New Brunswick Physicians' Manual

May 18, 2017

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CHAPTER 1: GENERAL MEDICARE INFORMATION

Section 1: Conditions of Participation

1.1 Definition of a Practitioner

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

1.2 Participating Practitioner

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

1.3 Procedure to become a non-participating practitioner

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

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

1.3.1 Opted Out Practitioners

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

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

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

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

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

1.4 Conditions Regarding Submission and Payment of Claims

1.4.1 Opted-in practitioners

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

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

1.5 Information to patients regarding opted-out status

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

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

b) If the charges are to be in excess of the Medicare tariff, the practitioner must inform the beneficiary prior to rendering the services:
    - that he is opting-out and charging fees above such tariff;
    - that in accepting service under these conditions the beneficiary waives all rights to Medicare reimbursement; and
    - that the patient is entitled to seek the services from another practitioner on an opted-in basis.

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

1.6 Participating Physician's Agreement

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

1.7 Claims Submission and Payment Procedure

1.7.1 Required Information – Electronically Submitted Claims

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

(a) the patient's name;
(b) the patient's Medicare number;
(c) the patient's day, month and year of birth;
(d) the patient's sex;
(e) the practitioner number of the participating medical practitioner or the participating oral and maxillofacial surgeon;
(f) the role the participating medical practitioner or participating oral and maxillofacial surgeon played in providing the service;
(g) the time spent by the participating medical practitioner or participating oral and maxillofacial surgeon on the entitled service if that is required to determine the amount of payment;
(h) the number of the transferring or referring medical practitioner, oral and maxillofacial surgeon, nurse practitioner, optometrist or registered nurse who works in a pre-operative clinic;
(i) the diagnosis;
(j) the dates of hospital days charged;
(k) the number of hospital days charged;
(l) the date or dates of the entitled service;
(m) whether the entitled service was provided at the participating medical practitioner's office, patient's home, in-patient or out-patient department of a hospital facility, nursing home or elsewhere;
(n) the description of the entitled service, the service code for the entitled service and fee charges;
(o) the site code of the hospital facility, nursing home or other place where the service was provided;
(p) whether, to the knowledge of the participating medical practitioner or participating oral and maxillofacial surgeon, the entitled services was one with respect to which a claim could be made;
(q) the date of the account;
(r) the specific anesthesia modifier to describe the service type;
(s) the service modifier to further define the service rendered;
(t) the vaccine lot number of the immunization being administered;
(u) the on-call code when a participating medical practitioner or participating oral and maxillofacial surgeon submits a fee for service claim provided under the mandated on-call program;
(v) the referral date being the date on which the patient was referred;
(w) the referral type where the participating medical practitioner or participating oral and maxillofacial surgeon indicates whether he or she was referred a patient or whether he or she referred a patient to another practitioner;

(x) the rotation code where the participating medical practitioner or participating oral and maxillofacial surgeon indicates the on-call rotation code for the specific on-call rotation he or she is covering; and

(y) the assigned number from the prior consultation process that determines coverage of a service where reasonable doubt exists as to its eligibility as an entitled service.

1.7.2 Required Information – Paper Claims Submitted

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

(a) whether the participating medical practitioner, the participating oral and maxillofacial surgeon or the beneficiary is to be paid;

(b) the patient's name;

(c) the patient's Medicare number;

(d) the patient's day, month and year of birth;

(e) the patient's sex;

(f) the beneficiary's address where the address is different than that on the New Brunswick Medicare Card;

(g) the name and practitioner number of the participating medical practitioner or the participating oral maxillofacial surgeon;

(h) the role the participating medical practitioner or the participating oral and maxillofacial surgeon played in providing the entitled service;

(i) the time spent by the participating medical practitioner or the participating oral and maxillofacial surgeon on the service if that is required to determine the amount of payment;

(j) the name of the transferring or referring medical practitioner, oral or maxillofacial surgeon, nurse practitioner, optometrist or registered nurse who works in a pre-operative clinic;

(k) the diagnosis;

(l) the dates of hospital days charged;

(m) the number of hospital days charged;

(n) the date or dates of the entitled service;

(o) whether the entitled service was provided at the participating medical practitioner's office, patient's home, in-patient or out-patient department of a hospital facility, nursing home or elsewhere;

(p) the description of the entitled service, the service code for the entitled service and fee charges;

(q) the name of the hospital facility, nursing home or other place where the entitled service was provided;

(r) whether, to the knowledge of the participating medical practitioner or participating oral and maxillofacial surgeon, the entitled service was one for which a claim could be made

  i. under any statute listed in Schedule 1 of this Regulation, or

  ii. against a third party or an insurer by reason of a motor vehicle accident, occupational injury, industrial disease or otherwise;

(s) the treatment information or remarks;

(t) the signature of the participating medical practitioner, the participating oral and maxillofacial surgeon or designate and the date of the account;
(u) the specific anesthesia modifier to describe the service type;
(v) the service modifier to further define the service rendered;
(w) the vaccine lot number of the immunization being administered;
(x) the on-call code when a participating medical practitioner or participating oral and maxillofacial surgeon submits a fee for service claim provided under the mandated on-call program;
(y) the referral date being the date on which the patient was referred;
(z) the referral type where the participating medical practitioner or participating oral and maxillofacial surgeon indicates whether he or she was referred a patient or whether he or she referred a patient to another practitioner;
(aa) the rotation code where the participating medical practitioner or participating oral and maxillofacial surgeon indicates the on-call rotation code for the specific on-call rotation he or she is covering; and
(bb) the assigned number from the prior consultation process that determines coverage of a service where reasonable doubt exists as to its eligibility as an entitled service.

1.7.3 Time Limit for Submission of Claims

To be *eligible for payment*, claims must be submitted to Medicare within *three* months of the date of service.

The *Practitioner's Claims to Correct Statement* identifies the cancelled claims with an accompanying message to indicate what information is incorrect or incomplete. Payment can only be considered if a new claim(s) is/are transmitted with the corrected information within *three months* from the date of the Claims to Correct Statement.

However, resubmission of a cancelled claim under a *different Medicare number* must be submitted on a paper claim if the date of service is greater than three months. Reference to the previous claim number must be provided.

Please note that any claim older than three months may be submitted for Independent Consideration however must be accompanied by an explanation for the delay in billing as well as all supporting documentation.

1.7.4 Submission of Claim Form

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

In order to submit claims electronically, a practitioner should first complete the Claims Submission Agreement http://www.gnb.ca/0394/pdf/2015/medicare-claims-submission-agreement.pdf and return it to the Practitioner Registrar at the following address Medicare.Practitioner.Registrar@gnb.ca. Once the form has

been received, reviewed and approved the practitioner will receive a notification requesting their billing software preference by one of the following approaches.

In cases where Medicare has an email address on file for the practitioner:
The practitioner shall receive an email entitled **Medicare – Claims Submission/ L'Assurance-maladie - Soumission des réclamations Process request / Traitement de demande**

- The practitioner should reply to the email and indicate their billing software preference.

If the practitioner replies to the email and has indicated Medicare Claims Entry as their software preference they will be provided with a link to the web site, user manual and contact information for Medicare's Practitioner Liaison Agents by email.

In cases where Medicare does not have an email address on file for the practitioner:
Health Application Services / Services provinciaux des applications en santé user support staff will attempt to contact the practitioner by telephone in order to collect this information.

- The practitioner should indicate their billing software preference during the call

If the practitioner indicates Medicare Claims Entry as their software preference they will be provided with the details to access the web site and contact information for Medicare's practitioner liaison agents during the call. User support staff will also determine with how to deliver the user manual to the practitioner.

In cases where the practitioner has indicated a preference for billing software from a private company:

- The practitioner or their associated billing delegate should be in contact with Health Application Services / Services provinciaux des applications en santé user support staff at (506)453-8274 option 4 during implementation of their software. All appropriate information such as claim ranges and reconciliation passwords will be provided during the call.

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

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

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

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

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

1.7.5 Submission of claims – opted-out services

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

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

1.7.6 Residents of other countries

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

1.7.7 Residents of other provinces

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

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

1.7.8 Non-resident claim form

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

1.8 Services Excluded Under the Interprovincial Agreements for Processing

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

1. Surgery for alteration of appearance (cosmetic surgery);
2. Sex-reassignment surgery;
3. Surgery for reversal of sterilization;
4. Routine periodic health examinations including routine eye examinations;
5. In-vitro fertilization, artificial insemination;
6. The treatment of port-wine stains on other than the face or neck, regardless of the modality of treatment;
7. Acupuncture, acupressure, transcutaneous electro-nerve stimulation (TENS), moxibustion, biofeedback, hypnotherapy;
8. Services to persons covered by other agencies: Armed Forces, WorkSafe New Brunswick (WSNB), Department of Veterans Affairs, Correctional Services of Canada (Federal penitentiaries);
9. Services requested by a "third-party";
10. Team conference(s);
11. Genetic screening and other genetic investigation, including DNA probes;
12. Procedures still in the experimental/developmental phase;
13. Anaesthetic services and surgical assistant services associated with all the foregoing
14. Dental Services
15. PET Scans
16. Gamma Knife
17. Bariatric Surgery

1.9 Payment of Claims

1.9.1 Payment to practitioners

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

Each cheque/direct deposit covers the paid claims listed on the reconciliation statement to which the cheque/direct deposit refers.

1.9.2 Adjustment to claims

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

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

The Practitioner Payment Reconciliation Statementprovides an explanation of these adjustments and the statement also includes a list of outstanding claims to be manually reviewed.

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

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

For further information regarding rejected claims and appeal procedures, refer to Appeal Procedures in Chapter 1, Section 2.1.

1.9.3 Patient identification

The beneficiary's identification card contains their name, date of birth, Medicare identification number, expiry date and indicates if organ donor. This information is required on the claim form except for the expiry date and organ donor information.

1.9.4 Procedure if patient is not registered

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

a) The practitioner can opt-out for the service in question and bill the patient directly, putting the onus on the patient to register and to obtain payment from Medicare if eligible.
b) The practitioner can assist the patient by advising him/her to write directly to Medicare Registration for a registration form, which the patient must complete and return. Having been issued an identification number, the patient should then give this information to the practitioner who can enter it on a completed form and bill Medicare directly.
c) Advise patient to contact Service New Brunswick

1.9.5 Prior Approval

Physicians are required to apply to Medicare in writing for consideration prior to rendering the service to determine the coverage status of proposed surgery whenever reasonable doubt exists as to its eligibility for benefits. A request form has been developed for this purpose (see http://www.gnb.ca/0394/pdf/2015/request-for-prior-approval.pdf)

Section 2: Appeal Procedures

2.1 Appeals by Physician

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

The formal appeal process is explained in Sections 33.001 to 33.005 of Regulation 84-20 under the *Medical Services Payment Act* by selecting "**View entire document**" at the following website: http://laws.gnb.ca/en/showpdf/cs/M-7.pdf

For additional information, please contact the New Brunswick Medical Society or the Appeal Officer at Medicare – Insured Services and Physician Remuneration.

2.2 Appeals by beneficiaries

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

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

This review will be undertaken on receipt by the Director of Medicare -Insured Services and Physician Remuneration of a request from the beneficiary.

The Insured Services Appeal Committee will advise the Minister with respect to the disputed entitlement or assessment. The Minister will then decide on the action to be taken.

Section 3: Excluded Services

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

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

(a) *elective plastic surgery or other services for cosmetic purposes;*
(a.01) *correction of inverted nipple;*
(a.02) *breast augmentation;*
(a.03) *otoplasty for persons over the age of eighteen;*

(a.04) *removal of minor skin lesions, except where the lesions are or are suspected to be pre-cancerous;*

(a.1) *abortion, unless the abortion is performed in a hospital facility approved by the jurisdiction in which the hospital facility is located;*

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

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

(c) *vaccines, serums, drugs and biological products listed in sections 106 and 108 of New Brunswick Regulation 88-200 under the Health Act;*

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

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

(f) *dental services provided by a medical practitioner or an oral and maxillofacial surgeon;*

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

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

(g) *Repealed: 96-111*

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

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

(j) *services provided by medical practitioners or oral and maxillofacial surgeons to members of their immediate family;*

(k) *psychoanalysis;*

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

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

(n) *refractions;*

(n.1) *services provided within the Province by medical practitioners, oral and maxillofacial surgeons or dental practitioners for which the fee exceeds the amount payable under this Regulation;*

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

(p) *trans-sexual surgery;*

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

(q) *acupuncture;*

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

(s) *circumcision of the newborn;*

(t) *reversal of vasectomies;*

(u) *second and subsequent injections for impotence;*

(v) *reversal of tubal ligations;*

(w) *intrauterine insemination;*

(x) *bariatric surgery unless the person has a body mass index (See **Chapter 1, Section 1.8**)*
(i) of 40 or greater, or
(ii)of 35 or greater but less than 40, as well as obesity-related comorbid conditions;

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

Section 4: Supplies and Materials

As a general principle, a practitioner shall not charge for those items related to supplies and equipment usually provided in an office except as identified below in Section 4.2. Equally, as a general principle, a practitioner may charge for those items of supplies and equipment usually provided primarily by the hospital.

4.1 Included

Included in the fees for entitled services unless otherwise specified:

a) All administrative processes surrounding a visit (whether under direct control of the physician or not) such as appointments, registration, charting, billing and reporting to a referring physician.
b) The use of all materials and equipment usually available in the office such as gowns, thermometers, specula and diagnostic and therapeutic equipment.
c) Any disposable items such as gowns, table paper, thermometers, lancets, specula, syringes (less than 10cc) and needles.
d) Single use supplies and materials utilized, applied or administered at the time of the entitled service, for example:
    1. in the simple dressing of wounds or lesions;
    2. for the taking, preservation or standard mailing of specimens;
    3. in the use of diagnostic equipment, such as ECG paper and disposable electrodes; and
    4. in the performance of allergy testing, with the exception of rare specific antigens.
e) Simple patient aids such as basic prepared instructions and diet sheets.

4.2 Excluded

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

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

Section 5: Patient Eligibility and Registration

Refer to the Medicare Website:
http://www2.gnb.ca/content/gnb/en/departments/health/MedicarePrescriptionDrugPlan.html

Section 6: Forms

Refer to the Medicare Website:
http://www2.gnb.ca/content/gnb/en/departments/health/MedicarePrescriptionDrugPlan.html

Section 7: Monitoring and Compliance

7.1 General Information

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

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

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

All claims submitted to NB Medicare must be verifiable by your patient records with respect to the service performed and billed. If such records cannot be produced and in the absence of suitable explanation, then the specific service involved will be deemed not to have been rendered and thus not payable. A practitioner shall make every effort to provide or make available, upon request by Medicare, patient records to clarify or verify services submitted for payment.

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

7.2 Records standards

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

- Patient name, Medicare # and Date of Birth
- Name of referring practitioner, where applicable
- Name of Consultant, if referred
- Date of Service
- Reason for the service, i.e. Presenting complaint
- Findings/evidence of physical examination (part or region) or emotional disorder – if applicable.
- Diagnosis
- Plan of investigation or treatment (including medications, if applicable)
- For time based codes such as counseling, start and end time is required.

- For procedures, in addition to the above; a Clinical Record/Operative Report/Procedural Report or another type of supporting document providing the details of the procedure performed, including pathology reports (when applicable) must be included.
- For time of day codes, i.e. Emergency visits, premium fees, the time of day is required.

7.3 Interval

- All practitioners will be audited on a random basis.
- Non-random audit will be conducted as warranted, based on utilization review or other data.

7.4 On-site Visits

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

7.5 Verification Letters

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

7.6 Findings

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

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

7.7 Professional Review Committee

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

CHAPTER 2: ASSESSMENT RULES

Section 1: Basis of Payment

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

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

1.1 Assessment Rules – General

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

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

All of the assessment rules are shown in the numbered list on the following pages. The list includes those rules, which are in the body of the Fee Schedule.

1.2 Assessment Rules – Details

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

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

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

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

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

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

Rule 6 Services listed in Schedule 2 of the Regulations under the *Medical Services Payment Act* are not entitled services under Medicare. (See **Chapter 1, Section 3**).

☞ ***Medicare Note: Supplies And Materials, See Chapter 1, Section 4.***

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

Rule 8 (Deleted 01/07/83)

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

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

☞ ***Medicare Note: See Medicare Note in Chapter 5, Section 1.10 and Chapter 5, Section 17.5).***

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

☞ ***Medicare Note: See Medicare Note in Chapter 3, Section 1.2.8.***

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

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

Rule 14 Venipuncture (service code 2050 and 2051) for the taking of specimens for laboratory testing is not payable when a visit, consultation or procedure fee is paid to the physician.

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

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

Rule 17 Claims under detention fee cannot be approved unless supporting information is provided describing the necessity for detention. The total time including start and end time (visit + detention) spent with the patient must be provided

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

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

Rule 20 (Deleted 01/04/81)

Rule 21 (Deleted 01/11/97)

Rule 22 (Deleted 01/08/94)

Rule 23 (Deleted 01/04/81)

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

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

Rule 26 (Deleted 01/08/92)

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

☞ ***Medicare Note: See Medicare Note in Chapter 3, Section 1.2.7.***

Rule 28 For surgical procedures the normal postoperative period will be taken as 30 days, however, the following exceptions apply:

i. If the patient is transferred/re-admitted to a different hospital after a surgical procedure, care by a different physician will be payable in the post-op period.
ii. Similarly, when a surgeon is required to travel to another facility within or outside of his/her Region to perform surgery, post operative care is

payable to a family physician for the management of the patient's care in a different facility.

iii. Subsequent to pacemaker insertion to a different physician/specialty.

iv. Subsequent to minor therapeutic endoscopic procedure to a different physician/specialty (where the procedure is not the reason for the admission) provided there is a different diagnosis.

- A minor therapeutic endoscopic procedure is defined as a procedure on a hospitalized patient, which is intended to stabilize the patient and is performed through an existing (non-incisional) orifice.

v. Physical Medicine and Rehabilitation services provided during the post-operative period where the procedure(s) has been performed by another physician.

Rule 29 Unless otherwise specified two collaborating surgeons may each be paid 70% of the amounts that would be paid to a solo surgeon including add-on procedures. Payment of an assistance fee to a third physician will only be made if the need for the assistant is explained on the surgeon's claim or accompanying documentation. (See Chapter 4, Section 2.6)

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

Rule 31 (Deleted 15/09/94)

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

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

i. 100% of the listed fee when the endoscopy is the sole procedure performed;

ii. 75% of the listed fee when it is followed by surgery on the same day;

iii. 0% if normally done as part of a concurrent operative procedure (e.g. peritoneoscopy and tubal ligation).

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

Rule 35 When a patient is transferred to a specialist immediately prior to or during delivery due to the development of unforeseen complications, the fee for the "Attendance at Labour Leading to Delivery" is payable to the transferring General Practitioner and the fee for the "Delivery" is payable to the specialist.

If the complications lead to a caesarean section, the transferring General Practitioner may be paid a surgical assistant fee in addition, where applicable.

Rule 36 (Deleted 01/04/80)

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

Rule 38 (Deleted 01/04/85)

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

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

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

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

Rule 43 (Deleted 01/09/93)

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

Rule 45 Regular custodial care will not be paid on a FFS basis where a nursing home is covered under a sessional payment arrangement, unless otherwise approved by NB Medicare.

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

Rule 47 An outpatient or emergency department service paid by sessional or fee-for-service will not be paid in addition to a hospital admission fee when done during the same hospital-based encounter. However, should a hospital-based visit fee during one visit be followed by an admission, during a separate visit, both services shall be deemed payable. Time of day must be indicated for these types of billings. This rule is intended to support the general payment principle that when separate services are provided at separate times (unless precluded by another assessment rule) both shall be payable.

CHAPTER 3: GENERAL PREAMBLE

Section 1: Introduction

Fees as specified are for professional services and do not include charges for drugs, injectable materials or appliances.

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

1.1 Principles of Billing

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

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

Specific exemptions include:

- Immunizations given in office
- Pap smears performed by nurses in office in conjunction with a physician office visit
- Chronic Disease codes 8109 and 8113
- Injection codes 2 and 1894
- Chemotherapy code 1950
- Dialysis codes 1923, 1924, 1743 and 1927
- Physicians billings for a resident or Medical student providing a service to a patient

The physician must be on-site in a supervisory capacity in the office for these to be eligible for payment.

In the case of residents working in hospital, physicians are eligible for payment for services rendered by these individuals, as long as they are under the supervision of a physician whether they are on or off-site.

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

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

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

☞ ***Medicare Note: A participating physician under Medicare who "opts out" for the management of a particular patient is required to inform the patient as outlined in Chapter 1, Section 1.3.1.***

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

The service codes listed in the Physicians' Manual have been negotiated between the New Brunswick Medical Society (NBMS) and the Department of Health. Not all service codes in the Manual are applicable to all the Sections. Please refer to your specialty section in Chapter 5 and to the service codes listed in Chapter 4 – Common to all. Surgical procedures are found in the sections relative to the anatomy of the procedural intervention.

If you do not find a service code in your section for the service you wish to provide, you should contact either the Department of Health or the NBMS for further information.

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

Each medical practitioner participating in the care of a patient should render directly to the patient or to the financially responsible party a statement of charges, preferably specifying service or procedure with the appropriate fee as laid down in the New Brunswick Physician Manual.

This should be done at the time service is rendered or at regular intervals. Should any variations from this Schedule be appropriate or desirable, an explanation should be added, e.g. courtesy reduction in consideration of special circumstances.

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

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

1.2 Terms and Definitions

1.2.1 Specialist

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

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

1.2.2 Visit

Visit refers to services by a physician to a patient for diagnosis and/or treatment at home, office, or hospital.

A visit fee applies to, and includes, services such as:

- initial hyposensitization injection and assessment;
- removal of foreign body from eye;
- otoscopy and/or removal of cerumen;
- urinary bladder catheterization;
- proctoscopic examination;
- repeat routine Pap smear;
- postcoital test;
- simple removal of finger or toenail;
- insertion of naso-gastric tube;
- certain supplies and materials (see Chapter 1, Section 4);
- prostatic massage;
- vaginal insufflation.

a. Office visit - Services rendered in the doctor's office (excluding special procedures, consultations, etc.).
   i. First - In new illness, or in prolonged illness in which the physician has not rendered services during the previous 30 days.
   ii. Subsequent - Continuing services except (i)
   iii. For injection, or procedure, only - visits solely for this purpose.

b. Hospital visit - Services rendered to a patient formally admitted to hospital for diagnosis and/or treatment.
   i. First visit - Major assessment on day of admission and same day visit, office or walk-in/after-hours clinic may be paid to the same physician if both services are medically necessary.

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

   ii. Subsequent visits - Subsequent daily care fees – normally includes a face to face encounter, involving the physician and the patient, but may from time to time be precluded by special extenuating circumstances.

   iii. Out patient and emergency department visits - Apply to attendance on an outpatient basis.

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

d. Emergency visit - A situation where the demands of the patient and/or the physician's interpretation of the condition require that he responds immediately at the sacrifice of regular office hours or routine of medical practice. The need for immediate response is the intended controlling feature. Immediate attendance because of personal choice or availability of the

physician is not considered an emergency visit. Urgent visits for acute or chronic conditions, which do not interfere with routine medical practice, do not constitute emergency visits. **Emergency visits may include any visit codes for services rendered on an emergency basis at the office, home, nursing home, Extra Mural, or hospital, or emergency calls in which the patient is seen outside - e.g. on the street. All claims for emergency based visits must show the time of day the services were rendered.**

e. ICU visit and services rendered to a patient formally admitted to the unit for diagnosis and/or treatment.
   i. Initial Assessment payable once for each admission except in case where anaesthetists bill for respiratory care. Refer to Medicare note in Chapter 4, Section 2.9.

f. i. Closed ICU unit where a team of appropriately credentialed physician intensivists are continuously available (within 10-15 minutes) to provide management of critically ill patients. Only a member of the intensivist team may admit, manage daily care and discharge patients
   ii. Open ICU - The patient is admitted and remains under the care of the attending physician.

1.2.3 Examination

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

☞ ***Medicare Note: See Chapter 2, Assessment Rules 7 and 12.***

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

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

☞ ***Medicare Note: Claims for regional examination will be allowed only once in any 90 day period for any patient. In addition, such claims will not be allowed if the visit took place within 90 days of a preceding first visit with complete examination (See Chapter 2, Assessment Rule 9).***

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

e) A health examination (for insurance, pre-employment, preschool, routine periodic, etc.) refers to examination of individuals at any age who may or may not have signs or symptoms of disease or disability. The fee charged will depend upon the evaluation. Examinations additional to 1.2.3 a) or 1.2.3 b) may warrant an increased fee.

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

☞ ***Medicare Note: Health examinations for or at the request of a third party are not entitled services under Medicare. (See*** Chapter 2***, Assessment Rule 1) Routine health examinations for purposes of a periodic check-up are not entitled services.***

1.2.4 Consultations

A Consultation refers to the situation where a physician in light of his/her professional knowledge of the patient, or when recently asked to do so by the patient or person acting on the patient's behalf, specifically requests the opinion of another physician competent to give advise in this field, because of the complexity, obscurity or seriousness of the case. The consultant is obliged to perform an assessment, review the laboratory or other data and submit his/her findings, opinions and recommendations in writing to the referring physician.
A consultation is not to be claimed as such when:

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

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

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

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

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

☞ ***Medicare Note: Payment for a consultation under Medicare will not be made unless the recorded medical history for the patient indicates a prior service rendered by the physician shown on the consultant's claim form as the referring physician. If there is no such prior service by the referring physician the claim will be paid as a non-referred office visit. (See*** Chapter 2***, Assessment Rule 11). See Medicare Notein Chapter 3, Section 1.2.8).***

PRINCIPLES OF CONSULTATION BILLINGS

These principles were drafted to assist Physicians in the appropriate billing of Consultation codes as found in the various sections of the New Brunswick Physician's Manual. Instructions regarding referrals, physical examinations, documentation required, applicability of the after-hours emergency premium, and consultation billings when physicians are receiving sessional payment are provided.

Introduction

A billable consultation refers to the situation where a recognized provider (see Chapter 1, Section 1.7.1 (h) or Chapter 1, Section 1.7.2 (j) of the Physician Manual) specifically requests the opinion of a physician who is competent to give advice in the requested field because of the complexity, obscurity or seriousness of the case. The request may result from the referring provider's own assessment of the patient or from his concurrence with a request by the patient or a person acting on behalf of the patient.

A consultation IS:

- Initiated by the referring physician, **not the consultant.**
- A written or verbally requested assessment of a patient that is correctly documented in the patients clinical file, including date and time of the request.
- Made by an approved allied healthcare professional.
- A request for reassessment of a patient after a change in the existing condition

A consultation IS NOT:

- A follow-up care visit/service provided to a patient where an existing diagnosed condition has been managed by the consultant/physician/specialty.
- A subsequent visit arranged by the consultant for follow-up (see visit code listed in the specialty section).
- To provide temporary/routine patient coverage for patients in the physicians absence.
- A transfer of care from same specialty for continuation of care.
- A referred patient for a procedure that has not received the proper assessment of a consultation.

Note: A patient referred for diagnostic procedure needs complete assessment consultation in order to bill a consultation.

Required documentation in order to Support the Referral

In order to meet the billing requirements of a consultation, a written referral or documentation of a referral by telephone must be included in the file. The documentation must include:

A. Patient's name, Medicare number, and date of birth
B. Consultant's name or the name of service being referred to
C. Specialty
D. Date of the referral

E. Name of the referring Physician
F. Reason for requesting an opinion
G. Date and time of verbal request by telephone when applicable.

Note: A form issued by the consultant to the referring physician, asking them to sign and return it to the consultant physician, does not constitute an acceptable consultation request.

Documentation Required in the Consultation Report

In order to fulfill a requested consultation, "The consultant is obliged to perform an assessment as per the definition of a consultation in Chapter 3, section 1.2.4 and ensure inclusion in the Consultation report.

The documentation must include:

A. Written communication back to the referring Physician including the patient's name, Medicare number and date of birth
B. Name of the referring Physician
C. Date of the consultation
D. Name of the consultant
E. Evidence of a history and appropriate comprehensive examination of the pertinent system(s) having been performed
F. Review of laboratory or other pertinent data (as required)
G. Opinion and further recommendations for management

Note: It is incumbent upon the physician to maintain adequate clinical records that support the service(s) being claimed when using electronic medical record software (eg Meditech) for billing a service. (Chapter 1, section 7.2)

After-Hours Emergency Premium

The definition of emergency services for the purpose of billing premiums, refers to those services which must be performed without delay because of the medical condition of the patient. The time of the service provision is not in itself the determining factor for premium charges. There must be documented evidence as to the emergent nature of the after-hours service. This premium is only payable when both criteria have been met; an emergency service (Chapter 3, section 1.2.2 d) provided after-hours (Chapter 4, section 2.12).

Fee-for-Service Consultation Billings and Sessional Remuneration

Unless otherwise specified, sessional fees are all inclusive rates and physicians are not to bill fee-for-service in addition to their sessional payment, regardless of where the service is provided.

1.2.5 Obstetrical Services

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

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

1.2.6 Paediatric services

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

a) Newborn care refers to routine care of a newborn during the first three (3) days, including complete examination and necessary parental advice.
b) Premature care refers to care of an infant weighing 5½ lbs., (2.5 kg), or less at birth.
c) Well baby care refers to periodic visits of a well baby up to one year of age, (code 19 and 89) for routine supervision of growth and development and parental instructions.

1.2.7 Surgical services

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

i. Normal preoperative examination and visits when the patient proceeds to surgery done by the same surgeon within a period of 30 days.
ii. Investigation and preparation of the patient
iii. The total postoperative care during the normal postoperative period (30 days).

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

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

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

☞ ***Medicare Note: All medical services (including home, office and hospital care) rendered by the surgeon during the normal postoperative period are deemed to be included in the surgical fee. (See Chapter 2, Assessment Rule 27). For all surgical procedures the normal postoperative period will be taken as 30 days. (See Chapter 2, Assessment Rule 28).***

1.2.8 Referred and transferred patients

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

☞ ***Medicare Note: Medicare will require that the consulting practitioner fill in the referring practitioner's name and number on the claim form.***

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

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

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

b) For services rendered as an assistant during an operation the referring physician may charge an assistant's fee (see Chapter 4, Section 2.5).

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

c) For the services rendered after an operation, the referring physician may charge on the basis of supportive care fees and/or convalescent care fees as outlined in the New Brunswick Physicians' Manual (see Chapter 4, Section 2.7)

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

1.2.9 Anaesthetic Services

See preamble to section on anaesthetic services (Chapter 5, Section 2.1).

1.2.10 Independent Consideration

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

The attending physician or physicians should assess their charges in equity with comparable items in the Schedule (see Chapter 4, Section 2.12.1)

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

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

1.2.11 New Services Items

Definition:

A new service is defined as new fee item(s) created for new procedure(s), new technique(s), new technology or new program(s). The New Service Items Committee process is not to be used for fee increases or for new fee items that have a higher fee for a service currently adequately described and paid under an existing fee code.

Funding:

The mandate of the New Service Item Committee will include sourcing new money for approved new items.

For items not approved, the individual sections may seek to fund them through distribution or through the Fee Schedule Revision Process or through the existing budget for the Specialty making the request.

No payment will be made for new service items until the submission to NSIC has been finalized and approval to proceed is given.

Process:

A physician planning to introduce a new service item should proceed as follows:

1. Provide written submission to the Section Liaison Representative for approval.
2. The Section liaison representative will send a submission to the NBMS for consideration by the New Service Item Committee.
3. New Service Items are to be time stamped by the New Brunswick Medical Society and a copy is forwarded to the Department of Health.
4. The Department of Health will undertake a review of the request with the RHA if applicable.
5. Requests are reviewed by the committee and a response is provided to the Section within 6 months of the date of receipt.

New Service Item Committee:

The New Service Items Committee is a subcommittee of the NBMS Economics Committee and will report pertinent information to the Economics Committee as necessary.

It is recognized, however, that on occasion it may be necessary for the Section Liaison Representative to delegate involvement to other members of the Section. In those instances, the Section Representative must clearly indicate to whom authority is delegated, and any follow-up information will be sent to both the Representative and the delegate.

Meetings will be held regularly, no more than 2 months apart. Meetings will be scheduled in advance. If a meeting is cancelled or postponed, a new meeting date must be accepted shortly after the cancellation date.

Minutes and a task list will be completed for each meeting. The minutes will include committee attendees, the new service items discussed, any pertinent discussion notes, and any action items indicating those responsible for the follow-up. Minutes will be provided to the FFS Economics Committee.

A master document containing the outstanding NSI list will be maintained electronically by the Department of Health and will be updated after every NSI meeting. The master list will include the item requested, the date of application, the section requesting the new service item, the Doctor who submitted the request, the Section Liaison Representative, discussion notes on the item from the subcommittee meeting and the estimated time of the procedure/service. Any notes added to the master list will be dated, and any actions items will have an expected completion date attached for follow-up. It will be noted on the master list if the action item was completed or not.

All requests must be received in writing on the approved New Service Item Request form.

1.2.12 Iatrogenic Injuries

Repair of iatrogenic injuries cannot be billed to Medicare (The injury and repair occurs at the same session and is corrected by the same surgeon/collaborator).

1.2.13 Detention Fees

A detention fee may be charged when the physician is required to spend considerable extra time in immediate attendance on the patient (and to the exclusion of all other work). (See Chapter 4, Section 2.4)

1.2.14 Laboratory Services

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

b) Outpatients: Most laboratory procedures are available to physicians on referring their patients or specimens through a hospital or outpatient department of a hospital, and are classified as outpatient laboratory services
A listing of laboratory procedures available and their current cost rates on a cost basis is available from the Provincial Laboratory Services

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

1.3 Disputed Fees

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

1.4 Revision of Schedule

A continuing committee on tariff is maintained by the New Brunswick Medical Society. Its purpose is to relate fees to the current practice of medicine. Members who detect errors in this Schedule, or wish to make recommendations regarding new procedures

should forward their observations to the Executive Director of the Society. Amendments to the Schedule of Fees may be issued from time to time.

1.5 Unit Values

Specialty	Rate	Date
Anaesthesia		
General Unit (Z)	$1.52	01/04/14
General Unit (I)	$1.51	01/04/15
Anaesthesia Unit (I & Z)	$18.04	01/04/15
Cardiac Surgery	$1.14	01/04/11
Dermatology	$1.49	01/04/11
Diagnostic Radiology	$1.34	01/04/10
Uncertified	$1.01	01/04/10
Emergency Medicine	$1.52	01/04/14
General Internal Medicine	$1.14	01/04/15
General Surgery (Thoracic, Vascular)	$1.30	01/04/15
General Practice	$1.52	01/04/14
Generic	$1.01	01/02/07
Internal Medicine (Medical Oncology, Radiation Oncology, Geriatric)	$1.13	01/04/11
Laboratory Medicine (Anatomical, General Pathology, Medical Microbiology)	$1.13	01/04/11
Maternal Fetal Medicine	$1.36	01/04/17
Neurology	$1.46	01/04/15
Neurosurgery	$2.28	01/04/14
Nuclear Medicine	$1.39	01/04/10
Uncertified (75% of certified rate)	$1.04	01/04/10
Obstetrics and Gynaecology	$1.36	01/04/15
Ophthalmology	$1.18	01/04/11
Orthopaedic Surgery	$1.29	01/04/15
Otolaryngology	$1.06	01/04/15
Paediatrics	$1.44	01/04/15
Physical Medicine & Rehab	$1.83	01/04/15
Plastic Surgery	$1.53	01/04/15
Psychiatry	$1.32	01/04/15
Respirology	$1.59	01/04/15
Rheumatology	$1.31	01/04/15
Surgical Assist	$1.53	01/04/15
Urology	$1.26	01/04/15
Walk in Clinic	$1.05	01/04/10

☞ ***Medicare Note: Unless otherwise specified in the Physicians' Manual, uncertified specialists will be remunerated at the rate of the certified specialists for all procedures rendered, exclusing Radiology. Uncertified specialists must bill consultations and visit fees per the General Practice Section of the Manual.***

1.6 Sessional Rates

Specialty	Rates	Effect Date
General Sessional	$137.39	01/04/15
Obstetrical/Anaes	$180.40	01/04/15
Emergency Medicine	$192.95	01/04/14
General Practice (ER)	$192.95	01/04/14

NOTE: Payment on sessional basis precludes remuneration of other services in addition unless otherwise stipulated.

1.7 Legend

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

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

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

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

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

☞ ***Medicare Note: For all procedures, a Clinical Record/Operative Report/Procedureal Report or another type of supporting document providing the details of the procedure performed, including pathology reports (when applicable), must be included in the patient's file.***

Abbreviations

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

CHAPTER 4: ITEMS COMMON TO ALL PRACTITIONERS

Section 1: Uninsured Services

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

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

☞ ***Medicare Note: Services rendered for or at the request of a third party are not entitled services. (See Chapter 2, Assessment Rule 1).***

1.2 Blood alcohol samples and documentation at the request of the Department of Public Safety

1.2.1 Visit and Examination

Injured patient: bill under appropriate Medicare codes and fees

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

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

1.2.2 Blood samples and documentation

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

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

1.2.3 Detention

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

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

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

Section 2: Miscellaneous Services

2.1 Nursing Homes

Pre-admission complete examination	2000	45
First patient seen during visit	2001	40
Emergency visit, night time and weekends, first patient	1752	56
Each additional patient	9	25

☞ ***Medicare Note: Payment will be made only for visits for which the physician is specially called to the nursing home. Routine, regular visits for custodial care will not be paid on this basis (see Chapter 2, Assessment Rule 45). Claims for emergency visits (as defined in Chapter 3, Section 1.2.2 d)) must show the time of day the services were rendered including weekends and statutory holidays.***

2.2 Emergency Visits

This listing applies to bona fide emergency visits, as defined in ***Chapter 3, Section 1.2.2 d)***), that are made to the hospital (for in-patient only), to the office, or to undefined locations such as the scene of an accident. It does not apply to home visits, nursing homes visits or to visits in an outpatient or emergency department: specific provisions for these categories of services are listed elsewhere in this Manual.

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

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

Daytime emergency visit	2855	21
Additional patient, office	2858	21
Additional patient, other location	2859	14
Night time and weekends	2856	70
Additional patient	2861	33

Statutory Holidays

a) New Year's Day;
b) Good Friday;
c) Easter Monday;
d) Celebration of the birthday of Sovereign (Victoria Day);
e) Canada Day;
f) New Brunswick Day;
g) Labour Day;
h) Thanksgiving Day;
i) Remembrance Day;
j) Christmas Day;

k) Boxing Day.

When New Year's Day; Canada Day; or Remembrance Day falls on a Saturday or Sunday the following Monday will be "in lieu of".

Statutory Holidays related to Christmas:

a) If Christmas Day falls on a weekday, Monday through Thursday, the 25th and 26th of December are the holidays.
b) If Christmas Day falls on a Friday, the 25th of December is the holiday and the 28th of December will be a day in lieu.
c) If Christmas falls on a Saturday or Sunday, the following Monday and Tuesday will be days in lieu.

This applies where payment is made based on statutory holidays.

☞ ***Medicare Note: Claims for emergency visits (as defined in Chapter 3, Section 1.2.2 d) must show the time of day the services were rendered.***

2.3 Visits to hospital emergency or outpatient departments

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

Service code 2854 is limited to once per hour, i.e. one hour must elapse between billings.

Daytime attendance		
First patient, when called to attend	2020	27
First patient, special visit from on-site office	2925	23
Additional patient – **Emergency Room**	2021	23
Scheduled out-patient clinic visit (see appropriate specialty section)		
Telemedicine follow-up, if appropriate – See Chapter 4, Section 2.15.13		
Nighttime and weekend attendance		
First patient attended (other than by the scheduled on-site physician)in a hospital where on-site coverage is provided	2831	39
First patient attended in a hospital without any on-site coverage	2854	91
Physician coming from on-site office	2926	39
Additional patient, any hospital	2832	28

☞ ***Medicare Note: All scheduled appointments and clinics in out-patient departments should be billed per the appropriate service code in the specialty section. Claims for scheduled visits in the outpatient Department do not require time of day. When the performance of a list A or B procedure is the sole purpose of attendance in an outpatient or emergency department, the fee for the procedure alone is payable. Also, if any visit or consultation fee has been paid during the preceding 30 days, no further visit or consultation fee may be claimed on the day of the List A or B procedure except in an emergency situation where independent consideration must be requested. (Chapter 2, Assessment Rule 13). Claims submitted under hospital emergency codes must show the time of day the services were rendered including weekends and statutory holidays. Time of day is required when billing Service Code 2021.***

Emergency services non-regional facilities

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

Physicians who are eligible for the $400 premium may be paid a fee of $190.00 per hour. Physicians may opt to receive this fee from the 6pm-12am shift seven days a week only or may also elect to receive such fees for the 8am-6pm shifts on weekends and statutory holidays.

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

2.4 Detention Fee

See definition in the General Preamble, Chapter 3, Section 1.2.13, per 15 minutes	200	23

☞ ***Medicare Note: Claims under detention fee cannot be approved unless supporting information is provided describing the necessity for detention (see Chapter 2, Assessment Rule 17). By definition detention may be claimed only when the practitioner's whole time is given to the patient to the exclusion of all other work. This is interpreted to mean that the physician is occupied at the patient's bedside; it does not cover waiting time, etc. Detention fees do not apply until the specified time for an appropriate visit has elapsed (for example: consult, complete exam, admission to hospital or intensive care = 1 hr; and repeat consult, hospital or intensive care day and office visit = ½ hr). Detention is not paid in addition to procedures.***

A visit, is not applicable when: you are already on the hospital premises and are called to see your hospitalized patient (you are the attending physician) on an emergency basis, or you are the operative surgeon rendering a visit in the post operative period; however a submission for detention alone, may apply if time spent with the patient is over and above the first ½ hr.

Your billing must indicate the total time including start and end time (visit + detention) spent with the patient, if no visit being billed please indicate why.

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

2.5 Surgical Assistance fee Role 3

a) i) A surgical assistant is paid 33% (minimum 25 units) of the Surgeon's fee. For subsequent procedures during the same operative session, the assistant is paid at 33% of either 50% or 75% of the surgeon's fee.
   ii) Surgical assistant fees are not eligible for the Cancer premium.

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

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

d) Assistance fees are not payable for diagnostic endoscopic procedures unless specified in the New Brunswick Physicians' Manual.

e) Surgical assistance fees are not payable to a surgeon who received procedures fees for other surgery during the same operative session with a surgeon of the same specialty.

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

☞ ***Medicare Note: If more than one assistant is required, the medical necessity must be explained on the surgeon's claim or accompanying documentation.*** ***(See Chapter 2, Assessment Rule 29)***

2.5.1 Explaining the need for a second assistant

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

In electronic billing, the only field available to record this is the **DIAGNOSIS** field, and also the **SERVICE DESCRIPTION** field when the billing software has been programmed to allow overwriting of the service description that automatically appears when entering a service code.
To enable the required information to be entered in such a limited space and so avoid the need for a paper claim, the use of a special code "EEE" is proposed, to be followed by a brief statement of the reason for the second assistant. For example, if the reason for having a second assistant is the presence of a large tumor in a grossly obese patient, one could write "EEE large tumor, obese++", and enter a diagnosis or service description. The use of the letters EEE of course simply says: "A second assistant was required because…" .

2.6 Collaborating Surgery Role 6

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

Collaborating surgery fees include the participation of both surgeons in patient evaluation and management as necessary, prior to and/or following surgery, to the same extent as if one were billing as a solo surgeon. (See Chapter 2, Assessment Rule 29).

2.7 Concurrent Care

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

2.7.1 Directive Care

Directive care is care provided by a specialist at the request of the attending physician (1st week consult (where applicable), and 3 visits; 4 visits per week thereafter) at the appropriate daily hospital care rates (see specific specialty codes).

☞ ***Medicare Note: The referral number of the attending physician must be included when submitting claims for directive care.***

2.7.2 Continuing Care

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

2.7.3 Supportive Care

Supportive care is necessary care rendered by the referring physician in addition to that rendered by a consultant physician while a patient is hospitalized and may include up to four visits per week at the appropriate daily hospital care rates. 199 29

2.7.4 Transfer of Care

Definition:

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

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

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

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

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

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

2.8 Sessional fees

(See Chapter 3, Section 1.6 for rates)

☞ ***Medicare Note: The fees apply to prearranged sessions, approved by Medicare. The total time including start and end time billed is calculated to the nearest half-hour increment or part thereof. All sessional fees are an all-inclusive rate, unless otherwise stipulated.***

☞ ***Medicare Note: In cases where a physician is rendering a service that begins during a Sessional Shift and continues more than 30 minutes beyond the end of that shift, the appropriate detention code may apply. Claims under the detention fee cannot be approved unless accompanied by adequate explanatory information describing the circumstances which necessitated detention. By definition, detention may be claimed only when the practitioner's whole time is given to the patient to the exclusion of all other work. This is interpreted to mean that the physician is occupied at the patient's bedside; it does not cover waiting time, phone calls etc. Detention would begin 30 minutes after the Sessional Shift has elapsed and may be billed per 15 minute intervals or part thereof. Detention is not paid in addition to procedures. Your billing must indicate the total time including start and end time spent with the patient, the time of day that the Sessional Shift has expired and the time of day detention began. If this service does not exceed 30 minutes beyond the expired Sessional Shift, the time spent with the patient is to be considered continuation of care and no further payment will be considered.***

2.9 Special Care Units

Intensive care – the following fees apply to services rendered in intensive care units and concentrated care units recognized as such by the Department of Health, including

neonatal intensive care units and burn units, by physicians with relevant training and/or experience. (See Chapter 3 Section 1.2.2 for definition)

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

☞ ***Medicare Note: See service description on detention Chapter 4, Section 2.4.***

☞ ***Medicare Note: Directive care in an intensive care units: 1st week - consult (where applicable) and 4 visits, 5 visits per week thereafter.***

Non-specialists		25	18
Specialists (all specialties)		198	22
For patient on ventilator, per day, (payable only in ICU or CCU to the physician who supervises the ventilator care), add		1798	58

☞ ***Medicare Note: The referral number of the attending physician must be included when submitting claims for directive care.***

☞ ***Medicare Note: A consultation fee is not payable in addition to the initial assessment fee. As well, an initial assessment code does not apply where the same physician has rendered a major consultation within the previous 24 hours. Daily care ICU fees would apply. Intensive care fees are inclusive of procedures, unless otherwise specified. During the first 24 hours following surgery these fees do not apply to the surgeon unless admission to the intensive care unit occurred prior to surgery or unless the patient is transferred to the unit after his return to the surgical floor. Claims for detention must include appropriate explanatory information (see Chapter 2, Assessment Rule 17).***

2.10 Miscellaneous Services

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

Anticoagulants – supervision of long term therapy, per month (telephone service)	C	1898	12
Haemoglobin estimation	C	1886	3
Urinalysis - complete, including microscopic	C	1884	3
Venipuncture – adult or child 4 years and older **(IC Only)**	C	2050	5
Venipuncture – infant or child under 4 years **(IC Only)**	A	2051	8

☞ ***Medicare Note: Venipunctures (service codes 2050 and 2051) are entitled services under Medicare only when the physician is specifically called to perform the procedure in hospital (see Chapter 2, Assessment Rule 14).***

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

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

Tray fee for pap test	C	1999	9

2.11 Total Parenteral Nutrition (hyperalimentation)

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

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

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

2.12 After Hours Emergency Premium

After-hours is defined as 18:00 to 08:00 hours on weekdays and all day on Saturdays, Sundays and statutory holidays; and, for non-specialists only, anaesthesia at the sacrifice of regularly scheduled office hours. The premium is 50% of the normal rate of payment with a minimum for the total billing of 30 general units or 3 anaesthesia units. Between the hours of midnight and 06:00 hours, the premium increases to 100%. When multiple services are performed, the minimum 30 general units or 3 anaesthesia units is only applicable for the primary service.

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

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

The premium applies to the following emergency services:

a. surgical procedures performed under general, spinal or epidural anaesthesia and surgical assistance and anaesthesia related thereto;
b. procedures performed under major nerve root blocks;
c. reduction of shoulder dislocations (Service Code 502);
d. daytime anaesthesia by non-specialist at the sacrifice of regularly scheduled office hours;
e. consultations;
f. emergency hospital admissions;
g. initial assessments in intensive care and concentrated care units;
h. initial management of trauma;
i. after-hours detention;
j. cadaver - organ, tissue or bone removal;
k. obstetrical deliveries, including medically indicated induction of labour, which proceeds to delivery after hours;
l. **Conscious Sedation:**
Conscious sedation (moderate sedation/analgesia) is a deeper level of sedation/analgesia than anxiolysis (minimal sedation). It (moderate sedation) is defined as a drug-induced depression of consciousness during which patients respond purposefully (reflex withdrawal from a painful stimulus is not considered a purposeful response) to verbal commands, either alone or accompanied by light tactile stimulation. The medically controlled state of depressed consciousness:
- Allows protective reflexes to be maintained;
- Retains the patient's ability to maintain a patient airway independently and continuously.

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

Refer to Chapter 4, Section 2.12.1 for values and details for billing purposes.

2.12.1 Information Table Re: Claiming IC / Cancer / Emergency Premium

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

I.C. NUMERIC VALUE	DESCRIPTION	HOW TO CALCULATE THE DESIRED BILLED FEE
1	Independent Consideration	Enter the I.C. Fee Requested in "Fee" Field
2	After Hours Emergency Premium	Listed Fee + 50% or 30U minimum = Total Fee
3	I.C. & After Hours Emergency Premium	I.C. Fee Requested + 50% or 30U minimum = Total Fee
4	Cancer Premium	Listed Fee + 35% (Surgeon Only) = Total Fee
5	Cancer Premium & After Hours Emergency Premium	Listed Fee + 35% + 50% = Total Fee
6	I.C. & Cancer Premium	I.C. Fee Requested + 35% = Total Fee
7	I.C., Cancer Premium & After Hours Emergency Premium	I.C. Fee Requested + 35% + 50% = Total Fee
8	After hours Emergency Premium – Midnight – 06:00	Listed fee + 100% or minimum 30U = Total Fee
9	I.C. & After Hours Emergency Premium – Midnight – 06:00	I.C. Fee Requested + 100% or 30U minimum = Total Fee

Anaesthesia Billings: Basic Units + Time + 50% or 3 anaesthesia units minimum – **IC (2)**
Basic Units + Time + 100% or 3 anaesthesia units minimum – **IC (8)**

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

Please submit your claim using the following IC code value as follows:

Weekdays
18:00 – 23:59 = IC (2)
24:00 – 05:59 = IC (8)
06:00 – 07:59 = IC (2)

Weekends and Holidays
24:00 – 05:59 weekends & holidays = IC (8)
06:00 – Midnight weekends & holidays = IC (2)

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

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

2.12.2 Service Codes Eligibile for AHEP Under Conscious Sedation

The following list of service codes will now be eligible for AHEP when performed under conscious sedation or under the criteria indicated in the Physicians' Manual.

Code	Code Description
499	STERNOCLAVICULAR
500	ACROMIOCLAVICULAR JOINT, NON-OPER.
502	SHOULDER,DISLOCATION
503	ELBOW DISLOCATION, CLOSED
505	WRIST DISLOCATION,CLOSED REDUCTION
507	FINGER,THUMB OR TOE DISLOCATION CLS
509	HIP DISLOCATION,CLOSED REDUCTION
511	PATELLA DISLOCATION
512	TARSAL JOINTS,DISLOCATION,CLOSED
687	INTUBATION OF LARYNX
699	FLEXIBLE BRONCHOSCOPY +/- BIOPSY
814	PTCA, ONE VESSEL, ADDITIONAL LESIONS
815	PTCA, ADDITONAL VESSEL, ADD
964	OESOPHAGOSCOPY
965	OESOPHAGOSCOPY WITH REMOVAL OF BODY
966	REPEAT INJECTION OESOPHAGEAL VARICE
967	BLAKEMORE TUBE
979	INJ.OESOPHAGEAL VARICES, OESOPHAGOS.
1007	GASTROSCOPY,REMOVAL OF FOREIGN BODY
1400	ABORTION, INCOMPLETE, INCLUDING D & C
1724	TRANSBRONCHIAL LUNG BIOPSY VIA FLEXIBLE BRONCHOSCOPE
1864	CATHETERIZATION, LEFT HEART, RETROGRADE
1866	SELECTIVE CORONARY CATHERIZATION AND ANGIOGRAMS, ADD
1870	DIAGNOSTIC LEFT +/- RIGHT HEART ANGIOPLASTY PLUS CORONARY ANGIOGRAPHY DONE AT THE TIME OF ANGIOPLASTY, WHEN PAYABLE, TOTAL ADD-ON FEE
1949	KNEE DISLOCATION,CLOSED REDUCTION
2057	COLONOSCOPY
2242	NASO-ORBITAL FRACTURE,CLOSED REDUCT
2649	PHALANGES,TERMINAL,CLOSED REDUCTION
2652	PHALANGES,MIDDLE OR PROXIMAL,CL RED
2658	METACARPALS,CLOSED REDUCTION

Code	Code Description
2673	RADIUS OR ULNA,CLOSED REDUCTION
2676	RADIUS AND ULNA,CLOSED REDUCTION
2681	RADIUS,HEAD OR NECK,CLOSED REDUCT.
2684	OLECRANON,CLOSED REDUCTION
2687	HUMERUS,EPICONDYLE,CLOSED REDUCTION
2690	HUMERUS,SUPRA,CLOSED REDUCTION
2693	HUMERUS,SHAFT,CLOSED REDUCTION
2696	HUMERUS, TUBEROSITY, CLOSED REDUCT.
2699	HUMERUS,NECK,CLOSED REDUCTION
2701	HUMERUS,NECK,DISLOCATION,CLOSED RED
2704	SCAPULA,CLOSED REDUCTION
2707	CLAVICLE,CLOSED REDUCTION
2710	PHALANGES,TERMINAL,CLOSED REDUCTION
2713	PHALANGES,MIDDLE OR PROXIMAL,CL.RED
2717	METATARSALS,CLOSED REDUCTION
2721	TARSALS,CLOSED REDUCTION
2724	OS CALCIS,CLOSED REDUCTION
2729	ANKLE, MEDIAL MALLEOLUS,CLOSED RED.
2731	ANKLE, LATERAL MALLEOLUS,CLOSED RED.
2737	FIBULA,CLOSED REDUCTION
2740	TIBIA +/- FIBULA,CLOSED REDUCTION
2742	PATELLA,CLOSED REDUCTION
2748	FEMUR, SHAFT OR TRANSCONDYLAR,CLSD.
2749	FEMUR, SHAFT OR TRANSCONDYLAR,CLSD.
2752	FEMUR, NECK OR INTERTROCH. CLSD.RED.
2757	TRUNK, PELVIS, ONE+ BONES,CLOSED RED.
2759	TRUNK, ACETABULUM +/- DISL. CLSD.RED
2779	JOINTS,TOE, CLOSED
2781	JOINTS,ANKLE, CLOSED
2784	JOINTS, HIP, CONG.DISLOC.CLSD.UNILAT.

Mutual agreement of the Department of Health and the New Brunswick Medical Society is required to add new items

2.13 Cancer Premium

See Chapter 6, Section 1

2.14 Surgical Obesity Premium

Surgical Premium, BMI >40	8132	100
Surgical Assistant, BMI>40	8133	33
Collaborating Surgery, BMI >40 (per collaborating surgon)	8134	70

☞ ***Medicare Note: This premium is payable at the generic unit value of $1.01 for all specialties. The surgical obesity premium is billed, once per session, in addition to eligible surgical procedures as outlined below***

The following criteria must be met:

Definition:
Major surgical procedure is defined as a *procedure performed in the main OR that has a value of 77 units or more.*

For the purposes of this premium, the definition of main OR includes day surgery and labour and delivery.

Criteria
Premium paid to physicians treating morbidly obese patients once per surgical session per patient for the major surgical procedure where a morbidly obese patient undergoes major surgery to the neck, hip, trunk, and **knee (Service Code 1978**) under the following conditions:

- The patient has a BMI greater than 40 for major surgery on the trunk and hip or the neck
- The surgery is rendered under general , spinal, epidural, or epidural anesthesia using an open surgical technique for the neck, hip and **knee (Service Code 1978),** or an open or laparoscopic surgical technique for the trunk or nerve block when the procedure is performed in OR, day surgery, or labour and delivery
- **Medical record requirements – the benefit is only eligible for payment when the BMI is recorded in the patient's permanent medical record (the supporting documentation for the procedure or service should reflect the actual BMI eg OR report)**
- **The patient's actual BMI must be indicated in the diagnosis field of the Medicare claim form along with the diagnosis**.
- Premium is payable to surgeon(s) and surgical assistant

Not eligible:

- When the **principle surgical technique** is aspiration, core or fine needle biopsy, dilation, endoscopy, mediastinoscopy, thoracoscopy, cautery, ablation or catheterization
- Not payable where precluded by other agreements.
- Not payable for surgical procedures with a value of less than 77 units.
- Premium is not payable to Radiology
- Premium not eligible for payment if surgery is rendered under local anaesthesia or conscious sedation
- Cannot be billed for any procedure performed on the skin or subcutaneous tissue alone

- Not open to Bariatric Surgery

2.15 Miscellaneous Visit Fees

2.15.1 Extramural Program

The following service codes apply exclusively to services related to patients admitted to the Extramural Program.

Extramural Home visit		
With admission to the program	204	150
To a previously admitted patient	205	124
Emergency visit	206	150
Extramural Palliative Care Home visit		
To a previously admitted patient to the program	847	124
Emergency visit	848	150
Additional patient, admitted or not, seen during a home visit	208	24
Visit (other than home visit) with admission to the program	209	35
Mileage, per KM outside a 5 KM radius (If the patient's residence is within a 5 km radius of the physician's office, no mileage can be claimed. For patients who live outside a 5 km radius of the physician's office, then 1 unit per km can be claimed for mileage outside the 5 km radius)	207	1
Communication (by hardcopy, phone or other means of electronic communication i.e. fax, e-mail, video-conference) initiated by an Extramural Program staff member requiring a response from a physician	210	15
Visit to a physician's office by an Extramural Program staff member to discuss health matters		
in relation to an Extramural patient	195	15
in relation to two or more patients	196	21

☞ ***Medicare Note: Billings under Service code 196 are to be submitted on a single patient claim form using one patient's Medicare number. The names and Medicare numbers of the other patients discussed must be provided in the remarks section of the claim. Service codes 195 and 196 are payable in addition to same-day visits or communication (hardcopy, phone or other means of electronic communication).***

☞ ***Medicare Note: Claims for emergency visits (as defined in Chapter 3, Section 1.2.2 d) must show the time of day the services were rendered.***

2.15.2 Counseling

a) Patient counseling – per ¼ hour	193	21

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

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

b) Family counseling – per ¼ hour 216 21

Discussion of a patient's health with family member(s) in situations where such discussion is necessary for a treatment decision or for arranging support services.

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

Explanatory Notes

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

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

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

2.15.3 Home Visits

First patient seen (see appropriate service code under each specialty listing)
Emergency visit (requiring immediate attention initiated by the patient or someone acting on the patient's behalf).....8 60
Additional patient, any home visit.....5 25

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence, including special care homes. Claims for emergency visits (as defined in Chapter 3, Section 1.2.2 d) must show the time of day the services were rendered.***

Location 9 has been established and must be entered on all claims submitted for services provided in a Special Care Home.

☞ ***Medicare Note: For Medicare purposes, the civic address of the special care home is considered the personal residence of the patient.***

2.15.4 Extended care/restorative care

The following service codes apply exclusively to services related to hospital patients admitted to designated extended care units:

First day's assessment and care, except where the physician was attending the patient immediately prior to transfer to the extended care unit	1745	34
Subsequent days	1746	12
Additional daily fee for unit director	1747	6
Medically discharged patients	8117	12

☞ ***Medicare Note:***

- ***Service code 8117 is not payable with Service Code 1747***
- ***Only billable for patients who have been medically discharged from the hospital and are awaiting placement in a nursing home or special care home.***
- ***Diagnosis (eg post-MI, post-stroke) and indicate waiting for placement in the diagnosis field of the claim.***
- ***Physicians paid under salary or alternate payment model should shadow bill this code correctly.***

Date of Discharge

Comprehensive coordination of activities surrounding patient discharge from hospital which over the course of the hospital stay, may include but is not limited to: communication with the patient, the discharge planning officer, the family or other responsible person, as required, and other physicians involved in the care of the patient, writing prescriptions and referral requests, organizing follow-up, documentation of a final diagnosis and completion of a concise discharge summary within 30 days	8747	28

☞ ***Medicare Note: See Chapter 2, Assessment Rule 46.***

2.15.5 Reassessment for Chemotherapy

Minimum 28 day interval.....283 33

2.15.6 Initial Management of multiple systems trauma

This service code applies to the comprehensive assessment and the performance of usual resuscitative or stabilizing measures by the physician in charge. It includes, as required, intravenous lines, pressure infusion sets and Pharmaceutical agents, urinary catheters, blood gases, nasogastric tubes and tracheal toilet. This code is payable in instances of trauma or injury which is life-threatening, or trauma affecting more than one system or area of the body with a high risk of disabling injury .....C 2956 120

(See also specific Specialty listings for management of trauma)

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

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

2.15.7 Attendance During Transport

When a physician is required to attend a patient in transport to another health care facility and the return trip of the physician to the originating hospital, detention per quarter hour.....2979 52

☞ ***Medicare Note: Claims must state the total duration of the two way trip (actual traveling time), excluding waiting time or making arrangements.***

2.15.8 Attendance Fees – Victims of Alleged Sexual Assault

Examination and early attendance to include necessary examinations, medical attendance and patient counseling (including parents when the patient is a child) as well as taking of specimens, completion of reports and forms and other medico-legal requirements and liaison with other parties. 1893 280

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

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

2.15.9 Organ Donor Maintenance Fee

Organ Donor Maintenance, per ¼ hour
(use generic unit value of $1.01).....8271 25

☞ ***Medicare Note:***

- ***This fee will be available to physicians working in Open Intensive Care Units only***
- ***Not applicable for physicians during hours for which they are remunerated on a sessional or salaried basis.***
- ***Physician not required to be on-site but must respond in a timely manner (response within 10 minutes and on site attendance within 20 minutes).***
- ***Procedures, payable in addition (same patient).***
- ***Fee-For-Service payable in addition (different patient).***
- ***After-hours Emergency Premiums (AHEP) cannot be billed in addition to this fee.***
- ***Physicians can begin billing once the patient is considered a candidate and organ donation has been confirmed.***
- ***The onset of Organ Donor Maintenance does not apply until the specified time for an appropriate visit has elapsed. Time of visit must be indicated.***
- ***Time of day session begins and ends are required.***
- ***Submissions beyond 24 hours will require a second claim.***
- ***Claims must be submitted manually***
- ***NOT applicable to live donors***

☞ ***Medicare Note: Claim must be submitted as Independent Consideration (see Chapter 3, Section 1.2.10 for details).***

2.15.10 Injections

Intradermal, intramuscular or subcutaneous, and
therapeutic injections (one or more per visit) .....C 2 13
Hyposensitization including supervision
(except initial injections, and assessment) per visit .....C 1894 13

2.15.11 Immunizations

Immunization including all supplies (Maximum
4 (3 @100% + 1 @ 50%)
Refer to the following list for service codes payable with a same day office visit.

Please submit a claim for each immunization given.

☞ ***Medicare Note: The following immunization codes are only open to General Practice and Pediatrics except for Service Code 8540 which is also open to OBS/GYN.***

☞ ***Medicare Note: Fee-for-service claims for the provincially funded immunizations require that these billings:***

1. ***Meet the criteria for vaccines supplied by the Public Health Services;***
2. ***Follow Medicare's billing guidelines as outlined in Chapter 1, Section 1.7 (requiring valid/acceptable diagnosis) and Chapter 1, Section 3;***
3. ***The product name and vaccine lot number must be indicated in the appropriate field designated for this purpose on the claim.***

Service Code payable with visit (8 units)	***Service Code – solo visit (Not payable with office visit) (13 units) List C Procedure***	***Description***	***Product Name***
8630	8660	DIPHTHERIA, TETANUS, ACELLULAR PERTUSSIS, INACTIVATED POLIO,	• QUADRACEL
8631	8661	DIPHTHERIA, TETANUS, ACELLULAR PERTUSSIS, INACTIVATED POLIO, *HAEMOPHILUS INFLUENZAE* TYPE B	• PEDIACEL
8632	8662	HEPATITIS A	• HAVRIX 720 JUNIOR • HAVRIX 1440 • VAQTA PEDIATRIC/ADOLESCENT • VAQTA ADULT
8633	8663	HEPATITIS A & B	• TWINRIX JUNIOR • TWINRIX
8634	8664	HEPATITIS B	• RECOMBIVAX HB PEDIATRIC • RECOMBIVAX HB ADULT • RECOMBIVAX HB DIALYSIS
8635	8665	HAEMOPHILUS INFLUENZAE TYPE B	• ACT-HIB
8636	8666	HUMAN PAPILLOMAVIRUS	• GARDASIL
8637	8667	INFLUENZA	• AGRIFLU • FLUVIRAL • VAXIGRIP • FLUZONE QUADRIVALENT • FLULAVAL TETRA
8638	8668	INACTIVATED POLIO	• IMOVAX POLIO
8639	8669	MEASLES, MUMPS RUBELLA	• M-M-R II • PRIORIX
8640	8670	MEASLES, MUMPS, RUBELLA, VARICELLA	• PRIORIX-TETRA • PROQUAD
8641	8671	MENINGOCOCCAL CONJUGATE MONOVALENT	• NEIS VAC-C • MENJUGATE
8642	8672	MENINGOCOCCAL CONJUGATE QUADRIVALENT	• MENVEO
8643	8673	MENINGOCOCCAL POLYSACCHARIDE	• MENOMUNE
8644	8674	PNEUMOCOCCAL CONJUGATE 13-VALENT	• PREVNAR 13
8645	8675	PNEUMOCOCCAL POLYSACCHARIDE 23-VALENT	• PNEUMOVAX 23
8646	8676	RABIES	• IMOVAX RABIES
8647	8677	TETANUS, DIPHTHERIA (REDUCED)	• TD ADSORBED
8648	8678	TETANUS, DIPHTHERIA (REDUCED), ACELLULAR PERTUSSIS (REDUCED)	• ADACEL • BOOSTRIX
8649	8679	TETANUS, DIPHTHERIA (REDUCED) ACELLULAR PERTUSSIS (REDUCED), INACTIVATED POLIO	• ADACEL-POLIO • BOOSTRIX-POLIO

8650	8680	VARICELLA	• VARILRIX • VARIVAX III
8651	8681	MULTICOMPONENT MENINGOCOCCAL B VACCINE	• BEXSERO
8652	8682	LIVE ATTENUATED ROTAVIRUS VACCINE (ORAL SUSPENSION 1.5ML)	• ROTARIX (effective June 1, 2017)

2.15.12 Surgical Prioritization Tool Completion

Not payable on the day of Surgery. 1810 10
Uses the generic unit value (i.e. $1.01)

☞ ***Medicare Note: The surgical prioritization tool is to be completed as part of the required documentation to book a patient for surgery. The tool is to be completed by the primary surgeon only – 1 per patient per surgical episode regardless of the number of procedures and/or surgeons.***

2.15.13 Telemedicine

A "telemedicine" ™ service is defined as:

"A physician delivered health service provided to a patient at a designated telehealth site through the use of video technology, including store and forward. The patient must be in attendance at the sending site and the physician at the receiving site at the time of the video capture. Videotechnology means the recording, reproducing and broadcasting of visual images. Store and forward is defined as a system that provides the ability to capture and store text, audio, static and video images and forward them for the review and opinion of a physician".

A designated telehealth site means services where receiving and/or sending takes place within an RHA facility.

Payment of telemedicine service is limited to services provided in facilities approved by the Department of Health.

Telemedicine services should be billed using current codes and fees provided the service can be rendered using the technology as described above. All services must adhere to the rules and regulations as set out in the Physicians' Manual.

The site code where the patient is physically located must be recorded on the claim submission.

☞ ***Medicare Note: When submitting claims for telemedicine, a location of "8" must be used with the appropriate site code. All site codes for telemedicine are within 400-499 range.***

Technical Standby, per ¼ hour 8719 20

☞ ***Medicare Note: Service Code 8719 is an all-inclusive fees that cover a maximum of 30 minutes per patient. No other service can be billed during this time. Only applies if the***

telemedicine service is delayed or interrupted for technical reasons. Referral number of remote specialist is required.

Telemedicine follow-up (use the generic value of $1.01) 8119 50

☞ ***Medicare Note: Service code 8119 is open to Location 8 only and is to be used instead of the service code for scheduled OPD clinics when providing a follow-up Telemedicine service as outlined in the Physicians' Manual in Chapter 4, Section 2.15.13. Service Code 8119 is not billable with Service Codes 8717 and 8718 (same physician or Service Codes 8898 or 8899).***

Telemedicine Site Codes

Site codes have been assigned to each hospital facility in the province for telemedicine services. When a service provided via telemedicine is billed, the site code on your claim submission should stipulate the actual facility in which the patient is receiving the service.

Site Code	Facility
401	Dr. Everett Chalmers Regional Hospital
405	Hôpital régional de Campbellton
408	Saint Joseph Hospital - Dalhousie
409	Hôpital régional d'Edmundston
411	Restigouche Hospital Centre
412	Stan Cassidy Centre for Rehabilitation
415	Centracare
416	Grand Manan Hospital
417	Harvey Health Centre
418	Hôpital et Centre de santé communautaire de Lamèque
419	Queens North Community Health Centre ER
420	The Moncton Hospital
422	Miramichi Regional Hospital
423	Hotel-Dieu of St. Joseph
424	Tobique Valley Hospital
426	Sackville Memorial Hospital
429	Saint John Regional Hospital
431	St. Joseph's Hospital
432	Hotel-Dieu Saint-Joseph de Saint-Quentin
433	Charlotte County Hospital
434	Sussex Health Centre
435	Hôpital de Tracadie
436	Carleton Memorial Hospital
438	Albert County Hospital
439	Hôpital régional Chaleur
440	Hôpital de Tracadie-Sheila
441	Hôpital de l'Enfant-Jésus RHSJ+

442	Hôpital général de Grand-Sault
443	Northern Carleton Hospital
445	Hôpital Stella-Maris-de-Kent
446	Oromocto Public Hospital
448	Hôpital régional Dr-Georges-L.-Dumont
449	Centre de santé nebtake communautaire d'Edmundston TLM
450	Upper River Valley Hospital
451	Service de traitement des dépendances d'Edmundston TLM
452	CSMC de Campbellton TLM
453	Services régionaux de traitement des dépendances de Campbellton TLM
454	CSMC de Bathurst TLM
455	CSMC de Caraquet TLM
456	Centre de santé Saint- Isidore TLM
457	Hôpital et centre de santé communautaire de Lamèque TLM
458	CSMC de Richibucto TLM
459	Centre médical régional de Shediac TLM

2.15.14 Rural Health Care

Travel Clinic/Telemedicine session, 1st patient seen, add-on 8898 15%

☞ ***Medicare Note: Payable once per day with service codes 8720-8740 and 1927 for the 1st patient seen.***

Travel Clinic/Telemedicine session – Consultation, 1st patient seen, add-on 8899 15%

☞ ***Medicare Note: Payable once per day with Major Consultation for the 1st patient seen only.***

☞ ***Medicare Note: Service codes 8898/8899 are not applicable same day, same or different patient, same establishment.***

2.15.15 Travel Stipend

Travel Stipend (per 20 minute interval – use generic unit value).....8889 25

The travel stipend recognizes and remunerates in-province specialists who provide face to face services in NB rural communities greater than 40 KM from their "primary practice location" for approved clinics (as identified by Regional Health Authority/Zone) in facilities administered by the RHA (OPD clinic, CHC).

General practitioners, with expertise in an area where there is no in-province specialist available (e.g allergies), may be eligible for reimbursement under this program if supported by the RHA and provided in an approved facility.

This must be broken down into 25 units per 20 minute intervals. Travel time/distance is required in the diagnosis field. Travel time will be required in the "Start time and end time" fields
Similar to mandated on-call, you are required to use patient id 111111118

2.15.16 New Brunswick Medicare On-Call Programs

(payable only one per service date per physician per service rotation – use generic unit value $1.01.)
Mandated on-call (see Chapter 4, Section 2.15.17)

General Practice (FFS and Salaried) rotations	8989	147
Specialists (FFS and Salaried) rotations	8990	147
Nursing Home rotations	8991	147
Provincial Jail rotations	8992	147

Second Call (see Chapter 4, Section 2.15.17)
(payable only one per service date per physician per service rotation – use generic unit value of $1.01.) 8997 147

☞ ***Medicare Note: All on-call rotations must be mandated by each Regional Hospital Authority Board and approved by the Department of Health (DH) and the New Brunswick Medical Society (NBMS).***

☞ ***Medicare Note: Applicable mandated on-call rotation code must be indicated on each claim (see Chapter 4, Section 2.15.18).***

Provincial Call (see Chapter 4, Section 2.15.19)
(payable only one per service date per physician per service rotation – use generic unit value of $1.00.)..... 8998 500

☞ ***Medicare Note: Applicable mandated on-call rotation code must be indicated on each claim (see Chapter 4, Section 2.15.18).***

☞ ***Medicare Note: All On-Call arrangements, listed below must be approved by the DH.***

Rural General Surgery / General Practice Anaesthesia

Rural On-Call General Surgery	8975	400
Rural On-Call Anaesthesia	8976	400
Rural On-Call OBS (Specialist)	8977	400
Rural On-Call OBS (Family Practice)	8978	400

☞ ***Medicare Note: Above noted service codes are payable at the generic unit value of $1.00***

☞ ***Medicare Note: Above noted service codes payable only one per service date.***

Closed Adult Intensive Care / Coronary Care Units
(Hospitals without on-site coverage)

"Closed" physician staffing model – unit where a team of appropriately credentialed physician intensivists are continuously available to provide management of critically ill patients. Only a member of the intensivist team may admit, manage daily care and discharge patients.

Adult ICU On-Call.....8970 400
Closed CCU On-Call 8971 400

☞ ***Medicare Note: Above noted service codes are payable at the generic unit value of $1.00***

☞ ***Medicare Note: Above noted service codes payable only one per service date.***

Neonatal Intensive Care Units

NICU On-Call.....8974 400

☞ ***Medicare Note: Above noted service codes are payable at the generic unit value of $1.00***

☞ ***Medicare Note: Above noted service codes payable only one per service date.***

Provincial Trauma Control Leader / Trauma Team Leader

Provincial Trauma Control Leader 8972 400
Trauma Team Leader.....8973 400

The service codes will be billed under Medicare #111111118. In keeping with the guidelines for all mandated On-Call rotations, only one rotation can be billed regardless of how many calls are covered by a physician on the same night.

☞ ***Medicare Note: Above noted service codes are payable at the generic unit value of $1.00***

☞ ***Medicare Note: Above noted service codes payable only one per service date.***

Non-Regional Emergency Rooms
(Hospitals without 24 hour sessional on-site coverage)
$400 + fee-for-Service for nights, weekends and holidays.
During regular day time hours, physicians will be remunerated at the fee-for-service, salary or sessional rate, as appropriate.

☞ ***Medicare Note: Changes to on-call agreements are subject to the approval of the Department of Health and the New Brunswick Medical Society.***

2.15.17 Mandated On – Call / Second Call Program

1.0 Mandate

1.1 To provide compensation for mandated on-call/second call in New Brunswick hospitals, nursing homes, and NB Provincial Jails for specialists and general practitioners.

2.0 Objective

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

3.0 Definitions

Where used in this Agreement, the following terms and expressions shall have the meaning indicated opposite such terms and expressions:

3.1 "non-regional hospital" means all hospitals, other than a "regional hospital";

3.2 "regional hospital" means the following New Brunswick hospitals: Dr. Everett Chalmers, Saint John Regional, The Moncton Hospital, Dr. Georges L. Dumont, Campbellton Regional, Chaleur Regional, Edmundston Regional, and Miramichi Regional;

3.3 "on-call" means, any period outside regular working hours (Monday through Friday and on weekends and statutory holidays", whereby a Physician will be available to respond to urgent or emergent requests from a facility (hospital, nursing home, or an NB Provincial Jail) for the purpose of examining, treating, providing diagnostic services or advice regarding a patient.

3.3.1 In the case of a hospital facility this includes discharged or unaffiliated patients who: present from the community via the emergency room, are referred by Physicians from other facilities or are in-patients admitted under the care of a Physician in another specialty.

3.3.2 In the case of nursing homes, this includes all existing or newly admitted residents.

3.4 "On-site" means attendance at a facility.

4.0 **Staff By-laws, Privilege Rules and Regulations**

This Schedule does not modify, nullify or void any medical staff by-laws, privilege rules and regulations between a Regional Health Authority and a Physician concerning work performed on an on-call basis;

5.0 **Exclusions**

5.1 The Program applies to Physicians working under all payment modalities. Physicians who receive on-call remuneration or other methods of compensation, agreed to separately by the Department and the Society to reimburse them for mandated on-call/second call, will be excluded.

5.2 The Department and the Society have agreed to the following exclusions:

- On call for surgeons and anesthetists in Sussex;
- Non-regional emergency rooms;
- Intensivists working in closed ICUs without on-site coverage;
- Psychiatry on-call at the Restigouche Hospital Center and Centracare;
- Obstetrics rural on-call at Campbellton Regional Hospital;
- Provincial Trauma Team Control Leader and Trauma Team Leaders in Saint John – SJRH and Moncton – TMH;
- Neonatal Intensive Care Units in Fredericton – DECH, Saint John – SJRH and Moncton – TMH;
- Alternate Funding Arrangements
- Any future payment arrangements agreed to by the Parties which include remuneration for on-call.

Other DH initiatives which are excluded are as follows:

- Hospitalist projects (Miramichi and Saint John Regional Hospitals)

6.0 **Principles**

6.1 Remuneration is only available for mandated on-call as determined by the Medical Advisory Committee (MAC) for the Zone or the Regional Medical Advisory Committee (RMAC) within the Regional Health Authorities and/or by individual Nursing Homes and/or through a request from the Department of Public Safety on behalf of NB Provincial Jails.

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

6.3 This Program does not include routine consultations or work not defined as emergent/urgent. Physicians may continue to provide these services during the on-call period but must be available as described in article 6.2 above. This Program does not include routine on-call coverage for a Physician's own patients and those of their

on-call group, however coverage applies to new admissions and orphan patients. As always, providing on-call coverage includes caring for hospitalized patients.

6.3.1 This compensation does not include on-call availability during normal working hours on week days.

6.3.2 After Hours Emergency Premium is not applicable to service code 8999 or any other service code for an on-call compensation.

6.4 Any request for a new Mandated On-call rotation must be submitted to MAC /RMAC and if approved, submitted in writing to the Department of Health. The Department will forward all requests for new call groups to the NBMS. The approval process will now be a two-step process:

1. Approve the Call – MAC/RMAC
2. Approve the Funding-NBMS Economics Committee/Dept. of Health

The NBMS FFS Economics Committee in conjunction with the Department of Health will have the authority to approve or deny an application for a new call group rotation. Each year the Economics Committee will report to the NBMS Board on the applications received throughout the year and the decisions regarding approval.

6.5 A regular review of all active On-call groups will be done by the NBMS FFS Economics Committee in conjunction with the Department of Health. The FFS Economics Committee will have the authority to request groups appear before the committee for review.

6.6 The Department requires two weeks prior notification, from the RHA, Nursing Home, or NB Provincial Jail, of any proposed additions or deletions to the number of rotations. Any changes will be made following proper consultation with the Society. The Department will notify the appropriate Party of the decision.

6.7 Notwithstanding article 6.6, the number of rotations for NB Provincial Jails shall not exceed two (2) unless otherwise agreed to by the Parties.

6.8 Second call will be compensated effective April 1, 2006 for Anesthesia, Obs/Gyn and General Surgery for the 8 Regional Hospitals as mandated by the individual RHAs.

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

6.10 Criteria for availability: If a Physician is participating as part of a service that is available 365 days (24x7) then they would qualify. If a Physician is part of group that is unable to cover 365 days then the following applies: a solo Physician must be

available a minimum of 90 days of the year. A 2 Physician group must be available a minimum of 180 days, a 3 Physician group must be available a minimum of 270 days and 4 or more Physician group must be available 365 days. This criterion will be monitored quarterly by the parties.

6.11 Effective April 1, 2014 $2,000,000 will be transferred from the Salaried Physician Mandated On-call program to the FFS Mandated On-call budget to create a single Mandated On-call protected funding pool.

6.12 All claims for on call coverage, including FFS, salaried or Alternate Payment, Academic Payment or Alternate Funding Plans, must be submitted FFS.

6.13 A Physician will receive on-call compensation only once per night, regardless of how many services are covered or if it is for one or more regions/nursing homes/NB Provincial Jails of the province.

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

6.15 When a Physician is called in to examine, diagnose and treat a patient he/she may bill the appropriate FFS fee and the After Hours Emergency Premium, as applicable.

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

6.17 Separate funding pools will be created to assist in the management and sustainability of the program. The funding pools are listed below:

A. General Practice Funding Pool
   Including non-regional, GP Addiction, GP Obs/Gyn, GP sexual Assault, Palliative Care, GP Geriatrics, Hospitalists, Methadone, Newborns and OR assists
B. Specialty Funding Pool
C. Nursing Home Funding Pool
D. Jails Funding Pool

7.0 Billing

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

7.2 Service code 8997 has been developed for FFS billing purposes for a second call.

8.0 Residual

a) The yearly expenses will not exceed allocated funding.

b) Three (3) percent of the allocated funding will be held back to fund additions to the roster list through the year. Any residual at year end will be allocated retroactively to adjust the rate to Physicians who have provided on-call coverage during the period.

c) The NBMS FFS Economics Committee in collaboration with the Department of Health will determine each year whether requests for call groups will be funded through contingency funding or a fee distribution or if a decision is made not to fund a request, the requesting group, either Specialist or General Practitioners, would need to determine whether a new call group will be funded out of the existing budget, which may result in a reduced daily call rate for that funding pool.

d) If provided, additional funding for second call coverage will be part of the original funding pool and therefore any residual will be available for retroactive adjustments including the 3% holdback.

e) Should the residual be depleted prior to the end of the fiscal year, the over-expenditure will be funded from any funds available from the second call and Inter-Regional Call pools prior to the residuals of these pools being paid out.

f) The percentage of hold back will be examined by the Parties at each year end.

9.0 Over-Expenditure

If the actual amount spent exceeds the available amount in any fiscal year, then the rate for the next fiscal period will be adjusted proportionately.

2.15.18Mandated On-Call Rotations

Description	Code	Description	Code
ANESTHESIA	I	MEDICAL ONCOLOGY	BK
CARDIAC ANESTHESIA	IC	NEONATAL/PERINATAL MEDICINE	BG
CARDIAC SURGERY	AA	NEPHROLOGY	BH
CARDIOLOGY	BC	NEUROLOGY	J
DERMATOLOGY	M	NEUROSURGERY	O
DIAGNOSTIC RADIOLOGY	H	NUCLEAR MEDICINE	CA
FAMILY MEDICINE	T	OBSTETRICS AND GYNECOLOGY	C
FMED-ADDICTION SERVICES	TA	OPHTHALMOLOGY	L
FMED-HOSPITALISTS	TH	ORAL MAXILLOFACIAL SURGERY	DB
FMED-JAILS	TJ	ORTHOPAEDIC SURGERY	E
FMED-METHADONE	TM	OTOLARYNGOLOGY - HEAD & NECK SURG	F
FMED-NEWBORNS	TN	PATHOLOGY	N
FMED-O/R ASSISTS	TO	PEDIATRIC NEUROLOGY	DJ
FMED-OBSTETRICS	TC	PEDIATRIC PSYCHIATRY	KC
FMED-PALIATIVE CARE	TP	PEDIATRICS	D
FMED-SEXUAL ASSAULT	TS	PHYSICAL MEDICINE & REHAB	R
GASTROENTEROLOGY	BE	PLASTIC SURGERY	P
GENERAL SURGERY	A	PSYCHIATRY	K
GERIATRIC MEDICINE	BM	RADIATION ONCOLOGY	CB
GYNECOLOGIC ONCOLOGY	CE	RESPIRATORY MEDICINE	BI
HEMATOLOGICAL PATHOLOGY	NC	RHEUMATOLOGY	BJ
INFECTIOUS DISEASES	BL	THERAPEUTIC RADIOLOGY	S
INTERNAL MEDICINE	B	THORACIC SURGERY	Q
INTERVENTIONAL CARDIOLOGY	BB	UROLOGY	G
INTERVENTIONAL RADIOLOGY	HI	VASCULAR SURGERY	AV
MEDICAL MICROBIOLOGY	NE		

2.15.19 Province-Wide On-Call Program

1.0 Definitions

In this Schedule:

"Province-wide on-call services" means any period outside regular working hours Monday through Friday and on weekends and statutory holidays, whereby a physician will be available to respond to urgent or emergent requests from a facility for the purpose of examining, treating, providing diagnostic services or advice regarding a patient.

"Mandated on-call" is defined in the Mandated On-call Guidelines, Schedule C of the Fee-for-Service Master Agreement signed October 20, 2009.

2.0 Mandate

To provide compensation for Province-wide on-call services in New Brunswick hospitals for the specialties of designated groups. This call will be formally arranged by the specialty group to cover the Province. All physicians in each specialty group must participate in the Province-wide on-call services unless otherwise specified.

3.0 Objective

3.1 The primary objective of the program is to remunerate on-call physicians providing Province-wide on-call services including medical advice to physicians within and outside their home region/zone for emergent/urgent referrals.

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

4.0 Responsibilities of the On-call Physician

4.1 The on-call physician will provide province wide on-call services in New Brunswick hospitals.

4.2 There must normally be a response within 20 minutes unless alternative arrangements are stipulated by the Department of Health

4.3 This Program does not include routine consultations or work not defined as emergent/urgent. Physicians may continue to provide these services during the on-call period but must be available as described in article 4.1.1 above. This Program does not include routine on-call coverage for a Physician's own patients and those of their on-call group; however coverage applies to new admissions and orphan patients. As always, providing on-call coverage includes caring for hospitalized patients.

4.4 The group must be available to provide on-call services for a minimum of 115 days (weekends and statutory holidays) per year

4.5 All claims for on-call coverage, including FFS, Salaried or Alternate Payment, Academic Payment or Alternate Funding Plans, must be submitted FFS.

4.6 A Physician will receive on-call compensation only once per night, regardless of how many services are covered.

4.7 Locums will be eligible for this remuneration if they are replacing a Physician who meets the criteria.

4.8 When a Physician is called in to examine, diagnose and treat a patient he/she may bill the appropriate FFS fee and the After Hours Emergency Premium, as applicable.

5.0 Principles

5.1 RHAs will be required to submit information upon request providing monthly details (Physician's name, specialty and date of service).

5.2 Monthly rotation schedules are to be completed within the on-call group and forwarded to each RHA. Each RHA must then forward to each Medical Director who will notify each hospital of the on-call schedules.

5.3 Remuneration is only available for Province-wide on-call as approved by the New Brunswick Medical society and the Department of Health.

5.4 No other Supplementary on-call payments made by an RHA.

6.0 Billing

6.1 Service code 8998 has been developed for FFS billing purposes. The date of service on the claim will reflect the date the on-call shift begins. One Physician will be compensated per date of service. Only one service/date can be on a claim.

6.2 Remuneration for each date of service will be set at $500.

6.3 A physician can only bill once in a 24-hour period.

7.0 Residual

7.1 A dedicated funding pool of $600,000 has been set aside for this initiative.

7.2 The yearly expenses will not exceed allocated funding.

7.3 Any residual at year end will be allocated retroactively to adjust the rate to physicians who have rendered mandated on-call coverage (under Schedule C of the FFS Master Agreement) during the period. The remainder of the dedicated funds will remain in the protected funding pool until March 31, 2014 at which time the Department of Health and the New Brunswick Medical Society will review.

CHAPTER 5: SPECIALTIES

Section 1: General Practice

See legend – Chapter 3, Section 1.7 for description of lists A, B, C and D.

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

1.1 Consultations

(See definitions in General Preamble, Chapter 3, Section 1.2.4)

Major or regional consultation	10	50
Repeat, within 30 days	12	31

1.2 Office Visits

To include where applicable hemoglobin, urinalysis, injections, pelvic examination and services to which they apply as outlined in Chapter 3, Section 1.2.2.

Office visit, to be billed by General/Family physicians when providing service within the context of a community-based family practice, which is defined as one in which the physician maintains a comprehensive patient chart to record the service code 1 and all other encounters, provides all necessary follow-up care for that encounter and takes responsibility for initiation and follow-up on all related referrals	1	30

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

Chart Initiation Fee (use the generic unit value of $1.00) 8107 50
Payment is based on a fee of 150 units in installments of 50 units per visit x 3 visits.
It is payable in addition to appropriate visit fees.

The parameters for the Program will include the following:

- Must be in community-based family practice which has been established for not less than one year. If a Physician has accepted the Minimum Guaranteed Income, no payment will be for new chart initiation until the Physicians have met their obligation related to volume.
- The family Physician must initiate the establishment of a permanent patient chart
- New patients are defined as currently unattached patients and transfers.
- As this will be one of the evaluation criteria, the Parties will work collaboratively to reduce the NB Patient Connect list in the Province through a combination of this initiative and the promotion of the list to new Physicians.

- This Program does not apply to newborns.
- ***Patients taken from the NB Patient Connect list will be eligible for the full chart initiation fee i.e. 50 units added to the appropriate visit fee, in installments of 50 units per visit x 3 visits, even if the fee has been previously paid out for the patient.***
- In order for claims to be processed and paid, claims will have to be submitted on an IC basis

Seniors Office Visit
For complex case assessment for seniors 70 years of age or over, presenting with multiple systems pathology including medication review, as required 8101 36

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

Opiate Addiction – Office Visit
For diagnosis and follow-up of opiate addiction.....8116 30

☞ ***Medicare Note: This service code IS NOT merely for prescribing/refilling of prescriptions of methadone/alternatives.***

☞ ***Medicare Note: Patients must have been diagnosed with an opiate addiction and physicians should adhere to the College of Physicians and Surgeons of New Brunswick Guidelines for the Treatment of Opioid Addiction; http://www.cpsnb.org/english/Guidelines/TreatmentofOpioidAddiction.htm***

☞ ***Medicare Note: Please note that physicians with the appropriate license requirements should bill Service Code 8116 when the sole purpose of the visit is for treatment of an opioid addiction. Refer to Chapter 3, Section 1.1 for the principles of billing. This also applies to physicians who are required to submit shadow billing. A copy of your license permitting the prescribing of methadone/alternative must be submitted to the Practitioner Registrar at Medicare Eligibility and Claims.***

Chronic Disease Management Diabetes
(use the generic unit value of $1.01).....8109 83

The Program is intended to recognize the additional work required by General Practitioners, beyond that of a regular office visit, when providing guideline-based care to patients with selected qualifying Chronic Diseases.

Required Indicators/Risk Factors
In order to claim the year one **Diabetes** incentive for Type 1 & Type 2, the following indicators/risk factors are required to be addressed as part of the annual cycle of care for diabetes:

Common indicators:
- Blood Pressure - 2 times per year
- Lipids – once per year
- Weight/nutrition counselling – once per year
- Smoking cessation – once per year if smoker (document smoker or non-smoker)

Plus

- HbA1C – ordered 2 times per year
- Renal function – ordered once per year
- Foot exam with monofilament or 128 hz tuning fork –completed once per year
- Eye exam – referred once per year for a routine dilated eye exam

Requirements for Incentive
Patients must be seen, in relation to their chronic disease, a minimum of two times per year by a licensed health care provider, including at least one visit with the family physician claiming the CDM incentive.

Every CDM indicator does not need to be addressed at each visit, but indicators should be addressed at the frequency required for claiming the annual CDM incentive.

Eligible GPs / FMs will be paid a base incentive annually for each Diabetic patient they manage in their practice. The annual incentive is to be billed once per year after all elements of the required indicators are addressed.

Chronic Disease Management - Chronic Obstructive Pulmonary Disease (COPD)
(use the generic unit value of $1.01).....8113 60

Required Indicators
In order to claim the COPD incentive:

- Ensure diagnosis of COPD was made with Spirometry testing and meets the following Canadian Thoracic Societies criteria to establish a diagnosis of COPD: Post bronchodilator FEV1/FVC ratio > 0.7.
    - **To SOB to leave the house, or SOB when dressing**(if yes MRC score of grade 5 = severe stage COPD)
    - **Stops for breath after walking about 100 yards** (If yes, MRC score of grade 4 = moderate stage COPD)
    - **Walks slower than people of same age on the level, or stops for breath while walking at own pace on the level** (If yes, MRC score of grade 3 = moderate stage COPD)
    - **SOB when hurrying on a level surface or walking up a slight hill** (If yes, MRC score of grade 2 = mild stage COPD)
    - **SOB with strenuous exercise** (If yes, MRC score of grade 1 = very mild stage of COPD)

Requirements for incentive
Patients must be seen, in relation to their chronic disease, **a minimum of two times per year** by a licensed health care provider, including at least one visit with the family physician claiming the CDM incentive.

Every CDM indicator does not need to be addressed at each visit, but indicators should be addressd at the frequency required for claiming the annual CDM incentive.

Eligible GPs / FMs will be paid a base incentive annually for each COPD patient they manage in their practice. The annual incentive is to be billed once per year after all elements of the required indicators are addressed.

NP/GP Collaborative Codes

Case conference (in person or by telephone) to review care and treatment plan/decision for continuing care in the collaborative model, per 15 minutes 8104 20

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

Patient transfer (in person or by telephone) to review care and treatment plan of a patient when the patient is transferred to the care of the collaborating family physician, per 15 minutes 8105 20

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

Review for referral, if required at the request of the NP – to review treatment plan of a patient for the appropriateness of a referral to a specialist. The patient may or may not be present 8106 30

☞ ***Medicare Note: This code will carry the same assessment rules as service code 1 (GP office visit).***

Injections

See Chapter 4, Section 2.15.10

Walk-in Clinic – Visit

Office visit by a Family Physician which does not meet the definition of an office visit under service code 1 and is delivered in a location identified as a walk-in clinic (use the walk-in clinic unit value of $1.05) 3 28

☞ ***Medicare Note: Visits provided in a location identified as a walk-in clinic that meet the definition of service code 1 may be billed under that service code. However, this does not imply that all visits delivered in a walk-in clinic physically located in a community***

location, qualify as service code 1 visit by virtue of location. Such visits must meet the definition of an office visit under service code 1.

Complete Physician Examination
Complete examination performed for medically necessary purposes.....7 36

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

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

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

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

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

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

Supportive Care (See service description in Chapter 4, Section 2.7.3).....199 29

1.3 Hospital Care

First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding

30 days 2173 40
Subsequent
2nd to 30th day, per day.....2174 29
After 30 days, per day.....2176 15

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Chapter 2, Assessment Rules 16, 18, 19, and 24.***

In-Patient Consultation 8110 36

☞ ***Medicare Note: For a situation where a family practitioner is asked by a specialist to assess a patient for an existing condition for which the family / general practitioner has knowledge. The patient is not transferred to the family practitioner for care of the condition while the specialist is the attending physician.***

First Visit by attending physician – hospital 8108 28
Service must include the following:

- Review of emergency room records
- Review of previous medical records (hospital and office chart)
- Completion of complete history and physical
- Review of initial lab data and investigations
- Establish an appropriate continuing care plan
- Interaction with family
- Coordination of consultants and other health care disciplines as required

☞ ***Medicare Note: Must be provided within four (4) days of admission***

Date of Discharge
Comprehensive coordination of activities surrounding patient discharge from hospital which over the course of the hospital stay, may include but is not limited to: communication with the patient, the discharge planning officer, the family or other responsible person, as required, and other physicians involved in the care of the patient, writing prescriptions and referral requests, organizing follow-up, documentation of a final diagnosis and completion of a concise discharge summary within 30 days. 2175 32

The foregoing requirements are to be met during the discharge process and will normally include a face-to-face encounter on the day of discharge, involving the physician and patient, but may from time to time be precluded by special extenuating circumstances.

☞ ***Medicare Note: The day of discharge fee will be reduced to the payment for a subsequent visit for physicians who do not complete the discharge summary within the expected time frame.***

Transfer Code
Hospital care
(See service description in Chapter 4, Section 2.7.4) 45 31
ICU care
(See service description in Chapter 4, Section 2.9) 1819 31

1.4 Outpatient Department – Scheduled Visits

OPD Scheduled Visit 8720 23

1.5 Initial management of multiple systems trauma

This code applies to the comprehensive assessment and the performance of usual resuscitative or stabilizingmeasures by the physician in charge. It includes, as required, intravenous lines, pressure infusionsets and pharmaceutical agents, urinary catheters, blood gases, nasogastric tubes and tracheal toilet. This code is payable in instances of trauma or injury which is life-threatening, or trauma affecting more than one system or area of the body with a high risk of disabling injury……C 2923 120

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

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

1.6 Home Visits

See also Chapter 4. Section 2.15.3.....4 40

☞ ***Medicare Note: These fees are payable for medically necessary visits made to a patient at his/her personal residence including Special Care Homes. They do not apply to patients in nursing homes. Claims for emergency visits (Chapter 3, Section 1.2.2d) must show the time of day the services were rendered.***

☞ ***Medicare Note: For Medicare purposes, the civic address of the Special Care Home is considered the personal residence of the patient. Location 9 has been established and must be entered on all claims submitted for services provided in a Special Care Home.***

1.7 Visit to vessel

In harbour	214		40
At wharf	386		35

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

1.8 Post-mortem examination

Post-mortem examination	IC		

☞ ***Medicare Note: Post-mortem examinations are not entitled services.***

1.9 Obstetrical care

Payable on the basis of visit fees plus a delivery fee. Refer to ***Chapter 2***, Assessment Rule 34 and 35.

Delivery	D	14	395
Multiple births - per additional birth, add	D	1413	205
Attendance at labour leading to delivery	D	8715	330

☞ ***Medicare Note: This service code recognizes a service involving constant or periodic attendance on a patient during the period of labour, providing all aspects of care up to but not including delivery when the physician refers a patient to a specialist because of complications. This includes the initial assessment, and such subsequent assessment as may be indicated, insuring ongoing monitoring of the patient. This fee is not payable when one General Practitioner refers a patient to another General Practitioner for an uncomplicated vaginal delivery. The service code for Attendance at Labour leading to delivery (service code 8715) and service code for a General Practice Delivery (service code 14) cannot be billed by the same physician. Service code 8715 is payable only when the patient is transferred to a specialist for delivery.***

Prenatal complete examination	15	50
Pre and/or postnatal visits other than complete Examinations (See also ***Chapter 2***, Assessment Rule 34)	16	30

Prenatal care and assisting at caesarean section - visit basis plus assistant fee.

☞ ***Medicare Note: Delivery fees include attendance during prolonged labour. The fee for a prenatal complete examination, service code 15 is not payable within 42 days of a previous complete examination. service code 7, is not payable within 42 days of a prenatal complete examination.***

1.10 Newborn Care

Newborn infant care - Per child	17		70

☞ ***Medicare Note: The routine care of a newborn in hospital up to three (3) days, including complete physical examination and necessary instructions to mother.***

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

Premature care
Up to three weeks, per week 18 56
Next three weeks, per week 30 56

☞ ***Medicare Note: Premature care refers to the care of an infant weighing 2.5 kilograms or less at birth and where more than one child is involved the listed fee applies per child. (See Chapter 2, Assessment Rule 37).***

Well -baby care
To include examination and instructions
regarding health care.....19 30

1.11 Psychotherapy
Per 15 minutes.....20 24

☞ ***Medicare Note: See Chapter 2, Assessment Rule 10, psychotherapy fees do not apply until after one hour has elapsed for the major consultation or first hospital admission. When billing alone or in combination with other services, the total time including start and end time must be provided.***

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

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

1.12 Anaesthesia fees
Refer to section "Specialists in Anaesthesia", Chapter 5, Section 2.
Denver screening .....B 2172 35

1.13 Telemedicine
Attendance – 1st patient seen, first 15 minutes.....8717 40
Add – per 15 minutes.....8718 20

☞ ***Medicare Note: Payable for the first patient seen in a telemedicine session, payable once per day by same or different patient. Referral number of remote specialist is required***

☞ ***Medicare Note: Referral number of remote specialist is required.***

Technical Standby, per 15 minutes.....8719 20

Section 2: Services in Anaesthesia

2.1 Anaesthetic Services Preamble

See legend - Chapter 3, Section 1.7 for description of lists A, B, C and D.

The fee is for professional services only and includes:

a) Preanaesthetic evaluation of the patient as an anaesthetic risk, ordering of the premedication as indicated, administration of all types of anaesthesia, fluids or blood incident to anaesthesia or surgical procedure, and immediate postanaesthesia supervision.
b) Immediate supportive and resuscitative measures in the operating room and/or the recovery ward as indicated by the patient's condition and by the surgeon's requirements including cases for resuscitation of an infant delivered by Caesarian Section or Operative Delivery. However, insertion of arterial cannulae, catheterization for central venous pressure and the insertion of Swan Ganz catheter are payable in addition.
c) Treatment of any complication arising from anaesthesia within 48 hours.

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

***For procedures with basic units ≤ 6**, time units are computed by allowing one unit for each 15 minutes or part thereof of anaesthesia time up to one hour and two units for each 15 minutes or part thereof up to 4 hours than 3 units for remaining time for each 15 minutes or part thereof.

***For procedures with basic units > 6**, time units are computed by allowing one unit for each 15 minutes or part thereof of anaesthesia time up to two hours and two units for each 15 minutes or part thereof up to 4 hours than 3 units for remaining time for each 15 minutes or part thereof.

☞ ***Medicare Note: The elapsed time on which the charge for anaesthesia is based is calculated as starting at the point at which the anaesthetist commences to administer the anaesthesia and ending when the patient is removed from the operating theatre to go to the recovery room. The time involved in preparing the patient prior to administration of the anaesthesia and the time involved in supervising the patient's recovery after he has been removed from the operating theatre are not intended to be included in the elapsed time on which the charge for anaesthesia is based. (See Chapter 2, Assessment Rule 39).***

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

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

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

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

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

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

Unit Value – See Chapter 3, Section 1.5

2.2 Modifying Units

To be added according to the following:

1.	Infants less than 5 kg. (11 lbs.) in weight	5
2.	Intraoperative haemodynamic manipulation (hypotension) to facilitate surgery (25% below normal range).....	10
3.	Deep hypothermia circulatory arrest.....	10
4.	Use of controlled hypothermia to 32°C or less.....	15
5.	Infants between 5 and 10 kg	1
6.	Patient over age 70.....	1
7.	One lung anaesthesia	6
8.	Awake endotracheal intubation for difficult airway (Not payable in addition to one lung anaesthesia)	6
9.	Spinal cord integrity monitoring (including wake-up test).	6
10.	Morbid obesity including labour epidural insertion (BMI>40)	6
11.	Malignant hyperthermia.....	8
12.	Prone/sitting position	3
13.	American Society of Anaesthesiologist's classification IV	5

- Patients have severe systemic disease that limits activity and is a constant threat to life. Patients are unable to walk up one flight of stairs or two level city blocks. Distress is present even at rest. Examples: unstable angina pectoris, myocardial infarction or cerebrovascular accident within the last six months, high blood pressure, severe congestive heart failure or chronic obstructive pulmonary disease, uncontrolled epilepsy, diabetes, or thyroid condition

14. Morbid obesity including labour epidural insertion (BMI > 50) 15

After Hours Emergency Premium – See Chapter 4, Section 2.12

2.3 Special Procedures

Minor procedure or maneuver requiring anaesthesia.....	C	832	4

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

Obstetrical anaesthesia.....	C	1909	4
Dental anaesthesia.....	C	1910	4
Neuraxial anaesthesia			
For surgery - basic units for procedure plus time units.			

Obstetrical neuraxial analgesia/anaesthesia for labor and delivery, continuous infusion or intermittent top-ups.

Institution	C	2449	8
Maintenance			
Continuous Epidural infusion, labour, per half-hour, (maximum 22 units), add	C	1793	1
Intermittent top-ups, per injection, (maximum 10 units), add	C	1794	2
Delivery – add.....	C	1795	TU

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

Continuous Epidudral infusion ,Acute Post-op pain			
Lumbar, institution.....	C	2452	6
Maintenance (maximum 32 units) - per 2 hours, add.....	C	1796	1
Thoracic, institution	C	2454	8
Maintenance (maximum 32 units) - per 2 hours, Add	C	1797	1
Brachial Plexus Analgesia Institution.....	C	8323	8
Re-injection			
Visit/consult incl. daytime, add	C	8325	2
Visit/consult incl. night time/weekend, add.....	C	8326	3
Uninterrupted perfusion (max 26 units) per 2 h.....	C	8324	1
Intermittent neuraxial injection of narcotic substance via a catheter for pain control.			
Installation of catheter or blood patch graft including first injection (Consultation payable in addition, if applicable)	C	1770	8
Subsequent injection, visit/consultation fee included			
Daytime.....	C	1771	2

	Lists	Code	Units
Night time, weekends and legal holidays	C	1772	3

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

Resuscitation

During anaesthesia – included in anaesthesia time			
Independent of anaesthesia	C	219	8
Maximum			14

2.4 Consultations and Visits

Assessment re fitness for anaesthesia	201	32
If followed by anaesthetic		0
Preanaesthetic consultation, above and beyond the normal preoperative assessment, at the specific request of the attending physician - Specialist	217	75
Non-specialist	218	39
Major or regional consultation	1505	75
Repeat consultation	1084	45
Office visit	1499	33
Senior's visit add	8901	15

Payable with a major consult regardless of the presenting complaint in cases of complex case assessment for seniors 70 years of age or over, presenting with multiple system pathology, including medication review, as required.

2.5 Hospital Care

First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days	2927	71
Subsequent		
2nd to 30th day, per day	2928	29
After 30 days, per day	2929	14

Date of discharge

Comprehensive coordination of activities surrounding patient discharge from hospital which over the course of the hospital stay, may include but is not limited to: communication with the patient, the discharge planning officer, the family or other responsible person, as required, and other physicians involved in the care of the patient, writing prescriptions and referral requests, organizing follow-up, documentation of a final

diagnosis and completion of a concise discharge summary within 30 days. 8327 32

The foregoing requirements are to be met during the discharge process and will normally include a face-to-face encounter on the day of discharge, involving the physician and patient, but may from time to time be precluded by special extenuating circumstances.

☞ ***Medicare Note: The day of discharge fee will be reduced to the payment for a subsequent visit for physicians who do not complete the discharge summary within the expected time frame.***

Transfer Code
Hospital care (See service description Chapter 4, Section 2.7.4) 300 62
Directive care (See service description Chapter 4, Section 2.7.1) 40 29

2.6 Outpatient Department – Scheduled Visits

OPD Scheduled Visit 8721 23

2.7 Intensive Care

This is to apply to services rendered in recognized intensive care units and concentrated care units.

Initial assessment and institution of care 313 221
Daily rate, per day 314 39
Intensive care, requiring detention, per ¼ hour 315 50
Directive care 198 22
Transfer code - ICU Care (see service description Chapter 4, Section 2.9) 1820 62

☞ ***Medicare Note: See Medicare note under Intensive care,*** Chapter 4, Section 2.9***.***

Monitored perioperative care and supportive care (incorporates anaesthesia "stand-by") 1812 4

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

Patient controlled analgesia is an acute pain management modality utilized in lieu of traditional intramuscular narcotic injection for pain management. It allows the patient to exercise control of their acute pain. Initiation of PCA would involve patient assessment,

education, and the actual activation of the PCA apparatus. Maintenance of PCA would involve 24 hour coverage of patients on PCA. This includes visits and telephone consultation by same or different physician.

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

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

Initiation		841	62
Maintenance		842	12

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

Radiofrequency Denervation of a facet joint			
Thoracic or Lumbar spine	C	8072	74

☞ ***Medicare Note: Service Code 8072 applies per level (2 facet joints). Additional levels payable at 50%.***

Sacro-iliac Joint (S.I.)	C	8073	99

☞ ***Medicare Note: Service 8073 applies per joint with second joint payable at 50%***

Cervical Spine Facet Joint	C	8074	99

☞ ***Medicare Note: Applies per level (2 facet joints). Additional level payable at 5***

Section 3: Specialists in Cardiac Surgery

See legend - Chapter 3, Section 1.7 for description of lists A, B, C and D.

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

Referred Cases

3.1 Consultations

(See definitions in the General Preamble)
Major or regional consultation.....100 130
Repeat consultation – within 30 days
for same illness or complication thereof.....101 59

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

Senior's visit, add.....8901 15
Payable with a major consult regardless of the presenting complaint in cases of complex case assessment for seniors 70 years of age or over, presenting with multiple system pathology, including medication review, as required.

3.2 Hospital Care

First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days 8320 49

Subsequent
2nd to 30th day, per day.....8321 26
After 30 days, per day.....8322 15

Date of discharge
Comprehensive coordination of activities surrounding patient discharge from hospital which over the course of the hospital stay, may include but is not limited to: communication with the patient, the discharge planning officer, the family or other responsible person, as required, and other physicians involved in the care of the patient, writing prescriptions and referral requests, organizing follow-up, documentation of a final diagnosis and completion of a concise discharge summary within 30 days. 8112 32

The foregoing requirements are to be met during the discharge process and will normally include a face-to-face encounter on the day of discharge, involving the physician and patient, but may from time to time be precluded by special extenuating circumstances.

☞ ***Medicare Note: The day of discharge fee will be reduced to the payment for a subsequent visit for physicians who do not complete the discharge summary within the expected time frame.***

3.3 Outpatient Department – Scheduled Visits

OPD Scheduled Visit 8722 23

3.4 Directive Care

See service description Chapter 4, Section 2.7.1 .....8111 29

3.5 Other Visit Fees

As for specialists in General Surgery (Chapter 5, Section 5).

Section 4: Specialists in Dermatology

See legend - Chapter 3, Section 1.7 for description of lists A, B, C and D.

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

Referred cases

4.1 Consultations

(See definitions in the General Preamble)

Major or regional consultation.....125 79

Repeat within 30 days for same illness
or complication thereof.....126 62

4.2 Office Visits

First visit with complete dermatological examination.....119 39

First visit with regional examination 120 33

Other office visits.....121 32

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

Senior's visit, add.....8901 15

Payable with a major consult regardless of the presenting complaint in cases of complex case assessment for seniors 70 years of age or over, presenting with multiple system pathology, including medication review, as required.

4.3 Hospital Care

First visit, major assessment on day of admission,
except where the physician has done a major consultation,
a complete examination or another major assessment
on the patient during the preceding 30 days 2255 71

Subsequent

2nd to 30th day, per day.....2256 29

After 30 days, per day.....2258 14

Date of discharge

Comprehensive coordination of activities surrounding patient discharge from hospital which over the course of the hospital stay, may include but is not limited to: communication with the patient, the discharge planning officer, the family or other responsible person, as required, and other physicians involved in the care of the patient, writing prescriptions and referral requests, organizing

follow-up, documentation of a final diagnosis and completion of a concise discharge summary within 30 days. 2257 32

The foregoing requirements are to be met during the discharge process and will normally include a face-to-face encounter on the day of discharge, involving the physician and patient, but may from time to time be precluded by special extenuating circumstances.

☞ ***Medicare Note: The day of discharge fee will be reduced to the payment for a subsequent visit for physicians who do not complete the discharge summary within the expected time frame.***

Transfer Code
Hospital care (See service description Chapter 4, Section 2.7.4) 310 62
ICU care (See service description Chapter 4, Section 2.9).....1822 62
Directive care (See service description Chapter 4, Section 2.7.1) 46 29

☞ ***Medicare Note: For ICU service codes (see Chapter 4, Section 2.9).***

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Chapter 2, Assessment Rules 16, 18, 19 and 24.***

4.4 Outpatient Department – Scheduled Visits

OPD Scheduled Visit 8723 23

4.5 Home Visits

See also Chapter 4. Section 2.15.3.....127 40

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence.***

4.6 Dermatological Procedures

Diagnostic skin biopsy (Restricted to specialists) .....A 134 34
Ultraviolet phototherapy (UVB).....C 155 5
PUVA therapy.....C 154 23
Narrow Band Ultraviolet Therapy .....C 8121 23

☞ ***Medicare Note: One visit per week is payable in addition toservice code 155 or 154.***

Dermabrasion of face, see Plastic Surgical Procedures, Chapter 20.
Dermabrasion of single area (e.g. trauma scar), see Integumentary System, Chapter 7.
Allergy tests .....B 1895

(See Chapter 21, Section 1)

Laser destruction of skin lesions			
Lesion up to one centimeter in diameter, not involving nails, joints or orifices – claim under appropriate surgical excision code and fee			
Other lesions – requiring up to ½ hour of laser treatment	B	129	108
Up to ¾ hour	B	130	140
Up to 1 hour	B	131	172
Each additional ¼ hour	B	135	30

☞ ***Medicare Note: Laser treatment fees include intraoperative biopsies. The time elapsed must be noted on the claim form. Claims for laser treatment extending beyond two hours must be accompanied by an operative report.***

4.7 MOHS Micrographic Surgery

Initial	D	8350	254
One or more additional levels	D	8351	218

☞ ***Medicare Note: The following closure service codes are only payable after MOHs surgery, if required, and are paid at 100% if done by the same surgeon on the same day. If done on a different day or done by a second surgeon, use the equivalent appropriate service codes in the Plastic Surgery section of the manual.***

Single tissue shift	D	8352	150	4
Multiple tissue shift	D	8353	240	5
Eyebrow, eyelid, lip, ear, nose				
Single tissue shift	D	8354	180	5
Multiple tissue shift	D	8355	240	5
Full thickness skin grafts	D	8356	173	5
Head and or/neck > 62.5 sq.cm (10 sq. in.), partial thickness skin graft	D	8357	116	5

Section 5: Specialists in General Surgery

See legend – Chapter 3, Section 1.7 for description of lists A, B, C and D.

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

Referred cases

5.1 Consultations

(See definitions in the General Preamble)

Major or regional consultation	31	85
Repeat consultation, within 30 days for same illness or complication thereof	33	66

5.2 Office Visits

New condition seen for the first time, to include complete history and physical examination	26	48
First visit with regional examination	27	33
Subsequent visit, with complete examination – allowed once in any 90 day period (this code is to be used for the reevaluation of patients previously treated for malignant disease or for major arterial disease)	28	48
Other office visits	29	41

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

Senior's visit, add	8901	15

Payable with a major consult regardless of the presenting complaint in cases of complex case assessment for seniors 70 years of age or over, presenting with multiple system pathology, including medication review, as required.

5.3 Hospital Care

First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days	2381	48
Subsequent		
2nd to 30th day, per day	2382	29
After 30 days, per day	2384	15

Date of discharge
Comprehensive coordination of activities surrounding patient discharge from hospital which over the course of the hospital stay, may include but is not limited to: communication with the patient, the discharge planning officer, the family or other responsible person, as required, and other physicians involved in the care of the patient, writing prescriptions and referral requests, organizing follow-up, documentation of a final diagnosis and completion of a concise discharge summary within 30 days. 2383 32

The foregoing requirements are to be met during the discharge process and will normally include a face-to-face encounter on the day of discharge, involving the physician and patient, but may from time to time be precluded by special extenuating circumstances.

☞ ***Medicare Note: The day of discharge fee will be reduced to the payment for a subsequent visit for physicians who do not complete the discharge summary within the expected time frame.***

Transfer Code - Hospital care (See service description Chapter 4, Section 2.7.4) 327 36
Directive care (See service description Chapter 4, Section 2.7.1) 47 29

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Chapter 2, Assessment Rules 16, 18, 19 and 24.***

5.4 Outpatient Department – Scheduled Visits

OPD Scheduled Visit 8724 23

5.5 Home Visits

See also Chapter 4, Section 2.15.3 ..... 34 40

Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence.

5.6 Intensive Care

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

Initial assessment and institution of care 2833 221
Daily rate, per day 2834 39
Intensive care, requiring detention
Per ¼ hour 2835 50
Directive care 198 22

Transfer Code - ICU care (See service description Chapter 4, Section 2.9).....1823 36

☞ ***Medicare Note: See Medicare note under Intensive care, Chapter 4, Section 2.9.***

☞ ***Medicare Note: ICU detention fees following same day surgery by general surgeon may be approved on an individual consideration basis. The practitioner must provide sufficient documentation describing the circumstances which necessitated detention. See service description page Chapter 4, Section 2.4.***

5.7 Initial Management of Multiple Systems Trauma

This code applies to the comprehensive assessment and the performance of usual resuscitative or stabilizing measures by the physician in charge. It includes, as required, intravenous lines, pressure infusion sets and pharmaceutical agents, urinary catheters, blood gases, nasogastric tubes and tracheal toilet. This code is payable in instances of trauma or injury, which is life-threatening, or trauma affecting more than one system or area of the body with a high risk of disabling injury. .....C 2416 120

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

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

Section 6: Specialists in General Internal Medicine

See legend - Chapter 3, Section 1.7 for description of lists A, B, C and D.

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

Referred Cases

6.1 Consultations

(See definitions in the General Preamble)

Major or regional consultation		8764	141
Repeat consultation – within 30 days for same illness or complication thereof		8765	110
Senior's visit, add		8901	15

Payable with a major consult regardless of the presenting complaint in cases of complex case assessment for seniors 70 years of age or over, presenting with multiple system pathology, including medication review, as required.

6.2 Office Visits

First office visit with complete exam and diagnostic survey of a new patient not attended during the previous 90 days		8760	73
First office visit with Regional exam		8761	48
Subsequent visit with complete re-examination		8762	48
Other office visits		8763	49

6.3 Hospital Care

First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceeding 30 days		8766	85
Subsequent			
2nd to 30th day, per day		8767	29
After 30 days, per day		8768	16

Date of discharge

Comprehensive coordination of activities surrounding patient discharge from hospital which over the course of the hospital stay, may include but is not limited to: communication with the patient, the discharge planning officer, the family or other responsible person, as required, and other physicians involved in the care of the patient, writing prescriptions and referral requests, organizing follow-up, documentation of a final diagnosis and completion of a concise discharge summary within

30 days. 8769 32

The foregoing requirements are to be met during the discharge process and will normally include a face-to-face encounter on the day of discharge, involving the physician and patient, but may from time to time be precluded by special extenuating circumstances.

☞ ***Medicare Note: The day of discharge fee will be reduced to the payment for a subsequent visit for physicians who do not complete the discharge summary within the expected time frame.***

6.4 Outpatient Department – Scheduled Visits

OPD Scheduled Visit 8740 23

6.5 Directive Care

See service description **Chapter 4, Section 2.7.1** 8770 29

6.6 Other Visit Fees

As for specialists in Internal Medicine (**Chapter 5, Section 6.3**).

Section 7: Specialists in Internal Medicine

See legend – Chapter 3, Section 1.7 for description of lists A, B, C and D.

(Applicable to subspecialties e.g. Allergy, Cardiology)

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

Referred cases

7.1 Consultations

(See definition in the General Preamble)

Major or regional consultation	A	41	129
Repeat – within 30 days for same illness or complication thereof	A	42	98

Radiation Oncology and Medical Oncology

Consultation (use the generic unit value of $1.01)	A	73	58

☞ ***Medicare Note: Service Code 73 is to be billed for first time diagnosis of cancer. It is not billable for subsequent visits for the same diagnosis. It can be billed for a new cancer diagnosis on same patient.***

Senior's visit, add	A	8901	15

Payable with a major consult regardless of the presenting complaint in cases of complex case assessment for seniors 70 years of age or over, presenting with multiple system pathology, including medication review, as required.

7.2 Office Visits

First visit with complete examination and diagnostic survey of a new patient not attended during the previous 90 days	A	35	71
First visit with regional examination	A	36	47
Subsequent visit with complete re-examination	A	37	47
Other office visits	A	38	46

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

☞ ***Medicare Note: See Chapter 2, Assessment Rule 7.***

7.3 Hospital Care

First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days	A	2401	85

Subsequent
2nd to 30th day, per day 2402 29
After 30 days, per day 2404 16

Date of discharge
Comprehensive coordination of activities surrounding patient discharge from hospital which over the course of the hospital stay, may include but is not limited to: communication with the patient, the discharge planning officer, the family or other responsible person, as required, and other physicians involved in the care of the patient, writing prescriptions and referral requests, organizing follow-up, documentation of a final diagnosis and completion of a concise discharge summary within 30 days. 8144 32

The foregoing requirements are to be met during the discharge process and will normally include a face-to-face encounter on the day of discharge, involving the physician and patient, but may from time to time be precluded by special extenuating circumstances.

☞ ***Medicare Note: The day of discharge fee will be reduced to the payment for a subsequent visit for physicians who do not complete the discharge summary within the expected time frame.***

Transfer Code
Hospital care (See service description Chapter 4, Section 2.7.4) 301 62
Directive care (See service description Chapter 4, Section 2.7.1) 197 29

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Chapter 2, Assessment Rules 16, 18, 19 and 24.***

7.4 Outpatient Department – Scheduled Visits

OPD Scheduled Visit 8725 23

7.5 Home Visits

See also Chapter 4, Section 2.15.3 ..... 44 40

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence.***

7.6 Intensive Care

This is to apply to services rendered in recognized intensive care units and concentrated care units.

Initial assessment and institution of care	220	226
Daily rate, per day	221	81
Intensive care, requiring detention		
Per ¼ hour (See service description Chapter 4, Section 2.4)	222	50
Directive care	198	22
Transfer code		
ICU care (see service description Chapter 4, Section 2.9)	1821	62

☞ ***Medicare Note: See Medicare note under Intensive care, Chapter 4, Section 2.9.***

7.7 Pacemaker

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

Section 8: Specialists in Laboratory Medicine

See legend - Chapter 3, Section 1.7 for description of lists A, B, C and D.

8.1 Outpatient Department – Scheduled Visits

OPD Scheduled Visit	8739	23

8.2 Miscellaneous

Call back to hospital, night or weekend.....	74	126
Applies to all specialties under Laboratory Medicine		

☞ ***Medicare Note: One per day, same patient, all-inclusive fee (no other visit/procedure on same day), time of day required.***

Section 9: Specialists in Neurology

See legend - Chapter 3, Section 1.7 for description of lists A, B, C and D.

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

Referred cases

9.1 Consultations

(See definitions in the General Preamble)
Major or regional consultation.....161 99
Repeat consultation - within 30 days
for same illness or complication thereof.....162 66

Senior's visit, add.....8901 15
Payable with a major consult regardless of the presenting complaint in cases of complex case assessment for seniors 70 years of age or over, presenting with multiple system pathology, including medication review, as required.

9.2 Office Visits

First visit, with complete examination and diagnostic survey
of a new patient not attended during the previous 90 days.....156 77
Subsequent visit, with complete re-examination 157 42
Subsequent visit for complete reassessment of a previously
referred patient; allowed once in any 30 day period.....160 64

Other office visits.....159 40
The code for other office visits applies also to office consultations and examination that cannot be claimed under a higher fee code, for example due to limitations in frequency or service intervals.

9.3 Hospital Care

First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days 2501 71
Subsequent
2nd to 30th day, per day.....2502 29
After 30 days, per day.....2504 14

Date of discharge
Comprehensive coordination of activities surrounding patient discharge from hospital which over the course of the hospital stay, may include but is not limited to: communication with the patient, the discharge planning officer, the family or other responsible person, as required,

and other physicians involved in the care of the patient, writing prescriptions and referral requests, organizing follow-up, documentation of a final diagnosis and completion of a concise discharge summary within 30 days. 2503 32

The foregoing requirements are to be met during the discharge process and will normally include a face-to-face encounter on the day of discharge, involving the physician and patient, but may from time to time be precluded by special extenuating circumstances.

☞ ***Medicare Note: The day of discharge fee will be reduced to the payment for a subsequent visit for physicians who do not complete the discharge summary within the expected time frame.***

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Chapter 2, Assessment Rules 16, 18, 19 and 24.***

Transfer Code
- Hospital care (See service description Chapter 4, Section 2.7.4) 8302 62
- Directive Care (See service description Chapter 4, Section 2.7.1) 61 29

9.4 Outpatient Department – Scheduled Visits

OPD Scheduled Visit 8726 23

9.5 Home Visits

See also Chapter 4, Section 2.15.3 ..... 164 40

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence.***

9.6 Intensive Care

This is to apply to services rendered in recognized intensive care units and concentrated care units.

- Initial assessment and institution of care 224 221
- Daily rate per day 225 35
- Intensive care, requiring detention
  Per ¼ hour (See service description Chapter 4, Section 2.4) 226 50
- Directive care 198 22
- Transfer code
  - ICU care (See service description Chapter 4, Section 2.9) 1827 62

☞ ***Medicare Note: See Medicare note under Intensive Care, Chapter 4, Section 2.9.***

9.7 Special Procedures

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

See also "Diagnostic and Therapeutic Procedures" on page Chapter 21, "Clinical Procedures" on Chapter 22 and "Diagnostic and Minor Treatment Procedures" in Chapter 17, Section 4.

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

9.8 *Botulinum Toxin Injection

Face - unilateral	C	8135	77
Other areas - unilateral	C	8136	77

Other Areas

Other areas include the following:

- Neck
- Arm and/or shoulder
- Forearm and/or hand
- Thigh and/or girdle
- Calf and/or foot
- Whole back

Multiple Injections
Guidelines for multiple injections for the same patient in the same sessions are as follows:

Face: unilateral (one or more injections) – 77 units; bilateral at 50%
Other areas: unilateral (one or more injections) – 77 units; bilateral at 75%

☞ ***Medicare Note: On the face, back and neck, where two bilateral injections may come within 2 to 3 cm of each other (i.e. left and right side of nose – procerus muscles or left and right paraspinal muscles, these should be counted as one injection instead of bilateral.***

☞ ***Medicare Note: Can only be billed for conditions approved by Medicare as guided by Health Canada indications.***

Section 10: Specialists in Neurosurgery

See legend - Chapter 3, Section 1.7 for description of lists A, B, C and D.

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

Referred cases

10.1 Consultations

(See definitions in the General Preamble)
Major or regional consultation.....186 72
Repeat consultation - within 30 days for
same illness or complication thereof.....188 33
Senior's visit, add.....8901 15
Payable with a major consult regardless of the presenting complaint in cases of complex case assessment for seniors 70 years of age or over, presenting with multiple system pathology, including medication review, as required.

10.2 Office Visits

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

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

10.3 Hospital Care

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

Date of discharge
Comprehensive coordination of activities surrounding patient discharge from hospital which over the course of the hospital stay, may include but is not limited to: communication with the patient, the discharge planning officer, the family or other responsible person, as required, and other physicians involved in the care of the patient, writing prescriptions and referral requests, organizing follow-up, documentation of a final diagnosis and completion of a concise discharge summary within 30

	Lists	Code	Units
days.		2393	28

The foregoing requirements are to be met during the discharge process and will normally include a face-to-face encounter on the day of discharge, involving the physician and patient, but may from time to time be precluded by special extenuating circumstances.

☞ ***Medicare Note: The day of discharge fee will be reduced to the payment for a subsequent visit for physicians who do not complete the discharge summary within the expected time frame.***

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Chapter 2, Assessment Rules 16, 18, 19 and 24.***

Transfer Code

Hospital care (See service description Chapter 4, Section 2.7.4)		8303	75
Directive care (See service description Chapter 4, Section 2.7.1)		62	18
Major consultation in hospital		2857	78
Closed head injury, complete assessment – initial examination and recommendation re. Further management	C	1512	88

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

10.4 Outpatient Department – Scheduled Visits

OPD Scheduled Visit		8727	23

10.5 Intensive Care

This is to apply to services rendered in recognized intensive care units and concentrated care units.

Initial assessment and institution of care		1508	221
Daily rate, per day		1513	39
Intensive care, requiring detention			
Per ¼ hour (see service description Chapter 4, Section 2.4)		1514	50
Directive care		198	22
Transfer Code			
ICU care (See service description Chapter 4, Section 2.9)		1828	75

☞ ***Medicare Note: See Medicare Note under Intensive care, Chapter 4, Section 2.9***

Section 11: Specialists in Obstetrics and Gynaecology

See legend - Chapter 3, Section 1.7 for description of lists A, B, C and D.

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

Referred Cases

11.1 Consultations

(See definitions in the General Preamble)
Major or regional consultation.....54 69
Repeat consultation - within 30 days for
same illness or complication thereof.....56 38
Senior's visit, add.....8901 15
Payable with a major consult regardless of the presenting complaint in cases of complex case assessment for seniors 70 years of age or over, presenting with multiple system pathology, including medication review, as required.

11.2 Office Visits

First visit with complete examination.....48 48
Regional examination 49 38
Other office visits.....50 38

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

Hospital care
First visit, major assessment on day of admission,
except where the physician has done a major consultation,
a complete examination or another major assessment on
the patient during the preceding 30 days 2411 48
Subsequent
2nd to 30th day, per day.....2412 29
After 30 days, per day.....2414 15

Date of discharge
Comprehensive coordination of activities surrounding patient discharge from hospital which over the course of the hospital stay, may include but is not limited to: communication with the patient, the discharge planning officer, the family or other responsible person, as required, and other physicians involved in the care of the patient, writing prescriptions and referral requests, organizing

follow-up, documentation of a final diagnosis and completion of a concise discharge summary within 30 days. 2413 32

The foregoing requirements are to be met during the discharge process and will normally include a face-to-face encounter on the day of discharge, involving the physician and patient, but may from time to time be precluded by special extenuating circumstances.

☞ ***Medicare Note: The day of discharge fee will be reduced to the payment for a subsequent visit for physicians who do not complete the discharge summary within the expected time frame.***

Transfer Code

Hospital care (See service description Chapter 4, Section 2.7.4) 8309 36
ICU care (See service description Chapter 4, Section 2.9)..... 1834 36
Directive care (See service description Chapter 4, Section 2.7.1) 166 29

☞ ***Medicare Note: For ICU service codes (see Chapter 4, Section 2.9)***

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Chapter 2, Assessment Rule 16, 18, 19 and 24.***

11.3 Outpatient Department – Scheduled Visits

OPD Scheduled Visit 8728 23

11.4 Home Visits

See also Chapter 4, Section 2.15.3..... 53 40

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at her personal residence.***

Insertion of laminaria tent.....A 2083 23

11.5 Obstetrical Care

Payable on the basis of visit fees plus a delivery fee.
Refer to Chapter 2, Assessment Rule 34 and 35.

Obstetrical delivery (complicated or uncomplicated).....D 58 480
Multiple births - per additional birth, add.....D 1413 205
First prenatal visit with complete examination.....2002 53
Subsequent prenatal and/or postnatal visits 60 38
(See also Chapter 2, Assessment Rule 34)

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

11.6 Gynecology Procedures – Add-on fee

Gynecology Procedures 8706 113

Payable if any of the following conditions apply:

- 3 or more previous laparotomies
- Frozen pelvis found at time of laparotomy
- Pregnancy >/= 12 weeks (excluding delivery)
- Age > 70 years
- Mullerian abnormality
- Immunosuppression (ChemoRX, HIV, oral steroid use)
- Paraplegia or quadriplegia
- Blood borne illness

☞ ***Medicare Note: Not payable with services listed under the section "Vulva".***

	List	Code	Units Gen	Units An

Section 12: Specialists in Ophthalmology

See legend - Chapter 3, Section 1.7 for description of lists A, B, C and D.

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

Referred Cases

12.1 Consultations

(See definitions in the General Preamble)				
Major or regional consultation		69	81	
Repeat - within 30 days for same illness or complication thereof		71	51	
Other Referrals				
Complete Ophthalmological examination at the request of an optometrist, including a written report to the optometrist and, where appropriate, copy to the family physician		282	81	

12.2 Office Visits

First visit with complete ophthalmological examination		64	45	

☞ ***Medicare Note: A first visit with complete examination for specialists in ophthalmology will include the following special procedures where these are necessary: fundus examination, gonioscopy, tonometry, biomicroscopy, indirect ophthalmoscopy or three mirror slit lamp examination of fundus (Chapter 2, Assessment Rule 44).***

First visit not requiring a complete exam		65	28	
Other office visits, not including special tests or procedures		66	29	

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

12.3 Procedures

Tonography as an individual procedure	C	228	23	
Fundus examination, gonioscopy, tonometry, biomicroscopy as individual procedures, each	C	229	9	
Fundus examination under general anaesthetic	B	230	77	4
Indirect ophthalmoscopy or 3 mirror slit lamp examination of fundus	C	232	15	
Ophthalmodynamometry	B	280	15	
Fundus photos, technical fee	B	233	20	

	List	Code	Units Gen	Units An
Retinophoto interpretation	B	2996	9	
Fundus Photo, technical fee and Retinophoto interpretation	B	8181	28	
Ultrasound, eye, for axial length or foreign body	B	2403	21	
Keratometry	B	2997	12	
Farnsworth 100 Color Vision Test	C	2998	20	
Hess Lancaster Test	C	2999	15	
Pachymetry – measuring corneal thickness	B	8079	7	
Optical Coherence Tomography				
Professional	B	8080	11	
Technical	B	8081	17	

☞ ***Medicare Note: Service Code 8079 can only be billed once per patient/lifetime.***

☞ ***Medicare Note: Service Code 8080 and 8081 can only be billed once per 28 days. Prior approval is required for situations requiring additional testing within 2 days.***

12.4 Hospital Care

First visit, major assessment on day of admission, except where the physician had done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days		2421	49
Subsequent			
2nd to 30th day, per day		2422	29
After 30 days, per day		2424	15

Date of discharge

Comprehensive coordination of activities surrounding patient discharge from hospital which over the course of the hospital stay, may include but is not limited to: communication with the patient, the discharge planning officer, the family or other responsible person, as required, and other physicians involved in the care of the patient, writing prescriptions and referral requests, organizing follow-up, documentation of a final diagnosis and completion of a concise discharge summary within 30 days.		2423	32

The foregoing requirements are to be met during the discharge process and will normally include a face-to-face encounter on the day of discharge, involving the physician and patient, but may from time to time be precluded by special extenuating circumstances.

☞ ***Medicare Note: The day of discharge fee will be reduced to the payment for a subsequent visit for physicians who do not complete the discharge summary within the expected time frame.***

	List	Code	Units Gen	Units An
Transfer Code				
Hospital care (See service description Chapter 4, Section 2.7.4)		330	36	
ICU care (See service description Chapter 4, Section 2.9)		1825	36	
Directive care (See service description Chapter 4, Section 2.7.4)		57	29	

☞ ***Medicare Note: For ICU service codes (see Chapter 4, Section 2.9).***

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Chapter 2, Assessment Rules 16, 18, 19 and 24.***

12.5 Outpatient Department – Scheduled Visits

OPD Scheduled Visit		8729	23	

12.6 Home Visits

See also Chapter 4, Section 2.15.3		72	40	

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence.***

12.7 Visual Fields

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

12.8 Computerized Visual Fields

Automated threshold static perimetry, complete				
Performance & interpretation	B	105	40	
Performance only	B	106	26	
Interpretation only	B	112	15	
Automated suprathreshold perimetry (central screening)				
Performance & interpretation	B	113	25	
Performance only	B	114	15	
Interpretation only	B	115	10	

12.9 Ultrasound - Eye

Quantitative standardized “A” scan	B	2023	34	
Real time “B” scan	B	2027	34	
“A” and “B” modes	B	2029	51	
“A” and “B” modes plus immersion	B	2031	68	

	List	Code	Units Gen	Units An
12.10 Contact Lens Fitting				
Therapeutic contact lens fitting, including 3 months follow up care (excludes cost of lens)	D	2911	200	
Bilateral, add	D	2912	77	

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

The appropriate type of contact lens may be fitted at the discretion of the physician to protect the integrity of the healthy cornea in conditions which threaten it, to promote healing of the cornea when damaged in disease processes or surgical procedures, to restore monocular or binocular vision where this cannot be achieved by other methods and to improve visual field where this is compromised high refractive error. The improvement of visual acuity per se does not come within this definition.
When medically indicated, Medicare coverage applies in the following conditions: albinism, aniridia, anterior membrane corneal dystrophies, aphakia, astigmatism requiring over 5 dioptres of cylindrical correction, bullous keratopathy, chronic corneal edema, corneal abrasion, corneal burn, corneal lacerations, corneal ulcer, descemetocele, dry eye syndromes, entropion, high refractive errors (6 dioptres spherical equivalent or over in children under age 16, 10 dioptres spherical equivalent or over in adults), keratoconus, neuroparalytic keratopathy, nystagmus, trachoma, paralysis of superior rectus muscle, pemphigus, post penetrating keratoplasty, post-operative discomfort or lacerations or perforations, prevention of symblepharon, recurrent corneal erosion, Stevens-Johnson syndrome, stromal herpes simplex, thermal burns, trichiasis, vernal conjunctivitis. As developments and improvements occur, additional conditions may be added to this list.

Bandage contact lens Includes follow-up care. Consultation payable in addition.	D	2913	77	
Corneal foreign bodies	C	235	30	
Under anaesthesia	C	236	77	4
Low vision therapy	C	234	35	
12.11 Heidelberg Retinal Tomography (HRT)				
Professional	B	8953	11	
Technical	B	8954	17	

☞ ***Medicare Note: Medicare Note: to be performed only on patients in who glaucoma has been previously diagnosed; not for "suspected" cases or to rule out glaucoma, except where intraocular pressure is at 22mm Hg or greater on two separate consecutive examinations. Two (2) payable per 12-month period.***

Section 13: Specialists in Orthopaedic Surgery

See legend - Chapter 3, Section 1.7 for description of lists A, B, C and D.

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

Referred Cases

13.1 Consultations

(See definitions in the General Preamble)

Major or regional consultation		81	80
Repeat consultation - within 30 days for same illness or complication thereof		83	50
Senior's visit, add		8901	15

Payable with a major consult regardless of the presenting complaint in cases of complex case assessment for seniors 70 years of age or over, presenting with multiple system pathology, including medication review, as required.

13.2 Office Visits

New condition seen for the first time, to include complete history and physical examination		76	53
First visit with regional examination		77	42
Other office visits		78	41

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

13.3 Hospital Care

First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days		2431	49
Subsequent			
2nd to 30th day, per day		2432	29
After 30 days, per day		2434	15

Date of discharge

Comprehensive coordination of activities surrounding patient discharge from hospital which over the course of the hospital stay, may include but is not limited to: communication with the patient, the discharge planning officer, the family or other responsible person, as required, and other physicians involved in the care of the patient, writing prescriptions and referral requests, organizing follow-up, documentation of a final diagnosis and

	List	Code	Units Gen	Units An
completion of a concise discharge summary within 30 days.		2433	32	

The foregoing requirements are to be met during the discharge process and will normally include a face-to-face encounter on the day of discharge, involving the physician and patient, but may from time to time be precluded by special extenuating circumstances.

☞ ***Medicare Note: The day of discharge fee will be reduced to the payment for a subsequent visit for physicians who do not complete the discharge summary within the expected time frame.***

Transfer Code				
Hospital care (See service description Chapter 4, Section 2.7.4)		8304	36	
ICU care (See service description Chapter 4, Section 2.9)		1829	36	
Directive care (See service description in Chapter 4, Section 2.7.1)		63	29	

☞ ***Medicare Note: For ICU service codes (see Chapter 4, Section 2.9)***

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Chapter 2, Assessment Rules 16, 18, 19 and 24.***

Management of Multiple Orthopaedic Trauma See Chapter 4, Section 2.15.6	C	2922	80	

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

Management of multiple systems trauma (Chapter 4, Section 2.15.6)	C	2956	120	

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

13.4 Outpatient Department – Scheduled Visits

OPD Scheduled Visit		8730	23	

13.5 Home Visits

See also page Chapter 4, Section 2.15.3		84	40	

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence.***

Section 14: Specialists in Otolaryngology

See legend - Chapter 3, Section 1.7 for description of lists A, B, C and D.

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

Referred Cases

14.1 Consultations

(See definitions in the General Preamble)
Major or regional consultation.....107 83
Repeat - within 30 days for same illness or complication thereof 109 52
Senior's visit, add.....8901 15
Payable with a major consult regardless of the presenting complaint in cases of complex case assessment for seniors 70 years of age or over, presenting with multiple system pathology, including medication review, as required.

14.2 Office Visits

First visit, transferred or not transferred, requiring complete history and detailed examination.....102 46

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

First visit not requiring complete examination 103 34
Other office visits.....104 34

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

☞ ***Medicare Note: See Chapter 2, Assessment Rule 42.***

14.3 Hospital Care

First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days 2441 53

Subsequent
2nd to 30th day, per day.....2442 29
After 30 days, per day.....2444 17

	List	Code	Units Gen	Units An
Date of discharge Comprehensive coordination of activities surrounding patient discharge from hospital which over the course of the hospital stay, may include but is not limited to: communication with the patient, the discharge planning officer, the family or other responsible person, as required, and other physicians involved in the care of the patient, writing prescriptions and referral requests, organizing follow-up, documentation of a final diagnosis and completion of a concise discharge summary within 30 days.		2443	32	
The foregoing requirements are to be met during the discharge process and will normally include a face-to-face encounter on the day of discharge, involving the physician and patient, but may from time to time be precluded by special extenuating circumstances.				

☞ ***Medicare Note: The day of discharge fee will be reduced to the payment for a subsequent visit for physicians who do not complete the discharge summary within the expected time frame.***

	List	Code	Units Gen	Units An
Transfer Code				
Hospital care (See service description Chapter 4, Section 2.7.4)		329	36	
ICU care (See service description Chapter 4, Section 2.9)		1824	36	
Directive care (See service description Chapter 4, Section 2.7.4)		52	29	

☞ ***Medicare Note: For ICU service codes (see Chapter 4, Section 2.9)***

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Chapter 2, Assessment Rules 16, 18, 19 and 24.***

14.4 Outpatient Department – Scheduled Visits

	List	Code	Units Gen	Units An
OPD Scheduled Visit		8731	23	

14.5 Home Visits

	List	Code	Units Gen	Units An
See also Chapter 4, Section 2.15.3		110	40	

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence.***

14.6 Intra Tympanic Injection of Medication

	List	Code	Units Gen	Units An
Unilateral	B	8951	23	4
Bilateral	B	8952	46	4

	List	Code	Units Gen	Units An

☞ ***Medicare Note: Although this service is described as a List B Procedure, please note that a visit is only payable for the initial service. Subsequent injections would be at 23 units for service code 8951 and at 46 units for service code 8952 and would be billed as the sole reason for the visit (no visit / consultations code). After 30 days, an initial visit or consultations may be billed in addition, on the same patient, only if there is a recurrence or a new condition has arisen regarding intra-tympanic injection of medication. It cannot be billed for a continuation of treatment of the same episode.***

14.7 Special Examination

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

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

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

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

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

☞ ***Medicare Note: See Chapter 2, Assessment Rules 40 & 41. The use of special examination codes is restricted to Specialists in Otolaryngology.***

c) Other examinations

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

14.8 Electronystagmography

Electronystagmography	C	2036	30

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

	List	Code	Units Gen	Units An
14.9 Tonsillectomy +/- adenoidectomy				
Under 16 years	D	240	138	4
Adult	D	241	138	4
Adenoidectomy	C	242	76	4

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

14.10 Botulinum Toxin Injection				
Face - unilateral	C	8135	77	
Other areas - unilateral	C	8136	77	

Other Areas

Other areas include the following:

- Neck
- Arm and/or shoulder
- Forearm and/or hand
- Thigh and/or girdle
- Calf and/or foot
- Whole back

Multiple Injections

Guidelines for multiple injections for the same patient in the same sessions are as follows:

Face: unilateral (one or more injections) – 77 units; bilateral at 50%
Other areas: unilateral (one or more injections) – 77 units; bilateral at 75%

☞ ***Medicare Note: On the face, back and neck, where two bilateral injections may come within 2 to 3 cm of each other (i.e. left and right side of nose – procerus muscles or left and right paraspinal muscles, these should be counted as one injection instead of bilateral.***

☞ ***Medicare Note: Can only be billed for conditions approved by Medicare as guided by Health Canada indications***

Section 15: Specialists in Paediatrics

See legend - Chapter 3, Section 1.7 for description of lists A, B, C and D.

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

Referred Cases

15.1 Consultations

(See definitions in the General Preamble)			
Major or regional consultation		93	157
Repeat consultation - within 30 days for same illness or complication thereof		94	97

15.2 Office Visits

First visit with complete examination		85	68
First visit with regional examination		86	52
Subsequent visit requiring complete examination – allowed once in any 30-day period (This code to be used only on the treatment of children with major chronic health problems. A specific pathological diagnosis must be given.)		90	96
Well-baby care to include examination and instructions regarding health care		89	51
Other office visits		87	46

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

15.3 Injections

See Chapter 4, Section 2.15.10 and 2.15.11

15.4 Hospital Care

First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days		2451	155
Subsequent			
2nd to 30th day, per day		2453	29
After 30 days, per day		2455	17

Date of discharge

Comprehensive coordination of activities surrounding patient discharge from hospital which over the course of the hospital stay, may include but is not limited to:

	List	Code	Units Gen	Units An
communication with the patient, the discharge planning officer, the family or other responsible person, as required, and other physicians involved in the care of the patient, writing prescriptions and referral requests, organizing follow-up, documentation of a final diagnosis and completion of a concise discharge summary within 30 days.		8214	32	
The foregoing requirements are to be met during the discharge process and will normally include a face-to-face encounter on the day of discharge, involving the physician and patient, but may from time to time be precluded by special extenuating circumstances.				

☞ ***Medicare Note: The day of discharge fee will be reduced to the payment for a subsequent visit for physicians who do not complete the discharge summary within the expected time frame.***

Transfer Code				
Hospital care (See service description Chapter 4, Section 2.7.4)		8305	87	
Directive care (See service description Chapter 4, Section 2.7.1)		68	29	

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Chapter 2, Assessment Rules 16, 18, 19 and 24.***

Special attendance at delivery	A	2171	95	

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

Newborn care for first 3 days, including parental advice		92	64	

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

15.5 Premature Care

First visit with complete examination		243	56	
Thereafter up to 3 weeks, per week		244	56	
Next 3 weeks, per week		245	31	
After 6 weeks, per visit (Not to exceed 2 visits per week)		246	16	
Supportive care, per visit		2860	16	

	List	Code	Units Gen	Units An
15.6 Outpatient Department – Scheduled Visits				
OPD Scheduled Visit		8732	23	
15.7 Home Visit				
See also Chapter 4, Section 2.15.3		96	40	

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence.***

15.8 IntensiveCare

This is to apply to services rendered in paediatric intensive care units and concentrated care units.

Initial assessment and institution of care		247	230	
Daily rate, per day		248	45	
Intensive care requiring detention				
Per ¼ hour (See service description Chapter 4, Section 2.4)		237	50	
Directive care		198	22	
Transfer code				
ICU care (See service description Chapter 4, Section 2.9)		1830	87	

☞ ***Medicare Note: See Medicare note under Intensive care, Chapter 4, Section 2.9.***

15.9 Special Procedures

Denver screening	B	2172	35	
Neurodevelopmental examination for learning disabilities	C	91	225	
Replacement transfusion				
First	A	249	192	
Subsequent	A	250	100	

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

Interpretation of hospital performed sleep E.E.G.	B	8211	65	
Electroencephalography – interpretation only	B	8212	25	
Routine survey of pulmonary function to provide information in ventilation, gas mixing and diffusion	B	8213	45	
Psychotherapy, per 15 minutes		2228	21	
Family counseling, per 15 minutes		239	50	
Discussion of a child's health with family member(s). This service applies only to counseling for severe life threatening conditions, major chronic health problems, severe behavioral problems or school learning difficulties.				
Therapeutic interview, per 15 minutes		194	44	

	List	Code	Units Gen	Units An
Case conference on behalf of the patient with allied health workers, teachers and clergy, but excluding hospital personnel				
Evaluation of abused child 16 years and under ..... Attendance by physician, to include necessary examinations, collection of specimens, completion of reports and forms, and other medico-legal requirements and liaison with other parties.		8216	280	

☞ ***Medicare Note: Total time including start and end time of service code 8216 must be given when billing detention. Attendance fees are not payable when physician rendering the services is remunerated under a Sessional or Salaried arrangement. After-hours premium does not apply to the service.***

	List	Code	Units Gen	Units An
Pediatric Colposcopy 16 years and under ..... Investigation under colposcopic technique, including biopsies, curetting, sampling for medical legal purposes.	B	8215	50	

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

	List	Code	Units Gen	Units An

Section 16: Specialists in Physical Medicine and Rehabilitation

See legend - Chapter 3, Section 1.7 for description of lists A, B, C and D.

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

Referred Cases

16.1 Consultations

(See definitions in the General Preamble)

Major or regional consultation	A	202	113
Repeat consultation - within 30 days for same illness or complication thereof	A	287	78
Senior's visit, add	A	8901	15

Payable with a major consult regardless of the presenting complaint in cases of complex case assessment for seniors 70 years of age or over, presenting with multiple system pathology, including medication review, as required.

16.2 Office Visits

First visit with complete examination of a new patient not attended during the previous 90 days	A	288	45
First visit with regional examination	A	289	43
Other office visits	A	290	42

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

16.3 Hospital Care

First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days	A	2491	71
Subsequent			
2nd to 30th day, per day	A	2492	29
After 30 days, per day	A	2494	17

Date of discharge

Comprehensive coordination of activities surrounding patient discharge from hospital which over the course of the hospital stay, may include but is not limited to: communication with the patient, the discharge planning officer, the family or other responsible person, as required, and other physicians involved in the care of the patient, writing prescriptions and referral requests, organizing follow-up, documentation of a final diagnosis and completion of a concise discharge summary within			

	List	Code	Units Gen	Units An
30 days.		2493	32	
The foregoing requirements are to be met during the discharge process and will normally include a face-to-face encounter on the day of discharge, involving the physician and patient, but may from time to time be precluded by special extenuating circumstances.				

☞ ***Medicare Note: The day of discharge fee will be reduced to the payment for a subsequent visit for physicians who do not complete the discharge summary within the expected time frame.***

Transfer Code				
Hospital care (See services description Chapter 4, Section 2.7.4)		8308	62	
ICU care (See services description Chapter 4, Section 2.9)		1833	62	
Directive care (See service description Chapter 4, Section 2.7.1)		98	29	

☞ ***Medicare Note: For ICU service codes (see Chapter 4, Section 2.9)***

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Chapter 2, Assessment Rules 16, 18, 19 and 24.***

16.4 Outpatient Department – Scheduled Visits

OPD Scheduled Visit		8733	23	

16.5 Home Visits

See also Chapter 4, Section 2.15.3		293	40	

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence.***

16.6 Miscellaneous

Physical medical and rehabilitative supervision, per treatment day where required	C	298	6	

16.7 Special Procedures

Faradic and galvanic testing	A	299	15	
Electromyography				
Major - muscles of more than one region examined	B	302	60	
Minor - examination of a specific muscle or region	B	303	30	
Nerve conduction studies				
Nerve conduction studies, per nerve studied (in addition to electromyographic examination fee if done				

	List	Code	Units Gen	Units An
at the same time)	B	176(1)	20	
Timed repetitive stimulation study (max 3)	B	831	40	
Single fibre EMG	B	830	160	
Other therapeutic procedures not exceeding 1 hour – e.g. heat, light electrotherapy, ultrasound, hydrotherapy, mechanotherapy, exercise, and occupational therapy - visit fee	B	304	8	
Injection of Frozen Shoulder under Ultra Sound Guidance	B	8088	15	

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

16.8 Botulinum Toxin Injection

Face - unilateral	C	8135	77	
Other areas - unilateral	C	8136	77	

Other Areas

Other areas include the following:

- Neck
- Arm and/or shoulder
- Forearm and/or hand
- Thigh and/or girdle
- Calf and/or foot
- Whole back

Multiple Injections

Guidelines for multiple injections for the same patient in the same sessions are as follows:

Face: unilateral (one or more injections) – 77 units; bilateral at 50%
Other areas: unilateral (one or more injections) – 77 units; bilateral at 75%

☞ ***Medicare Note: On the face, back and neck, where two bilateral injections may come within 2 to 3 cm of each other (i.e. left and right side of nose – procerus muscles or left and right paraspinal muscles), these should be counted as one injection instead of bilateral.***

☞ ***Medicare Note: Can only be billed for conditions approved by Medicare as guided by Health Canada indications.***

	List	Code	Units Gen	Units An

Section 17: Specialists in Plastic Surgery

See legend - Chapter 3, Section 1.7 for description of lists A, B, C and D.

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

Referred Cases

17.1 Consultations

(See definitions in the General Preamble)

Major or regional consultation	A	305	67
Repeat consultation - within 30 days for same illness or complication thereof	A	306	37
Senior's visit, add	A	8901	15

Payable with a major consult regardless of the presenting complaint in cases of complex case assessment for seniors 70 years of age or over, presenting with multiple system pathology, including medication review, as required.

17.2 Office Visits

First visit, depending on the complexity of the case and time involved	A	307	46
First visit with regional examination	A	203	33
Other office visits	A	308	39

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

17.3 Hospital Care

First visit, major assessment on day of admission, except where the physician had done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days	A	2461	44
Subsequent			
2nd to 30th day, per day	A	2462	29
After 30 days, per day	A	2464	14

Date of discharge

Comprehensive coordination of activities surrounding patient discharge from hospital which over the course of the hospital stay, may include but is not limited to: communication with the patient, the discharge planning officer, the family or other responsible person, as required, and other physicians involved in the care of the patient, writing prescriptions and referral requests, organizing follow-up, documentation of a final diagnosis and

	List	Code	Units Gen	Units An
completion of a concise discharge summary within 30 days.		2463	32	
The foregoing requirements are to be met during the discharge process and will normally include a face-to-face encounter on the day of discharge, involving the physician and patient, but may from time to time be precluded by special extenuating circumstances.				

☞ ***Medicare Note: The day of discharge fee will be reduced to the payment for a subsequent visit for physicians who do not complete the discharge summary within the expected time frame.***

Transfer Code				
Hospital care (See service description Chapter 4, Section 2.7.4)		8306	36	
ICU care (See service description Chapter 4, Section 2.9)		1831	36	
Directive care (See service description Chapter 4, Section 2.7.1)		80	29	

☞ ***Medicare Note: For ICU service codes (see Chapter 4, Section 2.9)***

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Chapter 2, Assessment Rules 16, 18, 19 and 24.***

17.4 Outpatient Department – Scheduled Visits

OPD Scheduled Visit		8734	23	

17.5 Home Visits

See also Chapter 4, Section 2.15.3		311	40	

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence.***

17.6 Team Procedures – Major Complex Reconstruction Surgery

a. Plastic surgeons must bill under the existing service code for the procedure and may request independent consideration based on a time based fee.

b. If no service code exists for the procedure, the plastic surgeon may claim under independent consideration (service code 888) for the payment of major complex reconstructive surgical procedures on a time basis.

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

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

Section 18: Specialists in Psychiatry

See legend - Chapter 3, Section 1.7 for description of lists A, B, C and D.

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

Referred Cases

18.1 Consultations

(See definitions in the General Preamble)

Major or regional consultation		321	212
Repeat consultation - within 30 days for same illness or complication thereof		322	86
Senior's visit, add		8901	15

Payable with a major consult regardless of the presenting complaint in cases of complex case assessment for seniors 70 years of age or over, presenting with multiple system pathology, including medication review, as required.

18.2 Office Visits

First visit with complete examination, including psychiatric evaluation and certification if indicated		324	111
Other office visits		325	40

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

Opiate Addiction – Office Visit

For diagnosis and follow-up of opiate addiction		8116	30

☞ ***Medicare Note: This service code IS NOT merely for prescribing/refilling of prescriptions of methadone/alternatives.***

☞ ***Medicare Note: Patients must have been diagnosed with an opiate addiction and physicians should adhere to the College of Physicians and Surgeons of New Brunswick Guidelines for the Treatment of Opioid Addiction; http://www.cpsnb.org/english/Guidelines/TreatmentofOpioidAddiction.htm***

☞ ***Medicare Note: Please note that physicians with the appropriate license requirements should bill Service Code 8116 when the sole purpose of the visit is for treatment of an opioid addiction. Refer to Chapter 3, Section 1.1 for the principles of billing. This also applies to physicians who are required to submit shadow billing. A copy of your license permitting the prescribing of methadone/alternative must be submitted to the Practitioner Registrar at Medicare Eligibility and Claims.***

	List	Code	Units Gen	Units An
☞				
Hospital Care				
First visit, major assessment on day of admission, except where the physician had done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days		2471	111	
Subsequent				
2nd to 30th day, per day		2472	29	
After 30 days, per day		2474	16	
Date of discharge				
Comprehensive coordination of activities surrounding patient discharge from hospital which over the course of the hospital stay, may include but is not limited to: communication with the patient, the discharge planning officer, the family or other responsible person, as required, and other physicians involved in the care of the patient, writing prescriptions and referral requests, organizing follow-up, documentation of a final diagnosis and completion of a concise discharge summary within 30 days.		2473	32	
The foregoing requirements are to be met during the discharge process and will normally include a face-to-face encounter on the day of discharge, involving the physician and patient, but may from time to time be precluded by special extenuating circumstances.				

☞ ***Medicare Note: The day of discharge fee will be reduced to the payment for a subsequent visit for physicians who do not complete the discharge summary within the expected time frame.***

Transfer Code				
Hospital care (See service description Chapter 4, Section 2.7.4)		8301	80	
ICU care (See service description Chapter 4, Section 2.9)		1826	80	
Directive care (See service description Chapter 4, Section 2.7.1)		59	29	

☞ ***Medicare Note: For ICU service codes (see Chapter 4, Section 2.9)***

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Chapter 2, Assessment Rules 16, 18, 19 and 24.***

18.3 Outpatient Department – Scheduled Visits

OPD Scheduled Visit		8735	23	

	List	Code	Units Gen	Units An
18.4 Home Visits				
See also page Chapter 4, Section 2.15.3		328	40	

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence..***

18.5 Other Procedures				
Electroconvulsive therapy	A	333	42	4
Psychotherapy, per ¼ hour		332	45	
Psychiatric care: assessment and treatment (other than by psychotherapy) of a patient by a psychiatrist for the purpose of altering the patient's biopsychosocial functioning, per ¼ hour		331	45	

Medicare Note: For a major or regional consultation or a first day's hospital care, service codes 331 and 332 do not apply to the first hour. When billing these service codes alone or in combination with other services, the total time including start and end time must be provided. See also Chapter 2, Assessment Rule 10. Psychoanalysis is not a benefit under Medicare.

Group psychiatric care or psychotherapy – 2 or more persons, per ¼ hour	341	45	
Family psychiatric care or psychotherapy – 2 or more family members receiving care during the same session, per ¼ hour	2837	45	

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

Diagnostic and/or therapeutic interview with para medical organizations, employers, teachers, clergy (not applicable to interviews with persons working in hospitals or clinics where the psychiatrist practices); similar interviews with members of the family, child guidance with parents, assessment conference with parents; per ¼ hour	340	45	

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

	List	Code	Units Gen	Units An

Section 19: Specialists in Respirology

See legend - Chapter 3, Section 1.7 for description of lists A, B, C and D.

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

Referred Cases

19.1 Consultations

(See definitions in the General Preamble)

Major or regional consultation	A	8310	132
Repeat consultation – within 30 days for same illness or complication thereof	A	8311	72
Senior's visit, add	A	8901	15

Payable with a major consult regardless of the presenting complaint in cases of complex case assessment for seniors 70 years of age or over, presenting with multiple system pathology, including medication review, as required.

19.2 Office Visits

First office visit with complete exam and diagnostic survey of a new patient not attended during the previous 90 days	A	8242	64
First office visit with Regional exam	A	8243	43
Subsequent visit with complete re-examination	A	8244	43
Other office visits	A	8245	39

19.3 Hospital Care

First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days	A	8312	80
Subsequent			
2nd to 30th day, per day	A	8313	29
After 30 days, per day	A	8314	15

Date of discharge

Comprehensive coordination of activities surrounding patient discharge from hospital which over the course of the hospital stay, may include but is not limited to communication with the patient, the discharge planning officer, the family or other responsible person, as required, and other physicians involved in the care of the patient, writing prescriptions and referral requests, organizing follow-up, documentation of a final diagnosis and completion of a concise discharge summary within 30 days.	A	8246	32

The foregoing requirements are to be met during the discharge process and will normally include a face-to-face encounter on the day of discharge, involving the physician and patient, but may from time to time be precluded by special extenuating circumstances.

☞ ***Medicare Note: The day of discharge fee will be reduced to the payment for a subsequent visit for physicians who do not complete the discharge summary within the expected time frame.***

19.4 Outpatient Department – Scheduled Visits

OPD Scheduled Visit 8736 23

19.5 Directive Care

See service description Chapter 4, Section 2.7.1 .....8241 29

19.6 Other Visit Fees

As for specialists in Internal Medicine (Chapter 5, Section 6.3)

	List	Code	Units Gen	Units An

Section 20: Specialists in Rheumatology

See legend - Chapter 3, Section 1.7 for description of lists A, B, C and D.

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

Referred Cases

20.1 Consultations

(See definitions in the General Preamble)

Major or regional consultation	A	8315	129
Repeat consultation – within 30 days for same illness or complication thereof	A	8316	60
Senior's visit, add	A	8901	15

Payable with a major consult regardless of the presenting complaint in cases of complex case assessment for seniors 70 years of age or over, presenting with multiple system pathology, including medication review, as required.

20.2 Office Visits

First office visit with complete exam and diagnostic survey of a new patient not attended during the previous 90 days	A	8344	79
First office visit with Regional exam	A	8345	53
Subsequent visit with complete re-examination	A	8346	54
Other office visits	A	8347	52

20.3 Hospital Care

First visit, major assessment on day of admission, except where the physician has done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days	A	8317	81
Subsequent			
2nd to 30th day, per day	A	8318	29
After 30 days, per day	A	8319	16

Date of discharge

Comprehensive coordination of activities surrounding patient discharge from hospital which over the course of the hospital stay, may include but is not limited to: communication with the patient, the discharge planning officer, the family or other responsible person, as required, and other physicians involved in the care of the patient, writing prescriptions and referral requests, organizing follow-up, documentation of a final diagnosis and completion of a concise discharge summary within 30 days.	A	8343	32

The foregoing requirements are to be met during the discharge process and will normally include a face-to-face encounter on the day of discharge, involving the physician and patient, but may from time to time be precluded by special extenuating circumstances.

☞ ***Medicare Note: The day of discharge fee will be reduced to the payment for a subsequent visit for physicians who do not complete the discharge summary within the expected time frame.***

20.4 Outpatient Department – Scheduled Visits

OPD Scheduled Visit 8737 23

20.5 Directive Care

See service description Chapter 4, Section 2.7.1 .....8342 29

20.6 Other Visit Fees

As for specialists in Internal Medicine (Chapter 5, Section 6.3).

	List	Code	Units Gen	Units An

Section 21: Specialists in Urology

See legend - Chapter 3, Section 1.7 for description of lists A, B, C and D.

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

Referred Cases

21.1 Consultations

(See definitions in the General Preamble)

Major or regional consultation		343	70
Repeat consultation – within 30 days for same illness or complication thereof		345	47
Senior's visit, add		8901	15

Payable with a major consult regardless of the presenting complaint in cases of complex case assessment for seniors 70 years of age or over, presenting with multiple system pathology, including medication review, as required.

21.2 Office Visits

New condition seen for the first time, to include complete history and physical examination		346	43
First visit with regional examination only		347	37
Other office visits		349	37

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

21.3 Hospital Care

First visit, major assessment on day of admission, except where the physician had done a major consultation, a complete examination or another major assessment on the patient during the preceding 30 days		2481	46
Subsequent			
2nd to 30th day, per day		2482	29
After 30 days, per day		2484	14

Date of discharge

Comprehensive coordination of activities surrounding patient discharge from hospital which over the course of the hospital stay, may include but is not limited to: communication with the patient, the discharge planning officer, the family or other responsible person, as required, and other physicians involved in the care of the patient, writing prescriptions and referral requests, organizing

	List	Code	Units Gen	Units An
follow-up, documentation of a final diagnosis and completion of a concise discharge summary within 30 days.		2483	32	
The foregoing requirements are to be met during the discharge process and will normally include a face-to-face encounter on the day of discharge, involving the physician and patient, but may from time to time be precluded by special extenuating circumstances.				

☞ ***Medicare Note: The day of discharge fee will be reduced to the payment for a subsequent visit for physicians who do not complete the discharge summary within the expected time frame.***

Transfer Code				
Hospital care (See service description Chapter 4, Section 2.7.4)		8307	36	
ICU care (See service description Chapter 4, Section 2.9)		1832	36	
Directive care (See service description Chapter 4, Section 2.7.1)		97	29	

☞ ***Medicare Note: For ICU service codes (see Chapter 4, Section 2.9)***

☞ ***Medicare Note: The first visit fee is not payable on transferred patients. See also Chapter 2, Assessment Rules 16, 18, 19 and 25.***

21.4 Outpatient Department – Scheduled Visits

OPD Scheduled Visit		8738	23	

21.5 Home Visits

See also Chapter 4, Section 2.15.3		351	40	

☞ ***Medicare Note: These fees are payable for a medically necessary visit made to a patient at his/her personal residence.***

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

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

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

	List	Code	Units Gen	Units An
21.6 Sacral Afferent Nerve Stimulation				
Initial treatment	C	8605	30	
Maintenance	C	8606	30	

☞ ***Medicare Note: Service Code 8605 is payable 1 per week for a maximum of 12 weeks and then Service Code 8606 is payable 1 per month for maintenance purposes as required.***

	List	Code	Units Gen	Units An

*Section 22: Specialists in Maternal Fetal Medicine

See legend Chapter 3, Section 1.7 for description of lists A, B, C and D.

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

Referred Cases

22.1 Consultations

(See definition in the General Preamble)			
Major or regional consultation		8360	67
Repeat consultation – within 30 days for same illness or complication thereof		8361	36

22.2 Office Visits

First visit with complete examiniation		8363	48
Regional examination		8364	38
Other office visits		8365	38

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

☞ ***Medicare Note: Site code must be recorded when office location is in establishment.***

22.3 Ultrasounds

Biophysical profile – performed and interpreted by the physician	B	1896	46
Physician present but not performing the procedure (interpretation only)	B	1897	23
Ultrasound < 16 weeks	B	8366	48
Each additional fetus (multiple gestation), add		8367	36
Assessment of Nuchal Translucency / First Trimester Screening	B	8368	63
Each additional fetus (multiple gestation), add		8369	47
Ultrasound > 16 weeks	B	8370	49
Each additional fetus (multiple gestation), add		8371	37
Genetic Sonogram	B	8372	108
Each additional fetus (multiple gestation), add		8373	81
Transvaginal	B	8374	69

☞ ***Medicare Note: Service Code 8374, Transvaginal ultrasounds only applies to the following indications (Multiple pregnancy, history of cervical excisional procedures, previous history***

	List	Code	Units Gen	Units An	

of preterm birth/pprom, signs or symptoms of preterm labour, suspicion of short cervix on physical exam, suspicion of placenta previa/vasa previa, fetal neurosonography, history of cervical insufficiency, antepartum hemorrhage, assessment of NT if fetus persistently vertical, improve resolution of fetal structures depending on fetal presentation).

Umbilical Artery Doppler	B	8375	36	
Each additional fetus (multiple gestation), add		8376	27	
Middle Cerebral Artery / Ductus Venosus Doppler	B	8377	48	
Each additional fetus (multiple gestation), add		8378	36	
Fetal Echocardiography	B	8379	140	
Each additional fetus (multiple gestation), add		8380	105	
Intra-operative ultrasound	B	8381	85	

☞ ***Medicare Note: Service Code 8381 is only applicable to Cerclage placement, Complicate DNC, Emergency C-section and Twin delivery.***

22.4 Procedures

Amniocentesis	B	1414	50	
Therapeutic Amino Reduction	B	8382	134	
Cordocentesis	B	8383	179	
US Guided Needle Insertion/Aspiration of Fetal Cavity	B	8384	179	
Chorionic Villous Sampling	B	8385	90	
Insertion of Fetal Shunt – Bladder or Chest to Amniotic Cavity	B	8386	269	
Fetal Transfusion/ Medication Infusion	B	1412	359	
Cerclage (Incompetent cervix – any suture repair) Including Prophylactic	D	1477	154	4
For cervix open 2 cm or more	D	8387	185	4
External Cephalic Version	C	8704	100	

☞ ***Medicare Note: Ultrasound used for guidance during a procedure is included in the fee (a comprehensive fee.***

CHAPTER 6: SURGICAL PROCEDURES

Section 1: Preamble

As a general rule:

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

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

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

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

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

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

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

      1. The hand or foot, including dorsal and volar aspects, but not the digits or the metacarpophalangeal joints.
      2. The face as defined in Chapter 7, Section 1.2 (2nd note) (Bilateral procedures on eyelids and eyebrows are also payable at 50%).
      3. The knee and immediately adjacent structures.
      4. The scrotum or perineum and the anal region.

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

   The Cancer premium is not payable:
   - to the surgical assistant
   - for secondary procedures unrelated to the treatment of the cancer
   - for reconstructive procedures

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

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

6. Iatrogenic Injuries - See Chapter 3, Section 1.2.12

7. Surgical Obesity Premium – See Chapter 4, Section 2.14

8. Major Complex Surgery (Collaborating Surgery)

a. Surgeons (excluding Plastic Surgeons, see page 148) must bill under the existing service code for the procedure and may request independent consideration based on a time based fee.

b. If no service code exists for the procedure, the physician may claim under independent consideration (Service Code 888) for payment of major complex surgical procedures on a time basis.

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

d. The special form of payment is limited to complex procedures such as reconstruction following extensive resection of head and neck cancer, reconstruction following major trauma, or after extensive ablative surgery to the trunk or limbs. It cannot be claimed unless the operative time covers at least four (4) hours.

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	List	Code	Units Gen	Units An

CHAPTER 7: INTEGUMENTARY SYSTEM

See legend – Chapter 3, Section 1.7 for description of lists A, B, C and D.

Section 1: Skin and Subcutaneous Tissue

1.1 Incision

Abscess				
Subcutaneous – boil, carbuncle, infected cyst, superficial lymphadenitis, paronychia, felon, etc.				
Local anaesthetic	C	355	20	
General anaesthetic	C	356	31	4
Perianal or pilonidal – local anaesthetic	C	357	20	
General anaesthetic – complete care	D	358	92	4
Ischiorectal – simple incision, local anaesthetic	C	359	20	
Unroofing – complete care	D	360	113	4
Haematoma – local anaesthetic	C	362	20	
General anaesthetic – depending on size and other complicating factors	C	363	31	4
Tongue-tie, release				
Infant			VF	
Child				
Local anaesthetic	C	365	20	
General anaesthetic	C	366	31	4
Removal of foreign body or fibroma				
Local anaesthetic	C	367	20	
General anaesthetic	C	368	46	4

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

1.2 Skin Lesions

☞ ***Medicare Note: Since September 15, 1994, the removal of skin lesions is not an insured service except when cancer is suspected or more specifically:***

a) Medicare Covers:

1. The removal of lesions recognized as presenting a significant risk of producing malignant lesions. Examples are neurofibromatosis (Von Recklinghausen's disease), keratosis in chronic dialysis patients and actinic keratosis.

2. The removal of non-malignant skin lesions which, because of their location or size, result in significant functional problems, recurrent frequent bleeding or recurring infections that do not respond well to medical management.

	List	Code	Units Gen	Units An

b) Medicare does not cover:

1. The removal of benign skin lesions which do not carry a significant risk of becoming malignant nor causing any functional problems (for example: common warts, skin tags, papillomata, sebaceous cysts, seborrheic keratosis).

2. Chronic irritation, by itself is not an example of medical necessity for Medicare coverage purposes. Prior submissions for approval may be made to Medicare in special or unusual situations.

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

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

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

Lipoma				
Simple	C	378	52	4
Complicated	D	379	IC	4
Carcinoma of skin				
Excision and repair	C	370	54	4
Complicated or extensive excision and repair, depending on site	C	371	IC	4
Prior to skin grafting	C	373-374		
(Chapter 20, Section 6)				

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

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

	List	Code	Units Gen	Units An
Introduction				
Implantation of hormone pellets	C	385	38	

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

Suture				
Face				
First 5 cm	D	2227	46	5
More than 5 cm but not exceeding 10 cm	D	2487	72	5
Complicated	D	387	IC	6

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

Other areas				
First 5 cm	D	99	23	4
More than 5 cm but not exceeding 10 cm	D	2488	38	4
Complicated	D	387	IC	6

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

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

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

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

See also Plastic Surgical Procedures Chapter 20, Section 10.

1.3 Tendons, Tendon Sheaths, Fascia

See Chapter 8, Section 6

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

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

☞ ***Medicare Note: Service Code 843 and 844 are not payable in addition to code 409***

☞ ***Medicare Note: Revision of cosmetic surgery is not an insured service:***

- ***In cases where the patient had previous cosmetic breast augmentation and goes on to develop breast contractures or implant rupture, the removal of the previous prosthesis as well as any potential implant of new ones cannot be billed to Medicare.***
- ***Correction of asymmetry of breasts or nipple areola complexes post cosmetic surgery cannot be billed to Medicare.***

Mastectomy: See Plastic Surgical Preamble, Chapter 20, Section 1.

Repair: See Plastic Surgical Procedures, Chapter 20, Section 17.

	List	Code	Units Gen	Units An

CHAPTER 8: MUSCULOSKELETAL SYSTEM

See legend – Chapter 3, Section 1.7 for description of lists A, B, C and D.

Section 1: Preamble

1. Bone grafts associated with arthrodesis are not payable as additional procedures.
2. Except when due to complications, the removal of internal fixation devices during the defined postoperative period is included in the procedure fees.
3. Fees for dislocations, fractures and other major musculoskeletal procedures include preoperative splinting, the application of initial and one repeat cast or splint, and the removal of all casts and splints during the defined postoperative period.
4. Cast or splint application fees include the removal during the defined postoperative period.
5. Unless otherwise provided a fracture fee applies also to a fracture-dislocation.
6. Manipulation fees are not payable in addition to fracture or dislocation fees.
7. Closed reduction fees include skin or skeletal traction.
8. Closed reductions requiring external skeletal fixation are payable as operative reductions.
9. The fee for management of a compound fracture not requiring operative reduction is the fee for a closed reduction plus 50%. When an operative reduction is required, the operative reduction fee only shall apply.
10. When a closed reduction is followed on the same day by an operative reduction or a transfer the closed reduction is payable at 75% except if performed by the same physician, in which case a cast fee only is payable.

Section 2: Classification

Section 3: Casts and Splints

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

Casts – upper extremity	D	516	23	4
Shoulder spica	D	515	77	4
Club foot, cast or strapping				
Unilateral	C	520	23	4
Bilateral	C	521	38	4

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

Section 4: Bones

☞ ***Medicare Note: "Large bone" means femur, tibia, fibula, humerus, radius, ulna, pelvis, spine and mandible.***

Incision				
Bone biopsy				
Punch biopsy				
Vertebra +/- x-ray control	B	538	115	4
Other bones	B	2598	50	4
With x-ray control	B	2599	92	4
Open biopsy				
Vertebra	B	539	231	7
Pelvis	B	1961	115	4
Other bones	B	1960	77	4
Drainage of bone (osteomyelitis)				
Incision of periosteum and drainage	D	2250	38	4
Saucerization and/or sequestrectomy				
Small bone	D	2248	115	4
Large bone	D	561	231	5
Secondary closure	D	2601	IC	4
Vertebrae				
Incision and drainage	D	2602	115	5
Sequestrectomy and/or saucerization	D	2603	231	5
Osteotomy (+/- internal fixation)				
Phalanx, metacarpal or metatarsal	D	2041	77	4
Each additional	D	2605	77	TU

Chapter 8: Musculoskeletal System	List	Code	Units Gen	Units An
Ulna	D	2606	231	4
Radius	D	2607	231	4
Radius and ulna	D	2608	269	4
Humerus	D	528	346	5
Clavicle	D	2609	192	5
Midtarsal	D	2610	308	4
Os calcis	D	2611	308	4
Tibia +/- fibula				
Child	D	2612	269	4
Adult	D	2637	385	6
Femur	D	2613	385	8
Pelvis – innominate osteotomy, shelf operation	D	555	346	8
Vertebra	D	2614	462	8
Excision (See also "Fractures" and "Amputation")				
Removal of internal fixation appliances	D	475	115	4
Minor incision only	D	1963	38	4
Exostosis				
Small bone	D	1998	77	4
Large bone	D	2068	154	4
Bone cyst, curettage and packing				
Phalanges	D	2597	154	4
Carpal or tarsal bone	D	2615	269	4
Radius or ulna	D	2616	231	4
Humerus or tibia	D	598	269	5
Femur	D	599	385	6
Insertion of Gentamicin beads				
Large bones	D	833	115	4
Small bones	D	834	77	4
Ostectomy (See also: "Joints – reconstruction")				
Hand – phalanx	D	2617	115	4
Metacarpal	D	2618	154	4
Carpal	D	535	192	4
With prosthetic replacement	D	2619	308	4
Radius				
Styloid	D	2620	154	4
Head	D	531	154	4
With prosthetic replacement	D	2621	385	4
Ulna				
Distal end	D	534	154	4
Olecranon	D	2622	192	4
Humerus, head	D	2623	308	5
With prosthetic replacement	D	2624	568	10
Clavicle – partial or total	D	2830	192	5
Acromium	D	526	154	5
Foot – phalanx	D	2626	115	4
Metatarsal	D	2627	154	4

	List	Code	Units Gen	Units An
Bunion – exostectomy only	D	587	77	4
Scaphoid or accessory	D	2628	192	4
Tarsal bar	D	2629	308	4
Talus	D	2630	269	4
Patella				
Partial	D	571	265	4
Complete	D	572	303	4
Hip – femoral head and neck (Girdlestone)	D	558	308	8
Coccygectomy	D	440	154	4
Vertebra – neural arch with nerve exploration (Gill procedure)	D	2727	539	8
Repair and reconstruction (Osteoplasty)				
Shortening of small bone	D	2631	115	4
Each additional	D	2632	75%	TU
Shortening of radius and ulna	D	2633	269	4
Shortening of humerus, tibia or femur	D	564	423	8
Lengthening of tibia or femur	D	565	539	8
Epiphysiodesis or stapling				
Tibia or femur	D	582	231	5
Tibia and femur	D	583	308	5
Slipped epiphysis – internal fixation	D	556	385	8
Wedge osteotomy plus fixation	D	557	462	8
Bone graft				
Bone graft, not associated with arthrodesis, add	D	2634	35%	TU

☞ ***Medicare Note: A bone graft applies to the taking of bone from another site; it does not apply, therefore, to packing with fragments or cancellous bone from the operative site itself.***

Removal of cadaver bone for allografts				
From femur	D	603	269	
From tibia +/- fibula	D	604	231	
Fractures				
Initial traction treatment prior to operative reduction	C	2017	38	
Use of AO type compression apparatus, additional to the fee for operative reduction	C	2018	46	TU
Insertion of cranioskeletal traction or fixation devices	D	1541	250	5
with Halo jacket (include readjustments)	D	2946	375	5
Reinsertion of cranioskeletal traction or fixation devices	D	2947	96	5
Bone stimulator, including application of electrodes (if done in conjunction with osteotomy, plating or grafting: payable at 50%)	D	1972	231	4
Upper extremity				
Phalanges				

Chapter 8: Musculoskeletal System	List	Code	Units Gen	Units An
Terminal				
No reduction, one or more	D	2648	31	
Closed reduction	D	2649	62	4
Operative reduction	D	2650	115	4
Middle or proximal				
No reduction, one or more	D	2651	31	
Closed reduction	D	2652	62	4
Operative reduction	D	2653	115	4
Each additional fracture	D	2654	75%	TU
Bennett's fracture-dislocation				
Closed reduction	D	2655	77	4
Operative reduction	D	2656	154	4
Metacarpals				
No reduction, one or more	D	2657	31	
Closed reduction	D	2658	62	4
Operative reduction	D	2659	115	4
Each additional fracture	D	2660	75%	TU
Carpal bones except scaphoid				
No reduction, one or more	D	2661	77	
Closed reduction	D	2662	77	4
Operative reduction	D	2663	192	4
Scaphoid				
No reduction	D	2664	92	
Operative reduction	D	2665	269	4
Partial or complete excision	D	2666	192	4
Radius or ulna				
No reduction	D	2672	62	
Closed reduction	D	2673	115	4
Operative reduction	D	2674	231	4
Radius and ulna				
No reduction	D	2675	62	
Closed reduction	D	2676	115	4
Monteggia or Galeazzi	D	2677	115	4
Operative reduction	D	2678	269	4
Monteggia or Galeazzi	D	2679	269	4
Radius, head or neck				
No reduction	D	2680	92	
Closed reduction	D	2681	115	4
Operative reduction	D	2682	154	4
Olecranon				
No reduction	D	2683	62	
Closed reduction	D	2684	62	4
Operative reduction	D	2685	192	4
Humerus, epicondyle and condyle, medial or lateral				
No reduction	D	2686	77	
Closed reduction	D	2687	154	4
Operative reduction	D	2688	269	4

Chapter 8: Musculoskeletal System	List	Code	Units Gen	Units An
Humerus, supra or transcondylar				
No reduction	D	2689	62	
Closed reduction	D	2690	154	4
With traction	D	2604	154	4
Operative reduction	D	2691	303	6
Humerus, shaft				
No reduction	D	2692	77	
Closed reduction	D	2693	154	4
Operative reduction	D	2694	269	5
IM locking nails	D	1839	350	6
Humerus, tuberosity				
No reduction	D	2695	77	
Closed reduction	D	2696	154	4
Operative reduction	D	2697	269	6
Humerus, neck				
No reduction	D	2698	77	
Closed reduction	D	2699	154	4
Operative reduction	D	2700	269	6
Humerus, neck, with dislocation of humeral head				
Closed reduction	D	2701	154	4
Operative reduction	D	2702	303	6
Scapula				
No reduction	D	2703	46	
Closed reduction	D	2704	154	4
Operative reduction	D	2705	269	5
Clavicle				
No reduction	D	2706	46	
Closed reduction	D	2707	77	4
Operative reduction	D	2708	192	5
Lower extremity				
Phalanges				
Terminal				
No reduction, one or more	D	2709	31	
Closed reduction	D	2710	62	4
Operative reduction	D	2711	115	4
Middle or proximal				
No reduction, one or more	D	2712	31	
Closed reduction	D	2713	62	4
Operative reduction	D	2714	115	4
Each additional fracture	D	2715	75%	TU
Metatarsals				
No reduction, one or more	D	2716	31	
Closed reduction	D	2717	62	4
Operative reduction	D	2718	115	4
Each additional fracture	D	2719	75%	TU
Tarsal bones except os calcis				
No reduction, one or more	D	2720	77	
Closed reduction	D	2721	154	4

Chapter 8: Musculoskeletal System	List	Code	Units Gen	Units An
Operative reduction	D	2722	269	4
Os calcis				
No reduction	D	2723	77	
Closed reduction	D	2724	154	4
Operative reduction	D	2725	269	4
With primary arthrodesis	D	2726	385	4
Ankle				
No reduction	D	2728	62	
Medial malleolus				
Closed reduction	D	2729	77	4
Operative reduction	D	2730	192	4
Lateral malleolus				
Closed reduction	D	2731	62	4
Operative reduction	D	2732	192	4
Bimalleolar or trimalleolar				
Closed reduction	D	2733	154	4
Operative reduction	D	2735	231	4
Fibula				
No reduction	D	2736	54	
Closed reduction	D	2737	54	4
Operative reduction	D	2738	192	4
Tibia +/- fibula – no reduction	D	2739	77	
Closed reduction	D	2740	154	4
With traction	D	2734	251	4
Operative reduction	D	2741	269	4
IM locking nails	D	1840	350	6
Patella				
Closed reduction	D	2742	77	
Operative reduction	D	2743	265	4
Patellectomy				
Partial	D	2744	265	4
Total	D	2745	303	4
Femur, shaft or transcondylar				
Closed reduction				
Child	D	2748	192	4
Adult	D	2749	269	4
Operative reduction	D	2750	385	8
IM locking nails	D	1838	450	8
Femur, neck or intertrochanteric				
Closed reduction	D	2752	269	4
Operative reduction, blind pinning				
(e.g. Smith-Petersen, Knowles)	D	2753	350	8
Direct reduction with internal fixation				
(e.g. compression screw and sideplate)	D	2754	510	8
Femur, head – prosthetic replacement	D	2755	568	8
Trunk				
Pelvis – no reduction – maximum	D	2756	77	
One or more bones – closed reduction				

Chapter 8: Musculoskeletal System	List	Code	Units Gen	Units An
by manipulation, sling or traction	D	2757	231	4
Operative reduction	D	2758	385	8
Acetabulum +/- dislocation – closed reduction	D	2759	231	4
Operative reduction, hips	D	2760	432	8
One pillar	D	2642	875	8
Two pillars	D	2643	1250	8
Spine				
Coccyx, non-operative	C	2761	VF	
Sacrum, non-operative	C	2762	VF	
Vertebral process	C	2763	VF	
Surgical removal	D	2764	115	8
Vertebral body – no reduction (cast extra)	C	2765	VF	
Closed reduction (cast, frame, brace, etc. extra)	C	2766	VF	
Operative reduction (graft extra)	D	2767	462	10
Double Harrington instrumentation, add	D	2751	200	TU
Decompression laminectomy and operative reduction	D	2768	462	10
Anterior cervical decompression +/- fusion	D	2769	462	10
Two levels	D	2746	539	10
Ribs	C	2770	VF	
Complicated	D	2747	IC	
Sternum				
No reduction	C	2771	VF	
Closed reduction	D	2772	46	4
Operative reduction	D	2773	IC	4-13
Skull – injuries				
Non-operative			VF	
Elevation of depressed fracture of skull or removal of bone fragments with no dural penetration (simple)	D	414	231	10
Debridement and closure of compound craniocerebral injury with treatment of brain laceration, repair of dura, skull and scalp	D	415	462	11
Craniectomy with evacuation of intracranial haematoma, extradural or subdural	D	416	462	11
Cranioplasty, meaning closure of skull defect with any material (metallic, plastic or bone)	D	417	308	11
Subtemporal decompression	D	418	308	11
Facial bones				
Mandible, fractures – no reduction			VF	
Interdental and intermaxillary wiring	D	423	154	8
Simple or compound, unilateral or bilateral, reduction and fixation	D	424	269	8
Skeletal pinning, circumferential wiring of mandible, wiring of Gunning splints or dentures	D	2229	231	8

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

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

Facial Bones – Other Procedures

Osteotomies – facial bones (not applicable to fractures)				
Malar (maxillary)	D	1703	582	15
Low maxillary osteotomy and advancement (LeFort I), including bone grafts	D	1704	582	15

Chapter 8: Musculoskeletal System	List	Code	Units Gen	Units An
Two segments	D	1705	769	15
Three or more segments	D	1706	910	15
Maxillary osteotomy and advancement (LeFort II), including bone grafts	D	1707	910	20
Total maxillary advancement (LeFort III), including bone grafts	D	1708	1219	25
Hypertelorism correction				
Extracranial approach	D	1709	1151	25
Intracranial approach	D	1710	1546	25
Maxillectomy – partial or complete	D	2096	500	12
With orbital exenteration	D	2097	650	12
Section 5: Joints				
Manipulation under general anaesthesia	B	2145	31	4
With aspiration and/or injection	B	2671	46	4
Dislocations – reduction				
Finger, thumb				
Closed	D	507	23	4
Operative	D	508	108	4
Metacarpophalangeal joint – operative	D	2774	115	4
Wrist, carpal bones				
Closed	D	505	115	4
Operative	D	506	231	4
Elbow				
Closed	D	503	54	4
Operative	D	2775	154	4
Shoulder				
Closed	D	502	54	4
Operative	D	2776	269	6
Recurrent dislocation repair	D	525	308	6
Acromioclavicular joint				
Closed	D	500	46	4
With pin fixation	D	2777	120	4
Operative +/- pin fixation	D	501	192	5
Sternoclavicular joint				
Closed	D	499	38	4
Operative	D	2778	308	5
Toe				
Closed	D	2779	23	4
Operative	D	2780	108	4
Tarsal joint				
Closed	D	512	115	4
Operative	D	513	231	4
Ankle				
Closed	D	2781	115	4
Operative	D	2782	231	4

Chapter 8: Musculoskeletal System	List	Code	Units Gen	Units An
Patella				
Closed	D	511	54	4
Recurrent dislocation repair	D	2783	269	4
Knee				
Closed	D	1949	154	4
Operative with ligament repair	D	1959	308	4
Hip				
Closed	D	509	154	4
Operative	D	510	308	8
Hip, congenital dislocation				
Closed reduction				
Unilateral	D	2784	154	4
Bilateral	D	2785	231	4
Closed plus adductor tenotomy				
Unilateral	D	553	231	4
Bilateral	D	554	308	4
Operative reduction	D	551	385	8
With shelf operation	D	552	462	8
Sacrococcygeal joint, non-operative	C	2788	VF	
Spine – see "Joints – excision" and "Joints – arthrodesis"				
Temporomandibular joint	D	2244	23	4
Arthroscopy (+/- biopsy)				
Diagnostic arthroscopy	B	1962	139	6
Arthroscopic meniscectomy, knee				
One meniscus	D	2932	355	6
Medial and lateral	D	2933	412	6
Arthroscopic meniscal suturing	D	1841	355	6
Arthroscopic removal of loose body				
Knee	D	2934	296	6
Ankle	D	2935	258	6
Shoulder	D	2936	296	6
Elbow	D	2937	258	6
Division of synovial plica	D	2938	295	6
Osteochondritis dissecans				
Curettage	D	2939	252	6
Internal fixation	D	2940	412	6
Lateral retinacular release	D	2941	219	6
Chondral shaving of patella	D	2942	210	6
Shaving of one femoral condyle	D	2943	231	6
Of both femoral condyles	D	2944	308	6
Removal of foreign body, staples, screws or pins	D	2945	219	6
Secondary arthroscopic procedure, same knee				
Lateral retinacular release, add	D	1779	77	TU
Debridement of the medial femoral condyle, add	D	1780	77	TU
Debridement of tibial plateau, add	D	1781	77	TU
Debridement of the patello-femoral joint, add	D	1782	77	TU
Division of synovial plica, add	D	1783	77	TU

	List	Code	Units Gen	Units An
☞ ***Medicare Note: Only one secondary procedure, service codes 1779-1783, is payable in addition to a primary arthroscopic procedure on the same knee.***				
Incision (Arthrotomy, exploration, debridement, loose body removal)				
Finger	D	2790	108	4
Toe	D	2791	108	4
Wrist	D	2792	154	4
Elbow	D	532	154	4
Shoulder	D	2793	192	6
Ankle	D	1967	154	4
Knee	D	570	192	4
Hip	D	547	269	8
Excision				
Ganglion, synovial cyst	D	398	77	4
Capsulectomy, capsulotomy, synovectomy, finger or metacarpophalangeal joint	D	2796	192	4
Each additional, same finger	D	2797	50%	TU
Synovectomy, wrist +/- ulnar head excision	D	2798	269	4
Popliteal (Baker's) cyst of knee	D	575	192	4
Meniscectomy, knee				
One meniscus	D	568	251	4
Medial and lateral	D	569	308	4
Synovectomy, knee	D	2005	231	4
Osteochondritis dissecans				
Curettage	D	2800	251	4
Internal fixation	D	2801	308	4
Neurectomy, hip	D	559	269	4
Discectomy – lumbar	D	542	385	8
Thoracic				
Posterior approach	D	1596	539	10
Transthoracic	D	2370	539	13
Cervical				
Posterior approach	D	2802	462	10
Anterior approach	D	2600	462	10
Any level				
Repeat	D	2647	539	8-13
Two or more	D	2803	539	8-13
Meniscectomy, temporomandibular joint	D	2245	154	6
Condylectomy	D	2246	231	6
Reconstructive arthroplasty (See also "Ostectomy")				
Finger or thumb joint, including synovectomy and silastic replacement	D	2317	192	4
Each additional joint, maximum 539 units	D	2318	77	TU
Carpal bone replacement	D	2619	308	4

	List	Code	Units Gen	Units An
Wrist				
Ulnar head replacement	D	1755	385	4
Radio-carpal replacement	D	2804	385	4
Total replacement	D	2799	539	4
Elbow				
Radial head replacement	D	2621	385	4
Total replacement	D	2625	462	4
Shoulder – total replacement	D	2805	568	10
Revision of replacement arthroplasty of the shoulder, add	D	8402	40%	10
Acromioclavicular joint	D	2806	192	4
Toe, including Keller, McBride (see also "Ostectomy")	D	585	192	4
Mitchell osteotomy or Lapidus procedure	D	2829	269	4
Hammer toe	D	588	115	4
Each additional toe, either foot	D	589	77	TU
Overlapping 5th toe	D	2807	115	4
Hoffmann procedure for rheumatoid arthritis	D	2808	385	4
Ankle, total replacement	D	2809	462	6
Knee – hemiarthroplasty				
Single component	D	1979	308	6
Double component	D	1997	377	6
Total replacement	D	1978	611	11
Revision of replacement arthroplasty of the knee, add	D	8403	40%	10
Meniscal allograpt transplantation	D	8449	886	6

☞ ***Medicare Note: The above fee is contingent upon all of the following components being part of the surgery: service code 2932 – Arthroscopic Menisectomy one Meniscus; service code 1979 – Single Component Hemiarthroplasty; service code 578– Meniscal Suturing; service code 2634 – Bone Graft (35% of service code 2932); service code 504 – Exterior Fixator. If one of the above is omitted (not performed), then the necessary codes should be billed individually, not service code 8449.***

Hip				
Femoral prosthesis	D	2786	568	8
Cup arthroplasty	D	2787	539	10
Total replacement	D	2004	682	13
Revision of replacement arthroplasty, add	D	2789	40%	12

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

	List	Code	Units Gen	Units An
Tenoplasty service codes 2309 and 2310 performed via separate incisions are payable at 75%.				
"Removal" only (solo) of prothesis				
Non-cemented	D	8400	420	8
Cemented	D	8401	524	8
Arthrodesis (fusion)				
Finger, thumb	D	2813	154	4
Wrist	D	533	308	4
Elbow	D	530	308	4
Shoulder	D	523	385	6
Foot				
Midtarsal, subtalar, triple	D	592	385	4
Pantalar	D	593	462	4
Ankle	D	584	346	4
Knee	D	574	346	4
Hip	D	548	462	8
Sacroiliac joint	D	546	308	7
Spine – fusion only	D	541	462	8
Each additional level, add	D	2814	77	TU
Fusion(s) additional to other procedures, add	D	2815	115	TU
Instrumentation (excluding plate, wires, etc.)	D	8404	1175	12
☞ ***Medicare Note: Instrumentation to include fractures, disc operations, fusions, grafts and corporectomy.***				
Scoliosis – anterior approach	D	2810	IC	9
Harrington rods – correction, fusion and casts	D	540	900	12
Removal of Harrington apparatus	D	2812	192	8
Luque instrumentation – with fusion	D	543	1175	12

Section 6: Tendons, Fascia, Ligaments

Incision				
Web space abscess				
Local anaesthesia	C	2635	15	
General anaesthesia	C	2636	31	4
Acute tenosynovitis, tenovaginitis, total care	D	361	92	4
Exploration of fascia, fasciotomy	D	396	113	4
Closed (blind) fasciotomy	D	2818	62	4
Four-compartment fasciotomy	D	397	231	4
Exploration of tendon, tendon sheath (including drainage, removal of foreign body)	D	392	92	4
Tendon release				
Trigger finger	D	394	92	4
Wrist	D	395	92	4
Tenotomy	D	2819	115	4

	List	Code	Units Gen	Units An
Dupuytren's Disease – Total Care				
Localized excision (no contractures, only palmar or finger nodules	D	401	154	4
Palmar fasciectomy (MCP and/or PIP contracture greater than 15 degrees	D	403	462	4
Plus skin graft	D	402	550	4
Needle aponeurotomy (MCP and/or PIP contracture Greater than 15 degrees	D	845	462	4

MCP and/or PIP angles must be indicated in the diagnosis field of the claim.

☞ ***Medicare Note: Total care includes intra-operative Doppler, neurolysis and/or Z-plasty and as such is included in the fee.***

Excision				
Ganglion, tendon sheath	D	2821	77	4
Tumor, tendon sheath	D	2822	77	4
Tendon sheath for tuberculosis	D	400	231	4
Tenosynovectomy (independent procedure)				
Extensor	D	2823	115	4
Flexor tendon	D	2824	192	4
Fibrosis, tendon sheath: de Quervain, etc	D	399	92	4
Decompression of carpal tunnel	D	611	115	4
Epicondylar stripping (tennis elbow)	D	1964	115	4
Repair, reconstruction				
Tendon suture -hand, wrist, foot, ankle				
Extensor				
One	D	613	115	4
Multiple	D	614	231	4
Flexor				
One	D	615	192	4
Two	D	616	269	4
Each additional	D	2820	77	TU
Collateral ligament repair	D	2641	192	4
Repair of digital or palmar nerve during a procedure, add	D	2325	115	4
Suture of minor nerve, independent procedure	D	2324	154	4
Repair of tendon				
Biceps, upper or lower end	D	619	231	5
Achilles	D	618	269	4
Patellar	D	2825	269	4
Quadriceps	D	620	269	4
Tenoplasty: shortening or lengthening, Tenonectomy, any location, independent procedure				

Chapter 8: Musculoskeletal System	List	Code	Units Gen	Units An
One tendon	D	2309	115	4
Two or more tendons	D	2310	192	4
ACL Reconstruction +/- Arthroscopy	D	822	533	6
Reconstruction of flexor tendon pulleys	D	2640	192	4
Patelloplasty	D	2638	269	4
Lateral retinacular release	D	2639	115	4
Hip flexion contracture	D	560	269	6
Insertion of silastic tendon	D	2307	269	4
Insertion of silastic rod in flexor tendon sheath	D	2308	192	4
Club foot, vertical talus				
Tendon lengthening	D	594	154	4
Plus posterior capsulotomy	D	595	231	4
Medial release and tendon lengthening	D	596	308	4
Tarsal – metatarsal release	D	591	250	4
Tendon transfer, transposition, tenodesis				
One	D	2069	308	4
Each additional	D	2070	50%	4
Free tendon graft, total procedure	D	617	308	4
Intrinsic release of finger, independent procedure	D	2320	154	4
Correction of boutonniere deformity	D	2321	154	4
Correction of swan neck deformity	D	2322	154	4
Repair of rotator cuff, shoulder	D	524	269	6
Detachment of fascia lata, lengthening iliotibial band	D	1968	154	6
Digital transplant, vascular pedicle – total care	D	2313	500	4
Multiple injured hand, e.g. lawnmower or chain saw injuries involving several structures – total care, including staged procedures (operative reports required) maximum 769 units	D	2316	IC	6
Repair traumatic amputation of finger				
distal to metacarpophalangeal joint	D	2006	38	4
With free skin graft, complete care	D	2007	77	4
With pedicle graft, complete care	D	2008	115	4
Ligaments				
Ankle				
Early repair	D	2667	192	4
Each additional	D	2668	50%	TU
Late repair	D	2794	231	4
Each additional	D	2669	50%	TU
Knee				
Early repair	D	576	231	4
Each additional	D	577	50%	TU
Later repair	D	2795	269	4
Each additional	D	2670	50%	TU
Meniscal suture				
One meniscus	D	578	251	4
Medial and lateral menisci	D	579	308	4

Chapter 8: Musculoskeletal System	List	Code	Units Gen	Units An
Section 7: Bursae				
Excision				
Elbow – olecranon bursa	D	601	77	4
Shoulder	D	527	154	4
Knee – prepatellar bursa	D	602	77	4
Hip – trochanteric bursa	D	2826	154	4
Section 8: Muscles				
Incision				
Myotomy – tennis elbow	D	2827	115	4
Division of sternomastoid – torticollis	D	522	208	4
Division of scalenus anticus	D	605	231	4
with resection of cervical rib	D	606	308	5
Excision				
Biopsy of muscle	B	607	38	4
Removal of foreign body or fibroma				
Local anaesthetic	D	2828	77	
General anaesthetic	D	608	IC	4
Excision of muscle tumor	D	609	IC	4
Reconstruction				
Gastrocnemius slide, unilateral	D	1969	154	4
Quadricepsplasty	D	567	269	4
Iliopsoas transplant	D	1966	385	6
Section 9: Botulinum Toxin Injection				
Face - unilateral	C	8135	77	
Other areas - unilateral	C	8136	77	

Other Areas
Other areas include the following:

- Neck
- Arm and/or shoulder
- Forearm and/or hand
- Thigh and/or girdle
- Calf and/or foot
- Whole back

Multiple Injections
Guidelines for multiple injections for the same patient in the same sessions are as follows:

Face: unilateral (one or more injections) – 77 units; bilateral at 50%
Other areas: unilateral (one or more injections) – 77 units; bilateral at 75%

	List	Code	Units Gen	Units An

☞ ***Medicare Note: On the face, back and neck, where two bilateral injections may come within 2 to 3 cm of each other (i.e. left and right side of nose – procerus muscles or left and right paraspinal muscles, these should be counted as one injection instead of bilateral.***

☞ ***Medicare Note: Can only be billed for conditions approved by Medicare as guided by Health Canada indicaitons*.**

Section 10: Amputations

Upper extremity				
Hand				
Metacarpophalangeal joint or distal				
One	D	629	54	4
Each additional	D	630	38	TU
Transmetacarpal, thumb or finger				
One	D	627	77	4
Each additional	D	628	38	TU
All metacarpals	D	626	192	4
Ray amputation	D	2314	192	4
Wrist, disarticulation	D	625	192	4
Forearm, through radius and ulna	D	624	231	4
Arm, through humerus	D	623	231	5
Shoulder, disarticulation	D	622	269	9
Interthoracoscapular (forequarter)	D	621	462	15
Lower extremity				
Foot				
Any joint or phalanx				
One	D	640	54	4
Each additional	D	641	38	TU
Transmetatarsal				
One	D	637	77	4
Each additional	D	638	38	TU
All	D	636	192	4
Ankle (Syme's)	D	635	269	4
Leg, through tibia and fibula	D	634	231	6
Thigh, through femur	D	633	269	6
Hip, disarticulation	D	632	385	10
Interpelviabdominal (hindquarter)	D	631	539	15

	List	Code	Units Gen	Units An
CHAPTER 9: RESPIRATORY SYSTEM				
See legend – Chapter 3, Section 1.7 for description of lists A, B, C and D.				
Section 1: Nose				
Incision				
Drainage of nasal abscess, complete care	D	642	59	
Drainage of septal abscess, complete care	D	643	98	4
Excision				
Biopsy of soft tissue	B	644	54	4
Biopsy of bone	B	645	31	
Excision of nasal polyps – unilateral	B	647	77	4
Excision of choanal polyp	D	648	54	4
Excision of nasopharyngeal fibroma	D	649	385	4
Excision of intranasal lesions by lateral rhinotomy approach	D	1773	375	7
Excision of tumor of nasopharynx (Wilson, transpalatal approach)	D	2037	308	4
Rhinophyma, complete, including skin grafts if necessary	D	650	154	4
Septectomy, submucous resection	D	651	154	4
Including septoplasty	D	652	192	4
With correction of nasal deformity	D	653	385	6
Repair				
Rhinoplasty, complete management, including septectomy and grafts where necessary	D	660	462	8
☞ ***Medicare Note: Rhinoplasty: See plastic surgical preamble, Chapter 20, Section 1.***				
Turbinate reduction, unilateral or bilateral, to include cautery, cryosurgery or turbinectomy	B	654	45	4
Endoscopy				
Rhinoscopy with removal of foreign body in nose	B	658	15	
Under general anaesthesia	B	659	31	4
Nasopharyngoscopy	C	2853	36	
Surgical technique for atrophic rhinitis				
Unilateral	D	661	115	4
Bilateral	D	662	231	4
Insertion of septal button	D	700	115	4
Manipulation				
Control of primary nasal haemorrhage				
With cauterization of nasal septum	B	666	15	4
With anterior nasal packing	A	667	15	4
With posterior nasal packing				

	List	Code	Units Gen	Units An
Local anaesthesia	D	668	77	
General anaesthesia	D	670	115	4
With cauterization (electric) of nasal septum	B	669	31	4
Control of secondary haemorrhage – same as above				
Catheterization of Eustachian tube				
for infiltration of middle ear	A	1922	29	

Section 2: Nose – Accessory Sinuses

Endoscopy				
Diagnostic sinoscopy –				
Unilateral	B	1786	92	4
With biopsy +/- removal of benign growth	B	1788	123	4
Bilateral	B	1787	138	4
With biopsy +/- removal of benign growth	B	1789	185	4
Incision				
Antrum puncture, unilateral	A	672	15	4
Maxillary sinusotomy, simple antrum window operation				
Unilateral	D	673	92	4
Bilateral	D	674	154	4
Radical antrum, unilateral	D	675	231	4
Sphenoid sinusotomy	D	676	115	4
Frontal sinusotomy, external trephine operation				
Simple	D	677	115	4
Radical	D	678	385	4
Combined external frontal, ethmoid and sphenoid sinusotomy	D	679	385	4
Excision				
Ethmoidectomy –				
Unilateral	D	656	154	4
With sinoscopy +/- construction of maxillary ostium	D	1790	231	4
Bilateral	D	657	231	4
With sinoscopy +/- construction of maxillary ostium	D	1791	347	4
Radical ethmoidectomy – external approach	D	1777	300	4
transantral (including Caldwell-Luc)	D	1778	300	4
Debridement of lymphomas (face-ethmoid/nasal structures)				
Location 3 and 5	D	823	98	5
Repeat	D	824	74	5

Section 3: Larynx

Excision				
Laryngectomy				
Without neck dissection	D	680	550	10

	List	Code	Units Gen	Units An
With neck dissection				
Unilateral	D	681	804	14
Bilateral	D	682	950	14
Epiglottidectomy	D	683	192	10
Laryngofissure	D	684	308	6
Thyrotomy (McNaughton Keel)	D	685	231	6
Introduction				
Intubation of larynx (independent procedure)	C	687	23	
Endoscopy				
Laryngoscopy, direct				
Without biopsy	B	688	62	6
With biopsy	B	689	62	6
Laryngoscopy				
With removal of foreign body	D	690	115	6
With removal of benign growth	D	691	154	6
With injection of vocal cord	D	692	154	6
Microlaryngoscopy, additional to laryngoscopy fee	C	1728	36	TU
Repair				
Laryngoplasty: plastic operation on larynx	D	693	IC	7
Arytenoidopexy (King or Kelly)	D	694	308	6
Laryngocele				
External	D	695	308	6
Internal	D	696	231	6

Section 4: Trachea and Bronchi

	List	Code	Units Gen	Units An
Introduction				
Tracheal aspiration in infants (independent procedure)	A	704	15	
Endoscopy **(See also Chapter 2, Assessment Rules 32 and 33)**				
Rigid bronchoscopy +/- biopsy	B	698	92	6
Therapeutic, including suctioning	B	2587	92	6
Rigid bronchoscopy				
Therapeutic, with removal of foreign body	D	701	154	6
Dilatation of stenosis	D	2588	92	6
Repeat	D	2589	115	6
Flexible bronchoscopy +/- biopsy	B	699	108	6
Therapeutic, including suctioning	B	2591	92	6
Flexible bronchoscopy, diagnostic – brush biopsy of all segments	B	2590	293	6
Transbronchial lung biopsy via flexible bronchoscope	B	1724	150	6
Bronchoscopy with palliative endobronchial tumor resection including laser or cryotherapy, add	B	731	54	TU

Chapter 9: Respiratory System	List	Code	Units Gen	Units An
Incision				
Tracheostomy	D	697	185	6
Change of tracheostomy tube			VF	
Creation of tracheo-oesophageal fistula	D	702	154	4
Insertion of voice prosthesis	B	703	20	4
Excision				
Segmental resection of cervical trachea	D	2485	600	24
Resection of mediastinal trachea with either sternotomy or thoracotomy	D	2486	700	24
Repair				
Tracheal trauma				
Tracheorrhaphy				
Cervical	D	706	150	6
Intrathoracic	D	2490	308	13
Closure of tracheostomy or tracheal fistula	D	707	115	6
Closure of tracheoesophageal fistula	D	708	593	13
Tracheoplasty: plastic operation on trachea	D	705	IC	13
Section 5: Chest Wall and Mediastinum				
Endoscopy				
Thoracoscopy +/- biopsy	B	735	92	6
Mediastinoscopy	B	713	185	6
Mediastinopleuroscopy	B	2509	254	6
Incision				
Mediastinotomy with drainage	D	709	308	12
Excision				
Chest wall tumor involving ribs or cartilage	D	711	385	12
with prosthetic reconstruction of chest wall	D	2507	539	12
Mediastinal tumor	D	712	700	12
Anterior mediastinotomy	D	2508	254	6
Repair				
Reconstruction of pectus excavatum	D	710	625	12
Rewiring of the Sternum	D	820	154	10
Surgical collapse, thoracoplasty				
One stage	D	714	308	10
Multistage, each	D	715	185	10
Schede's operation	D	716	370	5
Pneumolysis				
Intrapleural	D	717	139	5
Extrapleural	D	718	231	5
Apicolysis				
Intrafascial or extrafascial	D	719	231	5
Extrapleural	D	720	231	5
Pneumothorax				

Chapter 9: Respiratory System	List	Code	Units Gen	Units An
First	C	721	23	
Subsequent	C	722	12	5
Phrenicotomy	D	723	92	5

Section 6: Lungs and Pleura

Incision				
Tube thoracostomy with water seal				
Pneumothorax or effusion	B	724	38	4
Drainage of empyema, aftercare extra	C	725	115	6
Drainage of lung abscess	D	726	277	13
Talc Slurry Pleurodesis Thoracostomy, solo procedure	B	8146	50	4
Thoracotomy – exploratory, including biopsy and/or removal of foreign body	D	727	277	13
With repair of lung fistula	D	2495	IC	13
With control of haemorrhage (includes postoperative haemorrhage)	D	2496	277	13
With talc poudrage	D	2499	462	15
With pulmonary decortication				
Partial	D	2498	462	15
Total	D	2497	539	15
With decortication and muscle graft closure of bronchopleural fistula	D	2500	539	15
Biopsy of pleura or lung – open	D	728	277	13
Excision				
Pneumonectomy	D	729	625	13
Lobectomy, total or segmental	D	730	625	13
With concomitant decortication	D	2505	639	15
Wedge resection, single or multiple	D	732	450	13
With pleurectomy	D	779	639	13
Sleeve resection with lobectomy	D	2506	616	13
Pleurectomy, any type (independent procedure)	D	733	462	15
Resection of bullae	D	734	462	15
With pleurectomy	D	782	639	15

	List	Code	Units Gen	Units An

CHAPTER 10: CARDIOVASCULAR SYSTEM

See legend – Chapter 3, Section 1.7 for description of lists A, B, C and D.

Section 1: Veins

Repair				
Major peripheral vein	D	1970	154	5
With graft	D	1971	231	5
Venous anastomosis				
Portocaval	D	737	850	10
Splenorenal				
Proximal	D	738	850	10
Distal	D	2510	900	10
Mesocaval +/- graft	D	739	850	10
Resection of A-V aneurysm or fistula +/- graft	D	740	IC	10
Creation of A-V fistula	D	741	277	8
Revision, reversal or closure of arteriovenous fistula	D	783	114	8
Insertion or removal of peritoneal/venous shunt (Denver)	D	840	254	8
Suture				
Declotting of shunt	D	2511	75	6
Ligation				
Jugular vein, internal	D	742	115	10
Femoral	D	743	116	5
Inferior vena cava, ligation or placation	D	744	308	10
Insertion of special transvenous devices	D	2512	150	10
Popliteal	D	745	115	5
Saphenous	C	746	38	4
Excision, ligation, injection				
Injection				
Single	C	747	8	4
Multiple at same sitting	C	748	15	4
Ligation, multiple – one leg	D	749	92	4
Ligation, long saphenous, saphenofemoral junction – one leg	D	750	92	4
Ligation – long saphenous – one leg with stripping	D	751	139	4
With multiple low ligation – ligation of perforators	D	752	154	4
Ligation and stripping – short saphenous	D	753	77	4
Long and short saphenous veins – one leg	D	754	192	4
With multiple low ligation	D	2178	231	4
High ligation – bilateral with stripping	D	755	231	4
With multiple low ligation	D	756	269	4
Bilateral long and short saphenous – high ligation				

	List	Code	Units Gen	Units An
and stripping	D	757	308	4
With multiple low ligation	D	2177	385	4
Recurrent complicated varicose veins	D	758	IC	4
Excision of ulcer, multiple ligation of veins and skin graft				
One leg	D	759	192	4
Both legs	D	760	308	4
Above plus sympathectomy – extra	D	761	115	6
Excision of stasis ulcer and skin graft				
One leg	D	762	123	4
Both legs	D	763	158	4
Subfascial ligation	D	764	231	4
With stripping of veins	D	765	308	4
Thrombectomy, iliac or femoral	D	766	385	8

Section 2: Arteries

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

	List	Code	Units Gen	Units An
Excision and/or repair (repair of artery implies endarterectomy and/or bypass graft and includes thrombo/embolectomy of vessels in the same area or through the same incision).				
Glomectomy – unilateral	D	2521	150	10
Carotid body tumor	D	794	462	15
Carotid endarterectomy	D	1973	700	15
Carotid aneurysm – reconstruction or excision with graft	D	2523	462	15
Aortic arch reconstruction; innominate, subclavian and/or vertebral	D	2525	539	15
With thoracotomy, add	D	2526	139	TU
Ruptured, add	D	798	165	TU
Subclavian aneurysm – reconstruction or excision with graft	D	2527	462	15
Thoracic aorta aneurysm – repair or excision with graft				
Ascending	D	773	1120	45
Arch	D	774	1322	45
Descending +/- temporary shunt	D	2528	1066	IC
With rupture (thoracic or abdominal) add	D	846	165	TU
Thoraco-abdominal aneurysm	D	799	IC	IC
Abdominal aorta aneurysm	D	775	925	17
Plus implantation of major branch or reconstruction of iliac arteries	D	2529	1070	17
With rupture (thoracic or abdominal) add	D	846	165	TU
Renal artery – endarterectomy	D	1974	539	10
Aneurysm – reconstruction or excision with graft	D	2536	539	10
Splenic artery aneurysm – reconstruction or excision with graft	D	777	385	12
Mesenteric or coeliac artery repair – aneurysm	D	2533	385	10
Removal of band only	D	2534	385	10
Endarterectomy or graft	D	2535	462	10
Aortoiliac repair				
Bifurcation – repair only	D	784	693	17
Plus common femoral repair				
Unilateral	D	2530	743	17
Bilateral	D	2531	900	17
Iliac repair	D	785	539	17
Iliofemoral bypass graft	D	2537	500	17
Common femoral/profunda femoris repair (when sole procedure performed)	D	2538	385	10
Extended profundoplasty	D	2524	575	10
Axillofemoral or femorofemoral graft	D	2339	539	12
Aortofemoral unilateral graft	D	2340	539	17
Femoropopliteal endarterectomy and/or bypass graft (synthetic)	D	2539	539	10
Femoral or popliteal aneurysm – excision, reconstruction or ligation	D	780	385	10

	List	Code	Units Gen	Units An
With graft	D	781	539	10
Repair of Femoral False Aneurysm	D	8131	667	10
Femoro-ante/posttibial endarterectomy and/or bypass graft (synthetic)	D	2179	575	10
Femoropopliteal/tibial vein graft	D	786	700	10
Removal of infected Aortic/Femoralpopliteal Bypass Graft	D	8091	258	10
In situ saphenous vein arterial bypass				
Femoral/popliteal	D	787	945	10
Femoral/tibial or peroneal (trifurcation)	D	795	1135	10
Femoral/pedal	D	796	1300	10
Reversed vein distal bypass graft with mid-calf vein implantation	D	788	945	10
Arterioplasty +/- patch graft	D	804	231	10
Auto Transfusion	C	8092	77	
Miller Cuff, (add-on)		8089	100	
Peripheral arteries other than listed – aneurysm	D	2540	300	10

Section 3: Heart and Pericardium

3.1 Preamble - Catheterization

a) Therapeutic catheterization fees (service codes 814 to 819, Chapter 10, Section 3.4) include all same-day heart and coronary catheterization and angiography except when done for the first time or when more than 30 days have elapsed since angiography was last performed. In such cases either service code 1870 or 1871, (Chapter 10, Section 3.2) is payable in addition.

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

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

d) Procedure service codes 814 to 819, Chapter 10, Section 3.4, include usual preoperative and postoperative care; intensive care (except on the day of the procedure) and preoperative consultations are payable as for major surgery. After-hours premiums apply only to consultations and to procedures done under general anaesthesia.

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

3.2 Diagnostic Procedures

Atrial or ventricular puncture	B	1921	77	5
Catheterization, right heart	B	1918	115	5
Hepatic wedge pressure	B	1919	77	4

	List	Code	Units Gen	Units An
Catheterization, left heart, retrograde	B	1864	177	5
Intercoronary Ultrasound, add	B	8086	60	TU
Coronary Pressure Derived Fractional Flow Reserve add	B	8087	60	TU

☞ ***Medicare Note: Service Code 8086 and 8087 are add-on codes to Service Codes 814 and 1864 and are billable once per patient per procedure.***

Transseptal catheterization	B	1865	255	5
Selective coronary catheterization and angiograms, add	B	1866	100	TU
Bypass graft catheterization, each, add	B	1867	67	TU
Internal mammary graft (subclavian), add	B	1868	67	
Angiography, except coronary, all injections, add	B	1869	49	TU
Diagnostic left +/- right heart angiography plus coronary angiography done at the time of angioplasty, when payable, total add-on fee	B	1870	159	TU
Diagnostic coronary angiography done at the time of angioplasty, when payable, total add-on fee	B	1871	87	TU
Selective pulmonary catheterization, add	B	1872	40	TU
Assessment of pulmonary vascular resistance changes (includes all agents), add	B	1873	55	TU
Ergonivine stimulation test, add	B	1874	85	TU
Studies: Fick determination, thermodilution cardiac output, metabolic studies, oxymetry, isotope studies, etc, per series, add	B	1875	29	TU
Ascending aortogram (for aortic pathology),add	B	1876	48	TU
Percutaneous myocardial biopsy, add	B	1877	78	TU

3.3 Electrophysiology and Pacemakers

Introduction of catheter pacemaker	B	825	154	5
Insertion of internal pacemaker				
Thoracotomy and implantation of electrodes into myocardium	D	826	385	20
Insertion of permanent external pacemaker and placement of transvenous electrodes				
Team procedure				
Cardiologist	D	2009	192	9
Surgeon	D	2009	192	9
Solo procedure	D	2010	308	9
Replacement or readjustment of transvenous electrodes				
Team procedure				
Cardiologist	D	2011	115	9
Surgeon	D	2011	115	9
Solo procedure	D	2012	154	9
Placement of pulse generator only				
Team procedure				
Cardiologist	D	2025	115	9
Surgeon	D	2025	115	9

	List	Code	Units Gen	Units An
Solo procedure	D	2026	154	9
Two-chamber pacings,				
Team procedure				
Cardiologist	D	1912	288	9
Surgeon	D	1912	288	9
Solo procedure	D	1913	410	9
Reprogramming of Pacemaker			VF	
Removal or insertion of implantable loop recorder	D	8125	154	5

Refer to Chapter 5, Section 7.7 for "follow-up Pacemaker visits".

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

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

Electrophysiologic study with programmed stimulation of atria or ventricles and/or endomyocardial mapping	D	1878	330	9
Repeat electrophysiological study to assess response to medication or surgery	D	1879	165	9
His bundle and atrial pacing	D	1880	165	9

3.4 Therapeutic Procedures

Intraaortic balloon pump, percutaneous (includes removal)	C	812	257	10
Decannulation by another physician	C	813	54	5
PTCA (percutaneous transluminal coronary angioplasty),				
one vessel, all lesions	D	814	445	20
additional vessel, add	D	815	176	TU
Insertion of intracoronary Stents, add on	D	8071	100	

☞ ***Medicare Note: Service Code 8071 is not billable with service code 1864. Billable once per vessel to a maximum of 3 vessels.***

Intracoronary Ultrasound, add	B	8086	60	TU
Coronary Pressure Derived Fractional Flow Reserve add,	B	8087	60	TU

☞ ***Medicare Note: Service Code 8086 and 8087 are add-on codes to Service Codes 814 and 1864 and are billable once per patient per procedure.***

Percutaneous balloon valuloplasty	D	816	458	20
Percutaneous angioplasty for coarctation of aorta	D	817	367	20
Percutaneous closure of patent ductus arteriosus	D	818	341	20
Creation of ASD by balloon septostomy	D	819	270	20

	List	Code	Units Gen	Units An

Section 4: Cardiac Surgery

4.1 General

Pump bypass and/or cardiac mechanical stabilization to include cannulation, decannulantion and supervision, add	D	8000	310	TU
Re-operation with pump and/or cardiac mechanical stabilization more than one month after original operation , add	D	8001	548	TU

☞ ***Medicare Note: A fee of 45 anaesthesia basic units shall apply to any surgery requiring pump bypass.***

Circulatory assist device, e.g. intraaortic balloon (includes daily care & supervision), open, decannulation extra	D	8002	295	15
percutaneous; see Interventional Cardiology				
Decannulation of circulatory assist device (Includes repair of artery) – open	A	8003	118	10
Repositioning of intra-aortic balloon pump (Beyond 24 hours or original insertion) – open	A	8004	123	15

Preliminary diagnostic catheterization extra.

4.2 Incision and/or Excision

Cardiac massage – open, add to surgery fee	D	8005	154	TU
Rewiring of Sternum	D	820	154	10
Pericardiectomy				
One side open	D	8006	476	20
Both sides open or sternal splits	D	8007	782	20
Cardiotomy with exploration and/or removal of foreign body or tumor and/or ligation of left atrial appendage	D	8008	543	20
His bundle ablation and/or division or accessory conduction pathway (to include cardiotomy and mapping)	D	8010	748	45
Resection/ablation for ventricular tachycardia (to include cardiotomy, mapping, with or without His bundle)	D	8011	953	45
Excision – tumour of ventricular wall	D	8012	892	45
Ventricular aneurysm	D	8013	845	45
Aneurysm of sinus of Valsalva	D	8014	845	45
Excision of extensive endocardial scar, add to ventriculotomy or aneurysm repair	D	8015	123	TU
Ligation or division of patent ductus arteriosus				
Under 16	D	8016	520	20

	List	Code	Units Gen	Units An
Adult	D	8017	684	20
Interruption of bronchial collateral arteries (one or more)				
Sole procedure	D	8018	684	20
When done in conjunction with other cardiac surgery, add	D	8019	171	TU
Resection of coarctation of aorta				
Under 16	D	8020	616	20
Adult	D	8021	756	20
Congenital heart procedures – e.g. Blalock, Glenn, Potts, Waterston or Central	D	8022	600	20
Creation or atrial septal defect by thoracotomy or Sterling Edwards	D	8023	600	20
Closure of atrial septal defect: secundum	D	8024	684	45
With anomalous pulmonary venous drainage	D	8025	771	45
Endocardial cushion and valve defect	D	8026	1018	45
Closure of ventricular septal defect(s)	D	8027	927	45
Donor cardiectomy	D	8028	415	20
Donor heart-lung removal	D	8029	531	20
4.3 Repair				
Coronary endarterectomy	D	8030	783	45
When done in conjunction with coronary artery repair, add	D	8031	189	TU
Coronary artery bypass/repair				
One	D	8032	915	45
Two	D	8033	1145	45
Each additional	D	8034	165	TU
Use of internal mammary for construction of bypass graft, add	D	8035	171	TU
Total repair Tetralogy of Fallot	D	8036	1019	45
with previous arterial shunt	D	8037	1159	45
Total anomalous pulmonary venous drainage	D	8038	879	45
Total correction transposition or great vessels	D	8039	879	45
Arterial repair of transposition	D	8040	1318	45
Complete A-V canal	D	8041	1157	45
Single ventricle	D	8042	1318	45
Double outlet – right/left ventricle	D	8043	1019	45
Double outlet ventricle with transposition	D	8044	1318	45
Truncus arteriosus	D	8045	1318	45
Interrupted aortic arch	D	8046	1157	45
Aorto-pulmonary window	D	8047	737	45
R-V outflow tract with valve and tubular graft	D	8048	832	45
Debanding arterioplasty or pulmonary artery	D	8049	546	20
Pulmonary artery banding	D	8050	737	20
Correction or cor triatriatum	D	8051	737	45
Vascular ring	D	8052	546	20

Chapter 10: Cardiovascular System	List	Code	Units Gen	Units An
4.4 Valves				
Pulmonary valvotomy	D	8053	828	45
Pulmonary valvotomy and infundibular resection	D	8054	933	45
Pulmonary valve replacement	D	8055	933	45
Tricuspid valvotomy	D	8056	882	45
Tricuspid annuloplasty	D	8057	782	45
Tricuspid valve replacement	D	8058	933	45
Mitral valvotomy	D	8059	805	45
Mitral valvotomy – restenosis	D	8060	871	45
Mitral annuloplasty	D	8061	871	45
Mitral replacement	D	8062	1015	45
Mitral valvoplasty	D	8063	968	45
Aortic valvuloplasty	D	8064	871	45
Aortic valvotomy	D	8065	849	45
Aortic infundibular resection (ventriculomyotomy)	D	8066	969	45
Aortic valve replacement	D	8067	1019	45
Transcatheter aortic valve implantation – Cardiac surgery	D	8130	1019	45
Patch aortoplasty with pericardium or graft, add	D	8068	171	TU
Aortic annuloplasty (reconstruction and enlargement of aortic annulus) add	D	8069	270	TU
Replacement of aortic valve, of ascending aorta and reimplantation of coronary arteries (modified Bentall procedure)	D	8070	1889	45

	List	Code	Units Gen	Units An

CHAPTER 11: HAEMIC AND LYMPHATIC SYSTEMS

See Legend – Chapter 3, Section 1.7 for description of lists A, B, C and D.

Section 1: Spleen and Marrow

	List	Code	Units Gen	Units An
Incision				
Splenic puncture – biopsy	A	1954	46	
For injection of contrast substance	A	864	46	
Excision				
Splenectomy	D	865	308	7
See also: laparotomy for acute trauma				
Hodgkin's disease – staging, laparotomy, splenectomy, liver biopsy and retroperitoneal node biopsy	D	2341	385	7
Biopsy of marrow				
Aspiration, needle or punch	B	866	38	4
Bone button	B	867	46	4
Iliac crest open biopsy	B	1961	115	4

Section 2: Lymph Channels

	List	Code	Units Gen	Units An
Excision				
Cystic hygroma	D	868	277	6
Lymphoedema				
Kondoleon	D	869	277	4
Radical sleeve excision	D	870	539	6
Lymphangiogram	B	871	139	4
Excision of lymph glands				
Tumor, suprahyoid				
Unilateral	D	872	231	6
Bilateral	D	873	346	6
Radical neck dissection	D	874	508	14
Dissection of inguinal glands	D	875	231	4
Radical dissection of axillary glands	D	876	350	4
Radical dissection of inguinal glands including iliac glands	D	877	339	6
Radical dissection of inguinal and iliac glands, bilateral	D	878	508	6
Radical retroperitoneal node dissection	D	2019	508	8
Biopsy – cervical, axillary, inguinal	B	879	66	4
Scalene	B	880	92	4
Sentinel node Biopsy				
solo procedure	D	843	350	
in conjunction with another procedure – add on	D	844	200	

☞ ***Medicare Note: Service Code 843 and 844 are not payable in addition to Service Code 409.***

	List	Code	Units Gen	Units An

CHAPTER 12: DIGESTIVE SYSTEM

See legend – Chapter 3, Section 1.7 for description of lists A, B, C and D.

Section 1: Mouth

Incision				
Drainage of Ludwig's angina, complete care	D	881	98	5
Excision				
Biopsy	B	882	31	4
Excision of simple lesion	C	883	31	4
Excision of leukoplakia				
Limited	C	884	46	4
Extensive	D	885	185	4
Excision of ranula or dermoid cyst	D	886	92	4
Local excision for carcinoma of floor of mouth, mandible, alveolar margin or buccal mucosa	D	887	139	4
With hemimandibulectomy	D	889	308	10
Either of above combined with unilateral neck dissection	D	890	616	14
Composite resection of lesion of oral cavity and/or oropharynx with partial resection of mandible	D	1774	500	12
Extended resection, as above with partial resection of maxilla	D	1775	650	12
Destruction				
Cauterization of leukoplakia	C	891	46	4
Suture				
Closure of antro-oral fistula				
With flap	D	892	231	4
With radical antrotomy	D	893	269	4

Section 2: Lips

Excision				
Biopsy	B	894	31	4
Lip shave	D	895	154	4
Excision of simple lesion	C	896	31	4
V-excision for carcinoma	D	897	139	4
Plus radical neck dissection	D	898	500	14
Excision one-half lip plus reconstruction, one or more stages, total fee	D	899	308	4
Plus radical neck dissection	D	900	539	14
Total excision of lip plus reconstruction, one or more stages, total fee	D	901	462	6
Plus radical neck dissection	D	902	539	14

	List	Code	Units Gen	Units An
Repair				
Hare lip				
Unilateral	D	903	231	8
Bilateral	D	904	385	8

Section 3: Tongue

Excision				
Biopsy	B	905	31	4
Local excision of simple tumor	D	906	92	4
Hemiglossectomy	D	907	254	8
Plus radical neck dissection	D	908	593	14
Total glossectomy	D	909	305	8
Plus radical neck dissection	D	910	593	14
Repair				
Suture of extensive lacerations	D	911	IC	4
Minor lacerations	C	912	23	4

Section 4: Teeth and Gums

Incision				
Drainage of alveolar abscess – general anaesthetic	C	913	52	4
Excision				
Biopsy of gum	B	914	31	4
Dentigerous cyst	D	915	185	4
Mucous cyst	C	916	52	4
Suture				
Suture of gum, secondary	C	917	31	4

Section 5: Palate and Uvula

Incision				
Palate abscess	C	918	52	4
Excision				
Uvulectomy – independent procedure	C	919	52	4
Biopsy	B	920	31	4
Excision of simple lesion	C	921	46	4
Excision of malignant lesion with reconstruction	D	922	IC	4
Repair				
Cleft palate	D	923	269	8
Revision, with bone graft	D	2291	308	8
Suture				
Suture of palate wound	C	924	23	4

	List	Code	Units Gen	Units An
Uvulopalatopharyngoplasty	D	828	225	4
Push-back of palate and/or pharyngeal flap	D	925	346	8
Repair of palate fistula	D	2292	231	8
Section 6: Salivary Glands and Ducts				
Incision				
Sialolithotomy, under general anaesthesia – simple	C	926	46	4
Complicated	D	927	139	4
Excision				
Submandibular gland	D	928	185	4
Parotid gland – excision of tumor only	D	929	277	6
Superficial parotid lobectomy	D	1976	484	7
Total parotidectomy	D	930	571	8
Plus radical neck dissection	D	931	825	14
Repair				
Plastic repair of duct	D	932	192	4
Relocation or repositioning, submandibular duct	D	1975	290	4
Dilation of duct as independent procedure	C	933	59	4
Probing				
Duct	C	934	29	
Catheterization for sialogram	C	935	59	4
Section 7: Pharynx, Adenoids and Tonsils				
Incision				
Biopsy of pharynx	B	936	31	4
Fine needle aspiration of tonsillar abscess	B	1801	15	
Drainage of retropharyngeal abscess				
Internal approach	B	937	77	4
External approach	D	938	136	4
Drainage of peritonsillar abscess, operation only	C	939	44	4
Excision				
Branchial cyst	D	940	231	4
Branchial sinus	D	941	308	4
Pharyngo-oesophageal diverticulum	D	942	385	4
Thyroglossal duct cyst	D	943	192	4
Cyst and sinus	D	944	277	4
Tonsillectomy +/- adenoidectomy				
Under 16	D	945	90	4
Adult	D	946	120	4
Adenoidectomy	D	863	68	4
Excision of tonsil tag, unilateral	D	947	62	4
Excision of lingual tonsil (independent procedure)	D	948	62	4

	List	Code	Units Gen	Units An
Excision of tumor of parapharyngeal space	D	1776	500	8
Pharyngectomy, transhyoid or lateral	D	1727	520	9
Repair				
Choanal atresia	D	949	385	8
Choanal atresia dilation				
Initial	C	2038	59	4
Repeat	C	2039	40	4
Push–back flap (pharyngeal)	D	950	346	8
Retropharyngeal insertion of plastic for rhinolalia	D	951	115	4
Suture				
Suture of external wound or injury of pharynx	D	952	IC	4

Section 8: Oesophagus

Dilation of oesophagus				
Active +/- guiding string	B	982	66	4
Passive, using mercury filled tubes	B	983	35	4
Dilation, pneumatic dilator	B	984	66	4
Retrograde dilation	B	985	43	4
Dilation under fluoroscopic control	B	988	74	4
Dilation with oesophagoscopy, indirect				
Initial	D	986	185	4
Repeat	D	987	93	4
Upper Gastrointestinal Botulinum toxin injection for Achalasia via Endoscopy	D	8137	147	4

☞ ***Medicare Note: Can only be billed for conditions approved by Medicare as guided by Health Canada indications.***

Endoscopy (See also Chapter 2, Assessment Rules 32 and 33)				
Oesophagoscopy +/- biopsy	B	964	97	4
With removal of foreign body	D	965	154	4
Introduction of Souttar tube – via oesophagus	D	968	115	4
Blakemore tube	D	967	100	4

☞ ***Medicare Note: Gastroscopy payable in addition to service codes 967 and 968.***

Insertion of Wall Stents – includes Endoscopy	D	8957	250	4
Endoscopic Haemostasis	D	1003	206	4
Repeat within 30 days	D	1005	103	4
Injection				
Oesophageal varices with oesophagoscopy				
Initial	D	979	206	4
Repeat	D	966	103	4
Introduction of Mousseau or Bardin tube	D	981	231	6
Incision				
Cervical oesophagostomy				

Chapter 12: Digestive System	List	Code	Units Gen	Units An
Adult	D	953	231	6
Newborn	D	2542	308	13
Thoracic oesophagostomy	D	954	308	13
Heller procedure	D	955	462	13
Total thoracic oesophageal myotomy when sole procedure performed	D	2543	562	13
Excision				
Intrathoracic diverticulum or leiomyoma of oesophagus	D	956	407	13
Cricopharyngeal diverticulum or cricopharyngeal myotomy	D	957	346	13
Endoscopic treatment of cricopharyngeal diverticulum by endoscopy	D	8120	250	4
Radiofrequency ablation for Barrett's esophagus dysplasia – Halo 360 and Halo 90	D	8625	250	
Endomucusal resection of esophageal lesion	D	8626	153	
Oesophageal resection, including reconstruction				
1st surgeon	D	1784	900	15
2nd surgeon	D	1785	500	
Oesophagogastrectomy	D	962	678	13
Oesophageal bypass with colon or jejunum when sole procedure performed	D	963	593	13
Repair				
Oesophagoplasty (repair of stricture)	D	969	508	13
Oesophageal hiatus hernia				
Abdominal approach	D	970	385	7
Laparoscopic Nissen Fundoplication	D	8114	385	7
Plus cholecystectomy, if indicated	D	971	555	7
Transthoracic approach	D	972	500	13
With gastroplasty or intrathoracic fundal placation	D	2547	515	13
Recurrent hiatus hernia				
Abdominal or transthoracic approach	D	2342	539	13
Thoracoabdominal approach	D	2548	639	13
With myotomy, add	D	2549	91	TU
Rupture oesophagus	D	973	424	13
Cervical drainage	D	974	269	6
Transabdominal repair of diaphragmatic rupture	D	977	500	13
Oesophagogastrostomy	D	975	593	7
Oesophagoduodenostomy or oesophagojejunostomy	D	976	593	7
Oesophagotomy with ligation of varices	D	978	407	13
Section 9: Stomach				
Incision				
Gastrotomy button	A	2985	46	5
Gastrotomy with removal of tumor or foreign body	D	989	254	7
Pyloromyotomy (Ramstedt's)	D	990	254	10
Simple tube gastrostomy	D	991	254	5
In conjunction with abdominal surgery, add	D	1051	75	TU

	List	Code	Units Gen	Units An
Introduction of Souttar tube – via laparotomy	D	2546	308	7
Living tissue gastrostomy (Janeway etc,)	D	992	339	7
Percutaneous endoscopic gastrostomy				
Two physician team, per surgeon	B	1000	150	5
Solo Procedure	D	2986	204	5
Excision				
Excisional biopsy				
By gastroscopy	B	993	153	4
By gastrotomy	D	994	254	7
By intubation	B	995	34	
Gastrectomy – wedge resection for ulcer	D	996	305	7
Partial or subtotal	D	997	575	7
Plus repair of hiatus hernia	D	998	593	7
After previous gastroenterostomy or				
partial gastrectomy	D	999	593	7
Parietal cell vagotomy for peptic ulcer	D	2181	508	7
Total gastrectomy	D	1001	678	7
Excision of gastroduodenal lesion (recurrent ulcer)	D	1002	593	7
Excision of gastrojejunal lesion (recurrent ulcer)	D	1004	593	7
Revision of gastrectomy plus Roux-en-y anastomosis,				
interposition of jejunal loop or reverse jejunal loop	D	2182	593	7
Any of the above plus vagotomy, add	D	2553	127	TU
Any of the above plus cholecystectomy, add	D	1006	170	TU
Plus cholecystectomy and cholangiography, add	D	2550	204	TU
Plus choledochoscopy, add	D	2551	60	TU
Plus cholecystectomy and exploration of				
common bile duct, add	D	2552	204	TU
And cholangiography, add	D	1032	233	TU
Endoscopy				
Upper gastrointestinal tract +/- biopsy	B	964	97	4
Gastroscopy removal of foreign body	D	1007	154	4

☞ ***Medicare Note: Excludes visualization of the small bowel through the extension of a gastroscope.***

Retrograde enteroscopy through stoma	B	8084	46	4
Double Balloon Small Bowel Enteroscopy	B	8085	300	

☞ ***Medicare Note: Service Code 8085 is not payable with Service Code 964***

Endoscopic Ultrasound (See Chapter 21, Section 5)				
Capsule Endoscopy	C	8145	311	
Repair				
Pyloroplasty	D	1009	305	7
Plus vagotomy	D	1010	424	7
Vagotomy, bilateral – after previous gastric surgery				

Chapter 12: Digestive System	List	Code	Units Gen	Units An
for peptic ulcer	D	1977	254	7
Gastroduodenostomy, gastrojejunostomy, or gastrogastrostomy	D	1011	305	7
Plus vagotomy	D	1012	424	7
Pyloroplasty or gastroenterostomy with vagotomy and hiatal hernia	D	1013	508	7
Any of the above plus cholecystectomy, add	D	1014	170	TU
Suture				
Closure of gastrostomy of other external fistula of stomach	D	1015	204	5
Closure of perforated ulcer or wound of stomach	D	1016	305	7
Closure of gastrocolic or gastrojejunocolic fistula				
One stage	D	1017	593	7
Two stages including colostomy	D	1018	593	7
With vagotomy	D	2344	678	
Gastric cooling	D	1019	92	4
Bariatric Surgery				
Sleeve Gastrectomy	D	1008	834	13
Gastric banding	D	8122	569	10
Bariatric Roux-en-Y	D	8123	872	10
Bilio Pancreatic diversion	D	8124	1000	13
Section 10: Intestines (Except Rectum)				
Endoscopy				
Sigmoidoscopy +/- biopsy of rectum or sigmoid	B	2046	23	4
Fibersigmoidoscopy	B	2045	38	4
☞ ***Medicare Note: Sigmoidoscopy (service code 2046) and Fibersigmoidoscopy (service code 2045) is included in the fee for a Colonoscopy (Service code 2057)***				
Colonoscopy +/- biopsy	B	2057	165	4
With fulguration of polyp, add	B	2465	40	
Each additional polyp (max. 2)	B	2466	15	
With excision of polyp, add	B	2467	90	
Each additional polyp (max. 2)	B	2468	35	
Ileoscopy in conjunction with colonoscopy, add	B	827	46	
Endoscopic Ultrasounds (See Chapter 21, Section 5)				
Incision				
Ileostomy for ulcerative colitis	D	1020	426	6
Kock's pouch ileostomy	D	2183	428	6
Ileostomy or jejunostomy (with tube)	D	1021	355	6
Nutritional jejunostomy, in conjunction with other abdominal surgery, add	D	2987	75	TU
1st stage Mikulicz	D	1022	426	6
Colostomy	D	1023	355	6

	List	Code	Units Gen	Units An
Revision for stenosis	D	1024	92	6
Caecostomy, as single procedure	D	1025	355	6
Enterotomy or colostomy	D	1026	305	6
With operative sigmoidoscopy	D	1027	339	6
Multiple	D	1028	424	6
Colomyotomy	D	2554	385	6
Excision				
Biopsy by intubation	A	1029	46	4
Local excision of lesion of small intestine	D	1030	305	6
Preparation of intestinal segment for ureteral substitution	D	2168	339	6
Resection of diverticulum of duodenum	D	2555	359	6
Enterectomy – small intestine	D	1031	400	6
Large intestine				
Terminal ileum, caecum and ascending colon	D	1034	508	7
Partial colectomy	D	1035	478	7
Hemicolectomy				
Right	D	1036	508	7
Left	D	2556	578	7
Total colectomy				
With ileostomy – without perineal resection	D	1037	850	8
With abdominoperineal resection, single team	D	1038	900	10
Two team				
1st surgeon	D	1039	850	10
2nd surgeon	D	1040	300	
With ileorectal anastomosis	D	2184	678	8
Intestinal obstruction				
Without resection	D	1042	375	8
With Baker's jejunostomy tube, add	D	2557	100	TU
With resection	D	1043	500	8
Reduction of volvulus or intussusception, etc	D	1044	339	8
Enteroenterostomy	D	1045	339	8
Duodenal atresia – duodenojejunostomy	D	1046	375	8

Multiple stage procedures, preliminary colostomy, bowel resection, closure of colostomy, etc. to be paid at fee listed for the individual procedure.

Repair				
Faecal fistula, radical with resection	D	1047	465	6
Revision of ileostomy or colostomy	D	1048	92	6
Full thickness	D	2185	296	6
Closure of perforation	D	1049	296	6
With colostomy	D	1050	339	6
Closure of colostomy +/- resection	D	1053	350	6
Plication of small intestine for adhesions	D	1054	407	6

Chapter 12: Digestive System	List	Code	Units Gen	Units An
Manipulation				
Dilation of enterostomy, colostomy etc.				
With anaesthetic	C	1055	31	4
Without anaesthetic			VF	
Intubation of small intestine	B	1057	36	4
Revision of intestinal bypass	D	2558	462	8
Meconium ileus (Hiatt-Wilson)	D	2559	385	10
Dilation of a colonic or pyloric stricture				
Passive	B	838	35	4
With balloon	B	839	66	4
Section 11: Meckel's Diverticulum and the Mesentery				
Excision				
Meckel's diverticulum	D	1058	360	6
Local excision of lesion	D	1059	360	6
Resection of mesentery	D	1060	360	6
Section 12: Appendix				
Incision				
Drainage of abscess, complete care	D	1061	300	6
Excision				
Appendectomy	D	1062	300	6
Section 13: Rectum				
Incision				
Proctotomy – with exploration	D	1064	92	4
With decompression (imperforate anus)	D	1065	92	4
With drainage (perirectal abscess)	D	1066	92	4
Pelvic abscess – drainage	D	1067	127	4
Manipulation				
Anorectal manometry	B	1073	38	
Excision				
Proctectomy – anterior resection of rectum	D	1068	725	7
Proctectomy/Pelvic Pouch procedure	D	802	939	8
Perineal resection of rectum	D	1069	407	7
Abdominoperineal resection plus colostomy				
Single team	D	1070	850	10
Two team				
1st surgeon	D	1071	800	10
2nd surgeon	D	1072	300	
Hartmann procedure	D	1074	500	7
Colonic reconstruction – following				
Hartmann procedure	D	2186	600	7
Abdominoperineal pull-through for Hirschsprung's disease				

Chapter 12: Digestive System	List	Code	Units Gen	Units An
or imperforated anus	D	1075	593	8
Proctosigmoidectomy for prolapse	D	1079	508	8
Transrectal excision of large villous adenoma of rectum	D	2560	265	4
Posterior approach for excision of rectal lesion with resection of sacrococcygeal segment	D	2561	265	6
Polyp excision or cauterization – low rectum	B	1080	46	4
Upper rectum and sigmoid through sigmoidoscope	B	1081	92	4
Biopsy of rectosigmoid for Hirschsprung's disease	B	1082	62	4
Rectal disimpaction	C	2850	23	
Repair				
Excision of mucous membrane	D	1085	154	4
Major repair				
Perineal approach	D	1086	305	4
Abdominal approach	D	1087	525	7
Thiersch wire procedure	D	1088	101	7
Suture of rectum				
External approach	D	1089	204	4
Intraperitoneal approach	D	1090	339	7
Closure of fistula				
Rectovaginal	D	1091	339	6
Rectovesical	D	1092	339	6
Section 14: Anus				
Incision				
Thrombosed haemorrhoid				
Local anaesthetic	C	1093	23	
General anaesthetic	C	1094	38	4
Excision				
Local excision of anal lesion such as fissure or malignancy (including sphincterotomy)	D	1095	92	4
Haemorrhoidectomy (sigmoidoscopy extra if not performed in preceding 30 days)	D	1096	154	4
With excision of anal fissure, add	D	1095	50%	TU
Using rubber band technique or infrared coagulation	C	1980	50	
Anal polyp, haemorrhoidectomy tags	C	1097	46	4
Fistula-in-ano – low level	D	1098	154	4
High level with division of internal sphincter	D	1099	277	4
Biopsy – general anaesthesia	B	1100	31	4
Introduction				
Haemorrhoid injections				
Initial	A	1101	15	
Subsequent	A	1102	8	
Injections for pruritus ani or fissure	A	1103	15	4

	List	Code	Units Gen	Units An
Dilation of anal fistula	B	1083	43	4
Repair				
Excision of scar for stenosis	D	1104	92	4
Anoplasty for stenosis	D	1105	185	4
Repair of anal sphincter	D	1106	231	4
Plus repair of anorectal ring	D	1107	254	4
Repair of imperforate anus – membranous obstruction of anus	D	1108	92	4
Rectal atresia – perineal repair	D	1109	407	4
Abdominoperineal repair	D	1110	508	10
With normal anal canal – abdominoperineal repair	D	1114	593	10
Destruction				
Cauterization of fissure	C	1118	15	4
Electrodesiccation of condylomata	C	1119	77	4
Manipulation				
Dilation of anal sphincter under general anaesthesia (independent procedure)	C	1120	15	4
Section 15: Liver				
Incision				
Hepatotomy – exploratory	D	1121	305	8
Drainage of abscess or cyst	D	1122	305	8
Removal of foreign body	D	1123	305	8
Incision and packing of wound	D	1124	305	8
Excision				
Hepatectomy – local excision of lesion	D	1125	305	7
Left lobectomy	D	1126	678	12
Partial lobectomy	D	2562	447	12
Extended or complete right lobectomy	D	2563	823	12
Biopsy – needle	B	1953	38	4
Wedge/Open liver biopsy, add (when performed in addition to abdominal surgery)	B	2989	54	TU
Repair				
Marsupialization of cyst or abscess	D	1128	305	7
Suture				
Rupture or wound	D	1129	305	7
Section 16: Biliary Tract				
Endoscopy				
Cholecystoscopy	B	2983	100	6
Endoscopy retrograde cholangiopancreatography (ERCP), +/- biopsy, +/- cytology	B	2875	202	6

	List	Code	Units Gen	Units An
Endoscopic sphincterotomy, add	B	2894	90	TU
Endoscopic placement of biliary or pancreatic duct stent, add	B	2895	77	TU
Biliary lithotripsy, add	B	2984	77	TU
Extraction of common bile duct stones, add	B	2896	77	TU
Balloon dilatation of common bile duct or pancreatic duct stricture, add	B	2897	77	TU
Nasobiliary drainage, add	B	2898	77	TU
Incision				
Cholecystostomy	D	1130	254	7
Cholecystoenterostomy, including enteroenterostomy	D	1131	400	7
Plus gastroenterostomy	D	2565	508	7
Cholecystogastrostomy	D	1133	305	7
Choledochoduodenostomy or choledochoenterostomy	D	1134	508	7
Common bile duct exploration	D	1135	407	7
With duodenotomy, sphincterotomy	D	1136	508	7
Plus sphincteroplasty, add	D	2566	58	TU
Plus pancreatogram, add	D	2567	58	TU
Plus internal drainage of pancreatic cyst, add	D	2568	255	TU
Plus external drainage of pancreatic cyst or abscess, add	D	2569	250	TU
Open pancreatic biopsy, additional	B	2988	58	TU
Excision				
Lesion of hepatic ducts	D	1137	465	7
Excision of ampulla of Vater	D	1139	465	7
Cholecystectomy (by laparoscopy or laparotomy)	D	1140	339	7
With operative cholangiogram	D	1141	407	7
Cholecystectomy and exploration of bile duct	D	1142	420	7
With operative cholangiogram	D	1143	482	7
Plus duodenotomy	D	1144	524	7
Plus pancreatogram, add	D	2570	58	TU
Plus internal drainage of pancreatic cyst, add	D	2571	255	TU
Plus external drainage of pancreatic cyst or abscess, add	D	2572	250	TU
Excision of gallbladder remnant or cystic duct remnant	D	2573	370	7
Plus cholangiogram, add	D	2574	58	TU
With exploration of common bile duct and Cholangiogram	D	2575	539	7
Choledochoscopy in addition to bile duct surgery, add	D	1138	60	TU
Any bile duct surgery plus hiatal hernia repair,add	D	2576	193	TU
Repair				
Surgical reconstruction of common bile duct	D	1145	678	7

Chapter 12: Digestive System	List	Code	Units Gen	Units An
Transhepatic hepaticojejunostomy with stent (Rodney-Smith)	D	2577	786	12
Suture				
Closure of fistula	D	1146	423	7
Section 17: Pancreas				
Incision				
Pancreatotomy	D	1147	425	7
Pancreatic abscess or cyst	D	1148	500	7
Excision				
Pancreatectomy – total	D	1149	1000	7
Local excision of lesion	D	1150	407	7
Distal pancreatectomy and splenectomy	D	1151	900	7
Pancreaticoduodenal resection (Whipple type operation)	D	1152	1000	12
Excision pancreatic cyst	D	1153	407	7
Repair				
Pancreatic cystogastrostomy (by laparotomy)	D	1154	510	7
Pancreatic cystoduodenostomy (by laparotomy)	D	1155	510	7
Pancreatic cystojejunostomy				
Side to side	D	1156	510	7
Roux-en-Y	D	2578	580	7
Longitudinal pancreatic jejunostomy (Puestow)	D	2971	804	12
Marsupialization of cyst	D	1157	425	7
Pancreatic cyst gastrostomy or duodenostomy by endoscopy	D	8139	250	4
Section 18: Abdomen, Peritoneum and Omentum				
Introduction				
Injection of air	B	1168	31	
Endoscopy				
Peritoneoscopy (laparoscopy)	B	1169	150	6
Cautery/fulguration of Endometriosis (add-on to 1169)		8083	40	
Therapeutic laparoscopy with laser				
Including the first ½ hour	D	2975	169	6
Each additional ¼ hour	D	2976	30	TU

☞ ***Medicare Note: Laser treatment fees include intraoperative biopsies. The time elapsed must be noted on the claim form.***

Incision				
Diagnostic laparotomy with the finding				

	List	Code	Units Gen	Units An
of non-resectable cancer	B	1078	137	6
Laparotomy +/- biopsy	D	1158	192	6
Mini-laparotomy	D	2990	137	6
Lysis of adhesions	D	1033	IC	6

☞ ***Medicare Note: Service code 1033 applies only in cases of special difficulty (see Surgical Preamble, Chapter 6, Section 1). Normally no payment will be made under this service code when the fees for concurrent procedures exceed 192 units.***

Multiple system trauma – laparotomy for acute trauma	D	2456	265	10
Post cancer treatment laparotomy, or staging laparotomy, for ovarian carcinoma	D	2954	350	7
Peritoneal abscess – drainage of subphrenic abscess	D	1159	305	7
Intraabdominal abscess, other	D	1160	300	6
Drainage of abdominal wall abscess, general anaesthetic	B	1161	46	4
Removal foreign body, abdominal wall				
Gun shot	D	1162	IC	6
Removal of deep infected sutures (not applicable to operating surgeon during postoperative period)	D	2188	92	4
Debridement of Wounds (When preformed under general anaesthetic or major nerve block), per 15 minutes	D	8090	50	4
Excision				
Desmoid tumor, depending on extent	D	1163	IC	4
Omentectomy (cancer related) with major surgery, add	D	2991	96	TU
Umbilectomy, plastic	D	1164	92	4
Lipectomy, removal of panniculus	D	1165	693	10

☞ ***Medicare Note: Abdominoplasty: To determine the coverage status of proposed surgery. See Plastic Surgical Preamble, Chapter 20, Section 1.***

Retroperitoneal tumor	D	1166	370	6
Mesenteric cyst	D	1167	231	6
Repair				
Herniotomy and herniorrhaphy				
Inguinal or femoral				
Single	D	1170	250	4
Bilateral	D	1171	369	4
Bilateral – one primary, one recurrent	D	2579	424	4
Repair of congenital hernia with hydrocele				
Unilateral	D	1172	254	4
Bilateral	D	2580	370	4

	List	Code	Units Gen	Units An
Inguinal and femoral – same side	D	1173	254	4
Sliding hernia	D	1174	254	4
Inguinal or femoral repair by prosthesis or graft	D	1175	254	4
Recurrent hernia	D	1176	305	4
Bilateral	D	2581	424	4
Recurrent hernia repair by prosthesis or graft	D	1177	339	4
Preperitoneal approach for inguinal hernia repair	D	2582	254	4
Umbilical hernia				
Adult	D	1178	254	4
Child	D	1179	169	4
Enterocele, infant	D	1180	254	10
Omphalocele, infant	D	1181	339	10
Diaphragmatic hernia	D	1182	424	12
With prosthesis	D	1183	465	12
Transabdominal repair of diaphragmatic rupture	D	977	500	13
Incisional or ventral hernia				
Repair by suture	D	1184	305	6
Repair by prosthesis	D	1185	339	6
Recurrent incisional or ventral	D	2583	365	6
With prosthesis	D	2584	400	6
Repair of ventral hernia at same session as a definitive intra-abdominal procedure, add	D	2585	153	TU
Component separation for complicated recurrent hernia repair with mesh	D	8127	800	12

☞ ***Medicare Note: Service codes 1184, 1185 and 2585 apply also to the repair of a diastasis recti exceeding 5 cm.***

Epigastric hernia	D	1186	185	4
Strangulated or incarcerated hernia				
Without resection	D	1187	339	6
With resection	D	1188	500	6
Suture				
Secondary closure for evisceration	D	1189	154	6

	List	Code	Units Gen	Units An
CHAPTER 13: ENDOCRINE SYSTEM				
See legend – Chapter 3, Section 1.7 for description of lists A, B, C and D.				
Section 1: Thyroid Gland				
Incision				
Abscess, complete care	D	1190	92	4
Excision				
Fine needle aspiration	B	1754	31	4
Biopsy				
Needle	B	1191	31	4
Surgical	D	1192	185	6
Thyroidectomy				
Bilateral total thyroidectomy	D	1193	550	8
Total lobectomy	D	1194	400	8
Subtotal bilateral thyroidectomy	D	1195	360	8
Partial lobectomy	D	1196	305	8
Excision of solitary nodule	D	1197	284	8
If one of the following procedures is carried out with codes 1193 to 1197, add:				
Limited node dissection				
Unilateral	D	1198	101	TU
Bilateral	D	1199	204	TU
Radical neck dissection, unilateral	D	1200	296	14
Section 2: Parathyroid, Thymus and Adrenal Glands				
Excision				
Parathyroidectomy for hyperplasia	D	1201	500	10
Parathyroid tumor	D	1202	438	10
If sternal splitting required	D	1203	508	12
Thymectomy	D	1204	508	12
Adrenal exploration, unilateral	D	1205	254	10
Adrenal functional tumor (pheochromocytoma)	D	1223	308	17
Adrenalectomy, unilateral	D	1206	900	10
Laparoscopic	D	8613	900	10
Laparoscopic Marsupialisation of Adrenal Cyst	D	8094	545	7

	List	Code	Units Gen	Units An

CHAPTER 14: UROLOGICAL PROCEDURES

See legend – Chapter 3, Section 1.7 for description of lists A, B, C and D.

The fee for a urological surgical procedure shall include the usual postoperative care as carried out by the operating surgeon in accordance with paragraph (7) of "Surgical Services" of the General Preamble, Chapter 3, Section 1.2.7. The surgical fee shall include certain preoperative care as outlined in Chapter 2, Assessment Rule 25.

Section 1: Kidney and Perinephrium

Endoscopy				
Renal pelvis – endoscopic brush biopsy, to include cystoscopy	B	1267	196	4
Operative nephroscopy	D	1731	308	7
In conjunction with another procedure, add	D	1732	60	TU
Incision				
Drainage of kidney abscess, including excision of carbuncle	D	1211	231	7
Drainage of perinephric abscess	D	1212	154	7
Adrenal exploration, unilateral	D	1213	303	10
Renal exploration or open renal biopsy	D	1214	231	7
Nephrostomy	D	1215	269	7
Nephrolithotomy	D	1216	350	7
For staghorn calculus filling renal pelvis and calyces, to include x-ray control	D	2345	440	7
Transection of aberrant renal vessel	D	1217	269	7
Secondary operation – additional	D	1218	77	TU
Pyelostomy	D	1219	269	7
Cutaneous pyelostomy, unilateral	D	1982	308	7
Pyelolithotomy	D	1220	308	7
With diversion of urine	D	1221	350	7
Coagulum pyelolithotomy, unilateral	D	1730	370	7
Excision				
Renal cyst	D	1224	269	7
Heminephrectomy	D	1225	1000	13
partial laparoscopic nephrectomy		8607	1000	13
Nephrectomy				
Ectopic	D	1227	440	7
Laparoscopic	D	8608	440	7
Lumbar	D	1228	375	7
Laparoscopic	D	8609	375	7
Transperitoneal	D	1229	368	7
Thoracoabdominal	D	1230	500	13
Radical nephrectomy (including hilar nodes)	D	1231	545	13
Laparoscopic	D	8610	545	13

	List	Code	Units Gen	Units An
Nephroureterectomy with resection of ureterovesical junction	D	1233	609	10
Laparoscopic	D	8611	609	10
Laparoscopic Marsupialisation of Adrenal Cyst	D	8094	545	7
Regional lymphadenectomy (paracaval and/or para-aortic nodes and/or pelvic nodes) add	D	8622	343	TU

☞ ***Medicare Note: Add on to Service Codes 1233, 8611, 1231 and 8610 only.***

Renal transplantation				
Donor nephrectomy				
Live	D	2071	368	8
Cadaver, uni or bilateral	D	2072	368	8
Return travel time for purposes of performing a donor nephrectomy – detention fee basis (Chapter 4, Section 2.4)		200		
Total nephrological management of donor	D	2073	215	
Supervision of renal perfusion only	C	2074	72	
Transplantation, total surgical care	D	2075	715	13
Nephrological component of transplantation	D	2076	215	
Repair				
Pyeloureteroplasty or endoscopic pyleoplasty	D	1235	381	7
Laparoscopic pyeloplasty	D	8612	381	7
Nephropexy	D	1236	231	7
With renal sympathectomy	D	1237	308	7
Symphysiotomy for horse shoe kidney +/- nephropexy and associated procedures	D	1238	440	7
Renal hypothermia – additional	D	1239	38	TU
Suture				
Ruptured or lacerated kidney – repair or removal	D	1241	323	8

Section 2: Ureter

Extra Corporeal Lithotripsy (ESWL)				
(Consultation payable in addition, if applicable)	D	1815	300	6
Endoscopic procedures				
Calibration and/or dilation, one/both sides	B	1263	62	4
Removal of calculus including ureteral meatotomy if required (basket extraction)	D	1264	204	4
Manipulation only, stone not removed	D	1265	120	4
Therapeutic ureteroscopy				
Therapeutic ureteroscopy for removal of calculi or treatment of tumor, including ureteral dilation	D	1278	286	6

Chapter 14: Urological Procedures	List	Code	Units Gen	Units An
plus basket extraction, add	D	1269	77	TU
plus stent insertion, add	D	1270	115	TU
plus ultrasound or electrohydraulic lithotripsy, add	D	1271	77	TU
Percutaneous procedures				
Establishment of nephrostomy tract for stone extraction with simultaneous extraction of renal stone	B	2121	340	6
under fluoroscopy, add	D	2058	133	TU
Endoscopic removal of stones through percutaneous tract, first attempt	D	1272	254	6
Subsequent attempts to remove stones for same illness per session	D	1273	190	6
removal or attempt using ultrasound or electrohydraulic lithotripsy, add	D	1276	77	TU
Incision				
Periureteral abscess	D	1242	308	6
Ureterotomy, including ureterolithotomy				
Upper two-thirds	D	1243	308	6
Lower one-third	D	1244	370	6
Excision				
Ureterectomy	D	1245	269	6
Including ureterovesical junction	D	1246	331	6
Repair				
Ureterovesical anastomosis, reimplantation	D	1247	457	6
Ureterocolic anastomosis or transplant	D	1250	346	7
With cystectomy, one stage	D	1251	554	11
With cystectomy and colostomy	D	1252	646	11
Ileoureteral substitution	D	1253	462	7
Ureteroileal conduit – total procedure	D	1248	554	9
Team procedure – urologist	D	2166	346	9
Preparation of stoma, add	D	2167	45	
Preparation of intestinal segment	D	2168	339	
Cystectomy, additional to ileoureteral surgery	D	1249	254	
Revision of ureterointestinal anastomosis	D	2346	370	7
Ureteroureterostomy	D	1254	385	6
Transureteroureterostomy	D	1734	462	7
Ureterostomy, cutaneous – unilateral	D	1255	308	6
Ureterovaginal fistula	D	1256	370	6
Ureterolysis for periureteral fibrosis, unilateral	D	1257	308	6
Spontaneous or traumatic rupture or transection				
Immediate				
upper two-thirds	D	1259	269	6
lower one-third	D	1260	308	6
Late repair				
upper two-thirds	D	1261	308	6
lower one-third	D	1262	346	6

	List	Code	Units Gen	Units An
Section 3: Bladder				
Cystoscopy **(See also Chapter 2, Assessment Rule 32)**				
Diagnostic – this service includes catheterization of ureters, calibration of ureters, injection of opaque medium for pyelography and ureterography (retrograde pyelogram), collection of ureteral specimens of urine (split function test, Howard's test, intravenous function tests), urethroscopy, calibration and dilation of urethra, and bimanual examination	B	1266	69	4
With meatotomy and plastic repair	D	1281	110	4
☞ ***Medicare Note: Diagnostic cystoscopy done in conjunction with service code 1274, 1275 or 1394 is payable once during the 30-day preoperative period and at 75% of the listed fee if performed on the same day of surgery.***				
Therapeutic – this service includes simple electrocoagulation of tumors and of Hunner's ulcer, resection of the bladder neck in the female, electrosurgical meatotomy of ureteral orifice, removal of foreign body or calculus, evacuation of clot and biopsy. Simple meatotomy, dilation of urethra etc., if required, are included in this service	D	1277	162	4
With electroexcision of tumors including base and adjacent muscles				
Single	D	1274	238	5
Multiple	D	1275	339	5
With insertion of radioactive substance in addition to associated procedures, add	D	1279	38	TU
Litholapaxy, visual or tactile, and removal of fragments	D	1280	185	4
Insertion of Gibbon's stent or indwelling J catheter	D	1753	231	6
BCG/Chemotherapy of Bladder via catheter with drainage and removal	C	8099	55	4
Spinal/Neurostimulator for Bladder dysfunction				
1st Stage	D	8076	318	8
2nd Stage	D	8077	300	8
Unit Removal or Battery change	D	8078	225	7
☞ ***Medicare Note: Service Code 349 is to be submitted for programming.***				
Urodynamic studies			P	T
Cystometrogram, complete study	B	2077	23	46
Electromyography	B	2078	23	46
Urethral pressure study	B	2079	30	60
Urinary flow study	B	2080	7	14
Trans-abdominal ultrasound for determination				

Chapter 14: Urological Procedures	List	Code	Units Gen	Units An
of bladder volume	B	8604	5	10
(P, T = professional, technical components)				
Incision				
Cystotomy or cystostomy (Please indicate whether cystotomy or cystostomy when billing with other procedures)	D	1282	115	5
With electrocoagulation of tumor	D	1283	231	5
Cystotomy with trochar and cannula and insertion of tube	B	1284	54	4
Cystolithotomy	D	1285	154	5
Excision				
Ureterocelectomy	D	1286	231	5
With ureteral reimplantation	D	1287	620	5
Cystectomy, partial – for atony	D	1288	308	6
For tumor or diverticulum	D	1289	370	6
With reimplantation of uretero	D	1290	415	6
Cystectomy or prostatocystectomy, total	D	1291	370	11
Additional to ileoureteral surgery	D	1249	254	
With colocystoplasty	D	1292	616	11
Second surgeon	D	1293	154	
Radical cystectomy, to include hysterectomy in the female, and seminal vesicles and prostate in the male	D	1268	609	8
Pelvic lymphadenectomy, add		8623	343	
Ileal-Neo Bladder	D	8603	900	9
Excision of urachus and repair of bladder	D	1294	231	6
Repair				
Exstrophy – primary closure	D	1295	308	6
Urinary diversion for bladder exstrophy and excision of ectopic bladder and repair of abdominal wall	D	1296	616	6
Excision of bladder and repair of abdominal wall	D	1297	231	6
Cutaneous vesicostomy	D	1984	358	6
Repair of ruptured bladder	D	1298	277	6
Ileocystoplasty (or colocystoplasty)	D	1299	562	7
Boari flap +/- psoas hitch	D	1733	462	6
Suprapubic resection of bladder neck	D	1300	231	6
Plastic repair of bladder neck (child-adult)	D	1301	308	6
With ureteroneocystostomy unilateral, add on	D	1302	77	TU
bilateral, add on	D	1303	154	TU
Closure of fistula – external, suprapubic	D	1304	185	5
Vesicovaginal – transvesical approach	D	1305	415	6
Vesicorectal or vesicosigmoid	D	1306	308	6
Vesicopexy, with fixation of anterior vesical wall	D	1208	370	5
Fascial Wall Sling	D	8600	550	5

Chapter 14: Urological Procedures	List	Code	Units Gen	Units An
Suburethral Sling using prosthetic material to include TVT, SPARC, TOT and similar procedures – female only	D	8251	408	5

Section 4: Urethra

Endoscopy				
Biopsy including endoscopy	B	1307	46	4
Internal urethrotomy	D	1308	92	4
Removal of foreign body or calculus	D	1309	115	4
Meatal extraction of foreign body	C	1310	23	4
Incision				
Urethral sphincterotomy	D	2170	254	4
Urethrotomy				
External	D	1311	185	4
Internal, under direct vision	D	2862	185	4
Meatotomy and plastic repair	C	1312	54	4
For extravasation of urine with multiple drainage	D	1313	185	4
With external urethrotomy or cystotomy	D	1314	277	4
Periurethral abscess	C	1315	38	4
Excision				
Caruncle	C	1316	54	4
With cystoscopy	D	1317	92	4
Urethral papilloma, single or multiple	D	1318	92	4
Prolapse	C	1319	62	4
With cystoscopy	D	1320	92	4
Stricture				
One stage, with diversion	D	1321	277	4
Two stage				
first stage	D	1322	139	4
second stage	D	1323	277	4
Diverticulectomy – male or female	D	1324	400	4
Posterior urethral valve – by endoscopy	C	1325	252	4
Open operation	D	1326	192	4
Biopsy	B	1327	23	4
Urethrectomy, total	D	1985	308	4
Repair				
Artificial urinary sphincter implant /male sling	D	1207	500	5
Male Sling Removal	D	8096	330	4
Male Sling Adjustment	D	8097	100	4
Urethrovesical suspension for stress incontinence	D	1329	277	5
With partial cystectomy	D	1330	370	5
Laparoscopic bladder suspension	D	8341	356	5
Surgical prosthesis for incontinence	D	1986	308	4
Urethroplasty	D	1987	IC	4
(Johanson) each stage	D	2298	310	4

Chapter 14: Urological Procedures	List	Code	Units Gen	Units An
One-stage patch urethroplasty	D	1729	700	4
Nerve Sparing perineal resection of the prostate with vesiculectomy	D	8098	708	7
Duckett-Neurovascular Flap	D	8093	500	4
Peri-urethral collagen injections for the correction of incontinence	D	836	225	4
Suture				
Rupture – anterior urethra (diversion of urine extra)	D	1331	185	4
Posterior urethra				
Immediate repair	D	1332	323	4
Late repair	D	1333	462	4
Membranous urethra	D	1334	277	4
Rectourethral fistula	D	1335	308	6
With colostomy	D	1336	385	6
Manipulation				
Dilation of stricture - local anaesthetic	A	1337	15	
General anaesthetic	A	1338	38	4
Filiforms and followers	A	1339	28	

	List	Code	Units Gen	Units An

CHAPTER 15: MALE REPRODUCTIVE SYSTEM

See legend – Chapter 3, Section 1.7 for description of lists A, B, C and D.

Section 1: Penis

	List	Code	Units Gen	Units An
Cytology				
Cytology, using colposcopic technique, Includes biopsies and curetting	B	1957	32	
Incision				
Preputiotomy				
Newborn	C	1340	8	
Infant or child under 12 years	C	1341	8	4
Adult	C	1342	15	4
Reduction of paraphimosis, including dorsal slit, general anaesthesia	C	2084	38	4
Excision				
Circumcision – surgical removal of foreskin	D	1345	162	4
Penile frenotomy – general anaesthetic	C	2085	38	4
Condylomata	C	1346	38	4
Biopsy	B	1347	23	4
Amputation				
Partial	D	1348	231	4
With inguinal glands dissection – 1 or 2 stages	D	1349	370	5
Total with inguinal and femoral glands dissection – 1 or 2 stages	D	1350	462	5
Repair				
Plastic reconstruction following circumcision	D	2086	116	4
Epispadias	D	1351	231	4
Hypospadias – including urinary diversion				
Chordee repair – first stage	D	1352	304	4
Plastic reconstruction of urethra – penile	D	1353	419	4
Penoscrotal or perineal	D	1354	546	4
Closure of urethrocutaneous fistula	D	1355	254	4
Priapism, vascular shunt, single surgeon or team procedure	D	1988	231	4
Penile prosthesis for impotence	D	2347	154	4
Inflatable penile prosthesis				
Insertion or reinsertion	D	8339	340	4
Removal	D	8340	255	4

☞ ***Medicare Note: Reinsertion fee includes the removal of original prosthesis.***

Excision of Peyronie's plaque	D	8601	194	4
Nesbit procedure for Peyronie's Disease	D	8602	350	4
Surgical management of penile fracture (includes				

Chapter 14: Urological Procedures	List	Code	Units Gen	Units An
exploration under general anaesthesia with or without repair of tunica albuginea)	D	8138	350	4

☞ ***Medicare Note: Service Codes 1332 or 1331 are billable at 50% with Service Code 8138 if applicable.***

Section 2: Testes

Incision				
Abscess	C	1356	38	4
Excision				
Orchidectomy – unilateral	D	1357	139	4
Radical for malignancy (complete removal of cord to internal inguinal ring)	D	2348	250	4
Biopsy – single	B	1358	38	4
With vasography	D	1359	77	4
Repair				
Orchidopexy or exploration of testis by inguinal approach, unilateral	D	1360	352	4
Reduction of torsion of testis or appendix testis and repair	D	1361	139	4
Ruptured testicle	D	1362	139	4
Testicular prosthesis for congenital defect	D	2349	123	4

Section 3: Epididymis

Incision				
Abscess	C	1363	38	4
Excision				
Spermatocele	D	1364	139	4
Epididymectomy, unilateral	D	1365	139	4
Anastomosis, epididymovasostomy, unilateral	D	1366	139	4

Section 4: Tunica Vaginalis

Excision				
Hydrocele, unilateral	D	1367	139	4
Aspiration	B	1368	8	

Section 5: Scrotum

Incision				
Abscess or haematocele	C	1369	38	4
Exploration, unilateral	D	1370	92	4
Suture				
Trauma – laceration – depending on extent and Complications (see lacerations, Integumentary System)	D	1371	IC	4

Chapter 15: Male Reproductive System	List	Code	Units Gen	Units An
Section 6: Vas Deferens				
Vasography – single procedure	C	1372	38	4
Repair				
Anastomosis, unilateral	D	1373	130	4
Including biopsy and vasography	D	1374	177	4
Suture				
Ligation, bilateral (vasectomy)	C	1375	132	4
Section 7: Spermatic Cord				
Excision				
Hydrocele – single	D	1377	139	4
Varicocele – single	D	1376	139	4
High ligation through retroperitoneum	D	2863	228	6
Laparoscopic Varicocoelectomy	D	8095	228	4
Section 8: Seminal Vesicles				
Incision				
Abscess	D	1378	77	4
Excision				
Vesiculectomy	D	1379	462	4
Section 9: Prostate				
Incision				
With drainage of abscess	D	1380	77	4
With removal of calculus (perineal)	D	1381	269	4
Biopsy, perineal – open operation	D	1382	154	4
Needle	B	1383	62	4
With cystoscopy	B	1384	101	4
Ultrasound of prostate	B	1209	77	4
With needle biopsy	B	1210	108	4
Excision				
Perineal	D	1385	370	7
Radical	D	1386	462	7
With vesiculectomy	D	1387	554	7
Nerve Sparing perineal resection of the prostate with vesiculectomy	D	8098	708	5
Suprapubic – one stage or two stages	D	1388	407	7
With diverticulectomy	D	1389	508	7
With partial cystectomy for atony of bladder	D	1390	508	7
Retropubic – simple	D	1391	407	7

Chapter 14: Urological Procedures	List	Code	Units Gen	Units An
Radical	D	1392	508	7
Prostatectomy	D	1393	609	7
Regional lymphadenectomy (internal iliac nodes and/or obturator nodes), add		8624	343	

☞ ***Medicare Note: Add on to Service Code 1393 only.***

Section 10: Endoscopy

Transurethral resection / Ablation	D	1394	427	6
Transurethral drainage	C	1395	77	5
Resection of bladder neck				
Child	D	1396	153	5
Adult	D	1397	254	5

	List	Code	Units Gen	Units An

CHAPTER 16: FEMALE REPRODUCTIVE SYSTEM

See legend – Chapter 3, Section 1.7 for description of lists A, B, C and D.

Section 1: Abortion

Incomplete. Examination of uterus without D & C or anaesthesia (in hospital procedure only)	C	1398	50	0
Complete			VF	
Incomplete, including D & C (prenatal visits extra according to office schedule)	D	1400	100	4
Therapeutic, including saline or prostaglandin induction	D	1401	125	4
Hysterotomy, abdominal or vaginal	D	1402	192	6

Section 2: Operative Delivery

Caesarean section (restricted to Spec. Obs/Gyn)	D	8701	530	8
Caesarean section	D	1404	425	8
Caesarean hysterectomy, subtotal or total (restricted to Spec. Obs/Gyn)	D	8702	600	10
Caesarean hysterectomy, subtotal or total	D	1405	600	10
Compression sutures, add		8707	100	

☞ ***Medicare Note: Service Code 8707 is payable with Service Code 8700, 8701, 8702, 1404, 1405, 1158 and 1455 only.***

Operative delivery, other than by caesarean section (restricted to Spec. Obs/Gyn)	D	8703	506	7
Operative delivery, other than by caesarean section	D	1406	370	7
Multiple births, either vaginal or caesarean section deliveries – per additional birth, add	D	1413	205	TU
Repair of perineal, cervical or vaginal lacerations (intrapartum) – consultation and procedure	D	1407	250	7
Retained placenta removal – consultation and procedure	D	1408	250	7
Surgical or medical induction of labor – consultation and procedure, one or more attempts	C	1409	130	5
VBAC attempt (successful or not) (OBS/GYN only)	C	8118	150	

Payable with a consultation or delivery codes (OBS/GYN only)
Payable on day of delivery with either the consultation or the delivery once per Session

☞ ***Medicare Note: Delivery fees include attendance during prolonged labour. Service Codes 1407 and 1408 are not payable in addition to a delivery fee to the same physician. Similarly, service code 1409 is not payable if delivery or caesarean section follows within three days.***

Suture of incompetent cervix during pregnancy	D	1411	154	4
External Cephalic Version	C	8704	100	

	List	Code	Units Gen	Units An
Amniocentesis	B	1414	50	
Prenatal scalp sampling, total fee for first and subsequent pH samplings	B	2953	50	
Insertion of an intra-uterine pressure catheter	B	1811	50	
Oxytocin challenge test	A	2350	23	

Section 3: Vulva

Incision				
Hymenectomy				
Local anaesthesia	C	1415	23	
General anaesthesia	C	1416	38	4
Abscess of vulva, Bartholin or Skene's gland				
Complete care	C	1417	38	
Local anaesthesia	C	1418	38	
General anaesthesia	C	1419	38	4
Marsupialization (under local or general anaesthesia) or cautery	C	1420	100	4
Excision				
Superficial laser destruction of vulvar lesions (Chapter 5, Section 4.5)				
Vulvectomy				
Simple	D	1421	185	6
Radical				
Without gland dissection	D	1422	269	6
With complete bilateral gland dissection	D	1423	462	6
Cyst of Bartholin's gland	D	1424	150	4
Clitoris – amputation	D	1425	92	4
Condylomata	D	1426	77	4

Section 4: Vagina

Incision				
Colpotomy, posterior, drainage or needling	C	1427	70	4
Excision				
Local excision of cyst	D	1428	108	4
Repair				
Cystocele or rectocele	D	1429	174	4
Cystocele and rectocele	D	1430	300	4
Cystocele, rectocele and prolapse (Fothergill)	D	1431	308	4
Cystocele, rectocele and excision of cervical stump	D	1432	308	4

☞ ***Medicare Note: For service codes 1429 to 1431 please indicate cystocele or rectocele on claim.***

Cystocoele or rectocoele repair with mesh

	List	Code	Units Gen	Units An
(includes enterocoele)	D	8173	450	4
Cystocoele and rectocoele repair with mesh (includes enterocoele)	D	8174	600	4

☞ ***Medicare Note: Service Code 1433 (enterocoele) is not billable with Service Codes 8173 and 8174.***

Suburethral Sling using prosthetic material to include TVT, SPARC, TOT and similar procedures - female only, add		8175	50	

☞ ***Medicare Note: Service Code 8175 is only billable with Service Codes 8173 and 8174. Service Code 8251 is not billable with Service Codes 8173 and 8174.***

Transvaginal Sacrospinous colpopexy with/without mesh (to include enterocoele)	D	8176	450	4

☞ ***Medicare Note: Service Code 1430 is not billable with 8176.***

☞ ***Medicare Note: If the patient has both a cystocoele and rectocoele, then only Service Code 1429 is billable at 50% with Service Code 8176, as one of them will be the approach.***

If TVT (TOT) bladder suspension is performed at the sme time as 8176, then code 8251 can be billed additionally at 50%

Vaginal vault prolapse (anterior (cysto), prosterior (recto) and enterocoele repair)	D	1433	348	4

☞ ***Medicare Note: Service Codes 1429, 1430 and 1443 are not payable in addition to Service Code 1433.***

☞ ***Medicare Note: Service Codes 1429, 1430, 1433 or 1443 are payable with Service Code 8251 at 50% if TVT (TOT) is performed.***

Colposacropexy (abdominal) for vaginal vault prolapse including enterocoele	D	2973	450	7

☞ ***Medicare Note: Service Code 1429 or 1430 are billable at 75% with Service Code 2973 if a vaginal repair of a cystocoele and/or rectocoele is performed.***

Rectocele and repair of anal sphincter	D	1434	277	4
Perineorrhaphy	D	1435	102	4
Colpocleisis (LeFort)	D	1436	277	4
Operation for artificial vagina	D	1437	308	6
Repair of double vagina	D	1438	139	4
Closure of fistula Vesicovaginal	D	1439	308	6

Chapter 16: Female Reproductive System	List	Code	Units Gen	Units An
Rectovaginal	D	1440	308	6
Ureterovaginal	D	1441	370	6
Urethral caruncle or prolapse of mucosa	D	1442	62	4
Enterocele	D	1443	319	5
Retropubic operation for incontinence (Marchetti)	D	1444	277	5
Suburethral Sling using prosthetic material to include TVT, SPARC, TOT and similar procedures female only	D	8251	408	5
Ureterolysis for release of ureteric obstruction – Laparotomy or Laparoscopy	D	1257	308	6
Haematoma – evacuation, local anaesthesia	C	362	15	
Evacuation of vulvar or vaginal haematoma, general anaesthesia	C	2851	85	4
Repair of lacerations	(Chapter 7, Section 1.2)			
Perineal release/double Z-plasty	D	8335	300	4
Manipulation				
Examination and/or dilation, general anaesthesia (independent operation)	C	1445	31	4

Section 5: Fallopian Tubes

Endoscopy				
Culdoscopy	C	1446	77	4
Incision				
Ectopic pregnancy – management by conservative surgical technique	D	1792	311	6
Excision				
Salpingectomy and salpingo-oophorectomy (uni or bilateral) (laproscopy or laparotomy)	D	1447	300	6
Repair				
Tubal plastic operation	D	1448	261	6
Sterilization, abdominal or vaginal (full fee payable in addition to delivery, 50% if with caesarean section) with or without hysteroscopic insertion of fallopian coils	D	1449	200	6

☞ ***Medicare Note: Please indicate abdominal or vaginal when billing other procedures.***

Section 6: Ovary

Excision				
Ovarian cyst	D	1450	300	6
Paraovarian cyst	D	1451	300	6
Wedge biopsy – ovaries	D	1760	300	6
Post-cancer treatment laparotomy, or staging laparotomy, for ovarian carcinoma	D	2954	350	7

Chapter 17: Neurosurgical Procedures	List	Code	Units Gen	Units An

Section 7: Uterus and Cervix Uteri

Incision				
Hysterotomy	D	1452	290	6
Excision				
Diagnostic curettage	B	1453	81	4
Myomectomy	D	1454	277	6
Hysterectomy				
Laparoscopic assisted Vaginal Hysterectomy	D	835	485	6
Total – abdominal (restricted to spec Obs/Gyn)	D	8700	380	6
Total – abdominal	D	1455	358	6
Vaginal	D	1456	380	6
Abdominal or vaginal with rectocele and/or cystocele repair	D	1457	462	6

☞ ***Medicare Note: Please indicate abdominal or vaginal when billing other procedures.***

Hysterectomy (Partial or subtotal)	D	1458	239	6
McCall Suture or McCall culdoplasty, add		8177	50	

☞ ***Medicare Note: Service Code 8177 is an add-on <u>only</u> to existing hysterectomy codes (835, 8700, 1455, 1456, 1458, 1460 and 1817).***

☞ ***Medicare Note: 8177 is not billable with 1457 or 1459.***

With rectocele and/or cystocele	D	1459	319	6
Sacrospinous vault suspension, add	D	2974	150	TU
Radical (Wertheim)	D	1460	610	8
Extended Hysterectomy with staging	D	1817	530	6
Para-aortic node sampling (add on)	D	1818	110	
Septate uterus	D	1461	308	6
Cervical polyp, without D & C	B	1462(1)	15	4
Amputation of cervix	D	1463	139	4
Cervical stump				
Vaginal	D	1464	185	4
Abdominal	D	1465	231	6
Biopsy of cervix, vagina or vulva under general anaesthesia	B	1466	38	4
Hydrocele of canal of Nuck	D	1467	92	4
Presacral neurectomy	D	1468	277	6
Transcervical endometrial resection/ablation	D	1835	328	6

(1) These service codes are payable at 100% of the fee whenever eligible for payment.

Introduction				
Insufflation, Rubin's test	C	1469	31	4
Paracervical block for pelvic evaluation	B	1803	38	
Endometrial biopsy	B	1470(1)	20	4
Hysterosalpingogram	B	2164	63	

	List	Code	Units Gen	Units An
Saline Sonohysterogram	B	8075	63	4
I U C D				
Insertion	B	1472(1)	25	4
Removal	C	2852	15	
Diaphragm fitting	A	1723	13	
Insertion of Pessary	A	8705	13	

(1) These codes are payable at 100% of the fee whenever eligible for payment.

☞ ***Medicare Note: Only one visit per 30 days with procedure***

Endoscopy				
Hysteroscopy – Diagnostic, +/- D and C, +/- biopsy	B	2977	100	4
Therapeutic Hysteroscopy	D	2978	162	4
Hysteroscopic resection endometrial or myometrial tumors	D	1836	339	6
Colposcopy				
Screen	C	2419	8	
Investigation of abnormal cytology under colposcopic technique including biopsies and curetting	B	2420	48	
Laser conization of cervix or loop electrosurgical excision procedure of the cervix including same day colposcopy	B	2930	113	4
Laser conization within 30 days of prior colposcopy or conisation	B	2931	77	4

☞ ***Medicare Note: Consultations on referred cases are payable in addition to service codes 2930 and 2931 unless a consultation fee has been paid in the preceding 30 days.***

Repair				
Suturing of vagina, cervix or vulva under general anaesthesia (extra partum)	D	1722	85	6
Hysteropexy (uterine suspension)	D	1473	192	6
With D & C	D	1474	277	6
With rectocele and cystocèle	D	1475	308	6
Cervix +/- biopsy	D	1476	139	3
*Cerclage (Incompetent cervix – any suture repair) including prophylactic	D	1477	154	4
Repair of inversion of uterus				
Operative	D	1478	277	4
Manual	D	1479	115	4
Interposition operation	D	1480	308	4
Electrocautery of cervix,	B	1481(1)	15	
Cryotherapy or laser treatment of cervix for condylomata	C	2351	30	4
Biopsy of vagina, cervix or vulva	B	1482(1)	15	
Conization of cervix	D	1483	92	4
Insertion of radium – per application	D	1484	154	4

(1) These service codes are payable at 100% of the fee whenever eligible for payment.

	List	Code	Units Gen	Units An

CHAPTER 17: NEUROSURGICAL PROCEDURES

See legend – Chapter 3, Section 1.7 for description of lists A, B, C and D.

Section 1: Preamble

In cases of paraplegia and in cases of cerebral lesions, traumatic or other, treated surgically the schedule of fees for daily visits is added to the surgical fee after one month of hospitalization.

☞ ***Medicare Note: The normal postoperative period is 30 days***

Section 2: Peripheral Nerves

Nerve biopsy	B	1546	38	4
Primary suture, major nerve	D	1485	269	4
Exploration and neurolysis, or transposition, major	D	1486	192	4
Neurectomy				
Major nerve	D	1487	231	4
Minor nerve	D	1497	154	4
Secondary suture, major nerve	D	1488	269	4
Nerve graft	D	1503	314	4
Exploration brachial plexus	D	1489	385	5
Sciatic nerve exploration and neurolysis	D	1490	308	4
Entrapment syndrome	D	1491	154	4
Transplantation of neuroma	D	1504	154	4
Excision of tumor	D	1492	308	4

Section 3: Neurovegetative System

Sympathectomy				
Cervical	D	1493	308	6
Cervical thoracic	D	1494	385	10
Thoracolumbar (Smithwick)	D	1495	616	13
Lumbar	D	1496	254	6

Section 4: Diagnostic and Minor Treatment Procedures

(See also "Diagnostic and Therapeutic Procedures" in Chapter 21 and "Clinical Procedures" in Chapter 22)

Lumbar puncture	B	177	38	
Subdural tap	B	178	23	
Each additional tap	B	179	23	
Ventricular puncture	C	1500	77	4
Ventricular drainage (continuous)	D	1501	154	4
Cisternal puncture	B	180	46	
Myelogram	B	181	63	4
Pneumoencephalogram	B	182	107	5
Ventriculogram	B	1506	179	6
Echoencephalogram	B	173	15	

Chapter 17: Neurosurgical Procedures	List	Code	Units Gen	Units An
Stimulation – dorsal column, visit fee included	C	2377	23	
Cerebellar, visit fee included	C	2378	38	
Transcutaneous (excludes acupuncture)				
Initial, including consultation, examination, etc	C	2379	77	
Subsequent, visit fee included	C	2380	23	

Section 5: Cranial Trauma

Skull				
Traction	(Chapter 8 Section 4)			
Operative treatment				
Simple depressed fracture - Dura intact	D	1517	231	15
Dura lacerated	D	1518	385	15
Serious brain damage	D	1519	462	15
Compound depressed fracture - Dura intact	D	1520	308	15
Dura lacerated	D	1521	462	15
Sinus involvement or serious brain damage (foreign body, haematoma, etc.)	D	1522	550	15
Decompressive craniectomy				
Subtemporal	D	1523	308	15
Suboccipital	D	1524	462	15
Diagnostic burr holes				
Initial	D	1525	154	15
Each additional	D	1526	77	
Craniotomy for orbital decompression	D	1527	539	15
Cranioplasty	D	1528	462	15
Meninges, surgical management of extradural haematoma, or subdural haematoma, hygroma, effusion – extradural	D	1529	616	11
Subdural				
With burr holes	D	1530	462	11
With craniotomy	D	1531	616	11
Child by repeated aspiration	D	1532	231	11

Section 6: Spinal Trauma

See also Chapter 8.

Fracture of spinous process (surgical removal)	D	1533	115	8
Vertebral fracture, fracture-dislocation, dislocation or subluxation				
Without cord injury – supervision bed rest			VF	
Operative reduction	D	2767	462	10
With internal fixations	D	1539	539	8
Operative reduction and fusion in conjunction with orthopaedic surgeon (neurosurgical fee)	D	1540	462	8
Cranioskeletal traction tongs	D	1541	250	5
With cord injury – supervision bed rest only			VF	
Operative reduction	D	1543	539	8

Chapter 17: Neurosurgical Procedures	List	Code	Units Gen	Units An
With internal fixations	D	1544	539	8
Operative reduction and fusion in conjunction with orthopaedic surgeon (neurosurgical fee)	D	1545	462	8
Cranioskeletal traction tongs	D	1541	250	5
Instrumentation (excluding plate, wires, etc.)	D	8404	1175	12

☞ **Medicare Note: Instrumentation to include fractures, open dislocations, fusions, grafts and corporectomy.**

Section 7: Skull Lesions

Linear craniectomy for craniosynostosis - one suture	D	1547	308	11
Two sutures, total fee, one or two stages	D	1548	462	11
More than two sutures, total fee, one or more stages	D	2353	616	11
Excision of skull tumor	D	1549	385	11
With cranioplasty	D	2354	462	11
Craniectomy for osteomyelitis	D	1550	IC	11
Reopening of craniotomy for postoperative haematoma or infection, or for removal of bone or plate	D	2376	231	11
Craniotomy for hypertelorism	D	2355	616	15

Section 8: Brain

Craniotomy				
Supratentorial approach – for removal of foreign body, cyst, tumor, pituitary tumor, intracerebral haematoma, lobectomy	D	1551	769	15
Infratentorial or basal approach	D	2957	1200	15
For excision of cortical scar for epilepsy	D	1552	769	15
For hemispherectomy	D	1553	769	15
For arteriovenous malformation	D	1554	1600	15
For obliteration of cerebral aneurysm	D	1555	1600	15
For brain biopsy	D	1556	616	15
For hypophysectomy or section of pituitary stalk	D	1557	769	15
For transsphenoidal hypophysectomy	D	2951	1160	15
For medullary or mesencephalic tractotomie	D	1558	769	15
For carotid-cavernous fistula	D	1559	769	15
For stereotactic destruction of nerve including ventriculography	D	2365	616	15
For cerebrospinal fluid rhinorrhea	D	1758	850	15
Craniotomy – use of operative microscope, add	D	2958	100	
Stereotactic biopsy of tumors, abscesses or other lesions	D	1837	450	15
Awake Craniotomy with Cortical mapping for brain tumor	D	8750	1700	15
Brain abscess				
Craniotomy and total excision, complete care	D	2356	769	15
Burr hole and aspiration	D	2357	308	7

Chapter 17: Neurosurgical Procedures	List	Code	Units Gen	Units An
Subsequent	D	2358	154	7
Subsequent aspiration	D	2359	77	7
Shunts for treatment of hydrocephalus – any type, including revision (ventriculoatrial, ventriculoperitoneal, lumboperitoneal, etc.), ventriculocisternostomy (Torkildsen)	D	1561	462	15
Removal of shunt	D	2360	154	10
As an additional procedure	C	1502	85	
Puncture of shunt reservoir for aspiration or injection procedure	D	2361	154	7
Stereotactic thalamotomy, pallidotomy, cingulotomy with depth recording and stimulation	D	1563	616	15
Puncture for aspiration or tumor biopsy (including burr hole)	D	1564	231	7
Lobotomy	D	1565	231	15
Implantation of cerebellar stimulators	D	2362	154	15
Implantation of pressure recording device catheter or transducer for monitoring	D	2363	154	15
Subsequent revision or replacement	D	2364	38	7
Section 9: Vascular Procedures				
Silverstone clamp or ligation of carotid	D	1566	308	15
Carotid endarterectomy	D	1973	700	15
With patch graft	D	1568	764	15
With graft and bypass shunt	D	1569	828	15
Cerebral artificial embolization				
Extracranial	D	1570	385	15
Intracranial	D	1571	616	15
Vertebral endarterectomy with patch graft	D	1572	539	15
Intracranial arterial reconstructive surgery (embolectomy, endarterectomy, etc.)	D	1573	769	15
Cerebral revascularization – extracranial-intracranial microvascular anastomosis	D	1560	1040	15
Section 10: Spinal Cord				
Laminectomy - For excision of neoplasm, haematoma, vascular anomaly, constrictive pachymeningitis of spinal cord or nerve roots	D	1574	539	8
For opening of dura and exploration or biopsy of cord or nerve roots or section of denticulate ligaments	D	1575	539	12
For decompression of spinal cord or cauda equine	D	1576	539	8
For treatment of epidural abscess	D	1577	539	8
For exploration of syringomyelic cavity	D	1578	539	12
For spinothalamic tractotomy (cordotomy)	D	1579	462	8
For anterior or posterior rhizotomy	D	1580	462	8
For rhizotomy for spasmodic torticollis				

Chapter 17: Neurosurgical Procedures	List	Code	Units Gen	Units An
including spinal accessory nerve	D	1581	539	9
Multiple level laminectomies	D	821	639	8
Implantation of spinal cord stimulator – permanent	D	2366	539	8
Temporary (percutaneous)	D	2367	231	8
Removal or revision of cord stimulator	D	2368	231	8
Percutaneous cordotomy (lesion generator)	D	2950	350	6
Excision of meningocele	D	1582	308	12
Excision of myelomeningocele or encephalocele	D	1583	462	12
Myelotomy, unilateral or bilateral	D	2369	539	8
Section 11: Cranial Nerves				
Posterior fossa craniectomy				
With rhizotomy	D	1584	616	15
With grafting VII nerve	D	1585	539	15
Microvascular decompression of trigeminal nerve	D	1757	900	15
Percutaneous trigeminal rhizotomy	D	2948	300	6
Revision within 60 days	D	2949	225	6
Nerve anastomosis – facial-hypoglossal or facial-accessory nerve	D	1586	385	6
Subtemporal craniectomy – with rhizotomy of V nerve	D	1587	539	15
With decompression of Gasserian ganglion	D	1588	539	15
Extracranial section of spinal accessory nerve and/or other peripheral nerve for treatment of spasmodic torticollis	D	1589	231	6
Avulsion of mandibular, supraorbital, infraorbital, occipital nerves	D	1590	92	4
Chemical destruction	C	1591	54	
Section 12: Discs				
Cervical				
Removal of protrudes disc - unilateral	D	1592	539	10
Bilateral, multiple or recurrent	D	1593	650	10
Anterior disc and fusion				
One space	D	1594	539	10
Two spaces	D	1595	650	10
Thoracic - Removal of protruded disc	D	1596	539	10
Transthoracic removal of disc lesion	D	2370	539	13
Lumbar				
Unilateral	D	1597	385	8
Bilateral, multiple or recurrent	D	1598	539	8
Removal of disc or laminectomy in conjunction with orthopaedic surgeon for fusion - unilateral	D	1599	385	8
Bilateral, multiple or recurrent	D	1600	462	8
Chemonucleolysis under fluoroscopic control	D	1759	250	6

	List	Code	Units Gen	Units An

CHAPTER 18: OPERATIONS OF THE EYE

See legend – Chapter 3, Section 1.7 for description of lists A, B, C and D.

All major surgical procedures include 30 days postoperative care.

☞ ***Medicare Note: No additional fee is payable for the use of an operative microscope in the performance of ophthalmological procedures.***

Section 1: Surgical Removal of the Eye

Evisceration of ocular contents				
Without implant	D	1646	192	5
With implant +/- attachment of muscles	D	1647	231	5
Enucleation of eyeball				
Without implant	D	1643	192	5
With implant +/- attachment of muscles	D	1644	231	5
Secondary procedures on implant	D	1645	154	5
Removal of donor eyes	C	2470	80	
Corneal – Scleral rim removal	C	2994	154	
Preservation of corneal tissue	C	2995	115	

Section 2: Exenteration of Orbit +/- Skin Graft

Removal of orbital contents +/- skin graft	D	1660	462	5
With therapeutic removal of orbital bone	D	1661	616	5
With temporalis muscle transplant	D	2189	462	5

Section 3: Operations on Extraocular Muscles

Strabismus surgery – one or more muscles	D	1655	600	6
Subsequent operations, within three months	D	1656	115	6
Biopsy	D	2190	231	5
Removal of lesion	D	2191	231	5
Repair of muscles after trauma	D	2192	231	5

Section 4: Other Operations on Orbit

Orbital abscess, incision and drainage	D	1657	154	5
Orbital exploration	D	1658	385	5
Removal of orbital tumor or lesion	D	1659	385	5
Orbitotomy with removal of intraorbital foreign body	D	1662	231	5
Retro-orbital injection	C	1663	38	
Reduction of orbital floor fracture +/- plasty of floor of orbit	D	2241	269	8
Orbital rim				
Closed reduction	D	2193	115	4
Operative reduction	D	2194	231	4

	List	Code	Units Gen	Units An
Section 5: Eyelids				
Trichiasis epilation	A	1624	8	
Electrolysis and/or cryotherapy	C	1625	23	4
Botulinum oculin toxin injection for blephrospasm	C	2992	50	
☞ ***Medicare Note: Spasms related to strabmismus and entropion are included in Service Code 2992.***				
☞ ***Medicare Note: Can only be billed for conditions approved by Medicare as guided by Health Canada indications.***				
Abscess, incision and drainage	C	1626	15	4
Chalazion or tarsal cyst				
Local anaesthesia	C	1627	125	
General anaesthesia	C	2415	38	4
Canthotomy division of canthus with sutures	C	1628	23	4
All plastic operations on lid or orbit				
Minor	D	1630	48	5
Major	D	1631	318	5
Ptosis – lid suspension or levator resection	D	2266	225	5
☞ ***Medicare Note: Blepharoplasty: To determine the coverage status of proposed surgery. See plastic surgical preamble, Chapter 20, Section 1.***				
Tarsorrhaphy	D	2195	115	4
Repair of ectropion or entropion				
Simple, Ziegler operation,	C	2267	38	
Full thickness horizontal shortening of lid ect/ent	D	2268	150	4
Excision and full thickness reconstruction				
of lid for malignant tumor or suspicious lesion, total care				
Up to and including 1/3 of lid	D	2271	150	5
Greater than 1/3 of lid	D	2272	385	5
Repair trauma of eyelid				
Repair laceration	D	2227	46	5
Repair full thickness	D	2196	154	5
Section 6: Nasolacrimal System				
Dilatation, probing or irrigation,				
Single	A	1633	15	
Bilateral	A	1634	23	
Probing lacrimal duct, uni or bilateral – general anaesthetic	C	1635	49	4
Lacrimal sac abscess – incision	C	1636	38	4
Dacryocystectomy	D	1637	231	5
Dacryocystorhinostomy	D	1638	500	5
Lacrimal gland excision	D	1639	231	5
Intubation nasolacrimal duct	C	1640	54	4
Repair of torn canaliculus	D	1641	231	5
Conjunctivorhinostomy +/- tube	D	2197	308	5

Chapter 18: Operations of the Eye	List	Code	Units Gen	Units An
Repair of fistula	D	2198	269	5
Minor operations on punctum	C	2199	23	5
Injection for radiography	C	2277	23	
Section 7: Conjunctiva				
Subconjunctival or sub-tenon injection	A	1601	15	4
Wound suture	C	1602	23	4
Excision pterygium	D	1603	102	4
Peritomy	D	1604	54	4
Biopsy of conjunctiva	B	1605	54	4
Grattage (scraping of conjunctiva for trachoma follicles)	C	1606	23	4
Rolling of conjunctiva follicles	C	1607	23	4
Gunderson's flap	D	1608	269	4
Purse string conjunctival flap	D	1609	115	4
Free graft of conjunctiva	D	1610	77	4
Buccal mucous membrane	D	1611	115	4
Excision of malignant lesion, conjunctiva	D	2296	154	4
With graft	D	2297	231	4
Division of symblepharon	D	2374	154	4
Removal of subconjunctival foreign body	C	2385	23	4
Reconstruction of cul-de-sac +/- graft	D	2386	231	4
Incision and drainage	C	2387	38	4
Section 8: Sclera				
All penetrating wounds +/- prolapse	D	1621	500	6
Repair of staphyloma	D	2388	308	6
Section 9: Cornea				
Cauterization of corneal ulcer – chemical, thermal, electric or mechanical	C	1612	15	4
Penetrating wounds of cornea +/- iris prolapse	D	1613	500	6
Paracentesis of aqueous	C	1614	38	4
Superficial keratectomy	D	1615	231	6
Lamellar keratoplasty	D	1616	385	6
Penetrating keratoplasty	D	1617	619	6
Penetrating graft combined with cataract extraction	D	2389	600	6
Dermoid cyst	D	1618	115	6
Keratotomy	C	1619	38	6
Removal by magnet of foreign body embedded in cornea	C	1620	38	4
Biopsy	B	2390	54	4
Diagnostic scraping	C	2395	15	4
EDTA or similar treatment	C	2396	23	4
Section 10: Operations for Glaucoma				
Posterior sclerotomy (independent procedure)	D	2397	115	6
Trabeculectomy	D	2469	750	6

Chapter 18: Operations of the Eye	List	Code	Units Gen	Units An
Iridotomy, iridectomy or other procedure for relief of glaucoma	D	1622	245	6
Section 11: Intraocular				
Laser of the eye other than retina	D	1814	232	6
Does not apply to refractive correction				
Intraocular foreign body (all forms)	D	1642	310	6
Section 12: Cataract Operations				
Cataract, adult, all forms, including dislocated types	D	1648	442	6
Cataract, congenital or development - Initial	D	1649	442	6
Subsequent needling	C	1650	77	6
Capsulectomy, as independent procedure	D	1651	346	6
Cataract extraction with intraocular lens insertion, One stage	D	2398	434	6
Secondary insertion of intraocular lens	D	2399	375	6
Removal of intraocular lens	D	1672	257	6
Surgical replacement of dislocated intraocular lens	D	1673	257	6
Section 13: Other Operations on Anterior Segment				
(i.e. other than operations on cornea and operations for glaucoma or cataract)				
Lysis of adhesions in anterior segment	D	2400	115	6
Removal of iris tumor	D	1623	154	6
Removal of lesion by (irido) cyclectomy	D	2405	IC	6
Removal of epithelial downgrowth	D	2406	IC	6
Needling post-trabeculectomy	C	8082	100	
Section 14: Retina				
Retinopexy – any method	D	1653	616	6
Removal of encircling band +/- scleral implant	D	2371	150	6
Removal of scleral implant as sole procedure (not payable in addition to major surgery)	D	2372	115	6
Cryotherapy of retina, for any reason	D	1654	300	6
Laser of the retina	D	1813	286	6
Does not apply to refractive correction				
Intravenous fluorescein				
Without photography	B	2407	23	
With fundus photos, no interpretation	B	2408	38	
With fundus photos and interpretation	B	281	58	
Angiogram, interpretation only	B	284	26	
Section 15: Vitreous				
Aspiration/injection of vitreous	C	1652	92	6
Discission of anterior hyaloid membrane and/or vitreous strands	C	2409	77	6
Vitrectomy				

Chapter 18: Operations of the Eye	List	Code	Units Gen	Units An
Anterior	D	2410	231	6
Posterior	D	2040	611	8

	List	Code	Units Gen	Units An

CHAPTER 19: OPERATIONS OF THE EAR

See legend – Chapter 3, Section 1.7 for description of lists A, B, C and D.

Section 1: External Ear

	List	Code	Units Gen	Units An
Incision				
Drainage of abscess or haematoma of auricle or external auditory canal	C	1664	59	4
Drainage of extensive haematoma of pinna, under general anaesthetic	C	1769	115	4
Excision				
Biopsy of ear	B	1665	15	
Local excision of lesion on ear	C	1666	59	4
Complete excision of ear – amputation of ear	D	1667	115	4
Radical excision of malignant lesion of external ear canal	D	1668	308	4
Endoscopy				
Removal of cerumen (Chapter 3, Section 1.2.2)		VF		
Otoscopy with removal of foreign body or myringotomy tubes from external ear canal	C	1669	15	
Under general anaesthetic	C	1670	38	4
Repair				
Otoplasty – correction of congenitally deformed ears, Unilateral (under 18 years of age)	D	1671	318	5

☞ ***Medicare Note: Adult Otoplasty: see Plastic Surgical Preamble, Chapter 20.***

Reconstruction of ear for microtia or loss of ear				
Partial				
First stage	D	2273	154	5
Subsequent stages	D	2274	154	5
Total				
Major stage	D	2275	231	4
Minor stage	D	2276	154	4
Maximum			616	
Drainage of haematoma	C	2278	38	4
Wedge excision and reconstruction	D	2280	115	4
Accessory auricle – removal	D	2281	75	4
Preauricular sinus				
Simple	D	2282	77	4
Complicated or recurrence	D	2283	154	4
Construction of ear canal for congenital atresia				
Without mastoidectomy	D	1674	539	4
With mastoidectomy	D	1675	616	7
Removal of ear canal exostosis	D	2042	231	4

	List	Code	Units Gen	Units An
Section 2: Middle Ear				
Incision				
Myringotomy, tympanotomy, plicotomy (without aftercare)				
Unilateral	C	1676	23	4
Bilateral	C	1677	46	4
Myringotomy, (operative microscope) and insertion of prosthesis				
Unilateral	C	1678	38	4
Bilateral	C	1679	88	4
☞ ***Medicare Note: A consultation is payable in addition to service codes 1676, 1677 and 1678.***				
Excision				
Mastoidectomy, Simple, unilateral	D	1680	231	7
Radical or modified radical, unilateral	D	1681	385	7
Microsurgical cleaning of mastoid cavity	C	1735	98	5
Removal of middle ear polyp by snare	C	1682	31	4
Ossiculectomy	C	1683	77	5
Repair				
Tympanotomy with round window fistula repair and closure	D	1768	325	7
Revision of radical mastoid cavity	D	1684	385	7
Stapes mobilization	D	1685	385	7
Stapedectomy	D	1686	539	7
Facial nerve decompression	D	1687	462	7
Facial nerve graft	D	1688	539	7
Middle ear exploration	D	1689	231	7
Section 3: Internal Ear				
Incision				
Labyrinthotomy – any type	D	1690	385	7
Excision				
Labyrinthectomy	D	1691	462	7
Repair				
Fenestration of semicircular canal	D	1692	385	7
Revision of fenestration operation	D	1693	385	7
Endolymphatic shunt (House)	D	1694	IC	7
Endolymphatic sac decompression	D	1736	539	7
Myringoplasty	D	1695	231	7
Ossicular chain reconstruction				
Without myringoplasty	D	1696	308	7
With myringoplasty	D	1697	385	7
Tympanoplasty	D	1698	539	7
Tympanomastoid (mastoidectomy plus tympanoplasty +/- musculoplasty)	D	1699	616	7

CHAPTER 20: PLASTIC SURGICAL PROCEDURE

See legend – Chapter 3, Section 1.7 for description of lists A, B, C and D.

Section 1: Preamble

1. Refer to the Surgical Procedures Preamble in Chapter 6 for payment guidelines on multiple procedures.
2. The postoperative period for plastic surgery is 30 days; listed fees include all management of the patient during that period including the management of all complications of the procedures performed.
3. Surgery performed for cosmetic purposes is not an entitled service under Medicare. It follows that anaesthesia and hospitalization incurred for these procedures are not entitled services.

   In more specific terms, the following are examples of services not eligible for payment:
   a) Hair transplantation
   b) Rhytidectomy
   c) Excision of xanthelasma
   d) Aesthetic lasabrasion
   e) Excision of tattoos, except for late complications
   f) Adult otoplasty except post-trauma
   g) Aesthetic blepharoplasty
   h) Aesthetic rhinoplasty
   i) Mastopexy
   j) Aesthetic augmentation mammoplasty
   k) Aesthetic abdominoplasty
   l) Aesthetic liposuction

4. Revision of cosmetic surgery is not an insured service:

   In cases where the patient had previous cosmetic breast augmentation and goes on to develop breast contractures or implant rupture, the removal of the previous prosthesis as well as any potential implant of new ones cannot be billed to Medicare.

   Correction of asymmetry of breasts or nipple areola complexes post cosmetic surgery cannot be billed to Medicare.

5. Plastic surgery performed other than for cosmetics to correct the effects of trauma, burns, sepsis, as well as the surgical excision of lesions for treatment or diagnosis, is eligible for benefits.

   The length of time since the causal event occurred as well as the age of the patient will be taken into account for purposes of determining coverage in specific cases. In the case of acne scars, the time elapsed since the condition has last been active will be considered.

List	Code	Units Gen	Units An

6. Plastic surgery initiated prior to the age of 18 years for the correction of congenital cosmetic defects is eligible for benefits. Moreover, corrective surgery for the following indications is eligible for benefits without any age limitation:
   a) Breast agenesis, dysgenesis or congenital deformity
   b) Cleft lip growth deformities
   c) Growth abnormalities
   d) Gynaecomastia surgery for tumor of major functional disability.

(Specific exceptions are listed in paragraph 3). There is also no age limitation for the correction of the effects of trauma to the nose.

7. Physicians are required to apply to Medicare in writing for consideration prior to rendering the service to determine the coverage status of proposed surgery whenever reasonable doubt exists as to its eligibility for benefits. A request form has been developed for this purpose. (see http://www.gnb.ca/0394/pdf/2015/request-for-prior-approval.pdf)

8. Iatrogenic Injuries - See Chapter 3 Section 1.2.12

Section 2: Skin Grafts and Tissue Shifts

2.1 Local Tissue Shifts

The following fees apply in situations requiring unusual time-consuming techniques of excision or repair such as Z-plasty, rotation flaps, local pedicle flaps, etc. commonly employed by plastic and reconstructive surgeons to obtain maximum functional results. The stated fees include the creation of defect and the necessary preparation for repair or the debridement and repair of complicated lesions.

Multiple tissue flaps are those shifts/Z – plasties required to close a single defect/area.

These fees are for major procedures, e.g. joint contracture; they do not apply to simple closure of wounds, undermining of wound edges, etc.

☞ ***Medicare Note: When lesser procedures of the above nature are necessary an adjusted fee should be claimed.***

☞ ***Medicare Note: Claims submitted to Medicare must state the size and location of the lesion and the type of repair.***

Single tissue shift	D	2200	200	4
With free skin graft to secondary defect	D	2201	260	4
Multiple [(1)]	D	2202	320	5
With free skin graft to secondary defect	D	2203	361	5
Eyebrow, eyelid, lip, ear, nose, nipple				
Single	D	2204	241	5
Multiple [(1)]	D	2205	320	5

[(1)] In same functional area

2.2 Flaps from a Distance

Upper limb, first stage (each additional, add 50%)	D	2206	277	4
With skin graft to donor area	D	2207	320	4

Chapter 20: Plastic Surgical Procedure	List	Code	Units Gen	Units An
Lower limb, first stage including cast				
(each additional, add 50%)	D	2208	415	4
With skin graft to donor area	D	2209	462	4
Indirect flaps – tubes and jumps				
First stage	D	2865	277	4
With free skin graft	D	2866	393	4
Each additional stage	D	2867	208	4
With free skin graft	D	2868	324	4
Muscle pedicle flap, including skin grafts	D	612	420	5
Neurovascular pedicle flap	D	805	500	10
2.3 Head and Neck Reconstruction				
First stage, with deltopectoral flap, including lining of flap	D	2210	462	12
Second stage deltopectoral flap	D	2211	231	9

Section 3 Skin Grafts

The fees listed for skin grafts include the taking and the application of the grafts including refrigerated autografts.

Xenografts and homografts may be claimed at 50% of the appropriate listed fee.

Full thickness				
Eyelids, nose, lips, areola complete treatment	D	2212	231	5
Tip of finger, complete treatment	D	2007	77	4
Finger, more than one phalanx, complete treatment	D	2213	154	4
Partial thickness				
Non-functional region – area covered				
Less than 6.25 sq. cm. (1 sq. in.)	D	2214	54	4
Less than 62.5 sq. cm. (10 sq. in.)	D	2215	115	4
Less than 625 sq. cm. (100 sq. in.)	D	2216	231	5
Each additional 6.25 sq. cm. (1 sq. in.)	D	2217	3	TU
Functional areas				
Important major joints or the hand – primary	D	2218	231	4
Secondary, to include excision of scar tissue	D	2219	385	4
Head and/or neck – less than 62.5 sq. cm.				
(10 sq. in.)	D	2220	154	5
62.5 to 187.5 sq. cm. (10 – 30 sq. in.)	D	2221	231	5
More than 187.5 sq. cm. (30 sq. in.)	D	2222	539	5
Cavity grafting				
Orbit, including mucosa	D	2223	308	5
Nose	D	2224	231	5
Mouth	D	2225	308	4
Operation for congenital absence of vagina –				
plastic surgery and postoperative care	D	2226	308	5
Perineal/rectal cavity grafting	D	2295	308	5
Bone cavity grafting, large bone, up to 7.5 cm.	D	580	463	5

	List	Code	Units Gen	Units An
3.1 Tissue Expanders				
Insertion of tissue expander – head, neck, covering a major joint, or for myelomeningocele	C	2315	462	4
breast or other area	C	2311	308	4

☞ ***Medicare Note: Each additional expander insertion during the same operative session is payable at 75% of the listed fee if different or bilateral area, or 50% if the same or adjacent area (e.g. face and neck same side; either side of the spine).***

Subsequent inflation of tissue expander	C	2319	25	

☞ ***Medicare Note: Each additional expander inflation during the same visit is payable at 50% of the listed fee.***

Section 4 Skin Lesions, Superficial Tumors, Etc.

See Chapter 7, Section 1.2

Section 5 Laser Destruction of Skin Lesions

See Chapter 5, Section 4.5

Section 6 Carcinoma

Wide excision prior to skin grafting, if done during different operative sessions				
Head and neck	C	373	92	6
Trunk and limbs	C	374	66	4

Section 7 Wounds

See Sutures Chapter 7, Section 1.2

Section 8 Burns

Initial care				
Minor burns		388	VF	
Severe extensive	C	389	IC	
Surgical debridement of necrotic tissue				
Initial, for each 5% of body surface area	C	317	30	5
Repeat for each 5% of body surface area	C	318	20	5
Tangential total excision of burn tissue prior to immediate graft, additional to skin graft fee				
First 5% of body surface area, add	C	319	100	5
Each additional 5% area, add	C	320	50	

	List	Code	Units Gen	Units An

☞ ***Medicare Note: In cases of severe burns treated in burn units, claims may be submitted on an intensive care fee basis, using the appropriate service codes. In other location, claims may be submitted on a detention fee basis, using service code 389. Claims under service code 389 must give the location and percentage of body surface burned by degree of burn, and any significant details concerning the patient's general health.***

☞

Section 9 Keloids

Intralesional injection of scar – per session	C	381	28	
Large or functional areas	C	382	IC	4

☞ ***Medicare Note: Service codes 381 and 382 are restricted to specialists in plastic surgery and dermatology.***

Section 10 Cheeks

Facial paralysis - Static slings	D	2251	308	5
Dynamic slings	D	2252	385	5
Composite repair for facial paralysis, plication of paralyse muscles and resection or paralysis of overactive muscles	D	2253	385	6
Combined muscle transplant done in one or more stages for facial paralysis	D	2254	539	6
Dermabrasion				
Less than ¼ of face	C	150	67	6
¼ to ½ of face	D	151	200	6
Full face	D	152	405	6

☞ ***Medicare Note: Dermabrasion for cosmetic purposes is not covered. To determine the coverage status of proposed surgery see Plastic Surgical Preamble, Chapter 20, Section 1.***

Salivary fistula – repair of Stensen's duct	D	932	192	4

Section 11 Nose

Removal of hump	D	2259	154	4
Reconstruction of nasal tip, ala or columella	D	2260	269	4
Nasal implant				
Bone graft	D	2261	308	4
Synthetic	D	2262	231	4
Septectomy, submucous resection, including septoplasty, with correction of nasal deformity	D	653	385	6
Rhinoplasty, complete management, including septectomie and grafts where necessary	D	660	462	8
Forehead rhinoplasty – total care	D	2263	539	6

	List	Code	Units Gen	Units An

☞ ***Medicare Note: Rhinoplasty for cosmetic purposes is not covered. To determine the coverage status of proposed surgery, see Plastic Surgical Preamble, Chapter 20, Section 1.***

Rhinophyma, complete, including skin grafts if required	D	650	154	4
Nasal fractures				
No reduction			VF	
Closed reduction	D	420	77	6
Operative reduction	D	421	154	6

Section 12 Orbit

Bone graft to orbit				
Autologous	D	2264	308	5
Non-autologous	D	2265	231	5
Ptosis – lid suspension or levator resection	D	2266	225	5
Repair of ectropion or entropion				
Simple, Ziegler operation, office procedure	C	2267	38	
Full thickness horizontal shortening of lid ent/ect	D	2268	150	4
Chalazion or other benign lesion of lid or conjunctive	C	1627	125	
Coronal or bilateral eyebrow lift	D	2180	320	4
Direct flap to eyebrow, total fee				
1st stage	D	2269	231	4
2nd stage	D	2270	115	4
Excision and full thickness reconstruction of lid for malignant tumor, total care				
Up to and including 1/3 of lid	D	2271	150	5
Greater than 1/3 of lid	D	2272	385	5

Section 13 Ears

Otoplasty – correction of congenitally deformed ears, unilateral (under 18 years of age)	D	1671	318	5
Reconstruction of ear, for microtia of loss of ear				
Partial				
First stage	D	2273	154	5
Subsequent stage	D	2274	154	5
Total				
Major stage	D	2275	231	4
Minor stage	D	2276	154	4
Maximum			616	
Drainage of haematoma	C	2278	38	4
Wedge excision and reconstruction	D	2280	115	4
Complete excision of ear	D	1667	115	4
Accessory auricle – removal	D	2281	75	4
Accessory sinus				
Simple	D	2282	77	4
Complicated or recurrence	D	2283	154	4

Chapter 20: Plastic Surgical Procedure	List	Code	Units Gen	Units An
Section 14 Mouth				
Biopsy	B	882	31	4
Excision of simple lesion	C	883	31	4
Excision of ranula or dermoid cyst	D	886	92	4
Local excision for carcinoma of floor of mouth, mandible, alveolar margin or buccal mucosa	D	887	139	4
With hemimandibulectomy	D	889	308	10
Closure of antro-oral fistula				
With flap	D	892	231	4
With radical antrotomy	D	893	269	4
Genioplasty for facial reconstruction				
One-step advancement	D	1701	130	6
Two-step advancement	D	1702	162	6
Section 15 Lips				
Biopsy	B	894	31	4
Lip shave, vermilionectomy	D	895	154	4
Excision of simple lesion	C	896	31	4
V-excision, vermilion	D	2284	115	4
V-excision to sulcus	D	2285	192	4
Traumatic cleft lip	D	391	192	4
Excision one-half lip and reconstruction, one or more stages	D	899	308	4
Total excision of lip and reconstruction, one or more stages	D	901	462	6
Abbe reconstruction, total care	D	2286	385	6
Cleft lip repair, including repair of nasal deformity				
Unilateral				
One stage	D	2287	350	8
Staged procedure, maximum	D	2288	500	8
Bilateral				
One stage	D	2289	500	8
Staged procedure, maximum	D	2290	625	8
Section 16 Palate and Uvula				
Uvulectomy – independent procedure	C	919	52	4
Biopsy	B	920	31	4
Excision of simple lesion	C	921	46	4
Excision of malignant lesion with reconstruction	D	2336	IC	4
Cleft palate, repair	D	923	269	8
Revision, with bone graft	D	2291	308	8
Push-back of palate and/or pharyngeal flap	D	925	346	8
Repair of palate fistula	D	2292	231	8

	List	Code	Units Gen	Units An

Section 17 Breast

Reconstruction following mastectomy				
Immediate prosthesis insertion, add	D	2845	197	
Breast mound creation by prosthesis and/or soft tissue	D	2846	392	5
Breast reconstruction				
Grafts or pedicle flaps	D	2900	641	6
Repair/closure of abdominal wall	D	8900	145	TU
Transverse lower abdominal rectus flap (Drever)	D	352	573	5
Second procedure or revision	D	2848	392	5
Removal of prosthesis	D	2849	92	4
Reduction mammoplasty	D	411	535	6

Criteria for breast reduction:

a. Miminum weight removed per side – 200 grams
b. Less than 200 grams would require prior approval
c. Weight must be included in the diagnosis field of the claim (i.e. left 250 grams, right 260 grams
d. If the surgery occurs and less than 200 grams is removed per side, however the physician believes it to be medically necessary, he should submit a single patient claim form with a letter of explanation

Augmentation mammoplasty	D	412	392	5

☞ ***Medicare Note: Mammoplasty and breast reconstruction are not entitled procedures unless performed for other than cosmetic reasons. To determine the coverage status of proposed surgery see Plastic Surgical Preamble, Chapter 20, Section 1. Reconstruction following mastectomy for medical reasons is not considered cosmetic.***

Section 18 Trunk

Decubitus ulcer

For total care – excision of all tissue including bone and all necessary repair procedures such as rotation of a flap to cover the primary defect and application of skin grafts to secondary defects.

Closure of sacral or trochanteric decubitus ulcer				
Not requiring excision of bone	D	2293	320	5
With excision of bone	D	2294	420	5
Abdominal lipectomy (for functional disability only)				
with repair of hernia	D	2337	924	10

☞ ***Medicare Note: Service code 2337 applies also to repair of diastasis recti by a major procedure such as kiehl-type, double-layer shelving or vest-type aponeurosis repair. Prior approval must be requested from Medicare in each case to determine eligibility for coverage as an entitled benefit.***

Section 19 Genitalia

Epispadias	D	1351	231	4
Hypospadias – first stage, including urinary diversion	D	1352	304	4

Chapter 20: Plastic Surgical Procedure	List	Code	Units Gen	Units An
Plastic reconstruction of urethra – penile	D	1353	419	4
Penoscrotal or perineal	D	1354	546	4
Closure of urethrocutaneous fistula	D	1355	254	4
Urethral stricture, repair one stage, with diversion	D	1321	277	4
Two stages				
First	D	1322	139	4
Second	D	1323	277	4
Urethroplasty (Johanson) each stage	D	2298	310	4
Section 20 Limbs				
For lymphoedema of limbs – Kondoleon	D	869	277	4
Radical sleeve excision – entire lower limb, total care	D	870	539	6
Thompson procedure				
Upper extremity				
Forearm	D	2299	231	4
Arm	D	2300	154	4
Entire upper extremity – one or two stages – total care	D	2301	385	4
Lower extremity				
Leg	D	2302	385	4
Thigh	D	2303	385	4
Entire lower extremity – one or two stages– total care	D	2304	769	4
Excision of ulcer, multiple ligation of veins and skin graft				
One leg	D	759	192	4
Both legs	D	760	308	4
Excision of stasis ulcer and skin graft				
One leg	D	762	23	4
Both legs	D	763	185	4
Section 21 Hand				
Syndactyly – first cleft, local flaps	D	2305	154	4
Skin grafts, free or pedicle	D	2306	231	4
Direct full thickness flap to finger, total fee	D	2008	115	4
Neurovascular pedicle flap	D	2418	308	4
Section 22 Microsurgical Repair				
Total amputation: reimplantation				
Thumb	D	2880	1071	14
Finger	D	2881	928	14
(Maximum thumb and/or fingers: 2463 units)				
Hand, to include at least 3 digits	D	2882	2000	14
Forearm	D	2883	2000	14
Foot	D	2884	1786	14
Leg	D	2885	1786	14
Partial amputation: microsurgical repair – payable on an				

Chapter 20: Plastic Surgical Procedure	List	Code	Units Gen	Units An
individual structure basis; total fee not to exceed 75% of repair fee for total amputation	D	2886	IC	9
Individual structure microsurgery				
Microvascular surgery – artery or vein	D	2887	314	5
Microneural surgery – neuroplasty, neuroanastomosis	D	2888	314	5
Nerve graft	D	2889	478	5
(Cable graft additional 50% of fee)				
(Multiple cable remote payable at 75%)				
Free vascularized skin and subcutaneous tissue transplant				
Elevation of transplant and closure of donor site	D	1843	766	14
Preparation of microvascular recipient site	D	1844	810	14
Transplantation, with microvascular anastomoses	D	1845	810	14
Free vascularized innervated skin and subcutaneous tissue transplant				
Elevation of transplant and closure of donor tissue	D	1846	900	14
Preparation of microvascular recipient site	D	1847	900	14
Transplantation, with microvascular anastomoses and microneural nerve repair	D	1848	842	14
Free vascularized muscle or musculocutaneous tissue transplant				
Elevation of transplant and closure of donor site	D	1849	766	14
Preparation of microvascular recipient site	D	1850	810	14
Transplantation, with microvascular anastomoses	D	1851	766	14
Free vascularized muscle or musculocutaneous tissue transplant with tendon and nerve				
Evaluation of transplant and closure of donor site	D	1852	1036	14
Preparation of microvascular recipient site	D	1853	1036	14
Transplantation, with microvascular anastomoses, microneural repair, and tendon repairs	D	1854	1036	14
Free vascularized bone transplant				
Elevation of transplant and closure of donor site	D	1855	766	14
Preparation of microvascular recipient site	D	1856	810	14
Transplantation, with microvascular anastomoses and bony fixation	D	1857	900	14
Free vascularized osteocutaneous or osteomuscular tissue transplant				
Elevation of transplant and closure of donor site	D	1858	918	14
Preparation of microvascular recipient site	D	1859	918	14
Transplantation, with microvascular anastomoses, Osteotomies, and bony fixation	D	1860	918	14
Free microvascular toe or finger transplant				
Elevation of transplant and closure of donor site	D	1861	918	14
Preparation of microvascular recipient site	D	1862	918	14
Transplantation, with microvascular anastomoses, tendon, nerve, and bone repair	D	1863	1080	14

Section 23 Miscellaneous

Repair of meningocele, total care	D	1582	308	8

	List	Code	Units Gen	Units An
Encephalocele or myelomeningocele	D	1583	462	8
If team procedure plastic surgeon's portion of above				
Multiple flaps +/- graft	D	2326	269	8
Single flap				
With skin graft	D	2327	231	8
Without skin graft	D	2328	154	8
Excision of axillary sweat glands for hyperhidrosis, unilateral	D	2329	269	4
Dermis-fat graft	D	2417	308	4
Lipoma				
Suction assisted lipectomy – small area	D	353	115	4
Large area, or head, neck or major joint	D	354	154	4

☞ ***Medicare Note: Aesthetic Liposuction: to determine the coverage status of proposed surgery, see Plastic Surgical Preamble Chapter 20, Section 1.***

☞ ***Medicare Note: Claims submitted to Medicare using service code 354 must give details of lesion, size location, etc.***

Section 24 Tattooing Surgery

(for haemangioma, vitiligo, lentigines, etc.)

	List	Code	Units Gen	Units An
Face				
¼ or less	D	2330	77	4
¼ to ½	D	2331	154	4
Full face	D	2332	231	4
Non-facial area				
Per 6.25 sq. cm. (1 sq. in.)	D	2333	38	4
62.5 sq. cm. (10 sq. in.)	D	2334	77	4
625 sq. cm. (100 sq. in.)	D	2335	154	4

☞ ***Medicare Note: Tattooing surgery for cosmetic purposes is not an entitled service under Medicare. To determine the coverage status of proposed surgery, see Plastic Surgical Preamble, Chapter 20, Section 1.***

CHAPTER 21: DIAGNOSTIC AND THERAPEUTIC PROCEDURES

See legend – Chapter 3, Section 1.7 for description of lists A, B, C and D.

These fees apply when such procedures are carried out by or under the supervision of a physician. Cost of medication used in any of these procedures is additional.

☞ ***Medicare Note: The cost of medication is not a benefit under Medicare.***

☞ ***Medicare Note: See Chapter 2, Assessment Rule 13.***

Section 1 Allergy

Hyposensitization				
Initial injection and assessment		(Chapter 4, Section 2.15.10)		
Hyposensitization injection, including supervision (except initial injection and assessment), per visit.....	C	1894	13	
Desensitization acute, e.g. antitetanus serum, penicillin	B	1892	8	
Tests, and antigen, any method – per test	B	1895	3	
Maximum for any 6 month period: 30 tests.....			90	
Injection and Ingestant Challenges				
Challenge Testing	C	8158	100	
Each additional challenge test, during same visit, add		8159	13	
Resuctitation, if required, add.....		8160	100	

☞ ***Medicare Note: Requires FRCPC training as a Clinical Immunology and Allergy Specialist. FRCPC trained internists may be considered on an IC basis.***

Aspiration of (also see injection of medication)				
Abdomen – see paracentesis				
Bladder.....	A	1899	15	
Breast cyst.....	A	1900	15	
Bursa	A	1901	15	
Cisterna magna.....	A	1902	23	
Duodenum – by intubation for secretion test (after one hour charge extra on detention fee basis).....	B	1903	38	
Hydrocele.....	B	1368	8	
Joint.....	A	1905	15	
Lumbar puncture.....	B	177	38	
Oesophagus or stomach and preparation of material for cytological exam	B	1907	15	
Pericardium – aspiration or needle biopsy.....	A	1908	115	4
Thyroid cyst	A	1911	15	
B.C.G. vaccination, including necessary tuberculin tests.....	B	1914	8	
Cardiac arrest – supervision of resuscitative measures (including cardioversion where applicable).....	A	1725	77	
Services of an additional physician (max. 2).....	A	1726	20	

	List	Code	Units Gen	Units An
☞ ***Medicare Note: Service code 1725 or 1726 represents the total fee payable for a physician's services during the emergency. However, the attending physician or the consultant may claim for services provided at different times on the same day by indicating this on the claim form.***				
Cardiology, interventional - see Cardiovascular System - Chapter 10				
Cardioversion	B	1916	77	5
Catheterization – Eustachian tube	A	1922	29	
Dialysis for renal failure – acute renal failure and chemical intoxications, to include diagnosis, management, supervision of first dialysis and attendance during the first 24 hours	C	1923	462	
Each succeeding dialysis, supervision and care associated therewith	C	1924	308	
Dialysis for chronic renal failure – initiation of home dialysis regimen, including consultation, assessment, advice and management of problems, as well as first dialysis (any method)	C	1743	308	
In hospital dialysis (any method), including management during dialysis	B	1927	62	
☞ ***Medicare Note: Service Code 8898 – Travel Clinic, 1st patient seen, add-on is billable with Service Code 1927.***				
Home dialysis, weekly management and supervision fee. For the monitoring of home dialysis patients by telephone, by office/clinic based physician who directs dialysis teams, per patient. Not applicable when another dialysis fee is payable during t hat week, per patient	B	1744	35	
Dilation of ileostomy or colostomy	A	1990	8	
Dilation of oesophagus (See also Chapter 12, Section 8)				
Dye dilution densimetry curve including procedure and interpretation				
Initial (from the ear)	B	1928	23	
Repeat	B	1929	8	
Initial (from the artery)	B	1930	38	
Repeat	B	1931	15	
Electrocardiogram **(See Chapter 2, Assessment Rule 15)**				
Procedure with interpretation				
Office	B	1932	20	
Home	B	1933	23	
Before and after exercise	B	1934	23	
Interpretation only, office	B	1935	8	
Interpretation of tracings taken in hospital for all ECGs is paid at $5.00.				

	List	Code	Units Gen	Units An
☞ ***Medicare Note: Hospital electrocardiograms are billed to and paid by the hospital. The payment rate is based on the combined (inpatients and outpatients) total annual tracings taken in a hospital, whether interpreted by one or by many physicians.***				
24 hour ambulatory blood pressure monitoring	B	8950	25	
Holter 24 hr monitoring-total interpretation fee	B	2952	39	
Submaximal stress E.C.G. – with treadmill or ergometer and oscilloscopic continuous monitoring including E.C.G.'s taken during the procedure and resting E.C.G.'s before and after procedure	B	2373	62	
Pharmacologic stress test	B	8955	62	
Endocrinology and metabolism				
Antidiuretic hormone response test	B	1936	23	
Hypertonic saline infusion test	B	1937	38	
Benzodioxine histamine	B	1938	23	
Water tolerance test	B	1939	15	
Insulin sensitivity test	B	1940	38	
Endometrial aspiration	B	2352	12	
Enterotest (string)	B	1906	8	
Examination of eye under general anaesthesia	B	2049	31	
Fluoroscopy and/or orthodiagram	B	1941	8	
Fractional test-meal, samples and analysis	B	1943	23	
Augmented histamine test-meal	B	1944	31	4
Gastric lavage – diagnostic and emergency	B	1942	15	
Injections (Cost of injectable material additional)				
By cutdown	A	1946	23	
By scalp vein	A	1947	15	
Injection of medication – bursa, ganglion, joint or tendon, including preliminary aspiration if necessary or intramuscular	B	1948	15	
Radioactive Iodine Treatment	C	8100	48	
Intravenous or intramuscular cancer chemotherapy supervision – per treatment	B	1950	10	
Children 16 years or under	B	2838	95	
Injection of I.V. infusion of albumin	B	1881	10	
Injection of I.V. gammoglobulin	B	1882	10	
Intravenous injection for haemophiliacs, per treatment				
Adults	B	2816	10	
Children under 10 years	B	2817	15	
Lumbar puncture with intrathecal chemotherapy	B	1983	50	
Children 16 years and under	B	1809	150	
Needle biopsy procedures				
Bone marrow	B	866	38	4
Kidney	A	1952	54	
Liver	B	1953	38	4
Spleen	A	1954	46	
Pleura	A	1955	31	
Transthoracic lung biopsy with fluoroscopy	B	2066	63	

Chapter 21: Diagnostic and Therapeutic Procedures	List	Code	Units Gen	Units An
Pericardium	A	1908	115	4
Synovial tissue	A	1956	38	
Prostate	B	1383	62	4

☞ ***Medicare Note: The following codes are not to be used in conjunction with surgical or obstetrical procedures, in which case the appropriate procedure codes apply.***

Section 2 Nerve Blocks, Diagnostic and Therapeutic

Head and neck				
Supraorbital nerve	B	295	23	
Infraorbital nerve	B	296	23	
Occipital nerve	B	297	23	
Maxillary nerve	B	260	64	
Mandibular nerve	B	259	38	
Trigeminal ganglion	B	425	92	
Other cranial nerve block	B	270	46	
Cervical plexus	B	258	46	
Stellate ganglion	B	1056	64	
Superior laryngeal nerve	B	1399	64	
Brachial plexus	B	261	38	
Trunk				
Suprascapular nerve	B	271	23	
Intercostal block				
First nerve	B	272	23	
Additional nerve	B	273	12	
Paravertebral block				
Thoracic nerve	B	1534	46	
Additional thoracic nerve	B	1542	23	
Lumbar nerve	B	274	46	
Additional lumbar nerve	B	275	23	
Coeliac ganglion	B	413	92	
Sympathetic block				
Thoracic	B	276	92	
Lumbar (unilateral)	B	257	54	
Miscellaneous nerve blocks				
Single somatic nerve, not specifically listed	B	1762	23	
additional nerve	B	1763	12	
Diagnostic intrathecal block	B	1764	46	
Epidural block				
Cervical	B	1765	100	
Thoracic	B	1766	80	
Lumbar	B	1767	46	
Caudal	B	263	38	
Epidural with steroid, add	B	277	10	
Injection of joint				
Sacroiliac	B	1887	29	
Vertebral	B	1888	50	
Trigger point injection	B	1889	15	

Chapter 21: Diagnostic and Therapeutic Procedures	List	Code	Units Gen	Units An
additional	B	1890	8	
Intravenous Guanethidine block	B	1802	64	
Injection of alcohol, phenol or other sclerosing agents – basic fee as above	B	294	IC	
Nerve block with cryoanalgesia, add	B	292	50%	
Special noninvasive procedures such as transcutaneous electrical nerve stimulation (TENS) (excludes acupuncture)			VF	
Pain clinics – the initial visit by each physician is payable at a consultation fee, when not covered by a sessional fee.				
Oesophagus				
HCL drip test	B	2094	23	
Motility studies	B	2095	54	
Oesophagus and stomach				
24 hour Ph. Ambulatory monitoring	B	1799	54	
Paracentesis				
Thoracic – puncture of pleural cavity for aspiration (diagnostic and therapeutic), initial or subsequent	B	2592	38	
Abdominal – aspiration for diagnostic sample	B	1992	15	
Therapeutic aspiration, including diagnostic and sample	B	1993	38	
Thoracic or abdominal – administration of chemotherapy, including therapeutic aspiration and sample	B	1994	38	4
Perirenal insufflation of air	B	1995	38	
Phonocardiogram – supervision and interpretation	B	1996	23	
Plasmapheresis				
Initial	B	1535	75	
Repeat, 2nd to 5th	B	1536	50	
Additional, same year	B	1537	38	
Pulmonary function studies				
1. Routine survey of pulmonary function to provide information in ventilation, gas mixing and diffusion.	B	2098	38	
2. Individual tests				
a) Arterial carbon dioxide tension by a breathing technique	B	2099	15	
b) Arterial puncture with gas analysis at rest	B	2100	23	
c) Arterial puncture with gas analysis at rest and on exercise	B	2101	38	
d) Blood volumes	B	2102	15	
e) Diffusion capacity at rest	B	2103	15	
f) Diffusion capacity on exercise	B	2104	15	
g) Dye dilution curve – ear oximeter	B	2105	8	
h) Dye dilution curve and cardiac output	B	2106	15	
i) Gas mixing	B	2107	8	
j) Lung volumes (residual volume, total lung capacity)	B	2108	23	
k) Maximum breathing capacity	B	2109	8	
l) Mechanics of breathing at rest	B	2110	23	

Chapter 21: Diagnostic and Therapeutic Procedures	List	Code	Units Gen	Units An
m) Mechanics of breathing on exercise	B	2111	23	
n) Oximetry				
i. 90% desaturation time	B	2112	8	
ii. Change of arterial oxygen saturation on exercise	B	2113	8	
iii. Change of arterial oxygen saturation on exercise breathing oxygen	B	2114	8	
o) Oxygen consumption	B	2115	8	
p) Respiratory centre carbon dioxide stimulation test	B	2116	15	
q) Resting ventilation, spirogram and vital capacity	B	2117	8	
r) Timed vital capacity	B	2118	8	
s) Non specific bronchial provocative test	B	2131	50	
Replacement of pyelostomy, ureterostomy, nephrostomy or cystostomy tube	B	1989	8	4
Rheumatology & physical medicine – examination of joint fluid for white cell count	B	2135	10	
Uric acid crystals	B	2136	15	
Mucin clot	B	2137	6	
Overnight sleep apnea study – interpretation only	B	2134	46	
Stasis ulcer – application and/or change of Unna's paste or similar application, icthopaste, etc	A	2043	8	
Sterility investigation – male, sperm cell count and morphology	B	2047	8	
Female, see Female Reproduction System				
Tonometry, by tonometer	B	2048	8	
Section 3 Ultrasound - Heart				
Trans-eosophageal echocardiogram	B	1816	51	
Echography, pericardial effusion, M-mode	B	2980	14	
Echocardiography, complete, M-mode	B	2981	31	
With bidimensional imaging	B	2982	49	
Echocardiography – Doppler				
Qualitative, to detect absence or presence of valvular disease - Interpretation	B	2966	19	
Interpretation and performance	B	2967	25	
Quantitative, to detect valvular disease and calculate valve areas and pressure gradients interpretation	B	2968	34	
interpretation and performance	B	2969	45	
Section 4 Ultrasound - Carotid				
Carotid assessment – unilateral or bilateral for spectral analysis	B	2970	41	
Section 5 Endoscopic Ultrasound				
Upper Endoscopic Ultrasound (Scope not payable in addition) Through oesophagus	B	8147	51	4

Chapter 21: Diagnostic and Therapeutic Procedures	List	Code	Units Gen	Units An
Through stomach	B	8148	148	4
Through duodenum	B	8149	184	4
Lower GI Tract Endoscopic Ultrasound (Scope not payable in addition)	B	8150	100	4
Add-ons for both Upper and Lower GI Tract Endoscopic Ultrasounds				
Fine needle aspiration	B	8151	77	
Dilation of stricture	B	8152	77	
Fine needle injection	B	8153	77	
Drainage of pseudocyst	B	8154	77	

☞ ***Medicare Note: In exceptional circumstances, if the EUS scope is removed and a second/different scope is inserted in order to visualize the GI tract better or perform another procedure, this second scope (i.e. service code 964) may be paid at 75%. That information must be provided on the claim submission otherwise it will be paid at zero.***

Section 6 Ultrasound – Obstetrical

Biophysical profile – performed and interpreted by the physician	B	1896	46	
*Physician present but not performing the procedure (interpretation only)	B	1897	23	

Section 7 Ultrasound – Peripheral Vascular (including Doppler)

Peripheral vascular assessment, one area (ex: ankle), one or two levels	B	2425	10	
One limb only	B	2122	8	
Bilateral assessment (see Medicare Note below)	B	2123	13	
As above with segmental pressure recordings and/or wave form analysis and/or spectral analysis, +/- exercise testing	B	2955	20	
One limb only	B	2124	15	
Bilateral assessment (see Medicare Note below)	B	2125	25	
Peripheral vascular testing of limb (at least 3 levels), with segmental pressure recordings and/or wave form analysis and/or spectral analysis	B	2126	25	
One limb only	B	2127	19	
Bilateral assessment (see below)	B	2128	31	
Peripheral testing of limb, as above, with exercise testing	B	2586	31	
One limb only	B	2129	23	
Bilateral assessment (see Medicare Notebelow	B	2130	39	

Section 8 Non-Invasive Vascular Tests (Ultrasound, Duplex Only)

Non-invasive vascular assessment of abdominal aorta, mesenteric, renal or iliac arteries	B	1804	30	
Arterial vascular assessment, upper or lower extremity – +/- graft (with or without exercise)				
Unilateral	B	1805	54	
Bilateral	B	1806	108	
Venous vascular assessment, upper or lower extremity				

	List	Code	Units Gen	Units An
Unilateral	B	1807	54	
Bilateral	B	1808	108	

☞ ***Medicare Note: Duplex examinations include doppler when performed on same area/limb.***

☞ ***Medicare Note: The Doppler and Duplex service codes and fees include the physician's supervision and participation in the procedures, as applicable, and must comprise a permanent record of the interpretation of the findings. They do not apply to subsequent interpretations by any practitioner. Service Codes 2425, 2955, 2126 and 2586 include contralateral comparison studies; the "bilateral assessment" fee is payable solely when symptomatology in the second limb warrants assessment as confirmed by the studies.***

Venipuncture - Infant or child under 4 years I.C. only (see note Chapter 4, Section 2.10)	A	2051	8	
adult or child 4 years and older I.C. only (see note Chapter 4, Section 2.10)	C	2050	5	
Femoral vein puncture	A	2052	15	
Jugular vein puncture	A	2053	15	
Umbilical vein catheterization	A	2081	15	
Umbilical artery catheterization	A	2082	31	
Venisection, therapeutic	A	2054	8	
Phlebotomy, therapeutic, for polycythemia	A	2055	8	

Section 9 Venous Cannulation

Applies also to replacement unless otherwise stated. (Excludes simple venipunctures such as phlebotomy, intravenous medication via syringe, butterfly setups for IV drips, etc.).

Insertion of peripheral indwelling venous catheter	A	2477	15	
Insertion of central indwelling catheter via peripheral route, such as for central venous pressure or total parenteral nutrition – payable in addition to ICU daily care	A	2476	30	
Insertion and subcutaneous tunnelling of central indwelling catheter to vena cava, such as Hickman-Broviac or Port-A-Cath or Pas-Port	B	1885	115	4
With subcutaneous chamber	B	1883	200	4
Removal: See Medicare note				
Insertion of central venous catheter via puncture of a proximal vein	B	8155	86	4
Right heart catheterization, such as by Swan-Ganz catheter for cardiac monitoring, see service code 1918 under Cardiovascular System (Chapter 10).				
Insertion or Removal of permanent Peritoneal Dialysis Catheter	B	8336	200	

☞ ***Medicare Note: If separate site, both insertion and removal will be paid at 100%. If otherwise, second procedure will be paid at 75%. This must be clearly indicated on claim submission. An attempted insertion will be paid as an insertion.***

Chapter 21: Digestive and Theraputic Procedures	List	Code	Units Gen	Units An
Insertion or removal of permanent peritoneal dialysis catheter by laparoscopy	D	8126	339	7

CHAPTER 22: CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC IMAGING (LIST B)

See legend – Chapter 3, Section 1.7 for description of lists A, B, C and D.

These procedural fees are intended to cover compensation for professional services such as placing an instrument and introducing contrast media (except oral or rectal administration for study of the alimentary tract and intravenous injections). Radiological charges are additional.

☞ ***Medicare Note: See unit values, Chapter 3, Section 1.5.***

Section 1 Special Procedural Fees

	List	Code	Units Gen	Units An
Breast mass, needle localization with mammography	B	1715	63	
Myelogram				
1 area	B	181	63	4
2 or more areas	B	2013	89	4
Posterior fossa	B	2014	107	6
Discogram				
One level	B	2146	63	4
Each additional level	B	2119	32	TU
Facet joint injection – per joint	B	2120	50	
Bronchogram				
Unilateral	B	2147	36	6
Bilateral	B	1711	54	6
Laryngogram	B	2148	36	4
Arthrogram	B	2149	27	4
Double contrast	B	2062	44	
Pneumoencephalogram	B	182	107	5
Ventriculogram	B	1506	179	6
Velopharyngogram	B	1991	36	
Angiography				
Arteriography – percutaneous (needle only)	B	800	77	4
Non-selective				
Percutaneous (with catheter)	B	2156	89	4
By cut-down	B	2154	133	4
Selective (e.g. renal, cerebral, vertebral) – each artery, add	B	2063	44	TU
Super selective (e.g. gastroduodenal, distal hepatic, pudendal, distal mesenteric branch) – each artery, add	B	2061	59	TU
Myocardial perfusion scan (inj Thallium)	B	1738	28	
Myocardial wall motion scan	B	1741	54	
Myoview test/ejection fraction	B	1742	64	

☞ ***Medicare Note: If interpretation only, bill at 50% of listed fee for service codes 1738, 1741 and 1742.***

	List	Code	Units Gen	Units An
☞ ***Medicare Note: If an ejection fraction is not performed then the appropriate Service Codes (1741 or 1738) should be billed for a wall motion scan or a myocardial perfusion scan.***				
Angioplasty (Percutaneous transluminal dilation of arterial stenoses and occlusions under local anaesthesia)				
Iliac	B	1712	340	
Femoral	B	1713	340	
Renal	B	1714	425	
Venogram	B	736	44	4
Inferior venacavagram	B	2839	89	
Transjugular liver biopsy (includes selective venous catheterization, contrast injection, manometry and performance of biopsy)	B	2155	160	
Embolization of vessel, additional to angiography fee	B	2515	85	TU
Lymphogram	B	2158	89	5
Bilateral	B	2064	133	
Sialogram	B	2159	44	4
Dacryocystogram	B	2160	44	4
Presacral insufflation	B	2161	44	4
Splenoportogram	B	2162	63	4
Percutaneous transhepatic portography	B	1721	89	
Percutaneous transhepatic cholangiogram	B	2163	89	4
Percutaneous biliary drainage (introduction of catheter into the common bile duct and duodenum under diagnostic imaging) – includes percutaneous transhepatic cholangiogram	B	1716	340	
Percutaneous extraction of common bile duct stone under fluoroscopy	B	2375	133	4
Endoscopic retrograde cholangiopancreatography (ERCP) +/- biopsy, +/- cytology	B	2875	202	6
Hysterosalpinogram	B	2164	63	4
Saline senohysterogram	B	8075	63	4
Bead chain examination of bladder	B	2169	46	
Voiding cystourethrogram	B	2165	9	
Retrograde urethrogram or cystogram, without cystoscopy	B	2015	27	
Percutaneous renal cystogram	B	2016	63	4
Percutaneous insertion of nephrostomy tube under local anaesthesia, under fluoroscopy	B	2840	133	
Percutaneous nephrostomy with ureteric dilation or stent insertion under diagnostic imaging	B	1720	231	
Percutaneous establishment of nephrostomie tract for stone extraction	B	2121	340	6
Ileal loopogram	B	2087	27	
Hypotonic duodenography with intubation	B	2065	17	
Intubation of small intestine	B	1057	36	4
Percutaneous diagnostic tap of fluid collection under diagnostic imaging	B	1717	63	

Chapter 22: Clinical Procedures Associated With Diagnostic Imaging (List B)	List	Code	Units Gen	Units An
Percutaneous insertion of drainage tube into fluid collection under diagnostic imaging	B	1718	95	
Percutaneous intraabdominal needle biopsy of solid mass under diagnostic imaging	B	1719	79	
Transthoracic lung biopsy with fluoroscopy	B	2066	63	6
Endobronchial brush biopsy	B	2067	63	6
Pelvic Ultrasound				
Professional	B	8171	20	
Technical	B	8172	20	
Transcatheter aortic valve implantation (Interventional Cardiology)	D	8129	1634	45

☞ ***Medicare Note: Service Code 8129 is an all-inclusive fee. No other service codes are billable with this service.***

CHAPTER 23: SPECIALISTS IN DIAGNOSTIC RADIOLOGY

The fees include interaction between the certified diagnostic radiologist and the referring physician as well as, the supervision and interpretation of diagnostic imaging studies.-

1. For purposes of this schedule, "radiology" refers to Diagnostic Radiology, Interventional Radiology and Nuclear Medicine.
2. The rate(s) of payment per unit (unit values) are listed in Chapter 3, Section 1.5 of the General Preamble.
3. If the examinations which are requested by the referring physician yield abnormal findings or if they would yield information which, in the opinion of the radiologist, would be insufficient or if a different examination is necessary to obtain the diagnostic information required, governed by the needs of the patient, the radiologist may add further views or change the examination and claim for them in accordance with the listing.

Section 1 Fee Schedule Interpretation

1. The number of views obtained is governed by the needs of the patient and requirements of the referring physician and the opinion of the radiologist. The radiologist may claim for views thus obtained and in accordance with the listing. (Reference - item 3 above).
2. The fee for "additional views extra" may only be claimed for interpretation of a view which is not considered to be included in the routine examination of that part or area and which has been specifically requested by the referring physician or deemed clinically necessary by the interpreting radiologist.
3. Fluoroscopy charges should not be submitted for any examination performed by the radiologist where fluoroscopy is generally regarded as an integral part of the examination e.g. examinations of the G.I. tract, clinical procedures associated with diagnostic imaging.
4. Three or more views of the chest should not be routinely claimed when a chest examination is requested.
5. In general, when billing for a diagnostic imaging study, additional billing service codes may not be added for areas of anatomy which are incidentally included in the field of view of the primary study, unless imaging of the additional areas of anatomy was requested by the radiologist or referring physician and all the customary views of the additional area were obtained.
6. Claims for new procedures or interpretations not precisely covered by an existing service code in the Radiology fee schedule, must be submitted to Medicare as I.C. under service code 888 and include the billing information. Subsequently, a submission should be sent to the New Service Items Committee.
7. After Hours Emergency Premiums for Computerized Tomography and Ultrasounds

   After Hours is defined as 18:00 to 08:00 on weekdays and all day on Saturday, Sunday and statutory holidays. The premium is paid as follows:

   If the radiologist returns to the hospital the following premiums apply:

06:00 to 08:00	50% of the normal rate of payment
18:00 to 24:00	50% of the normal rate of payment
24:00 to 06:00	100% of the normal rate of payment

If the radiologist uses tele-radiology services from a location outside of the hospital facility, the following premium applies:

06:00 to 08:00	35% of the normal rate of payment
18:00 to 24:00	35% of the normal rate of payment
24:00 to 06:00	70% of the normal rate of payment

Saturday, Sunday and Statutory Holidays, the radiologist will be able to bill the 50% premium if he/she comes to the hospital or the 35% premium if he/she does it from another location using tele-radiology. This does not include scheduled scans during the weekend hours or scans held by the radiologist and read during the weekend. These are not considered emergencies.

The following criteria apply:

- The service must be rendered in an emergency defined as a service which must be performed without delay because of the medical condition of the patient. The time of the service is not by itself the determining factor for premium charges. There must be documented evidence as to the emergent nature of the after-hours service. The premium is only payable when both criteria are met; an emergency service is performed after-hours.
- The request should generally be received, read and reported in the after-hours period, in order to qualify.
- The radiologist must complete all necessary documentation (Report of Findings)
- Documentation of each service provided in the after-hours must be maintained for audit purposes. The following elements are to be maintained:
    - Name of Radiologist
    - Name of the Patient(s)
    - Hospital Identifiers (this can include the Accession/Exam number, PPRN or Medicare number of the patient)
    - Time of the Verbal Report to the requesting physician
    - Where the report was read (home or hospital)

Note: This information must be kept on-site for audit purposes. It is understood that there are various processes within the Zones and as such, it will be up to the radiologists and their respective Zones to determine how and who will be responsible for maintaining this information in a manner that will be easily accessible to Monitoring and Compliance personnel.

☞ ***Medicare Note: The time of day the service was rendered must be provided including weekends and statutory holidays.***

See Items Common to All Practitioners – After Hours Emergency Premium for further information (Chapter 4, Section 2.12)

Interpretation of Images

	List	Code	Units Gen	Units An
Section 2 Chest and Thoracic Viscera				
Chest				
Single view		3000	3	
Two views		3001	6	
Three or more views including dual energy		3002	7	
Portable chest film		3003	5	
Thoracic fluoroscopy with films		3005	11	
Thoracic inlet		3006	5	
Ribs				
One side		3007	5	
Both sides		3008	7	
Sternum or sternoclavicular joints		3009	5	
Tomography		3010	12	
Section 3 Abdomen and Gastrointestinal Tract				
Abdomen				
Single view		3011	5	
Multiple views – perforation/obstruction		3012	8	
Portable abdomen				
Single view		3232	5	
Two or more views		3233	8	
Upper GI				
Pharynx and oesophagus		3013	9	
Dilation of oesophagus under fluoroscopic control		3234	8	
Upper G.I. series (oesophagus, stomach & duodenum)				
Single Contrast		3014	17	
Double Contrast		3015	23	
Single or Double contrast with glucagon (Barium meal examination)		3235	23	
Combined G.I. with delayed film		3017	22	
with Maxeran		3236	28	
Small bowel motility exam		3018	17	
with Maxeran		3019	23	
Enteroclysis		3229	23	
Cholangiogram				
Operative		3023	7	
T-tube with fluoroscopy		3024	10	
Barium enema				
Single Contrast		3028	17	
Double contrast		3029	23	
Single or double contrast with glucagon		3030	23	
Endoscopic retrograde cholangiopancreatography (ERCP)		3031	70	
Tomography		3033	12	

	List	Code	Units Gen	Units An
Section 4 Genitourinary System				
Pyelogram				
Intravenous +/- rapid sequence		3034	17	
With tomography		3035	23	
With diuretic washout		3036	23	
Retrograde		3037	6	
Retrograde ileal conduit pyelogram		3038	6	
With fluoroscopy		3039	12	
Cystogram		3040	6	
Cystourethrogram (voiding) Retrograde		3041	17	
Urodynamic study		3043	17	
Retrograde urethrogram		3044	17	
Functional pyelogram				
Drip infusion		3045	19	
With diuretic washout		3046	23	
With tomography		3047	23	
Percutaneous antegrade pyelogram		3049	6	
With fluoroscopy		3050	12	
Nephrostomy tube pyelogram		3051	6	
With fluoroscopy		3052	12	
Hysterosalpingogram		3055	6	
With fluoroscopy		3056	12	
Tomography		3061	12	
Section 5 Head and Neck				
Skull		3062	7	
Special additional views extra		3063	4	
Portable skull		3214	7	
Facial bones		3065	6	
Orbit, special views extra		3215	5	
Paranasal sinuses		3066	6	
Mastoids		3067	7	
Nose		3069	5	
Eye - Foreign body		3071	5	
Mandible or maxilla		3073	6	
Portable mandible		3216	6	
Temporomandibular joints		3074	6	
Teeth		3077	7	
Salivary gland region		3078	6	
Nasopharynx and/or neck – soft tissues		3079	5	
Portable neck – soft tissue		3217	5	
Tomography		3080	12	
Section 6 Upper Extremities				
Shoulder		3081	5	
Clavicle		3082	5	
Scapula		3083	5	
Acromioclavicular joints		3084	5	

Chapter 23: Specialists in Diagnostic Radiology	List	Code	Units Gen	Units An
With weights		3085	7	
Humerus		3086	5	
Elbow		3087	5	
Forearm		3088	5	
Wrist		3089	5	
Scaphoid		3090	3	
Hand (two or more fingers)		3091	5	
Hand for soft tissues		3218	5	
Finger or thumb		3092	3	
Specialized views of any of the above		3093	3	
Portable upper extremity		3219	5	
Tomography		3094	12	
Section 7 Lower Extremities				
Hip		3095	5	
Hip pinning				
Interpretation only		3096	6	
Supervision and interpretation		3097	20	
Femur		3098	5	
Knee		3099	5	
Patella		3100	3	
Lower leg		3101	5	
Ankle		3102	5	
Os calcis		3103	5	
Foot (2 or more toes)		3104	5	
Toe		3105	3	
Specialized views of any of the above		3106	3	
Portable lower extremity		3220	5	
Leg length studies (scanogram)		3107	6	
Full length leg (standing)		3224	6	
Tomography		3108	12	
Section 8 Spine and Pelvis				
Cervical spine - Routine		3109	6	
With additional views (including obliques)		3110	8	
Thoracic spine		3111	6	
With additional views		3112	8	
Lumbar spine		3113	6	
With additional views		3114	8	
Sacrum and/or coccyx		3115	5	
Sacroiliac joints		3116	5	
Facet joint injections – radiological fluoroscopy control		3117	8	
Pelvis		3118	5	
Additional views extra		3221	3	
Pelvis and hip		3119	6	
Pelvis and sacroiliac joints		3120	6	
Portable pelvis and spine		3222	6	
Spine – scoliosis series		3121	12	
Tomography		3122	12	

	List	Code	Units Gen	Units An

Section 9 Miscellaneous

Call back to hospital, night or weekend (not payable when AHEP is claimed)		3311	27

☞ ***Medicare Note: "Call back" to hospital applies when a radiologist is called back to the hospital after the normal working hours.***

a) "night time" applies to attendance between 18:00 and 08:00 hours during weekdays.

b) "weekends" applies to attendance on Saturdays, Sundays and legal holidays. (See Chapter 4, Sectio 2.12.1).

A call back does not apply when a radiologist has come from another location on the hospital premises nor when a radiologist is providing scheduled after hour coverage during the time periods described above. Only one call back per trip to the hospital is payable regardless of the number of studies examined. An additional call back is payable for additional trips made within the same shift or period as outlined above.

☞ ***Medicare Note: Claims for "call back" must show the time of day the service was rendered.***

☞ ***Medicare Note: A "call back" to the hospital fee cannot be billed for Ultrasounds and CT Scans when the after hours emergency premium has been applied.***

Directive Care visit	4102	16
Interpretation of submitted films – per examination	3123	8

☞ ***Medicare Note: Service code 3123 is to compensate a radiologist when studies made elsewhere are sent to the radiologist for an opinion. It does not apply when the studies referred to above are used for comparison purposes with studies made in the consultant's facility.***

Skeletal survey		
1st anatomical area	3124	6
Each additional anatomical area	3125	3
Screening mammography bilateral (asymptomatic)	3206	19
Diagnostic mammography	3207	23
Body section study – tomogram	3128	12
Bone age determination (skeletal maturation)	3130	6
Bone density (mineral content measurement)		
First site	3131	12
Additional sites (once/patient, max 2 sites)	3225	6
Tissue specimen (max 1 per surgical/biopsy site)	3223	3
Transvenous cardiac pacemaker placement (temporary or permanent) – radiological control	3133	15
Regional fluoroscopy (specify area)	3135	8

	List	Code	Units Gen	Units An
Stillborn Examinations				
Chest radiograph		3183	3	
Abdomen radiograph		3184	5	
CT Chest		3185	75	
CT Abdomen		3186	75	
MRI Whole Body Scan		3187	209	

Section 10 Procedures Interpretation Only

Myelogram				
1 area		3136	15	
2 or more areas		3137	23	
Sinus tract injection		3129	9	
Discogram		3139	15	
Bronchogram				
One side		3140	15	
Both sides		3141	22	
Arthrogram		3143	15	
Double contrast		3144	15	
Velopharyngogram		3145	15	
Venography				
Peripheral venogram				
unilateral		3147	9	
bilateral		3148	14	
Venacavagram, inferior or superior				
Bilateral simultaneous injections		3149	15	
Vascular cine fluoro or video capture		3150	23	
Arteriography				
Using single films				
non-selective		3153	8	
selective		3154	15	
Vascular cine fluoro or video capture				
non-selective		3155	15	
selective		3156	23	

Section 11 Cardiac Angiography and angioplasty

Radiologist's interpretation and reporting of any same-day combination of the following procedures done in conjunction with left and/or right heart catheterization: left/right ventriculography, left/right coronary arteriography, bypass graft angiography, aortic arch interpretation, assessment of valves for stenosis/insufficiency/etc., coronary angioplasty, valvuloplasty		3202	88	

If an emergency or sudden change in the patient's condition results in additional cardiac angiography on the same day, the radiology component is payable as a separate fee under this code.

Chapter 23: Specialists in Diagnostic Radiology	List	Code	Units Gen	Units An
Lymphogram		3157	15	
Sialogram		3158	8	
Dacryocystogram		3159	8	
Percutaneous transhepatic cholangiogram		3162	15	
Transthoracic lung biopsy with fluoroscopy		3164	15	
CT Angiography of Coronary **Arteries** - Reporting the condition of the ascending Aorta is included in the services		3316	200	
CT Angiography other than coronary		3317	75	
Section 12 Computerized Tomography				
Head Scan without / delayed enhancement		3166	50	
AHEP @ 50%		3400	25	
AHEP @ 100%		3401	50	
AHEP @ 35%		3402	18	
AHEP @ 70%		3403	35	
With enhancement		3167	58	
AHEP @ 50%		3404	29	
AHEP @ 100%		3405	58	
AHEP @ 35%		3406	20	
AHEP @ 70%		3407	41	
With repeat scan with enhancement		3168	75	
AHEP @ 50%		3408	38	
AHEP @ 100%		3409	75	
AHEP @ 35%		3410	26	
AHEP @ 70%		3411	53	
Sinus / Facial Bones without / delayed enhancement		3230	50	
AHEP @ 50%		3400	25	
AHEP @ 100%		3401	50	
AHEP @ 35%		3402	18	
AHEP @ 70%		3403	35	
With enhancement		3213	58	
AHEP @ 50%		3404	29	
AHEP @ 100%		3405	58	
AHEP @ 35%		3406	20	
AHEP @ 70%		3407	41	
Sella without / delayed enhancement		3126	50	
AHEP @ 50%		3400	25	
AHEP @ 100%		3401	50	
AHEP @ 35%		3402	18	
AHEP @ 70%		3403	35	
With enhancement		3127	58	
AHEP @ 50%		3404	29	
AHEP @ 100%		3405	58	
AHEP @ 35%		3406	20	
AHEP @ 70%		3407	41	
Orbits without / delayed enhancement		3151	50	

Chapter 23: Specialists in Diagnostic Radiology	List	Code	Units Gen	Units An
AHEP @ 50%		3400	25	
AHEP @ 100%		3401	50	
AHEP @ 35%		3402	18	
AHEP @ 70%		3403	35	
With enhancement		3152	58	
AHEP @ 50%		3404	29	
AHEP @ 100%		3405	58	
AHEP @ 35%		3406	20	
AHEP @ 70%		3407	41	
Temporal Bones without / delayed enhancement		3160	50	
AHEP @ 50%		3400	25	
AHEP @ 100%		3401	50	
AHEP @ 35%		3402	18	
AHEP @ 70%		3403	35	
With enhancement		3161	58	
AHEP @ 50%		3404	29	
AHEP @ 100%		3405	58	
AHEP @ 35%		3406	20	
AHEP @ 70%		3407	41	
TMJ (Temporomandibular Joint) without / delayed enhancement Includes open and closed mouth scans		3181	50	
AHEP @ 50%		3400	25	
AHEP @ 100%		3401	50	
AHEP @ 35%		3402	18	
AHEP @ 70%		3403	35	
With enhancement		3182	58	
AHEP @ 50%		3404	29	
AHEP @ 100%		3405	58	
AHEP @ 35%		3406	20	
AHEP @ 70%		3407	41	
Chest without / delayed enhancement		3169	75	
AHEP @ 50%		3408	38	
AHEP @ 100%		3409	75	
AHEP @ 35%		3410	26	
AHEP @ 70%		3411	53	
With enhancement		3165	75	
AHEP @ 50%		3408	38	
AHEP @ 100%		3409	75	
AHEP @ 35%		3410	26	
AHEP @ 70%		3411	53	
Neck without / delayed enhancement		3308	75	
AHEP @ 50%		3408	38	
AHEP @ 100%		3409	75	
AHEP @ 35%		3410	26	
AHEP @ 70%		3411	53	
With enhancement		3318	75	
AHEP @ 50%		3408	38	
AHEP @ 100%		3409	75	
AHEP @ 35%		3410	26	
AHEP @ 70%		3411	53	

Chapter 23: Specialists in Diagnostic Radiology	List	Code	Units Gen	Units An
Abdomen without / delayed enhancement		3309	75	
AHEP @ 50%		3408	38	
AHEP @ 100%		3409	75	
AHEP @ 35%		3410	26	
AHEP @ 70%		3411	53	
With enhancement		3319	75	
AHEP @ 50%		3408	38	
AHEP @ 100%		3409	75	
AHEP @ 35%		3410	26	
AHEP @ 70%		3411	53	
Pelvis without / delayed enhancement		3310	75	
AHEP @ 50%		3408	38	
AHEP @ 100%		3409	75	
AHEP @ 35%		3410	26	
AHEP @ 70%		3411	53	
With enhancement		3320	75	
AHEP @ 50%		3408	38	
AHEP @ 100%		3409	75	
AHEP @ 35%		3410	26	
AHEP @ 70%		3411	53	
Extremity without / delayed enhancement		3226	75	
AHEP @ 50%		3408	38	
AHEP @ 100%		3409	75	
AHEP @ 35%		3410	26	
AHEP @ 70%		3411	53	
With enhancement		3228	75	
AHEP @ 50%		3408	38	
AHEP @ 100%		3409	75	
AHEP @ 35%		3410	26	
AHEP @ 70%		3411	53	
Joint without / delayed enhancement		3321	75	
AHEP @ 50%		3408	38	
AHEP @ 100%		3409	75	
AHEP @ 35%		3410	26	
AHEP @ 70%		3411	53	
With enhancement		3322	75	
AHEP @ 50%		3408	38	
AHEP @ 100%		3409	75	
AHEP @ 35%		3410	26	
AHEP @ 70%		3411	53	
Cervical Spine without / delayed enhancement		3312	75	
AHEP @ 50%		3408	38	
AHEP @ 100%		3409	75	
AHEP @ 35%		3410	26	
AHEP @ 70%		3411	53	
With enhancement		3323	75	
AHEP @ 50%		3408	38	
AHEP @ 100%		3409	75	
AHEP @ 35%		3410	26	
AHEP @ 70%		3411	53	

	List	Code	Units Gen	Units An
Thoracic Spine without / delayed enhancement		3324	75	
AHEP @ 50%		3408	38	
AHEP @ 100%		3409	75	
AHEP @ 35%		3410	26	
AHEP @ 70%		3411	53	
With enhancement		3325	75	
AHEP @ 50%		3408	38	
AHEP @ 100%		3409	75	
AHEP @ 35%		3410	26	
AHEP @ 70%		3411	53	
Lumbar Spine without / delayed enhancement		3326	75	
AHEP @ 50%		3408	38	
AHEP @ 100%		3409	75	
AHEP @ 35%		3410	26	
AHEP @ 70%		3411	53	
With enhancement		3327	75	
AHEP @ 50%		3408	38	
AHEP @ 100%		3409	75	
AHEP @ 35%		3410	26	
AHEP @ 70%		3411	53	

Section 13 Ultrasound

The following unit values are applied to interpretation of diagnostic ultrasound investigations:

Head and neck				
Neonate brain		3170	43	
AHEP @ 50%		3440	22	
AHEP @ 100%		3441	43	
AHEP @ 35%		3442	15	
AHEP @ 70%		3443	30	
Transcranial adult (including doppler)		3227	41	
AHEP @ 50%		3500	21	
AHEP @ 100%		3501	41	
AHEP @ 35%		3502	14	
AHEP @ 70%		3503	29	
Carotid assessment – unilateral or bilateral, duplex exam		3201	41	
AHEP @ 50%		3500	21	
AHEP @ 100%		3501	41	
AHEP @ 35%		3502	14	
AHEP @ 70%		3503	29	
Thyroid		3171	22	
AHEP @ 50%		3444	11	
AHEP @ 100%		3445	22	
AHEP @ 35		3446	8	
AHEP @ 70%		3447	15	
Thorax				

Chapter 23: Specialists in Diagnostic Radiology	List	Code	Units Gen	Units An
Chest masses, pleural effusion		3196	36	
AHEP @ 50%		3484	18	
AHEP @ 100%		3485	36	
AHEP @ 35%		3486	13	
AHEP @ 70%		3487	25	
Breast or tissue specimen – each breast		3197	22	
AHEP @ 50%		3444	11	
AHEP @ 100%		3445	22	
AHEP @ 35%		3446	8	
AHEP @ 70%		3447	15	
Heart echography pericardial effusion, M-mode		3172	22	
AHEP @ 50%		3444	11	
AHEP @ 100%		3445	22	
AHEP @ 35%		3446	8	
AHEP @ 70%		3447	15	
Complete, M-mode		3173	45	
AHEP @ 50%		3452	23	
AHEP @ 100%		3453	45	
AHEP @ 35%		3454	16	
AHEP @ 70%		3455	32	
With bidimensional imaging		3174	72	
AHEP @ 50%		3456	36	
AHEP @ 100%		3457	72	
AHEP @ 35%		3458	25	
AHEP @ 70%		3459	50	
Abdomen – complete scan (more than one area/organ)		3175	45	
AHEP @ 50%		3452	23	
AHEP @ 100%		3453	45	
AHEP @ 35%		3454	16	
AHEP @ 70%		3455	32	
Limited exam – gallbladder, aorta, etc (one area/organ)		3176	25	
AHEP @ 50%		3464	13	
AHEP @ 100%		3465	25	
AHEP @ 35%		3466	9	
AHEP @ 70%		3467	18	
Pelvis -Trans-abdominal		3177	36	
AHEP @ 50%		3484	18	
AHEP @ 100%		3485	36	
AHEP @ 35%		3486	13	
AHEP @ 70%		3487	25	
Pelvis - Endovaginal		3328	36	
AHEP @ 50%		3484	18	
AHEP @ 100%		3485	36	
AHEP @ 35%		3486	13	
AHEP @ 70%		3487	25	
Endorectal prostate		3231	66	
AHEP @ 50%		3504	33	
AHEP @ 100%		3505	66	
AHEP @ 35%		3506	23	
AHEP @ 70%		3507	46	

Chapter 23: Specialists in Diagnostic Radiology	List	Code	Units Gen	Units An
Endorectal prostate with biopsy		3237	92	
AHEP @ 50%		3508	46	
AHEP @ 100%		3509	92	
AHEP @ 35%		3510	32	
AHEP @ 70%		3511	64	
Obstetrics, pregnancy – complete		3178	40	
AHEP @ 50%		3472	20	
AHEP @ 100%		3473	40	
AHEP @ 35%		3474	14	
AHEP @ 70%		3475	28	
Each additional fetus		3180	40	
AHEP @ 50%		3472	20	
AHEP @ 100%		3473	40	
AHEP @ 35%		3474	14	
AHEP @ 70%		3475	28	
Testes, popliteal cysts, ganglia, etc		3198	25	
AHEP @ 50%		3464	13	
AHEP @ 100%		3465	25	
AHEP @ 35%		3466	9	
AHEP @ 70%		3467	18	
Single vessel or lesion vascular study/doppler		3179	15	
AHEP @ 50%		3476	8	
AHEP @ 100%		3477	15	
AHEP @ 35%		3478	5	
AHEP @ 70%		3479	11	
Extremities				
Peripheral arterial study				
One leg/arm		3238	45	
AHEP @ 50%		3452	23	
AHEP @ 100%		3453	45	
AHEP @ 35%		3454	16	
AHEP @ 70%		3455	32	
Two legs/arms		3239	90	
AHEP @ 50%		3516	45	
AHEP @ 100%		3517	90	
AHEP @ 35%		3518	32	
AHEP @ 70%		3519	63	
Peripheral venous study/ deep vein thrombosis				
One leg/arm		3240	45	
AHEP @ 50%		3452	23	
AHEP @ 100%		3453	45	
AHEP @ 35%		3454	16	
AHEP @ 70%		3455	32	
Two legs/arms		3241	90	
AHEP @ 50%		3516	45	
AHEP @ 100%		3517	90	
AHEP @ 35%		3518	32	
AHEP @ 70%		3519	63	

	List	Code	Units Gen	Units An

Notes:

1. M-mode implies a one dimensional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo-producing structures.
2. Scan B-mode implies a two-dimensional ultrasonic scanning procedure with a two-dimensional display.

Section 14 Magnetic Resonance Images

The following fees include provision of clinical supervision (approving, modifying and intervening in the imaging examination); provision of quality control of all elements of the technical components of the procedure; and interpretation of the results of the diagnostic examination.

Brain		3600	98
Orbits		3601	98
Temporomandibular joint (TMJ)		3602	98
Internal Auditory Canal (IAC)/ Temporal Bones		3603	98
Cranial nerves		3604	98
Sella turcica		3605	98
Sinuses		3606	98
MR Tractography		3607	98
MR Spectroscopy		3608	98
Neck/skull base		3609	98
Brachial plexus/Thoracic Outlet		3610	98
Cervical spine		3611	98
Thoracic spine		3612	98
Lumbar spine		3613	98
Lumbosacral plexus		3614	98
Sacrum/SI Joints		3615	98
Chest		3616	98
Cardiac morphology		3617	98
Cardiac functional assessment and quantification		3618	98
Cardiac viability		3619	98
Breast-Right		3620	98
Breast-Left		3621	98
Abdomen		3622	98
MRCP		3623	98
MR Elastography		3624	98
Pelvis		3625	98
Fetal		3626	98
Right upper extremity:			
Shoulder		3627	98
Humerus		3628	98
Elbow		3629	98
Forearm		3630	98

List	Code	Units Gen	Units An
Wrist ……..	3631	98	
Hand ……..	3632	98	
Finger …….……	3633	98	
Left upper extremity:			
Shoulder …….	3634	98	
Humerus …….	3635	98	
Elbow …….	3636	98	
Forearm ……..…	3637	98	
Wrist …….….	3638	98	
Hand ……..….	3639	98	
Finger ……	3640	98	
Right lower extremity:			
Hip ……	3641	98	
Femur	3642	98	
Knee ……..	3643	98	
Tibia/Fibula ……...	3644	98	
Ankle …….	3645	98	
Foot ……	3646	98	
Toe …….	3647	98	
Left lower extremity:			
Hip ……	3648	98	
Femur	3649	98	
Knee ……..….	3650	98	
Tibia/Fibula ……..	3651	98	
Ankle ……..……..	3652	98	
Foot ……...	3653	98	
Toe ……	3654	98	
MR Angiography:			
Brain MRA(Circle of Willis) ……	3655	98	
Brain MRV.....	3656	98	
Neck MRA (Carotids).....	3657	98	
Neck MRV ……..….	3658	98	
Chest MRA ……..	3659	98	
Chest MRV ……..	3660	98	
Abdomen MRA …….....	3661	98	
Abdomen MRV …….....	3662	98	
Renal MRA…….....	3663	98	
Renal MRV ……..…	3664	98	
Pelvis MRA ……..	3665	98	
Pelvis MRV ……..	3666	98	
Lower extremity MRA-Left leg	3667	98	
Lower extremity MRA-Right leg …….	3668	98	

Chapter 23: Specialists in Diagnostic Radiology	List	Code	Units Gen	Units An
Upper extremity MRA-Left arm		3669	98	
Upper extremity MRA-Right arm		3670	98	
Peripheral angiogram/run-off MRA (Unilateral or bilateral)				
-aorto-femoral		3671	98	
-superficial femoral		3672	98	
-popliteal and distal		3673	98	
Whole Body Scan		3674	209	
Gadolinium injection (contrast) including additional views and interpretation		3212	31	

Section 15 Clinical and Diagnostic Procedures

This series of service codes includes the clinical procedural services plus the interpretations of acquired imaged views – Service codes for interpretation of images only are not to be billed in conjunction with service codes from this section.

15.1 Liver Biliary System

Percutaneous extraction of bile duct stone under fluoroscopy plus cholangiogram		3242	123	
Percutaneous transhepatic cholangiogram		3243	90	
Percutaneous biliary drainage		3244	301	
Biliary stent (in addition)		3286	286	
Percutaneous trans-hepatic portography		3293	88	

15.2 Urinary

Percutaneous insertion of nephrostomy tube with local anaesthesia under fluoroscopy		3245	123	
Percutaneous nephrostomy with ureteric dilation or stent insertion under diagnostic imaging		3246	203	
Percutaneous establishment of nephrostomy tract for stone extraction		3247	283	
Percutaneous renal cystogram		3294	57	
Retrograde urethrogram or cystogram without cystoscopy		3295	39	
Voiding cystourethrogram		3296	24	
Hysterosalpingogram (includes procedure, fluoroscopy and interpretation by radiologist)		3298	63	
Ileal loopogram (conduit)		3299	34	

15.3 Other Procedures

Percutaneous diagnostic tap of fluid collection under imaging		3248	51	
Percutaneous insertion of a drainage tube under imaging		3249	77	
Percutaneous needle biopsy of solid mass under imaging		3250	64	
Exchange of drainage tube under imaging		3252	49	
Sinogram (sinus tract injection)/ tube check/tube removal		3291	25	
Transthoracic lung biopsy under imaging		3251	66	
Percutaneous gastrostomy or jejeunostomy		3255	130	

Chapter 23: Specialists in Diagnostic Radiology	List	Code	Units Gen	Units An
Intubation of small intestine under imaging		3300	30	
Plasty/dilation of non-vascular structure via angioballoon		3329	346	
GI Stents		3330	400	
Radiofrequency ablation of tumours		3331	400	
Percutaneous gastro-jejeunostomy		3332	160	
Hypotonic duodenography with intubation		3301	30	
Breast				
Needle localization under imaging (per lesion/target)		3258	59	
Biopsy and/or clip insertion under imaging (per lesion/target)		3259	105	
Mammary galactography		3260	25	
Myelogram				
One area		3261	68	
Two or more areas		3262	98	
Nerve Root Block				
One nerve		3333	68	
Two or more nerves		3334	98	
Discogram				
One level		3264	68	
Each additional		3265	42	
Facet joint injection (per joint)		3266	42	
Sacro-iliac joint injection (per joint)		3267	42	
Arthrogram				
Single		3268	38	
Double contrast		3269	52	
Arteriography				
Aorto bifemoral and peripheral run-off (including arterial access)		3287	164	
Access arterial system and flush		3270	88	
Selective arterial (first order) injection (includes as many views/runs as needed;		3271	59	
Super selective (beyond first order) plus injection (includes as many views as needed)		3273	71	
Thrombolytic therapy (arterial) or percutaneous thrombectomy		3302	187	
Pharmacology intervention		3272	19	
Embolization (per vessel) (arterial or venous)		3257	71	
Percutaneous removal of intravascular foreign bodies (i.e. catheter, snare, ultrasound, angiography)		3253	122	
Angioplasty (percutaneous transluminal dilation of arterial, venous stenosis and occlusions under local anaesthesia)				
Aorta, iliac, femoral popliteal, infra popliteal		3280	277	
Renal, brachiocephalic, cerebral, Renal artery denervation		3281	346	
Stent arterial or venous (includes angioplasty)		3288	400	
Transcatheter aortic valve implantation (Interventional Radiology)	D	8128	1274	45

Chapter 23: Specialists in Diagnostic Radiology	List	Code	Units Gen	Units An

☞ ***Medicare Note: Service Code 8128 is an all-inclusive fee. No other Service Codes are billable with this service.***

Please note, you must submit Service Code 8128 through MCE. It cannot be transmitted via Meditech.

Venography			
Access venous system (central)		3274	96
Selective venous injection any vein		3275	59
Peripheral venogram			
Unilateral		3276	45
Bilateral		3277	86
Central venous catheter check		3335	45
Transjugular liver biopsy		3256	130
Tunneled catheter insertion (vascular or other)			
Without subcutaneous port		3278	97
With subcutaneous port		3279	168
IVC Filter (transjugular or transfemoral)		3289	210
Thrombolytic therapy (venous or percutaneous thrombectomy)		3303	187
Transjugular intrahepatic portosystemic shunt		3254	494
Velopharyngogram		3304	44
Lymphogram			
Single leg		3282	90
Bilateral		3283	142
Sialogram		3284	45
Dacryocystogram		3285	45
Lumbar puncture		3315	31

CHAPTER 24: SPECIALISTS IN THERAPEUTIC RADIOLOGY AND NUCLEAR MEDICINE

Referred cases			
Nuclear Medicine Consultation (See definitions in the General Preamble)			
Major or regional consultation		4096	61
Partial Clinical Evaluation		4097	19
Hospital Care			
Daily Care visit		4102	16

Section 1 Radioisotope Therapy

Treatment of hyperthyroidism, per course		4060	46
Radioisotope therapy – carcinoma thyroid – per course		4011	62
Treatment of polycythaemia vera, per course		4012	38
Treatment of metastatic cancer (other than thyroid) per course		4013	46
Joint injections (includes procedure and interpretation)		4015	28

Section 2 Radioisotope Diagnostic Procedures

2.1 Thyroid

Thyroid uptake			
Single determination		4016	8
Multiple determinations		4017	12
Thyroid scan		4018	18
Thyroid uptake and scan		4019	27

2.2 Renal Urinary System

Renal scan		4029	23
Baseline renal scan plus renogram		4030	38
Renal scan plus renogram with diuretic		4106	38
Renal scan plus renogram with ACE inhibitor		4090	61
Renal function study (eg: GFR)		4031	15
Bladder residual in addition to other tests		4066	15
Testicular scan (including flow study)		4062	39
Voiding cystogram		4094	20

2.3 Gastrointestinal Tract

Salivary gland scan		4042	30
Oesophageal transit study (includes upright and supine)		4076	82
Gastric reflux		4093	33
Gastric emptying (liquid)		4064	63
Gastric emptying (solid)		4107	63
Gallbladder ejection fraction (includes hepatobiliary scan)		4079	53
Hepatobiliary scan (liver, gallbladder and bile duct)		4037	30
Repeat with morphine		4108	30
Hepatobiliary kinetics (bile leak or post-cholecystectomy			

	List	Code	Units	Units
dynamic)		4077	46	
Liver scan/spleen scan		4036	23	
Hepatobiliary post CCK		4078	51	
Liver and spleen tomoscintigraphy to include liver scan		4074	41	
Hepatic tomography RBC to include pool & flow		4075	64	
GI Bleed search (includes flow study and tag red cell scan)		4080	46	
Delayed imaging 1 to 24 hrs per course		4063	23	
Delayed imaging after 24 hrs per course		4081	13	
Abdominal scintigraphy with pertechnetate (Meckel's) including pool and flow		4085	46	
Schilling		4038	8	
Repeat after intrinsic factor		4039	8	
Schilling test with dual isotopes and intrinsic factor		4040	12	
2.4 Cardiovascular System				
Dynamic flow study (aorta, branches & veins)		4045	23	
Venoscintigraphy		4088	45	
Monitoring pharmacology study		4065	56	
Myocardial perfusion scan (planar)		4068	23	
Myocardial perfusion scan with tomography includes planar study (stress or pharmacology)		4091	45	
Myocardial perfusion scan with tomography includes planar study (rest or redistribution)		4092	45	
Infarct-avid cardiac scan		4069	23	
With tomography		4095	42	
Ejection fraction scan		4070	23	
Myocardial wall motion scan		4071	44	
In conjunction with myocardial perfusion scan (includes rest and/or stress/pharmacology)		4109	22	
Myocardial wall motion scan with ejection fraction		4072	52	
In conjunction with myocardial perfusion scan (includes rest and/or stress/pharmacology)		4110	26	
Radioisotopic detection of cardiac shunt		4103	40	
2.5 Respiratory System				
Lung scan				
Ventilation or perfusion		4047	38	
Ventilation and perfusion on same day		4048	63	
Radioisotopic pulmonary aspiration study		4101	20	
2.6 Central Nervous System				
Brain scan		4049	31	
Brain scan and flow study		4050	38	
Radioisotopic cisternography including CSF leak imaging		4051	77	
Cerebral perfusion tomography (includes brain scan)		4084	49	
Radioisotopic study of ventricular shunt		4099	39	

		List	Code	Units	Units
2.7	**Skeletal System**				
	Bone scan		4052	46	
	Bone tomoscintigraphy (includes service code 4052)		4083	64	
	Skeletal System Metabolic Studies		4053	23	
2.8	**Other Systems**				
	Whole body (non-bone)		4086	46	
	Parathyroid scan		4055	23	
	Gallium scan		4056	49	
	Tagged white blood cell scan		4061	46	
	Tear duct scintigraphy		4087	40	
	Tomography – for any nuclear scan, add		4058	29	

☞ ***Medicare Note: Service Code 4058 is intended as an add-on to service codes that do not include a tomography or those that include a tomography but require an additional tomography for same or different area.***

	Scintimammography		4098	40	
	PET Scan				
	One region		4104	141	
	2 or more regions		4105	203	
	Lymphoscintigraphy		4100	49	
	Delayed imaging after 24 hrs per course		4081	13	
	MIBG whole body scan		4082	50	

CHAPTER 25: SITE CODES

25.1 Walk-in Clinics – definition

- Primary care services offered through clinics/offices characterized by extended hours of operation; no requirement for an appointment; and episodic care with little or no follow-up.
- There is no standard patient roster – the patient list is constantly changing.

Please contact Medicare for any new or existing clinics not listed below. When billing service code 0003, a site code will be mandatory on you claim submission.

Site Code	Name	Address
300	Nashwaaksis After Hours Clinic	Fredericton
301	Regent Street After Hours Clinic	Fredericton
302	St. George Street After Hours Clinic	Moncton
303	Riverview After Hours Clinic	Riverview
304	St. Peter Avenue After Hours Clinic	Bathurst
305	Saint John After Hours Medical Clinic	Saint John
306	New Maryland After Hours Medical Clinic	New Maryland
307	KV After Hours Medical Clinic	Rothesay
308	Chatham After Hours Clinic	Miramichi East
309	Pleasant St. After Hours Clinic	Miramichi West
310	Clinique sans rendez-vous (Bateman St.)	Edmundston
311	After Hours Medical Clinic –Moncton North	Moncton
312	Saint John Outreach	Saint John
313	Clinique Dr Louis N Bourque	Moncton
314	Clinique Apres Heures Providence	Moncton
315	Centre Medical Regional Shediac	Shediac
316	Clinique Après Heure Champlain	Dieppe
317	Charlotte County Family Medicine Clinic	St. Stephen
318	Main Street Family Medical Clinic	Moncton
319	Sussex Family Medical Clinic	Sussex
320	St Andrews Medical Clinic	St Andrews
321	Mountain Road Afterhour Clinic	Moncton
322	Clinique Médicale sans rendez-vous	Shippagan
323	Clinique Depannage du Marais	Dieppe
324	Causeway Medical Clinic	Riverview
325	Clinique Médicale du soir	Caraquet
326	Prospect After Hours Clinic	Fredericton
327	Dr Jaswinder Afterhours Clinic	Moncton
328	Woodstock Medical Clinic After Hours Clinic	Woodstock
329	Clinique sans rendez-vous Beresford Walk-In Clinic	Beresford

330	Walk-in Clinic sans rendez-vous Dr. Tran	St. Jacques
331	Clinique sans randez-vous du Haut-Madawaska	Clair
332	Brookside Mall Walk-in Clinic	Fredericton
333	Maritime After Hours Clinic	Moncton
334	Dr. Paul Smith Walk in Clinic	Fredericton
335	Trinity Medical Clinic	Moncton
336	Dundonald After Hours Clinic	Fredericton
337	Optimal Health	Moncton
338	Elsipogtog Health Centre and Wellness Centre	Elsipogtog
339	Viveta Medical Clinic	Woodstock
340	Kent Same Day Medical Clinic	Richibucto
341	Medecine Familiale de Shedac	Shediac
342	Clinique de Dépannage Memramcook	Memramcook
343	Clinique Médicale de Cocagne	Cocagne
344	Nackawic After Hours Clinic	Nackawic
345	Eel Ground Health & Wellness Center Walk in Clinic	Eel Ground
346	Millidgeville Medical Clinic	Saint John
347	Dr. Jacques Beland Evening Clinic	Fredericton
348	Moncton Medical Clinic – After Hours Coverage	Moncton
349	Maple Tree Clinic	St. Stephen
350	Dr. Kaminska Walk-in Clinic	St. George
351	Lower Cover After Hours Clinic	Sussex
352	Coverdale After Hours Medical Clinic	Riverview
353	Restigouche Walke-In Clinic	Campbellton
354	Millennium Medical Clinic	Quispamsis

25.2 Community Mental Health Clinics

Site Code	Name
101	RHA 1SE – MONCTON (HORIZON) CMHC
111	RHA 1B – MONCTON (VITALITE)
113	RHA 1B – RICHIBUCTO CMHC
114	RHA 1 – SACKVILLE CMHC
115	RHA 1 – SHEDIAC CMHC
121	RHA 2 – SAINT JOHN CMHC
123	RHA 2 – SUSSEX CMHC
125	RHA 2 – ST STEPHEN CMCH
126	RHA 2 – GRAND MANAN CMHC
127	RHA 2 – ST GEORGE CMHC
131	RHA 3 – FREDERICTON CMHC
133	RHA 3- WOODSTOCK CMHC
134	RHA 3 – PERTH-ANDOVER CMCH
141	RHA 4 – EDMUNDSTON CMHC
143	RHA 4 – GRAND FALLS CMHC
144	RHA 5 – KEDGWICK CMHC
151	RHA 5 – CAMPBELLTON CMHC
152	RHA 5 – CENTRE OF EXCELLENCE FOR YOUTH – CAMPBELLTON CMHC

161	RHA 6 – BATHURST CMCH
163	RHA 6 – CARAQUET
164	RHA – 6 SHIPPAGAN CMHC
165	RHA 6 – TRACADIE-SHEILA CMHC
171	RHA 7 – MIRAMICHI CMHC