PHYSICIANS' BULLETIN

msi

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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On-line documentation available at :

http://www.medavie.bluecross.ca/msiprograms

ELECTRONIC BULLETIN LAUNCH ON SEPTEMBER 16, 2013

The Department of Health and Wellness, in collaboration with Medavie Blue Cross and Doctors Nova Scotia is very pleased to announce the launch of the new MSI website, effective Monday, September 16, 2013. The website can be found at www.medavie.bluecross.ca/msiprograms.

The new website will include simplified electronic access to important documents such as the MSI Physician's Manual; the Billing Instructions Manual and the MSI Physicians' Bulletins. The website will also contain a "frequently asked questions" section along with a searchable archive of bulletins. The new website marks an important and progressive step into the ever advancing age of technology and away from paper based communication and information.

One of the key features of the new website is the ability for physicians and billing staff to be able to subscribe to electronic notification of upcoming MSI Physicians' Bulletins. The MSI Physicians' Bulletins contains important information for physicians, as it includes MSI billing updates, policy changes and other key topics related to insured services.

Please note, that effective January 1, 2014, bulletins will only be available on the MSI website. To be automatically notified of upcoming bulletins, follow the "Subscribe" link located on the home page. Physicians will continue to receive paper copies of bulletins until December 31, 2013. Bulletins can be easily saved and printed directly from the new MSI website

Subscribing to electronic access to physicians' bulletins is not only important, but strongly encouraged as it is the responsibility of all physicians to be aware of changes, updates, new billing codes and practices, communicated in the bulletins.

If for some reason you are unable to access the website please contact MSI at 496-7011 or 1-866-553-0585.

NEW FEES

Note: Physicians holding eligible services must submit their claims from August 1, 2013 onward within 90 days of the date of this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.

Effective August 1, 2013 the following new health service codes are available for billing:

Category	Code		Unit Value	
VEDT	50.37D	**EVAR – endovascular abdominal aortic aneurysm repair with stent graft**		
		RO=FPHN Vascular surgeon or Interventional radiologist only	380	15+T
		RO=SPHN Vascular surgeon or Interventional radiologist only	228	

Endovascular abdominal aortic aneurysm repair using stent grafting.

Billing Guidelines:
This is a comprehensive fee to include preoperative planning and measurements, arteriotomy(ies) as required, the insertion of all catheters including initial access, intra-operative angiography, interpretation of any images taken at the time of the procedure, balloon angioplasties within the treatment zone, iliac endarterectomy, angioplasty, and/or repair as required, and removal of access catheters with any necessary closure of vessels.

Preamble rules 9.3.3(g) apply.

Second physician specialty restriction is the same as for first physician.

Not to be billed with:
MASG 50.37A Aortic graft plus bilateral femoral artery repair
Any additional angioplasties to be billed at LV 50 to a maximum of four, stents billed as ADON 51.59Q to a maximum of four.

Specialty Restriction:
Vascular surgery
Interventional radiology

Location:
Hospital

Category	Code		Unit Value
VIST	03.04D	**Geriatrician's Initial Comprehensive Geriatric Consultation to Include CGA (Comprehensive Geriatric Assessment)**	150

Description:
For the comprehensive assessment of the frail patient 65 years or older (frailty as characterized by low functional reserve, decreased muscle strength, and high susceptibility to disease). To be billed only when the entire assessment is performed by a physician with a Geriatric Medicine Subspecialty or Internal Medicine plus completion of a minimum 8 weeks training (PGY4 or greater) in geriatric assessment. The Comprehensive Geriatric Assessment will include all of the following elements and be documented in the heath record in addition to Start and Stop times. Assessment required a minimum of 90 minutes of patient to physician contact.

A) Assessment of cognition – usually using the Mini-Mental State Examination. If cognitive impairment is present, whether it meets the criteria for dementia, delirium or depression.
B) Other aspects of the mental state. Such as the presence of depression or other mood disorder. The presence of perceptual disturbances. Motivation. Health attitude.
C) Evaluation of special senses – functional ability in speech, hearing and vision is recorded.
D) Neuromascular examination to assess strength and specifically to evaluate deconditioning.
E) A functional assessment of mobility and balance to include detailed recording of the hierarchal assessment of balance and mobility (MacKnight C., Rockwood K., A hierarchical assessment of balance and mobility, Age and Ageing, 1995;24:126-130) is carried out.
F) Bowel and bladder function is recorded.
G) A brief nutritional screen focusing on weight and appetite is completed.
H) Functional capacity in personal instrumental and basic activities of daily living is recorded.
I) Sleep disruptions are recorded as is the presence of daytime somnolence.
J) Social Assessment. To include information about the extent of
social engagement, the presence of a caregiver, the marital state and living arrangements of the individual, condition of the house and whether or not they need to be able to navigate stairs in order to be safe at home. The presence of supports is recorded as well as some information about the caregiver, including their coping ability, their own health and their outlook.
K) Documentation of advanced care directives.
CGA procedure: Note 1: For people being assessed during an acute illness, items D through H are recorded both for the baseline state (2 weeks

previously) and currently.
CGA procedure Note 2: All this information is in addition to the general medical information recorded in the general medicine consult.

Billing Guidelines:
Time based fee requiring a minimum of 90 minutes.
Greater than 80% of time must be spent in direct patient contact.
No other fee codes may be billed for that patient in the same time period.

This Initial Assessment may be billed only once per patient per lifetime.

Specialty Restriction:
Geriatric Medicine
Internal Medicine with a minimum of 8 weeks recognized Geriatric subspecialty training (PGY4 level or greater)

Location:
Hospital/Clinic/Office

Category	**Code**		**Unit Value**
VIST	03.04E	**Initial Geriatric Inpatient Medical Assessment**	38.1

Description:
This fee is for the complete initial assessment of the geriatric hospital inpatient, age greater than or equal to 65 years, by the family physician most responsible for the patient's ongoing inpatient hospital care. Billed only once per patient per admission. May not be billed again for 6 months for the same patient.
This complete assessment is to include all of the following elements and be documented in the health record – include all positive and pertinent negative finds (based on *Guidelines for Medical Record-keeping 2008,* CPSNS):

1. Complete history: Extended history of the Chief Complaint, review of systems related to the problem, complete past medical and social history, pertinent family history.
2. Comprehensive Physical Examination: Extensive examination of the affected body area(s) and related system(s) plus extensive multisystem examination (3 or more systems in total).
3. Review of patient's hospital documents relating to current and prior visits.
4. Obtaining collateral history and information from caregivers.
5. Performance of a complete medication review to include collateral information from pharmacy and long term care facility as appropriate.
6. Obtaining advanced care directives (code status).
7. Reviewing and documenting relevant laboratory, imaging, and other test results pertaining to the present visit.

8. Formulating diagnoses and identifying important issues affecting the present admission.
9. Initiating an appropriate and timely management plan including a treatment plan, further investigations, advanced care planning and specialist or interdisciplinary consultation.

Billing Guidelines:
Not to be billed for transfers within the same hospital.

Recognized Systems:
- Eyes
- Ears, nose, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

Specialty Restriction:
GENP

Location:
Hospital only

Category	Code		Unit Value	
MASG	61.69G	**Comprehensive Anal Sphincteroplasty for the Treatment of Anal Incontinence**	220	4+T

Description:
Comprehensive fee for the layered repair of the anal sphincter complex for the treatment of anal incontinence. Includes repair of internal and external anal sphincter, approximation of transverse perineal muscles, reattachment of bulbocavernosus muscles and perineal body reconstruction.

Billing Guidelines:
Not to be billed for acute anal sphincter trauma (use HSC 61.69E for acute non-obstetrical trauma, and HSC 87.82A or B, as appropriate, for acute obstetrical trauma). Not to be billed with MASG 83.61 (suture of vulva and perineum).

Specialty Restriction:
GNSG, OBGY

Location:
Hospital Only

Category	Code		Unit Value
MASG	54.47A	**Esophagectomy with immediate reconstruction by Interposition of Hollow Viscus (Stomach, colon, or small bowel)**	1000
		AP=ABDO	7+T
		AP=CERV	6+T
		AP=THOR	13+T

Description:
This is a comprehensive fee for the total, or near total (greater than 2/3) removal of the esophagus with immediate reconstruction using the interposition of a hollow viscus stomach, colon, or small bowel), includes esophagogastrostomy, vagotomy, proximal gastrectomy, pyloromyotomy, bowel mobilization and preparation, and feeding tube placement where required.

Billing Guidelines:
Not to be billed with:
MASG 54.33A Resection of esophagus one stage
MASG 54.42 Esophagogastrostomy (intrathoracic)
MASG 54.43 Esohageal anastomosis with interposition of small bowel
MASG 54.44A Esophageal bypass with colon/jejunum
MASG 54.45 Esophageal anastomosis with interposition of colon intrathoracic

MASG 54.47 Esophageal anastomosis with other interposition (intrathoracic)
MASG 46.2 Medistinal tissue destruction
MASG 55.1 Percutaneous gastrostomy
MASG 55.3 Pyloromotomy
MASG 55.5 Partial gastrectomy with anastomosis to esophagus
MASG 58.39A Percutaneous jejunostomy

Specialty Restriction:
GNSG, THSG

Location:
Hospital Only

MULTIPLE BIRTHS BY CAESARIAN SECTION

The new fee for **Multiple births by Caesarian Section** previously announced in the July 19th, 2013 bulletin will not receive a new health service code. Instead, effective August 1, 2013 it has been included as the second multiple for the following Caesarean Section fees:

Category	Code		Unit Value	
MASG	86.1	**Cervical Caesarean Section**		
		SP=OBGY	260	7+T
		Multiple births – *plus multiple, if applicable*	35	
MASG	86.1A	**Caesarean Section with tubal ligation**		
		SP=OBGY	280	7+T
		Multiple births – *plus multiple, if applicable*	35	

To claim for additional multiple births on either of these services provided from August 1, 2013 to September 12, 2013, please submit a delete for the original Caesarian Section service followed by a new claim with the 2nd multiple indicated.

PATHOLOGY FEE INCREASES

Effective July 1, 2013 the following pathology fee increases are now in effect (Relative calculations are based on Preamble Section 7.4.2)

Code	Description	Old Fee Value	New Fee Value
P2325	Surgicals, gross and microscopic	19.08	23.85
P3325	Surgicals, gross and microscopic (premium 35%)	28.08	32.85
P5325	Surgicals, gross and microscopic (premium 50%)	28.62	35.78
P2328	Interpretation - fine needle aspiration biopsy	15	18.75
P3328	Interpretation - fine needle aspiration biopsy (premium 35%)	24	27.75
P5328	Interpretation - fine needle aspiration biopsy (premium 50%)	24	28.13
P2332	Interpretation and report - NON GYN cytology slides	5.61	7.01
P3332	Interpretation and report - NON GYN cytology slides (premium 35%)	14.61	16.01
P5332	Interpretation and report - NON GYN cytology slides (premium 50%)	14.61	16.01
P2345	Surgicals, gross and microscopic - three or more separate surgical specimens	29.62	37.03
P3345	Surgicals, gross and microscopic - three or more separate surgical specimens (premium 35%)	39.99	49.99
P5345	Surgicals, gross and microscopic - three or more separate surgical specimens (premium 50%)	44.43	55.55
P2346	Surgicals, gross and microscopic - single large complex CA specimen including lymph nodes	29.62	37.03
P3346	Surgicals, gross and microscopic - single large complex CA	39.99	49.99

Code	Description	Old Fee Value	New Fee Value
	specimen including lymph nodes (premium 35%)		
P5346	Surgicals, gross and microscopic - single large complex CA specimen including lymph nodes (premium 50%)	44.43	55.55

NOTE: Claims for these codes with a service date from July 1, 2013 to September 12, 2013 will be identified and a reconcilliation will occur in January 2014. The reconciliation will be calculated after the 90 day waiting period for submission of claims.

BILLING REMINDERS

Nursing Home Visits

MSI staff have recently received a number of inquiries for billing for individuals who reside in residential care facilities (RCF) or are in an RCF unit or bed within a nursing home. Services for these individuals cannot be claimed using nursing home health service codes. The correct visit code for these individuals is a home visit. Preamble requirements for home visits are outlined in Preamble section 7.2.6 (c)

A list of locations eligible for nursing home fees can be found at the following location:
http://novascotia.ca/health/ccs/pubs/approved_facilities/Dir_approved_facilities_NH.pdf

Residential care facilities (claimed using home visits) are listed in the following document:
http://novascotia.ca/health/ccs/pubs/approved_facilities/Dir_approved_facilities_RCF.pdf

Unattached Patient Bonus

It has come to MSI's attention that some physicians are claiming this code when there has been no inpatient or medically necessary emergency department visit. Physicians must insure that this requirement has been met before claiming the incentive. Any changes to this requirement will be communicated via an MSI Bulletin.

This incentive is available for all eligible General Practitioners (GPs) who take on a patient who does not have a family physician and meets the supplied criteria, into their community-based family practice. The program is intended to address the specific issue of hospitalized patients or patients treated in the emergency department for medical problems who require follow-up in the community and who do not have a family physician. It is not intended to cover every patient who does not have a family doctor; i.e. situations such as practice closures or patient transfers.

Billing Guidelines

- The GP has had an established community-based family practice for at least one year prior to taking the Unattached Patient into his/her practice.
- The GP agrees to take the Unattached Patient into his/her practice following an inpatient or medically necessary emergency department hospital encounter where the patient has been identified as an Unattached Patient. The hospital encounter may have been directly with the GP or the GP may agree to take on the patient through a referral from the hospital.
- The GP keeps the Unattached Patient in his/her practice and maintains an open chart for the patient for a minimum of one year.

The GP must confirm and document at the initial visit with the Unattached Patient that the patient is unattached (i.e., does not already have a regular family physician). **Information about the hospital encounter that resulted in the GP taking the Unattached Patient into his/her practice must also be recorded in the patient's record.** This can be a referral form from the hospital emergency department, an inpatient hospital report or other documentation. **(Other documentation may include a note by the**

physician, documenting their discussion with the patient, confirming the hospital encounter.)

NOTE: Physicians are advised not to send patients to the emergency department to be referred in an effort to claim this fee. Upon audit, MSI will be verifying that an eligible hospital-based encounter did occur and that there was a medical necessity for the hospital encounter.

Date of Death and Organ Procurement

"Effective immediately, claims related to organ procurement can be submitted up to 5 days after the date of death in cases when a patient is pronounced "deceased" but is maintained on life support for the purpose of organ donation. There should be no further issues when submitting claims which meet these criteria."

MSI Documentation Reminder

As in the past, for MSI purposes, an appropriate medical record must be maintained for all insured services claimed. This record must contain the patient's name, health card number, date of service, reason for the visit or presenting complaint(s), clinical findings appropriate to the presenting complaint(s), the working diagnosis and the treatment prescribe, and start and stop times if applicable.

From the documentation recorded for psychotherapy services, it should be evident that in the treatment of mental illness, behavioural maladaptions, or emotional problems, the physician “deliberately established a professional relationship with the patient for the purposes of removing, modifying or alleviating existing symptoms, of attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development.” There should be evidence of the discussions that took place between the physician and the patient, the patient’s response, and the subsequent advice that was given to the patient by the physician in an attempt to promote an improvement in the emotional well being of the patient. Similarly, for all counselling services, the presenting problem should be outlined as well as advice given to the patient by the physician and the ongoing management/treatment plan. The recording of symptoms followed by “long discussion,” “long talk,” “counselled,” “supportive psychotherapy,” etc., is not considered appropriate documentation for the billing of psychotherapy or counselling services.

Where a procedural code is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the Fee Schedule.

Where a differential fee is claimed based on time, location, etc., the information on the patient's record must substantiate the claim.

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

All claims submitted to MSI must be verifiable from the patient records associated with the services claimed. If the record does not substantiate the claim for the service on that date, then the service is not paid for or a lesser benefit is given. **When the clinical record does not support the service claimed, there will be a recovery to MSI at the time of audit.** Documentation of services which are being claimed to MSI must be completed before claims for those services are submitted to MSI.

All service encounters claimed to MSI are the sole responsibility of the physician rendering the service with respect to appropriate documentation and claim submission.

WCB REVISIONS

Effective September 30, 2013 the following WCB codes will be terminated:

Category	Code		Unit Value
WCB	WCB18	**Special assessment service requiring WCB approval prior to use**	$61.70
WCB	WCB19	**Special reporting service requiring WCB approval prior to use**	$61.70

Effective October 1, 2013 the following WCB code will only be billable by General Practitioners and Emergency Medicine:

Category	Code		Unit Value
WCB	WCB11	**Physician assessment service** Combined office visit and completion of Form 8/10	$123.40

Also effective October 1, 2013 WCB codes **WCB13**, **WCB14**, and **WCB20** cannot be billed in combination with any other type of service encounter nor can they be billed together for the same patient on the same day.

Community Services – New - Request for Essential Medical Treatment

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

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

Once completed for a patient on behalf of Community Services, the *Request for Essential Medical Treatment" form* will be delivered to the assigned caseworker by the patient. The service encounter is submitted electronically to MSI. The appropriate health service code is C9999, Payment responsibility COM with a diagnostic code Z99 (i.e. community services). The HSC is claimed at 25 units, however; in this case the payment rate is remunerated at one dollar ($1.00) per unit for a total of $25.00. Any patient over 65 years of age does not qualify for this service.

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

EXPLANATORY CODES

The following new explanatory codes have been added to the system:

DE015 Service encounter has been refused as the previously claimed 03.04D also includes the fee for a comprehensive geriatric assessment.

MA035 Service encounter has been refused as you have previously billed HSC 83.61 at the same encounter.

MA036 Service encounter has been refused as you have previously billed HSC 61.69G at the same encounter.

MA037 Service encounter has been refused as you have already billed a portion of this comprehensive fee (HSC 54.33A, 54.42, 54.43, 54.44A, 54.45, 54.47, 46.2, 55.1, 55.3, 55.5, or 58.39A).

MA038 Service encounter has been refused as you have previously billed the comprehensive fee for esophagectomy with immediate reconstruction by interposition of hollow viscous (HSC 54.47A).

VA053 Service encounter has been refused as you have previously billed HSC 50.37D at the same encounter.

VA054 Service encounter has been refused as you have previously billed HSC 50.37A at the same encounter.

VA055 Service encounter for surgical assist has been refused as the role of second physician was previously billed for this service.

VT111 Service encounter has been refused as the patient is less than 65 years old.

VT112 Service encounter has been refused as the initial geriatric inpatient medical assessment has already been claimed for this hospital admission.

VT113 Service encounter has been refused as the initial geriatric inpatient medical assessment has already been claimed for this patient within the past 6 months.

VT114 Service encounter has been refused as the geriatrician's initial comprehensive geriatric consultation has previously been claimed for this patient.

VT115 Service encounter has been refused as you have previously billed another service for this patient during the same time period.

WB027 Service encounter has been refused as this WCB code cannot be claimed if you have already claimed another fee for the same patient on the same date.

WB028 Service encounter has been refused as you have previously claimed WCB13, WCB14, or WCB20 for this patient on this date.

WB029 Service encounter has been refused as you are not authorized to bill for a WCB12 or WCB16.

UPDATED FILES – AVAILABILITY

Updated files reflecting changes are available for download on Friday, September 13th, 2013. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), and explanatory codes (EXPLAIN.DAT).

PROGRAMS OF THE NOVA SCOTIA DEPT. OF HEALTH
PO BOX 500 HALIFAX NOVA SCOTIA B3J 2S1
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NOVA SCOTIA MEDICAL SERVICES INSURANCE

PATHOLOGY STATISTICAL BILLING REPORT

Provider Name or Group Name:	
Provider Number or Group Number:	
Institution Name and Number:	
Business Arrangement Number:	
Billing Period From:	
Billing Period To:	
Contact Name / Phone Number:	

CODE	EXAMINATION DESCRIPTION	UNITS	In Patient	Out Patient	Number of Exams	TOTAL UNITS
P2320	Autopsy, gross (all ages)	123.50				
P2321	Autopsy, gross, negative cranium	95.42				
P2322	Autopsy, gross, limited	28.07				
P2323	Autopsy Tissues (Maximum 25 per autopsy)	4.49				
P2324	Surgicals, gross	7.30				
P2325	Surgicals, gross and microscopic	23.85				
P2326	Frozen Sections	31.99				
P2328	Interpretation–fine needle aspiration biopsy	18.75				
P2329	Cell Block	14.60				
P2330	Cytology (with a screener)	1.00				
P2331	Interpretation & Report–GYN cytology slides	5.00				
P2332	Interpretation & Report–NON GYN cytology slides	7.01				
P2333	Sex Chromatin Analysis	5.61				
P2334	Karyotype Test A–5 cells & 2 karyotypes	16.84				
P2335	Karyotype Test B–30 cells & 4 karyotypes	22.46				
P2336	Electron Microscopy Anatomical Pathology only	52.90				
P2337	* Immunohistochemistry–Head and Neck	10.00				
P2338	* Immunohistochemistry–Anterior Torso	10.00				
P2339	* Immunohistochemistry–Posterior Torso	10.00				
P2340	* Immunohistochemistry–Right arm	10.00				
P2341	* Immunohistochemistry–Left arm	10.00				
P2342	* Immunohistochemistry–Right leg	10.00				
P2343	* Immunohistochemistry–Left leg	10.00				
P2344	Liquid based preparation (thin prep) non gynaecological cytology (per slide)	15.00				
P2345	Surgicals, gross and microscopic 3 or more separate surgical specimens	37.03				
P2346	Surgicals, gross and microscopic, single large complex CA specimen including lymph notes	37.03				
* Immunohistochemistry Staining and Interpretation of Surgical (Anatomic) Pathology Specimens		TOTAL UNITS CLAIMED:				

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NOVA SCOTIA MEDICAL SERVICES INSURANCE

PATHOLOGY STATISTICAL BILLING REPORT - PREMIUM FEES

Provider Name or Group Name:	
Provider Number or Group Number:	
Institution Name and Number:	
Business Arrangement Number:	
Billing Period From:	
Billing Period To:	
Contact Name / Phone Number:	

CODE	EXAMINATION DESCRIPTION-PREMIUM TIME	Premium value	Unit value	In patient	Out patient	No. of exams	TOTAL UNITS
P3320	Autopsy, gross (all ages)	35%	166.73				
P5320	Autopsy, gross (all ages)	50%	185.25				
P3321	Autopsy, gross, negative cranium	35%	128.82				
P5321	Autopsy, gross, negative cranium	50%	143.13				
P3322	Autopsy, gross, limited	35%	37.89				
P5322	Autopsy, gross, limited	50%	42.11				
P3323	Autopsy Tissues (Maximum 25 per autopsy)	35%	13.49				
P5323	Autopsy Tissues (Maximum 25 per autopsy)	50%	13.49				
P3324	Surgicals, gross	35%	16.30				
P5324	Surgicals, gross	50%	16.30				
P3325	Surgicals, gross and microscopic	35%	32.85				
P5325	Surgicals, gross and microscopic	50%	35.78				
P3326	Frozen Sections	35%	43.19				
P5326	Frozen Sections	50%	47.99				
P3328	Interpretation - fine needle aspiration biopsy	35%	27.75				
P5328	Interpretation - fine needle aspiration biopsy	50%	28.13				
P3329	Cell Block	35%	23.60				
P5329	Cell Block	50%	23.60				
P3330	Cytology (with a screener)	35%	10.00				
P5330	Cytology (with a screener)	50%	10.00				
P3331	Interpretation & Report - GYN cytology slides	35%	14.00				
P5331	Interpretation & Report - GYN cytology slides	50%	14.00				
P3332	Interpretation & Report - NON GYN cytology slides	35%	16.01				
P5332	Interpretation & Report - NON GYN cytology slides	50%	16.01				
P3333	Sex Chromatin Analysis	35%	14.61				
P5333	Sex Chromatin Analysis	50%	14.61				
P3334	Karyotype Test A - 5 cells & 2 karyotypes	35%	25.84				
P5334	Karyotype Test A - 5 cells & 2 karyotypes	50%	25.84				
P3335	Karyotype Test B - 30 cells & 4 karyotypes	35%	31.46				
P5335	Karyotype Test B - 30 cells & 4 karyotypes	50%	33.69				
P3336	Electron Microscopy Anatomical Pathology only	35%	71.42				
P5336	Electron Microscopy Anatomical Pathology only	50%	79.35				
P3345	Surgicals, gross and microscopic 3 or more separate surgical specimens	35%	49.99				
P5345	Surgicals, gross and microscopic 3 or more separate surgical specimens	50%	55.55				
P3346	Surgicals, gross and microscopic, single large complex CA specimens including lymph notes	35%	49.99				
P5346	Surgicals, gross and microscopic, single large complex CA specimens including lymph notes	50%	55.55				
						TOTAL UNITS CLAIMED:	