ligations and stripping tributaries (3-5 incisions)	2+T	183.50
7111	Multiple ligations and stripping tributaries (6 or more incisions)	2+T	315.90

GENERAL SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
7112	Ligation of 2 or more perforators or partial fasciotomy with or without multiple ligations	2+T	330.80
7113	Complete fasciotomy, with or without multiple ligations	2+T	587.20

RECURRENT VARICOSE VEINS

7117	Re-exploration of groin and/or popliteal fossa	2+T	551.10
7118	Multiple ligations, strippings and perforators, re-exploration of groin and/or popliteal fossa	3+T	835.90
7119	Multiple ligations, strippings, re-exploration of groin and complete fasciotomy	3+T	1,087.70
7120	Excision of ulcer and grafting - add full fee to venous procedures (operation only)	3+T	220.40
7123	Ligation of femoral vein	2+T	365.20
7124	Ligation of fenestration of inferior vena cava	5+T	859.00
7125	Thrombectomy for acute ilio-femoral thrombophlebitis	5+T	1,073.60

Portal Hypertension:

7128	Spleno-renal shunt	8+T	1,603.30
7129	Porto-caval shunt	8+T	1,603.30

Intra-Venous Catheters:

7132	Jugulo-caval Holter Lifeline (operation only)	2+T	214.50
7133	- under 3 months of age or 3 kg weight	4+T	429.70
7134	Peritoneal Venous Shunt for ascites	6+T	643.60

Excision and Grafting:

7216	Lymphedema of limbs - entire leg	3+T	1,288.40
7217	- entire lower extremity	3+T	1,932.60

Incision:

7229	Thrombectomy with or without angioplasty	5+T	964.80
7230	Embolectomy - trunk or both extremities	5+T	1,073.60
7231	Embolectomy - one side	5+T	772.90

Bypass graft (synthetic) and/or Thromboendarterectomy:

7233	- Innominate	5+T	1,345.50
7234	- Subclavian	5+T	1,288.40

GENERAL SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
7237	- Carotid	8+T	1,145.30
7232	- Aorta and/or iliac - unilateral	9+T	1,288.40
7235	- bilateral	9+T	1,503.20
7240	- Aorto-femoral or ilio-femoral - unilateral	9+T	1,503.20
7243	- bilateral	9+T	1,717.70
7244	- Superior mesenteric	7+T	1,460.20
7245	- Renal	7+T	1,388.60
7242	- Anterior or posterior tibial or peroneal	5+T	1,287.00
7226	- Axillo-femoral - unilateral	7+T	1,288.40
7227	- bilateral	7+T	1,503.20
7274	- Femoro-femoral crossover	5+T	1,073.60
7238	- Femoral (common or superficial endarterectomy)	5+T	944.90
7246	- Femoral-popliteal (synthetic)	5+T	1,245.30
7275	- Femoral-popliteal (endarterectomy)	5+T	1,173.90
7248	- Venous crossover graft for iliac obstruction	5+T	1,073.60
Bypass Graft (autogenous vein)			
7261	- superior mesenteric	7+T	1,388.60
7262	- renal	7+T	1,388.60
7263	- aorta	9+T	1,503.20
7264	- iliac	8+T	1,503.20
7265	- femoral	5+T	1,245.30
7266	- popliteal	5+T	1,245.30
7276	- anterior, posterior tibial or peroneal	5+T	1,460.20
7277	- Femoro-femoral crossover	7+T	1,202.40
7278	- Axillo-femoral - unilateral	7+T	1,431.60
7267	- 2nd operator, synchronous combined bypass graft - extremities		535.50
7247	- trunk NOTE: fee code 7267 and 7247 provide operative report by second operator when requested from payment agency		535.50

GENERAL SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
Excision:			
7250	Arteriovenous aneurysm	9+T	859.10
7252	Abdominal aneurysm, with grafting	9+T	1,717.70
7254	Ruptured aneurysm, with grafting	10+T	2,032.80
7281	Resection of abdominal aneurysm with associated femoral dissection, one or both sides (extra fee to be added to procedure) NOTE: Peripheral aneurysm - charge associated by-pass graft procedure	9+T	214.50
Suture:			
7270	Repair injury of major vessel in extremity - suture	6+T	643.90
7271	- graft	6+T	1,073.60
7269	Repair injury of major vessel in trunk - suture	6+T	1,274.10
7273	- graft	9+T	1,700.00
7272	Ligation of carotid artery	5+T	429.70
7283	Re-dissection of groin (after 21 days), extra	4+T	192.60
	NOTE: Not to be charged when billing for a complete repeat procedure		

LYMPHATIC SYSTEM

7360	Splenectomy	6+T	859.10
7361	TB Glands - radical removal	4+T	429.70
7362	Radical axillary dissection	3+T	744.60
7363	Radical femoral, inguinal and iliac dissection	5+T	859.10
7365	Isolated limb perfusion to include groin dissection and laparotomy	5+T	1,503.20
7366	Laparotomy and staging of lymphoma to include splenectomy	6+T	1,266.40
7367	Repair of laceration or rupture of spleen by suture	6+T	859.10

BREAST

7488	Microdochectomy	2+T	214.50
7489	Biopsy or removal of simple tumor or segmental resection	2+T	171.80
7490	Mastectomy - simple	3+T	429.70
7491	Mastectomy - radical or modified	3+T	1,016.40

GENERAL SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
7492	Mastectomy - radical with skin graft	3+T	1,116.20
7493	Triple biopsy of breast for cancer	2+T	429.70
7496	Double biopsy of breast for cancer	2+T	214.50
7494	Radical mastectomy with triple biopsy	3+T	1,231.00
7495	Radical mastectomy with triple biopsy and skin graft closure	3+T	1,345.50
7497	Biopsy or segmental resection of non-palpable breast lesion with pre and intra-operative radiological localization	2+T	279.20
7498	Mastectomy subcutaneous, female - unilateral	3+T	640.80
6164	Prosthetic breast replacement following mastectomy - unilateral	3+T	529.90
6165	- bilateral	3+T	856.40

DIGESTIVE SYSTEM

Jaws:

7500	Resection of mandible	5+T	644.00

Pharynx:

7511	Excision of pharyngo-esophageal diverticulum	6+T	859.00
7512	Excision of congenital cyst/fistula from neck	4+T	643.90

Salivary Glands:

7520	Sialolithotomy - simple, in duct	3+T	107.40
7521	- complicated, in gland	3+T	320.70
7522	Local excision parotid tumor	3+T	214.50
7527	Subtotal parotidectomy with complete facial nerve dissection	4+T	1,179.70
7523	Total parotidectomy with nerve dissection for malignancy or deep lobe tumor	4+T	1,288.40
7524	Excision of submandibular gland	4+T	429.70
7525	Salivary fistula - plastic to Stenson's duct	4+T	643.90
7526	Dilation of salivary duct (operation only)	3+T	42.70

Esophagus:

7529	Esophagectomy - upper 2/3 to include esophagostomy and gastrostomy	8+T	1,717.70
7530	Esophago-gastrectomy-combined thoraco-abdominal	8+T	1,932.40

GENERAL SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
7531	Cervical esophagostomy and division of tracheoesophageal fistula with gastrostomy	8+T	1,288.40
7532	Plastic operation for cardiospasm - Heller	8+T	1,073.60
7533	Esophageal diverticulum - intrathoracic resection	8+T	1,073.60
7534	Correction of esophageal atresia with closure of tracheoesophageal fistula	8+T	1,932.40
7535	Replacement of esophagus with intestine	8+T	2,147.30
7536	Direct ligation of esophageal varices	7+T	1,179.70
7537	Ruptured esophagus - transthoracic repair	8+T	1,073.60
7538	- cervical drainage	4+T	701.40
7539	Insertion of celestin tube	4+T	744.60
7540	- souttar type tube	1+T	320.70
7541	Intramural tumor of esophagus	6+T	1,179.70
7542	Esophageal replacement performed as a team procedure - first operator	8+T	1,889.70
7543	- second operator		758.80
7544	Brusque pneumatic esophageal dilation (operation only)	3+T	178.80
7545	- repeat within one month (operation only)	3+T	89.40
7546	Sclerosing of esophageal varices to include endoscopy (operation only)	3+T	289.20
7547	Bougie dilation (operation only)	3+T	107.40
7555	Zenkers Diverticulotomy	5+T	570.50

ABDOMEN

Trauma fee items are to be charged in cases of blunt and/or penetrating abdominal injury. They do not apply to incidental intraoperative injury to abdominal structures.

Trauma:

7430	Diagnostic peritoneal lavage (catheter)	1+T	138.00
7431	Repair diaphragmatic injury	8+T	1,079.70
7432	Laparotomy in the trauma patient	5+T	575.90
7433	Laparotomy to include removal of injured spleen	7+T	865.00
7434	Laparotomy to include splenic repair	7+T	865.00
7435	Repair of lacerations to stomach	7+T	768.50

GENERAL SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
7436	Exploration and mobilization of duodenum and pancreas	7+T	865.00
7437	Repair of laceration of duodenum	7+T	1,151.80
7438	Resection and debridement of duodenal injury, to include duodenal diverticulisation where indicated	7+T	1,440.70
7439	Repair liver laceration	8+T	865.00
7440	Resectional debridement of liver	8+T	1,009.20
7441	Hepatic artery ligation, to include resectional debridement where indicated	8+T	1,151.80
7442	Hepatic lobectomy for trauma	9+T	1,729.50
7443	Resection of distal pancreas for trauma	8+T	1,151.80
7445	Repair of lacerations to small bowel	7+T	768.50
7446	Resection of injured small bowel	7+T	865.00
7447	Repair of mesenteric injury	7+T	768.50
7448	Repair of colonic injury with or without colostomy	7+T	1,151.80
7449	Resection of colonic injury	7+T	1,151.80
7450	Exteriorization of colonic injury	7+T	720.60
7451	Thoracic extension of abdominal incision, extra	8+T	383.20
7452	Repair of extra peritoneal rectum with or without colostomy	7+T	1,151.80
7453	Repair of bladder injury	5+T	562.90
7454	Repair of injury to major vessel	6+T	1,274.10
Incision:			
7587	Laparotomy requiring extensive examination and colostomy (with operative report)	5+T	681.40
7597	Post-operative hemorrhage - intra-abdominal management	6+T	429.70
7600	Exploratory laparotomy with/without biopsy	5+T	535.50
7601	Intra-abdominal abscess including intrahepatic	5+T	701.40
7602	Pneumoperitoneum-therapeutic (operation only)		42.70
7603	Resuture abdominal wound evisceration	5+T	429.70
Hernia:			
7592	Inguinal - child - bilateral	2+T	643.90

GENERAL SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
7604	Hernia - with emergency repair	3+T	643.90
7605	Inguinal or femoral	2+T	543.80
7606	- recurrent	2+T	643.90
7607	- with bowel resection	5+T	1,016.40
7608	Ventral, incisional - repair by suture	2+T	701.40
7609	- repair by prosthesis	2+T	801.70
7568	- emergency repair	3+T	801.70
7610	Epigastric	4+T	429.70
7611	Umbilical - adult to include lipectomy if necessary	2+T	643.90
7612	- infant and neonate	2+T	314.90
7613	- child	2+T	415.30
7614	Omphalocele - temporary repair	7+T	644.20
7615	- permanent repair	7+T	859.00
7616	Diaphragmatic or hiatal to include vagotomy and drainage procedures where indicated (with operative report)	6+T	1,173.90
7593	- recurrent (with operative report)	6+T	1,388.70
7594	Diaphragmatic hernia - neonatal	9+T	1,217.10
7595	- traumatic	8+T	1,288.40
7596	Hernia - incisional - repair following laparotomy (with operative report) extra	2+T	214.50
Stomach Incision:			
7617	Congenital pyloric stenosis - Ramstedt operation	5+T	643.90
7618	Vagotomy - abdominal	6+T	859.00
7625	- thoracic	8+T	859.00
7578	Highly selective vagotomy	5+T	1,016.40
7619	Gastrotomy for removal of foreign body, etc.	5+T	643.90
Stomach Excision:			
7620	Total gastrectomy	6+T	1,915.60
7621	Subtotal gastrectomy	6+T	1,231.00

GENERAL SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
7622	- with vagotomy	6+T	1,331.30
7623	Revision gastrectomy after previous gastrectomy with or without vagotomy	6+T	1,603.30
7624	Emergency gastrectomy for continued hemorrhage (with operative report)	7+T	1,603.30
7574	Gastric polypectomy to include gastroscopy (operation only)	5+T	337.20
Stomach Suture:			
7626	Pyloroplasty	5+T	643.90
7627	Gastrojejunostomy	5+T	687.30
7628	Gastrojejunostomy or pyloroplasty with vagotomy, with or without gastrostomy	5+T	1,016.40
7629	Emergency gastrojejunostomy or pyloroplasty with vagotomy and suture of bleeder for continued hemorrhage	7+T	1,288.40
7630	Gastrostomy - simple	5+T	344.40
7631	- with living tube	5+T	750.00
7632	Repair of perforated peptic ulcer, wound or injury to stomach	6+T	750.00
7633	Closure of gastrojejuno colic fistula	5+T	1,817.80
Intestine Incision:			
7634	Enterotomy or colotomy (single)	5+T	687.30
7635	Multiple colotomy with operative sigmoidoscopy	5+T	916.50
Intestine Excision:			
7636	Resection of small intestine with anastomosis	5+T	959.10
7637	Hemicolectomy - right	6+T	1,231.00
7591	- left	6+T	1,288.40
7638	Anterior resection of rectosigmoid for carcinoma with or without protective colostomy	6+T	1,503.20
7639	Limited resection of colon	6+T	1,116.30
7640	Total colectomy with ileoproctostomy	6+T	1,603.30
7642	Bowel resection without anastomosis and with ileostomy	5+T	1,092.70
7641	Total proctocolectomy with perineal excision of rectum and ileostomy	7+T	2,147.40
7589	- synchronous - abdominal portion	7+T	1,875.10
7590	- synchronous - perineal portion	7+T	535.50

GENERAL SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
7643	Enteroenterostomy	5+T	701.50
7644	Enterostomy or caecostomy	5+T	429.70
7570	Colo-colostomy or enterocolostomy NOTE: fee code 7570 applies to unprepared, non-resectable bowel obstruction. In all other instances fee code 7643 applies	6+T	959.30
7645	Colostomy - loop	5+T	485.30
7588	- end	5+T	535.50
7646	Closure of colostomy without resection	4+T	535.50
7647	Closure of colostomy with resection and anastomosis	5+T	801.70
7648	Revision of colostomy, ileostomy - simple incision of scar, etc.	4+T	320.70
7649	Revision of colostomy, ileostomy - radical	5+T	535.50
7650	Intestinal obstruction resection of bands	5+T	801.70
7651	Reduction of volvulus, intussusception or internal hernia	5+T	744.60
7575	Kock intra-abdominal pouch with continent ileostomy	6+T	1,603.40
Intestine Suture:			
7653	Atresia of the small bowel	6+T	1,173.90
7654	Intestinal obstruction - plication or insertion of intraluminal tube	5+T	916.50
7655	Excision of Meckel's diverticulum	4+T	587.10
7656	Appendectomy	4+T	486.70
7657	Appendectomy - perforated with abscess or generalized peritonitis	5+T	701.50
7658	Exteriorisation of large bowel lesion (carcinoma, perforation, etc.)	5+T	859.00
Rectum Excision:			
7660	Rectal drainage of pelvic abscess	2+T	320.70
7661	Hartmann resection	7+T	1,174.10
7659	Reconstruction Hartmann with or without protective colostomy	7+T	1,073.60
7662	Abdomino-perineal resection	7+T	1,717.70
7663	Synchronous combined abdomino-perineal resection - abdominal portion	7+T	1,503.20
7664	- perineal portion	7+T	535.50
7665	Full thickness rectal biopsy for Hirschsprung's Disease	2+T	214.50

GENERAL SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
7670	Pull-through procedure for Hirschsprung's Disease	7+T	1,717.70
7576	Pull through procedure - Second operator		535.50
7667	Rectal prolapse - perineal approach	5+T	429.70
7668	Excision or fulguration of rectal or sigmoidal tumors to include operative sigmoidoscopy - small - less than 1 cm.	2+T	107.40
7669	- medium - 1 to 2.5 cm.	2+T	150.40
7673	- large - greater than 2.5 cm.	2+T	320.70
Rectum Repair:			
7671	Anal stricture plastic repair	2+T	643.90
7672	Complete rectal prolapse - abdominal or perineal approach	5+T	964.80
7580	Trans-sacral (Kraske) resection	5+T	744.60
7581	Colonoscopy with flexible colonoscope	2+T	386.50
7582	- biopsy	2+T	429.70
7583	- removal polyp	2+T	643.90
7584	Fulguration rectal carcinoma - palliative	2+T	320.70
7585	- radical (with operative report)	2+T	535.50
7586	- repeat	2+T	214.50
Anus Incision:			
7675	Fistula-in-ano - submucous	2+T	214.50
7676	- submuscular	2+T	486.70
7677	- multiple (with operative report)	2+T	643.90
7678	Incision and drainage of superficial perianal abscess (operation only)	1+T	107.40
7679	Ischio-rectal abscess (operation only)	2+T	150.40
7666	Anus incision (fistula-in-ano second stage), division of sphincter after placement of seton	2+T	187.10
Anus Excision:			
7681	Fissurectomy with or without sphincterotomy under general anaesthetic (operation only)	2+T	214.50
7683	Hemorrhoidectomy with or without sigmoidoscopy	2+T	374.90

GENERAL SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
7688	Hemorrhoids - elastic band ligation (operation only)	1+T	74.50
7682	- additional band, same sitting (operation only) Note: Maximum sittings chargeable per year five (5)	1+T	48.20
7684	Enucleation of external thrombotic hemorrhoid	1+T	53.70
7685	Pilonidal sinus-excision or marsupialization	2+T	429.70
7686	Anal polyp	1+T	64.60
7687	Anal fissure excision under local anaesthesia		107.40
7689	Anal dilation - (operation only)	1+T	107.40
7697	Excision sacrococcygeal teratoma	6+T	1,503.20
7674	Fulguration anal condylomata - simple	1+T	107.40
7680	- complicated (with operative report) and laboratory findings, if required, and a written report	1+T	214.50
Anus Repair:			
7690	Anoplasty for imperforate anus	4+T	859.00
7691	Imperforate anus - simple incision	1+T	42.80
7692	Repair major ano-rectal anomalies with concurrent urogenital malformations via sacral approach	7+T	1,288.40
Liver:			
7693	Drainage of hepatic abscess	6+T	701.50
7694	Ruptured liver - repair by suture	8+T	844.30
7695	- thoracoabdominal approach with suture	8+T	1,286.90
7696	Resection of liver - hepatic lobectomy-total	8+T	1,932.60
7775	- partial	8+T	859.00
Biliary Tract:			
7757	Biliary tract endoscopy	2+T	178.80
7698	Cholecystostomy	5+T	643.90
7699	Cholecystectomy	5+T	859.00
7764	Cholangiography - operative, extra		88.40
7701	Choledochostomy	5+T	1,002.20
7769	Duodenotomy and sphincteroplasty	5+T	887.10

GENERAL SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
7703	Choledochoduodenostomy	6+T	1,288.40
7705	Choledochojejunostomy	6+T	1,420.80
7706	Cholecystoenterostomy	6+T	643.90
7704	Surgical reconstruction for stricture or congenital atresia	6+T	1,503.20
7719	Resection of carcinoma of common bile duct - middle and lower	6+T	1,603.50
7737	- upper	6+T	1,817.80
7776	Repair of cholecystoenteric fistula	5+T	887.10
7777	U-tube insertion for common bile duct malignancy	5+T	1,064.90
7573	Endoscopic papillotomy (Ampulla of Vater) to include retrograde pancreatography (0809) (operation only)	5+T	711.10
Pancreas:			
7711	Drainage of pseudocyst - cystogastrotomy	5+T	964.80
7733	- Roux-en-Y	5+T	1,216.90
7712	Pancreatico-duodenectomy (Whipple)	7+T	2,147.40
7713	Partial pancreatectomy	7+T	1,130.80
7714	Pancreaticojejunostomy	7+T	1,503.20
7710	Pancreatogram with or without sphincterotomy done in conjunction with any of the biliary or pancreatic surgical procedures - extra	5+T	107.40
7734	Pancreatitis - acute - gastrostomy, jejunostomy, cholecystostomy	4+T	964.80
7722	Percutaneous biopsy of pancreas - operation only	2+T	178.80

HEAD AND NECK

7735	Tongue tie - under general anaesthetic	3+T	150.40
7736	Local excision tongue - under general anaesthetic	3+T	214.50
7738	Excision cystic hygroma	3+T	859.00
7720	Lip shave - vermilionectomy	3+T	429.70
7721	Glossectomy - partial for carcinoma	6+T	643.90
7723	Alveolectomy	3+T	320.70
7724	Transpalatal maxillectomy, ethmoidectomy and sphenoidectomy	5+T	1,288.40

GENERAL SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
7725	Maxillectomy	5+T	1,288.40
7726	- with exenteration of orbit and skin graft	5+T	1,717.70
7739	Transoral maxillectomy with skin graft	5+T	1,503.20
7749	Partial maxillectomy for malignancy -fenestration	5+T	859.00
7727	Composite resection -tongue, mandible, radical neck dissection and tracheotomy (3 months post-op care)	7+T	2,147.40
7728	Resection mandible, floor of mouth, suprahyoid dissection and tracheostomy - malignancy	7+T	1,288.40
7729	Laryngo-pharyngo-esophagectomy - primary excision only	6+T	2,147.40
7730	Radical neck dissection	6+T	1,288.40
7731	Partial unilateral neck dissection	5+T	429.70
7766	Unilateral radical neck plus contralateral suprahyoid dissection	5+T	1,503.20
7767	Suprahyoid neck dissection for malignancy	5+T	429.70
7768	Excision tuberculosis lymph nodes neck (with operative report)	4+T	429.70
7796	Excision neurogenic neoplasm neck	5+T	859.00
7771	Picking operation - metastatic neck nodes for thyroid carcinoma (with operative report)	5+T	643.90

ENDOCRINE SYSTEM

7740	Thyroid biopsy - open	4+T	214.50
7741	Local excision thyroid lesion	4+T	535.50
7742	Thyroidectomy - subtotal bilateral or total unilateral	4+T	859.00
7743	- bilateral total for malignancy	4+T	1,217.10
7759	- Graves' disease	4+T	1,073.60
7758	Recurrent thyroidectomy (after 6 weeks from previous operation)	4+T	1,057.50
7745	Parathyroidectomy	4+T	1,073.60
7744	Subtotal parathyroidectomy	4+T	988.90
7748	Parathyroidectomy with sternal split	6+T	1,503.20
7746	Adrenalectomy - unilateral extra peritoneal approach	8+T	859.00
7747	- unilateral or bilateral - intraperitoneal approach	8+T	1,288.40

GENERAL SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
SYMPATHECTOMY			
7750	Lumbar sympathectomy - unilateral	4+T	643.90
7751	Cervical sympathectomy - unilateral	5+T	787.40
7754	Lumbar sympathectomy with abdominal procedure - unilateral (extra)		214.50
7755	- bilateral (extra)		429.70
7752	Preganglionic sympathectomy, upper dorsal region - unilateral	7+T	787.40
7753	Lumbo-dorsal sympathectomy and splanchnic neurectomy - unilateral	7+T	787.40
ORGAN TRANSPLANTS - Kidney Implantation of Kidney Graft			
7760	Urologist	7+T	1,503.20
7761	Vascular surgeon	7+T	1,503.20
Removal of Donor Kidney			
7762	From cadaver with necessary kidney preservation	7+T	429.70
7763	From living donor NOTE: (i) Anaesthetist and Nephrologist charge fee for service. (ii) A certified surgical assistant will be required with billing under fee code 7019	7+T	859.00
RENAL DIALYSIS			
7239	Insertion of new A-V bypass (no consultation charged)	4+T	427.60
7187	Creation of internal arteriovenous fistula	4+T	640.80
7186	Thrombectomy of arteriovenous fistula	3+T	601.30
7598	Removal of hemodialysis shunt	2+T	106.90
7599	Insertion of permanent catheter	3+T	319.20
7579	A-V Shunt with Bovine Graft	4+T	859.00
7577	Removal by dissection of chronic peritoneal catheter (operation only) NOTE: Removal of Tenchov-type chronic peritoneal catheter not requiring surgical dissection - use visit fees.	3+T	192.60

CARDIO-THORACIC SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

7810	Consultation: To include complete history and physical examination, review of x-ray and laboratory findings, if required, and a written report		124.90
7812	Repeat or Limited Consultation: To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee		70.20

Continuing Care by Consultant:

7807	Subsequent office visit		33.50
7808	Subsequent hospital visit		21.40
7809	Subsequent home visit		70.20

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250	Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care		47.80
0251	Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays		131.10
0252	Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care		153.50

ARTERIAL SYSTEM

7825	Resecting aneurysms in conjunction with another procedure	10+T	415.30
7828	Repair of aortic injury (thoracic)	10+T	2,213.20
7829	Repair of traumatic injury of major intrathoracic vessels	10+T	1,233.40

HEART AND MEDIASTINUM

Heart:

7843	Endocardial pacemaker (ventricular)	4+T	715.70
7847	Endocardial pacemaker (Atrial A-V sequential)	4+T	709.40
7953	Double lead endocardial pacemaker	4+T	709.40
7952	Electronic monitoring of pacing and pacemaker function		126.00
7844	Implantation or replacement of pulse generator for cardiac pacing	4+T	314.90

CARDIO-THORACIC SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
7845	Repair, replacement, adjustment of electrode NOTE: For implantation of temporary pacemaker see fee code 0330	4+T	314.90
7846	Surgical treatment of cardiac arrest by cardiac massage (operation only) NOTE: To be supported by letter. Paragraphs 11(b) and 11(d) of the Preamble will apply	11+T	415.30
Mediastinum:			
7921	Mediastinal cyst or tumor	8+T	1,145.30
7922	Thymectomy	8+T	821.50

RESPIRATORY SYSTEM

Pleura and Lung:			
7924	Decompression of traumatic pneumothorax (operation only)	4+T	64.60
7925	Artificial pneumothorax	4+T	42.70
7926	Closed drainage of chest (operation only)	4+T	214.60
7927	Rib resection for empyema	6+T	629.80
7928	Exploratory thoracotomy with or without biopsy or removal of foreign body	8+T	715.70
7929	Decortication of lung	8+T	1,030.40
7930	Pleurectomy	8+T	648.30
7931	Closure of pleurostomy following long term management of empyema with rib section	6+T	648.30
7932	Segmental resection of lung (including operative report)	8+T	1,245.30
7933	Lobectomy	8+T	1,145.30
7934	Pneumonectomy	9+T	1,531.70
7935	Thoracotomy including wedge resection	8+T	715.70
7936	Drainage of lung abscess - operation only	8+T	629.80
7938	Closure of bronchopleural fistula	10+T	1,255.60
7939	Repair of ruptured bronchus	9+T	1,255.60
Ribs and Chest Wall:			
7941	Thoracoplasty	6+T	629.80
7945	Cervical rib resection	5+T	629.80
7946	Intrathoracic tumor - without lung involvement	5+T	816.20
7948	Trans-axillary resection of first rib	5+T	735.30

CARDIO-THORACIC SURGERY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
7955	Tracheal resection	10+T	1,255.60
7956	- with laryngeal release, extra	10+T	620.50
7957	- with hilar release, extra	10+T	620.50
7958	Chest wall tumor with rib resection	6+T	861.00

MECHANICAL DEVICES

7960	Intra-aortic balloon insertion, removal and care		881.50
7960	NOTE: For an isolated procedure (anaesthetic procedural units)	10+T	

UROLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

8010	Consultation: To include complete history and physical examination, review of x-ray and laboratory findings, if required, and a written report		124.90
8012	Repeat or Limited Consultation: To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee		70.20

Continuing Care by Consultant:

8007	Subsequent office visit		33.50
8008	Subsequent hospital visit		21.40
8009	Subsequent home visit		70.20

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250	Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care		47.80
0251	Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays		131.10
0252	Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care		153.50

KIDNEY AND PERINEPHRIUM

8100	Drainage of perinephric abscess	5+T	429.70
8101	Exploration of renal and perirenal tissues	5+T	643.90
8102	Nephrotomy or nephrostomy	5+T	816.30
8103	Pyelotomy or pyelostomy	5+T	816.30
8117	Nephrolithotomy and/or pyelolithotomy	5+T	816.30
8118	Nephrolithotomy or pyelolithotomy with x-ray control with or without nephroscopy	5+T	1,073.60
8119	Nephrolithotomy or pyelolithotomy with renal cooling, with or without x-ray control, with or without nephroscopy	6+T	1,173.90
8104	Hemi-nephrectomy or partial nephrectomy	5+T	859.00
8105	Nephrectomy	5+T	816.30

UROLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
8106	- ectopic kidney	5+T	816.30
8107	- transperitoneal	5+T	816.30
8108	- thoracoabdominal	8+T	1,288.40
8109	- radical with gland dissection	6+T	959.00
8110	Nephrourecterectomy to include bladder cuff	6+T	1,216.90
8111	Excision of stenosed renal artery with reimplantation or bypass homograft	8+T	1,288.40
8112	Open renal biopsy (as independent procedure)	5+T	429.70
8113	Symphysiotomy and nephropexy or nephrectomy in horseshoe kidney	5+T	959.00
8114	Pyeloplasty including management of aberrant vessels and nephropexy	5+T	835.30
8115	Nephropexy	5+T	816.30
8116	Ruptured or lacerated kidney-repair or removal	4+T	859.00

URETER

8149	Ureterotomy/ureterolithotomy - upper ureter	5+T	744.60
8150	- lower ureter	5+T	816.30
8151	Ureterotomy or removal of stump	5+T	816.30
8152	Uretero-vesical reanastomosis - unilateral	5+T	744.60
8148	- bilateral	5+T	1,288.40
8156	Ureteroureterostomy	5+T	1,073.60
8157	Uretero-cutaneous anastomosis - unilateral	5+T	643.90
8158	Ureteral sigmoid anastomosis - bilateral	5+T	859.00
8159	Ureterolysis	5+T	859.00
8160	Reconstruction lower segment ureter by bladder flap	5+T	959.00
8161	Transurethral manipulation of ureteral calculus with recovery of calculus	3+T	429.70
8162	Ureteroplasty	5+T	859.00
8163	Uretero-vesical anastomosis in the presence of ureterocele or ureteral duplication	5+T	1,073.60

URINARY DIVERSION AND CYSTECTOMY

8170	Preparation of intestinal segment and reanastomosis	5+T	859.00

UROLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
8171	Transplantation of ureters to an intestinal segment	6+T	643.90
8172	Cystectomy (isolated procedure)	6+T	1,288.40
8173	Radical cystectomy with pelvic lymphadenectomy (isolated procedure)	7+T	1,503.20
8174	Preparation of intestinal segment, reanastomosis and ureteral transplantation (same surgeon)	6+T	1,503.20
8175	Cystectomy and ureteral transplantation (same surgeon)	6+T	1,288.40
8176	Radical cystectomy and ureteral transplantation (same surgeon)	7+T	1,503.20
8177	Preparation of intestinal segment, ureteral transplantation and cystectomy (same surgeon)	6+T	2,147.40
8178	Preparation of intestinal segment, ureteral transplantation with radical cystectomy	7+T	2,361.80
8179	Mobilization of bladder and anastomosis to intestinal segment	6+T	643.90
8180	Mobilization of bladder and anastomosis plus preparation of intestinal segment (same surgeon)	6+T	1,503.20
8181	Ileoplasty or colocystoplasty	6+T	1,173.90

BLADDER

8200	Cystoscopy with fulguration or for operative control of post-prostatectomy hemorrhage	2+T	214.60
8201	Cystostomy	2+T	429.70
8202	Cystostomy by trochar	1+T	107.40
8203	Cystolithotomy	2+T	429.70
8204	Cystectomy-partial for tumor or diverticulum	5+T	859.00
8207	Ruptured bladder repair	5+T	744.60
8210	Differential renal function studies		214.60

Endoscopy:

8250	Transurethral resection of bladder or urethral tumor and adjacent muscle and electrocoagulation as necessary	3+T	629.80
8251	Transurethral resection bladder neck, female	3+T	429.70
8252	Transurethral removal of vesical or urethral foreign body	3+T	429.70
8253	Y-V vesical neck plasty	4+T	729.90
8254	Litholapaxy and removal of fragments	2+T	372.50
8255	Closure of fistula - suprapubic, vesico- vaginal, vesico-rectal or vesico-sigmoid	5+T	859.00

UROLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
8256	Transurethral resection of external urinary sphincter	3+T	429.70

URETHRA

8260	Urethrotomy, external or internal	2+T	320.70
8261	Urethrostomy	2+T	320.70
8262	Meatotomy and plastic repair (operation only)	1+T	42.70
8263	Urethrectomy - total	3+T	643.90
8264	Stricture of urethra - office dilation (operation only)		32.50
8265	- dilation in hospital, isolated procedure with anaesthesia (operation only)	1+T	42.70
8266	- first stage plastic repair (excluding urethrostomy)	3+T	429.70
8259	- first stage plastic repair requiring pedicle graft	3+T	1,073.60
8267	- second stage plastic repair (excluding urethrostomy)	3+T	429.70
8268	Urethral diverticulectomy, male or female	2+T	429.70
8269	TUR posterior urethral valves	2+T	429.70
8270	Transurethral removal of foreign body or calculus	3+T	429.70
4431	Retropubic operation for urinary incontinence	4+T	750.10
8272	Urethral fistula (penile excision)	2+T	320.70
8273	Abdominal repair of vesico-vaginal fistula	5+T	859.00
8274	Hypospadias excluding urethrostomy - 1st stage chordee	2+T	429.70
8275	- Second stage (penile)	2+T	643.90
8276	- penoscrotal	2+T	859.00
8277	- epispadias plastic repair	2+T	859.00
8278	Suprapubic cystostomy and primary repair of urethra	3+T	859.00
8279	Prolapse of urethra - repair	2+T	429.70
8280	Urethral caruncle - excision, including cystoscopy	2+T	214.60

PENIS

8300	Priapism: sapheno-cavernous shunt	2+T	744.60
8301	Dorsal slit	1+T	42.80

UROLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
8303	Circumcision - child NOTE: Routine circumcision of the newborn for non-medical reasons is not a benefit under Insured Health Services	1+T	86.10
8304	- adult	1+T	214.60
8305	Simple amputation of penis	2+T	343.40
8299	Radical amputation of penis	2+T	744.60
8306	Clitoridectomy	2+T	171.80
8308	Excision of femoral and inguinal glands with or without iliac glands - unilateral	4+T	1,288.40
8309	- bilateral	4+T	1,932.60
8307	Excision of Peyronies plaque, with replacement graft (tissue or synthetic)	2+T	718.60
8296	Penile prosthesis (eg. small carrion) insertion following traumatic or surgical injury	3+T	631.50
8363	Revision of penile prosthesis (includes removal, correction of any mechanical failure, and replacement) NOTE: In cases in which impotence is not the direct result of surgery or trauma, prior authorization should be obtained from Insured Health Services	3+T	426.00

PROSTATE

8310	Open prostatic biopsy - perineal or retropubic prostatectomy (including meatoplasty, dorsal slit, urethral dilation, panendoscopy, cystoscopy, retrograde pyelography, vasectomy, or bladder-neck surgery done while patient is under anaesthetic for the prostatectomy)	3+T	429.70
8311	- perineal, suprapubic, retropubic, prostate, seminal, urethral approaches	5+T	1,030.40
8314	- radical perineal retropubic prostate- seminal vesiculectomy NOTE: No charge for repeat prostatectomies done within a period of three months by the same operator, except where radical prostatectomy is required subsequently for cancer	7+T	1,073.60
8315	Perineal incision of prostate with drainage of abscess	2+T	429.70
8316	Prostatic massage		17.30
8317	Anti-incontinence procedure (Kaufman)	4+T	1,073.60
8318	Radical prostatectomy to include lymphadectomy	7+T	1,451.00

TESTIS

8320	Hydrocele or spermatocele - aspiration		42.80
8321	Orchidectomy - unilateral	2+T	214.60
8322	Orchidopexy - one or two stages	2+T	629.80

UROLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
8323	Exploration of scrotal contents - unilateral	2+T	214.60
8324	Exploration of undescended testicle, without orchidopexy	2+T	429.70
8328	Recurrent undescended testis	2+T	709.40
8325	Reduction of torsion of testis and spermatic cord, repair - bilateral	2+T	429.70
8326	Ruptured testicle - repair	2+T	320.70
8327	Biopsy of testis	2+T	107.40

EPIDIDYMIS

8339	Male venereal warts, cautery or excision (not for application of podophyllin) (operation only)		42.80
8340	Abscess, incision, complete care	1+T	214.60
8341	Spermatocele or hydrocele - excision	2+T	358.10
8342	Epididymectomy - unilateral	2+T	320.70
8344	Vasogram - bilateral	2+T	214.60
8345	Vasectomy - bilateral	2+T	214.60
8346	Varicocele - resection	2+T	320.70
8347	Avulsion of penile skin and scrotum - repair	2+T	859.00
8348	Investigation of sterility in the male, including complete examination of male genitalia, prostatic fluid, serology and written report		64.60
8349	Retroperitoneal lymphadenectomy for carcinoma of testis	4+T	1,073.60
8350	Urethro-vesical neck plasty for congenital incontinence	4+T	1,073.60
8351	Excision extrophied bladder and plastic repair abdominal wall	4+T	1,073.60
8352	- with ureterosigmoidostomy	5+T	1,288.40
8353	Plastic repair of extrophy and plastic repair of bladder with skin	5+T	1,388.60

DIAGNOSTIC ROENTGENOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY

These fees cannot be correctly interpreted without reference to the Preamble (Applicable in full for Certified Radiologists and at 75% for all other physicians)

HEAD AND NECK

8500	Skull - routine	69.30
8501	Skull - special studies additional	46.20
8502	Ventriculogram or encephalogram (not including procedural fee)	162.00
8503	Paranasal sinuses	71.30
8504	Facial bones - orbit	71.30
8505	Nasal bones	46.20
8506	Mastoids	69.30
8507	Mandible	46.20
8508	Temporomandibular joints	49.90
8509	Salivary gland region	46.20
8510	Sialogram	69.30
8511	Eye - for foreign body	46.20
8512	For foreign body localization - additional	61.90
8513	Dacrocystogram	46.20
8514	Nasopharynx and/or soft tissue, neck - single lateral view	23.50
8515	Laryngogram (excluding procedural fee) Teeth - bitewing or routine dental	69.30
8516	- single film	21.50
8517	- full series NOTE: When less than a full series is performed, individual films may be charged up to the fee for a full series	94.10

UPPER EXTREMITY

8520	Shoulder Girdle	46.20
8521	Humerus	46.20
8522	Elbow	46.20
8523	Forearm	46.20
8524	Wrist	46.20

DIAGNOSTIC ROENTGENOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
8525	Hand (any part)		46.20
8526	Special requested views in upper extremity		22.80

LOWER EXTREMITY

8530	Hip		46.20
8531	Femur		46.20
8532	Knee		46.20
8533	Tibia and Fibula		46.20
8534	Ankle		46.20
8535	Foot (any part)		46.20
8536	Leg length films - any method		46.20
8537	Special requested additional views for lower extremity		22.80

SPINE AND PELVIS

8540	Cervical spine		66.40
8541	Thoracic spine		66.40
8542	Lumbar spine		112.40
8543	Sacrum and coccyx		66.40
8549	Spine - requested additional views (flexion, bending views, etc.) NOTE: Fee code 8549 is not intended to cover normal projections		46.20
8544	Pelvis		46.20
8545	Sacro-iliac joints		49.90
8546	Scoliosis films - single AP or lateral - 14 x 36 film taken at 6 feet		66.40
8547	Pelvis and additional requested views ie. sacroiliac joints, hip, etc.		61.90
8548	Myelogram and/or posterior fossa positive contrast (excluding procedural fee)		124.50

CHEST

8550	Thoracic viscera		46.20
8551	Thoracic inlet		46.20
8552	- additional requested views		22.80

DIAGNOSTIC ROENTGENOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
8553	Fluoroscopy, when requested		31.40
8554	Ribs - one side		46.20
8555	Ribs - both sides		69.30
8556	Sternum or sternoclavicular joints		46.20
8557	Sternum and sternoclavicular joints		69.30
8558	Bronchogram, excluding preliminary films (excluding procedural fees) - one side		115.80
8559	- both sides		159.90

ABDOMEN

8570	Abdomen		46.20
8571	Abdomen, multiple views		69.30

GASTRO-INTESTINAL TRACTS

8572	Esophagus, only		79.90
8573	Esophagus, stomach and duodenum		115.80
8574	Small bowel		115.80
8576	Colon or double contrast air studies		115.80
8577	Hypotonic duodenography		115.80
8578	Pancreatography (excluding procedural fee)		69.30
8579	Glucagon assisted contrast study (in addition to routine fee)		49.80

GALLBLADDER

8580	Oral cholecystogram		69.30
8581	Intravenous cholangiogram		101.30
8582	Operative cholangiogram (transhepatic also)		69.30
8583	Direct post-operative cholangiogram		69.30
8584	Removal of biliary calculi by Burhenne technique or equivalent including necessary cholangiogram and fluoroscopy (excluding procedural fee)		85.80

GENITO-URINARY SYSTEM

8590	K.U.B.		46.20

DIAGNOSTIC ROENTGENOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
8591	Pyelogram - intravenous		99.70
8592	IVP-special studies, ie. rapid sequence, drip infusion		136.90
8593	Pyelogram - retrograde		69.30
8594	Intravenous pyelogram with voiding cystourethrogram		138.70
8595	Cystogram or retrograde urethrogram (not including catheterization)		69.30
8596	Hysterosalpingogram (excluding injection)		115.80
8597	Pelvimetry		92.70
8598	Placentogram (with or without contrast)		69.30
8599	Voiding cystourethrogram		115.80

MISCELLANEOUS

8600	Cine study-50% added to the fee for region studied		
8601	Radiographic study of sinus, fistula, etc with contrast media, including injection and fluoroscopy, if necessary		69.30
8602	Body section radiography - applies to all tomographic procedures (including polytomography when done in one plan) per plane series, including orthopantogram		104.10
8603	Bone age - whatever method		46.20
8604	Bone survey - first anatomical area		46.20
8605	- each subsequent anatomical area		22.80
8606	Arthrogram, shoulder (excluding injection of contrast)		46.20
8607	Arthrogram, hip (excluding injection of contrast)		46.20
8608	Arthrogram, knee (excluding injection of contrast)		99.70
8609	Arthrogram, ankle (excluding injection of contrast)		46.20
8610	Mammography - unilateral		69.30
8611	- bilateral		115.80
8612	Xeromammography - unilateral		106.50
8613	- bilateral		171.60
8614	Lymphangiogram - one extremity		92.70
8615	Cerebral angiography - unilateral		162.00

DIAGNOSTIC ROENTGENOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
8616	- bilateral		256.60
8617	Peripheral angiography (arteriography and venography) - unilateral		92.70
8618	- bilateral for trauma		138.70
8619	Orbital venography		106.50
8620	Aortography (aortography plus peripheral angiography)		234.80
8621	Cerebral stereotaxy		185.30
8622	Cerebral stereotaxy - radiologist present additional		22.80
8623	Retroperitoneal gas insufflation		115.80
	The entry "Thoracic or abdominal angiogram" is intended to include the following: Ascending Lumbar Angiocardiogram Coronary arteriogram Celiac arteriogram Bronchial arteriogram Cavogram Mediastinal angiogram Renal arteriogram Mesenteric arteriogram Pelvic arteriogram Pulmonary arteriogram Splenoportogram Superior or inferior vena Lumbar aortogram Pelvic venogram, etc. Retrograde aortogram Ilio-femoral arteriogram Thoracic aortogram		
8624	Thoracic or abdominal angiogram (Cine or videotape surcharge not applicable) - using single film - non-selective		92.70
8625	- selective		22.80
8626	- using multiple sequential views - non-selective		177.70
8627	- selective		162.00
8628	Interpretation of submitted films - per examination NOTE: This item to be charged only in those situations where a third party requests a second written radiological opinion		22.80
8629	Radiologist in attendance for fluoroscopy for various clinical procedures (ie. small bowel biopsy; insertion of pacemaker, etc.		22.80
8630	Percutaneous transluminal angioplasty		417.50

COMPUTERIZED TOMOGRAPHY

8690	Head scan - without contrast		64.60
8691	- with contrast		90.10
8692	- double scan or 2 planes		116.60
8693	Body scan - one region without contrast		129.20

DIAGNOSTIC ROENTGENOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
8694	- one region with contrast		142.80
8695	- double scan or 2 regions		195.30

DIAGNOSTIC ULTRASOUND

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY

These fees cannot be correctly interpreted without reference to the Preamble

HEAD AND NECK

0916	Echoencephalography - midline A mode	32.10
8640	Echoencephalography - complete (midline and ventricular size)	84.60
8641	Ophthalmic B scan - immersion technique	228.30
2639	Ophthalmic ultrasound A scan for determination of axial length (to be billed only if patient proceeds to lens implant surgery)	82.50
8642	Thyroid B scan	82.50

HEART

8643	Echocardiography - M mode	194.70
8638	Echocardiography - real time	147.40
8661	Echocardiography - combined two dimensional real time and M mode	205.90
8644	Ultrasonically guided pericardiocentesis	172.10

THORAX

8645	B scan	172.10
8646	Ultrasonically guided thoracentesis	172.10
8647	B scan for breast mass - per breast	57.10

ABDOMEN

8648	Abdominal B scan for liver, pancreas, mass, aortic, aneurysm, etc.	172.10
8649	Renal B scan	172.10
8650	Ultrasonically guided biopsy or cyst puncture	172.10

OBSTETRIC AND GYNAECOLOGY

8651	Obstetrical B scan - 20 weeks gestation or over	162.90
8652	B scan IUD localization	68.60
8653	Non-obstetrical pelvic B scan	172.10
8654	Ultrasonically guided amniocentesis	172.10

DIAGNOSTIC ULTRASOUND

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
BRAIN			
8659	B scan		123.90
EXTREMITIES			
8658	B scan - cyst or mass		78.20
DOPPLER STUDIES			
	NOTE: The Doppler Vascular listings are applicable to hospital based accredited and approved ultrasound vascular studies laboratories only.		
8656	Assessment of ventricular arterial shunt		33.90
Peripheral Arterial:			
8664	Resting arterial assessment: To include multiple wave form and/or segmental pressure analysis, calculation and ankle/arm index		80.50
8665	Treadmill stress examination with or without ECG monitoring: To include sequential post stress measurement and calculations - with monitoring physician present		142.80
8666	- without monitoring physician present		96.70
8667	Reactive hyperemia with sequential pressures		60.80
8668	Vasopastic assessment: To include digital pressures and/or plethysmography - cold and hot stress responses and/or multiple extremity wave form analysis		96.70
8669	Sympathetic tone response: To include resting arterial assessment plus plethysmograph and/or impedance monitoring and/or digital wave forms, response to Valsalva maneuvers or other stimuli		59.10
Peripheral Venous:			
8670	Laboratory assessment of deep venous thrombosis: To include determination of venous sounds at multiple sites, response to standard compression maneuvers with documentation of sounds and responses		59.10
8671	Laboratory assessment of venous hypertension and venous reflux, delineation of incomplete perforators		59.10
Extracranial:			
8672	Carotid imaging: To include delineation of extra cranial vessels on both sides of the neck - ultrasound imaging		99.30
8673	- ultrasonic arteriography plotting		94.90
8674	- continuous wave audioangiography with or without wave forms		37.10
8675	- spectrum analysis		59.10
8676	- duplex scan, ie. ultrasonic image and placement, doppler flow assessment		146.40

DIAGNOSTIC ULTRASOUND

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
8677	Periorbital assessments; either oculoplethysmograph (OPG) or photoplethysmography (PPG), and/or doppler directional determination with extra-cranial artery compression maneuvers		59.10
8678	Subclavian or vertebral assessment including assessment of subclavian steal: To include directional doppler determination of flow direction in vertebral arteries with or without arm compression and other maneuvers		80.50

THERAPEUTIC ROENTGENOLOGY

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY

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

MALIGNANT DISEASE

Consultation in therapy for malignant lesion should include complete history and examination, review of x-ray and laboratory findings, routine urine and blood studies and written report.

8712	- skin	44.10
8711	- if biopsy is included	66.70
8710	Hemapoietic, reproductive (male or female), urinary, gastrointestinal or nervous system	88.70

X-RAY RADIATION

8715	Where an incomplete course of x-ray therapy or cobalt therapy is given, per treatment	22.00
8716	Multiple therapy, each additional port	11.00

NON-MALIGNANT DISEASE

8786	First treatment, including consultation and written report to referring physician	66.70
8787	- subsequent treatment	33.10

LABORATORY PROCEDURE (Short List)

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
Tests performed in physicians' offices that are accepted for payment by Insured Health Services.			
9000	Hemoglobin - other methods		4.30
9003	Hematocrit - micro or macro		4.30
9005	Hematology profile (automatic to include HGB, WCT, HCT, RBC indices) NOTE: When all components of the hematology profile (fee code 9005) are normal, a white count differential (fee code 9012) is not required and will not be performed unless medically required and specifically requested by a physician		16.70
9007	Hemoglobin - cyanmethemoglobin method		8.70
9011	White blood cell count only		8.70
9012	Differential white cell count		13.00
9031	Sedimentation rate		6.60
9066	Latex test		15.70
9074	Mono test		15.50
9077	Anti-nuclear factor		65.50
9101	Simple stained smear		10.70
9104	Urine culture		17.30
9106	Throat culture		13.70
9110	Secretion smear for eosinophils		10.70
9111	Examination for pinworm ova		8.70
9113	Direct examination for cutaneous fungus - KOH preparation		10.70
9115	Trichomonas and/or Candida (direct exam)		6.60
9119	Candida culture		8.10
9125	Serological tests 1 to 3 antigens		42.80
9126	Serological tests 4 or more antigens		64.80
9195	Lithium		21.80
9209	Potassium		17.30
9219	Dextrostix		4.30
9220	Glucose determination by reflectometer		7.90
9221	Glucose determination by reflectometer following ingestion of predetermined amount of glucose containing solution		11.80

LABORATORY PROCEDURE (Short List)

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
9234	Occult blood		8.70
9366	Complete urine analysis		8.70
9349	Immunological gonadotrophin (pregnancy test)		21.50
9364	Microscopic examination on centrifuged specimen of urine		6.50
9365	Routine screening urinalysis (to include sugar, protein, blood, pH, bile and ketones or any part thereof)		2.30
9429	Seminal examination for presence or absence of sperm		21.50
9436	Fern test		8.70
9827	T3		39.10
9830	T4		47.30
9242	Serum uric-acid		27.90

YUKON DENTAL FEES

		Anaes. Proc. Unit	YHCIP and YWCHSB ONLY
SURGICAL REMOVAL OF TEETH			
8504	Orthopan x-ray		71.30
9940	Erupted first tooth		48.00
9941	Each additional		24.00
9943	Soft tissue impaction		92.00
9944	Bony impaction (partial)		165.00
9945	Complete bony impaction		245.00
9950	Alveoloplasty		75.00
9987	Sulcus deepening and ridge construction per arch		393.00
9951	Exposure of tooth for orthodontic treatment		145.00
9984	Treatment of traumatic injuries of soft tissue with the mouth		97.00
9948	Root resection		172.00
9955	Incision and drainage of abscess of dental origin		54.00
9983	Frenectomy		170.00
9970	Closed reduction of fracture of mandible and maxilla		435.00
9966	Excision of intraoral cysts - small		218.00
9967	- large		411.00
9954	Intraoral biopsy - soft tissue		72.00
9969	- bony tissue		144.00
9960	Excision of benign intraoral tumors, under 1 cm.		210.00
9961	Excision of benign intraoral tumors, over 1 cm.		411.00
9964	Removal of root or foreign body from maxillary antrum		319.00
9965	Repair and closure of antro-oral fistula		259.00
9973	Closed reduction of temporomandibular dislocation		110.00
9958	Sialolithotomy		109.00
0110	Consultation written (at hospital)		118.60