Government of
Northwest Territories

INSURED SERVICES TARIFF

APPROVED BY THE MINISTER OF HEALTH AND SOCIAL SERVICES

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EFFECTIVE: April 1, 2025

Preamble to the Insured Services Tariff for Physicians

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A Purpose and Structure of the Preamble

A.1 The preamble to the Insured Services Tariff for Physician Services (the "Schedule") assists medical practitioners in the Northwest Territories in submitting appropriate claims for the provision of insured medical services. The preamble provides the billing rules under which the services are claimed; these rules are a roadmap designed to clarify the use of the Schedule.

A.2 In some instances, a specialty-specific preamble is also provided (see Section G); if there is an inadvertent conflict between a specialty-specific preamble and any other section of the Schedule, the interpretation of the specialty-specific preamble shall prevail.

A.3 The preamble is divided into six interdependent sections:

- B Introduction to the Preamble
- C Administrative Items
- D Definitions
- E Types of Services
- F Premiums
- G Specialty-Specific Preambles

A.4 Two appendices further support the Schedule:

- H New Service Item Committee
- I Updating and Maintenance of the Schedule

B Introduction to the Preamble

B.1 All benefits listed in the Schedule, except where specific exceptions are identified, must include the following as part of the service being claimed; payment for these inherent components is included in the listed fees:

a. Direct face-to-face encounter with the patient by the medical practitioner, appropriate physical examination when pertinent to the service and ongoing monitoring of the patient's condition during the encounter, where indicated. (For exceptions to this rule, refer to Section E.2, Telehealth Services).

b. Any inquiry of the patient or other source, including review of available medical records, necessary to arrive at an opinion as to the nature and history of the patient's condition.

c. Appropriate care for the patient's condition, as specifically listed in the Schedule for the service and as traditionally and historically expected for the service rendered.

d. Arranging for any related assessments, procedures, and therapy as may be appropriate, and interpreting the results, except where separate listings are applicable to these services.

e. Arranging for any follow-up care that may be appropriate.

f. Discussion with and providing advice and information to the patient or the patient's representative(s) regarding the patient's condition and recommended therapy, including advice as to the results of any related assessments, procedures and/or therapy which may have been arranged. No additional claims may be made for such advice and discussion, or for the provision of prescriptions and/or laboratory requisitions, unless the patient's medical condition indicates that the patient should be seen and assessed again by the medical practitioner in order to receive such advice.

g. Making and maintaining an adequate medical record of the encounter that supports appropriately the service being claimed. A service for which an adequate medical record has not been recorded and retained is considered not to be complete and is not a benefit.

B.2 Where a benefit in the Schedule is stated to be payable by **assessment**, the value of that benefit will be assessed by the Director of Medical Care Services with consideration of what is fair and equitable in the clinical circumstances.

B.3 It is not possible to interpret accurately the fee service codes or to submit appropriate claims using those codes without an understanding of the Preamble.

C Administrative Items

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C.1 Fees Payable by the Schedule

a. A payment schedule for insured medical services provided by medical practitioners is established under the *Act* and is referenced in master agreements between the Government of the Northwest Territories (GNWT) and the Northwest Territories Medical Association (NWTMA). Benefits payable under the Act are limited to services which are medically required for the diagnosis and/or treatment of a patient, which are not excluded by legislation or regulation, and which are rendered personally by medical practitioners or by others delegated to perform them if compliant with the policies of the Department of Health and Social Services (DHSS) on delegated services.

b. Services requested or required by a third party for other than medical requirements are not insured or payable under the Act. Services, such as consultations, laboratory investigations, anaesthesia, and surgical assistance, rendered solely in association with other services which are not benefits also are not considered benefits of the Schedule, except in special circumstances as approved by the Minister of Health and Social Services.

C.2 Setting and Modification of Fees

a. Additions, deletions, fee changes, or other modifications to the Schedule are the responsibility of the DHSS, with due consideration of consultation with the NWTMA and the recommendation(s) of the New Service Item Committee (NSIC).

b. The structure, mandate, and processes of the NSIC are provided as an appendix, namely Section G, to this preamble.

c. The processes of the updating and maintenance of the Schedule are provided as an appendix, namely Section H, to this preamble.

C.3 Services Not Listed in the Schedule

Services not listed in the Schedule must not be billed to the DHSS under other listings. Medical practitioners who wish to have modifications to the Schedule should submit their proposals to the NWTMA for subsequent consideration by the NSIC and the DHSS. Interim listings may be designated by the DHSS for new procedures or other services for a limited period of time to allow definitive listings to be established, if appropriate.

C.4 Exceptional Circumstances

When a medical practitioner satisfies the Director by means of supporting evidence, that a procedure has involved unusual complications or has required the exercise of an unusual degree of skill, care, responsibility, or an unusual amount of time, the Director may allow a benefit greater than the benefit approved in the Schedule.

C.5 Insured Services Rendered Outside of Canada

Subject to the provisions of *Exceptional Circumstances*, the benefits payable in respect of insured services shall not exceed the benefits listed in the Schedule

for services rendered within the Northwest Territories. The Director may pay benefits in respect of insured services rendered outside of Canada, where:

a. The insured and required medical treatment is not available within Canada and the patient has been referred to a medical practitioner outside of Canada with the prior approval of the Director, or

b. In the opinion of the Director, circumstances exist which warrant medical treatment outside of Canada. This may include personal reimbursement for insured services received while on vacation; such personal reimbursement is limited to the value indicated in the Schedule. That notwithstanding, the benefits payable under these circumstances, as authorized by the Director, may exceed the benefits prescribed in the Schedule.

C.6 Reciprocal Claims

All provinces, and territories, except Quebec, have entered an agreement to pay for insured services provided to residents of other provinces when a patient presents with a valid provincial health registration card. However, the services listed below are exempt from this agreement and should be billed directly to the non-resident patient.

Medical practitioner services excluded under the inter-provincial agreements for the reciprocal processing of out-of-province medical claims are, as follows:

a. Surgery for alteration of appearance (cosmetic surgery)
b. Gender-reassignment surgery
c. Surgery for reversal of sterilization
d. Therapeutic abortions
e. Routine periodic health examinations including routine eye examinations
f. In-vitro fertilization, artificial insemination
g. Acupuncture, acupressure, transcutaneous electro-nerve stimulation (TENS), moxibustion, biofeedback, hypnotherapy

h. Services to persons covered by other agencies: Armed Forces, Workers' Compensation Board, Department of Veterans Affairs, Correctional Services of Canada (Federal Penitentiaries)
i. Services requested by a "Third Party"
j. Team conference(s)
k. Genetic screening and other genetic investigation, including DNA probes
l. Procedures still in the experimental/developmental phase
m. Anaesthetic services and surgical assistant services associated with all of the foregoing.

The services on this list may or may not be reimbursed by the home province. The patient should make enquires of that home province after direct payment to the Northwest Territories medical practitioner.

C.7 Medical Travel for Insured Services Outside of Northwest Territories

a. The Director may pay benefits for medical travel in respect of insured services rendered in Canada but outside of Northwest Territories, where the insured and required medical treatment is not available within Northwest Territories and the patient has been referred to a medical practitioner outside of Northwest Territories with the prior approval of the Director or, in the opinion of the Director, circumstances exist which warrant medical treatment outside of Northwest Territories.

b. For clarity, benefits for medical travel will be paid according to the GNWT policy on medical travel and with the explicit authorization of the Director.

C.8 Adequate Medical Records of an Insured Benefit

A medical record of a benefit in the Schedule is considered adequate when it contains all information which may be designated or implied in the Schedule for the service, and when another medical practitioner of the same specialty, who is unfamiliar with both the patient and the attending medical practitioner, would be

able to readily determine the following from that record and/or the patient's medical records from previous encounters:

a. Date and location of the service
b. Identification of the patient and the attending medical practitioner
c. Presenting complaint(s) and presenting symptoms and signs, including their history
d. All pertinent previous history including pertinent family history
e. The relevant results, both negative and positive, of a systematic enquiry pertinent to the patient's problem(s)
f. Identification of the extent of the physical examination including pertinent positive and negative findings
g. Results of any investigations carried out during the encounter
h. Summation of the problem and plan of management

C.9 Uninsured Medical Services

Benefits shall not be paid for:

a. Medical-legal services, including:

    i. Examinations performed at the request of third parties in connection with legal proceedings
    ii. The giving of evidence by a medical practitioner in legal proceedings, or
    iii. The preparation of reports or other documents relating to the results of a medical practitioner's examination for use in legal proceedings or otherwise and whether requested by the medical practitioner's patient or by a third party

b. Examinations required for the use of third parties including examinations required for:

    i. Drivers' licenses

ii. Pre-school or university
iii. Attendance at a camp
iv. Employment requirements

c. Services not medically required including, but not limited to, the completion of sick leave forms
d. Group immunization
e. In vitro-fertilization
f. Services provided by a medical practitioner to his or her own family
g. Telephone advice or prescriptions given over the telephone
h. Surgery for cosmetic purposes except where medically required
i. Dental services other than oral surgery as set out in the approved tariff
j. Dressings, drugs, vaccines, biologicals and related materials, eyeglasses and special appliances, plaster, surgical appliances or special bandages
k. Treatments rendered in the course of chiropractics, physiotherapy, podiatry or any other practice ordinarily carried on by persons who are not medical practitioners
l. Optometry services
m. Mileage charges
n. Laboratory or x-ray services performed in a facility not approved by the Director
o. Services that a person is eligible to receive under
    i. A statute of any other province or territory
    ii. Any law of a jurisdiction outside the Territories relating to workers' compensation, and
    iii. Any statute of the Parliament of Canada
p. Routine annual check-up where there is no definable diagnosis, except where a patient has attained 65 years of age or is less than 10 years of age
q. Services not provided by or under the supervision of a medical practitioner

C.10 Specialist Benefits

a. Only those medical practitioners who have received a specialist certificate recognized by a College of Physicians and Surgeons in Canada may claim specialist benefits for assessments.

b. Specialist benefits for procedures may be claimed by those medical practitioners who have received a specialist certificate recognized by a College of Physicians and Surgeons in Canada; also by other medical practitioners who perform specialist procedures as General Practitioners granted credentials by a health authority or hospital to perform such procedures.

c. Specialists who have received a specialist certificate recognized by a College of Physicians and Surgeons in Canada may claim for procedures other than those generally accepted as within the scope of their specialty training, when granted credentials by a health authority or hospital to perform such procedures.

C.11 Inclusive Services and Fees

Some services listed in the Schedule have fees that are specifically intended to cover multiple services over extended time periods. Examples include most surgical procedures, critical care per diem listings, and some obstetrical listings. The preambles and Schedule are explicit where these intentions occur.

C.12 Medical Research

Costs of medical services (such as examinations by medical practitioners, laboratory procedures, other diagnostic procedures) that are provided solely for the purposes of research or experimentation are not the responsibility of the patient or DHSS. However, it is recognized that medical research may involve what is generally considered to be accepted therapies or procedures, and the fact that a therapy or procedure is performed as part of a research study or protocol does not preclude it from being an insured service. In the situation where therapies or procedures are part of a research study, only those reasonable costs customarily related to routine and accepted care of a patient's problem will be considered insurable; additional services carried out specifically for the purposes of the research are not the responsibility of DHSS.

C.13 Experimental Medicine

a. Costs of medical services that are provided for the purpose of what is considered to be experimental medicine are not the responsibility of the patient or DHSS.

b. New procedures and therapies not performed elsewhere and which involve a radical departure from the customary approaches to a medical problem, are considered to be experimental medicine. Services related to such experimental medicine are not chargeable to DHSS.

c. New therapies and procedures which have been described elsewhere may or may not be deemed by the Director of Medical Insurance to be experimental medicine for the purposes of determining eligibility for payment by DHSS.

d. Where such a new therapy or procedure is being introduced into Northwest Territories and the medical practitioners performing the new therapy or procedure wish to have a new fee item inserted in to the fee schedule to cover the new therapy or procedure, the process describing the New Service Item Committee (See Appendix G) must be followed.

e. When a new therapy or procedure is being performed outside Northwest Territories, a patient or patient advocate may request that the services associated with this new therapy or procedure be considered insured services by DHSS. The Director of Medical Insurance, utilizing information obtained from various sources, such as medical practitioners, the NWTMA, or evidence-based research, will review the situation. If it is determined that the new therapy or procedure is experimental, then the cost of medical services provided for this type of medical care will not be the responsibility of DHSS. If it is considered that the therapy or procedure is not experimental, the cost of medical services associated with this treatment will be evaluated by the DHSS to determine if it is an insured service in the Northwest Territories.

f. If procedures are accepted as no longer being experimental, they may be considered as an insured benefit in the Schedule on an interim basis and will be reviewed again within five years.

C.14 Services to Family and Household Members

a. Services are not benefits of the Schedule if a medical practitioner provides them to the following members of the medical practitioner's family:

    i. Spouse,
    ii. Son or daughter,
    iii. Step-son or stepdaughter,
    iv. Parent or stepparent,
    v. Mother-in-law or a father-in-law,
    vi. Grandparent,
    vii. Grandchild, or
    viii. Brother or sister

b. Services are not benefits of the Schedule if a medical practitioner provides them to a member of the same household as the medical practitioner.

D Definitions

Please note that definitions of specific types of medical assessments and services are provided in the corresponding section of the Preamble.

Act

Medical Care Act

age categories

Premature baby – neonate born before 37 weeks gestation
Newborn or Neonate – from birth up to, and including, 28 days of age
Infant – from 29 days up to the first birthday
Child – from 1 year up to the sixteenth birthday

antenatal care

Pregnancy-related visits from the time of confirmation of pregnancy to delivery
(same as prenatal)

dental surgeon

A person lawfully entitled to practise operative dentistry

DHSS

Department of Health and Social Services of the Government of the Northwest Territories

emergency department physician

Either a medical practitioner who is a specialist in emergency medicine or a medical practitioner who is physically and continuously present in the Emergency Department or its environs for a scheduled, designated period of time

For purposes of providing consultation services upon referral from a physician not providing services in the same Emergency Department, the

emergency department physician is recognized as FRCP (EM), CCFP (EM), or ABEM

holiday

The list of dates designated as statutory holidays will be issued annually by the DHSS and will reflect those dates identified in the Human Resource Manual under section 813.5

home

Patient's place of residence, including a multiple resident dwelling or single location that shares a common external building entrance, other than a hospital or long-term care institution

independent consideration

A process for assessing the value of services where a value is not listed in the *Insured Service Tariff*

intensive care unit

Special areas recognized and funded by the DHSS to provide high intensity care

medical advisor

A licensed physician designated as the medical advisor by the DHSS

office

The location where a physician is practising his or her profession, whether in a physician's home, in a hospital, in an institution, or in other facilities or buildings

palliative care

Care provided to a terminally ill patient during the final year of life, where a decision has been made that there will be no aggressive treatment of the underlying disease, and care is directed to maintaining the comfort of the patient until death occurs

participating province

A province or territory in which there is a health care insurance plan in respect of which a contribution is payable under the *Canada Health Act*

postnatal care

A single visit performed approximately 6 weeks following delivery for the purpose of assessment and advice to the mother

postpartum care

Inpatient hospital visits to the mother following delivery

premium

A fee that may be claimed by a physician in addition to the fee for an insured medical service, outlined in the tariff, and in situations described in Section F of the preamble

prenatal care

See antenatal care

professional fee

A fee able to be claimed by a registered medical practitioner for providing an insured medical service, other than an identified and insured technical fee that supports the equipment used for that service

referral

A request from one practitioner to another practitioner to render a service with respect to a specific patient; typically the service is one or more of a consultation, a laboratory procedure, or other diagnostic test, or specific surgical or medical treatment

specialist

A medical practitioner who is a certificant or a fellow of the Royal College of Physicians and Surgeons of Canada, and is licensed to practice in the Northwest Territories as a specialist

technical fee

A fee able to be claimed in support of equipment used to provide an insured medical service for which a professional fee can be billed

third party

A person or organization other than the patient or his/her agent that is requesting and/or assuming financial responsibility for a medical or medically related service

transferal

The transfer of responsibility from one medical practitioner to another for the care of patient, temporarily or permanently

This is distinguished from a referral, and normally does not provide the basis for billing a consultation; the exception is that, when the complexity or severity of illness necessitates that accepting the transferal requires an initial chart review and physical examination, a limited or full consultation may be medically necessary and is requested by the transferring medical practitioner

time categories

12-month period – any period of twelve consecutive months
Calendar year – the period from January 1 to December 31
Day – a calendar day
Fiscal year – from April 1 of one year to March 31 of the following year
Month – a calendar month
Week – any period of 7 consecutive days

uninsured service

A service that is not prescribed as insured by the DHSS

visit

A service rendered by a medical practitioner to a patient for diagnosis or treatment or both in the office, home, hospital, or elsewhere

E Types of Services

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E.1 Introduction

a. Where services are provided to the same patient by the same medical practitioner, or by another medical practitioner within the same clinic, major first visit benefits, including consultation benefits, shall not be paid more frequently than once in each six months.

b. The 6-month limitation does not apply to a major consultation by a specialist if that consultation is for a referred service that differs from the previous consultation.

c. A consultation for a referred medical service may be claimed on the same day as a procedure in an office, clinic, or hospital, performed subsequent to that consultation.

d. When a medical practitioner sees a patient for the sole purpose of receiving an injection or undergoing a procedure for which the benefit is less than that approved for a visit, the visit benefit shall not be paid.

e. Claims for special visits to an Emergency or Outpatient Department must indicate the actual time the patient was seen by the medical practitioner in the outpatient department.

E.2 Telehealth and Teleconference Services

a. “Telehealth Services” are defined as a medical practitioner delivering a health service provided to a patient at a Health Authority approved, publicly funded telehealth program, and live image transmission of those images to a receiving medical practitioner at another approved site, through the use of video technology.

b. “Video technology” means the recording, reproducing, and broadcasting of live visual images utilizing a direct interactive video link with a patient. In order for payment to be made, the patient must be in attendance at the sending site at the time of the video capture. Only those services that are designated as telehealth services may be claimed; other services/procedures require face-to-face encounters.

c. Telehealth services are payable only when patients are informed and are provided opportunity to agree to services rendered using this modality.

d. ”Telehealth examination” means an examination of a patient by the consultant at the receiving site using “telehealth services” as defined above.

e. In those cases where a specialist service requires a general practitioner at the patient’s site to assist with the essential physical assessment, without which the specialist service would be ineffective, the specialist must indicate the requirement in the medical record.

f. Where a receiving medical practitioner, after having provided a telehealth consultation service to a patient, decides s/he must examine the patient in person, the medical practitioner should claim the subsequent visit as a limited consultation, unless more than 6 months has passed since the telehealth consultation.

g. Where a telehealth service is interrupted for technical failure, and is not able to be resumed within a reasonable period of time, and therefore is unable to be completed, the receiving medical practitioner should submit a claim under the appropriate miscellaneous code for independent consideration with appropriate substantiating information.

h. Video technology services are generally payable once per patient/per day/per medical practitioner. Information regarding the medical necessity and times of additional services should accompany related claims.

i. Teleconference services may originate from a nurse practitioner, home care nurse, public health nurse, or midwife in a community health centre with no resident physician and directed to a medical practitioner, or from a physician in a community health centre outside of Yellowknife and directed to a specialist.

E.3 Electrocardiography

Only medical practitioners who have been accredited by a College of Physicians and Surgeons in Canada to provide such services may claim for the interpretation of an electrocardiogram.

E.4 Consultation

a. A consultation applies when a medical practitioner, or a health care practitioner (midwife, for obstetrical or neonatal related consultations; nurse practitioner; optometrist, for ophthalmology consultations; oral/dental surgeon, for diseases of mastication; community nurse), in the light of his/her professional knowledge of the patient and because of the complexity, obscurity, or seriousness of the case,

requests the opinion of a medical practitioner competent to give advice in this field.

b. The referring physician is expected to provide the consulting physician with a letter of referral that includes the reason for the request and the relevant background information on the patient.

c. The service includes the initial services of a consultant necessary to enable the consultant to prepare and render a written report, including his/her findings, opinions, and recommendations, to the referring practitioner. A consultation must not be claimed unless the attending practitioner specifically requested it and unless the written report is rendered. It is expected that a written report will be generated by the medical practitioner providing the consultation within 2 weeks of the date-of-service. In exceptional circumstances, when beyond the consultant's control, a delay of up to 4 weeks is acceptable.

d. When a consultation is followed by a procedure performed by the consultant, a benefit shall be paid for both the consultation and the procedure.

e. A benefit for continuing care shall be paid to a consultant following a consultation where the continuing care is provided by the consultant at the request of the referring medical practitioner.

f. Where the benefits for continuing care by a consultant are applicable, a benefit for insured services provided by the referring medical practitioner after the consultation shall only be paid to the referring medical practitioner after the full responsibility for the care of the patient has been returned to the referring medical practitioner, unless the complexity of the clinical needs of the patient require the services of the referring medical practitioner in addition to those of the consultant.

g. A consultation for the same diagnosis is not normally payable as a full consultation unless an interval of at least six months has passed since the

consultant has last billed any visit for the patient; a **limited consultation** may be payable within the six month interval, if medically necessary.

h. A **minor** or **repeat consultation** requires all of the components expected of a full consultation for that specialty but is less demanding and normally requires substantially less of the medical practitioner's time than a full consultation.

i. It is expected that a minor or repeat consultation, when medically necessary, will be billed as part of continuing care, and that a full consultation is not billed simply because of the passage of time.

j. A new and unrelated diagnosis can be billed as a full consultation without regard to the passage of time since the consultant has last billed any visit for the patient.

k. Once a consultation has been rendered and the written report submitted to the referring practitioner, this aspect of the care of the patient normally is returned to the referring practitioner; however, if by mutual agreement between the consultant and the referring practitioner, the complexities of the case are felt to be such that its management should remain for a time in the hands of the consultant, the consultant should claim for continuing care according to the Schedule pertaining to the specialty.

l. Where the care of this aspect of the case has been transferred, except for a patient in hospital, the referring practitioner generally should not charge for this aspect of the patient's care unless and until the full responsibility is returned to him/her; for hospitalized patients, supportive care may apply.

m. Continuing care by a specialist, following consultation, normally is paid at the specialist rates; however, continuing care requires that a written update of the patient's condition and care be appropriately reported to the referring practitioner at least every six months, until the responsibility for this aspect of the patient's care is returned to the referring practitioner.

E.5 Counseling

a. Counseling is defined as the discussion with the patient, caregiver, spouse, or relative about a medical condition which is recognized as difficult by the medical profession or over which the patient is having significant emotional distress, including the management of malignant disease. Counseling, to be claimed as such, must not be delegated and must last at least 20 minutes.

b. Counseling is not to be claimed for advice that is a normal component of any visit or as a substitute for the usual patient examination fee, whether or not the visit is prolonged. For example, the counseling codes must not be used simply because the assessment and/or treatment may take 20 minutes or longer, such as in the case of multiple complaints. The counseling codes are also not intended for activities related to attempting to persuade a patient to alter diet or other lifestyle behavioural patterns. Nor are the counseling codes generally applicable to the explanation of the results of diagnostic tests. A counseling service cannot be claimed for a time in excess of 90 minutes.

c. Group counseling fee items apply only when two or more patients are provided counseling in a group session lasting 60 minutes or more, but not greater than 90 minutes. The group counseling fee items are not applicable when there is a discussion with the patient in the presence of a caregiver, spouse, or relative when the patient is the only person requiring medical care. In those situations, only the applicable individual counseling fee item could be billed, using that patient's personal health number.

d. Group counseling fee items are not billable for each person in the group. Claims should be submitted under the name of only one of the beneficiaries, with the names of the other patients attending the session listed in the note record. Times should be included with billings for group counseling fee items.

e. A claim for greater than 90 minutes counseling in any single session or day requires assessment by the medical advisor.

f. Claims for counseling to non-psychiatric patients and in excess of 5 sessions annually require assessment by the medical advisor.

E.6 Referral and Transferral

a. A **referral** is defined as a request from one practitioner to another practitioner to render a service with respect to a specific patient. Such service usually would be a consultation, a laboratory procedure or other diagnostic test, or specific surgical or medical treatment.

b. When the medical practitioner to whom a patient has been referred makes further referrals to other medical practitioners, it is the usual practice that the original referring medical practitioner be informed of these further referrals.

c. A **transferral**, as distinguished from a referral, involves the transfer of responsibility for the care of the patient temporarily or permanently. Thus, when one medical practitioner is going off call or leaving on holidays and is unable to continue to treat his/her cases, medical practitioners who are substituting for that medical practitioner should consider that the patients have been temporarily transferred (not referred) to their care.

d. The medical practitioner to whom a patient has been transferred normally should **not** bill a consultation for that patient. However, when the complexity or severity of the illness requires that the medical practitioner accepting the transfer reviews the records of the patient and examines the patient, a limited or full consultation may be billed when specifically requested by the transferring medical practitioner.

E.7 House Visits

a. A house visit is considered necessary and may be billed only when the patient cannot practically attend a medical practitioner and the patient's complaint indicates a serious or potentially serious medical problem that requires a medical practitioner's attendance in order to determine appropriate management.

b. If a house visit is determined to be necessary and is initiated by the patient during the medical practitioner's regular office hours, the house visit should be billed as a home visit irrespective of when the service is rendered. Service charges do not apply to pre-booked house visits rendered after regular office hours.

c. The necessity and detail and the time of the visit should be documented in the patient's clinical record

E.8 Hospital Care

a. Where an outpatient visit results in the admission of a patient to a hospital the maximum benefit paid is that of a first visit when not seen in house or office.

b. An in-hospital admission examination may be claimed when a patient is admitted to an acute care hospital for medical care rendered by a general practitioner. The service also may be applicable when a medical practitioner is required to perform an admission examination prior to a hospital service being delivered by a health care practitioner (e.g., a dental surgeon). The hospital admission examination listing is not applicable when a patient has been admitted for surgery or when a patient is admitted for care rendered by a specialist. This service is applicable only once per patient per hospitalization and is in lieu of a "hospital visit" on the day it is rendered. This service includes all of the components of a complete examination.

c. A subsequent hospital visit is the routine monitoring and/or examination(s) that are medically required following a patient's admission to an acute care hospital. Payments for subsequent hospital visits are usually limited to one per patient per day for a period up to 30 days; however, it is not the intent of the Schedule that subsequent visit fees be claimed for every day a patient is in hospital unless the visits are medically required and unless a medical practitioner visits the patient each day.

d. If it is medically required for a patient to be visited more than once per day at any

time, or daily beyond the initial 30-day period, an explanation should be submitted with the claim and consideration will be given.

e. If a surgeon who is not resident in the Northwest Territories provides surgical services in the Northwest Territories and is unable to render the usual post-operative care, the medical practitioner who performs the post-operative services for the patient may claim for necessary hospital visits.

f. For those medical cases where the medical indications are of such complexity that the concurrent services of more than one medical practitioner are required for the adequate care of a patient, subsequent visits should be claimed as **concurrent care** by each medical practitioner, as required for that care.

g. Where a case has been referred and the referring medical practitioner no longer is in charge of the patient's care, but for which continued liaison with the family and/or reassurance of the patient is necessary while the patient is hospitalized, **supportive care** may be claimed by the referring medical practitioner. Payments for supportive care are limited to one visit for every day of hospitalization for the first ten days and, thereafter, one supportive care visit for every seven days of hospitalization.

h. **Newborn care in hospital** is the routine care of a well baby up to 10 days of age and includes an initial complete assessment and examination and all subsequent visits as may be appropriate, including instructions to the parent(s) and/or the patient's representative(s) regarding health care. Newborn well baby care in hospital normally is not payable to more than one medical practitioner for the same patient; however, when a well baby is transferred to another hospital, because of the mother's state of health, separate claims for newborn care when rendered by a different medical practitioner at each hospital may be made.

i. When visits are required to patients in long-term-care institutions, such as nursing homes, intermediate care facilities, extended care units, rehabilitation facilities, chronic care facilities, convalescent care facilities and personal care facilities, whether or not any of these facilities are situated on the campus of an acute care facility, claims may be made to a maximum of one visit every two

weeks. It is not sufficient, however, for the medical practitioner simply to review the patient's chart. A face-to-face patient/medical practitioner encounter must be made. For acute concurrent illnesses or exacerbation of original illness requiring institutional visits beyond the foregoing limitations, additional institutional visits may be claimed with accompanying written explanation.

E.9 Designated Procedures

a. When a patient enters a hospital and undergoes a procedure for which no booking was made in advance, and where the procedure is indicated in the Insured Services Tariff with the notation "+", benefits shall be paid for:

    i. Visits before and after the day on which the procedure is performed,
    ii. Visits on the day on which the procedure is performed, and
    iii. The procedure

b. When a patient attends at a medical practitioner's office or clinic and undergoes a procedure for which no booking was made in advance, and where the procedure is indicated in the Insured Services Tariff with the notation "+", benefits shall be paid for the procedure and either:

    i. The visit on the day on which the procedure is performed, or
    ii. Consultation on the day on which the procedure is performed

E.10 Emergency Detention Time

a. Benefits for emergency detention time shall be paid to a medical practitioner for the time s/he is medically required to personally and continuously attend and treat an illness or injury of an emergency nature.

b. Illness of an emergency nature includes mental or emotional disorders.

c. No medical detention time benefit shall be paid to a medical practitioner unless the medical practitioner submits, in writing, a simple explanation of the activity

and the time spent in performing the activity.

d. Medical detention time shall not apply to:

    i. Counseling or psychotherapy;
    ii. Waiting for results of laboratory or x-ray examinations;
    iii. Giving advice to family members of the patient or to the patient;
    iv. Waiting for a family medical practitioner or consultant;
    v. Service provided in the office in conjunction with routine visits, except when it is documented that an emergency existed; or
    vi. Medivac detention time described in section E.11.

e. Where a visit benefit is claimed, the medical detention time benefit does not apply until 2 hours after the start of the visit.

f. The maximum time for which benefits are payable as medical detention is seven hours.

E.11 Medivac Detention Time

a. Medivac detention time shall be paid to a medical practitioner for the time s/he is medically required to personally and continuously attend a patient being transported by surface or air ambulance.

b. No medivac detention time benefit shall be paid to a medical practitioner unless the medical practitioner submits, in writing, a simple explanation of the activity and the time spent in performing the activity.

c. Where a patient is being transported from a medical facility to another medical facility, medivac detention time begins when the patient is discharged from the medical facility and ends when the patient is admitted to the receiving medical facility.

d. Where a patient who has not been admitted to a medical facility is being transported to a medical facility, medivac detention time begins when the medical

practitioner begins to prepare the patient for transportation to a medical facility and ends when the patient is admitted to the facility.

e. Where a medical practitioner has to travel outside his or her community to reach a patient, medivac detention time includes the time the medical practitioner spends in reaching the patient.

f. The maximum time for which medivac detention time benefits are payable is 12 hours.

g. Return travel time, or time stranded, shall be paid to a medical practitioner who is out of his or her community as a direct result of an emergency medivac for the time the medical practitioner spends in returning home, or is stranded outside his or her community after the completion of the medivac.

h. No benefit for return travel or time stranded shall be paid to a medical practitioner unless the medical practitioner submits, in writing, the times for the beginning and end of the period the medical practitioner claims under this benefit.

i. The maximum time for which return travel or time stranded benefits are payable is five hours per day.

E.12 Cosmetic Procedures

a. Surgery to alleviate significant physical symptoms or to restore or to improve function to any area altered by disease, trauma, or congenital deformity normally is a benefit of the Schedule.

b. Surgery solely to alter or restore appearance is not considered medically necessary and is not a benefit of the Schedule.

E.13 Surgical Assisting

a. Where the surgical assistant is also the attending physician requesting the surgical consultation that leads to provision of a procedure, he or she shall be entitled to claim either the emergency benefit or the admission benefit in addition to the assisting benefit.
b. Claims for surgical assisting must indicate the lesser of the actual operating time from induction of anaesthesia to skin closure, or the total time of attendance by the medical practitioner; assisting time shall not exceed the anaesthetic time.

c. Premiums payable for a surgical procedure apply equally to the payment for surgical assisting.

d. Procedures for which surgical assisting benefits are not payable are:
    i. Minor cutaneous and subcutaneous tumors and biopsies
    ii. D and C, minor gynecological procedures
    iii. Anal fissure, ischiorectal abscess, anal and rectal polypi
    iv. Abscesses, except for major abscesses
    v. Endoscopic procedures and examinations
    vi. Transfusions
    vii. Closed reductions of fractures, except femur, tibia, radius and ulna
    viii. Application of plaster casts, orthopaedic appliances and manipulations
    ix. Ingrown toenails
    x. Minor plastic surgery, such as stamp graft, dermabrasion
    xi. Thoracentesis and closed drainage
    xii. Arteriography
    xiii. Tympanoplasty, fenestration
    xiv. Tonsillectomy and adenoidectomy
    xv. Vasectomy
    xvi. Submucous resection, rhinoplasty
    xvii. A-V shunt
    xviii. Release carpal tunnel

e. Procedures for which surgical assisting benefits may be required sometimes and are payable by assessment are:
    i. Phalangeal and digital amputations

ii. Ganglion wrist
iii. Excisional breast biopsy
iv. Simple fistula
v. Hemorrhoidectomy
vi. Bunionectomy
vii. Mastoidectomy
viii. Open reduction of fractured finger
ix. Hammer toe repair
x. Morton's neuroma

A claim for discretionary surgical assisting benefits, as listed herein, requires an explanatory letter from the surgeon, applicable to that claim.

E.14 Unlisted Services

Provision of a medically necessary service for which there is no service code or value in the Insured Services Tariff may be claimed using the code K-500.

A claim of K-500 will lead to an assessment by the Medical Advisor and decision whether the service, as provided, should be funded and at what value.

It is anticipated that the physician submitting a claim of K-500 will also give consideration to request consideration by the New Service Item Committee using the processes outlined in Appendix H of this Preamble.

F Modifiers

Index to Modifiers

F.1 Eligibility for Special Visit Premiums

Special visit premiums are based on the time of a request for a service and the performance of service. The special visit premium can apply to the provision of a consultation or a procedure, but not to both when the consultation leads to the procedure within the designated times.

F.2 General Practice Special Visit Premiums

For General Practice, special visit premiums are available for hospital visits to Emergency and Outpatient Departments, as follows:

1. When specially called from home or office from 08:00 to 17:00:
   SV-001 $95.00

2. Repeat visit when patient previously seen same day in Emergency or Outpatient Department or office:
   SV-002 $35.00

3. When specially called from home or office from 17:00 to 08:00 or Saturdays, Sundays, or statutory holidays:
   SV-003 $95.00

F.3 Consultations and Procedures Special Visit Premiums

For consultations and procedures rendered by medical and surgical specialists and General Practice Anaesthetists, special visit premiums may be claimed, as follows:

a. Special visit premium when the service request is placed between 17:00 and 00:00 and the service is rendered between 17:00 and 08:00, for the first service only:
SV-004 $95.00

b. Special visit premium when the service request is placed between 00:00 and 08:00 and the service is rendered between 00:00 and 08:00, for the first service only:
SV-005 $125.00

c. Special visit premium on a weekend and statutory holiday when the service request is placed between 08:00 and 17:00 and the service is rendered between 08:00 and 17:00, for the first service only:
SV-006 $95.00

F.4 Consultations and Procedures After Hours Premiums

a. After hours premiums may be claimed for the provision of non-elective consultations, surgical and anaesthetic procedures in the operating room, and obstetrical deliveries.

b. The after hours premiums are based on the time of day that an eligible non-elective service is initiated, applying the following codes and percentage increases to the submitted claim:

i. 17:00 to 00:00
AH-001 50%

ii. 00:00 to 08:00

AH-002 75%

iii. 08:00 to 17:00 on Saturday, Sunday, and a statutory holiday

AH-003 50%

F.5 Body Mass Index Premium

For surgical and anaesthetic services that are performed in the operating room, a body mass index (BMI) modifier may be claimed if the BMI exceeds 40. The premium is an additional 20% applied to the surgical, anaesthetic, and surgical assistant fees, using the code **BP-001 for surgical and surgical assisting claims**. **For anaesthetic BMI modifiers, refer to codes AN-025 and AN-026 in the Insured Services Tariff.**

G Specialty-Specific Preambles

Index to Specialty-Specific Preambles

G.1 Surgical Specialties

a. Payment for Pre-operative and Post-operative Care

i. Benefits for surgical procedures, other than an obstetrical procedure, listed in the Insured Services Tariff and valued at greater than $175.00 include compensation for post-operative care for a period of 14 days following the procedure.

ii. Notwithstanding subsection G.1.a.i, additional benefit may be claimed for services required to deal with a complication to the procedure or, when unusual clinical circumstances require that additional medical services are provided, the additional services are not part of the inclusive fee and may be claimed separately.

iii. When a surgeon does not provide the major portion of the post-operative care during the period of 14 days following the procedure, the benefit for the procedure shall be assessed by the medical advisor and paid at a lesser rate than the procedural rate listed in the Insured Services Tariff.

iv. When a medical practitioner other than the surgeon provides the major portion of the post-operative care during the period of 14 days following the procedure, the benefit paid to that medical practitioner shall be based on the number of hospital, home, or office visits provided to that patient.

v. Hospital care provided prior to a procedure may be claimed on the basis of first and subsequent visits by the medical practitioner who performed the surgery or by a different medical practitioner providing such care.

b. Multiple Surgical Procedures

i. When two or more similar surgical procedures, including bilateral procedures, are performed at one time, the procedure with the greater

listed fee may be claimed in full and the fees for the additional procedures are reduced to 75%, unless otherwise indicated in the Schedule.

ii. When two or more different procedures are performed through separate incisions under the same anaesthetic, and repositioning or re-draping of the patient or more than one separately draped surgical operating field is medically or surgically required (because of the nature of the procedure and/or the safety of the patient), both procedures may be claimed in full, unless otherwise indicated in the Schedule.

iii. Secondary surgical procedures, including those performed for post-operative complications, by the same surgeon for the same or related condition, shall be paid at 75% pf the listed benefit for the secondary procedure. That notwithstanding, when an emergency procedure is followed by a procedure intended conclusively to stabilize the condition of the patient, then each procedure may be claimed in full.

iv. When two procedures are performed under the same anaesthetic by two surgeons and both procedures are within the competence of either one of the surgeons, the total surgical fee claimed should be no greater than that which would be payable if both procedures had been performed by one surgeon plus one fee for surgical assisting.

c. Abandoned Surgical Procedures

Surgical procedures that are abandoned before completion will be given independent consideration and paid in accordance with the services performed.

d. Diagnostic Surgical Procedures

Payment rules for diagnostic surgical procedures vary according to the site of service and the listed benefit value for the procedure. These are summarized in the following table:

Site of Service	Benefit of $175.00 or less	Benefit Exceeding $175.00
Hospital	**Benefit shall be paid for** the procedure **and** visits before and after the day on which the procedure is performed	**Benefit shall be paid for** the procedure **and** visits before the day on which the procedure is performed
Office or Clinic	**Benefit shall be paid for** the procedure **or** the visit on the day of the procedure	**Benefit shall be paid for** visits before the day on which the procedure is performed **and** **either** the procedure **or** the visit on the day of the procedure

G.2 Obstetrics

a. The obstetrical benefit includes services provided for minor prenatal and minor coincidental medical conditions occurring during the pregnancy.

b. The obstetrical benefit does not include claims made for visits for unrelated major medical conditions, which may be claimed separately.

c. The obstetrical benefit includes minor postnatal conditions and contraceptive advice.

G.3 Paediatrics

a. When a Paediatrician Provides Care for a Premature or Newborn Infant

i. Newborn care on the date of birth and the date of discharge may be claimed when a medical practitioner has referred a healthy newborn to a Paediatrician; a consultation may not be claimed in this circumstance.

ii. If it becomes apparent that, while in the care of the Paediatrician, the newborn is ill, then the appropriate consultation benefit shall be paid and benefits shall be paid for the appropriate number of hospital days involved.

iii. When the Paediatrician requests consultation with another specialist, a consultation benefit shall be paid to the specialist.

iv. Claims for routine care and care for minor complications of a premature infant shall be paid as a minor or repeat consultation for the initial visit and in accordance with the approved tariff for subsequent daily care benefits.

b. When a Medical Practitioner other than a Paediatrician Provides Care for a Premature or Newborn Infant

i. Where a consultation is required, the referring physician may claim the benefit for newborn assessment on the day of birth and the consultant shall be paid a consultation benefit.

ii. When the ongoing care of the newborn is transferred to a consultant, the attending medical practitioner shall be paid by assessment, based on medical necessity.

iii. The routine care of, or the care for minor complications of, a healthy premature infant shall be paid in accordance with the approved tariff for daily hospital care.

c. Subsequent Office Visit of a Newborn Infant

i. When a medical practitioner has already claimed benefits for each of the delivery and postnatal care, newborn care on the day of birth, and newborn care on the day of discharge:

- No benefit shall be paid for a subsequent office visit if the newborn is well.

- A subsequent visit benefit shall be paid if the newborn is sick.

- Subsequent to the initial post-partum visit, claims may be made for whatever benefit items are appropriate for the care provided.

ii. When a medical practitioner has received a benefit only for newborn care on the day of birth, and newborn care on the day of discharge, an office benefit may be claimed for a first visit not requiring a general assessment and subsequent visits, whether the newborn is ill or well.

G.4 Orthopaedic Surgery – Fractures

a. When a medical practitioner attempts a closed reduction of fracture unsuccessfully and finds it necessary to transfer the patient into the care of another medical practitioner, the initial benefit may be claimed at 50% of the listed benefit.

b. A medical practitioner receiving a transferred patient after an initial unsuccessful closed reduction of a fracture may claim the full benefit for the final reduction.

c. A medical practitioner performing an open reduction after his/her initial unsuccessful closed reduction of a fracture shall claim only the benefit for the open reduction.

d. Rigid immobilization of a fracture that does not require a closed reduction may be claimed at 50% of the listed benefit for the closed reduction.

e. Closed reduction of a compound fracture may be claimed at 150% of the listed benefit.

G.5 Psychiatry

a. Individual psychotherapy or counseling may be claimed when the intent of the encounter is the therapy of one individual.

b. Group psychotherapy may be claimed when all members of the group, present at the encounter, are receiving therapy in the session.

c. Individual counseling by a general practitioner may be claimed only where an appointment is specifically for the purpose of psychotherapy.

G.6 Anaesthesia

a. An anaesthesia benefit is based on the time between the induction of anaesthesia and when the attendance of the anaesthetist is no longer required, and an additional benefit that reflects the nature of the procedure.

b. For the purpose of assessment of anaesthetic benefits, each anaesthestic procedure shall be considered as a separate and complete procedure.

c. The listed benefit is for professional services including pre-anaesthesia evaluation and **post-anaesthetic** follow-up and all immediate supportive measures.

d. In special cases where the Department, in the interests of the patient, considers more than one Anaesthetist necessary, the benefit payable to the second Anaesthetist may not exceed 75% of the benefit otherwise prescribed for the procedure.

e. If multiple surgical procedures are provided to a patient under a single anaesthetic, the principles, which apply to the payment of surgeons, are applicable to the payment of anaesthetic benefits.

f. For diagnostic and therapeutic anaesthetic procedures, the anaesthetic benefit is for professional services and excludes the cost of materials but includes examination, **post-treatment** observation, and **follow-up**; consultations, when requested, may be charged in addition to nerve block procedures.

g. Claims submitted for general anaesthesia must include the services provided, the duration of the anaesthesia, the fee code and its descriptor; as well, the letter "AX" must be placed after the fee code to indicate that it is an anaesthesia claim.

h. Where the anaesthetist is the medical practitioner in attendance of a patient, and consultation by a surgeon, the anaesthetist is entitled to claim either:

    i. The emergency benefit or the admission benefit, and
    ii. The anaesthetic benefit, if applicable

i. In addition to the entitlement to claim the anaesthetic benefit, the anaesthetist may claim

    i. The admission benefit, where the anaesthetist is the admitting medical practitioner, and
    ii. The daily care benefit, where the anaesthetist has been

providing daily care prior to surgery

G.7 Critical Care

a. **Life threatening critical care** is care to a critically ill or injured patient, where the illness or injury acutely impairs one more vital organ systems and results in imminent life threatening deterioration in the patient's conditions, or makes such deterioration highly probable. This can include, but is not limited to central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure.

b. Life threatening critical care is time-based and includes the following services that are not eligible to be claimed when rendered to the same patient by the same physician on the same day:

    i. Assessment and ongoing monitoring of the patient's condition
    ii. Intravenous lines
    iii. Cutdowns
    iv. Arterial and/or venous catheters
    v. Central venous pressure lines
    vi. Endotracheal intubation
    vii. Tracheal toilet
    viii. Blood gases
    ix. Nasogastric intubation with/without anaesthesia with/without lavage
    x. Urinary catheterization
    xi. Pressure infusion sets and pharmacological agents
    xii. Defibrillation
    xiii. Cardioversion

c. The time claimed for life threatening critical care may be consecutive or non-consecutive, but must be spent fully devoted to the care of the patient. It cannot be claimed for the services of a physician on the same day for which the physician claims a per diem fee for critical

care in the intensive care unit, ventilatory support, or comprehensive care.

d. **Other critical care** is a service rendered for resuscitation, assessment, and related procedures, other than those described as life threatening critical care but where there is a potential threat to life and limb such that the medical care is necessary to prevent the loss of limb or the requirement for life threatening care.

e. Other critical care is time-based and includes the following services that are not eligible to be claimed when rendered to the same patient by the same physician on the same day:

    i. Assessment and ongoing monitoring of the patient's condition
    ii. Intravenous lines
    iii. Cutdowns
    iv. Arterial and/or venous catheters
    v. Central venous pressure lines
    vi. Endotracheal intubation
    vii. Tracheal toilet
    viii. Blood gases
    ix. Nasogastric intubation with/without anaesthesia with/without lavage
    x. Urinary catheterization
    xi. Pressure infusion sets and pharmacological agents

f. **Critical care per diem** claims apply per patient treated by the physician-in-charge of a patient in the intensive care unit and reflect the number of days the patient has received such care.

g. Critical care per diem charges can be any of Critical Care, Ventilatory Support, or Comprehensive Care (both Critical Care and Ventilatory Support); when claimed, no other critical care codes may be used by the same physician.

h. **Critical Care** is the provision by a physician of all aspects of the care of a critically ill patient in the intensive care unit, excluding Ventilatory Support.

i. **Ventilatory Support** is the provision of ventilatory care to a critically ill patient in the intensive care unit, including initial consultation and assessment, peripheral intravenous lines, endotracheal intubation with positive pressure ventilation, insertion of arterial and central venous lines, tracheal toilet, use of artificial ventilator, and the interpretation of all related laboratory testing.

j. **Comprehensive Care** is the provision of both Critical Care and Ventilatory Support to a critically ill patient in the intensive care unit.

k. Physicians other than those providing Critical Care or Comprehensive Care may claim consultation, visit, or procedural fees not listed as part of critical care. If Ventilatory Care is the only service provided by one physician, another may claim Critical Care fees or the appropriate consultation, visit, or procedural fees.

l. The critical care per diem fees should not be claimed for stabilized patients or for those patients who are in the intensive care unit for the purpose of monitoring.

G.8 Emergency Medicine

a. The schedule of services for Emergency Medicine apply only to assessments and procedures rendered by the emergency physician(s) who are on duty and on-site in the emergency department.

b. The time designations for assessments and procedures in the emergency department are, as follows:

i. Day 08:00 – 18:00
ii. Evening 18:00 – 24:00
iii. Night 24:00 – 08:00
iv. Weekend and Holidayservices are defined as occurring from 08:00 to 24:00 on a Saturday, Sunday, or statutory holiday

c. When not specific to the emergency department, procedures shall be claimed using the appropriate service codes designated in other specialty sections of the Schedule, providing that the emergency physician has the appropriate credentials and privileges to provide these services.

d. **Level I** visits in the emergency department are defined as a level of service pertaining to the evaluation and treatment of a single condition requiring a short history, examination, and treatment; it shall include review of related laboratory tests and x-rays. This visit level shall pertain, as well, to patients not meeting the criteria for Level II or Level III care.

e. **Level II** visits in the emergency department pertain to the evaluation of a medical condition that necessitates a detailed medical history and physical examination of three or more regions; it shall include review of related laboratory tests and x-rays, and the initiation of appropriate treatment. This visit level shall pertain, as well, to those patients whose illness or injury requires prolonged observation, continuous therapy, and multiple reassessments.

f. **Level III** visits in the emergency department pertain to the evaluation of a patient with serious multiple or complex medical problem(s) which can be obscure and which require a detailed and comprehensive history and complete physical examination; it shall include review of related laboratory tests and x-rays, and the initiation of appropriate

treatment, in addition to discussions with the patient, family members, and other physicians.

g. **Critical care** visits in the emergency department are defined as **life threatening critical care** and **other critical care** in section G.7 of this preamble.

h. **Medivac preparation** of a patient includes those assessments and interventions required after the decision to transport a seriously ill patient is confirmed by the receiving hospital.

H Appendix: New Service Item Committee

H.1 The New Service Item Committee (NSIC) is a joint committee constituted by representatives of the Northwest Territories Medical Association (NWTMA) and the Department of Health and Social Services (DHSS) of the Government of the Northwest Territories (GNWT).

H.2 The mandate of the NSIC is to recommend to the Minister of Health and Social Services (the ”Minister”) the inclusion of new insured medical services in the Insured Services Tariff (the “Schedule”), as published by the GNWT.

H.3 Implementation of the recommendations of the NSIC requires the approval of the Deputy Minister of Health and Social Services (if the recommendation is not cost neutral) or the Director of Health Services Administration (if the recommendation is cost neutral).

H.4 All recommendations of the NSIC will incorporate proposed billing rules around a new service item, including but not limited to site of service, eligible specialty(ies), anaesthesia units (where applicable), and associated eligible premiums.

H.5 The NWTMA shall appointment two physicians to serve on the NSIC with the following responsibilities:

a. Chair the NSIC
b. Receive new service items requests from clinical specialty representatives of the NWTMA, or from the DHSS
c. Set the agenda and provide items for discussion at NSIC meetings, with input from the DHSS
d. Provide liaison between the NSIC and the originator of a proposal, clarifying related issues and reporting results of the committee deliberations
e. Work with DHSS staff in developing billing rules for a recommended new service item

H.6 The Director, Health Services Administration of the DHSS shall appoint two GNWT representatives to serve on the NSIC with the following responsibilities:

a. Organize materials for the DHSS representatives
b. Document and collate NWTMA and DHSS proposals
c. Document and collate actions and correspondence on each new service item under consideration by the NSIC
d. Prepare relevant utilization data on each new service item under consideration by the NSIC
e. Prepare a cost impact analysis on each new service item under consideration by the NSIC
f. Where required, obtain an independent clinical perspective on a new service item that is under consideration, and provide that perspective for consideration by the NSIC
g. Provide liaison between the NSIC and Deputy, or the delegate of the Deputy, clarifying related issues and reporting results of the committee deliberations
h. Where required, undertake environmental scans across the country concerning the items being considered by the NSIC, including but not limited to codes for the specific services, insured benefits, service volumes, and associated descriptions of the service
i. Work with the NWTMA in developing billing rules for a recommended new service item

H.7 The CEO of the Stanton Territorial Health Authority shall appoint two hospital representatives to serve on the NSIC with the following responsibilities:

a. Provide the perspective of hospital services
b. Provide the perspective of other health authorities, where applicable
c. Where required, provide technology expertise and advice to the NSIC

H.8 Following is the process that guides the activities of the NSIC:

a. The NWTMA, DHSS, or the health authorities, using a standard New Service Item Request Form, can submit a request for a new service item to the Chair of the NSIC.
b. When a physician contacts the DHSS Medical Advisor and requests to be paid through Independent Consideration (IC) for a new service which does not have a specific code for it in the Insured Services Tariff, the Medical Advisor or Consultant may assign an interim value for the service and advise the physician to bill the service/procedure as an IC, using a manual payment form. It is then incumbent upon the physician to ensure there is a New Service Item Request Form completed and sent to the NWTMA within six months. If no formal request has been received by the NWTMA and the DHSS notified of the request, payment of the service through IC will be discontinued.
c. DHSS documents and collates proposals, actions, and correspondence that relate to potential new service items, under consideration by the NSIC
d. The Chair of the NSIC, after consultation with the Director, Health Services Administration, will call a meeting of the NSIC and provide all available documentation prior to that meeting; the documentation includes that provided by both the NWTMA and the DHSS
e. Requests for a new service item are duly considered by the NSIC with respect to merit, validity, completeness, cost, and perceived benefit. If the NSIC determines that there are necessary clarifications or extra information required, the Chair, on behalf of the NSIC, will undertake to contact the appropriate resource for such clarification or extra information
f. NSIC decisions are based on consensus, and could be any of the following: acceptance, as submitted; acceptance, with adjustments; rejection; or referral
g. NSIC decisions are communicated to the originator of the proposal for a response. If the decision is acceptance of the requested item and the originator is in agreement with the conditions on which the NSIC has based its decision, the matter can move forward to the next step; if however, the requestor does not accept the decision, the issue may be brought back to the NSIC for further discussion and possible adjustment.

h. Once both the NSIC and the originator of the proposal accept the documented decision, the NSIC will submit the new service item for consideration by the Deputy, or delegate, or the Director, Health Services Administration, depending on the financial implications of the decision. This submission will include the supporting documents available to the NSIC, including the recommended billing rules.

I Appendix: Updating and Maintenance of the Schedule

I.1 Updating and maintenance of the Insured Services Tariff (the "Schedule") is essential to reflecting care and to its continuing relevance to government and to physicians. Further, technology advances can necessitate revision to a fee service code and its constituent elements.

I.2 Updating and maintenance of the Schedule can include any or all of:

a. Adding a code
b. Deleting a code
c. Changing the value of a code
d. Modifying a code descriptor, a billing rule, or a payment rule

I.3 Responsibility for updating and maintenance of the Schedule rests with the Department of Health and Social Services (DHSS), and can include consultation and advice from the Northwest Territories Medical Association (NWTMA).

I.4 Decision-making requires clearly articulated objectives and goals that are explicit, reasonable, and objective. Outcome measures should target the needs of patients, providers, and the payer.

I.5 Evaluating the efficacy of the process of updating and maintenance of the Schedule requires identification of goals, measuring the outcome against those goals, and timeliness.

I.6 The three sources of codes for annual review are:

a. New code approved through the process established by the New Service Item Committee (NSIC)
b. Codes submitted for consideration by either the DHSS or the NWTMA
c. A further total of fifty codes selected randomly from the top fifteen codes, by service volume, for each clinical specialty

I.7 Each review will include a relativity assessment and determination of the impact of technology on the provision of the service.

I.8 The relativity assessment will be the basis of valuating a new code or modifying the value of an existing code. The basis of the relativity assessment is the derivation of intensity and its measurement against an existing intensity rating. The existing intensity rating will be that of an anchor code for each specialty; the anchor code can be either a procedure or an assessment that is performed commonly and is easily understood.

I.9 The intensity rating is a derived relative value for the code. These ratings have been calculated for most commonly used codes in the Northwest Territories; each will be confirmed for the anchor services. The service being evaluated will measure relative value as a function of knowledge and judgment, technical skills, communication skills, and risk and stress. These components of physician work and the typical time required to perform a service will be derived from consultation with the NWTMA and external resources, as required.

I.10 Therefore, the valuation formula is, as follows:

$$V_1 = V_2 \ (I_1 \ / \ I_2)$$

where

V_1	is	calculated value for the new or assessed code
V_2	is	existing value for anchor code
I_1	is	intensity rating for the new or assessed code
I_2	is	intensity rating for anchor code

where

I	is	sum of 1-7 ratings for each of knowledge and judgment, technical skills, communication skills, and risk and stress, multiplied by the average time required for the service

INDEX TO INSURED SERVICES TARIFF FOR PHYSICIANS	
Please Note	**The use of this schedule requires awareness and the application of the explanatory notes and billing rules that are detailed in the Preamble to the Insured Services Tariff for Physicians**
Page	**Clinical Sections**

Fee Code	Descriptor	Price	
	SECTION AN ANAESTHESIA		
	Consultations and Assessments		
AN-001	Major consultation for a life-threatening condition, either by itself or in association with proposed anaesthesia and surgery	173.03	
AN-002	Minor consultation for a regional complaint which does not require a complete history and physical examination	103.82	
AN-003	Assessment and initiation of treatment of a non-anaesthetic condition, when requested and urgent	69.22	
	Time-Based Benefits for Surgery		
AN-004	For up to the first 30 minutes of anaesthetic time	152.24	
AN-005	For up to the second 30 minutes of anaesthetic time	83.08	
AN-006	After one hour of anaesthetic time, for each subsequent 15 minutes or major portion of 15 minutes	62.29	
AN-007	After three hours of anaesthetic time, for each 7.5 minutes or major portion of 7.5 minutes	62.29	
	Procedural Benefits for Surgery		
Where the total surgical benefit is $200 or greater, additional anaesthetic procedural benefits are:			
AN-008	Where total surgical benefit exceeds $ 200	83.08	
AN-009	Where total surgical benefit exceeds $ 250	124.56	
AN-010	Where total surgical benefit exceeds $ 300	166.08	
AN-011	Where total surgical benefit exceeds $ 350	207.63	
AN-012	Where total surgical benefit exceeds $ 400	249.16	
AN-013	Where total surgical benefit exceeds $ 450	290.68	
AN-014	Where total surgical benefit exceeds $ 500	332.21	
AN-015	Where total surgical benefit exceeds $ 550	373.72	

AN-016	Where total surgical benefit exceeds $ 600	415.25	
AN-017	Where total surgical benefit exceeds $ 650	456.76	
AN-018	Where total surgical benefit exceeds $ 700	498.29	
AN-019	Where total surgical benefit exceeds $ 750	539.83	
AN-020	Where total surgical benefit exceeds $ 800	581.35	
AN-021	Where total surgical benefit exceeds $ 850	622.88	
AN-022	Where total surgical benefit exceeds $ 900	664.42	
AN-023	Where total surgical benefit exceeds $ 950	705.92	
AN-024	Where total surgical benefit exceeds $ 1,000	747.47	
	Anaesthesia Modifiers		
AN-025	Body Mass Index (BMI) greater than 40	20% (of time-based benefits + procedural benefits)	
AN-026	Sleep apnea patient using C-PAP apparatus and with a Body Mass Index (BMI) less than 40	20% (of time-based benefits + procedural benefits)	
AN-027	ASA III	55.35	
AN-028	ASA IV	173.03	
AN-029	ASA V	346.04	
AN-030	Infant from 0-12 months	89.96	
AN-031	Age 1-8 years	34.59	
AN-032	Age 70 years or greater	34.59	
AN-033	Prone position	69.22	
AN-034	Awake intubation	69.22	
AN-035	Malignant hyperthermia susceptible	89.96	

AN-036	Acute airway obstruction	173.03	
	Nerve Blocks		
AN-037	Brachial plexus	96.90	
AN-038	Celiac ganglion	138.42	
AN-039	Combined 3-in-1 block of femoral, obturator, and lateral femoral cutaneous nerves - unilateral	173.03	
AN-040	Femoral nerve - unilateral	96.90	
AN-041	Femoral nerve - bilateral	138.42	
AN-042	Intercostal	48.43	
AN-043	Lumbar epidural or caudal epidural block	214.54	
AN-044	Lumbar epidural or intrathecal injection of sclerosing agent	311.44	
AN-045	Lumbar epidural injection of adrenal steroid or autologous blood	124.56	
AN-046	Lumbar epidural injection post-laminectomy into operative site	166.08	
AN-047	Obturator nerve - unilateral	96.90	
AN-048	Obturator nerve - bilateral	138.42	
AN-049	Occipital nerve - unilateral to maximum of 3 per day or 48 per calendar year	48.43	
AN-050	Other cranial nerve block	124.56	
AN-051	Other somatic or peripheral nerve blocks not specifically listed	62.29	
AN-052	Paravertebral - initial	96.90	
AN-053	Paravertebral - additional or repeat	62.29	
AN-054	Pudendal nerve - unilateral	96.90	
AN-055	Pudendal nerve - bilateral	138.42	

AN-056	Sciatic nerve - unilateral	96.90	
AN-057	Sciatic nerve - bilateral	138.42	
AN-058	Supraorbital nerve	62.29	
AN-059	Sympathetic block - lumbar or thoracic - unilateral	96.90	
AN-060	Sympathetic block - lumbar or thoracic - bilateral	138.42	
AN-061	Transverse scapular nerve	96.90	
AN-062	Trigeminal ganglion	138.42	
	Continuous Epidural Anaesthesia		
AN-063	Initial induction including consultation	214.54	
AN-064	Each additional injection	55.35	
AN-065	For each hour of continuous infusion	27.70	
	Procedural Sedation Other Than in Operating Room		
AN-066	For first 30 minutes	124.56	
AN-067	For each 5 minutes greater than 30 minutes	13.86	
Fee Code	**Descriptor**	**Price**	
	SECTION CC CRITICAL CARE		
	Life Threatening Critical Care		
CC-001	Life threatening critical care - first 15 minutes or part thereof for up to three physicians	166.08	
CC-002	Life threatening critical care - second 15 minutes or part thereof for up to three physicians	83.08	
CC-003	Life threatening critical care - per 15 minutes or part thereof after the first 30 minutes for up to three physicians	55.35	
	Other Critical Care		
CC-004	Other critical care - first 15 minutes or part thereof for up to three physicians	83.08	

CC-005	Other critical care - per 15 minutes or part thereof after the first 15 minutes for up to three physicians	41.52	
	Critical Care Per Diem Charges		
CC-006	Critical Care per diem for physician-in-charge of patient in intensive care - day 1	415.25	
CC-007	Critical Care per diem for physician-in-charge of patient in intensive care - day 2-30	207.63	
CC-008	Critical Care per diem for physician-in-charge of patient in intensive care - day 31 onwards	103.82	
	Ventilatory Support Per Diem Charges		
CC-009	Ventilatory Support per diem for physician-in-charge of ventilatory care of patient in intensive care - day 1	332.21	
CC-010	Ventilatory Support per diem for physician-in-charge of ventilatory care of patient in intensive care - day 2-30	166.08	
CC-011	Ventilatory Support per diem for physician-in-charge of ventilatory care of patient in intensive care - day 31 onwards	83.08	
	Comprehensive Care Per Diem Charges		
CC-012	Comprehensive Care per diem for physician-in-charge of patient in intensive care - day 1	553.68	
CC-013	Comprehensive Care per diem for physician-in-charge of patient in intensive care - day 2-30	276.83	
CC-014	Comprehensive Care per diem for physician-in-charge of patient in intensive care - day 31 onwards	138.42	
Fee Code	**Descriptor**	**Price**	
	SECTION DI DIAGNOSTIC IMAGING		
	Head		
	Maximum of 2 CT scans may be claimed per patient per day	0.00	
DI-001	Skull	22.82	
DI-002	Facial bones	24.25	
DI-003	Mandible	18.67	
DI-004	Panorex	10.39	

DI-005	Nasal bones	12.47	
DI-006	Adenoids or nasopharynx	13.86	
DI-007	Adenoids or nasopharynx, lateral and AP	20.76	
DI-008	Mastoids	20.76	
DI-009	Sinuses-Paranasal	18.67	
DI-010	Temporo-mandibular joints	18.67	
DI-011	Sella turcica	18.67	
DI-012	Orbit - for foreign body	16.63	
DI-013	Orbit - for foreign body localization	33.20	
DI-014	Optic foramina	22.15	
DI-015	Internal auditory canal	13.86	
DI-016	Salivary gland regions	16.63	
DI-017	Sialography (interpretation only)	24.91	
DI-018	Sialography (injection of opaque material)	96.90	
	Chest		
DI-019	Chest - single view	13.86	
DI-020	Chest - multiple view	18.00	
DI-021	Thoracic inlet views	18.00	
DI-022	Ribs	13.86	
DI-023	Chest - fluoroscopy	13.86	
DI-024	Chest - bronchography (interpretation only)	41.52	

DI-025	Bronchogram - instillation of opaque material	96.90	
DI-026	Mammography (one breast)	41.52	
DI-027	Mammoductography	55.35	
DI-028	Mammocystography	55.35	
DI-029	Mammography (both breasts)	69.22	
DI-030	Needle localization under mammographic control prior to biopsy of the breast - single lesion	47.07	
DI-031	Sternum/sterno-clavicular joints	19.37	
	Upper Extremity		
DI-032	Finger	9.01	
DI-033	Hand	14.53	
DI-034	Wrist/carpal bone (wrist & hand)	16.63	
DI-035	Carpal tunnel view additional benefits	5.52	
DI-036	Radius and ulna	14.53	
DI-037	Elbow	15.22	
DI-038	Humerus	14.53	
DI-039	Clavicle	14.53	
DI-040	Acromioclavicular joints	14.53	
DI-041	Shoulder girdle	17.29	
DI-042	Scapula	15.93	
DI-043	Arthrogram - any upper extremity joint (interpretation only)	45.68	
DI-044	Injection for arthrogram	107.97	

	Lower Extremity		
DI-045	Toe	9.01	
DI-046	Foot	14.53	
DI-047	Ankle	16.63	
DI-048	Os calcis	13.86	
DI-049	Tibia & fibula	14.53	
DI-050	Knee	18.67	
DI-051	Skyline tunnel view of knee, additional benefit	5.52	
DI-052	Arthrogram - any lower extremity joint (interpretation only)	45.68	
DI-053	Injection for arthrogram	107.97	
DI-054	Femur or thigh	14.53	
DI-055	Hip	18.67	
DI-056	Hip - arthrogram	45.68	
DI-057	Hip pinning	27.70	
DI-058	Hip pinning with fluoroscopy	41.52	
DI-059	Pelvis	20.76	
DI-060	Pelvis & one hip	26.31	
DI-061	Pelvis & both hips	30.43	
DI-062	Sacro-iliac joints	20.76	
	Stress View of a Limb Additional Benefit		
DI-063	Stress View of a Limb Additional Benefit - unilateral	6.23	

DI-064	Stress View of a Limb Additional Benefit - bilateral	9.69	
	Spine		
DI-065	One area	27.70	
DI-066	One area - with obliques	34.59	
DI-067	Two areas	45.68	
DI-068	Two areas - of the spine with obliques of each area	62.29	
DI-069	Complete spine	52.59	
DI-070	Spine - flexion and extension additional benefit	6.90	
DI-071	Spine - lateral bending, additional benefit	6.90	
DI-072	Spine - both, additional benefits	10.39	
DI-073	Myelogram, x-ray and fluoroscopy	48.43	
DI-074	Myelogram, cervical or thoracic	48.43	
DI-075	Myelogram injection	103.82	
DI-076	Discogram injection	179.94	
	Genito-Urinary		
DI-077	Kidney, Ureter, Bladder	18.67	
DI-078	Cystography (excluding catheterization, interpretation only)	18.67	
DI-079	Urethrography (excluding catheterization)	15.93	
DI-080	Excretory pyelography (interpretation only)	49.82	
DI-081	Pyelography (injection only)	49.82	
DI-082	Retrograde pyelogram	27.70	

DI-083	Nephrotomography (interpretation only)	89.96	
DI-084	Minute sequence excretory pyelography (interpretation only)	76.13	
DI-085	Pelvimetry	29.07	
DI-086	Hystero - salpingography (with or without fluoroscopy, interpretation only)	34.59	
DI-087	Hystero - salpingogram (insufflation or injection of opaque material)	103.82	
	Gastrointestinal		
DI-088	Esophagus with fluoroscopy (interpretation only)	55.35	
DI-089	Stomach & duodenum with fluoroscopy (interpretation only)	62.29	
DI-090	Double contrast examination of stomach (additional fee)	9.69	
DI-091	Follow-up film taken following day	6.90	
DI-092	Stomach, duodenum and small bowel follow through and with fluoroscopy (including follow-up film taken next day if necessary) (interpretation only)	83.08	
DI-093	Small bowel only fluoroscopy (interpretation only)	44.30	
DI-094	Selective hypotonic duodenography	55.35	
DI-095	Small bowel studies including fluoroscopy & administration of cholinergic drugs (enteroclysis)	110.75	
DI-096	Intubation for duodenography	69.22	
DI-097	Colon (with fluoroscopy and films) (interpretation only)	41.52	
DI-098	Colon (with fluoroscopy) combined with air contrast examination (interpretation only)	55.35	
DI-099	Barium enema for reduction of intussuesception	117.67	
DI-100	Cholecystography (including repeat examination on following day if necessary)	24.91	
DI-101	Cholecystography with fluoroscopy	51.22	
DI-102	Trans-hepatic percutaneous cholangiography	89.96	

DI-103	Operative cholangiogram (interpretation only)	39.46	
DI-104	T-tube cholangiogram (including injections)	122.51	
DI-105	Abdomen - single view	18.00	
DI-106	Abdomen - multiple views	24.91	
	Skeletal Survey		
DI-107	Skull, shoulder, chest, spine and pelvis	55.35	
DI-108	Tomogram (laminogram & planogram) including stereos & fluoroscopy when necessary, any area	48.43	
DI-109	Fluoroscopy of areas not specified elsewhere in schedule	83.08	
DI-110	Bone age	15.57	
DI-111	Singogram or fistulogram without fluoroscopy	32.19	
	Vascular		
DI-112	Artery or vein (interpretation only)	48.43	
DI-113	Peripheral venography (direct puncture and injection)	103.82	
	Diagnostic Ultrasound Head and Neck		
DI-114	Echoencephalography, complete, diencephalic midline and ventricular size (Real Time)	55.35	
DI-115	Echography thyroid (Real Time)	48.43	
	Diagnostic Ultrasound Heart		
DI-116	Echocardiography, pericardial effusion, M-mode	41.52	
DI-117	Pericardiocentesis by ultrasound guidance	89.96	
DI-118	Echocardiography, cardiac valve(s), M-mode	69.22	
DI-119	Echocardiography, M-mode (X-213 and X-215, combined and chamber dimensions)	110.75	

DI-120	Real Time echocardiography, includes M-mode tracing	110.75	
DI-121	Doppler Echocardiography	103.82	
DI-122	Echocardiography, limited eg. follow-up or limited study	41.52	
DI-123	Echography, Pleural Effusion (Real Time)	55.35	
DI-124	Thoracentesis by ultrasound guidance	83.08	
DI-125	Echography breast, unilateral (Real Time)	62.29	
DI-126	Echography breast, bilateral (Real Time)	96.90	
	Diagnostic Ultrasound Abdomen and Retroperitoneum		
DI-127	Complete, Real Time abdominal study including liver, gallbladder, pancreas, kidneys, aorta and including hard copy images of all areas described	117.67	
DI-128	Limited, eg. follow-up or limited study	62.29	
DI-129	Renal	89.96	
DI-130	Ultrasound guidance for aspiration or biopsy	89.96	
	Diagnostic Ultrasound Obstetrics and Gynecology and Pelvis		
DI-131	Placenta localization or follow up	55.35	
DI-132	Pregnancy, complete under 14 weeks (including twins and triplets)	83.08	
DI-133	Pregnancy, complete over 14 weeks (including twins and triplets)	124.56	
DI-134	Pelvic	69.22	
DI-135	Transvaginal	83.08	
	Diagnostic Ultrasound Peripheral Vascular		
DI-136	Peripheral flow study (Doppler), arterial	62.29	
DI-137	Venous (Doppler)	62.29	

DI-138	Arterial & venous (X-245 and X-246)	83.08	
	Diagnostic Ultrasound Miscellaneous		
DI-139	Scrotal ultrasound	55.35	
DI-140	Ultrasound, guidance only	83.08	
DI-141	Biophysical profile	152.24	
	Diagnostic Ultrasound Real Time Extremities or Joints		
DI-142	Unilateral	52.17	
DI-143	Bilateral	71.76	
	Computerized Tomography Head		
DI-144	Without contrast	78.29	
DI-145	With contrast	110.89	
DI-146	Double scan or 2 planes, without contrast	143.53	
DI-147	Double scan or 2 planes, with contrast	163.09	
	Computerized Tomography Body		
DI-148	One area, without contrast	156.59	
DI-149	One area, with contrast	169.62	
DI-150	Double scan or 2 regions, without contrast	234.87	
DI-151	Double scan or 2 regions, with contrast	280.52	
Fee Code	**Descriptor**	**Price**	
	SECTION DT DIAGNOSTIC AND THERAPEUTIC PROCEDURES		
	Vascular System		
DT-001	Intravenous injection	20.76	

DT-002	Cutdown of peripheral vein	55.35	
DT-003	Cutdown of peripheral artery	346.04	
DT-004	Obtaining blood sample for transport to distant laboratory if approved by facility responsible for the collection	16.63	
DT-005	Venipuncture of patient under 16 years of age	34.59	
DT-006	Scalp infusion or insertion of intravenous line where patient under 16 years of age	48.43	
DT-007	Phlebotomy	34.59	
DT-008	Arterial puncture	27.70	
DT-009	Insertion of Swan Ganz catheter and all related monitoring	207.63	
DT-010	Left ventricular pressures, aortic gradients	346.04	
DT-010A	Bone marrow aspiration	62.62	
DT-010B	Bone marrow core biopsy	117.43	
	Gastrointestinal System		
DT-011	Stomach lavage and gavage	69.22	
DT-012	Esophageal dilation by sound bouginage - initial	138.42	
DT-013	Esophageal dilation by sound bouginage - repeat	69.22	
DT-014	Gastric cytology washings by a medical practitioner	69.22	
DT-015	Diagnostic laparoscopy with or without biopsy	346.04	
	Other Systems		
DT-016	Intramuscular or subcutaneous injections	13.86	
DT-017	Allergy scratch or patch - each antigen - annual maximum $65.00	3.46	

DT-018	Allergy scratch or patch on patient less than 5 years old - each antigen - annual maximum $65.00	6.90	
DT-019	Endotracheal aspiration of sputum	69.22	
DT-020	Interpretation of pulmonary function tests involving lung volumes, diffusing capacities, mixing efficiency, alveolar CO_2	41.52	
DT-021	Lumbar puncture	69.22	
DT-022	Cardioversion	173.03	
DT-023	Insertion of intra-uterine contraceptive device	76.13	
DT-024	Compression sclerotherapy - includes multiple injections, compression bandaging and one post-injection visit	110.75	
DT-025	Repeat compression sclerotherapy	41.65	
(+) DT-026	Periodic papanicolaou smear with maximum of one per patient per 12 months and excluding smears provided in conjunction with a consultation or general assessment	11.75	
(+) DT-027	Additional papanicoloau smear provided as follow-up of abnormal or inadequeate smears	11.75	
DT-028	Papanicolau smear performed outside of hospital - tray fee	15.08	
DT-029	Split thickness skin graft or full thickness pedicle flap	456.65	
DT-030	Laser treatment of cutaneous vascular tumours, per session	163.09	
Fee Code	**Descriptor**	**Price**	
	SECTION EM EMERGENCY MEDICINE		
	Level I Emergency Care		
EM-001	Day	48.43	
EM-002	Evening	62.29	
EM-003	Night	89.96	
EM-004	Weekend and statutory holidays	62.29	

	Level II Emergency Care		
EM-005	Day	89.96	
EM-006	Evening	117.67	
EM-007	Night	166.08	
EM-008	Weekend and statutory holidays	117.67	
	Level III Emergency Care		
EM-009	Day	166.08	
EM-010	Evening	221.46	
EM-011	Night	276.83	
EM-012	Weekend and statutory holidays	221.46	
	Repeat Assessment in Emergency Department		
EM-012A	Repeat assessment of a patient in the Emergency Department required due to the acuity of illness of that patient, but who is not being admitted to hospital nor discharged from the Emergency Department after an initial assessment; the repeat assessment would normally occur two or more hours after the initial assessment	117.67	
EM-012B	Repeat assessment of a patient in the Emergency Department if seen earlier on the same day in the office, Emergency Department, or outpatient department	117.67	
	Life Threatening Critical Care		
EM-013	Life threatening critical care - first 15 minutes or part thereof for up to three physicians	166.08	
EM-014	Life threatening critical care - second 15 minutes or part thereof for up to three physicians	83.08	
EM-015	Life threatening critical care - per 15 minutes or part thereof after the first 30 minutes for up to three physicians	55.35	
	Other Critical Care		
EM-016	Other critical care - first 15 minutes or part thereof for up to three physicians	83.08	
EM-017	Other critical care - per 15 minutes or part thereof after the first 15 minutes for up to three physicians	41.52	
	Procedural Sedation		
EM-018	For first 30 minutes	124.56	

EM-019	For each 5 minutes greater than 30 minutes	13.86	
	Other Services		
EM-020	Performance and interpretation of an ultrasound examination	103.82	
EM-021	Management of psychiatric emergency per 15 minutes	55.35	
EM-022	Certification of mental illness	124.56	
EM-023	Medivac preparation of a patient	249.16	
EM-024	Medivac detention time - outgoing trip per hour to maximum of 12 hours	276.83	
EM-025	Medivac detention time - return trip per hour to maximum of 5 hours	138.42	
EM-026	Insertion of chest tube	69.22	
EM-027	Pericardiocentesis	207.63	
EM-028	Emergency thoracotomy	553.68	
Fee Code	**Descriptor**	**Price**	
	SECTION GP GENERAL PRACTICE		
	Office Visits		
GP-001	First visit requiring general assessment for new illness - maximum of one claim every six months	117.43	
GP-001F	First visit requiring general assessment for new illness - maximum of one claim every six months	124.56	
GP-002	First visit not requiring general assessment, and subsequent office visits other than a simple follow up visit	52.17	
GP-002F	First visit not requiring general assessment, and subsequent office visits other than a simple follow up visit	59.54	
GP-003	Simple follow up visit within two weeks of first visit	26.11	
GP-003F	Simple follow up visit within two weeks of first visit	29.76	
GP-004	Repeat office visit if seen earlier on the same day in the office, emergency department, or outpatient department	43.04	

GP-004F	Repeat office visit if seen earlier on the same day in the office, emergency department, or outpatient department	42.21	
	House Visits		
GP-005	Initial scheduled visit between 08:00 and 18:00	78.29	
GP-005F	Initial scheduled visit between 08:00 and 18:00	117.67	
GP-006	Each additional patient seen during visit	32.63	
GP-006F	Each additional patient seen during visit	53.99	
GP-007	Repeat visit same day at any time	78.29	
GP-007F	Repeat visit same day at any time	119.02	
GP-008	Initial visit on Saturday, Sunday, or statutory holiday, or emergency visit with sacrifice of office hours	163.09	
GP-008F	Initial visit on Saturday, Sunday, or statutory holiday, or emergency visit with sacrifice of office hours	175.77	
GP-009	Evening or night visit initiated and made between 18:00 and 08:00	163.09	
GP-009F	Evening or night visit initiated and made between 18:00 and 08:00	175.77	
	In-Patient Hospital Visits		
GP-010	Initial visit after admission regardless of the time of day that this initial visit is provided	117.43	
GP-010F	Initial visit after admission regardless of the time of day that this initial visit is provided	119.02	
GP-011	Subsequent visit - most responsible physician	34.59	
GP-012	Concurrent care	34.59	
GP-013	Supportive care	34.59	
GP-014	Admission for respite care	58.72	
GP-014F	Admission for respite care	55.35	
GP-015	Chronic care visit to maximum of 3 visits per week or 15 visits per 3-months	34.59	

GP-016	Special visit to hospital inpatient initiated by hospital staff	117.43	
GP-016F	Special visit to hospital inpatient initiated by hospital staff	124.56	
GP-017	Special **visit** to long-term care facility resident, initiated by facility staff	117.43	
GP-017F	Special **visit** to long-term care facility resident, initiated by facility staff	124.56	
	Consultation		
GP-018	Major consultation at the request of another medical practitioner	156.59	
GP-018F	Major consultation at the request of another medical practitioner	152.24	
GP-019	Minor or repeat consultation for same problem at the request of another medical practitioner	78.29	
GP-019F	Minor or repeat consultation for same problem at the request of another medical practitioner	83.08	
GP-020	Major consultation at the request of a nurse in a community health centre in which no physician resides	156.59	
GP-020F	Major consultation at the request of a nurse in a community health centre in which no physician resides	152.24	
GP-021	Minor or repeat consultation for same problem at the request of a nurse in a community health centre in which no physician resides	78.29	
GP-021F	Minor or repeat consultation for same problem at the request of a nurse in a community health centre in which no physician resides	83.08	
	Counseling		
GP-022	Individual counselling by a general practitioner, per 15 minutes (maximum 1.5 hours per visit)	58.72	
GP-022F	Individual counselling by a general practitioner, per 15 minutes (maximum 1.5 hours per visit)	59.54	
GP-023	Group counselling by a general practitioner, per 15 minutes session (maximum 1.5 hours per visit) - bill to one patient	58.72	
GP-023F	Group counselling by a general practitioner, per 15 minutes session (maximum 1.5 hours per visit) - bill to one patient	55.35	
	Special Examinations		
GP-024	Complete assessment of alleged sexual assault	626.26	
GP-024F	Complete assessment of alleged sexual assault	310.41	

GP-025	Complete assessment of sexually transmitted disease	78.29	
GP-025F	Complete assessment of sexually transmitted disease	69.22	
	Additional Hospitalist Services		
GP-026	Discharge planning session with patient, staff, and family where necessary	71.76	
GP-026F	Discharge planning session with patient, staff, and family where necessary	69.22	
GP-027	Additional visits to seriously ill patients while already in hospital	39.13	
GP-027F	Additional visits to seriously ill patients while already in hospital	34.59	
GP-028	Detention time per 15 minutes where a seriously ill inpatient requires undivided attention - after the first hour	65.22	
GP-028F	Detention time per 15 minutes where a seriously ill inpatient requires undivided attention - after the first hour	62.29	
	Surgical Assisting		
GP-029	First hour	242.24	
GP-030	Each 15 minutes after first hour	59.54	
Fee Code	**Descriptor**	**Price**	
	SECTION GS GENERAL SURGERY		
	Visits and Assessments		
GS-001	Major consultation including complete history, examination, review of x-ray and laboratory findings and a written report	193.79	
GS-002	Minor consultation for dealing with one particular problem, or repeat consultation for same problem within 6 months	96.90	
GS-003	Non-referred or transferred patient, first visit requiring complete history and physical examination	124.56	
GS-004	Non-referred or transferred patient, first visit not requiring complete history and physical examination	55.35	
GS-005	Subsequent office visits if not included in surgical fee	27.70	
GS-006	Subsequent hospital visits if not included in surgical fee	34.59	

	Diagnostic Procedures		
GS-007	Biopsy - muscle	166.08	
GS-008	Biopsy - skin or mucosa - incisional or excisional	48.43	
GS-009	Biopsy - skin or mucosa - incisional or excisional, tray fee	27.70	
GS-010	Biopsy (needle) - liver	138.42	
GS-011	Biopsy (needle) - thyroid or breast	138.42	
GS-012	Colonoscopy sigmoid and descending colon	103.82	
GS-013	Colonoscopy to splenic flexure	103.82	
GS-014	Colonoscopy to hepatic flexure	207.63	
GS-015	Colonoscopy to cecum	276.83	
GS-016	Colonoscopy into terminal ileum	346.04	
GS-017	Multiple screening biopsies for malignant changes in ulcerative colitis through colonoscope	83.08	
GS-018	Polypectomy - removal of up to two polyps through colonoscope	207.63	
GS-019	Polypectomy - removal of more than two polyps through colonoscope	311.44	
GS-019A	Multiple screening biopsies through colonoscope other than for maignant changes in ulcerative colitis or polypectomies	83.08	
GS-020	Sigmoidoscopy - rigid - with or without biopsy	83.08	
GS-021	Extended flexible sigmoidoscopy - greater than 20 cm	138.42	
GS-022	Gastroscopy and duodenoscopy - initial with or without biopsy	276.83	
GS-023	Gastroscopy and duodenoscopy - repeat within 3 months with or without biopsy	207.63	
GS-024	Esophagoscopy, with or without biopsy	276.83	
GS-024A	Esophagoscopy with removal of foreign body	313.12	

GS-025	Thoracoscopy, with poudrage and catheter drainage	346.04	
GS-026	Thoracentesis	69.22	
GS-027	Paracentesis	69.22	
	Integumentary System		
	Verrucae - Keratoses - Naevi		
GS-028	Excision of first lesion	48.43	
GS-029	Excision of each additional lesion to maximum of five	20.76	
GS-030	Fulgaration of first lesion	34.59	
GS-031	Fulgaration of each additional lesion to maximum of five	13.86	
GS-032	Cryotherapy or chemotherapy of first lesion	20.76	
GS-033	Cryotherapy or chemotherapy of each additional lesion to maximum of five	9.69	
GS-034	Excision or fulgaration of first pigmented benign naevus, excluding face	48.43	
GS-035	Excision or fulgaration of first pigmented benign naevus of face	83.08	
GS-036	Each additional pigmented benign naevus to maximum of 5	48.43	
GS-037	Excision of malignant melanoma with skin graft excluding face	380.66	
GS-038	Excision of malignant melanoma of face with skin graft	553.68	
GS-039	Plantar wart - single	76.13	
GS-040	Plantar warts - each additional	20.76	
	Cysts		
GS-041	Excision of sebaceous cyst, dermoid cyst, or lipoma - 5 cm or less	103.82	
GS-042	Excision of sebaceous cyst, dermoid cyst, or lipoma - greater than 5 cm	152.24	

GS-043	Excision of additional sebaceous cyst, dermoid cyst, or lipoma - 5 cm or less to maximum of 5	48.43	
GS-044	Excision of sebaceous cyst or lipoma - tray fee	27.70	
GS-045	Dissection and removal of pilonidal cyst	553.68	
GS-046	Marsupialization of pilonidal cyst	484.47	
GS-047	Excision of branchial cyst	553.68	
GS-048	Excision of branchial sinus and fistula	553.68	
	Abscesses		
GS-049	Incision and drainage - subcutaneous or submucous abscess	83.08	
GS-050	Incision and drainage - subcutaneous or submucous abscess - tray fee	27.70	
GS-051	Incision and drainage - palmar space or radial or ulnar bursa	207.63	
GS-052	Incision and drainage - tendon sheath	207.63	
GS-053	Incision and drainage - deep cervical abscess	207.63	
GS-054	Incision and drainage - suppurative bursitis	103.82	
	Lacerations		
GS-055	Suture of minor laceration (5 cm or less)	55.35	
GS-056	Suture of minor laceration (5 cm or less) - tray fee	27.70	
GS-057	Suture of laceration (5.1 cm or more) - per cm	13.86	
GS-058	Suture of laceration (5.1 cm or more) - tray fee	27.70	
GS-059	Debridement of wound when it is the sole surgical procedure being performed on patient that day - per 15 minutes	62.29	
GS-060	Debridement of wound - tray fee	27.70	

	Nail Surgery		
GS-061	Ingrown toenail - wedge excision	69.22	
GS-062	Ingrown toenail - wedge excision - tray fee	27.70	
GS-063	Ingrown toenail - radical excision	138.42	
GS-064	Ingrown toenail - radical excision - tray fee	27.70	
GS-065	Ingrown toenail - bilateral radical excision	221.46	
GS-066	Ingrown toenail - bilateral radical excision - tray fee	27.70	
	Lymphatic System		
GS-067	Biopsy of superficial lymph node - excision	110.75	
GS-068	Biopsy of deep lymph node - excision	166.08	
GS-069	Radical dissection of axillary lymph nodes	1038.13	
GS-070	Radical dissection of inguinal lymph nodes	1038.13	
GS-071	Limited block dissection	1038.13	
GS-072	Complete block dissection - unilateral	1661.00	
GS-073	Complete block dissection - bilateral	2422.29	
GS-074	Regional node excision for tuberculosis	553.68	
GS-075	Sentinel node biopsy	276.83	
GS-076	Excision of scalene fat pad	346.04	
GS-077	Excision of cystic hygroma	346.04	
	Vascular System		
GS-078	External carotid artery ligation	692.06	
GS-079	Internal jugular vein ligation	346.04	

GS-080	Saphenous vein ligation - unilateral	415.25	
GS-081	Saphenous vein ligation - bilateral	622.88	
GS-082	Ligation and stripping of long saphenous veins - unilateral	692.06	
GS-083	Ligation and stripping of long saphenous veins - bilateral	1038.13	
GS-084	Ligation and stripping of long and short saphenous veins - unilateral	968.92	
GS-085	Ligation and stripping of long and short saphenous veins - bilateral	1245.75	
GS-086	Ligation and stripping of short saphenous veins	415.25	
GS-087	Radical multiple ligation of incompetent communicating veins of lower leg (extra-fascial ligation or Crockett procedure, sub-fascial ligation) - excludes stripping of long saphenous vein	1038.13	
GS-087A	Individual ligation of a branch varicose vein elsewhere in leg	97.85	
GS-088	Post-phlebitic leg - ligation of deep vein and stripping of saphenous vein	968.92	
GS-089	Excision of fascia of calf or skin graft - add-on fee	346.04	
GS-090	Superficial femoral ligation	415.25	
GS-091	Introduction of venous catheter for central venous pressure monitoring or for intravenous hyperalimentation - percutaneously or by cut-down	83.08	
	Thyroid and Parathyroid Glands		
GS-092	Thyroglossal duct cyst - excision	968.92	
GS-093	Thyroidectomy - subtotal - unilateral	622.88	
GS-094	Thyroidectomy - total unilateral	1176.55	
GS-095	Thyroidectomy - subtotal - bilateral	968.92	
GS-096	Thyroidectomy - total - bilateral	1661.00	
GS-097	Thyroidectomy - total - bilateral with formal neck dissection	2422.29	

	Breast		
GS-099	Excisional breast biopsy	276.83	
GS-100	Excisional breast biopsy with x-ray localization	346.04	
GS-101	Segmental resection of breast	366.81	
GS-102	Lumpectomy	366.81	
GS-103	Simple mastectomy	346.04	
GS-104	Limited radical mastectomy	692.06	
GS-106	Simple mastectomy - male - pathological breast disease	519.09	
GS-107	Mammoplasty - reduction - bilateral	1038.13	
GS-108	Unilateral breast gynecomastia - male - benign - prior approval required	276.83	
GS-109	Bilateral breast gynecomastia - male - benign - prior approval required	519.09	
	Abdomen		
GS-110	Laparotomy - with or without biopsy	761.30	
GS-111	Intraperitoneal abscess - incision and drainage	1107.33	
GS-112	Subphrenic abscess - incision and drainage	1107.33	
GS-113	Retroperitoneal tumor - biopsy	692.06	
GS-114	Retroperitoneal tumor - excision	1245.75	
GS-115	Percutaneous endoscopic gastrostomy (PEG) - one surgeon	346.04	
GS-117	Percutaneous endoscopic gastrostomy (PEG) - second of two surgeons	173.03	
GS-118	Adhesion bands or volvulus, without resection	899.71	
GS-119	Adhesion bands or volvulus, with resection	1591.79	
GS-120	Intussusception, without resection	899.71	

GS-121	Intussusception, with resection	1591.79	
	Hernia		
GS-122	Epigastric hernia	692.06	
GS-123	Inguinal or femoral hernia - unilateral	830.50	
GS-124	Inguinal or femoral hernia - bilateral	1038.13	
GS-125	Inguinal or femoral - recurrent	1038.13	
GS-126	Umbilical hernia - adults	484.47	
GS-127	Umbilical hernia - child	553.68	
GS-128	Diaphragmatic hernia	1453.39	
GS-129	Bochdalek hernia	1868.65	
GS-130	Strangulated with resection - all hernias	1661.00	
GS-131	Incarcerated - all hernias	1107.33	
GS-132	Wound dehiscence - superficial	346.04	
GS-133	Wound dehiscence - complete	830.50	
GS-134	Incisional ventral hernia	899.71	
GS-135	Incisional ventral hernia with prosthetic mesh	1107.33	
	Gallbladder and Biliary Tree		
GS-136	Cholecystostomy	622.88	
GS-137	Cholecystectomy	1453.39	
GS-138	Cholecystectomy with cholangiogram	1522.59	
GS-139	Laparoscopic cholecystectomy	1453.39	

GS-140	Cholecysto-gastrostomy or enterostomy	1453.39	
GS-141	Choledochostomy	1522.59	
GS-142	Transduodenal sphincteroplasty	1799.43	
GS-143	Choledocho-enterostomy	1522.59	
	Liver		
GS-144	Open biopsy - sole procedure	484.47	
GS-145	Rupture with suture	1107.33	
GS-146	Partial resection for tumor	1384.18	
	Spleen		
GS-147	Splenectomy	1522.59	
GS-148	Laparoscopic splenectomy	1314.97	
	Esophagus		
GS-149	Esophagostomy - fistulization	968.92	
GS-150	Esophagostomy - foreign body or benign tumor	1522.59	
GS-151	Endoscopic banding of esophageal varicosities	152.24	
GS-152	Esophageal balloon dilatation (gastroscopy additional)	34.59	
	Stomach and Duodenum		
GS-153	Laparoscopic Nissen fundoplication	1453.39	
GS-154	Vagotomy - transthoracic	968.92	
GS-155	Vagotomy - transabdominal	1314.97	
GS-156	Gastrostomy with or without feeding tube	830.50	

GS-157	Gastrostomy with removal of tumor or foreign body	1176.55	
GS-158	Percutaneous endoscopic gastrostomy (PEG) - performed by one surgeon only	346.04	
GS-159	Percutaneous endoscopic gastrostomy (PEG) - performed by two surgeons, per surgeon	207.63	
GS-160	Closure of perforated gastric or duodenal ulcer	1176.55	
GS-161	Pyloromyotomy (Rammsteadt procedure)	692.06	
GS-162	Pyloroplasty with vagotomy	1176.55	
GS-163	Gastroenterostomy with vagotomy	1176.55	
GS-164	Gastrectomy - subtotal with or without vagotomy	1730.22	
GS-165	Gastrectomy - radical subtotal	1868.65	
GS-166	Gastrectomy -total	2283.89	
GS-167	Duodenal diverticulum	1107.33	
GS-168	Balloon dilatation of upper GI tract including stomach, duodenum, and jejunum - gastroscopy additional	1107.33	
	Small Intestine		
GS-169	Balloon dilation of intestinal anastamoses (by endoscopy)	346.04	
GS-170	Enterostomy	1038.13	
GS-171	Enterotomy with removal of foreign body or tumor, single	1107.33	
GS-172	Enterotomy with removal of foreign body or tumors multiple	1384.18	
GS-173	Entero-enterostomy	1384.18	
GS-174	Small bowel resection	1384.18	
GS-175	Small bowel plication, any method	1384.18	
GS-176	Massive resection (over 60%)	1384.18	

	Colon		
GS-177	Appendectomy	761.30	
GS-178	Caecostomy	830.50	
GS-179	Colostomy (loop)	830.50	
GS-180	Decompression of sigmoid volvulus (trans-rectal)	899.71	
GS-181	Closure of colostomy	622.88	
GS-182	Colostomy with removal of foreign body or tumor, single	1176.55	
GS-183	Colostomy with removal of foreign body or tumors, multiple	1384.18	
GS-184	Segmental resection, single or multiple stages	1661.00	
GS-185	Hemicolectomy, single or staged and segmental resection	1937.83	
GS-186	Colectomy, total, without removal of rectum, with or without ileostomy (single or multiple stages)	2491.50	
	Rectum		
GS-187	Rectal biopsy for Hirschsprung's disease	276.83	
GS-188	Rectal prolapse - massive - abdominal approach	1591.79	
GS-189	Rectal prolapse - massive - Thiersch procedure	346.04	
GS-190	Rectal prolapse - massive - perineal approach	692.06	
GS-191	Rectal resection - perineal	1937.83	
GS-192	Rectosigmoid resection - anterior segmental	2491.50	
GS-193	Rectovaginal or vesicovaginal fistula repair	1107.33	
GS-194	Rectovesical fistula - resection	1453.39	

	Anus		
GS-195	Perianal abscess - incision and drainage	166.08	
GS-196	Fissure with rectal abscess - incision and drainage	276.83	
GS-197	Ischiorectal abscess - incision and drainage	207.63	
GS-198	External skin tag - excision	55.35	
GS-199	External skin tag - excision - tray fee	27.70	
GS-200	Thrombosed external haemorrhoid - excision or evacuation	89.96	
GS-201	Thrombosed external hemorrhoid - excision or evacuation - tray fee	27.70	
GS-202	Simple anal polyp, excision	103.82	
GS-203	Rectal polyp - excision	186.87	
GS-204	Villous adenoma - excision	311.44	
GS-205	Haemorrhoid banding (maximum of one visit per three week period)	166.08	
GS-206	Fissure - excision	179.94	
GS-207	Fistula-in-ano - simple	332.21	
GS-208	Fistula-in-ano - complicated - total sphincter involvement or multiple fistulae	899.71	
GS-209	Haemorrhoidectomy including sigmoidoscopy	484.47	
GS-210	Transanal polypectomy	761.30	
	Peripheral Nerves		
GS211	Peripheral repair – major – primary	1082.14	
GS212	Peripheral repair – major – secondary	1169.37	
GS213	Peripheral repair – minor – primary or secondary	541.18	

Fee Code	Descriptor	Price	
	SECTION GY GYNECOLOGY		
	Visits and Assessments		
GY-001	Major consultation including complete history, examination, review of x-ray and laboratory findings and a written report	193.79	
GY-002	Minor consultation for dealing with one particular problem, or repeat consultation for same problem within 6 months	96.90	
GY-003	DELETED	0.00	
GY-004	DELETED	0.00	
GY-005	Subsequent office visits if not included in surgical fee	27.70	
GY-006	Subsequent hospital visits if not included in surgical fee	34.59	
	Diagnostic Procedures		
(+) GY-007	Biopsy of vulva or vagina under local anaesthesia	103.82	
(+) GY-008	Vaginoscopy	173.03	
(+) GY-009	Removal of cervical polyp in office	69.22	
(+) GY-010	Biopsy and cauterization or cryotherapy of cervix	69.22	
(+) GY-011	Colposcopy	41.52	
(+) GY-012	Examination under anaesthetic	124.56	
(+) GY-013	Examination under anaesthetic - pre-adolescent female	138.42	
(+) GY-014	Hysterosalpingogram or hydrotubation	173.03	
(+) GY-015	Endometrial biopsy	103.82	
GY-016	Diagnostic laparoscopy	346.04	
GY-017	Diagnostic hysteroscopy	346.04	
GY-018	Hysteroscopy with endometrial ablation	692.06	

(+) GY-019	Wet prep examination	27.70	
GY-019A	Performance and iunterpretation of urodynamics	130.49	
	Urogynecology		
(+) GY-020	Cautery or excision of urethral caruncle	173.03	
GY-021	Urethrovaginal or vesicovaginal fistula repair	1453.39	
GY-022	Burch culposuspension	692.06	
GY-023	Transvaginal or transobturator tape urethral suspension	692.06	
	Vulva		
GY-024	Excision or fulguration of vulvar lesion or genital warts under general anaesthesia	207.63	
GY-025	Perineorrhaphy or medically indicated labioplasty - unless part of a rectocoele repair	415.25	
GY-026	Repair of old third degree laceration	761.30	
GY-027	Bartholin's gland duct cyst or abscess - incision and drainage and marsupialization	276.83	
GY-028	Bartholin gland - excision	276.83	
	Vagina		
GY-029	Excision of congenital septum	276.83	
GY-030	I and D of hematocolpos	173.03	
GY-031	Excision of congenital vaginal cyst or cysts	415.25	
GY-032	Cystocoele or rectocoele repair	899.71	
GY-033	Cystocoele and rectocoele repair	1245.75	
GY-034	Enterocoele repair, including posterior wall repair	1245.75	
GY-035	LeFort operation	899.71	

GY-036	Diagnostic colpotomy - includes D&C if performed	346.04	
GY-037	Sacro-spinous ligament suspension	1730.22	
GY-038	Vault prolapse including anterior and posterior wall repair (Manchester or Fothergill type) or McCall culdoplasty	1384.18	
GY-039	Paravaginal repair	484.47	
	Cervix		
GY-040	D & C - including EUA with removal of polyp and/or biopsy	276.83	
GY-041	Cone biopsy	380.66	
GY-042	LEEP excision of cervix under local anaesthesia	276.83	
GY-043	Cold knife cone biopsy under general or spinal anaesthesia	380.66	
GY-044	Removal of cervical cerclage under general or spinal anaesthesia	276.83	
GY-044A	Placement of cervical cerclage	326.16	
GY-045	Removal of cervical stump, abdominal	1245.75	
GY-045A	Removal of cervical stump, vaginal	848.05	
GY-046	DELETED	0.00	
GY-047	DELETED	0.00	
	Uterus		
GY-048	Myomectomy - vaginal	692.06	
GY-049	Hysteroscopic myomectomy or septum excision	692.06	
GY-050	Myomectomy - abdominal	1051.96	
GY-051	Subtotal hysterectomy	1245.75	
GY-052	Total abdominal hysterectomy - not including oophorectomy	1384.18	

GY-053	Total abdominal hysterectomy with oophorectomy	1565.67	
GY-053A	Total abdominal hysterectomy, salpingo-oophorectomy, omentectomy, staging, and debulking for pelvic malignancy	2348.47	
GY-054	DELETED	0.00	
GY-055	Colposacropexy	1730.22	
GY-056	Total vaginal hysterectomy	1384.18	
GY-056A	Vaginal hysterectomy with oophorectomy	1661.00	
GY-057	Vaginal hysterectomy and repair	1730.22	
GY-058	DELETED	0.00	
GY-059	Laparoscopic supracervical hysterectomy	1107.33	
GY-060	Laparoscopic total hysterectomy	1661.00	
GY-061	Endometrial ablation - any procedure	553.68	
GY-062	Repeat endometrial ablation - any procedure	415.25	
GY-063	Postoperative hemorrhage - laparotomy	692.06	
GY-064	Postoperative hemorrhage - vaginal approach	346.04	
	Adnexae		
GY-065	Salpingectomy, ovarian cystectomy, and/or oophorectomy	899.71	
GY-066	DELETED	0.00	
GY-067	Removal of broad ligament cyst	899.71	
GY-068	Omentectomy for abdominal malignancy	207.63	
GY-069	Sterilization by tubal interruption - any approach	622.88	
(+) GY-070	Laparoscopic cauterization of endometriosis or adhesions, lysis of adhesions, or drainage of cyst or abscess	207.63	

Fee Code	Descriptor	Price	
	SECTION IM INTERNAL MEDICINE		
	Visits and Assessments		
IM-001	Major consultation including complete history, examination, review of x-ray and laboratory findings and a written report	332.21	
IM-002	Major consultation for Inpatient or for patient in Emergency Department	380.66	
IM-003	Minor consultation for dealing with one particular problem, or repeat consultation for same problem within 6 months	166.08	
IM-004	Non-referred or transferred patient, first visit requiring complete history and physical examination	124.56	
IM-005	Non-referred or transferred patient, first visit not requiring complete history and physical examination	55.35	
IM-006	Initiation of Insulin therapy	207.63	
IM-007	Adjustment of Insulin therapy - minimum 15 minutes	69.22	
IM-008	Initiation of Insulin pump - one month of office visits, telephone consultations, written and verbal instructions	484.47	
IM-009	Adjustment of Insulin pump minimum 30 minutes	103.82	
IM-010	Subsequent office visits	83.08	
IM-011	Subsequent hospital visits	55.35	
	Diagnostic Procedures		
IM-012	Electrocardiogram - interpretation	20.76	
IM-013	Holter monitor - interpretation	48.43	
IM-014	Continuous, personal medical practitioner monitoring of graduated maximal stress test - technical fee and monitoring	138.42	
IM-015	Continuous, personal medical practitioner monitoring of graduated maximal stress test - interpretation	48.43	
IM-016	Echocardiography, pericardial effusion, M-mode	55.35	
IM-017	Echocardiography, cardiac valve(s), M-mode	69.22	

IM-018	Echocardiography, M-mode (X-213 and X-215, combined and chamber dimensions)	110.75	
IM-019	Real Time echocardiography, includes M-mode tracing	110.75	
IM-020	Doppler Echocardiography	103.82	
IM-021	Echocardiography - limited follow-up or limited study	62.29	
IM-022	Single chamber permanent programmable pacemaker testing - professional fee	62.29	
IM-023	Single chamber permanent programmable pacemaker testing - technical fee	27.70	
IM-024	Dual chamber permanent programmable pacemaker testing - professional fee	96.90	
IM-025	Dual chamber permanent programmable pacemaker testing - technical fee	62.29	
Fee Code	**Descriptor**	**Price**	
	SECTION LP LABORATORY AND PATHOLOGY		
	Visits and Assessments		
LP-001	Complete blood count (haemoglobin, white blood count, differential, and either red blood count or haematocrit, with no additional charge for indices), by any method	34.59	
LP-002	Haemoglobin	9.01	
LP-003	White blood count only	10.39	
LP-004	Differential	21.45	
LP-005	Sedimentation rate	9.01	
LP-006	Haematocrit	6.90	
LP-007	Platelet count	11.05	
LP-008	Glucose	16.63	
LP-009	Stick test for glucose	2.78	
LP-010	Basic routine examination of urine, including examination of centrifuged sediment	9.69	

LP-011	Urinalysis without microscopic examination of centrifuged sediment	2.78	
LP-012	Occult blood	13.86	
LP-013	Antibiotic tests, disc method - three or less	13.86	
LP-014	Antibiotic tests, disc method - four or more per organism	27.70	
LP-015	Routine culture	29.07	
LP-016	Anaerobic culture	27.70	
LP-017	Biochemical identification of micro-organism	41.52	
LP-018	Urinary and other bacteria counts	27.70	
LP-019	Smear, preparation and examination	17.29	
LP-020	Yeast identification, serological or by chlamydospores	17.29	
LP-021	Immunologic test for infectious mononucleosis	17.29	
LP-022	Latex agglutination slide test (rheumatoid arthritis)	17.29	
LP-023	Semen analysis, including sperm count	27.70	
LP-024	Examination for presence of sperm only	13.86	
LP-025	Pregnancy test	20.76	
	Miscellaneous Procedures		
LP-026	Tissue, gross and microscopic examination with report	124.56	
LP-027	Pap smear	34.59	
LP-028	Chlamydia cultures	5.89	
LP-029	Rapid test for Group A Streptococcus (GAS)	7.83	

Fee Code	Descriptor	Price	
	SECTION NP NEPHROLOGY		
	Visits and Assessments		
NP-001	Major consultation including complete history, examination, review of x-ray and laboratory findings and a written report	332.21	
NP-002	Major consultation for Inpatient or for patient in Emergency Department	380.66	
NP-003	Minor consultation for dealing with one particular problem, or repeat consultation for same problem within 6 months	166.08	
NP-004	Non-referred or transferred patient, first visit requiring complete history and physical examination	124.56	
NP-005	Non-referred or transferred patient, first visit not requiring complete history and physical examination	55.35	
	Procedures		
NP-006	Hemodialysis - initial and acute - medical component	415.25	
NP-007	Hemodialysis - initial and acute - surgical component	415.25	
NP-008	Hemodialysis - subsequent - medical component	346.04	
NP-009	Peritoneal dialysis - acute	276.83	
NP-010	Peritoneal dialysis - repeat acute up to 48 hours	249.16	
NP-011	Peritoneal dialysis - subsequent	138.42	
	Monitoring of Advanced Renal Insufficiency or Dialysis		
NP-012	Multidisciplinary team meetings - in person or remotely no greater than once weekly and minimum of 30 minutes each - claim is per each 30 minutes or part thereof and made using one patient	163.09	
NP-012F	Multidisciplinary team meetings - in person or remotely no greater than once weekly and minimum of 30 minutes each - claim is per each 30 minutes or part thereof and made using one patient	186.87	
Fee Code	**Descriptor**	**Price**	
	SECTION NE NEUROLOGY		
	Visits and Assessments		
NE-001	Major consultation including complete history, examination, review of x-ray and laboratory findings and a written report	332.21	

NE-002	Major consultation for Inpatient or for patient in Emergency Department	380.66	
NE-003	Minor consultation for dealing with one particular problem, or repeat consultation for same problem within 6 months	166.08	
NE-004	Non-referred or transferred patient, first visit requiring complete history and physical examination	124.56	
NE-005	Non-referred or transferred patient, first visit not requiring complete history and physical examination	55.35	
	Diagnostic Procedures		
NE-006	Electroencephalogram - professional fee	55.35	
(+) NE-007	Major electromyography or nerve conduction study - professional fee	124.56	
(+) NE-008	Minor electromyography or nerve conduction study - professional fee	62.29	
NE-009	Electromyography or nerve conduction study - technical fee	89.96	
Fee Code	**Descriptor**	**Price**	
	SECTION OB OBSTETRICS		
	Visits and Assessments		
OB-001	Major consultation including complete history, examination, review of x-ray and laboratory findings and a written report	193.79	
OB-002	Minor consultation for dealing with one particular problem, or repeat consultation for same problem within 6 months	96.90	
OB-003	Non-referred or transferred patient, first visit requiring complete history and physical examination	124.56	
OB-004	Non-referred or transferred patient, first visit not requiring complete history and physical examination	55.35	
OB-005	Subsequent office visits if not included in surgical fee	27.70	
OB-006	Subsequent hospital visits if not included in surgical fee	34.59	
OB-007	Initial major prenatal assessment	138.42	
OB-008	Routine prenatal and postnatal visits including minor conditions related to pregnancy	55.35	

	Diagnostic Procedures		
OB-009	Fetal monitoring interpretation	55.35	
(+) OB-010	Amniocentesis	138.42	
(+) OB -011	Fetal scalp sampling	104.36	
(+) OB - 011F	Fetal scalp sampling	69.22	
(+) OB-012	Non-stress test - interpretation and documentation	41.52	
(+) OB-013	Fetal fibronectin or equivalent test for pre-term labour	41.52	
(+) OB-014	Ferning test for ruptured membranes	27.70	
(+) OB-015	Performance and interpretation of an ultrasound examination for gestation less than 14 weeks	83.08	
(+) OB-016	Performance and interpretation of an ultrasound examination for gestation greater than 14 weeks	124.56	
(+) OB-017	Performance and interpretation of an ultrasound examination for biophysical profile of fetus	152.24	
(+) OB-018	Performance and interpretation of an ultrasound examination during third trimester for fluid checks and deepest pocket	69.22	
(+) OB-019	Performance and interpretation of a limited ultrasound examination for estimated fetal weight	83.08	
(+) OB-020	Performance and interpretation of a limited ultrasound examination for doppler umbilical artery in high risk patient	103.82	
(+) OB-021	Performance and interpretation of a limited ultrasound examination for presentation, position, or placental localization	62.29	
(+) OB-021A	Ultrasound guidance at amniocentesis or external cephalic version	83.08	
	Therapeutic Procedures		
(+) OB-022	D&C for incomplete abortion	276.83	
(+) OB-023	Postpartum D&C for retained products of conception	276.83	
(+) OB-024	Medical management of postpartum hemorrhage	138.42	
OB-025	Medical termination for gestation less than 7 weeks - includes all visits, ultrasound examinations, and injections	415.25	
(+) OB-026	Insertion of laminaria tent prior to abortion	83.08	

OB-027	Therapeutic abortion by D&C for gestation less than 14 weeks	415.25	
OB-028	Therapeutic abortion by D&E for gestation 14-18 weeks	622.88	
OB-029	Therapeutic abortion by D&E for gestation greater than 18 weeks	830.50	
OB-030	Surgical management of ectopic pregnancy	830.50	
OB-031	Medical management of ectopic pregnancy	415.25	
OB-032	Resuscitation by a physician of a seriously depressed infant in the case room	138.42	
(+) OB-033	Manual removal of retained placenta	293.58	
(+) OB-033F	Manual removal of retained placenta	138.42	
(+) OB-034	Repair of extensive laceration of cervix, vagina or perineum including third degree lacerations, including consultation	207.63	
OB-035	Evacuation of vulvar or paravaginal hematoma under regional or general anaesthesia	358.79	
OB-035F	Evacuation of vulvar or paravaginal hematoma under regional or general anaesthesia	242.24	
(+) OB-035A	Repair of fourth degree tear	326.16	
	Confinement Services		
OB-036	Care of healthy newborn in hospital on date of birth	69.22	
OB-037	Care of healthy newborn in hospital on date of discharge	69.22	
OB-038	Daily care of newborn in hospital other than date of birth or discharge	34.59	
(+) OB-039	Intravenous syntocinon induction or augmentation of labour - continuous care by physician - per hour	110.75	
OB-040	Vaginal delivery including application of fetal scalp electrodes and provision of routine postpartum care	692.06	
(+) OB-041	Breech vaginal delivery	587.12	
(+) OB-041F	Breech vaginal delivery	899.71	
(+) OB-041A	Mid-cavity or rotational forceps or vacuum delivery	415.25	

(+) OB-042	Other operative vaginal delivery including application of fetal scalp electrodes and provision of routine postpartum care	899.71	
OB-043	Attendance during labour and delivery if circumstances require the delivery to be performed by another physician	346.04	
OB-044	Attendance of a second physician at a high risk delivery when requested to provide assistance by the primary physician	326.16	
OB-044F	Attendance of a second physician at a high risk delivery when requested to provide assistance by the primary physician	276.83	
OB-045	Management of high risk labour by consulting Obstetrician if delivery subsequently performed by general practitioner	415.25	
OB-045A	Management of labour, attendance at delivery, and routine postpartum care for patient delivered by emergency Caesarean Section	587.12	
OB-046	Vaginal delivery after previous Caesarean Section, including induction using syntocinon	1107.33	
OB-047	Delivery by Caesarean Section	1038.13	
OB-048	Multiple births - any method of delivery - for each additional child	276.83	
(+) OB-049	Low/outlet vacuum or forceps delivery	207.63	
(+) OB-050	External cephalic version with or without ultrasound guidance - attempted or successful	276.83	
+ OB-051	Midcavity forceps rotation or vacuum extraction during vaginal delivery	415.25	
Fee Code	**Descriptor**	**Price**	
	SECTION OP OPHTHALMOLOGY		
	Visits and Assessments		
OP-001	Major consultation including complete history, examination, biomicroscopy, tonometry, ocular motility and report	152.24	
OP-002	Major consultation for Inpatient or for patient in Emergency Department	166.08	
OP-003	Minor consultation for dealing with one particular problem, or repeat consultation for same problem within 6 months	103.82	
OP-004	Non-referred or transferred patient, first visit requiring complete history and physical examination	110.75	
OP-005	Non-referred or transferred patient, first visit not requiring complete history and physical examination	55.35	
OP-006	Examination of eyes - complete	124.56	

OP-007	Subsequent office visits	34.59	
	Diagnostic Procedures		
OP-008	A-scan - one or both eyes	69.22	
OP-009	B-scan - one or both eyes	124.56	
OP-010	Photography - external eye	41.52	
OP-011	Photography - ocular fundus	62.29	
OP-012	Gonioscopy - diagnostic	34.59	
OP-013	Orthoptic analysis - interpretation	138.42	
OP-014	Orthoptic analysis - reassessment	69.22	
(+) OP-015	Manual (Goldman) perimetry - 2 or more isopters	62.29	
(+) OP-016	Computerized perimeter - professional fee	55.35	
(+) OP-017	Conjunctival scraping - diagnostic	27.70	
(+) OP-018	Colour vision, perception lantern test and other tests	69.22	
(+) OP-019	Fluorescein angiography, A scan (Axial length measurement, computerized, performed by technician) for cataract surgery	207.63	
(+) OP-020	A-scan (Axial length measurement, computerized, performed by technician) for cataract surgery	207.63	
OP-021	Corneal pachymetry	13.86	
(+) OP-021A	Slit lamp examination when provided as a service other than part of a consultation	58.72	
	Therapeutic Procedures		
OP-022	Bandage contact lens, only where pathology is present or suspected	41.52	
OP-023	Cauterization of lids or corneal ulcers	96.90	
OP-024	Injections - subconjunctival - per eye	55.35	

OP-025	Injections - retrobulbar or sub-Tenon's - first, per eye	96.90	
OP-026	Injections - retrobulbar - subsequent, per eye	55.35	
OP-027	Injections - retrobulbar - alcohol	249.16	
OP-028	Measurement and fitting artificial eye	553.68	
OP-029	Botulinum A toxin injection - ocular muscle	221.46	
	Eyelids		
OP-030	Chalazion - surgical removal under local anaesthetic	83.08	
OP-031	Chalazion - surgical removal under general anaesthetic	138.42	
OP-032	Epilation - electrolytic and non-electrolytic	55.35	
OP-033	Tumor of lid - benign - surgical excision	103.82	
OP-034	Blepharoplasty: plastic repair of eyelid with or without graft any type - minor	484.47	
OP-035	Blepharoplasty: plastic repair of eyelid with or without graft any type - major	1245.75	
OP-036	Incision - hordeolum, hematoma, lid abscess	69.22	
OP-037	Ectropion and entropion - repair by cautery puncture	166.08	
OP-038	Ectropion and entropion - plastic repair	968.92	
OP-039	Quickert suture for lower lid entropion	249.16	
OP-040	Tarsorrhaphy	359.89	
OP-041	Tarsorrhaphy - temporary	110.75	
	Lacrimal Apparatus		
OP-042	Irrigation or probing of adult nasolacrimal duct under local anaesthesia	69.22	
OP-043	Probing or irrigation of infant or adult lacrimal duct(s) under general anaesthesia	207.63	

OP-044	Catheterization of nasolacrimal duct	249.16	
OP-045	"Three Snip" operation on punctum	110.75	
OP-046	Occlusion of lacrimal gland tubules	242.24	
OP-047	Drainage of lacrimal gland abscess	242.24	
OP-048	Lacerated canaliculi repair	1003.53	
OP-049	Dacryocystectomy	761.30	
OP-050	Dacryocystorhinostomy	1522.59	
OP-051	Conjunctival dacroystorhinostomy	1522.59	
OP-052	Dacryoadenectomy	761.30	
OP-053	Lacrimal gland tumor excision	1522.59	

	Conjunctivae		
OP-054	Removal of foreign body from surface, under general anaesthesia	55.35	
OP-055	Removal of foreign body from surface, under local anaesthesia	55.35	
OP-056	Removal of foreign body from surface, under local anaesthesia, tray fee	16.63	
OP-057	Repair of lacerated conjunctiva	207.63	
OP-058	Biopsy of conjunctiva - local anaesthesia	138.42	
OP-059	Biopsy of conjunctiva - general anaesthesia	186.87	
OP-060	Removal of simple tumor	186.87	
	Cornea		
OP-061	Removal foreign body, under local anaesthetic	138.42	
OP-062	Removal foreign body, under local anaesthesia, tray fee	41.52	

OP-063	Removal foreign body, under general anaesthetic	138.42	
OP-064	Paracentesis	263.00	
OP-065	Dermoid excision	865.10	
OP-066	Malignant tumor of cornea	1176.55	
OP-067	Pterygium	332.21	
OP-068	Recurrent pterygium and graft	899.71	
OP-069	Tattoo	173.03	
OP-070	Corneal transplant (keratoplasty) - penetrating	2353.09	
OP-071	Corneal transplant (keratoplasty) - lamellar	1937.83	
OP-072	Corneal wound repair with sutures or conjunctival flap	1245.75	
OP-073	Superficial keratectomy	968.92	
	Sclera		
OP-074	Sclerotomy	415.25	
OP-075	Scleral resection - myopia, scleromalacia perforans, etc.	2076.22	
OP-076	Scleral wound repair - tissue prolapse through laceration or split in sclera	1245.75	
	Iris, Ciliary Body, Choroid		
OP-077	Laser iridotomy	449.85	
OP-078	Glaucoma - all major procedures, including shunts and trabeculectomy	1661.00	
OP-079	Cyclodialysis	968.92	
OP-080	Laser trabeculoplasty	1003.53	

	Lens		
OP-081	Needling, capsulotomy, discission, synechotomy	484.47	
OP-082	Needling, simple only	276.83	
OP-083	Cataract extraction with intraocular lens implant	1107.33	
OP-084	Secondary insertion of intraocular lens	830.50	
OP-085	Removal or repositioning of anteriorly dislocated pseudophakos with secondary suturing	830.50	
OP-086	Removal or repositioning of posteriorly dislocated pseudophakos into vitreous, with secondary suturing	1661.00	
OP-087	Dislocated lens - removal	899.71	
OP-088	YAG laser capsulotomy	207.63	
	Vitreous		
OP-089	Total posterior vitrectomy	1384.18	
OP-090	Intra vitreal surgical section of scar tissue with scissors	1384.18	
OP-091	Anterior vitrectomy	692.06	
	Retina		
OP-092	Scleral resection - buckling - partial tubing	2076.22	
OP-093	Encircling tubing	2353.09	
OP-094	Posterior vitrectomy with vitreous implant	2353.09	
OP-095	Light coagulation or cryopexy - posterior segment	830.50	
	Ocular Muscles		
OP-096	Strabismus, repair - one or two muscles	622.88	
OP-097	Strabismus, repair - per additional muscle	242.24	
OP-098	Muscle transplant - Hummelsheim, etc.	830.50	

	Eyeball		
OP-099	Enucleation or evisceration - without implant	830.50	
OP-100	Enucleation or evisceration - with implant	1107.33	
OP-101	Exenteration	1868.65	
OP-102	Replacement of implant	1107.33	
OP-103	Magnetic extraction of intraocular foreign body - anterior chamber	1176.55	
OP-104	Magnetic extraction of intraocular foreign body - other than anterior chamber	1522.59	
OP-105	Intraocular foreign body extraction (anterior or posterior route) non-magnetic extraction with enucleation if necessary	1799.43	
OP-106	Extraction of non-magnetic intraocular foreign body from elsewhere in eye	2353.09	
	Orbit		
OP-107	Abscess - incision and drainage	553.68	
OP-108	Removal of anterior orbital tumor	692.06	
OP-109	Removal of posterior orbital tumor	2076.22	
OP-110	Orbitotomy - exploration or biopsy or both	553.68	
OP-111	Orbitotomy - exploration and decompression	1384.18	
Fee Code	**Descriptor**	**Price**	
	SECTION OR ORTHOPAEDIC SURGERY		
	Visits and Assessments		
OR-001	Major consultation including complete history, examination, review of x-ray and laboratory findings and a written report	193.79	
OR-002	Minor consultation for dealing with one particular problem, or repeat consultation for same problem within 6 months	96.90	
OR-003	Non-referred or transferred patient, first visit requiring complete history and physical examination	124.56	

OR-004	Non-referred or transferred patient, first visit not requiring complete history and physical examination	55.35	
OR-005	Subsequent office visits if not included in surgical fee	27.70	
OR-006	Subsequent hospital visits if not included in surgical fee	34.59	
	Diagnostic Procedures		
OR-007	Vertebral body or disc - needle biopsy	415.25	
OR-008	Biopsy bone tumor - superficial	207.63	
OR-009	Biopsy bone tumor - deep	415.25	
OR-010	Diagnostic arthroscopy - shoulder	214.54	
OR-011	Diagnostic arthroscopy - wrist	214.54	
OR-012	Diagnostic arthroscopy - knee	346.04	
	Amputation		
OR-013	Finger - single	346.04	
OR-014	Finger - each additional	173.03	
OR-015	Metacarpal - entire ray	553.68	
OR-016	Through metacarpal or metacarpal-phalangeal joint	311.44	
OR-017	Hand - transmetacarpal	1107.33	
OR-018	Disarticulation at wrist	1107.33	
OR-019	Forearm	830.50	
OR-020	Disarticulation at elbow	1038.13	
OR-021	Arm - through humerus	830.50	
OR-022	Toe - single	138.42	

OR-023	Toe - each additional	69.22	
OR-024	Metatarsal - entire ray	484.47	
OR-025	Foot - transmetatarsal	692.06	
OR-026	Foot - mid-tarsal	692.06	
OR-027	Ankle - Symes	1107.33	
OR-028	Leg - below knee	968.92	
OR-029	Disarticulation at knee - supracondylar	1107.33	
OR-030	Thigh	1107.33	
	Arthrodesis		
OR-031	Arthrodesis - shoulder	1522.59	
OR-032	Arthrodesis - elbow	1245.75	
OR-033	Arthrodesis - wrist	830.50	
OR-034	Arthrodesis or tenodesis - finger or thumb	346.04	
OR-035	Arthrodesis - sacroiliac	1245.75	
OR-036	Arthrodesis - hip	2076.22	
OR-037	Arthrodesis - knee	1418.76	
OR-038	Arthrodesis - ankle	1487.99	
OR-039	Arthrodesis - single tarsal joint, including bone block	830.50	
OR-040	Triple arthrodesis	1661.00	
OR-041	Panarthrodesis	2076.22	
OR-042	Metatarsal-phalangeal joint great toe - unilateral	553.68	

OR-043	Metatarsal-phalangeal joint great toe - bilateral	1107.33	
OR-044	Interphalangeal joint - great toe	415.25	
OR-045	Other toe joints - single	207.63	
OR-046	Other toe joints - each additional	103.82	
	Arthroplasty		
OR-047	Arthroplasty - acromio-clavicular or sterno-clavicular	968.92	
OR-048	Arthroplasty - shoulder	1522.59	
OR-049	Arthroplasty - elbow	1522.59	
OR-050	Arthroplasty - lower radio-ulnar joint	692.06	
OR-051	Arthroplasty - wrist	1245.75	
OR-052	Arthroplasty finger - single joint including Flatt replacement arthroplasty	622.88	
OR-053	Each additional joint	276.83	
OR-054	Total hip replacement - including acetabulum and femoral head	2076.22	
OR-055	Revision of total hip replacement - Exeter/Ling system or similar	2422.29	
OR-055A	Arthroplasty hip - Austin Moore/Girdlestone or equivalent	2087.54	
OR-056	Arthroplasty knee - resurfacing of tibia and femoral condyles - with or without patellar replacement - one or both condyles/plateaus may be replaced	1730.22	
OR-057	Total knee replacement	2076.22	
OR-058	Revision of total knee replacement, with or without bone graft	2422.29	
OR-059	Arthroplasty - ankle	1384.18	
OR-060	Arthroplasty great toe - single including bunionectomy	553.68	
OR-061	Arthroplasty great toe - bilateral - including bunionectomy	1038.13	

OR-062	Arthroplasty - other toes - including hammer toes - single joint excision metatarsal head (Hoffmann's procedure)	235.30	
OR-063	Each additional toe	69.22	
	Arthrotomy		
OR-064	Arthrotomy - temporomandibular including menisectomy	692.06	
OR-065	Arthrotomy - shoulder	1038.13	
OR-066	Arthrotomy - elbow	830.50	
OR-067	Arthrotomy - wrist	692.06	
OR-068	Operative arthroscopy - wrist	1038.13	
OR-069	Arthrotomy - finger	276.83	
OR-070	Arthrotomy - knee - including menisectomy or meniscal cyst	899.71	
OR-071	Arthroscopic meniscectomy	761.30	
OR-072	Arthroscopic debridement of knee	761.30	
OR-073	Arthroscopic repair of meniscus of knee	761.30	
OR-074	Arthrotomy - ankle	899.71	
OR-075	Arthrotomy - other joints - lower extremity	761.30	
OR-076	Arthrotomy metatarsophalangeal joint - great toe including excision sesmoids	449.85	
OR-077	Arthrotomy - other toes	173.03	
OR-078	Arthroscopy if procedure followed immediately by arthrotomy	173.03	
	Back Surgery		
OR-079	Laminectomy - thoracic or lumbar - single level	1453.39	
OR-080	Laminectomy - thoracic or lumbar - multiple levels	1834.02	

	Bone Grafting		
OR-081	Bone graft - clavicle	1107.33	
OR-082	Bone graft - humerus	1314.97	
OR-083	Bone graft - radius or ulna	899.71	
OR-084	Bone graft - radius and ulna	1245.75	
OR-085	Bone graft - carpal scaphoid	830.50	
OR-086	Bone graft - metacarpal	553.68	
OR-087	Bone graft - phalanges	553.68	
OR-088	Bone graft - femur	1661.00	
OR-089	Bone graft - tibia	1314.97	
OR-090	Bone graft - medial malleolus	761.30	
OR-091	Bone graft - calcaneus	1038.13	
OR-092	Bone graft - metatarsal	553.68	
OR-093	Bone graft - mandible	1176.55	
	Bone Tumours		
OR-094	Excision tumor, saucerization, sequestrectomy- large bone	1107.33	
OR-095	Excision tumor, saucerization, sequestrectomy- large bone - with bone graft	1661.00	
OR-096	Excision tumor, saucerization, sequestrectomy - metacarpal, metatarsal, phalanx	415.25	
OR-097	Excision tumor, saucerization, sequestrectomy - metacarpal, metatarsal, phalanx - with bone graft	622.88	
	Bursa, Ganglion, and Tendon		
OR-098	Excision tendon sheaths - forearm or wrist	899.71	

OR-099	Excision olecranon or prepatellar bursa	346.04	
OR-100	Excision subacromial, ischial, or trochanteric bursa	657.47	
OR-101	Excision calcaneous deposits shoulder cuff	761.30	
OR-102	Excision ganglion	346.04	
OR-102A	Rotator cuff repair with acromioplasty	1109.01	
OR-103	Excision ganglion - joint	311.44	
OR-104	Excision Baker's cyst	761.30	
OR-105	Subacromial bursa - aspiration and injection	55.35	
OR-105A	Hip or trochanteric burssa - aspiraton and injection	78.29	
OR-106	Other bursae, tendon sheaths, ganglion of wrist or ankle - aspiration and injection	34.59	
OR-107	Repair of mallet finger - open	311.44	
OR-108	Repair of mallet finger - closed with pin	249.16	
OR-109	Primary repair of flexor tendon	899.71	
OR-110	Primary repair of extensor tendon	449.85	
OR-111	Primary repair - each additional tendon	346.04	
OR-112	Primary repair - Achilles tendon	761.30	
OR-113	Secondary repair - flexor tendon	899.71	
OR-114	Secondary repair - extensor tendon	449.85	
OR-115	Secondary repair - each additional tendon	242.24	
OR-115A	Tendon or muscle transfer	1174.24	
OR-116	Repair of trigger finger or thumb	276.83	

OR-117	Tenolysis - single	830.50	
	Casts		
OR-118	Minerva jacket	242.24	
OR-119	Shoulder or hip - spica	173.03	
OR-120	Shoulder or hip - spica - bilateral	221.46	
OR-121	Body cast	290.68	
OR-122	Upper extremity - excluding finger	62.29	
OR-123	Finger	34.59	
OR-124	Long leg cast	62.29	
OR-125	Below the knee cast	48.43	
OR-126	Wedging of plaster cast	34.59	
OR-127	Unna's boot	34.59	
	Deformities		
OR-128	Congenital club foot - metatarsus varus - unilateral - manipulation and plaster - closed treatment - per manipulation and cast	166.08	
OR-129	Congenital club foot - metatarsus varus - bilateral - manipulation and plaster - closed treatment - per manipulation and cast	249.16	
	Dislocations		
OR-130	Sterno-clavicular dislocation - closed reduction	173.03	
OR-131	Sterno-clavicular dislocation - open reduction	899.71	
OR-132	Acromio-clavicular dislocation - closed reduction	173.03	
OR-133	Acromio-clavicular dislocation - open reduction	899.71	
OR-134	Shoulder dislocation - closed reduction including radiological confirmation	242.24	

OR-135	Shoulder dislocation - open reduction	1107.33	
OR-136	Elbow dislocation - closed reduction	242.24	
OR-137	Elbow dislocation - open reduction	1245.75	
OR-138	Carpal bone or bones dislocation - closed reduction	449.85	
OR-139	Carpal bone or bones dislocation - open reduction	899.71	
OR-140	Carpo-metacarpal dislocation - closed reduction	103.82	
OR-141	Carpo-metacarpal dislocation - open reduction	830.50	
OR-142	Finger, thumb or toe - metacarpal, metatarsal, or interphalangeal dislocation - closed reduction	55.35	
OR-143	Finger, thumb or toe - metacarpal, metatarsal, or interphalangeal dislocation - open reduction	484.47	
OR-144	Hip dislocation - closed reduction	622.88	
OR-145	Hip dislocation - open reduction	1661.00	
OR-146	Hip dislocation - open reduction and internal fixation of acetabulum	1937.83	
OR-147	Knee dislocation (tibio-femoral) - closed reduction	622.88	
OR-148	Knee dislocation (tibio-femoral) - open reduction	1453.39	
OR-149	Knee dislocation (patello-femoral) - closed reduction	173.03	
OR-150	Knee dislocation (patello-femoral) - open reduction	1107.33	
OR-151	Ankle dislocation - closed reduction	449.85	
OR-152	Ankle dislocation - open reduction	1038.13	
OR-153	Tarsus dislocation - closed reduction	484.47	
OR-154	Tarsus dislocation - open reduction	1038.13	
OR-155	Metatarsal dislocation - single - closed reduction	103.82	

OR-156	Metatarsal dislocation - each additional - closed reduction	69.22	
OR-157	Metatarsal dislocation - single - open reduction	519.09	
OR-158	Metatarsal dislocation - each additional - open reduction	159.17	
OR-159	Temporomandibular dislocation - closed reduction	193.79	
OR-160	Mandible dislocation - without displacement - reduction	193.79	
OR-161	Malar dislocation - without displacement - reduction	69.22	
	Epiphyseal Stapling Arrest		
OR-162	One epiphysis - one side	830.50	
OR-163	One epiphysis - both sides	1245.75	
OR-164	More than one epiphysis	1661.00	
OR-165	Removal of staples	415.25	
	Fascia and Tendon Sheath		
OR-166	Carpal tunnel release	415.25	
OR-167	Dupuytren’s contracture - radical fasciectomy	1107.33	
OR-168	Dupuytren’s contracture - partial fasciectomy or fasciotomy	761.30	
OR-169	Ulnar nerve release with or without transposition of nerve	553.68	
OR-170	Incision of tendon sheath - digit	173.03	
OR-171	Fasciotomy - leg or arm - one compartment for compartment syndrome	415.25	
OR-172	Each additional compartmental release - maximum of 3 compartments	173.03	
OR-173	Plantar fasciotomy	692.06	

	Fractures - Upper Limbs		
OR-174	Clavicle - adult - closed reduction	242.24	
OR-175	Clavicle - child - closed reduction	110.75	
OR-176	Clavicle - open reduction	553.68	
OR-177	Humerus - surgical neck - closed reduction	484.47	
OR-178	Humerus - surgical neck - closed reduction with anaesthesia and manipulation	622.88	
OR-179	Humerus - surgical neck - open reduction	1176.55	
OR-180	Humerus - shaft - closed reduction	553.68	
OR-181	Humerus - shaft - closed reduction with anaesthesia and manipulation	761.30	
OR-182	Humerus, shaft, open reduction	1176.55	
OR-183	Humerus - supracondylar - adult - closed reduction	553.68	
OR-184	Humerus - supracondylar - child - closed reduction with anaesthesia and manipulation	761.30	
OR-185	Humerus - supracondylar - traction or external skeletal fixation	968.92	
OR-186	Humerus - supracondylar - open reduction	1453.39	
OR-187	Elbow - one or more bones - closed reduction	346.04	
OR-188	Elbow - medial and/or lateral condyle - open reduction	1107.33	
OR-189	Olecranon - open reduction - excision or internal fixation	830.50	
OR-190	Radius head - closed reduction	276.83	
OR-191	Radius head - closed reduction with manipulation and anaesthesia	415.25	
OR-192	Radius head or neck - excision or open reduction	968.92	
OR-193	Radius shaft - closed reduction	415.25	
OR-194	Radius shaft - open reduction	899.71	

OR-195	Radius - Colles - closed reduction	415.25	
OR-196	Radius - Colles - skeletal fixation	622.88	
OR-197	Radius - Colles - open reduction	899.71	
OR-198	Styloid process radius - closed reduction	207.63	
OR-199	Styloid process ulna - closed reduction	83.08	
OR-200	Ulna shaft - closed reduction	415.25	
OR-201	Ulna shaft - open reduction	830.50	
OR-202	Monteggia fracture - closed reduction	622.88	
OR-203	Monteggia fracture - open reduction	968.92	
OR-204	Radius and ulna - adult - closed reduction	622.88	
OR-205	Radius and ulna - child - not requiring reduction	207.63	
OR-206	Radius and ulna - child - greenstick - requiring reduction	380.66	
OR-207	Radius and ulna - child - complete requiring reduction	692.06	
OR-208	Radius and ulna - open reduction	1245.75	
OR-209	Carpal bone or bones - closed reduction	415.25	
OR-210	Carpal scaphoid - closed reduction	449.85	
OR-211	Carpal bone or bones - open reduction	1038.13	
OR-212	Metacarpal - closed reduction	276.83	
OR-213	Metacarpal or metatarsal - each additional - closed reduction	62.29	
OR-214	Metacarpal - open reduction	553.68	
OR-215	Bennett’s - closed reduction	415.25	

OR-216	Bennett's - open reduction	761.30	
OR-217	Phalanx - single - closed reduction	276.83	
OR-218	Finger - simple distal phalanx	55.35	
OR-219	Phalanx - each additional - closed reduction	83.08	
OR-220	Phalanx - single - open reduction	484.47	
OR-221	Phalanx - each additional - open reduction	207.63	
	Fractures - Pelvis and Lower Limbs		
OR-222	Pelvis - fracture - simple - no reduction	415.25	
OR-223	Acetabulum - closed reduction	830.50	
OR-224	Central dislocation pelvis - displaced - skeletal traction	1245.75	
OR-225	Central dislocation pelvis - open reduction acetabulum	1799.43	
OR-226	Femur neck - intertrochanteric fracture - undisplaced	692.06	
OR-227	Femur neck - internal fixation	1661.00	
OR-228	Femur - intertrochanteric - skeletal traction	968.92	
OR-229	Femur - intertrochanteric - internal fixation	1661.00	
OR-230	Slipped upper femoral epiphysis - closed reduction	830.50	
OR-231	Slipped upper femoral epiphysis - internal fixation	1661.00	
OR-232	Slipped upper femoral epiphysis - osteotomy and nail	1937.83	
OR-233	Femur - shaft - closed reduction - adult	1107.33	
OR-234	Femur - shaft - closed reduction - child	830.50	
OR-235	Femur including single femoral condyle - displaced lower femoral epiphysis - open reduction	1661.00	

OR-236	Fracture femoral condyle - simple - open reduction	830.50	
OR-237	Fracture femoral condyle - complicated supracondylar - open reduction	1245.75	
OR-238	Patella - closed reduction	311.44	
OR-239	Patella - open reduction	761.30	
OR-240	Tibial plateau - closed reduction and traction	692.06	
OR-241	Tibial plateau - open reduction	1176.55	
OR-242	Tibial shaft with or without fibula - closed reduction - adult	692.06	
OR-243	Tibial shaft with or without fibula - closed reduction - child	692.06	
OR-244	Tibia - open reduction internal fixation	1384.18	
OR-245	Tibia - external fixation	1038.13	
OR-246	Medial malleolus - closed reduction	415.25	
OR-247	Medial or lateral malleolus with displacement of astragalus - closed reduction	553.68	
OR-248	Medial malleolus - open reduction	761.30	
OR-249	Fibula or lateral malleolus - closed reduction	311.44	
OR-250	Fibula or lateral malleolus - open reduction	761.30	
OR-251	Ankle - bi-malleolar - closed reduction	622.88	
OR-252	Ankle - bi-malleolar - open reduction	934.30	
OR-253	Ankle - tri-malleolar - closed reduction	830.50	
OR-254	Ankle - tri-malleolar - open reduction with fixation	1245.75	
OR-255	Talus - closed reduction	415.25	
OR-256	Talus - open reduction	1038.13	

OR-257	Calcaneus - closed reduction	415.25	
OR-258	Calcaneus - external skeletal fixation	899.71	
OR-259	Calcaneus - open reduction and bone graft	1384.18	
OR-260	Other tarsal bones - closed reduction	311.44	
OR-261	Other tarsal bones - open reduction	692.06	
OR-262	Metatarsal - single - closed reduction	249.16	
OR-263	Metatarsal - each additional - closed reduction	110.75	
OR-264	Metatarsal - single - open reduction	553.68	
OR-265	Metatarsal - each additional - open reduction	166.08	
OR-266	Phalanx or phalanges - one toe - closed reduction	69.22	
OR-267	Phalanx or phalanges - each additional toe - closed reduction	34.59	
OR-268	Phalanx or phalanges - one toe - open reduction	346.04	
OR-269	Phalanx or phalanges - each additional toe - open reduction	124.56	
OR-270	Femur - intramedullary fixation	1799.43	
OR-271	Insertion proximal and/or distal locking screw femur - completed on separate day from intramedullary fixation procedure	138.42	
OR-272	Tibia - intramedullary fixation	1799.43	
OR-273	Insertion distal locking screw tibia - completed on separate day from intramedullary fixation procedure	138.42	
	Osteotomy		
OR-274	Osteotomy - clavicle	830.50	
OR-275	Osteotomy - humerus	1107.33	
OR-276	Osteotomy - radius	1107.33	

OR-277	Osteotomy - ulna	1107.33	
OR-278	Osteotomy - metacarpal	415.25	
OR-279	Osteotomy - femur	1661.00	
OR-280	Osteotomy - tibia	1107.33	
OR-281	Osteotomy malunited fracture-dislocation - ankle	1661.00	
OR-282	Osteotomy - calcaneus	1107.33	
OR-283	Osteotomy - lesser bones of foot	553.68	
	Repair and Reconstruction		
OR-284	Repair recurrent sterno-clavicular, acromioclavicular dislocation	1107.33	
OR-285	Repair recurrent dislocation, shoulder	1522.59	
OR-286	Repair recurrent dislocation, elbow	1522.59	
OR-287	Repair recurrent dislocation metacarpal-phalangeal, metatarsal-phalangeal, or interphalangeal joint	692.06	
OR-288	Repair torn collateral ligaments knee - early	1245.75	
OR-289	Repair torn collateral and cruciate ligaments knee - early	1522.59	
OR-290	Arthroscopic anterior cruciate ligament reconstruction	1937.83	
OR-291	Reconstruction of one ligament of knee - old tear	1661.00	
OR-292	Reconstruction of two or more ligaments of knee - old tear	1937.83	
OR-293	Recurrent dislocation patella - reconstruction - patellar tendon transplant	1314.97	
OR-294	Repair ligaments of ankle - old tear	1314.97	
OR-295	Repair recurrent dislocation peroneal tendons	1038.13	

	Therapeutic Procedures - Miscellaneous		
OR-296	Morton's neuroma - excision	415.25	
OR-297	Excision foreign body muscle	276.83	
OR-298	Removal of plate, screw, nail - superficial - unless hardware inserted only for temporary fixation	249.16	
OR-299	Removal of plate, screw, nail - deep - unless hardware inserted only for temporary fixation	442.93	
OR-300	Incision and drainage subperiosteal abscess - acute osteomyelitis	346.04	
OR-301	Manipulation of major joints, or spine under anaesthesia	166.08	
OR-302	Manipulation of minor joints or examination under anaesthesia	69.22	
OR-303	Neurolysis of lateral cutaneous nerve of thigh	276.83	
(+) OR-303A	Joint aspiration, injection - hip	65.22	
(+) OR-303B	Joint aspiration, injection - other joints	52.17	
Fee Code	**Descriptor**	**Price**	
	SECTION OT OTOLARYNGOLOGY		
	Visits and Assessments		
OT-001	Major consultation including complete history, examination, review of x-ray and laboratory findings and a written report	193.79	
OT-002	Minor consultation for dealing with one particular problem, or repeat consultation for same problem within 6 months	96.90	
OT-003	Non-referred or transferred patient, first visit requiring complete history and physical examination	124.56	
OT-004	Non-referred or transferred patient, first visit not requiring complete history and physical examination	55.35	
OT-005	Subsequent office visits if not included in surgical fee	27.70	
OT-006	Subsequent hospital visits if not included in surgical fee	34.59	
	Diagnostic Procedures		
(+) OT-007	Audiogram interpretation	27.70	

OT-008	Impedance audiometry - procedure and interpretation	41.52	
OT-009	Pure tone audiometry	27.70	
OT-010	Otoacoustic emissions	27.70	
(+) OT-011	Acoustic reflexes	27.70	
(+) OT-012	Speech discrimination	27.70	
(+) OT-013	Speech audiometry	27.70	
(+) OT-014	Doerfler-Stewart and other special tests for malingering	27.70	
OT-015	Audiometry work-up, including four or more of the above	83.08	
OT-016	Oral cavity or oropharyngeal biopsy	103.82	
OT-017	Biopsy nasopharynx - local anaesthetic	96.90	
OT-018	Biopsy or examination nasopharynx -general anaesthetic	152.24	
OT-019	Examination under anaesthesia	83.08	
OT-020	Tympanogram (including procedure and interpretation)	27.70	
(+) OT-021	Nasal endoscopy	62.29	
(+) OT-022	Laryngoscopy, direct	166.08	
(+) OT-023	Laryngoscopy, with biopsy	193.79	
(+) OT-024	Laryngoscopy, with removal of foreign body	470.63	
OT-025	Bronchoscopy	346.04	
OT-026	Bronchoscopy, with biopsy	380.66	
OT-027	Bronchoscopy, with aspiration	380.66	
OT-028	Differential caloric tests	69.22	

OT-029	Differential with electro-nystagmography - initial	69.22	
OT-030	Central vestibular testing	41.52	
OT-031	Video nystagmography interpretation	207.63	
OT-032	Excisional face biopsy and plastic repair	207.63	
	Lips		
OT-033	Simple excision of carcinoma or precancerous lesion of lip	173.03	
OT-034	Major excision of carcinoma of lip	346.04	
OT-035	Major excision of carcinoma of lip with major plastic repair	968.92	
OT-036	Leucoplakia vermilionectomy	692.06	
	Tongue		
OT-037	Partial glossectomy	484.47	
OT-038	Hemiglossectomy	1038.13	
OT-039	Complete glossectomy - with or without tracheostomy	1799.43	
OT-040	Release of tongue tie	124.56	
	Salivary Glands		
OT-041	Salivary duct calculus - extraction or surgical removal	276.83	
OT-042	Submaxillary gland excision	692.06	
OT-043	Parotid gland - complete removal of superficial lobe with preservation of facial nerve	1384.18	
OT-044	Parotidectomy - total with preservation of facial nerve	2076.22	
	Throat		
OT-045	Tonsillectomy and adenoidectomy - less than 16 years of age	484.47	

OT-046	Tonsillectomy - greater than 16 years of age or over	587.12	
OT-047	Adenoidectomy	179.94	
OT-047A	Incision and drainage of peritonsillar abscess	182.67	
OT-048	Post tonsillectomy haemorrhage - consultation with treatment	276.83	
	Ears		
OT-049	Fitting of hearing aid	69.22	
OT-050	Aural polyp removal, general anaesthesia	179.94	
OT-051	Aural polyp removal, local anaesthesia	89.96	
OT-052	Simple removal of cerumen	34.59	
OT-053	Excision of preauricular pit	415.25	
OT-054	Removal of foreign body requiring general anaesthetic	179.94	
OT-055	Closure of post-auricular fistula	415.25	
OT-056	Myringotomy - with or without insertion of ventilation tube - general anaesthesia	159.17	
OT-057	Lavage with or without tube	242.24	
OT-058	Cautery of tympanic membrane	166.08	
OT-059	Removal of myringotomy tube under general anaesthesia	69.22	
OT-060	Stapedectomy, stapedoplasty or stapedotomy	1661.00	
OT-061	Decompression and shunt of endolymphatic sac	1937.83	
OT-062	Labyrinthine repositioning	41.52	
OT-063	Trans-tympanotomy approach to excision of glomus tumour	1038.13	
OT-064	Incomplete atresia	1107.33	

OT-065	Complete atresia	2076.22	
OT-066	Removal of osteoma or exostosis ear canal	519.09	
OT-067	Protruding ear - unilateral - requires prior approval	692.06	
OT-068	Protruding ear - bilateral - requires prior approval	1176.55	
OT-069	Canalplasty	519.09	
	Mastoid		
OT-070	Simple mastoidectomy	1038.13	
OT-071	Simple mastoid-facial recess	415.25	
OT-072	Radical or modified radical mastoidectomy	1661.00	
OT-073	Radical or modified radical mastoidectomy with tympanoplasty	1937.83	
OT-074	Tympanoplasty	1799.43	
OT-075	Ossiculoplasty or insertion of middle ear prosthesis	1799.43	
OT-076	Tympanotomy - exploratory with elevation of tympanomeatal flap	484.47	
	Sinuses		
OT-077	Maxillary sinus - puncture and irrigation - initial	83.08	
OT-078	Maxillary sinus - puncture and irrigation - repeat	83.08	
OT-079	Intranasal maxillary antrostomy - unilateral	311.44	
OT-080	Caldwell Luc and closure of antra-oral fistula	1384.18	
OT-081	Radical maxillary sinusectomy with obliteration by abdominal fat graft	1591.79	
OT-082	Postoperative nasal/sinus cavity cleaning and debridement	124.56	
OT-083	Intranasal ethmoidectomy	968.92	

OT-084	External ethmoidectomy	1162.72	
OT-085	Intranasal sphenoidectomy	719.78	
OT-086	Frontal sinus - trephine	553.68	
OT-087	Intranasal frontal sinusectomy	968.92	
OT-088	External (Lynch or Howarth type) frontal sinusectomy	1107.33	
OT-089	Osteoplastic flap with obliteration by fat or bone graft.	2076.22	
OT-090	Trans-antral orbital decompression	1799.43	
	Nose and Proximal Respiratory		
OT-091	Rhinoplasty - performed for airway obstruction	1038.13	
OT-092	Rhinoplasty - simple - prior approval is required	1038.13	
OT-093	Rhinoplasty and reconstruction of nasal septum - prior approval required	1384.18	
OT-094	Rhinoplasty with composite graft	1038.13	
OT-094A	Fractured nose, intra-nasal reduction and splinting	360.61	
OT-095	Removal of nasal foreign body - simple	55.35	
OT-096	Removal of foreign body - simple - tray fee	20.76	
OT-097	Removal of nasal foreign body - general anaesthesia	179.94	
OT-098	Cauterization of nasal turbinate	69.22	
OT-099	Turbinectomy	276.83	
OT-100	Submucous resection of nasal septum	692.06	
OT-101	Nasal reconstruction using auricular cartilage graft	276.83	
OT-102	Nasal polypectomy - unilateral	242.24	

OT-103	Nasal polypectomy - bilateral	332.21	
OT-104	Initial epistaxis visit including anterior packing or cautery	83.08	
OT-105	For first visit including anterior packing or cautery - tray fee	41.52	
OT-106	Nasal cautery - general anaethesia	152.24	
OT-107	Repeat anterior packing or cautery	34.59	
OT-108	Repeat anterior packing or cautery - tray fee	41.52	
OT-109	Epistaxis - anterior and posterior packing	193.79	
OT-110	Ligation of ethmoid vessels in-orbit unilateral	346.04	
OT-111	Trans-antral ligation of internal maxillary artery - unilateral	968.92	
OT-112	Sphenopalatine artery cautery or ligation	415.25	
OT-113	Lateral rhinotomy	1245.75	
OT-114	Sublabial rhinotomy	968.92	
OT-115	Excision of nasopharyngeal tumor - via oropharnyx	692.06	
OT-116	Excision of nasopharyngeal tumor - trans-palatine	1384.18	
	Larynx and Distal Respiratory		
OT-117	Cricopharyngeal myotomy	1384.18	
OT-118	Laryngoscopy with removal of benign tumor	622.88	
OT-119	Laryngoscopy suspension	346.04	
OT-120	Suspension microlaryngoscopy	415.25	
OT-121	Laryngoscopy and laryngeal dilation	346.04	
OT-122	Laryngoscopy and laryngeal dilation - repeat	346.04	

OT-123	Bronchoscopy with removal of foreign body or tumor	692.06	
OT-124	Thyrotomy laryngofissure	1384.18	
OT-125	Decompression of recurrent laryngeal nerve	1038.13	
OT-126	Thyroplasty	1384.18	
OT-127	Injectable implantation vocal cords	1038.13	
OT-128	Glottic stenosis - repair	1591.79	
OT-129	Supraglottic stenosis - repair	2214.67	
OT-130	Infraglottic stenosis - repair	2214.67	
OT-131	Tracheostomy	553.68	
OT-132	Tracheal fenestration	1038.13	
	Plastic Surgery		
OT-133	Closed reduction and external fixation of fracture of mandible	978.53	
OT-134	Open reduction and internal fixation of single fracture of manadible	1109.01	
OT-135	Open reduction and internal fixation of multiple fractures of manadible	1696.12	
OT-136	Hook or temporal elevation of malar fracture	358.79	
OT-137	Hook and antral packing of malar fracture	508.83	
OT-138	Open reduction and fixation of malar fracture	913.31	
OT-139	Orbital floor fracture	1435.17	
OT-140	Open reduction and suspension of maxilla fracture	1369.95	
OT-141	Full thickness skin graft - face or hands - up to five (5) square inches	717.58	
OT-142	Full thickness skin graft - face or hands - greater than five (5) square inches	1109.01	

OT-143	Flaps or tubes from a distance - major stage	1056.83	
OT-144	Flaps or tubes from a distance - minor stage	691.51	
OT-145	Transplantation of costal cartilage or bone graft autogenous nose, orbit, forehead, other	1239.47	
OT-146	Transplantation of mucous membrane	561.02	
Fee Code	**Descriptor**	**Price**	
	SECTION PA PAEDIATRICS		
	Visits and Assessments		
PA-001	Major consultation including complete history, examination, review of x-ray and laboratory findings and a written report	332.21	
PA-002	Major consultation for Inpatient or for patient in Emergency Department	380.66	
PA-003	Minor consultation for dealing with one particular problem, or repeat consultation for same problem within 6 months	166.08	
PA-004	Non-referred or transferred patient, first visit requiring complete history and physical examination	124.56	
PA-005	Non-referred or transferred patient, first visit not requiring complete history and physical examination	55.35	
PA-006	Standby fee for attendance at delivery at the request of the obstetrician or surgeon - per 1/4 hour	48.43	
PA-007	Subsequent office visits	83.08	
PA-008	Subsequent hospital visits	55.35	
	Procedures		
PA-009	Resuscitation of a seriously depressed infant in the case room at the request of the attending medical practitioner	207.63	
PA-010	Replacement transfusion	484.47	
PA-011	Repeat replacement transfusion	346.04	
PA-012	Umbilical venous catheterization	41.52	
PA-013	Umbilical arterial catheterization	83.08	

PA-014	Insertion of artificial surfactant via endotracheal tube in premature infant with hyaline membrane disease	62.29	
PA-015	Suprapubic aspiration of urine for culture where catheterization of infant has been unsuccessful	62.29	
	Child Development Team Conferences		
PA-016	Multidisciplinary team meetings - in person or remotely no greater than once weekly and minimum of 30 minutes each - claim is per each 30 minutes or part thereof and made using one patient	163.09	
Fee Code	**Descriptor**	**Price**	
	SECTION PS PSYCHIATRY		
	Visits and Assessments		
PS-001	Major consultation including complete history, examination, and a written report	332.21	
PS-002	Major consultation for Inpatient or for patient in Emergency Department	380.66	
PS-003	Repeat consultation for same problem within six months	166.08	
PS-004	Minor consultation for dealing with one particular problem	69.22	
PS-005	Non-referred or transferred patient, first visit requiring complete history and physical examination	124.56	
PS-006	Non-referred or transferred patient, first visit not requiring complete history and physical examination	55.35	
PS-007	Initial assessment of one hour - complete examination and investigation	249.16	
PS-008	Psychiatric care other than psychotherapy - one hour	249.16	
PS-009	Subsequent office visits	83.08	
PS-010	Subsequent hospital visits	55.35	
PS-011	Evaluation interview with family member without presence of patient - per 5 minute intervals - maximum 3 claims per day	16.63	
PS-012	Environmental intervention on a psychiatric patient's behalf with agencies, employers or institutions per 5 minute intervals - maximum 3 claims per day	16.63	
PS-013	Interpreting results of psychological, psychiatric or other medical examinations to family or other responsible persons per 5 minute intervals - maximum 3 claims per day	16.63	

	Individual Psychotherapy		
PS-014	Per 30 minute intervals or major portion thereof - maximum of 2 1/2 hours per day	124.56	
	Group Psychotherapy		
PS-015	6-7 patients - per patient per 1/2 hour - maximum 1 1/2 hours daily	20.76	
PS-016	8-9 patients - per patient per 1/2 hour - maximum 1 1/2 hours daily	16.63	
PS-017	10-12 patients - per patient per 1/2 hour - maximum 1 1/2 hours daily	13.86	
PS-018	Family - per 1/2 hour - maximum 1 1/2 hours daily	124.56	
Fee Code	**Descriptor**	**Price**	
	SECTION TE TELEHEALTH AND TELECONFERENCE		
TE-001	Participation in remote telehealth consultation by consultant using audio-video-data communications	207.63	
TE-002	Participation in remote telehealth consultation by the medical practitioner initiating the consultation - per 1/4 hour - maximum of 1.5 hours per telehealth session	62.29	
TE-003	Review of radiograph by non-radiologist medical practitioner without patient consultation	34.59	
TE-004	Teleconference with physician when initiated by another physician, nurse practitioner, midwife in different community	20.76	
Fee Code	**Descriptor**	**Price**	
	SECTION UR UROLOGY		
	Visits and Assessments		
UR-001	Major consultation including complete history, examination, review of x-ray and laboratory findings and a written report	193.79	
UR-002	Minor consultation for dealing with one particular problem, or repeat consultation for same problem within 6 months	96.90	
UR-003	Non-referred or transferred patient, first visit requiring complete history and physical examination	124.56	
UR-004	Non-referred or transferred patient, first visit not requiring complete history and physical examination	55.35	
UR-005	Subsequent office visits if not included in surgical fee	27.70	
UR-006	Subsequent hospital visits if not included in surgical fee	34.59	

	Diagnostic Procedures		
UR-007	Cystoscopy with or without biopsy, urethral dilation, or meatotomy	186.87	
UR-008	Cystoscopy with retrograde pyelography	207.63	
UR-009	Ureteroscopy includes cystoscopy - unilateral or bilateral	415.25	
UR-010	Cystogram and voiding cystourethrogram	89.96	
UR-011	Cystometrogram	69.22	
UR-012	Needle biopsy - prostate	138.42	
UR-013	Open prostatic biopsy - perineal or retropubic	692.06	
UR-014	Urethra and bladder testing for urinary incontinence in the female - professional fee	69.22	
UR-015	Urethra and bladder testing for urinary incontinence in the female - technical fee	41.52	
UR-016	Testicular biopsy	179.94	
	Urethra		
(+) UR-017	Catheterization - therapeutic	34.59	
UR-018	Caruncle or prolapse of urethral mucosa, fulguration or excision	346.04	
UR-019	Extraction foreign body - anterior urethra	103.82	
UR-020	Urethral dilation - initial	69.22	
UR-021	Urethral dilation - subsequent	34.59	
UR-022	Urethral meatotomy	69.22	
UR-023	Internal or external urethrotomy	553.68	
UR-024	Excision or urethral diverticulum	830.50	
UR-025	Repair - urethral rupture - cystotomy and catheter	692.06	

UR-026	Repair - urethral rupture, cystotomy and catheter - suprasphincteric	830.50	
UR-027	Repair - urethral stricture - infrasphincteric - one stage	761.30	
UR-028	Repair - urethral stricture - infrasphincteric - first stage	588.27	
UR-029	Repair - urethral stricture - suprasphincteric - one stage	1384.18	
UR-030	Repair - urethral stricture - suprasphincteric - first stage	1003.53	
UR-031	Repair - urethral stricture - infrasphincteric or suprasphincteric - second stage	415.25	
UR-032	Endoscopic internal urethrotomy	242.24	
UR-033	Transurethral fulgaration of condylomata - including cystoscopy	276.83	
	Bladder		
(+) UR-034	Cystotomy - aspiration with needle	69.22	
UR-035	Cystotomy - trochar and tube	179.94	
UR-036	Cystotomy - open	692.06	
UR-037	Partial cystectomy	532.90	
UR-038	Total cystectomy	1107.33	
UR-039	Removal of vesical calculus - transurethral or suprapubic	692.06	
UR-040	Repair of ruptured bladder	1245.75	
UR-041	Removal of foreign body and/or calculus including cystoscopy	380.66	
UR-042	Transurethral resection bladder tumour - moderate - less than 30 minutes of resecting	346.04	
UR-043	Transurethral resection bladder tumour/s - large or multiple tumours - more than 30 minutes of resecting	830.50	
UR-044	Excision of bladder diverticuum	588.27	
UR-044A	Therapeutic injection into bladder for chronic dysfunction	424.04	

	Ureter and Kidney		
UR-045	Renal exploration, including nephrostomy, open renal biopsy, drainage of renal or perirenal abscess, drainage of renal cyst	761.30	
UR-046	Nephrectomy - complete	1384.18	
UR-047	Nephrectomy - radical - any approach to include surrounding tissue	1661.00	
UR-048	Ruptured kidney repair	1384.18	
UR-049	Nephrolithotomy	1384.18	
UR-050	Uretero-ureterostomy - contralateral	1730.22	
UR-051	Endoscopic removal of ureteral calculus - basket extraction	311.44	
UR-052	Removal of calculus from ureter by percutaneous, ureteroscopic, or open surgery approach	968.92	
UR-053	Nephroureterectomy with excision of bladder cuff	1661.00	
UR-054	Pyeloplasty	1176.55	
UR-055	Removal of renal calculus by percutaneous, ureteroscopic, or open surgery approach	1453.39	
UR-056	Uretero-ureterostomy - ipsilateral	1038.13	
UR-057	Uretero-neocystostomy	1038.13	
UR-058	Uretero-neocystostomy with bladder flap	1211.14	
UR-059	Insertion of double J stent - includes cystoscopy	242.24	
UR-060	Removal of double J stent - includes cystoscopy	207.63	
	Penis		
UR-061	Circumcision - newborn - including consultation	103.82	
UR-062	Circumcision - newborn - tray fee	41.52	
UR-063	Circumcision - child	332.21	

UR-064	Circumcision - adult	332.21	
UR-065	Repair hypospadias - first stage	692.06	
UR-066	Repair hypospadias - second stage	1384.18	
	Testis		
UR-067	Orchidectomy - unilateral	359.89	
UR-068	Orchidectomy - bilateral	664.42	
UR-069	Orchidopexy	1003.53	
UR-070	Torsion of testicle, or suspected torsion, excision of sperm granuloma, correction of torsion of epididymis or appendix testes	692.06	
UR-071	Exploration of undescended testicle without orchidopexy	692.06	
UR-072	Ruptured testicle - repair	553.68	
UR-073	Repair of communicating hydrocele	622.88	
UR-074	Radical orchidectomy with resection of cord	692.06	
	Scrotum and Vas Deferens		
UR-075	Hydrocoele - aspiration - initial	69.22	
UR-076	Hydrocoele - aspiration - initial - tray fee	20.76	
UR-077	Hydrocoele - radical	692.06	
UR-078	Varicocele - resection	484.47	
UR-079	Avulsion of penile skin and scrotum repair	1384.18	
UR-080	Bilateral vasectomy	311.44	
UR-081	Bilateral vasectomy - tray fee	41.52	
	Prostate Gland		
UR-082	Prostatectomy - transurethral, suprapubic or retropubic	1661.00	
UR-083	Perineal drainage of prostatic abscess	692.06	