MANITOBA
PHYSICIAN'S MANUAL

APRIL 1, 2006

Issued by:
The Minister of Health
manitoba.ca/health/manual

Manitoba
Health

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NUMERIC TARIFF INDEX

CLAIMS SUBMISSION AND PAYMENT PROCEDURE

The Manitoba Physician's Manual is an integral part of the negotiated contract between the Minister of Health and the Manitoba Medical Association regarding compensation for fee-for-service physicians. The most current version of the manual can be found on Manitoba Health's website @ manitoba.ca/health/manual.

PART I—SUBMISSION OF CLAIMS

Claims are usually paid within four (4) weeks of the date they are received. There are exceptions, depending on factors such as patient eligibility, complexity of the case and completeness of information. Claims submitted later than three (3) months from the date of service must be manually researched before processing and therefore delays in payment may occur.

Processing Cycle

Claims should be submitted weekly or at more frequent intervals. Claims will be processed on a continuous basis and payments will be made twice monthly, at mid-month and month-end.

Time Limit

Where a claim(s) is not submitted to the Claims Section within six (6) months from the date on which the service was rendered, the claim(s) will not be payable. This requirement may be waived under exceptional circumstances. An explanatory letter outlining the circumstances should be submitted with the claim(s).

Method of Submission

- Front counter:

  Claims may be delivered on weekdays to the reception area located at 300 Carlton Street from 8:30 a.m. to 4:30 p.m. A receipt will be provided upon request.

- Deposit box:

  Located at the south-west (rear) entrance of the building for delivery outside of office hours.

- Mail:

  Mailing address—300 Carlton Street, Winnipeg MB R3B 3M9.

  Return-addressed envelopes are available upon request.

  Claims should be adequately packaged to prevent loss and damage.

  Use sufficient postage for first class rate.

Claim Form Supply

- A supply of claim forms bearing the physician's name, number and bloc of practice will be provided to each physician. An additional supply of claim forms will be provided upon receipt of an order form.
- Written notice (signed by the physician) must be received by the Physician Registry, 300 Carlton Street in order to effect changes of name, address or bloc of practice.
- It is important to complete the claim form accurately and legibly. In this regard, we request that claims be completed by typewriter or neatly hand printed, using a black pen.

Incomplete Claims

- Many claims are received which do not contain sufficient information for processing.
- These claims are returned to the physician with the words "Incomplete—Over" stamped on the face of the claim; the requested information is indicated on the reverse side of the claim.
- The original claims should be returned to our office with the required information for processing. It is not necessary to prepare a new claim form.

Electronic Media Claims

In addition to the existing paper claim submission, the following methods of computerized data transmission are acceptable:

- Telecommunication from providers of service mini-computers or approved personal computers.
- Diskette.
- For further information, please telephone:.....(204) 786-7385; Fax (204) 942-2356

PART II—DIRECTORY—300 CARLTON STREET

Physician's Registry

- ..... (204) 788-2567 or 788 2591; Fax (204) 942-2356
- Registration of new physicians
- Registration of laboratory and x-ray facilities
- Locum tenens registration
- Claim form supplies
- Claim form information and payment cycles
- Physician's manual orders
- ***By Report*** Form supplies
- Claim Query Form supplies: (to be used for queries and re-submission of electronic and paper claims).

Claims Coding and Assessment

- Electronic claims .....(204) 788-2581 or 786-7202; Fax (204) 942-2356
- Paper claims.....(204) 786-7361; Fax (204) 942-2356
- Tariff number information
- Diagnostic code information
- "Incomplete claim" enquiries
- Medical data requirements

Eligibility Investigation

- .....(204) 788-2580; Fax (204) 942-2356
- Registration number request forms
- Physician cheque enquiry (opt-in)
- Claims pending for eligibility

Complex Claims

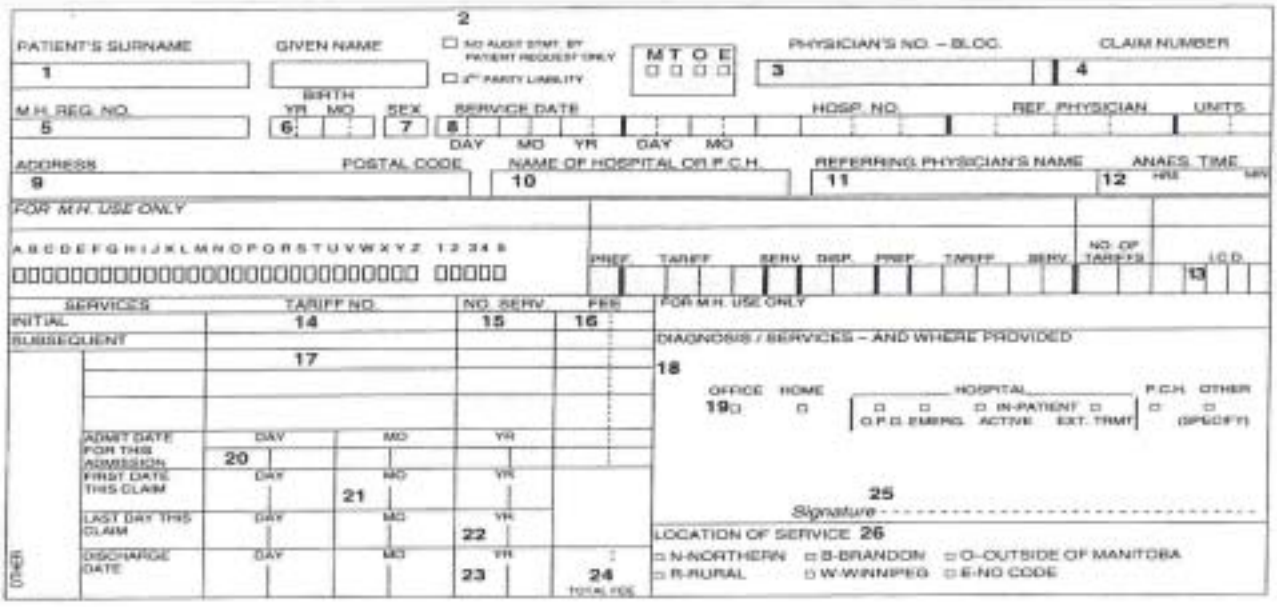
- Enquiries on reduced or rejected claims ..... (204) 786-7271; or (204) 786-7355
- Claims pending for assessment..... (204) 786-7271; or (204) 786-7355
- Applications for cosmetic/plastic surgery.....(204) 786-7334; Fax (204) 772-2248

Medical Assessor(s)

- ..... (204) 788-2548
- ..... Fax (204) 772-2248

PART III—INSTRUCTIONS FOR COMPLETION OF CLAIM FORMS

CLAIM FORM (GENERAL)



Claim for a benefit(s) shall include:

Reference
Location

1 Patient's Surname and Given Name—Complete in full to the extent of space allowed.

2 a) No Audit Statement by Patient Request Only—All Claims are handled in a confidential manner. However, in order to exclude a service from a "Notification of Health Benefits Paid" statement at the request of the patient, it will be necessary to complete this field. This is not to be used as a routine.

b) Third Party Liability—Complete, if applicable, third party responsibility (e.g., accident cases).

3 Your Personal Physician's Number and Bloc of Practice—This is preprinted information. No entry is required by the physician.

4 Claim Number—This is preprinted information. No entry is required by the physician.

5 Patient's Registration Number—Please ensure that this is accurately reported. The registration number is a maximum of six (6) numerics with no alphabetic characters.

6 Patient's Year and Month of Birth—Complete two (2) positions of year of birth, and month of birth if available.

7 Patient's Sex—Enter as "M" or "F."

8 Service Date—Enter date of service using two (2) positions for each: day, month and year for other than in-patient hospital care in this area. If multiple service dates involved (e.g. psychotherapy), complete in location 18. Refer to Exhibit III.

9 Patient's Address—Complete to extent of space available and include postal code if known.

10 Hospital or Personal Care Home—Complete for all services provided in a hospital/personal care home.

11 Referring Physician's Name—Enter physician's first name/initials and surname.

12 Anesthetic Time—Enter anesthesia in hours and minutes.

13 I.C.D.—Office use only (except when otherwise authorized).

14 Tariff Number—Enter the tariff number of the applicable service as listed in the Physician's Manual.

15 Number of Services—Enter when multiple services are claimed.

16 Fee—Completion of this field is optional.

17 Additional Tariff(s)—Use this area to report additional tariff numbers.

18 Diagnosis/Services—In addition to diagnosis, enter the written description of services rendered to verify the tariff number and any other information reported on the claim.

19 Services/Where Provided—Identify the location of service by completing this section as well as the name of the institution where applicable (reference location 10). When marking the "OTHER" box, please specify the location where the services were rendered.

20 In-Patient Hospital Care—Refer to Exhibit I.

21 In-Patient Hospital Care—Refer to Exhibit I.

22 In-Patient Hospital Care—Refer to Exhibit I.

23 In-Patient Hospital Care—Refer to Exhibit I.

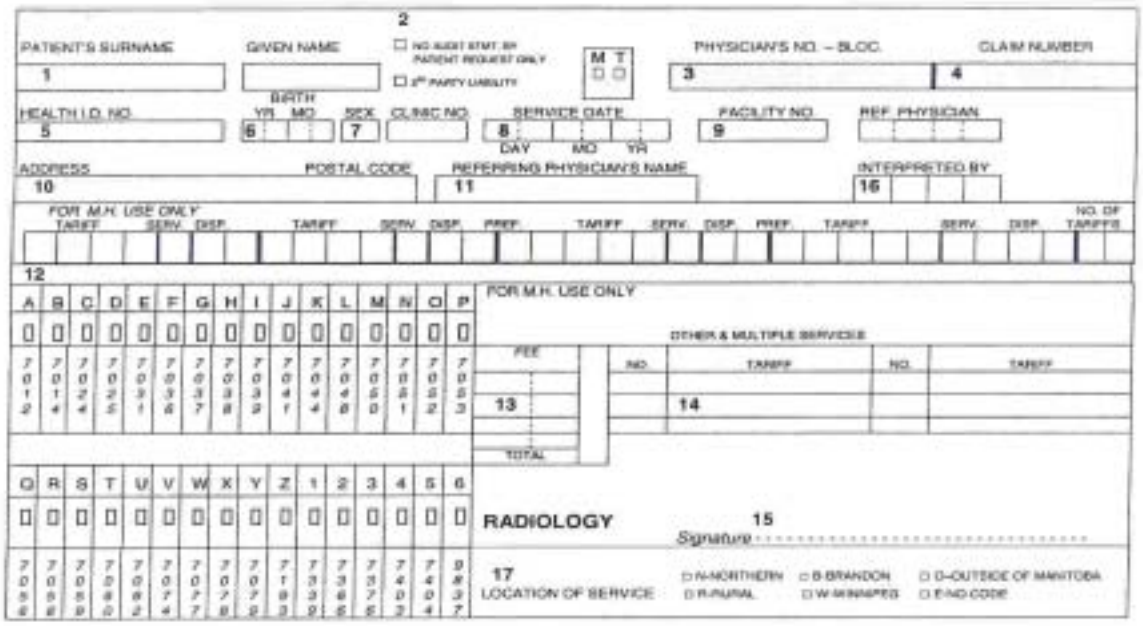
24 Total Fee—Completion of this field is optional.

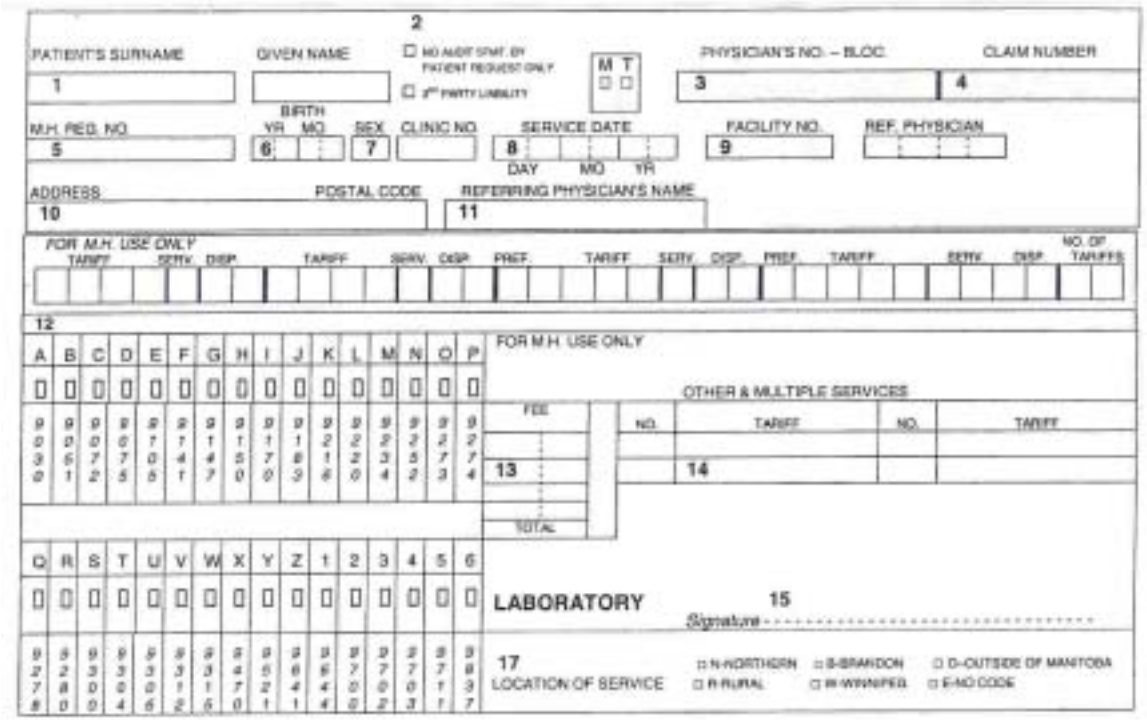
25 Physician's Signature—Claim forms must bear the personal signature of the physician, an approved signature stamp, or an approved computer produced signature.

26 Location Of Service Code—Enter location service was rendered.

PART III—INSTRUCTIONS FOR COMPLETION OF CLAIM FORMS

CLAIM FORMS (RADIOLOGY AND LABORATORY)





Reference Location

1 Patient's Surname and Given Name—Complete in full to the extent of space allowed.

2 a) No Audit Statement by Patient Request Only—All claims are handled in a confidential manner. However, in order to exclude a service from a "Notification of Health Benefits Paid" statement at the request of the patient, it will be necessary to complete this field.

b) Third Party Liability—Complete, if applicable, third party responsibility (e.g. accident cases).

3 Your Personal Physician's Number and Bloc of Practice—This is preprinted information. No entry is required by the physician.

4 Claim Number—This is preprinted information. No entry is required by the physician.

5 Patient's Registration Number—Please ensure that this is accurately reported. The registration number is a maximum of six (6) numerics with no alphabetic characters.

6 Patient's Year and Month of Birth—Complete two (2) positions of year of birth, and month of birth if available.

7 Patient's Sex—Enter as "M" or "F."

8 Service Date—Use two (2) positions for each: day, month and year.

9 Facility Number—This is preprinted information.

10 Patient's Address—Complete to extent of space available and include postal code if known.

11 Referring Physician's Name—Enter physician's first name/initials and surname.

12 Tariff Number—This area is to be used for reporting single services only.

Mark the appropriate field(s) above the preprinted tariff number(s). (Fill in the mark sense box completely).

13 Fee/Total Fee—Completion of this field is optional.

14 Other and Multiple Services—Use this area to report multiple services and any single service not listed in the preprinted tariff number area–reference location 12.

Example:

Radiology—if both knees are x-rayed on the same day, enter 7056 x 2 in location 14.

Laboratory—if two (2) urinalysis are done on the same day, enter 9641 x 2 in location 14.

15 Physician's Signature—Claim forms must bear the personal signature of the physician, an approved signature stamp, or an approved computer produced signature.

16 Interpreted By (radiology claim only)—Identify the radiologist doing the interpretation. If self, please indicate with a (slash) in location 16, rather than the physician's billing number.

17 Location of Service Code—Enter location service was rendered.

PART III— INSTRUCTIONS FOR COMPLETION OF CLAIM FORMS

CLAIM FORM (DETAILED EXHIBITS)

In-Patient Hospital Care General Claiming Instructions

Services for acute hospital care should be submitted monthly or for a period not exceeding two (2) months on the first claim, and monthly thereafter.

In addition to recording the dates of the first visit and last visit claimed, provide the original admission date and discharge date if applicable for this hospital stay. In case of transfers to Extended Treatment Hospitals, refer to Rule 18.

Services provided prior to hospital admission on the same day, such as office visits, out-patient care and emergency department care, should be included on the same claim as the initial in-patient care. Identify the location where the services were provided by marking the appropriate box.

Special services provided during the hospital stay such as Complete History and Physical Exams, E.C.T., Psychotherapy, etc., should be listed along with the relative service dates in the Diagnosis/Services—and Where Provided section of the claim form—See Exhibit III.

Exhibit I Admit Date—Patient admitted August 27, 2005
First day this claim—first hospital visit 8520 claimed—August 28, 2005
Last day this claim—September 30, 2005
Discharge date—September 30, 2005

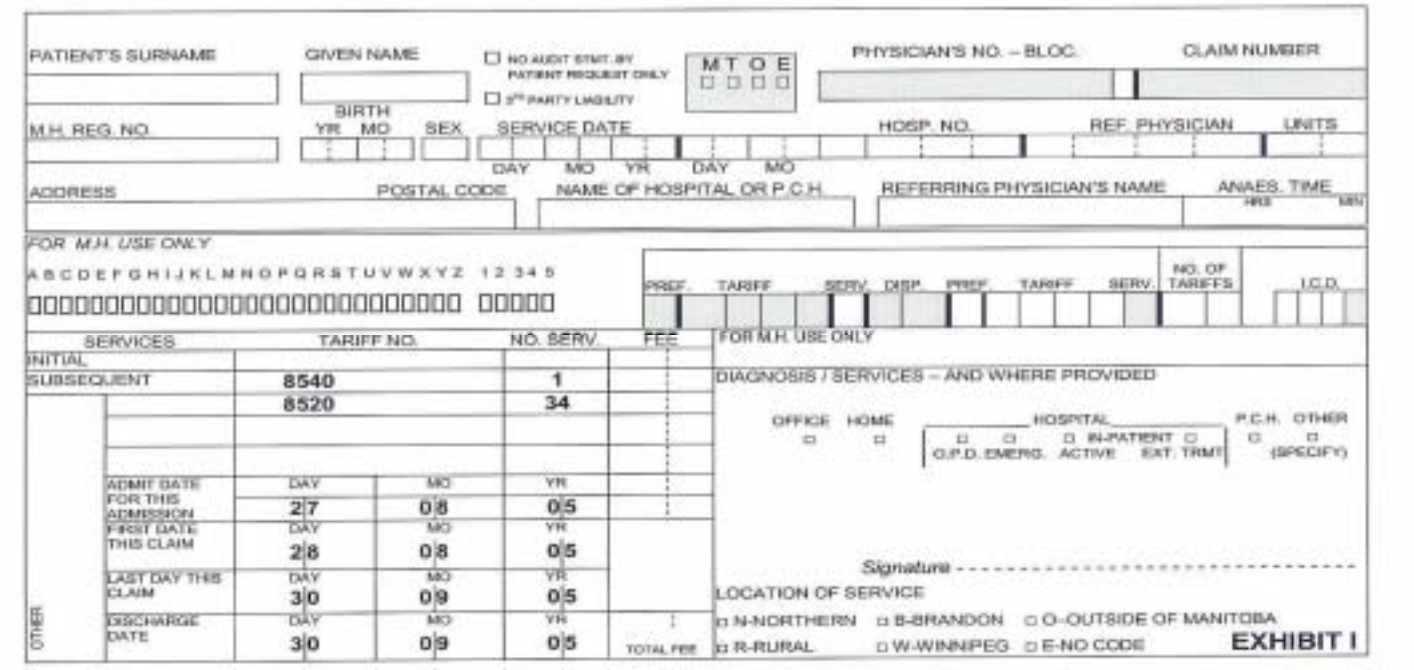


Exhibit II If patient was not discharged on September 30, 2005 but remained in hospital until October 25, 2005, then submit another claim the following month.

Admit date—August 27, 2005
First day this claim—October 1, 2005
Last day this claim—October 25, 2005
Discharge date—October 25, 2005

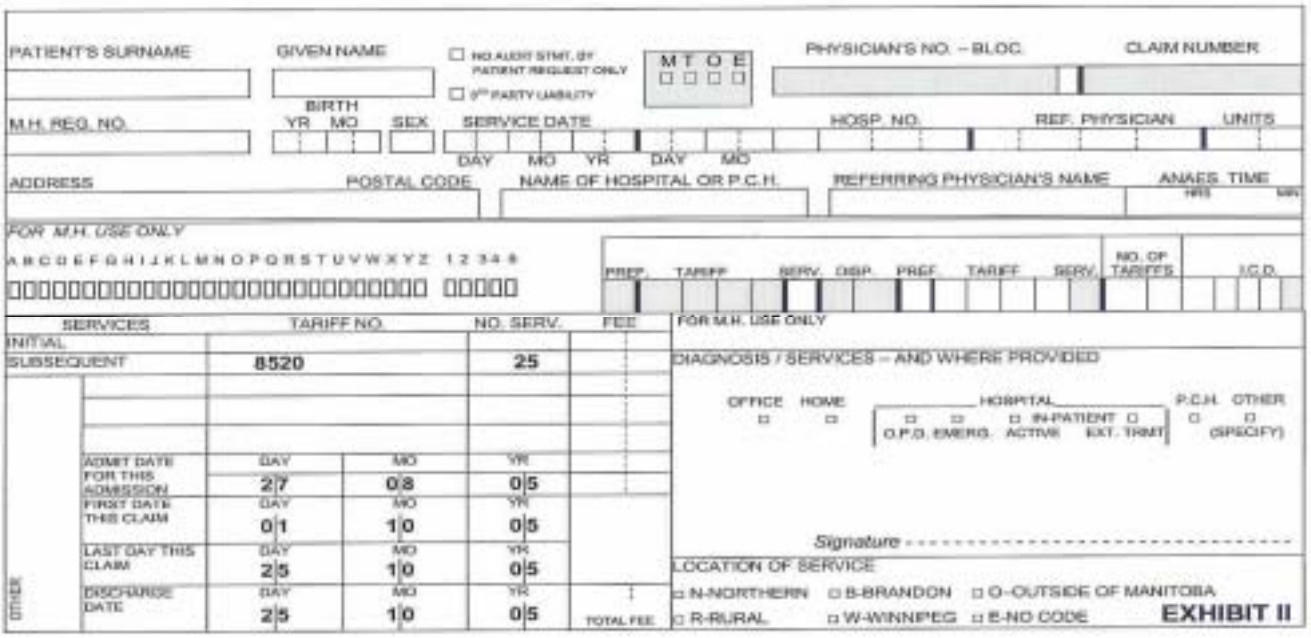
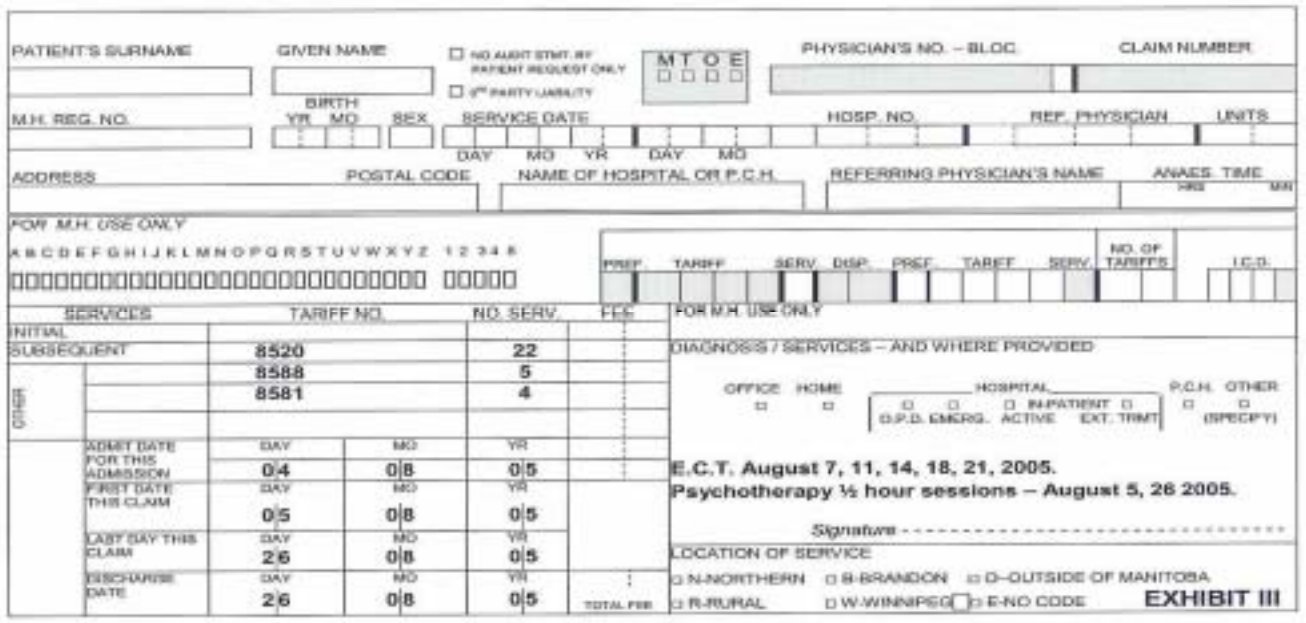


Exhibit III Hospital stay with special services during the stay.
Admit date—August 4, 2005
First day this claim 8520—August 5, 2005
Last day this claim—August 26, 2005
Discharge date—August 26, 2005
Special Services Dates—E.C.T.—August 7, 11, 14, 18, 21, 2005
Psychotherapy—1/2 hour sessions—August 5, 26, 2005

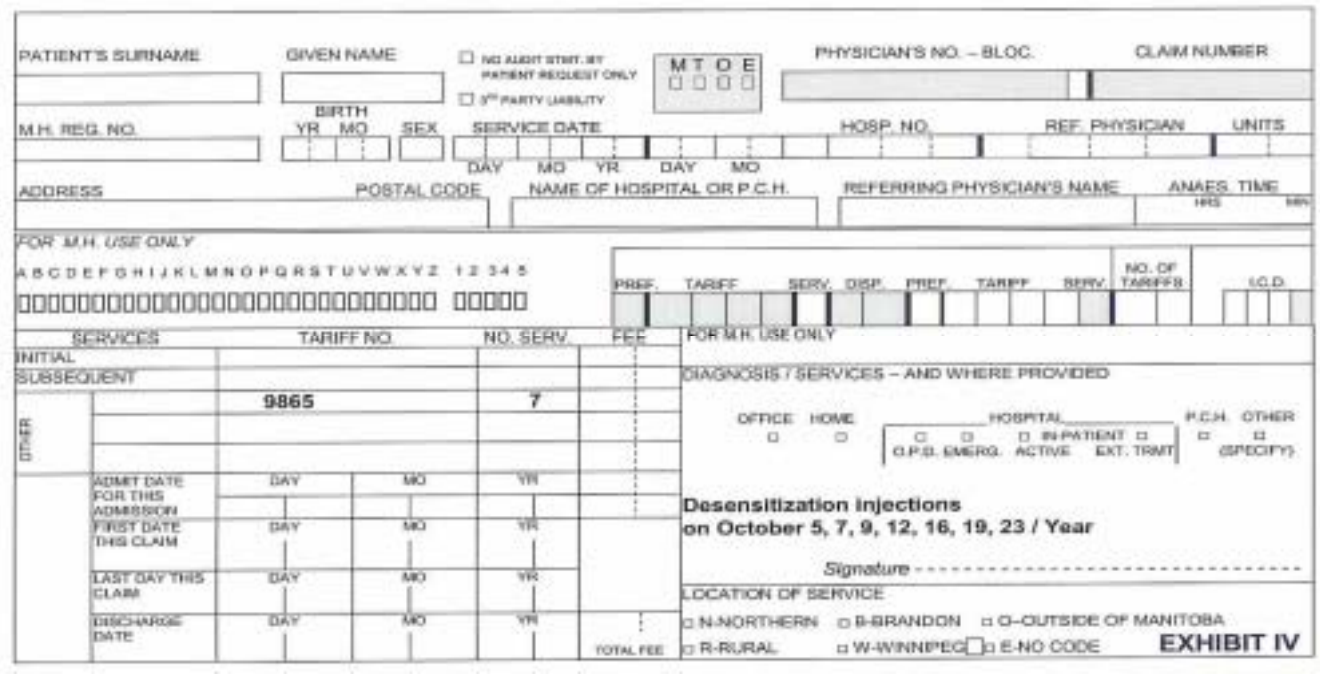


Identical Repetitive Services

In general, the claim form is designed for one (1) form per day per patient and the physician is encouraged to submit claims daily or weekly to take advantage of the semi-monthly payment cycle.

In situations where the patient may be treated several times during the month, e.g., allergy desensitization, hemodialysis, chronic care, etc., these identical, repetitive services may be submitted on one (1) claim (for each month). The relative service dates must be listed in the Diagnosis/Services—and Where Provided section of the claim form.

Exhibit IV—Allergy desensitization injections.



PART IV—REMITTANCE ADVICE

Itemized statements will be forwarded to you in the middle and at the end of each month, listing all claims that were ready for payment at the time the Remittance Advice was prepared. The processed claims will appear on these statements in alphabetical order by patient surname and will include the following information:

- Patient's surname and given name
- Patient's registration number, year of birth, sex
- Day, month and year of service
- Tariff number
- Number of services
- Disposal codes
- Approved and total approved fees

In the event that claims are delayed in process, they will appear on all subsequent remittance advice statements under the "Listing of Pending Claims" or a subsequent remittance advice statement under the "Listing of Processed Claims." The suitable disposal code will accompany each claim appearing under the "Pending" list to identify the reason for delay.

The amount of information that is recorded on the "Listing of Pending Claims" will vary according to the cause of delay in processing.

PART V—INTEREST

Effective July 1, 2001, if an electronic claim is not paid within thirty (30) days of receipt of the claim by Manitoba Health, or a paper claim is not paid within sixty (60) days of receipt of the claim by Manitoba Health, provided the claim has included all required information as set out in the Physician's Manual, interest shall by paid on the outstanding amount of the claim until the date of actual payment, and rate of interest per annum shall be:

i) for the period January 1 to June 30 in each year, the prime lending rate of the Bank of Canada as that rate stood on January 1 of that year, plus 1%; and

ii) for the period July 1 to December 31 in each year, the prime lending rate of the Bank of Canada as that rate stood on July 1 of that year, plus 1%, compounded annually.

Where a physician submits a formal query about the disposition of a claim, and the claim is adjusted in such a manner that the payment ultimately exceeds the amount, if any, originally paid by Manitoba Health, interest at the rate set out above shall be payable on the difference from thirty (30) days after receipt of the claim by Manitoba Health in the event of an electronic claim, and sixty (60) days after receipt of the claim by Manitoba health in the event of a paper claim, to the actual date of payment.

PART VI—BY REPORT

It is not possible to list every variation of a procedure. Some procedures may vary from minor to major and cannot be listed with a definite benefit, and will require assessment.

In order to correctly assess a fee tariff number designated as ***By Report***, the assessor must have complete information. This may be provided on the claim form itself, by the operating room report, a separate letter, or on a ***By Report*** form ***attached to the claim form*** (not stapled).

There are several factors which will assist in assessment, e.g., the size of the lesion, the area involved, complications and the time required to perform the procedure. Where possible, the claimant may relate the service to an existing tariff number of similar complexity which carries a definite benefit or may suggest a suitable benefit. If you are in disagreement with an assessment, please refer to the appeal mechanism listed below.

PART VII—DISPUTES

Informal Resolution of Disputes

The assessment of a claim is not necessarily final and is always subject to appeal. It should be recognized, however, that an unsatisfactory assessment may result from a misunderstanding or a lack of information. An initial contact with the medical assessor may resolve the assessment to the physician's satisfaction.

In the event that a claim assessment cannot be satisfactorily resolved, we suggest the physician submit a written request for a decision to the Chairman of the Assessment and Benefit Policy Committee—Insured Benefits Branch, Manitoba Health.

Referral to Medical Review Committee

Where a dispute arises between a physician and the Minister concerning the application of the Physician's Manual or any matter thereto as it applies to such physician which cannot be satisfactorily resolved on an informal basis, the physician or the Manitoba Medical Association (acting on behalf of the physician) may refer the dispute in writing to the Medical Review Committee for a decision.

The Medical Review Committee shall request the positions of the physician and the Minister in writing, and such positions shall be provided to the Medical Review Committee within thirty (30) days of the request having been made. The Medical Review Committee shall serve, by registered mail, a copy of its decision on the physician or the Manitoba Medical Association (acting on behalf of the physician), as the case may be, and the Minister.

Appeal to Board of Grievance Arbitration

A decision of the Medical Review Committee under this Part may be appealed to a Board of Grievance Arbitration by the Minister, the physician or the Manitoba Medical Association (acting on behalf of the physician) by providing written notice, to be served by registered mail, to the other party to the dispute within thirty (30) days from the date the Medical Review Committee decision was served upon the parties to the dispute.

Where an appeal of a decision of the Medical Review Committee might have been taken to a Board of Grievance Arbitration but the Minister, the physician or the Manitoba Medical Association (acting on behalf of the physician) did not appeal the decision by providing written notice to the other party to the dispute within thirty (30) days from the date the decision was served upon the parties, a decision of the Medical Review Committee under this Part is final and binding and shall not be appealed to or reviewed by any court or removed by certiorari.

Such Board of Grievance Arbitration shall be composed of three (3) physicians entitled to practice medicine in the Province of Manitoba, one (1) appointed by the physician or the Manitoba Medical Association as the case may be, one (1) appointed by the Minister, and the Chairperson to be selected by the appointees of the parties. The decision of the Board of Grievance Arbitration shall be final and binding on both parties.

The Board of Grievance Arbitration constituted hereunder shall have the power to determine its own procedures and shall have the power to receive and accept such evidence and information the Board sees fit, whether admissible in a Court of Law or not; and the Board of Grievance Arbitration shall give full opportunity to the parties to present evidence, make submissions, and to be heard. The Board of Grievance Arbitration shall have full remedial authority and shall order such remedy as may be just, but the Board of Grievance Arbitration shall have no authority to amend this Regulation or the provisions of the agreement respecting fee-for-service physicians between the Minister and the Manitoba Medical Association dated March 8, 1994.

The Board of Grievance Arbitration shall make its award in regard to the specific matter(s) referred to it within thirty (30) days of completion of the hearing respecting the matter(s), or within such longer period of time as the parties may mutually agree upon.

The decision of a majority of the members of the Board of Grievance Arbitration shall be the decision of the Board of Grievance Arbitration.

Each party of the Board of Grievance Arbitration shall be responsible for the approved and agreed to costs and expenses of its appointees to such Board of Grievance Arbitration and the approved and agreed to costs and expenses of the Chairperson shall be shared equally between the parties.

Except as provided herein, a decision of the Board of Grievance Arbitration under this Part is final and binding, and shall not be appealed to or reviewed by any court or removed by certiorari.

PART VIII—INFORMATION RELATING TO PATIENT ELIGIBILITY

The following information is a general outline—for more specific information, please refer to "The Health Services Insurance Act" and Regulations or contact our office.

Registration certificates are issued to families and single persons eighteen (18) years of age and older. The public have been instructed (through brochures, etc.) to present their registration certificates when seeking services insured under the Plan, however, in the event a patient cannot provide you with a registration number, contact us using the forms designed for this purpose and we will attempt to identify the patient as a Manitoba resident. Please note that registration numbers have a maximum of six (6) numerics with no alphabetic characters.

Persons Eligible

In general, residents who make their home and are ordinarily present in Manitoba are eligible for benefits under the Plan.

Persons Not Eligible

Tourists, students from other countries, transients, visitors and other persons temporarily in Manitoba are not residents and, therefore are not eligible for coverage under the Manitoba Plan.

Registration Requirements

All residents of Manitoba are required to register themselves and their dependents either with their employer [if employer has three (3) or more employees], with the municipality in which they reside, or directly with the Insured Benefits Branch.

PART IX—FEE DIFFERENTIALS

Definitions

1. General

"locum tenens" is a physician who enters into an arrangement whereby he or she provides medical services on behalf of an absentee physician on a temporary basis.

"northern Manitoba" means that part of Manitoba north of the 53rd parallel of latitude.

"rural Manitoba" means that part of Manitoba south of the 53rd parallel of latitude except the city of Winnipeg and the city of Brandon.

Fees

2. The fees set out in the Schedule, titled "Physician's Manual", are benefits payable under "The Manitoba Health Services Insurance Act" with respect to the cost of insured medical services.

Fee Differentials

3. In addition to the amount set out in the Schedule, the Minister shall pay the percentage set out in Column I of the following Table for each medical service provided by a physician in the location set out opposite in Column II.

Table	
Column I	**Column II**
10%	Northern Manitoba
5%	Rural Manitoba
2.5%	City of Brandon
0%	City of Winnipeg
0%	Outside Manitoba

Conditions Applicable to Locum Tenens Physicians Without a Personal Billing Number and Claim Forms

4.1 a) The locum tenens physician must be appropriately licensed with The Manitoba College of Physicians and Surgeons.

b) The locum tenens physician must receive written approval from The College of Physicians and Surgeons to act in place of another physician.

c) The locum tenens physician must be of the same specialty as the absentee physician.

d) Prior written notification must be given to the Insured Benefits Branch of the name of the locum tenens physician and the exact dates of the locum tenens physician's practice.

e) Locum tenens physicians who act in place of another physician for a period exceeding sixty (60) continuous days will be required to register for a personal billing number and use that number for billing purposes. Under extenuating circumstances, the Minister may extend the sixty (60) day time limit for locum tenens.

Payments: If these conditions are met, the claim forms of the absentee physician may be used by the locum tenens physician; however, the signature of the locum tenens must appear on the claim form either alone or over the stamp signature of the regular physician. Payments will continue to be made to the absentee physician. (The financial arrangements between the two (2) physicians is a matter to be dealt with by those individuals.)

Note: *For locum tenens physicians who are duly registered in Manitoba and choose not to use their own claim forms, the above conditions under section 4.1 apply and payments will be made to the absentee physician.*

Conditions Applicable to Locum Tenens Physicians Who are Duly Registered in Manitoba and Choose to Use Their Own Personal Billing Number and Claim Forms

4.2 a) The locum tenens physician must be of the same specialty as the absentee physician.

b) It is not a requirement for the absentee physician to notify the Insured Benefits Branch of the locum tenens arrangement.

Payments: In this situation, payments will be made directly to the locum tenens physician.

RULES OF APPLICATION

1—CALL OR VISIT

A ***Call Or Visit*** is the service by a physician to a patient for diagnosis and/or treatment and may take place in office, home, hospital or elsewhere. A claim for a call or a visit may also be made in exceptional circumstances such as where a third party is involved, but this may require an explanation.

Counselling to a patient or to members of the family or to others concerned regarding family planning, premarital, sterilization, child behaviour problems, psychotherapy and other such matters is included in the patient's visit fee and/or the procedure or treatment carried out on the patient.

The above mentioned fees are intended to cover the time spent in explanations and instructions to the third party.

If the counselling occurs during a psychotherapy visit and involves a patient together with a third party, the time charged for the psychotherapy visit should be the total time spent with the patient and the third party and the claims should be made out in the name of the patient.

If the counselling occurs at the time of a visit with the patient and explanations and/or discussions with the third party at that time are necessary, this counselling will be included in the patient's visit and no separate charge should be made for the counselling.

If the situation with respect to the patient requires a separate visit by a third party—by formal appointment for a minimum of fifteen (15) minutes duration—under exceptional circumstances the physician may charge as a separate visit under the patient's name.

Where appropriate, tariff 8474 "Case Management Conference" and tariff 8473 "Patient Care Family Conference" may be claimed. See General Schedule Case Management Conference or General Schedule Patient Care Family Conference.

In exceptional circumstances: See Rule 55.

2—SPECIALIST

A ***Specialist*** (for the purposes of application of the Schedule of Benefits) shall be defined as a physician whose name is in the specialist register of The College of Physicians and Surgeons of Manitoba and shall be paid according to the listed benefit in the Schedule of Benefits for that specialty.

A ***Specialist*** is permitted to do and shall be paid for a procedure outside his specialty.

Where there is no "office and hospital visit" page for that specialty or where the procedure has been done by a specialist which is not listed in the "office and hospital visit" page of that specialty, payment will be made according to the general practice schedule except tariffs specifically mentioned elsewhere in the general schedule.

3—SPECIAL CALL

Whenever a physician is required to make a special trip, over and above the physician's regular routine, to attend a patient, a ***Special Call*** benefit may be claimed in addition to the benefits listed for assessment and/or procedural medical services (except as listed below). Only one (1) ***Special Call*** per response is applicable.

A ***Special Call*** must be initiated by someone other than the physician (except when services are rendered outside the hospital) and requires the physician to travel from one location to another (not within the same building complex) to attend the patient

A ***Special Call*** benefit will be paid even if the patient is deceased, on the arrival of the physician called, or, if the patient has left the premises prior to the physician's arrival provided the physician was not unreasonably tardy.

Subject to the Exclusions listed below, all ***Special Call*** benefits may be claimed under the following tariffs:

8561 For special calls made to a patient's home 28.00

8598 For special calls made to the emergency department or O.P.D. of a hospital 35.50

8566 For special calls made in obstetrics by:
i) the physician receiving payment for the delivery, excluding the day of delivery;
ii) the physician not receiving payment for the delivery. 40.00

8567 For special calls made in non-elective surgical cases, in the postoperative period. 40.00

8563 All other special calls not covered under Tariffs 8561, 8566, 8567 or 8598 (including, but not limited to, special calls made to personal care homes and to attend to registered hospital patients, subject to Exclusion (a) below) may be claimed under this tariff. 40.00

EXCLUSIONS

Special Call benefits do not apply under the following circumstances:

a) Care to registered hospital patients during the physician's regular daily round.

b) Regularly scheduled daily office appointments.

c) Scheduled N.F.A. medical services.

d) Routine care provided to patients in personal care homes.

e) Scheduled routine in-patient surgical activity.

f) Where the physician is already in the hospital.

g) All elective surgery both pre and postoperative.

h) In obstetrical care, on the day of delivery, by the physician performing the delivery, including caesarean section.

4—COMPLETE HISTORY AND PHYSICAL EXAMINATION

A ***Complete History and Physical Examination*** is a service that will vary from specialty to specialty. In the case of regional specialties, the service may comprise only a full history of the presenting complaint, inquiry concerning and detailed examination of the affected part, region or system, as needed to make a diagnosis, exclude disease and/or assess function, a complete record and advice to the patient. In case of general practitioners, the service is defined with tariff 8540.

5—REGIONAL HISTORY AND EXAMINATION

A ***Regional History and Examination*** is the service rendered to a patient who consults the physician for a condition—usually relatively minor—which does not require as full an assessment as described under "Complete History and Physical Examination."

6—SUBSEQUENT VISIT

A ***Subsequent Visit*** is one that follows either a complete or regional history and examination by the same physician, for the same condition within a period of sixty (60) days; i.e., if the patient has been seen by the same doctor within any sixty (60) day period for the same condition, only a subsequent visit may be claimed for any visit following the initial visit. However, in the case of certain illnesses, for example the continuing management of a chronic illness, when the physician deems it necessary to do a more extensive examination such as a complete physical examination or a regional or a reassessment within the sixty (60) day period, a claim for such a visit may be allowed but only by ***Special Report***.

7—CONSULTATION

A ***Consultation*** is the situation in which a physician, after appropriate examination of the patient, requests the opinion of another physician because of the complexity, obscurity or seriousness of the patient's illness, or because another opinion is requested by the patient or a person acting on his behalf. After the consultation, the patient is usually returned to the care of the attending physician—See Rule 9.

8—CONSULTATION

A ***Consultation*** shall consist of such examination of the patient as necessary and appropriate to the consultant's field of practice, review of the laboratory or other data, a written opinion regarding diagnosis and recommendations as to treatment.

9—CONTINUING CARE BY A CONSULTANT

Continuing Care By A Consultant 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 benefit will be provided for this consultation and continuing care (including procedures) according to the schedule of benefits pertaining to the specialty of the consultant.

10—MANDATORY CONSULTATIONS

Mandatory Consultations, i.e. those required by statute or hospital by-law are regarded as being in the best interest of the patient and the appropriate benefit will be provided.

11—DISTINCTION BETWEEN REFERRAL AND CONSULTATION

If a physician recommends that his patient attend another physician for treatment solely because the patient's condition is outside the field of the first physician, the second physician should receive the patient as a referred case, as this is not considered a consultation, and the benefit shall not be provided at the consultation value.

12—HOSPITAL CARE

Hospital Care applies to the care of registered bed patients formally admitted to hospital, benefits for which are listed on the Visit Pages, and are claimable from the date of admission to the date of medical discharge by the attending physician. Only one (1) visit per day, per patient, will be paid for in-hospital care regardless of the necessity of multiple visits on the same day. Whenever a visit to an in-patient necessitates a special trip, however, as defined in Rule 3, a ***Special Call*** benefit will also apply.

After the date of medical discharge, visits will be claimable on a per visit basis according to the Rules of Application governing chronic care.

13—SUPPORTIVE CARE

Supportive Care is the situation where the responsibility for the medical and surgical care of the patient in hospital has temporarily been transferred from the family or referring doctor to a consultant, but it remains necessary and/or desirable for the family or referring doctor to visit the patient for purposes of reassurance, liaison with the family, etc. The fee for each visit by the referring doctor will be the same as for hospital visits and will be limited to three visits per week. Claims for supportive care will be paid only when a ***Special Report*** is submitted to justify the necessity of this service.

14—CONCOMITANT CARE

When the complexities of the case require the continued attendance of more than one physician, with supplementary skills in different fields of practice, fees for the services given by each physician will be paid according to the Schedule of Benefits, but any claim under this section shall be accompanied by a ***Special Report***.

The guidelines for ***Concomitant Care*** are outlined in Rules 47 to 54.

15—DELETED (JULY 1, 2005)

16—PERSONAL CARE HOME CARE

Personal Care Home Care is defined as care by a physician of a patient or a resident in an institution, such as in a home for the aged, hostel, or personal care home insured under "The Manitoba Health Services Insurance Act."

Visits shall be paid as follows:

a) Benefits listed under Tariff 8511 (Chronic Care) in the General Schedule shall apply for a routine visit to a chronic care patient in such an institution to examine, assess or evaluate the patient's condition, and give advice as necessary to the patient and/or the nursing staff concerning management of the patient.

b) A visit to a patient with an "acute illness", which occurs during the physician's routine attendance at the institution, shall be paid as an office visit appropriate to each bloc of practice.

For the purpose of this Rule, "acute illness" is defined as an illness of such a nature that the physician would likely have been requested to make a special trip to visit the patient, were the physician not scheduled for a routine attendance at the institution on the day the illness arises.

For the purpose of this Rule:

i) an illness which is chronic, or

ii) an "acute illness", which has previously been diagnosed by the physician but is not in an acute phase at the time of the subsequent visit, does not qualify as an "acute illness."

A claim for a visit to a patient with an "acute illness", which occurs during a routine attendance at the institution, must include the words "acute illness" as well as a brief explanation of the nature of the illness.

c) When a physician is required to make a special trip to the institution to visit a patient, the visit shall be paid as an office visit appropriate to each bloc of practice, and the appropriate ***Special Call*** benefit shall be paid.

17—GYNAECOLOGICAL EXAMINATIONS

17(a)—COMPLETE HISTORY AND PHYSICAL EXAM WITH GYNAECOLOGICAL EXAM *INCLUDING* CYTOLOGICAL SMEARS—CERVIX

A Complete History and Physical Examination with Gynaecological Examination, Including the Taking of Cytological Smears for Cancer Screening—Cervix, is a service provided to a patient, which will usually comprise of:

- A full patient history;
- An inquiry into and an examination of all relevant parts or stystems required to make a diagnosis or differential diagnosis;
- A review of results of investigations ordered by the physician;
- Taking cytological smears for cancer screening – cervix;
- A comprehensive pelvic examination;
- A complete written or electronic record, and
- Advice to patient.

Note: *Tariff 9795 (cytological smears for cancer screening) may not be claimed in addition to this service.*

In the case of Obstetricians/Gynaecologists, the service is defined with tariff 8495.

17(b)—COMPLETE HISTORY AND PHYSICAL EXAM WITH GYNAECOLOGICAL EXAM *EXCLUDING* CYTOLOGICAL SMEARS—CERVIX

A Complete History and Physical Examination with Gynaecological Examination, Excluding the Taking of Cytological Smears for Cancer Screening is a service provided to a patient, which will usually comprise of:

- A full patient history;
- An inquiry into and an examination of all relevant parts or systems required to make a diagnosis or differential diagnosis;
- A review of results of investigations ordered by the physician;
- A comprehensive pelvic examination;
- A complete written or electronic record, and
- Advice to the patient.

Note: *Tariff 9795 (cytological smears for cancer screening) may not be claimed in addition to this service. In the case of Obstetricians/Gynaecologists, the service is defined with tariff 8540.*

17(c)—REGIONAL INTERMEDIATE VISIT WITH GYNAECOLOGICAL EXAMINATION *INCLUDING* THE TAKING OF CYTOLOGICAL SMEARS—CERVIX

A Regional Intermediate Visit—Regional or Subsequent with Gynaecological Examination, Including the Taking of Cytological Smears for Cancer Screening—Cervix, is a service provided to a patient for a problem specific assessment, which shall be comprised of:

- A history of the presenting complaint(s);
- An examination of the parts or systems related to the presenting complaint(s);
- Taking of cytological smears for cancer screening – cervix;
- A comprehensive pelvic examination;
- A review of all pertinent investigations;
- A complete written or electronic record, and
- Advice to the patient.

Note: *Tariff 9795 (cytological smears for cancer screening) may not be claimed in addition to this service. In the case of Obstetricians/Gynaecologists, the service is defined with tariff 8496.*

17(d)—REGIONAL INTERMEDIATE VISIT WITH GYNAECOLOGICAL EXAMINATION *EXCLUDING* THE TAKING OF CYTOLOGICAL SMEARS—CERVIX

A Regional Intermediate Visit—Regional or Subsequent with Gynaecological Examination, Excluding the Taking of Cytological Smears for Cancer Screening is a service provided to a patient for a problem specific assessment, which shall be comprised of:

- A history of the presenting complaint(s);
- An examination of the parts or systems related to the presenting complaint(s);
- A comprehensive pelvic examination;
- A review of all pertinent investigations;
- A complete written or electronic record, and
- Advice to the patient.

Note: *Tariff 9795 (cytological smears for cancer screening) may not be claimed in addition to this service. In the case of Obstetricians/Gynaecologists, the service is defined with tariff 8497.*

17(e)—A COMPREHENSIVE PELVIC EXAMINATION

A Comprehensive Pelvic Examination is comprised of the following elements:

- Performance of visual inspection of the vulva and perineum;
- Insertion of speculum into the vagina to inspect the vault and cervix;
- Bimanual examination of a the uterus and ovaries, and
- Conduction of pelvi-rectal examination (where indicated).

18—CHRONIC CARE

Chronic Care is defined as care of a patient in the Extended Treatment Unit of a hospital as designated by Manitoba Health.

Where a patient is transferred to a new physician in an extended treatment hospital, the new physician may claim a Complete History and Physical Examination if the service is performed in addition to any other services to which the physician may be entitled.

In surgical cases, where a patient is transferred to an extended care hospital following surgery, the six (6) week postoperative period which applies to the care of the patient by the surgeon does not apply to the physician caring for the patient in the extended care hospital.

Benefits listed for the situations outlined above apply to the physician who will be attending the patient following surgery and do not affect those benefits listed for surgical tariffs. The six (6) week definition will still apply to the surgeon attending the patient during that period.

19—PREMATURE BABY CARE

Premature Baby Care is the care of a baby weighing 5 ½ lbs (2500 gms.) or less, at birth, or with a gestational age of less than thirty-seven (37) weeks.

20—CHILD/INFANT

Wherever used in these Rules of Application and Schedule of Benefits ***child***, is defined as a patient who has not reached his/her sixteenth (16^{th}) birthday, excepting where noted otherwise.

Whenever used in these Rules of Application and Schedule of Benefits ***baby*** or ***infant*** is defined as a patient under two (2) years of age.

SURGICAL RULES

21—ASTERISKED PROCEDURE

A tariff followed by an ***asterisk*** means that the fee is for the procedure alone. The usual management of the case and follow-up care will be paid in addition.

22—INDEPENDENT PROCEDURE

Certain of the listed procedures are commonly carried out as an integral part of a total service, and as such no separate fee should be charged. When such a procedure is carried out as a separate entity, not immediately related to other services, the indicated fee for “independent procedure” is applicable.

23—BENEFITS FOR MAJOR SURGICAL TREATMENT PROCEDURES

Benefits for Major Surgical Treatment Procedures include six (6) weeks postoperative care (also See Rules 29 and 31). In conditions requiring prolonged hospital care in themselves, and where an incidental surgical treatment procedure is interposed, appropriate hospital care benefits may be claimed for these situations but such claims must be accompanied by a ***Special Report***.

24—PREOPERATIVE CARE

Preoperative Care of normal duration after admission to hospital for Elective surgery is included in the benefits listed for the operation. Where medical complications result in unduly long preoperative stay, claims for daily visits up to the time of surgery may be made by ***Special Report*** which should describe the treatment required to justify the delay in the operation.

25—MULTIPLE SURGICAL PROCEDURES

In ***Multiple Surgical Procedures***, performed through the same incision by the same surgeon or his assistant, fees will only be provided for the major procedure, except under exceptional circumstances and by ***Special Report***, when fees for the lesser procedure(s) may be provided at 50% of the fee under the schedule.

26—UNRELATED PROCEDURES

Unless otherwise stated in the schedule, when two or more ***Unrelated Procedures*** are done by the same surgeon or his assistant, in remote operative fields and through separate incisions, but utilizing the same anesthetic, 100% of the fee in the schedule will be paid for the major procedure and only 75% of the fee will be paid for the minor or other procedure.

27—UNRELATED PROCEDURES

When two or more ***Unrelated Procedures*** are done through separate incisions or in unrelated areas, but utilizing the same anesthetic, by two different surgeons in different fields of practice and with different skills, the fee provided in the schedule under each procedure will be paid at 100% to each surgeon.

28—BILATERAL PROCEDURES

Fees for ***Bilateral Procedures*** in separate fields, performed in separate hospital admissions or at separate operative sessions, will be provided at the full scheduled fee for each side. When done during the same operative session, utilizing the same anesthetic, the fee will be 100% of the schedule fee for the first side and 75% of the schedule for the second side.

29—ADDITIONAL SURGICAL PROCEDURES

Benefits for ***Additional Surgical Procedures*** which are performed within six (6) weeks of, but not directly related to a preceding operation, will be provided at the full schedule fee. For complications requiring surgery, however, benefits will be based on the nature of the work performed, and its relation to prior surgery, and on the submission of a ***Special Report***.

30—TWO SURGEONS

When ***Two Surgeons*** are involved in the management of a surgical case, by prior agreement, the total fee may be apportioned in relation to the responsibility taken and the work done. Each surgeon should send in his own claim card showing the agreed apportionment to each surgeon.

31—POSTOPERATIVE SURGICAL CARE

Postoperative Surgical Care is the responsibility of the surgeon. If a postoperative patient is transferred to the care of another physician, that physician may claim for the services rendered, and benefits paid to this doctor may be withdrawn from payment made to the surgeon up to a maximum of 15%.

32—SURGICAL ASSISTANT

A ***Surgical Assistant*** is defined as a physician who assists the operating surgeon through the duration of the operation. Assistants' benefits will be provided only when medical necessity justifies the need for an assistant in respect to the primary procedure performed during the operation. When a claim is made by a surgical assistant, no additional claim should be made for supportive care by the assistant for the postoperative period. If concomitant care is rendered by the assistant, appropriate claims may be made in addition to that for surgical assistance. In multiple surgical procedures, benefits will be provided to the assistant based on the total of all benefits paid to the principal surgeon (i.e. the total of all benefits for all procedures performed by the principal surgeon throughout the duration of the operation, including those procedures for which there is no medical necessity for the presence of a surgical assistant).

When a second surgical assistant is required, benefits listed in the General Schedule for surgical assistance will also apply to the second assistant, and shall also be based on the total of all benefits paid to the principle surgeon as note above.

33—OBSTETRICS

a) ***Pre-natal care*** includes a comprehensive pre-natal assessment, follow-up pre-natal visits, which would generally occur at four week intervals to 28 weeks, followed by visits every second week to 36 weeks, then weekly until delivery. However, complicated pregnancies may require additional visits.

b) A ***comprehensive pre-natal assessment*** (8400) includes a full patient history, an inquiry into and examination of all relevant parts or systems, a comprehensive pelvic examination, completion of the pre-natal record and advice to the patient. All other pre-natal visits (8401), as well as post-natal visit (8402) include the necessary history, examination, appropriate record and advice to the patient. All pre-natal visits include pregnancy related counselling in the form of providing advice to the patient or the patient's representative(s).

c) The ***initial comprehensive pre-natal assessment*** (8400) generally should be about 20 minutes or longer in duration. The pre-natal visit (8401), as well as the post-natal visit (8402) generally should be about 10 minutes in duration, otherwise tariff 8509 (General Practice) or 8530 (Obstetrics & Gynaecology) should be claimed.

d) Other than during the pre-natal or post-natal visit, the physician may charge for all visits for conditions unrelated to the pregnancy, under the appropriate fee items listed elsewhere.

e) A post-natal visit (8402) may only be billed once following delivery. The post-natal period is usually considered as 6 weeks (42 days) following delivery. However, complicated pregnancies may require additional visits which should be claimed under the appropriate office, home or hospital visit tariffs.

f) Necessary laboratory investigations, routine urinalysis and haemoglobin estimations, etc., are payable in addition to the benefits for obstetrical care.

g) Benefits listed under the headings ***Induction of Labour and Management of Complications of Labour*** will be paid in addition to other obstetrical care benefits as outlined in the manual. A physician may claim for more than one complication of the first and second stage of labour.

h) Benefits for complications of the third and fourth stage of labour may be claimed by either the physician who performed the delivery or another physician that is called in specifically for these complications. A maximum of one of tariffs 4843, 4844, 4845, 4846, and 4847 may be claimed.

i) Serious complications that require hospitalization prior to delivery are not included in the benefits provided for obstetrical care. Such complications will be paid for at the scheduled benefits if substantiated by ***Special Report***.

j) If during the course of labour the attending physician calls a consultant to perform the delivery or caesarean section because complications have arisen, the attending physician may claim either tariff 4824, 4825 or 4826, in addition to the pre- and post-natal visits.

34—FRACTURES

Benefits listed for fractures are intended to include the application of casts, and are for full care for a period of six (6) weeks, but do not include the cost of materials.

35—FRACTURES REQUIRING NO REDUCTION

Fees for ***Fractures Requiring No Reduction*** will be provided on a "Fee for Service" (F/S) basis, e.g. visits, application of casts, etc. The fee in these circumstances shall not exceed the fee for closed reduction of the corresponding fracture.

36—MULTIPLE FRACTURES

For ***Multiple Fractures*** benefits will be based on 100% of the scheduled fee for the major fracture (the one with the highest benefit) plus 100% of those listed for other fracture(s).

In complicated cases with many fractures, lacerations, cut tendons, nerves and arteries, etc., the total benefit should be determined in relation to the work done. Claims for such cases will require a ***Detailed Report*** giving operating details and time, etc.

37—TWO CLOSED REDUCTIONS

In cases where ***Two Closed Reductions*** are done for one fracture by different physicians, benefits will be provided at 85% of those listed for the first reduction, as well as 100% of those for the final reduction.

38—REVISION OF A CLOSED REDUCTION

Where a ***Revision of a Closed Reduction*** is required within six (6) weeks of the original reduction by the same physician, claims for the revision will not be paid.

39—CLOSED REDUCTION

Where a ***Closed Reduction is Followed By an Open Reduction***, by the same or different physician(s), benefits will be based on 85% of those listed for the closed reduction and 100% of those for the open reduction.

40—OPEN REDUCTION IS FOLLOWED BY A SECOND OPEN REDUCTION

Where an ***Open Reduction is Followed by a Second Open Reduction*** by the same physician within the six (6) week period, 100% of the listed benefit will be paid for the first open reduction and 75% for the second reduction. The circumstances of the second requirement must be given by ***Special Report*** to justify this assessment.

41—COMPOUND FRACTURES

Fees for ***Compound Fractures*** requiring closed reduction may be higher than the fees for simple fractures requiring closed reduction, as shown in the fee schedule.

42—OPEN REDUCTION

Open Reduction of compound or closed shaft fractures requiring reconstruction procedures, skin shifts, or with neurovascular damage requiring reconstruction, etc. by the same surgeon, may be provided at a fee greater than the scheduled fee when justified by a ***Special Report***.

43—SECONDARY AMPUTATION OR EXCISION

Fees for any ***Secondary Amputation or Excision*** will be provided at 50% of the scheduled fee, unless otherwise specified in the Schedule of Benefits.

44—DIALYSIS

Benefits for ***Acute Renal Failure*** outlined in the schedule apply to the first four (4) weeks of management, and include the care of such medical complications as septicemia, cannula clotting, cardiac monitoring, mechanically assisted ventilation, etc.

Benefits for surgical procedures such as cannula revision, bronchoscopy and tracheostomy will be paid separately as provided in the schedule. Should dialysis be required beyond four (4) weeks, benefits will be the same as for repeat dialysis for chronic renal failure.

45—CHRONIC RENAL FAILURE

When patients with ***Chronic Renal Failure*** are admitted for complications, benefits for hospital stay will be the same as for any other medical admission and may be in addition to repeat dialysis.

46—DEPUTIZING

When a doctor knows that he is ***deputizing*** for another doctor and has access to the patient's file and all the information he needs to give temporary care to the patient on behalf of his colleague, he should consider his services a continuation of the care and claim for a subsequent visit.

However, should the doctor feel that because he has not the record of the patient or has difficulty in properly assessing the patient, or is confronted with a new problem, a statement from him on the claim card will justify payment for an initial visit as a new patient.

GUIDELINES ON CONCOMITANT CARE

When the complexities of the case require the continued attendance of more than one physician, with supplementary skills in different fields of practice, on a patient in hospital, each doctor may charge fees subject to the following interpretations.

47—CONCOMITANT CARE

That where surgery is performed, concomitant care shall not be charged for the care and treatment of usual or often encountered complications. Such "usual" complications are called minor and include those listed below, and the like. For these complications, the reasonable competence of the doctor is expected and concomitant care should not be expected.

This list is not intended to be exhaustive, but rather to indicate the type of condition on which a charge should not be based.

Complications of the Procedure:

a) Postoperative bleeding

b) Gastrointestinal states; states including nausea and vomiting and up to obstruction

c) Postoperative hemorrhagic shock

d) Urinary retention

e) Cerebral edema

f) Due to incising of sutures

Complications of Site of Procedure:

a) Wound infections

b) Wound rupture

Complications of Immobility and Sequelae:

a) Thrombophlebitis

b) Pressure excoriations of skin

c) Bronchitis, pneumonitis, pneumonia

d) Atelectasis

e) Mild diabetic imbalance

f) Angina pectoris

48—CONCOMITANT CARE/MAJOR COMPLICATIONS

That where surgery is performed and where there are "major" complications as set out below, and the like, and where the referring doctor requests continued assistance with management of the case, concomitant care fees should equal that of one complete history and physical examination, followed by the daily hospital visit fee.

Fees for concomitant care should be charged for only if:

a) the additional physician's services are not within the same field of practice, ***and***,

b) each condition would independently, and in its own right, require hospitalization.

The following is a list of complications wherein a doctor of reasonable competence may need assistance in management and where concomitant care could be expected. This list is not intended to be exhaustive but rather to indicate the type of condition on which a charge could be made:

a) Disorders of Consciousness
   i) Cerebro vascular episode—thrombotic, embolic or hemorrhagic
   ii) Associated with electrolytic imbalance
   iii) Associated with shock
   iv) Associated with convulsive disorder

b) Pulmonary embolus—attended by shock or heart failure

c) Acute myocardial infarction

d) Cardiac Failure
   i) pulmonary edema
   ii) congestive heart failure
   iii) cardiac arrest

e) Hepatic failure
   i) pre-coma or coma

f) Renal Failure
   i) acute renal failure—renal shutdown
   ii) chronic renal failure

g) Serious cardiac arrhythmias
   i) ventricular tachycardia, atrial flutter
   ii) atrial tachycardia with block, heart block, etc.

h) Shock

   i) cardiogenic and bacteremic

i) Septicemia with or without shock

j) Adrenal insufficiency and pituitary insufficiency

k) Diabetes (discovered postop)

   i) balancing after surgery

l) Severe drug reactions or severe reactions to blood transfusions (i.e. associated with anaphylaxis, shock, anemia or renal shutdown)

m) Infections

   i) Meningitis and

   ii) Bacterial endocarditis

n) Respiratory Failure

   i) respiratory acidosis

   ii) respiratory arrest

o) Blood dyscrasis

p) Acute confusional states

49—CONCOMITANT CARE/MAJOR PRE-EXISTING CONDITIONS

That where a "major" pre-existing condition, as set out in Rule 51 below, and the like, requires continued care by a physician while a patient is in hospital for treatment of another condition by another physician, concomitant care fees should be equal to the appropriate daily hospital visit fee.

Concomitant care should be charged for ***only*** if the additional physician's services are not within the same field of practice as that of the attending physician or surgeon.

50—CONCOMITANT CARE/OTHER PRE-EXISTING CONDITIONS

That where other pre-existing conditions—not listed below—require continued care by a physician while a patient is in a chronic care hospital for treatment of another condition by another physician, concomitant care fees should be charged at the rate applicable to chronic care hospitals.

In the case as well, concomitant care should be charged for ***only*** if:

a) the additional physician's services are not within the same field of practice, ***and***

b) each condition would independently, and in its own right, require hospitalization.

51—CONCOMITANT CARE/NEW ILLNESS

That where a new illness develops, not related to the illness originally necessitating hospital care, and where the continued management of the new illness by another physician is requested by the referring doctor, concomitant care fees should equal the rate of the appropriate daily hospital visit fees if the new illness is "major" as listed below, or at the rate applicable to chronic care hospitals for illness not therein listed.

Again, concomitant care may be charged for ***only*** if:

a) the additional physician's services are not within the same field of practice, ***and***

b) each condition would independently, and in its own right, require hospitalization.

The following is a list of pre-existing conditions when a doctor of reasonable competence may need assistance in management and where concomitant care could be expected.

This list is not intended to be exhaustive but rather to indicate the type of condition on which a charge could be made:

a) Ischemic heart disease if:
   i) Associated with heart failure at time of surgery
   ii) Associated with continuing angina
   iii) Associated with infarction within one (1) year prior to surgery
   iv) Associated with serious arrhythmia

b) Rheumatic heart disease and luetic heart disease and congenital heart disease if:
   i) Associated with heart failure at time of surgery
   ii) Associated with angina
   iii) Associated with serious arrhythmia
   iv) Associated with cardiac surgery

c) Hypertensive heart disease if:
   i) Associated with heart failure at time of surgery
   ii) Associated with serious arrhythmia
   iii) Associated with uremia or malignant hypertension
   iv) Associated with cardiac surgery—e.g. coarctation

d) Endocrine disorder
   i) Adrenal insufficiency
      - Iatrogenic (i.e. associated with previous steroid Tx)
      - Addison’s disease or hypopituitarism
   ii) Myxedema (unless controlled)
   iii) Pheochromocytoma
   iv) Pancreatic islet cell tumor—functioning
   v) Myasthenia gravis
   vi) Diabetes mellitus requiring insulin
   vii) Hyperparathyroidism

e) Respiratory disorders
   i) Severe obstructive bronchiolar disease
   ii) Active tuberculosis
   iii) Fungal infection
   iv) Respiratory acidosis

f) Gastrointestinal disorders
   i) Active cirrhosis
      - portal
      - biliary
   ii) Portal hypertension with bleeding varices
g) Hematological disorders
   i) Thrombocytopenic purpura
   ii) Severe bleeding dyscrasia
h) Renal disorders
   i) Uremia, exclusive of pre-renal uremia
   ii) Acute renal failure, (i.e. renal shutdown)

52—CONCOMITANT CARE/QUALIFIED MEDICAL PRACTIONERS

That concomitant care apply to only duly qualified medical practitioners.

53—CONCOMITANT CARE/REFERRING DOCTOR

That concomitant care apply only if the referring doctor requests such care.

54—CONCOMITANT CARE/HOSPITAL VISIT FEE

If not otherwise specified, the concomitant care fee will be that of the appropriate daily hospital visit fee.

55—EXTRAORDINARY CIRCUMSTANCE

Notwithstanding the above rules and conditions that apply, extraordinary circumstances will be given special consideration if substantiated ***By Report***.

56—PROVISIONAL TARIFFS

A tariff preceded by a tilde (~) is a provisional tariff. A provisional tariff means that the particular service is under evaluation for a period of time not to exceed eighteen (18) months from its effective date. Payment for claims shall be made in accordance with the same Rules of Application that apply to permanent tariffs. In addition to the normal requirements for submitting a claim as set out in ***Claims Submission and Payment Procedure—Part III Instructions for Completion of Claim Forms,*** for surgical procedures an operative report and for non-surgical services a descriptive report, including the length of time for the procedure or service, must be submitted with any claim for a provisional tariff. The reports may be reviewed by Manitoba Health and the Manitoba Medical Association as part of the evaluation of the provisional tariff. At the end of the evaluation period the tariff shall either become a permanent tariff or amended/deleted upon the agreement of Manitoba Health and Manitoba Medical Association.

ANESTHESIA

See Section C Anesthesia.

VISITS/EXAMINATIONS—INTERNAL MEDICINE (01)

These benefits cannot be correctly interpreted without reference to the Rules of Application.[1]

OFFICE, HOME VISITS

8540 Complete History and Physical Examination—new patient or new illness or complete examination of old patient 66.50

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 45.25

8403 Regional History and Examination or Subsequent Visit 38.65

8550 Consultation requested by Physician or Dentist/Oral Surgeon—See Rules 7 to 11 .....126.00

8416 Midwifery Assessment & Report—See General Schedule

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540 Complete History and Physical Examination—new patient or new illness 66.50

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 45.25

8550 Consultation requested by Physician or Dentist/Oral Surgeon—See Rules 7 to 11 .....126.00

8595 Consultation—Unassigned Patient 157.00

Note: *"Unassigned Patient" means a patient who requires assessment by an Internal Medicine Specialist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 11 inclusive apply.*

8510 Regional History Examination 30.00

8520 Hospital Care—per day 25.75

CONCOMITANT CARE

8524 Concomitant Care—per day 25.75

CHRONIC CARE—SEE GENERAL SCHEDULE

[1] The above tariffs and benefits can also be claimed by those physicians who are Fellows of the Royal College of Physicians and Surgeons of Canada in Community Medicine and whose names are on the specialist register of The College of Physicians and Surgeons of Manitoba (Rule 2).

NEUROLOGY (01-1)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination—new patient or new illness, or complete examination of old patient 66.50

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 31.20

8403 Regional History and Examination or Subsequent Visit 39.40

8492 Comprehensive Cognitive Assessment 200.00

Note: *This assessment includes the following:*

- *Extensive testing, direct patient contact (minimum 1 ½ hours).*
- *Interpretation of tests (minimum ½ hour) and report to referring physician.*

8494 Follow–up Comprehensive Cognitive Assessment 100.00

- *Reassessment and retesting, behavioural function tests.*
- *Six (6) to twelve (12) months after 8492.*

Note: *A consultation or other visit fee may be claimed in addition to 8492 or 8494 on the same day.*

8550 Consultation requested by Physician or Dentist/Oral Surgeon—See Rules 7 to 11 ..... 129.25

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540 Complete History and Physical Examination—new patient or new illness 66.50

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 31.20

8550 Consultation requested by Physician or Dentist/Oral Surgeon—See Rules 7 to 11 ..... 129.25

8595 Consultation—Unassigned Patient 160.40

Note: *"Unassigned Patient" means a patient who requires assessment by a Neurologist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 11 inclusive apply.*

8510 Regional History and Examination 35.00

8520 Hospital Care—per day 25.00

CONCOMITANT CARE

8524 Concomitant Care—per day 25.00

CHRONIC CARE—SEE GENERAL SCHEDULE

GERIATRIC MEDICINE (01-2)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination—new patient or new illness, or complete examination of old patient 80.00

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 50.00

8403 Regional History and Examination or Subsequent Visit 53.00

8550 Consultation—See Rules 7 to 11 ..... 153.00

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540 Complete History and Physical Examination—new patient or new illness 80.00

8502 Complete or extensive re-examination for same illness 50.00
By Report—See Rule 6

8550 Consultation—See Rules 7 to 11 ..... 153.00

8510 Regional History and Examination 53.00

8520 Hospital Care—per day 25.95

CONCOMITANT CARE

8524 Concomitant Care—per day 25.95

CHRONIC CARE—SEE GENERAL SCHEDULE

RHEUMATOLOGY MEDICINE (01-3)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination—new patient or new illness, or complete examination of old patient 74.90

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 54.25

8403 Regional History and Examination or Subsequent Visit 41.50

8550 Consultation—See Rules 7 to 11 ..... 134.00

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540 Complete History and Physical Examination—new patient or new illness, or complete examination of old patient 74.90

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 54.25

8550 Consultation—See Rules 7 to 11 ..... 134.00

8595 Consultation—Unassigned Patient 162.85

Note: *"Unassigned Patient" means a patient who requires assessment by a Rheumatologist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 11 inclusive apply.*

8510 Regional History and Examination 40.00

8520 Hospital Care—per day 27.50

CONCOMITANT CARE

8524 Concomitant Care—per day 27.50

CHRONIC CARE—SEE GENERAL SCHEDULE

CARDIOLOGY (01-4)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination—new patient or new illness, or complete examination of old patient 72.00

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 38.00

8403 Regional History and Examination or Subsequent Visit 35.00

8550 Consultation requested by Physician or Dentist/Oral Surgeon—See Rules 7 to 11 ..... 127.00

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540 Complete History and Physical Examination—new patient or new illness 72.00

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 38.00

8550 Consultation requested by Physician or Dentist/Oral Surgeon—See Rules 7 to 11 ..... 127.00

8595 Consultation—Unassigned Patient 158.25

Note: *"Unassigned Patient" means a patient who requires assessment by a Cardiologist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 11 inclusive apply.*

8510 Regional History and Examination 30.00

8520 Hospital Care—per day 27.95

CONCOMITANT CARE

8524 Concomitant Care—per day 27.95

CHRONIC CARE—SEE GENERAL SCHEDULE

GASTROENTEROLOGY (01-5)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination—new patient or new illness, or complete examination of old patient 64.00

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 38.00

8403 Regional History and Examination or Subsequent Visit 35.60

8550 Consultation—See Rules 7 to 11 ..... 130.00

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540 Complete History and Physical Examination—new patient or new illness 64.00

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 38.00

8550 Consultation—See Rules 7 to 11 ..... 130.00

8595 Consultation—Unassigned Patient 162.00

Note: *"Unassigned Patient" means a patient who requires assessment by a Gastroenterologist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 11 inclusive apply.*

8510 Regional History and Examination 30.00

8520 Hospital Care—per day 23.25

CONCOMITANT CARE

8524 Concomitant Care—per day 23.25

CHRONIC CARE—SEE GENERAL SCHEDULE

NEPHROLOGY (01-6)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination—new patient or new illness, or complete examination of old patient 71.95

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 48.70

8403 Regional History and Examination or Subsequent Visit 41.40

8550 Consultation—See Rules 7 to 11 ..... 138.00

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540 Complete History and Physical Examination—new patient or new illness 71.95

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 48.70

8550 Consultation—See Rules 7 to 11 ..... 138.00

8595 Consultation—Unassigned Patient 171.95

Note: *"Unassigned Patient" means a patient who requires assessment by a Nephrologist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months Rules of Application 7 to 11 inclusive apply.*

8510 Regional History and Examination 30.00

8520 Hospital Care—per day 25.70

CONCOMITANT CARE

8524 Concomitant Care—per day 25.70

CHRONIC CARE—SEE GENERAL SCHEDULE

ALLERGY & CLINICAL IMMUNOLOGY (01-7)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination—new patient or new illness, or complete examination of old patient 66.50

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 38.00

8403 Regional History and Examination or Subsequent Visit 38.00

8550 Consultation—See Rules 7 to 11 ..... 126.00

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540 Complete History and Physical Examination—new patient or new illness 66.50

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 38.00

8550 Consultation—See Rules 7 to 11 ..... 126.00

8510 Regional History and Examination 30.00

8520 Hospital Care—per day 22.50

CONCOMITANT CARE

8524 Concomitant Care—per day 22.50

CHRONIC CARE—SEE GENERAL SCHEDULE

MEDICAL GENETICS (01-8)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination—new patient or new illness, or complete examination of old patient 70.00

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 45.00

8403 Regional History and Examination or Subsequent Visit 41.50

8550 Consultation—See Rules 7 to 11 ..... 140.00

8416 Midwifery Assessment & Report—See General Schedule

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540 Complete History and Physical Examination—new patient or new illness 70.00

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 45.00

8550 Consultation—See Rules 7 to 11 ..... 140.00

8595 Consultation—Unassigned Patient 169.05

Note: *"Unassigned Patient" means a patient who requires assessment by a Genetics Specialist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 11 inclusive apply.*

8510 Regional History and Examination 35.00

8520 Hospital Care—per day 35.00

CONCOMITANT CARE

8524 Concomitant Care—per day 35.00

CHRONIC CARE—SEE GENERAL SCHEDULE

PAEDIATRICS (02)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination 64.25

8498 Complete History and Physical Examination with Gynaecological Examination, **including** the taking of cytological smear for cancer screening—cervix 75.95

Note: *See Rule 17(a) for full tariff description.*

8499 Complete History and Physical Examination with Gynaecological Examination, **excluding** the taking of cytological smears for cancer screening 75.95

Note: *See Rule 17(b) for full tariff description.*

8550 Consultation requested by Physician or Dentist/Oral Surgeon—See Rules 7 to 11 .....122.50

8416 Midwifery Assessment and Report—See General Schedule

8582 Paediatric/Adolescent Behavioural Therapy, per fifteen (15) minute period or major portion thereof [minimum duration—thirty (30) minutes, maximum duration—ninety (90) minutes] 35.25

Note: *This tariff is claimable only by Paediatricians with appropriate training or experience in adolescent medicine as may be agreed upon from time to time by the MMA and Manitoba Health.*

8470 Regional Intermediate Visit—regional or subsequent visit with Gynaecological examination, **including** the taking of cytological smears for cancer screening—cervix..... 50.20

Note: *See Rule 17(c) for full tariff description.*

8471 Regional Intermediate Visit—regional or subsequent visit with Gynaecological examination, **excluding** the taking of cytological smears for cancer screening..... 50.20

Note: *See Rule 17(d) for full tariff description.*

8509 Regional Basic Visit—Regional or Subsequent Visit 33.40

Note: *A Regional Basic Visit is a service rendered to a patient who consults the physician for a condition—usually relatively minor. The assessment of the patient's condition is problem focused and little or no physical examination is included.*

Note: *Generally, less than ten (10) minutes of physician time is required.*

8529 Regional Intermediate Visit—Regional or Subsequent Visit or Well Baby Care 36.75

Note: *A Regional Intermediate Visit for a problem specific Assessment is a service provided to a patient which shall be comprised of:*

- *A history of the presenting complaint(s);*
- *An examination of the parts or systems related to the presenting complaint(s);*
- *A review of all pertinent investigations;*
- *A complete written record and advice to the patient.*

Note: *The visit shall be a minimum of ten (10) minutes of physician time.*

Child Developmental Assessment Including High Risk Neonatal Program

8552 Developmental assessment and report per fifteen (15) minute period or major portion thereof..... 35.25

Note: *This tariff is applicable to children ages 17 and under, and includes, but is not limited to, the following services:*

- *history taking;*
- *assessment;*
- *collateral contacts (e.g., parents, social workers, speech pathologists, other health care professionals, teachers, etc.) by way of meetings, receipt/writing or correspondence or telephone calls;*
- *preparation of assessment report.*

Note: *If a physical examination of the child is conducted in conjunction with the assessment, the appropriate visit fee may be claimed in addition to this tariff.*

Assessments within 60 days of a previous developmental assessment and report 8552 shall be claimed under tariff 8404 ***By Report****; and Assessments after 60 days shall be submitted using tariff 8552 in aggregate* ***By Report****.*

8404 Complete or extensive re-assessment and report within 60 days per fifteen (15) minute period or major portion thereof—***By Report***..... 35.25

8555 Parent interview and counselling related to a previous developmental assessment, per fifteen (15) minute period or major portion thereof 35.25

8558 Behaviour therapy conducted subsequent to a developmental assessment, per fifteen (15) minute period or major portion thereof 35.25

Note: *Tariffs 8552, 8404, 8555 and 8558 may be claimed by a physician who is agreed by Manitoba Health and the Manitoba Medical Association to be adequately trained in developmental paediatrics.*

Child Developmental Assessment Re: Feeding

8560 Initial Feeding Assessment and Report per fifteen (15) minute period or major portion thereof..... 35.25

Note: *This tariff is applicable to children ages 17 and under, and includes, but is not limited to, the following services:*

- *history taking;*
- *feeding observation;*
- *assessment;*
- *review of the diet record;*
- *preparation of assessment report.*

Note: *If a physical examination of the child is conducted in conjunction with the assessment, the appropriate visit fee may be claimed in addition to this tariff.*

8562 Attendance during Swallowing Studies in Hospital Radiology Department, per fifteen (15) minute period or major portion thereof [maximum sixty (60) minutes per study may be claimed]..... 35.25

Note: *This includes participation by the Developmental Paediatrician in the interpretation of the radiographic studies.*

8564 Feeding reassessment following initial feeding assessment and report, per fifteen (15) minute period or major portion thereof [maximum sixty (60) minutes per patient per month may be claimed]. Additional units may be claimed "***By Report***." 32.95

8597 Feeding Case Management per fifteen (15) minute period or major portion thereof 26.15

Note: *Includes the review of the assessment and progress of the child and/or the provision of advice on medication or ongoing therapy with a collateral professional by way of meetings, receipt/writing of correspondence or telephone calls.*

Note: *Tariffs 8560, 8562, 8564 and 8597 may only be claimed by a Developmental Paediatrician who is agreed by Manitoba Health and the Manitoba Medical Association to be adequately trained in feeding disorders.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540 Complete History and Physical Examination 64.25

8550 Consultation requested by Physician or Dentist/Oral Surgeon—See Rules 7 to 11 .....122.50

8498 Complete History and Physical Examination with Gynaecological Examination, **including** the taking of cytological smear for cancer screening—cervix 75.95

Note: *See Rule 17(a) for full tariff description.*

8499 Complete History and Physical Examination with Gynaecological Examination, **excluding** the taking of cytological smears for cancer screening 75.95

Note: *See Rule 17(b) for full tariff description.*

8470 Regional Intermediate Visit—regional or subsequent visit with Gynaecological examination, **including** the taking of cytological smears for cancer screening—cervix..... 50.20

Note: *See Rule 17(c) for full tariff description.*

8471 Regional Intermediate Visit—regional or subsequent visit with Gynaecological examination, **excluding** the taking of cytological smears for cancer screening..... 50.20

Note: *See Rule 17(d) for full tariff description.*

8510 Regional History and Examination 38.45

8520 Hospital Care—per day..... 27.00

CONCOMITANT CARE

8524 Concomitant Care—per day..... 27.00

NEONATAL AND PAEDIATRIC INTENSIVE, COMPREHENSIVE CRITICAL CARE AND VENTILATORY SUPPORT FEE SCHEDULE

Preamble

This fee schedule is intended to be used by physicians who provide direct Neonatal and Paediatric Intensive Care, Comprehensive Care, Critical Care and Ventilator Support to critically ill and unstable neonatal and Paediatric patients.

It is recognized that more than one physician may manage complicated problems when a patient is critically ill. The daily rate is payable, per patient, to the physician providing care.

When claiming under this fee schedule, no other critical care tariff codes may be claimed by the physician.

It is recognized that specialists other than Paediatricians or neonatologists may be called upon to provide care. For example, this may include nephrology management of dialysis, neurologic opinion and treatment, infectious disease review and management of complicated infections. In some intensive care units, parenteral nutrition may be prescribed by a physician who is not a Paediatrician or neonatologist or an anaesthesiologist may be called in to insert a difficult arterial line. In such cases, physicians may bill in accordance with the services provided.

This schedule does not preclude family physicians billing daily hospital visits where appropriate for infants over 28 days of age.

After Hours Premiums and Special Call

After Hours premiums and ***Special Call*** benefits do not apply when claims are made under this Fee Schedule.

Patient Re-Admittance

Where a patient is discharged from the Neonatal, Comprehensive, Critical Care, or Ventilatory Support Units, but is re-admitted within 48 hours, the second day rates shall be charged.

Where the patient is re-admitted more than 48 hours after discharge, first day rates shall be charged.

Change of Neonatal Acuity Level

Where a patient changes acuity level (up or down), then the appropriate second day rate shall be charged.

Transfer of Patient From One Hospital to Another

Where Critically ill patients are transferred from one hospital to another the original intensive care team may bill for the day of the patient's transfer. First day rates shall apply to the receiving intensive care teams where more than two hours bedside care is provided.

Physicians required to be in attendance during the transporting of a patient may claim in accordance with the Physician's Manual.

Designated Intensive Care Areas

Neonatal Care, Comprehensive Care, Critical Care and Ventilatory Support fees may be claimed when patients receive care in a Neonatal Intensive Care Unit (NICU) or Paediatric Intensive Care Unit (PICU) or other designated area of a hospital where one to one nursing care is being provided.

Duration

This fee schedule shall be effective from July 1, 1998. The duration of this agreement shall be consistent with the fee-for-service agreement between the Province of Manitoba and the Manitoba Medical Association subject to determination under the Interest Arbitration Agreement.

Other

This schedule does not apply to non-ventilated stable patients admitted to a special care unit for routine postoperative care.

Fees for NICU Level A, B and C may be claimed for pre-operative and/or postoperative patients requiring NICU admission. However, if where the patient is transferred directly from an Operating Room or a Recovery Room to the NICU, intensive care tariffs should be claimed commencing with the second day rate of the appropriate level.

In cases where resuscitation and stabilization have been accomplished before the patient is transferred to the NICU/PICU, the payment will begin at the appropriate second day rate.

NEONATAL INTENSIVE CARE

These fees apply to physicians providing intensive care to neonate patients (from birth until first discharged from hospital or, following discharge, up to and including 28 days of age).

Included in these daily composite fees are the initial consultation or assessment, subsequent visits and examinations as required in any given day. Also included, but not limited to, are the insertion of arterial, venous, CVP or urinary catheters, intravenous lines, interpretation of blood gases, insertion of nasogastric tubes, infusion of pharmaceutical agents including TPN, endotracheal intubation and artificial ventilation and all other necessary respiratory support.

There are three levels of neonatal intensive care depending on the procedures performed.

Level A Infants requiring artificial Ventilation, full invasive monitoring and parenteral alimentation if necessary.

8300	Day 1	440.00
8301	Day 2 – 10, per day	153.55
8302	Day 11 onwards, per day	76.30

Level B Infants requiring full monitoring, both invasive and IV therapy or parenteral alimentation, but without ventilatory support.

8303	Day 1	210.00
8304	Day 2 – 10, per day	96.80
8305	Day 11 onwards, per day	76.30

Level C Infants requiring oxygen administration and/or non-invasive monitoring, and/or gavage feeding.

8306	Day 1	140.35
8307	Day 2 – 10, per day	55.65
8308	Day 11 onwards, per day	29.00

COMPREHENSIVE CARE

These fees apply to physicians who provide both critical care and ventilatory support to infants (non-neonate patients who have been discharged from hospital and are over the age of 28 days), children and adolescents (under age 18). These fees include, but are not limited to, initial consultation and assessment and subsequent examinations of the patient, family counseling, endotracheal intubation, tracheal toilet, artificial ventilation and all necessary measures for respiratory support, emergency resuscitation, insertion of intravenous lines, cutdowns, arterial and/or venous catheters, pressure infusion sets and pharmacological agents, insertion of C.V. P. lines, defibrillation, cardioversion and usual resuscitative measures, insertion of urinary catheters and nasogastric tubes, securing and interpretation of blood gases, intracranial pressure monitoring interpretation and assessment when indicated (excluding insertion of ICP measuring device).

Note: *Separate billable intervention may be claimed for:*

- *Insertion of chest tube for closed drainage (tariff code 2157).*
- *Bilateral at same sitting (tariff code 2156).*
- *Swan-Ganz Catherization: Cardiac catherization, right heart (tariff code 2303).*

8309	Day 1	342.45
8310	Day 2 – 10, per day	171.45
8311	Day 11 onwards, per day	85.70

CRITICAL CARE—(WITHOUT VENTILATOR SUPPORT)

These fees apply to physicians who provide critical care to infants (non neonate patients who have been discharged from hospital and are over the age of 28 days), children and adolescents (under age 18). It includes, but is not limited to initial consultation and assessment, family counseling, emergency resuscitation, intra-venous lines, cutdowns, pressure infusion set and pharmacological agents, insertion of arterial C.V.P or urinary catheters and nasogastric tubes, defibrillation, cardioversion and usual resuscitative measures, securing and interpretation of laboratory tests, oximetry, transcutaneous blood gases and intracranial pressure monitoring interpretation and assessment when indicated (excluding insertion if ICP measuring device).

Where ventilatory support only is provided, claims should be made under Ventilatory Support and Critical Care fees shall not apply.

Note: *Separate billable intervention may be claimed for:*

- *Insertion of chest tube for closed drainage (tariff code 2157).*
- *Bilateral at same sitting (tariff code 2156).*
- *Swan Ganz Catherization: Cardiac catherization, right heart (tariff code 2303).*

8312	Day 1	235.15
8313	Day 2 – 10, per day	117.60
8314	Day 11 onwards, per day	58.80

VENTILATORY SUPPORT

These fees apply to physicians who provide ventilatory support to infants (non-neonate patients who have been discharged from hospital and are over the age of 28 days), children and adolescents (under age 18). It includes, but is not limited to initial consultation and assessment, family counseling, endotracheal intubation with positive pressure ventilation, insertion of intravenous lines, cutdowns, pressure infusion, insertion of arterial and C.V. lines, tracheal toilet, use of artificial ventilator and all necessary measures for its supervision, obtaining and the interpretation of blood gases, oximetry, end tidal CO^2, transcutaneous blood gas application and assessment and maximum inspiratory pressure monitoring and non-invasive metabolic measurements.

Note: *Separate billable intervention may be claimed for:*

- *Insertion of chest tube for closed drainage (tariff code 2157).*
- *Bilateral at same sitting (tariff code 2156).*
- *Swan Ganz Catherization: Cardiac catherization, right heart (tariff code 2303).*

8315	Day 1	203.80
8316	Day 2 – 10, per day	78.95
8317	Day 11 onwards, per day	63.35

PSYCHIATRY (03)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

PSYCHIATRY GENERAL

- In addition to the visit codes, Psychiatry services are classified as:
  - individual psychotherapy;
  - group psychotherapy;
  - patient care family conference;
  - electroconvulsive therapy (ECT);
  - psychiatric care;
  - child and youth management conference; and
  - psychiatric social interview
- Only specialists in psychiatry are eligible to submit claims in respect of "Psychiatry" services under this part.
- More than one psychiatrist may submit claims for psychiatry services for the same patient on the same day.
- Psychotherapy is a procedure for the treatment of mental, emotional and/or psychosomatic illness by means of a professional relationship between a psychiatrist and a patient, carried out through a series of prearranged medical services.
- Psychotherapy is undertaken to remove, modify or retard existing symptoms, or attenuate or reverse disturbed patterns of behaviour and to promote the patient's positive personality growth and development.
- Psychotherapy procedures include direct patient contact by a psychiatrist for the purpose of evaluation, diagnosis, physical and/or drug treatment, patient education, general psychiatric counseling and documentation in the patient's record.
- A psychiatrist may submit claims for individual psychotherapy, group psychotherapy, patient care family conference, psychiatric social interview and/or a child and youth management conference—for the same patient on the same day.
- Individual psychotherapy and psychiatric care cannot be claimed for the same patient on the same day by the same psychiatrist.
- Individual or group psychotherapy cannot be claimed for the same patient on the same day as ECT.
- A psychiatrist may submit claims for ECT and psychiatric care, a patient care family conference, psychiatric social interview and/or child youth management conference for the same patient on the same day.
- Psychoanalysis is an excluded service and cannot be claimed.
- Psychiatry services shall be documented in the patient's record as required by the College of Physicians and Surgeons of Manitoba, and such documentation is required to support the claim submitted to Manitoba Health.

OFFICE, HOME VISITS

8503 Complete History and Psychiatric Examination—adult..... 99.00

8504 Complete History and Psychiatric Examination—child.....133.00

8530 Subsequent Visit..... 28.80

8553 Consultation—adult—See Rules 7 to 11.....142.00

8554 Consultation—child—See Rules 7 to 11.....182.65

8472 Child and Youth Management Conference..... 35.00

A Child and Youth Management Conference is defined as a conference between a psychiatrist and allied health professionals, educators, peace officers, correctional workers or appropriate community workers to share information to better manage a patient's care.

Note:

- *The patient must be twenty (20) years of age or younger.*
- *In hospital "physician-with-physician" patient care conferences are excluded.*
- *The conference must be a formal scheduled conference.*
- *Tariff rate is payable for the first full fifteen (15) minute period and for each additional fifteen (15) minutes or major portion thereof.*
- *Maximum of one (1) hour may be claimed per conference.*
- *Maximum of three (3) hours per patient may be claimed within any twelve (12) month period.*
- *The tariff must be claimed in the name of the patient.*
- *Additional Child and Youth Management conferences may be claimed by written report.*

8475 Psychiatry—Patient Care Family Conference..... 35.00

A Patient Care Family Conference is defined as a formal scheduled conference between the psychiatrist and relative(s) or guardian(s) relating to the care and treatment of a patient with a psychiatric disorder

Note:

- *A patient Care Family Conference may include, but is not limited to, discussions about the condition and care of a patient with serious and complex psychiatric problems. It may include the assessment of the need for care from other providers and/or community agencies.*
- *Patient may or may not be present at the Patient Care Family Conference.*
- *Tariff rate is payable for the first full fifteen (15) minute period and for each additional fifteen (15) minutes or major portion thereof.*
- *The service must be claimed in the name of the patient.*
- *Maximum of one (1) hour may be claimed per Patient Care Family Conference.*
- *Maximum of two (2) hours may be claimed per patient within any twelve (12) month period.*
- *Additional Patient Care Family Conference may be claimed by written report.*

8476 Psychiatric Social Interview 35.00

A Psychiatric Social Interview is defined as an interview by a psychiatrist with an individual who has close knowledge of, or association with, a patient.

Note: 1) *The person being interviewed may include, but is not limited to, a spouse, member of the family, community psychiatric nurse, teacher, member of the clergy or social worker.*

2) *Tariff rate is payable for the first full fifteen (15) minutes and for each additional fifteen (15) minutes or major portion thereof.*

3) *Interview must be on a one-to-one basis between the psychiatrist and the person being interviewed, and must take place in person. The patient shall not be present during the interview.*

4) *In hospital "physician-with-physician" patient care conferences are excluded.*

5) *The tariff must be billed in the name of the patient. The psychiatrist must document the name of the person interviewed and their knowledge of, or association with, the patient.*

6) *Maximum one (1) hour may be claimed per interview.*

7) *Maximum of two (2) hours per patient may be claimed within any twelve (12) month period.*

8) *Additional Psychiatric Social Interviews may be claimed by written report.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8503 Complete History and Psychiatric Examination—adult 99.00

8504 Complete History and Psychiatric Examination—child 133.00

8553 Consultation—adult—See Rules 7 to 11 ..... 142.00

8554 Consultation—child—See Rules 7 to 11 ..... 182.65

8595 Consultation—Unassigned Patient—adult 173.55

8596 Consultation—Unassigned Patient—child 214.20

Note: *"Unassigned Patient" means a patient who requires assessment by a Psychiatrist, who has not rendered a Complete History and Physical Examination (tariff 8503 or 8504) or Consultation service (tariff 8553, 8554, 8595 or 8596) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 11 inclusive apply.*

8520 Hospital Care—per day 23.50

Note: *For patients participating in hospital day care programs the physician is to claim the appropriate visit or therapy fee only for those days when the physician actually provides a direct service to the patient.*

CONCOMITANT CARE

8524 Concomitant Care—per day 23.50

PSYCHOTHERAPY (WITH OR WITHOUT INTRAVENOUS DRUGS)

8581 Individual 35.25

Note: *1) Tariff rate is payable for each of the first two full fifteen(15) minute periods and for each additional fifteen (15) minute period or major portion thereof.*

2) A minimum of a full thirty (30) minute period and a maximum of ninety (90) minutes may be claimed per patient per day.

3) Where psychotherapy sessions with a patient extend beyond two and one-half (2 ½) hours in any seven (7) day period, a written report is required.

Group psychotherapy is defined as the treatment of two or more patients together in a session, and may include members of a family group.

8444 Group of two (2)—four (4) patients 41.25

8446 Group of five (5) or more patients 47.25

Note: *1) Tariff rate is payable for each of the first two full fifteen (15) minute periods and for each additional fifteen (15) minute period or major portion thereof.*

2) A minimum of a full thirty (30) minute period and a maximum of ninety (90) minutes may be claimed per day.

3) Where group psychotherapy session(s) extend beyond these limits, a written report is required.

4) The total fee listed for the group is divided by the number of patients in the group and billed for each separate claim.

ELECTROCONVULSIVE THERAPY

8588 Electroconvulsive Therapy (ECT) 64.00

PSYCHIATRIC CARE

Psychiatric care means the provision of individual psychotherapy services that may or may not be prearranged.

8584 Individual 35.25

Note: *1) A minimum of a full fifteen (15) minute period and a maximum of thirty (30) minutes may be claimed per patient per day.*

2) Tariff rate is payable for the first full fifteen (15) minute period and for the second fifteen (15) minutes or major portion thereof.

GENERAL SURGERY (04-1)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540	Complete History and Physical Examination	44.00
8403	Regional History and Examination or Subsequent Visit	27.50
8550	Consultation—See Rules 7 to 11	81.00

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540	Complete History and Physical Examination	44.00
8550	Consultation—See Rules 7 to 11	81.00
8595	Consultation—Unassigned Patient	113.40

Note: *"Unassigned Patient" means a patient who requires assessment by a General Surgeon Specialist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 11 inclusive apply.*

8510	Regional History and Examination	25.00
8520	Hospital Care—per day	22.00

CONCOMITANT CARE

8524	Concomitant Care—per day	22.00

CHRONIC CARE—SEE GENERAL SCHEDULE

CARDIAC SURGERY (04-2)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination 40.00

8403 Regional History and Examination or Subsequent Visit 25.00

8550 Consultation—See Rules 7 to 11 ..... 80.50

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540 Complete History and Physical Examination 40.00

8550 Consultation—See Rules 7 to 11 ..... 80.50

8595 Consultation—Unassigned Patient 110.55

Note: *"Unassigned Patient" means a patient who requires assessment by a Cardiovascular Surgeon, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 11 inclusive apply.*

8510 Regional History and Examination 25.00

8520 Hospital Care—per day 20.50

CONCOMITANT CARE

8524 Concomitant Care—per day 20.50

CHRONIC CARE—SEE GENERAL SCHEDULE

PLASTIC & RECONSTRUCTIVE SURGERY (04-3)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540	Complete History and Physical Examination	40.00
8530	Subsequent Visit	25.00
8550	Consultation requested by Physician or Dentist/Oral Surgeon—See Rules 7 to 11	65.15

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540	Complete History and Physical Examination	40.00
8550	Consultation requested by Physician or Dentist/Oral Surgeon—See Rules 7 to 11	65.15
8520	Hospital Care—per day	20.85

CONCOMITANT CARE

8524	Concomitant Care—per day	20.85

CHRONIC CARE—SEE GENERAL SCHEDULE

UROLOGY (04-4)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540	Complete History and Physical Examination	44.40
8403	Regional History and Examination or Subsequent Visit	28.45
8550	Consultation requested by Physician or Dentist/Oral Surgeon—See Rules 7 to 11	65.30

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540	Complete History and Physical Examination	44.40
8550	Consultation requested by Physician or Dentist/Oral Surgeon—See Rules 7 to 11	65.30
8510	Regional History and Examination	26.50
8520	Hospital Care—per day	24.50

CONCOMITANT CARE

8524	Concomitant Care—per day	24.50

CHRONIC CARE—SEE GENERAL SCHEDULE

ORTHOPAEDIC SURGERY (04-5)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540	Complete History and Physical Examination	41.70
8403	Regional History and Examination or Subsequent Visit	24.90
8550	Consultation requested by Physician or Dentist/Oral Surgeon—See Rules 7 to 11	70.30
8440	Orthopaedic Spinal Consultation	171.40

Note: *1) This tariff may be claimed by Orthopaedic and Neurological Surgeons recognized by the Manitoba Orthopaedic Society or the Division of Neurosurgeons,University of Manitoba, and the WRHA Medical Director, Surgery Program, as having appropriate training in spinal surgery.*

2) The visit shall be a minimum of forty (40) minutes of physician time.

3) The physician time shall be documented in the patient's record.

4) Rules of Application 7-11 apply. In addition, the consultation must include a complete neurological assessment and review of all appropriate imaging and laboratory results and be consistent with the following Guidelines—Orthopaedic Spinal Consultation:

Guideline—Orthopaedic Spinal Consultation

Goal

To provide a thorough history and physical examination of the spine and related structures with interpretation of the appropriate radiographs. With this information the surgeon will formulate a treatment plan and follow up recommendation.

Consultation Format

The format of a consultation is generally divided into the headings of: history, physical examination, radiography, conclusion and plan. Within each heading the basic feature will be outlined as follows:

History

Identification of the entrance complaint, characteristics of the pain (e.g., duration, quality, type, exacerbating and relieving factors, radiation of pain, treatment response), constitutional symptoms, bladder and bowel function, symptoms of spinal instability, symptoms of claudication, radicular or myelopathic symptoms, change in posture, change in fitting of clothing, history of inflammatory arthropathy, past spinal surgery, reviews of systems related to presenting problem, and social history.

Physical Examination

Evaluation of gait, frontal and sagittal alignment, range of motion of the cervical, thoracic and lumbar spine (flexion, extension, rotation and lateral bending), tenderness of the spine, examination of proximal joints to the line, neurologic examination including motor and sensory function, deep tendon reflexes, upper motor neuron signs, peripheral vascular exam, rectal exam if indicated. Special tests: Straight leg raise, crossed straight leg raise, Lasegue sign, Hoffman's sign, Babinski sign.

Radiology

Evaluation and interpretation of relevant imaging including plain x-rays lateral, flexion/extension views, AP lateral bending films, nuclear medicine imaging, MRI, CT/myelogram (include date of exam and facility performed), documentation of measured progression of deformity, most recent films should be no older than one year or less than six months when there has been a recent change in symptoms in a paediatric patient.

Conclusion

This is a summary of finding in history, in physical and radiography with a diagnosis of the problem and a special emphasis on a defined treatment plan, ordering the further investigation if warranted and follow up recommendation particularly for chronic non surgical cases.

8441* Distance Management of an Injured Orthopaedic Patient 35.00

Note:

1) *This tariff may be claimed by an Orthopaedic Surgeon (whose name appears in the specialist register of the College of Physicians and Surgeons of Manitoba).*
2) *This tariff is for written advice to the referring physician on the management of a case based upon review of patient files and x-rays by an Orthopaedic Surgeon.*
3) *Payable once per case only.*
4) *The referring physician who initiates the request must be situated outside the city of Winnipeg (includes St. Norbert).*
5) *The Orthopaedic Surgeon who receives the request must be situated in Manitoba in a community **other than** where the referring physician is situated.*
6) *After hour premiums may be claimed only for urgent/emergent cases.*
7) *Tariff 8001 may not be claimed in addition for same patient, same condition.*
8) *Telehealth may not be claimed in addition for same patient, same condition.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540 Complete History and Physical Examination 41.70

8550 Consultation requested by Physician or Dentist/Oral Surgeon—See Rules 7 to 11 ..... 70.30

8595 Consultation—Unassigned Patient 99.25

Note: *"Unassigned Patient" means a patient who requires assessment by an Orthopaedic Specialist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550, 8595 or 8440) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 11 inclusive apply.*

8510 Regional History and Examination 25.00

8520 Hospital Care—per day 25.00

CONCOMITANT CARE

8524 Concomitant Care—per day 25.00

CHRONIC CARE—SEE GENERAL SCHEDULE

NEUROLOGICAL SURGERY (04-6)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540	Complete History and Physical Examination	60.00
8403	Regional History and Examination or Subsequent Visit	30.00
8550	Consultation requested by Physician or Dentist/Oral Surgeon—See Rules 7 to 11	100.00
8440	Orthopaedic Spinal Consultation	171.40

Note: *1) This tariff may be claimed by Orthopaedic and Neurological Surgeons recognized by the Manitoba Orthopaedic Society or the Division of Neurosurgeons, University of Manitoba, and the WRHA Medical Director, Surgery Program, as having appropriate training in spinal surgery.*

2) The visit shall be a minimum of forty (40) minutes of physician time.

3) The physician time shall be documented in the patient's record.

4) Rules of Application 7-11 apply. In addition, the consultation must include a complete neurological assessment and review of all appropriate imaging and laboratory results and be consistent with the following Guidelines—Orthopaedic Spinal Consultation:

Guideline

Orthopaedic Spinal physical examination of the spine and related Consultation

Goal

To provide a thorough history and physical examination of the spine and related structures with interpretation of the appropriate radiographs. With this information the surgeon will formulate a treatment plan and follow up recommendation.

Consultation Format

The format of a consultation is generally divided into the headings of: history, physical examination, radiography, conclusion and plan. Within each heading the basic feature will be outlined as follows:

History

Identification of the entrance complaint, characteristics of the pain (e.g., duration, quality, type, exacerbating and relieving factors, radiation of pain, treatment response), constitutional symptoms, bladder and bowel function, symptoms of spinal instability, symptoms of claudication, radicular or myelopathic symptoms, change in posture, change in fitting of clothing, history of inflammatory arthropathy, past spinal surgery, reviews of systems related to presenting problem, and social history.

Physical Examination

Evaluation of gait, frontal and sagittal alignment, range of motion of the cervical, thoracic and lumbar spine (flexion, extension, rotation and lateral bending), tenderness of the spine, examination of proximal joints to the line, neurologic examination including motor and sensory function, deep tendon reflexes, upper motor neuron signs, peripheral vascular exam, rectal exam if indicated. Special tests: Straight leg raise, crossed straight leg raise, Lasegue sign, Hoffman's sign, Babinski sign.

Radiology

Evaluation and interpretation of relevant imaging including plain x-rays lateral, flexion/extension views, AP lateral bending films, nuclear medicine imaging, MRI, CT/myelogram (include date of exam and facility performed), documentation of measured progression of deformity, most recent films should be no older than one year or less than six months when there has been a recent change in symptoms in a paediatric patient.

Conclusion

This is a summary of finding in history, in physical and radiography with a diagnosis of the problem and a special emphasis on a defined treatment plan, ordering the further investigation if warranted and follow up recommendation particularly for chronic non surgical cases.

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540	Complete History and Physical Examination	60.00
8550	Consultation requested by Physician or Dentist/Oral Surgeon—See Rules 7 to 11	100.00
8510	Regional History and Examination	17.40
8520	Hospital Care—per day	30.00

CONCOMITANT CARE

8524	Concomitant Care—per day	30.00

CHRONIC CARE—SEE GENERAL SCHEDULE

OPHTHALMOLOGY (05-1)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8543	Complete History and Ocular Examination, including refraction and other necessary tests (other than those listed as Special Diagnostic Ocular Tests in the Ocular Section)	57.35
8505	Regional History and Examination of the Eye	34.05
8530	Subsequent Visit	27.40
8556	Consultation requested by Physician or Optometrist, including refraction and other necessary tests (other than those listed as Special Diagnostic Ocular Tests in the Ocular Section)	68.95

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8543	Complete History and Ocular Examination, including refraction and other necessary tests (other than those listed in Special Diagnostic Ocular Tests in the Ocular Section)	57.35
8556	Consultation requested by Physician or Optometrist, including refraction and other necessary tests (other than those listed as Special Diagnostic Ocular Tests in the Ocular Section)	68.95
8510	Regional History and Examination of the Eye	30.00
8520	Hospital Care—per day	22.50

CONCOMITANT CARE

8524	Concomitant Care—per day	22.50

CHRONIC CARE—SEE GENERAL SCHEDULE

OTORHINOLARYNGOLOGY (05-2)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8544 Complete History and ENT Examination, including screening audiogram when necessary 52.50

8403 Regional History and Examination or Subsequent Visit 32.50

8557 Consultation requested by Physician or Dentist/Oral Surgeon, including screening audiogram when necessary—See Rules 7 to 11 ..... 72.60

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8544 Complete History and ENT Examination, including screening audiogram when necessary 52.50

8512 Regional History and Examination..... 32.50

8557 Consultation requested by Physician or Dentist/Oral Surgeon, including screening audiogram when necessary—See Rules 7 to 11 ..... 72.60

8410 Voice Clinic Consultation includes full voice history, physical examination of relevant parts, analysis of voice testing data, consultation with recognized speech pathologist, video laryngeal and stroboscopic examination, development of treatment plan and advice. 240.00

8411 Subsequent Voice Consultation includes the necessary history and physical examination, analysis of voice testing data, repeat video and/or stroboscopic examination. 60.00

8520 Hospital Care—per day 31.00

CONCOMITANT CARE

8524 Concomitant Care—per day 31.00

CHRONIC CARE—SEE GENERAL SCHEDULE

DERMATOLOGY (06)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Dermatological Examination..... 37.50

8530 Subsequent Visit..... 23.00

8550 Consultation—See Rules 7 to 11 ..... 60.00

Note: *Where a primary care physician refers a patient to a dermatologist with respect to warts or molluscum contagiosum, and the warts or molluscum contagiosum are treated by the dermatologist:*

- *The dermatologist shall bill the appropriate visit fee(s) under either tariff 8540 or 8530, whichever is applicable;*
- *The dermatologist shall NOT bill for a consultation under tariff 8550;*
- *Where a biopsy is provided, the dermatologist shall be entitled to bill under tariff 0171;*
- *The dermatologist shall be entitled to bill under the appropriate tariff for the treatment rendered.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540 Complete History and Dermatological Examination..... 37.50

8550 Consultation—See Rules 7 to 11 ..... 60.00

8452 Complex In-Hospital Consultation.....113.75

Note: *1) The visit shall be a minimum of thirty (30) minutes of physician time.*

2) Rules of Application 7 to 11 inclusive apply.

8520 Hospital Care—per day..... 22.00

CONCOMITANT CARE

8524 Concomitant Care—per day..... 22.00

CHRONIC CARE—SEE GENERAL SCHEDULE

OBSTETRICS AND GYNAECOLOGY (09)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Gynaecological Examination **excluding** the taking of cytological smears for cancer screening 49.00

Note: *Where tariff 8540 is claimed the physician shall have performed a comprehensive pelvic examination comprised of the following elements:*

- *Performance of a visual inspection of the vulva and perineum;*
- *Insertion of a speculum into the vagina to inspect the vault and cervix;*
- *Bimanual examination of the uterus and ovaries; and*
- *Conduction of a pelvi-rectal examination (where indicated).*

Note: *Tariff 9795 (cytological smears for cancer screening) may not be claimed in addition to tariff 8540.*

8495 Complete History and Gynaecological Examination **including** the taking of cytological smears for cancer screening—cervix 49.00

Note: *Where tariff 8495 is claimed, the physician shall have performed a comprehensive pelvic examination comprised of the following elements:*

- *Performance of a visual inspection of the vulva and perineum;*
- *Insertion of a speculum into the vagina to inspect the vault and cervix;*
- *Bimanual examination of the uterus and ovaries; and*
- *Conduction of a pelvi-rectal examination (where indicated).*

Note: *Tariff 9795 (cytological smears for cancer screening) may not be claimed in addition to tariff 8495.*

8505 Regional History and Examination 25.00

8497 Regional History and Examination with Gynaecological Examination, **excluding** the taking of cytological smears for cancer screening—cervix 36.00

Note: *See Rule 17(d) for full tariff description.*

8496 Regional History and Examination with Gynaecological Examination, **including** the taking of cytological smears for cancer screening—cervix 36.00

Note: *See Rule 17(c) for full tariff description.*

8530 Subsequent Visit 24.00

8550 Consultation—See Rules 7 to 11 ..... 74.00

8416 Midwifery Assessment & Report—See General Schedule

8400 Comprehensive pre-natal assessment 53.55

8401 Pre-natal visit 24.75

8402 Post-natal visit 33.90

OBSTETRICAL CARE—SEE OBSTETRICAL BENEFITS/FEMALE GENITAL SECTION

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540 Complete History and Gynaecological Examination **excluding** the taking of cytological smears for cancer screening 49.00

Note: *Where tariff 8540 is claimed, the physician shall have performed a comprehensive pelvic examination comprised of the following elements:*

- *Performance of a visual inspection of the vulva and perineum;*
- *Insertion of a speculum into the vagina to inspect the vault and cervix;*
- *Bimanual examination of the uterus and ovaries; and*
- *Conduction of a pelvi-rectal examination (where indicated).*

Note: *Tariff 9795 (cytological smears for cancer screening) may not be claimed in addition to tariff 8540.*

8495 Complete History and Gynaecological Examination **including** the taking of cytological smears for cancer screening—cervix 49.00

Note: *Where tariff 8495 is claimed, the physician shall have performed a comprehensive pelvic examination comprised of the following elements:*

- *Performance of a visual inspection of the vulva and perineum;*
- *Insertion of a speculum into the vagina to inspect the vault and cervix;*
- *Bimanual examination of the uterus and ovaries; and*
- *Conduction of a pelvi-rectal examination (where indicated).*

Note: *Tariff 9795 (cytological smears for cancer screening) may not be claimed in addition to tariff 8495.*

8550 Consultation—See Rules 7 to 11 ..... 74.00

8510 Regional History and Examination 15.80

8520 Hospital Care—per day 22.00

CONCOMITANT CARE

8524 Concomitant Care—per day 22.00

CHRONIC CARE—SEE GENERAL SCHEDULE

ANESTHESIOLOGY (10)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination, new patient or new illness, or complete examination of old patient 44.05

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 35.00

8403 Regional History and Examination or Subsequent Visit 26.00

8550 Consultation—See Section C

8416 Midwifery Assessment & Report—See General Schedule

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540 Complete History and Physical Examination, new patient or new illness..... 44.05

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 35.00

8550 Consultation—See Section C

8510 Regional History and Examination..... 15.90

8508 Pre-anesthetic evaluation leading to delay in surgery—See Section C

8520 Hospital Care—per day 26.00

CONCOMITANT CARE

8524 Concomitant Care—per day 26.00

GENERAL PRACTICE (11)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination 52.80

Note: *This is a service provided to a patient, which will usually comprise of:*

- *A full patient history;*
- *An inquiry into and an examination of all relevant parts or systems required to make a diagnosis or differential diagnosis;*
- *A review of results of investigations ordered by the physician;*
- *A complete written or electronic record; and*
- *Advice to the patient during the visit, and/or later by telephone, if appropriate.*
- *Where medically indicated, a return visit to advise the patient may be claimed. Abnormal test results generally require a follow-up visit.*

8498 Complete History and Physical Examination with Gynaecological Examination, **including** the taking of cytological smear for cancer screening—cervix 62.65

Note: *See Rule 17(a) for full tariff description.*

8499 Complete History and Physical Examination with Gynaecological Examination, **excluding** the taking of cytological smears for cancer screening 62.65

Note: *See Rule 17(b) for full tariff description.*

8450 Complete History and Physical Examination with Gynaecological Examination, **including** the taking of cytological smears for cancer screening—cervix—patients aged 70 years and over 64.15

Note: *See Rule 17(a) for full tariff description.*

8460 Complete History and Physical Examination with Gynaecological Examination, **excluding** the taking of cytological smears for cancer screening—patients aged 70 years and over 64.15

Note: *See Rule 17(b) for full tariff description.*

8500 Complete History and Physical Examination—patients aged 70 years and over 59.25

8550 Consultation requested by Physician or Dentist/Oral Surgeon—See Rules 7 to 11 ..... 57.45

8516 Anesthetic consultation 106.63

Note: *For other anesthetic services—See Section C*

8416 Midwifery Assessment & Report—See General Schedule

8470 Regional Intermediate Visit—regional or subsequent visit with Gynaecological examination, **including** the taking of cytological smears for cancer screening—cervix 37.45

Note: *See Rule 17(c) for full tariff description.*

8471 Regional Intermediate Visit—regional or subsequent visit with Gynaecological examination, **excluding** the taking of cytological smears for cancer screening 37.45

Note: *See Rule 17(d) for full tariff description.*

8451 Regional Intermediate Visit— regional or subsequent visit with Gynaecological examination, **including** the taking of cytological smears for cancer screening—cervix patients aged 70 years and over 40.15

Note: *See Rule 17(c) for full tariff description.*

8461 Regional Intermediate Visit— regional or subsequent visit with Gynaecological examination, **excluding** the taking of cytological smears for cancer screening—patients aged 70 years and over 40.15

Note: *See Rule 17(d) for full tariff description.*

8513 Regional or Subsequent Visit—patients aged 70 years and over 33.05

8509 Regional Basic Visit—Regional or Subsequent Visit 19.20

Note: *A Regional Basic Visit is a service rendered to a patient who consults the physician for a condition—usually relatively minor. The assessment of the patient's condition is problem focused and little or no physical examination is included.*

Note: *Generally, less than ten (10) minutes of physician time is required.*

8529 Regional Intermediate Visit—Regional or Subsequent Visit or Well Baby Care 27.70

Note: *A Regional Intermediate Visit for a problem specific assessment is a service provided to a patient which shall be comprised of:*

- *A history of the presenting complaint(s);*
- *An examination of the parts or systems related to the presenting complaint(s);*
- *A review of all pertinent investigations;*
- *A complete written record and advice to the patient.*

Note: *The visit shall be a minimum of ten (10) minutes of physician time.*

8400 Comprehensive pre-natal assessment 55.60

8401 Pre-natal visit 25.45

8402 Post-natal visit 33.90

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540 Complete History and Physical Examination 52.80

Note: *This is a service provided to a patient, which will usually comprise of:*

- *A full patient history;*
- *An inquiry into and an examination of all relevant parts or systems required to make a diagnosis or differential diagnosis;*
- *A review of results of investigations ordered by the physician;*
- *A complete written or electronic record; and*
- *Advice to the patient during the visit, and/or later by telephone, if appropriate.*
- *Where medically indicated, a return visit to advise the patient may be claimed. Abnormal test results generally require a follow-up visit.*

8498 Complete History and Physical Examination with Gynaecological Examination, **including** the taking of cytological smear for cancer screening—cervix 62.65

Note: *See Rule 17(a) for full tariff description.*

8499 Complete History and Physical Examination with Gynaecological Examination, **excluding** the taking of cytological smears for cancer screening 62.65

Note: *See Rule 17(b) for full tariff description.*

8470 Regional Intermediate Visit—regional or subsequent visit with Gynaecological examination, **including** the taking of cytological smears for cancer screening—cervix 37.45

Note: *See Rule 17(c) for full tariff description.*

8471 Regional Intermediate Visit—regional or subsequent visit with Gynaecological examination, **excluding** the taking of cytological smears for cancer screening 37.45

Note: *See Rule 17(d) for full tariff description.*

8500 Complete History and Physical Examination—patients aged 70 years and over 59.25

8450 Complete History and Physical Examination with Gynaecological Examination, **including** the taking of cytological smears for cancer screening—cervix—patients aged 70 years and over 64.15

Note: *See Rule 17(a) for full tariff description.*

8460 Complete History and Physical Examination with Gynaecological Examination, **excluding** the taking of cytological smears for cancer screening—patients aged 70 years and over 64.15

Note: *See Rule 17(b) for full tariff description.*

8451 Regional Intermediate Visit— regional or subsequent visit with Gynaecological examination, **including** the taking of cytological smears for cancer screening—cervix—patients aged 70 years and over 40.15

Note: *See Rule 17(c) for full tariff description.*

8461 Regional Intermediate Visit— regional or subsequent visit with Gynaecological examination, **excluding** the taking of cytological smears for cancer screening—patients aged 70 years and over 40.15

Note: *See Rule 17(d) for full tariff description.*

8594 Complete History and Physical Examination—Unassigned patient 80.40

Note: *1) "Unassigned patient" generally means that no ongoing physician-patient relationship exists. Specifically:*

2) This tariff may be claimed by a general practitioner who performs a Complete History and Physical Examination of a patient to assess whether admission to hospital is appropriate or to admit the patient to hospital under the care of that physician, so long as that physician has not claimed tariff 8540, 8500, 8498 or 8499 in respect of that patient within the last 12 consecutive months prior to the assessment or admission. This tariff is to be claimed in lieu of tariff 8540, 8500, 8498 or 8499.

3) Where the patient has a regular family physician, and where another physician, who is part of the regular family physician's call group, performs a Complete History and Physical Examination prior to the patient's admission to hospital, this tariff may not be claimed if the patient's regular family physician has claimed tariff 8540, 8500, 8498, 8499 in respect of that patient within the last 12 consecutive months prior to the patient's admission to hospital.

4) The limitation in Note 3 does not apply to a physician who has agreed to be "Doctor of the Day".

8550 Consultation requested by Physician or Dentist/Oral Surgeon—See Rules 7 to 11 ..... 57.45

8510 Regional History and Examination 27.70

8514 Regional History and Examination—patients aged 70 years and over 31.00

8520 Hospital Care—per day 27.70

CONCOMITANT CARE

8524 Concomitant Care—per day 27.70

CHRONIC CARE—SEE GENERAL SCHEDULE

EMERGENCY MEDICINE (11-3)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

HOSPITAL-EMERGENCY DEPARTMENT ONLY

8540 Complete History and Physical Examination 35.10

8599 Regional or Subsequent Visit 21.20

8550 Consultation—See Rules 7 to 11 ..... 61.10

An emergency medicine consultation applies when a patient is referred by another physician (other than an E.R. physician) who has seen and examined the patient and requested the opinion of an emergency medicine specialist because of the complexity, obscurity or seriousness of the case. The consultant shall perform the necessary assessment, review the laboratory, x-ray or other data and submit his or her findings, opinions and recommendations in writing to the referring physician. A copy of the E.R. chart does not constitute a consultation report. This consultation is not chargeable for the routine transfer of care to the E.R. nor for the provision of treatment for a previously diagnosed condition. It does not apply to patients who present themselves to the E.R. or are brought by people acting on their behalf. It is anticipated that these consultations will replace some of the consultations that would otherwise be provided by consultants in other branches of medicine. If the consultation leads to admission to hospital, no separate fee is chargeable for the admission assessment by the same physician.

Note: *The above benefits include reassessment of the patient in the emergency or observation area on the same day.*

PHYSICAL MEDICINE AND REHABILITATION (12)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination 75.70

8502 Complete or extensive re-examination for same illness 55.00
By Report—See Rule 6

8403 Regional History and Examination or Subsequent Visit 52.20

8550 Consultation—See Rules 7 to 11 ..... 139.00

8483 Physiatry Family Conference 30.00

A Physiatry Family Conference is a formal scheduled conference between a physiatrist, the patient's family, guardians or caregivers with or without allied health personnel.

Note:
- *A Physiatry Family Conference may include, but is not limited to, discussions regarding the condition and care of the patient with serious and complex problems, including catastrophic or terminal illness, developmental and/or multiple handicap disorders, and chronic pain.*
- *This tariff may also be claimed for a meeting involving the discharge of a patient, including the assessment of the need for care from other providers and/or community agencies.*
- *Patient may or may not be present at the Physiatry Family Conference.*
- *Tariff rate is payable for the first full fifteen (15) minute period and for each additional fifteen (15) minutes or major portion thereof.*
- *The service shall be claimed in the name of the patient.*
- *A physiatrist may claim a maximum of three (3) hours of Patient Care Family Conferences per patient within any twelve (12) month period.*
- *Additional Physiatry Care Family Conferences may be claimed by written report.*

8484 Physiatry Community Conference 30.00

A Physiatry Community Conference is a formal scheduled conference between a physiatrist, community representative (e.g., teacher, workplace manager) with or without other allied health professional(s) to review and share information in order to better manage care and resolve physical rehabilitation issues for patients returning to the community

Note:
- *The patient may or may not be present.*
- *Tariff rate is payable for the first full fifteen (15) minute period and for each additional fifteen (15) minutes or major portion thereof.*
- *Maximum of three (3) hours of Physiatry Community Conferences per patient may be claimed in any twelve (12) month period.*
- *Additional Physiatry Community Conferences may be claimed by written report.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540 Complete History and Physical Examination 75.70

8502 Complete or extensive re-examination for same illness 55.00
By Report—See Rule 6

8550 Consultation—See Rules 7 to 11 ..... 139.00

8595 Consultation—Unassigned Patient 167.55

Note: *"Unassigned Patient" means a patient who requires assessment by a Physical Medicine and Rehabilitation Specialist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 11 inclusive apply*

8477 Physiatry Team Management Conference 30.50

A Physiatry Team Management Conference is a formal scheduled conference between a physiatrist and allied health professional(s) to review and share information in order to better manage care and establish physical rehabilitation goals for their patients, per fifteen (15) minutes or major portion thereof.

Note:

- *Tariff 8477 covers all patients reviewed at the conference;*
- *The formally scheduled conference must be conducted in the hospital (office and home visits are excluded);*
- *Patients reviewed may include outpatients or registered bed patients;*
- *A minimum of four (4) patients must be reviewed per scheduled conference;*
- *Patient may or may not be present during their own review;*
- *Allied health professionals includes, but is not limited to home care coordinators, nurses, VON, public health nurses, psychiatric nurses, mental health workers, nurses located in northern nursing stations, occupational therapists, physiotherapists, respiratory therapists and ambulance paramedics;*
- *Allied health professionals **does not** include physicians;*
- *Maximum of one (1) Physiatry Team Management Conference per calendar week per physician;*
- *Maximum of three (3) hours per conference may be claimed;*
- *Additional Physiatry Team Management Conferences may be claimed by written report;*
- *Only the organizing physiatrist may submit claims for the Team Management Conference;*
- *The total fee listed for the group is divided by the number of patients in the group and billed for each patient on a separate claim;*
- *The Team Management Conference must be documented in the patient's records.*

8510 Regional History and Examination 40.00

8520 Hospital Care—per day 22.50

CONCOMITANT CARE

8524 Concomitant Care—per day 22.50

CHRONIC CARE—SEE GENERAL SCHEDULE

VASCULAR SURGERY (14-1)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540	Complete History and Physical Examination	60.00
8403	Regional History and Examination or Subsequent Visit	30.00
8550	Consultation—See Rules 7 to 11	85.25

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540	Complete History and Physical Examination	60.00
8550	Consultation—See Rules 7 to 11	85.25
8595	Consultation—Unassigned Patient	115.10

Note: *"Unassigned Patient" means a patient who requires assessment by a Vascular Surgeon, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 11 inclusive apply.*

8510	Regional History and Examination	30.00
8520	Hospital Care—per day	30.00

CONCOMITANT CARE

8524	Concomitant Care—per day	30.00

CHRONIC CARE—SEE GENERAL SCHEDULE

THORACIC SURGERY (14-2)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination 65.00

8403 Regional History and Examination or Subsequent Visit 34.50

8550 Consultation—See Rules 7 to 11 ..... 84.50

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540 Complete History and Physical Examination 65.00

8550 Consultation—See Rules 7 to 11 ..... 84.50

8595 Consultation—Unassigned Patient 114.05

Note: *"Unassigned Patient" means a patient who requires assessment by a Thoracic Surgeon, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 11 inclusive apply.*

8510 Regional History and Examination 32.00

8520 Hospital Care—per day 27.50

CONCOMITANT CARE

8524 Concomitant Care—per day 27.50

CHRONIC CARE—SEE GENERAL SCHEDULE

MALIGNANT DISEASE SPECIALIST (15)

These benefits cannot be correctly interpreted without reference to the Rules of Application[2]

OFFICE, HOME VISITS

8540 Complete History and Physical Examination 66.50

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 45.25

8536 Complete or extensive re-examination of a cancer patient 50.05

These patients are defined as those who have had or are presently receiving any of the following treatments: radiation, chemotherapy (either parenteral or oral), hormonal therapy, vaccine immunotherapy, or other biological cancer therapies and are at risk for recurrence.

Tariff 8536 may be claimed every twenty-one (21) days. In the event the patient is seen again within any twenty-one (21) day period, the physician shall claim tariff 8403—Regional History and Examination or Subsequent Visit.

A claim for tariff 8403 within a twenty-one (21) day period does not preclude a physician from claiming tariff 8536 for further visits.

Example

Physician provides care on Day 1, Day 15, Day 22.

Physician is eligible to claim as follows:

Day 1—8536

Day 15—8403

Day 22—8536

8403 Regional History and Examination or Subsequent Visit 38.65

8550 Consultation—See Rules 7 to 11 ..... 126.00

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540 Complete History and Physical Examination—new patient 66.50

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 45.25

8550 Consultation—See Rules 7 to 11 ..... 126.00

[2] The above tariffs and benefits may be claimed by physicians recognized by the College of Physicians and Surgeons of Manitoba as having specialist qualifications in a relevant field who have in addition been designated by Cancer Care Manitoba as eligible.

8595 Consultation—Unassigned Patient 157.00

Note: *"Unassigned Patient" means a patient who requires assessment by a Malignant Disease Specialist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 11 inclusive apply.*

8510 Regional History and Examination..... 30.00

8520 Hospital Care—per day 25.75

CONCOMITANT CARE

8524 Concomitant Care—per day 25.75

RADIATION ONCOLOGY SPECIALIST (15-8)

These benefits cannot be correctly interpreted without reference to the Rules of Application.[3]

OFFICE, HOME VISITS

8540 Complete History and Physical Examination 66.50

8536 Complete or extensive re-examination of a cancer patient 50.05

These patients are defined as those who have had or are presently receiving any of the following treatments: radiation, chemotherapy (either parenteral or oral), hormonal therapy, vaccine immunotherapy, or other biological cancer therapies and are at risk for recurrence.

Tariff 8536 may be claimed every twenty-one (21) days. In the event the patient is seen again within any twenty-one (21) day period, the physician shall claim tariff 8403—Regional History and Examination or Subsequent Visit.

A claim for tariff 8403 within a twenty-one (21) day period does not preclude a physician from claiming tariff 8536 for further visits.

Example

Physician provides care on Day 1, Day 15, Day 22. Physician is eligible to claim as follows:

Day 1—8536

Day 15—8403

Day 22—8536

8403 Regional History and Examination or Subsequent Visit 38.65

8550 Consultation—See Rules 7 to 11 ..... 126.00

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540 Complete History and Physical Examination—New patient 66.50

8550 Consultation—See Rules 7 to 11 ..... 126.00

8595 Consultation—Unassigned Patient 157.00

Note: *"Unassigned Patient" means a patient who requires assessment by a Radiology Oncologist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 11 inclusive apply.*

8510 Regional History and Examination 30.00

8520 Hospital Care—per day 25.75

[3] The above tariffs and benefits may be claimed by physicians recognized by the College of Physicians and Surgeons of Manitoba as having specialist qualifications in a relevant field who have in addition been designated by Cancer Care Manitoba as eligible.

These benefits cannot be correctly interpreted without reference to the Rules of Application.[4]

CONCOMITANT CARE

8524	Concomitant Care—per day	25.75

RADIOTHERAPY—TELETHERAPY

7240	Simulation—Simple case < 40 minute booking	60.00
7241	Simulation—Complex > 40 minute booking	80.00
7242	Clinical Set—Up on treatment machine	30.00
7243	Clinical Set—Up in Mould Room (patient and physician present)	30.00

RADIOTHERAPY—BRACHYTHERAPY

7244	Tandem and Colpostats (Cervix or Uterus)—per treatment	125.00
7245	Vaginal Vault—per treatment	40.00
7246	Oesophagus—per treatment	120.00
7247	Lung—Placement of catheters and first treatment	100.00
7248	Lung—Subsequent treatments	40.00
7249	Interstitial—Placement of catheters in OR including planning and first treatment	500.00
7250	Interstitial—Single catheter implant	100.00
7251	Interstitial—Subsequent treatments, any number	60.00
7252	Plaque or Mould—First application	40.00
7253	Plaque or Mould—Subsequent treatments	40.00
7254	Prostate—Seed Implant	200.00
7255	Intravascular Brachytherapy—peripheral artery	100.00
7256	Intravascular Brachytherapy—cardiac	200.00
7279	Brachytherapy Biliary Ducts	260.00

[4] The above tariffs and benefits may be claimed by physicians recognized by the College of Physicians and Surgeons of Manitoba as having specialist qualifications in a relevant field who have in addition been designated by Cancer Care Manitoba as eligible.

GENERAL SCHEDULE

AFTER HOURS PREMIUMS

5555	5:00 P.M. to 12:00 A.M., add	40% to payable fee
5553	12:01 A.M. to 7:00 A.M., add	60% to payable fee
5550	7:01 A.M. to 12:00 A.M., add On Saturday, Sunday or a designated Holiday (see Note 5 below)	40% to payable fee

After Hours Premiums shall apply to all urgent or emergent medical services commencing between the hours set out above, except as follows:

- Any physician receiving "on-call" or any other form of non fee-for-service remuneration during this time period. This exception does not apply to any physician who receives non fee-for-service remuneration pursuant to an agreement to which Manitoba Health is a party if the agreement specifically provides that the physician is entitled to submit fee-for-service claims.
- Obstetrical fees if labour is induced by medical and/or surgical means by the same physician, unless the reason for the induction is fetal distress, diabetes, premature rupture of the membrane, severe pre-eclampsia—hypertension, abruption or other medically necessary reason ***By Report***.
- Full or part-time emergency physicians and on-site practitioners providing coverage in drop-in emergency clinics or hospital emergency rooms.
- During or after a "shift" by emergency or other physicians who have elected or are required to be physically or continuously present in the Emergency Department.
- Laboratory services or interpretation of test results, unless provided under urgent or emergent circumstances on-site.
- Anticoagulant monitoring under tariff 8002.
- Telephone/Facsimile/Email Communications—EDS Approval under tariff 8003.
- Services deemed to be urgent or emergent include, but are not limited to:
    - Non-elective surgery/procedures
    - Obstetrical deliveries
    - Clinical procedures associated with diagnostic radiological examinations, e.g., angiography
    - Detention in ambulance
    - Emergent psychiatric cases
    - Services rendered to an "unassigned" patient coincident with an assessment for admission or admission to hospital

Note: *1) For obstetrical deliveries, including caesarean sections, the time of delivery shall be used to determine the applicable after hours premium period for the delivery and all services rendered in conjunction with the delivery. For greater certainty, these services include tariffs listed under the headings Induction of Labour, Management of Complications of First and Second Stages of Labour, and Management of Complications of Third and Fourth Stages of Labour, as well as tariffs 4824 and 4826.*

The time of delivery must be entered on the claim.

(For tariff 4825, determine after hours premiums in accordance with note 3 below)

2) For operative procedures, the time the patient enters the operating theatre shall be used to determine the applicable after hours premium period and must be entered on the claim.

3) For all other services not covered by notes 1 and 2 the time the service commences shall be used to determine the applicable after hours premium period and must be entered on the claim.

4) Provided the service is an urgent or emergent medical service, After Hours Premiums are payable for services rendered regardless of location, including services in Personal Care Homes, in Hospital, Hospital Emergency Departments and Out-Patient Departments, except as set out above.

5) Designated Holidays include: New Year's Day, Good Friday, Easter Monday, Victoria Day, Canada Day, August Civic Holiday, Labour Day, Thanksgiving Day, Remembrance Day, Christmas Day and Boxing Day.

If any of these days fall on a Saturday or Sunday, the day will be observed as stated in the Physician's newsletter.

SPECIAL CALL—RULE OF APPLICATION 3

Whenever a physician is required to make a special trip, over and above the physician's regular routine, to attend a patient, a **Special Call** benefit may be claimed in addition to the benefits listed for assessment and/or procedural medical services (except as listed below). Only one (1) **Special Call** per response is applicable.

A **Special Call** must be initiated by someone other than the physician (except when services are rendered outside the hospital) and requires the physician to travel from one (1) location to another (not within the same building complex) to attend the patient.

A **Special Call** benefit will be paid even if the patient is deceased, on the arrival of the physician called, or, if the patient has left the premises prior to the physician's arrival provided the physician was not unreasonably tardy.

Subject to the Exclusions listed below, all **Special Call** benefits may be claimed under the following tariffs:

8561	For special calls made to a patient's home.	28.00
8598	For special calls made to the emergency department or O.P.D. of a hospital	35.50
8566	For special calls made in obstetrics by: i) the physician receiving payment for the delivery, excluding the day of delivery; ii) the physician not receiving payment for the delivery.	40.00
8567	For special calls made in non-elective surgical cases, in the postoperative period.	40.00
8563	All other special calls not covered under Tariffs 8561, 8566, 8567 or 8598 (including, but not limited to, special calls made to personal care homes and to attend to registered hospital patients, subject to Exclusion 1 below) may be claimed under this tariff.	40.00

Exclusions:

Special Call benefits do not apply under the following circumstances:

1. Care to registered hospital patients during the physician's regular daily round.
2. Regularly scheduled daily office appointments.
3. Scheduled N.F.A. medical services.
4. Routine care provided to patients in personal care homes.
5. Scheduled routine in-patient surgical activity.
6. Where the physician is already in the hospital.
7. All elective surgery both pre and postoperative.
8. In obstetrical care, on the day of delivery, by the physician performing the delivery, including caesarean section.

DETENTION WITH A CRITICALLY ILL PATIENT

Detention time means the doctor is detained with a critically ill patient for at least half an hour. Detention time does not apply where the doctor is detained when doing procedures such as fractures or operations, etc., or while waiting for reports of x-rays or the laboratory.

It implies the presence of the physician at the bedside of the patient whose condition is critical and requires constant attention beyond the scope of the staff or family.

At the termination of the critical period, as indicated by the doctor being able to leave the patient in the care of the staff or family, detention time no longer applies for subsequent visits on that day or subsequent days. Unless a new crisis develops, an ordinary visit should be sufficient to adjust orders so that the patient can continue to be cared for by the staff.

Should a new crisis develop or some unusual care require further detention time on the same day or subsequent days, a ***Special Report*** must be submitted to justify this.

8572 Care of critically ill patient for the first half hour, after this Tariff 8573 applies 69.75

8573 Detention with a critically ill patient anywhere beyond the half hour above, when no procedural benefit applies, benefit $31.70 for each additional fifteen (15) minute period..... 31.70

8574 Special consideration in exceptional circumstances and prolonged detention .....***By Report***

8565 Return trip following ambulance transfer, per fifteen (15) minute block of time (or major portion thereof)..... 20.00

Note: *1) Tariff 8565 is not claimable for return trips of less than thirty (30) minutes in duration or fifty (50) kilometers in distance.*

2) The maximum claim per return trip is $560.00

RESUSCITATION—BY NON-ANESTHETISTS (OR BY ANESTHETISTS OUTSIDE THE OPERATING ROOM)

2556 Cardio-respiratory resuscitation including cardiac arrest, for the first half-hour..... 65.25

2565 For each additional fifteen (15) minute period or portion thereof 22.40

TELEPHONE CALLS

8000 Telephone/Facsimile/Email Communications initiated by allied health care personnel 12.85

Note: *1) This tariff may be claimed for communications from allied health care personnel, who are responsible for and/or assigned to the care of:*

i) a patient receiving home care,

ii) a patient in a personal care home,

iii) a paneled patient at home or in hospital who is awaiting placement in a personal care home,

iv) a patient in a special care home, (in-patient or out-patient), e.g., St. Amant Centre, Manitoba Developmental Centre,

v) a chronic care patient in an extended care facility, (in-patient or out-patient) e.g., Deer Lodge Centre Extended Treatment Unit,

vi) a patient presenting at a northern nursing station,

vii) a patient registered in the Manitoba Home Nutrition Program, or

viii) a patient registered in the Manitoba Home IV program.

2) Allied health care personnel includes, but is not limited to:

i) Home care coordinators,

ii) Nurses,

iii) VON,

iv) Public health nurses,

v) Psychiatric nurses,

vi) Mental health workers,

vii) Nurses located in northern nurses'stations,

viii) Occupational therapists,

ix) Physiotherapists,

x) Respiratory therapists,

xi) Ambulance paramedics.

3) Communications initiated by a pharmacist generally are not eligible, unless the pharmacist has been assigned to the care of a patient, e.g., scheduled medication reviews in a personal care home or special care home which subsequently require discussion with a physician.

4) Communications initiated by a midwife are also eligible following a Midwifery Assessment and Report by the physician.

5) The claim must include the name and positon of the person who initiated the communication, the name of the patient concerned and the time of day the communication takes place.

6) Claims for communications respecting patients receiving home care should include the words "home care" on the claim.

7) Except as set out above, no claim may be made for communications regarding patients in hospital receiving acute care.

8) *A maximum of five (5) communications per patient per seven–day week may be claimed, regardless of the number of allied health care personnel who are responsible for and/or assigned to the care of the patient.*

9) *Only one (1) claim per communication may be made.*

10) *No claim may be made for communications in which only a physician proxy, e.g., nurse or clerk, participates.*

11) *Claims for more than one communication per patient per day should be submitted on a single claim.*

12) *Services shall be documented in the patient's record as required by the College of Physicians and Surgeons of Manitoba, and such documentation is required, upon request by Manitoba Health, to support the claim submitted.*

8001 Telephone/Facsimile/Email communications to a Specialist initiated by a General Practitioner 15.00

Note: 1) *This tariff may be claimed by a Specialist (whose name is in the Specialist Register of the College of Physicians and Surgeons of Manitoba) for communications from a General Practitioner regarding a patient who is receiving medical care from the General Practitioner.*

2) *No claim may be made where only a proxy for the Specialist communicates with the General Practitioner, or where the sole purpose of the call is to arrange a hospital bed for the patient.*

3) *Only one (1) claim per communication may be made.*

4) *The claim must include the name of the General Practitioner who initiated the communication, the name of the patient concerned, and the time of day the communication takes place.*

5) *Services shall be documented in the patient's record as required by the College of Physician's & Surgeons of Manitoba, and such documentation is required, upon request by Manitoba Health to support the claim submitted.*

6) *This tariff may not be claimed by a General Practitioner.*

8002 Monitoring anticoagulant therapy–by telephone, facsimile or email, per calendar month 12.85

Note: *1) Service includes monitoring the condition of a patient receiving anticoagulant therapy including ordering blood tests, interpreting results,inquiry into possible complications and adjusting the dosage of the anticoagulant therapy.*

2) Claims for additional services rendered to a patient (e.g., visits) may be made in addition to this tariff.

3) Services shall be documented in the patient's record as required by the College of Physicians and Surgeons of Manitoba, and such documentation is required, upon request by Manitoba Health, to support the claim submitted.

8003 Telephone/Facsimile/Email Communications–EDS Approval 12.85

This tariff may be claimed for telephone, facsimile or email communications incidental to applications for drug coverage pursuant to Part 3 of the Prescription Drugs Cost Assistance Act, specified Drugs Regulation (Exception Drug Status approval).

Note: *1) A maximum of five (5) communications per patient per thirty (30) day period may be claimed.*

2) Only one (1) claim per communication may be made.

3) No claim may be made for communications in which only a physician proxy, e.g.,nurse or clerk participates.

4) Claims for more than one (1) communication per patient per day should be submitted on a single claim.

5) Services shall be documented in the patient's record as required by the College of Physicians and Surgeons of Manitoba, and such documentation is required, upon request by Manitoba Health, to support the claim submitted.

CASE MANAGEMENT CONFERENCE

		GENERAL PRACTITIONER	SPECIALIST
8474	Case Management Conference	28.65	28.65

A Case Management Conference is a conference between the physician in charge of the patient's care and allied health professionals, educators, correctional workers, appropriate community workers or other physician(s) to share information to better manage a patient's care.

Note:

1) The conference must be a formal scheduled conference pertaining to one named patient.

2) This tariff may not be claimed with respect to additional patients discussed on an impromptu basis during the course of a conference. However, consecutive formal scheduled conferences, each pertaining to one named patient, are permitted.

3) Tariff rate is payable for the first full fifteen (15) minute period spent discussing one named patient and for each additional fifteen (15) minute period or major portion thereof spent discussing that same named patient.

4) Maximum of one (1) hour may be claimed per conference.

5) A physician may claim a maximum of two (2) Case Management Conferences per patient, per year. Additional conferences may be claimed By Report.

6) The claim must include the name of the physician in charge of the patient's care, the time the conference took place, the location of the conference and the names of all persons in attendance at the conference. This information must also be documented in the patient's chart.

7) All physicians in charge of or involved with the patient's care in attendance at the conference may submit a claim.

8) For Psychiatrists and Physical Medicine Specialists, see appropriate visit pages.

PATIENT CARE FAMILY CONFERENCE

		GENERAL PRACTITIONER	SPECIALIST
8473	Patient Care Family Conference	28.65	28.65

A Patient Care Family Conference may include, but is not limited to, discussions about the condition and care of a patient with serious and complex problems, a catastrophic or terminal illness, developmental and multiple handicap disorders, or chronic pain. It may include the assessment of the need of care from other providers and/or community agencies.

Note:

1) *Patient may or may not be present at the Patient Care Family Conference.*
2) *The session must relate to the care and treatment of the patient.*
3) *Maximum of four (4) fifteen-minute sessions per patient per year. Additional conferences may be claimed **By Report**.*
4) *Maximum of sixty (60) minutes may be claimed per conference.*
5) *Tariff rate is payable for the first full fifteen (15) minute period and for each additional fifteen (15) minute period or major portion thereof.*
6) *Services must be claimed in the name of the patient.*
7) *Physician may claim either Palliative Care Counselling tariff or Patient Care Family Conference, but not both.*
8) *Services shall be documented in the patient's record as required by the College of Physicians and Surgeons of Manitoba, and such documentation is required, upon request by Manitoba Health, to support the claim submitted.*
9) *For Psychiatrists and Physical Medicine Specialists, see appropriate visit pages.*
10) *No claim may be made for a service, including a visit, rendered during the same period of time, or any portion thereof, in respect to which the physician submits a claim under this tariff, but nothing shall prevent a claim being made for a service, including a visit, rendered either immediately preceding, or immediately following, the period of time in respect to which the physician submits a claim under this tariff.*

MANITOBA HOME NUTRITION PATIENT CARE CONFERENCE

8493 Manitoba Home Nutrition Patient Care Conference..... 26.00

Note: *1) A Manitoba Home Nutrition Patient Conference is a formal scheduled conference relating to the care and treatment of a patient registered in the Manitoba Home Nutrition Program.*

2) The conference shall include a pre-assessment team conference with allied health professionals and a post-assessment conference with patient's family and/or other care givers.

3) The patient is not present at the pre-assessment team conference and may or may not be present at the post assessment family conference.

*4) Maximum of twelve (12) conferences per patient per year. Additional conferences may be claimed **By Report**.*

5) The total time for the conference shall be claimed.

6) Maximum of sixty (60) minutes per conference.

7) Tariff rate is payable for the first full fifteen (15) minute period and for each additional fifteen (15) minute period or major portion thereof.

8) Services must be claimed in the name of the patient.

9) Services shall be documented in the patient's record as required by the College of Physician's and Surgeon's of Manitoba, and such documentation is required, upon request by Manitoba Health, to support the claim submitted.

10) An appropriate visit tariff for the physical examination of the patient may be claimed in addition to the conference.

PSYCHOTHERAPY

Psychotherapy (with or without intravenous drugs)

Note: *These benefits apply to services of physicians who are not certified specialists in Psychiatry and apply only when it has been determined during a regular office visit that a course of psychiatric treatment is necessary.*

8580 Individual 28.65

Note: *1) Tariff rate is payable for each of the first two (2) full fifteen (15) minute periods and for each additional fifteen (15) minute period or major portion thereof.*

2) A minimum of a full thirty (30) minute period and a maximum of ninety (90) minutes may be claimed per patient per day.

3) Where psychotherapy sessions with a patient extend beyond two and one-half (2½) hours in any seven (7) day period, a written report is required.

Group psychotherapy is defined as the treatment of two (2) or more patients together in a session, and may include members of a family group.

8589 Group [two (2) or more patients] 31.35

Note: *1) Tariff rate is payable for each of the first two (2) full fifteen (15) minute periods and for each additional fifteen (15) minute period or major portion thereof.*

2) A minimum of a full thirty (30) minute period and a maximum of ninety (90) minutes may be claimed per group per day.

3) Where group psychotherapy session(s) extend beyond these limits, a written report is required.

4) The total fee listed for the group is divided by the number of patients in the group and billed for each patient on a separate claim.

ELECTROCONVULSIVE THERAPY

8587 Electroconvulsive Therapy (ECT)..... 18.40

Note: *1) These benefits apply to services of physicians who are not certified specialists in Psychiatry*

2) In-patient (ECT); no additional benefit shall be provided for hospital care on days the (ECT) is given except under exceptional circumstances.

PALLIATIVE CARE

8585 Palliative Care Counselling..... 28.65

Palliative care is the care of a patient after the decision has been made that there will be no aggressive treatment of the underlying disease process and that care is to be directed to maintaining comfort of the patient until death occurs.

The palliative care counselling tariff code applies to physicians who provide counselling to a patient with a terminal disease such as cancer, AIDS or advanced neurological disease and/or counselling to that patient's family. The goal of palliative care is achievement of the best possible quality of life for people for who cure is no longer possible.

Specifically,

- A patient or family member may request a counselling session with the physician because of specialized management of a patient with terminal illness.
- Counselling session may be with the patient, with the patient and the family, or with the family without the patient present.
- Palliative care counselling generally is provided during a period not greater than three (3) months prior to death. Where circumstances require a longer duration of palliative care, this may be claimed ***By Report***.
- Tariff rate is payable for the first full fifteen (15) minute period and for each additional fifteen (15) minute period or major portion thereof.
- Counselling beyond one (1) hour must be submitted ***By Report***.

CHRONIC CARE

8511 Chronic Care, per visit 22.70
See Rule 18

ALLEGED SEXUAL ASSAULT

8578 Female 205.00

8579 Male 167.50

Note: *This is an all-inclusive fee except that a special call, if appropriate, will be paid. A portion of each benefit is for the collection of evidence and will be recovered by the Minister from the Department of the Attorney-General. To be eligible for the above benefits, the evidence must be collected and the documentation submitted to the appropriate law enforcement agency. If evidence is not collected and submitted, the physician may claim the appropriate visit fee and a special call if appropriate, or detention time Tariff 8574 when appropriate and should not claim Tariffs 8578 or 8579.*

BLOOD ALCOHOL SAMPLING

8577 Blood alcohol sampling 28.00

Note: *This benefit covers the following:*

1) a) Assessment to determine that obtaining a sample is safe.

b) Assessment of the patient's ability to consent to the procedure.

c) Completing the police form.

d) Taking the sample, labelling the specimen and recording the event on the patient's hospital record.

2) a) Where the usual criteria as described in the Physician's Manual are met, the physician may claim a special call.

b) Only where medical indications exist may the physician also claim appropriate examination and treatment tariffs (e.g., repairing lacerations).

COMPLETE EYE EXAMINATION

8543 Complete eye examination and refraction by a physician other than a specialist in Ophthalmology 45.60

WELL BABY CARE

8523 Well Baby Care by a physician other than a Paediatrician or a General Practitioner 12.80

MIDWIFERY ASSESSMENT AND REPORT

- A Midwifery Assessment and Report is the situation in which a midwife, after an appropriate examination of the patient, requests the opinion of a physician due to the complexity, obscurity or seriousness of the patient's condition or because another opinion is requested by the patient or a person acting on her behalf. After the Assessment & Report, the patient is usually returned to the care of the attending midwife, similar to Rule of Application 9.
- A Midwifery Assessment and Report shall consist of such examination of the patient as necessary and appropriate to the rendering physicians' field of practice, review of the laboratory or other data, a written opinion regarding diagnosis and recommendations as to treatment.
- Continuing care by a rendering physician may follow the Midwifery Assessment and Report at the request of the referring midwife, if the complexities of the case are such that its management should remain for a time in the hands of the rendering physician. In such circumstances, payment shall be provided for the Midwifery Assessment and Report and continuing care (including procedures) according to the schedule of benefits pertaining to the specialty of the rendering physician.
- Midwives may request a Midwifery Assessment and Report from General Practitioners, Obstetricians, Paediatricians, Medical Geneticists, Internal Medicine physicians and Anesthesiologists.
- The tariff shall be billed in the name of the patient.
- A Midwifery Assessment and Report may be claimed by physicians in the blocs of practice set out below, under Tariff **8416**:

  Eligible Blocs:

  Internal Medicine $126.00

  Medical Genetics $140.00

  Paediatrics $122.50

  Obstetrics $74.00

  Anesthesia $106.63

  General Practice $57.45

TELEMEDICINE

Definitions

"Telemedicine service" is a medical service provided to a patient presenting at an approved telemedicine site, through the recording of visual images and transmission of those images to receiving physician at an approved telemedicine site. Telemedicine services shall only be provided at the following approved sites: Exceptions will only be made with prior approval.

- Ashern
- Berens River First Nations
- Bethel Hospital
- Brandon
- Churchill
- Boundary Trails Health Centre (Morden/Winkler)
- Dauphin
- Flin Flon
- Health Science Centre
- Gillam
- Killarney
- Leaf Rapids
- Lynn Lake
- Norway House
- Portage La Prairie
- Pine Falls
- Russell
- Rehabilitation for Children (Winnipeg)
- Selkirk
- Steinbach
- Swan River
- The Pas
- Thompson
- St Boniface General Hospital

"Live telemedicine service" is a telemedicine service utilizing a direct interactive video link with a patient.

"Store and forward telemedicine service" is a telemedicine service utilizing the recording, storing and subsequent transmission to a receiving physician of visual images.

Rules of Application

Receiving Physicians

For live telemedicine services, a receiving physician shall claim Tariff 8480, which tariff shall have a benefit rate equal to the consultation benefit rate for the physician's bloc of practice.

For store and forward telemedicine services, a receiving physician shall claim Tariff 8481, which tariff shall have a benefit rate equal to the regional history and examination or subsequent visit benefit rate for the physician's bloc of practice.

General Practitioners shall not be entitled to claim as receiving physicians for live or store and forward telemedicine services.

Where a receiving physician, after having provided a telemedicine service to a patient, decides he/she must examine the patient in person, the physician may claim a complete examination fee for the in-person examination, notwithstanding that the in-person examination has been provided within sixty (60) days of the telemedicine service.

Where a telemedicine service is interrupted for technical reasons, and is not able to be resumed within a reasonable period of time, and is therefore not able to be completed.

1) The receiving physician shall be entitled to claim ***By Report*** for the telemedicine service which he/she began to provide prior to the interruption, to the same effect as if the provision of the service had been completed.

2) Where a subsequent telemedicine service is provided to the patient for the same condition by the physician, the physician shall be entitled to claim ***By Report*** for the second telemedicine service, notwithstanding that the second telemedicine service has been provided within sixty (60) days of the initial telemedicine service.

3) Where a subsequent in-person service is provided to the patient for the same condition by the physician, the physician shall be entitled to claim ***By Report*** a complete examination fee for the in-person service, notwithstanding that the in-person service, has been provided within sixty (60) days of the telemedicine service.

Assisting Physicians

Where a physician is required to be present with the patient to assist with essential physical/psychiatric assessment, the assisting physician shall claim tariff 8482.

For other services rendered by the assisting physician, either prior to or subsequent to the telemedicine service, the appropriate tariff codes may be claimed.

Psychiatry

A Psychiatrist shall claim tariff 8480 for a live telemedicine service, unless the service which is provided is individual psychotherapy, in which case tariff 8479 shall be claimed, or psychiatric care, in which case tariff 8478 shall be claimed. Except by prior approval of Manitoba Health, group psychotherapy shall not be provided via telemedicine service.

Radiology

Radiologists who interpret diagnostic images received via store and forward telemedicine services shall be paid at the same rate as is currently paid for equivalent hard film examinations. Where a radiologist interprets a diagnostic image received via a store and forward telemedicine service, no claim may be made for the interpretation of the same image received on hard film.

General

After hours premiums may be claimed in relation to live telemedicine services when provided in urgent or emergent situations.

Special call fees may be claimed in relation to live telemedicine services in accordance with the Rule of Application relating to special calls.

After hours premiums and special call fees may not be claimed in relation to store and forward telemedicine services.

8480	Live Telemedicine Service —Receiving Physician	Claim rate equal to consultation rate for receiving physician's bloc of practice.
8479	Live Telemedicine Service —Individual Psychotherapy —Receiving Psychiatrist	Claim rate equal to individual psychotherapy (psychiatry rate).
8478	Live Telemedicine Service —Psychiatric Care —Receiving Psychiatrist	Claim rate equal to psychiatric care rate.
8481	Store and Forward Telemedicine Service —Receiving Physician	Claim rate equal to appropriate regional history and examination rate for receiving physician's bloc of practice.

Note: *1) Dermatology; Plastic & Reconstructive Surgery; Psychiatry claim rate equal to subsequent visit rate*

2) Obstetrics and Gynaecology claim rate equal to 8505 rate

3) Paediatrics claim rate equal to 8529 rate

8482 Telemedicine Service (live or store and forward)—Assisting Physician per fifteen (15) minute period or major portion thereof..... 25.00

Note: *Maximum of one (1) hour per telemedicine service except* ***By Report***

PSORALEN ULTRA VIOLET A TREATMENT

9885	P.U.V.A., each treatment	17.15
9886	professional component	8.60
9887	technical component	8.55

Note: *Includes follow-up visits on same day.*

THERAPEUTIC PLASMAPHERESIS BY CELL SEPARATOR

Note: *This service is to be claimed only by one (1) physician at a time and only by one (1) of the designated physicians approved by the Canadian Blood Agency. This service is to be claimed only when used for conditions approved for plasmapheresis by The College of Physicians and Surgeons of Manitoba.*

After a year without plasmapheresis, a patient's next plasmapheresis can be claimed as an initial or first service.

2605*	First	88.50
2606*	Second to fifth	58.25
2607*	Sixth or more, each	41.25

DIABETIC CARE

8575	Insulin pump instruction (individual) per fifteen (15) minute period	25.00
8576	Diabetes self-care teaching sessions (group) per fifteen (15) minute period	25.00

THERAPEUTIC INJECTIONS AND IMMUNIZATIONS

These benefits under this section are for the procedure alone and not for the management of the case.

THERAPEUTIC INJECTIONS

No visit benefit will be paid in addition to the following procedures if the patient's visit is for the procedure alone.

8954 Intramuscular or subcutaneous 7.50

8957* Intravenous (injection) 7.50

Note: *When a physician performs a venipuncture and injects medication, the service may be claimed under Tariff 8957.*

Injecting medication into I.V. tubing by a physician or staff person is not claimable.

2560 Intravenous therapy, establishment 22.22

Note: *This fee may not normally be charged by a physician who has charged for a visit or anesthetic that day or a block fee for a surgical procedure. It may be claimed only by a physician with special experience (example—anesthetist) who is requested to perform the procedure because of exceptional technical difficulties.*

2563 Arterial Puncture, for therapeutic injection of medicine 9.60

2300* for blood withdrawal 11.84

8952* Infiltration analgesia 7.50

Note: *This does not apply to injections of local Anesthesia for the purpose of repairs or excisions where the local is injected for absorption into or proximal to the area. It applies only to the injection of analgesic agents into a large area to relieve spasm, e.g., lumbar muscles, or other substances into painful areas of neuritis, etc.*

2446 Blood-exchange transfusion for erythroblastosis 168.50

CHEMOTHERAPY (COMMUNITY CANCER CARE PROGRAM NETWORK—SEE TARIFF 8409)

Chemical/Biological Intravenous Cancer Therapy

2610* This tariff applies to either of the following clinical circumstances: 14.00

*1) Intravenous single agent chemotherapy where **all** of the following criteria apply:*

a) duration of administration of the agent itself, or administration of the agent in combination with other agents requires one (1) hour or less;

b) dosage administered is within the conventional range;

c) potential for extravasation, cardiovascular or allergic reactions is normally low. (Examples of these single agents include, but are not limited to 5-FU, methotrexate, cyclophosphamide, fludarabine, Ara-C, and bleomycin subsequent to first dose).

2) *Administration of biological agents, including vaccines, antibodies, interferons and other cytokines, administered subsequent to the first dose, except where documented allergic or other serious reactions have occurred with the first dose and the patient remains at risk of subsequent reactions.*

2611* This tariff applies to either of the following clinical circumstances: 6.30

1) *Administration of each additional agent that meets the criteria for Tariff 2610.*

2) *Administration of leucovorin, when administered with 5-FU for chemopotentiation.*

2613* This tariff applies to each of the following clinical circumstances: 58.95

1) *Administration of single or multiple agent requiring greater than one (1) and less than six (6) hours to infuse, where continuous cardiovascular monitoring is not normally required (e.g., platinum compounds).*

2) *Administration of single or multiple agent where one (1) or more agents have the potential to cause serious extravasation, cardiovascular or allergic reactions but where continuous cardiovascular monitoring is not normally required (e.g., anthracyclines, etoposide, vinca alkaloids, first dose bleomycin).*

3) *First time administration of biological agents (vaccines, antibodies, interferons and cytokines), where the risk of allergic reaction is, by reason of being the first dose, unknown.*

4) *Subsequent doses of biological therapy where, because of a previously documented serious adverse reaction (e.g., bronchospasm, hypotension, anaphylaxis, severe urticaria) the patient remains at high risk for further serious adverse reactions requiring antihistamines and/or corticosteroid or other recognized adjunctive antidote therapy.*

2614* This tariff applies to each of the following clinical circumstances: 81.00

1) *Administration of single or multiple agents requiring greater than six (6) hours at one time to infuse.*

2) *Single or multiple agents administered more frequently than once within a 24-hour period (e.g., Ara-C, etoposide and cis-platin)*

3) *Administration of any agent administered at a dose 25% or greater than the usually administered dose (e.g., Ara-C, cyclophosphamide, nitrosourea)*

4) *Administration of any agent requiring a specific antidote to prevent serious toxicity or death (e.g., methotrexate at doses requiring leucovorin; ifosfamide requiring mesna; anthracyclines requiring dexrazoxane to prevent or stabilize low cardiac function (LVEF<50%).*

5) *Administration of any agent routinely requiring both premedication to prevent serious allergic reactions and continuous cardiovascular monitoring, regardless of the duration of administration (e.g., Taxol; Taxotere)*

Note: *Where treatments that fall under Tariff 2614 are administered consecutively for more than one (1) day, Tariff 2614 shall be claimed on the first day of treatment and Tariff 2613 shall be claimed on subsequent days of the treatment cycle (e.g., ifosfamide/mesna daily x 5 days).*

2224* Administration of chemotherapy, including aspiration, thoracentesis and sample 29.50

3905* Chemotherapeutic instillations in bladder, per instillation, to include necessary catheterization (Professional Fee Only) 32.90

2226 Subcutaneous injection of chemo-therapeutic rod for prostate or breast cancer 30.00

Note: *1) This tariff may be claimed by:*

a) physicians participating in a recognized Community Cancer Care Program Network (CCPN); or

b) physicians in rural areas where there is no cancer treatment clinic, as approved by Cancer Care Manitoba.

~2228 Subcutaneous injection of chemo-therapeutic rod for prostate or breast cancer 30.00

Note: *This tariff may be claimed by physicians practicing in Winnipeg as approved by Cancer Care Manitoba.*

5063* Intrathecal antineoplastic chemotherapy by cisternal route 51.10

5061* Intrathecal antineoplastic chemotherapy by lumbar route..... 49.60

8409 Complete or extensive re-examination of a cancer patient..... 52.85

These patients are defined as those who have had or are presently receiving any of the following treatments: radiation, chemotherapy, (either parenteral or oral), hormonal therapy, vaccine immunotherapy, or other biological cancer therapies and are at risk for recurrence.

Tariff 8409 may be claimed every twenty-one (21) days. In the event the patient is seen again within any twenty-one (21) day period, the physician shall claim the appropriate subsequent visit tariff from their visit page.

A claim for a subsequent visit within a twenty-one (21) day period does not preclude a physician from claiming tariff 8409 for further visits.

For example: Physician provides care on Day 1, Day 15, Day 22. Physician is eligible to claim as follows:

- Day 1—8409
- Day 15—subsequent visit
- Day 22—8409

Note: *1) This tariff may be claimed by:*

a) physicians participating in a recognized Community Cancer Care Program Network (CCPN); or

b) physicians in rural areas where there is no cancer treatment clinic, as approved by Cancer Care Manitoba.

2) This tariff may only be claimed by physicians designated as eligible by Cancer Care Manitoba.

3) Physicians may continue to claim the appropriate visit tariff when conducting an initial or subsequent examination on a cancer patient.

4) Physicians eligible to claim tariff 8409 may also claim the chemotherapy tariffs listed under the heading "Chemical/Biological Intravenous Cancer Therapy" in the General Schedule of the Physician's Manual.

Immunizations

Immunizations are excluded for purposes of travel, employment, emigration and in certain other circumstances as is determined from time to time by the Communicable Disease Control Unit at the Public Health Branch, Manitoba Health.

BCG—Bacille Calmette–Guerin Vaccine

8731 single dose 7.50

BoAtox—Botulism antitoxin

8910 single dose 7.50

CPOX—Varicella

8674 single dose 7.50

DaPTP—Diphtheria, acellular Pertussis, Tetanus, Polio (combined vaccine)

8924 single dose 7.50

DaPTP/Hib—Diphtheria, acellular Pertussis, Tetanus, Polio, Haemophilus influenza B (combined vaccine)

8802 first dose 7.50

8804 second dose 7.50

8806 third dose 7.50

8807 fourth dose 7.50

DiAtox—Diphtheria antitoxin

8928 single dose 7.50

DT–Polio—Diphtheria, Tetanus and Polio (combined vaccine)

8798 single dose 7.50

HAV—Hepatitis A

8904 child–single dose 7.50

8698 adult–single dose 7.50

HBIG—Hepatitis B Immune Globulin

8916 single dose 7.50

HBV—Hepatitis B Vaccine

8911 first dose 7.50

8912 second dose 7.50

8913 third dose 7.50

HEP A/B—Hepatitis A/B

8899 child–single dose 7.50

8905 adult–single dose 7.50

Hib—Haemophilus influenzae B

8901 single dose 7.50

INF—Influenza

8791 single dose 7.50

IPV—Polio Vaccine, inactivated

8931 single dose 7.50

ISG—Immune Serum Globulin

8920 single dose 7.50

MCV—Meningococcal conjugate

8685 single dose 7.50

MVA/C/Y/W—Meningococcal Polysaccharide Quadavelant–135

8981 single dose 7.50

MMR—Measles, Mumps, Rubella (combined vaccine)

8670 single dose 7.50

PPV–23—Pneumococcal Polysaccharide

8961 single dose 7.50

PVC7—Pneumococcal conjugate

8681 first dose 7.50

8682 second dose 7.50

8683 third dose 7.50

8684 fourth dose 7.50

RAB–Post Rabies Vaccine, Post Exposure

8751 single dose 7.50

RAB—Pre–Rabies Vaccine, Pre–Exposure

8761 single dose 7.50

RIG—Rabies Immune Globulin

8768 single dose 7.50

Td—Tetanus, diphtheria (combined vaccine)

8651 single dose 7.50

TdaP—Tetanus, diphtheria, accellular Pertussis (combined vaccine)

8907 single dose 7.50

Td–Polio—Tetanus, diphtheria and Polio, adsorbed (combined vaccine)

8805 single dose 7.50

TIG—Tetanus Immune Globulin

8690 single dose 7.50

VZIG—Varicella Zoster Immune Globulin

8672 single dose 7.50

Other Vaccines

8800 other vaccines not listed above, single dose 7.50

ALLERGY

The benefits under this section are for the procedure alone and not for the management of the case.

Allergy Tests as an aid in the diagnosis of disease states, if read and interpreted by a physician.

9860* Comprehensive Allergy Investigation 96.30

Note: *1) Includes all investigations necessary to assess the role of allergy in contributing to a patient's illness(es).*

2) Investigation may include appropriate skin testing with inhalants, foods, stinging insect venoms, chemicals and/or drugs.

*3) Tariff 9860 may only be claimed once for the same patient by the same physician in a twelve (12) consecutive month period. (Exceptional circumstances will be considered on a "**By Report**" basis).*

4) Tariff 9861 may be claimed for the same patient by the same physician within the twelve (12) consecutive month period.

9861* Limited Allergy Investigation 37.50

Note: *1) Includes investigations required to assess a specific allergic condition such as drug allergy, limited food allergies, contact reactions.*

*2) Tariff 9861 may only be claimed twice for the same patient by the same physician in a twelve (12) consecutive month period. (Exceptional circumstances will be considered on a "**By Report**" basis).*

9871* Intradermal tests, including tuberculin Mantoux tests, (excluding the Tine test), Shick, fungal and other skin tests, per ten (10) tests 11.70

9872* minimum 6.70

9875* Patch tests, per one (1) test 1.55

9876* minimum 6.60

9867* Epicutaneous tests, per ten (10) (to a maximum of twenty (20) 6.90

DESENSITIZATION

9865* Per treatment visit [one (1) or more injection(s)] 10.60

9864* Single and casual visit [one (1) or more injection(s)] 6.80

Note: *Office visits will be paid in addition to the allergy injection **only** when the doctor has to examine the patient, and provides explanation on the claim card.*

INGESTANT AND INJECTION CHALLENGES

Note: *Challenges are to be administered in an appropriate clinical setting **with full resuscitation equipment available**, and performed by administration of incremental oral or subcutaneous doses of a substance which has the potential for inducing a systemic reaction as suggested by history and/or in vivo or in vitro testing for allergen-specific IgE.*

9817* per fifteen (15) minutes or major portion thereof, to a maximum of three (3) hours per day per patient 20.50

VENOM IMMUNOTHERAPY

Note: *Subsequent to an initial major assessment (consultation) and appropriate epicutaneous and/or intradermal testing, the patient may receive incremental dose venom immunotherapy (rush or modified rush).*

9818* per injection to a maximum of six (6) injections per day 16.95

9862* for maintenance venom immunotherapy, per injection, to a maximum of two (2) per day 16.95

9863* Sting challenge with a live venomous stinging insect per quarter hour 22.40

Note: *Tariff 9863 is to be claimed for this service **only** when performed in a hospital emergency room or an intensive care setting with appropriate precautions including vascular access and electrocardiograph monitoring.*

SURGICAL ASSISTANT

"A Surgical Assistant is defined as a physician who assists the operating surgeon throughout the duration of the operation. Assistants' benefits will be provided only when medical necessity justifies the need for an assistant in respect to the primary procedure performed during the operation. When a claim is made by a surgical assistant, no additional claim should be made for supportive care by the assistant for the postoperative period. If concomitant care is rendered by the assistant, appropriate claims may be made in addition to that for surgical assistance. In multiple surgical procedures, benefits will be provided to the assistant based on the **total** of all benefits paid to the principal surgeon (ie., the total of all benefits for all procedures performed by the principal surgeon throughout the duration of the operation, including those procedures for which there is no medical necessity for the presence of a surgical assistant.)

When a second surgical assistant is required, benefits listed in the General Schedule for surgical assistance will also apply to the second assistant, and shall also be based on the **total** of all benefits paid to the principal surgeon as note above."

Surgical Assistant Benefits. These Include Supportive Care.

Surgical Benefit	Surgical Assist Benefit	Surgical Benefit	Surgical Assist Benefit
$ 0—155.65	$ Nil	$ 2,164.01—2,267.00	$ 477.00
$ 155.66—207.00	$ 61.75	$ 2,267.01—2,370.00	$ 498.00
$ 207.01—310.00	$ 82.50	$ 2,370.01—2,473.00	$ 518.00
$ 310.01—413.00	$ 103.50	$ 2,473.01—2,576.00	$ 539.00
$ 413.01—516.00	$ 124.00	$ 2,576.01—2,679.00	$ 560.00
$ 516.01—619.00	$ 145.00	$2,679.01—2,782.00	$ 581.00
$ 619.01—722.00	$ 165.50	$ 2,782.01—2,885.00	$ 601.00
$ 722.01—825.00	$ 186.50	$ 2,885.01—2,988.00	$ 622.00
$ 825.01—928.00	$ 207.00	$ 2,988.01—3,091.00	$ 643.00
$ 928.01—1,031.00	$ 228.00	$ 3,091.01—3,194.00	$ 664.00
$1,031.01—1,134.00	$ 249.00	$ 3,194.01—3,297.00	$ 684.00
$1,134.01—1,237.00	$ 269.00	$ 3,297.01—3,400.00	$ 705.00
$1,237.01—1,340.00	$ 290.00	$ 3,400.01—3,503.00	$ 726.00
$1,340.01—1,443.00	$ 311.00	$ 3,503.01—3,606.00	$ 747.00
$1,443.01—1,546.00	$ 332.00	$ 3,606.01—3,709.00	$ 767.00
$1,546.01—1,649.00	$ 352.00	$ 3,709.01—3,812.00	$ 788.00
$1,649.01—1,752.00	$ 373.00	$ 3,812.01—3,915.00	$ 809.00
$1,752.01—1,855.00	$ 394.00	$ 3,915.01—4,018.00	$ 830.00
$1,855.01—1,958.00	$ 415.00	$ 4,018.01—4,121.00	$ 850.00
$1,958.01—2,061.00	$ 435.00	$ 4,121.01—4,224.00	$ 871.00
$ 2,061.01—2,164.00	$ 456.00		

ANESTHESIA

TABLE OF CONTENTS

PART I—GENERAL PROVISIONS

Anesthetists shall continue to be eligible to bill fee-for-service for all other services not expressly covered by this Agreement, in accordance with the Manitoba Physician's Manual, being an integral part of the fee-for service Agreement in effect from time to time between the parties.

PART II—RULES OF APPLICATION FOR ANESTHESIA SERVICES

Unless otherwise expressly stated herein, in the event of a conflict between the Rules of Application in this Part and the general Rules of Application contained in the Physician's Manual, the Rules in this Part shall prevail.

1. DEFINITIONS

a) "Anesthetist" means a medical practitioner who is enrolled on the Specialist Register of the College of Physicians and Surgeons of Manitoba and whose registration is so defined

or

a medical practitioner with privileges to administer anesthesia as determined by the College of Physicians and Surgeons of Manitoba (commonly referred to as either a non-specialist anesthetist or general practitioner anesthetist).

b) All anesthetists are entitled to submit claims for all anesthetic services, including modifiers and premiums, in accordance with these Rules of Application and accompanying appendices.

c) "Unit value" means the particular unit rating of an anesthetic service.

d) "Unit value rate" means the remuneration payable for the provision of one (1) anesthetic unit. The unit value rate is one dollar and forty eight and one cent ($1.481).

e) "Anesthetic services" means the various services provided by an anesthetist, including but not limited to, anesthetic procedural services.

f) "Scheduled slate" means anesthetic procedural services provided in an operating room or designated location between 0700 hours (7:00 a.m.) and 1600 hours (4:00 p.m.) Monday to Friday inclusive.

2. ANESTHETIC PROCEDURAL SERVICES

a) Anesthetic procedural services and applicable unit values are listed in Appendix A. These services include the administration of the anesthetic and the necessary anesthesia care during the procedure, including intubation and/or turning, and regular monitoring services.

b) Anesthetic procedural services are time based. Anesthetic time shall be calculated in fifteen (15) minute periods or portion thereof.

c) Anesthetic procedural services have been evaluated and rated on the basis of complexity and intensity. There are five different levels of complexity/intensity with respect to anesthetic services. The least complex/intense services are assigned a complexity/intensity rating of one (1), and the most complex/intensive services are assigned a rating of five (5).

d) Each of the five levels of complexity/intensity are assigned a number of units (the unit value) per fifteen (15) minute periods or portion thereof as follows:

Level of Complexity/ Intensity	Unit Value [per fifteen (15) minute period or portion thereof]
1	20.000
2	21.375
3	22.750
4	24.125
5	25.500

e) An anesthetic procedural service shall be deemed to have commenced with the attendance of the anesthetist for the purpose of administering an anesthetic or providing monitored care. The anesthetic service shall be deemed to have ceased when the anesthetist has transferred the care of the patient.

3. PRE–ANESTHETIC EVALUATION

a) Tariff **8515** is for a pre-anesthetic evaluation. This is a service provided by an anesthetist and is comprised of a focused patient history, examination of the patient and review of the patient's records for the purposes of:

i) anesthetic risk stratification,

ii) optimizing fitness for surgery and anesthesia, and

iii) explaining the anesthetic service(s) to the patient.

b) Tariff **8515** shall be claimed in conjunction with other anesthetic services, except as otherwise noted. This tariff may only be claimed once per patient per calendar day by the same anesthetist.

c) Tariff **8515** may be claimed notwithstanding a patient's prior attendance at a pre-operative anesthesia clinic, services for which are payable in accordance with Rules of Application for Anesthesia Services 12.

d) Tariff **8515** shall not be claimed where the same anesthetist has provided an anesthetic consultation within seventy-two (72) hours of the provision of the anesthetic service.

e) The unit value of Tariff **8515** is twelve (12) units. Payment is based on the listed unit value of the service regardless of the time required for the evaluation.

f) Where a pre-anesthetic evaluation is completed and there is a delay in surgery, Tariff **8508** shall be claimed instead of Tariff **8515**. The unit value of Tariff **8508** is twenty-five (25) units. Payment is based on the unit value regardless of the time required.

4. ANESTHETIC PROCEDURAL MODIFIERS

a) Tariffs **2635**, **2615**, **2616**, **2600** and **2617** are anesthetic procedural modifiers that may be claimed, where the clinical circumstances warrant, in addition to Anesthetic Procedural Services listed in Appendix A , Diagnostic and Therapeutic Anesthetic Procedures listed in Appendix B and Monitored Anesthetic Care Rules of Application for Anesthesia Services 7.

b) Anesthetic procedural modifiers are not time based. Payment is based on the listed unit value of the service regardless of the time required.

c) Anesthetic procedural modifiers may not be claimed in conjunction with the following services: Consultations, Visits, Resuscitation, Critical Care, Chronic Pain Management or Acute Pain Services.

d) Anesthetic procedural modifier **2617** may be claimed in addition to either, **2635**, **2615**, **2616** or **2600**, where the clinical circumstances warrant. Tariff **2635** may be claimed in addition to either **2616** or **2617** where the clinical circumstances warrant.

e) The unit values of the anesthetic procedural modifiers are as follows:

2615 Neonates (less than 44 gestational weeks and/or 2500 grams or less) ..... 50 units

2616 Patients over 70 years of age ..... 8 units

2600 Patients under one year of age (not to be billed in addition to Tariff **2615**) ..... 40 units

2617 Patient entering the operating room with hemodynamic instability requiring blood transfusion and/or vasopressor administration and with respiratory insufficiency requiring endotracheal intubation ..... 40 units

2635 Morbidly obese patients ..... 42 units

Note: *1) Patient is morbidly obese when twice ideal body weight or forty-five (45) kilograms over ideal body weight or Body Mass Index > thirty-five (35).*

2) Claims involving a morbidly obese patient must include the patient's Body Mass Index and weight.

5. Diagnostic and Therapeutic Anesthetic Procedures

a) Diagnostic and therapeutic anesthetic procedures include nerve blocks and intravenous procedures, and are used to determine the cause of pain and to provide relief of pain through treatment.

b) Diagnostic and therapeutic anesthetic procedures are not time based. Payment is based on the listed unit value of the service regardless of the time required, except for Tariff **5113**.

c) Diagnostic and therapeutic anesthetic procedures are listed in Appendix B with the exception of Tariff **5113**.

d) Subject to Rules of Application for Anesthesia Services 6 d) iii) and 6 e) iii), Tariff **8515** pre-anesthetic evaluation may be claimed in addition to diagnostic and therapeutic anesthetic procedures.

e) Tariff **5113** is Titration of a Long-Term Percutaneous Catheter. This is a service provided by an anesthetist for the titration of medication and monitoring of effectiveness and side effects following the insertion of a long-term percutaneous catheter. The unit value of Tariff **5113** is twenty (20) units per fifteen (15) minute period or portion thereof.

6. Chronic Pain Management Services

a) Chronic Pain Management Clinics designated by Manitoba Health are:

Chronic Pain Management Clinics	Funded Sessions Per Year
Chronic Pain Clinics in the City of Winnipeg	925
Brandon Regional Health Centre Chronic Pain Clinic	125

b) A session means eight (8) hours.

c) Chronic Pain Management Services shall only be claimable by those anesthetists who have been agreed upon from time to time by Manitoba Health and the Association.

d) Chronic Pain Management Initial Assessment Tariff **8570**

i) An initial assessment shall consist of an appropriate examination of the patient, a review of radiological and/or laboratory findings, and a written report. The anesthetist, through initial assessment, determines an initial diagnostic opinion and/or therapeutic management of chronic pain and/or related problems.

ii) Chronic Pain Management Initial Assessment Tariff **8570** unit value is twenty-one (21) units per fifteen (15) minute period or portion thereof.

iii) Tariff **8515** (pre-anesthetic evaluation) is not claimable in addition to Tariff **8570**.

iv) Diagnostic or therapeutic anesthetic procedures may be claimed in addition to Tariff **8570**.

v) An anesthetist may not claim Tariff **8570** during any period when diagnostic or therapeutic procedures are provided.

e) Chronic Pain Management Follow-up Assessment Tariff **8571**

i) A follow-up assessment applies when a patient is seen for the same condition/problem by the same anesthetist within six (6) months, or when, in the judgement of the anesthetist, the visit does not warrant the services described in Tariff **8570**.

ii) Chronic Pain Management Follow-up Assessment Tariff **8571** unit value is twenty (20) units per fifteen (15) minute period or portion thereof.

iii) Tariff **8515** (pre-anesthetic evaluation) is not claimable in addition to Tariff **8571**.

iv) Diagnostic or therapeutic anesthetic procedures may be claimed in addition to Tariff **8571**.

v) An anesthetist may not claim Tariff **8571** during any period when diagnostic or therapeutic procedures are provided.

f) Anesthetic Services provided in accordance with Rules of Application for Anesthesia Services 6 d) and 6 e) may not exceed the Funded Sessions per Rules of Application for Anesthesia Services 6 a).

7. MONITORED ANESTHETIC CARE

a) Monitored Anesthetic Care is the situation where a surgeon, gastroenterologist, radiologist or cardiologist and, in exceptional circumstances, other medical practitioner, requests an anesthetist's continuous attendance during a procedure. The anesthetist shall be in attendance and not engaged in any other duties. The anesthetist shall be remunerated in accordance with Anesthetic Procedural Services listed in Appendix A.

b) For any procedure not listed in Appendix A, the anesthetist shall be paid at the rate of twenty (20) units per fifteen (15) minute period or portion thereof.

8. POST ANESTHETIC RECOVERY

a) The immediate post anesthetic care is considered terminated when the anesthetist has transferred care of the patient.

b) Where the anesthetist is required to attend the patient in the recovery area, other than in the circumstances described in Rules of Application for Anesthesia Services 8 c), the anesthetist shall be paid per fifteen (15) minute period or portion thereof at the unit value of the original anesthetic procedural service.

c) Where an anesthetist is called to provide care to a critically ill patient, this may be claimed in accordance with the Physician's Manual, General Schedule, "Detention with a Critically Ill Patient" and/or "Resuscitation".

9. VISIT PAGES

a) An anesthetist who is enrolled on the Specialist Register of the College of Physicians and Surgeons of Manitoba and whose registration is so defined is entitled to submit claims for visit services in accordance with Section A (Anesthesiology visit page) of the Physician's Manual.

b) Non-specialist or general practitioner anesthetists as defined in Rules of Application for Anesthesia Services 1 a) are entitled to submit claims for visit services in accordance with Section A, (General Practice visit page) of the Physician's Manual.

c) Notwithstanding Rules of Application for Anesthesia Services 9, where an anesthetic consultation Tariff **8550** or **8516** is provided in accordance with Rules of Application for Anesthesia Services 15, the anesthetist shall be remunerated per Rule of Application for Anesthesia Services 15 d).

10. Out–of–Hours Premiums

a) An out-of-hours premium may be claimed on anesthetic services as follows:

Tariff	Time Period	Premium
5556	1700 to 2400 hours (5:00 p.m. to 12:00 a.m.) Seven days per week	40%
5557	2400 to 0700 hours (12:00 a.m. to 7:00 a.m.) Seven days per week	60%
5558	0700 to 1700 hours (7:00 a.m. to 5:00 p.m.) Saturday, Sunday and Holidays (listed on Appendix D)	40%

b) Out-of-hours premiums do not apply to the first case of a scheduled slate.

c) Rule of Application for Anesthesia Services 10 b) does not apply to the situation where the first case of a scheduled slate is not completed by 1700 hours (5:00 p.m.).

d) An out-of-hours premium shall only apply to a procedural fee modifier in those cases where the procedure is commenced within an out-of-hours period.

e) The out-of-hours premium shall apply to all anesthetic services performed during the out-of-hours period. Where part of an anesthetic service is provided within the out-of-hours period, the premium shall be payable. No premium shall apply to the portion of the anesthetic service provided outside of the out-of-hours premium period.

f) Appendix G provides examples of the calculation of remuneration for anesthetic services with out-of-hours premiums.

11. Calculation of Remuneration for Anesthetic Procedural Services

a) Remuneration for the provision of Anesthetic Procedural Services is calculated as follows:

Step 1—Determination of remuneration for the pre-anesthetic evaluation

i) Subject to Rules of Application for Anesthesia Services 3 d), 3 f), 5 d) and 15 c), the pre-anesthetic evaluation is calculated by multiplying the unit value of twelve (12) by the unit value rate of one dollar and forty eight and one cent ($1.481).

Step 2—Determination of remuneration for anesthetic procedural services

i) Select the appropriate Anesthetic Procedural Service(s) from Appendix A and determine the unit value per fifteen (15) minute period or portion thereof.

ii) Calculate the time taken to perform the Anesthetic Procedural Service in fifteen (15) minute periods or portion thereof.

iii) Multiply the unit value times the number of fifteen (15) minute periods and portion thereof (as calculated at **Step 2** ii)).

iv) Multiply the result of **Step 2** iii) by the unit value rate of one dollar and forty eight and one cent ($1.481) to determine the remuneration for the Anesthetic Procedural Service.

Step 3—Determination of remuneration for anesthetic procedural modifiers, special invasive procedures and other non-time based services.

i) Where applicable, select the appropriate anesthetic procedural modifiers, special invasive procedures and other non-time based services and multiply the corresponding unit value by the unit value rate of one dollar and forty eight and one cent ($1.481).

Step 4—Determination of Out-of-Hours Premiums

i) For anesthetic services performed during an out-of-hours period, and for those procedural modifiers applying to procedures commenced during an out-of-hours period, multiply the applicable number of units by the appropriate premium percentage times the unit value rate of one dollar and forty eight and one cent ($1.481).

b) Remuneration for the provision of anesthetic procedural services is the sum of **Steps 1** to **4** inclusive.

c) Appendix F provides examples of the calculation of remuneration for Anesthetic Procedural Services.

12. PRE–OPERATIVE ANESTHESIA CLINICS

a) Pre-operative anesthesia clinics shall only be held at locations approved and funded by Manitoba Health.

b) The anesthesia services provided in a pre-operative anesthesia clinic are time based. Anesthetic time shall be calculated in fifteen (15) minute periods or portion thereof.

c) The unit value of services provided in a pre-operative anesthesia clinic is twenty (20) units per fifteen (15) minute period or portion thereof, and claimed under Tariff **8517**.

d) Sessions approved and funded by Manitoba Health for pre-operative anesthesia clinics are as follows:

Pre-Operative Anesthesia Clinics	Funded Sessions Per Year
Pre-Operative Anesthesia Clinics in the City of Winnipeg	1,092
Brandon Regional Health Centre Pre-Operative Anesthesia Clinic	70

e) A funded session means eight (8) hours.

f) The Anesthesia Medical Director of the Winnipeg Regional Health Authority or the Brandon Regional Health Authority, in consultation with anesthetists, shall determine the specific locations, days and times that pre-operative anesthetic clinics operate.

g) Where the Anesthesia Medical Director of the Winnipeg Regional Health Authority determines that the funded sessions need to be reallocated, the matter shall be referred to the Anesthesia Committee for review.

h) The Guidelines for Anesthesia Consultation are attached as Part V.

13. SPECIAL INVASIVE PROCEDURES

a) Special invasive procedures for the purpose of monitoring complicated patients are not included in the anesthetic procedural service as referenced inRules of Application for Anesthesia Services 2 a).

b) Special invasive procedures are not time based procedures. Payment is based on the unit value of the service regardless of the time required.

c) The unit values of the special invasive procedures are as follows:

i) Tariff **2300**—Arterial puncture for blood withdrawal for blood gas estimations ..... 8 units

ii) Tariff **2301**—Continuous arterial catheter for blood gases ..... 15 units

iii) Tariff **9834**—Vein—insertion of venous pressure catheter and including venous pressure measurements—Percutaneous ..... 25 units

iv) Tariff **2303**—Cardiac catheterization, right heart (Swan Ganz)..... 30 units

d) Where clinical circumstances warrant, an anesthetist may claim more than one (1) special invasive procedure.

14. ACUTE PAIN SERVICES

a) Acute pain services and unit values are as follows:

i) Tariff **8951**—Single epidural/intrathecal injection service, to include patient assessment and preparation.....40 units

ii) Tariff **8953**—Indwelling epidural analgesia service, to include patient assessment, testing of the epidural catheter, and first analgesic/anesthetic injection (when independent of an operative procedure).....70 units

iii) Tariff **8955**—Indwelling epidural analgesia service, when used as an adjunct to general anesthesia, and subsequently for postoperative analgesia.....50 units

iv) Tariff **8956**—Supervision of indwelling epidural analgesia catheter service (per 24 hours or major portion thereof). The initial monitoring fee of 15 units all be paid in all cases. However, in the second and subsequent 24 hour periods the 15 units shall only be payable after 12 hours.....15 units

v) Tariff **8958**—Subsequent epidural analgesic injections/assessment (to a maximum of 3 per 24 hours) per rendered attendance. (Time of injection should be reported on claim).....15 units

vi) Tariff **8942**—Peripheral nerve sheath catheters inserted at the time of surgery for the purpose of postoperative pain relief.....40 units

vii) Tariff **8943**—Supervision of peripheral nerve sheath catheter service (per 24 hours or major portion thereof). The initial monitoring fee of 15 units shall be paid in all cases. However, in the second and subsequent 24 hour periods, the 15 units shall only be payable after 12 hours.....15 units

viii) Tariff **8944**—Subsequent peripheral nerve sheath catheter analgesic/anesthetic injections and/or assessment (to a maximum of 3 per 24 hours) per rendered attendance (time of injection should be reported on claim).....15 units

ix) Tariff **8940**—Insertion of peripheral nerve sheath catheter outside the OR setting.....50 units

b) The tariffs listed in Rule of Application for Anesthesia Services 14 a) are not included in the anesthetic procedural service as referenced in Rule of Application for Anesthesia Services 2 a).

c) Acute Pain Services are not time based. Payment is based on the unit value of the service regardless of the time required.

15. CONSULTATION

a) A consultation (Tariff **8550**) may be claimed by an anesthetist when a medical practitioner or dentist/oral surgeon has requested, in writing, the anesthetist's opinion as to a patient's fitness for surgery or anesthesia or as to further treatment required before anesthesia can be undertaken.

b) Where an anesthetist provides an anesthetic service following a consultation, the full anesthetic fee shall be paid in addition to payment for the consultation.

c) Where an anesthesia consultation (Tariff **8550** or **8516**) is claimed within 72 hours of an anesthetic service, Tariff **8515** will not be paid unless the anesthetic service is provided by an anesthetist who did not provide the consultation as per Rule of Application for Anesthesia Services 15 a).

d) The unit value of a consultation (Tariff **8550** or **8516**) is seventy-two (72) units. Payment is based on the unit value regardless of the time required.

e) The Guidelines for Anesthesia Consultation are attached as Part V.

f) A consultation may not be claimed where an anesthetist provides such services in a pre-operative anesthetic clinic.

16. Requirement for Second Anesthetist

a) Where clinical circumstances necessitate the attendance of a second anesthetist, such anesthetist shall be remunerated at seventy percent (70%) of the total anesthetic remuneration payable to the first anesthetist.

b) Where one anesthetist commences an anesthetic service and is replaced by another anesthetist during the provision of the anesthetic services, the total remuneration shall not exceed the amount payable had the one anesthetist completed the anesthetic service.

Part III—In–Hospital On–Call Anesthesia Coverage

Where an anesthetist provides In-Hospital On-Call Anesthesia Coverage remuneration shall be in accordance with this Part.

17. Sites and Services

One anesthetist per site is required to provide twenty-four (24) hour per day In-Hospital On-Call Anesthetic Coverage at the following sites and services:

Tariff	Site	Service	Unit Value [per fifteen (15) minute period or portion thereof]
8201	St. Boniface General Hospital	Obstetrics	21.5
8202	Brandon Regional Health Centre	Obstetrics and Emergency Surgery	20
8203	Health Sciences Centre	Obstetrics	21.5
8204	Health Sciences Centre	Emergency Surgery	17.5

18. Anesthetic Services

a) In-Hospital On-Call Anesthesia Coverage is time based and shall be calculated in fifteen (15) minute periods or portion thereof.

b) Where an anesthetist providing coverage under Part III at Brandon Regional Health Centre or Health Sciences Centre is required to provide anesthetic services other than obstetrical procedures listed in Rule of Application for Anesthesia 19 a), such anesthetist shall be remunerated in accordance with Rule of Application for Anesthesia Services 20.

19. In–Hospital On–Call Anesthesia Coverage for Obstetrics

a) An anesthetist who provides In-Hospital On-Call Anesthesia Coverage for obstetrics as per Rule of Application for Anesthesia Services 17 may claim for any of the following anesthetic procedural services:

Tariff Number	Procedure
4800	Caesarean section, with or without sterilization (procedure only)
4803	Caesarean hysterectomy
4809	Incompetent cervix in pregnancy, suture
4832	Abnormal presentation or position (delivered vaginally), multiple pregnancy
4833	Transverse or occiput posterior position with forceps extraction and/or vacuum extraction (other than elective forceps)
4843	Manual removal of placenta
4847	Management of post partum haemorrhage requiring reassessment under anesthesia
4562	Post-partum sterilization by any method, unilateral or bilateral
4581	Ovarian cysts, excision, unilateral or bilateral
2128*	Tracheal aspiration for meconium staining under direct vision (independent procedure)
4711	Dilatation of cervix, in-hospital
4855	Abortion, spontaneous, requiring dilatation and curettage
4870	Dilatation and curettage for post-partum bleeding (on re-admission to hospital)

b) It is specifically agreed that the In-Hospital On-Call Anesthesia Coverage for obstetrics is intended to cover anesthesia obstetrical services other than those listed in Rule of Application for Anesthesia Services 19 a) and 19 d).

c) Where an anesthetist provides services listed in Rule of Application for Anesthesia Services 19 a) or 19 d), remuneration shall be in accordance with Part II—Rules of Application for Anesthesia Services

d) Notwithstanding Rule of Application for Anesthesia 20 b) where an anesthetist provides obstetrical epidural services, Tariff **4877** may be claimed once per patient per delivery in addition to claims for In-Hospital On-Call Anesthesia Coverage.

20. Provision of Anesthetic Services During In–Hospital On–Call Anesthesia Coverage

a) Where an anesthetist is required to provide anesthetic services during a period of In-Hospital On-Call Anesthesia Coverage, such anesthetist shall be remunerated in accordance with Part II—Rules of Application for Anesthesia Services.

b) The In-Hospital On-Call Anesthesia Coverage remuneration shall not apply during the period of time that the anesthetist provides anesthetic services in accordance with Part II—Rules of Application for Anesthesia Services.

c) When the anesthetic services have been completed in accordance with Part II—Rules of Application for Anesthesia Services, then the anesthetist shall resume providing In-Hospital On-Call Anesthesia Coverage and shall again be remunerated in accordance with Part III.

PART IV—OUT–OF–HOSPITAL ON–CALL ANESTHESIA COVERAGE

Where an anesthetist provides Out-of-Hospital On-Call Anesthesia Coverage, remuneration shall be in accordance with this Part.

21. COVERAGE

Out-of-Hospital On-Call Coverage is categorized as follows:

Out-of-Hospital On-Call Anesthesia Coverage		
Block A[5]	Evening Coverage	Monday to Friday inclusive, from 1600 to 2400 hours (4:00 P.M. to 12:00 A.M.).
Block B	Night Coverage	Monday to Sunday inclusive, from 2400 hours to 0700 hours (12:00 A.M. to 7:00 A.M.).
Block C	Saturday, Sunday and Holidays Coverage (listed on Appendix D)	0700 hours to 2400 hours (7 A.M. to 12 A.M.).

22. OUT–OF–HOSPITAL ON–CALL ANESTHESIA COVERAGE

Out-of-Hospital On-Call Anesthesia Coverage is time-based and shall be calculated in sixty (60) minute periods or portion thereof.

23. COMMUNITY FACILITIES

a) Seven Oaks General Hospital

Grace General Hospital

Victoria General Hospital

Concordia General Hospital

Out-of-Hospital On-Call Coverage to be provided by one anesthetist at each hospital as follows:

Tariff **8210**—Block A—one anesthetist at 35 units per hour;

Tariff **8211**—Block B—one anesthetist at 24.5 units per hour; and

Tariff **8212**—Block C—one anesthetist at 35 units per hour.

b) Misericordia Health Centre

Out-of-Hospital On-Call Coverage to be provided by one anesthetist at the Centre as follows:

Tariff **8210**—Block A—one anesthetist at 35 units per hour;

Tariff **8211**—Block B—one anesthetist at 24.5 units per hour; and

Tariff **8212**—Block C—one anesthetist at 35 units per hour.

[5] For Rural Hospital Facilities, Block A coverage shall commence at 1600 hours or at the completion of the scheduled slate, whichever is earlier.

24. TERTIARY FACILITIES

a) St. Boniface General Hospital

Four anesthetists to provide Out-of-Hospital On-Call Coverage as follows:

General Anesthesia—one anesthetist

Cardiac—one anesthetist

Acute/Chronic Pain—one anesthetist

Back-up—one anesthetist

b) Health Sciences Centre—Four anesthetists to provide Out-of-Hospital On-Call Coverage as follows:

General Anesthesia—one anesthetist

Cardiac—one anesthetist

Acute/Chronic Pain—one anesthetist

Paediatric—one anesthetist

c) Tariff **8213**—Block A at 35 units per hour per anesthetist;

Tariff **8214**—Block B at 24.5 units per hour per anesthetist; and

Tariff **8215**—Block C at 35 units per hour per anesthetist

d) Tariff **8219**—Health Sciences Centre Paediatric Back-up

Block C rate at 35 units per hour for twenty-four (24) hour coverage on Saturday, Sunday and Holidays.

25. RURAL FACILITIES

Selkirk & District Hospital

Portage General Hospital

Boundary Trails Health Centre

Bethesda Hospital Steinbach

Bethel Hospital Winkler

Dauphin General Hospital

Thompson General Hospital

Out-of-Hospital On-Call Coverage is provided by one anesthetist at each hospital as follows:

Tariff **8216**—Block A—one anesthetist at 15 units per hour;

Tariff **8217**—Block B—one anesthetist at 8 units per hour; and

Tariff **8218**—Block C—one anesthetist at 15 units per hour.

26. CALL BACK TO HOSPITAL

a) Where an anesthetist who is providing On-Call Out-of-Hospital Anesthesia Coverage is called back to provide anesthesia services in an emergency, the following shall apply:

b) The On-Call Out-of-Hospital Anesthesia Coverage remuneration shall discontinue when the anesthetist commences an anesthetic service in accordance with Part II—Rules of Application for Anesthesia Services.

c) The anesthetist shall claim for anesthetic services in accordance with Part II—Rules of Application for Anesthesia Services.

d) When the anesthetic services have been completed then the anesthetist shall resume providing On-Call Out-of-Hospital Anesthesia Coverage and shall be remunerated in accordance with this Part.

e) For information purposes, a detailed summary of facilities and payments, based on the unit value rate of one dollar and forty eight and one cent ($1.481), is provided as Appendix E.

27. SPECIAL CALL

Where an anesthetist is not covered by Part IV Out-of-Hospital On-Call Anesthesia Coverage, such anesthetist shall be eligible for a Special Call benefit in accordance with the Rule of Application 3 in the Physician's Manual.

PART V—GUIDELINES FOR ANESTHESIA CONSULTATIONS

28. GUIDELINES

a) The Rules of Application regarding Anesthesia Consultation are set out in Rule of Application for Anesthesia Services 15. Part V is intended to assist in determining when an Anesthesia Consultation would be appropriate.

b) The requirement for an Anesthetic Consultation is dependant upon the severity of the condition, the magnitude of the proposed procedure and the extent of previous investigations. The attached list provides instances where a patient would benefit from a pre-operative consultation with an anesthetist. The objective of these consultations is to modify risk factors, provide advice on suitability for surgery and facilitate high quality, efficient and safe peri-operative care.

c) The list is not intended to be exhaustive.

Airway Conditions

Previous failed intubation

Known or suspected difficult intubation

Emergency airway management outside OR

Obstructive sleep apnea

Permanent tracheostomy

Syndromes associated with difficult airway anatomy (e.g. Pierre Robin, Treacher-Collins)

Anesthesia Related Conditions

Known or suspected history of Malignant Hyperthermia

Known or suspected family history of Malignant Hyperthermia

Plasma-cholinesterase deficiency or family history

Anesthetic complications with previous surgery

Quantification of anesthesia risk

Evaluation following **or** cancellation for medically unfit

Latex allergy

Cardiac Disease

- Suboptimal treatment of Congestive heart failure
- Ischemic heart disease:
  - Suboptimally treated I.H.D.
  - History of recent MI (within 6 months)
  - Low threshold angina (Class III & IV)
  - Recent change in previously stable angina
  - Chest pain not previously investigated
- Symptomatic Valvular Heart Disease
- Significant murmur not investigated
- Symptomatic arrythmia
- Symptomatic cardiomyopathy
- Pulmonary hypertension
- Complex congenital heart disease
- Hypertension poorly controlled (e.g. diastolic > 110)
- Hemodynamically unstable patient
- Pericardial tamponade
- Superior vena cava syndrome
- Previous heart transplant

Endocrine Disease

- Morbid obesity (Body Mass Index > 35)
- Carcinoid syndrome
- Pheochromocytoma
- Cushing's Syndrome
- Uncontrolled hyperthyroidism
- Untreated hypothyroidism
- Pregnant patient for non-obstetrical surgery, excluding peripheral procedures
- Type I diabetic for major vascular, abdominal, thoracic, renal transplant, or major orthopaedic procedure
- Paediatric insulin dependent diabetic with complications

Gastro-Intestinal Disease

- Active hepatitis
- Advanced cirrhosis
- Metastatic liver disease with impaired function
- Previous liver transplantation with impaired function
- Obstructive jaundice
- Biliary atresia
- GT anomalies (e.g. omphalocoele, gastroschisis)

Hematologic Conditions

Severe symptomatic anemia

Sickle-cell disease with anemia or history of crisis

Bleeding diathesis excluding minor surgery

Patient refusal of blood products excluding minor surgery

Pre-operative management of chronic anticoagulant therapy

Leukemia on active treatment

Metabolic Conditions

Acute or chronic renal failure requiring medical therapy

Major electrolyte disturbance

Significant acidosis

Porphyria

Cachexia

Severe burn > 30 %

Septic shock

Extremes of age: (e.g. octogenarian for radical surgery)

newborn apgar < 8

Inborn errors of metabolism (e.g. Hunter-Hurler)

Neurologic Disease

History of TIA or Stroke in past 8 weeks

Critical carotid stenosis

Intracranial mass or raised intracranial pressure

Neuromuscular disease such as muscular dystrophy, myasthesia…etc.

Uncontrolled seizure disorder

Musculo-Skeletal Conditions

Major congenital deformity (e.g. dwarfism, phocomelia)

Quadriplegia/paraplegia

Severe rheumatoid arthritis

Severe kypho-scoliosis with pulmonary dysfunction

Pharmacologic

Recent chemotherapy (e.g. cardiotoxic drugs, alkylating agents)

Drug interactions—MAO inhibitors, amiodarone

Complicated drug allergy histories

Pulmonary Disease

Past history of post-op respiratory complication

Sleep apnea

Recurrent pneumonia or recent pneumonia

Severe respiratory disease:

Asthma requiring frequent hospitalization

COPD on home Oxygen or FEVl < 50% of predicted

Pulmonary fibrosis

Anterior mediastinal mass with airway or vascular compression

Chronic ventilatory patients

Significant perinatal apnea

History of SIDS or near SIDS

Pulmonary Disease of prematurity

Miscellaneous

Trauma patient with 2 or more systems involved

Rare condition not previously mentioned

Unusual situation not previously mentioned

PART VI—ANESTHESIA COMMITTEE

29. GUIDING PRINCIPLES

a) The parties recognize that this Agreement represents a major change in the remuneration of anesthetic services. The parties therefore agree to the establishment of an Anesthesia Committee to assist in the administration of this Agreement and make recommendations as may be appropriate from time to time.

b) The Committee shall be governed by the primary principle guiding the fee schedule reform process—"that physician services should be remunerated in a fair and equitable manner".

30. THE COMMITTEE

The Committee shall be made up of three members appointed by Manitoba Health and three members appointed by the Association's Board of Directors.

31. TERMS OF REFERENCE

a) The Committee shall be responsible for monitoring the implementation of this Agreement and making recommendations to the parties.

b) The Committee shall be responsible to ensure that the principles of relative value are maintained when new anesthetic services are introduced and make such recommendations as may be appropriate to the parties.

c) Either party may request the Committee to review any issues regarding this Agreement.

32. DISPUTE RESOLUTION

Notwithstanding the provisions of Rules of Application for Anesthesia Services 29 to 31 inclusive, or any other provision of this Agreement, any dispute arising under this Agreement shall be subject to determination in accordance with the Dispute Resolution/Grievance Arbitration Process set out in the Physician's Manual.

APPENDICES

APPENDIX A—ANESTHETIC PROCEDURAL SERVICES

(In Accordance with Part II—Rule of Application 2 in Anesthesia Section)

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
0101	20.000	0140	21.375	0289	20.000	0317	21.375
0103	20.000	0141	21.375	0290	20.000	0318	21.375
0104	20.000	0142	21.375	0291	20.000	0319	20.000
0105	20.000	0143	21.375	0292	21.375	0320	20.000
0106	20.000	0145	21.375	0293	21.375	0321	21.375
0107	20.000	0146	21.375	0294	21.375	0322	21.375
0108	20.000	0147	21.375	0295	21.375	0323	20.000
0109	20.000	0148	21.375	0296	21.375	0324	21.375
0110	20.000	0149	21.375	0297	21.375	0325	21.375
0111	20.000	0170	20.000	0298	21.375	0326	21.375
0112	20.000	0171	20.000	0299	21.375	0327	21.375
0113	20.000	0172	20.000	0300	21.375	0328	21.375
0114	20.000	0230	20.000	0301	21.375	0329	21.375
0116	20.000	0247	20.000	0302	21.375	0330	21.375
0117	20.000	0248	20.000	0303	21.375	0331	21.375
0118	20.000	0249	20.000	0304	22.750	0332	21.375
0119	20.000	0250	20.000	0305	22.750	0333	21.375
0120	20.000	0251	20.000	0306	24.125	0334	21.375
0121	20.000	0253	20.000	0307	20.000	0335	21.375
0122	20.000	0254	20.000	0308	20.000	0336	21.375
0123	20.000	0255	20.000	0309	21.375	0337	20.000
0124	20.000	0256	20.000	0310	21.375	0338	20.000
0126	20.000	0257	20.000	0311	20.000	0339	22.750
0127	20.000	0258	20.000	0312	20.000	0341	22.750
0128	20.000	0259	20.000	0313	21.375	0344	22.750
0129	20.000	0286	20.000	0314	21.375	0345	20.000
0130	20.000	0287	20.000	0315	20.000	0346	22.750
0132	20.000	0288	20.000	0316	20.000	0347	22.750

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
0348	22.750	0394	20.000	0430	20.000	0469	22.750
0349	22.750	0395	20.000	0431	20.000	0470	21.375
0350	22.750	0396	20.000	0437	20.000	0471	21.375
0352	21.375	0397	20.000	0438	21.375	0472	21.375
0353	22.750	0398	20.000	0439	20.000	0473	20.000
0357	22.750	0399	20.000	0440	20.000	0474	22.750
0358	22.750	0400	20.000	0441	20.000	0475	22.750
0359	22.750	0401	20.000	0442	21.375	0476	22.750
0360	22.750	0403	20.000	0443	21.375	0477	20.000
0361	22.750	0404	20.000	0444	21.375	0478	20.000
0362	22.750	0405	20.000	0445	21.375	0489	21.375
0363	22.750	0406	20.000	0446	21.375	0501	20.000
0364	22.750	0407	20.000	0447	20.000	0503	20.000
0365	22.750	0408	20.000	0448	20.000	0504	20.000
0366	22.750	0409	20.000	0449	20.000	0506	20.000
0367	22.750	0410	20.000	0450	21.375	0510	20.000
0368	22.750	0411	20.000	0451	21.375	0517	20.000
0369	22.750	0412	20.000	0452	21.375	0518	20.000
0370	22.750	0413	20.000	0453	21.375	0519	20.000
0371	22.750	0414	20.000	0454	21.375	0520	20.000
0372	22.750	0415	20.000	0455	21.375	0521	20.000
0373	22.750	0416	20.000	0456	21.375	0523	20.000
0374	22.750	0417	20.000	0457	21.375	0524	20.000
0375	22.750	0418	20.000	0458	21.375	0525	20.000
0376	22.750	0419	20.000	0459	21.375	0526	21.375
0377	22.750	0420	20.000	0460	21.375	0527	21.375
0378	22.750	0421	20.000	0461	20.000	0530	20.000
0379	22.750	0422	20.000	0462	20.000	0531	20.000
0384	22.750	0423	20.000	0463	20.000	0532	21.375
0389	22.750	0424	20.000	0464	20.000	0534	21.375
0390	22.750	0425	20.000	0465	22.750	0536	21.375
0391	22.750	0426	20.000	0466	22.750	0537	20.000
0392	22.750	0427	20.000	0467	22.750	0539	22.750
0393	20.000	0429	20.000	0468	22.750	0541	20.000

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
0543	22.750	0590	24.125	0625	21.375	0694	20.000
0549	21.375	0591	20.000	0626	24.125	0696	20.000
0550	20.000	0592	24.125	0627	24.125	0699	21.375
0551	20.000	0593	20.000	0628	24.125	0701	21.375
0552	21.375	0594	24.125	0629	24.125	0703	20.000
0553	21.375	0595	20.000	0630	24.125	0704	21.375
0554	20.000	0596	24.125	0631	24.125	0705	21.375
0555	20.000	0597	24.125	0632	24.125	0706	21.375
0556	20.000	0598	24.125	0633	24.125	0720	21.375
0557	20.000	0599	24.125	0634	21.375	0723	22.750
0558	20.000	0600	24.125	0635	22.750	0733	21.375
0559	20.000	0601	24.125	0636	22.750	0734	21.375
0560	21.375	0602	24.125	0637	21.375	0739	21.375
0561	20.000	0603	24.125	0638	21.375	0740	21.375
0563	20.000	0604	24.125	0639	21.375	0742	21.375
0564	20.000	0605	24.125	0640	21.375	0754	21.375
0565	20.000	0606	24.125	0641	21.375	0757	21.375
0566	20.000	0607	24.125	0642	22.750	0770	21.375
0567	20.000	0608	24.125	0643	22.750	0771	21.375
0568	20.000	0610	24.125	0644	22.750	0772	22.750
0570	20.000	0611	21.375	0645	24.125	0773	22.750
0572	20.000	0612	21.375	0646	22.750	0774	22.750
0576	21.375	0613	21.375	0647	24.125	0780	20.000
0577	20.000	0614	21.375	0648	22.750	0782	21.375
0580	22.750	0615	21.375	0654	21.375	0785	20.000
0581	22.750	0616	22.750	0655	21.375	0787	21.375
0582	22.750	0617	21.375	0656	21.375	0789	20.000
0583	24.125	0618	20.000	0659	21.375	0790	21.375
0584	24.125	0619	21.375	0661	21.375	0792	20.000
0585	24.125	0620	21.375	0686	21.375	0794	21.375
0586	24.125	0621	24.125	0687	21.375	0801	21.375
0587	24.125	0622	21.375	0688	21.375	0803	20.000
0588	24.125	0623	21.375	0691	20.000	0805	21.375
0589	24.125	0624	20.000	0693	21.375	0807	20.000

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
0809	20.000	0912	21.375	1050	20.000	1132	22.750
0810	21.375	0914	20.000	1051	20.000	1133	22.750
0811	21.375	0916	21.375	1053	20.000	1134	22.750
0813	20.000	0926	20.000	1065	21.375	1136	24.125
0816	21.375	0928	21.375	1073	22.750	1137	24.125
0818	20.000	0930	20.000	1074	22.750	1138	24.125
0819	21.375	0933	20.000	1075	22.750	1139	24.125
0821	20.000	0935	21.375	1076	22.750	1141	21.375
0823	21.375	0936	20.000	1077	21.375	1143	20.000
0830	21.375	0937	21.375	1082	21.375	1144	20.000
0842	20.000	0938	20.000	1085	21.375	1145	20.000
0844	21.375	0941	21.375	1093	21.375	1149	22.750
0848	21.375	0944	20.000	1095	21.375	1152	21.375
0852	20.000	0946	21.375	1101	21.375	1153	20.000
0854	21.375	0961	20.000	1102	21.375	1154	24.125
0865	20.000	0963	21.375	1103	21.375	1162	20.000
0868	22.750	0964	20.000	1104	21.375	1163	20.000
0870	22.750	0967	20.000	1105	24.125	1164	20.000
0872	20.000	0970	20.000	1107	24.125	1165	20.000
0874	22.750	0980	20.000	1109	24.125	1166	20.000
0877	20.000	0982	20.000	1111	24.125	1167	20.000
0879	22.750	0985	20.000	1113	24.125	1168	20.000
0881	20.000	0989	21.375	1114	22.750	1170	20.000
0882	21.375	1001	21.375	1116	22.750	1172	22.750
0883	21.375	1002	20.000	1118	22.750	1173	21.375
0884	22.750	1003	20.000	1119	22.750	1174	22.750
0885	20.000	1006	20.000	1121	22.750	1175	21.375
0887	21.375	1007	21.375	1124	24.125	1176	20.000
0897	21.375	1008	21.375	1125	24.125	1177	20.000
0901	20.000	1010	20.000	1126	24.125	1178	20.000
0904	21.375	1013	20.000	1128	22.750	1180	22.750
0907	20.000	1017	20.000	1129	22.750	1181	20.000
0910	21.375	1026	20.000	1130	22.750	1182	22.750
0911	20.000	1049	20.000	1131	22.750	1183	20.000

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
1184	20.000	1223	20.000	1317	20.000	1417	22.750
1185	20.000	1224	20.000	1328	20.000	1418	22.750
1186	22.750	1226	20.000	1332	20.000	1419	24.125
1187	20.000	1227	20.000	1334	21.375	1420	25.500
1188	22.750	1228	20.000	1335	22.750	1421	25.500
1189	22.750	1232	20.000	1336	21.375	1422	22.750
1190	20.000	1241	20.000	1337	24.125	1423	22.750
1191	21.375	1242	20.000	1338	24.125	1424	22.750
1192	22.750	1244	20.000	1339	24.125	1425	22.750
1193	22.750	1245	20.000	1344	20.000	1426	25.500
1194	22.750	1246	20.000	1346	21.375	1430	20.000
1195	22.750	1247	20.000	1352	20.000	1431	20.000
1196	21.375	1251	20.000	1355	20.000	1433	20.000
1197	21.375	1256	21.375	1357	20.000	1435	20.000
1198	21.375	1258	22.750	1361	20.000	1436	20.000
1200	22.750	1262	21.375	1363	20.000	1440	22.750
1201	21.375	1264	22.750	1371	20.000	1442	22.750
1202	20.000	1267	21.375	1373	20.000	1444	22.750
1203	22.750	1270	22.750	1378	20.000	1446	22.750
1204	22.750	1273	20.000	1387	20.000	1448	22.750
1205	22.750	1275	21.375	1401	20.000	1450	20.000
1206	22.750	1278	20.000	1402	22.750	1452	20.000
1207	22.750	1281	21.375	1403	22.750	1453	20.000
1208	22.750	1284	20.000	1404	21.375	1454	21.375
1211	21.375	1286	21.375	1405	21.375	1456	21.375
1212	21.375	1290	20.000	1406	20.000	1458	20.000
1213	21.375	1292	20.000	1407	24.125	1460	20.000
1214	21.375	1295	20.000	1408	24.125	1461	21.375
1215	21.375	1297	20.000	1409	24.125	1511	20.000
1216	20.000	1298	20.000	1410	20.000	1514	20.000
1217	20.000	1299	20.000	1411	24.125	1519	20.000
1218	20.000	1301	20.000	1412	24.125	1521	20.000
1221	20.000	1304	20.000	1415	22.750	1522	20.000
1222	20.000	1306	20.000	1416	25.500	1525	20.000

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
1531	20.000	1661	20.000	1804	21.375	1924	21.375
1534	20.000	1701	22.750	1811	20.000	1928	21.375
1535	20.000	1703	21.375	1815	20.000	1929	21.375
1536	20.000	1705	21.375	1817	20.000	1930	21.375
1539	20.000	1708	20.000	1819	21.375	1935	21.375
1541	20.000	1709	20.000	1851	20.000	1949	21.375
1552	20.000	1710	21.375	1854	20.000	1950	21.375
1553	20.000	1711	21.375	1856	20.000	1951	21.375
1562	21.375	1712	20.000	1860	20.000	1952	22.750
1570	20.000	1718	20.000	1862	20.000	1953	21.375
1573	20.000	1722	20.000	1867	20.000	1954	21.375
1574	20.000	1725	20.000	1870	20.000	1955	21.375
1580	20.000	1739	20.000	1878	20.000	1956	21.375
1582	20.000	1740	20.000	1882	20.000	1957	21.375
1583	20.000	1741	20.000	1885	20.000	1966	21.375
1585	20.000	1742	20.000	1886	20.000	1967	21.375
1586	20.000	1743	20.000	1889	20.000	1968	21.375
1589	20.000	1745	24.125	1890	20.000	1969	21.375
1593	20.000	1748	22.750	1891	20.000	1978	22.750
1595	20.000	1750	21.375	1892	20.000	1979	22.750
1596	20.000	1752	22.750	1893	20.000	1981	21.375
1612	20.000	1760	22.750	1894	20.000	1985	21.375
1613	20.000	1761	20.000	1895	20.000	1988	21.375
1616	20.000	1763	22.750	1896	20.000	1991	21.375
1632	20.000	1767	21.375	1897	20.000	1992	21.375
1633	20.000	1771	21.375	1898	20.000	1994	22.750
1635	21.375	1772	20.000	1899	20.000	1995	21.375
1636	21.375	1774	21.375	1904	21.375	1996	22.750
1640	20.000	1778	21.375	1905	21.375	2006	21.375
1641	20.000	1782	21.375	1906	20.000	2007	21.375
1654	21.375	1785	21.375	1907	21.375	2009	21.375
1655	21.375	1788	21.375	1908	20.000	2010	21.375
1657	20.000	1802	21.375	1917	21.375	2011	21.375
1659	20.000	1803	21.375	1922	22.750	2012	21.375

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
2013	22.750	2089	24.125	2153	25.500	2219	24.125
2014	21.375	2100	22.750	2154	22.750	2220	22.750
2015	21.375	2101	22.750	2155	25.500	2221	20.000
2017	21.375	2102	21.375	2156	21.375	2222	20.000
2018	21.375	2103	21.375	2157	21.375	2224	20.000
2019	21.375	2104	21.375	2158	22.750	2225	20.000
2020	21.375	2105	22.750	2159	25.500	2302	21.375
2021	21.375	2112	24.125	2160	24.125	2304	21.375
2022	21.375	2113	22.750	2170	24.125	2305	21.375
2023	21.375	2115	22.750	2171	24.125	2306	21.375
2024	21.375	2116	24.125	2172	24.125	2307	21.375
2025	21.375	2117	22.750	2173	24.125	2308	21.375
2026	21.375	2118	22.750	2174	24.125	2309	21.375
2027	21.375	2119	24.125	2177	24.125	2310	24.125
2028	21.375	2120	22.750	2178	24.125	2311	21.375
2029	21.375	2121	22.750	2180	20.000	2312	21.375
2030	20.000	2122	22.750	2183	20.000	2314	20.000
2031	20.000	2123	22.750	2188	24.125	2316	25.500
2032	21.375	2124	22.750	2190	24.125	2317	20.000
2033	21.375	2125	22.750	2191	25.500	2318	25.500
2034	21.375	2126	22.750	2192	24.125	2319	22.750
2041	22.750	2127	22.750	2193	24.125	2320	25.500
2051	24.125	2129	22.750	2194	24.125	2321	22.750
2052	22.750	2130	22.750	2196	24.125	2322	25.500
2053	22.750	2131	22.750	2197	25.500	2323	24.125
2054	22.750	2132	24.125	2198	25.500	2324	25.500
2070	22.750	2133	25.500	2199	25.500	2325	21.375
2071	22.750	2134	25.500	2200	24.125	2326	22.750
2074	22.750	2135	25.500	2201	24.125	2327	21.375
2077	22.750	2136	24.125	2202	24.125	2328	21.375
2078	22.750	2137	24.125	2209	24.125	2329	21.375
2079	24.125	2139	25.500	2210	24.125	2330	21.375
2080	24.125	2151	25.500	2211	22.750	2332	24.125
2081	22.750	2152	24.125	2212	22.750	2334	21.375

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
2336	25.500	2379	21.375	2430	25.500	2467	22.750
2338	25.500	2381	21.375	2431	24.125	2468	25.500
2339	21.375	2388	25.500	2432	25.500	2469	24.125
2340	25.500	2390	25.500	2433	22.750	2470	25.500
2342	25.500	2392	25.500	2434	25.500	2471	22.750
2344	25.500	2394	25.500	2435	25.500	2472	24.125
2345	21.375	2396	25.500	2436	25.500	2473	24.125
2348	21.375	2398	25.500	2437	25.500	2474	22.750
2349	21.375	2400	25.500	2438	25.500	2475	24.125
2350	24.125	2402	25.500	2439	25.500	2476	24.125
2351	22.750	2403	21.375	2440	25.500	2477	24.125
2352	24.125	2404	25.500	2441	25.500	2479	24.125
2353	24.125	2405	25.500	2442	25.500	2480	21.375
2354	25.500	2406	25.500	2443	25.500	2481	22.750
2355	21.375	2407	25.500	2444	25.500	2482	25.500
2356	25.500	2408	25.500	2447	22.750	2483	22.750
2357	21.375	2409	25.500	2448	25.500	2484	25.500
2358	25.500	2410	25.500	2449	22.750	2485	22.750
2359	21.375	2411	25.500	2451	25.500	2486	25.500
2360	25.500	2412	25.500	2450	25.500	2487	24.125
2361	21.375	2413	25.500	2452	25.500	2488	25.500
2362	24.125	2415	25.500	2453	25.500	2489	24.125
2363	21.375	2417	25.500	2454	25.500	2490	24.125
2364	24.125	2418	25.500	2455	25.500	2491	24.125
2365	21.375	2420	25.500	2456	25.500	2492	25.500
2366	24.125	2421	25.500	2457	25.500	2493	24.125
2367	21.375	2422	25.500	2458	25.500	2495	24.125
2369	25.500	2423	25.500	2459	25.500	2496	24.125
2372	25.500	2424	25.500	2461	24.125	2497	24.125
2373	21.375	2425	25.500	2462	25.500	2498	24.125
2375	25.500	2426	25.500	2463	24.125	2499	24.125
2376	25.500	2427	25.500	2464	25.500	2500	24.125
2377	21.375	2428	25.500	2465	24.125	2501	24.125
2378	25.500	2429	24.125	2466	21.375	2502	24.125

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
2503	24.125	2537	24.125	2589	24.125	2645	21.375
2504	24.125	2538	24.125	2590	24.125	2652	22.750
2505	25.500	2539	24.125	2591	24.125	2658	21.375
2506	24.125	2540	24.125	2592	24.125	2665	22.750
2507	25.500	2541	22.750	2593	22.750	2666	22.750
2508	22.750	2543	22.750	2594	22.750	2672	20.000
2509	25.500	2545	22.750	2595	22.750	2674	22.750
2510	24.125	2546	20.000	2598	20.000	2675	22.750
2511	25.500	2547	22.750	2599	24.125	2676	21.375
2512	24.125	2548	20.000	2601	22.750	2678	21.375
2513	25.500	2549	20.000	2602	20.000	2684	21.375
2514	24.125	2550	20.000	2604	24.125	2685	22.750
2515	25.500	2552	24.125	2608	21.375	2686	25.500
2516	24.125	2553	20.000	2609	24.125	2687	22.750
2517	25.500	2554	22.750	2619	21.375	2689	25.500
2518	24.125	2555	20.000	2620	21.375	2691	24.125
2519	24.125	2569	25.500	2621	21.375	2693	24.125
2520	24.125	2572	22.750	2622	21.375	2696	24.125
2521	24.125	2573	22.750	2623	21.375	2699	22.750
2522	20.000	2574	22.750	2624	21.375	2700	25.500
2523	24.125	2575	22.750	2625	21.375	2701	21.375
2524	22.750	2576	22.750	2626	21.375	2702	25.500
2525	22.750	2577	22.750	2627	21.375	2703	25.500
2526	20.000	2578	24.125	2628	21.375	2704	25.500
2527	22.750	2579	25.500	2629	21.375	2705	24.125
2528	20.000	2580	24.125	2630	21.375	2706	25.500
2529	24.125	2581	24.125	2631	20.000	2708	25.500
2530	20.000	2582	24.125	2632	21.375	2709	25.500
2531	22.750	2583	24.125	2633	21.375	2710	25.500
2532	22.750	2584	24.125	2634	21.375	2711	25.500
2533	24.125	2585	24.125	2641	20.000	2712	25.500
2534	22.750	2586	22.750	2642	21.375	2713	25.500
2535	24.125	2587	24.125	2643	20.000	2715	25.500
2536	25.500	2588	24.125	2644	20.000	2716	25.500

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
2717	25.500	2789	22.750	2971	24.125	3060	22.750
2718	25.500	2790	22.750	2975	21.375	3063	21.375
2719	25.500	2799	24.125	2979	24.125	3065	21.375
2720	25.500	2815	24.125	2980	21.375	3066	21.375
2721	25.500	2819	20.000	2981	21.375	3067	24.125
2722	25.500	2871	21.375	2982	21.375	3068	24.125
2723	25.500	2881	20.000	2987	22.750	3070	24.125
2724	25.500	2883	22.750	2989	20.000	3072	24.125
2725	25.500	2885	21.375	2990	20.000	3075	21.375
2729	25.500	2887	21.375	2992	21.375	3076	24.125
2730	25.500	2889	22.750	2993	21.375	3077	22.750
2731	25.500	2890	22.750	2994	24.125	3078	24.125
2732	25.500	2891	21.375	2996	21.375	3079	24.125
2733	25.500	2892	22.750	2998	21.375	3080	21.375
2734	25.500	2894	22.750	3000	21.375	3081	24.125
2741	21.375	2895	22.750	3002	21.375	3083	24.125
2742	21.375	2897	22.750	3004	21.375	3085	22.750
2743	21.375	2898	22.750	3006	24.125	3086	24.125
2746	21.375	2899	22.750	3008	20.000	3089	25.500
2752	20.000	2915	21.375	3011	22.750	3092	21.375
2754	21.375	2916	21.375	3020	22.750	3093	21.375
2758	21.375	2918	21.375	3021	22.750	3094	21.375
2759	21.375	2919	21.375	3022	22.750	3095	21.375
2762	21.375	2921	21.375	3031	21.375	3096	21.375
2765	21.375	2925	21.375	3033	22.750	3097	21.375
2769	21.375	2927	21.375	3038	22.750	3098	21.375
2775	21.375	2930	21.375	3040	25.500	3099	21.375
2781	20.000	2934	22.750	3041	25.500	3100	20.000
2783	21.375	2937	22.750	3043	24.125	3101	22.750
2784	21.375	2941	21.375	3044	24.125	3103	21.375
2785	22.750	2949	22.750	3046	24.125	3104	21.375
2786	20.000	2950	21.375	3053	21.375	3105	22.750
2787	22.750	2951	21.375	3055	21.375	3112	22.750
2788	24.125	2961	21.375	3057	21.375	3114	22.750

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
3115	22.750	3185	21.375	3285	21.375	3357	20.000
3117	22.750	3186	21.375	3286	24.125	3364	20.000
3118	22.750	3187	21.375	3288	24.125	3365	20.000
3121	21.375	3188	21.375	3289	24.125	3371	20.000
3122	21.375	3189	21.375	3290	22.750	3372	20.000
3123	21.375	3190	21.375	3292	22.750	3377	20.000
3131	22.750	3191	22.750	3296	20.000	3380	20.000
3133	22.750	3193	22.750	3297	21.375	3392	20.000
3134	21.375	3194	22.750	3298	22.750	3395	20.000
3135	22.750	3195	22.750	3299	20.000	3396	20.000
3136	21.375	3201	22.750	3300	20.000	3397	20.000
3137	22.750	3203	21.375	3301	24.125	3401	20.000
3138	24.125	3204	22.750	3311	20.000	3420	21.375
3139	24.125	3205	22.750	3313	20.000	3421	20.000
3140	24.125	3207	22.750	3315	20.000	3422	21.375
3141	22.750	3208	22.750	3317	20.000	3424	21.375
3142	22.750	3209	22.750	3319	20.000	3425	21.375
3149	24.125	3211	22.750	3320	20.000	3426	21.375
3153	22.750	3221	22.750	3321	21.375	3427	21.375
3160	20.000	3223	22.750	3322	21.375	3428	22.750
3161	22.750	3224	22.750	3323	20.000	3429	20.000
3162	21.375	3225	21.375	3325	22.750	3433	20.000
3166	22.750	3226	22.750	3326	22.750	3434	20.000
3171	22.750	3227	22.750	3328	22.750	3456	21.375
3172	22.750	3228	22.750	3329	22.750	3458	21.375
3174	22.750	3231	21.375	3331	21.375	3464	24.125
3175	22.750	3235	22.750	3333	21.375	3471	22.750
3177	21.375	3241	22.750	3335	21.375	3472	22.750
3179	22.750	3251	21.375	3340	20.000	3481	24.125
3180	24.125	3259	22.750	3341	21.375	3491	24.125
3181	24.125	3261	21.375	3353	20.000	3492	24.125
3182	24.125	3262	22.750	3354	20.000	3493	22.750
3183	24.125	3263	22.750	3355	20.000	3494	24.125
3184	22.750	3283	20.000	3356	20.000	3495	22.750

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
3496	24.125	3577	22.750	3792	21.375	3858	22.750
3497	24.125	3580	22.750	3793	21.375	3861	21.375
3498	20.000	3582	22.750	3794	20.000	3865	21.375
3499	24.125	3583	22.750	3800	21.375	3866	21.375
3503	22.750	3584	22.750	3801	21.375	3867	21.375
3504	22.750	3585	22.750	3802	22.750	3871	22.750
3505	21.375	3586	22.750	3803	21.375	3872	21.375
3506	21.375	3587	22.750	3804	21.375	3873	21.375
3515	22.750	3591	21.375	3805	21.375	3874	22.750
3516	22.750	3592	21.375	3806	21.375	3875	21.375
3518	22.750	3593	21.375	3807	20.000	3876	22.750
3520	24.125	3595	21.375	3808	22.750	3877	22.750
3522	22.750	3596	21.375	3811	22.750	3878	21.375
3524	22.750	3597	21.375	3812	22.750	3879	21.375
3526	22.750	3619	22.750	3813	21.375	3880	22.750
3528	22.750	3631	20.000	3817	22.750	3881	22.750
3541	22.750	3632	20.000	3819	22.750	3882	21.375
3542	24.125	3633	21.375	3820	21.375	3883	21.375
3544	22.750	3635	21.375	3821	22.750	3884	22.750
3546	22.750	3636	20.000	3822	22.750	3885	22.750
3547	22.750	3646	20.000	3823	24.125	3886	22.750
3550	22.750	3651	21.375	3824	22.750	3887	21.375
3551	24.125	3660	22.750	3825	22.750	3888	21.375
3552	24.125	3661	21.375	3827	22.750	3889	22.750
3565	22.750	3663	21.375	3829	21.375	3890	21.375
3567	22.750	3664	21.375	3830	21.375	3891	21.375
3568	22.750	3666	21.375	3831	22.750	3892	21.375
3569	24.125	3668	22.750	3835	22.750	3893	21.375
3571	22.750	3707	24.125	3839	22.750	3895	22.750
3572	21.375	3708	25.500	3841	22.750	3900	20.000
3573	22.750	3709	24.125	3845	22.750	3901	20.000
3574	21.375	3710	22.750	3846	22.750	3902	20.000
3575	22.750	3734	22.750	3851	22.750	3906	20.000
3576	21.375	3790	21.375	3857	22.750	3907	20.000

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
3908	21.375	3944	20.000	3989	21.375	4139	21.375
3909	21.375	3945	21.375	3991	20.000	4141	20.000
3910	24.125	3947	21.375	3994	20.000	4142	20.000
3911	22.750	3951	20.000	4000	20.000	4143	20.000
3912	22.750	3952	22.750	4001	20.000	4144	20.000
3913	24.125	3953	22.750	4004	20.000	4145	20.000
3914	22.750	3954	20.000	4005	20.000	4146	21.375
3915	24.125	3955	22.750	4006	20.000	4148	20.000
3916	22.750	3956	21.375	4011	21.375	4152	20.000
3917	24.125	3957	21.375	4019	21.375	4153	20.000
3918	21.375	3958	21.375	4021	21.375	4154	20.000
3919	24.125	3959	21.375	4031	20.000	4155	20.000
3920	22.750	3960	22.750	4033	20.000	4156	20.000
3921	21.375	3961	22.750	4034	20.000	4157	20.000
3922	22.750	3965	21.375	4035	20.000	4159	20.000
3923	21.375	3966	21.375	4101	20.000	4161	20.000
3924	21.375	3967	21.375	4111	20.000	4163	20.000
3926	20.000	3968	21.375	4114	20.000	4165	20.000
3927	20.000	3969	21.375	4115	20.000	4174	20.000
3928	21.375	3970	22.750	4116	20.000	4176	20.000
3929	20.000	3971	20.000	4118	20.000	4181	20.000
3930	20.000	3972	22.750	4119	20.000	4182	20.000
3931	20.000	3973	20.000	4120	20.000	4189	20.000
3932	20.000	3974	22.750	4122	20.000	4191	20.000
3933	20.000	3975	22.750	4123	20.000	4200	20.000
3934	20.000	3976	20.000	4125	20.000	4201	20.000
3935	20.000	3977	20.000	4126	20.000	4202	20.000
3936	22.750	3978	20.000	4127	20.000	4209	20.000
3937	21.375	3979	20.000	4128	20.000	4211	20.000
3939	21.375	3980	21.375	4129	20.000	4215	20.000
3940	20.000	3981	20.000	4130	20.000	4221	20.000
3941	20.000	3982	20.000	4133	20.000	4224	20.000
3942	20.000	3983	20.000	4135	20.000	4227	20.000
3943	21.375	3987	21.375	4138	22.750	4229	20.000

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
4241	20.000	4423	21.375	4486	22.750	4613	20.000
4251	20.000	4424	21.375	4488	20.000	4614	21.375
4252	20.000	4425	21.375	4489	20.000	4617	22.750
4259	20.000	4426	21.375	4493	20.000	4620	22.750
4271	20.000	4427	20.000	4494	21.375	4621	22.750
4275	20.000	4428	20.000	4497	21.375	4627	22.750
4278	20.000	4429	21.375	4499	20.000	4631	22.750
4279	20.000	4430	20.000	4500	21.375	4632	21.375
4281	20.000	4431	20.000	4501	20.000	4633	20.000
4291	20.000	4432	20.000	4507	20.000	4634	21.375
4299	20.000	4433	20.000	4511	20.000	4635	20.000
4301	20.000	4434	20.000	4521	20.000	4636	20.000
4302	20.000	4441	20.000	4545	21.375	4639	22.750
4305	20.000	4443	20.000	4551	21.375	4641	20.000
4307	20.000	4444	21.375	4561	21.375	4645	20.000
4308	20.000	4445	21.375	4562	21.375	4646	20.000
4311	22.750	4455	20.000	4566	20.000	4647	20.000
4313	24.125	4461	20.000	4567	22.750	4648	20.000
4316	22.750	4463	20.000	4571	21.375	4671	20.000
4318	22.750	4471	20.000	4581	21.375	4672	20.000
4319	22.750	4472	20.000	4583	21.375	4677	20.000
4320	24.125	4473	21.375	4585	21.375	4678	20.000
4321	22.750	4474	20.000	4586	22.750	4679	20.000
4322	20.000	4475	20.000	4600	22.750	4681	21.375
4324	22.750	4476	20.000	4601	22.750	4694	21.375
4325	20.000	4477	20.000	4602	22.750	4695	21.375
4326	21.375	4478	20.000	4603	22.750	4696	21.375
4327	21.375	4479	21.375	4604	22.750	4699	22.750
4329	22.750	4480	21.375	4605	22.750	4701	22.750
4403	20.000	4481	20.000	4606	22.750	4705	20.000
4404	20.000	4482	20.000	4607	22.750	4706	20.000
4405	20.000	4483	22.750	4608	22.750	4711	20.000
4411	20.000	4484	20.000	4611	20.000	4735	20.000
4421	20.000	4485	21.375	4612	20.000	4745	20.000

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
4800	22.750	4866	20.000	5019	22.750	5092	24.125
4802	20.000	4870	21.375	5021	24.125	5093	24.125
4803	24.125	4899	24.125	5023	24.125	5095	24.125
4806	20.000	4907	21.375	5025	24.125	5097	24.125
4809	21.375	4909	20.000	5027	24.125	5098	25.500
4811	22.750	4910	20.000	5029	24.125	5099	22.750
4812	21.375	4911	21.375	5031	24.125	5101	24.125
4815	20.000	4912	21.375	5033	24.125	5103	24.125
4816	21.375	4914	21.375	5035	24.125	5105	24.125
4822	20.000	4917	21.375	5037	24.125	5106	24.125
4829	21.375	4924	21.375	5049	22.750	5107	22.750
4830	21.375	4925	21.375	5056	22.750	5118	22.750
4831	21.375	4940	21.375	5057	21.375	5201	21.375
4832	21.375	4941	21.375	5058	22.750	5202	21.375
4833	21.375	4949	22.750	5059	22.750	5203	22.750
4834	21.375	4971	21.375	5060	21.375	5205	22.750
4835	21.375	4972	24.125	5061	21.375	5207	22.750
4836	21.375	4979	24.125	5062	22.750	5209	22.750
4837	21.375	4988	24.125	5063	21.375	5210	22.750
4838	21.375	4989	24.125	5065	24.125	5213	22.750
4839	21.375	4990	24.125	5067	24.125	5215	22.750
4840	21.375	4991	24.125	5071	24.125	5217	24.125
4841	21.375	4993	22.750	5073	24.125	5219	24.125
4842	21.375	4994	22.750	5075	24.125	5221	22.750
4843	22.750	4999	22.750	5077	24.125	5223	22.750
4844	21.375	5001	24.125	5079	24.125	5224	22.750
4845	21.375	5003	24.125	5081	24.125	5225	21.375
4846	21.375	5005	24.125	5083	24.125	5226	22.750
4847	22.750	5007	24.125	5084	22.750	5227	21.375
4850	20.000	5009	24.125	5085	25.500	5228	22.750
4855	20.000	5011	24.125	5087	25.500	5229	24.125
4860	20.000	5013	24.125	5089	25.500	5230	22.750
4861	20.000	5015	24.125	5090	25.500	5231	22.750
4862	20.000	5017	22.750	5091	24.125	5233	21.375

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
5235	20.000	5452	22.750	5614	21.375	5731	21.375
5237	21.375	5456	22.750	5615	21.375	5732	21.375
5239	21.375	5457	22.750	5622	21.375	5734	21.375
5244	20.000	5458	20.000	5624	21.375	5741	20.000
5284	20.000	5471	22.750	5630	21.375	5742	20.000
5286	20.000	5481	22.750	5631	22.750	5743	20.000
5287	20.000	5492	22.750	5632	22.750	5744	20.000
5288	21.375	5493	22.750	5633	22.750	5751	20.000
5289	22.750	5494	22.750	5634	21.375	5753	20.000
5291	22.750	5495	21.375	5635	20.000	5775	22.750
5292	20.000	5501	21.375	5636	21.375	5777	22.750
5293	21.375	5521	22.750	5638	22.750	5778	22.750
5296	20.000	5532	21.375	5639	22.750	5801	20.000
5371	22.750	5533	21.375	5641	21.375	5803	20.000
5372	22.750	5534	21.375	5642	21.375	5804	20.000
5375	24.125	5535	21.375	5643	21.375	5811	20.000
5376	24.125	5536	21.375	5644	21.375	5813	20.000
5381	21.375	5537	21.375	5647	21.375	5815	20.000
5382	21.375	5538	21.375	5651	22.750	5821	20.000
5385	22.750	5541	21.375	5652	22.750	5831	20.000
5386	22.750	5542	21.375	5653	22.750	5833	20.000
5390	22.750	5546	21.375	5662	22.750	5835	20.000
5399	22.750	5547	21.375	5664	22.750	5841	20.000
5401	21.375	5551	21.375	5665	22.750	5842	20.000
5411	22.750	5552	21.375	5681	22.750	5843	20.000
5413	22.750	5554	21.375	5691	21.375	5844	20.000
5414	22.750	5561	21.375	5692	21.375	5845	20.000
5431	21.375	5601	21.375	5697	21.375	5882	22.750
5438	22.750	5602	21.375	5698	21.375	5883	24.125
5439	22.750	5604	21.375	5702	21.375	5884	22.750
5441	22.750	5610	21.375	5703	21.375	5885	22.750
5445	22.750	5611	21.375	5712	21.375	5886	22.750
5446	22.750	5612	21.375	5728	21.375	5887	22.750
5451	22.750	5613	21.375	5730	21.375	5888	22.750

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
5889	22.750	6104	21.375	6152	21.375	6193	21.375
5922	21.375	6106	21.375	6153	21.375	6195	21.375
5925	21.375	6107	21.375	6154	21.375	6197	20.000
5940	21.375	6108	21.375	6155	21.375	6198	20.000
5955	20.000	6109	21.375	6156	21.375	6200	20.000
5956	20.000	6110	20.000	6157	21.375	6201	20.000
5957	21.375	6111	22.750	6158	21.375	6202	20.000
5959	20.000	6112	22.750	6159	21.375	6203	20.000
5960	21.375	6113	24.125	6160	21.375	6204	20.000
5961	20.000	6114	20.000	6161	20.000	6205	20.000
5962	20.000	6115	20.000	6162	20.000	6206	20.000
5963	20.000	6117	21.375	6163	21.375	6207	20.000
5969	22.750	6118	21.375	6165	24.125	6208	20.000
5970	21.375	6120	20.000	6166	21.375	6209	20.000
5971	21.375	6121	20.000	6167	24.125	6210	20.000
5972	21.375	6122	20.000	6168	24.125	6211	20.000
5975	21.375	6123	20.000	6169	24.125	6212	20.000
5976	22.750	6124	21.375	6170	24.125	6213	20.000
5977	21.375	6125	21.375	6171	21.375	6214	20.000
5981	20.000	6126	20.000	6172	21.375	6215	20.000
5983	21.375	6127	20.000	6178	24.125	6216	20.000
5991	21.375	6128	20.000	6179	24.125	6217	20.000
5992	21.375	6131	22.750	6180	24.125	6218	20.000
5993	21.375	6132	20.000	6181	24.125	6219	20.000
5995	22.750	6141	20.000	6182	24.125	6220	20.000
5997	21.375	6143	21.375	6183	24.125	6221	20.000
5998	21.375	6144	20.000	6184	24.125	6222	20.000
6001	21.375	6145	22.750	6185	24.125	6223	20.000
6011	21.375	6146	20.000	6186	24.125	6224	20.000
6031	21.375	6147	21.375	6187	24.125	6225	20.000
6033	21.375	6148	22.750	6188	24.125	6226	20.000
6100	21.375	6149	22.750	6189	22.750	6227	20.000
6101	21.375	6150	22.750	6190	22.750	6228	22.750
6102	21.375	6151	22.750	6191	20.000	6229	20.000

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
6230	20.000	6272	24.125				
6231	20.000	6273	24.125				
6232	20.000	6274	24.125				
6235	20.000	6275	24.125				
6236	20.000	6276	24.125				
6237	20.000	6999	21.375				
6238	20.000	7202	20.000				
6239	20.000	7203	20.000				
6240	20.000	7204	20.000				
6241	20.000	7205	20.000				
6242	20.000	7216	20.000				
6243	20.000	9822	20.000				
6244	20.000	9823	20.000				
6245	20.000	9824	20.000				
6246	20.000	9825	20.000				
6247	20.000	9826	20.000				
6250	20.000	9827	20.000				
6251	20.000	9828	20.000				
6252	20.000	9833	20.000				
6253	20.000	9835	20.000				
6255	20.000	9850	20.000				
6256	20.000						
6260	21.375						
6261	21.375						
6262	21.375						
6263	21.375						
6264	21.375						
6265	21.375						
6266	21.375						
6267	21.375						
6268	21.375						
6269	21.375						
6270	21.375						
6271	24.125						

APPENDIX B—DIAGNOSTIC AND THERAPEUTIC ANESTHETIC PROCEDURES

TARIFF	PROCEDURE	UNITS
5312*	Intercostal, one or more	30
5318*	Phrenic	60
5317*	Sciatic	60
5320*	Sphenopalatine ganglion	60
5311*	Nerve plexus blocks	40
5319*	Peripheral nerve—single and multiple	30
	Epidural Blocks	
5304	Lumbar or Caudal	60
5305	Thoracic	80
5306	Cervical	80
	Nerve Root or Facet Blocks	
5300*	Cervical single	60
5307	Cervical multiple	80
5308	Thoracic single	60
5309	Thoracic multiple	80
5310	Lumbar single	40
5321	Lumbar multiple	60
5328	Nerve Root or Facet—Cryotherapy and/or Neurolysis, additional benefit	20
	Subarachnoid (spinal) Blocks	
5322	Subdural/Spinal	60
5323	Differential spinal	72
	Sympathetic Nerve Blocks	
5302*	Stellate ganglion	60
5298*	Paravertebral (lumbar sympathetic)	60
5315*	Splanchnic/Coeliac plexus	80
	Permanent Cryosection and/or Neurolysis	
5324	Major plexus or nerve root	120
5325	Single peripheral nerve	30
5326	Multiple peripheral nerves	76
5327	Epidural or subarachnoid neurolysis	120
5316	Supra and infra diaphragmatic nerve neurolysis including splanchnic, coeliac and sympathetic nerves with x-ray contrast and x-ray control	120

Injection Tendon Sheath, Ligaments

TARIFF	PROCEDURE	UNITS
1046	Single injections	10
1047	Multiple injections, regardless of number	15
1048	IV injections for diagnosis and/or therapeutic management of pain syndromes	20
2566	IV sympathetic blockade	60

Intra-Articular Injections

1055	Intra-Articular injections with fluoroscopic control	45

Note: *1) This procedural fee is intended to cover the procedural portion of the service including the placing of an instrument into the joint space and introducing local anesthetic and/or contrast media and/or steroids and/or other analgesic/diagnostic agents under fluoroscopic control.*

2) When two (2) or more intra-articular injections are performed on the same patient on the same day by the same physician, 100% of the unit value shall be paid for the first injection and 75% for each additional injection.

Percutaneous Insertion of long term epidural catheters

5110	Lumbar or Caudal	72
5111	Thoracic	84
5112	Cervical	92

Percutaneous Insertion of long term intrathecal catheters

5114	Lumbar or Caudal	84
5115	Thoracic	92
5116	Cervical	100
5117	Implantation of permanent epidural/intrathecal catheter, (e.g. DuPen catheter system)	106
5224	Percutaneous implantation of neurostimulator electrodes-epidural	190
5228	Incision and placement of subcutaneous neurostimulator/receiver	182
5230	Revision or removal of permanent spinal neurostimulator receiver and/or electrodes	182

Therapeutic Procedures

8950	Epidural injection of autologous blood, any site	50
2128*	Tracheal aspiration for meconium staining under direct vision	50
2596	Anesthesia for emergency relief of acute upper airway (above the carnia) obstruction (excluding choanal atresia)	120
2597	Intubation not associated with an anesthetic service	50
2618	Controlled hypothermia and/or pump oxygenation in non-cardiac anesthesia	80
2560	Intravenous therapy, establishment	15
2567	Autonomic blockade by pharmacologic or major neuraxial technique to minimize blood loss or facilitate surgery. A sustained mean blood pressure below 60 mmHg is required to bill this tariff.	60

Pulsed Radiofrequency Lesioning

TARIFF	PROCEDURE	UNITS
	Lesioning of nerves arising from cervical or thoracic levels:	
~5800	first level, per side	225
~5802	subsequent level, per side	170
	Lesioning of nerves arising from lumbar or sacral levels:	
~5805	first level, per side	170
~5806	subsequent level, per side	125
	Lesioning of cranial nerves:	
~5807	first level	525

Note: *1) Bilateral lesioning shall be claimed at 100% of the above fees when performed at the same sitting.*

2) To be claimed only at approved sites.

3) To be claimed only by qualified physicians designated by the WRHA Medical Director, Anesthesia Program in consultation with the Medical Director for the Provincial Pain Management Service.

4) Where monitored Anesthesia Care is required during these procedures it shall be claimed only when provided by a separate anesthesiologist.

5) The above procedures include fluorsocopy.

Pregnancy and Maternity

4875	Continuous Conduction Anesthesia (Epidural)	60
4876	Continuous Conduction Anesthesia, per each subsequent injection	20
4877	Continuous Conduction Anesthesia (Epidural) by In-Hospital On-Call Anesthetist providing coverage under Part III	65

Note: *1) Tariff 4877 may only be claimed when the anesthetist is claiming In-Hospital On-Call Anesthetic Coverage at St Boniface General Hospital (Tariff 8201), Brandon Regional Health Centre (Tariff 8202) or Health Science Centre (Tariff 8203).*

2) Pre-anesthetic Evaluation, Tariff 8515, is not payable in addition to Tariff 4877.

Electro-Convulsive Therapy

8586	Anesthesia only	25

Patient Controlled Analgesia

8406	Initial assessment and recommendations by anesthetists or GP anesthetists when requested by an attending service	12
8407	Subsequent assessment and recommendations	8

Note: *Patient controlled analgesia means patient controlled intravenous or subcutaneous analgesia—usually via an indwelling catheter. Medication is infused and controlled by a monitoring device. The device (pump) can be set to deliver a predetermined dose of medication—there is a "lock out" capability which does not allow the patient to exceed a pre-set dosage.*

Intra-Operative Procedures

2106 Intra-Operative Comprehensive Transesophageal..... 108
Echocardiography (TEE) Study including setup and patient preparation, cardiac monitoring and re-evaluation, 2-D study, color flow mapping, doppler study and M-mode, interpretation and reporting per case.

Note: *This tariff shall only be claimed when provided by qualified anesthetists in relation to cardiac surgery.*

2107 Epiaortic/Epicardiac Ultrasound Study and on-heart monitoring 30

Note: *This tariff may not be claimed in addition to Tariff 2106.*

Anesthesia Miscellaneous

Local Anesthesia

40000 Local injections to anesthetise an area through absorption by area nerves. 3.65
This includes anesthetic injected directly into desired area or injected proximally for absorption into nerves supplying the area, (e.g. "ring anesthesia" in a finger proximal to the area; but does not include specific nerve blocks.)
This excludes topical anesthesia.

		UNIT VALUE [per fifteen (15) minute period or portion thereof]
6999	Dental Anesthesia	21.375
2490	Multi-organ donor	24.125

APPENDIX C—PHYSICIANS ELIGIBLE TO CLAIM FOR CHRONIC PAIN MANAGEMENT SERVICES

In accordance with Rules of Application for Anesthesia Services 6 c), anesthetists who are eligible to claim for the provision of Chronic Pain Management Services are those with the appropriate training, as may be agreed upon from time to time by the MMA and Manitoba Health.

APPENDIX D—HOLIDAYS

"Holiday" means:

- New Year's Day
- Good Friday
- Easter Monday
- Victoria Day
- Canada Day
- August Civic Holiday
- Labour Day
- Thanksgiving Day
- Remembrance Day
- Christmas Day
- Boxing Day

"Day" means calendar day.

Note: *If any of these days falls on a Saturday or Sunday, the day observed will apply as stated in the Physician's Newsletter.*

APPENDIX E—OUT–OF–HOSPITAL ON–CALL ANESTHESIA COVERAGE—REMUNERATION

Facility/Program	Evening	Night	Weekend/Holiday
	16:00 to 24:00 (4 p.m. to midnight)	00:00 to 07:00 (midnight to 7 a.m.)	07:00 to 24:00 (7 a.m. to midnight)
Total Hours	**8**	**7**	**17**
I. Urban Community Facilities			
Seven Oaks/Grace/Victoria/Concordia	$414.68	$253.99	$881.20
Per person per hour	$51.84	$36.28	$51.84
Units per hour	35.00	24.50	35.00
Misericordia Health Centre	$414.68	$253.99	$881.20
Per person per hour	$51.84	$36.28	$51.84
Units per hour	35.00	24.50	35.00
II. Urban Tertiary Facilities			
St. Boniface General	$414.68	$253.99	$881.20
St. Boniface Cardiac	$414.68	$253.99	$881.20
St. Boniface Acute/Chronic Pain	$414.68	$253.99	$881.20
St. Boniface Backup	$414.68	$253.99	$881.20
Units per hour	35.00	24.50	35.00
HSC General	$414.68	$253.99	$881.20
HSC Cardiac	$414.68	$253.99	$881.20
HSC Paediatric	$414.68	$253.99	$881.20
HSC Acute/Chronic Pain	$414.68	$253.99	$881.20
HSC Paediatric Backup (24 hours)	$-	$-	$1,184.40
Units per hour	35.00	24.50	35.00
III. Rural Facilities			
Steinbach, Selkirk, Portage la Prairie	$177.72	$82.94	$377.66
Morden, Winkler, Dauphin, Thompson	$177.72	$82.94	$377.66
Per Anesthetist per hour	$22.22	$11.85	$22.22
Units per hour	15.00	8.00	15.00

NOTE 1) HSC Paediatric backup is for a twenty-four hour period.

2) Based on a unit value rate of $1.481.

APPENDIX F—EXAMPLES: CALCULATION OF REMUNERATION FOR ANESTHETIC PROCEDURAL SERVICES

Example 1

Case History: A 60 year old women undergoing a hepatic lobectomy. Arterial line, percutaneous venous pressure catheter and epidural inserted for the procedure.

Duration of case—5 hours, 20 minutes.

Service Category	Tariff	Service Description	Unit Value	# Time Periods	Total Units	Unit Value Rate	Payment
Pre-Anesthetic Evaluation	8515	Pre-Anesthetic Evaluation	12	n/a	12	$1.481	$17.77
Anesthetic Procedural Service	3494	Hepatic Lobectomy—Left	24.125	22	530.8	$1.481	$786.11
Special Invasive Procedure	9834	Venous Pressure Catheter	25	n/a	25	$1.481	$37.03
Special Invasive Procedure	2301	Continuous Arterial Catheter	15	n/a	15	$1.481	$22.22
Acute Pain Service	8955	Indwelling epidural analgesia	50	n/a	50	$1.481	$74.05
Total Remuneration							**$937.18**

Example 2

Case History: A 5 year old child undergoing a tonsillectomy.

Duration of case—40 minutes.

Service Category	Tariff	Service Description	Unit Value	# Time Periods	Total Units	Unit Value Rate	Payment
Pre-Anesthetic Evaluation	8515	Pre-Anesthetic Evaluation	12	n/a	12	$1.481	$17.77
Anesthetic Procedural Service	2992	Tonsillectomy—Child	21.375	3	64.13	$1.481	$94.98
Total Remuneration							**$112.75**

Example 3

Case History: A 55 year old male undergoing repair of an inguinal hernia.

Duration of case—55 minutes.

Service Category	Tariff	Service Description	Unit Value	# Time Periods	Total Units	Unit Value Rate	Payment
Pre-Anesthetic Evaluation	8515	Pre-Anesthetic Evaluation	12	n/a	12	$1.481	$17.77
Anesthetic Procedural Service	3631	Inguinal hernia – Initial	20	4	80	$1.481	$118.48
Total Remuneration							**$136.25**

Example 4

Case History: A 75 year old male undergoing an aortic valve replacement. Arterial line and a percutaneous venous pressure catheter inserted for the procedure.

Cardiopulmonary bypass operator—90 minutes.

Duration of case—6 hours.

Service Category	Tariff	Service Description	Unit Value	# Time Periods	Total Units	Unit Value Rate	Payment
Pre-Anesthetic Evaluation	8515	Pre-Anesthetic Evaluation	12	n/a	12	$1.481	$17.77
Anesthetic Procedural Service	2378	Aortic valve replacement with prosthetic valve	25.5	24	612	$1.481	$906.37
Anesthetic Procedural Modifier	2616	Patient over 70 years of age	8	n/a	8	$1.481	$11.85
Special Invasive Procedure	9834	Venous Pressure Catheter	25	n/a	25	$1.481	$37.03
Special Invasive Procedure	2301	Continuous Arterial Catheter	15	n/a	15	$1.481	$22.22
Total Remuneration							**$995.24**

Note: *There is no charge for the cardiopulmonary bypass operator.*

APPENDIX G—EXAMPLES: CALCULATION OF REMUNERATION FOR ANESTHETIC PROCEDURAL SERVICES AND OUT–OF–HOURS PREMIUMS

Case History: A weekday emergency cholecystectomy for a 80 year old male. Arterial line inserted for the procedure. Duration of case—1 hour, 20 minutes.

Example 1. Case starts at 1000 hours and finishes at 1120 hours

Service Category	Tariff	Service Description	Unit Value	# Time Periods	Total Units	Unit Value Rate	Payment
Pre-Anesthetic Evaluation	8515	Pre-Anesthetic Evaluation	12	na	12	$1.481	$17.77
Anesthetic Procedural Service	3515	Cholecystectomy	22.75	6	136.5	$1.481	$202.16
Anesthetic Procedural Modifier	2616	Patient over 70 years of age	8	na	8	$1.481	$11.85
Special Invasive Procedure	2301	Continuous Arterial Catheter	15	na	15	$1.481	$22.22
Total Remuneration							**$254.00**

Note: *All services were provided outside the out-of-hours premium periods.*

Example 2. Case starts at 1630 hours and finishes at 1750 hours

Service Category	Tariff	Service Description	Unit Value	# Time Periods	Total Units	Unit Value Rate	Payment
Pre-Anesthetic Evaluation	8515	Pre-Anesthetic Evaluation	12	n/a	12	$1.481	$17.77
Anesthetic Procedural Service	3515	Cholecystectomy	22.75	6	136.5	$1.481	$202.16
Anesthetic Procedural Modifier	2616	Patient over 70 years of age	8	n/a	8	$1.481	$11.85
Special Invasive Procedure	2301	Continuous Arterial Catheter	15	n/a	15	$1.481	$22.22
Subtotal							**$254.00**

Out-of-Hours Premiums	Tariff	Service Description	Unit Value	# Time Periods	Total Units	Unit Value Rate	Premium	Payment
From 1700 to 2400 hours	3515	Cholecystectomy	22.75	4	91	$1.481	40%	$53.91
Subtotal								$53.91
Total Remuneration Including Out-of-Hour Premium								**$307.91**

Note: *Tariffs 8515, 2616, 2301 and the first two (2) periods of tariff 3515 were provided before 1700 hours and are not eligible for the 40% out-of-hours premium.*

Example 3. Case starts at 1700 hours and finishes at 1820 hours

Service Category	Tariff	Service Description	Unit Value	# Time Periods	Total Units	Unit Value Rate	Payment
Pre-Anesthetic Evaluation	8515	Pre-Anesthetic Evaluation	12	n/a	12	$1.481	$17.77
Anesthetic Procedural Service	3515	Cholecystectomy	22.75	6	136.5	$1.481	$202.16
Anesthetic Procedural Modifier	2616	Patient over 70 years of age	8	n/a	8	$1.481	$11.85
Special Invasive Procedure	2301	Continuous Arterial Catheter	15	n/a	15	$1.481	$22.22
Subtotal							$254.00

Out-of-Hours Premiums	Tariff	Service Description	Unit Value	# Time Periods	Total Units	Unit Value Rate	Premium	Payment
From 1700 to 2400 hours	8515	Pre-Anesthetic Evaluation	12	n/a	12	$1.481	40%	$7.11
	3515	Cholecystectomy	22.75	6	136.5	$1.481	40%	$80.86
	2616	Patient over 70 years of age	8	n/a	8	$1.481	40%	$4.74
	2301	Continuous Arterial Catheter	15	n/a	15	$1.481	40%	$8.89
Subtotal								$101.60
Total Remuneration Including Out-of-Hour Premium								**$355.60**

Note: *All services were provided between 1700 and 2400 hours and are eligible for the 40% out-of-hours premium.*

Example 4. Case starts at 2330 hours and finishes at 0050 hours

Service Category	Tariff	Service Description	Unit Value	# Time Periods	Total Units	Unit Value Rate	Payment
Pre-Anesthetic Evaluation	8515	Pre-Anesthetic Evaluation	12	n/a	12	$1.481	$17.77
Anesthetic Procedural Service	3515	Cholecystectomy	22.75	6	136.5	$1.481	$202.16
Anesthetic Procedural Modifier	2616	Patient over 70 years of age	8	n/a	8	$1.481	$11.85
Special Invasive Procedure	2301	Continuous Arterial Catheter	15	n/a	15	$1.481	$22.22
Subtotal							$254.00

Out-of-Hours Premiums	Tariff	Service Description	Unit Value	# Time Periods	Total Units	Unit Value Rate	Premium	Payment
From 1700 to 2400 hours	8515	Pre-Anesthetic Evaluation	12	n/a	12	$1.481	40%	$7.11
	3515	Cholecystectomy	22.75	2	45.5	$1.481	40%	$26.95
	2616	Patient over 70 years of age	8	n/a	8	$1.481	40%	$4.74
	2301	Continuous Arterial Catheter	15	n/a	15	$1.481	40%	$8.89
Subtotal								$47.69

	Tariff	Service Description	Unit Value	# Time Periods	Total Units	Unit Value Rate	Premium	Payment
From 2400 to 0700 hours	3515	Cholecystectomy	22.75	4	91	$1.481	60%	$80.86
Subtotal								$80.86
Total Remuneration Including Out-of-Hour Premium								**$382.55**

Note: *Tariffs 8515, 2616, 2301 and the first two (2) periods of tariff 3515 were provided after 1700 hours and before 2400 hours and are eligible for the 40% premium. The last periods of tariff 3515 occur after 2400 hours and are eligible for the 60% out-of-hours premium.*

Example 5. Case starts at 2400 hours and finishes at 0120 hours

Service Category	Tariff	Service Description	Unit Value	# Time Periods	Total Units	Unit Value Rate	Payment
Pre-Anesthetic Evaluation	8515	Pre-Anesthetic Evaluation	12	n/a	12	$1.481	$17.77
Anesthetic Procedural Service	3515	Cholecystectomy	22.75	6	136.5	$1.481	$202.16
Anesthetic Procedural Modifier	2616	Patient over 70 years of age	8	n/a	8	$1.481	$11.85
Special Invasive Procedure	2301	Continuous Arterial Catheter	15	n/a	15	$1.481	$22.22
Subtotal							$254.00

Out-of-Hours Premiums	Tariff	Service Description	Unit Value	# Time Periods	Total Units	Unit Value Rate	Premium	Payment
From 2400 to 0700 hours	8515	Pre-Anesthetic Evaluation	12	n/a	12	$1.481	60%	$10.66
	3515	Cholecystectomy	22.75	6	136.5	$1.481	60%	$121.29
	2616	Patient over 70 years of age	8	n/a	8	$1.481	60%	$7.11
	2301	Continuous Arterial Catheter	15	n/a	15	$1.481	60%	$13.33
Subtotal								$152.39
Total Remuneration Including Out-of-Hour Premium								**$406.39**

NOTE All services were provided between 2400 and 0700 hours and are eligible for the 60% out-of-hours premium

INTEGUMENTARY SYSTEM

These benefits cannot be correctly interpreted without reference to the Rules of Application.

SURGICAL PROCEDURES

Note: *1) When a surgical procedure is indicated by an asterisk, the benefit is for the procedure and not for the management of the case. The benefit for the initial visit(s) and follow-up care shall be provided in addition to the procedural benefit.*

Rules of Application such as 23, 24, 25, 26, 27, 28, 29 and 31 are not to be applied to asterisked procedures unless the procedure is an integral part of another surgical procedure and, as such, is included in a block fee.

2) The minimum benefit for procedures performed with general anesthesia shall be $31.15 notwithstanding that a lesser benefit, or no benefit at all, may be listed for the procedure performed without general anesthetic.

3) In multiple surgical procedures done on the same day, the benefit of the first is paid at 100% and, unless otherwise stated in the schedule, the others at 50% if the same incision is used, and at 75% if in another area or another incision is required.—See Rules of Application

4) Fee for Service (F/S) means that the procedure is included in the visit fee or any other procedure which is involved with it,(e.g. the application of a cast).

CUTANEOUS PROCEDURES

INVESTIGATION

		UNIT VALUE	
0171*	Biopsy of skin, subcutaneous tissue or mucous membrane, including simple closure or punch biopsy (independent procedure)	24.35	20.000
0172*	Dermatoscopy	8.95	20.000
	Note: *Limited to specialists in Dermatology.*		
0415*	Woods light examination	3.75	20.000

INCISION

0106*	Abscess or hematoma, puncture aspiration	6.70	20.000
0103*	Carbuncle drainage	19.30	20.000
0101*	Superficial localized infection such as steatoma, furuncle, boil, paronychia, felon, pilonidal abscess—incision and drainage	9.55	20.000
0170*	Acne Surgery—Marsupialization, opening or removal of multiple milia, comedones, cysts, pustules, etc.—each sitting	5.45	20.000
0130*	Foreign body subcutaneous tissue, removal, simple	19.30	20.000
0256	removal, complicated	***By Report***	20.000
0128*	Pulsed dye laser, first square inch (6.25 sq. cm.) or portion thereof	48.50	20.000
0129*	each additional square inch or portion thereof, same session	53.00	20.000
0394*	Laser vaporization—face—one (1) lesion	52.75	20.000
0395*	two (2) lesions	79.25	20.000
0396*	three (3) or more lesions	120.30	20.000
0397*	Elsewhere—one (1) lesion	26.40	20.000
0398*	two (2) lesions	40.85	20.000
0399*	three (3) or more lesions	55.25	20.000

REVISION AND REPAIR

			UNIT VALUE
0251*	Wound repair (local anesthetic included) simple, any location	35.10	20.000
0250	multiple	***By Report***	20.000
0132*	Indifferent electrode, permanent type for A.V. block subcutaneous insertion	19.20	20.000
0412*	Intralesional injections, up to and including seven (7) lesions	12.45	20.000
0413*	more than seven (7) lesions	17.85	20.000
0414*	Ultraviolet light therapy	3.60	20.000
0245*	Ultraviolet B therapy (UVB) per treatment	12.50	

Note: *A physician may claim subsequent visits for re-assessment at the rate of one (1) visit per eight (8) UVB treatments. More frequent visits may be claimed* ***By Report****.*

0240	Narrow Band UVB Phototherapy (NB–UVB)—Professional Component	11.00	
0241	Narrow Band UVB Phototherapy (NB–UVB)—Technical Component	11.00	

Note: *1) Tariffs 0240 and 0241 are limited to specialists in Dermatology.*

2) A physician may claim subsequent visits for re-assessment at a rate of one (1) visit per five (5) NB-UVB treatments.

RESECTION

Skin or subcutaneous lesion (removal of sutures included in visit)

0253*	single	47.85	20.000
0254*	two (2), three (3), four (4), and five (5) lesions, each	31.70	20.000
0255	multiple	***By Report***	20.000
	Removal of sutures by other than the surgeon or his deputy or his assistant.	F/S	
0230*	Nail Removal, avulsion, partial or complete	32.65	20.000
0257	nail and matrix removed; partial or complete (i.e., from ingrown or deformed nail)	85.45	20.000
0402*	Warts and fibrocutaneous tags, simple	6.50	
	Plantar Warts—removal by any method with or without primary closure		
0420*	first plantar wart, each sitting	27.00	20.000
0421*	two (2) plantar warts, each sitting	39.80	20.000
0422*	three (3) or more, each sitting	56.15	20.000

Note: *Tariffs 0420, 0421 or 0422 may be claimed for each sitting, regardless of whether the warts(s) are "recurrent" or "new".*

0258	Pilonidal cyst or sinus, excision—packing or primary closure	240.00	20.000
0247	excision and plastic closure	289.00	20.000
0248	marsupialization	120.50	20.000

		UNIT VALUE	
0400*	Cautery (electro, chemo, cryo) destruction or simple surgical excision of benign or pre-malignant lesions, face, one (1) lesion with or without curettage	25.70	20.000
0401*	Elsewhere	15.35	20.000
0404*	second lesion	50%	20.000
0405*	additional lesions, each	25%	20.000
0406	complicated lesions	***By Report***	20.000
0407*	Cautery (electro, chemo, cryo) destruction of malignant lesions confirmed by biopsy, trunk	18.60	20.000
0408*	other areas	31.10	20.000
0416*	second lesion	50%	20.000
0417*	additional lesions, each	25%	20.000
0409*	Epilation, electrolytic, each ½ hour	17.60	20.000
0410*	under general anesthesia—minimum	30.00	20.000
0411	special cases	***By Report***	20.000
	Abrasion of skin, total face for removal of scars and acne scars		
0333	primary	136.50	21.375
0334	secondary	53.50	21.375
0335	Abrasion regional cheeks, chin, 1/4 face, forehead or elsewhere, primary	93.75	21.375
0336	secondary	54.00	21.375
0337	Dermajection	276.00	20.000
0340*	Dermajection intralesional	19.30	
0403*	Cryotherapy (CO^2 slush, liquid N^2)	9.85	20.000
0249	**Unlisted or Unusually Complicated**	***By Report***	20.000

BURNS

0351*	Burn—initial or subsequent treatment, first degree, when no more than local treatment is necessary	9.60	

DRESSINGS

Dressings—second or third degree burns, single or multiple, initial or subsequent without anesthesia

0354* small 13.50

0355* medium (whole face or whole extremity, etc.) 19.35

0356* large 25.50

Dressings—second or third degree burns, initial or subsequent, with general anesthesia

			UNIT VALUE
0352*	small or medium	28.35	21.375
0353*	large, or with major debridement, per hour	97.00	22.750
0357	unlisted or unusually complicated	***By Report***	22.750
0359	Non Burn Dressings, major debridement and dressing, with anesthesia (excluding local anesthesia)	***By Report***	22.750
0259*	Debridement of full thickness chronic skin ulcer, i.e., neuropathic or vascular, down to fascia, up to 30 sq. cm. in size, involving the foot or leg below the knee	38.60	20.000
0260*	Debridement of full thickness chronic skin ulcer, i.e., neuropathic or vascular, down to fascia, bone and/or muscle, up to 30 sq. cm. in size, involving the foot or leg below the knee	63.10	

RECONSTRUCTIVE AND PLASTIC SURGERY

Note: *1) In multiple surgical procedures done on the same day, the benefit of the first is paid at 100%, and unless otherwise stated in the schedule, the others at 50% if the same incision is used, and at 75% if in another area or another incision is required—See Rules of Application*

2) Elective Plastic Surgery:

The Manitoba Health Services Insurance Act has certain exclusions for elective plastic surgery for cosmetic purposes except where the Minister is satisfied prior to the operation that surgery is medically required.

a) Not all plastic surgery operations for cosmetic purposes are eligible for benefits.

b) All plastic surgery initiated prior to the age of 16 years for the correction of congenital defects is eligible for benefits.

c) All plastic surgery performed to correct or minimize the effects of trauma, burns, sepsis or surgical excision of lesions for treatment or diagnosis is also eligible for benefits.

d) Elective plastic surgery for beautifying purposes, such as:

- *Blepharoplasty*
- *Rhytidectomy*
- *Rhinoplasty*
- *Otoplasty*
- *Mammoplasty*

are generally not eligible for benefits unless the Minister is satisfied, prior to the operation, that such surgery is necessary for medical reasons.

The following tariffs are not to be used for ordinary and usual excisions of lesions or repairs of lacerations. (The tariffs for such remain namely, 0253, 0254, 0255 and 0251, 0250)

They are to be used only where special considerations apply such as, the site of the lesion, the extent of the lesion, possible interference with function, and, as well as treating the lesion to achieve the optimal cosmetic result.

EXCISION AND/OR REPAIR BY DIRECT CLOSURE OF A LACERATION RESULTING IN LINEAR CLOSURE

Note: *1) 2nd, 3rd, 4th, and 5th lacerations, each 75%*

six (6) or more, each 50%

2) When

a) the nature of the injury and/or

b) the medical circumstances of the patient, are such that the laceration(s) cannot be repaired under local anesthesia; then a claim for the augmented fee for treatment under general anesthesia can be made ***By Report.***

0100 Add on to surgical fee when performed under general anesthesia 41.05

TRUNK, ARMS, LEGS

			UNIT VALUE
0104*	Resulting in a repair less than 5 cm.	51.25	20.000
0105*	Resulting in a repair 5—10 cm.	63.25	20.000

FACE, SCALP, NECK, GENITALIA, HANDS, FEET

0107*	Resulting in a repair less than 5 cm.	75.15	20.000
0108*	Resulting in a repair 5—10 cm.	106.90	20.000

EYELIDS, EARS, LIPS, NOSE, MUCOUS MEMBRANE

0109*	Resulting in a repair less than 2 cm.	91.45	20.000
0110*	Resulting in a repair 2—4 cm.	92.25	20.000
0111	**Unlisted or Unusually Complicated**	***By Report***	20.000

EXCISION AND/OR REPAIR BY DIRECT CLOSURE OF A LESION RESULTING IN LINEAR CLOSURE

Note: *1) Second lesion 75%*

third lesion 75%

2) A maximum of three (3) lesions may be claimed.

TRUNK, ARMS, LEGS

			UNIT VALUE
0112	Resulting in a repair less than 5 cm.	55.00	20.000
0113	Resulting in a repair 5—10 cm.	79.45	20.000

FACE, SCALP, NECK, GENITALIA, HANDS, FEET

0116	Resulting in a repair less than 5 cm.	76.00	20.000
0117	Resulting in a repair 5—10 cm.	88.00	20.000

EYELIDS, EARS, LIPS, NOSE, MUCOUS MEMBRANE

0118	Resulting in a repair less than 2 cm.	100.00	20.000
0119	Resulting in a repair 2—4 cm.	122.20	20.000
0120	**Unlisted or Unusually Complicated**	***By Report***	20.000

ADJACENT TISSUE TRANSFER

Excision and/or repair by **adjacent** tissue transfer or re-arrangement (e.g., Z-plasty, rotation flap, double pedicle, advancement flap).

TRUNK

0286	Defect up to 6 sq. cm.	179.80	20.000
0287	Between 6 sq. cm. and 19 sq. cm.	286.35	20.000
0288	More than 19 sq. cm.	***By Report***	20.000

ARMS, LEGS AND SCALP

0289	Defect up to 6 sq. cm.	211.45	20.000
0290	Between 6.25 sq. cm. and 19 sq. cm.	317.40	20.000
0291	More than 19 sq. cm.	***By Report***	20.000

AXILLA, CHEEKS, CHIN, FEET, FOREHEAD, GENITALIA, HANDS, MOUTH AND NECK

0292	Defect up to 6 sq. cm.	306.90	21.375
0293	Between 6 sq. cm. and 19 sq. cm.	394.00	21.375
0294	More than 19 sq. cm.	***By Report***	21.375

EARS, EYELIDS, LIPS AND NOSE

			UNIT VALUE
0295	Defect up to 6 sq. cm.	333.30	21.375
0296	Between 6 sq. cm. and 19 sq. cm.	476.90	21.375
0297	More than 19 sq. cm.	***By Report***	21.375
0298	Eyelid, full-thickness, excision and repair, by advancement flaps up to 1/4 eyelid margin	238.00	21.375
0299	over 1/4 eyelid margin	307.00	21.375
0300	By transfer of flaps or tarso-conjunctiva from opposing eyelid, up to 2/3 of eyelid	325.00	21.375
0301	Repair of total eyelid, one (1) or more stages, lower lid	***By Report***	21.375
0302	upper lid	***By Report***	21.375

RHYTIDECTOMY

Note: *Rhytidectomy, when done as elective plastic surgery for cosmetic purposes is an exclusion under the Plan, except when the Minister is satisfied prior to the operation that such surgery is medically required. It is the responsibility of the physician to obtain this approval prior to the operation.*

0327	Rhytidectomy, cheeks and chin	437.00	21.375
0328	eyelid, lower	174.50	21.375
0329	eyelid, upper	107.15	21.375
0330	forehead	289.00	21.375
0331	glabellar frown	257.00	21.375
0332	neck	450.00	21.375

REPAIR WEB FINGERS

1811	Freeing of web fingers with flaps	220.00	20.000
1815	with graft	324.30	20.000
1817	complex	***By Report***	20.000
0338	Removal of tattoos	***By Report***	20.000

Note: *Claims for removal of tattoos must be accompanied by a full description as to size, area involved, procedures used, and time consumed. Benefits payable will be in accordance with existing tariffs in the fee manual depending upon the method of closure used.*

HYPERHYDROSIS, UNILATERAL

0418	excision with direct closure	52.75	20.000
0423	excision with extensive undermining	255.00	20.000
0424	excision with graft	356.00	20.000

HYDRADENITIS SUPPURATIVE, UNILATERAL

			UNIT VALUE
	Excision of skin and subcutaneous tissue		
0425	with direct closure	52.75	20.000
0426	with skin graft	356.00	20.000
0427	with regional flap	426.00	20.000

SKIN GRAFTS

Note: *1) In multiple surgical procedures done on the same day, the benefit of the first is paid at 100%, and unless otherwise stated in the schedule, the others at 50% if the same incision is used, and at 75% if in another area or another incision is required—See Rules of Application*

2) Benefit shall be determined according to the size and location of the recipient area and the type of graft.

3) Unless as otherwise noted below, benefits include simple debridement of granulations or recent avulsions, the creation and/or surgical preparation of the defect, obtaining and placing of graft, and the care of the donor site.

4) When repair of the donor site requires skin graft or local flap, only 75% of the benefit for this is payable—See Rule of Application 25 and 26.

5) When the skin graft involves the use of Living Skin Equivalents, 65% of the benefit shall be paid.

0345*	Graft, pinch, split or full thickness to cover small ulcer, tip of digit or other minimal open area (except on face), up to defect size (2 cm.) diameter	33.50	20.000

Tissue Expansion–(areas other than the breast)

~0140	Insertion of tissue expander, face, neck and scalp	225.20	21.375
~0141	insertion of an additional expander through a different incision	180.25	21.375
~0142	Insertion of expander in other areas, extremeties, trunk excluding breast	200.25	21.375
~0143	insertion of additional expander through a different incision	150.20	21.375
~0144	Removal of injection port under local anesthesia	45.25	
~0145	Removal of an injection port under general anesthesia	65.20	21.375
~0146	Removal and replacement of ruptured or leaking expander, face, neck, scalp	168.90	21.375
~0147	Removal and replacement of ruptured or leaking expander, extremities, trunk excluding breast	150.20	21.375
~0148*	Inflation of tissue expander, one (1)	20.80	21.375
~0149*	Inflation of each additional expander at same visit to a maximum of three (3)	10.40	21.375

SPLIT SKIN GRAFTS

			UNIT VALUE
0303	Split skin grafts, arms, legs, scalp and trunk up to 100.0 sq. cm.	224.70	21.375
0304	each additional 100.0 sq. cm. or part thereof	41.20	22.750
0305	Split skin grafts, ears, face, feet, genitalia, hands, multiple digits, neck, up to 100.0 sq. cm.	304.00	22.750
0306	each additional 100.0 sq. cm. or part thereof	42.40	24.125

BURNS

Note: *For burn eschar and burn scars, when the recipient area for split skin grafting is created by surgical excision of essentially intact eschar or scar, including subcutaneous tissue, 50% should be claimed by means of the following tariffs in addition to the appropriate split thickness graft tariffs. This applies for both immediate and delayed grafting.*

0380	Creation of recipient area as above, claim with 0303	92.35	
0381	Creation of recipient area as above, claim with 0304	14.90	
0382	Creation of recipient area as above, claim with 0305	127.50	
0383	Creation of recipient area as above, claim with 0306	21.20	

BENIGN AND MALIGNANT LESIONS

Note: *For benign and malignant lesions, when the recipient area for split skin grafting is created by surgical excision of the lesion(s), including subcutaneous tissue, the excision should be claimed by means of the following tariffs in addition to the appropriate split thickness graft tariffs (area less than 10 sq. cm.—graft benefit only, no benefit for excision).*

0121	Area 10—50 square cm.	41.05	20.000
0122	Area 50—100 square cm.	82.00	20.000
0123	Area over 100 square cm.	***By Report***	20.000

FULL THICKNESS GRAFTS

Full thickness, free, up to 19 sq. cm., including direct closure of donor site.

0307	Trunk (19 sq. cm.)	121.00	20.000
0308	Arms, legs, scalp	207.00	20.000
0309	Axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth, neck	256.00	21.375
0310	Ears, eyelids, lips, nose	299.00	21.375

For each additional 19 sq. cm. in the above procedures, add 50% of area benefit.

For repair of donor site requiring skin graft or local flaps—See Rule of Application 26.

BURNS

Note: *For burn eschar and burn scars, when the recipient area for full thickness grafting is created by surgical excision of essentially intact eschar or scar, including subcutaneous tissue, 50% should be claimed by means of the following tariffs in addition to the appropriate full thickness graft tariffs. This applies to both immediate and delayed grafting.*

0385	Creation of recipient area as above, claim with 0307	60.50
0386	Creation of recipient area as above, claim with 0308	103.50
0387	Creation of recipient area as above, claim with 0309	128.00
0388	Creation of recipient area as above, claim with 0310	149.50

BENIGN AND MALIGNANT LESIONS

Note: *For benign and malignant lesions, when the recipient area for full thickness grafting is created by surgical excision of the lesion(s), including subcutaneous tissue, the excision should be claimed by means of the following tariffs in addition to the appropriate full thickness graft tariffs (area less than 10 sq. cm.—graft benefit only, no benefit for excision).*

			UNIT VALUE
0124	Area 10—50 square cm.	41.05	20.000
0126	Area 50—100 square cm.	84.75	20.000
0127	Area over 100 square cm.	***By Report***	20.000

RECONSTRUCTION BY THE DISTANT TRANSFER OF TISSUE

Benefits for the following tariffs do not include extensive immobilization and plaster casts may be claimed in addition—See Plaster Casts.

0311	Preparation (raising) of pedicle flap, direct or tubed, including direct closure of donor site, trunk	221.00	20.000
0312	arms, legs and scalp	234.00	20.000
0313	axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth and neck	278.00	21.375
0314	ears, eyelids, lips and nose	268.00	21.375
0315	Delay, intermediate transfer or sectioning of pedicle or tubed or direct flap, trunk	171.00	20.000
0316	arms, legs and scalp	228.00	20.000
0317	axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth and neck	255.00	21.375
0318	ears, eyelids, lips and nose	255.00	21.375
0319	Excision of lesion and/or preparation of recipient site and attachment of direct or tubed pedicle flap, trunk	251.00	20.000
0320	arms, legs and scalp	291.00	20.000
0321	axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth and neck	356.00	21.375
0322	ears, eyelids, lips and nose	461.00	21.375

GRAFTS TO SPECIAL SITES

			UNIT VALUE
0323	Composite grafts (full-thickness of external ear or nasal alae)	237.00	20.000
0324	Derma-fat-fascia-graft (except to breast)	237.00	21.375
0325	Facial nerve paralysis, free fascia grafts	425.00	21.375
0326	Re-animation of muscle transfers	623.00	21.375

REIMPLANTATION INVOLVING VASCULAR AND NEUROANASTOMOSIS

Note: *Surgical Assistants benefits will be 30% of the surgical fee if the assistant is a plastic surgeon; otherwise, the assistant fees listed under the General Schedule (Section B) will apply.*

0344	Digit, with or without vein graft	1,684.50	22.750
0346	Major limb, including upper extremity proximal to wrist; lower extremity proximal to ankle; hand or foot	***By Report***	22.750
0347	Revision—minor	***By Report***	22.750
0348	Revision—major	***By Report***	22.750

Note: *Benefits for revision will be calculated on the basis of $234.25 per hour.*

FREE TISSUE TRANSFER

Note: *1) When the three (3) elements in the procedure are done **sequentially**, 100% of the most expensive element will be paid; plus 85% of the other two (2) elements plus an assistant's fee. If the assistant is **not** a plastic surgeon, the assistant fees listed under the General Schedule (Section B) will apply. If the assistant is a plastic surgeon, 30% will apply.*

*2) When the three (3) procedures are **synchronous**, 100% will be paid for two (2) elements plus 85% for the third element plus a 30% assistant's fee for the third element.*

0349	Elevation of free island skin and subcutaneous flap and closure of defect	794.60	22.750
0350	Preparation of microvascular recipient site for free island skin subcutaneous flap	800.15	22.750
0358	Transplantation of free island skin and subcutaneous flap with microvascular anastomosis(es)	794.00	22.750
0341	Free jejunal loop transfers	1,865.75	22.750

INNERVATED FREE ISLAND SKIN AND TISSUE TRANSFER

0360	Elevation of innervated free island skin and subcutaneous flap and closure of defect	882.00	22.750
0361	Preparation of microvascular recipient site for innervated free island skin and subcutaneous flap	882.00	22.750
0362	Transplantation of innervated free island skin and subcutaneous flap with microvascular anastomosis(es) and nerve repair	886.00	22.750

FREE MUSCLE AND SKIN FLAP TRANSFER

			UNIT VALUE
0363	Elevation of free island skin and muscle flap and closure of defect	794.60	22.750
0364	Preparation of microvascular recipient site for free island skin and muscle flap	820.05	22.750
0365	Transplantation of free island skin and muscle flap with microvascular anastomosis(es)	923.60	22.750

FREE INNERVATED MYOCUTANEOUS FLAP INCLUDING TENDON AND NERVE

0366	Elevation of free island muscle flap with tendon and nerve and closure of defect	1,016.00	22.750
0367	Preparation of microvascular recipient site for muscle, tendon and nerve anastomosis(es)	1,016.00	22.750
0368	Transplantation of free island muscle flap with tendon nerve and microvascular anastomosis(es)	1,016.00	22.750

FREE OSSEOUS TISSUE TRANSFER

0369	Elevation of free island bone flap and closure of defect	751.00	22.750
0370	Preparation of microvascular recipient site for free island bone flap	794.00	22.750
0371	Transplantation of free island bone flap for micro-vascular anastomosis(es) and bone fixation	882.00	22.750

FREE OSSEOCUTANEOUS TISSUE TRANSFER

0372	Elevation of free island skin and bone flap and closure of defect	900.00	22.750
0373	Preparation of microvascular recipient site for free island skin and bone flap	900.00	22.750
0374	Transplantation of free island skin and bone flap with microvascular anastomosis(es) and bone fixation	900.00	22.750

FREE TOE OR FINGER TRANSFER

0375	Elevation of free toe or finger and closure of defect	900.00	22.750
0376	Preparation of microvascular recipient site for free toe or finger transplant	900.00	22.750
0377	Transplantation of free island toe or finger with microvascular anastomosis(es) and tendon nerve and bone repair	1,059.00	22.750
0378	Revision of free vascularized tissue transfer—minor	***By Report***	22.750
0379	Revision—major with microvascular reanastomosis or vein grafts	***By Report***	22.750

Note: *Benefits for revision will be calculated on the basis of $234.25 per hour.*

MYOCUTANEOUS FLAPS

0384	Sternomastoid, tensor fascia lata, gluteus maximus, gracilis sartorius, rectus femoris, gastrocnemius (medial and lateral) trapezius	639.70	22.750
0389	Pectoralis major, latissimus dorsi, unilateral rectus abdominus	693.00	22.750
0390	Lower rectus abdominus flap	626.45	22.750

			UNIT VALUE
0391	Repair of abdominal defect, same surgeon, add	192.60	22.750
0392	Repair of abdominal defect, different surgeon, add	356.00	22.750
0339	**Unlisted or Unusually Complicated**	***By Report***	22.750

BREAST

These benefits cannot be correctly interpreted without reference to the Rules of Application.

INVESTIGATION

			UNIT VALUE
0430*	Cyst aspirations	34.10	20.000
0440*	Needle (core) biopsies	35.75	20.000
0437	Wire Guided Breast Biopsy	220.00	20.000
0441*	Single biopsy—one (1) breast	150.00	20.000
0439*	Two (2) or more biopsies through separate incisions, one (1) breast	224.00	20.000
0447	Bilateral breast biopsies	224.00	20.000
0438	Sentinel lymph node biopsy in breast neoplasm	350.00	21.375

Note: *1) When one (1) or more of the procedures (0438, 0442, 0457, 0443, 0471, 2658) are performed by the same surgeon under the same anesthetic in addition to sentinel lymph node biopsy, the procedure with the highest fee shall be paid at 100% and the remaining procedures at 75%.*

2) When more than one (1) lymph node basin identified as having a sentinel node (separate surgical site) at the same anesthetic—claim 2nd sentinel at 75% in addition.

3) Completion of axillary node dissection following a positive sentinel node biopsy on final pathological diagnosis not at the same anesthesia—claim Tariff 2658 at 100% regardless of time interval.

INCISION

0114*	Superficial abscess drainage	9.55	20.000
0431	Mastotomy with exploration and drainage of deep abscess	122.40	20.000

REVISION OR REPAIR

Note: *These procedures have certain restrictions under the Regulations when done as elective surgery. To be certain that the case is covered, written approval from the Minister should be obtained before the procedure is undertaken.*

No Previous Breast Surgery

0450	Reduction mammoplasty, unilateral	433.80	21.375
0451	Reduction mammoplasty, bilateral	788.95	21.375
0452	Balancing breast surgery, where there has been ablative surgery on the opposite side	466.00	21.375
0453	Augmentation mammoplasty, unilateral, with prosthesis	255.00	21.375
0454	Augmentation mammoplasty, bilateral, with prosthesis	447.00	21.375

Following Previous Breast Surgery

Note: *1) The following are insured services, if the previous breast surgery was an insured service.*

2) The treatment of complications of previous cosmetic (uninsured) breast surgery will be approved only for symptomatic physical disorders. Additional cosmetic procedures including the procurement and replacement of secondary prosthesis are not insured.

			UNIT VALUE
0455	Reconstruction mammoplasty—definitive, unilateral with permanent prosthesis	405.15	21.375
0456	Replacement mammoplasty—two (2) stages, unilateral, first stage, insertion of tissue expander, subcutaneous	177.50	21.375
0458	submuscular	279.70	21.375
0459	Second stage—removal of tissue expander and insertion of prosthesis	176.50	21.375
0460*	Inflation of tissue expander per visit; each additional expander to a maximum of three (3) per visit, add 50%	20.80	21.375
0461*	Breast capsulotomy closed, no anesthetic—local	11.20	20.000
0462*	general anesthetic	71.25	20.000
0463	Breast open capsulotomy with or without replacement of breast prosthesis	210.50	20.000
0473	Capsulectomy	267.00	20.000
0464	Breast total capsulectomy and replacement mammoplasty	***By Report***	20.000
0465	Breast mound reconstruction latissimus dorsi, myocutaneous flap	900.55	22.750
0466	vertical rectus abdominis myocutaneous flap	693.00	22.750
0467	upper transverse rectus abdominis myocutaneous flap	693.00	22.750
0468	with lower transverse abdominis flap	863.70	22.750
0469	Breast mound creation by soft tissue (claimable in addition to Tariff 0468 only)	92.25	22.750
0474	Repair of abdominal defect—same surgeon	176.50	22.750
0475	different surgeon	341.00	22.750
0476	Revision of breast mound	251.75	22.750

NIPPLE AND AREOLA RECONSTRUCTION

NIPPLE

0307	Full thickness graft	121.00	20.000
0323	Composite graft (full thickness of external ear or nasal alae)	237.00	20.000
0286	Local flap	179.80	20.000
0393	Other methods	***By Report***	20.000

AREOLA

			UNIT VALUE
0303	Split thickness graft	224.70	21.375
0419	Tattooing areola	***By Report***	20.000
0429	Other methods	***By Report***	20.000

COMBINED SURGERY

	Subcutaneous mastectomy for benign breast disease and immediate insertion of permanent mammary prosthesis		
0477	unilateral—one (1) surgeon	458.00	20.000
0478	two (2) surgeons	513.00	20.000

RESECTION

0448	Removal of subareolar button, male	112.20	20.000
0449	Subcutaneous mastectomy, male or female	340.00	20.000
0445	Excision of cyst, fibro adenoma or other benign tumor, aberrant breast tissue, duct lesion, nipple lesion (including any other partial mastectomy) unilateral	150.00	21.375
0444	bilateral	312.40	21.375
0442	Partial mastectomy (lumpectomy) for malignancy	240.00	21.375
0443	Partial mastectomy (lumpectomy) & axillary node dissection	700.00	21.375
0457	Simple complete mastectomy	385.00	21.375
0471	Modified radical mastectomy	715.00	21.375
0470	Radical mastectomy	585.00	21.375
0446	Excision of breast tumor including chest wall	463.00	21.375
0472	Removal of pectoral muscles, subsequent for recurrence	183.60	21.375
2658	Axilla dissection alone	460.00	21.375
0489	**Unlisted or Unusually Complicated**	***By Report***	21.375

MUSCULOSKELETAL SYSTEM

These benefits cannot be correctly interpreted without reference to the Rules of Application.

BONES

Benefits include the application of first cast or traction device and subsequent casts required for six (6) weeks.

			UNIT VALUE
0549*	Biopsy, needle, vertebra (x-ray control)	138.50	21.375
0551*	excision, femur, humerus, pelvis, radius, skull, tibia, vertebra	189.00	20.000
0550*	other bones	93.50	20.000
	Note: *Biopsy preceding definitive surgery, 50% of listed benefit.*		
0501*	Bone marrow aspirations, single or multiple, any number of sites, at the same sitting	35.15	20.000
0503*	curette	29.80	20.000
0504*	Bone marrow biopsy by trephine, single or multiple sites, at the same sitting, with or without marrow aspirations, with or without local anesthesia, total	127.05	20.000
0506*	professional	62.45	20.000
0507*	Harvesting Hemipelves and Long Bones for Bone Bank from Cadavers, initial bone, all inclusive benefit, additional bones, each to be paid at 50% of Tariff 0507	135.50	

BONE WIRING, ETC.

0595*	Tongs or Caliper, insertion (Independent Procedure)	150.00	20.000
0593*	Metal pin (Steinmann pin), insertion	28.55	20.000
0519*	Removal, pin or wire, closed	19.00	20.000
0520*	Open removal of plates, pins, wires, screws, etc., one (1) incision	123.25	20.000
0521*	two (2) incisions	137.25	20.000
0523*	three (3) incisions	199.00	20.000
0591*	Wire (Kirschner wire), insertion	27.15	20.000
0525*	**Unlisted or Unusually Complicated**	***By Report***	20.000

ALTERATION OF LIMB LENGTH

0654	Epiphyseal arrest—stapling or epiphysiodesis, femur	287.00	21.375
0655	tibia and fibula	300.00	21.375
0656	femur, tibia and fibula combined	474.00	21.375
0659	Hemi-epiphyseal arrest—for knock-knee or bow leg, femur or tibia	224.20	21.375
0661	femur and tibia	317.60	21.375

			UNIT VALUE
0611	Osteoplasty, shortening of bone, femur, humerus, tibia	478.00	21.375
0612	radius, ulna	286.00	21.375
0613	other bones	180.00	21.375
0614	lengthening of bone, femur, tibia and fibula	555.00	21.375
0517	Removal of staples, two (2)	98.75	20.000
0518	three (3) or more	141.50	20.000

BONE GRAFT

Osteoperiosteal graft, periosteal graft, includes obtaining and placing of graft

0624	carpal scaphoid	237.00	20.000
0619	chin	213.00	21.375
0625	clavicle	333.00	21.375
0617	femur	476.00	21.375
0617	humerus	476.00	21.375
0619	malar prominences	213.00	21.375
0617	mandible, major portion	476.00	21.375
0619	nose	213.00	21.375
0618	radius	333.00	20.000
0617	radius and ulna	476.00	21.375
0615	skull	456.00	21.375
0617	tibia	476.00	21.375
0623	tibia—medial malleolus	189.00	21.375
0618	ulna	333.00	20.000
0620	other bones	189.00	21.375
0622	Cartilage graft—to ear, face, nose or skull	299.00	21.375

EXCISION OF BONE

0558	carpus, proximal row	333.00	20.000
0557	single bone	237.00	20.000
0552	clavicle—partial	237.00	21.375
0553	total	333.00	21.375
0560	coccyx	186.00	21.375
0559	femur, head and neck	377.00	20.000
0556	fibula—partial or total	186.00	20.000
0559	humerus, head	377.00	20.000

			UNIT VALUE
0563	metatarsal—partial	162.00	20.000
0564	total	187.50	20.000
0561	patella—partial or total	237.00	20.000
0555	radius—head	189.00	20.000
0555	styloid process	189.00	20.000
0568	sesamoid, one (1) or more, unilateral	132.50	20.000
0554	talus	377.00	20.000
0570	tarsal scaphoid, accessory	189.00	20.000
0572	ulna, lower end	189.00	20.000

OSTEOMYELITIS

0510	acute drainage of bone	189.00	20.000
	Chronic sequestrectomy minor (no anesthetic)	F/S	
0576	major, craterization, guttering or saucerization of bone; diaphysectomy, including closed irrigation of femur, humerus, pelvis, tibia, fibula, radius, ulna	287.00	21.375
0577	other bones	192.00	20.000

Excision of bone cyst, chondroma or exostosis

0566	femur, humerus, pelvis, tibia	310.20	20.000
0565	fibula, radius, ulna	265.00	20.000
0567	other bones	132.50	20.000

OSTEOTOMY

Cutting, division or transection of bone with or without fixation

0524	calcaneum (Dwyer's operation)	237.00	20.000
0526	clavicle	242.00	21.375
0532	femur, subtrochanteric	476.00	21.375
0534	supracondylar	476.00	21.375
0527	humerus	287.00	21.375
0539	pelvis—for congenital dislocation of hip	476.00	22.750
0541	for ectopia vesicae	694.00	20.000
0530	radius (malunited Colles' fracture)	348.90	20.000
0543	spine—for ankylosing spondylitis	783.00	22.750
0536	tibia	400.00	21.375
0531	ulna	242.00	20.000
0537	lesser bones (fibula, metatarsals, etc.)	218.30	20.000

		UNIT VALUE	
0580	Radical resection of bone for tumor with bone grafting, if required, maxilla, femur, humerus, pelvis, scapula and tibia	674.00	22.750
0581	other bones	334.00	22.750
0582	**Unlisted or Unusually Complicated**	***By Report***	22.750

CRANIOFACIAL SURGERY

Note: *1) When the surgical assistant is a specialist (e.g. neurosurgeon or plastic surgeon), assistant's benefits will be 30% of the surgical fee; otherwise 25% applies.*

2) Those benefits denoted by + include harvesting of bone and cartilage grafts.

0583+	Lefort II maxillary osteotomy and advancement	1,309.00	24.125
0584	Onlay bone grafts to face when not part of standard osteotomy for reconstruction, maxilla—unilateral	365.00	24.125
0585	bilateral	454.00	24.125
0586	zygoma—unilateral	320.00	24.125
0587	bilateral	410.00	24.125
0588	frontal—unilateral	410.00	24.125
0589	bilateral	499.00	24.125
0590	Forward bilateral osteotomy of the zygoma including bone graft	253.00	24.125
0592+	Bilateral periorbital correction, Treacher-Collins Syndrome with or without bone grafts (extracranial)	1,530.00	24.125
0594+	Bilateral periorbital correction, Treacher-Collins Syndrome with skull and muscle transpositions (includes skull reconstruction—intracranial)	1,937.00	24.125
0596+	Lefort III total maxillary advancement	1,825.00	24.125
0597+	Lefort III and subcranial hypertelorism and correction	2,306.00	24.125
0598+	Lefort III and Lefort I maxillary advancement	2,083.00	24.125
0599+	Lefort II, subcranial hypertelorism correction, Lefort I maxillary advancement	2,600.00	24.125
0600+	Upper Lefort III advancement without occlusal change, unilateral	865.00	24.125
0601+	bilateral	1,309.00	24.125
0602	Forehead advancement (bone grafts not included), unilateral	1,086.00	24.125
0603	bilateral	1,309.00	24.125
0616	Mandibular osteoplasty—for prognathism or micrognathism, one (1) or two (2) stages	664.00	22.750
0604+	Cranial vault reshaping—anterior or posterior half	1,380.00	24.125
0605+	Total cranial vault reshaping	1,806.00	24.125
0606	Medial transnasal canthopexy—unilateral	413.00	24.125
0607	when done in conjunction with another procedure	133.50	24.125

			UNIT VALUE
0608	Lateral canthoplasty—unilateral	232.00	24.125
0610	when done in conjunction with another procedure	88.75	24.125
0621+	Hypertelorism correction, intracranial approach	2,083.00	24.125
0626+	subcranial U osteotomies	1,750.00	24.125
0627+	medial orbital wall osteotomies	1,122.00	24.125
0628+	medial and lateral orbital wall osteotomies	1,456.00	24.125
0629+	Orbital dystopia—intracranial approach	1,750.00	24.125
0630+	extracranial approach	1,345.00	24.125
0631	Four (4) wall orbital decompression for malignant exophthalmos	1,699.00	24.125
0648	Two (2) wall orbital decompression	555.55	22.750
0632	Late correction traumatic enophthalmos (Tessier Technique, total periorbital stripping bone grafts)—intracranial	1,790.00	24.125
0633	extracranial	1,309.00	24.125
0634	Harvesting of bone graft when not included—iliac bone graft	90.00	21.375
0637	rib graft—one (1) rib	136.00	21.375
0638	each subsequent rib	67.00	21.375
0639	costochondral or chondral graft—one (1) rib	200.00	21.375
0640	each subsequent rib	134.00	21.375
0641	split cranial graft	178.00	21.375

SPINE

ANTERIOR INSTRUMENTATION

Cervical C2-C7

1105	two (2) vertebrae	750.00	24.125
1106	add on per additional vertebra	200.00	

Cervico-Thoracic C7-T4

1107	two (2) vertebrae	1,000.00	24.125
1108	add on per additional vertebra	250.00	

Dorsal and Lumbar (includes exposure)—any number of vertebrae

0645	Anterior Instrumentation of Spine and/or Osteotomy, via chest	949.00	24.125
0646	via abdomen	1,006.00	22.750
0647	via chest and abdomen	1,138.00	24.125

DECOMPRESSION

			UNIT VALUE
Cervical-Thoracic-Lumbar			
5203	Intervertebral discs, excision anterior approach, cervical	600.00	22.750
5205	Laminectomy, for decompression of the spinal cord and nerve roots	761.70	22.750
5207	for lesion of spinal cord or meninges	812.50	22.750
5209	Laminotomy, for removal of intervertebral discs cervical	672.00	22.750
5210	with spinal fusion	685.00	22.750
5213	thoracic	640.00	22.750
5223	Spondylolisthesis, laminectomy	666.00	22.750
1074	Excision of lumbar intervertebral disc, one (1)	662.80	22.750
1073	more than one (1)	846.30	22.750
1075	with spinal fusion, one (1) surgeon for dorsal and cervical discs – See Nervous System	664.00	22.750
1109	Vertebrectomy including disc and adjacent end plates	1,105.60	24.125
1110	add on per additional vertebra	350.00	
1111	Radical total disc excision with end plates	544.30	24.125
1112	add on per additional vertebra	225.00	
1113	Partial vertebrectomy	350.00	24.125
1114	Posteriolateral decompressions-one side includes lamina, facets, pedicles	815.60	22.750
1115	add per side or per additional vertebra	250.00	

FUSION-CERVICAL

POSTERIOR FUSION

1116	Occipito-cervical fusion (includes wires, screws and graft when necessary)	1,800.00	22.750
1117	add on per vertebra below C2	250.00	
1118	C1-C2 fusion—wires and graft	600.00	22.750
1119	C1-C2 fusion including transarticular screws and wires	1,200.00	22.750
1120	add on flat bone graft	250.00	

CERVICO-THORACIC-LUMBAR

0636	Spine, two (2) vertebrae, (e.g. lumbo-sacral)	666.00	22.750
0635	three (3) to five (5) vertebrae	800.00	22.750
0642	More than five (5) vertebrae (including Harrington Spinal Fusion)	1,200.00	22.750

			UNIT VALUE
1121	Posterior or Posteriolateral fusion with instrumentation including pedicle screws, two (2) vertebrae	1,223.30	22.750
1122	add on per additional vertebra	250.00	
1123	add on per Sacral vertebra (maximum per patient $3,000.00)	300.00	

ALIF OR PLIF

Alif-(anteriorlumbar interbody fusion)

Plif-(posteriorlumbar interbody fusion)

1124	Vertebra Replacement—with bone, cement, tri-cortical bone and/or cage per vertebra	350.00	24.125
1125	add on tricortical strut graft for vertebral body placement	350.00	24.125
1126	Intervertebral disc replacement after radical disc excision per vertebra	350.00	24.125
1127	add on tricortical strut graft for radical disc replacement, prosthetic replacement or allograft	300.00	

KYPHO-SCOLIOSIS

Anterior Release—includes discectomy and section of longitudinal ligament including open or thoroscopic approach

1128	one (1) intervertebral disc space	700.00	22.750
1129	two (2)—three (3) intervertebral disc spaces	1,050.00	22.750
1130	four (4)—six (6) intervertebral disc spaces	1,400.00	22.750
1131	Greater than six (6) intervertebral disc spaces (maximum per patient including fusion $3000.00)	150.00	22.750
1132	Fusion with anterior release with morselized non-structural bone graft per intervertebral disc space	150.00	22.750

BONE GRAFT

Procurement and application of graft from remote site

1133	Onlay graft for posterior lateral fusion	250.00	22.750

MISCELLANEOUS

1134	Laminoplasty	800.00	22.750
1135	add on per additional vertebra	200.00	
1136	Odontoidectomy, transoral with microscope	1,500.00	24.125
	Odontoid fracture		
1137	a) anterior-discectomy, fusion instrumentation	1,200.00	24.125
1138	b) anterior and posterior	2,700.00	24.125
1139	Open Vertebroplasty	1,200.00	24.125

FRACTURES

These benefits cannot be correctly interpreted without reference to Rules of Application 34 to 42.

Note: *In compound fractures requiring closed reduction $47.00 may be added to the fee for closed reduction.*

HEAD

Skull, non operative depressed with operation – See Nervous System

FACIAL BONES

			UNIT VALUE
0686	Nasal, simple, closed reduction with or without nasal packing or splinting	38.60	21.375
0687	compound, closed reduction	90.75	21.375
0688	simple or compound, open reduction	132.00	21.375
0691	Malar, simple closed reduction	36.55	20.000
0693	simple or compound, depressed, open reduction	196.50	21.375
0694	multiple surgical procedures	421.60	20.000
0696	Maxilla, simple, closed reduction	39.45	20.000
0699	simple or compound, closed reduction with wiring of teeth	220.00	21.375
0701	simple or compound, open reduction with wiring of teeth or local fixation	346.00	21.375
0703	Mandible, simple closed reduction	37.65	20.000
0704	simple or compound, closed reduction and wiring of teeth	259.50	21.375
0705	simple or compound, open reduction	416.90	21.375
0706	skeletal pinning with external fixation	283.00	21.375

SPINE AND TRUNK

0739	Clavicle, closed reduction—child	57.75	21.375
0740	adult	76.75	21.375
0742	open reduction	189.00	21.375
0733	Sacrum, reduction, closed or open	***By Report***	21.375
0734	Ribs, where operative procedure necessary	***By Report***	21.375
0754	Scapula, open reduction	390.00	21.375
0757	Sternum, reduction, closed or open	***By Report***	21.375
0720	Vertebra, process, one (1) or more, body, closed reduction	192.50	21.375
0723	open reduction, with or without plating or grafting	586.00	22.750

PELVIS

			UNIT VALUE
(Ilium, ischium, pubis including acetabulum)			
0770	Pelvis, closed reduction, with traction	287.00	21.375
0771	open reduction	491.00	21.375
0772	Acetabular fracture, lips, open reduction	563.55	22.750
0773	one (1) pillar, open reduction	890.60	22.750
0774	two (2) pillars, open reduction	1,335.50	22.750

UPPER EXTREMITY

0780	Humerus, neck, closed reduction	143.50	20.000
0782	open reduction	375.00	21.375
0785	shaft, closed reduction	94.25	20.000
0787	open reduction	525.00	21.375
0789	supracondylar or dicondylar, closed reduction	188.50	20.000
0790	open reduction	482.60	21.375
0792	medial or lateral condyle, closed reduction	94.25	20.000
0794	open reduction	325.00	21.375
0809	Radius, head or neck, closed reduction	145.00	20.000
0801	open reduction or excision	288.50	21.375
0803	shaft, closed reduction	95.75	20.000
0805	open reduction	237.00	21.375
0807	distal end (e.g., Colles'), closed reduction	128.80	20.000
0811	skeletal pinning, with external fixation	188.50	21.375
0810	open reduction	313.10	21.375
0813	Ulna, olecranon or shaft, closed reduction	95.75	20.000
0816	open reduction or excision	237.00	21.375
0818	with dislocation of radial head (Monteggia fracture), closed reduction	145.50	20.000
0819	open reduction	289.00	21.375
0821	Radius and ulna, closed reduction	190.00	20.000
0823	open reduction	386.10	21.375
0830	Carpal bones, one (1) or more, open reduction	191.50	21.375
0842	Metacarpal, closed reduction	86.00	20.000
0848	skeletal pinning with external fixation	143.50	21.375
0844	open reduction, one (1) or more	229.10	21.375
0852	Phalanges, fingers or thumbs, closed reduction	75.00	20.000
0854	open reduction	206.95	21.375

LOWER EXTREMITY

			UNIT VALUE
0865	Femur, neck, closed reduction, cast or traction	300.00	20.000
0868	open reduction with internal fixation	572.90	22.750
0870	prosthetic replacement	547.30	22.750
0877	slipped upper femoral epiphysis, closed reduction, cast or traction	287.00	20.000
0884	open reduction with internal fixation by pin, pins or bone graft	476.00	22.750
0879	reconstruction	664.00	22.750
0872	intertrochanteric, closed reduction	300.00	20.000
0874	open reduction	549.90	22.750
0881	shaft or supracondylar, closed reduction	300.00	20.000
0882	skeletal pinning with external fixation	333.00	21.375
0883	open reduction	570.60	21.375
0885	condyle or condyles, closed reduction	139.50	20.000
0887	open reduction	513.90	21.375
0897	Patella, open reduction	237.00	21.375
0911	Tibia, condyle, plateau or spines, closed reduction	143.50	20.000
0912	open reduction	430.40	21.375
0901	shaft, closed reduction	143.50	20.000
0904	open reduction	300.00	21.375
0907	medial malleolus, closed reduction	120.00	20.000
0910	open reduction	188.50	21.375
0914	Fibula, shaft, or lateral malleolus, closed reduction	97.00	20.000
0916	open reduction	210.00	21.375
0926	Tibia and fibula, shaft, closed reduction	150.00	20.000
0930	skeletal pinning with external fixation	189.00	20.000
0928	open reduction	377.90	21.375
0933	bimalleolar, closed reduction	143.50	20.000
0935	open reduction	460.00	21.375
0938	trimalleolar, closed reduction	143.50	20.000
0941	open reduction	444.70	21.375
0936	Talus, closed reduction	96.00	20.000
0937	open reduction	360.00	21.375
0961	Calcaneum, closed reduction	94.75	20.000
0964	skeletal pinning with external fixation	188.50	20.000
0963	open reduction	430.10	21.375

			UNIT VALUE
0944	Tarsal bones, except talus and calcaneum, closed reduction	93.00	20.000
0946	open reduction	220.00	21.375
0967	Metatarsal, closed reduction	67.00	20.000
0970	open reduction	175.00	20.000
0980	Phalanges, closed reduction	67.00	20.000
0982	open reduction	141.00	20.000
0985	Electrical treatment for fractures exhibiting delayed union, requiring the insertion of percutaneous electrodes for electrical stimulation for bone growth and healing	199.50	20.000
	Note: *Spinal fractures are excluded. The benefit covers full care for six (6) weeks including cast changes, electrode changes and removal. Major complications requiring surgery can be claimed in addition,* ***By Report****,(e.g. drainage of abscesses or sequestrectomy.)*		
0989	**Unlisted or Unusually Complicated**	***By Report***	21.375

JOINTS

1049*	Puncture for aspiration and/or injection of medication into joint, bursa, or tendon sheath	19.85	20.000
1050*	Arthroscopy (with or without biopsy), large joint	113.00	20.000
1051*	small joint (M.P. or I.P.)	66.50	20.000
1053*	small joint	34.85	20.000

MANIPULATION, (INDEPENDENT PROCEDURES)

Of joint under general anesthesia, not including reduction of dislocation, including application of cast or traction

1221*	Shoulder	29.20	20.000
1222*	Elbow	29.55	20.000
1223*	Wrist	29.45	20.000
1224*	Digits, one (1) or more, under anesthesia, where no other surgical procedure is performed	29.15	20.000
1226*	Hip	29.40	20.000
1227*	Knee	35.50	20.000
1228*	Ankle	29.20	20.000
1244*	Club foot with application of cast, unilateral, initial	35.00	20.000
1245*	subsequent	35.00	20.000
1246*	bilateral, initial	55.00	20.000
1247*	subsequent	55.00	20.000
1232*	Spine	28.80	20.000

ARTHRODESIS

Fusion of joint, with or without bone graft

			UNIT VALUE
1166	Shoulder	476.00	20.000
1167	Elbow	399.00	20.000
1168	Wrist	333.00	20.000
1170	Finger or thumb—one (1) joint	135.50	20.000
1173	Sacroiliac	291.00	21.375
1175	Hip	683.00	21.375
1176	Knee	476.00	20.000
1177	Ankle	550.00	20.000
1185	Foot, triple arthrodesis, unilateral	500.00	20.000
1187	with tendon transplantation	547.60	20.000
1178	Toe, one (1) (50% for each additional toe)	132.50	20.000

ARTHRECTOMY

Excision of joint – See Arthroplasty

1065	Temporomandibular joint, unilateral	247.00	21.375
1076	Exploration for intervertebral disc, none found	146.50	22.750
1077	Chemonucleolysis of intervertebral disc	231.00	21.375
1078	each additional disc injected at the same sitting, add	58.25	

Note: *The above benefit includes the use of x-ray control and/or other imaging techniques by the operating physician, and includes six (6) weeks postoperative care.*

0643	Electrospinal Instrumentation	451.00	22.750
0644	Removal or replacement of electrodes	219.00	22.750
1595	Toes, multiple arthrodesis for claw foot, one (1) foot	287.00	20.000
1596	both feet	476.00	20.000
1181	Hallux rigidus	199.00	20.000
1183	Tarsal joint, one (1) or more	290.00	20.000
1184	Other joints, lower extremity	190.00	20.000
1190	Stabilization of joints by bone block	265.00	20.000
1191	Acromionectomy	342.85	21.375

ARTHROPLASTY

Plastic or reconstructive operation on joint, any type

Shoulder Arthroplasty

Note: *Includes, except where noted below, all associated bone and soft tissue procedures including partial acromionectomy, partial excision of end clavicle, osteotomy, synovectomy, injection of medications and rotator cuff repair.*

		UNIIT VALUE	
1141	Shoulder	653.20	21.375
1200	Shoulder, total arthroplasty with glenoid and humeral components	710.00	22.750
1203	Shoulder arthroplasty with humeral component	710.00	22.750
1204	Shoulder, revision of one or both components of shoulder arthroplasty	1,150.00	22.750
1205	Shoulder revision to temporary arthroplasty using prostalac	1,150.00	22.750
1206	Shoulder, removal of one or both components of shoulder arthroplasty without replacement	750.00	22.750
1207	Autogenous, structural bone graft from another site, add	238.00	22.750
1208	Allogenous, structural bone graft, add	100.00	22.750
	Elbow Arthroplasty		
	Note: *Includes, except where noted, below, all associated bone and soft tissue procedures including ligament balancing, neurolysis and nerve transposition and synovectomy.*		
1180	Radial head arthroplasty only with implant	300.00	22.750
1182	Primary total elbow arthroplasty (2 or 3 components) includes synovectomy, excision of radial head and transposition of ulnar nerve	600.00	22.750
	Revision Elbow Arthroplasty		
1186	Revision total elbow arthroplasty–humeral component only	550.00	22.750
1188	Revision total elbow arthroplasty–ulnar component only	550.00	22.750
1189	Revision total elbow arthroplasty–radial head only	300.00	22.750
1192	Revision total elbow arthroplasty–humeral and ulnar or all three components	900.00	22.750
1193	Revision total elbow arthroplasty–humeral or ulnar and radial head	700.00	22.750
1194	Autogenous, structural bone graft from another site, add	166.50	22.750
1195	Allograft, structural bone graft, add	100.00	22.750
	Revision Elbow Arthroplasty Without Replacement		
1196	Removal of one component without replacement	241.35	21.375
1197	Removal of two (2) or more components without replacement	399.00	21.375
1198	Elbow, flexor–plasty—Soft tissue correction of elbow flexion contracture	351.00	21.375
	Distraction/Interposition Arthroplasty		
	Note: *Includes application of distraction and/or external fixation device.*		
1172	using autogenous material, bone or soft tissue from another site	750.00	22.750

		UNIIT VALUE	
1174	using allograft material	650.00	22.750
	Note: *Removal and revison arthroplasty includes all associated bone and soft tissue procedures including osteotomy, use of bone substitute, osteoset, nerve transposition and synovectomy. Applies only to tariffs 1186, 1188, 1189, 1192, 1193, 1196 and 1197.*		
1143	Wrist	323.00	20.000
1144	Finger, one (1) joint	127.50	20.000
1145	four (4) fingers for rheumatoid disease, including synovectomy and redirecting of extensor tendons	845.95	20.000
	Hip Arthroplasty		
	Rules: *1) All arthroplasty fees include associated bone and soft tissue procedures, including but not limited to synovectomy, ligament and tendon release and lengthening and repair, and injection of medications.*		
	2) Revision fees include insertion of PROSTALAC type components.		
	Note: *1) Repair of periprosthetic femoral fracture when done at the same time and the same incision as hip arthroplasty – add on 50% of fracture tariffs 0874 or 0883.*		
	2) Repair of periprosthetic femoral fracture when done at the same time as hip arthroplasty but through separate incision – add on 75% of fracture tariff 0883.		
	3) Repair of periprosthetic acetabular fracture at the same time and same incision as revision hip arthroplasty – add on 50% of fracture tariffs, 0772, 0773, or 0774.		
~1415	Total hip arthroplasty	763.90	22.750
1149	femoral head replacement type	620.00	22.750
1154	where previous prosthesis, cup or plates require removal, add	110.00	24.125
~1416	Total hip arthroplasty with take down of arthrodesis	1,006.00	25.500
~1417	Revision total hip arthroplasty with exchange of acetabular liner only	500.00	22.750
~1418	Revision total hip arthroplasty with removal and replacement of modular head component	385.85	22.750
~1419	Revision total hip arthroplasty with exchange of acetabualar liner and removal and replacement of modular head component	770.00	24.125
~1420	Revision total hip arthroplasty with removal and replacement of one component	978.50	25.500
~1421	Revision total hip arthroplasty with removal and replacement of both components	1,360.20	25.500
~1422	Removal of hip prosthesis without replacement	650.00	22.750
~1423	Bipolar hip arthroplasty	620.00	22.750
~1424	Unipolar hip arthroplasty	620.00	22.750
~1425	Resection, femoral head (e.g. Girdlestone procedure)	554.00	22.750
~1426	Peri-acetabular osteotomy	1,350.00	25.500

Knee Arthroplasty

Rules: *1) All arthroplasty fees include associated bone and soft tissue procedures, including but not limited to synovectomy, ligament and tendon release and lengthening and repair, and injection of medications.*

2) Revision fees include insertion of PROSTALAC type components.

			UNIT VALUE
~1402	Total knee arthroplasty, with patellar resurfacing	737.00	22.750
~1403	Total knee arthroplasty without patellar resurfacing	587.80	22.750
~1404	Unicondylar knee arthroplasty, medial or lateral compartment	571.30	21.375
~1405	Patellar resurfacing only	350.00	21.375
~1407	Total knee arthroplasty with removal of previous partial prosthesis	1,000.00	24.125
~1408	Revision knee arthroplasty with removal and replacement of modular tibial bearing surface (with or without patellar revision)	425.00	24.125
~1409	Revision of knee arthroplasty with removal and replacement of one or both femoral or tibial components (with or without patellar component revision)	1,250.00	24.125
~1411	Removal of knee prosthesis with or without spacer insertion	600.00	24.125
~1412	Removal of knee prosthesis with knee arthrodesis, with or without bone graft	1,263.00	24.125
	Add – ons to Arthroplasty Fees for Hip and Knee		
~1440	Structural bone graft and bone graft substitutes, including fixation of graft e.g. Tantalum type, to one or more sites, add	350.00	22.750
~1442	Morsellized bone graft, to one or more sites, add	150.00	22.750
~1444	Impaction bone graft to femur (Exeter/Ling technique), add	350.00	22.750
~1446	Extended trochantaric osteotomy, add	200.00	22.750
~1448	Non-structural bone substitute, to one or more sites, add	25.00	22.750
1152	Ankle	660.00	21.375
1153	Toe, one (1) joint (50% for each additional)	132.50	20.000
1162	Metatarsophalangeal joint (bunion operation), all methods including tendon re-arrangement	244.60	20.000
1163	Reconstruction, all metacarpophalangeal joints, one (1) hand	476.00	20.000
1164	all metatarsophalangeal joints, one (1) foot	287.00	20.000
1165	both feet	476.00	20.000

ARTHROTOMY OR CAPSULOTOMY

With exploration, drainage, or removal of loose body, (e.g. for osteochondritis, foreign body or synovial biopsy).

1001	Shoulder	289.85	21.375
1002	Elbow	267.35	20.000
1003	Wrist	223.10	20.000
1017	Finger, one (1)	92.50	20.000

			UNIT VALUE
1006	Other joints of upper extremity	143.50	20.000
1007	Hip	385.85	21.375
1008	Knee	290.00	21.375
1010	Ankle	241.35	20.000
1026	Toe, great toe	94.75	20.000
1013	Other joints lower extremity	144.00	20.000

DISLOCATION

1251*	Dislocation, temporomandibular joint, closed reduction	33.50	20.000
1256	Vertebrae, cervical, closed reduction	209.00	21.375
1258	open reduction	472.00	22.750
1262	dorsal, simple, closed reduction	246.00	21.375
1264	open reduction	490.00	22.750
1267	lumbar, simple, closed reduction	252.00	21.375
1270	open reduction	490.00	22.750
1273	Clavicle, sternoclavicular, closed reduction	57.75	20.000
1275	open reduction	193.00	21.375
1278	acromioclavicular, closed reduction	67.25	20.000
1281	open reduction	188.50	21.375
1284	Shoulder, humerus, closed reduction	67.00	20.000
1286	open reduction	273.00	21.375
1290	Elbow, closed reduction	68.50	20.000
1292	open reduction	265.00	20.000
1295	Wrist carpal, one (1) bone, closed reduction	68.75	20.000
1297	open reduction	192.00	20.000
1298	more than one (1) bone, closed reduction	66.25	20.000
1301	open reduction	255.00	20.000
1299	Club hand, congenital, open reduction	490.00	20.000
1304	Metacarpal, one (1) bone, closed reduction	67.00	20.000
1306	open reduction	132.50	20.000
	Finger, one (1) or more joints, closed reduction	F/S	
1317	open reduction	127.50	20.000
	Thumb, closed reduction	F/S	
1328	open reduction	130.00	20.000
1332	Hip, closed reduction	94.25	20.000
1334	open reduction	333.00	21.375

		UNIT VALUE	
	Congenital, closed reduction	F/S	
1336	open reduction	192.00	21.375
~1335	Open reduction congenital hip dislocation, includes open adduction tenotomy, arthrotomy hip, Psoas tendon lengthening	650.00	22.750
~1337	Open reduction congenital hip dislocation with pelvic osteotomy, includes open adduction tenotomy, arthrotomy hip, Psoas tendon lengthening and pelvic osteotomy	1,030.00	24.125
~1338	Open reduction congenital hip dislocation, includes open adduction tenotomy, arthrotomy hip, Psoas tendon lengthening, with femoral osteotomy	1,030.00	24.125
~1339	Open reduction congenital hip dislocation, includes open adduction tenotomy, arthrotomy hip, Psoas tendon lengthening, with femoral and pelvic osteotomy	1,385.00	24.125
1344	Knee, closed reduction	66.75	20.000
1346	open reduction	328.00	21.375
	Patella, closed reduction	F/S	
1352	open reduction	193.00	20.000
1355	Ankle, closed reduction	67.00	20.000
1357	open reduction	287.00	20.000
1361	Tarsal, closed reduction	69.75	20.000
1363	open reduction	283.00	20.000
1371	Talotarsal, closed reduction	66.75	20.000
1373	open reduction	298.00	20.000
	Metatarsal, one (1) bone, closed reduction	F/S	
1378	open reduction	141.50	20.000
	Toe, one (1), closed reduction	F/S	
1387	open reduction	93.00	20.000

MENISCECTOMY

1082	Meniscectomy—excision of semilunar cartilage of knee joint	320.00	21.375
1085	Meniscus of temporomandibular joint	250.00	21.375

SUTURE

Capsulorrhaphy—suture or repair of joint capsule for recurrent dislocation

1201	Shoulder (independent procedure)	542.25	21.375
1202	Patella (independent procedure)	378.90	20.000
1211	Knee, suture of torn, ruptured, or severed collateral ligament, one (1)	347.20	21.375
1212	cruciate ligament, one (1)	374.80	21.375
1213	collateral and cruciate ligament	454.10	21.375
1215	reconstruction, collateral or cruciate ligaments (both)	509.50	21.375
1214	reconstruction, collateral and cruciate ligaments	664.00	21.375

			UNIT VALUE
1218	Ankle, reconstruction, collateral ligament, one (1)	333.00	20.000
1216	both	491.00	20.000
1217	Reconstruction, metacarpophalangeal or interphalangeal ligaments, both, one (1) finger	234.00	20.000

SYNOVECTOMY

1095	Shoulder	318.00	21.375
1093	Elbow	287.00	21.375
1101	Hip, complete	477.00	21.375
1102	Knee	399.00	21.375
1103	Ankle	261.00	21.375
1104	Wrist	253.00	21.375

BURSA

1401*	Drainage of infected bursa	47.80	20.000
1049*	Puncture for aspiration and/or injection of medication into joint, bursa, or tendon sheath	19.85	20.000
1406	Calcareous deposits, subdeltoid, removal	143.50	20.000
1410	trochanteric, removal	98.00	20.000
1430	Excision of bursa, radical, forearm, wrist or palm, (e.g. for Rheumatoid or Tuberculous tenosynovitis).	331.00	20.000
1436	Excision of bursa, ischial	94.00	20.000
1431	olecranon	86.00	20.000
1433	prepatellar	85.75	20.000
1435	subacromial	146.00	20.000

EXCISION

1562	Baker's cyst, synovial cyst of popliteal space, excision	215.00	21.375
1430	Bursa, forearm, radical excision, (e.g. for tenosynovitis fungosa, tuberculosis and other granulomas).	331.00	20.000

MUSCLES

Electromyogram – See Central Nervous System

1460*	Biopsy of muscle	100.00	20.000
1461*	Biopsy of muscle for malignant hyperthermia, three (3) or more	139.50	21.375
1450	Foreign body in muscle, removal, general anesthesia	***By Report***	20.000
1452	Gastrocnemius, recession, at calf	192.00	20.000
1453	at knee	247.00	20.000

			UNIT VLAUE
1456	Scalenus anticus, division, with resection of cervical rib	397.00	21.375
1454	without resection of cervical rib	191.50	21.375
1458	Sternomastoid, division, for torticollis, open operation	192.50	20.000

TENDONS, TENDON SHEATHS AND FASCIA

1049*	Puncture for aspiration and/or injection of medication into joint, bursa, or tendon sheath	19.85	20.000

INCISION

1511	Tendon sheath, drainage, for acute tenosynovitis, one (1) digit	59.50	20.000
1514	single, palm and/or wrist, ulnar or radical bursa infection, in hospital	155.50	20.000
1519	incision, for stenosing tenosynovitis, to include freeing of tendons or removal of foreign body, in hospital	147.05	20.000
1521	Club foot, soft tissue correction, including tendoachilles lengthening	600.00	20.000
1522	Steindler release or plantar fasciotomy (for club foot)	159.00	20.000
1525	Humerus, lateral epicondyle, stripping for “Tennis Elbow”	143.50	20.000
1531	Iliotibial band, division, open operation	188.50	20.000
1534	Ilium, stripping (Soutter operation)	278.00	20.000
1535	Tenotomy, corrective, single digit, subcutaneous	29.50	20.000
1536	multiple	58.50	20.000
1541	hip adductors, open	188.50	20.000
1539	subcutaneous	47.25	20.000
5235	Decompression, median nerve at carpal tunnel, simple	178.70	20.000

EXCISION

1552	Tendon, or fibrous sheath, excision of lesion, including ganglion, digits only	126.50	20.000
1553	other locations	275.70	20.000
1570	Fasciotomy, single, palm or sole, subcutaneous	75.75	20.000
	Fasciectomy		
1573	for Dupuytren’s contracture, partial	400.00	20.000
1574	including finger extensions and vertical bands, radical	434.00	20.000

REPAIR

1616	Abdominal fascial transplant, bilateral	415.00	20.000
1640	Biceps tendon, ruptured, from insertion to elbow	236.00	20.000
1641	Elbow, flexor-plasty	351.00	20.000
1580	Extensor tendon, repair or suture, single, distal to wrist or ankle	170.00	20.000
1582	forearm or leg	110.00	20.000

			UNIT VALUE
1583	Flexor tendon, repair or suture, single, unless otherwise listed	279.65	20.000
1612	Fascial graft, free, for reconstruction of tendon pulley or repair bowstring tendon, single (independent procedure)	205.00	20.000
1613	for reconstruction of tendon pulley or repair bowstring tendon to form gliding surface for tendons	127.50	20.000
1657	Iliopsoas transfer	477.00	20.000
1659	Long head of biceps, ruptured	115.00	20.000
1632	Patellar advancement	342.00	20.000
1661	Pectoralis to biceps transfer (Clark's operation)	477.00	20.000
1633	Quadriceps, ruptured, insertion	226.00	20.000
1655	Scapulopexy	366.00	21.375
1654	supraspinatus tendon or musculotendinous cuff shoulder, repair	333.00	21.375
1635	Tendo Achilles, ruptured, suture	226.00	21.375
1636	fascial graft	303.00	21.375
1589	Tendon, lengthening or shortening Retrieve or reroute, through separate incision, add 25% of benefit.	250.00	20.000
1585	Transfer or transplant, or free graft, single distal to elbow, distal to knee	386.20	20.000
1586	elbow to shoulder, knee to hip	333.00	20.000
1593	multiple transfer, for peripheral nerve palsy	439.00	20.000
1595	for claw hand or foot, one (1) hand or foot	287.00	20.000
1596	both hands or both feet	476.00	20.000

AMPUTATION

UPPER EXTREMITY

1701	Interthoracoscapular	684.00	22.750
1703	Shoulder, disarticulation	477.00	21.375
1705	Humerus	273.00	21.375
1710	guillotine	195.00	21.375
1709	secondary closure or minor scar revision	96.00	20.000
1711	reamputation	191.50	21.375
1708	Radius and ulna	279.00	20.000
1712	Cineplasty, complete procedure	677.00	20.000
1718	Wrist, disarticulation	189.50	20.000
1722	Hand through metacarpal bones	183.50	20.000
1725	Metacarpal, with finger or thumb, one (1), with split or Wolff Graft, or skin-plasty, and/or tenodesis with definite resection of palmar digital nerves	135.00	20.000

			UNIT VALUE
1740	Finger or thumb, any joint distal to metacarpal, or phalanx, one (1) with skin graft	129.50	20.000
1741	additional fingers, same hand, with skin graft, each	65.75	20.000
1742	Finger or thumb, any joint distal to metacarpal, or phalanx, one (1) without skin graft	110.45	20.000
1743	additional fingers, same hand, without skin graft, each	41.75	20.000
1739	all fingers, same hand	273.00	20.000
	Note: *Repair of stump of already amputated finger or toe, requiring only simple repair of wound.*		
0251*	Wound, simple repair (including local anesthetic)	35.10	20.000

LOWER EXTREMITY

1745	Interpelviabdominal	761.00	24.125
1748	Hip, disarticulation	536.00	22.750
1752	Femur, including supracondylar	439.00	22.750
1760	guillotine	245.00	22.750
1761	secondary closure or minor scar revision	98.50	20.000
1763	reamputation	194.50	22.750
1750	Knee, disarticulation	377.00	21.375
1767	Tibia and fibula	446.65	21.375
1771	guillotine	191.00	21.375
1772	secondary closure or minor scar revision	88.50	20.000
1774	reamputation	145.00	21.375
1778	Ankle (Syme, Pirogoff), with skin-plasty and resection of nerves	275.00	21.375
1782	Foot, transmetatarsal	314.60	21.375
1785	midtarsal	261.00	21.375
1788	Metatarsal with toe, split or Wolff Graft, or skin plasty and/or tenodesis, with definitive resection of digital nerves	146.00	21.375
1802	Toe, any joint or phalanx, one (1)	122.60	21.375
1804	each additional toe, same foot	50.00	21.375
1803	all toes, one (1) foot	180.50	21.375
1819	**Unlisted or Unusually Complicated**	***By Report***	21.375

PLASTER CASTS (INDEPENDENT PROCEDURES ONLY)

1862*	Shoulder plaster, shoulder spica	57.50	20.000
1860*	shoulder to hand	34.35	20.000
1854*	Elbow to fingers	25.80	20.000
1851*	Forearm	25.80	20.000
1856*	Hand and wrist	25.80	20.000

			UNIT VALUE
1867*	Knee (foot to thigh)	28.80	20.000
1893*	Cylinder cast (ankle to thigh)	28.15	20.000
1894*	Ankle (foot to mid leg) short leg	31.45	20.000
1895*	long leg	38.40	20.000
1890*	Patellar tendon bearing leg cast	37.90	20.000
1896*	Ambulatory leg cast—short leg	31.45	20.000
1897*	long leg	37.80	20.000
1878*	Spica, hip to foot, unilateral	56.75	20.000
1882*	bilateral	94.25	20.000
1885*	Body, shoulder to hips	56.75	20.000
1886*	including head	93.75	20.000
1241*	Risser jacket, localizer, body only	86.50	20.000
1242*	including head	147.00	20.000
1898*	Turnbuckle jacket, body only	88.50	20.000
1899*	including head	127.00	20.000
1891*	Unna boot	19.30	20.000
1892*	Wedging cast	18.85	20.000
1870*	Application of cast brace	66.00	20.000
1889	**Unlisted or Unusually Complicated**	***By Report***	20.000

RESPIRATORY SYSTEM

These benefits cannot be correctly interpreted without reference to the Rules of Application.

NOSE

EXTERNAL

Note: *Rhinoplasty, when done as elective plastic surgery for cosmetic purposes is an exclusion under the regulations, except where the Minister is satisfied prior to the operation that such surgery is medically required. It is the responsibility of the physician to obtain this approval prior to the operation.*

			UNIT VALUE
1924	Rhinophyma, excision or planing	219.00	21.375
1950	Rhinoplasty, complete, external parts including bony pyramid, lateral and alar cartilages and elevation of tip, if necessary	490.60	21.375
1949	with septoplasty	560.00	21.375
1956	tip only	264.00	21.375

For saddle deformity by autogenous bone or other implant – See Bone Graft, Musculoskeletal Section

INTERNAL

1904*	Drainage of nasal abscess	19.10	21.375
1905*	septal abscess	19.50	21.375
1906*	Proetz treatment	3.85	20.000
1908*	Biopsy, soft tissue nose including simple closure	9.75	20.000
1907*	Nose, foreign body removal	13.50	21.375
1915*	polyp single excision in office	13.55	
1965*	Turbinate cautery	29.10	
1966*	with general anaesthetic	48.15	21.375

Note: *For Tariffs 1965 and 1966, 50% of the listed benefit is payable when done in conjunction with other nasal procedures for which a bloc fee is listed.*

9843*	Rhinomanometry	19.20	
1967*	Epistaxis, control by anterior packing	19.10	21.375
1968*	posterior packing	102.60	21.375
1969	freezing—See Section C—Anesthesia	***By Report***	21.375
1970*	Epistaxis, control by cautery of the septum in a nose that is not actively bleeding	7.65	
1971*	actual control of a bleeding nose	19.10	
1951	Choanal atresia, correction intranasal	48.20	21.375
1952	transpalatine approach	466.00	22.750

		UNIT VALUE	
	Microsurgical Trans-nasal Repair of Choanal Atresia		
1953	unilateral	275.00	21.375
1954	bilateral	412.50	21.375
1917	Nasal polyps, multiple, unilateral, excision in hospital	96.50	21.375
1922	Nasopharyngeal fibroma excision	***By Report***	22.750
1928	Septoplasty or classic submucous resection	261.90	21.375
1929	with repair of septal perforation—including graft	339.00	21.375
1955	Septoplasty and dorsal hump removal	375.00	21.375
1957	Dorsal hump removal	150.00	21.375
	Note: *Notes 1 and 2 apply to tariffs 1955 and 1957.*		
	1) The patient must have had previous trauma.		
	2) These procedures have certain restrictions under the Regulations when done as elective surgery. To be certain that the case is covered, written approval from the Minister should be obtained before the procedure is undertaken.		
1930	Endonasal microplasty	469.00	21.375
1935*	Turbinectomy, partial or complete	67.50	21.375
0686	Fractured nose, simple, closed reduction with or without nasal packing or splinting	38.60	21.375
0687	compound, closed reduction	90.75	21.375
0688	simple or compound, open reduction	132.00	21.375

SINUSES

1981*	Antrum puncture and washout	19.45	21.375
	Note: *For Tariff 1981, 50% of the listed benefit is payable when done in conjunction with other nasal procedures for which a bloc fee is listed.*		
1978	Ligation of artery, anterio ethmoid	198.50	22.750
1979	internal maxillary via Caldwell-Luc	387.00	22.750
2006	Obliteration of sinuses, ethmoids, intranasal, unilateral	194.50	21.375
2007	frontal, osteoplastic approach	774.00	21.375
1994	Frontal, ethmoids and sphenoids, radical exenteration by external approach	586.00	22.750
1995	Maxillary	603.00	21.375
1996	Otolaryngological component of craniofacial resection for tumor of ethmoid or frontal sinus or orbit (in conjuction with neurosurgeon)	2,100.00	22.750
	Note: *Tariff 1996 includes rhinotomy, ethmoidectomy, cribform plate, and orbital exenteration.*		
2032	Oro-antral fistula, closure by Caldwell-Luc and Antrum window and mucosal or muco periosteal flaps	384.00	21.375

			UNIT VALUE
1988	Sinusotomy, Caldwell-Luc	291.00	21.375
1992	frontal, trephine	135.00	21.375
1991	sphenoid	194.50	21.375
1985	maxillary, antrostomy	115.50	21.375

COMBINED INTRANASAL PROCEDURES

2013	External ethmoidectomy unilateral	346.00	22.750
	Ethmoidectomy		
2009	and antrostomy, unilateral	320.00	21.375
2010	bilateral	550.00	21.375
2011	and polypectomy, unilateral	300.00	21.375
2012	bilateral	520.00	21.375
2014	and polypectomy and antrostomy, unilateral	400.00	21.375
2015	bilateral	680.00	21.375
2017	Polypectomy and antrostomy, unilateral	210.00	21.375
2018	bilateral	360.00	21.375
	Septoplasty		
2019	and antrostomy, unilateral	380.00	21.375
2020	bilateral	450.00	21.375
2021	and ethmoidectomy, unilateral	445.00	21.375
2022	bilateral	560.00	21.375
2023	and polypectomy, unilateral	360.00	21.375
2024	bilateral	479.95	21.375
2025	and polypectomy and ethmoidectomy, unilateral	500.75	21.375
2026	bilateral	754.35	21.375
2027	and polypectomy and ethmoidectomy and antrostomy, unilateral	620.00	21.375
2028	bilateral	898.10	21.375
2033	and ethmoidectomy and antrostomy, unilateral	535.00	21.375
2034	and ethmoidectomy and antrostomy, bilateral	798.50	21.375
2029	**Unlisted or Unusually Complicated**	***By Report***	21.375

LARYNX

Cervical lymph node dissection—See Lymph Nodes

2071*	Laryngoscopy, direct, diagnostic	66.25	22.750
2074*	direct, with biopsy	108.00	22.750
2070*	direct for foreign body removal (in office)	67.00	22.750

			UNIT VALUE
2030*	Fiberoptic nasendoscopy nasopharyngoscopy flexible	36.20	20.000
2031*	Fiberoptic nasopharyngolaryngoscopy flexible	41.15	20.000
	Note: *These items may be claimed by appropriately trained specialists only where visualization of the larynx or nasopharynx has failed with the laryngeal mirror.*		
2078	Suspension micro-laryngoscopy without CO^2 laser	135.00	22.750
2079	Suspension laryngoscopy with removal of complicated lesion from larynx or trachea by CO^2 laser	250.00	24.125
6131	Laryngogram (procedural portion of Radiology)	19.90	22.750
2053	Arytenoidectomy, external approach	386.00	22.750
2051	Laryngectomy, partial, with preservation of voice	880.00	24.125
2052	total	997.50	22.750
2054	Thyroplasty with Silastic Implant	386.00	22.750
2041	Laryngo-fissure with removal of tumor or laryngocele	341.00	22.750
2081	Laryngoscopy, direct with complete removal of cord lesion	262.50	22.750
2077	with foreign body removal	103.00	22.750
2080	Laryngotracheoplasty–with bronchoscopy or laryngoscopy, with or without local flap or graft, with or without tracheostomy, with or without suprahyoid release, with or without resection of the cricoid and/or blunt retro sternal tracheo-bronchial mobilization.	1400.00	24.125
	Note: *A surgical assistant benefit may be claimed in addition to Tariff 2080. The total fee (Tariff 2080 and the surgical assistant benefit) may be apportioned in accordance with the Rule of Application 30.*		
2089	**Unlisted or Unusually Complicated**	***By Report***	24.125

TRACHEA AND BRONCHI

2127*	Trachea, aspiration under direct vision (independent procedure)	69.00	22.750
2128*	Tracheal aspiration for meconium staining under direct vision (independent procedure)	74.05	
6145	Tracheogram (procedural portion of radiology)	20.50	22.750
2129*	Dilatation tracheostenosis	107.00	22.750
2131	with suspension laryngoscopy	157.00	22.750
2113*	Bronchoscopy, with biopsy if necessary	125.00	22.750
2121*	with bronchial aspiration	106.00	22.750
2126*	with catheterization of bronchi for broncho-spirometry (independent procedure)	66.25	22.750
2122*	with drainage of lung abscess or cavity	106.00	22.750
2123*	with lipiodol injection	106.50	22.750
2116	with stent placement	208.00	24.125
2119	with brachytherapy	208.00	24.125

			UNIT VALUE
2136	total lung washout lavage—(unilateral)	800.00	24.125
2137	with bronchopleural fistula—tisseel injection	150.00	24.125
2124*	subsequent (i.e. in same hospital admission)	71.95	22.750
2125*	Bronchoscopy with esophagoscopy or gastroscopy, when done at the same sitting, with or without biopsy	95.75	22.750
2130*	Quadroscopy with or without biopsy, (nasopharyngoscopy, laryngoscopy, bronchoscopy, esophagoscopy with or without gastro-duodenoscopy) using separate instruments in search of malignant disease.	272.05	22.750
2112	Bronchoscopy, with control of severe hemorrhage	177.50	24.125
2120	with excision of tumor, with or without laser	208.00	22.750
2115*	with lung biopsy	198.00	22.750
2117	with removal of foreign body—adult	186.85	22.750
2118	with removal of foreign body—child	252.00	22.750
2105	Tracheal fenestration	331.00	22.750
2132	Tracheoplasty, intrathoracic	882.00	24.125
2101*	Tracheotomy (not to be claimed with tariff 2052 laryngectomy, total)	265.00	22.750
2100	Cricothyroidotomy	171.00	22.750
2102	Tracheoesophageal puncture following laryngectomy (separate operation) including delayed insertion of voice prosthesis	235.00	21.375
2103	Tracheoesophageal puncture at the time of laryngectomy, including delayed insertion of voice prosthesis.	117.50	21.375
2104*	Repeat insertion of voice prosthesis (independent procedure)	23.80	21.375
2134	Bronchoplasty, excise stenosis and anastomosis	929.00	25.500
2133	graft repair	973.00	25.500
2135	with lobectomy and anastomosis	1,200.00	25.500
2139	**Unlisted or Unusually Complicated**	***By Report***	25.500

LUNGS AND PLEURA

2180*	Lung, needle biopsy	49.75	20.000
2225*	Pleura, needle biopsy (including thoracentesis)	48.50	20.000
2220*	Thoracoscopy, with or without biopsy	200.00	22.750
2183*	Thoracentesis	46.80	20.000
2221*	Pneumothorax, diagnostic or therapeutic, initial	34.40	20.000
2222*	subsequent	13.75	20.000
2224*	Administration of chemotherapy, including aspiration thoracentesis and sample	29.50	20.000
2684*	Mediastinoscopy	252.00	21.375
2193	Lobectomy, total or subtotal	1,130.00	24.125
2191	Pneumonectomy, total	1,385.00	25.500

			UNIT VALUE
2194	Wedge resection	825.00	24.125
2177	Pulmonary decortication	750.00	24.125
2171	Pleurectomy	600.00	24.125
2172	Wedge resection with partial pleurectomy	825.00	24.125
2173	Decortication with parietal pleurectomy and empyemectomy	1,200.00	24.125
2174	Late decortication for fibrothorax	1,500.00	24.125
2192	Lobectomy with concomitant decortication of remaining lung	1,120.00	24.125
2178	Pulmonary resection with concomitant thoracoplasty	1,126.00	24.125
2157*	Insertion of chest tube for closed drainage (independent procedure)	114.05	21.375
2156*	bilateral at same sitting (independent procedure)	187.80	21.375
2151	Thoracotomy, cardiac massage	509.00	25.500
2152	exploratory, including biopsy	420.00	24.125
2153	hemorrhage control, not postoperative	653.20	25.500
2155	Thoracotomy for postoperative bleeding following lung or esophageal surgery	332.20	25.500
2170	Pneumonotomy, open drainage of abscess or cyst of lung	397.00	24.125
2160	Removal of foreign body from lung	470.00	24.125
2154	Open drainage of empyema cavity by rib resection (independent procedure)	360.90	22.750
2190	Lung Harvesting—Unilateral	939.00	24.125
2196	Lung Harvesting—Bilateral	1,408.50	24.125
2197	Lung Transplantation—Unilateral	2,945.20	25.500
2198	Lung Transplantation—Bilateral	5,087.05	25.500

Note: *a) The above fees include the recipient pneumonectomy.*

b) First assistant—30% of fee payable to principle surgeon.

c) Second assistant—25% of fee payable to principle surgeon.

VIDEO ASSISTED PLEUROLYSIS

2188	Pleurolysis and scope—via scope	300.00	24.125
2199	**Unlisted or Unusually Complicated**	***By Report***	25.500

RIBS AND CHEST WALL

1456	Scalenus anticus, division, with resection of cervical rib	397.00	21.375
1454	without resection of cervical rib	191.50	21.375
2209	Intrathoracic tumors without lung involvement, excision	498.00	24.125
2210	Pectus excavatum or carinatum, correction	879.20	24.125
2211	Thoracoplasty, first stage	379.00	22.750
2212	second stage	198.50	22.750

			UNIT VALUE
2200	Chest wall tumor resection—with one (1) rib	600.00	24.125
2201	Chest wall tumor resection—two (2) or more	800.00	24.125
2202	with prosthetic reconstruction	1,050.00	24.125
2203	Chest wall reconstruction add to lobectomy or pneumonectomy,	250.00	
2204	with merthacrolyate cement reconstruction—add to previous tariff	250.00	
2219	**Unlisted or Unusually Complicated**	***By Report***	24.125

LUNG FUNCTION TESTS

Note: *1) No visit benefit will be paid in addition to the following procedures if the patient's visit is for the procedure alone.*

2) All complex lung function tests involve a written record; analysis of it, calculation of the predicted value for the subject, and interpretation of the results plus a report.

The interpretation and report should include at least the specific tariffs listed under each test but the fee also covers all other measurements, interpretations and the report of them which can be derived from the test.

3) Where test is repeated after drug administration the cost of the drug is included in the benefit.

Simple spirometry, recording of FVC and FEV/1

9882*	Total	12.00
9878*	Professional component	5.95
9881*	Technical component	6.05

Forced expiration measuring FVC, FEV/1, FEV/1/FVC and MMEFR

8810*	Total	25.45
8811*	Professional component	11.20
8812*	Technical component	14.25

Repeat after drug administration, add

8850*	Total	2.85
8813*	Professional component	1.40
8814*	Technical component	1.45

The following complex lung function tests will be claimable only when done in a “designated” facility which is under the direction of an appropriately trained physician.

Flow volume loops measuring at least FVC, PEFR and Flow 50%

8815* Total 34.05

8816* Professional component..... 14.30

8817* Technical component..... 19.75

Repeat after drug administration, add

8851* Total 10.05

8818* Professional component..... 4.15

8819* Technical component..... 5.90

Measurement of lung volumes by any method and recording of RLC, FRC, and RV including airway resistance if plethysmography is used,

8820* Total 41.35

8821* Professional component..... 15.10

8822* Technical component..... 26.25

Repeat after drug administration, add

8852* Total 14.20

8823* Professional component..... 5.25

8824* Technical component..... 8.95

Simple breath Nitrogen washout curve analysis

8825* Total 30.70

8826* Professional component..... 15.15

8827* Technical component..... 15.55

Repeat after drug administration, add

8853* Total 10.15

8828* Professional component..... 5.10

8829* Technical component..... 5.05

Measurement of diffusing capacity by any method

8830* Total 30.60

8831* Professional component..... 13.70

8832* Technical component..... 16.90

Lung compliance with static pressure—volume curve

8833* Total 83.00

8834* Professional component..... 45.80

8835* Technical component..... 37.20

GAS EXCHANGE WITH OR WITHOUT EXERCISE STUDIES

Stage 1—progressive exercise testing—measurement of ventilation and cardiac response, EKG monitoring

8836* Total 58.00

8837* Professional component 22.80

8838* Technical component 35.20

With additional recording of oxygen saturation, add

8854* Total 22.25

8839* Professional component 7.65

8840* Technical component 14.60

Steady state gas exchange at rest—includes arterial blood gas collection, blood gas analysis measurement of expired gas volumes and concentrations

8841* Total 107.50

8842* Professional component 45.75

8843* Technical component 61.75

Steady state gas exchange at exercise—as above but done during steady state exercise at various levels

8844* Total 104.75

8845* Professional component 45.50

8846* Technical component 59.25

PULMONARY PROVOCATION STUDIES

Note: *1) The Notes 1, 2 and 3, under LUNG FUNCTION TESTS apply.*

2) The studies are claimable only when done in a "designated" facility which is under the direction of an appropriately trained physician.

3) The fee covers the physicians' supervision of the tests and the cost of drugs or antigens or both. It also includes any skin testing necessary for judging the starting dose of antigens administered.

4) The fee covers all possible methods and numbers of measurements and a whole session of provocation (including a pre test, test and post test measurement). Only one (1) study session of provocation per patient per day may be claimed, except that, two (2) claims may be made when there is exercise administration for asthma detection (Tariff 8860) and also cold air administration for measurement of non specific reactivity for asthma (Tariff 8863).

Exercise administration for asthma detection

8862* Total 58.25

8860* Professional component 22.70

8861* Technical component 35.55

Histamine, methacholine, cold air administration for measurement of non specific reactivity for asthma

8865* Total 59.75

8863* Professional component..... 24.20

8864* Technical component..... 35.55

Antigen administration for detection of specific reactivity for asthma

8868* Total 59.50

8866* Professional component..... 24.10

8867* Technical component..... 35.40

Antigen administration for detection of specific reactivity for allergic alveolitis

8871* Total 79.75

8869* Professional component..... 32.65

8870* Technical component..... 47.10

SLEEP STUDY

8872 Diagnostic Polysomnography—Includes continuous overnight monitoring of sleep (EEG, EOG, EMG), oxygen saturation, ECG, airflow and respiratory effort, as well as the interpretation and preparation of sleep study report. 200.00

8873 Therapeutic Polysomnography—Includes continuous monitoring of sleep (EEG, EOG, EMG), oxygen saturation, ECG, airflow and respiratory effort during which specific therapy for sleep disordered breathing is administered (this may include CPAP/BiPAP or mandibular advancement device) and the effect monitored. 100.00

8874 Multiple Sleep Latency Testing..... 100.00

Note: *1) The above are payable only for the services provided in a designated sleep laboratory (Health Science Centre; St. Boniface General Hospital; Children's Hospital, Brandon Regional Health Centre) by Specialists with training in sleep medicine or paediatric sleep studies.*

2) Special Call Premiums and After Hour Premiums may not be claimed in addition.

3) Split night diagnostic and therapeutic polysomnography provided as a one-night study claim Tariff 8872 and Tariff 8873 each at a 100%.

CARDIOVASCULAR SYSTEM

HEART AND PERICARDIUM

These benefits cannot be correctly interpreted without reference to the Rules of Application.

Note: *Numbers (1) through (4) are applicable to Manitoba Physicians only.*

1) ECGs that are performed for screening or are medically unnecessary are not insured services.

2) Neither Tariff 9837 (tracing) nor Tariff 9838 (interpretation) will be paid unless:

- *The tracing is interpreted within a period of 30 days from the time the tracing was taken, and*
- *The interpretation is conducted by a physician deemed by the College of Physicians and Surgeons of Manitoba to be qualified to interpret ECGs.*

3) The benefit for interpretation includes the written interpretation/report.

4) The benefits in this section apply to ECGs generated on equipment with a minimum capacity of 12 leads.

9836*	Electrocardiogram, with interpretation and report twelve (12) leads	20.30
9837*	without interpretation and report twelve (12) leads	10.80
9838*	interpretation and report by physician who did not take tracing twelve (12) leads	9.50
9832*	Ergometer exercise test with interpretation and report (cardiovascular assessment)	90.25
9831*	professional component	57.80
9830*	technical component	32.45
9794*	Regitine test for Pheochromocytoma	19.10
9840*	Phonocardiogram	11.85
9841*	Continuous ambulatory monitoring, professional fee for interpretation of the tapes	40.00

Note: *1) Continuous ambulatory monitoring is an insured service only when performed under the direction of an appropriately trained physician in facilities designated by the Minister which are now the Health Sciences Centre, St. Boniface General Hospital and Brandon Regional Health Centre.*

*2) The **professional portion** of this service is an insured service when provided by appropriately trained physicians in designated facilities which are now the Grace General Hospital, Misericordia Health Centre and Victoria General Hospital.*

9796*	Interpretation and written report on ECG rhythm strip or strips, including baseline reading and comparisons, by phone or direct examinations using event recorders, per event, to a maximum of three (3) per week.	3.95	

Note: *1) The above tariff(s) can only be claimed using equipment capable of recording up to three (3) events on one (1) tape, this being the equipment current in April 1989. If equipment with greater capabilities becomes available, the above tariff is not applicable and new tariffs will be negotiated.*

2) These services are only insured services when provided by appropriately trained physicians in designated facilities which are now the Health Sciences Centre and St. Boniface General Hospital (April 1989).

			UNIT VALUE
2302*	Cardiac catheterization, left heart	214.55	21.375
2304*	left heart plus right heart	269.00	21.375
2306*	Cardiac catheterization, right heart, outside the O.R. setting	143.75	21.375
2307*	Selective coronary artery arteriography	254.55	21.375
2308*	and left heart catheterization	372.00	21.375
2325*	and right heart catheterization	317.00	21.375
2327*	and both left heart catheterization and right heart catheterization	367.00	21.375
~2401*	Coronary pressure derived fractional flow reserve (Coronary FFR) per coronary vessel, add	110.00	

Note: *1) Tariff 2401 may be claimed in addition to tariffs 2307, 2308, 2325, or 2327.*

2) Coronary angioplasty (tariffs 6267, 6268, or 6269) is payable at 100% when rendered on the same day as the above

2305*	Coronary artery bypass graft angiogram including internal mammary artery implant per graft injection regardless of any number of distal anastomoses	68.85	21.375

Note: *When the above bypass angiography is done along with any other procedure, claim 50% for the bypass angiogram benefit.*

2310*	Septostomy, balloon (additional to cardiac catheterization) (independent procedure)	214.00	24.125
9842*	Circulation time	8.30	
2312*	Cardioversion, D.C. countershock, including immediate follow-up care	60.00	21.375
~2381*	Implantation or Removal of Loop Recorder	189.00	21.375
2323*	Endomyocardial biopsies, transvascular, right or left heart	178.20	24.125

Note: *When other procedures are carried out at the same sitting, fees for lesser procedures are to be claimed at 50% of the listed benefits whether or not they are asterisked.*

2316	Aortico-pulmonary window, closed repair	846.00	25.500
2318	anastomosis, Edward's repair	929.00	25.500
2320	Pott's repair	937.00	25.500
2322	Atrial septal defect, closed creation (Blalock-Hanlon procedure)	941.00	25.500

			UNIT VALUE
2324	Cardiac arrest, surgical treatment by open cardiac massage (independent procedure)	526.45	25.500

PACEMAKER

2326	Cardiac pacemaker, implantation with thoracotomy	661.45	22.750
2332	repeat implantation with thoracotomy	825.00	24.125
2309*	Insertion of temporary transvenous endocardial electrode for cardiac pacemaking	148.50	21.375
2328	Insertion of permanent transvenous endocardial electrode and implantation of pack (includes insertion of temporary transvenous electrode at same surgical procedure)	315.00	21.375
2329	Insertion of atrio-ventricular sequential dual chamber pacemaker with permanent atrial and ventricular endocardial electrodes	500.00	21.375
2330	Change of pacemaker battery (independent procedure)	189.00	21.375
2334	repeat transvenous	259.95	21.375
2345	Repositioning of endocardial electrode	262.50	21.375
2373	Removal of pacemaker pack with or without partial removal of electrodes	189.45	21.375

CARDIAC ELECTROPHYSIOLOGY

2311*	Electrophysiology Study using previously inserted electrode	257.05	21.375
2348*	Electrophysiology Study with insertion of one (1) or two (2) electrode(s)	468.35	21.375
2349*	Catheter Ablation (AV nodal as a sole procedure)	400.00	21.375
2355*	Catheter Ablation in addition to an Electrophysiology Study	215.00	21.375
2357*	Full Electrophysiology Study [insertion of three (3) or more electrodes]	1,075.00	21.375
2359*	Full Electrophysiology Study with Catheter Ablation	1,275.00	21.375
2383*	Electrophysiology/Catheter Ablation—Assistant Fee per fifteen (15) minutes or portion thereof	30.00	
2361*	Repeat Catheter Ablation at a different site, same study	112.50	21.375
2363*	Implantation of Internal Cardioverter Defibrillator including induction of arrhythmia and cardioversion when necessary	930.00	21.375
2365*	Internal Cardioverter Defibrillator Replacement without new transvenous electrode	340.00	21.375
2367*	Internal Cardioverter Defibrillator, Defibrillation Testing	370.00	21.375
2377*	Atrial lead with Internal Cardiac Defibrillator (add-on)	145.00	21.375
2379*	Implantation of dual chamber Internal Cardioverter Defribillator including induction of arrhythmia and cardioversion when necessary	1,075.00	21.375
2343*	Esophageal Electrophysiological Studies (EEP)	200.00	
	Note: *The fee for Tariff 2343 includes conscious sedation, monitoring, placement of an esophageal electrode catheter, followed by various pacing protocols.*		
2339*	Tilt Table Testing	190.00	21.375

CARDIAC SURGERY

			UNIT VALUE
2336	Cardiorrhaphy suture of heart wound or injury	688.40	25.500
2338	Cardiotomy for intracardiac foreign bodies	590.00	25.500
2340	Cardiotomy for intracardiac foreign bodies with cardiopulmonary bypass and hypothermia	846.00	25.500
2342	Mitral commissurotomy, closed	838.00	25.500
2344	Mitral commissurotomy, repeat closed	1,069.00	25.500
2350	Patent ductus arteriosus, closure—adult	839.40	24.125
2352	Patent ductus arteriosus, closure—child	643.00	24.125
2351	Transcutaneous catheter occlusion of the patent ductus arteriosis	300.00	22.750
2353	Pericardiocentesis	34.70	24.125
2360	Pericardium, biopsy (thoracotomy)	340.90	25.500
2354	Pericardial cysts or tumors, removal	804.85	25.500
2356	Pericardiectomy for constrictive pericarditis	1,600.00	25.500
2358	Pericardiotomy exploratory, with drainage, or removal of foreign bodies	639.00	25.500
2362	Pulmonary artery, banding	655.15	24.125
2364	subclavian anastomosis (Blalock)	832.05	24.125
2366	superiorcaval anastomosis (Glenn)	980.65	24.125
2486	Coarctation of the aorta—adult	1,001.60	25.500
2488	Coarctation of the aorta—child	966.00	25.500
2470	Aortic arch anomalies, vascular ring	773.00	25.500
2521	Pump assist, balloon, intra-aortic, including removal	675.00	24.125
2522	percutaneous, including removal	320.00	20.000
2523	Anesthetic basic value for removal	***By Report***	24.125
2369	**Unlisted or Unusually Complicated**	***By Report***	25.500

The following benefits are for procedures performed with cardio-pulmonary bypass and/or hypothermia. The first assistant's benefit for these procedures is 30% of full benefit.

Second and third assistant's benefit—same formula as used for first assistant in General Schedule.

Additional special services, per hour or fraction thereof 84.75

For multiple open heart procedures, an additional 50% of the listed procedural benefits will be added for each additional tariff, however, the complete pump bypass benefit will only be charged once. Notwithstanding the above, for multiple valve repair/replacement procedures, the first valve repair/replacement procedure shall be paid at 100% of the listed benefit.

The second valve repair/replacement procedure shall be paid at 75% of the listed benefit.

The third valve repair/replacement procedure shall be paid at 75% of the listed benefit.

2371 Complete pump bypass 450.00

Note: *1) To be added to applicable open heart surgical procedure, i.e. the benefit for any open heart surgical procedure will be the listed benefit plus the additional benefit for the pump bypass.*

2) Tariff 2371 may be added to other (non-open heart) procedures when applicable or may be done independent of any other surgical procedure for maintenance of circulation.

~2735 Addition of deep hypothermia circulatory arrest to cardiopulmonary bypass, add to surgical fee 400.00

~2736 Axillary cannulation for CPB with or without graft, add to surgical and bypass fee 300.00

~2737 Femoral cannulation for CPB with or without graft, add to surgical and bypass fee 200.00

			UNIT VALUE
2375	Anesthetic basic value for complete bypass when employed independent of any other surgical procedure for maintenance of circulation.	197.25	25.500
	Note: *The above service is not claimable in addition to anaesthetic basic value for surgery.*		
2370	Cardiopulmonary bypass operator	197.90	
	Note: *1) When tariff 2370 is claimed by an Anesthetist, that physician may not claim for anesthetic time for that period during which the pump is operating.*		
	2) When tariff 2370 is claimed in addition to anesthetic fees, the total anesthetic time and the pump run time should be reported on the claim form.		
2372	Anomalous pulmonary venous drainage, total correction	927.30	25.500
2376	Aortic sinus of valsalva, ruptured with fistula	1,162.00	25.500
2378	Aortic valve, replacement with prosthetic valve	1,450.00	25.500
2388	supravalvular stenosis, correction	990.00	25.500
2390	valvulotomy	865.55	25.500
~2700	Aortic valve repair (e.g. Suture or patch repair of cusp or cusps, commissurotomy, decalcification of valve or excision of valve lesion)	1,000.00	25.500
~2702	Aortic valve repair and replacement of ascending aorta with artificial graft	1,950.00	25.500
~2703	Aortic valve replacement with stentless aortic valve—subcoronary technique without coronary reimplantation	2,500.00	25.500

			UNIT VALUE
~2704	Aortic valve replacement with stentless aortic valve—full root technique with coronary reimplantation	2,800.00	25.500
~2706	Aortic valve replacement with homograft with coronary reimplantation	2,800.00	25.500
~2707	Aortic root enlargement with pericardial or synthetic patch, add to tariffs ~2700, ~2702, ~2703, ~2704 and 2378	600.00	
~2708	Aortic valve sparing root replacement (David or Yacoub) with coronary reimplantation	3,200.00	25.500
~2712	Aortic valve replacement with prosthetic valve and resection/replacement of ascending aortic aneurysm with artificial graft	2,400.00	25.500
~2713	Ascending aortic aneurysm repair and replacement of lesser curvature of aortic arch (hemi-arch replacement)	1,875.00	25.500
~2714	Plication of ascending aorta, add to surgical fee	600.00	
2392	Aorticopulmonary window, open	927.30	25.500
2394	Atrial septal defect, primum	994.85	25.500
2396	secundum suture	768.65	25.500
2398	patch	768.65	25.500
2400	plus pulmonary stenosis	886.00	25.500
2402	plus partial anomalous pulmonary drainage	876.00	25.500
~2403	Percutaneous closure of atrial septal defect or patent foramen ovale	418.55	21.375
~2738	Suture of Patent Foramen Ovale (PFO) at time of open heart operation, add to surgical fee	200.00	
2404	Atrioventricularis communis	1,071.50	25.500
2406	Coronary artery, arterioplasty, direct repair, with arterioplasty and/or endarterectomy	898.95	25.500
2407	Coronary bypass graft, single	1,200.00	25.500
2409	two (2)	1,475.00	25.500
2411	three (3)	1,715.00	25.500
2413	four (4)	1,960.00	25.500
2415	five (5)	2,200.00	25.500
2417	six (6) or more	2,313.80	25.500
2421	Arterial conduit, add on to coronary bypass graft (per arterial conduit)	195.00	
~2709	Bentall procedure with bilateral coronary reimplantation	2,800.00	25.500
~2710	Bentall procedure including one direct coronary reimplantation and one interposition graft	3,000.00	25.500

		UNIT VALUE	
~2711	Bentall procedure including bilateral interposition grafts (no direct coronary reimplanation)	3,200.00	25.500
	Note: *For tariffs ~2709, ~2710, ~2711, Bentall procedure is defined as follows:* *1) Replacement of the aortic root and the aortic valve with a composite graft-valve device and reimplantation of the main coronary arteries into the sides of the conduit.* *2) For distal coronary artery disease Coronary Artery Bypass Graft (CABG) procedure may be claimed in addition at 50%.*		
2408	Intracardiac tumor, excision	1,400.00	25.500
2410	Mitral valve, annuloplasty	1,250.00	25.500
2412	replacement	1,450.00	25.500
2405	Mitral valve repair—leaflet and/or chordal repair with annuloplasty ring	1,570.00	25.500
2418	Pulmonary valve, infundibulectomy	1,177.00	25.500
2420	patch	1,201.00	25.500
2422	valvulotomy	1,000.00	25.500
2424	Tetralogy of Fallot, complete correction	962.85	25.500
2426	with atrial septal defect	886.00	25.500
2428	with outflow patch	886.00	25.500
2430	with patent ductus arteriosus	1,025.00	25.500
2432	with previous Blalock anastomosis	1,027.45	25.500
2434	with previous Edward's anastomosis	1,025.00	25.500
2436	with previous Pott's anastomosis	1,025.00	25.500
2438	Transposition of great vessels—complete correction	1,100.10	25.500
2440	Tricuspid valve, annuloplasty and/or commissurotomy	1,240.00	25.500
2441	Tricuspid valve replacement	1,430.00	25.500
2442	Ebstein's syndrome, correction by valve replacement	886.00	25.500
2444	replacement	886.00	25.500
2448	Ventricular septal defect, repair, suture of patch	912.60	25.500
2450	plus aortic regurgitation	861.00	25.500
2452	plus corrected transposition	886.00	25.500
2454	plus patent ductus arteriosus	970.20	25.500
~2719	Repair of post infarction ventricular septal defect with or without patch	2,200.00	25.500
~2720	Ventricular aneurysm—resection and repair	1,200.00	25.500
~2721	Repair of sub-aortic left ventricular out flow tract obstruction	1,200.00	25.500
~2729	Heart transplantation including recipient cardiectomy and donor heart implant	2,500.00	25.500
~2730	Donor cardiectomy	1,000.00	25.500
~2731	Recipient cardiectomy	1,000.00	25.500

			UNIT VALUE
2456	Repeat open heart procedures; for any lesion	400.00	25.500
2159	Mediansternotomy or Thoracotomy for postoperative bleeding following cardiac or aortic surgery	332.20	25.500
~2732	Delayed closure of sternotomy wound post cardiac surgery	300.00	25.500
~2733	Repair sternal wound dehiscence/non–union minimum of one week post cardiac surgery	750.00	25.500
~2734	Debridement of sternum and mediastinum and repair of wound dehiscence minimum of one week post cardiac surgery	1,000.00	25.500
	Note: *Rule of Application 29 does not apply to tariffs ~2732, ~2733 and ~2734 i.e., A Special Report is not required.*		
2459	**Unlisted or Unusually Complicated**	***By Report***	25.500

ARTERIES

ANGIOGRAPHY—SEE ANGIOGRAPHY

2300*	Arterial puncture of blood withdrawal (independent procedure)	11.84	
2301	Continuous arterial catheter for blood gases	22.22	
2314*	Artery—cutdown for insertion of cannula or needle (independent procedure)	19.95	20.000
2317*	Biopsy—of temporal or other artery (independent procedure)	50.00	20.000
2319	Ligation of peripheral artery or arteries for hemorrhage control	***By Report***	22.750
2321	Ligation of major artery for hemorrhage control as a separate procedure	421.00	22.750

ANEURYSM, AORTA—REPAIR/RECONSTRUCTION

2458	Abdominal aorta, with grafting (tubular graft)	1,147.65	25.500
2455	aorto-femoral repair, bilateral	1,442.00	25.500
2457	aorto-iliac repair, bilateral	1,376.50	25.500
2462	Thoracic aorta, ascending	1,295.00	25.500
2464	descending	1,225.00	25.500
~2715	Aortic arch replacement—with complete island graft	2,800.00	25.500
~2716	with two (2) separate arch vessel anastamoses	3,000.00	25.500
~2717	with three (3) separate arch vessel anastamoses	3,200.00	25.500
~2718	with four (4) separate arch vessel anastamoses	3,400.00	25.500
~2722	Thoracoabdominal aortic aneurysm repair—proximal to celiac artery	2,400.00	25.500
~2723	with one (1) viceral artery anastamosis (or island)	2,600.00	25.500
~2724	with two (2) viceral artery anastamoses (or islands)	2,800.00	25.500
~2725	with three (3) viceral artery anastomoses (or islands)	3,000.00	25.500
~2726	for each anastomosis to spinal artery (ies), add to the above tariffs ~ 2722, ~2723, ~2724, ~2725 or tariff 2464	100.00	

~2727	Aortic dissectioin with or without external rupture, add to surgical fee	25% premium
~2728	Aortic aneurysm with rupture, add to surgical fee	25% premium

ANEURYSM, PERIPHERAL VESSELS—REPAIR/RECONSTRUCTION

			UNIT VALUE
Unilateral			
2463	axillary	978.00	24.125
2465	carotid	976.00	24.125
2467	common femoral	826.00	22.750
2469	innominate	929.00	24.125
2471	popliteal	1,061.50	22.750
2473	subclavian	949.00	24.125
2475	visceral	928.00	24.125

Note: *Ruptured on any of the above aneurysms, add 25%.*

ANEURYSM, TRAUMATIC—REPAIR/RECONSTRUCTION

2477	with ligation	603.90	24.125
2479	with reconstruction	988.70	24.125

ARTERIO-VENOUS FISTULA

For Hemodialysis—See Hemodialysis Section.

2481	Congenital	***By Report***	22.750
2483	Traumatic, with obliteration	563.00	22.750
2485	with reconstruction	1,014.15	22.750

ARTERIOTOMY, FOR REMOVAL OF EMBOLUS

2472	aorta	495.00	24.125
2487	axillary	401.00	24.125
2489	brachial	379.00	24.125
2491	carotid	515.00	24.125
2493	femoral	431.20	24.125
2495	iliac	510.00	24.125
2497	innominate	500.00	24.125
2499	popliteal	415.00	24.125
2501	renal	745.00	24.125
2503	superior mesenteric	808.00	24.125
2480	Carotid, artery, ligation	195.00	21.375

			UNIT VALUE
2482	Chemotherapy, by continuous arterial infusion	***By Report***	25.500
2484	by isolation perfusion	***By Report***	25.500

GRAFTING, BYPASS GRAFT

2492	abdominal aorto-tubular	932.00	25.500
2505	aorto-carotid	982.00	25.500
2507	aorto-femoral, unilateral	1,102.20	25.500
2509	bilateral or aorto-bifemoral	1,441.95	25.500
2511	aorto-femoral, with concomitant femoral (deep femoral) endarterectomy, unilateral	1,437.00	25.500
2513	bilateral	1,995.05	25.500
2515	aorto-iliac, unilateral	977.00	25.500
2517	bifurcation	1,372.10	25.500
2519	aorto-axillary, unilateral	971.00	24.125
2504	aorto-superior mesenteric	1,076.45	24.125
2525	axillary	923.00	22.750
2527	axillo-axillary, prosthetic	795.60	22.750
2531	vein	946.00	22.750
2533	axillo-femoral, unilateral	928.40	24.125
2535	bilateral	1,214.55	24.125
2537	carotid-subclavian, prosthetic	964.70	24.125
2599	vein	988.00	24.125
2572	cross-femoral—femoral prosthetic	844.00	22.750
2573	vein	1,003.70	22.750
2574	femoral-popliteal, prosthetic	844.00	22.750
2575	vein	1,107.70	22.750
2576	femoral-tibial, posterior or anterior prosthetic	932.00	22.750
2577	vein	1,314.30	22.750
2496	iliac, unilateral	1,102.20	24.125
2578	ilio-femoral, unilateral	1,050.00	24.125
2498	innominate	941.00	24.125
2579	juxta-renal, aorto-femoral	1,543.15	25.500
2500	renal, unilateral	1,154.95	24.125
2580	bilateral	1,492.00	24.125
2502	subclavian, unilateral	1,095.55	24.125
2581	bilateral	1,484.00	24.125

			UNIT VALUE
2582	subclavian—subclavian, subcutaneous, prosthetic	795.00	24.125
2583	vein	958.00	24.125

THROMBOENDARTERECTOMY (INDEPENDENT PROCEDURES)

2506	aorta	947.00	24.125
2584	aorta-iliac, unilateral	1,029.00	24.125
2585	bilateral	1,273.00	24.125
2586	axillary, unilateral	807.00	22.750
2587	aorto-ilio-femoral, unilateral	998.00	24.125
2588	bilateral	1,219.00	24.125
2508	femoral, unilateral	928.40	22.750
2510	iliac, unilateral	844.00	24.125
2512	innominate	1,005.00	24.125
2514	internal carotid	830.70	24.125
2516	renal, unilateral	1,172.85	24.125
2589	bilateral	1,435.00	24.125
2518	subclavian	1,004.40	24.125
2520	superior mesenteric	1,020.00	24.125
2590	vertebral, with or without patch graft	988.00	24.125

PROFUNDOPLASTY

2524	Extended profundoplasty with endarterectomy common femoral to 3rd branch of profunda with or without patch	844.00	22.750

WOUND OR INJURY OF MAJOR ARTERY, REPAIR

2591	aorta	1,128.80	24.125
2592	trunk vessels	1,014.05	24.125
2593	peripheral vessels, suture	379.80	22.750
2594	prosthetic graft	907.50	22.750
2595	vein graft	1,072.50	22.750
2529	**Unlisted or Unusually Complicated**	***By Report***	24.125

ARTERIAL GRAFT RE-DO OPERATIONS

INFECTED ABDOMINAL AORTIC GRAFTS

2423	Removal of total graft without reconstruction payable at 100% of the current fee listed for the initial graft	100%	25.500
2425	Removal of total graft with in situ replacement payable at 50% of the current fee listed for the initial graft	50%	25.500

			UNIT VALUE
2427	Removal of total graft with extra anatomic reconstruction payable at 75% of the current fee listed for the initial graft	75%	25.500
2429	Removal of one (1) limb segment only payable at 50% of the current fee listed for the initial graft	50%	24.125

Note: *Above procedures apply to tariffs 2458, 2455, 2457, 2509.*

Initial graft procedure tariff number should be submitted on claim in notes or remarks area.

Reconstruction at same operation is payable at 100% of the appropriate service tariff.

INFECTED EXTREMITY PROSTHETIC GRAFTS

2431	Ilio-femoral, axillo-femoral or cross-femoral graft removal payable at 75% of the current fee listed for the initial graft	75%	24.125
2433	Removal of graft, femoral, popliteal, tibial payable at 50% of the current fee listed for the initial graft	50%	22.750

Note: *Above procedures apply to tariffs 2578, 2533, 2535, 2527, 2574, 2576, 2572, 2582.*

Initial graft procedure tariff number should be submitted on claim in the notes or remarks area.

Reconstruction at same operation is payable at 100% of the appropriate service tariff.

INTESTINAL PROSTHETIC FISTULA

2435	Direct repair of aorta with or without omental coverage (no graft reconstruction)	955.00	25.500
2437	Intestinal repair—with or without resection (same as small bowel resection) when done by second surgeon	570.00	25.500
2439	intestinal repair when done by same surgeon, add.	427.50	

Note: *For graft removal and repair see infected grafts.*

ANASTOMOTIC ANEURYSM

Graft Replacement of Anastomotic Aneurysm include thrombectomy and repair.

2443	Aortic or iliac anastomotic aneurysm add 25% to appropriate service tariffs	Add 25%	25.500

Note: *Above procedure applies to tariffs 2458, 2455, 2457, 2509.*

Lower Extremity—Femoral, Popliteal, Tibial

2447	femoral anastomotic aneurysm repair—(pay at 50% when done with aorta-femoral repair)	826.00	22.750
2449	anastomotic aneurysm at other sites: pay same as repair of primary aneurysm at that site		22.750
2451	repair of ruptured aneurysm add 25% of the current fee assigned to site involved	Add 25%	25.500

Graft Thrombosis after Six (6) Weeks—Post op

2453	aortic graft limb thrombectomy with revision of anastomosis or graft replacement	844.00	25.500

Lower Extremity—Femoral, Popliteal, Tibial

			UNIT VALUE
2461	graft thrombectomy with revision of anastomosis.	500.00	24.125
2466	graft thrombectomy only	431.20	21.375

Reoperation within Two (2) Weeks—Post op

2468	abdominal graft—graft or anastomotic bleeding post-op	400.00	25.500
2474	extremity graft—graft or anastomotic bleeding post-op	200.00	22.750

Graft Thrombosis—within Six (6) Weeks Post-op

2476	thrombectomy with or without revision payable at 25% of the current fee listed for the initial procedure	25%	24.125

HEMODIALYSIS ARTERIO—VENOUS FISTULA

Revisions [after six (6) weeks post-op]

PROSTHETIC GRAFT FISTULA (3801)

2608	Patch angioplasty prosthesis—artery or vein anastomosis with or without thrombectomy (75% of 3801)	314.20	21.375
2619	Patch angioplasty or revision prosthesis vein and artery anastomosis with or without thrombectomy (same as 3801)	418.90	21.375
2620	Prosthesis graft thrombectomy—only (50% of 3801)	209.45	21.375
2621	Prosthetic graft replacement with or without graft excision or graft thrombectomy (same as 3801)	418.90	21.375
2622	Prosthetic graft excision with closure of artery and vein anastomosis (e.g. infected graft or false aneurysm—75% of 3801)	314.20	21.375
2623	Banding for steal syndrome (50% of 3801)	209.45	21.375
2624	Interposition graft (100% of 3801)	418.90	21.375

AUTOGENOUS ARTERIO-VENOUS FISTULA (3800)

2625	Brachial basilic with transposition	680.00	21.375
2626	Banding for steal syndrome (3800 x 50%)	197.00	21.375
2627	Revision of, or new anastomosis artery or vein with or without thrombectomy (3800 x 75%)	295.00	21.375
2628	Revision of, or new anastomosis artery and vein with or without thrombectomy	394.00	21.375
2629	Closure of fistula with direct repair of artery	295.50	21.375
2630	Ligation of vein and/or artery for closure of fistula (3800 x 25%)	98.50	21.375
2632	Excision of venous aneurysm without repair (3800 x 50%)	197.00	21.375
2633	Excision of arterial aneurysm without repair (3800 at 50%)	197.00	21.375
2634	Interposition autogenous graft (3800 at 100%)	394.00	21.375

VEINS

INVESTIGATION—SEE VENOGRAMS

Add 50% to fee payable for procedural fees when patient is less than two (2) years of age. Premium applies to tariffs 9822, 9823, 9825, 9826, 9828 and 9833.

INCISION

8957*	Intravenous (injection)	7.50	
2560	Intravenous therapy, establishment	22.22	
	Note: *This fee may not normally be charged by a physician who has charged for a visit or anesthetic that day or a block fee for a surgical procedure. It is to be charged only in emergency situations, or when a physician with special experience (e.g., Anesthetist) has to perform the procedure because of exceptional difficulties.*		
			UNIT VALUE
2561*	Phlebotomy, therapeutic	9.60	
9833*	Cutdown for insertion of needle or cannula (independent procedure)	20.15	20.000
9834*	Vein—insertion of venous pressure catheter and including venous pressure measurements (independent procedure) percutaneous	37.03	
9835*	exposure and incision of vein	28.40	20.000

CATHETERIZATION FOR CHEMOTHERAPY, HYPERALIMENTATION OR HEMODIALYSIS

9822	Centrally positioned catheter inserted by stab techniques with six (6) weeks care of the catheter and wound, including replacement if required (independent procedure)	65.25	20.000
9823	Partially buried, centrally positioned catheter with Dacron cuff, (e.g. Broviac, Hickman, Cook) with six (6) weeks care of the catheter and wound including replacement, if required (independent procedure)	176.00	20.000
9824	Replacement in a new site within six (6) weeks of insertion	51.50	20.000
9825	Removal of a partially buried catheter which had been centrally placed after six (6) weeks of insertion, or of revision, or of replacement	34.10	20.000
9826	Insertion of a totally buried catheter with subcutaneous reservoir including replacement if necessary and six (6) weeks care of the wound (e.g., Portacath) with catheter located in a central vein or peritoneal cavity	176.00	20.000
9827	Revision of above after six (6) weeks of insertion	63.25	20.000
9828	Removal after six (6) weeks from insertion	52.25	20.000
	Note: *Physicians supervising T.P.N. are to claim concomitant care for those days in which they attend the patients.*		
2536	Pulmonary, embolectomy (with cardiac bypass)	1,209.00	25.500
2541	Thrombectomy for vena cava	434.15	22.750
2543	for iliac vein	429.00	22.750
2545	for common femoral	382.00	22.750
2547	on either one (1) of these veins with additional ligation of the vena cava	737.00	22.750

REVISION AND REPAIR

			UNIT VALUE
2528	Ligation, femoral vein	166.00	20.000
2530	iliac vein	331.00	20.000
2532	inferior vena cava	393.00	22.750
2534	Plication, inferior vena cava	387.00	22.750
2538	Shunt porto-caval	1,058.00	24.125
2540	spleno-renal	1,155.60	24.125
2539	meso-caval (with or without graft)	988.00	24.125
2552	Wound or injury of major vein, suture, trunk	394.00	24.125
2554	extremity	129.50	22.750
2526	Insertion of endovenous filter by transcutaneous catheterization—Greenfield umbrella or filter	145.00	20.000
2569	**Unlisted or Unusually Complicated**	***By Report***	25.500

VARICOSE VEINS—ITEMS INCLUDE THE LOCAL ANESTHETIC

INCISION

2313*	Varicose vein injection	13.50	
2544	maximum accumulative benefit, per leg (including Fegan techniques)	199.50	
2549*	Incision and ligation or avulsion of varicose veins under local or general anaesthetic at any one (1) sitting, initial vein	14.90	20.000
2551*	each additional	10.30	
2598	maximum accumulative benefit, per leg	206.80	20.000

REVISION AND REPAIR

2546	Long saphenous vein at saphenofemoral junction, ligation and division with or without retrograde injection or distal interruptions	152.35	20.000

RESECTION

2550	Long or short saphenous vein, ligation and division and complete stripping	238.10	20.000
2548	Long and short saphenous vein, ligation and division and complete stripping	320.70	20.000
2553	Linton or Cockett's procedure	301.00	20.000
2555	with complete stripping	400.00	20.000

ANGIOGRAMS

Procedural Services

Note: *1) These procedural benefits are intended to cover compensation for the professional service of placing an instrument and introducing contrast media (except in excretion studies of the biliary and renal tracts, and oral or rectal administration for study of the alimentary canal).*

2) The same benefits may be charged for similar services associated with diagnostic physiological studies of non-radiological nature, for example, catheterization for physiological sampling or the transmission of pressure, sound or electrical waves or the therapeutic injection of drugs.

3) For Angiography procedures, introduction may be made by:

- *Percutaneous needle or cutdown on superficial peripheral vein.*
- *Percutaneous catheter or cutdown on peripheral vein.*
- *Exposure of major artery.*

4) In Column C ONLY; when two (2) or more examinations are done on the same patient on the same day, 50% of the benefits of the others are paid, and if bilateral, 75% of the others are paid.

"Selective" means instrument passed deliberately into branch, tributary or cardiac chamber.

COLUMN C: Represents the additional benefit for the professional procedural portion of the examinations and is separate and distinct from the professional supervisory and interpretative benefits of Column Pro.

ANGIOGRAPHY

AORTOGRAMS

		COLUMN C	UNIT VALUE
6200	Abdominal	120.00	20.000
6201	Arch	68.00	20.000
6202	Intravenous	71.50	20.000
6203	Thoracic	75.35	20.000
6204	Translumbar	68.00	20.000
6205	Other—specify	71.00	20.000

For two (2) examinations done on same patient, same day—See NOTE 4

SELECTIVE ANGIOGRAMS

		COLUMN C	UNIT VALUE
6210	Adrenal arteriogram	98.75	20.000
6211	Angiographic examination dialysis shunt	98.75	20.000
6212	Axillary	105.00	20.000
6213	Brachial	102.00	20.000
6208	Cerebral (brachial retrograde)	106.50	20.000
6214	Bronchial	102.50	20.000
6215	Carotid	118.15	20.000
6216	Celiac	118.15	20.000
6217	Common iliac	102.00	20.000
6229	Popliteal, with antegrade catheterization	103.50	20.000
6218	External carotid arteriogram	102.00	20.000
6219	Hepatic	102.00	20.000
6220	Inferior mesenteric	102.00	20.000
6221	Innominate	102.00	20.000
6222	Internal iliac	102.00	20.000
6223	Renal	118.15	20.000
6224	Superior mesenteric	118.15	20.000
6225	Subclavian	102.00	20.000
6226	Splenic	102.00	20.000
6227	Vertebral	118.15	20.000
6228	Transcatheter therapy, embolization, any method	231.00	22.750
6235	Bilateral selective angiogram or venogram	206.00	20.000
6206	Internal mammary	105.15	20.000
6207	Left gastric	105.15	20.000
6209	Gastroduodenal	105.15	20.000
6231	Internal carotid	105.15	20.000
6232	Super selective angiogram (e.g., Distal branch of any of the above selective)	123.00	20.000
	For two (2) examinations done on the same patient, same day—See NOTE 4.		

FEMORAL ARTERIOGRAMS

6230	Unilateral	120.00	20.000
	bilateral—See NOTE 4		

VENOGRAMS

		COLUMN C	UNIT VALUE
6236	Azygogram	71.50	20.000
6237	Femoral	69.00	20.000
6238	Iliac	66.50	20.000
6239	Inferior vena cavogram	100.00	20.000
6240	Intraosseous	71.50	20.000
6241	Jugular	67.50	20.000
6242	Lower limb	68.00	20.000
6243	Subclavian	68.00	20.000
6244	Superior vena cavogram	68.00	20.000
6245	Umbilical vein catheterization	71.50	20.000
6246	Upper limb	68.00	20.000
6247	Orbital venogram	71.50	20.000
	For two (2) examinations done on same patient, same day—See NOTE 4		

SELECTIVE VENOGRAMS

6250	Adrenal	103.50	20.000
6251	Hepatic	106.50	20.000
6252	Jugular	105.00	20.000
6253	Renal	102.00	20.000
6235	Bilateral selective angiogram or venogram	206.00	20.000
	For two (2) examinations done on same patient, same day—See NOTE 4		

ANGIOGRAPHY

6255	By exposure of major vein, abdominal or thoracic	138.50	20.000
6256	cerebral	163.00	20.000

ANGIOCARDIOGRAMS

6260	Atrial, left	196.50	21.375
6261	right	150.50	21.375
6262	Pulmonary angiogram	161.30	21.375
6263	Selective coronary angiogram	270.30	21.375
6264	with left and/or right heart catheterization	327.00	21.375
6265	Ventricular, left	217.45	21.375
6266	right	161.30	21.375

		COLUMN C	UNIT VALUE
6267	Percutaneous transluminal balloon coronary angioplasty including angiography with or without pressure measurements on one (1) or more sites on a single coronary artery	560.00	21.375
6268	on two (2) coronary arteries (i.e., right and circumflex, or right and anterior descending, or circumflex and anterior descending)	775.00	21.375
6270	on three (3) coronary arteries, right, circumflex, and anterior descending	990.00	21.375

Note: *1) Tariffs 6267, 6268 and 6270 include associated angiograms at the time of the procedure and pressure measurement, aortography, pacemaker adjustments including connecting to a guide wire, cardioversion, and continuing care during that hospital admission.*

2) Only one (1) of the three tariffs (6267, 6268 or 6270) can be claimed for one (1) sitting.

3) If a patient does not have a pacemaker and one has to be inserted at the time, such will be paid for at 50% notwithstanding the fact that the benefit is asterisked.

6278	Insertion of stent(s) in single (1) coronary artery	112.00	
6279	Insertion of stent(s) in two (2) coronary arteries	155.00	
6280	Insertion of stent(s) in three (3) coronary arteries	198.00	

Note: *The fees for tariffs 6278, 6279 and 6280 shall be equivalent to 20% of the fees for tariffs 6267, 6268, 6270 respectively.*

6271	Aortic balloon valvuloplasty	370.00	24.125
6272	Coarctation balloon valvuloplasty	370.00	24.125
6273	Pulmonary balloon valvuloplasty	436.00	24.125
6274	Mitral valve balloon valvuloplasty	488.00	24.125
6275	Pulmonary artery stenosis, first vessel	410.00	24.125
6276	each additional vessel	102.50	24.125

Note: *Each of the above tariffs 6271, 6272, 6273, 6274, 6275, and 6276, includes angiographs, pressure measurements, aortography, pacemaker adjustments, cardioversion and care during that admission.*

6269	**Unlisted or Unusually Complicated**	***By Report***	21.375

HEMIC AND LYMPHATIC SYSTEMS

These benefits cannot be correctly interpreted without reference to the Rules of Application.

Add 50% to fee payable for procedural fees when patient is less than two (2) years of age. Premium applies to tariffs 2691 and 2693.

LYMPH NODES

INVESTIGATION

			UNIT VALUE
2643*	Cervical lymph node biopsy (independent procedure)	107.95	20.000
2642*	Anterior scalene dissection (independent procedure)	110.50	21.375
2644*	Axilla lymph node biopsy (independent procedure)	85.15	20.000
2641*	Other nodes biopsy (independent procedure)	65.00	20.000
0438	Sentinel lymph node biopsy in breast neoplasm	300.00	21.375

Note: *1) When one (1) or more of the procedures (0438, 0442, 0457, 0443, 0471, 2658) are performed by the same surgeon under the same anesthetic in addition to sentinel lymph node biopsy, the procedure with the highest fee shall be paid at 100% and the remaining procedures at 75%.*

2) When more than one (1) lymph node basin identified as having a sentinel node (separate surgical site) at the same anesthetic—claim 2nd sentinel at 75% in addition.

3) Completion of axillary node dissection following a positive sentinel node biopsy on final pathological diagnosis not at the same anesthesia—claim Tariff 2658 at 100% regardless of time interval.

2645	Sentinel lymph node biopsy in melanoma	250.00	21.375

Note: *1) With wide excision when one (1) or more procedures are performed by the same surgeon under the same anesthetic in addition to sentinel lymph node biopsy, the procedure with the highest fee shall be paid at 100% and the remaining procedures at 75%.*

2) When more than one (1) lymph node basin identified as having a sentinel node (separate surgical site) at the same anesthetic—claim 2nd sentinel at 75% in addition.

3) Completion of lymphadenectomy following a positive sentinel node biopsy on final pathological diagnosis not at the same anesthesia—claim Tariff 2658 or Tariff 2672 at 100% regardless of time interval.

3582	Staging laparotomy for lymphoma with retroperitoneal node dissection and dissection of porta hepatis	505.00	22.750
3583	two (2) or more liver biopsies, add	60.25	22.750
3584	splenectomy, add	210.00	22.750
3585	lateral ovary transposition, add	101.50	22.750
3586	medial ovary transposition, add	58.75	22.750
3587	open iliac crest biopsy, add	100.50	22.750

INCISION

			UNIT VALUE
2631*	Abscess of lymph node, simple drainage	21.65	20.000

REVISION AND REPAIR

2696	Thoracic duct repair	595.00	24.125

RESECTION

2665	Lymphadenectomy, cervical, radical, unilateral	840.00	22.750
2676	suprahyoid, unilateral	353.00	21.375
2678	bilateral	424.00	21.375
2658	axilla, radical	460.00	21.375
2672	inguinal, superficial	353.00	20.000
2652	iliac, deep	547.75	22.750
2674	retroperitoneal, including pelvic, aortic and renal dissection	718.45	22.750
2675	staging pelvic lymphadenectomy for prostate cancer	492.40	22.750
2666	Modifed Radical Neck Dissection including removal of all cervical lymph nodes (level 1-5 inclusive) with preservation of any or all of the sternocleidomastoid muscle, the internal jugular vein and the accessory nerve	1,200.00	22.750
2699	**Unlisted or Unusually Complicated**	***By Report***	22.750

SPLEEN

INVESTIGATION

2602*	Needle biopsy	48.80	20.000
2603	Biopsy of spleen when exposed at other operations	29.75	

REPAIR

2604	Suture repair or partial splenectomy (excluding intraoperative trauma)	***By Report***	24.125

RESECTION

2601	Splenectomy	630.00	22.750
2609	**Unlisted or Unusually Complicated**	***By Report***	24.125

MEDIASTINUM

INVESTIGATION

			UNIT VALUE
2684*	Mediastinoscopy	252.00	21.375
2685*	Mediastinoscopy with bronchoscopy or esophagoscopy, or gastroscopy with or without biopsy	350.00	22.750
2687	Bronchoscopy, mediastinoscopy and left anterior mediastinotomy	418.15	22.750

RESECTION

2691	Mediastinal cyst excision	612.00	24.125
2693	Mediastinal tumor excision	836.60	24.125
2686	Thymectomy	744.85	25.500
2689	**Unlisted or Unusually Complicated**	***By Report***	25.500

DIGESTIVE SYSTEM

These benefits cannot be correctly interpreted without reference to the Rules of Application.

Add 50% to fee payable for procedural fees when patient is less than two (2) years of age. Premium applies to tariffs 3067, 3105, 3133, 3135, 3141, 3172, 3174, 3179, 3191, 3195, 3201, 3231, 3235 and 3226.

LIPS

INVESTIGATION

2753*	Biopsy of lip	9.55	

INCISION

			UNIT VALUE
2752*	Abscess of lips, drainage	13.30	20.000

REVISION AND REPAIR

2754	Cleft lip repair, primary, unilateral	526.60	21.375
2758	bilateral, one (1) stage	512.00	21.375
2759	two (2) stages—per stage	366.00	21.375
2762	secondary repair by creation of defect and re-closure, unilateral	425.00	21.375
2765	bilateral, per major stage	356.00	21.375

RESECTION

2741	V excision of lip, less than 1/3	123.00	21.375
2743	1/3 to 1/2	180.00	21.375
2742	Vermilionectomy—(lip peel)	274.00	21.375
2746	Resection of more than 1/2 the lip without plastic closure	174.00	21.375
2769	**Unlisted or Unusually Complicated**	***By Report***	21.375

MOUTH

INVESTIGATION

2819*	Biopsy of cheek or gum mucosa	21.30	20.000
4908*	Needle biopsy of neck masses	25.25	

INCISION

2815*	Abscess, alveola, gum or cheek intraoral drainage	13.00	24.125
2705*	Ludwig's angina, external drainage	68.05	24.125

RESECTION

			UNIT VALUE
2790	Malignant intraoral lesion with incontinuity neck dissection	1,500.00	22.750
2788	Malignant intraoral lesion with incontinuity neck dissection and resection of mandible	1,700.00	24.125
2799	**Unlisted or Unusually Complicated**	***By Report***	24.125

TONGUE

INVESTIGATION

2781*	Biopsy anterior 1/3	21.65	20.000
2783*	Posterior 2/3	35.10	21.375

INCISION

2701*	Lingual or sublingual abscess drainage	13.65	21.375
2775*	Thyroglossal duct abscess drainage	21.70	21.375

REVISION AND REPAIR

2786	Tongue tie, incision of frenulum under local or general anesthetic (tongue tie in infant included in visit)	29.25	20.000

RESECTION

2784	Benign or small malignant tumor under 1.5 cm. local or general anesthetic	123.00	21.375
2785	Partial glossectomy for lesions over 1.5 cm.	279.00	22.750
2787	Total glossectomy	509.00	22.750
4941	Thyroglossal duct, cyst or sinus excision	386.40	21.375
2789	**Unlisted or Unusually Complicated**	***By Report***	22.750

PALATE

INVESTIGATION

2881*	Biopsy palate	21.30	20.000

INCISION

2871*	Palate abscess drainage	13.50	21.375

REVISION AND REPAIR—CLEFT PALATE

2891	Alveolar ridge anterior palate defect	193.50	21.375
2892	Complete, including alveolar ridge	554.75	22.750
2890	partial	356.00	22.750

			UNIT VALUE
2895	Major revision complete cleft	519.00	22.750
2894	Major revision partial cleft	356.00	22.750
2897	Secondary lengthening	478.00	22.750
2898	Pharyngoplasty—attachment of pharyngeal flap to palate	356.00	22.750

RESECTION

2885	Palate lesion resection	374.00	21.375
2887*	Uvulectomy	21.30	21.375
2888*	Complete assessment of cleft palate function including complete history and physical examination, video and audio recordings, local nasal and pharyngeal anesthesia and nasendoscopy	62.50	
2899	**Unlisted or Unusually Complicated**	***By Report***	22.750

PHARYNX

INVESTIGATION

2981*	Biopsy nasopharynx	34.65	21.375
2982*	oropharynx	21.30	21.375
2980*	hypopharynx	35.95	21.375

INCISION

2979*	Peritonsillar abscess drainage	88.45	24.125
2971*	Retropharyngeal or parapharyngeal abscess, intraoral or extra-oral drainage	97.75	24.125

REVISION AND REPAIR

2994	Hemorrhage post-tonsillectomy	96.50	24.125
3021	Pharynx wound repair	***By Report***	22.750
3077	Pyriformotomy (independent procedure)	97.00	22.750
3011	Pharyngoplasty—reconstructive operation on pharynx	***By Report***	22.750
2883	Uvulopalatopharyngoplasty (UPPP) with or without tonsillectomy or other pharyngeal surgery	374.00	22.750

Note: *UPPP is an insured service when sleep apnea has been confirmed by a provincial sleep laboratory study and there is evidence of an anatomical problem of the oral pharynx amenable to surgical correction.*

RESECTION

2975	Nasopharyngeal fibroma	***By Report***	21.375
2989	Branchial cleft cyst or sinus, subcutaneous	110.50	20.000
2990	deep	529.50	20.000
2987	Pharyngeal diverticulum resection and/or crico-pharyngeal myotomy	465.45	22.750

			UNIT VALUE
2996	Adenoidectomy alone	118.85	21.375
2992	Tonsillectomy with or without adenoidectomy or uvulectomy, child under thirteen (13) years	207.40	21.375
2993	adult	211.15	21.375
2997*	Tonsil tag, local anesthesia	9.45	
2998*	general anesthesia	28.40	21.375
2889	**Unlisted or Unusually Complicated**	***By Report***	22.750

SALIVARY GLAND AND DUCTS

INVESTIGATION

2921*	Biopsy salivary gland	35.95	21.375

INCISION

2915*	Submaxillary or parotid duct calculus, uncomplicated, intraoral removal, office procedure	49.65	21.375
2919	difficult, intraoral removal in hospital	118.80	21.375
2916	Parotid calculus, extra-oral removal	178.00	21.375
2918*	Submaxillary or parotid abscess drainage	79.15	21.375

REVISION AND REPAIR

2961*	Salivary duct dilation	7.80	21.375
2941	plastic repair	238.00	21.375
2951	Salivary fistula closure	275.00	21.375
2950	Rerouting of submandibular ducts	336.80	21.375

RESECTION

2930	Submaxillary tumor and/or gland excision	384.95	21.375
2925	Superficial parotid tumor, excision without nerve dissection	141.00	21.375
2927	Superficial parotid lobectomy with nerve dissection	750.00	21.375
2934	Total parotid excision with facial nerve dissection	1,031.00	22.750
2937	with facial nerve sacrifice	787.50	22.750
2949	**Unlisted or Unusually Complicated**	***By Report***	22.750

ABDOMEN

INVESTIGATION

			UNIT VALUE
3572*	Laparoscopy, diagnostic	145.65	21.375
3574*	Laparoscopy, diagnostic when followed at the same sitting by an open abdominal operation, add	70.00	21.375
3589*	Abdominal lavage for trauma	28.00	
3577	Laparotomy for trauma	460.00	22.750
	Note: *Laparotomy for trauma includes complete exploration of intraperitoneal and retroperitoneal structures including hematoma and evacuation of blood and control of bleeding from minor vessels. [When one or more abdominal procedures are performed by the same surgeon in addition to laparotomy for trauma, the procedure with the highest fee (including tariff 3577) shall be paid at 100%, and the remaining procedures (including tariff 3577) shall be paid at 50%.]*		
3571	Exploratory laparotomy	360.00	22.750
3594	Second look procedure after ischemic bowel resection	204.00	22.750

INCISION

3588*	Abdominal paracentesis, initial	46.25	
3590*	subsequent	44.80	
3573	Abscess, intra-abdominal drainage including subphrenic and pelvic abscess exclusive of appendicular	395.00	22.750
3285	Transrectal abscess drainage	110.50	21.375
3575	Subphrenic abscess drainage	353.00	22.750

REVISION AND REPAIR

3668	Omphalocele first stage or subsequent stage regardless of when performed	530.00	22.750
3663	Epigastric hernia, initial	280.00	21.375
3664	recurrent	315.00	21.375
3666	Umbilical hernia	305.00	21.375
3661	Ventral hernia, incisional repair with or without prosthesis includes enterolysis (independent procedure)	550.00	21.375
3660	Ventral hernia—massive incisional—with or without enterolysis, with or without prosthesis (independent procedure)	700.00	22.750
3646	Femoral hernia, initial	279.40	20.000
3651	recurrent	360.95	21.375

			UNIT VALUE
3631	Inguinal hernia, initial	321.30	20.000
3632	pediatric with negative contralateral exploration	340.70	20.000
3636	with excision of hydrocele and/or orchiectomy	385.00	20.000
3635	recurrent	410.00	21.375
3633	Incarcerated hernia without bowel resection	400.00	21.375
3734	Wound disruption (postop), secondary suture	200.00	22.750
3591	Peritoneo-venous shunt, placement	421.60	21.375
3592	removal for infection	238.05	21.375
3593	removal and replacement of valve for blockage	177.50	21.375
3707	Diaphragm (transabdominal or thoracic), rupture, early repair	591.00	24.125
3708	diaphragm hernias excluding anti-reflux surgery	686.65	25.500
3706	with prosthesis, add	250.00	

RESECTION

~3595	Abdominal lipectomy—small (vertical skin resection up to 15 cm.)	220.00	21.375
~3596	Abdominal lipectomy—large (vertical skin resection 15 cm. to 30 cm.)	460.00	21.375
~3597	Abdominal lipectomy—massive (vertical skin resection over 30 cm.)	960.00	21.375

Note: *These procedures have certain restrictions under the Regulations when done as elective surgery. To be certain that the case is covered, written approval from the Minister should be obtained before the procedure is undertaken.*

3580	Retroperitoneal or transperitoneal tumor or cyst; excision	505.00	22.750
3619	**Unlisted or Unusually Complicated**	***By Report***	22.750

ENDOSCOPY

ESOPHAGUS

3055*	Esophagoscopy, diagnostic, with or without biopsy	100.00	21.375
3063*	subsequent, same hospital admission	68.00	21.375
3060*	with bronchoscopy	99.85	22.750
3057	with foreign body removal	165.00	21.375
3065*	with injection of varices or band ligation	148.50	21.375

STOMACH

3121*	Gastroscopy, diagnostic with or without biopsy	101.85	21.375
3122*	with polypectomy	169.05	21.375
3123*	Esophagogastroduodenoscopy (EGD) with or without biopsy	105.80	21.375

SMALL INTESTINE

		UNIT VALUE
3190*	Small bowel enteroscopy by mouth using designated enteroscope or colonoscope.....200.00	21.375
	Note: *Pathology report may be required.*	
3192	Capsule Endoscopy–Includes the review of imaging of the small bowel and report to the referring physician.....300.00	
	Note: *1) A visit cannot be claimed at the same sitting as the initiation of capsule endoscopy.*	
	2) Minimum time for the service is one (1) hour including the assessment of referrals to determine indication for procedure.	
	3) Patients will have previously undergone some or all of the following: Esophagogastroduodenoscopy (EGD), colonoscopy, small bowel enteroscopy and/or small bowel series–radiography & fluoroscopy.	
	4) Payable only for services provided by a Gastroenterologist at a facility to be designated by Manitoba Health (Health Science Centre).	

COLON AND APPENDIX

3185*	Colonoscopy.....160.20	21.375
3186*	with biopsy 169.10	21.375
3187*	with polypectomy using snare 249.20	21.375
3189*	with polypectomy using electro-cautery device 236.80	21.375
3188*	more than one (1) polyp removed at the same sitting, add to 3187 or 3189 for each to a maximum of four (4) additional polyps, (using snare or electro-cautery device).....59.60	21.375

RECTUM

3311*	Proctosigmoidoscopy, rigid or flexible up to 25 cm., alone.....37.80	20.000
3313*	with biopsy 35.50	20.000
3315*	Proctosigmoidoscopy, with removal of single lesion.....40.25	20.000
3317*	multiple lesions.....60.25	20.000
3319	complicated for hemorrhage control or removal of foreign body.....***By Report***	20.000
3320*	flexible sigmoidoscopy between 25 cm. and 65 cm., with or without biopsy 77.50	20.000
3323*	without biopsy, with removal of a single polyp.....100.00	20.000
3324*	more than one (1) polyp removed at the same time, add $22.90 for each to a maximum of four (4) additional polyps..... 22.90	
	Note: *The following may be claimed in addition to tariffs 3123, 3121, 3055, 3060, 3065, 3185, 3186, ~3020, ~3022:*	
3000*	Balloon dilatation of colonic, pyloric, esophageal or small bowel strictures, add 69.35	21.375
3002*	Botox injection, add 43.05	21.375
3004*	Hemostasis G. I. Tract by any endoscopic method or technique (e.g., cautery, injection, banding), add.....83.00	21.375

			UNIT VALUE
3006*	Hemodynamic instability, add	50.00	24.125
	Note: *Claim, forTariff 3006, must indicate that the patient exhibits one (1) or more of the following: Pulse Rate >100/minute; Blood pressure <80 systolic; hemoglobin <80; On-going bleeding.*		
3008*	Placement of jejunal or small bowel feeding tube beyond pyloris, add	50.00	20.000

ENDOSCOPIC ULTRASOUND

Payable only for echo-endoscope or mini-probe services provided by gastroenterologist at a facility designated by Manitoba Health, which are now at Health Science Center and St. Boniface General Hospital.

Echo-Endoscope

~3020	Endoscopic ultrasound using linear or radial echo-endoscope excluding biliary or pancreatic examination	200.00	22.750
~3022	Endoscopic ultrasound using linear or radial echo-endoscope including biliary and/or pancreatic examination	250.00	22.750
	Note: *Tariff ~3024 through Tariff ~3036 may be claimed in addition toTariff ~3020 or Tariff ~3022.*		
~3024	Fine needle aspiration, to a maximum of five (5) per lesion, add	50.00	
~3026	Core needle biopsy, per lesion, to a maximum of two (2), add	50.00	
~3028	Fine needle aspiration of pancreatic cyst with removal of cyst fluid, including fine needle aspiration of cyst wall, add	150.00	
~3030	Injection into one or more of the following–metastases, nodes, masses, or celiac plexus, add	140.00	
~3034	Cap-assisted endoscopic mucosal or sub-mucosal resection, add	100.00	
~3036	Endoscopic ultrasound assisted drainage of pancreatic pseudocyst including stent insertion, add	200.00	

Note:

1) *Tariff ~3020 may not be claimed with Tariff ~3022 for the same sitting.*

2) *EGD, Gastroscopy, Flexible Sigmoidoscopy or Colonoscopy (Tariffs 3123, 3121, 3320, or 3185) may not be claimed in addition toTariff ~3020 or Tariff ~3022 unless the endoscopy is required due to the limited visualization with the linear or radial echo-endoscope.*

3) *EGD, Gastroscopy, Flexible Sigmoidoscopy or Colonoscopy (Tariffs 3123, 3121, 3320, or 3185) may be claimed on the same day as Tariff ~3030 or Tariff ~3022 if the endoscopic examination is clinically indicated and precedes the echo-endoscopic examination.*

4) *Patients will have previously undergone examinations of the upper/lower G.I. e.g. endoscopy or Radiological studies (MRI, CT Contrast).*

Mini Probe

Note: *The following may be claimed in addition to endoscopy Tariffs 3123, 3121, 3320 or 3185.*

~3038	Endoscopic ultrasound, radial or linear mini probe through endoscope to endoscopy fee, add	100.00	22.750

Note: *~3020, ~3024, ~3026 or ~3034 may be claimed in addition to ~3038.*

Miscellaneous Doppler Studies

~3039 Where doppler is used as an additional diagnostic modality on any endoscopic ultrasound procedure, add 20.00

Note: *The above tariff ~3039 may be claimed in addition to tariffs, ~3020, ~3022, and ~3038 .*

ESOPHAGUS

INVESTIGATION

3064 Esophageal motility test 30.30

INCISION

			UNIT VALUE
3075	Cervical esophagostomy (external fistulization of esophagus)	421.00	21.375
3031	Cervical esophagotomy with or without foreign body removal	390.00	21.375
3033	Transthoracic esophagotomy with or without foreign body removal	529.00	22.750

REVISION AND REPAIR

3098*	Stricture of esophagus, dilatation, indirect with wire or thread, initial	49.35	21.375
3099*	dilatation, indirect with wire or thread, subsequent	29.95	21.375
3094*	Wire-Guided esophageal dilatation requiring general anesthetic and fluoroscopy, including esophagoscopy	172.25	21.375
3095	Esophagoscopy with dilatation with pneumatic balloon for stricture or achalasia	174.35	21.375
3092*	simple dilatation with bougie or sound	50.00	21.375
3093	Esophageal dilatation with bougie under general anesthetic	100.00	21.375
3066	prosthesis, endoesophageal tube insertion for malignant stricture	500.00	21.375
3072	cardioplasty, esophagogastric for stricture	541.00	24.125
3096*	Achalasia, dilatation of cardia, initial (pneumatic)	103.60	21.375
3097*	dilatation of cardia, subsequent	50.50	21.375
3076	esophagomyotomy (Heller procedure)	527.00	24.125
3710	Hiatus hernia (anti-reflux surgery), transabdominal	680.00	22.750
3709	transthoracic	723.00	24.125
3068	direct ligation	550.00	24.125
3050*	esophageal tamponade insertion (Sengstaken-Blakemore balloon)	35.65	

Note: *Only one (1) claim for insertion will be paid per twenty-four (24) hour period.*

3078	Tracheoesophageal fistula with atresia repair	1,200.00	24.125
3079	Tracheoesophageal fistula repair with gastrostomy	1,086.00	24.125
3080	Cervical esophageal fistula closure	313.00	21.375
3086	Thoracic esophageal fistula closure	495.00	24.125

			UNIT VALUE
3085	Ruptured esophagus, cervical repair	530.00	22.750
3081	mediastinal drainage	471.00	24.125
3083	thoracic repair	531.00	24.125
3053	Radioactive substance—insertion via esophagoscopy	110.50	21.375

RESECTION

3070	Esophageal diverticulum—transthoracic resection with or without myotomy and anti-reflux surgery	543.20	24.125
3044	Esophagectomy, transthoracic, end to end lower 1/3	1,200.00	24.125
3043	upper 2/3	1,500.00	24.125
3046	Esophagogastrectomy, either thoracoabdominal or through separate abdominal and thoracic incisions	1,575.00	24.125
3067	Total esophagectomy with replacement by intestine or stomach	1,950.00	24.125
3040	Esophageal defunctioning, esophagectomy with or without gastrectomy, with cervical esophagostomy and gastrostomy with or without feeding jejunostomy, without immediate esophageal reconstruction	1,450.00	25.500
3041	Delayed esophageal reconstruction, with stomach, colon or intestine, with or without feeding jejunostomy	2,006.00	25.500
3089	**Unlisted or Unusually Complicated**	***By Report***	25.500

STOMACH

INVESTIGATION

3100*	Gastric biopsy via tube	35.20	20.000
3103*	superficial, when stomach is exposed at another procedure	30.25	21.375

INCISION OR DRAINAGE

3101	Gastrotomy with exploration or foreign body removal	353.00	22.750
3102*	Gastric lavage	19.35	
3104*	Gastrostomy, button insertion, removal, or replacement	50.00	21.375

REVISION AND REPAIR

3141	Closure or repair, gastrorrhaphy for perforated ulcer	470.00	22.750
3142	repair wound or laceration	500.00	22.750
3153	closure gastrostomy	369.95	22.750
3137	Gastrostomy creation (independent procedure)	390.00	22.750
3136*	Percutaneous Endoscopic Gastrostomy (P.E.G.)	210.00	21.375
3134*	Insertion or reinsertion of jejunostomy (“J”) tube through gastrostomy opening	50.00	21.375

			UNIT VALUE
3131	Drainage procedures, pyloroplasty	470.00	22.750
3133	gastroduodenostomy	470.00	22.750
3135	gastrojejunostomy	525.00	22.750
3120	revision of gastroenterostomy and gastrectomy, add	232.00	
3105	pyloromyotomy (Ramstedt)	410.00	22.750
3118	Vagotomy, truncal transabdominal	395.60	22.750
2152	truncal transthoracic	420.00	24.125
3119	as an addition to other procedure, add	101.00	
2158	Highly selective (parietal cell) vagotomy when performed as the sole procedure without pyloroplasty or gastro enterostomy	586.30	22.750
3138	Gastric bypass for morbid obesity	736.00	24.125
3139	Gastroplasty (gastric partitioning)	627.00	24.125
3140	Intestinal bypass for morbid obesity	561.00	24.125

RESECTION

3112	Gastric ulcer or tumor, local excision	600.00	22.750
3115	Gastrectomy, subtotal, less than 2/3	880.00	22.750
3117	high, subtotal, more than 2/3	950.00	22.750
3114	total	1,100.00	22.750
3149	**Unlisted or Unusually Complicated**	***By Report***	24.125

SMALL INTESTINE

INVESTIGATION

3160*	Jejunal biopsy, tube	34.45	20.000

INCISION

3161	Enterotomy with exploration or removal of foreign body	422.00	22.750
3177	Biopsy of small bowel when exposed at other procedures	30.25	21.375

REVISION AND REPAIR

3141	Closure, duodenorrhaphy for perforated ulcer	470.00	22.750
3221	repair of traumatic laceration, single	495.00	22.750
3223	repair multiple lacerations	***By Report***	22.750
3227	small bowel fistula, external or internal including resection	***By Report***	22.750
3201	Small bowel obstruction, nonresective operative management, (i.e. enterolysis, reduction, volvulus, intussusception, internal hernia, enteroanastomosis)	565.00	22.750
3228	Noble plication procedure	420.00	22.750

			UNIT VALUE
3194	Jejunostomy-creation (independent procedure)	353.00	22.750
3211	Enterolysis in the absence of bowel obstruction	282.00	22.750
3193	Ileostomy, alone	353.00	22.750
3203	revision skin level (independent procedure)	35.95	21.375
3204	revision full thickness	181.25	22.750
3205	revision from simple to continent ileostomy (Kock)	704.00	22.750
3206	continent ileostomy as part of a resective procedure, add	286.00	
3207	repair of continent ileostomy	260.75	22.750
3208	closure of loop ileostomy (simple), (independent procedure)	335.60	22.750
3209	closure of ileostomy by internal anastomosis	422.00	22.750
3140	Intestinal bypass for morbid obesity	561.00	24.125
3241	Mesentery suture	282.00	22.750
3191	Enteroanastomosis	422.00	22.750
0341	Free jejunal loop transfers	1,865.75	22.750

RESECTION

3171	Excision of one (1) or more lesions through a single enterotomy	422.00	22.750
3172	multiple enterotomies	494.00	22.750
3174	Small bowel resection with or without anastomosis or proximal enterostomy	630.00	22.750
3175	Massive small bowel resection greater than fifty (50) % of small bowel	719.40	22.750
3231	Meckel's diverticulum resection	353.00	21.375
3235	Mesentery excision	353.00	22.750
3259	**Unlisted or Unusually Complicated**	***By Report***	22.750

COLON AND APPENDIX

INVESTIGATION

3177	Biopsy of colon when exposed at other operations, add	30.25	

INCISION

3251	Appendix abscess, transabdominal drainage	222.00	21.375
3162	Colotomy with exploration with or without foreign body removal	465.00	21.375

REVISION AND REPAIR

3221	Colon laceration, perforation, or rupture, single suture with or without ileostomy or colostomy	495.00	22.750
3223	multiple	***By Report***	22.750

			UNIT VALUE
3195	Colostomy or cecostomy (independent procedure)	470.00	22.750
3203	revision, simple	35.95	21.375
3204	revision, full-thickness	181.25	22.750
3225	closure of loop colostomy—no bowel resection (independent procedure)	310.00	21.375
3226	closure by internal anastomosis (laparotomy) (independent procedure)	422.00	22.750
3224	closure with internal anastomosis (subsequent to Hartman's procedure) (independent procedure)	830.00	22.750
3166	Exteriorization (Mikulicz)	505.00	22.750

RESECTION

3261	Appendectomy	294.50	21.375
3262	perforated appendix	345.00	22.750
3263	with drainage of abscess	370.25	22.750
	Excision of one (1) or more lesions by colotomy		
3171	single enterotomy	422.00	22.750
3172	multiple enterotomies	494.00	22.750
3179	Colectomy, partial, with or without anastomosis or colostomy	775.00	22.750
3180	total, with or without anastomosis or ileostomy	1,090.00	24.125
3181	total colectomy and proctectomy—one (1) surgeon	1,254.60	24.125
3182	two (2) surgeons (1st surgeon)	933.30	24.125
3183	two (2) surgeons (2nd surgeon)	321.30	24.125
3184	Mucosal proctectomy, ileal-anal anastomosis with formation of an ileal pelvic pouch and proximal ileostomy, with total colectomy or after a previous total colectomy	1,775.00	22.750
3259	**Unlisted or Unusually Complicated**	***By Report***	22.750

RECTUM

INCISION

3285	Pelvic abscess transrectal drainage—See Abdomen Section	110.50	21.375

REVISION AND REPAIR

3310*	Stricture, bougie dilatation of rectum	19.30	
3296	division of rectal stricture	141.00	20.000
3321	proctoplasty	282.00	21.375
3335	Fistula, rectovaginal closure	402.00	21.375
3333	rectourethral closure	509.00	21.375
3331	rectovesical closure	450.00	21.375

			UNIT VALUE
3341*	Procidentia, perineal approaches, reduction (independent procedure)	13.70	21.375
3322	perirectal injection of sclerosing solution	70.25	21.375
3426	Thiersch wire procedure	180.00	21.375
3297	Rhen-Delorme	505.00	21.375
3321	perineal proctoplasty for mucous membrane prolapse	282.00	21.375
3328	resection with anastomosis posterior approach—(Kraske)	422.00	22.750
3325	Procidentia, abdominal approach, abdominal proctopexy	422.00	22.750
3326	resection and anastomosis	601.00	22.750
3329	combined approach	698.50	22.750

RESECTION

Local Removal

3300	Extensive local excision of benign or malignant lesion	282.00	20.000
3299	Electrocoagulation of a large villous adenoma or a malignant lesion	150.50	20.000

Proctectomy

3290	Anterior resection, with anastomosis, below the peritoneal reflection, or with end colostomy (Hartmann)	945.00	22.750
3298	Posterior resection (Kraske) for malignant tumor of the rectum, primary or recurrent	557.00	22.750
3292	Rectal resection for congenital megacolon	1,015.20	22.750

Abdomino-perineal proctosigmoidectomy

3289	one (1) surgeon	1,260.00	24.125
3288	two (2) surgeons—abdominal surgeon	1,030.00	24.125
3286	two (2) surgeons—perineal surgeon	335.00	24.125
3301	**Unlisted or Unusually Complicated**	***By Report***	24.125

ANUS

Note: *Proctosigmoidoscopy will be paid in addition to the procedure at the same sitting if it has not been done by the same surgeon within forty-two (42) days of the operation.*

INVESTIGATION

3340*	Biopsy, anus	9.75	20.000

INCISION

3392*	External hemorrhoid (enucleate thrombosis)	21.15	20.000
3283*	Perianal abscess, incision and drainage	86.05	20.000
3357	Ischiorectal abscess (independent procedure)	150.00	20.000

REVISION AND REPAIR

			UNIT VALUE
3427	Imperforate anus, perineal reconstruction	537.00	21.375
3428	combined reconstruction	1,122.00	22.750
3365*	Anal stenosis or stricture, dilatation anus	10.20	20.000
3421*	anoplasty, infant, minor thin septum	35.95	20.000
3364*	sphincterotomy (independent procedure)	107.85	20.000
3420	anoplasty	282.00	21.375
3422	Posterior saggital anorectoplasty	470.75	21.375
3425	Anal incontinence, sphincteroplasty	282.00	21.375
3424	muscle transplant	***By Report***	21.375

RESECTION

3433*	Condylomata, external, electrodesiccation, initial sitting	21.10	20.000
3434*	subsequent, per sitting	13.40	20.000
3372	extensive, removal under general anesthesia	140.50	20.000
3371	Fissure, fissurectomy with or without sphincterotomy	235.00	20.000
3353	Fistula, fistulotomy or fistulectomy, subcutaneous	70.50	20.000
3356	submuscular	282.00	20.000
3354	complex or multiple	***By Report***	20.000
3355	second stage	70.50	20.000
3318*	Seaton removal in the office	13.80	
3395*	Hemorrhoids, tag or polyp (independent procedure), single	21.15	20.000
3396*	multiple	34.35	20.000
3397*	Barron ligation of internal hemorrhoid, per sitting	45.00	20.000
3401*	Injection of sclerosing solution, per sitting	14.15	20.000
3377	Hemorrhoidectomy, external, complete	134.00	20.000
3380	internal and external with or without fissurectomy or fistulotomy	270.00	20.000
3429	**Unlisted or Unusually Complicated**	***By Report***	20.000

BILIARY TRACT

Note: *Where cholangiogram by instillation into the bile ducts at the time of the operation is done, no procedural benefit is paid to the surgeon.*

INVESTIGATION

3505*	E.R.C.P. (endoscopic retrograde cholangio-pancreatography)	245.00	21.375
3506*	E.R.C.P., subsequent, when provided within sixty (60) days of tariff 3505	191.00	21.375
3498*	Add-on to E.R.C.P. (any combination of spincterotomy, dilatation, stent, naso-biliary tubing)	98.30	

INCISION

			UNIT VALUE
3504	Gallbladder, cholecystotomy with drainage of the gallbladder with or without removal of calculus	390.00	22.750
3495	Bile ducts, choledochostomy with drainage of the bile ducts with or without calculus removal	775.00	22.750
3518	transduodenal choledocholithotomy	723.80	22.750
3493	sphincterotomy or sphincteroplasty transduodenal	775.00	22.750
3503	atresia of bile ducts (congenital) exploration	520.20	22.750

REVISION AND REPAIR

3526	Gallbladder,—Roux-en-Y or anastomosis loop	550.00	22.750
3528	Roux-en-Y anastomosis to G.I. tract	550.00	22.750
3520	Bile ducts , end-to-end reconstruction	850.00	24.125
3522	direct anastomosis to G.I. tract	850.00	22.750
3524	Hepatico-jejunostomy Roux-en-Y or anastomosis loop	1,300.00	22.750

RESECTION

3515	Gallbladder, cholecystectomy	500.20	22.750
3516	with open exploration of common duct	835.00	22.750
3499	**Unlisted or Unusually Complicated**	***By Report***	24.125

LIVER

INVESTIGATION

3456*	Needle biopsy	100.00	21.375
3457*	Open biopsy of liver, needle, one or more, when exposed at other operation, add	40.00	
3459*	Open biopsy of liver, excisional, one or more, when exposed at other operation, add	100.00	
3458	Transjugular liver biopsy, including history, examination, advice, pressure readings, fluoroscopy, angiography, and any other imaging by the same physician	184.00	21.375

INCISION

3471	Liver abscess drainage	505.00	22.750
3472	Marsupialization or drainage of liver cyst	503.00	22.750

REVISION AND REPAIR

3481	Hepatorrhaphy, suture of wound or injury including omental pack	600.00	24.125

RESECTION

			UNIT VALUE
3464	Partial hepatectomy greater than sixty-four (64) cubic centimeters	775.00	24.125
3494	hepatic lobectomy left	1,635.00	24.125
3492	hepatic lobectomy right	1,635.00	24.125
3491	tri-segmentectomy	1,950.00	24.125
3496	Radiofrequency ablation of single liver tumor	775.00	24.125
3497	Ablation of a second or subsequent tumor add to tariff 3496 for each additional tumor	193.75	24.125
3499	**Unlisted or Unusually Complicated**	***By Report***	24.125

PANCREAS

INVESTIGATION

Biopsy pancreas, additional for when exposed at other operations.

3564*	needle biopsy	100.00
3566*	incision biopsy	114.55

INCISION

3565	Marsupialization of pseudocyst	594.60	22.750
3541	Drainage of pancreatic abscess	750.00	22.750
3542	Acute pancreatitis, abdominal drainage	450.00	24.125
3544	Pancreatic calculus removal	623.00	22.750

REVISION AND REPAIR

3567	Pancreatic pseudocyst, cystogastrostomy	651.90	22.750
3568	cystojejunostomy Roux-en-Y	693.60	22.750
3546	Pancreaticojejunostomy	890.95	22.750
3547	Longitudinal anastomosis of pancreatic duct to intestine (Peustow)	1,200.00	22.750

RESECTION

3550	Distal pancreatectomy with or without splenectomy	1,500.00	22.750
3551	Pancreaticoduodenectomy	1,900.00	24.125
3552	Total pancreatectomy with or without splenectomy	1,500.00	24.125
3569	**Unlisted or Unusually Complicated**	***By Report***	24.125

URINARY SYSTEM

These benefits cannot be correctly interpreted without reference to the Rules of Application.

URODYNAMIC STUDIES

9869*	Uroflow studies, professional	16.30
9870*	total	29.10
9873*	Cystometry with rectal and vesical pressures, professional	41.05
9874*	total	61.50
9877*	Urethral pressure profile studies, professional	41.05
9888*	total	56.50
9897*	All above tests, combined, professional	92.90
9899*	total	145.00
9889*	Cystometry with flow studies, professional	41.05
9896*	total	66.75
9844*	Video fluoroscopic multichannel urodynamic assessment to include monitoring of intravesicular, intra-abdominal, and urethral pressures, with simultaneous fluoroscope imaging and recording of filling and voiding phases including interpretation	68.75

Note: *Fees listed for urodynamic services are payable in hospital (professional) and in private offices (total) except whereotherwise specified.*

The Rules of Application apply in the urinary system for diagnostic and therapeutic procedures. Multiple procedures done at the same sitting and in the same area, have benefits of 100% of the schedule for the major procedure, (the one with the greatest benefit) and 50% for all others. When a procedure is done by means of the cystoscope, any cystoscopic examinations at that sitting are included in the benefit for the procedure.

Fee for Service (F/S) means that the procedure is included in the Visit fee or any other procedure which is involved with it, (e.g. the application of a cast).

CYSTOSCOPY DIAGNOSTIC

			UNIT VALUE
3931*	Cystoscopy, diagnostic, office or hospital, male or female, initial	65.80	20.000
3932*	subsequent, (i.e. for the same condition in hospital or office)	34.05	20.000
3933*	with biopsy	95.95	20.000
3926*	with manometry (cystometrogram or bladder capacity evaluation)	69.70	20.000
3927*	with needle biopsy of prostate	97.00	20.000
3928*	with ureteral catheterization, with or without retrograde pyelogram, unilateral or bilateral	95.70	21.375
3939*	with ureteral meatotomy	136.45	21.375
3929*	with differential renal function studies	95.50	20.000

PANENDOSCOPY

			UNIT VALUE
3930*	cystoscopy and urethroscopy	73.65	20.000
3934*	cystoscopy, urethroscopy, urethral meatotomy and dilatation, male (under general anesthesia)	87.35	20.000
3935	**Unlisted or Unusually Complicated**	***By Report***	20.000

KIDNEY

	Artery, renal, surgery for hypertension—See Arteries		
	Catheter, change or reinsert in nephrostomy	F/S	
3818	Biopsy of kidney, additional for, when done at the time of other operations	29.25	
3820*	Biopsy, kidney needle	75.00	21.375
3829*	Kidney or renal pelvis, aspiration or injection of cyst	50.15	21.375
3830*	Perirenal insufflation, unilateral or bilateral	104.50	21.375
3813	Aberrant renal vessels, division or transection (independent procedure)	416.00	21.375
3819*	Biopsy, open renal (independent procedure)	243.65	22.750
3827	Cyst of kidney, excision	406.75	22.750
3845	Fistula, closure, pyelostomy or nephrostomy	549.00	22.750
3824	Heminephrectomy	824.20	22.750
3846	Horseshoe kidney, symphysiotomy	541.00	22.750
3821	Nephrectomy, including partial ureterectomy through same incision	768.10	22.750
3822	plus total ureterectomy with resection of uretero-vesical junction	894.60	22.750
3825	without resection of uretero-vesical junction	708.60	22.750
3823	radical, including thoracic approach if necessary	978.95	24.125
3811	Nephrolithotomy, including removal of staghorn calculus	484.00	22.750
3812	Renal fillet (splitting of kidney) for removal of staghorn calculus	676.00	22.750
3835	Nephropexy, fixation or suspension of kidney (independent procedure)	400.00	22.750
3841	Nephrorrhaphy, suture of kidney wound or injury	490.00	22.750
3808	Nephrostomy, nephrotomy with drainage	406.75	22.750
3802	Perirenal abscess, drainage (independent procedure)	279.00	22.750
3831	Pyeloplasty, plastic operation on renal pelvis with or without plastic operation or ureter	542.70	22.750
3817	Pyelotomy, with drainage or removal of calculus, pyelolithotomy	444.00	22.750
3839	**Unlisted or Unusually Complicated**	***By Report***	22.750

URETER

			UNIT VALUE
3851	Unilateral drainage, exploration by open surgery, with or without ureterotomy (independent procedure)	408.00	22.750
3895	Fistula, ureteral closure	***By Report***	22.750
3958*	Cystoscopy and diagnostic ureteroscopy above the intramural ureter using the rigid or flexible ureteroscope	249.80	21.375
3956*	plus post-procedure ureteric stenting	344.30	21.375
3959	Cystoscopy and ureteroscopy above the intramural ureter with calculus manipulation and removal using the rigid or flexible ureteroscope	455.00	21.375
3957	with electrohydraulic or ultrasonic calculus disintegration using the rigid or flexible ureteroscope	475.00	21.375
3928*	Cystoscopy with ureteral catheterization, with or without retrograde pyelogram, unilateral or bilateral	95.70	21.375
3939*	with ureteral meatotomy	136.45	21.375
3945	ureterocele, fulguration or resection	214.35	21.375
3937	ureteral calculus, manipulation, including ureteral meatotomy if necessary, and including repeat manipulation(s), if necessary	194.30	21.375
3865	Endoscopic insertion of ureteral stent including ureteral meatotomy if necessary, and including repeated attempts at insertions if necessary	206.90	21.375
3866	bilateral, insertion at one sitting	289.95	21.375
	Note: *Claim 50% for repeat insertion(s) if needed within six (6) weeks.*		
3867	Endoscopic removal of ureteral stent(s)	72.40	21.375
3861	Ureterectomy, with bladder cuff (independent procedure)	524.00	21.375
3936	Open excision of ureterocoele with concomitant ipsilateral ureteric reimplant	775.00	22.750
3876	Ureteroneocystostomy, anastomosis of ureter to bladder, unilateral	578.90	22.750
3877	bilateral	908.90	22.750
3870	ureteral tapering with neouretero cystostomy add	200.00	
3880	Ureteroenterostomy, anastomosis of ureter to intestine, unilateral	507.45	22.750
3881	bilateral	641.35	22.750
3885	Ureterostomy, transplantation of ureter to skin, unilateral	400.00	22.750
3886	bilateral	557.00	22.750
3857	Ureterolithotomy, upper three-quarters of ureter	406.75	22.750
3858	lower one-quarter of ureter	527.60	22.750
3871	Ureteroplasty, plastic operation on ureter	527.60	22.750
3874	Ureteropyelostomy, anastomosis of ureter and renal pelvis	743.50	22.750
3884	Ureterorrhaphy, suture of ureter (independent procedure)	345.35	22.750
3889	**Unlisted or Unusually Complicated**	***By Report***	22.750

EXTRA CORPOREAL SHOCK WAVE LITHOTRIPSY

			UNIT VALUE
3893*	Extra corporeal shock wave lithotripsy of renal and ureteric calculi	348.80	21.375

Note: *E.S.W.L. includes the associated services by the urologist, starting the I.V., administering sedatives and analgesics as required, accepting responsibility for the safety of the patient both during the procedure and during the recovery period. Bilateral treatment of calculi is to be claimed at 100% for the first side and 75% for the second, at the same sitting.*

PERCUTANEOUS TRANSRENAL OPERATIVE PROCEDURES FOR STONE REMOVAL

3872	Percutaneous nephrostomy for stone removal with or without selective catheterization of calyx or calyces	179.50	21.375
3873	Single stone removal without electrohydraulic or ultrasound lithotripsy, with or without antegrade stent insertion including tract dilatation and nephroscopy	451.05	21.375
3875	plus nephrostomy, by the same physician, at the same sitting	529.60	21.375
3878	with electrohydraulic or ultrasound lithotripsy, with or without antegrade stent insertion including tract dilatation and nephroscopy	546.70	21.375
3879	plus nephrostomy, by the same physician, at the same sitting	620.20	21.375
3882	Multiple stone removal without electrohydraulic or ultrasound lithotripsy, with or without antegrade stent insertion including tract dilatation and nephroscopy	546.70	21.375
3883	plus nephrostomy, by the same physician, at the same sitting	861.10	21.375
3887	with electrohydraulic or ultrasound lithotripsy, with or without antegrade stent insertion including tract dilatation and nephroscopy	733.00	21.375
3888	plus nephrostomy, by the same physician, at the same sitting	963.60	21.375
3890	Repeat stone removal through the original access after any of the above by the same surgeon	367.50	21.375
3891	by a different surgeon	***By Report***	21.375
3892	through new access after any of the above	***By Report***	21.375

BLADDER

3900*	Bladder, aspiration by needle	34.50	20.000
3902*	insertion of suprapubic catheter by trochar	77.80	20.000
3903*	function studies	19.90	
3904*	Initial catheterization for acute urinary retention when performed by a physician (independent procedure)	6.85	
	Change or reinsertion of catheter, suprapubic	F/S	
3960	Urachal cyst and umbilical hernia repair	275.00	22.750
3961	Bladder injury or rupture, cystorrhaphy	448.00	22.750
3918	Bladder neck, female, transurethral resection	272.85	21.375
3966	Cutaneous Vesicostomy	428.65	21.375
3967	Cystoplasty, plastic operation on bladder, anterior YV-plasty, etc.	451.05	21.375

			UNIT VALUE
3968	Vesico urethroplasty for incontinence (Tanagho Procedure)	635.30	21.375
	Fascial sling for incontinence—primary procedure		
3974	including fascial harvesting	500.00	22.750
3975	with synthetic material or allograft fascia	400.00	22.750
	Fascial sling incontinence—following previous failed procedure(s)		
3970	with fascia	600.00	22.750
3972	with prosthesis	500.00	22.750
3969	Hydraulic urinary sphincter for incontinence, insertion of, male or female	812.55	21.375
3906	Cystotomy, with drainage	272.85	20.000
3901	with fulguration	406.75	20.000
3907	with removal of calculus	342.35	20.000
3920	Diverticulum, bladder, excision (independent procedure)	487.30	22.750
3914	Diverticulum of bladder—transurethral roller ball cautery	200.00	22.750
3965	Fistula, closure, vesicorectal	443.00	21.375
3921	vesicouterine	438.00	21.375
3923	vesicovaginal	485.10	21.375
3925	when a colostomy is part of the above, add	65.25	
3908	Perivesical or prevesical space abscess drainage	201.00	21.375
3922	Tumor bladder, excision	404.00	22.750
3909	Cystostomy, closure (independent procedure)	205.40	21.375
3955	Diversion, urinary, to isolated intestine where bladder is mobilized and anastomosed to intestinal segment	870.00	22.750
3953	Bladder augmentation with intestine or stomach	650.00	22.750
3905*	Chemotherapeutic instillations in bladder, per instillation, to include necessary catheterization (professional fee only)	42.45	

CYSTOSCOPY THERAPEUTIC

3940*	With fulguration or treatment of minor (less than 0.5 cm.) lesion, with or without biopsy	87.35	20.000
3941	Bladder tumors, small (0.5 cm. to 2.0 cm.) fulguration, initial	285.00	20.000
3942	subsequent, (i.e. during same hospital admission)	86.60	20.000
3924	large, transurethral resection	450.00	21.375
3943	Radioactive substance, insertion, with or without biopsy or fulguration	178.00	21.375
3944	Interstitial cystitis, dilatation, electro- and/or chemo-fulguration, under general anaesthetic	97.15	20.000

			UNIT VALUE
3954	Collagen injection periurethral/ureteral under cystoscopy control	150.00	20.000
3947	Foreign body, including calculus, removal from bladder or urethra	136.45	21.375
3951	Calculus in bladder, litholapaxy	290.60	20.000
3952	Ileal loop creation, and transplanting ureters to it (without cystectomy)	804.20	22.750

CYSTECTOMY

3911	partial, without ureter transplants	487.30	22.750
3912	with one or both ureter transplants to bladder	601.10	22.750
3916	total (with or without dissection of pelvic nodes), and the ureters transplanted to skin at the same operation	936.00	22.750
3915	with ureters transplanted to colon at the same operation	982.00	24.125
3913	when ureters previously transplanted to ileal loop, or colon, or skin	735.90	24.125
3917	total, and creation of ileal loop and transplanting ureters	1,768.10	24.125
3910	Anterior pelvic exenteration bladder, uterus, ovaries, pelvic nodes, continent ileal bladder (or pouch), autogenous bladder	2,229.00	24.125
3919	**Unlisted or Unusually Complicated**	***By Report***	24.125

URETHRA

3978	Abscess, periurethral, drainage	68.50	20.000
3981	Caruncle, urethral, excision or fulguration	82.00	20.000
4031*	Urethral stricture, dilatation, male, initial	19.60	20.000
4033*	subsequent	19.60	20.000
4034*	under general anaesthesia	48.50	20.000
4035*	female, local or general	9.70	20.000
3977*	Meatotomy, male (independent procedure)	38.90	20.000
3976*	female, including meatoplasty	67.00	20.000
4000*	Urethroscopy, diagnostic, initial or subsequent	34.05	20.000
4021	Wounds, urethral: urethrorrhaphy	***By Report***	21.375
4011	Urethroplasty, plastic operation on urethra	***By Report***	21.375

URETHROSCOPY THERAPEUTIC

4006	With fulguration of posterior urethra	99.45	20.000
4004	With internal urethrotomy, blind	136.45	20.000
4005	With visual internal urethrotomy using cold knife urethrotome	195.00	20.000
4001	With removal of calculus or foreign body	136.45	20.000
3971*	Urethrotomy, external, anterior	100.70	20.000
3973*	perineal	136.45	20.000
3994	Polyps, urethral, excision or fulguration with or without urethroscopy	97.15	20.000

		UNIT VALUE
3991	Diverticulum of urethra, excision (independent procedure)..... 300.15	20.000
3979	Urinary, extravasation, simple perineal drainage (independent procedure)..... 170.00	20.000
3980	complicated..... 208.00	21.375
4019	Extravasation, perineal urinary, drainage with diversion of urinary stream..... 338.30	21.375
3982	Fistula, urethral, closure (independent procedure)..... ***By Report***	20.000
3983	urethrovaginal closure..... 298.05	20.000
3987	Urethrectomy, perineal approach..... 342.35	21.375
3989	**Unlisted or Unusually Complicated**..... ***By Report***	21.375

HEMODIALYSIS

These benefits cannot be correctly interpreted without reference to the Rules of Application.

Performance of hemodialysis includes supervision and procedure, history, physical and appropriate adjustments of solutions and other problems arising during dialysis.

Where patients with ***Chronic Renal Failure*** are admitted for complications such as bacteremia, peritonitis, problems in fluid management, osteodystrophy, etc., charges for hospital stay should be the same as for any other medical admission, and may be in addition to those made for repeat dialysis—See also Peritoneal Dialysis.

ACUTE RENAL FAILURE

			UNIT VALUE
9798	Initial hemodialysis—See Rules 44 and 45	396.00	
9799	subsequent hemodialysis, each	148.50	
3803	Insertion of arteriovenous bypass for acute renal failure (AV shunt) each time new cannula is required	200.00	21.375
3800	Hemodialysis—arteriovenous fistula side-to-side anastomosis	394.00	21.375
3801	Hemodialysis—prosthetic AV fistula	418.90	21.375
3804	Hemodialysis—AV venous bypass graft	695.00	21.375
3790	Insertion of temporary AV catheter, one (1) or more sites, per sitting	120.00	21.375

CHRONIC RENAL FAILURE

9801	Initial hemodialysis—See Rules 44 and 45	99.00	
9802	subsequent hemodialysis, each	46.00	
3803	Insertion of arteriovenous bypass (each time new cannula required) (AV shunt)	200.00	21.375
3800	Hemodialysis—arteriovenous fistula side-to-side anastomosis	394.00	21.375
3801	Hemodialysis—prosthetic AV fistula	418.90	21.375
3804	Hemodialysis—AV venous bypass graft	695.00	21.375
3790	Insertion of temporary AV catheter, one (1) or more sites, per sitting	120.00	21.375
3792	Declotting of AV shunts	95.75	21.375

Note: *The above fee is not claimable for patients with acute renal failure—See Rule 44*

9820	Home dialysis and self-care dialysis weekly retainer for administration, routine visits, and supervision	71.25

Note: *The above fee is not applicable if the patient is admitted to hospital as an in-patient.*

PERITONEAL DIALYSIS

See general remarks in Hemodialysis.

ACUTE RENAL FAILURE

			UNIT VALUE
9805	Initial peritoneal dialysis, complete medical management, up to two (2) weeks	396.00	
9807	subsequent dialysis, after two (2) weeks	148.50	
3793	Insertion of temporary (stylocath) catheter	93.25	21.375
3805	Insertion of permanent catheter	225.00	21.375
3807	Removal of permanent catheter	175.20	20.000

CHRONIC RENAL FAILURE

9806	Initial peritoneal dialysis, first twenty-four (24) hours	99.00	
9819	Intermittent subsequent dialysis (maximum $180.00 per week)	60.00	
3805	Insertion of permanent catheter	225.00	21.375
3807	Removal of permanent catheter	175.20	20.000
3793	Insertion of temporary (stylocath) catheter	93.25	21.375
9610	Chronic ambulatory peritoneal dialysis, in hospital, per day	22.50	
3794	Declotting of permanent catheter	96.75	20.000
	Note: *The above is not claimable for patients with acute renal failure—See Rule 44*		
9821	Home dialysis and self-care dialysis weekly retainer for administration, routine visits, and supervision	72.00	
	Note: *The above fee is not applicable if the patient is admitted to hospital as an in-patient.*		
3806	**Unlisted or Unusually Complicated**	***By Report***	21.375

MALE GENITAL SYSTEM

These benefits cannot be correctly interpreted without reference to the Rules of Application.

PENIS

			UNIT VALUE
4111*	Biopsy penis (independent procedure)	19.00	20.000
4120*	Penile skin lesion, including warts, local excision or fulguration, per sitting	33.20	20.000
3977*	Meatotomy penis	38.90	20.000
4101*	Prepuce, dorsal or lateral "split" (independent procedure)	50.10	20.000
4122*	Circumcision, newborn	19.50	20.000
4123	surgical excision other than clamp or dorsal slit, any age except newborn	122.60	20.000
4135	Epispadias, plastic operation for penile epispadias distal external sphincter	***By Report***	20.000
4138	Plastic operation on penis with exstrophy of bladder	***By Report***	22.750

TREATMENT OF ERECTILE DYSFUNCTION

	First visit—appropriate visit fee applies—See Rules of Application	F/S	
4102	Second visit—consecutive—See Note 1	20.00	
4103	Penile injection—See Note 2	19.30	

Note: *1) All other visits related to this service are not claimable.*

*2) A **total** of two injections are claimable when provided during the first and/or second visit. All other injections related to this service which may be provided during visits subsequent to the second visit are not claimable.*

HYPOSPADIAS

4125	One stage procedure, chordee release and construction of urethra	570.00	20.000
4126	release of chordee only	285.00	20.000
4127	Second stage procedure, penile	403.20	20.000
4128	scrotal hypospadias repair	366.50	20.000
4129	perineal hypospadias repair	564.00	20.000
4130	closure—urethro-cutaneous fistula	330.80	20.000
4133	Nesbitt procedure, correction of penile curvature	197.65	20.000
4114	Amputation of penis, partial	203.40	20.000
4115	complete	345.35	20.000
4116	radical	678.60	20.000
4119	Prosthesis, penis (Pearman, etc.)	293.00	20.000
4118	Hydraulically operated erectile prosthesis, insertion of	659.50	20.000
4139	**Unlisted or Unusually Complicated**	***By Report***	21.375

TESTIS

			UNIT VALUE
4141*	Biopsy, testis, needle (independent procedure)	20.35	20.000
4142	Biopsy, incisional (independent procedure) unilateral	67.45	20.000
4143	bilateral	101.70	20.000
4144	Orchiectomy, simple, unilateral	175.00	20.000
4145	bilateral	320.00	20.000
4146	radical, with retro-peritoneal gland dissection, unilateral or bilateral	691.00	21.375
4155	Testicular prosthesis	127.50	20.000
	Note: *No fee payable if done at time of orchiectomy.*		
4148	Inguinal approach for testicular mass, with or without orchiectomy	227.35	20.000
4156	Orchiopexy, any type, with or without hernia repair	418.60	20.000
4157	second stage, Thorek type	70.50	20.000
4152	Torsion of testis, surgical reduction	305.10	20.000
4153	with fixation of contralateral testis	373.35	20.000
4154	fixation of contralateral testis (independent procedure)	162.30	20.000
4159	**Unlisted or Unusually Complicated**	***By Report***	20.000

EPIDIDYMIS

4161*	Epididymis, drainage of abscess	20.20	20.000
4176	Epididymectomy, unilateral	223.75	20.000
4163	Epididymis, exploration, with or without biopsy	68.00	20.000
4181	Epididymovasostomy, anastomosis of epididymis to vas deferens, unilateral	298.10	20.000
4182	bilateral	426.80	20.000
4174	Spermatocele, excision, with or without epididymectomy	150.10	20.000
4165	Vasogram, unilateral	65.45	20.000
4189	**Unlisted or Unusually Complicated**	***By Report***	20.000

TUNICA VAGINALIS

4191*	Hydrocele, puncture aspiration, with or without injection	30.00	20.000
4200	repair	207.40	20.000
4201	excision, unilateral	150.00	20.000
4202	with hernia repair	300.00	20.000
4209	**Unlisted or Unusually Complicated**	***By Report***	20.000

SCROTUM

			UNIT VALUE
4211*	Scrotum, drainage of abscess	19.85	20.000
4215	Foreign body in scrotum, removal	***By Report***	20.000
4224	Resection of scrotum	***By Report***	20.000
4227	Scrotoplasty, plastic operation on scrotum	***By Report***	20.000
4221	Skin lesion, scrotum, local excision	33.50	20.000
4229	**Unlisted or Unusually Complicated**	***By Report***	20.000

VAS DEFERENS

4241	Vasectomy, partial or complete, unilateral or bilateral (independent procedure)— See Rule of Application 1 re: counselling	158.80	20.000
4251	Vasovasostomy (anastomosis) unilateral	272.85	20.000
4252	bilateral	406.75	20.000
4259	**Unlisted or Unusually Complicated**	***By Report***	20.000

SPERMATIC CORD

4271	Hydrocele of spermatic cord, excision, unilateral (independent procedure)	179.70	20.000
4275	Varicocele, excision, unilateral (independent procedure)	174.20	20.000
4278	with hernia repair and/or hydrocele and/or varicocele excision	273.00	20.000
4279	**Unlisted or Unusually Complicated**	***By Report***	20.000

SEMINAL VESICLES

4291	Vesiculectomy	***By Report***	20.000
4281	Vesiculotomy, unilateral	***By Report***	20.000
4299	**Unlisted or Unusually Complicated**	***By Report***	20.000

PROSTATE

4305*	Biopsy prostate, needle without cystoscopy	100.00	20.000
4301	Abscess, prostatic, external drainage, prostatotomy	112.00	20.000
4307	Biopsy, incisional, perineal approach (independent procedure)	204.00	20.000
4308	transrectal	50.25	20.000

			UNIT VALUE
4311	Prostatectomy, perineal, subtotal	471.00	22.750
4313	radical	945.20	24.125
4318	retropubic	519.00	22.750
4319	retropubic, radical	954.20	22.750
4320	Combined radical prostatectomy and staging lymphadenectomy	1,232.50	24.125
	Note: *The above does not apply for simple prostatectomy (non-radical) combined with staging lymphadenectomy.*		
4316	suprapubic	487.30	22.750
4321	transurethral, including control of postoperative bleeding	477.40	22.750
4324	revision, delayed, within twelve (12) months	203.40	22.750
~4322	Transurethral Microwave Thermotherapy	400.00	20.000
4325	Transurethral sphincterotomy—male	304.15	20.000
4326	Prosthesis for urinary incontinence (Kauffman procedure)	376.00	21.375
4327	Removal of prosthesis (Kauffman procedure)	139.50	21.375

PROSTATE BRACHYTHERAPY

~4300	Planning Ultrasound–Urological component	175.00	
	Note: *A surgical assistant benefit may not be claimed in addition to tariff ~4300.*		
~4302	Seed Implantation–Urological component including diagnostic cystoscopy and/or urethroscopy	640.00	20.000
4329	**Unlisted or Unusually Complicated**	***By Report***	22.750

FEMALE GENITAL SYSTEM

These benefits cannot be correctly interpreted without reference to the Rules of Application.

VULVA

Local incision of lesion of vulva or urethra—See Integumentary System

			UNIT VALUE
4421*	Biopsy	23.80	20.000
4430*	Condylomata accuminata, excision or destruction by any method, of less than ten (10) warts over an area no more than 25% of the vulvar area	34.40	20.000
4432*	of ten (10) or more warts over an area of more than 25% of the vulvar area	76.25	20.000
4427	Extensive removal under general anesthesia. Extensive condylomata involving massive lesions of the vulva, the perineum, the vagina and anus	134.00	20.000
4434*	Carcinoma in situ or dysplasia, biopsy proven, excision or destruction by any method	76.25	20.000
4403*	Vulva, abscess, incision and drainage	17.30	20.000
4404	varicocele, excision, unilateral (independent procedure)	177.00	20.000
4405*	Bartholin's gland, abscess, incision and drainage	17.30	20.000
4428	Clitoridectomy	57.75	20.000
4433	Cyst, Bartholin, excision or marsupialization	86.75	20.000
4431	Hymen, excision	57.75	20.000
4411	incision	33.60	20.000
4455	Injury of vulva and/or perineum, recent, non-obstetrical repair	***By Report***	20.000
4745	Perineal fistula, closure	148.50	20.000
4735	laceration, old, third degree, repair	290.00	20.000
4443	Prolapse of urethral mucosa, plastic repair (independent procedure)	***By Report***	20.000
4441	Vulva and/or perineum, plastic repair	***By Report***	20.000
4423	Vulvectomy, complete	307.00	21.375
4424	partial, more than 1/3	230.00	21.375
4426	radical, without regional node dissection	403.00	21.375
4425	including regional lymph nodes	674.00	21.375
4429	**Unlisted or Unusually Complicated**	***By Report***	21.375

Note: *If more than one (1) of the following procedures are done at the same sitting, payments will be 100% for the first, 75% for the second and 75% for the third, etc., 4430, 4432, 4434, 4472, 4475, 4482, 4633, 4635 and 4636.*

VAGINA

			UNIT VALUE
9783*	Huhner test	14.35	
4471*	Vagina, biopsy	20.25	20.000
4472*	Condylomata accuminata, excision or destruction by any method, of less than ten (10) warts, or of warts over an area no more than 25% of the vaginal area	34.40	20.000
4475*	Condylomata accuminata, excision or destruction by any method, of ten (10) or more warts, or of warts over an area more than 25% of the vaginal area	76.25	20.000
4482*	Carcinoma in situ or dysplasia, biopsy proven, excision or destruction by any method	76.25	20.000
4511*	dilatation under general anesthesia	28.75	20.000
4497	Artificial vagina, construction of, for congenital absence	***By Report***	21.375
4476	Benign lesion of vagina, excision	86.75	20.000
4477*	Colposcopy with or without biopsy cervix or vagina	49.70	20.000
4463*	Colpopuncture—aspiration of pouch of Douglas	23.05	20.000
4461	Colpotomy, diagnostic, or drainage of pelvic abscess	115.00	20.000
4521	Culdoscopy (independent procedure)	117.50	20.000
3335	Fistula, repair, recto-vaginal	402.00	21.375
4507	urethro-vaginal	281.90	20.000
3923	vesico-vaginal	485.10	21.375
4501	Injury of vagina, recent, non-obstetrical, suture	***By Report***	20.000
4802	Reverse Episiotomy	79.25	20.000
4478	Vaginal septum, excision	96.00	20.000
4473	Vaginectomy, complete or partial	440.65	21.375
4480	**Unlisted or Unusually Complicated**	***By Report***	21.375

Note: *If more than one (1) of the following procedures are done at the same sitting, payments will be 100% for the first, 75% for the second and 75% for the third, etc. , 4430, 4432, 4434, 4472, 4475, 4482, 4633, 4635 and 4636.*

VAGINAL PROCEDURES ON CERVIX OR UTERUS

CERVIX

			UNIT VALUE
	Chemocautery—silver nitrate, etc.—included in visit fee	F/S	
9795*	Taking of cytological smears for cancer screening	11.10	
4611*	Cervix—local excision of lesion, cauterization or biopsy, one (1) or more sites	20.25	20.000
4634	Amputation of cervix (independent procedure)	141.45	21.375
4632	Cervical stump, removal	363.00	21.375
4633*	Carcinoma in situ or dysplasia, biopsy proven, destruction by any method, of an area no more than 25% of the circumference	34.40	20.000
4635*	more than 25% of the circumference (including immediately contiguous vaginal areas)	105.10	20.000
4636*	Conization by any method, with or without D & C	152.95	20.000
4641*	Cryosurgery of the cervix for other conditions	***By Report***	20.000
4646	Dilatation and curettage	86.75	20.000
4711	Dilatation of cervix, in hospital	57.50	20.000
4706	Incompetent cervix, non-pregnant, repair	191.50	20.000
4671	Radioactive substances, insertion into cervix and/or uterus, initial	173.00	20.000
4672	subsequent	115.00	20.000
4705	Trachelorrhaphy, suture of recent non-obstetrical injury or laceration of cervix	***By Report***	20.000

Note: *If more than one (1) of the following procedures are done at the same sitting, payments will be 100% for the first, 75% for the second and 75% for the third, etc. , 4430, 4432, 4434, 4472, 4475, 4482, 4633, 4635 and 4636.*

BIRTH CONTROL

4677*	Intrauterine device insertion	30.60	20.000
4678	Removal impacted I.U.D.—office	28.40	20.000
4679	hospital (under general anesthesia)	86.75	20.000
4675*	Insertion of subcutaneous contraceptive capsules, e.g. Norplant	50.00	
4676*	Removal of subcutaneous contraceptive capsules, e.g. Norplant	50.00	

UTERUS

			UNIT VALUE
4850	Abortion, spontaneous [under twenty (20) weeks] no surgery, fee-for-service, to maximum of	84.25	20.000
4855	requiring dilatation and curettage	115.00	20.000
4860	therapeutic, by dilatation and curettage and/or suction method	129.95	20.000
4861	by amnio infusion with or without D & C	154.15	20.000
4862	therapeutic dilatation and extraction D & E	250.00	20.000
	Note: *The above procedure is payable for services rendered after fifteen (15) weeks gestation.*		
4866*	Insertion of Laminaria Tent (s)	30.60	20.000
4612*	Endometrium, biopsy (independent procedure)	23.35	20.000
4613*	Curettage—aspiration technique—professional services only	30.90	20.000
4566*	Uterus and tubes, insufflation with CO^2 (Rubin's test)	23.05	20.000
4647*	Hysteroscopy with or without biopsy with or without D & C	124.45	20.000
4479	Myomectomy, vaginal	192.50	21.375
4631	Hysterectomy, vaginal, with or without repair	516.65	22.750
4645	Metroplasty	285.00	20.000
4648	Hysteroscopically—guided endometrial ablation	308.75	20.000
4639	**Unlisted or Unusually Complicated**	***By Report***	22.750

PLASTIC OPERATIONS FOR GENITAL PROLAPSE

4483	Combined abdominovaginal two-team urethral sling following previous failed sling procedure(s) with or without cystocele repair with or without cystoscopy,		
	vaginal surgeon	312.00	22.750
4486	abdominal surgeon	312.00	22.750
	Note: *A Surgical Assist fee may not be claimed in addition by a surgeon who claims tariff 4483 or tariff 4486.*		
4488	Cystocele and rectocele	290.00	20.000
4489	with amputation of cervix	403.00	20.000
4481	Cystocele and/or urethrocele	230.00	20.000
4493	Enterocele repair—vaginal approach	290.00	20.000
4474	Le Fort operation	204.00	20.000
4484	Rectocele	202.00	20.000
4444	Urethral suspension, suprapubic (Marshall-Marchetti)	312.70	21.375
4445	Urethral suspension re-operation	325.00	21.375
4631	Vaginal hysterectomy, with or without complete repair	477.00	22.750
4499	Vault prolapse, post hysterectomy	403.00	20.000

		UNIT VALUE
4485	Urethral sling repair, vaginal approach, with or without cystocele repair .....319.40 Rectocele done at time of 4485—pay 4484 at 75%	21.375
4500	**Unlisted or Unusually Complicated**.....***By Report***	21.375

LAPAROSCOPIC SURGERY

Note: *1) For multiple laparoscopic surgical procedures done at the same sitting, benefits for the following will be paid at:*

- *First procedure ..... 100% the listed fee*
- *Second procedure ..... 50% of the listed fee*
- *Third procedure ..... 50% of the listed fee*
- *Fourth procedure ..... 25% of the listed fee*
- *More than four procedures 0%*

2) Procedures are eligible for surgical assistants where residents are unavailable.

3) Where the total value of all procedures is less than $155.66 the surgical assistant shall be paid $61.75.

4) Any laparoscopic operative procedure includes diagnostic laparoscopy.

			UNIT VALUE
4600	Ovarian drilling unilateral or bilateral	250.00	22.750
4601	Laparoscopic utero sacral nerve ablation (LUNA) unilateral or bilateral	250.00	22.750
4602	Hydatid cyst of Morgagni greater than > 2.5 cm unilateral or bilateral	240.00	22.750
4603	Pelvic adhesions – minor, unilateral or bilateral	250.00	22.750
	Note: *Tariff 4603 is not to be claimed with tariffs 4551 or 4608.*		
4604	Pelvic adhesions – major (e.g. dense and/or bilateral and/or affecting the bowel) lysis requiring longer than forty-five (45) minutes of operating time	375.00	22.750
4605	Treatment of endometriosis – any stage, cautery of lesions requiring less than forty-five (45) minutes of operating time	250.00	22.750
4606	Treatment of endometriosis – major e.g., Stage 3 or 4 – Removal/destruction of tissues requiring at least 45 minutes of operating time e.g., salpingo/oophorectomy cautery plaque involving ovary or obliteration of cul de sac	390.00	22.750
	Note: *Only one of tariffs 4603, 4604, 4605, 4606 may be claimed at one sitting.*		
4607	Laparoscopic assisted vaginal hysterectomy (LAVH) – with or without adnexa add to tariff 4631, or 4621	217.50	22.750
4608	Salpingolysis e.g. Fimbrioplasty, lysis of adhesions/debridement for infertility, unilateral or bilateral	250.00	22.750
	Note: *Tariff 4608 is not to be claimed with tariffs 4551 or 4603.*		
4551	Tuboplasty (e.g. salpingostomy) for infertility, unilateral or bilateral	372.70	21.375
	Note: *Tariff 4551 is not to be claimed with tariffs 4603 or 4608.*		
4696	The procedure(s) described above under Tariff 4551 when medically necessary to operate under the operating microscope	423.00	21.375
3572*	Laparoscopy, diagnostic	145.65	21.375
3574	Laparoscopy, diagnostic when followed at the same sitting by an open abdominal operation, add	70.00	21.375

		UNIT VALUE
3576*	Laparoscopy, diagnostic, performed at the time of possible I.V.F. or G.I.F.T. procedure 120.50	21.375

Note: This tariff is claimable only when done in a designated facility, by an appropriately trained physician who is a member of the I.V.F./G.I.F.T. team, and only when a previous diagnostic laparoscopy has not been performed within the previous nine (9) months by any member of the I.V.F./G.I.F.T. team.

ABDOMINAL OPERATIONS

4494	Enterocele repair—abdominal approach 282.00	21.375
4811	Extrauterine pregnancy, ectopic, removal by laparotomy 344.45	22.750
4561	Sterilization by any method, unilateral or bilateral 173.05	21.375
4562	Post partum sterilization by any method, unilateral or bilateral 173.00	21.375
4815	Hydatidiform mole, removal by dilatation and curettage 115.00	20.000

Note: *Repeat D & C for hydatidiform mole will be paid at the same rate.*

4829	Abdominal hysterotomy (mole or previable fetus) 290.00	21.375
4627	Hysterectomy, radical, with pelvic lymphadenectomy 828.25	22.750
4621	sub-total, with or without adnexal surgery 443.30	22.750
4617	total, with or without adnexal surgery 456.25	22.750
4620	Morbid obesity and/or stage 3-4 endometriosis–add to hysterectomy 102.00	22.750

Note: *1) Patient is morbidly obese when twice ideal body weight or 45 kilograms over ideal body weight or Body Mass Index > 35.*

2) Claims involving a morbidly obese patient must include the patient's Body Mass Index and weight.

3) For claims involving stage 3-4 endometriosis, documentation of the pathology report indicating stage 3-4 Endometriosis shall be included in the patient's record in order to support the claim to Manitoba Health.

4618	Selective pelvic lymph node dissection for gynaecologic cancer as an add on to Tariff 4617 ..... 317.80	
4619	Total extensive omentectomy at time of hysterectomy, for gynaecological cancer only 83.05	
4694	Hysterosalpingostomy and/or midtubal anastomosis, resection and anastomosis of tubes to uterus and/or resection and reanastomosis of the tube(s), unilateral or bilateral 370.00	21.375
4695	The procedure(s) described above under Tariff 4694 when medically necessary to operate under the operating microscope 447.00	21.375
4614	Myomectomy 385.00	21.375
4583	Oophorectomy, unilateral or bilateral, complete or partial 290.00	21.375
4571	Ovarian abscess or cyst, abdominal drainage 228.00	21.375
4581	cysts, excision, unilateral or bilateral 308.30	21.375

			UNIT VALUE
4567	Presacral neurectomy	***By Report***	22.750
4701	Ruptured uterus, non-obstetrical, suture	275.00	22.750
4545	Salpingectomy or Salpingo-oophorectomy total, unilateral or bilateral, when removed for morbidity, not for sterilization	398.30	21.375
4681	Uterine suspension	230.00	21.375
3571	Laparotomy, exploratory	360.00	22.750
4585	Laparotomy with biopsies to determine chemotherapy response for carcinoma of ovary	522.00	21.375
4586	with hysterectomy	561.00	22.750
4699	**Unlisted or Unusually Complicated**	***By Report***	22.750

OBSTETRICS

PREGNANCY AND MATERNITY

Please refer to General Schedule to determine the applicable after hours premium period for obstetrical deliveries and related services.

RULE OF APPLICATION 33

Obstetrics

33. a) Pre-natal care includes a comprehensive pre-natal assessment, follow-up pre-natal visits, which would generally occur at four week intervals to 28 weeks, followed by visits every second week to 36 weeks, then weekly until delivery. However, complicated pregnancies may require additional visits.

b) A comprehensive pre-natal assessment (8400) includes a full patient history, an inquiry into and examination of all relevant parts or systems, a comprehensive pelvic examination, completion of the pre-natal record and advice to the patient. All other pre-natal visits (8401), as well as post-natal visit (8402) include the necessary history, examination, appropriate record and advice to the patient. All pre-natal visits include pregnancy related counselling in the form of providing advice to the patient or the patient's representative(s).

c) The initial comprehensive pre-natal assessment (8400) generally should be about 20 minutes or longer in duration. The pre-natal visit (8401), as well as the post-natal visit (8402) generally should be about 10 minutes in duration, otherwise tariff 8509 (General Practice) or 8530 (Obstetrics & Gynaecology) should be claimed.

d) Other than during the pre-natal or post-natal visit, the physician may charge for all visits for conditions unrelated to the pregnancy, under the appropriate fee items listed elsewhere.

e) A post-natal visit (8402) may only be billed once following delivery. The post-natal period is usually considered as 6 weeks (42 days) following delivery. However, complicated pregnancies may require additional visits which should be claimed under the appropriate office, home or hospital visit tariffs.

f) Necessary laboratory investigation, routine urinalysis and haemoglobin estimation, etc., are payable in addition to the benefits for obstetrical care.

g) Benefits listed under the headings Induction of Labor and Management of Complications of Labor will be paid in addition to other obstetrical care benefits as outlined in the manual. A physician may claim for more than one complication of the first and second stage of labor.

h) Benefits for complications of the third and fourth stage of labor may be claimed by either the physician who performed the delivery, or another physician that is called in specifically for these complications. A maximum of one of tariffs 4843, 4844, 4845, 4846 and 4847 may be claimed.

i) Serious complications that require hospitalization prior to delivery are not included in the benefits provided for obstetrical care. Such complications will be paid for at the scheduled benefits if substantiated by **Special Report**.

j) If during the course of labor the attending physician calls a consultant to perform the delivery or caesarean section because complications have arisen, the attending physician may claim either tariff 4824, 4825 or 4826, in addition to the pre- and post-natal visits.

OBSTETRICAL BENEFITS

OBSTETRICAL CARE

			UNIT VALUE
4822	Routine vaginal delivery without manual removal of placenta, with or without repair of minor lacerations	406.10	20.000
4824	Attendance by physician during labor and delivery, or cesarean section when no surgical assistance or anesthesia services are provided by the physician, and the delivery/procedure is carried out by a consultant	250.00	
	Note: *The above benefit is not payable in addition to an assistant's fee.*		
4825	Attendance by physician during labor when the physician must transfer the patient to another facility because of fetal or maternal indications	150.00	
4826	Attendance by physician during labor and delivery, or caesarean section when the physician provides surgical assistance or anesthesia services and the delivery/procedure is carried out by a consultant	190.00	
	Note: *The physician may claim tariff 4826, and any applicable surgical assistant or anesthetic benefits.*		
4803	Caesarean hysterectomy	603.75	24.125
4800	Caesarean section with or without sterilization	473.80	22.750
4869	Physician attending a delivery for the care of the newborn at the request of another physician (due to high risk delivery or caesarean section)	110.00	
	Note: *This benefit will only be payable when accompanied by a* ***Special Report*** *when substantiated by the physician rendering the obstetrical service, and is chargeable in addition to the subsequent care of the newborn, or any other services provided by the physician. The attendance includes up to thirty (30) minutes care. In the event that procedures are performed during the first thirty (30) minutes these may be claimed if desired rather than Tariff 4869. In cases where care is necessary longer than thirty (30) minutes after birth, then fees for detention time beyond thirty (30) minutes should apply, subject to Tariff 8573 "Detention with a critically ill patient"—See* *General Schedule*		
4806*	Amniocentesis, initial or subsequent	56.90	20.000
4805*	Oxytocin challenge test with interpretation, technical component	28.05	
4804*	professional component	10.70	
4818*	Chorionic villus sampling, including ultrasound guidance for trophoblast biopsies for prenatal diagnosis	71.75	
4870	Dilatation and curettage for post partum bleeding (on re-admission to hospital)	90.00	21.375
4812	Fetal transfusion, intrauterine, initial and subsequent	290.00	21.375
4816	Diagnostic or therapeutic fetal umbilical vessel puncture and aspiration, including ultrasound guidance at the time of sampling only, or sampling and direct intravascular fetal transfusion	290.00	21.375
	Note: *The above benefit is for division between the two (2) physicians, the ultrasound guidance physician and the physician inserting the needle.*		
4817*	Physician transfusionist serving with the above service Tariff 4816	82.00	

		UNIT VALUE	
4819*	Dynamic ultrasound fetal risk initial assessment, including the collection and interpretation of biometric and morphometric data	32.05	
	Note: *1) In addition to the above, the physician may claim the appropriate visit examination benefit.*		
4820	Subsequent ultrasound fetal risk assessment, including the collection and interpretation of biometric or morphometric data and the patient assessment. This benefit is all inclusive and no visit fee is claimable in addition	35.00	
	Note: *2) The above two (2) services, Tariffs 4819 and 4820 are insured services only when provided in designated facilities and performed by appropriately trained physicians.*		
4809	Incompetent cervix in pregnancy, suture	120.50	21.375
4562	Post partum sterilization by any method, unilateral or bilateral	173.00	21.375
4875	Continuous conduction anesthesia (epidural)	88.86	
4876	for each subsequent injection	29.62	
4899	**Unlisted or Unusually Complicated**	***By Report***	24.125

INDUCTION OF LABOR

Note: *Only one (1) of the following may be claimed on any one (1) patient.*

4813*	Surgical	25.85	
4814*	Medical	72.45	

MANAGEMENT OF COMPLICATIONS OF FIRST AND SECOND STAGE OF LABOR

4828*	Initiation and supervision of internal electronic fetal monitoring	60.65	
	Note: *1) May only be claimed when a physician initiates and monitors the patient's progress.*		
	2) May be claimed in addition to delivery benefits regardless of who performs the delivery.		
	3) May only be claimed by one physician per delivery.		
	4) A claim for fetal monitor clip application under tariff 4836 may not be made in addition to this tariff.		
4830*	Abnormal presentation or position (delivered vaginally), breech	71.50	21.375
4831*	face and brow	69.25	21.375
4832*	multiple pregnancy	150.00	21.375
4833*	Transverse or occiput posterior position with forceps extraction and/or vacuum extraction (other than elective forceps)	71.50	21.375
4834*	Augmentation of labor (other than simple artificial ruptured membranes)	72.45	21.375
4835*	Prolonged rupture of membranes [twenty-four (24) hours or more]	71.50	21.375
4836*	Fetal monitor clip application and/or intrauterine catheter insertion (for measuring intrauterine pressures)	26.70	21.375
4837*	Scalp blood sampling for assessing fetal states in labor	26.70	21.375

			UNIT VALUE
4838*	Abruptio placenta	71.50	21.375
4839*	Double set-up (to rule out placenta praevia if patient does not proceed to cesarean section)	71.50	21.375
4840*	Hypertensive disorders requiring hypotensive regime and monitoring—P.E.T./Eclampsia	89.50	21.375
4841*	Vaginal delivery following previous caesarean section	71.50	21.375
4842*	Severe associated maternal condition or risk during pregnancy (e.g.—diabetes, chronic nephritis, renal transplant, Rh carditis)	69.75	21.375

MANAGEMENT OF COMPLICATIONS OF THIRD AND FOURTH STAGES OF LABOR

Note: *Only one (1) of the following may be claimed on any one (1) patient.*

4843	Manual removal of placenta	81.75	22.750
4844	3rd or 4th degree laceration	81.75	21.375
4845	Extensive vault and/or cervical laceration	81.75	21.375
4846	Evacuation of vulval hematoma under anesthesia	81.75	21.375
4847	Management of post partum hemorrhage requiring reassessment under anesthesia	81.75	22.750

ENDOCRINE SYSTEM

These benefits cannot be correctly interpreted without reference to the Rules of Application.

THYROID

INVESTIGATION

			UNIT VALUE
4910*	Needle aspiration biopsy (cytology)	20.20	20.000
4909*	Needle core biopsy (histology)	50.25	20.000
4908*	Needle biopsy of Neck Masses	25.25	
4907	Open biopsy	136.50	21.375

INCISION

4940*	Aspiration of thyroid cyst	18.15	21.375
2775*	Thyroglossal duct cyst incision and drainage	21.70	21.375

RESECTION

4911	Thyroidectomy, adenoma or cyst excision	282.00	21.375
4912	lobectomy, unilateral	572.70	21.375
4917	subtotal thyroidectomy	422.00	21.375
4914	total thyroidectomy	867.15	21.375
4925	Thyroidectomy, total or partial with neck dissection, modified (limited)	702.00	21.375
4924	radical (block)	805.00	21.375
4941	Thyroglossal duct cyst or sinus excision	386.40	21.375
4949	**Unlisted or Unusually Complicated**	***By Report***	22.750

PARATHYROID

RESECTION

4971	Exploration of the neck and/or removal of parathyroids or parathyroid tumor	896.80	21.375
4972	Mediastinal exploration by splitting of the sternum	657.00	24.125
4979	**Unlisted or Unusually Complicated**	***By Report***	24.125

ADRENAL

RESECTION

			UNIT VALUE
4988	Adrenalectomy or biopsy, unilateral	700.00	24.125
4989	bilateral, one (1) stage	678.00	24.125
4990	bilateral, two (2) stages	839.00	24.125
4991	**Unlisted or Unusually Complicated**	***By Report***	24.125

CAROTID BODY

RESECTION

4994	Carotid body tumor, excision	492.00	22.750
4993	excision with sacrifice of the carotid artery	684.00	22.750
4999	**Unlisted or Unusually Complicated**	***By Report***	22.750

RENAL TRANSPLANTS

These benefits cannot be correctly interpreted without reference to the Rules of Application.

			UNIT VALUE
5883	Renal transplant	1,800.00	24.125
5884	Cadaver nephrectomy—single for local implant or export	336.00	22.750
5885	Cadaver nephrectomy—double for local implants or export	660.00	22.750
5886	Live donor nephrectomy	812.20	22.750
5887	Rejection transplant nephrectomy	550.00	22.750
5888	Pre-transplant nephrectomy (recipient)—unilateral	490.00	22.750
5889	bilateral	859.00	22.750
5882	Marsupialization of post transplant lymphocele	498.40	22.750

Note: *The above fees represent the total fees of those surgeons in actual attendance and will be divided among the team in accordance with their involvement. They do not include Nephrologists fees which are listed below.*

NEPHROLOGISTS BENEFITS

5898	Donor related services; including the nephrological management of organ procurement, management of the neurologically "dead" donor on life support systems, the assessment of renal functions pre-nephrectomy, immunotherapy pre-nephrectomy, and assessment of potential recipients, etc.	281.00
5899	Recipient related services; including nephrological management of transplantation including examination. Supervision of osmotic loading, tissue typing, and interpretation of cytotoxicity tests, timing of initial suppression and detention in the operative theatre and complete patient care for the first three (3) days	393.00
5894	Subsequent postoperative routine care at daily care rates, per day	30.00
5895	Management of rejection crises, care ordinarily equivalent to that of the first three (3) postoperative days, per day	44.40
5896	Management of rejection crises requiring dialysis; as for acute renal failure (includes daily care by a Nephrologist); equivalent to repeat hemodialysis in acute renal failure, per dialysis—See existing schedule	148.50
5897	Dialysis without rejection crises, care equivalent to that for chronic renal failure on repeat hemodialysis, per dialysis—See existing schedule	39.65

Note: *The above fees represent the total fees for those Nephrologists directly involved with the transplant and will be divided amongst them according to the involvement of each.*

NERVOUS SYSTEM

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

These benefits cannot be correctly interpreted without reference to the Rules of Application.

		UNIT VALUE	
5290*	Alcohol injection subarachnoid	34.70	
5294*	2nd or 3rd branch of trigeminal nerve	56.00	
5295*	under x-ray control, excluding x-ray	64.25	
5296*	retrobulbar	63.50	20.000
5049*	Crutchfield tongs or other skeletal traction device, application	36.65	22.750
7900*	Nerve Conduction Studies Simple—Professional Testing performed on 2 or fewer motor and/or sensory nerves potentially involved by a disease process, with or without comparison testing. The physician performs or supervises the performance of the studies and interprets the results.	51.95	
7901*	Nerve Conduction Studies Simple—Technical	27.75	
7902*	Nerve Conduction Studies Intermediate—Professional Testing performed on 3 or 4 motor and/or sensory nerves potentially involved by a disease process, with or without a comparison test. The physician performs or supervises the performance of the studies and interprets the results.	73.85	
7903*	Nerve Conduction Studies Intermediate—Technical	29.65	
7904*	Nerve Conduction Studies Complex—Professional Testing performed on 5 or more sensory and/or motor nerves potentially involved by a disease process, with or without comparison testing of normal or opposite side nerves. The physician performs or supervises the performance of the studies and interprets the results	82.60	
7905*	Nerve Conduction Studies Complex—Technical	31.95	
7906*	Special Nerve Conduction Testing—Professional Special Nerve Conduction Studies may be claimed in addition to nerve conduction studies included in complex testing. The physician performs or supervises the performance of this test, and interprets the results	89.00	
7907*	H-Reflex—Claim in addition to tariffs 7900, 7902, and 7904 This test requires a comparison of left and right limbs	13.35	
7908*	EMG Complex—Professional Needle EMG testing performed on more than 4 muscles potentially manifesting consequences of a disease process, with or without comparison testing of normal or opposite side muscles	77.90	
7909*	EMG Complex—Technical	31.95	
7910*	EMG Limited—Professional Needle EMG performed on 4 or less muscles potentially manifesting consequences of a disease process, with or without comparison testing of normal or opposite side muscles	51.95	
7911*	EMG Limited—Technical	27.75	

7912* Repetitive Nerve Stimulation
Testing of 2 or more nerve/muscle combinations, with or without exercise. The test must be performed or supervised by the physician 46.25

7913* Brain Stem Evoked Audiometry Potentials—Technical
Should be conducted with bilateral stimulation unless patient context precludes 26.70

7914* Brain Stem Evoked Audiometry Potentials—Professional
Physician performance or supervision is required 19.65

7915* Brain Stem Evoked Audiometry Potentials—Interpretation 12.60

7916* Electroretinography—Technical 34.80

7917* Electroretinography—Interpretation 14.10

7939* Electroretinography—Professional Physician performance or supervision is required 23.85

7918* EEG Routine—Technical
16 or more channels recorded over a 20 minute period with referential and bipolar montages. Hyperventilation stimulation should be done in all cases possible where a contraindication exists 37.20

7919* EEG Routine—Professional 30.00

7920* Sleep Deprived Recordings
Sleep deprived recordings should be performed for at least 40 minutes. This tariff is not to be claimed in addition to studies testing sleep disorders, overnight recording, telemetry or other ambulatory EEG monitoring 59.70

7921* Screening Sleep Disorder Study—Interpretation
2 hour sleep study with continuous monitoring of oxygen saturation, ECG and ventilation by polysomngraphy with a technician in attendance during the study period 89.00

7922* Screening Sleep Disorder—Technical 80.10

7923* Prolonged (10 minutes) EEG—Professional
Supplemental recording of 16 or more channels mandated by the diagnostic issue being addressed, e.g., sleep deprived recording. Maximum of 30 minutes. Supplemental recording beyond 30 minutes must be submitted By-Report 10.30

7924* EMG—Single Fibre Electomyography (professional) 187.20

7925* EMG—Specialised Professional
Diaphragm, laryngeal, extraocular muscle or genital/rectal muscle needle EMG performed alone or in addition to other EMG. Needle EMG of other muscles requiring special techniques/expertise may be performed and submitted on a By-Report basis 62.50

7926* EMG Specialised—Technical 40.25

7927* Blink Reflex
Test must be performed or supervised by the physician, with testing of 2 or more nerve/muscle combinations, with or without exercise 35.60

7928* Autonomic Neurophysiology—Professional
Requires the performance of more than 2 tests of the autonomic nervous system function with electrophysiologic recording. Testing must be performed with physician supervision and interpretation. 35.60

7929* Evoked Potentials: Somatosensory—Technical
(Includes set-up per patient maintenance as necessary, as well as processing). 41.75

7930* Evoked Potentials: Somatosensory—Professional
Recording is required from any combination of 2 limbs. Physician performance or supervision is required 83.10

7931* Evoked Potentials: Additional 2 limbs—Professional
Physician performance or supervision is required..... 31.00

7932* Evoked Potentials: Additional 2 limbs—Interpretation 12.40

7933* Evoked Potentials: Additional 2 limbs—Technical 4.45

7934* Evoked Potentials: Somatosensory—Interpretation..... 24.25

7935* Visual Evoked Potentials—Technical
Monocular or binocular recording should be performed unless patient context precludes. Flash or pattern shift stimulation should be used. 18.85

7936* Visual Evoked Potentials—Professional
Physician performance or supervision is required..... 19.70

7937* Visual Evoked Potentials—Interpretation..... 10.60

7938* Tensilon Test..... 18.75

7940* Prolonged EEG—Technical..... 5.40

7941* EEG Telemetry—Professional..... 48.15

7942* EEG Telemetry—Technical..... 46.45

7943* Ambulatory (12-24 hrs.) EEG—Technical
Recording by telemetry or patient monitored recording device. Includes set-up per patient maintenance as necessary, as well as processing..... 41.30

7944* Ambulatory EEG—Professional..... 44.35

7945* Ischaemic forearm lactate exercise tests 44.50

BOTULINUM TOXIN

9757 Series of bilateral intramuscular injections of Botulinum Toxin for control of blepharospasms, including pre-injection assessment, any necessary EMG control, subsequent visits and any further injections within six (6) weeks.....130.00

9758 Series of intramuscular injections of Botulinum Toxin for control of hemifacial spasms, including pre-injection assessment, any necessary EMG control, subsequent visits and any further injections within six (6) weeks 130.00

9766 Series of unilateral or bilateral intramuscular injections of Botulinum Toxin for control of spasmodic torticollis, focal painful dystonia and strabismus, and spasmodic dysphonia including any EMG control, subsequent visits and any further injections within six (6) weeks.....146.55

Note: *Notwithstanding the above, in exceptional circumstances and by* ***Special Report*** *a physician may claim any of the above three tariffs a second time within the six (6) weeks following the initial series of injections.*

BOTULINUM TOXIN FOR HYPERHIDROSIS

9731 A series of botulinum toxin injections for axillary hyperhidrosis (bilateral) 200.00

9733 A series of botulinum toxin injections for palmar hyperhidrosis (bilateral) 300.00

9735 A series of botulinum toxin injections for plantar hyperhidrosis (bilateral) 450.00

Note: *1) Botulinum toxin injections are indicated in those cases of hyperhidrosis where conservative measures (e.g. aluminum choride, iontophoresis, or systemic medications) fail to resolve the problem or where the symptoms of hyperhidrosis are severe enough to give rise to emotional and social, as well as functional problems that impact the patient's quality of life.*

2) The treatment shall be administered by a specialist in Dermatology, Plastic Surgery or Neurology with appropriate experience/training in the use of botulinum toxin for these indications, as determined by a consultant group of the Manitoba Medical Association consisting of representatives from Dermatology, Plastic Surgery and Neurology.

3) The treatment includes pre-injection assessment, nerve blocs/local anesthetic, subsequent visits and any further injections within 12 (twelve) weeks.

PULSED RADIOFREQUENCY LESIONING

Lesioning of nerves arising from cervical or thoracic levels:

~5800 first level, per side 333.23

~5802 subsequent level, per side 251.77

Lesioning of nerves arising from lumbar or sacral levels:

~5805 first level, per side 251.77

~5806 subsequent level, per side 185.13

Lesioning of cranial nerves:

~5807 first level 777.53

Note: *1) Bilateral lesioning shall be claimed at 100% of the above fees when performed at the same sitting.*

2) To be claimed only at approved sites.

3) To be claimed only by qualified physicians designated by the WRHA Medical Director, Anesthesia Program in consultation with the Medical Director for the Provincial Pain Management Service.

4) Where monitored Anesthesia Care is required during these procedures it shall be claimed only when provided by a separate anesthesiologist.

5) The above procedures include fluorsocopy.

IMPLANTABLE INTRATHECAL DRUG PUMPS

8925* Assessment of intrathecal drug test doses 200.00

8926* Coordination, monitoring, and assistance in implantation of intrathecal drug pump 175.00

8927* Refill of implanted intrathecal drug pump 100.00

Note: *1) May be claimed by physicians designated as Physiatrists by The College of Physicians and Surgeons of Manitoba; or*

2) May be claimed by physicians designated as Anesthetists by The College of Physicians and Surgeons of Manitoba who provide services at the Health Science Centre Pain Clinic.

NERVE BLOCKS

Are paid as benefits only when injections are made to specific nerves as an isolated service for diagnostic or therapeutic purposes. They are not intended for cases where local anesthesia is used in lacerations and repairs, etc., and is obtained by general infiltration around the area of the nerve and they will not be paid in these cases except by ***Special Report***.

The benefit includes whatever number of injections are required for the specific nerve listed.

5311* Nerve plexus blocks 59.24

5300* cervical, single 88.86

5313* coccygeal 73.00

5361* ilioinguinal and iliohypogastric 33.90

5312* intercostal, one (1) or more 44.43

5313* lumbar 73.00

5298* paravertebral, (lumbar sympathetic) 88.86

5318* phrenic 88.86

5314* pudendal 34.15

5313* sacral 73.00

5317* sciatic 88.86

5320* sphenopalatine ganglion 88.86

5315* splanchnic/coeliac plexus 118.48

5316 supra and infra diaphragmatic nerve neurolysis including splanchnic, coeliac sympathetic nerves with x-ray contrast and x-ray control 177.72

5302* stellate ganglion 88.86

5319* peripheral nerve—single and multiple 44.43

~5301 Paraspinous block, per injection 50.00

Note: *1) Limited to specialists in Physical Medicine.*

2) Maximum of two (2) injections per visit.

3) No visit benefit will be paid in addition to this tariff if the patient's visit is for the procedure alone.

4) Maximum of six (6) treatments (of up to two (2) injections each) in a six (6) month period.

			UNIT VALUE
5062*	Puncture, cisternal (independent procedure)	21.60	22.750
5063*	Intrathecal antineoplastic chemotherapy by cisternal route	51.10	21.375
5061*	by lumbar route	49.60	21.375
5060*	Puncture, spinal, lumbar simple (independent procedure)	58.20	21.375
5057*	diagnostic, initial, with study of hydrodynamics	59.20	21.375
5059	if patient is under four (4) years, add the following to above two (2) procedures	7.00	22.750
5056*	subdural, through fontanelle (infant)	22.95	22.750
5058*	ventricular, through previous burr holes or fontanelle	37.55	22.750
5099*	Ventricular, with introduction of dye and recovery by spinal puncture	142.00	22.750
9866*	Photomotogram, tracing and interpretation	6.25	

SKULL, MENINGES AND BRAIN

See Rules 25 to 29 re multiple procedures at same operation sitting.

CRANIOTOMY FOLLOWING TRAUMA

5001	Brain scar, excision	***By Report***	24.125
5003	Burr Holes, exploratory, for subdural puncture, not followed by surgery, unilateral	236.40	24.125
5005	multiple, bilateral	360.00	24.125
5007	Cranioplasty for skull defect, bone, metal or plastic	733.00	24.125
5009	Dura repair by graft, including repair for cerebro-spinal Rhinorrhea	733.00	24.125
5011	Foreign body, removal from brain	729.00	24.125
5013	Hematoma, subdural, extradural or intracerebral, evacuation by burr holes only	684.00	24.125
5015	requiring craniotomy	808.00	24.125
5017	Skull fracture, depressed, “Ping Pong Ball” elevation	104.50	22.750
5019	depressed, simple elevation	568.00	22.750
5021	with debridement of brain and repair of dura	733.00	24.125

CRANIOTOMY FOR NON-TRAUMATIC CAUSES

5023	Burr Holes, exploratory, ventricular puncture, or ventriculography, not followed by surgery	146.00	24.125
5025	followed by surgery	146.00	24.125
5027	Craniectomy for craniostenosis, single suture	568.00	24.125
5029	multiple sutures	719.00	24.125
5031	sub-occipital for brain tumor	1,181.00	24.125
5033	sub-occipital for tractotomy or section of 5th, 8th, 9th or cranial nerves	1,114.30	24.125
5035	subtemporal for decompression	808.00	24.125
5037	for osteomyelitis of skull	***By Report***	24.125

		UNIT VALUE	
5065	Craniotomy, for brain abscess, drainage	626.00	24.125
5067	subsequent tapping aspiration, in operating room	70.75	24.125
5069	at bedside	36.30	
5071	for choroid plexus, excision	365.00	24.125
5073	for Gasserian ganglion, sensory root surgery	806.00	24.125
5075	for lobotomy, unilateral	290.00	24.125
5077	bilateral	437.00	24.125
5079	for orbital decompression, unilateral	776.00	24.125
5081	for pallidectomy, any method, including localizing techniques, single or multiple stages	776.00	24.125
5083	for topectomy	727.00	24.125
5084	Percutaneous thermocoagulation of trigeminal nerve, unilateral	594.40	22.750
5085	Craniotomy, osteoplastic, for arteriovenous malformation	***By Report***	25.500
5087	for excision of brain tumor, abscess or cyst, supratentorial	1,084.00	25.500
5089	for obliteration of aneurysm	1,243.00	25.500
5090	Carotid cavernous fistula closure with preservation of carotid artery	3,468.00	25.500
5098	Extracranial—intracranial arterial bypass	1,225.00	25.500
5091	Encephalocele, repair	***By Report***	24.125

HYDROCEPHALUS

	Percutaneous irrigation of shunt	F/S	
5093	Obstructed valve, replacement	248.40	24.125
5092	Revision of shunt under general anesthesia	155.60	24.125
5095	Shunt, removal in toto without replacement	232.00	24.125
5097	Ventricular catheter, replacement	239.40	24.125
5101	Ventriculo-auricular shunt	729.00	24.125
5103	Ventriculo-auricular peritoneal pleural ureteral shunt	733.00	24.125
5105	Ventriculocisternostomy	733.00	24.125

Note: *Re-opening of cranial operations within six (6) week period—50% of scheduled benefit, except for re-opening to remove infected bone flap when benefit will be:*

5106	Removal of infected bone flap	159.00	24.125

STEREOTACTIC SURGERY FOR INTRACRANIAL LESIONS, CYSTS OR ABSCESSES

			UNIT VALUE
5107	Computed tomography guided stereotactic surgery for needle biopsy of intracranial lesions, and for drainage of intracranial cysts or abscesses, to include ventriculography	700.00	22.750
5108	with implantation and removal of radioactive sources in the brain, add	200.00	
5118	Gamma Knife Radiosurgery – Neurosurgery component	800.00	22.750

Note: *1) Includes the review of submitted data, application of the stereotactic frame to the patient's head and revision and review of obtained images (either CT and/or MRI), the outline of the treatment plan and attendance with the patient for the duration of the radiosurgery.*

2) This surgery should be done in conjunction with the radiation oncologist.

5119	Gamma Knife Radiosurgery – Radiation Oncology Component	500.00	

Note: *1) Includes entering data from CT scan into the treatment planning computer, determining the treatment plan and prescription with the radiotherapy physicist, responsibility for the administration of the single fraction radiosurgery and presence throughout the entire procedure.*

2) This procedure is done in conjunction with the neurosurgeon.

SPINE AND SPINAL CORD

Laminotomy—Lumbar—See Arthrectomy

5201	Cordotomy, cervico-dorsal	706.00	21.375
5202	Percutaneous cordotomy (thermocoagulation technique), unilateral	655.00	21.375
5203	Intervertebral discs, excision anterior approach, cervical	600.00	22.750
5205	Laminectomy, for decompression of the spinal cord and nerve roots	761.70	22.750
5207	for lesion of spinal cord or meninges	812.50	22.750
5209	Laminotomy, for removal of intervertebral discs cervical	672.00	22.750
5210	with spinal fusion	685.00	22.750
5213	thoracic	640.00	22.750
5215	Lumbar subarachnoid-peritoneal-ureteral shunt	586.00	22.750
5217	Meningocele, repair	540.00	24.125
5219	Meningomyelocele	684.00	24.125
5221	Rhizotomy	568.00	22.750
5223	Spondylolisthesis, laminectomy	666.00	22.750
5224	Percutaneous implantation of neurostimulator electrodes, epidural or intradural	281.39	22.750
5226	Laminectomy for implantation of neurostimulator, epidural electrodes	476.40	22.750
5228	Incision and placement of subcutaneous neurostimulator/receiver (pack)	269.54	22.750

		UNIT VALUE
5230	Revision or removal of permanent spinal neurostimulator/receiver (pack) and/or electrodes beyond six (6) weeks from placement....269.54	22.750

Note: *Re-opening of spinal cord lesions within six (6) weeks—50% of schedule benefits.*

PERIPHERAL NERVES, OTHER EXTRACRANIAL NERVES AND GANGLIA

5225	Avulsion or transection of nerves, infraorbital....141.00	21.375
5227	occipital....290.00	21.375
5229	phrenic....108.50	24.125
5231	spinal....288.00	22.750
5233	Anastomosis, to establish other than normal anatomical continuity; spinal accessory-facial, spinal accessory-hypoglossal, hypoglossal-facial, etc....532.00	21.375
5235	Decompression, median nerve at carpal tunnel, simple....178.70	20.000
5237	Neurectomy, obturator....273.00	21.375
5239	Stoefel's....281.00	21.375
5244*	Sural nerve biopsy....56.25	20.000

SUTURE OF NERVES, PRIMARY

Note: *1) Additional nerves will be paid at 50% if done through the same incision; 75% if done through different incision.*

2) Microsurgery "add on" will be 40% payable on the basic fee only.

3) For secondary or delayed anastomosis or reanastomosis including local advancement to overcome a gap, add 25% to fee for primary repair.

5286	Suture and/or excision neuroma and/or neurolysis—minor nerve digital or cutaneous....180.90	20.000
5287	Suture and/or excision neuroma, and/or neurolysis—major nerve....371.80	20.000
5288	brachial plexus....***By Report***	21.375
5289	lumbar plexus....***By Report***	22.750
5291	sciatic nerve....***By Report***	22.750
5292	graft to minor nerve (e.g. digital or cutaneous)....253.00	20.000
5293	graft to major nerve....567.85	21.375
5284	Ulnar nerve, transplantation, including neurolysis (independent procedure)....170.00	20.000

VEGETATIVE NERVOUS SYSTEM

See Rules 25 to 29 re multiple procedures at same operation sitting.

SYMPATHECTOMY

			UNIT VALUE
5371	Cervical, unilateral	422.00	22.750
5372	bilateral	570.00	22.750
5375	Cervico-thoracic, Smithwicke type, supra and infra-diaphragmatic, unilateral	449.00	24.125
5376	bilateral, concomitant or delayed	717.00	24.125
5381	Lumbar, unilateral	400.00	21.375
5382	bilateral	545.00	21.375
5385	Splanchnicectomy, Peet type, unilateral	461.00	22.750
5386	bilateral	570.00	22.750
5390	Presacral neurectomy, hypogastric plexus	***By Report***	22.750

CENTRAL NERVOUS SYSTEM

5399	**Unlisted or Unusually Complicated**	***By Report***	22.750

OCULAR SYSTEM

These benefits cannot be correctly interpreted without reference to the Rules of Application.

SPECIAL DIAGNOSTIC OCULAR TESTS

			UNIT VALUE
9855*	Contact lens fitting, supervision for six (6) months, including three (3) visits	45.45	
9898	Initial fitting of contact lens following congenital cataract surgery [fee includes cost of lenses and services for six (6) months]	***By Report***	
9851*	Electroretinography	45.45	
5635*	Examination under general Anesthesia	79.50	20.000
	Note: *The above cannot be claimed together with a non-asterisked procedure at the same sitting.*		
9856*	Fluorescein fundus angiography, total	43.30	
9852*	professional	21.65	
9857*	Fluorescein fundus angioscopy	24.15	
9850*	Fundus photography (mm or Polaroid), unilateral or bilateral	9.15	20.000
9848*	Glaucoma, provocative test	20.05	
9847*	Gonioscopy or three mirror examination, bilateral	10.65	
9858*	Indirect ophthalmoscopy with scleral depressions for complete examination of the fundus and periphery with detailed drawing in patients with retinal pathology or suspected retinal pathology	18.25	
	Note: *An indirect ophthalmoscopy examination without a detailed drawing of pathology is often part of a routine eye examination. Tariff 9858 is not to be claimed in such circumstances.*		
9854*	Low vision aid assessment	27.45	
9849*	Special muscle studies	9.15	
9859*	Subconjunctival injection (independent procedure)	9.15	
9845*	Tonography	20.00	
	Note: *The above is done by a machine which makes a graph. Tonometry—the measurement only, is part of refractions and when done separately is included in the office visit.*		
9853*	Visual fields, perimetry or tangent screen	16.40	
9846*	perimetry and tangent screen	26.40	
9789*	Computerized perimetry screening, professional component	8.30	
9771*	technical component	10.35	
9790*	total	18.65	
9791*	Computerized perimetry threshold, professional component	10.35	
9772*	technical component	20.75	
9792*	total	31.10	

		UNIT VALUE
9890*	Ultrasonography of eye to determine axial length (ophthalmic biometry A-mode)—payable only when done in preparation for cataract surgery, total	59.00
9891*	professional component	29.55
9892*	technical component	29.45
9893*	Ultrasonography of eye A-mode for other conditions (specify condition)	50.00
9894*	professional component	25.00
9895*	technical component	25.00

Note: *For bilateral ultrasonography procedures, add 50%. The above tariffs are to be claimed only when the services are performed outside of publicly funded institutions.*

ANESTHESIA FOR EYE SURGERY

The following procedure has a single benefit whether one (1) or more is used and is in addition to the surgical procedure.

5500*	O'Brian Akinesia—Retrobulbar Block—Van Lint Akinesia (not to be claimed with tariff 5612 unless in conjunction with a second major procedure)	27.45

EYE SURGERY

ORBIT

5662	Orbit, excision of benign lesion requiring bone flap	582.00	22.750
5681	plastic repair	***By Report***	22.750
5664	Orbital contents, exenteration or evisceration with or without graft	563.00	22.750
5651	Orbitotomy, with exploration	437.25	22.750
5652	with drainage of intraorbital abscess	400.00	22.750
5653	with removal of intraorbital foreign body	383.00	22.750
5665	Blowout fracture of orbit and repair surrounding tissues with or without implantation of silicone	366.00	22.750
5296*	Retrobulbar injection of alcohol	63.50	20.000

EYELIDS

	Repair of lacerations of eyelids—See Integumentary System		
5691*	Blepharotomy with drainage of abscess	13.40	21.375
5692*	with drainage of Meibomian glands, Hordeolum (stye)	13.40	21.375
5728*	Ectropion or entropion, cautery puncture	31.90	21.375
5730	Entropion or trichiasis, simple plastic repair (e.g. Wheelers operation)	90.75	21.375
5731	Ectropion or Entropion—full thickness, excision and repair by advancement flaps (including tarsal plate) up to 1/4 eyelid margin	280.85	21.375
5732	over 1/4 eyelid margin	320.00	21.375

			UNIT VALUE
5698	Levator palpebrae muscle, resection or equivalent surgery for ptosis	367.95	21.375
5697	recession	325.00	21.375
5712*	Epilation, electrolytic or by cryotherapy	18.60	21.375
5702*	Meibomian gland (chalazion) incision and excision, single	38.25	21.375
5703*	multiple	47.25	21.375
5734	Tarsorrhaphy, suture of tarsal cartilage	100.50	21.375

RHYTIDECTOMY

Note: *Rhytidectomy, when done as elective plastic surgery for cosmetic purposes is an exclusion under the "Act", except where the Minister is satisfied prior to the operation that such surgery is medically required. It is the responsibility of the physician to obtain this approval prior to the operation.*

See Rhytidectomy under Integumentary Section.

0328	Rhytidectomy, eyelid lower	174.50	21.375
0329	eyelid upper	107.15	21.375

BOTULINUM TOXIN

9757	Series of bilateral intramuscular injections of Botulinum Toxin for control of blepharospasms, including pre-injection assessment, any necessary EMG control, subsequent visits and any further injections within six (6) weeks	130.00	
9758	Series of intramuscular injections of Botulinum Toxin for control of hemifacial spasms, including pre-injection assessment, any necessary EMG control, subsequent visits and any further injections within six (6) weeks	130.00	

Note: *Notwithstanding the above, in exceptional circumstances and by* ***Special Report*** *a physician may claim either of the above two tariffs a second time within the six (6) weeks following the initial series of injections.*

LACRIMAL DUCT, SAC AND WALL

5803*	Lacrimal sac, drainage	25.95	20.000
5843*	Naso-lacrimal duct, probing, initial	21.05	20.000
5844*	subsequent	9.45	20.000
5845*	under general Anesthesia	87.45	20.000
5835*	Punctum, closure by cautery	25.45	20.000
5841*	dilatation and irrigation of naso-lacrimal duct	12.75	20.000
5842*	Canaliculoplasty (3 snip procedure)	47.65	20.000
5831	Canaliculi, plastic repair	334.45	20.000
5811	Dacryoadenectomy, excision of lacrimal gland	199.00	20.000
5813	Dacryocystectomy, excision of lacrimal sac	300.00	20.000
5804	Dacryocystomy or dacryocystostomy, intranasal	121.50	20.000

			UNIT VALUE
5833	Dacryocystorhinostomy fistulization of lacrimal sac into nasal cavity with or without anterior ethmoidectomy, Toti	439.85	20.000
5801	Lacrimal gland, drainage of abscess	64.75	20.000
5815	tumor excision	321.00	20.000
5821	Lacrimal nasal duct, catheterization, initial, in hospital	63.50	20.000

OCULAR MUSCLES

5647	Muscle transplant	320.00	21.375
5641	Myotomy, tenotomy, recession, resection, advancement or shortening of ocular muscles for strabismus, one muscle	334.65	21.375
5642	each additional muscle at the same operation whether unilateral or bilateral	110.50	21.375
5643	subsequent operation, one muscle	131.00	21.375
5644	each additional muscle	33.45	21.375
5645	for adjustable suture(s), per eye, add	115.15	

CONJUNCTIVA

5751*	Biopsy	42.85	20.000
5753*	Cyst or other lesion, excision	31.90	20.000
5741*	Foreign body removal, from surface	6.70	20.000
5742*	embedded, single	13.40	20.000
5744*	multiple	***By Report***	20.000
5743*	Suture for laceration	18.60	20.000
9859*	Subconjunctival injection (independent procedure)	9.15	
5775	Conjunctival flap for corneal ulcer, perforating wound, etc.	175.00	22.750
5777	Conjunctiva or mucous membrane graft	***By Report***	22.750
5778	Conjunctiva dacryocystorhinostomy with implant	406.00	22.750

CORNEA

5445*	Foreign body removal, single	23.05	22.750
5446*	multiple	***By Report***	22.750
5465*	Ulcer, curettage and cauterization	18.25	
5451	Keratectomy, partial	191.50	22.750
5452	complete	259.00	22.750
5471	Keratoplasty, corneal transplant, lamellar or penetrating	576.45	22.750
5441	Keratotomy, any type	63.75	22.750
5481	Perforated cornea suture	228.40	22.750

			UNIT VALUE
5456	Epikeratophakia in cases with medical necessity such as aphakia in children, and aphakia in adults in whom intraocular lenses are unacceptable or secondary lenses inappropriate, severe astigmatism, certain corneal abnormalities, and injury. Epikeratophakia is not an insured service when done as a cosmetic procedure.	517.00	22.750
5457	Pterygium, excision	127.00	22.750
5458	and repair of defect by free conjunctival graft, including repair of donor site	275.00	20.000

SCLERA AND ANTERIOR CHAMBER

5496*	Aspiration, diagnostic	24.80	
5497*	Injection	26.50	
5501	Anterior chamber, irrigation and reformation	320.00	21.375
5493	Intraocular foreign body, removal with magnet without operative incision	195.00	22.750
5492	removal from anterior and posterior chamber with magnet, with incision	320.00	22.750
5494	removal of non-magnetic intraocular foreign body from posterior chamber with incision	383.00	22.750
5495	Sclerotomy, posterior	186.00	21.375
5521	Suture of sclera for wound or injury	***By Report***	22.750

IRIS AND CILIARY BODY

5551	Ciliary body, diathermy or cryotherapy	156.50	21.375
5554	Cyclodialysis	320.00	21.375
5401	Goniotomy, primary	198.50	21.375
5552	Iridodialysis, repair	256.00	21.375
5533	Iridotomy with photocoagulator	63.50	21.375
5541	Lesion of iris, excision	331.00	21.375
5542	and ciliary body, excision	461.00	21.375
5546	Surgical iridectomy	280.00	21.375
5547	Surgical trabeculectomy or similar filtering procedure for the treatment of glaucoma	425.00	21.375
5561	Prolapsed iris, repair with suture of perforated sclera or cornea	***By Report***	21.375
5532	Laser iridotomy, professional	103.00	21.375
5534	total	193.30	21.375
5538	Laser trabeculoplasty, professional	125.00	21.375
5537	total	196.00	21.375

CRYSTALLINE LENS

5604	Aspiration of lens material for congenital cataract, one or more stages	320.00	21.375
5601	Discission, needling of lens, primary	127.00	21.375
5602	secondary	63.50	21.375

			UNIT VALUE
5611	Extraction of lens, intracapsular or extracapsular, unilateral, with or without iridectomy	419.80	21.375
5610	Insertion of secondary intraocular lens	337.00	21.375
5612	Extraction of lens with insertion of intraocular implant—unilateral, with or without iridectomy	491.35	21.375
5615	Repositioning of intraocular lenses	122.00	21.375
5614	Removal of intraocular implant, unilateral	276.00	21.375
5613	Capsulectomy	228.00	21.375
5535	Laser capsulotomy, vitreolysis of vitreous bands, iridoplasty, pupilloplasty, synechiotomy, professional	103.00	21.375
5536	total	163.00	21.375

VITREOUS

5622	Planned anterior vitrectomy as a secondary procedure	254.00	21.375
5624	Removal of vitreous body by posterior or anterior approach with or without extraction of lens	824.45	21.375

RETINA

5631	Reattachment of retina; coagulation, scleral resection, with insertion of implant, with or without encircling band	684.45	22.750
5638	subsequent operation	730.00	22.750
5639	removal of band	268.00	22.750
5634	Coagulation of retina for neovascular disease, initial	263.95	21.375
5636	subsequent [within sixty (60) days of last coagulation treatment]	171.50	21.375
5632	Coagulation of retinal break(s), one (1) or more stages	244.00	22.750
5630	Coagulation of retina for tumor(s), one (1) or more stages of the same lesion	247.30	21.375
5633	with draining of subretinal fluid	445.00	22.750

PHOTODYNAMIC THERAPY

Note: *Payable only for services rendered at a designated facility (Misericordia Health Centre) by a retinal specialist.*

5693	Photodynamic therapy for wet macular degeneration—one eye	350.00
5694	Photodynamic therapy for wet macular degeneration—second eye at same sitting, add	100.00
5695	Photodynamic therapy for choroidal neovascularization other than wet macular degeneration—one eye	350.00
5696	Photodynamic therapy for choroidal neovascularization other than wet macular degeneration—second eye at same sitting, add	100.00

EYEBALL

			UNIT VALUE
5411	Enucleation or evisceration	228.00	22.750
5413	with implant	433.90	22.750
5414	secondary implant	304.25	22.750
5438	Enucleation of eye for eye bank, unilateral or bilateral	103.00	22.750
5431	Suture of eyeball for wound or injury	***By Report***	21.375

OCULAR

5439	**Unlisted or Unusually Complicated**	***By Report***	22.750

AUDIO-VESTIBULAR SYSTEM

These benefits cannot be correctly interpreted without reference to the Rules of Application.

DIAGNOSTIC PROCEDURES

Automated impedance tympanometer with hand-held micro tympanometer (included in visit fee) ..... F/S

Audiogram—screening ..... F/S

9745* Audiogram—puretone—air & bone (bilateral), total 18.25

9740* professional portion 8.55

9746* air & bone with speech tests (bilateral), total 24.50

9742* professional portion 11.40

9749* air & bone with speech tests and suprathreshold tests (bilateral), total 24.00

9744* professional portion 12.00

9770* Automated impedance tympanometer with or without ipsilateral or contralateral reflexes, total 8.20

9786* professional portion 6.95

ADVANCED TESTING

Note: *1) A maximum of three (3) advanced tests are payable at the same sitting.*

2) When performed at the same sitting as Tariffs 9770 and 9786, a maximum of two (2) advanced tests are payable in addition.

3) When performing contralateral reflexes as a single test, claim Tariff 9770 or 9786.

4) The benefit amounts listed are for unilateral or bilateral testing.

5) These tariffs are payable only to physicians with appropriate training in advanced testing as determined by The College of Physicians and Surgeons.

9788* Four (4) frequency acoustic reflex thresholds to test the integrity across brain stem pathways, total 15.00

9797* professional portion 6.35

9709* to assist in diagnosis of recruitment, total 15.00

9712* professional portion 6.35

9714* Two (2) frequency acoustic reflex decay estimations to assist in diagnosis of cochlear nerve lesions, total 15.00

9723* professional portion 6.35

9755* Torsional rotation test 27.00

		UNIT VALUE	
9756*	Cortical evoked or brain stem evoked audiometry (electrocochleography) professional fee only	50.00	
	Note: *The above service is an insured service only when provided in a facility designated by the Minister.*		
9747*	Hearing aid evaluation	25.00	
9748*	Caloric tests	25.00	
9750*	Electronystagmography	52.00	

EAR CANAL

5979*	Removal of Cerumen, by syringing, irrigation, curretting or debridement, unilateral or bilateral	13.50	
5980*	Ear, foreign body removal	13.50	
5981*	Ear, foreign body removal in hospital under local or general anesthetic	47.30	20.000
5982*	Polyp removal in office	32.90	
5959*	Microscopic debridement of ears	29.10	20.000
	Note: *The above benefit may be claimed when indicated in cases of chronic otitis media with cholesteatosis and/or pathology in the middle ear or mastoid cavities, keratosis obturans, cholesteatosis of the external canal, and postop or post-radiotherapy debridement. This benefit is not to be claimed when debridement of ears under microscopy is done for removal of cerumen or examination only.*		
5955*	Microscopic debridement of the external auditory canal when medically necessary for other reasons, ***By Report***	28.55	20.000
5961*	Myringotomy	19.65	20.000

EXTERNAL EAR

5922	Exostoses, excision, single, pedunculated	96.00	21.375
5925	multiple, sessile	393.00	21.375

OTOPLASTY

Note: *Otoplasty in patients over the age of sixteen (16) years is generally not eligible for benefits unless the Minister is satisfied prior to the operation that such surgery is necessary for medical reasons.*

5940	Otoplasty: plastic operation on ear—unilateral	245.60	21.375

Reconstruction of ear with graft of skin plus cartilage, bone or other implant—
See Integumentary System and Bone Graft.

MIDDLE EAR

6011	Labyrinthotomy or labyrinthectomy	541.00	21.375
5977	Mastoid obliteration	388.00	21.375
5970*	Cautery and patching of ear drum	19.45	21.375

			UNIT VALUE
5971	Mastoidectomy, cortical	291.00	21.375
5975	radical or modified radical	527.35	21.375
5976	Temporal Bone Resection for neoplasm, subtotal and lateral, to include mastoidectomy and excision of external auditory canal but not including muscle flap reconstruction.	1,265.25	22.750
	Note: *Muscle flap reconstruction is payable in addition under Tariff 0384.*		
5972	Implantation of electromagnetic bone conductor hearing device	350.00	21.375
5993	Myringoplasty	339.00	21.375
5983	Polyp, middle ear, removal in hospital	67.50	21.375
6001	Post-aural fistula, closure	134.50	21.375
6031	Stapedectomy with prosthesis, fenestration of oval window	676.00	21.375
6033	Stapes mobilization	386.00	21.375
5992	Tympanoplasty with mastoidectomy	676.00	21.375
5991	without mastoidectomy	479.90	21.375
5962	Myringotomy, with insertion of tubes, unilateral or bilateral	125.00	20.000
5963	removal of tubes under general anesthetic	29.10	20.000
5956	Tympanotomy, exploratory for deafness or other reason	231.00	20.000
5997	Major congenital ear anomalies operations unilateral (up to a maximum of $667.00)	***By Report***	21.375
5998	less than major procedures, unilateral	***By Report***	21.375
5995	Endolymphatic shunt, unilateral	676.00	22.750
5957	Posterior tympanotomy with full ear reconstruction, unilateral	662.00	21.375
5960	Closure of perilymph fistula	399.00	21.375
5958	Iontophoresis of middle ear, per treatment	67.75	

AUDIO–VESTIBULAR SYSTEM

5969	**Unlisted or Unusually Complicated**	***By Report***	22.750

DIAGNOSTIC RADIOLOGICAL PROCEDURES

Column Tec.

The benefit for radiographic examinations, including the production of radiographs, supply of contrast media, equipment maintenance, capital cost of replacement equipment, fixed and variable overhead costs of the premises, technical services administration, production of one or more copies of the report by a certified radiologist and fee collection costs.

Column Pro.

The benefit for supervision of imaging services, advising the referring physician as to the most appropriate imaging modality, maintenance of quality control, imaging interpretation and fluoroscopic assessment.

CONSULTATIONS

8550	Radiology Consultation	53.85

Note: *A radiology consultation may be claimed following a written request from a physician for a radiologist's opinion regarding the advisability of performing a radiological procedure. It shall consist of such examination of the patient as necessary and appropriate and a discussion of the risks and limitations of the proposed procedure. A written or dictated report shall be provided to the referring physician.*

This tariff may be claimed regardless of whether the radiologist renders additional services and/or procedures to the patient during or following the initial visit.

		COLUMN TEC	COLUMN PRO
7600	Review of Submitted Imaging Study		24.75

Note: *1) This tariff may be claimed following a written request from a physician for a review and interpretation of a submitted imaging study performed elsewhere.*

2) This tariff may be claimed for each imaging study reviewed.

3) A written or dictated report shall be provided to the referring physician.

HEAD AND NECK

7004	Eye—orbits	19.60	6.00
7009	Facial bones	17.40	7.90
7022	Larynx or nasopharynx or neck for soft tissue	17.40	6.00
7006	Mandible	24.40	6.00
7008	Mastoids routine	29.70	7.90
7010	Nasal bones	19.60	6.00
7001	Panorex	12.85	4.20
7012	Paranasal sinuses	25.70	11.60
7020	Salivary gland	17.40	6.00

		COLUMN TEC	COLUMN PRO
7014	Skull	27.35	7.90
7015	Zygomatic Arch Views	21.10	4.80
7007	Temporomandibular joints	31.55	6.30
7400	Added views of any of the above (not films) additional	7.50	4.00
CHEST			
7024	Chest, single P.A.	18.50	8.00
7025	P.A. and lateral	22.40	10.00
7027	Chest fluoroscopy	6.20	7.00
7032	fluoroscopy and radiography	23.70	12.80
7033	Pacemaker (fluoro and films)	17.45	5.65
7026	Portable chest	18.55	8.00
7331	Ribs, both sides	24.75	9.80
7031	one (1) side	24.40	6.00
7332	Thoracic Inlet [two (2) views]	18.05	5.35
7401	Added views of any of the above (not films) additional	7.50	4.00
SPINE AND PELVIS			
7039	Pelvis, A.P. view	20.50	9.00
7339	with lateral hip joint	30.30	12.60
7041	Sacroiliac joints	19.60	6.00
7341	Skeletal survey [thorax, skull, thoracic and lumbar spine, pelvis, two (2) long bones]	65.75	17.95
7035	Spine, complete	64.35	21.40
7037	two (2) full areas	55.75	21.40
7277	Skeletal survey—suspect child abuse	65.75	31.15
7036	Cervical spine, routine views	31.00	12.00
7038	with special added views (obliques, and/or flexion and extension)	35.70	15.10
7193	Lumbo-sacral, routine views	31.10	12.10
7054	with special added views (obliques, and/or flexion and extension)	35.70	15.20
7194	Thoracic spine	30.00	7.00
7061	Single combining region (thoraco-lumbar)	28.55	7.00

		COLUMN TEC	COLUMN PRO
7034	Sacrum and/or coccyx	27.95	7.45
7057	Scoliosis series	66.05	15.70
7402	Special views [minimum two (2) views] e.g., obliques done as a special request (at a separate visit)	28.55	7.00

Note: *1) When examination includes routine views of two (2) areas e.g., lumbo-sacral and cervical, this should be claimed as—two (2) full areas—See Tariff 7037*

2) When examination includes routine views of three (3) or more areas, this should be claimed as—spine, complete—See Tariff 7035.

UPPER EXTREMITY

7065	Bone age studies	12.25	6.00
7046	Clavicle	17.40	6.00
7048	Elbow	23.00	8.00
7052	Fingers	15.00	8.00
7049	Forearm	22.10	4.80
7051	Hand	17.50	8.00
7047	Humerus	21.10	4.80
7093	Joints—acromio-clavicular with weights	20.85	7.50
7045	sterno clavicular	29.65	6.00
7046	Scapula	17.40	6.00
7044	Shoulder, A.P. and lateral routine	22.50	10.10
7069	Sternum	18.80	4.80
7050	Wrist	18.20	8.00
7403	Added views of any of the above (not films) additional	7.50	4.00

LOWER EXTREMITY

7059	Ankle	18.20	8.00
7066	Bone length study with precise measurement	12.40	11.80
7366	Calcaneus	20.00	4.80
7055	Femur	23.00	4.80
7060	Foot	17.50	8.00
7053	Hip	26.70	10.00
7056	Knee or patella	19.30	8.50
7058	Tibia and fibula	23.00	4.80
7062	Toes	8.70	2.95
7404	Added views of any of the above (not films) additional	8.00	4.00

		COLUMN TEC	COLUMN PRO
ABDOMEN			
7067	Abdomen, single view	18.80	6.75
7068	two (2) views	30.00	12.20
7072	Management of long intestinal tube manipulation fluoroscopy	25.30	35.20
GASTROINTESTINAL TRACT			
7073	Esophagus, fluoroscopy and radiography	27.35	20.00
7116	Swallowing function, pharynx and/or esophagus with fluoroscopy and/or video.	29.55	24.90
7117	Video palate study fluoroscopy and/or video	29.55	20.20
7074	Stomach and duodenum, fluoroscopy and radiography (including esophagus)	52.40	22.70
7190	hypotonic duodenography	36.60	19.90
7075	with small bowel series	63.00	27.00
7376	Esophagus, stomach, duodenum (including survey films, if taken) double contrast with or without glucagon or other relaxant	65.00	33.00
7377	with small bowel series	59.40	30.60
7076	Small bowel series—radiography and fluoroscopy	37.15	20.00
7077	Colon—Single contrast barium enema	54.20	23.00
7078	Colon—Double contrast barium enema	82.00	39.70
7079	Cholecystogram, oral	33.90	10.30
7081	retrograde/tube cholangiogram	27.95	9.35
7082	in operating room	28.20	8.35
URINARY TRACT			
7192	Ileal Conduit Loopogram	48.20	11.70
7083	K.U.B.	21.60	9.50
7084	Pyelogram, intravenous, routine including preliminary film	49.75	25.50
7385	Retrograde pyelogram	27.35	7.90
7387	Retrograde urethrography	21.30	16.45
7405	Added views of any of the above (not films) additional	7.50	4.00
7118	Nephrostogram	27.35	7.05
OBSTETRICAL STUDIES			
7089	Abdomen and pelvis for fetus	18.80	4.80
7090	Pelvimetry	28.55	9.00

COMPUTERIZED AXIAL TOMOGRAPHY

		COLUMN PRO
BRAIN		
7112	Infused examination of the brain	66.00
7113	Non-infused examination of the brain	48.00
7114	Infused and non-infused examination of the brain	76.00
NON-BRAIN		
7221	Skull base (internal auditory canals, sella turcica) examination	95.00
7222	Facial bone (orbits) examination	95.00
7223	Neck examination	95.00
7224	Thorax examination	95.00
7225	Abdomen and/or pelvis examination	99.85
7226	Musculoskeletal examination	95.00
7227	Spine—cervical examination	95.00
7228	thoracic examination	95.00
7229	lumbar examination	95.00
7230	Biopsy and/or drainage	95.00
7231	3-D Workstation Review (applies to CT schedule)	80.00

Note: *1) Additional CT scans of **different** anatomic regions on any one (1) patient on the same day may be claimed at 100% of the fee schedule.*

*2) A second CT scan of the **same** anatomic region on any one (1) patient on the same day may be claimed at 50% of the fee schedule but only in exceptional circumstances, and by **Special Report**.*

3) Computerized Axial Tomography is an insured service only when provided in a facility designated by the Minister.

SPECIAL PROCEDURES—ANGIOGRAPHY

SUPERVISION & INTERPRETATION

For Column C (The Procedural Portion) Of Angiograms—See Angiograms Section.

		COLUMN TEC	COLUMN PRO
AORTOGRAMS			
7120	Abdominal	76.30	41.20
7121	Arch	76.30	41.20
7122	Intravenous	76.30	31.20
7123	Thoracic	76.30	41.20
7124	Translumbar	76.30	31.20
7125	Other—specify	76.30	31.20
7126	For two (2) examinations done on same patient, on same day	102.35	41.65
SELECTIVE ANGIOGRAMS			
7130	Adrenal arteriogram	76.30	31.20
7131	Angiographic examination dialysis shunt	76.30	31.20
7132	Axillary	76.30	31.20
7133	Brachial	76.30	31.20
7107	Cerebral (brachial retrograde)	76.30	31.20
7134	Bronchial	76.30	31.20
7135	Carotid	63.80	41.20
7136	Celiac	76.30	41.20
7137	Common iliac	76.30	31.20
7129	Popliteal, with antegrade catheterization	76.30	31.20
7138	External carotid arteriogram	76.30	31.20
7139	Hepatic	72.95	29.05
7140	Inferior mesenteric	76.30	31.20
7141	Innominate	73.50	29.50
7142	Internal iliac	76.30	31.20
7143	Renal	76.30	41.20
7144	Superior mesenteric	76.30	41.20
7145	Subclavian	76.30	31.20

		COLUMN TEC	COLUMN PRO
7146	Splenic	71.30	31.20
7147	Vertebral	72.95	39.05
7148	For two (2) examinations done on same patient, on same day	102.35	41.65
7149	For three (3) examinations done on same patient, on same day	152.75	62.25
7152	Bilateral selective angiogram or venogram	102.35	41.65
7127	Internal mammary	76.30	31.15
7128	Left gastric	76.30	31.15
7180	Gastroduodenal	76.30	31.15

SUPERVISION & INTERPRETATION

7181	Internal carotid	76.30	36.40
7182	Super selective angiogram (e.g. distal branch of any of the above selectives)	76.30	36.40

FEMORAL ARTERIOGRAMS

7150	Unilateral	50.95	22.75
7151	Bilateral	76.30	34.65

VENOGRAMS

7153	Azygogram	72.95	29.05
7154	Femoral	73.50	29.50
7155	Iliac	76.30	31.20
7156	Inferior vena cavogram	76.30	31.20
7157	Intraosseous	76.30	31.20
7158	Jugular	76.30	31.20
7159	Lower limb	76.30	41.20
7179	Orbital venogram	76.30	31.20
7160	Subclavian	76.30	31.20
7161	Superior vena cavogram	72.80	31.70
7162	Umbilical vein catheterization	76.30	31.20
7163	Upper limb	72.95	29.05
7164	For two (2) examinations done on same patient, on same day	97.70	38.80

SELECTIVE VENOGRAMS

7165	Adrenal	76.30	31.20
7166	Hepatic	76.30	31.20
7167	Jugular	76.30	31.20

		COLUMN TEC	COLUMN PRO
7168	Renal	76.30	31.20
7152	Bilateral selective angiogram or venogram	102.35	41.65
7169	For two (2) examinations done on same patient, on same day	102.35	41.65

ANGIOGRAPHY, BY EXPOSURE OF MAJOR VEIN

7170	Abdominal or thoracic	76.30	31.20
7171	Cerebral	76.30	31.20

ANGIOCARDIOGRAMS

7172	Atrial, left	76.30	31.20
7173	right	72.95	29.05
7174	Pulmonary angiogram	72.95	29.05
7175	Selective coronary angiogram	76.30	33.00
7176	with left or right heart catheterization	76.30	31.20
7177	Ventricular, left	76.30	50.00
7178	right	76.30	31.20

Note: *For all above Angiography procedures, introduction may be made by:*

- *Percutaneous needle or cut down on superficial peripheral vein.*
- *Percutaneous catheter or cut down on superficial peripheral vein.*
- *Exposure of major artery.*

"Selective" means instrument passed deliberately into branch, tributary or cardiac chamber.

INTERVENTIONAL NEURORADIOLOGY

SUPERVISION & INTERPRETATION

For Column C (the procedural portion) of Neuroradiology, see Angiograms Section

7183	Intracranial AVM embolization	36.65
7184	Intracranial AVM coiling	36.65
7185	Intracranial intra arterial thrombolysis	36.65
7186	Intracranial intravenous thrombolysis	36.65
7187	Intracranial tumor embolization	36.65
7188	Embolization of epistaxis	36.65
7189	Carotid cavernous fistula occlusion	36.65
7195	Carotid artery balloon test occlusion	36.65
7196	Carotid artery permanent balloon occlusion	36.65
7197	Angioplasty of intracranial vasospasm	42.80

		COLUMN TEC	COLUMN PRO
7198	Percutaneous vertebroplasty		32.55
7199	Percutaneous imaging guided nerve root injection		32.55
7200	Percutaneous imaging guided facet joint injection		32.55

TRANSCATHETER PROCEDURES—INTERVENTIONAL RADIOLOGY

SUPERVISION & INTERPRETATION

For Column C (the procedural portion) see Transcatheter Procedures.

7257	Venous sampling through catheter, (eg. for parathyroid hormone, renin)		36.65
7258	Transcatheter therapy, embolization, any method		36.65
7259	Transcatheter therapy, infusion, any method, (eg. Thrombolysis other than coronary)		36.65
7260	Percutaneous placement of IVC filter		36.65
7261	Transcatheter retrieval, percutaneous, of intravascular foreign body (eg. fractured venous or arterial catheter)		36.65
7262	Transluminal angioplasty, any method, peripheral artery		42.80
7263	Transluminal angioplasty, venous (eg. subclavian stenosis)		42.80
7264	T.I.P.S (Transjugular intrahepatic portosystemic shunt)		36.65
7265	Mammary ductogram or galactogram, single duct		13.35
7266	Mammary ductogram or galactogram, multiple ducts		13.35
7267	Dialysis Graft Thrombectomy		36.65
7268	Image guided central line placement		36.65
7269	Vascular stent placement		36.65
7270	Non vascular stent placement		36.65
7271	Gastrointestinal stent placement		36.65
7272	Tracheobronchial stent placement		36.65
7273	Endovascular stent grafting (eg. aorta)		36.65
7274	Carotid angioplasty		36.65
7275	Carotid stent placement		36.65
7276	Uterine embolization		36.65

SPECIAL OTHER RADIOLOGICAL PROCEDURES

		COLUMN TEC	COLUMN PRO
	Note: *The following are all independent procedures (for Column C, See Special Procedures).*		
7063	Arthrography	36.60	19.90
7109	Biliary tract stones—non-operative extraction	89.80	31.20
7030	Bronchography, unilateral	28.90	14.65
7330	bilateral	50.95	21.05

CENTRAL NERVOUS SYSTEM

7043	Discography	49.35	19.90
7042	Myelography	49.35	19.90
7003	Ventriculography	73.50	29.50

MISCELLANEOUS

7382	Cholangiography, percutaneous	35.65	12.55
7086	Cystogram	22.30	7.90
7087	Stress cysto urethrogram	33.60	12.75
7088	Voiding Cysto-urethrogram	41.80	15.70
7389	Vaginogram	46.30	11.45
7386	Dacrocystography	25.65	10.55
7392	Fetal transfusion, intrauterine	38.20	21.05
7394	Fistula, injection with fluoroscopy	19.85	15.70
7071	Fluoroscopy (isolated)	4.85	12.90
7371	Fluoroscopic control of clinical procedures done by another physician, per ¼ hour	11.70	21.30
7372	High filtration—High K.V. (larynx, etc.)	28.20	8.35
7092	Hysterosalpingography	45.00	11.80
7097	Pericardiocentesis	13.05	10.40
7101	Tomography	49.20	9.80
7301	with contrast procedure, add	12.40	9.65
7322	Laryngogram	32.15	15.50
7323	Lung biopsy (needle)	13.00	10.40

		COLUMN TEC	COLUMN PRO
7103	Lymphangiography, unilateral	50.70	21.05
7303	bilateral	76.30	31.20
7099	Mammography, unilateral	43.30	23.60
7098	bilateral	71.50	39.70
	Note: *Tariffs 7098 and 7099 are payable for all diagnostic mammographies, bilateral or unilateral as determined by a physician's requisition, except for requisitions for Screening Mammography services performed in compliance with the requirements of Tariff 7104.*		
7324	Operating room arteriogram	76.30	31.20
7325	Percutaneous antegrade pyelogram	28.20	8.35
7396	Portable Machine Examination, in hospital, extra	12.85	
7096	in home, extra	70.40	
7021	Sialography	27.35	9.80
7094	Sinogram	19.85	15.70
7384	Renal puncture; percutaneous	25.60	10.40
7106	Tracheogram, etc.	32.15	15.50
7326	Vasogram	21.95	5.95
7327	Specimen radiograph	9.05	3.15
7100	Bone Mineral Densitometry with DEXA (Dual—Energy X-ray Absorptiometry), one or more sites		51.95
7375	Nephrostomy catheter exchange	28.20	7.45
7374	Abscessogram	19.85	13.95
7378	Percutaneous cecostomy	19.85	13.95
7379	Percutaneous gastrostomy	19.85	13.95

SCREENING RADIOLOGICAL PROCEDURES

		COLUMN PRO
7104	Screening Mammography, bilateral.....	19.90

Note: *Tariff 7104 is payable:*

a) where the service is requested for an asymptomatic woman between the age of 50 and 69 years;

b) where the service is provided:

i) in one of the following designated facilities:

- *Misericordia Health Centre*
- *Brandon Regional Health Centre*
- *Thompson General Hospital*
- *St. Boniface Breast Health Centre; or*

ii) in the Program's mobile van: and

*c) only once within **any** twenty-four month period in respect of each qualifying patient, unless authorized by a representative of the Manitoba Breast Screening Program.*

Note: *"Asymptomatic" woman means a woman who has not had breast cancer, or signs/symptoms such as breast masses, clear or bloody nipple discharge or dimpling;*

An asymptomatic woman with a first degree relative with breast cancer is eligible for either a Screening Mammography or a diagnostic mammography (Tariffs 7098 and 7099) as determined by a physician's requisition or by a representative of the Manitoba Breast Screening Program.

"First degree relative" means the woman's mother or sister(s).

INTERVENTIONAL RADIOLOGY

Column C: These procedural fees are intended to cover the procedural portion of the examination and are separate and distinct from the professional supervisory and interpretative fees of Column Pro.

Represents the additional benefit for the professional procedural portion of the examinations and is separate and distinct from the professional supervisory and interpretative benefits of Column Pro.

Note: *1) These procedural fees are intended to cover compensation for the professional service of placing an instrument and introducing contrast media (except in excretion studies of the biliary and renal tracts, and oral or rectal administration for study of the alimentary canal).*

2) The same fees may be charged for similar services associated with diagnostic physiological studies of non-radiological nature, for example—catheterization for physiological sampling or the transmission of pressure, sound or electrical waves or the therapeutic injection of drugs.

3) In Column C ONLY; when two (2) or more examinations are done on the same patient on the same day, 50% of the benefits of the others are paid, and if bilateral, 75% of the others are paid.

"Selective" means instrument passed deliberately into branch, tributary or cardiac chamber.

		COLUMN C	UNIT VALUE
6110	Arthrography	40.00	20.000
6109	Biliary tract stones—non-operative extraction	194.00	21.375
6107	Percutaneous transhepatic catheter drainage of obstructed bile ducts, including daily supervision and including percutaneous Cholangiogram and catheterization to duodenum, if achieved	230.00	21.375
6108	Replacement of catheter in above	34.45	21.375
6111	Bronchography, unilateral	19.55	22.750
6112	bilateral	29.35	22.750
6113	Pericardiocentesis	34.25	24.125
6196	Galactogram, cannulation of direct injection of contrast and subsequent mammographic imaging	45.95	
6197	Intra mammary needling for localization of occult breast lesion(s)	45.95	20.000
6191	Percutaneous diagnostic biopsies/aspirations	83.00	20.000
6198	Therapeutic procedure of large needle and tube insertion for drainage of abnormal fluid collections, including subsequent catheter care, and adjustment as required	124.05	20.000
6193	Stereotactic breast biopsies (CORE)	111.25	21.375
6199	Core needle biopsy	71.90	
6195	Image guided central line placement	115.00	21.375
6106	Biliary stent placement	89.00	21.375
6120	Cystogram	17.70	20.000
6121	Stress Cystogram	7.70	20.000
6122	Voiding Cystourethrogram	10.75	20.000

		COLUMN C	UNIT VALUE
6126	Vaginogram	8.05	20.000
6123	Dacrocystography	9.75	20.000
6127	Hysterosalpingography	48.90	20.000
6131	Laryngogram	19.90	22.750
6124	Lung biopsy (needle)	78.00	21.375
6132	Lymphangiography, unilateral bilateral—See Rules of Application.	58.25	20.000
6125	Percutaneous antegrade, pyelogram	38.95	21.375
6141	Sialography	22.05	20.000
6143	Renal puncture, percutaneous	38.95	21.375
6144	Splenoportography	69.25	20.000
6145	Tracheogram, etc.	20.50	22.750
6146	Retrograde urethrography	8.00	20.000
6147	Hydrostatic reduction of intussusception by barium enema	54.50	21.375
6100	Percutaneous cecostomy	131.55	21.375
6101	Retrograde cholangiogram	7.10	21.375
6102	Abscessogram	19.70	21.375
6103	Nephrostogram	17.35	
6104	Percutaneous Gastrostomy	131.55	21.375
6105	Jejunal Biopsy	30.65	
6119	Cecostomy/Gastrostomy Tube Catheter Exchange	66.75	

INTERVENTIONAL NEURORADIOLOGY

6114	Discography	68.00	20.000
6115	Myelography	75.00	20.000
6117	Ventriculography	69.25	21.375
6118	Cholangiography, percutaneous	48.55	21.375
6178	Intracranial AVM embolization	445.00	24.125
6179	Intracranial AVM coiling	667.50	24.125
6180	Intracranial intra arterial thrombolysis	267.00	24.125
6181	Intracranial intravenous thrombolysis	267.00	24.125
6182	Intracranial tumor embolization	267.00	24.125
6183	Embolization of epistaxis	467.25	24.125
6184	Carotid cavernous fistula occlusion	667.50	24.125
6185	Carotid artery balloon test occlusion	89.00	24.125
6186	Carotid artery permanent balloon test occlusion	267.00	24.125

		COLUMN C	UNIT VALUE
6187	Angioplasty of intracranial vasospasm	520.00	24.125
6188	Percutaneous vertebroplasty	267.00	24.125
6189	Percutaneous imaging guided nerve root injection	66.75	22.750
6190	Percutaneous imaging guided facet joint injection	66.75	22.750

PERCUTANEOUS TRANSRENAL OPERATIVE PROCEDURES FOR STONE REMOVAL

6148	Insertion of temporary antegrade stent by the radiologist in any of the percutaneous transrenal procedures performed by the urologist	67.50	22.750
6149	Dilatation of the skin to kidney tract by the radiologist	83.75	22.750

Note: *The fees for tariffs 6148 and 6149 are to be deducted from the urologist's fee.*

PERCUTANEOUS TRANSRENAL OPERATIVE PROCEDURES FOR DRAINAGE IN NON-STONE CASES

6150	Percutaneous nephrostomy under ultrasound or fluoroscopy for drainage of obstructive uropathy, with or without the insertion of any temporary stent	139.50	22.750
6151	Insertion of a permanent indwelling antegrade stent and/or antegrade dilatation of a stricture	85.40	22.750
6152	Nephrostomy catheter exchange	66.75	21.375

TRANSCATHETER PROCEDURES

		COLUMN C	UNIT VALUE
6153	Venous sampling through catheter, (e.g. for parathyroid hormone, renin)	61.85	21.375
6228	Transcatheter therapy, embolization, any method	231.00	22.750
6154	Transcatheter therapy, infusion, any method, (e.g. Thrombolysis other than coronary)	342.35	21.375
6155	Transcatheter retrieval, percutaneous, of intravascular foreign body (e.g. fractured venous or arterial catheter)	213.60	21.375
6128	Transluminal angioplasty, any method, peripheral artery	225.00	20.000
6156	Transluminal angioplasty, any method, each additional peripheral artery	100.15	21.375
6157	Transluminal angioplasty, any method, renal or other visceral artery	300.00	21.375
6158	Transluminal angioplasty, any method, each additional visceral artery	133.50	21.375
6159	Transluminal angioplasty, venous (e.g. Subclavian stenosis)	310.00	21.375
6160	T.I.P.S (Transjugular intrahepatic portosystemic shunt)	547.35	21.375
6161	Mammary ductogram or galactogram, single duct	40.90	20.000
6162	Mammary ductogram or galactogram, multiple ducts	40.90	20.000
6163	Dialysis graft Thrombolysis and/or Removal of Clot	471.05	21.375

Note: *This tariff includes the following:*

1) *Interrogation of central veins (venogram)*
2) *Treatment of venous stenosis (angioplasty)*
3) *Removal of clot within graft (whether thrombolytic therapy or mechanical device or combination of both)*
4) *Removal of arterial plug*
5) *Hemostasis*
6) *Introduction of one, two or more sheaths to do procedure*
7) *Completion angiogram of graft post procedure*

6195	Image quided central line placement	115.00	21.375
6165	Vascular stent placement	89.00	24.125
6166	Gastrointestinal stent placement	222.50	21.375
6167	Tracheobronchial stent placement	222.50	24.125
6168	Endovascular stent grafting (e.g. Aorta)	667.50	24.125
6169	Carotid angioplasty	445.00	24.125
6170	Carotid stent placement	89.00	24.125
6171	Uterine embolization	311.50	21.375
6172	Uterine embolization—additional uterine artery at 50%	155.75	21.375

ANGIOGRAMS

Procedural Services

Note: *1) These procedural benefits are intended to cover compensation for the professional service of placing an instrument and introducing contrast media (except in excretion studies of the biliary and renal tracts, and oral or rectal administration for study of the alimentary canal).*

2) The same benefits may be charged for similar services associated with diagnostic physiological studies of non-radiological nature, for example, catheterization for physiological sampling or the transmission of pressure, sound or electrical waves or the therapeutic injection of drugs.

3) For Angiography procedures, introduction may be made by:

- *Percutaneous needle or cutdown on superficial peripheral vein.*
- *Percutaneous catheter or cutdown on peripheral vein.*
- *Exposure of major artery.*

*4) In Column C **only**; when two (2) or more examinations are done on the same patient on the same day, 50% of the benefits of the others are paid, and if bilateral, 75% of the others are paid.*

"Selective" means instrument passed deliberately into branch, tributary or cardiac chamber.

Column C: Represents the additional benefit for the professional procedural portion of the examinations and is separate and distinct from the professional supervisory and interpretative benefits of Column Pro.

ANGIOGRAPHY

AORTOGRAMS

		COLUMN C	UNIT VALUE
6200	Abdominal	120.00	20.000
6201	Arch	68.00	20.000
6202	Intravenous	71.50	20.000
6203	Thoracic	75.35	20.000
6204	Translumbar	68.00	20.000
6205	Other—specify	71.00	20.000

For two (2) examinations done on same patient, same day—See Note 4

SELECTIVE ANGIOGRAMS

		COLUMN C	UNIT VALUE
6210	Adrenal arteriogram	98.75	20.000
6211	Angiographic examination dialysis shunt	98.75	20.000
6212	Axillary	105.00	20.000
6213	Brachial	102.00	20.000
6208	Cerebral (brachial retrograde)	106.50	20.000
6214	Bronchial	102.50	20.000
6215	Carotid	118.15	20.000
6216	Celiac	118.15	20.000
6217	Common iliac	102.00	20.000
6229	Popliteal, with antegrade catheterization	103.50	20.000
6218	External carotid arteriogram	102.00	20.000
6219	Hepatic	102.00	20.000
6220	Inferior mesenteric	102.00	20.000
6221	Innominate	102.00	20.000
6222	Internal iliac	102.00	20.000
6223	Renal	118.15	20.000
6224	Superior mesenteric	118.15	20.000
6225	Subclavian	102.00	20.000
6226	Splenic	102.00	20.000
6227	Vertebral	118.15	20.000
6235	Bilateral selective angiogram or venogram	206.00	20.000
6206	Internal mammary	105.15	20.000
6207	Left gastric	105.15	20.000
6209	Gastroduodenal	105.15	20.000
6231	Internal carotid	105.15	20.000
6232	Super Selective Angiogram (e.g. Distal branch of any of the above selective)	123.00	20.000

For two (2) examinations done on the same patient, same day—See Note 4

FEMORAL ARTERIOGRAMS

6230	Unilateral	120.00	20.000

Bilateral—See Note 4

VENOGRAMS

		COLUMN C	UNIT VALUE
6236	Azygogram	71.50	20.000
6237	Femoral	69.00	20.000
6238	Iliac	66.50	20.000
6239	Inferior vena cavogram	100.00	20.000
6240	Intraosseous	71.50	20.000
6241	Jugular	67.50	20.000
6242	Lower limb	68.00	20.000
6243	Subclavian	68.00	20.000
6244	Superior vena cavogram	68.00	20.000
6245	Umbilical vein catheterization	71.50	20.000
6246	Upper limb	68.00	20.000
6247	Orbital venogram	71.50	20.000
	For two (2) examinations done on same patient, same day—See Note 4		

SELECTIVE VENOGRAMS

6250	Adrenal	103.50	20.000
6251	Hepatic	106.50	20.000
6252	Jugular	105.00	20.000
6253	Renal	102.00	20.000
6235	Bilateral selective angiogram or venogram	206.00	20.000
	For two (2) examinations done on same patient, same day—See Note 4		

ANGIOGRAPHY

6255	By exposure of major vein, abdominal or thoracic	138.50	20.000
6256	cerebral	163.00	20.000

ANGIOCARDIOGRAMS

		COLUMN C	UNIT VALUE
6260	Atrial, left	196.50	21.375
6261	right	150.50	21.375
6262	Pulmonary angiogram	161.30	21.375
6263	Selective coronary angiogram	270.30	21.375
6264	with left and/or right heart catheterization	327.00	21.375
6265	Ventricular, left	217.45	21.375
6266	right	161.30	21.375
6267	Percutaneous transluminal balloon coronary angioplasty including angiography with or without pressure measurements on one (1) or more sites on a single coronary artery	560.00	21.375
6268	On two (2) coronary arteries (i.e., right and circumflex, or right and anterior descending, or circumflex and anterior descending)	775.00	21.375
6270	On three (3) coronary arteries, right, circumflex, and anterior descending	990.00	21.375

Note: *1) Tariffs 6267, 6268 and 6270 include associated angiograms at the time of the procedure and pressure measurement, aortography, pacemaker adjustments including connecting to a guide wire, cardioversion, and continuing care during that hospital admission.*

2) Only one (1) of the three tariffs (6267, 6268 or 6270) can be claimed for one (1) sitting.

3) If a patient does not have a pacemaker and one has to be inserted at the time, such will be paid for at 50% notwithstanding the fact that the benefit is asterisked.

6269	**Unlisted or Unusually Complicated**	***By Report***

MAGNETIC RESONANCE IMAGING SERVICES

HEAD

		COLUMN PRO
7501	Multislice T2 (1 or 2 echoes)	69.00
7502	Multislice I.R. or T1	60.00
7503	Repeat (another plane, different pulse sequence to a maximum of 2 repeats)	35.00

NECK

7504	Multislice T2 (1 or 2 echoes)	69.00
7505	Multislice I.R. or T1	45.00
7506	Repeat (another plane, different pulse sequence to a maximum of 3 repeats)	35.00

THORAX

7507	Multislice T2 (1 or 2 echoes)	80.00
7508	Multislice I.R. or T1	69.00
7509	Repeat (another plane, different pulse sequence to a maximum of 3 repeats)	40.00

ABDOMEN

7510	Multislice T2 (1 or 2 echoes)	80.00
7511	Multislice I.R. or T1	74.20
7512	Repeat (another plane, different pulse sequence to a maximum of 3 repeats)	40.00

PELVIS

7513	Multislice T2 (1 or 2 echoes)	80.00
7514	Multislice I.R. or T1	69.00
7515	Repeat (another plane, different pulse sequence to a maximum of 3 repeats)	40.00

EXTREMITIES

7516	Multislice T2 (1 or 2 echoes)	69.00
7517	Multislice I.R. or T1	45.00
7518	Repeat (another plane, different pulse sequence to a maximum of 2 repeats)	35.00

LIMITED SPINE (ONE SEGMENT)

		COLUMN PRO
7519	Multislice T2 (1 or 2 echoes)	64.00
7520	Multislice I.R. or T1	56.00
7521	Repeat (another plane, different pulse sequence to a maximum of 2 repeats)	32.00

INTERMEDIATE SPINE (2 ADJOINING SEGMENTS)

7522	Multislice T2 (1 or 2 echoes)	78.00
7523	Multislice I.R. or T1	64.00
7524	Repeat (another plane, different pulse sequence to a maximum of 2 repeats)	38.00

COMPLEX SPINE (2 OR MORE NON-ADJOINING SEGMENTS)

7525	Multislice T2 (1 or 2 echoes)	111.00
7526	Multislice I.R. or T1	64.00
7527	Repeat (another plane, different pulse sequence to a maximum of 2 repeats)	56.00
7528	3D Workstation review (applies to MRI schedule)	101.00

DIAGNOSTIC ULTRASOUND SERVICES

HEAD AND NECK

7300	Cranial Sonography	35.90
7302	Sonography, soft tissues (e.g. Thyroid, parathyroid, salivary glands, orbits) real time study	37.00

CHEST

7304	Sonography, chest (e.g., pleural, chest wall, or mediastinal mass) real time study	35.90
7305	Sonography, breast unilateral real time study	32.50
7306	Sonography, breast bilateral real time study	41.85
7307	Sonography, breast unilateral real time study where performed by sonologist	64.00
7308	Sonography, breast bilateral real time study where performed by sonologist	78.50

ABDOMEN AND RETROPERITONEUM

		COLUMN PRO
7309	Sonography, abdominal complete real time	38.90
7310	Sonography, abdominal limited (e.g. single organ, quadrant, follow up time) real time	32.50
7311	Sonography, renal (bilateral), or aorta or retroperitoneum real time	32.50
7312	Sonography of organ transplant real time & doppler studies	35.90
7313	Complete doppler exam of portal venous system	35.90
7314	Complete doppler exam of mesenteric veins	35.90

SPINAL CANAL

7315	Sonography, spinal canal and contents	35.90

SKIN AND SUBCUTANEOUS TISSUES

7316	Sonography, skin and subcutaneous tissues real time	35.90

OBSTETRICS AND FEMALE PELVIS

7317	Sonography, pregnancy uterus complete fetal and maternal evaluation	37.00
7318	Sonography, complete fetal/maternal evaluation multiple gestation	46.40
7319	Sonography, pregnancy uterus limited (fetal size, heart beat, placental localization, position or emergency in delivery room)	31.40
7320	Fetal biophysical profile scoring	10.45
7321	Echocardiography, fetal, cardiovascular system, real time with or without M-mode and/or doppler studies	46.40
7328	Echocardiography, fetal follow up or repeat study of above	31.40
7329	Sonography—pregnancy uterus first trimester	37.00
7334	Sonography—pregnancy uterus late first trimester/early second trimester	37.00
7335	Sonography—transvaginal	37.00
7336	Sonography—pelvic (non obstetric)—complete	37.00
7337	Hysterosonography	35.90
7338	Sonography—translabial	10.45

GENITALIA

7342	Sonography, scrotum	37.00
7343	Sonography, transrectal	35.90
7344	Sonography, penis	35.90

EXTREMITIES

		COLUMN PRO
7345	Sonography, extremity, non-vascular-real time (hips, shoulders, knee, etc.)	35.90

MISCELLANEOUS—DOPPLER STUDIES

7346	Where doppler is used as the primary diagnostic modality on any of the above procedures, add	32.50
7347	Where doppler is used not as the primary diagnostic modality but has a reasonable likelihood of providing ancillary diagnostic information, add	16.50

VASCULAR STUDIES

7348	Duplex scan or extra cranial arteries—complete bilateral	82.70
7349	Duplex scan of extra cranial arteries—limited/follow up study	35.90
7350	Duplex scan of extremity arteries—complete unilateral	35.90
7351	Duplex scan of extremity arteries—complete bilateral	46.40
7352	Duplex scan of extremity arteries—limited/follow up study	35.90
7353	Duplex scan of extremity veins—complete unilateral	37.00
7354	Duplex scan of extremity veins—complete bilateral	46.40
7355	Duplex scan of extremity veins—limited/follow up study	31.40
7356	Duplex scan of arterial inflow and/or venous outflow of abdominal, pelvic and/or retroperitoneal organs	35.90
7357	Duplex scan of aorta, IVC, iliac vasculature or bypass grafts	35.90
7358	Duplex scan of vascular access graft	46.40
7359	Video review of vascular studies, add	32.50
7360	Intravenous contrast enhancement, add	10.45
7361	Ultrasound guided compression repair of arterial pseudo-aneurysm or A-V fistula per ¼ hour	19.50
~7399	Ultrasound 3-D Workstation Review	46.40

SONOLOGIST PERFORMED PROCEDURES

		COLUMN C
7362	Portable ultrasound examination performed by sonologist [or the first full thirty (30) minute period and for each additional thirty (30) minute period or portion thereof]	47.50
7363	Sonologist performs part of examination for a minimum of ten (10) minutes or less where the sonologists input revises the technologists initial or provisional finding or changes the management of the patient's care	22.00
7365	Sonologist performs all of examination	43.00
7367	Hysterosonography	46.40
7368	Sonography, intraoperative real time study performed by radiologist [for the first full thirty (30) minute period and for each additional thirty (30) minute period or portion thereof]	46.40

Note: *RE: Sonologist performs all examination where due to particular circumstances a sonologist performs all of an examination, examples would include but are not limited to:*

i) Rural Manitoba no technician available

ii) After hours no technician available

iii) New or complex procedure no qualified technician

SPECIAL OTHER RADIOLOGICAL PROCEDURES

Where a sonologist provides interventional and/or invasive procedures he/she shall be eligible to claim tariffs from the Diagnostic Radiological Procedures Fee Schedule regardless of the imaging modality.

NUCLEAR MEDICINE—IN VIVO

Column Tec.
This includes fees for the technical and physical aspects of the services rendered. The cost of the material is additional.

Column Pro.
This is the fee for the professional services only, performed by a physician.

DIAGNOSTIC ISOTOPE PROCEDURES

BLOOD (FERROKINETICS)

		COLUMN TEC	COLUMN PRO
9919	Plasma clearance	79.30	31.20
9920	Iron turnover	79.30	31.50
9923	Red blood cell utilization	79.30	31.20
9941	with serial organ counts, add	62.85	15.90
9910	Plasma volume	23.35	11.05
9903	Red blood cell volume	45.75	20.75
9904	survival	79.30	31.20
9942	with serial organ counts, add	62.00	15.65
9901	Schilling test	46.70	19.50
9902	with intrinsic factor, add	22.90	10.65
9905	Red blood cell labelling		8.90
9907	White blood cell labelling		15.40

BONE AND JOINT

9943	Bone Scan, regional	124.20	72.45
9944	whole body	175.75	76.60
9945	Joint Scan, regional	106.50	42.50
9946	whole body	160.60	62.90
9947	Bone marrow scan	106.60	61.10

BRAIN (CENTRAL NERVOUS SYSTEM)

9930	Brain scan	85.45	55.85
9949	with flow study, add	17.05	17.70
9951	C.S.F. circulation	143.75	62.90
9952	Myelogram	58.90	45.60

CARDIOVASCULAR

		COLUMN TEC	COLUMN PRO
9912	Cardiac output	47.70	18.80
9913	Circulation time	47.70	18.80
9953	Myocardial scan	74.80	34.70
9954	Myocardial perfusion scan, immediate	77.60	40.00
9955	immediate and delayed	252.25	93.05
9957	Myocardial wall motion, rest (does not include computerization)	124.90	52.20
9958	combined rest and stress (does not include computerization)	163.35	34.65
9959	Administered and supervised pharmacological or physical stress on any of the above, add	29.45	47.65
9960	Additional measurements [maximum of three (3)]	27.10	8.65
9961	Cardiomyography (first pass non-gated)	73.45	23.30
9962	Venogram	73.25	58.60
9963	Arteriography	73.25	41.75
9964	Thrombosis localization	73.25	41.75

EYE

9933	Tumor localization	56.25	51.75
9965	Lacrimal duct study	84.95	30.55

GASTROINTESTINAL

9980	Gastrointestinal mucosa scan	101.10	50.00
9966	Biliary tract scan	93.40	41.30
9925	Liver scan	85.45	29.30
9936	Spleen scan	79.95	31.30
9967	Liver and spleen (when both requested)	90.35	54.00
9968	Dynamic liver study	84.95	30.55
9969	Salivary gland scan	88.00	32.50
9914	Gastrointestinal absorption/malabsorption (this includes tests, such as G.I. protein loss, evaluation of enterohepatic circulation or assessment of gastrointestinal absorption of other agents such as iron or copper)	79.30	31.20
9970	Stool blood loss	40.85	20.90
9971	Liver/lung scan	158.75	63.25

LUNG

9932	Perfusion scan	163.15	70.00
9972	Ventilation scan	83.50	56.00

KIDNEY

		COLUMN TEC	COLUMN PRO
9928	Renogram	74.30	31.20
9927	Renal scan	79.30	35.00
9974	Reflux cystogram	98.25	62.00
9975	Sequential scan: one (1) isotope	130.50	66.80
9976	two (2) isotopes	121.75	41.75

THYROID

9906	Uptake	23.50	13.50
9977	Scan	64.15	39.00
9937	Uptake with scan	92.15	44.35
9908	Scan after stimulation	63.20	21.05
9938	after suppression	45.20	21.05
9978	Uptake with washout	36.00	14.50

MISCELLANEOUS

9979	Adrenal scan	157.25	50.60
9935	Placental scan	22.60	41.65
9981	Soft tissue scan: total body (Gallium and/or any other radionuclide)	158.00	85.00
9982	regional (Gallium and/or any other radionuclide)	100.55	70.00
9983	Lymph nodes and lymphangiogram	84.95	70.00
9984	Skin flow	79.30	31.20
9931	Parathyroid imaging		71.50
9939	Abdominal shunt patency		31.70
9940	Gastrointestinal motility, including esophageal, gastric, and bowel studies		60.00
9950	Gastrointestinal bleeding		52.00
9986	Blood flow to an organ, or an add on to another procedure when not otherwise listed	72.00	38.20
9987	Assessment of fatty liver	73.45	23.30
9926	Administered and supervised pharmacological intervention as part of other imaging		10.00
	Note: *Tariff 9926 shall be claimed for non-cardiac studies only.*		
9988	CO^2 exhalation studies	41.95	19.80
9996	Extra views or films of any specific organ	16.85	10.00
	Note: *Tariff 9996 shall be claimed when additional images are necessary to clarify abnormal findings or inconclusive studies.*		

DATA MANIPULATION (INCLUDES REFORMATTING, GATING, AND COMPUTERIZATION)

Note: *Nuclear medicine—in Vitro—See Radioassay under Laboratory—General*

		COLUMN TEC	COLUMN PRO
9989	Curve analysis, without blood samples	36.00	51.75
9990	with blood samples	56.75	51.75
9991	Ejection fraction and cine formatting (usually done in conjunction with wall motion studies) one (1) analysis (plus appropriate wall motion charge)	36.05	35.00
9992	each additional [maximum of three (3)]	27.10	22.50
9993	Image enhancement	18.10	22.50
9994	Gating (already included in myocardial wall motion)	50.70	17.30
9995	Quantitation of static studies	36.05	32.00
9929	S.P.E.C.T.—Single Photon Emission Computerized Tomography	48.00	33.60
9924	S.P.E.C.T. with transmission attenuation correction	43.50	46.00

Note: *1) The specific organ imaged will also be claimed under its own tariff number.*

2) Only one of 9929 or 9924 may be claimed for S.P.E.C.T. Imaging.

Therapeutic Isotope Procedures

8550	Consultation (by Isotope Therapist only) See Rules of Application 7, 8, 11	52.00
7213	Radionuclide treatment	98.00 74.85
7214	re-treatment	97.15 29.85
7212	Radiation Synovectomy	71.50

Therapeutic Radiology Radium Therapy

7208	Intracavity, single	191.00
7209	course	353.00
7210	Interstitial	266.00
7211	in combination with x-ray therapy	133.00
7207	Superficial, plaque or mold	52.75

Radio-Therapy

			UNIT VALUE
7202	Superficial, benign, single lesion, treatment per visit	6.80	20.000
7203	multiple lesions, treatments per visit	9.75	20.000
7216	Plantar wart per treatment, visit	9.75	20.000
7204	Superficial, malignant, single lesion, total treatment for any number of visits	64.25	20.000
7205	multiple lesions, total treatment for any number of visits	110.00	20.000

Deep Therapy

7206	Deep x-ray or cobalt beam per treatment	55.50

LABORATORY PROCEDURES—GENERAL

Benefits are provided for laboratory procedures in this section when the service is provided in a Registered Facility, for those procedures approved by the Minister. The scheduled benefit includes the collection of specimens, where necessary, except spinal fluid and arterial blood samples.

BACTERIOLOGY

9660	Antibiotic level, serum	11.55
9663	Antibiotic Sensitivity, per organism	7.05

Cultures—One (1) per Site—With Identification of Bacteria and Fungi With or Without Colony Count

9686	blood, aerobic and anaerobic	16.15
9700	throat swab	11.65
9701	sputum or tracheal or bronchial washings	11.85
9702	urine	11.80
9703	cervical	11.80
9704	vaginal	11.80
9705	urethral	11.80
9706	bowel contents for enteric organisms	11.80
9707	pus for other sites	11.80
9708	body fluids, (e.g. ascitic, pleural, spinal fluids, etc).	11.80
9687	other than above	11.85
9689	tuberculosis	11.85
9692	other, depending on complexity	***By Report***
9695	Dark Field examination	16.00
9715	Microscopic Examination of Smears and Wet Preparations, trichomonads	3.85
9716	fungi	6.45
9717	pinworms (Scotch Tape Method)	3.85
9718	parasites (stool)	15.00
9719	routine stain (Methylene Blue, grams, etc.) on direct specimen, when specimen does NOT proceed to culture	5.45
9720	routine stain (Methylene Blue, grams, etc.) on direct specimen, when specimen proceeds to culture	2.55
9713	Zn or special stain	8.75
9711	Screening test for bacteruria, spoon or agar slide technique	4.15
9710	Beta-Lactamase (Penicillinase)	3.95
9737	sterility tests	9.70
9738	Microscopic examination of synovial fluid under polarized light for uric acid crystals	5.85

BIOCHEMISTRY

See also "Feces, Hematology, Spinal Fluids and Misellaneous Tests," and "Urine"

All tests quantitative, unless otherwise specified. The fees listed are the benefits payable for manual tests.

9006	Alcohol	23.70
9008	Amino acid chromatography, quantitative	112.00
9015	Ammonia	23.35
9018	Amylase	9.70
9024	Phenobarbital	32.40
9029	Bilirubin, direct and total	8.75
9030	total	6.45
9045	Bromides	8.20
9051	Calcium	11.85
9057	Carbon dioxide content	11.85
9066	Carbon monoxide, quantitative	22.90
9069	Carotenes	8.75
9072	Chlorides	8.75
9073	Cholinesterase and pseudo-cholinesterase	10.50
9100	Ceruloplasmin (copper oxidase)	7.30
9103	Creatine phosphokinase (CPK)	19.40
9105	Creatinine	5.50
9109	Cryoglobulin	2.05
9137	Gamma Glutamyl Transferase	11.80
9140	Glucose-6-phosphate dehydrogenase	11.15
9141	Glucose, quantitative	4.95
9142	Glucose, reflectance meter/photoelectric estimation	2.35
	Note: *The above should only be ordered when clinically indicated. This test may be ordered for diabetics or patients with increased risk factors for diabetes, and for pregnant women.*	
9144	tolerance test up to and including five (5) bloods and five (5) urines	25.35
9146	Haptoglobin	31.30
9153	Hemoglobin, chromatography or electrophoresis	23.70
9155	Glycosylated hemoglobin—Hbg A1	16.70
9173	Immunoelectrophoresis-polyvalent sera	30.40
9176	monovalent sera, each	14.75
9177	to a maximum of	45.20
9175	Iron binding capacity	16.15
9174	Iron, serum	16.15

9304	Urea, quantitative	4.95
9306	Uric Acid	8.75
9320	Xylose absorption	28.10

AUTOMATED BIOCHEMISTRY

Automated biochemistry maximum 13.00

Note: *1) For biochemical tests done on automated multi-channel equipment, the fee for each test shall be the same as the fee for the comparable manual test, up to an accrued maximum of $13.00 per patient per day.*

2) For tariffs 9029, 9154 and 9242, the fees for the automated components ($6.45, $4.95 and $8.75 respectively) shall contribute to the accrued automated amount and shall be subject to the automated biochemistry maximum. In addition, and notwithstanding Note 1 above, fees for the manual components of $2.30, $6.00 and $10.60 respectively shall be paid in addition to the fees for the automated components, and these amounts shall not contribute to the accrued automated amount nor shall they be subject to the automated biochemistry maximum.

3) Notwithstanding Note 1 above, when multiple blood samples from the same patient are tested on the same day, payment for Tariff 9141 for the second and subsequent blood samples shall not contribute to the accrued automated amount for those samples nor shall such payment be subject to the automated biochemistry maximum for those samples. For greater clarity, payment for Tariff 9141 for the second and subsequent blood samples shall be payable separate and apart from, and in addition to, the accrued automated amount for those samples.

CYTOLOGY AND TISSUES

Cytology

9462	Chromosome analysis	104.50
9464	Cytological examination, Buccal smear for sex chromatin	8.95
9470	cervico-vaginal smear	14.80
9473	other submitted smears prepared by the clinician from body fluids	11.35
9474	preparation and examination of smears from fluids submitted when direct smears are made in the laboratory	19.50
9475	preparation and examination of smears from submitted specimens requiring centrifugation and/or filtration	19.50
9477	preparation and examination of smears from submitted specimens requiring centrifugation and/or filtration and preparation of cell blocks	25.55
9782	Seminal fluid, complete analysis	24.55
9784	Sperm, search, post vasectomy or in vaginal fluid	9.50

Tissues

9458	Surgical specimens—with paraffin sections	38.80

FECES

9374 Blood, occult 2.05

Note: *The above should only be ordered when clinically indicated.*

9394 Trypsin, quantitative 11.05

9398 Urobilinogen, quantitative 15.75

GASTRIC CONTENTS

9407 Cell Count and differential 5.30

9413 Gastric analysis, single 10.75

9414 with histamine 16.80

HEMATOLOGY

9116 Autohemolysins 18.30

9042 Bone marrow film, collection and examination 57.05

9043 examination only 32.65

AUTOMATED HEMATOLOGY

For two (2) or more of the following hematology procedures done on automated equipment and on one sample of blood (W.B.C., R.B.C., HgB., Hematocrit and indices), the fee for each procedure shall be the same as the comparable manual test, to an accrued maximum of 5.65

Note: *Claims are to be made under the tariff numbers of the individual tests ordered by the attending physician even though a profile was analyzed.*

9111 eosinophil count 4.75

9234 platelet count 5.45

9264 red cell count (Electric Counter) 2.55

9267 reticulocyte count 5.45

9312 White cell count 2.55

Note: *The above should only be ordered when clinically indicated.*

9315 White cell differential count and cell morphology 5.20

Note: *The above should only be ordered when clinically indicated. When the White cell count (Tariff 9312) is outside the normal range of 4-11 x 10 to the power of 9 per litre, a laboratory may, without a further requisition from the ordering physician, perform a White cell differential count and cell morphology (Tariff 9315).*

9124 Hemoglobin F (by alkaline denaturization) 15.15

9033 Coagulation tests, template bleeding time 9.15

9034 circulating anticoagulants (not Fi test) 19.35

9084 retraction 1.10

9112 clotting factor assays: factor X111 ..... 7.45

9115 factors, V, VII, VIII, IX, X—each 25.95

9222 Determination of factor VIII related antigen 33.60

9090 clotting time 4.75

9117 quantitative 16.15

9235 platelet adhesive index 15.15

9234 count 5.45

9258 prothrombin, consumption 11.85

9252 one (1) stage—(Quick) 6.45

9221 Ristocetin Cofactor for the Functional Quantitation of von Willebrand Factor 31.70

9295 thrombin time 6.45

9296 time, partial 11.85

9036 Examination, with report, of blood smear by a Pathologist, or by a Hematologist who has not seen the patient in formal consultation, when specifically requested by a referring physician 10.70

9131 Fetal cells 10.65

9132 Fragility, red cells 8.75

9147 Hematocrit 2.55

Note: *The above should only be ordered when clinically indicated.*

9150 Hemoglobin (photoelectric) 1.95

9159 Hemolysins, acid, complete 23.70

9156 presumptive 11.40

9165 Hemolysins, cold, complete 23.10

9162 presumptive 10.85

9172 Iron stain 2.05

9180 Kaolin Plasma Recalcification Time 10.60

9198 Malaria, or other parasites 5.45

9199 Platelet Aggregation test 10.20

9268 Nitro Blue Tetrazolium Reduction test (NBT Test) 11.05

9273 Sedimentation rate 2.55

Note: *The above test is a non-specific indicator of disease processes, its measurement should only be ordered in limited clinical situations.*

9276 Sickle cell identification 6.45

9285 Stippled cells 6.45

9286 Stypven platelet factor III 16.00

9217 W.B.C. alkaline phosphatase stain 11.30

SEROLOGY

9722	Agglutinins—plate method, per antigen, H & O included, if required	2.00
9725	tube method, per antigen	4.05
9684	Antibody determination, percipitin test	8.75
9688	Antinuclear antibodies (to include positive and negative controls)	21.35
9690	Crithidium Lucilia Test (Fluorescent, Anti-Body Test for double stranded DNA, Native DNA)	21.35
9691	Antistreptolysin titre	9.70
9096	Cold agglutinins	11.80
9683	Complement fixation tests (Wasserman, etc.)	8.60
9337	Coombs tests, direct and indirect	11.40
9340	direct only	8.55
9761	C-reactive protein	8.75
9126	Flocculation tests (Kline, Kahn, etc.)—each	4.00
9170	Heterophile antibodies, screen (single tube or single slide test)	8.75
9184	Latex fixation	8.75
9266	Modified Rose Waaler Test	8.75
9734	Staphylococcus antitoxin titre	9.70
9298	Thyroid antibodies	32.40

SPINAL FLUIDS AND MISCELLANEOUS TESTS

Cytology—See Cytology

9401	Amniotic fluid, cytology	10.75
9428	Cell count	2.05
9431	Chloride	8.55
9432	Electrophoresis	20.65
9435	Nasal smear for eosinophiles	5.45
9443	Protein	2.05
9446	Sugar	4.90

URINE

9479	Albumen, biuret	6.45
9487	Amino acid chromatography, quantitative	115.50
9491	Amylase	9.70
9503	Bence-Jones protein	2.05
9506	Bilirubin	2.05
9512	Calcium, quantitative	11.85
9515	Chloride, quantitative	8.75
9520	Coproporphyrin or urocoproporphyrin, quantitative	15.70
9524	Creatine, quantitative	8.65
9527	Creatinine, quantitative	8.75
9528	clearance	16.15
9529	Cystine	2.05
9533	Fat, sudan stain	1.90
9540	Glucose, quantitative (not stick, tablet or tape)	4.95
9549	Hemosiderin	2.05

HORMONES

9513	catechol test, quantitative	22.40
9521	chorionic gonadotropins (pregnancy test) immunological	7.45
9523	quantitative titration	16.05
9536	F.S.H. (Follicle stimulating hormone, bioassay)	63.25
9556	17-ketogenic steroids	22.90
9557	17-ketosteroids	23.10
9615	serotonin, as 5-hydroxy indole acetic acid, quantitative	32.40
9651	vanillylmandelic acid test (V.M.A.), quantitative	31.60
9653	Growth hormone	28.95
9566	Lead (quantitative)	23.30
9581	Phenyl-pyruvic acid (qualitative)	2.00
9578	Phosphorus	8.75
9587	Porphobilinogen (Watson-Schwartz test)	5.45
9593	Porphyrins, fractional	25.30
9614	Salicylates	8.35
9619	Stone, analysis	15.15
9624	Sugar chromatography	14.85
9626	Sulphonamide crystals, microscopic	1.95

9632 Tyrosine 11.65

9635 Urea 5.00

9638 clearance 15.65

9637 Uric Acid 8.75

9644 Urinalysis, stick, tape or tablet for sugar, protein, ketones, urobilinogen, bilirubin or blood, or any other qualitative assessment not listed elsewhere 2.50

Note: *The above should only be ordered when clinically indicated.*

9641 Urinalysis, complete, including microscopic examination of centrifuged specimen 3.30

Note: *The above should be reserved for those patients who have abnormalities detected by urinalysis, stick, tape or tablet for sugar, protein, ketones, urobilinogen, bilirubin or blood, or any other qualitative assessment not listed elsewhere (Tariff 9644) or who have clinical indications for complete urinalysis.*

9647 Urobilinogen, qualitative 2.05

9650 quantitative 10.85

RADIOASSAY AND LIGAND ASSAY

Note: *The following listings are to be used if the assay involves the use of a radioisotope, enzyme, fluorescent label or other methodology. Tests currently listed under "hormones" to be listed under "Radioassay and Ligand Assay."*

9009	Aldosterone	23.60
9231	Chorionic Gonadotropin	19.30
9101	Cortisol	19.30
9272	Digoxin	7.30
9026	Dilantin (phenytoin)	7.30
9128	Folic Acid	23.90
9232	F.S.H. (Pituitary Gonadotropins)	19.30
9281	Gastrin	20.45
9653	Growth hormone	19.30
9179	Immunoglobulin	12.50
9178	Insulin	19.30
9233	L.H. (Luteinizing hormone)	19.30
9599	Pregnanediol	23.60
9600	Pregnanetriol	23.60
9263	Progesterone	19.30
9010	Renin	20.45
9277	Testosterone	19.30
9271	Vitamin B12	23.85
9800	Anti-DNA or RNA	19.30
9811	Calcitonin	19.30
9812	Carcino-Embryonic Antigen	23.85
9803	Cyclic-AMP (Cyclic Adenosine Monophosphate)	25.60
9804	Desoxy Cortisol	23.60
9813	Estradiol	19.30
9808	Ferritin	19.30
9809	17-Hydroxyprogesterone	19.30
9810	Prolactin	19.30

THYROID FUNCTION TESTS

Note: *1) Thyroid function tests (Tariffs 9274, 9113, 9118 and 9278) are not indicated for routine screening of asymptomatic patients or for the investigation of single, non-specific symptoms, e.g., fatigue.*

2) If a significant possibility of thyroid disease exists, the appropriate test is a Thyroid Stimulating Hormone (sTSH).

3) If the sTSH is abnormal, further testing shall be done by the laboratory on the saved specimen, in accordance with the protocol developed by The College of Physicians and Surgeons of Manitoba.

9274	Thyroxine T-4 (Free or Total)	17.00
9113	T-3 Uptake	17.45
9118	Tri-iodo Thyroxine T-3 (Free or Total)	17.00
9278	Thyroid Stimulating Hormone (TSH)	19.30

Note: *A requisitioning physician may order additional tests by telephone request on specimens that have already been collected or received by the laboratory.*

LABORATORY PROCEDURES (SHORT LIST)

Claims for the following procedures will be accepted only from physicians who have been approved under the Manitoba Quality Assurance Program (MANQAP) administered by The College of Physicians and Surgeons of Manitoba, and who limit performance of laboratory work for the diagnosis of his/her own patients to those laboratory procedures which have been approved. The above approval is not required by physicians who practice outside of Manitoba. The schedule benefit includes the collection of specimens, where necessary.

BACTERIOLOGY

9715 Microscopic examination, trichomonads 3.85

9717 pinworms (Scotch Tape Method) 3.85

BIOCHEMISTRY

9142 Glucose, reflectance meter/photoelectric estimation 2.35

Note: *Tariff 9142 should only be ordered when clinically indicated. This test may be ordered for diabetics or patients with increased risk factors for diabetes, and for pregnant women.*

FECES

9374 Blood occult 2.05

Note: *Tariff 9374 should only be ordered when clinically indicated.*

HEMATOLOGY

For automated procedures—See Hematology

9312 White cell count 2.55

Note: *Tariff 9312 should only be ordered when clinically indicated.*

9315 White cell differential count and cell morphology 5.20

Note: *Tariff 9315 should only be ordered when clinically indicated. When the White Cell Count (Tariff 9312) is outside the normal range of 4-11 x 10 to the power of 9 per litre, a laboratory may, without a further requisition from the ordering physician, perform a white cell morphology (Tariff 9315).*

9147 Hematocrit 2.55

Note: *Tariff 9147 should only be ordered when clinically indicated.*

9150 Hemoglobin (photoelectric) 1.95

9273 Sedimentation rate 2.55

Note: *Tariff 9273 is a non-specific indicator of disease processes, its measurement should only be ordered in limited clinical situations.*

SEROLOGY

9170 Heterophile antibodies, slide test (monotest) 8.75

9721 Throat Swab—Rapid Antigen Detection Test 11.65

URINE

9521 Chorionic gonadotropins (pregnancy test) immunological..... 7.45

9641 Urinalysis, complete, including microscopic examination of centrifuged specimen..... 3.30

Note: *Tariff 9641 should be reserved for those patients who have abnormalities detected by Urinalysis, stick, tape or tablet for sugar, protein, ketones, urobilinogen, bilirubin or blood, or any other qualitative assessment not listed elsewhere (Tariff 9644) or who have clinical indications for complete urinalysis.*

9644 Urinalysis, stick, tape or tablet for sugar, protein, ketones urobilinogen, bilirubin or blood, or any other qualitative assessment not listed elsewhere..... 2.50

Note: *Tariff 9644 should only be ordered when clinically indicated.*

9711 Screening test for Bacteruria, spoon or agar slide technique..... 4.15

DISPOSAL CODES

00	Note the change in registration number—please update your records accordingly.
01	The registration number as reported on your claim is not valid—claim rejected. Submit claim with corrected registration number.
02	Note the change/correction in surname—please check your records.
03	Duplicate account—claim previously processed.
04	Registration cancelled prior to date of service—claim rejected.
05	Service prior to effective date of coverage—claim rejected.
06	Unable to identify as a Manitoba resident—claim rejected.
07	Note the change of sex code.
08	This service excluded from coverage under the Plan—service rejected.
09	Not an approved facility—service rejected.
10	Facility not approved for this service—service rejected.
11	Service included in bloc fee—service assessed accordingly.
12	Service processed in accordance with Medical Officer Assessment.
14	Referring doctor not on current College of Physicians and Surgeons Registry. Claim processed accordingly.
15	Patient identified as a resident of another province or country.
16	The provincial health identification number as reported on this reciprocal claim is invalid. Claim rejected.
17	Another doctor charged for identical services—service rejected.
18	Patient as identified by given name, year of birth and sex not on registration. Claim rejected.
19	Patient not eligible for benefits under the Plan—Armed Forces, R.C.M.P., or persons in federal institutions.
20	Service processed in accordance with advice of practising physician consultant in bloc of practice concerned.
21	Service included in operation, or anaesthetic fee—service assessed accordingly.
22	Query not answered—claim rejected.
23	Claim received after six (6) months from date of service–claim rejected.
24	Maximum benefit for routine eye examination has been reached—fee assessed accordingly.
25	Maximum benefit has been reached—fee assessed accordingly.
26	Surgeon's claim did not indicate delegation of postoperative care—claim rejected.
28	Service included in examination fee—service rejected.
30	Letter of explanation written regarding this assessment.
31	Surgical benefit less than required minimum for assistant—service rejected.
32	Claim is W.C.B. liability—claim rejected.
33	Maximum automated haematology benefit limit has been reached—fee assessed accordingly.
34	Maximum automated biochemistry benefit limit has been reached—fee assessed accordingly.
35	Note the change in birth date—please check your records.
36	Note the change in given name—please check your records.
37	Note correct surname for this patient only—not the same as the family head of this registration.

38 This service required prior approval of the Minister—service rejected.

39 Patient voluntarily signed agreement to restrict office visits to one primary physician—claim rejected. Please check P.U.R.C. listing.

44 Registration number and/or patient information do not match—claim rejected.

49 Team surgery—tariff and fee assessed accordingly.

50 Fee has been adjusted to benefit level.

51 Fee has been reduced to benefit level.

52 Fee has been adjusted to laboratory benefit level.

53 Tariff number has been changed and the fee assessed accordingly.

54 Repeat procedure—assessed according to Rules of Application 29, 38, 39, 40, 43.

55 Multiple procedure—assessed according to Rules of Application 25, 26, 27, 36, 37.

56 Bilateral procedure—assessed according to Rule of Application 28.

60 In-hospital Radiology only—insured payable.

61 In-hospital Radiology only—insured non-payable.

62 In-hospital Radiology only—non-insured payable.

63 In-hospital Radiology only—non-insured non-payable.

"Listing of Pending Claims" Codes

40 Claim has been returned to provider of service—additional information required.

41 Claim can not be located—please submit a new claim.

42 Claim held pending establishment of fee.

43 Claim held pending receipt or processing of Application form for medical/cosmetic determination.

70 Claim received and in process.

71 Claim under investigation—edit.

72 Claim under investigation—eligibility.

73 Claim under investigation—assessment.

74 Electronic media claim—received and in process.

DR Withdrawal—service previously paid in error.

CR Credit Adjustment—service processed incorrectly on prior remittance.

APPENDICES