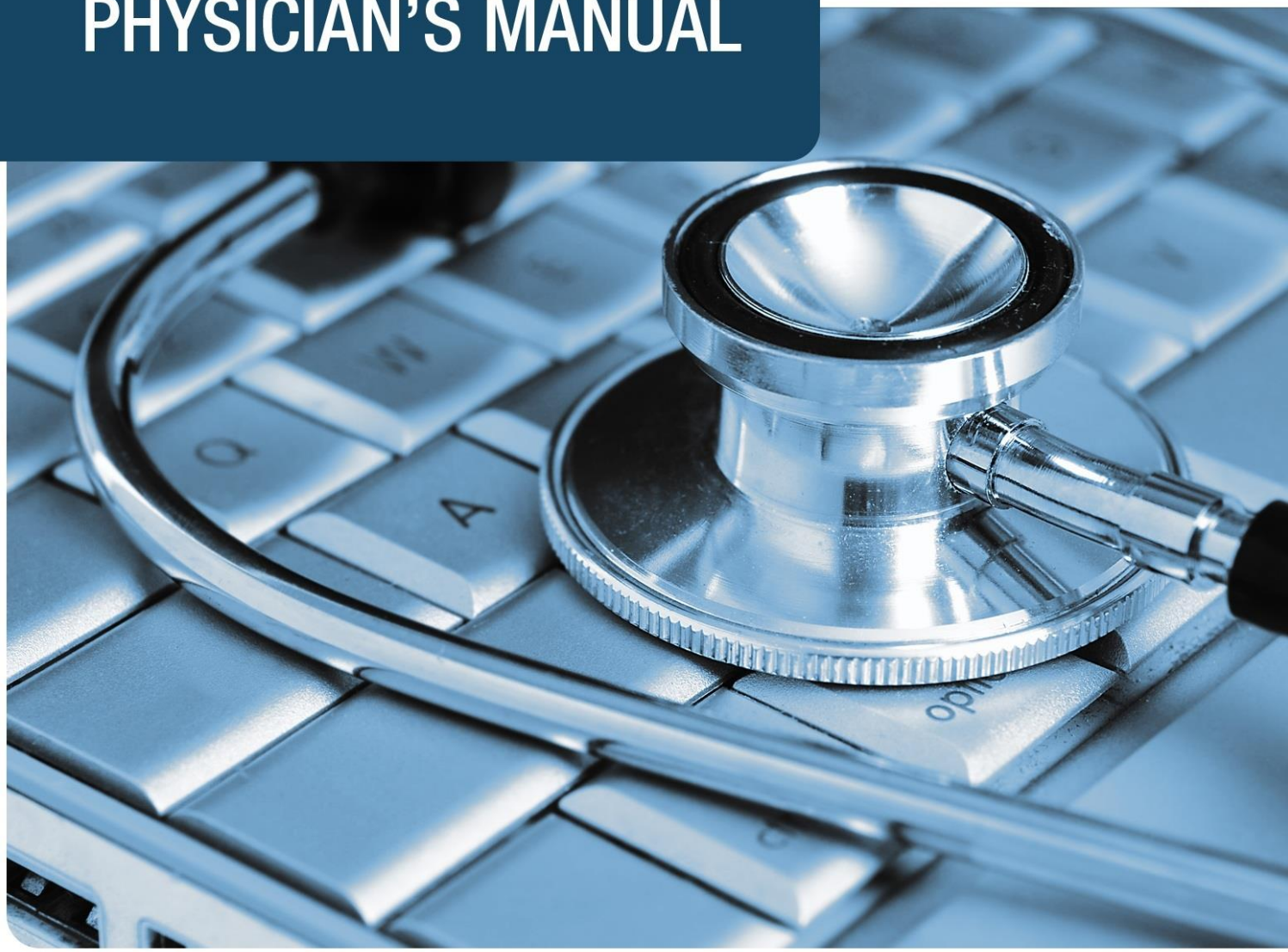
NOVA SCOTIA MEDICAL SERVICES INSURANCE

PHYSICIAN'S MANUAL



2025

Last updated: April 2025

PHYSICIAN'S MANUAL 2025 - INTRODUCTION

A key purpose of the Nova Scotia Physician's Manual is to prepare and sustain accurate and supporting documentation. This newly updated Physician's Manual integrates policy changes as previously published in Physician's Bulletins from 2014 onward including those approved by the Medical Advisory Management Group.

NS MSI PHYSICIAN'S MANUAL 2025 - ORIENTATION

The NS MSI Physician's Manual 2025 has eight sections:

- Section 1: General Considerations
- Section 2: Services Insured, Not Insured, Out of Province and Third Party
- Section 3: Service Reporting and Claims Submission
- Section 4: Tariff
- Section 5: Claim Submission Assessment Rules
- Section 6: Terms and Definitions
- Section 7: Appendices
- Section 8: Nova Scotia Medical Services Insurance Schedule of Benefits

- The introductory page to each section provides an overview of the content of the section and includes the definitions of key terms.
- Italicized numeric paragraph identifiers (e.g., 1.0.2) are included at the end of all headings and paragraphs in Section 1 to 7. These identifiers can be used when needing to refer to a specific item, for example when a billing clerk is contacting MSI with a question.
- There are more cross-references across Sections.

The contents of this Manual are updated regularly to include updates published in the Physician's Bulletins; however, it may be necessary to refer to Physician's Bulletins for additional detailed information and any billing clarifications or reminders.

The Physician's Manual is comprised of:

- *Preamble*
- *List of insured health service codes and descriptions*
- *Explanatory codes and descriptions*

QUESTIONS

If you have any questions as you use this Manual, please contact MSI for assistance. Refer to Section I: General Considerations of this Manual for contact information. MSI will make every attempt to reply to inquiries in a prompt and accurate manner.

TABLE OF CONTENTS

SECTION 1: GENERAL CONSIDERATIONS *(1.0.0)*

This section provides an overview of each component's contents. *(1.0.1)*

The schedule of medical benefits lists all insured procedures, their descriptions and codes, any special conditions, and the value in units. When the term schedule is used in this Preamble, it means the schedule of benefits (this refers to the electronic document). *(1.0.2)*

This section also explains that participating physicians are those who are registered with MSI to receive compensation for insured medical services and that non-participating physicians have elected not to receive compensation for insured medical services from MSI. Reporting obligations for each physician group are identified. *(1.0.3)*

Lastly, contact information for various resources available to provide assistance with reporting questions is listed. *(1.0.4)*

Key Terms Relevant *to This Section* *(1.0.5)*

Bulletin: An MSI administrative update that indicates and/or clarifies changes and subjects of concern with respect to service encounter submissions, assessment and other pertinent information. *(1.0.6)*

PREAMBLE *(1.1.0)*

The Preamble is the authority for the proper interpretation of the fee schedule. Fees will not be correctly interpreted without reference to the Preamble. This fee schedule is maintained through mutual agreement by the Department of Health and Wellness and Doctors Nova Scotia. *(1.1.1)*

Physicians may be paid by the Nova Scotia Department of Health and Wellness using various remuneration methods. The Medical Services Insurance (MSI) physician's manual details fee-for-service remuneration. Remuneration methods, other than fee-for-service, follow the conditions of the contracts or agreements as agreed to by the physicians, the Nova Scotia Department of Health and Wellness and Doctors Nova Scotia with respect to the specific arrangement. *(1.1.2)*

Each physician who participates in the care of a patient is entitled to fair and appropriate compensation for the services rendered to the patient. *(1.1.3)*

The fee schedule identifies the amounts prescribed as claimable for insured services rendered by physicians. Insured services mean all services that are medically necessary and are not specifically excluded by legislation or regulation. The listing of any service or procedure in the fee schedule does not ensure payment by MSI if the service is provided when it is not medically necessary. *(1.1.4)*

Unless otherwise indicated, fees listed are for professional services only. *(1.1.5)*

Professional services provided to a patient may be claimed by a physician only when they personally render the visit or procedure or when they supervise the procedure. *(1.1.6)*

If, however a family physician directly employs a nurse or nurse practitioner, the physician may claim for pap smears and simple injections such as immunizations done by the nurse, provided the physician is on the premises. This does not apply to other procedures, visits or counselling nor for services done by nurses who are employed by third parties such as the Nova Scotia Health Authority. *(1.1.61)*

When a patient lacks the capacity to make decisions, physicians may interact with the patient's substitute decision maker (SDM), as described through the Nova Scotia Personal Directives Act, to provide services to their patients. The patient must be present during the service encounter. This provision is not intended for family meetings. The SDM and the circumstances requiring the physician to provide care through the SDM must be documented in the patient's health record. *(1.1.62)*

All insured services include, where appropriate, any necessary discussion or advice to the patient or their substitute decision maker (SDM), completion of a medical record, prescribing of medication or therapy, requisitioning of diagnostic services, arranging referrals, including a letter of referral where required, and similar activities normally associated with providing insured services to patients. *(1.1.7)*

Where provision of a service generates charges for long distance telephone calls, unusual postal or other expenses, the physician may deem them to exceed the normal allowance made in the tariff and bill the patient directly, subject to the conditions for billing non-insured services. *(1.1.8)*

Physicians are required to submit service encounters for insured services provided to eligible patients in the format prescribed by MSI. Non-participating physicians are required by Regulation under the Health Services and Insurance Act to give reasonable notice of this fact to a patient or someone acting on their behalf, before providing a service. *(1.1.9)*

Service encounters submitted beyond 90 days from date of service shall not be payable and will be adjudicated to pay zero unless MSI is of the opinion the delay is justified. Resubmission of refused service encounters must be within 185 days of the date of service. The only exception to this policy will be through special consideration in exceptional extenuating circumstances. Note: WCB and facility-based service encounters follow the same ruling. (See Section 3 (3.2.7)) *(1.1.10)*

Claims for registered hospital inpatients must also be submitted within the 90-day time limitation whether or not the patient has been discharged or continues as an inpatient. *(1.1.11)*

In situations where the physician knows that the claims will not be submitted within the prescribed time period, loss of revenue can potentially be avoided by contacting MSI to request an extension. *(1.1.12)*

For unregistered babies, the service encounters should be held for a minimum period of one week to allow sufficient time for the parent/guardian to register the baby. It is the responsibility of the parent/guardian to contact MSI. For deceased or adopted babies, a generic health card number will be provided to enable the submission of a claim. Please contact the MSI Assessment Department to obtain the generic health card number. *(1.1.13)*

Service encounters for services to patients from other provinces that are covered under the reciprocal billing agreement must be submitted within one year of date of service. (See Section 2 Interprovincial Reciprocal Billing Agreement (2.4.2) for further details on reciprocal billing). *(1.1.14)*

PRINCIPLES OF ETHICAL BILLING *(1.1.15)*

A physician who provides professional services to a patient is entitled to compensation commensurate with the services provided to the patient. These services are designated as either insured or non-insured. Insured services are those listed in the MSI Physician's Manual. *(1.1.16)*

Ethical principles of billing for non-insured services can be obtained by contacting Doctors Nova Scotia. *(1.1.17)*

The following principles apply to service encounters for insured services: *(1.1.18)*

- All insured services claimed must reflect services rendered personally by the physician in an appropriate clinical setting. Certain delegated medical acts done under supervision of the physician present on the premises may also be claimed. *(1.1.19)*
- A physician will not claim for services rendered to members of their family. *(1.1.20)*
- It is not appropriate for two physicians to claim the same service for the same patient on the same day.
- As part of the provision of an insured service, patients may be charged directly for the provision of consumable items not covered by MSI, completing forms, photocopying, long distance telephone, and similar charges. These charges must be explained and agreed to by the patient before the insured service is provided. (See Section 2 (2.2.36)) *(1.1.21)*

Billing for insured and non-insured services at the same visit: *(1.1.22)*

- A physician must exercise caution whenever billing MSI and the patient or a third party during the same visit. In principle, under no circumstances should any service, or any component of a service, be claimed for twice. *(1.1.23)*
- Whenever possible, the attending physician must acquaint the patient, or person responsible for the patient, with the financial obligation involved in the patient's care. *(1.1.24)*
- If the insured service is the primary reason for the visit, any additional charges for non-insured services must be explained to, and accepted by, the patient before provision of these services. Charges for non-insured services will reflect only those services over and above those provided on an insured basis. It is not appropriate to bill both MSI and Workers' Compensation Board (WCB) for the same service. *(1.1.25)*
- At no time should provision of insured services be contingent upon the patient agreeing to accept additional non-insured services. *(1.1.26)*
- When physicians are providing non-insured services, they are required to advise the patient of insured alternatives, if any exist. *(1.1.27)*
- Incidental findings:

1. If an inconsequential health matter or finding is discovered or discussed during the provision of a non-insured service, it is not appropriate to claim for an insured service.
2. If a significant health matter or finding becomes evident, necessitating additional insured examinations or treatments, then these subsequent medically necessary services may be claimed to MSI. *(1.1.28)*

- When a non-insured service is the primary reason for the visit, any service encounter for insured services provided as a medical necessity will reflect only services over and above those provided on a non-insured basis. *(1.1.29)*

PHYSICIAN RECORD REQUIREMENTS TO SUPPORT CLAIMS *(1.1.30)*

This section is to further assist the service provider and billing staff in submitting service encounters to MSI. *(1.1.31)*

Use the W5 approach – what, when, where, why and who. Translate this information into codes that the system can process. Some fields are mandatory which means the service encounter will not be processed if they are not completed. Please take care to ensure that all required fields are completed and that the information is accurate. This will reduce the number of adjustments or refusals that occur and the follow up that you will have to do.

WHAT The service that was done, coded by health service code from the Physician's Manual Schedule of Benefits, and what role the service provider performed.

WHEN The time of day that the service occurred, translated into services unscheduled, subdivisions of the day, or time modifiers.

WHERE The facility number, functional centre and location code for service provided.

WHY The diagnostic codes and injury diagnostic code if applicable.

WHO The health care number (HCN) and date of birth (DOB) of the service recipient and the service provider number. *(1.1.32)*

An appropriate medical record must be maintained for all insured services claimed. The minimum record must contain, for MSI purposes, the following:

a) Patient's name
b) Patient's Nova Scotia health card number
c) Date of the service for which the claim is being made
d) Reason for the visit/presenting complaints
e) Any clinical findings appropriate to the presenting complaints and reflective of the service codes claimed
f) Working diagnosis
g) Treatment prescribed
h) Time and duration of visit in the case of time-based fees
i) Name of referring physician, where appropriate
j) Name of consultant and rationale of referral, where appropriate, and whether referred for diagnosis or treatment and
k) A consultant will send a report to the referring physician where appropriate and retain same on file. *(1.1.33)*

Procedural codes are listed by anatomical region in each appropriate section of the Physician's Manual. The numeric index contains the health service code and the page on which it can be found. All health service codes for visits are found in each specialty section in the Physician's Manual. *(1.1.34)*

Where a procedural code is claimed, the patient record of that procedure must contain information that is sufficient to verify the type and extent of the procedure according to the fees claimed. *(1.1.35)*

All claims submitted to MSI must be verifiable from the patient records associated with the services claimed and be billed in accordance with the Preamble. If the record does not substantiate the claim for the service, then the service is not paid for or a lesser benefit is given. *(1.1.36)*

Where a differential fee is claimed based upon time, location, etc., the information on the patient record must substantiate the claim. *(1.1.37)*

Where the fee claimed is calculated on a time basis, start and finish times must be part of the patient record of that service. *(1.1.38)*

Documentation of services that are being claimed to MSI must be completed before claims for those services are submitted to MSI. *(1.1.39)*

For MSI purposes, it is required that physicians maintain records supporting services claimed to MSI for a period of five years in order to substantiate claims submitted. For medicolegal purposes adult patients' records should be retained for a minimum of 10 years from the date of the last entry in the record. For patients who are children, physicians should keep the record until 10 years after the day on which the patient reached or would have reached the age of 19 years, the age of majority in Nova Scotia. When implementing business practices at the time of entering into a group practice or locum tenens, or when winding down a practice, physicians should confirm that their records will be easily retrievable if they are required to substantiate claims to MSI. *(1.1.40)*

All service items claimed to MSI are the sole responsibility of the physician rendering the service with respect to appropriate documentation and claim submission. *(1.1.41)*

USING NOVA SCOTIA MEDICAL SERVICES INSURANCE SERVICES *(1.1.42)*

INFORMATION *(1.1.43)*

MSI publishes the Physician's Manual of insured services for registered service providers. The Manual consists of three components: *(1.1.44)*

- Preamble: Contains policies, rules and assessment directives that apply to the submission of service encounters. *(1.1.45)*
- Health Service Codes List: Indicates health service codes, qualifiers, unit values, and any applicable modifiers and cross references. *(1.1.46)*
- Explanatory Codes: These codes explain why a service encounter has been refused, reduced in payment or otherwise changed. *(1.1.47)*

The Physician's Manual Preamble is essential to the service provider and billing staff to ensure the codes, modifiers and rules are accurate and appropriate for the services provided. *(1.1.48)*

BULLETINS *(1.1.49)*

MSI Physician Bulletins are published periodically throughout the year and are available on the MSI website https://msi.medavie.bluecross.ca/physicians-bulletins/ to highlight subjects of concern and to provide clarification on special topics. The detailed billing guidelines associated with health service codes are detailed and updated in these bulletins. Tables are published yearly indicating the cut off and payment dates for submissions as well as recognized holidays for the year. Please ensure the Bulletins are provided to billing staff. As well, storing Bulletins along with the Physician's Manual allows for easy cross-reference. Physicians can subscribe to receive email notifications of new Physicians Bulletins being published on the MSI website at https://msi.medavie.bluecross.ca/subscription/. *(1.1.50)*

DEPARTMENTS AND THEIR RESPONSIBILITIES *(1.1.51)*

There are a number of departments within MSI which provide information and materials required by service providers submitting service encounters. *(1.1.52)*

SERVICES *(1.1.53)*

Please contact MSI for assistance with inquiries concerning any aspect of the billing process. MSI will make every attempt to reply to inquiries in a prompt and accurate manner. *(1.1.54)*

CONTACTS *(1.1.55)*

Various kinds of assistance and information may be obtained by contacting the following numbers: *(1.1.56)*

Registration and Enquiry can help with information pertaining to:

- Patient eligibility
- Health card number identification
- Birthdates

Telephone: 902-496-7008
Toll Free: 1-800-563-8880
Fax: 902-481-3160
Email: msi@medavie.ca *(1.1.57)*

MSI Assessment Department can help with:

- Electronic billing, adjudication, or payment questions
- Service encounter submission policies and procedures
- Forms and reference material
- Bank deposit enquiries

Telephone: 902-496-7011
Toll Free: 1-866-553-0585
Fax: 902-490-2275
Email: MSI_Assessment@medavie.bluecross.ca *(1.1.58)*

Provider Coordinator Department can assist with enquiries regarding:

- Registration of new service providers
- Changes to provider address
- Change of bank or account information

Telephone: 902-496-7011
Toll Free: 1-866-553-0585
Fax: 902-496-4674 or 1-877-910-4674
Email: MSIProviders@medavie.ca *(1.1.59)*

The phone lines are staffed from 8:00 to 5:00 – Mondays through Fridays, except for the Government's Statutory Holidays.

Mailing Address:
Nova Scotia Medical Services Insurance
PO Box 500
Halifax NS B3J 2S1

Physical Address:
Nova Scotia Medical Services Insurance
230 Brownlow Avenue
Park Place V
Dartmouth NS B3B 0G5 *(1.1.60)*

SECTION 2: SERVICES INSURED, NOT INSURED, OUT OF PROVINCE AND THIRD PARTY *(2.0.0)*

Nova Scotia Medical Services Insurance Plan is administered and operated in accordance with the Nova Scotia Health Services and Insurance Act on a not-for-profit basis to provide benefits for health services to all eligible residents of Nova Scotia. MSI is responsible for maintaining health care insurance information such as registration of residents, processing service encounters and maintaining payments to service providers. Medavie Blue Cross administers the MSI programs on behalf of the Department of Health and Wellness. (2.0.1)

The Medical Reciprocal Program is an agreement by which a Nova Scotia service provider obtains payment for medically necessary services provided to eligible residents of other Canadian provinces and territories, excluding Quebec. (2.0.2)

Medically necessary services may be defined as those services provided by a physician to a patient with the intent to diagnose or treat physical or mental disease or dysfunction, as well as those services generally accepted as promoting health through prevention of disease or dysfunction. (2.0.3)

The provision of a service listed in the schedule of benefits does not ensure payment by MSI. Services provided in circumstances where they were not medically necessary are not insured. For the purpose of this Preamble, medical services that are explicitly deemed to be non-insured under the Health Services and Insurance Act or its Regulations remain uninsured regardless of individual judgments regarding their medical necessity. (2.0.4)

***Key Terms Relevant to This Section** (2.0.5)*

- *Health Card Number (HCN): A lifetime identification number used to identify all Nova Scotia residents who are registered with MSI. (2.0.6)*
- *Resident of Nova Scotia: A person lawfully entitled to be or remain in Canada, and who makes their home and is ordinarily present in Nova Scotia. A resident does not include a tourist, a transient or a visitor to Nova Scotia. (2.0.7)*
- *Service Provider: An individual who provides a health service for which a service encounter is submitted to MSI. (2.0.8)*
- *Third Party: A person or organization other than the patient, their substitute decision maker (SDM), or MSI that is requesting and/or assuming financial responsibility for a medical or medically related service. (2.0.9)*
- *Travel: Movement from one geographic location to another. Interpretations specific for travel to certain locations: (2.0.10)*
    - *Within an apartment building, movement from one unit to another is considered travel. (2.0.11)*
    - *Movement within a hospital, even between separate buildings on one contiguous site, is not considered travel. If a hospital has several geographically separate sites, movement between sites is considered travel. (2.0.12)*
    - *Movement between rooms or units of a licensed nursing home or special care institution is not considered travel. (2.0.13)*
    - *If a physician maintains a medical office within or adjoining their place of residence, entering the office for the purpose of rendering emergency treatment is considered travel during certain time periods. (2.0.14)*
    - *If a physician has arranged to have an office in a hospital or in an attached building, going from the office to the hospital to attend a patient is not considered travel. (2.0.15)*

SERVICES INSURED BY MSI *(2.1.0)*

Services insured by MSI include: *(2.1.1)*

- Physician's services rendered to persons registered with MSI in a recognized clinical setting, e.g. the patient's home, the doctor's office, at a hospital, clinic or institution, or scene of an emergency. This includes all diagnostic, medical, psychiatric, surgical, or therapeutic procedures, including the services of anaesthetists and assistants as per the definition of medical necessity (See Section 6 (6.0.52)). Some services may require prior approval (See Appendix C Service Encounters Requiring Prior Approval/Preauthorization (7.3.0)). *(2.1.2)*

Services that are insured, but with restrictions: *(2.1.5)*

- Coverage for routine refractive vision analysis is limited to once every 24 months for persons under 10 years of age and for those 65 years of age and over. For all others, routine refractive vision analysis is an uninsured service. *(2.1.6)*
- Age specific preventive services where indicated as determined by current guidelines for well baby care, vaccinations, inoculations, etc. This would include examinations offered to individuals who have a family history, symptoms or signs or other diseases that put them at risk for preventable target conditions. *(2.1.7)*
- Group sessional clinics, e.g., immunization or "well person", when preapproved by MSI. (See Section 6 (6.0.86)) *(2.1.8)*
- Complete history and physical examinations, but only when medically necessary to establish a diagnosis. (See Services Not Insured by MSI) *(2.1.9)*
- The services of an anaesthetist when required in conjunction with specified dental surgical procedures listed in the Insured Dental Service Tariff Regulations of the Health Services and Insurance Act and only when medical necessity requires these services to be performed in a hospital. *(2.1.10)*
- Dental services as described in the Children's Oral Health Program and Dental Surgical Program. *(2.1.12)*
- Services provided virtually via telephone, telehealth network, or PHIA compliant network when in compliance with the Provision of Publicly Funded Virtual Health Services Policy. *(2.1.13)*

When complications occur following a non-insured procedure, treatment that is medically necessary is an insured service. *(2.1.11)*

SERVICES NOT INSURED BY MSI *(2.2.0)*

The following services are not insured by MSI. The physician must determine who has responsibility for payment, if any. *(2.2.1)*

- Services available to residents of Nova Scotia under the Workers' Compensation Act, through the Department of Veterans Affairs, Canadian Forces, the Hospital Insurance Act, any Act of the Parliament of Canada or under any statute or law of any other jurisdiction either within or without Canada. *(2.2.2)*
- Outside of the telephone prescription renewal TPR1, when a prescription or a requisition for a diagnostic or therapeutic service is provided to a patient without a clinical evaluation of the patient, the requirements of an insured visit service have not been met and no service encounter should be submitted. *(2.2.3)*
- Diagnostic, preventive or other physician's services available through the Nova Scotia Hospital Insurance Program, the Department of Health and Wellness, or other government agencies. *(2.2.4)*
- Physician's services provided to their own families *(2.2.6)*
- Services which, in the opinion of the Department of Health and Wellness, have been performed for cosmetic purposes only: *(2.2.7)*
    - Cosmetic surgery is defined as a service done solely for the purpose of altering the appearance of the patient and not medically necessary. *(2.2.8)*
    - When there is doubt as to whether the proposed surgery is medically required or cosmetic, the operating surgeon should obtain prior approval from MSI. Anaesthetic and other fees associated with non-insured services are non-insured as well. MSI will pay for a visit or consultation to determine if a treatment method is insured, even though the proposed procedure is non-insured. If the proposed procedure or treatment is always uninsured, a visit or consultation may not be claimed. *(2.2.9)*
- Group immunizations performed without receiving preapproval by MSI. *(2.2.10)*
- Acupuncture *(2.2.11)*
- Electrolysis *(2.2.12)*
- Reversal of sterilization *(2.2.13)*
- In vitro fertilization *(2.2.14)*
- Provision of travel vaccines *(2.2.15)*
- Newborn circumcision *(2.2.16)*
- Release of tongue tie in newborn *(2.2.17)*
- Removal of cerumen, except in the case of a febrile child *(2.2.18)*
- Treatment of warts or other benign conditions of the skin by excision, cryotherapy, electrocautery, curettage or any other means with the exception of the following:
    - Plantar warts or molluscum contagiosum.
    - Treatment of a malignant or recognized premalignant condition (includes clinical suspicion of malignancy)
    - Excision of a sebaceous cyst when infected or otherwise medically necessary
    - Excision of a lipoma when large and/or causing interference with function
    - Excision of a subcutaneous neuroma when large and/or causing interference with function
    - Other specific conditions as outlined in the Schedule of Benefits *(2.2.19)*

Comprehensive visits when there are no signs, symptoms or family history of disease or disability that would make such an examination medically necessary. This excludes those examinations performed in accordance with guidelines (See Section 2 (2.1.7)) relating to preventive health exams. *(2.2.20)*

Services provided by other health care workers, with certain exceptions, are not insured under MSI. This would include services of pharmacists, chiropractors, podiatrists, physiotherapists, naturopaths, osteopaths, psychologists, nurses, nurse practitioners or other paramedical personnel: *(2.2.21)*

- Dental services, except those which are described as benefits under the MSI Dental Program. Information can be obtained by contacting Green Shield Canada 1-833-739-4035. *(2.2.22)*
- Ancillary services, such as charges for an ambulance, etc. *(2.2.23)*
- Optometric services, except those that are described as benefits under the MSI Optometric Program. Information can be obtained by contacting the MSI office. *(2.2.24)*

The following are excluded from the definition of insured psychotherapy and therefore not insured: movement therapy, energy therapy, and other types of alternative or integrative treatments.

Costs of medical services that are primarily related to research or experimentation are not the responsibility of the patient or MSI. *(2.2.25)*

Meet and Greet *(2.2.54)*

Outside of the new patient intake visit NPIV1, all services billed to MSI must be medically necessary. There must be a specific health related concern/complaint that has led the patient to seek medical attention. It is not appropriate to bill MSI for a "meet and greet" visit with a new patient unless a health-related concern/complaint has been addressed at the visit. Similarly, it is not appropriate to bill a comprehensive visit or counselling for such encounters unless the visit is medically necessary and Preamble requirements for the codes have been satisfied. *(2.2.55)*

Services at the Request of Third Parties *(2.2.26)*

Health examinations or provision of health information required in connection with employment, insurance, admission, legal proceedings, etc., or any similar request by a third party are not insured. Responsibility for payment may lie either with the patient or the third party requesting the examination or information. This excludes third party as defined in Section 18 of the Health Services and Insurance Act. *(2.2.27)*

The following are examples only and do not represent a complete list: *(2.2.28)*

- Insurance company examinations and requests for medical information. *(2.2.29)*
- Examinations requested by educational institutions, youth groups, summer camps. *(2.2.30)*
- Employer requested examinations and sick certificates. *(2.2.31)*
- Examinations required to support legal claim. *(2.2.32)*
- Services required by a legal proceeding including preparation of records, reports, letters or certificates, or appearance and/or testimony in a court or other tribunal. *(2.2.33)*
- Department of Immigration passport or visa. *(2.2.34)*
- Any diagnostic services associated with the above. *(2.2.35)*

Services, Supplies and Other Materials Not Part of Office Overhead *(2.2.36)*

Services, supplies and other materials provided through the physician's office when such supplies are not normally considered part of office overhead: *(2.2.37)*

- Photocopying or other costs associated with transfer of records. See clause 14 and 15 under the Personal Health Information Act regarding accessing Personal Health Information Records. *(2.2.38)*
- Long distance telephone charges incurred specifically on the patient's behalf. *(2.2.39)*
- Items such as drugs, injectable materials, biological sera, dressings, strapping, tray fees, etc. used in rendering medical care, except for Pap smear tray fees and provincial immunization tray fees. *(2.2.40)*
- Medical or health devices e.g., eyeglasses, contact lenses, hearing aids, surgical appliances, trusses, wheelchairs, crutches and prosthetic appliances. *(2.2.41)*

- Physician's advice by letter, fax or e-mail is an uninsured service. However, telephone, fax or e-mail advice for home dialysis, home care, anticoagulant supervision and palliative care are insured services under certain circumstances. Telephone services are insured when in compliance with the Provision of Publicly Funded Virtual Health Services Policy. *(2.2.42)*
- Mileage or travelling time except as defined in (See Section 5 (5.1.48)) relating to detention time or blended mileage/travel detention for home visits *(2.2.43)*
- For patients registered in home care, physicians may claim blended mileage/travel detention to compensate for travel expenses and time incurred for home visits. Blended mileage/travel detention will be reimbursed only for those home visits initiated by the care coordinator or health care professionals of Home Care Nova Scotia. *(2.2.56)*
- Mileage for home visits will be reimbursed only when a visit has been requested by the patient or patient's representative and the patient is considered homebound. The mileage/travel detention fee is a blended rate based on kilometres travelled for the round trip. Text for the claim must include: The start and finish time of the visit, point of origin, destination address, and the distance in kilometers. The distance in kilometres should be entered in the multiple field of the service encounter. A record should be kept in your office of the starting and destination points. *(2.2.44)*

Blood Alcohol Sampling Impaired Drivers *(2.2.45)*

Claims for blood alcohol sampling on impaired drivers will be processed by Medavie Blue Cross, Accounting Department and then reimbursed by the Department of Justice. The total fee should include:

a) Venipuncture, if performed by the physician at the rate listed in the schedule of benefits.
b) Kilometres to be paid at the current government rate (can be obtained from the Department of Health and Wellness or any other provincial department).
c) If travel is involved, the rate will be based on the fee for detention as listed in the Schedule of Benefits.
d) If appropriate documents are completed a fee of 45 units may be claimed.
e) If insured services are provided to the impaired driver, the physician should claim under the appropriate MSI health service code in the usual manner. If insured medical services are not provided to the impaired driver, the appropriate visit fee may be added to the above and billed the Department of Justice. It is not appropriate to bill both MSI and the Department of Justice for the same service. *(2.2.46)*

Please forward service encounters for the above on the physician's letterhead to:

MSI Accounting Department
PO Box 500
Halifax, NS B3J 2S1 *(2.2.47)*

Sexual Assault Examination *(2.2.48)*

This is an assessment of a patient in which the physician follows the protocol prescribed by the Department of Justice for the investigation of alleged sexual assault. *(2.2.49)*

The forensic examination portion of the treatment of a sexual assault victim is not insured under MSI, but payment is included in the Health Services Code 03.03G Examination of a victim of an alleged sexual assault and evidence collection. MSI will recover this portion of the fee from the Department of Justice. *(2.2.50)*

HSC 03.03G: This fee includes all aspects of the medical history, the medical, psychological and forensic examination, including collection of evidence according to the protocol prescribed by the Department of Justice for the investigation of an alleged sexual assault and the initial medical treatment of the victim by the physician. Not to be billed with any other fees during the same time period. To be eligible for this fee, the evidence must be collected and the documentation submitted according to the Department of Justice protocol. *(2.2.51)*

Physician Testimony – Sexual Assault Prosecution ***(2.2.52)***

In the event that a charge of sexual assault is laid and a prosecution results, a physician may be subpoenaed by the Crown to testify in court. All costs associated with preparation for that court appearance and testifying in court should be submitted in an invoice to the Nova Scotia Public Prosecution Service by the physician. *(2.2.53)*

REGISTRATION AND CONDITIONS OF PARTICIPATION FOR NOVA SCOTIA RESIDENTS *(2.3.0)*

INTRODUCTION *(2.3.1)*

Service providers can claim payment from MSI for insured services provided to eligible Nova Scotia residents. The registration covers insured services and hospitalization benefits. Permanent residents of Nova Scotia are required to register with MSI. *(2.3.2)*

DEFINITION OF A RESIDENT *(2.3.3)*

A resident of Nova Scotia is a person who is:

- lawfully entitled to be in Canada
- makes their home in Nova Scotia
- ordinarily physically present at least 183 days in a calendar year in Nova Scotia
- not a visitor, tourist or transient.

The following section is provided to help determine if and when a patient may be eligible. *(2.3.4)*

ELIGIBILITY GENERAL RULES *(2.3.5)*

CANADIAN CITIZENS AND PERMANENT RESIDENTS *(2.3.6)*

a) A Canadian citizen or permanent resident moving to Nova Scotia from elsewhere in Canada with the intent of establishing permanent residence in the province is entitled to receive benefits under MSI commencing on the first day of the third month immediately following the month in which they become residents of Nova Scotia, e.g., arrived January 17th, eligibility date will be April 1st.

b) A Canadian or permanent resident moving to Nova Scotia from outside Canada, who is lawfully entitled to remain in Canada, with the intent of establishing permanent residence in the province, is entitled to receive benefits under MSI commencing on the day they become a resident of Nova Scotia.

c) Proof of Canadian citizenship or permanent residency is required. *(2.3.7)*

STUDENTS FROM OTHER PROVINCES *(2.3.8)*

Students from other Canadian provinces are normally not eligible for MSI. They are insured by their home province. *(2.3.9)*

STUDENTS FROM OTHER COUNTRIES *(2.3.10)*

a) Coverage is effective the first day of the thirteenth month after the student's arrival in Nova Scotia; providing the student is in possession of a valid study permit and has not been absent from Nova Scotia for more than 31 consecutive days during that period or any subsequent year, except in the course of their studies.

b) Such coverage valid only for health services received in Nova Scotia.

c) Dependents of students to be granted coverage on the same basis once the student has gained entitlement.

d) Coverage is effective until the expiry date on the study permit or health card. To maintain coverage, the student must not be absent from Nova Scotia for more than 31 consecutive days, except in the course of study, and a declaration must be presented to MSI each year.

e) Once coverage has terminated, the student is treated as never having qualified for health services and must comply with paragraph (a) above before coverage will be extended. *(2.3.11)*

WORKERS FROM OTHER COUNTRIES *(2.3.12)*

a) Workers may register for MSI on the date of arrival in Nova Scotia; provided they are in possession of a valid work permit for at least a 12-month period.
b) Dependents of workers to be granted coverage on the same basis once the worker has gained entitlement.
c) Coverage effective until the expiry date on the work permit or health card. To maintain coverage, the worker must not be absent from Nova Scotia for more than 31 consecutive days, except in the course of employment, and a renewal and declaration must be presented to MSI each year.
d) Once coverage has terminated, the worker is treated as never having qualified for health services and must comply with paragraph (a) above before coverage will be extended. *(2.3.13)*

PERSONS WITH OTHER IMMIGRATION DOCUMENTS *(2.3.14)*

Persons in possession of other immigration documents may or may not be eligible for MSI benefits. They should be encouraged to contact the MSI office for clarification of their status. *(2.3.15)*

TRANSIENTS, TOURISTS, OR VISITORS TO NOVA SCOTIA *(2.3.16)*

Transients, tourists, or visitors to Nova Scotia are not eligible to receive benefits under MSI. *(2.3.17)*

TEMPORARY ABSENCE FROM NOVA SCOTIA *(2.3.18)*

Residents of Nova Scotia who leave the province on a temporary basis with the intention of returning may be eligible to receive benefits under MSI for insured services. The period and extent of MSI coverage will vary according to the circumstances surrounding the resident's temporary absence. *(2.3.19)*

PERMANENT DEPARTURE FROM NOVA SCOTIA *(2.3.20)*

a) Residents leaving the province to establish residence elsewhere in Canada will be covered under MSI up to and including the last day of the second month following the month in which they establish residence in their new province, e.g., persons establishing residency on June 21st, their eligibility will cease August 31st.
b) If the resident is moving outside Canada, coverage will cease from the date of departure from Canada. *(2.3.21)*

OTHER *(2.3.22)*

Eligibility situations not outlined in the previous sections should be clarified by contacting MSI at 902-496-7008 or toll free 1-800-563-8880. *(2.3.23)*

REGISTRATION *(2.3.24)*

In order to register for MSI, the new resident(s) must complete an Application for Health Services which can be obtained by calling or visiting the MSI office. It should be noted that although an individual or family may have registered with MSI, they will not become eligible for benefits until they have satisfied the residency requirements. Upon the successful completion of an Application for Health Services, every eligible Nova Scotia resident will receive a health card reflecting their unique 10-digit lifetime health number. The health number is required for claims to be prepared. The health card shows the resident's name, date of birth, gender if applicable, date of eligibility for MSI, card expiry date and organ donor status. *(2.3.25)*

REPORTING CHANGES *(2.3.26)*

It is important that residents keep MSI informed of any changes in their registration information. Any changes e.g., birth, adoption, death, marriage, legal separation, change of address, or departure from the province should be reported to the MSI office without delay. *(2.3.27)*

ORGAN DONATION *(2.3.28)*

The Human Organ and Tissue Donation Act became effective January 2021. Eligible Nova Scotia residents who do not have a donation decision recorded in the province's health card registry are considered donors after death. Eligible Nova Scotia residents can register their decision to be a donor or opt out by contacting MSI, or residents can also opt out at www.novascotia.ca/organtissuedonation. Their decision will be kept on their registration file and the word donor will be embossed on their health card with a one-digit code. The codes are: (1) indicates they wish to donate all organs and tissues and (2) indicates only specific organs or tissues are to be donated, alternatively 'opt out' will be embossed on the health card should the resident choose to opt out. The signed health card with donor designation is a legal document. *(2.3.29)*

EXPIRY DATES *(2.3.30)*

Nova Scotia health cards have an expiry date which provides for regular contact with our residents to maintain accurate files. The expiry date is a four-year term determined by birthdate, e.g., birthdate June 15, 2020, health card expiry date would be May 31, 2024. The expiry date is in relation to the duration of the card and not necessarily to the eligibility status of the individual. Renewal notices will be mailed to the address on the registration file three months prior to the expiry date. *(2.3.31)*

LOST OR STOLEN HEALTH CARDS *(2.3.32)*

If a resident indicates that their health card has been lost or stolen, please advise them to contact the MSI office immediately. There is a fee to replace a lost or stolen card. *(2.3.33)*

NEW PATIENTS *(2.3.34)*

Please take special care to review the patient's personal health card the first-time treatment is provided. Additional identification must be requested to ensure the patient's identity. *(2.3.35)*

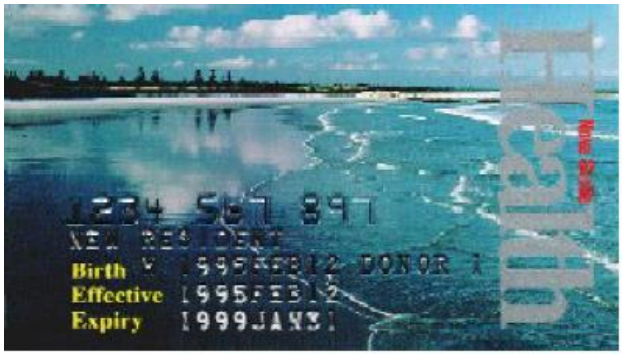
CLAIM REFUSAL *(2.3.36)*

In some situations, a service provider's claims may be refused; the existence of a health card is not a guarantee of coverage. It is the service provider's responsibility to try and contact the patient. However, if unsuccessful, please contact the MSI Registration Department for assistance.

Telephone: 902-496-7008

Toll Free: 1-800-563-8880

Sample of Nova Scotia Health Card *(2.3.37)*



(2.3.38)

SERVICE ENCOUNTERS FOR PATIENTS FROM OUT OF PROVINCE *(2.4.0)*

INTERPROVINCIAL RECIPROCAL BILLING AGREEMENT *(2.4.1)*

Service providers may be required to render medical services to patients from other provinces within Canada who are visiting or travelling within Nova Scotia. Effective April 1, 1988, all provinces and territories, except Quebec, agreed to participate in a reciprocal billing agreement under which a service provider would submit service encounters directly to their own provincial medical plan for eligible Canadian patients. *(2.4.2)*

CRITERIA *(2.4.3)*

For a service encounter to be processed through the reciprocal billing agreement, it must meet all of the following conditions:

- The service must be medically necessary and must be provided by a registered service provider.
- The service must be provided to eligible residents from a Canadian province or territory, except for Quebec. Please contact the MSI Assessment Department at 902-496-7011 or toll free 1-866-533-0585, if out of province claim forms are required.
- The benefit must be claimed according to the Nova Scotia Medical Services Physician's Manual schedule of benefits. *(2.4.4)*

All provinces have their own established fee schedule, regulations and assessment rules for insured services provided to eligible residents. The medical plans, in turn, arrange periodic reimbursement between one another for the medical service encounters paid on behalf of eligible patients from other provinces/territories. *(2.4.5)*

Overall, the reciprocal program enhances the universality of Canada's Medicare program. The system allows for smoother, faster, and less costly processing and payment of service encounters for eligible out of province patients. This benefits physicians, patients, and medical plans. *(2.4.6)*

ELIGIBILITY REQUIREMENTS *(2.4.7)*

To be eligible to submit service encounters through the reciprocal billing agreement the following conditions must be met:

- The patient must be insured through the medical plan in their own province of residence.
- The patient must show a valid health insurance card from their home province as evidence of eligibility.
- To verify that a card is valid, please check that it indeed applies to the patient in question; also check for an effective date of coverage and/or an expiry date. Make sure that either the effective date of coverage or the expiry date or both are current for the dates of services you are providing.
- If the patient cannot present a valid card, the service provider cannot submit a service encounter to MSI under the medical reciprocal program. *(2.4.8)*

Note: Health insurance cards differ from one provincial medical plan to another and in some cases quite substantially. To help identify valid out of province cards, full descriptions of each card, including an illustration, plus pointers on what to look for are included in Appendix A Interprovincial Health Cards (7.1.0). *(2.4.9)*

CHECKING FOR EXCLUDED SERVICES *(2.4.10)*

The intent of the reciprocal billing agreement is to provide universal medical service coverage for out of province patients. However, because each province has slightly different coverage, or has special rules for certain services, not all services are covered by the reciprocal billing agreement. *(2.4.11)*

Identified Excluded Services *(2.4.12)*

The following services are excluded from Canada's reciprocal billing agreement for processing out of province medical service encounters:

1. Surgery for alteration of appearance (cosmetic surgery)
2. Gender affirming surgery
3. Breast augmentation surgery for transgender women
4. Surgery for reversal of sterilization
5. Routine periodic health examinations, including routine eye examinations
6. In vitro fertilization, artificial insemination
7. Lithotripsy for gallbladder stones
8. Treatment of port wine stains on other than the face or neck, regardless of the modality of treatment
9. Acupuncture, acupressure, transcutaneous electronerve stimulation (TENS), moxibustion, biofeedback, hypnotherapy
10. Services to persons covered by other agencies; Armed Forces, Workers' Compensation Board, Department of Veterans Affairs, and Correctional Services of Canada federal penitentiaries
11. Services requested by a third party
12. Team conferences
13. Genetic screening and other genetic investigation, including DNA probes
14. Procedures still in the experimental or developmental phase
15. Anaesthetic services and surgical assistant services associated with all of the foregoing *(2.4.13)*

It should be noted that some services, even though excluded from the reciprocal billing agreement, might still be covered by individual provincial medical plans. In this situation, it is suggested that an out of province claim is completed. *(2.4.14)*

SPECIAL RECIPROCAL BILLING SITUATIONS *(2.4.15)*

There are several situations relating to payment for medical services provided which require special attention. They include service encounters for newborns, Workers' Compensation Board patients and some referred patients. *(2.4.16)*

NEWBORNS *(2.4.17)*

When claiming for services rendered to children from other provinces that are not yet registered in their home province, use the mother's health insurance number and the child's name and the child's birth date. *(2.4.18)*

WCB EXCLUSION *(2.4.19)*

Workers' Compensation Board service encounters are excluded from medical reciprocal processing. Please submit Workers' Compensation Board service encounter for an out of province patient to the Workers' Compensation Board of whichever province is responsible. Check with the patient to determine which province is responsible for the WCB claim. *(2.4.20)*

SUBMITTING RECIPROCAL SERVICE ENCOUNTERS FOR PAYMENT *(2.4.21)*

There are two methods available to obtain payment for services: *(2.4.22)*

1) To obtain payment through the reciprocal billing agreement:

   Submit service encounters for eligible patients the same as claims for eligible Nova Scotia patients. For the payment responsibility, indicate the applicable province code and include a person data record (See

Section 3 (3.2.141)). Payments for these service encounters are based on the Nova Scotia Medical Services (MSI) Physician's Manual, the master service unit (MSU) and governing rules. *(2.4.23)*

2) The alternate method for submitting service encounters for patients not eligible for reciprocal billing is the out of province claim form developed specifically for this purpose. The procedure is as follows:

   When completed, the service encounter is sent to the provincial health care plan with which the patient has coverage. The service provider may mail the service encounter, or the patient may be asked to forward it, particularly if payment is to be made to the patient.

Note: Submit out of province service encounters promptly. The time limit for submission in most provinces is one year from the date of service. *(2.4.24)*

INFORMATION CONCERNING VARIOUS SERVICE ENCOUNTER SITUATIONS *(2.5.0)*

WCB SERVICE ENCOUNTERS FOR NOVA SCOTIA RESIDENTS *(2.5.1)*

WCB service encounters are processed through the electronic system at Medavie using the same technology as for the submission of MSI related service encounters. Physicians must submit their service encounters through this system for Nova Scotia residents 16 years of age and over who meet the eligibility requirements of WCB. Medical and surgical appliances as well as other services will continue to be the responsibility of the Workers' Compensation Board. Section 3 (3.2.115) details the payment responsibility field to enter for a WCB service encounter. When submitting a claim with a payment responsibility of WCB, the patient's WCB claim number, and/or the patient's injury date (month and year) is required in the appropriate fields. *(2.5.2)*

Health Service Codes to be Used When Claiming for WCB Services *(2.5.3)*

DEFT	WCB2	WCB Office Visit Examination for Pneumoconiosis	20.5 units
DEFT	WCB12	EPS physician assessment Service. Combined office visit and completion of Form 8/10 RO=EPS1 RP=INTL RO=EPS1 RP=SUBS	 $225.65+MU $225.65
DEFT	WCB13	Chart Summaries / Written Reports. Detailed reports billed in 15-minute intervals - plus multiples, if applicable (SP=GENP) RO=EPS1 Specialists	 $55.27 per 15 min $66.05 per 15 min $74.32 per 15 min
DEFT	WCB15	Case Conferencing and Teleconferencing (Treating Physician) Conferencing billed by the Treating Physician - plus multiples, if applicable (SP=GENP) RO=EPS1 Specialists	 $55.27 per 15 min $66.05 per 15 min $74.32 per 15 min
DEFT	WCB17	Photocopying of charts. Photocopying of chart notes 10 pages or less ME=UP10 11-25 pages ME=UP25 26-50 pages ME=UP50 Over 50 pages ME=OV50	 $33.11 $66.05 $131.91 $197.68
DEFT	WCB20	Carpal Tunnel Syndrome (CTS) Form Payment This form is only to be used upon request from the WCB case worker	 $84.66
DEFT	WCB21	Follow-up visit report	$49.58
DEFT	WCB22	Completed Mandatory Generic Exemption Request Form	$16.63 per form
DEFT	WCB23	Completed Non-Opioid Special Authorization Request Form	$16.63 per form
DEFT	WCB24	Completed Opioid Special Authorization Request Form	$55.56 per form
DEFT	WCB25	Completed WCB Substance Abuse Assessment Form	$37.08
DEFT	WCB26	Return to Work Report – Physician's Report Form 8/10	$84.66

DEFT	WCB27	Eye Report	$74.32
DEFT	WCB28	Comprehensive Visit for Work Related Injury or Illness	$85.21
DEFT	WCB29	Initial Request Form for Medical Cannabis	$91.93
DEFT	WCB30	Extension Request Form for Medical Cannabis	$55.27
DEFT	WCB31	WCB Interim Fee- Comprehensive Visit for Work Related Injury or Illness When Condition Has Changed	$85.21
DEFT	WCB32	WCB Safe Work Connectedness Report Specialists	$74.32

Note: All forms are forwarded directly to the Workers' Compensation Board whereas the service encounter is billed electronically to MSI. *(2.5.5)*

WCB Service Encounters for Non-Residents *(2.5.6)*

A Workers' Compensation Board service encounter for a non-resident cannot be submitted electronically to MSI for payment. Service encounters for services provided to a non-resident temporarily working for a Nova Scotia company, as a result of an on-the-job injury, should be submitted directly to the Nova Scotia Workers' Compensation Board at the following address:

Workers' Compensation Board of Nova Scotia
5668 South Street
PO Box 1150
Halifax NS B3J 2Y2 *(2.5.7)*

Service encounters and appropriate WCB forms provided to a non-resident working for a non-Nova Scotia company must be sent directly to the Workers' Compensation Board of their home province. *(2.5.8)*

Below is the list of WCB locations for the Provinces and Territories: *(2.5.9)*

WORKERS' COMPENSATION BOARD OF ALBERTA
PO Box 2415
9912-107 Street
Edmonton AB T5J 2S5
Tel: 780-498-3999
Toll Fee Fax: 1-800-661-1993
Toll Free: 1-866-922-9221
http: www.wcb.ab.ca

WORKSAFEBC
WorkSafeBC
PO Box 5350
Vancouver, BC V6B 5L5
Tel: 604-273-2266
Fax: 604-276-3151
Toll Free: 1-888-967-5377
http: www.worksafebc.com

WORKERS' COMPENSATION BOARD OF THE NORTHWEST TERRITORIES AND NUNAVUT
PO Box 8888
Yellowknife NT X1A 2R3
Tel: 867-920-3888
Fax: 867-873-4596
Toll Free: 1-800-661-0792
http: www.wscc.nt.ca

WORKERS' COMPENSATION BOARD OF NOVA SCOTIA
5668 South Street
PO Box 1150
Halifax NS B3J 2Y2
Tel: 902-491-8999
Fax: 902-491-8002
Toll Free Mainland Nova Scotia 1-800-870-3331
Toll Free Sydney 1-800-880-0003
http: www.wcb.ns.ca

WORKERS' COMPENSATION BOARD OF MANITOBA
333 Broadway
Winnipeg MB R3C 4W3
Tel: 204-954-4321
Fax: 204-954-4968
Toll Free: 1-855-954-4321
http: www.wcb.mb.ca

WorkSafeNB
1 Portland Street
PO Box 160
Saint John NB E2L 3X9
Tel: 506-632-2200
Fax: 506-632-4999
Toll Free: 1-800-999-9775
http: www.worksafenb.ca

WorkplaceNL
146-148 Forest Road
PO Box 9000, Station B
St. John's NL A1A 3B8
Tel: 709-778-1000
Fax: 709-738-1714
Toll Free: 1-800-563-9000
http: https://workplacenl.ca/

SASKATCHEWAN WORKERS' COMPENSATION BOARD
200-1881 Scarth Street
Regina SK S4P 4L1
Tel: 306-787-4370
Fax: 306-787-0213
Toll Free: 1-800-667-7590
http: http://www.wcbsask.com/

WORKPLACE SAFETY AND INSURANCE BOARD
200 Front Street West
Toronto ON M5V 3J1
Tel: 416-344-1000
Fax: 416-344-3999
Toll Free: 1-800-387-0750
http: www.wsib.on.ca

WORKERS COMPENSATION BOARD OF PRINCE EDWARD ISLAND
14 Weymouth Street
Charlottetown PE C1A 4Y1
Tel: 902-368-5680
Fax: 902-368-5705
Toll Free: 1-800-237-5049
http: www.wcb.pe.ca

COMMISSION DE LA SANTÉ ET DE LA SÉCURITÉ DU TRAVAIL DU QUEBEC (Occupational Health and Safety Commission)
524, rue Bourdages Quebec (Quebec) G1M 1A1Tel Can and US: 1-844-838-0808
Outside Can and US: 514-906-3266
http: www.cnesst.gouv.qc.ca

YUKON WORKERS' COMPENSATION HEALTH & SAFETY BOARD
401 Strickland Street
Whitehorse YK Y1A 5N8
Tel: 867-667-5645
Fax: 867-393-6279
Toll Free: 1-800-661-0443
http: www.wcb.yk.ca *(2.5.10)*

COMMUNITY SERVICES MEDICAL ASSESSMENT *(2.5.11)*

A medical assessment form completed for a patient on behalf of Community Services (COM) is to be forwarded to Community Services. 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 health service code (HSC) is claimed at 40 units, however; in this case the payment rate is remunerated at one dollar ($1.00) per unit for a total of $40.00. Any patient over 65 years of age does not qualify for this service. *(2.5.12)*

If the 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. *(2.5.13)*

COMMUNITY SERVICES – REQUEST FOR ESSENTIAL MEDICAL TREATMENT *(2.5.14)*

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. *(2.5.15)*

A 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. *(2.5.16)*

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 40 units, however; in this case the payment rate is remunerated at one dollar ($1.00) per unit for a total of $40.00. Any patient over 65 years of age does not qualify for this service. *(2.5.17)*

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. *(2.5.18)*

SECTION 3: SERVICE REPORTING AND CLAIMS SUBMISSION *(3.0.0)*

A business arrangement is an agreement between a service provider and MSI covering the payment arrangements for health services provided. The business arrangement defines the service providers and the payee. All service providers registered with MSI must have or be part of a business arrangement in order to claim for services. Some service providers may have and/or be part of more than one business arrangement. It is the service provider's decision not to have basic health insured services submitted to MSI for direct payment. (3.0.1)

An accredited submitter is an organization or individual accredited by MSI to send service encounter transactions in an electronic format on behalf of service providers with the ability to retrieve results electronically from MSI. A list of approved service bureaus can be found on the MSI website. (3.0.2)

An accredited vendor is an organization or individual that has developed a software program that has been accredited by MSI to electronically submit service encounters. A list of approved vendors can be found on the MSI website. (3.0.3)

An electronic adjudication response results is sent to a submitter detailing the assessment results of each service encounter submission. It will be produced whenever service encounter submissions are processed. Service encounters that are reduced, refused or paid at zero will have an explanatory code attached. (3.0.4)

***Key Terms Relevant to This Section** (3.0.5)*

Claims Assessment: (3.0.6)

- *Bottom Line Adjustments: Adjustments in payment made by MSI that reflect credits or debits resulting from extenuating circumstances e.g., audit recovery. (3.0.7)*
- *Explanatory Code: An explanation that indicates why a service encounter has been refused, reduced, paid at zero or changed in some other manner. (3.0.8)*
- *Paid at Zero: Term used to indicate that additional information may be required from the provider to aid in the assessment of the claim. (3.0.9)*
- *Statement of Account: A statement is based on the number of service encounters processed on a biweekly basis indicating the amount MSI has released for payment. The statement can be retrieved electronically from the MSI system. (3.0.10)*

Clinical Vocabularies: (3.0.11)

- *Canadian Classification of Diagnostic, Therapeutic and Surgical Procedures (CCP): A catalogue of procedures that was produced by Statistics Canada to provide a national procedure classification standard. (3.0.12)*
- *Diagnostic Code: A three-to-five-digit international coding system which identifies the medical condition for which a service provider is billing services ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification). (3.0.13)*
- *Health Service Code (HSC): A code identifying services or procedures performed by a service provider to a service recipient. In most cases, these codes are CCP codes or CCP codes with a qualifier to further define the service. NOTE: Non-CCP health services codes are used to identify non-procedural services. Example: C9999. (3.0.14)*

Physician Types: (3.0.15)

- *General Practitioner: A physician who engages in the general practice of medicine or a physician who is not a specialist as defined by the Medical Act. (3.0.16)*
- *Locum Tenens: A service provider who replaces and provides services for another established service provider who is temporarily away from work. (3.0.17)*

- *Most Responsible Physician: The most responsible physician (MRP) is the attending physician who is primarily responsible for the day-to-day care of the patient in hospital.* (3.0.18)
- *Physician: A legally qualified medical practitioner whose name is entered in the register kept by the College of Physicians and Surgeons of Nova Scotia as being qualified and licensed to practice medicine. They must be in good standing and not under suspension pursuant to any of the provisions of the Medical Act.* (3.0.19)
- *Specialist/Specialty: A specialist is defined as one whose name appears in the specialist register of the College of Physicians and Surgeons of Nova Scotia. However, when the term specialty is used, it means any or all specialties, including general or family practice. For the purpose of this Preamble, the terms general and family practice are used interchangeably.* (3.0.20)

Other Terms: (3.0.21)

- *Accredited Service Bureau: An approval given by MSI to a service bureau to provide service encounter submissions for service providers.* (3.0.22)
- *Age: Where age is a factor in determining eligibility for payment, or modifies the service, the following age ranges are defined:*
  - *Premature – 2,500 grams or less at birth*
  - *Neonate/Newborn - the 10 days following delivery*
  - *Infant - up to and including 23 months*
  - *Child - up to and including 15 years of age*
  - *Adult - 16 years of age and over* (3.0.23)
- *Direct Deposit: A method by which a service provider's payments from MSI are transferred directly into their bank account. This is also referred to as electronic funds transfer.* (3.0.24)
- *Discipline: A specific branch or field of study in which a service provider has been licensed to participate, e.g., medicine, dentistry, optometry or pharmacy.* (3.0.25)
- *Facility: A physical location, e.g., hospital, institution or office, where health services are routinely performed. All facilities are formally recognized on the MSI Register.* (3.0.26)
- *Facility Number: A number which uniquely identifies a physical location where health services are routinely performed.* (3.0.27)
- *Locum Period: A period of time during which a locum tenens provides services in the absence of the established service provider.* (3.0.28)
- *Payment Responsibility: A mandatory field on a service encounter that identifies which organization is responsible for the payment of the service, i.e., MSI, WCB, Community Services (COM). There are also out of province codes that identify the provincial health care plan where the patient has medical coverage.* (3.0.29)
- *Service Encounter: A transaction which describes the health service performed by the provider to the service recipient.* (3.0.30)
- *Service Encounter Number: A number assigned to each service encounter, which distinguishes that service encounter from others. It is comprised of the submitter ID, year, sequence number and check digit.* (3.0.31)
- *Service Recipient: An individual who receives insured services by a registered Nova Scotia service provider.* (3.0.32)

RECORDING SERVICE PROVIDER INFORMATION *(3.1.0)*

BACKGROUND *(3.1.1)*

All service providers who wish to receive compensation from Medical Service Insurance (MSI) for insured medical services must be registered with MSI. *(3.1.2)*

PROVIDER REGISTRY *(3.1.3)*

The provider coordinators maintain all records for registered service providers. Below are some of the services that are processed into the MSI system by the provider coordinator.

- Locum tenens
- Business arrangements
- New facility registration
- Specialties
- Address changes
- Updates from College of Physicians and Surgeons Nova Scotia *(3.1.4)*

Keeping registration details current is a very important matter for every service provider. Changes may have an effect on the payment of service encounters. Please notify MSI immediately of changes. *(3.1.5)*
To Contact MSI:

Nova Scotia Medical Services Insurance
Telephone: 902-496-7011
Toll Free: 1-866-553-0585
Fax: 902-469-4674 or 1-877-910-4674
E-mail: MSIproviders@medavie.ca *(3.1.6)*

LOCUM TENENS *(3.1.7)*

Locum tenens refers to a physician who temporarily replaces another physician who is absent from an existing practice. Locum service providers must use their own billing number. A business arrangement number must also be effective in order to submit service encounters under the MSI program. *(3.1.8)*

The provider coordinators should be notified prior to any locum arrangements. All documents should be completed and returned to the provider coordinators to ensure payment of service encounters. *(3.1.9)*

Should locum physicians desire to participate in supplemental activities (e.g., Community Hospital Inpatient Program, Primary Maternity Care), they will be eligible to do so in addition to the locum hours and will be compensated per the supplemental program's funding model. However, a locum physician must fulfill the hours specified for the locum income received on the day before claiming any additional remuneration. Locum hours cannot be 'made up' on a subsequent day. *(3.1.25)*

- Where possible, the supplemental activity should be fulfilled before or after the 'locum' hours.
- Where frequent interruptions are expected throughout any given day (e.g., urgent inpatient response, antenatal services) and there is a considerable likelihood a full day of locum services cannot be achieved, the host/locum physicians should consider the half-day guarantee or FFS remuneration for the care services.
- If a locum physician does not fulfill the service requirement as stated on the host application and/or claim form, the locum physician must advise Medavie for an adjustment to the locum compensation where applicable. *(3.1.26)*

BUSINESS ARRANGEMENTS/DIRECT BANK DEPOSITS *(3.1.10)*

A business arrangement is an agreement between a service provider and MSI that defines payment of health services provided. *(3.1.11)*

All service providers registered with MSI must have their own or be part of a group business arrangement in order to claim for services. Some service providers may have and/or be part of more than one business arrangement. Please contact the Provider Coordinator whenever business arrangements need to be added, changed or ended. *(3.1.12)*

NEW FACILITY *(3.1.13)*

A facility is a physical location (e.g., service provider's office, institution, or hospital) where health services are routinely performed. All recognized facilities are assigned a unique identifier number. *(3.1.14)*

All service providers applying for payment through the MSI billing system are required to identify their practice location and notify MSI of any changes. For further information, please call 902-496-7011 or Toll Free 1-866-553-0585. *(3.1.15)*

SPECIALTIES/SPECIALIST *(3.1.16)*

A specialist is defined as one whose name appears on the specialist register provided by the College of Physicians and Surgeons. The College of Physicians and Surgeons provides MSI with a specialties listing which designates specialty accreditation under which services can be performed; such as dermatology, general surgery, etc. *(3.1.17)*

Specialty codes are used to determine the applicable payment amount, e.g., a specialist may be paid a different amount for a visit than a general practitioner. *(3.1.18)*

Please advise MSI if planning to practise and submit service encounters requiring specific specialties. MSI cannot recognize a specialty without confirmation from the appropriate licensing body. *(3.1.19)*

OPTING OUT OF THE NOVA SCOTIA MEDICAL SERVICES INSURANCE PLAN *(3.1.20)*

OPTED OUT SERVICE PROVIDERS *(3.1.21)*

A service provider may at any time notify MSI, in writing, of the decision to opt out of the MSI program. Such a request will become effective from the first day of the month after the expiration of sixty days from the date the MSI Program receives notice. To charge the patient for insured services, the provider must give reasonable notice to the patient prior to rendering the service. The service provider must also provide the necessary information to the patient to enable them to claim the insured services directly from MSI. *(3.1.22)*

BILLING ABOVE TARIFF *(3.1.23)*

Under an agreement effective July 1, 1984, Nova Scotia service providers who submit claims to MSI may not bill their patients in excess of the current rates for basic health services. If a service is medically required, a service encounter is submitted to MSI and no additional amount may be billed to the patient. It is important that service providers keep in mind that the amendments to the Act relate only to insured services. There is no change in the service provider's right to charge for uninsured services such as periodic health assessments, the cost of medical supplies such as drugs, dressings and other items not insured by MSI. *(3.1.24)*

PREPARING SERVICE ENCOUNTERS *(3.2.0)*

SERVICE ENCOUNTER FORMAT *(3.2.1)*

This section contains information about these requirements. It is to assist service providers and their staff by describing the structural format of a service encounter transaction by detailing how the data fields of each service encounter are to be completed. *(3.2.2)*

Accredited vendors have been approved by MSI based on their ability to meet established criteria. If you wish to receive a list of accredited vendors, please visit our website under the New Registration section. *(3.2.3)*

The accredited vendor selected will assist with system requirements and technical training to facilitate the submission of service encounters to MSI. *(3.2.4)*

This manual defines the conditions under which service encounters for services provided may be submitted. *(3.2.5)*

SERVICE ENCOUNTER SUBMISSION DEADLINE *(3.2.6)*

The deadline for service encounter submission is 90 days from the date of service unless evidence of extenuating circumstances is provided in writing to the MSI office to request approval. Resubmission of services must be received within 185 days from the date of service. Note: WCB and facility based non patient specific service encounters follow the same ruling. *(3.2.7)*

SERVICE ENCOUNTER TRANSACTION COMPONENTS *(3.2.8)*

All service encounter transactions are assigned a unique service encounter number by the billing system. This number is important for reconciliation and follow up purposes. All service encounter numbers consist of the submitter ID, year, sequence number and check digit. *(3.2.9)*

SERVICE ENCOUNTER SEGMENTS *(3.2.10)*

There are four record types and every service encounter transaction is made up of at least one record. However, there can be more than one record type in a service encounter depending on the nature of the service encounter. *(3.2.11)*

1. **Service Encounter Detail Record** *(3.2.12)*
   This record contains the base data for service encounters submitted by in province service providers. Most in province service encounters will only require this record. *(3.2.13)*
2. **Person Data Record** *(3.2.14)*
   The person data record is used to provide information on individuals who do not have a Nova Scotia health card number. The person data record is mandatory if the service recipient is from out of province. *(3.2.15)*
3. **Supporting Text Record** *(3.2.16)*
   This record is used when supporting text is required to adjudicate a service encounter. In addition, a text record must be submitted when the '**R**' (re-adjudicate) action code is used. Up to 999 records, each containing three lines of text can be included for one service encounter. *(3.2.17)*
4. **Supporting Text Cross Reference Record** *(3.2.18)*
   This record is used when the supporting text for the service encounter is used for another service encounter. Only one record can be included to indicate the other service encounter number that shares the same text. *(3.2.19)*

ACTION CODES *(3.2.20)*

Every service encounter transaction requires an action code. The action code indicates whether the service encounter is new or is a request for re-adjudication of a previously processed service. The valid action codes that can be attached to a service encounter are **A**, **R** and **D**. *(3.2.21)*

A Enter this action code when submitting a service encounter for the first time or resubmitting a service encounter that had previously been refused. A refused service encounter is one that passes through the system and is refused due to an edit rule, assessment rule, a type of restriction, etc. Having been processed through the system, this service encounter will show as R refused on the adjudication response along with an explanatory code. If resubmitting this type of refused service encounter use action code A and a new service encounter number. *(3.2.22)*

R Enter this action code to allow a previously approved service encounter to be re-adjudicated with supporting text explaining in the text record why the original assessment is to be reviewed. In normal circumstances, supporting text is not taken into account when a service encounter is initially adjudicated, except for specific situations e.g., service encounter for exceptional circumstances. A base service encounter record cannot be included. All re-adjudication requests must be initiated electronically. *(3.2.23)*

D Enter this action code to reverse or delete a service encounter that has been approved, reduced or paid at zero. The original service encounter number must be provided. However, the detail record is not required. *(3.2.24)*

MODIFIERS *(3.2.25)*

MSI adjudication system employs modifiers to determine the payment amount of a service encounter (See Appendix H Modifier Types and Values (7.8.0)). Modifiers can affect payment such as:

- Adding an amount to the basic fee
- Subtracting an amount from the basic fee
- Replacing the basic fee with a different amount
- Indicating role, time, method, age *(3.2.26)*

IMPLICIT MODIFIERS *(3.2.27)*

Some modifiers are known as implicit or derived modifiers. This kind of modifier is derived by the service encounter processing system based on the information submitted on a service encounter and is not entered as a modifier such as, specialty of physician, functional centre, referral, etc. The implicit modifier for location is derived from the location code field on the service encounter transaction. *(3.2.28)*

EXPLICIT MODIFIERS *(3.2.29)*

Some modifiers are called explicit modifiers. These modifiers are required to further identify the nature of the service for payment purposes. Explicit modifiers exist as data entry fields and must be indicated on the incoming service encounter transaction. Up to six explicit modifiers can be entered on a service encounter to further identify the nature of the service being claimed. *(3.2.30)*

An example of an explicit modifier is the role modifier. This modifier indicates the role that the service provider was performing for the service, e.g., RO=SRAS surgical assistant, RO=ANAE anaesthetist. *(3.2.31)*

An example of two modifiers being required thus two explicit modifier fields are completed, is a service encounter involving a role and an unscheduled service time block. Payment would be affected by the role of the service provider, e.g., "RO=ANAE anaesthetist and by the time block, e.g., US=PREM premium time in which the service was performed. *(3.2.32)*

The applicable explicit modifiers for each type of service encounter are described at the end of this chapter. *(3.2.41)*

SERVICE ENCOUNTER SUBMISSION LAYOUT *(3.2.42)*

FIELD NAME FIELD VALUE AND CHARACTER LENGTH *(3.2.43)*

A – Alphanumeric, N – Numeric, ( ) Number of Characters *(3.2.44)*

Field Name	Field Value/ Character Length	Other
Service Encounter Type	A (4)	
Provider Type	A (2)	
Service Provider Number	N (6)	
Specialty Code	A (4)	
Service Recipient HCN	A (12)	
Service Recipient Birth Date	N (8)	(YYYY/MM/DD)
Health Service Code	A (6)	
Service Start Date	N (8)	(YYYY/MM/DD)
Service Occurrence Number	N (1)	
Diagnostic Code	A (5)	1._____2._____3._____
Multiples	N (3)	
Explicit HSC Modifier	A (6)	1._____2._____3._____ 4._____5._____6._____
Facility Number	N (6)	
Functional Centre	A (4)	
Location Code	A (4)	
Business Arrangement	N (7)	
Pay To Code	A (4)	
Pay To HCN	N (10)	
Referral Provider Type	A (2)	
Referral Provider Number	N (6)	
OOP Referral Indicator	A (1)	Can only be "Y" or blank
Payment Responsibility	A (3)	
Program	A (3)	
Chart Number	A (5)	
Claimed Unit Value	N (9)	
Claimed Amount	N (9)	
Unit Value Indicator	A (1)	Can only be "Y" or blank
Paper Supporting Document Indicator	A (1)	Can only be "Y" or blank
Hospital Admit Date	N (8)	(YYYY/MM/DD)
Intensive Care Unit Admit Date	N (8)	(YYYY/MM/DD)
First Anaesthetist Start Time	N (4)	
Consecutive Anaesthetist Start Time	N (4)	
Preauthorization Number	A (8)	
Injury Diagnostic Code	A (5)	

(3.2.45)

SERVICE ENCOUNTER FIELDS REQUIRING COMPLETION *(3.2.46)*

This section describes the individual fields and records that make up a service encounter for a provider's services. Careful attention to the instructions provided should facilitate prompt payment of service encounters. *(3.2.47)*

The individual fields requiring completion are described below: *(3.2.48)*

1. Service encounter type *(3.2.49)*
   For all in province service providers, the service encounter type is RGLR. Every service encounter must have this code entered in this field. *(3.2.50)*
2. Provider type *(3.2.51)*
   The discipline of the service provider, e.g., PH for physician. *(3.2.52)*
3. Service provider number *(3.2.53)*
   All service providers are assigned a unique six-digit ID number by MSI. *(3.2.54)*
4. Specialty code *(3.2.55)*
   The specialty under which the service provider provided the service. The valid specialty or specialties for each provider are maintained by MSI provider coordinators. *(3.2.56)*
5. Service recipient health card number (HCN) *(3.2.57)*
   Eligible residents of Nova Scotia have a unique 10-digit health card number. If the service recipient is from out of province, the registration number from the home province is entered here. *(3.2.58)*
6. Service recipient birth date *(3.2.59)*
   Mandatory for Nova Scotia HCN YYYYMMDD format. *(3.2.60)*
7. Health service codes (HSC) *(3.2.61)*
   The health service performed (may or may not be a defined CCP).
   The HSC applies to:
   - A valid service based on the provider's specialty and any service restriction applicable to the specialty.
   - A service relevant to a recipient's gender and age.
   - A service based on the restriction defined by the business arrangement number.
   - A facility functional centre based on restrictions defined by the capabilities of the facility.
   - The HSC and modifiers implicit and explicit must be a valid service and will determine the amount that MSI reimburses for the service.
   - Implicit modifiers derived from other data fields on the service encounter.
   - Explicit modifiers entered on the service encounter in one or more of the explicit modifier fields. *(3.2.62)*

   Qualifiers, alpha characters appended to a health service code, are used to distinguish multiple MSI service codes where the unit value differs and/or they cannot be distinguished by modifiers. The primary HSC and wording appears as part of the text above the qualified code that represents the definition of the composite fee. *(3.2.63)*

   Examples of Qualifiers:
   e.g. 01.03A Endoscopy with removal of benign growth – larynx
   01.03B Endoscopy with removal of foreign body – larynx
   01.03G Direct laryngoscopy without biopsy *(3.2.64)*

8. Service start date *(3.2.65)*
   The day the health service was performed YYYYMMDD format. A separate service encounter is submitted for each hospital visit. The hospital admit date is required for each hospital inpatient visit service encounter. *(3.2.66)*

9. Service occurrence number *(3.2.67)*
   The occurrence refers to the medical necessity of the number of separate times the same provider sees the same recipient on the same day. Enter the number which indicates if the service was performed during the first, second, third, etc. time that the service provider saw the service recipient on the same day. All services performed during the same encounter with the service recipient must be given the same service occurrence number. Second and subsequent service occurrences may only be submitted for separate and distinct episodes of care. *(3.2.68)*

10. Diagnostic code *(3.2.69)*
    The diagnostic code format is the ICD-9-CM version. The code for the primary diagnosis is entered in the first field. Two additional diagnostic code fields are available to enter any secondary diagnosis, if applicable. *(3.2.70)*

11. Multiples *(3.2.71)*
    The multiples (MU) field is used to indicate either the number of services performed, (e.g., number of lesions), the length of time, (e.g., 15-minute time blocks detention, counselling) or the percentage of the body, (e.g. burns or surface area treated, e.g. sq. inches). If the number of multiples exceeds the number indicated for the health service code, the maximum for the code will be paid. To claim additional multiples, a service encounter must be resubmitted with action code R indicating total number of multiples with supporting text and a copy of the patient record. *(3.2.72)*

Following are examples of multiples used when billing certain services: *(3.2.81)*

Psychotherapy time values: Psychotherapy cannot be paid for less than 30 minutes with a maximum of 1 1/2 hours per day *(3.2.82)*

Minutes	Multiple	Units
30	3	30
45	4	45
60	5	60
75	6	75
90	7	90

(3.2.83)

Excision of Lesions with a Base Unit of 20 i.e., enter the multiple that corresponds to the number of lesions, e.g., five lesions = five multiples *(3.2.84)*

Multiples of: *(3.2.85)*

# of Lesions	# of Units
1 to 5	20
6 to 10	30
11 to 15	40
16 to 20	50
21 to 25	60

(3.2.86)

For simple excision, cryotherapy, curettage, electrocautery, when the value exceeds 60 units, the rate is paid on the basis of 60 units per hour and supporting text and duration of service must be submitted. *(3.2.87)*

Excision of burned tissue prior to immediate skin grafting: Multiples are shown as percent of the body surface (e.g., one percent = multiple of one). *(3.2.88)*

Multiples up to: *(3.2.89)*

Percent of Body Surface	# of Units
5	50
6 – 10	+ 25
11 – 15	+ 25
16 – 20	+ 25
21 – 25	+ 25

(3.2.90)

Debridement of Burns *(3.2.91)*

Multiples of: *(3.2.92)*

Percent of Body Surface	# of Units
1 to 5	20
6 to 10	40
11 to 15	60
16 to 20	80
21 to 25	100
26 to 30	120
31 to 35	140
36 to 40	160
41 to 45	180
46 to 50	200
51 to 55	220
56 to 60	240
61 to 65	260

(3.2.93)

Multiples of Fingers and Toes/Joints *(3.2.94)*

When the same procedure is claimed on the right and left region for multiples on either side and/or multiple joints on the same digit, submit a re-adjudicate on the previously approved service encounter with supporting text indicating which joints/digits are involved, e.g., HSC 93.16 Metatarsophalangeal Fusion. *(3.2.95)*

Other Multiples *(3.2.96)*

When billing multiples of the same procedure, submit as one service encounter indicating in the multiples field the number of times the procedure was performed.

Examples:

a) HSC 98.81C Category MISG
Three biopsies from the area leg/arm/neck MU 3
First procedure paid at 100 percent each additional paid at 65 percent

b) HSC 97.91 Category VADT
Three breast aspirations MU 3
First procedure paid at 100 percent each additional paid at 50 percent *(3.2.97)*

12. Explicit health service code modifier *(3.2.98)*
The explicit HSC modifier fields are used to further identify the nature of the service for payment purposes. Six fields are provided if needed. Explicit HSC modifiers are those that cannot be derived from other data on the service encounter. An example of an explicit HSC modifier is the role modifier which indicates the role, e.g., surgical assist RO=SRAS, or anaesthetist RO=ANAE. *(3.2.99)*

13. Facility number *(3.2.100)*
All institutions, hospitals and service provider offices are assigned unique numbers by MSI. A facility number is required for locations other than HOME, OTHR or HMHC. If services are performed at a different location other than your assigned sites, you must use the facility number of the location where the service was rendered. The facility number for hospitals can be obtained from your software program or by contacting MSI. *(3.2.101)*

14. Functional centre *(3.2.102)*
The functional centre code must be entered if the service is performed at a registered hospital facility. MSI catalogues the valid functional centres as determined by the Department of Health and Wellness (DHW) for each registered facility. It identifies the specific area within the facility where the service was performed, e.g., outpatient department FN=OTPT, or neonatal intensive care centre FN=NICU. The functional centre should be indicated as FN=INPT on all registered inpatients except when the patient is in intensive care where the functional centre should be indicated as FN=NICU or FN=INCU. When a registered inpatient is taken to the outpatient department for a service, the functional centre FN=OTPT should be indicated and text is required explaining the details. *(3.2.103)*

15. Location code *(3.2.104)*
"A location code is required on all service encounters. Examples of location codes are:

HOME	The service recipient's home
OTHR	Other (side of the road, etc.)
HMHC	Home Hospital Care
HOSP	Hospital
NRHM	Nursing Home
OFFC	Office
CCNT	Correctional Centre *(3.2.105)*

16. Business arrangements are agreements between providers or provider groups and the Nova Scotia Department of Health and Wellness for payment of services. All providers in Nova Scotia must have a business arrangement registered with MSI in order to claim for services. Providers may have multiple business arrangements to reflect, among other things, different locations in which they practice or different arrangements to make payment to provider groups, as opposed to the specific provider claiming the service. *(3.2.106)*

17. Pay to code *(3.2.107)*
The pay to code indicates the person or organization to which payment is to be made. The pay to code refers to the business arrangement under which the service was performed. Value for pay to code is: BAPY Business Arrangement Payee, e.g., service provider, group. *(3.2.108)*

18. Referral provider type *(3.2.109)*
The discipline of the referring provider, e.g., PH for physician, DE for dentist, OP for optometrist, NP for nurse practitioner and MW for midwife. *(3.2.110)*

19. Referral provider number *(3.2.111)*
    When claiming a referred service from another provider in Nova Scotia, the referring service provider's number must be entered here. The referral number for all dental practitioners is 103481. *(3.2.112)*

20. Out of province (OOP) referral indicator *(3.2.113)*
    If applicable, enter Y to indicate that the service was referred from an OOP service provider. *(3.2.114)*

21. Payment responsibility *(3.2.115)*
    Normally the payment responsibility for most services is entered as MSI. However, there are instances where the payment responsibility will change, for example, service encounters under Workers' Compensation Board (WCB), Out of Province (OOP) and Community Services (COM). If the service encounter is for services provided to a service recipient registered with another provincial health plan except Quebec the home province code is entered in this field, e.g., NB, ON, PE. The service also requires a person data record for the service recipient.
    Acceptable province codes:

NB New Brunswick	PE Prince Edward Island
NF Newfoundland	ON Ontario
MB Manitoba	SK Saskatchewan
AB Alberta	BC British Columbia
YT Yukon Territories	NT Northwest Territories
NU Nunavut	

    WCB (WCB service encounters) Note: WCB claims can only be claimed for Nova Scotia residents 16 years of age and over who are eligible for MSI coverage.
    COM (Community Services) *(3.2.116)*

22. Program *(3.2.117)*
    The MSI program applicable to the service claimed. Currently, the only value is MC for Medicare or HD for Home Dialysis. *(3.2.118)*

23. Chart number *(3.2.119)*
    This is a service providers use field. A source reference number can be entered here, if desired. *(3.2.120)*

24. Claimed unit value *(3.2.121)*
    The unit value claimed by the service provider. If this field is blank, the unit value indicator should also be blank. *(3.2.122)*

25. Claimed amount *(3.2.123)*
    This field is for submitter/provider reconciliation purposes. It may be left blank or could be used to carry the software calculations indicating the amount anticipated to be paid by MSI. *(3.2.124)*

26. Unit value indicator *(3.2.125)*
    Enter a Y in this field if claiming a unit value less than the normal unit value listed in the Physician's Manual. The claimed unit value must also be entered. *(3.2.126)*

27. Paper supporting documentation indicator *(3.2.127)*
    Enter Y in this field if a paper document is being sent. Paper documentation should be sent when it is not possible to include the information in the electronic text field. The paper supporting documentation must reference the service encounter number and the patient's health card number. *(3.2.128)*

28. Hospital admit date *(3.2.129)*
    Service encounters for visits or procedures claimed for a registered inpatient must be submitted listing the date of admission on each service encounter. Format YYYYMMDD *(3.2.130)*

29. Intensive care unit admit date *(3.2.131)*
    The date the service recipient was admitted to the intensive care unit. Format YYYYMMDD. It is required on all intensive care unit visits. *(3.2.132)*
30. First anaesthetist start time *(3.2.133)*
    The start time of the first anaesthetist involved in the procedure. This field is required on service encounters submitted by the replacement anaesthetist. Format HHMM 24-hour clock. *(3.2.134)*
31. Consecutive anaesthetist start time *(3.2.135)*
    When consecutive anaesthetists are submitting, the role modifier must indicate RO=ANAE and the service will be identified by entering the first anaesthetist start time and consecutive anaesthetist start time. Format HHMM 24-hour clock. *(3.2.136)*
32. Preauthorization number *(3.2.137)*
    A preauthorization number is required when approval has been granted for certain procedures. Your request for preauthorization information should be forwarded to the medical consultant at MSI. Upon approval of this request, a preauthorization number will be issued. The number must be indicated on the claim in the appropriate field. Please note: If indicated in the electronic text, the service encounter will be refused. *(3.2.138)*
33. Injury diagnostic code *(3.2.139)*
    A diagnostic code field used to indicate the external cause of injury that initiated the service encounter. They are located in the E-Section of the International Classification of Diseases (External Causes of Injury). *(3.2.140)*

PREPARING SERVICE ENCOUNTERS PERSON DATA RECORD *(3.2.141)*

The person data record is used to provide information on individuals who do not have a Nova Scotia health card number. The person data record is mandatory if the service recipient is from out of province. *(3.2.142)*

The following describes the breakdown of this record:

Surname - Mandatory - Enter the last name of the service recipient
Given name - Mandatory - Enter the first name of the service recipient
Date of birth - Mandatory for reciprocal billing YYYYMMDD format
Gender code - Mandatory for reciprocal billing - valid codes are (M) and (F)
Address line 1 - Mandatory
Address line 2
City Name - Mandatory
Postal code
Province code - Mandatory
Country
Guardian/parent HCN *(3.2.143)*

SUPPORTING TEXT RECORD *(3.2.144)*

This record is used when supporting electronic text is required to adjudicate a service encounter. In addition, a text record must be submitted when the **R** action code re-adjudicate is used. Up to 999 records, each containing three lines of text can be included for one service encounter. *(3.2.145)*

SUPPORTING TEXT CROSS REFERENCE *(3.2.146)*

This record is used when the supporting electronic text for the service encounter is used for another service encounter. Only one record can be included to indicate the other service encounter number, which shares the same text. *(3.2.147)*

RECEIVING SERVICE ENCOUNTER RESULTS *(3.3.0)*

SERVICE ENCOUNTER PROCESS *(3.3.1)*

BACKGROUND *(3.3.2)*

All service encounters to MSI are transmitted electronically in a batch format that utilizes a high-speed computer process to handle the numerous claim submissions. *(3.3.3)*

Incomplete or incorrect information will cause a service encounter to be rejected, refused or be held for further processing thereby causing a possible delay in processing and payment. *(3.3.4)*

The adjudication response is the report that MSI issues to help you track your service encounters and identify what problems or delays if any that may have occurred following each submission. Details of the report will be outlined in this section. *(3.3.5)*

VERIFICATION OF YOUR SERVICE ENCOUNTER *(3.3.6)*

SUBMISSION OF SERVICE ENCOUNTER DATA *(3.3.7)*

After the necessary data for the service encounter has been successfully submitted, each service undergoes a thorough validation with regards to an edit check, i.e., patient's health card number eligibility under MSI and any assessment rule that may govern that particular service. *(3.3.8)*

If a problem is identified, the service encounter will be returned with the appropriate explanatory code. A corrected service encounter must be submitted whether it is a re-adjudicate or an add claim. If a deletion is required on a previously approved service, the adjudication must be returned showing the delete as accepted prior to submitting a new service encounter. If not, it will cause the new service encounter to refuse as a duplicate. *(3.3.9)*

SERVICE ENCOUNTER PROCESSING RESULT *(3.3.10)*

CHECKING YOUR ADJUDICATION RESPONSE *(3.3.11)*

After each service encounter transmission has been received and processed an adjudication response is prepared for the site to retrieve. Service encounters can be submitted on a daily basis; however: each submission creates an individual adjudication response. *(3.3.12)*

This verifies the outcome of the service encounters and allows the person submitting service encounters to maintain a record and to identify any that may require further action. *(3.3.13)*

The adjudication response also indicates a service encounter number that is comprised of a submitter ID, year, seven-digit sequence number and a check digit. The adjudication response also includes a sequence number that increases in increments of one each time a response is produced. It assists in reconciling the service encounters. *(3.3.14)*

An explanatory code is intended to explain the reason for any modification on the service encounter. The codes cannot be correctly interpreted without reference to the Preamble. *(3.3.15)*

A format of the adjudication response follows along with descriptions of the fields. *(3.3.16)*

SERVICE ENCOUNTER ADJUDICATION RESPONSE FIELD DESCRIPTION *(3.3.17)*

This adjudication response file contains the results of processing for all service encounter transactions submitted. Only the service encounters applicable to a submitter are provided to that submitter. *(3.3.18)*

These details can be used by the submitter for any processing requirements, e.g., reconciliation of input files. Each result record will also include the service recipient's HCN. *(3.3.19)*

If a service encounter transaction has been held by MSI for review, the adjudication response for the transaction will indicate held and a subsequent adjudication response detail record will be sent when the final outcome of the transaction has been determined. *(3.3.20)*

If a previously processed service encounter is internally reassessed with a resulting change in the approved unit value, an adjudication response detail record will be sent to the submitter who initiated the transaction. *(3.3.21)*

1. Service encounter number *(3.3.22)*
   It is comprised of the submitter ID (3), Year (4), sequence number (7) and check digit (1). The service encounter number has a total number of 15 digits. *(3.3.23)*
2. Transaction tag number *(3.3.24)*
   Set to 0001 for the initial transaction that created a service encounter and then incremented by one for every transaction/reassessment against the service encounter. *(3.3.25)*
3. Transaction action code *(3.3.26)*
   A Indicates the adjudication response is for the originating service encounter add transaction
   D Indicates the adjudication response is for a delete transaction
   R Indicates the adjudication response is for a re-adjudication transaction *(3.3.27)*
4. Reassess explanation code *(3.3.28)*
   If the adjudication response detail is for a re-adjudication of a service encounter, this indicates the reason for the adjudication, e.g., affected by another service. *(3.3.29)*
5. Assessment outcome *(3.3.30)*
   Indicates the outcome of the submitted transaction. The outcome can be one of: **A** Indicates transaction was approved/accepted and an approved unit value has been determined. The unit value could be a reduced unit value or could be zero. In these cases, the explanatory codes indicate the reason for the reduction. An approved service encounter can later be reassessed. **H** Indicates transaction is currently being held for review by MSI. **R** Indicates transaction was refused. The explanatory codes indicate the reason for the refusal. Refused add transactions must be resubmitted as a new service encounter once the correct information is determined. If a re-adjudicate or delete transaction is refused, the original service encounter is left unchanged. *(3.3.31)*
6. Assessment result action *(3.3.32)*
   R indicates the record is a reversal of an adjudication response result for the service encounter. If the assessment outcome is **A** Approved and the transaction action code is an **R** Re-adjudication, two adjudication response detail records will be created; the first is a reversal of the old approved unit value and the second is the new approved unit value. Both records will have different transaction tag numbers. If the assessment outcome is **A** Approved and the transaction action code is **A** Add or the assessment outcome is **R** Refused or **H** Held, only a current assessment result record will be created. If the assessment outcome is **A** Approved and the transaction action code is **D** Delete, only a reversal record will be created. *(3.3.33)*
7. Chart number *(3.3.34)*
   As originally coded on the submitted service encounter from an individual site. *(3.3.35)*
8. Service recipient health card number *(3.3.36)*
   A lifetime identification number used to uniquely identify all residents who are registered with MSI. Also used for reciprocal registration. *(3.3.37)*

9. Expected payment date YYYYMMDD *(3.3.38)*
   The expected date on which your payment will occur. *(3.3.39)*
10. Adjudication date YYYYMMDD *(3.3.40)*
    The date the service encounter was adjudicated/re-adjudicated. *(3.3.41)*
11. Approved unit value 9999999V99 *(3.3.42)*
    Approved unit value is the value that has been assessed for the service encounter. These fields will not have commas or decimal points in them. The format will be 9999999V99, where the V designates an implied decimal point. If you were to look at the physical file, you would see 999999999. *(3.3.43)*
12. Claimed amount 9999999V99 *(3.3.44)*
    The claimed amount as coded on the submitted transaction. These fields will not have commas or decimal points in them. The format will be 9999999V99, where the V designates an implied decimal point. If you were to look at the physical file, you would see 999999999. *(3.3.45)*
13. Unit value indicator *(3.3.46)*
    Y indicates that the service provider claimed a unit value less than the normal unit value for the service. *(3.3.47)*
14. Explanatory codes (Up to six) *(3.3.48)*
    If the approved unit value is not the normal value to be paid for the service or the service encounter has been refused, the explanatory codes provide the reason for the reduction or refusal. *(3.3.49)*
15. Health service code (HSC) *(3.3.50)*
    A code identifying services/procedures performed by a service provider to a service recipient. *(3.3.51)*
16. HSC modifiers used *(3.3.52)*
    The list of implicit and explicit fee modifiers that were used to determine the approved unit value. *(3.3.53)*
17. Business arrangement number *(3.3.54)*
    The business arrangement that the service provider is claiming under. *(3.3.55)*
18. Provider type *(3.3.56)*
    Indicates the discipline of the service provider. *(3.3.57)*
19. Service provider number *(3.3.58)*
    All service providers will have a unique ID number assigned by MSI. *(3.3.59)*
20. Service start date *(3.3.60)*
    Indicates the date the health service was performed. *(3.3.61)*
21. Pay to code *(3.3.62)*
    Indicates to what person or organization the payment is to be made. *(3.3.63)*
22. Preauthorization number *(3.3.64)*
    Is used when submitting a service encounter that has previously been authorized. *(3.3.65)*

RECONCILE REGULARLY *(3.3.66)*

MSI recommends that all service providers regularly reconcile each of their adjudication responses with their service encounter submissions to ensure that all submitted service encounters have been processed. Most of this reconciliation effort can be done via computer output details obtained from your accredited submitter. Your reconciliation routine should acknowledge service encounters that have been received but not yet been fully assessed. Each of these service encounters will appear on a future statement once the assessment is complete. *(3.3.67)*

CHECKING YOUR STATEMENT OF ACCOUNT *(3.3.68)*

MSI also issues a report called the Statement of Account. This report outlines the amounts being released for payment based on service encounters assessed. It is produced in conjunction with the payment process, which is currently on a biweekly basis. *(3.3.69)*

A current Statement of Account contains summary information regarding the adjudication response that was issued since the previous statement of account was produced. It will also identify any other payments and recoveries that may be made in the interim, e.g., bottom line adjustments. *(3.3.70)*

STATEMENT OF ACCOUNT *(3.3.71)*

GENERAL DESCRIPTION *(3.3.72)*

This document describes in point form the electronic statement format for providers. *(3.3.73)*

There will normally be one statement for each business arrangement, whether the business arrangement belongs to a group or to a provider. If multiple business arrangements for a group or provider point to one bank account, those business arrangements will be combined on one statement for the direct deposit. Separate totals will be given for every business arrangement on a statement: *(3.3.74)*

- It is possible that a statement could be for negative amounts if the provider's reversals for the pay period added up to more than the service encounters. Bottom line adjustments will never cause negative statements. *(3.3.75)*
- Each statement is in a separate file. *(3.3.76)*
- The file is in comma delimited format.
    - Fields are not fixed length,
    - All fields are separated by commas,
    - Character fields are surrounded in double quotes, and
    - All records end in carriage return line feed. *(3.3.77)*
- Numeric fields that specify the decimal will include the decimal point, but no dollars or commas. They are not zero filled. Negative numbers will be preceded by the negative sign. The negative sign counts as one of the digits defined in the maximum length. For instance, a number defined as having eight digits before the decimal and two after, e.g., numeric 8.2, can fall in the range: -9999999.99 to 99999999.99. *(3.3.78)*
- There are four types of records that may be in each statement. Their formats are given in the next section:*(3.3.79)*

  1. Detail records: These contain the service encounter details and amounts paid and occur first in the statement. There is one detail record for every service encounter and reversal in the pay period. These records are sorted in order of business arrangement number, provider type, provider number, service date, service encounter number, sequence number, and tag number. *(3.3.80)*

  2. Bottom line adjustment records: These contain adjustment amounts applied to a provider or provider group in the pay period. There is one bottom line adjustment record for every business arrangement, which was adjusted during the current pay period. If a business arrangement was not adjusted during the pay period, there will be no records of this type. If a business arrangement was adjusted by more than one type of adjustment, there will be one record for each adjustment applied. These records occur after the detail records for the business arrangement to which they apply. If it is a group business arrangement, the adjustment records occur after the detail records for the specific provider being adjusted. *(3.3.81)*

3. Service provider total records: These contain totals per service provider and business arrangement, including a bottom-line adjustment total. There is one service provider total record after each service provider's detail records. These occur after the bottom-line adjustment records in a statement. There could be multiple of these records if the statement is for a group or if the statement includes multiple business arrangements. *(3.3.82)*

4. Group total records: These contain the totals per group and business arrangement before and after bottom line adjustments. There is one group total record for each business arrangement for a provider group. The records occur after the last provider total and last bottom line adjustment for the business arrangement. There are no group total records if the statement is not for a group. *(3.3.83)*

RECORD FORMATS *(3.3.84)*

Data Statement Record/Statement Details *(3.3.85)*

Field	Format (Max Length)	Value
Record Type	Character (1)	D (Detail)
Group Number	Numeric (6)	Unique identifier for a provider group
Provider Type	Character (2)	Physicians (PH), dentists (DE), midwives (MW), nurse practitioners (NP), optometrists (OP)
Provider Number	Numeric (6)	Unique identifier for the provider
Business Arrangement Number	Numeric (7)	Unique identifier for a business arrangement
Payment Run Number	Numeric (7)	Internal MSI identifier for the payment runs. The same number appears for all service encounters in one payment period. It's not consecutive from one pay period to the next.
Payment Responsibility	Character (3)	One of MSI, WCB, COM (Community Services), or a valid 2 letter province code for reciprocal service encounters (AB, BC, MB, NB, NF, NT, NU, ON, PE, SK, YT)
Health Card Number	Character (12)	Service recipient's health card number
Service Start Date	Numeric (8)	Format is: YYYYMMDD
Health Service Code	Character (6)	CCP code and qualifier
Service Encounter Number	Character (15)	Service encounter number – corresponds to what was supplied on adjudication response
Service Encounter Sequence Number	Character (4)	Service encounter sequence – corresponds to what was supplied on adjudication response
Transaction/Response Tag Number	Character (4)	Transaction Response Tab Number – corresponds to what was supplied on adjudication response (not necessarily consecutive)

(3.3.86)

Bottom Line Adjustment Records *(3.3.87)*

Field	Format (Max Length)	Value
Record Type	Character (1)	A (bottom line adjustment)
Group Number	Numeric (6)	Unique identifier for a provider group
Provider Type	Character (2)	Physicians (PH), dentists (DE), midwives (MW), nurse practitioners (NP), optometrists (OP)
Provider Number	Numeric (6)	Unique identifier for provider
Business Arrangement Number	Numeric (7)	Unique identifier for a business arrangement

Field	Format (Max Length)	Value
Bottom Line Adjustment Number	Numeric (7)	Unique identifier for a bottom line adjustment
Payment Run Number	Numeric (7)	Internal MSI identifier for the payment run
Adjustment Amount	Numeric (8.2) 99999999.99	Adjustment amount on a business arrangement (negative or positive)
Adjustment Type	Numeric (5)	Type of adjustment. Possible values: 1 = Garnishee 2 = Audit recovery 3 = Capping reconciliation adjustment

(3.3.88)

Provider Total Records *(3.3.89)*

Field	Format (Max Length)	Value
Record Type	Character (1)	T (Total)
Group Number	Numeric (6)	Unique identifier for a provider group
Provider Type	Character (2)	PH for physicians, OP for optometrists, NP for nurse practitioners
Provider Number	Numeric (6)	Unique identifier for provider
Business Arrangement Number	Numeric (7)	Unique identifier for a business arrangement
Payment Run Number	Numeric (7)	Internal MSI identifier for the payment run
Statement Start Date	Numeric (8) YYYYMMDD	Start date of payment period
Statement End Date	Numeric (8) YYYYMMDD	End date of payment period
Total Units	Numeric (8.2) 99999999.99	Total units amassed this pay period
Total Fees	Numeric (8.2) 99999999.99	Fees paid, before adjustments (+ or -)
Total Adjustments	Numeric (8.2) 99999999.99	Total bottom line adjustments (+ or -)
Total Paid	Numeric (8.2) 99999999.99	Fees paid + adjustments (+ or -)
Number of Service Encounters	Numeric (5)	Number of service encounters for provider
Number of Reversals	Numeric (5)	Number of reversals for provider

(3.3.90)

Provider Group Total Records *(3.3.91)*

Field	Format (Max Length)	Value
Record Type	Character (1)	G (Group Total)
Group Number	Numeric (6)	Unique identifier for a provider group
Business Arrangement Number	Numeric (7)	Unique identifier for a business arrangement
Payment Run Number	Numeric (7)	Internal MSI identifier for the payment run

Field	Format (Max Length)	Value
Statement Start Date	Numeric (8) YYYYMMDD	Start date of payment period
Statement End Date	Numeric (8) YYYYMMDD	End date of payment period
Total Units	Numeric (8.2) 99999999.99	Total approved units (+ or -)
Total Fees	Numeric (8.2) 99999999.99	Feed paid, before adjustments (+ or -)
Total Adjustments	Numeric (8.2) 99999999.99	Total bottom line adjustments (+ or -)
Total Paid	Numeric (8.2) 99999999.99	Fees paid + bottom line adjustments (+ or -)
Number of Service Encounters	Numeric (5)	Number of service encounters per group
Number of Reversals	Numeric (5)	Number of reversals per group

(3.3.92)

FOLLOWING UP ON PROCESSED SERVICE ENCOUNTERS *(3.3.93)*

The adjudication response, whether received directly from MSI or an accredited submitter, reports the results after the service encounters have been processed. *(3.3.94)*

When reconciling the statement, there may be some service encounters that have been reduced in payment or altered in some other way. It may be determined that a paid service encounter contains some incorrect information, or a processed service encounter should not have been submitted. It is important that service encounters be reviewed to determine any need for follow-up action. *(3.3.95)*

REFUSED SERVICE ENCOUNTERS *(3.3.96)*

If a service encounter transaction has been refused due to incorrect service encounter data, a correction can be submitted by creating a new service encounter transaction using a new service encounter number and action code A. *(3.3.97)*

REASSESS SERVICE ENCOUNTERS *(3.3.98)*

If the service encounter information is correct but MSI review of the assessment of a service encounter which has been reduced or paid at zero is desired, then resubmit the service encounter using the same service encounter number and action code R. A supporting text segment explaining the request for a reassessment must be included. *(3.3.99)*

CHANGING SERVICE ENCOUNTER DATA *(3.3.100)*

If the service encounter information has been submitted in error or is not correct for a service encounter which has been paid in full, reduced or paid at zero and a correction is to be created, first submit a delete with action code D on the original service encounter. No data portion is required; just the header portion which indicates the service encounter number of the previous submission. The adjudication response will indicate that the service accepted as deleted and then a new service encounter with action code A can be submitted. Failure to wait for the delete before submitting will result in a duplicate service encounter submission for the service. *(3.3.101)*

The results of the add, re-adjudicate or delete service encounters transactions will be reported on the adjudication response with appropriate explanatory codes. If any of these resubmissions are refused, the service encounter that was to be deleted, added or re-adjudicated is left as is. *(3.3.102)*

Review of Section 3 (3.2.0) will provide details about submitting service encounters, whether for the first time or as a follow-up to previously submitted service encounters. The accredited software vendor will assist with the technical details surrounding service encounters submission processes. *(3.3.103)*

PUBLIC PSYCHIATRY ACTIVITY REPORTING *(3.3.104)*

The public psychiatry activity record is a form that may be used by individual psychiatric contract or salaried service providers for reporting to the facility's finance department. A callback to the facility may be recorded on the callback record. These, or similar forms collecting the same information, must be used to record regular and callback activities. *(3.3.105)*

PSYCHIATRY BILLING INFORMATION *(3.3.106)*

All billing information on the service provider's forms is recorded and paid at an hourly rate. Facilities will submit the psychiatry forms and be reimbursed according to the hourly rate in effect on the dates of services. All facilities will be provided with updates prior to changes affecting payment. Facilities will then be responsible for reimbursement of their salaried and contracting service providers. Please use the table below for contracted psychiatric services. Billing must be done within three months of date of service. *(3.1.107)*

District Psychiatry Contract – Hourly Rates *(3.3.108)*

District Psychiatry Contract – Hourly Rates							
	2018-19	**2019-20**	**2020-21**	**2021-22**	**2022-23**	**2023-24**	**2024-25**
Certified	$153.67	$156.74/186.91	$204.20	$209.59	$213.83	$220.24	$226.85
Non-Certified	$113.33	$115.60/137.85	$150.60	$154.57	$157.70	$165.62	$170.59

(3.3.109)

Callbacks are paid through the facility and are billed on the callback records provided for that purpose. Recording of the patient's name and MSI number are required. Callbacks may be claimed by contract or salaried physicians, noting that a callback must be an urgent request for attendance by facility staff necessitating a return to the facility outside normal facility working hours. Separate entries must be made for each individual patient seen. *(3.3.110)*

DIRECT PATIENT CARE *(3.3.111)*

Involves face to face clinical interaction with patients. Care of patients registered with the mental health facility through inpatient, outpatient or day programs of the facility. The charting of progress notes is included as direct patient care time. *(3.3.112)*

- Inpatient Medical Earned Hours: Those medical earned hours of direct patient care provided on inpatient units. *(3.3.113)*
- Clinics Medical Earned Hours: Those medical earned hours of direct patient care provided to all outpatients. *(3.3.114)*
- Day Hospital Medical Earned Hours: Those medical earned hours of direct patient care provided to mental health day hospital partial hospital programs. *(3.3.115)*

INDIRECT CARE MEDICAL EARNED HOURS *(3.3.116)*

Non-patient contact activities directly related to the care of an individual patient or group of patients including: *(3.3.117)*

- **Third Party**: Interviewing family members or other persons relevant to patient care. *(3.3.118)*
- **Staff Liaison**: Coordination of care with other health care workers. *(3.3.119)*
- **Case Conferences**: Discussion of cases with other health care workers. *(3.3.120)*

- **Reports**: Reading or preparing clinical reports. *(3.3.121)*
- **Academic Hours**: This includes academic administration education and research. *(3.3.122)*
- **Travel/Medical Earned Hours:** Time spent in authorized travel, e.g., clinic to satellite, hospital to home visit. It does not include commuting to or from home or private office to the facility. *(3.3.123)*
- **Community Care Medical Earned Hours**: Includes community liaison time spent in consultation with other organizations or agencies relating to community health or support services. This time is not patient specific. When time involves providing consultation to a community agency regarding a specific registered patient of the facility, then that time is considered indirect care/medical earned hours. *(3.3.124)*
- **Administration Medical Earned Hours**: Nonclinical time related to supervision of staff and programs of a facility. *(3.3.125)*
- **Telephone Calls**: Providing it relates to patient care would also be included as indirect care medical earned hours. *(3.3.126)*

SECTION 4: TARIFF *(4.0.0)*

A tariff is compensation associated with the provision of insured health services as governed by the Nova Scotia Health Services and Insurance Act. *(4.0.1)*

The MSI tariff is the actual monetary value of a service. It is derived from the number of units applicable to a service which may vary according to relevant modifiers, the Medical Service Unit Value, and any individual billing factors based on practice location or billing thresholds, or other factors that may exist from time to time. The MSI schedule of benefits uses units to represent the value of a service. The value of a unit varies according to the applicable tariff. Two unit values exist: an anaesthetic unit value used specifically for claiming anaesthetic services, and a medical service unit value specifying the dollar value of all other services. *(4.0.2)*

Tariffs are paid on a fee-for-service, contractual or sessional basis according to an approved plan for payment or insured list of professional services or products. Payments are made directly to service providers when rendering services to registered residents of Nova Scotia. Payments are also made to registered residents of Nova Scotia who provide proof of payment for receipt of an insured service. *(4.0.3)*

Allowance is sometimes made for alteration of the tariff associated with individual service encounters when a physician can demonstrate significantly increased difficulty, time, or other factors involved in providing care. When the tariff for a service is modified by specialty, time, or some other factor, the applicable tariff may vary according to the specific circumstances. *(4.0.4)*

***Key Terms Relevant to This Section** (4.0.5)*

- *Independent Consideration: A process for assessing services where a unit value is not listed.* *(4.0.6)*
- *Interim Fee: May be established in certain circumstances with approval by Department of Health and Wellness. A CCP code will be activated to describe the new service and an interim fee assigned. Interim fees will be published in the MSI Physician's Bulletin.* *(4.0.7)*
- *Modifiers: Special codes added to the record of a service that identify the generic context within which the service was provided, e.g., specialty, time, place, etc. Some modifiers are for the purpose of clarification; others affect the tariff applied to the service.* *(4.0.8)*
- *Qualifier: A qualifier is an alpha character appended to some service codes to subdivide the code and thereby distinguish differences specific to that procedure, e.g., 03.26A, 98.12B.* *(4.0.9)*
- *Service: When the term service is used in this manual, it is in the context of an insured visit or procedure that is identified by a specific service code in the MSI schedule of benefits.* *(4.0.10)*

TARIFF *(4.1.0)*

The MSI tariff is negotiated between the Department of Health and Wellness and Doctors Nova Scotia. *(4.1.1)*

The Canadian Classification of Diagnostic Therapeutic and Surgical Procedures (CCP) forms the basis for descriptions of services in the schedule of benefits insured by MSI. *(4.1.2)*

The MSI adaptation of CCP does not include all possible CCP codes and MSI uses two additional levels of detail as follows: *(4.1.3)*

- Qualifiers are appended to a CCP code to distinguish between related procedures applied to the same anatomic area or condition, or to accommodate procedures that are a composite of two or more services *(4.1.4)*
- Modifiers describe the context of a service according to who performed the service, who received the service and when, where, and sometimes how the service was provided. *(4.1.5)*

Units per service are determined through the Fee Committee, a standing committee of the Physician Agreement Management Group with representation from Doctors Nova Scotia, Department of Health and Wellness and the District Health Authorities. An attempt is made to set the number of units for a service relative to other services in the schedule, reflecting factors such as duration, complexity, overhead, specialty status, and time of day or week. Practitioners are expected to use the published units for insured services except in the following instances: *(4.1.6)*

MAAS	IC	Independent Consideration	IC
MAAS	IF	Interim Fee	IF
MAAS	EC	Exceptional Circumstances	EC *(4.1.7)*

- **Independent Consideration:** Is applied to certain services recognized to have wide variation in case-to-case complexity and time. Independent consideration services must be accompanied by complete details, including duration of service, adequate to explain and justify the number of units requested (See Section 6 (6.0.43)). *(4.1.8)*

- **Interim Fees:** May be established in certain circumstances with approval by Department of Health and Wellness. A CCP code will be activated to describe the new service and an interim fee assigned. Interim fees will be published in the MSI Physician's Bulletin. A complete list of all current active interim fees can be found on the MSI Website: Interim Fee Reference Guide (PDF). *(4.1.10)*

- **Exceptional Clinical Circumstances**: May warrant a fee other than that listed in the schedule of benefits. In the event a practitioner performs a service they believe should be insured but is unable to find an appropriate service code or finds an appropriate service code but feels the listed tariff does not adequately compensate the service, a request for an exceptional fee may be submitted. The service encounter is submitted under health service code EC and it must contain electronic text concerning the procedure, start/finish time and a claimed unit value. The request must be accompanied by complete details adequate to explain and justify the number of units requested.
  - Note: The exceptional fee process is not intended for use on a routine basis when a physician disagrees with the listed tariff for a service. *(4.1.11)*

If a physician feels a particular fee is under or overvalued in relation to similar services, they should request Doctors Nova Scotia consider renegotiating the fee with the Department of Health and Wellness. *(4.1.12)*

PROCEDURES FOR AMENDMENTS TO THE PREAMBLE AND FEE SCHEDULE *(4.1.13)*

In the course of normal program administration, interim fees are occasionally set and will be published in a Physician's Bulletin as necessary. Before becoming permanent, interim fees are reviewed to ensure the codes description, billing rules and value are aligned with other, similar fees. *(4.1.14)*

UNIT VALUES *(4.1.18)*

Two unit values exist, an Anaesthetic Unit (AU) value used specifically for claiming anaesthetic services and a Medical Service Unit (MSU) specifying the unit value of all other services. The chart below reflects the historical MSU and AU rate increases for both MSI and WCB. Changes to payment rates are communicated via Physicians Bulletins. *(4.1.19)*

	April 1, 2018 to September 30, 2019	October 1, 2019 to March 31, 2020	April 1, 2020 to March 31, 2021	April 1, 2021 to March 31, 2022	April 1, 2022 to March 31, 2023	April 1, 2023 to March 31, 2024	April 1, 2024 to March 31, 2025	April 1, 2025 to March 31, 2026
MSU (MSI)	$2.48	$2.53	$2.58	$2.63	$2.68	$2.76	$2.84	$2.90
AU (MSI)	$21.07	$21.56	$22.71	$23.88	$25.30	$26.06	$26.84	$27.38
MSU (WCB)	$2.76	$2.81	$2.87	$2.92	$2.98	$3.07	$3.16	$3.23
AU (WCB)	$23.41	$23.96	$25.23	$26.53	$28.11	$28.96	$29.83	$30.43

(4.1.20)

SESSIONAL PAYMENT RATES *(4.1.21)*

	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Specialists	$173.60	$180.60	$184.10	$187.60	$193.23	$199.03	$203.01
GP	$148.80	$154.80	$157.80	$160.80	$165.62	$170.59	$174.00

(4.1.22)

SECTION 5: CLAIM SUBMISSION ASSESSMENT RULES *(5.0.0)*

This section provides important information about approved policy on which assessment rules are built and applied to submitted claims. Individuals responsible for submitting claims should have a deep understanding of the content included in this section and refer to the information when uncertain about making a claim for provided health services. *(5.0.1)*

Examples of topics covered in this section include an explanation of different types of visits and related reporting requirements, content specific to physician specialties and assessment rules for procedures. *(5.0.2)*

Key Terms Relevant to This Section** **(5.0.3)

Care Locations (5.0.4)

- *Emergency Care Centre: A special designation provided by the Department of Health and Wellness to emergency departments meeting certain standards including 24 hour onsite on call.* *(5.0.5)*
- *Functional Centre: A standard area or site within a hospital or institution; e.g., outpatient department, intensive care unit, etc. Assigned functional centre modifier will be required as part of a service encounter for services provided in such areas.* *(5.0.6)*
- *Home/Residence: Includes patient's home, group homes, seniors' lodges, personal care homes and provincial correctional centres. It does not include institutions.* *(5.0.7)*
- *Hospital: For the purposes of this Preamble, hospital means a facility for the observation, care and treatment of persons suffering from a psychiatric disorder or a hospital for treatment of persons with sickness, disease or injury, including maternity care, as approved under the Health Services and Insurance Act.* *(5.0.8)*
- *Institution: Licensed and approved chronic care hospitals, residential centres, nursing homes and homes for special care.* *(5.0.9)*
- *Intensive Care Unit: Special areas recognized and funded by the Department of Health and Wellness to provide high intensity care. These units would include neonatal, paediatric, coronary, and such other units as are recognized by the Department. Generally, special fees apply to patients in such areas unless the patients no longer need the care of such a unit, but remain in the intensive care area, e.g., due to lack of beds on general ward or recovery room.* *(5.0.10)*
- *Office: The location where a physician is practicing their profession. An office may be located in the physician's home, in a hospital, in an institution, or in other facilities or buildings.* *(5.0.11)*
- *Other Locations: This modifier applies to locations of service not defined elsewhere, such as recreational facilities, watercraft, or roadside.* *(5.0.12)*

Home Care *(5.0.13)*

- *Home Care: Home support services, personal care services, nursing services and home oxygen services to persons with assessed unmet needs who are convalescing, chronically ill, disabled, or experiencing debilities of old age. Services provided have the objectives of maintaining or improving the individual's level of functioning; addressing the individuals' needs during rehabilitation or convalescence; delaying or preventing admission into institutions; and/or providing family relief services to the individual's informal caregivers.* *(5.0.15)*

Visits Related to Pregnancy *(5.0.16)*

- *Antenatal or Prenatal: Applies to pregnancy related visits from the time of confirmation of pregnancy to delivery.* *(5.0.17)*
- *Postnatal: Describes a single limited visit performed approximately six weeks following delivery for the purpose of assessment and advice to the mother.* *(5.0.18)*
- *Postpartum: Describes in hospital limited visits to the mother following delivery.* *(5.0.19)*

Other Important Terms (5.0.20)

- *Add-On: A procedure that is always performed in association with another procedure and never by itself. An add-on procedure is paid at full fee. (5.0.21)*
- *Detention and Office Visits: Medical detention occurs when a practitioner's time is given exclusively to one patient for active treatment and/or monitoring of that patient at the sacrifice of all other work. Detention time may only be claimed for emergency care and/or treatment provided outside of the office. (5.0.22)*
- *Group Practice Clinic: A group practice is defined as the arrangement whereby two or more physicians are in practice, and each physician maintains and has access to medical records and histories of the patients. (5.0.23)*
- *Interpretive Component: This is the interpretation of the results of a diagnostic procedure for which a fee may be claimed separately from performing the procedure itself. Any claim with the modifier RO=INTP (role = interpretation) must be submitted with the date the services were performed and not the date of interpretation. (5.0.24)*
- *Premium Fees: Additional amounts paid above normal or customary rates on eligible services provided on an emergency basis during designated times. An emergency basis is defined as services that must be performed without delay because of the medical condition of the patient. (5.0.25)*
- *Sessional Fees: Apply to preapproved services of a physician engaged on a time basis; e.g., approved group immunization and Well Women's Clinics, public health medicine or other professional services to a government department, agency or public body. (5.0.26)*
- *Statutory Holiday: Holidays are defined for the purpose of claiming special rates as New Year's Day, Heritage Day, Good Friday, Easter Monday, Victoria Day, Canada Day, Civic Holiday, Labour Day, Truth and Reconciliation Day, Thanksgiving, Remembrance Day, Christmas Day and Boxing Day. The list of dates designated as statutory holidays will be issued annually by MSI. Note: If a physician chooses to provide routine, scheduled services during a statutory holiday, they are not entitled to payment at the holiday rate. (5.0.27)*
- *Technical Component: Some diagnostic procedures have separately listed technical and interpretive components. When a physician must perform the technical component of a procedure that is normally carried out by a technician, the physician may claim a fee for the technical component. If a technician carries out the technical component, the physician may claim for the interpretive component only. (5.0.28)*
- *Transfer of Care: Occurs when the responsibility for the care of a patient is completely transferred, either temporarily or permanently, from one physician to another. (5.0.29)*

ASSESSMENT RULES FOR VISITS AND RELATED SERVICES *(5.1.0)*

Visit is a generic term used for service encounters where there is an evaluation of a patient either as the sole service or in association with one or more procedural services. A visit may not be claimed where the procedural service includes a visit component or where claiming a visit is otherwise prohibited. Visits are governed by a common set of rules, and more specific rules apply to different categories of visits. Visits may occur in all locations and include consultations, counselling, psychotherapy and care, as in ICU, directive, continuing, or supportive care. *(5.1.1)*

There are several different Canadian Classification of Procedures (CCP) codes that apply to visits and multiple factors that modify these codes. Care must be taken to identify the appropriate code for the visit service provided, and any modifying factors. Not all combinations of codes and modifiers are valid. *(5.1.2)*

There are 5 health service codes that describe diagnostic interview and evaluation and consultations including:

03.03 - Diagnostic Interview and Evaluation, described as Limited - Limited assessment with history of the presenting problem.

03.04 - Diagnostic Interview and Evaluation, described as Comprehensive - In depth evaluation with complete history and physical examination.

03.05 - Other Diagnostic Interview and Evaluation (includes critical care, ventilatory care, comprehensive care, intensive care, neonatal intensive care).

03.07 - Consultation, described as Limited – Examination limited to the relevant body systems and a history relating to the presenting problem with a written report to the referring provider.

03.08 - Consultation, described as Comprehensive – In depth evaluation with complete history and physical examination appropriate to the physician's specialty with a written report to the referring provider. *(5.1.3)*

VISIT TYPES *(5.1.4)*

LIMITED VISIT *(5.1.5)*

A limited visit or an initial limited visit may be claimed when the physician provides a limited assessment for diagnosis and treatment of a patient's condition. It includes a history of the presenting problem and an evaluation of relevant body systems. *(5.1.6)*

COMPREHENSIVE VISIT *(5.1.7)*

A comprehensive visit or a subsequent comprehensive visit is an in-depth evaluation of a patient necessitated by the seriousness, complexity, or obscurity of the patient's complaints or medical condition. This service includes ensuring a complete history is recorded in the medical record and performing a physical examination appropriate to the physician's specialty and the working diagnosis. *(5.1.8)*

Documentation of the following provides a clear indication that a comprehensive visit has taken place:

1. A detailed patient history including:

- Relevant history of presenting complaint
- Relevant past medical and surgical history
- Medication list
- Allergies
- Family history, as appropriate
- Social history, as appropriate

2. A complete physical exam including:

- A complete physical examination, appropriate to the physician's specialty and relevant to the presenting complaint.
- Documentation describing the pertinent positive and negative findings of the physical examination. It is not adequate to indicate 'physical exam is normal' without indicating what was examined.

In situations in which these criteria are not met, it would be appropriate to claim the visit as a limited visit, i.e., 03.03.

Comprehensive visits may not be claimed within 30 days of a previous limited or comprehensive visit. However, a subsequent comprehensive visit may be claimed by the specialties of internal medicine, neurology and paediatrics.

For internal medicine, neurology and paediatrics, an initial comprehensive visit may be claimed provided all of the above requirements are met and the patient is being seen for a new condition or complication of an existing condition. If the patient is not being seen for a new condition or complication of an existing condition, an initial visit may not be claimed and either a subsequent 03.04 or 03.03 should be claimed, depending on whether the above requirements have been satisfied.

It is not appropriate to claim either an initial or subsequent 03.04 for all follow-up visits after 30 days have passed; the requirements noted above must be satisfied.

GENERAL VISIT RULES *(5.1.9)*

a) When the sole reason for the visit is to provide a procedure to a patient, only the listed procedure fee will apply. *(5.1.10)*
b) Only one visit may be claimed from a single service encounter. *(5.1.11)*
c) A comprehensive or initial limited visit may not be claimed within 30 days of a comprehensive consultation on the same patient for the same condition. *(5.1.12)*
d) A comprehensive visit may not be claimed within 30 days of a previous limited or comprehensive visit. However, a subsequent comprehensive visit service may be claimed by the specialties of internal medicine, neurology, and paediatrics. These restrictions do not apply to general practice. *(5.1.13)*
e) An initial limited visit service used by certain specialties may not be claimed within 30 days of any visit or procedure. A limited visit only will apply. *(5.1.14)*
f) Visits requested in one time period and performed in another time period must always be claimed using the lesser of the two rates. *(5.1.15)*
g) When follow-up visits are made at the convenience of the physician, the 0800 to 1700, Monday to Friday visit rate will apply. *(5.1.16)*
h) If more than one visit is provided by the same physician to the same patient on the same day in separate service encounters, documentation of the necessity for the extra visits must be recorded on the chart. Time of service occurrence must be provided on second and subsequent visits. *(5.1.17)*
i) A Pap smear may not be claimed in addition to a visit, consultation or procedure for a gynaecological or obstetrical diagnosis, nor is it payable in addition to a complete physical exam. *(5.1.18)*
j) When a visit is made solely for an injection, then only an injection may be claimed. The injection must be provided under the direct supervision of a physician physically present on the premises. *(5.1.19)*
k) A visit is not claimable with psychotherapy or counselling codes at the same service encounter. *(5.1.20)*

CARE BY MORE THAN ONE PHYSICIAN – LIMITED VISITS *(5.1.21)*

Care by more than one physician refers to ongoing visit services provided to a patient where some form of coordination of the responsibility for the patient's care between a referring physician and the consultants is implied. All care visits are coded as limited visits, and the nature of the responsibility of the physicians involved determines the role claimed (See Definition for Transfer of Care in Section 6 (6.0.100)). *(5.1.22)*

Supportive Care: Is defined as a limited visit provided by the family physician or referring physician in a situation where the responsibility for the medical and surgical care of a registered hospital inpatient has temporarily been transferred to a consultant.

a) Service encounters are limited to only once every three days from the date of hospital admission up to and including the ninth day, and twice weekly thereafter for the remainder of the patient's hospital stay.
b) If medical complications develop or are present that require active management by the referring physician, regular hospital visits, not supportive care, should be claimed. *(5.1.23)*

Directive Care: Is defined as a limited visit following a consultation that can be claimed for services provided in the office, home or to registered inpatients by specialist consultants. It is intended that the referring physician is responsible for the general condition of the patient and that the consultant is directing only the care relevant to their specialty. In such cases the consultant may claim directive care and the referring physician may claim the appropriate home, office or inpatient visit. More than one specialist at a time may claim directive care on a patient. *(5.1.24)*

Continuing Care: Is defined as a limited visit following a consultation that can be claimed for services provided in the office, home or to registered inpatients by specialist consultants. It is intended that the consultants assume responsibility for the care of the patient's medical condition. When the patient remains in the hospital and the consultant is providing continuing care, the general practitioner or paediatrician may claim supportive care. Only one consultant may claim continuing care for a hospital inpatient at a time. When a specialist is providing continuing care in the home or office, the general practitioner may claim the appropriate visit code. *(5.1.25)*

LIMITED VISITS BY LOCATION *(5.1.26)*

a) **Office**: A limited visit may be claimed when the physician sees the patient and performs a limited assessment for a new condition or when monitoring or providing treatment of an established condition. *(5.1.27)*
b) **Outpatient Department (OPD) Emergency Department**: A limited visit may be claimed when the physician provides medical treatment to a patient presenting to an OPD emergency department. It is payable at the appropriate fee for the time at which the service is provided. *(5.1.28)*
c) **Hospital**: A limited visit may be claimed when the physician provides daily care to the patient. Daily limited visits may be claimed by more than one physician when different conditions are being treated. A weekly maximum applies to routine hospital visits to patients after 56 days hospitalization except for paediatricians. Multiple unscheduled visits on the same day are excluded from the weekly maximum. This composite fee includes reviewing lab work, discussions with the patients and/or their families and instances in which the physician electively returns to reassess a patient. Additional visits may not be claimed for such activities as they are included in the daily rate. *(5.1.29)*
d) **Home Care**: A limited visit may be claimed when the physician provides daily care to the patient and may occur at the patient's home or OPD. Home care services are to be discontinued when no longer required. The patient's requirement for home care is reviewed regularly. *(5.1.33)*

In exceptional circumstances, extended admissions for up to a total of 30 days may be authorized by the care coordinator in consultation with the attending physician. *(5.1.34)*

e) **Home or Other Locations**: A limited visit may be claimed when the physician provides a limited examination for diagnosis and treatment of a patient's condition or provides ongoing treatment of an established condition. Requirements specific to location (5.1.44) must be met. *(5.1.35)*

f) **Institutions**: See Section 6 (6.0.45). *(5.1.36)*

COMPREHENSIVE VISITS BY LOCATION *(5.1.37)*

a) **Office**: Comprehensive visits in the office may not be claimed more than once every 30 days when diagnosing and treating a new condition or further complications of an existing condition. Visits provided within a 30-day period for the same condition or complication should be claimed as a limited visit. *(5.1.38)*

b) **OPD or Emergency Department**: A comprehensive visit may be claimed, when appropriate, in the OPD or emergency when a patient is seen for the first time that day by that physician. Follow-up visits for the same condition on the same or subsequent day should be claimed as a limited visit. *(5.1.39)*

c) **Hospital**: A comprehensive visit may be claimed for the first examination in hospital for diagnosis and treatment once per patient per admission for each specialty involved in the care of the patient. If a patient has a comprehensive visit in the emergency department (ED) by the family doctor covering the ED and is then admitted and has a second comprehensive visit by a different admitting family doctor, the ED physician may claim the complete examination code and the admitting physician may claim the first examination code. *(5.1.40)*

   i. If a specialist readmits a referred patient within 30 days for the same or related condition, only a limited visit may be claimed.
   ii. There are no restrictions on paediatricians readmitting referred patients.
   iii. If a specialist readmits a non-referred patient within 10 days for the same or related condition, only a limited visit may be claimed.
   iv. If a general practitioner readmits any patient within 10 days for the same or related condition, only a limited visit may be claimed. *(5.1.41)*

d) **Home or Other Locations**: A comprehensive visit may be claimed when diagnosing and treating a new condition or further complication of an existing condition but may not be claimed more than once every 30 days. Comprehensive visits provided within a 30-day period will be approved at the appropriate limited visit fee. Requirements specific to location (5.1.44) must be met. *(5.1.42)*

e) **Institutions**: See Section 6 (6.0.45). *(5.1.43)*

RULES SPECIFIC TO LOCATION *(5.1.44)*

a) **OPD and Emergency Department**: If the patient is kept in OPD or emergency under observation for more than four hours, an additional limited visit may be claimed when the need can be supported by the patient's condition and documentation on the chart. *(5.1.45)*

   i. First Patient Seen: The rate for the first patient seen is only applicable for those cases requiring the physician to make a separate trip to the OPD or emergency department.
   ii. Additional Patients: An extra patient limited visit is applicable for additional patients seen following the first patient. The rate for extra patients is applicable for additional patients seen following each separate trip to the hospital. An extra patient limited visit applies in those situations where a physician is in the hospital for any purpose and is asked to see a patient in the OPD or Emergency Room. *(5.1.46)*

b) **The Emergency Care Centre**: Visit rates may only be claimed in designated emergency care centres approved by the Department of Health and Wellness. *(5.1.47)*

c) **A Home Visit**: Is a service rendered by a physician to a homebound patient or patients following travel to the patient's home. The patient or patient's representative has requested a visit with the physician. A home visit may only be claimed when the patient's condition or situation justifies the service, and the patient is homebound.
A patient is considered to be homebound when one or more of the following conditions are met and documented in the health record:
i. Leaving the home isn't recommended because of the patient's condition;
ii. The patient's condition keeps them from leaving home without help (such as using a wheelchair or walker, needing special transportation, or getting help from another person);
iii. Leaving home takes a considerable and taxing effort.
If the patient is not considered homebound, the visit is considered to be rendered at home for convenience. In this situation, the visit may be claimed at the normal office rate and travel may not be claimed. *(5.1.48)*
   i. Additional patients seen in the same apartment or private dwelling: The first person seen is claimed at the appropriate home visit. Other patients seen are claimed as additional patients. However, a visit to another apartment in the same building is regarded as a separate home visit and the appropriate fee should be claimed for the first person seen therein. *(5.1.49)*

d) **An Institutional First Visit**: Arises when, at the specific request of an appropriate institutional authority, patient or patient's family or guardian, the physician visits and renders services to the patient in an institution. *(5.1.50)*
   i. Additional patients seen at the same visit should be claimed at the appropriate limited visit fee.
   ii. When prearranged routine trips are made to an institution, limited visit fees shall be claimed only for those patients where medical necessity exists.
   iii. If the physician believes their services are inadequately compensated under the institutional visit rules, they may enter into a contractual agreement with the institution for a form of retainer or other remuneration method to supplement their income from visit fees.
   iv. Physicians may also report additional visits when required by medical necessity (or necessity for follow up of an ongoing medical problem) and there has been a request from the patient, their family or nursing home staff for the visit. *(5.1.51)*

URGENT VISITS (ALL LOCATIONS) *(5.1.52)*

An urgent visit is such that the physician responds immediately with regard to the patient's condition. Attendance due to personal choice or availability does not constitute an urgent visit. If a physician is called to attend a patient that interrupts their regular office hours and travels from one location to another, the appropriate explicit modifier must be entered on the service encounter to ensure payment of the appropriate rate. For example, modifier type and value US=UIOH describes unscheduled = urgent visit interrupting normal office hours. Travel is defined in 2.0.10. *(5.1.53)*

The underlying principle is that the demands of the patient's condition and/or the physician interpretation of that condition, is such that the physician must respond immediately. Immediate attendance because of personal choice or availability does not constitute an urgent visit. (See Section 6 (6.0.101)). While an urgent visit is appropriate for the first patient seen at a facility, it does not apply to the second or subsequent patients seen at the same location as the physician is already physically in the facility and thus no travel occurred. *(5.1.54)*

a) **Urgent Visit Hospital Inpatient**: Request by hospital staff. An urgent visit applies when a physician travels to see a registered inpatient at the request of hospital staff. *(5.1.55)*

b) **Urgent Care in Office Request by Patient**: An urgent care visit applies when the physician is called to see the patient and must travel to their office outside the hours of 0800 to 1700 Monday to

Friday or during other scheduled office hours. An urgent care visit does not apply to a patient attending the office during scheduled office hours regardless of the patient's condition. If additional patients are seen at the same time, a limited visit applies. *(5.1.56)*

c) **Urgent Visit Sacrifice of Office Hours**: All other locations. An urgent visit may be applied when the physician is called to see a patient and interrupts their regular office hours and travels from one location to another to attend the patient. *(5.1.57)*

GENERAL PRACTICE COMPLEX CARE VISIT *(5.1.58)*

A complex care visit code may be billed a maximum of four times per patient per year by the family physician and/or the practice (not by walk in clinics) providing ongoing comprehensive care to the patient who is under active management for three or more of the following chronic diseases: asthma, chronic obstructive pulmonary disease, diabetes, chronic liver disease, hypertension, chronic renal failure, congestive heart failure, ischemic heart disease, dementia, chronic neurological disorders, or cancer. The physician must spend at least 15 minutes in direct patient intervention and the visit must address at least one of the chronic diseases either directly or indirectly. Start and finish times are to be recorded on the patient's chart. *(5.1.59)*

Documentation must indicate the three eligible chronic diseases under active management or there must be a readily accessible patient profile listing the chronic diseases in the patient record. The documentation or profile may include the date of onset (when/if this is known by the physician). *(5.1.60)*

Definitions *(5.1.61)*

- The term active management is intended to mean that the patient requires ongoing monitoring, maintenance or intervention to control, limit progression, or palliate a chronic disease. *(5.1.62)*
- The term chronic neurological disorders is intended to include progressive degenerative disorders such as multiple sclerosis, amyotrophic lateral sclerosis, Parkinson's disease, Alzheimer's disease, stroke or other brain injury with a permanent neurological deficit, paraplegia or quadriplegia and epilepsy. *(5.1.63)*
- Chronic Renal Failure is defined as: (eGFR) <60 mL/min/1.73 m^2 for three months or equivalent calculated creatinine clearance. *(5.1.64)*

CASE MANAGEMENT CONFERENCE FEE *(5.1.65)*

A case management conference is a formal, scheduled, multidisciplinary health team meeting. It is initiated by an employee of the Nova Scotia Health Authority/Izaak Walton Killam Hospital or a Director of Nursing or Director of Care of an eligible long term care facility to discuss the provision of health care to a specific patient. Neither the patient nor the family need to be present. *(5.1.66)*

It may be claimed by more than one physician simultaneously as necessary for case management. *(5.1.67)*

The case conference must be documented in the health record with a list of all physician participants. *(5.1.68)*

To claim the case management conference fee, the physician must participate in the conference for a minimum of 15 minutes and remuneration will be calculated in 15-minute time increments based on the sessional rate. Start and finish times are to be recorded on the patient's chart. 80% of a 15-minute time interval must be spent at the conference in order to bill that time interval. *(5.1.69)*

Multi-disciplinary refers to the attendance of two or more licensed health care professionals in addition to a physician. *(5.1.70)*

The case management conference fee is not to be used for attendance at regularly scheduled meetings concerning ongoing care planning or patient management for one or more patients; i.e., grand rounds, tumor board case rounds, teaching rounds, transplant rounds or other similar methods of specialist physicians

conferring about the medical management of complex cases. It is not to be used in circumstances which are a usual part of patient care such as transfer of care between physicians on evenings and weekends. *(5.1.71)*

Physician attendance at case management conferences held by video conferencing or teleconferencing is eligible for payment providing all other eligibility requirements are met. *(5.1.72)*

Each case conference must be specific to an individual patient and the time spent by the physician at the conference must be documented in the health record of that patient. However, consecutive formal scheduled conferences, each pertaining to one named patient, with start and finish times recorded in each health record, would be permitted. *(5.1.73)*

NOTE: If the patient is located in an institution, documentation pursuant to the billing guidelines must be located within the patient record in the institution. If the patient is not located in an institution, documentation regarding the case management conference must be readily available; e.g., in the patient record maintained by the physician claiming the fee. The onus will be on the physician billing the fee to ensure appropriate documentation is readily available. *(5.1.74)*

DETENTION TIME *(5.1.75)*

Medical detention occurs when a service provider's time is given exclusively to one patient for active treatment and/or monitoring of that patient at the sacrifice of all other work. Detention time is not payable when provided in the office. (See Section 6 (6.0.23)) *(5.1.76)*

Visits: When detention is claimed with limited or comprehensive visit services, detention commences 30 minutes after the practitioner is first in attendance and may be claimed in 15-minute increments thereafter. The first 30 minutes is the appropriate visit fee.

Consultations: When detention is claimed with a Comprehensive or Limited consultation, detention time commences after 1 hour.

Obstetrical Delivery: When detention is claimed with an obstetric delivery provided by a general practitioner, detention time commences after 3 hours.

This may include time spent with the patient travelling from one location to another. However, travel time to transport donor organs from a donor facility to the recipient facility for transplantation begins at the time the retrieving surgeon accompanied by the donor organs leave the donor facility. Where any service is performed during the time spent with the patient, either the service or the detention time, but not both, should be claimed. The circumstances in each case, and the start and finish times involved, should be documented with the service encounter and in the patient record. *(5.1.77)*

The fee for detention is 15 units per 15 minutes for general practitioners and 17.5 units per 15 minutes for specialists. The detention modifier RO=DETE must be indicated on the service encounter. *(5.1.78)*

Detention time does not apply to:

a) Waiting time for an operating room, x-rays, laboratory results or administrative duties
b) Counselling or psychotherapy
c) Advice given to the patient or patient's family or representatives
d) Waiting time for a patient's arrival for assessment or treatment
e) Waiting time for attendance by another medical practitioner or consultant
f) Return trip if the physician is not in attendance with a patient
g) Time spent in completing or reviewing patient charts
h) More than one patient at a time
i) Office visits *(5.1.79)*

Detention time is not payable in conjunction with fees paid for the following on the same day:

a) Intensive care or critical care (See Section 5 (5.1.123 and 5.1.133))
b) Diagnostic and therapeutic procedures
c) Obstetrical delivery by specialties other than general practitioner *(5.1.80)*

PREMIUM FEES *(5.1.81)*

Premium fees (See Section 6 (6.0.72)) may be claimed for certain services provided on an emergency basis during designated time periods. An emergency basis is defined as services that must be performed without delay because of the medical condition of the patient. *(5.1.82)*

Premium fees may be claimed for:

a) Consultations except where a consult is part of the composite fee
b) Surgical procedures except those performed under local or no anaesthetic
c) Fractures regardless of whether an anaesthetic is administered
d) Obstetrical deliveries
e) Newborn Resuscitation
f) Selected diagnostic imaging services
g) Pathology services
h) Selected endoscopic procedures (See Appendix F 7.6.0) *(5.1.83)*

The designated times where premium fees may be claimed and the payment rates are: *(5.1.84)*

Time Period	Time	Payment Rate Increase
Monday to Friday	17:00 – 23:59	US = PREM (35 percent)
Tuesday to Saturday	00:00 – 07:59	US = PR50 (50 percent)
Saturday	08:00 – 16:59	US = PREM (35 percent)
Saturday to Monday	17:00 – 07:59	US = PR50 (50 percent)
Recognized Holidays	08:00 – 23:59	US = PR50 (50 percent)

(5.1.85)

Premium fees also apply to emergency anaesthesia for a surgical procedure (not a diagnostic or therapeutic procedure) provided by a non-certified anaesthetist at the interruption of their regularly scheduled office hours. *(5.1.86)*

Premium fees are paid at 35 percent or 50 percent of the appropriate service code but at not less than 18 units for patient specific services and at not less than 9 units for non-patient specific diagnostic imaging and pathology. *(5.1.87)*

The premium fee modifier type and value US=PREM Unscheduled Premium 35 percent or US=PR50 Unscheduled Premium 50 percent must be indicated. *(5.1.88)*

If a service requires use of an anaesthetic, the anaesthetic start time determines if a premium fee may be claimed. *(5.1.89)*

Premium fees may not be claimed with:

a) Detention
b) Critical care/intensive care
c) Diagnostic and therapeutic procedures other than selected diagnostic imaging services and selected endoscopic procedures (See Appendix F 7.6.0)
d) Surgeons and assistants fees for liver transplants *(5.1.90)*

RADIOLOGY PREMIUM FEES *(5.1.201)*

Premium fees can be claimed in situations in which there has been a direct request made to a radiologist for an emergency interpretation of a specific study because of the condition of the patient and the radiologist responds without delay to the request. Services of a non-emergency nature or services of an emergency nature but not performed without delay during these times do not qualify for premium rates. This includes booked procedures performed during premium hours, during times the radiologist or the resident they are supervising is scheduled to be onsite in the radiology department, and interpretations done after hours for which there has not been a specific request made to the radiologist about a specific imaging study. If a study has been ordered but the radiologist has not been specifically contacted by the attending physician and requested to provide an emergency interpretation, a premium cannot be claimed. *(5.1.202)*

All physicians claiming premium fees are required to be able to provide documentation that verifies requirements for these services have been met. *(5.1.203)*

AFTER HOURS SERVICE PREMIUM (AHSP1) *(5.1.204)*

This premium applies in circumstances where elective procedures are moved to an eligible premium time period due to factors beyond control of the physician. The 35% after hours service premium is intended to compensate the physician for the disruption of their personal time while providing extended hours of service in addition to the scheduled workday. *(5.1.205)*

The AHSP1 may only be reported for scheduled electively booked interventional procedures that have been moved to a premium eligible time period due to factors beyond control of the physician. The premium does not apply to elective procedures that have been intentionally booked to start before 0800 hours, scheduled weekend joint replacement OR lists etc. *(5.1.206)*

Only one claim for AHSP1 is required for all applicable services billed during the same occurrence. While not a billing requirement, physicians may reference in the text the service encounter number(s) or health service code(s) the premium should apply to, as this may expedite processing and reduce wait times. *(5.1.207)*

The AHSP1 is restricted to hospital location and surgical specialities, endoscopies and interventional radiology.

Time Period	Time
Monday to Friday	17:00 – 23:59
Tuesday to Saturday	00:00 – 07:59
Saturday	08:00 – 16:59
Saturday to Monday	17:00 – 07:59
Recognized Holidays	08:00 – 23:59

(5.1.208)

REFERRED SERVICES *(5.1.91)*

Referred services include all types of consultations and any visits subsequent to the original referral. In the absence of a proper referral, specialty rates may not apply. *(5.1.92)*

A consultation may not be claimed in the circumstances listed below:

a) Where ongoing care is provided without an original referral the appropriate non-referred visit is payable.
b) The patient's regular attending physician cannot claim a consultation and must claim the appropriate visit.
c) A consult may not be claimed for referrals from other health care professionals; e.g., nurses, podiatrists. However, consults may be claimed for referrals from nurse practitioners, midwives, optometrists and dentists. *(5.1.93)*

Some services may not be claimed in addition to a consultation (See Section 5 (5.3.25)). *(5.1.94)*

Consultation: A consultation is a service resulting from a formal request by the patient's physician, nurse practitioner, midwife, optometrist or dentist after appropriate evaluation of the patient, for an opinion from a physician qualified to furnish advice. This may arise when the complexity, obscurity or seriousness of the patient's condition demands a further opinion, when the patient requires access to specialized diagnostic or therapeutic services, or when the patient, or an authorized person acting on the patient's behalf, requests another opinion. *(5.1.95)*

A consultation requires a written report to the referring physician, nurse practitioner, midwife, optometrist or dentist; an evaluation of relevant body systems; an appropriate record and advice to the patient. It may include the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient, other persons relevant to the case, and the referring physician, nurse practitioner, midwife, optometrist or dentist. The composition of a consultation will vary with a particular specialty. *(5.1.96)*

Consultations are listed as health service codes 03.08 comprehensive consultation and 03.07 limited or repeat consultation. The amount payable for the service varies according to the specialty and additional modifiers or modifier combinations. For example, a repeat consultation with a premium fee would be shown as modifier type and value, RP=REPT, US=PREM a repeat service, unscheduled premium fee 35 percent. A valid referring service provider number must be provided when submitting a service encounter for a consultation. *(5.1.97)*

The Health Services and Insurance Act, Item 33, provides that Nova Scotia Medical Services Insurance has the authority to require a copy of the consultation report for administrative purposes. *(5.1.98)*

Comprehensive Consultation: A comprehensive consultation is a comprehensive visit (See Section 5 (5.1.7)) with a written report to the referring physician, nurse practitioner, midwife, optometrist or dentist. This service includes performing and recording of a complete history and a complete physical examination appropriate to the physician's specialty. *(5.1.99)*

Limited Consultation: A limited consultation is performed when the nature of the patient's problem does not warrant a comprehensive consultation. A limited consultation includes a history limited to and related to the presenting problem, and an examination that is limited to relevant body systems. *(5.1.100)*

Repeat Consultation: A repeat consultation applies only where there has been a re-referral of the patient by the same physician, nurse practitioner, midwife, optometrist or dentist to the same consultant for the same condition or complication thereof within 30 days of the initial consultation. A repeat consultation requires all the elements of a limited consultation and implies interval care by another physician. *(5.1.101)*

The situation where the consultant requests the patient to return for a later examination is not a repeat consultation. *(5.1.102)*

Prolonged Consultation: A prolonged consultation may be applied to cases where the consultation extends beyond one hour for comprehensive consultations. A prolonged consultation cannot be claimed with a limited consultation. Prolonged consultations are paid in 15-minute time blocks or portion thereof. Prolonged consultations are not to be confused with active treatment associated with detention. These are entered on the service encounter as multiples. As with all services paid based on time, start and finish times must be recorded on the patient record. *(5.1.103)*

An obstetrics and gynaecology prolonged consultation may be applied to cases where the consultation extends beyond thirty minutes for a Comprehensive Consultation specifically for preconceptual consultation (Maternal fetal medicine), consultation for issues of sexual dysfunction, reproductive endocrinology, gynaecologic oncology, and urogynaecology and may be claimed by physicians with recognized expertise in these fields. No other fee codes may be billed for the same patient for that time

period. Obstetrics and gynaecology prolonged consultations are paid in 15-minute time intervals or portions thereof, 80% of the time must be direct physician to patient contact *(5.1.104)*

A prolonged consultation may be claimed only by the following specialties:

a)	Anaesthesia	15 units per 15 minutes
b)	Internal medicine	13.5 units per 15 minutes
c)	Neurology	13.5 units per 15 minutes
d)	Physical medicine	13.5 units per 15 minutes
e)	Paediatrics	16.3 units per 15 minutes
f)	Obstetrics and gynaecology	13.5 units per 15 minutes
g)	Palliative care	15.5 units per 15 minutes *(5.1.105)*

Example: Internal medicine comprehensive consultation

MU=2	1 1/4 hour	Total Time
MU=3	1 1/2 hour	Total Time
MU=4	1 3/4 hour	Total Time
MU=5	2 hour	Total Time

Repeat consultation or obstetrics and gynaecology consultation

MU=2	3/4 hour	Total Time
MU=3	1 hour	Total Time
MU=4	1 1/4 hour	Total Time
MU=5	1 1/2 hour	Total Time

Example: Obstetrics and gynaecology

Comprehensive consultation

MU=2	3/4 hour	Total Time
MU=3	1hour	Total Time

Repeat consultation

MU=2	3/4 hour	Total Time
MU=3	1 hour	Total Time *(5.1.106)*

Non-specialist physicians: Consultations for non-specialist physicians will usually be paid at the general practitioner consultation rate except where alternative arrangements have been made with the Department of Health and Wellness. *(5.1.107)*

Extended Comprehensive Psychiatry Consultation 03.08A *(5.1.209)*

When direct physician to patient time exceeds 60 minutes. The extended comprehensive psychiatry consultation follows all preamble rules pertaining to comprehensive visits and consultations. After the initial 60 minutes of direct physician to patient time, the psychiatrist must spend at least 80% of the time in direct physician to patient contact. Multiples may be claimed after 75 minutes and are calculated in 15-minute intervals, or portion thereof to a maximum of 180 minutes. 80% of the time must be in direct physician to patient contact. *(5.1.210)*

Example:	Multiples	Time Claimed	Time spent with patient
	MU=1	61 minutes	61-71 minutes
	MU=2	75 minutes	72-86 minutes
	MU=3	90 minutes	87-101 minutes
…max	MU=9	180 minutes	177-180 minutes

Colon Cancer Prevention Program Referral

When a patient is referred with a formal referral from the Colon Cancer Prevention Program for a colonoscopy, a limited consultation (HSC 03.07) may be billed at the time of the colonoscopy procedure, in accordance with the Preamble rules, if the patient has not previously been seen in consultation. *(5.1.211)*

When a patient is referred from the CCPP with a formal referral from the Colon Cancer Prevention Program for a medical assessment prior to booking a colonoscopy a comprehensive (03.08) or limited (03.07) consultation may be billed depending on the situation, in accordance with the Preamble rules. *(5.1.212)*

OTHER CARE OR VISITS *(5.1.108)*

TRANSFER OF CARE *(5.1.109)*

a) **A transferral**: As distinguished from a referral, takes place when there is formal transfer of responsibility for the patient's care from one physician to another (See Section 6 (6.0.100)). *(5.1.110)*
Temporary transfer: Would include situations where the first physician must be absent, e.g., holiday or illness and arranges patient coverage by the second physician with the intention of resuming care of the patient upon return. *(5.1.111)*
Permanent transfer: Would involve any situation where the physician has no intention of resuming care of the patient. *(5.1.112)*

b) Regardless of specialty, the physician to whom the patient is transferred is not entitled to a consultation or comprehensive visit fee. When transfers occur from one specialty to another or from one hospital to another, the receiving physician may be entitled to a consultation or comprehensive visit fee. *(5.1.113)*

c) However, if the patient has a medical problem necessitating referral to another physician, and responsibility for the patient's care is transferred with or subsequent to the referral, it is appropriate for the receiving physician to claim a consultation. *(5.1.114)*

SUPERVISION *(5.1.115)*

Supervision of treatment by a physician, without actually having a face-to-face interaction with the patient, is a service that may be claimed in the following special cases: *(5.1.116)*

Supervision of home dialysis refers to supervision by a nephrologist of patients registered in a home dialysis program.

a) Home dialysis program registration is initiated when a patient begins training or is accepted into a program, and terminates with successful transplantation, change to in centre dialysis, loss of resident status, or death.

b) No inpatient chronic dialysis supervision fees may be charged on the registered patients. However, if a registered patient is admitted to a centre without an attending nephrologist and the patient is incapable of performing their own dialysis, the attending physician may claim the treatment of chronic renal failure by any dialytic method. Other inpatient visits and procedures may be claimed during hospital admission.

c) The supervisory fee is for comprehensive management of all aspects of home dialysis care for registered patients, including all scheduled or emergent outpatient visits, direction of care by phone or other means, and liaison with other treating physicians.

d) Supervisory fee is claimed monthly by the supervising nephrologist for each home dialysis program patient registered as of the first day of that month. For newly registered patients, service encounters commence the following month. *(5.1.117)*

Payment for supervision of a home care patient can include medical chart review, telephone calls, fax or e-mail advice and blended mileage travel detention (See Section 2 (2.2.43)). *(5.1.119)*

Supervision of a patient on long term warfarin therapy (13.99C) may be claimed once monthly if the patient's treatment is managed by telephone, fax or e-mail advice and the patient is not participating in the Community Pharmacy-led Anticoagulant Management Services. If the date of service falls within a complete month of hospitalization, this service may not be claimed. *(5.1.118)*

Community Pharmacy-led Anticoagulant Management Services (CPAMS) enables patients on warfarin to see a pharmacist for point-of-care INR testing and dosage adjustments. If a physician's patient is participating in CPAMS, the physician may only bill the management fee (13.99H) when they are specifically asked to consult with the pharmacy on the patient's case. More information can be found on the Pharmacy Association of Nova Scotia (PANS) website: https://pans.ns.ca/cpams *(5.1.213)*

DISCHARGE SERVICES *(5.1.214)*

Hospital Discharge Fee (03.02A) *(5.1.215)*

This fee may be claimed by the physician, either a general practitioner or a specialist when a patient is admitted for non-surgical hospitalization, who performs the activities involved in discharging a hospital inpatient. These activities include, as necessary, the completion of the patient's chart, discharge summary, writing prescriptions for the patient, providing discharge instructions to the patient and arranging for follow-up care for the patient.

The fee is not payable where major surgery, minor surgery, major fracture and/or minor fracture care is provided in a hospital setting unless a patient is transferred to a general practitioner for follow-up care after surgery/fracture care. In this case, the general practitioner may claim the discharge fee if the general practitioner performs the discharge duties. This fee cannot be claimed by the operation surgeon in association with any surgical code being billed. A hospital visit fee may be claimed in addition to the discharge fee where a hospital visit is provided on the same day. *(5.1.216)*

Complex Comprehensive Acute Care Hospital Discharge Fee (03.04F) *(5.1.217)*

This fee may be claimed by the most responsible physician only (the general practitioner) in charge of the patients care for any given day and only once per hospital inpatient hospital admission. It is intended to be used when the services provided on the day of discharge require greater than 30 minutes of the physicians time. This HSC includes all services provided to the patient on the day of discharge from the acute care hospital. These services include the discharge day examination of the patient, the completion of the patients chart, discharge summary, writing any prescriptions required for the patient, providing discharge instructions to the patient (or caregivers) and arranging for follow-up care for the patient. Every effort is made by the discharge physician to communicate with the community physician who will be most responsible for the patient's care after discharge.

If the situation arises where the complex comprehensive discharge process occurs over 2 days, the code must be reported on the date of discharge, the cumulative time spent must be greater than 30 minutes, the code may only be claimed once by the MRP and may not be unbundled to accommodate splitting the workload.

A hospital visit is considered an integral part of this service and is not reportable in addition. The physician claiming this health service code may not report any other visit service for the same patient, same day. In addition, 03.02A may not be claimed as this service is included in 03.04F. Do not count time for services provided after the patient physically leaves the hospital. *(5.1.218)*

First Visit After Acute Care Inpatient Hospital Discharge – Complex Care (HSC 03.03S) *(5.1.219)*

A complex care patient is defined as: a patient with multiple (two or more) chronic conditions; a condition expected to last one year or more, a condition that requires ongoing medical management.

This is an additional fee for the first office visit of the patient requiring ongoing complex care within 14 days of acute care inpatient hospital discharge to the primary care provider responsible for the patient's ongoing care. The physician or their office staff should make every effort to communicate with the patient and/or caregiver within 2 business days of discharge to better facilitate the patient being seen within 14 days. It is not reportable in the walk-in clinic setting. This add on is restricted to 03.03, 03.03A and 03.03E. *(5.1.220)*

This fee is reportable only if the visit occurs in the primary physician's office or the patient home within 14 calendar days after hospital discharge. It is not reportable for services rendered in other locations such as nursing homes, residential care facilities, or hospice. Hospital length of stay must be greater than or equal to 48 hours. It is not reportable if the admission to hospital was for the purpose of performing elective surgery or fracture care (major or minor), obstetrical care or newborn care. The physician must be the provider most responsible for the patient's ongoing complex care. Once per patient per inpatient admission and not reportable for any subsequent discharges within 30 days. Not reportable with in the same month as other monthly care fees such as 13.99C. Maximum of 4 claims per physician per patient per year. *(5.1.221)*

First Visit After Inpatient Hospital Discharge – Maternal and Newborn Care (HSC 03.03P) *(5.1.222)*

This is an additional fee for the first maternal/newborn office visit within 14 days of inpatient hospital discharge to the primary care provider responsible for the patient's ongoing care. The primary care physician or their office staff should make every effort to communicate with the patient and/or caregiver within 2 business days of discharge to better facilitate the patient being seen within 14 days. It is not reportable in the walk-in clinic setting. This add on is restricted to 03.03 office visit and well baby care. *(5.1.223)*

This fee is reportable only if the visit occurs in the primary physician's office or the patient home within 14 calendar days after hospital discharge. Physician must be the provider most responsible for the mother and child's ongoing care. Claimable once per patient per inpatient admission for obstetrical delivery and only reportable if the reason for admission to hospital was for the purpose of obstetrical delivery. It is not reportable for any subsequent discharges within 30 days. Maximum of one claim per pregnancy (mother) and one claim per infant. *(5.1.224)*

MANAGEMENT OF CLOSED HEAD INJURY *(5.1.120)*

Initial examination and recommendation re: further treatment. This service may be claimed only by a paediatrician or neurosurgeon. *(5.1.121)*

INTENSIVE CARE UNIT *(5.1.122)*

Intensive care unit (ICU) services refers to services rendered in intensive care units (ICUs) approved by the Department of Health and Wellness by physicians who have been assigned by a hospital to the ICU staff by reason of special training or experience. *(5.1.123)*

General Rules *(5.1.124)*

i) The 24-hour time period for claiming ICU services is from 8 a.m. to 8 a.m. of the following day. *(5.1.125)*

ii) There should only be one Day 1 (first day) claimed during the same ICU admission even if the patient's status changes. Day 1 is normally the date of admission to the ICU. However, if the physician does not actually see the patient until the next day, e.g., because a resident is covering, then day 1 can be the date when the patient is first seen by the physician. Day 1 can only be claimed again if the patient is readmitted to the ICU at least 24 hours after discharge. This does not preclude ventilatory care day 1 and critical care day 1 being claimed on the same day. *(5.1.126)*

iii) Two physicians may claim ICU fees for the same patient on the same day but not the same fee code; e.g., one can claim critical care and the other can claim ventilatory care. However, no other

ICU fee code may be claimed in addition to comprehensive care. Also, the intensive care daily rate may not be claimed in addition to critical care. *(5.1.127)*

iv) If a patient is transferred from one ICU to another in the same institution, both sites can claim ICU fees on the same day. However, this precludes billing another day 1. *(5.1.128)*

v) When a transfer to a different hospital occurs, more than one physician (in different hospitals) can claim in a 24-hour period. *(5.1.129)*

vi) ICU fees can be claimed up to and including the day that the patient is medically suitable for transfer from the ICU or off ICU care. Then the intensive care daily rate or continuing care, depending on the condition of the patient, should be claimed if the patient remains in the ICU after the transfer order is written. *(5.1.130)*

vii) To claim ICU fees under ordinary circumstances, intensivists should be immediately available to the ICU. *(5.1.131)*

viii) A surgeon can claim ICU fees, except for ICU day 1 codes immediately following surgery, for their own postoperative patient if they are the sole providing physician to the patient in the ICU. Surgeons do not ordinarily claim ICU fees during the postoperative period because other physicians provide care in the ICU. However, some facilities do not have enough staff available for separate coverage of the ICU and, under these circumstances a surgeon can claim ICU fees. This does not prevent a surgeon from claiming ICU fees for nonoperative patients. If more than one physician is covering the ICU, only one physician may claim a visit. *(5.1.132)*

Critical Care Codes (Critical Care, Ventilatory Care and Comprehensive Care) *(5.1.133)*

These codes may only be claimed for daily care of critically ill patients admitted to intensive care units approved by the Department of Health and Wellness. The critical care, ventilatory care and comprehensive care services listed below include initial consultation and assessment and daily management of the patient. Use of these codes precludes claiming for detention on any patient on the same day. *(5.1.134)*

a) **Critical Care**: Critical care comprises all aspects of care of a critically ill patient in a designated intensive care area. Critical care excludes ventilatory support except as designated below. These fees do not apply when patients who are not critically ill are admitted to an intensive care area or when patients who were critically ill recover but remain in the intensive care area, e.g., lack of beds on general ward or recovery room. *(5.1.135)*

b) **Ventilatory Care**: This includes provision of all types of ventilatory care including face mask ventilation; e.g., BiPAP ventilation; management of the intubated airway, including tracheal toilet by suction catheter with or without instillation; and use of mechanical ventilation of the critically ill patient as well as the supervision and obtaining of blood for blood gas assessment. *(5.1.136)*

c) **Comprehensive Care**: When a physician provides both critical care and ventilatory support services to a patient, a service encounter claim should be submitted for comprehensive care. *(5.1.137)*

d) **Extracorporeal membrane Oxygenation (ECMO)**: When one physician provides critical care, ventilator support services, and manages extracorporeal membrane oxygenation for the patient in a designated intensive care area, a service encounter claim should be submitted for Comprehensive care for patient requiring Extracorporeal Membrane Oxygenation. *(5.1.138)*

e) The following specific procedures are included within the critical care tariff:
- Arterial puncture
- Blood gases
- Cardiac arrest
- Cardioversion and noninvasive transthoracic pacing
- Defibrillation
- Emergency resuscitation
- Haematology and biochemistry

- Insertion of arterial lines percutaneously or by cut down
- Insertion of chest tube
- Insertion of CVP catheters percutaneously or by cut down
- Insertion of intravenous lines
- Insertion of urinary catheters and nasogastric tubes
- Interpretation of laboratory tests
- Interpretation of rhythm strips
- Intracranial pressure monitoring interpretation
- Lumbar puncture
- Management of cardiac arrhythmias
- Paracentesis
- Stress test
- Thoracentesis
- Venipuncture of peripheral and central veins *(5.1.139)*

f) The following procedures are excluded from critical care and may be claimed separately:

- Bedside percutaneous tracheostomy
- Bronchoscopy
- Insertion of temporary pacemakers
- Intra-aortic balloon catheters
- Left heart catheterization with angiograms and coronary arteriograms
- Esophagogastroscopy
- Peritoneal dialysis for acute renal failure
- Radionuclide scans
- Selective coronary graft angiography
- Selective pulmonary angiogram
- Swan Ganz catheterization
- Ultrasonography *(5.1.140)*

INTENSIVE CARE *(5.1.141)*

The intensive care daily rate may be claimed by one physician per patient per 24 hours. Should a procedure be performed on the patient during this time, then the physician has the option of claiming for the procedure or for the intensive care but not for both. *(5.1.142)*

Intensive care detention may be claimed on an hourly basis, if needed, when a patient destabilizes. If codes for detention are claimed for a patient, then the intensive care daily rate cannot be claimed for that patient. The daily rate may be charged for other patients. The duration of service must be provided on these service encounters and, as with all services paid based on time, start and finish times of the encounter must be recorded on the patient record. An hourly sessional fee may be claimed in certain circumstances. *(5.1.143)*

BEATING HEART DONOR *(5.1.144)*

If the support of a beating donor (03.05A) does not require continuous attendance by an ICU physician and the physician can attend to other patients, then the regular intensive care unit codes are to be claimed for the support of the beating donor. *(5.1.145)*

PALLIATIVE CARE *(5.1.146)*

Consultation *(5.1.147)*

The palliative care consultation can only be claimed by designated physicians, general practitioners or specialists, with recognized expertise in palliative care. The service provided must fulfill the normal requirements for a consultation as specified in the Preamble. The consultation includes a psychosocial assessment, comprehensive review of pharmacotherapy, appropriate counselling, and consideration of appropriate community resources where indicated. Specialists can claim the palliative care consultation fee or the consultation fee appropriate to their specialty. It is payable once per patient per physician. Physicians billing the palliative care consult must forward a letter to MSI indicating their credentials. *(5.1.148)*

Physicians providing palliative care consultations must have completed a minimum of six days of intensive didactic or small group training in palliative care, and a one week clinical practicum in palliative care with a qualified physician supervisor. *(5.1.149)*

Support Visit *(5.1.150)*

The palliative care support visit is a time-based all-inclusive visit for the purpose of providing pain and symptom management, emotional support and counselling to patients with terminal disease. The physician must spend at least 80 percent of the time claimed with the patient and cannot claim for any other visits with the patient on the same day. Can be claimed if the patient is registered with the district integrated palliative care service. *(5.1.151)*

Chart Review and/or Telephone Call *(5.1.152)*

The palliative care medical chart review and/or telephone call, fax or e-mail advice services eligible for payment are those initiated by health care professionals involved with the care of the palliative care patient. Telephone calls, fax or e-mails initiated by the palliative patient or their family members are not eligible. Physicians and health care professionals involved should keep a detailed record of telephone calls, fax or e-mails. Palliative care medical chart review and/or telephone calls, fax or e-mails can be claimed if the patient is registered with the district integrated palliative care service. *(5.1.153)*

HOME CARE *(5.1.154)*

Physicians can claim for medical chart review and telephone call, fax or e-mail advice for patients registered in the home care program. Medical chart review and/or telephone call, fax, or e-mail advice for up to three per day per patient can be claimed at a total of 11.5 medical service units (MSUs) for each patient per day. Each additional group of up to three per patient per day can be claimed at 11.5 MSUs in total. Only services initiated by the care coordinator or health care professionals of Home Care Nova Scotia are eligible for this reimbursement. Physicians and Home Care Nova Scotia representatives are advised to keep a record of telephone calls, faxes, or e-mails. *(5.1.155)*

CANCER CARE *(5.1.156)*

Telephone advice and medical chart review of a cancer patient by the medical oncologist at the request of the physician(s) monitoring the patient's care outside the Cancer Care Centre. This is only payable when the call is initiated by the physician(s) in the patient's home community who are responsible for monitoring the administration of chemotherapy between visits to the oncologist. Both physicians must keep a detailed record of the phone call. *(5.1.157)*

Comprehensive reassessment of a cancer patient: This is a comprehensive visit by a medical or radiation oncologist with a cancer patient who is currently undergoing cytotoxic antineoplastic chemotherapy or radiation treatments. It may be claimed once every 21 days during the active treatment cycles. It may not be claimed for hormonal therapy, immunotherapy or when using other biological modifiers. *(5.1.158)*

GERIATRIC CARE *(5.1.159)*

Geriatrician's Initial Comprehensive Geriatric Consultation to Include Comprehensive Geriatric Assessment (CGA) (HSC 03.04D) *(5.1.160)*

This fee is 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 requires a minimum of 90 minutes of patient to physician contact. Time spent with family/care givers to obtain pertinent information that cannot be obtained from the patient will constitute time spent in direct contact with the patient for the purposes of billing this code. *(5.1.161)*

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. Neuromuscular 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. *(5.1.162)*

This is a 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. Time spent with family/care givers to obtain pertinent information that cannot be obtained from the patient will constitute time spent in direct contact with the patient for the purpose of billing this code. *(5.1.163)*

Family Physician's Initial Geriatric Inpatient Medical Assessment (HSC 03.04E) *(5.1.164)*

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. May be billed only once per patient per admission. May not be billed again for 6 months for the same patient. *(5.1.165)*

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 Professional Standard Regarding Medical Records - 2016, 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.

Not to be billed for transfers within the same hospital. *(5.1.166)*

Recognized Systems for the purpose of billing this code:

- Eyes
- Ears, nose, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic *(5.1.167)*

Long Term Care Geriatric Assessment (CGA) *(5.1.168)*

The Long-Term Care Clinical Geriatric Assessment (CGA) is an evidence-based clinical process that allows for interdisciplinary input to best assess the complexity of the nursing home resident. The CGA process and form, once completed, gives a point in time assessment of medical, functional and psychosocial needs of the resident which serves as a benchmark to treat to when the clinical condition changes. The physician is directly responsible for completing the medication list, diagnostic categories, cognition, emotional, behaviors, and provides the final overall opinion of the frailty level of the resident once the other disciplines have completed their assessments. The frailty level has been determined to be a predictor of the clinical trajectory of the resident, which is helpful in determining what course of care is reasonable, and a reference to use when discussing a resident's care plan with the resident, families and/or staff. The physician has the option to fill out the other fields on the CGA form as well. However, the CGA process is best served when all disciplines involved with the resident complete their sections so as to provide accuracy and encourage dialogue among the clinical team. The other providers who may provide input for the CGA include: nursing, social work, physiotherapy, occupational therapy, pharmacy and/or other health care disciplines consistent with their scope of practice. *(5.1.69)*

The CGA form should be near the front of every nursing home chart and will serve as the lead clinical document that will travel with the resident when a transfer (ER, other facility etc.) occurs. In this way accurate clinical information is provided to other caregivers the resident may need to be treated by. This will help ensure accurate communication of the resident's care directives, and all relevant baseline clinical information so any care outside the facility or by any on-call physician can be provided with this vital clinical information that will enhance the quality of care given. *(5.1.170)*

Billing Guidelines:

- Family physicians will be remunerated for the completion of a Long-Term Care Clinical Geriatric Assessment (CGA) for residents of licensed Nursing Homes and Residential Care Facilities (RCF's) funded by the Department of Health only.
- The CGA may be billed twice per fiscal year (April 1 – March 31), per resident. The initial CGA is recommended to be completed as soon as possible following Nursing Home or RCF admission once the physician and clinical team have had time to become familiar with the resident/patient.
- The CGA is normally completed through a collaborative team process involving the family physician and other licensed long-term care healthcare providers. The physician claiming the CGA fee is responsible for the diagnostic section (Cognitive Status, Emotional and Behaviors), the medication section, and providing the final overall opinion of the frailty level of the resident once the other disciplines have completed their assessment. Other sections of the CGA may be completed by the physician or by other licensed healthcare providers. *(5.1.171)*

The CGA requires one direct service encounter with the resident by the physician on the date of the final completion and signing of the CGA form. This service encounter is included in the CGA fee. The CGA evaluation process may involve additional service encounters (visits) which would be paid separately from the CGA per the Preamble requirements. The dates of all physician service encounters associated with the completion of the CGA must be tracked on the CGA form. *(5.1.172)*

- Prior to claiming the CGA fee, the physician must review, complete, and sign the CGA form in the long-term care facility on the date of the final CGA service encounter and place a note in the resident's clinical record (progress notes) corroborating that the CGA has been completed.
- The date of service is the date when the final CGA service encounter occurs and the CGA form is completed and signed by the physician.
- The CGA fee is billable by eligible fee-for service physicians and by eligible APP contract physicians, based on shadow billings. *(5.1.173)*

It is recommended that the CGA form is attached to any applicable transfer forms, including inter facility transfers whenever possible. *(5.1.174)*

Eligible APP Physicians will be required to shadow bill the new fee code in order to receive payment. Eligible claims will be reviewed and paid quarterly from MSI. *(5.1.175)*

Community-based Comprehensive Geriatric Assessment *(5.3.257)*

A community-based Comprehensive Geriatric Assessment (CGA) equips primary health care providers with a well-established, evidence-informed process to detect the early onset of health problems in their geriatric patients and potentially enable timely intervention to improve health. The CGA is a process of care available to all physicians, in which older adults health and function are assessed and a corresponding treatment plan is developed. The CGA and documentation thereof in a patient's health record may form part of the prolonged geriatric visit. Age-related health problems once identified through the CGA could be modified through targeted interventions. Evidence supports the role of early intervention in slowing the progression of health conditions and improving long-term health outcomes. *(5.3.258)*

It is recommended that the CGA process be initiated and documented as a baseline in all patients over the age of 65 who exhibit signs of frailty. If frailty is identified, development and implementation of a wellness plan is recommended with the CGA process repeated and documented yearly. In the non-frail elderly population, it is recommended that the CGA process be repeated every five years. The CGA should be made available to frail patients for inclusion in their Green Sleeve, for presentation when seeking acute care, and be attached to all consultation requests. *(5.3.259)*

The CGA tool is available to all primary care providers in paper-based or electronic format in their EMRs.

Long Term Care Medication Review *(5.1.176)*

This incentive is available for Family Physicians who complete medication reviews for residents of provincially licensed Nursing Homes and Residential Care Facilities (RCFs) only. Information about eligible facilities can be found on the Department of Health Continuing Care website at:

https://novascotia.ca/dhw/ccs/documents/Nursing-Homes-and-Residential-Care-Directories.pdf *(5.1.177)*

Billing Guidelines:

- To claim the fee, the physician must review, complete, date and sign the pharmacy- generated Medical Administration Recording System (MARS) drug review sheet for the resident.
- A maximum of two (2) medication reviews will be payable per resident per fiscal year, regardless of Nursing home or RCF facility of residence. A facility transfer does not necessarily require a new medication review if the existing medication review is up to date.
- The medication review fee is payable in addition to any associated visit fee, if applicable.
- The date of service is the date the MARS form is signed by the physician.
- A copy of the completed and signed MARS form needs to be readily available within the patient record (located in the Nursing Home)

NOTE: This fee can only be claimed for reviewing, completing and signing the pharmacy-generated MARS form. The fee is not to be claimed for re-ordering of medications requested by the nursing home or the completion of any other type of form. *(5.1.178)*

ADULTS WITH DEVELOPMENT DISABILITIES (HSC 03.03E and 03.04C) *(5.1.179)*

These fees apply to the care of adults with developmental disabilities by family physicians in the office, hospital, at home, or in residential care facilities. The following diagnostic codes are eligible:

- 29900 Autism
- 29980 Retts Disorder, Pervasive Developmental Disorder, Asperger's Disorder
- 3155 Mixed Developmental Disorder
- 3430 Cerebral Palsy (paraplegic, congenital)
- 3431 Cerebral Palsy (hemiplegic, congenital)
- 7580 Chromosomal Abnormalities
- 7580 Down's Syndrome
- 7583 Cri du Chat syndrome
- 7583 Velo-cardiofacial syndrome
- 7595 Tuberous sclerosis
- 75989 Noonan Syndrome
- 75981 Prader Willi
- 75983 Fragile X
- 75989 Angelman's Syndrome
- 76071 Fetal Alcohol Syndrome

To include those not specifically coded:

- Under 758:
  - Williams Syndrome
  - Deletion 22q11.2
  - Smith-Magenis Syndrome (17p deletion)
  - Charge (Hall Hittner) Syndrome
- Under 3155:

May include conditions that are frequently but not always associated with developmental or cognitive disability, such as:

- Cerebral Palsy, Neurofibromatosis
- Deletion22q11.2
- Chronic Brain injury (traumatic or hypoxic).

In these cases, the physician may be expected to record the ICD code, if one is available, and add "with Developmental Disability" or "with DD" in text. *(5.1.180)*

ADVANCE CARE PLANNING DISCUSSION (ADCP1) *(5.3.260)*

Advance Care Planning Discussion may be claimed when the patient's family physician, or if the patient is admitted to an acute care facility, their most responsible physician, has a face to face (in person) conversation with the patient (or the patients substitute decision maker either face to face or virtually) to discuss their wishes for future health care based on their beliefs and values, determines the substitute decision maker (SDM), documents the conversation in the patient's health record, and captures the outcome of that conversation by completing the initial Patient-Centred Priorities and Goals of Care (GOC) form. In extenuating circumstances, for established homebound patients only, as defined by the Preamble, this service may be rendered virtually by telephone or PHIA compliant video platform. The circumstances necessitating the virtual visit must be documented in the health record. Where possible, the GOC form should be submitted to the patient's hospital chart through the appropriate health records department. A copy of the document must be shared with the patient so that it may be added to their Green Sleeve folder, if applicable.

GP ENHANCED OFFICE VISIT FEES (ME=CARE) *(2.2.225)*

Family physicians who deliver comprehensive and continuous care to patients with whom they have an ongoing relationship will have an increase to several health service codes (See Section 8: Schedule of Benefits – Family Practice). The enhanced fees are only available to family physicians who attest, via confirmation letter, that they are providing comprehensive and continuous care to patients. To claim the enhanced fee, physicians should use the ME=CARE modifier on applicable claims. *(5.1.226)*

Comprehensive and continuous care is defined as having an ongoing relationship as a primary care provider to the patient and you ensure the continuity of their medical care. It does not include episodic care provided to walk-in patients. If your practice offers evening hours or walk-in service, you should bill the enhanced fee whenever you are seeing one of your own patients, or a patient of your practice (that is, you may bill the enhanced fee for any patient for whom you, or a colleague in your practice provide comprehensive and continuous care and maintain their medical record). *(5.1.227)*

When providing prenatal care to patients, physicians may bill the enhanced fees in the following scenarios:

i) When providing prenatal care to your own long-term patients;
ii) When providing prenatal care to patients of colleagues within your practice;
iii) When providing prenatal care to patients referred from the community from another family physician (i.e., temporary transfer) Document that you are prepared to assume comprehensive and continuous care of the patient for the duration of the patients pregnancy;
iv) When providing prenatal care to patients referred to you from a walk-in clinic without a family physician. Document that you are prepared to assume comprehensive and continuous care of the patient for the duration of the patients pregnancy. *(5.1.228)*

GP ENHANCED HOURS MODIFIER *(5.1.188)*

This modifier is intended to promote enhanced patient access to primary care outside of traditional office hours. This modifier is available for select services to physicians who have an ongoing relationship with their patients and select services for physicians providing care at walk-in clinics. *(5.1.189)*

Billing Guidelines:

- The eligible time periods are from 6a.m. to 8a.m. weekday mornings and 5p.m to 10p.m on weeknights where weekdays are defined as Monday through Friday. On Saturday, Sunday and Holidays (as defined by the MSI Physicians Bulletin) the eligible time period is from 9a.m to 10p.m
- Physicians should offer and book appointments during these time periods.
- Select services provided in walk-in clinics are eligible for the Enhanced Hours Modifier during these eligible time periods. *(5.1.190)*

The following visit services are eligible for the 25% Enhanced Hours Modifier:

- 03.03 Office visits – includes WBCR, ANTL, PTNT etc.
- 03.03A Geriatric office visits
- 03.03C Palliative care support
- 03.03E Adults with developmental disabilities
- 03.03J OAT initial visit
- 03.03K OAT transfer of care from program
- 03.03L OAT transfer of care
- 03.03V Medical abortion
- 03.04 Comprehensive visit
- 03.04I PSP Mental health visit
- 03.09C Palliative care consultation
- 08.41 Hypnotherapy
- 08.44 Group therapy
- 08.45 Family therapy
- 08.49A Counselling
- 08.49B Psychotherapy

The following visit services are eligible for the 25% Enhanced Hours Modifier when billed by the patient's family physician only. Walk-in clinics may not bill the following services:

- 03.03B Complex care
- 08.49C Lifestyle counselling *(5.1.229)*

Claims for eligible services should be submitted with the modifier TI=GPEW. *(5.1.191)*

NOTE: For services where the Enhanced Hours Modifier has been claimed, a record must be maintained and readily available to verify that the patient was seen for an appointment during a premium-eligible time period. The appointment time should be recorded in the patient's record. *(5.1.192)*

Contract physicians may shadow bill the GP Enhanced Hours Modifier as appropriate. *(5.1.193)*

Time Period	Time	Payment Rate Increase
Monday to Friday	6:00a.m – 8:00a.m	TI=GPEW (25%)
Monday to Friday	5:00p.m – 10:00p.m	TI=GPEW (25%)

Saturday and Sunday	9:00a.m – 10:00p.m	TI=GPEW (25%)
Recognized Holidays	9:00a.m – 10:00p.m	TI=GPEW (25%)

(5.1.230)

FAMILY PHYSICIAN CHRONIC DISEASE MANAGEMENT INCENTIVE PROGRAM *(5.1.195)*

The Chronic Disease Management Incentive is intended to recognize the additional work of General Practitioners, beyond office visits, of providing guidelines-based care to patients with chronic diseases. *(5.1.196)*

The CDM incentive is claimed through a fee code, HSC CDM1. APP contract physicians are also eligible for the incentive and are paid quarterly based on their aggregate shadow billings. *(5.1.197)*

CDM Incentive Billing Rules

1. The CDM Incentive fee can be claimed by family physicians only.
2. The base incentive fee may be claimed once per fiscal year (April 1 to March 31) for each patient managed for one qualifying chronic disease condition. An additional incentive amount per patient may be claimed once per fiscal year as part of the fee if the patient has additional qualifying chronic diseases (s) for each qualifying disease.
3. The family physician is expected to act as case manager to ensure care based on key guidelines is provided for patients with selected chronic diseases. The physician may or may not provide this care directly and will not be held responsible if patients do not follow through on recommendations, including for investigations, follow-up visits and/or referrals.
4. Patients must be seen a minimum of two times per year by a licensed health care provider (includes physicians) in relation to their chronic disease(s), including at least one visit with the family physician claiming the CDM incentive fee.
5. Every required CDM indicator does not necessarily have to be addressed at each visit but indicators should be addressed at the frequency required for claiming the annual CDM incentive.
6. Providing all eligibility requirements are met, the CDM incentive fee can be billed once per patient per fiscal year and must be submitted on or before March 31 of that year.
7. The qualifying chronic diseases eligible for the CDM incentive payment are:
   - Type 1 and Type 2 Diabetes defined as: FPG ^{3}7.0 mmol/L or Casual PG ^{3}11.1 mmol/L + symptoms or 2hPG in a 75-g OGTT ^{3}11.1 mmol/L; and/or,
   - Ischemic Heart Disease (IHD) characterized by reduced blood supply to the myocardium, most often due to coronary atherosclerosis, and as evidenced by: a failed stress test; abnormal EKG compatible with IHD; wall motion study; abnormal Smibi; abnormal myocardial perfusion scan; abnormal cardiac catheterization; and/or abnormal stress echocardiogram (includes post-MI <=5 yr);
   - Chronic Obstructive Pulmonary Disease (COPD), a respiratory disorder largely caused by smoking that is characterized by progressive, partially reversible airway obstruction and lung hyperinflation, systemic manifestations, and increasing frequency and severity of exacerbations. Spirometry is essential for diagnosis and requires both a postbronchodilator FEV_1< 80% and predicted FEV_1/FVC < 0.70.
8. For patients managed for COPD, a COPD Action Plan must be developed and then reviewed and completed annually, with a copy given to the patient ad a copy available in the patients record.
9. The CDM incentive can be claimed once per fiscal year (April 1 to March 31 inclusive) if the following conditions are met:
   - the patient is seen by the family physician in relation to their chronic disease(s) at least once in the fiscal year for which the CDM incentive is being claimed;

- the patient has had at least one other appointment with the physician or another licensed health care provider in relation to their chronic disease(s) in the previous 12 months; and,
- the CDM indicators required for the CDM incentive payment have been addressed at the required frequency and documented in the clinical record or optional CDM flow sheet at or before the time of billing. *(5.1.198)*

In order to claim a CDM incentive payment the following indicators/risk factors are required to be addressed as part of the annual cycle of care for diabetes and/or IHD. The required indicators include all relevant common indicators plus the specific indicators for each disease. *(5.1.199)*

Common Indicators for Diabetes and IHD

- Blood pressure – 2 times per year
- Lipids – once per year
- Weight/nutrition counseling – once per year

Common Indicators for Diabetes, IHD, and COPD

- Smoking cessation – discussed once per year if smoker (document smoker or non-smoker)
- Immunizations discussed and or given – once per year
- Exercise/activity – discussed, including possible referrals, once per year

Plus either of the following:

Indicators for Diabetes only

- HbA1C – ordered 2 times per year
- Renal function – ACR or Egfr ordered once per year
- Foot exam with 10-g monofilament – referred or completed once per year
- Eye exam – discussed and/or referred once per year for routine dilated eye exam

Indicators for IHD only

- Anti-platelet therapy – considered/reviewed once per year
- Beta-blocker – considered/reviewed once per year
- ACEI/ARB – considered/reviewed once per year
- Discuss Nitroglycerin – considered/reviewed once per year
- Consider further cardiac investigations – considered/reviewed once per year

Indicator for COPD only

- COPD Action Plan required – Develop and then review and complete once per year *(5.1.200)*

MEDICAL ASSISTANCE IN DYING (MAiD) *(5.1.231)*

Please refer to the College of Physicians and Surgeons of Nova Scotia Professional Standard regarding Medical Assistance in Dying.

Fees are paid for an increment of 15 minutes, with multiples for each additional 15 minutes up to 4 hours. Start and stop times must be recorded in the patient's medical record and on the MSI claim. Total duration of all components may be claimed. *(5.1.232)*

First Physician Assessor (03.03M) *(5.1.233)*

This fee is to compensate the first physician assessor for time spent providing MAiD services. It includes but is not limited to; the time spent engaging the patient in a discussion of their diagnosis, prognosis, and treatment

options, discussing the availability of palliative care for terminally ill patients, assessment of patient for MAiD criteria and arrangement for a second physician to assess the patient. *(5.1.234)*

Non face to face components include all documentation, discussion with other Regulated Health Professionals as necessary and the family as required. *(5.1.235)*

If the physician is a specialist and the patient has been formally referred the physician may bill the appropriate specialist prolonged consult fee with the same documentation requirements as noted above. MAiD must be noted in the text on the MSI claim. *(5.1.236)*

Second Physician Assessor (03.03O) *(5.1.237)*

This fee is to compensate the second physician assessor for time spent providing MAiD services. It includes but is not limited to; the time spent conducting the subsequent assessment of the patient for MAiD criteria. *(5.1.238)*

Non face to face components include all documentation, discussion with other Regulated Health Professionals as necessary and the family as required. *(5.1.239)*

Prescribing Physician (03.03N) *(5.1.240)*

This fee is to compensate the prescribing physician for time spent providing MAiD services. It includes, but is not limited to; procuring the medication and administration at the patient's request. This physician must also be either the first physician or second physician assessor. *(5.1.241)*

Non face to face components include all documentation required by the pharmacist and the administration process. *(5.1.242)*

RO=FPHN must have previously claimed for a MAiD service with the same patient. When a second physician assists at the time of administering the medication, RO=SPHN may be claimed. This fee is not intended to compensate for a second physician for administrative duties or procurement/return of medications as these activities are considered to be the responsibility of the FPHN. *(5.1.243)*

GENDER AFFIRMING CARE *(5.1.275)*

03.04K Gender transition readiness assessment, follow up of patients undergoing medical transition, and follow up of patients undergoing surgical transition where the primary care provider is required to provide postoperative care.

Gender transition readiness assessment, gender transition follow-up of patients who are undergoing medical transition, and postoperative care of patients who have had gender affirming surgery provided to them in or out of province.

Any necessary counselling or physical examinations are included in the 03.04K and should not be claimed separately. This code is to be used only for services provided that are directly related to Gender Affirming Care; it does not replace all visit codes for that patient.

The 03.04K has a base of 30 minutes of time spent by the physician in direct patient care with multiples of 15 minutes when the service encounter exceeds 30 minutes, to a maximum of 75 minutes. 80% of the time claimed must be in direct patient care. When claiming multiples on a time-based service, the start and stop times must be documented in the health record and submitted in the text on the msi claim.

Physicians providing Gender Affirming Care (GAC) and billing for GAC codes must be informed, knowledgeable and experienced in providing culturally competent and safe trans care and are required to complete and return the GAC Competency Declaration. *(5.1.276)*

OPIOID AGONIST TREATMENT (OAT) *(5.1.244)*

The required elements of HSC 03.03J, 03.03K and 03.03L include: *(5.1.245)*

- A complete substance use history including illicit, prescription, and OTC medications with a risk of abuse and a DSM diagnosis for each problematic drug
- A complete addiction treatment history
- Past medical and surgical history
- Family history
- Psychosocial history, including living situation, source of income and education
- Review of systems
- A focused physical examination
- Review of treatment options
- Formulation of treatment plan
- Communication with the patient and/or family to obtain information for the assessment as well as with support staff working in the treatment environment
- Communication with previous care providers, including family doctors, pharmacists, Mental Health and Addictions staff, etc. as necessary
- Obtain a patient profile for the previous 12 months through the Nova Scotia Prescription Monitoring Program (NSPMP) or Drug Information System (DIS)
- Obtain a urine drug screen
- The health care provider should request blood work serology (screening for HIV, and Hepatitis A, B and C) if not done recently by a previous provider
- Consider obtaining an ECG if indicated

Start and stop times are to be documented in the health record. It is recognized that the required elements may be gathered over several visits with the patient. This fee is for the initial visit only. *(5.1.246)*

Initial Opioid Use Disorder Assessment for Initiation of Opioid Agonist Treatment – Community Primary Care Setting Only (03.03J) *(5.1.247)*

This is a time-based fee for the complete assessment of the patient entering into opioid agonist treatment (OAT) for the first time as prescribed by their primary care provider. The required elements of the service must be documented in the patient's health record. *(5.1.248)*

Billable only by the health care provider who is most responsible for the patients ongoing OAT in the community primary care setting. Once per health care provider per patient. Not reportable if care provided in an Opioid Use Disorder Treatment Program. Multiples may be billed in addition to the base fee to a maximum of 60 minutes in total. 80% of the time must be in face-to-face contact with the patient and/or family. If time is less than 25 minutes, bill as a regular visit. *(5.1.249)*

Initial Opioid Use Disorder Assessment for Opioid Agonist Treatment – Transfer from Opioid Use Disorder Treatment Program to Community Primary Care Provider (03.03K) *(5.1.250)*

This is a fixed fee for the complete assessment of the patient being transferred from an established Opioid Use Disorder Treatment Program to the primary health care provider who will be most responsible for that patient's ongoing OAT. *(5.1.251)*

Reportable only by the health care provider who is most responsible for the patient's ongoing OAT in the community primary care setting. Once per patient per health care provider. Applies only to patients transferred from a recognized Opioid Use Disorder Treatment Program. Not reportable by health care providers who have previously seen the patient in a recognized Opioid Use Disorder Treatment Program. *(5.1.252)*

Permanent Transfer of a Patient on Active Opioid Agonist Treatment for Opioid Use Disorder – Full Acceptance of Responsibility for Ongoing Care – Initial Visit with Accepting Health Care Provider (03.03L) *(5.1.253)*

This is a fixed fee available to the primary care provider accepting full and ongoing responsibility for OAT for the patients substance use disorder from the community health care provider currently providing care, due to a patient's relocation or desire for permanent change in health care provider.

Regular visit fees may be billed as subsequent visits. *(5.1.254)*

Reportable only by the heath care provider who is most responsible for the patient's ongoing OAT. Once per patient per health care provider. Reportable only by the accepting health care provider. Not reportable for health care providers within the same group practice. Not reportable by health care providers who have previously seen the patient in a recognized Opioid Use Disorder Treatment Program. *(5.1.255)*

The required elements of OAT Monthly Management Fees OAT1 and OAT2 include: *(5.1.256)*

- All medication reviews and OAT dosage adjustments as required
- Communicating on a regular and timely basis with the pharmacy responsible for administering the patient's opioid agonist dose for the provision of safe and effective OAT: managing missed doses, checking on daily presentation at the pharmacy, helping coordinate prescriptions going to multiple pharmacies if there are Sunday or holiday closures or if a patient is travelling
- Providing and/or coordinating care for the patient's concurrent physical and mental health conditions
- Counselling the patient on issues related to their opioid use disorder
- Connecting the patient to appropriate community resources
- Providing case management and coordination of care functions, and facilitating connection with other addiction care providers
- Arranging random point of care (POC) urine drug screening (UDS) appropriate to the patient's phase of treatment; To include generation of random UDS encounters, collection of urine, interpretation of results, documentation of the process of randomization and results of the screen in the health care record, and provision of feedback to the patient based on the results

A visit may not be claimed if the sole purpose of the patient's office encounter is to provide a urine sample.

An annual discussion of treatment options with rationale for continued OAT must be documented in the health record. *(5.1.257)*

Monthly Management Fee for the Comprehensive Primary Care Provider Only (OAT1) *(5.1.258)*

This fee may be billed once per month by the comprehensive primary care provider, outside of the Opioid Use Disorder Treatment Program, who is most responsible for providing opioid agonist treatment as defined by the current DSM-criteria. The patient will be seen by the health care provider for a face-to-face visit or counselling session at least once per month (not including visits for urine drug screening alone). *(5.1.259)*

Only one claim per patient per month. Billable only by the comprehensive primary care provider working outside of the Opioid Use Disorder Treatment Program who is most actively supervising/responsible for the patient's use of OAT (ME=CARE). If there is no evidence to support randomization of the POC UDS then the fee will not be

paid. Not reportable for care provided in an Opioid Use Disorder Treatment Program. Payment stops when the patient stops OAT. Will not be paid unless at least 1 face to face visit or counselling session has been reported for the same patient by the same health care provider in the previous 30-day period. *(5.1.260)*

Monthly Management Fee for Provision of OAT Only (OAT2) *(5.1.261)*

Patient Referred by Another Health Care Provider with Written Progress Updates Supplied to the Primary Care Provider at least quarterly. *(5.1.262)*

This fee may be billed once per month by the health care provider, outside of the Opioid Use Disorder Treatment Program, who is most responsible for providing opioid agonist treatment as defined by the current DSM-criteria. The patient will be seen by the health care provider for a face-to-face visit or counselling session at least once per month (not including visits for urine drug screening alone). *(5.1.263)*

Written progress updates will be supplied to the patient's comprehensive primary care provider at least quarterly and documented in the health record. *(5.1.264)*

Only one claim per patient per month. Billable only by the health care provider working outside of the Opioid Use Disorder Treatment Program who is most actively supervising/responsible for the patient's use of OAT. If there is no evidence to support randomization of the POC UDS then the fee will not be paid. Not reportable for care provided in an Opioid Use Disorder Treatment Program. Payment stops when the patient stops OAT. Will not be paid unless at least 1 face to face visit or counselling session has been reported for the same patient by the same health care provider in the previous 30-day period. *(5.1.265)*

Urine Drug Screen Tray Fee (UDS1) *(5.1.266)*

When the physician has incurred the cost of supplies when performing a UDS, a tray fee can be claimed. The tray fee may not be claimed if the UDS kits have been provided free of charge. *(5.1.267)*

The HSC UDS1 is an add on for 03.03J, 03.03K, 03.03L, OAT1 and OAT2. *(5.1.268)*

Maximum of 1 UDS tray fee per patient for health service codes 03.03J, 03.03K and 03.03L. *(5.1.269)*

Maximum of 4 UDS tray fees per patient per 30 days for health service codes OAT1 and OAT2. Special permission is required if greater than 4 tests have been provided to a patient in 30 days. *(5.1.270)*

Insertion of Buprenorphine Implant for Treatment of Opioid Use Disorder (13.59P) *(5.1.271)*

This health service code is for the insertion of the non-biodegradable buprenorphine delivery implant for the treatment of opioid use disorder (e.g., Probuphine).

Removal of Buprenorphine Implant (13.59Q) *(5.1.272)*

This health service code us for the removal of the non-biodegradable buprenorphine delivery implant.

For removal and reinsertion of the non-biodegradable buprenorphine delivery implant, report the removal code at 100% and the insertion code at LV50. *(5.1.273)*

Codes may not be claimed in addition to OAT1 or OAT2 by any physician for the same patient for 6 months following implantation. If the implant is removed early or there are special circumstances to consider, the physician should add text to the OAT management claim explaining the circumstances. *(5.1.274)*

USE OF OFFICIAL INTERPRETER SERVICES WHEN CARING FOR PATIENT OF LIMITED ENGLISH PROFICIENCY (OFI1) *(5.)*

This incentive is available to health care professionals who utilize the services of an official interpreter, as designated by the NSHA or IWK, when providing care to a patient of Limited English Proficieny (LEP). LEP refers to individuals who do not speak English as their primary language and have a limited ability to read, apeak, write or understand English. This definition includes individuals who are deaf or hearing impaired and communicate using American Sign Language. Contact with the interpreter may be in person or via real time PHIA compliant technology. The interpreter's official identification must be documented in the patient's health record.

ASSESSMENT RULES FOR SPECIALIZED SERVICES *(5.2.0)*

GENERAL RULES REGARDING SPECIALIZED SERVICES *(5.2.1)*

PAYMENT OF SPECIALIST FEES (SEE SECTION 3 (3.1.16)) *(5.2.2)*

Under MSI, insured services provided by specialists would only be payable at the rate listed for visits under that particular specialty when the service provided is within the field of the specialty concerned. If such services are not considered to be within the specialty field, payment will be made at appropriate family practice rates. Physicians who are not specialists but do specialist work will not be paid specialist rates. Specialist visit rates are payable only to those physicians whose names appear on the specialist register of the College of Physicians and Surgeons of Nova Scotia and where there has been a referral of the patient to the specialist by the attending physician, nurse practitioner, midwife, optometrist or dentist. Patients seen at the initiative of the specialist without a referral will not entail payment of specialist rates. *(5.2.3)*

The MSI physician number of the referring doctor, the MSI midwife number of the referring midwife, optometrist provider number, dentist provider number or the MSI nurse practitioner number of the referring nurse practitioner, who is subject to a collaborative practice agreement with a physician as approved by the Diagnostics and Therapeutics Committee of the College of Registered Nurses of Nova Scotia ("the Nurse Practitioner") and who has the agreement of the physician to refer patients to specialists, must appear on the service encounter. If the number of the referring doctor, the nurse practitioner, midwife, optometrist, or dentist is not indicated, then the service encounter will be returned for resubmission. Where no prior service by the referring doctor, nurse practitioner, optometrist, dentist or midwife can be identified, a confirmation of referral may be requested. *(5.2.4)*

CLINICAL SUPERVISION *(5.2.5)*

1. **ELIGIBLE CLAIMS**:
    a. A physician who supervises a Medical Trainee who renders an insured service is eligible to submit a claim for the insured service as if the physician had performed the insured service personally, subject to any terms, conditions and limitations fund in this Clinical Supervision section.

    b. The terms, conditions and limitations described in this Clinical Supervision section are for the sole purpose of defining when an insured service is payable by Nova Scotia Medical Services Insurance (MSI). These terms and conditions do not alter the College of Physicians and Surgeons of Nova Scotia professional standards and guidelines, or any requirements of Dalhousie Medical School providing undergraduate or postgraduate education. *(5.2.6)*

2. **DEFINITIONS**:
    a. **Supervision**: is performed by the supervising physician and includes the responsibility to guide, observe and assess the clinical activities of the Medical Trainee.
        i. Supervision of the Medical Trainee may occur in person, by telephone, or PHIA compliant virtual care video platform, provided that the Supervising Physician and the Medical Trainee are physically present in the same clinical facility at the time the insured service is rendered.
        ii. Supervision provided in a setting approved by Dalhousie Medical School.
        iii. The Supervising Physician and Medical Trainee must be physically present in Nova Scotia.

    b. **Medical Trainee**:
        i. A Medical Trainee is defined as the following:
            1. Undergraduate medical students registered with Dalhousie Medical School;

2. Residents in an accredited postgraduate specialty or subspecialty training program through Dalhousie Medical School;
3. Practice ready assesses participating in the remaining cohorts or the Practie Ready Assessment Program (PRAP).
4. Other practice ready assesses not part of the Physician Assessment Centre of Excellence (PACE).

ii. A Medical Trainee does not include:
1. Clinical Observers
2. Clinical fellows
3. PACE assessees
4. Physician extenders such as physician assistants or associate physicians, and their learners
5. other healthcare providers, and their learners *(5.2.7)*

3. BILLING GUIDELINES:

a. An insured service rendered by a Medical Trainee is only eligible for payment to the Supervising Physician where Supervision is provided as defined in the other areas of this Clinical Supervision section.

b. Where a Medical Trainee with an MSI provider number is providing insured services independently and outside their training program, the insured service is not eligible for payment to a Supervising Physician as there is no supervision provided.

c. Provider to provider insured services are not eligible for payment to the Supervising Physician when rendered by a Medical Trainee (e.g., 03.09K, 03.09L etc.). *(5.2.8)*

4. INSURED SERVICES

a. An insured service rendered by a Medical Trainee is only eligible for payment to the Supervising Physician when the Supervising Physician:
i. Is aware the Medical Trainee will render the insured service; and
ii. Is physically present in the same clinical facility as the Medical Trainee at the time the insured service is rendered; and
iii. Is immediately available to personally respond to the patient when requested by the patient, the Medical Trainee or other healthcare professionals.

b. An insured service that includes the completion of a form is not eligible for payment to a Supervising Physician if rendered by a Medical Trainee unless the form has been reviewed and signed by the Supervising Physician.

c. When there is more than one Medical Trainee participating in the rendering of an insured service, only the insured service (and the time units or multiples, if applicable) rendered by one Medical Trainee are eligible for payment to the Supervising Physician.

d. Any time taken in general medical education with the Medical Trainee about the case, but not specific to the insured service, *is not eligible* for payment in this Clinical Supervision section.

e. As a reminder, as per the Canadian Medical Protective Association (CMPA), patients must be informed about the involvement of Medical Trainees in their care. *(5.2.9)*

5. DOCUMENTATION:

a. Supervision of the Medical Trainee by the Supervising Physician must be evident in the patient's medical record. This may include a physical visit to the patient and/or a chart review with detailed discussion between the Supervising Physician and the Medical Trainee and other member(s) of the healthcare team (where appropriate). *(5.2.10)*

b. An insured service is only eligible for payment to the Supervising Physician when the medical record of the patient(s) identifies all the following information at the time of the provision of the insured service:
   i. The Supervising Physician
   ii. The Medical Trainee and the level of training
   iii. The description of the insured service performed by the Medical Trainee *(5.2.11)*

c. The Supervising Physician must have signed off on the insured service rendered by the Medical Trainee in the patient's medical record. *(5.2.12)*

d. The service date used for claims is the date the Medical Trainee rendered the insured service to the patient. *(5.2.13)*

ANAESTHETIC SERVICES *(5.2.14)*

An anaesthetic consultation applies if a registered anaesthetist is requested by another physician to see a patient in consultation because of the complexity, obscurity, or significance of pre-existing medical problems prior to the administration of an anaesthetic. In these circumstances, the anaesthetist may claim a consultation fee as well as the anaesthetic fee. *(5.2.15)*

An anaesthetic consultation may also apply in situations where the anaesthetist has been referred a patient for the purpose of pain control or other anaesthesia specialty related services. *(5.2.16)*

The routine preanaesthetic evaluation does not qualify as a consultation, regardless of where and when this evaluation is performed, as this evaluation is included in the fee for the anaesthesia. Preanaesthetic clinic assessments for same day surgery shall not be deemed to form part of the fee for anaesthesia services. *(5.2.17)*

GENERAL RULES FOR ANAESTHETIC SERVICES *(5.2.18)*

The fees listed are for all types of anaesthetic services required for the performance of an insured procedure by another physician. *(5.2.19)*

a) A physician cannot claim for both the anaesthesia and the procedures performed under that anaesthesia, except where the procedure is an anaesthesia related procedure; e.g., fibreoptic bronchoscopy for airway management, pulmonary toilet, etc. *(5.2.20)*
b) All anaesthetic services are time based composite fees that normally include a preoperative evaluation, administration of anaesthetic substances, injections, transfusions, IVs, procedures such as intubation, laryngoscopy, use of anaesthesia monitoring equipment, other procedures related to the anaesthetic technique used and postoperative attendance. *(5.2.21)*
c) Postoperative attendance is interpreted as terminating at that time when the anaesthetist is no longer in personal attendance, having determined that the patient can safely be placed under the

customary postoperative supervision. Additional time for repeat visits to the patient in the recovery room, as the need occurs, may be added to the anaesthesia time. *(5.2.22)*

d) Approved preanaesthetic clinics for same day surgery are paid as sessional fees. *(5.2.23)*

e) Anaesthetic services must be provided in a hospital or facility approved by the Department of Health and Wellness. *(5.2.24)*

If general anaesthetic is deemed medically necessary when providing a dental service, the anaesthetic fee is payable whether the dental surgery is an insured or uninsured service. The anaesthetist must indicate the medical necessity in the text segment of the service encounter. *(5.2.25)*

CALCULATION OF ANAESTHETIC FEES *(5.2.26)*

Anaesthetic fees are determined by adding the basic units and anaesthesia time units. *(5.2.27)*

Basic Unit: Is listed for most procedures. It is the value assigned to each procedure to cover all anaesthetic services except the time actually spent either in administering the anaesthesia or in unusual detention with the patient. Additional procedures, not routine components of an anaesthetic procedure, will be billed either as additional anaesthesia procedures or as replacements for, or additions to, the basic units. These procedures include the following items, for which the basic rate will be increased or replaced by a unit value specific to the factors listed below: *(5.2.28)*

i. **Controlled Hypotension**: When using a specific technique to produce hypotension in association with an anaesthetic, the units will be increased. The use of CO=CHYO is intended for longer cases with excessive bleeding to minimize blood loss and reduce the need for transfusions provided there are no contradictions for this technique. It is also intended for specific cases in order to optimize surgical view. Text is required on the MSI claim. *(5.2.29)*

ii. **Resuscitation of Newborn**: When providing anaesthesia for a delivery, it becomes necessary to provide active resuscitation of the newborn, an additional fee may be added to the mother's service encounter for anaesthetic. If the anaesthetist was not involved in the mother's care, service encounters for resuscitation should be claimed under resuscitation in the normal manner. *(5.2.30)*

iii. **Anaesthesia for infants under 5,000 grams**: The units are increased. *(5.2.31)*

iv. **Anaesthetic for pacemakers**: When monitoring of pacemaker function with pacemaker monitoring programming equipment is performed in addition to the anaesthesia for pacemaker insertion, an additional fee may be claimed. *(5.2.32)*

v. **Cardiac Bypass**: When a pump with or without an oxygenator and with or without hypothermia is employed in conjunction with an anaesthetic, the anaesthetic basic units will be replaced. Note: Arterial catheterization, right cardiac catheterization (Swan Ganz) and central venous pressure monitoring may not be claimed in addition to the basic units for cardiac bypass. *(5.2.33)*

vi. **Hypothermia**: When employed in conjunction with anaesthesia, the basic unit will be replaced. *(5.2.34)*

vii. **Epidural Anaesthesia**: The basic units for obstetrical or non-obstetrical pain management for the introduction of catheter and maintenance care are different and will be distinguished by an appropriate modifier. *(5.2.35)*

HSC 16.91R: This service is paid as a flat rate of 166 MSU. To include the entire epidural insertion, all top ups, maintenance, normal vaginal delivery and removal of epidural catheter. To be billed only by the physician who initiates the epidural. Once per patient per labour. *(5.2.36)*

HSC 16.91J: The maintenance for this service is calculated as one anaesthetic unit for each subsequent injection or 1/2 hour of maintenance to a maximum of six units. *(5.2.37)*

viii. **Morbid Obesity:** When providing general, or neuraxial anaesthesia for a patient with a body mass index (BMI) greater than or equal to 40, the units will be increased. The health service code to claim for this add on is 99.09A. The Morbid Obesity add on fee is billable once per

patient per physician in addition to the amount payable for the major procedure(s) where a morbidly obese patient undergoes surgery to the neck, hip, or trunk and:

a. has a BMI (body mass index) greater than or equal to 40 and this is recorded in the patient's health record.
b. the procedure is performed using an open technique through an incision for major neck and hip surgery and an open or laparoscopic technique for the trunk and is performed under general, or neuraxial anaesthesia.
c. the principal technique is neither aspiration, core or fine needle biopsy, dilation, endoscopy, cautery, ablation, nor catheterization.
d. not billable for bariatric surgery. *(5.2.38)*

Anaesthetic Time Units: For the purposes of calculating anaesthesia time units, time should be calculated from the time documented in the perioperative record when both the patient and anaesthetist are present in the OR and the time ends when both the patient and anaesthetist leave the OR (See Section 1 (1.1.38)). In addition to this documented time an additional single time unit may be claimed for the preoperative assessment and anaesthesia setup, another single time unit may be claimed for the postoperative attendance of the patient. (See Section 5 (5.2.22)). These 2 additional units may be claimed without the need for any additional documentation requirements over and above that recorded in the perioperative record. *(5.2.39)*

In unusual circumstances where the preoperative care is prolonged or repeat trips back to PACU are required, additional time may be added to the anaesthesia time. This additional time must be clearly documented by the anaesthetist in the patient medical record with start and stop times. (See Section 1 (1.1.38)). *(5.2.40)*

It is understood that there may be overlapping time units in anaesthesia. *(5.2.41)*

If resuscitation is necessary during the anaesthetic time, add the time for resuscitation to the anaesthetic time. Resuscitation and anaesthesia time cannot be claimed simultaneously. *(5.2.42)*

When billing anaesthetic double set up for obstetrical complications and no further procedure is required, the appropriate HSC is 87.99A with a basic of four + time. If double set up has started and anaesthesia is required for delivery, time units only for the double set up should be added to the basic + time for the delivery. *(5.2.43)*

ANAESTHETIC SERVICES *(3.2.73)*

When claiming an anaesthetic service with a base unit of four or five, the rate is one unit per 15 minutes, or portion thereof, for the first hour. The rate for time over one hour is two units per 15 minutes, or portion thereof. *(3.2.74)*

When claiming an anaesthetic service with a base unit of six or greater, the rate is one unit per 15 minutes, or portion thereof, up to two hours. The rate for time over two hours is two units per 15 minutes, or portion thereof. *(3.2.75)*

Examples of Anaesthetic Base Units *(3.2.76)*

The number indicated in the multiple fields will determine the number of units paid: *(3.2.77)*

Base +	Time/Minutes	Anaesthetic Units	Multiple
4	0	4	1
4	15	5	2
4	30	6	3

Base +	Time/Minutes	Anaesthetic Units	Multiple
4	45	7	4
4	60	8	5
4	75	10	6
4	90	12	7
4	105	14	8
4	120	16	9

(3.2.78)

Base +	Time/Minutes	Anaesthetic Units	Multiple
5	0	5	1
5	15	6	2
5	30	7	3
5	45	8	4
5	60	10	5
5	75	11	6
5	90	13	7
5	105	15	8
5	120	17	9

(3.2.79)

Base +	Time/Minutes	Anaesthetic Units	Multiple
6	0	6	1
6	15	7	2
6	30	8	3
6	45	9	4
6	60	10	5
6	75	11	6
6	90	12	7
6	105	13	8
6	120	14	9
6	135	16	10
6	150	18	11
6	165	20	12
6	180	22	13
6	195	24	14
6	210	26	15
6	225	28	16
6	240	30	17

(3.2.80)

EXPLICIT MODIFIERS THAT CHANGE OR REPLACE THE BASIC UNIT OF AN ANAESTHETIC PROCEDURE *(3.2.33)*

1. Controlled Hypotension: When using a specific technique to produce hypotension in association with an anaesthetic, the basic unit is increased by 10. The explicit modifier for this is CO=CHYO. It is intended for longer cases with excessive bleeding to minimize blood loss and reduce the need for transfusions provided there are no contradictions for this technique. It is also intended for specific cases in order to optimize surgical view. *(3.2.34)*

2. Resuscitation of Newborn: The anaesthetist services include the usual and immediate care of the newborn. When active resuscitation is necessary, add three units. The explicit modifier for this is CO=INFE. *(3.2.35)*
3. Anaesthesia for infants under five kilograms or 5,000 grams. The anaesthesia fee is increased by five basic units. The explicit modifier for this is CO=UN5K. If the cardiac bypass pump is used use CO=BPU5. *(3.2.36)*
4. Monitoring for Insertion of Pacemaker: An extra five units is added to the anaesthetic fee when monitoring of pacemaker function is performed. The explicit modifier for this is CO=PACM. *(3.2.37)*
5. Cardiac Bypass: When a pump with or without an oxygenator and with or without hypothermia is employed in conjunction with an anaesthetic, the anaesthetic basic will be 35. The explicit modifier for this is CO=CRBY. *(3.2.38)*
6. Hypothermia: When hypothermia is employed in conjunction with anaesthesia, the basic unit will be 25. The explicit modifier for this is CO=HPTH. *(3.2.39)*

Note: If billing for a health service code that requires the explicit modifier indicated above, but not listed in the electronic health service code file, the original service encounter must be re-adjudicated with action code R indicating in electronic text the requested explicit modifier and the increase of units required. *(3.2.40)*

CLAIMING FOR PROCEDURES IN ADDITION TO ANAESTHETIC FEES *(5.2.44)*

When an approved add-on procedure is performed for the purpose of monitoring a patient intraoperatively or postoperatively, e.g., insertion of an arterial line, pulmonary artery catheter (Swan Ganz) or central venous pressure catheter, nerve block or insertion of epidural catheter for postoperative pain management, the appropriate HSC codes may be claimed in addition to the usual anaesthetic fee according to rules for payment of multiple diagnostic and therapeutic procedures. *(5.2.45)*

ANAESTHETIST'S PRESENCE REQUIRED *(5.2.46)*

Where a physician requests an anaesthetist to be available to provide monitored anaesthesia care at any period during which the physician is carrying out a procedure without general or regional anaesthesia, they shall be paid the usual anaesthetic fee for basic and time value for the complete period, whether or not anaesthesia is administered for any or all of that period. *(5.2.47)*

The anaesthetist should be in the operating room area. During this time no other procedures may be claimed. *(5.2.48)*

MORE THAN ONE ANAESTHETIST PRESENT AT THE SAME TIME *(5.2.49)*

When special circumstances require the services of more than one anaesthetist in the interest of the patient, the second anaesthetist will be entitled to claim 50 percent of the applicable anaesthetic fee, except in the case where specific second anaesthetist fee schedules exist, e.g., liver transplantation. *(5.2.50)*

CONSECUTIVE ANAESTHETIST *(5.2.51)*

Where one anaesthetist starts a procedure and is replaced by another during an anaesthetic procedure, the first anaesthetist should claim the appropriate basic fee plus time units for the time they are present, and the second anaesthetist should claim the time units for which they are present. The start time of the first anaesthetist shall dictate when double time units begin, for either and both anaesthetists. The second anaesthetist will start to claim double time units when the double time unit point is reached, based on the case start time, if not already beyond this point, in which case double time units would be claimed at the time of takeover. Accordingly, the consecutive anaesthetist must indicate the case start time as well as the consecutive start time. The end time for the first anaesthetist and the start time for the consecutive anaesthetist should coincide. *(5.2.52)*

ANAESTHETIC STAND BY FEE *(5.2.53)*

This fee applies only when a scheduled anaesthesia is not given or is delayed for more than one hour. The standby fee is claimed using the medical service unit value rather than the anaesthetic unit value and is calculated in half hour intervals or portion thereof. The specific anaesthetic stand by fee code is to be used. *(5.2.54)*

CANCELLED SURGERY *(5.2.55)*

a) If an anaesthetist examines a patient prior to surgery and
   i. Determines the patient is not a candidate for surgery and the operation is cancelled prior to the induction of anaesthesia, the anaesthetist may claim a limited consult; or
   ii. If the surgery is cancelled for some other non-anaesthetic reason prior to the induction of anaesthesia, they may claim a limited visit for this service. *(5.2.56)*

b) If the operation is cancelled after induction, regardless of whether the surgeon has started, the procedural basic units plus time units shall apply, except in the case where a higher basic fee would apply as might occur, for example, in the case of cardiac arrest resuscitation. *(5.2.57)*

BILATERAL/MULTIPLE PROCEDURES *(5.2.58)*

When bilateral or multiple surgical, diagnostic, or therapeutic procedures are performed during the same anaesthetic, the anaesthetist shall claim the basic units corresponding to the procedure having the highest basic, plus time units. When procedures are performed at separate times with separate anaesthetics, the anaesthetist is entitled to claim full anaesthetic units for each procedure. *(5.2.59)*

ANAESTHETIC DETENTION *(5.2.60)*

When the safety and welfare of the patient necessitates the presence of an anaesthetist immediately before or after anaesthesia for services not considered usual pre or postoperative care, it is appropriate to claim this time as anaesthetic time and add it to the total time claimed. *(5.2.61)*

If an epidural has not been inserted for labour or for the surgical delivery (caesarean section) but is inserted post-delivery for pain control, an anaesthetist may claim for maintenance of postoperative epidural pain control using time units only. *(5.2.62)*

An anaesthetist may claim a new basic for postoperative pain control following an initial anaesthetic service if there has been a time lapse from the time that they released the patient to the recovery room staff. *(5.2.63)*

ANAESTHETIC INDEPENDENT CONSIDERATION *(5.2.64)*

Anaesthetic independent consideration is for a health service code that has no listed anaesthetic unit value. For procedures indicated that have no listed value, the basic portion of the calculated value will be the same as that listed for a comparable procedure. The service encounter is submitted using the appropriate HSC with electronic text indicating the basic unit value as listed for a comparable procedure with consideration for region and modifying conditions or techniques. Documentation of the modifying factors is required by MSI (See Section 3 (3.2.25)). *(5.2.65)*

OBSTETRICAL SERVICES *(5.2.66)*

ROUTINE PRENATAL CARE *(5.2.67)*

a) Routine prenatal care includes care for less serious obstetrical complications incidental to the pregnancy, e.g., cystitis and simple anaemia, false labour, mild hypertension, leucorrhea, vaginal discharge and obesity. *(5.2.68)*

b) Only one prenatal comprehensive visit may be claimed per pregnancy. *(5.2.69)*

c) No more than 12 limited (routine) prenatal visits may be claimed for one patient's pregnancy regardless of the number of physicians involved. *(5.2.70)*

d) All prenatal visits include pregnancy related counselling or advice to the patient or patient's representatives. *(5.2.71)*

e) Any prenatal visit, limited or comprehensive, includes a Pap smear. The prenatal comprehensive assessment includes venipuncture as well. *(5.2.72)*

f) Complicated pregnancies may require more than the limit of 12 prenatal visits. Prenatal care does not include services rendered for major complications related to pregnancy requiring hospital care, visits or services for conditions unrelated to pregnancy, or care of the newborn. If billing for additional visits for major complications of pregnancy such as preeclampsia, extremely high blood pressure, diabetes, etc. include the diagnostic code for the complication on the service encounter. *(5.2.73)*

Visits for less serious obstetrical complications incidental to the pregnancy, e.g., cystitis, simple anaemia, false labour, mild hypertension, leucorrhoea, vaginal discharge and obesity are included in the 12 prenatal visits and additional visits may not be claimed for them. *(5.2.74)*

ATTENDANCE AT LABOUR AND DELIVERY *(5.2.75)*

This is a service involving constant or periodic attendance on a patient during the period of labour to provide all aspects of care. This includes the initial assessment, and such subsequent assessments as may be indicated, including ongoing monitoring of the patient's condition. *(5.2.76)*

Obstetrical delivery covers services rendered during delivery, including medical or surgical inductions by the attending physician, suturing of minor lacerations, hypnosis, detention time during labour except as identified in 5.1.75, local or regional anaesthesia and manual removal of placenta by the attending physician, and all obstetrical manoeuvers that may be required, e.g., use of forceps. *(5.2.77)*

OBSTETRICAL DELIVERY SPECIFIC RULES *(5.2.78)*

a) All deliveries performed between 1700 to 0800 hours; all day Saturdays, Sundays and holidays (See Section 6 (6.0.93)) qualify for the appropriate premium fee (See Section 5 (5.1.81)). *(5.2.79)*

b) Multiple deliveries
   i. Multiple vaginal births are paid additional fees.
   ii. In the case of multiple births, when both a vaginal delivery and a caesarean section must be performed, the C-section is claimed at full fee and the vaginal delivery at 65 percent.
   iii. When multiple babies are delivered by caesarean section, only one service encounter may be made with the addition of the fee for multiple births by caesarean section where appropriate. *(5.2.80)*

c) Obstetrical surgeries do not follow the usual surgical rules (See Section 5 (5.3.54 and 5.3.55)). Pre and postoperative visits with a pregnancy related diagnosis are paid in addition to the surgical procedure. *(5.2.81)*

d) Obstetrical non-surgical deliveries.
   i. Pre-delivery consultation for obstetrical non-surgical deliveries may be billed only in exceptional clinical circumstances.
   ii. The delivery fee may be billed only when the estimated gestational age is greater than twenty weeks. When the estimated gestational age is less than twenty weeks, only the appropriate procedural fee or visit code is payable. *(5.2.82)*

POSTPARTUM CARE *(5.2.83)*

In hospital postpartum care is the routine care of a well mother in the postpartum period. Visits may be billed starting on the first calendar day following birth. Although not normally claimed by more than one physician, general practitioners and delivering specialists may charge postpartum visits concurrently. *(5.2.84)*

POSTNATAL CARE VISIT *(5.2.85)*

A postnatal care visit usually occurs about six weeks following delivery. The service may include a pelvic examination with Pap smear. It may be billed only once following delivery by one physician. A diaphragm fitting or insertion of an intrauterine device can be claimed with a post-natal visit. *(5.2.86)*

SPECIALIST OBSTETRICAL CARE *(5.2.87)*

Specialist rates may be claimed only when there is both a referral and medical necessity for the referral. The fact that the patient has been referred does not in itself indicate the presence of obstetrical difficulties necessitating referral. The indications for the medical necessity must be stated on the service encounter. Where there is no medical necessity, transfer of a patient to a doctor who does not practice obstetrics is not a referral. *(5.2.88)*

OBSTETRICIAN OR GP PRESENT TO ASSIST AT DELIVERY *(5.2.89)*

The following services may be claimed in addition to the service encounter for delivery by the physician receiving assistance. *(5.2.90)*

a) When an obstetrician's presence is requested at a delivery, performed by another physician, they should claim an obstetrical delivery using the assistant modifier type and value RO=OBDA (role = obstetrical delivery assistant). *(5.2.91)*
b) When an obstetrician is present at a delivery to assist a general practitioner, they may claim a specialist obstetrical delivery. *(5.2.92)*
c) MSI recognizes and preauthorizes certain non-obstetricians in areas without specialist obstetrical services as being allowed to claim obstetrical assistance to another physician during labour and delivery. The rate claimed is equivalent to the specialist obstetrical delivery. *(5.2.93)*

OBSTETRICAL PATIENTS TRANSFERRED DURING LABOUR *(5.2.94)*

A transfer fee may be claimed for situations where a general practitioner admits and provides care for an obstetrical patient and then transfers that patient to another facility for delivery because of complications of the mother and/or fetus requiring specialist intervention. This fee is billable by general practitioners only. *(5.2.95)*

Detention may be claimed with this fee if the general practitioner accompanies the patient by ambulance to the second facility but is only payable for the time the physician spends on route to the second facility. *(5.2.96)*

The transfer fee, with or without detention, is not payable if the referring general practitioner attends the delivery at the second facility and is paid the delivery fee. *(5.2.97)*

PRENATAL ULTRASOUND *(5.2.98)*

Nuchal translucency: The 11-14 week prenatal screening ultrasound for the determination of nuchal translucency requires that images of the nuchal area, nasal bones, intracranial contents, abdomen, heart and upper and lower extremities must be obtained in addition to the standard images for ultrasound <13 weeks. This fee may be billed by fetal maternal medicine specialists and radiologists only. Operators must be certified by the

Fetal Maternal Medicine Foundation of Canada or the UK to perform NT measurements. Operators and the centre in which the service is provided, must supply evidence of current certification to MSI to be kept on file. Only physicians with qualifications as stipulated will be eligible for remuneration for this service. *(5.2.99)*

Genetic sonogram: The genetic sonogram for known or suspected fetal anatomic or genetic abnormality in high-risk pregnancies in multifetal pregnancies includes all standard biometry and anatomic review, a detailed fetal heart assessment, and an assessment of potential ultrasound markers (soft markers). Soft markers to include: Increased nuchal translucency, absent nasal bone, echogenic bowel, pyelectasis, ventriculomegaly, shortened long bones (humerus, femur), echogenic intracardiac focus, choroid plexus cysts. This fee may be billed only once per patient per pregnancy. Patients must be at an increased risk for genetic aneuploidy either by maternal age>40, or by past obstetrical or family history. To be billed only by fetal maternal medicine specialists and radiologists with the credentials to perform fetal ultrasound/echocardiography. The sonogram must be performed personally by the physician specialist for payment. The fee includes all necessary imaging. Routine ultrasound codes are not to be billed in addition to these patient specific codes. *(5.2.100)*

PAEDIATRIC SERVICES *(5.2.101)*

NEWBORN CARE *(5.2.102)*

Newborn care is the routine in hospital care of a healthy infant on a daily basis up to the first five days after birth. It includes a comprehensive assessment, limited visits as appropriate and necessary parental advice. Care of unhealthy infants who are born with an existing medical condition, or whose condition deteriorates after birth, should be claimed as any other hospitalized patient. Newborn care includes treatment of minor conditions *(5.2.103)*

Newborn care may not normally be claimed for the same patient by more than one physician per day. When a well baby is transferred to another hospital, service encounters for newborn care by a physician at each hospital may be appropriate. *(5.2.104)*

WELL BABY CARE *(5.2.105)*

Well baby care refers to periodic office visits of a well baby for routine measurement of growth and development, necessary parental instructions, and necessary immunizations. Well infant/childcare visits are payable as one per month during the first six months; one visit during each three-month period up to one year of age; and one visit at 18 months of age. It is recommended that the Rourke Baby Record be used to guide each visit and be documented in the health record. In order to provide optimal protection, age recommendations from the Nova Scotia Provincial Immunization Schedule must be followed.

A comprehensive well infant/child visit may be claimed for 2 visits between 0 and <6 months, 1 between 6 months and <12 months, 1 visit between 12 months and <18 months, and 1 visit between 18 months and <24 months. In order to claim the comprehensive well infant/child visit, a complete physical and developmental assessment must be performed, the Rourke Baby Record (RBR) must be used to guide the visit, completed in full, reviewed and signed by the physician and documented in the health record. Age-appropriate preventative care and education to the parent(s)/caregiver according to the RBR must be delivered and documented in the RBR and recorded in the health record

All other well infant/child visits to be claimed at the regular, applicable well baby care rate. *(5.2.106)*

PAEDIATRIC CARE BY A PAEDIATRICIAN *(5.2.107)*

a) If newborn and premature care is provided by a paediatrician (care of a healthy newborn in hospital) the paediatrician must claim at the same rate as newborn care for a general practitioner. No consultation is payable to the paediatrician if the infant is referred for the care of a healthy newborn. *(5.2.108)*

b) If newborn and premature care is provided by a paediatrician to an infant who appears initially well but becomes ill after a number of days with a condition that would normally require a consultation, a consultation may be claimed. *(5.2.109)*

c) Routine care is considered to include minor conditions; e.g., mild jaundice, cradle cap and mild skin conditions. *(5.2.110)*

ATTENDANCE AT HIGH-RISK DELIVERY *(5.2.111)*

a) Paediatrician
Attendance by a paediatrician at a high-risk delivery is payable as a comprehensive consultation and, if it is extended beyond one hour, it is payable as a prolonged consultation. *(5.2.112)*

b) Non-Paediatrician
Attendance by a non-paediatrician at a high-risk delivery is payable as a limited visit in hospital modified with the role of resuscitation. *(5.2.113)*

PAEDIATRIC CARE OF OVERAGE PATIENTS AGE 16 UP TO AND INCLUDING 18 YEARS OF AGE *(5.2.114)*

a) Services associated with the care of overage patients in hospital by a paediatrician are to be paid at paediatric rates. *(5.2.115)*

b) Paediatric consultations, whether comprehensive or limited, at any location for overage patients are to be paid at paediatric rates. *(5.2.116)*

c) Visits, excluding paediatric consultations, outside hospital for overage patients are not to be paid at paediatric rates except for:
   i. Behavioural management.
   ii. Follow-up visits in a paediatrician's office for approved overage patients with complex multisystem medical problems. Application must be made in writing to the MSI Medical Consultant and prior approval obtained for each patient. *(5.2.117)*

Application for approval must clearly state the diagnosis and provide sufficient clinical information to support complex multi-system medical problems.

ANTENATAL PALLIATIVE CARE *(5.2.118)*

Antenatal Palliative Care Limited Consultation and follow up visit codes (HSC 03.09H and 03.03H). *(5.2.119)*

This may be billed for the limited consultation and follow up visits provided by the paediatric palliative care specialist to the mother of the fetus diagnosed with a potentially lethal anomaly or condition. The consultation covers the physical, emotional, social, spiritual issues related to the birth of a newborn diagnosed with a potentially lethal condition. To be billed by the paediatric palliative care physician using the MSI number of the mother for services rendered during the antenatal period. Consultation may only be billed once per mother per pregnancy. A list of qualified specialists is to be kept on file at MSI. The fetal diagnosis must be recorded in text and on the mother's health record. *(5.2.120)*

COMPREHENSIVE EVALUATION OF SUSPECTED AUTISM SPECTRUM DISORDER (HSC 03.04J) *(5.2.160)*

This is a comprehensive health service code for the developmental paediatrician who is present for all components of the diagnostic evaluation and assessment of patients referred with suspected autism disorder performed by a multidisciplinary team at the IWK Health Centre. This service is expected to encompass at least three hours of time with the patient and care providers plus one hour for scoring of assessment tools. This HSC may be reported only when the physician's time has been dedicated to this service encounter and no other concurrent clinical work. Time to generate a report and recommendations is considered to be included in the service. Start and stop times must be recorded in the health record. Reportable no more than once per patient

per 12 month period. Restricted to IWK and Developmental Paediatrics trained in the administration of the Autism Diagnostic Interview. *(5.2.161)*

GENETICS SERVICES *(5.2.162)*

Complex Genetic Counselling Consultation (03.09A) *(5.2.163)*

This code may only be used by a physician who is: certified in Medical Genetics by the RCPSC or certified in Clinical Genetics by the Canadian College of Medical Genetics and/or registered by the College of Physicians and Surgeons of Nova Scotia as a specialist in Medical Genetics (SP=MEGE) or Human Genetics (SP=HUGE). *(5.2.164)*

This is a specific and detailed activity, which includes interviewing of appropriate family members, and collection and assessment of adequate clinical and genetic data to characterize the problem, establish a likely diagnosis (or differential diagnosis), construct a family pedigree and assess (both qualitatively and quantitatively) the risks to the persons seeking advice. It includes imparting this information and the various options for dealing with the problem to the individuals and appropriate family members in such a way that they can make informed decisions about the genetic problem. It may, in addition or alternatively, include establishment or verification of a plan for further, investigative and/or therapeutic management. *(5.2.165)*

This type of consultation is to be distinguished from a routine genetics consult. It requires one of both of the following: Detailed, intensive review of patient data (including medical records and diagnostic studies) or detailed and lengthy review of appropriate medical literature because of the complexity and/or rarity of the problem. *(5.2.166)*

Because of the complexity involved in such a service is it expected that more than one hour is required for the completion of this consultation. A prolonged Complex Genetic Counselling Consultation may be reported if the encounter exceeds 90 minutes. Two additional 15-minute multiples may be reported for a total of 120 minutes. If reporting prolonged consultation service, start and stop times must be documented in the health record and the text field of the MSI claim. *(5.2.167)*

As is the case for all consultations, a request for consultation must be initiated by a referring physician, and a written report with the opinion and recommendations of the consultant must be sent to the referring physician. A written summary report may be also sent to the patient or family. This fee code may be claimed only once per patient. No other fee codes may be reported for the same patient for that time period. *(5.2.168)*

This service may be performed via PHIA compliant, synchronous, virtual care platform (ME=VTCR). *(5.2.169)*

Medical Geneticist Virtual Care Follow-up Visit (03.03W ME=VTCR) *(5.2.170)*

This is a time-based health service code for follow up visits by the geneticist post genetics consultation using a PHIA compliant, synchronous, virtual care platform. Report virtual face to face care with geneticist only, 80% of the documented clinical encounter time must be virtual face to face with the geneticist. Start and stop times must be documented in the health record and text field of the MSI claim. A total of four 15-minute time increments may be reported for any one encounter. Should the patient-physician encounter take longer than 60 minutes, report EC with text explaining the clinical circumstances. (SP=HUGE, SP=MEGE) *(5.2.171)*

Clinical Interpretation of Complex Genetics Tests (HSC 03.39T) *(5.2.172)*

E.g., microarray analysis, next generation sequencing, and exome sequencing) by geneticist, findings must be recorded in the health record and recommendations made in writing to the referring physician. *(5.2.173)*

This is a time-based code, per 15 minutes, to enable clinical reporting of the time spent by the geneticist who interprets complex abnormal genetic test results and relays that information in writing to the referring physician.

Start and stop times must be recorded in the health record. No other health service codes are reportable during that time period for that physician. (SP=HUGE, SP=MEGE). *(5.2.174)*

Review by Geneticist of Patient Encounter with Genetics Counsellor (HSC RGN1) *(5.2.175)*

This health service code is for the review by the geneticist of the patient encounter performed solely by the genetics counsellor. This service includes the review of any pertinent investigations and results. The letter back to the referring physician must be reviewed and co-signed by the geneticist and must indicate that the patient was seen by the genetics counsellor. It is not payable if the patient has been seen by the geneticist within 30 days. The encounter must be documented in the health record and indicate that the patient was seen by the genetics counsellor alone but the clinical information and letter to the referring physician were reviewed by the geneticist. (SP=HUGE, SP=MEGE). *(5.2.176)*

STIPENDS *(5.2.177)*

Teaching Stipend *(5.2.178)*

HEALTH SERVICE CODE	DESCRIPTION / MODIFIERS	PAYMENT
TESP1	Teaching Stipend for Medical Student	$90 per day
TESP2	Teaching Stipend for Resident Elective	$90 per day

Electronic claims for TESP1 and TESP2 should be claimed using health card number 0000002352 with date of birth April 1, 1969. Diagnostic code V623 is required. *(5.2.179)*

Claims for teaching stipend services are designated to remunerate for any teaching responsibilities incurred during the service date. These daily codes are available as both FFS and APP claims for physicians that meet the eligibility criteria. The maximum claimable amount per weekly period is $450 (i.e., only 5 teaching stipend claims per physician per week will be accepted). *(5.2.180)*

The teaching stipends are only available to those who have an academic appointment and are teaching Dalhousie residents and students. Fee for service family physicians and fee for service royal college specialists are eligible. APP physicians are able to shadow bill at the $90 daily rate. AFP physicians are not eligible for this fee code for work done in the AFP, likewise FFS physicians working within one of the FFS Academic Departments are not eligible. Physicians who are part time Academic Department and part time FFS are eligible for work done outside of the Academic Health Centre/IWK and not otherwise compensated through their clinical department or AFP (for example, a physician in their private clinic teaching a student/resident). *(5.2.181)*

Dalhousie will confirm the list of physicians approved to claim the teaching stipend to MSI, as well as any updates to the list as they occur. *(5.2.182)*

Primary Maternity Care (PMC) Program *(5.2.183)*

The Primary Maternity Care (PMC) program is a funding model that provides an increased daily and on-call stipend for doctors who provide primary maternity care services in eligible Nova Scotian regional hospital communities. This is intended to ensure all PMC patients, with or without a family doctor, can receive comprehensive regional primary maternity care (including newborns) as required to meet community needs 24/7/365 across the province. The PMC program has been designed to stabilize primary maternity care services at participating sites. The PMC funding model is available to family physicians providing primary maternity care at the following regional hospitals:

- South Shore Regional Hospital, Bridgewater
- St. Martha's Regional Hospital, Antigonish
- Cumberland Regional Hospital, Amherst
- Yarmouth Regional Hospital, Yarmouth
- Cape Breton Regional Hospital, Sydney *(5.2.184)*

Physicians participating in the PMC program will be paid a daily stipend. Each month, the site's Representative Physician (or designate) will submit a payment form to Medavie. *(5.2.185)*

The PMC model is designed to support the primary maternity care services in eligible Nova Scotian regional hospital communities. Physicians will sign a declaration demonstrating their agreement toward contributing to the site delivery plan and overall requirements of the program. *(5.2.186)*

Additional details can be found in Schedule H of the 2023-2027 Physician Agreement.

Community Hospital Inpatient Program (CHIP) *(5.2.187)*

The Community Hospital Inpatient Program (CHIP) us a funding model that supports 24/7/365 care in eligible community hospitals across the province. The program provides an increased daily and on-call stipend for family physicians who provide inpatient care at these facilities. The overall goal of CHIP is quality and safe patient care for all patients, attached and unattached. *(5.2.188)*

Physicians participating in the program will be paid a daily stipend. Each site has been approved for a fixed daily rate. Rates vary by site dependant on the number/acuity of patients. Each month, the site's Representative Physician will submit a payment form to Medavie. *(5.2.189)*

The CHIP model is designed to support the delivery of inpatient care in eligible Nova Scotian community hospitals. Each site develops a site delivery plan outlining the services they will provide and expectations for participation in the program. Physicians will sign a declaration demonstrating their agreement toward contributing to the site delivery plan and overall requirements of the program. *(5.2.190)*

Additional details can be found in Schedule G of the 2023-2027 Physician Agreement.

Facility On-Call *(5.2.191)*

Facility On-Call payments are made directly to MSI as Fee-for-Service electronic claims. Health service codes are established for each rota and physicians are paid per the categories as specified in the Nova Scotia Facility On-Call Program Guidelines. *(5.2.192)*

Although the Facility On-Call Program is for 24-hours, the funding being provided is intended to recognize "after-hours" emergency calls/services, not routine consultation, or the routine care of inpatients. "After-hours" is defined as weekday (Mon-Thurs) evenings/nights (1700 – 0800), weekends (Fri, Sat, Sun) (24 hours) and holidays (24 hours) beginning at 0800. It is meant to provide remuneration for the physician where personal time is disrupted by having to provide on-call services. *(5.2.193)*

Claims for Facility On-Call should be submitted with the generic health card number 0000002352, date of birth April 1, 1969 and diagnostic code V689. Use the service date that aligns with the beginning time of the shift covered (i.e., weekday coverage claims should be made with the service date that aligns with the 1700 start time) *(5.2.194)*

This process does not apply for on-call services remunerated within program funding (e.g., AFP, ICU-APP Option Levels 1-3). *(5.2.195)*

The following options exist where rotas have organized themselves to share in the call payments for any given shift(s):

- Use the 50% modifier when billing; both physicians would claim the Facility On-Call fee and use the modifier PO=HALF.
- Multiple physicians regularly share in the call stipend: using a group BA; the most responsible physician would claim the stipend for the shift. MSI will make the payment to the group bank account. It is left to the group administrator to disburse funding to the participating physicians. *(5.2.196)*

The Health Service Code can be billed once per eligible physician per rota per 24-hour period. *(5.2.197)*

For quarterly and annual review purposes, DHW will require documentation. This will include written on-call schedules and, for callback claims, documentation of the reason for each callback. Physicians should keep records of their call participation and what portion of call shifts are fulfilled. Additionally, all service claims made while on-call should use the appropriate modifiers where applicable (e.g., nighttime claims should use nighttime and/or urgent modifiers). *(5.2.198)*

CATEGORY	HEALTH SERVICE CODE	DESCRIPTION / MODIFIERS	PAYMENT
FACILITY ON-CALL CATEGORY 1			
1	F1001	Anaesthesia Weekday	$350
		Anaesthesia Weekend/Holiday (DA=RGE1)	$500
1	F1002	General Surgery Weekday	$350
		General Surgery Weekend/Holiday (DA=RGE1)	$500
1	F1003	Internal Medicine Weekday	$350
		Internal Medicine Weekend/Holiday (DA=RGE1)	$500
1	F1004	Obstetrics/Gynecology Weekday	$350
		Obstetrics/Gynecology Weekend/Holiday (DA=RGE1)	$500
		RO=OBS1 (Yarmouth and IWK only) Weekday	$350
		RO=OBS1 (Yarmouth and IWK only) Weekend/Holiday (DA=RGE1)	$500
		RO=OBS2 (IWK only) Weekday	$350
		RO=OBS2 (IWK only) Weekend/Holiday (DA=RGE1)	$500
		RO=GYN1 (Dartmouth and IWK only) Weekday	$350
		RO=GYN1 (Dartmouth and IWK only) Weekend/Holiday (DA=RGE1)	$500
1	F1005	Family Medicine-Primary Maternity Care Weekday	$350
		Family Medicine-Primary Maternity Care Weekend/Holiday (DA=RGE1)	$500
1	F1006	Hospitalist Weekday	$350
		Hospitalist Weekend/Holiday (DA=RGE1)	$500
1	F1007	Diagnostic Imaging Weekday	$350
		Diagnostic Imaging Weekend/Holiday (DA=RGE1)	$500
1	F1008	Family Medicine O.R. Call Assists Weekday	$350
		Family Medicine O.R. Call Assists Weekend/Holiday (DA=RGE1)	$500

1	F1009	Family Medicine (Mental Health) Weekday	$350
		Family Medicine (Mental Health) Weekend/Holiday (DA=RGE1)	$500
1	F1010	Orthopedics Weekday	$350
		Orthopedics Weekend/Holiday (DA=RGE1)	$500
1	F1011	Pediatrics Weekday	$350
		Pediatrics Weekend/Holiday (DA=RGE1)	$500
1	F1012	Psychiatry Weekday	$350
		Psychiatry Weekend/Holiday (DA=RGE1)	$500
1	F1013	Urology Weekday	$350
		Urology Weekend/Holiday (DA=RGE1)	$500
1	F1014	Ophthalmology Weekday	$350
		Ophthalmology Weekend/Holiday (DA=RGE1)	$500
1	F1015	Palliative Care Weekday	$350
		Palliative Care Weekend/Holiday (DA=RGE1)	$500
1	F1016	Nephrology Weekday	$350
		Nephrology Weekend/Holiday (DA=RGE1)	$500
1	F1017	Otolaryngology Weekday	$350
		Otolaryngology Weekend/Holiday (DA=RGE1)	$500

FACILITY ON-CALL CATEGORY 2

2	F2011	Pediatrics Weekday	$300
		Pediatrics Weekend/Holiday (DA=RGE1)	$350
2	F2013	Urology Weekday	$300
		Urology Weekend/Holiday (DA=RGE1)	$350
2	F2014	Ophthalmology Weekday	$300
		Ophthalmology Weekend/Holiday (DA=RGE1)	$350
2	F2017	Otolaryngology Weekday	$300
		Otolaryngology Weekend/Holiday (DA=RGE1)	$350
2	F2018	Vascular Surgery Weekday	$300
		Vascular Surgery Weekend/Holiday (DA=RGE1)	$350
2	F2004	Obstetrics/Gynecology Weekday	$300
		Obstetrics/Gynecology Weekend/Holiday (DA=RGE1)	$350
2	F2019	Plastic Surgery Weekday	$300
		Plastic Surgery Weekend/Holiday (DA=RGE1)	$350

2	F2020	Neonatology Weekday	$300
		Neonatology Weekend/Holiday (DA=RGE1)	$350
2	F2021	Neurosurgery Weekday	$300
		Neurosurgery Weekend/Holiday (DA=RGE1)	$350
2	F2022	Neurology Weekday	$300
		Neurology Weekend/Holiday (DA=RGE1)	$350

FACILITY ON-CALL CATEGORY 3

3	F3012	Psychiatry Weekday	$200
		Psychiatry Weekend/Holiday (DA=RGE1)	$250
		Psychiatry Callback (US=CALL)	$150
3	F3023	Pathology Weekday	$200
		Pathology Weekend/Holiday (DA=RGE1)	$250
		Pathology Callback (US=CALL)	$150
3	F3024	Child Psychiatry Weekday	$200
		Child Psychiatry Weekend/Holiday (DA=RGE1)	$250
		Child Psychiatry Callback (US=CALL)	$150
3	F3016	Nephrology Weekday	$200
		Nephrology Weekend/Holiday (DA=RGE1)	$250
		Nephrology Callback (US=CALL)	$150
3	F3017	Otolaryngology Weekday	$200
		Otolaryngology Weekend/Holiday (DA=RGE1)	$250
		Otolaryngology Callback (US=CALL)	$150
3	F3025	Radiation Oncology Weekday	$200
		Radiation Oncology Weekend/Holiday (DA=RGE1)	$250
		Radiation Oncology Callback (US=CALL)	$150
3	F3026	Medical Oncology Weekday	$200
		Medical Oncology Weekend/Holiday (DA=RGE1)	$250
		Medical Oncology Callback (US=CALL)	$150
3	F3027	Tissue Bank Weekday	$200
		Tissue Bank Weekend/Holiday (DA=RGE1)	$250
		Tissue Bank Callback (US=CALL)	$150
3	F3028	Hyperbaric Unit Weekday	$200
		Hyperbaric Unit Weekend/Holiday (DA=RGE1)	$250
		Hyperbaric Unit Callback (US=CALL)	$150
3	F3029	Urology Transplant Weekday	$200
		Urology Transplant Weekend/Holiday (DA=RGE1)	$250
		Urology Transplant Callback (US=CALL)	$150

3	F3030	Ophthalmology – Orbital Reconstruction Weekday	$200
		Ophthalmology – Orbital Reconstruction Weekend/Holiday (DA=RGE1)	$250
		Ophthalmology – Orbital Reconstruction Callback (US=CALL)	$150
3	F3040	Inpatient Withdrawal Management Weekday	$200
		Inpatient Withdrawal Management Weekend/Holiday (DA=RGE1)	$250
3	F3041	Recovery Support Center Weekday	$200
		Recovery Support Center Weekend/Holiday (DA=RGE1)	$250

A physician may also claim a callback rate in addition to the Category 3 daily rate if they are required to return to the hospital while providing call services. To claim, first submit for the appropriate daily rate, followed by a second claim for the same health service code using the US=CALL modifier. Physicians not scheduled to provide Facility On-Call services may not claim a callback. *(5.2.199)*

FACILITY ON-CALL CATEGORY 4

4	F4CB1	Callback (US=CALL)	$350

Facility On-Call category 4 callback fee may only be claimed once per 24 hours. It is available to physicians whose specialty or subspecialty does not have a designated on-call rota. *(5.2.200)*

COMMUNITY HOSPITAL INPATIENT PROGRAM (CHIP)

FCHP1		Community Hospital Inpatient Program Weekday	$350
FCHP1		Community Hospital Inpatient Program Weekend/Holiday (DA=RGE1)	$500

COMMUNITY ON CALL CEC

C1001		Community On-Call for CEC Physicians Weeknight/Weekend/Holiday	$150

Community On-Call for CEC physicians should use the generic HCN 0015713084, DOB April 1, 1969 and Dx code V689 for billing purposes. For coverage running from 1700 to 0800 hours the following day, the claim should include the service date that aligns with the 1700 start time. Only one physician can bill the stipend her site, per night. Call coverage is remuneration $150 per night regardless of weeknight/weekend/holiday.

PSYCHIATRIC SERVICES *(5.2.121)*

DOCUMENTATION FOR PSYCHIATRIC AND COUNSELLING SERVICES *(5.2.201)*

From the documentation recorded for psychotherapy services, it should be evident that in the treatment of mental illness, behavioural maladaptation's, 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 wellbeing 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 of counselling services. *(5.2.202)*

PSYCHIATRIC CARE *(5.2.122)*

Psychiatric care is any form of assessment or treatment by a psychiatrist on the register of specialists of the Province of Nova Scotia, in which there is consideration and attempted alteration of the patient's biopsychosocial functioning. When psychiatric care extends beyond six months, the psychiatrist must document the rationale for continued specialist care in the patients health record, and in a brief written report to the patient's primary care provider at least every six months. *(5.2.123)*

PSYCHIATRIC ASSESSMENT *(5.2.124)*

Psychiatric assessment of an accused person when requested by the court requires the name of the judge involved in the case. *(5.2.125)*

THERAPEUTIC/DIAGNOSTIC INTERVIEW *(5.2.126)*

This service relates to a specific child and may take place with parents and/or caregivers allied health professionals, education, correction, or other community resources. This applies to interviews by psychiatrists but does not preclude medical resident involvement. *(5.2.127)*

SALARIED OR CONTRACT FACILITY BASED PSYCHIATRY *(5.2.128)*

This refers to non-fee-for-service psychiatric care provided in the context of public mental health services.

a) Physicians providing these services are remunerated on a salaried or contract basis.
b) No physician providing salaried or contract psychiatric services may claim on a fee-for-service basis for any services to a patient registered as a public mental health services client except by special arrangement between the director of the facility at which the patient is registered, MSI, and the psychiatrist involved. *(5.2.129)*

PSYCHOTHERAPY *(5.2.130)*

The following services apply to general practitioners and psychiatrists. Restrictions apply to general practitioners only (See Section 6 (6.0.36)). *(5.2.131)*

The provision of psychotherapeutic services by general practitioners is limited to 20 hours per patient or family or group per physician per year. To exceed this limit for individual patients or families or groups, the general practitioner must either: document on the chart and notify MSI, through the text field on the service encounter, that a psychiatrist concurs that extended psychotherapeutic services are needed; or, if the general practitioner is unable to access a psychiatric consultant directly, then the option will be available to obtain an exemption in a timely manner through MSI from a psychiatric consultant skilled in psychotherapy and its applications. *(5.2.132)*

INDIVIDUAL PSYCHOTHERAPY *(5.2.133)*

Individual psychotherapy is any form of treatment for mental illness, behavioural maladaptation's and/or other problems that are assumed to be of an emotional nature in which a physician deliberately establishes a professional relationship with a patient for the purposes of removing, modifying or retarding existing symptoms, of attenuating or reversing disturbed patterns of behaviour and of promoting positive personality growth and development. *(5.2.134)*

a) Individual psychotherapy is claimed in 15-minute intervals. The therapist must spend at least 80 percent of the time claimed in therapeutic intervention with the patient. Start and finish times must be recorded in the patient record and in the text field of the MSI claim *(5.2.135)*
b) Restrictions apply to general practitioners only:
    i. A minimum of two intervals must be claimed per visit.

ii. Treatment for medical complaints, acute adjustment reactions or bereavement reactions do not qualify as psychotherapy. They should more appropriately be claimed as counselling.
iii. Unless unusual clinical circumstances can be demonstrated to the medical consultant at MSI, individual psychotherapy may not be claimed for the following:
  - More than 90 continuous minutes or six continuous 15-minute intervals per patient per day.
  - A patient younger than four years old.
  - More than one general practitioner treating the same illness for a particular patient. *(5.2.136)*

GROUP PSYCHOTHERAPY *(5.2.137)*

Group psychotherapy differs from individual psychotherapy in that it is provided to a group of four to eight individuals per session. *(5.2.138)*

a) Group Psychotherapy is claimed in 15-minute intervals. The therapist must spend at least 80 percent of the time claimed in therapeutic intervention with the group of patients. Start and finish times must be recorded in each patient record and in the text field of the MSI claims. *(5.2.132)*
b) Restrictions apply to general practitioners only:
  i. A minimum of two intervals must be claimed per group session.
    - Unless unusual clinical circumstances can be demonstrated to the medical consultant at MSI, group psychotherapy may not be claimed for the following:
      - More than two continuous hours or eight continuous 15-minute intervals per group per day.
      - A group member younger than four years old.
      - More than one general practitioner treating the same illness for a particular group of patients. *(5.2.139)*

FAMILY THERAPY *(5.2.140)*

Family therapy is defined as psychotherapy in which the therapist regards the patients as a subsystem of a family and in which the therapeutic responsibility is not only to the patients but to other family members as well. *(5.2.141)*

a) The assessment rules are the same as for group psychotherapy, but two or more members of the family must be present for the session to qualify as family therapy. *(5.2.142)*
b) Family therapy is claimed in 15-minute intervals. The therapist must spend at least 80 percent of the time claimed in therapeutic intervention with the family. Start and finish times must be recorded in the patient record and in the text field of the MSI claim *(5.2.143)*
c) Restrictions apply to general practitioners only:
  i. A minimum of two intervals must be claimed per family session.
  ii. Unless unusual clinical circumstances can be demonstrated to the medical consultant at MSI, family therapy may not be claimed for the following:
    - More than two continuous hours or eight continuous 15-minute intervals per family per day.
    - A patient younger than four years old.
    - More than one general practitioner treating the same family group. *(5.2.144)*

HYPNOTHERAPY *(5.2.145)*

The following services apply to general practitioners and psychiatrists. Restrictions apply to general practitioners only. *(5.2.146)*

Physicians practicing hypnotherapy must provide proof of current full membership in the Canadian Federation of Clinical Hypnosis (CFCH) to bill hypnotherapy. These credentials can be forwarded to msi_assessment@medavie.bluecross.ca for review.

Hypnotherapy is therapy undertaken with a patient who has been placed in an altered state of consciousness. *(5.2.147)*

a) Hypnotherapy is claimed in 15-minute intervals. The hypnotherapist must spend at least 80 percent of the time claimed in direct therapeutic intervention with the patient. Start and finish times must be recorded in the patient record and in the text field of the MSI claim *(5.2.148)*
b) Physicians practising hypnotherapy must have at least 20 hours of training in clinical hypnotherapy and be an active member in good standing of a recognized Canadian Clinical Hypnosis society. *(5.2.149)*
c) Restrictions apply to general practitioners only:
    i. A minimum of two intervals must be claimed per session.
    ii. Unless unusual clinical circumstances can be demonstrated to the medical consultant at MSI, hypnotherapy may not be claimed for the following:
        - More than 10 hours per patient per physician per year.
        - More than 90 continuous minutes or six continuous intervals per patient per day.
        - A patient younger than four years old.
        - More than one general practitioner treating the same illness for a particular patient. *(5.2.150)*

MINDFULNESS BASED COGNITIVE THERAPY (MBCT) (08.44A) *(5.2.203)*

Mindfulness Based Cognitive Therapy is defined as a specific psychological intervention incorporating elements of cognitive behavioral therapy and mindfulness. The HSC 08.44A is for each two hour session of the eight week MBCT course provided for a group of 8-12 patients with recurrent episodes of depression. Fee is per patient, per two hour session. One series of 8 sessions per patient per 365 days. The session dates and start/stop times must be documented in the health record of each participant. Additional fees may be charged to the patient for non-billable services such as the provision of course materials and for the services of a privately paid non-MD therapist, if applicable. Session outline and activities are standardized to be completed in 2 hours. *(5.2.204)*

Physicians eligible to claim this code must submit credentials to MSI directly. *(5.2.205)*

PRACTICE SUPPORT PROGRAM (PSP) MENTAL HEALTH COMPREHENSIVE VISIT (03.04I) *(5.2.206)*

This code is for the complete assessment of the patient with a confirmed mental illness meeting the diagnosis criteria in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of sufficient severity and acuity to cause significant distress or impairment in social, occupational, or other important areas of functioning and warrant the development of a Mental Health care plan. It is not intended for patients with self-limited or short-lived mental health symptoms. *(5.2.207)*

The assessment is to be performed by the PSP trained family physician most responsible for the patient's mental health care. The Mental Health Plan and start and stop times must be documented in the health record. *(5.2.208)*

The complete assessment is to include all of the following elements and be documented in the health record prior to reporting the PSP Mental Health Plan visit service:

- The patient's DSM diagnosis, psychiatric history, and current mental state, including suicide risk assessment as appropriate
- Obtaining collateral history and information from caregivers as required
- Performance of a complete medication review to include collateral information from pharmacy and assisted living facility as appropriate
- Reviewing and documenting results of relevant validated assessment tools, laboratory, and other test results
- Documentation of a clinical plan for the patients care over the next year. Includes advanced care planning where appropriate
- Outline of expected outcomes as a result of treatment plan
- Outline of linkages with other health care providers and community resources who will be involved in the patient's care
- Confirmation that the plan has been created jointly and shared with the patient or their medical representative. The plan is to be shared with other care providers as appropriate
- A documented care plan must be in place before access to additional counselling hours is provided. *(5.2.209)*

If more than one visit is required to complete the required elements, only the final visit may be reported as the PSP health service code 03.04I, all other visits may be reported at the usual rate. The 03.04I is payable at 50 MSU for the first 30 minutes, 25 MSU for each additional 15 minutes up to a maximum of 1 hour. *(5.2.210)*

The PSP MHP visit is only reportable by the patient's PSP trained physician. It is not reportable with any other visit fee for the same physician, same patient, same day. Reportable once per patient per year. It is not reportable for services provided at walk-in clinics* or for patients living in nursing homes, residential care facilities or hospices. Start and stop times must be reported in the text field of the claim to MSI as well as in the health record. *(5.2.211)*

***Note**: The HSC may be claimed by physicians in episodic walk-in clinics if the patient is unattached (this must be documented in the health record and text on the claim). *(5.2.212)*

COUNSELLING *(5.2.151)*

The following services and restrictions apply to general practitioners only. *(5.2.152)*

a) Counselling is a prolonged discussion directed at addressing issues pertaining to the patients underlying mental illness, acute adjustment disorder or bereavement. Counselling may be claimed by family physicians for patients who meet the current DSM (Diagnosis and Statistical Manual of Mental Disorders) diagnostic criteria for the diagnosis of a mental health disorder. *(5.2.153)*

b) Counselling may be claimed in 15-minute intervals. At least 80 percent of the time claimed must be spent in direct patient intervention. Start and finish times must be recorded in the patient record and in the text field of the MSI claim. *(5.2.154)*
Restrictions:
Unless unusual clinical circumstances can be demonstrated to the medical consultant at MSI, counselling may not be claimed for the following:
   - More than five hours per patient per physician per year.
   - More than one hour per patient per day.
   - A patient younger than four years old.
   - More than one general practitioner providing counselling to a particular patient.

Physicians who have completed training in the Practice Support Program Adult Mental Health Module may have access to an additional 4 hours of counselling per patient per year. The physicians name must be in the Nova Scotia Health Authority database confirming completion of training. *(5.2.155)*

LIFESTYLE COUNSELLING *(5.2.156)*

The following services and restrictions apply to general practitioners only.

Lifestyle Counselling is a prolonged discussion where the physician attempts to direct the patient in the proper management of health related concern; e.g., lipid or dietary counselling, AIDS advice, smoking cessation, healthy heart advice, etc. This is only billable by the general practitioner providing on-going primary care to the patient. *(5.2.157)*

a) Lifestyle counselling may be claimed in 15-minute intervals. At least 80 percent of the time claimed must be spent in direct patient intervention. Start and finish times must be recorded in the patient record and in the text field of the MSI claim *(5.2.158)*

b) Restrictions:
Unless unusual clinical circumstances can be demonstrated to the medical consultant at MSI, lifestyle counselling may not be claimed for the following:

- More than two hours per patient per physician per year.
- More than 30 minutes per patient per day.
- A patient younger than four years old.
- More than one general practitioner providing lifestyle counselling to a particular patient at the same service encounter. *(5.2.159)*

ASSESSMENT RULES FOR PROCEDURES *(5.3.0)*

Procedures are a type of patient service distinguished from visits by several features. They generally have a specifically defined technique involving either a physical therapeutic intervention with the patient; the obtaining of some diagnostic sample, image or biophysiological measurement; or the interpretation of a sample, measurement, or image. A procedure may include elements of a visit, evaluation, or care depending on the specific procedure and the clinical setting. *(5.3.1)*

- Procedures fall into three categories for assessment purposes: diagnostic and therapeutic procedures, surgical procedures, and fractures. Subject to the rules in this section, procedures may be claimed in association with visit services, or with other procedures. *(5.3.2)*
- Procedures may be claimed only when they are carried out by, or under the supervision of, a physician. *(5.3.3)*

DIAGNOSTIC AND THERAPEUTIC PROCEDURES *(5.3.4)*

Diagnostic and therapeutic procedures are divided into two groups, procedures that cannot be claimed with a visit code and those where a visit service may be claimed if one is provided. *(5.3.23)*

a) Procedures designated as visit excluded cannot have a service encounter for any visit service from the same service encounter.
   i. When a visit excluded procedure is the sole reason for the service encounter, the procedure alone should be claimed.
   ii. If a visit service and a visit excluded procedure are provided at the same service encounter, only the service of greater value should be claimed. *(5.3.24)*

b) Procedures designated as visit allowed may have a service encounter for any visit related service from the same service encounter with the exception that the following procedures may not be claimed in association with a consult:
   i. Tonometry
   ii. Gonioscopy
   iii. Visual fields tangent, screen and/or perimetry
   iv. Flexible fibreoptic endoscopy of the nose, nasopharynx, and larynx
   v. Pap smear
   vi. Venipuncture of a person seven years or older
   vii. Medical certificate for observation for psychiatric evaluation 1st doctor
   viii. Medical certificate for observation for psychiatric evaluation 2nd doctor *(5.3.25)*

No premium fees may be claimed for diagnostic and therapeutic procedures other than selected diagnostic imaging services and selected endoscopic procedures (See Section 5 (5.1.81)). *(5.3.5)*

Diagnostic and therapeutic procedures can be performed in any location, with the exception of the following procedures which have location specific restrictions and may be claimed only when performed by a physician in the appropriate subspecialty: *(5.3.6)*

a) When performed outside of a hospital
   i. Electrocardiogram – internist and paediatrician.
   ii. Electromyogram – neurologist (including paediatric neurologist), physiatrist and neurosurgeon.
   iii. Electroencephalogram – neurologist (including paediatric neurologist) and neurosurgeon. *(5.3.7)*

b) When performed in hospital
   i. Stress Test – internist and physiatrist in approved centres as they have a cardiologist, access to a cardiologist, or an internist with a special interest in cardiology, who supervises the program. *(5.3.8)*
   ii. Procedures performed in a catheterization lab – cardiologist including paediatric cardiologist and radiologist. *(5.3.9)*

SUBMAXIMAL EXERCISE TESTING *(5.3.10)*

This service may only be claimed in approved centres. *(5.3.11)*

a) If the patient has been seen in consultation by the specialist performing the test within the previous 14 days, no visit service or consultation may be claimed. *(5.3.12)*
b) If the patient has not been seen by the specialist within the previous 14 days, a comprehensive initial visit or consultation service may be claimed. However, it should be noted that there must be a medical necessity for the comprehensive visit and components of this visit (See Section 5 (5.1.7)) must be performed and documented in the patient's chart. Similarly, if a consultation is claimed with an exercise test, the rules governing referred services (See Section 5 (5.1.91)) must be followed. *(5.3.13)*
c) If the patient has been examined by another specialist within the previous 14 days for a problem related to the condition for which the exercise test is being performed, a comprehensive initial visit service, but not a consultation, may be claimed. *(5.1.14)*

INTERPRETATION OF HOLTER MONITORING STUDIES *(5.3.15)*

Interpretation of Holter Monitoring may be claimed only when abnormalities are present. *(5.3.15)*

CARDIAC ABLATION PROCEDURES *(5.3.16)*

Cardiac ablation for complex cardiac arrhythmias (HSC 49.98I): This is a composite fee for the intracardiac catheter ablation of an arrythmogenic focus or foci. The fee may be claimed for the treatment of complex cardiac arrhythmias (not atrioventricular nodal reentry or atrioventricular reentry), atrial fibrillation, ventricular tachycardia, and cases of arrhythmia in patients with complex congenital heart malformations. This fee includes percutaneous right heart catheterization, transeptal left heart catheterization, all diagnostic imaging (including angiography), electrocardiograms, electrophysiologic mapping, ablation, and electric counter shock of heart as required. This fee does not apply to the treatment of reentrant supraventricular tachycardia (atrioventricular nodal reentry or atrioventricular reentry). This fee is not billable with:

- 49.95, A, B
- 49.96, A through H
- 49.97, A through G
- 49.98, A through H
- ADON 50.83, 50.91, 50.98A, 13.72 *(5.3.16)*

Where multiple diagnostic and therapeutic procedures are performed at the same service encounter, the procedure with the greater value is claimed at 100 percent and subsequent procedures at 50 percent. Procedures defined as add-ons in the schedule text may be claimed at 100 percent. *(5.3.17)*

Service encounters by assistants are not normally applicable to diagnostic and therapeutic procedures with the following exceptions. Assistant fees should be claimed at the current surgical assistant rate (See Section 5 (5.3.119)). *(5.3.18)*

a) Excisional breast biopsy after localization of a mammographic abnormality

b) Mediastinoscopy: when assisting with a mediastinoscopy, regardless of whether a flexible or rigid bronchoscopy is also performed, claim the assistant fee for mediastinoscopy alone
c) Fetal procedures under ultrasound guidance
d) Catheter ablation of cardiac arrhythmias
e) Percutaneous endoscopic gastrostomy
f) Percutaneous endoscopic gastrojejunostomy *(5.3.19)*

VENIPUNCTURE *(5.3.20)*

Venipuncture for the purpose of blood collection is not an insured service when performed by a physician with the following exceptions:

a) The physician's office is greater than 24 km (15 miles) from the closest laboratory blood collection service.
b) When the physical condition of the patient makes it medically necessary for the physician to personally take the sample. *(5.3.20)*

INSERTION OF NASOGASTRIC TUBE *(5.3.21)*

Nasogastric (Levine) tube insertion is considered part of the appropriate visit service encounter. *(5.3.21)*

INSERTION OF INTRAVENOUS *(5.3.22)*

Intravenous insertion may only be claimed when the physician has personally performed the service. These health service codes may not be claimed when they are carried out by another health care provider such as a nurse, nurse practitioner or X-Ray technologist as part of their usual duties. *(5.3.22)*

CATHETER INSERTION *(5.3.227)*

Health Service Code 69.94; insertion of indwelling urinary catheter, should only be claimed as a stand-alone procedure. Physicians may only claim for insertion of a catheter when they have personally performed the service. It may not be claimed when carried out by another health care provider such as a nurse, nurse practitioner, or X-Ray technologist as part of their usual duties. Text is required on all claims explaining why the physician had to personally perform the catheter insertion. If performed by a urologist, no other procedures may be claimed during the same encounter. *(5.3.228)*

LASER TREATMENT *(5.3.229)*

Laser treatment of malignant neoplasms of esophagus bronchi, etc. in addition to scope, HSC 44.0A is an add-on fee and should only be claimed after an appropriate base fee for bronchoscopy or esophagoscopy is paid. *(5.3.230)*

PROVINCIAL IMMUNIZATIONS *(5.3.26)*

Physicians may claim for the administration of immunizations covered by the Provincial Immunization Program. These services may be claimed by any registered physician. *(5.2.27)*

If one vaccine is administered but there is no associated office visit billable, i.e., the sole purpose of the visit is the immunization, one injection can be claimed at a full fee. *(5.3.28)*

If one or more vaccines are administered in conjunction with an office visit, the office visit and the first injection can be claimed at full fee. All subsequent injections will be paid at 50 percent of the specified MSU. *(5.3.29)*

If two vaccines are administered at the same visit but there is no associated office visit, a claim for each specific immunization can be submitted at full fee. All subsequent injections will be paid at 50 percent of the specified MSU. *(5.3.30)*

For children 18 months of age and under, if a vaccine is administered in conjunction with a well baby care visit, the well baby care visit and the immunization may be claimed. *(5.3.31)*

Provincial Immunization Tray Fee *(5.3.32)*

When a physician has incurred the cost of supplies when administering an immunization covered by the provincial program, a tray fee can be claimed for each injection. There is to be no charge to the patient or family for the supplies and/or disposables associated with any of these immunizations. Enter multiples for additional tray fees. Maximum of four tray fees can be claimed per service encounter. *(5.3.33)*

PAP SMEARS *(5.3.34)*

An office visit may be claimed in conjunction with a Pap smear only if the visit is for a non-gynaecologic complaint. A Pap smear may not be claimed in addition to a visit, consultation or procedure for a gynaecologic or obstetrical diagnosis nor is it payable in addition to a complete physical examination. *(5.3.35)*

A visit for a Pap smear and an unrelated medical condition can include a claim for the office visit, Pap smear and Pap smear tray fee. *(5.3.36)*

Pap Smear Tray Fee *(5.3.37)*

When a physician has incurred the cost of supplies when performing a pap smear, a tray fee can be claimed. There will be no charge to the patient for any supplies, equipment or disposables associated with the performance of a pap smear. *(5.3.38)*

A Pap smear tray fee can be claimed when a pap smear is performed alone or as part of a comprehensive examination, an office visit, or a gynaecological procedure. *(5.3.39)*

COMPREHENSIVE PELVIC EXAMINATION WITH SPECULUM *(5.3.256)*

For the performance of a comprehensive pelvic examination in either a symptomatic patient, or screening for sexually transmitted infections, when a PAP smear is not indicated nor required.

Visual inspection of the vulva and perineum, insertion of the speculum into the vagina to inspect the vault and cervix, bimanual examination of the pelvis when required, and conduction of a pelvi-rectal examination where indicated are elements to be documented in the heath record.

The comprehensive pelvic examination 03.26C is not billable with PAP smear 03.26A or tray fee 03.26B. *(5.3.256)*

ELECTROMYOGRAPHY *(5.3.40)*

When referring to electromyography with muscles of more than one region, or examination of a specific region, region is intended to mean one or more of the four following anatomical areas: head and neck, both upper limbs, both lower limbs or trunk anterior and posterior. *(5.3.41)*

When referring to nerve condition studies, per nerve studied is intended to mean both the motor and sensory nerve conduction examination of a single nerve, mixed, motor or sensory. Multiples may be claimed when another nerve, mixed, motor or sensory is examined and when separate nerve conduction studies of a major nerve branch are required.

Health service codes 07.08A, 07.08B and 07.08C are to be used when the appropriate studies are performed as part of a diagnostic work-up. It is not appropriate to use these codes as proxies for intraoperative nerve integrity testing. Such testing is considered an integral part of surgical procedures performed near vital nerve structures. *(5.3.42)*

PACEMAKER VISIT AND PROGRAMMING *(5.3.231)*

Health Service Codes 49.83B and 49.83C visit and programming to a pacemaker include a visit in their description. It is not appropriate to make a separate claim for a visit or consult service at the same encounter. *(5.3.232)*

Health service codes for pacemaker battery change and leads replacement/adjustment include any necessary programming. It is not appropriate to make a separate claim for pacemaker programming. *(5.3.233)*

SLEEP STUDIES *(5.3.43)*

Health service codes exist in Nova Scotia for Level 1, Level 2, and Level 3 sleep studies. When claiming these studies, the following requirements apply:

Health service code 03.19C is for a Level 1 study (overnight polysomnography) a full sleep study in a hospital sleep laboratory with a sleep technician in continuous attendance. At a minimum, all of the following must be recorded: 2-3 leads of electroencephalogram, 2 leads of electrooculogram, submental EMG, ECG, airflow nose and mouth by thermistor or nasal pressure cannulae, respiratory effort, oxygen saturation, snoring, anterior tibialis electromyogram and body position. Physicians must have formal fellowship level training and be credentialed to interpret Level 1 sleep studies by the Nova Scotia Health Authority in order to claim this health service code.

Health service code 03.19F is Level 2 sleep apnea testing. At a minimum all of the following must be measured: electrooculogram, heart rate, air flow, respiratory effort, oxygen saturation, anterior tibialis EMG, and body position. Physicians must have completed fellowship level training including interpretation of sleep studies.

Health service code 03.19G is Level 3 sleep apnea testing. All of the following parameters must be measured: heart rate, air flow, respiratory effort, oxygen saturation, body position. Physicians must have completed fellowship level training including interpretation of sleep studies. *(5.3.44)*

AUDIOMETRY *(5.3.234)*

HSC 09.41E is described as Impedance audiometry including tympanometry, static compliance, multiple frequency acoustic reflex and/or reflex decay testing including interpretation. HSC 09.41F is described as Impedance audiometry interpretation only of tympanogram, impedance/compliance and stapedial reflex tests. HSC 09.41G is described as Impedance audiometry including tympanometry, static compliance, single frequency acoustic reflex and/or reflex decay testing including interpretation. *(5.3.235)*

HSC 09.41E and 09.41G should only be claimed when the physician personally performs and interprets the test. HSC 09.41F should only be claimed when the physician personally interprets the tests (09.41E or G). Only one of these codes may be claimed per patient per day. *(5.3.236)*

All components of a complete hearing test: pure tone audiometry (air and bone), tympanometry, and a speech test must be performed in order to claim health service code 09.41D. *(5.3.237)*

It is not appropriate to claim Health Service Code 09.41H Tympanometry only if another code was claimed during the same encounter that includes tympanometry. *(5.3.238)*

PERIPHERAL NERVE BLOCKS *(5.3.45)*

If at the time of performing temporary nerve blocks (HSC 17.72C) additional injections are needed to secure adequate analgesia, either at the trunk level or more peripherally, this is included in the original nerve block code and not payable as a multiple. Additionally, only one occipital nerve block per side may be claimed. *(5.3.46)*

TRIGGER POINT INJECTIONS *(5.3.47)*

The correct health service code when claiming for injection of trigger points is 17.72J (myofascial injections). Health service codes 93.92A (injection into joint or ligament) and 95.94A (injection into soft tissue) are not to be used when carrying out trigger point injections. *(5.3.48)*

INJECTION OF BOTOX *(5.3.239)*

MSI insures the injection of Botox by physicians for the following clinical indications only:

- focal spasticity related to stroke, multiple sclerosis, spinal cord or traumatic brain injury,
- laryngeal dystonia,
- equinus foot deformity in cerebral palsy patients 2 years of age and older,
- cervical dystonia,
- blepharospasm, hemifacial spasm (VII nerve disorder) or strabismus in patients 12 years of age and older,
- achalasia,
- urinary incontinence due to neurogenic detrusor overactivity resulting from neurogenic bladder associated with multiple sclerosis (MS) or subcervical spinal cord injury (SCI) in patients who have failed to respond to behavioral modification and anticholinergics and/or are intolerant to anticholinergics,
- idiopathic overactive bladder unresponsive to behaviour modification, medications and peripheral nerve stimulation. *(5.3.240)*

INTRAVENOUS INFUSION FOR CHRONIC PAIN MANAGEMENT *(5.3.241)*

In the performance of Health Service Code 13.59N intravenous infusion of local anaesthetic/adrenergic drugs for chronic pain management procedure, patients are to be monitored with both an electrocardiogram and a pulse oximeter. An intravenous line is established and an infusion pump is used to deliver the drug. The physician must be in attendance or readily available to intervene to ensure that side effects do not occur and to make the necessary adjustments in the dosage of the medication. The patient must be monitored 10-15 minutes after the infusion is completed and then transferred to a 'post-recovery area' where they are continued to be monitored for a further 30 minutes before being discharged. *(5.3.242)*

ACUTE STROKE PROTOCOL *(5.3.243)*

Health service code 13.99F assessment and management of patient with acute stroke, from activation of Acute Stroke Protocol through completion of thrombolytic therapy (e.g., t-PA) is specific for the assessment and management of a patient experiencing symptoms of acute stroke, and for whom the Acute Stroke Protocol has been activated. The service includes ongoing evaluation, clinical monitoring, diagnostic evaluation, review of diagnostic imaging and completion of thrombolytic therapy (e.g., t-PA) and is reportable by one physician per patient per day. Must complete thrombolytic therapy in order to report this HSC, if patient does not receive thrombolytic therapy, only the pertinent visit code is reportable. Is it reportable from provincial stroke centres only. *(5.3.244)*

Health service code 13.99G assessment and management of patient with acute stroke, from activation of Acute Stroke Protocol through receiving endovascular thrombectomy (EVT) with or without administration of thrombolytic therapy is specific for the assessment and management of a patient experiencing symptoms of acute stroke and for whom the Acute Stroke Protocol has been activated. The service includes ongoing evaluation, clinical monitoring, diagnostic evaluation, review of diagnostic imaging, with or without thrombolytic therapy, and supervision of patient receiving EVT and is reportable by one physician per patient per day. Patient must undergo EVT to report this HSC. It is specialty restricted to Neurologists and the Halifax Infirmary. *(5.3.245)*

SURGICAL SERVICES *(5.3.49)*

SURGICAL SERVICES MAJOR *(5.3.50)*

Surgical procedures are described as major if they have a value in excess of 50 units: *(5.3.51)*

The procedure fee is intended to cover the operation and customary preoperative, operative and postoperative care by the surgeon or a designated covering physician. *(5.3.52)*

a) A consultation at any time prior to surgery may be claimed, even if the surgery is on the same day. A visit other than a consultation is not payable the same day as a major surgical procedure. *(5.3.53)*
b) Preoperative care includes:
    i. Comprehensive visit (the admission history and physical exam)
    ii. Hospital visits for up to two calendar days immediately prior to and including the day of surgery
    iii. Hospital visits in a preoperative period that extends beyond two days should be claimed using the appropriate visit codes *(5.3.54)*
c) Postoperative care includes care during the postoperative hospital stay up to 14 days. *(5.3.55)*
d) Urgent visits or emergency hospital visits (See Section 5 (5.1.52)) to attend the patient for an unrelated condition are not included in the surgical benefit and may be claimed accordingly. *(5.3.56)*
e) Hospital visits may be claimed starting on the 15th postoperative day for visits if the post-operative in hospital stay exceeds 14 consecutive calendar days. For the purpose of calculation, the day of the last operative procedure is considered day zero. Weekly routine visit maximums beyond 56 days apply starting from the date of admission. *(5.3.57)*
f) When a patient is readmitted to hospital during the first 14 days of the post surgical period because of postoperative complications which do not require a surgical procedure, the surgeon or other physician attending this readmitted patient should claim hospital visits as for a new admission. *(5.3.58)*

SURGICAL SERVICES MINOR *(5.3.60)*

Surgical procedures are described as minor if they are less than or equal to 50 units: *(5.3.61)*

a) When a visit service is provided during the same service encounter as a minor surgical procedure for a reason other than the condition for the minor surgery, the greater of either the visit or the minor surgery may be claimed, otherwise only the minor surgery service encounter applies. However, in the case of a service encounter for suture of a laceration with a value less than or equal to 50 units, the appropriate visit may also be claimed. *(5.3.62)*
b) A consultation prior to surgery may be claimed, even if the surgery is on the same day, except where the consultation is explicitly included as part of the procedure. *(5.3.63)*
c) Postoperative care following minor surgery may be claimed, except for those minor surgical procedures which specify complete care (See Appendix D Complete Care Codes (7.4.0)) and include all postoperative visits by the same physician in the 14 days following the procedure. *(5.3.64)*
d) The services of an assistant at minor surgery are not usually required. *(5.3.65)*

SURGICAL SERVICES MAJOR OR MINOR *(5.3.66)*

Special restrictions or interpretations applicable to major or minor surgery: *(5.3.67)*

a) Procedural codes and their associated tariff are intended to remunerate the physician for all parts of the procedure that would normally be considered the defined technique for that procedure. It is not appropriate to deconstruct (unbundle) the procedure into constituent parts and bill MSI for these codes in addition to the procedural codes. *(5.3.68)*
b) Local anaesthesia is not payable in addition to the surgical fee. *(5.3.69)*
c) Endoscopic procedures performed on a patient on the same day as major urological surgery by the same physician may be claimed at 50 percent in addition to the major surgical fee except where the surgery is done in a separate operating room. Other diagnostic and therapeutic procedures may be claimed at 100 percent with other major urology surgery. *(5.3.70)*
d) When one physician performs a definitive procedure on an organ or within a body cavity, only that service should be claimed. The procedure used to provide surgical exposure should not be claimed;

e.g. a laparotomy is not to be claimed to provide access to the abdominal cavity except when no definitive procedure is performed within the abdomen. When one physician provides surgical exposure for a procedure performed by a physician in another specialty, the exposure and definitive procedures may be claimed separately by the respective physicians. *(5.3.71)*

e) Fees for the application of casts, splints and dressings at the time of surgery may not be claimed. *(5.3.72)*

f) Fees for the application or removal, by the operating surgeon, of casts, splints and dressings during the 30 days following surgery may not be claimed. *(5.3.73)*

g) Vascular Procedure Service encounters
   i. Repair/bypass/graft includes thromboendarterectomy and/or anastomosis and/or thrombectomy of the peripheral artery being repaired and harvesting of vein unless otherwise specified in the procedure description.
   ii. Common femoral artery repair includes repair to the profunda artery before the second major branch of the profunda artery.
   iii. If the profunda artery repair extends beyond the second major branch of the profunda artery, an extended profundoplasty fee may be claimed in addition as the second procedure.
   iv. When resection of an abdominal aneurysm is combined with an aortic graft plus femoral artery repair (unilateral or bilateral) only one procedure, whichever has the higher unit value, should be claimed. *(5.3.74)*

h) Arthroscopy
   i. Composite arthroscopy fees include the procedure and arthroscopy.
   ii. When other or multiple surgical procedures are performed through the arthroscope, only the major fee applies. *(5.3.75)*

i) Injections of medication into a bursa, ganglion, joint, or tendon may not be claimed with surgery performed in the same location. This applies whether the medication is delivered via arthroscope or directly into the location. *(5.3.76)*

j) Compression Sclerotherapy (Feganization)

k) Codes for compression sclerotherapy for varicose veins are designed to cover all services for that diagnosis, for the same leg, for a period of one year. *(5.3.77)*

l) Bilateral Procedures
   i. Unless otherwise specified, bilateral procedures are claimed at an additional 70 percent of the unilateral procedure.
   ii. When bilateral procedures are performed subsequent to a major procedure through the same incision they should be claimed at 70 percent and 35 percent.
   iii. When bilateral procedures are performed subsequent to a major procedure through a separate incision, they should be claimed at 70 percent and 35 percent.
   iv. When performed under separate anaesthetics at an interval, the full fee will be charged for each procedure. *(5.3.78)*

m) Multiple Surgical Procedures Same Physician
   i. When multiple operative procedures are performed through a single incision in the course of an abdominal operation or on any one organ or cavity, the principal procedure will be claimed plus 70 percent for the secondary procedures (secondary incidental procedures, such as appendectomy, which are not indicated by pathology, shall not be claimed).
   ii. A physician who performs multiple operative procedures simultaneously in different areas and through different incisions shall claim for the major procedure plus an additional 70 percent for each of the lesser procedures. Laparoscopic operations are considered to utilize a single incision regardless of the number of incisions.
   iii. When an appendectomy is claimed with another abdominal surgery, a pathology report must be available that supports the rationale for the appendectomy. *(5.3.79)*

n) The full procedural fee will apply when subsequent, related operative procedures are performed during the postoperative period. *(5.3.80)*

o) Combinations of multiple and bilateral procedures should be claimed based on the rules applicable to the highest valued procedure. *(5.3.81)*

p) Unrelated surgical procedures different physicians
When two or more unrelated procedures are performed through separate incisions or in unrelated areas, but utilizing the same anaesthetic, by two different physicians in different fields of practice and with different skills, the fee provided in the schedule under each procedure will be paid at 100 percent to each physician. *(5.3.82)*

q) An arthrodesis procedure includes bone grafting. *(5.3.83)*

r) Percutaneous urteroscopy with ultrasonic lithotripsy and/or uteroscopy with electohydraulic lithotripsy (HSC 68.85B) should not be claimed with HSC 68.98C, 68.99A, 68.99C as all are inherent parts of this procedure.

s) HSC 98.22, 98.22A, 98.22B, and 98.22D may only be claimed when suturing of lacerations is provided as a stand-alone procedure. They may not be claimed where skin suturing is an integral aspect of another procedure such as removal of a cutaneous lesion. Physicians may claim multiples when multiple lacerations are sutured. It is not appropriate to claim multiples for each suture.

t) Health service codes 69.0A cystoscopy with removal of foreign body/calculus, 01.34A cystoscopy with or without catheterization of ureters, and 01.34B cystoscopy with urethral dilation, cannot be claimed in the same encounter as 72.1B endoscopy transurethral electro-resection, and vice versa.

u) Debridement
All claims for debridement, HSC 98.11, must indicate in electronic text the area debrided, the start and finish time, and whether performed under a local or general anaesthetic. Only the time from the start to the finish of the debridement may be claimed. *(5.3.84)*

v) The Morbid Obesity add on fee is billable once per patient per physician in addition to the amount payable for the major procedure(s) where a morbidly obese patient undergoes surgery to the neck, hip, or trunk and:
a. has a BMI (body mass index) greater than or equal to 40 and this is recorded in the patient's health record.
b. the procedure is performed using an open technique through an incision for major neck and hip surgery and an open or laparoscopic technique for the trunk and is performed under general, or neuraxial anaesthesia.
c. the principle technique is neither aspiration, core or fine needle biopsy, dilation, endoscopy, cautery, ablation, nor catheterization.
d. not billable for bariatric surgery. *(5.3.85)*

CANCELLED SURGERY *(5.3.86)*

a) In the event of cancellation of surgical procedure before it has started, regular visit rules apply for surgeons.

b) In the event of cancellation of surgical procedure after it has commenced, the procedural units for the intended principal procedure will apply. *(5.3.87)*

FRACTURES *(5.3.88)*

SURGICAL RULES *(5.3.89)*

Surgical rules (See Section 5 (5.3.49)) apply to treatment of fractures except:

a) A fracture procedure, not dislocation, includes necessary after care up to 14 days. The application and removal of casts or traction devices is included in the fee, even if removal takes place after the 14 day period.

b) Regardless of the type of anaesthesia employed, all fracture service encounters are eligible for premium fees during the designated times. *(5.3.90)*

MAJOR FRACTURES *(5.3.91)*

Major fractures are defined as those requiring procedures in excess of 50 units. Rules for major surgery apply and an appropriate consult may be claimed preoperatively. A comprehensive consultation is appropriate only for those patients who are referred with significant systemic illness or requiring general anaesthesia. A limited consultation is appropriate only for those patients who are referred and where the diagnosis is unclear, or management alternatives require prolonged discussion or assessment. *(5.3.92)*

MINOR FRACTURES *(5.3.93)*

Minor fractures are defined as those procedures less than or equal to 50 units. Minor surgical rules apply to minor fractures including preoperative consultation (See Section 5 (5.3.60)). Rules regarding non-bilateral multiple fractures may be claimed at fee + 65 percent. A fracture procedure (not dislocation) includes necessary after care up to 14 days. *(5.3.94)*

FRACTURE AND NON-FRACTURE PROCEDURES PERFORMED AT THE SAME SERVICE ENCOUNTER *(5.3.95)*

a) When fracture procedures and non-fracture procedures are performed at different sites, claim 100 percent for the greater and 65 percent for the lesser procedure.
b) When performed at the same site, claim 100 percent for the greater procedure and 50 percent for the lesser procedure. *(5.3.96)*

TREATMENT OF FRACTURE WITH NO REDUCTION *(5.3.97)*

When a fracture is treated by any method other than an open or closed reduction, visit fees apply. This shall include the application, changing and removal of casts and/or splints. *(5.3.98)*

CLOSED REDUCTION *(5.3.99)*

Closed reduction is the reduction of a fracture by manipulation or traction. *(5.3.100)*

MULTIPLE CLOSED REDUCTIONS *(5.3.101)*

Where multiple closed reductions are carried out for the same fracture, at different service encounters, the following rules apply:

a) When performed by the same physician, claim 50 percent for each reduction.
b) When performed by different physicians, the first physician's payment will be reduced to 50 percent of the listed fee and the second physician's payment will be valued at 100 percent. *(5.3.102)*

OPEN REDUCTION *(5.3.103)*

Open reduction is the reduction of a fracture by an operative procedure and includes exposure of the fracture site with fixation as indicated. If an open reduction with extensive debridement is necessary, the appropriate open reduction should be claimed plus a service encounter for independent consideration or exceptional clinical circumstances covering the debridement portion of the service. The supporting text should indicate the total duration of service. *(5.3.104)*

MULTIPLE OPEN REDUCTIONS *(5.3.105)*

Multiple open reductions performed at different service encounters may each be claimed at 100 percent. *(5.3.106)*

CLOSED FOLLOWED BY OPEN REDUCTION *(5.3.107)*

Where a closed reduction is followed by an open reduction, whether performed by the same or different physician, the service encounter will be reduced to 50 percent for the closed reduction and the service encounter for the open reduction will be valued at 100 percent. *(5.3.108)*

COMPOUND FRACTURES OR DISLOCATIONS *(5.3.109)*

The following should be applied when claiming for treatment of a compound fracture or dislocation:

a) The service encounter for closed treatment of a compound fracture or dislocation is 150 percent of the service encounter for the appropriate non-compound fracture or dislocation.
b) If an open reduction is performed, only a service encounter for the open reduction will apply. *(5.3.110)*

MULTIPLE FRACTURES *(5.3.111)*

a) Where multiple major fractures are treated by the same surgeon, the greater procedure is claimed at 100 percent and 50 percent is claimed for each additional fracture.
b) When multiple major fractures involve different long bones where long bones are specified as clavicle, humerus, radius, contralateral ulna, femur, tibia and contralateral fibula, occur at the same time and are managed under the same anaesthetic, the greater procedure is claimed 100 percent and 85 percent is claimed for each additional long bone fracture, unless specified otherwise. This does not apply to fractures of the ulna when the radius on the same side is fractured or fractures of the fibula when the tibia on the same side is fractured.

   See Appendix G (7.7.0) for a list of applicable codes. *(5.3.112)*

REFRACTURE *(5.3.113)*

Where a refracture procedure has been performed, a service encounter for exceptional clinical circumstances may be made. *(5.3.114)*

BONE GRAFTING FOR FRACTURES *(5.3.115)*

a) For a primary bone graft in a fresh fracture, claim 50 percent of the appropriate bone graft code in addition to the primary fracture procedure.
b) Treatment of a nonunion fracture with bone grafting is claimed under the appropriate bone graft procedure code except when there is a new displacement where both the open reduction and the bone graft are claimed.
c) Reaming is not considered a bone graft for assessment purposes and should not be claimed. *(5.3.116)*

SURGICAL ASSISTANTS *(5.3.117)*

A surgical assistant is defined as a physician who assists the operating surgeon throughout a substantial portion of the operation. *(5.3.118)*

SURGICAL ASSISTANT'S SERVICE ENCOUNTER *(5.3.119)*

An assistant should render a separate service encounter for services provided. A surgical assistant's service encounter is 33.8 percent of the surgical fee regardless of whether the assistant is certified as a specialist. The health service codes claimed for surgical assistant services are expected to align with those submitted by the primary surgeon and all surgical assistant claims should adhere to the Preamble guidelines. The service encounter should be calculated to the nearest unit with a minimum of 21 units. However, when a general practitioner who has participated in the prenatal care assists at a vaginal delivery or a caesarean section, they will be paid a full

general practitioner delivery fee. The delivery fee would apply to another general practitioner covering the practice. *(5.3.120)*

a) Surgical assists are not payable for minor procedures or diagnostic and therapeutic services (See Section 5 (5.3.18)). When add-on ADON procedures are done during a major surgical procedure for which a surgical assistant is payable, the assistant's service encounter is 33.8 percent of the total surgical fee. In unusual circumstances where an assistant fee is not normally paid, the assistant should submit a service encounter with an accompanying letter from the surgeon explaining the necessity. In cases of fracture procedures, no visits may be claimed pertaining to the post fracture care up to 14 days following the fracture procedure (See Section 5 (5.3.88)). *(5.3.121)*
b) A surgical assist is not payable for some major surgical procedures. (See Appendix E Major Surgical Procedures with no Assistant Allowed (7.5.0)). *(5.3.122)*
c) Service encounters for routine hospital visits, in the 14 days postoperative, are not allowed in addition to an assist fee. However, service encounters for the following services are allowed:
    i. A home, office or OPD visit on the same day if medical necessity is established
    ii. Comprehensive visit same day as trauma or emergency surgery
    iii. Procedures with visits allowed
    iv. Supportive care
    v. Visits in postoperative period for diagnosis unrelated to the surgery
    vi. If transfer of care from the surgeon to the assistant occurs because the surgeon is unavailable, e.g., out of town, the assistant may claim daily visits for in hospital postoperative care. *(5.3.123)*

The assistant fee for insured dental surgery performed by a dentist is claimed at 33.8 percent of the dental surgical fee. The service encounter is submitted under HSC 36.99A with modifier type and value RO=DTAS role = dental assistant with electronic text indicating the procedure performed. *(5.3.124)*

SECOND ASSISTANT *(5.3.125)*

When a second surgical assistant is necessary, the service is paid at 50 percent of the stated fee paid to the first assistant to a minimum of 10.5 units. The need for a second assistant is to be supported by a letter from the surgeon explaining the necessity. A supporting letter from the surgeon explaining the necessity for a second assistant should be forwarded to the MSI Medical Consultant for approval. *(5.3.126)*

HSC 54.45, 54.47 Esophageal anastomosis with interposition of colon and/or other interposition and 67.51 Renal transplantation are set up with modifier type and value RO=SNAS role = second assistant. *(5.3.127)*

All other service encounters for a second surgical assistant are to be entered using HSC EC with text indicating the HSC of the procedure performed and the duration of the service, as well as indicating approval has been granted for the second surgical assist claim. *(5.3.128)*

CANCELLED SURGERY *(5.3.129)*

a) When an anaesthetic has begun and the operation is cancelled prior to commencement of surgery, if the assistant has scrubbed but is not required to do more, only a hospital visit may be claimed.
b) If the operation is cancelled after surgery has commenced, the procedural units for the intended principal procedure will apply. *(5.3.130)*

RADIATION ONCOLOGY *(5.3.131)*

Treatment planning may not be claimed with a consultation on the same day by the same physician. However, it may be claimed as an additional fee following gold seed and caesium needle implants. Gold seed and caesium needle implants should be classified as major surgical procedures. *(5.3.132)*

PATHOLOGY AND DIAGNOSTIC IMAGING SERVICES *(5.3.133)*

Most service encounters for services in the schedule of benefits for these specialties are processed by a special arrangement with MSI. These service encounters are limited to hospital-based physicians in the appropriate specialties. Procedures not covered by these special arrangements should be claimed on a fee-for-service basis as listed in the schedule of benefits. *(5.3.134)*

Diagnostic Imaging service encounters should conform to the requirements set out in the Preamble. *(5.3.135)*

RADIOLOGY *(5.3.139)*

Interpretation Fee *(5.3.140)*

This represents the benefit for consultation between the radiologist and the referring service provider, fluoroscopy, interpretation of diagnostic images, fluoroscopic findings and supervision of diagnostic imaging services by a radiologist. If a formal written report is not generated on a separate document, the interpretation fee is incomplete and may not be billed. In addition, an immediate oral report may be given if indicated and/or requested. Additionally, radiologists may only claim for the services provided by a resident if they, as the attending, are onsite. A physician may claim either for the resident's procedure or for their own services, but not both, when they are performed at the same time. *(5.3.141)*

Fee Schedule Interpretation *(5.3.142)*

Self referral is not ethical and a consultation with the referring service provider should be held before performing any further examination. However, where the referring service provider is not immediately available, in exceptional cases further examination may be provided if considered necessary by the radiologist. *(5.3.143)*

Although there is no provision for additional views, the fee schedule recognizes that added views are sometimes necessary; therefore, this has been taken into consideration for fees where additional views may be performed. *(5.3.144)*

A. Radiographs *(5.3.145)*

- When a requisition for one extremity is received, no additional charge shall be made for comparison x-rays of the opposite site. *(5.3.146)*
- IVP includes an abdominal survey film. No separate claim shall be made for the abdomen. If tomography is routinely performed there shall be no extra fee. *(5.3.147)*
- The fluoroscopy claim shall not be submitted for an examination performed by the radiologist where fluoroscopy is an integral part of the examination; e.g., examination of gastrointestinal tract, urinary tract, special procedures. *(5.3.148)*
- The fluoroscopy only charge is for use when no other procedure is claimed. *(5.3.149)*
- Abdomen and chest studies shall not be claimed in gastrointestinal. *(5.3.150)*
- Sacrum, coccyx, abdomen, sacroiliac joints and pelvis shall not be claimed in lumbar spine examinations. Thoracic spine shall not be claimed in chest examinations. *(5.3.151)*
- Chest studies shall not be claimed in mammography cases. *(5.3.152)*
- Nasal bones or sinuses shall not be claimed in skull examinations. *(5.3.153)*
- An upper GI series includes a study of the swallowing mechanism and esophagus. An esophagus can only be billed if additional special views including video, food bolus, etc., are made. *(5.3.154)*
- Submitted films are films deemed to be those from another institution whose reinterpretation has been requested by a service provider. *(5.3.155)*
- The necessity of having plain film studies available prior to special procedures, is obvious. It is not essential that they be done at the same institution. If they have been done at an outside institution, then it is the responsibility of the referring service provider and the radiologist to have these

images available. If, however, they cannot be made available to the radiologist, it is acceptable practice to repeat the appropriate examination and claim for it. *(5.3.156)*

- Reasonable effort should be made to review original examinations from another centre. No current outside examination of acceptable quality should be repeated. *(5.3.157)*
- When using the paediatric codes, upper GI, colon and cystography, it is recognized the added time these examinations take; however, the age limit for these fee codes is 12 years not 16 years as in the workload measurement system. *(5.3.158)*
- When a CT examination is performed with and without contrast, the combined code shall be used. *(5.3.159)*
- HSC 1180 may only be claimed when 3D reconstruction has been carried out. It may not be claimed for 2D reconstruction or multiplanar reconstruction.
- The 3D add-on for CT scans is for volume rendering only

B. Ultrasound ***(5.3.160)***

- An abdominal general ultrasound includes a study of all appropriate areas and organs. No restricted or special fees may be added to this examination. Specific fees shall be used as appropriate; e.g., pylorus, appendix, aorta, kidneys and bladder; these fees are not cumulative. *(5.3.161)*
- An ultrasound examination of the pelvis in the first trimester of pregnancy is to be billed as a pelvic ultrasound. *(5.3.162)*
- Biophysical profile shall only be charged when films are made and a written report generated by a radiologist. *(5.3.163)*
- The fee for a radiologist performing a portable examination is an add-on fee to be charged for studies performed outside the department which require the radiologist to be in attendance for the entire examination. *(5.3.164)*
- When both pelvic and endovaginal examinations are performed, they shall be as endovaginal with pelvic. *(5.3.165)*
- The intraoperative code is to be used when the radiologist is present in the operating room and no other code may be claimed for that examination. *(5.3.166)*

C. Vascular Studies ***(5.3.167)***

- Unilateral and bilateral venogram studies of the extremities should include a central film. No additional claim may be made for that film. *(5.3.168)*
- Only one claim should be made for angiography, irrespective of the number of modalities used; e.g., cut film, DSA, cine. *(5.3.169)*
- No claim may be made for an arch or abdominal aortic angiogram unless a proper flush study has been performed. An angiographic interpretation fee may only be charged when the vessel has been specifically selected and films taken. *(5.3.170)*
- The DSA interpretation fees apply to venous injections only. *(5.3.171)*

D. Drainage or Biopsy Procedures ***(5.3.172)***

- Drainage or biopsy procedures charged through MSI billing include imaging and no separate claim may be made for the imaging or interpretation. Abscess cavity films are part of the drainage fee. *(5.3.173)*

E. Nuclear Medicine ***(5.3.174)***

- A thyroid uptake special includes stimulation and/or suppression studies. *(5.3.175)*

- Bill both plasma volume and red cell volume only if they are measured separately. *(5.3.176)*
- ACE inhibitor renogram should be billed when the ACE Inhibitor is administered by and directly supervised by the service provider. If not, a renal scan and renogram should be billed. *(5.3.177)*
- Renal static imaging is to be billed instead of a renal scan and renogram when only static (e.g., DMSA) images are obtained. *(5.3.178)*
- Residual urine volume is an add-on fee. *(5.3.179)*
- Tomography will be an add-on fee, every time it is used. *(5.3.180)*
- Hepatobiliary with a pharmacological stimulation includes either morphine stimulation or CCK stimulation. *(5.3.181)*
- One area for bone, bone marrow and gallium scans indicates one body area; e.g. skull, foot, pelvis. *(5.3.182)*
- Flow studies, when appropriate, will be an add-on fee. *(5.3.183)*
- Computer manipulation is included in the interpretation fee and is no longer recognized as a separate item. *(5.3.184)*
- Myocardial rest quantitative, myocardial stress and rest quantitative are add-on fees. *(5.3.185)*
- Tumour imaging includes one whole body imaging for thyroid cancer or specialized tumour imaging studies; e.g., labeled antibody studies for the specific detection of tumours. It does not include other studies with specific codes. It is not an add-on fee. *(5.3.186)*
- PET/CT is insured for the following indications:

Cancer	Indications
Breast	Evaluation of recurrence/residual disease, distant metastases (staging/restaging) and disease/therapeutic monitoring
Colorectal	Evaluation of recurrence/restaging, distant metastases and disease/therapeutic monitoring
Lung	Diagnosis of single pulmonary nodule, staging distant metastases, recurrence/restaging and disease/therapeutic monitoring
Head and Neck	Diagnosis of occult and synchronous tumours and recurrence/restaging and radiation planning
Lymphoma	Staging, restaging and monitoring
Oesophageal	Staging, restaging and monitoring
Melanoma	Recurrence/restaging, distant metastases
Thyroid	Limited to recurrent disease not confirmed by I^{131} scintigraphy
Pancreatic	Diagnosis when conventional imaging results are inclusive

(5.3.187)

F. Magnetic Resonance Imaging *(5.3.246)*

The claim for MRI interpretation repeat sequence fee should only be made after the matching base spin echo or inversion recovery MRI interpretation has been claimed and accepted at the same occurrence. All interpretation requests generated from the same encounter should be claimed using the same service occurrence number. A repeat sequence code cannot be submitted until after the matching base MRI code has been submitted. *(5.3.247)*

INTERNAL MEDICINE *(5.3.188)*

- Electrocardiogram, electroencephalogram and Holter monitoring are for interpretation only when performed in hospital. *(5.3.189)*
- Pulmonary functions: simple spirometry, flow/volume loops, helium dilution, carbon monoxide single breath, pulmonary stress test, bedside spirometry, body plethysmography are insured when performed in hospital. *(5.3.190)*

- Echocardiography: M mode, two dimensional, Doppler quantitative, Doppler qualitative are insured when performed in hospital. *(5.3.191)*
- When submitting claims for echocardiograms, physicians may claim either I1312 (Doppler – quantitative) or I1313 (Doppler – qualitative), but not both. A quantitative study includes elements of a qualitative study. *(5.3.248)*

PATHOLOGY *(5.3.192)*

Effective April 1, 2015, Pathologists may claim pathology units from MSI by submitting their services as patient specific electronic claims. Pathology interpretation billing and service date must be the date the patient was seen in hospital and had specimens removed. The date the report was completed is not the correct service date. The only exception would be for consults or second opinion, which should be claimed for the date of service of the consult. *(5.3.194)*

Third party requests for services should continue to be billed directly to the third party, e.g., medical examiners autopsies or requests from WCB, etc. *(5.3.195)*

Surgicals: Gross and Microscopic *(5.1.196)*

When more than one surgical specimen is received from a patient, the following rules apply:

- P2325 may be claimed for each specimen taken from anatomically distinct surgical sites.
- P2345 may be claimed when three or more separate surgical specimens are taken from the same anatomic site.
- P2346 may be claimed when a single large complex cancer specimen, which includes lymph nodes, is examined for the purposes of providing a pathologic cancer staging. *(5.3.197)*

Definitions: Anatomically distinct site *(5.3.198)*

For the purposes of correctly interpreting anatomic pathology fee code P2325, the body is considered to be divided into the following distinct anatomical areas: head and neck; upper limbs; trunk anterior and posterior. The following organ systems are also considered to be distinct surgical sites: upper GI tract; reproductive system; separate organs within the abdominal or thoracic cavities may be claimed as distinct sites. For example, two separate skin specimens from the right and left arms are considered as one site; specimens from uterus and ovary are one site; specimens from colon and liver are two sites. *(5.3.199)*

Clarifications *(5.3.200)*

Frozen sections intra operative consult with tissue: For the purposes of correctly interpreting anatomic pathology fee code P2326, all frozen sections taken from one surgical specimen are considered to be one frozen section. When separate organs or anatomic areas are sent for frozen section, then it is appropriate to bill for two frozen sections; separate sentinel nodes may also be considered as separate specimens. For example, examination of several margins from one skin cancer is one frozen section; examination of multiple margins from two separate skin cancers, even though they may be within the same anatomically distinct surgical site as defined above, can be considered as two frozen sections. *(5.3.201)*

Second opinion consults: Health Service codes 03.09I and 03.09J are for use when a pathologist has been asked to review material sent by an outside institution or when a second opinion is medically necessary from a pathologist who has additional training/expertise in the area of concern. They may not be claimed for quality assurance activities. The date of service on the claim should reflect the date the pathologist has rendered their opinion. *(5.3.202)*

Pathologists are reminded that they may claim either HSC P2330 (cytology with a screener) or P2331 (interpretation and report – GYN cytology slides) but not both for the same specimen. If a pathologist claims a P2330, then later signs out the case and wishes to change the claim to P2331, they must delete the claim for the P2330 first. *(5.3.249)*

The multiples permitted for HSC P2345 or P2325 may not be the same as the number of specimens received and examined. Please ensure the multiples claimed are submitted correctly. *(5.3.250)*

OPHTHALMOLOGICAL SERVICES *(5.3.203)*

COMPLETE EYE EXAM *(5.3.204)*

a) An eye examination is payable under MSI when it is medically required. The service encounter should show an indication of presenting symptoms or diagnoses. *(5.3.205)*
b) Coverage for routine refractive vision analysis is limited to once every 24 months for persons under 10 years of age and for those 65 years of age and over. For all others, routine refractive vision analysis is an uninsured service. *(5.3.206)*
c) Visual fields, tonometry and gonioscopy are included in the fee for a complete eye exam and ophthalmological consultation. *(5.3.207)*

A complete ophthalmological exam including refraction may be claimed before and after cataract surgery. *(5.3.208)*

CONTACT LENS FITTING *(5.3.209)*

Fitting of medically indicated contact lenses by a physician is an insured service under Nova Scotia Medical Services Insurance. In view of continuing developments and improvements in contact lens materials and therapy, it is recognized that they may prove to be of benefit in conditions not as yet listed. *(5.3.210)*

a) There are two types of lenses recognized:
    i. Bandage contact lens/lenses should be claimed for zero prescription lens/lenses applied to immobilize the eye to enable recovery for certain conditions. Follow-up visits may be claimed in addition.
    ii. Corrective lenses may be fitted to restore monocular or binocular vision where this cannot be achieved by other methods and to improve visual fields where this is compromised by high refractive error. *(5.3.211)*
b) Conditions for which contact lens fitting is an insured service on the basis of medical necessity: Albinism, aniridia, anterior membrane corneal dystrophies, aphakia, astigmatism requiring over five 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 (six dioptres spherical equivalent or over in children under age 16, 10 dioptres spherical equivalent or over in adults), keratoconus, neuroparalytic keratopathy, nystagmus, old trachoma, paralysis of superior rectus muscle, pemphigus, post penetrating keratoplasty, post-operative discomfort or lacerations or perforations, prevention of symblepharon, recurrent cornea erosion, Stevens Johnson disease, stromal herpes simplex, thermal burns, trichiasis, vernal conjunctivitis, anisometropia, corneal degeneration, epithelial defect, pathological myopia, Marfan's Syndrome and pseudophakia. *(5.3.212)*
c) Conditions for which contact lens fitting may not be claimed:
Macular degeneration, open angle glaucoma, diabetic retinopathy, strabismus, borderline glaucoma and amblyopia *(5.3.213)*
d) Contact lens fitting includes follow up for 90 days by the same physician. *(5.3.214)*

When, as the result of an error or omission by the patient, an insured service is provided within the two year limit, the provider will be notified by MSI that an uninsured service has been rendered. The provider may then bill the patient the usual and customary fee. If the provider is unable to collect, a reduced fee will be paid by MSI. This service applies only to patients in the insured age group. *(5.3.215)*

INTRAVITREAL INJECTION OF PHARMACOLOGIC AGENT (HSC 28.73F) *(5.3.218)*

This fee includes the counselling of the patient, preparation of the eye, administration of subconjunctival anaesthesia and topical antibiotic as required and injection of the pharmacologic agent. It may only be claimed

with the following specific diagnoses: 362.52 Exudative senile macular degeneration, 362.01 Diabetic macular edema, 362.35 Central retinal vein occlusion 362.36 Venous tributary (branch) occlusion, and 379.27 Vitreomacular adhesion (VMA). *(5.3.219)*

OPTIC NERVE IMAGING (HSC 02.02B) *(5.3.251)*

Optic Nerve Imaging by any means (e.g., OCT, HRT) for patients with a diagnosis of glaucoma, wet AMD, retinal vein occlusion, diabetic macular edema, and patients starting hydroxychloroquine or chloroquine treatment. This fee is for the interpretation of scanning computerized ophthalmic diagnostic imaging, with interpretation and written report, unilateral or bilateral, of the optic nerve and/or retina regardless of the technology used to perform the imaging. Not to be used for glaucoma screening. It may only be claimed with the specific diagnoses: 362.52 Exudative Senile Macular Degeneration, 362.01 Background Diabetic Retinopathy, 362.35 Central retinal vein occlusion, 362.36 Venous tributary occlusion, 379.27 Vitreomacular adhesion, 365.9 unspecified glaucoma, and for patients on hydroxychloroquine as there is no specific ICD9 code, use 362.10 background retinopathy unspecified. When using this DX the claim will require text stating the type of medication and any additional risk factors. *(5.3.252)*

RETINAL DETACHMENT *(5.3.220)*

When claiming for repair of a retinal detachment, physicians may only bill for one therapeutic modality i.e. either diathermy (Health Service Codes 28.41 and 28.41A), or cryotherapy (Health Service Codes 28.42 and 28.42A), or photocoagulation (Health Service Codes 28.44A, 28.44B and 28.44C). It is not permitted to bill more than one of these codes for the same repair. *(5.3.221)*

CATARACT SURGERY *(5.3.253)*

Monitoring of intraocular pressure is a part of the customary operative or post-operative care when providing cataract surgery. Health service code 03.12 Tonometry should not be reported in addition. This applies only to the day of surgery, and not over the remainder of the post-operative period. *(5.3.253)*

TRABECULECTOMY *(5.3.254)*

Health service codes for trabeculectomy (HSC 26.25, 26.25B, 26.25C and 26.25D) are for invasive major surgical procedures and as such may only be claimed for services provided in an operating room. *(5.3.254)*

IRIDOTOMY (HSC 26.52) *(5.3.255)*

The fee for iridotomy should only be used when treating glaucoma. It is not appropriate to bill iridotomy when the procedure is solely used as means of access for another procedure. *(5.3.255)*

PRONOUNCEMENT OF DEATH *(5.3.222)*

For attendance on the patient for the purpose of pronouncement of death, a limited visit may be claimed. This service may not be claimed using an urgent modifier. If another health care provider, such as a nurse, pronounces the patient, the physician may not claim a visit. It is not appropriate to claim a visit for filling out the death certificate or for telephone calls related to the death. *(5.3.223)*

DENTAL SERVICES *(5.3.224)*

Referrals from dentists to physician specialists are acceptable provided that the dentist discusses the patient with the family physician before seeking such consultation and that the physician specialist sends a copy of their report to the family physician as well as to the referring dentist. *(5.3.225)*

Other physician's services provided at the request of a dentist are regarded as non-referred services; consultation or referred visit service codes shall not be used when submitting service encounters. *(5.3.226)*

SECTION 6: TERMS AND DEFINITIONS *(6.0.0)*

Term	Definition
Accredited Service Bureau	An approval given by MSI to an organization or individual to send service encounter transactions in an electronic format on behalf of service providers, with the ability to retrieve results electronically from MSI. A list of approved bureaus can be found on the MSI website. *(6.0.1)*
Accredited Submitter	An organization or individual accredited and approved by MSI to send service encounter transactions in an electronic format on behalf of service providers with the ability to retrieve results electronically from MSI, e.g., individual physician, group or service bureau. *(6.0.2)*
Accredited Vendor	An organization or individual that has developed a software program that has been accredited by MSI to electronically submit service encounters. A list of approved vendors can be found on the MSI website. *(6.0.3)*
Add-On	An add-on is a procedure that is always performed in association with another procedure and never by itself. An add-on procedure is paid at full fee. *(6.0.7)*
Adjudication Response/Results	An electronic response that is sent to a submitter detailing the assessment results of each service encounter submission. It will be produced whenever service encounter submissions are processed. Service encounters that are reduced, refused or paid at zero will have an explanatory code attached. These explanatory codes are listed in the MSI Physician's Manual. *(6.0.8)*
Age	Where age is a factor in determining eligibility for payment, or modifies the service, the following age ranges are defined: • Premature – 2,500 grams or less at birth • Neonate/Newborn – the 10 days following delivery • Infant – up to and including 23 months • Child – up to and including 15 years of age • Adult – 16 years of age and over *(6.0.9)* Health service codes age distinction or modification *(6.0.10)* The following are examples of age related services. The appropriate modifiers must be indicated on the service encounter. HSC 50.99H Modifiers Venipuncture: a) Person seven years and older AG=PR07 b) Child up to seven years AG=CH07 HSC 76.0 Circumcision: a) Infant or child under 16 years AG=CH16 b) Adult AG=ADUT *(6.0.11)* Please note: Circumcision of a newborn is uninsured from birth to age one unless medical necessity warrants payment. *(6.0.12)*
Amount Above Tariff	Any amount above tariff or balance billing has been prohibited in Nova Scotia since July 1, 1984 for physicians, and July 1, 1988 for optometrists. *(6.0.13)*
Antenatal (Prenatal)	The term antenatal or prenatal applies to pregnancy related visits from the time of confirmation of pregnancy to delivery. *(6.0.14)*
Basic Health Benefits	The *Health Services and Insurance Act* makes provision for the payment of benefits with respect to the costs of health services provided to eligible residents. The basic health services provided include: • Medically required physician's services • Optometric services *(6.0.15)*

Term	Definition
Bottom Line Adjustments	Bottom line adjustments refer to adjustments in payment made by MSI that reflect credits or debits resulting from extenuating circumstances, e.g., audit recovery. *(6.0.16)*
Bulletin	An MSI administrative update that indicates and/or clarifies changes and subjects of concern with respect to service encounter submissions, assessment and other pertinent information. *(6.0.17)*
Business Arrangement (BA)	An agreement between a service provider and MSI covering the payment arrangements for health services provided. The business arrangement defines the service providers and the payee. All service providers registered with MSI must have or be part of a business arrangement in order to claim for services. Some service providers may have and/or be part of more than one business arrangement. *(6.0.18)*
Canadian Classification of Diagnostic, Therapeutic and Surgical Procedures (CCP)	A catalogue of procedures that was produced by Statistics Canada to provide a national procedure classification standard. *(6.0.19)*
Certification	The certification by a licensing body that recognizes specific capabilities of a service provider to provide health services. *(6.0.20)*
Home Care	home care provides home support services, personal care services, nursing services and home oxygen services to persons with assessed unmet needs who are convalescing, chronically ill, disabled, or experiencing debilities of old age. Services provided have the objectives of maintaining or improving the individual's level of functioning; addressing the individuals' needs during rehabilitation or convalescence; delaying or preventing admission into institutions; and/or providing family relief services to the individual's informal caregivers. The location modifier type and value for home care is LO=HMHC. Home Care Nova Scotia can be contacted by telephone at 1-800-225-7225. *(6.0.21)*
Default	Default means the action which automatically happens in the system, unless you give instruction otherwise. *(6.0.22)*
Detention and Office Visits	Medical detention occurs when a practitioner's time is given exclusively to one patient for active treatment and/or monitoring of that patient at the sacrifice of all other work. Detention time may only be claimed for emergency care and/or treatment provided outside of the office (See Section 5 (5.1.75)). *(6.0.23)*
Diagnostic Code	A three to five digit international coding system which identifies the medical condition for which a service provider is billing services ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification). *(6.0.24)*
Direct Deposit	A method by which a service provider's payments from MSI are transferred directly into their bank account. This is also referred to as electronic funds transfer. *(6.0.25)*
Discipline	A specific branch or field of study in which a service provider has been licensed to participate, (e.g., medicine, dentistry, optometry or pharmacy). *(6.0.26)*
Electronic Funds Transfer (EFT)	A method by which a service provider's payments from MSI are transferred directly into their bank account. *(6.0.27)*
Emergency Care Centres	An emergency care centre is a special designation provided by the Department of Health and Wellness to emergency departments meeting certain standards including 24 hour on site on call. *(6.0.28)*
Exceptional Clinical Circumstances	Allowance is sometimes made for alteration of the tariff associated with individual service encounters when a physician can demonstrate significantly increased difficulty, time, or other factors involved in providing care (See Section 4 (4.1.11)). *(6.0.29)*
Excluded Reciprocal Services	Excluded reciprocal services are medical services, which have been identified as not payable under the Medical Reciprocal Program. *(6.0.30)*

Term	Definition
Explanatory Code	An explanation that indicates why a service encounter has been refused, reduced, paid at zero or changed in some other manner. *(6.0.31)*
Facility	Facility is a physical location, e.g., hospital, institution or office where health services are routinely performed. All facilities are formally recognized on the MSI Register. *(6.0.32)*
Facility Number	A number which uniquely identifies a physical location where health services are routinely performed (See Section 3 (3.2.100). *(6.0.33)*
Functional Centre	Facilities may have a further definition of their structure. This is done by identifying the functional centres within that facility (See Section 3 (3.2.102). *(6.0.34)* Examples of functional centres include a standard area or site within a hospital or institution; e.g. outpatient department, intensive care unit, etc. Assigned functional centre modifiers will be required as part of a service encounter for services provided in such areas. *(6.0.35)*
General Practitioner	General practitioner means a physician who engages in the general practice of medicine. *(6.0.36)*
Governing Organization	An organization that has the mandate to certify or license service providers or facility capabilities, e.g., College of Physicians & Surgeons of Nova Scotia and the Department of Health and Wellness, etc. *(6.0.37)*
Group Practice/Clinic	A group practice is defined as the arrangement whereby two or more physicians are in practice, and each physician maintains and has access to medical records and histories of the patients. *(6.0.38)*
Health Card Number (HCN)	A lifetime identification number used to identify all Nova Scotia residents who are registered with MSI. *(6.0.39)*
Health Service Code (HSC)	A code identifying services/procedures performed by a service provider to a service recipient. In most cases, these codes are CCP codes or CCP codes with a qualifier to further define the service. A list of health service codes and their descriptions are found in the Physician's Manual. Note: Non-CCP health services codes are used to identify non-procedural services. Example: C9999. *(6.0.40)*
Home/Residence	Home includes patient's home, group homes, seniors' lodges, personal care homes and provincial correctional centres. It does not include institutions. *(6.0.41)*
Hospital	For the purposes of this Preamble, hospital means a facility for the observation, care and treatment of persons suffering from a psychiatric disorder or a hospital for treatment of persons with sickness, disease or injury, including maternity care, as approved under the *Health Services and Insurance Act*. *(6.0.42)*
Independent Consideration	Independent consideration is a process for assessing services where a unit value is not listed (See Section 4 (4.1.8)). *(6.0.43)*
In Province Registries	The Nova Scotia College of Physicians & Surgeons is responsible for the registration and licensing of a new physician and for making changes to the physician registry information. *(6.0.44)*
Institution	Licensed and approved chronic care hospitals, residential care facilities, nursing homes and homes for special care. *(6.0.45)*
Intensive Care Unit	Intensive care units are special areas recognized and funded by the Department of Health and Wellness to provide high intensity care. These units would include neonatal, paediatric, coronary, and such other units as are recognized by the Department. Generally, special fees apply to patients in such areas unless the patients no longer need the care of such a unit, but remain in the intensive care area (e.g., due to lack of beds on general ward or recovery room). *(6.0.46)*
Interim Fee	May be established in certain circumstances with approval by Department of Health and Wellness. A CCP code will be activated to describe the new service and an interim fee assigned. Interim fees will be published in the MSI Physician's Bulletin. (See Section 4 (4.1.10)). *(6.0.47)*

Term	Definition
Interpretive Component	This is the interpretation of the results of a diagnostic procedure for which a fee may be claimed separately from performing the procedure itself. *(6.0.48)*
Locum Tenens	A physician who temporarily replaces another physician who is absent from the practice (See Section 3 (3.1.7)). Note: The locum physician may not claim under the billing number of the physician being replaced. *(6.0.49)*
Locum Period	A period of time during which a locum tenens provides services in the absence of the established service provider. *(6.0.50)*
Medavie Blue Cross	Medavie Blue Cross administers the MSI programs on behalf of the Department of Health and Wellness. *(6.0.51)*
Medical Necessity	Medically necessary services may be defined as those services provided by a physician to a patient with the intent to diagnose or treat physical or mental disease or dysfunction, as well as those services generally accepted as promoting health through prevention of disease or dysfunction. *(6.0.52)* The provision of a service listed in the schedule of benefits does not ensure payment by Medical Services Insurance. Services provided in circumstances where they were not medically necessary are not insured. For the purpose of this Preamble, medical services that are explicitly deemed to be non-insured under the *Health Services and Insurance Act* or its Regulations remain uninsured regardless of individual judgments regarding their medical necessity. *(6.0.53)*
Medical Reciprocal Program	An agreement by which a Nova Scotia service provider obtains payment for medically required services provided to eligible residents of other Canadian provinces and territories, excluding Quebec. *(6.0.54)*
Medical Reciprocal Service Encounter	Service encounters submitted to MSI for service recipients from other provinces and territories that are eligible under the Medical Reciprocal Program. *(6.0.55)*
Modifier	Modifiers are codes added to the service encounter to identify the generic context within which the service was provided, e.g., specialty, time, place, etc. Some modifiers are for the purpose of clarification; others affect the tariff applied to the service. Modifiers can be explicit or implicit. Explicit modifiers need to be entered as modifiers on a service encounter. Example: A service encounter for role of surgical assist is made by indicating the appropriate modifier, (RO=SRAS). Implicit modifiers are derived by the system based on the information submitted on the service encounter or from information that exists in the system. The purpose of implicit modifiers is to eliminate duplicate entry and data that is already available. Example: service provider's specialty. A detailed list of modifiers may be found in Appendix H Modifier Types and Values (See Section 7 (7.8.0)) *(6.0.56)*
Most Responsible Physician	The most responsible physician is the attending physician who is primarily responsible for the day to day care of the patient in hospital. *(6.0.57)*
Non-Participating Physician	A physician who has elected not to receive compensation for insured medical services from MSI (See Section 3 (3.1.20)). *(6.0.58)*
Nova Scotia Medical Services Insurance (MSI)	MSI is responsible for maintaining health care insurance information such as registration of residents, processing service encounters and maintaining payments to service providers. *(6.0.59)*
Nova Scotia Medical Services Insurance Plan	A plan administered and operated in accordance with the *Nova Scotia Health Services and Insurance Act* on a not for profit basis to provide benefits for health services to all eligible residents of Nova Scotia. *(6.0.60)*
Office	An office is defined as the location where a physician is practicing their profession. An office may be located in the physician's home, in a hospital, in an institution, or in other facilities or buildings. *(6.0.61)*
Opting In	It is the service provider's decision to have all basic health insured services submitted to MSI for direct payment. *(6.0.62)*

Term	Definition
Opting Out	It is the service provider's decision not to have basic health insured services submitted to MSI for direct payment. *(6.0.63)*
Other Locations	This modifier applies to locations of service not defined elsewhere, such as recreational facilities, watercraft, or roadside. *(6.0.64)*
Paid at Zero	Term used to indicate that additional information may be required from the provider to aid in the assessment of the claim. *(6.0.65)*
Participating Physician	A physician who is registered with MSI to receive compensation for insured medical services. *(6.0.66)*
Payment Responsibility	The payment responsibility is a mandatory field on a service encounter that identifies which organization is responsible for the payment of the service, i.e., MSI, WCB, Community Services (COM). There are also out of province codes that identify the provincial health care plan where the patient has medical coverage (See Section 3 (3.2.115)). *(6.0.67)*
Physician	Physician means a legally qualified medical practitioner whose name is entered in the register kept by the College of Physicians & Surgeons of Nova Scotia as being qualified and licensed to practice medicine. They must be in good standing and not under suspension pursuant to any of the provisions of the *Medical Act*. *(6.0.68)*
Physician's Manual	The physician's manual is comprised of: • Preamble • List of Insured Health Service Codes and Descriptions • Explanatory Codes and Descriptions *(6.0.69)*
Post Natal	The term postnatal describes a single limited visit performed approximately six weeks following delivery for the purpose of assessment and advice to the mother. *(6.0.70)*
Postpartum	The term postpartum describes in hospital limited visits to the mother following delivery. *(6.0.71)*
Premium Fees	Premium fees are additional amounts paid above normal or customary rates on eligible services provided on an emergency basis during designated times. An emergency basis is defined as services that must be performed without delay because of the medical condition of the patient (See Section 5 (5.1.81)). *(6.0.72)*
Qualifiers	A qualifier is an alpha character appended to some health service codes (HSC) to subdivide the code and thereby distinguish differences specific to that procedure, e.g., 98.12W excision of lesions, 98.12U cryotherapy of lesions, and 98.12X electrocautery of lesions (See Section 3 (3.2.63)). *(6.0.73)*
Rate	When the tariff for a service is modified by specialty, time, or some other factor, the applicable tariff may vary according to the specific circumstances. *(6.0.74)*
Registrant	Nova Scotia resident in whose name the Nova Scotia Health Care coverage is specifically registered. *(6.0.75)*
Registry	A registry is a single repository containing pertinent data about service recipients, service providers, facilities, etc. which are part of the Nova Scotia health service delivery system. *(6.0.76)*
Resident of Nova Scotia	A person lawfully entitled to be or remain in Canada, and who makes their home and is ordinarily present in Nova Scotia. A resident does not include a tourist, a transient or a visitor to Nova Scotia. *(6.0.77)*
Schedule of Benefits	The schedule lists all insured procedures, their descriptions and codes, any special conditions, and the value in units. When the term schedule is used in this Preamble, it means the schedule of benefits (This refers to the electronic document). *(6.0.78)*
Service	When the term service is used in this manual, it is in the context of an insured visit or procedure that is identified by a specific service code in the MSI schedule of benefits. *(6.0.79)*
Service Encounter	A transaction which describes the health service performed by the provider to the service recipient. *(6.0.81)*

Term	Definition
Service Encounter Number	A service encounter number is assigned to each service encounter which distinguishes that service encounter from others. It is comprised of the submitter ID, year, sequence number and check digit. *(6.0.82)*
Service Provider	A service provider is an individual who provides a health service for which a service encounter is submitted to MSI. *(6.0.83)*
Service Recipient	An individual who receives insured services by a registered Nova Scotia service provider. *(6.0.84)*
Service Representatives	Personnel within MSI who offer assistance with inquiries to service providers and their staff. *(6.0.85)*
Sessional Fees	Sessional fees apply to preapproved services of a physician engaged on a time basis. *(6.0.86)* These include for example: Well Woman's Clinic (requires prior approval) Well Man's Clinic (requires prior approval) Immunization Clinic (requires prior approval) Anaesthetic Clinic Paediatric Amputee Clinic Palliative Care Correctional Centre Public Health Medicine Other professional services to a government department, agency or public body *(6.0.87)*
Submitter ID	This is a unique identifier originally given to the Submitter, from MSI, attached to business arrangement numbers to download electronic payment statements directly to the office that is billing for a provider. *(6.0.88)*
Specialist/Specialty	A specialist is defined as one whose name appears in the specialist register of the College of Physicians & Surgeons of Nova Scotia. *(6.0.89)*
Specialty	A specialty is a certification recognized by a governing body which is used in the provision of a health service, e.g., family practice, general surgery. *(6.0.90)* However, when the term specialty is used, it means any or all specialties, including general or family practice. For the purpose of this Preamble, the terms general and family practice are used interchangeably. *(6.0.91)*
Statement of Account	A statement is based on the number of service encounters processed on a biweekly basis indicating the amount MSI has released for payment. The statement can be retrieved electronically from the MSI system. *(6.0.92)*
Statutory Holiday	Holidays are defined for the purpose of claiming special rates as New Year's Day, Heritage Day, Good Friday, Easter Monday, Victoria Day, Canada Day, Civic Holiday, Labour Day, Thanksgiving, Remembrance Day, Christmas Day and Boxing Day. The list of dates designated as statutory holidays will be issued annually by MSI. Note: If a physician chooses to provide routine, scheduled services during a statutory holiday, they are not entitled to payment at the holiday rate. *(6.0.93)*
Tariff	A tariff is compensation associated with the provision of insured health services as governed by the *Nova Scotia Health Services and Insurance Act*. *(6.0.95)* Tariffs are paid on a fee-for-service, contractual or sessional basis according to an approved plan for payment or insured list of professional services or products. Payments are made directly to service providers when rendering services to registered residents of Nova Scotia. Payments are also made to registered residents of Nova Scotia who provide proof of payment for receipt of an insured service. *(6.0.96)* The MSI tariff is the actual monetary value of a service. It is derived from the number of units applicable to a service which may vary according to relevant modifiers, the medical service unit value, and any individual billing factors based on practice location or billing thresholds, or other factors that may exist from time to time. *(6.0.97)*

Term	Definition
Technical Component	Some diagnostic procedures have separately listed technical and interpretive components. When a physician must perform the technical component of a procedure that is normally carried out by a technician, the physician may claim a fee for the technical component. If a technician carries out the technical component, the physician may claim for the interpretive component only. *(6.0.98)*
Third Party	A person or organization other than the patient, their agent, or MSI that is requesting and/or assuming financial responsibility for a medical or medically related service. *(6.0.99)*
Transfer of Care	Transfer of care occurs when the responsibility for the care of a patient is completely transferred, either temporarily or permanently, from one physician to another (See Section 5 (5.1.109)). *(6.0.100)*
Travel	Travel means movement from one geographic location to another. Interpretations specific for travel to certain locations: *(6.0.101)* Within an apartment building, movement from one unit to another is considered travel. *(6.0.102)* Movement within a hospital, even between separate buildings on one contiguous site, is not considered travel. If a hospital has several geographically separate sites, movement between sites is considered travel. *(6.0.103)* Movement between rooms or units of a licensed nursing home or special care institution is not considered travel. *(6.0.104)* If a physician maintains a medical office within or adjoining their place of residence, entering the office for the purpose of rendering emergency treatment is considered travel during certain time periods. *(6.0.105)* Travel from physician personal home location to patient home is not eligible for travel, only travel from office to patient home. (Unless the physician has at at-home office registered with MSI). If a physician has arranged to have an office in a hospital or in an attached building, going from the office to the hospital to attend a patient is not considered travel. *(6.0.106)*
Units/Unit Value	The MSI schedule of benefits uses units to represent the value of a service. The value of a unit varies according to the applicable tariff. Two unit values exist, an anaesthetic unit value used specifically for claiming anaesthetic services, and a medical service unit value specifying the dollar value of all other services. *(6.0.107)*

SECTION 7: APPENDICES *(7.0.0)*

APPENDIX A – INTERPROVINCIAL HEALTH CARDS *(7.1.0)*

SAMPLE OF NOVA SCOTIA HEALTH CARD *(7.1.1)*

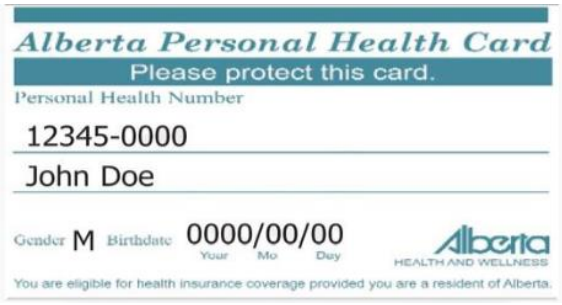
The plastic card with a magnetic-stripe depicts a Nova Scotia scene of the Kejimkujik Seaside Adjunct National Park. The card contains the 10-digit lifetime identification number, the resident's name, gender (if applicable), date of birth, organ donor status, effective date and expiry date of the card. This information is in silver, embossed lettering.

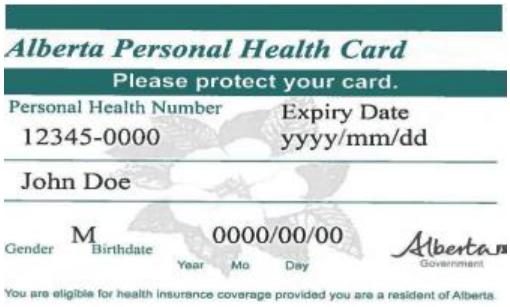
(7.1.2)

SAMPLE OF ALBERTA HEALTH CARD *(7.1.3)*

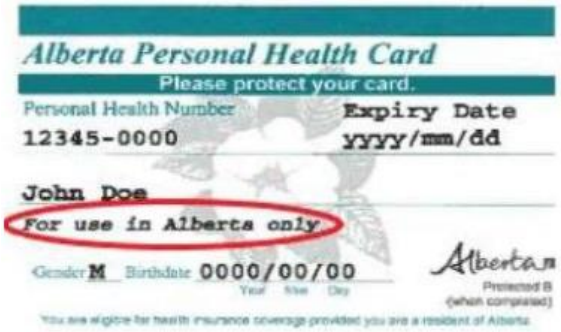
Annual personal health cards are no longer issued. New residents and newborns are issued cards when they are registered. Replacement cards are issued upon request. *(7.1.4)*

Information on the card includes the individual's nine-digit personal health number (PHN), name, gender (if applicable), date of birth and expiry date of the card if applicable. *(7.1.5)*





Cards indicated 'For use in Alberta only' cannot be used for Reciprocal Billing.



(7.1.6)

SAMPLE OF BRITISH COLUMBIA HEALTH CARD *(7.1.7)*

The regular card is on a white background with the word "Care Card" filling the background in grey. The words "British Columbia Care" are blue and "Card" is red. The flag is red, blue, white and yellow. Plan member information is in black. *(7.1.8)*

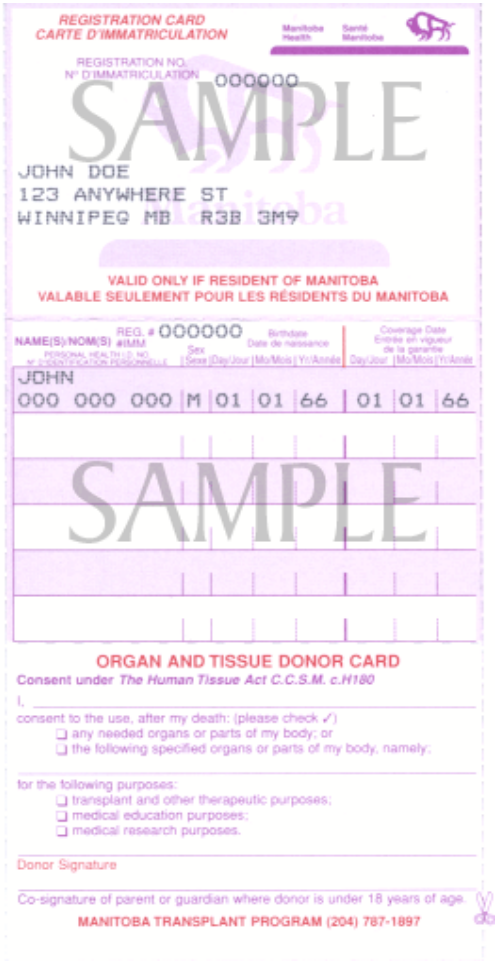
(7.1.9)

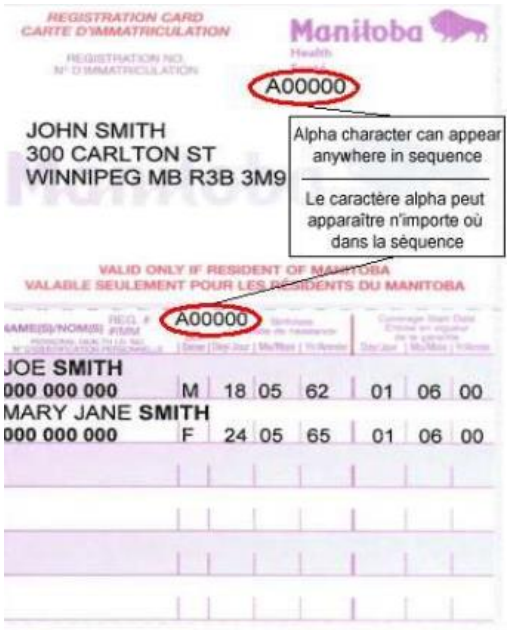
A gold Care Card is issued to seniors a few weeks before they reach age 65. It is gold with the words "British Columbia Care Card FOR SENIORS" in white. Plan information is also in white. *(7.1.10)*

(7.1.11)

SAMPLE OF MANITOBA HEALTH CARD *(7.1.12)*

Manitoba Health issues a card (or registration certificate) to all Manitoba residents, which includes a 9-digit lifetime identification number for each family member. The white paper card has purple and red print and includes the previous 6-digit family or single person's registration number, name and address of Manitoba resident, family member's given name and alternate (if applicable), sex, birth date, effective date of coverage, and 9-digit Personal Health Identification Number (PHIN). *(7.1.13)*

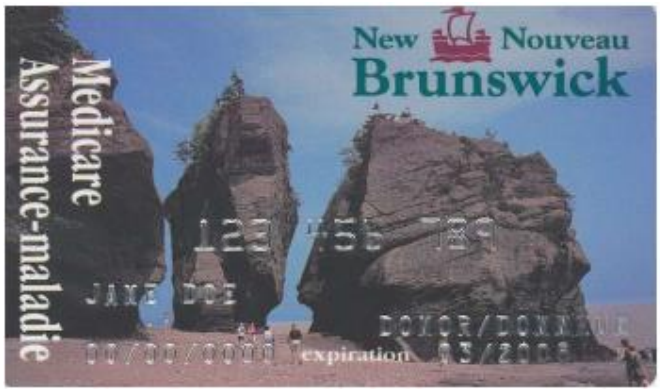




(7.1.14)

SAMPLE OF NEW BRUNSWICK HEALTH CARD *(7.1.15)*

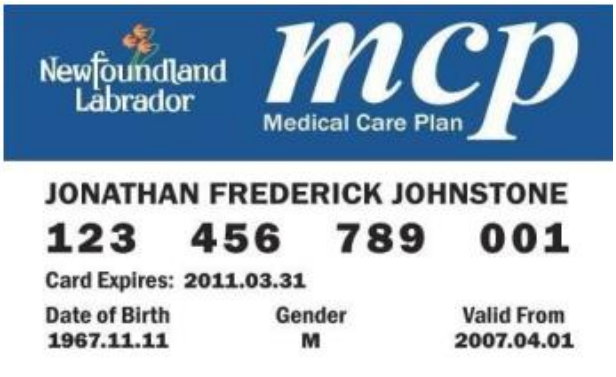
The plastic card with a magnetic-stripe depicts a New Brunswick scene of the Flowerpot Rocks-Hopewell Cape. The New Brunswick logo is displayed in the upper right corner. The card contains the 9-digit Medicare registration number, the subscriber's name, date of birth and expiry date of the card. This information is in silver, embossed lettering. *(7.1.16)*



(7.1.17)

SAMPLE OF NEWFOUNDLAND HEALTH CARD *(7.1.18)*

The MCP cards contains the 12-digit identification number, an individual's name, gender, MCP number and birth date to provide additional security to ensure that only the person to whom the card is issued will be able to use it. In addition, the cards have an expiry date to allow the Department of Health and Community Services to periodically update the MCP database and provide an improved mechanism for accountability. *(7.1.19)*



(7.1.20)

SAMPLE OF NORTHWEST TERRITORIES HEALTH CARD *(7.1.21)*

The Northwest Territories have a paper health card which features a northern landscape as a faint background screen. The letters and numbers are in black. The card bears the name, 7-digit identification number and expiry date. *(7.1.22)*

Close attention should be paid to the expiry date. *(7.1.23)*

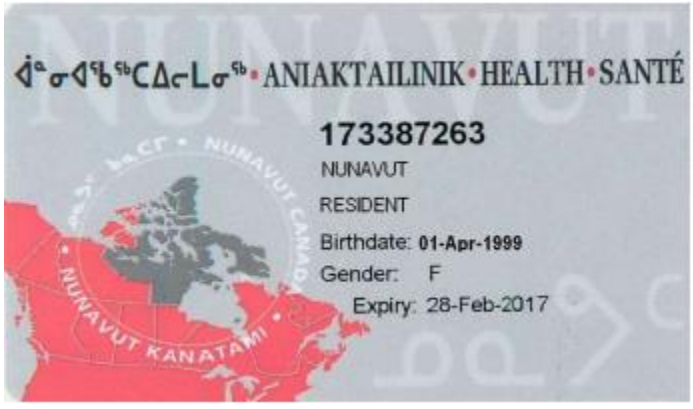
(7.1.24)

SAMPLE OF NUNAVUT HEALTH CARD *(7.1.25)*

The Nunavut health card is made of pale grey plastic. It features a territorial map of Canada, in red, on which Nunavut is shown in dark grey. A circle is superimposed around the Territory, with the words NUNAVUT CANADA in three languages. In the upper portion of the card the word NUNAVUT appears in pale grey, with the word HEALTH superimposed in four languages. The card bears the following information: the nine-digit health insurance number, name and date of birth of the insured person, as well as the card's expiry date. *(7.1.26)*

The reverse side features the address and telephone number of the Nunavut administrative services, as well as the signature of the cardholder. *(7.1.27)*

Close attention should be paid to the expiry date. *(7.1.28)*



(7.1.29)

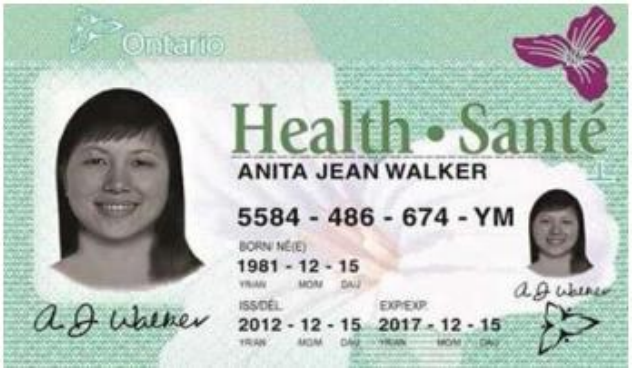
SAMPLE OF ONTARIO HEALTH CARD *(7.1.30)*

The Ministry of Health and Long-Term Care recognizes the importance of having a secure Health Card and is introducing changes to enhance the security of its current card. These additional security enhancements will make the Health Card more tamperproof and counterfeit resistant. In order to further protect personal health information, address information has been removed from the back of the Health Card. *(7.1.31)*

Ontarians will not receive an enhanced Health Card until their current card expires, or a replacement card is required. Both the red and white and the current photo health card remain acceptable as proof of entitlement to medically necessary insured health services providing they are valid and belong to the person presenting the card. *(7.1.32)*

The additional security features include:
- A new security background
- Secondary photo and signature
- Tactile features (Health Number, Version Code, and Ontario trillium logo)
- A 2D bar code

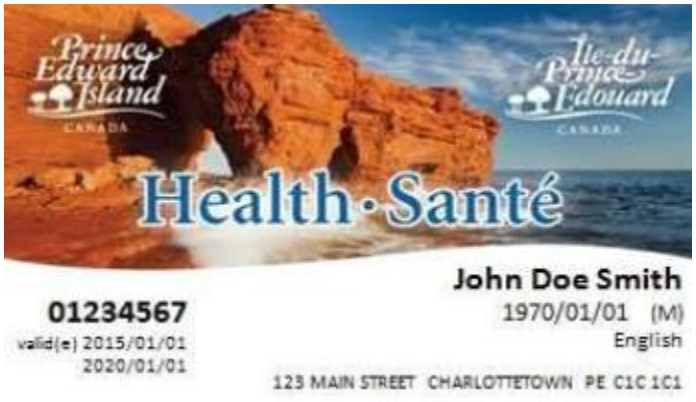
Children under the age of 15 ½ years have health cards that are exempt from both photo and signature. *(7.1.33)*



(7.1.34)

SAMPLE OF PRINCE EDWARD ISLAND HEALTH CARD *(7.1.35)*

This card assigns a unique 8-digit lifetime identification number to all eligible P.E.I. residents. Also displayed on the card are the given name(s), birth date, gender of the resident and expiry date of the health card. *(7.1.36)*



(7.1.37)

SAMPLE OF SASKATCHEWAN HEALTH CARD *(7.1.38)*

The plastic cards are blue above and grey below a green, yellow and white stripe. Cards contain a Personal Health Number, name, effective date for coverage, termination date for coverage, sex, beneficiary's month and year of birth and 8-digit Family/Beneficiary number. *(7.1.39)*

(7.1.40)

SAMPLE OF QUEBEC HEALTH CARD *(7.1.41)*

The Régie issues a Health Insurance Card to persons eligible for the Québec Health Insurance Plan. Because the Health Insurance Card gives access to insured healthcare services, it is important for insured persons to carry their card with them at all times. This card contains the 12-digit health insurance number, the person's first and last names at birth, spouses name or sequential number, date of birth, sex, the year and month of expiry, photo and signature (if applicable), consent to organ donation and number of cards issued to the person since 1984. The two dimensional bar-code issued as of January 24, 2018 contains information such as first and last names and date of birth. *(7.1.42)*

(7.1.43)

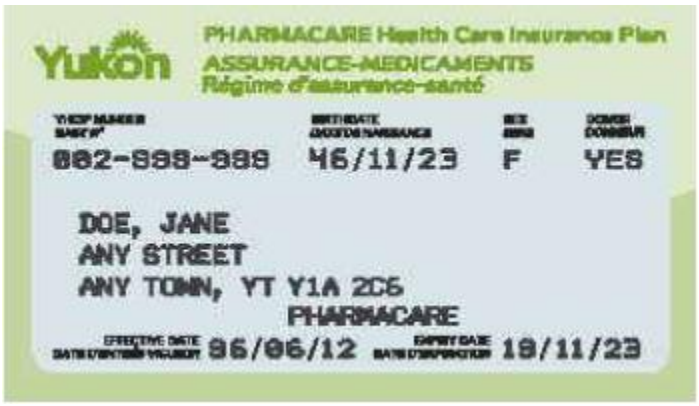
The person's photograph and signature, are digitized and incorporated into the card. Cards issued to persons not required to provide a photo and a signature, such as children under age 14, have no photo or signature spaces, while cards issued to persons exempt from providing their photo, their signature or both, are marked "exempté" in the appropriate space(s). *(7.1.44)*

SAMPLE OF YUKON HEALTH CARD *(7.1.46)*

The plastic cards are blue in color with black print. It contains the 9-digit identification number, the resident's name, gender, date of birth, organ donor status, address, effective date and expiry date of the card. *(7.1.47)*

(7.1.48)

A green health care card is issued to Yukon senior citizens registered with the Pharmacare and Extended Benefits programs, replacing the blue health care insurance plan card. This one card entitles holders to all seniors' benefits, hospital and physician services. Persons are eligible for the card if they are a Yukon resident aged 65 years or older, or if they are 60 years of age or older and married to a living Yukon resident who is 65 years of age or older. *(7.1.49)*



(7.1.50)

APPENDIX B – ABBREVIATIONS *(7.2.0)*

SPECIALTY ABBREVIATIONS *(7.2.1)*

ANAE	-	Anaesthesia
ANPA	-	Anatomical Pathology
CARD	-	Cardiology
CASG	-	Cardiovascular/Thoracic Surgery
CLIA	-	Clinical Immunology & Allergy
COMD	-	Community Medicine
DENT	-	Dental Practitioner
DERM	-	Dermatology
DIRD	-	Diagnostic Radiology
EMMD	-	Emergency Medicine
ENDO	-	Endodontics
ENME	-	Endocrinology & Metabolism
GAST	-	Gastroenterology
GEMD	-	Geriatric Medicine
GENP	-	General Practitioner
GNSG	-	General Surgery
HAGY	-	Haematology
HAPA	-	Haematological Pathology
HUGE	-	Human Genetics
INDI	-	Infectious Diseases
INMD	-	Internal Medicine
MDON	-	Medical Oncology
MEBI	-	Medical Biochemistry
MEGE	-	Medical Genetics
MEMI	-	Medical Microbiology
NCMD	-	Nuclear Medicine
NEPA	-	Neuropathology
NEPE	-	Neurology Paediatric
NEPH	-	Nephrology
NEUR	-	Neurology
NUSG	-	Neurosurgery
OBGY	-	Obstetrics & Gynaecology
ODON	-	Orthodontics
OPHT	-	Ophthalmology
OPTO	-	Optometry
ORAL	-	Oral Surgery
ORTH	-	Orthopaedic Surgery
OTOL	-	Otolaryngology
PATH	-	General Pathology
PEDI	-	Paediatrics
PEDO	-	Pedodontics
PERI	-	Periodontics
PHMD	-	Physical Medicine & Rehabilitation
PLAS	-	Plastic Surgery
PROS	-	Prosthodontics
PSYC	-	Psychiatry
RADI	-	Diagnostic & Therapeutic Radiology
RDON	-	Radiation Oncology
RHEU	-	Rheumatology
RSMD	-	Respiratory Medicine
THSG	-	Thoracic Surgery
UROL	-	Urology
VASG	-	Vascular Surgery *(7.2.2)*

CATEGORY ABBREVIATIONS *(7.2.3)*

ADON	-	Add On
ALPM	-	Alternate Payments
ANAE	-	Anaesthesia
BOGR	-	Bone Graft
CASP	-	Casts and Splints
COCR	-	Complete Care
CONS	-	Consultation
CRCR	-	Intensive Care / Critical Care
DEFT	-	Default
DISL	-	Dislocation
MAAS	-	Manual Assess
MAFR	-	Major Fracture
MASG	-	Major Surgery
MIFR	-	Minor Fracture
MISG	-	Minor Surgery
OBST	-	Obstetrical
OPTO	-	Optometry
PMNO	-	Pain Management (non obstetrical)
PSYC	-	Psychiatric Care
VADT	-	Visit Allowed Diagnostic & Therapeutic Procedure
VEDT	-	Visit Excluded Diagnostic & Therapeutic Procedure
VIST	-	Visit *(7.2.4)*

APPENDIX C – SERVICE ENCOUNTERS REQUIRING PRIOR APPROVAL/PREAUTHORIZATION (NOVA SCOTIA RESIDENTS) *(7.3.0)*

A request by a specialist must be submitted in writing to the Medical Consultant MSI outlining the medical necessity for the procedure. Upon review of the information a response will be issued. If the procedure is approved you will be advised of the Preauthorization Number. To ensure payment of the service the Preauthorization Number has to be entered in the appropriate field on the service encounter. *(7.3.1)*

PRIOR APPROVAL/PREAUTHORIZATION (RECIPROCAL RESIDENTS) *(7.3.2)*

The same listing of health service codes also applies for service encounters submitted using the reciprocal billing process. Approval has to be obtained from the recipient's home province Medicare Plan. If approval is received, forward a copy of the documentation to MSI requesting a Preauthorization Number. To ensure payment of the service the Preauthorization Number has to be entered in the appropriate field on the service encounter. *(7.3.3)*

Service encounters submitted for the following procedures must have prior approval and a valid referral in order to be paid. *(7.3.5)*

***Please note the health service codes not requiring prior approval if performed for malignant or premalignant conditions.** *(7.3.4)*

***** Prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition *(7.3.6)*

Health Service Code	Description
13.59O	Injection of OnabotulinumtoxinA for treatment of Chronic Migraine
22.5C	Plastic repair (without skin graft) eyelid - no prior approval required if condition is trauma related
30.4	Surgical correction of prominent ear – congenital (18 years and older)
30.61A	External ear otoplasty, exclusive of simple lacerations (minor)
30.61A	External ear otoplasty, exclusive of simple lacerations (major)
30.61B	Total reconstruction of ear (Pinna) (18 years and older)
33.74	Rhinoplasty with bone or cartilage graft (entire)
33.74	Rhinoplasty with bone or cartilage graft (partial)
33.76B	Complete rhinoplasty with submucous resection without skin grafting
33.76D	Rhinoplasty – removal of hump
33.76E	Scalping rhinoplasty – two stages
33.79B	Reconstruction of nasal tip, ala and columella
56.93	Gastroplasty or gastric bypass for morbid obesity
97.31A*	Unilateral mammoplasty with nipple transplantation
97.31C	Unilateral functional pedicled breast reduction (unilateral)
97.32*	Bilateral reduction mammoplasty
97.32B	Bilateral functional pedicled breast reduction
97.43*	Unilateral augmentation mammoplasty by implant or graft
97.44*	Bilateral augmentation mammoplasty by implant or graft
97.6B*	Breast reconstruction by myocutaneous flap and breast prosthesis
97.6C*	Breast reconstruction using rectus abdominis flap, including reconstruction of the rectus sheath as required.
97.6D*	Deep inferior epigastric perforator (DIEP) free flap breast reconstruction

Health Service Code	Description
97.75A*	Breast reconstruction by myocutaneous flap and prosthesis
97.77*	Other repair or reconstruction of nipple
97.94A*	Removal of breast prosthesis
97.94B*	Removal of breast prosthesis with capsulectomy
98.12R	Destruction (dermabrasion) of single area (e.g. trauma scar)
98.93A	Dermabrasion – full face
98.93B	Dermabrasion – less than 1/4 of face
98.93C	Dermabrasion of single area face (e.g., trauma scar)
98.93D	Dermabrasion between 1/4 and 1/2 of face

(7.3.7)

NOTE: The diagnostic code and description to use when billing for malignant or premalignant conditions are as follows: *(7.3.8)*

Code	Description
1740	Mal Neo Breast Nipple/Areola
1741	Mal Neo Central Portion Breast
1742	Mal Neo Upper Inner Quad Breast
1743	Mal Neo Lower Inner Quad Breast
1744	Mal Neo Upper Outer Quad Breast
1745	Mal Neo Lower Outer Quad Breast
1746	Mal Neo Auxiliary Tail Breast
1748	Oth Spec Mal Neo Female Breast
1749	Mal Neo Breast Unspec
19881	Secondary Mal Neo Breast
2330	Carcinoma in situ of Breast

(7.3.9)

APPENDIX D – COMPLETE CARE CODES *(7.4.0)*

Complete care codes are minor surgical procedures, which include the visit the same day and related visits by the same physician for 14 days following the procedure. Counselling related to the procedure cannot be claimed during this period. The following is a list of complete care codes: *(7.4.1)*

COMPLETE CARE CODES *(7.4.2)*

HSC	Description
10.15	Fitting for contraceptive diaphragm (complete care)
22.13A	Chalazion or tarsal cyst single or multiple complete care (one lid), local or general anaesthetic
32.09A	Myringotomy general anaesthetic complete care
33.1A	Drainage of abscess or hematoma of septum, complete care
39.0	Drainage of Ludwig's angina, complete care
40.0A	Drainage of retropharyngeal abscess intra oral, complete care
66.0A	Drainage of abdominal wall abscess general anaesthetic complete care
81.8	IUCD (complete care)
83.2C	Abscess of vulva, Bartholin's or Skene's gland complete care local anaesthetic
98.02	Perianal or pilonidal general anaesthetic, complete care

(7.4.3)

APPENDIX E – MAJOR SURGICAL PROCEDURES WITH NO ASSISTANT ALLOWED

(7.5.0)

There are some major surgical procedures where no assistant fee is allowed. A list of these procedures is as follows: *(7.5.1)*

HSC	Descriptions
01.03A	Endoscopy with Removal of Benign Growth
01.03B	Endoscopy with Removal of Foreign Body
01.34D	Cystoscopy with Brush Biopsy of Renal Pelvis
01.34F	With Urethral Meatotomy and Plastic Repair
06.34A	Gold seed implants
06.34B	Caesium needle implants
12.24A	Removal of Foreign Body or Calculus
14.13C	Burr Holes Diagnostic
14.85	Percutaneous Ventriculogram
15.42B	Exteriorization of distal end cerebralspinal fluid shunt
17.08C	Avulsion of Mandibular, Supraorbital
17.08E	Morton's Neuroma
17.61B	Repair of Palmar Nerve
17.61D	Peripheral Nerve Minor digital, primary suture
19.09	Incision Abscess (Thyroid Gland)
22.41	Ptosis Lid Suspension
22.5B	Tarsorrhaphy
22.5C	Plastic Repair (Without Graft)
22.5D	Plastic Repair with Graft
22.69C	Flap to Eyebrow – 2nd Stage
26.37	Cyclocryotherapy
26.62	Freeing of other anterior synechiae
26.62B	Intraocular synechiolysis with or without surgery to the pupil and iris
27.3	Capsulotomy
27.49A	Excision Crystalline Lens Senile or Other
27.59A	Excision Crystalline Lens Senile or Other
27.71A	Repositioning Dislocated Intraocular Lens
27.72	Insertion of Intraocular Lens Prosthesis with Cataract Extraction One stage
27.73	Secondary Insertion of Intraocular Lens Prosthesis
27.8	Removal of implanted Lens
28.44A	Photocoagulation Repeat
31.11	Stapedectomy with Prosthesis
31.59A	Tympanoplasty and Ossiculoplasty with/without Canal Plasty
33.04	Ligation of Anterior Ethmoid Artery
33.05	Ligation Internal Maxillary Artery
33.06	Suture Ligation Carotid in Neck – Simple
33.21A	Excision of Choanal Atresia – Bony
33.4A	Submucous Resection Including Resection of Inferior Turbinates
33.4	Submucous Resection
33.74	Grafting for Nasal Deformity
34.1A	Maxillary, Intranasal – Unilateral

HSC	Descriptions
34.31	Frontal Trephine and Sinusectomy
34.42A	Ethmoidotomy
34.43A	Sphenoidostomy with Sinusoscopy Control
37.09B	Local Excision of Simple Tumor Tongue
39.39B	Excision of Ranula or Dermoid Cyst
40.0B	Lateral Pharyngeal
40.2A	Tonsillectomy (Child Under 16)
40.2A	Tonsillectomy (Adult GA)
40.2A	Tonsillectomy (Adult LA)
40.7A	Post op Haemorrhage T&A Referred (Consult and Procedure)
42.09	Excision Benign Growth(s)
46.04A	Incision thoracotomy – closed drainage, includes Hemlick valve device
46.81A	Thoracoscopy with installation of Fibrin Glue
50.48E	Short Saphenous Ligation and Stripping
50.48P	Cauterization of Varicose Veins
50.72A	Suture Ligation – Jugular
50.78A	Suture Ligation – Femoral
51.92	Injection of sclerosing agent or solution into vein – compression sclerotherapy (feganization)
54.71	Introduction of Souter Tube
54.91A	Injection, Oesophageal Varices with Esophagoscopy Initial
54.92E	Dilation of Oesophagus with Esophagoscopy Initial
58.41A	Revision of Colostomy or Ileostomy
58.41C	Revision of Ileostomy
58.44A	Revision of Colostomy or Ileostomy
60.0A	Proctotomy With Exploration
60.0B	- With Decompression (Imperforate Anus)
60.0C	- With Drainage (Perirectal Abscess)
60.0D	Pelvic Abscess Drainage
60.21A	Cauterization of Small Rectal Carcinoma
60.24C	Transanal endoscopic microsurgery
60.39E	Membranous Obstruction of Anus
61.01B	Unroofing Complete Care
61.2	Local excision of lesion (fissure)
61.4A	Internal Sphincterotomy plus Excision of Fissure
61.69C	Excision Scar for Stenosis
62.49B	Donor hepatectomy
66.2A	Umbilectomy Plastic
66.83	Laparoscopy
66.83	Laser Laparoscopy
67.11D	Percutaneous Endopyelotomy
68.0B	Manipulation Only Stone Not Removed
68.89A	Ureterocoele
68.95A	Ureteroscopy with or without Biopsy
68.95B	Ureteroscopy with ultrasonic lithotripsy and/or ureteroscopy with electrodynamic lithotripsy
68.95C	Ureteroscopy plus basket

HSC	Descriptions
69.0A	- With Removal of Foreign Body or Calculus
69.0B	- With Litholapaxy, Visual or Tactile and Removal of Fragments
69.0C	Cystoscopy with Ultrasonic or Electrohydraulic Lithotripsy
69.13	Cystotomy
69.14	Cystostomy
69.29A	With electrocoagulation or Tumor-Single
69.29B	With electroexcision of Tumor or Tumors including Base and adjacent muscle-Single
69.29C	- With electrocoagulation of Hunner's Ulcers
69.29D	- With Resection of Bladder Neck
69.29E	- With Electrosurgical Ureteral Meatotomy
69.29G	Cystoscopy with electrocoagulation of tumor – multiple
69.29H	Cystoscopy – with electroexcision of Tumor or Tumors including base and adjacent muscle – multiple
70.0A	Perineal Urethrostomy
70.2C	Caruncle – Including Cystoscopy
70.2D	Urethral Papilloma
70.2L	Prolapse with Cystoscopy
70.4B	Internal Urethrotomy
71.7B	Cystoscopy and Endoscopic Mucosal Injection Teflon (Sting)
71.7C	Cystoscopy and Injection of Collagen into Periurethral Tissue at Bladder Neck for Stress Urinary Incontinence
71.7F	Cystoscopy with intravesicular injection(s) of chemodenervating agent
72.1B	Transurethral Electro-Resection
72.1C	Endoscopy Resection of Bladder Neck – Transurethral Prostatectomy
72.1D	Transurethral Electro-Resection
73.0B	Exploration Scrotum
73.2B	Resection Scrotum
74.1B	Biopsy of Testis with Vasography
74.2	Orchidectomy – Unilateral
74.31	Orchidectomy – both testes
74.51A	Ruptured Testicle
75.0A	Hydrocoele – Single
75.0B	Varicocoele – Single
75.1A	Spermatocoele
75.3	Epididymectomy – Unilateral
75.42	Reduction of torsion of testes or spermatic cord
75.73	Anastomosis
78.49A	Sterilisation by transcervical tubal occlusion (both tubes)
79.1	Conization of Cervix by any Means
81.01	Incomplete Abortion
81.61	Incomplete Abortion
81.91	Insertion of Radium
82.23C	Local Excision of Cyst
83.14	Bartholin's Gland Cyst
83.3B	Clitoris – Amputation
83.61	Perineorrhaphy

HSC	Descriptions
87.94	Manual Replacement of Inverted Uterus
89.19B	Foraging of os calcis (regions required)
89.59D	Bone biopsy – superficial
89.98A	Punch biopsy of vertebra
89.99B	Punch biopsy – with x-ray control
91.08L	Spinal trauma without cord injury cranio-skeletal traction tongs
91.08M	Spinal trauma with cord injury cranio-skeletal traction tongs
94.01A	Acute Tenosynovitis of Finger – Drainage
94.01B	Tendon Sheath – Simple Ganglion
94.01C	Tendon or Tendon Sheath – Explore
94.04	Incision and Drainage of palmer and thenar space
94.11A	Tendon Sheath – Release – Finger
94.11B	Tenotomy
94.13	Fasciotomy
94.21A	Tendon Sheath – Simple Ganglion
94.21D	Biopsy Through Incision
94.82A	Tenotomy
94.86B	Tenodesis – hand
95.01A	Tendon Sheath – Simple Ganglion
95.01B	Tendon or Tendon Sheath – Explore
95.01	Incision of Tendon Sheath
95.03C	Ulnar or Radial Bursa – Drainage
95.09A	Palmar or Plantar Space
95.13B	Tendon Sheath – Release – Wrist
95.13C	Tenotomy
95.15A	Plantar Fasciotomy
95.15	Fasciotomy
95.21A	Tendon Sheath – Simple Ganglion
95.21B	Biopsy Through Incision
95.35A	Fasciotomy
95.76C	Tenotomy
95.77A	Tenodesis – hand
97.11A	Excisional Biopsy with Intra operative needle localization
97.11B	Lumpectomy for breast tumor (regions required)
97.11	Excisional Biopsy Breast
98.12F	Lipoma
98.12H	Dermoid Cyst
98.12P	Lip Shave
98.13A	Carcinoma Local Excision Skin Graft
98.13B	Carcinoma Local Excision Graft Larger Than 5 sq. in.
98.13C	Carcinoma Local Excision with Rotation Flaps
98.13F	V-Excision for Carcinoma
98.14A	Pilonidal Cyst
98.99H	MOHS micrographic surgery (MMS) for the removal of histologically confirmed cutaneous malignancy – initial level and debulking

(7.5.2)

APPENDIX F – SELECT ENDOSCOPIC PROCEDURES ELIGIBLE FOR PREMIUM FEES

(7.6.0)

HSC	Description
01.08A	Transbronchial lung biopsy with fiberscope
01.09	Other nonoperative bronchoscopy
01.09A	Bronchoscopy with biopsy
01.09B	Bronchoscopy - with foreign body removal
01.12	Other nonoperative esophagoscopy
01.12A	Esophagobronchoscopy
01.12B	Esophagoscopy with biopsy
01.12C	Esophagoscopy - with removal of foreign body
01.14A	Injection of ulcer through the scope for G.I. bleed or application of crazy glue into fundal region of stomach (scope included)
01.14C	Esophagogastroscopy
01.14D	Esophagogastroscopy with biopsy
01.14E	Esophagogastroscopy - with removal of foreign body
01.14F	Insertion of intragastric balloon in addition to gastroscopic fee
01.14G	Removal of polyps in addition to the appropriate esophagogastroscopy – plus multiples, if applicable
01.22C	Colonoscopy of descending colon
01.22F	Balloon dilation of colonic stricture (In addition to colonoscopy)
54.21A	Electrocautery of GI bleeding lesions - add on to endoscopic fees
63.82A	Esophagogastroduodenoscopy - with papillotomy
63.95A	Esophagogastroduodenoscopy - with basket extraction of stones
63.95B	Esophagogastroduodenoscopy - with indwelling nasobiliary catheter
63.95C	Esophagogastroduodenoscopy - with biliary stents
64.91A	Esophagogastroduodenoscopy - with cannulation of pancreatic duct
64.91B	Choledochoscopy with associated procedure

(7.6.1)

APPENDIX G – SELECT MULTIPLE FRACTURE PROCEDURES ELIGIBLE FOR LV=85 FEES *(7.7.0)*

HSC	Descriptions
91.30A	Fractured humerus neck without dislocation of head – open reduction
91.30B	Fractured humerus shaft – open reduction
91.30C	Fractured humerus – epicondyle – medial – open reduction
91.30D	Fractured humerus – epicondyle – lateral – open reduction
91.30E	Fractured humerus tuberosity – open reduction
91.30F	Fractured humerus neck with dislocation of head – open reduction
91.30G	Fractured humerus – supra or transcondylar – open reduction
91.31	Open reduction of fracture with internal fixation, radius and ulna
91.31A	Open reduction – fractured olecranon
91.31B	Open reduction – radius – head or neck
91.31C	Open reduction fractured radius or ulna – shaft
91.31D	Colles' or Smith's fracture – open reduction
91.31E	Monteggia's or Galleazzi's fracture – open reduction
91.31G	Distal comminuted intra-articular fracture of radius (to include distal ulna) due to high energy trauma. To include open reduction, internal/external fixation as required when performed in conjunction with remote donor site bone graft.
91.34A	Fracture femur neck – open reduction with internal fixation
91.34B	Fractured femur – pertrochanteric – open reduction
91.34C	Fractured femur – shaft or transcondylar – open reduction
91.34D	Fracture femur neck – prosthetic replacement
91.35A	Fracture – tibia with or without fibula – shaft – open reduction
91.35B	Fractured tibial plafond, with or without fibula, open reduction and internal fixation – including removal of pre-existing internal or external fixation devices.
91.35C	Fractured tibia with or without fibula – plateau – open reduction
91.35D	Fractured ankle – single malleolus – open reduction
91.35E	Fracture fibula – open reduction
91.35F	Fractured ankle – bi or trimalleolar – open reduction
91.35G	Orif bicondylar tibial plateau fracture
91.38A	Fractured – clavicle – open reduction
91.95C	External fixation of tibial plafond fracture
91.95D	External fixation of tibial plafond fracture, with open reduction and internal fixation of fibular fracture.

(7.7.1)

APPENDIX H – MODIFIER TYPES AND VALUES *(7.8.0)*

MSI adjudication system employs modifiers to determine the payment amount of a service encounter. Modifiers can affect payment such as:

- Adding an amount to the basic fee
- Subtracting an amount from the basic fee
- Replacing the basic fee with a different amount
- Indicating role, time, method, age *(7.8.1)*

Modifier Type	Name	Description
AG	Age	Indicates the age of the patient
AN	Anaesthetic	Type of anaesthetic
AP	Approach	Defines the approach taken to perform the procedure
CO	Condition	The condition of the patient under anaesthetic
CT	Component	Defines the component of the procedure
DA	Date Of Service	Daily rate or date range
FN	Functional Centre	Indicates a specific type of centre within a facility
IN	Intensive Care	Describes the level and type of intensive care
LO	Location	Indicates where the service was provided
LV	Lesser Value	Second or subsequent procedure
ME	Method/Technique	Defines the technique of the procedure
OL	Originating Location	Indicates the location from where the home hospital care patient was admitted
PO	Portion	Defines the degree which a procedure is performed
PT	Patient	Defines first or additional patient seen at the same location
RF	Referred	Physician's referring number
RG	Region	Defines the region of the body
RO	Roles	The function the service provider performs at the service encounter
RP	Repeat Or Subsequent	When the same or similar service is provided more than once
SE	Sex	Gender of patient
SP	Specialty Code	Indicates physician's specialty
TI	Time	Defines the time block the service was provided
US	Unscheduled	Defines the type of unscheduled service

(7.8.2)

MODIFIER VALUES *(7.8.3)*

The following is a list of all available modifiers. In order to be paid the correct value for the service rendered, the appropriate modifiers and/or modifier combinations must be submitted. This Physician's Manual provides a list of the base unit values for the Health Service Codes. The complete list of all unit values and modifiers or modifier combinations is also available on your computer system. *(7.8.4)*

Type	Value	Description
AG	ADUT	Person 16 years and older
AG	CH03	Child up to three years
AG	CH04	Child up to four years
AG	CH07	Child up to seven years
AG	CH12	Child up to twelve years
AG	CH16	Child up to sixteen years
AG	NWBN	Newborn (infant up to and including ten days)
AG	OV65	Person 65 years and older
AG	PR07	Person seven years and older
AN	DFED	Delivery following epidural introduction
AN	EPID	Epidural anaesthetic
AN	GENL	General anaesthetic
AN	LABR	Labour
AN	LOCL	Local anaesthetic
AN	PNCT	Pain control
AN	REGL	Regional
AP	ABDO	Abdominal
AP	ANTE	Anterior
AP	CERV	Cervical
AP	CLSD	Closed procedure
AP	DRSL	Dorsal
AP	EXTR	External
AP	INPR	Intra peritoneal
AP	LMBR	Lumbar
AP	OPEN	Open procedure
AP	PERC	Percutaneous approach
AP	PERI	Perineal
AP	PHON	Occurred via telephone
AP	POST	Posterior
AP	SUBC	Subcutaneous
AP	THOR	Thoracic
AP	TRUR	Transurethral
AP	VAGN	Vaginal
AP	VIRC	Occurred via virtual care video platform
AP	WPLC	With pleura closed
AP	WPLO	With pleura open
CO	BPU5	Bypass pump – patient under 5000 grams
CO	CHYO	Controlled hypotension
CO	CRBY	Cardiac bypass with pump

Type	Value	Description
CO	HPTH	Hypothermia
CO	INFE	Infant resuscitation after delivery
CO	PACM	Pacemaker monitoring
CO	UN5K	Patient under 5000 grams
CT	PROF	Professional component
CT	TECH	Technical component
DA	DA23	Second or third date of admission or day out of ICU
DA	DA45	Fourth or fifth day of care
DA	DA47	Fourth to seventh date of admission or day out of ICU
DA	DALY	Daily rate applies
DA	RGE1	Date range defining Saturday, Sunday and Holidays
DA	RGE2	Sundays and Statutory Holidays
DA	WKLY	Weekly rate applies
FN	DTOX	Detox Centre
FN	EMCC	Emergency Care Centre
FN	INCU	Intensive care
FN	INPT	Inpatient
FN	NICU	Neonatal Intensive Care
FN	OTPT	Outpatient
IN	CC01	Critical care first day
IN	CC10	Critical care day 2 to 10 inclusive
IN	CC11	Critical care 11th day onward
IN	CP01	Comprehensive care first day
IN	CP10	Comprehensive care day 2 to 10 inclusive
IN	CP11	Comprehensive care 11th day onward
IN	INCR	Intensive care per day
IN	INHD	Intensive care per half day
IN	INPH	Intensive care per hour
IN	NIC1	Neonatal intensive care day 1
IN	NIC4	Neonatal intensive care day 2 to 4 inclusive
IN	NIC5	Neonatal intensive care day 5 onward
IN	RCV5	Respiratory care per visit
IN	RPC1	Respiratory care day 1 hourly rate
IN	RPC4	Respiratory care day 2 to 4 inclusive hourly rate
IN	RPC5	Respiratory care day 5 onward hourly rate
IN	VC01	Ventilatory care first day
IN	VC10	Ventilatory care day 2 to 10 inclusive
IN	VC11	Ventilatory care 11th day onward
LO	CCNT	Correctional Centre
LO	HMHC	Home Care
LO	HOME	Home
LO	HOSP	Hospital
LO	NRHM	Nursing Home
LO	OFFC	Office
LO	OTHR	Other

Type	Value	Description
LV	DIFF	Indicates the surgical procedure done through a separate approach
LV	LV50	The second or subsequent procedure done through the same approach
LV	LV65	Indicates a procedure done through separate approach
LV	LV85	The second or subsequent procedure involving the fracture of a different long bone
LV	SAME	The second or subsequent surgical procedure done through the same approach
ME	ABDM	Abdominal
ME	CARE	Comprehensive and Continuous care for Family Physicians
ME	CMST	Composite procedure
ME	COMP	Complicated procedure
ME	CONV	Occurred at home for convenience
ME	CRYO	Cryotherapy treatment by freezing
ME	CURT	Curettage scraping
ME	ECMO	Extracorporeal membrane oxygenation
ME	ELEC	Electrocautery removal by burning
ME	EXRM	Removal by excision
ME	EXTN	External
ME	FTSG	First stage
ME	HEMO	Hemodialysis
ME	INTN	Internal
ME	INTR	Intrauterine
ME	LAPA	Procedure performed by laparotomy
ME	LASR	Procedure performed using laser technique
ME	MAJO	Extensive complication
ME	MINO	Complexity minor or limited
ME	OV50	Photocopying – over 50 pages
ME	PERI	Peritoneal Dialysis
ME	RADI	Radical extensive procedure
ME	SCOP	Procedure performed through scope
ME	SDSG	Second stage
ME	SIMP	Simple procedure
ME	TELE	Telemedicine Conference
ME	UP10	Photocopying – 10 pages or less
ME	UP25	Photocopying – 11 to 25 pages
ME	UP50	Photocopying – 26 to 50 pages
ME	VAGN	Vaginal
ME	VTCR	Virtual care platform
PO	COML	Entire procedure performed
PO	ONTW	One to twenty percent of body
PO	PART	Partial procedure performed
PO	RADI	Procedure to the fullest extent
PO	SBTL	Subtotal (less than complete)
PO	SEGM	Segmental part of the body
PO	TOTF	Twenty-one to thirty-five percent of body
PO	TSOV	Thirty-six percent of body and over
PO	WEGE	Wedge part of the segment

Type	Value	Description
PT	CDDR	Cadaver donor
PT	DONR	Donor
PT	EXPT	Additional patient seen at same location
PT	FTPT	First patient seen
PT	LIDR	Live donor
PT	PRBK	Patient referred back
PT	PRTO	Patient referred to Ophthalmologist
PT	RECP	Recipient
PT	RISK	High risk patient
RF	REFD	Referring doctor
RG	ASCE	Ascending
RG	BOT2	Both sides, 2 levels
RG	BOT3	Both sides, 3 levels
RG	BOTH	Bilateral procedure
RG	CAUD	Caudal
RG	CERV	Cervical
RG	DESC	Descending
RG	FEMR	Femur head and neck
RG	GVCC	Great Vessel – left common carotid
RG	GVIB	Great Vessel – innominate / brachiocephalic
RG	GVSA	Great Vessel – left subclavian
RG	INRE	Infra renal
RG	IVCA	Inferior Vena Cava (IVC)
RG	LANT	Anterior Tibial – left side
RG	LAXI	Axillary – left side
RG	LBAC	Basilic or cephalic – left side
RG	LBRA	Brachial – left side
RG	LBRC	Brachiocephalic – left side
RG	LCOI	Common iliac – left side
RG	LCSF	Common femoral / Superficial femoral – left side
RG	LEFT	Procedure performed on the left side of the body
RG	LEXI	External iliac – left side
RG	LINI	Internal iliac – left side
RG	LPER	Peroneal – left side
RG	LPOP	Popliteal – left side
RG	LPOT	Posterior Tibial – left side
RG	LPRF	Profunda femoris – left side
RG	LRMV	Renal (main vessel) – left side
RG	LRSV	Renal (segmental vessel) – left side
RG	LRUA	Radial or ulnar – left side
RG	LSIG	Sigmoid sinus – left side
RG	LSUB	Subclavian – left side
RG	LTRA	Transverse sinus – left side
RG	LUMB	Lumbar
RG	ONE2	One side, 2 levels

Type	Value	Description
RG	ONE3	One side, 3 levels
RG	OTSE	Other segments
RG	RANT	Anterior Tibial – right side
RG	RAXI	Axillary – right side
RG	RBAC	Basilic or cephalic – right side
RG	RBRA	Brachial – right side
RG	RBRC	Brachiocephalic – right side
RG	RCOI	Common iliac – right side
RG	RCSF	Common femoral / Superficial femoral – right side
RG	REXI	External iliac – right side
RG	RIGT	Procedure performed on the right side of the body
RG	RINI	Internal iliac – right side
RG	RPER	Peroneal – right side
RG	RPOP	Popliteal – right side
RG	RPOT	Posterior Tibial – right side
RG	RPRF	Profunda femoris – right side
RG	RRMV	Renal (main vessel) – right side
RG	RRSV	Renal (segmental vessel) – right side
RG	RRUA	Radial or ulnar – right side
RG	RSIG	Sigmoid sinus – right side
RG	RSUB	Subclavian – right side
RG	RTRA	Transverse sinus – right side
RG	SAGG	Saggital sinus
RG	SURE	Supra renal
RG	SVCA	Superior Vena Cava
RG	VCEL	Visceral – celiac
RG	VHEP	Visceral – hepatic
RG	VIMA	Visceral – IMA
RG	VPOR	Visceral – portal
RG	VREN	Visceral – renal
RG	VSMA	Visceral – SMA
RG	VSPL	Visceral – splenic
RG	VSUM	Visceral – superior mesenteric
RO	ABAS	Abdominal assistant
RO	ABDM	Abdominal surgeon two team approach
RO	ABDO	Abdominal surgeon
RO	ANAE	Anaesthetist
RO	ANCO	Anticoagulant supervision per month
RO	ANTL	Antenatal
RO	CAPT	Comprehensive reassessment of a cancer patient
RO	CCDT	Continuing care and detention
RO	CCDX	Continuing care in conjunction with attending and describing a differential diagnosis
RO	CHDT	Closed head injury with detention
RO	CLHD	Closed head injury
RO	CNTC	Continuing care

Type	Value	Description
RO	CO19	Covid-19 immunization
RO	COMB	Combination of injections not otherwise defined in conjunction with visit
RO	CRTC	Palliative care medicine chart review (and/or telephone call, fax or e-mail initiated by a health care professional)
RO	DBSU	Double set up
RO	DETE	Detention
RO	DIRC	Directive care
RO	DRDT	Directive care and detention
RO	DTAS	Dental assistant
RO	DUTY	Duty doctor
RO	DYDT	Duty doctor and detention
RO	EPS1	WCB EPS Physician
RO	EXEM	Injection when potential for allergic reaction to ingredient exists
RO	FPHN	First physician
RO	GAIG	Measles immunoglobulin
RO	HAHB	Hepatitis A and B vaccine
RO	HAIG	Hepatitis A immunoglobulin
RO	HAVV	Hepatitis A vaccine
RO	HBIG	Hepatitis B immunoglobulin
RO	HBVV	Hepatitis B vaccine
RO	HDIN	High-dose influenza – inactivated
RO	HIBV	Haemophilus influenza type B vaccine
RO	HMDY	Home dialysis
RO	HMTE	home care, medical chart review, telephone calls, fax or e-mail
RO	HPV4	HPV-4 Human Papillomavirus vaccine
RO	HPV9	HPV-9 Human Papillomavirus vaccine
RO	INCH	Physician in hyperbaric chamber
RO	INFL	Injection for various strains of influenza
RO	INPR	Interpretation and procedure
RO	INTP	Interpretation
RO	IPVV	IPV inactivated polio vaccine
RO	MENB	Meningococcal B vaccine
RO	MENC	Meningococcal type C conjugate vaccine
RO	MENQ	Men-C-ACYW-135 Meningococcal conjugate quadrivalent vaccine
RO	MMAR	Injection for measles, mumps and rubella
RO	MMRT	Injection for MMR for travel to at risk areas (See July 2014 Bulletin)
RO	MMRV	Measles, Mumps, Rubella, and Varicella vaccine
RO	NBCR	Newborn care
RO	OBDA	Obstetrical delivery assist
RO	OTCH	Physician out of hyperbaric chamber
RO	PAMO	Pathology materials only
RO	PCSV	Palliative care support visit
RO	PEAS	Perineal assistant
RO	PENT	Injection for diphtheria, pertussis, tetanus, poliomyelitis and haemophilus influenza type B
RO	PNEC	Pneumococcal conjugate vaccine (Prevnar)

Type	Value	Description
RO	PNEU	Injection for pneumococcal pneumonia, bacteraemia and meningitis
RO	PRIN	Perineal surgeon two team approach
RO	PROC	Procedure
RO	PTNT	Post natal
RO	PTPP	Post partum
RO	RABI	Rabies immunoglobulin
RO	RABV	Rabies vaccine
RO	RESC	Resuscitation
RO	RNDT	Resuscitation of newborn with detention
RO	SNAS	Second assistant
RO	SPCR	Supportive care
RO	SPHN	Second physician
RO	SPIN	Supervision and interpretation
RO	SRAS	Surgical assistant
RO	SSAN	Second simultaneous anaesthetist
RO	STBY	Standby
RO	SUPV	Supervision
RO	TCCP	Telephone advice and medical chart review of a cancer patient by the Oncologist
RO	TDAP	Tetanus toxoid, diphtheria, acellular pertussis vaccine
RO	TDPP	Tetanus toxoid, diphtheria, acellular pertussis, polio vaccine
RO	TEDV	Tetanus toxoid, diphtheria vaccine
RO	TEIG	Tetanus immunoglobulin
RO	TIPV	TD-IPV vaccine
RO	TRPL	Treatment planning
RO	TRTL	Trauma team leader
RO	UPCK	Visit pacemaker check
RO	VAIG	Varicella zoster immunoglobulin
RO	VARV	Varicella vaccine
RO	VGSG	Vaginal surgeon
RO	WBCR	Well baby care
RP	CON2	Second chronic disease managed
RP	CON3	Third chronic disease managed
RP	INTL	Initial
RP	REPT	A repeat of a service
RP	REVS	Revision
RP	SUBS	Subsequent similar service
SE	FEML	Female
SE	MALE	Male
SP	ANAE	Anaesthetist
SP	ANPA	Anatomical Pathology
SP	CARD	Cardiology
SP	CASG	Cardiovascular/Thoracic surgery
SP	CLIA	Clinical Immunology and Allergy
SP	COMD	Community Medicine
SP	DENT	Dental General Practitioner

Type	Value	Description
SP	DERM	Dermatology
SP	DIRD	Diagnostic Radiology
SP	EMMD	Emergency Medicine
SP	ENDO	Endodontics
SP	ENME	Endocrinology and Metabolism
SP	GAST	Gastroenterology
SP	GEMD	Geriatric Medicine
SP	GENP	General Practitioner
SP	GNSG	General Surgery
SP	HAGY	Haematology
SP	HAPA	Haematological Pathology
SP	HUGE	Human Genetics
SP	INDI	Infectious Diseases
SP	INMD	Internal Medicine
SP	MDON	Medical Oncology
SP	MEBI	Medical Biochemistry
SP	MEGE	Medical Genetics
SP	MEMI	Medical Microbiology
SP	NCMD	Nuclear Medicine
SP	NEPA	Neuropathology
SP	NEPE	Neurology Paediatric
SP	NEPH	Nephrology
SP	NEUR	Neurology
SP	NUSG	Neurosurgery
SP	OBGY	Obstetrics and Gynaecology
SP	ODON	Orthodontics
SP	OPHT	Ophthalmology
SP	OPTO	Optometry
SP	ORAL	Oral Surgery
SP	ORTH	Orthopaedic Surgery
SP	OTOL	Otolaryngology
SP	PATH	General Pathology
SP	PEDI	Paediatrics
SP	PEDO	Pedodontics
SP	PERI	Periodontics
SP	PHMD	Physical Medicine and Rehabilitation
SP	PLAS	Plastic Surgery
SP	PROS	Prosthodontics
SP	PRPR	Prosthetic Provider
SP	PSYC	Psychiatry
SP	RADI	Diagnostic and Therapeutic Radiology
SP	RDON	Radiation Oncology
SP	RHEU	Rheumatology
SP	RSMD	Respiratory Medicine
SP	THSG	Thoracic Surgery

Type	Value	Description
SP	UROL	Urology
SP	VASG	Vascular Surgery
TI	AMNN	0801-1200
TI	ETMD	2001-2359
TI	EVNT	1701-2000
TI	EVWH	Weekday evenings after 1800, weekends and holidays
TI	GPEW	General Practice enhanced hours premium (M-F 0600-0800 1700-2200 or S/S/H 0900-2200)
TI	MDNT	0000-0800
TI	NNEV	1201-1700
US	PREM	Premium fee of 35 percent
US	PR50	Premium fee of 50 percent
US	SCHD	Planned / Scheduled outpatient visit (0800-2000)
US	UIOH	Urgent visit interrupting normal office hours
US	UNOF	Urgent visit not interrupting office hours

(7.8.5)

APPENDIX I – EXPLANATORY CODES *(7.9.0)*

Explanatory Code	Description
AD001	Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved.
AD002	Service encounter has been refused as a duplicate billing exists.
AD003	Service encounter has been refused as electronic text is required.
AD004	Service encounter has been refused as this service has previously been approved.
AD005	Service encounter has been refused. A previous service encounter for 13.59L, RO=INPN has been approved at this same encounter.
AD006	Service encounter has been refused as a previous service encounter has been approved and includes this service.
AD007	Service encounter has been refused as previous payment has been approved under 13.59L, RO=INTD.
AD008	Service encounter has been refused. Delete original immunization approved this day and submit a new service encounter using the appropriate combination modifier value.
AD009	Service encounter has been refused. Delete one of the original submissions and submit a service encounter for the combination of this immunization and the one from the deleted service encounter.
AD010	Service encounter has been refused as previous payment has been made this day for a portion of this combination.
AD011	Service encounter has been refused. Previous payment has been made this day for a portion of this combination injection.
AD012	Service encounter has been refused. Previous payment has been made this date for a portion of this combination injection.
AD013	Service encounter has been refused as electronic text is required for this service to be approved at location indicated.
AD014	Service encounter has been disallowed as surgery has been performed during this hospitalization.
AD015	Service encounter has been disallowed as a previous service encounter has been approved for the discharge fee at this hospitalization.
AD016	Service encounter has been disallowed as surgery has been performed by you during this hospitalization.
AD017	Service encounter has been disallowed as patient history indicates conflicting hospital admit dates. Check your records to confirm admit date and submit a reassess (action code R) once you have verified the date.
AD018	Service encounter has been refused as you have been approved this service under a combination code.
AD019	Service encounter has been refused. A portion of this combination service has previously been approved to you.
AD020	Service encounter has been refused. Previous payment has been made to you for a portion of this service.
AD021	Service encounter has been refused. Previous approval has occurred to you under MMRV.
AD022	Service encounter has been refused. Previous approval has occurred to you under PENV.
AD023	Service encounter has been refused. Previous approval has occurred to you under MMQU.
AD024	Service encounter has been refused. Previous approval has occurred under MMR2 and/or QUAD.
AD025	Service encounter has been refused as previous approval has occurred to you under MMQU.
AD026	Service encounter has been refused as you have previously been approved an injection covered in this service.
AD027	Service encounter has been refused as a portion of this service has been previously approved.

Explanatory Code	Description
AD028	Service encounter has been reduced to 50%. Only one immunization at full fee is payable when a visit is claimed.
AD029	Service encounter has been reduced to 50% as two previous immunizations were paid at full fee on this date.
AD030	Service encounter has been refused. Two immunizations have been paid at full fee this date. Delete one immunization and resubmit at LV50 along with your visit/consult claim.
AD031	Service encounter has been refused as the patient's birth date is inappropriate for this service.
AD032	Service encounter has been refused as the maximum number of PENT injections has been reached.
AD033	Service encounter has been refused as patient must be one year of age.
AD034	Service encounter has been reduced to 50% as a visit and previous injection have been billed.
AD035	Service encounter has been refused as the maximum number of PNEC injections have been approved.
AD036	Service encounter has been refused as the patient has not reached the appropriate age for this type of injection.
AD037	Service encounter has been refused as the diagnostic code indicated and age of patient does not warrant payment of the influenza vaccine.
AD038	Service encounter has been refused as a maximum of three 13.59L RO=PNEU immunizations have been previously paid.
AD039	Service encounter has been refused as a claim for Thrombolysis has already been made for this day
AD040	Service encounter has been refused as you have previously billed HSC 98.51C, 98.51D, 95.01, 92.63A, 92.63B, 93.79B, 93.79C, or 93.79E for this patient on the same day.
AD042	Service encounter has been refused as a claim was already made for this service on the same date.
AD043	Service encounter has been refused as a claim was previously made for HSC 46.04L: Intraoperative placement of interpleural catheter for paravertebral block, for this patient on the same day.
AD044	Service encounter has been refused as you have previously billed the maximum of two claims for HSC 13.59L RO=MMRV for this patient.
AD045	Service encounter has been refused as this patient has previously received a dosage of Quadracel vaccine.
AD046	Service encounter has been refused as an immunization injection must be claimed prior to the tray fee.
AD047	Service encounter has been refused as HSC 98.49C must be submitted prior to the add on 98.49D.
AD048	Service encounter has been refused as you have previously billed HSC 66.3E or 66.3F.
AD049	Service encounter has been refused as the patient age is not within 6 months and one week prior to 12 months.
AD050	Service encounter has been refused as electronic text is required stating the reasoning for administering the MMRT immunization.
AD051	Service encounter has been disallowed. When claiming for high-risk patients (PT=RISK), text is required. Please resubmit with the appropriate text.
AD052	Service encounter has been refused as the patient is less than 6 weeks old.
AD053	Service encounter has been refused as a PENT injection has been previously approved in the previous 4 weeks.
AD054	Service encounter has been refused as you have been previously billed HSC 90.09G for this patient on this day.
AD055	Service encounter has been refused as there is no claim for an eligible premium service billed at the same encounter
AD056	Service encounter has been disallowed as you have previously billed HSC 95.94A at the same encounter

Explanatory Code	Description
AD057	Service encounter has been refused as an influenza injection has already been approved in the previous 6 months.
AD058	Service encounter has been refused as a third injection for RO=HPV4 requires modifier PT=RISK
AD059	Service encounter has been refused as the maximum number of HPV4 injections has been reached.
AD060	Service encounter has been refused as the second dose of the measles, mumps and rubella vaccine cannot be administered within 28 days of the first dose.
AD061	Service encounter has been refused as the tetanus toxoid, diphtheria, and acellular pertussis immunization has previously been claimed for this patient while over 18 years of age.
AD062	Service encounter has been refused as the maximum number of IPVV injections has been reached.
AD063	Service encounter has been refused as a tetanus toxoid, diphtheria injection has already been approved in the previous 10 years.
AD064	Service encounter has been disallowed as claim does not include electronic text. To claim the HOVM1 fee, text must include the start and finish time of day, point of origin, destination address, and distance in KM. Please resubmit with text.
AD065	Service encounter has been refused as in order to claim HOVM1, a home visit with the patient must be submitted first for the same service occurrence.
AD066	Service encounter has been refused as a colonoscopy add on fee may only be claimed after a colonoscopy is billed for the same occurrence.
AD067	Service encounter has been refused. Resubmit using the appropriate health service code and modifier combination with the PT=RISK modifier and text explaining high risk.
AD068	Service encounter has been refused as the HSC 03.03P has previously been paid.
AD069	Service encounter has been refused. You must claim an appropriate office visit service before claiming this add on fee for the same encounter.
AD070	Service encounter has been refused as you have previously claimed the first visit after discharge add on fee for this period.
AD071	Service encounter has been refused as you have previously claimed the first visit after discharge add on fee the maximum of four times in the past year.
AD072	Service encounter has been refused as you have previously claimed a monthly care fee in the same calendar month.
AD073	Service encounter has been refused as you have previously claimed HSC 03.03S in the same calendar month.
AD074	Service encounter has been refused as patient is 5 years of age or over.
AD075	Service encounter has been disallowed as text is required indicating the need for additional doses of the MMAR vaccine.
AD076	Service encounter has been refused as the HSC 03.03P cannot be claimed for patient ages 1-10.
AD077	Service encounter has been refused as a third injection for RO=HPV9 requires PT=RISK. Please resubmit with the appropriate modifiers.
AD078	Service encounter has been refused as patient is not 65 years of age or older.
AD079	Service encounter has been disallowed as RO=HDIN may only be claimed from a long-term care/residential care facility.
AD080	Service encounter has been refused as the maximum number or HPV9 injections has been reached.
AD081	Service encounter has been refused as HSC HOVM1 cannot be claimed on home visits that occur for patient or physician convenience.
AD082	Service encounter has been refused as the interpreter incentive may only be claimed after a visit or consult during the same occurrence.
AD083	Service encounter has been refused based on the age of the recipient.

Explanatory Code	Description
AD084	Service encounter has been refused as HSC 02.84A which is a stand-alone procedure has already been claimed during the same encounter.
AD085	Service encounter has been refused as the maximum number of rotavirus immunizations has been reached.
AD086	Service encounter has been refused as you must claim the base delivery dee (HSC 87.98) prior to claiming detention during obstetrical delivery.
AD087	Service encounter has been disallowed as RO=HDIN may only be claimed from a long-term care/residential care facility or hospital inpatient for patient designated alternate level of care awaiting long term care facility placement.
AD088	Service encounter has been refused as a claim for 13.59L RO=CO19 has been approved in the previous 18 days.
AD089	Service encounter has been refused as this is an add on fee to HSC associated with OAT provision only.
AD090	Service encounter has been refused as only 1 urine drug screen tray fee can be billed in association with 03.03J, 03.03K or 03.03L.
AD091	Service encounter has been disallowed as the maximum of 4 urine drug screen tray fees per patient in the previous 30 days has been reached. Please include text indicating if special permission has been granted to exceed this maximum.
AD092	Service encounter has been refused as the maximum number of mpox injections has been reached
AD093	Service encounter has been refused as a claim for 13.59L RO=MPOX has been approved in the previous 28 days
AD094	Service encounter has been reduced to 50%. Only one 13.59L at full fee is payable when NPIV1 is claimed.
AD095	Service encounter has been refused as you must claim the diagnostic mammography fee prior to claiming digital breast tomosynthesis. This service may not be claimed independently.
AD096	Service encounter has been refused as the date of birth of the patient is prior to January 1, 1970. Please resubmit with text indicating if the patient is a healthcare worker or post secondary student.
AD097	Service encounter has been refused as the maximum number of doses of 13.59L RO=PNEU immunizations have previously been paid.
AD098	Service encounter has been disallowed as RO=RSVV may not be claimed from this location
AJ001	Service encounter has been adjusted according to information provided by you.
AJ002	Service encounter has been adjusted according to information provided on another service encounter.
AN001	Service encounter has been refused. When multiple procedures are performed during the same time, only one anaesthetic fee applies.
AN002	Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved.
AN003	Service encounter has been refused as this service can only be claimed by Anaesthesiologists.
AN004	Service encounter has been refused as the first anae start time specified on this claim does not match the time provided on the previously submitted claim for the first anaesthesiologist service,
AN005	Consecutive anaesthetist claims cannot be processed until after the first anaesthetist claim has been submitted. A per preamble 5.2.52.
AN006	Service encounter has been refused as the consecutive anaesthetic health service code claimed does not match first anaesthetic health service coded. Please resubmit using the correct health service code.
BG001	Service encounter has been approved at 50% of the appropriate bone graft code in addition to the primary fracture procedure.

Explanatory Code	Description
BG002	Service encounter has been reduced. When multiple procedures are performed at the same time, only one is approved at 100%.
BG003	Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved.
BG004	Service encounter has been approved at 50% as another procedure has been approved at 100% for this same service encounter.
BG005	Service encounter has been approved at 50%. When multiple procedures are performed at the same time only one is approved at 100%.
BK001	Service encounter has been disallowed as you have not included text referring to the anatomical site specimen was taken from. Please resubmit with appropriate text.
BK002	Service encounter has been refused as you have previously claimed for an abdominal survey film at the same encounter.
BK003	Service encounter has been refused as you have previously claimed for an intravenous urogram (IVP) at the same encounter.
BK004	Service encounter has been disallowed as at the same encounter you have claimed for an intravenous urogram (IVP) which cannot be claimed with routine tomography. If tomography was not routine, please resubmit with text indicating the situation.
BK005	Service encounter has been refused as you have previously billed for a service in which fluoroscopy is included for the same encounter.
BK006	Service encounter has been refused as you have previously billed for a fluoroscopy during the same encounter.
BK007	Service encounter has been refused as this service is not yet eligible for electronic billing.
BK008	Service encounter for fluoroscopy has been refused as you have previously billed for another service at the same encounter.
BK009	Service encounter has been refused as you have previously billed for a stand-alone fluoroscopy fee at the same encounter.
BK010	Service encounter has been refused as the patient is over 12 years old. Please submit a claim for the applicable non paediatric code for payment.
BK011	Service encounter has been refused as you have previously claimed for an upper G.I. series for this patient at the same encounter.
BK012	Service encounter has been refused as you have previously claimed for a colon G.I. series for this patient at the same encounter.
BK013	Service encounter has been refused as you have previously claimed for a cystography or cystourethrogram for this patient at the same encounter.
BK014	Service encounter has been refused as you have previously claimed a CT fee for the same region during this encounter. When a CT examination is performed with and without contrast, the combined code should be used.
BK015	Service encounter has been refused as you have previously submitted a separate claim for this CT with or without contrast at the same encounter. Please submit a delete for the individual fee before claiming this combined code.
BK016	Service encounter has been refused as you have previously submitted a claim for this CT with and without contrast combination code at the same encounter.
BK017	Service encounter has been refused as you have previously billed for an ultrasound of the aorta, appendix, kidneys, or pylorus at the same encounter. These are meant to be included in the abdomen general ultrasound fee.
BK018	Service encounter has been refused as you have previously billed for an abdomen general ultrasound at the same encounter. An ultrasound of the aorta, appendix, kidneys, or pylorus is meant to be included in the abdomen general ultrasound fee.

Explanatory Code	Description
BK019	Service encounter has been refused as you have previously billed for an U/S of the aorta, appendix, kidneys, or pylorus at the same encounter. These fees are not cumulative. An abdominal general U/S (HSC R1205) is the composite fee for these services.
BK020	Service encounter has been refused as this fee is considered to be an add on code and may only be claimed after a base service has been billed.
BK021	Service encounter has been refused as you have previously billed for an endovaginal U/S (R1225) at the same encounter. To claim for both, please submit a delete for the endovaginal U/S and create a new claim for endovaginal with pelvic (R1226).
BK022	Service encounter has been refused as you have previously billed for a pelvic ultrasound (R1220) at the same encounter. To claim for both, please submit a delete for the pelvic ultrasound and create a new claim for endovaginal with pelvic (R1226)
BK023	Service encounter has been refused as you have previously billed for the endovaginal and pelvic ultrasound combination fee at the same encounter.
BK024	Service encounter has been refused as you have previously submitted a claim for either the stand alone pelvis ultrasound or endovaginal ultrasound fee.
BK025	Service encounter has been refused as you have previously submitted for another code at the same encounter. When the intraoperative code is used, no other code may be claimed for that examination.
BK026	Service encounter has been refused as you have previously submitted for an intraoperative ultrasound fee at the same encounter. When the intraoperative code is used, no other code may be claimed for that examination.
BK027	Service encounter has been refused as HSC 03.38A has already been claimed for this patient on this day.
BK028	Service encounter has been refused as you have previously submitted the bilateral fee code for his patient at the same encounter.
BK029	Service encounter has been refused as you have previously submitted the unilateral fee code for this service at the same encounter. Please submit a delete for the unilateral service before claiming the bilateral fee.
BK030	Service encounter has been refused as you have previously submitted a venogram extremity claim at the same encounter. The venogram extremity fee includes the central film.
BK031	Service encounter has been refused as you have previously submitted a central film claim at the same encounter. A venogram extremity fee includes he central film. Please submit a delete for HSC R605 before resubmitting the venogram extremity fee.
BK032	Service encounter has been refused as you have previously submitted a renal scan and renogram claim at the same encounter.
BK033	Service encounter has been refused as you have previously submitted an A.C.E. renal scan claim at the same encounter.
BK034	Service encounter has been disallowed. Please resubmit indicating in the text field who performed the injection.
BK035	Service encounter has been refused as this fee is considered to be an add on code and may only be claimed after a renal scan (R1875, R1880, or R1881) has been billed.
BK036	Service encounter has been refused as you have previously billed for the multiple areas fee at the same encounter.
BK037	Service encounter has been refused as you have previously billed for the single area fee at the same encounter.
BK038	Service encounter has been refused as an autopsy has already been claimed for this individual.
BK039	Service encounter has been disallowed as you have previously claimed a visit for this individual at the same encounter.

Explanatory Code	Description
BK040	Service encounter has been disallowed as you have previously claimed a consult for this individual at the same encounter.
BK041	Service encounter has been refused as this facility is not permitted to claim for these mammogram fees.
BK042	Service encounter has been refused as you have previously claimed for renal static imaging at the same encounter.
BK043	Service encounter has been accepted at a reduced value as a claim for cytology screener code P2330 has previously been made for this specimen.
BK044	Service encounter has been refused as a claim has previously been made for the interpretation and report of these GYN cytology slides (HSC P2331)
BK045	Service encounter has been refused as you have previously billed for a Doppler quantitative interpretation at the same encounter.
BK046	Service encounter has been refused as you have previously billed for a Doppler qualitative interpretation at the same encounter.
BK047	Service encounter has been refused as you have previously billed for a genetic sonogram at the same encounter. A genetic sonogram includes all necessary imaging.
BK048	Service encounter has been refused as you have previously billed a critical or comprehensive care fee for the patient on this day which includes all EKG interpretation performed.
BK049	Service encounter has been refused as you have previously billed an EKG interpretation fee for the patient on this day. Please submit a delete for the EKG interpretation before making a submission for a critical or comprehensive care fee.
BK050	Service encounter has been refused as HSC 03.38B or 03.38C has already been claimed for this patient on this day,
BK051	Service encounter has been refused as a mammography screening has already been claimed for this patient on this day.
BK052	Service encounter has been refused as you have previously billed this MRI interpretation service for the same patient on this day.
BK053	Service encounter has been refused as a repeat sequence can only be claimed after the matching base multisection MRI fee is claimed for the same occurrence. Please claim the base fee for this MRI before submitting the repeat sequence claim.
BK054	Service encounter has been refused as you have already claimed this service for the same patient on the same day.
BK055	Service encounter has been refused as a fee for gating may only be claimed after a MRI thorax with multiple sequences has been claimed during the same encounter.
BK056	Service encounter has been disallowed as this echocardiograph service has already been claimed for this patient on this day. Please resubmit with electronic text explaining the reason for the subsequent service.
BK057	Service encounter has been refused as this service cannot be billed from this facility.
BK058	Service encounter has been disallowed as you have previously billed for a quantitative or qualitative Doppler interpretation on the same day. Please resubmit this claim with electronic text explaining the necessity of the 2nd interpretation.
BK060	Service encounter has been refused as the following HSCs I1310, I1312 and I1313 may only be billed once per patient per day.
BK061	Service Encounter has been disallowed. Please submit a copy of the first and subsequent echo reports along with clinical documentation before requesting a reassessment for this claim.
BK062	Service encounter has been refused as HSC 02.75C has already been claimed for this patient at the same encounter.

Explanatory Code	Description
BK063	Service encounter has been disallowed as this service has already been claimed on the same day as 50.0B. Please resubmit with text indicating the medical necessity for an additional claim.
BK064	Service encounter has been disallowed as you have not included text referring to the inspired program. Please resubmit with appropriate text
CC001	Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved.
CC002	Service encounter has been approved at 50% as another procedure has previously been approved at 100% at this same encounter.
CC004	Service encounter has been disallowed as HSC 03.05 has previously been claimed. Documentation must be provided if re-assessment is required.
CN001	Service encounter has been refused. When billing a stress test and a consultation and the patient has been examined by a different cardiologist in the previous 14 days, a visit fee only applies.
CN002	Service encounter has been refused as a repeat consultation is not payable unless a consultation for a related diagnosis with the same referring physician has been approved in the previous 30 days.
CN003	Service encounter has been refused as a complete care code includes related visits for the following 14 days.
CN004	Service encounter has been refused as you have previously been paid a visit or consultation this day under the same service occurrence number.
CN005	Service encounter for a consultation with detention has been refused as you have previously been approved a visit allowed procedure at the same service encounter.
CN006	Service encounter has been refused as a consultation and psychotherapy or counselling are not payable at the same service encounter.
CN007	Service encounter has been disallowed as this service is included in the post-operative care.
CN008	Service encounter has been disallowed as this service is included in the post-operative care of fractures.
CN009	Service encounter has been disallowed as contact lens fitting includes follow up for three months.
CN010	Service encounter has been disallowed. The first post-operative clinic or office recheck should be claimed but will be approved at 0 units during the 90 days following major surgery.
CN011	Service encounter has been disallowed as a consultation is not approved the same day as critical care.
CN012	Service encounter has been disallowed as compression sclerotherapy includes after care for one year.
CN013	Service encounter has been refused as detention is not payable in the office.
CN014	Service encounter has been disallowed as it is included as post-operative care of a fracture.
CN015	Service encounter has been disallowed. Contact lens fitting includes follow up for three months.
CN016	Service encounter has been disallowed as a consultation is considered included in the procedural code for induction of labour by artificial rupture of membranes as well as the procedural code for removal of retained placenta.
CN017	Service encounter has been disallowed as this service is payable once per patient per physician.
CN018	When a comprehensive or limited consultation is billed within 30 days of a PACS consultation the PACS consultation is disallowed.
CN019	Service encounter has been disallowed as a consultation is considered included in the fee for an obstetrical trauma repair.
CN020	Service encounter has been disallowed as an 03.09B has previously been approved for this day.
CN021	Service encounter has been refused as you have already billed remote specialist telephone advice for this patient on this date.
CN022	Invalid referral provider type for specialty code present on service encounter.

Explanatory Code	Description
CR001	Service encounter has been disallowed as a comprehensive critical care visit has been approved to you or another physician on this day.
CR002	Service encounter has been refused as another intensive care visit has been approved to you or another physician this day.
CR003	Service encounter has been refused as modifier type {in} value, date of service and admit to intensive care date do not agree.
CR004	Service encounter has been disallowed. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved.
CR005	Service encounter has been refused as date of service indicated is prior to intensive care admit date given.
CR006	Service encounter has been refused as you have previously been approved a consultation or visit this day.
CR007	Service encounter has been disallowed. Critical care and ventilatory support are included in comprehensive care.
CR008	Service encounter has been refused as your specialty is not valid for providing intensive care associated with respiratory insufficiency.
CR009	Service encounter has been refused as modifier type {in} value, admit to intensive care date and date of service do not agree.
CR010	Service encounter has been refused as modifier type {in} value, date of service and admit to intensive care date do not agree.
CR011	Service encounter has been refused as this service has already been billed for this date.
CR012	Service encounter has been refused as a fee for intensive care has already been claimed for this patient on this date. Critical or comprehensive care cannot be claimed on the same day as intensive care.
CR013	Service encounter has been refused. When a physician provides both critical and ventilatory care to a patient they should claim comprehensive care. Please delete the previously paid ventilatory care and submit a claim for comprehensive care.
CR014	Service encounter has been refused. When a physician provides both critical and ventilatory care to a patient they should claim comprehensive care. Please delete the previously paid critical care and submit a claim for comprehensive care.
CR015	Service encounter has been refused as a fee for comprehensive care has previously been claimed for this patient on this day (5.1.124).
CR016	Service encounter has been refused as a fee for critical or ventilatory care has previously been claimed for this patient on this day (5.1.124).
CR017	Service encounter has been refused as a fee for intensive care has previously been claimed for this patient on this date.
CR018	Service encounter has been refused as a fee for comprehensive or critical care has previously been claimed for this patient on this date.
CR019	Service encounter has been disallowed as the day one fee has already been claimed for this patient during the same ICU admission. Please submit a new claim with the appropriate daily modifier.
CR020	Service encounter has been disallowed as a claim for directive care or continuing care has already been approved for this patient on the same day.
CS001	Service encounter has been disallowed as application of casts and/or splints is not approved following a fracture procedure.
CS002	Service encounter has been disallowed as application of casts and/or splints is included in the fracture procedure.
CS003	Service encounter has been disallowed as it is included in the surgery performed.

Explanatory Code	Description
CS004	Service encounter has been reduced. When multiple procedures are performed at the same time only one is approved at 100%.
CS006	Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved.
CS007	Service encounter has been disallowed. When a visit and cast and/or splint are performed at the same service encounter, only one is approved.
CS008	Service encounter has been disallowed as application of casts and/or splints is included in the fracture procedure.
DE001	Service encounter has been refused as payment responsibility is invalid for service provided.
DE002	Service encounter has been refused as payment responsibility is not valid for service indicated.
DE003	Service encounter has been refused. Payment responsibility indicated is not valid for this service.
DE004	Service encounter has been refused as payment responsibility and service indicated do not agree.
DE005	Service encounter has been disallowed as electronic text is required for this service.
DE006	Service encounter has been disallowed as C9999 has been approved to you or another provider in the previous 30 days.
DE007	Service encountered has been disallowed as this service is restricted to individuals aged 18-64 years.
DE008	Service encounter has been disallowed as the recipient is 65 years of age or older.
DE009	Service encounter has been refused as this service has already been approved for this year.
DE010	Service encounter has been refused as two medication reviews have previously been approved for this year.
DE011	Service encounter has been refused as the second condition amount has already been approved for this year.
DE012	Service encounter has been refused as there is already one Unattached Patient Bonus payment claim on history.
DE013	Service encounter has been refused as two Long-Term Care Clinical Geriatric Assessments have previously been paid this year.
DE014	Service encounter has been refused as invalid or omitted location.
DE015	Service encounter has been refused as the previously claimed 03.04D also includes the fee for a comprehensive geriatric assessment.
DE016	Service encounter has been refused as the second condition amount has already been approved for this year.
DE017	Service encounter has been refused as the care plan oversight fee has previously been claimed for this patient for the same month.
DE018	Service encounter has been refused as the care plan oversight fee has already been claimed the maximum of six times for this patient during this calendar year.
DE019	Service encounter has been refused as in order to claim the care plan oversight fee you must have seen the patient for a face-to-face visit at least once in the past six months prior to reporting CPO.
DE020	Service encounter has been refused as a claim for long term care medication review has previously been made for this patient during the same calendar year. CPO1 cannot be claimed with either of these fees.
DE021	Service encounter has been refused as a claim for supervision of long-term care anticoagulant therapy has previously been made for this patient during the same calendar month. CPO1 cannot be claimed with this fee.
DE022	Service encounter has been refused as a claim for care plan oversight has previously been made for this patient during the same calendar year. ENH1 cannot be claimed with this fee.
DE023	Service encounter has been refused as a claim for care plan oversight has previously been made for this patient during the same calendar month. 13.99C cannot be claimed with this fee.

Explanatory Code	Description
DE024	Service encounter has been refused as this service has already been approved for this month.
DE029	Service encounter has been refused as a claim for care plan oversight or long-term care clinical geriatric assessment has previously been made for this patient during the same calendar month.
DE030	Service encounter has been refused as a claim for care plan oversight has previously been made for this patient during the same calendar month.
DE031	Service encounter has been disallowed. When both a clinical geriatric assessment and care plan oversight fee been claimed for a patient in the same calendar year, the second CGA fee requires text explaining the necessity. Please resubmit this claim with text referring to the necessity of this service.
DE033	Service encounter has been refused as there have been no visit services claimed by you for this patient in the previous 365 days.
DE034	Service encounter has been refused as there have been no services claimed by you for this patient in the previous 30 days.
DE035	Service encounter has been disallowed as OAT1 and OAT2 may not be claimed in the 6 months following an insertion of buprenorphine implant for the treatment of opioid use disorder.
DE036	Service encounter has been refused as a claim 13.99H (CPAMS) has previously been billed for this patient in the same month. CPO1 cannot be claimed with this fee.
DE037	Service encounter has been refused as the maximum number of 4 telephone prescription renewals per patient per year has been reached.
DE038	Service encounter has been refused as you have already billed a visit or procedure service for this patient on the same day.
DE039	Service encounter has been refused as this service may only be claimed once per patient per day.
DE040	Service encounter has been disallowed as text indicating necessity/intervention is required when there has already been a visit claimed for this patient on the same day. Please resubmit with appropriate text.
DE041	Service encounter has been refused as you must submit your signed confirmation letter in order to claim NPIV1.
DE042	Service encounter has been refused as comprehensive care services have previously been claimed for this patient.
DE043	Service encounter has been refused as this service may only be claimed once per patient.
DE045	Service encounter has been refused as a visit or procedure has previously been billed for this patient on the same day.
DE046	Service encounter has been refused. Two immunizations have been paid at full fee this date. Delete one immunization and resubmit at LV50 along with your NPIV1 claim.
DE048	Service has been disallowed as you have claimed a visit on the same day. Please resubmit with explanatory text.
DE049	Service encounter is refused as it is included in a service already claimed on this date.
DE050	Service encounter has been refused. Please resubmit with text indicating the circumstances of the virtual service.
DL001	Service encounter has been reduced. When multiple procedures are performed at the same time, only one is approved at 100%.
DL002	Service encounter has been disallowed. When a visit and dislocation are performed at the same service encounter, only one is approved.
DL003	Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved.
DL004	Service encounter has been approved at 50% as another procedure has previously been approved at 100%.

Explanatory Code	Description
DL005	Service encounter has been reduced to 50% as another procedure has previously been approved at 100% at this same encounter.
DL006	When multiple procedures are performed at the same time, only one is approved at 100%.
DL007	Service encounter has been disallowed as a visit and major surgery are not both payable the same day.
ED001	Invalid or omitted record type.
ED002	Omitted action code or invalid action code and record sub-type combination.
ED003	Invalid service encounter number. (Invalid or omitted submitter ID, year, sequence number, and/or check digit.)
ED004	Invalid or omitted txn. Type.
ED005	Omitted record sub-type or invalid txn. Type and record sub-type combination.
ED006	Invalid payment responsibility.
ED007	Invalid or omitted service encounter type.
ED008	Invalid or omitted service start date.
ED009	Invalid or omitted service occurrence number.
ED010	Invalid or omitted diagnostic code 1.
ED011	Invalid or omitted diagnostic code 2 or 3.
ED012	Invalid multiples indicated.
ED013	Invalid modifier type, modifier value or invalid combination of type and value.
ED014	Invalid claimed unit value.
ED015	Claimed unit value must be numeric if unit value indicator contains a value of Y or health service code contains a value of EC, IC, or IF.
ED016	Invalid claimed amount.
ED017	Invalid unit value indicator.
ED018	Unit value indicator must be blank if claimed unit value is blank.
ED019	Invalid paper support document indicator.
ED020	Invalid or omitted hospital admit date or hospital admit date inappropriate for the location.
ED021	Hospital admit date cannot be subsequent to service date.
ED022	Hospital admit date must be present if service is for a registered inpatient.
ED023	Invalid intensive care admit date.
ED024	Intensive care admit date cannot be prior to hospital admit date.
ED025	Intensive care admit date is required when functional centre contains a value of NICU or INCU.
ED026	Invalid start time.
ED027	Invalid pre-authorization number.
ED028	Invalid injury diagnostic code.
ED029	Omitted or invalid service provider number or number not valid for date of service.
ED030	Invalid or omitted provider type.
ED031	Provider type is not valid for service provider number and/or date of service indicated.
ED032	Invalid referral provider number
ED033	Referral provider number must be present and must be valid.
ED034	Referral provider number and referral provider type must be blank if OOP referral indicator contains a value of Y.
ED035	Referral provider number must be blank if referral provider type is blank.
ED036	Referral provider number must be present if referral provider type is present.
ED037	Invalid referral provider type.

Explanatory Code	Description
ED038	Referral provider type must be blank if referral provider number is blank.
ED039	Invalid business arrangement for provider number or provider type or ineffective for the service start date on the service encounter.
ED040	Business arrangement is not valid for service provider number and/or date of service.
ED041	Invalid or omitted specialty code.
ED042	Specialty code not valid for service provider number and/or date of service.
ED043	Specialty code present on service encounter is invalid for business arrangement indicated.
ED044	Invalid or omitted facility number or functional centre.
ED048	Invalid or omitted service recipient health card number.
ED049	Invalid service recipient health card number for date of service or recipient is ineligible for the program.
ED050	Duplicate service encounter number previously submitted.
ED051	Service encounter number match not found.
ED052	Referral provider type must be present and valid for service date if referral provider number is indicated.
ED053	Invalid or omitted referral provider type.
ED054	Referral provider type not valid for date of service for referral provider number indicated.
ED055	Facility number invalid for location code indicated.
ED056	Facility number present on service encounter is invalid for business arrangement indicated.
ED057	Invalid or omitted location code.
ED058	Invalid or omitted program.
ED060	Service recipient birth date is omitted, or service start date is prior to birth date.
ED062	Health service code is invalid, omitted, or invalid for the business arrangement indicated.
ED063	Invalid or omitted pay to code.
ED064	Invalid pay to health card number.
ED065	Service encounter has been refused as the service encounter that shares the same text cannot be found.
ED066	Invalid record sequence.
ED067	Invalid or omitted surname on person data record.
ED068	Invalid or omitted given name on person data record.
ED069	Invalid date of birth on person data record.
ED070	Birth date in person data record must be blank if pay to code is OTHR and birth date must be present on person data record if pay to code is RECP.
ED071	Invalid gender code on person data record.
ED072	Omitted address on person data record.
ED073	Invalid or omitted city name on person data record.
ED074	Invalid or omitted province/state code on person data record.
ED075	Invalid country on person data record.
ED076	Service encounter has been refused as the person data record is absent.
ED077	Only one CPD1, CBE1, or CTX1 permitted for each service encounter transaction.
ED078	Recipient health card number and pay to health card number are the same.
ED079	Remuneration method not fee for service or shadow billing.
ED080	Health service code must contain supporting text and claimed unit value.
ED081	Invalid health card number check digit.
ED082	Invalid record length.

Explanatory Code	Description
ED083	CPD1 record sub-type present when it is not required.
ED084	Out of province referral indicator is not blank or it contains a value other than Y.
ED085	Non-printable characters in chart number field.
ED086	Non-printable characters in unused field.
ED087	Invalid postal code format.
ED088	Guardian/parent HCN is not alphanumeric.
ED089	Supporting text contains unprintable characters.
ED090	Invalid submitter ID.
ED091	Invalid year in the service encounter number on the CTX1 record sub type.
ED092	Invalid sequence number in the service encounter number on the CTX1 record sub type.
ED093	Invalid check digit on the service encounter number on the CTX1 record sub type.
ED094	Unsupported transaction type.
ED095	Transaction badly formed.
ED096	Parent or guardian must contact MSI to validate health card number for preregistered newborn.
ED097	Date of service is subsequent to expiry date for health card number.
ED098	Hospital admit date and intensive care admit date must be blank for action code of P.
ED099	Birth date is blank on base service encounter record and person data record.
ED100	Duplicate service encounter number previously submitted, currently in held status, waiting for manual review.
ED101	Provider type not allowed to bill.
ED102	Provider type not allowed to refer.
ED103	Service recipient birth date does not match birth date on health card.
ED104	Service encounter accepted at zero as it is outdated.
ED105	Service encounter has been refused as outside date of death grace period.
ED106	Payment responsibility is incorrect for the health card number provided.
ED118	Invalid WCB claim number.
ED119	Invalid date of injury.
ED120	WCB claim number and date of injury are missing.
ED121	Invalid WCB claim number and DOI.
ED122	WCB claim number not found.
ED123	HSC is invalid for LTB claim.
ED124	HSC is invalid for WCB RTW claim.
ED125	WCB claim number and/or DOI not valid for claim payment responsibility.
ED126	Service encounter has been refused as the compensation variable must be a two digit numerical value.
ED127	Service encounter has been refused as the compensation variable used is invalid.
ED128	Service encounter has been refused as compensation variable may not be claimed for payment responsibility used.
ED129	Service encounter has been refused as a compensation variable may not be used for provider type used.
GN001	Service encounter has been refused as a similar service has been approved on the same day.
GN002	Service encounter has been refused as hospital admit date is required for services performed on registered inpatients.
GN003	Service encounter has been refused as this is an excluded service under the reciprocal billing agreement.

Explanatory Code	Description
GN004	Service encounter has been refused as self referral is not acceptable.
GN005	Service encounter has been refused as payment responsibility WCB is not valid for patient under sixteen.
GN006	Service encounter has been refused as hospital admit date is necessary for processing this service.
GN007	Service encounter has been refused as modifier AG value does not agree with age of patient.
GN008	Service encounter has been disallowed as this procedure is included in critical care.
GN009	Service encounter has been refused as patient's sex is invalid for service provided.
GN010	Service encounter has been refused. Please resubmit with text indicating specific areas involved.
GN011	Service encounter has been disallowed as a consultation has been approved to you in the previous 14 days.
GN012	Service encounter has been refused as no preauthorization number was indicated or number indicated is invalid.
GN013	Service encounter has been refused as it is a duplicate submission.
GN014	Service encounter has been refused as a previously reduced matching service encounter is not present.
GN015	Service encounter has been reassessed.
GN016	Invalid or omitted health service code.
GN017	Service encounter has been refused as your specialty is not approved for performing this service.
GN018	Service encounter has been refused as first and consecutive anaesthetic start times cannot be the same.
GN019	Service encounter has been refused as it is an exact duplicate to a previously submitted service encounter.
GN020	Service encounter has been adjudicated according to information provided.
GN021	Service encounter has been adjudicated according to a decision by the medical claims evaluation committee.
GN022	Service encounter has been refused as it is an uninsured service under MSI.
GN023	Service encounter has been refused as it is outdated.
GN024	Service encounter has been disallowed as it is an uninsured service under MSI.
GN025	Service encounter has been refused as this service is included in the composite fee.
GN026	Service encounter has been adjudicated based on duration of service.
GN027	Service encounter has been refused as it requires multiples. Resubmit using the correct number of multiples.
GN028	Service encounter has been disallowed. Resubmit indicating duration of service.
GN029	Service encounter has been refused as an assistant is not approved for this service.
GN030	Service encounter has been refused. If resubmitting, provide all details that will assist in determining payment.
GN031	Service recipient birth date does not match birth date on health card. Birth date from health card should be used. This does not affect payment.
GN032	Service encounter has been refused. Resubmit using the appropriate health service code(s) as listed in your Physician's Manual.
GN033	Service encounter has been refused. Resubmit, indicating in the claimed unit value field the number of units required for the procedure performed.
GN034	Service encounter has been refused as the pay to code indicated is not appropriate.
GN035	Service encounter has been refused as pay to code indicated is not valid for payment responsibility indicated.

Explanatory Code	Description
GN036	Service encounter has been refused as a previous service under this same service code has been approved.
GN037	Service encounter has been refused as a previous service has been approved under this same service code at this service encounter.
GN038	Service encounter has been refused as a previous service encounter has been accepted for this same service code.
GN039	Service encounter has been refused as a previous service encounter for this same health service code has been approved.
GN040	Service encounter has been disallowed as a visit and surgery are not both payable.
GN041	Service encounter has been refused as a previous service encounter was approved for this same health service code.
GN042	Service encounter has been refused as payment responsibility is not valid for date of service indicated.
GN043	Service encounter has been disallowed. Resubmit indicating start and finish time for procedure performed.
GN044	Service encounter has been disallowed as a service occurrence other than one has been used without explanatory text.
GN045	Service encounter has been disallowed as text provided does not include the original service encounter number.
GN046	Service encounter had been disallowed as text provided does not include the time of the encounter.
GN047	Service encounter has been refused. Submit a reassess (action code R) for the original submission to aid in the assessment of your claim.
GN048	Service encounter has been disallowed. Submit a reassess (action code R) for the original submission to aid in the assessment of your claim.
GN049	Service encounter has been disallowed as text provided does not provide sufficient details. If resubmitting, please provide more details to aid in the assessment of your claim.
GN050	Service encounter has been refused. Resubmit under the same health service code using the appropriate lesser value modifier for the service provided.
GN051	Service encounter has been refused as a service occurrence one (1) has not been claimed for this day by this physician.
GN052	Service encounter has been disallowed. Please submit a reassess (action code R) along with a copy of the time sheet for the surgery performed to aid in the adjudication of your claim.
GN053	Service encounter has been refused as it is not appropriate to claim diagnostic code V650, V651, V681, V709, or V729 for this service.
GN054	Service encounter has been refused as the diagnostic code submitted is not valid for patients over 18 months of age.
GN055	Service encounter has been refused as you have already claimed the surgeon/surgical assist fee for this service.
GN056	Service encounter has been refused as you have already claimed the surgical assist fee for this service.
GN057	Service encounter has been disallowed as the diagnostic code submitted does not warrant a premium fee.
GN058	When claiming multiples for a time-based service the start and end times must be included in the text field.
GN059	A consult has previously been approved for your specialty during this hospitalization.
GN060	Service encounter has been reduced to reflect maximum daily time allowed.

Explanatory Code	Description
GN061	Service encounter has been refused based on the preamble ruling for payment of detention time. See Preamble 5.1.75.
GN062	Service encounter has been refused as you have not supplied the start and end times in the electronic text field.
GN063	Multiple SRAS have claimed for this patient on the same day. If second surgical assist for same surgery claim EC. If claiming as surgical assist on a different surgery (same patient/same day) resubmit with text indicating subsequent surgery.
GN064	Surgical assist claims (RO=SRAS) cannot be claimed until after the surgeon's claim has been received and processed. Once this is complete, you may resubmit using the same HSC as the surgeon.
GN065	Service encounter has been refused as this service has already been claimed by another provider on this day.
GN066	Service encounter has been refused as the clinical documentation provided appears to be a duplicate of previously provided documentation with no new clinical information to support this claim.
GN067	Service encounter has been refused as you have previously billed HSC 82.64D at the same encounter
GN068	Service encounter has been refused as you have already billed HSC 82.64E at the same encounter.
GN069	Service encounter has been disallowed (refused) as the service date is not within the approved date range.
GN070	Service encounter has been refused as this service can not be billed from this facility.
GN071	Service encounter has been disallowed as you have previously billed for sole operative procedure fee 90.69D at the same encounter.
GN072	Service encounter has been disallowed as you have previously billed another service at the same encounter. HSC 90.69D can only be billed if the removal of fixation device is the sole operative procedure.
GN073	Please submit documentation to further assist in assessing this claim.
GN074	The information provided on your claim does not match the surgeon's submission.
GN075	Please provide text indicating approval was given by public health.
GN076	Service encounter has been disallowed as you have already billed a visit at the same encounter. Please submit a delete for the visit before resubmitting for the CGA1.
GN077	Service encounter has been disallowed as you have already claimed a service that includes suturing at the same encounter.
GN078	Service encounter has been refused as the provider number is not valid for this service.
GN079	Service encounter has been disallowed. IV insertion is considered a part of this procedure and it has already been claimed at the same service encounter.
GN080	MSI Result.
GN081	Service encounter has been refused as the hospital admit date is before the date of birth.
GN082	Service encounter has been disallowed as you are not currently permitted to bill this service. Please contact CPSNS to register. Refer to November 2016 Physicians Bulletin.
GN083	Service encounter has been disallowed as the documentation does not include a description of the claimed procedure.
GN084	Service encounter has been disallowed because the procedure is a necessary part of another paid service encounter.
GN085	Service encounter has been disallowed as assistant fees cannot be claimed in these circumstances.
GN086	For attendance on the patient for the purpose of pronouncement of death, a limited visit only may be claimed, per Preamble 5.3.223.
GN087	Service encounter has been refused as you have previously bulled HSC 68.95B at the same encounter.
GN088	Service encounter has been refused as a claim for HSC 57.6D has been approved on this day.
GN089	Service encounter has been disallowed. Please resubmit with text indicating specific areas involved.

Explanatory Code	Description
GN090	Service encounter has been disallowed because the procedure is necessary to allow access/visualization to perform the surgery.
GN091	Service encounter has been refused. Please resubmit using the appropriate modifier(s).
GN092	Service encounter has been refused as text is required for non face to face services.
GN093	Service encounter has been refused as you have already billed a non face to face service for this patient on the same day.
GN094	You have billed for a non face to face service and we are requesting the supporting documentation to aid in the evaluation of this claim.
GN095	Service encounter has been reduced to the appropriate fee for the service provided.
GN096	Pre Payment Review. Please submit documentation to further assist in assessing this claim.
GN097	Service encounter has been disallowed. Ensuring the functional integrity of vital structures during a surgical procedure is included in the surgical HSC.
GN098	Service encounter has been disallowed. There was no separate and distinct surgical service. The HSC claimed was part of another paid service encounter.
GN099	Service encounter has been disallowed; insertion of the indwelling urinary catheter can not be claimed with any other procedure fees during the same encounter.
GN100	Service encounter has been refused as you must submit your signed Physician Confirmation letter in order to bill the enhanced fees for office and geriatric visits.
GN101	Service encounter has been refused as this service is not billable from a hospice facility.
GN102	Service encounter has been refused as HSC 02.84A which is a stand-alone procedure has already been claimed during the same encounter. If an ultrasound has occurred, the appropriate ultrasound fee should be claimed along with add on HSC 02.84B – obstetrical doppler in conjunction with ultrasound.
GN103	Service encounter has been disallowed as this service may not be billed if a pathologist has reviewed the slides and claimed for the service.
GN104	Service Encounter has been refused. Health card number is not valid for service provided.
GN105	Service encounter has been disallowed as you have already claimed a surgical procedure on this day. Tonometry is considered to be an included part of any surgical procedure.
GN106	Service encounter has been disallowed as you have already claimed tonometry on this day for this patient. Tonometry is considered to be an included part of any surgical procedure.
GN107	Service encounter has been refused as you have already claimed a teaching stipend on this date.
GN108	Service encounter has been refused as you are not authorized to claim the teaching stipend.
GN109	Service encounter has been refused as this ROTA has already been claimed at either half or full value from this facility for this same service date.
GN110	Service encounter has been refused as this ROTA has already been claimed at full value from this facility for the same service date.
GN111	Service encounter has been refused as you have already claimed a facility on-call callback rate for this service date.
GN112	Service encounter has been refused as the community hospital inpatient program has already been claimed from the same hospital on this date.
GN113	Service encounter has been refused as you must claim a category 3 facility on-call daily rate prior to claiming the associated callback fee.
GN114	Service encounter has been refused as the maximum of 2 ophthalmology ROTAs have already been claimed from this facility on this date.
GN115	Service encounter has been refused as the maximum of 4 diagnostic imaging ROTAs have already been claimed from this facility on this date.

Explanatory Code	Description
GN116	Service encounter has been refused as a claim for the facility on call obstetrics/gynecology ROTA using the same role modifier has already been claimed from the IWK for this date.
GN117	Service encounter has been refused as claims for F1004 from this facility should not include a role modifier.
GN118	Service encounter has been refused as claims for HSC F1004 from Yarmouth should be made using the RO=OBS1 modifier.
GN119	Service encounter has been refused as claims for HSC F1004 from Dartmouth General should be made using the RO=GYN1 modifier.
GN120	Service encounter has been refused as claims for HSC F1004 from the IWK should be made using the appropriate RO modifier for 1st or 2nd obstetrics, or 1st gynecology.
GN121	Service encounter has been disallowed as a claim for HSC 50.0B has already been claimed at the same encounter. HSC 50.0B is a comprehensive fee that includes all access and visualization to perform the procedure.
GN122	Service encounter has been disallowed as this service is not reportable if the consultation results in a face to face service within the next 14 days or the next available appointment.
GN123	Service encounter has been refused as the maximum of 2 hospitalist rotas have already been claimed from this facility on this date.
GN131	Service encounter has been refused as you must submit your completed GAC physician declaration in order to claim 03.04K.
GN132	Service encounter has been refused as you have already billed a telephone prescription renewal for this patient on the same day.
GN133	Service encounter has been refused as NPIV1 has previously been billed for this patient on the same day.
GN134	Service encounter has been refused. Health card number is not valid for the HSC being claimed.
GN135	Service encounter has been refused as you have already claimed a facility on-call inpatient withdrawal management rota for this service date.
GN136	Service encounter has been refused as you have already claimed a facility on-call recovery support center rota for this service date.
GN137	Invalid referral provider type for this service.
GN138	Service encounter has been refused as this service may not be claimed with ADCP1.
LF001	Service encounter has been refused as no more than 24 hours may be billed per day for HSC HDAY1.
LF002	Service encounter has been refused as no more than 24 hours may be billed per day for HSC HEVW1.
LF003	Service encounter has been refused as you cannot claim 0 hours for this HSC.
LF004	Service encounter has been refused as no more than 24 hours may be billed per day for all longitudinal family medicine (LFM) model hourly fee codes combined.
LF005	Service encounter has been refused as this HSC has already been claimed for this date.
LF006	Service encounter has been refused as no more than 24 hours may be billed per day for HSC HUTC1
LF007	Service encounter has been refused as no more than 24 hours may be billed per day for HSC HEDD1
LF008	Service encounter has been refused as no more than 24 hours may be billed per day for HSC HEDE1
LF009	Service encounter has been refused as no more than 24 hours may be billed per day for HSC HIPD1
LF010	Service encounter has been refused as no more than 24 hours may be billed per day for HSC HIPE1
MA001	Service encounter has been approved at 50%. When multiple closed or no reductions are performed on the same fracture at different service encounters by the same provider, 50% for each reduction should be claimed.
MA002	Service encounter has been reduced. 50% of the listed fee for the initial closed or no reduction is approved when a different physician performs a subsequent closed or no reduction on the same fracture.

Explanatory Code	Description
MA003	Service encounter for closed reduction has been approved at 50% of the listed fee as it has been followed by an open reduction.
MA004	Service encounter has been reduced. When multiple procedures are performed at the same time, only one is approved at 100%.
MA005	Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved.
MA006	Service encounter has been reduced. When multiple procedures are performed at the same encounter only one is approved at 100%.
MA007	Service encounter has been reduced. Only one procedure is approved at 100% when multiple procedures are performed at the same time.
MA008	Service encounter has been refused. Interim service code has expired. Application must be submitted to the Fee Committee for establishing a permanent health service code.
MA009	Service encounter has been refused as you have already made a claim for health service code 90.4A, 98.79A, 90.69B, 89.3A, or a BOGR category code at the same encounter.
MA010	Service encounter has been refused as you have already made a claim for health service code 90.40B at the same encounter.
MA011	Service encounter has been refused as you have already made a claim for health service code 16.09A, 16.09B, 16.09C, 16.09D, 16.1A, 16.1B, 16.2A, 16.2B, 16.3A, 16.3B, 16.3C, 16.49A, 16.5A, 16.5B, 16.93D at the same encounter.
MA012	Service encounter has been refused as you have already made a claim for health service code 16.09J at the same encounter.
MA013	Service encounter has been refused as you have already made a claim for health service code 17.05D or 17.5A at the same encounter.
MA014	Service encounter has been refused as you have already made a claim for health service code 17.5B at the same encounter.
MA015	Service encounter has been refused as you have already billed a blepharoptosis code for the same eye on that date.
MA016	Service encounter has been refused as you have already billed a blepharoplasty code for the same eye on that date.
MA017	Service encounter has been refused as you have already billed a blepharoplasty or blepharoptosis code for the same eye on that date.
MA018	Service encounter has been refused as you have already billed a removal of periorbital fat code for the same eye on that date.
MA019	Service encounter has been refused. When a blepharoplasty is performed for a diagnosis of blepharochalasis or dermatochalasis, code 22.5C should be used, not a lid ptosis code. Prior to submitting 22.5C, please contact the assessment dept for a PA number.
MA020	Service encounter has been refused as you have already billed HSC 28.41/28.41A/28.42/28.42A/28.44A or 28.72 on that date.
MA021	Service encounter has been refused as you have already billed HSC 28.73E or 28.49A on that date.
MA022	Service encounter has been refused as you have already billed HSC 28.41/28.41A/28.42/28.42A or 28.44A on that date.
MA023	Service encounter has been disallowed as you have previously billed another major surgery for this patient on the same day.
MA024	Service encounter has been refused as HSC 77.19C, 57.59A, or 80.4C has been billed at this encounter.
MA025	Service encounter has been refused as HSC 66.83 has been billed at this same encounter.
MA026	Service encounter has been refused as you have previously billed a portion of this composite service at the same encounter (bronchoscopy, decortication, or mediastinal lymph node dissection).

Explanatory Code	Description
MA027	Service encounter has been refused as you have previously billed a VATS lung lobectomy at the same encounter.
MA028	Service encounter has been refused as you have previously billed health service code 77.3 at the same encounter.
MA029	Service encounter has been refused as you have previously billed health service code 77.19A at the same encounter.
MA030	Service encounter has been refused as you have previously billed health service code 77.52 at the same encounter.
MA032	Service encounter has been refused as a surgical assist cannot be performed in the office.
MA033	Service encounter has been refused as you have previously claimed health service code 26.62 or 26.62B at the same encounter.
MA034	Service encounter has been refused as you have previously claimed a composite cataract fee at the same encounter.
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).
MA039	Service encounter has been refused as you have previously billed for a laparoscopy at the same encounter.
MA040	Service encounter has been refused as you have previously billed HSC 78.39A at the same encounter.
MA041	Service encounter has been refused as you have previously claimed an oophorectomy for this patient (same side) at the same encounter.
MA042	Service encounter has been refused as you have previously claimed HSC 78.1A for this patient (same side) at the same encounter.
MA043	Service encounter has been refused as you have previously claimed a salpingectomy, salpingostomy, or oophorectomy for this patient at the same encounter.
MA044	Service encounter has been refused as you have previously claimed for a removal of extrauterine pregnancy (HSC 86.3A) at the same encounter.
MA045	Service encounter has been refused as you have previously billed HSC 80.81, 81.09, 81.09A, 81.69A, 80.19B, or 03.26 at the same encounter.
MA046	Service encounter has been refused as you have previously billed HSC 80.19A endometrial ablation at the same encounter.
MA047	Service encounter has been refused as you have previously billed HSC 29.94A, 29.94B, or 29.94C at the same encounter.
MA048	Service encounter has been refused as you have previously billed HSC 22.5C at the same encounter.
MA049	Service encounter has been refused as cataract surgery cannot be claimed with tonometry.
MA050	Service encounter has been refused as you have previously billed 58.11 or 57.59.
MA051	Service encounter has been refused as you have previously billed HSC 60.55.
MA052	Service encounter has been refused as you have previously billed HSC 66.4A or 66.3.
MA053	Service encounter has been refused as you have previously billed HSC 65.51D or 65.51E
MA054	Service encounter has been refused as you have previously billed HSC 97.95, 97.43, 97.44
MA055	Service encounter has been refused as you have previously billed HSC 97.6E
MA056	Service encounter has been refused as you have previously billed for a resection of bowel or formation of colostomy or ileostomy.

Explanatory Code	Description
MA057	Service encounter has been refused as you have previously billed for a laparoscopic total colectomy or laparoscopic assisted abdominoperineal resection.
MA058	Service encounter has been refused as you have previously billed HSC 83.61.
MA059	Service encounter has been refused as you have previously billed HSC 83.61.
MA060	Service encounter has been refused as you have previously billed HSC 66.82A
MA061	Service encounter has been disallowed. Please submit a reassess (action code R) along with a copy of the operative report and indicate skin to skin time in text to aid in the assessment.
MA062	Service encounter has been refused as a cystoscopy has previously been billed for this patient on the same day.
MA063	Service encounter has been refused as cystoscopy is included in the fee for HSC 71.4C which has been previously billed for this patient on this day.
MA064	Service encounter has been refused as you have previously billed for a sigmoidoscopy, colostomy, or ileostomy at the same encounter.
MA065	Service encounter has been refused as you have previously billed for 57.5B, 60.4C or 60.52B at this encounter. If you are attempting to claim an ileostomy with this procedure, please use the add on HSC 58.01A
MA066	Service encounter has been refused as a second physician claim exists for this encounter. A surgical assist cannot also be claimed.
MA067	Service encounter has been refused as HSC 60.52B cannot be claimed with HSC 66.19, 66.83, 60.52A at the same encounter.
MA068	Service encounter has been refused as HSC 66.19 or 66.83 cannot be claimed with HSC 60.52B at the same encounter.
MA069	Service encounter has been refused as the patient is over 6 months old.
MA070	Service encounter has been disallowed has you have previously claimed another surgery on this eye during the same encounter. The fee for iridotomy should only be used when it is a stand-alone procedure.
MA071	Service encounter has been refused as HSC 01.34A, 68.83A, 68.99A, or 68.99C has already been billed at the same encounter.
MA072	Service encounter has been refused as HSC 03.12 was billed at the same encounter and is a component of this procedure.
MA073	Claim for radical neck dissection has been refused as it is not payable at the same encounter as a glossectomy, parotidectomy or floor of mouth tumor codes. Composite fees exist that should be used instead.
MA074	Claim for glossectomy, parotidectomy or floor of mouth tumor has been refused as it is not payable at the same encounter as a radical neck dissection. Composite fees exist that should be used instead.
MA075	Service encounter has been refused as your specialty is not approved to bill this service. If the exploration of a peripheral nerve has been done as a separate and distinct procedure, the service can be submitted as EC with text and include the operative report which will be reviewed prior to payment.
MA076	Service encounter has been refused as you are not permitted to claim this fee.
MF001	Service encounter has been refused as a removal of fixation device claim was previously made for the same region on that service date.
MF002	Service encounter has been refused as a removal of fixation device fee is included in previously billed 91.35B
MF003	Service encounter has been refused as you have already made a claim for health service code 91.35B or 91.35E.
MF004	Service encounter has been refused as you have already made a claim for health service code 91.35C or 91.35D.

Explanatory Code	Description
MF005	Service encounter has been reduced. When multiple procedures for fractures involving different long bones are performed at the same time, only one is approved at 100%.
MF006	Service encounter has been refused as you have previously claimed HSC 90.06A, 90.09A, 92.15 or 92.89N for the same patient on the same day.
MF007	Service encounter has been refused as you have previously bulled for an ORIF bicondylar tibial plateau fracture for this patient on this day.
MF008	Service encounter has been refused as you have previously claimed a fracture code for the same site/region on this day.
MF009	Service encounter has been refused as this health service code cannot be claimed with HSC 92.89N at the same encounter.
MI001	Service encounter has been approved at 50%. When multiple closed or no reductions are performed on the same fracture at different service encounters by the same provider, 50% for each reduction should be claimed.
MI002	Service encounter has been refused. 50% of the listed fee for the initial closed or no reduction is approved when a different provider performs a subsequent closed or no reduction on the same fracture.
MI003	Service encounter for no or closed reduction has been approved at 50% of the listed fee as it has been followed by an open reduction.
MI004	Service encounter has been reduced. When multiple procedures are performed at the same time, only one is approved at 100%.
MI005	Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved.
MI006	Service encounter has been reduced. When multiple procedures are performed at the same encounter, only one is approved at 100%.
MI007	Service encounter has been refused as you have previously billed HSC 03.03, 09.02C or 09.02F on this day.
MI008	Service encounter has been refused as the maximum of 3 procedures per patient per lifetime has been reached.
MJ001	Service encounter has been reduced to 50%. When multiple surgical procedures are performed at the same time, only one is approved at 100%.
MJ002	Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved.
MJ003	Service encounter has been refused as this once per lifetime procedure has previously been approved.
MJ004	Service encounter has been refused as this adjustment of leads occurred within 30 days of pacemaker insertion.
MJ005	Service encounter has been refused as initial cauterization of the rectum has been approved in the previous 30 days.
MJ006	Service encounter has been refused as initial photo coagulation has been approved for eye(s) indicated in the previous 30 days.
MJ007	Service encounter has been refused as this is not the appropriate health service code for post-op haemorrhage when claimed by the surgeon who performed the tonsillectomy.
MJ008	Service encounter has been refused as a preauthorization number was not indicated.
MJ009	Service encounter has been adjudicated based on the surgeon's submission.
MJ010	Service encounter has been refused. Resubmit with a copy of the operative report to aid in the adjudication of your service encounter.
MJ011	Service encounter has been refused based on the age of the recipient.

Explanatory Code	Description
MJ012	Service encounter has been refused as this health service is not appropriate for persons 16 years or older.
MJ013	Service encounter has been refused as this health service is not appropriate for persons under 16 years of age.
MJ014	Service encounter has been reduced to 50%. Only one procedure is approved at 100% when multiple surgical procedures are performed at the same time.
MJ015	Service encounter has been disallowed as this procedure is included in a previously approved service.
MJ016	Service encounter has been disallowed as this service is included in a previously approved procedure.
MJ017	Service encounter has been refused as no preauthorization number was indicated.
MJ018	Service encounter has been disallowed as this service requires electronic text or a prior approval number.
MJ019	Service encounter has been refused as a previous service encounter for a second physician has been approved.
MJ020	Service encounter has been refused as a previous service encounter for an assist fee has been approved.
MJ021	Service encounter has been disallowed. Resubmit with a copy of the outpatient report to aid in the adjudication of your service encounter.
MJ022	Service encounter has been refused as a total abdominal hysterectomy or repair of inverted uterus has already been claimed by you for this date.
MJ023	Service encounter has been refused as you have already claimed a repair of obstetrical trauma or anal sphincter on this date.
MJ024	Service encounter has been refused as you have already claimed a repair of obstetrical trauma on this date.
MJ025	Service encounter has been refused as a claim for donor has already been received for this patient. A patient cannot be both a donor and recipient of a liver.
MJ026	Service encounter has been refused as a claim for recipient has already been received for this patient. A patient cannot be both a donor and recipient of a liver.
MJ027	Service encounter has been disallowed as the injected substance has not been indicated.
MJ028	Service encounter has been refused as a claim for the ICD insertion team fee has already been made for this patient.
MJ029	Service encounter has been refused as a claim for the ICD insertion composite fee has already been made for this patient.
MJ030	Service encounter has been refused as you have previously billed HSC 82.41, 82.42, or 82.43 for this patient on the same day.
MJ031	Service encounter has been refused as you have previously billed HSC 80.2B, 80.3A, or 80.4A for this patient on the same day.
MJ032	Service encounter has been refused as you have previously billed HSC 71.5A for this patient on the same day.
MJ033	Service encounter has been refused as you have previously billed HSC 80.3B for this patient on the same day.
MJ034	Service encounter has been refused as you have previously billed a local tissue shift (HSC 98.51C or 98.51D) for this patient on the same day.
MJ035	Service encounter has been refused as you have previously billed a complex palmar fasciectomy (HSC 94.13C) for this patient on the same day.
MJ036	Service encounter has been refused as you have previously billed HSC 66.19 or 66.83 for this patient on the same day.

Explanatory Code	Description
MJ037	Service encounter has been refused as you have previously billed HSC 57.59A or 60.52B for this patient on the same day.
MJ038	Service encounter has been refused as you cannot bill a 60.52A and a 60.52B for this patient on the same day.
MJ039	Service encounter has been refused as you have previously billed health service code 94.13D for this patient on the same day.
MJ040	Service encounter has been refused as a 01.34A has previously been billed for this patient on this day.
MJ041	Service encounter has been refused as you have already billed a service that is included in this fee.
MJ042	Service encounter has been refused as you have already billed HSC 94.13E at the same encounter.
MJ043	Service encounter has been disallowed as the provider number is not valid for this service.
MJ044	Service encounter has been refused as HSC 01.24C has previously been billed fir this patient on this day.
MJ045	Service encounter has been refused as HSC 01.34A has already been billed for this patient on this day.
MJ046	Service encounter has been disallowed as surgical assist claims for HSC 98.49C or 98.49D cannot be claimed until the surgeon has claimed for the surgical services
MJ047	Service encounter has been refused as HSC 57.59 or 60.52 has previously been billed for this patient on the same day.
MJ048	Service encounter has been refused as HSC 60.55C has previously been billed for this patient on the same day.
MJ049	Service encounter has been refused as you have previously billed HSC 90.06B for this patient on this day.
MJ050	Service encounter has been refused as you have previously billed on of the following HSCs 01.34A,B,C,D,E,F,G,H 71.02, 82.7 or 68.98 at the same encounter.
MJ051	Service encounter has been refused as you have already billed an enterocele repair (HSC 82.7 or 82.64B) at the same encounter.
MJ052	Service encounter has been refused as you have already billed HSC 82.64F at the same encounter.
MJ053	Service encounter has been refused as you have previously billed 01.24C at the same encounter.
MJ054	HSC 46.41 decortication of lung may not be billed with any other major surgery.
MJ055	Service encounter has been disallowed as MSI requires the start and end times of this procedure to assess. Please resubmit this claim with the start and end times in the text field.
MJ056	Service encounter has been disallowed as you have previously billed health service code 68.95B for this patient at the same encounter. Please submit a reassess (action code R) along with the OR report to aid in the assessment of your claim.
MJ057	Service encounter has been disallowed as you have previously billed health service code 68.0A for this patient at the same encounter. Please submit a reassess (action code R) along with a copy of the operative report to aid in the assessment of your claim.
MJ058	Service encounter has been refused as HSC 29.94A, 24.94B and 29.94C may not be claimed together at the same encounter.
MJ059	Date of service on claim does not match date of service on operative report.
MJ060	Service encounter has been disallowed as a claim for cystoscopy has already been submitted for this patient at the same encounter. If additional cystoscopic procedure is required, please resubmit with supporting text.
MJ061	Service encounter has been disallowed as you have previously billed HSC 72.1B at the same encounter. If additional cystoscopic procedure is required, please resubmit with supporting text.

Explanatory Code	Description
MJ062	Service encounter has been disallowed as you have previously billed HSC 07.08A, B or C at the same encounter.
MJ063	Service encounter has been refused as you have previously billed a cystoscopy related service at the same encounter.
MJ064	Service encounter has been refused as you have previously claimed for urethral dilation at the same encounter. This service includes any urethral dilation required to insert the device.
MJ065	Service encounter has been refused as claim for programming to a pacemaker which is part of this service has already been claimed on this day.
MJ066	Service encounter has been refused as you have previously claimed for health service code 47.25, 48.13 or 50.34B at the same encounter.
MJ067	Service encounter has been refused as you have previously claimed for health service code 47.25A or B at the same encounter.
MJ068	Service encounter has been reduced to 70%. When multiple surgical procedures are performed at the same time, only one is approved at 100%.
MJ069	Service encounter has been refused as you have previously billed HSC 33.59A at the same encounter.
MJ070	Service encounter has been refused as you have previously billed HSC 34.32 at the same encounter.
MJ071	Service encounter has been refused as you have previously billed HSC 34.31 at the same encounter.
MJ072	Service encounter has been refused as you have previously billed HSC 34.42 at the same encounter.
MJ073	Service encounter has been refused as you have previously billed HSC 34.42A, 34.54A or 34.54B at the same encounter.
MJ074	Service encounter has been refused as you have previously billed HSC 34.42A at the sae encounter
MJ075	Service encounter has been refused as you have previously billed HSC 34.54A or 34.54B at the same encounter.
MJ076	Service encounter has been refused as you have previously billed HSC 34.4A at the same encounter.
MJ077	Service encounter has been refused as you have previously billed HSC 34.55 or 34.54A at the same encounter.
MJ078	Service encounter has been refused as HSC 34.54A and 34.54B may not be claimed together at the same encounter.
MJ079	Service encounter has been refused as HSC 34.55 and 34.54A may not be claimed together at the same encounter.
MJ080	Service encounter has been disallowed as you have already claimed HSC 33.22A or 34.0A at the same encounter which is considered to be an included part of the procedure.
MJ081	Service encounter has been refused as there is already a paid claim on history for HSC 97.12, 97.13, 97.14, 97.15, 97.31A, 97.31C, 97.32, 97.32B, 97.77, 98.51B, 98.51C, 98.51D or 98.51E at the same encounter.
MJ082	Service encounter has been refused as there is already a paid claim on history for HSC 97.79B at the same encounter.
MJ083	Service encounter has been refused as there is already a paid claim on history for HSC 97.43, 97.44, 98.98, 97.6B, 97.6C, 97.6D, 97.75A, 97.77, 98.51B, 98.51C, 98.51D or 98.51E at the same encounter.
MJ084	Service encounter has been refused as there is already a paid claim on history for HSC 97.44A at the same encounter.
MJ085	Service encounter has been refused as there is already a paid claim on history for HSC 97.99B at the same encounter.
MJ086	Service encounter has been refused as HSC 26.29F may only be claimed once per eye per surgical encounter.
MJ087	Service encounter has been refused as HSC 26.25, 26.25D, 26.29D, 26.29E or 26.34 has already been claimed at the same encounter.

Explanatory Code	Description
MJ088	Service encounter has been refused as HSC 26.29F has already been claimed at the same encounter.
MJ089	Service encounter has been refused as HSC 26.29G may only be claimed once per eye per surgical encounter.
MJ090	Service encounter has been refused as HSC 26.25, 26.25C, 26.25D, 26.29E or 26.34 has already been claimed at the same encounter.
MJ091	Service encounter has been refused as HSC 26.29G has already been claimed at the same encounter.
MJ092	Service encounter has been refused as HSC 92.89N cannot be claimed with HSC 91.35A or 91.35C at the same encounter.
MJ093	Service encounter has been refused as you have previously claimed HSC 72.1A, 72.1B, 72.1C or 72.1D at the same encounter.
MJ094	Service encounter has been effused as you have previously claimed 71.2E at the same encounter.
MJ095	Service encounter has been refused as HSC 92.84B has already been claimed for this patient on this day.
MJ096	Service encounter has been refused as HSC 92.is a composite fee and may not be claimed at the same service occurrence as any other procedures involving the hip.
MJ097	Service encounter has been refused as HSC 92.is a composite fee. No other procedures involving the hip may be claimed at the same service occurrence.
MN001	Service encounter has been disallowed as it is included in the delivery.
MN002	Service encounter has been disallowed as compression sclerotherapy includes after care for one year.
MN003	Service encounter has been disallowed. When a visit and a surgical procedure are claimed together, only one is approved.
MN004	Service encounter has been disallowed. When a visit and minor surgery are performed at the same service encounter, only one is approved.
MN005	Service encounter has been refused as this procedure has been performed within the previous 7 days.
MN006	Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved.
MN007	Service encounter has been reduced. When multiple procedures are performed at the same time, only one is approved at 100%.
MN008	Service encounter has been refused as it is an uninsured service for patients under one year of age.
MN009	Service encounter has been reduced. When multiple procedures are performed at the same encounter, only one is approved at 100%.
MN010	Service encounter has been disallowed as it is included in the fee for the adenoidectomy.
MN011	Service encounter has been disallowed as procedure claimed and a consultation are not both payable.
MN012	Service encounter has been disallowed as you have already claimed this service for this patient on the same day.
MN014	Service encounter has been refused as HSC 60.52A cannot be claimed with 60.52B at the same encounter.
MN015	Service encounter has been disallowed as you previously billed at the same encounter a service where suturing of the skin is included in the procedure.
MN016	Service encounter has been refused as you have previously claimed for an insertion or removal with or without reinsertion of a penile prosthesis at the same encounter which includes any urethral dilation required to insert the device.
MN017	Service encounter has been refused as you have previously billed HSC 34.31, 34.32, 34.54A, 34.54B or 34.55 at the same encounter.

Explanatory Code	Description
MN018	Service encounter has been refused as this procedure is considered part of the surgery performed at the same encounter.
MN019	Service encounter has been refused as there is already a paid claim on history for HSC 97.77, 98.51B, 98.51D or 98.51E at the same encounter.
MS001	Service encounter has been refused. Complete details are necessary when billing this service.
NR001	Service encounter has been adjudicated based on a decision by the medical consultant.
NR002	Service encounter has been approved under the appropriate code.
NR003	Service encounter has been refused as a second assistant is not approved for this service.
NR004	Service encounter has been adjudicated based on the fee payable for the assistant.
NR005	Service encounter has been adjudicated based on the fee payable to the second assistant.
NR006	Service encounter has been disallowed. Indicate actual procedure performed when resubmitting.
NR007	Service encounter has been approved at the general practice rate re age of patient.
NR008	Service encounter has been refused. Submit a new service encounter once approval has been received from the psychotherapy waiver review committee.
NR009	Please delete original submission and submit a new service encounter for a partial eye exam.
NR010	Service encounter has been refused as this visit is not payable during intensive care.
NR011	Service encounter has been refused as date of service appears incorrect according to our records.
NR012	Service encounter has been adjusted based on information provided by MSI audit.
NR013	Service encounter has been refused. Delete original submission and resubmit using the appropriate modifier of region both.
NR014	Service encounter has been disallowed. Resubmit with a copy of the pathology report to aid in the adjudication of your service encounter.
NR015	Service encounter has been approved at the internal medicine rate re age of patient.
NR016	Service encounter has been disallowed as all the requirements for billing this service have not been met.
NR017	Service encounter has been refused as a previous payment covers all or a portion of this combination.
NR018	Service encounter has been refused as previous payment covers this submission.
NR019	Service encounter has been refused as this same service has been approved for another provider.
NR020	Service encounter has been refused. Resubmit using the appropriate service occurrence number.
NR021	Service encounter has been adjudicated based on the time indicated for the consecutive anaesthetist.
NR022	Service encounter has been adjudicated according to the weekly maximum payable after 56 days of hospitalization.
NR023	Service encounter has been disallowed as a pap smear is not payable with a visit for a gynaecological or obstetrical diagnosis.
NR024	Service encounter has been adjusted in accordance with the surgical rules described in the Preamble.
NR025	Service encounter has been adjudicated based on the Preamble ruling for outdated submissions.
NR026	Service encounter has been refused as the hospital admit date indicated is incorrect.
NR027	Service encounter has been adjudicated based on Preamble rules.
NR028	Service encounter has been adjudicated based on payment for a bilateral procedure.
NR029	Resubmit under the appropriate health service code for this bilateral procedure.
NR030	Service encounter has been disallowed as medical necessity was not indicated.
NR031	Service encounter has been disallowed as the appropriate documentation has not been received.
NR032	Service encounter has been disallowed as copies of the referral letter and consult report are required.

Explanatory Code	Description
NR033	Service encounter has been disallowed as the required WCB form was not received within the appropriate time.
NR034	Service encounter has been adjudicated according to the rate set by workers' compensation board.
NR035	Service encounter has been refused as region (right, left, both) was not indicated.
NR036	Service encounter may be readjudicated according to the submission by the surgeon.
NR037	Service encounter has been disallowed as the injection indicated is not on the provincial immunization list.
NR038	Service encounter has been disallowed as the tray fee is not applicable for service provided.
NR039	Service encounter has been accepted at zero as it is outdated.
NR040	Service encounter has been refused as prior approval number indicated is not valid.
NR041	Service encounter has been disallowed as the maximum number of this type of visit allowed without a prior approval number has been approved for this episode.
NR042	Service encounter has been disallowed as the maximum number of preauthorized visits for this episode has been approved.
NR043	Service encounter has been disallowed as the maximum number of encounters for this service per year has been reached.
NR044	Service encounter has been disallowed as the maximum number of well baby visits allowed has been approved for payment.
NR045	Service encounter has been refused. Resubmit using the appropriate health service code(s) as listed in the Physician's Manual and/or Physician's Bulletin.
NR046	Service encounter payment has been calculated based on the percentage payable on the total major surgical procedural fee(s) excluding the premium fee portion.
NR047	Service encounter has been refused. Resubmit using the appropriate health service code based on information provided.
NR048	Service encounter has been refused. Resubmit indicating the base units used for the procedure performed.
NR049	Service encounter has been refused. Resubmit indicating the correct region.
NR050	Service encounter has been disallowed as text provided does not warrant approval.
NR051	Patient history transfer has occurred due to duplicate registration of individual. Patient history will now appear under the active registration number.
NR052	Service encounter has been refused as previous payment has occurred under an incorrect HCN. Internal adjustment will be made to correct our records.
NR053	Service encounter has been refused as the business arrangement indicated is incorrect according to our records.
NR054	Service encounter has been disallowed. Delete the original submission and submit a new service encounter under the appropriate business arrangement.
NR055	Service encounter has been disallowed as patient history indicates conflicting intensive care admit dates. Confirm intensive care admit date and submit a reassess (action code R) once you have verified the date you have indicated is correct.
NR056	Service encounter has been adjudicated based on information published in a Physician's Bulletin.
NR058	Service encounter has been adjudicated based on information contained in the Physician's Manual.
NR059	Service encounter has been refused as electronic text was not present explaining date of service and modifier used in relation to intensive care admit date indicated.
NR060	Service encounter has been refused. Delete the original submission and submit a new encounter based on the information you have provided.
NR061	Service encounter has been refused re diagnosis indicated.

Explanatory Code	Description
NR062	Service encounter has been refused as this service is only insured in conjunction with prescribed medication. An over-the-counter drug or product is not insured.
NR063	Service encounter has been refused as diagnosis indicated does not warrant approval of a comprehensive visit.
NR064	Service encounter has been refused. Referring provider indicated is invalid for referral.
NR065	Service encounter has been adjudicated based on telephone conversation.
NR066	Service encounter has been refused as hospital admit date is incorrect.
NR067	Service encounter has been refused as intensive care admit date is incorrect.
NR068	Service encounter has been adjudicated based on the operative and/or pathology report.
NR069	Service encounter has been refused. Resubmit a new service encounter based on information published in the Physician's Bulletin.
NR070	Service encounter has been adjudicated based on the time indicated for the simultaneous anaesthetist.
NR071	Indicate type of anaesthesia (general or local) for procedure performed.
NR072	Service encounter has been disallowed. Submit a reassess (action code R) along with a copy of the operative report to aid in the assessment of your service encounter.
NR073	Service encounter has been disallowed as a pap smear is not payable in addition to a visit, consultation or procedure for a gynaecological or obstetrical diagnosis.
NR074	Service encounter has been refused. A maximum of one hour only for a Palliative Care Support Visit is payable per patient per day.
NR075	Service encounter for tray fee has been adjusted to agree with number of injections approved.
NR076	Service encounter has been adjudicated based on diagnosis indicated.
NR077	Service encounter has been adjudicated based on correspondence from MSI.
NR078	Service encounter has been disallowed. Submit a reassess (action code R) along with a copy of the outpatient report to aid in the assessment of your service encounter.
NR079	Service encounter payment has been calculated based on the percentage payable on the total major surgical procedure(s).
NR080	Service encounter has been refused as the pay to code is not BAPY.
NR081	Service encounter has been adjudicated according to the weekly maximum of 80 units per week after 56 days from admission.
NR082	Please contact MSI regarding this claim.
NR083	Service encounter has been refused as a substance other than air was injected.
NR084	Service encounter has been refused. Resubmit using the appropriate health service code. If there is no code for the service you are trying to claim, please contact Doctors NS to apply for a new fee.
NR085	Service encounter has been paid as a result of a pre-payment assessment review.
NR086	Request for readjudication has been refused. Delete this submission and submit a new encounter based on the information you have provided.
NR087	Service encounter has been refused as you have previously billed HSC 71.7F at the same encounter.
NR088	Service encounter has been refused as you have previously claimed for urethral dilation at the same encounter. This service includes any urethral dilation required to insert the device.
NR089	Service encounter has been refused as this procedure should only be billed from a hospital location. If valid reason exits for billing this procedure from a location other than hospital, please resubmit with supporting documentation.
OB001	Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved.

Explanatory Code	Description
OB002	Service encounter has been disallowed as you have previously been approved for transfer during labour.
PC002	Service encounter has been refused as psychotherapy or counselling and a visit are not payable at the same service encounter.
PC003	Service encounter has been refused. A maximum of 90 continuous minutes of individual psychotherapy only is allowed per patient per day.
PC004	Service encounter has been refused as a minimum of one-half hour must be spent per visit for psychotherapy to be payable.
PC005	Service encounter has been refused as patient is under four years of age.
PC006	Service encounter has been adjudicated according to total hours approved in the previous 365 days.
PC007	Service encounter has been refused as another physician is providing psychotherapy to this patient.
PC008	Service encounter has been refused. A maximum of 2 hours of group psychotherapy only is allowed per patient per day.
PC009	Service encounter has been refused. A maximum of 2 hours of family therapy only is allowed per patient per day.
PC010	Service encounter has been refused as you have previously been approved the intensive care daily rate this day.
PC011	Service encounter has been refused. A maximum of 90 minutes of hypnotherapy only is allowed per patient per day.
PC012	Service encounter has been refused. A minimum of one-half hour must be spent per visit for hypnotherapy to be payable.
PC013	Service encounter has been refused. A maximum of one hour of counselling only is allowable per patient per day.
PC014	Service encounter has been refused. A maximum of 30 minutes of lifestyle counselling only is allowable per patient per day.
PC015	Service encounter has been refused as you have not indicated that a waiver or prior approval has been issued. Maximum limit of 15 hours per year for individual psychotherapy has previously been approved.
PC016	Service encounter has been refused as you have not indicated that a waiver or prior approval has been issued. Maximum limit of 15 hours per year of group psychotherapy has previously been approved.
PC017	Service encounter has been refused. Maximum limit of 15 hours of family therapy per year has previously been approved.
PC018	Service encounter has been refused. Maximum limit of 10 hours of hypnotherapy per year has previously been approved.
PC019	Service encounter has been refused. Maximum limit of 5 hours of counselling per year has previously been approved.
PC020	Service encounter has been refused. Maximum limit of 2 hours of lifestyle counselling per year has previously been approved.
PC021	Service encounter has been approved at the maximum allowed per day for this service.
PC022	Service encounter has been disallowed as patient is 19 years of age or greater.
PC023	Service encounter has been disallowed as location and/or provider specialty is not appropriate for service claimed.
PC024	Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 20 hours per year for individual psychotherapy has previously been approved.
PC025	Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 20 hours per year for group psychotherapy has previously been approved.

Explanatory Code	Description
PC026	Service encounter has been refused. Maximum limit of 20 hours of family therapy per year has previously been approved.
PC027	Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 20 hours per year for family therapy has previously been approved.
PC028	Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 20 hours per year for group therapy has previously been approved.
PC029	Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 20 hours per year for individual therapy has previously been approved.
PC030	Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 10 hours per year for hypnotherapy has previously been approved.
PC031	Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 2 hours per year for lifestyle counselling has previously been approved.
PC032	Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 5 hours per year for counselling has previously been approved.
PC033	Service encounter has been refused as psychotherapy or counselling and a consult are not payable at the same service encounter.
PC034	Service encounter has been disallowed as you do not have approval to bill for this service. Please submit your qualifications to provide hypnotherapy to MSI.
PC035	Service encounter has been refused as the maximum of 8 sessions for mindfulness based cognitive therapy in a 365-day period has been reached.
PC036	Service encounter has been refused as you have not indicated that prior approval has been issued. Maximum limit of 9 hours for a PSP physician per year for counselling has previously been approved.
RF001	Service encounter has been refused. No adjustment is warranted.
RF002	Service encounter has been refused. Delete original submission(s) and submit new action code A transaction based on correct information or information provided by you.
RF003	Request for readjudication has been refused. Approval for this request has been previously processed.
RF004	Request for readjudication has been refused. Denial of this request has been previously processed.
RF005	Payment under this visit service cannot be approved. Delete the original service encounter and submit under the appropriate subsequent visit service.
VA001	Service encounter has been disallowed as a pap smear is not payable with a comprehensive evaluation.
VA002	Service encounter has been refused as this service is included in the consultation.
VA003	Service encounter has been reduced. When multiple diagnostic and therapeutic procedures are performed, only the fee for one is approved at 100%.
VA004	Service encounter has been disallowed as this procedure cannot be claimed in addition to the basic units for cardiac bypass.
VA005	Service encounter has been disallowed as it is included in limited prenatal and postnatal visits.
VA006	Service encounter has been disallowed as it is included in the delivery.
VA007	Service encounter has been disallowed as venipuncture is not payable in hospital unless medical necessity exists.
VA008	Service encounter has been refused as service is not approved in location indicated.
VA009	Service encounter has been disallowed as the maximum limit per week has previously been approved.
VA010	Service encounter has been disallowed as local anaesthetic is not approved when performed in conjunction with minor surgery.

Explanatory Code	Description
VA011	Service encounter has been refused as you have previously been approved a consultation with detention at the same service encounter.
VA012	Service encounter has been refused as venipuncture is included in the comprehensive prenatal exam.
VA013	Service encounter has been refused as modifier value indicated and patient's age do not agree.
VA014	Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved.
VA015	Service encounter has been disallowed as this service is included in a visit or consultation.
VA016	Service encounter has been refused as this service is included in the fee for a complete eye exam.
VA017	Service encounter has been refused as your specialty is not approved for performing this procedure.
VA018	Service encounter has been reduced. When multiple diagnostic and therapeutic procedures are performed, only one is approved at 100%.
VA019	Service encounter has been refused as it is a stand-alone procedure and another service has been approved.
VA020	Service encounter has been refused as a previous stand-alone procedure has been approved.
VA021	Service encounter has been refused as you have previously been approved a visit with detention at the same service encounter.
VA022	Service encounter has been refused as this service is included in the comprehensive visit.
VA023	Service encounter has been refused. This service is included in the comprehensive visit.
VA024	Service encounter has been refused as this procedure is included in the comprehensive visit.
VA025	Service encounter has been disallowed as this service is included in the surgery.
VA026	Service encounter has been refused as the provider must be a qualified allergist.
VA027	Service encounter has been refused as this service is only approved at hospital locations.
VA028	Service encounter has been disallowed as this service is included in the visit previously approved at this same service encounter.
VA029	Service encounter has been disallowed as this procedure is included in the previously approved visit.
VA030	Service encounter has been disallowed as local anaesthesia is not payable in addition to the surgical fee.
VA031	Service encounter has been refused as a comprehensive examination for the same or similar diagnosis has been approved to you within the past year. Please provide further details regarding the medical necessity of this complete examination.
VA032	Service encounter has been refused as a comprehensive examination has been paid to you within the last year.
VA033	Service encounter has been refused as you have already claimed the maximum of four subsequent days for invasive EEG video telemetry.
VA034	Service encounter has been refused as you have already claimed the maximum of nine subsequent days for non-invasive EEG video telemetry.
VA035	Service encounter has been refused as you cannot claim electrophysiology studies on the same day as the insertion of CRT pacemaker/defibrillator device.
VA036	Service encounter has been refused as you have already billed the maximum of four angioplasties for the same encounter.
VA037	Service encounter has been disallowed as the injection used to treat wet AMD has not been specified. Please resubmit, indicating the injected substance.
VA038	Service encounter has been refused as the maximum of six OCT fees have already been claimed for this patient within the past year.
VA039	Service encounter has been refused as you have already claimed an angioplasty for the same extremity or region during this encounter.
VA040	Service encounter has been refused as an angioplasty can only be billed from a hospital location.

Explanatory Code	Description
VA041	Service encounter has been refused as you have already billed 2 vessels for this side.
VA042	Service encounter has been refused as you have previously claimed a pay smear or tray fee for this patient on the same day.
VA043	Service encounter has been refused as you have previously claimed a pelvic examination for this patient on the same day.
VA044	Service encounter has been refused as you cannot claim a tray fee with a pelvic examination (HSC 03.26C).
VA045	Service encounter has been disallowed as HSC 69.94 requires text indicating why the catheter insertion was performed by the physician.
VA046	Service encounter has been refused as only one 09.13B can be paid in a 365-day period.
VA047	Service encounter has been refused. HSC 03.26A and 03.26C is included in the complete care code 81.8 which was previously billed for this patient on this day.
VA048	Service encounter has been refused as cystoscopy cannot be billed in addition to HSC 71.4B.
VA049	Service encounter has been refused as a 01.14C, 54.71, or 54.92E has been billed at this same encounter.
VA050	Service encounter has been refused as a 01.14H has been billed at the same encounter.
VA051	Service encounter has been refused as a 49.95A, 49.95B, 49.96A,B,C,D,E,F,G,H, 49.97A,B,C,D,E,F,G, 49.98A,B,C,D,E,F,G,H, 50.83, 50.91, 50.98A, or 13.72 has been billed at this same encounter.
VA052	Service encounter has been refused as a 49.98I has been billed at this same encounter.
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.
VA056	Service encounter has been refused as the diagnostic code provided is not valid for this service.
VA057	Service encounter has been refused as tonometry cannot be claimed with cataract surgery.
VA058	Service encounter has been refused as HSC 60.24C has previously been billed for this patient on this day.
VA059	Service encounter has been refused as HSC 71.4D has already been billed on this day which includes cystoscopy.
VA060	Service encounter has been refused as you have previously billed HS 09.02 or 09.04 for this patient at the same encounter.
VA061	Service encounter has been refused as only six 03.19H can be billed per patient per year for this diagnosis.
VA062	Service encounter has been refused as only two 03.19H can be billed per patient per year for this diagnosis.
VA063	Service encounter has been refused as the diagnostic code used us not valid for this service.
VA064	Provider is not permitted to claim for this service and must contact the medical consultant for approval.
VA065	Service encounter has been refused as you have previously billed for a colectomy with coloproctostomy at this encounter.
VA066	Service encounter has been refused as you have previously billed 60.59B at the same encounter.
VA067	Service encounter has been refused as you have previously billed HSC 09.02H at the same encounter.
VA068	Service encounter has been disallowed as you have previously billed HSC 13.59L at the same encounter.
VA069	Service encounter has been refused as you have previously billed for an ultrasound fee at the same encounter. Genetic sonogram includes all necessary imaging. Please submit a delete for original interpretation before resubmitting genetic sonogram.

Explanatory Code	Description
VA070	Service encounter has been refused as only one optic nerve imaging fee can be billed per year for this diagnosis.
VA071	Service encounter has been refused as the maximum of 6 claims allowed per year for this service have been approved.
VA072	Service encounter has been disallowed as there is already a claim at the same encounter for a procedure that includes intravenous insertion.
VA073	Service encounter has been refused as a claim for dialysis has already been billed for this patient on this day.
VA074	Service encounter has been refused as only one fee for either HSC 09.41E, 09.41F or 09.41G should be claimed per patient per day.
VA075	Service encounter has been refused as you have previously billed HSC 09.41D at the same encounter which includes this procedure.
VA076	Service encounter has been refused as HSC 09.41A, 09.41B or 09.41H has already been billed at the same encounter and is a component of this procedure.
VA077	Service encounter has been disallowed, please resubmit with documentation indicating that the service was provided by the physician, not another professional.
VA078	Service encounter has been refused as you have already billed an esophagogastroduodenoscopy code at the same encounter.
VA079	Service encounter has been refused as you must bill the appropriate base fee for bronchoscopy or esophagoscopy.
VA080	Service encounter has been refused as HSC 27.72, 27.72B, 27.73, 27.73A or 27.73B was billed at the same encounter and includes this procedure.
VA081	Service encounter has been disallowed as a claim for 51.95 RP=INTL has already been claimed for this patient.
VA082	Service encounter has been disallowed; insertion of the indwelling urinary catheter can not be claimed with any other procedure fees during the same encounter.
VA083	Service encounter has been disallowed as you have previously billed 72.1B at the same encounter. If an additional cystoscopic procedure is required, please resubmit with supporting text.
VA084	Service encounter has been disallowed as you have previously billed a major surgery procedure at the same encounter.
VA085	Service encounter has been refused as you have previously billed HSC 97.99A at the same encounter.
VA086	Service encounter has been refused as a visit or consult has already been claimed at the same encounter. HSC 49.83B and 49.83C include the accompanying visit in the health service description.
VA087	Service encounter has been refused as you have previously claimed for an insertion or removal with or without reinsertion of a penile prosthesis at the same encounter which includes any urethral dilation required to insert the device.
VA088	Service encounter has been disallowed. Please resubmit, indicating in the text field this claim is for the removal of an intradermal device.
VA089	Service encounter has been disallowed as HSC 50.99A requires text indicating the intravenous was performed by the physician.
VA090	Service encounter has been refused as the previously billed HSC 09.41E, F or G includes tympanometry.
VA091	Service encounter has been refused. HSC 09.41E, F or G cannot be billed at the same encounter has HSC 09.41H as they include tympanometry.
VA092	Service encounter has been refused as a claim for either battery or leads replacement/adjustment has already been claimed on this day which includes any necessary programming.
VA093	Service encounter has been disallowed as it is included in the remuneration of another service recently billed for this patient.

Explanatory Code	Description
VA094	Service encounter has been refused as electronic text is required on the claim stating type of medication and any additional risk factors.
VA095	Service encounter has been refused as the maximum number of OCT fees per year for this diagnosis have previously been claimed in the past year.
VA096	Service encounter has been refused as HSC 02.84A is a stand-alone procedure and may not be claimed with any other ultrasounds during the same encounter.
VA097	Service encounter has been refused as you have previously billed HSC 01.09D or 01.09E for this patient at the same encounter
VA098	Service encounter has been refused as you have previously billed 01.08A, 01.09, 01.09A or B, 46.82, 46.82A or B for this patient at the same encounter.
VA099	Service encounter has been disallowed as you have not included text stating the number of stations or structures.
VA100	Service encounter has been refused as you have previously claimed one of the following health service codes: 50.99C, 50.06C, or 50.08B. These services are considered to be inclusive of the current claim.
VA101	Service encounter has been disallowed as you have previously claimed one of the following health service codes: 50.82, 50.82C or 50.88A. These services are considered to be inclusive of the current claim.
VA102	Service encounter has been refused as you have previously claimed on of the following comprehensive health service codes: 48.0A, 48.0C, 48.0F.
VA103	Service encounter has been disallowed as you have previously claimed one of the following comprehensive health service codes: 48.0A, 48.0C, 48.0F.
VA104	Service encounter has been refused as you have previously claimed HSC 48.0A percutaneous coronary angioplasty during this encounter. The claim for coronary angioplasty includes selective coronary angiography.
VA105	Service encounter has been disallowed as you have previously claimed a portion of this fee (HSC 48.98B selective coronary angiography) during this encounter. Please submit a reversal for the prior 48.98B before submitting a reassessment request for this comprehensive claim.
VA106	Service encounter has been refused as a claim for Community Pharmacy-led Anticoagulant Management Service (CPAMS) has previously been billed for this patient in the same month.
VA107	Service encounter has been refused as a claim 13.99H (CPAMS) has previously been billed for this patient in the same month. 13.99C cannot be claimed with this fee.
VA108	Service encounter has been refused as a claim for 13.99C has previously been billed for this patient in the same month. 13.99H (CPAMS) cannot be claimed with this fee.
VA109	Service encounter has been refused as you have previously billed HSC 09.13A at the same encounter.
VA110	Service encounter has been refused as you have previously billed HSC 09.13A at the same encounter.
VA111	Service encounter has been refused as you have previously billed HSC 03.12, 09.13A or 19.13B at the same encounter.
VA112	Service encounter has been refused as you have previously billed HSC 02.02C at the same encounter.
VE001	Service encounter has been disallowed as visit excluded procedures are included in the consultation.
VE002	Service encounter has been reduced. When multiple diagnostic and therapeutic procedures are performed, only the fee for one is approved at 100%.
VE003	Service encounter has been disallowed. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved.
VE004	Service encounter has been disallowed as visit excluded procedures and a visit are not payable at the same service encounter.
VE005	Service encounter has been refused. When a procedure and the daily rate for intensive care are both claimed, only one, the procedure or intensive care is approved.

Explanatory Code	Description
VE006	Service encounter has been disallowed as this service applies only to patients in the insured age group.
VE007	Service encounter has been refused as the conduction of anaesthesia for relief of pain in labour has already been claimed for this patient.
VE008	Service encounter has been refused as you have previously billed HSC 09.03A for this patient at the same encounter.
VE009	Service encounter has been refused as this service has already been claimed for this patient on the same day.
VE010	Service encounter has been refused as HSC I1110 or I1140 has already been claimed for this patient on this day.
VE011	Service encounter has been refused as you have previously billed one of the following services at the same encounter 03.12, 09.01A, 09.05 or 09.13B.
VE012	Service encounter has been disallowed as the maximum limit per year has already been approved for this service.
VE013	Service encounter has been refused as a physician has previously billed another pulmonary function test for this patient on the same day.
VE014	Service encounter has been refused as a physician has previously billed for a stand-alone fee 03.38D for this patient on the same day.
VE015	Service encounter has been refused as you cannot bill 03.38B and 03.38C on the same day.
VE016	Service encounter has been refused as the patient requires one previously billed cataract surgery in the past year to claim for the third examination in a year, or two cataract surgeries for the fourth examination.
VE017	Service encounter has been refused as HSC 04.49B has already been claimed for this patient on this day.
VE018	Service encounter has been refused as HSC 04.49A has already been claimed for this patient on this day.
VE019	Service encounter has been refused as you have previously billed HSC 66.89A at the same encounter.
VE020	Service encounter has been refused as an injection of ONA for chronic migraine has already been approved in the previous 10 weeks.
VE021	Service encounter has been refused as no more than 11 injections of ONA for chronic migraine may be claimed over a 24-month period. If treatment continues to be recommended after this time period, prior approval must be requested again.
VE022	Service encounter has been refused as a claim for assessment and management of a patient with acute stroke was previously made for this patient on this day.
VE023	Service encounter has been refused as this facility is not authorized to claim the acute stroke protocol fee.
VE024	Service encounter has been refused as this service may only be claimed from the QEII.
VE025	Service encounter has been refused as you previously claimed a visit with this patient in the last 30 days.
VE026	Service encounter has been refused as no other fees are payable during the same time period as HSC 03.39T.
VE027	Service encounter has been refused as no other fees are payable during the same time period as HSC 03.09A.
VE028	Service encounter has been refused as a chronic dialysis management daily treatment and supervision fee has already been claimed for this patient on that date.
VE029	Service encounter has been disallowed as an outpatient visit or consult from a related specialty has been claimed for this patient on that date.

Explanatory Code	Description
VE030	Service encounter has been refused as the specialty submitted may only claim this service from the Yarmouth Regional Hospital.
VE031	Service encounter has been refused as another chronic dialysis fee has already been claimed for this patient on that date.
VE032	Service encounter has been refused as HSC R1135, R1141, R1145 or R1180 has already been claimed for this patient at the same encounter.
VE033	Service encounter has been refused as you have previously claimed a separate fee for a portion of this service on the same date.
VE034	Service encounter has been refused as you have previously claimed the comprehensive transcutaneous aortic valve implantation (TAVI) fee for this patient on this day.
VE035	Service encounter has been disallowed as this interpretation is included in the comprehensive fee for transcutaneous aortic valve implantation performed on that date.
VE036	Service encounter has been disallowed as a claim for access or visualization has already been claimed at the same encounter. HSC 50.0B is a comprehensive fee that includes all access and visualization.
VE037	Service encounter has been refused as this service may only be billed once per patient.
VE038	Service encounter has been refused as this service may not be claimed with any other autopsy HSC.
VE039	Service encounter has been refused as HSC 03.8C has already been claimed at the same encounter.
VE040	Service encounter has been disallowed as this service may not be billed if performed as part of a complete autopsy.
VE041	Service encounter has been refused. You may not claim a visit and 99.82A or 99.82B with the same diagnosis within the same week
VE042	Service encounter has been refused as you have previously billed health service code 99.82A or 99.82B for this patient in the previous week
VE043	Service encounter has been disallowed as you have not included text referring to the inspired program. Please resubmit with appropriate text
VE044	Service encounter has been disallowed as prior approval is required for this service.
VT001	Service encounter has been disallowed as this service is included in the postoperative care of fractures.
VT002	Service encounter for comprehensive evaluation has been refused as a comprehensive evaluation has been approved in the previous 30 days.
VT003	Service encounter for in-patient comprehensive evaluation has been refused as another incpa-patient comprehensive evaluation has been approved to you or another physician in your specialty for this admission.
VT004	Service encounter has been disallowed as an in-patient comprehensive evaluation has previously been approved and the patient has been readmitted within 30 days for the same or related condition.
VT005	Service encounter has been refused as the patient has been readmitted within 10 days for the same or similar diagnosis.
VT006	Service encounter has been refused as a comprehensive pregnancy exam has been approved during the previous nine months to you or another physician.
VT007	Service encounter has been refused as a previous postnatal care visit has been approved to you or another physician.
VT008	Service encounter has been disallowed as a complete care code includes a visit the same day and related visits for the following 14 days.
VT009	Service encounter has been disallowed as a fracture procedure has been approved to you on the same day or in the previous 14 days.
VT010	Service encounter has been disallowed as a well baby visit is not payable after one year of age.

Explanatory Code	Description
VT011	Service encounter has been disallowed as a well baby visit has been approved to you or another physician during this age interval.
VT012	Service encounter has been disallowed as after six months of age well baby visits are approved on the basis of once every three months up to one year of age.
VT013	Service encounter for comprehensive visit has been refused as you have been approved a consultation in the previous 30 days.
VT014	Service encounter has been disallowed as the maximum number of prenatal visits have been approved.
VT015	Service encounter has been disallowed as a post partum visit cannot be approved on the same day as a delivery.
VT016	Service encounter has been refused as you or another physician have previously been approved for first exam of healthy newborn.
VT017	Service encounter has been refused as newborn care of a healthy infant is only approved for the first five days after birth.
VT018	Service encounter has been disallowed as visit excluded procedures and a visit are not payable at the same service encounter.
VT019	Service encounter has been disallowed as another physician has been approved an inpatient hospital visit on this date.
VT020	Service encounter has been disallowed as this is included in the assist fee.
VT021	Service encounter has been refused as continuing or directive care must be preceded by a consultation.
VT022	Service encounter has been refused as a visit and psychotherapy or counselling are not payable at the same service encounter.
VT023	Service encounter has been refused as you have previously been approved a visit or consultation this day under the same service occurrence number.
VT024	Service encounter has been disallowed as this service is included in the preoperative care.
VT025	Service encounter has been disallowed as this service is included in the postoperative care.
VT026	Service encounter has been refused as you or another physician have previously been approved anticoagulant supervision for this same month.
VT027	Service encounter has been disallowed as contact lens fitting includes follow up for three months.
VT028	Service encounter for a visit on the same day as a stress test has been disallowed as the patient was seen in consultation in the previous 14 days.
VT029	Service encounter has been disallowed as a visit is not approved the same day as critical care.
VT030	Service encounter has been disallowed as compression sclerotherapy includes after care for one year.
VT031	Service encounter has been refused as detention is not payable in the office.
VT032	Service encounter for a visit with detention has been refused as you have previously been approved a visit allowed procedure at the same service encounter.
VT033	Service encounter has been adjudicated according to the weekly maximum of 44 units allowed per week after 56 days from admission.
VT034	Service encounter has been disallowed as an inpatient comprehensive evaluation has previously been approved and the patient has been readmitted within 10 days for the same or related condition.
VT035	Service encounter has been disallowed as a comprehensive visit has been previously approved to you this day or subsequent day for the same or related condition.
VT036	Service encounter has been refused as a comprehensive visit has been approved to you in the previous 30 days.
VT037	Service encounter has been refused as a previous visit has been claimed by you in the previous 30 days.

Explanatory Code	Description
VT038	Service encounter has been refused as you have been approved a consultation in the previous 30 days for the same or related diagnosis.
VT039	Service encounter for initial limited visit has been refused as you have attended this patient in the previous 30 days.
VT040	Service encounter has been disallowed as supportive care is approved once every three days up to and including the ninth day from admission and twice weekly thereafter.
VT041	Service encounter has been accepted at zero. The first postoperative clinic or office recheck should be claimed but will be approved at 0 units during the 90 days following major surgery.
VT042	Service encounter has been disallowed. When a visit and surgery are performed at the same service encounter, only one is approved.
VT043	Service encounter has been refused as a newborn care visit has previously been approved for this day.
VT044	Service encounter has been refused as modifier DA value is inappropriate after 56 days from admission.
VT045	Service encounter has been refused as this is an invalid service for age of patient.
VT046	Service encounter has been refused as health service code and modifier combination indicated is invalid for your specialty.
VT047	Service encounter has been refused as the maximum of three services per patient per day has been approved.
VT048	Service encounter has been disallowed as it is not payable in addition to the assistant fee.
VT049	Service encounter has been disallowed as it is included in the postoperative care of fractures.
VT050	Service encounter has been refused. Resubmit under the visit code using modifier for role of detention in conjunction with all other required modifiers.
VT051	Service encounter has been refused. You have previously been approved a comprehensive evaluation during this hospitalization.
VT052	Service encounter has been disallowed as a previous well baby visit has been approved for this three-month period.
VT053	Service encounter has been disallowed as it is included in the surgery performed at this same encounter.
VT054	Service encounter has been disallowed as it is included in the fracture procedure performed this same day.
VT055	Service encounter has been disallowed. Contact lens fitting includes follow up care for three months.
VT056	Service encounter has been disallowed as this service has been approved to you or another physician.
VT057	Service encounter has been disallowed as attendance with patient during labour is included in the delivery.
VT058	Service encounter has been refused as the patient has not yet reached the age of 65.
VT059	Service encounter has been refused. Two previous service encounters have been approved for immunizations at this same encounter.
VT060	Service encounter has been disallowed as a visit the same day as major surgery is included in the surgery.
VT061	Service encounter has been disallowed as it is included in a diagnostic and therapeutic procedure previously approved at this same service encounter.
VT062	Service encounter has been disallowed as you have previously been approved a delivery fee.
VT063	Service encounter has been disallowed as delivery did occur at the same facility.
VT064	Service encounter has been disallowed as a visit is included in the previously approved procedure.

Explanatory Code	Description
VT065	Service encounter has been disallowed as 30 days has not elapsed since recipient was last seen by this provider.
VT066	Service encounter has been disallowed. Comprehensive visits cannot be approved within 30 days of a previous visit by the same provider.
VT067	Service encounter has been disallowed. This service is only approved for general practitioners.
VT068	Service encounter has been refused. Resubmit as a limited visit or resubmit providing electronic text explaining the medical necessity of a comprehensive visit within 30 days of a previous visit.
VT069	Service encounter has been disallowed based on the limitations applied to supportive care visits.
VT070	Service encounter has been disallowed as you have been approved a visit during the previous two days.
VT071	Service encounter for supportive care has been disallowed as you have been approved two visits within the previous two days.
VT072	Service encounter for supportive care has been disallowed as you have been approved two visits within the previous three days.
VT073	Service encounter for supportive care has been disallowed as you have been approved two visits within the previous four days.
VT074	Service encounter for supportive care has been disallowed as you have been approved two visits within the previous five days.
VT075	Service encounter for supportive care has been disallowed as you have been approved two visits within the previous six days.
VT076	Service encounter has been refused as modifier value OV65 does not agree with age of patient.
VT077	Service encounter has been refused. Resubmit under the same health service code using the appropriate modifiers for the service provided.
VT078	Service encounter has been refused as patient's age is inappropriate for this service.
VT079	Service encounter has been refused as the maximum number of complex care visits for the year has previously been approved.
VT080	Service encounter has been refused as modifier DA value is inappropriate after 56 days from hospital admission.
VT081	Service encounter has been refused as the maximum of eight well baby care visits in the first 13 months of life has been approved.
VT082	Service encounter has been refused as the maximum of eight well baby care visits in the first 13 months of life has been approved.
VT083	Service encounter has been refused as the patient is not insured for this service at this time.
VT084	Service encounter has been refused as the patient is not insured for this service at this time.
VT085	Service encounter has been refused as the maximum of nine well baby care visits has previously been approved.
VT086	Service encounter has been refused as only one well baby care visit is insured when patient age is 18 months.
VT087	Service encounter has been refused as you have previously been approved this service for this diagnosis.
VT088	Service encounter has been refused as you or another provider have previously been approved this service for this diagnosis.
VT089	Service encounter has been refused as functional center is not indicated.
VT090	Service encounter has been disallowed as electronic text is required to indicate the start date and duration of the current treatment cycle.
VT091	Service encounter has been disallowed as this service is included in the CGA1 service that has previously been approved.

Explanatory Code	Description
VT092	Service encounter has been refused as 03.03 supportive care has been claimed this day.
VT093	Service encounter has been refused as 03.03E or 03.04C has been claimed this day.
VT094	Service encounter has been refused as you have not used a qualifying diagnostic code.
VT095	Service encounter has been refused as an initial hospital visit has already been claimed for this patient on the same admission date.
VT096	Service encounter has been refused as the maximum number of subsequent limited visits has already been claimed for this patient this week.
VT097	Service encounter has been refused as you have already been approved for a supportive care claim within the past three days (Preamble 5.1.23).
VT098	Service encounter has been refused as you have already been approved for two supportive care claims within the past seven days (Preamble 5.1.23).
VT099	Service encounter has been refused as you can only claim subsequent weekly visits after 56 days from hospital admission. Prior to that you may claim subsequent daily visits.
VT100	Service encounter has been refused as a 03.26A or 03.26C has previously been billed for this patient on the same day.
VT101	Service encounter has been refused as a diagnostic code used is not valid for urgent services.
VT102	Service encounter has been disallowed. Please submit a copy of the clinical record before requesting a reassessment for this claim.
VT103	A comprehensive or initial limited visit may not be claimed within 30 days of a comprehensive consultation on the same patient for the same condition. See Preamble 5.1.12.
VT104	A comprehensive visit may not be claimed within 30 days of a previous limited or comprehensive visit. See Preamble 5.1.13.
VT105	Service encounter has been disallowed as a previously approved surgery includes post-operative care for up to 14 days after the date of service. (Preamble 5.3.50).
VT106	Service encounter has been disallowed as a consultation has been billed in the previous 7 days for this patient by this provider.
VT107	Service encounter has been refused as four of these services have previously been approved in the past 365 days.
VT108	Service encounter has been refused as this code is not payable in addition to any other service for the same patient by the same physician on the same day.
VT109	Service encounter has been refused as no other fees are payable during the same time period as 03.03G.
VT110	Service encounter has been refused as HSC 03.03G is not payable when other fees are billed during the same time period.
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.
VT116	Service encounter has been refused as you have previously billed a visit or consultation on this day for this patient.
VT117	Service encounter has been refused as you have previously claimed HSC 03.09G on this day for this patient.

Explanatory Code	Description
VT118	Service encounter has been disallowed as HSC 03.09G has previously been approved for this patient.
VT119	Service encounter has been refused as a consult and psychotherapy or counselling are not payable at the same service encounter.
VT120	Service encounter has been disallowed as HSC 03.09H has previously been approved for this patient.
VT121	Service encounter has been disallowed as the provider number is not valid for this service.
VT122	When claiming this service the fetal diagnosis must be recorded in the text field.
VT123	Service encounter has been disallowed as you do not have approval to bill for this service.
VT124	Service encounter has been disallowed as an urgent visit (all locations) applies only when a physician travels from one location to another. Preamble 5.1.52. Resubmit with text stating details of physician's travel.
VT125	Service encounter has been refused as this claim does not meet the criteria for an urgent visit, as per Preamble 5.1.55, 5.1.56, 5.1.57.
VT126	Service encounter has been disallowed as an additional visit for an OPD or EMERG patient is only payable if the patient is under observation for more than 4 hours. Preamble 5.1.45. Resubmit with text explaining the necessity of an additional visit.
VT127	Service encounter has been refused. The documentation provided supports a continuing care visit, not a consult. (See Preamble 5.1.25). Please resubmit with the appropriate HSC.
VT128	Service encounter has been refused. The documentation provided supports a limited visit, not a comprehensive visit. (See Preamble 5.1.4). Please resubmit with the appropriate HSC.
VT129	Service encounter has been refused as HSC 82.64E is a comprehensive service and you have already claimed another service at the same encounter.
VT130	Service encounter has been refused. The documentation provided supports an initial visit with complete examination, not a consult (see Preamble 5.1.7). Please resubmit with the appropriate HSC.
VT131	Claim has been disallowed as this service should be billed in groups of 3. If 4 or more are necessary, submit an additional service occurrence for each additional group of 3 with supporting text.
VT132	Service encounter has been disallowed as a claim for critical care has already been approved for this patient on the same day.
VT133	Service encounter has been refused as you have previously billed HSC WCB28 for this patient on the same day.
VT134	Service encounter has been refused as the initial opioid use disorder assessment has previously been paid.
VT135	Service encounter has been refused as the initial opioid use disorder assessment for methadone treatment – transfer from clinic to physician has been paid.
VT136	Service encounter has been refused as the permanent transfer of patient on active methadone treatment for substance use disorder – initial visit with accepting physician has been previously paid.
VT137	It is not appropriate to bill MSI for a meet and greet visit with a new patient unless a health-related concern/complaint has been addressed at the visit.
VT138	Service encounter has been refused and cannot be processed until after the first physician claim has been received and processed.
VT139	Service encounter has been refused as MSI requires first and second physician claims to process the prescribing physician claim.
VT140	Service encounter has been refused as a minimum of one-half hour must be spent for MAiD fees to be payable.
VT141	Service encounter has been reduced as a maximum of 2 hours is payable per patient for this health service code.
VT142	Service encounter has been refused as a daily hospital visit rate for the most responsible physician has already been claimed for the patient on this day.

Explanatory Code	Description
VT143	Service encounter has been refused as the DA=DA23 modifier may only be used on the 2nd and 3rd admission dates (or days out of ICU).
VT144	Service encounter has been refused as the DA=DA47 modifier may only be used on the 4th to 7th admission dates (or days out of ICU).
VT145	Service encounter has been refused as you have already claimed a visit service for this patient on the same day.
VT146	Service encounter has been refused as you have already claimed the complex comprehensive acute care hospital discharge fee for this patient on the same day.
VT147	Service encounter has been refused as the patient must have previously been seen for a face-to-face encounter by this provider within the last 9 months.
VT148	Service encounter has been refused as HSC 03.09K may not be billed in addition to any other service for this patient on the same day.
VT149	Service encounter has been refused as calls between a referring provider and specialist in the same institution or practice location are not permitted for this service.
VT150	Service encounter has been disallowed as you have previously billed for specialist telephone advice for this patient within the previous 14 days which includes any subsequent calls necessary to complete the consultation.
VT151	Service encounter has been disallowed as you have already billed a face-to-face visit for this patient in the previous 14 days.
VT152	Service encounter has been disallowed as the text does not warrant payment of a comprehensive visit, please resubmit as a limited visit.
VT153	Service encounter has been disallowed as an urgent visit applies when a physician travels to see a registered inpatient at the request of hospital staff. Preamble 5.1.54. Resubmit with text stating the necessity of the service and travel details.
VT155	Service encounter has been refused as a claim for HSC 49.83B or 49.83C has already been claimed at the same encounter and includes the accompanying visit in the health service description.
VT156	Service encounter has been disallowed as start and stop times for this service must be included in text.
VT162	Service Encounter has been refused as HSC 03.03V may not be billed in addition to other services for this patient on the same day.
VT163	Service encounter has been refused as a consult may not be claimed in addition to 03.03V for this patient on the same day.
VT164	Service encounter has been disallowed as Medical Assistance in Dying claims require start and stop times.
VT165	Service encounter has been refused as HSC 03.03N cannot be claimed unless the provider has previously claimed for a MaiD service with the same patient.
VT166	Service encounter has been disallowed as text indicating the stop and start times for this service is required
VT167	Service encounter has been refused as HSC 03.04I is not reportable with any other visit fees on the same day
VT168	Service encounter has been refused as HSC 03.04I may only be reported once per patient per year
VT169	Service encounter has been refused as you are not authorized to provide this service over a virtual care platform
VT170	Service encounter has been refused as 03.04J has already been approved for this patient in the previous 12 months.
VT171	Service encounter has been refused as you have already made the maximum of two claims for HSC 03.03X for this patient on this service date.

Explanatory Code	Description
VT172	Service encounter has been disallowed as a chronic dialysis management daily treatment and supervision fee has been claimed for this patient on that date.
VT173	Service encounter has been disallowed as you have previously claimed a daily dialysis management fee for this patient on this date. If this visit is unrelated to dialysis management, please submit a reassess request with supporting information.
VT174	Service encounter has been refused as the maximum of 9 well infant/child visits has been reached.
VT175	Service encounter has been refused as the maximum of 5 comprehensive well infant/child visits using the Rourke Baby Record has been reached.
VT176	Service encounter has been disallowed as a well infant/child visit claimed by a provider other than the family physician requires text indicating that the patient is unattached.
VT177	Service encounter has been refused as it can only be claimed by the physician who claimed the original GAS surgery.
VT178	Service encounter has been refused as this service is only payable once per patient within 18 months post surgery.
VT179	Service encounter has been refused. You may not claim a visit and 99.82A or 99.82B with the same diagnosis within the same week
VT180	Service encounter has been disallowed as you have claimed NSHP1 or NSHP2 on the same day. Please resubmit with explanatory text.
WB001	Service encounter has been disallowed according to information provided by workers' compensation board.
WB004	Service encounter has been adjusted based on an audit of the form 8/10 for legibility, completeness or quality as per contract conditions. The visit fee only (WCB28) will be paid on this claim.
WB007	Service encounter has been refused as this form code has not been approved for implementation.
WB008	Service encounter has been refused re payment responsibility indicated.
WB010	Service encounter has been refused as a consultation service has not been claimed for this date.
WB011	Service encounter has been refused as this type of visit is no longer payable under WCB. Please resubmit using the appropriate physician assessment health service code.
WB012	Service encounter has been refused as you have previously claimed a physician assessment service this day.
WB013	Service encounter has been refused as you have previously claimed a physician assessment service this day.
WB014	Service encounter has been refused as you have previously been paid a special assessment service for this date.
WB015	Service encounter has been refused as you have previously been paid an assessment service with completion of form 8/10 this date.
WB016	Service encounter has been refused as a previous assessment has been claimed by you for this date.
WB017	Service encounter has been refused as a previous assessment has been claimed by you for this date.
WB018	Service encounter has been refused as a previous chart summary has been claimed by you for this date.
WB019	Service encounter has been refused as a previous chart summary has been claimed by you for this date.
WB020	Service encounter has been refused as a previous case conference has been claimed by you for this date.
WB021	Service encounter has been refused as a previous case conference has been claimed by you for this date.
WB022	Service encounter has been disallowed as a previous service for WCB has been claimed this day.
WB023	Service encounter has been disallowed as a previous visit fee has been claimed this day.

Explanatory Code	Description
WB024	WCB has adjusted this claim to the appropriate visit fee as the client is on long term benefits and form 8/10 is only necessary when there is a change in condition or treatment as per contract conditions.
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.
WB030	Service encounter has been disallowed as you can only bill for WCB21 after a follow-up office visit code has been claimed.
WB031	Service encounter has been refused as the provider indicated is not valid for this service.
WB033	Service encounter has been refused as the required WCB form was not received within the appropriate time.
WB034	Service encounter has been refused as you are not listed as an approved EPS physician.
WB035	Service encounter has been refused as a claim for WCB17 has already been approved for this date.
WB036	Service encounter has been refused as the initial or extension medical cannabis form has already been claimed for this patient on this day.
WB037	Service encounter has been refused as an initial or extension request for medical cannabis was previously claimed in the past seven weeks.
WBHLT	HSC invalid for WCB LTB claim.
WBHNC	Individual has no WCB coverage.
WBHRT	HSC Invalid for WCB RTW claim.
WBHSD	Service date not within WCB coverage period.
WBHUJ	File is being adjudicated for workers compensation with a province other than NS.
WBHOK	Eligibility approved by WCB.
WBHNM	WCB did not receive medical documentation for service date billed.
WBPPC	Physician compliance. Fees adjusted or reversed due to non-compliance of the DOCS NS contract.
WBPUF	Firm / Employer not registered with WCB.
WBPUH	No WCB claim with that health card number.
WBPUI	WCB claim inactive / closed.
WBPUJ	Not in WCB NS Jurisdiction.
WBPUM	WCB claim disallowed.
WBPUP	Provider compliance – fees reduced or reversed due to form 8/10 quality issues (incomplete fields, timelines, illegibility, etc.).
WBPUW	Not work related / no action.

(7.9.1)

APPENDIX J – HEALTH SERVICE CODES WITH PHYSICIAN RESTRICTIONS *(7.10.0)*

MSI adjudication system has rules in place to ensure physicians have the appropriate qualifications to claim specific services. *(7.10.1)*

Health Service Code	Restriction	Specialties
02.75B	Diagnostic & Therapeutic Radiology level 2 (150 cases plus 8 weeks training in CT angiography) or greater certification for CT angiography as described by the Canadian Association of Radiologists and Canadian Cardiovascular Society. Qualifications must be submitted to be kept on file at MSI.	SP=RADI, SP=DIRD
02.89A	Fetal maternal medicine specialists only. Operators must be certified by the Fetal Maternal Medicine Foundation of Canada or the UK to perform NT measurements. Operators and the centre must provide evidence of current certification and quality assurance to MSI.	SP=OBGY
02.89B **R1225, R1226, R1245, R1246, R1250, R1255, R1256, R1306, R1309**	Fetal maternal medicine specialists and radiologists with the credentials to perform fetal ultrasound/echocardiography.	SP=OBGY, SP=DIRD, SP=RADI
03.03 ME=VTCR **03.03A ME=VTCR**	Providers must be designated as Virtual Care Health Care Providers.	SP=ANAE, SP=DERM, SP=GENP, SP=ENME, SP=GEMD, SP=HAGY, SP=INMD, SP=MDON, SP=NEPH, SP=RHEU, SP=NUSG, SP=OBGY, SP=ORTH, SP=PEDI, SP=HUGE, SP= MEGE, SP=PHMD, SP=PLAS, SP=PSYC, SP=RDON, SP=CASG, SP=GNSG, SP=THSG
03.03 ME=CARE **03.03A ME=CARE**	Physicians must sign a confirmation letter confirming that they will bill the enhanced fees only for visits with patients for whom they are providing comprehensive and continuous care.	SP=GENP
03.03H **03.09H**	Paediatrician with additional training in Paediatric Palliative Care.	SP=PEDI
03.09C	Physicians with recognized expertise in Palliative Care or Certificate of added competence	
03.04D	Physician with Geriatric Medicine speciality or Internal Medicine with a minimum of 8 weeks recognized Geriatric subspecialty training (PGY4 or greater).	SP=GEMD SP=INMD +
03.04I	Practice Support Program trained General Practitioner	SP=GENP
03.04K	Gender Affirming Care, Transition Readiness Assessment, Follow-up. Must be informed, knowledgeable and experienced in providing culturally competent and safe trans care and are required to complete and return the GAC Competency Declaration.	SP=GENP

Health Service Code	Restriction	Specialties
08.41	Physicians providing hypnotherapy must have at least 20 hours of training in clinical hypnotherapy and be an active member in good standing of a recognized Canadian Clinical Hypnosis society.	SP=PSYC, SP=GENP
08.44A	PSYC trained in MBCT or GENP trained in group psychotherapy and MBCT. Credentials must be submitted to MSI directly.	SP=PSYC, SP=GENP
38.39C	Members of the head and neck subsection within the Dalhousie Division of ORL-HNS	SP=OTOL
51.95A **51.95C**	Internal Medicine specialist must be in acting role of the Nephrologist at the Yarmouth Regional Hospital as designated by NSHA Renal Program Senior Medical Director.	SP=NEPH SP=INMD
52.31A	Members of the head and neck subsection within the Dalhousie Division of ORL-HNS	SP=OTOL
60.4B	Fellowship in colorectal surgery and/or fellowship in minimally invasive surgery (MIS) is required to be submitted and kept on file at MSI	SP=GNSG
60.24C	Fellowship in colorectal surgery and/or fellowship in minimally invasive surgery (MIS) is required to be submitted and kept on file at MSI	SP=GNSG
60.52B	Primary surgeon – Fellowship in minimally invasive surgery MIS required to be submitted and kept on file at MSI	SP=GNSG
98.99H **98.99I**	Proof of Mohs Micrographic Surgery Fellowship in keeping with the standards of the American College of Mohs Surgery (ACMS) is required to be kept on file at MSI	SP=DERM, SP=PLAS

(7.10.2)

SECTION 8: NOVA SCOTIA MEDICAL SERVICES INSURANCE SCHEDULE OF BENEFITS

SERVICES FOR MULTIPLE SPECIALTIES

(Specialties with unit values that differ from the below will be specified in their respective sections)

CATEGORY	HEALTH SERVICE CODE	DESCRIPTION / MODIFIERS	BASE UNITS	ANAES UNITS
PALLIATIVE CARE				
CONS	03.09C	Palliative Care Consultation (Once per patient per physician)	62+MU	
VIST	03.03C	Palliative Care Support Visit RO=PCSV	30 per 30 min	
		(15 units per 15 min. thereafter, maximum of 60 min. per patient per day)		
VIST	03.03	Palliative Care Medical Chart Review and/or Telephone Call, Fax or E-mail initiated by a health care professional - up to three telephone calls/faxes or e-mails per day per patient RO=CRTC	11.5	
		Note: Each additional group of three telephone calls, faxes or e-mails/per day/per patient can be claimed at 11.5 units		
HOME				
VIST	03.04	Initial Visit LO=HOME (RF=REFD)	23	
		LO=HOME, RO=DETE (RF=REFD)	23+MU	
VIST	03.03	Home Visit (0800 - 1700) LO=HOME, PT=FTPT (RF=REFD)	21.3	
		LO=HOME, PT=FTPT, RO=DETE (RF=REFD)	21.3+MU	
VIST	03.03	Home Visit (1701 - 2000) LO=HOME, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD)	28.3	
		LO=HOME, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD)	28.3+MU	
VIST	03.03	Home Visit (2001 - 2359) LO=HOME, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD)	28.3	
		LO=HOME, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD)	28.3+MU	
VIST	03.03	Home Visit (0000 - 0800) LO=HOME, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)	38.3	
		LO=HOME, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)	38.3+MU	
VIST	03.03	Home Visit (0801 - 1200) Sat., Sun., Holidays LO=HOME, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)	28.3	
		LO=HOME, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)	28.3+MU	

VIST 03.03 Home Visit (1201 - 1700) Sat., Sun., Holidays
LO=HOME, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD) 28.3
LO=HOME, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Home Visit - Extra Patient
LO=HOME, PT=EXPT (RF=REFD) 10.5

VIST 03.03 Home Emergency Visit
LO=HOME, US=UIOH (RF=REFD) 35.2
LO=HOME, US=UIOH, RO=DETE (RF=REFD) ..... 35.2+MU

VIST 03.03 Continuing Care
LO=HOME, RO=CNTC, RF=REFD 13.5
LO=HOME, RO=CCDT, RF=REFD ..... 13.5+MU

VIST 03.03 Directive Care
LO=HOME, RO=DIRC, RF=REFD 13.5
LO=HOME, RO=DRDT, RF=REFD ..... 13.5+MU

HOME CARE

VIST 03.04 Transfer to Home Care from Inpatient
LO=HMHC, OL=INPT (RF=REFD) 28.6
LO=HMHC, OL=INPT, RO=DETE (RF=REFD) ..... 28.6+MU

HOSPITAL DETOX CENTRE

VIST 03.03 Detox Centre (0800 - 1700)
LO=HOSP, FN=DTOX, PT=FTPT (RF=REFD) 21.3
LO=HOSP, FN=DTOX, PT=FTPT RO=DETE (RF=REFD) ..... 21.3+MU

VIST 03.03 Detox Centre (1701 - 2000)
LO=HOSP, FN=DTOX, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) 28.3
LO=HOSP, FN=DTOX, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Detox Centre (2001 - 2359)
LO=HOSP, FN=DTOX, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) 28.3
LO=HOSP, FN=DTOX, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Detox Centre (0000 - 0800)
LO=HOSP, FN=DTOX, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) 38.3
LO=HOSP, FN=DTOX, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) ..... 38.3+MU

VIST 03.03 Detox Centre (0801 - 1200) Sat., Sun., Holidays
LO=HOSP, FN=DTOX, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF
(RF=REFD) 28.3
LO=HOSP, FN=DTOX, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF,
RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Detox Centre (1201 - 1700) Sat., Sun., Holidays
LO=HOSP, FN=DTOX, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF
(RF=REFD) 28.3
LO=HOSP, FN=DTOX, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF,
RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Detox Centre (0801 - 1201) Extra Patient
LO=HOSP, FN=DTOX, PT=EXPT, TI=AMNN (RF=REFD) 8.4
LO=HOSP, FN=DTOX, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD) ..... 8.4+MU

VIST 03.03 Detox Centre (1201 - 1700) Extra Patient
LO=HOSP, FN=DTOX, PT=EXPT, TI=NNEV (RF=REFD)..... 8.4
LO=HOSP, FN=DTOX, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD)..... 8.4+MU

VIST 03.03 Detox Centre (1701 - 2000) Extra Patient
LO=HOSP, FN=DTOX, PT=EXPT, TI=EVNT (RF=REFD) 10.5
LO=HOSP, FN=DTOX, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD)..... 10.5+MU

VIST 03.03 Detox Centre (2001 - 2359) Extra Patient
LO=HOSP, FN=DTOX, PT=EXPT, TI=ETMD (RF=REFD) 10.5
LO=HOSP, FN=DTOX, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD)..... 10.5+MU

VIST 03.03 Detox Centre (0000 - 0800) Extra Patient
LO=HOSP, FN=DTOX, PT=EXPT, TI=MDNT (RF=REFD)..... 10.5
LO=HOSP, FN=DTOX, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD)..... 10.5+MU

VIST 03.03 Detox Centre (0801 - 1200) Extra Patient, Sat., Sun., Holidays
LO=HOSP, FN=DTOX, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD) 10.5
LO=HOSP, FN=DTOX, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD) ..... 10.5+MU

VIST 03.03 Detox Centre (1201 - 1700) Extra Patient, Sat., Sun., Holidays
LO=HOSP, FN=DTOX, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD)..... 10.5
LO=HOSP, FN=DTOX, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD)..... 10.5+MU

CORRECTIONAL CENTRE

VIST 03.03 Office Visit
LO=CCNT, RP=SUBS (RF=REFD)..... 12.5

VIST 03.03 Urgent Care - Request by Patient (1701 - 2000)
LO=CCNT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Request by Patient (2001 - 2359)
LO=CCNT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Request by Patient (0000 - 0800)
LO=CCNT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)..... 38.3

VIST 03.03 Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays
LO=CCNT, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays
LO=CCNT, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD)..... 28.3

VIST 03.03 Urgent Care - Extra Patient
LO=CCNT, PT=EXPT (RF=REFD)..... 10.5

VIST 03.03 Correctional Centre - Emergency Visit
LO=CCNT, US=UIOH (RF=REFD)..... 35.2
LO=CCNT, US=UIOH, RO=DETE (RF=REFD)..... 35.2+MU

OTHER

VIST 03.03 Unspecified Emergency Visit
LO=OTHR, US=UIOH (RF=REFD) 35.2
LO=OTHR, US=UIOH, RO=DETE (RF=REFD) ..... 35.2+MU

VIST 03.03 Unspecified Location (0800-1700)
LO=OTHR, PT=FTPT (RF=REFD) 21.3
LO=OTHR, PT=FTPT, RO=DETE (RF=REFD) ..... 21.3+MU

VIST 03.03 Unspecified Location (1701-2000)
LO=OTHR, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) 28.3
LO=OTHR, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Unspecified Location (2001-2359)
LO=OTHR, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) 28.3
LO=OTHR, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Unspecified Location (0000-0800)
LO=OTHR, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) 38.3
LO=OTHR, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) ..... 38.3+MU

VIST 03.03 Unspecified Location (0801-1200) Sat., Sun., Holidays
LO=OTHR, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)..... 28.3
LO=OTHR, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)..... 28.3+MU

VIST 03.03 Unspecified Location (1201-1700) Sat., Sun., Holidays
LO=OTHR, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD) 28.3
LO=OTHR, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Unspecified Location - Extra Patient
LO=OTHR, PT=EXPT (RF=REFD) 10.5

OTHER TERMINATION OF EARLY PREGNANCY

VIST 03.03V Medical abortion/termination of early pregnancy..... 67.03

CASE MANAGEMENT CONFERENCE

VIST 03.03D Case Management Conference Fee..... 17.5 per 15 min
(SP=GENP)..... 15 per 15 min

MEDICAL ASSISTANCE IN DYING

VIST	03.03M	MAiD – First Physician assessor (15 units for each 15 min. thereafter)	30 per 15 min + MU
VIST	03.03O	MAiD – Second Physician assessor (15 units for each 15 min. thereafter)	30 per 15 min + MU
VIST	03.03N	MAiD – Prescribing Physician RO=FPHN (15 units for each 15 min. thereafter) RO=SPHN	30 per 15 min + MU 56

INCENTIVE

ADON	OFI1	Incentive for use of Official Interpreter services when caring for a patient of limited English proficiency (LEP)	5

ANAESTHESIA

(SP=ANAE)

CATEGORY	HEALTH SERVICE CODE	DESCRIPTION / MODIFIERS	BASE UNITS	ANAES UNITS
CONSULTATIONS				
CONS	03.08	Comprehensive Consultation (Prolonged)		
		RF=REFD (ME=TELE)	59.5+MU	
		RF=REFD, US=PREM (ME=TELE)	80.33+MU	
		RF=REFD, US=PR50 (ME=TELE)	89.25+MU	
		RF=REFD, RO=DETE (ME=TELE)	59.5+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	80.33+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	89.25+MU	
CONS	03.07	Limited Consultation		
		RF=REFD (ME=TELE)	41	
		RF=REFD, US=PREM (ME=TELE)	59	
		RF=REFD, US=PR50 (ME=TELE)	61.5	
		RF=REFD, RO=DETE (ME=TELE)	41+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	59+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	61.5+MU	
CONS	03.07	Repeat Consultation (Prolonged)		
		RF=REFD, RP=REPT (ME=TELE)	36+MU	
		RF=REFD, RP=REPT, US=PREM (ME=TELE)	54+MU	
		RF=REFD, RP=REPT, US=PR50 (ME=TELE)	54+MU	
		RF=REFD, RO=DETE, RP=REPT (ME=TELE)	36+M	
		RF=REFD, RO=DETE, RP=REPT, US=PREM (ME=TELE)	54+MU	
		RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE)	54+MU	
OFFICE				
VIST	03.04	Initial Visit with Complete Examination		
		LO=OFFC (RF=REFD)	24	
VIST	03.03	Initial Visit with Regional Examination		
		LO=OFFC, RP=INTL (RF=REFD)	12	
		LO=OFFC, AG=OV65, RP=INTL (RF=REFD)	16.5	
VIST	03.03	Subsequent Visits		
		LO=OFFC, RP=SUBS (ME=VTCR*) (RF=REFD)	13	
		*Physician Restrictions in Place (See Appendix J)		
VIST	03.03A	Geriatric Office Visit (for patients aged 65+)		
		LO=OFFC (ME=VTCR*) (RF=REFD)	16.5	
		*Physician Restrictions in Place (See Appendix J)		

VIST 03.03 Continuing Care
LO=OFFC, RO=CNTC, RF=REFD 13.5
LO=OFFC, AG=OV65, RO=CNTC, RF=REFD 16.5

VIST 03.03 Directive Care
LO=OFFC, RO=DIRC, RF=REFD 13.5
LO=OFFC, AG=OV65, RO=DIRC, RF=REFD 16.5

VIST 03.03 Urgent Care - Request by Patient (1701 - 2000)
LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Request by Patient (2001 - 2359)
LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Request by Patient (0000 - 0800)
LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) 38.3

VIST 03.03 Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Extra Patient
LO=OFFC, PT=EXPT (RF=REFD) 10.5

HOSPITAL (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

VIST 03.04 Anaesthetic Standby (refer to the Preamble)
LO=HOSP, FN=INPT, RO=STBY, SP=GENP, SP=ANAE (RF=REFD) ..... 10+MU per ½ hour

VIST 03.04 Initial Visit with Complete Examination
LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD) 24
LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD) ..... 24+MU

VIST 03.04 Initial Visit
LO=HOSP, FN=INPT, RP=INTL (RF=REFD) 25
LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD) ..... 25+MU

VIST 03.03 Continuing Care
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC, RF=REFD 15
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT, RF=REFD ..... 15+MU

VIST 03.03 Directive Care
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD 15
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD ..... 15+MU

VIST 03.03 Subsequent Visit - Daily to 56 Days
LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) 15
LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU

VIST	03.03	Subsequent Visit - Weekly after 56 Days - Maximum 44 units per week
		LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD) 15
		LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU
VIST	03.03	Resuscitation of Newborn
		LO=HOSP, FN=INPT, RO=RESC (RF=REFD)..... 50
		LO=HOSP, FN=INPT, RO=RESC, US=PREM (RF=REFD)..... 68
		LO=HOSP, FN=INPT, RO=RESC, US=PR50 (RF=REFD) 75
		LO=HOSP, FN=INPT, RO=RNDT (RF=REFD)..... 50+MU
		LO=HOSP, FN=INPT, RO=RNDT, US=PREM (RF=REFD)..... 68+MU
		LO=HOSP, FN=INPT, RO=RNDT, US=PR50 (RF=REFD) ..... 75+MU
ADON	03.02A	Hospital Discharge Fee
		LO=HOSP, FN=INPT 10
VIST	03.03	Urgent Hospital Care
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)..... 22
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD)..... 22+MU
VIST	03.03	Emergency Visit
		LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)..... 35.2
		LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)..... 35.2+MU
VIST	03.03	Outpatient Visit (0800 - 1700)
		LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD) 13.5
		LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD) ..... 13.5+MU
VIST	03.03	Outpatient Visit (1701 - 2000)
		LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) 20
		LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU
VIST	03.03	Outpatient Visit (2001 - 2359)
		LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) 20
		LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU
VIST	03.03	Outpatient Visit (0000 - 0800)
		LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)..... 26
		LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)..... 26+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Sat., Sun., Holidays
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, (RF=REFD)..... 20
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Sat., Sun., Holidays
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF(RF=REFD) 20
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient
		LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD)..... 7
		LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 7+MU

VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD) 7	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 7+MU	
VIST	03.03	Outpatient Visit (1701 - 2000) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD) 10.5	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD) ..... 10.5+MU	
VIST	03.03	Outpatient Visit (2001 - 2359) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD) 10.5	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD) ..... 10.5+MU	
VIST	03.03	Outpatient Visit (0000 - 0800) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) 11.4	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) 11.4	
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, US=UNOF (RF=REFD)..... 10.5	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, US=UNOF,RO=DETE (RF=REFD)	10.5+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) 10.5	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 10.5+MU	

PROCEDURES

OTHER COMPUTERIZED AXIAL TOMOGRAPHY

ANAE	02.75A	CAT scan performed under general anaesthesia.....	4+T

MAGNETIC RESONANCE IMAGING

ANAE	02.76	Magnetic resonance imaging.....	4+T

OTHER NONOPERATIVE MEASUREMENTS AND EXAMINATIONS

ANAE	03.39Q	Examination under anaesthesia with intubation.....	4+T
ANAE	03.39R	Examination under anaesthesia without intubation.	4+T

OTHER RADIOTHERAPEUTIC PROCEDURE

ANAE	06.39A	Radiotherapy procedures without intubation.....	4+T
ANAE	06.39B	Radiotherapy procedures with intubation	4+T

INSERTION OF ENDOTRACHEAL TUBE

ANAE	10.04	Insertion of endotracheal tube for airway obstruction.....	6+T

OTHER LAVAGE OF BRONCHUS AND TRACHEA

MISG	10.66A	Tracheo-bronchial toilet to include laryngoscopy if necessary two hour post-operative (other than immediate post-op care) 25	
ANAE	10.66B	Bronchio-alveolar lavage	8+T

INJECTION OR INFUSION OF THERAPEUTIC OR PROPHYLACTIC SUBSTANCE NEC

PMNO	13.59K	Acute pain management (non-obstetrical) consultation, institution of PCA and care on day 1 when unrelated to delivery of anaesthesia SP=ANAE, SP=GENP 41	
PMNO	13.59H	Acute pain management (non-obstetrical) institution of PCA and care on day 1 when in addition to delivery of anaesthesia on that day SP=ANAE, SP=GENP 13.5	
PMNO	13.59F	Acute pain management (non-obstetrical) maintenance care, per day, day 2 onwards SP=ANAE, SP=GENP 13.5	

OTHER CONVERSION OF CARDIAC RHYTHM

ANAE	13.79A	Cardio-pulmonary resuscitation - outside anaesthesia including cardiac arrest - maximum of 15 anaesthetic units.....	6+T

INJECTION OF ANAESTHETIC INTO SPINAL CANAL FOR ANALGESIA

ANAE	16.91J	Continuous epidural block AN=PNCT, RP=INTL	5+T
		AN=PNCT, RP=SUBS	Time Only
VADT	16.91L	Post-op pain control performed in conjunction with anaesthesia (caudal/intercostal/intrapleural/psoas compartment) - plus multiples, if applicable SP=ANAE, SP=GENP 10	
PMNO	16.91M	Acute pain management (non-obstetrical) consultation unrelated to delivery of anaesthesia, insertion of epidural/spinal catheter and care on day 1 SP=ANAE, SP=GENP 100	
PMNO	16.91N	Acute pain management (non-obstetrical) assessment and care following epidural/spinal catheter placement, when the catheter is inserted by another physician, day 1 SP=ANAE, SP=GENP 59	
PMNO	16.91O	Acute pain management (non-obstetrical) insertion of epidural/spinal catheter in conjunction with anaesthesia SP=ANAE, SP=GENP 33	

PMNO 16.91P Acute pain management (non-obstetrical) maintenance of epidural/spinal catheter by primary anaesthetist, day 1
SP=ANAE, SP=GENP 26

PMNO 16.91Q Acute pain management (non-obstetrical) maintenance, per day, day 2 onwards
SP=ANAE, SP=GENP 30

VEDT 16.91R Continuous conduction anaesthesia for relief of pain in labour
SP=ANAE, AN=LABR 166
SP= GENP, AN=LABR 166

INJECTION OF ANAESTHETIC INTO SYMPATHETIC NERVE FOR ANALGESIA

ANAE 18.21F Monitored anaesthesia care with retrobulbar block by ophthalmologist ..... 4+T

OTHER DENTAL OPERATIONS NEC

ANAE 36.99 Other dental operations NEC..... 5+T

INSERTION OF INTERPLEURAL CATHETER

PMNO 46.04D Acute pain management (non-obstetrical) consultation, insertion of interpleural catheter and care on day 1 when unrelated to delivery of anaesthesia.
SP=ANAE; SP=GENP 54

PMNO 46.04E Acute pain management (non-obstetrical) insertion of interpleural catheter and care on day 1 when in addition to delivery of anaesthesia on that day.
SP=ANAE; SP=GENP 30

PMNO 46.04F Acute pain management (non-obstetrical) interpleural catheter maintenance care, per day, day 2 onwards.
SP=ANAE; SP=GENP 20

PMNO 46.04G Acute pain management (non-obstetrical) consultation unrelated to delivery of anaesthesia, insertion of CPNB catheter and care on day 1.
SP=ANAE 75

PMNO 46.04H Acute Pain management (non-obstetrical) assessment and care following CPNB catheter placement, when the catheter is inserted by another physician, day 1.
SP=ANAE 44

PMNO 46.04I Acute pain management (non-obstetrical) insertion of CPNB catheter in conjunction with anaesthesia.
SP=ANAE 25

PMNO 46.04J Acute pain management (non-obstetrical) maintenance of CPNB catheter by primary anaesthetist, day 1.
SP=ANAE 25

PMNO 46.04K Acute pain management (non-obstetrical) CPNB maintenance, per day, day 2 onwards.
SP=ANAE 25

CONTROL OF HEMORRHAGE, NOT OTHERWISE SPECIFIED

ANAE	51.98A	Post partum haemorrhage	6+T

DELIVERY NEC

ANAE	87.98	Delivery NEC	4+T
		AN=DFED	Time Only
		CO=INFE	7+T

OTHER OBSTETRIC OPERATIONS NEC

ANAE	87.99A	Anaesthetic double set-up	4+T

SURGICAL PROCEDURES NOS

ADON	99.09A	Morbid obesity surgical add on	32.9	4.6

PREMIUM

ADON	AHSP1	After Hours Service Premium (extended service hours)	35%

INTERPRETATIONS

The service date of electronic claims should be the date the patient had the procedure conducted and not the date the interpretation was completed (if they differ). The fee is for the interpretation.

These codes must be claimed from LO=HOSP

ECHOCARDIOGRAPHY

BULK	I1310	Two dimensional	47.56
BULK	I1312	Doppler – quantitative	30.45
BULK	I1313	Doppler – qualitative	15.23

DERMATOLOGY

(SP=DERM)

CATEGORY	HEALTH SERVICE CODE	DESCRIPTION / MODIFIERS	BASE UNITS	ANAES UNITS
CONSULTATIONS				
CONS	03.08	Comprehensive Consultation		
		RF=REFD (ME=TELE)	52	
		RF=REFD, US=PREM (ME=TELE)	70.2	
		RF=REFD, US=PR50 (ME=TELE)	78	
		RF=REFD, RO=DETE (ME=TELE)	52+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	70.2+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	78+MU	
CONS	03.07	Limited Consultation		
		RF=REFD (ME=TELE)	28	
		RF=REFD, US=PREM (ME=TELE)	46	
		RF=REFD, US=PR50 (ME=TELE)	46	
		RF=REFD, RO=DETE (ME=TELE)	28+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	46+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	46+MU	
CONS	03.07	Repeat Consultation		
		RF=REFD, RP=REPT (ME=TELE)	27.1	
		RF=REFD, RP=REPT, US=PREM (ME=TELE)	45.1	
		RF=REFD, RP=REPT, US=PR50 (ME=TELE)	45.1	
		RF=REFD, RP=REPT, RO=DETE (ME=TELE)	27.1+MU	
		RF=REFD, RP=REPT, RO=DETE, US=PREM (ME=TELE)	45.1+MU	
		RF=REFD, RP=REPT, RO=DETE, US=PR50 (ME=TELE)	45.1+MU	
OFFICE				
VIST	03.04	Initial Visit with Complete Dermatological Examination		
		LO=OFFC (RF=REFD)	24	
VIST	03.03	Initial Visit with Regional Examination		
		LO=OFFC, RP=INTL (RF=REFD)	12	
		LO=OFFC, AG=OV65, RP=INTL (RF=REFD)	16.5	
VIST	03.03	Subsequent Visit		
		LO=OFFC, RP=SUBS (ME=VTCR*) (RF=REFD)	13	
		*Physician Restrictions in Place (See Appendix J)		
VIST	03.03A	Geriatric Office Visit (for patients aged 65+)		
		LO=OFFC (ME=VTCR*) (RF=REFD)	16.	
		*Physician Restrictions in Place (See Appendix J)		

VIST	03.03	Continuing Care	
		LO=OFFC, RO=CNTC, RF=REFD	13.5
		LO=OFFC, AG=OV65, RO=CNTC, RF=REFD	16.5
VIST	03.03	Directive Care	
		LO=OFFC, RO=DIRC, RF=REFD	13.5
		LO=OFFC, AG=OV65, RO=DIRC, RF=REFD	16.5
VIST	03.03	Urgent Care - Request by Patient (1701 - 2000)	
		LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD)	28.3
VIST	03.03	Urgent Care - Request by Patient (2001 - 2359)	
		LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD)	28.3
VIST	03.03	Urgent Care - Request by Patient (0000 - 0800)	
		LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)	38.3
VIST	03.03	Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays	
		LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD)	28.3
VIST	03.03	Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays	
		LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF(RF=REFD)	28.3
VIST	03.03	Urgent Care - Extra Patient	
		LO=OFFC, PT=EXPT (RF=REFD)	10.5

HOSPITAL (Includes LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

VIST	03.04	Initial Visit with Complete Dermatological Examination	
		LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD)	24
		LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD)	24+MU
VIST	03.04	Initial Visit	
		LO=HOSP, FN=INPT, RP=INTL (RF=REFD)	25
		LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD)	25+MU
VIST	03.03	Continuing Care	
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC, RF=REFD	15
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT, RF=REFD	15+MU
VIST	03.03	Directive Care	
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD	15
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD	15+MU
VIST	03.03	Subsequent Visit - Daily to 56 Days	
		LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD)	15
		LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD)	15+MU
VIST	03.03	Subsequent Visit - Weekly after 56 Days - Maximum 44 units per week	
		LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD)	15
		LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD)	15+MU

ADON	03.02A	Hospital Discharge Fee	
		LO=HOSP, FN=INPT	10
VIST	03.03	Urgent Hospital Visit	
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)	22
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD)	22+MU
VIST	03.03	Hospital Emergency Visit	
		LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)	35.2
		LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)	35.2+MU
VIST	03.03	Outpatient Visit (0800 - 1700)	
		LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD)	13.5
		LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD)	13.5+MU
VIST	03.03	Outpatient Visit (1701 - 2000)	
		LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD)	20
		LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD)	20+MU
VIST	03.03	Outpatient Visit (2001 - 2359)	
		LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD)	20
		LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD)	20+MU
VIST	03.03	Outpatient Visit (0000 - 0800)	
		LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF(RF=REFD)	26
		LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)	26+MU
VIST	03.03	Outpatient Visit (0801 - 1200) - Sat., Sun., Holidays	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)	20
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF,RO=DETE (RF=REFD)	20+MU
VIST	03.03	Outpatient Visit (1201 - 1700) - Sat., Sun., Holidays	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)	20
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF,RO=DETE (RF=REFD)	20+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD)	7
		LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN RO=DETE (RF=REFD)	7+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV(RF=REFD)	7
		LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD)	7+MU
VIST	03.03	Outpatient Visit (1701 - 2000) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, US=UNOF (RF=REFD)	10.5
		LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD)	10.5+MU

VIST	03.03	Outpatient Visit (2001 - 2359) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, US=UNOF (RF=REFD) ..... 10.5 LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 10.5+MU	
VIST	03.03	Outpatient Visit (0000 - 0800) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, US=UNOF (RF=REFD)..... 11.4 LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)..... 11.4+MU	
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, US=UNOF (RF=REFD)..... 10.5 LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, US=UNOF,RO=DETE (RF=REFD) ..... 10.5+MU	
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, US=UNOF(RF=REFD) ..... 10.5 LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, US=UNOF,RO=DETE (RF=REFD) ..... 10.5+MU	

PROCEDURES

APPLICATION OF PRESSURE DRESSING

MISG	07.56A	Plantar warts, application of occlusive boot 30	

LOCAL EXCISION OR DESTRUCTION OF LESION OR TISSUE OF SKIN AND SUBCUTANEOUS TISSUE

MISG	98.12R	Destruction (dermabrasion) of single area (e.g., trauma scar)..... 35 (Prior-Approval Required)	4+T
MAAS	98.12S	Extensive and complicated lesions IC	4+T
MISG	98.12T	Carcinoma of skin, curettage and electrocautery - plus multiples, if applicable 38	4+T

BIOPSY OF SKIN AND SUBCUTANEOUS TISSUE

MISG	98.81C	Biopsy of skin or mucosa - malignant or recognized pre-malignant condition or biopsy necessary for histological diagnosis for patient management - plus multiples, if applicable 20	4+T
MISG	98.81D	Punch biopsy of skin or mucosa - malignant or recognized pre-malignant condition or biopsy necessary for histological diagnosis for patient management - plus multiples, if applicable..... 15	

DERMABRASION

MASG	98.93A	Dermabrasion full face (prior approval) 100	5+T
MISG	98.93B	Dermabrasion less than 1/4 of face (prior approval) 25	5+T

MISG	98.93C	Dermabrasion single area face; e.g., trauma scar (prior approval) 35		4+T
MASG	98.93D	Dermabrasion between 1/4 and 1/2 face (prior approval) 75		5+T

OTHER OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE NEC

MISG	98.99C	Treatment of lesions by dye tunable or krypton lasers for port wine stain (face/neck only) glomus tumours, lymphangiomas, pyogenic granulomas, Fabry's Disease ..... 0.76+MU		4+T
MASG	98.99H	MOHS micrographic surgery (MMS) for the removal of a histologically confirmed cutaneous malignancy – initial level and debulking..... 155 *Physician Restrictions in Place (See Appendix J)		
ADON	98.99I	Additional levels (comprehensive of all additional levels for complete excision) ..... 135 *Physician Restrictions in Place (See Appendix J)		

PHOTOTHERAPY

VEDT	99.82A	Supervision of Photodynamic Therapy by Dermatologist – per patient per week in the office setting wherein the dermatologist is responsible for payment of the technician's salary in addition to the purchase and maintenance of the phototherapy equipment LO=OFFC 25		
VEDT	99.82B	Supervision of Photodynamic Therapy by Dermatologist – per patient per week in hospital outpatient setting wherein the dermatologist is not responsible for payment of the technician's salary or the purchase and maintenance of the phototherapy equipment LO=HOSP 10		

DIAGNOSTIC & THERAPEUTIC

CATEGORY	HEALTH SERVICE CODE	DESCRIPTION / MODIFIERS	BASE UNITS	ANAES UNITS
RHINOSCOPY				
VADT	01.01	Rhinoscopy (included in a consultation)	10	4+T
INDIRECT LARYNGOSCOPY				
VADT	01.02A	Indirect endoscopy of larynx with biopsy	20	6+T
DIRECT LARYNGOSCOPY (for other laryngoscopy procedures, refer to the Otolaryngology Section)				
VADT	01.03C	Direct laryngoscopy with dilation	50	6+T
VADT	01.03D	Direct endoscopy of larynx with biopsy	36	6+T
VADT	01.03G	Direct laryngoscopy without biopsy	22.5	6+T
VADT	01.03H	Guided laryngoscopic botox injection of vocal cord (includes visit, laryngoscopy of any kind and injection)	50	6+T
OTHER NONOPERATIVE LARYNGOSCOPY				
VADT	01.04A	Flexible fibre-optic endoscopy of nasopharynx or larynx (Included in a consultation)	10	4+T
VADT	01.04B	Videostroboscopy (to include the procedure and interpretation)	50	6+T
FIBEROPTIC BRONCHOSCOPY				
VADT	01.08A	Transbronchial lung biopsy with fiberscope	110	6+T
OTHER NONOPERATIVE BRONCHOSCOPY				
VADT	01.09	Other nonoperative bronchoscopy	60	6+T
VADT	01.09A	Bronchoscopy with biopsy	65	6+T
VADT	01.09B	Bronchoscopy - with foreign body removal	85	6+T
OTHER NONOPERATIVE ESOPHAGOSCOPY				
VADT	01.12	Other nonoperative esophagoscopy	60	4+T
VADT	01.12A	Esophagobronchoscopy	85	6+T

VADT	01.12B	Esophagoscopy with biopsy	65	4+T
VADT	01.12C	Esophagoscopy - with removal of foreign body	85	4+T
VADT	01.12E	Functional endoscopic examinations of swallowing mechanism	45	

OTHER NONOPERATIVE GASTROSCOPY

VADT	01.14A	Injection of ulcer through the scope for G.I. bleed or application of crazy glue into fundal region of stomach (scope included)	120	4+T
VADT	01.14C	Esophagogastroscopy	70	4+T
VADT	01.14D	Esophagogastroscopy with biopsy	75	4+T
VADT	01.14E	Esophagogastroscopy-with removal of foreign body	85	4+T
ADON	01.14F	Insertion of intragastric balloon in addition to gastroscopic fee	50	
ADON	01.14G	Removal of polyps in addition to the appropriate esophagogastroscopy - plus multiples, if applicable	10	
VADT	01.14H	Esophagogastroscopy plus endoscopic placement of esophageal stent with or without the use imaging	90	4+T

OTHER NONOPERATIVE COLONOSCOPY

ADON	01.22A	Colonoscopy with one/more biopsies	10	
ADON	01.22B	Polypectomy via colonoscopy (OPD and Pathology report required with submission) - plus multiples, if applicable	20	
VADT	01.22C	Colonoscopy of descending colon	40	4+T
VADT	01.22D	Colonoscopy of descending and transverse colon	70	4+T
VADT	01.22E	Colonoscopy of descending, transverse and ascending colon	100	4+T
ADON	01.22F	Balloon dilation of colonic stricture (in addition to colonoscopy)	30	

OTHER NONOPERATIVE PROCTOSIGMOIDOSCOPY

VADT	01.24	Other nonoperative proctosigmoidoscopy AG=CH16	25	4+T
VADT	01.24B	Proctoscopic examination	5	
VADT	01.24C	Sigmoidoscopic examination (with or without biopsy of rectum or sigmoid) AG=ADUT	15	4+T
VADT	01.24D	Biopsy of rectosigmoid for Hirschsprung's Disease through sigmoidoscope	40	4+T

OTHER NONOPERATIVE CYSTOSCOPY (for other cystoscopy procedures, refer to the Urology Section)

VADT	01.34A	Cystoscopy with or without catheterization of ureters (the performance of a cystoscopy is included in the fee for urethral vesicle sling procedure)	43.6	4+T
VADT	01.34B	Cystoscopy - with urethral dilation	45.5	4+T
VADT	01.34C	Cystoscopy - with bladder dilation	52	4+T
VADT	01.34G	Cystoscopy - with multiple biopsies of bladder	52.5	4+T

OTHER NONOPERATIVE ENDOSCOPY NEC

VADT	01.39B	Sinusoscopy	25	

CYSTOGRAM NEC

VADT	02.42	Cystogram NEC	15	4+T

ILEAL CONDUITOGRAM

VADT	02.43	Ileal conduitogram	16	
VADT	02.43A	Ileal conduitogram with dilation of stoma	25	

X-RAY OF FALLOPIAN TUBES AND UTERUS

VADT	02.46A	Sonohysterography only (patient specific)	58.45	
VADT	02.46B	Sonohysterography, including transvaginal ultrasound (TVUS) with interpretation and written report (patient specific)	85	

COMPUTERIZED AXIAL TOMOGRAPHY OF ABDOMEN

VADT	02.51A	Percutaneous biopsy of solid masses for cytology or histology using CAT	100	

OTHER COMPUTERIZED AXIAL TOMOGRAPHY

VEDT	02.75B	Coronary CT angiography	120	

MAGNETIC RESONANCE IMAGING

VEDT	02.76A	Bilateral breast MRI - first sequence units	46.6	
		Subsequent sequence units (maximum 3 multiples)	23.3	

OTHER X-RAY NEC

VADT	02.79A	Fluoroscopy and/or orthodiagram	5	
VEDT	02.79B	PET / CT scan and interpretation, one body region	87	4+T
VEDT	02.79C	PET / CT scan and interpretation, multiple body regions (Including whole body scan)	125	4+T

DIAGNOSTIC ULTRASOUND OF HEART

ADON	02.82C	Intracoronary ultrasound in addition to coronary angioplasty/stenting..... 40	

DIAGNOSTIC ULTRASOUND OF DIGESTIVE SYSTEM

VADT	02.84A	Obstetrical doppler of umbilical artery in the presence of IUGR and other pregnancies at high risk for IUGR - stand alone procedure..... 20	4+T
ADON	02.84B	Obstetrical doppler of umbilical artery in the presence of IUGR and other pregnancies at high risk for IUGR in conjunction with obstetrical ultrasound..... 10	4+T

DIAGNOSTIC ULTRASOUND NEC

VADT	02.89A	11-14 week prenatal screening ultrasound for the determination of nuchal translucency..... 35 Each additional fetus (maximum 3) SP=OBGY..... 24.5 *Physician Restrictions in Place (See Appendix J)	
VADT	02.89B	Genetic Sonogram Includes all standard biometry and anatomic review, a detailed fetal heart assessment, and an assessment of potential ultrasound markers (soft markers) ..... 60 Each additional fetus (maximum 3) SP=OBGY..... 42 *Physician Restrictions in Place (See Appendix J)	

OTHER THERMOGRAPHY

VADT	02.99A	Thermography - total body interpretation only - in chronic pain patients 10	
VADT	02.99B	Thermography - regional interpretation only - in chronic pain patients..... 5	

TONOMETRY

VADT	03.12	Tonometry (included in a consultation and surgical procedures)..... 4.5	

ELECTROENCEPHALOGRAM

VADT	03.16	Electroencephalogram RO=INTP..... 10.5	
ADON	03.16A	Electroencephalogram - with insertion of subtemporal needles - plus multiples, if applicable 10.5	
ADON	03.16B	Electroencephalogram - with activating drugs, metrazol - additional - plus multiples, if applicable 10.5	
VADT	03.16C	EEG video monitor - maximum 28 units per event, maximum 6 per week per patient 28	
VADT	03.16D	Video-EEG telemetry - maximum once per patient per day..... 60	

VADT	03.16E	EEG monitoring during intracarotid sodium amytal study	30
VADT	03.16F	EEG Video Telemetry - Invasive Day 1 SP=NEUR or SP=NUSG, LO=HOSP, FN=INPT	150
VADT	03.16G	EEG Video Telemetry - Invasive Subsequent day (maximum 4 days) SP=NEUR, SP=NUSG, LO=HOSP, FN=INPT	100
VADT	03.16H	EEG Video Telemetry - Non-invasive Day 1 SP=NEUR, SP=NUSG, LO=HOSP, FN=INPT	90
VADT	03.16I	EEG Video Telemetry - Non-invasive Subsequent days (maximum 5 days per week, maximum 2 weeks) SP=NEUR, SP=NUSG, LO=HOSP, FN=INPT	60

OTHER NONOPERATIVE NEUROLOGICAL FUNCTION TESTS

VADT	03.17A	Major testing of innervation of more than 3 muscles	18
VADT	03.17B	Faradic & galvanic testing (strength duration and chronaxie)	10
VADT	03.17C	Minor testing of innervation	7.5
VADT	03.17D	Repetitive nerve stimulation study - plus multiples, if applicable RO=INPR	20
ADON	03.17E	Reflex latency studies - plus multiples, if applicable RO=INPR, RG=BOTH	15
VADT	03.17F	Anterior compartment pressure studies	30

OTHER NONOPERATIVE MEASUREMENTS AND EXAMINATIONS OF NERVOUS SYSTEM AND SENSE ORGANS NEC

VADT	03.19A	Somatosensory evoked potential - plus multiples, if applicable RO=INPR	35
VADT	03.19B	Sensory evoked potential	35
VADT	03.19E	Interpretation by Ophthalmologists of Orthoptic Evaluation including measurements of all of the following: visual acuity (distance and near), ocular alignment (distance and near), binocularity including stereopis and vergences and ductions. RO=INPR	10

URINARY MANOMETRY

VADT	03.21A	Whittaker test	50

CYSTOMETROGRAM

VADT	03.22	Cystometrogram - plus multiples, if applicable	17.8

URETHRAL SPHINCTER ELECTROMYOGRAM

VADT	03.23	Urethral sphincter electromyogram	32.7

UROFLOMETRY (UFR)

VADT	03.24	Uroflometry (UFR)	32.7

URETHRAL PRESSURE PROFILE (UPP)

VADT	03.25	Urethral pressure profile (UPP) - plus multiples, if applicable	32.7

GYNECOLOGICAL EXAMINATION

VADT	03.26A	Pap smear (included in a consultation)	10.5
ADON	03.26B	Pap smear tray fee	2
VADT	03.26C	Comprehensive pelvic examination with speculum	10.5

ESOPHAGEAL MANOMETRY

VADT	03.32	Esophageal manometry	
		CT=PROF	9.5

OTHER NONOPERATIVE MEASUREMENTS AND EXAMINATIONS

VADT	03.39A	Esophageal motility study	
		CT=TECH	24
VADT	03.39B	Anorectal motility studies	
		RO=INTP	5
		CT=TECH	15
VADT	03.39C	Secretin test	
		CT=PROF	5
VADT	03.39D	Gastric secretory studies	
		CT=PROF	5
VADT	03.39E	HCL drip test	
		CT=PROF	5
		CT=TECH	10
VADT	03.39F	ACTH Stimulation test	
		RO=INPR	10

VADT	03.39G	Dexamethasone suppression test for diagnosis of Cushing's Syndrome RO=INTP	7.5
VADT	03.39H	Pentagastrin stimulation test of calcitonin RO=INPR	25
VADT	03.39I	Water deprivation test	15
VADT	03.39J	Propranolol exercise growth hormone stimulation test RO=INTP	10
VADT	03.39K	Prolonged fast test RO=INPR	10
VADT	03.39L	Tolbutamide tolerance test RO=PROC	15
VADT	03.39M	Insulin hypoglycemia test RO=INPR	25
VADT	03.39N	TRH stimulation test RO=INPR	10
VADT	03.39O	Arginine insulin stimulation test RO=INPR	25
VADT	03.39P	Glucagon stimulation test RO=INPR	10

CARDIOVASCULAR STRESS TEST USING TREADMILL

VADT	03.41A	Pulmonary stress test (non-invasive)	38
VADT	03.41B	Pulmonary stress test (invasive) to include insertion of an arterial line for blood gas monitoring. Includes EKG's and ECG monitoring	48

CARDIOVASCULAR STRESS TEST USING BICYCLE ERGOMETER

VADT	03.43	Cardiovascular stress test using bicycle ergometer	38

OTHER CARDIOVASCULAR STRESS TEST

VADT	03.44A	Myocardial perfusion study includes IV setup and medication	48
VADT	03.44B	Graded testing utilizing treadmill with continuous ECG monitoring	38

ARTIFICIAL PACEMAKER RATE CHECK

VADT	03.45A	Remote follow up ICD device	15

OTHER ELECTROCARDIOGRAM

VADT	03.52	Other electrocardiogram	
		RO=INPR	9.2
		RO=INTP	4.6
VADT	03.52A	Electrocardiogram before and after exercise	15.6
VEDT	03.52B	Review of Pacemaker patient's chart, following technologist clinic visit or remote interrogation	8
		(Includes review and interpretation of interrogation record and ECG, and written report to family physician or referring physician and applies to all permanently implanted single chamber, dual chamber and defibrillating pacemakers.)	

VECTORCARDIOGRAM (WITH EKG)

VADT	03.53	Vectorcardiogram (with EKG)	
		CT=TECH	10
		RO=INTP	10

PHONOCARDIOGRAM WITH EKG LEAD

VADT	03.55	Phonocardiogram with EKG lead	
		RO=SPIN	10

OTHER CARDIOVASCULAR MEASUREMENTS NEC

VADT	03.69A	Tilt table study includes IV injection	50

MICROSCOPIC EXAMINATION OF SPECIMEN FROM EAR, NOSE, THROAT AND LARYNX – OTHER MICROSCOPIC EXAMINATION

VEDT	04.29A	Nasal smear for eosinophils	2

MICROSCOPIC EXAMINATION OF BLOOD, OTHER MICROSCOPIC EXAMINATION

VEDT	04.49A	HLA typing	52.90
VEDT	04.49B	HLA identification and crossmatch	52.90
VEDT	04.49C	Peripheral blood film review	10
VEDT	04.49D	Flow cytometry	52.90

MICROSCOPIC EXAMINATION OF SPECIMEN FROM BLADDER, URETHRA, PROSTATE, SEMINAL VESICLE, PERIVESICAL TISSUE, AND OF URINE AND SEMEN - CULTURE AND SENSITIVITY

VADT	05.23A	Antidiuretic hormone response test	15
VADT	05.23B	Vasopressor or depressor test	15

MICROSCOPIC EXAMINATION OF SPECIMEN FROM BLADDER, URETHRA, PROSTATE, SEMINAL VESICLE, PERIVESICAL TISSUE, AND OF URINE AND SEMEN - OTHER MICROSCOPIC EXAMINATION

VADT 05.29A Fertility investigation, sperm count and morphology 5

SUPERFICIAL RADIATION

VADT 06.31 Superficial radiation 6

INJECTION OR INSTILLATION OF RADIOISOTOPES

VADT 06.35B Thyroid malignancy 20

VADT 06.35C Hyperthyroidism 20

VADT 06.35D Polycythemia 10

VADT 06.35E Metastatic disease of bone 20

VADT 06.35F Arthritis single or multiple site 8

OTHER RADIOTHERAPEUTIC PROCEDURE

VADT 06.39D Percutaneous image guided radiofrequency ablation of solid tumour
- plus multiples, to a maximum of 3, if applicable ..... 250 4+T

ELECTROMYOGRAPHY (EMG)

VADT 07.08A Electromyography, major with muscles of more than one region examined 38

VADT 07.08B Electromyography, minor, examination of a specific muscle/region 20

VADT 07.08C Nerve conduction studies, per nerve studied
- plus multiples, to a maximum of 6, if applicable, ... 27

VADT 07.08D MS system - single fibre (EMG (SFEMG))
- minimum of 20 coupled potentials 84

PSYCHIATRIC COMMITMENT EVALUATION

VADT 08.12 Psychiatric commitment evaluation (included in a consultation)
RO=FPHN 15
RO=SPHN 15

LIMITED EYE EXAMINATION

VADT 09.01A Gonioscopy (included in a consultation) 6

COMPREHENSIVE EYE EXAMINATION

VEDT 09.02 Comprehensive eye examination - Including refraction 20.3

VEDT 09.02A Low vision clinic fees (for prolonged visits beyond one hour, a rate of 13.7 units per 15 minutes applies) - plus multiples, if applicable
RP=INTL 50

VEDT	09.02B	Reduced payment for uninsured service	10.4	
VEDT	09.02D	Low vision clinic fees - follow-up after 30 days	25	

EYE EXAMINATION UNDER ANAESTHESIA

VEDT	09.04	Eye examination under anaesthesia	27	4+T
		Prolonged eye examinations under general anaesthesia for children (50 units per half hour) - plus multiples, if applicable		
		AG=CH16	50	4+T

VISUAL FIELD STUDY

VADT	09.05	Visual field study (included in a consultation)	12	

FLUORESCEIN ANGIOGRAPHY OR ANGIOSCOPY OF EYE

VADT	09.12	Fluorescein angiography or angioscopy of eye	22	
VADT	09.12B	Indocyanine green angiography - including interpretation	22	

ULTRASOUND STUDY OF EYE

VADT	09.13A	Real time (eye) ultrasound	38.70	
VADT	09.13B	Axial length measurement by ultrasound	25.44	

ELECTRORETINOGRAM (ERG)

VADT	09.21	Electroretinogram (ERG)		
		RO=INTP	8	
		RO=SUPV	17	

ELECTRO-OCULOGRAM (EOG)

VADT	09.22	Electro-oculogram (EOG)		
		RO=INTP	10	
		RO=SUPV	15	

VISUAL EVOKED POTENTIAL (VEP)

VADT	09.23	Visual evoked potential (VEP)		
		RO=INTP	12	

ELECTRONYSTAGMOGRAM (ENG)

VADT	09.24	Electronystagmogram	35	
		RO=INTP	13.5	

TONOGRAPHY, PROVOCATIVE TESTS, AND OTHER GLAUCOMA TESTING

VADT	09.26	Tonography, provocative tests, and other glaucoma testing		
		CT=PROF	10	
		CT=TECH	10	

VADT	09.26A	Kinetic minimum, two isopters	17
VADT	09.26B	Kinetic, with static cuts or Humphrey field analysis	22
VADT	09.26C	Ophthalmodynamometry	10

PRESCRIPTION, FITTING, AND DISPENSING OF CONTACT LENS

VADT	09.32A	Contact lens fitting - with follow-up for 3 months	
		AG=ADUT	196
		AG=CH16	245
VADT	09.32B	Bandage contact lens (regions required)	40

AUDIOMETRY

VADT	09.41	Audiometry	
		RO=INTP	4.5
VADT	09.41A	Pure tone audiogram, right, left or both	
		SP=OTOL	9
VADT	09.41B	Pure tone audiogram, bone conduction	
		SP=OTOL	11
VADT	09.41C	Bekesy audiometry	10
VADT	09.41D	Complete hearing test (including audiometry, tuning fork and speech test)	23
VADT	09.41E	Impedance, audiometry, including tympanometry, static compliance, multiple, etc.,	
		RO=INTP	15
VADT	09.41F	Impedance audiometry interpretation only of tympanogram, impedance/compliance and stapedial reflex studies	5
VADT	09.41G	Impedance audiometry tympanometry, static compliance, single frequency acoustic reflex and/or reflex decay testing	
		RO=INTP	7.5
VADT	09.41H	Tympanometry only	
		SP=OTOL	5

OTHER AUDITORY AND VESTIBULAR FUNCTION TESTS

VADT	09.46	Other auditory and vestibular function tests	21.6
VADT	09.46A	SISI tests	5
VADT	09.46B	Speech reception and discrimination test	
		SP=OTOL	10

VADT	09.46C	Tone decay tests	10	
VADT	09.46D	Alternate loudness balance	15	
VADT	09.46E	Auditory evoked potential RO=INPR	35	
		RO=INTP	5	

INSERTION OF SENGSTAKEN TUBE

VADT	10.06A	Gastroesophageal tamponade	20	4+T

INSERTION OF OTHER (NASO-) GASTRIC TUBE

VADT	10.07A	24-hour pH measurement of the upper GI Tract	19

INSERTION OF OTHER VAGINAL PESSARY

VADT	10.16	Insertion of other vaginal pessary examination and insertion of pessary and 1 follow-up visit	33.16

GASTRIC LAVAGE

VADT	10.33	Gastric lavage	10
VADT	10.33A	Aspiration of esophagus/stomach and preparation of material for cytological examination	10

OTHER GENITOURINARY INSTILLATION

VADT	10.56A	Instillation of chemotherapy with bladder catheterization	17.5

IRRIGATION OF EAR

VADT	10.62B	Removal of cerumen from a febrile child, with or without irrigation, unilateral or bilateral AG=CH12 (included in a consultation)	5

OTHER LAVAGE OF BRONCHUS AND TRACHEA

VADT	10.66C	Total lung lavage requiring a double lumen endotracheal tube, generally used for alveolar proteinosis - per hour - plus multiples, if applicable	58	8+T

EXCHANGE TRANSFUSION (ADULT) (NEWBORN)

VADT	13.01	Exchange transfusion (adult) (newborn)	165

OTHER TRANSFUSION OF WHOLE BLOOD

VADT	13.03	Other transfusion of whole blood	6

TRANSFUSION OF PACKED (RED) CELLS

VADT	13.04A	Therapeutic plasmapheresis	25

VACCINATION AGAINST TUBERCULOSIS

VADT	13.13	Vaccination against tuberculosis 5	

IMMUNIZATION FOR ALLERGY

VEDT	13.42	Immunization for allergy - plus multiples, if applicable RP=INTL..... 10.5 RP=SUBS..... 6	

INJECTION OF ANTIBIOTIC

VADT	13.51A	Transtympanic injection of Gentamycin - maximum of three injections per day . 15 (regions required)	

INJECTION OF STEROID

VADT	13.53A	Intradermal progestin contraceptive device 20	
VADT	13.53C	Removal of Intradermal progestin contraceptive device ..... 20 (text required)	

INJECTION OF OTHER HORMONE

VADT	13.54A	Intradermal scalp injection for alopecia areata..... 5	
VADT	13.54B	Implantation of hormone pellets..... 10	4+T

INJECTION OR INFUSION OF CANCER CHEMOTHERAPEUTIC SUBSTANCE NEC

VADT	13.55	Injection or infusion of cancer chemotherapeutic substance NEC - plus multiples, if applicable AG=ADUT ..... 7.7 AG=CH16..... 11.6	
VADT	13.55B	Administration by a physician of a test dose of a chemotherapeutic agent when there is a risk of a severe allergic reaction e.g. L-asparaginase Maximum once per patient per drug 15	

INJECTION OR INFUSION OF THERAPEUTIC OR PROPHYLACTIC SUBSTANCE NEC

VEDT	13.59	Injection or infusion of therapeutic or prophylactic substance NEC one/more injections at one visit 6	
VADT	13.59A	Multiple inoculation for immunotherapy (e.g., treatment of warts by DNCB) 15	
VADT	13.59B	A.N.S. - temporary blocks - bier block with guanethidine/reserpine 45	
VADT	13.59C	Intracorporal injection 10	
VADT	13.59E	Tensilon test 10	

VADT	13.59G	Injection of myochrysine gold salts	6
ADON	13.34A	Rotavirus Immunization	6
ADON	13.59L	Provincial immunizations (Preamble 5.3.26)	
		RO=CO19	6
		RO=EXEM	6
		RO=GAIG PT=RISK	6
		RO=HAHB PT=RISK	6
		RO=HAIG PT=RISK	6
		RO=HAVV PT=RISK	6
		RO=HBIG PT=RISK	6
		RO=HBVV (PT=RISK)	6
		RO=HDIN (PT=RISK)	6
		RO=HIBV (PT=RISK)	6
		RO=HPV4 (PT=RISK)	6
		RO=HPV9 (PT=RISK)	6
		RO=INFL	6
		RO=IPVV	6
		RO=MENB PT=RISK	6
		RO=MENC (PT=RISK)	6
		RO=MENQ (PT=RISK)	6
		RO=MMAR	6
		RO=MMRT PT=RISK	6
		RO=MMRV	6
		RO=MPOX	6
		RO=PENT	6
		RO=PNEC (PT=RISK)	6
		RO=PNEU (PT=RISK)	6
		RO=RABI PT=RISK	6
		RO=RABV PT=RISK	6
		RO=RSVV	6
		RO=TDAP	6
		RO=TDPP	6
		RO=TEDV (PT=RISK)	6
		RO=TEIG PT=RISK	6
		RO=TIPV	6
		RO=VAIG PT=RISK	6
		RO=VARV (PT=RISK)	6
ADON	13.59M	Provincial immunization tray fee/maximum 4 - per multiple	1.5
VADT	13.59N	Intravenous infusion of local anaesthetic/adrenergic drugs for chronic pain Management (e.g. lidocaine)	45
VADT	13.59P	Insertion of Buprenorphine Implant (e.g. Probuphine) for the treatment Of opioid use disorder	20
VADT	13.59Q	Removal of Buprenorphine Implant (e.g. Probuphine)	20
ADON	13.59R	Evusheld injection for the prevention of COVID-19 in immune compromised adults and children	6+MU

HYPERBARIC OXYGENATION

VADT 13.65 Hyperbaric oxygenation - plus multiples, if applicable
RO=INCH 27
RO=OTCH 20

OTHER ELECTRIC COUNTERSHOCK OF HEART

VADT 13.72 Other electric countershock of heart ..... 48 5+T

OTHER MISCELLANEOUS DIAGNOSTIC & THERAPEUTIC PROCEDURES NEC

VADT 13.99A Patch test for allergens (application and reading) per series
- plus multiples, if applicable 28.5

VADT 13.99B Maximum for complete testing, allergy testing 40

VADT 13.99D Ingestant provocation studies for high risk patients only in hospital by a qualified allergist (multiples required) 60
(60 units first hour, 15 units for each additional 1/4 hour up to 3 hours)

VADT 13.99E Ingestant provocation studies for low risk patients by a qualified allergist 50

VEDT 13.99F Assessment and management of patient with Acute Stroke 130
From activation of Acute Stroke Protocol through completion of Thrombolytic therapy (e.g. t-PA)

OTHER MISCELLANEOUS ANTICOAGULANT SUPERVISION NEC

VADT 13.99C Supervision of long-term warfarin therapy
(per month telephone/fax/e-mail communications) 10

VADT 13.99H Consult with pharmacy for patient participating in CPAMS 10

CISTERNAL PUNCTURE

VADT 14.01 Cisternal puncture 30

VADT 14.01A Cisterna magna aspiration 15

OTHER CRANIAL PUNCTURE

VADT 14.09A Subdural puncture - plus multiples, if applicable
RP=INTL 35

VADT 14.09B Ventricular puncture 35

OTHER INVASIVE DIAGNOSTIC PROCEDURES ON BRAIN AND CEREBRAL MENINGES

VADT 14.88A Electrocorticogram
RO=SPIN 100.5

VADT 14.88B Depth E.E.G., electrical stimulation, during thalamotomies 50

IMPLANTATION OF INTRACRANIAL NEUROSTIMULATOR

VADT	15.93A	Percutaneous diagnostic stimulation of the brain	170	
VADT	15.93B	Implantation or revision of stimulation packs or leads (spinal cord, brain and peripheral nerve)	160	7+T
VADT	15.93C	Stimulation pack, battery change	125	7+T

INJECTION OF DESTRUCTIVE AGENT INTO SPINAL CANAL

VADT	16.7	Injection of destructive agent into spinal canal	69	

SPINAL TAP

VADT	16.81	Spinal tap		4+T
		AG=ADUT	37.5	
		AG=CH16	47	

OTHER INVASIVE DIAGNOSTIC PROCEDURES ON SPINAL CORD AND SPINAL CANAL STRUCTURES

VADT	16.89A	Discogram	30	4+T

INJECTION OF ANAESTHETIC INTO SPINAL CANAL FOR ANALGESIA

VADT	16.91A	Chronic epidural catheter insertion, tunnelling and reservoir implantation	100	
VADT	16.91B	Temporary trans-sacral nerve root block	41	
VADT	16.91C	Thoracic/cervical intrathecal/epidural Injections – Temporary Block	52	
VADT	16.91D	Differential spinal-epidural block	80	
VADT	16.91E	Caudal block	29	
VADT	16.91F	Insertion of permanent epidural catheter	57	
VADT	16.91G	Insertion of permanent epidural catheter with tunnelling	69	
VADT	16.91H	Intrathecal/epidural injections - thoracic or cervical areas Permanent Block with a sclerosing agent	91	
VADT	16.91I	Subarachnoid block (diagnostic spinal)	30	
VADT	16.91L	Post-op pain control performed in conjunction with anaesthesia (caudal/intercostal/ intrapleural/psoas compartment) - plus multiples, if applicable		
		SP=ANAE, SP=GENP	10	
VEDT	16.91R	Continuous conduction anaesthesia for relief of pain in labour		
		SP=ANAE, AN=LABR	166	
		SP= GENP, AN=LABR	166	

INJECTION OF OTHER AGENT INTO SPINAL CANAL

VADT	16.92	Injection of other agent into spinal canal (with installation of chemotherapeutic agents).....	4+T
		AG=ADUT 56.3	
		AG=CH16..... 70.5	
VADT	16.92A	Epidural, single injection as with cortisone 35	
VADT	16.92C	Epidural infusion of baclofen includes programming and filling of the pump 15	

INSERTION OR REPLACEMENT OF SPINAL NEUROSTIMULATOR

VADT	16.93A	Percutaneous diagnostic stimulation of the spinal cord 170	
VADT	16.93B	Implantation or revision of stimulation packs or leads (spinal cord, brain and peripheral nerve) 160	7+T
VADT	16.93C	Stimulation pack, battery change 125	7+T

SPINAL BLOOD PATCH

VADT	16.95	Spinal blood patch 40	

PERCUTANEOUS DENERVATION OF FACET

VADT	16.96	Percutaneous denervation of facet - plus multiples, if applicable 46	

DIVISION OF TRIGEMINAL NERVE

VADT	17.03C	Facet nerve rhizotomy - plus multiples, if applicable 34	4+T

DESTRUCTION OF CRANIAL AND PERIPHERAL NERVES

VADT	17.1A	Therapeutic blocks with sclerosing solution - permanent trans-sacral nerve block..... 69	
VADT	17.1B	Permanent coeliac plexus block with Phenol 91	
VADT	17.1C	Gasserian ganglion block 60	
VADT	17.1D	Transverse scapular nerve 30	
VADT	17.1E	Single somatic block - plus multiples, if applicable..... 28	

PERIPHERAL NERVE INJECTION, UNQUALIFIED

VADT	17.71A	Mandibular block..... 25	
VADT	17.71B	Maxillary block..... 25	

INJECTION OF ANAESTHETIC INTO PERIPHERAL NERVE FOR ANALGESIA

VADT	17.72A	Cervical plexus block..... 30	

VADT	17.72B	Sciatic block	29	
VADT	17.72C	Temporary blocks - somatic nerve/paravertebral somatic nerve - plus multiples, if applicable	20	
VADT	17.72D	Obturator block	29	
VADT	17.72E	Pudendal block	23	
VADT	17.72F	Lateral femoral cutaneous nerve block	30	
VADT	17.72G	Brachial plexus block	25	
VADT	17.72H	Maxillary or mandibular division of trigeminal nerve	35	
VADT	17.72I	Superior laryngeal nerve	60	
VADT	17.72J	Myofascial trigger point injection of therapeutic agent, regardless of the number of injections	10	

BIOPSY OF PERIPHERAL NERVE OR GANGLION

VADT	17.81A	Sural nerve biopsy	50	4+T

IMPLANTATION OR REPLACEMENT OF PERIPHERAL NEUROSTIMULATOR

VADT	17.92B	Sacral nerve stimulator programming inclusive of visit	24	

OTHER OPERATIONS ON CRANIAL AND PERIPHERAL NERVES NEC

ADON	17.99D	Sciatic nerve catheter insertion at time of amputation	10	

INJECTION OF ANAESTHETIC INTO SYMPATHETIC NERVE FOR ANALGESIA

VADT	18.21A	Presacral block	25	
VADT	18.21B	Lumbar sympathetic block (regions required)	41	
VADT	18.21C	Stellate ganglion block	46	
VADT	18.21D	Coeliac plexus block	46	
VADT	18.21E	Femoral nerve block	25	

INJECTION OF NEUROLYTIC AGENT INTO SYMPATHETIC NERVE

VADT	18.22A	Cardiac sensory nerve block	60	
VADT	18.22B	Lumbar sympathetic block	69	
VADT	18.22C	Sphenopalatine ganglion block	30	
VADT	18.22D	Stellate ganglion block	91	

OTHER INJECTION INTO SYMPATHETIC NERVE OR GANGLION

VADT	18.29A	Paravertebral - nerve block - plus multiples, if applicable	35	

ASPIRATION OF THYROID FIELD

VADT	19.01	Aspiration of thyroid field	10	

SUBCONJUNCTIVAL INJECTION

VADT	24.91	Subconjunctival injection (regions required)	15	4+T

INJECTION OF VITREOUS SUBSTITUTE

VADT	28.73D	Intravitreal injection of antibiotics (regions required)	25	
VADT	28.73F	Intravitreal injection of a pharmacologic agent for the treatment of specific retinal diseases	25	

OTHER INVASIVE DIAGNOSTIC PROCEDURES ON MIDDLE AND INNER EAR

VADT	32.89A	Glycerol test - includes repeated audiometric testing same day		
		RO=INPR	30	
		RO=INTP	15	

OPERATIONS ON EUSTACHIAN TUBE

VADT	32.97A	Catheterization of eustachian tube (regions required)	5	

TEMPORARY TRACHEOSTOMY

VADT	43.1B	Bedside percutaneous tracheostomy	100	6+T

CONTRAST LARYNGOGRAM

VADT	43.83A	Laryngogram	10	

OTHER OPERATIONS ON TRACHEA

ADON	43.96A	Tracheal dilation - add on to rigid bronchoscopy	50	

LOCAL EXCISION OR DESTRUCTION OF LESION OR TISSUE OF BRONCHUS

ADON	44.0A	Laser treatment of malignant neoplasms of esophagus, bronchi, etc. in addition to scope	50	13+T

OTHER CONTRAST BRONCHOGRAM

VADT	45.86	Other contrast bronchogram	25.5	6+T

INSERTION OF INTERCOSTAL CATHETER (WITH WATER SEAL) FOR DRAINAGE

VADT	46.04B	Insertion of temporary chest tube	40	

MEDIASTINOSCOPY

VADT	46.82	Mediastinoscopy	120	6+T
VADT	46.82A	Mediastinoscopy with flexible bronchoscopy	140	6+T
VADT	46.82B	Mediastinoscopy with rigid bronchoscopy	150	6+T

PLEURAL BIOPSY

VADT	46.84	Pleural biopsy	20	

THORACENTESIS

VADT	46.91A	Thoracentesis - therapeutic aspiration including diagnostic sample	24	4+T
VADT	46.91B	Thoracentesis - administration of chemotherapy including therapeutic aspiration and sample	25	
VADT	46.91D	Thoracentesis - aspiration for diagnostic sample	20	

CLOSED HEART VALVOTOMY, UNSPECIFIED VALVE

VADT	47.01	Closed heart valvotomy, unspecified valve	250	15+T

ENLARGEMENT OF EXISTING ATRIAL SEPTAL DEFECT

VADT	47.42	Enlargement of existing atrial septal defect balloon septostomy	125	9+T

OTHER AND UNSPECIFIED REPAIR OF ATRIAL SEPTAL DEFECT

VADT	47.72A	Percutaneous Atrial Septal Defect Closure/Patent Foramen Ovale Closure	200	8+T

REMOVAL OF CORONARY ARTERY OBSTRUCTION

VADT	48.0A	Percutaneous coronary angioplasty (including selective coronary arteriography and right heart catheterization) - plus multiples, if applicable		15+T
		AG=ADUT	250	
		AG=CH16	275	
VADT	48.0C	Directional atherectomy - includes one angioplasty (if subsequent angioplasties are performed prior to the atherectomy when the patient's condition has changed, they should be paid in addition to the atherectomy composite fee. If the patient's condition has not changed since the first angioplasty, subsequent angioplasty should not be paid. This applies whether it is the same or different cardiologist)	300	15+T

VADT	48.0D	Arm venogram angioplasty for hemodialysis fistula (regions required)	137.7	
VADT	48.0F	Insertion of intracoronary stent - includes one angiogram (when additional angiograms are performed prior to stenting when the patient's condition has changed, they should be paid in addition to the stenting. If the patient's condition has not changed since the first angiogram, the subsequent angiogram(s) should not be paid. This applies whether it is the same or different cardiologist. When a stentor is called in to place a stent during angioplasty by another interventional cardiologist, only 50 units is payable to the stentor. When three or more stents are placed, an additional 25 units is payable regardless of the number of additional stents)		
		- plus multiples, if applicable	300	15+T
		RO=SPHN	50	

OTHER CORONARY ARTERIOGRAPHY

VADT	48.98B	Selective coronary angiography	121	5+T

PERICARDIOCENTESIS

VADT	49.0	Pericardiocentesis	48	
VADT	49.0A	Left ventricular puncture	50	5+T

IMPLANT OF PULSATION BALLOON

VADT	49.61A	Percutaneous insertion of intra-aortic balloon pump	175	

IMPLANTATION OF HEART ASSIST SYSTEM

VADT	49.7A	Insertion of Implantable of Loop Recorder	70	4+T

IMPLANTATION OF ENDOCARDIAL ELECTRODES

VADT	49.73	Implantation of endocardial electrodes	96	
		Temporary, by transvenous (percutaneous) approach		

REPLACEMENT OF PULSE GENERATOR

VADT	49.83B	Visit and programming to a standard pacemaker	24	
VADT	49.83C	Visit and programming to a dual chamber pacemaker	36	

REMOVAL OF CARDIAC PACEMAKER SYSTEM WITHOUT REPLACEMENT

VADT	49.87A	Removal of Loop Recorder	40	4+T

BIOPSY OF HEART

VADT	49.93	Biopsy of heart	82	8+T

BIOPSY OF PERICARDIUM

VADT	49.94A	Biopsy of pericardium by needle 75	

RIGHT CARDIAC CATHETERIZATION

VADT	49.95	Right cardiac catheterization	8+T
		AG=ADUT 68	
		AG=CH16 85	
ADON	49.95A	Extra angiogram more than two - plus multiples, if applicable	
		AG=ADUT 22	
		AG=CH16 28	
ADON	49.95B	Assessment of pulmonary vascular resistance changes (includes all agents add on to right heart catheterization)	
		AG=ADUT 36	
		AG=CH16 44	

LEFT CARDIAC CATHETERIZATION

VADT	49.96	Left cardiac catheterization	8+T
		AG=ADUT 90	
		AG=CH16 115	
VADT	49.96A	Left heart catheterization with selective coronary arteriogram 156	8+T
VADT	49.96B	Left heart catheterization with angiograms and selective coronary arteriogram. 180	8+T
ADON	49.96C	Ergonovine provocation (for coronary artery spasm) add on to right heart catheterization	
		AG=ADUT 45	
		AG=CH16 55	
ADON	49.96D	Selective coronary graft angiography add on to catheterization of heart - left - plus multiples, if applicable	
		AG=ADUT 33	
		AG=CH16 41	
VADT	49.96E	Transeptal left heart catheterization	8+T
		AG=ADUT 135	
		AG=CH16 165	
VADT	49.96F	Left heart catheterization via atrial septal defect/foramen ovale	
		AG=ADUT 90	
		AG=CH16 110	
ADON	49.96G	Extra angiogram - more than two - plus multiples, if applicable	
		AG=ADUT 22	
		AG=CH16 28	
VADT	49.96H	Intracoronary ultrasound including left heart catheterization, left ventricular angiogram and selective coronary arteriography 250	

COMBINED RIGHT AND LEFT CARDIAC CATHETERIZATION

VADT	49.97	Combined right and left cardiac catheterization	8+T
		AG=ADUT ... 125	
		AG=CH16 ... 150	
VADT	49.97A	Combined right and left cardiac catheterization with angiograms	8+T
		AG=ADUT ... 145	
		AG=CH16 ... 180	
VADT	49.97B	Combined right and left cardiac catheterization with angiograms and either Fick or thermodilution cardiac output	8+T
		AG=ADUT ... 150	
		AG=CH16 ... 185	
VADT	49.97C	Combined right and left cardiac catheterization with selective coronary arteriogram	8+T
		AG=ADUT ... 180	
		AG=CH16 ... 220	
VADT	49.97D	Combined right and left cardiac catheterization with angiograms and selective coronary arteriogram	8+T
		AG=ADUT ... 200	
		AG=CH16 ... 250	
VADT	49.97E	Combined right and left cardiac catheterization with angiograms, selective coronary arteriogram and Fick or thermodilution cardiac output	8+T
		AG=ADUT ... 205	
		AG=CH16 ... 255	
ADON	49.97F	Extra angiogram more than two - plus multiples, if applicable	
		AG=ADUT ... 22	
		AG=CH16 ... 28	
ADON	49.97G	Cardiac output ... 5	

OTHER INVASIVE DIAGNOSTIC PROCEDURES ON HEART AND PERICARDIUM

VADT	49.98A	Electrophysiological study with programmed stimulation of the atria or ventricles	8+T
		AG=ADUT ... 180	
		AG=CH16 ... 220	
VADT	49.98B	Electrophysiological study to assess response to medication or surgery	
		AG=ADUT, RP=REPT ... 90	
		AG=CH16, RP=REPT ... 110	
VADT	49.98C	Electrophysiologic study with endomyocardial mapping	9+T
		AG=ADUT ... 180	
		AG=CH16 ... 220	

VADT	49.98D	Atrial pacing and HIS bundle studies	9+T
		AG=ADUT 90	
		AG=CH16 110	
ADON	49.98E	Dye curves (including all curves) add on to right heart catheterization	
		AG=ADUT 22	
		AG=CH16 28	
VADT	49.98F	Catheter ablation therapy for cardiac arrhythmias	
		RO=FPHN 250	
		RO=SPHN 75	
VADT	49.98G	Catheter ablation - composite fee, including endocardial mapping and electrophysiological study 430	
VADT	49.98H	Atrial pacing studies	
		AG=ADUT 45	9+T
VADT	49.98I	Complex cardiac ablation for atrial fibrillation and complex cardiac arrhythmias 796	9+T

INCISION OF VESSEL

VADT	50.0A	Percutaneous image guided retrieval of intravascular foreign body (composite fee - to include all necessary imaging studies) 150	10+T

RESECTION OF VESSEL WITH REPLACEMENT

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	

PLICATION OF VENA CAVA

VADT	50.6D	Percutaneous image guided IVC filter removal (composite fee - to include all necessary imaging studies) 135	10+T

OTHER SURGICAL OCCLUSION OF VESSELS - ABDOMINAL ARTERIES

VADT	50.76E	Uterine fibroid embolization, to include embolization of all supply arteries and necessary angiography 200	

OTHER SURGICAL OCCLUSION OF VESSELS - UNSPECIFIED SITE

ADON	50.79A	Vascular embolization or infusion of chemotherapy - add to arteriogram 51	

ANGIOGRAPHY USING CONTRAST MATERIAL, SITE UNSPECIFIED

VADT	50.80A	Intraoperative arteriography 15	

ANGIOGRAPHY OF CEREBRAL VESSELS

VADT	50.81B	Carotid arteriography 51	5+T

AORTOGRAPHY

VADT	50.82	Aortography AP=PERC	50.5	5+T
VADT	50.82A	Aortography, trans-lumbar	50.5	5+T
VADT	50.82B	Angioplasty of coarctation of the aorta	200	15+T
VADT	50.82C	Aortic arch study	75	5+T
VADT	50.82D	Aortography - exposure of major artery	75	4+T

ANGIOGRAPHY OF PULMONARY VESSELS

ADON	50.83	Angiography of pulmonary vessels add on to catheterization of heart - right - plus multiples, if applicable AG=ADUT AG=CH16	 22 28	
VADT	50.83A	Study of aorto-pulmonary shunts	75	

ANGIOGRAPHY OF OTHER INTRA-ABDOMINAL VESSELS

VADT	50.87A	Superior/inferior venacavogram	25.5	5+T
VADT	50.87B	Selective visceral venography - plus multiples, if applicable	40	5+T
VADT	50.87C	Percutaneous transhepatic portography	150	
VADT	50.87D	Selective abdominal angiographic studies - one catheter - plus multiples, if applicable	65	5+T
VADT	50.87E	Selective abdominal angiographic studies - two catheters - plus multiples, if applicable	75	5+T

ANGIOGRAPHY OF FEMORAL VESSELS

VADT	50.88A	Femoral arteriography (regions required)	15.3	4+T

ANGIOGRAPHY OF OTHER VESSELS NEC

VADT	50.89A	Digital vascular angiography RO=PROC	 100	
VADT	50.89B	Carotid vertebral or brachial arteriography by cutdown	75	8+T
VADT	50.89C	Capillaroscopy	10	
ADON	50.89D	Extra angiogram more than two - plus multiples, if applicable AG=ADUT AG=CH16	 22 28	

VADT	50.89E	Venogram - peripheral	15.3	
VADT	50.89F	Vertebral arteriography	51	5+T
VADT	50.89G	Selective abdominal angiographic studies - one catheter - plus multiples, if applicable	65	5+T
VADT	50.89H	Selective abdominal angiographic studies - two catheters	75	5+T

ARTERIAL CATHETERIZATION

VADT	50.91	Arterial catheterization	25	4+T

OTHER VENOUS CATHETERIZATION

VADT	50.93A	Flushing of portacath LO=OFFC LO=HOSP, FN=INPT, FN=OTPT	10 10	
VADT	50.93C	Percutaneous insertion of central venous line AG=CH04	40	
VADT	50.93F	Insertion of central venous pressure catheter	24	
VADT	50.93J	Insertion of a central venous line (infants under 3 kg)	125	7+T
VADT	50.93K	Hepatic wedge pressure	51	5+T

VENOUS CUTDOWN

VADT	50.96	Venous cutdown	11	

OTHER PUNCTURE OF ARTERY

VADT	50.98A	Arterial puncture - plus multiples, if applicable	7	

OTHER PUNCTURE OF VEIN

VADT	50.99A	Intravenous - plus multiples, if applicable	9	
VADT	50.99B	Intravenous - by scalp vein	14.5	
VADT	50.99C	Femoral vein puncture (regions required)	14	
VADT	50.99D	Jugular vein puncture (regions required)	14	
VADT	50.99E	Venesection, therapeutic	6.5	
VADT	50.99F	Phlebotomy, therapeutic	6.5	
VADT	50.99G	Subclavian vein puncture for hyperalimentation	24	

VADT	50.99H	Venipuncture (included in a consultation)		
		AG=CH07	8.8	
		AG=PR07 - plus multiples, if applicable	3	
VADT	50.99L	Thrombolysis with urokinase (includes interpretation, angiograms, angioplasty and all re-adjustments and infusion)	300	

OTHER REPAIR OF BLOOD VESSEL NEC

VADT	51.59I	Percutaneous arterial angioplasty – upper limbs		
		RG=RRUA (Radial or ulnar artery, right side)	183.6	8+T
		RG=LRUA (Radial or ulnar artery, left side)	183.6	8+T
		RG=RBRA (Brachial, right side)	137.7	8+T
		RG=LBRA (Brachial, left side)	137.7	8+T
VADT	51.59J	Percutaneous arterial angioplasty – central vessels		
		RG=INRE (Infra renal)	137.7	15+T
		RG=SURE (Supra renal)	200	15+T
		RG=GVIB (Great vessel, innominate / brachiocephalic)	183.6	15+T
		RG=GVCC (Great vessel, left common carotid)	183.6	15+T
		RG=GVSA (Great vessel, left subclavian)	183.6	15+T
		RG=VCEL (Visceral, celiac)	183.6	8+T
		RG=VSMA (Visceral, SMA)	183.6	8+T
		RG=VIMA (Visceral, IMA)	183.6	8+T
		RG=VSPL (Visceral, splenic)	183.6	8+T
		RG=VHEP (Visceral, hepatic)	183.6	8+T
		RG=RRMV (Renal - main vessel, right side)	183.6	8+T
		RG=LRMV (Renal – main vessel, left side)	183.6	8+T
		RG=RRSV (Renal – segmental vessel, right side)	183.6	8+T
		RG=LRSV (Renal – segmental vessel, left side)	183.6	8+T
VADT	51.59K	Percutaneous arterial angioplasty – lower limbs		
		RG=RPOP (Popliteal, right side)	137.7	8+T
		RG=LPOP (Popliteal, left side)	137.7	8+T
		RG=RANT (Anterior tibial, right side)	183.6	8+T
		RG=LANT (Anterior tibial, left side)	183.6	8+T
		RG=RPOT (Posterior tibial, right side)	183.6	8+T
		RG=LPOT (Posterior tibial, left side)	183.6	8+T
		RG=RPER (Peroneal, right side)	183.6	8+T
		RG=LPER (Peroneal, left side)	183.6	8+T
		RG=RCOI (Common iliac, right side)	137.7	8+T
		RG=LCOI (Common iliac, left side)	137.7	8+T
		RG=RINI (Internal iliac, right side)	137.7	8+T
		RG=LINI (Internal iliac, left side)	137.7	8+T
		RG=REXI (External iliac, right side)	137.7	8+T
		RG=LEXI (External iliac, left side)	137.7	8+T
		RG=RCSF (Common femoral / Superficial femoral, right side)	137.7	8+T
		RG=LCSF (Common femoral / Superficial femoral, left side)	137.7	8+T
		RG=RPRF (Profunda femoris, right side)	137.7	8+T
		RG=LPRF (Profunda femoris, left side)	137.7	8+T

VADT	51.59L	Venous angioplasty – head		
		RG=RSIG (Sigmoid sinus, right side)	183.6	10+T
		RG=LSIG (Sigmoid sinus, left side)	183.6	10+T
		RG=RTRA (Transverse sinus, right side)	183.6	10+T
		RG=LTRA (Transverse sinus, left side)	183.6	10+T
		RG=SAGG (Saggital sinus)	183.6	10+T
VADT	51.59M	Venous angioplasty – upper limbs		
		RG=RRUA (Radial or ulnar, right side)	137.7	8+T
		RG=LRUA (Radial or ulnar, left side)	137.7	8+T
		RG=RBAC (Basilic or cephalic, right side)	137.7	8+T
		RG=LBAC (Basilic or cephalic, left side)	137.7	8+T
		RG=RAXI (Axillary, right side)	137.7	8+T
		RG=LAXI (Axillary, left side)	137.7	8+T
VADT	51.59N	Venous angioplasty – central vessels		
		RG=VREN (Visceral - renal)	183.6	10+T
		RG=VSUM (Visceral – superior mesenteric)	183.6	10+T
		RG=VSPL (Visceral – splenic)	183.6	10+T
		RG=VHEP (Visceral – hepatic)	183.6	10+T
		RG=VPOR (Visceral – portal)	183.6	10+T
		RG=IVCA (Inferior Vena Cava – IVC)	137.7	10+T
		RG=SVCA (Superior Vena Cava)	137.7	10+T
		RG=RBRC (Brachiocephalic, right side)	137.7	10+T
		RG=LBRC (Brachiocephalic, left side)	137.7	10+T
		RG=RSUB (Subclavian, right side)	137.7	10+T
		RG=LSUB (Subclavian, left side)	137.7	10+T
VADT	51.59O	Venous angioplasty – lower limbs		
		RG=RCSF (Common femoral / Superficial femoral, right side)	137.7	8+T
		RG=LCSF (Common femoral / Superficial femoral, left side)	137.7	8+T
		RG=RPRF (Profunda femoris, right side)	137.7	8+T
		RG=LPRF (Profunda femoris, left side)	137.7	8+T
		RG=RCOI (Common iliac, right side)	137.7	8+T
		RG=LCOI (Common iliac, left side)	137.7	8+T
		RG=RINI (Internal iliac, right side)	137.7	8+T
		RG=LINI (Internal iliac, left side)	137.7	8+T
		RG=REXI (External iliac, right side)	137.7	8+T
		RG=LEXI (External iliac, left side)	137.7	8+T
		RG=RPOP (Popliteal, right side)	137.7	8+T
		RG=LPOP (Popliteal, left side)	137.7	8+T

NOTE: Each angioplasty code is intended to include all angiography performed of the extremity region at the time of the angioplasty procedure. Each code is intended to include all angioplasties necessary within the vessel or region regardless of the length or number of vascular occlusions. The maximum number of anatomic regions that may be billed at one service encounter is 4.

ADON	51.59P	Subintimal recanalisation of vascular occlusion	125
ADON	51.59Q	Non-cardiac, endovascular stent placement	50
ADON	51.59R	Thrombolysis following non-cardiac angiography	150

INSERTION OF VESSEL-TO-VESSEL CANNULA

VADT	51.93A	Insertion of venovenous catheters for acute hemodialysis	25	

HEMODIALYSIS

VADT	51.95	Hemodialysis		
		AG=ADUT	35	
		RP=INTL	288	
		RP=SUBS	96	

OTHER PERFUSION

VADT	51.97	Other perfusion - regional isolation perfusion	100	4+T

EXCISION OF DEEP CERVICAL LYMPH NODE (WITH EXCISION OF SCALENE FAT PAD)

VADT	52.11	Excision of deep cervical lymph node (with excision of scalene fat pad)	62	4+T

BIOPSY OF BONE MARROW

VADT	53.81	Biopsy of bone marrow		
		AG=ADUT	25	4+T
		AG=CH16	50	4+T
		RO=INTP	15	
VEDT	53.81A	Bone marrow interpretation	28.62	

ASPIRATION BIOPSY OF SPLEEN

VADT	53.83	Aspiration biopsy of spleen	25	4+T

OTHER BIOPSY OF SPLEEN

VADT	53.84A	Splenic puncture biopsy	25	4+T

ENDOSCOPIC EXCISION OR DESTRUCTION OF LESION OR TISSUE OF ESOPHAGUS

ADON	54.21A	Electrocautery of GI bleeding lesions - add on to endoscopic fees	10	

TEMPORARY GASTROSTOMY

VADT	55.1A	Percutaneous gastrostomy - performed under imaging control	90	
VADT	55.1B	Percutaneous endoscopic gastrostomy (PEG) - includes the scope	90	7+T
VADT	55.1C	Reposition or exchange of percutaneous gastrostomy tube when performed under imaging control	50	

OTHER ENTEROSTOMY NEC

VADT	58.39B	Percutaneous endoscopic jejunostomy (PEJ) - includes the scope	120	

CORRECTION OF VOLVULUS / INTUSSUSCEPTION

VADT	58.81A	Reduction of intussusception by barium enema	30	
VADT	58.81B	Relief of bowel obstruction due to meconium by radiological methods	60	

INJECTION OF HEMORRHOIDS

VADT	61.32	Injection of hemorrhoids		
		RP=INTL	10	
		RP=SUBS	5	

LIGATION OF HEMORRHOIDS

VADT	61.35A	Banding of hemorrhoids - per session	30	4+T

PERCUTANEOUS BIOPSY OF LIVER

VADT	62.81	Percutaneous biopsy of liver	38	4+T
		AG=CH16	80	4+T

OTHER BIOPSY OF LIVER

VADT	62.82	Other biopsy of liver	100	
		AG=CH16	80	4+T
VADT	62.82A	Transjugular liver biopsy	100	

PERCUTANEOUS ASPIRATION OF LIVER

VADT	62.91A	Percutaneous transhepatic biliary drainage	153	

OTHER CHOLECYSTOTOMY AND CHOLECYSTOSTOMY

VADT	63.09A	Percutaneous cholecystostomy - performed under imaging control	120	

COMMON DUCT EXPLORATION FOR REMOVAL OF CALCULUS

VADT	63.31B	Basket extraction for retained bile duct stones	51	4+T

INSERTION OF CHOLEDOCHOHEPATIC TUBE FOR DECOMPRESSION

VADT	63.33A	Percutaneous transhepatic biliary drainage	153	
VADT	63.33B	Percutaneous dilatation of biliary stricture and insertion of stent when performed under imaging control	75	
VADT	63.33C	Reposition or exchange of percutaneous placed biliary drain or stent when performed under imaging control	75	

INCISION OF OTHER BILE DUCTS FOR RELIEF OF OBSTRUCTION

VADT	63.39A	Transhepatic biliary stone extraction when performed under imaging control	85	

PANCREATIC SPHINCTEROTOMY

VADT	63.82A	Esophagogastroduodenoscopy - with papillotomy	230	4+T

OTHER OPERATIONS ON SPHINCTER OF ODDI

VADT	63.89A	Esophagogastroduodenoscopy - with manometry of ampulla of vater	170	4+T

ENDOSCOPIC RETROGRADE CHOLANGIOGRAPHY (ERC)

VADT	63.95A	Esophagogastroduodenoscopy - with basket extraction of stones	173.4	4+T
VADT	63.95B	Esophagogastroduodenoscopy - with indwelling nasobiliary catheter	170	4+T
VADT	63.95C	Esophagogastroduodenoscopy - with biliary stents	170	4+T

INTRA-OPERATIVE OR INTRAVENOUS CHOLANGIOGRAM OR PERCUTANEOUS HEPATIC CHOLANGIOGRAM

VADT	63.96	Intra-operative or intravenous cholangiogram or percutaneous hepatic cholangiogram	35.7	

OTHER BIOPSY OF GALLBLADDER OR BILIARY TRACT

VADT	63.98A	Percutaneous brush or needle biopsy through drain or stent when performed under imaging control (regardless of the number of biopsies)	40	

CANNULATION OF PANCREATIC DUCT (TRANSDUODENAL)

VADT	64.91A	Esophagogastroduodenoscopy - with cannulation of pancreatic duct	120	4+T
ADON	64.91B	Choledochoscopy with associated procedure	25	

OTHER BIOPSY OF PANCREAS

VADT	64.96A	Esophagogastroduodenoscopy - with selective pancreatic duct cytology	170	4+T

OTHER INVASIVE DIAGNOSTIC PROCEDURES ON ABDOMINAL REGION

VADT	66.89A	Percutaneous biopsy of solid masses for cytology or histology using ultrasound or fluoroscopy - plus multiples, if applicable	51+MU	

PERCUTANEOUS ABDOMINAL PARACENTESIS

VADT	66.91	Percutaneous abdominal paracentesis	10	
VADT	66.91A	Trocar insertion of silastic peritoneal catheter - Tenchkoff type	40	
VADT	66.91B	Removal of trocar insertion silastic peritoneal catheter of Tenchkoff type	20	
VADT	66.91C	Percutaneous diagnostic tap of fluid collections	40.8	

VADT	66.91D	Percutaneous insertion of drainage tube into fluid collection excluding nephrostomy	61.2	
VADT	66.91E	Abdominal paracentesis - therapeutic aspiration including diagnostic sample	24	4+T
VADT	66.91F	Abdominal paracentesis - administration of chemotherapy including therapeutic aspiration and sample	25	

INJECTION OF AIR INTO PERITONEAL CAVITY

VADT	66.96	Injection of air into peritoneal cavity	25	

PERITONEAL DIALYSIS

VADT	66.98	Peritoneal dialysis		
		AG=ADUT	35	
		AG=CH07, RP=INTL	168	
		AG=CH07, RP=SUBS	112	
		AG=CH16	90	
		AG=PR07, RP=INTL	150	
		AG=PR07, RP=SUBS	96	
VADT	66.98	Peritoneal dialysis - Home Dialysis (Program=HD) RO=HMDY, SP=NEPH	83	
VADT	66.98A	Diagnostic peritoneal lavage	35	

NEPHROSTOMY

VADT	67.02C	Percutaneous nephrostomy tube insertion under ultrasound or fluoroscopy (regions required)	81.6	

PERCUTANEOUS BIOPSY OF KIDNEY

VADT	67.81	Percutaneous biopsy of kidney		
		AG=ADUT	40.8	4+T
		AG=CH16	80	4+T

PERCUTANEOUS ASPIRATION OF KIDNEY

VADT	67.92A	Percutaneous aspiration of renal cyst under imaging guidance - plus multiples, if applicable	40.7	
VADT	67.92B	Percutaneous aspiration of renal cyst with sclerosing injection	51	

REPLACEMENT OF NEPHROSTOMY TUBE

VADT	67.93A	Removal of nephrostomy tube	10.5	

OTHER OPERATIONS ON URETER NEC

VADT	68.99A	Removal of J-stent including cystoscopy (regions required)	43.6	4+T
VEDT	68.99G	Renal access and nephroureteral stent placement for stone extraction	160	
VEDT	68.99H	Antegrade ureteric stent insertion with or without balloon dilation	120	
VEDT	68.99I	Balloon dilation of ureteric stricture	100	

PERCUTANEOUS ASPIRATION OF BLADDER

VADT	69.11	Percutaneous aspiration of bladder	17.5	

OTHER INVASIVE DIAGNOSTIC PROCEDURES ON BLADDER

VADT	69.89B	Induced ejaculation, vibratory and/or electrical to include catheterization and sigmoidoscopy as necessary	100	4+T

INSERTION OF INDWELLING URINARY CATHETER

VADT	69.94	Insertion of indwelling urinary catheter (stand alone procedure)	12.5	

OTHER OPERATIONS ON URETHRA AND PERIURETHRAL TISSUE NEC

VADT	70.99B	Aristospan injection into the periurethral space	10	

URETERAL CATHETERIZATION

VADT	71.8A	Differential renal function test (Stamey)	100	4+T
VADT	71.8B	Cystoscopy with bilateral sodium excretion estimation (Howard Test)	50	4+T

NEEDLE BIOPSY OF PROSTATE

VADT	72.91A	Biopsy of prostate, perineal needle	35	4+T
VADT	72.91B	Needle biopsy, perineal, with cystoscopy	54.4	4+T
VADT	72.91C	Ultrasound guided biopsy of the prostate	45	

PERCUTANEOUS ASPIRATION OF TUNICA VAGINALIS

VADT	73.91A	Aspiration of hydrocoele	10	

OTHER INVASIVE DIAGNOSTIC PROCEDURES ON PENIS

VADT	76.89A	Corpus cavernosagram	26	4+T

INSERTION OF THERAPEUTIC DEVICE INTO UTERUS

VADT	81.91A	Insertion of intrauterine catheter RO=INPR	15	

CULDOSCOPY

VADT	82.81A	Colposcopy	8.5	

AMNIOCENTESIS

VADT	87.3A	Therapeutic amniocentesis	75	

INTRAUTERINE TRANSFUSION

VADT	87.4A	Transabdominal amnioinfusion RO=FPHN	100	
VADT	87.4B	Intrauterine intravascular fetal transfusion	200	

FETAL BLOOD SAMPLING AND BIOPSY

VADT	87.53	Fetal blood sampling and biopsy - plus multiples, if applicable	15	
VADT	87.53A	Percutaneous umbilical blood sampling RO=FPHN RO=SPHN	100 100	

FETAL MONITORING, UNQUALIFIED

VADT	87.54A	Oxytocin challenge test RO=INPR	15	

OTHER DIAGNOSTIC PROCEDURES ON FETUS AND AMNION

VADT	87.55A	Chorionic villus sampling (CVS)	50	

OTHER INTRAUTERINE OPERATIONS ON FETUS AND AMNION NEC

VADT	87.59A	Transabdominal fetal thoracocentesis RO=FPHN (regions required)	100	
VADT	87.59B	Fetal therapeutic shunts pleural-amniotic or urinary-amniotic RO=FPHN	150	

EXCISION OF INTERVERTEBRAL DISC

VADT	92.31A	Chemonucleolysis - placement of needle under imaging - plus multiples, if applicable	50	7+T
VADT	92.31B	Chemonucleolysis - injection of lysing material	50	7+T
VADT	92.31C	Chemonucleolysis - placement of needle under imaging and injection of lysing material (same physician)	100	7+T

CONTRAST ARTHROGRAM, OTHER SPECIFIED SITE, SPINE

VADT	92.78A	Injection of cervical posterior intervertebral joints (facet joints) under imaging control - plus multiples, if applicable	40	

BIOPSY OF JOINT STRUCTURE, UNSPECIFIED SITE

VADT	92.99A	Needle biopsy - synovial tissue	25	

ARTHROCENTESIS

VADT	93.91	Arthrocentesis - plus multiples, if applicable	13	

INJECTION OF THERAPEUTIC SUBSTANCE INTO JOINT OR LIGAMENT

VADT	93.92A	Injection of therapeutic substance into joint or ligament including aspiration if necessary - plus multiples, if applicable	13	4+T
VADT	93.92B	Facet joint injection - plus multiples, if applicable	23	

BIOPSY OF MUSCLE, TENDON, FASCIA, AND BURSA

VADT	95.81A	Percutaneous muscle biopsy	30	

INJECTION OF THERAPEUTIC SUBSTANCE INTO TENDON

VADT	95.92A	Injection of therapeutic substance into tendon including aspiration if necessary - plus multiples, if applicable	13	4+T

INJECTION OF THERAPEUTIC SUBSTANCE INTO BURSA

VADT	95.93A	Injection of therapeutic substance into bursa including aspiration if necessary - plus multiples, if applicable	13	4+T

INJECTION OF THERAPEUTIC SUBSTANCE INTO OTHER SOFT TISSUE

VADT	95.94A	Injection of therapeutic substance into other soft tissue including aspiration if necessary - plus multiples, if applicable	13	4+T
VADT	95.94B	Injection for pruritus ani/fissure	10	

ASPIRATION OF BURSA

VADT	95.95	Aspiration of bursa - plus multiples, if applicable	13	4+T

CONTRAST MAMMARY DUCTOGRAM

VADT	97.83	Contrast mammary ductogram	10	

OTHER INVASIVE DIAGNOSTIC PROCEDURES ON BREAST

VADT	97.89A	Breast biopsy after localization of mammographic abnormality by Radiologist - plus multiples, if applicable	80	4+T

ASPIRATION OF BREAST (CYST)

VADT	97.91	Aspiration of breast (cyst) - plus multiples, if applicable	10

OTHER OPERATIONS OF THE BREAST

VEDT	97.99A	MRI guided placement of MRI compatible clip to locate a breast abnormality, with or without biopsy, to include all necessary imaging	70

OTHER INCISION WITH DRAINAGE OF SKIN AND SUBCUTANEOUS TISSUE

VADT	98.03	Other incision with drainage of skin and subcutaneous tissue - plus multiples, if applicable AN=LOCL	6 6

OTHER INVASIVE DIAGNOSTIC PROCEDURES ON SKIN AND SUBCUTANEOUS TISSUE

VADT	98.89B	Scratch/intradermal tests for allergens per series - plus multiples, if applicable	18
VADT	98.89C	Skin scrapings when direct microscopic examination is carried out, using KOH, immediately following the scraping of the lesions	7.7

INSERTION OF TISSUE EXPANDER(S)

MASG	98.98	Insertion of tissue expander(s) - plus multiples, if applicable	100	4+T
VADT	98.98A	Percutaneous expansion/inflation of a tissue expander - plus multiples, if applicable	13	

FAMILY PRACTICE

(Includes SP=GENP, EMMD, COMD)

CATEGORY	HEALTH SERVICE CODE	DESCRIPTION / MODIFIERS	BASE UNITS	ANAES UNITS

CONSULTATIONS

CONS	03.08	Consultation	
		RF=REFD (ME=TELE)	30
		RF=REFD, US=PREM (ME=TELE)	48
		RF=REFD, US=PR50 (ME=TELE)	48
		RF=REFD, RO=DETE (ME=TELE)	30+MU
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	48+MU
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	48+MU
CONS	03.07	Repeat Consultation	
		RF=REFD, RP=REPT (ME=TELE)	13
		RF=REFD, RP=REPT, US=PREM (ME=TELE)	31
		RF=REFD, RP=REPT, US=PR50 (ME=TELE)	31
		RF=REFD, RP=REPT, RO=DETE (ME=TELE)	13+MU
		RF=REFD, RP=REPT, RO=DETE, US=PREM (ME=TELE)	31+MU
		RF=REFD, RP=REPT, RO=DETE, US=PR50 (ME=TELE)	31+MU

OFFICE

VIST	03.04	Complete Examination	
		LO=OFFC (RF=REFD)	24
		LO-OFFC, TI=GPEW	30
VIST	03.04C	Adults with developmental disabilities complete examination	
		LO=OFFC, AG=ADUT	36
		LO-OFFC, AG=ADUT, TI=GPEW	45
VIST	03.04K	Gender transition readiness assessment, follow up of patients undergoing Medical transition, and follow up of patients undergoing surgical transition where the primary care provider is required to provide postoperative care	
		LO=OFFC	40+MU
		LO-OFFC, TI=GPEW	50+MU
		*Physician Restrictions in Place (See Appendix J)	
VIST	03.03	Office Visit	
		LO-OFFC, RP=SUBS (ME=VTCR*) (RF=REFD)	13
		LO-OFFC, RP=SUBS, ME=CARE	17+MU
		LO-OFFC, RP=SUBS, ME=CARE, TI=GPEW	21.25+MU
		LO-OFFC, RP=SUBS, TI=GPEW	16.25
		*Physician Restrictions in Place (See Appendix J)	

VIST	03.03A	Geriatric Office Visit (for patients aged 65+)	
		LO=OFFC (ME=VTCR*) (RF=REFD)	16.5
		LO=OFFC, ME=CARE	20.99+MU
		LO-OFFC, ME=CARE, TI=GPEW	26.24+MU
		LO=OFFC, TI=GPEW	20.63
		*Physician Restrictions in Place (See Appendix J)	
VIST	03.03B	Complex Care Visit	
		LO=OFFC (RF=REFD)	21
		LO=OFFC, TI=GPEW	26.25
VIST	03.03E	Adults with developmental disabilities visit	
		LO=OFFC, AG=ADUT	19.5
		LO=OFFC, AG=ADUT, TI=GPEW	24.38
VIST	03.03	Urgent Care - Request by Patient (1701 - 2000)	
		LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD).	28.3
VIST	03.03	Urgent Care - Request by Patient (2001 - 2359)	
		LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD).	28.3
VIST	03.03	Urgent Care - Request by Patient (0000 - 0800)	
		LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD).	38.3
VIST	03.03	Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays	
		LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD)	28.3
VIST	03.03	Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays	
		LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD)	28.3
VIST	03.03	Extra Patient to: Urgent Care Codes	
		LO=OFFC, PT=EXPT (RF=REFD)	10.5
		LO=OFFC, PT=EXPT, ME=CARE	11.92
VIST	03.04	Complete Pregnancy Exam	
		LO=OFFC, RO=ANTL, RP=INTL (RF=REFD)	29.7
		LO=OFFC, RO=ANTL, RP=INTL, TI=GPEW	37.13
VIST	03.03	Routine Pre Natal Visit	
		LO=OFFC, RO=ANTL, RP=SUBS (RF=REFD)	13
		LO=OFFC, RO=ANTL, RP=SUBS, ME=CARE	16.96
		LO=OFFC, RO=ANTL, RP=SUBS, ME=CARE, TI=GPEW	21.2
		LO=OFFC, RO=ANTL, RP=SUBS, TI=GPEW	16.25
VIST	03.03	Post Natal Care Visit	
		LO=OFFC, RO=PTNT (RF=REFD)	19
		LO=OFFC, RO=PTNT, TI=GPEW	23.75

VIST	03.03	Comprehensive Well Infant/Child Visit Using the Rourke Baby Record
		LO=OFFC, CT=RKBR, RO=WBCR 24
		LO=OFFC, CT=RKBR, RO=WBCR, TI=GPEW 30
VIST	03.03	Well Baby Care
		LO=OFFC, RO=WBCR (RF=REFD) 13
		LO=OFFC, RO=WBCR, ME=CARE 16.96
		LO=OFFC, RO=WBCR, ME=CARE, TI=GPEW 21.2
		LO=OFFC, RO=WBCR, TI=GPEW 16.25
ADON	03.03P	First Visit after In-Patient Hospital Discharge – Maternal and Newborn Care
		LO=OFFC 10
ADON	03.03S	First Visit after Acute Care In-Patient Hospital Discharge – Complex Care
		LO=OFFC 10

HOSPITAL (LO=HOSP: FN=INPT, INCU, NICU, OTPT, DTOX or EMCC)

VIST	03.04	Complete Examination
		LO=HOSP, FN=EMCC, FN=OTPT, FN=DTOX (RF=REFD) 24
		LO=HOSP, FN=EMCC, FN=OTPT, FN=DTOX, RO=DETE (RF=REFD) ..... 24+MU
VIST	03.04	Trauma Team Leader
		LO=HOSP, FN=EMCC, RO=TRTL, SP=EMMD, SP=GENP (RF=REFD) 60
VIST	03.04	First Examination
		LO=HOSP, FN=INPT, RP=INTL (RF=REFD) 30
		LO=HOSP, FN=INPT, RO=DETE, RP=INTL (RF=REFD) ..... 30+MU
VIST	03.04C	Adults with developmental disabilities complete examination
		LO=HOSP, AG=ADUT 36
VIST	03.04E	Initial Geriatric Inpatient Medical Assessment
		LO=HOSP, FN=INPT 38.1
VIST	03.03E	Adults with developmental disabilities visit
		LO=HOSP, AG=ADUT 19.5
VIST	03.03G	Examination of a victim of an alleged sexual assault and evidence collection
		LO=HOSP ..... 245+MU
		(15 units per 15 min. after 3 hours to a maximum of six 15 minute time intervals)
VIST	03.03	Subsequent Daily Hospital Visit (first days out of ICU)
		LO=HOSP, FN=INPT, DA=DA23 ..... 26.43
		LO=HOSP, FN=INPT, DA=DA47 ..... 21.84
VIST	03.03	Subsequent Visit - Daily up to 56 days
		LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) 18.39
		LO=HOSP, FN=INPT, DA=DALY, RO=DETE, RP=SUBS (RF=REFD) ..... 18.39+MU

VIST	03.03	Subsequent Visit - Weekly after 56 days - Maximum 80 units per week		
		LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD)	18.39	
		LO=HOSP, FN=INPT, DA=WKLY, RO=DETE, RP=SUBS (RF=REFD)	18.39+MU	
VIST	03.03	Supportive Care		
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=SPCR (RF=REFD)	15	
ADON	03.02A	Hospital Discharge Fee		
		LO=HOSP, FN=INPT	10	
VIST	03.04F	Complex comprehensive acute care hospital discharge		
		LO=HOSP, FN=INPT	45	
VIST	03.03	Urgent Hospital Visit		
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)	35.2	
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DETE, US=UNOF (RF=REFD)	35.2+MU	
VIST	03.03	Hospital Emergency Visit		
		LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)	35.2	
		LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)	35.2+MU	
VIST	03.04A	Transfer During Labour		
		LO=HOSP, FN=INPT (RF=REFD)	100	
		LO=HOSP, FN=INPT, RO=DETE (RF=REFD)	100+MU	
OBST	87.98	Delivery NEC		
		RF=REFD	282.24	4+T
		Multiple vaginal births - each additional - plus multiples, if applicable	91.73	
ADON	87.98A	Detention during obstetrical delivery (for attendance beyond three hours)		
		RO=DETE	15+MU	
VIST	03.03	Post-Partum Visit		
		LO=HOSP, FN=INPT, RO=PTPP, DA=DA23	26.43	
		LO=HOSP, FN=INPT, RO=PTPP, DA=DA47	21.84	
		LO=HOSP, FN=INPT, RO=PTPP (RF=REFD)	16	
VIST	03.03	Resuscitation of Newborn		
		LO=HOSP, FN=INPT, RO=RESC (RF=REFD)	50	
		LO=HOSP, FN=INPT, RO=RESC, US=PREM (RF=REFD)	68	
		LO=HOSP, FN=INPT, RO=RESC, US=PR50 (RF=REFD)	75	
		LO=HOSP, FN=INPT, RO=RNDT (RF=REFD)	50+MU	
		LO=HOSP, FN=INPT, RO=RNDT, US=PREM (RF=REFD).	68+MU	
		LO=HOSP, FN=INPT, RO=RNDT, US=PR50 (RF=REFD)	75+MU	
VIST	03.04	First Examination - Newborn Care Healthy Infant		
		LO=HOSP, FN=INPT, RO=NBCR, RP=INTL (RF=REFD)	24	
VIST	03.03	Subsequent Care - Newborn Healthy Infant		
		LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS, DA=DA23	26.43	
		LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS, DA=DA45	19	
		LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS (RF=REFD)	16	

VIST	03.03	Emergency Care Centre (0801 - 1200) LO=HOSP, FN=EMCC, TI=AMNN, SP=EMMD, SP=GENP (RF=REFD) ..... 10.5 LO=HOSP, FN=EMCC, TI=AMNN, RO=DETE, SP=EMMD, SP=GENP (RF=REFD) ..... 10.5+MU
VIST	03.03	Emergency Care Centre (1201 - 1700) LO=HOSP, FN=EMCC, TI=NNEV, SP=EMMD, SP=GENP (RF=REFD) ..... 10.5 LO=HOSP, FN=EMCC, TI=NNEV, RO=DETE, SP=EMMD, SP=GENP (RF=REFD) ..... 10.5+MU
VIST	03.03	Emergency Care Centre (1701 - 2000) LO=HOSP, FN=EMCC, TI=EVNT, SP=EMMD, SP=GENP (RF=REFD) ..... 10.5 LO=HOSP, FN=EMCC, TI=EVNT, RO=DETE, SP=EMMD, SP=GENP (RF=REFD) ..... 10.5+MU
VIST	03.03	Emergency Care Centre (2001 - 2359) LO=HOSP, FN=EMCC, TI=ETMD, SP=EMMD, SP=GENP (RF=REFD) ..... 15.5 LO=HOSP, FN=EMCC, TI=ETMD, RO=DETE, SP=EMMD, SP=GENP (RF=REFD) ..... 15.5+MU
VIST	03.03	Emergency Care Centre (0000 - 0800) LO=HOSP, FN=EMCC, TI=MDNT, SP=EMMD, SP=GENP (RF=REFD) ..... 15.5 LO=HOSP, FN=EMCC, TI=MDNT, RO=DETE, SP=EMMD, SP=GENP (RF=REFD) ..... 15.5+MU
VIST	03.03	Emergency Care Centre (0801 - 1200) Sundays and Holidays LO=HOSP, FN=EMCC, DA=RGE2, TI=AMNN, SP=EMMD, SP=GENP (RF=REFD) ..... 15.5 LO=HOSP, FN=EMCC, DA=RGE2, TI=AMNN, RO=DETE, SP=EMMD, SP=GENP (RF=REFD)..... 15.5+MU
VIST	03.03	Emergency Care Centre (1201 - 1700) Sundays and Holidays LO=HOSP, FN=EMCC, DA=RGE2, TI=NNEV, SP=EMMD, SP=GENP (RF=REFD) ..... 15.5 LO=HOSP, FN=EMCC, DA=RGE2, TI=NNEV, RO=DETE, SP=EMMD, SP=GENP (RF=REFD)..... 15.5+MU
VIST	03.03	Emergency Care Centre (1701 - 2000) Sundays and Holidays LO=HOSP, FN=EMCC, DA=RGE2, TI=EVNT, SP=EMMD, SP=GENP (RF=REFD) ..... 15.5 LO=HOSP, FN=EMCC, DA=RGE2, TI=EVNT, RO=DETE, SP=EMMD, SP=GENP (RF=REFD)..... 15.5+MU
VIST	03.03	Outpatient Visit (0800 - 1700) LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD) ..... 13.5 LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD) ..... 13.5+MU
VIST	03.03	Outpatient Visit (1701 - 2000) LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 20 LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU
VIST	03.03	Outpatient Visit (2001 - 2359) LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 20 LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU

VIST	03.03	Outpatient Visit (0000 - 0800) LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)..... 26 LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)..... 26+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)..... 20 LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)..... 20+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)..... 20 LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD)..... 20+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD)..... 7 LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 7+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD)..... 7 LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD)..... 7+MU
VIST	03.03	Outpatient Visit (1701 - 2000) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD)..... 10.5 LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD)..... 10.5+MU
VIST	03.03	Outpatient Visit (2001 - 2359) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD)..... 10.5 LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD)..... 10.5+MU
VIST	03.03	Outpatient Visit (0000 - 0800) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD)..... 11.4 LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD)..... 11.4+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD)..... 10.5 LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 10.5+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD)..... 10.5 LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD)..... 10.5+MU
VIST	03.03	Outpatient Visit-Doctor on Duty LO=HOSP, FN=OTPT, RO=DUTY (RF=REFD)..... 7 LO=HOSP, FN=OTPT, RO=DYDT (RF=REFD)..... 7+MU
VIST	03.03	Detox Centre (0800 - 1700) LO=HOSP, FN=DTOX, PT=FTPT (RF=REFD)..... 21.3 LO=HOSP, FN=DTOX, PT=FTPT, RO=DETE (RF=REFD)..... 21.3+MU

VIST 03.03 Detox Centre (1701 - 2000)
LO=HOSP, FN=DTOX, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) 28.3
LO=HOSP, FN=DTOX, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Detox Centre (2001 - 2359)
LO=HOSP, FN=DTOX, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) 28.3
LO=HOSP, FN=DTOX, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Detox Centre (0000 - 0800)
LO=HOSP, FN=DTOX, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) 38.3
LO=HOSP, FN=DTOX, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) ..... 38.3+MU

VIST 03.03 Detox Centre (0801 - 1200) Sat., Sun., Holidays
LO=HOSP, FN=DTOX, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF
(RF=REFD) 28.3
LO=HOSP, FN=DTOX, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF,
RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Detox Centre (1201 - 1700) Sat., Sun., Holidays
LO=HOSP, FN=DTOX, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF
(RF=REFD) 28.3
LO=HOSP, FN=DTOX, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF,
RO=DETE (RF=REFD) ..... 28.3+MU

VIST 03.03 Detox Centre (0800 - 1200) Extra Patient
LO=HOSP, FN=DTOX, PT=EXPT, TI=AMNN (RF=REFD) 15.8
LO=HOSP, FN=DTOX, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD) ..... 15.8+MU

VIST 03.03 Detox Centre (1201 - 1700) Extra Patient
LO=HOSP, FN=DTOX, PT=EXPT, TI=NNEV (RF=REFD) 15.8
LO=HOSP, FN=DTOX, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 15.8+MU

VIST 03.03 Detox Centre (1701 - 2000) Extra Patient
LO=HOSP, FN=DTOX, PT=EXPT, TI=EVNT (RF=REFD) 10.5
LO=HOSP, FN=DTOX, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD) ..... 10.5+MU

VIST 03.03 Detox Centre (2001 - 2359) Extra Patient
LO=HOSP, FN=DTOX, PT=EXPT, TI=ETMD (RF=REFD) 10.5
LO=HOSP, FN=DTOX, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD) ..... 10.5+MU

VIST 03.03 Detox Centre (0000 - 0800) Extra Patient
LO=HOSP, FN=DTOX, PT=EXPT, TI=MDNT (RF=REFD) 10.5
LO=HOSP, FN=DTOX, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) ..... 10.5+MU

VIST 03.03 Detox Centre (0801 - 1200) Extra Patient, Sat., Sun., Holidays
LO=HOSP, FN=DTOX, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD) 10.5
LO=HOSP, FN=DTOX, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD) ..... 10.5+MU

VIST 03.03 Detox Centre (1201 - 1700) Extra Patient, Sat., Sun., Holidays
LO=HOSP, FN=DTOX, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) 10.5
LO=HOSP, FN=DTOX, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 10.5+MU

INSTITUTIONAL VISITS

VIST	03.04	Complete Examination (Not to be used for admission to Nursing Home)	
		LO=NRHM (RF=REFD)	24
		LO=NRHM, RO=DETE (RF=REFD)	24+MU
VIST	03.04C	Adults with developmental disabilities complete examination	
		LO=NHRM, AG=ADUT	36
VIST	03.03E	Adults with developmental disabilities visit	
		LO=NHRM, AG=ADUT	19.5
VIST	03.03	Nursing Home Visit (0800 - 1700)	
		LO=NRHM (RF=REFD)	21.3+MU
		LO=NRHM, RO=DETE (RF=REFD)	21.3+MU
VIST	03.03	Nursing Home Visit (1701 - 2000)	
		LO=NRHM, TI=EVNT (RF=REFD)	28.3+MU
		LO=NRHM, TI=EVNT, US=UNOF, RO=DETE (RF=REFD)	28.3+MU
VIST	03.03	Nursing Home Visit (2001 - 2359)	
		LO=NRHM, TI=ETMD (RF=REFD)	28.3+MU
		LO=NRHM, TI=ETMD, US=UNOF, RO=DETE (RF=REFD)	28.3+MU
VIST	03.03	Nursing Home Visit (0000 - 0800)	
		LO=NRHM, TI=MDNT (RF=REFD)	38.3+MU
		LO=NRHM, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)	38.3+MU
VIST	03.03	Nursing Home Visit (0801 - 1200) Sat., Sun., Holidays	
		LO=NRHM, DA=RGE1, TI=AMNN, US=UNOF (RF=REFD)	28.3+MU
		LO=NRHM, DA=RGE1, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)	28.3+MU
VIST	03.03	Nursing Home Visit (1201 - 1700) Sat., Sun., Holidays	
		LO=NRHM, DA=RGE1, TI=NNEV, US=UNOF (RF=REFD)	28.3+MU
		LO=NRHM, DA=RGE1, TI=NNEV, US=UNOF, RO=DETE (RF=REFD)	28.3+MU
VIST	03.03	Nursing Home - Emergency Visit	
		LO=NRHM, US=UIOH (RF=REFD)	35.2
		LO=NRHM, US=UIOH, RO=DETE (RF=REFD)	35.2+MU

HOME

VIST	03.04	Complete Examination	
		LO=HOME (RF=REFD)	40.6
		LO=HOME, RO=DETE (RF=REFD)	40.6+MU
VIST	03.04C	Adults with developmental disabilities complete examination	
		LO=HOME, AG=ADUT	36
VIST	03.03E	Adults with developmental disabilities visit	
		LO=HOME, AG=ADUT	19.5

VIST	03.03	Home Visit (0800 - 1700)	
		LO=HOME, PT=FTPT (RF=REFD)	36
		LO=HOME, PT=FTPT, RO=DETE (RF=REFD)	36+MU
VIST	03.03	Home Visit (1701 - 2000)	
		LO=HOME, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD)	47.8
		LO=HOME, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD)	47.8+MU
VIST	03.03	Home Visit (2001 - 2359)	
		LO=HOME, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD)	47.8
		LO=HOME, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD)	47.8+MU
VIST	03.03	Home Visit (0000 - 0800)	
		LO=HOME, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)	64.7
		LO=HOME, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)	64.7+MU
VIST	03.03	Home Visit (0801 - 1200) Sat., Sun., Holidays	
		LO=HOME, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)	47.8
		LO=HOME, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)	47.8+MU
VIST	03.03	Home Visit (1201 - 1700) Sat., Sun., Holidays	
		LO=HOME, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)	47.8
		LO=HOME, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD)	47.8+MU
VIST	03.03	Home Visit - Extra Patient	
		LO=HOME, PT=EXPT (RF=REFD)	13
VIST	03.03	Home- Emergency Visit	
		LO=HOME, US=UIOH (RF=REFD)	59.5
		LO=HOME, US=UIOH, RO=DETE (RF=REFD)	59.5+MU
VIST	03.03	Home Visit – Visit of Convenience (not homebound)	
		LO=HOME, ME=CONV, PT=FTPT	13
		LO=HOME, ME=CONV, PT=FTPT, AG=OV65	16.5
ADON	HOVM1	Blended Mileage and travel detention for Home Visits	0.46+ MU
		1 multiple per kilometer	
ADON	03.03P	First Visit after In-Patient Hospital Discharge – Maternal Care	
		LO=HOME	10
ADON	03.03S	First Visit after Acute Care In-Patient Hospital Discharge – Complex Care	
		LO=HOME	10

HOME CARE

VIST	03.04	Direct Admission to Home Care from Home (0800 - 1700)	
		LO=HMHC, OL=HOME, SP=GENP (RF=REFD)	46.3
		LO=HMHC, OL=HOME, SP=GENP RO=DETE (RF=REFD)	46.3+MU

VIST 03.04 Direct Admission to Home Care from Home (1701 - 2000)
LO=HMHC, OL=HOME, TI=EVNT, SP=GENP (RF=REFD) 53.3
LO=HMHC, OL=HOME, TI=EVNT, RO=DETE, SP=GENP (RF=REFD) ..... 53.3+MU

VIST 03.04 Direct Admission to Home Care from Home (2001 - 2359)
LO=HMHC, OL=HOME, TI=ETMD, SP=GENP (RF=REFD) 53.3
LO=HMHC, OL=HOME, TI=ETMD, RO=DETE, SP=GENP (RF=REFD) ..... 53.3+MU

VIST 03.04 Direct Admission to Home Care from Home (0000 - 0800)
LO=HMHC, OL=HOME, TI=MDNT, SP=GENP (RF=REFD) 63.3
LO=HMHC, OL=HOME, TI=MDNT, RO=DETE, SP=GENP (RF=REFD) ..... 63.3+MU

VIST 03.04 Direct Admission to Home Care from Home (0801 - 1200) Sat., Sun., Holidays
LO=HMHC, DA=RGE1, OL=HOME, TI=AMNN, SP=GENP (RF=REFD) 53.3
LO=HMHC, DA=RGE1, OL=HOME, TI=AMNN, RO=DETE, SP=GENP (RF=REFD) ..... 53.3+MU

VIST 03.04 Direct Admission to Home Care from Home (1201 - 1700) Sat., Sun., Holidays
LO=HMHC, DA=RGE1, OL=HOME, TI=NNEV, SP=GENP (RF=REFD) 53.3
LO=HMHC, DA=RGE1, OL=HOME, TI=NNEV, RO=DETE, SP=GENP (RF=REFD) ..... 53.3+MU

VIST 03.04 Direct Admission to Home Care from Office
LO=HMHC, OL=OFFC, SP=GENP (RF=REFD) 35.5

VIST 03.04 Direct Admission to Home Care from Emergency
LO=HMHC, OL=USEM, SP=GENP (RF=REFD) 59.91
LO=HMHC, OL=USEM, RO=DETE, SP=GENP (RO=REFD) ..... 59.91+MU

VIST 03.04 Direct Admission to Home Care from Outpatient (0801 - 1200)
LO=HMHC, OL=OTPT, TI=AMNN, SP=GENP (RF=REFD) 35.4
LO=HMHC, OL=OTPT, TI=AMNN, RO=DETE, SP=GENP (RF=REFD) ..... 35.4+MU

VIST 03.04 Direct Admission to Home Care from Outpatient (1201 - 1700)
LO=HMHC, OL=OTPT, TI=NNEV, SP=GENP (RF=REFD) 35.4
LO=HMHC, OL=OTPT, TI=NNEV, RO=DETE, SP=GENP (RF=REFD) ..... 35.4+MU

VIST 03.04 Direct Admission to Home Care from Outpatient (1701 - 2000)
LO=HMHC, OL=OTPT, TI=EVNT, SP=GENP (RF=REFD) 35.4
LO=HMHC, OL=OTPT, TI=EVNT, RO=DETE, SP=GENP (RF=REFD) ..... 35.4+MU

VIST 03.04 Direct Admission to Home Care from Outpatient (2001 - 2359)
LO=HMHC, OL=OTPT, TI=ETMD, SP=GENP (RF=REFD) 40.5
LO=HMHC, OL=OTPT, TI=ETMD, RO=DETE, SP=GENP (RF=REFD) ..... 40.5+MU

VIST 03.04 Direct Admission to Home Care from Outpatient (0000 - 0800)
LO=HMHC, OL=OTPT, TI=MDNT, SP=GENP (RF=REFD) 40.5
LO=HMHC, OL=OTPT, TI=MDNT, RO=DETE, SP=GENP (RF=REFD) ..... 40.5+MU

VIST 03.04 Direct Admission to Home Care from Outpatient, Sundays and Holidays
LO=HMHC, DA=RGE2, OL=OTPT, SP=GENP (RF=REFD) 40.5
LO=HMHC, DA=RGE2, OL=OTPT, RO=DETE, SP=GENP (RF=REFD) ..... 40.5+MU

VIST	03.04	Transfer to Home Care from Inpatient
		LO=HMHC, OL=INPT, SP=GENP, SP=EMMD, SP=COMD (RF=REFD) 28.6
		LO=HMHC, OL=INPT, RO=DETE, SP=GENP, SP=EMMD, SP=COMD (RF=REFD) ..... 28.6+MU
VIST	03.03	Home Care - Home Visit (0800 - 1700)
		LO=HMHC, SP=GENP (RF=REFD) 21.3
		LO=HMHC, SP=GENP, RO=DETE (RF=REFD) ..... 21.3+MU
VIST	03.03	Home Care - Home Visit (1701 - 2000)
		LO=HMHC, TI=EVNT, SP=GENP (RF=REFD) 28.3
		LO=HMHC, TI=EVNT, RO=DETE, SP=GENP (RF=REFD) ..... 28.3+MU
VIST	03.03	Home Care - Home Visit (2001 - 2359)
		LO=HMHC, TI=ETMD, SP=GENP (RF=REFD) 28.3
		LO=HMHC, TI=ETMD, RO=DETE, SP=GENP (RF=REFD) ..... 28.3+MU
VIST	03.03	Home Care - Home Visit (0000 - 0800)
		LO=HMHC, TI=MDNT, SP=GENP (RF=REFD) 38.3
		LO=HMHC, TI=MDNT, RO=DETE, SP=GENP (RF=REFD) ..... 38.3+MU
VIST	03.03	Home Care - Home Visit (0801 - 1200) Sat., Sun., Holidays
		LO=HMHC, DA=RGE1, TI=AMNN, SP=GENP (RF=REFD) 28.3
		LO=HMHC, DA=RGE1, TI=AMNN, RO=DETE, SP=GENP (RF=REFD) ..... 28.3+MU
VIST	03.03	Home Care - Home Visit (1201 - 1700) Sat., Sun., Holidays
		LO=HMHC, DA=RGE1, TI=NNEV, SP=GENP (RF=REFD) 28.3
		LO=HMHC, DA=RGE1, TI=NNEV, RO=DETE, SP=GENP (RF=REFD) ..... 28.3+MU
VIST	03.03	Home Care - Urgent Callback By Staff
		LO=HMHC, US=UCHH, SP=GENP (RF=REFD) 35.2
		LO=HMHC, US=UCHH, RO=DETE, SP=GENP (RF=REFD) ..... 35.2+MU
VIST	03.03	Home Care - Outpatient Visit (0801 - 1200)
		LO=HOSP, FN=OTPT, OL=HMHC, TI=AMNN, SP=GENP (RF=REFD) 10.5
		LO=HOSP, FN=OTPT, OL=HMHC, TI=AMNN, RO=DETE, SP=GENP (RF=REFD) ..... 10.5+MU
VIST	03.03	Home Care - Outpatient Visit (1201 - 1700)
		LO=HOSP, FN=OTPT, OL=HMHC, TI=NNEV, SP=GENP (RF=REFD) 10.5
		LO=HOSP, FN=OTPT, OL=HMHC, TI=NNEV, RO=DETE, SP=GENP (RF=REFD) ..... 10.5+MU
VIST	03.03	Home Care - Outpatient Visit (1701 - 2000)
		LO=HOSP, FN=OTPT, OL=HMHC, TI=EVNT, SP=GENP (RF=REFD) 10.5
		LO=HOSP, FN=OTPT, OL=HMHC, TI=EVNT, RO=DETE, SP=GENP (RF=REFD) ..... 10.5+MU
VIST	03.03	Home Care - Outpatient Visit (2001 - 2359)
		LO=HOSP, FN=OTPT, OL=HMHC, TI=ETMD, SP=GENP (RF=REFD) 15.5
		LO=HOSP, FN=OTPT, OL=HMHC, TI=ETMD, RO=DETE, SP=GENP (RF=REFD) ..... 15.5+MU
VIST	03.03	Home Care - Outpatient Visit (0000 - 0800)
		LO=HOSP, FN=OTPT, OL=HMHC, TI=MDNT, SP=GENP (RF=REFD) 15.5
		LO=HOSP, FN=OTPT, OL=HMHC, TI=MDNT, RO=DETE, SP=GENP (RF=REFD) ..... 15.5+MU

VIST 03.03 Home Care - Outpatient Visit, Sunday and Holidays
LO=HOSP, FN=OTPT, DA=RGE2, OL=HMHC, SP=GENP (RF=REFD)..... 15.5
LO=HOSP, FN=OTPT, DA=RGE2, OL=HMHC, RO=DETE, SP=GENP (RF=REFD)..... 15.5+MU

VIST 03.03 Home Care, Medical Chart Review and/or Telephone
Call, Fax or E-mail Advice - up to three per day per patient
LO=HMHC, RO=HMTE, SP=GENP (RF=REFD) 11.5
Note: Each additional group of three telephone calls, faxes or e-mails/per day/per patient can be claimed at 11.5 MSU

ADON HHCMI Blended Mileage/Detention Time for Home Care..... 0.46+ MU
(1 multiple = 1 km)

VIST 03.03 Home Care Emergency Visit
LO=HMHC, US=UIOH, SP=GENP, SP=EMMD, SP=COMD (RF=REFD)..... 35.2
LO=HMHC, US=UIOH, RO=DETE, SP=GENP, SP=EMMD, SP=COMD (RF=REFD)..... 35.2+MU

CORRECTIONAL CENTRE

VIST 03.04 Complete Examination
LO=CCNT (RF=REFD) 24

VIST 03.03 Office Visit
LO=CCNT, RP=SUBS (RF=REFD) 12.5

VIST 03.03 Urgent Visit - Request by Patient (1701 - 2000)
LO=CCNT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Visit - Request by Patient (2001 - 2359)
LO=CCNT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Visit - Request by Patient (0000 - 0800)
LO=CCNT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)..... 38.3

VIST 03.03 Urgent Visit - Request by Patient (0801 - 1200) Sat., Sun., Holidays
LO=CCNT, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Visit - Request by Patient (1201 - 1700) Sat., Sun., Holidays
LO=CCNT, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD)..... 28.3

VIST 03.03 Urgent Visit - Request by Patient, Extra Patient
LO=CCNT, PT=EXPT (RF=REFD)..... 10.5

VIST 03.03 Correctional Centre - Emergency Visit
LO=CCNT, US=UIOH (RF=REFD)..... 35.2
LO=CCNT, US=UIOH, RO=DETE (RF=REFD)..... 35.2+MU

VIST 03.04 Complete Pregnancy Exam
LO=CCNT, RO=ANTL, RP=INTL (RF=REFD) 29.7

VIST 03.03 Routine Pre-Natal Visit
LO=CCNT, RO=ANTL, RP=SUBS (RF=REFD) 13

OTHER

VIST	03.04	Complete Examination
		LO=OTHR (RF=REFD) 24
		LO=OTHR, RO=DETE (RF=REFD) ..... 24+MU
VIST	03.03	Unspecified Emergency Visit
		LO=OTHR, US=UIOH (RF=REFD) 35.2
		LO=OTHR, US=UIOH, RO=DETE (RF=REFD) ..... 35.2+MU
VIST	03.03	Unspecified Location (0800 - 1700)
		LO=OTHR, PT=FTPT (RF=REFD) 21.3
		LO=OTHR, PT=FTPT, RO=DETE (RF=REFD) ..... 21.3+MU
VIST	03.03	Unspecified Location (1701 - 2000)
		LO=OTHR, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) 28.3
		LO=OTHR, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU
VIST	03.03	Unspecified Location (2001 - 2359)
		LO=OTHR, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) 28.3
		LO=OTHR, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU
VIST	03.03	Unspecified Location (0000 - 0800)
		LO=OTHR, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) 38.3
		LO=OTHR, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) ..... 38.3+MU
VIST	03.03	Unspecified Location (0801 - 1200) Sat., Sun., Holidays
		LO=OTHR, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)..... 28.3
		LO=OTHR, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)..... 28.3+MU
VIST	03.03	Unspecified Location (1201 - 1700) Sat., Sun., Holidays
		LO=OTHR, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD) 28.3
		LO=OTHR, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU
VIST	03.03	Unspecified Location - Extra Patient
		LO=OTHR, PT=EXPT (RF=REFD) 10.5

PALLIATIVE CARE

CONS	03.09C	Palliative Care Consultation..... 62+MU
		RF=REFD, TI=GPEW ..... 77.5+MU
		(Once per patient per physician)
VIST	03.03C	Palliative Care Support Visit
		RO=PCSV ..... 30 per 30 min
		(15 units per 15 min. thereafter, maximum of 60 min. per patient per day)
		RO=PCSV, TI=GPEW ..... 37.5 per 30 min
		(18.75 units per 15 min. thereafter, maximum of 60 min. per patient per day)

VIST 03.03 Palliative Care Medical Chart Review and/or Telephone Call, Fax or E-mail initiated by a health care professional - up to three telephone calls/faxes or e-mails per day per patient
RO=CRTC 11.5
Note: Each additional group of three telephone calls, faxes or e-mails/per day/per patient can be claimed at 11.5 units

PROCEDURES

IMPLANT FOR OPIOID USE DISORDER

VADT 13.59P Insertion of Buprenorphine Implant (e.g. Probuphine) for the treatment Of opioid use disorder 20

VADT 13.59Q Removal of Buprenorphine Implant (e.g. Probuphine) 20

ACUTE STROKE PROTOCOL

VEDT 13.99F Assessment and management of patient with Acute Stroke 130
From activation of Acute Stroke Protocol through completion of Thrombolytic therapy (e.g. t-PA)

SUTURES

MISG 98.22 Suture of skin and subcutaneous tissue of other sites 20

MISG 98.22A Suture of simple wounds or lacerations – child's face 25

MISG 98.22D Suture minor laceration or foreign body wound 20

VADT 98.03 Other incision with drainage of skin and subcutaneous tissue
AN-LOCL 10

PSYCHIATRIC SERVICES

Refer to the Preamble for billing Psychiatric Health Service Codes (5.2.131).

VIST 03.04I Practice Support Program Mental Health Comprehensive Visit* ..... 50 per 30 min.
(25 units per 15 min. thereafter to a maximum 1 hour)
TI=GPEW ..... 62.50 per 30 min.
(31.25 units per 15 min. thereafter to a maximum 1 hour)
*Physician Restrictions in Place (See Appendix J)

PSYC 08.41 Hypnotherapy* ..... 30 per 30 min.
(15 units per 15 min. thereafter)
TI=GPEW ..... 37.50 per 30 min.
(18.75 units per 15 min. thereafter)
*Physician Restrictions in Place (See Appendix J)

PSYC	08.44	Group therapy	
		Group psychotherapy per patient (4 - 8 members)	7.6 per 30 min.
		(3.2 units per 15 min. thereafter)	
		TI=GPEW	9.50 per 30 min.
		(4.75 units per 15 min. thereafter)	
PSYC	08.44A	Mindfulness-Based Cognitive Therapy (MBCT)* (min 8 – max 12 patients)	
		Group therapy fee per patient per two-hour session	14.3
		*Physician Restrictions in Place (See Appendix J)	
PSYC	08.45	Family therapy (2 or more members)	30 per 30 min.
		(15 units per 15 min. thereafter)	
		TI=GPEW	37.50 per 30 min.
		(18.75 units per 15 min. thereafter)	
PSYC	08.49A	Counselling	30 per 30 min.
		(15 units per 15 min. thereafter)	
		TI=GPEW	18.75 per 15 min.
PSYC	08.49B	Psychotherapy	30 per 30 min.
		(15 units per 15 min. thereafter)	
		TI=GPEW	37.50 per 30 min.
		(18.75 units per 15 min. thereafter)	
PSYC	08.49C	Lifestyle counselling	15 per 15 min.
		TI=GPEW	18.75 per 15 min.

ADDITIONAL SERVICES

For further information refer to the Preamble.

MAAS	EC	Exceptional Circumstances	EC
MAAS	IC	Independent Consideration	IC
MAAS	IF	Interim Fee	IF

COMMUNITY SERVICES (See Community Services Medical Assessment (2.5.11) of Preamble)

DEFT	C9999	Community Services Medical Assessment Form and request for Essential Medical Treatments Form	$40.00

OTHER DENTAL OPERATIONS NEC

MAAS	36.99A	Assistant for dental surgery performed by a dentist	
		(RO=DTAS)	IC

OPIOID AGONIST TREATMENT (OAT)

VIST	03.03J	Initial Opioid Use Disorder Assessment for Initiation of OAT	
		Community Primary Care Setting Only (30 minutes)	50 + MU
		TI=GPEW	62.5 + MU

VIST	03.03K	Initial Opioid Use Disorder Assessment for Initiation of OAT	50
		Transfer from Opioid Use Disorder Treatment Program to Community Primary Care Provider	
		TI=GPEW	62.5
VIST	03.03L	Permanent Transfer of a Patient on Active OAT for Opioid Use Disorder	
		Full Acceptance of Responsibility for Ongoing Care	
		Initial Visit with Accepting Health Care Provider	50
		TI=GPEW	62.5
DEFT	OAT1	OAT Monthly Management Fee – Primary Care Provider Only	
		ME=CARE	60
DEFT	OAT2	OAT Monthly Management Fee for provision of OAT only	
		Patient Referred by another health care provider with written progress updates supplied the primary care provider at least quarterly	45
ADON	UDS1	Urine Drug Screen Tray Fee	2.3

INCENTIVE PROGRAMS

DEFT	CDM1	Family Physician Chronic Disease Management Incentive Program -	
		(First qualifying condition)	$100.00
		RP=CON2 (Second qualifying condition)	$75.00
		(Can be claimed once per fiscal year per condition)	
		RP=CON3 (Third qualifying condition)	$50.00
		(Can be claimed once per fiscal year per condition)	
DEFT	ENH1	Long Term Care Medication Review	11.95
		(Can be claimed twice per fiscal year)	
DEFT	CGA1	Long Term Care Clinical Geriatric Assessment	26.32
		(Can be claimed twice per fiscal year)	

WORKERS' COMPENSATION BOARD

DEFT	WCB12	EPS Physician Assessment Service	
		Combined office visit and completion of Form 8/10	
		RO=EPS1, RP=INTL	$225.65 +MU
		RO=EPS1, RP=SUBS	$225.65
DEFT	WCB13	Chart Summaries / Written Reports. Detailed reports billed	
		- plus multiples, if applicable	$55.27 per 15 min
		RO=EPS1	$66.05 per 15 min
DEFT	WCB15	Case Conferencing and Teleconferencing (Treating Physician)	
		Conferencing billed by the Treating Physician - plus multiples, if applicable	$55.27 per 15 min
		RO=EPS1	$66.05 per 15 min

DEFT	WCB17	Photocopying of charts. Photocopying of chart notes ME=UP10 ..... $33.11 ME=UP25 ..... $66.05 ME=UP50 ..... $131.91 ME=OV50 ..... $197.68
DEFT	WCB20	Carpal Tunnel Syndrome (CTS) Form Payment This form is only to be used upon request form the WCB case worker $84.66
DEFT	WCB21	Follow-up visit report $49.58
DEFT	WCB22	Completed Mandatory Generic Exemption Request Form ..... $16.63 per form
DEFT	WCB23	Completed Non-Opioid Special Authorization Request Form ..... $16.63 per form
DEFT	WCB24	Completed Opioid Special Authorization Request Form ..... $55.56 per form
DEFT	WCB25	Completed WCB Substance Abuse Assessment Form $37.08
DEFT	WCB26	Return to Work Report – Physician's Report Form 8/10 ..... $84.66
DEFT	WCB27	Eye Report $74.32
DEFT	WCB28	Comprehensive Visit for Work Related Injury or Illness $85.21
DEFT	WCB29	Initial request form for Medical Cannabis $91.93
DEFT	WCB30	Extension request form for Medical Cannabis $55.27
DEFT	WCB31	WCB Interim Fee- Comprehensive Visit for Work Related Injury or Illness When Condition has Changed. $85.21

INTENSIVE CARE UNIT

(Includes Critical Care, Ventilatory Care, Comprehensive Care, Intensive Care and Neonatal Intensive Care)

For further details refer to the Preamble.

CATEGORY	HEALTH SERVICE CODE	DESCRIPTION / MODIFIERS	BASE UNITS	ANAES UNITS
CRITICAL CARE				
CRCR	03.05	First Day LO=HOSP, IN=CC01, FN=INCU	105.8	
CRCR	03.05	Day 2 - 10 Inclusive LO=HOSP, IN=CC10, FN=INCU	52.9	
CRCR	03.05	Eleventh Day Onward LO=HOSP, IN=CC11, FN=INCU	26.45	
VENTILATORY CARE				
CRCR	03.05	First Day LO=HOSP, IN=VC01, FN=INCU	100	
CRCR	03.05	Day 2 - 10 Inclusive LO=HOSP, IN=VC10, FN=INCU	50	
CRCR	03.05	Eleventh Day Onward LO=HOSP, IN=VC11, FN=INCU	25	
COMPREHENSIVE CARE				
CRCR	03.05	First Day LO=HOSP, IN=CP01, FN=INCU	155.8	
CRCR	03.05	Day 2 - 10 Inclusive LO=HOSP, IN=CP10, FN=INCU	77.9	
CRCR	03.05	Eleventh Day Onward LO=HOSP, IN=CP11, FN=INCU	38.95	
COMPREHENSIVE CARE (for patient requiring extracorporeal membrane oxygenation ECMO)				
CRCR	03.05	First Day LO=HOSP, IN=CP01, FN=INCU, ME=ECMO	205.08	
CRCR	03.05	Day 2 - 10 Inclusive LO=HOSP, IN=CP10, FN=INCU, ME=ECMO	102.9	
CRCR	03.05	Eleventh Day Onward LO=HOSP, IN=CP11, FN=INCU, ME=ECMO	51.45	

INTENSIVE CARE

CRCR 03.05 Intensive Care, Per Day
LO=HOSP, IN=INCR, FN=INCU, FN=NICU..... 19.3

CRCR 03.05 Requiring Detention, Per Hour
LO=HOSP, IN=INPH, FN=INCU..... 45

CRCR 03.05A Continuous Attendance for Support of a Beating Donor, maximum 36 hours
LO=HOSP, FN=INCU ..... 15+MU

NEONATAL INTENSIVE CARE - with respiratory insufficiency requiring ventilatory assistance

CRCR 03.05 First Day
LO=HOSP, IN=NIC1, FN=NICU 150

CRCR 03.05 2nd, 3rd and 4th Day
LO=HOSP, IN=NIC4, FN=NICU 75

CRCR 03.05 5th Day Onward
LO=HOSP, IN=NIC5, FN=NICU 50

MEDICINE

(Includes SP=INMD, CARD, CLIA, ENME, GAST, GEMD, HAGY, INDI, MDON, MEMI, NEPH, RHEU, RSMD)

For further details refer to the Preamble.

CATEGORY	HEALTH SERVICE CODE	DESCRIPTION / MODIFIERS	BASE UNITS	ANAES UNITS
CONSULTATIONS				
CONS	03.08	Comprehensive Consultation (Prolonged)		
		RF=REFD (ME=TELE)	62+MU	
		RF=REFD, US=PREM (ME=TELE)	83.7 +MU	
		RF=REFD, US=PR50 (ME=TELE)	93+MU	
		RF=REFD, RO=DETE (ME=TELE)	62+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	83.7 +MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	93+MU	
CONS	03.07	Limited Consultation		
		RF=REFD (ME=TELE)	37	
		RF=REFD, US=PREM (ME=TELE)	55	
		RF=REFD, US=PR50 (ME=TELE)	55.5	
		RF=REFD, RO=DETE (ME=TELE)	37+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	55+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	55.5+MU	
CONS	03.07	Repeat Consultation (Prolonged)		
		RF=REFD, RP=REPT (ME=TELE)	27.4+MU	
		RF=REFD, RP=REPT, US=PREM (ME=TELE)	45.4+MU	
		RF=REFD, RP=REPT, US=PR50 (ME=TELE)	45.4+MU	
		RF=REFD, RO=DETE, RP=REPT (ME=TELE)	27.4+MU	
		RF=REFD, RO=DETE, RP=REPT, US=PREM (ME=TELE)	45.4+MU	
		RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE)	45.4+MU	
OFFICE				
VIST	03.04	Initial Visit with Complete Examination		
		LO=OFFC (RF=REFD)	24	
VIST	03.04	Subsequent Visit with Complete Re-Examination		
		LO=OFFC, RP=SUBS (RF=REFD)	12	
VIST	03.04D	Geriatrician's Initial Comprehensive Geriatric Consultation to include CGA* (Comprehensive Geriatric Assessment)		
		LO=OFFC	150	
		*Physician Restrictions in Place (See Appendix J)		
VIST	03.03	Subsequent Visit with Regional Exam		
		LO=OFFC, RP=SUBS (ME=VTCR*) (RF=REFD)	13	
		*Physician Restrictions in Place (See Appendix J)		

VIST 03.03A Geriatric Office Visit (for patients aged 65+)
LO=OFFC (ME=VTCR*) (RF=REFD) 16.5
*Physician Restrictions in Place (See Appendix J)

VIST 03.03 Continuing Care
LO=OFFC, RO=CNTC, RF=REFD 13.5
LO=OFFC, AG=OV65, RO=CNTC, RF=REFD 16.5

VIST 03.03 Directive Care
LO=OFFC, RO=DIRC, RF=REFD 13.5
LO=OFFC, AG=OV65, RO=DIRC, RF=REFD 16.5

VIST 03.03 Urgent Care - Request by Patient (1701 - 2000)
LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Request by Patient (2001 - 2359)
LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Request by Patient (0000 - 0800)
LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) 38.3

VIST 03.03 Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Extra Patient
LO=OFFC, PT=EXPT (RF=REFD) 10.5

HOSPITAL (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

VIST 03.04 Initial Visit with Complete Examination
LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD) 24
LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD) ..... 24+MU

VIST 03.04 Initial Visit
LO=HOSP, FN=INPT, RP=INTL (RF=REFD) 25
LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD) ..... 25+MU

VIST 03.04B Screening for Potential Organ / Tissue Donor and Family Approach for Consent
..... 35

VIST 03.04D Geriatrician's Initial Comprehensive Geriatric Consultation to include CGA* (Comprehensive Geriatric Assessment)
LO=HOSP 150
*Physician Restrictions in Place (See Appendix J)

VIST 03.03 Continuing Care
LO=HOSP, FN=INCU, FN=NICU, RO=CNTC, RF=REFD 15
LO=HOSP, FN=INCU, FN=NICU, RO=CCDT, RF=REFD ..... 15+MU

VIST	03.03	Continuing Care	
		LO=HOSP, FN=INPT, RO=CNTC, RF=REFD	18.39
		LO=HOSP, FN=INPT, DA=DA23, RO=CNTC, RF=REFD	26.43
		LO=HOSP, FN=INPT, DA=DA47, RO=CNTC, RF=REFD	21.84
VIST	03.03	Directive Care	
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD	15
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD	15+MU
VIST	03.03	Subsequent Visit - Daily to 56 Days	
		LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD)	15
		LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD)	15+MU
VIST	03.03	Subsequent Visit - Weekly after 56 Days - Maximum 44 units per week	
		LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD)	15
		LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD)	15+MU
ADON	03.02A	Hospital Discharge Fee	
		LO=HOSP, FN=INPT	10
VIST	03.03	Urgent Hospital Visit	
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)	22
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD)	22+MU
VIST	03.03	Hospital Emergency Visit	
		LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)	35.2
		LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)	35.2+MU
VIST	03.03	Outpatient Visit (0800 - 1700)	
		LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD)	13.5
		LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD)	13.5+MU
VIST	03.03	Outpatient Visit (1701 - 2000)	
		LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD)	20
		LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD)	20+MU
VIST	03.03	Outpatient Visit (2001 - 2359)	
		LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD)	20
		LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD)	20+MU
VIST	03.03	Outpatient Visit (0000 - 0800)	
		LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)	26
		LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)	26+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Sat., Sun., Holidays	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)	20
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)	20+MU

VIST	03.03	Outpatient Visit (1201 - 1700) Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)..... 20 LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD)..... 7 LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 7+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD) ..... 7 LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 7+MU
VIST	03.03	Outpatient Visit (1701 - 2000) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD) 10.5
VIST	03.03	Outpatient Visit (2001 - 2359) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD)..... 10.5 LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD)..... 10.5+MU
VIST	03.03	Outpatient Visit (0000 - 0800) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) ..... 11.4 LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) ..... 11.4+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD)..... 10.5 LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 10.5+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) ..... 10.5 LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 10.5+MU

CANCER PATIENT

VIST	03.04	Comprehensive reassessment of a cancer patient RO=CAPT RP=SUBS..... 25
VIST	03.03	Telephone advice and medical chart review of a cancer patient by the Oncologist RO=TCCP 11.5

PROCEDURES

OTHER NONOPERATIVE BRONCHOSCOPY

VADT	01.09D	Bronchoscopy and endobronchial ultrasound (EBUS) with sampling of one or two mediastinal nodal stations and or hilar nodal stations or structures..... 125
VADT	01.09E	Bronchoscopy and endobronchial ultrasound (EBUS) with sampling of three or more nodal stations and or hilar nodal stations or structures..... 150

OTHER NONOPERATIVE MEASUREMENTS AND EXAMINATIONS OF NERVOUS SYSTEM AND SENSE ORGANS NEC

VADT 03.19C Sleep studies - plus multiples, if applicable
RO=INTP, SP=RSMD 60

VADT 03.19F Level II Sleep Apnea Testing Interpretation
(SP=INMD) (SP=RSMD) 35

VADT 03.19G Level III Sleep Apnea Testing Interpretation
(SP=INMD) (SP=RSMD) 25

CARDIOVASCULAR STRESS TEST USING BICYCLE ERGOMETER

VADT 03.43 Cardiovascular stress test using bicycle ergometer 38

OTHER CARDIOVASCULAR STRESS TEST

VADT 03.44A Myocardial perfusion study includes IV set-up and medication 48

VADT 03.44B Graded testing utilizing treadmill with continuous ECG monitoring 38

OTHER ASTHMA ASSESSMENT

VEDT 03.38A Bronchial challenge testing with methacholine or similar compounds-
Includes baseline spirometry and all spirometric determinations post
Administration of agent(s) RO=INTP 19

VEDT 03.38B Exercise Induced Asthma Assessment, interpretation.
Includes interpretation of all serial spirometry, flow/volume loops, bronchodilation
responsiveness, and oximetry required to assess the patient. 20

VEDT 03.38C Interpretation of spirometry pre and post bronchodilator 10

VEDT 03.38D Six Minute Walk Test, interpretation, when this is the sole procedure 2

ACUTE STROKE PROTOCOL

VEDT 13.99F Assessment and management of patient with Acute Stroke 130
From activation of Acute Stroke Protocol through completion of
Thrombolytic therapy (e.g., t-PA)

OTHER REPLACEMENT OF AORTIC VALVE

VEDT 47.25C Transcutaneous Aortic Valve Implantation/Replacement (TAVI)
RO=FPHN 611
RO=SPHN 611

CHRONIC DIALYSIS *Physician Restrictions in Place (See Appendix J)

VEDT 51.95A Chronic Dialysis – treatment and supervision of care for a patient with
end stage kidney disease, in hospital (hemodialysis or peritoneal dialysis)
or in central outpatient hemodialysis units for a 24-hour period. 12.11

VEDT 51.95B Chronic Hemodialysis – treatment and supervision of care for the patient
with end stage kidney disease, in an urban satellite hemodialysis unit as
designated by the Health Authority for a 24-our period 12.11

VEDT	51.95C	Chronic hemodialysis – treatment and supervision of care, in a rural satellite hemodialysis unit as designated by the Health Authority for a 24-hour period	12.11
VEDT	51.95D	Chronic Dialysis – treatment and supervision of care for the patient on home peritoneal dialysis or home hemodialysis for a 24-hour period ME=PERI, ME=HEMO	12.11

INTERPRETATIONS

The service date of electronic claims should be the date the patient had the procedure conducted and not the date the interpretation was completed (if they differ). The fee is for the interpretation.

These codes must be claimed from LO=HOSP[1]

ELECTRO DIAGNOSTICS

BULK	I1168	Electrocardiogram - interpretation	4.60
BULK	I1171	Electroencephalogram – interpretation only	10.50
BULK	I6208	Holter monitoring – interpretation only	25

PULMONARY FUNCTIONS

BULK	I1110	Simple Spirometry	5
BULK	I1140	Flow/volume loops	5
BULK	I1210	Helium dilution	5
BULK	I1410	Carbon monoxide single breath	5
BULK	I1710	Pulmonary stress test	20
BULK	I1120	Bedside spirometry	5
BULK	I1230	Body plethysmography	5

ECHOCARDIOGRAPHY

BULK	I1311	M – mode	25.44
BULK	I1310	Two dimensional	47.56
BULK	I1312	Doppler – quantitative	30.45
BULK	I1313	Doppler – qualitative	15.23

[1] Specialties SP=INMD and SP=RSMD may claim health service codes I1110 and I1140 from locations LO=OFFC, LO=OTHER or LO=HOME. These locations are restricted to the mobile INSPIRED program and physicians are required to enter 'INSPIRED' in the text field of the MSI claim when submitting claims for this program.

NEUROLOGY

(SP=NEUR)

For further details refer to the Preamble.

CATEGORY	HEALTH SERVICE CODE	DESCRIPTION / MODIFIERS	BASE UNITS	ANAES UNITS
CONSULTATIONS				
CONS	03.08	Comprehensive Consultation (Prolonged)		
		RF=REFD (ME=TELE)	62+MU	
		RF=REFD, US=PREM (ME=TELE)	83.7+MU	
		RF=REFD, US=PR50 (ME=TELE)	93+MU	
		RF=REFD, RO=DETE (ME=TELE)	62+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	83.7+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	93+MU	
CONS	03.07	Limited Consultation		
		RF=REFD (ME=TELE)	37	
		RF=REFD, US=PREM (ME=TELE)	55	
		RF=REFD, US=PR50 (ME=TELE)	55.5	
		RF=REFD, RO=DETE (ME=TELE)	37+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	55+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	55.5+MU	
CONS	03.07	Repeat Consultation (Prolonged)		
		RF=REFD, RP=REPT (ME=TELE)	27.1+MU	
		RF=REFD, RP=REPT, US=PREM (ME=TELE)	45.1+MU	
		RF=REFD, RP=REPT, US=PR50 (ME=TELE)	45.1+MU	
		RF=REFD, RO=DETE, RP=REPT (ME=TELE)	27.1+MU	
		RF=REFD, RO=DETE, RP=REPT US=PREM, (ME=TELE)	45.1+MU	
		RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE)	45.1+MU	
OFFICE				
VIST	03.04	Initial Visit with Complete Examination		
		LO=OFFC (RF=REFD)	24	
VIST	03.04	Subsequent Visit with Complete Re-Examination		
		LO=OFFC, RP=SUBS (RF=REFD)	12	
VIST	03.03	Subsequent Visit with Regional Exam		
		LO=OFFC, RP=SUBS (RF=REFD)	13	
VIST	03.03A	Geriatric Office Visit (for patients aged 65+)		
		LO=OFFC (RF=REFD)	16.5	
VIST	03.03	Continuing Care		
		LO=OFFC, RO=CNTC, RF=REFD	13.5	
		LO=OFFC, AG=OV65, RO=CNTC, RF=REFD	16.5	

VIST	03.03	Directive Care LO=OFFC, RO=DIRC, RF=REFD ..... 13.5 LO=OFFC, AG=OV65, RO=DIRC, RF=REFD 16.5
VIST	03.03	Urgent Care - Request by Patient (1701 - 2000) LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) 28.3
VIST	03.03	Urgent Care - Request by Patient (2001 - 2359) LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) 28.3
VIST	03.03	Urgent Care - Request by Patient (0000 - 0800) LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) 38.3
VIST	03.03	Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) 28.3
VIST	03.03	Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) 28.3
VIST	03.03	Urgent Care - Extra Patient LO=OFFC, PT=EXPT (RF=REFD) 10.5

HOSPITAL (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

VIST	03.04	Initial Visit with Complete Examination LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD) ..... 24 LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD) ..... 24+MU
VIST	03.04	Initial Visit LO=HOSP, FN=INPT, RP=INTL (RF=REFD) ..... 25 LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD) ..... 25+MU
VIST	03.03	Continuing Care LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC, RF=REFD ..... 15 LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT, RF=REFD ..... 15+MU
VIST	03.03	Directive Care LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD ..... 15 LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD ..... 15+MU
VIST	03.03	Subsequent Visit - Daily to 56 Days LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) ..... 15 LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU
VIST	03.03	Subsequent Visit - Weekly after 56 Days - Maximum 44 units per week LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD) ..... 15 LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU
ADON	03.02A	Hospital Discharge Fee LO=HOSP, FN=INPT 10

VIST	03.03	Urgent Hospital Visit LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)..... 22 LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD)..... 22+MU
VIST	03.03	Hospital Emergency Visit LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)..... 35.2 LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)..... 35.2+MU
VIST	03.03	Outpatient Visit (0800 - 1700) LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD)..... 13.5 LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD)..... 13.5+MU
VIST	03.03	Outpatient Visit (1701 - 2000) LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD)..... 20 LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD)..... 20+MU
VIST	03.03	Outpatient Visit (2001 - 2359) LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD)..... 20 LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD)..... 20+MU
VIST	03.03	Outpatient Visit (0000 - 0800) LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)..... 26 LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)..... 26+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)..... 20 LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)..... 20+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)..... 20 LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD)..... 20+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD)..... 7 LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 7+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD)..... 7 LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD)..... 7+MU
VIST	03.03	Outpatient Visit (1701 - 2000) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD)..... 10.5 LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD)..... 10.5+MU
VIST	03.03	Outpatient Visit (2001 - 2359) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD)..... 10.5 LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD)..... 10.5+MU

VIST 03.03 Outpatient Visit (0000 - 0800) Extra Patient
LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) 11.4
LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) ..... 11.4+MU

VIST 03.03 Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays
LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD)..... 10.5
LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 10.5+MU

VIST 03.03 Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays
LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) 10.5
LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 10.5+MU

PROCEDURES

OTHER NONOPERATIVE MEASUREMENTS AND EXAMINATIONS OF NERVOUS SYSTEM AND SENSE ORGANS NEC

VADT 03.19C Sleep studies - plus multiples, if applicable
RO=INTP..... 60

VADT 03.19F Level II Sleep Apnea Testing Interpretation..... 35

VADT 03.19G Level III Sleep Apnea Testing Interpretation..... 25

INJECTION OR INFUSION OF THERAPEUTIC OR PROPHYLACTIC SUBSTANCE NEC

VEDT 13.59O Injection of onabotulinumtoxinA for treatment of chronic migraine 70
(Prior Approval)

ACUTE STROKE PROTOCOL

VEDT 13.99F Assessment and management of patient with Acute Stroke 130
From activation of Acute Stroke Protocol through completion of Thrombolytic therapy (e.g., t-PA)

VEDT 13.99G Assessment and management of patient with Acute Stroke 170
From activation of Acute Stroke Protocol through receiving endovascular Thrombectomy (EVT) with or without administration of thrombolytic therapy

INTERPRETATIONS

The service date of electronic claims should be the date the patient had the procedure conducted and not the date the interpretation was completed (if they differ). The fee is for the interpretation.

Code must be claimed from LO=HOSP

ELECTRO DIAGNOSTICS

BULK I6208 Holter monitoring – interpretation only..... 25

NEUROSURGERY

(SP=NUSG)

For further details refer to the Preamble.

CATEGORY	HEALTH SERVICE CODE	DESCRIPTION / MODIFIERS	BASE UNITS	ANAES UNITS
CONSULTATIONS				
CONS	03.08	Comprehensive Consultation		
		RF=REFD (ME=TELE)	40.3	
		RF=REFD, US=PREM (ME=TELE)	58.3	
		RF=REFD, US=PR50 (ME=TELE)	60.45	
		RF=REFD, RO=DETE (ME=TELE)	40.3+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	58.3+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	60.45+MU	
CONS	03.07	Limited Consultation		
		RF=REFD (ME=TELE)	24.5	
		RF=REFD, US=PREM (ME=TELE)	42.5	
		RF=REFD, US=PR50 (ME=TELE)	42.5	
		RF=REFD, RO=DETE (ME=TELE)	24.5+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	42.5+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	42.5+MU	
CONS	03.07	Repeat Consultation		
		RF=REFD, RP=REPT (ME=TELE)	22.5	
		RF=REFD, RP=REPT, US=PREM (ME=TELE)	40.5	
		RF=REFD, RP=REPT, US=PR50 (ME=TELE)	40.5	
		RF=REFD, RO=DETE, RP=REPT (ME=TELE)	22.5+MU	
		RF=REFD, RO=DETE, RP=REPT, US=PREM (ME=TELE)	40.5+MU	
		RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE)	40.5+MU	
OFFICE				
VIST	03.04	Initial Visit with Complete Examination		
		LO=OFFC (RF=REFD)	24	
VIST	03.03	Initial Visit with Regional Examination		
		LO=OFFC, RP=INTL (RF=REFD)	12	
		LO=OFFC, AG=OV65, RP=INTL (RF=REFD)	16.5	
VIST	03.03	Subsequent Visit		
		LO=OFFC, RP=SUBS (ME=VTCR*) (RF=REFD)	13	
		*Physician Restrictions in Place (See Appendix J)		
VIST	03.03A	Geriatric Office Visit (for patients aged 65+)		
		LO=OFFC (ME=VTCR*) (RF=REFD)	16.5	
		*Physician Restrictions in Place (See Appendix J)		

VIST	03.03	Continuing Care	
		LO=OFFC, RO=CNTC, RF=REFD	13.5
		LO=OFFC, AG=OV65, RO=CNTC, RF=REFD	16.5
VIST	03.03	Directive Care	
		LO=OFFC, RO=DIRC, RF=REFD	13.5
		LO=OFFC, AG=OV65, RO=DIRC, RF=REFD	16.5
VIST	03.03	Urgent Care - Request by Patient (1701 - 2000)	
		LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD)	28.3
VIST	03.03	Urgent Care - Request by Patient (2001 - 2359)	
		LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD)	28.3
VIST	03.03	Urgent Care - Request by Patient (0000 - 0800)	
		LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)	38.3
VIST	03.03	Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays	
		LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD)	28.3
VIST	03.03	Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays	
		LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD)	28.3
VIST	03.03	Urgent Care - Extra Patient	
		LO=OFFC, PT=EXPT (RF=REFD)	10.5

HOSPITAL (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

VIST	03.04	Initial Visit with Complete Examination	
		LO=HOSP, FN=EMCC FN=OTPT (RF=REFD)	24
		LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD)	24+MU
VIST	03.04	Closed Head Injury - Initial Examination and Recommendation Re Further Management	
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, FN=OTPT, FN=EMCC,	
		RO=CLHD, RP=INTL (RF=REFD)	30
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, FN=OTPT, FN=EMCC,	
		RO=CHDT, RP=INTL (RF=REFD)	30+MU
VIST	03.03	Daily Management in Hospital, Per Day	
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, DA=DALY, RO=CLHD (RF=REFD)	7
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, DA=DALY, RO=CHDT (RF=REFD)	7+MU
VIST	03.04	Initial Visit	
		LO=HOSP, FN=INPT, RP=INTL (RF=REFD)	25
		LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD)	25+MU
VIST	03.03	Continuing Care	
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC, RF=REFD	15
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT, RF=REFD	15+MU

VIST	03.03	Directive Care LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD ..... 15 LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD ..... 15+MU
VIST	03.03	Subsequent Visit - Daily to 56 Days LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) ..... 15 LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU
VIST	03.03	Subsequent Visit - Weekly after 56 Days - Maximum 44 units per week LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD) ..... 15 LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU
ADON	03.02A	Hospital Discharge Fee LO=HOSP, FN=INPT 10
VIST	03.03	Urgent Hospital Visit LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)..... 22 LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DETE, US=UNOF (RF=REFD)..... 22+MU
VIST	03.03	Hospital Emergency Visit LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)..... 35.2 LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)..... 35.2+MU
VIST	03.03	Outpatient Visit (0800 - 1700) LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD) ..... 13.5 LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD) ..... 13.5+MU
VIST	03.03	Outpatient Visit (1701 - 2000) LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 20 LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU
VIST	03.03	Outpatient Visit (2001 - 2359) LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 20 LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU
VIST	03.03	Outpatient Visit (0000 - 0800) LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)..... 26 LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)..... 26+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)..... 20 LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)..... 20+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)..... 20 LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU

VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD) 7	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD) ..... 7+MU	
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD) 7	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 7+MU	
VIST	03.03	Outpatient Visit (1701 - 2000) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD) 10.5	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD) ..... 10.5+MU	
VIST	03.03	Outpatient Visit (2001 - 2359) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD) 10.5	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD) ..... 10.5+MU	
VIST	03.03	Outpatient Visit (0000 - 0800) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) 11.4	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) ..... 11.4+MU	
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD)..... 10.5	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 10.5+MU	
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) 10.5	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 10.5+MU	

PROCEDURES

APPLICATION OF PLASTER JACKET

MISG	07.51A	Vertebral fracture/other trauma without cord injury - body plaster 25	

APPLICATION OF NECK SUPPORT

MISG	07.52A	Vertebral fracture/other trauma without cord injury - Minerva plaster jacket 40	
MISG	07.52B	Vertebral fracture/other trauma without cord injury - plaster collar 30	

OTHER CRANIOTOMY

MASG	14.13A	Skull trauma - decompression craniectomy - subtemporal (regions required)..... 300		14+T
MASG	14.13B	Skull trauma - decompression craniectomy - suboccipital (regions required)..... 524		14+T
MASG	14.13C	Burr holes - diagnostic - plus multiples, if applicable 141		9+T
MASG	14.13D	Craniotomy for craniofacial repair..... 675		14+T

MASG	14.13E	Extradural with burr holes	269	9+T
MASG	14.13F	Extradural with craniotomy	423	14+T
MASG	14.13G	Trephine/burr hole with cerebral needling for aspiration or injection or biopsy	212	9+T
MASG	14.13H	Surgical management of brain abscess by craniotomy - to include multiple taps or procedures	564	14+T

OTHER CRANIECTOMY

MAAS	14.14A	Craniectomy for osteomyelitis	IC	14+T
MASG	14.14B	Removal of infected bone flap	175	14+T

INCISION OF CEREBRAL MENINGES

MASG	14.21A	Subdural with burr holes	269	9+T
MASG	14.21B	Subdural with craniotomy	423	14+T
MASG	14.21C	Subdural by repeated aspiration AG=CH16	150	9+T

LOBOTOMY AND TRACTOTOMY

MASG	14.22	Lobotomy and tractotomy (regions required)	200	14+T
MASG	14.22A	Craniotomy for medullary or mesencephalic tractotomy	652	14+T

OTHER INCISION OF BRAIN

MASG	14.29A	Surgical management of brain abscess by burr hole to include multiple taps or procedures	564	9+T
MASG	14.29B	Craniotomy - removal of foreign body	467	14+T
MASG	14.29C	Craniotomy for removal cyst, tumour, pituitary tumour, intracerebral hematoma, lobectomy - plus multiples, if applicable	608	14+T

OPERATIONS ON THALAMUS AND GLOBUS PALLIDUS (INCLUDING ANSA AND CINGULUS)

MASG	14.3B	Stereotactic thalamotomy, pallidotomy, cingulotomy with depth recording and stimulation	400	14+T
MASG	14.3C	CT-Guided stereotactic surgery includes biopsy, chemotherapy, radiotherapy, draining abscess, deep brain stimulation, includes attendance by Neurosurgeon at imaging localization	662	9+T

HEMISPHERECTOMY

MASG	14.42	Hemispherectomy (regions required)	765	14+T

LOBECTOMY OF BRAIN

MASG	14.43	Lobectomy of brain - plus multiples, if applicable	608	14+T

OTHER EXCISION OR DESTRUCTION OF LESION OR TISSUE OF BRAIN

MASG	14.49A	Craniotomy for removal of acoustic neuroma	961	14+T
MASG	14.49B	Craniotomy for excision of cortical scar for epilepsy	890	14+T
MASG	14.49C	Craniotomy for excisional brain biopsy	410	14+T
MASG	14.49D	Craniotomy for obliteration of cerebral aneurysm	809	14+T
MASG	14.49E	Craniotomy for arteriovenous malformation	809	14+T
MASG	14.49F	Craniotomy with clipping of internal carotid intracranially or of feeding blood vessel to arteriovenous malformation	375	14+T
MASG	14.49G	Craniotomy for carotid-cavernous fistula	550	14+T
MASG	14.49H	Craniotomy - by direct attack	800	14+T
MASG	14.49I	Craniotomy - by embolization	400	14+T
MASG	14.49J	Posterior fossa craniotomy	975	14+T

EXCISION OF LESION OF SKULL

MASG	14.5A	Linear craniectomy for craniosynostosis excision of skull tumour	170	14+T

OTHER CONTRAST RADIOGRAM OF BRAIN AND SKULL

MASG	14.85	Other contrast radiogram of brain and skull AP=PERC	75	7+T
MISG	14.85A	Ventriculogram by drill or burr hole	45	7+T

OPENING OF CRANIAL SUTURE

MASG	15.01A	Linear craniectomy for craniosynostosis - one suture	229	14+T
MASG	15.01B	Linear craniectomy for craniosynostosis - more than one suture	350	14+T

ELEVATION OF SKULL FRACTURE FRAGMENTS

MASG	15.02A	Simple depressed fracture of skull - dura lacerated	268	14+T
MASG	15.02B	Simple depressed fracture of skull - dura intact	198	10+T
MASG	15.02C	Compound depressed fracture of skull - dura intact	269	14+T
MASG	15.02D	Compound depressed fracture of skull - dura lacerated	339	14+T

MASG	15.02E	Compound depressed fracture of skull - sinus involvement/serious brain damage (foreign body, hematoma, etc)	339	14+T
MASG	15.02F	Simple depressed fracture of skull - serious brain damage	300	14+T

OTHER CRANIAL OSTEOPLASTY

MASG	15.06	Other cranial osteoplasty	298	14+T
MASG	15.06B	Craniotomy - replacement of bone flap	220	14+T

OTHER REPAIR OF CEREBRAL MENINGES

ADON	15.12B	Duraplasty	125	
MASG	15.12C	Repair of cerebro-spinal fluid leak by craniotomy (regions required)	564	14+T

VENTRICULOSTOMY

MASG	15.2	Ventriculostomy (regions required)	251	14+T
MASG	15.2A	Endoscopic third ventriculostomy	250	14+T

VENTRICULAR SHUNT TO CIRCULATORY SYSTEM

MASG	15.32A	Ventriculoatrial shunt (Holter or Pudenz valve)	251	14+T

VENTRICULAR SHUNT TO ABDOMINAL CAVITY AND ORGANS

MASG	15.34	Ventricular shunt to abdominal cavity and organs	251	14+T

OTHER OPERATIONS TO ESTABLISH DRAINAGE OF VENTRICLE

MASG	15.39	Other operations to establish drainage of ventricle (continuous)	114	14+T

REPLACEMENT OF VENTRICULAR SHUNT

MASG	15.42A	Revision of shunt	177	14+T
		CO=UN5K		19+T
MASG	15.42B	Exteriorization of distal end cerebro-spinal fluid shunt	55	8+T

REMOVAL OF VENTRICULAR SHUNT

MASG	15.43	Removal of ventricular shunt	110	14+T

INSERTION OF INTRACRANIAL PRESSURE MONITOR

MASG	15.94	Insertion of intracranial pressure monitor	168	

OTHER EXPLORATION AND DECOMPRESSION OF SPINAL CANAL

MASG	16.09A	Laminectomy for decompression of spinal cord anterior or posterior		
		AP=CERV	322	8+T
		AP=DRSL	236	7+T
		AP=LMBR	236	7+T

MASG	16.09B	Laminectomy for treatment of epidural abscess	300	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T
MASG	16.09C	Laminectomy for exploration of syringomyelic cavity	423	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T
MASG	16.09D	Laminectomy for excision of hematoma of spinal cord or nerve roots	467	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T
MASG	16.09F	Neural arch with nerve root exploration - unilateral or bilateral - with or without discectomy to include laminectomy, laminotomy or foraminotomy - 1 level	240	7+T
MASG	16.09G	Neural arch with nerve root exploration - unilateral or bilateral - with or without discectomy to include laminectomy, laminotomy or foraminotomy - 2 levels	280	7+T
MASG	16.09H	Neural arch with nerve root exploration - unilateral or bilateral - with or without discectomy to include laminectomy, laminotomy or foraminotomy - 3 or more levels	325	7+T
MASG	16.09I	Multiple level anterior decompression (vertebrectomy) to include fusion and/or internal fixation and harvesting of graft	600	11+T
MASG	16.09J	Cervical laminoplasty	500	8+T

DIVISION OF INTRASPINAL NERVE ROOT

MASG	16.1A	Laminectomy for anterior or posterior rhizotomy	456	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T
MASG	16.1B	Laminectomy for rhizotomy torticollis including spinal accessory nerve	350	6+T

CHORDOTOMY

MAAS	16.2	Chordotomy		
		AP=PERC	IC	9+T
MASG	16.2A	Laminectomy for spinothalamic tractotomy (cordotomy) - unilateral (Regions required)	510	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T

MASG	16.2B	Laminectomy for spinothalamic tractotomy (cordotomy) - bilateral	510	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T

EXCISION OR DESTRUCTION OF LESION OF SPINAL CORD AND SPINAL MENINGES

MASG	16.3A	Laminectomy for opening of dura and exploration or biopsy of cord or nerve roots or section of dentate ligaments	350	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T
MASG	16.3B	Laminectomy for excision of neoplasm, vascular anomaly, constrictive pachymeningitis of spinal cord or nerve roots	467	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T
MASG	16.3C	Dorsal root entry zone lesions (DREZ)	543	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T

REPAIR OF (SPINAL) MENINGOCELE

MASG	16.41	Repair of (spinal) meningocele	228	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T
MASG	16.41A	Gardner Procedure operation for syringomyelia	575	14+T

REPAIR OF (SPINAL) MYELOMENINGOCELE

MASG	16.42	Repair of (spinal) myelomeningocele or encephalocele		
		AP=CERV	310	11+T
		AP=DRSL	310	11+T
		AP=LMBR	310	11+T
MASG	16.42A	Bischoff's tractotomy or modifications	510	7+T
MASG	16.42B	Rickham Reservoir	150	11+T

REPAIR OF VERTEBRAL FRACTURE

MASG	16.43A	Open reduction without cord injury	200	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T
MASG	16.43B	Open reduction with internal fixation without cord injury	285	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T

MASG	16.43C	Open reduction and fusion in conjunction with Orthopaedic Surgeon		
		SP=NUSG	225	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T
MASG	16.43D	Injury - antero-lateral decompression of thoracic spinal cord	425	7+T
MASG	16.43E	Open reduction with cord injury	250	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T
MASG	16.43F	Open reduction with internal fixation with cord injury	275	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T
MASG	16.43G	Open reduction and fusion in conjunction with Orthopaedic Surgeon		
		SP=NUSG	200	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T
MAFR	16.43H	Spine fracture or fracture dislocation - anterior cervical decompression and/or fusing	300	7+T
MAFR	16.43I	Spine fracture or fracture dislocation - open reduction with decompression of cord or nerve roots	300	7+T
MAFR	16.43J	Spine fracture or fracture dislocation - open reduction	200	7+T
MASG	16.43K	Reduction, internal fixation C1-C2 including harvesting of bone graft if by same surgeon	365	11+T

OTHER REPAIR AND PLASTIC OPERATION ON SPINAL CORD STRUCTURES

MASG	16.49A	Laminectomy for repair of disastematomyelia	460	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T

FREEING OF ADHESIONS OF SPINAL CORD AND NERVE ROOTS

MASG	16.5A	Laminectomy for repair of spinal lipomeningocele (To include release of tethered spinal cord)	554	11+T
MASG	16.5B	Laminectomy for intradural section of tethered conus	424	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T

SPINAL SUBARACHNOID-PERITONEAL SHUNT

MASG	16.61	Spinal subarachnoid-peritoneal shunt	251	14+T

SPINAL SUBARACHNOID-URETERAL SHUNT

MASG	16.62A	Lumboureteral shunt	300	14+T

CONTRAST MYELOGRAM

MISG	16.83	Contrast myelogram		
		AP=CERV	40.8	5+T
		AP=LMBR	30.6	4+T

INSERTION OR REPLACEMENT OF SPINAL NEUROSTIMULATOR

MASG	16.93D	Laminectomy for implantation of spinal cord stimulating electrode	307	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T
MASG	16.93E	Implantation of stimulation pack for cord stimulation system	140	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T

REMOVAL OF NEUROSTIMULATOR FROM SPINAL CANAL

MASG	16.94	Removal of neurostimulator from spinal canal or revision	120	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T

DIVISION OF TRIGEMINAL NERVE

MASG	17.03A	Percutaneous trigeminal rhizotomy (regions required)	217	6+T
MASG	17.03B	Subtemporal craniectomy and rhizotomy of V nerve (regions required)	275	14+T

DIVISION OR CRUSHING OF Other CRANIAL AND PERIPHERAL NERVES

MASG	17.04A	Rhizotomy including MacKenzie Procedure	510	14+T

OTHER INCISION OF CRANIAL AND PERIPHERAL NERVES

MASG	17.05A	Extracranial section of spinal accessory, nerve and/or other peripheral nerves for treatment of spasmodic torticollis	100	6+T
MASG	17.05B	Exploration of brachial plexus (regions required)	315	6+T
MASG	17.05C	Sciatic nerve exploration and neurolysis	200	4+T
MASG	17.05D	Explore peripheral nerve transplant or transposition with/without neurolysis (Excluding median nerve at the carpal tunnel)	100	4+T

OTHER EXCISION OR AVULSION OF CRANIAL AND PERIPHERAL NERVES

MASG	17.08B	Neurectomy, major nerve	85	4+T
MASG	17.08C	Avulsion of mandibular, supraorbital, infraorbital occipital nerves (Regions required)	85	4+T
MASG	17.08D	Excision of nerve tumour	190	4+T
MASG	17.08E	Excision of Morton's neuroma (regions required)	76	4+T
MASG	17.08F	Inguinal neurectomy (regions required)	130	4+T
MASG	17.08G	Retroperitoneal neurectomy	160	6+T

DESTRUCTION OF CRANIAL AND PERIPHERAL NERVES

MISG	17.1F	Chemical destruction	35	

SUTURE OF CRANIAL AND PERIPHERAL NERVES

MASG	17.2A	Peripheral nerves - primary suture, major nerve	100	4+T

DECOMPRESSION OF TRIGEMINAL NERVE ROOT

MASG	17.31A	Decompression of Gasserian ganglion	255	14+T

OTHER CRANIAL NERVE DECOMPRESSION

MASG	17.32	Other cranial nerve decompression	570	14+T

OTHER PERIPHERAL NERVE OF GANGLION DECOMPRESSION OR FREEING OF ADHESIONS

MASG	17.39A	Entrapment syndrome	85	4+T
MASG	17.39B	Neuroplasty of major peripheral nerve of the upper extremity (excluding median nerve at the carpal tunnel, and ulnar nerve at the elbow). Specifically; Guyon's Canal (ulnar nerve release at wrist), anterior interosseous nerve (median nerve in forearm),posterior interosseus nerve (radial nerve in forearm wrist) (regions required)	125	4+T
MASG	17.39C	Neuroplasty of major peripheral nerve of the lower extremity. Specifically; Peroneal nerve release, tarsal tunnel (posterior tibial nerve) (regions required)	125	4+T

CRANIAL OR PERIPHERAL NERVE GRAFT

MASG	17.4A	Grafting of VII cranial nerve	350	14+T

TRANSPOSITION OF CRANIAL AND PERIPHERAL NERVES

MASG	17.5A	Exploration of peripheral nerve transplant or nerve transposition with or without neurolysis (excluding median nerve at carpal tunnel)	100	4+T

MASG	17.5B	Ulnar nerve release at the elbow (cubital tunnel) (regions required)	125	4+T
		RP=REPT	200	4+T

ANASTOMOSIS OF CRANIAL OR PERIPHERAL NERVE

MASG	17.61A	Facial hypoglossal or facial accessory nerve anastomosis	304	6+T
MASG	17.61C	Repair of peripheral nerve - major primary suture (regions required)	100	4+T

IMPLANTATION OR REPLACEMENT OF PERIPHERAL NEUROSTIMULATOR

MASG	17.92C	Vagal nerve stimulator implantation	200	7+T
MASG	17.92D	Vagal nerve stimulator battery change	100	7+T

CERVICAL SYMPATHECTOMY

MASG	18.12	Cervical sympathectomy	200	6+T
MASG	18.12A	Cervical - dorsal sympathectomy (regions required)	150	10+T

LUMBAR SYMPATHECTOMY

MASG	18.13	Lumbar sympathectomy (regions required)	200	6+T

OTHER SYMPATHECTOMY AND GANGLIONECTOMY

MASG	18.19A	Thoracolumbar - complete (Smithwick)	400	3+T
MASG	18.19B	Sympathectomy - dorsal (regions required)	150	10+T

PARTIAL EXCISION OF PITUITARY GLAND, TRANSFRONTAL APPROACH

MASG	20.51	Partial excision of pituitary gland, transfrontal approach - plus multiples, if applicable	608	14+T
MASG	20.51A	Craniotomy for hypophysectomy	365	14+T

PARTIAL EXCISION OF PITUITARY GLAND, TRANSSPHENOIDAL APPROACH

MASG	20.52A	Transphenoidal microsurgery of pituitary fossa for removal of tumour	651	14+T

TOTAL EXCISION OF PITUITARY GLAND, TRANSSPHENOIDAL APPROACH

MASG	20.55A	Transphenoidal hypophysectomy	400	15+T

OTHER ORBITOTOMY

MASG	29.09A	Skull trauma - craniotomy for orbital decompression (regions required)	554	14+T

ENDARTERECTOMY OF OTHER VESSELS OF HEAD AND NECK

MASG	50.12	Endarterectomy of other vessels of head and neck (regions required)	271	10+T
MASG	50.12B	Vertebral endarterectomy with patch graft	300	14+T
MASG	50.12C	Carotid endarterectomy - with graft and by-pass shunt (regions required)	300	10+T
MASG	50.12D	Carotid endarterectomy - with patch graft (regions required)	300	10+T

RESECTION OF INTRACRANIAL VESSELS WITH ANASTOMOSIS

MASG	50.21A	Superficial temporal to middle cerebral branch anastomosis (regions required)	625	14+T

RESECTION OF INTRACRANIAL VESSELS WITH REPLACEMENT

MASG	50.31A	Intracranial arterial reconstructive surgery	400	14+T

OTHER SURGICAL OCCLUSION OF INTRACRANIAL VESSELS

MASG	50.71C	Cerebral embolization - intracranial	350	14+T
MASG	50.71D	Embolization of intracranial arteriovenous malformations with glue - congenital and acquired - 1st pedicle - plus multiples, if applicable	350	14+T
		(each additional pedicle)	175	

OTHER SURGICAL OCCLUSION OF OTHER VESSELS OF HEAD AND NECK

MASG	50.72B	Cerebral embolization - extracranial	250	14+T
MASG	50.72C	Ligation of carotid (regions required)	150	5+T

BIOPSY OF BLOOD VESSEL

MISG	50.97A	Biopsy of temporal artery (regions required)	35	4+T

CLIPPING OF ANEURYSM

MASG	51.51	Clipping of aneurysm (Silverstone clamp)	168	10+T

OTHER REPAIR OF ANEURYSM

MASG	51.52A	Endovascular occlusion of cerebral aneurysm	809	14+T

OTHER PARTIAL OSTECTOMY, OTHER SPECIFIED SITE

MASG	89.78A	Spinal trauma - fracture of spinous process (surgical removal)	75	5+T

CLOSED REDUCTION OF FRACTURE (WITHOUT INTERNAL FIXATION), OTHER SPECIFIED BONE

MASG	91.08L	Spinal trauma without cord injury cranio-skeletal traction tongs	85	5+T
		AN=GENL	110	5+T
MASG	91.08M	Spinal trauma with cord injury cranio-skeletal traction tongs	85	5+T
		AN=GENL	110	5+T

EXCISION OF INTERVERTEBRAL DISC

MASG	92.31	Excision or destruction of intervertebral disc		
		AP=CERV (regions required)	303	8+T
		AP=LMBR (regions required)	212	7+T
MASG	92.31D	Discectomy - cervical or dorsal		
		AP=ANTE	573	
		AP=POST	250	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T
MASG	92.31E	Discectomy - bilateral - recurrent or multiple levels		
		AP=LMBR	246	7+T
		AP=CERV		8+T
		AP=DRSL		7+T
MASG	92.31F	Removal of protruded disc - bilateral or multiple		
		AP=CERV	425	8+T
		AP=DRSL		7+T
		AP=LMBR		7+T
MASG	92.31G	Removal of protruded lumbar disc to include fusion and/or internal fixation if indicated		
		AP=ANTE	350	11+T

OTHER CERVICAL SPINAL FUSION

MASG	93.02A	Removal of anterior cervical disc and fusion - one space	366	8+T
MASG	93.02B	Removal of anterior cervical disc and fusion - two spaces	548	8+T

OTHER SPINAL FUSION

MASG	93.09A	Removal of lumbar disc or laminectomy in conjunction with Orthopaedic Surgeon for fusion		
		SP=NUSG (regions required)	210	7+T

OTHER REPAIR OF JOINT

MASG	93.96A	Cervical Total Disc Arthroplasty (artificial disc)	750	8+T

SUTURE OF SKIN AND SUBCUTANEOUS TISSUE OF OTHER SITES

MISG	98.22	Suture of skin and subcutaneous tissue of other sites - plus multiples, if applicable		
		ME=SIMP, AN=LOCL	11	
		ME=SIMP	11	
MAAS	98.22C	Scalp laceration - extensive, multiple or complicated	IC	4+T

SURGICAL PROCEDURES NOS

ADON	99.09A	Morbid obesity surgical add on	32.9	4.6

OBSTETRICS & GYNAECOLOGY

(SP=OBGY)

CATEGORY	HEALTH SERVICE CODE	DESCRIPTION / MODIFIERS	BASE UNITS	ANAES UNITS
CONSULTATIONS				
CONS	03.08	Comprehensive Consultation (Prolonged)		
		RF=REFD (ME=TELE)	40.1+MU	
		RF=REFD, US=PREM (ME=TELE)	58.1+MU	
		RF=REFD, US=PR50 (ME=TELE)	60.15+MU	
		RF=REFD, RO=DETE (ME=TELE)	35.1+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	53.1+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	53.1+MU	
CONS	03.07	Limited Consultation		
		RF=REFD (ME=TELE)	29.5	
		RF=REFD, US=PREM (ME=TELE)	47.5	
		RF=REFD, US=PR50 (ME=TELE)	47.5	
		RF=REFD, RO=DETE (ME=TELE)	24.5+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	42.5+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	42.5+MU	
CONS	03.07	Repeat Consultation (Prolonged)		
		RF=REFD, RP=REPT (ME=TELE)	27.5+MU	
		RF=REFD, RP=REPT, US=PREM (ME=TELE)	45.5+MU	
		RF=REFD, RP=REPT, US=PR50 (ME=TELE)	45.5+MU	
		RF=REFD, RO=DETE, RP=REPT (ME=TELE)	22.5+MU	
		RF=REFD, RO=DETE, RP=REPT, US=PREM (ME=TELE)	40.5+MU	
		RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE)	40.5+MU	
CONS	03.09G	Medical Management of Ectopic Pregnancy		
		RF=REFD	56	
		RF=REFD, US=PREM	75.6	
		RF=REFD, US=PR50	84	
OFFICE				
VIST	03.04	Initial Visit with Complete Examination		
		LO=OFFC (RF=REFD)	24	
VIST	03.03	Initial Visit with Regional Examination		
		LO=OFFC, RP=INTL (RF=REFD)	12	
		LO=OFFC, AG=OV65, RP=INTL (RF=REFD)	16.5	
VIST	03.03	Subsequent Visit		
		LO=OFFC, RP=SUBS (ME=VTCR*) (RF=REFD)	13	
		*Physician Restrictions in Place (See Appendix J)		

VIST	03.03A	Geriatric Office Visit (for patients aged 65+) LO=OFFC (ME=VTCR*) (RF=REFD) ..... 16.5 *Physician Restrictions in Place (See Appendix J)
VIST	03.03	Continuing Care LO=OFFC, RO=CNTC, RF=REFD ..... 13.5 LO=OFFC, AG=OV65, RO=CNTC, RF=REFD 16.5
VIST	03.03	Directive Care LO=OFFC, RO=DIRC, RF=REFD ..... 13.5 LO=OFFC, AG=OV65, RO=DIRC, RF=REFD 16.5
VIST	03.04	Complete Pregnancy Exam LO=OFFC, RO=ANTL, RP=INTL (RF=REFD) 29.7
VIST	03.03	Pre Natal Visit LO=OFFC, RO=ANTL, RP=SUBS (RF=REFD) 15.5
VIST	03.03	Routine Pre Natal Visit LO=OFFC, RO=ANTL, RP=SUBS 13
VIST	03.03	Post Natal Visit LO=OFFC, RO=PTNT, RF=REFD 22.6
VIST	03.03	Post Natal Care Visit LO=OFFC, RO=PTNT 19
VIST	03.03	Urgent Care - Request by Patient (1701 - 2000) LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) 28.3
VIST	03.03	Urgent Care - Request by Patient (2001 - 2359) LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) 28.3
VIST	03.03	Urgent Care - Request by Patient (0000 - 0800) LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) 38.3
VIST	03.03	Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) 28.3
VIST	03.03	Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) 28.3
VIST	03.03	Urgent Care - Extra Patient LO=OFFC, PT=EXPT (RF=REFD) 10.5

HOSPITAL (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

VIST	03.04	Initial Visit with Complete Examination	
		LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD)	24
		LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD)	24+MU
VIST	03.04	Initial Visit	
		LO=HOSP, FN=INPT, RP=INTL (RF=REFD)	25
		LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD)	25+MU
VIST	03.03	Continuing Care	
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC, RF=REFD	15
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT, RF=REFD	15+MU
VIST	03.03	Directive Care	
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD	15
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD	15+MU
VIST	03.03	Subsequent Visit - Daily to 56 Days	
		LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD)	15
		LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD)	15+MU
VIST	03.03	Subsequent Visit - Weekly after 56 Days - Maximum 44 units per week	
		LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD)	15
		LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD)	15+MU
ADON	03.02A	Hospital Discharge Fee	
		LO=HOSP, FN=INPT	10
VIST	03.03	Urgent Hospital Visit	
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)	22
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD)	22+MU
VIST	03.03	Post Partum Care; Per Visit	
		LO=HOSP, FN=INPT, RO=PTPP, DA=DA23	23
		LO=HOSP, FN=INPT, RO=PTPP, DA=DA47	19
		LO=HOSP, FN=INPT, RO=PTPP (RF=REFD)	16
VIST	03.03	Resuscitation of Newborn	
		LO=HOSP, FN=INPT, RO=RESC (RF=REFD)	50
		LO=HOSP, FN=INPT, RO=RESC, US=PREM (RF=REFD)	68
		LO=HOSP, FN=INPT, RO=RESC, US=PR50 (RF=REFD)	75
		LO=HOSP, FN=INPT, RO=RNDT (RF=REFD)	50+MU
		LO=HOSP, FN=INPT, RO=RNDT, US=PREM (RF=REFD)	68+MU
		LO=HOSP, FN=INPT, RO=RNDT, US=PR50 (RF=REFD)	75+MU
VIST	03.04	First Examination - Newborn Care	
		LO=HOSP, FN=INPT, RP=INTL, RO=NBCR (RF=REFD)	16
VIST	03.03	Subsequent Care - Newborn	
		LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS (RF=REFD)	16

VIST	03.03	Emergency Visit	
		LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)	35.2
		LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)	35.2+MU
VIST	03.03	Outpatient Visit (0800 - 1700)	
		LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD)	13.5
		LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD)	13.5+MU
VIST	03.03	Outpatient Visit (1701 - 2000)	
		LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD)	20
		LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD)	20+MU
VIST	03.03	Outpatient Visit (2001 - 2359)	
		LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD)	20
		LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD)	20+MU
VIST	03.03	Outpatient Visit (0000 - 0800)	
		LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)	26
		LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)	26+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Sat., Sun., Holidays	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)	20
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)	20+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Sat., Sun., Holidays	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)	20
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD)	20+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD)	7
		LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)	7+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD)	7
		LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD)	7+MU
VIST	03.03	Outpatient Visit (1701 - 2000) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD)	10.5
		LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD)	10.5+MU
VIST	03.03	Outpatient Visit (2001 - 2359) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD)	10.5
		LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD)	10.5+MU
VIST	03.03	Outpatient Visit (0000 – 0800) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD)	11.4
		LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD)	11.4+MU

VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD)..... 10.5 LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 10.5+MU	
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) ..... 10.5 LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 10.5+MU	

CANCER PATIENT

VIST	03.04	Comprehensive reassessment of a cancer patient RO=CAPT, RP=SUBS 25	

PROCEDURES

VAGINOSCOPY

MISG	01.36	Vaginoscopy..... 50	4+T

GYNECOLOGICAL EXAMINATION

MISG	03.26	Gynaecological examination and/or dilation AN=GENL..... 19	4+T

IMPLANTATION OR INSERTION OF RADIOACTIVE ELEMENTS

MASG	06.34A	Gold seed implants 90	
MASG	06.34B	Caesium needle implants..... 90	

INJECTION OR INSTILLATION OF RADIOISOTOPES

MISG	06.35A	Strontium 90 treatment..... 15	

INSERTION OF VAGINAL DIAPHRAGM

COCR	10.15	Insertion of vaginal diaphragm 15	

INSERTION OF OTHER VAGINAL PESSARY

VADT	10.16	Insertion of other vaginal pessary examination and insertion of pessary And 1 follow-up visit 33.16	

REMOVAL OF INTRAUTERINE CONTRACEPTIVE DEVICE (IUD)

MISG	11.71	Removal of intrauterine contraceptive device (IUD) AN=GENL..... 50	4+T

PRESACRAL SYMPATHECTOMY

MASG	18.14A	Presacral neurectomy..... 180	6+T

INCISION OF LYMPHATIC STRUCTURES

MISG	52.0A	Superficial lymph node aspiration for diagnostic purposes 10	

OTHER OPERATIONS ON LYMPHATIC STRUCTURES

MISG	52.9D	Drainage of pelvic lymphocyst with insertion of suction catheter (With or without installation of sclerosing agents)	40.8	4+T
MASG	52.9E	Drainage of pelvic lymphocyst with laparotomy for pelvic lymphocyst with window format/insertion of omental pedicle	200	7+T

OTHER REPAIR OF ANUS AND ANAL SPHINCTER

MASG	61.69G	Comprehensive anal sphincteroplasty for the treatment of anal incontinence	220	4+T

EXCISION OR DESTRUCTION OF LESION OR TISSUE OF PERITONEUM

MASG	66.3E	Infracolic omentectomy	75	6+T
MASG	66.3F	Infragastric omentectomy	140	6+T

CLOSURE OF OTHER FISTULA OF URETER

MASG	68.84	Closure of other fistula of ureter	240	6+T
MASG	68.84A	Repair - uretero-vaginal fistula (regions required)	240	6+T

REPAIR OF OTHER FISTULA OF BLADDER

MASG	69.73B	Closure of fistula, vesico-vaginal	205	6+T
MASG	69.73C	Repair of vesico-vaginal fistula with omental graft	300	6+T

EXCISION OR DESTRUCTION OF URETHRAL LESION OR TISSUE

MISG	70.2A	Urethral caruncle or prolapse of mucosa	40	4+T

SUPRAPUBIC SLING OPERATION

MASG	71.4C	Synthetic mid urethral sling for urinary incontinence, any approach	150	4+T
MASG	71.4D	Pubo-vaginal sling with autologous fascia for urinary incontinence, includes Cystoscopy as required (If skin to skin time exceeds 4 hours it shall be paid IC)	350	6+T

RETROPUBIC URETHRAL SUSPENSION

MASG	71.5B	Paravaginal repair - includes the repair of cystocoele and Burch Sling or Marshall Marchetti AP=ABDO	200	6+T
MASG	71.5C	Paravaginal repair of cystocoele AP=ABDO or AP=VAGN	150	6+T
MASG	71.7F	Cystoscopy with intravesicular injection(s) of chemodenervating agent	90	4+T

OOPHOROTOMY

MASG	77.0	Oophorotomy (regions required)	130	6+T

WEDGE RESECTION OF OVARY

MASG	77.12	Wedge resection of ovary (regions required)	130	6+T

OTHER LOCAL EXCISION OR DESTRUCTION OF OVARY

MASG	77.19A	Salpingectomy and salpingo-oophorectomy (regions required)	183.45	6+T
MASG	77.19B	Excision of ovarian cyst (regions required)	130	6+T
MASG	77.19C	Laparoscopic ovarian cystectomy (regions required)	211.68	6+T

UNILATERAL OOPHORECTOMY

MASG	77.2	Unilateral oophorectomy (regions required)	130	6+T

UNILATERAL SALPINGO-OOPHORECTOMY

MASG	77.3	Unilateral salpingo-oophorectomy (regions required)	130	6+T

REMOVAL OF BOTH OVARIES (AT SAME OPERATIVE EPISODE)

MASG	77.41	Removal of both ovaries (at same operative episode)	195	6+T

REMOVAL OF REMAINING OVARY

MASG	77.42	Removal of remaining ovary (regions required)	130	6+T

REMOVAL OF BOTH OVARIES AND TUBES (AT SAME OPERATIVE EPISODE)

MASG	77.51	Removal of both ovaries and tubes (at same operative episode)	275.18	6+T

REMOVAL OF REMAINING OVARY AND TUBE

MASG	77.52	Removal of remaining ovary and tube (regions required)	130	6+T

ASPIRATION BIOPSY OF OVARY

MISG	77.81A	Transvaginal ultrasound - guided needle aspiration of endometrium or simple ovarian cyst		
		SP=GNSG	35	
		SP=OBGY	35	

TOTAL SALPINGECTOMY (UNILATERAL)

MASG	78.1A	Salpingectomy for morbidity, not for sterilization (regions required)	183.45	6+T

OTHER BILATERAL ENDOSCOPIC DESTRUCTION OR OCCLUSION OF FALLOPIAN TUBES

MASG	78.39A	Interruption or removal of fallopian tubes for purposes of sterilization: Abdominal, vaginal, laparoscopic-not hysteroscopic (unilateral or bilateral)	148.18	6+T

OTHER BILATERAL ENDOSCOPIC DESTRUCTION OR OCCLUSION OF FALLOPIAN TUBES (NEC)

MASG	78.49A	Sterilisation by transcervical tubal occlusion (both tubes). Includes access (eg. Hysteroscopy) and any necessary imaging	90	4+T

BILATERAL PARTIAL SALPINGECTOMY, UNQUALIFIED

ADON	78.53B	Tubal ligation, unilateral or bilateral (in addition to General Practice delivery fee as assist at c-section) (regions required)	10	

OTHER REPAIR OF FALLOPIAN TUBE

MASG	78.69A	Salpingoplasty	141	6+T

INSUFFLATION OF FALLOPIAN TUBE

MISG	78.7	Insufflation of fallopian tube - Rubin's test	19	4+T
MISG	78.7A	Insufflation with endometrial biopsy	28.5	4+T

CONIZATION OF CERVIX

MASG	79.1	Conization of cervix including colposcopy	71.97	4+T

DESTRUCTION OF LESION OF CERVIX BY CAUTERIZATION

MISG	79.22	Destruction of lesion of cervix by cauterization	13.5	
		AN=GENL	23.5	4+T
MISG	79.22A	Laser vaporization of the cervix	28.5	4+T
MISG	79.22B	Cryosurgery of cervix	13.5	

DESTRUCTION OF LESION OF CERVIX BY CRYOSURGERY

MISG	79.23A	Laser vaporization of the cervix including colposcopy	28.5	4+T

OTHER EXCISION OR DESTRUCTION OF LESION OR TISSUE OF CERVIX NEC

MAAS	79.29A	Debulking of tumour	IC	6+T
MISG	79.29B	Excision of cervical polyp, without D&C	14.1	4+T

AMPUTATION OF CERVIX

MASG	79.3	Amputation of cervix	90	4+T
		AP=ABDO	150	6+T
		AP=VAGN	120	4+T

REPAIR OF INTERNAL CERVICAL OS

MASG	79.4	Repair of internal cervical os (incompetent cervix, any suture repair)	75	4+T
OBST	79.4A	Suture of incompetent cervix during pregnancy	75	4+T
MASG	79.4B	Rescue cerclage suture	120	4+T
MISG	79.4C	Removal cerclage suture		
		AN=GENL	50	4+T
		AN=REGL	50	4+T

ENDOCERVICAL BIOPSY

MISG	79.81	Endocervical biopsy	13.5	
		AN=GENL	23.5	4+T

OTHER CERVICAL BIOPSY

MISG	79.82	Other cervical biopsy		
		AN=GENL	23.5	4+T

HYSTEROTOMY

MASG	80.0	Hysterotomy	150	6+T

INCISION OR EXCISION OF CONGENITAL SEPTUM OF UTERUS

MASG	80.12	Incision or excision of congenital septum of uterus	200	4+T
MASG	80.12A	Uterine unification procedure	200	6+T

OTHER EXCISION OR DESTRUCTION OF LESION OF UTERUS

MASG	80.19	Other excision or destruction of lesion of uterus myomectomy	180	6+T
MASG	80.19A	Endometrial ablation including D&C	225.79	6+T
MASG	80.19B	Endometrial polypectomy using resectoscope	80	4+T

SUBTOTAL ABDOMINAL HYSTERECTOMY

MASG	80.2A	Subtotal abdominal hysterectomy	338.69	6+T
MASG	80.2B	Subtotal abdominal hysterectomy with rectocoele and/or cystocoele repair	287	6+T

TOTAL ABDOMINAL HYSTERECTOMY

MASG	80.3	Total abdominal hysterectomy	338.69	6+T
MASG	80.3A	Uterus-total abdominal with rectocoele and/or cystocoele repair	405.01	6+T
MASG	80.3B	Total abdominal hysterectomy with retropubic incontinence repair	287	6+T
MASG	80.3C	Abdominal hysterectomy with salpingo-ophorectomy including bilateral selective pelvic lymphadenectomies, omental biopsy and selective periaortic lymphadenectomy	564.48	6+T

VAGINAL HYSTERECTOMY (SUBTOTAL) (TOTAL)

MASG	80.4	Vaginal hysterectomy (subtotal) (total)	338.69	6+T
MASG	80.4A	Uterus-total vaginal with rectocoele and/or cystocoele repair	405.01	6+T
MASG	80.4C	Laparoscopic hysterectomy – Total, subtotal, or laparoscopically assisted	423.36	6+T

RADICAL ABDOMINAL HYSTERECTOMY

MASG	80.5A	Radical abdominal hysterectomy-Wertheim	356	8+T
MASG	80.5B	Modified radical abdominal hysterectomy	306	8+T
MASG	80.5C	Radical abdominal hysterectomy with pelvic para-aortic lymphadenectomy	440	8+T

HYSTEROSCOPY

MISG	80.81	Hysteroscopy	59.98	4+T

OPAQUE DYE CONTRAST HYSTEROSALPINGOGRAPHY

MISG	80.85	Opaque dye contrast hysterosalpingography	25.5	4+T

OTHER INVASIVE DIAGNOSTIC PROCEDURES ON UTERUS AND SUPPORTS NEC

MISG	80.89A	Abortion - incomplete; examination of the uterus without D&C or anaesthesia (in hospital procedure only)		
		FN=EMCC, LO=HOSP	35.28	
		FN=INPT, LO=HOSP	35.28	
		FN=OTPT, LO=HOSP	35.28	

DILATION AND CURETTAGE FOLLOWING DELIVERY OR ABORTION

MASG	81.01	Dilation and curettage following delivery or abortion	80.44	4+T

OTHER DILATION AND CURETTAGE

MISG	81.09	Other dilation and curettage	59.98	4+T
MISG	81.09A	Endocervical curettage	14.11	

OTHER EXCISION OR DESTRUCTION OF LESION OR TISSUE OF UTERINE SUPPORTS

MASG	81.29A	Hydrocoele of canal of Nuck	60	4+T
MASG	81.29B	Excision of paraovarian cyst (regions required)	150	6+T

INTERPOSITION OPERATION

MASG	81.31	Interposition operation	200	5+T

OTHER UTERINE SUSPENSION

MASG	81.32	Other uterine suspension hysteropexy	103	6+T
MASG	81.32A	Hysteropexy with rectocoele and cystocoele repair	200	6+T
MASG	81.32B	Hysteropexy with D&C	180	6+T

PARACERVICAL UTERINE DENERVATION

MASG	81.4	Paracervical uterine denervation	75	6+T

ASPIRATION CURETTAGE FOLLOWING DELIVERY OR ABORTION

MASG	81.61	Aspiration curettage following delivery or abortion	80.44	4+T

OTHER ASPIRATION CURETTAGE OF UTERUS

MISG	81.69A	Endometrial biopsy	26.81	

INSERTION OF INTRAUTERINE CONTRACEPTIVE DEVICE

COCR	81.8	Insertion of intrauterine contraceptive device	45.16	

INSERTION OF THERAPEUTIC DEVICE INTO UTERUS

MASG	81.91	Insertion of therapeutic device into uterus	76	4+T
		Insertion of radium (per application)		
MASG	81.91B	Intrauterine balloon for PPH tamponade	70	4+T

INSERTION OF LAMINARIA

MISG	81.93	Insertion of laminaria	14.1	

HYMENOTOMY

MISG	82.11	Hymenotomy	15	
		AN=GENL	25	4+T
		AN=LOCL	15	

COLPOTOMY OR CULDOTOMY

MISG	82.12	Colpotomy or culdotomy	40	4+T

OTHER VAGINOTOMY

MASG	82.14	Other vaginotomy - repair of double vagina	90	4+T

EXCISION OR DESTRUCTION OF LESION OR TISSUE OF VAGINA

MISG	82.23	Excision or destruction of lesion or tissue of vagina	14.1	
		AN=GENL	23.5	4+T
		AN=LOCL	14.1	
MISG	82.23A	True cut needle biopsy of transvaginal mass	25	4+T
MASG	82.23C	Local excision of cyst	70	4+T

OBLITERATION AND TOTAL EXCISION OF VAGINA

MASG	82.3	Obliteration and total excision of vagina		
		PO=RADI	260	6+T
MASG	82.3A	Total vaginectomy with replacement skin graft	300	6+T
MASG	82.3B	Vaginectomy		
		PO=SEGM	200	4+T
MASG	82.3C	Colpocleisis (Lefort)	180	5+T

REPAIR OF CYSTOCOELE

MASG	82.41	Repair of cystocoele - paravaginal repair	85	4+T

REPAIR OF RECTOCOELE

MASG	82.42	Repair of rectocoele - paravaginal repair	85	4+T
MASG	82.42A	Rectocoele and repair of anal sphincter	180	4+T

REPAIR OF CYSTOCOELE AND RECTOCOELE

MASG	82.43	Repair of cystocoele and rectocoele or paravaginal repair	151	4+T
MASG	82.43A	Cystocoele, (paravaginal repair), rectocoele and prolapse (Fothergill)	200	5+T
MASG	82.43B	Cystocoele, (paravaginal repair), rectocoele and excision of cervical stump	200	5+T

VAGINAL RECONSTRUCTION

MASG	82.52	Vaginal reconstruction	200	4+T

REPAIR OF FISTULA OF VAGINA

MASG	82.62	Repair of fistula of vagina	200	6+T

VAGINAL SUSPENSION AND FIXATION

MISG	82.64A	Resuturing vaginal cuff of vault - post hysterectomy		
		AP=ABDO	50	6+T
		AP=VAGN	50	4+T
MASG	82.64B	Repair - vaginal vault prolapse (post hysterectomy, vaginal or abdominal)	200	6+T
MASG	82.64D	Abdominal Sacral Colpopexy	350	6+T
MASG	82.64E	Laparoscopic Sacral Colpopexy (IC)	140MSU/hr	6+T
MASG	82.64F	Colpopexy, vaginal; fixation to sacrospinous ligament(s)	200	6+T

OTHER REPAIR OF VAGINA NEC

MASG	82.69A	Vaginoplasty - low perineal construction	240	5+T
MASG	82.69B	Vaginoplasty - high perineal construction	350	8+T

OBLITERATION OF VAGINAL VAULT

MASG	82.7	Obliteration of vaginal vault enterocele	151	4+T

CULDOSCOPY

VADT	82.81A	Colposcopy	12	

MARSUPIALIZATION OF BARTHOLIN'S GLAND (CYST)

MISG	83.13	Marsupialization of Bartholin's gland (cyst)	25	4+T

EXCISION OR OTHER DESTRUCTION OF BARTHOLIN'S GLAND (CYST)

MASG	83.14	Excision or other destruction of Bartholin's gland (cyst)		
		(Regions required)	60	4+T

OTHER LOCAL EXCISION OR DESTRUCTION OF VULVA AND PERINEUM

MISG	83.2B	Ablation of vin, vain, cin, condylomata, regardless of the method	50	4+T
COCR	83.2C	Abscess of vulva - Bartholin's or Skene's gland (regions required)	25	
		AN=GENL (regions required)	25	4+T
		AN=LOCL (regions required)	25	
MISG	83.2D	Excision of condylomata	42.5	4+T

OPERATIONS ON CLITORIS

MASG	83.3A	Clitoroplasty	100	4+T
MASG	83.3B	Clitoris amputation	60	6+T

RADICAL VULVECTOMY

MASG	83.4A	Radical vulvectomy without gland dissection	175	6+T
MASG	83.4B	Radical vulvectomy with complete bilateral gland dissection	300	6+T
MASG	83.4C	Radical vulvectomy with inguinal and deep pelvic lymphadenectomy	400	10+T

UNILATERAL VULVECTOMY

MASG	83.51	Unilateral vulvectomy (regions required)	120	4+T
MASG	83.51A	Segmental vulvectomy (without reconstruction) (regions required)	85	4+T
MASG	83.51B	Skinning vulvectomy P.A.I.N. excision without skin graft	100	4+T

BILATERAL VULVECTOMY

MASG	83.52	Bilateral vulvectomy		
		ME=SIMP	180	4+T

SUTURE OF VULVA AND PERINEUM

MASG	83.61	Suture of vulva and perineum (a perineorrhaphy is included in the fee for a posterior repair)	60	4+T

OTHER REPAIR OF VULVA AND PERINEUM

MISG	83.69A	Third degree laceration - consultation and procedure	50	4+T

LOW FORCEPS DELIVERY WITHOUT EPISIOTOMY

OBST	84.0	Low forceps delivery (without episiotomy)		
		RF=REFD (SP=OBGY)	366.91	4+T
		Multiple vaginal births - each additional - plus multiples, if applicable	65	
		AN=DFED		Time Only
		CO=INFE		7+T
		RO=OBDA, RF=REFD, SP=OBGY	68	
		RO=OBDA, SP=OBGY	68	

LOW FORCEPS DELIVERY WITH EPISIOTOMY

OBST	84.1	Low forceps delivery (with episiotomy)		
		RF=REFD (SP=OBGY)	366.91	4+T
		Multiple vaginal births - each additional - plus multiples, if applicable	65	
		AN=DFED		Time Only
		CO=INFE		7+T
		RO=OBDA, RF=REFD, SP=OBGY	68	
		RO=OBDA, SP=OBGY	68	

MID FORCEPS DELIVERY WITH EPISIOTOMY

OBST	84.21	Mid forceps delivery with episiotomy		
		RF=REFD (SP=OBGY)	366.91	4+T
		Multiple vaginal births - each additional - plus multiples, if applicable	65	
		AN=DFED		Time Only
		CO=INFE		7+T
		RO=OBDA, RF=REFD, SP=OBGY	68	
		RO=OBDA, SP=OBGY	68	

OTHER MID FORCEPS DELIVERY

OBST	84.29	Other mid forceps delivery		
		RF=REFD (SP=OBGY)	366.91	4+T
		Multiple vaginal births - each additional - plus multiples, if applicable	65	
		AN=DFED		Time Only
		CO=INFE		7+T
		RO=OBDA, RF=REFD, SP=OBGY	68	
		RO=OBDA, SP=OBGY	68	

HIGH FORCEPS DELIVERY WITH EPISIOTOMY

OBST	84.31	High forceps delivery with episiotomy		
		RF=REFD (SP=OBGY)	366.91	4+T
		Multiple vaginal births - each additional - plus multiples, if applicable	65	
		AN=DFED		Time Only
		CO=INFE		7+T
		RO=OBDA, RF=REFD, SP=OBGY	68	
		RO=OBDA, SP=OBGY	68	

OTHER HIGH FORCEPS DELIVERY

OBST	84.39	Other high forceps delivery		
		RF=REFD (SP=OBGY)	366.91	4+T
		Multiple vaginal births - each additional - plus multiples, if applicable	65	
		AN=DFED		Time Only
		CO=INFE		7+T
		RO=OBDA, RF=REFD, SP=OBGY	68	
		RO=OBDA, SP=OBGY	68	

BREECH EXTRACTION, UNQUALIFIED

OBST	84.51	Breech extraction, unqualified		
		RF=REFD (SP=OBGY)	366.91	4+T
		Multiple vaginal births - each additional - plus multiples, if applicable	65	
		AN=DFED		Time Only
		CO=INFE		7+T
		RO=OBDA, RF=REFD, SP=OBGY	68	
		RO=OBDA, SP=OBGY	68	

PARTIAL BREECH EXTRACTION

OBST	84.52	Partial breech extraction		
		RF=REFD (SP=OBGY)	366.91	4+T
		Multiple vaginal births - each additional - plus multiples, if applicable	65	
		AN=DFED		Time Only
		CO=INFE		7+T
		RO=OBDA, RF=REFD, SP=OBGY	68	
		RO=OBDA, SP=OBGY	68	

TOTAL BREECH EXTRACTION

OBST	84.53	Total breech extraction		
		RF=REFD (SP=OBGY)	366.91	4+T
		Multiple vaginal births - each additional - plus multiples, if applicable	65	
		AN=DFED		Time Only
		CO=INFE		7+T
		RO=OBDA, RF=REFD, SP=OBGY	68	
		RO=OBDA, SP=OBGY	68	

PARTIAL BREECH EXTRACTION WITH FORCEPS TO AFTERCOMING HEAD

OBST	84.61	Partial breech extraction with forceps to aftercoming head		
		RF=REFD (SP=OBGY)	366.91	4+T
		Multiple vaginal births - each additional - plus multiples, if applicable	65	
		AN=DFED		Time Only
		CO=INFE		7+T
		RO=OBDA, RF=REFD, SP=OBGY	68	
		RO=OBDA, SP=OBGY	68	

TOTAL BREECH EXTRACTION WITH FORCEPS TO AFTERCOMING HEAD

OBST	84.62	Total breech extraction with forceps to aftercoming head		
		RF=REFD (SP=OBGY)	366.91	4+T
		Multiple vaginal births - each additional - plus multiples, if applicable	65	
		AN=DFED		Time Only
		CO=INFE		7+T
		RO=OBDA, RF=REFD, SP=OBGY	68	
		RO=OBDA, SP=OBGY	68	

OTHER FORCEPS APPLICATION TO AFTERCOMING HEAD

OBST	84.69	Other forceps application to aftercoming head		
		RF=REFD (SP=OBGY)	260	4+T
		Multiple vaginal births - each additional - plus multiples, if applicable	65	
		AN=DFED		Time Only
		CO=INFE		7+T
		RO=OBDA, RF=REFD, SP=OBGY	68	
		RO=OBDA, SP=OBGY	68	

VACUUM EXTRACTION WITH EPISIOTOMY

OBST	84.71	Vacuum extraction with episiotomy		
		RF=REFD (SP=OBGY)	366.91	4+T
		Multiple vaginal births - each additional - plus multiples, if applicable	65	
		AN=DFED		Time Only
		CO=INFE		7+T
		RO=OBDA, RF=REFD, SP=OBGY	68	
		RO=OBDA, SP=OBGY	68	

OTHER VACUUM EXTRACTION

OBST	84.79	Other vacuum extraction		
		RF=REFD (SP=OBGY)	366.91	4+T
		Multiple vaginal births - each additional - plus multiples, if applicable	65	
		AN=DFED		Time Only
		CO=INFE		7+T
		RO=OBDA, RF=REFD, SP=OBGY	68	
		RO=OBDA, SP=OBGY	68	

OTHER SPECIFIED INSTRUMENTAL DELIVERY

OBST	84.8	Other specified instrumental delivery		
		RF=REFD (SP=OBGY)	366.91	4+T
		Multiple vaginal births - each additional - plus multiples, if applicable	65	
		AN=DFED		Time Only
		CO=INFE		7+T
		RO=OBDA, RF=REFD, SP=OBGY	68	
		RO=OBDA, SP=OBGY	68	

UNSPECIFIED INSTRUMENTAL DELIVERY

OBST	84.9	Unspecified instrumental delivery		
		RF=REFD (SP=OBGY)	366.91	4+T
		Multiple vaginal births - each additional - plus multiples, if applicable	65	
		AN=DFED		Time Only
		CO=INFE		7+T
		RO=OBDA, RF=REFD, SP=OBGY	68	
		RO=OBDA, SP=OBGY	68	

INDUCTION OF LABOUR BY ARTIFICIAL RUPTURE OF MEMBRANES

OBST	85.01	Induction of labour by artificial rupture of membranes Consultation and procedure	23.5	4+T

EXTERNAL VERSION

MISG	85.91A	External cephalic version under ultrasound control	50	4+T

CERVICAL CAESAREAN SECTION

OBST	86.1	Cervical Caesarean section		
		SP=GNSG	366.91	7+T
		SP=OBGY	260	7+T
		-plus multiples, if applicable	35	
		CO=INFE		10+T
OBST	86.1A	Caesarean section with tubal ligation		
		SP=GNSG	395.13	7+T
		SP=OBGY	280	7+T
		-plus multiples, if applicable	35	
		CO=INFE		10+T

REMOVAL OF INTRAPERITONEAL EMBRYO

MASG	86.3	Removal of intraperitoneal embryo (regions required)	130	6+T
MASG	86.3A	Surgical removal of extrauterine (ectopic) pregnancy - by any means (regions required)	183.45	6+T

INTRA-AMNIOTIC INJECTION FOR TERMINATION OF PREGNANCY

MASG	87.0	Intra-amniotic injection for termination of pregnancy	71	4+T

VACUUM ASPIRATION FOR TERMINATION OF PREGNANCY

MASG	87.1	Vacuum aspiration for treatment of pregnancy	71	4+T

DILATION AND CURETTAGE FOR TERMINATION OF PREGNANCY

MASG	87.21	Dilation and curettage for termination of pregnancy	100.19	4+T

OTHER TERMINATION OF PREGNANCY NEC

MASG	87.29	Other termination of pregnancy NEC	71	4+T

AMNIOCENTESIS

MISG	87.3	Amniocentesis	18	

INTRAUTERINE TRANSFUSION

OBST	87.4	Intrauterine transfusion	125	
MISG	87.4C	Amniocentesis for erythroblastosis	21	

REMOVAL OF RETAINED PLACENTA

MISG	87.6	Removal of retained placenta - consultation and procedure	70	4+T

REPAIR OF OBSTETRIC LACERATION OF SPHINCTER ANI

MASG	87.82A	Obstetrical trauma – Repair 3rd degree laceration - consultation and procedure	75	4+T
MASG	87.82B	Obstetrical trauma – Repair 4th degree laceration - consultation and procedure	100	4+T

MANUAL REPLACEMENT OF INVERTED UTERUS

MASG	87.94	Manual replacement of inverted uterus	75	4+T
MASG	87.94A	Operative repair of inversion of uterus	180	4+T

DELIVERY NEC

OBST	87.98	Delivery NEC	282.24	4+T
		RF=REFD, SP=OBGY	366.91	4+T
		Multiple vaginal births - each additional - plus multiples, if applicable	91.73	
		AN=DFED		Time Only
		CO=INFE		7+T
		RO=OBDA, RF=REFD, SP=OBGY	95.40	
		RO=OBDA, SP=OBGY	95.40	

OTHER OBSTETRIC OPERATIONS NEC

MASG	87.99B	Application of Uterine Compression Sutures	200	6+T

LOCAL EXCISION OR DESTRUCTION OF LESION OR TISSUE OF SKIN AND SUBCUTANEOUS TISSUE

MISG	98.12V	Curettage of warts, including papillomata, keratosis, nevi, moles, pyogenic Granulomata, etc., for malignant or recognized pre-malignant condition -includes clinical suspicion of malignancy – plus multiples, if applicable	16.93	4+T

SURGICAL PROCEDURES NOS

ADON	99.09A	Morbid obesity surgical add on	32.9	4.6

OPHTHALMOLOGY

(SP=OPHT)

CATEGORY	HEALTH SERVICE CODE	DESCRIPTION / MODIFIERS	BASE UNITS	ANAES UNITS
CONSULTATIONS				
CONS	03.08	Comprehensive Consultation		
		RF=REFD (ME=TELE)	37.6	
		RF=REFD, US=PREM (ME=TELE)	55.6	
		RF=REFD, US=PR50 (ME=TELE)	56.4	
		RF=REFD, RO=DETE (ME=TELE)	37.6+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	55.6+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	56.4+MU	
CONS	03.07	Limited Consultation		
		RF=REFD (ME=TELE)	24.1	
		RF=REFD, US=PREM (ME=TELE)	42.1	
		RF=REFD, US=PR50 (ME=TELE)	42.1	
		RF=REFD, RO=DETE (ME=TELE)	24.1+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	42.1+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	42.1+MU	
CONS	03.07	Repeat Consultation		
		RF=REFD, RP=REPT (ME=TELE)	22.5	
		RF=REFD, RP=REPT, US=PREM (ME=TELE)	40.5	
		RF=REFD, RP=REPT, US=PR50 (ME=TELE)	40.5	
		RF=REFD, RO=DETE, RP=REPT (ME=TELE)	22.5+MU	
		RF=REFD, RO=DETE, RP=REPT, US=PREM (ME=TELE)	40.5+MU	
		RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE)	40.5+MU	
CONS	09.02E	Oculogenetic Consultation for Patients with Congenital or Hereditary Visual Problems		
		RF=REFD	50	
		Note: Refer to Diagnostic & Therapeutic Section for complete eye examination codes		
OFFICE				
VIST	03.04	Initial Visit with Complete Examination		
		LO=OFFC (RF=REFD)	20.3	
VIST	03.03	Initial Visit Not Requiring Complete Examination		
		LO=OFFC, RP=INTL (RF=REFD)	12	
		LO=OFFC, AG=OV65, RP=INTL (RF=REFD)	16.5	
VIST	03.03	Subsequent Visit		
		LO=OFFC, RP=SUBS (RF=REFD)	13	
VIST	03.03A	Geriatric Office Visit (for patients aged 65+)		
		LO=OFFC (RF=REFD)	16.5	

VIST	03.03	Continuing Care
		LO=OFFC, RO=CNTC, RF=REFD 13.5
		LO=OFFC, AG=OV65, RO=CNTC, RF=REFD 16.5
VIST	03.03	Directive Care
		LO=OFFC, RO=DIRC, RF=REFD 13.5
		LO=OFFC, AG=OV65, RO=DIRC, RF=REFD 16.5
VIST	03.03	Urgent Care - Request by Patient (1701 - 2000)
		LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) 28.3
VIST	03.03	Urgent Care - Request by Patient (2001 - 2359)
		LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) 28.3
VIST	03.03	Urgent Care - Request by Patient (0000 - 0800)
		LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) 38.3
VIST	03.03	Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays
		LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) 28.3
VIST	03.03	Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays
		LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) 28.3
VIST	03.03	Urgent Care - Extra Patient
		LO=OFFC, PT=EXPT (RF=REFD) 10.5

HOSPITAL (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

VIST	03.04	Initial Visit
		LO=HOSP, FN=INPT, RP=INTL (RF=REFD) 25
		LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD) ..... 25+MU
VIST	03.03	Continuing Care
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC, RF=REFD 15
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT, RF=REFD ..... 15+MU
VIST	03.03	Directive Care
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD 15
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD ..... 15+MU
VIST	03.03	Subsequent Visit - Daily to 56 Days
		LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) 15
		LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU
VIST	03.03	Subsequent Visit - Weekly after 56 Days - Maximum 44 units per week
		LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD) 15
		LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU
ADON	03.02A	Hospital Discharge Fee
		LO=HOSP, FN=INPT 10

VIST	03.03	Urgent Hospital Visit	
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)	22
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD)	22+MU
VIST	03.03	Hospital Emergency Visit	
		LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)	35.2
		LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)	35.2+MU
VIST	03.03	Outpatient Visit (0800 - 1700)	
		LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD)	13.5
		LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD)	13.5+MU
VIST	03.03	Outpatient Visit (1701 - 2000)	
		LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD)	20
		LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD)	20+MU
VIST	03.03	Outpatient Visit (2001 - 2359)	
		LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD)	20
		LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD)	20+MU
VIST	03.03	Outpatient Visit (0000 - 0800)	
		LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)	26
		LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)	26+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Sat., Sun., Holidays	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)	20
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)	20+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Sat., Sun., Holidays	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)	20
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD)	20+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD)	7
		LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)	7+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD)	7
		LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD)	7+MU
VIST	03.03	Outpatient Visit (1701 - 2000) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD)	10.5
		LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD)	10.5+MU
VIST	03.03	Outpatient Visit (2001 - 2359) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD)	10.5
		LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD)	10.5+MU

VIST	03.03	Outpatient Visit (0000 - 0800) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) ..... 11.4 LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) ..... 11.4+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD)..... 10.5 LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 10.5+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) ..... 10.5 LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 10.5+MU

PROCEDURES

OTHER TOMOGRAPHY OF HEAD

VADT	02.02B	Optic Nerve Imaging 8

OTHER BIOMETRY

VADT	02.02C	Ophthalmic Biometry by partial coherence interferometry with IOL (intraocular lens) power calculation, unilateral or bilateral 25.44

OTHER NONOPERATIVE MEASUREMENTS AND EXAMINATIONS OF NERVOUS SYSTEM AND SENSE ORGANS NEC

VEDT	03.19E	Interpretation by Ophthalmologists of Orthoptic Evaluation including measurements of all of the following: visual acuity (distance and near), ocular alignment (distance and near), binocularity including stereopis and vergences and ductions. RO=INPR..... 10
VADT	03.19H	Corneal Topography of both eyes for corneal disease (not refractive eye surgery) RO=INTP..... 5.8

COMPREHENSIVE EYE EXAMINATION

VEDT	09.02	Comprehensive eye examination including refraction..... 20.3
VEDT	09.02A	Low vision clinic fees (for prolonged visits beyond one hour, a rate of 13.7 units per 15 minutes applies) - plus multiples, if applicable RP=INTL..... 50
VEDT	09.02B	Reduced payment for uninsured service..... 10.4
VEDT	09.02D	Low vision clinic fees - follow-up after 30 days 25
CONS	09.02E	Oculogenetic consultation for patients with congenital or hereditary visual problems SP=OPHT, RF=REFD..... 50
VEDT	09.02H	Comprehensive Eye Examination of both eyes including refraction..... 29
VADT	09.03A	Examination for Retinopathy of Prematurity 15

EYE EXAMINATION UNDER ANAESTHESIA

VEDT	09.04	Eye examination under anaesthesia	27	4+T
		Prolonged eye examinations under general anaesthesia for children (50 units per half hour) - plus multiples, if applicable		
		AG=CH16	50	4+T

FLUORESCEIN ANGIOGRAPHY OR ANGIOSCOPY OF EYE

VADT	09.12	Fluorescein angiography or angioscopy of eye	22	

REMOVAL OF PENETRATING FOREIGN BODY FROM EYELID OR CONJUNCTIVA WITHOUT INCISION

MISG	12.32	Removal of penetrating foreign body from eyelid or conjunctiva without incision		
		AN=GENL (regions required)	25	4+T
		No anaesthetic (regions required)	10.4	

DILATION OF LACRIMAL PUNCTUM

MISG	21.31	Dilation of lacrimal punctum (regions required)	35	4+T

PROBING OF NASOLACRIMAL DUCT

MISG	21.33	Probing of nasolacrimal duct (regions required)		
		AN=LOCL, RP=INTL	12.5	
		AN=LOCL, RP=REPT	5	
		RP=INTL	12.5	
		RP=REPT	5	
MISG	21.33A	Probing and dilation of nasolacrimal duct - initial or repeat, unilateral or bilateral		
		AN=GENL	20	4+T

INTUBATION OF NASOLACRIMAL DUCT

MISG	21.34	Intubation of nasolacrimal duct (regions required)	35	4+T

INCISION OF LACRIMAL SAC

MISG	21.41A	Dacryocystotomy (regions required)		
		AN=GENL	25	4+T

EXCISION OF LACRIMAL SAC OR LESION

MASG	21.5	Excision of lacrimal sac or lesion (regions required)	125	4+T
MASG	21.5A	Excision of lacrimal gland (regions required)	200	4+T

OTHER REPAIR OF CANALICULUS AND PUNCTUM

MASG	21.69A	Repair wounds involving canaliculi (regions required)	100	4+T

DACRYOCYSTORHINOSTOMY (DCR)

MASG	21.71	Dacryocystorhinostomy (DCR) (regions required)	325	4+T

BIOPSY OF LACRIMAL GLAND

MISG	21.81	Biopsy of lacrimal gland (regions required)	50	4+T

OTHER EXCISION OF SINGLE LESION OF EYELID

COCR	22.13A	Excision of chalazion or tarsal cyst - single or multiple - one lid		
		AN=GENL (regions required)	30	4+T
		AN=LOCL (regions required)	24	
		No anaesthetic (regions required)	24	
MASG	22.13B	Excision of malignant eyelid lesion with reconstruction (regions required)	200	4+T

OTHER CORRECTION OF ENTROPION OR ECTROPION

MASG	22.39	Other correction of entropion or ectropion (regions required)	147	4+T
MASG	22.39B	Quickert suture repair of entropion (regions required)	65	4+T

FRONTALIS MUSCLE TECHNIQUE WITH SUTURE FOR CORRECTION OF BLEPHAROPTOSIS

MASG	22.41	Frontalis muscle technique with suture for correction of blepharoptosis (Regions required)	137	4+T

BLEPHARORRHAPHY

MASG	22.5A	Skin or mucous membrane grafts - eyelid (regions required)	100	4+T
MASG	22.5B	Tarsorrhaphy (regions required)	60	4+T
MASG	22.5C	Plastic repair (without skin graft) eyelid (regions required) - prior approval required other than trauma related conditions	65	4+T
MASG	22.5D	Plastic repair with graft - eyelid (regions required)	85	4+T

OTHER EYELID REPAIR

MISG	22.69A	Punctal occlusion (regions required)	25	4+T

ELECTROSURGICAL EPILATION

MISG	22.71A	Cryotherapy to eyelid margins (regions required)	25	
MISG	22.71B	Epilation of eyelashes by electrolysis - per lid (regions required) - plus multiples, if applicable	25	4+T

ADVANCEMENT OR RECESSION OF OCULAR MUSCLES

ADON	23.2A	Posterior fixation of extraocular muscles (Faden Procedure) in addition to strabismus repair	200	
MASG	23.2B	Strabismus repair one or two muscles same or different eye		
		AG=ADUT	190	6+T
		AG=CH16	180	6+T
ADON	23.2C	Strabismus repair (additional muscles over two) - plus multiples, if applicable		
		AG=ADUT	30	
		AG=CH16	50	

OTHER SHORTENING OF OCULAR MUSCLES

MASG	23.4A	Superior oblique muscle tuck (regions required)	200	6+T

REPAIR OF (TRAUMATIC) LACERATION OF MUSCLE, TENDON, OR TENON'S CAPSULE

MASG	23.91A	Surgical exploration and repair of two or more extraocular muscles (Regions required)	200	6+T

OTHER OPERATIONS ON OCULAR MUSCLES OR TENDONS NEC

ADON	23.99A	Adjustable suture in addition to strabismus repair (regions required)	100	
MISG	23.99B	Injection of chemodenervating agent into extraocular muscle(s) for strabismus		
		AG=CH03	25	4+T

EXCISION OF LESION OR TISSUE OF CONJUNCTIVA

MISG	24.22	Excision of lesion or tissue of conjunctiva biopsy (regions required)	15	4+T
MISG	24.22A	Excision of conjunctival tumour malignant (regions required)	50	4+T

CONJUNCTIVAL FLAP

MASG	24.35	Conjunctival flap Gunderson (total conjunctival) flap (regions required)	200	4+T

OTHER CONJUNCTIVOPLASTY

MASG	24.39B	Excision of conjunctival tumour malignant - with plastic repair (Regions required)	125	4+T
MASG	24.39C	Excision of conjunctival tumour requiring graft (regions required)	150	4+T

SUTURE OF CONJUNCTIVA

MISG	24.5	Suture of conjunctiva (regions required)	20	4+T
MISG	24.5A	Suture repair of a conjunctional wound or bleb leak (regions required)	25	4+T

OTHER OPERATIONS ON CONJUNCTIVA NEC

MISG	24.99A	Laser treatment of conjunctival bleb (regions required)	50	4+T
MISG	24.99B	Autologous blood injection (regions required)	25	
MISG	24.99C	Needling of Bleb - office procedure (regions required)	50	
MASG	24.99D	Needling of Bleb - OR setting (regions required)	100	6+T

INCISION OF CORNEA

MISG	25.1A	Removal embedded foreign body cornea		
		AN=GENL (regions required)	25	4+T
		No anaesthetic (regions required)	20	

OTHER EXCISION OF PTERYGIUM

MISG	25.29	Other excision of pterygium (regions required)	49	4+T
MASG	25.29A	Excision of pterygium with conjunctival flap (regions required)	65	4+T

THERMOCAUTERIZATION OF CORNEAL LESION

MISG	25.32	Thermocauterization of corneal lesion or corneal ulcer (regions required)	10	4+T

OTHER REMOVAL OR DESTRUCTION OF CORNEAL LESION

MISG	25.39B	Excision of corneal scar or debridement of cornea (regions required)	50	4+T
MASG	25.39C	Excision of dermoid cyst of cornea (regions required)	75	4+T
MASG	25.39D	Excision of malignant tumour of cornea (regions required)	150	4+T
MASG	25.39E	Superficial keratectomy cornea (regions required)	196	7+T

SUTURE OF CORNEA

MASG	25.4A	Suture of cornea with excision of iris (regions required)	160	6+T
MASG	25.4B	Suture of cornea without excision of iris (regions required)	120	6+T

LAMELLAR KERATOPLASTY (WITH HOMOGRAFT)

MASG	25.53	Lamellar keratoplasty (with homograft) (regions required)	250	8+T

PENETRATING KERATOPLASTY (WITH HOMOGRAFT)

MASG	25.55	Penetrating keratoplasty (with homograft) (regions required)	345	8+T

SCRAPING OF CORNEA FOR SMEAR OR CULTURE

MISG	25.81	Scraping of cornea for smear or culture (regions required)	20	

DIVISION OF CORNEAL BLOOD VESSELS

MASG	25.91	Division of corneal blood vessels (regions required)	100	6+T

TATTOOING OF CORNEA

MISG	25.92A	Microperforations of corneal stroma (regions required)	20	4+T

OTHER OPERATIONS ON CORNEA NEC

MISG	25.99C	Application of glue for corneal perforation (regions required)	50	
MISG	25.99D	Corneal measurement for congenital glaucoma (regions required)	20	4+T
MASG	25.99F	Procurement of Ocular Tissue for Eye Bank (regions required)	100	

OTHER SCLERAL FISTULIZATION WITH IRIDECTOMY

MASG	26.23A	Iridocyclectomy	250	4+T

TRABECULECTOMY AB EXTERNO

MASG	26.25	Trabeculectomy ab externo (regions required)	225	6+T
MASG	26.25B	Corneoscleral filtering (regions required)	160	4+T
MASG	26.25C	Trabeculectomy on an eye with a previous major ocular surgical procedure with or without post op laser suture lysis (regions required)	292	6+T
MASG	26.25D	Trabeculectomy with the use of anti-metabolites with or without post-op laser suture lysis (regions required)	292	6+T

OTHER RELIEF OF INTRAOCULAR TENSION

MASG	26.29A	Laser cyclodestructive procedure (regions required)	80	4+T
MASG	26.29D	Trabeculoplasty (regions required)	250	6+T
MASG	26.29E	Placement of glaucoma tube shunt (regions required)	300	6+T
MASG	26.29G	Glaucoma surgery (such as stent insertion) ab interno approach, for the relief of intraocular pressure through drainage of aqueous humor to the subconjunctival space (regions required)	175	6+T

GONIOTOMY WITH GONIOPUNCTURE

MASG	26.33	Goniotomy with goniopuncture (regions required)	160	4+T

TRABECULOTOMY AB EXTERNO

MASG	26.34	Trabeculotomy ab externo (regions required)	225	6+T

CYCLODIALYSIS (INITIAL) (SUBSEQUENT)

MASG	26.35	Cyclodialysis (initial) (subsequent) (regions required)	100	4+T

CYCLOCRYOTHERAPY

MASG	26.37	Cyclocryotherapy (regions required)	70	4+T

DESTRUCTION OF LESION OF CILIARY BODY, NONEXCISIONAL

MASG	26.44	Destruction of lesion of ciliary body, nonexcisional (regions required)	100	4+T

OTHER IRIDOTOMY

MASG	26.52	Other iridotomy (regions required)	113	4+T

IRIDECTOMY (BASAL)

MASG	26.53	Iridectomy (basal) (regions required)	113	4+T
MISG	26.53A	Ziegler puncture for correction of entropion or ectropion (regions required)	15	4+T

FREEING OF OTHER ANTERIOR SYNECHIAE

MASG	26.62	Freeing of other anterior synechiae (regions required)	90	6+T
MASG	26.62B	Intraocular synechiolysis with or without surgery to the pupil and iris (Regions required)	90	6+T

SUTURE OF (TRAUMATIC) LACERATION OF SCLERA

MASG	26.71A	Suture uncomplicated wound without prolapse (regions required)	110	6+T
MASG	26.71B	Suture complicated wound with prolapse (regions required)	170	6+T

OTHER SCLEROPLASTY

MASG	26.79A	Scleral transplant for reconstruction (regions required)	200	6+T

ASPIRATION OF ANTERIOR CHAMBER

MISG	26.91	Aspiration of anterior chamber (regions required)	30	4+T

OTHER OPERATIONS ON IRIS

MASG	26.95A	Suture repair of iris in conjunction with intraocular surgery (regions required)	100	4+T

OTHER OPERATIONS ON SCLERA

MASG	26.97A	Sclerotomy AP=POST (regions required)	75	4+T

DISCISSION OF LENS AND CAPSULOTOMY

MASG	27.3	Discission of lens and capsulotomy (regions required)	88	4+T
MASG	27.3A	Needling of capsule (regions required)	100	5+T

OTHER INTRACAPSULAR EXTRACTION

MASG	27.49A	Excision - crystalline lens - senile or others (regions required)	172.5	4+T
MASG	27.49B	Excision - crystalline lens - senile or others, high risk patients, monocular patients, or patients who require cataract surgery in association with glaucoma, vitreoretinal surgery, corneal transplantation or serious complications of previous cataract surgery (regions required)	172.5	4+T

OTHER EXTRACAPSULAR EXTRACTION (See Cataract Fee Revisions

MASG	27.59A	Excision - crystalline lens - senile or others (regions required)	172.5	4+T
MASG	27.59B	Excision - crystalline lens - senile or others, high risk patients, monocular patients, or patients who require cataract surgery in association with glaucoma, vitreoretinal surgery, corneal transplantation or serious complications of previous cataract surgery (regions required)	172.5	4+T

INSERTION OF PSEUDOPHAKOS, UNQUALIFIED

MASG	27.71A	Repositioning of dislocated intra-ocular lens (regions required)	65	4+T
MASG	27.71B	Repositioning of dislocated intra-ocular lens, high risk patients, monocular patients, or patients who require cataract surgery in association with glaucoma, vitreoretinal surgery, corneal transplantation or serious complications of previous cataract surgery (regions required)	65	4+T

INSERTION OF INTRAOCULAR LENS PROSTHESIS WITH CATARACT EXTRACTION, ONE STAGE

MASG	27.72	Insertion of intraocular lens prosthesis with cataract extraction, one stage (Regions required)	225	4+T
MASG	27.72B	Insertion of intraocular lens prosthesis with cataract extraction, high risk patients, monocular patients or patients who require cataract surgery in association with glaucoma, vitreoretinal surgery, corneal transplantation or serious complications of previous cataract surgery (regions required)	244	4+T

SECONDARY INSERTION OF INTRAOCULAR LENS PROSTHESIS

MASG	27.73	Secondary insertion of intraocular lens prosthesis (regions required)	150	6+T
MASG	27.73A	Transcleral suturing of secondary posterior chamber intraocular lens (Regions required)	250	6+T
MASG	27.73B	Secondary insertion of intraocular lens prosthesis, high risk patients, monocular patients or patients who require cataract surgery in association with glaucoma, vitreoretinal surgery, corneal transplantation or serious complications of previous cataract surgery (regions required)	150	6+T

REMOVAL OF IMPLANTED LENS

MASG	27.8	Removal of implanted lens (regions required)	120	6+T

MASG	27.8A	Removal of implanted lens, high risk patients, monocular patients, or patients who require cataract surgery in association with glaucoma, vitreoretinal surgery, corneal transplantation, or serious complications of previous cataract surgery (regions required)	120	6+T

SCLERAL BUCKLING WITH IMPLANT

MASG	28.2A	Non-circling tube or buckle procedure (regions required)	250	7+T
MASG	28.2B	Scleral buckle for circling tube		
		RP=INTL (regions required)	294	7+T
		RP=SUBS (regions required)	392	7+T

OTHER SCLERAL BUCKLING

MASG	28.3	Other scleral buckling scleral resection (regions required)	250	6+T
MASG	28.3A	Scleral resection with cryosurgery or electrocoagulation (regions required)	250	7+T

REPAIR OF RETINAL DETACHMENT WITH DIATHERMY

MASG	28.41	Repair of retinal detachment with diathermy (regions required)	200	6+T
MASG	28.41A	Diathermy or electrocoagulation repair of retina (regions required)	200	7+T

REPAIR OF RETINAL DETACHMENT WITH CRYOTHERAPY

MASG	28.42	Repair of retinal detachment with cryotherapy (regions required)	200	6+T
MASG	28.42A	Cryosurgical repair of retina without scleral resection (regions required)	196	7+T

REPAIR OF RETINAL DETACHMENT WITH LASER PHOTOCOAGULATION

MASG	28.44A	Re-attachment of retina and choroid by photocoagulation - retinal disease		
		RP=INTL (regions required)	171	7+T
		RP=REPT (regions required) repeat same eye - within 30 days	80	6+T
MASG	28.44B	Laser photocoagulation retinal or vascular		
		RP=INTL (regions required)	147	6+T
		RP=REPT (regions required) repeat same eye - within 30 days	73	6+T
MASG	28.44C	Re-attachment of retina and choroid by photocoagulation - vascular		
		RP=INTL (regions required)	125	7+T
		RP=REPT (regions required) repeat same eye - within 30 days	65	6+T

OTHER OPERATIONS FOR REPAIR OF RETINA NEC

MASG	28.49A	Pneumatic retinopexy (regions required)	250	6+T
MASG	28.54A	Laser Photocoagulation for the treatment of Retinopathy of Prematurity	160	6+T

OTHER DESTRUCTION OF LESION OF RETINA OR CHOROID

MASG	28.59A	Coagulation with scleral flap (regions required)	250	7+T

REMOVAL OF IMPLANTED MATERIAL FROM POSTERIOR SEGMENT

MASG	28.61B	Removal of scleral buckle (regions required)	90	5+T

OTHER OPERATIONS ON RETINA

MASG	28.63A	Membrane peeling (regions required)	200	6+T
MASG	28.63B	Retinotomy (regions required)	100	6+T

REMOVAL OF VITREOUS, ANTERIOR APPROACH (PARTIAL)

MASG	28.71	Removal of vitreous, anterior approach (partial) (regions required)	147	8+T
MASG	28.71A	Anterior vitrectomy or anterior chamber washout (regions required)	147	8+T

REMOVAL OF VITREOUS, OTHER APPROACH

MASG	28.72	Removal of vitreous, other approach AP=POST (regions required)	367	8+T

INJECTION OF VITREOUS SUBSTITUTE

MASG	28.73A	Silicone oil injection (regions required)	100	6+T
MASG	28.73B	Air/fluid/gas exchange (regions required)	200	6+T
MASG	28.73C	Intraocular or intravitreal injection of air (regions required)	60	4+T
VADT	28.73D	Intravitreal injection of antibiotics (regions required)	25	
MASG	28.73E	Scleral resection - with vitreous implant (regions required)	275	6+T
VADT	28.73F	Intravitreal injection of a pharmacologic agent for the treatment of specific retinal diseases	25	

DISCISSION OF VITREOUS STRANDS

MASG	28.74A	Laser lysis of vitreous strands (regions required)	100	6+T

OTHER OPERATIONS ON VITREOUS

MASG	28.79A	Scleral resection with vitreous injection of implant (regions required)	275	7+T

OTHER ORBITOTOMY

MASG	29.09B	Orbital exploration for foreign body (regions required)	100	6+T
MASG	29.09C	Orbital exploration for foreign body and decompression (regions required)	225	6+T
MASG	29.09D	Incision drainage of abscess of the orbit (regions required)	100	6+T

REMOVAL OF PENETRATING FOREIGN BODY FROM UNSPECIFIED STRUCTURE OF EYE

MASG	29.1	Removal of penetrating foreign body from unspecified structure of eye		
		AP=POST (regions required)	200	4+T
		AP=ANTE (regions required)	125	4+T
MASG	29.1A	Foreign body non-magnetic		
		AP=POST (regions required)	250	4+T
		AP=ANTE (regions required)	125	4+T

REMOVAL OF OCULAR CONTENTS WITH IMPLANT INTO SCLERAL SHELL

MASG	29.21	Removal of ocular contents with implant into scleral shell (regions required)	200	6+T

OTHER EVISCERATION OF EYEBALL

MASG	29.29	Other evisceration of eyeball (regions required)	150	6+T

ENUCLEATION OF EYEBALL WITH IMPLANT INTO TENON'S CAPSULE WITH ATTACHMENT OF MUSCLES

MASG	29.31	Enucleation of eyeball with implant into tenon's capsule with muscles (Regions required)	200	6+T

OTHER ENUCLEATION OF EYEBALL

MASG	29.39	Other enucleation of eyeball (regions required)	130	6+T
		(PT=CDDR) (regions required)	125	
MASG	29.39A	Secondary operation after enucleation of eyeball to replace implant (Regions required)	100	4+T

OTHER EXENTERATION OF ORBIT

MASG	29.49A	Exenteration and skin graft (regions required)	350	6+T

RETROBULBAR INJECTION OF THERAPEUTIC AGENT

MISG	29.91	Retrobulbar injection of therapeutic agent (regions required)	15	
MISG	29.91B	Retrobulbar injection with alcohol (regions required)	25	

EXCISION OF LESION OF ORBIT

MASG	29.94A	Excision of tumour, Kronlein Procedure (regions required)	400	6+T
MASG	29.94B	Tumour - removal by anterior route (regions required)	300	6+T
MASG	29.94C	Tumour - removal by intracranial route (regions required)	300	6+T

OTHER OPERATIONS ON EYEBALL

MASG	29.98A	Laser gonioplasty (regions required)	125	4+T

OPEN REDUCTION OF ORBITAL FRACTURE

MASG	88.16	Open reduction of orbital fracture (regions required)	216	6+T

ORTHOPAEDICS

(SP=ORTH)

CATEGORY	HEALTH SERVICE CODE	DESCRIPTION / MODIFIERS	BASE UNITS	ANAES UNITS
CONSULTATIONS				
CONS	03.08	Comprehensive Consultation		
		RF=REFD (ME=TELE)	38.2	
		RF=REFD, US=PREM (ME=TELE)	56.2	
		RF=REFD, US=PR50 (ME=TELE)	57.3	
		RF=REFD, RO=DETE (ME=TELE)	38.2+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	56.2+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	57.3+MU	
CONS	03.07	Limited Consultation		
		RF=REFD (ME=TELE)	27.5	
		RF=REFD, US=PREM (ME=TELE)	45.5	
		RF=REFD, US=PR50 (ME=TELE)	45.5	
		RF=REFD, RO=DETE (ME=TELE)	27.5+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	45.5+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	45.5+MU	
CONS	03.07	Repeat Consultation		
		RF=REFD, RP=REPT (ME=TELE)	25.5	
		RF=REFD, RP=REPT, US=PREM (ME=TELE)	43.5	
		RF=REFD, RP=REPT, US=PR50 (ME=TELE)	43.5	
		RF=REFD, RO=DETE, RP=REPT (ME=TELE)	25.5+MU	
		RF=REFD, RO=DETE, RP=REPT, US=PREM (ME=TELE)	43.5+MU	
		RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE)	43.5+MU	
OFFICE				
VIST	03.04	Initial Visit with Complete Examination		
		LO=OFFC (RF=REFD)	24	
VIST	03.03	Initial Visit with Regional Examination		
		LO=OFFC, RP=INTL (RF=REFD)	12	
		LO=OFFC, AG=OV65, RP=INTL (RF=REFD)	16.5	
VIST	03.03	Subsequent Visit		
		LO=OFFC, RP=SUBS (ME=VTCR*) (RF=REFD)	13	
		*Physician Restrictions in Place (See Appendix J)		
VIST	03.03A	Geriatric Office Visit (for patients aged 65+)		
		LO=OFFC (ME=VTCR*) (RF=REFD)	16.5	
		*Physician Restrictions in Place (See Appendix J)		

VIST 03.03 Continuing Care
LO=OFFC, RO=CNTC, RF=REFD 13.5
LO=OFFC, AG=OV65, RO=CNTC, RF=REFD 16.5

VIST 03.03 Directive Care
LO=OFFC, RO=DIRC, RF=REFD 13.5
LO=OFFC, AG=OV65, RO=DIRC, RF=REFD 16.5

VIST 03.03 Urgent Care - Request by Patient (1701 - 2000)
LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Request by Patient (2001 - 2359)
LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Request by Patient (0000 - 0800)
LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) 38.3

VIST 03.03 Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Extra Patient
LO=OFFC, PT=EXPT (RF=REFD) 10.5

HOSPITAL (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

VIST 03.04 Initial Visit with Complete Examination
LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD) 24
LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD) ..... 24+MU

VIST 03.04 Initial Visit
LO=HOSP, FN=INPT, RP=INTL (RF=REFD) 25
LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD) ..... 25+MU

VIST 03.03 Continuing Care
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC, RF=REFD 15
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT, RF=REFD ..... 15+MU

VIST 03.03 Directive Care
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD 15
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD ..... 15+MU

VIST 03.03 Subsequent Visit - Daily to 56 Days
LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) 15
LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU

VIST 03.03 Subsequent Visit - Weekly after 56 Days - Maximum 44 units per week
LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD) 15
LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU

ADON	03.02A	Hospital Discharge Fee LO=HOSP, FN=INPT 10
VIST	03.03	Urgent Hospital Care LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)..... 22 LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD)..... 22+MU
VIST	03.03	Emergency Visit LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)..... 35.2 LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)..... 35.2+MU
VIST	03.03	Outpatient Visit (0800 - 1700) LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD) ..... 13.5 LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD) ..... 13.5+MU
VIST	03.03	Outpatient Visit (1701 - 2000) LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 20 LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU
VIST	03.03	Outpatient Visit (2001 - 2359) LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 20 LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU
VIST	03.03	Outpatient Visit (0000 - 0800) LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)..... 26 LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)..... 26+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)..... 20 LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)..... 20 LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD)..... 7 LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 7+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD) ..... 7 LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 7+MU
VIST	03.03	Outpatient Visit (1701 - 2000) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD)..... 10.5 LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD)..... 10.5+MU

VIST	03.03	Outpatient Visit (2001 - 2359) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD) ..... 10.5 LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD) ..... 10.5+MU	
VIST	03.03	Outpatient Visit (0000 - 0800) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) ..... 11.4 LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) ..... 11.4+MU	
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD)..... 10.5 LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 10.5+MU	
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) ..... 10.5 LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 10.5+MU	

PROCEDURES

MANUAL RUPTURE OF JOINT ADHESIONS

MISG	07.27A	Manipulation - shoulder including application of cast or traction AN=GENL (regions required)..... 25	4+T
MISG	07.27B	Manipulation - elbow including application of cast or traction AN=GENL (regions required)..... 25	4+T
MISG	07.27C	Manipulation - wrist including application of cast or traction AN=GENL (regions required)..... 25	4+T
MISG	07.27D	Manipulation - hip including application of cast or traction AN=GENL (regions required)..... 25	4+T
MISG	07.27E	Manipulation - knee including application of cast or traction AN=GENL (regions required)..... 25	4+T
MISG	07.27F	Manipulation - ankle including application of cast or traction AN=GENL (regions required)..... 25	4+T
MISG	07.27G	Manipulation - vertebral column including application of cast or traction AN=GENL..... 25	5+T

OTHER FORCIBLE CORRECTION OF DEFORMITY

MISG	07.29A	Congenital foot deformity - manipulation and casts - initial - unilateral ..... 25 (Regions required)	
MISG	07.29B	Congenital foot deformity - manipulation and casts - subsequent - unilateral..... 15 (Regions required)	
MISG	07.29C	Congenital foot deformity - manipulation and casts - initial - bilateral..... 35	
MISG	07.29D	Congenital foot deformity - manipulation and casts - subsequent - bilateral..... 23.8	
MISG	07.29E	Congenital foot deformity - manipulation and casts AN=GENL (regions required)..... 25	4+T

SPINAL TRACTION USING SKULL DEVICE

MIFR	07.41	Spinal traction using skull device	50	5+T

APPLICATION OF PLASTER JACKET

MISG	07.51	Application of plaster jacket AN=GENL	50	4+T
CASP	07.51B	Application of plaster casts, body - shoulder to hips	25	
CASP	07.51C	Application of plaster casts, body - including head	35	

APPLICATION OF NECK SUPPORT

CASP	07.52	Application of neck support	10	

APPLICATION OF OTHER CAST

CASP	07.53A	Application of plaster cast, bilateral wedging	15	
CASP	07.53B	Molded plaster to forearm (regions required)	12.5	
CASP	07.53C	Application of plaster cast, elbow to finger (regions required)	12.5	
CASP	07.53D	Application of plaster cast, hand to wrist (regions required)	12.5	
CASP	07.53E	Application of plaster cast, shoulder to hand (regions required)	12.5	
CASP	07.53F	Shoulder spica (regions required)	25	
CASP	07.53G	Application of plaster cast, ankle (foot to mid-leg) (regions required)	12.5	
CASP	07.53H	Application of plaster cast, knee (foot to thigh) (regions required)	15	
CASP	07.53I	Ambulatory leg cast (regions required)	15	
CASP	07.53J	Molded plaster to leg (regions required)	15	
CASP	07.53K	Spica (rib margin to toe) (regions required)	25	

APLICATION OF SPLINT

CASP	07.54A	Unna Boot (regions required)	5	
CASP	07.54B	Application of corrective splints, fingers, hand, wrist (regions required)	10	
CASP	07.54C	Application of splints, elbow (regions required)	10	
CASP	07.54D	Application of corrective splints, shoulder (regions required)	10	
CASP	07.54E	Application of corrective splints, below knee (including foot) (regions required)	10	
CASP	07.54F	Application of corrective splints knee (regions required)	10	
CASP	07.54G	Application of corrective splints whole leg (mid-thigh to toe) (regions required)	10	

OTHER EXPLORATION AND DECOMPRESSION OF SPINAL CANAL

MASG	16.09J	Cervical laminoplasty	500	8+T

REPAIR OF VERTEBRAL FRACTURE

MASG	16.43A	Open reduction without cord injury	200	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T
MASG	16.43B	Open reduction with internal fixation without cord injury	285	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T
MASG	16.43C	Open reduction and fusion in conjunction with Orthopaedic Surgeon		
		SP=NUSG	225	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T
MASG	16.43D	Injury - antero-lateral decompression of thoracic spinal cord	425	7+T
MASG	16.43E	Open reduction with cord injury	250	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T
MASG	16.43F	Open reduction with internal fixation with cord injury	275	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T
MASG	16.43G	Open reduction and fusion in conjunction with Orthopaedic Surgeon		
		SP=NUSG	200	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T
MAFR	16.43H	Spine fracture or fracture dislocation - anterior cervical decompression and/or fusing	300	7+T
MAFR	16.43I	Spine fracture or fracture dislocation - open reduction with decompression of cord or nerve roots	300	7+T
MAFR	16.43J	Spine fracture or fracture dislocation - open reduction	200	7+T
MASG	16.43K	Reduction, internal fixation C1-C2 including harvesting of bone graft if by same surgeon	365	11+T

OTHER EXCISION OR AVULSION OF CRANIAL AND PERIPHERAL NERVES

MASG	17.08H	Neurectomy - elbow or knee (regions required)	150	4+T
MASG	17.08I	Neurectomy - hip (regions required)	175	5+T

RELEASE OF CARPAL TUNNEL

MASG	17.33A	Decompression including neurolysis if medically indicated (regions required)	85	4+T
		RP=REPT (regions required)	137.5	

OTHER PERIPHERAL NERVE OF GANGLION DECOMPRESSION OR FREEING OF ADHESIONS

MASG	17.39B	Neuroplasty of major peripheral nerve of the upper extremity (excluding median nerve at the carpal tunnel, and ulnar nerve at the elbow). Specifically; Guyon's Canal (ulnar nerve release at wrist), anterior interosseous nerve (median nerve in forearm), posterior interosseus nerve (radial nerve in forearm wrist) (regions required)	125	4+T
MASG	17.39C	Neuroplasty of major peripheral nerve of the lower extremity. Specifically; Peroneal nerve release, tarsal tunnel (posterior tibial nerve) (regions required)	125	4+T

TRANSPOSITION OF CRANIAL AND PERIPHERAL NERVES

MASG	17.5B	Ulnar nerve release at the elbow (cubital tunnel) (regions required)	125	4+T
		RP=REPT	200	4+T

OTHER INCISION OF FACIAL BONE WITHOUT DIVISION

MISG	88.29	Other incision of facial bone without division	25	7+T

TEMPOROMANDIBULAR ARTHROPLASTY

MASG	88.6	Temporomandibular arthroplasty	175	10+T
MASG	88.6A	Arthrotomy (meniscectomy or condylectomy)	150	8+T
MASG	88.6B	Temporomandibular joint - meniscectomy (regions required)	150	5+T

CLOSED REDUCTION OF TEMPOROMANDIBULAR DISLOCATION

DISL	88.92	(Closed) reduction of temporomandibular dislocation (regions required)	15	
		AN=GENL (regions required)	25	4+T
		AN=LOCL (regions required)	25	
		AN=REGL (regions required)	25	

OPEN REDUCTION OF TEMPOROMANDIBULAR DISLOCATION

DISL	88.93	Open reduction of temporomandibular dislocation (regions required)	125	5+T

SEQUESTRECTOMY, OTHER SPECIFIED SITE

MASG	89.08	Sequestrectomy, other specified site		
		ME=SIMP	200	4+T

MISG	89.08A	Pelvis	25	4+T
MASG	89.08B	Vertebrae incision and drainage	250	4+T

SEQUESTRECTOMY, UNSPECIFIED SITE

MASG	89.09C	Large bones - secondary closure	100	4+T
MASG	89.09D	Small bones - secondary closure	75	4+T
MASG	89.09E	Sequestrectomy - large bones	150	4+T
MASG	89.09F	Sequestrectomy - small bones	150	4+T

OTHER INCISION OF BONE WITHOUT DIVISION, OTHER SPECIFIED SITE

MASG	89.18A	Forage of hip (regions required)	175	6+T
MISG	89.18B	Skull and facial bones	25	7+T

OTHER INCISION OF BONE WITHOUT DIVISION, UNSPECIFIED SITE

MISG	89.19A	Incision of subperiosteal abscess	25	4+T
MASG	89.19B	Foraging of os calcis (regions required)	75	4+T
MISG	89.19D	Large bones - incision and drainage	25	4+T

OTHER DIVISION OF BONE - SCAPULA, CLAVICLE, AND THORAX (RIBS AND STERNUM)

MASG	89.30A	Sternal split (when billed alone)	200	20+T
MASG	89.30B	Osteotomy - clavicle	125	4+T
MASG	89.30C	Glenoid osteotomy (regions required)	300	7+T

OTHER DIVISION OF BONE - HUMERUS

MASG	89.31A	Osteotomy - humerus (regions required)	150	4+T

OTHER DIVISION OF BONE - RADIUS AND ULNA

MASG	89.32	Other division of bone, radius and ulna (regions required)	200	4+T
MASG	89.32A	Osteotomy - radius (regions required)	150	4+T
MASG	89.32B	Osteotomy - ulna (regions required)	150	4+T

OTHER DIVISION OF BONE - CARPALS AND METACARPALS

MASG	89.33A	Osteotomy - metacarpal or metatarsal - with or without internal fixation (Regions required) - plus multiples, if applicable	95	4+T

OTHER DIVISION OF BONE - FEMUR

MASG	89.34A	Osteotomy - femur, neck, intertrochanteric or shaft (regions required)	200	6+T
MASG	89.34B	Osteotomy - femur, supracondylar, bilateral	300	6+T
MASG	89.34C	Osteotomy - femur, supracondylar and tibia, fibula (regions required)	300	6+T

OTHER DIVISION OF BONE - TIBIA AND FIBULA

MASG	89.36A	Osteotomy - tibia (with or without fibula) (regions required)	190	4+T

OTHER DIVISION OF BONE - TARSALS AND METATARSALS

MASG	89.37A	Osteotomy - with or without internal fixation (regions required) - plus multiples, if applicable	95	4+T

OTHER DIVISION OF BONE - OTHER SPECIFIED SITE

MASG	89.38A	Osteotomy - phalanx, single (regions required) - plus multiples, if applicable	75	4+T
MAAS	89.38B	Osteotomy - spine	IC	7+T
MASG	89.38C	Pelvis - innominate osteotomy	200	4+T
MASG	89.38D	Pelvis - osteotomy - with iliopsoas transfer	250	7+T
DISL	89.38E	Dislocation hip - congenital - Chiari osteotomy (regions required)	350	8+T
DISL	89.38F	Dislocation hip - congenital - open reduction with limbectomy or derotation osteotomy (regions required)	250	9+T
DISL	89.38G	Dislocation hip - congenital - open reduction with innominate osteotomy (Regions required)	350	9+T

OTHER DIVISION OF BONE - UNSPECIFIED SITE

MASG	89.39A	Osteotomy - os calcis (regions required)	150	4+T

BUNIONECTOMY WITH SOFT TISSUE CORRECTION AND OSTEOTOMY OF THE FIRST METATARSAL

MASG	89.41	Bunionectomy with soft tissue correction and osteotomy of the first metatarsal (regions required)	114	4+T

OTHER BUNIONECTOMY WITH SOFT TISSUE CORRECTION

MASG	89.43	Other bunionectomy with soft tissue correction (regions required)	100	4+T
MASG	89.43A	Foot reconstruction - Joplin, Lapidus (regions required)	150	4+T

OTHER EXCISION OF BUNION

MASG	89.49A	Keller's Procedure (regions required)	95	4+T

LOCAL EXCISION OF LESION OR TISSUE OF BONE - HUMERUS

MASG	89.51A	Upper limb resection of malignant musculoskeletal tumour of bone (Regions required)	400	15+T
MASG	89.51B	Upper limb resection of malignant musculoskeletal tumour of bone - with allograft reconstruction with or without ligament or tendon reconstruction (Regions required)	550	15+T

LOCAL EXCISION OF LESION OR TISSUE OF BONE - RADIUS AND ULNA

MASG	89.52A	Upper limb resection of malignant musculoskeletal tumour of bone (Regions required)	400	15+T
MASG	89.52B	Upper limb resection of malignant musculoskeletal tumour of bone - with allograft reconstruction with or without ligament or tendon reconstruction (Regions required)	550	15+T

LOCAL EXCISION OF LESION OR TISSUE OF BONE - FEMUR

MASG	89.54A	Resection of femoral malignant bone tumour (regions required)	500	15+T
MASG	89.54B	Resection of femoral malignant bone tumour with allograft reconstruction with or without ligament or tendon reconstruction (regions required)	650	15+T

LOCAL EXCISION OF LESION OR TISSUE OF BONE - TIBIA AND FIBULA

MASG	89.56A	Resection of tibial malignant bone tumour (regions required)	500	15+T
MASG	89.56B	Resection of tibial malignant bone tumour with allograft reconstruction with or without ligament or tendon reconstruction (regions required)	650	15+T

LOCAL EXCISION OF LESION OR TISSUE OF BONE - OTHER SPECIFIED SITE

MASG	89.58A	Bone biopsy - vertebrae - open	150	7+T
MASG	89.58B	Vertebrae - saucerization (costotransversectomy) with graft as necessary	250	7+T
MASG	89.58C	Pelvic resection for malignant tumour (internal as part of limb salvage procedure)	700	20+T
MASG	89.58D	Pelvic resection for malignant tumour (internal as part of limb salvage procedure) - with allograft reconstruction with or without ligament or tendon reconstruction	850	20+T

LOCAL EXCISION OF LESION OR TISSUE OF BONE - UNSPECIFIED SITE

MASG	89.59A	Large bones - saucerization	150	4+T
MASG	89.59B	Small bones - saucerization	100	4+T

MASG	89.59C	Small bones - saucerization and bone graft	200	4+T
MASG	89.59D	Bone biopsy - superficial	75	4+T
MASG	89.59E	Bone biopsy - open	95	4+T
MASG	89.59F	Major bone - excision bone tumours, bone cyst, exostosis	119	4+T
		RG=FEMR		5+T
MASG	89.59G	Excision bone tumours, bone cyst, exostosis - major bone - with bone graft	175	4+T
		RG=FEMR		5+T
MASG	89.59H	Excision bone tumours, bone cyst, exostosis - minor bone	95	4+T
		RG=FEMR		5+T
MASG	89.59I	Excision bone tumours, bone cyst, exostosis - minor bone - with bone graft	125	4+T
		RG=FEMR		5+T
MASG	89.59J	Saucerization and bone graft major bones	200	4+T

EXCISION OF BONE FOR GRAFT - UNSPECIFIED SITE

MAAS	89.69B	Removal of malignant bone tumour - to include excision of bone, excision of soft tissue including nerves, vessels, muscles, ligaments and tendons. Includes removal of existing hardware and the application of internal or external hardware. To include bone graft of any type and prosthesis if needed .	IC	IC+T

OTHER PARTIAL OSTECTOMY - SCAPULA, CLAVICLE, AND THORAX (RIBS AND STERNUM)

MASG	89.70A	Acromion or outer end of clavicle included in composite rotator cuff repair (Regions required)	95	4+T

OTHER PARTIAL OSTECTOMY - HUMERUS

MASG	89.71A	Humerus - head (regions required)	175	4+T
MASG	89.71B	Humerus - head, with replacement (regions required)	250	4+T
MAAS	89.71C	Humerus - head, with extensive reconstruction (regions required)	IC	4+T

OTHER PARTIAL OSTECTOMY - RADIUS AND ULNA

MASG	89.72A	Radius - head (regions required)	100	4+T
MASG	89.72B	Radius - styloid (regions required)	100	4+T
MASG	89.72C	Radius - head, with prosthetic replacement (regions required)	150	4+T
MASG	89.72D	Ulna - olecranon and repair (regions required)	125	4+T
MASG	89.72E	Ulna - excision of distal end (regions required)	100	4+T
ADON	89.72F	Ulna - excision of distal end in combination with other procedure – Darroch Procedure (regions required)	50	

OTHER PARTIAL OSTECTOMY - CARPALS AND METACARPALS

MASG	89.73A	Metatarsal head (regions required) - plus multiples, if applicable	75	4+T

OTHER PARTIAL OSTECTOMY - FEMUR

MASG	89.74A	Femur - head and neck (regions required)	200	5+T

OTHER PARTIAL OSTECTOMY - PATELLA

MASG	89.75	Other partial ostectomy, patella (regions required)	150	4+T

OTHER PARTIAL OSTECTOMY - UNSPECIFIED SITE

MAAS	89.79C	Bone tumours - major bone radical excision and reconstruction	IC	4+T
		RG=FEMR		5+T
MAAS	89.79D	Bone tumours - minor bone radical excision and reconstruction	IC	4+T
		RG=FEMR		5+T

TOTAL OSTECTOMY - SCAPULA, CLAVICLE AND THORAX (RIBS AND STERNUM)

MASG	89.80B	Claviculectomy (regions required)	150	4+T
MASG	89.80C	Cervical rib (regions required)	150	10+T

TOTAL OSTECTOMY - CARPALS AND METACARPALS

MASG	89.83	Total ostectomy, carpals and metacarpals (regions required) - plus multiples, if applicable	125	4+T
MASG	89.83A	Carpectomy (regions required) - plus multiples, if applicable	125	4+T
MASG	89.83B	Scaphoid, accessory (regions required)	100	4+T

TOTAL OSTECTOMY - PATELLA

MASG	89.85	Total ostectomy, patella (regions required)	150	4+T

TOTAL OSTECTOMY - TARSALS AND METATARSALS

MASG	89.87A	Tarsal bar (regions required)	100	4+T
MASG	89.87B	Talus (regions required)	150	4+T

TOTAL OSTECTOMY - OTHER SPECIFIED SITE

MASG	89.88A	Sesamoids one or more (regions required)	100	4+T
MASG	89.88B	Phalanx (regions required) - plus multiples, if applicable	71	4+T
MAAS	89.88C	Radical excision and reconstruction bone tumours - vertebral column	IC	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T

TOTAL OSTECTOMY - UNSPECIFIED SITE

MASG	89.89A	Coccygectomy	75	5+T

BIOPSY OF BONE - OTHER SPECIFIED SITE

MASG	89.98A	Punch biopsy of vertebra	75	4+T

BIOPSY OF BONE - UNSPECIFIED SITE

MISG	89.99A	Punch biopsy - without x-ray control	38	4+T
MASG	89.99B	Punch biopsy - with x-ray control	65	4+T

BONE GRAFT - SCAPULA, CLAVICLE, AND THORAX (RIBS AND STERNUM)

BOGR	90.00A	Bone graft - clavicle (for primary bone grafts in a fresh fracture, add 50% of the code to the primary procedure) (regions required)	175	4+T

BONE GRAFT - HUMERUS

BOGR	90.01	Bone graft, humerus (for primary bone grafts in a fresh fracture, add 50% of the bone graft code to the primary procedure (regions required)	200	4+T

BONE GRAFT - RADIUS AND ULNA

BOGR	90.02	Bone graft, radius and ulna (for primary bone grafts in a fresh fracture, add 50% of the bone graft code to the primary procedure) (regions required)	200	4+T
BOGR	90.02A	Bone graft - radius or ulna (for primary bone grafts in a fresh fracture, add 50% of the bone graft code to the primary procedure) (regions required)	175	4+T

BONE GRAFT - CARPALS AND METACARPALS

BOGR	90.03	Bone graft, carpals and metacarpals (for primary bone grafts in a fresh fracture, add 50% of the bone graft code to the primary procedure) (Regions required) - plus multiples, if applicable	100	4+T
BOGR	90.03A	Bone graft, scaphoid (for primary bone grafts in a fresh fracture, add 50% of the bone graft code to the primary procedure) (regions required)	175	4+T

BONE GRAFT - FEMUR

BOGR	90.04A	Bone graft - femur - neck or shaft (for primary bone grafts in a fresh fracture, add 50% of the bone graft code to the primary procedure) (Regions required)	190	6+T

BONE GRAFT - TIBIA AND FIBULA

BOGR	90.06A	Bone graft - tibia (for primary bone grafts in a fresh fracture, add 50% of the bone graft code to the primary procedure) (regions required)	190	4+T
ADON	90.06B	Fixation of vascularized fibula graft for limb salvage - not eligible for premium fees (patient specific)	150	

BONE GRAFT - TARSALS AND METATARSALS+

BOGR	90.07	Bone graft, tarsals and metatarsals (for primary bone grafts in a fresh fracture, add 50% of the bone graft code to the primary procedure) (Regions required) - plus multiples, if applicable	100	4+T
BOGR	90.07A	Bone graft - talus (for primary bone grafts in a fresh fracture, add 50% of the bone graft code to the primary procedure) (regions required)	200	4+T

BONE GRAFT - OTHER SPECIFIED SITE

BOGR	90.08A	Bone graft - phalanx (for primary bone grafts in a fresh fracture, add 50% of the bone graft code to the primary procedure) (regions required) - plus multiples, if applicable	75	4+T
MAAS	90.08B	Bone graft - pelvis (for primary bone grafts in a fresh fracture, add 50% of the bone graft code to the primary procedure)	IC	7+T

BONE GRAFT - UNSPECIFIED SITE

ADON	90.09A	Morselized allograft	50	

EPIPHYSEAL STAPLING - FEMUR

MASG	90.24	Epiphyseal stapling, femur (regions required)	150	4+T
MASG	90.24A	Epiphysiodesis (regions required)	150	4+T

EPIPHYSEAL STAPLING - TIBIA AND FIBULA

MASG	90.26	Epiphyseal stapling, tibia and fibula (regions required)	150	4+T
MASG	90.26A	Epiphysiodesis (regions required)	150	4+T

EPIPHYSEAL STAPLING - OTHER SPECIFIED SITE

MASG	90.28A	Tibia and femur (regions required)	200	4+T
MASG	90.28B	Epiphysiodesis - tibia and femur (regions required)	200	4+T

OTHER CHANGE IN BONE LENGTH - HUMERUS

MASG	90.31A	Shortening of humerus with or without bone graft (regions required)	250	4+T

OTHER CHANGE IN BONE LENGTH - RADIUS AND ULNA

MASG	90.32A	Shortening of radius and ulna (regions required)	150	4+T

OTHER CHANGE IN BONE LENGTH - FEMUR

MASG	90.34A	Shortening of femur with or without bone graft (regions required)	250	4+T

OTHER CHANGE IN BONE LENGTH - TIBIA AND FIBULA

MASG	90.36A	Shortening of tibia with or without bone graft (regions required)	250	4+T
MASG	90.36B	Lengthening of tibia (regions required)	250	4+T

OTHER CHANGE IN BONE LENGTH - TARSALS AND METATARSALS

MASG	90.37A	Osteoplasty of metatarsal - single (regions required)	125	4+T
MASG	90.37B	Osteoplasty of metatarsal - more than one (regions required)	175	4+T

OTHER CHANGE IN BONE LENGTH - UNSPECIFIED SITE

MASG	90.39A	Lengthening of major bone	300	4+T

OTHER REPAIR OR PLASTIC OPERATION ON BONE - SCAPULA, CLAVICLE, AND THORAX (RIBS AND STERNUM)

MASG	90.40A	Scapulopexy	250	6+T

OTHER REPAIR OR PLASTIC OPERATION ON BONE OTHER REPAIR OR PLASTIC OPERATION ON BONE, SCAPULA, CLAVICLE, AND THORAX (RIBS AND STERNUM)

MASG	90.40B	Repair of Sternal Non-union	750	20+T

OTHER REPAIR OR PLASTIC OPERATION ON BONE - UNSPECIFIED SITE

MISG	90.49A	Electromagnetic bone stimulator with external generator	40	

REMOVAL OF INTERNAL FIXATION DEVICE

MASG	90.6A	Removal of Harrington Rod apparatus	125	6+T

REMOVAL OF INTERNAL FIXATION DEVICE - UNSPECIFIED SITE

MASG	90.69B	Removal of internal fixation - metal plate, band, screw or nail (Regions required)	71	4+T
MISG	90.69C	Removal of percutaneous k-wire (when the fee for removal of multiple k-wires exceeds 50 units, the surgical rules apply) - plus multiples, if applicable	10	4+T
MASG	90.69D	Removal of Complex Internal Fixation Device(s) (IM nail, locking plate) as sole Operative procedure	110	4+T

CLOSED REDUCTION OF FRACTURE (WITHOUT INTERNAL FIXATION) - HUMERUS

MAFR	91.00A	Fractured humerus neck without dislocation of head - closed reduction (Regions required)	100	4+T
MAFR	91.00B	Fractured humerus shaft - closed reduction (regions required)	95	4+T
MAFR	91.00C	Fractured humerus - epicondyle - medial - closed reduction (Regions required)	75	4+T
MAFR	91.00D	Fractured humerus - epicondyle - lateral - closed reduction (Regions required)	75	4+T
MAFR	91.00E	Fractured humerus tuberosity - closed reduction (regions required)	75	4+T

MAFR	91.00F	Fractured humerus neck with dislocation of head - closed reduction (Regions required)	100	4+T
MAFR	91.00G	Fractured humerus - supra or transcondylar - closed reduction (Regions required)	100	4+T

CLOSED REDUCTION OF FRACTURE (WITHOUT INTERNAL FIXATION) - RADIUS AND ULNA

MAFR	91.01	Closed reduction of fracture (without internal fixation), radius and ulna (Regions required)	95	4+T
MIFR	91.01A	Closed reduction fractured radius - head or neck (regions required)	50	4+T
MAFR	91.01B	Closed reduction fractured radius or ulna - shaft (regions required)	71	4+T
MAFR	91.01C	Colles' or Smith's fracture - closed reduction (regions required)	57	4+T
MAFR	91.01D	Monteggia's or Galleazzi's fracture - closed reduction (regions required)	100	4+T

CLOSED REDUCTION OF FRACTURE (WITHOUT INTERNAL FIXATION) - CARPALS AND METACARPALS

MIFR	91.02A	Closed reduction - carpus (excluding scaphoid) (regions required)	50	4+T
MIFR	91.02B	Closed reduction metacarpal (regions required) - plus multiples, if applicable	50	4+T
MIFR	91.02C	Closed reduction Bennett's fracture (regions required)	50	4+T

CLOSED REDUCTION OF FRACTURE (WITHOUT INTERNAL FIXATION) - PHALANGES OF HAND

MIFR	91.03A	Closed reduction phalanx, terminal - upper extremity (regions required) - plus multiples, if applicable	35	4+T
MIFR	91.03B	Closed reduction phalanx - middle or proximal (regions required) - plus multiples, if applicable	35	4+T

CLOSED REDUCTION OF FRACTURE (WITHOUT INTERNAL FIXATION) - FEMUR

MISG	91.04A	Fractured femur - shaft or transcondylar - cast bracing of the femoral shaft (Regions required)	50	4+T
MAFR	91.04B	Fractured femur neck - closed reduction with external fixation (Regions required)	150	6+T
MAFR	91.04C	Fractured femur - pertrochanteric - closed reduction with external fixation (Regions required)	150	6+T
MAFR	91.04D	Fractured femur - shaft or transcondylar- closed reduction (Regions required)	142	6+T

CLOSED REDUCTION OF FRACTURE (WITHOUT INTERNAL FIXATION) - TIBIA AND FIBULA

MAFR	91.05A	Fracture - tibia with or without fibula - closed reduction (regions required)	119	4+T
MAFR	91.05B	Fractured ankle - medial malleolus - closed reduction (regions required)	75	4+T
MIFR	91.05C	Fracture fibula - closed reduction (regions required)	35	4+T
MIFR	91.05D	Fractured ankle - lateral malleolus - closed reduction (regions required)	50	4+T
MAFR	91.05E	Fractured ankle - bimalleolar (including Pott's) - closed reduction (Regions required)	100	4+T
MAFR	91.05F	Fractured ankle - trimalleolar - closed reduction (regions required)	100	4+T

CLOSED REDUCTION OF FRACTURE (WITHOUT INTERNAL FIXATION) - TARSALS AND METATARSALS

MIFR	91.06A	Fracture tarsus except os calcis - closed reduction (regions required)	50	4+T
MIFR	91.06B	Fractured talus - closed reduction (regions required)	50	4+T
MAFR	91.06C	Fracture os calcis - closed reduction (regions required)	75	4+T
MAFR	91.06D	Fracture os calcis - closed reduction with external pin fixation (Regions required)	100	4+T
MIFR	91.06E	Closed reduction metatarsal (regions required) - plus multiples, if applicable	35	4+T

CLOSED REDUCTION OF FRACTURE (WITHOUT INTERNAL FIXATION) - OTHER SPECIFIED BONE

MIFR	91.08A	Fractured olecranon - closed reduction (regions required)	50	4+T
MAFR	91.08B	Spine fracture or fracture dislocation - closed reduction with cast, frame or brace	150	5+T
MIFR	91.08C	Fracture - clavicle - closed reduction (regions required)	50	4+T
MAFR	91.08D	Fracture - scapula - body, neck or glenoid - closed reduction (Regions required)	75	4+T
MAAS	91.08E	Fracture sternum - closed reduction	IC	
		AP=WPLC		4+T
		AP=WPLO		9+T
MAAS	91.08F	Fracture - ribs - complicated	IC	
		AP=WPLC		4+T
		AP=WPLO		9+T
MAFR	91.08G	Fracture - pelvis - closed reduction - manipulation with x-ray control	150	4+T
MAFR	91.08H	Fracture - acetabulum, with or without pelvic fracture - closed reduction	75	4+T

MAFR	91.08I	Pelvis - central fracture - dislocation - closed reduction	150	4+T
MIFR	91.08J	Fracture patella - closed reduction (regions required)	35	4+T
MAFR	91.08K	Spine fracture or fracture dislocation - halo pelvic traction	115	5+T

CLOSED REDUCTION OF FRACTURE WITH PERCUTANEOUS FIXATION

MAFR	91.11A	External skeletal pin fixation - Radius and Ulna (regions required)		
		AG=ADUT	100	4+T
		AG=CH16	75	4+T
MAFR	91.12A	External skeletal pin fixation – Carpals and Metacarpals (regions required) -plus multiples, if applicable		
		AG=ADUT	100+MU	4+T
		AG=CH16	75+MU	4+T
MAFR	91.13A	External skeletal pin fixation – Phalanges of hand (regions required) - plus multiples, if applicable		
		AG=ADUT	100+MU	4+T
		AG=CH16	75+MU	4+T
MAFR	91.16A	External skeletal pin fixation – Tarsals and Metatarsals (regions required) - plus multiples, if applicable		
		AG=ADUT	100+MU	4+T
		AG=CH16	75+MU	4+T
MAFR	91.17A	External skeletal pin fixation – Phalanges of the foot (regions required) -plus multiples, if applicable		
		AG=ADUT	100+MU	4+T
		AG=CH16	75+MU	4+T

OPEN REDUCTION OF FRACTURE WITH INTERNAL FIXATION - HUMERUS

MAFR	91.30A	Fractured humerus neck without dislocation of head - open reduction (Regions required)	200	4+T
MAFR	91.30B	Fractured humerus shaft - open reduction	175	4+T
MAFR	91.30C	Fractured humerus - epicondyle - medial - open reduction (Regions required)	100	4+T
MAFR	91.30D	Fractured humerus - epicondyle - lateral - open reduction (Regions required)	125	4+T
MAFR	91.30E	Fractured humerus tuberosity - open reduction (regions required)	150	4+T
MAFR	91.30F	Fractured humerus neck with dislocation of head - open reduction (Regions required)	200	4+T
MAFR	91.30G	Fractured humerus - supra or transcondylar - open reduction (Regions required)	175	4+T

OPEN REDUCTION OF FRACTURE WITH INTERNAL FIXATION - RADIUS AND ULNA

MAFR	91.31	Open reduction of fracture with internal fixation, radius and ulna (Regions required)	150	4+T
MAFR	91.31A	Open reduction - fractured olecranon (regions required)	119	4+T
MAFR	91.31B	Open reduction - radius - head or neck (regions required)	100	4+T
MAFR	91.31C	Open reduction fractured radius or ulna - shaft (regions required)	125	4+T
MAFR	91.31D	Colles' or Smith's fracture - open reduction (regions required)	75	4+T
MAFR	91.31E	Monteggia's or Galleazzi's fracture - open reduction (regions required)	175	4+T
MAFR	91.31F	External skeletal pin fixation (regions required)		
		AG=ADUT	100	4+T
		AG=CH16	75	4+T
MAFR	91.31G	Distal comminuted intra-articular fracture of radius (to include distal ulna) due to high energy trauma. To include open reduction, internal/external fixation as required when performed in conjunction with remote donor site bone graft (regions required)	200	4+T

OPEN REDUCTION OF FRACTURE WITH INTERNAL FIXATION - CARPALS AND METACARPALS

MAFR	91.32A	Open reduction - carpus (excluding scaphoid) (regions required)	100	4+T
MAFR	91.32B	Open reduction - metacarpal (regions required)		
		- plus multiples, if applicable	96	4+T
MAFR	91.32C	Open reduction - scaphoid (regions required)	100	4+T
MAFR	91.32D	External skeletal pin fixation (regions required)		
		AG=ADUT	100+MU	4+T
		AG=CH16	75+MU	4+T
MAFR	91.32E	Open reduction and internal fixation using plates and/or screws - phalangeal or metacarpal fractures (regions required)	105	4+T

OPEN REDUCTION OF FRACTURE WITH INTERNAL FIXATION - PHALANGES OF HAND

MAFR	91.33A	Upper extremity - phalanx, terminal - open reduction (regions required)		
		- plus multiples, if applicable	75	4+T
MAFR	91.33B	Open reduction - Bennett's fracture (regions required)	100	4+T
MAFR	91.33C	Fracture scaphoid - excision (regions required)	125	4+T
MAFR	91.33D	Open reduction phalanx - middle or proximal (regions required)		
		- plus multiples, if applicable	72	4+T

OPEN REDUCTION OF FRACTURE WITH INTERNAL FIXATION - FEMUR

MAFR	91.34A	Fracture femur neck - open reduction with internal fixation (Regions required)	214	9+T
MAFR	91.34B	Fractured femur - pertrochanteric - open reduction (regions required)	214	9+T
MAFR	91.34C	Fractured femur - shaft or transcondylar - open reduction (Regions required)	190	9+T
MAFR	91.34D	Fracture femur neck - prosthetic replacement (regions required)	214	9+T
MAFR	91.34E	Locked femoral I.M. nails - regular (regions required)	250	9+T
MAFR	91.34F	Locked femoral I.M. nails - reconstruction nail (regions required)	300	9+T
MASG	91.34G	Locked tibial I.M. nails (regions required)	250	4+T

OPEN REDUCTION OF FRACTURE WITH INTERNAL FIXATION - TIBIA AND FIBULA

MAFR	91.35A	Fracture - tibia with or without fibula - shaft - open reduction (Regions required)	166	4+T
MAFR	91.35C	Fractured tibia with or without fibula - plateau - open reduction (Regions required)	166	4+T
MAFR	91.35D	Fractured ankle - single malleolus - open reduction (regions required)	95	4+T
MAFR	91.35E	Fracture fibula - open reduction (regions required)	75	4+T
MAFR	91.35F	Fractured ankle - bi or trimalleolar - open reduction (regions required)	142	4+T
MAFR	91.35G	Open Reduction and Internal Fixation (ORIF) Bicondylar Tibial Plateau Fracture	250	4+T

OPEN REDUCTION OF FRACTURE WITH INTERNAL FIXATION - TARSALS AND METATARSALS

MAFR	91.36A	Fracture talus - excision (regions required)	150	4+T
MAFR	91.36B	Fracture os calcis - open reduction and primary arthrodesis (Regions required)	200	4+T
MAFR	91.36C	Fracture tarsus except os calcis - open reduction (regions required)	150	4+T
MAFR	91.36D	Fractured talus - open reduction (regions required)	150	4+T
MAFR	91.36E	Fracture os calcis - open reduction (regions required)	150	4+T
MAFR	91.36F	Fractured metatarsal - open reduction (regions required) - plus multiples, if applicable	100	4+T

OPEN REDUCTION OF FRACTURE WITH INTERNAL FIXATION - PHALANGES OF FOOT

MIFR	91.37A	Fractured phalanx - lower extremity - open reduction (regions required) - plus multiples, if applicable	35	4+T

OPEN REDUCTION OF FRACTURE WITH INTERNAL FIXATION - OTHER SPECIFIED BONE

MAFR	91.38A	Fracture - clavicle - open reduction (regions required)	100	4+T
MAFR	91.38B	Fracture - scapula - body, neck or glenoid - open reduction (Regions required)	150	4+T
MAAS	91.38C	Fracture - sternum - open reduction	IC	
		AP=WPLC		4+T
		AP=WPLO		9+T
MAFR	91.38G	Fracture - acetabulum, with or without pelvic fracture - open reduction	250	4+T
MAFR	91.38H	Pelvis - central fracture - dislocation - open reduction	250	4+T
MAFR	91.38I	Fracture patella - excision and simple repair (regions required)	150	4+T
MAFR	91.38J	Fracture patella - excision and fascial repair (regions required)	175	4+T
MAFR	91.38K	Fracture patella - open reduction with tension band wiring (Regions required)	166	4+T
MAFR	91.38L	Open reduction pelvis for traumatic disruption - one pillar - all inclusive to include acetabulum if required	500	11+T
MAFR	91.38M	Pelvis - open reduction for traumatic disruption - 2 pillars - all inclusive to include acetabulum if required	700	11+T

CLOSED REDUCTION OF SEPARATED (SLIPPED) EPIPHYSIS - FEMUR

MAFR	91.44	(Closed) reduction of separated (slipped) epiphysis, femur (Regions required)	175	6+T

OPEN REDUCTION OF SEPARATED (SLIPPED) EPIPHYSIS - FEMUR

MAFR	91.54	Open reduction of separated (slipped) epiphysis, femur (Regions required)	225	9+T

CLOSED REDUCTION OF DISLOCATION OF SHOULDER

DISL	91.70	Closed reduction of dislocation of shoulder (regions required)	50	4+T

CLOSED REDUCTION OF DISLOCATION OF ELBOW

DISL	91.71	Closed reduction of dislocation of elbow (regions required)	50	4+T
MAAS	91.71A	Repair of recurrent dislocation of elbow (regions required)	IC	4+T

CLOSED REDUCTION OF DISLOCATION OF WRIST

DISL	91.72A	Dislocation of wrist and carpal bones - closed reduction (Regions required)	50	4+T

CLOSED REDUCTION OF DISLOCATION OF HAND AND FINGER

DISL	91.73A	Dislocation - metacarpophalangeal joint - closed reduction (Regions required) - plus multiples, if applicable	25	4+T
DISL	91.73B	Dislocation - interphalangeal joint - upper extremity - closed reduction (Regions required)	15	4+T

CLOSED REDUCTION OF DISLOCATION OF HIP

DISL	91.74	Closed reduction of dislocation of hip (regions required)	75	4+T
DISL	91.74A	Congenital dislocation - closed reduction (regions required)	150	4+T
DISL	91.74B	Central dislocation - closed reduction (regions required)	150	4+T
DISL	91.74C	Congenital - repeat - manipulation and plaster (regions required)	60	4+T

CLOSED REDUCTION OF DISLOCATION OF KNEE

DISL	91.75	Closed reduction of dislocation of knee (regions required)	75	4+T

CLOSED REDUCTION OF DISLOCATION OF ANKLE

DISL	91.76	Closed reduction of dislocation of ankle (regions required)	75	4+T

CLOSED REDUCTION OF DISLOCATION OF FOOT AND TOE

DISL	91.77A	Dislocation - tarsal - closed reduction (regions required) - plus multiples, if applicable	50	4+T
DISL	91.77B	Dislocation - metatarsophalangeal joint - closed reduction (Regions required) - plus multiples, if applicable	25	4+T
DISL	91.77C	Dislocation - interphalangeal joint - lower extremity - closed reduction (Regions required)	10	4+T

CLOSED REDUCTION OF DISLOCATION OF OTHER SPECIFIED SITES

DISL	91.78A	Dislocation spine-intervertebral - closed reduction including traction, etc	150	5+T
DISL	91.78B	Dislocation - sternoclavicular - closed reduction (regions required)	25	4+T
DISL	91.78C	Dislocation - acromioclavicular - closed reduction (regions required)	25	4+T
DISL	91.78D	Dislocation - patella - closed reduction (regions required)	25	4+T
DISL	91.78E	Dislocation - sacroiliac - closed reduction including traction, etc	75	5+T

OPEN REDUCTION OF DISLOCATION OF SHOULDER

DISL	91.80	Open reduction of dislocation of shoulder (regions required)	175	4+T

OPEN REDUCTION OF DISLOCATION OF ELBOW

DISL	91.81	Open reduction of dislocation of elbow (regions required)	150	4+T
MAAS	91.81A	Repair of recurrent dislocation of elbow (regions required)	IC	4+T

OPEN REDUCTION OF DISLOCATION OF WRIST

DISL	91.82A	Dislocation of wrist and carpal bones - open reduction (regions required)	150	4+T

OPEN REDUCTION OF DISLOCATION OF HAND AND FINGER

DISL	91.83A	Dislocation - metacarpophalangeal joint - open reduction (Regions required) - plus multiples, if applicable	75	4+T
DISL	91.83B	Dislocation - interphalangeal joint - upper extremity - open reduction (Regions required)	50	4+T
DISL	91.83C	Dislocation thumb - open reduction (regions required)	75	4+T

OPEN REDUCTION OF DISLOCATION OF HIP

DISL	91.84	Open reduction of dislocation of hip (regions required)	175	7+T
DISL	91.84A	Central dislocation - open reduction (regions required)	200	7+T
DISL	91.84B	Congenital dislocation - open reduction (regions required) ME=SIMP	225	9+T
DISL	91.84C	Congenital dislocation - open reduction with acetabuloplasty (Regions required)	250	9+T

OPEN REDUCTION OF DISLOCATION OF KNEE

DISL	91.85	Open reduction of dislocation of knee (regions required)	175	4+T
DISL	91.85A	Patella - repair of recurrent dislocation (regions required)	142	4+T

OPEN REDUCTION OF DISLOCATION OF ANKLE

DISL	91.86	Open reduction of dislocation of ankle (regions required)	125	4+T

OPEN REDUCTION OF DISLOCATION OF FOOT AND TOE

DISL	91.87A	Dislocation - tarsal - open reduction (regions required) - plus multiples, if applicable	125	4+T
DISL	91.87B	Dislocation - metatarsophalangeal joint - open reduction (Regions required) - plus multiples, if applicable	75	4+T
DISL	91.87C	Dislocation - interphalangeal joint - lower extremity - open reduction (Regions required)	50	4+T

OPEN REDUCTION OF DISLOCATION OF OTHER SPECIFIED SITES

DISL	91.88A	Dislocation spine - intervertebral - open reduction	200	7+T
		AP=CERV		8+T
DISL	91.88B	Dislocation - spine - intervertebral - open reduction and fusion	300	7+T
		AP=CERV		8+T
DISL	91.88C	Dislocation - sternoclavicular - open reduction (regions required)	100	4+T
DISL	91.88D	Dislocation - acromioclavicular - open reduction (regions required)	125	4+T
DISL	91.88E	Dislocation - patella - open reduction (regions required)	100	4+T
DISL	91.88F	Dislocation - sacroiliac - open reduction	150	5+T

OTHER OR UNSPECIFIED OPERATIONS ON BONE INJURIES NEC - HUMERUS

MIFR	91.90A	Fractured humerus shaft - no reduction (regions required)	50
MIFR	91.90B	Fractured humerus neck without dislocation of head - no reduction (Regions required)	50
MIFR	91.90C	Fractured humerus tuberosity - no reduction (regions required)	50
MIFR	91.90D	Fractured humerus neck with dislocation of head - no reduction (Regions required)	50
MIFR	91.90E	Fractured humerus supra or transcondylar - no reduction (Regions required)	50

OTHER OR UNSPECIFIED OPERATIONS ON BONE INJURIES NEC - FEMUR

MAFR	91.94A	Fractured femur shaft or transcondylar - no reduction (regions required)	75
MAFR	91.94B	Fracture femur - pertrochanteric - no reduction (regions required)	75
MAFR	91.94C	Fracture femur - neck - no reduction (regions required)	75

OTHER OR UNSPECIFIED OPERATIONS ON BONE INJURIES NEC - TIBIA AND FIBULA

MAFR	91.95A	Fracture tibia with or without fibula - no reduction (regions required)	75

PLAFOND FRACTURE PROCEDURES

MAFR	91.35B	Fractured tibial plafond, with or without fibula, open reduction and internal fixation -including removal of pre-existing internal or external fixation devices (Regions required)	200	4+T
MAFR	91.95C	External fixation of tibial plafond fracture (regions required)	150	4+T
MAFR	91.95D	External fixation of tibial plafond fracture, with open reduction and internal fixation of fibular fracture (regions required)	175	4+T

OTHER OR UNSPECIFIED OPERATIONS ON BONE INJURIES NEC - OTHER SPECIFIED BONE

MIFR	91.98B	No reduction of fractured malleolus	35	
MIFR	91.98C	Fracture tarsus except os calcis - no reduction (regions required)	50	

OTHER OR UNSPECIFIED OPERATIONS ON BONE INJURIES NEC - UNSPECIFIED BONE

ADON	91.99A	Fractures requiring cement	25	

OTHER ARTHROTOMY - SHOULDER

MASG	92.10	Other arthrotomy, shoulder (regions required)	150	4+T

OTHER ARTHROTOMY - ELBOW

MASG	92.11	Other arthrotomy, elbow (regions required)	100	4+T

OTHER ARTHROTOMY - WRIST

MASG	92.12	Other arthrotomy, wrist (regions required)	100	4+T

OTHER ARTHROTOMY - HAND AND FINGER

MASG	92.13A	Arthrotomy - metacarpophalangeal joint (regions required) - plus multiples, if applicable	75	4+T
MISG	92.13B	Arthrotomy - interphalangeal joint (regions required) - plus multiples, if applicable	50	4+T

OTHER ARTHROTOMY - HIP

MASG	92.14	Other arthrotomy, hip (regions required)	166	5+T

OTHER ARTHROTOMY - KNEE

MASG	92.15	Other arthrotomy, knee (regions required)	95	4+T
MISG	92.15A	Shaving patella (regions required)	25	4+T

OTHER ARTHROTOMY - ANKLE

MASG	92.16	Other arthrotomy, ankle (regions required)	100	4+T

OTHER ARTHROTOMY - FOOT AND TOE

MASG	92.17A	Arthrotomy - metatarsophalangeal joint (regions required) - plus multiples, if applicable	75	4+T
MISG	92.17B	Arthrotomy - interphalangeal joint (regions required) - plus multiples, if applicable	50	4+T

OTHER ARTHROTOMY - OTHER SPECIFIED SITE

MASG	92.18A	Arthrotomy - temporomandibular joint (regions required)	125	5+T

DIVISION OF JOINT CAPSULE, LIGAMENT, OR CARTILAGE - KNEE

MASG	92.25A	Arthroscopy and open lateral retinacular release (regions required)	122	4+T

EXCISION OF INTERVERTEBRAL DISC

MASG	92.31	Excision or destruction of intervertebral disc		
		AP=CERV (regions required)	303	8+T
		AP=LMBR (regions required)	212	7+T
MASG	92.31D	Discectomy - cervical or dorsal		
		AP=ANTE	573	
		AP=POST	250	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T
MASG	92.31E	Discectomy - bilateral - recurrent or multiple levels	246	
		AP=LMBR		7+T
		AP=CERV		8+T
		AP=DRSL		7+T
MASG	92.31F	Removal of protruded disc - bilateral or multiple	425	
		AP=CERV		8+T
		AP=DRSL		7+T
		AP=LMBR		7+T
MASG	92.31G	Removal of protruded lumbar disc to include fusion and/or internal fixation if indicated		
		AP=ANTE	350	11+T

EXCISION OF SEMILUNAR CARTILAGE OF KNEE

MASG	92.32A	Meniscectomy - knee (regions required)	119	4+T

SYNOVECTOMY - ELBOW

MASG	92.41	Synovectomy, elbow (regions required)	175	4+T

SYNOVECTOMY - WRIST

MASG	92.42	Synovectomy, wrist (regions required)	144	4+T

SYNOVECTOMY - HIP

MASG	92.44	Synovectomy, hip (regions required)	250	5+T

SYNOVECTOMY - KNEE

MASG	92.45	Synovectomy, knee (regions required)	142	4+T

SYNOVECTOMY - ANKLE

MASG	92.46	Synovectomy, ankle (regions required)	150	4+T

OTHER EXCISION OF JOINT - SHOULDER

MASG	92.60	Other excision of joint, shoulder (regions required)	175	4+T

OTHER EXCISION OF JOINT - WRIST

MASG	92.62A	Meniscectomy - wrist (regions required)	125	4+T

OTHER EXCISION OF JOINT - HAND AND FINGER

MASG	92.63A	Excision (capsulectomy, synovectomy, debridement) metacarpophalangeal joint (regions required) - plus multiples, if applicable	100	4+T
MASG	92.63B	Excision (capsulectomy, synovectomy, debridement) interphalangeal joint (Regions required) - plus multiples, if applicable	100	4+T

OTHER EXCISION OF JOINT - FOOT AND TOE

MASG	92.67A	Excision (capsulectomy, synovectomy, debridement) metatarsophalangeal joint (regions required) - plus multiples, if applicable	100	4+T
MASG	92.67B	Excision (capsulectomy, synovectomy, debridement) interphalangeal joint (Regions required) - plus multiples, if applicable	100	4+T

CONTRAST ARTHROGRAM - UNSPECIFIED SITE

MISG	92.79	Contrast arthrogram, unspecified site	15	
MISG	92.79A	Arthrogram, double contrast	25.5	

ARTHROSCOPY - KNEE

MASG	92.85A	Arthroscopy and open lateral retinacular release (regions required)	122	4+T

ARTHROSCOPY - UNSPECIFIED SITE

MASG	92.89	Arthroscopy, unspecified site (regions required)	71	4+T
MASG	92.89A	Arthroscopy and open lateral retinacular release (regions required)	122	4+T
MASG	92.89B	Arthroscopic removal of osteochondral fragment and drilling of femoral condyle (regions required)	162	4+T
MASG	92.89C	Arthroscopic pinning of osteochondral defect (regions required)	162	4+T
MASG	92.89D	Arthroscopic resection of plica and/or biopsies of synovium (regions required)	107	4+T
MASG	92.89E	Arthroscopy and removal of loose body arthroscopically (regions required)	137	4+T
MASG	92.89F	Arthroscopic meniscectomy (regions required)	162	4+T
MASG	92.89G	Arthroscopic trimming of meniscus and minor debridement (regions required)	117	4+T
MASG	92.89H	Arthroscopic synovectomy - partial removal (one compartment) (Regions required)	137	4+T

MASG	92.89I	Arthroscopic synovectomy - total removal (one compartment) (Regions required)	162	4+T
MASG	92.89J	Arthroscopic synovectomy - total anterior (more than one compartment) (Regions required)	187	4+T
MASG	92.89K	Arthroscopic synovectomy - total anterior and posterior (more than one compartment) (regions required)	187	4+T
MASG	92.89L	Arthroscopic debridement - (one compartment)		
		ME=MAJO (regions required)	137	4+T
		ME=MINO (regions required)	117	4+T
MASG	92.89M	Arthroscopic debridement of the knee - major (tricompartmental) (Regions required)	187	4+T
MASG	92.89N	Arthroscopic meniscal repair (regions required)	212	4+T

BIOPSY OF JOINT STRUCTURE - OTHER SPECIFIED SITE

MISG	92.98A	Punch biopsy of synovial membrane	25	4+T

DORSOLUMBAR SPINAL FUSION WITH HARRINGTON ROD

MASG	93.04	Dorsolumbar spinal fusion with Harrington Rod	700	11+T
MAAS	93.04A	Spinal fusion for scoliosis with spinal osteotomy	IC	8+T

OTHER DORSOLUMBAR SPINAL FUSION

MASG	93.05A	Spinal fusion - Luque Procedure	665	11+T
MAFR	93.05B	Fracture spine - open reduction and fusion	300	7+T

OTHER SPINAL FUSION

MASG	93.09B	Spinal fusion from four to seven spaces	300	7+T
MASG	93.09C	Spinal fusion - Dwyer Procedure	600	13+T
MASG	93.09D	Spinal fusion - one stage	200	7+T
MASG	93.09E	Spinal fusion from eight to fifteen spaces	350	7+T
MASG	93.09F	Spinal fusion - two spaces	285	7+T
MASG	93.09G	Spinal fusion - three spaces	300	7+T
MASG	93.09H	Spinal fusion with pedicle fixation and metal rod support (not Luque or Harrington Procedure) two or more levels as indicated without decompression	500	11+T
MASG	93.09I	Spinal fusion with pedicle fixation and metal rod support (not Luque or Harrington Procedure) two or more levels as indicated, with decompression of nerve roots and/or disc excision	550	11+T

ANKLE FUSION

MASG	93.11	Ankle fusion (regions required)	200	4+T
MASG	93.11A	Bone block stabilization - ankle (regions required)	150	5+T

TRIPLE ARTHRODESIS (AND STRIPPING)

MASG	93.12	Triple arthrodesis (and stripping) (regions required)	190	4+T

SUBTALAR FUSION

MASG	93.13	Subtalar fusion (regions required)	190	4+T

MIDTARSAL FUSION

MASG	93.14	Midtarsal fusion (regions required)	190	4+T

METATARSOPHALANGEAL FUSION

MASG	93.16	Metatarsophalangeal fusion (regions required)	71	4+T
MASG	93.16A	MP joint fusion great toe (Marin fusion, etc.) (regions required)	150	4+T

OTHER FUSION OF FOOT

MASG	93.17A	Arthrodesis - foot - pantalar (regions required)	250	4+T

ARTHRODESIS OF HIP

MASG	93.21	Arthrodesis of hip (regions required)	300	5+T

ARTHRODESIS OF KNEE

MASG	93.22	Arthrodesis of knee (regions required)	200	4+T

ARTHRODESIS OF SHOULDER

MASG	93.23	Arthrodesis of shoulder (regions required)	250	4+T

ARTHRODESIS OF ELBOW

MASG	93.24	Arthrodesis of elbow (regions required)	200	4+T

CARPORADIAL FUSION

MASG	93.25	Carporadial fusion (regions required)	200	4+T

METACARPOCARPAL FUSION

MASG	93.26A	Bone block stabilization - wrist (regions required)	150	5+T

METACARPOPHALANGEAL FUSION

MASG	93.27	Metacarpophalangeal fusion (regions required) - plus multiples, if applicable	100	4+T

INTERPHALANGEAL FUSION

MASG	93.28	Interphalangeal fusion (regions required)	100	4+T

ARTHRODESIS OF OTHER AND UNSPECIFIED JOINTS

MASG	93.29A	Arthrodesis - sacroiliac or symphysis pubis	200	5+T

ARTHROPLASTY OF FOOT AND TOE WITH SYNTHETIC PROSTHESIS

MASG	93.31A	Prosthetic arthroplasty - toe (regions required) - plus multiples, if applicable	150	4+T

OTHER ARTHROPLASTY OF FOOT AND TOE

MASG	93.39A	Hoffman Procedure - reconstruction of rheumatic foot (regions required)	176	4+T
MASG	93.39B	Arthroplasty - toe (except great toe) (regions required) - plus multiples, if applicable	71	4+T

TOTAL KNEE REPLACEMENT (GEOMEDIC) (POLYCENTRIC)

MASG	93.41	Total knee replacement (Geomedic) (Polycentric) (regions required)	299	6+T

PATELLAR STABILIZATION

MASG	93.44A	Roux-Goldthwaite Procedure (regions required)	150	4+T
MASG	93.44B	Patellar advancement (regions required)	104	4+T

OTHER REPAIR OF THE CRUCIATE LIGAMENTS

MASG	93.45A	Suture of torn, ruptured or severed cruciate ligaments (fresh) (Regions required)	150	4+T

OTHER REPAIR OF THE COLLATERAL LIGAMENTS

MASG	93.46	Other repair of the collateral ligaments (regions required)	120	4+T

OTHER REPAIR OF KNEE

MASG	93.47A	Arthroplasty - knee (regions required)	190	4+T
MASG	93.47B	Composite ligamentous reconstruction of knee (regions required)	214	4+T
MASG	93.47C	LSOT reconstruction (regions required)	214	4+T
MASG	93.47D	Revision of total knee replacement (regions required)	500	6+T
MASG	93.47E	Reconstruction - knee - early (regions required)	175	4+T
MASG	93.47F	Reconstruction - knee - late (regions required)	200	4+T

TOTAL ANKLE REPLACEMENT

MASG	93.48A	Total ankle arthroplasty with prosthesis (regions required)	350	4+T

OTHER REPAIR OF ANKLE

MASG	93.49	Other repair of ankle RP=INTL (regions required)	125	4+T
MASG	93.49A	Arthroplasty - ankle (regions required)	190	4+T
DISL	93.49B	Repair of recurrent subluxation - ankle (regions required)	175	4+T
MASG	93.49C	Reconstruction - ankle - late (regions required)	175	4+T

OTHER TOTAL HIP REPLACEMENT

ADON	93.59A	Bone graft with revision of total hip replacement (regions required)	50	
MASG	93.59B	Arthroplasty - hip - cup or total (regions required)	299	9+T
MASG	93.59C	Arthroplasty - revision of total hip (regions required)	380	9+T
MASG	93.59D	Exeter/Ling hip system to include impacted cancellous allograft and all other technical variations or additions (to include acetabular and/or femoral components)	450	9+T
MASG	93.59E	Revision of total hip with allograft reconstruction with or without ligament or tendon reconstruction (regions required)	530	15+T

REPLACEMENT OF HEAD OF FEMUR WITH USE OF METHYL METHACRYLATE

MASG	93.61A	Arthroplasty - hip - simple prosthesis or excision of head and neck (Regions required)	250	7+T

OTHER REPAIR OF HAND AND FINGER

MASG	93.79A	Reconstruction of rheumatoid joints - multiple (regions required)	211	4+T
MASG	93.79B	Arthroplasty - interphalangeal or metacarpophalangeal - single (Regions required)	100	4+T
MASG	93.79C	Reconstruction - both interphalangeal or metacarpophalangeal ligaments (Regions required)	125	4+T
MASG	93.79D	Arthroplasty - wrist (regions required)	190	4+T
MASG	93.79E	Arthroplasty - interphalangeal or metacarpophalangeal - multiple (Regions required)	200	4+T
MASG	93.79F	Thumb CMC joint tendon interpositional Arthoplasty (Regions required)	190	4+T

ARTHROPLASTY OF SHOULDER WITH SYNTHETIC PROSTHESIS

MASG	93.81	Arthroplasty of shoulder with synthetic prosthesis (regions required)	350	10+T
MASG	93.81A	Total shoulder replacement (regions required)	380	8+T

REPAIR OF RECURRENT DISLOCATION OF SHOULDER

DISL	93.82	Repair of recurrent dislocation of shoulder (regions required)	190	4+T

OTHER REPAIR OF SHOULDER

MASG	93.83A	Arthroplasty - shoulder (regions required)	190	4+T
MASG	93.83B	Arthroplasty - acromio or sternoclavicular (regions required)	119	4+T
MASG	93.83C	Reconstruction - acromio - or sterno-clavicular (regions required)	125	4+T
MASG	93.83E	Total shoulder revision arthroplasty of prior unipolar shoulder arthroplasty to include cancellous or structural bone graft including all other technical variations or additions (regions required)	400	10+T
MASG	93.83F	Total shoulder revision arthroplasty of prior shoulder arthroplasty to include cancellous or structural bone graft including all other technical variations or additions (regions required)	425	10+T

ARTHROPLASTY OF ELBOW WITH SYNTHETIC PROSTHESIS

MASG	93.84	Arthroplasty of elbow with synthetic prosthesis (regions required)	315	6+T

OTHER REPAIR OF ELBOW

MASG	93.85A	Revision of total elbow replacement including decompression of ulnar nerve (Regions required)	396	6+T
MASG	93.85B	Arthroplasty - elbow (regions required)	190	4+T
MASG	93.85C	Flexorplasty of elbow (regions required)	150	4+T
MASG	93.85D	Reconstruction elbow - late (regions required)	100	4+T

OTHER REPAIR OF WRIST

MASG	93.87A	Reconstruction - wrist - late (regions required)	100	4+T

INCISION OF TENDON SHEATH OF HAND

MASG	94.01A	Acute tenosynovitis of finger - drainage (regions required) - plus multiples, if applicable	75	4+T
MASG	94.01B	Incision of tendon sheath - simple ganglion or Dequervain's (Regions required)	60	4+T
MASG	94.01C	Exploration - tendon or tendon sheath (regions required)	58	4+T

TENOTOMY OF HAND

MASG	94.11A	Incision - tendon sheath - release - finger (regions required) - plus multiples, if applicable	58	4+T

MASG	94.11B	Tenotomy - including lengthening or section of tendon of hand (Regions required)	71	4+T
MASG	94.11C	Tenotomy with capsulotomy (regions required) - plus multiples, if applicable	95	4+T

FASCIOTOMY OF HAND FOR DIVISION

MASG	94.13	Fasciotomy of hand for division AP=SUBC (regions required)	60	4+T
MASG	94.13B	Partial excision fascia (open) – Palmar Dupuytren's Disease PO=PART (regions required)	100	4+T
MASG	94.13C	Complex palmar fasciectomy for Dupuytren's Disease (regions required)	180	4+T
ADON	94.13D	Release of each additional digit including proximal interphalangeal joint release (Add on to complex palmar fasciectomy) - plus multiples, if applicable	70	
MASG	94.13E	Release of a single digit including the interphalangeal joint(s) for Dupuytren's disease (regions required)	120	4+T

EXCISION OF LESION OF TENDON (SHEATH) OF HAND

MASG	94.21A	Excision of tendon sheath - simple ganglion or Dequervain's (Regions required)	60	4+T
MASG	94.21D	Biopsy through incision, tendon sheath (regions required)	75	4+T

OTHER EXCISION OF TENDON OF HAND

MASG	94.32	Other excision of tendon of hand (regions required)	100	4+T
		ME=RADI (regions required)	150	4+T
MASG	94.32A	Excision of tendon of finger (regions required) - plus multiples, if applicable	100	4+T

EXCISION OF BURSA OF HAND

MASG	94.36	Excision of bursa of hand (regions required)	150	4+T

OTHER TRANSFER OR TRANSPLANTATION OF TENDON OF HAND

MASG	94.55A	Hand and forearm - opponens transfer (regions required)	125	4+T
MASG	94.55B	Tendon transplant - hand and forearm - single (regions required)	100	4+T
MASG	94.55C	Tendon transplant - hand and forearm - multiple (regions required)	175	4+T

OTHER CHANGE IN LENGTH OF MUSCLE, TENDON, AND FASCIA OF HAND

MASG	94.82	Other change in length of muscle, tendon, and fascia of hand ME=SIMP (regions required)	100	4+T

MASG	94.82A	Tenotomy, including lengthening or section of tendon of hand (Regions required)	71	4+T

REPAIR OF MALLET FINGER

MASG	94.85	Repair of mallet finger (regions required) - plus multiples, if applicable		
		AP=OPEN	72	4+T
MISG	94.85	Repair of mallet finger		
		AP=CLSD	25	4+T

INCISION OF TENDON SHEATH

MASG	95.01	Incision of tendon sheath	75	4+T
MASG	95.01A	Incision of tendon sheath - simple ganglion	60	4+T
MASG	95.01B	Exploration - tendon or tendon sheath	58	4+T

MYOTOMY

MISG	95.02A	Incision - muscle - intramuscular abscess	25	4+T
MISG	95.02B	Incision - muscle - removal of foreign body		
		AN=GENL, ME=COMP	50	IC+T
		AN=GENL, ME=SIMP	25	4+T
		ME=COMP	50	IC+T
		ME=SIMP	25	4+T

BURSOTOMY

MISG	95.03	Bursotomy	25	4+T
MASG	95.03A	Removal of subtrochanteric calcium (regions required)	125	4+T
MASG	95.03B	Removal of subdeltoid calcium (regions required)	100	4+T
MASG	95.03C	Ulnar or radial bursa - drainage (regions required)	60	4+T

OTHER TENOTOMY

MASG	95.13A	Tenotomy for congenital torticollis	70	5+T
MASG	95.13B	Incision - tendon sheath - release - wrist (regions required)	60	4+T
MASG	95.13C	Tenotomy, including lengthening or section of tendon	71	4+T
MASG	95.13E	Hip adductors - open (regions required)	75	4+T
MISG	95.13F	Hip adductors - closed (regions required)	25	4+T
MASG	95.13G	Hip adductors - with peripheral obturator neurectomy (regions required)	100	4+T

MISG	95.13H	Tenotomy - toe (regions required) - plus multiples, if applicable	25	4+T
MASG	95.13I	Incision muscle - myotomy for tennis elbow (regions required)	95	4+T
MASG	95.13J	Tenotomy with capsulotomy of the foot (regions required) - plus multiples, if applicable	95	4+T

MYOTOMY FOR DIVISION

MASG	95.14A	Psoas muscle release	75	4+T
MASG	95.14B	Scalenus anticus, without resection of cervical or first rib	100	5+T
MASG	95.14C	Scalenus anticus, with resection of cervical or first rib	200	5+T
MASG	95.14D	Incision - muscles - sternomastoid - unipolar	70	5+T
MASG	95.14E	Incision - muscles - sternomastoid - bipolar	75	5+T
MASG	95.14F	Major muscle release	100	5+T

FASCIOTOMY FOR DIVISION

MASG	95.15	Fasciotomy for division AP=SUBC	60	4+T
MASG	95.15A	Plantar fasciotomy at multiple levels (regions required)	75	4+T
MASG	95.15B	Plantar fasciectomy – open (regions required)	100	4+T
MASG	95.15C	Removal of calcaneal spur and plantar fasciotomy (regions required)	100	4+T
MASG	95.15D	Fasciotomy for compartment syndrome	100	4+T
MISG	95.15E	Incision – plantar fascia (regions required)	35	4+T
ADON	95.15F	Plantar fasciotomy with other procedure, add to procedure (regions required)	25	

EXCISION OF LESION OF TENDON (SHEATH)

MASG	95.21A	Excision of tendon sheath – simple ganglion	60	4+T
MASG	95.21B	Biopsy through incision – tendon sheath	75	4+T

EXCISION OF LESION OF MUSCLE

MAAS	95.22A	Excision - tumour, etc.	IC	IC+T
MISG	95.22B	Biopsy of muscle	25	4+T

EXCISION OF LESION OF OTHER SOFT TISSUE

MASG	95.29A	Excision of Baker's cyst of knee (regions required)	100	4+T
MASG	95.29C	Resection of subfascial benign lesion over 5 cm. in size excluding lipoma	100	4+T

OTHER EXCISION OF TENDON

MASG	95.32A	Excision - tendon sheath		
		ME=RADI	150	4+T

OTHER EXCISION OF FASCIA

MASG	95.35A	Fasciotomy, single, of sole (regions required)		
		AP=SUBC	60	4+T

OTHER EXCISION OF OTHER SOFT TISSUE

MASG	95.39A	Resection of malignant soft tissue sarcoma over 5 cm. in diameter	250	8+T

EXCISION OF BURSA

MASG	95.4A	Excision - bursa - olecranon or prepatellar (regions required)	71	4+T
MASG	95.4B	Excision - bursa - forearm (regions required)	150	4+T
MASG	95.4C	Excision - bursa - ischial or subtrochanteric (regions required)	125	4+T

REPAIR OF MUSCULOTENDINOUS CUFF

MASG	95.53A	Reconstruction - rotator cuff repair (regions required)		
		ME=CMST	190	4+T
		ME=SIMP	100	4+T

OTHER SUTURE OF TENDON

MASG	95.54E	Tendon transplant - Achilles or biceps repair (regions required)	100	4+T

OTHER SUTURE OF MUSCLE

MAAS	95.55A	Repair of muscle laceration or rupture	IC	IC+T

OTHER TRANSFER OR TRANSPLANTATION OF TENDON

MASG	95.65A	Tendon transplant - knee - single or multiple (regions required)	150	4+T
MASG	95.65C	Tendon transplant - foot and ankle - single (regions required)	100	4+T
MASG	95.65D	Tendon transplant - hip - iliopsoas (regions required)	250	5+T
MASG	95.65E	Tendon transplant - foot and ankle - multiple (regions required)	175	4+T

OTHER TRANSFER OR TRANSPLANTATION OF MUSCLE

MASG	95.66	Other transfer or transplantation of muscle	200	6+T

PLASTIC OPERATION WITH GRAFT OF TENDON

MASG	95.72A	Fascial repair or tendon graft for rupture	150	4+T

RELEASE OF CLUBFOOT NEC

MASG	95.75A	Congenital foot deformity - operative - arthrodesis and tendon transfer (Regions required)	250	4+T
MASG	95.75B	Composite club foot reconstruction - Turco Procedure (regions required)	250	4+T
MASG	95.75C	Congenital foot deformity - operative - medial release and tendon lengthening. (Regions required)	150	4+T

OTHER CHANGE IN LENGTH OF MUSCLE, TENDON, AND FASCIA

MASG	95.76A	Recession of muscle	100	4+T
MASG	95.76B	Ober or Yount and spica, skeletal pins, etc.	150	4+T
MASG	95.76C	Tenotomy, including heel cord lengthening and lengthening or section of tendon of hand or foot AP=PERC (regions required)	71	4+T
MASG	95.76D	Tenoplasty - shortening, lengthening of any tendon any location (Regions required) - plus multiples, if applicable	95	4+T
MASG	95.76E	Fasciotomy and fasciectomy simple lengthening	100	4+T

OTHER PLASTIC OPERATIONS ON TENDON

MASG	95.77B	Tendon transplant - foot - tenodesis (regions required)	100	4+T

OTHER PLASTIC OPERATIONS ON MUSCLE

MASG	95.78A	Quadricepsplasty (regions required)	150	6+T
MASG	95.78B	Tendon transplant - shoulder - pectoralis minor included in composite rotator cuff repair (regions required)	100	4+T
MASG	95.78C	Tendon transplant - shoulder - trapezius (regions required)	175	4+T
MASG	95.78D	Tendon transplant - hip - abdomen (regions required)	200	5+T
MASG	95.78E	Tendon transplant - quadriceps, muscle or tendon (regions required)	125	4+T

AMPUTATION AND DISARTICULATION OF FINGER(S), EXCEPT THUMB

MAAS	96.01	Amputation and disarticulation of finger(s), except thumb (regions required) ME=COMP	IC	4+T
MISG	96.01	Amputation and disarticulation of finger(s), except thumb (regions required) - plus multiples, if applicable ME=SIMP	30	4+T

AMPUTATION AND DISARTICULATION OF THUMB

MAAS	96.02	Amputation and disarticulation of thumb (regions required) ME=COMP	IC	4+T
MISG	96.02	Amputation and disarticulation of thumb ME=SIMP	30	4+T

AMPUTATION THROUGH HAND

MASG	96.03	Amputation through hand (regions required)	100	4+T

DISARTICULATION OF WRIST

MASG	96.04	Disarticulation of wrist (regions required)	100	4+T

AMPUTATION THROUGH FOREARM

MASG	96.05	Amputation through forearm (regions required)	125	4+T

DISARTICULATION OF ELBOW OR AMPUTATION THROUGH HUMERUS

MASG	96.06	Disarticulation of elbow or amputation through humerus (regions required)	125	4+T
MASG	96.06A	Amputation of humerus (regions required)	125	4+T

DISARTICULATION OF SHOULDER

MASG	96.07	Disarticulation of shoulder (regions required)	175	9+T

INTERTHORACOSCAPULAR AMPUTATION

MASG	96.08	Interthoracoscapular amputation	275	15+T

AMPUTATION AND DISARTICULATION OF TOE(S)

MAAS	96.11A	Amputations - lower extremity - metatarsal or metatarsophalangeal joint ME=COMP (regions required)	IC	4+T
MASG	96.11A	Amputations - lower extremity - metatarsal or metatarsophalangeal joint (Regions required)	75	4+T
MISG	96.11B	Amputations - lower extremity - phalanx (regions required)	30	4+T

AMPUTATION AND DISARTICULATION OF FOOT

MASG	96.12	Amputation and disarticulation of foot (regions required)	150	5+T
MASG	96.12A	Amputations - lower extremity - transmetatarsal (regions required) - plus multiples, if applicable	125	4+T

AMPUTATION AND DISARTICULATION OF ANKLE

MASG	96.13	Amputation and disarticulation of ankle (regions required)	150	5+T

AMPUTATION OF LOWER LEG

MASG	96.14	Amputation of lower leg (regions required)	145	5+T

AMPUTATION OF THIGH AND DISARTICULATION OF KNEE

MASG	96.15	Amputation of thigh and disarticulation of knee (regions required)	145	5+T
MASG	96.15A	Amputations - lower extremity - knee, including Gritti-Stokes or Callander (Regions required)	125	5+T

DISARTICULATION OF HIP

MASG	96.16	Disarticulation of hip (regions required)	250	10+

ABDOMINOPELVIC AMPUTATION

MASG	96.17	Abdominopelvic amputation	350	15+T

OTHER REATTACHMENT

MAAS	96.39A	Debridement and plastic repair of traumatically amputated extremities (Regions required)	IC	IC+T

OTHER OPERATIONS ON THE MUSCULOSKELETAL SYSTEM NEC

MASG	96.99A	Open biopsy of musculoskeletal neoplasm	100	4+T

SURGICAL PROCEDURES NOS

ADON	99.09A	Morbid obesity surgical add on	32.9	4.6

OTOLARYNGOLOGY

(SP=OTOL)

CATEGORY	HEALTH SERVICE CODE	DESCRIPTION / MODIFIERS	BASE UNITS	ANAES UNITS
CONSULTATIONS				
CONS	03.08	Comprehensive Consultation		
		RF=REFD (ME=TELE)	35.1	
		RF=REFD, US=PREM (ME=TELE)	53.1	
		RF=REFD, US=PR50 (ME=TELE)	53.1	
		RF=REFD, RO=DETE (ME=TELE)	35.1	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	53.1	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	53.1	
CONS	03.07	Limited Consultation		
		RF=REFD (ME=TELE)	24.5	
		RF=REFD, US=PREM (ME=TELE)	42.5	
		RF=REFD, US=PR50 (ME=TELE)	42.5	
		RF=REFD, RO=DETE (ME=TELE)	24.5+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	42.5+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	42.5+MU	
CONS	03.07	Repeat Consultation		
		RF=REFD, RP=REPT (ME=TELE)	22.5	
		RF=REFD, RP=REPT, US=PREM (ME=TELE)	40.5	
		RF=REFD, RP=REPT, US=PR50 (ME=TELE)	40.5	
		RF=REFD, RO=DETE, RP=REPT (ME=TELE)	22.5+MU	
		RF=REFD, RO=DETE, RP=REPT, US=PREM (ME=TELE)	40.5+MU	
		RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE)	40.5+MU	
OFFICE				
VIST	03.04	Initial Visit		
		LO=OFFC (RF=REFD)	24	
VIST	03.03	Initial Visit Not Requiring a Complete Examination		
		LO=OFFC, RP=INTL (RF=REFD)	12	
		LO=OFFC, AG=OV65, RP=INTL (RF=REFD)	16.5	
VIST	03.03	Subsequent Visit		
		LO=OFFC, RP=SUBS (RF=REFD)	13	
VIST	03.03A	Geriatric Office Visit (for patients aged 65+)		
		LO=OFFC (RF=REFD)	16.5	
VIST	03.03	Continuing Care		
		LO=OFFC, RO=CNTC, RF=REFD	13.5	
		LO=OFFC, AG=OV65, RO=CNTC, RF=REFD	16.5	

VIST	03.03	Directive Care	
		LO=OFFC, RO=DIRC, RF=REFD	13.5
		LO=OFFC, AG=OV65, RO=DIRC, RF=REFD	16.5
VIST	03.03	Urgent Care - Request by Patient (1701 - 2000)	
		LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD)	28.3
VIST	03.03	Urgent Care - Request by Patient (2001 - 2359)	
		LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD)	28.3
VIST	03.03	Urgent Care - Request by Patient (0000 - 0800)	
		LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)	38.3
VIST	03.03	Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays	
		LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD)	28.3
VIST	03.03	Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays	
		LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD)	28.3
VIST	03.03	Urgent Care - Extra Patient	
		LO=OFFC, PT=EXPT (RF=REFD)	10.5

HOSPITAL (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

VIST	03.04	Initial Visit with Complete Examination	
		LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD)	24
		LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD)	24+MU
VIST	03.04	Initial Visit	
		LO=HOSP, FN=INPT, RP=INTL (RF=REFD)	25
		LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD)	25+MU
VIST	03.03	Continuing Care	
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC, RF=REFD	15
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT, RF=REFD	15+MU
VIST	03.03	Directive Care	
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD	15
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD	15+MU
VIST	03.03	Subsequent Visit - Daily to 56 Days	
		LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD)	15
		LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD)	15+MU
VIST	03.03	Subsequent Visit - Weekly after 56 Days - Maximum 44 units per week	
		LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD)	15
		LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD)	15+MU
ADON	03.02A	Hospital Discharge Fee	
		LO=HOSP, FN=INPT	10

VIST	03.03	Urgent Hospital Visit LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)..... 22 LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD)..... 22+MU
VIST	03.03	Hospital Emergency Visit LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)..... 35.2 LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)..... 35.2+MU
VIST	03.03	Outpatient Visit (0800 - 1700) LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD)..... 13.5 LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD)..... 13.5+MU
VIST	03.03	Outpatient Visit (1701 - 2000) LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 20 LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU
VIST	03.03	Outpatient Visit (2001 - 2359) LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 20 LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 20+MU
VIST	03.03	Outpatient Visit (0000 - 0800) LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)..... 26 LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)..... 26+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)..... 20 LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)..... 20+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)..... 20 LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD)..... 20+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD)..... 7 LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 7+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD) ..... 7 LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 7+MU
VIST	03.03	Outpatient Visit (1701 – 2000) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD)..... 10.5 LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD)..... 10.5+MU
VIST	03.03	Outpatient Visit (2001 - 2359) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD)..... 10.5 LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD)..... 10.5+MU

VIST	03.03	Outpatient Visit (0000 - 0800) Extra Patient		
		LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD)	11.4	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD)	11.4+MU	
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays		
		LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD)	10.5	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)	10.5+MU	
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays		
		LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD)	10.5	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD)	10.5+MU	

PROCEDURES

DIRECT LARYNGOSCOPY

MASG	01.03A	Endoscopy with removal of benign growth - larynx	90	6+T
MASG	01.03B	Endoscopy with removal of foreign body - larynx	75	6+T

PHARYNGOSCOPY

MISG	01.05	Pharyngoscopy	25	4+T

OTHER NONOPERATIVE ENDOSCOPY NEC

MISG	01.39A	Maxillary sinusoscopy	50	4+T

OTHER NONOPERATIVE MEASUREMENTS AND EXAMINATIONS OF NERVOUS SYSTEM AND SENSE ORGANS NEC

VADT	03.19F	Level II Sleep Apnea Testing Interpretation	35	
VADT	03.19G	Level III Sleep Apnea Testing Interpretation	25	

OTHER RADIOTHERAPEUTIC PROCEDURE

MISG	06.39C	Radium application to nasopharynx	10	5+T

OTHER INTUBATION OF RESPIRATORY TRACT

MISG	10.05A	Intubation of larynx	25	

IRRIGATION OF EAR

MISG	10.62	Irrigation of ear		
		AN=GENL (regions required)	27	4+T

REMOVAL OF INTRALUMINAL FOREIGN BODY FROM NOSE WITHOUT INCISION

MISG	12.01	Removal of intraluminal foreign body from nose without incision		
		AN=GENL, ME=COMP	35	4+T
		ME=SIMP	20	

REMOVAL OF INTRALUMINAL FOREIGN BODY FROM EAR WITHOUT INCISION

MISG	12.21	Removal of intraluminal foreign body from ear without incision		
		AN=GENL, ME=COMP (regions required)	30	4+T
		ME=SIMP (regions required)	15	

OTHER REPAIR OF CEREBRAL MENINGES

MASG	15.12A	Rhinoplasty - rhinorrhoea - CSF leak	300	7+T

OTHER EXCISION OR AVULSION OF CRANIAL AND PERIPHERAL NERVES

MASG	17.08A	Retro-labyrinthine vestibular neurectomy		
		SP=NUSG (regions required)	375	14+T
		SP=OTOL (regions required)	375	14+T

OTHER CRANIAL NERVE DECOMPRESSION

MASG	17.32A	Repair - facial nerve decompression	350	6+T
MASG	17.32B	Repair facial nerve decompression with graft	300	6+T

EXCISION OF THYROGLOSSAL DUCT OR TRACT

MASG	19.6	Excision of thyroglossal duct or tract	120	4+T
MASG	19.6A	Excision of thyroglossal duct - cyst and sinus	200	5+T

TOTAL EXCISION OF PITUITARY GLAND, TRANSSPHENOIDAL APPROACH

MASG	20.55A	Transphenoidal hypophysectomy	400	15+T

EXCISION OF PREAURICULAR SINUS/CYST

MASG	30.11	Excision of preauricular sinus/cyst	100	4+T
MASG	30.11A	Excision of perilymph fistula	200	4+T

EXCISION OR DESTRUCTION OF OTHER LESION OF EXTERNAL EAR

MISG	30.19A	Excision of polyp of external ear (regions required)	25	4+T
		AN=GENL	30	4+T
		AN=LOCL	25	
MASG	30.19B	Partial excision of ear (regions required)	75	4+T
MASG	30.19C	Removal of ear canal exostosis - single (regions required)	150	5+T
MASG	30.19D	Removal of ear canal exostosis with skin graft (regions required)	300	5+T
MASG	30.19E	Removal of ear canal exostosis - multiple (regions required)	225	5+T

AMPUTATION OF EXTERNAL EAR

MASG	30.22	Amputation of external ear (regions required)	125	5+T

SURGICAL CORRECTION OF PROMINENT EAR

MASG	30.4	Surgical correction of prominent ear - congenital deformity	96	5+T

RECONSTRUCTION OF EXTERNAL AUDITORY CANAL

MASG	30.5A	Repair congenital atresia of canal (including necessary mastoid surgery) (Regions required)	330	5+T
MASG	30.5B	Meatoplasty for external auditory canal stenosis (regions required)	100	4+T

CONSTRUCTION OF AURICLE OF EAR

MASG	30.61A	External ear otoplasty, exclusive of simple lacerations - prior approval ME=MAJO (regions required)	125	5+T
MISG	30.61A	External ear otoplasty, exclusive of simple lacerations - prior approval ME=MINO (regions required)	50	5+T
MASG	30.61B	Total reconstruction of ear (pinna) (regions required) - prior approval	125	5+T

STAPES MOBILIZATION

MASG	31.0A	Middle ear stapes mobilization (regions required)	200	6+T

STAPEDECTOMY WITH INCUS REPLACEMENT

MASG	31.11	Stapedectomy with incus replacement (regions required)	375	6+T

OTHER OPERATIONS ON OSSICULAR CHAIN

MASG	31.3A	Ossiculoplasty without tympanic repair (regions required)	250	6+T

MYRINGOPLASTY

MASG	31.4	Myringoplasty (regions required)	135	4+T
MISG	31.4A	Cauterization of perforated ear drum (regions required)	15	4+T
		AN=GENL (regions required)	20	4+T
		AN=LOCL (regions required)	15	
MASG	31.4B	Tympanoplasty (type one) with graft only (regions required)	250	6+T

TYPE II TYMPANOPLASTY

MISG	31.51A	Other tympanoplasty applying plastic plate for perforated ear drum (Regions required)	10	4+T

TYPE V TYMPANOPLASTY

MASG	31.54A	Tympanoplasty with graft and canaloplasty (regions required)	300	6+T

OTHER TYMPANOPLASTY

MASG	31.59A	Tympanoplasty and ossiculoplasty with/without canaloplasty (Regions required)	350	6+T

OTHER REPAIR OF MIDDLE EAR

MASG	31.9A	Repair mastoid fistula, closure (regions required)	125	4+T

MYRINGOTOMY WITH INSERTION OF TUBE

MISG	32.01	Myringotomy with insertion of tube (regions required)	48	4+T

OTHER MYRINGOTOMY

COCR	32.09A	Middle ear myringotomy (regions required)		
		AN=GENL	30	4+T
MISG	32.09A	Middle ear myringotomy (regions required)		
		AN=LOCL	20	
MASG	32.09B	Tympanotomy with insertion of plastic or silastic sheeting (Regions required)	200	6+T
MISG	32.09C	Tympanocentesis (regions required)	18	
MISG	32.09D	Aspiration for serous otitis (regions required)	10	4+T
MISG	32.09E	Microscopic aspiration of ears (regions required)	10	4+T

REMOVAL OF TYMPANOSTOMY TUBE

MISG	32.1	Removal of tympanostomy tube (regions required)		
		AN=GENL, LO=HOSP	20	4+T
		LO=OFFC	5	

INCISION OF MIDDLE EAR

MASG	32.23A	Repair - exploration middle ear (regions required)	100	4+T

SIMPLE MASTOIDECTOMY

MASG	32.31	Simple mastoidectomy (regions required)	125	4+T

RADICAL MASTOIDECTOMY

MASG	32.32	Radical mastoidectomy (regions required)	224.8	4+T

OTHER MASTOIDECTOMY

MISG	32.39A	Cleaning mastoid cavity (regions required)	13.5	

EXCISION OF LESION OF MIDDLE EAR

MASG	32.41A	Intratympanic microscopic excision of aural lesion (regions required)	90	4+T

FENESTRATION OF INNER EAR

MASG	32.5	Fenestration of inner ear (regions required)	300	6+T

ENDOLYMPHATIC SHUNT

MASG	32.71	Endolymphatic shunt (regions required)	350	7+T
MASG	32.71A	Placement of Silverstein ventilating tube (regions required)	150	4+T
MASG	32.71B	Endolymphatic sac decompression or shunting (regions required)	350	6+T

OTHER INCISION, EXCISION, AND DESTRUCTION OF INNER EAR

MASG	32.79A	Trans-mastoid labyrinthectomy (regions required)	300	6+T
MASG	32.79C	Total labyrinthectomy, trans-canal (regions required)	250	6+T
MASG	32.79D	Endolymphatic decompression inner ear (regions required)	350	6+T

IMPLANTATION OF ELECTRO-MAGNETIC HEARING AID

MASG	32.95B	Cochlear implant - to include mastoidectomy and facial nerve decompression (Regions required)	400	6+T
MASG	32.95C	Insertion of Bone-Anchored Hearing Aid (BAHA) single stage (Regions required)	225	6+T
MASG	32.95D	Insertion of Bone-Anchored Hearing Aid (BAHA) two-stage: implantation of fixture (regions required)	225	6+T
MISG	32.95E	Insertion of Bone-Anchored Hearing Aid (BAHA) two-stage: loading of abutment (regions required)	50	4+T

OTHER OPERATIONS ON MIDDLE AND INNER EAR

MAAS	32.96A	Excision of glomus jugular tumour	IC	6+T

CONTROL OF EPISTAXIS BY ANTERIOR NASAL PACKING

MISG	33.01	Control of epistaxis by anterior nasal packing	20	

CONTROL OF EPISTAXIS BY POSTERIOR (AND ANTERIOR) PACKING

MISG	33.02A	Treatment of epistaxis posterior packing	30	4+T

CONTROL OF EPISTAXIS BY LIGATION OF ETHMOIDAL ARTERIES

MASG	33.04	Control of epistaxis by ligation of ethmoidal arteries	51	4+T

CONTROL OF EPISTAXIS BY (TRANSANTRAL) LIGATION OF THE MAXILLARY ARTERY

MASG	33.05	Control of epistaxis by (transantral) ligation of the maxillary artery	225	7+T

INCISION OF NOSE

COCR	33.1A	Drainage of abscess or hematoma of septum	25	4+T

EXCISION OF LESION OF NOSE, UNQUALIFIED

MASG	33.21A	Excision of choanal atresia - bony	200	6+T
MASG	33.21B	Excision of choanal atresia - membranous	200	6+T

LOCAL EXCISION OR DESTRUCTION OF INTRANASAL LESION

MISG	33.22A	Excision of nasal polyp (regions required)	25	4+T
MISG	33.22B	Excision of single choanal polyp	40	4+T

MISG	33.22C	Biopsy of nasal septum	15	
		AN=GENL	30	4+T
		AN=LOCL	15	

SUBMUCOUS RESECTION OF NASAL SEPTUM

MASG	33.4	Submucous resection of nasal septum	125	4+T
MASG	33.4A	SMR including submucous resection of inferior turbinates	134.9	4+T

TURBINECTOMY BY DIATHERMY OR CRYOSURGERY

MISG	33.51	Turbinectomy by diathermy or cryosurgery - single or bilateral	27	4+T
		AN=GENL	40.5	4+T
		AN=LOCL	27	

OTHER TURBINECTOMY

MISG	33.59A	Submucous resection of turbinates (regions required)	50	4+T

RHINOPLASTY WITH BONE OR CARTILAGE GRAFT

MASG	33.74	Rhinoplasty with bone or cartilage graft - prior approval		
		PO=COML	192	7+T
		PO=PART	75	7+T

OTHER RHINOPLASTY OR SEPTOPLASTY

MASG	33.76A	Septal reconstruction	150	4+T
MASG	33.76B	Complete rhinoplasty with submucous resection without skin grafting - prior approval	254	7+T
MISG	33.76C	Insertion of nasal septal button	30	4+T

FREEING OF ADHESIONS OF NOSE

MISG	33.91A	Repair - lysis of synechiae of nose with insertion of plastic stent	50	4+T

OTHER OPERATIONS ON NOSE NEC

MISG	33.99A	Repair - choanal atresia - dilation	25	4+T
		RP=REPT	10	6+T

PUNCTURE OF NASAL SINUS

MISG	34.0	Puncture of nasal sinus (regions required)		
		LO=HOSP	37.8	4+T
		LO=OFFC	35	
MISG	34.0A	Lavage-maxillary sinus antrum (regions required)	10	4+T
MISG	34.0C	Proetz displacement lavage	5	4+T

INTRANASAL ANTROTOMY

MASG	34.1A	Removal accessory maxillary, intranasal sinus (regions required)	75	4+T

RADICAL MAXILLARY ANTROTOMY

MASG	34.21	Radical maxillary antrotomy (regions required)	134.9	4+T

FRONTAL SINUSECTOMY

MASG	34.31	Frontal sinusectomy (regions required)	75	4+T

FRONTAL SINUSECTOMY

MASG	34.32	Frontal sinusectomy, radical (regions required)	250	6+T

ETHMOIDOTOMY

MASG	34.42	Ethmoidotomy (regions required)	69.2	4+T
MASG	34.42A	Ethmoidotomy and widening middle meatus with or without maxillary sinusoscopy (regions required)	75	4+T

SPHENOIDOTOMY

MASG	34.43A	Sphenoidostomy with sinusoscopy control	75	4+T

ETHMOIDECTOMY

MASG	34.54A	Removal of external fronto-ethmoidal with sphenoid if necessary (Regions required)	250	6+T
MASG	34.54B	Intranasal anterior & posterior ethmoidectomy traversing the ground lamella (Regions required)	100	4+T

SPHENOIDECTOMY

MASG	34.55	Sphenoidectomy (regions required)	102	4+T

CLOSURE OF SINUS FISTULA (OROANTRAL)

MASG	34.61	Closure of sinus fistula (oroantral)	150	4+T

OTHER REPAIR AND PLASTIC OPERATIONS ON SALIVARY GLAND

MASG	38.39C	Resection of salivary gland malignancy with lymphadectomy *Physician Restrictions in place (See Appendix J)	640	10+T

INCISION AND DRAINAGE OF TONSIL AND PERITONSILLAR STRUCTURES

MISG	40.0	Incision and drainage of tonsil and peritonsillar structures	5	
		AN=GENL	30	4+T
		AN=LOCL	30	
COCR	40.0A	Drainage of retropharyngeal abscess - intraoral	30	4+T
MASG	40.0B	Drainage of lateral pharyngeal abscess	75	4+T

TONSILLECTOMY WITH ADENOIDECTOMY

MASG	40.2A	Tonsillectomy only or tonsillectomy and adenoidectomy hospital location only		
		AG=ADUT, AN=GENL	95	4+T
		AG=ADUT, AN=LOCL	95	
		AG=CH16	95	4+T

ADENOIDECTOMY WITHOUT TONSILLECTOMY

MISG	40.5	Adenoidectomy without tonsillectomy	28.8	4+T

CONTROL OF HEMORRHAGE AFTER TONSILLECTOMY AND ADENOIDECTOMY - SAME SURGEON

MISG	40.7	Control of hemorrhage after tonsillectomy and adenoidectomy – same surgeon	30	4+T
MASG	40.7A	Post-operative hemorrhage tonsillectomy - adenoidectomy referred consult and procedure	55	4+T

PHARYNGOTOMY

MISG	41.0A	Removal foreign body of pharynx	35	4+T

OTHER EXCISION OR DESTRUCTION OF LESION OR TISSUE OF PHARYNX

MASG	41.2	Excision or destruction of lesion or tissue of nasopharynx	200	4+T
MISG	41.2A	Biopsy of pharynx	35	4+T

PLASTIC OPERATION ON PHARYNX

MASG	41.3A	Palatopharyngouvuloplasty	200	5+T

CLOSURE OF BRANCHIAL CLEFT FISTULA

MASG	41.42A	Excision branchial cyst	150	4+T
MASG	41.42B	Excision branchial sinus	150	5+T

OTHER EXCISION OR DESTRUCTION OF LESION OR TISSUE OF LARYNX

MASG	42.09	Other excision or destruction of lesion or tissue of larynx	89.9	6+T

HEMILARYNGECTOMY (ANTERIOR) (LATERAL)

MASG	42.1	Hemilaryngectomy (anterior) (lateral)	325	9+T

OTHER PARTIAL LARYNGECTOMY NEC

MASG	42.29	Other partial laryngectomy NEC	400	8+T
MASG	42.29A	Supra glottic laryngectomy	350	10+T
MASG	42.29B	Excision of laryngofissure	200	6+T
MASG	42.29C	Arytenoidectomy	200	6+T

COMPLETE LARYNGECTOMY

MASG	42.3	Complete laryngectomy	269.7	8+T
MASG	42.3A	Excision by laryngofissure - with block dissection	400	6+T
MASG	42.3B	Pharyngolaryngectomy	343	8+T

INJECTION OF LARYNX

MAAS	43.0A	Teflon injection vocal cord	IC	6+T

TEMPORARY TRACHEOSTOMY

MASG	43.1	Temporary tracheostomy	100	6+T
MASG	43.1A	Placement of Montgomery T-tube	100	6+T

OTHER REPAIR OF LARYNX

MAAS	43.59A	Laryngoplasty	IC	6+T
MASG	43.59B	Arytenoidopexy	200	6+T

RADICAL NECK DISSECTION, UNQUALIFIED

MASG	52.31A	Resection of upper aerodigestive tract malignancy with lymphadectomy *Physician Restrictions in Place (See Appendix J)	800	10+T

INJECTION OR LIGATION OF ESOPHAGEAL VARICES

MASG	54.91A	Esophageal varices with esophagoscopy	90	4+T

OTHER PARTIAL OSTECTOMY - UNSPECIFIED SITE

MASG	89.79A	Excision elongated styloid process via tonsillar fossa	80	4+T
MASG	89.79B	Excision elongated styloid process via neck exploration (external)	150	4+T

SURGICAL PROCEDURES NOS

ADON	99.09A	Morbid obesity surgical add on	32.9	4.6

PAEDIATRICS

(Includes SP=PEDI, HUGE, MEGE, NEPE)

For further details refer to the Preamble.

CATEGORY	HEALTH SERVICE CODE	DESCRIPTION / MODIFIERS	BASE UNITS	ANAES UNITS
CONSULTATIONS				
CONS	03.08	Comprehensive Consultation (Prolonged)		
		RF=REFD (ME=TELE)	71+MU	
		RF=REFD, US=PREM (ME=TELE)	95.85+MU	
		RF=REFD, US=PR50 (ME=TELE)	106.5+MU	
		RF=REFD, RO=DETE (ME=TELE)	71+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	95.85+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	106.5+MU	
CONS	03.07	Limited Consultation		
		RF=REFD (ME=TELE)	42	
		RF=REFD, US=PREM (ME=TELE)	60	
		RF=REFD, US=PR50 (ME=TELE)	63	
		RF=REFD, RO=DETE (ME=TELE)	42+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	60+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	63+MU	
CONS	03.07	Repeat Consultation (Prolonged)		
		RF=REFD, RP=REPT (ME=TELE)	37.3+MU	
		RF=REFD, RP=REPT, US=PREM (ME=TELE)	55.3+MU	
		RF=REFD, RP=REPT, US=PR50 (ME=TELE)	55.95+MU	
		RF=REFD, RO=DETE, RP=REPT (ME=TELE)	37.3+MU	
		RF=REFD, RO=DETE, RP=REPT, US=PREM (ME=TELE)	55.3+MU	
		RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE)	55.95+MU	
OTHER CONSULTATION				
CONS	03.09A	Complex Genetic Counselling Consultation		
		RF=REFD, SP=HUGE or MEGE (ME=VTCR)	125+MU	
		(Fee to be billed once per physician per patient)		
OFFICE				
VIST	03.04	Initial Visit with Complete Examination		
		LO=OFFC (RF=REFD)	53	
VIST	03.04	Follow-up Visit with Complete Examination		
		LO=OFFC, RP=SUBS (RF=REFD)	39	
VIST	03.04J	Comprehensive Diagnostic Evaluation of Suspected Autism Spectrum Disorder		
		LO=OFFC (restricted to IWK)	284	

VIST 03.03 Initial Visit with Regional Examination
LO=OFFC, RP=INTL (RF=REFD) 26.4

VIST 03.03 Subsequent Visit
LO=OFFC, RP=SUBS (ME=VTCR*) (RF=REFD) 13
*Physician Restrictions in Place (See Appendix J)

VIST 03.03 Comprehensive Well Infant/Child Visit Using the Rourke Baby Record
LO=OFFC, CT=RKBR, RO=WBCR 24

VIST 03.03 Well Baby Care
LO=OFFC, RO=WBCR (RF=REFD) 8

VIST 03.03 Continuing Care
LO=OFFC, RO=CNTC, RF=REFD 15

VIST 03.03 Directive Care
LO=OFFC, RO=DIRC, RF=REFD 15

VIST 03.03 Urgent Care - Request by Patient (1701 - 2000)
LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Request by Patient (2001 - 2359)
LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Request by Patient (0000 - 0800)
LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) 38.3

VIST 03.03 Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Extra Patient
LO=OFFC, PT=EXPT (RF=REFD) 10.5

HOSPITAL (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

VIST 03.04 Initial Visit with Complete Examination
LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD) 53
LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD) ..... 53+MU

VIST 03.04 Closed Head Injury - Initial Examination and Recommendation Re Further Management
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, FN=OTPT, FN=EMCC, RO=CLHD,
RP=INTL (RF=REFD) 30
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, FN=OTPT, FN=EMCC, RO=CHDT,
RP=INTL (RF=REFD) ..... 30+MU

VIST 03.04J Comprehensive Diagnostic Evaluation of Suspected Autism Spectrum Disorder
LO=HOSP (restricted to IWK) 284

VIST	03.03	Daily Management - Per Day
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, DA=DALY, RO=CLHD (RF=REFD) 7
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, DA=DALY, RO=CHDT (RF=REFD)..... 7+MU
VIST	03.04	Complete Examination
		LO=HOSP, FN=INPT (RF=REFD) 53
		LO=HOSP, FN=INPT, RO=DETE (RF=REFD) ..... 53+MU
VIST	03.04	First Examination – Newborn Care Healthy Infant
		LO=HOSP, FN=INPT, RO=NBCR, RP=INTL (RF=REFD) 16
VIST	03.03	Subsequent Care – Newborn Healthy Infant
		LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS, DA23 23
		LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS, DA45 19
		LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS (RF=REFD) 16
VIST	03.03	Continuing Care
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC, RF=REFD 16.5
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT, RF=REFD ..... 16.5+MU
VIST	03.03	Directive Care
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD 16.5
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD ..... 16.5+MU
VIST	03.03	Subsequent Visit - Daily
		LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) 13
		LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD) ..... 13+MU
VIST	03.03	Supportive Care
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=SPCR (RF=REFD)..... 11.5
VIST	03.03W	Medical Geneticist Virtual Care Follow Up Visit – Per 15 minutes
		LO=HOSP, ME=VTCR 16.3
ADON	03.02A	Hospital Discharge Fee
		LO=HOSP, FN=INPT 10
VIST	03.03	Urgent Hospital Visit
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)..... 40
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD)..... 40+MU
VIST	03.03	Hospital Emergency Visit
		LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)..... 35.2
		LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)..... 35.2+MU
VIST	03.03	Emergency Care Centre (0801 - 1200)
		LO=HOSP, FN=EMCC, TI=AMNN (RF=REFD)..... 10.5
		LO=HOSP, FN=EMCC, TI=AMNN, RO=DETE (RF=REFD)..... 10.5+MU
VIST	03.03	Emergency Care Centre (1201 - 1700)
		LO=HOSP, FN=EMCC, TI=NNEV (RF=REFD) 10.5
		LO=HOSP, FN=EMCC, TI=NNEV, RO=DETE (RF=REFD) ..... 10.5+MU

VIST	03.03	Emergency Care Centre (1701 - 2000)	
		LO=HOSP, FN=EMCC, TI=EVNT (RF=REFD)	10.5
		LO=HOSP, FN=EMCC, TI=EVNT, RO=DETE (RF=REFD)	10.5+MU
VIST	03.03	Emergency Care Centre (0801 - 1200) Sundays and Holidays	
		LO=HOSP, FN=EMCC, DA=RGE2, TI=AMNN (RF=REFD)	15.5
		LO=HOSP, FN=EMCC, DA=RGE2, TI=AMNN, RO=DETE (RF=REFD)	15.5+MU
VIST	03.03	Emergency Care Centre (1201 - 1700) Sundays and Holidays	
		LO=HOSP, FN=EMCC, DA=RGE2, TI=NNEV (RF=REFD)	15.5
		LO=HOSP, FN=EMCC, DA=RGE2, TI=NNEV, RO=DETE (RF=REFD)	15.5+MU
VIST	03.03	Emergency Care Centre (1701 - 2000) Sundays and Holidays	
		LO=HOSP, FN=EMCC, DA=RGE2, TI=EVNT (RF=REFD)	15.5
		LO=HOSP, FN=EMCC, DA=RGE2, TI=EVNT, RO=DETE, (RF=REFD)	15.5+MU
VIST	03.03	Emergency Care Centre (2001 - 2359)	
		LO=HOSP, FN=EMCC, TI=ETMD (RF=REFD)	15.5
		LO=HOSP, FN=EMCC, TI=ETMD, RO=DETE (RF=REFD)	15.5+MU
VIST	03.03	Emergency Care Centre (0000 - 0800)	
		LO=HOSP, FN=EMCC, TI=MDNT (RF=REFD)	15.5
		LO=HOSP, FN=EMCC, TI=MDNT, RO=DETE, (RF=REFD)	15.5+MU
VIST	03.03	Outpatient Visit (0800 - 1700)	
		LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD)	13.5
		LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD)	13.5+MU
VIST	03.03	Outpatient Visit (1701 - 2000)	
		LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD)	20
		LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD)	20+MU
VIST	03.03	Outpatient Visit (2001 - 2359)	
		LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD)	20
		LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD)	20+MU
VIST	03.03	Outpatient Visit (0000 - 0800)	
		LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)	26
		LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)	26+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Sat., Sun., Holidays	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)	20
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)	20+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Sat., Sun., Holidays	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)	20
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD)	20+MU

VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient
		LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD) 7
		LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD) ..... 7+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient
		LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD) 7
		LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 7+MU
VIST	03.03	Outpatient Visit (1701 - 2000) Extra Patient
		LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD) 10.5
		LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD) ..... 10.5+MU
VIST	03.03	Outpatient Visit (2001 - 2359) Extra Patient
		LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD) 10.5
		LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD) ..... 10.5+MU
VIST	03.03	Outpatient Visit (0000 - 0800) Extra Patient
		LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) 11.4
		LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) ..... 11.4+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays
		LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD)..... 10.5
		LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 10.5+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays
		LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) 10.5
		LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 10.5+MU

HOME

VIST	03.04	Initial Visit with Complete Examination
		LO=HOME (RF=REFD)..... 23
		LO=HOME, RO=DETE (RF=REFD)..... 23+MU
VIST	03.03	Initial Visit with Regional Examination
		LO=HOME, RP=INTL (RF=REFD)..... 20
		LO=HOME, RP=INTL, RO=DETE (RF=REFD)..... 20+MU
VIST	03.03	Home Visit (0800 - 1700)
		LO=HOME, PT=FTPT (RF=REFD) 21.3
		LO=HOME, PT=FTPT, RO=DETE (RF=REFD) ..... 21.3+MU
VIST	03.03	Home Visit (1701 - 2000)
		LO=HOME, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD)..... 28.3
		LO=HOME, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD)..... 28.3+MU
VIST	03.03	Home Visit (2001 - 2359)
		LO=HOME, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD)..... 28.3
		LO=HOME, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD)..... 28.3+MU

VIST	03.03	Home Visit (0000 - 0800) LO=HOME, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) ..... 38.3 LO=HOME, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) ..... 38.3+MU
VIST	03.03	Home Visit (0801 - 1200) Sat., Sun., Holidays LO=HOME, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD) ..... 28.3 LO=HOME, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU
VIST	03.03	Home Visit (1201 - 1700) Sat., Sun., Holidays LO=HOME, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD) ..... 28.3 LO=HOME, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) ..... 28.3+MU
VIST	03.03	Home Visit - Extra Patient LO=HOME, PT=EXPT (RF=REFD) 10.5
VIST	03.03	Home Emergency Visit LO=HOME, US=UIOH (RF=REFD) ..... 35.2 LO=HOME, US=UIOH, RO=DETE (RF=REFD) ..... 35.2+MU
VIST	03.03	Continuing Care LO=HOME, RO=CNTC, RF=REFD ..... 15 LO=HOME, RO=CCDT, RF=REFD ..... 15+MU
VIST	03.03	Directive Care LO=HOME, RO=DIRC, RF=REFD ..... 15 LO=HOME, RO=DRDT, RF=REFD ..... 15+MU

PALLIATIVE CARE

CONS	03.09C	Palliative Care Consultation ..... 62+MU (Once per patient per physician)
CONS	03.09H	Antenatal Palliative Care Consultation (Limited) RF=REFD ..... 42 *Physician Restrictions in Place (See Appendix J)
VIST	03.03C	Palliative Care Support Visit RO=PCSV ..... 30 per 30 min (15 units per 15 min. thereafter, maximum of 60 min. per patient per day)
VIST	03.03H	Antenatal Palliative Care follow up visit ..... 13 *Physician Restrictions in Place (See Appendix J)
VIST	03.03	Palliative Care Medical Chart Review and/or Telephone Call, Fax or E-mail initiated by a health care professional - up to three telephone calls/faxes or e-mails per day per patient RO=CRTC ..... 11.5 **Note**: Each additional group of three telephone calls, faxes or e-mails/per day/per patient can be claimed at 11.5 units

PROCEDURES

BEHAVIORAL THERAPY

PSYC	08.43A	Behavioural Management (16.7 units per 15 minutes thereafter, maximum one hour per day)	33.4+MU per ½ hour

OTHER ASTHMA ASSESSMENT

VEDT	03.38A	Bronchial challenge testing with methacholine or similar compounds- Includes baseline spirometry and all spirometric determinations post administration of agent(s) RO=INTP	19
VEDT	03.38B	Exercise induced asthma assessment. Includes interpretation of all serial spirometry, flow/volume loops, bronchodilation responsiveness, and oximetry required to assess the patient.	20
VEDT	03.38C	Interpretation of spirometry pre and post bronchodilator	10

OTHER NONOPERATIVE MEASUREMENTS AND EXAMINATIONS

VEDT	03.39T	Clinical Interpretation of complex genetics tests (e.g., microarray analysis, next generation sequencing, and exome sequencing) by geneticist – findings must be recorded in health record and recommendations made in writing to the referring physician. Per 15 minutes RO=INTP, LO=OFFC, LO=HOSP	15

GENETECIST REVIEW OF PATIENT ENCOUNTER

VEDT	RGN1	Review by Geneticist of Patient encounter with Genetics Counsellor LO=OFFC, LO=HOSP	30

INTERPRETATIONS

The service date of electronic claims should be the date the patient had the procedure conducted and not the date the interpretation was completed (if they differ). The fee is for the interpretation.

These codes must be claimed from LO=HOSP

ELECTRO DIAGNOSTICS

BULK	I1168	Electrocardiogram - interpretation	4.60
BULK	I1171	Electroencephalogram – interpretation only	10.50
BULK	I6208	Holter monitoring – interpretation only	25

PULMONARY FUNCTIONS

BULK	I1110	Simple Spirometry	5
BULK	I1140	Flow/volume loops	5
BULK	I1410	Carbon monoxide single breath	5
BULK	I1230	Body plethysmography	5

ECHOCARDIOGRAPHY

BULK	I1311	M – mode	25.44
BULK	I1310	Two dimensional	47.56
BULK	I1312	Doppler – quantitative	30.45
BULK	I1313	Doppler – qualitative	15.23

PATHOLOGY

(Includes SP=PATH, ANPA, HAPA, MEBI, NEPA)

CATEGORY	HEALTH SERVICE CODE	DESCRIPTION / MODIFIERS	BASE UNITS	ANAES UNITS

CONSULTATIONS

CONS	03.08	Operating Room Consultation, Without Frozen Section		
		SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RF=REFD (ME=TELE)	36	
		SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RF=REFD, US=PREM (ME=TELE)	54	
		SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RF=REFD, US=PR50 (ME=TELE)	54	
		SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RO=DETE, RF=REFD (ME=TELE)	36+MU	
		SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RO=DETE, RF=REFD, US=PREM (ME=TELE)	54+MU	
		SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RO=DETE, RF=REFD, US=PR50 (ME=TELE)	54+MU	
CONS	03.08	Initial Consultation, Total Care		
		SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RF=REFD (ME=TELE)	36	
		SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RF=REFD, US=PREM (ME=TELE)	54	
		SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RF=REFD, US=PR50 (ME=TELE)	54	
		SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RO=DETE, RF=REFD (ME=TELE)	36+MU	
		SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RO=DETE, RF=REFD, US=PREM (ME=TELE)	54+MU	
		SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RO=DETE, RF=REFD, US=PR50 (ME=TELE)	54+MU	
CONS	03.08	Initial Consultation, Pathology Material Only		
		SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RO=PAMO, RF=REFD (ME=TELE)	30	
		SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RO=PAMO, RF=REFD, US=PREM (ME=TELE)	48	
		SP=ANPA, SP=HAPA, SP=NEPA, SP=PATH, RO=PAMO, RF=REFD, US=PR50 (ME=TELE)	48	
CONS	03.09I	Anatomic Pathology Consultation		
		Diagnostic Consultation, with review of records and specimens, with report on referred material prepared elsewhere	45	
CONS	03.09J	Anatomic Pathology Consultation		
		Special Diagnostic Consultation, with review of records and specimens, with report on referred material and requiring preparation of additional slides, and/or ordering and interpretation of special tests	60	

MICROSCOPIC EXAMINATION OF SPECIMEN FROM UNSPECIFIED SITE

VEDT	05.99A	Immunofluorescence, interpretation of any and all markers required for Diagnosis; any method	30
VEDT	05.99B	Molecular testing, interpretation of any and all analyses/test required for Diagnosis; any method	40
VEDT	05.9A	Complex, small surgical specimens, gross and microscopic	60
		US=PREM	81
		US=PR50	90
VEDT	03.8A	Complete autopsy, non-complex, gross and microscopic – all ages	500
		US=PREM	675
		US=PR50	750
VEDT	03.8B	Limited autopsy, non-complex, gross and microscopic – all ages (Regions required)	332.5
		US=PREM	448.88
		US=PR50	498.75
VEDT	03.8C	Complex autopsy, gross and microscopic – all ages	665
		US=PREM	897.75
		US=PR50	997.5
VEDT	03.8D	Autopsy, brain and/or spinal cord only with detailed neuropathologic examination as part of a full autopsy, gross and microscopic – all ages	200
		US=PREM	270
		US=PR50	300
VEDT	03.8E	Autopsy, removal of brain and/or spinal cord only for detailed neuropathologic examination	75
		US=PREM	101.25
		US=PR50	112.5

INTERPRETATIONS

Must be claimed from LO=HOSP

Pathology interpretation billing and service date must be the date the patient was seen in hospital and had specimens removed. The date the report was completed is not the correct service date

BULK	P2324	Surigcals, gross	7.30
		US=PREM, US=PR50	16.30
BULK	P2325	Surgicals, gross and microscopic	23.85 +MU
		US=PREM	32.85 +MU
		US=PR50	35.78 +MU
BULK	P2326	Frozen sections	31.99 +MU
		US=PREM	43.19 +MU
		US=PR50	47.99 +MU
BULK	P2328	Interpretation – fine needle aspiration biopsy	18.75
		US=PREM	27.75
		US=PR50	28.13

BULK	P2329	Cell block	14.60
		US=PREM, US=PR50	23.60
BULK	P2330	Cytology (with a screener)	1
		US=PREM, US=PR50	10
BULK	P2331	Interpretation and report (GYN cytology slides)	5
		US=PREM, US=PR50	14
		CT=CYSR	4
		CT=CYSR, US=PREM, US=PR50	13
BULK	P2332	Interpretation and report (non GYN cytology slides)	7.01
		US=PREM, US=PR50	16.01
BULK	P2333	Sex chromatin analysis	5.61
BULK	P2334	Karyotype Test A – five cells and two karyotypes	16.84
		US=PREM, US=PR50	25.84
BULK	P2335	Karyotype Test B – 30 cells and four karyotypes	22.46
		US=PREM	31.46
		US=PR50	33.69
BULK	P2336	Electron microscopy - Anatomical pathology only	52.90
BULK	P2337	*Immunohistochemistry – head and neck	10
BULK	P2338	*Immunohistochemistry – anterior torso	10
BULK	P2339	*Immunohistochemistry – posterior torso	10
BULK	P2340	*Immunohistochemistry – right arm	10
BULK	P2341	*Immunohistochemistry – left arm	10
BULK	P2342	*Immunohistochemistry – right leg	10
BULK	P2343	*Immunohistochemistry – left leg	10

* Immunohistochemistry – Staining and Interpretation of Surgical (Anatomic) Pathology Specimens

BULK	P2344	Liquid based preparation (thin prep) non GYN cytology (per slide)	15 +MU
BULK	P2345	Surgicals, gross and microscopic – three or more separate surgical specimens	37.03 +MU
BULK	P2346	Surgicals, gross and microscopic – single large complex CA specimen – Including lymph nodes	37.03
		US=PREM	49.99
		US=PR50	55.55

Note: The multiples permitted for HSC P2345 or P2325 may not be the same as the number of specimens received and examined. Please ensure the multiples claimed are submitted correctly.

PHYSICAL MEDICINE

(SP=PHMD)

For further details refer to the Preamble.

CATEGORY	HEALTH SERVICE CODE	DESCRIPTION / MODIFIERS	BASE UNITS	ANAES UNITS
CONSULTATIONS				
CONS	03.08	Comprehensive Consultation (Prolonged)		
		RF=REFD (ME=TELE)	62+MU	
		RF=REFD, US=PREM (ME=TELE)	83.7+MU	
		RF=REFD, US=PR50 (ME=TELE)	93+ MU	
		RF=REFD, RO=DETE (ME=TELE)	62+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	83.7+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	93+MU	
CONS	03.07	Limited Consultation		
		RF=REFD (ME=TELE)	37	
		RF=REFD, US=PREM (ME=TELE)	55	
		RF=REFD, US=PR50 (ME=TELE)	55.5	
		RF=REFD, RO=DETE (ME=TELE)	37+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	55+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	55.5+MU	
CONS	03.07	Repeat Consultation (Prolonged)		
		RF=REFD, RP=REPT (ME=TELE)	27.1+MU	
		RF=REFD, RP=REPT, US=PREM (ME=TELE)	45.1+MU	
		RF=REFD, RP=REPT, US=PR50 (ME=TELE)	45.1+MU	
		RF=REFD, RO=DETE, RP=REPT (ME=TELE)	27.1+MU	
		RF=REFD, RO=DETE, RP=REPT, US=PREM (ME=TELE)	45.1+MU	
		RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE)	45.1+MU	
OFFICE				
VIST	03.04	Initial Visit with Complete Examination		
		LO=OFFC (RF=REFD)	24	
VIST	03.03	Initial Visit with Regional Exam		
		LO=OFFC, RP=INTL (RF=REFD)	12	
		LO=OFFC, AG=OV65, RP=INTL (RF=REFD)	16.5	
VIST	03.03	Subsequent Visit		
		LO=OFFC, RP=SUBS (ME=VTCR*) (RF=REFD)	13	
		*Physician Restrictions in Place (See Appendix J)		
VIST	03.03A	Geriatric Office Visit (for patients aged 65+)		
		LO=OFFC (ME=VTCR*) (RF=REFD)	16.5	
		*Physician Restrictions in Place (See Appendix J)		

VIST 03.03 Continuing Care
LO=OFFC, RO=CNTC, RF=REFD 13.5
LO=OFFC, AG=OV65, RO=CNTC, RF=REFD 16.5

VIST 03.03 Directive Care
LO=OFFC, RO=DIRC, RF=REFD 13.5
LO=OFFC, AG=OV65, RO=DIRC, RF=REFD 16.5

VIST 03.03 Urgent Care - Request by Patient (1701 - 2000)
LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Request by Patient (2001 - 2359)
LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Request by Patient (0000 - 0800)
LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) 38.3

VIST 03.03 Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Extra Patient
LO=OFFC, PT=EXPT (RF=REFD) 10.5

HOSPITAL (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

VIST 03.04 Initial Visit with Complete Examination
LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD) 24
LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD) ..... 24+MU

VIST 03.04 Initial Visit
LO=HOSP, FN=INPT, RP=INTL (RF=REFD) 25
LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD) ..... 25+MU

VIST 03.03 Continuing Care
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC, RF=REFD 15
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT, RF=REFD ..... 15+MU

VIST 03.03 Directive Care
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD 15
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD ..... 15+MU

VIST 03.03 Subsequent Visit - Daily to 56 Days
LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) 15
LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU

VIST 03.03 Subsequent Visit - Weekly after 56 Days - Maximum 44 units per week
LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD) 15
LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU

ADON	03.02A	Hospital Discharge Fee LO=HOSP, FN=INPT 10
VIST	03.03	Urgent Hospital Visit LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)..... 22 LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD)..... 22+MU
VIST	03.03	Hospital Emergency Visit LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)..... 35.2 LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)..... 35.2+MU
VIST	03.03	Outpatient Visit (0800 - 1700) LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD) ..... 13.5 LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD) ..... 13.5+MU
VIST	03.03	Outpatient Visit (1701 - 2000) LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... .20 LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU
VIST	03.03	Outpatient Visit (2001 - 2359) LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 20 LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU
VIST	03.03	Outpatient Visit (0000 - 0800) LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)..... 26 LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)..... 26+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)..... 20 LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)..... 20 LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD)..... 20+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD)..... 7 LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 7+MU
VIST	03.03	Outpatient Visit (0800 - 1700) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD) ..... 7 LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 7+MU
VIST	03.03	Outpatient Visit (1701 - 2000) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD) ..... 10.5 LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD) ..... 10.5+MU

VIST	03.03	Outpatient Visit (2001 - 2359) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD) ..... 10.5 LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD) ..... 10.5+MU
VIST	03.03	Outpatient Visit (0000 - 0800) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) ..... 11.4 LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) ..... 11.4+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD)..... 10.5 LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 10.5+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) ..... 10.5 LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 10.5+MU

PLASTIC SURGERY

(SP=PLAS)

CATEGORY	HEALTH SERVICE CODE	DESCRIPTION / MODIFIERS	BASE UNITS	ANAES UNITS
CONSULTATIONS				
CONS	03.08	Comprehensive Consultation		
		RF=REFD (ME=TELE)	38.1	
		RF=REFD, US=PREM (ME=TELE)	56.1	
		RF=REFD, US=PR50 (ME=TELE)	57.15	
		RF=REFD, RO=DETE (ME=TELE)	38.1+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	56.1+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	57.15+MU	
CONS	03.07	Limited Consultation		
		RF=REFD (ME=TELE)	27	
		RF=REFD, US=PREM (ME=TELE)	45	
		RF=REFD, US=PR50 (ME=TELE)	45	
		RF=REFD, RO=DETE (ME=TELE)	27+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	45+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	45+MU	
CONS	03.07	Repeat Consultation		
		RF=REFD, RP=REPT (ME=TELE)	24.9	
		RF=REFD, RP=REPT, US=PREM (ME=TELE)	42.9	
		RF=REFD, RP=REPT, US=PR50 (ME=TELE)	42.9	
		RF=REFD, RO=DETE, RP=REPT (ME=TELE)	24.9+MU	
		RF=REFD, RO=DETE, RP=REPT, US=PREM (ME=TELE)	42.9+MU	
		RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE)	42.9+MU	
CONS	03.09M	Preoperative Comprehensive Assessment for Gender Affirming Surgery	24.9	
OFFICE				
VIST	03.04	Initial Visit		
		LO=OFFC (RF=REFD)	24	
VIST	03.03	Initial Visit with Regional Examination		
		LO=OFFC, RP=INTL (RF=REFD)	12	
		LO=OFFC, AG=OV65, RP=INTL (RF=REFD)	16.5	
VIST	03.03	Subsequent Visit		
		LO=OFFC, RP=SUBS (ME=VTCR*) (RF=REFD)	13	
		*Physician Restrictions in Place (See Appendix J)		
VIST	03.03A	Geriatric Office Visit (for patients aged 65+)		
		LO=OFFC (ME=VTCR*) (RF=REFD)	16.5	
		*Physician Restrictions in Place (See Appendix J)		

VIST	03.03	Continuing Care	
		LO=OFFC, RO=CNTC, RF=REFD	13.5
		LO=OFFC, AG=OV65, RO=CNTC, RF=REFD	16.5
VIST	03.03	Directive Care	
		LO=OFFC, RO=DIRC, RF=REFD	13.5
		LO=OFFC, AG=OV65, RO=DIRC, RF=REFD	16.5
VIST	03.03	Urgent Care - Request by Patient (1701 - 2000)	
		LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD)	28.3
VIST	03.03	Urgent Care - Request by Patient (2001 - 2359)	
		LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD)	28.3
VIST	03.03	Urgent Care - Request by Patient (0000 - 0800)	
		LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)	38.3
VIST	03.03	Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays	
		LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD)	28.3
VIST	03.03	Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays	
		LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD)	28.3
VIST	03.03	Urgent Care - Extra Patient	
		LO=OFFC, PT=EXPT (RF=REFD)	10.5
VIST	03.03Y	Post Operative Care – Gender Affirming Surgery	
		LO=OFFC	36

HOSPITAL (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

VIST	03.04	Initial Visit with Complete Examination	
		LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD)	24
		LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD)	24+MU
VIST	03.04	Initial Visit	
		LO=HOSP, FN=INPT, RP=INTL (RF=REFD)	25
		LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD)	25+MU
VIST	03.03	Continuing Care	
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC, RF=REFD	15
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT, RF=REFD	15+MU
VIST	03.03	Directive Care	
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD	15
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD	15+MU
VIST	03.03	Subsequent Visit - Daily to 56 Days	
		LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD)	15
		LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD)	15+MU

VIST	03.03	Subsequent Visit - Weekly after 56 Days - Maximum 44 units per week
		LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD) 15
		LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU
ADON	03.02A	Hospital Discharge Fee
		LO=HOSP, FN=INPT 10
VIST	03.03	Urgent Hospital Visit
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)..... 22
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD)..... 22+MU
VIST	03.03	Emergency Visit
		LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)..... 35.2
		LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)..... 35.2+MU
VIST	03.03	Outpatient Visit (0800 - 1700)
		LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD) 13.5
		LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD) ..... 13.5+MU
VIST	03.03	Outpatient Visit (1701 - 2000)
		LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) 20
		LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU
VIST	03.03	Outpatient Visit (2001 - 2359)
		LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) 20
		LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU
VIST	03.03	Outpatient Visit (0000 - 0800)
		LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)..... 26
		LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)..... 26+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Sat., Sun., Holidays
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)..... 20
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)..... 20+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Sat., Sun., Holidays
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)..... 20
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD)..... 20+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient
		LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD)..... 7
		LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 7+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient
		LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD) 7
		LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 7+MU
VIST	03.03	Outpatient Visit (1701 - 2000) Extra Patient
		LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD)..... 10.5
		LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD)..... 10.5+MU

VIST	03.03	Outpatient Visit (2001 - 2359) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD) ..... 10.5 LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD) ..... 10.5+MU	
VIST	03.03	Outpatient Visit (0000 - 0800) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) ..... 11.4 LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) ..... 11.4+MU	
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD)..... 10.5 LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 10.5+MU	
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) ..... 10.5 LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 10.5+MU	

PROCEDURES

APPLICATION OF OTHER WOUND DRESSING

MISG	07.57	Application of other wound dressing (applicable to burn wounds only) AN=GENL..... 20	4+T

REPAIR OF SKULL WITH FLAP OR GRAFT

MASG	15.03	Repair of skull with flap or graft 150	4+T

REPAIR OF (SPINAL) MENINGOCELE

MASG	16.41B	Meningocele multiple flaps with or without skin grafts..... 175	7+T
MASG	16.41C	Meningocele single flap with skin graft 125	7+T
MASG	16.41D	Meningocele single flap without skin graft 100	7+T

OTHER INCISION OF CRANIAL AND PERIPHERAL NERVES

MASG	17.05D	Explore peripheral nerve transplant or transposition with/without neurolysis (Excluding median nerve at the carpal tunnel)..... 100	4+T

SUTURE OF CRANIAL AND PERIPHERAL NERVES

MASG	17.2A	Peripheral nerves - primary suture, major nerve 100	4+T
MASG	17.2B	Peripheral nerves - secondary suture, major nerve 150	4+T

OTHER PERIPHERAL NERVE OF GANGLION DECOMPRESSION OR FREEING OF ADHESIONS

MASG	17.39B	Neuroplasty of major peripheral nerve of the upper extremity (excluding median nerve at the carpal tunnel, and ulnar nerve at the elbow). Specifically; Guyon's Canal (ulnar nerve release at wrist), anterior interosseous nerve (median nerve in forearm),posterior interosseus nerve (radial nerve in forearm wrist) (regions required) 125	4+T
MASG	17.39C	Neuroplasty of major peripheral nerve of the lower extremity. Specifically; Peroneal nerve release, tarsal tunnel (posterior tibial nerve) (regions required)..... 125	4+T

CRANIAL OR PERIPHERAL NERVE GRAFT

MASG	17.4B	Bilateral exploration of facial nerve and trans-facial nerve grafting with unilateral repair (microneural)	750	6+T
MASG	17.4C	Bilateral exploration of facial nerve and trans-facial nerve grafting with bilateral repair of facial nerve (microneural)	1020	6+T
MASG	17.4D	Exploration and grafting of facial nerve with microneural repair	600	6+T
MASG	17.4E	Peripheral nerve graft - major nerve with microneural repair	450	4+T
MASG	17.4F	Peripheral nerve graft - minor nerve with microneural repair	225	4+

TRANSPOSITION OF CRANIAL AND PERIPHERAL NERVES

MASG	17.5A	Exploration of peripheral nerve transplant or nerve transposition with or without neurolysis (excluding median nerve at carpal tunnel)	100	4+T
MASG	17.5B	Ulnar nerve release at the elbow (cubital tunnel) (regions required)	125	4+T
		RP=REPT	200	4+T
MASG	17.5C	Nerve Transfer with Microneural coaptation for the treatment of proximal 3rd, 4th, or 5th degree nerve injury to the brachial plexus or other major peripheral nerve IC	130/hr	4+T

ANASTOMOSIS OF CRANIAL OR PERIPHERAL NERVE

MASG	17.61B	Repair of palmar nerve (regions required) - plus multiples, if applicable	84.5	4+T
MASG	17.61C	Repair of peripheral nerve - major primary suture (regions required)	100	4+T
MASG	17.61D	Repair of peripheral nerve - minor digital, primary suture (regions required) - plus multiples, if applicable	84.5	4+T

OTHER OPERATIONS ON CRANIAL AND PERIPHERAL NERVES NEC

MASG	17.99A	Exploration and microneural repair - major nerve	250	4+T
MASG	17.99B	Exploration and microneural repair - minor nerve	125	4+T

WEDGE RESECTION OR HALVING PROCEDURE OF EYELID

MISG	22.12A	Excision of benign tumour of eyelids (regions required)	15	4+T
MISG	22.12B	Excision of benign tumour of eyelid margins of conjunctiva (regions required)	25	4+T

CANTHOPLASTY

MASG	22.23	Canthoplasty (regions required)	100	6+T
MASG	22.23A	Medial transnasal canthopexy (regions required)	230	6+T

OTHER OPERATIONS ON CANTHUS AND TARSUS

MASG	22.29A	Hypertelorism correction, intracranial approach	1250	14+T

CORRECTION BY EXTENSIVE BLEPHAROPLASTY

MASG	22.32A	Split thickness grafts - ectropion/entropion - complicated, including neoplasms and plastic repair (regions required)	125	4+T

FRONTALIS MUSCLE TECHNIQUE WITH SUTURE FOR CORRECTION OF BLEPHAROPTOSIS

MASG	22.41	Frontalis muscle technique with suture for correction of blepharoptosis (Regions required)	137	4+T

FRONTALIS MUSCLE TECHNIQUE WITH FASCIAL SLING FOR CORRECTION OF BLEPHAROPTOSIS

MASG	22.42A	Ptosis - lid suspension living tissue sutures (regions required)	200	4+T

TARSOLEVATOR RESECTION FOR CORRECTION OF BLEPHAROPTOSIS

MASG	22.43	Tarsolevator resection for correction of blepharoptosis (regions required)	196	4+T

OTHER EYELID REPAIR

MASG	22.69B	Direct flap to eyebrow - 1st stage (regions required)	150	4+T
MASG	22.69C	Direct flap to eyebrow - 2nd stage (regions required)	75	4+T
MASG	22.69D	Repair of avulsed and complicated wounds of eyelids (regions required)	96	4+T

INSERTION OF ORBITAL IMPLANT

MASG	29.56A	Orbital floor reconstruction with bone graft (regions required)	216	5+T

REPAIR OR MODIFICATION OF ORBITAL SOCKET

MASG	29.7A	Late correction traumatic enophthalmos (Tessier Technique) (Regions required)	815	10+T

OTHER OPERATIONS ON ORBIT

MASG	29.97A	Cavity grafting - eye socket (regions required)	200	4+T
MASG	29.97B	Cavity grafting - eye socket with mucosa (regions required)	250	4+T

SURGICAL CORRECTION OF PROMINENT EAR

MASG	30.4	Surgical correction of prominent ear congenital deformity (Regions required) - prior approval required if age over 17 years	96	5+T

CONSTRUCTION OF AURICLE OF EAR

MASG	30.61C	Loss of ear - major stage (total account not to exceed 400 units) PO=COML (regions required)	150	5+T
MASG	30.61D	Loss of ear - per stage (total account not to exceed 400 units) PO=PART (regions required)	100	5+T
MASG	30.61E	Loss of ear - minor stage (total account not to exceed 400 units) PO=COML (regions required)	100	5+T
MASG	30.61F	Total ear reconstruction (regions required)	400	9+T

OTHER PLASTIC REPAIR OF EXTERNAL EAR

MASG	30.69	Other plastic repair of external ear ME=COMP (regions required)	72	4+T

REDUCTION (CLOSED) OF NASAL FRACTURE

MIFR	33.61	Reduction (closed) of nasal fracture	25	4+T
MIFR	33.61A	Compound fracture of nasal bones requiring reduction and internal fixation	48	4+T

OPEN REDUCTION OF NASAL FRACTURE

MAFR	33.62	Open reduction of nasal fracture	100	4+T

SUTURE OF (TRAUMATIC) LACERATION OF NOSE

MASG	33.71	Suture of (traumatic) laceration of nose ME=COMP	72	4+T

RHINOPLASTY WITH BONE OR CARTILAGE GRAFT

MASG	33.74	Rhinoplasty with bone or cartilage graft - prior approval PO=COML PO=PART	192 75	7+T 7+T

OTHER RHINOPLASTY OR SEPTOPLASTY

MASG	33.76B	Complete rhinoplasty with submucous resection without skin grafting - prior approval	254	7+T
MASG	33.76D	Rhinoplasty - removal of hump - prior approval	150	7+T
MASG	33.76E	Scalping rhinoplasty - two stages - prior approval	350	7+T
MASG	33.76F	Rhinoplasty composite graft	125	7+T
MASG	33.76G	Rhinophyma	100	4+T

OTHER REPAIR AND PLASTIC OPERATIONS ON NOSE

MASG	33.79A	Nasal refracture	150	7+T
MASG	33.79B	Reconstruction of nasal tip, ala and columella - prior approval	168	7+T
ADON	33.79C	Lowering of floor of nose	50	

OTHER REPAIR AND PLASTIC OPERATIONS ON SALIVARY GLAND

MASG	38.39	Other repair and plastic operations on salivary gland	120	5+T
MASG	38.39A	Salivary fistula - plastic to Stenson's duct (regions required)	150	5+T

OTHER REPAIR OF MOUTH

MASG	39.49A	Cavity grafting - mouth	200	4+T

CORRECTION OF CLEFT PALATE

MASG	39.52	Correction of cleft palate	150	8+T
MASG	39.52A	Push-back of palate with pharyngeal flap or similar procedure	225	8+T

PLASTIC OPERATION ON PHARYNX

MASG	41.3	Plastic operation on pharynx or pharyngeal flap	150	8+T

OTHER OPERATIONS ON LYMPHATIC STRUCTURES

MASG	52.9B	Radical sleeve excision	300	6+T
MASG	52.9C	Lymphovenous anastomosis	250	6+T
MASG	52.9F	Lymphedema of limbs - modified Kondoleon- excision and grafting (Regions required)	180	5+T
MASG	52.9G	Lymphedema - entire lower limb (regions required)	250	5+T

REPAIR OF OTHER HERNIA OF ANTERIOR ABDOMINAL WALL

MASG	65.59D	Total Abdominal Wall Reconstruction with myofascial advancement flaps IC	130/hr	8+T

VAGINAL CONSTRUCTION (ABBE) (MCINDOE) (WILLIAMS)

MASG	82.51	Vaginal construction (Abbe) (McIndoe) (Williams)	300	4+T

(CLOSED) REDUCTION ON MALAR AND ZYGOMATIC FRACTURE

MAFR	88.02A	Fractured malar bone - simple elevation - open or closed	58	5+T

(CLOSED) REDUCTION OF MANDIBULAR FRACTURE

MAFR	88.04A	Fractured mandible - simple, interdental and intermaxillary wiring	100	8+T

OPEN REDUCTION OF FACIAL FRACTURE, UNQUALIFIED

MASG	88.11A	Nasoethmoid fracture - open reduction and internal fixation	300	10+T

OPEN REDUCTION OF MALAR AND ZYGOMATIC FRACTURE

MASG	88.12	Open reduction of malar and zygomatic fracture with rigid three or four plate fixation	250	5+T
MAFR	88.12A	Fractured malar bone - open reduction with pinning	100	5+T
MAFR	88.12B	Fractured malar bone - open reduction with interosseous wiring	144	5+T

OPEN REDUCTION OF MAXILLARY FRACTURE

MAFR	88.13A	Fractured maxilla - compound - requiring reduction and soft tissue repair	200	10+T
MAFR	88.13B	Fractured maxilla - requiring a radical antrostomy	150	8+T

OPEN REDUCTION OF MANDIBULAR FRACTURE

MAFR	88.14A	Open reduction and rigid internal fixation of fractured mandible	240	10+T
MAFR	88.14B	Mandible - compound and comminuted fracture - interosseous external fixation by pinning	175	10+T

OPEN REDUCTION OF OTHER FACIAL FRACTURE

MAFR	88.19A	Major fracture in middle third of face - LeFort type III	300	10+T
MASG	88.19B	Complex facial maxillary fracture - open reduction and rigid mini-plate fixation	400	10+T

PARTIAL OSTECTOMY, MANDIBLE

MASG	88.51A	Resection of mandible	150	7+T

TOTAL MANDIBULECTOMY WITH RECONSTRUCTION

MASG	88.52A	Tumours - enucleation, partial or complete resection with bone graft	225	5+T
MASG	88.52B	Reconstruction mandible with bone grafts and/or reconstruction plate	400	10+T
MASG	88.52C	Tumours - enucleation, partial or complete resection	150	5+T

TEMPOROMANDIBULAR ARTHROPLASTY

MASG	88.6	Temporomandibular arthroplasty	175	10+T
MASG	88.6A	Arthrotomy (meniscectomy or condylectomy)	150	8+T

AUGMENTATION GENIOPLASTY

MASG	88.74	Augmentation genioplasty	250	8+T

PROGNATHIC RECESSION

MASG	88.75	Prognathic recession	250	8+T

RECONSTRUCTION OF OTHER FACIAL BONE WITHOUT ASSOCIATED RESECTION

MASG	88.77A	Jaw or face bone graft	168	5+T

SEQUESTRECTOMY - UNSPECIFIED SITE

MASG	89.09A	Saucerization, muscle flap or bone graft	200	4+T
MASG	89.09B	Sequestrectomy and saucerization	150	4+T

EXCISION OF BONE FOR GRAFT - UNSPECIFIED SITE

ADON	89.69A	Harvesting of bone graft for facial reconstruction	100	4+T

BONE GRAFT - UNSPECIFIED SITE

MASG	90.09B	Elevation of a free vascularized bone transplant and closure of the donor site	340	6+T
MASG	90.09C	Preparation of a microvascular recipient site for a free vascularized bone transplant	340	6+T
MASG	90.09D	Transplantation of a free vascularized bone transplant with microvascular anastomoses and bony fixation	375	6+T
MASG	90.09E	Elevation of a free vascularized osteocutaneous or osteomuscular tissue transplant with closure of donor site	410	6+T
MASG	90.09F	Preparation of a microvascular recipient site for a free vascularized osteocutaneous or osteomuscular tissue transplant	410	6+T
MASG	90.09G	Transplantation of a free vascularized osteocutaneous or osteomuscular tissue transplant with microvascular anastomoses, osteotomies and bony fixation	410	6+T

ARTHROPLASTY OF HAND AND FINGER WITH SYNTHETIC PROSTHESIS

MASG	93.71A	Replacement of metacarpophalangeal or interphalangeal joint of hand by synthetic prosthesis - single (regions required) - plus multiples, if applicable	150	4+T

OTHER REPAIR OF HAND AND FINGER

MASG	93.79A	Reconstruction of rheumatoid joints- multiple (regions required)	211	4+T
MASG	93.79F	Thumb CMC joint tendon interpositional Arthoplasty (regions required)	190	4+T

INCISION OF TENDON SHEATH OF HAND

MASG	94.01A	Acute tenosynovitis of finger - drainage (regions required) - plus multiples, if applicable	75	4+T
MASG	94.01B	Incision of tendon sheath - simple ganglion or Dequervain's (Regions required)	60	4+T

FASCIOTOMY OF HAND FOR DIVISION

MASG	94.13B	Excision fascia - Dupuytren's PO=PART (regions required)	100	4+T
MASG	94.13C	Complex palmar fasciectomy for Dupuytren's Disease (regions required)	180	4+T
ADON	94.13D	Release of each additional digit including proximal interphalangeal joint release (Add on to complex palmar fasciectomy) - plus multiples, if applicable	70	

MASG	94.13E	Release of a single digit including the interphalangeal joint(s) for Dupuytren's disease (regions required)	120	4+T

EXCISION OF LESION OF TENDON (SHEATH) OF HAND

MASG	94.21A	Excision of tendon sheath - simple ganglion or Dequervain's (regions required)	60	4+T
MASG	94.21B	Ganglion of the wrist		
		AN=GENL (regions required)	100	4+T
		AN=REGL (regions required)	100	
MASG	94.21C	Excision of giant cell tumour of tendon sheath (regions required)	96	4+T

OTHER EXCISION OF TENDON OF HAND

MASG	94.32	Other excision of tendon of hand (regions required)	100	4+T
		ME=RADI (regions required)	150	4+T
MASG	94.32A	Excision of tendon of finger (regions required) - plus multiples, if applicable	100	4+T

DELAYED SUTURE OF OTHER TENDON OF HAND

MASG	94.43A	Correction boutonniere deformity (regions required) - plus multiples, if applicable	100	4+T

OTHER SUTURE OF FLEXOR TENDON OF HAND

MASG	94.44A	Suture flexor tendon - single (regions required) - plus multiples, if applicable	106	4+T

OTHER SUTURE OF OTHER TENDON OF HAND

MISG	94.45A	Suture extensor tendon - single (regions required) -plus multiples, if applicable	50	4+T

OTHER TRANSFER OR TRANSPLANTATION OF TENDON OF HAND

MASG	94.55D	Tendon transfer - single (regions required) - plus multiples, if applicable	96	4+T

POLLICIZATION (OPERATION) WITH NEUROVASCULAR BUNDLE CARRYOVER

MASG	94.61	Pollicization (operation) with neurovascular bundle carryover (Regions required)	300	4+T

PLASTIC OPERATION ON HAND WITH GRAFT OF TENDON

MASG	94.72A	Tendon graft - autogenous (regions required)	192	4+T

TRANSFER OF FINGER EXCEPT THUMB

MASG	94.81	Transfer of finger except thumb digital transplant (regions required) - plus multiples, if applicable	200	4+T

OTHER PLASTIC OPERATIONS ON TENDON OF HAND

MASG	94.86A	Reconstruction of flexor sheath finger by silicone tendon graft - single (Regions required)	150	4+T
MASG	94.86B	Tenodesis (regions required)	85	4+T
MASG	94.86C	Reconstruction of flexor sheath of finger by silicone tendon graft - multiple (Regions required)	300	4+T

FREEING OF ADHESIONS OF MUSCLE, TENDON, FASCIA, AND BURSA OF HAND

MASG	94.91A	Tenolysis - single (regions required)	96	4+T

INCISION OF TENDON SHEATH

MASG	95.01	Incision of tendon sheath	75	4+T
MASG	95.01A	Incision of tendon sheath - simple ganglion	60	4+T

BURSOTOMY

MASG	95.03C	Ulnar or radial bursa - drainage (regions required)	60	4+T

OTHER TENOTOMY

MASG	95.13A	Tenotomy for congenital torticollis	70	5+T

MYOTOMY FOR DIVISION

MASG	95.14D	Incision - muscles - sternomastoid - unipolar	70	5+T
MASG	95.14E	Incision - muscles - sternomastoid - bipolar	75	5+T

EXCISION OF LESION OF TENDON (SHEATH)

MASG	95.21A	Excision of tendon sheath - simple ganglion	60	4+T

OTHER EXCISION OF TENDON

MASG	95.32B	Ganglion of the foot or major joint		
		AN=GENL (regions required)	100	4+T
		AN=REGL (regions required)	100	

OTHER EXCISION OF MUSCLE

MASG	95.34A	Tenotomy for congenital torticollis - resection of sternomastoid - total	150	5+T

OTHER SUTURE OF TENDON

MISG	95.54A	Suture extensor tendon - plus multiples if applicable	50	4+T
MASG	95.54B	Suture flexor tendon - plus multiples if applicable	106	4+T
MASG	95.54C	Achilles or biceps, repair of tendon rupture (regions required)	100	4+T
MASG	95.54D	Distal biceps repair (regions required)	150	4+T

OTHER TRANSFER OR TRANSPLANTATION OF TENDON

MASG	95.65F	Tendon transfer - plus multiples if applicable	96	4+T

OTHER TRANSPOSITION OF MUSCLE

MASG	95.68A	Major muscle and myocutaneous flaps	384	8+T

PLASTIC OPERATION WITH GRAFT OF MUSCLE

MASG	95.73A	Elevation of a free vascularized muscle or musculocutaneous tissue transplant and closure of the donor site	340	6+T
MASG	95.73B	Preparation of a microvascular recipient site for a free vascularized muscle or musculocutaneous tissue transplant	340	6+T
MASG	95.73C	Transplantation of a free vascularized muscle or musculocutaneous tissue transplant with microvascular anastomoses	340	6+T
MASG	95.73D	Transplantation of a free vascularized muscle or musculocutaneous tissue transplant with microvascular anastomoses, microneural repair and tendon repairs	460	8+T

PLASTIC OPERATION WITH GRAFT OF FASCIA

MASG	95.74A	Elevation of a free vascularized muscle or musculocutaneous tissue transplant with tendon and nerve and closure of the donor site	460	8+T
MASG	95.74B	Preparation of a microvascular recipient site for a free vascularized muscle or musculocutaneous transplant with tendon and nerve repairs	460	8+T

OTHER CHANGE IN LENGTH OF MUSCLE, TENDON, AND FASCIA

MASG	95.76D	Tenoplasty - shortening, lengthening of any tendon any location (Regions required) - plus multiples, if applicable	95	4+T

OTHER PLASTIC OPERATIONS ON TENDON

MASG	95.77A	Tenodesis	85	4+T

FREEING OF ADHESIONS OF MUSCLE, TENDON, FASCIA, AND BURSA

MASG	95.91A	Tenolysis - single	96	4+T

REATTACHMENT OF FINGER(S)

MASG	96.31A	Elevation of a free vascularized finger transplant and closure of donor site (Regions required) - plus multiples, if applicable	410	6+T
MASG	96.31B	Preparation of a microvascular recipient site for a free vascularized finger transplant (regions required) - plus multiples, if applicable	410	6+T
MASG	96.31C	Transplantation of a free vascularized finger transplant with microvascular anastomoses, tendon, nerve and bone repair (regions required) - plus multiples, if applicable	410	6+T
MASG	96.31D	Replantation of a single digit (regions required) - plus multiples, if applicable	550	8+T

REATTACHMENT OF TOE(S)

MASG	96.35A	Elevation of a free vascularized toe transplant and closure of donor site (Regions required) - plus multiples, if applicable	410	6+T
MASG	96.35B	Preparation of a microvascular recipient site for a free vascularized toe transplant (regions required) - plus multiples, if applicable	410	6+T
MASG	96.35C	Transplantation of a free vascularized toe transplant with microvascular anastomoses, tendon, nerve and bone repair (regions required) - plus multiples, if applicable	410	6+T
MASG	96.35D	Replantation of a single digit (regions required) - plus multiples, if applicable	550	8+T

OTHER REATTACHMENT

MAAS	96.39	Other reattachment of limbs (regions required)	IC	6+T

UNILATERAL REDUCTION MAMMOPLASTY

MASG	97.31A	Unilateral mammoplasty with nipple transplantation (regions required) - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition	163	8+T
MASG	97.31C	Unilateral functional pedicled breast reduction (regions required) - prior approval unless performed for malignant or pre-malignant conditions	250	8+T

BILATERAL REDUCTION MAMMOPLASTY

MASG	97.32	Bilateral reduction mammoplasty - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition	244.5	8+T
MASG	97.32B	Bilateral functional pedicled breast reduction - prior approval unless performed for malignant or pre-malignant conditions	375	8+T

UNILATERAL AUGMENTATION MAMMOPLASTY BY IMPLANT OR GRAFT

MASG	97.43	Unilateral augmentation mammoplasty by implant or graft (regions required) - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition	128	5+T

BILATERAL AUGMENTATION MAMMOPLASTY BY IMPLANT OR GRAFT

MASG	97.44	Bilateral augmentation mammoplasty by implant or graft - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition	192	5+T

TOTAL RECONSTRUCTION OF BREAST

MASG	97.6B	Breast reconstruction by myocutaneous flap and breast prosthesis (Regions required) - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition	400	6+T
MASG	97.6C	Breast reconstruction using rectus abdominis flap, including reconstruction of the rectus sheath as required (regions required) - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition	600	6+T

MASG	97.6D	Deep inferior epigastric perforator (DIEP) free flap breast reconstruction - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition RO=FPHN ..... 900 RO=SPHN ..... 400 **Note**: No assistant fee will be allowed if the second surgeon code is used.		8+T
MASG	97.6E	Post Mastectomy Breast Reconstruction with tissue expander or implant, immediate or delayed 140		4+T

MUSCLE FLAP GRAFT TO BREAST

MASG	97.75A	Breast reconstruction by myocutaneous flap and prosthesis (Regions required) - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition 400		6+T

OTHER REPAIR OR RECONSTRUCTION OF NIPPLE

MASG	97.77	Other repair or reconstruction of nipple (regions required) - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition 150		4+T

REMOVAL OF IMPLANT

MISG	97.94A	Removal of breast prosthesis (regions required) - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition 50		4+T
MASG	97.94B	Removal of breast prosthesis with capsulectomy (regions required) - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition 100		4+T

INSERTION OF BREAST TISSUE EXPANDER(S)

MASG	97.95	Insertion of breast tissue expander(s) (regions required) 100		4+T

POST MASTECTOMY OR LUMPECTOMY FAT GRAFTING

MISG	97.6F	Minor Fat Grafting to breast post mastectomy or lumpectomy for malignant or premalignant conditions to breast – to include harvesting and grafting of autologous fat ≤100ml (regions required) 100		4+T
MISG	97.6G	Major Fat Grafting to breast post mastectomy or lumpectomy for malignant or premalignant conditions to breast – to include harvesting and grafting of autologous fat >100ml (regions required) 150		4+T

GENDER AFFIRMING SURGERY (Prior Approval)

MASG	97.44A	Feminization of Chest Wall (Prior Approval) 350		4+T
MASG	97.79B	Masculinization of Chest Wall (Prior approval) 425		4+T
MISG	97.99B	Revision of gender affirming chest surgery (Prior Approval) (regions required) .. 150		4+T

INCISION WITH REMOVAL OF FOREIGN BODY OF SKIN AND SUBCUTANEOUS TISSUE

MISG	98.04B	Removal of complicated foreign body - plus multiples, if applicable AN=GENL 50		4+T

DEBRIDEMENT OF WOUND OR INFECTED TISSUE

MAAS	98.11	Debridement of wound or infected tissue		
		ME=COMP	IC	IC+T
ADON	98.11B	Surgical debridement of burns - for each 5% of body surface - plus multiples, if applicable		
		AN=GENL	20	
		PO=ONTW		4+T
		PO=TOTF		6+T
		PO=TSOV		8+T
ADON	98.11C	Surgical excision of burn tissue prior to immediate skin grafting - each 5% of body surface - plus multiples, if applicable		
		AN=GENL	50	
		PO=ONTW		4+T
		PO=TOTF		6+T
		PO=TSOV		8+T

LOCAL EXCISION OR DESTRUCTION OF LESION OR TISSUE OF SKIN AND SUBCUTANEOUS TISSUE

MISG	98.12Q	Wedge resection of lip, vermillion	33.6	4+T
MISG	98.12R	Destruction (dermabrasion) of single area (e.g., trauma scar) (Prior-Approval Required)	35	4+T
MAAS	98.12S	Extensive and complicated lesions	IC	4+T

RADICAL EXCISION OF SKIN LESION

MASG	98.13F	Wedge resection of lip, vermilion to sulcus	90	4+T

SUTURE OF SKIN AND SUBCUTANEOUS TISSUE OF OTHER SITES

MISG	98.22	Suture of skin and subcutaneous tissue of other sites - plus multiples, if applicable		
		ME=SIMP, AN=LOCL	11	
		ME=SIMP	11	
MISG	98.22A	Suture of simple wounds or lacerations - child's face - plus multiples, if applicable	17	4+T
MASG	98.22B	Complicated lacerations of the scalp, cheek and neck	96	4+T
MISG	98.22D	Suture minor laceration or foreign body wound - plus multiples, if applicable	20	
		AN=GENL	20	4+T
MISG	98.22F	Suture extensive laceration or foreign body wound - plus multiples, if applicable	50	
		AN=GENL	50	4+T

FULL THICKNESS SKIN GRAFT TO HAND

MISG	98.42A	Full thickness grafts - finger tip (regions required) - plus multiples, if applicable	40	4+T
MASG	98.42B	Full thickness grafts - palm (regions required)	125	4+T

OTHER FREE SKIN GRAFT

MASG	98.43A	Split thickness grafts - functional areas - late with scar excision graft (Regions required)	144	4+T
MASG	98.43B	Elevation of a free vascularized skin and subcutaneous tissue transplant and closure of the donor site (regions required)	340	6+T
MASG	98.43C	Preparation of a microvascular recipient site free vascularized skin and subcutaneous tissue transplant (regions required)	340	6+T
MASG	98.43D	Transplantation of a free vascularized skin and subcutaneous tissue transplant with microvascular anastomoses (regions required)	340	6+T
MASG	98.43E	Elevation of free vascularized innervated skin and subcutaneous tissue transplant and closure of the donor site (regions required)	375	6+T
MASG	98.43F	Preparation of a microvascular recipient site for a free vascularized innervated skin and subcutaneous tissue transplant (regions required)	375	6+T
MASG	98.43G	Transplantation of a free vascularized innervated skin and subcutaneous tissue transplant with microvascular anastomoses and microneural nerve repair (regions required)	375	6+T
MASG	98.43H	Split thickness grafts - early (regions required)	144	4+T

FULL THICKNESS SKIN GRAFT TO OTHER SITES

MASG	98.44A	Free skin grafts (including mucosa) full thickness grafts - eyelid, nose, lips	150	4+T
MASG	98.44B	Full thickness grafts - finger, more than one phalanx (regions required) - plus multiples, if applicable	125	4+T
MASG	98.44C	Full thickness grafts - sole (regions required)	125	4+T
MISG	98.44D	Full thickness grafts - toe pulp graft (regions required) - plus multiples, if applicable	50	4+T

OTHER FREE GRAFTS TO OTHER SITES

MISG	98.49A	Split thickness grafts - non functional areas - less than 1 square inch	25	4+T
MISG	98.49B	Split thickness grafts - non functional areas - less than 10 square inches	50	4+T
MASG	98.49C	Split thickness grafts - non functional areas - less than 100 square inches	96	4+T
ADON	98.49D	Split thickness grafts - non functional areas - for each square inch over 100 square inches - plus multiples, if applicable	1	4+T

MASG	98.49E	Split thickness grafts - functional areas - major joints - early (regions required)	144	4+T
MASG	98.49F	Split thickness grafts - functional areas - major joints - late with scar excision graft (regions required)	144	4+T
MASG	98.49G	Split thickness grafts - functional areas - head and neck - less than 10 square inches	100	4+T
MASG	98.49H	Split thickness grafts - functional areas - head and neck - in excess of 10 square inches	150	4+T
MASG	98.49I	Split thickness grafts - functional areas - head and neck - in excess of 30 square inches	350	4+T
MASG	98.49J	Cavity grafting - nose	150	4+T
MASG	98.49K	Cavity grafting - lining pedicle flaps	100	4+T
MASG	98.49L	Bone cavity grafting over 3 inches diameter in large bone; e.g., femur (Regions required)	250	4+T
MASG	98.49M	Bone cavity grafting up to 3 inches in large bone (regions required)	150	4+T
MASG	98.49N	Bone cavity grafting in small bone; e.g., hand or foot (regions required)	75	4+T
MASG	98.49O	Elevation of a free vascularized skin and subcutaneous tissue transplant and closure of the donor site	340	6+T
MASG	98.49P	Preparation of a microvascular recipient site free vascularized skin and subcutaneous tissue transplant	340	6+T
MASG	98.49Q	Transplantation of a free vascularized skin and subcutaneous tissue transplant with microvascular anastomoses	340	6+T
MASG	98.49R	Elevation of free vascularized innervated skin and subcutaneous tissue transplant and closure of the donor site	375	6+T
MASG	98.49S	Preparation of a microvascular recipient site for a free vascularized innervated skin and subcutaneous tissue transplant	375	6+T
MASG	98.49T	Transplantation of a free vascularized innervated skin and subcutaneous tissue transplant with microvascular anastomoses and microneural nerve repair	375	6+T

FLAP OR PEDICLE GRAFT, UNQUALIFIED

MASG	98.51B	Local tissue shifts with free skin graft to secondary defect - single	125	4+T
MASG	98.51C	Local tissue shifts - advancements, rotations, transpositions, 'Z' plasty - single	96	4+T

MASG	98.51D	Local tissue shifts - advancements, rotations, transpositions, 'Z' plasty - multiple	144	4+T
MASG	98.51E	Local tissue shifts with free skin graft to secondary defect - multiple	225	4+T
MASG	98.51F	Neurovascular pedicle repair	200	4+T

CUTTING AND PREPARATION OF FLAP OR PEDICLE GRAFT

MISG	98.52	Cutting and preparation of flap or pedicle graft	30	4+T

ADVANCEMENT OF FLAP OR PEDICLE GRAFT

MASG	98.53A	Local tissue shifts, advancements, rotations, transpositions, 'Z' plasty, etc., eyebrow, eyelid, lip, ear, nose - single	96	4+T
MASG	98.53B	Local tissue shifts, advancements, rotations, transpositions, 'Z' plasty, etc., eyebrow, eyelid, lip, ear, nose - two stages	200	4+T
MASG	98.53C	Flaps from a distance - indirect - tubes, jumps - minor stage - per operation	100	4+T
MASG	98.53D	Flaps from a distance - indirect - tubes, jumps - major stage - per operation	150	4+T

ATTACHMENT OF FLAP OR PEDICLE GRAFT TO HAND

MASG	98.54A	Flaps from distance - direct (2 stages) - upper extremity	150	4+T
MASG	98.54B	Flaps from distance - direct (2 stages) - upper extremity with free skin graft to secondary defect	175	4+T
MASG	98.54C	Direct flap to finger for covering bare bone/tendon - 2 stages (Regions required) - plus multiples, if applicable	125	4+T

ATTACHMENT OF FLAP OR PEDICLE GRAFT TO OTHER SITES

MASG	98.55A	Flaps from distance - direct (2 stages) - lower extremity	200	4+T
MASG	98.55B	Decubitus ulcers, excision and treatment of bone rotation flaps and skin graft to secondary defect	216	7+T

ATTACHMENT OF FLAP OR PEDICLE GRAFT TO LIP AND EXTERNAL MOUTH

MASG	98.63C	Abbe operation - 2 stages	250	8+T
MASG	98.63D	Full lip thickness transfer by rotation flap	200	8+T

OTHER PLASTIC OPERATIONS ON LIP AND EXTERNAL MOUTH

MASG	98.69A	Repair of harelip (regions required)	158	8+T
MASG	98.69B	Repair of avulsed and complicated wounds of the lips	96	4+T

CORRECTION OF SYNDACTYLY

MASG	98.71A	Syndactyly - local flaps (regions required) - plus multiples, if applicable	100	4+T
MASG	98.71B	Syndactyly - local flaps with skin graft (regions required) - plus multiples, if applicable	150	4+T

REPAIR FOR FACIAL WEAKNESS

MASG	98.73A	Fascial slings or muscle transfer (regions required)	225	5+T

DERMABRASION

MASG	98.93A	Dermabrasion full face - prior approval	100	5+T
MISG	98.93B	Dermabrasion less than 1/4 of face - prior approval	25	5+T
MISG	98.93C	Dermabrasion single area face; e.g., trauma scar - prior approval	35	4+T
MASG	98.93D	Dermabrasion between 1/4 and 1/2 face - prior approval	75	5+T

INSERTION OF TISSUE EXPANDER(S)

MASG	98.98	Insertion of tissue expander(s) - plus multiples, if applicable	100	4+T
VADT	98.98A	Percutaneous expansion/inflation of a tissue expander - plus multiples, if applicable	13	

OTHER OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE NEC

MASG	98.99H	MOHS micrographic surgery (MMS) for the removal of a histologically confirmed cutaneous malignancy – initial level and debulking *Physician Restrictions in Place (See Appendix J)	155	
ADON	98.99I	Additional levels (comprehensive of all additional levels for complete excision). *Physician Restrictions in Place (See Appendix J)	135	

SURGICAL PROCEDURES NOS

ADON	99.09A	Morbid obesity surgical add on	32.9	4.6

PSYCHIATRY

(SP=PSYC)

For further details refer to the Preamble.

CATEGORY	HEALTH SERVICE CODE	DESCRIPTION / MODIFIERS	BASE UNITS	ANAES UNITS
CONSULTATIONS				
CONS	03.08	Comprehensive Consultation		
		RF=REFD (ME=TELE)	105.75	
		RF=REFD, US=PREM (ME=TELE)	142.76	
		RF=REFD, US=PR50 (ME=TELE)	158.63	
		RF=REFD, RO=DETE (ME=TELE)	75+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	101.25+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	112.50+MU	
CONS	03.08A	Extended Comprehensive Psychiatry Consultation – When direct physician to patient time exceeds 60 minutes		
		RF=REFD (ME=TELE)	132.19+MU	
		RF=REFD, US=PREM (ME=TELE)	178.46+MU	
		RF=REFD, US=PR50 (ME=TELE)	198.29+MU	
CONS	03.07	Limited Consultation		
		RF=REFD (ME=TELE)	48.22	
		RF=REFD, US=PREM (ME=TELE)	66.22	
		RF=REFD, US=PR50 (ME=TELE)	72.33	
		RF=REFD, RO=DETE (ME=TELE)	48.22+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	66.22+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	72.33+MU	
CONS	03.07	Repeat Consultation		
		RF=REFD, RP=REPT (ME=TELE)	37.5+MU	
		RF=REFD, RP=REPT, US=PREM (ME=TELE)	55.5+MU	
		RF=REFD, RP=REPT, US=PR50 (ME=TELE)	56.25+MU	
		RF=REFD, RO=DETE, RP=REPT (ME=TELE)	37.5+MU	
		RF=REFD, RO=DETE, RP=REPT, US=PREM (ME=TELE)	55.5+MU	
		RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE)	56.25+MU	
OFFICE				
VIST	03.04	Initial Visit with Complete Examination Including Psychiatric Evaluation and Certification if indicated		
		LO=OFFC (RF=REFD)	34.29	
VIST	03.03	Subsequent Visit		
		LO=OFFC, RP=SUBS (ME=VTCR*) (RF=REFD)	14.41	
		*Physician Restrictions in Place (See Appendix J)		

VIST 03.03A Geriatric Office Visit (for patients aged 65+)
LO=OFFC (ME=VTCR*) (RF=REFD) 17.69
*Physician Restrictions in Place (See Appendix J)

VIST 03.03 Continuing Care
LO=OFFC, RO=CNTC, RF=REFD 14.47
LO=OFFC, AG=OV65, RO=CNTC, RF=REFD 17.69

VIST 03.03 Directive Care
LO=OFFC, RO=DIRC, RF=REFD 14.47
LO=OFFC, AG=OV65, RO=DIRC, RF=REFD 17.69

VIST 03.03 Urgent Care - Request by Patient (1701 - 2000)
LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) 30.32

VIST 03.03 Urgent Care - Request by Patient (2001 - 2359)
LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) 30.32

VIST 03.03 Urgent Care - Request by Patient (0000 - 0800)
LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) 41.04

VIST 03.03 Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) 30.32

VIST 03.03 Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) 30.32

VIST 03.03 Urgent Care - Extra Patient
LO=OFFC, PT=EXPT (RF=REFD) 11.25

HOSPITAL (LO=HOSP: FN=INPT, INCU, NICU, OTPT, DTOX or EMCC)

VIST 03.04 Initial Visit with Complete Examination
Including Psychiatric Evaluation and Certification if indicated
LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD) 34.29
LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD) ..... 34.29+MU

VIST 03.04 Initial Visit
LO=HOSP, FN=INPT (RF=REFD) 32.15
LO=HOSP, FN=INPT, RO=DETE (RF=REFD) ..... 32.15+MU

VIST 03.03 Continuing Care
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC (RF=REFD) 16
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT (RF=REFD) ..... 16+MU

VIST 03.03 Directive Care
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC (RF=REFD) 16
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT (RF=REFD) ..... 16+MU

VIST	03.03	Subsequent Visit - Daily to 56 Days	
		LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD)	16
		LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD)	16+MU
VIST	03.03	Subsequent Visit - Weekly after 56 Days - Maximum 80 units per week	
		LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD)	16
		LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD)	16+MU
ADON	03.02A	Hospital Discharge Fee	
		LO=HOSP, FN=INPT	10
VIST	03.03	Urgent Hospital Visit	
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)	23.57
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD)	23.57+MU
VIST	03.03	Hospital Emergency Visit	
		LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)	37.72
		LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)	37.72+MU
VIST	03.03	Outpatient Visit (0800 - 1700)	
		LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD)	14.47
		LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD)	14.47+MU
VIST	03.03	Outpatient Visit (1701 - 2000)	
		LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD)	21.43
		LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD)	21.43+MU
VIST	03.03	Outpatient Visit (2001 - 2359)	
		LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD)	21.43
		LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD)	21.43+MU
VIST	03.03	Outpatient Visit (0000 - 0800)	
		LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)	27.86
		LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)	27.86+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Sat., Sun., Holidays	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)	21.43
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)	21.43+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Sat., Sun., Holidays	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)	21.43
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD)	21.43+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD)	7.5
		LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)	7.5+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD)	7.5
		LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD)	7.5+MU

VIST 03.03 Outpatient Visit (1701 - 2000) Extra Patient
LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD) 11.25
LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD) ..... 11.25+MU

VIST 03.03 Outpatient Visit (2001 - 2359) Extra Patient
LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD) 11.25
LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD) ..... 11.25+MU

VIST 03.03 Outpatient Visit (0000 - 0800) Extra Patient
LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) 11.86
LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) ..... 11.86+MU

VIST 03.03 Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays
LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD)..... 11.25
LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 11.25+MU

VIST 03.03 Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays
LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) 11.25
LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 11.25+MU

VIST 03.03 Detox Centre (0800 - 1700)
LO=HOSP, FN=DTOX, PT=FTPT (RF=REFD) 22.83
LO=HOSP, FN=DTOX, PT=FTPT, RO=DETE (RF=REFD) ..... 22.83+MU

VIST 03.03 Detox Centre (1701 - 2000)
LO=HOSP, FN=DTOX, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD)..... 30.32
LO=HOSP, FN=DTOX, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD)..... 30.32+MU

VIST 03.03 Detox Centre (2001 - 2359)
LO=HOSP, FN=DTOX, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD)..... 30.32
LO=HOSP, FN=DTOX, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD)..... 30.32+MU

VIST 03.03 Detox Centre (0000 - 0800)
LO=HOSP, FN=DTOX, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) 41.04
LO=HOSP, FN=DTOX, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) ..... 41.04+MU

VIST 03.03 Detox Centre (0801 - 1200) Sat., Sun., Holidays
LO=HOSP, FN=DTOX, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)..... 30.32
LO=HOSP, FN=DTOX, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE
(RF=REFD) ..... 30.32+MU

VIST 03.03 Detox Centre (1201 - 1700) Sat., Sun., Holidays
LO=HOSP, FN=DTOX, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)..... 30.32
LO=HOSP, FN=DTOX, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE
(RF=REFD) ..... 30.32+MU

VIST 03.03 Detox Centre (0801 - 1200) Extra Patient
LO=HOSP, FN=DTOX, PT=EXPT, TI=AMNN (RF=REFD) 9
LO=HOSP, FN=DTOX, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD) ..... 9+MU

VIST 03.03 Detox Centre (1201 - 1700) Extra Patient
LO=HOSP, FN=DTOX, PT=EXPT, TI=NNEV (RF=REFD) 9
LO=HOSP, FN=DTOX, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 9+MU

VIST 03.03 Detox Centre (1701 - 2000) Extra Patient
LO=HOSP, FN=DTOX, PT=EXPT, TI=EVNT (RF=REFD) 11.25
LO=HOSP, FN=DTOX, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD) ..... 11.25+MU

VIST 03.03 Detox Centre (2001 - 2359) Extra Patient
LO=HOSP, FN=DTOX, PT=EXPT, TI=ETMD (RF=REFD) 11.25
LO=HOSP, FN=DTOX, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD) ..... 11.25+MU

VIST 03.03 Detox Centre (0000 - 0800) Extra Patient
LO=HOSP, FN=DTOX, PT=EXPT, TI=MDNT (RF=REFD) 11.25
LO=HOSP, FN=DTOX, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) ..... 11.25+MU

VIST 03.03 Detox Centre (0801 - 1200) Extra Patient, Sat., Sun., Holidays
LO=HOSP, FN=DTOX, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD) 11.25
LO=HOSP, FN=DTOX, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD) ..... 11.25+MU

VIST 03.03 Detox Centre (1201 - 1700) Extra Patient, Sat., Sun., Holidays
LO=HOSP, FN=DTOX, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) 11.25
LO=HOSP, FN=DTOX, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 11.25+MU

INSTITUTIONAL VISITS

VIST 03.03 Nursing Home Visit (0800 - 1700)
LO=NRHM, PT=FTPT (RF=REFD) 22.83
LO=NRHM, PT=FTPT, RO=DETE (RF=REFD) ..... 22.83+MU

VIST 03.03 Nursing Home Visit (1701 - 2000)
LO=NRHM, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) 30.32
LO=NRHM, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 30.32+MU

VIST 03.03 Nursing Home Visit (2001 - 2359)
LO=NRHM, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) 30.32
LO=NRHM, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 30.32+MU

VIST 03.03 Nursing Home Visit (0000 - 0800)
LO=NRHM, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) 41.04
LO=NRHM, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) ..... 41.04+MU

VIST 03.03 Nursing Home Visit (0801 - 1200) Sat., Sun., Holidays
LO=NRHM, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD) 30.32
LO=NRHM, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD) ..... 30.32+MU

VIST 03.03 Nursing Home Visit (1201 - 1700) Sat., Sun., Holidays
LO=NRHM, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD) 30.32
LO=NRHM, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) ..... 30.32+MU

VIST	03.03	Nursing Home Visit (0801 – 1200) Extra Patient	
		LO=NRHM, PT=EXPT, TI=AMNN (RF=REFD)	11.25
		LO=NRHM, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)	11.25+MU
VIST	03.03	Nursing Home Visit (1201 – 1700) Extra Patient	
		LO=NRHM, PT=EXPT, TI=NNEV (RF=REFD)	11.25
		LO=NRHM, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD)	11.25+MU
VIST	03.03	Nursing Home Visit (1701 - 2000) Extra Patient	
		LO=NRHM, PT=EXPT, TI=EVNT (RF=REFD)	11.25
		LO=NRHM, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD)	11.25+MU
VIST	03.03	Nursing Home Visit (2001 - 2359) Extra Patient	
		LO=NRHM, PT=EXPT, TI=ETMD (RF=REFD)	11.25
		LO=NRHM, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD)	11.25+MU
VIST	03.03	Nursing Home Visit (0000 - 0800) Extra Patient	
		LO=NRHM, PT=EXPT, TI=MDNT (RF=REFD)	11.25
		LO=NRHM, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD)	11.25+MU
VIST	03.03	Nursing Home Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays	
		LO=NRHM, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD)	11.25
		LO=NRHM, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)	11.25+MU
VIST	03.03	Nursing Home Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays	
		LO=NRHM, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD)	11.25
		LO=NRHM, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD)	11.25+MU
VIST	03.03	Nursing Home - Emergency Visit	
		LO=NRHM, US=UIOH (RF=REFD)	37.72
		LO=NRHM, US=UIOH, RO=DETE (RF=REFD)	37.72+MU

HOME

VIST	03.04	Initial Visit	
		LO=HOME (RF=REFD)	26.79
		LO=HOME, RO=DETE) (RF=REFD)	26.79+MU
VIST	03.03	Home Visit (0800 - 1700)	
		LO=HOME, PT=FTPT (RF=REFD)	22.83
		LO=HOME, PT=FTPT, RO=DETE (RF=REFD)	22.83+MU
VIST	03.03	Home Visit (1701 - 2000)	
		LO=HOME, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD)	30.32
		LO=HOME, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD)	30.32+MU
VIST	03.03	Home Visit (2001 - 2359)	
		LO=HOME, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD)	30.32
		LO=HOME, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD)	30.32+MU

VIST	03.03	Home Visit (0000 - 0800)	
		LO=HOME, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)	41.04
		LO=HOME, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)	41.04+MU
VIST	03.03	Home Visit (0801 - 1200) Sat., Sun., Holidays	
		LO=HOME, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)	30.32
		LO=HOME, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)	30.32+MU
VIST	03.03	Home Visit (1201 - 1700) Sat., Sun., Holidays	
		LO=HOME, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)	30.32
		LO=HOME, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD)	30.32+MU
VIST	03.03	Home Visit - Extra Patient	
		LO=HOME, PT=EXPT (RF=REFD)	11.25
VIST	03.03	Home Emergency Visit	
		LO=HOME, US=UIOH (RF=REFD)	37.72
		LO=HOME, US=UIOH, RO=DETE (RF=REFD)	37.72+MU
VIST	03.03	Continuing Care	
		LO=HOME, RO=CNTC, RF=REFD	14.47
		LO=HOME, RO=CCDT, RF=REFD	14.47+MU
VIST	03.03	Directive Care	
		LO=HOME, RO=DIRC, RF=REFD	14.47
		LO=HOME, RO=DRDT, RF=REFD	14.47+MU

HOME CARE

VIST	03.04	Transfer to Home Care from Inpatient	
		LO=HMHC, OL=INPT (RF=REFD)	30.64
		LO=HMHC, OL=INPT, RO=DETE (RF=REFD)	30.64+MU

CORRECTIONAL CENTRE

VIST	03.03	Office Visit	
		LO=CCNT, RP=SUBS (RF=REFD)	13.91
VIST	03.03	Urgent Care - Request by Patient (1701 - 2000)	
		LO=CCNT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD)	30.32
VIST	03.03	Urgent Care - Request by Patient (2001 - 2359)	
		LO=CCNT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD)	30.32
VIST	03.03	Urgent Care - Request by Patient (0000 - 0800)	
		LO=CCNT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)	41.04
VIST	03.03	Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays	
		LO=CCNT, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD)	30.32

VIST 03.03 Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays
LO=CCNT, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD)..... 30.32

VIST 03.03 Urgent Care - Extra Patient
LO=CCNT, PT=EXPT (RF=REFD)..... 11.25

VIST 03.03 Correctional Centre - Emergency Visit
LO=CCNT, US=UIOH (RF=REFD)..... 37.72
LO=CCNT, US=UIOH, RO=DETE (RF=REFD)..... 37.72+MU

OTHER

VIST 03.03 Unspecified Emergency Visit
LO=OTHR, US=UIOH (RF=REFD) 37.72
LO=OTHR, US=UIOH, RO=DETE (RF=REFD) ..... 37.72+MU

VIST 03.03 Unspecified Location (0800 - 1700)
LO=OTHR, PT=FTPT (RF=REFD) 22.83
LO=OTHR, PT=FTPT, RO=DETE (RF=REFD) ..... 22.83+MU

VIST 03.03 Unspecified Location (1701 - 2000)
LO=OTHR, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) 30.32
LO=OTHR, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 30.32+MU

VIST 03.03 Unspecified Location (2001 - 2359)
LO=OTHR, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) 30.32
LO=OTHR, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 30.32+MU

VIST 03.03 Unspecified Location (0000 - 0800)
LO=OTHR, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) 41.04
LO=OTHR, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) ..... 41.04+MU

VIST 03.03 Unspecified Location (0801 - 1200) Sat., Sun., Holidays
LO=OTHR, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)..... 30.32
LO=OTHR, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)..... 30.32+MU

VIST 03.03 Unspecified Location (1201 - 1700) Sat., Sun., Holidays
LO=OTHR, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD) 30.32
LO=OTHR, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD) ..... 30.32+MU

VIST 03.03 Unspecified Location - Extra Patient
LO=OTHR, PT=EXPT (RF=REFD) 11.25

PROCEDURES

PSYCHIATRIC MENTAL STATUS DETERMINATION

PSYC 08.11A Psychiatric assessment of accused person requested by the court
(it is necessary to indicate the judge's name involved in the case)..... 43.94

OTHER PSYCHIATRIC EVALUATION AND INTERVIEW

PSYC	08.19A	Child psychiatric assessment (25.29 units per 15 min. thereafter)	50.57 per 30 min.	
PSYC	08.19B	Therapeutic/diagnostic interview - relating to a child with parents and/or caregivers, allied health professionals, education, correction and other community resources (22.37 units per 15 min. thereafter)	44.73 per 30 min.	

OTHER ELECTROSHOCK THERAPY (EST)

MISG	08.38A	Electroconvulsive therapy	42.97	4+T

HYPNOTHERAPY

PSYC	08.41	Hypnotherapy* (17.90 units per 15 min. thereafter) *Physician Restrictions in Place (See Appendix J)	35.8 per 30 min.	

GROUP THERAPY

PSYC	08.44	Group therapy Group psychotherapy per patient 4-8 members (6.04 units per 15 min. thereafter)	12.07 per 30 min.	
PSYC	08.44A	Mindfulness-Based Cognitive Therapy (MBCT)* (min 8 – max 12 patients) Group therapy fee per patient per two-hour session *Physician Restrictions in Place (See Appendix J)	14.3	

FAMILY THERAPY

PSYC	08.45	Family therapy (2 or more members) (18.81 units per 15 min. thereafter)	37.62 per 30 min.	

UNSPECIFIED PSYCHIATRIC THERAPEUTIC PROCEDURES

PSYC	08.49B	Psychotherapy (22.38 units per 15 min. thereafter)	44.76 per 30 min.	

ROUTINE PSYCHIATRIC VISIT NEC

PSYC	08.5B	Psychiatric care (21.78 units per 15 min. thereafter)	43.56 per 30 min.	

RADIOLOGY

(Includes SP=DIRD, NCMD, RADI, RDON)

CATEGORY	HEALTH SERVICE CODE	DESCRIPTION / MODIFIERS	BASE UNITS	ANAES UNITS

CONSULTATIONS

CONS	03.08	Comprehensive Consultation (Major Malignancy)	
		SP=RDON, RF=REFD (ME=TELE)	34
		SP=RDON, RF=REFD, US=PREM (ME=TELE)	52
		SP=RDON, RF=REFD, US=PR50 (ME=TELE)	52
		SP=RDON, RO=DETE, RF=REFD (ME=TELE)	34+MU
		SP=RDON, RO=DETE, RF=REFD, US=PREM (ME=TELE)	52+MU
		SP=RDON, RO=DETE, RF=REFD, US=PR50 (ME=TELE)	52+ MU
CONS	03.07	Limited Consultation (Minor Malignancy)	
		SP=RDON, RF=REFD (ME=TELE)	23.5
		SP=RDON, RF=REFD, US=PREM (ME=TELE)	41.5
		SP=RDON, RF=REFD, US=PR50 (ME=TELE)	41.5
		SP=RDON, RO=DETE, RF=REFD (ME=TELE)	23.5+MU
		SP=RDON, RO=DETE, RF=REFD, US=PR50 (ME=TELE)	41.5+MU
		SP=RDON, RO=DETE, RF=REFD, US=PREM (ME=TELE)	41.5+MU
CONS	03.07	Repeat Consultation	
		SP=RDON, RP=REPT, RF=REFD (ME=TELE)	23
		SP=RDON, RP=REPT, RF=REFD, US=PREM (ME=TELE)	41
		SP=RDON, RF=REPT, RO=REFD, US=PR50 (ME=TELE)	41
		SP=RDON, RP=REPT, RO=DETE, RF=REFD (ME=TELE)	23+MU
		SP=RDON, RP=REPT, RO=DETE, RF=REFD, US=PREM (ME=TELE)	41+MU
		SP=RDON, RP=REPT, RO=DETE, RF=REFD, US=PR50 (ME=TELE)	41+MU
CONS	03.08	Therapeutic Radiology Comprehensive Consultation	
		SP=DIRD/NCMD/RADI, RF=REFD (ME=TELE)	30
		SP=DIRD/NCMD/RADI, RF=REFD, US=PREM (ME=TELE)	48
		SP=DIRD/NCMD/RADI, RF=REFD, US=PR50 (ME=TELE)	48
		SP=DIRD/NCMD/RADI, RO=DETE, RF=REFD (ME=TELE)	30+MU
		SP=DIRD/NCMD/RADI, RO=DETE, RF=REFD, US=PREM (ME=TELE)	48+MU
		SP=DIRD/NCMD/RADI, RO=DETE, RF=REFD, US-PR50 (ME=TELE)	48+MU
CONS	03.09B	Second Opinion Consultation review of an outside institution non-plain film imaging study including but not limited to CT, Ultrasound, MRI, Nuclear medicine or angiographic studies at the request of a specialist	30+MU

OFFICE

VIST	03.03	Treatment Planning, Dosage Calculation and Preparation LO=OFFC, SP=RDON, RO=TRPL (RF=REFD) 20	
VIST	03.03	Office Visit LO=OFFC, RP=SUBS (ME=VTCR*) (RF=REFD) ..... 13 *Physician Restrictions in Place (See Appendix J)	
VIST	03.03	Urgent Care - Request by Patient (1701 - 2000) LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) 28.3	
VIST	03.03	Urgent Care - Request by Patient (2001 – 2359) LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) 28.3	
VIST	03.03	Urgent Care - Request by Patient (0000 - 0800) LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) 38.3	
VIST	03.03	Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) 28.3	
VIST	03.03	Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) 28.3	
VIST	03.03	Urgent Care - Extra Patient LO=OFFC, PT=EXPT (RF=REFD) 10.5	

CANCER PATIENT

VIST	03.04	Comprehensive reassessment of a cancer patient RO=CAPT, RP=SUBS 25	
VIST	03.03	Telephone advice and medical chart review of a cancer patient by the Oncologist RO=TCCP 11.5	

PROCEDURES

DIGITAL BREAST TOMOSYNTHESIS

ADON	02.25C	Unilateral Diagnostic Digital Breast Tomosynthesis (regions required) (not to be used for screening) 5	
ADON	02.25D	Bilateral Diagnostic Digital Breast Tomosynthesis (regions required) (not to be used for screening) 10	

OTHER X-RAY NEC

VEDT	02.79B	PET / CT scan and interpretation, one body region 87	4+T
VEDT	02.79C	PET / CT scan and interpretation, multiple body regions (Including whole body scan) 125	4+T
ADON	02.89C	Ultrasound performed by radiologist during premium time 30	

IMPLANTATION OR INSERTION OF RADIOACTIVE ELEMENTS

MASG	06.34A	Gold seed implants	90
MASG	06.34B	Caesium needle implants	90

INJECTION OR INSTILLATION OF RADIOISOTOPES

MISG	06.35A	Strontium 90 treatment	15
VADT	06.35B	Thyroid malignancy	20
VADT	06.35C	Hyperthyroidism	20
VADT	06.35D	Polycythemia	10
VADT	06.35E	Metastatic disease of bone	20
VADT	06.35F	Arthritis single or multiple site	8

OTHER RADIOTHERAPEUTIC PROCEDURE

VADT	06.39D	Percutaneous image guided radiofrequency ablation of solid tumour - plus multiples, to a maximum of 3, if applicable	250	4+T
VEDT	50.0B	Endovascular Thrombectomy-Intracranial	300	

INTERPRETATIONS

These codes must be claimed from LO=HOSP.
Exceptions are the following Mammography interpretations: R484, R485, R486

CODE	GROUP	DESCRIPTION	UNIT VALUE
R1	Other	Interpretation of submitted films	6.25
		US=PREM, US=PR50	15.25
R2	Other	Fluoroscopy in O.R	3.13
R3	Other	Conventional tomography	9.38
R5	H&N	Skull – routine views	4.40
		US=PREM, US=PR50	13.40
R6	H&N	Temporomandibular joints	4.34
R7	H&N	Internal auditory meati	4.34
R8	H&N	Sella turcica	4.34
R9	H&N	Optic foramina	4.34
R11	H&N	Mastoids – added view	4.34

R12	H&N	Eye for foreign body	4.34
		RG=BOTH	8.68
		US=PREM, US=PR50	13.34
		RG=BOTH, US=PREM, US=PR50	26.68
R15	H&N	Facial bones	4.40
		US=PREM, US=PR50	13.40
R20	H&N	Mandible	3.31
		US=PREM, US=PR50	12.31
R25	H&N	Nasal bones	3.31
R30	H&N	Sinuses – paranasal	3.88
		US=PREM, US=PR50	12.88
R35	H&N	Salivary gland region	3.31
R45	H&N	Panorex (teeth – full set)	4.97
R50	H&N	Arthrogram	20.76
		RG=BOTH	41.52
R55	H&N	Dacrocystogram	5.53
		RG=BOTH	11.06
R60	H&N	Sialogram	9.38 +MU
		RG=BOTH	18.76 +MU
R70	H&N	Speech study	44.24
R105	Bone	Cervical spine	5.19
		US=PREM, US=PR50	14.19
R110	Bone	Thoracic spine	3.31
		US=PREM, US=PR50	12.31
R115	Bone	Lumbar spine	5.19
		US=PREM, US=PR50	14.19
R120	Bone	Sacrum / coccyx	3.31
		US=PREM, US=PR50	12.31
R125	Bone	Scoliosis series	8.85
R126	Bone	Scoliosis with stress	11.07
R129	Bone	Metastatic series (5)	9.12
R130	Bone	Metabolic bone survey	9.12

R131	Bone	All long bones added to R129	2.28
R140	Mylo	Discogram	11.07
R150	Mylo	Lumbar myelogram	18.75
		US=PREM	27.75
		US=PR50	28.13
R151	Mylo	Complete myelogram	28.14
		US=PREM	37.99
		US=PR50	42.21
R152	Mylo	Cervical injection myelogram	18.75
R185	Other	Fetal study	3.31
R205	Bone	Shoulder	3.41
		RG=BOTH	6.82
		US=PREM, US=PR50	12.41
		RG=BOTH, US=PREM, US=PR50	24.82
R210	Bone	Scapula	3.41
		RG=BOTH	6.82
R215	Bone	A.C joints with and without weights	3.41
		RG=BOTH	6.82
R220	Bone	Clavicle	3.41
		RG=BOTH	6.82
R221	Bone	Bone age determination	4.53
R223	Bone	Scaphoid	3.41
		RG=BOTH	6.82
		US=PREM, US=PR50	12.41
		RG=BOTH, US=PREM, US=PR50	24.82
R224	Bone	Humerus	3.41
		RG=BOTH	6.82
		US=PREM, US=PR50	12.41
		RG=BOTH, US=PREM, US=PR50	24.82
R225	Bone	Elbow	3.41
		RG=BOTH	6.82
		US=PREM, US=PR50	12.41
		RG=BOTH, US=PREM, US=PR50	24.82
R226	Bone	Wrist	3.41
		RG=BOTH	6.82
		US=PREM, US=PR50	12.41
		RG=BOTH, US=PREM, US=PR50	24.82

R227	Bone	Forearm	3.41
		RG=BOTH	6.82
		US=PREM, US=PR50	12.41
		RG=BOTH, US=PREM, US=PR50	24.82
R228	Bone	Hand	3.41
		RG=BOTH	6.82
		US=PREM, US=PR50	12.41
		RG=BOTH, US=PREM, US=PR50	24.82
R229	Bone	Finger	1.71 +MU
		RG=BOTH	3.42 +MU
R230	Bone	Arthrogram shoulder	20.76
		RG=BOTH	41.52
R305	Bone	Hip	3.41
		RG=BOTH	6.82
		US=PREM, US=PR50	12.41
		RG=BOTH, US=PREM, US=PR50	24.82
R310	Bone	Pelvis	3.41
		US=PREM, US=PR50	12.41
R315	Bone	Pelvis and hips	3.99
R320	Bone	Sacroiliac joints	3.31
R321	Bone	Patella	3.41
		RG=BOTH	6.82
		US=PREM, US=PR50	12.41
		RG=BOTH, US=PREM, US=PR50	24.82
R322	Bone	Foot	3.41
		RG=BOTH	6.82
		US=PREM, US=PR50	12.41
		RG=BOTH, US=PREM, US=PR50	24.82
R323	Bone	Ankle	3.41
		RG=BOTH	6.82
		US=PREM, US=PR50	12.41
		RG=BOTH, US=PREM, US=PR50	24.82
R324	Bone	Knee	3.41
		RG=BOTH	6.82
		US=PREM, US=PR50	12.41
		RG=BOTH, US=PREM, US=PR50	24.82
R325	Bone	Calcaneus	3.41
		RG=BOTH	6.82
		US=PREM, US=PR50	12.41
		RG=BOTH, US=PREM, US=PR50	24.82

R326	Bone	Tibia and fibula	3.41
		RG=BOTH	6.82
		US=PREM, US=PR50	12.41
		RG=BOTH, US=PREM, US=PR50	24.82
R327	Bone	Toe	1.71 +MU
		RG=BOTH	3.42 +MU
R328	Bone	Feet – weight bearing	6.64
		RG=BOTH	13.28
R335	Bone	Femur	3.41
		RG=BOTH	6.82
		US=PREM, US=PR50	12.41
		RG=BOTH, US=PREM, US=PR50	24.82
R340	Bone	Orthoroentgenogram (leg length measurement)	2.58
R350	Bone	Arthrogram hip	20.76
		RG=BOTH	41.52
R351	Bone	Arthrogram knee	20.76
		RG=BOTH	41.52
R403	Other	Fluoroscopy 10 minutes	12.50
		US-PREM, US=PR50	21.50
R404	Chest	Single view	3.13
		US=PREM, US=PR50	12.13
R405	Chest	Multiple views	5.13
		US=PREM, US=PR50	14.13
R425	Chest	Ribs, each side	2.90
		RG=BOTH	5.80
		US=PREM, US=PR50	11.90
		RG=BOTH, US=PREM, US=PR50	23.80
R435	Chest	Sternum	3.31
		US=PREM, US=PR50	12.31
R439	Bone	Dual photon densitometry	11.73
R440	Bone	Sternoclavicular joints	3.41
R445	H&N	Neck – for soft tissue	3.31
		US=PREM, US=PR50	12.31

R470	Chest	Bronchogram unilateral	11.07
R484	Mammo	Mammography screening bilateral	5.09
R485	Mammo	Mammography unilateral	7.19
R486	Mammo	Breast cystography	6.63
		RG=BOTH	13.26
R490	Mammo	Mammography diagnostic bilateral	14.07
R495	Mammo	Needle localization	34.39
		RG=BOTH	68.78
R500	Mammo	Galactography	6.63
		RG=BOTH	13.26
R505	Mammo	Stereotactic localization	19.29
		RG=BOTH	38.58
R510	Mammo	Surgical specimen radiography	3.82
		RG=BOTH	7.64
R605	Abdomen	Survey Film	3.13
		US=PREM, US=PR50	12.13
R610	Abdomen	Multiple films	3.88
		US=PREM, US=PR50	12.88
R620	G.I.	Esophagus	14.62
R625	G.I.	Upper G.I. series	18.69
		US=PREM	27.69
		US=PR50	28.04
R630	G.I.	Upper G.I. paediatric	28.05
R635	G.I.	Small bowel study	9.67
R640	G.I.	Enteroclysis	26.57
R650	G.I.	Colon – barium only	14.91
		US=PREM, US=PR50	23.91
R655	G.I.	Colon paediatric –single	22.37
		US=PREM	31.37
		US=PR50	33.56
R660	G.I.	Colon – double contrast	19.92
R666	G.I.	Defaecography	26.57

R670	G.I.	Cholecystogram	4.97
R690	G.I.	T-tube cholangiogram	6.63
R691	G.I.	Operative cholangiogram	4.66
R695	G.I.	ERCP	6.63
R709	G.I.	Herniography	9.38
R710	G.I.	Fistula/sinus with contrast	4.40
		US=PREM, US=PR50	13.40
R745	G.I.	Percutaneous transhepatic cholangiogram	6.63
		US=PREM, US=PR50	15.63
R815	G.I.	Intravenous urogram (IVP)	14.53
		US=PREM, US=PR50	23.53
R823	G.U.	Retrograde pyelogram	4.53
R830	G.U.	Voiding cystourethrogram	11.07
R835	G.U.	Cystogram paediatric	18.75
R840	G.U.	Loopogram	4.40
R845	G.U.	Retrograde urethrogram	4.53
		US=PREM, US=PR50	13.53
R846	G.U.	Cavernosogram	4.40
R850	G.U.	Antegrade (t-tube) pyelogram	4.53
		RG=BOTH	9.06
		US=PREM, US=PR50	13.53
		RG=BOTH, US=PREM, US=PR50	27.06
R865	G.U.	Renal cystogram	6.63
		RG=BOTH	13.26
R885	G.U.	Vasogram	4.40
		RG=BOTH	8.80
R895	G.U.	Hysterosalpingogram	5.53
R910	G.U.	Pelvimetry	6.63
R1001	Vascular	Venous DSA – abnormal or renal	35.52
		US=PREM	47.95
		US=PR50	53.28

R1002	Vascular	Venous DSA – aortic arch	39.58
		US=PREM	53.43
		US=PR50	59.37
R1003	Vascular	Pulmonary angiogram bilateral	93.79
		US=PREM	126.62
		US=PR50	140.69
R1004	Vascular	Pulmonary angiogram unilateral	62.53
R1006	Vascular	Unilateral peripheral arteriogram	22.14
		US=PREM	31.14
		US=PR50	33.21
R1007	Vascular	Bilateral peripheral arteriogram	33.21
		US=PREM	44.83
		US=PR50	49.82
R1008	Vascular	Aortography (abdominal)	44.21
		US=PREM	59.68
		US=PR50	66.32
R1009	Vascular	Visceral selective arteriogram	44.21
		US=PREM	59.68
		US=PR50	66.32
R1010	Vascular	Venogram extremity	25.01
		RG=BOTH	50.02
		US=PREM	34.01
		US=PR50	37.52
		RG=BOTH, US=PREM	68.02
		RG=BOTH, US=PR50	75.04
R1011	Vascular	Venocavogram selective	22.14
R1012	Vascular	Visceral venogram	22.14
R1013	Vascular	Spinal artery selective	22.14
		US=PREM	31.14
		US=PR50	33.21
R1014	Vascular	Bronchial artery selective	44.21
R1015	Vascular	Lymphangiogram	44.21
R1016	Vascular	Arch aortogram	44.21
		US=PREM	59.68
		US=PR50	66.32
R1017	Vascular	Spleenoportogram	53.90

R1018	Vascular	Intraoperative angiogram	43.77
R1021	Vascular	Common carotid bilateral	55.83
		US=PREM	75.37
		US=PR50	83.75
R1022	Vascular	Internal carotid bilateral	55.83
		US=PREM	75.37
		US=PR50	83.75
R1023	Vascular	External carotid bilateral	55.83
		US=PREM	75.37
		US=PR50	83.75
R1024	Vascular	Vertebral bilateral	55.83
		US=PREM	75.37
		US=PR50	83.75
R1026	Vascular	Common carotid unilateral	30.45
		US=PREM	41.11
		US=PR50	45.68
R1027	Vascular	Internal carotid unilateral	30.45
		US=PREM	41.11
		US=PR50	45.68
R1028	Vascular	External carotid unilateral	30.45
		US=PREM	41.11
		US=PR50	45.68
R1029	Vascular	Vertebral unilateral	30.45
		US=PREM	41.11
		US=PR50	45.68
R1056	Cardiac	Coronary arteries	50.75
		US=PREM	68.51
		US=PR50	76.13
R1057	Cardiac	Coronary arteries with ergot	25.38
R1058	Cardiac	Coronary artery grafts	50.75
		US=PREM	68.51
		US=PR50	76.13
R1059	Cardiac	P.T.C.A	50.75
		US=PREM	68.51
		US=PR50	76.13
R1061	Cardiac	Right ventriculogram	25.38
		US=PREM	34.38
		US=PR50	38.07

R1062	Cardiac	Left venticulogram	25.38
		US=PREM	34.38
		US=PR50	38.07
R1063	Cardiac	Cardiac panning <45 min.	60.90
R1064	Cardiac	Cardiac panning >45 min.	121.81
R1071	Cardiac	Aortic root (cardiac)	25.38
		US=PREM	34.38
		US=PR50	38.07
R1105	C.T.	CT head without contrast	42.33
		US=PREM	57.15
		US=PR50	63.50
R1111	C.T.	CT head with contrast	42.33
		US=PREM	57.15
		US=PR50	63.50
R1115	C.T.	CT head with and without contrast	53.27
		US=PREM	71.91
		US=PR50	79.91
R1121	C.T.	CT neck without contrast	42.33
R1125	C.T.	CT neck with contrast	42.33
		US=PREM	57.15
		US=PR50	63.50
R1130	C.T.	CT neck with and without contrast	53.27
R1135	C.T.	CT thorax without contrast	42.33
		US=PREM	57.15
		US=PR50	63.50
R1141	C.T.	CT thorax with contrast	42.33
		US=PREM	57.15
		US=PR50	63.50
R1145	C.T.	CT thorax with and without contrast	53.27
		US=PREM	71.91
		US=PR50	79.91
R1150	C.T.	CT abdomen without contrast	42.33
		US=PREM	57.15
		US=PR50	63.50
R1155	C.T.	CT abdomen with contrast	42.33
		US=PREM	57.15
		US=PR50	63.50

R1160	C.T.	CT abdomen with and without contrast	53.27
		US=PREM	71.91
		US=PR50	79.91
R1162	C.T.	CT extremities without contrast	42.33
		RG=BOTH	84.66
		US=PREM	57.15
		US=PR50	63.50
		RG=BOTH, US=PREM	114.30
		RG=BOTH, US=PR50	127
R1163	C.T.	CT extremities with contrast	42.33
		RG=BOTH	84.66
R1164	C.T.	CT extremities with and without contrast	53.27
		RG=BOTH	106.54
R1165	C.T.	CT pelvis without contrast	42.33
		US=PREM	57.15
		US=PR50	63.50
R1166	C.T.	CT pelvis with contrast	42.33
		US=PREM	57.15
		US=PR50	63.50
R1167	C.T.	CT pelvis with and without contrast	53.27
		US=PREM	71.91
		US=PR50	79.91
R1169	C.T.	CT spine without contrast	42.33 +MU
		US=PREM	57.15 +MU
		US=PR50	63.50 +MU
R1170	C.T.	CT spine with contrast	42.33 +MU
R1172	C.T.	CT spine with and without contrast	53.27 +MU
R1173	C.T.	Densitometry CT	9.07
R1180	C.T.	3D reconstruction	12.16
		US=PREM, US=PR50	21.16
R1186	C.T.	CT head special without contrast	42.33 +MU
		US=PREM	57.15 +MU
		US=PR50	63.50 +MU
R1187	C.T.	CT head special with contrast	42.33 +MU
		US=PREM	57.15 +MU
		US=PR50	63.50 +MU

R1188	C.T.	CT head special with and without contrast	53.27 +MU
		US=PREM	71.91 +MU
		US=PR50	79.91 +MU
R1205	Ultrasound	Abdomen General	25.39
		US=PREM	34.39
		US=PR50	38.09
R1206	Ultrasound	Spine	25.39
R1211	Ultrasound	Aorta	12.50
		US=PREM, US=PR50	21.50
R1212	Ultrasound	Appendix	18.75
		US=PREM	27.75
		US=PR50	28.13
R1213	Ultrasound	Kidneys	18.75
		US=PREM	27.75
		US=PR50	28.13
R1214	Ultrasound	Pylorus	18.75
		US=PREM	27.75
		US=PR50	28.13
R1220	Ultrasound	Pelvis	18.75
		US=PREM	27.75
		US=PR50	28.13
R1225	Ultrasound	Endovaginal	26.95
		US=PREM	36.38
		US=PR50	40.43
R1226	Ultrasound	Endovaginal with pelvic	38.70
		US=PREM	52.25
		US=PR50	58.05
R1231	Ultrasound	Endorectal	25.39
R1245	Ultrasound	Obstetrical	27.51
		US=PREM	37.14
		US=PR50	41.27
R1246	Ultrasound	Obstetrical, recheck	12.50
		US=PREM, US=PR50	21.50
R1250	Ultrasound	Biophysical profile	4.84 +MU
		US=PREM, US=PR50	13.84 +MU
R1255	Ultrasound	Obs. Multiple (add on)	20.04 +MU
		US=PREM	29.04 +MU
		US=PR50	30.06 +MU

R1256	Ultrasound	Obs. Multiple – recheck (add on)	6.25 +MU
R1264	Ultrasound	Cerebral	33.49
		US=PREM	45.21
		US=PR50	50.24
R1265	Ultrasound	Thyroid/parathyroid (neck)	18.75
R1275	Ultrasound	Scrotum	25.45
		US=PREM	34.45
		US=PR50	38.18
R1280	Ultrasound	Shoulder	18.75
		RG=BOTH	37.50
R1285	Ultrasound	Hip	18.75
		RG=BOTH	37.50
		US=PREM	27.75
		US=PR50	28.13
		RG=BOTH, US=PREM	55.50
		RG=BOTH, US=PR50	28.13
R1295	Ultrasound	Breast, single	12.50
		RG=BOTH	25
R1296	Ultrasound	Chest	18.75
R1297	Ultrasound	Popliteal fossa	12.50
		RG=BOTH	25
R1298	Ultrasound	Subcutaneous mass	12.50
		US=PREM, US=PR50	21.50
R1306	Ultrasound	Intraoperative U/S	47.56
R1307	Ultrasound	Portable – M.D. in attendance	18.75
		US=PREM	27.75
		US=PR50	28.13
R1309	Ultrasound	Fetal echo	78.16 +MU
R1310	Ultrasound	Two dimensional cardiac	47.56
R1311	Ultrasound	M-Mode cardiac	25.44
R1312	Ultrasound	Doppler – quantitative, cardiac	30.45
R1313	Ultrasound	Doppler – qualitative, cardiac	15.23

R1335	Ultrasound	Doppler abdominal blood vessels	33.49
		US=PREM	45.21
		US=PR50	50.24
R1340	Ultrasound	Carotid doppler	33.49
R1345	Ultrasound	Doppler – extremities	18.75 +MU
		RG=BOTH	37.50 +MU
		US=PREM	57.75 +MU
		US=PR50	28.13 +MU
		RG=BOTH, US=PREM	55.50 +MU
		RG=BOTH, US=PR50	56.26 +MU
R1405	M.R.I.	Cranial multisection SE	40.97
		US=PREM	55.31
		US=PR50	61.46
R1406	M.R.I.	Cranial multisection IR	25.76
R1407	M.R.I.	Cranial repeat, sequence	19.91 +MU
		US=PREM	28.91 +MU
		US=PR50	29.87 +MU
R1409	M.R.I.	Ent multisection SE	40.97
		US=PREM	55.31
		US=PR50	61.46
R1411	M.R.I.	Ent multisection IR	25.76
R1412	M.R.I.	Ent repeat, sequence	19.91 +MU
		US=PREM	28.91 +MU
		US=PR50	29.87 +MU
R1415	M.R.I.	Thorax multisection SE	46.83
		US=PREM	63.22
		US=PR50	70.25
R1416	M.R.I.	Thorax multisection IR	40.97
		US=PREM	55.31
		US=PR50	61.46
R1417	M.R.I.	Thorax repeat, sequence	23.42 +MU
		US=PREM	32.42 +MU
		US=PR50	35.13 +MU
R1420	M.R.I.	Abdomen multisection SE	46.83
		US=PREM	63.22
		US=PR50	70.25
R1421	M.R.I.	Abdomen multisection IR	40.97
		US=PREM	55.31
		US=PR50	61.46

R1422	M.R.I.	Abdomen repeat, sequence	23.42 +MU
		US=PREM	32.42 +MU
		US=PR50	35.13 +MU
R1425	M.R.I.	Pelvis multisection SE	46.83
		US=PREM	63.22
		US=PR50	70.25
R1426	M.R.I.	Pelvis multisection IR	40.97
		US=PREM	55.31
		US=PR50	61.46
R1427	M.R.I.	Pelvis repeat sequence	23.42 +MU
		US=PREM	32.42 +MU
		US=PR50	35.13 +MU
R1430	M.R.I.	Extremities multisection SE	40.97 +MU
		RG=BOTH	81.94 +MU
		US=PREM	55.31 +MU
		US=PR50	61.46 +MU
		RG=BOTH, US=PREM	110.62 +MU
		RG=BOTH, US=PR50	122.92 +MU
R1431	M.R.I.	Extremities multisection IR	25.76 +MU
		RG=BOTH	51.52 +MU
R1432	M.R.I.	Extremities repeat, sequence	19.91 +MU
		RG=BOTH	39.82 +MU
		US=PREM	28.91 +MU
		US=PR50	29.87 +MU
		RG=BOTH, US=PREM	57.82 +MU
		RG=BOTH, US=PR50	59.74 +MU
R1440	M.R.I.	Spine (one seq.) multisection SE	37.47
		US=PREM	50.58
		US=PR50	56.21
R1441	M.R.I.	Spine (one seq.) multisection IR	24.58
R1442	M.R.I.	Spine (one seq.) repeat, sequence	18.73 +MU
		US=PREM	27.73 +MU
		US=PR50	28.10 +MU
R1445	M.R.I.	Spine (two adjoining) multisection SE	44.50
		US=PREM	60.08
		US=PR50	66.75
R1446	M.R.I.	Spine (two adjoining) multisection IR	37.47
R1447	M.R.I.	Spine (two adjoining) repeat sequence	22.25 +MU
		US=PREM	31.25 +MU
		US=PR50	33.38 +MU

R1450	M.R.I.	Spine (two not add.) multisection SE	66.74
R1451	M.R.I.	Spine (two not add.) multisection IR	37.47
R1452	M.R.I.	Spine (two not add.) repeat sequence	32.78 +MU
R1453	M.R.I.	Add 30 percent for gating	7.03 +MU
		US=PREM, US=PR50	16.03 +MU
R1776	Nuc. Med.	Labelled WBC	41.04
		US=PREM	55.40
		US=PR50	61.56
R1777	Nuc. Med.	Gallium (one area)	28.14
R1778	Nuc. Med.	Gallium (multiple areas)	35.08
R1790	Nuc. Med.	Vascular study (flow) add on	11.73
		US=PREM, US=PR50	20.73
R1810	Nuc. Med.	Brain scan	11.73
		US=PREM, US=PR50	20.73
R1811	Nuc. Med.	Brain perfusion	46.89
		US=PREM	63.30
		US=PR50	70.34
R1812	Nuc. Med.	CSF study (cisternogram)	35.18
R1813	Nuc. Med.	Shunt function study	46.89
R1814	Nuc. Med.	Radionuclide arthrogram	35.18
R1816	Nuc. Med.	Bone scan – one area	23.45
		US=PREM	32.45
		US=PR50	35.18
R1817	Nuc. Med.	Bone scan – multiple areas	28.14
		US=PREM	37.99
		US=PR50	42.21
R1818	Nuc. Med.	Bone marrow – one area	23.45
R1819	Nuc. Med	Marrow scan – multiple areas	28.14
R1820	Nuc. Med.	Bone density	11.73
R1830	Nuc. Med.	Lung ventilation scan	23.45
		US=PREM	32.45
		US=PR50	35.18

R1835	Nuc. Med.	Lung scan perfusion	23.45
		US=PREM	32.45
		US=PR50	35.18
R1840	Nuc. Med.	Liver and spleen	18.75
R1843	Nuc. Med.	Haemangioma (RBC)	28.14
R1845	Nuc. Med.	Spleen scan (RBC)	18.75
R1850	Nuc. Med.	Hepatobiliary	23.45
		US=PREM	32.45
		US=PR50	35.18
R1853	Nuc. Med.	Bile salt study	23.45
R1855	Nuc. Med.	Gastric emptying	23.45
R1860	Nuc. Med	Ectopic gastric mucosa	23.45
R1865	Nuc. Med	G.I. Bleed	46.89
		US=PREM	63.30
		US=PR50	70.34
R1870	Nuc. Med.	G.E. reflux	18.75
R1871	Nuc. Med	Esophageal motility	46.89
R1872	Nuc. Med.	Ciliary motion study	31.27
R1873	Nuc. Med.	Peritoneal/venous shunt	23.45
R1875	Nuc. Med.	Renal static imaging	11.73
		US=PREM, US=PR50	20.73
R1880	Nuc. Med.	Renal scan and renogram	35.18
		US=PREM	47.49
		US=PR50	52.77
R1881	Nuc. Med.	A.C.E. renal scan	46.89
R1885	Nuc. Med.	Diuretic stimulation (add on)	11.73
R1890	Nuc. Med.	Testicular scan	23.56
		US=PREM	32.45
		US=PR50	35.18
R1899	Nuc. Med	Residual urine (add on)	11.73

R1904	Nuc. Med.	Myocardial rest	23.45
		US=PREM	32.45
		US=PR50	35.18
R1905	Nuc. Med.	Myocardial stress and rest	37.52
		US=PREM	50.65
		US=PR50	56.28
R1906	Nuc. Med.	Myocardial rest quantitative (add on)	7.04
		US=PREM, US=PR50	16.04
R1907	Nuc. Med.	Myocardial stress and rest quantitative (add on)	11.73
		US=PREM, US=PR50	20.73
R1910	Nuc. Med.	MUGA with quantitative	23.45
R1911	Nuc. Med.	Exercise MUGA	58.62
R1912	Nuc. Med.	Myocardial infarction	23.45
		US=PREM	32.45
		US=PR50	35.18
R1913	Nuc. Med.	Cardiac first pass	28.14
R1914	Nuc. Med.	Cardiac shunt	23.45
R1915	Nuc. Med.	Venoscintigram	23.45
R1920	Nuc. Med.	Thyroid uptake	18.75
R1921	Nuc. Med.	Thyroid scan	18.75
R1922	Nuc. Med.	Thyroid uptake special	23.45
R1925	Nuc. Med.	Adrenal scan	70.34
R1930	Nuc. Med.	Parathyroid scan	35.18
R1935	Nuc. Med.	Tumour imaging	28.14
R1940	Nuc. Med.	Salivary gland scintigraphy	23.45
R1945	Nuc. Med.	Dacroscintigraphy	30.48
R1946	Nuc. Med.	Lymphoscintigram	23.45
R1947	Nuc. Med.	Isolated limb perfusion	11.73
		RG=BOTH	23.46
R1950	Nuc. Med.	Tomography (add on)	12.50 +MU

R1951	Nuc. Med.	Hepatobiliary with pharmacologic stimulation	35.18
R1955	Nuc. Med.	Hyperthyroidism (therapy)	42.21
R1960	Nuc. Med.	Carcinoma of thyroid (therapy)	58.62
R1961	Nuc. Med.	Metastatic carcinoma (therapy)	42.21
R1962	Nuc. Med.	Ascites or pleural effusion (therapy)	42.21
R1963	Nuc. Med.	Synovectomy (therapy) RG=BOTH	42.21 84.42
R1964	Nuc. Med.	Polycythemia (therapy)	42.21
R1970	Nuc. Med.	Red cell volume	11.73
R1971	Nuc. Med.	Plasma volume	11.73
R1972	Nuc. Med.	Red cell survival	23.45
R1973	Nuc. Med.	Sequestration study	46.89
R1974	Nuc. Med.	Ferrokinetics	23.45
R1976	Nuc. Med.	Stool for blood loss	11.73
R1977	Nuc. Med.	I-131 Gastrointestinal protein loss study	11.73
R1978	Nuc. Med.	C-14 Breath test	11.73
R1979	Nuc. Med.	Glomerular filtration rate (with blood samples) US=PREM, US=PR50	11.73 20.73
R1981	Nuc. Med.	Schilling test with or without intrinsic factor	11.73
R1995	Nuc. Med.	Retrograde nuclide cystogram	18.75

SURGERY

(Includes SP=GNSG, CASG, THSG, VASG)

CATEGORY	HEALTH SERVICE CODE	DESCRIPTION / MODIFIERS	BASE UNITS	ANAES UNITS
CONSULTATIONS				
CONS	03.08	Comprehensive Consultation		
		RF=REFD (ME=TELE)	39.4	
		RF=REFD, US=PREM (ME=TELE)	57.4	
		RF=REFD, US=PR50 (ME=TELE)	59.1	
		RF=REFD, RO=DETE (ME=TELE)	39.4+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	57.4+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	59.1+MU	
CONS	03.07	Limited Consultation		
		RF=REFD (ME=TELE)	29.1	
		RF=REFD, US=PREM (ME=TELE)	47.1	
		RF=REFD, US=PR50 (ME=TELE)	47.1	
		RF=REFD, RO=DETE (ME=TELE)	29.1+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	47.1+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	47.1+MU	
CONS	03.07	Repeat Consultation		
		RF=REFD, RP=REPT (ME=TELE)	27	
		RF=REFD, RP=REPT, US=PREM (ME=TELE)	45	
		RF=REFD, RP=REPT, US=PR50 (ME=TELE)	45	
		RF=REFD, RP=REPT, RO=DETE (ME=TELE)	27+MU	
		RF=REFD, RP=REPT, RO=DETE, US=PREM (ME=TELE)	45+MU	
		RF=REFD, RP=REPT, RO=DETE, US=PR50 (ME=TELE)	45+MU	
OFFICE				
VIST	03.04	Initial Visit		
		LO=OFFC (RF=REFD)	24	
VIST	03.03	Initial Visit with Regional Exam		
		LO=OFFC, RP=INTL (RF=REFD)	12	
		LO=OFFC, AG=OV65, RP=INTL (RF=REFD)	16.5	
VIST	03.03	Subsequent Visit		
		LO=OFFC, RP=SUBS (ME=VTCR*) (RF=REFD)	13	
		*Physician Restrictions in Place (See Appendix J)		
VIST	03.03A	Geriatric Office Visit (for patients aged 65+)		
		LO=OFFC (ME=VTCR*) (RF=REFD)	16.5	
		*Physician Restrictions in Place (See Appendix J)		

VIST 03.03 Continuing Care
LO=OFFC, RO=CNTC, RF=REFD 13.5
LO=OFFC, AG=OV65, RO=CNTC, RF=REFD 16.5

VIST 03.03 Directive Care
LO=OFFC, RO=DIRC, RF=REFD 13.5
LO=OFFC, AG=OV65, RO=DIRC, RF=REFD 16.5

VIST 03.03 Urgent Care - Request by Patient (1701 - 2000)
LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Request by Patient (2001 - 2359)
LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Request by Patient (0000 - 0800)
LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) 38.3

VIST 03.03 Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Extra Patient
LO=OFFC, PT=EXPT (RF=REFD) 10.5

HOSPITAL (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

VIST 03.04 Initial Visit with Complete Examination
LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD) 24
LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD) ..... 24+MU

VIST 03.04 Initial Visit
LO=HOSP, FN=INPT, RP=INTL (RF=REFD) 25
LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD) ..... 25+MU

VIST 03.03 Continuing Care
LO=HOSP, FN=INPT, FN=INCU, FN=NICU RO=CNTC, RF=REFD 15
LO=HOSP, FN=INPT, FN=INCU, FN=NICU RO=CCDT, RF=REFD ..... 15+MU

VIST 03.03 Directive Care
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD 15
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD ..... 15+MU

VIST 03.03 Subsequent Visit - Daily to 56 Days
LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) 15
LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU

VIST 03.03 Subsequent Visit - Weekly After 56 Days - Maximum 44 unit per week
LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD) 15
LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU

ADON	03.02A	Hospital Discharge Fee	
		LO=HOSP, FN=INPT	10
VIST	03.03	Urgent Hospital Care	
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)	22
		LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD)	22+MU
VIST	03.03	Emergency Visit	
		LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)	35.2
		LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)	35.2+MU
VIST	03.03	Resuscitation of Newborn	
		LO=HOSP, FN=INPT, RO=RESC (RF=REFD)	50
		LO=HOSP, FN=INPT, RO=RESC, US=PREM (RF=REFD)	68
		LO=HOSP, FN=INPT, RO=RESC, US=PR50 (RF=REFD)	75
		LO=HOSP, FN=INPT, RO=RNDT (RF=REFD)	50+MU
		LO=HOSP, FN=INPT, RO=RNDT, US=PREM (RF=REFD)	68+MU
		LO=HOSP, FN=INPT, RO=RNDT, US=PR50 (RF=REFD)	75+MU
VIST	03.03	Outpatient Visit (0800 - 1700)	
		LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD)	13.5
		LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD)	13.5+MU
VIST	03.03	Outpatient Visit (1701 - 2000)	
		LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD)	20
		LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD)	20+MU
VIST	03.03	Outpatient Visit (2001 - 2359)	
		LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD)	20
		LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD)	20+MU
VIST	03.03	Outpatient Visit (0000 - 0800)	
		LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)	26
		LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)	26+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Sat., Sun., Holidays	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)	20
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)	20+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Sat., Sun., Holidays	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)	20
		LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD)	20+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD)	7
		LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)	7+MU

VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD) 7	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 7+MU	
VIST	03.03	Outpatient Visit (1701 - 2000) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD) 10.5	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD) ..... 10.5+MU	
VIST	03.03	Outpatient Visit (2001 - 2359) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD) 10.5	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD) ..... 10.5+MU	
VIST	03.03	Outpatient Visit (0000 - 0800) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD) 11.4	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD) ..... 11.4+MU	
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD)..... 10.5	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 10.5+MU	
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD) 10.5	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 10.5+MU	

PROCEDURES

OTHER NONOPERATIVE BRONCHOSCOPY

VADT	01.09D	Bronchoscopy and endobronchial ultrasound (EBUS) with sampling of one or two mediastinal nodal stations and or hilar nodal stations or structures.....	125	
VADT	01.09E	Bronchoscopy and endobronchial ultrasound (EBUS) with sampling of three or more nodal stations and or hilar nodal stations or structures.....	150	

OTHER NONOPERATIVE ESOPHAGOSCOPY

MASG	01.12D	Esophagoscopy with insertion of selectron.....	150	4+T

SOFT TISSUE X-RAY OF FACE, HEAD AND NECK

MISG	02.05A	Catheterization for sialogram	10.2	

SINOGRAM OF ABDOMINAL WALL

MISG	02.53	Sinogram of abdominal wall - plus multiples, if applicable	10	

OTHER INTUBATION OF RESPIRATORY TRACT

MASG	10.05B	Insertion of intra-tracheal oxygen catheter.....	150	6+T

INSERTION OF (NASO-) INTESTINAL TUBE

MISG	10.08	Insertion of (naso-) intestinal tube	20.4	4+T

DILATION OF RECTUM

MISG	10.22	Dilation of rectum		
		AN=GENL	20	4+T

DILATION OF ANAL SPHINCTER

MISG	10.23	Dilation of anal sphincter	20	4+T

DILATION AND MANIPULATION OF ENTEROSTOMY STOMA

MISG	10.24	Dilation and manipulation of enterostomy stoma		
		AN=GENL	20	4+T

MANUAL REDUCTION OF RECTAL OR ANAL PROLAPSE

MISG	10.26	Manual reduction of rectal or anal prolapse		
		AN=GENL	50	4+T

REPLACEMENT OF GASTROSTOMY TUBE

MISG	11.02	Replacement of gastrostomy tube or jejunostomy tube	25	6+T
		AN=GENL	50	6+T
MISG	11.02A	Revision of gastrostomy	25	6+T
		AN=GENL	50	6+T

REMOVAL OF INTRALUMINAL FOREIGN BODY FROM RECTUM AND ANUS WITHOUT INCISION

MAAS	12.16	Removal of intraluminal foreign body from rectum and anus without incision	IC	IC+T

INJECTION OR INFUSION OF THERAPEUTIC OR PROPHYLACTIC SUBSTANCE NEC

MISG	13.59I	Tissue plasminogen activator (PDA) injection	50	

OTHER PERIPHERAL NERVE OF GANGLION DECOMPRESSION OR FREEING OF ADHESIONS

MASG	17.39B	Neuroplasty of major peripheral nerve of the upper extremity (excluding median nerve at the carpal tunnel, and ulnar nerve at the elbow). Specifically; Guyon's Canal (ulnar nerve release at wrist), anterior interosseous nerve (median nerve in forearm), posterior interosseus nerve (radial nerve in forearm wrist) (regions required)	125	4+T
MASG	17.39C	Neuroplasty of major peripheral nerve of the lower extremity. Specifically; Peroneal nerve release, tarsal tunnel (posterior tibial nerve) (regions required)	125	4+T

TRANSPOSITION OF CRANIAL AND PERIPHERAL NERVES

MASG	17.5B	Ulnar nerve release at the elbow (cubital tunnel) (regions required)	125	4+T
		RP=REPT	200	4+T

ASPIRATION OF THYROID FIELD

MISG	19.01A	Fine needle aspiration of thyroid - plus multiples, if applicable	25	4+T

OTHER INCISION OF THYROID FIELD

MASG	19.09	Other incision of thyroid field thyroid gland - abscess	60	4+T

UNILATERAL THYROID LOBECTOMY

MASG	19.1A	Total lobectomy	225	8+T

EXCISION OF LESION OF THYROID

MASG	19.22A	Excision of solitary nodule	150	8+T
MASG	19.22B	Surgical biopsy	120	6+T

OTHER PARTIAL THYROIDECTOMY NEC

MASG	19.29A	Sub-total bilateral thyroidectomy	275	8+T
MASG	19.29B	Partial lobectomy	225	8+T
ADON	19.29C	Unilateral limited node dissection (This code is an add-on to HSC codes 19.1A, 19.22A 19.29A, 19.29B and 19.3 (regions required). The anaesthetist should claim the code with the highest listed basic.)	60	9+T
ADON	19.29D	Bilateral limited node dissection (This code is an add-on to HSC codes 19.1A, 19.22A 19.29A, 19.29B and 19.3. The anaesthetist should claim the code with the highest listed basic.)	120	10+T

COMPLETE THYROIDECTOMY

MASG	19.3	Complete thyroidectomy	290	8+T
ADON	19.3A	Radical neck dissection (This code is an add-on to HSC codes 19.1A, 19.22A 19.29A, 19.29B and 19.3 (regions required). The anaesthetist should claim the code with the highest listed basic.)	200	10+T

EXCISION OF THYROGLOSSAL DUCT OR TRACT

MASG	19.6	Excision of thyroglossal duct or tract	120	4+T
MASG	19.6A	Excision of thyroglossal duct - cyst and sinus	200	5+T

PARTIAL PARATHYROIDECTOMY

MASG	19.71A	Parathyroidectomy for hyperplasia	275	7+T
MASG	19.71B	Excision of parathyroid tumour	275	7+T
MASG	19.71C	Excision of parathyroid tumour - if sternal splitting required	325	13+T

PERCUTANEOUS (NEEDLE) BIOPSY OF THYROID

MISG	19.81	Percutaneous (needle) biopsy of thyroid - Silverman/tru-cut needle biopsy	38	6+T

THYMECTOMY, UNQUALIFIED

MASG	20.71	Thymectomy, unqualified	300	13+T

CONTROL OF EPISTAXIS BY ANTERIOR NASAL PACKING

MISG	33.01	Control of epistaxis by anterior nasal packing	20	

CONTROL OF EPISTAXIS BY POSTERIOR (AND ANTERIOR) PACKING

MISG	33.02A	Treatment of epistaxis posterior packing	30	4+T

CONTROL OF EPISTAXIS BY LIGATION OF ETHMOIDAL ARTERIES

MASG	33.04	Control of epistaxis by ligation of ethmoidal arteries	51	4+T

CONTROL OF EPISTAXIS BY (TRANSANTRAL) LIGATION OF THE MAXILLARY ARTERY

MASG	33.05	Control of epistaxis by (transantral) ligation of the maxillary artery	225	7+T

CONTROL OF EPISTAXIS BY LIGATION OF THE EXTERNAL CAROTID ARTERY

MASG	33.06	Control of epistaxis by ligation of the external carotid artery (regions required)		
		ME=SIMP	76.5	5+T
MASG	33.06A	Application of occlusion clamp (regions required)	153	10+T

TURBINECTOMY BY DIATHERMY OR CRYOSURGERY

MISG	33.51	Turbinectomy by diathermy or cryosurgery - single or bilateral	27	4+T
		AN=GENL	40.5	4+T
		AN=LOCL	27	

INCISION OF GUM OR ALVEOLAR BONE

MISG	36.0	Incision of gum or alveolar bone		
		AN=GENL	20	4+T

EXCISION OF LESION OR TISSUE OF GUM

MISG	36.21	Excision of lesion or tissue of gum	20	4+T
MISG	36.21A	Excision of mucous cyst	20	4+T

SUTURE OF (TRAUMATIC) LACERATION OF GUM

MISG	36.22	Suture of (traumatic) laceration of gum	20	4+T

EXCISION OF DENTAL LESION OF JAW

MASG	36.3	Excision of dental lesion of jaw	120	4+T

OTHER LOCAL EXCISION OF TONGUE

MISG	37.09A	Excision tongue biopsy	20	4+T
MASG	37.09B	Local excision of simple tumour of tongue	75	4+T

PARTIAL GLOSSECTOMY

MASG	37.1	Partial glossectomy	150	8+T
MASG	37.1A	Hemiglossectomy plus radical neck dissection	375	10+T

COMPLETE GLOSSECTOMY

MASG	37.2	Complete glossectomy	180	8+T
MASG	37.2A	Total glossectomy plus radical neck dissection	375	10+T

SUTURE OF (TRAUMATIC) LACERATION OF TONGUE

MAAS	37.41	Suture of (traumatic) laceration of tongue	IC	6+T

INCISION OF SALIVARY GLAND OR DUCT

MASG	38.0	Incision of salivary gland or duct		
		AN=GENL, ME=COMP	90	4+T
		AN=LOCL, ME=COMP	90	
MISG	38.0	Incision of salivary gland or duct		
		AN=GENL, ME=SIMP	30	4+T
		AN=LOCL, ME=SIMP	30	

OTHER EXCISION OF LESION OF SALIVARY GLAND

MISG	38.19A	Biopsy of parotid tumour	25	4+T

SIALOADENECTOMY, UNQUALIFIED

MASG	38.21	Sialoadenectomy, unqualified	140	4+T

COMPLETE SIALOADENECTOMY

MASG	38.23A	Excision of parotid gland tumour only	180	6+T
MASG	38.23B	Removal of parotid tumour without preservation of facial nerve	245	7+T
MASG	38.23C	Removal of parotid tumour without preservation of facial nerve plus unilateral radical neck dissection	375	10+T
MASG	38.23D	Removal of parotid tumour with preservation of facial nerve	325	7+T
MASG	38.23E	Removal of parotid tumour with preservation of facial nerve plus unilateral radical neck dissection	455	10+T
MASG	38.23F	Removal of recurrent parotid tumour with preservation of facial nerve	350	7+T

OTHER REPAIR AND PLASTIC OPERATIONS ON SALIVARY GLAND

MASG	38.39	Other repair and plastic operations on salivary gland	120	5+T
MASG	38.39B	Repositioning submandibular salivary gland ducts for drooling	150	4+T

PROBING OF SALIVARY DUCT

MISG	38.91	Probing of salivary duct	5	
MISG	38.91A	Dilation of salivary duct	10	

DRAINAGE OF FACE OR FLOOR OF MOUTH

COCR	39.0	Drainage of face or floor of mouth - incision and drainage of Ludwig's angina	40	

INCISION OF PALATE

MISG	39.1	Incision of palate	20	4+T

LOCAL EXCISION OR DESTRUCTION OF LESION OR TISSUE OF PALATE

MISG	39.21A	Biopsy of palate and/or uvula	20	4+T
MISG	39.21B	Excision of simple lesion of palate and uvula	30	4+T

WIDE EXCISION OR DESTRUCTION OF LESION OR TISSUE OF PALATE

MASG	39.22A	Excision of malignant lesion of palate and uvula - with reconstruction	140	8+T

OTHER EXCISION OF MOUTH

MASG	39.39B	Excision of ranula or dermoid cyst	60	4+T
MASG	39.39C	Local excision for carcinoma of floor of mouth, mandible, alveolar margin or buccal mucosa	100	6+T
MASG	39.39D	Local excision for carcinoma of floor of mouth - with hemimandibulectomy	240	8+T
MASG	39.39E	Local excision for carcinoma of floor of mouth, mandible alveolar margin of buccal mucosa with hemimandibulectomy and unilateral neck dissection	345	8+T
MISG	39.39F	Biopsy - mouth	20	4+T
MASG	39.39G	Local excision for carcinoma of floor of mouth, mandible, alveolar margin or buccal mucosa with unilateral neck dissection	345	8+T

EXCISION OF UVULA

MISG	39.62	Excision of uvula, uvulectomy	20	4+T

OTHER OPERATIONS ON ORAL CAVITY

MASG	39.99A	Excision of leukoplakia ME=MAJO	120	4+T
MISG	39.99A	Excision of leukoplakia ME=MINO	30	4+T
		ME=SIMP	20	4+T
MISG	39.99B	Cauterization of leukoplakia	30	4+T

CLOSURE OF BRANCHIAL CLEFT FISTULA

MASG	41.42A	Excision branchial cyst	150	4+T
MASG	41.42B	Excision branchial sinus	150	5+T

CLOSURE OF TRACHEOSTOMY

MASG	43.62	Closure of tracheostomy	120	6+T

CLOSURE OF OTHER FISTULA OF TRACHEA

MASG	43.63	Closure of other fistula of trachea	350	7+T
		AP=ABDO		7+T
		AP=CERV		6+T
		AP=THOR		13+T

REVISION OF TRACHEOSTOMY

MASG	43.64	Revision of tracheostomy	120	6+T

CONSTRUCTION OF ARTIFICIAL LARYNX AND RECONSTRUCTION OF TRACHEA (WITH GRAFT)

MASG	43.65	Construction of artificial larynx and reconstruction of trachea (with graft)	400	13+T
MISG	43.65A	Tracheo esophageal puncture	50	4+T
MISG	43.65B	Placement of a voice prosthesis	50	6+T
MASG	43.65C	Tracheo esophageal puncture and placement of a voice prosthesis	100	6+T

OTHER REPAIR AND PLASTIC OPERATIONS ON TRACHEA

MASG	43.69	Other repair and plastic operations on trachea, tracheal splint, transthoracic	400	13+T
MISG	43.69A	Tracheal dilation	50	6+T

OTHER OPERATIONS ON LARYNX

MASG	43.95A	Excision - suprahyoid tumour (regions required)	150	6+T

OTHER LOCAL EXCISION OR DESTRUCTION OF LESION OR TISSUE OF LUNG

MASG	44.29A	Biopsy of pleural/lung (regions required)	200	13+T

SEGMENTAL RESECTION OF LUNG (BASILAR) (SUPERIOR)

MASG	44.3	Segmental resection of lung (basilar) (superior)		
		PO=SEGM (regions required)	300	13+T
		PO=WEGE (regions required) - plus multiples, if applicable	240	13+T

LOBECTOMY OF LUNG

MASG	44.4	Lobectomy of lung (regions required) - plus multiples, if applicable	385	13+T
MASG	44.4A	VATS lung lobectomy (regions required) - plus multiples, if applicable	480	13+T

COMPLETE PNEUMONECTOMY

MASG	44.5	Complete pneumonectomy (regions required)	400	13+T

INCISION OF LUNG

MASG	45.1A	Drainage of lung abscess (regions required)	180	13+T
MASG	45.1B	Exploratory removal of foreign body	250	13+T

DESTRUCTION OF PHRENIC NERVE FOR COLLAPSE OF LUNG

MASG	45.21	Destruction of phrenic nerve for collapse of lung	60	5+T

ARTIFICIAL PNEUMOTHORAX FOR COLLAPSE OF LUNG

MISG	45.22	Artificial pneumothorax for collapse of lung		
		RP=INTL	15	
		RP=SUBS	7.5	

THORACOPLASTY FOR COLLAPSE OF LUNG

MASG	45.24A	Thoracoplasty - one stage	200	10+T
MASG	45.24B	Thoracoplasty - multi-stage - each	120	9+T

OTHER SURGICAL COLLAPSE OF LUNG

MASG	45.29A	Apicolysis - extra-fascial (Sembs)	150	5+T
MASG	45.29B	Apicolysis - extra-pleural	150	5+T
MASG	45.29C	Schede's operation	240	10+T

FREEING OF ADHESIONS OF LUNG AND CHEST WALL

MASG	45.3A	Pneumolysis - intra-pleural	90	5+T
MASG	45.3B	Pneumolysis - extra-pleural	150	5+T

OTHER REPAIR AND PLASTIC OPERATION ON BRONCHUS

MASG	45.43A	Bronchoplasty	400	13+T

PUNCTURE OF LUNG

MASG	45.94A	Aspiration of lung tumour under fluoroscopy (regions required)	51	

EXPLORATORY THORACOTOMY

MASG	46.02	Exploratory thoracotomy	130	13+T

INSERTION OF INTERCOSTAL CATHETER (WITH WATER SEAL) FOR DRAINAGE

MASG	46.04A	Incision thoracotomy - closed drainage, includes Hemlick valve device (Regions required)	80	4+T

OTHER INCISION OF PLEURA

MASG	46.09A	Claggett window procedure (regions required)	325	13+T
MASG	46.09B	Incision thoracotomy - rib resection and drainage	120	13+T

INCISION OF MEDIASTINUM

MASG	46.1	Incision of mediastinum	150	6+T

EXCISION OR DESTRUCTION OF LESION OR TISSUE OF MEDIASTINUM

MASG	46.2	Excision or destruction of lesion or tissue of mediastinum	300	13+T

EXCISION OR DESTRUCTION OF LESION OF CHEST WALL

MASG	46.3A	Excision of chest wall tumour involving ribs or cartilage with reconstruction	310	9+T

DECORTICATION OF LUNG (PARTIAL) (TOTAL)

MASG	46.41	Decortication of lung – Primary procedure (regions required)	280	15+T
MASG	46.41A	Pleurectomy with bullous emphysema (regions required)	300	13+T

SCARIFICATION OF PLEURA

ADON	46.5A	Tetracycline poudrage (in addition to insertion of chest tube)	25	

REPAIR OF PECTUS DEFORMITY

MASG	46.64	Repair of pectus deformity	335	11+T
MASG	46.64A	Removal of pectus bar	75	4+T
MASG	46.64B	Removal of intra-aortic balloon	100	10+T
		CO=CRBY		35+T
		Note: For insertion of intra-aortic balloon, see Health Service Code 49.61		

OTHER OPERATIONS ON DIAPHRAGM

MASG	46.79A	Insertion of peritoneal venous shunt - Denver or Laveen	175	6+T
MASG	46.79B	Removal of peritoneal venous shunt - Denver or Laveen	100	6+T
MASG	46.79C	Revision of peritoneal venous shunt - Denver or Laveen	125	6+T

THORACOSCOPY, TRANSPLEURAL

MASG	46.81	Thoracoscopy, transpleural	100	13+T
MASG	46.81A	Thoracoscopy with instillation of Fibrin Glue	75	4+T

CLOSED HEART VALVOTOMY, MITRAL VALVE

MASG	47.02A	Valvotomy - transatrial	300	20+T
		CO=CRBY		35+T
MASG	47.02B	Valvotomy - transventricular	325	20+T
		CO=CRBY		35+T
MASG	47.02C	Valvotomy for re-stenosis of mitral valve	400	20+T
		CO=CRBY		35+T

CLOSED HEART VALVOTOMY, AORTIC VALVE

MASG	47.03	Closed heart valvotomy, aortic valve	400	35+T

CLOSED HEART VALVOTOMY, TRICUSPID VALVE

MASG	47.04	Closed heart valvotomy, tricuspid valve	350	20+T
		CO=CRBY		35+T

CLOSED HEART VALVOTOMY, PULMONARY VALVE

MASG	47.05A	Pulmonary stenosis - Brock Procedure (regions required)	300	20+T
		CO=CRBY		35+T
MASG	47.05B	Pulmonary valvotomy with inflow occlusion (regions required)	350	20+T
		CO=CRBY		35+T

OPEN HEART VALVULOPLASTY OF MITRAL VALVE WITHOUT REPLACEMENT

MASG	47.12A	Open mitral commissurotomy	400	35+T

OPEN HEART VALVULOPLASTY OF AORTIC VALVE WITHOUT REPLACEMENT

MASG	47.13	Open heart valvuloplasty of aortic valve without replacement	400	35+T

OPEN HEART VALVULOPLASTY OF TRICUSPID VALVE WITHOUT REPLACEMENT

MASG	47.14	Open heart valvuloplasty of tricuspid valve without replacement	500	20+T
		CO=BPU5		40+T
		CO=CRBY		35+T
		CO=UN5K		25+T

OPEN HEART VALVULOPLASTY OF PULMONARY VALVE WITHOUT REPLACEMENT

MASG	47.15	Open heart valvuloplasty of pulmonary valve without replacement (Regions required)	400	35+T

OTHER REPLACEMENT OF MITRAL VALVE

MASG	47.23	Other replacement of mitral valve	500	35+T
MASG	47.23A	Mitral valve replacement - double	600	35+T
MASG	47.23B	Mitral valve replacement - triple	1000	35+T

OTHER REPLACEMENT OF AORTIC VALVE

MASG	47.25	Other replacement of aortic valve	500	35+T
MASG	47.25A	Aortic valve and ascending aorta with reimplantation or coronary arteries (Bio-Bentall or Mechanical Bentall repair)	1105	35+T
MASG	47.25B	Valve sparing aortic root replacement or remodeling (David or Yacoub) with reimplantation of coronary arteries (VSR)	1105	35+T
VEDT	47.25C	Transcutaneous Aortic Valve Implantation/Replacement (TAVI)		
		RO=FPHN	611	20+T
		RO=SPHN	611	

ANNULOPLASTY

MASG	47.33A	Tricuspid annuloplasty	300	35+T
MASG	47.33B	Mitral annuloplasty	400	35+T

CREATION OF SEPTAL DEFECT IN HEART

MASG	47.43	Creation of septal defect in heart	350	20+T
		CO=CRBY		35+T

REPAIR OF ATRIAL SEPTAL DEFECT WITH PROSTHESIS, OPEN TECHNIQUE

MASG	47.52A	Closure atrial septal defect	350	20+T
		CO=CRBY		35+T

REPAIR OF VENTRICULAR SEPTAL DEFECT WITH PROSTHESIS

MASG	47.54	Repair of ventricular septal defect with prosthesis	450	35+T
MASG	47.54A	Repair of ventricular septal defect with removal of banding	500	20+T
		CO=CRBY		35+T

REPAIR OF ENDOCARDIAL CUSHION DEFECT WITH PROSTHESIS

MASG	47.55A	Closure of septum primum with/without value repair	500	35+T

TOTAL REPAIR OF TETRALOGY OF FALLOT

MASG	47.81	Total repair of Tetralogy of Fallot	500	35+T
MASG	47.81A	Total repair of Tetralogy of Fallot with previous systemic pulmonary shunt	600	35+T

TOTAL REPAIR OF TOTAL ANOMALOUS PULMONARY VENOUS CONNECTION

MASG	47.82	Total repair of total anomalous pulmonary venous connection (regions required)	350	20+T
		CO=CRBY		35+T

TOTAL REPAIR OF TRUNCUS ARTERIOSUS

MASG	47.83A	Repair of double outlet right ventricle	500	35+T

INTERATRIAL TRANSPOSITION OF VENOUS RETURN

MASG	47.91	Interatrial transposition of venous return repair - Mustard Procedure	500	35+T
		CO=BPU5		40+T

OTHER OPERATIONS ON VALVES OF HEART

MASG	47.96A	Fontan Procedure for single ventricle	517	35+T

REMOVAL OF CORONARY ARTERY OBSTRUCTION

MASG	48.0B	Open repair of coronary artery	350	20+T
		CO=CRBY		35+T
MASG	48.0G	Insertion or placement of endovascular stent	250	8+T
MASG	48.0H	Coronary endarterectomy (by-pass graft)	500	20+T
		CO=CRBY		35+T

AORTOCORONARY BYPASS OF ONE CORONARY ARTERY

MASG	48.12	Aortocoronary bypass of one coronary artery	450	20+T
		CO=CRBY		35+T

AORTOCORONARY BYPASS OF TWO CORONARY ARTERIES

MASG	48.13	Aortocoronary bypass of two coronary arteries	600	20+T
		CO=CRBY		35+T

AORTOCORONARY BYPASS OF THREE CORONARY ARTERIES

MASG	48.14	Aortocoronary bypass of three coronary arteries		
		- plus multiples, if applicable	700	20+T
		CO=CRBY		35+T

HEART REVASCULARIZATION BY ARTERIAL IMPLANT

MASG	48.2A	Repair - coronary arteries - Vineberg Procedure	350	20+T
		CO=CRBY		35+T
MASG	48.2B	Double Vineberg Procedure	450	20+T
		CO=CRBY		35+T
ADON	48.2C	Total arterial grafting	100	

PERICARDIOCENTESIS

MASG	49.0B	Pericardial insufflation with powder	150	20+T
		CO=CRBY		35+T
MISG	49.0C	Atrial or right ventricular puncture	20	5+T

CARDIOTOMY

MASG	49.12A	Cardiotomy with exploration	300	20+T
		CO=CRBY		35+T

MASG	49.12B	Cardiotomy with removal of foreign body	250	20+T
		CO=CRBY		35+T

PERICARDIECTOMY

MASG	49.2	Pericardiectomy		
		PO=SBTL	300	20+T
		PO=PART	200	20+T
		CO=CRBY		35+T
MASG	49.2A	Biopsy of pericardium by thoracotomy	150	13+T

EXCISION OF ANEURYSM OF HEART

MASG	49.31	Excision of aneurysm of heart	500	35+T

EXCISION OF OTHER LESION OF HEART

MASG	49.39A	Excision of tumours of heart; e.g., myxoma	450	35+T
MASG	49.39B	Excision of ventricular diverticulum	300	35+T
MASG	49.39C	Resection of myocardial fibrosis	500	35+T
MASG	49.39D	Resection of myocardium	500	35+T

REPAIR OF HEART AND PERICARDIUM

MASG	49.4A	Suture of wound	250	20+T

HEART TRANSPLANTATION

MASG	49.5A	Donor cardiectomy	257.56	35+T
MASG	49.5B	Orthotopic cardiac transplantation recipient	771.98	35+T

IMPLANT OF PULSATION BALLOON

MASG	49.61	Implant of pulsation balloon	134.5	10+T
		Note: For removal of intra-aortic balloon, see Health Service Code 46.64B		

IMPLANT OF OTHER HEART ASSIST SYSTEM

MASG	49.62A	Left or right external ventricular assist device implantation		
		(Regions required)	350	35+T

PACEMAKER IMPLANTATION NOS

MASG	49.71A	Permanent transvenous pacemaker/epicardial pacemaker	130	9+T
		CO=PACM		14+T
MASG	49.71B	A-V sequential pacemaker	200	9+T
		CO=PACM		14+T

MASG	49.71C	Insertion of atrial pacemaker	155	9+T
		CO=PACM		14+T
MASG	49.71D	Insertion of permanent pacemaker	130	20+T
		AP=THOR		20+T
		AP=THOR, CO=PACM		25+T
		ME=EXTN		9+T
		ME=EXTN, CO=PACM		14+T
MASG	49.71E	Insertion of CRT pacemaker/defibrillator device – composite fee	360	9+T
		CO=PACM		14+T
MASG	49.71F	Insertion of CRT pacemaker/defibrillator device – team fee		
		RO=FPHN	200	9+T
		RO=SPHN	160	9+T
		CO=PACM		14+T
ADON	49.71G	Defibrillator testing	60	9+T
		CO=PACM		14+T

IMPLANTATION OF ENDOCARDIAL ELECTRODES

MASG	49.73A	Implantation of AICD device	200	20+T
		CO=PACM		25+T

REPLACEMENT OF ENDOCARDIAL ELECTRODES

MASG	49.82	Replacement of endocardial electrodes	130	9+T
		CO=PACM		14+T
MASG	49.82A	Adjustment transvenous pacemaker leads - within 30 days of insertion	75	9+T
		CO=PACM		14+T
MASG	49.82B	Adjustment transvenous pacemaker leads - after 30 days of insertion	150	9+T
		CO=PACM		14+T

REPLACEMENT OF PULSE GENERATOR

MASG	49.83A	Battery change of pacemaker	100	
		AP=THOR		20+T
		AP=THOR, CO=PACM		25+T
		ME=EXTN, CO=PACM		14+T
		ME=EXTN		9+T

REMOVAL OF CARDIAC PACEMAKER SYSTEM WITHOUT REPLACEMENT

MASG	49.87	Removal of cardiac pacemaker system without replacement	150	6+T
MASG	49.87B	Complete removal of cardiac pacemaker system without replacement using laser sheath removal of the pacemaker leads, to include any necessary debridement of the chest wall and any imaging - plus multiples, if applicable.	200	14+T

OPEN CHEST CARDIAC MASSAGE

ADON	49.91	Open chest cardiac massage	100	

OTHER OPERATIONS ON HEART AND PERICARDIUM NEC

ADON	49.99A	Retrieval of heart for harvesting of valves	100	
ADON	49.99B	MAZE procedure performed during open-heart procedures	50	
ADON	49.99C	Repeat open heart surgery	120	

INCISION OF UPPER LIMB VESSELS

MASG	50.03A	Embolectomy - arm (regions required)	204	5+T

INCISION OF AORTA

MASG	50.04	Incision of aorta	76.5	5+T
MASG	50.04A	Embolectomy - aortic	255	10+T

INCISION OF OTHER THORACIC VESSELS

MASG	50.05A	Pulmonary embolectomy	300	20+T
		CO=CRBY		35+T

INCISION OF ABDOMINAL ARTERIES

MASG	50.06A	Embolectomy - inferior or superior	255	10+T
MASG	50.06B	Embolectomy - renal (regions required)	255	10+T
MASG	50.06C	Thrombectomy - iliac (regions required)	205	10+T

INCISION OF ABDOMINAL VEINS

MASG	50.07A	Embolectomy - iliac (regions required)	200	10+T

INCISION OF LOWER LIMB VESSELS

MASG	50.08A	Embolectomy - femoral (regions required)	200	10+T
MASG	50.08B	Thrombectomy - femoral (regions required)	205	10+T

INCISION OF VESSELS OF UNSPECIFIED SITE

MISG	50.09A	Arteriotomy	35.7	5+T

ENDARTERECTOMY OF INTRACRANIAL VESSELS

MASG	50.11A	Thromboendarterectomy - with patch graft	240	10+T

ENDARTERECTOMY OF OTHER VESSELS OF HEAD AND NECK

MASG	50.12A	Thromboendarterectomy - with patch graft	240	10+T

ENDARTERECTOMY OF UPPER LIMB VESSELS

MASG	50.13A	Thromboendarterectomy - with patch graft	240	10+T
MASG	50.13B	Peripheral arterial graft - brachial (regions required)	255	5+T
MASG	50.13C	Peripheral arterial graft - axillary (regions required)	255	6+T

ENDARTERECTOMY OF AORTA

MASG	50.14B	Thromboendarterectomy - with patch graft	240	10+T

ENDARTERECTOMY OF OTHER THORACIC VESSELS

MASG	50.15A	Thromboendarterectomy - with patch graft	240	10+T
MASG	50.15B	Peripheral arterial graft-subclavian (regions required)	306	6+T

ENDARTERECTOMY OF ABDOMINAL ARTERIES

MASG	50.16A	Thromboendarterectomy - with patch graft	240	10+T
MASG	50.16B	Peripheral arterial graft - mesenteric - inferior or superior	255	10+T

ENDARTERECTOMY OF ABDOMINAL VEINS

MASG	50.17A	Aorta-thromboendarterectomy	306	17+T
MASG	50.17B	Aorta-thromboendarterectomy and patch graft	340	17+T
MASG	50.17C	Peripheral arterial graft - renal (regions required)	255	10+T

ENDARTERECTOMY OF LOWER LIMB VESSELS

MASG	50.18A	Thromboendarterectomy - with patch graft	240	10+T
MASG	50.18B	Extended profundoplasty - thromboendarterectomy with/without graft	250	10+T

ENDARTERECTOMY OF VESSELS OF UNSPECIFIED SITE

MASG	50.19A	Thromboendarterectomy - with patch graft	240	10+T

RESECTION OF OTHER VESSELS OF HEAD AND NECK WITH ANASTOMOSIS

MASG	50.22A	Incision aneurysm of sinus of valsalva	510	35+T
MASG	50.22B	Excision of carotid aneurysm (regions required)	306	10+T

RESECTION OF AORTA WITH ANASTOMOSIS

MASG	50.24A	Coarctation of aorta	357	20+T

RESECTION OF OTHER THORACIC VESSELS WITH ANASTOMOSIS

MASG	50.25A	Excision of innominate aneurysm	306	10+T
MASG	50.25B	Excision of subclavian, innominate aneurysm (regions required)	204	10+T

RESECTION OF ABDOMINAL ARTERIES WITH ANASTOMOSIS

MASG	50.26A	Excision of iliac aneurysm (regions required)	204	10+T
MASG	50.26B	Excision of splenic/hepatic aneurysm	204	10+T

RESECTION OF LOWER LIMB VESSELS WITH ANASTOMOSIS

MASG	50.28A	Excision of femoral, popliteal aneurysm (regions required)	204	10+T

RESECTION OF INTRACRANIAL VESSELS WITH REPLACEMENT

MAAS	50.31	Resection of intracranial vessels with replacement	IC	IC+T

RESECTION OF OTHER VESSELS OF HEAD AND NECK WITH REPLACEMENT

MAAS	50.32	Resection of other vessels of head and neck with replacement	IC	IC+T
MASG	50.32A	Excision of carotid aneurysm (regions required)	306	10+T

RESECTION OF UPPER LIMB VESSELS WITH REPLACEMENT

MAAS	50.33	Resection of upper limb vessels with replacement	IC	IC+T

RESECTION OF AORTA WITH REPLACEMENT

MASG	50.34A	Dissecting aneurysm	408	17+T
MASG	50.34B	Excision of thoracic aorta aneurysm	510	35+T
MASG	50.34C	Excision of abdominal aorta aneurysm with rupture	430	20+T
MASG	50.34D	Excision of thoracic aorta aneurysm with rupture	550	35+T
MASG	50.34E	Excision of abdominal aortic aneurysm	380	17+T

RESECTION OF OTHER THORACIC VESSELS WITH REPLACEMENT

MAAS	50.35	Resection of other thoracic vessels with replacement	IC	IC+T
MASG	50.35A	Excision of innominate aneurysm	306	10+T
MASG	50.35B	Repair of subclavian, innominate aneurysm by graft (regions required)	255	10+T

RESECTION OF ABDOMINAL ARTERIES WITH REPLACEMENT

MASG	50.36A	Repair of iliac aneurysm by graft	255	10+T
MASG	50.36B	Excision aneurysm - splenic, hepatic - with grafting	306	10+T

RESECTION OF ABDOMINAL VEINS WITH REPLACEMENT

MASG	50.37A	Aortic graft plus bilateral common femoral artery repair	420	17+T
MASG	50.37B	Aortic graft plus unilateral common femoral artery repair	400	17+T
MASG	50.37C	Aorta - bifurcation graft	340	17+T

RESECTION OF LOWER LIMB VESSELS WITH REPLACEMENT

MAAS	50.38	Resection of lower limb vessels with replacement	IC	IC+T
MASG	50.38A	Repair of femoral, popliteal aneurysm by graft (regions required)	255	10+T

MASG	50.38B	Femoral graft with prosthesis (regions required)	270	10+T
MASG	50.38C	Femoral graft with reverse saphenous vein including harvesting of vein (Regions required)	310	10+T

RESECTION OF VESSELS OF UNSPECIFIED SITE WITH REPLACEMENT

MAAS	50.39	Resection of vessels of unspecified site with replacement	IC	IC+T

LIGATION AND STRIPPING OF VARICOSE VEINS OF LOWER LIMB VESSELS

MASG	50.48A	Ligation of varicose veins - multiple - one leg (regions required)	80	4+T
MISG	50.48B	Venous ligation - long saphenous - sapheno - femoral junction (Regions required)	50	4+T
MASG	50.48C	Venous ligation - long saphenous with stripping (regions required)	96.9	4+T
MASG	50.48D	Ligation - long saphenous - with multiple low ligation - ligation of perforators (Regions required)	100	4+T
MASG	50.48E	Venous ligation - short saphenous ligation and stripping (regions required)	56.1	4+T
MASG	50.48F	Venous ligation and stripping - long and short saphenous (regions required)	130	4+T
MASG	50.48G	High venous ligation with stripping - bilateral	170	4+T
MASG	50.48H	High venous ligation with stripping and multiple low ligations - bilateral	200	4+T
MASG	50.48I	Bilateral long and short saphenous, high ligation and stripping	180	4+T
MAAS	50.48J	Recurrent complicated varicose veins	IC	4+T
MASG	50.48K	Excision of ulcer - venous ligation and skin graft (regions required)	127.5	4+T
MASG	50.48L	Excision of ulcer - venous ligation and skin graft - both legs	204	4+T
ADON	50.48M	Excision of ulcer - venous ligation and skin graft plus sympathectomy - both legs	76.5	4+T
MASG	50.48N	Sub-fascial venous ligation	153	4+T
MASG	50.48O	Sub-fascial venous ligation - with stripping of veins	204	4+T
MASG	50.48P	Cauterization of varicose veins	56.1	4+T

PLICATION OR OTHER INTERRUPTION OF VENA CAVA

MASG	50.6B	Insertion of filters/balloon into the inferior vena cava AP=PERC	125	10+T
MASG	50.6C	Suture ligation - inferior vena cava	183.6	10+T

OTHER SURGICAL OCCLUSION OF OTHER VESSELS OF HEAD AND NECK

MASG	50.72A	Suture ligation - jugular vein (regions required)	61.2	8+T

OTHER SURGICAL OCCLUSION OF AORTA

MASG	50.74A	Division of vascular ring - esophagus	255	20+T

OTHER SURGICAL OCCLUSION OF OTHER THORACIC VESSELS

MASG	50.75A	Repair - banding of pulmonary artery (regions required)	300	35+T
		CO=BPU5		40+T
MASG	50.75B	Coil embolization of collateral vessels in children		
		- plus multiples, if applicable	250	8+T
		AP=PERC	350	8+T
MASG	50.75C	Device closure of patent ductus arteriosus - in a child	250	8+T
MASG	50.75D	Repair - patent ductus arteriosus	250	20+T
		CO=CRBY		35+T
		CO=UN5K		25+T
MASG	50.75E	Transection of artery - intra-thoracic	102	IC+T
MASG	50.75F	Percutaneous device closure of patent ductus arteriosus - in an adult	200	

OTHER SURGICAL OCCLUSION OF ABDOMINAL ARTERIES

MASG	50.76B	Transection of artery - intra-abdominal	102	IC+T

OTHER SURGICAL OCCLUSION OF ABDOMINAL VEINS

MASG	50.77A	Transection of artery - peripheral	76.5	4+T
MASG	50.77B	Suture ligation - iliac vein (regions required)	153	10+T
MAAS	50.77C	Portal Vein Embolization	IC at 140 MSU/hr	

OTHER SURGICAL OCCLUSION OF LOWER LIMB VESSELS

MASG	50.78A	Suture ligation - femoral vein superficial (regions required)	61.2	8+T
MASG	50.78B	Suture ligation - popliteal vein (regions required)	61.2	8+T
MISG	50.78C	Suture ligation - saphenous vein (regions required)	25.5	4+T
MASG	50.78D	Suture ligation - femoral vein - deep (regions required)	61.2	8+T
MASG	50.78E	Suture ligation - femoral vein - common (regions required)	61.2	8+T

OTHER VENOUS CATHETERIZATION

MASG	50.93G	Implantation of subcutaneous venous access system (i.e., port-a-cath)	100	5+T
MISG	50.93H	Removal/manipulation of venous access system	25	4+T

SYSTEMIC TO PULMONARY ARTERY SHUNT

MASG	51.0A	Pulmonary repair - aortic anastomosis - Potts (regions required)	350	20+T
		CO=CRBY		35+T
MASG	51.0B	Pulmonary repair - subclavian - Blalock	350	20+T
		CO=CRBY		35+T
MASG	51.0C	Repair - Waterston shunt	350	20+T
		CO=CRBY		35+T

INTRA-ABDOMINAL VENOUS ANASTOMOSIS

MASG	51.1A	Transjugular intrahepatic porto-systematic shunt	150	
MASG	51.1B	Venous anastomosis - umbilical to saphenous shunt	306	10+T
MASG	51.1C	Venous anastomosis - porto-caval (regions required)	357	10+T
MASG	51.1D	Venous anastomosis - spleno-renal (regions required)	357	10+T
MASG	51.1E	Venous anastomosis - meso-caval (regions required)	357	10+T

OTHER SHUNT OR VASCULAR BYPASS

ADON	51.2A	Ex-vivo reconstruction of pancreas with vascular grafts	200	

AORTA-SUBCLAVIAN-CAROTID BYPASS

MASG	51.22	Aorta-subclavian-carotid bypass including harvesting of vein	300	10+T

AORTA-RENAL BYPASS

MASG	51.24	Aorta-renal bypass including harvesting of vein	380	17+T

AORTA-ILIAC-FEMORAL BYPASS

MASG	51.25A	Aortic graft plus femoropopliteal graft	550	17+T
MASG	51.25B	Iliac artery to popliteal/femoral (regions required)	275	10+T

OTHER INTRA-ABDOMINAL SHUNT OR BYPASS

MASG	51.26A	Spleno/hepato/ileo by-pass graft including harvesting of vein	380	17+T

ARTERIOVENOSTOMY FOR RENAL DIALYSIS

MASG	51.27	Arteriovenostomy for renal dialysis	140	4+T

OTHER (PERIPHERAL) SHUNT OR BYPASS

MASG	51.29A	Crossed femoral graft	240	10+T
MASG	51.29B	Axillo-femoral graft (regions required)	275	10+T
MASG	51.29C	Popliteal-tibial arterial graft (regions required)	255	10+T

MASG	51.29D	In situ venous femoral artery bypass graft (regions required)	380	10+T
MASG	51.29E	Femoral post tibial/peroneal/ant tibial graft with prosthesis (regions required)	300	10+T

SUTURE OF VESSEL

MASG	51.3A	Repair of severed digital artery (regions required) - plus multiples, if applicable	150	4+T

REMOVAL OF ARTERIOVENOUS SHUNT FOR RENAL DIALYSIS

MASG	51.43	Removal of arteriovenous shunt for renal dialysis	102	7+T

OTHER REVISION OF VASCULAR PROCEDURE

MASG	51.49A	Removal of infected graft including revascularization - aortic/iliac	700	10+T
MASG	51.49B	Removal of infected graft including revascularization - femoral (Regions required)	350	10+T

OTHER REPAIR OF BLOOD VESSEL NEC

MASG	51.59D	Arterioplasty - femoral (regions required)	153	10+T
MASG	51.59E	Arterioplasty - iliac (regions required)	153	10+T
MASG	51.59F	Femoral post tibial/peroneal/ant tibial graft with reversed vein (Regions required)	330	10+T
ADON	51.59H	Re-Implantation of spinal arteries, per island	100	

EXTRACORPOREAL CIRCULATION AUXILIARY TO OPEN HEART SURGERY

ADON	51.61	Extracorporeal circulation auxiliary to open heart surgery PO=COML PO=PART	204 204	
MASG	51.61A	Manipulation - cardiac massage - assisted circulation for cardiac/respiratory failure	400	35+T
ADON	51.61B	Off pump CAB (Coronary Artery Bypass) surgery (Octopus, etc.)	204	

OPERATIONS ON CAROTID BODY AND OTHER VASCULAR BODIES

MASG	51.8A	Excision of carotid body tumour with graft (regions required)	331.5	10+T
MASG	51.8B	Excision of carotid body tumour with vessel bypass (regions required)	357	10+T
MASG	51.8C	Excision of carotid body tumour (regions required)	255	6+T

INJECTION OF SCLEROSING AGENT OR SOLUTION INTO VEIN

MASG	51.92	Injection of sclerosing agent or solution into vein (regions required) ..... 77 Compression sclerotherapy (feganization) one per leg per year		
MISG	51.92	Injection of sclerosing agent or solution into vein (regions required) Compression sclerotherapy (feganization) RP=SUBS ..... 15.3 (RP=SUBS - after the first 12 months, 15.3 units is payable per treatment to a maximum of 100 units per succeeding 12-month period) Note: Service encounters with a diagnosis of varicose veins, varicose veins with inflammation, or any claim that states compression sclerotherapy or feganization is payable. Service encounters with a diagnosis of spider veins or nevi, telangiectasia, superficial varicosities or for cosmetic reasons are not payable. Any after care (consults or visits) with the same diagnosis by the physician who performed the service is not payable in the following year.		
MISG	51.92A	Injection (vein) single or multiple 10.2		

REPLACEMENT OF VESSEL-TO-VESSEL CANNULA

MISG	51.94A	Removal of A.V. shunt 25.5		6+T

SIMPLE EXCISION OF LYMPHATIC STRUCTURE

MASG	52.1A	Cystic hygroma..... 180		6+T

EXCISION OF AXILLARY LYMPH NODE

MISG	52.13	Excision of axillary lymph node (regions required)..... 32		4+T

EXCISION OF INGUINAL LYMPH NODE

MISG	52.14	Excision of inguinal lymph node (regions required) 32		4+T

SIMPLE EXCISION OF OTHER LYMPHATIC STRUCTURE

MISG	52.19	Simple excision of other lymphatic structure (regions required)..... 32 Excision - cervical gland biopsy		4+T

RADICAL NECK DISSECTION, UNILATERAL

MASG	52.32	Radical neck dissection, unilateral (regions required)..... 360		10+T
MASG	52.32A	Radical neck dissection with preservation of spinal accessory nerve (Regions required) 380		10+T

RADICAL NECK DISSECTION, BILATERAL

MASG	52.33	Radical neck dissection, bilateral..... 540		10+T
MASG	52.33A	Radical neck dissection with preservation of spinal accessory nerve 570		10+T

RADICAL EXCISION OF OTHER LYMPH NODES

MASG	52.4A	Retro-peritoneal lymph node dissection 300		8+T

RADICAL EXCISION OF AXILLARY LYMPH NODES

MASG	52.42	Radical excision of axillary lymph nodes (regions required)	185	6+T

RADICAL EXCISION OF PERI-AORTIC LYMPH NODES

MASG	52.43	Radical excision of peri-aortic lymph nodes	150	8+T

RADICAL EXCISION OF ILIAC LYMPH NODES

MASG	52.44	Radical excision of iliac lymph nodes (regions required)	210	6+T

RADICAL GROIN DISSECTION

MASG	52.45	Radical groin dissection (regions required)	100	6+T

RADICAL EXCISION OF OTHER LYMPH NODES

MASG	52.49A	Staging operation for Hodgkin's Disease	300	8+T
MASG	52.49B	Deep pelvic lymphadenectomy (regions required)	110	8+T

OTHER LYMPHANGIOGRAM

MASG	52.85	Other lymphangiogram (regions required)	91.8	5+T

OTHER INVASIVE DIAGNOSTIC PROCEDURES ON LYMPHATIC STRUCTURES

MASG	52.89A	Staging laparotomy includes omentectomy, biopsies and washings (stand alone composite fee)	275	8+T
ADON	52.89B	Staging laparotomy includes omentectomy, biopsies and washings (add on) (when a staging laparotomy is done in conjunction with other procedures by the same surgeon, an add on fee may be approved)	100	
MASG	52.89C	Staging laparotomy in addition supracolic omentectomy - stand alone	325	8+T
ADON	52.89D	Staging laparotomy in addition supracolic omentectomy - add on	150	
ADON	52.89E	Sentinel Lymph Node Biopsy for cancer	50	

OTHER OPERATIONS ON LYMPHATIC STRUCTURES

MASG	52.9B	Radical sleeve excision	300	6+T
MASG	52.9C	Lympho-venous anastomosis	250	6+T
MASG	52.9F	Lymphedema of limbs - modified Kondoleon - excision and grafting	180	5+T
MASG	52.9G	Lymphedema - entire lower limb	250	5+T

BONE MARROW TRANSPLANT

MASG	53.0	Bone marrow transplant	2900	9+T
		Composite fee day 1-39 in hospital		
MASG	53.0A	Composite fee day 40 -100 in hospital	580	9+T

PUNCTURE OF SPLEEN

MISG	53.1A	Splenic puncture for injection of contrast substance	30	4+T

ASPIRATION OF BONE MARROW FROM DONOR FOR TRANSPLANT

MASG	53.41	Aspiration of bone marrow from donor for transplant	150	9+T

REPAIR AND PLASTIC OPERATIONS ON SPLEEN

MASG	53.53A	Splenectomy	250	7+T

OTHER OPERATIONS ON SPLEEN NEC

MISG	53.59	Other operations on spleen NEC (excision - bone button)	30	4+T

OTHER INCISION OF ESOPHAGUS

MASG	54.09	Other incision of esophagus		
		Esophagotomy		
		AP=CERV	120	6+T
		AP=THOR	180	13+T

OTHER LOCAL EXCISION OF ESOPHAGEAL DIVERTICULUM

MASG	54.22A	Excision intrathoracic diverticulum	240	
		AP=ABDO		7+T
		AP=CERV		6+T
		AP=THOR		13+T
MASG	54.22B	Excision extrathoracic diverticulum - one stage	180	
		AP=ABDO		7+T
		AP=CERV		6+T
		AP=THOR		13+T

TOTAL ESOPHAGECTOMY

MASG	54.33A	Resection of esophagus one stage	400	
		AP=ABDO		7+T
		AP=CERV		6+T
		AP=THOR		13+T

ESOPHAGOGASTROSTOMY (INTRATHORACIC)

MASG	54.42	Esophagogastrostomy (intrathoracic)	300	
		AP=ABDO		7+T
		AP=CERV		6+T
		AP=THOR		13+T

ESOPHAGEAL ANASTOMOSIS WITH INTERPOSITION OF SMALL BOWEL (INTRATHORACIC)

MASG	54.43	Esophageal anastomosis with interposition of small bowel (intrathoracic)	300	
		AP=ABDO		7+T
		AP=CERV		6+T
		AP=THOR		13+T

OTHER ESOPHAGOENTEROSTOMY (INTRATHORACIC)

MASG	54.44A	Esophageal bypass with colon/jejunum	350	
		AP=ABDO		7+T
		AP=CERV		6+T
		AP=THOR		13+T

ESOPHAGEAL ANASTOMOSIS WITH INTERPOSITION OF COLON (INTRATHORACIC)

MASG	54.45	Esophageal anastomosis with interposition of colon (intrathoracic)		
		RO=FPHN	400	
		RO=SPHN	100	
		RO=SNAS	115	
		AP=ABDO		7+T
		AP=CERV		6+T
		AP=THOR		13+T

ESOPHAGEAL ANASTOMOSIS WITH OTHER INTERPOSITION (INTRATHORACIC)

MASG	54.47	Esophageal anastomosis with other interposition (intrathoracic)		
		RO=FPHN	400	
		RO=SPHN	100	
		RO=SNAS	115	
		AP=ABDO		7+T
		AP=CERV		6+T
		AP=THOR		13+T
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

ESOPHAGOMYOTOMY

MASG	54.6	Esophagomyotomy	300	
		AP=ABDO		7+T
		AP=CERV		6+T
		AP=THOR		13+T
MASG	54.6A	Esophagomyotomy and valvuloplasty	350	
		AP=ABDO		7+T
		AP=CERV		6+T
		AP=THOR		13+T

INSERTION OF PERMANENT TUBE INTO ESOPHAGUS

MASG	54.71	Insertion of permanent tube into esophagus - introduction of Souter tube	75	4+T

SUTURE OF ESOPHAGUS

MASG	54.72	Suture of esophagus	300	
		Repair ruptured esophagus		
		AP=ABDO		7+T
		AP=CERV		6+T
		AP=THOR		13+T
MASG	54.72A	Repair ruptured esophagus - cervical drainage	175	
		AP=ABDO		7+T
		AP=CERV		6+T
		AP=THOR		13+T

REPAIR OF ESOPHAGEAL STRICTURE

MASG	54.75	Repair of esophageal stricture	250	
		AP=ABDO		7+T
		AP=CERV		6+T
		AP=THOR		13+T
MASG	54.75A	Thal Procedure	350	
		AP=ABDO		7+T
		AP=CERV		6+T
		AP=THOR		13+T

INJECTION OR LIGATION OF ESOPHAGEAL VARICES

MASG	54.91A	Esophageal varices with esophagoscopy	90	4+T
MASG	54.91D	Esophagotomy with ligation of varices	240	
		AP=ABDO		7+T
		AP=CERV		6+T
		AP=THOR		13+T
ADON	54.91E	Ligation of esophageal varices	50	
ADON	54.91F	Injection of esophageal varices	50	

DILATION OF ESOPHAGUS

MISG	54.92A	Dilation of esophagus indirect - active, with/without guiding string	28.5	4+T
MISG	54.92B	Dilation of esophagus - passive, using mercury filled tubes	9.5	4+T
MISG	54.92C	Pneumatic dilator	30	4+T
MISG	54.92D	Retrograde dilation	10	4+T
MASG	54.92E	Dilation of esophagus with esophagoscopy		
		RP=INTL	120	4+T

MISG	54.92E	Dilation of esophagus with esophagoscopy		
		RP=REPT	50	4+T
MISG	54.92F	Dilation of esophagus under fluoroscopic control	35	4+T

GASTROTOMY

MASG	55.0A	Gastrotomy with removal of foreign body	150	7+T

TEMPORARY GASTROSTOMY

MASG	55.1	Temporary gastrostomy	175	7+T

PERMANENT GASTROSTOMY

MASG	55.2	Permanent gastrostomy	200	7+T

PYLOROMYOTOMY

MASG	55.3	Pyloromyotomy	210	10+T
		CO=UN5K, RO=ANAE		15+T

OTHER LOCAL EXCISION OF LESION OR TISSUE OF STOMACH

MASG	55.43A	Gastrectomy - wedge resection for ulcer	185	7+T

PARTIAL GASTRECTOMY WITH ANASTOMOSIS TO ESOPHAGUS

MASG	55.5	Partial gastrectomy with anastomosis to esophagus	400	
		AP=ABDO		7+T
		AP=CERV		6+T
		AP=THOR		13+T

PARTIAL GASTRECTOMY WITH ANASTOMOSIS TO DUODENUM

MASG	55.6A	Gastrectomy		
		PO=PART	300	7+T
		PO=SBTL	300	7+T
MASG	55.6B	Antrectomy or subtotal gastrectomy - plus vagotomy	300	7+T
MASG	55.6C	Gastrectomy plus cholecystectomy at same time		
		PO=PART	350	7+T
		PO=SBTL	350	7+T
MASG	55.6D	Gastrectomy plus repair of hiatus hernia		
		PO=PART	350	7+T
		PO=SBTL	350	7+T
MASG	55.6E	Gastrectomy after previous gastroenterostomy or partial gastrectomy	350	7+T

PARTIAL GASTRECTOMY WITH ANASTOMOSIS TO JEJUNUM

MASG	55.7A	Antrectomy or subtotal gastrectomy - plus vagotomy	300	7+T
MASG	55.7B	Gastrectomy plus repair of hiatus hernia		
		PO=PART	350	7+T
		PO=SBTL	350	7+T
MASG	55.7C	Roux-en-y Anastomosis	240	7+T
MASG	55.7D	Gastrectomy after previous gastroenterostomy or partial gastrectomy	350	7+T

OTHER PARTIAL GASTRECTOMY

MASG	55.8A	Gastrogastrostomy	180	7+T
MASG	55.8B	Gastrogastrostomy plus vagotomy	240	7+T

OTHER TOTAL GASTRECTOMY

MASG	55.99	Other total gastrectomy	350	7+T

VAGOTOMY

MASG	56.0	Vagotomy		
		AP=ABDO	180	7+T
		AP=THOR	240	7+T

SELECTIVE VAGOTOMY

MASG	56.03	Selective vagotomy	245	7+T

PYLOROPLASTY

MASG	56.1	Pyloroplasty	180	7+T
MASG	56.1A	Pyloroplasty and vagotomy	240	7+T

GASTROENTEROSTOMY (WITHOUT GASTRECTOMY)

MASG	56.2A	Gastroduodenostomy or gastrojejunostomy	180	7+T
MASG	56.2B	Gastroduodenostomy or gastrojejunostomy plus vagotomy	240	7+T

REVISION OF GASTRIC ANASTOMOSIS

MASG	56.4A	Excision of gastroduodenal lesion (recurrent ulcer)	350	7+T
MASG	56.4B	Excision of gastro-jejunal lesion (recurrent ulcer)	350	7+T
MASG	56.4C	Excision of gastro-jejunal lesion (recurrent ulcer) plus vagotomy	400	7+T
MASG	56.4D	Excision of gastroduodenal lesion (recurrent ulcer) plus vagotomy	400	7+T
MASG	56.4E	Conversion of Billroth II to Billroth I	375	7+T

SUTURE OF STOMACH

MASG	56.51	Suture of stomach	180	7+T

CLOSURE OF GASTROSTOMY

MASG	56.52	Closure of gastrostomy	150	5+T

CLOSURE OF OTHER GASTRIC FISTULA

MASG	56.53A	Closure of gastrocolic/gastro-jejuno-colic fistula - one stage	350	7+T
MASG	56.53B	Closure of gastrocolic/gastro-jejuno-colic fistula including colostomy - two stages	350	7+T

OTHER REPAIR OF STOMACH NEC

MASG	56.59A	Collis gastroplasty	400	13+T

GASTRIC PARTITIONING FOR OBESITY

MASG	56.93	Gastric partitioning for obesity - prior approval	300	10+T
MASG	56.93A	Reversal of gastroplasty	300	10+T

INCISION OF LARGE INTESTINE

MASG	57.04A	Enterotomy or colotomy - single	180	6+T
MASG	57.04B	Multiple colotomy with operative sigmoidoscopy	240	6+T

OTHER LOCAL EXCISION OR DESTRUCTION OF LESION OR TISSUE OF DUODENUM

MASG	57.12	Other local excision or destruction of lesion or tissue of duodenum	200	6+T

OTHER LOCAL EXCISION OR DESTRUCTION OF LESION OR TISSUE OF SMALL INTESTINE, EXCEPT DUODENUM

MASG	57.14	Other local excision or destruction of lesion or tissue of small intestine, except duodenum	200	6+T
MASG	57.14A	Meckel's diverticulum	175	6+T

OTHER PARTIAL RESECTION OF SMALL INTESTINE

MASG	57.42A	Enterectomy with anastomosis - small intestine - duodenectomy	240	6+T
MASG	57.42B	Enterectomy with anastomosis - small intestine - other	240	6+T

CAECECTOMY

MASG	57.52A	Terminal ileum, caecum and ascending colon	300	6+T

RIGHT HEMICOLECTOMY

MASG	57.53	Right hemicolectomy	300	7+T
MASG	57.53A	Excision of terminal ileum plus caecum	300	6+T

LEFT HEMICOLECTOMY

MASG	57.55	Left hemicolectomy	300	7+T

OTHER PARTIAL EXCISION OF LARGE INTESTINE

MASG	57.59	Other partial excision of large intestine	300	6+T
MASG	57.59A	Laparoscopic assisted colectomy; right, left, or segmental		
		RG=ASCE	350	8+T
		RG=DESC	350	8+T
		RG=OTSE	350	8+T
MASG	57.59B	Low anterior resection of rectosigmoid with low pelvic anastomosis (coloproctostomy)		
		RO=FPHN	405	8+T
		RO=SPHN	300	8+T

TOTAL COLECTOMY

MASG	57.6A	Enterectomy with colostomy, caecostomy or ileostomy, resection of colon, total colectomy with ileostomy and abdominal perineal resection	550	8+T
		RO=ABAS	169	8+T
		RO=ABDM	500	8+T
		RO=PEAS	68	8+T
		RO=PRIN	200	8+T
MASG	57.6B	Total colectomy without perineal resection	400	8+T
MASG	57.6C	Laparoscopic Total Colectomy	500	8+T
MASG	57.6D	Total proctocolectomy with ileostomy and abdominal perineal resection		
		RO=FPHN	550	8+T
		RO=SPHN	400	8+T

SMALL-TO-SMALL INTESTINAL ANASTOMOSIS

MASG	57.7A	Entero-enterostomy - plus multiples, if applicable	180	6+T
MASG	57.7B	Duodenal atresia-duodeno-jejunostomy	200	6+T

BRUSH BIOPSY OF SMALL INTESTINE

MISG	57.91	Brush biopsy of small intestine	50	
ADON	57.94A	Colonic biopsy during pull through operation for Hirschsprung's Disease (maximum 3 biopsies) - plus multiples, if applicable	25	

EXTERIORIZATION OF SMALL INTESTINE

ADON	58.01A	Ileostomy (loop or defunctioning)	90	
		RO=SPHN	67.50	

EXTERIORIZATION OF LARGE INTESTINE

MASG	58.03	Exteriorization of large intestine - first stage Mikulicz	180	6+T

COLOSTOMY, UNQUALIFIED

MASG	58.11	Colostomy, unqualified	175	6+T
MASG	58.11A	Caecostomy - as single procedure	120	6+T
MASG	58.11B	Colostomy within one month of definitive procedure	100	6+T

ILEOSTOMY, UNQUALIFIED

MASG	58.21A	Ileostomy for ulcerative colitis	180	6+T
MASG	58.21B	Continent ileostomy	450	6+T

OTHER ENTEROSTOMY NEC

MASG	58.39A	Ileostomy/jejunostomy with tube	175	6+T

REVISION OF INTESTINAL STOMA, UNQUALIFIED

MASG	58.41A	Revision of colostomy/ileostomy	65	6+T
MASG	58.41B	Revision for stenosis/obstruction more than 4 weeks after original operation	75	6+T
MASG	58.41C	Revision of ileostomy	60	6+T

OTHER REVISION OF STOMA OF LARGE INTESTINE

MASG	58.44A	Revision of colostomy/ileostomy	65	6+T
MASG	58.44B	Revision for stenosis/obstruction more than 4 weeks after original operation	75	6+T

CLOSURE OF STOMA OF SMALL INTESTINE

MASG	58.52A	Closure of enterostomy plus resection	200	6+T

CLOSURE OF STOMA OF LARGE INTESTINE

MASG	58.53	Closure of stoma of large intestine - closure of colostomy	200	5+T

OTHER SUTURE OF SMALL INTESTINE, EXCEPT DUODENUM

MASG	58.73	Other suture of small intestine, except duodenum	150	6+T

SUTURE OF LARGE INTESTINE

MASG	58.75A	Closure of perforation	150	6+T
MASG	58.75B	Closure of perforation with colostomy	250	6+T

CLOSURE OF FISTULA OF LARGE INTESTINE

MASG	58.76A	Repair of faecal fistula, radical with resection	250	6+T

CORRECTION OF VOLVULUS/INTUSSUSCEPTION

MASG	58.81	Correction of volvulus/intussusception	185	6+T

APPENDECTOMY

MASG	59.0	Appendectomy (when an appendectomy is claimed with other abdominal surgery, a pathology report is required)	175	6+T

DRAINAGE OF APPENDICEAL ABSCESS

MASG	59.1	Drainage of appendiceal abscess	120	6+T

PROCTOTOMY

MASG	60.0A	Proctotomy with exploration	60	4+T
MASG	60.0B	Proctotomy with decompression (imperforate anus)	60	4+T
MASG	60.0C	Proctotomy with drainage (perirectal abscess)	60	4+T
MASG	60.0D	Pelvic abscess – drainage	75	4+T

PROCTOSTOMY

MASG	60.1	Proctostomy	150	4+T

FULGURATION OF RECTAL LESION OR TISSUE (WITH CAUTERY)

MISG	60.21	Fulguration of rectal lesion or tissue (with cautery)	30	6+T
MASG	60.21A	Cauterization of small rectal carcinoma	75	4+T
MISG	60.21A	Cauterization of small rectal carcinoma RP=REPT (up to 30 days after initial procedure)	30	4+T

LOCAL EXCISION OF RECTAL LESION OR TISSUE

MISG	60.24A	Rectal or sigmoid polyp - low	30	4+T
MASG	60.24B	Rectal or sigmoid polyp - upper rectum and sigmoid	60	4+T
MASG	60.24C	Transanal Endoscopic Microsurgery *Physician Restrictions in Place (See Appendix J)	325	6+T

SOAVE SUBMUCOSAL RESECTION OF RECTUM

MASG	60.31B	Anterior resection, mucosectomy and coloanal anastomosis	450	8+T
		RO=ABAS	119	8+T
		RO=ABDM	350	8+T
		RO=PEAS	68	8+T
		RO=PRIN	200	8+T

OTHER PULL-THROUGH RESECTION OF RECTUM

MASG	60.39A	Abdominal - perineal pull through for Hirschsprung's Disease or imperforate anus	450	10+T
		RO=ABAS	135	10+T
		RO=ABDM	350	10+T
		RO=PEAS	108	10+T
		RO=PRIN	200	10+T
MASG	60.39B	Rectal atresia - perineal repair	240	4+T
MASG	60.39C	Rectal atresia - abdomino-perineal repair	450	8+T
		RO=ABAS	135	8+T
		RO=ABDM	350	8+T
		RO=PEAS	108	8+T
		RO=PRIN	200	8+T
MASG	60.39D	Abdomino-perineal repair with normal anal canal	450	8+T
		RO=ABAS	135	8+T
		RO=ABDM	350	8+T
		RO=PEAS	108	8+T
		RO=PRIN	200	8+T
MASG	60.39E	Repair of imperforate anus - membranous obstruction.	60	4+T

ABDOMINOPERINEAL RESECTION OF RECTUM

MASG	60.4B	Laparoscopic Assisted Abdominoperineal Resection *Physician Restrictions in Place (See Appendix J)	630	8+T
MASG	60.4C	Open abdominoperineal resection; complete proctectomy with colostomy		
		RO=FPHN	550	8+T
		RO=SPHN	400	8+T

OTHER ANTERIOR RESECTION

MASG	60.52	Other anterior resection	350	8+T
MISG	60.52A	Lower anterior resection where E.E.A. stapler is used		
		RO=SPHN	50	
MASG	60.52B	Laparoscopic assisted anterior resection		
		RO=FPHN *Physician Restrictions in Place (See Appendix J)	420	8+T
		RO=SPHN	315	8+T

POSTERIOR RESECTION

MASG	60.53	Posterior resection	240	6+T

HARTMANN RESECTION

MASG	60.55	Hartmann resection	325	8+T
MASG	60.55B	Sleeve resection villus adenoma and rectal mucosa	100	5+T

MASG	60.55C	Closure of Enterostomy, large or small intestine; with resection and colorectal/ Ileorectal anastomosis (eg, closure of Hartmann type procedure)	390	8+T

OTHER RESECTION OF RECTUM NEC

MASG	60.59A	Proctosigmoidectomy for prolapse	300	6+T
MASG	60.59B	Proctectomy with rectal mucosectomy, ileoanal anastomosis, and creation of ileal reservoir (Ileal Pouch Anal Astomosis)	630	8+T

SUTURE OF RECTUM

MASG	60.61	Suture of rectum		
		AP=EXTR	120	4+T
		AP=INPR	200	6+T

ABDOMINAL PROCTOPEXY

MASG	60.65	Abdominal proctopexy	180	6+T

OTHER PROCTOPEXY

MASG	60.66A	Rectal prolapse - excision of mucous membrane	90	4+T
MASG	60.66B	Rectal prolapse perineal repair major	180	4+T
MASG	60.66C	Rectal prolapse abdominal approach	250	6+T

INCISION OF PERIANAL ABSCESS

MISG	61.01	Incision of perianal abscess	25	
		AN=LOCL	25	
MISG	61.01A	Ischiorectal abscess	25	
		AN=LOCL	25	
MASG	61.01B	Unroofing	60	4+T

ANAL FISTULOTOMY

MISG	61.11A	Seton suture for post-operative fistula	25	4+T
MASG	61.11B	Fistula in-ano, low level	90	4+T
MASG	61.11C	Fistula in-ano, high with division of internal sphincter	180	4+T

LOCAL EXCISION OR DESTRUCTION OF OTHER LESION OR TISSUE OF ANUS

MASG	61.2	Local excision or destruction of other lesion or tissue of anus	60	4+T
MISG	61.2A	Cauterization of fissure	10	4+T

MISG	61.2B	Electro-desiccation of condylomata	25	4+T
MISG	61.2C	Local excision for malignancy	30	4+T
MISG	61.2D	Excision biopsy of anus		
		AN=GENL	20	4+T

EXCISION OF HEMORRHOIDS

MASG	61.36A	Hemorrhoidectomy with sigmoidoscopy and excision of fissure	90	4+T

EVACUATION OF THROMBOSED HEMORRHOIDS

MISG	61.37	Evacuation of thrombosed hemorrhoids - plus multiples, if applicable	22.5	
		AN=GENL	35	4+T
		AN=LOCL	22.5	

OTHER PROCEDURES ON HEMORRHOIDS

MISG	61.39A	Excision of anal polyp, hemorrhoidal tags	30	4+T

DIVISION OF ANAL SPHINCTER

MASG	61.4A	Internal sphincterotomy plus excision of fissure	85	4+T

OTHER REPAIR OF ANUS AND ANAL SPHINCTER

MASG	61.69B	Rectal prolapse - Thiersch Wire Procedure	60	4+T
MASG	61.69C	Excision of scar, for stenosis	60	4+T
MASG	61.69D	Anoplasty - for stenosis	120	4+T
MASG	61.69E	Repair of anal sphincter	150	4+T
MASG	61.69F	Repair of anal sphincter and anorectal ring	200	4+T
MASG	61.69G	Comprehensive anal sphincteroplasty for the treatment of anal incontinence	220	4+T

HEPATOTOMY

MASG	62.0	Hepatotomy	180	7+T
MASG	62.0A	Drainage of abscess/cyst of liver	180	7+T
MASG	62.0B	Removal of foreign body of liver	180	7+T
MASG	62.0C	Incision and packing of wound of liver	180	7+T

MARSUPIALIZATION OF LESION OF LIVER

MASG	62.11	Marsupialization of lesion of liver	185	7+T

PARTIAL HEPATECTOMY

MASG	62.12	Partial hepatectomy - local excision of lesion	200	7+T
ADON	62.12A	Open liver biopsy	25	

LOBECTOMY OF LIVER

MASG	62.2	Lobectomy of liver	475	12+T

OTHER TRANSPLANT OF LIVER

MASG	62.49	Other transplant of liver		
		RO=FPHN	1450	45+T
		RO=SPHN		460
		RO=SSAN		Time Only
MASG	62.49A	Recipient hepatectomy		
		RO=FPHN	1000	
		RO=SPHN	460	
MASG	62.49B	Donor hepatectomy		
		RO=FPHN	500	20+T
		RO=SPHN	350	20+T

SUTURE OF LIVER

MASG	62.51	Suture of liver	185	8+T

OTHER CHOLECYSTOTOMY AND CHOLECYSTOSTOMY

MASG	63.09	Other cholecystotomy and cholecystostomy	175	7+T

TOTAL CHOLECYSTECTOMY

MASG	63.12	Total cholecystectomy	235	7+T
MASG	63.12A	Cholecystectomy and exploration of bile duct	275	7+T
MASG	63.12B	Cholecystectomy with operative cholangiogram	260	7+T
MASG	63.12C	Cholecystectomy and exploration of bile duct with operative cholangiogram	300	7+T
MASG	63.12D	Cholecystectomy and exploration of bile duct plus duodenostomy	300	7+T

ANASTOMOSIS OF GALLBLADDER TO INTESTINE

MASG	63.22	Anastomosis of gallbladder to intestine	180	7+T
MASG	63.22A	Cholecystenterostomy plus enteroenterostomy	250	7+T

ANASTOMOSIS OF GALLBLADDER TO STOMACH

MASG	63.24	Anastomosis of gallbladder to stomach	180	7+T

ANASTOMOSIS OF COMMON BILE DUCT TO INTESTINE

MASG	63.26	Anastomosis of common bile duct to intestine	240	7+T
MASG	63.26A	Choledochojejunostomy with roux-en-y loop	300	8+T

COMMON DUCT EXPLORATION FOR REMOVAL OF CALCULUS

MASG	63.31A	Common duct exploration with duodenotomy, sphincterotomy and removal of stone	300	7+T

INCISION OF COMMON DUCT

MASG	63.41	Incision of common duct - common duct exploration	240	7+T

EXCISION OF AMPULLA OF VATER (WITH REIMPLANTATION OF COMMON DUCT)

MASG	63.52	Excision of ampulla of vater (with reimplantation of common duct)	275	7+T

OTHER EXCISION OF COMMON DUCT

MASG	63.53	Other excision of common duct choledochectomy	300	7+T

EXCISION OF OTHER BILE DUCT

MASG	63.59	Excision of other bile duct lesion of hepatic ducts	275	7+T

CHOLEDOCHOPLASTY

MASG	63.62	Choledochoplasty	400	7+T

REPAIR OF OTHER BILE DUCTS

MASG	63.69A	Biliary tract - closure of fistula	275	7+T
MASG	63.69B	Repair of hepatic duct injuries by jejunal mucosal grafting (regions required)	500	8+T

OTHER PANCREATOTOMY

MASG	64.09	Other pancreatotomy	200	7+T

LOCAL EXCISION OR DESTRUCTION OF LESION OR TISSUE OF PANCREAS AND PANCREATIC DUCT

MASG	64.1	Local excision or destruction of lesion or tissue of pancreas and pancreatic duct	240	7+T
MASG	64.1A	Islet cell tumour	240	7+T
MASG	64.1B	Excision of pancreatic cyst	240	7+T

MARSUPIALIZATION OF PANCREATIC CYST

MASG	64.2	Marsupialization of pancreatic cyst	200	7+T

INTERNAL DRAINAGE OF PANCREATIC CYST

MASG	64.3	Internal drainage of pancreatic cyst	200	7+T

DISTAL PANCREATECTOMY

MASG	64.42	Distal pancreatectomy	240	7+T

TOTAL PANCREATECTOMY

MASG	64.5	Total pancreatectomy	500	9+T
MASG	64.5A	Donor pancreatectomy	500	10+T

RADICAL PANCREATICODUODENECTOMY

MASG	64.6	Radical pancreaticoduodenectomy	500	9+T

ANASTOMOSIS OF PANCREAS (DUCT)

MASG	64.7A	Pancreaticogastrostomy - duodenostomy - jejunostomy	240	7+T
MASG	64.7B	Pancreaticogastrostomy	240	7+T
MASG	64.7C	Pancreaticogastrostomy - duodenostomy	240	7+T
MASG	64.7D	Puestow Procedure	400	9+T

PANCREATIC TRANSPLANT, UNQUALIFIED

MASG	64.81A	Implantation of pancreas	460	10+T

REPAIR OF INGUINAL HERNIA, UNQUALIFIED

MASG	65.01	Repair of inguinal hernia, unqualified (regions required)	140	4+T
MASG	65.01A	Repair of inguinal hernia with hydrocoele (regions required)	160	4+T
MASG	65.01B	Strangulated/incarcerated hernia - without resection (regions required) - plus multiples, if applicable	160	8+T
MASG	65.01C	Strangulated/incarcerated hernia - with resection (regions required) - plus multiples, if applicable	250	8+T
MASG	65.01D	Recurrent hernia (regions required)	200	4+T
MASG	65.01E	Sliding hernia (regions required)	140	4+T
MASG	65.01F	Repair of inguinal hernia, unqualified, by laparoscopy (regions required)	140	6+T
MASG	65.01G	Repair of inguinal hernia, unqualified, by laparoscopy with hydrocoele (Regions required)	160	6+T
MASG	65.01H	Strangulated/incarcerated hernia - without resection - by laparoscopy (Regions required) - plus multiples, if applicable	160	8+T
MASG	65.01I	Recurrent hernia - by laparoscopy (regions required)	200	6+T
MASG	65.01J	Sliding hernia - by laparoscopy (regions required)	140	6+T

REPAIR OF FEMORAL HERNIA

MASG	65.04	Repair of femoral hernia (regions required)	140	4+T
MASG	65.04A	Strangulated/incarcerated hernia - without resection (Regions required) - plus multiples, if applicable	160	8+T
MASG	65.04B	Strangulated/incarcerated hernia - with resection (Regions required) - plus multiples, if applicable	250	8+T
MASG	65.04C	Recurrent hernia (regions required)	200	4+T
MASG	65.04D	Repair of femoral hernia by laparoscopy (regions required)	140	6+T
MASG	65.04E	Strangulated/incarcerated hernia - without resection - by laparoscopy (Regions required) - plus multiples, if applicable	160	8+T
MASG	65.04F	Recurrent hernia - by laparoscopy (regions required)	200	6+T
MASG	65.04G	Repair of inguinal and femoral hernia - same side (regions required)	160	4+T

REPAIR OF INGUINAL HERNIA, UNQUALIFIED, WITH GRAFT OR PROSTHESIS

MASG	65.11	Repair of inguinal hernia, unqualified, with graft or prosthesis (Regions required)	160	4+T
MASG	65.11A	Recurrent hernia repair by prosthesis or graft (regions required)	210	4+T

REPAIR OF FEMORAL HERNIA WITH GRAFT OR PROSTHESIS

MASG	65.14	Repair of femoral hernia with graft or prosthesis (regions required)	160	4+T
MASG	65.14A	Recurrent hernia repair by prosthesis or graft (regions required)	210	4+T

BILATERAL REPAIR OF INGUINAL HERNIA, UNQUALIFIED

MASG	65.21	Bilateral repair of inguinal hernia, unqualified	210	4+T
MASG	65.21A	Bilateral repair of inguinal hernia, unqualified, with hydrocoele	240	4+T
MASG	65.21B	Strangulated/incarcerated hernia - without resection	240	8+T
MASG	65.21C	Strangulated/incarcerated hernia - with resection	375	8+T
MASG	65.21D	Recurrent hernia	300	4+T
MASG	65.21E	Sliding hernia	210	4+T
MASG	65.21F	Bilateral repair of inguinal hernia, unqualified by laparoscopy	210	6+T
MASG	65.21G	Bilateral repair of inguinal hernia, unqualified by laparoscopy with hydrocoele	240	6+T
MASG	65.21H	Strangulated/incarcerated hernia - without resection - by laparoscopy	240	8+T

MASG	65.21I	Recurrent hernia - by laparoscopy	300	6+T
MASG	65.21J	Sliding hernia - by laparoscopy	210	6+T

BILATERAL REPAIR OF FEMORAL HERNIA

MASG	65.25	Bilateral repair of femoral hernia	210	4+T
MASG	65.25A	Strangulated/incarcerated hernia - without resection	240	8+T
MASG	65.25B	Strangulated/incarcerated hernia - with resection	375	8+T
MASG	65.25C	Recurrent hernia	300	4+T
MASG	65.25D	Bilateral repair of femoral hernia by laparoscopy	210	6+T
MASG	65.25E	Strangulated/incarcerated hernia - without resection - by laparoscopy	240	8+T
MASG	65.25F	Recurrent hernia - by laparoscopy	300	6+T
MASG	65.25G	Repair of inguinal and femoral hernia (both), each side	240	4+T

BILATERAL REPAIR OF INGUINAL HERNIA, UNQUALIFIED, WITH GRAFT OR PROSTHESIS

MASG	65.31	Bilateral repair of inguinal hernia, unqualified, with graft or prosthesis	240	4+T
MASG	65.31A	Recurrent hernia repair by prosthesis or graft	315	4+T

BILATERAL REPAIR OF FEMORAL HERNIA WITH GRAFT OR PROSTHESIS

MASG	65.35	Bilateral repair of femoral hernia with graft or prosthesis	240	4+T
MASG	65.35A	Recurrent hernia repair by prosthesis or graft	315	4+T

REPAIR OF UMBILICAL HERNIA WITH PROSTHESIS

MASG	65.41A	Recurrent umbilical hernia repair with prosthesis or graft	210	4+T

OTHER REPAIR OF UMBILICAL HERNIA

MASG	65.49	Other repair of umbilical hernia		
		AG=ADUT	150	4+T
		AG=CH16	90	4+T
MASG	65.49A	Strangulated/incarcerated hernia - without resection - plus multiples, if applicable	160	8+T
MASG	65.49B	Strangulated/incarcerated hernia - with resection - plus multiples, if applicable	250	8+T
MASG	65.49C	Omphalocoele - infant	250	10+T
MASG	65.49D	Recurrent hernia	200	4+T
MASG	65.49E	Strangulated/incarcerated hernia - without resection - by laparoscopy - plus multiples, if applicable	160	8+T

MASG	65.49F	Recurrent hernia - by laparoscopy	200	6+T

REPAIR OF INCISIONAL HERNIA

MASG	65.51	Repair of incisional hernia	200	6+T
MASG	65.51A	Recurrent hernia	200	4+T
MASG	65.51B	Incisional hernia post-operative repair by prosthesis	210	6+T
MASG	65.51D	Initial ventral or incisional hernia repair by laparoscopy, reducible or strangulated, with mesh, with or without enterolysis	220	6+T
MASG	65.51E	Reccurent verntral or incisional hernia repair, by laparoscopy, reducible Or strangulated, with mesh, with or without enterolysis	325	6+T

REPAIR OF OTHER HERNIA OF ANTERIOR ABDOMINAL WALL

MASG	65.59A	Recurrent hernia	200	4+T
MASG	65.59B	Epigastric hernia	140	4+T
MASG	65.59D	Total Abdominal Wall Reconstruction with myofascial advancement flaps	IC 130/hr	8+T

REPAIR OF DIAPHRAGMATIC HERNIA, ABDOMINAL APPROACH

MASG	65.7	Repair of diaphragmatic hernia, abdominal approach	240	9+T
MASG	65.7A	Recurrent hiatal hernia repair, abdominal approach	375	9+T
MASG	65.7B	Pyloroplasty/gastroenterostomy with vagotomy and hiatal hernia	300	7+T
MASG	65.7C	Diaphragmatic hernia with prosthesis	275	9+T
MASG	65.7D	Esophageal hiatus hernia	250	7+T

REPAIR OF DIAPHRAGMATIC HERNIA, THORACIC APPROACH

MASG	65.8	Repair of diaphragmatic hernia, thoracic approach	240	13+T
MASG	65.8A	Recurrent hiatal hernia repair, thoracic approach	375	13+T
MASG	65.8B	Belsey Procedure - modified/straight	325	13+T
MASG	65.8C	Esophageal hiatus hernia	275	13+T
MASG	65.8D	Repair of diaphragmatic hernia, thoracic approach with prosthesis	275	13+T

INCISION OF ABDOMINAL WALL

COCR	66.0A	Drainage of abdominal wall abscess AN=GENL	30	4+T
MAAS	66.0B	Gun shot - removal foreign body, abdominal wall	IC	IC+T

OTHER LAPAROTOMY

MASG	66.19	Other laparotomy	175	6+T
MASG	66.19A	Lap with insertion of zipper fastener	100	6+T
MASG	66.19B	Drainage of subphrenic abscess	180	7+T
MASG	66.19C	Drainage of abdominal abscess	180	6+T

EXCISION OR DESTRUCTION OF LESION OR TISSUE OF ABDOMINAL WALL OR UMBILICUS

MASG	66.2A	Umbilectomy - plastic	60	4+T

EXCISION OR DESTRUCTION OF LESION OR TISSUE OF PERITONEUM

MASG	66.3	Excision or destruction of lesion or tissue of peritoneum	175	6+T
MASG	66.3B	Resection of mesentery	175	6+T
MAAS	66.3C	Excision of desmoid tumour	IC	4+T
MASG	66.3D	Excision of mesenteric cyst	175	6+T

FREEING OF PERITONEAL ADHESIONS

MASG	66.4A	Intestinal obstruction - without resection	250	8+T
MASG	66.4B	Intestinal obstruction - with resection	300	8+T
MASG	66.4C	Intestinal obstruction - two stage with enterostomy, resection and subsequent closure	300	8+T

RECLOSURE OF POST-OPERATIVE DISRUPTION OF ABDOMINAL WALL

MASG	66.51A	Secondary closure for evisceration	115	6+T

PLICATION OF (SMALL) INTESTINE

MASG	66.61	Plication of (small) intestine	240	6+T

REPAIR OF GASTROSCHISIS

MASG	66.63	Repair of gastroschisis	100	10+T

OTHER REPAIR OF ABDOMINAL WALL

MASG	66.64A	Omental flap to repair extra-abdominal defect - abdominal surgery	250	IC+T
MASG	66.64B	Omental flap to repair extra-abdominal defect - plastic surgery	150	IC+T

BIOPSY OF PERITONEUM

ADON	66.82A	Omental biopsy	25	

LAPAROSCOPY

MASG	66.83	Laparoscopy	88	6+T
		ME=LASR	138	6+T
		ME=ELEC	138	6+T

CREATION OF PERITONEOVASCULAR SHUNT

MASG	66.94	Creation of peritoneovascular shunt	175	6+T

PERITONEAL DIALYSIS

MASG	66.98C	Laparotomy for insertion of peritoneal catheter	125	6+T
MASG	66.98D	Laparotomy for removal of peritoneal catheter	125	6+T

OTHER OPERATIONS IN ABDOMINAL REGION NEC

MASG	66.99A	Excision of retroperitoneal tumour	300	7+T
MAAS	66.99B	Cytoreductive Surgery with or without perioperative intraperitoneal chemotherapy (Sugarbaker Procedure)	IC at 175MSU/hr	12+T

REPAIR OF OTHER FISTULA OF BLADDER

MASG	69.73A	Closure of recto-vesical or rectro-vaginal fistula - including colostomy and closing of colostomy	300	6+T
MASG	69.73G	Closure of fistula recto-vesical	200	6+T
ADON	69.77A	Duodenal neocystotomy of a pancreas	180	

ASPIRATION BIOPSY OF OVARY

MISG	77.81A	Transvaginal ultrasound - guided needle aspiration of endometrium or simple ovarian cyst		
		SP=GNSG	35	
		SP=OBGY	35	

TOTAL SALPINGECTOMY (UNILATERAL)

MASG	78.1A	Salpingectomy for morbidity, not for sterilization (regions required)	130	6+T

OTHER BILATERAL ENDOSCOPIC DESTRUCTION OR OCCLUSION OF FALLOPIAN TUBES

MASG	78.39A	Interruption or removal of fallopian tubes for the purpose of sterilization: abdominal, vaginal, laparoscopic-not hysteroscopic (unilateral or bilateral)	105	6+T

PELVIC EVISCERATION

MASG	80.7	Pelvic evisceration		
		AP=ANTE	600	8+T
		AP=POST	600	8+T
		PO=COML	750	8+T

REPAIR OF FISTULA OF VAGINA

MASG	82.62	Repair of fistula of vagina	200	6+T

CERVICAL CAESAREAN SECTION

OBST	86.1	Cervical caesarean section		
		SP=GNSG	260	7+T
		SP=OBGY	260	7+T
		-plus multiples, if applicable	35	
		CO=INFE		10+T
OBST	86.1A	Caesarean section with tubal ligation		
		SP=GNSG	280	7+T
		SP=OBGY	280	7+T
		-plus multiples if applicable	35	
		CO=INFE		7+T

REMOVAL OF INTRAPERITONEAL EMBRYO

MASG	86.3A	Surgical removal of extrauterine (ectopic) pregnancy - by any means (regions required)	130	6+T

DELIVERY NEC

OBST	87.98	Delivery NEC		
		RF=REFD	200	4+T
		Multiple vaginal births - each additional		
		- plus multiples, if applicable	65	

DIVISION OF OTHER FACIAL BONE

MASG	88.72A	Maxillectomy for carcinoma	300	10+T

OTHER PARTIAL OSTECTOMY, UNSPECIFIED SITE

MASG	89.79B	Excision elongated styloid process via neck exploration external	150	4+T

TOTAL OSTECTOMY, SCAPULA, CLAVICLE AND THORAX (RIBS AND STERNUM)

MASG	89.80A	First rib resection with thoracotomy	250	13+T
MASG	89.80D	First rib resection	230	9+T

OTHER REPAIR OR PLASTIC OPERATION ON BONE

MASG	90.4A	Reclosure of sternal wound	150	9+T
MASG	90.4B	Resternotomy for post-op hemorrhage	150	20+T

OTHER REPAIR OR PLASTIC OPERATION ON BONE OTHER REPAIR OR PLASTIC OPERATION ON BONE, SCAPULA, CLAVICLE, AND THORAX (RIBS AND STERNUM)

MASG	90.40B	Repair of Sternal Non-union	750	20+T

INCISION AND DRAINAGE OF PALMAR AND THENAR SPACE

MASG	94.04	Incision and drainage of palmar and thenar space		
		AN=GENL (regions required)	80	4+T
		AN=REGL (regions required)	80	4+T

INCISION OF OTHER SOFT TISSUE

MASG	95.09A	Incision abscess – plantar space		
		AN=GENL (regions required)	80	4+T
		AN=REGL (regions required)	80	4+T

EXCISION OF LESION OF OTHER SOFT TISSUE

MISG	95.29B	Tru cut needle biopsy	38	

MASTOTOMY

COCR	97.0A	Incision and drainage of intramammary abscess single or multiloculated		
		RP=INTL (regions required)	40	4+T
		RP=REPT (regions required)	40	4+T

LOCAL EXCISION OF LESION OF BREAST

MASG	97.11	Local excision of lesion of breast (regions required)		
		- plus multiples, if applicable	62	4+T
MASG	97.11A	Excisional biopsy of breast - with imaging control (regions required)	100	4+T
		- plus multiples, if applicable		
MASG	97.11B	Lumpectomy for breast tumour (regions required)		
		- plus multiples, if applicable	75	4+T

UNILATERAL COMPLETE MASTECTOMY

MASG	97.12	Unilateral complete mastectomy		
		ME=SIMP, SE=FEML (regions required)	135	4+T
		ME=SIMP, SE=MALE (regions required)	120	4+T

BILATERAL COMPLETE MASTECTOMY

MASG	97.13	Bilateral complete mastectomy		
		ME=SIMP, SE=FEML	202.5	4+T
		ME=SIMP, SE=MALE	180	4+T

UNILATERAL EXTENDED SIMPLE MASTECTOMY

MASG	97.14	Unilateral extended simple mastectomy		
		ME=RADI (regions required)	280	6+T
ADON	97.14A	Where skin graft is necessary add to simple mastectomy or radical or modified radical mastectomy (regions required)	50	

BILATERAL EXTENDED SIMPLE MASTECTOMY

MASG	97.15	Bilateral extended simple mastectomy		
		ME=RADI	420	6+T
		May not be billed with 52.89E or 52.42		

ADON	97.15A	Where skin graft is necessary add to simple mastectomy or radical or modified radical mastectomy RG=BOTH 75		

RESECTION OF QUADRANT OF BREAST

MASG	97.27	Resection of quadrant of breast (regions required) 110		4+T
MASG	97.27A	Quadrant resection, lumpectomy, radical mastectomy with axillary dissection .. 280 (Regions required)		6+T

UNILATERAL REDUCTION MAMMOPLASTY

MASG	97.31A	Unilateral mammoplasty with nipple transplantation (regions required) ..... 163 - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition		8+T
MASG	97.31C	Unilateral functional pedicled breast reduction (regions required)..... 250 - prior approval unless performed for malignant or pre-malignant conditions		8+T

BILATERAL REDUCTION MAMMOPLASTY

MASG	97.32	Bilateral reduction mammoplasty ..... 244.5 - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition		8+T
MASG	97.32B	Bilateral functional pedicled breast reduction ..... 375 - prior approval unless performed for malignant or pre-malignant conditions		8+T

UNILATERAL AUGMENTATION MAMMOPLASTY BY IMPLANT OR GRAFT

MASG	97.43	Unilateral augmentation mammoplasty by implant or graft (regions required) .. 128 - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition		5+T

BILATERAL AUGMENTATION MAMMOPLASTY BY IMPLANT OR GRAFT

MASG	97.44	Bilateral augmentation mammoplasty by implant or graft ..... 192 - prior approval unless procedure is post-mastectomy for malignant or pre-malignant condition		5+T

INCISION OF PILONIDAL SINUS OR CYST

COCR	98.02	Incision of pilonidal sinus or cyst AN=GENL..... 30		4+T
MISG	98.02	Incision of pilonidal sinus or cyst ..... 25 AN=LOCL 25		4+T

OTHER INCISION WITH DRAINAGE OF SKIN AND SUBCUTANEOUS TISSUE

MISG	98.03A	Incision abscess, subcutaneous - boil, carbuncle, infected cyst, superficial lymphadenitis, paronychia, felon, etc. AN=GENL..... 25		4+T

MISG	98.03C	Incision of hematoma	28	
		AN=GENL	40	4+T
		AN=LOCL	28	

INCISION WITH REMOVAL OF FOREIGN BODY OF SKIN AND SUBCUTANEOUS TISSUE

MISG	98.04	Incision with removal of foreign body of skin and subcutaneous tissue	27.5	
		AN=GENL	27.5	4+T
		AN=LOCL	27.5	
MISG	98.04B	Removal of complicated foreign body - plus multiples, if applicable		
		AN=GENL	50	4+T

DEBRIDEMENT OF WOUND OR INFECTED TISSUE

MAAS	98.11	Debridement of wound or infected tissue		
		ME=COMP	IC	IC+T
MASG	98.11A	Excision of stasis ulcer and skin graft (regions required)	81.6	4+T

LOCAL EXCISION OR DESTRUCTION OF LESION OR TISSUE OF SKIN AND SUBCUTANEOUS TISSUE

MISG	98.12A	Removal of fibroma - plus multiples, if applicable	27.5	
		AN=GENL	27.5	4+T
		AN=LOCL	27.5	
MISG	98.12B	Carcinoma of skin - local excision, primary closure - plus multiples, if applicable	40	4+T
MASG	98.12F	Excision - lipoma - complicated, large and involving deeper structures	65	4+T
MASG	98.12H	Excision - dermoid cyst - face/skull	96	4+T
MISG	98.12M	Curettage of plantar warts, junctional nevi or molluscum contagiosum - plus multiples, if applicable	14	4+T
MISG	98.12N	Excision of plantar warts, junctional nevi or molluscum contagiosum - plus multiples, if applicable	25	4+T
MISG	98.12O	Excision lip biopsy	20	4+T
MASG	98.12P	Lip shave	60	4+T
MISG	98.12Q	Wedge resection of lip, vermilion	33.6	4+T
MISG	98.12R	Destruction (dermabrasion) of single area (e.g., trauma scar) (Prior-Approval Required)	35	4+T
MAAS	98.12S	Extensive and complicated lesions	IC	4+T
MISG	98.12U	Cryotherapy of warts, including papillomata, keratosis, nevi, moles, pyogenic granulomata, etc., for malignant or recognized pre-malignant condition - includes clinical suspicion of malignancy - plus multiples, if applicable	12	

MISG	98.12V	Curettage of warts, including papillomata, keratosis, nevi, moles, pyogenic granulomata, etc., for malignant or recognized pre-malignant condition - includes clinical suspicion of malignancy - plus multiples, if applicable	12	4+T
MISG	98.12W	Simple excision of warts, including papillomata, keratosis, nevi, moles, pyogenic granulomata, etc., for malignant or recognized pre-malignant condition - includes clinical suspicion of malignancy - plus multiples, if applicable	20	4+T
MISG	98.12X	Electrocautery of warts, including papillomata, keratosis, nevi, moles, pyogenic granulomata, etc., for malignant or recognized pre-malignant condition - includes clinical suspicion of malignancy - plus multiples, if applicable	12	4+T
MISG	98.12Y	Excision sebaceous cyst on face/neck - infected or other medical reason for excision - plus multiples, if applicable	20	4+T
MISG	98.12Z	Excision sebaceous cyst on other area - infected or other medical reason for excision - plus multiples, if applicable	16	4+T

RADICAL EXCISION OF SKIN LESION

MASG	98.13A	Carcinoma of skin - local excision plus full/split thickness graft - plus multiples, if applicable	70	4+T
MASG	98.13B	Carcinoma of skin - local excision plus skin graft larger than 5 square inches	85	4+T
MASG	98.13C	Carcinoma of skin - local excision with rotation flaps - plus multiples, if applicable	192	4+T
MISG	98.13D	Excision of hemangioma under general anaesthesia	50	4+T
MASG	98.13E	Excision of hydradenitis suppurative (regions required)	100	4+T
MASG	98.13F	Wedge resection of lip, vermilion to sulcus	90	4+T
MASG	98.13G	V-excision for carcinoma of lip - plus radical neck dissection	350	10+T
MASG	98.13H	V-excision for carcinoma of lip - 1/2 lip - plus reconstruction	150	4+T
MASG	98.13I	V-excision for carcinoma of lip - 1/2 lip - plus radical neck dissection	375	10+T
MASG	98.13J	Total excision of carcinoma of lip plus reconstruction	200	4+T
MASG	98.13K	Total excision carcinoma of lip plus reconstruction and radical neck dissection	375	10+T

EXCISION OF PILONIDAL SINUS OR CYST

MASG	98.14A	Simple excision or marsupialization of pilonidal cyst	100	4+T
MISG	98.22	Suture of skin and subcutaneous tissue of other sites - plus multiples, if applicable		
		ME=SIMP, AN=LOCL	11	
		ME=SIMP	11	
MISG	98.22A	Suture of simple wounds or lacerations - child's face - plus multiples, if applicable	17	4+T
MISG	98.22D	Suture minor laceration or foreign body wound - plus multiples, if applicable	20	
		AN=GENL	20	4+T
MISG	98.22F	Suture extensive laceration or foreign body wound - plus multiples, if applicable	50	
		AN=GENL	50	4+T

OTHER REPAIR AND RECONSTRUCTION OF SKIN AND SUBCUTANEOUS TISSUE NEC

MASG	98.79A	Reclosure of sternal wound	150	9+T

BIOPSY OF SKIN AND SUBCUTANEOUS TISSUE

MISG	98.81C	Biopsy of skin/mucosa - malignant or recognized pre-malignant condition or biopsy necessary for histological diagnosis for patient management	20	4+T
MISG	98.81D	Punch biopsy of skin or mucosa - malignant or recognized pre-malignant condition or biopsy necessary for histological diagnosis for patient management	15	

ASPIRATION OF SKIN AND SUBCUTANEOUS TISSUE

MISG	98.91A	Fine needle aspiration - plus multiples, if applicable	25	

REMOVAL OF NAIL, NAILBED OR NAILFOLD

MISG	98.96A	Excision of fingernail - radical, to include destruction of nail bed and shortening of phalanx, if necessary - plus multiples, if applicable	40	4+T
MISG	98.96B	Wedge resection toenail to include matrices (Regions required) - plus multiples, if applicable	30	
		AN=GENL	30	4+T
		AN=LOCL	30	
MISG	98.96C	Excision of fingernail - simple, complete, partial or wedge (Regions required) - plus multiples, if applicable	20	4+T
MISG	98.96D	Excision of toenail - simple, complete, partial or wedge (Regions required) - plus multiples, if applicable	20	4+T
MISG	98.96E	Excision of toenail - radical, to include destruction of nail bed and shortening of phalanx, if necessary (regions required) - plus multiples, if applicable	40	4+T

OTHER OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE NEC

MISG	98.99D	Excision lipoma - simple removal - large and causing interference with function - plus multiples, if applicable	20	
MISG	98.99E	Excision of simple neuroma - subcutaneous - large or causing interference with function - plus multiples, if applicable	20	
MISG	98.99F	Cryotherapy of plantar warts or molluscum contagiosum - plus multiples, if applicable	12	
MISG	98.99G	Electrocautery of plantar warts or molluscum contagiosum - plus multiples, if applicable	12	

SURGICAL PROCEDURES NOS

ADON	99.09A	Morbid obesity surgical add on	32.9	4.6

PREMIUM

ADON	AHSP1	After Hours Service Premium (extended service hours)	35%

UROLOGY

(SP=UROL)

CATEGORY	HEALTH SERVICE CODE	DESCRIPTION / MODIFIERS	BASE UNITS	ANAES UNITS
CONSULTATIONS				
CONS	03.08	Comprehensive Consultation		
		RF=REFD (ME=TELE)	35.6	
		RF=REFD, US=PREM (ME=TELE)	53.6	
		RF=REFD, US=PR50 (ME=TELE)	53.6	
		RF=REFD, RO=DETE (ME=TELE)	35.6+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	53.6+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	53.6+MU	
CONS	03.07	Limited Consultation		
		RF=REFD (ME=TELE)	26.1	
		RF=REFD, US=PREM (ME=TELE)	44.1	
		RF=REFD, US=PR50 (ME=TELE)	44.1	
		RF=REFD, RO=DETE (ME=TELE)	26.1+MU	
		RF=REFD, RO=DETE, US=PREM (ME=TELE)	44.1+MU	
		RF=REFD, RO=DETE, US=PR50 (ME=TELE)	44.1+MU	
CONS	03.07	Repeat Consultation		
		RF=REFD, RP=REPT (ME=TELE)	22.5	
		RF=REFD, RP=REPT, US=PREM (ME=TELE)	40.5	
		RF=REFD, RP=REPT, US=PR50 (ME=TELE)	40.5	
		RF=REFD, RO=DETE, RP=REPT (ME=TELE)	22.5+MU	
		RF=REFD, RO=DETE, RP=REPT, US=PREM (ME=TELE)	40.5+MU	
		RF=REFD, RO=DETE, RP=REPT, US=PR50 (ME=TELE)	40.5+MU	
OFFICE				
VIST	03.04	Initial Visit with Complete Examination		
		LO=OFFC (RF=REFD)	24	
VIST	03.03	Initial Visit with Regional Examination		
		LO=OFFC, RP=INTL (RF=REFD)	12	
		LO=OFFC, AG=OV65, RP=INTL (RF=REFD)	16.5	
VIST	03.03	Subsequent Visit		
		LO=OFFC, RP=SUBS (RF=REFD)	13	
VIST	03.03A	Geriatric Office Visit (for patients aged 65+)		
		LO=OFFC (RF=REFD)	16.5	

VIST 03.03 Continuing Care
LO=OFFC, RO=CNTC, RF=REFD 13.5
LO=OFFC, AG=OV65, RO=CNTC, RF=REFD 16.5

VIST 03.03 Directive Care
LO=OFFC, RO=DIRC, RF=REFD 13.5
LO=OFFC, AG=OV65, RO=DIRC, RF=REFD 16.5

VIST 03.03 Urgent Care - Request by Patient (1701 - 2000)
LO=OFFC, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Request by Patient (2001 - 2359)
LO=OFFC, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Request by Patient (0000 - 0800)
LO=OFFC, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) 38.3

VIST 03.03 Urgent Care - Request by Patient (0801 - 1200) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=AMNN, DA=RGE1, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Request by Patient (1201 - 1700) Sat., Sun., Holidays
LO=OFFC, PT=FTPT, TI=NNEV, DA=RGE1, US=UNOF (RF=REFD) 28.3

VIST 03.03 Urgent Care - Extra Patient
LO=OFFC, PT=EXPT (RF=REFD) 10.5

HOSPITAL (LO=HOSP: FN=INPT, INCU, NICU, OTPT or EMCC)

VIST 03.04 Initial Visit with Complete Examination
LO=HOSP, FN=EMCC, FN=OTPT (RF=REFD) 24
LO=HOSP, FN=EMCC, FN=OTPT, RO=DETE (RF=REFD) ..... 24+MU

VIST 03.04 Initial Visit
LO=HOSP, FN=INPT, RP=INTL (RF=REFD) 25
LO=HOSP, FN=INPT, RP=INTL, RO=DETE (RF=REFD) ..... 25+MU

VIST 03.03 Continuing Care
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CNTC, RF=REFD 15
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=CCDT, RF=REFD ..... 15+MU

VIST 03.03 Directive Care
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DIRC, RF=REFD 15
LO=HOSP, FN=INPT, FN=INCU, FN=NICU, RO=DRDT, RF=REFD ..... 15+MU

VIST 03.03 Subsequent Visit - Daily to 56 Days
LO=HOSP, FN=INPT, DA=DALY, RP=SUBS (RF=REFD) 15
LO=HOSP, FN=INPT, DA=DALY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU

VIST 03.03 Subsequent Visit - Weekly after 56 Days - Maximum 44 units per week
LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS (RF=REFD) 15
LO=HOSP, FN=INPT, DA=WKLY, RP=SUBS, RO=DETE (RF=REFD) ..... 15+MU

ADON	03.02A	Hospital Discharge Fee LO=HOSP, FN=INPT 10
VIST	03.03	Urgent Hospital Visit LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF (RF=REFD)..... 22 LO=HOSP, FN=INPT, FN=INCU, FN=NICU, US=UNOF, RO=DETE (RF=REFD)..... 22+MU
VIST	03.03	Emergency Visit LO=HOSP, FN=INPT, FN=OTPT, US=UIOH (RF=REFD)..... 35.2 LO=HOSP, FN=INPT, FN=OTPT, US=UIOH, RO=DETE (RF=REFD)..... 35.2+MU
VIST	03.03	Outpatient Visit (0800 - 1700) LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF (RF=REFD) ..... 13.5 LO=HOSP, FN=OTPT, PT=FTPT, US=UNOF, RO=DETE (RF=REFD) ..... 13.5+MU
VIST	03.03	Outpatient Visit (1701 - 2000) LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) ..... 20 LO=HOSP, FN=OTPT, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU
VIST	03.03	Outpatient Visit (2001 - 2359) LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) ..... 20 LO=HOSP, FN=OTPT, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) ..... 20+MU
VIST	03.03	Outpatient Visit (0000 - 0800) LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD)..... 26 LO=HOSP, FN=OTPT, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD)..... 26+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD)..... 20 LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE (RF=REFD)..... 20+MU
VIST	03.03	Outpatient Visit (1201-1700) Sat., Sun., Holidays LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD)..... 20 LO=HOSP, FN=OTPT, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE (RF=REFD)..... 20+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN (RF=REFD)..... 7 LO=HOSP, FN=OTPT, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)..... 7+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV (RF=REFD) ..... 7 LO=HOSP, FN=OTPT, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD) ..... 7+MU
VIST	03.03	Outpatient Visit (1701 - 2000) Extra Patient LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT (RF=REFD) ..... 10.5 LO=HOSP, FN=OTPT, PT=EXPT, TI=EVNT, RO=DETE (RF=REFD) ..... 10.5+MU

VIST	03.03	Outpatient Visit (2001 - 2359) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD (RF=REFD)	10.5
		LO=HOSP, FN=OTPT, PT=EXPT, TI=ETMD, RO=DETE (RF=REFD)	10.5+MU
VIST	03.03	Outpatient Visit (0000 - 0800) Extra Patient	
		LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT (RF=REFD)	11.4
		LO=HOSP, FN=OTPT, PT=EXPT, TI=MDNT, RO=DETE (RF=REFD)	11.4+MU
VIST	03.03	Outpatient Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN (RF=REFD)	10.5
		LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=AMNN, RO=DETE (RF=REFD)	10.5+MU
VIST	03.03	Outpatient Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays	
		LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV (RF=REFD)	10.5
		LO=HOSP, FN=OTPT, DA=RGE1, PT=EXPT, TI=NNEV, RO=DETE (RF=REFD)	10.5+MU

PROCEDURES

OTHER NONOPERATIVE CYSTOSCOPY

(For other cystoscopy procedures, please refer to Diagnostic and Therapeutic Section)

MASG	01.34D	Cystoscopy with brush biopsy of renal pelvis	75	4+T
ADON	01.34E	Cystoscopy with insertion of radioactive substance	25	4+T
MASG	01.34F	Cystoscopy with urethral meatotomy and plastic repair	55	4+T
MISG	01.34H	Cystoscopy - with biopsy of bladder (transurethral)	48	4+T

URETHROSCOPY

MISG	01.35	Urethroscopy	14.1	4+T
MISG	01.35A	Urethroscopy including biopsy	30	4+T

REMOVAL OF INTRALUMINAL FOREIGN BODY FROM URETHRA WITHOUT INCISION

MASG	12.24A	Removal of foreign body or calculus of urethra	75	4+T

OTHER REMOVAL OF INTRALUMINAL FOREIGN BODY WITHOUT INCISION

MISG	12.29A	Urethra meatal extraction of foreign body	15	4+T

INJECTION OF STEROID

MISG	13.53D	Injection of Peyronie's plaque	20	4+T

UNILATERAL EXPLORATION OF ADRENAL FIELD

MASG	20.02	Unilateral exploration of adrenal field (regions required)	150	7+T

BILATERAL EXPLORATION OF ADRENAL FIELD

MASG	20.03	Bilateral exploration of adrenal field	225	7+T

EXCISION OF LESION OF ADRENAL GLAND

MASG	20.11A	Excision of functioning tumours – pheochromocytoma (regions required)	200	10+T

UNILATERAL ADRENALECTOMY

MASG	20.12	Unilateral adrenalectomy (regions required)	200	10+T
MASG	20.12A	Adrenalectomy, bilateral	300	10+T

INSERTION OF INTERPLEURAL CATHETER

ADON	46.04L	Intraoperative placement of interpleural catheter for paravertebral block	50	

OTHER SURGICAL OCCLUSION OF ABDOMINAL ARTERIES

MASG	50.76C	Transection of aberrant renal vessel (regions required)	175	7+T

OTHER (PERIPHERAL) SHUNT OR BYPASS

MASG	51.29F	Microvascular penile revascularization using epigastric artery	550	8+T

REVISION OF INTESTINAL STOMA, UNQUALIFIED

MASG	58.41D	Partial resection of ileal conduit and revision of stoma (regions required)	200	5+T

NEPHROTOMY

MASG	67.01A	Drainage of kidney abscess, including excision of carbuncle (regions required)	150	7+T
MASG	67.01B	Renal exploration	125	7+T
MASG	67.01C	Nephrolithotomy (regions required)	210	7+T

NEPHROSTOMY

MASG	67.02	Nephrostomy (regions required)	175	7+T
MISG	67.02	Nephrostomy AP=PERC (regions required)	50	4+T
MASG	67.02E	Subcutaneous nephrostomy tunnelling for palliative urinary diversion: initial tube placement (regions required)	67	4+T
MISG	67.02F	Subcutaneous nephrostomy tunnelling for palliative urinary diversion: tube placement (regions required)	33	4+T

PYELOTOMY

MASG	67.11A	Extended pyelolithotomy and nephrostomy plus renal artery occlusion and hypothermia (regions required)	350	8+T
MASG	67.11B	Pyelolithotomy with diversion of urine (regions required)	200	7+T
ADON	67.11C	Secondary operation	50	
MASG	67.11D	Percutaneous endopyelotomy (regions required)	350	8+T
MASG	67.11E	Pyelolithotomy (regions required)	175	7+T

PYELOSTOMY

MASG	67.12	Pyelostomy (regions required)	175	7+T

MARSUPIALIZATION OF KIDNEY LESION

MASG	67.21A	Renal biopsy - open (regions required)	100	7+T

OTHER LOCAL EXCISION OR DESTRUCTION OF LESION OR TISSUE OF KIDNEY

MASG	67.29A	Excision of renal cyst (regions required)	175	7+T

PARTIAL NEPHRECTOMY

MASG	67.3	Partial nephrectomy (regions required)	220	7+T
ADON	67.3A	Heminephrectomy, adrenalectomy - secondary operation (regions required)	50	

TOTAL NEPHRECTOMY (UNILATERAL)

MASG	67.41	Total nephrectomy (unilateral) PT=CDDR (regions required)	170	
MASG	67.41A	Nephrectomy - ectopic (regions required)	200	7+T
MASG	67.41B	Nephrectomy - lumbar (regions required)	205	7+T
MASG	67.41C	Nephrectomy - transperitoneal (regions required)	200	7+T
MASG	67.41D	Nephrectomy - thoraco-abdominal (regions required)	275	13+T
MASG	67.41E	Radical nephrectomy lumbar of thoraco-abdominal (regions required)	282.1	13+T
MASG	67.41F	Nephro-ureterectomy (regions required)	240	7+T
MASG	67.41G	Nephro-ureterectomy with resection of ureterovesical junction (regions required)	300	7+T
ADON	67.41H	Secondary operation (regions required)	47	

BILATERAL NEPHRECTOMY

MASG	67.44	Bilateral nephrectomy		
		PT=CDDR	255	
MASG	67.44A	Nephrectomy - ectopic	300	7+T
MASG	67.44B	Nephrectomy - lumbar	307.5	7+T
MASG	67.44C	Nephrectomy - transperitoneal	300	7+T
MASG	67.44D	Nephrectomy - thoraco-abdominal	412.5	13+T
MASG	67.44E	Radical nephrectomy lumbar of thoraco-abdominal	423.15	13+T
MASG	67.44F	Nephro-ureterectomy	360	7+T
MASG	67.44G	Nephro-ureterectomy with resection of ureterovesical junction	450	7+T
ADON	67.44H	Secondary operation	94	

RENAL AUTOTRANSPLANTATION

MASG	67.51	Renal autotransplantation		
		RO=FPHN (regions required)	315	13+T
		RO=SNAS (regions required)	106	13+T
		RO=SPHN (regions required)	315	13+T

OTHER KIDNEY TRANSPLANTATION

MASG	67.59	Other kidney transplantation		
		SP=GNSG (regions required)	460	
		SP=UROL (regions required)	460	
		PT=RECP		10+T
		PT=DONR		7+T

NEPHROPEXY

MASG	67.6	Nephropexy (regions required)	150	7+T
MASG	67.6A	Nephropexy with renal sympathectomy (regions required)	200	7+T

SUTURE OF KIDNEY

MASG	67.71A	Suture ruptured/lacerated kidney - repair/removal (regions required)	210	7+T

SYMPHYSIOTOMY FOR HORSESHOE KIDNEY

ADON	67.75A	Renal hypothermia	25	
ADON	67.75B	Secondary operation (regions required)	50	
MASG	67.75C	Symphysiotomy for horse shoe kidney with or without nephropexy and associated procedure (regions required)	240	7+T

OTHER REPAIR OF KIDNEY NEC

MASG	67.79A	Pyeloureteroplasty (regions required)	210	7+T

NEPHROSCOPY

ADON	67.83	Nephroscopy (regions required)	50	
ADON	67.83A	Transvesical nephroscopy (regions required)	50	

PERCUTANEOUS ASPIRATION OF KIDNEY

MISG	67.92C	Aspiration of renal cyst (regions required)	50	4+T

REPLACEMENT OF NEPHROSTOMY TUBE

MISG	67.93	Replacement of nephrostomy tube (regions required)	15	4+T

OTHER OPERATIONS ON KIDNEY NEC

MASG	67.99A	Percutaneous renal and upper ureteral stone removal multiple stones without electrohydraulic or ultrasonic lithotripsy (regions required)	300	7+T
MASG	67.99B	Percutaneous renal and upper ureteral stone removal - multiple staghorn with electrohydraulic and/or ultrasonic lithotripsy (regions required)	330	7+T
MASG	67.99C	Repeat percutaneous ureteral stone removal through original access within one week (regions required)	200	7+T

TRANSURETHRAL CLEARANCE OF URETER AND RENAL PELVIS

MASG	68.0A	Endoscopic meatotomy if required (basket extraction)	138.6	4+T
MASG	68.0B	Ureteral manipulation only, stone not removed (regions required)	80	4+T

URETEROTOMY

MASG	68.2A	Ureterotomy upper two-thirds (regions required)	170	7+T
MASG	68.2B	Ureterotomy lower one-third (regions required)	220	7+T

URETERECTOMY, UNQUALIFIED

MASG	68.31	Ureterectomy, unqualified (regions required)	175	7+T

PARTIAL URETERECTOMY

MASG	68.32A	Ureterocelectomy	150	6+T
MASG	68.32B	Ureterocelectomy with ureteral reimplantation	240	6+T

TOTAL URETERECTOMY

MASG	68.33A	Ureterectomy including ureterovesical junction (regions required)	215	7+T

FORMATION OF CUTANEOUS URETEROILEOSTOMY

MASG	68.41	Formation of cutaneous ureteroileostomy	320	6+T
MASG	68.41A	Cystectomy, coke pouch and creation of continent urinary pouch diversion e.g., Indiana pouch	700	6+T
MASG	68.41B	Uretero-ileal conduit with total cystectomy	460	6+T
MASG	68.41C	Radical cystectomy and urethrectomy	590	6+T

FORMATION OF OTHER CUTANEOUS URETEROSTOMY

MASG	68.51	Formation of other cutaneous ureterostomy (regions required)	150	6+T
MASG	68.51A	Ureterostomy with t-tube (regions required)	150	6+T

REVISION OF OTHER CUTANEOUS URETEROSTOMY

MASG	68.52A	Revision of ileal conduit stoma (regions required)	100	5+T

OTHER URINARY DIVERSION TO INTESTINE

MASG	68.62A	Uretero-colic anastomosis/transplant (regions required)	225	6+T
MASG	68.62B	Uretero-colic anastomosis/transplant with cystectomy, one stage (Regions required)	360	6+T
MASG	68.62C	Uretero-colic anastomosis/transplant with cystectomy and colostomy (Regions required)	420	6+T

REVISION OF URETERO-INTESTINAL OR PYELO-INTESTINAL ANASTOMOSIS

MASG	68.63	Revision of uretero-intestinal or pyelo-intestinal anastomosis (Regions required)	240	6+T

URETERONEOCYSTOSTOMY

MASG	68.72A	Repeat repair to uretero-vesical junction with psoas hitch (regions required)	350	8+T
MASG	68.72B	Repeat repair to uretero-vesical junction with ureteral taper (regions required)	350	8+T
MASG	68.72C	Ureterovesical anastomosis, reimplantation (regions required)	250	6+T
MASG	68.72D	Ureterovesical anastomosis, reimplantation bilateral	315	6+T
MASG	68.72E	Bilateral ureteral reimplantation with bilateral tapering	425	8+T

TRANSURETEROURETEROSTOMY

MASG	68.73	Transureteroureterostomy (regions required)	300	6+T

OTHER ANASTOMOSIS OR BYPASS OF URETER NEC

MASG	68.79A	Uretero-ureterostomy (regions required)	250	6+T
MASG	68.79B	Repair to uretero-vesical junction RP=REPT (regions required)	290	8+T

SUTURE OF URETER

MASG	68.82A	Rupture/transection of ureter - immediate - upper 2/3 (regions required)	175	6+T
MASG	68.82B	Rupture/transection of ureter - immediate - lower 1/3 (regions required)	200	6+T
MASG	68.82C	Rupture/transection of ureter - late repair - upper 2/3 (regions required)	200	6+T
MASG	68.82D	Rupture/transection of ureter - late repair - lower 1/3 (regions required)	225	6+T

CLOSURE OF OTHER FISTULA OF URETER

MASG	68.84	Closure of other fistula of ureter	240	6+T
MASG	68.84A	Repair - uretero-vaginal fistula (regions required)	240	6+T

OTHER REPAIR OF URETER

MASG	68.89A	Ureterocoele (regions required)	75	6+T
MASG	68.89B	Ileo-ureteral substitution (regions required)	300	6+T

URETEROSCOPY

MASG	68.95A	Ureteroscopy with/without biopsy (regions required)	135	4+T
MASG	68.95B	Percutaneous ureteroscopy with ultrasonic lithotripsy and/or ureteroscopy with electrohydraulic lithotripsy (regions required)	300	7+T
MASG	68.95C	Ureteroscopy plus basket (regions required)	200	7+T

OTHER INVASIVE DIAGNOSTIC PROCEDURES ON URETER

MASG	68.98A	Exploration of ureter (regions required)	150	6+T

OTHER OPERATIONS ON URETER NEC

MASG	68.99B	Incision - peri-ureteral abscess (regions required)	100	6+T
MISG	68.99C	Calibration and/or dilation of ureter - one/both sides	40	4+T
MASG	68.99D	Ureteral stent - via cystoscope (regions required)	108.9	4+T
MASG	68.99E	Percutaneous ureteral stone removal - single stone without electrohydraulic or ultrasonic lithotripsy (regions required)	250	7+T
MASG	68.99F	Percutaneous ureteral stone removal - single stone with electrohydraulic and/or ultrasonic lithotripsy (regions required)	300	7+T

TRANSURETHRAL CLEARANCE OF BLADDER

MASG	69.0A	Cystoscopy with removal of foreign body/calculus	67.3	4+T
MASG	69.0B	Cystoscopy with litholapaxy, visual/tactile and removal of stone fragments	105	4+T
MASG	69.0C	Cystoscopy with ultrasonic/electrohydraulic lithotripsy	125	4+T

OTHER CYSTOTOMY

MASG	69.13	Other cystotomy	75	5+T
MASG	69.13A	Cystolithotomy	90	5+T

OPEN (SUPRAPUBIC) CYSTOSTOMY

MASG	69.14	Open (suprapubic) cystostomy	75	5+T
MISG	69.14A	Cystotomy with trochar and cannula and insertion of tube	30	5+T

OTHER TRANSURETHRAL EXCISION OR DESTRUCTION OF LESION OR TISSUE OF BLADDER

MASG	69.29A	Cystoscopy with electrocoagulation of tumour - single	55	4+T
MASG	69.29B	Cystoscopy with electroexcision of tumour/tumours including base and adjacent muscle - single	123.7	4+T
MASG	69.29C	Cystoscopy with electrocoagulation of Hunner's ulcers	60	4+T
MASG	69.29D	Cystoscopy with resection of bladder neck	90	4+T
MASG	69.29E	Cystoscopy with electrosurgical ureteral meatotomy	75	4+T
MISG	69.29F	Endoscopy - transurethral drainage	50	5+T
MASG	69.29G	Cystoscopy with electrocoagulation of tumour - multiple	87.1	4+T
MASG	69.29H	Cystoscopy with electroexcision of tumour/tumours including base and adjacent muscle - multiple	198	4+T

EXCISION OF URACHUS

MASG	69.31A	Excision of urachus and repair of bladder	125	6+T

OPEN EXCISION OR DESTRUCTION OF OTHER LESION OR TISSUE OF BLADDER

MASG	69.39A	Cystotomy/cystostomy with electrocoagulation of tumour	150	5+T
MASG	69.39B	Suprapubic resection of bladder neck	150	5+T

PARTIAL CYSTECTOMY

MASG	69.4A	Cystectomy, partial for atony	140	6+T
MASG	69.4B	Excision of bladder tumour/diverticulum	200	6+T
MASG	69.4C	Excision of bladder tumour/diverticulum with reimplantation of ureter	270	8+T

OTHER TOTAL CYSTECTOMY

MASG	69.59A	Complete cystectomy without transplant	240	6+T

RECONSTRUCTION OF URINARY BLADDER

MASG	69.6A	Complete cystectomy without transplant with colocystoplasty		
		RO=FPHN	400	8+T
		RO=SPHN	100	
MASG	69.6B	Ileocystoplasty (or colocystoplasty)	300	5+T

SUTURE OF BLADDER

MASG	69.71	Suture of bladder	180	5+T

REPAIR OF OTHER FISTULA OF BLADDER

MASG	69.73D	Closure of fistula external suprapubic	120	4+T
MASG	69.73E	Closure of fistula vesicovaginal - transvesical approach	240	6+T
MASG	69.73F	Closure of fistula vesicorectal or vesicosigmoid	200	6+T

CYSTOURETHROPLASTY AND PLASTIC REPAIR OF BLADDER NECK

MASG	69.74	Cystourethroplasty and plastic repair of bladder neck	200	5+T
ADON	69.74A	Plastic repair of bladder neck with ureteroneocystostomy (add-on to HSC 69.74 only) (regions required)	50	

REPAIR OF BLADDER EXSTROPHY

MASG	69.75A	Exstrophy, urinary diversion for bladder exstrophy and excision of ectopic bladder and repair of abdominal wall	400	6+T

CYSTOGRAM AND CYSTO-URETHROGRAM

MISG	69.83	Cystogram and cysto-urethrogram	16	4+T

SPHINCTEROTOMY OF BLADDER

MASG	69.91	Sphincterotomy of bladder		
		AP=TRUR	120	4+T

EXTERNAL URETHROTOMY

MASG	70.0	External urethrotomy	120	4+T
MASG	70.0A	Perineal urethrostomy	75	4+T

EXCISION OR DESTRUCTION OF URETHRAL LESION OR TISSUE

MISG	70.2A	Urethral caruncle or prolapse of mucosa	40	4+T
MISG	70.2B	Excision of urethral caruncle	35	4+T
MASG	70.2C	Excision of urethral caruncle - including cystoscopy	55	4+T
MASG	70.2D	Excision of urethral papilloma - single/multiple	60	4+T

MASG	70.2E	Excision of urethral stricture - one stage with diversion	180	4+T
MASG	70.2F	Excision of urethral stricture - two stage - first stage	90	4+T
MASG	70.2G	Excision of urethral stricture - two stage - second stage	180	4+T
MASG	70.2H	Diverticulectomy	125	4+T
MISG	70.2I	Excision of posterior urethral valve by endoscopy	50	4+T
MASG	70.2J	Excision of posterior urethral valve by endoscopy - open operation	125	4+T
MISG	70.2K	Excision of urethral prolapse	40	4+T
MASG	70.2L	Excision of urethral prolapse with cystoscopy	60	4+T
MISG	70.2M	Biopsy of urethra	15	4+T
MASG	70.2N	Excision urethra and re-anastomosis	200	6+T

SUTURE OF URETHRA

MASG	70.31A	Suture of rupture anterior urethra (diversion of urine stream)	120	4+T
MASG	70.31B	Suture of rupture posterior urethra - immediate repair	210	4+T
MASG	70.31C	Suture of rupture posterior urethra - late repair	300	4+T
MASG	70.31D	Suture of membranous urethra	180	4+T

CLOSURE OF OTHER FISTULA OF URETHRA

MASG	70.33A	Suture of recto-urethral fistula	200	6+T
MASG	70.33B	Suture of recto-urethral fistula with colostomy	250	6+T

OTHER RECONSTRUCTION OF URETHRA

MASG	70.35A	Urethroplasty for posterior urethral rupture		
		ME=FTSG	300	
		ME=SDSG	150	
MASG	70.35B	Urethroplasty for anterior urethral strictures		
		ME=FTSG	175	6+T
		ME=SDSG	100	6+T
MASG	70.35C	Urethroplasty - one stage with pedicle graft	300	6+T
MASG	70.35D	Urethroplasty marsupialization		
		ME=FTSG	100	6+T
		ME=SDSG	150	6+T

URETHRAL MEATOPLASTY

MISG	70.36A	Meatotomy and plastic repair	30	4+T
MASG	70.36B	Meatotomy and plastic repair for extravasation urine with multiple drainage	120	4+T
MASG	70.36C	Meatotomy and plastic repair with external urethrotomy/cystotomy	180	4+T

FREEING OF STRICTURE OF URETHRA

MASG	70.4A	Cold knife urethrotomy	128.7	4+T
MASG	70.4B	Internal urethrotomy	60	4+T

DILATION OF URETHRA

MISG	70.5	Dilation of urethra		
		AN=GENL	22	4+T
		AN=LOCL	10	
MISG	70.5A	Dilation of urethra filiforms and followers	22	4+T

INCISION OF PERIURETHRAL TISSUE

MISG	70.91A	Incision periurethral abscess	25	4+T

IMPLANTATION OF ARTIFICIAL URINARY SPHINCTER

MASG	70.93A	AMS artificial (hydraulic) urinary sphincter	280	6+T
MASG	70.93B	Bladder neck positioning of cuff for artificial sphincter	400	7+T
MAAS	70.93C	Differential fee for re-operation of bladder neck level	IC	7+T

URETEROLYSIS WITH FREEING OR REPOSITIONING OF URETER FOR RETROPERITONEAL FIBROSIS

MASG	71.02	Ureterolysis with freeing or repositioning of ureter for peri-ureteral fibrosis (Regions required)	215	6+T

OTHER INCISION OF RETROPERITONEAL TISSUE

MASG	71.09A	Drainage of perinephric abscess (regions required)	100	7+T

SUPRAPUBIC SLING OPERATION

MASG	71.4	Suprapubic sling operation	135	4+T
MASG	71.4C	Synthetic mid urethral sling for female urinary incontinence, any approach	150	4+T
MASG	71.4D	Pubo-vaginal sling with autologous fascia for female urinary incontinence, includes Cystoscopy as required	350	6+T

RETROPUBIC URETHRAL SUSPENSION

MASG	71.5A	Urethrovesical suspension for stress incontinence	158.4	5+T

OTHER REPAIR OF URINARY (STRESS) INCONTINENCE

MASG	71.7A	Insertion of rigid prosthesis for urinary incontinence	225	6+T
MASG	71.7B	Cystoscopy and endoscopic mucosal injection teflon (Sting) - plus multiples, if applicable	100	4+T
MASG	71.7C	Cystoscopy and injection of collagen into periurethral tissue at bladder neck for stress urinary incontinence	75	4+T
MASG	71.7D	Urethrovesical suspension with partial cystectomy/vesicopexy	200	5+T
MASG	71.7F	Cystoscopy with intravesicular injection(s) of chemodenervating agent	90	4+T

ULTRASONIC FRAGMENTATION OF URINARY STONES

MASG	71.96A	Lithotripsy - one side, one stone (regions required)	163.3	6+T
MASG	71.96B	Lithotripsy one side, one stone - repeat within one week (regions required)	160	6+T
MASG	71.96C	Lithotripsy bilateral stones	262.5	6+T
MASG	71.96D	Lithotripsy one side, multiple stones (regions required)	247.5	6+T
MASG	71.96E	Lithotripsy bilateral multiple stones	370	6+T

INCISION OF PROSTATE

MISG	72.0A	Incision of prostate with drainage of abscess	50	4+T
MASG	72.0B	Incision of prostate with removal of calculus (perineal)	175	4+T

TRANSURETHRAL PROSTATECTOMY

MAAS	72.1A	Endoscopy - revision of transurethral resection of prostate	IC	6+T
MASG	72.1B	Endoscopy - transurethral electro-resection	237.6	7+T
MASG	72.1C	Endoscopy - resection of bladder neck – transurethral prostatectomy	128.7	5+T
MASG	72.1D	Transurethral electro-resection of the prostate by laser	237.6	7+T
MASG	72.1E	Laser Anatomic Endoscopic Enucleation of prostate >60 grams with morcellation (HoLEP, ThuLEP not for photoselective vaporization or green light laser)	406	7+T

SUPRAPUBIC PROSTATECTOMY

MASG	72.2	Suprapubic prostatectomy	200	7+T
MASG	72.2A	Prostatectomy with diverticulectomy	300	7+T
MASG	72.2B	Prostatectomy with partial cystectomy for atony of bladder	300	8+T

RETROPUBIC PROSTATECTOMY

MASG	72.3	Retropubic prostatectomy ME=SIMP	232.6	7+T
MASG	72.3A	Prostatectomy radical with vesiculectomy includes deep pelvic lymphadenectomy	325	8+T
MASG	72.3B	Prostatectomy - radical includes deep pelvic lymphadenectomy	303	8+T

RADICAL PROSTATECTOMY

MASG	72.4A	Prostatectomy with vesiculectomy includes deep pelvic lymphadenectomy	360	8+T
MASG	72.4B	Prostatectomy - radical including deep pelvic lymphadenectomy	300	8+T

LOCAL EXCISION OF LESION OF PROSTATE

MASG	72.51A	Excision and open biopsy of prostate	100	4+T

PERINEAL PROSTATECTOMY

MASG	72.52	Perineal prostatectomy	240	7+T

INCISION OF SEMINAL VESICLE

MISG	72.62	Incision of seminal vesicle	50	4+T

EXCISION OF SEMINAL VESICLE

MASG	72.63	Excision of seminal vesicle	300	4+T

INCISION OF PERIPROSTATIC TISSUE

MASG	72.71A	Mobilization of prostate with bilateral pelvic lymphadenectomy	257.4	8+T
MASG	72.71B	Mobilization of prostate for insertion of interstitial radioisotopes	150	5+T

OTHER OPERATIONS ON PROSTATE NEC

MASG	72.89A	Insertion of prostatic stent including cystoscopy	100	4+T

INCISION OF SCROTUM AND TUNICA VAGINALIS

MISG	73.0A	Incision of scrotum abscess/hematocoele	25	4+T
MASG	73.0B	Incision and exploration of scrotum	60	4+T

EXCISION OF HYDROCOELE (OF TUNICA VAGINALIS)

MASG	73.1	Excision of hydrocoele (of tunica vaginalis) (regions required)	90	4+T

EXCISION OR DESTRUCTION OF LESION OR TISSUE OF SCROTUM

MISG	73.2A	Excision of minor scrotal lesions e.g., sebaceous cysts, fibroma	15	4+T
MASG	73.2B	Resection of scrotum	90	4+T

SUTURE OF SCROTUM AND TUNICA VAGINALIS

MAAS	73.31	Suture of scrotum and tunica vaginalis	IC	4+T

INCISION OF TESTES

MISG	74.0	Incision of testis (regions required)	25	4+T

EXCISION OR DESTRUCTION OF TESTICULAR LESION

MISG	74.1A	Excisional biopsy of testis (regions required)	25	4+T
MASG	74.1B	Excisional biopsy of testis with vasography (regions required)	60	4+T

UNILATERAL ORCHIECTOMY

MASG	74.2	Unilateral orchiectomy (regions required)	74.2	4+T
MASG	74.2A	Radical orchidectomy (regions required)	130	4+T

REMOVAL OF BOTH TESTES (IN SAME OPERATIVE EPISODE)

MASG	74.31	Removal of both testes (in same operative episode)	111.3	4+T
MASG	74.31A	Radical orchidectomy	195	4+T

ORCHIOPEXY

MASG	74.4	Orchiopexy (regions required)	163.3	4+T

SUTURE OF TESTES

MASG	74.51A	Repair ruptured testicle (regions required)	90	4+T

INSERTION OF TESTICULAR PROSTHESIS (BILATERAL) (UNILATERAL)

MISG	74.6	Insertion of testicular prosthesis (bilateral) (unilateral) (regions required)	50	4+T

EXCISION OF VARICOCOELE AND HYDROCOELE OF SPERMATIC CORD

MASG	75.0A	Excision of spermatic cord hydrocoele (regions required)	75	4+T
MASG	75.0B	Excision of spermatic cord varicocoele (regions required)	95	4+T

EXCISION OF CYST OF EPIDIDYMIS

MASG	75.1A	Excision of spermatocoele (regions required)	90	4+T

EPIDIDYMECTOMY

MASG	75.3	Epididymectomy (regions required)	80	4+T

REDUCTION OF TORSION OF TESTES OR SPERMATIC CORD

MASG	75.42	Reduction of torsion of testes or spermatic cord (regions required)	75	4+T

STERILIZATION PROCEDURE, UNQUALIFIED

MISG	75.61	Vasectomy procedure, unqualified	49.5	4+T

RECONSTRUCTION OF (SURGICALLY) DIVIDED VAS DEFERENS

MASG	75.72A	Anastomosis vas deferens - not post vasectomy (regions required)	200	4+T
MASG	75.72B	Anastomosis vas deferens with biopsy and vasography (regions required)	100	4+T

EPIDIDYMOVASOSTOMY

MASG	75.73	Epididymovasostomy (regions required)	90	4+

CONTRAST VASOGRAM

MISG	75.83	Contrast vasogram	25	4+T

EPIDIDYMOTOMY

MISG	75.92A	Incision of epididymis abscess	25	4+T

CIRCUMCISION

MISG	76.0	Circumcision		
		AG=ADUT	44.5	4+T
		AG=CH16	45	4+T

LOCAL EXCISION OR DESTRUCTION OF LESION OF PENIS

MISG	76.1A	Excision of penis condylomata	20	4+T

AMPUTATION OF PENIS

MASG	76.2	Amputation of penis		
		PO=PART	90	4+T
MASG	76.2A	Amputation of penis with inguinal gland dissection - 1 or 2 stages		
		PO=PART	240	4+T
MASG	76.2B	Amputation of penis with inguinal and femoral glands - 1 or 2 stages		
		PO=COML	300	6+T

RELEASE OF CHORDEE

MASG	76.32	Release of chordee	125	5+T

REPAIR OF EPISPADIAS OR HYPOSPADIAS

MASG	76.33	Repair of epispadias or hypospadias	150	4+T

MASG	76.33A	Hypospadias repair and meatal advancement and glanuloplasty (MAGPI)	150	4+T
MASG	76.33B	One stage hypospadias flip/flap repair	180	5+T
MASG	76.33C	Repair of hypospadias with tibular graft, glansplasty and suprapubic or perineal cystostomy one stage	450	4+T
MASG	76.33D	Hypospadias including urinary diversion chordee repair ME=FTSG	100	4+T
MASG	76.33E	Closure urethrocutaneous fistula	100	4+T
MASG	76.33F	Repair of peno-scrotal or perineal hypospadias	260	4+T

OTHER REPAIR OF PENIS

MISG	76.39A	Frenuloplasty	40	4+T
MASG	76.39B	Nesbitt Procedure	300	4+T
MISG	76.39C	Excision of Peyronie's plaque	50	4+T
MASG	76.39D	Excision of Peyronie's plaque with tunica vaginalis graft	275	6+T
MASG	76.39E	Plastic reconstruction urethra penile	175	4+T

BIOPSY OF PENIS

MISG	76.81	Biopsy of penis	15	4+T

DORSAL OR LATERAL SLIT OF PREPUCE

MISG	76.91	Dorsal or lateral slit of prepuce		
		AG=ADUT	10	4+T
		AG=CH16	5	4+T
		AG=NWBN	5	4+T

DIVISION OF PENILE ADHESIONS

MISG	76.93	Division of penile adhesions	25	4+T

INSERTION OR REPLACEMENT OF INTERNAL PROSTHESIS OF PENIS

MASG	76.95A	Insertion of rigid penile prosthesis for impotence	140	5+T
MASG	76.95B	Insertion of semi-rigid or malleable penile prosthesis	140	5+T
MASG	76.96B	Removal with or without reinsertion of semi-rigid or malleable penile prosthesis	IC 125/hr	5+T
MASG	76.95C	Inflatable penile prosthesis-insertion of all components (pump, cylinders and reservoir)	230	6+T

MASG	76.96C	Inflatable penile prosthesis-removal of any or all components (pump, cylinders and reservoir) with or without reinsertion	IC 130/hr	6+T

OTHER OPERATIONS ON PENIS

MASG	76.97A	Creation of corpus spongiosum to corpus cavernosum shunt	200	6+T

OTHER OPERATIONS ON EXTERNAL GENITAL ORGANS NEC

MASG	76.99A	Dorsal vein ligation	85	5+T
MASG	76.99B	Extensive dorsal vein ligation	300	5+T

SURGICAL PROCEDURES NOS

ADON	99.09A	Morbid obesity surgical add on	32.9	4.6

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