# Medical

# Procedure List

# As Of

# 01 January 2022

NOTE: 1. Functional areas includes the following anatomical areas:
Head, neck, axillae, elbow, wrist, hand, groin, perineum, hip, knee, ankle, foot and includes coverage of exposed vital structures (bone, tendon, major vessel, nerve)
2. Flaps (HSCs 98.53,98.5A,98.51A,98.51B) for functional areas are designated by FNCAR modifier, add 50% to total benefit.
3. Flap size 5-10 cms or double Z-plasty designated by 2ZPL

# I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES

## 01 NONOPERATIVE ENDOSCOPY

### 01.0 Nonoperative endoscopy of respiratory tract

#### 01.01 Rhinoscopy

| | | BASE | ANE |
|---|---|---|---|
| 01.01A | Sinus endoscopy, professional component<br>NOTE: May not be claimed with HSC 01.03. | 52.43 V | 104.34 |
| 01.01B | Sinus endoscopy, technical<br>NOTE: May not be claimed with HSC 01.03. | 61.79 | |
| 01.03 | Direct laryngoscopy<br>NOTE: May not be claimed with HSC 01.01A. | 71.68 V | 110.53 |

#### 01.04 Other nonoperative laryngoscopy

| | | | |
|---|---|---|---|
| 01.04A | Video laryngeal stroboscopy | 107.30 | |

#### 01.05 Pharyngoscopy

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|---|---|---|---|
| 01.05A | Nasendoscopy<br>NOTE: Payable only for the assessment of velopharyngeal incompetence. | 127.38 | 110.53 |
| 01.09 | Other nonoperative bronchoscopy<br>NOTE: 1. No additional benefit for aspiration.<br>2. May be claimed in addition to HSC 43.96E and 45.88A.<br>3. For a repeat, during the same hospitalization, benefit will be reduced. Refer to Price List.<br>4. For patients aged 12 months or younger, the procedural benefit varies. Refer to the Price List; modifier L1. | 132.62 V | 154.96 |

### 01.1 Nonoperative endoscopy of upper gastrointestinal tract

#### 01.12 Other nonoperative esophagoscopy

| | | | |
|---|---|---|---|
| 01.12A | Functional endoscopic esophageal study | 149.76 | |
| 01.12B | Other nonoperative esophagoscopy, rigid | 107.71 | 126.83 |
| 01.14 | Other nonoperative gastroscopy<br>Esophagogastroscopy<br>NOTE: 1. HSCs 11.02, 12.12B, 12.13A, 13.99AF, 54.21C, 54.21D, 54.21E, 54.91A, 54.91C, 54.92E, 54.99A, 55.1 B, 55.41A, 55.41B, 56.34A, 56.99A and 58.39B may be claimed in addition.<br>2. Benefit includes biopsies. | 113.99 | 132.51 |

#### 01.16 Other nonoperative endoscopy of small intestine

| | | | |
|---|---|---|---|
| 01.16A | Small bowel capsule endoscopy, interpretation, per 15 minutes or major portion thereof<br>NOTE: A maximum of 2 1/2 hours may be claimed. | 57.00 | |
| 01.16B | Balloon (single or double) enteroscopy, rectal route<br>NOTE: May be claimed in addition to HSCs 01.16C, 56.34A, 57.13A, 57.13B, 57.21A and 58.99C. | 341.97 | 110.53 |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

01 NONOPERATIVE ENDOSCOPY (cont'd)

01.1 Nonoperative endoscopy of upper gastrointestinal tract (cont'd)

01.16 Other nonoperative endoscopy of small intestine (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 01.16C | Balloon (single or double) enteroscopy, oral route | 341.97 | 110.53 |
| | NOTE: May be claimed in addition to HSCs 01.16B, 56.34A, 57.13A, 57.13B, 57.21A and 58.99C. | | |

01.2 Nonoperative endoscopy of lower gastrointestinal tract

| | | | |
|---|---|---|---|
| 01.22 | Other nonoperative colonoscopy | 180.21 | 110.53 |
| | NOTE: 1. HSCs 13.99AE, 57.13A, 57.13B, 57.21A, 57.21B, 57.21C and 58.99C may be claimed in addition.<br>2. Benefit includes biopsies.<br>3. Benefit includes the removal of diminutive polyps that are 5mm or less in size.<br>4. Refer to HSCs 01.22A, 01.22B and 01.22C for screening. | | |
| 01.22A | Other nonoperative colonoscopy for screening of high risk patients | 180.21 | 110.43 |
| | NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99C may be claimed in addition.<br>2. Benefit includes biopsies.<br>3. Benefit includes the removal of diminutive polyps that are 5mm or less in size.<br>4. May be claimed for screening purposes for those patients that have been considered to be of high risk for colon cancer.<br>5. High risk is defined as an individual that has a strong family history of colorectal cancer with multiple individuals affected but no genetic syndrome identified, family history of Hereditary Non-Polyposis Colorectal Cancer or a personal history of inflammatory bowel disease.<br>6. May be claimed once every year. | | |
| 01.22B | Other nonoperative colonoscopy for screening of moderate risk patients | 180.21 | 110.43 |
| | NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99C may be claimed in addition.<br>2. Benefit includes biopsies.<br>3. Benefit includes the removal of diminutive polyps that are 5mm or less in size.<br>4. May be claimed for screening purposes for those patients that have been considered to be of moderate risk for colon cancer.<br>5. Moderate risk is defined as an individual who has one or more first degree relatives with colorectal cancer or personal history of colorectal adenomatous polyps.<br>6. May be claimed once every 5 years. | | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

01 NONOPERATIVE ENDOSCOPY (cont'd)

01.2 Nonoperative endoscopy of lower gastrointestinal tract (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 01.22C | Other nonoperative colonoscopy for screening of average risk patients. . . . | 180.21 | 110.43 |
| | NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99C may be claimed in addition.<br>2. Benefit includes biopsies.<br>3. Benefit includes the removal of diminutive polyps that are 5mm or less in size.<br>4. May be claimed for screening purposes for those patients that have been considered to be of average risk for colon cancer.<br>5. Average risk is defined as an individual that is asymptomatic and aged 50 to 74 years.<br>6. May be claimed once every 10 years. | | |
| 01.24 | Other nonoperative proctosigmoidoscopy | | |
| 01.24A | Rigid proctosigmoidoscopy . . . . . | 52.82 V | 110.53 |
| | NOTE: 1. HSC 58.99D may be claimed in addition.<br>2. Benefit includes biopsies and/or polypectomies. | | |
| 01.24B | Flexible proctosigmoidoscopy, diagnostic only . . . . . | 74.92 V | 110.43 |
| | NOTE: 1. HSCs 13.99AE, 57.13A, 57.13B, 57.21A, 57.21B, 57.21C, 58.99C, and 58.99D may be claimed in addition.<br>2. Benefit includes biopsies.<br>3. Benefit includes the removal of diminutive polyps that are 5mm or less in size. | | |
| 01.24BA | Flexible proctosigmoidoscopy for screening of patients considered to be of high risk for colon cancer due to a family history of Familial Adenomatous Polyposis (FAP) . . . . . | 79.23 V | 110.43 |
| | NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99D may be claimed in addition.<br>2. Benefit includes biopsies.<br>3. Benefit includes the removal of diminutive polyps that are 5mm or less in size.<br>4. May be claimed once every year beginning at the age of 10. | | |
| 01.24BB | Flexible proctosigmoidoscopy for screening of patients who are considered to be of average risk for colon cancer . . . . . | 79.23 V | 109.21 |
| | NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C, and 58.99D may be claimed in addition.<br>2. Benefit includes biopsies.<br>3. Benefit includes the removal of diminutive polyps that are 5mm or less in size.<br>4. Average risk is defined as an individual who is asymptomatic and aged 50 to 74 years.<br>5. May be claimed once every 5 years. | | |

## I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

### 01 NONOPERATIVE ENDOSCOPY (cont'd)

#### 01.3 Other nonoperative endoscopy

| | | BASE | ANE |
|---|---|---|---|
| 01.32 | Otoscopy | 28.76 | 110.53 |
| | NOTE: May only be claimed when performed under general anesthesia. | | |
| 01.34 | Cystoscopy | 85.56 | 109.31 |
| | NOTE: Includes urethral dilation and/or meatotomy. | | |

### 02 DIAGNOSTIC RADIOLOGY AND RELATED TECHNIQUES

Radiology Section - Please See Section X

#### 02.7 Other x-ray

##### 02.75 Other computerized axial tomography

| | | | |
|---|---|---|---|
| 02.75A | Anesthetic for CAT scan or MRI | 154.96 | 154.96 |

#### 02.8 Diagnostic ultrasound

##### 02.82 Diagnostic ultrasound of heart

| | | | |
|---|---|---|---|
| 02.82A | Comprehensive diagnostic trans-esophageal echocardiography | 288.75 | 153.25 |
| | NOTE: 1. Benefit includes 2D, M-mode, Doppler, 3D acquisition and post-processing and bubble study if indicated.<br>2. May be claimed in addition to HSC 13.72A.<br>3. May be claimed in addition to a visit or a consultation.<br>4. May not be claimed for services provided intraoperatively. | | |

##### 02.83 Other diagnostic ultrasound of thorax

| | | | |
|---|---|---|---|
| 02.83A | Intravascular ultrasound (IVUS), additional benefit | 123.23 | 87.80 |
| | NOTE: May only be claimed in addition to HSCs 48.98A, 48.98B, 48.92A, 49.96A, 49.98B, 51.59D, 51.59E and 51.59F. | | |
| 02.83B | Endobronchial Ultrasonography (EBUS) | 165.55 | 124.33 |

##### 02.84 Diagnostic ultrasound of digestive system

| | | | |
|---|---|---|---|
| 02.84A | Endoscopic ultrasound of esophageal or gastric lesions | 199.49 | 132.51 |
| 02.84B | Endoscopic ultrasound of rectal lesions | 85.49 V | 110.43 |

### 03 CLINICAL EVALUATION AND EXAMINATION

#### 03.0 Diagnostic interview and evaluation or consultation

##### 03.01 Diagnostic interview and evaluation, unqualified

| | | |
|---|---|---|
| 03.01AD | Telephone advice to a patient or their agent (agent as defined in the Personal Directives Act) | 20.00 |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.01 Diagnostic interview and evaluation, unqualified (cont'd)

BASE ANE

NOTE: 1. May only be claimed if the service was initiated by the patient or their agent (agent as defined in the Personal Directives Act).
2. May only be claimed once per patient, per physician, per day.
3. Benefit includes providing a new prescription or prescription renewal if provided.
4. May not be claimed for services provided through Health Link.
5. Documentation of the request and advice given must be recorded.
6. May only be claimed when communication is provided by the physician.

03.01 Diagnostic interview and evaluation, unqualified

03.01MT Completion of a Physician Report form under the Mandatory Testing and Disclosure Act . . . . . 74.18

NOTE: May only be claimed for preparing Physician's report as outlined in the Mandatory Testing and Disclosure Act when requested by a patient for purposes of seeking a court order to require a source individual to submit to testing for blood-borne infections.

03.01AA After hours time premium . . . . . BY ASSESS

NOTE: 1. Use modifiers TDES, TEV, TNTA, TNTP, TST, TWK to claim for the after hours time unit premium in accordance with GR 15 and the SURT modifier definition.
2. Benefit will vary depending on the modifier used.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.01 Diagnostic interview and evaluation, unqualified (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.01NG Patient care advice to paramedic - pre hospital patch, Mobile Integrated Healthcare Unit paramedic, assisted living/designated assisted living and lodge staff, active treatment facility worker for hospital in-patient, long term care worker for patients in a long term care facility, nurse practitioner, hospice worker, home care worker, midwife or public health nurse weekdays 0700 to 1700 hours, provided via telephone or other telecommunication methods, in relation to the care and treatment of a patient . . . . . | 17.43 | |
| NOTE: Refer to notes following HSC 03.01NI. | | |
| 03.01NH Patient care advice to paramedic - pre hospital patch, Mobile Integrated Healthcare Unit paramedic, assisted living/designated assisted living and lodge staff, active treatment facility worker for hospital in-patient, long | | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.01 Diagnostic interview and evaluation, unqualified (cont'd)

| | BASE | ANE |
|---|---|---|
| term care worker for patients in a long term care facility, nurse practitioner, hospice worker, home care worker, midwife or public health nurse weekdays 1700 to 2200 hours, weekends and statutory holidays, 0700 to 2200 hours, provided via telephone or other telecommunication methods, in relation to the care and treatment of a patient . . . . . | 20.60 | |

NOTE: Refer to notes following HSC 03.01NI.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.01 Diagnostic interview and evaluation, unqualified (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.01NI Patient care advice to paramedic - pre hospital patch, Mobile Integrated Healthcare Unit paramedic, assisted living/designated assisted living and lodge staff, active treatment facility worker for hospital in-patient, long term care worker for patients in a long term care facility, nurse practitioner, hospice worker, home care worker, midwife or public health nurse any day 2200 to 0700 hours, provided via telephone or other telecommunication methods, in relation to the care and treatment of a patient | 23.77 | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.01 Diagnostic interview and evaluation, unqualified (cont'd)

BASE ANE

NOTE: 1. Active treatment facility worker may include registered: nurse, licensed practical nurse, midwife, occupational therapist, physiotherapist, speech language pathologist, social worker, pharmacist, psychologist, recreational therapist or respiratory therapist.
2. Long term care worker/hospice worker may include registered: nurse, licensed practical nurse, occupational therapist, physiotherapist, speech language pathologist, social worker, pharmacist, psychologist or recreational therapist.
3. Advice to nurse practitioners may only be claimed if the nurse practitioner is in autonomous practice or working at a nursing station where no physician is present. Advice to a public health nurse may only be claimed if the public health nurse is employed by AHS and working in an AHS health unit.
4. Advice to midwives may be claimed if the midwife is in independent practice or working at a midwifery center.
5. In the case of long term care or active treatment facility worker, claims may only be submitted when the physician is outside the facility where the patient is located.
6. May be claimed for advice given to midwife, hospice worker, home care worker or public health nurse in person as well as advice by telephone or other telecommunication methods.
7. HSCs 03.01NG, 03.01NH and 03.01NI are to be claimed using the Personal Health Number of the patient.
8. May only be claimed when the call is initiated by the long term care worker, assisted living/designated assisted living or lodge staff member, active treatment facility worker, home care worker, nurse practitioner, hospice worker, midwife, public health nurse or paramedic.
9. In the case of a long term care or hospice patient the call may be initiated by the physician if it is in response to receipt of diagnostic or other information that would affect the patient's treatment plan.
10. May be claimed in addition to visits or other services provided on the same day, by the same physician.
11. A maximum of two (any combination of HSC 03.01NG, 03.01NH, 03.01NI) claims may be made per patient, per physician, per day.
12. Documentation of the communication must be recorded in their respective records.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.01 Diagnostic interview and evaluation, unqualified (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.01NJ Patient care advice to active treatment facility worker in relation to a patient receiving outpatient IV medication day treatment, weekdays 0700 to 1700 hours | 31.79 | |
| NOTE: Refer to the notes following HSC 03.01NL. | | |
| 03.01NK Patient care advice to active treatment facility worker in relation to a patient receiving outpatient IV medication day treatment, weekdays 1700 to 2200 hours, weekends and statutory holidays 0700 to 2200 hours | 39.74 | |
| NOTE: Refer to the notes following HSC 03.01NL. | | |
| 03.01NL Patient care advice to active treatment facility worker in relation to a patient receiving outpatient IV medication day treatment, any day 2200 to 0700 hours | 47.69 | |

NOTE:
1. Active treatment facility worker may include registered: nurse, licensed practical nurse, occupational therapist, physiotherapist, speech language pathologist, social worker, pharmacist, psychologist, recreational therapist or respiratory therapist.
2. May only be claimed by hematology, infectious disease specialists, internal medicine and rheumatologists.
3. May only be claimed when the physician is outside the facility from where the patient is located.
4. May be claimed for advice given to the worker by telephone or other telecommunication means.
5. To be claimed using the Personal Health Number of the patient.
6. May only be claimed when the call is initiated by the health care worker.
7. A maximum of two (any combination of HSCs 03.01NJ, 03.01NK, 03.01NL) claims may be made per patient, per physician, per day.
8. Documentation of the communication must be recorded in their respective records.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.01 Diagnostic interview and evaluation, unqualified (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.01NM Patient care advice to a pharmacist provided via telephone or other telecommunication methods in relation to the care and treatment of a patient | 17.43 | |

NOTE:
1. It is expected that the purpose of the communication will be to seek the advice/opinion or to inform a physician when changes such as but not limited to prescription adaptations, pharmacist initiated prescriptions, care plans or medication reviews have occurred.
2. May only be claimed when the pharmacist has initiated the communication and the physician has provided an opinion or recommendation for patient treatment.
3. May not be claimed where the primary purpose of the communication is to clarify, decipher or interpret the physician's handwriting and/or written instructions.
4. May not be claimed for the authorization of repeat prescriptions for which long-term repeats would more properly have been authorized at the time of writing the initial prescription.
5. May not be claimed for instances where a physician directs a patient to request the pharmacist to contact the physician.
6. May not be claimed for patients in an active treatment, auxiliary, or nursing home facility.
7. May not be claimed when a physician proxy, e.g. nurse or clerk, provides advice to the pharmacist.
8. A maximum of one (1) communication per patient per day may be claimed, regardless of the number of issues or concerns discussed with the pharmacist.
9. Where more than one patient is discussed in a single communication, a claim may be submitted with respect to each patient discussed.
10. May be claimed in addition to visits or other services provided on the same day, by the same physician.
11. To be claimed using the Personal Health Number of the patient.
12. Documentation of the communication must be recorded in their respective records.

| | | |
|---|---|---|
| 03.01B Patient care advice provided to community mental health care workers, child protection workers, group home staff, or educational personnel weekdays 0700 to 1700 hours in relation to the care and treatment of a patient receiving community mental health care services under the Alberta community mental health care program. . . . . | 17.43 V | |

NOTE: Refer to notes following 03.01BB for further information.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.01 Diagnostic interview and evaluation, unqualified (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.01BA Patient care advice provided to community mental health care workers, child protection workers, group home staff, or educational personnel weekdays 1700 to 2200 hours, weekends and statutory holidays 0700 to 2200 hours in relation to the care and treatment of a patient receiving community mental health care services under the Alberta community mental health care program. | 21.47 V | |
| NOTE: Refer to notes following 03.01BB for further information. | | |
| 03.01BB Patient care advice provided to community mental health care workers, child protection workers, group home staff, or educational personnel any day 2200 to 0700 hours in relation to the care and treatment of a patient receiving community mental health care services under the Alberta community mental health care program. . . . . | 25.05 V | |
| NOTE: 1. HSCs 03.01B, 03.01BA, 03.01BB are to be claimed using the Personal Health Number of the patient. | | |
| 2. May only be claimed when the request for advice is initiated by the community mental health care worker, child protection worker, group home staff, or educational personnel. | | |
| 3. May be claimed: -for advice provided in person or via telephone or other telecommunication methods. -in addition to visits or other services provided on the same day by the same physician. | | |
| 4. A maximum of two (any combination of HSC 03.01B, 03.01BA, 03.01BB) claims may be claimed per patient, per physician, per day. | | |
| 5. Documentation of the request and advice must be recorded by both the physician and the community mental health care worker in their respective patient records. | | |
| 03.01C Telehealth assistance service . . . . . | 33.97 V | |
| NOTE: 1. May only be claimed if the physician is required to be present at the referring site to assist with essential physical assessment without which the consultant service would be ineffective. | | |
| 2. May be claimed in addition to other services provided in an emergency situation. | | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.01 Diagnostic interview and evaluation, unqualified (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 03.01J | Assessment of an unrelated condition in association with a Workers' Compensation service . . . . . NOTE: May only be claimed when services are provided for an unrelated illness or injury in conjunction with a WCB-related service, including visits. | 23.77 | |
| 03.01N | Management of anticoagulant therapy to include ordering necessary blood tests, interpreting results, adjusting the anticoagulant dosage as required NOTE: 1. May only be claimed twice per calendar month, per patient, regardless of whether the same or different physician provides the service. 2. May only be claimed in months where advice has been given regarding dosage. 3. May be claimed in addition to visits or other services provided on the same day by the same physician. 4. May not be claimed for hospital inpatients or hospital outpatients. 5. Documentation of the communication must be recorded. | 17.43 | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.01 Diagnostic interview and evaluation, unqualified (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.01O Physician or Nurse Practitioner to Physician secure E-Consultation, consultant | 68.65 | |

NOTE:
1. May only be claimed when both the referring physician or referring nurse practitioner and the consulting physician exchange communication using secure electronic communication that is in compliance with the CPSA guidelines on secure electronic communication and when the physician/nurse practitioner/clinic has submitted a Privacy Impact Assessment for this service acceptable to the Office of the Privacy Commissioner of Alberta.
2. This service is only eligible for payment if the consultant physician has provided an opinion/advice and/or recommendations for patient treatment and/or management within thirty (30) days from the date of the e-consultation request.
3. May only be claimed when initiated by the referring physician or referring nurse practitioner.
4. The consultant may not claim a major consultation, physician to physician phone call, or procedure for the same patient for the same condition within 24 hours of receiving the request for an e-consultation unless the patient was transferred from an outside facility and advice was given on management of that patient prior to transfer.
5. May only be claimed when the consultant has provided an opinion and recommendations for patient treatment as well as management after reviewing pertinent family/patient history, history of the presenting complaint as well as laboratory and other data where indicated. It is expected that the purpose of the communication will be to seek the advice of a physician more experienced in treating the particular problem in question, and that the referring physician or referring nurse practitioner intends to continue to care for the patient.
6. May not be claimed for situations where the purpose of the communication is to:
   a. arrange for an expedited consultation or procedure within 24 hours except when the conditions in note 4 are met
   b. arrange for laboratory or diagnostic investigations
   c. discuss or inform the referring physician of results of diagnostic investigations.
7. Documentation of the request and advice given must be recorded by the consultant in their patient records.
8. This service may not be claimed for transfer of care alone.
9. Advice to nurse practitioners may only be claimed if the nurse practitioner is in autonomous practice or working in a nursing station where no physician is present.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.01 Diagnostic interview and evaluation, unqualified (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 03.01R | Physician to Physician secure E-Consultation, referring physician . . . . . | 33.28 | |

NOTE:
1. Time spent completing the referral may not be claimed using complexity modifiers.
2. May only be claimed when both the referring and consulting physician exchange communication using secure electronic communication that is in compliance with the CPSA guidelines on secure electronic communication and when the physician/clinic has submitted a Privacy Impact Assessment for this service acceptable to the Office of the Privacy Commissioner of Alberta.
3. May not be claimed for situations where the purpose of the communication is to:
   a) arrange for laboratory or diagnostic investigations
   b) discuss or inform of results of diagnostic investigations, or
   c) arrange for an expedited consultation with the patient
4. Documentation of the request and advice given must be recorded in the patient record.
5. This service may not be claimed for transfer of care alone.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.01 Diagnostic interview and evaluation, unqualified (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 03.01S | Physician to patient secure electronic communication . . . . . | 20.00 | |

NOTE:
1. May only be claimed for medically necessary advice or follow up where the nature of the condition can safely be managed via secure email.
2. May only be claimed when the service is provided using a secure email system that is in compliance with the CPSA guidelines on secure electronic communication and when the physician/clinic has submitted a Privacy Impact Assessment for this service acceptable to the Office of the Privacy Commissioner of Alberta.
3. May only be claimed for those patients where an established physician-patient relationship exists and the physician has seen the patient in the previous 12 months.
4. Physicians and patients must have previously discussed and agreed to the limitations of health management using electronic means.
5. Secure electronic communication must inform patients when the physician is unavailable.
6. May only be claimed once per week per patient per physician.
7. A maximum of fourteen 03.01S per calendar week per physician may be claimed.
8. A visit service may not be claimed if provided within 24 hours following the electronic communication.
9. HSC 03.01S is not payable in the same calendar week as 03.05JR or 03.01T by the same physician for the same patient.
10. May not be claimed when the service is provided by a physician proxy.
11. Documentation of the service must be recorded in the patients' record.
12. May not be claimed for inpatients.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.01 Diagnostic interview and evaluation, unqualified (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 03.01T | Physician to patient secure videoconference . . . . . | 20.00 | |

NOTE:
1. May only be claimed for medically necessary advice or follow up where the nature of the condition can safely be managed via secure videoconference.
2. May only be claimed for those patients where an established physician-patient relationship exist and the physician has seen the patient in the previous 12 months.
3. May only be claimed when the service is provided using a secure videoconference system that is in compliance with the CPSA guidelines on secure electronic communication and when the physician/clinic has submitted a Privacy Impact Assessment for this service acceptable to the Office of the Privacy Commissioner of Alberta.
4. May only be claimed once per week per patient per physician.
5. A maximum of fourteen 03.01T per calendar week per physician may be claimed.
6. A visit service may not be claimed if provided within 24 hours following the electronic communication.
7. HSC 03.01T is not payable in the same calendar week as 03.05JR or 03.01S by the same physician for the same patient.
8. May not be claimed when the service is provided by a physician proxy.
9. Documentation of the service must be recorded in the patients' record.
10. May not be claimed for inpatients.

| | | | |
|---|---|---|---|
| 03.01LG | Physician to physician or podiatric surgeon telephone or telehealth videoconference or secure videoconference consultation, referring physician, weekdays 0700 to 1700 hours . . . . . | 33.28 | |

NOTE: Refer to notes following HSC 03.01LI.

| | | | |
|---|---|---|---|
| 03.01LH | Physician to physician or podiatric surgeon telephone or telehealth videoconference or secure videoconference consultation, referring physician, weekdays 1700 to 2200 hours, weekends and statutory holidays 0700 to 2200 hours . . . . . | 36.45 | |

NOTE: Refer to notes following HSC 03.01LI.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.01 Diagnostic interview and evaluation, unqualified (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.01LI Physician to physician or podiatric surgeon telephone or telehealth videoconference or secure videoconference consultation, referring physician, any day 2200 to 0700 hours . . . . . | 40.69 | |

NOTE:
1. HSCs 03.01LG, 03.01LH, 03.01LI may be claimed in addition to visits or other services provided on the same day by the same physician when criteria listed below are met.
2. May only be claimed when the consultant has provided an opinion and recommendations for patient treatment as well as management after reviewing pertinent family/patient history and history of the presenting complaint as well as discussion of the patient's condition and management after reviewing laboratory and other data where indicated. It is expected that the purpose of the call will be to seek the advice of a physician or podiatric surgeon more experienced in treating the particular problem in question, and that the referring physician intends to continue to care for the patient.
3. May not be claimed for situations where the purpose of the call is to:
   - arrange for transfer of care that occurs within 24 hours unless the patient was transferred to an outside facility and advice was given on management of that patient prior to transfer
   - arrange for an expedited consultation or procedure within 24 hours
   - arrange for laboratory or diagnostic investigations
   - discuss or inform the referring physician or podiatric surgeon of results of diagnostic investigations.
4. A maximum of two (any combination of HSC 03.01LG, 03.01LH, 03.01LI) claims may be claimed per patient, per physician, per day.
5. Documentation must be recorded by both the referring physician and the consultant in their respective records.
6. Telehealth videoconferences may only be claimed when all participants are participating in the videoconference from regional telehealth facilities.
7. Claims for secure videoconference may only be claimed when the service is provided using a secure videoconference system that is in compliance with the CPSA guidelines on secure electronic communication and when the physician/clinic has submitted a Privacy Impact Assessment for this service accepted by the Office of the Privacy Commissioner of Alberta.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.01 Diagnostic interview and evaluation, unqualified (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.01LJ Physician, nurse practitioner, midwife or podiatric surgeon to physician telephone or telehealth videoconference or secure videoconference consultation, consultant, weekdays 0700 to 1700 hours . . . . . NOTE: Refer to notes following HSC 03.01LL. | 77.74 | |
| 03.01LK Physician, nurse practitioner, midwife or podiatric surgeon to physician telephone or telehealth videoconference or secure videoconference consultation, consultant, weekdays 1700 to 2200 hours, weekends and statutory holidays 0700 to 2200 hours . . . . . NOTE: Refer to notes following HSC 03.01LL. | 115.07 | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.01 Diagnostic interview and evaluation, unqualified (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.01LL Physician, nurse practitioner, midwife or podiatric surgeon to physician telephone or telehealth videoconference or secure videoconference consultation, consultant, any day 2200 to 0700 hours . . . . . | 135.81 | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.01 Diagnostic interview and evaluation, unqualified (cont'd)

BASE ANE

NOTE:
1. HSCs 03.01LJ, 03.01LK, 03.01LL may only be claimed when initiated by the referring physician, nurse practitioner, midwife or podiatric surgeon.
2. The consultant may not claim a major consultation or procedure for the same patient for the same condition within 24 hours unless the patient was transferred from an outside facility and advice was given on management of that patient prior to transfer.
3. May only be claimed when the consultant has provided an opinion and recommendations for patient treatment as well as management after reviewing pertinent family/patient history and history of the presenting complaint as well as discussion of the patient's condition and management after reviewing laboratory and other data where indicated. It is expected that the purpose of the call will be to seek the advice of a physician more experienced in treating the particular problem in question, and that the referring physician, nurse practitioner, midwife or podiatric surgeon intends to continue to care for the patient.
4. May not be claimed for situations where the purpose of the call is to:
-arrange for an expedited consultation or procedure within 24 hours except when the conditions in note 2 are met
-arrange for laboratory or diagnostic investigations
-discuss or inform the referring physician or podiatric surgeon of results of diagnostic investigations.
5. A maximum of two (any combination of HSC 03.01LJ, 03.01LK, 03.01LL) claims may be claimed per patient, per physician, per day.
6. Documentation must be recorded by both the referring physician, nurse practitioner, midwife or the podiatric surgeon and the consultant in their respective records.
7. Telehealth videoconferences may only be claimed when all participants are participating in the videoconference from regional telehealth facilities.
8. Claims for secure videoconference may only be claimed when the service is provided using a secure videoconference system that is in compliance with the CPSA guidelines on secure electronic communication and when the physician/clinic has submitted a Privacy Impact Assessment for this service accepted by the Office of the Privacy Commissioner of Alberta.
communication and when the physician/clinic has submitted a Privacy Impact Assessment for this service accepted by the Office of the Privacy Commissioner of Alberta.
9. Advice to nurse practitioners may only be claimed if the nurse practitioner is in autonomous practice or working at a nursing station where no physician is present.
10. Advice to midwives may be claimed if the midwife is in independent practice or working at a midwifery center.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.01 Diagnostic interview and evaluation, unqualified (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.01LM Patient care advice to active treatment facility worker or nurse practitioner in relation to the obstetrical outpatient, weekdays 0700 - 1700 hours | 17.71 | |
| NOTE: Refer to the notes following HSC 03.01LO. | | |
| 03.01LN Patient care advice to active treatment facility worker or nurse practitioner in relation to the obstetrical outpatient, weekdays 1700 - 2200 hours, weekends and statutory holidays 0700 - 2200 hours | 26.16 | |
| NOTE: Refer to the notes following HSC 03.01LO. | | |
| 03.01LO Patient care advice to active treatment facility worker or nurse practitioner in relation to the obstetrical outpatient, any day 2200 - 0700 hours | 30.87 | |

NOTE:
1. Active treatment facility worker may include Registered Nurse, Licensed Practical Nurse, midwife.
2. To be claimed using the Personal Health Number of the patient.
3. May only be claimed by general practice or obstetrics and gynecology.
4. Advice to nurse practitioners may only be claimed if the nurse practitioner is in independent practice or working at a nursing station where no physician is present.
5. May only be claimed when the physician is outside the facility from where the patient is located.
6. May only be claimed when the call is initiated by the active treatment facility worker or nurse practitioner.
7. May only be claimed for advice given to the active treatment facility worker or nurse practitioner by telephone or other telecommunication means.
8. A maximum of two (any combination of HSC 03.01LM, 03.01LN or 03.01LO) may be claimed per patient, per physician, per day.
9. Documentation of the communication must be recorded in their respective records.

| | | |
|---|---|---|
| 03.01LT Online medical control (OLMC) - Telephone calls from EMS practitioners on site to OLMC physicians on duty weekdays 0700 - 1700 hours | 27.88 | |
| NOTE: Refer to the notes following HSC 03.01LV | | |
| 03.01LU Online medical control (OLMC) - Telephone calls from EMS practitioners on site to OLMC physicians on duty weekdays 1700 - 2200 hours, weekends and statutory holidays 0700 - 2200 hours | 34.85 | |
| NOTE: Refer to the notes following HSC 03.01LV. | | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.01 Diagnostic interview and evaluation, unqualified (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.01LV Online medical control (OLMC) - Telephone calls from EMS practitioners on site to OLMC physicians on duty any day 2200 - 0700 hours . . . . . | 38.76 | |

NOTE:
1. May only be claimed in those situations where the call to the OLMC physician has been dispatched through the STARS Link Centre, or a similar central dispatch centre for calls of this nature, on behalf of an EMS practitioner in attendance at an emergency situation where the EMS protocols, or the judgement of the EMS practitioner, necessitate contact with the OLMC physician.
2. May only be claimed when the OLMC physician has provided an opinion and recommendations for patient management to the EMS practitioner after reviewing the patient's history and condition with the EMS practitioner as well as review of laboratory and other data where indicated.
3. May not be claimed for situations where the purpose of the call is to:
-arrange for an expedited consultation or procedure within 24 hours except when the conditions in note 2 are met.
-arrange for laboratory or diagnostic investigations.
4. A maximum of two claims may be claimed per patient, per physician, per day.
5. Documentation of the phone call must be recorded in their respective records.

03.02 Diagnostic interview and evaluation, described as brief

| | | |
|---|---|---|
| 03.02A Brief assessment of a patient's condition requiring a minimal history with little or no physical examination . . . . . | 10.03 V | |

03.03 Diagnostic interview and evaluation, described as limited

| | | |
|---|---|---|
| 03.03A Limited assessment of a patient's condition requiring a history related to the presenting problems, an examination of the relevant body systems, appropriate records, and advice to the patient - in office. . . . . | 25.09 V | |

NOTE:
1. Benefit includes the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient.
2. May not be claimed in addition to HSC 03.05JB at the same encounter.

| | | |
|---|---|---|
| 03.03AZ Limited assessment of a patient's condition requiring a history related to the presenting problems, an examination of the relevant body systems, appropriate records, and advice to the patient - out of office. . . . . | 25.09 V | |

NOTE:
1. Benefit includes the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient.
2. May not be claimed in addition to HSC 03.05JB at the same encounter.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.03 Diagnostic interview and evaluation, described as limited (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.03CV Assessment of a patient's condition via telephone or secure videoconference. | 25.09 | V |

NOTE: 1. At a minimum a physician must complete a limited assessment of a patient's condition requiring a history related to the presenting problems, appropriate records, and advice to the patient. The total physician time spent providing patient care activities must last a minimum of 10 minutes. If the total physician time spent on the same day is less than 10 minutes, the service must be claimed using HSC 03.01AD.
2. May only be claimed if the service was initiated by the patient or their agent (agent as defined in the Personal Directives Act).
3. May only be claimed if the service is personally rendered by the physician.
4. Benefit includes the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient.
5. The patient's record must include a detailed summary of all services provided including time spent and start and stop times.
6. Time spent on administrative tasks cannot be claimed.
7. May not be claimed on the same day as HSC 03.01AD, 03.01S, 03.01T, 03.03FV, 03.05JR, 03.08CV, 08.19CV, 08.19CW, or 08.19CX by the same physician for the same patient.
8. May not be claimed on the same day as an in-person visit or consultation service by the same physician for the same patient.

| | | |
|---|---|---|
| 03.03B | Prenatal visit - in office. . . . . | 37.02 |
| 03.03BZ | Prenatal visit - out of office. . . . . | 37.02 |
| 03.03C | Routine post-natal office examination . . . . . | 37.02 |

NOTE: May be claimed once per patient per physician per pregnancy.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.03 Diagnostic interview and evaluation, described as limited (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.03D Hospital visits . . . . . | 42.26 V | |

NOTE: 1. Specialist rates are for referred hospital visits only.
2. A maximum of six level one days may be claimed when the same physician claims a comprehensive visit or consultation on the date of hospital admission.
3. Only one HSC 03.03D may be claimed per patient, per physician, per day. Special callbacks (HSCs 03.05N, 03.05P, 03.05QA, 03.05QB, 03.05R) may be claimed when the criteria listed under HSC 03.05R are met.
4. Modifier COINPT may be claimed for the management of complex acute care hospital inpatients with multi-system disease. Refer to the COINPT modifier definition for clarification regarding the use of this modifier.

03.03DF Visit to hospital in-patient in association with a callback . . . . . 44.45 V

NOTE: 1. May be claimed when HSC 03.03D has been claimed at a different encounter by the same or different physician.
2. May be claimed in addition to a special callback (HSC 03.03KA, 03.03LA, 03.03MC, 03.03MD) only where HSC 03.03D has been claimed for palliative or acute inter-current illness in an auxiliary hospital or nursing home.
3. Claims for second and subsequent patients seen on a priority basis after initial callback (HSC 03.05N, 03.05P, 03.05QA, 03.05QB, 03.05R) must be made using HSC 03.03AR, if HSC 03.03D has already been claimed at a different encounter by the same or different physician.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.03 Diagnostic interview and evaluation, described as limited (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.03DG Complex pediatric hospital visit per full 15 minutes . . . . . | 77.01 | |

NOTES:
1. May only be claimed for visits where the patient is complex and requires a minimum of 15 minutes on patient care management.
2. May not be claimed on the same date of service as any visit service by the same physician.
3. Time may be claimed on a cumulative basis.
4. May only be claimed by pediatricians and pediatric subspecialties.

| | | |
|---|---|---|
| 03.03AO Transfer of care of hospital in-patient . . . . . | 95.08 | V |

NOTE:
1. May only be claimed by endocrinology/metabolism, general internal medicine, gastroenterology, infectious disease, general surgery, cardiology, hematology, clinical immunology, medical oncology, and respiratory medicine.
2. May be claimed on the date of transfer by the receiving physician when assuming responsibility for care of a hospital in-patient.
3. Only one transfer may be claimed per patient, per calendar week, regardless of whether the same or different physician provides the service.
4. The physician from whom the care is being transferred may claim a hospital visit or intensive care visit on the day of transfer.
5. May not be claimed for weekend coverage or within 24 hours of admission to hospital.
6. May not be claimed during post-operative time periods unless complications occur.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.03 Diagnostic interview and evaluation, described as limited (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.03AU Transfer of care of hospital in-patient or out-patient to operating physician . . . . . | 94.12 | V |
| NOTE: 1. May only be claimed by general surgery, orthopedics and urology. 2. May only be claimed when a consultation for the patient has already been claimed by another physician of the same specialty. 3. May be claimed in addition to a procedure on the same date of service. | | |
| 03.03AT Patient admission at the request of an internal medicine specialist triage physician . . . . . | 198.70 | |
| NOTE: 1. May only be claimed by internal medicine at the time the patient is seen. 2. May be claimed on the date of transfer by the receiving physician when admitting the patient. 3. May not be claimed in addition to any other visit or consultation on the same date of service by the same physician. 4. Callbacks and HSC 03.03DF at a separate encounter for the same date of service by the same or different physician may be claimed in addition. | | |
| 03.03AR Urgent or priority attendance on hospital inpatient or long term care inpatient, at request of facility staff when physician is already on site. . | 47.54 | |
| NOTE: 1. May only be claimed by the patient's physician of record, or by physicians working as part of an on-call rotation. 2. May not be claimed by physician extenders. 3. May only be claimed for direct attendance with the patient. | | |
| 03.03E Periodic chronic care visit to a long term care patient . . . . . | 28.53 | V |
| NOTE: 1. May be claimed once per calendar week if no other visit precedes in the same calendar week for the same patient by the same physician. 2. HSC 03.03EA and special callbacks (HSCs 03.03AR, 03.03KA, 03.03LA, 03.03MC, 03.03MD) may be claimed subsequent to a 03.03E in the same calendar week for the same patient by the same physician. 3. HSC 03.03D may be claimed for palliative care or inter-current illness. | | |
| 03.03EA Visit to long term care patient in association with a special callback (HSC 03.03KA, 03.03LA, 03.03MC, 03.03MD) . . . . . | 66.56 | V |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.03 Diagnostic interview and evaluation, described as limited (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 03.03F | Repeat office visit or scheduled outpatient visit in a regional facility, referred cases only - in office. . . . . | 32.34 | V |
| 03.03FA | Prolonged repeat office or scheduled outpatient visit in a regional facility, referred cases only, full 15 minutes or portion thereof for the first call when only one call is claimed . . . . . | 25.09 | V |

NOTE: 1. May only be claimed in addition to HSC 03.03F or 03.03FZ when the 03.03F or 03.03FZ exceeds 30 minutes.
2. May only be claimed by pediatrics (including subspecialties) and clinical immunology and allergy for patients 18 years of age and under, or by cardiology, endocrinology/metabolism, gastroenterology, infectious diseases, internal medicine, hematology, medical genetics, medical oncology, neurology, physiatry, respiratory medicine, rheumatology, urology and vascular surgery (no age restriction).

| | | | |
|---|---|---|---|
| 03.03FZ | Repeat office visit or scheduled outpatient visit in a regional facility, referred cases only - out of office. . . . . | 32.34 | V |
| 03.03FV | Repeat office visit or scheduled outpatient visit, referred cases only via telephone or secure videoconference. . . . . | 32.34 | V |

NOTE: 1. At a minimum a physician must complete a limited assessment of a patient's condition requiring a history related to the presenting problems, appropriate records, and advice to the patient. The total physician time spent providing patient care activities must last a minimum of 10 minutes. If the total physician time spent on patient management activities on the same day is less than 10 minutes the services must be claimed using HSC 03.01AD.
2. May only be claimed if the service is personally rendered by the physician.
3. The patient's record must include a detailed summary of all services provided including time spent and start and stop times.
4. Time spent on administrative tasks cannot be claimed.
5. May not be claimed on the same day as HSC 03.01AD, 03.01S, 03.01T, 03.03CV, 03.05JR, 03.08CV, 08.19CV, 08.19CW or 08.19CX by the same physician for the same patient.
6. May not be claimed on the same day as an in-person visit or consultation service by the same physician for the same patient.

| | | | |
|---|---|---|---|
| 03.03H | Chronic poliomyelitis cases, monthly fee . . . . . | 85.38 | |
| 03.03J | Anesthetist hospital visit, unrelated to anesthetic . . . . . | 27.42 | |

NOTE: Supervising a respiratory problem as an example
Anesthetist specialty restriction.

| | | | |
|---|---|---|---|
| 03.03KA | Special callback to hospital emergency/outpatient department, AACC, UCC, auxiliary hospital or nursing home, when specially called from home or | | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.03 Diagnostic interview and evaluation, described as limited (cont'd)

| | BASE | ANE |
|---|---|---|
| office, weekday, (0700-1700 hours) . . . . . | 76.07 | |
| NOTE: Refer to the notes following HSC 03.03MD. | | |
| 03.03LA Special callback to hospital emergency/outpatient department, AACC, UCC, auxiliary hospital or nursing home, when specially called from home or office, weekdays 1700-2200 hours, weekends and statutory holidays 0700-2200 hours . . . . . | 114.10 | |
| NOTE: Refer to the notes following HSC 03.03MD. | | |
| 03.03MC Special callback to hospital emergency/outpatient department, AACC, UCC, auxiliary hospital or nursing home, when specially called from home or office, any day (2200-2400 hours) . . . . . | 152.14 | |
| NOTE: Refer to the notes following HSC 03.03MD. | | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.03 Diagnostic interview and evaluation, described as limited (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.03MD Special callback to hospital emergency/outpatient department, AACC, UCC, auxiliary hospital or nursing home, when specially called from home or office, any day (2400-0700 hours) . . . . . | 152.14 | |

NOTE: 1. For hospital emergency/outpatient department, AACC, UCC refer to GR 15.3.
2. For auxiliary hospital and nursing home visits, refer to the following notes:
- Benefits for HSCs 03.03KA, 03.03LA, 03.03MC, 03.03MD may only be claimed when the physician is requested to attend a patient, by the patient, the patient's relatives or a health care provider of the facility involved in managing the patients care.
- HSC 03.03EA may be claimed in addition to a special callback to an auxiliary hospital or nursing home.
- HSC 03.03D may be claimed for palliative care or acute inter-current illness.
- HSC 03.03DF may only be claimed where HSC 03.03D has been claimed for palliative care or acute inter-current illness in an auxiliary hospital or nursing home. Special callback benefits (03.03KA, 03.03LA, 03.03MC, 03.03MD) may be claimed in addition.
- Benefits for HSCs 03.03KA, 03.03LA, 03.03MC, 03.03MD are payable based on the time at which the encounter commences.
- The physician responds to such a call from outside the auxiliary hospital or nursing home, on an unscheduled basis.
- The patient is attended on a priority basis.
- Special callback benefits (HSCs 03.05N, 03.05P, 03.05QA, 03.05QB, 03.05R) may not be claimed in addition.

| | | |
|---|---|---|
| 03.03ME Special call to closed office, weekdays (0000-2400) . . . . . | 57.05 | |

NOTE: 1. When a physician must travel to his/her office which is closed, with no staff in attendance.
2. A maximum of five (5) per weekday, per physician may be claimed.
3. Subsequent patients seen may be claimed under code 03.02A, 03.03A, 03.04A or the appropriate procedural code.

| | | |
|---|---|---|
| 03.03MF Special call to closed office, weekends and statutory holidays (0000-2400) . | 57.05 | |

NOTE: 1. When a physician must travel to his/her office which is closed, with no staff in attendance.
2. A maximum of ten (10) per weekend day or statutory holiday, per physician may be claimed.
3. Subsequent patients seen may be claimed under code 03.02A, 03.03A, 03.04A or the appropriate procedural code.

Home Visits

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.03 Diagnostic interview and evaluation, described as limited (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 03.03N | Home visit - first patient . . . . . | 38.19 | V |
| | NOTE: At a minimum, a physician must complete a limited assessment of a patient's condition requiring a history related to the presenting problems, an examination of the relevant body systems, appropriate records, and advice to the patient. | | |
| 03.03P | Home visit - second/subsequent patients . . . . . | 14.82 | V |
| | NOTE: At a minimum, a physician must complete a limited assessment of a patient's condition requiring a history related to the presenting problems, an examination of the relevant body systems, appropriate records, and advice to the patient. | | |
| 03.03Q | Home visit - repeat visit same day . . . . . | 14.82 | V |
| 03.03R | Broker home visit . . . . . | 36.79 | |
| | NOTE: 1. Broker means an intermediary (agent or company) who provides a contact point for patients wishing to arrange for a home visit from a physician.<br>2. Broker home visit means a home visit arranged by an intermediary (agent or company). | | |
| 03.03NA | Home visit to patients residing in Assisted Living, Designated Assisted Living (DAL), group homes, seniors lodges or personal care home, first patient . . . . . | 85.58 | |
| | NOTE: 1. A maximum of one visit per day, per facility may be claimed. For the subsequent patient seen in the same facility on the same date of service, see HSC 03.03NB.<br>2. If a special call for attendance is made for a second visit on the same date of service, a second 03.03NA may be submitted with supporting information.<br>3. Modifiers OFEV, OFEVWK, OFNTAM or OFNTPM may only be claimed if a special call for attendance is received and the physician attends within 24 hours of receiving the call.<br>4. If the facility provides a room for the physician to see the patient, an appropriate visit (03.02A, 03.03A or 03.04A) should be billed instead.<br>5. At a minimum, a physician must complete a limited assessment of a patient's condition requiring a history related to the presenting problems, an examination of the relevant body systems, appropriate records, and advice to the patient. | | |
| 03.03NB | Home visit to patients residing in Assisted Living, Designated Assisted Living (DAL), group homes, seniors lodges or personal care home, second/subsequent patients . . . . . | 76.15 | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.03 Diagnostic interview and evaluation, described as limited (cont'd)

BASE ANE

NOTE: 1. A maximum of one visit per day, per facility, per patient may be claimed.
2. If a special call for attendance is made for a second visit on the same date of service, a second 03.03NB may be submitted with supporting information.
3. Modifiers OFEV, OFEVWK, OFNTAM or OFNTPM may only be claimed if a special call for attendance is received and the physician attends within 24 hours of receiving the call.
4. If the facility provides a room for the physician to see the patient, an appropriate visit (03.02A, 03.03A or 03.04A) should be billed instead.
5. At a minimum, a physician must complete a limited assessment of a patient's condition requiring a history related to the presenting problems, an examination of the relevant body systems, appropriate records, and advice to the patient.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.04 Diagnostic interview and evaluation, described as comprehensive

| | | BASE | ANE |
|---|---|---|---|
| 03.04A | Comprehensive assessment of a patient's condition requiring a complete history, a complete physical examination appropriate to the physician's specialty, an appropriate record and advice to the patient - in office. . . | 40.14 | V |

NOTE: 1. This may be used for an annual medical examination within the limitations of GR 4.6.1.
2. Complete physical examination shall include examination of each organ system of the body, except in psychiatry, dermatology and the surgical specialties. "Complete physical examination" shall encompass all those organ systems which customarily and usually are the standard complete examination prevailing within the practice of the respective specialty. What is customary and usual may be judged by peer review.
3. Benefit includes the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.04 Diagnostic interview and evaluation, described as comprehensive (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 03.04AZ | Comprehensive assessment of a patient's condition requiring a complete history, a complete physical examination appropriate to the physician's specialty, an appropriate record and advice to the patient - out of office. | 40.14 | V |
| | NOTE: 1. This may be used for an annual medical examination within the limitations of GR 4.6.1.<br>2. Complete physical examination shall include examination of each organ system of the body, except in psychiatry, dermatology and the surgical specialties. "Complete physical examination" shall encompass all those organ systems which customarily and usually are the standard complete examination prevailing within the practice of the respective specialty. What is customary and usual may be judged by peer review.<br>3. Benefit includes the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient. | | |
| 03.04F | Comprehensive visit in an emergency department, weekday, 0700-1700 hours . . | 99.19 | |
| | NOTE: Refer to the notes following 03.04H. | | |
| 03.04FA | Comprehensive visit in an AACC or UCC, weekday 0700-1700 hours . . . . . | 90.21 | |
| | NOTE: Refer to the notes following HSC 03.04HA. | | |
| 03.04G | Comprehensive visit in an emergency department, weekdays 1700-2200 hours, weekends and statutory holidays 0700-2200 hours . . . . . | 99.19 | |
| | NOTE: Refer to the notes following HSC 03.04H. | | |
| 03.04GA | Comprehensive visit in an AACC or UCC, weekdays 1700-2200 hours, weekends and statutory holidays 0700-2200 hours . . . . . | 90.21 | |
| | NOTE: Refer to the notes following HSC 03.04HA. | | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.04 Diagnostic interview and evaluation, described as comprehensive (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 03.04H | Comprehensive visit in emergency department, 2200-0700 hours . . . . . | 99.19 | |
| | NOTE: 1. HSCs 03.04F, 03.04G, 03.04H may only be claimed by emergency medicine physicians, full time emergency room physicians, general practitioners or pediatricians working a rotation duty shift in an emergency department with 24 hour on-site coverage or by physicians who are providing first call coverage in an emergency department that has greater than 25,000 visits to the emergency room per year. | | |
| | 2. HSCs 03.04F, 03.04G, 03.04H may be claimed for those patients whose illness/injury requires prolonged observation, continuous therapy and multiple reassessments as described in GR 4.2.7 or for female patients requiring an internal examination because of obstetrical problems or gynecological bleeding. | | |
| 03.04HA | Comprehensive visit in an AACC or UCC, 2200-0700 hours . . . . . | 90.21 | |
| | NOTE: 1. HSCs 03.04FA, 03.04GA, 03.04HA may only be claimed by physicians working a rotation duty shift in an AACC or UCC. | | |
| | 2. HSCs 03.04FA, 03.04GA, 03.04HA may be claimed for those patients whose illness/injury requires prolonged observation, continuous therapy and multiple reassessments as described in GR 4.2.7 or for female patients requiring an internal examination because of obstetrical problems or gynecological bleeding. | | |
| 03.04B | Initial prenatal visit requiring complete history and physical examination . | 104.60 | |
| | NOTE: 1. May not be charged within 90 days of another comprehensive visit or consultation. | | |
| | 2. May only be claimed once per pregnancy. | | |
| | 3. Includes a full history, examination, initiation of the prenatal record and advice to the patient. | | |
| 03.04C | Hospital admission . . . . . | 34.05 | V |
| 03.04D | Long term care admission (Nursing Home/Auxiliary Hospital or a long term care bed in a general hospital) . . . . . | 110.94 | |
| 03.04I | Comprehensive visit, including completion of form, required for admission to a regional health authority addiction residential treatment centre . . . | 123.61 | |
| 03.04E | Emergency home visit and admission to a hospital and hospital visit on the same day . . . . . | 38.98 | V |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.04 Diagnostic interview and evaluation, described as comprehensive (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.04K Comprehensive geriatric assessment, first full 90 minutes . . . . . | 313.79 | |

NOTE:
1. If the assessment is less than 90 minutes, then HSC 03.04A, 03.04AZ, 03.08A or 03.08AZ should be claimed.
2. May only be claimed in an AHS regional facility or AHS/Contracted partner run geriatric program(s) or community clinic where a PCN multi-disciplinary team is contributing to the assessment.
3. May only be claimed for patients aged 75 years or older.
4. May only be claimed by general practitioners, internal medicine specialists or geriatric medicine specialists.
5. May only be claimed once per patient per year.
6. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List, to a maximum of 7 calls.
7. Assessment must include the following components:
   a) Medical includes but is not limited to a complete physical examination, a problem list, co morbidity conditions and disease severity, a medication review and nutritional status.
   b) Functional includes but is not limited to a review of basic activities of daily living, instrumental activities of daily living, activity/exercise status, gait, balance and assessment of senior falls.
   c) Cognitive/psychological includes but is not limited to review of mental status, administration of the Mini Mental State Examination (MMSE) and mood/depression testing through Geriatric Depression Scale (GDS).
   d) Social includes but is not limited to a review of informal support needs and assets, care resource eligibility and a financial assessment.
   e) Environmental includes but is not limited to a review of current living situation, home safety and transportation.
8. Evidence that all components in note 7 were completed must be documented in the patient's records. This includes physician notes and copies of the MMSE and GDS.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.04 Diagnostic interview and evaluation, described as comprehensive (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 03.04M | Pre-operative history and physical examination in relation to an insured service . . . . . | 104.60 | |
| | NOTE: 1. May only be claimed when an examination and a standard form for pre-operative assessment have been completed.<br>2. A copy of the form must be retained in the patient's chart.<br>3. May not be claimed in addition to a surgical assist (SA, SAQS, SSOS) for the same patient by the same physician.<br>4. HSC 03.04M may not be claimed for a pre operative physical examination when the request is for a cataract procedure (HSC 27.72A) that will not require the use of a general anesthetic. | | |
| 03.04N | Comprehensive evaluation including completion of forms to determine capacity as defined by the Personal Directives Act (PDA) (RSA 2007 s9(2)(a)) | 193.34 | |
| | Note: 1. Benefit includes witnessing the agents' or service providers' assessment.<br>2. May be claimed to determine lack of capacity or to determine that capacity has been regained. | | |
| 03.04O | Follow-up care of patient with functioning renal transplant - first year . . | 100.36 | V |
| | NOTE: 1. May only be claimed 4 times per patient within the first 12 months following a renal transplant.<br>2. Should the required number of visits for the patient exceed four in the first year following a renal transplant, subsequent visits may be submitted using the appropriate visit HSC.<br>3. May only be claimed by physicians with GNSG or NEPH skill codes. | | |
| 03.04P | Follow-up care of patient with functioning renal transplant - second and subsequent years . . . . . | 100.36 | V |
| | NOTE: 1. May only be claimed 4 times per patient per year for the second and subsequent years following a renal tranplant.<br>2. Should the required number of visits exceed four within a given post-transplant year (beginning on the date of transplantation), subsequent visits may be submitted using the appropriate visit HSC.<br>3. May only be claimed by physicians with GNSG or NEPH skill codes. | | |
| 03.04Q | Post surgical cancer surveillance examination . . . . . | 103.93 | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.04 Diagnostic interview and evaluation, described as comprehensive (cont'd)

BASE ANE

NOTE: 1. Intended for patients requiring scheduled comprehensive evaluations relevant to the specific type of cancer.
2. Comprehensive evaluations must adhere to protocols as defined by the facility, program or surgeon from which the patient was discharged.
3. The discharge letter that states the protocols must be forwarded to Alberta Health for claim processing for each claim submitted. The letter must indicate:
a. Date of surgery
b. Schedule of required comprehensive visits and other diagnostic testing
c. Duration of required follow-ups (i.e. two years from date of surgery)

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation (cont'd)

03.04 Diagnostic interview and evaluation, described as comprehensive (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.04R Pre-surgical planning and patient navigation visit | 79.23 | V |

NOTE:
1. May only be claimed by general surgery.
2. May only be claimed for patients that have already received a consultation in the pre-operative period by the same physician who intends on performing the procedure.
3. May only be claimed in instances where more than one pre-surgical visit is necessary due to the complexities of the patients' circumstances and/or surgical needs.
4. May only be claimed in the pre-operative period for procedures with a category code of 3, 4, 6 or 14.

03.05 Other diagnostic interview and evaluation

| | | |
|---|---|---|
| 03.05A Intensive care unit visit per 15 minutes | 57.76 | |

NOTE:
1. Time spent with a patient must be claimed on a cumulative basis per day.
2. When a consultation is claimed in association with 03.05A during the same encounter, the consultation is considered to occupy the first 30 minutes of time spent with the patient.
3. Time spent performing procedures should be excluded from the cumulative time spent with the patient per day.
4. When a procedure and 03.05A are provided during the same encounter, only the greater benefit may be claimed.
5. Conditions for unscheduled services apply as per GR 15.7.

| | | |
|---|---|---|
| 03.03AI Transfer of care of intensive care patient | 164.67 | |

NOTE:
1. May be claimed on the date of transfer by the receiving physician when assuming responsibility for care of an intensive care patient.
2. Only one transfer may be claimed per patient, per calendar week, regardless of whether the same or different physician provides the service.
3. The physician from whom the care is being transferred may claim a hospital visit or intensive care visit, as appropriate, on the day of transfer.
4. May not be claimed for weekend coverage or within 24 hours of admission to hospital.
5. 03.05A may be claimed by the receiving physician after 30 minutes of time related to care of the patient has been spent.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.05 Other diagnostic interview and evaluation (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 03.05B | Trauma care visit . . . . . | 105.65 | |
| | NOTE: 1. Trauma care visit includes daily visit, review of blood work, laboratory and x-ray results, and management of care with co-ordination of required consultations. The first day of trauma care may be claimed using HSC 13.99GA.<br>2. May only be claimed by the co-ordinating surgical specialist.<br>3. May not be claimed in addition to a major surgical procedure performed by the same (trauma) physician.<br>4. May only be claimed for referred cases.<br>5. A maximum of 6 HSC 03.05B (one for each hospital day) may be claimed for care delivered following the trauma admission (HSC 13.99GA).<br>6. Daily hospital visits for those trauma patients requiring care past seven days, should be claimed using HSC 03.03D beginning on the eighth day and onwards.<br>7. May be claimed in addition to care provided by intensivists. | | |
| 03.05CR | Rotation duty, emergency department, 0700-1700 hours . . . . . | 29.18 | |
| | NOTE: Refer to the note following 03.05ER. | | |
| 03.05DR | Rotation duty, emergency department, weekdays 1700-2200 hours, weekends and statutory holidays 0700-2200 hours . . . . . | 29.18 | |
| | NOTE: Refer to the note following HSC 03.05ER. | | |
| 03.05ER | Rotation duty, emergency department, 2200-0700 hours . . . . . | 29.18 | |
| | NOTE: HSCs 03.05CR, 03.05DR and 03.05ER may only be claimed by physicians who are on-site and working a scheduled rotation duty shift in an emergency department, or are providing first call coverage in an emergency department with greater than 25,000 visits per year. | | |
| 03.05FR | Rotation duty, AACC or UCC, 0700-1700 hours . . . . . | 31.00 | |
| | NOTE: Refer to the notes following HSC 03.05HR. | | |
| 03.05GR | Rotation duty, AACC or UCC, weekdays 1700-2200 hours, weekends and statutory holidays 0700-2200 hours . . . . . | 31.00 | |
| | NOTE: Refer to the notes following HSC 03.05HR. | | |
| 03.05HR | Rotation duty, AACC or UCC, 2200-0700 hours . . . . . | 31.00 | |
| | NOTE: HSCs 03.05FR, 03.05GR and 03.05HR may only be claimed by physicians who are on-site and working in an AACC or UCC. | | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.05 Other diagnostic interview and evaluation (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 03.05F | Follow-up care of a patient remaining in an emergency department awaiting further evaluation, treatment, and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician, weekday, 0700 to 1700 hours . . . . . | 29.36 | |
| | NOTE: Refer to the notes following HSC 03.05FB. | | |
| 03.05FA | Follow-up care of a patient remaining in an emergency department awaiting further evaluation, treatment and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician, weekday, 1700 to 2200 hours, weekend and statutory holiday, 0700 to 2200 hours . . . . . | 29.36 | |
| | NOTE: Refer to the notes following HSC 03.05FB. | | |
| 03.05FB | Follow-up care of a patient remaining in an emergency department awaiting further evaluation, treatment and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician, any day, 2200 to 0700 hours . . . . . | 29.36 | |
| | NOTE: 1. HSCs 03.05F, 03.05FA and 03.05FB may not be claimed on the same shift by the physician who provided the initial assessment.<br>2. HSCs 03.05F, 03.05FA and 03.05FB may only be claimed once per patient per emergency room shift.<br>3. HSCs 03.05F, 03.05FA and 03.05FB may only be claimed by physicians on rotation duty in an emergency department, or providing first call coverage in an emergency department with greater than 25,000 visits per year.<br>4. Should the patient remain in the emergency room awaiting an in-patient bed after admission to hospital, HSCs 03.05F, 03.05FA and 03.05FB may not be claimed by the emergency room physician. | | |
| 03.05FC | Follow-up care of a patient remaining in an AACC or UCC awaiting further evaluation, treatment, transfer to another facility, or requiring extended care by a physician, weekday, 0700 to 1700 hours . . . . . | 35.18 | |
| | NOTE: Refer to the notes following HSC 03.05FE. | | |
| 03.05FD | Follow-up care of a patient remaining in an AACC or UCC awaiting further evaluation, treatment, transfer to another facility, or requiring extended care by a physician, weekday, 1700 to 2200 hours, weekend and statutory holiday, 0700 to 2200 hours . . . . . | 35.18 | |
| | NOTE: Refer to the notes following HSC 03.05FE. | | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.05 Other diagnostic interview and evaluation (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 03.05FE | Follow-up care of a patient remaining in an AACC or UCC awaiting further evaluation, treatment, transfer to another facility, or requiring extended care by a physician, any day, 2200 to 0700 hours . . . . . | 35.18 | |
| | NOTE: 1. HSCs 03.05FC, 03.05FD and 03.05FE may not be claimed on the same shift by the physician who provided the initial assessment.<br>2. HSCs 03.05FC, 03.05FD and 03.05FE may only be claimed once per patient per shift.<br>3. HSCs 03.05FC, 03.05FD and 03.05FE may only be claimed by physicians on rotation duty in an AACC or UCC. | | |
| 03.05FF | Follow-up care of a patient remaining in a non-rotation duty emergency department after awaiting further evaluation, treatment, and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician, 0700 - 1700 hours, weekdays . . . . . | 35.18 | |
| | NOTE: Refer to the notes following HSC 03.05FH. | | |
| 03.05FG | Follow-up care of a patient remaining in a non-rotation duty emergency department after awaiting further evaluation, treatment, and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician 1700 - 2200 hours, weekday, 0700 - 2200 hours weekend and statutory holiday . . . . . | 35.18 | |
| | NOTE: Refer to the notes following HSC 03.05FH. | | |
| 03.05FH | Follow-up care of a patient remaining in a non-rotation duty emergency department after awaiting further evaluation, treatment, and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician 2200 to 0700 hours any day . . . . . | 35.18 | |
| | NOTE: 1. May only be claimed by the same physician who provided the initial assessment when a second call for attendance has been made by staff or another physician.<br>2. May be claimed by a different physician who is taking over care of the patient. | | |
| 03.05G | Initial assessment of newborn . . . . . | 66.56 V | |
| 03.05GA | Care of healthy newborn in hospital (subsequent days) . . . . . | 53.25 V | |
| | NOTE: May only be claimed when no other visit service has been provided on that day, regardless of physician. | | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.05 Other diagnostic interview and evaluation (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.05JA Formal, scheduled, multiple health discipline team conference, full 15 minutes or major portion thereof for the first call when only one call is claimed . . . . . With para-medical personnel regarding the provision of health care where social and other issues are involved<br>NOTE: 1. May be claimed when the conference involves the physician and one or more allied health professionals.<br>2. May be claimed by more than one physician where circumstances warrant (text will be required).<br>3. May be claimed to a maximum of 12 calls or 3 hours per year (April 1 to March 31), per patient, per physician. | 42.47 | |
| 03.05JD Formal, scheduled, multiple health discipline team conference for purposes to include care planning, care plan review, annual integrated care conference, patient management, related to a patient in a continuing care facility where the facility or program, as outlined in the Continuing Care Health Service Standards, is responsible for patient care, full 5 minutes or major portion thereof for the first call when only one call is claimed, to a maximum of 12 units per hour . . . . . | 14.26 | |
| 03.05JE Formal, scheduled review of patient medication (multiple patients) for patients in continuing care facilities where the facility or program, as outlined in the Continuing Care Health Service Standards is responsible for medication management, by the physician most responsible for the patient's care . . . . . <br>NOTE: Refer to the notes following HSC 03.05JF. | 18.25 | |
| 03.05JF Second physician attendance where required at a formal, scheduled review of patient medication (multiple patients) for patients in continuing care facilities where the facility or program, as outlined in the Continuing Care Health Service Standards, is responsible for medication management on behalf of a specific patient . . . . . <br>NOTE: 1. HSCs 03.05JE and 03.05JF may only be claimed by physicians present during and directly involved in the medication review.<br>2. HSCs 03.05JE and 03.05JF are to be claimed using the Personal Health Number of the patient, naming the personnel, agencies or organizations involved.<br>3. Each physician involved in a patient conference may claim for patient services using HSCs 03.05JE or 03.05JF per patient, to a maximum of 6 patients in a 30-minute period.<br>4. HSC 03.05JF may be claimed when the physician most responsible for the patient's care has submitted a claim under HSC 03.05JE. | 14.94 | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.05 Other diagnostic interview and evaluation (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.05JB Formal, scheduled family conference relating to a specific patient, per 15 minutes or major portion thereof | 51.98 | |

NOTE: 1. May not be claimed at the same encounter as a visit.
2. May be claimed to a maximum of 12 calls or 3 hours per year (April 1 to March 31), per patient, per physician.

| | | |
|---|---|---|
| 03.05JG Formal, scheduled family conference relating to a deceased child, per 15 minutes or major portion thereof | 50.10 | |

NOTE: 1. This service is to be claimed using the Personal Health Number (PHN) of the parent or legal guardian.
2. May only be claimed for children 18 years of age and under at the time of death.
3. Supporting information identifying the name and PHN of the child must be submitted.
4. May only be claimed by pediatrics (including subspecialties) or by medical genetics.

| | | |
|---|---|---|
| 03.05JC Family conference relating to acute care facility in-patient or registered emergency or out-patient, or auxiliary hospital, nursing home patient, AACC or UCC patient, per 15 minutes or major portion thereof | 42.47 | |

NOTE: 1. Intended specifically for patients whose condition warrants periodic family conferences.
2. May be claimed to a maximum of 12 calls or 3 hours per year (April 1 to March 31), per patient, per physician.

| | | |
|---|---|---|
| 03.05JH Family conference via telephone, in regards to a community patient | 18.92 | |

NOTE: 1. This service is to be claimed using the Personal Health Number of the patient.
2. May be claimed in situations where:
a) location or mobility factors of family members at the time of the call preclude in person meetings.
b) communication about a patient's condition or to gather collateral information that is relative to patient management and care activities.
3. May not be claimed for:
a) relaying results for lab or diagnostics.
b) arranging follow up care.
4. Documentation of the communication to be maintained in the patient record.
5. May be claimed in the pre and post-operative periods.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.05 Other diagnostic interview and evaluation (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.05JP Family conference via telephone relating to acute care facility in-patient or registered emergency or out-patient, or auxiliary hospital, nursing home patient, hospice patient, AACC or UCC patient . . . . . | 41.20 | |

NOTE:
1. Intended specifically for patients whose condition warrants periodic family conferences or for patients who are unable to properly communicate with their physician (e.g., situations where there is a language barrier, unconscious patient, etc.).
2. This service is to be claimed using the Personal Health Number of the patient.
3. May be claimed in situations where:
   a) location or mobility factors of family members at the time of the call preclude in person meetings.
   b) timely communication with family members is essential to patient care or organ/tissue transfer collection, and
   c) communication about a patient's condition or to gather collateral information that is relative to patient management and care activities.
4. May not be claimed for:
   a) relaying results for lab or diagnostics.
   b) arranging follow up care.
5. Documentation of the communication to be maintained in the patient record.
6. May be claimed in addition to visits or other services provided on the same day, by the same physician.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.05 Other diagnostic interview and evaluation (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.05JQ Family conference with relative(s) via telephone in connection with the management of a patient with a psychiatric disorder . . . . . | 51.71 | |

NOTE:
1. This service is to be claimed using the Personal Health Number of the patient.
2. May be claimed in situations where:
   a) the patient's family is to be notified of a mental health crisis.
   b) location or mobility factors of family members at the time of the call preclude in person meetings.
   c) timely communication with family members is essential to patient care and/or management.
   d) communication about a patient's condition is required to gather collateral information that is relative to the patient management and care activities.
3. May not be claimed for:
   a) relaying results for lab or diagnostics.
   b) gathering information that is in relation to the development of a Community Treatment Order (CTO).
   c) arranging for follow-up care.
4. Documentation of the communication and relationship of family member to the patient must be recorded in the patient record.
5. May be claimed in addition to visits or other services provided on the same day, by the same physician.

| | | |
|---|---|---|
| 03.05JR Physician telephone call directly to patient, to discuss patient management/diagnostic test results . . . . . | 20.00 | |

NOTE:
1. A maximum of 14 telephone calls per physician, per calendar week may be claimed.
2. May not be claimed for management of patient's anticoagulant therapy (billable under HSC 03.01N).
3. May only be claimed when communication is provided by the physician.
4. Documentation of the communication to be recorded in the patient record.
5. May be claimed in addition to visits or other services provided on the same day, by the same physician.
6. Neither HSCs 03.01S or 03.01T are payable if HSC 03.05JR is claimed in the same calendar week by the same physician for the same patient.

| | | |
|---|---|---|
| 03.05K Formal, scheduled, team/family conference full 30 minutes or major portion thereof for the first call when only one call is claimed . . . . . | 120.29 | |

NOTE: May only be claimed by physiatrists.

| | | |
|---|---|---|
| 03.05T Formal, scheduled, professional interview relating to the care and treatment of a palliative care patient with other physicians, family, and/or direct therapeutic supervision of allied health professionals or | | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.05 Other diagnostic interview and evaluation (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| | community agencies, on behalf of a specific patient, full 15 minutes or major portion thereof for the first call when only one call is claimed . . . | 42.47 | |
| | NOTE: This service is to be claimed in the name of the patient by the physician most responsible for the patient. | | |
| 03.05U | Second and subsequent physician attendance at formal, scheduled, professional interview relating to the care and treatment of a palliative care patient with other physicians, family and/or direct therapeutic supervision of allied health professionals or community agencies, on behalf of a specific patient, full 15 minutes or major portion thereof for the first call when only one call is claimed . . . . . | 28.53 | |
| | NOTE: This service is to be claimed in the name of the patient. | | |
| 03.05V | Formal, scheduled, professional interview relating to the care and treatment of a patient with chronic pain with other physicians, and/or direct therapeutic supervision of allied health professionals or community agencies, on behalf of a specific patient, per 15 minutes . . . . . | 41.99 | |
| | NOTE: 1. This service is to be claimed by the physician most responsible for the patient where the physician spends a minimum of 30 minutes with medical and/or para-medical personnel regarding the management of chronic pain. | | |
| | 2. In those situations where the physician is not part of a comprehensive, coordinated, interdisciplinary chronic pain program, the patient must have been initially assessed at an interdisciplinary chronic pain program, the name of which must be identified in the patient's chart when the patient is referred back to the home community for ongoing treatment. | | |
| 03.05W | Second and subsequent physician attendance at a formal, scheduled, professional interview relating to the care and treatment of a patient with chronic pain with other physicians, family, and/or direct therapeutic supervision of allied health professionals or community agencies, on behalf of a specific patient, per 15 minutes . . . . . | 27.39 | |
| | NOTE: 1. This service is to be claimed in the name of the patient. | | |
| | 2. In those situations where the physician is not part of a comprehensive, coordinated, interdisciplinary chronic pain program, the patient must have been initially assessed at an interdisciplinary chronic pain program, the name of which must be identified in the patient's chart when the patient is referred back to the home community for ongoing treatment. | | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.05 Other diagnostic interview and evaluation (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.05X Formal, scheduled, professional interview with relative(s) relating to the care and treatment of a patient with chronic pain on behalf of a specific patient, full 15 minutes or major portion thereof for the first call when only one call is claimed . . . . . | 51.98 | |

NOTE: 1. This service is to be claimed in the name of the patient.
2. In those situations where the physician is not part of a comprehensive, coordinated, interdisciplinary chronic pain program, the patient must have been initially assessed at an interdisciplinary chronic pain program, the name of which must be identified in the patient's chart when the patient is referred back to the home community for ongoing treatment.

| | | |
|---|---|---|
| 03.05JM Formal, scheduled, professional conference related to the care and treatment of multiple patients undergoing rehabilitation therapy including those with chronic pain with other physician(s), allied health professionals, educational, correctional and other community agencies on behalf of a specific patient provided by the physiatrist most responsible for the patient's care per full 5 minutes to a maximum of 6 units in a 30 minute period . . . . . | 20.05 | |

NOTE: Refer to the notes following HSC 03.05JN.

| | | |
|---|---|---|
| 03.05JN Second and subsequent physician attendance at a formal, scheduled, professional conference related to the care and treatment of multiple patients undergoing rehabilitation therapy including those with chronic pain, when discussion occurs on behalf of a specific patient per full 5 minutes to a maximum of 6 units in a 30 minute period . . . . . | 14.26 | |

NOTE: 1. HSC 03.05JM may only be claimed by Physiatry.
2. HSC 03.05JN may be claimed by any physician that is participating in the conference.
3. HSCs 03.05JM and 03.05JN are to be claimed using the Personal Health Number of the patient.
4. HSC 03.05JN may be claimed when the physician most responsible for the patient's care has submitted a claim under 03.05JM.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.05 Other diagnostic interview and evaluation (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 03.05Y | Formal, scheduled, professional interview, case conference with other physicians and/or direct therapeutic supervision of allied health professionals, educational or other community agencies on behalf of a specific patient, provided by the physician most responsible for the patient's care. . . . . | 100.20 | |

NOTE:
1. May not be claimed unless the physician has seen the patient and been directly involved in the patient's care.
2. May only be claimed by:
   - pediatricians (including subspecialties) for patients 18 years of age and under
   - medical geneticists and psychiatrists (no age restriction)

   when a minimum of 30 minutes has been spent.
3. A maximum benefit of 3 hours applies per session.
4. A maximum benefit of 6 hours per patient, per physician, per benefit year, applies.
5. This service is to be claimed using the Personal Health Number of the patient.
6. HSC 03.03D may be claimed on the same day.

| | | | |
|---|---|---|---|
| 03.05YM | Second and subsequent physician attendance at a formal, scheduled, professional interview, case conference on behalf of a specific patient 18 years of age and under, full 15 minutes or major portion thereof for the first call when only one call is claimed . . . . . | 50.10 | |

NOTE: May only be claimed when the physician most responsible for the patient's care has submitted a claim under HSC 03.05Y.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.05 Other diagnostic interview and evaluation (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.05JJ Professional communication/discussion with allied health professionals, educational or other community agencies on behalf of a specific patient, full 5 minutes or major portion thereof for the first call when only one call is claimed . . . . . | 33.47 | |

NOTE: 1. May only be claimed by:
- pediatricians (including subspecialties) for patients 18 years of age and under;
- medical geneticists (no age restriction).

2. May only be claimed:
- when the communication is initiated by the allied health, educational or community agency;
- for services related to school difficulties, learning disorders, behavioural problems, psychiatric disorders, developmental disorders, major chronic disease, pre-transplant donor/recipient assessment, multiple handicap disorders, child abuse or neglect.

3. May be claimed:
- for communication provided in person, by telephone or other telecommunication methods;
- in addition to visits or other services provided on the same day by the same physician.

4. A maximum benefit of 60 minutes or 12 calls per physician, per week, applies.

5. This service is to be claimed using the Personal Health Number of the patient.

6. Documentation of the communication must be recorded in the patient record.

| | | |
|---|---|---|
| 03.05JK Pediatric conference with parents/guardians of patients, without the patient (child) being present . . . . . | 60.12 | |

NOTE: 1. May only be claimed by: pediatricians (including subspecialties) for patients 18 years of age and under, or by medical geneticists (no age restriction).

2. A maximum of two conferences may be claimed per patient, per physician, per calendar year.

3. May not be claimed on the same day as a visit.

| | | |
|---|---|---|
| 03.05LA Group session, multiple patients, per patient where a physician is involved in providing care and teaching to patients in attendance . . . . . | 15.85 | |

NOTE: May not be claimed in addition to a visit at the same encounter.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.05 Other diagnostic interview and evaluation (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 03.05LB | Group teaching session for patients and/or family members with chronic pain, previous amputation, stroke, brain injury, concussion, spinal cord injury, or other neuromusculoskeletal condition, first 45 minutes or major portion thereof for the first call when only one call is claimed . . . . . NOTE: May not be claimed for preparation time. | 253.60 | |
| 03.05M | Supportive care visit . . . . . NOTE: May be claimed to a maximum of four visits per patient hospitalization. | 28.53 | |
| 03.05MA | Supportive care visit by pediatrics (including subspecialties) for patients 18 years of age and under, or by medical genetics (no age restriction) . . . NOTE: A maximum of one visit per week, per physician, may be claimed. | 40.08 | |
| 03.05I | Direct care, reassessment, education and/or general counselling of a patient requiring palliative care, per 15 minutes or portion thereof - in office. . . . . | 52.32 | |
| 03.05IZ | Direct care, reassessment, education and/or general counselling of a patient requiring palliative care per 15 minutes or portion thereof - out of office. . . . . | 52.32 | |
| 03.05O | Direct management, reassessment, education and/or general counselling of a patient with chronic pain, per 15 minutes or portion thereof . . . . . NOTE: In those situations where the physician is not part of a comprehensive, coordinated, interdisciplinary chronic pain program, the patient must have been initially assessed at an interdisciplinary chronic pain program, the name of which must be identified in the patient's chart when the patient is referred back to the home community for ongoing treatment. | 44.90 V | |
| 03.05N | Special callback to hospital inpatient, when specially called from home or office, weekdays, (0700 - 1700 hours) . . . . . NOTE: Refer to notes following 03.05R for further information. | 75.59 | |
| 03.05P | Special callback to hospital inpatient, weekday, (1700 - 2200 hours) . . . . NOTE: Refer to notes following 03.05R for further information. | 113.38 | |
| 03.05QA | Special callback to hospital inpatient, (2200-2400 hours) . . . . . NOTE: Refer to notes following 03.05R. | 151.16 | |
| 03.05QB | Special callback to hospital inpatient, (2400-0700 hours) . . . . . NOTE: Refer to notes following 03.05R. | 151.16 | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.05 Other diagnostic interview and evaluation (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.05R Special callback to hospital inpatient, weekends and statutory holidays 0700-2200 hours | 113.38 | |

NOTE:
1. May only be claimed when a special call for attendance is made on the patient's behalf.
2. Benefits are payable based on the time at which the encounter commences.
3. The physician responds to such a call from outside the hospital, on an unscheduled basis.
4. The patient is attended on a priority basis.
5. There is direct attendance by the physician.
6. Second or subsequent patients seen during the same callback are not eligible for benefits under HSCs 03.05N, 03.05P, 03.05QA, 03.05QB or 03.05R but may be claimed using HSC 03.03AR.
7. May not be claimed in association with any HSC except HSC 03.01AA or 03.03DF. Refer to GR 15.8.
8. Special callback benefits (03.05N, 03.05P, 03.05QA, 03.05QB or 03.05R) should be claimed in addition to HSC 03.03DF.

| | | |
|---|---|---|
| 03.05Z Non-psychiatric insured medical services | 42.56 V | |

03.07 Consultation, described as limited

| | | |
|---|---|---|
| 03.07A Minor consultation - in office | 40.52 V | |

NOTE: May not be claimed in addition to a surgical assist (SA, SAQS, SSOS) for the same patient by the same physician.

| | | |
|---|---|---|
| 03.07AZ Minor consultation - out of office | 40.52 V | |

NOTE: 1. May not be claimed in addition to a surgical assist (SA,SAQS,SSOS) for the same patient by the same physician.

| | | |
|---|---|---|
| 03.07B Repeat consultation | 38.03 V | |
| 03.07C Repeat obstetrical consultation | 61.70 | |

03.08 Consultation, described as comprehensive

| | | |
|---|---|---|
| 03.08A Comprehensive consultation - in office | 79.23 V | |

NOTE:
1. May not be claimed in addition to a surgical assist (SA, SAQS, SSOS) for the same patient by the same physician.
2. A comprehensive consultation may not be claimed for a transfer of care.

| | | |
|---|---|---|
| 03.08AZ Comprehensive consultation - out of office | 79.23 V | |

NOTE:
1. May not be claimed in addition to a surgical assist (SA, SAQS,SSOS) for the same patient by the same physician.
2. A comprehensive consultation may not be claimed for a transfer of care.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.08 Consultation, described as comprehensive (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.08CV Comprehensive consultation via telephone or secure videoconference . . . . . | 79.23 | V |

NOTE: 1. May only be claimed if the service is personally rendered by the physician.
2. The patient's record must include a detailed summary of all services provided including time spent and start and stop times.
3. Time spent on administrative tasks cannot be claimed.
4. May not be claimed on the same day as HSC 03.01AD, 03.01S, 03.01T, 03.03CV, 03.03FV, 03.05JR, 08.19CV, 08.19CW or 08.19CX by the same physician for the same patient.
5. May not be claimed on the same day as an in-person visit or consultation service by the same physician for the same patient.

| | | |
|---|---|---|
| 03.08B | Obstetrical consultation - in office . . . . . | 92.55 |
| 03.08BZ | Obstetrical consultation - out of office . . . . . | 92.55 |
| 03.08M | Extended uro-gynecology, pediatric gynecological, gyne-oncology, reproductive endocrinology or perinatology consultation, per 15 minutes or major portion thereof . . . . . | 40.11 |

NOTE: May only be claimed in addition to HSC 03.08A, 03.08AZ, 03.08B or 03.08BZ when the consultation exceeds 30 minutes.

| | | |
|---|---|---|
| 03.08C | Formal major neuro-otolaryngological consultation . . . . . | 126.47 |

NOTE: May only be claimed by physicians who have neurotology (NEOT) certification or dual neurology/otolaryngology specialities.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.08 Consultation, described as comprehensive (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 03.08F | Formal, comprehensive consultation, for a patient with chronic pain, full 60 minutes or major portion thereof for the first call when only one call is claimed . . . . . NOTE: The physician must be part of a comprehensive, coordinated, interdisciplinary chronic pain program as defined in GR 4.2.5. | 182.62 | |
| 03.08J | Prolonged consultation or hospital admission by pediatrics (including subspecialties) and clinical immunology and allergy for patients 18 years of age and under, or by medical genetics (no age restriction), full 15 minutes or portion thereof for the first call when only one call is claimed - in office. . . . . NOTE: May only be claimed: - in addition to HSC 03.08A, 03.08AZ and 03.04C after 30 minutes; - in addition to HSC 03.07A, 03.07AZ, and 03.07B after 20 minutes. | 60.12 | |
| 03.08JZ | Prolonged consultation or hospital admission by pediatrics (including subspecialties) and clinical immunology and allergy for patients 18 years of age and under, or by medical genetics (no age restriction), full 15 minutes or portion thereof for the first call when only one call is claimed - out of office. . . . . NOTE: May only be claimed: - in addition to HSC 03.08A, 03.08AZ and 03.04C after 30 minutes; - in addition to HSC 03.07A, 03.07AZ, and 03.07B after 20 minutes. | 60.12 | |
| 03.08I | Prolonged cardiology, clinical immunology, endocrinology/metabolism, gastroenterology, hematology, infectious diseases, internal medicine, nephrology, physiatry, medical oncology, neurology, respiratory medicine or rheumatology consultation or visit, full 15 minutes or major portion thereof for the first call when only one call is claimed - in office. . . . NOTE: May only be claimed in addition to HSCs 03.04A, 03.04AZ, 03.04C, 03.07B, 03.08A, and 03.08AZ when these services exceed 30 minutes. | 40.24 | V |
| 03.08IZ | Prolonged cardiology, clinical immunology, endocrinology/metabolism, gastroenterology, hematology, infectious diseases, internal medicine, nephrology, physiatry, medical oncology, neurology, respiratory medicine or rheumatology consultation or visit, full 15 minutes or major portion thereof for the first call when only one call is claimed - out of office. . . . . NOTE: May only be claimed in addition to HSCs 03.04A, 03.04AZ, 03.04C, 03.07B, 03.08A, and 03.08AZ when these services exceed 30 minutes. | 40.24 | V |
| 03.08H | Formal major neuro- ophthalmology consultation, including complex consultations of orbit or oncology . . . . . NOTE: HSC 03.08H will be payable only to physicians who have been approved by the CPSA to provide these services. | 220.87 | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.0 Diagnostic interview and evaluation or consultation (cont'd)

03.08 Consultation, described as comprehensive (cont'd)

| | BASE | ANE |
|---|---|---|
| 03.08K Otolaryngological oncology consultation for patients with complex invasive malignancies of the head and neck . . . . . | 126.47 | |

NOTE: 1. May only be claimed for patients with:
- malignant mucosal disease of the upper aerodigestive tract, excluding salivary gland, thyroid and skin malignancy or
- malignant disease of the facial bones, sinuses or skull base or,
- head and neck sarcomas and other rare malignancies requiring significantly invasive surgery of the head and neck.

2. May only be claimed by physicians having at least one year's post-residency training in head and neck oncology.

| | | |
|---|---|---|
| 03.08L Prolonged anesthesia consultation, per full 5 minutes . . . . . | 14.50 | |

NOTE: 1. May only be claimed by physicians with an anesthesia specialty.
2. May only be claimed in addition to HSC 03.08A or 03.08AZ for consultations exceeding 30 minutes.
3. A maximum of six five-minute units may be claimed.
4. May not be claimed for chronic pain consultations.

03.09 Consultation, described as other

| | | |
|---|---|---|
| 03.09A Prenatal consultation for fetal assessment . . . . . | 195.65 | |

NOTE: 1. May only be claimed by pediatricians (including subspecialties) or by medical geneticists.
2. To be claimed under the maternal number.

| | | |
|---|---|---|
| 03.09B Teleophthalmology consultation for examination, evaluation and interpretation of stereoscopic digital retinal imaging using store and forward technology . . . . . | 73.80 | |

NOTE: Benefit includes written recommendation to the primary care physician for follow up and management.

03.1 Measurements and manual examinations of nervous system and sense organs

03.11 Vision screening examination

| | | |
|---|---|---|
| 03.11A Visual assessment for patients presenting with acute visual disturbances or painful eye(s) . . . . . | 99.19 | |

Note: 1. Assessment must include anterior and posterior chamber examinations, examination of retina, and may include pressure assessment if necessary.
2. May not be claimed for conditions or procedures related to obvious conjunctivitis, allergic conjunctival conditions, stye, eye lid conditions, foreign body or other similar conditions.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.1 Measurements and manual examinations of nervous system and sense organs (cont'd)

03.12 Tonometry

| | BASE | ANE |
|---|---|---|
| 03.12A Intraocular pressure measurement, unilateral or bilateral . . . . . | 26.03 | |

03.16 Electroencephalogram

| | | |
|---|---|---|
| 03.16A Electroencephalogram, technical . . . . . | 92.99 | 110.53 |
| 03.16B Electroencephalogram, interpretation . . . . . | 39.57 | |
| 03.16C Video/EEG telemetry, review and interpretation, first full 30 minutes or major portion thereof for the first call when only one call is claimed . . . | 126.63 | |

NOTE: 1. May not be claimed concurrently with other services.
2. Each subsequent 15 minutes, or major portion thereof, is payable at the rate specified on the Price List.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.1 Measurements and manual examinations of nervous system and sense organs (cont'd)

03.16 Electroencephalogram (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 03.16D | Stereo/EEG (SEEG) intracranial telemetry, review and interpretation, first full 30 minutes or major portion thereof for the first call when only one call is claimed | 149.66 | |
| | NOTE: 1. May not be claimed concurrently with other services.<br>2. Each subsequent 15 minutes, or major portion thereof, is payable at the rate specified on the Price List after the first full 30 minutes has elapsed. | | |

03.19 Other nonoperative measurements and examinations of nervous system and sense organs NEC

| | | | |
|---|---|---|---|
| 03.19C | Evoked potential, somatosensory, bilateral median nerve and bilateral legs, interpretation | 34.44 | |
| 03.19D | Sleep polygraph studies for apnea and SIDS, interpretation | 100.15 | |
| | NOTE: Pediatric specialty restriction. | | |

03.2 Measurements and manual examinations of genitourinary system

03.21 Urinary manometry

| | | | |
|---|---|---|---|
| 03.21A | Upper urinary tract flow studies | 164.33 | 131.04 |
| | NOTE: 1. Includes interpretation.<br>2. Includes cystoscopy. | | |

03.22 Cystometrogram

| | | | |
|---|---|---|---|
| 03.22A | Cystometrogram, simple | 34.22 V | 109.21 |
| 03.22B | Multi-channel cystometrogram | 85.56 V | 109.21 |
| | NOTE: 1. Includes utilization of rectal and bladder pressures, electromyography as well as interpretation.<br>2. Includes cystoscopy. | | |
| 03.25 | Urethral pressure profile (UPP)<br>NOTE: 1. Includes interpretation.<br>2. Includes cystoscopy. | 76.34 V | 109.21 |
| 03.26 | Gynecological examination<br>NOTE: May only be claimed when performed under general anesthesia. | 95.64 | 110.53 |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.2 Measurements and manual examinations of genitourinary system (cont'd)

03.29 Other nonoperative genitourinary system measurements and examinations

| | | BASE | ANE |
|---|---|---|---|
| 03.29A | Urethral and bladder testing for urinary incontinence in the female | 15.43 | |

03.3 Other measurements and manual examinations
Refer to GRs 11.2.1 and 11.2.2 for additional information pertaining to HSCs 03.37A to 03.38X inclusive.

03.37 Vital capacity determination

| | | | |
|---|---|---|---|
| 03.37A | Vital capacity | 10.72 | |
| 03.37B | Timed vital capacity | 9.41 | |

03.38 Other nonoperative respiratory measurements

| | | | |
|---|---|---|---|
| 03.38A | Pulmonary function tests, flow volume loops, interpretation | 13.36 | |
| 03.38B | Pulmonary function tests, closing volumes, before and after bronchodilators, interpretation | 12.04 | |
| 03.38C | Spirometry | 51.17 | |

NOTE: 1. Benefit includes maximum breathing capacity, vital capacity, tidal volume, inspiratory and expiratory reserve volume.
2. When bronchodilators are administered, the benefit includes both the administration and the cost of the bronchodilator.

| | | | |
|---|---|---|---|
| 03.38D | Vitalometry, alone | 22.19 | |
| 03.38E | Vitalometry, before and after bronchodilators | 17.87 | |

NOTE: Includes vital capacity and timed vital capacity.

| | | | |
|---|---|---|---|
| 03.38F | Flow-volume loop measurement before and after bronchodilator only, technical | 39.88 | |
| 03.38G | Flow-volume loop measurement before bronchodilator only, technical | 22.95 | |
| 03.38H | Lung volumes, diffusing capacities, mixing efficiency and alveolar C02 interpretation | 32.17 | |
| 03.38K | Lung compliance | 64.71 | |
| 03.38M | Residual lung volume | 31.60 | |
| 03.38N | Carbon monoxide diffusion capacity, at rest | 34.80 | |
| 03.38P | Oxygen saturation (ear oximetry with exercise) | 15.99 | |
| 03.38Q | Inhalation challenge test, technical, including interpretation | 223.67 | |
| 03.38R | Interpretation of diagnostic procedures involving vitalometry | 13.54 | |
| 03.38S | Body, plethysmography, technical | 34.80 | |
| 03.38T | Body, plethysmography, interpretation | 19.00 | |
| 03.38X | Asthma exercise test utilizing treadmill or bicycle ergometer | 150.50 | |

NOTE: 1. Benefit includes the technical, interpretation and continuous, personal physician monitoring components of the procedure.
2. Benefit includes monitoring heart rate, oximetry and flow volume loops.

03.39 Other nonoperative measurements and examinations

| | | | |
|---|---|---|---|
| 03.39A | 24-hour ambulatory blood pressure monitoring (ABPM), interpretation | 10.33 | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.3 Other measurements and manual examinations
Refer to GRs 11.2.1 and 11.2.2 for additional information pertaining to HSCs 03.37A to 03.38X inclusive. (cont'd)

03.39 Other nonoperative measurements and examinations (cont'd)

| | BASE | ANE |
|---|---|---|
| NOTE: May only be claimed by internal medicine specialists. | | |
| 03.39B 24-hour ambulatory blood pressure monitoring(ABPM), technical . . . . . | 69.94 | |
| NOTE: May only be claimed by internal medicine specialists. | | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

| | BASE | ANE |
|---|---|---|
| **03.4 Cardiac stress tests and pacemaker checks** | | |
| **03.41 Cardiovascular stress test using treadmill** | | |
| 03.41A Maximal stress electrocardiogram, with or without pulse oximetry, technical only | 33.16 | |
| NOTE: 1. Utilizing bicycle ergometer or treadmill. 2. Includes resting electrocardiograms before and after the procedure. | | |
| 03.41B Interpretation | 20.59 | |
| 03.41C Continuous personal physician monitoring, with or without pulse oximetry | 61.09 | |
| NOTE: 1. Utilizing bicycle ergometer or treadmill. 2. Benefit includes resting electrocardiograms before and after the procedure. | | |
| 03.41D Intravenous dipyridamole administration for thallium imaging, professional component only | 90.76 | |
| **03.44 Other cardiovascular stress test** | | |
| 03.44A Physician personal and continuous monitoring during the provision of dobutamine infusion for the purposes of pharmacologic stress imaging | 182.00 | |
| NOTE: Benefit does not include electrocardiograms. | | |
| **03.45 Artificial pacemaker rate check** | | |
| 03.45A Routine artificial pacemaker and ICD function check by a physician | 17.64 | |
| NOTE: May only be claimed for remote interpretation. | | |
| 03.45B Complex artificial pacemaker and ICD function check | 44.37 | |
| NOTE: 1. May only be claimed for remote interpretation in cases where the physician spends at least 15 minutes interpreting data due to complex issues arising from implanted device i.e. syncope, shocks etc. 2. May not be claimed for time spent setting up transmission or for difficulties in transmitting or receiving information. | | |
| **03.5 Other cardiac function tests** | | |
| **03.52 Other electrocardiogram** | | |
| 03.52A Electrocardiogram, technical | 24.50 | |
| 03.52B Electrocardiogram, interpretation | 9.83 | |
| 03.52C Tape ECG - ambulatory ECG monitoring record (greater than 12 hours), technical | 26.25 | |
| 03.52D Tape ECG - ambulatory ECG monitoring record (greater than 12 hours), interpretation | 31.50 | |
| **03.55 Phonocardiogram with EKG lead** | | |
| 03.55A Phonocardiogram with EKG lead, technical | 21.10 | |
| 03.55B Phonocardiogram with EKG lead, interpretation | 10.62 | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.5 Other cardiac function tests (cont'd)

03.56 Carotid pulse tracing with EKG lead

| | | BASE | ANE |
|---|---|---|---|
| 03.56A | Non-invasive cardiac study, technical . . . . . | 24.16 | |
| 03.56B | Non-invasive cardiac study, interpretation . . . . . | 33.47 | |

NOTE: Includes apexcardiogram, carotid pulse tracing, phonocardiogram plus or minus systolic time intervals.

03.6 Other cardiovascular measurements

| | | | |
|---|---|---|---|
| 03.63 | Implantable Loop Recorder, insertion or removal . . . . . | 221.80 | 147.37 |

NOTE: May not be claimed with HSC 49.84.

03.7 General physical examination

03.7 A Examination of stillborn . . . . . 66.56 V

NOTE: May be claimed in addition to other services provided on the same day by the same physician.

03.7 BA Medical Assistance in Dying - Determination Phase, full 15 minutes or major portion thereof for the first call when only one call is claimed . . . . . 51.80

NOTE:
1. May only be claimed for patient management for Medical Assistance in Dying.
2. Services related to the Determination Phase include:
   a. Patient assessment for Medical Assistance in Dying;
   b. Obtaining and reviewing medical records;
   c. Reviewing but not waiting for lab and other diagnostic information, and
   d. Completion of appropriate documents and forms.
3. All services must be provided in accordance with the CPSA standards for Medical Assistance in Dying.
4. May not be claimed in addition to a visit, consultation or assessment.
5. May not be claimed for travel time.
6. The total time spent during the Determination Phase may be calculated on a cumulative basis over the course of several hours or several days.
7. The patient's record must include a detailed summary of all services provided including a summary of time spent per day per activity.

03.7 BB Medical Assistance in Dying - Action Phase, full 15 minutes or major portion thereof for the first call when only one call is claimed . . . . . 51.80

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.7 General physical examination (cont'd)

| | BASE | ANE |
|---|---|---|
| NOTE: 1. May only be claimed for patient management for Medical Assistance in Dying.<br>2. Services related to the Action Phase include:<br>a. patient visit and assessment,<br>b. Pharmacy visit,<br>c. Communication with other health care providers,<br>d. Review and administration of medication,<br>e. Coordination of procedure, and<br>f. Completion of appropriate documents and forms.<br>3. All services must be provided in accordance with the CPSA standards for Medical Assistance in Dying.<br>4. May not be claimed in addition to a visit, consultation or assessment.<br>5. May not be claimed for travel time.<br>6. The total time spent during the Action Phase may be calculated on a cumulative basis over the course of several hours or several days.<br>7. The patient's record must include a detailed summary of all services provided including a summary of time spent per day per activity. | | |
| 03.7 BC Medical Assistance in Dying - Care After Death Phase, full 15 minutes or portion thereof for the first call when only one call is claimed . . . . . | 51.80 | |
| NOTE: 1. May only be claimed for patient management for Medical Assistance in Dying.<br>2. Services related to the Care After Death Phase include:<br>a. Reporting of event;<br>b. Post event arrangements and,<br>c. Completion of appropriate documents and forms.<br>3. All services must be provided in accordance with the CPSA standards for Medical Assistance in Dying.<br>4. May not be claimed for travel time.<br>5. The total time spent during the Care After Death Phase may be calculated on a cumulative basis over the course of several hours or several days.<br>6. The patient's record must include a detailed summary of all services provided including a summary of time spent per day per activity. | | |

06 NUCLEAR MEDICINE

06.3 Other therapeutic radiology and nuclear medicine

06.35 Injection or instillation of radioisotopes

| | | |
|---|---|---|
| 06.35A Intracavitary or interstitial administration radioactive gold (Au198) or radioactive colloidal chromic phosphate . . . . . | 131.09 | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

06 NUCLEAR MEDICINE (cont'd)

06.3 Other therapeutic radiology and nuclear medicine (cont'd)
06.35 Injection or instillation of radioisotopes (cont'd)

| | BASE | ANE |
|---|---|---|
| 06.35B Injection of radioactive phosphorus (P32) for polycythemia rubra vera, leukemia, bone metastases, etc. | 77.79 | |
| 06.39 Other radiotherapeutic procedure | | |
| 06.39A Administration radioactive iodine - hyperthyroidism | 69.63 | |
| 06.39B Administration radioactive iodine for ablation of normal thyroid gland, thyroid remnant or cancer of the thyroid | 131.41 | |

07 PHYSICAL MEDICINE, REHABILITATION, AND RELATED PROCEDURES

07.0 Diagnostic physical medicine
07.09 Other diagnostic physical medicine procedures

| | | |
|---|---|---|
| 07.09A Nerve conduction studies and electromyography, technical | 92.99 | |
| 07.09B Conduction studies and electromyography, one limb, interpretation | 75.19 | |
| NOTE: An additional call may be claimed at the rate specified on the Price List. | | |

07.2 Other physical medicine - musculoskeletal manipulation
07.27 Manual rupture of joint adhesions

| | | |
|---|---|---|
| 07.27A Manipulation of major joint(s) or spine | 175.80 | 110.53 |
| NOTE: May only be claimed when performed under general anesthesia. | | |
| 07.27B Manipulation of minor joint(s) or examination | 26.37 | 110.43 |
| NOTE: May only be claimed when performed under general anesthesia. | | |

07.29 Other forcible correction of deformity

| | | |
|---|---|---|
| 07.29A Metatarsus varus, manipulation and plaster, per closed treatment | 131.85 V | 110.43 |
| NOTE: May be claimed for club hand. | | |
| 07.29B Manipulation and application of Dennis Brown splints, direct, with adhesive strapping | 46.08 | |

07.4 Skeletal traction and other traction

| | | |
|---|---|---|
| 07.4 A Halo traction | 175.80 | |
| That for scoliosis | | |

07.5 Other immobilization, pressure, and attention to wound
07.51 Application of plaster jacket

| | | |
|---|---|---|
| 07.51A Body jacket | 177.41 | |
| 07.51C Turnbuckle, localiser jacket | 263.71 | |
| That for scoliosis | | |

07.53 Application of other cast

| | | |
|---|---|---|
| 07.53A Shoulder, hip, spica | 175.80 | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

07 PHYSICAL MEDICINE, REHABILITATION, AND RELATED PROCEDURES (cont'd)

07.5 Other immobilization, pressure, and attention to wound (cont'd)

07.53 Application of other cast (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 07.53B | Upper extremity, excluding finger | 47.54 | |
| 07.53C | Finger | 28.53 | |
| 07.53D | Lower extremity | 42.34 | |
| 07.53E | Wedging of cast | 47.54 | |
| 07.53H | Application of fibreglass cast, upper limb, excluding finger | 55.16 | |

NOTE: Refer to notes following 07.53J.

| | | | |
|---|---|---|---|
| 07.53J | Application of fibreglass cast, lower limb | 68.35 | |

NOTE:
1. Benefits for HSCs 07.53H and 07.53J include the cost of supplies and the application of cast (HSC 07.53B or 07.53D).
2. When HSC 07.53H or 07.53J are performed in a nursing home, general or auxiliary hospital, AACC, UCC or a facility which has a contract with Alberta Health Services to provide the insured service for which a fibreglass cast is applied, only the rate equivalent to HSC 07.53B or 07.53D will be paid.
3. When HSC 07.53H or 07.53J are claimed in association with fracture reduction HSCs, they will be reduced by a rate equivalent to HSC 07.53B or 07.53D.
4. HSC 07.53H or 07.53J may not be claimed in association with HSC 07.53B or 07.53D.

07.54 Application of splint

| | | | |
|---|---|---|---|
| 07.54A | Cast brace (other than fractures) | 175.80 | |
| 07.54B | Immobilization of hip joint, using splinting device | 263.71 | |

NOTES:
1. For developmental dislocation of the hip in infants.
2. May not be billed in addition to a visit or consultation.

07.56 Application of pressure dressing

| | | | |
|---|---|---|---|
| 07.56A | Unna's boot | 10.58 | |

07.57 Application of other wound dressing

| | | | |
|---|---|---|---|
| 07.57A | Initial treatment - minor burn | 38.03 | V |
| 07.57B | Subsequent treatment - minor burns - dressing and/or debridement | 57.05 | |

08 DIAGNOSTIC AND THERAPEUTIC PSYCHOLOGY AND PSYCHIATRY

08.1 Psychiatric evaluations, interviews, and consultations

08.11 Psychiatric mental status determination

| | | | |
|---|---|---|---|
| 08.11A | Requiring complete mental status examination and investigation, first full 45 minutes or major portion thereof for the first call when only one call is claimed | 43.51 | V |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

08 DIAGNOSTIC AND THERAPEUTIC PSYCHOLOGY AND PSYCHIATRY (cont'd)

08.1 Psychiatric evaluations, interviews, and consultations (cont'd)
08.11 Psychiatric mental status determination (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| | NOTE: 1. May only be claimed for the initial visit.<br>2. When visit does not require complete examination and investigation, the appropriate office visit HSC should be claimed.<br>3. HSCs 08.19GA, 08.19GZ or 08.19GB may not be claimed at the same encounter. The total time spent providing the non-referred first visit must be claimed using the applicable non-referred first visit code. | | |
| 08.11B | Evidence from a psychiatrist at a Review Panel on behalf of a specific patient, as required under section 37(3) of the Mental Health Act, per 15 minutes or portion thereof . . . . . | 50.33 | |
| | NOTE: 1. This service is to be claimed using the Personal Health Number of the patient.<br>2. May only be claimed by a psychiatrist or a generalist in mental health. | | |
| 08.11C | For complex patient, requiring complete mental status examination and investigation, first full 45 minutes or major portion thereof for the first call when only one call is claimed . . . . . | 187.90 | |
| | NOTE: 1. May only be claimed for the initial visit.<br>2. May only be claimed by psychiatrists.<br>3. May only be claimed when the patient meets the criteria outlined in note 4 and the score is identified in the patient's chart at least once every six months.<br>4. Complex patient is defined as:<br>a. An adult with a Global Assessment of Function (GAF) score of 40 or less.<br>b. A child with a Children's Global Assessment of Function (CGAS) score of 41 or less.<br>5. HSCs 08.19GA, 08.19GZ, or 08.19GB may not be claimed at the same encounter. The total time spent providing the non-referred first visit must be claimed using the applicable non-referred first visit code. | | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

08 DIAGNOSTIC AND THERAPEUTIC PSYCHOLOGY AND PSYCHIATRY (cont'd)

08.1 Psychiatric evaluations, interviews, and consultations (cont'd)

08.12 Psychiatric commitment evaluation

| | BASE | ANE |
|---|---|---|
| 08.12A Certification under the Mental Health Act . . . . . | 57.03 | |

08.19 Other psychiatric evaluation and interview

08.19A Formal major psychiatric consultation, first full 30 minutes or major portion thereof for the first call when only one call is claimed - in office. . . . . 52.22 V

NOTE: 1. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List after the first full 30 minutes has elapsed.
2. HSCs 08.19GA, 08.19GZ or 08.19GB may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code.

08.19AZ Formal major psychiatric consultation, first full 30 minutes or major portion thereof for the first call when only one call is claimed - out of office. . . . . 52.22 V

NOTE: 1. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List after the first full 30 minutes has elapsed.
2. HSCs 08.19GA, 08.19GB or 08.19GZ may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code.

08.19AA Formal major psychiatric consultation for a patient referred by a registered: occupational therapist, psychologist, community based psychiatric nurse, social worker or speech language pathologist, first full 30 minutes or major portion thereof for the first call when only one call is claimed . . . . . 189.58

NOTE: 1. May be claimed when a patient is referred to a psychiatrist by a registered: occupational therapist, psychologist, community based psychiatric nurse, social worker or speech language pathologist and the provisions that apply to consultations under GRs 4.3, 4.4 and 4.6 are met.
2. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List after the first full 30 minutes has elapsed.
3. HSCs 08.19GA, 08.19GZ or 08.19GB may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code.

08.19CX Formal major psychiatric consultation via telephone or secure videoconference, first full 30 minutes or major portion thereof for the first call when only one call is claimed . . . . . 52.22 V

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

08 DIAGNOSTIC AND THERAPEUTIC PSYCHOLOGY AND PSYCHIATRY (cont'd)

08.1 Psychiatric evaluations, interviews, and consultations (cont'd)

08.19 Other psychiatric evaluation and interview (cont'd)

BASE ANE

NOTE: 1. Each subsequent 15 minutes, or major portion thereof, of direct patient time may be claimed at the rate specified on the Price List after the first full 30 minutes has elapsed.
2. The patient's record must include a detailed summary of all services provided including time spent and start and stop times.
3. Only time spent communicating with the patient can be claimed as part of the service. Time spent on administrative tasks cannot be claimed.
4. May not be claimed on the same day as 03.01AD, 03.01S, 03.01T, 03.03CV, 03.03FV, 03.05JR, 03.08CV, 08.19CV or 08.19CW by the same physician for the same patient.
5. May not be claimed on the same day as an in-person visit or consultation service by the same physician for the same patient.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

08 DIAGNOSTIC AND THERAPEUTIC PSYCHOLOGY AND PSYCHIATRY (cont'd)

08.1 Psychiatric evaluations, interviews, and consultations (cont'd)

08.19 Other psychiatric evaluation and interview (cont'd)

| | BASE | ANE |
|---|---|---|
| 08.19B Minor psychiatric consultation, full 15 minutes or major portion thereof for the first call when only one call is claimed . . . . . | 43.51 | V |
| NOTE: HSCs 08.19GA, 08.19GZ, or 08.19GB may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code. | | |
| 08.19BB Minor psychiatric consultation for a patient referred by a registered: occupational therapist, psychologist, community based psychiatric nurse, social worker or speech language pathologist, full 15 minutes or major portion thereof for the first call when only one call is claimed . . . . . | 53.13 | |
| NOTE: 1. May be claimed when a patient is referred to a psychiatrist by a registered: occupational therapist, psychologist, community based psychiatric nurse, social worker or speech language pathologist and the provisions that apply to consultations under GRs 4.3, 4.4 and 4.6 are met. | | |
| 2. HSCs 08.19GA, 08.19GZ, or 08.19GB may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code. | | |
| 08.19C Repeat psychiatric consultation, per full 30 minutes or major portion thereof for the first call when only one call is claimed . . . . . | 43.51 | V |
| NOTE: HSCs 08.19GA, 08.19GB or 08.19GZ may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code. | | |
| 08.19CC Repeat psychiatric consultation for a patient referred by a registered: occupational therapist, psychologist, community based psychiatric nurse, social worker or speech language pathologist, per full 30 minutes or major portion thereof for the first call when only one call is claimed . . . . . | 150.44 | |
| NOTE: 1. May be claimed when a patient is referred to a psychiatrist by a registered: occupational therapist, psychologist, community based psychiatric nurse, social worker or speech language pathologist and the provisions that apply to consultations under GRs 4.3, 4.4 and 4.6 are met. | | |
| 2. HSCs 08.19GA, 08.19GZ or 08.19GB may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code. | | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

08 DIAGNOSTIC AND THERAPEUTIC PSYCHOLOGY AND PSYCHIATRY (cont'd)

08.1 Psychiatric evaluations, interviews, and consultations (cont'd)

08.19 Other psychiatric evaluation and interview (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 08.19D | Professional interview with relative(s) in connection with the management of a patient with a psychiatric disorder, but without the patient being present during the interview, per 15 minutes or major portion thereof . . . | 43.51 | V |
| | NOTE: 1. This service is to be claimed using the Personal Health Number of the patient.<br>2. The relationship of the patient to the person interviewed, must be indicated.<br>3. The maximum benefit to be claimed by a physician other than a psychiatrist, pediatrician, or a generalist mental health is 2 hours per patient, per benefit year. | | |
| 08.19F | Formal, scheduled, professional conference related to the care and treatment of a psychiatric patient with other physician(s), and/or direct therapeutic supervision of, allied health professionals, educational, correctional and other community agencies on behalf of a specific patient, provided by the physician most responsible for the patient's care, per 15 minutes or major portion thereof . . . . . | 42.47 | V |
| | NOTE: Refer to notes following 08.19H | | |
| 08.19H | Second and subsequent physician attendance at a formal, scheduled, professional conference related to the care and treatment of a psychiatric patient, on behalf of a specific patient, per 15 minutes or major portion thereof . . . . . | 28.53 | V |
| | NOTE: 1. 08.19F and 08.19H may only be claimed by general practice physicians, generalists in Mental Health, pediatricians, psychiatrists and specialists in Mental Health.<br>2. 08.19F and 08.19H are to be claimed using the Personal Health Number of the patient, naming the personnel, agencies or organizations involved.<br>3. 08.19H may be claimed when the physician most responsible for the patient's care has submitted a claim under 08.19F. | | |
| 08.19J | Formal, scheduled, professional conference related to the care and treatment of multiple psychiatric patients with other physician(s), allied health professionals, educational, correctional and other community agencies on behalf of a specific patient, provided by the physician most responsible for the patient's care . . . . . | 28.52 | |
| | NOTE: Refer to notes following 08.19K. | | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

08 DIAGNOSTIC AND THERAPEUTIC PSYCHOLOGY AND PSYCHIATRY (cont'd)

08.1 Psychiatric evaluations, interviews, and consultations (cont'd)

08.19 Other psychiatric evaluation and interview (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 08.19K | Second and subsequent physician attendance at a formal, scheduled, professional conference related to the care and treatment of multiple psychiatric patients, when discussion occurs on behalf of a specific patient | 22.93 | |

NOTE:
1. HSCs 08.19J and 08.19K may only be claimed by general practice physicians, generalists in Mental Health, pediatricians, psychiatrists, community medicine specialists and specialists in Mental Health.
2. HSCs 08.19J and 08.19K are to be claimed using the Personal Health Number of the patient, naming the personnel, agencies or organizations involved.
3. Each physician involved in a patient conference may claim for patient services using HSC 08.19J or 08.19K, per patient, to a maximum of 6 patients in a 30-minute period.
4. HSC 08.19K may be claimed when the physician most responsible for the patient's care has submitted a claim under HSC 08.19J.
5. HSC 08.19K may be claimed to a maximum of 2 calls per patient, per calendar week, per physician.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

08 DIAGNOSTIC AND THERAPEUTIC PSYCHOLOGY AND PSYCHIATRY (cont'd)

08.1 Psychiatric evaluations, interviews, and consultations (cont'd)

08.19 Other psychiatric evaluation and interview (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 08.19L | Issuance, development and documentation of a Community Treatment Order (CTO) as defined by the Mental Health Act including all activities and services that are directly related to the CTO initiation and development, per full 15 minutes . . . . . | 46.99 | V |

NOTE:
1. Services related to the development of the CTO include:
   a) Collecting and obtaining collateral information,
   b) Reviewing but not waiting for lab and other diagnostic information,
   c) Interviews with police, registered social workers, family, caregivers, facility staff etc.,
   d) Completion of related documents and forms,
   e) Communication with other health care providers and the physician receiving the patient in their respective community.
2. May not be claimed for travel time or direct psychiatric treatment with the patient. Claims for direct psychiatric treatment should be submitted using the appropriate HSC.
3. The total time spent developing the CTO may be calculated on a cumulative basis over the course of several hours or several days; however, the time spent developing the CTO must be recorded on a session by session basis in the patient's record. The claim for this HSC must be made when the CTO is complete and ready for implementation.
4. May only be claimed by psychiatrists or physicians who are designated to perform this service by Alberta Health Services.
5. May only be claimed once per patient per year.
6. If a CTO has been cancelled and reissued within the year, supporting text is required for payment.
7. Interviews mentioned above may be provided in person as well as by telephone or other telecommunication methods.

| | | | |
|---|---|---|---|
| 08.19M | Second physician involved in the issuance, development and documentation of a CTO, per full 15 minutes . . . . . | 46.99 | V |

NOTE:
1. May not be claimed for travel time.
2. The total time spent developing the CTO may be calculated on a cumulative basis over the course of several hours or several days; however, the time spent developing the CTO must be recorded on a session by session basis in the patient's record. The claim for this HSC must be made when the CTO is complete and ready for implementation.
3. May only be claimed once per patient per year.
4. If a CTO has been cancelled and reissued within the year, supporting text is required for payment.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

08 DIAGNOSTIC AND THERAPEUTIC PSYCHOLOGY AND PSYCHIATRY (cont'd)

08.1 Psychiatric evaluations, interviews, and consultations (cont'd)

08.19 Other psychiatric evaluation and interview (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 08.19N | Renewal, amendments, cancellation or expiry of a CTO as well as necessary work involved in the completion of an apprehension order, examination on apprehension, written statement or non-compliance report, per full 15 minutes . . . . . | 46.99 | V |

NOTE: 1. To be claimed by the psychiatrist most responsible, physician designated by Alberta Health Services to perform this service or in the case of examination on apprehension by an emergency room physician.
2. May not be claimed for travel time or direct psychiatric treatment with the patient. Claims for direct psychiatric treatment should be submitted using the appropriate HSC.
3. Benefit includes form completion and communication to community physician(s), and other health practitioners involved in the care of the patient.

| | | | |
|---|---|---|---|
| 08.19G | Direct contact with an individual patient for psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or general psychiatric counselling, per 15 minutes or major portion thereof - in office. . . . . | 47.54 | V |

NOTE: 1. May be claimed:
-if the intent of the session is the therapy of one individual patient, whether or not more than one person is involved in the session.
-when a physician assessment has established (during the same or previous visit) that the patient is suffering from a psychiatric disorder.
2. For treatment of non-psychiatric disorders, the appropriate office visit health service code should be claimed.

| | | | |
|---|---|---|---|
| 08.19GA | Direct contact with a patient for psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or psychiatric counseling, per 15 minutes or major portion thereof - in office. . . . . | 44.01 | V |

NOTE: 1. May only be claimed by a psychiatrist (PSYC), a generalist in Mental Health (GNMH) or by a specialist in Mental Health (SPMH) if the intent of the session is the therapy of one individual patient, whether or not more than one person is involved in the session.
2. May be claimed for both referred and non-referred patients with psychiatric disorders.
3. May not be claimed at the same encounter as HSCs 08.11A, 08.11C, 08.19A, 08.19AZ, 08.19AA, 08.19B, 08.19BB, 08.19C or 08.19CC.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

08 DIAGNOSTIC AND THERAPEUTIC PSYCHOLOGY AND PSYCHIATRY (cont'd)

08.1 Psychiatric evaluations, interviews, and consultations (cont'd)

08.19 Other psychiatric evaluation and interview (cont'd)

| | BASE | ANE |
|---|---|---|
| 08.19GB Direct contact with a complex patient for psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or psychiatric counseling, per 15 minutes or major portion thereof . . . . . | 46.99 | V |

NOTE:
1. May only be claimed by a psychiatrist or a generalist in mental health.
2. May only be claimed when the patient meets the criteria outlined in note 3 and the score is identified in the patient's chart at least once every six months.
3. Complex patient is defined as:
   a. An adult with a Global Assessment of Function (GAF) score of 40 or less.
   b. A child with a Children's Global Assessment of Function (CGAS) score of 41 or less.
4. May not be claimed at the same encounter as HSCs 08.11A, 08.11C, 08.19A, 08.19AA, 08.19AZ, 08.19B, 08.19BB, 08.19C or 08.19CC.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

08 DIAGNOSTIC AND THERAPEUTIC PSYCHOLOGY AND PSYCHIATRY (cont'd)

08.1 Psychiatric evaluations, interviews, and consultations (cont'd)

08.19 Other psychiatric evaluation and interview (cont'd)

| | BASE | ANE |
|---|---|---|
| 08.19GZ Direct contact with an individual patient for psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or psychiatric counselling, per 15 minutes or major portion thereof - out of office. . . . . | 44.01 | V |

NOTE: 1. May be claimed:
-if the intent of the session is the therapy of one individual patient, whether or not more than one person is involved in the session.
-when a physician assessment has established (during the same or previous visit) that the patient is suffering from a psychiatric disorder.
2. For treatment of non-psychiatric disorders, the appropriate office visit health service code should be claimed.
3. May not be claimed at the same encounter as HSCs 08.11A, 08.11C, 08.19A, 08.19AA, 08.19B, 08.19BB, 08.19C, 08.19CC or 08.19AZ.

| | | |
|---|---|---|
| 08.19CV Telephone or secure videoconference with a patient for psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or psychiatric counseling, including group and family therapy, per 15 minutes or major portion thereof | 44.01 | V |

NOTE: 1. May only be claimed by a psychiatrist (PSYC), a generalist in Mental Health (GNMH) or by a specialist in Mental Health (SPMH).
2. May be claimed for both referred and non-referred patients with psychiatric disorders.
3. The patient's record must include a detailed summary of all services provided including time spent and start and stop times.
4. Only time spent communicating with the patient can be claimed as part of the service. Time spent on administrative tasks cannot be claimed.
5. May not be claimed on the same day as 03.01AD, 03.01S, 03.01T, 03.03CV, 03.03FV, 03.05JR, 03.08CV, 08.19CW, or 08.19CX by the same physician for the same patient.
6. May not be claimed on the same day as an in-person visit or consultation service by the same physician for the same patient.
7. For group therapy sessions, claim the total time providing group therapy under only one patient's Personal Health Number (PHN).

| | | |
|---|---|---|
| 08.19CW Telephone or secure videoconference with a patient for scheduled psychiatric treatment (including group therapy) by a general practitioner or pediatrician, or for a palliative care or a chronic pain visit by an eligible physician, per full 15 minutes. . . . . | 47.54 | V |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

08 DIAGNOSTIC AND THERAPEUTIC PSYCHOLOGY AND PSYCHIATRY (cont'd)

08.1 Psychiatric evaluations, interviews, and consultations (cont'd)

08.19 Other psychiatric evaluation and interview (cont'd)

| | BASE | ANE |
|---|---|---|

NOTE: 1. May only be claimed by General Practitioners or Pediatricians if the session is for scheduled psychiatric treatment.
2. For treatment of non-scheduled psychiatric treatment, the appropriate office visit health service code should be claimed (03.03CV).
3. May be claimed by any physician for palliative care. Palliative care is defined as care given to a patient with a terminal disease such as cancer, AIDS or advanced neurologic disease. Palliative care involves active ongoing multi-disciplinary team care.
4. May be claimed by any physician that is part of an interdisciplinary chronic pain program for a chronic pain visit. A chronic pain visit is defined as pain which persists past the normal time of healing, is associated with protracted illness or is a severe symptom of a recurring condition. A chronic pain visit must be part of a comprehensive, coordinated, interdisciplinary program as defined in General Rule 4.2.5. A physician must be able to demonstrate that they have appropriate chronic pain training and experience.
5. The patient's record must include a detailed summary of all services provided including time spent and start and stop times.
6. Only time spent communicating with the patient can be claimed as part of the service. Time spent on administrative tasks cannot be claimed.
7. May not be claimed on the same day as 03.01AD, 03.01S, 03.01T, 03.03CV, 03.03FV, 03.05JR, 03.08CV, 08.19CV, or 08.19CX by the same physician for the same patient.
8. May not be claimed on the same day as an in-person visit or consultation service by the same physician for the same patient.

08.3 Psychiatric drug and shock therapy

| | | | |
|---|---|---|---|
| 08.38 | Other electroconvulsive therapy (ECT), per treatment . . . . . | 60.92 V | 109.21 |

NOTE: 1. May be claimed with a maximum of two HSC 08.19G, 08.19GA, 08.19GB or 08.19GZ if appropriate.
2. In order to claim HSC 08.38 and 08.19G, 08.19GA, 08.19GB, or 08.19GZ for the same date of service, one hour must have elapsed.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

08 DIAGNOSTIC AND THERAPEUTIC PSYCHOLOGY AND PSYCHIATRY (cont'd)

08.4 Other psychiatric therapeutic procedures

08.44 Group therapy

| | BASE | ANE |
|---|---|---|
| 08.44A Group psychotherapy, where all members of the group are receiving therapy in the session, full 15 minutes or major portion thereof for the first call when only one call is claimed . . . . . | 42.47 | V |

NOTE:
1. May be claimed by a physician other than a psychiatrist only when a physician assessment has established (during the same or a previous visit) that the patient is suffering from a psychiatric disorder.
2. For treatment of non-psychiatric disorders, the appropriate office visit HSC should be claimed.
3. Group therapy services for patients 18 years of age or younger may be claimed using HSC 08.44C or 08.44D.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

08 DIAGNOSTIC AND THERAPEUTIC PSYCHOLOGY AND PSYCHIATRY (cont'd)

08.4 Other psychiatric therapeutic procedures (cont'd)
08.44 Group therapy (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 08.44B | Second and subsequent physician attendance at group psychotherapy, where all members of the group are receiving therapy in the session, full 15 minutes or major portion thereof for the first call when only one call is claimed . . . . . | 70.46 V | |
| | NOTE: 1. May only be claimed by a psychiatrist.<br>2. Group therapy services for patients 18 years of age or younger may be claimed using HSC 08.44C or 08.44D. | | |
| 08.44C | Group psychotherapy, complex group, where all members of the group are receiving therapy in the session, full 15 minutes or major portion thereof for the first call when only one call is claimed . . . . . | 78.85 | |
| | NOTE: 1. May only be claimed by a psychiatrist.<br>2. May only be claimed for groups where one or more of the members has a significant personality disorder.<br>3. May be claimed for group therapy sessions for patients 18 years of age or younger. | | |
| 08.44D | Second and subsequent physician attendance at complex group psychotherapy, where all members of the group are receiving therapy in the session, full 15 minutes or major portion thereof for the first call when only one call is claimed . . . . . | 78.85 | |
| | NOTE: 1. May only be claimed by a psychiatrist.<br>2. May only be claimed for groups where one or more of the members has a significant personality disorder.<br>3. May be claimed for group therapy sessions for patients 18 years or younger. | | |
| 08.45 | Assessment or therapy of a family, requiring comprehensive psychiatric or family systems evaluation, first full 45 minutes or major portion thereof for the first call when only one call is claimed - in office. . . . . | 58.74 V | |
| | NOTE: 1. May only be claimed:<br>- when the purpose of the visit is to provide psychiatric assessment or therapy to deal with systemic issues in the family unit;<br>- by general practice physicians, generalists in Mental Health, pediatricians (including subspecialties) and psychiatrists.<br>2. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List after the first full 45 minutes has elapsed. | | |
| 08.45Z | Assessment or therapy of a family, requiring comprehensive psychiatric or family systems evaluation, first full 45 minutes or major portion thereof for the first call when only one call is claimed_- out of office. . . . . | 58.74 V | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

08 DIAGNOSTIC AND THERAPEUTIC PSYCHOLOGY AND PSYCHIATRY (cont'd)

08.4 Other psychiatric therapeutic procedures (cont'd)

08.44 Group therapy (cont'd)

| | BASE | ANE |
|---|---|---|

NOTE: 1. May only be claimed:
- when the purpose of the visit is to provide psychiatric assessment or therapy to deal with systemic issues in the family unit;
- by general practice physicians, generalists in Mental Health, pediatricians (including subspecialties) and psychiatrists.

2. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List after the first full 45 minutes has elapsed.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

08 DIAGNOSTIC AND THERAPEUTIC PSYCHOLOGY AND PSYCHIATRY (cont'd)

08.4 Other psychiatric therapeutic procedures (cont'd)
08.44 Group therapy (cont'd)

| | BASE | ANE |
|---|---|---|
| 08.45A Complex assessment or therapy of a family, requiring comprehensive psychiatric or family systems evaluation, first full 45 minutes or major portion thereof for the first call when only one call is claimed | 201.33 | |

NOTE:
1. May only be claimed by psychiatrists.
2. May only be claimed for family therapy where one or more members of the family has a significant personality disorder.
3. May only be claimed when the purpose of the visit is to provide psychiatric assessment or therapy to deal with systemic issues in the family unit.
4. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List after the first full 45 minutes has elapsed.

09 OPHTHALMOLOGICAL AND OTOLOGICAL DIAGNOSIS AND TREATMENT

09.0 General and subjective eye examination
09.01 Limited eye examination

| | | |
|---|---|---|
| 09.01A | Biomicroscopy (slit lamp examination) | 26.03 |
| 09.01B | Gonioscopy | 26.03 |
| 09.01C | Orthoptic analysis, interpretation | 34.59 |
| 09.01E | Orthoptic analysis, technical (may include Hess screen) | 33.90 |
| 09.01F | Complete oculo-visual examination | 36.64 |

NOTE:
1. Non-insured for residents aged 19 through 64 years.
2. May not be claimed in addition to any other complete examinations (03.04A, 03.04AZ, 03.08A, 03.08AZ, 03.08H and 09.04).
3. Intended for those circumstances in which a routine periodic eye examination is provided.
4. Claims may be submitted once every benefit year (July 1 - June 30) for residents 18 years of age or younger and 65 years and older.

09.02 Comprehensive eye examination

| | | |
|---|---|---|
| 09.02A | Inpatient examination for retinopathy of prematurity in infants or non-accidental trauma | 156.84 |

NOTE: May only be claimed for an infant up to one year of age.

| | | |
|---|---|---|
| 09.02B | Anterior chamber depth measurement | 1.54 |
| 09.02D | Community or outpatient retinopathy examination of prematurity in infants | 109.92 |

NOTE: May only be claimed for an infant up to one year of age.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

09 OPHTHALMOLOGICAL AND OTOLOGICAL DIAGNOSIS AND TREATMENT (cont'd)

09.0 General and subjective eye examination (cont'd)

09.02 Comprehensive eye examination (cont'd)

| | BASE | ANE |
|---|---|---|
| 09.02E Amblyopia evaluation for patients nine years of age and younger | 52.05 | |
| 09.04 Eye examination under anesthesia<br>NOTE: May not be claimed when topical anesthesia only is used. | 287.65 | 110.53 |

09.05 Visual field study

| | | |
|---|---|---|
| 09.05A Full threshold perimetric examination, technical | 39.72 | |
| 09.05B Full threshold perimetric examination, interpretation | 34.07 | |

09.06 Colour vision study

| | | |
|---|---|---|
| 09.06A Color vision test, interpretation and technical | 15.75 | |

09.07 Dark adaptation study

| | | |
|---|---|---|
| 09.07C Bilateral dark adaptation study - technical and interpretation | 15.75 | |

09.1 Examinations of form and structure of eye

09.11 Photography of fundus oculi

| | | |
|---|---|---|
| 09.11A Bilateral specular microscopy for corneal graft patients only - technical | 15.75 | |
| 09.11B Bilateral specular microscopy for corneal graft patients only - interpretation | 15.75 | |
| 09.11C Potential acuity measurement (PAM)<br>NOTE: May not be claimed in addition to HSC 09.13G. | 15.75 | |

09.12 Fluorescein angiography or angioscopy of eye

| | | |
|---|---|---|
| 09.12A Intravenous fluorescein angiography (IVFA), interpretation<br>NOTE: May not be claimed with HSC 13.59C. | 67.97 | |
| 09.12B Intravenous fluorescein angiography (IVFA), technical | 160.43 | |

09.13 Ultrasound study of eye

| | | |
|---|---|---|
| 09.13C Assessment of serial ocular ultrasonography measurements to evaluate change in tumour dimensions<br>NOTE: Refer to notes following 09.13D for further information. | 107.01 | |
| 09.13D Ocular ultrasonography, for intraocular pathology, interpretation<br>NOTE: HSCs 09.13C and 09.13D may only be claimed by an ophthalmologist. | 140.23 | |
| 09.13E Optical coherence tomography (OCT), for the diagnosis and management of ocular pathology, interpretation<br>NOTE: May not be claimed for routine examinations or routine screening. | 26.20 | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

09 OPHTHALMOLOGICAL AND OTOLOGICAL DIAGNOSIS AND TREATMENT (cont'd)

09.1 Examinations of form and structure of eye (cont'd)

09.13 Ultrasound study of eye (cont'd)

| | BASE | ANE |
|---|---|---|
| 09.13F Optical coherence tomography (OCT), for the diagnosis and management of ocular pathology, technical | 20.55 | |
| NOTE: May not be claimed for routine examinations or routine screening. | | |
| 09.13G Bilateral biometry for cataract surgery, technical | 50.17 | |
| NOTE: May only be claimed once every 5 years. | | |
| 09.13H Bilateral biometry for cataract surgery, interpretation | 34.07 | |
| NOTE: May only be claimed once every 5 years. | | |

09.2 Objective functional tests of eye

09.21 Electroretinogram (ERG)

| | | |
|---|---|---|
| 09.21A Electroretinogram (ERG), technical | 55.99 | |
| 09.21B Electroretinogram (ERG), interpretation | 67.29 | |

09.23 Visual evoked potential (VEP)

| | | |
|---|---|---|
| 09.23A Visual evoked potential (VEP), technical | 43.66 | |
| 09.23B Visual evoked potential (VEP), interpretation | 28.76 | |

09.24 Electronystagmogram (ENG)

| | | |
|---|---|---|
| 09.24B Electronystagmography (ENG) with differential vestibular testing, including caloric tests interpretation | 19.18 | |
| NOTE: This interpretation is limited to Otolaryngology/Neurology specialists only. | | |

09.26 Tonography, provocative tests, and other glaucoma testing

| | | |
|---|---|---|
| 09.26A Diurnal tension curve | 57.87 | |
| NOTE: Minimum 4 intraocular pressures separated by a minimum of 2 hours each. | | |
| 09.26D Bilateral corneal pachymetry | 15.75 | |
| NOTE: 1. May only be claimed once every five years. | | |
| 2. Billable only in non-refractive conditions. Excludes (Lasik and PRK). | | |

09.4 Nonoperative procedures related to hearing

09.41 Audiometry

| | | |
|---|---|---|
| 09.41A Impedance audiometry/tympanometry, technical | 9.13 | |
| NOTE: Includes acoustic reflexes and hard copy of results. | | |
| 09.41B Interpretation | 16.89 | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

09 OPHTHALMOLOGICAL AND OTOLOGICAL DIAGNOSIS AND TREATMENT (cont'd)

09.4 Nonoperative procedures related to hearing (cont'd)
09.41 Audiometry (cont'd)

BASE ANE

NOTE: Only one 09.41B fee, per patient, should be claimed, regardless of the number of tests performed per day.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

09 OPHTHALMOLOGICAL AND OTOLOGICAL DIAGNOSIS AND TREATMENT (cont'd)

09.4 Nonoperative procedures related to hearing (cont'd)

09.43 Audiological evaluation
NOTE: 1. HSCs 09.43A through 09.43E may be claimed by practitioners using sound-treated booths and calibrated equipment.
2. Audiometry workup to include four or more of the following HSCs to a maximum of $19.71.

| | | BASE | ANE |
|---|---|---|---|
| 09.43A | Pure tone audiometry, technical | 10.96 | |
| 09.43B | Speech audiometry, technical | 8.22 | |
| 09.43C | Special tests for malingering | 5.48 | |
| 09.43D | Tonal decay, technical | 5.48 | |
| 09.43E | Doerfler-Stewart, technical | 5.48 | |

09.46 Other auditory and vestibular function tests

| | | | |
|---|---|---|---|
| 09.46A | Auditory evoked potential, interpretation | 25.45 | |
| 09.46B | Particle repositioning maneuver for benign positional vertigo (Epley maneuver)<br>NOTE: May only be claimed by physicians who have neurotology (NEOT) certification or a specialty in neurology or otolaryngology. | 92.23 | |

09.49 Other nonoperative procedures related to hearing

| | | | |
|---|---|---|---|
| 09.49A | Automatic tympanometry<br>NOTE: Includes the technical and professional component. | 2.28 | |

10 NONOPERATIVE INTUBATION, IRRIGATION, AND MANIPULATION PROCEDURES

10.0 Nonoperative intubation of respiratory and gastrointestinal tracts

| | | | |
|---|---|---|---|
| 10.04 | Endotracheal intubation for aspiration of sputum<br>NOTE: May not be claimed with 13.62A. | 32.44 | |
| 10.04B | Intubation performed in an emergency room, AACC or UCC<br>NOTE: 1. May only be claimed when performed in an emergency room, AACC or UCC.<br>2. May not be claimed in addition to HSC 10.04 or 13.99E when performed by the same physician.<br>3. May be claimed in addition to visits or other services provided on the same day by the same physician. | 106.61 | |

10.08 Insertion of (naso-)intestinal tube

| | | | |
|---|---|---|---|
| 10.08A | Intubation for selective duodenography or small bowel studies | 38.92 | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

10 NONOPERATIVE INTUBATION, IRRIGATION, AND MANIPULATION PROCEDURES (cont'd)

10.0 Nonoperative intubation of respiratory and gastrointestinal tracts (cont'd)

10.16 Insertion of other vaginal pessary

| | | BASE | ANE |
|---|---|---|---|
| 10.16A | Pessary fitting | 84.36 | |
| | NOTE: May be claimed in addition to a visit or consultation. | | |
| 10.16B | Pessary removal, adjustment and/or reinsertion | 13.47 | |
| | NOTE: 1. May not be claimed in addition to HSC 10.16A. 2. May be claimed in addition to a visit or consultation. | | |

10.2 Other nonoperative dilation and manipulation procedures

| | | | |
|---|---|---|---|
| 10.23 | Dilation of anal sphincter | 52.82 V | 110.53 |
| | NOTE: 1. May only be claimed when performed under anesthesia. 2. HSC 61.63A may not be claimed in addition. | | |
| 10.25 | Therapeutic distention of bladder | 34.22 V | 110.53 |

10.3 Nonoperative alimentary tract irrigation, cleaning and local instillation

10.33 Gastric lavage

| | | | |
|---|---|---|---|
| 10.33A | Gastric lavage | 44.73 | |
| 10.33B | Gastric cytology washings | 41.04 | |
| 10.35 | Gastric gavage | 41.65 | |

10.5 Nonoperative irrigation, cleaning, and local instillation of genitourinary system

10.55 Irrigation of other indwelling urinary catheter

| | | | |
|---|---|---|---|
| 10.55A | Bladder irrigation | 51.34 | 110.43 |

10.56 Other genitourinary instillation

| | | | |
|---|---|---|---|
| 10.56A | Bladder instillation of chemotherapeutic agents | 51.34 | |
| | NOTE: Includes catheterization and visit. | | |

11 REPLACEMENT AND REMOVAL OF THERAPEUTIC APPLIANCES

11.0 Nonoperative replacement of gastrointestinal appliances

| | | | |
|---|---|---|---|
| 11.02 | Replacement of gastrostomy tube | 46.35 | 109.31 |
| | NOTE: May only be claimed in addition to 01.14. | | |
| 11.02A | Replacement of gastrostomy tube without gastroscopy | 142.97 | 110.53 |
| | NOTE: May only be claimed when performed under general anesthesia or procedural sedation, otherwise a visit health service code applies. | | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

11 REPLACEMENT AND REMOVAL OF THERAPEUTIC APPLIANCES (cont'd)

11.2 Other nonoperative replacement

11.23 Replacement of tracheostomy tube

| | | BASE | ANE |
|---|---|---|---|
| 11.23A | Tracheostomy tube change | 50.68 | |
| | NOTE: 1. May not be claimed with 01.09.<br>2. May only be claimed when performed by a physician where suitable qualified allied health personnel are unavailable. | | |

11.7 Nonoperative removal of therapeutic device from genital system

11.71 Removal of intrauterine contraceptive device (IUD)

| | | | |
|---|---|---|---|
| 11.71A | Removal of intrauterine contraceptive device (IUD) | 21.56 V | 110.53 |
| | NOTE: May be claimed in addition to a visit or consultation. | | |

11.8 Other nonoperative removal of therapeutic device

11.81 Removal of peritoneal drainage device

| | | | |
|---|---|---|---|
| 11.81A | Excision of indwelling intraperitoneal dialysis catheter with subcutaneous tunnel | 116.21 V | 147.37 |

12 NONOPERATIVE REMOVAL OF FOREIGN BODY

12.0 Removal of (non-penetrating) intraluminal foreign body from respiratory tract without incision

| | | | |
|---|---|---|---|
| 12.01 | Removal of intraluminal foreign body from nose without incision | 47.54 V | 110.53 |
| 12.03 | Removal of Intraluminal foreign body from larynx without incision | 145.76 | 110.43 |
| | NOTE: Includes laryngoscopy. | | |
| 12.05 | Removal of Intraluminal foreign body from bronchus without incision | 400.00 | 167.83 |
| | NOTE: Includes bronchoscopy. | | |

12.1 Removal of (non-penetrating) intraluminal foreign body from digestive system without incision

12.12 Removal of intraluminal foreign body from esophagus without incision

| | | | |
|---|---|---|---|
| 12.12A | Via rigid esophagoscopy | 439.23 | 147.37 |
| 12.12B | Via flexible esophagogastroscopy | 113.99 | 109.31 |
| | NOTE: May only be claimed in addition to 01.14. | | |

12.13 Removal of intraluminal foreign body from stomach without incision

| | | | |
|---|---|---|---|
| 12.13A | Via esophagogastroscopy | 113.99 | 109.31 |
| | NOTE: May only be claimed in addition to 01.14. | | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

12 NONOPERATIVE REMOVAL OF FOREIGN BODY (cont'd)

12.2 Removal of (non-penetrating) intraluminal foreign body from other sites without incision

| | | BASE | ANE |
|---|---|---|---|
| 12.21 | Removal of intraluminal foreign body from ear without incision | 47.54 V | 110.43 |
| 12.23 | Removal of intraluminal foreign body from vagina without incision<br>NOTE: For examination under general anesthetic, refer to 03.26. | 86.82 | 110.43 |
| 12.24 | Removal of intraluminal foreign body from urethra without incision<br>NOTE: May not be claimed in addition to 03.26. | 121.11 V | 110.53 |

12.3 Removal of other foreign body from head and neck without incision

| | | | |
|---|---|---|---|
| 12.31 | Removal of non-penetrating foreign body from eye without incision | 38.03 V | 110.43 |

13 OTHER NONOPERATIVE PROCEDURES

13.4 Injection or infusion of other therapeutic or prophylactic substance

| | | |
|---|---|---|
| 13.4 A | Scalp vein transfusion or infusion | 40.28 |

13.42 Immunization for allergy

| | | |
|---|---|---|
| 13.42A | Desensitization treatments with allergy serums<br>NOTE: 1. When performed by physician or under physician supervision.<br>2. A maximum of one office visit per month may be claimed for reassessment of the patient in lieu of a claim for desensitizing injection.<br>3. Benefit includes cost of all material other than allergy serum.<br>4. Only one benefit may be claimed per treatment regardless of number of injections given. | 21.47 |

13.5 Other injection or infusion of other therapeutic or prophylactic substance

13.53 Injection of steroid

| | | |
|---|---|---|
| 13.53A | Intranasal injection of steroid | 10.67 |
| 13.53B | Intralesional injection(s) of steroid<br>NOTE: May not be claimed in addition to HSCs 16.89B, 16.89C or 16.89D. | 21.66 |

13.55 Injection or infusion of cancer chemotherapeutic substance NEC

| | | |
|---|---|---|
| 13.55A | Chemotherapy<br>That for treatment of malignant disease | 79.48 |

13.57 Iontophoresis

| | | |
|---|---|---|
| 13.57A | Iontophoresis, ionization or gluing of corneal ulcer | 21.06 |

13.59 Injection or infusion of therapeutic or prophylactic substance NEC

| | | |
|---|---|---|
| 13.59A | Intramuscular or subcutaneous injections | 10.14 |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

13.5 Other injection or infusion of other therapeutic or prophylactic substance (cont'd)

13.59 Injection or infusion of therapeutic or prophylactic substance NEC (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| | NOTE: 1. May be claimed in addition to a visit or a consultation.<br>2. May not be claimed for injection of allergy serum. | | |
| 13.59B | Intravenous injections | 13.31 | |
| 13.59C | Initiation of intravenous<br>NOTE: 1. Sole procedure only and may not be claimed in addition to a radiology service.<br>2. May be claimed in addition to a visit or a consultation providing the purpose of the visit is not for the initiation of the intravenous.<br>3. May be claimed only when performed by a physician where suitable qualified nursing personnel are unavailable. | 30.35 | |
| 13.59D | Intracorporeal injection of penis<br>NOTE: 1. Includes visit.<br>2. Limit of one per patient, per physician.<br>3. Repeat visits, refer to 03.03A or 03.03AZ.<br>4. Includes patient teaching for self injection and observation. | 68.45 | |
| 13.59E | Injection of Botulinum A Toxin<br>For spasmodic torticollis | 164.22 | 110.53 |
| 13.59F | Follow up injection of Botulinum A Toxin for spasmodic torticollis | 85.08 | |
| 13.59K | Injection of Botulinum A Toxin<br>For treatment of spasticity due to upper motor neuron injury or disease<br>NOTE: 1. Single benefit applies regardless of the number of injections or limbs injected.<br>2. May only be claimed for purposes such as improving gait, reduction of pain, improving upper limb function.<br>3. May be claimed for initial and follow-up or repeat injections at a later date.<br>4. May not be claimed with 07.09A or 07.09B. | 162.38 | 110.53 |
| 13.59H | Local infiltration of tissue<br>NOTE: May not be claimed with any other procedure at the same encounter by the same or different physician except for HSC 95.94C. | 25.16 | |
| 13.59J | Injection with local anesthetic of myofascial trigger points<br>NOTE: 1. A maximum of three calls applies.<br>2. May not be claimed in addition to HSCs 16.89B, 16.89C or 16.89D. | 20.44 | |
| 13.59L | Botulinum toxin injection for treatment of sialorrhea | 67.57 V | 110.43 |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

13.5 Other injection or infusion of other therapeutic or prophylactic substance (cont'd)

13.59 Injection or infusion of therapeutic or prophylactic substance NEC (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 13.59N | Injection of Botulinum A Toxin for anal fissure . . . . . | 79.23 V | 110.53 |
| | NOTE: May be claimed in addition to a visit or a consultation. | | |
| 13.59M | Injection of therapeutic substance for lower urinary tract dysfunction . . . | 342.25 | 110.43 |
| | NOTE: 1. Benefit includes cystoscopy.<br>2. May only be claimed by urology, obstetrics and gynecology. | | |
| 13.59O | Injections of Botulinum A Toxin for the prophylaxis of chronic migraine headaches for eligible patients 18-65 years of age . . . . . | 100.91 V | 110.53 |
| | NOTE: 1. Eligible patients will have suffered headache activity for greater than 15 days per month with each episode lasting four or more hours for three consecutive months prior to the initial treatment.<br>2. Follow up treatment may be claimed in 12 week intervals.<br>3. Only one call may be claimed regardless of the number of injections performed.<br>4. May be claimed in addition to a visit or a consultation. | | |
| 13.59V | Immunization and administration of COVID-19 vaccine . . . . . | 25.00 | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

13.5 Other injection or infusion of other therapeutic or prophylactic substance (cont'd)

13.59 Injection or infusion of therapeutic or prophylactic substance NEC (cont'd)

| | BASE | ANE |
|---|---|---|

NOTE:
1. May only be claimed if the initial purpose of the visit is to administer the COVID-19 vaccine. May not be claimed on the same day as a visit service (except 13.59VA). If the COVID-19 vaccine is administered as part of a scheduled visit or any other service that was unrelated to the vaccine, the physician may bill the appropriate service and 13.59A with diagnostic code 079.82 or 079.8.
2. Benefit includes:
   a. Determination of appropriate candidacy of the patient for the vaccination. This includes but not limited to reviewing patient records in Alberta Netcare or another appropriate patient record system to ensure that vaccine dose being provided is appropriately sequenced.
   b. General discussion with the patient, parent, guardian and or agent as defined by the Personal Directives Act regarding the benefits and risks associated with the vaccine.
   c. Obtaining consent.
   d. Administration of a single dose of the vaccine.
   e. Monitoring the patient for any immediate post-vaccination adverse effects.
   f. Updating the patient's immunization record on the Immunization Direct Submission Mechanism.
   g. Appropriate record and scheduling the second/subsequent vaccine date as appropriate in the patient's record and reasonably follow-up with the patient to ensure the second dose is administered.
3. May be claimed by the physician when provided by a nurse or other qualified health provider under direct physician supervision or when the physician is on site and immediately available.
4. The patient's record must provide a detailed description of the service and must include the vaccine administered and the name of the provider who administered the vaccine.

| | | |
|---|---|---|
| 13.59VA | Prolonged COVID-19 vaccination - physician time only, greater than 10 minutes | 20.00 |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

13.5 Other injection or infusion of other therapeutic or prophylactic substance (cont'd)

13.59 Injection or infusion of therapeutic or prophylactic substance NEC (cont'd)

BASE ANE

NOTE 1. May only be claimed in addition to HSC 13.59V when the physician spends greater than 10 minutes directly with the patient. Does not include time spent on indirect patient care such as charting.
2. The patient's record must provide a detailed description of the service and must include:
a. Documentation of any counselling provided.
b. Documentation of any adverse reactions to the vaccine.
c. Start and stop times for all services personally rendered by the physician.
3. May not be claimed for post-vaccination-monitoring.
4. Concurrent time for overlapping services may not be claimed.
5. May not be claimed in addition to any other service except HSC 13.59V during the same encounter for the same patient.

13.6 Respiratory therapy

13.62 Other mechanical assistance to respiration

13.62A Ventilatory support, in Intensive Care Unit (ICU) . . . . . 96.60

NOTE: 1. Benefit includes endotracheal intubation with positive pressure ventilation, tracheal toilet, use of an artificial ventilator and continuous positive airway pressure (CPAP) through an artificial airway.
2. May only be claimed for services provided in approved level 2 and 3 and neonatal ICUs.
3. May only be claimed once per 24 hour period for any ventilated patient, irrespective of the number of physicians providing care.
4. May not be claimed for the same date of service by the same physician who provides either an anesthetic or surgical procedure.
5. May be claimed in association with other ICU services.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

13.7 Conversion of cardiac rhythm

13.72 Other electric countershock of heart

| | BASE | ANE |
|---|---|---|
| 13.72A Cardioversion | 103.25 | 110.53 |

NOTE: 1. May only be claimed for electrical conversion.
2. May not be claimed with electrophysiology studies.

13.8 Miscellaneous physical procedures

13.82 Ultraviolet light therapy

13.82A Psoralen ultraviolet A treatment, ultraviolet B or narrow-band ultraviolet B treatment . . . . . 20.41

13.9 Other miscellaneous diagnostic and therapeutic procedures

13.99 Other miscellaneous diagnostic and therapeutic procedures NEC

13.99AG Application of neurological navigation unit, with intracranial intracerebral localization by neurosurgical probe or instrument . . . . . 535.38

13.99BA Periodic Papanicolaou Smear for patients between the ages of 21 and 69 . . . 28.53

NOTE: 1. Two Papanicolaou smears may be claimed per patient, per physician, per year (April 1 of one year to March 31 of the following year). Additional claims may be submitted with supporting information.
2. May be claimed in addition to a visit or consultation.
3. When clinically indicated, Papanicolaou smears may be claimed for those patients not meeting the age requirements. In those instances, text must be submitted explaining the specific circumstance.
4. May not be claimed at the same encounter as HSC 13.99BD or 13.99BE.

13.99BE Pelvic examination using a speculum requiring swab(s) and/or sample(s) collection . . . . . 28.53

NOTE: 1. May be claimed with a visit or consultation.
2. May not be claimed at the same encounter as HSC 13.99BA or 13.99BD.

13.99BD Anal Papanicolaou Smear . . . . . 17.12

NOTE: 1. Two Anal Papanicolaou smears may be claimed per patient, per physician, per year (April 1 of one year to March 31 of the following year). Additional claims may be submitted with supporting information.
2. May be claimed in addition to a visit or consultation.
3. May not be claimed at the same encounter as HSC 13.99BA or 13.99BE.

13.99BB Needle biopsy of other superficial organs . . . . . 62.08 V

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

13.9 Other miscellaneous diagnostic and therapeutic procedures (cont'd)
13.99 Other miscellaneous diagnostic and therapeutic procedures NEC (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 13.99CC | Assessment of distal circulation by peripheral Doppler<br>NOTE: 1. May only be claimed by vascular surgeons and by general surgeons with additional training in vascular surgery.<br>2. If performing arterial and venous assessments, a second call may be claimed. | 75.26 | |
| 13.99DD | Non-surgical reduction of abdominal or inguinal hernia<br>NOTE: 1. May be claimed in addition to a visit or consultation at the same encounter.<br>2. May only be claimed in an emergency room, AACC or UCC. | 63.08 | 109.21 |
| 13.99AE | Placement of colonic stent, additional benefit<br>NOTE: May only be claimed in addition to HSCs 01.22 and 01.24B. | 170.99 | 163.96 |
| 13.99AF | Placement of duodenal stent via gastroscope, additional benefit<br>NOTE: May only be claimed in addition to HSCs 01.14 or 64.97A. | 170.99 | 163.96 |
| 13.99A | Hemodialysis treatment, unstable patient<br>For assessment and management of an unstable patient undergoing hemodialysis treatment where the physician attends and assesses or changes the treatment at the time of the visit | 113.97 | |
| 13.99B | Hemodialysis treatment, stable patient<br>For assessment and management of a stable patient with chronic renal failure<br>NOTE: May only be claimed when the patient is seen while receiving hemodialysis. If the patient is seen when they are not receiving hemodialysis, the appropriate visit HSC should be claimed. | 42.08 | |
| 13.99C | Assessment and management of an unstable patient with acute/chronic renal failure treated by peritoneal dialysis | 117.96 | |
| 13.99D | Assessment and management of a stable patient with chronic renal failure treated by peritoneal dialysis | 45.59 | |
| 13.99AA | Assessment and management of a patient undergoing therapeutic plasmapheresis<br>NOTE: 1. A benefit for central line placement or umbilical vein catheter, if required, may be claimed in addition.<br>2. May not be claimed for blood transfusion. | 113.97 | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

13.9 Other miscellaneous diagnostic and therapeutic procedures (cont'd)
13.99 Other miscellaneous diagnostic and therapeutic procedures NEC (cont'd)

| | BASE | ANE |
|---|---|---|
| 13.99AB Dialysis therapy, any modality, in the intensive care unit . . . . . | 144.02 | |

NOTE: 1. Benefit includes prescription, monitoring and ongoing manipulation of dialysis therapy.
2. May only be claimed by physicians working in a level II or level III ICU.
3. May only be claimed once per patient, per day regardless whether the same or different physician provides the service.
4. May be claimed in addition to other visits or services provided on the same day by the same physician.

| | | |
|---|---|---|
| 13.99AO Management of dialysis patients on home dialysis or receiving treatment in a remote hemodialysis unit (per week) . . . . . | 95.38 | |

NOTE: 1. May only be claimed by internal medicine specialists.
2. May be claimed for patients on either hemodialysis or peritoneal dialysis.
3. May not be claimed in addition to HSC 13.99B and 13.99D within the same calendar week unless documentation to support the claim is provided.
4. May be claimed once per patient within the same calendar week if not preceded by any visit except those outlined in Note 5.
5. HSC 03.03AR, 03.03DF and special callback benefits (HSCs 03.05N, 03.05P, 03.05QA, 03.05QB, 03.05R) may be claimed within the same calendar week for the same patient by the same physician.
6. The physician must be actively involved in the management of the patient's care in order to claim.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

13.9 Other miscellaneous diagnostic and therapeutic procedures (cont'd)
13.99 Other miscellaneous diagnostic and therapeutic procedures NEC (cont'd)

| | BASE | ANE |
|---|---|---|
| 13.99OA Management of patient on hemodialysis or peritoneal dialysis (per week) . . | 131.51 | |

NOTE:
1. May only be claimed by nephrologists.
2. May not be claimed in addition to HSC 13.99B or 13.99D within the same calendar week.
3. May be claimed once per patient within the same calendar week if not preceded by any visit except those outlined in Note 4.
4. HSCs 03.03AR, 03.03DF and special callback benefits (HSCs 03.03KA, 03.03LA, 03.03MC, 03.03MD, 03.05N, 03.05P, 03.05QA, 03.05QB, 03.05R) may be claimed within the same calendar week for the same patient by the same physician.
5. Other HSCs (03.08A, 03.08AZ, 03.07B, 03.04A, 03.04AZ, 03.03A, 03.03AZ, 03.03F, 03.03FZ) may not be claimed in the same calendar week for the same patient by any nephrologist. Exceptions to this include consultation and visit HSCs that are related to assessment for kidney/kidney-pancreas transplantation, which may be claimed within the same calendar week by nephrologists with special interest or training in transplantation. For the exceptions, supporting text must be submitted.
6. The physician must be actively involved in the management of the patient's care in order to claim.

| | | |
|---|---|---|
| 13.99AC Management of complex home total parenteral nutrition patients (TPN) (per week) . . . . . | 42.18 | |

NOTE:
1. May only be claimed for patients on home TPN.
2. May not be claimed in addition to office visits within the same calendar week unless documentation to support the claim is provided.
3. May be claimed once per patient within the same calendar week if not preceded by any visit except those outlined in Note 4.
4. HSC 03.03AR , 03.03DF and special callback benefits (HSCs 03.05N, 03.05P, 03.05QA, 03.05QB, 03.05R) may be claimed within the same calendar week for the same patient by the same physician.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

13.9 Other miscellaneous diagnostic and therapeutic procedures (cont'd)

Emergency Services

| | | BASE | ANE |
|---|---|---|---|
| 13.99E | Resuscitation, per 15 minutes or major portion thereof . . . . . | 96.52 | |

NOTE:
1. Resuscitation is defined as the emergency treatment of an unstable patient whose condition may result in imminent mortality without such intervention.
2. May be claimed when this service follows a consultation or hospital visit earlier in the same day as defined under GR 1.19.
3. When the condition of the patient is such that further care is provided, either before or after the patient is resuscitated, at a level consistent with the description of HSC 13.99H, 13.99HA, 13.99J, 13.99K, 13.99KA or 13.99KB, time spent providing that care may be claimed using these HSCs. Concurrent claims for overlapping time for the same or different patients may not be claimed.
4. If two claims for HSC 13.99E at different encounters are submitted by the same or different physician, text is required.
5. Two physicians may not claim HSC 13.99E for concurrent care. The second and subsequent physician involved in the resuscitation may claim HSC 13.99EC.

| | | | |
|---|---|---|---|
| 13.99EC | Resuscitation, per 15 minutes or major portion thereof for the second and subsequent physician actively participating and providing assistance to the primary physician at a resuscitation . . . . . | 87.66 | |

NOTE:
1. Resuscitation is defined as the emergency treatment of an unstable patient whose condition may result in imminent mortality without such intervention.
2. May only be claimed for the time spent when the physician is directly involved in assisting the primary physician in a resuscitation.
3. May not be claimed in addition to other procedures or visits at the same encounter by the same physician.
4. May not be claimed for Medical Emergency Team (MET) coverage.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

13.9 Other miscellaneous diagnostic and therapeutic procedures (cont'd)

Emergency Services (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 13.99EB | Medical Emergency Team Co-ordination by lead physician, per full 15 minutes or major portion thereof | 97.14 | |

NOTE:
1. Benefit includes patient assessment and necessary interventions including priority attendance, initial stabilization of patient with establishment of peripheral intravenous access, administration of oxygen, insertion of urinary catheter, initiation of appropriate medications and airway control for 'life-threatening' calling criteria.
2. May only be claimed by a Critical Care Specialists whose role is to respond as part of a recognized hospital Rapid Response or Medical Emergency Team when patients fulfill activation criteria and where intervention by physician is required to prevent death or support failing organ systems.
3. Concurrent claims for overlapping time for the same or different patients may not be claimed.
4. If two claims for HSC 13.99EB at different encounters are submitted by the same or different physician, text is required.
5. Two physicians may not claim HSC 13.99EB or 13.99E for concurrent care on the same day.

| | | | |
|---|---|---|---|
| 13.99F | Neonatal resuscitation | 47.92 | |

NOTE: May be claimed in addition to delivery benefits regardless of who performs the delivery.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

13.9 Other miscellaneous diagnostic and therapeutic procedures (cont'd)

Emergency Services (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 13.99GA | Trauma assessment, multiple trauma, severely injured patient . . . . . | 364.48 | |

NOTE:
1. Benefit includes the consultation and, when indicated, establishment of peripheral intravenous access, administration of oxygen, insertion of urinary catheter, spinal stabilization, oropharyngeal airway, and insertion of chest tube(s).
2. May only be claimed by the coordinating surgical specialist.
3. May be claimed in addition to a major surgical procedure by the same physician.
4. May only be claimed for referred cases.
5. Subsequent days of trauma care should be claimed using HSC 03.05B if a major surgical procedure has not been claimed by the same physician.
6. Following the seventh day of trauma care, the appropriate level of hospital care should be claimed using HSC 03.03D.
7. May be claimed in addition to care provided by intensivists.

| | | | |
|---|---|---|---|
| 13.99H | Critical care of severely ill or injured patient in a hospital emergency department requiring major treatment intervention(s), per 15 minutes . . . . | 58.61 | |

NOTE:
1. May only be claimed when a patient presents with a serious condition requiring at least a two hour stay in the active treatment portion of the emergency department or care results in hospitalization. The two hour period criterion does not apply in cases where the patient dies after having been seen.
2. Time may be claimed on a cumulative basis per day (defined as 0001 to 2400), and may include time spent with the patient, review of patient history including diagnostics, review of patient prescriptions and other activities the physician does in relation to the patient's care on the same date of service.
3. Time spent providing services compensated elsewhere in the Schedule, e.g., family conferences and procedures, may not be included in time claimed for HSC 13.99H.
4. Major treatment intervention is defined as a medical intervention which prevents or treats a condition that may result in significant morbidity.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

13.9 Other miscellaneous diagnostic and therapeutic procedures (cont'd)

Emergency Services (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 13.99HA | Critical care of severely ill or injured patient in an AACC or UCC department, or requiring major treatment intervention, per 15 minutes . . . | 60.22 | |

NOTE:
1. May only be claimed when a patient presents with a serious condition requiring at least a two hour stay in the active treatment portion of the AACC or UCC or care results in hospitalization. The two hour period criterion does not apply in cases where the patient dies after having been seen.
2. Time may be claimed on a cumulative basis per day (defined as 0001 to 2400), and may include time spent with the patient, review of patient history including diagnostics, review of patient prescriptions and other activities the physician does in relation to the patient's care on the same date of service.
3. Time spent providing services compensated elsewhere in the Schedule, e.g., family conferences and procedures, may not be included in time claimed for HSC 13.99HA.
4. Major treatment intervention is defined as a medical intervention which prevents or treats a condition that may result in significant morbidity.

| | | | |
|---|---|---|---|
| 13.99I | Hyperbaric oxygen therapy detention time, full 15 minutes or major portion thereof for the first call when only one call is claimed . . . . . | 47.54 | |

NOTE: May only be claimed when a physician personally and continuously attends a patient with the following conditions: air/gas embolism, severe CO poisoning, clostridial myonecrosis (gas gangrene), decompression sickness, necrotizing soft tissue infections, chronic diabetic leg and/or foot ulcers resistant to all forms of conventional therapy, radiation tissue damage (osteoradionecrosis), osteoradionecrosis (mandible), osteomyelitis (refractory), skin grafts and flaps (compromised), therapeutically irradiated patients requiring osseointegrated implants (dental implant following radiotherapy).

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

13.9 Other miscellaneous diagnostic and therapeutic procedures (cont'd)

Emergency Services (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 13.99J | Medical emergency detention time, per 15 minutes . . . . . | 60.22 | |

NOTE:
1. Time may be claimed on a cumulative basis per day (defined as 0001 to 2400), and may include time spent with the patient, review of patient history including diagnostics, review of patient prescriptions and other activities the physician does in relation to the patient's care on the same date of service.
2. Time spent providing services compensated elsewhere in the Schedule, e.g., family conferences and procedures, may not be included in time claimed for HSC 13.99J.
3. Supporting information must be submitted.
4. May be claimed by a physician during the time he/she is medically required to personally and continuously attend and treat an illness or injury of an emergency nature.
5. May not be claimed for such services as:
   - counseling or psychotherapy except for crisis intervention situations;
   - waiting for the results of laboratory or radiological examination;
   - giving advice to family members or the patient;
   - waiting for a family physician or consultant;
   - attendance at labour or fetal monitoring (see HSC 13.99JA);
6. Detention time may not be claimed if the service was provided in the office in conjunction with routine visits except when it is documented that an emergency existed.
7. Illness of an "emergency nature" may apply to mental or emotional disorders as well as to physical illness.
8. If a visit benefit is claimed, the detention time benefit may not be claimed until thirty minutes after the start of the visit.
9. Only HSC 13.99J or procedures provided during the same encounter (with the exception of HSC 13.99E) may be claimed, but not both. Concurrent claims for overlapping time for the same or different patients may not be claimed.
10. A maximum of 16 calls per physician per day may be claimed in any location other than a physician's office.
11. A maximum of 8 calls per physician per day may be claimed in the physician's office.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

13.9 Other miscellaneous diagnostic and therapeutic procedures (cont'd)

Emergency Services (cont'd)

| | BASE | ANE |
|---|---|---|
| 13.99JA Management of complex labour, per 15 minutes . . . . . | 52.45 | |

NOTE:
1. Time may be determined on a cumulative basis.
2. May be claimed for complex or non-progressive labour where the physician is actively managing a higher risk labour (defined as prolonged labour exceeding 12 hours during the first stage of labour or 1 hour during the second stage of labour, non-progressive labour, non-reassuring fetal/maternal status, multiple gestation, pregnancy induced hypertension, HELLP, insulin dependent diabetes, antepartum hemorrhage, prelabour ruptured membranes, non-reassuring fetal heart tracing, multiple pregnancy and preterm labour, seizure disorder, unstable patient).
3. May only be claimed when the physician is on-site and immediately available or when called to monitor or reassess the patient with complex or non-progressing labour.
4. Only HSC 13.99JA or the services relating to labour provided may be claimed, but not both. Concurrent billing for overlapping time for separate patient encounters/services may not be claimed.
5. May be claimed in addition to HSCs 86.9 B, 86.9 D or 87.98A.
6. May not be claimed in addition to HSCs 87.98B or 87.98C.
7. A maximum of twelve 15 minute units may be claimed per patient per pregnancy.

| | |
|---|---|
| 13.99K Ambulance detention time, full 15 minutes or major portion thereof, weekday, 0700 - 1700 hours . . . . . | 86.49 |

NOTE: Refer to the notes following HSC 13.99KB.

| | |
|---|---|
| 13.99KA Ambulance detention time, full 15 minutes or major portion thereof, weekdays 1700-2200 hours, weekends, statutory holidays 0700-2200 hours . . . | 118.50 |

NOTE: Refer to the notes following HSC 13.99KB.

| | |
|---|---|
| 13.99KB Ambulance detention time, full 15 minutes or major portion thereof, any day, 2200 - 0700 hours . . . . . | 142.58 |

NOTE:
1. Supporting information must be submitted for HSCs 13.99K, 13.99KA and 13.99KB.
2. May be claimed by a physician during the time he/she is medically required to personally and continuously attend a patient being transported by surface or air ambulance.
3. Only time in attendance with the patient may be claimed.
4. Concurrent billing for overlapping time for separate patient encounters/services may not be claimed.
5. A maximum of 20 calls applies.

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

13.9 Other miscellaneous diagnostic and therapeutic procedures (cont'd)

Emergency Services (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 13.99L | Donor maintenance, prior to cadaveric harvesting of organs, per 15 minutes<br>NOTE: 1. To be claimed using the Personal Health Number of the donor.<br>2. Payable for direct attendance by the physician.<br>3. Total time to be determined on a cumulative basis. | 56.74 | |
| 13.99M | Donor maintenance during cadaveric organ harvesting, first full 35 minutes<br>NOTE: Each subsequent full 5 minutes may be claimed at the rate specified on the Price List. | 154.50 | |
| 13.99AD | Application of image guided surgery system for sinus and skull base surgery, additional benefit | 112.77 | |
| 13.99V | Examination and crisis counselling for sexual/physical abuse, full 15 minutes or major portion thereof for the first call when only one call is claimed<br>NOTE: 1. A maximum of 16 calls may be claimed.<br>2. Time taken for forensic evidence is not to be included in total time. | 57.05 | |
| 13.99UM | Pre-lung transplant, assessment<br>NOTE: May only be claimed by Pediatric, Internal Medicine and Respiratory Medicine specialists. | 573.58 | |
| 13.99VM | Post-lung transplant, inpatient care, per day<br>NOTE: 1. May only be claimed by Pediatric, Internal Medicine and Respiratory Medicine specialists.<br>2. Daily fee includes all visit services provided including callbacks during a 24-hour period.<br>3. A maximum of 30 days may be claimed. | 114.75 | |
| 13.99W | Pre-liver transplant, assessment<br>NOTE: May only be claimed by Pediatric and Internal Medicine specialists. | 496.76 | |

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES (cont'd)

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

13.9 Other miscellaneous diagnostic and therapeutic procedures (cont'd)

Emergency Services (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 13.99X | Post-liver transplant, inpatient care, per day | 83.46 | |
| | NOTE: 1. May only be claimed by Pediatric and Internal Medicine specialists. 2. Daily fee includes all visit services provided including callbacks during a 24-hour period. 3. A maximum of 30 days may be claimed. | | |
| 13.99Y | Renal transplant care, day one | 482.19 | |
| 13.99Z | Day two and three, per day | 289.31 | |
| | NOTE: The daily fee for 13.99Y and 13.99Z, includes all visit services including callbacks during a 24 hour period. | | |
| 13.99AZ | Medical pre-transplant assessment, pancreas or islet cell transplantation | 727.40 | |
| | NOTE: 1. May only be claimed for out of province patients. 2. May only be claimed by endocrinologists. 3. To include all services relating to the pre-transplant assessment for patients undergoing pancreatic or islet cell transplantation. | | |

## II. OPERATIONS ON THE NERVOUS SYSTEM

### 14 INCISION AND EXCISION OF SKULL, BRAIN AND CEREBRAL MENINGES

Intracranial procedure involving microsurgical technique,for a second neurosurgeon, refer to Price List

| | BASE | ANE |
|---|---|---|
| **14.0 Cranial puncture** | | |
| **14.09 Other cranial puncture** | | |
| 14.09A Drainage of ventricle or cyst through existing burr holes | 96.37 V | 110.43 |
| 14.09B Aspiration of intracranial abscess | 935.58 | 183.46 |
| **14.1 Craniotomy and craniectomy** | | |
| **14.13 Other craniotomy** | | |
| 14.13A With exploration, burr holes | 401.54 | 184.21 |
| 14.13B Craniotomy or craniectomy with exploration | 1,070.76 | 350.01 |
| 14.13C Evacuation of epidural hematoma, abscess or fluid collection | 1,338.45 | 420.62 |
| 14.13D Decompressive craniectomy including hemicraniectomy | 1,472.30 | 460.53 |
| 14.13E Exploration of posterior fossa<br>NOTE: Includes that with rhizotomy. | 1,180.51 | 335.68 |
| 14.13F Intracranial endoscopy via skull base, neurosurgical component | 2,231.20 | 1,646.88 |
| 14.13G Intracranial endoscopy via cranial vault, neurosurgical component | 1,338.45 | 992.57 |
| **14.14 Other craniectomy** | | |
| 14.14A For osteomyelitis | 579.07 | 331.58 |
| 14.14B For neoplasm of skull | 1,070.76 | 331.58 |
| 14.14C With exploration | 803.07 | 350.01 |
| 14.14D For sub-temporal decompression | 622.38 | 218.60 |
| **14.2 Incision of brain and cerebral meninges** | | |
| **14.21 Incision of cerebral meninges** | | |
| 14.21B Evacuation of subdural hematoma, abscess or fluid collection | 1,673.06 | 509.18 |
| **14.22 Lobotomy and tractotomy** | | |
| 14.22A Resection of brain tissue for epilepsy, including lobectomy, tractotomy and corpus callostomy | 3,346.13 | 1,063.65 |
| **14.29 Other incision of brain** | | |
| 14.29A Resection of disrupted brain tissue | 2,007.68 | 460.53 |
| 14.29B Evacuation of intraparenchymal hematoma, abcess or fluid collection | 2,275.37 | 497.38 |
| **14.3 Operations on thalamus and globus pallidus (including ansa and cingulus)** | | |
| 14.3 A A Stereotactic ablation or stimulation of subcortical structures for functional indications, including thalamus and globus pallidus | 1,379.94 | 371.01 |
| 14.3 B Other stereotactic procedure, including application of stereotactic frame or frameless stereotaxy | 2,275.37 | 382.58 |
| **14.4 Other excision or destruction of brain and meninges** | | |
| **14.41 Excision of lesion or tissue of cerebral meninges** | | |
| 14.41A Craniotomy/craniectomy with repair of leptomeningeal cyst | 2,007.68 | 576.58 |
| 14.42 Hemispherectomy | 2,877.67 | 768.76 |

## II. OPERATIONS ON THE NERVOUS SYSTEM (cont'd)

### 14 INCISION AND EXCISION OF SKULL, BRAIN AND CEREBRAL MENINGES

Intracranial procedure involving microsurgical technique,for a second neurosurgeon, refer to Price List (cont'd)

14.4 Other excision or destruction of brain and meninges (cont'd)

14.49 Other excision or destruction of lesion or tissue of brain
Craniotomy/craniectomy with:

| | | BASE | ANE |
|---|---|---|---|
| 14.49A | Cerebral biopsy | 1,338.45 | 423.69 |
| 14.49B | Removal of tumor of cerebellopontine angle | 1,895.25 | 830.36 |
| 14.49C | Resection of intracranial intra-axial tumor, supratentorial | 3,346.13 | 774.83 |
| 14.49D | Removal or surgical correction of intracranial lesion, transclival approach | 3,479.97 | 1,043.62 |
| 14.49E | Craniotomy/craniectomy with removal of extra-axial tumor with or without microsurgical dissection | 4,684.58 | 1,081.98 |
| 14.49F | Cortical exploration and resection for epilepsy | 2,676.90 | 644.75 |
| 14.49G | With insertion of electrodes (epidural, subdural, or intraparenchymal) for epilepsy | 1,338.45 | 478.95 |
| 14.49H | Resection of skull base tumor, neurosurgical component<br>NOTE: For otolaryngological component, refer to Price List. | 3,164.07 V | 865.80 |
| 14.49J | Extended skull base craniotomy including anterior, middle or posterior fossa approaches, neurosurgical component<br>NOTE: For otolaryngological component, refer to Price List. | 3,008.80 V | 830.36 |
| 14.49K | Radiosurgery method for cranial or spinal lesion, neurosurgical component | 4,684.58 | 1,070.03 |

14.8 Invasive diagnostic procedures on skull, brain, and cerebral meninges

| | | | |
|---|---|---|---|
| 14.82 | Biopsy of brain<br>That by twist drill or burr hole | 962.35 | 270.82 |
| 14.85B | Injection of contrast media, via burr holes | 305.17 | 131.04 |

14.88 Other invasive diagnostic procedures on brain and cerebral meninges

| | | | |
|---|---|---|---|
| 14.88A | Electrocortography or microelectrode cellular recording, full 15 minutes or major portion thereof for the first call when only one call is claimed | 78.08 | |
| 14.88B | Insertion of special electrodes for epilepsy | 62.62 | |

### 15 OTHER OPERATIONS ON SKULL, BRAIN, AND CEREBRAL MENINGES

15.0 Cranioplasty

15.01 Opening of cranial suture

| | | | |
|---|---|---|---|
| 15.01A | Craniectomy for craniostenosis, single suture | 1,338.45 | 294.73 |

15.02 Elevation of skull fracture fragments

| | | | |
|---|---|---|---|
| 15.02A | Skull fracture, depressed, dura intact | 1,338.45 | 332.06 |
| 15.02B | Skull fracture, with laceration of brain | 1,673.06 | 386.85 |
| 15.02C | Skull fracture, with paranasal sinus involvement | 1,088.31 | 406.35 |

## II. OPERATIONS ON THE NERVOUS SYSTEM (cont'd)

### 15 OTHER OPERATIONS ON SKULL, BRAIN, AND CEREBRAL MENINGES (cont'd)

#### 15.0 Cranioplasty (cont'd)

##### 15.06 Other cranial osteoplasty

| | | BASE | ANE |
|---|---|---|---|
| 15.06A | Cranioplasty, or cranial vault repair | 1,003.84 | 420.62 |
| | NOTE: Benefit includes synthetic implant or plate fixation. | | |
| 15.06B | Craniofacial reconstruction, for congenital deformity, full 60 minutes or major portion thereof for the first call when only one call is claimed | 647.81 | |

#### 15.1 Repair of cerebral meninges

##### 15.12 Other repair of cerebral meninges

| | | | |
|---|---|---|---|
| 15.12A | Craniotomy and repair of C.S.F. fistula | 1,081.17 | 388.68 |
| 15.12B | Repair of cranial meningo-encephalocoele | 983.46 | 309.19 |
| 15.12C | Intracranial duraplasty with graft | 271.71 | 201.41 |

#### 15.2 Ventriculostomy

| | | | |
|---|---|---|---|
| 15.2 A | Ventriculostomy including insertion of cerebrospinal fluid (CSF) reservoir system | 1,003.84 | 497.37 |

#### 15.3 Extracranial ventricular shunt

| | | | |
|---|---|---|---|
| 15.3 | Extracranial ventricular shunt | 1,338.45 | 597.72 |

#### 15.4 Revision of ventricular shunt

| | | | |
|---|---|---|---|
| 15.4 | Revision of ventricular shunt | 1,338.45 | 287.79 |

#### 15.9 Other operations on skull, brain, and cerebral meninges

##### 15.93 Implantation of intracranial neurostimulator

| | | | |
|---|---|---|---|
| 15.93A | Internalization or minor repairs to leads, control unit, battery or battery replacement for deep brain stimulator or epidural electrodes | 401.54 | 110.53 |
| 15.93B | Insertion, requiring stereotactic procedures | 1,396.00 | 424.01 |
| 15.93C | Revision, requiring stereotactic procedures | 936.92 | 318.01 |
| | NOTE: May not be claimed within 90 days subsequent to 15.93B. | | |

##### 15.94 Insertion of intracranial pressure monitor

| | | | |
|---|---|---|---|
| 15.94A | Insertion of intracranial pressure monitoring device with recording | 304.56 | 147.37 |
| 15.94B | ICP and/or CSF monitoring in ICU, daily benefit | 61.62 | |

NOTE:
1. May be claimed for the monitoring and manipulation of the physiologic parameter of intracranial or cerebrospinal fluid pressure through an indwelling temporary catheter.
2. May only be claimed once per 24 hour period for any ventilated patient, irrespective of the number of physicians providing care.
3. May be claimed in association with other ICU services.
4. When a procedure and 03.05A are provided during the same encounter, only the greater benefit may be claimed.
5. Time spent performing this procedure should be excluded from cumulative 03.05A time spent with the patient per day.

II. OPERATIONS ON THE NERVOUS SYSTEM (cont'd)

15 OTHER OPERATIONS ON SKULL, BRAIN, AND CEREBRAL MENINGES (cont'd)

15.9 Other operations on skull, brain, and cerebral meninges (cont'd)

15.99 Other operations on skull, brain, and cerebral meninges NEC

| | | BASE | ANE |
|---|---|---|---|
| 15.99A | Application of skull tongs . . . . . | 200.77 | 109.21 |
| | NOTE: May be claimed in addition to a consultation. | | |

16 OPERATIONS ON SPINAL CORD AND SPINAL CANAL STRUCTURES

NOTE: The listed benefits are payable irrespective of the number of vertebrae involved if one incision utilized, unless otherwise stated.

16.0 Exploration and decompression of spinal canal

16.09 Other exploration and decompression of spinal canal

| | | | |
|---|---|---|---|
| 16.09F | Laminectomy with microsurgical exploration of spinal cord . . . . . | 2,007.68 | 939.49 |
| | For syringomyelia and shunting | | |
| | NOTE: Instrumentation may be claimed in addition. | | |
| 16.09G | Laminectomy, with microsurgical exploration of cervico-medullary junction . | 2,676.90 | 1,311.68 |
| | For syringomyelia or Arnold-Chiari malformation | | |
| | NOTE: Instrumentation may be claimed in addition. | | |
| 16.09J | Repeat decompression, cervical, thoracic or lumbar spine . . . . . | 1,265.79 | 515.80 |
| 16.09N | Intervertebral fusion, thoracic & lumbar spine only (anterior lumbar intervertebral fusion (ALIF), posterior lumbar intervertebral fusion (PLIF), or translateral lumbar intervertebral fusion (TLIF)) . . . . . | 1,318.53 | 460.54 |
| | NOTE: 1. Instrumentation may be claimed in addition. | | |
| | 2. Additional levels may be claimed at the rate specified on the Price List; a maximum benefit of five calls applies. | | |

## II. OPERATIONS ON THE NERVOUS SYSTEM (cont'd)

16 OPERATIONS ON SPINAL CORD AND SPINAL CANAL STRUCTURES (cont'd)
NOTE: The listed benefits are payable irrespective of the number of vertebrae involved if one incision utilized, unless otherwise stated.

16.0 Exploration and decompression of spinal canal (cont'd)
16.09 Other exploration and decompression of spinal canal (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 16.09O | Laminoplasty or decompression (cervical/thoracic/lumbar) | 1,211.30 | 331.58 |
| | NOTE: 1. Only 1 benefit may be claimed regardless of the number of levels. 2. Instrumentation may be claimed in addition. | | |
| 16.09P | Anterolateral or posterolateral decompression of spine, not simple discectomy or laminectomy | 1,111.96 | 553.45 |
| 16.1 | Division of intraspinal nerve root | | |
| 16.1 A | Cervical or thoracic dorsal root entry zone myelolysis | 2,001.43 | 777.35 |
| 16.1 B | Cervical, laminectomy with cordotomy or rhizotomy | 1,239.40 | 353.34 |
| | NOTE: Instrumentation may be claimed in addition. | | |
| 16.1 C | Thoracic or lumbar, laminectomy with cordotomy or rhizotomy | 857.04 | 305.76 |
| | NOTE: Instrumentation may be claimed in addition. | | |
| 16.1 D | Lumbar/sacral, laminectomy with selective posterior rhizotomy | 2,409.21 | 901.02 |
| | NOTE: Instrumentation may be claimed in addition. | | |
| 16.2 | Chordotomy | | |
| 16.2 A | Longitudinal myelotomy | 990.45 | 270.82 |
| 16.2 B | Percutaneous | 614.35 | |
| 16.3 | Excision or destruction of lesion of spinal cord and spinal meninges | | |
| | Thoracic or lumbar laminectomy | | |
| 16.3 A | With removal of tumor | 1,673.06 | 386.85 |
| | NOTE: Instrumentation may be claimed in addition. | | |
| 16.3 B | With removal of intradural tumor or arteriovenous malformation | 3,145.36 | 386.85 |
| | NOTE: Instrumentation may be claimed in addition. | | |
| | Cervical laminectomy | | |
| 16.3 C | With removal of tumor | 1,596.91 | 454.27 |
| | NOTE: Instrumentation may be claimed in addition. | | |
| 16.3 D | With removal of intradural tumor or arteriovenous malformation | 2,676.90 | 460.54 |
| | NOTE: Instrumentation may be claimed in addition. | | |

II. OPERATIONS ON THE NERVOUS SYSTEM (cont'd)

16 OPERATIONS ON SPINAL CORD AND SPINAL CANAL STRUCTURES (cont'd)

16.3 Excision or destruction of lesion of spinal cord and spinal meninges (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 16.3 E | Excision of spinal or paraspinal tumor | 1,673.06 | 765.15 |
| | NOTE: 1. Benefit is for the neurosurgical component, when an orthopedic surgeon claims 93.05D. | | |
| | 2. Instrumentation may be claimed in addition. | | |
| 16.3 F | Repair of lipomeningomyelocele with excision of intra-medullary lipoma | 2,676.90 | 989.37 |

16.4 Plastic operations on spinal cord and spinal meninges

16.42 Repair of (spinal) myelomeningocele

| | | | |
|---|---|---|---|
| 16.42A | Plastic repair of meningocoele or myelocoele | 1,338.45 | 276.32 |

16.43 Repair of vertebral fracture

| | | | |
|---|---|---|---|
| 16.43D | Repair of spine fracture/dislocation, posterior (cervical, thoracic, lumbar) Open reduction internal fixation, instrumentation and graft | 1,582.24 | 534.22 |
| 16.43E | Repair of spine fracture/dislocation, posterior (cervical, thoracic, lumbar) Open reduction internal fixation segmental wiring and graft | 966.92 | 318.01 |

16.49 Other repair and plastic operation on spinal cord structures

| | | | |
|---|---|---|---|
| 16.49A | Laminectomy (thoracic or lumbar) with repair of diastematomyelia | 1,916.29 | 636.01 |
| | NOTE: Instrumentation may be claimed in addition. | | |
| 16.49B | Laminectomy cervicothoracic, 2 levels or less | 1,318.53 | 460.54 |
| | NOTE: Instrumentation may be claimed in addition. | | |
| 16.49C | Laminectomy cervicothoracic, more than 2 levels | 1,626.19 | 552.63 |
| | NOTE: Instrumentation may be claimed in addition. | | |
| 16.49D | Laminectomy lumbar, for stenosis, 2 levels or less | 966.92 | 331.58 |
| | NOTE: Instrumentation may be claimed in addition. | | |

II. OPERATIONS ON THE NERVOUS SYSTEM (cont'd)

16 OPERATIONS ON SPINAL CORD AND SPINAL CANAL STRUCTURES (cont'd)

16.4 Plastic operations on spinal cord and spinal meninges (cont'd)

16.49 Other repair and plastic operation on spinal cord structures (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 16.49E | Laminectomy lumbar, for stenosis, more than 2 levels | 1,318.53 | 460.54 |
| | NOTE: Instrumentation may be claimed in addition. | | |
| 16.49F | Dural repair | 197.78 | 109.21 |
| 16.49G | Duralplasty | 337.29 | 109.21 |

16.5 Freeing of adhesions of spinal cord and nerve roots

| | | | |
|---|---|---|---|
| 16.5 A | Laminectomy (thoracic or lumbar) with release of tethered spinal cord | 2,275.37 | 921.07 |
| | NOTE: Instrumentation may be claimed in addition. | | |

16.8 Invasive diagnostic procedures on spinal cord and spinal canal structures

16.81 Spinal tap

| | | | |
|---|---|---|---|
| 16.81A | Spinal tap for diagnosis or imaging studies | 127.45 | |
| | NOTE: 1. May not be claimed in addition to HSC 50.98B or 50.99C. | | |
| | 2. May be claimed in addition to a visit or consultation. | | |

16.83 Contrast myelogram

| | | | |
|---|---|---|---|
| 16.83A | Lumbar, thoracic, cervical or complete | 58.58 | 110.53 |
| 16.83B | Supine myelography | 33.14 | |
| | NOTE: May be claimed in addition to 16.83A. | | |
| 16.83C | Cisternal or posterior fossa injection | 112.14 | 131.04 |

16.89 Other invasive diagnostic procedures on spinal cord and spinal canal structures

| | | | |
|---|---|---|---|
| 16.89A | Injection for discogram | 95.96 | |
| | NOTE: May not be claimed in addition to an operative procedure. | | |
| 16.89B | Percutaneous facet joint injection - Cervical | 106.75 | |
| | NOTE: Refer to notes following HSC 16.89D. | | |
| 16.89C | Percutaneous facet joint injection - Thoracic | 106.75 | |
| | NOTE: Refer to notes following HSC 16.89D. | | |
| 16.89D | Percutaneous facet joint injection - Lumbar/Sacral | 106.75 | |
| | NOTE: 1. A maximum of four calls may be made per patient, per day regardless of level (HSCs 16.89B, 16.89C or 16.89D). | | |
| | 2. A maximum of twelve calls may be claimed per patient, per benefit year regardless of level (HSCs 16.89B, 16.89C or 16.89D). | | |
| | 3. HSCs 16.89B, 16.89C and 16.89D may not be claimed in addition to HSCs 13.53B, 13.59J, 92.78B or 92.78C. | | |
| | 4. HSCs X 55 or X 56 may only be claimed in addition to HSCs 16.89B, 16.89C or 16.89D once per year, per patient. | | |

II. OPERATIONS ON THE NERVOUS SYSTEM (cont'd)

16 OPERATIONS ON SPINAL CORD AND SPINAL CANAL STRUCTURES (cont'd)

16.9 Other operations on spinal cord and canal structures

16.91 Injection of anesthetic into spinal canal for analgesia

| | | BASE | ANE |
|---|---|---|---|
| 16.91A | Epidural/regional catheter insertion for pain control management, including set up and initial injection . . . . . | 104.35 | |
| | NOTE: Refer to notes following 16.91B | | |
| 16.91B | Follow up encounter for pain control management subsequent to continuous epidural/regional catheter insertion for pain management . . . . . | 41.74 | |
| | NOTE: 1. 16.91A and 16.91B may not be claimed:<br>- for labour and delivery<br>- in addition to an anesthetic for the same encounter.<br>2. A maximum of four 16.91B may be claimed per physician, per patient, per day, which may include:<br>- up to two claims for regularly scheduled encounters, and<br>- a maximum of two claims for unscheduled encounters.<br>3. Surcharge benefits may be claimed for unscheduled encounters in accordance with GR 15. | | |
| 16.91C | Epidural catheter insertion for labour analgesia including set-up and initial injection . . . . . | 104.35 | |
| | NOTE: Refer to notes following 16.91G for further information. | | |
| 16.91G | Epidural analgesia for labour and delivery, monitoring and/or top-up/adjustment, each additional full 5 minutes, per patient . . . . . | 16.55 | |
| | NOTE: 1. May be claimed by an on-site physician when immediately available or when called to monitor or reassess the patient or top-up/adjust analgesia.<br>2. HSC 16.91G may not be claimed for the same patient until 35 minutes has elapsed from the time of the initiation of the HSC 16.91C recognizing that HSC 16.91C represents a full 30 minutes.<br>3. Concurrent billing for overlapping time for separate patient encounters/services may not be claimed.<br>4. Anesthetic benefits for a vaginal delivery by the same or a different physician may not be claimed in addition to HSCs 16.91C or 16.91G.<br>5. HSC 16.91F may be claimed for attendance at a forceps/vacuum delivery, vaginal breech delivery or vaginal delivery multiple birth, where an epidural was previously established by the same or different physician.<br>6. Listed anesthetic benefits for Cesarean section may be claimed in addition but not concurrently with HSC 16.91G, see Note 3.<br>7. A maximum of one surcharge benefit (SURC) for HSC 16.91G may be claimed per physician, per patient, if applicable, in accordance with GR 15. | | |

## II. OPERATIONS ON THE NERVOUS SYSTEM (cont'd)

### 16 OPERATIONS ON SPINAL CORD AND SPINAL CANAL STRUCTURES (cont'd)

16.9 Other operations on spinal cord and canal structures (cont'd)

16.91 Injection of anesthetic into spinal canal for analgesia (cont'd)

| | BASE | ANE |
|---|---|---|
| 16.91F Attendance at forceps/vacuum delivery, vaginal breech delivery or vaginal delivery multiple birth, where epidural was previously established | 104.35 | |
| NOTE: 1. May only be claimed when the physician is specially called and remains in attendance for the delivery. 2. May not be claimed if the delivery is by Caesarean section. | | |
| 16.92 Injection of other agent into spinal canal | | |
| 16.92A Implantation of intrathecal morphine infusion system | 877.60 | |
| 16.92B Differential spinal block | 337.71 | |
| 16.93 Insertion or replacement of spinal neurostimulator | | |
| 16.93A Implantation of epidural stimulator for intractable pain | 1,003.84 | 257.90 |
| 16.93B Revision of epidural stimulator for intractable pain | 1,003.84 | 239.48 |
| NOTE: May not be claimed within 90 days subsequent to 16.93A. | | |
| 16.95 Spinal blood patch | | |
| 16.95A Epidural blood patch | 111.47 | |
| 16.99 Other operations on spinal cord and spinal canal structures NEC | | |
| 16.99A Epidural injection of steroids | 111.11 | |

### 17 OPERATIONS ON CRANIAL AND PERIPHERAL NERVES

17.0 Incision, division, and excision of cranial and peripheral nerves

| | | |
|---|---|---|
| 17.02 Acoustic neurotomy | | |
| 17.02A Trans-labyrinthine resection of acoustic neuroma | 1,023.91 | 346.13 |
| 17.02B Middle fossa approach for acoustic neuroma | 1,252.79 | 401.85 |
| 17.03 Division of trigeminal nerve | | |
| 17.03A Trigeminal rhizotomy | 1,003.84 | 276.32 |
| 17.05 Other incision of cranial and peripheral nerves | | |
| Exploration of peripheral nerve (post traumatic neuropraxia) | | |
| 17.05A Major, proximal to mid palm | 272.08 | 165.79 |
| 17.05B Minor, distal to mid palm | 168.43 | 110.53 |
| 17.08 Other excision or avulsion of cranial and peripheral nerves | | |
| 17.08A Morton's neuroma, excision | 175.80 | 110.53 |
| 17.08B Excision of neuroma on peripheral nerve | 285.03 | 147.37 |
| 17.08C Obturator neurectomy | 241.85 | 131.04 |
| 17.08D Avulsion of supra-orbital or infra-orbital nerves | 207.67 | 109.21 |
| 17.08E Avulsion of suboccipital nerve | 195.67 | 109.21 |
| 17.08F Differential section of facial nerve | 382.19 | 174.72 |

II. OPERATIONS ON THE NERVOUS SYSTEM (cont'd)

17 OPERATIONS ON CRANIAL AND PERIPHERAL NERVES (cont'd)

17.0 Incision, division, and excision of cranial and peripheral nerves (cont'd)

17.08 Other excision or avulsion of cranial and peripheral nerves (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 17.08H | Trans-labyrinthine section of eight nerve | 692.66 | 331.97 |
| 17.08J | Transantral vidian neurectomy | 347.91 | 176.68 |
| 17.08K | Retrolabyrinthine selective vestibular neurectomy | 2,917.82 V | 768.76 |

NOTE: 1. Includes intraoperative electrodiagnostic monitoring.
2. For otolaryngological component - refer to Price List.

17.1 Destruction of cranial and peripheral nerves

| | | | |
|---|---|---|---|
| 17.1 A | Injection of alcohol, Trigeminal | 167.31 | 110.43 |

17.2 Suture of cranial and peripheral nerves

| | | | |
|---|---|---|---|
| 17.2 A | Peripheral nerve repair - major | 267.03 | 165.79 |
| 17.2 B | Peripheral nerve repair - minor | 183.75 | 110.53 |

Microsurgical anastomosis of intracranial portion of cranial nerve

| | | | |
|---|---|---|---|
| 17.2 C | Without graft, to include craniotomy | 1,634.25 | 583.03 |

NOTE: With other intracranial procedures, price will be modified, refer to Price List.

17.3 Freeing of adhesions and decompression of cranial and peripheral nerves

17.31 Decompression of trigeminal nerve root

| | | | |
|---|---|---|---|
| 17.31A | Craniotomy with microvascular decompression of cranial nerve V (Trigeminal) | 2,007.68 | 571.06 |

17.32 Other cranial nerve decompression

| | | | |
|---|---|---|---|
| 17.32A | Facial nerve decompression | 678.93 | 309.70 |

NOTE: May not be claimed in addition to HSCs 52.31A, 52.31B, 52.31C or 52.31D by the same or different physician at the same encounter.

| | | | |
|---|---|---|---|
| 17.32B | Craniotomy with microvascular decompression of cranial nerve VII (facial nerve) | 2,007.68 | 547.67 |
| 17.32C | Facial nerve decompression with insertion of graft | 696.22 | 273.84 |
| 17.33 | Release of carpal tunnel | 233.09 | 110.53 |

NOTE: May not be claimed in addition to HSC 17.39C.

17.39 Other peripheral nerve or ganglion decompression or freeing of adhesions

| | | | |
|---|---|---|---|
| 17.39A | Neurolysis, external and interfascicular release of nerve from scar tissue | 427.55 | 202.64 |

II. OPERATIONS ON THE NERVOUS SYSTEM (cont'd)

17 OPERATIONS ON CRANIAL AND PERIPHERAL NERVES (cont'd)

17.3 Freeing of adhesions and decompression of cranial and peripheral nerves (cont'd)

17.39 Other peripheral nerve or ganglion decompression or freeing of adhesions (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 17.39B | Major nerve exploration | 338.94 | 165.79 |
| | NOTE: 1. May not be claimed for the release of carpal tunnel (HSC 17.33) or procedures/diagnostic conditions related to carpal tunnel. 2. May not be claimed in addition to HSC 17.39C. | | |
| 17.39C | Release ulnar nerve (includes transposition) | 394.99 | 165.79 |
| | NOTE: May not be claimed with HSCs 17.5 A, 17.33 or 17.39B. | | |
| 17.39D | Brachial plexus exploration, full 60 minutes or major portion thereof for the first call when only one call is claimed | 647.81 | 202.64 |
| | NOTE: 1. May not be claimed with other procedures. 2. Each subsequent 15 minutes, or major portion thereof, is payable at the rate specified on the Price List after the first full 60 minutes has elapsed. | | |
| 17.39E | Neurolysis, lateral cutaneous nerve of thigh, minor | 96.23 V | 110.43 |
| 17.39F | Decompression recurrent laryngeal nerve | 269.39 | 148.51 |
| | NOTE: May only be claimed in addition to thyroid surgery (HSCs 19.3 A or 19.3 B) when the nerve is encased in malignant disease or in repeat thyroid procedures. | | |

17.4 Cranial or peripheral nerve graft

| | | | |
|---|---|---|---|
| | Microsurgical anastomosis of intracranial portion of cranial nerve | | |
| 17.4 A | With graft to include craniotomy | 1,460.59 | 646.47 |
| | NOTE: With other intracranial procedures, price will be modified, refer to Price List. | | |
| | Peripheral nerve reconstruction utilizing microsurgical technique | | |
| 17.4 B | Minor, single cable | 499.32 | 291.50 |
| 17.4 C | Major, multiple cables | 1,036.49 | 515.80 |

II. OPERATIONS ON THE NERVOUS SYSTEM (cont'd)

17 OPERATIONS ON CRANIAL AND PERIPHERAL NERVES (cont'd)

17.5 Transposition of cranial and peripheral nerves

| | BASE | ANE |
|---|---|---|
| 17.5 A Transposition of peripheral neuroma | 284.90 | 139.77 |
| NOTE: May not be claimed with 17.39C. | | |
| 17.5 D Submuscular ulnar nerve transposition | 527.41 | 184.21 |

17.6 Other cranial or peripheral neuroplasty

17.61 Anastomosis of cranial or peripheral nerve

| | | |
|---|---|---|
| 17.61A Spino facial or facio hypoglossal anastomosis | 570.07 | 218.39 |
| 17.61B Peripheral repair using microsurgical technique, primary | 414.60 | 165.79 |

17.63 Repair of old traumatic injury of cranial and peripheral nerves

| | | |
|---|---|---|
| 17.63A Peripheral repair using microsurgical technique, secondary | 518.25 | 218.60 |

17.7 Injection into peripheral nerve

17.71 Peripheral nerve injection, unqualified

| | | |
|---|---|---|
| 17.71A Local block(s) of somatic nerve(s) | 25.88 | |
| NOTE: May not be claimed with any other procedure at the same encounter by the same or different physician except for HSC 95.94C. | | |
| 17.71B Femoral nerve block - injection with or without ultrasound | 59.14 | |
| NOTE: 1. May not be claimed for services related to chronic pain management or treatment. | | |
| 2. May not be claimed in addition to any other anesthetic services by the same physician. | | |
| 3. May be claimed in addition to a visit or consultation by the same physician. | | |
| 4. May not be billed with a visit if another physician has provided and claimed a visit on the same date of service in the same location. | | |

17.8 Invasive diagnostic procedures on peripheral nervous system

17.81 Biopsy of peripheral nerve or ganglion

| | | |
|---|---|---|
| 17.81A Sural nerve biopsy | 95.96 V | 110.53 |
| 17.81B Fascicular nerve biopsy, with operating microscope | 220.87 | 109.31 |

17.89 Other invasive diagnostic procedures on cranial and peripheral nerves

| | | |
|---|---|---|
| 17.89A Intraoperative neural electrodiagnostic monitoring | 240.92 | |
| NOTE: 1. One fee only payable per sitting irrespective of the number of nerves involved. | | |
| 2. May be claimed in addition to items 16.1A, 16.1D, 16.3B, 16.3D, 16.5A 16.49A and 16.09F. | | |

II. OPERATIONS ON THE NERVOUS SYSTEM (cont'd)

17 OPERATIONS ON CRANIAL AND PERIPHERAL NERVES (cont'd)

17.9 Other operations on cranial and peripheral nerves

17.92 Implantation or replacement of peripheral neurostimulator

| | | BASE | ANE |
|---|---|---|---|
| 17.92A | Sacral nerve root stimulator, peripheral nerve evaluation, first full 30 minutes or major portion thereof for the first call when only one call is claimed | 129.58 | 110.53 |
| | NOTE: 1. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List after the first full 30 minutes has elapsed. 2. The anesthetic rate for HSC 17.92A may not be claimed in addition to an anesthetic rate for any other service. | | |
| 17.92B | Sacral nerve root stimulator, implantation of pulse generator, first full 30 minutes or major portion thereof for the first call when only one call is claimed | 129.58 | 110.53 |
| | NOTE: 1. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List after the first full 30 minutes has elapsed. 2. The anesthetic rate for HSC 17.92B may not be claimed in addition to an anesthetic rate for any other service. | | |
| 17.92C | Sacral nerve root stimulator, first or second stage (permanent implant), first full 60 minutes or major portion thereof for the first call when only one call is claimed | 513.37 | 110.53 |
| | NOTE: 1. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List after the first full 60 minutes has elapsed. 2. The anesthetic rate for HSC 17.92C may not be claimed in addition to an anesthetic rate for any other service. | | |

18 OPERATIONS ON SYMPATHETIC NERVES OR GANGLIA

18.1 Sympathectomy

18.13 Lumbar sympathectomy

| | | | |
|---|---|---|---|
| 18.13A | Thoracic or thoracolumbar | 517.30 | 291.48 |
| 18.13B | Lumbar | 427.88 | 183.46 |
| 18.14 | Presacral sympathectomy<br>Presacral neurectomy | 301.85 | 139.77 |

18.2 Injection into sympathetic nerve or ganglion

18.22 Injection of neurolytic agent into sympathetic nerve

| | | | |
|---|---|---|---|
| 18.22A | With sclerosing agents (alcohol) | 126.02 | |
| 18.22B | Celiac plexus ganglion block, with sclerosing agents (alcohol or phenol) | 147.36 | |

18.29 Other injection into sympathetic nerve or ganglion

| | | | |
|---|---|---|---|
| 18.29A | Chemical sympathectomy under fluoroscopic or CT control | 200.01 | |

## II. OPERATIONS ON THE NERVOUS SYSTEM (cont'd)

### 18 OPERATIONS ON SYMPATHETIC NERVES OR GANGLIA (cont'd)

#### 18.2 Injection into sympathetic nerve or ganglion (cont'd)

##### 18.29 Other injection into sympathetic nerve or ganglion (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 18.29B | Lumbar sympathetic block | 108.31 | |
| 18.29C | Stellate ganglion block | 107.50 | |
| 18.29D | Sphenopalatine ganglion block | 106.75 | |
| 18.29E | Paravertebral block | 106.75 | |
| 18.29F | Radiofrequency ablation of the facet joint medial branch nerves, using fluoroscopic guidance | 468.62 | |

## III. OPERATIONS ON THE ENDOCRINE SYSTEM

### 19 OPERATIONS ON THYROID AND PARATHYROID GLANDS

#### 19.0 Incision of thyroid field

##### 19.09 Other incision of thyroid field

| | | | |
|---|---|---|---|
| 19.09A | Exploration of the neck for penetrating injury, first hour of operating time | 396.17 | 317.63 |

NOTE:
1. May only be claimed for trauma patients.
2. Other procedures may be claimed in addition but the time spent in performing them may not be included in the time claimed for this procedure.
3. Each subsequent 15 minutes or major portion thereof may be claimed at the rate specified on the Price List.
4. A maximum of three hours may be claimed.

#### 19.1 Unilateral thyroid lobectomy

| | | | |
|---|---|---|---|
| 19.1 | Total thyroid lobectomy | 720.15 | 313.17 |

#### 19.3 Complete thyroidectomy

| | | | |
|---|---|---|---|
| 19.3 A | Total thyroidectomy | 1,320.56 | 515.80 |
| 19.3 B | Total thyroidectomy with formal neck dissection | 1,760.99 | 718.43 |

#### 19.6 Excision of thyroglossal duct or tract

| | | | |
|---|---|---|---|
| 19.6 A | Thyroglossal duct excision | 427.81 | 184.21 |
| 19.6 B | Recurrent thyroglossal duct excision | 615.14 | 257.90 |

#### 19.7 Parathyroidectomy

| | | | |
|---|---|---|---|
| 19.7 A | Parathyroidectomy | 1,227.26 | 626.33 |

NOTE: Benefit for a re-operation; use modifier REANE or REOP; refer to the Price List.

| | | | |
|---|---|---|---|
| 19.7 B | Parathyroidectomy with mediastinal exploration | 1,584.68 | 681.59 |

NOTE: May not be claimed in addition to HSC 20.73.

#### 19.8 Invasive diagnostic procedures on thyroid and parathyroid glands

| | | | |
|---|---|---|---|
| 19.81 | Percutaneous (needle) biopsy of thyroid | 66.98 V | 110.43 |

III. OPERATIONS ON THE ENDOCRINE SYSTEM (cont'd)

20 OPERATIONS ON OTHER ENDOCRINE GLANDS

| | | BASE | ANE |
|---|---|---|---|
| 20.1 | Partial adrenalectomy | | |
| 20.12 | Unilateral adrenalectomy | 1,035.32 | 354.21 |
| 20.12A | Unilateral laparoscopic adrenalectomy | 1,234.97 | 575.58 |
| 20.5 | Hypophysectomy | | |
| 20.54 | Total excision of pituitary gland, transfrontal approach | 1,879.49 | 646.47 |
| 20.55 | Total excision of pituitary gland, transsphenoidal approach | | |
| 20.55A | Total excision of pituitary gland, transsphenoidal approach<br>NOTE: 1. Also applies to transethmoidal approach. | 1,200.58 | 510.09 |
| 20.55B | Transphenoidal or transethmoidal hypophysectomy, Neurosurgical component | 1,338.45 | 419.02 |
| 20.7 | Thymectomy | | |
| 20.73 | Total excision of thymus<br>NOTE: May not be claimed in addition to HSC 19.7 B. | 1,034.60 | 335.67 |

## IV. OPERATIONS ON THE EYES

### 21 OPERATIONS ON LACRIMAL APPARATUS

#### 21.3 Manipulation of lacrimal passage (tract)

##### 21.31 Dilation of lacrimal punctum

| | | BASE | ANE |
|---|---|---|---|
| 21.31A | Diagnostic irrigation of nasolacrimal duct, office procedure, per eye | 31.33 | |
| 21.31B | Probing and irrigation of nasolacrimal duct for patients 18 years of age and under | 261.45 | 110.53 |
| | NOTE: 1. May only be claimed when performed in an operating room, day surgery or non hospital surgical facility.<br>2. Benefit rate includes both eyes. | | |

##### 21.32 Probing of lacrimal canaliculi

| | | | |
|---|---|---|---|
| 21.32B | Catheterization of nasolacrimal duct | 156.84 | 109.21 |
| | NOTE: May be claimed when performed at the same time as 21.71. | | |
| 21.32C | Unilateral probing with intubation of nasolacrimal duct | 287.65 | 110.53 |
| 21.32D | Replacement of Jones/bypass lacrimal tube, per eye | 230.63 | 172.55 |

#### 21.4 Incision of lacrimal sac and passage

| | | | |
|---|---|---|---|
| 21.41 | Incision of lacrimal sac<br>Drainage of lacrimal sac | 78.42 V | 109.21 |
| 21.42 | Snip incision of lacrimal punctum | 78.42 V | 109.21 |

#### 21.6 Repair of canaliculus and punctum

##### 21.69 Other repair of canaliculus and punctum

| | | | |
|---|---|---|---|
| 21.69A | Non-surgical closure of punctum, insertion of punctual plugs, per eye | 26.20 V | 109.21 |
| 21.69B | Lacerated canaliculi repair | 575.12 | 128.95 |
| | NOTE: Benefit includes intubation. | | |
| 21.69C | Surgical closure of punctum, not punctal plugs, per eye | 78.42 V | 109.21 |

#### 21.7 Fistulization of lacrimal tract to nasal cavity

| | | | |
|---|---|---|---|
| 21.71 | Dacryocystorhinostomy (DCR)<br>NOTE: May not be claimed in addition to HSCs 33.01A, 33.51B, 33.76C, 34.54A and 34.89A. | 627.35 | 163.96 |
| 21.72 | Conjunctivocystorhinostomy | 679.57 | 167.83 |

### 22 OPERATIONS ON EYELIDS

#### 22.1 Excision of lesion or tissue of eyelid

##### 22.13 Other excision of single lesion of eyelid

| | | | |
|---|---|---|---|
| 22.13A | Excision of eyelid lesion requiring pathology analysis | 156.84 | 109.31 |
| | NOTE: Single fee applies regardless of whether the upper or lower or both eyelids of same eye are involved. If second eye needs to be done, the fee for the second eye may be claimed at 75%. | | |

IV. OPERATIONS ON THE EYES (cont'd)

22 OPERATIONS ON EYELIDS (cont'd)

22.1 Excision of lesion or tissue of eyelid (cont'd)

22.13 Other excision of single lesion of eyelid (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 22.13B | Chalazion - surgical removal . . . . . | 120.20 V | 110.53 |
| | NOTE: May be claimed in addition to a visit or consultation. | | |
| 22.13C | Non cosmetic excision of benign tumor of eyelid not requiring pathology analysis, for functional reasons including obstruction of visual axis, tearing, inflammation or lid malposition . . . . . | 80.04 V | 110.43 |
| | NOTE: For services requiring pathology analysis see HSC 22.13A. | | |

22.3 Correction of entropion or ectropion

| | | | |
|---|---|---|---|
| 22.32A | Major full thickness repair of lid involving eyelid margin entropion, ectropion, trauma or tumor) . . . . . | 461.26 | 123.67 |

22.39 Other correction of entropion or ectropion

| | | | |
|---|---|---|---|
| 22.39A | Non full thickness lid procedure for entropion, ectropion or lid repair . . | 315.90 | 110.53 |

22.4 Correction of blepharoptosis

| | | | |
|---|---|---|---|
| 22.4 A | Eyelid ptosis repair requiring surgery on eyelid retractors - muller, levator, frontalis and/or lower lid equivalent . . . . . | 722.54 | 150.17 |

22.5 Blepharorrhaphy

| | | | |
|---|---|---|---|
| 22.5 A | Simple suture . . . . . | 142.19 V | 109.31 |
| | NOTE: Single fee applies regardless of whether the upper or lower or both eyelids of same eye are involved. If second eye needs to be done, the fee for the second eye may be claimed at 75%. | | |
| 22.5 B | Surgical tarsorrhaphy . . . . . | 313.67 | 109.21 |
| | Not to be used for botox | | |

22.51 Functional blepharoplasty - upper eyelid - without cosmetic intent

| | | | |
|---|---|---|---|
| 22.51A | Functional blepharoplasty - upper eyelid - without cosmetic intent . . . . . | 392.26 | 150.17 |
| | NOTE: May only be claimed for patients where at least half the pupil is covered by the skin of the upper eyelids. Sufficient evidence to support this must be documented in the patient record. | | |

22.6 Other repair of eyelid

22.62 Rhytidectomy of eyelid

| | | | |
|---|---|---|---|
| 22.62A | Lower/upper repair of redundant skin . . . . . | 196.00 | 110.43 |
| | NOTE: Single fee applies regardless of whether the upper or lower or both eyelids of same eye are involved. If second eye needs to be done, the fee for the second eye may be claimed at 75%. | | |

IV. OPERATIONS ON THE EYES (cont'd)

22 OPERATIONS ON EYELIDS (cont'd)

22.6 Other repair of eyelid (cont'd)

22.69 Other eyelid repair

| | | BASE | ANE |
|---|---|---|---|
| 22.69B | Major full thickness lid repair with flap or graft | 922.36 | 239.49 |
| | NOTE: Single fee applies regardless of whether the upper or lower or both eyelids of same eye are involved. If second eye needs to be done, the fee for the second eye may be claimed at 75%. | | |

22.7 Epilation of eyelid

| | | | |
|---|---|---|---|
| 22.71 | Electrosurgical epilation requiring injection of anesthesia | 141.08 | |

22.8 Invasive diagnostic procedures on eyelid

| | | | |
|---|---|---|---|
| 22.81 | Biopsy of eyelid | 77.53 V | 109.21 |
| | NOTE: Single fee applies regardless of whether the upper or lower or both eyelids of same eye are involved. If second eye needs to be done, the fee for the second eye may be claimed at 75%. | | |

23 OPERATIONS ON OCULAR MUSCLES OR TENDONS

23.9 Other operations on ocular muscles or tendons

23.99 Other operations on ocular muscles or tendons NEC

| | | | |
|---|---|---|---|
| 23.99A | Strabismus repair, one muscle | 705.94 | 165.79 |
| | NOTE: 1. Subsequent muscles, regardless if the same or different eye, are paid at a reduced rate as indicated in the Price List to a maximum benefit of five.<br>2. The add on fee applies once only per eye for a re-operation. | | |
| 23.99C | Strabismus repair, adjustable suture technique, additional benefit | 365.90 | 109.21 |
| | NOTE: 1. May only be claimed in addition to HSC 23.99A.<br>2. Single benefit applies regardless of the number of adjustable sutures used. | | |
| 23.99D | Injection of Botulinum A Toxin | 130.59 | |
| | For strabismus, blepharospasm or hemifacial spasm | | |
| | NOTE: May be claimed in addition to a visit or consultation. | | |

24 OPERATIONS ON CONJUNCTIVA

24.1 Other incision of conjunctiva

| | | | |
|---|---|---|---|
| 24.1 A | Peritomy | 156.84 | 109.21 |
| | NOTE: May not be claimed in addition to any other procedure on the same date of service. | | |

IV. OPERATIONS ON THE EYES (cont'd)

24 OPERATIONS ON CONJUNCTIVA (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 24.2 | Excision or destruction of lesion or tissue of conjunctiva | | |
| 24.22 | Excision of lesion or tissue of conjunctiva | | |
| 24.22A | Conjunctival biopsy or simple tumor excision with pathology analysis | 130.81 V | 110.53 |
| 24.3 | Conjunctivoplasty | | |
| 24.31 | Reconstruction of conjunctival cul-de-sac with buccal mucous membrane graft | | |
| 24.31A | Reconstruction of conjunctival fornix with graft | 922.36 | 176.68 |
| 24.32 | Other reconstruction of conjunctival cul-de-sac | | |
| 24.32A | Other reconstruction of conjunctival fornix | 461.26 | 182.17 |
| 24.35 | Conjunctival flap | | |
| 24.35A | Conjunctival flap for corneal ulcer | 461.26 | 110.53 |
| 24.5 | Suture of conjunctiva | | |
| 24.5 | Suture of conjunctiva | 156.84 V | 109.21 |

NOTE: May not be claimed in addition to other procedures at the same encounter.

| | | | |
|---|---|---|---|
| 24.89 | Other invasive diagnostic procedures on conjunctiva | | |
| | Allergy testing | | |
| 24.89A | Conjunctival test, per test | 7.90 | |

NOTE: 1. A maximum of 15 calls may be claimed per patient, per benefit year except when the patient has been referred to a specialist in which case the specialist may also claim a maximum of 15 calls.
2. Benefits do not include the cost of materials.

| | | | |
|---|---|---|---|
| 24.89B | Diagnostic conjunctival scraping | 18.49 | |
| 24.9 | Other operations on conjunctiva | | |
| 24.91 | Subconjunctival injection | 36.64 | |

NOTE: 1. May not be claimed in addition to other procedures at the same encounter.
2. May not be claimed for injection of local anesthetics.

25 OPERATIONS ON CORNEA

| | | | |
|---|---|---|---|
| 25.1 | Incision of cornea | | |
| 25.1 A | Removal of corneal foreign body | 40.58 V | 110.43 |
| 25.2 | Excision of pterygium | | |
| 25.21 | Excision or transposition of pterygium with graft | | |
| 25.21A | Excision of pterygium with graft | 461.26 | 147.37 |

IV. OPERATIONS ON THE EYES (cont'd)

25 OPERATIONS ON CORNEA (cont'd)

25.2 Excision of pterygium (cont'd)
25.21 Excision or transposition of pterygium with graft (cont'd)

| | BASE | ANE |
|---|---|---|
| 25.29 Other excision of pterygium | | |
| 25.29A Excision of pterygium without graft | 170.02 | 110.53 |
| 25.3 Excision or destruction of other lesion or tissue of cornea | | |
| 25.39 Other removal or destruction of corneal lesion | | |
| 25.39A Excision of corneal dermoid | 204.61 | 141.34 |
| 25.39B Malignant tumor of cornea | 512.63 | 148.51 |
| 25.39C Superficial keratectomy | 311.62 | 122.30 |
| 25.39D Phototherapeutic keratectomy - for corneal scar, epithelial irregularity or amblyogenic refractive error | 461.26 | |
| NOTE: May not be claimed for routine refractive purposes. | | |
| 25.4 Suture of cornea | | |
| 25.4 A Traumatic corneal wound repair that with sutures | 1,024.75 | 110.53 |
| 25.5 Corneal transplant | | |
| 25.53 Lamellar keratoplasty (with homograft) | | |
| 25.53A Anterior lamellar keratoplasty with graft | 922.36 | 221.05 |
| 25.53B Deep anterior lamellar keratoplasty with graft | 1,383.28 | 294.73 |
| 25.53C Endothelial keratoplasty | 1,024.75 | 294.73 |
| 25.55 Penetrating keratoplasty (with homograft) | | |
| 25.55A Penetrating keratoplasty | 1,280.89 | 294.73 |
| 25.6 Other repair of cornea | | |
| 25.63 Keratoprosthesis | 1,537.20 | 288.28 |
| 25.69 Other repair of cornea | | |
| 25.69A Therapeutic corneal cross-linking examination for progressing cases of keratoconus or pellucid marginal degeneration, per eye | 1,267.71 | 150.17 |

NOTE: 1. May not be claimed for services provided in association or in relation to refractive surgery either 2 years preceding refractive surgery or 2 years following refractive surgery. Patient must have a greater than 1 dioptre change in refractive astigmatism and a greater than one line loss of corrected acuity documented over a minimum of three examinations (one baseline and two follow ups).
2. May only be claimed for epithelium-off procedures.

IV. OPERATIONS ON THE EYES (cont'd)

25 OPERATIONS ON CORNEA (cont'd)

| | BASE | ANE |
|---|---|---|
| 25.8 Invasive diagnostic procedures on cornea | | |
| 25.81 Scraping of cornea for smear or culture | | |
| 25.81A Diagnostic corneal scraping | 18.49 | |

26 OPERATIONS ON IRIS, CILIARY BODY, SCLERA, AND ANTERIOR CHAMBER

| | | |
|---|---|---|
| 26.2 Operations for the relief of intraocular tension | | |
| 26.2 B Glaucoma implant procedures with reservoir shunts | 1,231.41 | 313.17 |
| 26.25 Trabeculectomy ab externo | | |
| 26.25B Trabeculectomy or major revision of trabeculectomy | 973.55 | 221.05 |
| 26.29 Other relief of intraocular circulation | | |
| 26.29A Ab-interno angle surgery (stent, trabectome or similar) for adult open-angle glaucoma | 470.51 | 221.05 |
| 26.29B Transcleral drainage of choroidal hemorrhages or subretinal fluid | 341.58 | 255.56 |
| 26.3 Facilitation of intraocular circulation | | |
| 26.34 Trabeculotomy ab externo | | |
| 26.34A Argon laser trabeculoplasty, selective laser trabeculoplasty, iridoplasty, goniopuncture | 418.29 | 312.94 |
| 26.4 Excision or destruction of lesion of iris, ciliary body, and sclera | | |
| 26.45 Excision of lesions of ciliary body | 1,793.35 | 279.56 |
| 26.5 Other iridectomy or iridotomy | | |
| 26.52 Other iridotomy | | |
| 26.52A Peripheral iridotomy - laser | 313.67 | 132.51 |
| NOTE: May not be claimed for capsulotomy. | | |
| 26.53 Iridectomy (basal) | | |
| 26.53A Surgical iridectomy | 512.46 | 163.96 |
| 26.6 Iridoplasty | | |
| 26.62 Freeing of other anterior synechiae | | |
| 26.62A Freeing of angle closure synechiae under gonioscopy | 228.75 | 109.31 |
| 26.69 Other iridoplasty | | |
| 26.69A Iridodialysis, repair | 512.63 | 150.17 |
| 26.7 Scleroplasty | | |
| 26.71 Suture of complicated (traumatic) laceration of sclera with or without laceration to cornea | 1,537.20 | 177.09 |
| 26.79 Other scleroplasty | | |
| 26.79A Scleroplasty/scleral resection | 954.03 | 273.27 |

IV. OPERATIONS ON THE EYES (cont'd)

26 OPERATIONS ON IRIS, CILIARY BODY, SCLERA, AND ANTERIOR CHAMBER (cont'd)

| | BASE | ANE |
|---|---|---|
| 26.9 Other operations on iris, ciliary body, sclera, and anterior chamber | | |
| 26.91 Aspiration of anterior chamber | | |
| 26.91A Aspiration or tap of anterior chamber through new wound | 112.83 V | 109.21 |
| 26.91B Anterior chamber washout for hyphema | 409.90 | 122.30 |
| 26.97 Other operations on sclera | | |
| 26.97B Placement of radioactive plaque with suturing to sclera | 830.07 | |
| 26.98 Other operations on anterior chamber | | |
| 26.98B Ciliary body ablation | 589.34 | 218.60 |

27 OPERATIONS ON LENS

| | | |
|---|---|---|
| 27.3 Discission of lens and capsulotomy | | |
| 27.3 C Yttrium Aluminium Garnet (YAG) laser capsulotomy | 209.06 | 109.21 |
| 27.4 Intracapsular extraction of lens | | |
| 27.4 A Intracapsular extraction of lens with or without intraocular lens | 768.60 | 200.94 |
| 27.5 Extracapsular extraction of lens | | |
| 27.5 A Pediatric cataract extraction<br>May only be claimed for children 6 years of age and under | 1,024.75 | 276.32 |
| 27.5 B Extracapsular cataract extraction - non phacoemulsification - with or without intraocular lens | 768.60 | 203.18 |
| 27.7 Insertion of prosthetic lens | | |
| 27.7 A Entry into anterior chamber for manipulation, repositioning of lens fragment, IOL or foreign body | 341.58 | 110.43 |
| 27.7 C Remove, replace or repositioning of subluxed or dislocated intraocular lens (IOL) or secondary insertion of posterior chamber intraocular lens with or without suturing | 723.06 | 202.64 |
| 27.7 D Removal, replace or repositioning of posteriorly dislocated pseudophakos, with secondary suturing | 1,018.75 | 279.56 |
| 27.72 Insertion of intraocular lens prosthesis with cataract extraction, one stage | | |
| 27.72A Phacoemulsification cataract extraction, anterior approach, with or without insertion of intraocular lens | 409.90 | 98.48 |
| 27.73 Secondary insertion of intraocular lens prosthesis | | |
| 27.73A Secondary insertion of anterior chamber intraocular lens, includes peripheral iridectomy | 675.63 | 185.51 |
| 27.9 Other operations on lens | | |
| 27.99 Other operations on lens NEC | | |
| 27.99A Dislocated lens, removal | 762.78 | 200.94 |

IV. OPERATIONS ON THE EYES (cont'd)

28 OPERATIONS ON RETINA, CHOROID, AND VITREOUS

28.2 Scleral buckling with implant

| | | BASE | ANE |
|---|---|---|---|
| 28.2 B | Segmental retinal repair | 920.47 | 276.32 |
| 28.2 C | Scleral buckling and encircling tubing | 989.13 | 313.17 |
| 28.2 D | Removal of scleral buckle material | 691.72 | 517.52 |

NOTE: May not be claimed with any other procedures at the same encounter.

28.4 Other operations for repair of retina

| | | | |
|---|---|---|---|
| 28.4 A | Light coagulation or cryopexy - posterior segment (repair of retinal tears) | 424.11 | 109.21 |
| 28.4 B | Light coagulation or cryopexy with drainage of subretinal fluids | 857.46 | 218.39 |

28.5 Excision or destruction of lesion of retina or choroid

| | | | |
|---|---|---|---|
| 28.5 A | Posterior segment cryopexy or focal or grid laser | 424.11 | 109.21 |
| 28.5 B | Cryopexy or laser treatment for retinopathy of prematurity | 776.48 | 123.67 |

28.54 Destruction of lesion of retina or choroid by unspecified photocoagulation

| | | | |
|---|---|---|---|
| 28.54A | Panretinal photocoagulation | 575.12 | 109.21 |

NOTE: A maximum of 8 calls per patient per lifetime may be claimed.

28.7 Operations on vitreous

28.71 Removal of vitreous, anterior approach (partial)

| | | | |
|---|---|---|---|
| 28.71A | Anterior vitrectomy using automated vitrector at the time of anterior segment surgery (complex cataract, trauma, keratoplasty, glaucoma filtering procedure) | 341.58 | 165.79 |

NOTE: 1. When only procedure performed.
2. For additional fee when performed in conjunction with another procedure - refer to Price List.

28.72 Removal of vitreous, other approach

| | | | |
|---|---|---|---|
| 28.72A | Aspiration/washout of vitreous cavity with replacement | 512.63 | 150.17 |
| 28.72B | Posterior total vitrectomy with 2 or 3 port infusion and cutting device | 982.11 | 313.17 |
| 28.72C | Posterior capsulotomy when performed with posterior vitrectomy | 104.61 | 78.27 |

28.73 Injection of vitreous substitute

| | | | |
|---|---|---|---|
| 28.73A | Pneumatic retinopexy - includes cryopexy, and/or laser, and/or gas injection, and/or paracentesis, and/or fluid drainage | 522.05 | 390.58 |

IV. OPERATIONS ON THE EYES (cont'd)

28 OPERATIONS ON RETINA, CHOROID, AND VITREOUS (cont'd)

28.7 Operations on vitreous (cont'd)

28.73 Injection of vitreous substitute (cont'd)

| | BASE | ANE |
|---|---|---|
| 28.73B Addition or removal of gas or air injection | 149.13 | |
| NOTE: Payable within 60 days following scleral buckling (HSC 28.2 C) or pneumatic retinopexy (HSC 28.73A). | | |

28.74 Discission of vitreous strands

| | | |
|---|---|---|
| 28.74B Stripping of premacular membrane associated with vitrectomy | 1,300.92 | 384.39 |

28.79 Other operations on vitreous

| | | |
|---|---|---|
| 28.79B Intravitreal injection for drug delivery | 111.98 | 109.21 |
| 28.79C Aspiration of vitreous for diagnostic purposes with or without intravitreal injection for drug delivery | 236.11 | 176.65 |
| NOTE: May not be claimed for injecting anti Vascular Endothelial Growth Factor (VEGF) medications. | | |

28.8 Invasive diagnostic procedures on retina, choroid, and vitreous

| | | |
|---|---|---|
| 28.8 A Eye tumor localization or planning of plaque placement | 307.51 V | 109.21 |

28.81 Biopsy of retina, choroid, and vitreous

| | | |
|---|---|---|
| 28.81A Biopsy of retina or choroid including intraoperative laser | 512.46 | 109.21 |

29 OPERATIONS ON ORBIT AND EYEBALL

29.0 Orbitotomy

| | | |
|---|---|---|
| 29.0 A Orbitotomy - exploration and/or biopsy | 524.96 | 147.37 |
| 29.0 B Orbitotomy for decompression | 922.36 | 331.58 |
| NOTE: A second, third or fourth call may be claimed at the rate specified on the Price List. | | |
| 29.0 C Orbitotomy - incision and drainage of abscess | 461.26 | 110.43 |

29.01 Orbitotomy with frontal approach

| | | |
|---|---|---|
| 29.01A Removal of anterior orbital tumor including lacrimal gland biopsy if performed | 691.72 | 147.37 |

29.02 Orbitotomy with lateral approach

| | | |
|---|---|---|
| 29.02A Complicated orbital reconstruction or tumor excision - first 90 minutes | 1,690.79 | 401.85 |

29.2 Evisceration of eyeball

29.21 Removal of ocular contents with implant into scleral shell

| | | |
|---|---|---|
| 29.21A Evisceration with or without implant | 922.36 | 165.79 |

IV. OPERATIONS ON THE EYES (cont'd)

29 OPERATIONS ON ORBIT AND EYEBALL (cont'd)

29.2 Evisceration of eyeball (cont'd)

29.21 Removal of ocular contents with implant into scleral shell (cont'd)

| | BASE | ANE |
|---|---|---|
| 29.29 Other evisceration of eyeball | 691.16 | 131.04 |

29.3 Removal of eyeball

29.31 Enucleation of eyeball with implant into tenon's capsule with attachment of muscles

| | | |
|---|---|---|
| 29.31A Enucleation with or without implant into tenon's capsule with attachment of extra ocular muscles | 1,152.82 | 165.79 |

29.4 Exenteration of orbital contents

| | | |
|---|---|---|
| 29.4 A Exenteration of orbital contents with or without flap graft | 1,445.06 | 203.18 |

29.5 Insertion of ocular or orbital implant

29.55 Other reinsertion of ocular implant

| | | |
|---|---|---|
| 29.55A Replacement of socket implant or dermal fat graft to socket | 867.57 | 141.34 |

29.9 Other operations on orbit or eyeball

| | | |
|---|---|---|
| 29.91 Retrobulbar injection of therapeutic agent | 130.81 | |

29.99 Other operations on eye, unspecified structure or type

| | | |
|---|---|---|
| 29.99A Removal of intraocular foreign body | 512.63 | 159.01 |

## V. OPERATIONS ON THE EARS

### 30 OPERATIONS ON EXTERNAL EAR

| | | BASE | ANE |
|---|---|---|---|
| 30.1 | Excision or destruction of lesion of external ear | | |
| 30.1 A | Removal of osteoma of ear canal | 184.46 | 110.53 |
| 30.11 | Excision of preauricular sinus | | |
| 30.11A | Excision of preauricular sinus, primary | 154.32 | 110.53 |
| 30.11B | Secondary excision of preauricular sinus | 328.73 | 167.83 |
| 30.19 | Excision or destruction of other lesion of external ear | | |
| 30.19A | Aural polyp removal | 26.07 V | 109.21 |
| 30.19B | Excision of accessory auricle | 112.46 V | 110.43 |
| 30.3 | Suture of (traumatic) laceration of external ear | | |
| 30.3 A | Post traumatic major ear reconstruction | 411.81 | 221.05 |
| 30.4 | Surgical correction of prominent ear | | |
| 30.4 A | Otoplasty<br>NOTE: Patient under 19 years of age. | 466.42 | 147.37 |
| 30.6 | Other plastic repair of external ear | | |
| 30.61 | Construction of auricle of ear | | |
| 30.61A | Major ear reconstruction, cartilage graft and flap or skin graft, per 60 minutes or major portion thereof for the first call when only one call is claimed<br>NOTE: Refer to notes following HSC 30.61B. | 647.81 | 1,007.03 |
| 30.61B | Major ear reconstruction, cartilage graft, per 60 minutes or major portion thereof for the first call when only one call is claimed<br>NOTE: 1. HSCs 30.61A and 30.61B may not be claimed with other procedures.<br>2. Benefits for HSCs 30.61A and 30.61B include harvesting and preparation of cartilage. | 647.81 | 653.70 |
| 30.8 | Invasive diagnostic procedures on external ear | | |
| 30.81 | Biopsy of external ear | | |
| 30.81A | Punch biopsy | 28.53 | |
| 30.9 | Other operations on external ear | | |
| 30.9 A | Closure of post-auricular fistula | 125.80 V | 109.21 |

### 31 RECONSTRUCTIVE OPERATIONS ON MIDDLE EAR

| | | | |
|---|---|---|---|
| 31.0 | Stapes mobilization | | |
| 31.0 | Stapes mobilization | 336.95 | 176.68 |
| 31.1 | Stapedectomy | | |
| 31.1 A | Stapedectomy, stapedoplasty or fenestration of oval window | 718.65 | 221.05 |
| 31.19 | Other stapedectomy | | |
| 31.19A | Laser stapedotomy | 934.15 | 594.05 |

V. OPERATIONS ON THE EARS (cont'd)

31 RECONSTRUCTIVE OPERATIONS ON MIDDLE EAR (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 31.3 | Other operations on ossicular chain | | |
| 31.3 A | Ossicular reconstruction | 743.31 | 386.85 |
| 31.4 | Myringoplasty | | |
| 31.4 | Myringoplasty<br>Tympanoplasty | 489.91 | 184.21 |
| 31.5 | Other tympanoplasty | | |
| 31.5 A | Tympanoplasty with antrotomy | 561.59 | 239.49 |
| 31.9 | Other repair of middle ear | | |
| 31.9 A | Excision of glomus tumors, trans-tympanotomy approach | 478.51 | 167.83 |

32 OTHER OPERATIONS ON MIDDLE AND INNER EAR

| | | BASE | ANE |
|---|---|---|---|
| 32.0 | Myringotomy | | |
| 32.01 | Myringotomy with insertion of tube | | |
| 32.01A | Myringotomy<br>With insertion of tube<br>NOTE: Single anesthetic benefit applies regardless of whether the procedure is performed bilaterally. | 62.09 V | 110.53 |
| 32.1 | Removal of tympanostomy tube | | |
| 32.1 | Removal of tympanostomy tube<br>NOTE: 1. May be claimed when performed under anesthesia.<br>2. If under local anesthesia, claim the appropriate office visit. | 70.31 V | 150.17 |
| 32.2 | Incision of mastoid and middle ear | | |
| 32.21 | Incision of mastoid | | |
| 32.21A | For removal of foreign body | 110.38 V | 109.21 |
| 32.23 | Incision of middle ear | | |
| 32.23A | Tympanotomy (exploratory) elevation of tympanomeatal flap | 122.36 V | 147.37 |
| 32.3 | Mastoidectomy | | |
| 32.31 | Simple mastoidectomy | 310.93 | 150.17 |
| 32.32 | Radical mastoidectomy | | |
| 32.32A | Radical or modified mastoidectomy | 690.34 | 202.64 |
| 32.32B | Radical or modified radical mastoidectomy, with tympanoplasty | 935.98 | 294.73 |
| 32.39 | Other mastoidectomy | | |
| 32.39A | Antrotomy | 101.31 V | 109.21 |
| 32.39B | Repair of atresia of ear, incomplete | 373.94 | 194.35 |

V. OPERATIONS ON THE EARS (cont'd)

32 OTHER OPERATIONS ON MIDDLE AND INNER EAR (cont'd)

32.3 Mastoidectomy (cont'd)

32.39 Other mastoidectomy (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 32.39C | Repair of atresia of ear, complete | 808.60 | 331.58 |
| 32.79B | Excision of glomus tumors, including resection of jugular bulb, internal jugular vein and sigmoid sinus | 1,202.16 | 442.11 |
| 32.79G | Labyrinth destruction, destruction of vestibular organ by cryotherapy | 352.48 | 183.46 |
| 32.79H | Labyrinth destruction, chemical | 504.52 | 176.68 |

32.8 Invasive diagnostic procedures on middle and inner ear

| | | | |
|---|---|---|---|
| 32.81 | Electrocochleography<br>Promontory stimulation test<br>NOTE: Includes the technical and professional components. | 127.84 | |

32.9 Other operations on middle and inner ear and eustachian tube

32.95 Implantation of electro-magnetic hearing aid

| | | | |
|---|---|---|---|
| 32.95A | Ear implant intracochlear, multiple or single channel | 1,247.82 | 497.38 |

32.96 Other operations on middle and inner ear

| | | | |
|---|---|---|---|
| 32.96A | Debridement of mastoid cavities and/or repair of small perforation under microscopy<br>NOTE: May not be claimed for removal of cerumen | 27.39 | |
| 32.96B | Debridement of mastoid cavities and/or repair of small perforation under microscopy<br>NOTE: 1. May not be claimed for removal of cerumen.<br>2. May only be claimed when performed as a sole procedure and under general or regional anesthesia excluding topical anesthesia techniques. | 93.14 | 184.21 |

## VI. OPERATIONS ON THE NOSE, MOUTH,AND PHARYNX

### 33 OPERATIONS ON NOSE

| | | BASE | ANE |
|---|---|---|---|
| 33.0 | Control of epistaxis | | |
| 33.01 | Control of epistaxis by anterior nasal packing | | |
| 33.01A | Control of epistaxis by anterior nasal packing with or without cautery | 125.00 | |
| | NOTE: 1. Benefit includes visit. 2. May not be claimed in addition to HSC 21.71. | | |
| 33.02 | Control of epistaxis by posterior (and anterior) packing | | |
| 33.02A | Control of epistaxis by posterior and anterior packing | 250.00 | 110.53 |
| 33.03 | Control of epistaxis by cauterization (and packing) | | |
| 33.03A | Control of epistaxis by cautery | 57.05 V | |
| | NOTE: 1. Benefit includes visit. 2. A repeat performed within 14 days is payable at a reduced rate. Refer to Price List. | | |
| 33.04 | Control of epistaxis by ligation of ethmoidal arteries | 280.79 | 110.53 |
| 33.05 | Control of epistaxis by (transantral) ligation of the maxillary artery | 505.89 | 165.79 |
| 33.1 | Incision of nose | | |
| 33.1 A | Lateral rhinotomy/sublabial | 291.30 | 141.34 |
| 33.2 | Excision or destruction of lesion of nose | | |
| 33.21 | Excision of lesion of nose, unqualified | | |
| 33.21A | Cauterization of nasal turbinate | 25.04 | |
| 33.21B | Dermoid cyst | 205.92 | 147.37 |
| 33.22 | Local excision or destruction of intranasal lesion | | |
| 33.22A | Nasal polyp removal | 89.03 V | 101.80 |
| 33.22B | Mucosal biopsy | 58.42 V | 110.43 |
| | NOTE: A maximum of three calls may be claimed. | | |
| 33.3 | Resection of nose | | |
| 33.3 A | Rhinophyma | 323.71 | 212.00 |
| 33.3 B | Rhinophyma with graft | 502.23 | 227.13 |
| 33.4 C | Septoplasty | 331.93 V | 122.16 |
| | NOTE: Benefit will be reduced if rhinoplasty is claimed by a second surgeon. Refer to Price List. | | |
| 33.5 | Turbinectomy | | |
| 33.51 | Turbinectomy by diathermy or cryosurgery | | |
| 33.51A | Submucosal diathermy of nasal turbinate | 77.16 V | 106.90 |
| 33.51B | Other methods | 96.79 V | 106.90 |
| | NOTE: 1. Includes that with steroid injections. 2. May not be claimed in addition to HSC 21.71. | | |

## VI. OPERATIONS ON THE NOSE, MOUTH,AND PHARYNX (cont'd)

### 33 OPERATIONS ON NOSE (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 33.6 | Reduction of nasal fracture | | |
| 33.61 | Reduction (closed) of nasal fracture | | |
| 33.61A | Fracture intra-nasal reduction and splinting | 129.56 V | 110.43 |
| 33.62 | Open reduction of nasal fracture | | |
| 33.62A | And mini-plate fixation | 518.25 | 185.51 |
| 33.62B | Mini-plate fixation via coronal approach | 1,140.14 | 594.05 |
| 33.7 | Repair and plastic operations on the nose | | |
| 33.73 | Rhinoplasty with implantation of inert material | | |
| 33.73A | Silicone elastomer implant | 182.63 | 122.30 |
| 33.74 | Rhinoplasty with bone or cartilage graft | | |
| 33.74A | Composite graft | 427.55 | 176.68 |
| | NOTE: Composite graft claimed for reconstruction of full thickness alar or columellar defects. | | |
| 33.76 | Other rhinoplasty or septoplasty | | |
| 33.76A | Tip revision | 224.64 | 127.26 |
| 33.76B | Hump removal | 180.80 | 150.17 |
| 33.76C | Infracture | 189.48 | 148.51 |
| | NOTE: May not be claimed in addition to HSC 21.71. | | |
| 33.76D | Hump removal and infracture | 246.17 | 150.17 |
| 33.76E | Complete (hump removal, infracture and tip revision) | 444.71 | 185.51 |
| 33.76F | Complete rhinoplasty and S.M.R. (1 surgeon) | 505.89 | 203.18 |
| 33.76G | Repair of nasal septum perforation | 339.24 | 141.34 |
| 33.76H | Repeat reconstructive rhinoplasty following previous complete rhinoplasty | 658.38 | 318.01 |
| | NOTE: May be claimed only when there is a history of a previous 33.76E. | | |
| 33.9 | Other operations on nose | | |
| 33.99 | Other operations on nose NEC | | |
| 33.99A | Choanal atresia, intranasal | 387.63 | 141.34 |
| 33.99B | Choanal atresia, transpalatine | 580.31 | 159.01 |

### 34 OPERATIONS ON NASAL SINUSES

| | | | |
|---|---|---|---|
| 34.0 | Puncture of nasal sinus | | |
| 34.0 A | Puncture and irrigation of maxillary sinus | 24.20 V | 106.90 |
| 34.1 | Intranasal antrotomy | | |
| 34.1 A | Intranasal antrostomy | 96.34 V | 101.80 |
| 34.2 | External maxillary antrotomy | | |
| 34.2 A | Caldwell Luc (radical) | 310.93 | 176.68 |
| 34.2 B | Caldwell Luc and closure of antra-oral fistula | 419.59 | 167.83 |
| 34.21 | Radical Maxillary antrotomy | | |
| 34.21A | With obliteration by abdominal fat graft | 415.94 | 209.65 |

## VI. OPERATIONS ON THE NOSE, MOUTH,AND PHARYNX (cont'd)

### 34 OPERATIONS ON NASAL SINUSES (cont'd)

#### 34.3 Frontal sinusotomy and sinusectomy

##### 34.32 Frontal sinusectomy

| | | BASE | ANE |
|---|---|---|---|
| 34.32A | Trephine | 240.62 | 109.21 |
| 34.32B | Intranasal | 440.60 | 148.51 |
| 34.32C | External (Lynch or Howarth type) | 674.36 | 174.72 |
| 34.32D | Osteoplastic flap with obliteration by fat or bone graft | 1,024.56 | 318.01 |

#### 34.5 Other nasal sinusectomy

##### 34.54 Ethmoidectomy

| | | | |
|---|---|---|---|
| 34.54A | Intranasal | 246.55 | 101.80 |
| | NOTE: May not be claimed in addition to HSC 21.71. | | |
| 34.54B | External | 296.97 | 165.98 |
| 34.54C | Transantral | 184.91 | 104.84 |
| | NOTE: May be claimed in addition to 34.2 A. | | |

##### 34.55 Sphenoidectomy

| | | | |
|---|---|---|---|
| 34.55A | Intranasal | 184.91 | 101.80 |
| 34.55B | Transantral | 100.45 | 34.95 |
| | NOTE: May be claimed in addition to 34.2 A. | | |

#### 34.8 Invasive diagnostic procedures on nasal sinus

##### 34.89 Other invasive diagnostic procedures on nasal sinuses

| | | | |
|---|---|---|---|
| 34.89A | Sinus endoscopy with polypectomy | 92.23 V | 110.43 |
| | NOTE: May not be claimed in addition to HSC 21.71. | | |

### 35 REMOVAL AND RESTORATION OF TEETH

#### 35.0 Forceps extraction of tooth (multiple) (single)

| | | |
|---|---|---|
| 35.0 A | Dental extraction/treatment | 55.22 V |
| | NOTE: May be claimed when performed by a physician on an emergency basis or when required as part of surgical repair of fractured mandible. | |

### 36 OTHER OPERATIONS ON TEETH, GUMS AND ALVEOLI

#### 36.9 Other dental operations

##### 36.99 Other dental operations NEC

| | | |
|---|---|---|
| 36.99AA | Anesthetic fee for dental surgery | 146.21 |
| | NOTE: May only be claimed when the conditions described in GRs 10.2 and 10.3 are met. | |
| 36.99F | Surgical assistant for dental surgery performed by oral surgeons | 148.05 |

VI. OPERATIONS ON THE NOSE, MOUTH,AND PHARYNX (cont'd)

37 OPERATIONS ON TONGUE

| | | BASE | ANE |
|---|---|---|---|
| 37.1 | Partial glossectomy | | |
| 37.1 A | Partial glossectomy | 252.94 | 154.90 |
| 37.1 B | Hemiglossectomy | 396.31 | 271.08 |
| 37.2 | Complete glossectomy | | |
| 37.2 | Complete glossectomy | 915.89 | 348.93 |
| 37.8 | Invasive diagnostic procedures on tongue | | |
| 37.81 | Needle biopsy of tongue | 37.83 V | 109.21 |
| 37.82 | Other biopsy of tongue | | |
| 37.82A | Biopsy of tongue | 40.64 V | 109.31 |
| | NOTE: A maximum of three calls may be claimed. | | |
| 37.82B | Punch biopsy of tongue | 29.68 | |
| 37.9 | Other operations on tongue | | |
| 37.91 | Lingual frenotomy | | |
| 37.91A | Release of simple tongue tie, clipping | 57.05 | 109.21 |
| 37.91B | Release of complex tongue tie | 205.00 | 128.95 |
| | That requiring Z plasty closure | | |

38 OPERATIONS ON SALIVARY GLANDS AND DUCTS

| | | | |
|---|---|---|---|
| 38.0 | Incision of salivary gland or duct | | |
| 38.0 A | Removal salivary gland calculus | 108.67 V | 110.43 |
| 38.2 | Sialoadenectomy | | |
| 38.21 | Sialoadenectomy, unqualified | | |
| 38.21A | Submandibular gland | 410.46 | 167.83 |
| 38.22 | Partial sialoadenectomy<br>Parotidectomy | | |
| 38.22A | Subtotal with preservation of facial nerve | 710.43 | 276.32 |
| 38.22B | Subtotal repeat with preservation of facial nerve | 983.01 | 388.68 |
| 38.22C | Subtotal without preservation of facial nerve | 147.02 | 109.21 |
| 38.23 | Complete sialoadenectomy<br>Parotidectomy | | |
| 38.23A | Total with preservation of facial nerve | 1,486.61 | 515.80 |
| 38.23B | Total without preservation of facial nerve | 1,041.91 | 384.39 |
| 38.8 | Invasive diagnostic procedures on salivary gland or duct | | |
| 38.89 | Other operations on salivary gland or duct NEC | | |
| 38.89A | Sublingual mucosal biopsy | 42.00 V | 110.43 |
| | NOTE: A maximum of three calls may be claimed. | | |

VI. OPERATIONS ON THE NOSE, MOUTH,AND PHARYNX (cont'd)

38 OPERATIONS ON SALIVARY GLANDS AND DUCTS (cont'd)

38.8 Invasive diagnostic procedures on salivary gland or duct (cont'd)
38.89 Other operations on salivary gland or duct NEC (cont'd)

| | BASE | ANE |
|---|---|---|
| 38.89B Injection of contrast material for sialography | 58.58 | |

39 OTHER OPERATIONS ON MOUTH AND FACE

39.2 Excision of lesion or tissue of palate
39.21 Local excision or destruction of lesion or tissue of palate

| | | |
|---|---|---|
| 39.21A Biopsy of palate | 40.64 V | 110.53 |
| NOTE: A maximum of three calls may be claimed. | | |

39.5 Palatoplasty
39.52 Correction of cleft palate

| | | |
|---|---|---|
| 39.52A Primary palate repair (alveolar cleft) | 636.92 | 221.39 |
| 39.52B Primary palate repair with bone graft (alveolar cleft) | 1,036.49 | 442.76 |
| NOTE: Includes harvesting. | | |
| 39.52C Secondary palate repair | 647.88 | 212.00 |
| 39.52D Secondary palate repair with intravelar veloplasty | 1,036.49 | 464.90 |

39.53 Revision of cleft palate repair

| | | |
|---|---|---|
| 39.53A Repeat palate reconstruction | 777.37 | 368.43 |

39.6 Operations on uvula
39.62 Excision of uvula

| | | |
|---|---|---|
| 39.62A Biopsy of uvula | 40.64 V | 110.53 |
| NOTE: A maximum of three calls may be claimed. | | |

39.8 Invasive diagnostic procedures on oral cavity
39.83 Biopsy of unspecified structure of mouth

| | | |
|---|---|---|
| 39.83A Incisional biopsy of mouth | 40.64 V | 110.53 |
| NOTE: A maximum of three calls may be claimed. | | |

39.9 Other operations on mouth and face
39.91 Labial frenotomy

| | | |
|---|---|---|
| 39.91B Labial frenotomy | 57.05 | 110.43 |
| That for clipping of frenulum of lip | | |
| 39.91C Labial frenotomy | 227.32 | 141.34 |
| That for release of frenulum of lip requiring Z plasty closure | | |

39.99 Other operations on oral cavity

| | | |
|---|---|---|
| 39.99A Removal of complicated leukoplakia | BY ASSESS | |

VI. OPERATIONS ON THE NOSE, MOUTH,AND PHARYNX (cont'd)

## 40 OPERATIONS ON TONSILS AND ADENOIDS

| | | BASE | ANE |
|---|---|---|---|
| 40.0 | **Incision and drainage of tonsil and peritonsillar structures** | | |
| 40.0 | Incision and drainage of tonsil and peritonsillar structures | 132.35 | 154.96 |
| 40.1 | **Tonsillectomy without adenoidectomy** | | |
| 40.1 | Tonsillectomy for patient 14 years of age and over | 364.80 | 202.64 |
| | NOTE: May be claimed in addition to HSC 40.5. | | |
| 40.1 A | Tonsillectomy for patient under 14 years of age | 292.21 | 200.39 |
| | NOTE: May be claimed in addition to HSC 40.5. | | |
| 40.5 | **Adenoidectomy without tonsillectomy** | | |
| 40.5 | Adenoidectomy | 82.64 V | 183.46 |
| | NOTE: May be claimed in addition to HSC 40.1 or 40.1 A. | | |
| 40.7 | **Control of hemorrhage after tonsillectomy and adenoidectomy** | | |
| 40.7 | Control of hemorrhage after tonsillectomy and adenoidectomy | 224.64 | 287.78 |
| 40.9 | **Other operations on tonsils and adenoids** | | |
| 40.92 | **Excision of lesion of tonsil and adenoid** | | |
| 40.92A | Biopsy of tonsil | 40.64 V | 109.31 |
| | NOTE: A maximum of three calls may be claimed. | | |

## 41 OPERATIONS ON PHARYNX

| | | | |
|---|---|---|---|
| 41.0 | **Pharyngotomy** | | |
| 41.0 A | Midline, Trotter | 466.16 | 203.18 |
| 41.0 B | Lateral | 656.56 | 256.18 |
| 41.0 C | Transhyoid | 421.42 | 185.51 |
| 41.1 | **Excision of branchial cleft cyst or vestiges** | | |
| 41.1 | Excision of branchial cleft cyst or vestiges | 364.35 | 165.79 |
| 41.2 | **Excision or destruction of lesion or tissue of pharynx** | | |
| 41.21 | Cricopharyngeal myotomy | 278.05 | 167.83 |
| 41.29 | **Other excision or destruction of lesion or tissue of pharynx** | | |
| 41.29A | Biopsy of nasopharynx under local anesthetic | 63.46 | |
| 41.29B | Biopsy or examination of nasopharynx | 127.84 | 110.43 |
| | NOTE: May only be claimed when performed under general anesthesia. | | |
| 41.29C | Excision nasopharyngeal tumor, via oropharynx | 193.59 | 141.34 |
| 41.29D | Excision nasopharyngeal tumor, transpalatine approach | 391.29 | 202.64 |
| 41.3 | **Plastic operation on pharynx** | | |
| 41.3 A | Pharyngoplasty | 436.94 | 202.64 |

VI. OPERATIONS ON THE NOSE, MOUTH,AND PHARYNX (cont'd)

41 OPERATIONS ON PHARYNX (cont'd)

41.3 Plastic operation on pharynx (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 41.3 B | Repair of nasopharyngeal stenosis | 347.91 | 194.35 |
| 41.3 D | Laser assisted uvulopalatoplasty (LAUP) | 436.94 | 183.46 |
| | NOTE: This benefit is only payable in cases with a proven diagnosis of obstructive sleep apnea, from an accredited sleep laboratory. | | |

41.4 Other repair of pharynx

| | | | |
|---|---|---|---|
| 41.42 | Closure of branchial cleft fistula | 395.85 | 202.64 |
| | Excision of branchial sinus or fistula | | |

## VII. OPERATIONS ON THE RESPIRATORY SYSTEM

### 42 EXCISION OF LARYNX

| | | BASE | ANE |
|---|---|---|---|
| 42.0 | Excision or destruction of lesion or tissue of larynx | | |
| 42.09 | Other excision or destruction of lesion or tissue of larynx | | |
| 42.09A | Removal of benign tumor to include laryngoscopy | 154.32 | 110.43 |
| 42.09B | Suspension, laryngoscopy | 252.94 | 154.96 |
| 42.09C | Glottic stenosis repair | 436.94 | 332.06 |
| 42.09D | Removal of complicated lesion from larynx or trachea | 330.10 | 154.96 |
| | That with suspension laryngoscopy and laser<br>NOTE: Limited to laryngeal papillomatosis, cancer of larynx or trachea or other lesions requiring a minimum of 30 minutes of laser treatment. | | |
| 42.1 | Hemilaryngectomy (anterior) (lateral) | | |
| 42.1 | Hemilaryngectomy (anterior) (lateral) | 712.26 | 265.01 |
| 42.3 | Complete laryngectomy | | |
| 42.3 A | Laryngectomy | 972.51 | 386.85 |
| 42.3 B | Laryngopharyngectomy | 1,296.22 | 388.68 |
| 42.3 C | Laryngopharyngectomy with reconstruction of phonatory mechanism - one stage | 1,130.48 | 600.70 |

### 43 OTHER OPERATIONS ON LARYNX AND TRACHEA

| | | | |
|---|---|---|---|
| 43.0 | Injection of larynx | | |
| 43.0 A | Laryngeal injection of material excluding Botulinum A Toxin | 291.30 | 182.17 |
| 43.0 B | Injection of Botulinum A Toxin, for spastic dysphonia | 110.95 | |
| | NOTE: HSC 01.03 may be claimed in addition. | | |
| 43.1 | Temporary tracheostomy | | |
| 43.1 A | Tracheostomy | 390.89 | 177.09 |
| | NOTE: May not be claimed when performed in association with any of the laryngectomy services. | | |
| 43.1 B | Emergency cricothyroidotomy | 215.98 | |
| 43.3 | Other incision of larynx or trachea | | |
| 43.3 A | Thyrotomy (laryngofissure) | 419.59 | 257.90 |
| 43.3 B | Tracheal fenestration | 268.10 | 109.31 |
| 43.3 C | Rigid laser bronchoscopy for removal of tracheal mass | 1,295.14 | 766.27 |
| | NOTE: Repeats within the 30 day post operative period may not be claimed except by anesthesia who may claim either the listed rate or the time release rate. | | |
| 43.5 | Repair of larynx | | |
| 43.54 | Repair of laryngeal fracture | 516.05 | 288.28 |
| | NOTE: Includes that with insertion of laryngeal strut. | | |
| 43.59 | Other repair of larynx | | |
| 43.59A | Arytenoidopexy or arytenoidectomy | 419.59 | 238.51 |

VII. OPERATIONS ON THE RESPIRATORY SYSTEM (cont'd)

43 OTHER OPERATIONS ON LARYNX AND TRACHEA (cont'd)

43.5 Repair of larynx (cont'd)

43.59 Other repair of larynx (cont'd)

| | BASE | ANE |
|---|---|---|
| 43.59B Meurman operation | 352.48 | 183.46 |
| 43.59C Repair of supraglottic stenosis | 908.59 | 442.76 |

43.6 Repair and plastic operations on trachea

43.63 Closure of other fistula of trachea

| | | |
|---|---|---|
| 43.63A Tracheo esophageal fistulectomy | 684.41 | 335.68 |
| 43.63B Transcervical repair of fistula | 689.89 | 257.90 |
| 43.63C Trans-thoracic repair of fistula | 879.41 | 346.13 |

43.65 Construction of artificial larynx and reconstruction of trachea (with graft)

| | | |
|---|---|---|
| 43.65C Secondary larynx tracheoesophageal puncture and valve insertion | 419.59 | 244.62 |

NOTE: May be claimed 30 days or more after laryngectomy.

43.69 Other repair and plastic operations on trachea

| | | |
|---|---|---|
| 43.69A Infraglottic stenosis repair | 908.59 | 442.76 |

43.8 Invasive diagnostic procedures on larynx and trachea

| | | |
|---|---|---|
| 43.81 Biopsy of larynx | 136.52 | 110.53 |

NOTE: Includes laryngoscopy.

| | | |
|---|---|---|
| 43.82 Biopsy of trachea | 130.56 | 109.21 |

NOTE: Includes bronchoscopy or laryngoscopy.

43.9 Other operations on larynx and trachea

43.95 Other operations on larynx

| | | |
|---|---|---|
| 43.95A Laryngeal dilation | 124.06 V | 109.21 |

NOTE: Includes laryngoscopy.

43.96 Other operations on trachea

| | | |
|---|---|---|
| 43.96A Tracheal or bronchial dilatation with rigid or flexible bronchoscope and balloon (balloon bronchoplasty) | 209.34 | 276.32 |

NOTE: 1. The anesthetic rate for 43.96A may not be claimed in addition to an anesthetic rate for any other service.
2. Benefit includes bronchoscopy.

| | | |
|---|---|---|
| 43.96B Electrosection and dilatation of tracheal or bronchial web stenosis | 300.69 | 276.32 |

NOTE: 1. The anesthetic rate for 43.96B may not be claimed in addition to an anesthetic rate for any other service.
2. Benefit includes bronchoscopy.

VII. OPERATIONS ON THE RESPIRATORY SYSTEM (cont'd)

43 OTHER OPERATIONS ON LARYNX AND TRACHEA (cont'd)

43.9 Other operations on larynx and trachea (cont'd)

43.96 Other operations on trachea (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 43.96C | Placement of self-expandable metal endotracheal or endobronchial stent<br>NOTE: 1. The anesthetic rate for 43.96C may not be claimed in addition to an anesthetic rate for any other service.<br>2. Benefit includes bronchoscopy. | 273.71 | 265.01 |
| 43.96D | Placement of silicone endotracheal or endobronchial stent under general anesthetic<br>NOTE: 1. The anesthetic rate for 43.96D may not be claimed in addition to an anesthetic rate for any other service.<br>2. Benefit includes bronchoscopy. | 276.54 | 265.01 |
| 43.96E | Placement of intratracheal or intrabronchial brachytherapy catheter, additional benefit<br>NOTE: May only be claimed in addition to 01.09. | 68.16 | |

44 EXCISION OF BRONCHUS AND LUNG

| | | | |
|---|---|---|---|
| 44.0 | Local excision or destruction of lesion or tissue of bronchus | | |
| 44.01 | Endoscopic excision or destruction of lesion or tissue of bronchus<br>That with removal of tumor<br>NOTE: Includes bronchoscopy. | 214.24 | 141.34 |
| 44.09 | Other local excision or destruction of lesion or tissue of bronchus | | |
| 44.09A | Bronchotomy for removal of tumor | 617.34 | 279.56 |
| 44.1 | Other excision of bronchus | | |
| 44.19 | Other excision of bronchus<br>Resection (wide sleeve) of bronchus | 1,396.71 | 728.72 |
| 44.2 | Local excision or destruction of lesion or tissue of lung | | |
| 44.21 | Plication of emphysematous bleb<br>Blebectomy | 775.95 | 382.58 |
| 44.22 | Endoscopic excision or destruction of lesion or tissue of lung | | |
| 44.22A | With laser resections<br>NOTE: 1. Includes bronchoscopy.<br>2. Includes subsequent resections within 30 days. | 495.70 | 147.37 |
| 44.3 | Segmental resection of lung (basilar)(superior) | | |
| 44.3 A | Segmental resection of lung (basilar) (superior) | 1,034.60 | 478.95 |
| 44.3 B | Wedge resection of lung or open lung biopsy | 775.95 | 354.21 |
| 44.4 | Lobectomy of lung | | |
| 44.4 A | Lobectomy of lung | 1,034.60 | 531.31 |

VII. OPERATIONS ON THE RESPIRATORY SYSTEM (cont'd)

## 44 EXCISION OF BRONCHUS AND LUNG (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 44.4 | Lobectomy of lung (cont'd) | | |
| 44.4 B | Bilobectomy | 1,241.52 | 686.28 |
| 44.4 C | Sleeve lobectomy | 1,396.71 | 698.88 |
| 44.5 | Complete pneumonectomy | | |
| 44.5 A | Pneumonectomy, complete | 1,034.60 | 553.46 |
| 44.5 B | Completion pneumonectomy | 1,241.52 | 489.21 |
| 44.5 C | Sleeve pneumonectomy | 1,858.98 | 698.88 |

## 45 OTHER OPERATIONS ON BRONCHUS AND LUNG

| | | | |
|---|---|---|---|
| 45.0 | Incision of bronchus | | |
| 45.0 A | Bronchotomy for removal of foreign body | 678.47 | 279.56 |
| 45.1 | Incision of lung | | |
| 45.1 A | Drainage, lung abscess | 425.22 | 192.20 |
| 45.1 B | Pneumonotomy, removal of foreign body | 672.49 | 273.27 |
| 45.4 | Repair and plastic operations on bronchus and lung | | |
| 45.42 | Closure of bronchial fistula | | |
| 45.42A | Repair bronchopleural fistula, post surgical | 620.76 | 611.52 |
| 45.43 | Other repair and plastic operation on bronchus<br>Bronchoplasty | 517.30 | 270.82 |
| 45.5 | Lung transplant | | |
| 45.5 A | Lung transplant<br>With recipient pneumonectomy<br>NOTE: 1. May be claimed with HSC 49.5 A.<br>2. When performed as a bilateral procedure and/or when claimed in addition to HSC 49.5A, the procedural benefit may be claimed at 100% for both lungs. This does not apply to the anesthetic rate. | 4,938.44 | 1,389.47 |
| 45.5 B | Donor pneumonectomy | 1,910.38 | 366.90 |
| 45.6 | Combined heart-lung transplantation | | |
| 45.6 B | Donor heart/lung resection | 2,387.12 | 724.36 |
| 45.8 | Invasive diagnostic procedures on bronchus and lung | | |
| 45.81 | Biopsy of bronchus by bronchoscopy | | |
| 45.81A | Biopsy of bronchus | 117.55 V | 109.21 |
| 45.83 | Percutaneous (needle) biopsy of lung | 69.75 V | 109.21 |
| 45.84 | Other biopsy of lung | | |
| 45.84A | Aspiration or trephine lung biopsy under fluoroscopic guidance | 102.51 V | 131.04 |
| 45.84B | Diagnostic lung biopsy performed with other thoracic surgery as a planned procedure | 115.88 | 52.42 |

VII. OPERATIONS ON THE RESPIRATORY SYSTEM (cont'd)

45 OTHER OPERATIONS ON BRONCHUS AND LUNG (cont'd)

45.8 Invasive diagnostic procedures on bronchus and lung (cont'd)

45.86 Other contrast bronchogram

| | | BASE | ANE |
|---|---|---|---|
| 45.86A | Instillation of opaque material | 54.23 | 109.21 |

45.88 Other invasive diagnostic procedures on lung

| | | | |
|---|---|---|---|
| 45.88A | Trans-bronchial biopsy of lung, additional benefit<br>NOTE: May only be claimed in addition to HSC 01.09. | 87.29 | 61.15 |

46 OPERATIONS ON CHEST WALL, PLEURA, MEDIASTINUM, AND DIAPHRAGM

46.0 Incision of chest wall and pleura

| | | | |
|---|---|---|---|
| 46.02 | Exploratory thoracotomy | 406.73 | 221.05 |

46.03 Reopening of recent thoracotomy site
NOTE: 1. Patient must have left both operating room suite and post anesthetic (recovery) room.
2. Redo modifier does NOT apply to these services.

| | | | |
|---|---|---|---|
| 46.03A | Reoperation for bleeding following thoracic surgery | 370.32 | 243.51 |
| 46.03B | Rewiring of sternum, irrigation or debridement of mediastinum with removal of intracardiac lines | 606.97 | 257.90 |

46.04 Insertion of intercostal catheter (with water seal) for drainage

| | | | |
|---|---|---|---|
| 46.04A | Tube thoracostomy<br>For conditions other than empyema or effusion | 90.34 | 110.43 |
| 46.04B | Tube thoracostomy<br>For empyema or effusion | 116.00 V | 110.53 |
| 46.04C | Installation of thrombolytics into pleural space for lysis of complex pleural adhesions | 43.27 | |

46.09 Other incision of pleura

| | | | |
|---|---|---|---|
| 46.09A | Open drainage, includes rib resection | 257.25 | 139.77 |
| 46.09B | Placement of tunneled pleural catheter | 206.93 V | 155.43 |
| 46.09C | Removal of tunneled pleural catheter | 116.63 V | 110.53 |

46.1 Incision of mediastinum

| | | | |
|---|---|---|---|
| 46.1 A | With removal of foreign body from mediastinum | 739.99 | 346.13 |
| 46.1 B | Anterior mediastinotomy (Chamberlain) | 310.38 | 165.79 |

46.2 Excision or destruction of lesion or tissue of mediastinum

| | | | |
|---|---|---|---|
| 46.2 A | Mediastinotomy with removal of cyst or tumor | 775.95 | 346.13 |

46.3 Excision or destruction of lesion of chest wall

| | | | |
|---|---|---|---|
| 46.3 A | Resection of chest wall, minor (one rib) | 310.38 | 184.21 |
| 46.3 B | Resection of chest wall, major (two ribs or more) | 619.66 | 313.17 |

VII. OPERATIONS ON THE RESPIRATORY SYSTEM (cont'd)

46 OPERATIONS ON CHEST WALL, PLEURA, MEDIASTINUM, AND DIAPHRAGM (cont'd)

| | BASE | ANE |
|---|---|---|
| 46.3 Excision or destruction of lesion of chest wall (cont'd) | | |
| 46.3 C Resection of chest wall, major with prosthesis | 1,034.60 | 331.58 |
| 46.4 Pleurectomy | | |
| 46.41 Decortication of lung | | |
| 46.41A Partial, total, at least one lobe | 724.22 | 354.21 |
| 46.49 Other excision of pleura | | |
| 46.49A Pleurectomy, parietal | 413.84 | 354.21 |
| 46.5 Scarification of pleura | | |
| 46.5 A Thoracoscopy with poudrage and catheter drainage | 103.46 | 131.04 |
| 46.6 Repair of chest wall | | |
| 46.64 Repair of pectus deformity | | |
| 46.64A Minor | 243.37 | 265.65 |
| 46.64B Major | 728.54 | 376.34 |
| 46.8 Invasive diagnostic procedures on chest wall, pleura, mediastinum and diaphragm | | |
| 46.81 Thoracoscopy | | |
| 46.81A Transpleural | 103.46 | 109.21 |
| NOTE: Includes biopsy. | | |
| 46.82 Mediastinoscopy | 258.65 | 147.37 |
| 46.84 Pleural biopsy | | |
| 46.84A Needle biopsy of pleura | 65.13 V | 109.21 |
| 46.88 Other invasive diagnostic procedures on chest wall, pleura and diaphragm | | |
| 46.88A Insertion of catheters and injection of dye | 50.10 | |
| That for sinograms or fistulograms, single or multiple studies | | |
| 46.9 Other operations on thorax | | |
| 46.91 Thoracentesis | 65.51 V | |
| NOTE: A repeat performed within 31 days is payable at a reduced rate. Refer to Price List. | | |

## VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM

### 47 OPERATIONS ON VALVES AND SEPTA OF HEART

| | | BASE | ANE |
|---|---|---|---|
| 47.0 | Closed heart valvotomy | | |
| 47.02 | Closed heart valvotomy, mitral valve | | |
| 47.02A | Closed heart valvotomy, mitral valve | 1,751.03 | 559.10 |
| 47.02B | Percutaneous mitral valvuloplasty | 1,312.50 | |
| | NOTE: Includes related catheterization procedures performed at the same time. | | |
| 47.02C | Mitral valve repair through mini thoracotomy | 2,264.82 | 1,008.83 |
| 47.03 | Closed heart valvotomy, aortic valve | | |
| 47.03A | Percutaneous aortic valvuloplasty | 980.00 | 587.40 |
| | NOTE: Includes related catheterization procedures performed at the same time. | | |
| 47.04 | Closed heart valvotomy, pulmonary valve | 1,113.35 | 708.42 |
| 47.1 | Open heart valvuloplasty without replacement | | |
| 47.12 | Open heart valvuloplasty of mitral valve, without replacement | | |
| 47.12A | Open heart valvuloplasty of mitral valve, without replacement | 1,698.62 | 700.02 |
| 47.12B | Reconstruction | 2,183.29 | 1,008.83 |
| 47.13 | Open heart valvuloplasty of aortic valve, without replacement | | |
| 47.13A | Open heart valvuloplasty of aortic valve, without replacement | 1,698.62 | 663.94 |
| 47.13B | Reconstruction aortic valve | 2,183.29 | 1,008.83 |
| 47.13C | Valvulotomy | 1,797.13 V | 943.48 |
| | NOTE: Age modifier required, refer to Price List. | | |
| 47.14 | Open heart valvuloplasty of tricuspid valve, without replacement | | |
| 47.14A | Open heart valvuloplasty of tricuspid valve, without replacement | 1,698.62 | 663.94 |
| 47.14B | Reconstruction tricuspid valve | 2,183.29 | 1,008.83 |
| 47.15 | Open heart valvuloplasty of pulmonary valve, without replacement | | |
| 47.15A | Open heart valvuloplasty of pulmonary valve, without replacement | 1,592.17 | 663.94 |
| 47.15B | Reconstruction pulmonary valve | 2,183.29 | 1,043.62 |
| 47.15C | Valvulotomy pulmonary valve | 1,818.65 V | 926.03 |
| | NOTE: Age modifier required, refer to Price List. | | |
| 47.2 | Valvuloplasty with replacement of heart valve | | |
| 47.23 | Other replacement of mitral valve | | |
| 47.23A | Mitral valve replacement | 1,862.81 | 663.75 |
| 47.23B | Mitral valve replacement through mini thoracotomy | 2,275.17 | 1,008.83 |
| 47.25 | Other replacement of aortic valve | | |
| 47.25A | Stented aortic valve replacement | 1,862.81 | 692.26 |
| 47.25C | Stentless aortic valve replacement | 3,099.41 | 995.91 |
| 47.25B | Valve conduit repair or replacement of the aortic valve and ascending aorta with reimplantation of the coronary arteries Associated with non-ruptured aortic aneurysm | 3,033.73 | 1,007.03 |
| 47.25D | Valve conduit repair or replacement of aortic valve and ascending aorta with reimplantation of the coronary arteries Associated with ruptured aortic aneurysm or aortic dissection | 4,200.11 | 1,669.80 |

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

47 OPERATIONS ON VALVES AND SEPTA OF HEART (cont'd)

47.2 Valvuloplasty with replacement of heart valve (cont'd)

47.25 Other replacement of aortic valve (cont'd)

| | BASE | ANE |
|---|---|---|
| 47.25E Transcatheter aortic valve replacement (TAVR) | 1,714.56 | 692.26 |

47.27 Other replacement of tricuspid valve

| | | |
|---|---|---|
| 47.27A Tricuspid valve replacement | 1,862.81 | 663.75 |

47.29 Other replacement of pulmonary valve

| | | |
|---|---|---|
| 47.29A Pulmonary valve replacement | 1,862.81 | 663.75 |
| 47.29B Transcatheter pulmonary valve replacement | 2,100.00 | 1,591.91 |

47.3 Operations on structures adjacent to valves

47.39 Operations on other structures adjacent to valves of heart

| | | |
|---|---|---|
| 47.39A Repair of sinus of valsalva<br>That for aneurysm/fistula | 1,698.62 | 663.94 |

47.4 Production of septal defect in heart

47.42 Enlargement of existing atrial septal defect

| | | |
|---|---|---|
| 47.42A Balloon atrial septostomy<br>NOTE: May be claimed in addition to cardiac catheterization. | 279.55 | 148.51 |

47.5 Repair of atrial and ventricular septa with prosthesis

47.54 Repair of ventricular septal defect with prosthesis

| | | |
|---|---|---|
| 47.54A Septation of single ventricle | 2,183.29 | 926.03 |
| 47.54B Closure of VSD with prosthesis | 1,940.95 | 926.03 |

47.55 Repair of endocardial cushion defect with prosthesis

| | | |
|---|---|---|
| 47.55A Atrial ventricular canal | 2,183.29 | 936.36 |
| 47.55B Primum atrial septal defect to include mitral valve reconstruction | 1,940.95 | 936.36 |
| 47.55C Sinus venosus ASD plus partial anomalous pulmonary venous drainage | 1,940.95 | 926.03 |

47.7 Other and unspecified repair of atrial and ventricular septa

47.72 Other and unspecified repair of atrial septal defect

| | | |
|---|---|---|
| 47.72A Closure of atrial septal defect (secundum) | 1,577.45 | 856.13 |
| 47.72B Closure of ASD<br>NOTE: May be claimed when performed with another procedure. | 423.52 | 109.21 |
| 47.72C Percutaneous closure, atrial septal defect | 1,225.00 | 571.06 |

NOTE:
1. Benefit includes other angiograms and cardiac catheterizations performed on the same date of service.
2. May not be claimed in association with angiocardiography (HSC 48.92A, 48.98A, 48.98B) or trans-esophageal echocardiography (HSC 02.82A).
3. For each additional occlusion device, refer to Price List.
4. Role modifier ASIC may be claimed for assistance by a second interventional cardiologist.

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

47 OPERATIONS ON VALVES AND SEPTA OF HEART (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 47.8 | Total repair of certain congenital cardiac anomalies | | |
| 47.81 | Total repair of tetralogy of Fallot | 1,940.95 | 926.03 |
| 47.82 | Total repair of total anomalous pulmonary venous connection | 2,183.29 | 926.03 |
| 47.83 | Total repair of truncus arteriosus | | |
| 47.83A | Total repair of truncus arteriosus | 2,027.01 | 954.03 |
| 47.83B | Closure of aortopulmonary window | 1,940.95 | 926.03 |
| 47.84 | Total correction of transposition of great vessels NEC | | |
| 47.84A | Arterial switch procedure for transposition of great vessels including repair of ASD | 2,669.09 | 1,252.35 |
| 47.9 | Other operations on valves and septa of heart | | |
| 47.91 | Interatrial transposition of venous return | | |
| 47.91A | Atrial switch procedure for transposition of great vessels | 2,027.01 | 926.03 |
| 47.92 | Creation of conduit between right ventricle and pulmonary artery | | |
| 47.92A | Correction of pulmonary atresia for subpulmonic stenosis | 2,183.29 | 926.03 |
| 47.92B | Remodelling of outflow tract to right ventricle | 2,183.29 | 926.03 |
| 47.92C | Removal of pulmonary artery banding and reconstruction of pulmonary artery | 2,183.29 | 926.03 |
| 47.93 | Creation of conduit between left ventricle and aorta | | |
| 47.93A | Remodelling of outflow tract to left ventricle<br>For subaortic membrane/band/perivalvular abscess/cavity/severe distortion/hypoplasia | 2,183.29 | 926.03 |
| 47.93B | Remodeling of outflow tract to left ventricle<br>For asymmetric septal hypertrophy | 2,649.84 | 1,051.90 |
| 47.95 | Other operations on septa of heart | | |
| 47.95A | Excision of intraatrial membrane<br>Cor triatriatum | 1,940.95 | 926.03 |

48 OPERATIONS ON VESSELS OF HEART

| | | | |
|---|---|---|---|
| 48.0 | Removal of coronary artery obstruction | | |
| 48.0 A | Endarterectomy<br>NOTE: A maximum of four calls may be claimed. | 303.49 | 109.21 |
| 48.1 | Bypass anastomosis for heart revascularization | | |
| 48.12 | Aortocoronary bypass of one coronary artery | 1,577.45 | 593.51 |
| 48.12A | Aortocoronary bypass of one coronary artery without cardiopulmonary bypass. | 2,021.35 | 803.23 |
| 48.13 | Aortocoronary bypass of two coronary arteries | 1,850.36 | 655.61 |
| 48.13A | Aortocoronary bypass of two coronary arteries without cardiopulmonary bypass | 2,294.26 | 820.54 |
| 48.14 | Aortocoronary bypass of three coronary arteries | 2,123.27 | 764.55 |
| 48.14A | Aortocoronary bypass of three coronary arteries without cardiopulmonary bypass | 2,568.31 | 960.00 |

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

48 OPERATIONS ON VESSELS OF HEART (cont'd)

48.1 Bypass anastomosis for heart revascularization (cont'd)

48.15 Aortocoronary bypass of four or more coronary arteries

| | | BASE | ANE |
|---|---|---|---|
| 48.15A | Of four coronary arteries | 2,397.31 | 819.51 |
| 48.15E | Aortocoronary bypass of four coronary arteries without cardiopulmonary bypass | 2,663.43 | 1,124.44 |
| 48.15B | Of five coronary arteries | 2,670.22 | 921.07 |
| 48.15F | Aortocoronary bypass of five coronary arteries without cardiopulmonary bypass | 2,932.69 | 1,061.02 |
| 48.15C | Of six coronary arteries | 2,943.13 | 971.70 |
| 48.15G | Aortocoronary bypass of six coronary arteries without cardiopulmonary bypass | 3,370.66 | 1,182.78 |
| 48.15D | Of seven coronary arteries | 2,986.17 | 1,078.42 |
| 48.15H | Aortocoronary bypass of seven coronary arteries without cardiopulmonary bypass | 3,642.53 | 1,269.75 |

48.19 Other bypass anastomosis for heart revascularization

48.19A Preparation of the internal mammary/gastroepiploic artery for coronary artery bypass grafting, additional benefit — 303.49 — 109.21
NOTE: A maximum of three calls applies.

48.9 Other operations on vessels of heart

48.92 Angiocardiography, unqualified

48.92A Selective angiocardiogram — 91.00
NOTE: May be claimed in addition to cardiac catheterization.

48.98 Other coronary arteriography
DEFINITION: Cannulation and angiography of the right and left coronary arteries.

48.98A Selective angiography of aortocoronary vein bypass graft, per graft — 105.00
Note: May not be claimed in addition to HSCs 50.91D or 50.91E.

48.98B Coronary angiography — 288.75
NOTE: May not be claimed in addition to HSCs 50.91D or 50.91E.

49 OTHER OPERATIONS ON HEART AND PERICARDIUM

49.0 Pericardiocentesis

49.0 Pericardiocentesis — 218.04 V — 110.53
NOTE: If a repeat service occurs within 14 days, benefit will be modified, refer to Price List.

49.1 Cardiotomy and pericardiotomy

| | | | |
|---|---|---|---|
| 49.12 | Cardiotomy | 570.73 | 314.50 |
| 49.12B | Cardiotomy with infarctectomy and reconstruction of ventricular wall<br>For post-infarction, ventricular rupture or repair of ventricular septal defect | 2,982.77 | 1,461.07 |

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

49 OTHER OPERATIONS ON HEART AND PERICARDIUM (cont'd)

49.1 Cardiotomy and pericardiotomy (cont'd)

49.13 Pericardiotomy

| | BASE | ANE |
|---|---|---|
| 49.13A Drainage, repair and insufflation | 322.22 | 273.84 |

49.2 Pericardiectomy

| | | |
|---|---|---|
| 49.2 A Parietal pericardiectomy | 972.82 | 708.42 |
| 49.2 B Visceral pericardiectomy for chronic pericardial constriction | 3,187.73 | 1,635.01 |

49.3 Excision of lesion of heart

| | | |
|---|---|---|
| 49.31 Excision of aneurysm of heart | 1,698.62 | 733.83 |
| 49.39 Excision of other lesion of heart | 1,698.62 | 663.94 |
| 49.39B Removal of atrial tumor or other lesion within or on the left or right atrium | 1,698.62 | 926.03 |
| 49.39C Removal of ventricular tumor with reconstruction of ventricular wall | 2,982.77 | 995.91 |

49.4 Repair of heart and pericardium

| | | |
|---|---|---|
| 49.4 A Cardiorrhaphy | 534.50 | 288.28 |
| 49.4 B Suture of (traumatic) laceration of heart | 1,698.62 | 671.35 |
| 49.4 C Coronary arterioplasty, additional benefit | 371.43 | 148.51 |

49.5 Heart transplantation

| | | |
|---|---|---|
| 49.5 A Heart transplantation, including recipient cardiectomy<br>NOTE: For heart/lung transplantation, may be claimed with HSC 45.5 A. | 5,312.14 | 1,669.80 |
| 49.5 B Donor cardiectomy | 1,910.38 | 419.33 |

49.6 Implantation of heart assist system

49.61 Implant of pulsation balloon

| | | |
|---|---|---|
| 49.61A Graft placement for intra aortic balloon pumping including removal | 483.54 | 192.20 |
| 49.61B Percutaneous insertion of intra aortic balloon pump to include removal<br>NOTE: When performed in conjunction with other procedures fee will be modified, refer to Price List. | 245.00 V | |

49.62 Implantation of other heart assist system

| | | |
|---|---|---|
| 49.62A Implantation of left or right ventricular assist device, temporary | 1,152.79 | 553.46 |
| 49.62B Implantation of left or right ventricular assist device, permanent | 5,203.42 | 2,487.30 |

49.64 Removal of heart assist system

| | | |
|---|---|---|
| 49.64A Removal of permanent left ventricular assist device or right ventricular assist device | 3,187.73 | 1,635.01 |

49.7 Implantation of cardiac pacemaker system

| | | |
|---|---|---|
| 49.7 A Insertion of AV sequential pacemaker | 560.00 | 239.49 |
| 49.7 F Insertion of AV sequential pacemaker, two lead | 533.75 | 239.49 |
| 49.7 G Insertion of AV sequential pacemaker, 3 lead | 883.75 | 478.95 |
| 49.7 H Insertion of AV sequential pacemaker, 4 lead | 1,193.50 | 524.16 |
| 49.7 J Implantation of automatic internal cardioverter defibrillator - single RV lead | 558.25 | 464.90 |

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

49 OTHER OPERATIONS ON HEART AND PERICARDIUM (cont'd)

49.7 Implantation of cardiac pacemaker system (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 49.7 JA | Single chamber (right ventricular) implantable cardioverter defibrillator, insertion and testing | 1,039.50 | 783.36 |
| | NOTE: 1. May only be claimed by cardiologists or thoracic surgeons. 2. May not be claimed in addition to electrophysiology studies (HSCs 49.98AA through 49.98Y). | | |
| 49.7 K | Implantation of automatic internal cardioverter defibrillator - atrial and right ventricular lead | 913.50 | 575.58 |
| 49.7 KA | Dual chamber implantable cardioverter defibrillator insertion and testing | 1,302.00 | 965.53 |
| | NOTE: 1. May only be claimed by cardiologists or thoracic surgeons. 2. May not be claimed in addition to electrophysiology studies (HSCs 49.98AA through 49.98Y). | | |
| 49.7 L | Implantation of automatic internal cardioverter defibrillator - right ventricular and left ventricular lead | 900.23 | 575.58 |
| 49.7 LA | Cardiac resynchronization defibrillator insertion without atrial lead and testing | 1,739.50 | 965.53 |
| | NOTE: 1. May only be claimed by cardiologists or thoracic surgeons. 2. May not be claimed in addition to electrophysiology studies (HSCs 49.98AA through 49.98Y). | | |
| 49.7 M | Implantation of automatic internal cardioverter defibrillator - atrial, right ventricular and left ventricular leads | 1,172.50 | 708.42 |
| 49.7 MA | Cardiac resynchronization defibrillator insertion and testing | 1,995.00 | 1,450.90 |
| | NOTE: 1. May only be claimed by cardiologists or thoracic surgeons. 2. May not be claimed in addition to electrophysiology studies (HSCs 49.98AA through 49.98Y). | | |
| 49.7 N | Percutaneous venoplasty for lead placement | 596.75 | 455.45 |
| | NOTE: 1. May only be claimed by cardiologists or thoracic surgeons. 2. May be claimed in addition to HSCs 49.7 A, 49.7 F, 49.7 G, 49.7 H, 49.7 JA, 49.7 KA, 49.7 LA and 49.7 MA. | | |
| 49.7 C | Transthoracic pacemaker | 842.51 | 294.73 |
| 49.7 D | Transvenous pacemaker, permanent | 329.00 | 165.79 |
| 49.7 E | Subxiphoid epicardial pacemaker | 662.46 | 221.05 |

49.73 Implantation of endocardial electrodes

| | | | |
|---|---|---|---|
| 49.73A | Temporary right heart catheter pacemaker | 131.25 | |
| | NOTE: Claims for temporary insertion of a pacemaker in conjunction with other cardiac procedures are included. | | |

49.8 Removal or replacement of implanted cardiac pacemaker

| | | | |
|---|---|---|---|
| 49.81 | Replacement of myocardial electrodes | 225.35 | 141.34 |

49.82 Replacement of endocardial electrodes

| | | | |
|---|---|---|---|
| 49.82A | Replacement of endocardial electrodes | 210.00 | 147.37 |
| 49.82B | Replacement of temporary right heart catheter pacemaker | 98.22 V | 109.21 |

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

49 OTHER OPERATIONS ON HEART AND PERICARDIUM (cont'd)

49.8 Removal or replacement of implanted cardiac pacemaker (cont'd)

49.83 Replacement of pulse generator

| | | BASE | | ANE |
|---|---|---|---|---|
| 49.83A | Adjustment of pacemaker | 50.11 | V | |
| 49.84 | Replacement of battery | | | |
| 49.84 | Replacement of battery | 213.50 | | 147.37 |
| 49.84B | Replacement of automatic internal cardioverter defibrillator battery | 502.25 | | 276.32 |
| 49.85 | Removal of myocardial electrodes | | | |
| 49.85 | Removal of myocardial electrode, per electrode, with or without new lead or pacemaker insertion | 223.08 | | 139.77 |
| 49.86 | Removal of endocardial electrodes | | | |
| 49.86 | Removal of endocardial electrode, per electrode, with or without new lead or pacemaker insertion | 227.50 | | 141.34 |
| 49.86B | Lead extraction requiring use of extractor sheath, per lead | 2,030.00 | | 960.96 |
| 49.87 | Removal of cardiac pacemaker system without replacement | | | |
| 49.87A | Removal of pacemaker from site other than new implant site | 224.00 | | 110.53 |
| 49.87B | Removal of automatic internal cardioverter defibrillator from site other than new implant site | 292.16 | | 123.67 |
| 49.9 | Other operations on heart and pericardium | | | |
| 49.9 A | Open heart surgery, not elsewhere classified | 1,698.62 | | 751.29 |
| 49.91 | Open chest cardiac massage | 303.49 | | |
| 49.93 | Biopsy of heart | | | |
| 49.93A | Percutaneous right ventricular endomycardial biopsy<br>NOTE: May be claimed in addition to cardiac catheterization. | 299.25 | | |
| 49.95 | Right cardiac catheterization<br>DEFINITION: Insertion and placement of a catheter into the right heart, to include the recording of oxygen saturations, by whatever methods, and the recording of pressures. | | | |
| 49.95A | Right cardiac catheterization with fluoroscopy<br>NOTE: May not be claimed in addition to HSCs 50.94D and 50.95A. | 201.25 | | 199.24 |

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

49 OTHER OPERATIONS ON HEART AND PERICARDIUM (cont'd)

49.9 Other operations on heart and pericardium (cont'd)

49.96 Left cardiac catheterization
DEFINITION: Insertion and placement of a catheter into the left heart, by whatever route, to include the recording of oxygen saturations, by whatever methods, and the recording of pressures.

| | | BASE | ANE |
|---|---|---|---|
| 49.96A | Left cardiac catheterization with fluoroscopy | 266.00 | |
| 49.96B | Trans-septal heart catheterization with fluoroscopy | 315.00 | |

DEFINITION: Insertion and placement of the catheter into the left atrium by puncture of the fossa Ovalis.
NOTE: May not be claimed in addition to HSCs 49.98AA, 49.98AB and 49.98AC.

49.98 Other invasive diagnostic procedures on heart and pericardium

| | | | |
|---|---|---|---|
| 49.98B | Pharmacological manipulation of physiological function and recording thereof | 61.62 | |

NOTE: 1. May be claimed in addition to cardiac catheterization.
2. May only be claimed once per day, per patient, per physician.

| | | | |
|---|---|---|---|
| 49.98C | Physical manipulation of physiological function and recording thereof | 61.62 | |

NOTE: 1. May be claimed in addition to cardiac catheterization.
2. May only be claimed once per day, per patient, per physician.

| | | | |
|---|---|---|---|
| 49.98D | Electrical manipulation of physiological function and recording thereof | 61.62 | |

NOTE: 1. May be claimed in addition to cardiac catheterization.
2. May only be claimed once per day, per patient, per physician.

| | | | |
|---|---|---|---|
| 49.98E | Cardiac mapping and surgical control (with or without use of cryoprobe of ventricular or supraventricular tachycardia) | 2,426.75 | 865.70 |

NOTE: May be claimed when performed in association with 48.98P by another physician.

| | | | |
|---|---|---|---|
| 49.98X | Surgical treatment of atrial fibrillation (Cox-Maze procedure) | 3,057.51 | 1,635.01 |

Electrophysiology Studies:

| | | | |
|---|---|---|---|
| 49.98AA | Diagnostic Electrophysiological (EP) study with or without Drug challenge AV node ablation or defibrillation testing | 665.00 | |

NOTE: 1. May not be claimed in addition to HSC 49.96B.
2. Refer to the notes following 49.98Y.

| | | | |
|---|---|---|---|
| 49.98AB | Complex ablation of arrhythmic substrate(s) | 2,222.50 | |

NOTE: 1. May not be claimed in addition to HSC 49.96B.
2. Refer to the notes following 49.98Y.

| | | | |
|---|---|---|---|
| 49.98AC | Standard ablation of arrhythmic substrate | 1,225.00 | |

NOTE: 1. May not be claimed in addition to HSC 49.96B.
2. Refer to the notes following 49.98Y.

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

49 OTHER OPERATIONS ON HEART AND PERICARDIUM (cont'd)

49.9 Other operations on heart and pericardium (cont'd)

Electrophysiology Studies: (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 49.98P | Intra-operative electrophysiologic studies . . . . . | 539.00 | |
| | NOTE: 1. May be claimed in addition to elements of electrophysiologic study. 2. Refer to the notes following 49.98Y. | | |
| 49.98Q | Noninvasive evaluation of cardiac pacemaker implanted for clinical bradyarrhythmia . . . . . | 54.10 | |
| | NOTE: Refer to the notes following 49.98Y. | | |
| 49.98R | Implanted for treatment of tachyarrhythmia . . . . . | 122.50 | |
| | NOTE: Refer to the notes following 49.98Y. | | |
| 49.98S | Interrogation of implanted cardioverter/defibrillator device . . . . . | 54.25 | |
| | NOTE: Refer to the notes following 49.98Y. | | |
| 49.98T | Interpretation of transtelephonic ECG or rhythm strip . . . . . | 10.62 | |
| | NOTE: Refer to the notes following 49.98Y. | | |
| 49.98U | Tilt table testing for evaluation of syncope (includes pharmacologic manipulation plus intra-arterial BP monitoring) . . . . . | 326.12 | |
| | NOTE: Refer to the notes following 49.98Y. | | |
| 49.98Y | Cardioversion . . . . . | 66.50 | |
| | NOTE: 1. These are not to be claimed in association with HSCs outside of the electrophysiology studies (EPS) section. 2. These may only be claimed when performed in a hospital. 3. HSC 49.98Y may only be claimed when performed with EPS HSCs (49.98AA through 49.98U). When it is not performed with EPS, then HSC 13.72A should be claimed. | | |
| 49.98W | Second operator at complicated EP studies per 15 minutes or major portion thereof . . . . . | 48.26 | |
| 49.99A | Transesophageal echocardiography guidance for percutaneous procedures, per 30 minutes or major portion thereof . . . . . | 136.50 | |
| | NOTE: 1. May not be claimed in addition to HSC 02.82A. 2. May not be claimed by the surgeon. | | |
| 49.99AA | Intraoperative trans-esophageal echocardiography, procedure and interpretation . . . . . | 135.92 | |
| | NOTE: May not be claimed by the surgeon if performed intraoperatively. | | |

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

50 INCISION, EXCISION, AND OCCLUSION OF VESSELS

50.0 Incision of vessel (embolectomy, exploration, thrombectomy)

50.01 Incision of intracranial vessels

| | BASE | ANE |
|---|---|---|
| 50.01A Intracranial arteriotomy under micro dissection | 2,282.19 | 689.02 |
| 50.03 Incision of upper limb vessels | | |
| 50.03A Venous thrombectomy | 343.35 | 221.05 |
| 50.03B Embolectomy or arteriothrombectomy | 464.84 | 221.05 |
| 50.04 Incision of aorta | | |
| 50.04A Embolectomy or arteriothrombectomy | 590.20 | 209.65 |
| 50.05 Incision of other thoracic vessels | | |
| 50.05A Pulmonary embolectomy (acute) | 1,543.47 | 803.71 |
| 50.06 Incision of abdominal arteries | | |
| 50.06A Embolectomy or arteriothrombectomy | 1,128.92 | 257.90 |
| 50.07 Incision of abdominal veins | | |
| 50.07A Venous thrombectomy | 342.25 | 192.20 |
| 50.08 Incision of lower limb vessels | | |
| 50.08A Embolectomy or arteriothrombectomy of femoral arteries | 752.61 | 221.05 |
| 50.08AA Embolectomy or arteriothrombectomy of popliteal/tibial arteries | 1,003.48 | 554.81 |
| 50.08B Venous thrombectomy | 348.94 | 203.18 |
| 50.09 Incision of vessel, unspecified site | | |
| 50.09A Embolectomy or arteriothrombectomy | 576.32 | 203.18 |
| 50.09B Venous thrombectomy | 579.35 | 192.20 |

50.1 Endarterectomy

| | | |
|---|---|---|
| 50.12 Endarterectomy of other vessels of head and neck | | |
| 50.12A Carotid endarterectomy | 1,594.35 | 376.34 |
| 50.12B Carotid endarterectomy with patch repair | 1,505.22 | 796.97 |
| 50.12C Carotid subclavian reconstruction - any method | 1,505.22 | 554.81 |
| 50.12D Carotid-carotid reconstruction - any method | 1,505.22 | 1,163.41 |
| 50.14 Endarterectomy, aorta | 1,013.68 | 244.62 |
| 50.15 Endarterectomy of other thoracic vessels | | |
| 50.15A Pulmonary endarterectomy and embolectomy (chronic) | 5,312.14 | 2,743.74 |
| 50.16 Endarterectomy of abdominal arteries | | |
| 50.16A Iliac | 1,318.66 | 247.34 |
| 50.18 Endarterectomy of lower limb vessels | | |
| 50.18A Femoral-profundoplasty | 1,003.48 | 309.93 |

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

50 INCISION, EXCISION, AND OCCLUSION OF VESSELS (cont'd)

50.2 Resection of vessel with anastomosis
50.24 Resection of aorta with anastomosis

| | | BASE | ANE |
|---|---|---|---|
| 50.24A | Coarctation repair<br>NOTE: For pediatric repair, refer to Price List. | 1,198.09 V | 885.51 |
| 50.24B | Correction of aortic vascular ring<br>Includes ligation of patent ductus arteriosus (PDA) | 871.96 | 300.34 |

50.3 Resection of vessel with replacement
50.32 Resection of head and neck vessels with replacement
NOTE: If full Y graft, increase anesthetic fee by 1/3. Additional payment applies only to Aneurysm or A.V. fistula, peripheral or visceral.

| | | | |
|---|---|---|---|
| 50.32A | Traumatic injury with graft | 1,377.79 | 335.68 |
| 50.32B | Resection of aneurysm with graft | 1,445.71 | 454.27 |
| 50.32C | Excision of AV fistula | 750.63 | 494.67 |

50.33 Resection of upper limb vessels with replacement

| | | | |
|---|---|---|---|
| 50.33A | Traumatic injury with graft | 1,028.57 | 376.34 |
| 50.33B | Resection of aneurysm with graft | 777.70 | 494.67 |
| 50.33C | Excision of AV fistula | 739.52 | 460.53 |

50.34 Resection of aorta with replacement

| | | | |
|---|---|---|---|
| 50.34A | Coarctation repair<br>NOTE: For pediatric repair, refer to Price List. | 1,239.55 V | 1,055.30 |
| 50.34B | Replacement of aortic arch<br>For aneurysm or occlusion | 3,033.73 | 1,043.62 |
| 50.34K | Replacement of aortic arch<br>For ruptured aneurysm, aortic dissection or traumatic injury | 4,200.11 | 1,614.12 |
| 50.34KA | Endovascular repair of aortic arch for aneurysm<br>NOTE: May not be claimed in addition to HSC 51.3 B. | 2,960.27 | 1,043.62 |
| 50.34KB | Endovascular repair of aortic arch for ruptured aneurysm, dissection or traumatic injury<br>NOTE: May not be claimed in addition to HSC 51.3 B. | 4,264.79 | 1,614.12 |
| 50.34C | Correction of interrupted aortic arch | 2,158.37 | 1,026.98 |
| 50.34D | Resection of thoracic aortic aneurysm | 1,335.11 | 686.28 |
| 50.34DA | Endovascular repair of thoracic aneurysm<br>NOTE: May not be claimed in addition to HSC 51.3 B. | 2,157.48 | 1,895.33 |
| 50.34L | Resection or repair of thoracic aortic aneurysm<br>For ruptured aneurysm, dissection or traumatic injury | 2,268.22 | 1,160.82 |
| 50.34LA | Endovascular repair of thoracic aneurysm for rupture, dissection or traumatic injury<br>NOTE: May not be claimed in addition to HSC 51.3 B. | 2,724.45 | 1,634.67 |

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

50 INCISION, EXCISION, AND OCCLUSION OF VESSELS (cont'd)

50.3 Resection of vessel with replacement (cont'd)

50.34 Resection of aorta with replacement (cont'd)

| | BASE | ANE |
|---|---|---|
| 50.34E Resection of thoraco-abdominal aneurysm | 4,108.75 | 1,895.33 |
| 50.34F Resection of abdominal aortic aneurysm, straight tube graft | 1,756.09 | 1,053.65 |
| 50.34FA Endovascular repair of abdominal aortic aneurysm (Tube graft) | 1,756.09 | 1,053.65 |
| NOTE: May not be claimed in addition to HSC 51.3 B. | | |
| 50.34G Resection of abdominal aortic aneurysm, reconstruction with aortic bi-iliac or aorto-bi-femoral graft | 2,458.53 | 1,475.12 |
| 50.34GA Endovascular abdominal aortic aneurysm repair (Bifurcated iliac) | 2,458.53 | 1,475.12 |
| NOTE: May not be claimed in addition to HSC 51.3 B. | | |
| 50.34H Resection of ruptured aortic aneurysm, straight tube graft | 2,508.70 | 1,505.22 |
| 50.34HA Endovascular repair of ruptured abdominal aortic aneurysm (Tube graft) | 2,508.70 | 1,505.22 |
| NOTE: May not be claimed in addition to HSC 51.3 B. | | |
| 50.34J Resection of ruptured aortic aneurysm, aorto-bi-iliac or bi-femoral graft | 3,211.14 | 1,926.68 |
| 50.34JA Endovascular repair of ruptured abdominal aortic aneurysm (Bifurcated graft) | 3,211.14 | 1,926.68 |
| NOTE: May not be claimed in addition to HSC 51.3 B. | | |
| 50.35 Resection of other thoracic vessels with replacement | | |
| 50.35A Traumatic injury with graft | 682.78 | 300.34 |
| 50.35B Aneurysm with graft | 692.08 | 459.36 |
| 50.35C Excision of AV fistula | 678.00 | 454.27 |
| 50.36 Resection of abdominal arteries with replacement | | |
| 50.36A Traumatic injury with graft | 1,136.89 | 282.68 |
| 50.36B Aneurysm with graft | 1,402.76 | 494.67 |
| 50.36C Excision of AV fistula | 725.00 | 454.27 |
| 50.37 Resection of abdominal veins with replacement | | |
| 50.37A Traumatic injury with graft | 1,143.39 | 297.01 |
| 50.37B Aneurysm with graft | 753.73 | 436.81 |
| 50.37C Excision of AV fistula | 739.70 | 436.81 |
| 50.38 Resection of lower limb vessels with replacement | | |
| 50.38A Traumatic injury with graft | 763.24 | 353.34 |
| 50.38B Aneurysm with graft | 1,053.65 | 515.80 |
| 50.38C Excision of AV fistula | 1,259.46 | 489.21 |
| 50.39 Resection of vessels of unspecified site with replacement | | |
| 50.39A Traumatic injury with graft | 815.12 | 279.56 |
| 50.39B Aneurysm with graft | 644.53 | 515.80 |
| 50.39C Excision of AV fistula | 802.16 | 487.02 |
| 50.4 Ligation and stripping of varicose veins | | |
| 50.4 A Saphenous ligation | 84.66 V | 110.53 |

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

50 INCISION, EXCISION, AND OCCLUSION OF VESSELS (cont'd)

50.4 Ligation and stripping of varicose veins (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 50.4 B | Ligation and stripping of long saphenous vein | 376.31 | 147.37 |
| 50.4 C | Ligation and stripping of long and short saphenous veins | 433.14 | 221.05 |
| 50.4 D | Ligation and stripping of short saphenous vein | 221.85 | 110.53 |
| 50.4 F | Radical multiple ligation of incompetent communicating veins of lower leg (extrafascial ligation or Cockett procedure, subfascial ligation) excludes stripping of long saphenous vein | 501.74 | 221.05 |

50.5 Other excision of vessels

50.51 Other excision of intracranial vessels

| | | | |
|---|---|---|---|
| 50.51A | Surgical treatment of intracranial arterio-venous malformation<br>NOTE: Includes craniotomy. | 3,618.45 | 663.17 |

50.53 Other excision of upper limb vessels

| | | | |
|---|---|---|---|
| 50.53A | Excision of congenital or traumatic peripheral AV fistula | 492.33 | 212.00 |

50.58 Other excision of lower limb vessels

| | | | |
|---|---|---|---|
| 50.58A | Preparation of autogenous saphenous vein for graft<br>NOTE: May not be claimed with HSCs 48.12, 48.13, 48.14, 48.15A, 48.15B, 48.15C and 48.15D. | 194.71 | 122.30 |
| 50.58B | Excision of congenital or traumatic peripheral AV fistula | 492.33 | 221.05 |
| 50.58C | Harvest of alternative autogenous conduit (radial artery, brachio-cephalic vein, superficial femoral vein, hypogastric artery), additional benefit<br>NOTE: 1. Benefit excludes harvest/preparation of vein for dialysis access.<br>2. May not be claimed with HSCs 48.12, 48.13, 48.14, 48.15A, 48.15B, 48.15C and 48.15D. | 531.10 | 109.21 |

50.59 Other excision of vessels, unspecified site

| | | | |
|---|---|---|---|
| 50.59A | Excision of congenital or traumatic peripheral AV fistula | 492.33 | 221.05 |

50.6 Plication or other interruption of vena cava

| | | | |
|---|---|---|---|
| 50.6 A | Ligation or plication of vena cava | 354.44 | 165.98 |
| 50.6 B | Percutaneous insertion of intravascular filter<br>NOTE: Includes contrast studies. | 450.12 | 165.98 |

50.7 Other surgical occlusion of vessels

50.71 Other surgical occlusion of intracranial vessels

| | | | |
|---|---|---|---|
| 50.71A | Repair of carotid-cavernous sinus fistula | 1,758.85 | 583.03 |
| 50.71B | Exploration of cavernous sinus<br>Includes that with removal or surgical correction of lesion(s) | 3,026.21 | 1,043.62 |
| 50.71C | Balloon embolization of caroticocavernous fistula<br>Includes intraoperative angiograms | 844.74 | |

50.72 Other surgical occlusion of head and neck vessels

| | | | |
|---|---|---|---|
| 50.72A | External carotid artery ligation | 218.89 | 109.21 |

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

50 INCISION, EXCISION, AND OCCLUSION OF VESSELS (cont'd)

50.7 Other surgical occlusion of vessels (cont'd)

50.72 Other surgical occlusion of head and neck vessels (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 50.72B | Ligation of carotid artery<br>That for intracranial aneurysm | 482.49 | 200.39 |
| 50.72C | Internal jugular vein ligation | 118.79 | 110.43 |

50.75 Other surgical occlusion of thoracic vessels

| | | | |
|---|---|---|---|
| 50.75A | Ligation or division of shunt in conjunction with a major procedure | 666.99 | 262.08 |
| 50.75B | Pulmonary artery banding | 666.99 | 350.01 |
| 50.75C | Ligation of patent ductus arteriosus | 666.99 | 376.67 |
| 50.75D | Ligation of patent ductus in association with congenital heart surgery | 121.17 | 109.21 |

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

50 INCISION, EXCISION, AND OCCLUSION OF VESSELS (cont'd)

50.7 Other surgical occlusion of vessels (cont'd)

50.75 Other surgical occlusion of thoracic vessels (cont'd)

| | BASE | ANE |
|---|---|---|
| 50.75E Percutaneous, transvascular closure of patent ductus arteriosus with umbrella | 786.12 | 541.63 |
| NOTE: Includes all associated catheterizations performed during the same sitting, includes pressure and oxygen saturation measurements, angiography and management of intra-procedural complications. | | |
| 50.76 Other surgical occlusion of abdominal arteries | | |
| 50.76A Ligation, iliac artery ligation | 320.85 | 139.77 |
| 50.77 Other surgical occlusion of abdominal veins | | |
| 50.77A Ligation, abdominal veins | 290.52 | 174.72 |
| 50.78 Other surgical occlusion of lower limb vessels | | |
| 50.78A Superficial femoral vein ligation | 301.04 | 109.21 |
| 50.79 Other surgical occlusion of vessels, site unspecified | | |
| 50.79A Vascular occlusion by catheter, to include intraoperative angiograms, any area | 411.58 | 165.79 |

50.8 Selective angiography using contrast material

NOTE: 1. A separate angiographic procedure can be billed whenever repositioning or exchange of a catheter is required to obtain an additional angiographic study of a different region of the same vessel, or to obtain selective or superselective injection of a different artery or vein. It may also be claimed when there is multiple site venous sampling that requires repositioning or exchange of a catheter.

2. For each additional selective injection, refer to Price List. Maximums apply.

| | | |
|---|---|---|
| 50.81 Angiography of cerebral vessels | | |
| 50.81A Selective arterial injection | 208.10 | |
| 50.81B Direct arterial injection, carotid artery | 105.98 | 110.53 |
| 50.81C Direct arterial injection, vertebral artery | 107.13 | 110.43 |
| 50.81D Direct arterial injection, carotid artery, requiring cutdown | 234.76 | 174.72 |
| 50.81E Retrograde brachial injection | 105.00 | |
| 50.82 Aortography | | |
| 50.82A Trans-arterial catheter injection | 201.25 | |
| 50.82B Direct trans-lumbar injection | 116.73 | 109.31 |
| 50.83 Angiography of pulmonary vessels | | |
| 50.83A Main pulmonary artery or selective arterial injection | 166.25 | |
| 50.84 Angiography of other intrathoracic vessels | | |
| 50.84A Superior vena cavography via SVC catheter | 183.44 | |

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

50 INCISION, EXCISION, AND OCCLUSION OF VESSELS (cont'd)

50.8 Selective angiography using contrast material (cont'd)

50.84 Angiography of other intrathoracic vessels (cont'd)

| | BASE | ANE |
|---|---|---|
| 50.84B Selective arterial injection | 148.75 | |
| 50.84C Selective venous injection | 122.50 | |
| **50.87 Angiography of other intra-abdominal vessels** | | |
| 50.87A Selective arterial injection | 208.10 | |
| 50.87B Inferior vena cavography via IVC catheter | 208.10 | |
| 50.87C Selective venous injection | 208.10 | |
| **50.88 Angiography of femoral vessels** | | |
| 50.88A Selective arterial injection | 199.63 | |
| **50.89 Angiography of other vessels NEC** | | |
| 50.89A Peripheral artery, direct arterial injection | 35.00 | 110.53 |
| 50.89B Peripheral venography direct injection, any area | 27.75 | |
| 50.89C Peripheral venography cutdown and direct injection | 41.95 | |
| 50.89D Selective arterial injection of unspecified site | 35.00 | |
| 50.89E Selective venous injection of unspecified site | 208.10 | |

50.9 Other invasive procedures on vessels

| | | |
|---|---|---|
| **50.91 Arterial catheterization** | | |
| 50.91B Peripheral artery, cutdown | 150.61 | |
| 50.91C Placement of indwelling vascular catheter in the hepatic artery for infusion therapy, includes correction of anomalous circulation when indicated | 118.94 | 235.88 |
| 50.91D Radial arterial line access<br>NOTE: May not be claimed in addition to HSCs 48.98A, 48.98B, 51.59A, 51.59B, 51.59D, 51.59E and 51.59F. | 54.02 | |
| 50.91E Femoral arterial line access<br>Note: May not be claimed in addition to HSCs 48.98A, 48.98B, 51.59A 51.59B, 51.59D, 51.59E and 51.59F. | 54.02 | |
| **50.93 Other venous catheterization** | | |
| 50.93A Percutaneous insertion of catheter into blood vessel<br>NOTE: For hemodialysis or hemoperfusion. | 161.86 | 147.37 |
| **50.94 Central venous pressure monitoring** | | |
| 50.94B Insertion of a tunnelled central line in an infant<br>NOTE: May only be claimed for infants of up to 5 kg or a post conceptual age of less than 60 weeks | 336.44 | 110.43 |

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

50 INCISION, EXCISION, AND OCCLUSION OF VESSELS (cont'd)

50.9 Other invasive procedures on vessels (cont'd)

50.94 Central venous pressure monitoring (cont'd)

| | | BASE | | ANE |
|---|---|---|---|---|
| 50.94D | Introduction of central venous catheter, with or without ultrasound guidance<br>NOTE: May not be claimed in addition to HSC 49.95A. | 67.18 | V | 141.34 |
| 50.94E | Introduction of catheter into peripheral vein, requiring ultrasound guidance<br>NOTE: May not be claimed for routine venous access or initiation of intravenous. | 67.06 | V | 141.34 |

50.95 Other circulatory monitoring

| | | | | |
|---|---|---|---|---|
| 50.95A | Insertion of flow directed (Swan Ganz) catheter, and all monitoring thereof<br>NOTE: May not be claimed in addition to HSC 49.95A. | 113.75 | | 148.51 |
| 50.95B | Cardiac output studies . . . . . <br>NOTE: 1. Claimable by whatever method.<br>2. One per day per patient.<br>3. May be claimed in addition to cardiac catheterization. | 105.00 | | |
| 50.96 | Venous cutdown . . . . . | 38.94 | | |

50.97 Biopsy of blood vessel

| | | | | |
|---|---|---|---|---|
| 50.97A | Biopsy of temporal artery . . . . . | 73.95 | V | 110.53 |

50.98 Other puncture of artery

| | | | | |
|---|---|---|---|---|
| 50.98A | For blood/gas analysis . . . . . | 17.12 | | |

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

50 INCISION, EXCISION, AND OCCLUSION OF VESSELS (cont'd)

50.9 Other invasive procedures on vessels (cont'd)

50.98 Other puncture of artery (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 50.98B | Arterial access procedure | 80.16 | |
| | NOTE: 1. May only be claimed:<br>-for hospital inpatients under the age of 3 years.<br>-where the procedure requires physician involvement due to a previously failed attempt or when suitable qualified personnel are unavailable.<br>2. May be claimed in addition to a hospital visit or consultation.<br>3. An unscheduled service modifier may not be claimed if a hospital visit or consultation is claimed.<br>4. May not be claimed in addition to 16.81A or 50.99C. | | |

50.99 Other puncture of vein

| | | | |
|---|---|---|---|
| 50.99A | Obtaining laboratory specimen (blood) | 16.33 | |
| | NOTE: 1. May only be claimed for services provided to out of province Canadian residents.<br>2. May be claimed by the facility responsible for the collection and referral of the specimen, if no examination is carried out on the specimen by the referring facility.<br>3. May not be claimed by non-laboratory facilities in urban and metropolitan areas. | | |
| 50.99B | Insertion of long dwelling intravascular catheter requiring subcutaneous tunnel | 231.61 | 145.58 |
| 50.99F | Removal and reinsertion of long dwelling intravascular catheter requiring subcutaneous tunnel under general anesthesia | 434.28 | 239.49 |
| 50.99G | Removal of long dwelling intravascular catheter requiring subcutaneous tunnel under general anesthesia | 158.47 | 110.53 |
| 50.99C | Venous access procedure | 80.16 | |
| | NOTE: 1. May only be claimed:<br>-for hospital inpatients under the age of 3 years.<br>-where the procedure requires physician involvement due to a previously failed attempt or when suitable qualified personnel are unavailable.<br>2. May be claimed in addition to a hospital visit or consultation.<br>3. An unscheduled service modifier may not be claimed if a hospital visit or consultation is claimed.<br>4. May not be claimed in addition to 16.81A or 50.98B. | | |
| 50.99D | Phlebotomy | 50.10 | |
| | NOTE: 1. May only be claimed for hospital inpatients under the age of 2 years.<br>2. May be claimed in addition to a hospital visit or consultation. | | |

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

50 INCISION, EXCISION, AND OCCLUSION OF VESSELS (cont'd)

50.9 Other invasive procedures on vessels (cont'd)

50.99 Other puncture of vein (cont'd)

| | BASE | ANE |
|---|---|---|
| 50.99E Peripheral embolectomy or endarterectomy, additional benefit | 205.71 | 109.21 |
| NOTE: May only be claimed in association with other vascular surgery through the same arteriotomy. | | |

51 OTHER OPERATIONS ON VESSELS

| | | |
|---|---|---|
| 51.0 Systemic to pulmonary artery shunt | | |
| 51.0 A Anastomosis, pulmonary, aortic, subclavian or superior vena cava | 727.01 | 571.06 |
| 51.1 Intra-abdominal venous anastomosis | | |
| 51.1 A Porto-systemic shunt | 1,143.29 | 405.27 |
| 51.2 Other shunt or vascular bypass | | |
| 51.21 Caval-pulmonary artery anastomosis | | |
| 51.21A Repair or correction of tricuspid atresia | 2,185.42 | 995.91 |
| 51.21B Anastomosis of pulmonary artery to systemic venous atrium (with or without conduit) | 2,549.05 | 1,182.78 |
| 51.21C Bidirectional cavopulmonary anastamosis | 2,549.05 | 1,182.78 |
| 51.22 Aorta-subclavian-carotid bypass | | |
| 51.22A Aorta-great vessel bypass - distal anastomosis | 1,756.09 | 1,357.32 |
| NOTE: If multiple anastomoses are performed, refer to price list. | | |
| 51.24 Aorta-renal bypass | | |
| 51.24A Renal artery reconstruction | 652.26 | 331.97 |
| 51.24B Aorto-renal or aorto-visceral reconstruction for occlusive disease or aneurysm | 1,254.35 | 497.38 |
| NOTE: May not be claimed with other services performed at the same operative encounter. | | |
| 51.25 Aorta iliac-femoral bypass | | |
| 51.25A Aorta femoral | 1,563.70 | 878.65 |
| 51.25B Aorta-bifemoral | 2,458.53 | 1,475.12 |
| 51.26 Other intra-abdominal shunt or bypass | | |
| 51.26A Visceral artery reconstruction, any method | 653.12 | 354.21 |
| 51.27 Arteriovenostomy for renal dialysis | | |
| 51.27A Creation of AV fistula | 485.98 | 184.21 |

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

51 OTHER OPERATIONS ON VESSELS (cont'd)

51.2 Other shunt or vascular bypass (cont'd)

51.28 Extracranial-intracranial (ED-IC) vascular bypass

| | | BASE | ANE |
|---|---|---|---|
| 51.28A | Intracranial arterial bypass | 3,346.13 | 1,137.01 |
| | NOTE: Includes vein graft harvesting. | | |
| 51.29 | Other (peripheral) shunt or bypass | | |
| 51.29A | Femoral-popliteal | 1,354.42 | 354.21 |
| 51.29C | Femoral-tibial | 1,605.57 | 420.62 |
| 51.29D | Axillo-femoral | 1,165.51 | 309.93 |
| 51.29E | Femoro-femoral | 1,124.80 | 276.32 |
| 51.29F | Prosthetic graft for vascular access | 459.76 | 184.21 |
| 51.29G | Superficial femoral to greater saphenous shunt | 702.44 | 227.13 |
| 51.3 | Suture of vessel | | |
| 51.3 A | Repair of traumatic injury to major vessels, trunk | 659.00 | 309.93 |
| 51.3 B | Repair to peripheral vessels, traumatic injury | 755.22 | 287.78 |
| | NOTE: May not be claimed in addition to HSCs 50.34DA, 50.34FA, 50.34GA, 50.34HA, 50.34JA, 50.34KA, 50.34KB and 50.34LA. | | |
| 51.3 C | Repair of thoracic aortic injury | 1,335.11 | 547.67 |
| 51.4 | Revision of vascular procedure | | |
| 51.43 | Removal of arteriovenous shunt for renal dialysis | 84.52 V | 110.53 |
| 51.49 | Other revision of vascular procedure | | |
| 51.49B | Excision of arteriovenous graft | 266.98 | 145.74 |
| 51.49C | Repair of aorto-enteric fistula, or removal of infected aortic graft, with extra anatomic bypass | BY ASSESS | |
| 51.5 | Other repair of vessels | | |
| 51.51 | Clipping of intracranial aneurysm | | |
| 51.51A | Surgical treatment of intracranial aneurysm includes craniotomy | 2,728.84 | 796.97 |
| 51.52 | Other repair of aneurysm | | |
| 51.52A | Ultrasound assisted percutaneous thrombosis of an arterial aneurysm | 194.61 | |
| 51.53 | Repair of arteriovenous fistula | | |
| 51.53A | Ligation and division, AV fistula | 116.25 V | 110.43 |
| 51.53B | Ultrasound assisted percutaneous thrombosis of an arterial fistula | 141.86 | |
| 51.58 | Repair of blood vessel with unspecified type of patch graft | | |
| 51.58A | Patch angioplasty - popliteal/tibial artery | 1,128.92 | 796.97 |
| 51.58B | Patch angioplasty - upper extremity vessel | 612.12 | 796.97 |

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

51 OTHER OPERATIONS ON VESSELS (cont'd)

51.5 Other repair of vessels (cont'd)

51.59 Other repair of blood vessel NEC

| | | BASE | ANE |
|---|---|---|---|
| 51.59A | Open transluminal angioplasty . . . . . | 382.51 | 212.00 |
| | NOTE: 1. Benefit includes intra-operative angiography. 2. Benefit will be reduced when performed in association with another vascular procedure; refer to Price List. 3. May not be claimed in addition to HSCs 50.91D or 50.91E. | | |
| 51.59B | Percutaneous transluminal angioplasty, excluding coronary vessels . . . . . | 547.23 | 150.17 |
| | NOTE: 1. May not be claimed in addition to HSCs 50.91D or 50.91E. | | |
| 51.59D | Percutaneous transluminal coronary angioplasty with associated diagnostic angiogram . . . . . | 1,163.75 | 353.34 |
| | NOTE: 1. May be claimed when the diagnostic angiogram is intended to determine appropriate treatment of the patient's coronary anatomy and is immediately followed by a coronary angioplasty by the same cardiologist. 2. Benefit includes other angiograms performed on the same date of service. 3. For each additional coronary vessel, refer to Price List. 4. Role modifier ASIC may be claimed for assistance at coronary angioplasty by a second interventional cardiologist. 5. May not be claimed in addition to HSCs 50.91D or 50.91E. | | |
| 51.59E | Percutaneous transluminal coronary angioplasty without associated angiogram | 901.25 | 349.44 |
| | NOTE: 1. Patient will have had a previous angiogram to determine appropriate treatment. 2. May be claimed where the diagnosis has been determined and the patient's need for angioplasty has been established before the date of the procedure. 3. Coronary angiography may not be claimed on the same date of service by the same or different physician. 4. For each additional coronary vessel, refer to Price List. 5. Role modifier ASIC may be claimed for assistance at coronary angioplasty by a second interventional cardiologist. 6. May not be claimed in addition to HSCs 50.91D or 50.91E. | | |

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

51 OTHER OPERATIONS ON VESSELS (cont'd)

51.5 Other repair of vessels (cont'd)

51.59 Other repair of blood vessel NEC (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 51.59F | Percutaneous transluminal coronary angioplasty without associated angiogram | 866.25 | 349.44 |
| | NOTE: 1. May be claimed when another physician has performed the angiogram on the same date of service which established the need for the angioplasty and has claimed 48.98B for the coronary angiogram. 2. Coronary angiography (48.98B) may not be claimed by the same physician on the same date of service. 3. For each additional coronary vessel, refer to Price List. 4. Role modifier ASIC may be claimed for assistance at coronary angiography by a second interventional cardiologist when medically required. 5. May not be claimed in addition to HSCs 50.91D or 50.91E. | | |
| 51.59G | Device assisted percutaneous coronary intervention including but not exclusive to rotoblation, retrograde total occlusions and clot aspiration devices, additional benefit . . . . . | 192.88 | |
| | NOTE: May only be claimed in addition to 51.59D, 51.59E and 51.59F. | | |

51.6 Extracorporeal circulation and procedures auxiliary to open heart surgery

51.61 Extracorporeal circulation auxiliary to open heart surgery

| | | | |
|---|---|---|---|
| 51.61A | For open heart surgery . . . . . | 613.77 | 218.39 |
| 51.61B | For other procedures not connected with open heart surgery . . . . . | 425.79 | 238.51 |
| 51.61C | Percutaneous cardiopulmonary bypass . . . . . | 460.60 | 109.21 |
| | NOTE: 1. May be claimed in addition to concomitant procedure fees. 2. Benefit includes care, removal and hemostasis. | | |
| 51.61D | Hypothermic circulatory arrest for open heart surgery . . . . . | 437.11 | 113.58 |

51.65 Extracorporeal membrane oxygenation (ECMO)

| | | | |
|---|---|---|---|
| 51.65A | Priming of oxygenator . . . . . | 155.14 | |
| 51.65B | Sedation for cannulation/decannulation . . . . . | 169.38 | |
| | NOTE: May not be claimed by the same physician who is claiming anesthetic services for HSCs 51.65A, 51.65C or 51.65D. | | |
| 51.65C | Arterial and venous cannulation . . . . . | 712.29 | |
| 51.65D | Arterial and venous decannulation . . . . . | 475.61 | |
| | NOTE: Includes repair of vessels. | | |

51.8 Operations on carotid body and other vascular bodies

| | | | |
|---|---|---|---|
| 51.8 A | Resection of carotid body tumor . . . . . | 1,379.79 | 1,066.46 |

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

51 OTHER OPERATIONS ON VESSELS (cont'd)

51.9 Other operations on vessels

51.92 Injection of sclerosing agent or solution into vein

| | BASE | ANE |
|---|---|---|
| 51.92A Varicose vein, single injection | 13.31 | |

NOTE: 1. Sclerotherapy for asymptomatic varicose veins is not an insured service.
2. At any one visit, a maximum of three HSC 51.92B may be claimed in addition to a 51.92A.
3. A maximum of six HSC 51.92A and eighteen 51.92B may be claimed per benefit year.
4. May be claimed in addition to a visit or a consultation.

| | | |
|---|---|---|
| 51.92B Varicose vein, additional injection | 6.97 | |

NOTE: Refer to notes following 51.92A.

51.98 Control of hemorrhage, not otherwise specified

| | | |
|---|---|---|
| 51.98A Reoperation for bleeding following cardiac surgery | 506.19 | 243.51 |

NOTE: Patient must have left both operating room suite and post anesthetic (recovery) room.

51.99 Other operations on vessels NEC

| | | |
|---|---|---|
| 51.99A Percutaneous removal or attempted removal of intravascular foreign bodies | 416.59 | 184.21 |
| 51.99B Percutaneous removal or lysis of embolus or thrombus in any vessel | 450.12 | 184.21 |

NOTE: Includes angiography performed during the procedure.

## IX. OPERATIONS ON THE HEMIC AND LYMPHATIC SYSTEMS

### 52 OPERATIONS ON LYMPHATIC SYSTEM

| | | BASE | ANE |
|---|---|---|---|
| 52.0 | Incision of lymphatic structure | | |
| 52.0 A | Drainage, deep cervical abscess | 310.93 | 110.53 |
| 52.1 | Simple excision of lymphatic structure | | |
| 52.1 A | Biopsy, superficial lymph node | 52.15 V | 110.53 |
| 52.1 B | Cystic hygroma, full 60 minutes or major portion thereof for the first call when only one call is claimed | 269.39 | 147.37 |
| 52.11 | Excision of deep cervical lymph node (with excision of scalene fat pad) | | |
| 52.11A | Excision deep cervical lymph node | 165.71 | 110.53 |
| 52.11B | Scalene fat pad excision | 220.59 | 110.53 |
| 52.12 | Excision of internal mammary lymph node | 150.39 | 110.43 |
| 52.13 | Excision of axillary lymph node | 184.88 | 110.53 |
| 52.14 | Excision of inguinal lymph node<br>That for tissue cross matching purposes | 169.03 | 110.53 |
| 52.2 | Regional lymph node excision | | |
| 52.2 | Regional lymph node excision<br>That for TB etc<br>NOTE: May not be claimed in addition to HSCs 55.8 B, 55.9 AA and 63.69A. | 249.34 | 110.53 |
| 52.3 | Radical excision of cervical lymph nodes | | |
| 52.31 | Radical neck dissection, unqualified | | |
| 52.31A | Limited neck dissection (suprahyoid)<br>NOTE: HSCs 17.32A or 98.51F may not be claimed in addition, by the same or different physician at the same encounter. | 397.22 | 184.21 |
| 52.31B | Modified neck dissection with preservation of either one or two of the non-lymphatic structures, (e.g., sternocleidomastoid muscle, jugular vein or spinal accessory nerve), unilateral including removal of all neck lymph nodes<br>NOTE: 1. May not be claimed with HSCs 50.72C or 95.14E.<br>2. HSCs 17.32A or 98.51F may not be claimed in addition, by the same or different physician at the same encounter. | 1,087.26 | 459.36 |
| 52.31C | Functional or selective neck dissection with preservation of all non-lymphatic structures, (e.g., sternocleidomastoid muscle, jugular vein, spinal accessory nerve), unilateral, including removal of three or more nodal levels in the neck | 1,539.57 | 607.91 |

IX. OPERATIONS ON THE HEMIC AND LYMPHATIC SYSTEMS (cont'd)

52 OPERATIONS ON LYMPHATIC SYSTEM (cont'd)

52.3 Radical excision of cervical lymph nodes (cont'd)
52.31 Radical neck dissection, unqualified (cont'd)

BASE ANE

NOTE: 1. May not be claimed with HSCs 50.72C or 95.14E
2. HSCs 17.32A or 98.51F may not be claimed in addition, by the same or different physician at the same encounter.

IX. OPERATIONS ON THE HEMIC AND LYMPHATIC SYSTEMS (cont'd)

52 OPERATIONS ON LYMPHATIC SYSTEM (cont'd)

52.3 Radical excision of cervical lymph nodes (cont'd)
52.31 Radical neck dissection, unqualified (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 52.31D | Extended neck dissection<br>Removal of all neck lymph nodes and some non-lymphatic structures other than spinal accessory nerve, sternocleidomastoid muscle, or jugular vein. These structures may include the scalene muscle, deep neck muscles, hypoglossal nerve, carotid artery extensive resection of skin, etc, all related to or required because of tumor invasion of those structures<br>NOTE: 1. May not be claimed with HSCs 50.72A, 50.72C, 95.14C, 95.14E.<br>2. HSCs 17.32A or 98.51F may not be claimed in addition, by the same or different physician at the same encounter. | 1,884.29 | 423.69 |

52.4 Radical excision of other lymph nodes

| | | | |
|---|---|---|---|
| 52.42 | Radical excision of axillary lymph nodes | 686.69 | 202.64 |

52.43 Radical excision of peri-aortic lymph nodes

| | | | |
|---|---|---|---|
| 52.43A | Radical Retroperitoneal lymph node dissection, thoracoabdominal or transperitoneal | 1,030.44 | 559.10 |
| 52.43B | Open retroperitoneal node dissection, thoracoabdominal or transperitoneal, for testicular cancer | 2,395.72 | 618.34 |

52.45 Radical groin dissection

| | | | |
|---|---|---|---|
| 52.45A | Radical inguinal lymph node dissection | 552.24 | 184.21 |

52.49 Radical excision of other lymph nodes

| | | | |
|---|---|---|---|
| 52.49A | Radical mediastinal node dissection | BY ASSESS | |
| 52.49B | Popliteal resection | 448.58 | 183.46 |
| 52.49C | Pelvic lymphadenectomy for gynecological malignancy | 490.54 | 221.39 |
| 52.49D | Pelvic lymphadenectomy<br>That for carcinoma of the prostate or bladder | 427.81 | 200.39 |

52.8 Invasive diagnostic procedures on lymphatic structures
52.85 Other lymphangiogram

| | | | |
|---|---|---|---|
| 52.85A | Injection, any area | 154.54 | |

52.89 Other invasive diagnostic procedures on lymphatic structures

| | | | |
|---|---|---|---|
| 52.89A | Staging laparotomy<br>NOTE: Includes splenectomy. | 969.18 | 405.27 |
| 52.89C | Sentinel node biopsy for skin and other cancers | 375.04 | 147.37 |

IX. OPERATIONS ON THE HEMIC AND LYMPHATIC SYSTEMS (cont'd)

## 53 OPERATIONS ON BONE MARROW AND SPLEEN

### 53.3 Splenectomy

| | | BASE | ANE |
|---|---|---|---|
| 53.34 | Total splenectomy of a normal sized spleen | 839.88 | 354.21 |
| | NOTE: 1. A normal sized spleen is defined as 20 cms or less for patients 12 years of age and older and less than 12 cms for patients younger than 12 years of age. 2. Benefits may not be claimed for incidential splenectomies. | | |
| 53.34A | Splenectomy for massive splenomegaly | 1,679.76 | 1,214.74 |
| | NOTE: 1. Massive splenomegaly is defined as greater than 20 cms or at least 12 cms for patients 12 years of age and younger. 2. Size must be confirmed by pre-operative imaging. | | |

### 53.4 Other operations on bone marrow

#### 53.42 Injection into bone marrow

| | | | |
|---|---|---|---|
| 53.42A | Intraosseous cannulation | 58.61 | |

### 53.5 Other operations on spleen

#### 53.51 Excision of accessory spleen

| | | | |
|---|---|---|---|
| 53.51A | Resection of accessory spleen | 903.26 | 338.46 |
| | NOTE: 1. Benefit will be paid at 100% when only procedure performed. 2. When performed with HSC 53.34, benefit will be paid as ADD. Refer to Price List. | | |

#### 53.53 Repair and plastic operations on spleen

| | | | |
|---|---|---|---|
| 53.53A | Spleen - rupture with repair | 744.80 | 346.13 |
| | NOTE: May not be claimed for incidental repair. | | |

### 53.8 Invasive diagnostic procedures on bone marrow and spleen

#### 53.81 Biopsy of bone marrow

| | | | |
|---|---|---|---|
| 53.81A | Aspiration biopsy of bone marrow | 55.64 | |
| 53.81B | Needle biopsy of bone marrow | 55.64 V | 110.53 |

#### 53.83 Aspiration biopsy of spleen

| | | | |
|---|---|---|---|
| 53.83A | Needle biopsy of spleen | 119.47 V | 109.21 |

# X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION

## 54 OPERATIONS ON ESOPHAGUS

| | | BASE | ANE |
|---|---|---|---|
| **54.0** | **Esophagotomy** | | |
| **54.09** | **Other incision of esophagus** | | |
| 54.09A | Esophagotomy for removal of foreign body, cervical | 595.20 | 239.49 |
| 54.09B | Esophagotomy for removal of foreign body, transthoracic | 654.80 | 244.62 |
| **54.1** | **Esophagostomy** | | |
| 54.12 | Cervical esophagostomy | 465.57 | 235.88 |
| 54.21B | Removal of tumor via rigid esophagoscopy | 198.06 | 123.67 |
| 54.21C | With palliative bipolar electrocoagulation for obstructive esophageal cancer<br>NOTE: May only be claimed in addition to 01.14. | 113.99 | 109.31 |
| 54.21D | With electrocautery or injection hemostasis for esophageal hemorrhage<br>NOTE: 1. May only be claimed in addition to 01.14.<br>2. Single benefit applies regardless of the number of sites or applications. | 136.79 | 109.31 |
| 54.21E | With esophageal polypectomy(s)<br>NOTE: May only be claimed in addition to 01.14. | 59.99 | 109.31 |
| **54.22** | **Local excision of esophageal diverticulum** | | |
| 54.22A | Esophagotomy for removal of diverticulum, cervical | 569.81 | 239.49 |
| 54.22B | Esophagotomy for removal of diverticulum, transthoracic | 681.20 | 265.01 |
| **54.29** | **Other local excision of other lesion or tissue of esophagus** | | |
| 54.29A | Esophagotomy for removal of tumor, cervical | 573.56 | 203.18 |
| **54.3** | **Excision of esophagus** | | |
| **54.32** | **Partial esophagectomy** | | |
| 54.32A | Resection with primary anastomosis | 1,034.60 | 464.90 |
| **54.33** | **Total esophagectomy** | | |
| 54.33A | Total esophagectomy | 1,241.52 | 531.31 |
| 54.33B | Total esophagectomy with immediate interposition of hollow viscus | 2,069.20 | 1,013.78 |
| **54.6** | **Esophagomyotomy** | | |
| 54.6 | Esophagomyotomy<br>NOTE: May not be claimed with 54.76A, 65.7B, 65.8B or 65.8C. | 877.81 | 368.43 |
| **54.7** | **Other repair of esophagus** | | |
| **54.76** | **Esophagogastroplasty** | | |
| 54.76A | Esophagogastric reconstruction for complex foregut procedure | 1,467.06 | 497.38 |
| **54.79** | **Other repair of esophagus NEC** | | |
| 54.79A | Primary repair of esophageal atresia and tracheoesophageal fistula | 2,329.47 | 1,007.03 |
| 54.79B | Reconstruction of esophagus by interposition of hollow viscus | 1,365.79 | 534.22 |

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

54 OPERATIONS ON ESOPHAGUS (cont'd)

54.8 Invasive diagnostic procedures on esophagus

54.89 Other invasive diagnostic procedures on esophagus

| | | BASE | ANE |
|---|---|---|---|
| 54.89A | Esophageal pH monitoring, 24 hours | 85.49 | |
| 54.89B | Measurement of esophageal motility using triple lumen tube | 113.99 | |
| 54.89D | Esophageal motility study and pH monitoring of distal esophagus, technical | 37.87 | |
| 54.89E | Esophageal motility study and pH monitoring of the distal esophagus, interpretation | 34.20 | |
| 54.89F | Acid infusion test (Berstein test) | 34.49 | |

54.9 Other operations on esophagus

54.91 Injection or ligation of esophageal varices

| | | | |
|---|---|---|---|
| 54.91A | Sclerotherapy, additional benefit. NOTE: May only be claimed in addition to HSC 01.14. | 113.99 | 26.20 |
| 54.91B | Trans-esophageal ligation of varicosites (through abdomen or chest) | 666.86 | 270.82 |
| 54.91C | Banding, additional benefit NOTE: May only be claimed in addition to HSC 01.14. | 113.99 | 109.21 |

54.92 Dilation of esophagus

| | | | |
|---|---|---|---|
| 54.92A | Rupture of inferior gastroesophageal sphincter by pneumatic bag That for achalasia | 170.99 | |
| 54.92B | Dilation by sound or bougie, without endoscopy | 49.58 | |
| 54.92C | Dilation by sound or bougie, via rigid esophagoscopy, initial | 147.93 | 110.53 |
| 54.92D | Dilation by sound or bougie, via rigid esophagoscopy, repeat NOTE: Repeat service should be claimed if provided within 14 days of initial. | 101.84 V | 110.53 |
| 54.92E | Dilation by sound or bougie, or esophageal balloon, additional benefit NOTE: May only be claimed in addition to HSC 01.14. | 102.59 | 109.31 |

54.99 Other operations on esophagus NEC

| | | | |
|---|---|---|---|
| 54.99A | Esophageal stent placement, additional benefit NOTE: May only be claimed in addition to HSC 01.14. | 170.99 | 139.77 |

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

55 INCISION AND EXCISION OF STOMACH

| | | BASE | ANE |
|---|---|---|---|
| 55.1 | Temporary gastrostomy | | |
| 55.1 A | Temporary gastrostomy | 566.89 | 184.21 |
| | NOTE: 1. Fee will be paid at 100% when only procedure performed. 2. With other abdominal or gastrointestinal procedures refer to Price List, fee will be paid as ADD or ADD2. | | |
| 55.1 B | Percutaneous endoscopic gastrostomy, additional benefit | 113.99 | 109.21 |
| | NOTE: May only be claimed in addition to HSC 01.14. | | |
| 55.2 | Permanent gastrostomy | | |
| 55.2 A | Surgical gastrostomy | 528.23 | 202.64 |
| | NOTE: 1. Benefit will be paid at 100% when only procedure performed. 2. When performed with other abdominal or gastrointestinal procedures, benefit will be paid as ADD or ADD2. Refer to Price List. | | |
| 55.3 | Pyloromyotomy | | |
| 55.3 | Pyloromyotomy Ramstedt | 510.06 | 265.65 |
| 55.4 | Local excision or destruction of lesion or tissue of stomach | | |
| 55.41 | Endoscopic excision or destruction of lesion or tissue of stomach | | |
| 55.41A | Endoscopic excision or destruction of lesion or tissue of stomach (tumor) | 100.44 | 109.31 |
| | NOTE: May only be claimed in addition to 01.14. | | |
| 55.41B | Endoscopic gastric polypectomy(s) | 45.40 | 109.31 |
| | NOTE: May only be claimed in addition to 01.14. | | |
| 55.43 | Other local excision of lesion or tissue of stomach | | |
| 55.43A | Gastrotomy for tumor, foreign body | 528.23 | 239.49 |
| 55.8 | Other partial gastrectomy | | |
| 55.8 A | Sub-total | 818.14 | 442.76 |
| | NOTE: May be claimed in addition to HSC 66.83. | | |
| 55.8 B | Radical sub-total | 1,637.50 | 531.31 |
| | NOTE: 1. May be claimed in addition to HSC 66.83. 2. May not be claimed in addition to HSCs 52.2, 56.2, 57.7 and 66.3 A. | | |
| 55.9 | Total gastrectomy | | |
| 55.9 A | Total gastrectomy | 1,457.90 | 575.58 |
| | NOTE: May be claimed in addition to HSC 66.83. | | |

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

55 INCISION AND EXCISION OF STOMACH (cont'd)

55.9 Total gastrectomy (cont'd)

| | BASE | ANE |
|---|---|---|
| 55.9 AA Total gastrectomy for malignancy | 2,192.13 | 575.58 |
| NOTE: May not be claimed with HSCs 52.2, 52.43A, 55.9 A, 56.2, 57.7 and 66.3 A. | | |

55.99 Other total gastrectomy

| | | |
|---|---|---|
| 55.99A Thoraco abdominal esophagogastrectomy | 1,887.90 | 974.07 |
| NOTE: May be claimed in addition to HSC 66.83. | | |

56 OTHER OPERATIONS ON STOMACH

56.0 Vagotomy

56.02 Truncal vagotomy

| | | |
|---|---|---|
| 56.02A Truncal vagotomy, transthoracic or abdominal | 304.02 | 218.39 |

56.03 Selective vagotomy

| | | |
|---|---|---|
| 56.03A Selective vagotomy | 859.75 | 305.76 |
| 56.03B For denervation of parietal cells | 863.43 | 309.70 |

56.1 Pyloroplasty

| | | |
|---|---|---|
| 56.1 Pyloroplasty | 523.08 | 291.50 |

56.2 Gastroenterostomy (without gastrectomy)

| | | |
|---|---|---|
| 56.2 Gastroenterostomy (without gastrectomy) | 739.52 | 368.43 |
| NOTE: May not be claimed with HSCs 55.8 B, 55.9 AA, 64.3, 64.43A, 64.49A or 64.7. | | |

56.3 Control of hemorrhage and suture of ulcer of stomach or duodenum

56.34 Endoscopic control of gastric or duodenal bleeding

| | | |
|---|---|---|
| 56.34A Endoscopic control of gastric or duodenal bleeding with electrocautery or injection hemostasis | 136.79 | 109.31 |
| NOTE: 1. May only be claimed in addition to HSCs 01.14, 01.16B and 01.16C. | | |
| 2. Single benefit applies per route (oral or rectal). | | |

56.39 Other control hemmorhage of stomach or duodenum

| | | |
|---|---|---|
| 56.39A Suture or other surgical control of bleeding or perforated gastric or duodenal ulcer | 903.26 | 567.92 |

56.4 Revision of gastric anastomosis

| | | |
|---|---|---|
| 56.4 A Gastrectomy revision with or without resection | 1,679.76 | 497.38 |
| NOTE: May not be claimed in addition to HSC 66.4 A. | | |

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

56 OTHER OPERATIONS ON STOMACH (cont'd)

56.9 Other operations on stomach
56.93 Gastric partitioning for obesity

| | | BASE | ANE |
|---|---|---|---|
| 56.93A | Roux-en-Y Gastric Bypass | 1,690.32 | 1,048.86 |
| | NOTE: May not be claimed in addition to any other procedure except HSC 65.7 A. | | |
| 56.93B | Adjustable gastric band fill | 158.47 V | |
| | NOTE: 1. A repeat is payable at a reduced rate; refer to the Price List. 2. A maximum of four repeat fills may be claimed per patient, per physician, per calendar year. | | |
| 56.93C | Sleeve gastrectomy for obesity | 1,040.60 | 678.68 |
| | NOTE: May not be claimed in addition to HSC 66.83. | | |
| 56.93D | Removal of gastric band | 713.10 | 529.68 |
| | NOTE: May not be claimed in addition to HSCs 56.93E, 66.4 A and 66.83. | | |
| 56.93E | Port revision or replacement | 374.99 | 147.37 |
| | NOTE: May not be claimed in addition to HSC 56.93D. | | |
| 56.93F | Placement of gastric band including port placement | 863.08 | 550.41 |

56.99 Other operations on stomach NEC

| | | | |
|---|---|---|---|
| 56.99A | Balloon dilatation of upper gastrointestinal stricture (stomach, duodenum or jejunum) | 89.22 | 87.36 |
| | NOTE: 1. May only be claimed in addition to 01.14. 2. A repeat performed within 90 days is payable at 50%. | | |

57 INCISION, EXCISION AND ANASTOMOSIS OF INTESTINE

57.0 Enterotomy

| | | | |
|---|---|---|---|
| 57.0 A | Removal of foreign body or tumor | 633.87 | 256.18 |

57.03 Other incisions of small intestine

| | | | |
|---|---|---|---|
| 57.03A | Intestinal lengthening, Serial transverse enteroplasty procedure (STEP) | 2,338.50 | 1,462.19 |

57.04 Incision of large intestine

| | | | |
|---|---|---|---|
| 57.04A | Colotomy with removal of foreign body or tumor | 633.87 | 276.32 |

57.1 Local excision or destruction of lesion or tissue of small intestine
57.12 Other local excision or destruction of lesion or tissue of duodenum

| | | | |
|---|---|---|---|
| 57.12A | Diverticulectomy of duodenum | 607.46 | 209.65 |
| 57.12B | Duodenal diverticulum with choledochostomy | 801.06 | 305.76 |

57.13 Endoscopic excision or destruction of lesion or tissue of small intestine except duodenum

| | | | |
|---|---|---|---|
| 57.13A | Bipolar electrocoagulation/heater probe hemostasis or endoclip placement or argon plasma coagulation for bleeding lesions of the colon following an | | |

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

57 INCISION, EXCISION AND ANASTOMOSIS OF INTESTINE (cont'd)

57.1 Local excision or destruction of lesion or tissue of small intestine (cont'd)

57.13 Endoscopic excision or destruction of lesion or tissue of small intestine except duodenum (cont'd)

| | BASE | ANE |
|---|---|---|
| initial procedure at a separate encounter, additional benefit . . . . . | 136.79 | 109.31 |

NOTE: 1. May only be claimed in addition to HSCs 01.16B, 01.16C, 01.22, 01.22A, 01.22B, 01.22C, 01.24B, 01.24BA and 01.24BB.
2. May only be claimed in situations where the patient has post-polypectomy bleeding following an initial procedure and must undergo a repeat procedure to manage post-polypectomy bleeding.
3. May not be claimed for services provided at the same encounter as the initial polypectomy.

57.13B Hemostasis of the colon via bipolar electrocoagulation/heater probe hemostasis, injection or endoclip placement or argon plasma coagulation for bleeding lesions of the colon that are not related to post polypectomy bleeds including but not limited to diverticulum bleeds, radiation enteritis, ulceration of the colon, additional benefit . . . . . 136.79 109.31

NOTE: 1. May only be claimed in addition to HSCs 01.16B, 01.16C, 01.22, and 01.24B.
2. May not be claimed for prophylactic clip placement.

57.14 Local excision of lesion or tissue of small intestine, except duodenum

57.14A Meckel's diverticulum resection . . . . . 528.23 276.32

57.2 Local excision or destruction of lesion or tissue of large intestine

57.21 Endoscopic excision or destruction of lesion or tissue of large intestine

57.21A Polypectomy of large intestine, additional benefit . . . . . 85.49 109.21

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

57 INCISION, EXCISION AND ANASTOMOSIS OF INTESTINE (cont'd)

57.2 Local excision or destruction of lesion or tissue of large intestine (cont'd)

57.21 Endoscopic excision or destruction of lesion or tissue of large intestine (cont'd)

BASE ANE

NOTE:
1. May only be claimed for the removal of polyps that are greater than 5mm in size.
2. May only be claimed with HSCs 01.16B, 01.16C, 01.22, 01.22A, 01.22B, 01.22C, 01.24B, 01.24BA and 01.24BB and when the removal of a colonic mucosal lesion is performed using a polypectomy snare (with or without electrocautery)or a hot biopsy forceps.
3. May be claimed in addition to HSC 57.21C if polyps are removed from different sites.
4. May not be claimed when a regular biopsy forceps is used to remove a diminutive polyp without electrocautery, even if multiple passes are required.
5. Benefit includes placement of clips at the time of polypectomy.
6. Each additional polyp may be claimed at the rate specified on the Price List; a maximum benefit of six calls applies.

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

57 INCISION, EXCISION AND ANASTOMOSIS OF INTESTINE (cont'd)

57.2 Local excision or destruction of lesion or tissue of large intestine (cont'd)

57.21 Endoscopic excision or destruction of lesion or tissue of large intestine (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 57.21B | Injection hemostasis, additional benefit . . . . . | 129.17 | 109.31 |

For vascular abnormalities of colon

NOTE: 1. May not be claimed for control of bleeding, following polypectomies.
2. Maximum of one per sitting irrespective of the number of sites involved.
3. May only be claimed in addition to HSCs 01.22, 01.22A, 01.22B, 01.22C, 01.24B, 01.24BA and 01.24BB.
4. May be claimed in addition to HSC 57.21C if polyps are removed from a different site.

| | | | |
|---|---|---|---|
| 57.21C | Removal of sessile polyp, additional benefit . . . . . | 175.00 | 145.74 |

NOTE: 1. May only be claimed for polyps greater than 2 cms in size requiring submucosal injection and piecemeal resection.
2. May only be claimed in addition to HSCs 01.22, 01.22A, 01.22B, 01.22C, 01.24B, 01.24BA and 01.24BB.
3. May be claimed in addition to HSC 57.21A if polyps are removed from different sites.
4. May not be claimed for pedunculated polyps.
5. Benefit includes placement of clips at the time of polypectomy.
6. A maximum of two calls applies.

57.4 Other excision of small intestine

57.42 Other partial resection of small intestine

| | | | |
|---|---|---|---|
| 57.42A | Small bowel resection . . . . . | 713.10 | 354.21 |

NOTE: 1. May only be claimed with HSC 57.59A when two anastomoses are performed.
2. May only be claimed with HSC 60.52B when two discontinuous areas are resected and two anastomoses are performed.
3. May not be claimed in addition to HSCs 57.7 or 63.12B.

| | | | |
|---|---|---|---|
| 57.42B | Massive resection, over 60% . . . . . | 1,056.45 | 368.43 |

NOTE: May not be claimed with HSCs 60.52A or 60.52B.

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

57 INCISION, EXCISION AND ANASTOMOSIS OF INTESTINE (cont'd)

57.5 Partial excision of large intestine

57.59 Other partial excision of large intestine

| | | BASE | ANE |
|---|---|---|---|
| 57.59A | Partial or segmental colectomy | 1,024.76 | 745.50 |
| | NOTE: 1. Benefit includes right hemicolectomy, left hemicolectomy, sigmoid colectomy or extended right hemicolectomy. 2. More than one call may be claimed if two or more anastomoses are performed. 3. May only be claimed with HSC 60.52B when two discontinuous areas are resected and two anastomoses are performed. 4. May not be claimed with HSC 60.52A or 63.12B. | | |

57.6 Total colectomy

| | | | |
|---|---|---|---|
| 57.6 A | Total colectomy with or without ileostomy | 1,336.41 | 655.61 |
| | NOTE: Refer to the note following HSC 57.6 E. | | |
| 57.6 B | Total proctocolectomy with ileostomy | 1,489.59 | 589.48 |
| | NOTE: Refer to the note following HSC 57.6 E. | | |
| 57.6 C | Total proctocolectomy with continent ileostomy | 1,684.99 | 671.35 |
| | NOTE: Refer to the note following HSC 57.6 E. | | |
| 57.6 D | Total proctocolectomy with diverting ileostomy, ileo-anal pouch and ileo-anal anastomosis | 2,424.55 | 681.59 |
| | NOTE: Refer to the note following HSC 57.6 E. | | |
| 57.6 E | Creation of ileo-anal pouch and ileo-anal anastomosis following previous total colectomy | 1,648.06 | 589.48 |
| | NOTE: HSCs 57.6 A through 57.6 E may not be claimed in addition to HSCs 60.52A or 60.52B. | | |
| 57.6 F | Colon j pouch or coloplasty construction, additional benefit | 153.19 | 110.53 |
| | NOTE: May only be claimed in addition to HSC 60.52B. | | |

57.7 Small to small intestinal anastomosis

| | | | |
|---|---|---|---|
| 57.7 | Small to small intestinal anastomosis | 739.52 | 276.32 |
| | NOTE: 1. May be claimed for ileostomy closure and/or stricturoplasty. 2. May not be claimed in addition to HSCs 55.8 B, 55.9 AA, 57.42A or 63.69A. | | |

57.8 Other anastomosis of intestine

57.82 Anastomosis of small intestine to rectal stump

| | | | |
|---|---|---|---|
| 57.82A | Reanastomosis of colon following Hartman procedure | 1,024.76 | 405.27 |

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

57 INCISION, EXCISION AND ANASTOMOSIS OF INTESTINE (cont'd)

57.8 Other anastomosis of intestine (cont'd)
57.85 Anastomosis of anus

| | | BASE | ANE |
|---|---|---|---|
| 57.85A | Completion of perianal portion of anastomosis | 153.19 | 122.16 |
| | NOTE: 1. This benefit is for the second surgeon.<br>2. May not be claimed in addition to any other procedures by the same physician at the same encounter. | | |

57.9 Invasive diagnostic procedures on intestine
57.92 Other biopsy of small intestine

| | | | |
|---|---|---|---|
| 57.92A | Crosby capsule, jejunal biopsy | 84.52 V | 131.04 |
| | NOTE: For under 13 years of age, refer to Price List. | | |

58 OTHER OPERATIONS ON INTESTINE

58.1 Colostomy
58.11 Colostomy, unqualified

| | | | |
|---|---|---|---|
| 58.11A | Colostomy | 448.99 | 239.49 |
| | NOTE: May be claimed when a temporary or permanent colostomy is performed regardless of the type, i.e. loop or end colostomy. | | |

58.12 Temporary colostomy

| | | | |
|---|---|---|---|
| 58.12A | Cecostomy | 448.99 | 147.37 |
| | NOTE: When only procedure performed. | | |
| 58.13C | Mitrofanoff antegrade continence enema | 684.49 | 265.01 |

58.3 Other enterostomy
58.39 Other enterostomy NEC

| | | | |
|---|---|---|---|
| 58.39A | Enterostomy primary procedure | 602.18 | 239.49 |
| | NOTE: 1. Fee will be paid at 100% when only procedure performed.<br>2. With other abdominal or gastrointestinal procedures refer to Price List, fee will be paid as ADD or ADD2.<br>3. To a maximum of two per operation. | | |
| 58.39B | Percutaneous endoscopic jejunostomy | 113.99 | 109.31 |
| | NOTE: May only be claimed in addition to 01.14. | | |
| 58.39C | Intra-operative placement of small bowel feeding tube, additional benefit | 99.53 | 109.21 |

58.4 Revision of intestinal stoma
58.42 Revision of stoma of small intestine

| | | | |
|---|---|---|---|
| 58.42A | Ileostomy revision | 528.23 | 257.90 |
| | NOTE: Includes laparotomy and lysis of adhesions. | | |

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

58 OTHER OPERATIONS ON INTESTINE (cont'd)

58.4 Revision of intestinal stoma (cont'd)

58.44 Other revision of stoma of large intestine

| | | BASE | ANE |
|---|---|---|---|
| 58.44A | Colostomy revision | 581.05 | 257.90 |
| | NOTE: Includes laparotomy and lysis of adhesions. | | |

58.7 Other repair of intestine

| | | | |
|---|---|---|---|
| 58.73 | Other suture of small intestine, except duodenum | 607.46 | 350.01 |
| | NOTE: 1. May not be claimed for incidental bowel perforations. | | |
| | 2. May not be claimed in addition to HSC 63.12B. | | |

58.75 Suture of large intestine

| | | | |
|---|---|---|---|
| 58.75A | Suture of large or small intestine | 713.10 | 350.01 |
| | NOTE: 1. May not be claimed for incidental bowel perforations. | | |
| | 2. May not be claimed in addition to HSC 63.12B. | | |

58.8 Intra-abdominal manipulation of intestine

58.81 Intra-abdominal manipulation of intestine, unqualified

| | | | |
|---|---|---|---|
| 58.81A | Any form of obstruction without resection | 713.10 | 354.21 |
| 58.81B | Any form of obstruction with enterotomy decompression | 871.57 | 420.62 |
| 58.81C | Any form of obstruction with resection | 1,067.01 | 441.82 |
| | NOTE: May not be claimed with HSCs 60.52A or 60.52B. | | |
| 58.81D | Neonatal intestinal obstruction, atresia or meconium ileus | 1,943.87 | 796.77 |

58.9 Other operations on intestines

58.99 Other operations on intestines NEC

| | | | |
|---|---|---|---|
| 58.99B | Decompression of sigmoid volvulus (trans-rectal) | 170.99 | 110.43 |
| 58.99C | Balloon dilatation of lower gastrointestinal (ileum or colonic) stricture | 91.19 | 87.36 |
| | NOTE: 1. May only be claimed in addition to HSCs 01.16B, 01.16C, 01.22, 01.22A, 01.22B, 01.22C and 01.24B. | | |
| | 2. A repeat performed within 90 days is payable at 50%. | | |
| 58.99D | Balloon dilatation of lower gastrointestinal (ileum or colonic) stricture in association with sigmoidoscopy | 63.39 | 87.36 |
| | NOTE: 1. May only be claimed in addition to HSCs 01.24A, 01.24B, 01.24BA and 01.24BB. | | |
| | 2. A repeat performed within 90 days is payable at 50%. | | |
| 58.99E | Intraoperative colonic lavage | 153.19 | |
| | NOTE: May only be claimed in addition to HSCs 57.59A, 57.6 A, 57.6 B, 57.6 C, 57.6 D, 57.6 E, 57.82A, 58.81A, 58.81B, 58.81C, 60.39A, 60.4 A, 60.4 B, 60.52A, 60.52B, 60.54, 60.59A and 60.59B. | | |

## X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

### 58 OTHER OPERATIONS ON INTESTINE (cont'd)

58.9 Other operations on intestines (cont'd)

58.99 Other operations on intestines NEC (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 58.99F | Manual disimpaction of stool . . . . . | 100.00 V | 110.53 |
| | NOTE: May be claimed in addition to a visit or consultation. | | |

### 59 OPERATIONS ON APPENDIX

59.0 Appendectomy

| | | | |
|---|---|---|---|
| 59.0 A | Appendectomy with or without abscess . . . . . | 528.23 | 184.21 |
| | NOTE: May not be claimed for incidental appendectomies. | | |

### 60 OPERATIONS ON RECTUM AND PERIRECTAL TISSUE

No additional benefits for sigmoidoscopy

60.2 Local excision or destruction of lesion or tissue of rectum

60.24 Local excision of rectal lesion or tissue

| | | | |
|---|---|---|---|
| 60.24C | Rectal polyp including villous adenoma, per 30 minutes or major portion thereof . . . . . | 311.65 | 147.37 |
| | NOTE: A maximum of three hours may be claimed. | | |

60.3 Pull-through resection of rectum

60.39 Other pull-through resection of rectum

| | | | |
|---|---|---|---|
| 60.39A | Imperforated anus, abdominal perineal repair . . . . . | 1,257.18 | 388.68 |

60.4 Abdominoperineal resection of rectum

| | | | |
|---|---|---|---|
| 60.4 A | Abdominal-perineal resection . . . . . | 1,648.06 | 509.18 |
| | NOTE: This benefit is for the abdominal surgeon. | | |
| 60.4 B | Perineal portion of abdomino-perineal resection . . . . . | 475.40 | |
| | NOTE: 1. May be claimed by the same or different physician regardless of who performed the abdominal portion of the surgery.<br>2. May only be claimed in addition to HSCs 57.6 B, 60.4 A and 60.52B | | |

60.5 Other resection of rectum

60.52 Other anterior resection

| | | | |
|---|---|---|---|
| 60.52A | Anterior segmental resection, rectosigmoid . . . . . | 1,103.99 | 509.18 |
| | NOTE: May not be claimed in addition to HSCs 57.42B, 57.59A, 57.6 A, 57.6 B, 57.6 C, 57.6 D, 57.6 E and 58.81C. | | |

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

60 OPERATIONS ON RECTUM AND PERIRECTAL TISSUE
No additional benefits for sigmoidoscopy (cont'd)

60.5 Other resection of rectum (cont'd)
60.52 Other anterior resection (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 60.52B | Total mesorectal excision<br>NOTE: 1. May only be claimed for rectal neoplasms (benign and or malignant tumors), or inflammatory bowel disease.<br>2. May not be claimed in addition to HSCs 57.6 A, 57.6 B, 57.6 C, 57.6 D, 57.6 E and 58.81C.<br>3. HSCs 57.42A and 57.59A may only be claimed in addition when two discontinuous areas are resected and two anastomoses are performed.<br>4. May be claimed in addition to HSC 57.6 F. | 1,648.06 | 509.18 |
| 60.54 | Duhamel resection | 1,024.76 | 388.68 |

60.59 Other resection of rectum NEC

| | | | |
|---|---|---|---|
| 60.59A | Perineal resection of rectum | 713.10 | 313.17 |
| 60.59B | Full thickness transanal or trans-sphincteric resection of rectum | 950.81 | 386.85 |

60.6 Repair of rectum

60.65 Abdominal protopexy

| | | | |
|---|---|---|---|
| 60.65 | Abdominal proctopexy<br>NOTE: May be claimed in addition to HSC 60.52A. | 1,024.61 | 294.73 |

60.66 Other proctopexy

| | | | |
|---|---|---|---|
| 60.66A | Rectal prolapse (massive) perineal approach | 528.23 | 184.21 |

60.7 Incision or excision of perirectal tissue or lesion
60.71 Incision of perirectal tissue

| | | | |
|---|---|---|---|
| 60.71B | Incision, excision or drainage of perirectal tissue, lesion or abscess<br>NOTE: May only be claimed when performed under general anesthesia. | 295.81 | 110.53 |

60.8 Invasive diagnostic procedures on rectum and perirectal tissue
60.82 Other biopsy of rectum

| | | | |
|---|---|---|---|
| 60.82C | Rectal biopsy for Hirschsprung's disease | 153.19 V | 110.53 |

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

60 OPERATIONS ON RECTUM AND PERIRECTAL TISSUE
No additional benefits for sigmoidoscopy (cont'd)

60.8 Invasive diagnostic procedures on rectum and perirectal tissue (cont'd)

60.89 Other invasive diagnostic procedures on rectum and perirectal tissue

| | | BASE | ANE |
|---|---|---|---|
| 60.89A | Rectal motility studies | 79.79 | |

61 OPERATIONS ON ANUS
NOTE: No additional payment for sigmoidoscopy

61.0 Incision or excision of perianal tissue

61.01 Incision of perianal abscess

| | | | |
|---|---|---|---|
| 61.01A | Ano-rectal abscess | 96.81 V | 110.53 |
| 61.01B | Ischiorectal abscess | 216.57 | 110.53 |
| 61.03 | Excision of perianal skin tags | 44.99 | |

61.2 Local excision or destruction of other lesion or tissue of anus

| | | | |
|---|---|---|---|
| 61.2 A | Anal fissurectomy<br>NOTE: May be claimed with 61.4 A. | 132.06 | 110.53 |

61.29 Other local excision or destruction of other lesion or tissue of anus

| | | | |
|---|---|---|---|
| 61.29B | Local excision or destruction of lesion, tissue or polyp of anus<br>NOTE: A maximum of six calls may be claimed. | 79.23 V | 110.53 |

61.3 Procedures on hemorrhoids

61.36 Excision of hemorrhoids

| | | | |
|---|---|---|---|
| 61.36A | Hemorrhoidectomy<br>Includes related ano-rectal procedures | 311.65 | 110.53 |

61.37 Evacuation of thrombosed hemorrhoids

| | | | |
|---|---|---|---|
| 61.37A | Incision or excision | 57.05 V | 110.43 |

61.39 Other procedures on hemorrhoids

| | | | |
|---|---|---|---|
| 61.39B | Scarification procedure on hemorrhoids<br>NOTE: May be claimed for any local treatment on hemorrhoids, i.e. banding, injection etc. | 79.23 V | 110.53 |

61.4 Division of anal sphincter

61.4 Sphincterotomy

| | | | |
|---|---|---|---|
| 61.4 A | Anoplasty or lateral sphincterotomy<br>NOTE: May be claimed with HSC 61.2 A. | 311.65 | 110.53 |

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

61 OPERATIONS ON ANUS
NOTE: No additional payment for sigmoidoscopy (cont'd)

61.6 Repair of anus

61.63 Closure of anal fistula

| | | BASE | ANE |
|---|---|---|---|
| 61.63A | Anal fistulotomy and other procedures for anal fistula | 290.52 | 110.53 |

NOTE: 1. Benefit includes insertion of seton, fibrin glue injection, anal fistula plug insertion, ligation of intersphincteric fistula tract.
2. Maximum of three calls may be claimed per encounter.
3. Second and third calls may not be claimed unless treatment is performed on documented separate internal openings for each call at the same encounter.
4. HSC 10.23 may not be claimed in addition.

61.69 Other repair of anus and anal sphincter

| | | | |
|---|---|---|---|
| 61.69B | Imperforate anus, plastic repair | 470.12 | 203.18 |

62 OPERATIONS ON LIVER

62.1 Local excision or destruction of lesion or tissue of liver

62.12 Partial hepatectomy

| | | | |
|---|---|---|---|
| 62.12A | Biopsy with laparotomy | 528.23 | 221.05 |
| 62.12B | Liver biopsy in conjunction with other open or laparoscopic abdominal procedure, additional benefit | 132.06 | 61.15 |

NOTE: May not be claimed for needle biopsy.

| | | | |
|---|---|---|---|
| 62.12C | Partial resection of liver | 1,441.95 | 531.31 |

NOTE: 1. May not be claimed for wedge biopsy.
2. May not be claimed in addition to HSCs 62.2 B, 63.12B or 63.69A.

62.2 Lobectomy of liver

| | | | |
|---|---|---|---|
| 62.2 A | Lobectomy of liver (living donor) | 4,099.03 | 1,586.38 |

NOTE: Benefit includes back table preparation.

| | | | |
|---|---|---|---|
| 62.2 B | Lobectomy of liver - 4 or more hepatic segments | 2,641.13 | 819.11 |

NOTE: May not be claimed in addition to HSCs 62.12C, 63.12B or 63.69A.

62.3 Total hepatectomy

| | | | |
|---|---|---|---|
| 62.3 A | Recipient | 2,377.01 | |

NOTE: The anesthetic fee for recipient hepatectomy is included in the anesthetic fee for hepatic transplantation.

| | | | |
|---|---|---|---|
| 62.3 B | Donor | 2,857.70 | 681.59 |

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

62 OPERATIONS ON LIVER (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 62.4 | Liver transplant | | |
| 62.4 | Liver transplant | 5,018.14 | 2,974.33 |
| 62.5 | Repair of liver | | |
| 62.51 | Suture of liver | 528.23 | 309.70 |
| | That for (traumatic) laceration | | |
| 62.8 | Invasive diagnostic procedures on liver | | |
| 62.81 | Percutaneous biopsy of liver | | |
| 62.81A | Needle biopsy of liver | 119.47 V | 110.53 |
| 62.82 | Other biopsy of liver | | |
| 62.82A | Transjugular liver biopsy | 235.08 | 132.51 |

63 OPERATIONS ON GALLBLADDER AND BILIARY TRACT

| | | | |
|---|---|---|---|
| 63.0 | Cholecystotomy and cholecystostomy | | |
| 63.09 | Other cholecystotomy and cholecystostomy | | |
| 63.09A | Cholecystostomy | 497.90 | 202.64 |
| 63.1 | Cholecystectomy | | |
| 63.12 | Total cholecystectomy | | |
| 63.12A | Open surgical cholecystectomy | 739.52 | 313.17 |
| | NOTE: 1. May not be claimed for laparoscopic cholecystectomy. | | |
| 63.12B | Cholecystectomy with closure of fistula to duodenum or colon | 1,320.56 | 368.43 |
| | Note: May not be claimed in addition to HSCs 57.42A, 57.59A, 58.73, 58.75A, 62.12C or 62.2 B. | | |
| 63.12D | Transduodenal sphincteroplasty with cholecystectomy | 1,559.15 | 528.31 |
| 63.12E | Choledocho-enterostomy with cholecystectomy | 1,579.39 | 477.03 |
| 63.14 | Laparoscopic cholecystectomy | 528.23 | 312.53 |
| | NOTE: May not be claimed for open surgical cholecystectomy. | | |
| 63.2 | Anastomosis of gallbladder or bile duct | | |
| 63.22 | Anastomosis of gallbladder to intestine | 828.68 | 270.82 |
| | NOTE: Refer to the note following HSC 63.27. | | |
| 63.27 | Anastomosis of hepatic duct to gastrointestinal tract | 1,769.55 | 600.70 |
| | NOTE: HSCs 63.22 and 63.27 may not be claimed in addition to HSCs 63.41, 63.69A, 64.3, 64.43A, 64.49A or 64.7. | | |
| 63.4 | Other incision of bile duct | | |
| 63.41 | Incision of common duct | 1,162.10 | 350.01 |

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

63 OPERATIONS ON GALLBLADDER AND BILIARY TRACT (cont'd)

63.4 Other incision of bile duct (cont'd)

| | BASE | ANE |
|---|---|---|
| NOTE: May not be claimed in addition to HSCs 63.22 or 63.27. | | |

63.6 Repair of bile ducts

63.69 Repair of other bile ducts

| | | |
|---|---|---|
| 63.69A Resection and reconstruction of common bile duct including secondary plastic repair and all anastomoses | 3,169.35 | 626.33 |
| NOTE: May not be claimed in addition to HSCs 52.2, 57.7, 62.12C, 62.2 B, 63.22 or 63.27. | | |

63.8 Other operations on biliary ducts and operations on sphincter of Oddi

63.86 Endoscopic sphincterotomy and papillotomy

| | | |
|---|---|---|
| 63.86A Billary sphincteroplasty, dilation of the ampulla of Vater | 113.99 | 87.36 |
| NOTE: May only be claimed in addition to 64.97A. | | |
| 63.87 Endoscopic insertion of nasobiliary drainage tube | 62.24 | |
| NOTE: 1. May not be claimed in association with 63.88. 2. May only be claimed in addition to 64.97A. | | |
| 63.88 Endoscopic pancreatic stent placement or insertion of stent into bile duct, additional benefit | 113.99 | |
| NOTE: 1. May not be claimed in addition to HSC 63.87. 2. May only be claimed in addition to HSC 64.97A. | | |

63.89 Other operations on sphincter of Oddi

| | | |
|---|---|---|
| 63.89A Transduodenal sphincteroplasty | 1,320.56 | 353.34 |

63.9 Other operations on biliary tract

63.90 Endoscopic removal of calculus (calculi) from biliary tract

| | | |
|---|---|---|
| 63.90A Mechanical stone lithotripsy | 113.99 | |
| 63.90B Stone extraction | 57.00 | |
| NOTE: 1. May not be claimed in association with each other. 2. May be claimed in addition to 64.97A. | | |

63.96 Intra-operative or intravenous cholangiogram or percutaneous hepatic cholangiogram

| | | |
|---|---|---|
| 63.96A Intra-operative injection of contrast media for cholangiogram | 105.65 | |
| 63.96B Percutaneous trans-hepatic cholangiography | 129.49 | 110.53 |

63.99 Other operations on biliary tract NEC

| | | |
|---|---|---|
| 63.99A Percutaneous removal or attempted removal of retained biliary tract stone(s) | 242.79 | 110.43 |

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

63 OPERATIONS ON GALLBLADDER AND BILIARY TRACT (cont'd)

63.9 Other operations on biliary tract (cont'd)

63.99 Other operations on biliary tract NEC (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 63.99B | Percutaneous biliary tract drainage, including transhepatic cholangiography, full 60 minutes or major portion thereof . . . . . | 272.85 | |
| | NOTE: Each subsequent 15 minutes, or major portion thereof after the first full 60 minutes has elapsed, is payable at the rate specified on the Price List; a maximum benefit applies. | | |
| 63.99C | Biliary lithotripsy for impacted distal common bile duct stone . . . . . | 437.31 V | |
| | NOTE: 1. Only one benefit may be claimed regardless of the number of calculi.<br>2. Physician in continuous attendance.<br>3. Includes injection of dye contrast material.<br>4. Includes injection of sedation when required.<br>5. Repeat within 42 days - refer to Price List. | | |
| 63.99D | Biliary drain exchange . . . . . | 89.41 | 139.77 |

64 OPERATIONS ON PANCREAS

64.0 Pancreatotomy

64.09 Other pancreatotomy

| | | | |
|---|---|---|---|
| 64.09A | Pancreatic abscess, drainage . . . . . | 1,452.62 | 487.03 |
| 64.3 | Internal drainage of pancreatic cyst . . . . . | 1,316.96 | 368.43 |
| | Pancreatico-cystoenterostomy | | |
| | NOTE: May not be claimed with HSCs 56.2, 63.22, 63.27 and 64.7. | | |

64.4 Partial pancreatectomy

64.43 Radical subtotal pancreatectomy

| | | | |
|---|---|---|---|
| 64.43A | Pancreatectomy 95% resection . . . . . | 2,239.67 | 792.12 |
| | NOTE: 1. May be claimed in addition to HSC 66.83.<br>2. May not be claimed with HSCs 56.2, 63.22, 63.27 and 64.7. | | |

64.49 Other partial pancreatectomy

| | | | |
|---|---|---|---|
| 64.49A | Other partial pancreatectomy - with or without splenectomy . . . . . | 1,584.68 | 442.76 |
| | NOTE: 1. May be claimed in addition to HSC 66.83.<br>2. May not be claimed with HSCs 56.2, 63.22, 63.27 and 64.7. | | |

64.6 Radical pancreaticoduodenectomy

| | | | |
|---|---|---|---|
| 64.6 A | Whipple/ pancreaticoduodenectomy . . . . . | 4,099.03 | 2,573.45 |

## X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

### 64 OPERATIONS ON PANCREAS (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 64.6 | Radical pancreaticoduodenectomy (cont'd) | | |
| | NOTE: 1. Benefit includes all portions of the reconstruction, i.e., biliary, gastric and pancreatic anastomosis, cholecystectomy and regional lymph node dissection and other standard steps in the procedure. 2. May not be claimed in addition to any other procedure at the same encounter. | | |
| 64.7 | Anastomosis of pancreas (duct) | | |
| 64.7 | Anastomosis of pancreas (duct) | 1,584.68 | 423.69 |
| | Pancreatico-enterostomy | | |
| | NOTE: May not be claimed with HSCs 56.2, 63.22, 63.27, 64.3, 64.43A or 64.49A. | | |
| 64.8 | Transplant of pancreas | | |
| 64.81 | Pancreatic transplant, unqualified | | |
| 64.81A | Pancreatic transplant and back table preparation | 2,995.04 | 2,013.11 |
| 64.81B | Donor pancreas removal | 982.50 | 892.67 |
| | NOTE: To be claimed under the donor PHN. | | |
| 64.9 | Other operations on pancreas | | |
| 64.95 | Aspiration biopsy of pancreas | | |
| 64.95A | Needle biopsy of pancreas | 113.99 V | 110.43 |
| 64.97 | Contrast pancreatogram | | |
| 64.97A | Endoscopic retrograde cholangiopancreatography (ERCP) | 262.18 | 165.79 |
| | NOTE: May be claimed in addition to HSCs 13.99AF, 63.86A, 63.87, 63.88, 63.90A, and 63.90B. | | |
| 65.04 | Repair of femoral hernia | | |
| 65.04A | Repair of femoral hernia | 448.99 | 147.37 |
| 65.04C | Incarcerated femoral | 448.99 | 184.21 |
| 65.1 | Repair of inguinofemoral hernia with graft or prosthesis (unilateral) | | |
| 65.1 A | Repair of recurrent inguinal or femoral hernia, including mesh if used | 650.67 | 268.63 |
| 65.1 B | Repair of inguinal or femoral hernia, including mesh | 448.99 | 268.63 |
| 65.11 | Repair of inguinal hernia, unqualified, with graft or prosthesis | | |
| 65.11A | Repair of inguinal hernia - with or without incarceration, obstruction or strangulation, includes the use of mesh if used | 448.99 | 145.79 |
| 65.4 | Repair of umbilical hernia | | |
| 65.4 A | Repair of omphalocele | 496.53 | 265.65 |
| 65.4 B | Omphalocele, staged | 655.00 | 279.56 |

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

64 OPERATIONS ON PANCREAS (cont'd)

65.4 Repair of umbilical hernia (cont'd)

65.49 Other repair of umbilical hernia

| | | BASE | | ANE |
|---|---|---|---|---|
| 65.49A | Repair of umbilical and/or epigastric hernia . . . . . | 375.04 | V | 147.37 |

NOTE: 1. Benefit for child under 11 years of age, refer to Price List.
2. Two calls may be claimed at 100% where both umbilical and epigastric hernias are repaired.

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

64 OPERATIONS ON PANCREAS (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 65.6 | Repair of other hernia of anterior abdominal wall with graft or prosthesis | | |
| 65.61 | Repair of incisional hernia with graft or prosthesis | | |
| 65.61A | Repair of incisional hernia including mesh, if used | 855.72 | 434.43 |
| | NOTE: 1. Refer to Price List for benefit when performed in conjunction with other abdominal procedures. 2. May not be claimed in conjunction with bowel obstruction HSCs 58.81A, 58.81B, or 58.81C. 3. A second call may only be claimed if a non-contiguous site requires repair. 4. HSC 66.4 A may not be claimed in addition. 5. Not for recurrent inguinal hernias. | | |
| 65.7 | Repair of diaphragmatic hernia (abdominal approach) | | |
| 65.7 A | Repair of diaphragmatic hernia, abdominal approach, acquired | 681.41 | 257.90 |
| | NOTE: When performed with HSCs 56.93A or 56.93C, the benefit will be paid as ADD. Refer to the Price List. | | |
| 65.7 B | Anti-reflux procedure | 839.88 | 420.62 |
| 65.7 D | Repair of congenital diaphragmatic hernia for infant 14 days of age and younger | 1,943.87 | 1,218.57 |
| 65.8 | Repair of diaphragmatic hernia, thoracic approach | | |
| 65.8 | Repair of diaphragmatic hernia | | |
| 65.8 A | Thoracic approach, congenital or acquired | 869.97 | 247.34 |
| 65.8 B | Anti-reflux procedure | 775.95 | 350.01 |
| 65.9 C | Repair of paraesophageal hernia, greater than 50% of stomach, intrathoracic, either abdominal or thoracic approach, confirmed by pre-operative imaging | 1,645.01 | 1,214.74 |
| 65.9 D | Parastomal hernia repair (includes revision and/or relocation of ileostotomy/colostomy and the incision hernia repair) | 1,325.84 | 982.46 |
| | NOTE: 1. May only be claimed in instances where the stoma has been re-sited. 2. May not be claimed in addition to other hernia repair procedures or bowel resection procedures. 3. Includes laparotomy and lysis of adhesions. | | |
| 65.9 E | Repair of diaphragmatic hernia, abdominal or thoracic approach, anti-reflux procedure | 1,679.76 | 586.24 |
| | That for recurrent esophagitis, following a previous repair | | |

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

66 OTHER OPERATIONS ON ABDOMINAL REGION

| | | BASE | ANE |
|---|---|---|---|
| 66.1 | Laparotomy | | |
| 66.19 | Other laparotomy | | |
| 66.19A | Other laparotomy | 390.19 | 199.24 |
| | NOTE: May not be claimed for hernia repair or in addition to hernia repair HSCs (65 series). | | |
| 66.19B | Drainage of intraperitoneal abscess, including subphrenic and pelvic | 496.53 | 309.93 |
| 66.19C | Transabdominal approach to the spine | 314.69 | 366.90 |
| | NOTE: Benefit is for the general surgeon when a spinal procedure is performed by a second operator. | | |
| 66.19D | Laparotomy for trauma patients, first 60 minutes | 433.14 | 321.18 |
| | NOTE: 1. Benefit includes exploration of hematoma(s), Kockerization of duodenum, lesser sac and control of minor bleeding as well as other explorations for injury in trauma patients. | | |
| | 2. Each subsequent 15 minutes or major portion thereof may be claimed at the rate specified on the Price List. | | |
| | 3. Other procedures may be claimed in addition but the time spent in performing them may not be included in the time claimed for this procedure. | | |
| | 4. A maximum of three hours may be claimed. | | |
| | 5. HSC 66.67A may be claimed in addition. | | |
| 66.19E | Intraperitoneal Chemotherapy | 507.10 | 309.93 |
| 66.3 | Excision or destruction of lesion or tissue of peritoneum | | |
| 66.3 A | Omentectomy, for abdominal malignancy, additional benefit | 262.24 | 61.15 |
| | NOTE: May be claimed in addition to the primary procedure performed, except for HSCs 55.8 B and 55.9 AA. | | |
| 66.3 B | Retroperitoneal tumor, excision | 694.16 | 332.06 |
| 66.3 C | Retroperitoneal tumor, biopsy | 559.83 | 221.05 |
| 66.4 | Freeing of peritoneal adhesions | | |
| 66.4 A | Lysis of adhesions | 79.23 | |
| | NOTE: 1. May only be claimed when a full 15 minutes has been spent on adhesions. Each subsequent 15 minutes or major portion thereof may be claimed at the rate specified on the Price List. | | |
| | 2. May not be claimed in addition to procedures billed with REDO modifier(s). | | |
| | 3. May not be claimed in addition to HSCs 58.42A, 58.44A, 58.81A, 58.81B, 58.81C, 65.61A and 81.29C. | | |
| 66.5 | Suture of abdominal wall and peritoneum | | |
| 66.51 | Reclosure of post-operative disruption of abdominal wall | | |
| 66.51A | Post-operative closure or delayed primary closure abdominal wall | 528.23 | 239.49 |
| 66.51B | Superficial | 122.74 | 110.53 |
| 66.52 | Delayed closure of granulating abdominal wound | 126.77 | 110.43 |

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

66 OTHER OPERATIONS ON ABDOMINAL REGION (cont'd)

66.5 Suture of abdominal wall and peritoneum (cont'd)
66.51 Reclosure of post-operative disruption of abdominal wall (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 66.63 | Repair of gastroschisis | 639.15 | 265.65 |

66.67 Other repair of mesentery

| | | | |
|---|---|---|---|
| 66.67A | Mesenteric tear repair, additional benefit | 79.23 | |

NOTE: 1. May not be claimed for incidental repair.
2. May only be claimed in addition to HSC 66.19D.

66.8 Invasive diagnostic procedures of abdominal region
66.82 Biopsy of peritoneum

| | | | |
|---|---|---|---|
| 66.82A | Retroperitoneal mass biopsy | 119.47 V | 110.53 |
| 66.83 | Laparoscopy<br>Diagnostic, with or without biopsy | 215.96 | 147.37 |

NOTE: 1. May not be claimed in addition to other procedures if the laparoscopy is an integral part of the procedure with the exception of HSCs 62.12B, 81.09, 82.63 or 83.2 B, which may be claimed at 100%.
2. May be claimed in addition to HSCs 55.8 A, 55.8 B, 55.9 A, 55.99A, 64.43A, 64.49A.
3. May not be claimed in addition to HSC 56.93D.

66.89 Other invasive diagnostic procedure on abdominal region

| | | | |
|---|---|---|---|
| 66.89A | Peritoneal lavage<br>For diagnosis of intra-abdominal bleeding after blunt abdominal trauma | 47.54 | |
| 66.89B | Instillation or injection of contrast media for loopogram | 32.37 | |
| 66.89C | Insertion of catheters and injection of dye<br>That for sinograms or fistulograms, single or multiple studies | 50.10 | |

66.9 Other operations in abdominal region
66.91 Percutaneous abdominal paracentesis

| | | | |
|---|---|---|---|
| 66.91A | Paracentesis | 55.11 | |
| 66.91B | Percutaneous catheter drainage of deep abscess<br>That in body cavity, requiring CT or ultrasound localization | 277.47 | 110.53 |
| 66.91C | Replacement of percutaneous catheter for drainage of deep abscess in body cavity | 89.41 | 110.53 |
| 66.94 | Creation of peritoneovascular shunt | 451.65 | 255.05 |

66.98 Peritoneal dialysis

| | | | |
|---|---|---|---|
| 66.98A | Insertion of indwelling intraperitoneal dialysis catheter | 201.03 | 147.37 |

NOTE: Not payable in addition to omentectomy.

## XI. OPERATIONS ON THE URINARY TRACT

### 67 OPERATIONS ON KIDNEY

#### 67.0 Nephrotomy and Nephrostomy

##### 67.01 Nephrotomy

| | | BASE | ANE |
|---|---|---|---|
| 67.01A | Renal exploration | 342.25 | 150.17 |
| | NOTE: Includes that with renal biopsy or renal cyst. | | |
| 67.01B | Renal exploration to include nephrostomy | 342.25 | 229.66 |
| 67.02 | Nephrostomy | 240.47 | |
| | Percutaneous | | |

#### 67.1 Pyelotomy and Pyelostomy

##### 67.11 Pyelotomy

| | | | |
|---|---|---|---|
| 67.11A | Extended pyelolithotomy with infundibulolithotomy | 855.61 | 291.50 |
| 67.11B | Removal of renal calculus | 855.61 | 239.49 |
| | Percutaneous, ureteroscopic or open surgery approach. | | |
| | NOTE: 1. Benefit includes cystoscopy and retrograde pyelogram and all related operative procedures for removal of stone performed during the same hospital admission. | | |
| | 2. For a repeat percutaneous or ureteroscopic procedure during the same hospitalization, benefit will be reduced. Refer to Price List. | | |
| | 3. Two calls may only be claimed for bilateral removal of calculus. | | |

##### 67.12 Pyelostomy

| | | | |
|---|---|---|---|
| 67.12A | Cutaneous | 342.25 | 194.35 |

#### 67.3 Partial nephrectomy

| | | | |
|---|---|---|---|
| 67.3 A | Open partial nephrectomy | 1,796.79 | 309.93 |
| 67.3 B | Laparoscopic partial nephrectomy | 1,796.79 | 1,373.10 |

#### 67.4 Total nephrectomy

| | | | |
|---|---|---|---|
| 67.4 A | Nephroureterectomy and excision of bladder cuff | 1,711.23 | 460.53 |
| 67.4 B | Donor, cadaver unilateral/bilateral | 681.41 | |
| 67.4 C | Donor, live | 1,368.98 | 294.73 |
| | NOTE: Includes perfusion and arrangements for shipping. | | |
| 67.4 D | Laparoscopic live donor nephrectomy | 1,796.79 | 671.35 |

##### 67.41 Total nephrectomy (unilateral)

| | | | |
|---|---|---|---|
| 67.41A | Total nephrectomy | 1,008.91 | 276.32 |
| 67.41B | Radical nephrectomy thoraco-abdominal or transperitoneal | 1,711.23 | 398.49 |
| | Includes complete peri and paranephric tissue | | |
| 67.41C | Laparoscopic radical nephrectomy | 1,711.23 | 907.65 |
| 67.41D | Radical nephrectomy with removal of suprahepatic tumor thrombus | 2,737.96 | 1,033.76 |

## XI. OPERATIONS ON THE URINARY TRACT (cont'd)

### 67 OPERATIONS ON KIDNEY (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| **67.5 Transplant of kidney** | | | |
| **67.59 Other kidney transplantation** | | | |
| 67.59A | Renal transplantation (homo, hetero, auto) | 1,695.60 | 642.00 |
| | NOTE: 1. Includes intra-operative renal biopsy. 2. May not be claimed in addition to HSCs 68.72A or 68.72C. | | |
| **67.6 Nephropexy** | | | |
| 67.6 | Nephropexy | 194.35 | 141.34 |
| **67.7 Other repair of kidney** | | | |
| 67.71 | Suture of kidney That for (traumatic) laceration | 631.49 | 279.56 |
| 67.72 | Closure of nephrostomy and pyelostomy | 667.38 | 244.62 |
| 67.75 | Symphysiotomy of horseshoe kidney | 687.55 | 192.20 |
| **67.79 Other repair of kidney NEC** | | | |
| 67.79A | Pyeloplasty | 684.49 | 294.73 |
| 67.79B | Laparoscopic pyeloplasty | 1,368.98 | 929.79 |
| **67.8 Invasive diagnostic procedures on kidney** | | | |
| 67.81 | Percutaneous biopsy of kidney | 114.07 V | 110.53 |
| 67.83 | Nephroscopy | 154.01 | 110.43 |
| 67.86 | Retrograde pyelogram | 136.90 V | 110.53 |
| | NOTE: 1. Includes cystoscopy. 2. Only one call may be claimed whether unilateral or bilateral. | | |
| **67.87 Percutaneous pyelogram** | | | |
| 67.87A | Percutaneous injection of contrast media into renal pelvis under CT or ultrasound guidance for antegrade pyelography | 134.88 | 109.21 |
| **67.89 Other invasive diagnostic procedures on kidney** | | | |
| 67.89A | Instillation or injection of contrast media for nephrostogram | 32.37 | |
| | NOTE: 1. May be claimed by the surgeon who performed the surgery only when the service is provided after the 14 day post-operative period. 2. Benefit for injection of opaque media without intubation being required is included in X77A and X77B. | | |
| **67.9 Other operations on kidney** | | | |
| 67.93 | Replacement of nephrostomy tube | 34.68 | 109.21 |
| | NOTE: May be claimed by the surgeon who performed the surgery only when the service is provided after the 14 day post-operative period. | | |

## XI. OPERATIONS ON THE URINARY TRACT (cont'd)

### 67 OPERATIONS ON KIDNEY (cont'd)

#### 67.9 Other operations on kidney (cont'd)

##### 67.96 Other injection into kidney of therapeutic substance acting locally

| | | BASE | ANE |
|---|---|---|---|
| 67.96A | Aspiration/injection of renal cyst | 74.76 V | 109.21 |

##### 67.99 Other operations on kidney NEC

| | | | |
|---|---|---|---|
| 67.99A | Renal bivalve and multiple selected nephrotomies<br>That for stag horn calculus<br>NOTE: Includes renal hypothermia and selective segmental renal artery dissection and occlusion. | 1,368.98 | 419.33 |

### 68 OPERATIONS ON URETER

#### 68.0 Transurethral clearance of ureter and renal pelvis

| | | | |
|---|---|---|---|
| 68.0 A | Endoscopic removal of ureteral calculus (basket extraction) | 171.12 | 110.53 |

#### 68.1 Ureteral meatotomy

| | | | |
|---|---|---|---|
| 68.1 | Ureteral meatotomy | 85.56 V | 110.53 |

#### 68.2 Ureterotomy

| | | | |
|---|---|---|---|
| 68.2 A | Removal of calculus from ureter<br>Percutaneous, ureteroscopic or open surgery approach<br>NOTE: 1. Benefit includes cystoscopy and retrograde pyelogram and all related operative procedures for removal of stone performed during the same hospital admission.<br>2. For a repeat percutaneous or ureteroscopic procedure during the same hospitalization, benefit will be reduced. Refer to Price List.<br>3. Two calls may only be claimed for bilateral removal of calculus. | 513.37 | 239.49 |

#### 68.3 Ureterectomy

| | | | |
|---|---|---|---|
| 68.3 | Ureterectomy | 513.37 | 150.17 |

##### 68.32 Partial ureterectomy

| | | | |
|---|---|---|---|
| 68.32A | Ureteroureterostomy, ipsilateral | 684.49 | 257.90 |
| 68.32B | Excision or incision of ureterocoele | 85.56 V | 109.21 |

#### 68.4 Cutaneous ureteroileostomy

##### 68.41 Formation of cutaneous ureteroileostomy

| | | | |
|---|---|---|---|
| 68.41A | Ureteral transplant to ileal conduit | 513.37 | 265.01 |
| 68.41B | Reimplantation of ureter to ileal conduit | 684.49 | 350.01 |
| 68.41C | Uretero-ileo-cutaneous conduit to include entero-enterostomy and ileostomy | 1,197.86 | 331.97 |

#### 68.5 Other external urinary diversion

| | | | |
|---|---|---|---|
| 68.51 | Formation of other cutaneous ureterostomy | 342.25 | 194.35 |

#### 68.6 Urinary diversion to intestine

##### 68.62 Other urinary diversion to intestine

| | | | |
|---|---|---|---|
| 68.62A | Uretero-sigmoid-cutaneous conduit | 684.49 | 350.01 |

## XI. OPERATIONS ON THE URINARY TRACT (cont'd)

### 68 OPERATIONS ON URETER (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 68.6 | Urinary diversion to intestine (cont'd) | | |
| 68.62 | Other urinary diversion to intestine (cont'd) | | |
| 68.62C | Continent urinary diversion<br>That with uretero-ileal anastomosis | 1,368.98 | 478.95 |
| 68.7 | Other anastomosis or bypass of ureter | | |
| 68.72 | Ureteroneocystostomy | | |
| 68.72A | Ureteroneocystostomy<br>NOTE: May not be claimed in addition to HSC 67.59A. | 598.93 | 255.05 |
| 68.72B | Ureteroneocystostomy plus excision ureterocoele | 598.93 | 331.97 |
| 68.72C | Ureteroneocystostomy with bladder flap<br>NOTE: May not be claimed in addition to HSC 67.59A. | 684.49 | 294.73 |
| 68.72D | Ureteroneocystostomy and simultaneous longitudinal ureterectomy and ureteroplasty | 684.49 | 294.73 |
| 68.73 | Transureteroureterostomy | 637.19 | 253.34 |
| 68.8 | Repair of ureter | | |
| 68.83 | Closure of ureterostomy | | |
| 68.83A | Closure of cutaneous ureterostomy | 342.25 | 141.34 |
| 68.9 | Other operations on ureter | | |
| 68.95 | Ureteroscopy<br>NOTE: 1. Includes cystoscopy.<br>2. Only one call may be claimed whether unilateral or bilateral. | 256.68 | 165.79 |
| 68.99 | Other operations on ureter NEC | | |
| 68.99A | Insertion of double "J" stent<br>NOTE: Includes cystoscopy. | 171.12 | 110.53 |
| 68.99B | Removal of double "J" stent<br>NOTE: Includes cystoscopy. | 119.79 | 110.53 |

### 69 OPERATIONS ON URINARY BLADDER

| | | | |
|---|---|---|---|
| 69.0 | Transurethral clearance of bladder | | |
| 69.0 A | Removal of vesical calculus | 256.68 | 147.37 |
| 69.0 B | Foreign body removal | 256.68 | 110.53 |
| 69.1 | Cystotomy and cystostomy | | |
| 69.11 | Percutaneous aspiration of bladder | 26.97 | |
| 69.13 | Other cystotomy | | |
| 69.13A | Removal of foreign body from bladder through open cystotomy | 342.25 | 110.53 |
| 69.13B | Removal of vesical calculus, suprapubic approach | 342.25 | 147.37 |

## XI. OPERATIONS ON THE URINARY TRACT (cont'd)

### 69 OPERATIONS ON URINARY BLADDER (cont'd)

#### 69.1 Cystotomy and cystostomy (cont'd)

##### 69.13 Other cystotomy (cont'd)

| | BASE | ANE |
|---|---|---|
| 69.13C Open (suprapubic) | 256.68 | 110.53 |
| 69.13D Trocar and tube | 62.69 V | 110.53 |

##### 69.14 Cystostomy

| | | |
|---|---|---|
| 69.14A Vesicostomy | 342.25 | 202.64 |

#### 69.2 Transurethral excision or destruction of lesion or tissue of bladder

##### 69.29 Other transurethral excision or destruction of lesion or tissue of bladder

| | | |
|---|---|---|
| 69.29A Bladder lesion or small tumor | 119.79 V | 110.53 |
| 69.29B Moderate sized tumor<br>That for less than 30 minutes of resecting | 342.25 | 110.53 |
| 69.29C Large or multiple tumors<br>That for more than 30 minutes | 513.37 | 221.05 |

#### 69.3 Other excision or destruction of lesion or tissue of bladder

| | | |
|---|---|---|
| 69.31 Excision of urachus | 342.25 | 184.21 |

##### 69.39 Open excision or destruction of other lesion or tissue of bladder

| | | |
|---|---|---|
| 69.39A Suprapubic excision or fulguration of bladder tumors | 256.68 | 167.83 |
| 69.39B Diverticulectomy of bladder | 513.37 | 150.17 |

#### 69.4 Partial cystectomy

| | | |
|---|---|---|
| 69.4 A Partial cystectomy | 338.06 | 165.79 |
| 69.4 B With reimplantation of ureters | 855.61 | 220.84 |

#### 69.5 Total cystectomy

| | | |
|---|---|---|
| 69.5 A Total cystectomy | 474.37 | 209.65 |
| 69.51 Radical cystectomy<br>That with total prostatectomy, seminal vesiculectomy or hysterectomy | 1,368.98 | 774.83 |

#### 69.6 Reconstruction of urinary bladder

| | | |
|---|---|---|
| 69.6 A Entero-cystoplasty | 855.61 | 335.68 |

#### 69.7 Other repair of urinary bladder

| | | |
|---|---|---|
| 69.71 Suture of bladder<br>That for (traumatic) laceration | 513.37 | 184.21 |

##### 69.73 Repair of other fistula of bladder

| | | |
|---|---|---|
| 69.73A Vesicovaginal fistula repair | 684.49 | 184.21 |
| 69.73B Rectovesical fistula, resection<br>NOTE: 1. Benefit will be paid at 100% when only procedure performed.<br>2. When performed with other procedures, benefit will be paid as ADD. Refer to Price List. | 422.58 | 200.94 |
| 69.73C Vesicovaginal fistula, transvesical repair | 770.05 | 257.90 |

## XI. OPERATIONS ON THE URINARY TRACT (cont'd)

### 69 OPERATIONS ON URINARY BLADDER (cont'd)

#### 69.7 Other repair of urinary bladder (cont'd)

##### 69.74 Cystourethroplasty and plastic repair of bladder neck

| | | BASE | ANE |
|---|---|---|---|
| 69.74A | Plastic repair of bladder neck | 342.25 | 184.21 |
| 69.74B | Insertion artificial external sphincter - to include urethrosphincteroplasty | 992.51 | 515.80 |
| 69.74C | Revision of artificial urinary bladder sphincter | 684.49 | 165.79 |
| 69.74D | Ligation of bladder neck for incontinence | 598.93 | 220.84 |

#### 69.8 Invasive diagnostic procedures on bladder

##### 69.83 Cystogram and cystourethrogram

| | | | |
|---|---|---|---|
| 69.83A | Voiding | 40.11 V | 109.31 |
| 69.83B | Retrograde urethrography | 34.22 V | 109.31 |

#### 69.9 Other operations on bladder

| | | | |
|---|---|---|---|
| 69.91 | Sphincterotomy of bladder | 256.68 | 148.51 |
| 69.94 | Insertion of indwelling urinary catheter<br>NOTE: May not be claimed in association with another procedure. | 51.34 | |

### 70 OPERATIONS ON URETHRA

#### 70.0 External urethrotomy

| | | | |
|---|---|---|---|
| 70.0 A | Perineal urethrostomy (solo procedure) | 256.68 | 139.77 |

#### 70.1 Urethral meatotomy (external)

| | | | |
|---|---|---|---|
| 70.1 | Urethral meatotomy (external) | 85.56 V | 110.53 |

#### 70.2 Excision or destruction of urethral lesion or tissue

| | | | |
|---|---|---|---|
| 70.2 A | Excision or cautery of caruncle | 83.30 V | 110.53 |
| 70.2 B | Caruncle or prolapse of urethral mucosa, fulguration or excision | 119.79 V | 110.53 |
| 70.2 C | Urethral diverticulum, excision | 256.68 | 147.37 |
| 70.2 D | Radical urethrectomy, male | 342.25 | 139.77 |
| 70.2 E | Radical urethrectomy, female | 171.12 | 110.43 |
| 70.2 F | Transurethral resection of prostatic valves | 342.25 | 150.17 |
| 70.2 G | Transvesical resection of prostatic valves | 342.25 | 139.77 |
| 70.2 H | Transurethral fulguration of urethral condyloma acuminata | 85.56 V | 110.43 |

#### 70.3 Repair of urethra

##### 70.31 Suture of urethra

| | | | |
|---|---|---|---|
| 70.31A | Urethral rupture, cystotomy and perineal repair | 427.81 | 203.18 |

##### 70.33 Closure of other fistula of urethra

| | | | |
|---|---|---|---|
| 70.33A | Urethral fistula repair | 256.68 | 141.34 |
| 70.33B | Repair of urethrovaginal fistula | 342.25 | 139.77 |

##### 70.39 Other repair of urethra

| | | | |
|---|---|---|---|
| 70.39A | Suprapubic exploration for ruptured urethra, cystotomy and catheter | 342.25 | 194.35 |

#### 70.4 Freeing of stricture of urethra

| | | | |
|---|---|---|---|
| 70.4 A | Repair, infrasphincteric, one stage | 552.24 | 221.05 |

## XI. OPERATIONS ON THE URINARY TRACT (cont'd)

### 70 OPERATIONS ON URETHRA (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 70.4 | Freeing of stricture of urethra (cont'd) | | |
| | NOTE: May only be claimed by Obstetrics and Gynecology. | | |
| 70.4 F | Internal urethrotomy | 85.56 V | 110.53 |
| 70.4 G | Internal urethrotomy endoscopic | 171.12 | 110.53 |
| 70.4 H | Anastomotic stricture repair | 1,026.74 | 619.41 |
| 70.4 I | One stage reconstruction of anterior urethra with tissue transfer | 1,540.10 | 1,051.90 |
| 70.4 J | Posterior reconstruction (urethral distraction defect after pelvic fracture) | 1,540.10 | 994.75 |
| 70.4 K | First stage urethral reconstruction (complex structures with fibrosis, fistulae or significant loss of urethra) | 1,283.42 | 892.67 |
| 70.4 L | Second stage urethral reconstruction (may only be claimed after first stage reconstruction) | 1,283.42 | 892.67 |
| 70.5 | Dilation of urethra | | |
| 70.5 A | Male | 51.34 V | 110.53 |
| | NOTE: Repeat service should be claimed if provided within 31 days of initial. | | |
| 70.5 B | Female | 17.11 | 110.43 |

### 71 OTHER OPERATIONS ON URINARY TRACT

| | | | |
|---|---|---|---|
| 71.0 | Dissection of retroperitoneal tissue | | |
| 71.02 | Ureterolysis with freeing or repositioning of ureter for retroperitoneal fibrosis | 431.92 | 157.25 |
| 71.4 | Suprapubic sling operation | | |
| 71.4 A | Fascia lata sling operation | 425.75 | 257.90 |
| | NOTE: An additional benefit of 100% may be claimed for a repeat by using modifier REPT. | | |
| 71.4 B | Vaginal portion, combined sub-urethral sling procedure, when performed by two surgeons | 323.94 | 350.01 |
| | NOTE: 1. HSC 82.64A may not be claimed in addition.<br>2. When performed as a second or subsequent procedure through the same incision, the procedural rate should be claimed at 50% using modifier LVP50. Anesthetic claims using ANE for second and subsequent procedures should use the LVP75 modifier.<br>3. An additional benefit of 100% may be claimed for a repeat by using modifier REPT. | | |

## XI. OPERATIONS ON THE URINARY TRACT (cont'd)

### 71 OTHER OPERATIONS ON URINARY TRACT (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| **71.4** | **Suprapubic sling operation (cont'd)** | | |
| 71.4 C | Abdominal portion, combined sub-urethral sling procedure, when performed by two surgeons | 530.64 | 350.01 |
| | NOTE: 1. HSC 82.64A may not be claimed in addition. 2. When performed as a second or subsequent procedure through the same incision, the procedural rate should be claimed at 50% using modifier LVP50. Anesthetic claims using ANE for second and subsequent procedures should use the LVP75 modifier. 3. An additional benefit of 100% may be claimed for a repeat by using modifier REPT. | | |
| **71.7** | **Other repair of urinary (stress) incontinence** | | |
| 71.7 A | Anterior urethropexy | 401.07 | 165.79 |
| | NOTE: An additional benefit of 50% may be claimed for a repeat by using modifier REPT. | | |
| 71.7 B | Repeat repair of urinary (stress) incontinence | 549.15 | 221.05 |
| | After failed previous stress incontinence surgery | | |
| 71.7 C | Correction of male incontinence | 598.93 | 257.90 |
| | With or without simple prosthesis | | |
| **71.8** | **Ureteral catheterization** | | |
| 71.8 | Ureteral catheterization | 136.90 | 110.53 |
| | NOTE: 1. Includes cystoscopy and renal function tests. 2. Only one call may be claimed whether unilateral or bilateral. | | |
| **71.9** | **Other operations on urinary system** | | |
| 71.95 | Replacement of cystostomy tube | 51.34 | 109.21 |
| **71.96** | **Ultrasonic fragmentation of urinary stones** | | |
| 71.96A | Extra-corporeal Shock Wave Lithotripsy (ESWL) | 342.25 V | |
| | That for upper urinary tract calculi | | |
| | NOTE: 1. Only one benefit may be claimed regardless of the number of calculi treated on one side. 2. Physician in continuous attendance. 3. Includes injection of dye contrast material. 4. Includes injection of sedation when required. 5. Repeat within 42 days, refer to Price List. 6. Cystoscopy and retrograde pyelography performed at the same encounter may be claimed. 7. Bilateral calculi may be claimed for the second side, refer to Price List. | | |

## XII. OPERATIONS ON THE MALE GENITAL ORGANS

### 72 OPERATIONS ON PROSTATE AND SEMINAL VESICLES

| | | BASE | ANE |
|---|---|---|---|
| 72.0 | Incision of prostate | | |
| 72.0 A | Perineal drainage of prostatic abscess | 256.68 | 109.21 |
| 72.1 | Transurethral prostatectomy | | |
| 72.1 A | Transurethral prostatectomy<br>NOTE: May not be claimed in addition to HSC 72.1 C. | 513.37 | 221.05 |
| 72.1 C | Photoselective vaporization of the prostate<br>NOTE: May not be claimed with HSC 72.1 A. | 770.05 | 352.06 |
| 72.1 B | Repeat transurethral resection of prostate or bladder neck contracture<br>NOTE: 1. May only be claimed before one year, by the same operator.<br>2. May not be claimed during the same hospital admission. | 256.68 | 221.05 |
| 72.2 | Suprapubic prostatectomy | | |
| 72.2 | Suprapubic prostatectomy | 684.49 | 221.05 |
| 72.3 | Retropubic prostatectomy | | |
| 72.3 | Retropubic prostatectomy | 684.49 | 221.05 |
| 72.4 | Radical prostatectomy | | |
| 72.4 | Radical prostatectomy<br>With prostatovesiculectomy<br>NOTE: Benefits for 69.74A may not be claimed in addition. | 1,026.74 | 331.58 |
| 72.4 A | Laparoscopic radical prostatectomy<br>NOTE: Benefits for 69.74A may not be claimed in addition. | 2,003.84 | 996.20 |
| 72.5 | Other prostatectomy | | |
| 72.52 | Perineal prostatectomy | 684.49 | 218.60 |
| 72.52A | Cryosurgery of prostate | 1,204.61 | 655.84 |
| 72.9 | Invasive diagnostic procedures on prostate and seminal vesicles | | |
| 72.91 | Needle biopsy of prostate | 84.78 V | 110.53 |
| 72.92 | Other biopsy of prostate | | |
| 72.92A | Open perineal biopsy of prostate | 239.08 | 109.21 |

### 73 OPERATIONS ON SCROTUM AND TUNICA VAGINALIS

| | | | |
|---|---|---|---|
| 73.0 | Incision of scrotum and tunica vaginalis | | |
| 73.0 A | Incision and drainage, deep scrotal abscess | 171.12 | 110.53 |
| 73.1 | Excision of hydrocele (of tunica vaginalis) | | |
| 73.1 A | Radical cure | 256.68 | 110.43 |
| 73.1 B | Repair of communicating hydrocele | 372.00 | 184.21 |

## XII. OPERATIONS ON THE MALE GENITAL ORGANS (cont'd)

### 73 OPERATIONS ON SCROTUM AND TUNICA VAGINALIS (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 73.2 | Excision or destruction of lesion or tissue of scrotum | | |
| 73.2 A | Laser therapy<br>NOTE: Excludes condylomata accuminata - refer to 98.12S, 98.12T, 98.12U. | 60.22 | 109.21 |
| 73.2 B | Scrotectomy | 342.25 | 141.34 |
| 73.9 | Other operations on scrotum and tunica vaginalis | | |
| 73.91 | Percutaneous aspiration of tunica vaginalis<br>Hydrocele - aspiration | 44.37 | |

### 74 OPERATIONS ON TESTES

| | | | |
|---|---|---|---|
| 74.2 | Unilateral orchiectomy | | |
| 74.2 A | Unilateral orchiectomy | 171.12 | 110.53 |
| 74.2 B | Radical<br>Includes complete removal of cord to internal ring | 342.25 | 165.79 |
| 74.4 | Orchiopexy | | |
| 74.4 A | Orchiopexy | 427.81 | 165.79 |
| 74.4 B | Inguinal exploration for cryptorchidism<br>Includes that with orchidectomy | 206.01 | 110.53 |
| 74.4 C | Retroperitoneal exploration for cryptorchid testicle<br>Includes that with orchidectomy, via inguinal approach | 342.25 | 165.79 |
| 74.4 D | Testicular fixation | 171.12 | 110.43 |
| 74.4 E | Laparoscopic Orchidopexy | 855.61 | 564.76 |
| 74.8 | Invasive diagnostic procedures on testes | | |
| 74.82 | Other biopsy of testes | | |
| 74.82A | Testicular biopsy | 85.56 V | 110.53 |

### 75 OPERATIONS ON SPERMATIC CORD, EPIDIDYMIS, AND VAS DEFERENS

| | | | |
|---|---|---|---|
| 75.0 | Excision of varicocele and hydrocele of spermatic cord | | |
| 75.0 | Excision of varicocele and hydrocele of spermatic cord | 256.68 | 110.53 |
| 75.1 | Excision of cyst of epididymis | | |
| 75.1 A | Excision of sperm granuloma or spermatocele | 205.35 | 110.53 |
| 75.3 | Epididymectomy | | |
| 75.3 | Epididymectomy | 256.68 | 110.53 |
| 75.4 | Repair of spermatic cord and epididymis | | |
| 75.42 | Reduction of torsion of testes or spermatic cord | 427.81 | 110.53 |

## XII. OPERATIONS ON THE MALE GENITAL ORGANS (cont'd)

### 75 OPERATIONS ON SPERMATIC CORD, EPIDIDYMIS, AND VAS DEFERENS (cont'd)

#### 75.6 Vasectomy and ligation of vas deferens

| | | BASE | ANE |
|---|---|---|---|
| 75.64 | Vasectomy (complete) (partial) | 177.50 | 110.53 |
| | NOTE: May not be claimed if vasectomy is subsequent to a previous reversal. If a repeat procedure is required due to a previously failed attempt, supporting documentation must be provided. | | |

#### 75.8 Invasive diagnostic procedures on spermatic cord, epididymis, and vas deferens

##### 75.83 Contrast Vasogram

| | | | |
|---|---|---|---|
| 75.83A | Injection of contrast for vasography | 85.56 | 109.21 |

### 76 OPERATIONS ON PENIS

#### 76.0 Circumcision

| | | | |
|---|---|---|---|
| 76.0 | Circumcision | 256.68 | 110.53 |
| | NOTE: Routine newborn circumcisions are not an insured service. | | |

#### 76.1 Local excision or destruction of lesion of penis

| | | | |
|---|---|---|---|
| 76.1 A | Laser therapy | 85.56 | 110.43 |
| | NOTE: Excludes condylomata accuminata - refer to 98.12S, 98.12T, 98.12U. | | |

#### 76.2 Amputation of penis

| | | | |
|---|---|---|---|
| 76.2 A | Partial | 342.25 | 165.79 |
| 76.2 B | Radical | 513.37 | 202.64 |
| 76.2 C | Radical, with unilateral gland dissection | 855.61 | 235.88 |
| 76.2 D | Radical, with bilateral lymphadenectomy | 1,197.86 | 335.68 |

#### 76.3 Repair and plastic operations on penis

##### 76.32 Release of chordee

| | | | |
|---|---|---|---|
| 76.32A | Correction of chordee without hypospadias | 342.25 | 147.37 |
| 76.32B | Correction of chordee with grafting | 684.49 | 276.32 |

##### 76.33 Repair of epispadias or hypospadias

| | | | |
|---|---|---|---|
| 76.33A | Hypospadias, first stage | 256.68 | 165.79 |
| 76.33B | Hypospadias, second stage | 427.81 | 202.64 |
| 76.33C | Hypospadias, one stage repair combining urethroplasty and chordee correction | 1,026.74 | 294.73 |

##### 76.39 Other repair of penis

| | | | |
|---|---|---|---|
| 76.39A | Repair of penile fracture | 342.25 | 147.37 |

#### 76.8 Invasive diagnostic procedures on penis

##### 76.89 Other invasive diagnostic procedures on penis

| | | | |
|---|---|---|---|
| 76.89A | Injection of contrast media for corpus cavernosogram | 37.65 | |

XII. OPERATIONS ON THE MALE GENITAL ORGANS (cont'd)

76 OPERATIONS ON PENIS (cont'd)

76.9 Other operations on male genital organs
76.91 Dorsal or lateral slit of prepuce

| | BASE | ANE |
|---|---|---|
| 76.91A Without circumcision | 85.56 V | 110.53 |
| NOTE: May not be claimed with 76.0. | | |
| 76.95 Insertion or replacement of internal prosthesis of penis | | |
| 76.95A Without scrotal pump or abdominal reservoir | 513.37 | 276.32 |
| 76.95B With abdominal and scrotal reservoir and inflatable prosthesis | 787.16 | 441.68 |
| 76.97 Other operations on penis | | |
| 76.97A Corpus-cavernosis to greater saphenous shunt or corpus spongiosis shunt | 342.25 | 282.68 |

XIII OPERATIONS ON THE FEMALE GENITAL ORGANS

77 OPERATIONS ON OVARY

77.9 Other operations on ovary
77.99 Other operations on ovary NEC

| | | |
|---|---|---|
| 77.99A Ovarian carcinoma, debulking, additional benefit | 145.00 | 61.15 |
| NOTE: May not be claimed in addition to HSC 66.3 A. | | |

78 OPERATIONS ON FALLOPIAN TUBES
78.5 Other salpingectomy
78.52 Salpingectomy

| | | |
|---|---|---|
| 78.52C Surgical treatment of ectopic pregnancy | 376.39 | 202.64 |
| 78.7 Insufflation of fallopian tube | | |
| 78.7 A Patency determination of fallopian tube(s) | 18.51 V | 109.21 |
| NOTE: A repeat performed within the same day is payable at a reduced rate. Refer to Price List. | | |

78.9 Other operations on fallopian tubes
78.99 Other operations on fallopian tubes NEC

| | | |
|---|---|---|
| 78.99B Other tubal sterilization, any method | 219.04 | 147.37 |
| NOTE: May not be claimed if sterilization is subsequent to a previous reversal. If a repeat procedure is required due to a previously failed attempt, supporting documentation must be provided. | | |

79 OPERATIONS ON CERVIX

79.1 Conization of cervix

| | | |
|---|---|---|
| 79.1 A Cone biopsy | 154.26 | 110.53 |
| NOTE: Includes D & C | | |

XIII OPERATIONS ON THE FEMALE GENITAL ORGANS (cont'd)

79 OPERATIONS ON CERVIX (cont'd)

79.2 Other excision or destruction of lesion or tissue of cervix

| | | BASE | ANE |
|---|---|---|---|
| 79.22 | Destruction of lesion of cervix by cauterization | 43.19 | |
| | NOTE: 1. Benefit includes biopsy. 2. May be claimed in addition to a visit or consultation. | | |
| 79.23 | Destruction of lesion of cervix by cryosurgery | | |
| 79.23A | Cryotherapy | 43.19 | |
| | NOTE: 1. Benefit includes biopsy. 2. May be claimed in addition to a visit or consultation. | | |
| 79.29 | Other excision or destruction of lesion or tissue of cervix NEC | | |
| 79.29C | By CO2 laser therapy | 141.92 | 110.53 |
| | For cervical interepithelial neoplasia | | |
| 79.29D | Loop electrical excision procedure (LEEP) | 141.92 | 110.53 |
| | For cervical interepithelial neoplasia | | |
| 79.29E | Biopsy of cervix | 43.19 V | |
| | NOTE: May not be claimed with any other procedure. | | |
| 79.3 | Amputation of cervix | | |
| 79.3 E | Excision of cervical stump, abdominal or vaginal approach | 404.15 | 184.21 |
| 79.4 | Repair of internal cervical os | | |
| 79.4 C | Suturing of cervix, encircling suture | 169.68 | 110.53 |
| | For cervical incompetence, elective | | |
| | NOTE: May be claimed in addition to a visit or consultation. | | |
| 79.4 D | Suturing of cervix, emergency cerclage after cervix has been effaced or opened | 228.30 | 165.79 |
| | NOTE: May be claimed in addition to a consultation or visit. | | |

80 OTHER INCISION AND EXCISION OF UTERUS

80.1 Excision or destruction of lesion or tissue of uterus

| | | | |
|---|---|---|---|
| 80.19 | Other excision or destruction of lesion of uterus | | |
| 80.19A | Correction of congenital abnormalities | 293.09 | 147.37 |
| 80.19B | Myomectomy, vaginal | 293.09 | 147.37 |
| 80.19C | Myomectomy, abdominal | 339.37 | 165.79 |
| 80.19D | Endometrial ablation by hysteroscopic method to include roller ball or resectoscope | 419.58 | 202.64 |
| | NOTE: 1. Benefit includes hysteroscopy. 2. Benefit includes insertion of a laminaria tent if required by same or different physician. | | |

## XIII OPERATIONS ON THE FEMALE GENITAL ORGANS (cont'd)

### 80 OTHER INCISION AND EXCISION OF UTERUS (cont'd)

80.1 Excision or destruction of lesion or tissue of uterus (cont'd)
80.19 Other excision or destruction of lesion of uterus (cont'd)

| | BASE | ANE |
|---|---|---|
| 80.19E Endometrial ablation by any non-hysteroscopic method (eg. microwave, thermablate, etc.) | 219.04 | 110.53 |
| NOTE: May not be claimed in addition to HSC 80.81. | | |

80.8 Invasive diagnostic procedures on uterus and supports

| | | |
|---|---|---|
| 80.81 Hysteroscopy | 138.83 | 110.53 |
| NOTE: 1. Benefit includes biopsy. 2. May not be claimed in addition to HSCs 80.19D or 80.19E. | | |

80.83 Uterine biopsy

| | | |
|---|---|---|
| 80.83B Endometrial biopsy | 43.19 V | 110.43 |

80.85 Opaque dye contrast hysterosalpingography

| | | |
|---|---|---|
| 80.85A Hysterosalpingogram insufflation or injection of opaque material | 86.38 | 109.21 |
| 80.85B Pneumohysterosalpingogram | 67.87 V | 109.21 |

### 81 OTHER OPERATIONS ON UTERUS AND SUPPORTS

81.0 Dilation and curettage (of uterus)
81.01 Dilation and curettage following delivery or abortion

| | | |
|---|---|---|
| 81.01D D & C for missed abortion or following delivery | 148.09 | 110.53 |
| NOTE: May be claimed in addition to a consultation. | | |

| | | |
|---|---|---|
| 81.09 Other dilation and curettage | 148.09 | 110.53 |
| NOTE: 1. Benefit includes biopsy or polypectomy. 2. May be claimed in addition to a consultation. | | |

81.2 Excision or destruction of lesion or tissue of uterine supports
81.29 Other excision or destruction of lesion or tissue of uterine supports

| | | |
|---|---|---|
| 81.29B Laparotomy, to include conservation procedures for endometriosis | 370.22 | 184.21 |
| 81.29C Laparoscopy, for conservative procedures for endometriosis and/or lysis of adhesions first full 15 minutes of operating time or major portion thereof for the first call when only one call is claimed | 200.53 | 131.04 |
| NOTE: Each subsequent 15 minutes, or major portion thereof, is payable at the rate specified on the Price List after the first full 15 minutes has elapsed. | | |

81.5 Repair of uterus
81.51 Suture of uterus

| | | |
|---|---|---|
| 81.51A Repair due to injury | 364.05 | 165.79 |

## XIII OPERATIONS ON THE FEMALE GENITAL ORGANS (cont'd)

### 81 OTHER OPERATIONS ON UTERUS AND SUPPORTS (cont'd)

81.5 Repair of uterus (cont'd)

81.51 Suture of uterus (cont'd)

NOTE: Excludes obstetrical trauma.

| | | BASE | ANE |
|---|---|---|---|
| 81.8 | **Insertion of intra-uterine contraceptive device** | | |
| 81.8 | Insertion of intra-uterine contraceptive device | 67.87 V | |
| | NOTE: May be claimed in addition to a visit or consultation. | | |
| 81.9 | **Other operations on uterus, cervix, and supporting structures** | | |
| 81.91 | **Insertion of therapeutic device into uterus** | | |
| 81.91A | Radium insertion - each insertion | 135.75 | 110.53 |
| | NOTE: 1. May be claimed in addition to a visit or consultation. | | |
| | 2. May not be claimed with any other procedure. | | |
| 81.96 | Removal of cerclage material from cervix | 55.53 V | 110.53 |
| | NOTE: 1. May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery. | | |
| | 2. May be claimed in addition to a visit or consultation. | | |
| 81.99 | **Other operations on cervix and uterus** | | |
| 81.99A | Hysterectomy, any method | 632.45 | 202.58 |
| | NOTE: If pelvic lymphadenectomy is performed for cancer, HSC 52.49C may be claimed in addition. | | |
| 81.99C | Laparoscopic radical hysterectomy and bilateral radical lymph node dissection | 1,983.74 | 1,142.58 |

### 82 OPERATIONS ON VAGINA AND CUL-DE-SAC

| | | | |
|---|---|---|---|
| 82.1 | **Incision of vagina and cul-de-sac** | | |
| 82.12 | **Colpotomy or culdotomy** | | |
| 82.12A | Diagnostic | 76.07 V | 109.21 |
| 82.12B | Therapeutic | 96.38 V | 110.43 |
| 82.12C | With D & C | 104.89 V | 109.21 |
| 82.12D | Drainage pelvic abscess | 274.58 | 110.53 |
| | NOTE: May only be claimed when performed under general anesthesia. | | |
| 82.14 | **Other vaginotomy** | | |
| 82.14D | Other vaginotomy | 132.66 V | 110.53 |
| | NOTE: 1. May be claimed in addition to a visit or consultation. | | |
| | 2. May not be claimed with any other procedure. | | |
| 82.3 | **Obliteration and total excision of vagina** | | |
| 82.3 A | LeFort operation | 265.32 | 110.53 |

XIII OPERATIONS ON THE FEMALE GENITAL ORGANS (cont'd)

82 OPERATIONS ON VAGINA AND CUL-DE-SAC (cont'd)

82.3 Obliteration and total excision of vagina (cont'd)

| | BASE | ANE |
|---|---|---|
| 82.3 B Colpectomy<br>For carcinoma | 539.90 | 309.70 |

82.4 Repair of cystocele and rectocele

82.41 Repair of cystocele

| | | |
|---|---|---|
| 82.41A Repair of cystocele<br>NOTE: An additional benefit of 50% may be claimed for a repeat by using modifier REPT. | 320.85 | 110.53 |

82.42 Repair of rectocele

| | | |
|---|---|---|
| 82.42A Rectocele repair<br>NOTE: An additional benefit of 50% may be claimed for a repeat by using modifier REPT. | 320.85 | 110.53 |

82.5 Vaginal construction and reconstruction

82.51 Vaginal construction, Abbe, McIndoe, Williams

| | | |
|---|---|---|
| 82.51A Plastic correction of congenital absence | 505.96 | 238.51 |

82.6 Other repair of vagina

82.61 Suture of vagina

| | | |
|---|---|---|
| 82.61A Repair of non-obstetrical laceration<br>NOTE: 1. May only be claimed when performed under general anesthesia.<br>2. May be claimed in addition to a consultation.<br>3. May not be claimed with any other procedure. | 135.75 | 110.53 |

82.62 Repair of fistula of vagina

| | | |
|---|---|---|
| 82.62A Rectovaginal fistula repair | 406.73 | 176.68 |
| 82.63 Hymenorrhaphy<br>NOTE: 1. May be claimed in addition to a consultation.<br>2. HSC 66.83 may be claimed in addition. | 138.83 | 110.53 |

82.64 Vaginal suspension and fixation

| | | |
|---|---|---|
| 82.64A Vaginal vault suspension, additional benefit<br>NOTE: 1. May only be claimed in addition to HSCs 81.99A, 81.99C, 82.41A, 82.42A and 82.69B.<br>2. An additional benefit of 100% may be claimed for a repeat by using modifier REPT. | 262.24 | 103.83 |
| 82.64B Other vaginal vault suspension, sacrospinous, ileo-coccygeal | 447.34 | 327.91 |

XIII OPERATIONS ON THE FEMALE GENITAL ORGANS (cont'd)

82 OPERATIONS ON VAGINA AND CUL-DE-SAC (cont'd)

82.6 Other repair of vagina (cont'd)

82.64 Vaginal suspension and fixation (cont'd)

BASE ANE

NOTE: 1. When performed as a second or subsequent procedure through the same incsision, the procedural rate should be claimed at 50% using modifier LVP50. Anesthetic claims using ANE for second and subsequent procedures should use the LVP75 modifier.
2. An additional benefit of 100% may be claimed for a repeat by using modifier REPT.

XIII OPERATIONS ON THE FEMALE GENITAL ORGANS (cont'd)

82 OPERATIONS ON VAGINA AND CUL-DE-SAC (cont'd)

82.6 Other repair of vagina (cont'd)

82.69 Other repair of vagina NEC

| | BASE | ANE |
|---|---|---|
| 82.69B Enterocoele repair | 320.85 | 145.74 |
| NOTE: An additional benefit of 100% may be claimed for a repeat by using modifier REPT. | | |
| 82.69C Insertion of prosthetic mesh | 64.79 | |
| NOTE: May only be claimed in addition to HSCs 71.4 A, 71.4 B, 71.4 C, 71.7 A, 71.7 B, 81.99A, 82.3 A, 82.41A, 82.42A, 82.64B, 82.69B, 82.69D, 82.7 A. | | |
| 82.69D Paravaginal repair | 404.15 | 236.84 |
| NOTE: 1. When performed as a second or subsequent procedure through the same incision, the procedural rate should be claimed at 50% using modifier LVP50. Anesthetic claims using ANE for second and subsequent procedures should use the LVP75 modifier. 2. An additional benefit of 100% may be claimed for a repeat by using modifier REPT. | | |
| 82.69E Excision of mesh or graft material (vaginal or abdominal approach) per full 15 minutes | 203.62 | 150.27 |
| NOTE: Each subsequent 15 minutes, or major portion thereof, is payable at the rate specified on the Price List after the first full 15 minutes has elapsed. | | |

82.7 Obliteration of vagina vault

| | | |
|---|---|---|
| 82.7 A Abdominal sacrocolpopexy | 632.45 | 221.05 |
| NOTE: An additional benefit of 100% may be claimed for a repeat by using modifier REPT. | | |

82.8 Invasive diagnostic procedures on vagina and cul-de-sac

82.81 Culdoscopy/Colposcopy

| | | |
|---|---|---|
| 82.81A Colposcopy | 43.19 V | 110.43 |
| NOTE: 1. Includes biopsy. 2. Repeat within 90 days, refer to Price List. | | |

82.9 Other operations on vagina and cul-de-sac

82.91 Other operations on vagina

| | | |
|---|---|---|
| 82.91A Biopsy of vagina | 43.19 V | 110.53 |
| NOTE: A maximum of three calls applies. | | |

XIII OPERATIONS ON THE FEMALE GENITAL ORGANS (cont'd)

## 83 OPERATIONS ON VULVA AND PERINEUM

### 83.0 Incision of vulva and perineum

#### 83.09 Other incision of vulva and perineum

| | | BASE | ANE |
|---|---|---|---|
| 83.09A | Perineal abscess, I & D, marsupialization | 138.83 | 110.53 |

NOTE: 1. May be claimed in addition to a visit or consultation.
2. May not be claimed with any other procedure.

### 83.1 Operations on Bartholin's gland

| | | | |
|---|---|---|---|
| 83.19A | Operations on Bartholin's gland | 138.83 | 110.53 |

NOTE: 1. May be claimed in addition to a consultation.
2. May not be claimed with any other procedure.

### 83.2 Other local excision or destruction of vulva and perineum

| | | | |
|---|---|---|---|
| 83.2 B | Other local excision or destruction of vulva and perineum | 138.83 | 110.53 |

NOTE: 1. May not be claimed for condylomata accuminata; refer to HSCs 98.12S, 98.12T, 98.12U.
2. May be claimed in addition to a visit or consultation.
3. May be claimed in addition to HSC 66.83.

### 83.4 Radical vulvectomy

| | | | |
|---|---|---|---|
| 83.4 A | Radical vulvectomy | 397.98 | 221.05 |
| 83.4 B | Radical vulvectomy with gland dissection | 823.73 | 294.73 |

### 83.5 Other vulvectomy

| | | | |
|---|---|---|---|
| 83.5 A | Labial reduction or large vulvar resection | 163.51 | 110.53 |

### 83.6 Repair of vulva and perineum

| | | | |
|---|---|---|---|
| 83.61 | Suture of vulva and perineum<br>Perineorrhaphy | 138.83 | 110.53 |

NOTE: 1. May not be claimed with any other procedure.
2. May be claimed in addition to a visit or consultation.

#### 83.69 Other repair of vulva and perineum

| | | | |
|---|---|---|---|
| 83.69B | Repair of old 3rd degree laceration | 293.09 | 147.37 |
| 83.69C | Repair of vulvar or vaginal hematoma | 145.00 | 110.53 |

NOTE: 1. May be claimed in addition to a consultation.
2. May not be claimed with any other procedure.

### 83.7 Other operations on vulva

| | | | |
|---|---|---|---|
| 83.7 A | Biopsy of vulva | 43.19 V | 110.53 |

NOTE: A maximum of three calls applies.

## XIII OPERATIONS ON THE FEMALE GENITAL ORGANS (cont'd)

### 83 OPERATIONS ON VULVA AND PERINEUM (cont'd)

#### 83.6 Repair of vulva and perineum (cont'd)

##### 83.9 Other operations on female genital organs NEC

| | | BASE | ANE |
|---|---|---|---|
| 83.9 A | Operations on the adnexa, any method | 373.30 | 165.79 |

NOTE:
1. May be claimed with HSCs 71.7 A, 82.7 A and 81.99A.
2. May not be claimed in association with a hysterectomy for the removal of fallopian tubes alone.
3. May not be claimed for sterilization.
4. When performed as a second or subsequent procedure through the same incision, the procedural rate should be claimed at 50% using modifier LVP50. Anesthetic claims using ANE for second and subsequent procedures should use the LVP75 modifier.

## XIV OBSTETRIC PROCEDURES

### 84 FORCEPS EXTRACTION AND OTHER INSTRUMENTAL DELIVERY

#### 84.2 Mid forceps delivery

##### 84.21 Mid forceps delivery with episiotomy

| | | | |
|---|---|---|---|
| 84.21D | Assisted delivery, forceps, vacuum with or without rotation, mid or lower cavity | 137.29 | 61.15 |

NOTE: May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery.

### 85 OTHER PROCEDURES INDUCING OR ASSISTING DELIVERY

#### 85.5 Medical induction of labour

| | | |
|---|---|---|
| 85.5 A | Medical induction | 120.21 |

NOTE:
1. May only be claimed when a physician has assessed the patient prior to the induction and monitors the patient's progress subsequent to the induction.
2. A maximum of two per 24 hour period to a maximum of four per pregnancy may be claimed unless the patient is transferred to another facility for a higher level of care.
3. If the patient is transferred to another facility for a higher level of care, the receiving physician may also claim a maximum of two per 24 hour period to a maximum of four per pregnancy.
4. May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery.

XIV OBSTETRIC PROCEDURES (cont'd)

85 OTHER PROCEDURES INDUCING OR ASSISTING DELIVERY (cont'd)

85.6 Manually assisted delivery

| | | BASE | ANE |
|---|---|---|---|
| 85.69B | Management of shoulder dystocia | 133.54 | 87.36 |
| | NOTE: 1. May only be claimed when one of the recognized maneuvers for correction of the situation is employed. 2. May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery. | | |
| 85.69C | Manually assisted delivery (breech presentation, manually or forceps assisted) | 188.19 | 61.15 |
| | NOTE: May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery. | | |

85.9 Other operations assisting delivery

85.91 External version

| | | | |
|---|---|---|---|
| 85.91 | External version | 151.17 | 122.16 |
| | Cephalic | | |
| | NOTE: 1. Service must be provided in hospital with level II & III obstetrical units. 2. Ultrasound must be available. 3. Immediate access to OR for Cesarean Section must be available. 4. May only be claimed by specialists or physicians with special accreditation by CPSA. 5. Gestation age must be 37 weeks or greater. | | |

86 CESAREAN SECTION AND REMOVAL OF FETUS

86.3 Removal of intraperitoneal embryo

| | | | |
|---|---|---|---|
| 86.3 | Removal of intraperitoneal embryo | 478.20 | 221.05 |

86.4 Other removal of embryo

| | | | |
|---|---|---|---|
| 86.41 | Hysterotomy to terminate pregnancy | 231.39 | 139.77 |

86.9 Cesarean section of unspecified type

| | | | |
|---|---|---|---|
| 86.9 B | Cesarean hysterectomy | 987.24 | 354.21 |
| 86.9 C | Elective Cesarean section, any approach | 487.45 | 264.69 |
| 86.9 D | Cesarean section of unspecified type following trial of labour for any reason | 681.82 | 287.08 |

XIV OBSTETRIC PROCEDURES (cont'd)

87 OTHER OBSTETRIC OPERATIONS

87.0 Intra-amniotic injection for termination of pregnancy

| | | BASE | ANE |
|---|---|---|---|
| 87.0 A | Termination of pregnancy between 13 and 20 weeks for medical or genetic reasons using potent prostaglandins by any route . . . . . | 151.17 | |
| | NOTE: 1. Includes the insertion of a laminaria tent if required. 2. A D & C required within 14 days should be claimed under 81.09. | | |

87.2 Other termination of pregnancy

87.29 Other termination of pregnancy NEC

| | | | |
|---|---|---|---|
| 87.29A | Suction curettage or dilation and curettage for termination of pregnancy . . | 148.09 | 109.21 |
| | NOTE: May only be claimed when performed in an active treatment hospital or by a physician approved to perform the procedure by the CPSA when performed in an accredited non-hospital surgical facility. | | |
| 87.29B | Termination of pregnancy, dilatation and evacuation (D&E) termination where imaging report confirms fetus is 12 weeks size or greater . . . . . | 256.07 | 200.39 |
| | NOTE: 1. May be claimed for termination of viable or non-viable pregnancy. 2. May only be claimed when performed in an active treatment hospital or by a physician approved to perform the procedure by the CPSA when performed in an accredited non-hospital surgical facility. | | |

87.3 Amniocentesis

| | | | |
|---|---|---|---|
| 87.3 | Amniocentesis . . . . . | 98.72 | |
| | NOTE: When performed for a twin pregnancy, refer to Price List. | | |

87.4 Intrauterine transfusion

| | | | |
|---|---|---|---|
| 87.4 | Intrauterine transfusion . . . . . | 373.30 | 176.68 |

87.5 Other intrauterine operations on fetus and amnion

87.53 Fetal blood sampling and biopsy

| | | | |
|---|---|---|---|
| 87.53A | Fetal scalp sampling . . . . . | 40.11 | |
| | NOTE: May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery. | | |
| 87.53B | Percutaneous umbilical blood sampling (Cordocentesis) . . . . . | 252.98 | |

XIV OBSTETRIC PROCEDURES (cont'd)

87 OTHER OBSTETRIC OPERATIONS (cont'd)

87.5 Other intrauterine operations on fetus and amnion (cont'd)

87.54 Fetal monitoring, unqualified

| | | BASE | ANE |
|---|---|---|---|
| 87.54A | Interpretation of non-stress test . . . . . | 15.43 | |
| | NOTE: May not be claimed if labour has commenced. | | |
| 87.54B | Interpretation and supervision of continuous fetal monitoring (includes application of internal electrode) . . . . . | 63.41 | |
| | NOTE: 1. May be claimed:<br>- for continuous monitoring by either internal or external electrical means.<br>- at 100% in addition to delivery benefits regardless of who performs the delivery.<br>2. May only be claimed in situations of suspected fetal or maternal compromise requiring greater than usual physician supervision.<br>3. May only be claimed once per hospitalization unless the patient is transferred to another physician or facility for a higher level of care. | | |

87.55 Other diagnostic procedures on fetus and amnion

| | | | |
|---|---|---|---|
| 87.55A | Chorionic villus sampling . . . . . | 107.98 | 109.21 |

87.6 Removal of retained placenta

| | | | |
|---|---|---|---|
| 87.6 | Removal of retained placenta . . . . . | 107.98 V | 128.95 |
| | Manual removal of retained placenta and membranes<br>NOTE: 1. May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery.<br>2. May be claimed in addition to a consultation. | | |

87.7 Repair of obstetric laceration of uterus

87.72 Repair of obstetric laceration of cervix

| | | | |
|---|---|---|---|
| 87.72A | Repair of extensive laceration of cervix . . . . . | 107.98 V | 141.34 |
| | NOTE: 1. May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery.<br>2. May be claimed in addition to a consultation. | | |

87.8 Repair of other obstetric lacerations

| | | | |
|---|---|---|---|
| 87.82 | Repair of obstetric laceration of sphincter ani . . . . . | 107.98 V | 145.74 |
| | NOTE: 1. May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery.<br>2. May be claimed in addition to a consultation. | | |

XIV OBSTETRIC PROCEDURES (cont'd)

87 OTHER OBSTETRIC OPERATIONS (cont'd)

87.8 Repair of other obstetric lacerations (cont'd)

87.89 Repair of other obstetric lacerations NEC

| | | BASE | ANE |
|---|---|---|---|
| 87.89A | Repair of obstetrical laceration involving rectal mucosa . . . . . | 120.32 V | 141.34 |
| | NOTE: 1. May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery.<br>2. May be claimed in addition to a consultation. | | |
| 87.89B | Repair of extensive vaginal laceration . . . . . | 107.98 V | 147.37 |
| | NOTE: 1. May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery.<br>2. A second call may only be claimed if a non-contiguous site requires suturing.<br>3. A maximum of two calls applies.<br>4. May be claimed in addition to a consultation. | | |

87.9 Other obstetric operations

| | | | |
|---|---|---|---|
| 87.91 | Evacuation of incisional hematoma . . . . . | 37.02 V | 110.53 |
| | NOTE: 1. May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery.<br>2. May be claimed in addition to a visit or consultation. | | |
| 87.92 | Evacuation of other hematoma of vulva or vagina . . . . . | 107.98 V | 110.43 |
| | NOTE: 1. May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery.<br>2. May be claimed in addition to a consultation. | | |

XIV OBSTETRIC PROCEDURES (cont'd)

87 OTHER OBSTETRIC OPERATIONS (cont'd)

87.9 Other obstetric operations (cont'd)

87.93 Surgical correction of inverted uterus

| | | BASE | ANE |
|---|---|---|---|
| 87.93A | Replacement of inverted uterus, abdominal approach | 401.07 | 183.46 |

NOTE: 1. May only be claimed when performed under general anesthesia.
2. May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery.

87.94 Manual replacement of inverted uterus

| | | | |
|---|---|---|---|
| 87.94C | Manual replacement of inverted uterus | 132.66 | 139.77 |

NOTE: May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery.

87.98 Delivery NEC

| | | | |
|---|---|---|---|
| 87.98A | Vaginal delivery | 447.34 | 174.72 |
| 87.98B | Management of labour and attempted delivery | 453.25 | 185.51 |

NOTE: 1. The benefit includes all usual hospital care associated with the confinement and provided by the referring physician.
2. May be claimed by the referring physician, when the referring physician intended to conduct the delivery, provided the following conditions are met:
- the referring physician attended the patient during labour and provided assessment of the progress of the labour, both initial and ongoing;
- there is a documented complication warranting the referral, such as fetal distress or dysfunctional labour (failure to progress), and
- the referring physician remains in attendance and assists the consultant; or
- where the physician must transfer the patient to another facility because of either fetal or maternal indications and delivery occurs within 24 hours of transfer.
3. The same physician may not claim both the delivery and management of labour and attempted delivery.

| | | | |
|---|---|---|---|
| 87.98C | Vaginal delivery following trial of labour after previous cesarean section | 681.82 | 185.51 |
| 87.98D | Multiple birth, vaginal delivery (for each additional newborn) | 151.17 | 61.15 |

NOTE: May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery.

XIV OBSTETRIC PROCEDURES (cont'd)

87 OTHER OBSTETRIC OPERATIONS (cont'd)

87.9 Other obstetric operations (cont'd)

87.98 Delivery NEC (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 87.98E | Attendance at delivery | 88.99 | |

NOTE: 1. May only be claimed when a physician is specifically requested by the physician intending to perform a delivery and no other service may be claimed for that attendance.
2. Care of healthy newborn (HSC 03.05G) may be claimed in addition.
3. This service is billable when physician attendance on behalf of the baby is required.

87.99 Other obstetric operations NEC

| | | | |
|---|---|---|---|
| 87.99A | Non-surgical management of post partum hemorrhage | 96.17 | |

NOTE: 1. May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery.
2. May be claimed in addition to a consultation.

| | | | |
|---|---|---|---|
| 87.99AA | Surgical management of severe post partum hemorrhage including but not limited to the use of an intrauterine balloon device or suturing encircling the uterus | 154.26 | 222.04 |
| 87.99B | Selective fetal reduction | 141.92 | 109.21 |

## XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

### 88 OPERATIONS ON FACIAL BONES AND JOINTS

| | BASE | ANE |
|---|---|---|
| **88.0 (Closed) reduction of facial fractures** | | |
| **88.02 (Closed) reduction of malar and zygomatic fracture** | | |
| 88.02A Hook or temporal elevation | 246.17 | 110.53 |
| 88.02B Hook or temporal elevation and antral packing | 207.30 | 139.77 |
| **88.03 (Closed) reduction of maxillary fracture** | | |
| 88.03A With external fixation | 349.82 | 176.68 |
| **88.04 (Closed) reduction of mandibular fracture** | | |
| 88.04A With external fixation | 349.82 | 184.21 |
| 88.04B Multiple fractures, with external fixation | 401.64 | 353.34 |
| **88.1 Open reduction of facial fractures** | | |
| **88.12 Open reduction of malar and zygomatic fracture** | | |
| 88.12A Fixation | 336.86 | 159.01 |
| 88.12B With mini-plate fixation of fractured zygoma, malar, one plate | 518.25 | 454.27 |
| 88.12C With mini-plate fixation of fractured zygoma, malar, more than one plate | 647.81 | 601.19 |
| 88.12D With mini-plate fixation of fractured zygoma, malar, via coronal approach | 1,140.14 | 803.71 |
| **88.13 Open reduction of maxillary fracture** | | |
| 88.13A With suspension | 440.51 | 236.84 |
| 88.13B With mini-plate fixation, one side only | 518.25 | 297.01 |
| 88.13C With mini-plate fixation, both sides | 1,088.31 | 674.05 |
| **88.14 Open reduction of mandibular fracture** | | |
| 88.14A With internal fixation, single | 375.73 | 406.35 |
| 88.14B Single and interdental fixation with splint | 531.20 | 477.03 |
| 88.14C Multiple and interdental fixation with splint | 634.85 | 506.70 |
| 88.14D Mini-plate fixation of fractured mandible, one plate or lag screws | 738.50 | 497.38 |
| 88.14E With mini-plate fixation of fractured mandible, more than one plate or lag screws in more than one fracture | 1,114.23 | 681.59 |
| **88.16 Open reduction of orbital fracture** | | |
| 88.16A Orbital floor fracture<br>NOTE: May not be claimed in addition to item 98.79A. | 570.07 | 202.64 |
| 88.16B Mini-plate fixation of fractured supraorbital ridge via coronal approach | 1,243.79 | 812.69 |
| **88.19 Open reduction of other facial fracture** | | |
| 88.19A With mini-plate fixation of fractured frontal bone via coronal approach | 1,243.79 | 646.47 |
| **88.4 Partial ostectomy of facial bone, except mandible** | | |
| 88.4 A Resection of maxilla | 1,103.54 | 424.01 |
| **88.5 Excision and reconstruction of mandible** | | |
| **88.51 Partial ostectomy, mandible** | | |
| 88.51A Segmental resection | 328.28 | 150.17 |
| 88.51B Hemiresection | 487.62 | 200.94 |

## XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

### 88 OPERATIONS ON FACIAL BONES AND JOINTS (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| **88.6** | **Temporomandibular arthroplasty** | | |
| 88.6 A | Temporomandibular arthroplasty | 480.61 | 200.94 |
| 88.6 B | Temporomandibular arthrotomy<br>NOTE: Includes menisectomy. | 364.09 | 141.34 |
| **88.7** | **Other facial bone repair and osteoplasty** | | |
| 88.76 | Reconstruction of mandible without associated resection<br>Bone graft mandible | 591.13 | 200.39 |
| **88.9** | **Other operations on facial bones and joints** | | |
| 88.92 | Closed reduction of temporomandibular dislocation | 70.58 V | 110.43 |
| 88.99 | Other operations on facial bones and joints NEC<br>Osseointegrated cranio-facial reconstruction<br>NOTE: May only be claimed following surgery for cancer or trauma or to patients with congenital anomalies. | | |
| 88.99A | One or two fixtures, first stage | 775.27 | 419.33 |
| 88.99B | One or two fixtures, second stage | 580.31 | 349.44 |
| 88.99C | Three fixtures, first stage | 1,066.56 | 681.41 |
| 88.99D | Three fixtures, second stage | 830.51 | 441.68 |
| 88.99E | Four or more fixtures, first stage | 1,377.03 | 848.02 |
| 88.99F | Four or more fixtures, second stage | 1,023.53 | 646.47 |

### 89 INCISION, EXCISION, AND DIVISION OF OTHER BONES

| | | | |
|---|---|---|---|
| **89.0** | **Sequestrectomy** | | |
| 89.0 A | Radical surgical debridement of sternum<br>NOTE: 1. Includes insertion of irrigation and drainage catheters.<br>2. Includes with or without closure of sternum. | 765.51 | 350.01 |
| 89.0 B | Reconstruction of sternum using plates and screws<br>NOTE: May not be claimed for closure of sternum for routine cardiac procedures. | 1,059.81 | 366.40 |
| 89.03 | Sequestrectomy, carpals and metacarpals | 229.58 | 110.43 |
| **89.08** | **Sequestrectomy, other specified site** | | |
| 89.08B | Phalanx | 228.03 | 110.53 |
| **89.09** | **Sequestrectomy, unspecified site** | | |
| 89.09A | Large bone | 439.44 | 202.64 |
| **89.1** | **Other incision of bone without division** | | |
| **89.12** | **Other incision of bone without division, radius and ulna** | | |
| 89.12A | Olecranon excision | 263.71 | 141.34 |
| 89.12B | Radial head or neck excision | 263.71 | 165.79 |
| **89.19** | **Other incision of bone without division, unspecified site** | | |
| 89.19A | Incision and drainage subperiosteal abscess | 263.71 | 110.43 |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

89 INCISION, EXCISION, AND DIVISION OF OTHER BONES (cont'd)

| | BASE | ANE |
|---|---|---|
| 89.2 Wedge osteotomy | | |
| NOTE: Benefits for HSCs 89.20A to 89.26A include fixation | | |
| 89.20 Wedge osteotomy, scapula, clavicle, and thorax (ribs and sternum) | | |
| 89.20A Clavicle | 439.51 | 110.53 |
| 89.21 Wedge osteotomy humerus | 703.22 | 165.79 |
| 89.22 Wedge osteotomy, radius and ulna | | |
| 89.22A Radius | 703.22 | 147.37 |
| 89.22B Ulna | 527.41 | 147.37 |
| 89.23 Osteotomy, carpal bones, phalanx or metacarpals (including fixation) | 388.68 | 110.53 |
| 89.24 Wedge osteotomy, femur | 1,054.82 | 221.05 |
| 89.26 Wedge osteotomy, tibia and fibula | | |
| 89.26A Tibia | 879.02 | 184.21 |
| 89.36 Osteotomy, tibia | | |
| 89.36A Mal-united fracture, dislocation, ankle | 879.02 | 221.05 |
| 89.36C Osteotomy, fibula (including fixation) | 263.71 | 110.53 |
| 89.37 Other division of bone, tarsals and metatarsals | | |
| 89.37A Osteotomy, calcaneum or talus | 527.41 | 165.79 |
| 89.37B Osteotomy, Lesser bone of foot | 263.71 | 110.53 |
| 89.38 Other division of bone, other specified site | | |
| 89.38B Osteotomy, pelvis (including fixation) | 1,054.82 | 276.32 |
| 89.38C Osteotomy for kyphosis correction, posterior cervical spine | 1,626.19 | 524.16 |
| 89.38D Osteotomy spine, posterior thoracolumbar | 791.12 | 273.27 |
| 89.38E Subtraction/decancellation posterior osteotomy, lumbar | 1,758.04 | 663.17 |
| 89.38F Anterior release, thoracolumbar, multilevel | 1,318.53 | 455.45 |
| 89.38G Periacetabular osteotomy | 2,637.06 | 902.65 |
| 89.4 Excision of bunion (bunionectomy) | | |
| 89.41 Bunionectomy with soft tissue correction and osteotomy of the first metatarsal | | |
| 89.41A Bunionectomy with distal osteotomy of the first metatarsal or proximal phalanx | 395.56 | 184.21 |
| 89.41B Bunionectomy with proximal osteotomy first metatarsal | 791.12 | 276.32 |
| NOTE: May not be claimed with other osteotomy services on the first metatarsal. | | |
| 89.42 Bunionectomy with soft tissue correction and arthrodesis | | |
| 89.42A Bunionectomy with soft tissue correction | 263.71 | 110.53 |
| 89.5 Local excision of lesion or tissue of bone | | |
| 89.53 Local excision of lesion or tissue of bone, metacarpal | | |
| 89.53A Excision of tumor | 347.22 | 110.53 |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

89 INCISION, EXCISION, AND DIVISION OF OTHER BONES (cont'd)

89.5 Local excision of lesion or tissue of bone (cont'd)

89.57 Local excision of lesion or tissue of bone, tarsals and metatarsals

| | | BASE | ANE |
|---|---|---|---|
| 89.57B | Local excision of lesion or tissue of bone, tarsals and metatarsals, sequestrectomy or saucerization | 175.80 | 110.53 |

89.58 Local excision of lesion or tissue of bone, phalanx

| | | | |
|---|---|---|---|
| 89.58A | Tumor | 347.22 | 110.53 |
| 89.58B | Saucerization | 190.75 | 110.43 |

89.59 Local excision of lesion or tissue of bone, unspecified site

| | | | |
|---|---|---|---|
| 89.59A | Biopsy bone tumor, superficial | 131.85 V | 110.53 |
| 89.59B | Percutaneous, biopsy bone tumor, deep | 138.73 | 110.53 |
| 89.59F | Local excision or saucerization, large bone | 439.51 | 202.64 |
| 89.59G | Open biopsy bone tumor, first full 30 minutes or major portion thereof for the first call when only one call is claimed | 197.78 | 110.53 |

NOTE: 1. May not be claimed with other procedures.
2. Each subsequent 15 minutes, or major portion thereof, is payable at the rate specified on the Price List after the first full 30 minutes has elapsed.

89.6 Excision of bone for graft

Allograft harvesting from cadaver for bone bank

| | | | |
|---|---|---|---|
| 89.6 A | Major, may include hemipelvis, long bone and joint articulation | 452.79 | |
| 89.6 C | Harvesting of autologous bone<br>That for grafting by a second surgeon for immediate insertion | 211.99 | |

89.7 Other partial ostectomy

89.78 Other partial ostectomy (specified site)

| | | | |
|---|---|---|---|
| 89.78D | Odontoidectomy, transoral approach | 2,342.29 | 611.52 |
| 89.78E | Temporal bone, subtotal resection<br>That for malignant disease | 2,781.92 | 459.36 |
| 89.78H | Vertebrectomy cervical, partial | 806.94 | 571.06 |

NOTE: 1. Benefit includes discectomy(s).
2. Fusion, bone graft harvesting and/or plating may be claimed in addition.

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

89 INCISION, EXCISION, AND DIVISION OF OTHER BONES (cont'd)

89.7 Other partial ostectomy (cont'd)
89.78 Other partial ostectomy (specified site) (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 89.78I | Vertebrectomy cervical, total, one level<br>NOTE: 1. Benefit includes discectomy(s).<br>2. Fusion, bone graft harvesting and/or plating may be claimed in addition. | 1,873.53 | 700.02 |
| 89.78L | Vertebrectomy cervical, total, two levels<br>NOTE: 1. Benefit includes discectomy(s).<br>2. Fusion, bone graft harvesting and/or plating may be claimed in addition. | 1,512.03 | 1,063.65 |
| 89.78M | Vertebrectomy cervical, total, three levels<br>NOTE: 1. Benefit includes discectomy(s).<br>2. Fusion, bone graft harvesting and/or plating may be claimed in addition. | 1,637.57 | 1,234.95 |
| 89.78N | Vertebrectomy cervical, total, four levels<br>NOTE: 1. Benefit includes discectomy(s).<br>2. Fusion, bone graft harvesting and/or plating may be claimed in addition. | 2,583.21 | 1,356.71 |
| 89.78J | Vertebrectomy, partial, thoracolumbar<br>NOTE: 1. Benefit includes discectomy(s).<br>2. Fusion, bone graft harvesting and/or plating may be claimed in addition. | 879.02 | 671.35 |
| 89.78K | Vertebrectomy, total, thoracolumbar, one level<br>NOTE: 1. Benefit includes discectomy(s).<br>2. Fusion, bone graft harvesting and/or plating may be claimed in addition. | 1,780.02 | 810.54 |
| 89.78P | Vertebrectomy, total, thoracolumbar, two levels<br>NOTE: 1. Benefit includes discectomy(s).<br>2. Fusion, bone graft harvesting and/or plating may be claimed in addition. | 2,409.21 | 1,414.62 |
| 89.78Q | Vertebrectomy, total, thoracolumbar, three levels<br>NOTE: 1. Benefit includes discectomy(s).<br>2. Fusion, bone graft harvesting and/or plating may be claimed in addition. | 1,659.95 | 1,513.26 |
| 89.78R | Vertebrectomy, total, thoracolumbar, four levels<br>NOTE: 1. Benefit includes discectomy(s).<br>2. Fusion, bone graft harvesting and/or plating may be claimed in addition. | 2,437.40 | 1,878.52 |
| 89.78S | Anterior cervical plating, 2 vertebrae | 643.44 | 419.33 |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

89 INCISION, EXCISION, AND DIVISION OF OTHER BONES (cont'd)

89.7 Other partial ostectomy (cont'd)
89.78 Other partial ostectomy (specified site) (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 89.78T | Anterior cervical plating, 3 vertebrae | 703.22 | 419.33 |
| 89.78U | Anterior cervical plating, 4 vertebrae | 894.42 | 419.33 |
| 89.78V | Anterior cervical plating, 5 vertebrae | 1,000.06 | 419.33 |
| 89.78W | Anterior thoracolumbar plating, 2 vertebrae | 773.54 | 419.33 |
| 89.78X | Anterior thoracolumbar plating, 3 vertebrae | 813.97 | 419.33 |
| 89.78Y | Anterior thoracolumbar plating, 4 vertebrae | 896.60 | 419.33 |

89.8 Total ostectomy

| | | | |
|---|---|---|---|
| 89.85 | Total patellectomy | 439.51 | 163.96 |

89.88 Total ostectomy (specified site)

| | | | |
|---|---|---|---|
| 89.88A | Coccygectomy | 439.51 | 110.53 |

89.89 Complete ostectomy, unspecified site

| | | | |
|---|---|---|---|
| 89.89B | Radical or wide en-bloc resection of bone or soft tissue tumor of limb and limb salvage reconstruction, full 60 minutes or major portion thereof for the first call when only one call is claimed | 527.41 | |

NOTE: Each subsequent 15 minutes, or major portion thereof, is payable at the rate specified on the Price List after the first full 60 minutes has elapsed.

89.9 Biopsy of bone
89.98 Biopsy of bone, other specified site

| | | | |
|---|---|---|---|
| 89.98A | Needle biopsy of vertebral body or disc | 138.73 | 110.53 |

90 OTHER OPERATIONS ON BONES EXCEPT FACIAL BONES

90.0 Bone graft

NOTE: Benefits for 90.00A to 90.08A include harvesting and fixation

90.00 Bone graft, scapula, clavicle, and thorax (ribs or sternum)

| | | | |
|---|---|---|---|
| 90.00A | Clavicle | 351.61 | 184.21 |
| 90.01 | Bone graft, humerus | 527.41 | 221.05 |

90.02 Bone graft, radius and ulna

| | | | |
|---|---|---|---|
| 90.02B | Radius | 351.61 | 176.68 |
| 90.02C | Ulna | 351.61 | 176.68 |

90.03 Bone graft, carpals and metacarpals

| | | | |
|---|---|---|---|
| 90.03A | Carpal scaphoid | 595.98 | 165.79 |
| 90.03B | Bone graft metacarpal or phalanx | 336.73 | 109.21 |
| 90.03C | Carpal, vascularized | 1,036.49 | 368.43 |
| 90.04 | Bone graft, femur | 527.41 | 294.73 |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

90 OTHER OPERATIONS ON BONES EXCEPT FACIAL BONES (cont'd)

90.0 Bone graft (cont'd)

90.05 Bone graft, patella

| | BASE | ANE |
|---|---|---|
| 90.05A Articular osteochondral graft in the knee | 791.12 | 276.32 |

90.06 Bone graft, tibia and fibula

| | | |
|---|---|---|
| 90.06A Tibia | 351.61 | 221.05 |
| 90.06B Medial malleolus | 263.71 | 176.68 |

90.07 Bone graft, tarsals and metatarsals

| | | |
|---|---|---|
| 90.07A Calcaneum | 527.41 | 192.20 |
| 90.07B Metatarsals | 351.61 | 110.53 |

90.08 Bone graft, other specified site

| | | |
|---|---|---|
| 90.08A Phalanges | 263.71 | 109.21 |
| 90.08B Ilioplasty, repair iliac crest defect following bone graft harvest | 87.90 | |

NOTE: Benefit includes repair with autograft, allograft, or bone cement.

90.09 Bone graft, unspecified site

| | | |
|---|---|---|
| 90.09A Preparation of allograft bone from bone bank, for insertion, including spinal cage insertion | 131.85 | |

NOTE: 1. For spinal surgery, may be claimed only once regardless of the number of levels.
2. May be claimed with 90.09B or 90.09C if autogenous bone is harvested.

| | | |
|---|---|---|
| 90.09B Harvest autogenous bone graft, iliac crest or different bone through a different incision | 263.71 | |

NOTE: May not be claimed in association with HSC 90.00A to 90.08A inclusive.

| | | |
|---|---|---|
| 90.09C Harvest autogenous bone graft, different bone | 131.85 | |

NOTE: May not be claimed in association with HSC 90.00A to 90.08A inclusive.

90.2 Epiphyseal stapling

| | | |
|---|---|---|
| 90.2 A Epiphyseal stapling, One side | 351.61 | 147.37 |

90.3 Other change in bone length

90.32 Other change in bone length, radius and ulna

| | | |
|---|---|---|
| 90.32A Shortening of radius | 388.68 | 139.77 |
| 90.32B Shortening of ulna | 351.61 | 147.37 |

90.34 Other change in bone length, femur

| | | |
|---|---|---|
| 90.34A Femur, (shortening) | 1,054.82 | 313.17 |
| 90.34B Femur, (lengthening) | 949.34 | 353.34 |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

90 OTHER OPERATIONS ON BONES EXCEPT FACIAL BONES (cont'd)

90.3 Other change in bone length (cont'd)

90.39 Other change in bone length, unspecified site

| | | BASE | ANE |
|---|---|---|---|
| 90.39A | Incremental lengthening or deformity correction using external fixation device, full 60 minutes or major portion thereof for the first call when only one call is claimed | 527.41 | 477.03 |
| | NOTE: Each subsequent 15 minutes, or major portion thereof, is payable at the rate specified on the Price List after the first full 15 minutes has elapsed. | | |

90.4 Other repair or plastic operation on bone

90.40 Other repair or plastic operation on bone, scapula, clavicle, and thorax (ribs and sternum)

| | | | |
|---|---|---|---|
| 90.40A | Congenital elevation scapula, scapulopexy | 709.23 | 192.20 |
| 90.40B | Vertical expandable prosthetic titanium rib (VEPTR) surgical insertion for scoliosis or other thoracic deficiency syndrome | 3,516.08 | 1,454.56 |
| 90.40C | Vertical expandable prosthetic titanium rib (VEPTR) lengthening procedure | 1,547.08 | 644.75 |

90.5 Internal fixation of bone (without fracture reduction)

| | | | |
|---|---|---|---|
| 90.5 A | Odontoid screw fixation | 1,626.19 | 552.63 |
| 90.5 B | C1 - C2 facet screw fixation and posterior tension band | 2,621.99 | 792.12 |

90.6 Removal of internal fixation device

| | | | |
|---|---|---|---|
| 90.6 D | Removal of external fixation device | 175.80 | 110.53 |
| | NOTE: May only be claimed when performed in a hospital operating theatre or non-hospital surgical suite | | |
| 90.6 E | Removal of hardware under local anesthetic | 87.90 | |
| | NOTE: Regardless of the number of pieces of hardware removed, only one call may be claimed per site. | | |
| 90.6 F | Removal of hardware, excluding external fixator devices, first full 30 minutes or major portion thereof for the first call when only one call is claimed | 197.78 | 110.53 |
| | NOTE: 1. May only be claimed when performed in a hospital operating theatre or non-hospital surgical suite.<br>2. Each subsequent 15 minutes, or major portion thereof, is payable at the rate specified on the Price List after the first full 30 minutes has elapsed. | | |

91 REDUCTION OF FRACTURE AND DISLOCATION

91.0 Closed reduction of fracture (without internal fixation)

91.00 Closed reduction of fracture, humerus

| | | | |
|---|---|---|---|
| 91.00A | Surgical neck | 120.09 | |
| 91.00B | Surgical neck with anesthesia and manipulation | 174.00 | 110.53 |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

91 REDUCTION OF FRACTURE AND DISLOCATION (cont'd)

91.0 Closed reduction of fracture (without internal fixation) (cont'd)

91.00 Closed reduction of fracture, humerus (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 91.00C | Shaft | 183.82 | 110.43 |
| 91.00D | Supracondylar | 214.92 | 110.53 |
| 91.00E | Supracondylar, traction or external skeletal fixation | 527.41 | 147.37 |
| 91.00F | Elbow, one or more bones | 120.09 | 110.53 |

91.01 Closed reduction of fracture, radius and ulna

| | | | |
|---|---|---|---|
| 91.01A | Radius head, not requiring anesthesia | 72.90 | |
| 91.01B | Radius head with manipulation and anesthesia | 91.73 | 110.53 |
| 91.01C | Radius, shaft | 109.07 | 110.53 |
| 91.01D | Ulna, shaft | 117.23 | 110.53 |
| 91.01E | Monteggia | 175.80 | 184.21 |
| 91.01F | Colles | 140.34 | 110.53 |
| 91.01G | CR fracture, Colles with pin fixation | 351.61 | 110.53 |
| 91.01H | Styloid process radius | 71.76 V | 109.31 |
| 91.01J | Styloid, ulna | 37.79 V | 109.21 |
| 91.01K | Undisplaced | 75.15 | |
| 91.01L | Greenstick | 109.07 | 110.43 |
| 91.01M | Closed reduction of fracture, radius and ulna, displaced | 183.82 | 110.53 |

91.02 Closed reduction of fracture, carpals and metacarpals

| | | | |
|---|---|---|---|
| 91.02A | Metacarpal | 71.08 V | 110.53 |
| 91.02B | Bennett's | 117.23 | 109.21 |
| 91.02C | Carpals, excluding scaphoid | 120.09 | 110.43 |
| 91.02D | Scaphoid | 140.34 | 109.21 |

91.03 Closed reduction of fracture, phalanges of hand

| | | | |
|---|---|---|---|
| 91.03A | Phalanx | 69.06 V | 110.53 |
| 91.03B | Simple distal phalanx | 34.77 V | 110.53 |

91.04 Closed reduction of fracture (without internal fixation), femur

| | | | |
|---|---|---|---|
| 91.04A | Femur (Intertrochanteric, undisplaced) | 183.82 | |
| 91.04B | Intertrochanteric, femur, skeletal traction | 424.02 | 200.39 |
| 91.04C | Shaft | 407.88 V | 200.39 |

NOTE: For under 10 years of age, refer to Price List.

| | | | |
|---|---|---|---|
| 91.04E | Closed reduction femoral shaft fracture, patient under 10 years of age | 527.41 | 184.21 |

NOTE: 1. Benefit includes application of hip spica.
2. May only be claimed when performed in a hospital operating theatre or non-hospital surgical suite.

91.05 Closed reduction of fracture, tibia and fibula

| | | | |
|---|---|---|---|
| 91.05A | Tibia, plateau, traction | 237.74 | 110.53 |
| 91.05B | Tibia, shaft, with or without fibula | 235.29 V | 110.53 |

NOTE: For under 10 years of age, refer to Price List.

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

91 REDUCTION OF FRACTURE AND DISLOCATION (cont'd)

91.0 Closed reduction of fracture (without internal fixation) (cont'd)

91.05 Closed reduction of fracture, tibia and fibula (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 91.05K | Closed reduction of tibia | 351.61 | 110.53 |
| | NOTE: May only be claimed when performed in a hospital operating theatre or non-hospital surgical suite. | | |
| 91.05C | Medial malleolus, without displacement of astragalus | 117.23 | 110.43 |
| 91.05D | Medial or lateral malleolus with displacement of astragalus | 164.16 | 109.21 |
| 91.05E | Fibula, shaft | 102.85 V | 109.21 |
| | NOTE: May be claimed in addition to 91.05C. | | |
| 91.05F | Ankle, bi-malleolar | 237.74 | 110.53 |
| 91.05G | Ankle, tri-malleolar | 237.74 | 184.21 |
| 91.05H | Lateral malleolus | 93.40 V | 110.43 |
| | NOTE: May not be claimed in addition to 91.05C. | | |

91.06 Closed reduction of fracture (without internal fixation), tarsals and metatarsals

| | | | |
|---|---|---|---|
| 91.06A | Talus | 140.87 | 109.31 |
| 91.06B | Calcaneus | 120.09 | 110.43 |
| 91.06C | Calcaneus, external skeletal fixation | 527.41 | 141.34 |
| 91.06D | Metatarsal | 72.59 V | 110.53 |
| 91.06E | Other tarsal bone(s) | 99.21 V | 109.21 |
| | NOTE: A second call may only be claimed when a fracture in the second foot is reduced. | | |

91.07 Closed reduction of fracture, phalanges of foot

| | | | |
|---|---|---|---|
| 91.07A | Phalanx or phalanges | 47.65 V | 109.21 |

91.08 Closed reduction of fracture (without internal fixation), other specified bone

| | | | |
|---|---|---|---|
| 91.08B | Scapula | 55.60 V | 109.21 |
| 91.08L | External fixation, pelvis | 791.12 | 332.06 |
| | NOTE: Benefit includes closed reduction | | |
| 91.08G | Central dislocation of hip, displaced, skeletal traction | 219.52 | 165.79 |
| 91.08J | Sacrum | 48.30 | |

91.09 Closed reduction of fracture (without internal fixation) unspecified bone

| | | | |
|---|---|---|---|
| 91.09A | Diaphyseal bone external fixation with possible metaphyseal fixation | 527.41 | 184.21 |
| | NOTE: This will include complex cases such as a severe tibial plateau fracture that can not be treated with internal fixation. | | |
| 91.09B | Closed reduction and pinning of distal radius metaphyseal fractures | 266.13 | 184.21 |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

91 REDUCTION OF FRACTURE AND DISLOCATION (cont'd)

| | BASE | ANE |
|---|---|---|
| 91.1 Closed reduction of fracture with internal fixation | | |
| 91.10 Closed reduction of fracture with internal fixation, humerus | | |
| 91.10A Closed reduction and percutaneous pinning proximal humeral fracture | 527.41 | 184.21 |
| 91.12 Closed reduction of fracture with internal fixation, carpals and metacarpals | | |
| 91.12A Metacarpal | 259.12 | 110.53 |
| 91.13 Closed reduction of fracture with internal fixation, phalange of hand | | |
| 91.13A Phalanx | 285.03 | 110.53 |
| 91.14 Closed reduction of fracture with internal fixation, femur | | |
| 91.14A Neck | 791.12 | 265.65 |
| 91.14B With insertion of intramedullary nail | 879.02 | 287.78 |
| 91.14C With insertion of locking intramedullary nail | 1,054.82 | 332.06 |
| 91.15 Closed reduction of fracture with internal fixation, tibia and fibula | | |
| 91.15A Closed reduction of fracture, tibia and fibula with insertion of intramedullary nail | 659.27 | 184.21 |
| 91.15B Closed reduction of fracture, tibia and fibula with insertion of locking intramedullary nail | 857.04 | 221.05 |
| 91.2 Open reduction of fracture (without internal fixation) | | |
| 91.22 Open reduction of fracture (without internal fixation), carpals and metacarpals | | |
| 91.22A Open reduction without internal fixation of carpal | 414.60 | 165.79 |
| 91.22B Open reduction without internal fixation of metacarpal | 227.53 | 110.43 |
| 91.23 Open reduction of fracture (without internal fixation) phalanges of hand | | |
| 91.23A Phalanx | 203.62 | 110.53 |
| 91.23B Bennett's | 298.87 | 141.34 |
| 91.3 Open reduction of fracture with internal fixation | | |
| 91.30 Open reduction of fracture with internal fixation, humerus | | |
| 91.30A Elbow (medial or lateral condyles) | 527.41 | 165.79 |
| 91.30B Surgical neck | 659.27 | 165.79 |
| 91.30C Shaft | 659.27 | 165.79 |
| 91.30D Supracondylar | 659.27 | 202.64 |
| 91.30F ORIF complex intercondylar distal humeral fracture (T-type, more than 2 articular fragments) | 1,186.68 | 405.27 |
| 91.30G ORIF simple intercondylar distal humeral fracture, 2 articular fragments | 703.22 | 257.90 |
| 91.30H ORIF complex proximal humeral fracture (3-4 part) including hemiarthroplasty | 1,186.68 | 405.27 |
| NOTE: This code may not be used for primary shoulder hemiarthroplasty for arthritis. | | |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

91 REDUCTION OF FRACTURE AND DISLOCATION (cont'd)

91.3 Open reduction of fracture with internal fixation (cont'd)

91.30 Open reduction of fracture with internal fixation, humerus (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 91.30I | ORIF glenoid fracture, excluding bony Bankart lesion repair(s) | 593.34 | 276.32 |

91.31 Open reduction of fracture with internal fixation, radius and ulna

| | | | |
|---|---|---|---|
| 91.31B | Radius shaft | 351.61 | 147.37 |
| 91.31C | Ulna shaft | 351.61 | 147.37 |
| 91.31D | ORIF of fracture, Colles (extra-articular) | 527.41 | 147.37 |
| 91.31E | Monteggia | 527.41 | 202.64 |
| 91.31F | Olecranon | 351.61 | 147.37 |
| 91.31G | ORIF complex distal radial fracture (comminuted, intra-articular), not percutaneous | 879.02 | 313.17 |
| 91.31H | ORIF Galeazzi fracture | 527.41 | 184.21 |
| 91.31J | ORIF radial head/neck or replacement radial head arthroplasty | 527.41 | 184.21 |
| 91.31K | Open reduction, complex comminuted fracture, proximal ulna | 615.31 | 350.01 |

91.32 Open reduction of fracture with internal fixation, carpals and metacarpals

| | | | |
|---|---|---|---|
| 91.32A | Metacarpal | 349.82 | 110.53 |
| 91.32D | ORIF scaphoid and carpal bones | 671.03 | 184.21 |

91.33 Open reduction of fracture with internal fixation, phalanges of hand

| | | | |
|---|---|---|---|
| 91.33A | Phalanx(s) | 362.77 | 110.53 |
| 91.33B | ORIF intra-articular or Bennett's fracture | 375.73 | 147.37 |

91.34 Open reduction of fracture with internal fixation, femur

| | | | |
|---|---|---|---|
| 91.34A | Inter-trochanteric | 791.12 | 265.65 |
| 91.34B | Bicondylar, supracondylar fracture, T-shaped | 1,186.68 | 464.90 |
| 91.34C | Supracondylar fracture | 879.02 | 464.90 |
| 91.34D | Fracture femoral condyle | 527.41 | 243.51 |
| 91.34E | Femur, neck | 791.12 | 265.65 |
| 91.34F | ORIF femoral head fracture | 879.02 | 376.34 |
| 91.34G | ORIF femoral shaft fracture | 879.02 | 376.34 |
| 91.34H | ORIF subtrochanteric femur fracture | 1,054.82 | 442.76 |

91.35 Open reduction of fracture with internal fixation, tibia and fibula

| | | | |
|---|---|---|---|
| 91.35A | Tibial plateau | 791.12 | 184.21 |
| 91.35B | Tibia | 593.34 | 184.21 |
| 91.35C | Medial malleolus | 263.71 | 147.37 |
| 91.35D | ORIF of fracture, Fibula, shaft | 307.66 | 147.37 |
| 91.35G | ORIF, Tibial plateau - bicondylar fracture (T type, comminuted, displaced) | 1,186.68 | 368.43 |
| 91.35H | ORIF of fracture, Lateral malleolus | 307.66 | 147.37 |
| 91.35K | ORIF tibial plafond (2 intra-articular fragments) | 791.12 | 276.32 |
| 91.35L | ORIF comminuted tibial plafond (more than 2 intra-articular fragments) | 1,186.68 | 405.27 |
| 91.35M | ORIF posterior malleolus | 175.80 | 110.53 |
| 91.35N | Syndesmosis screw insertion | 219.76 | 384.39 |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

91 REDUCTION OF FRACTURE AND DISLOCATION (cont'd)

91.3 Open reduction of fracture with internal fixation (cont'd)

91.36 Open reduction of fracture with internal fixation, tarsals and metatarsals

| | | BASE | ANE |
|---|---|---|---|
| 91.36A | Talus | 791.12 | 184.21 |
| 91.36B | ORIF of fracture, Calcaneus | 966.92 | 184.21 |
| 91.36I | ORIF intra-articular comminuted calcaneus fracture more than three intra-articular parts | 1,186.68 | 893.45 |
| 91.36C | ORIF of fracture, other tarsal bone, including navicular bone | 659.27 | 147.37 |
| 91.36D | ORIF of fracture, Metatarsal | 263.71 | 132.51 |
| 91.36E | ORIF Lisfranc fracture dislocation | 593.34 | 202.64 |
| 91.36G | ORIF Lisfranc fracture dislocation, 3 or more dislocations | 791.12 | 515.80 |
| 91.36H | Talar fracture, complex | 966.92 | 655.84 |

NOTE: May only be claimed for repairs of 2 of either:
-Body fracture (s)
-Neck fracture or
-lateral process fractures.

91.37 Open reduction of fracture with internal fixation, phalanges of foot

| | | | |
|---|---|---|---|
| 91.37A | Toe | 175.80 | 110.53 |

91.38 Open reduction of fracture with internal fixation, other specified bone

| | | | |
|---|---|---|---|
| 91.38A | Clavicle | 481.39 | 110.53 |
| 91.38B | Scapula | 527.41 | 141.34 |
| 91.38D | ORIF, Acetabulum - simple wall (anterior/posterior) | 1,054.82 | 368.43 |
| 91.38F | Patella | 395.56 | 165.79 |
| 91.38H | ORIF pubic symphysis or iliac wing | 791.12 | 276.32 |
| 91.38J | ORIF complex, acetabular (column) fracture | 2,109.65 | 885.51 |
| 91.38K | ORIF sacroiliac joint | 1,054.82 | 368.43 |

91.4 (Closed) reduction of separated (slipped) epiphysis

91.44 (Closed) reduction of separated (slipped) epiphysis (femur)

| | | | |
|---|---|---|---|
| 91.44B | Upper femoral, internal fixation | 879.02 | 221.05 |

91.7 Closed reduction of dislocation of joint
For those not listed - claim a visit.

91.70 Closed reduction of dislocation of shoulder

| | | | |
|---|---|---|---|
| 91.70A | Primary | 82.00 V | 110.53 |
| 91.70B | Recurrent | 82.00 V | 110.43 |

| | | | |
|---|---|---|---|
| 91.71 | Closed reduction of dislocation of elbow | 90.00 V | 110.53 |

NOTE: May not be claimed for dislocated radial head.

| | | | |
|---|---|---|---|
| 91.72 | Closed reduction of dislocation of wrist | 132.05 | 110.53 |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

91 REDUCTION OF FRACTURE AND DISLOCATION (cont'd)

91.7 Closed reduction of dislocation of joint (cont'd)

91.73 Closed reduction of dislocation of hand and finger

| | BASE | ANE |
|---|---|---|
| 91.73A Carpo-metacarpal | 50.77 V | 110.43 |
| 91.73B MP or IP joint | 53.40 V | 109.31 |

91.74 Closed reduction of dislocation of hip

| | | |
|---|---|---|
| 91.74A Closed reduction of dislocation of hip | 183.82 | 110.53 |
| 91.74B Closed reduction of developmental hip dislocation | 791.12 | 202.64 |

NOTE: May only be claimed when performed under general anesthetic.

91.75 Closed reduction of dislocation of knee

| | | |
|---|---|---|
| 91.75A Tibio-femoral | 165.44 | 110.43 |
| 91.75B Closed reduction of patellar dislocation | 72.59 | 109.21 |

NOTE: 1. May be claimed in addition to a visit or consultation at the same encounter.
2. May only be claimed in an emergency room, AACC or UCC.

| | | |
|---|---|---|
| 91.76 Closed reduction of dislocation of ankle | 145.83 | 110.43 |

91.77 Closed reduction of dislocation of foot and toe

| | | |
|---|---|---|
| 91.77A Tarsus | 129.41 | 110.53 |
| 91.77B Metatarsal | 65.00 V | 109.21 |
| 91.77C Toes | 30.24 V | 109.21 |

91.78 Closed reduction of dislocation of other specified sites

| | | |
|---|---|---|
| 91.78A Sterno-clavicular | 57.84 V | 110.43 |
| 91.78B Acromio-clavicular | 74.10 V | 109.21 |
| 91.78C Neck simple, with anesthetic | 139.93 | 109.21 |
| 91.78D Vertebra fracture, fracture dislocation, Halo traction, total care | 527.41 | |

NOTE: Includes total care.

91.8 Open reduction of dislocation of joint

| | | |
|---|---|---|
| 91.80 Open reduction of acute dislocation of shoulder, less than 21 days after injury | 659.27 | 221.05 |
| 91.80A Open reduction of chronic dislocation of shoulder, more than 21 days after injury | 879.02 | 674.05 |
| 91.81 Open reduction of dislocation of elbow | 659.27 | 184.21 |

91.82 Open reduction of dislocation of wrist

| | | |
|---|---|---|
| 91.82A ORIF, Carpal Dislocation | 659.27 | 147.37 |

91.83 Open reduction of dislocation of hand and finger

| | | |
|---|---|---|
| 91.83A Carpo-metacarpal | 310.95 | 110.53 |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

91 REDUCTION OF FRACTURE AND DISLOCATION (cont'd)

91.8 Open reduction of dislocation of joint (cont'd)

91.83 Open reduction of dislocation of hand and finger (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 91.83B | MP or IP joint | 311.47 | 110.53 |
| 91.84 | Open reduction of dislocation of hip | | |
| 91.84A | Open reduction of dislocation of hip | 659.27 | 276.32 |
| | NOTE: May be claimed in addition to 89.38B. | | |
| 91.84C | Open reduction of developmental hip dislocation | 1,054.82 | 220.84 |
| 91.84D | Repeat open reduction of developmental dislocation of hip | 1,582.24 | 512.35 |
| | NOTE: May not be claimed within 14 days of a 91.84C. | | |
| 91.85 | Open reduction of dislocation of knee | | |
| 91.85A | Tibio-femoral | 351.61 | 202.64 |
| 91.86 | Open reduction of dislocation of ankle | 263.71 | 184.21 |
| 91.87 | Open reduction of dislocation of foot and toe | | |
| 91.87A | Tarsus | 263.71 | 184.21 |
| 91.87B | Metatarsal | 195.14 | 132.51 |
| 91.87C | Toe | 175.80 | 110.53 |
| 91.88 | Open reduction of dislocation of other specified sites | | |
| 91.88A | Sterno-clavicular | 527.41 | 165.79 |
| 91.88B | Open reduction of dislocation acromio-clavicular, acute repair, less than 6 weeks from date of injury | 351.61 | 165.79 |
| 91.88C | Open reduction of dislocation acromio-clavicular chronic repair, greater than 6 weeks from date of injury | 395.56 | 276.32 |

91.9 Other or unspecified operations on bone injuries NEC

| | | | |
|---|---|---|---|
| 91.90 | Other or unspecified operations on bone injuries NEC, humerus | | |
| 91.90A | Open or closed reduction of fracture, humerus with insertion of intermedullary locking-nail | 857.04 | 239.49 |

92 INCISION AND EXCISION OF JOINT STRUCTURES

92.1 Other arthrotomy

NOTE: Benefits 92.10 through 92.19A (except 92.13) may not be claimed with other procedures on the same joint.

| | | | |
|---|---|---|---|
| 92.10 | Arthrotomy, shoulder | 395.56 | 165.79 |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

92 INCISION AND EXCISION OF JOINT STRUCTURES (cont'd)

92.1 Other arthrotomy (cont'd)
NOTE: Benefits 92.10 through 92.19A (except 92.13) may not be claimed with other procedures on the same joint. (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 92.11 | Arthrotomy, elbow | 351.61 | 147.37 |
| 92.12 | Arthrotomy, wrist | 419.78 | 110.53 |
| 92.13 | Arthrotomy, hand and finger | 147.70 | 109.31 |
| 92.14 | Arthrotomy, hip | 527.41 | 202.64 |
| 92.15 | Arthrotomy, knee<br>NOTE: May not be claimed with other procedures on the same joint. | 351.61 | 110.53 |
| 92.16 | Arthrotomy, ankle | 351.61 | 147.37 |

92.19 Other arthrotomy, unspecified site

| | | | |
|---|---|---|---|
| 92.19A | Arthrotomy of any joint, not elsewhere classified<br>NOTE: May not be claimed with other procedures on the same joint. | 263.71 | 110.53 |

92.3 Excision (or destruction) of certain specified joint structures

92.31 Excision or destruction of intervertebral disc

| | | | |
|---|---|---|---|
| 92.31C | Cervical discectomy with fusion, Neurosurgical component | 1,037.30 | 309.70 |
| 92.31D | Cervical discectomy with fusion, Orthopedic component | 639.93 | 309.70 |
| 92.31E | Anterior cervical discectomy and fusion, one level | 1,384.00 | 838.66 |
| 92.31M | Anterior cervical discectomy and fusion, two levels<br>NOTE: 1. Benefit includes discectomy(s).<br>2. Bone graft harvesting and/or plating may be claimed in addition. | 1,555.93 | 1,051.90 |
| 92.31N | Anterior cervical discectomy and fusion, three levels<br>NOTE: 1. Benefit includes discectomy(s).<br>2. Bone graft harvesting and/or plating may be claimed in addition. | 1,765.93 | 1,302.07 |
| 92.31P | Anterior cervical discectomy and fusion, four levels<br>NOTE: 1. Benefit includes discectomy(s).<br>2. Bone graft harvesting and/or plating may be claimed in addition. | 1,837.85 | 1,407.04 |
| 92.31Q | Microscopic assisted discectomy | 1,036.54 | 442.11 |
| 92.31R | Artificial disc replacement, cervical disc | 1,714.09 | 663.17 |
| 92.31S | Artificial disc replacement, lumbar disc | 1,933.84 | 716.35 |
| 92.31F | Thoracic disc, anterior approach | 1,277.52 | 406.35 |
| 92.31H | Cervical laminectomy for discectomy<br>NOTE: 1. Benefit includes discectomy.<br>2. Instrumentation may be claimed in addition. | 1,070.76 | 314.50 |
| 92.31J | Posterolateral fusion, lumbar, 2 levels or less | 703.22 | 218.60 |
| 92.31K | Posterolateral fusion, lumbar, more than 2 levels | 922.97 | 305.76 |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

92 INCISION AND EXCISION OF JOINT STRUCTURES (cont'd)

92.3 Excision (or destruction) of certain specified joint structures (cont'd)

92.31 Excision or destruction of intervertebral disc (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 92.31L | Cervical/lumbar discectomy without fusion | 791.12 | 331.58 |

92.32 Excision of semilunar cartilage of knee
NOTE: Benefits 92.32B through 92.32D may not be claimed with other procedures on the same knee.

| | | | |
|---|---|---|---|
| 92.32B | Arthroscopy knee, including menisectomy | 351.61 | 165.79 |
| 92.32C | Meniscal repair | 571.36 | 165.79 |
| 92.32D | Arthroscopy knee, including non-reconstructive procedures (loose body, plica, etc.) | 351.61 | 147.37 |

92.4 Synovectomy
NOTE: 1. 92.40 to 92.46 inclusive may only be claimed for total synovectomy.
2. Partial synovectomy is considered to be an incidental procedure and may not be claimed.

| | | | |
|---|---|---|---|
| 92.40 | Synovectomy, shoulder<br>NOTE: May not be claimed in addition to HSCs 93.81A, 93.81B or 93.96E. | 527.41 | 185.51 |
| 92.41 | Synovectomy, elbow<br>NOTE: May not be claimed in addition to HSCs 93.96D or 93.96E. | 527.41 | 159.01 |
| 92.42 | Synovectomy, wrist<br>NOTE: May not be claimed in addition to HSCs 93.87C, 93.96D or 93.96E. | 336.86 | 145.74 |

92.43 Synovectomy, hand and finger

| | | | |
|---|---|---|---|
| 92.43A | MP joint or IP joint | 207.30 | 110.43 |
| 92.44 | Synovectomy, hip<br>NOTE: May not be claimed in addition to HSCs 93.59A, 93.69B, 93.69C or 93.96E. | 659.27 | 192.20 |
| 92.45 | Synovectomy, knee<br>NOTE: May not be claimed in addition to HSCs 93.41A or 93.96E. | 527.41 | 202.64 |
| 92.46 | Synovectomy, ankle<br>NOTE: May not be claimed in addition to HSCs 93.96D or 93.96E. | 527.41 | 139.77 |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

92 INCISION AND EXCISION OF JOINT STRUCTURES (cont'd)

92.5 Other local excision or destruction of lesion of joint
92.5 Bursotomy

| | | BASE | ANE |
|---|---|---|---|
| 92.5 B | Synovial biopsy | 243.56 | 109.21 |
| | NOTE: May not be claimed with other procedures on the same joint. | | |

92.7 Contrast arthrogram

Injection for

| | | | |
|---|---|---|---|
| 92.70 | Shoulder | 58.58 V | |
| 92.71 | Elbow | 58.58 V | |
| 92.72 | Wrist | 58.58 V | |
| 92.74 | Hip | 58.58 V | |
| 92.75 | Knee | 58.58 V | |
| 92.76 | Ankle | 58.58 V | |

92.78 Contrast arthrogram, other specified site

| | | | |
|---|---|---|---|
| 92.78A | Temporomandibular joint | 58.58 | |
| 92.78B | Facet joint in spine | 58.58 | |
| | NOTE: May not be claimed in addition to HSCs 16.89B, 16.89C or 16.89D. | | |
| 92.78C | Contrast arthrogram, unspecified site | 58.58 V | |
| | NOTE: 1. May not be claimed in addition to HSCs 16.89B, 16.89C or 16.89D. | | |
| | 2. May be claimed in addition to HSC 95.94C. | | |

92.8 Arthroscopy

| | | | |
|---|---|---|---|
| 92.8 A | Arthroscopy diagnostic-knee, shoulder, elbow, wrist, ankle | 307.66 | 110.53 |
| | NOTE: May not be claimed when a subsequent therapeutic open or arthroscopic procedure is performed in the same body cavity. | | |
| 92.8 B | Arthroscopy, hip-diagnostic | 527.41 | 184.21 |
| | NOTE: May not be claimed when a subsequent therapeutic open or arthroscopic procedure is performed in the same body cavity. | | |
| 92.8 C | Arthroscopy, hip, therapeutic intervention, including debridement/drilling, etc. | 747.17 | 257.90 |
| 92.8 D | Arthroscopy, (wrist, elbow, ankle, shoulder, knee) therapeutic intervention, including debridement/drilling, etc. | 527.41 | 184.21 |
| | NOTE: May not be billed in addition to HSCs 92.32B, 92.32C or 92.32D. | | |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

93 REPAIR AND PLASTIC OPERATIONS ON JOINT STRUCTURES

| | | BASE | ANE |
|---|---|---|---|
| 93.0 | Spinal fusion | | |
| 93.01 | Atlas-axis spinal fusion | | |
| 93.01A | Foramen magnum, decompression and occiput-cervical: exploration, open reduction, internal fixation, and fusion with autogenous bone | 2,497.80 | 957.91 |
| 93.01B | Occipital cervical fusion with instrumentation | 2,681.28 | 902.65 |
| 93.02 | Other cervical spinal fusion | | |
| 93.02A | 2 vertebrae | 615.52 | 273.27 |
| 93.02B | 3 - 5 vertebrae | 675.19 | 309.70 |
| 93.05 | Other dorsolumbar spinal fusion | | |
| 93.05D | Instrumentation of spine following decompression | 1,110.86 | 368.43 |
| 93.05E | Instrumentation of spine following excision of spinal or paraspinal tumor | 1,741.88 | 692.28 |
| 93.06 | Lumbar spinal fusion | | |
| 93.06A | Spine fusion and disc Transabdominal<br>NOTE: This benefit is for the spinal procedure when the abdominal approach was performed by a second operator. | 710.72 | 366.90 |
| 93.09 | Other spinal fusion | | |
| 93.09B | Arthrodesis sacro-iliac or instrumentation sacrum to pelvis | 879.02 | 203.18 |
| 93.09C | Percutaneous sacroiliac joint fixation | 791.12 | 276.32 |
| 93.09E | Scoliosis correction (anterior or posterior more than 5 levels) | 3,516.08 | 1,454.56 |
| 93.09D | Instrumentation of dorsolumbar and cervical spine with or without fusion, posterior, 2 vertebrae | 1,023.18 | 437.23 |
| 93.09F | Instrumentation of dorsolumbar and cervical spine with or without fusion, posterior, 3 vertebrae | 1,199.86 | 497.38 |
| 93.09G | Instrumentation of dorsolumbar and cervical spine with or without fusion, posterior, 4 vertebrae | 1,371.27 | 571.06 |
| 93.09H | Instrumentation of dorsolumbar and cervical spine with or without fusion, posterior, 5 vertebrae | 1,547.08 | 644.75 |
| 93.1 | Arthrodesis of foot and ankle | | |
| 93.11 | Ankle fusion | | |
| 93.11A | Ankle fusion | 966.92 | 212.00 |
| 93.12 | Triple arthrodesis (and stripping) | | |
| 93.12A | Single hindfoot joint fusion or syndesmosis fusion | 580.15 | 203.18 |
| 93.12B | Double hindfoot joint fusion | 773.54 | 247.34 |
| 93.12C | Triple hindfoot joint fusion | 966.92 | 318.01 |
| 93.13 | Subtalar fusion | | |
| 93.13A | Arthrodesis of subtalar joint with bone block lengthening | 773.54 | 335.68 |
| 93.14 | Midtarsal fusion | | |
| 93.14 | Midtarsal fusion | 527.41 | 184.21 |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

93 REPAIR AND PLASTIC OPERATIONS ON JOINT STRUCTURES (cont'd)

93.1 Arthrodesis of foot and ankle (cont'd)

93.14 Midtarsal fusion (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| | NOTE: 1. A second call may only be claimed when a midtarsal joint in the other foot is fused.<br>2. Additional midtarsal fusions in the same foot may be claimed under 93.14A. | | |
| 93.14A | Each additional midtarsal fusion | 79.11 | 109.21 |
| | NOTE: 1. May only be claimed with 93.14.<br>2. A maximum benefit of 4 calls applies to each foot. | | |
| 93.16 | Metatarsophalangeal fusion | | |
| 93.16A | MP joint great toe | 351.61 | 132.51 |
| 93.18 | Other fusion of toe | | |
| 93.18A | IP joint great toe | 175.80 | 132.51 |
| 93.18B | Other toe joints | 175.80 | 132.51 |

93.2 Arthrodesis of other joints

| | | | |
|---|---|---|---|
| 93.21 | Arthrodesis of hip | 1,758.04 | 297.01 |
| 93.22 | Arthrodesis of knee | 1,054.82 | 218.60 |
| 93.23 | Arthrodesis of shoulder | 1,758.04 | 247.34 |
| 93.24 | Arthrodesis of elbow | 1,054.82 | 194.35 |
| 93.25 | Carporadial fusion | 879.02 | 202.64 |
| 93.26 | Metacarpocarpal fusion | 532.69 | 202.64 |
| 93.26A | Intercarpal fusion | 791.12 | 276.32 |
| 93.27 | Metacarpophalangeal fusion | 467.72 | 110.43 |
| 93.28 | Interphalangeal fusion<br>Arthrodesis or tenodesis | 407.66 | 110.53 |

93.3 Arthroplasty of foot and toe

| | | | |
|---|---|---|---|
| 93.39 | Other arthroplasty of foot and toe | | |
| 93.39B | Other toes, excision metatarsal head, Hoffmann's procedure<br>NOTE: Benefit includes hammer toes, single joint. | 175.80 | 110.53 |
| 93.39C | Arthroplasty great toe, MP joint<br>NOTE: Includes bunionectomy. | 263.71 | 147.37 |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

93 REPAIR AND PLASTIC OPERATIONS ON JOINT STRUCTURES (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 93.4 | Arthroplasty of knee and ankle | | |
| 93.41 | Total knee replacement (geomedic)(polycentric) | | |
| 93.41A | Total knee arthroplasty, including hemiarthroplasty | 1,054.82 | 441.82 |
| | NOTE: 1. May not be claimed in addition to HSC 92.45. 2. Benefit includes cancellous bone grafting of minor femoral and tibial cysts. | | |
| 93.44 | Patellar stabilization | | |
| 93.44A | Reconstruction, patellar tendon transplant for recurrent dislocation patella | 527.41 | 202.64 |
| 93.45 | Other repair of the cruciate ligaments | | |
| 93.45A | Anterior cruciate ligament reconstruction with bone - patellar tendon graft | 879.02 | 350.01 |
| 93.45B | Early repair knee cruciate ligament, less than 14 days | 527.41 | 184.21 |
| 93.45C | Anterior cruciate ligament reconstruction with meniscectomy | 966.92 | 368.43 |
| 93.45D | Anterior cruciate ligament reconstruction with meniscal repair | 1,318.53 | 405.27 |
| 93.45E | Revision anterior cruciate ligament reconstruction | 1,186.68 | 423.69 |
| 93.45F | Revision anterior cruciate ligament reconstruction with meniscal repair | 1,318.53 | 618.34 |
| 93.45J | Revision anterior cruciate ligament reconstruction with meniscectomy | 1,230.63 | 515.80 |
| 93.45G | Posterior cruciate ligament reconstruction | 1,230.63 | 371.01 |
| 93.45H | Posterior cruciate ligament reconstruction with meniscal repair | 1,362.48 | 759.69 |
| 93.45K | Revision posterior cruciate ligament reconstruction with meniscectomy | 1,230.63 | 663.94 |
| 93.47 | Other repair of knee | | |
| 93.47A | Early repair, knee, collateral ligament, less than 14 days | 439.51 | 165.79 |
| 93.47C | Reconstruction of collateral ligament, knee, late repair, more than 14 days | 719.02 | 239.49 |
| 93.49 | Other repair of ankle | | |
| 93.49A | Reconstruction ligament(s) ankle, early repair less than 14 days | 351.61 | 159.01 |
| 93.49B | Reconstruction ligament(s) ankle, late repair, more than 14 days | 527.41 | 221.05 |
| 93.49C | Arthroplasty, ankle | 527.41 | 184.21 |
| 93.5 | Total hip replacement | | |
| 93.59 | Other total hip replacement | | |
| 93.59A | Total hip arthroplasty | 1,054.82 | 441.82 |
| | NOTE: 1. May not be claimed in addition to HSC 92.44. 2. Benefit includes screw placement in the acetabulum and bone grafting minor acetabular cysts. | | |
| 93.6 | Other arthroplasty of hip | | |
| 93.6 A | Resection arthroplasty of hip | 791.12 | 276.32 |
| 93.6 B | Surgical hip dislocation with trochanteric flip, osteochondroplasty labral repair | 1,582.24 | 552.63 |
| 93.69 | Other repair of hip | | |
| 93.69A | Congenital dislocation of hip with acetabuloplasty or iliac osteotomy, or shelf | 1,582.24 | 313.17 |
| 93.69B | Hemiarthroplasty hip with uncemented prosthesis | 791.12 | 287.78 |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

93 REPAIR AND PLASTIC OPERATIONS ON JOINT STRUCTURES (cont'd)

93.6 Other arthroplasty of hip (cont'd)

93.69 Other repair of hip (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| | NOTE: May not be claimed in addition to HSC 92.44. | | |
| 93.69C | Hemiarthroplasty hip with cemented prosthesis | 843.86 | 354.21 |
| | NOTE: May not be claimed in addition to HSC 92.44. | | |

93.7 Arthroplasty of hand and finger

93.71 Arthroplasty of hand and finger with synthetic prosthesis

| | | | |
|---|---|---|---|
| 93.71A | Resection arthroplasty MP or IP joint, single | 349.82 | 110.53 |
| 93.71C | Reconstruction of collateral ligament and/or the volar plate of the MP or IP joint | 349.82 | 147.37 |
| 93.71D | Total finger joint arthroplasty (replacement with synthetic joint) | 440.51 | 165.79 |

93.8 Arthroplasty of upper extremity, except hand

| | | | |
|---|---|---|---|
| 93.8 A | Acromio-clavicular or sterno-clavicular | 395.56 | 221.05 |

93.81 Arthroplasty of shoulder with synthetic prosthesis

| | | | |
|---|---|---|---|
| 93.81A | Total joint arthroplasty of shoulder (glenoid and humeral replacement) | 1,054.82 | 313.17 |
| | NOTE: May not be claimed in addition to HSC 92.40. | | |
| 93.81B | Hemiarthroplasty of shoulder with synthetic prosthesis | 843.86 | 313.17 |
| | NOTE: May not be claimed with HSCs 92.40, 93.83D, 95.65B, 93.83H or 91.30H. | | |

93.83 Other repair of shoulder

| | | | |
|---|---|---|---|
| 93.83B | Repair recurrent sterno-clavicular, acromioclavicular dislocation with tendon graft from different site | 835.07 | 184.21 |
| 93.83C | Posterior shoulder instability repair | 703.22 | 276.32 |
| | NOTE: May not be claimed in association with 93.83D or 95.65B. | | |
| 93.83D | Bankart repair or capsular shift for anterior instability | 703.22 | 257.90 |
| 93.83E | Superior Labrum Anterior-Posterior (SLAP) repair (reattachment of the biceps anchor utilizing an anchoring device) | 593.34 | 202.64 |
| 93.83F | Bankart repair (reattachment of the labrum to the rim of the glenoid) plus Superior Labrum Anterior-Posterior (SLAP) repair (reattachment of the biceps anchor utilizing an anchoring device) | 835.07 | 294.73 |
| 93.83G | Other shoulder instability repair not elsewhere listed | 593.34 | 194.35 |
| | NOTE: May not be billed in association with 93.83D or 95.65B. | | |
| 93.83H | Rotator cuff repair, including tendon transfer | 527.41 | 184.21 |
| | NOTE: May not be claimed with 95.65B except where tendon transfers are performed through a different incision and do not involve rotator cuff muscles. | | |
| 93.83I | Rotator cuff repair, with Superior Labrum Anterior-Posterior (SLAP) or Bankart repair, including tendon transfer | 879.02 | 313.17 |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

93 REPAIR AND PLASTIC OPERATIONS ON JOINT STRUCTURES (cont'd)

93.8 Arthroplasty of upper extremity, except hand (cont'd)

93.83 Other repair of shoulder (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| | NOTE: May not be claimed with 95.65B except where tendon transfers are performed through a different incision and do not involve rotator cuff muscles. | | |
| 93.83N | Revision rotator cuff repair, including tendon transfer | 1,054.82 | 368.43 |
| | NOTE: May not be claimed with 95.65B except where tendon transfers are performed through a different incision and do not involve rotator cuff muscles. | | |
| 93.83O | Circumferential repair glenoid labrum | 1,054.82 | 512.35 |

93.84 Arthroplasty of elbow with synthetic prosthesis

| | | | |
|---|---|---|---|
| 93.84A | Arthroplasty of elbow with synthetic prosthesis/fascial graft | 1,054.82 | 291.50 |

93.85 Other repair of elbow

| | | | |
|---|---|---|---|
| 93.85A | Arthroplasty elbow | 527.41 | 221.05 |
| | NOTE: May not be billed in association with 92.41. | | |

93.87 Other repair of wrist

| | | | |
|---|---|---|---|
| 93.87A | Arthroplasty distal radio-ulnar joint, including resection soft tissue interposition technique or resection fusion technique | 351.61 | 141.34 |
| 93.87B | Arthroplasty of wrist - excision single carpal bone with or without insertion of synthetic prosthesis | 503.27 | 184.21 |
| 93.87C | Total arthroplasty of wrist using synthetic prosthesis | 697.94 | 229.66 |
| | NOTE: May not be claimed in addition to HSCs 92.42. | | |
| 93.87E | Resection arthroplasty of wrist (proximal row carpectomy) | 879.02 | 313.17 |
| 93.87J | Triangulo fibrocartilage complex repair, arthroscopic or open | 637.29 | 239.49 |
| 93.87K | Wrist ligament reconstruction (including scapholunate or lunotriquetral ligament) | 637.29 | 239.49 |

93.9 Other operations on joints

93.91 Arthrocentesis

| | | | |
|---|---|---|---|
| 93.91A | Joint aspiration, injection, hip | 37.38 V | 110.53 |
| | NOTE: Refer to notes following 93.91B. | | |
| 93.91B | Joint aspiration, injection, other joints | 19.83 V | 110.53 |
| | NOTE: 1. HSCs 93.91A and 93.91B may be claimed in addition to a visit or a consultation.<br>2. A second call may only be claimed for HSCs 93.91A and 93.91B when a second joint is either aspirated and/or injected.<br>3. HSCs 93.91A and 93.91B may be claimed in addition to HSC 95.94C. | | |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

93 REPAIR AND PLASTIC OPERATIONS ON JOINT STRUCTURES (cont'd)

93.9 Other operations on joints (cont'd)

93.96 Other repair of joint

| | | BASE | ANE |
|---|---|---|---|
| 93.96L | Ligament repair, elbow, acute, less than 14 days | 351.61 | 368.43 |
| 93.96B | Reconstruction, elbow single ligament, more than 14 days | 527.41 | 184.21 |
| 93.96C | Reconstruction, elbow two ligaments, more than 14 days | 879.02 | 313.17 |
| 93.96D | Primary total joint arthroplasty (ankle, elbow, wrist)<br>NOTE: May not be claimed in addition to HSCs 92.41, 92.42 or 92.46. | 1,054.82 | 368.43 |
| 93.96E | Primary total joint arthroplasty with major reconstruction including structural allograft, protrusio ring/custom implant (hip, knee, ankle, shoulder, elbow, wrist)<br>NOTE: May not be claimed in addition to HSCs 92.40, 92.41, 92.42, 92.44, 92.45 or 92.46. | 1,371.27 | 575.19 |
| 93.96F | Revision total joint arthroplasty - Bearing change only or patellar revision | 1,230.63 | 405.27 |
| 93.96G | Removal components insertion spacer (Prostalac or equivalent) | 1,582.24 | 642.00 |
| 93.96H | Revision total joint arthroplasty single side (excluding patellar revision) | 1,476.75 | 619.86 |
| 93.96I | Revision total joint arthroplasty both sides | 1,687.72 | 708.42 |
| 93.96J | Revision total joint arthroplasty with major reconstruction one side including structural allograft/protrusio ring/ custom implant | 2,109.65 | 885.51 |
| 93.96K | Revision total joint arthroplasty with major reconstruction both sides including structural allograft/protrusio ring/custom implant | 2,637.06 | 1,101.93 |

94 OPERATIONS ON MUSCLE, TENDON, FASCIA AND BURSA OF HAND

94.0 Incision of muscle, tendon, fascia and bursa of hand

94.01 Incision of tendon sheath of hand

| | | | |
|---|---|---|---|
| 94.01A | Incision of tendon sheath of hand | 155.47 | 110.53 |
| 94.01B | Incision and drainage of tendon sheath of hand | 194.26 | 110.53 |
| 94.04 | Incision and drainage of palmar and thenar space | 83.83 V | 110.43 |

94.2 Excision of lesion of muscle, tendon and fascia of hand

94.21 Excision of lesion of sheath tendon of hand

| | | | |
|---|---|---|---|
| 94.21A | Ganglion of hand | 181.39 | 110.53 |

94.3 Other excision of muscle, tendon and fascia of hand

94.35 Other excision of fascia of hand

| | | | |
|---|---|---|---|
| 94.35A | Radical fasciectomy for Dupuytren's contracture | 375.73 | 184.21 |
| 94.35B | Partial fasciectomy for Dupuytren's contracture | 246.17 | 147.37 |

94.4 Suture of muscle, tendon and fascia of hand
NOTE: For second and subsequent tendon repairs, claim 50% (flexor or extensor).

94.42 Delayed suture of flexor tendon of hand

| | | | |
|---|---|---|---|
| 94.42A | Secondary repair, flexor | 479.38 | 184.21 |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

94 OPERATIONS ON MUSCLE, TENDON, FASCIA AND BURSA OF HAND (cont'd)

94.4 Suture of muscle, tendon and fascia of hand (cont'd)

94.43 Delayed suture of other tendon of hand

| | BASE | ANE |
|---|---|---|
| 94.43A Secondary repair, extensor | 297.99 | 147.37 |
| 94.44 Other suture of flexor tendon of hand | | |
| 94.44A Primary repair, flexor | 388.68 | 184.21 |
| 94.45 Other suture of other tendon of hand | | |
| 94.45A Primary repair, extensor | 243.58 | 110.53 |
| 94.5 Transplantation of muscle and tendon of hand | | |
| 94.55 Other transfer or transplantation of tendon of hand | 453.46 | 165.79 |
| 94.6 Reconstruction of thumb | | |
| 94.61 Pollicization (operation) with neurovascular bundle carryover Thumb reconstruction | 1,191.96 | 273.84 |
| 94.7 Plastic operations on muscle, tendon, and fascia of hand with graft or implant | | |
| 94.71 Tendon pulley reconstruction | | |
| 94.71A Hand | 246.17 | 147.37 |
| 94.72 Plastic operation on hand with graft of tendon | | |
| 94.72A Flexor or extensor, tendon graft | 570.07 | 257.90 |
| 94.72B First stage of tendon graft using alloplastic spacer | 386.09 | 276.32 |
| 94.8 Other plastic operations on hand | | |
| 94.82 Other change in length of muscle, tendon, and fascia of hand | | |
| 94.82A Tendon lengthening or shortening | 263.71 | 141.34 |
| 94.85 Repair of mallet finger | 147.18 | 141.34 |
| 94.9 Other operations on muscle, tendon, fascia, and bursa of hand | | |
| 94.91 Freeing of adhesions of muscle, tendon, fascia and bursa of hand | | |
| 94.91A Tenolysis | 285.03 | 110.53 |
| 94.91B Tenolysis following flexor tendon graft | 558.18 | 194.35 |

95 OPERATIONS ON MUSCLES, TENDONS, FASCIA AND BURSA, EXCEPT HAND

| | | |
|---|---|---|
| 95.0 Incision of muscle, tendon, fascia and bursa | | |
| 95.01 Incision of tendon sheath | | |
| 95.01B Incision of tendon sheath, stenosing tenosynovitis or excision tendon sheath tumor | 155.47 | 110.43 |
| 95.02 Myotomy | | |
| 95.02A Myotomy That for removal of foreign body | 101.41 V | 109.31 |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

95 OPERATIONS ON MUSCLES, TENDONS, FASCIA AND BURSA, EXCEPT HAND (cont'd)

95.0 Incision of muscle, tendon, fascia and bursa (cont'd)

95.02 Myotomy (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 95.03 | Bursotomy | 26.57 V | 109.21 |
| | NOTE: May not be claimed for percutaneous aspiration of bursa. | | |

95.09 Incision of other soft tissue

| | | | |
|---|---|---|---|
| 95.09A | Removal of deep foreign body, with or without imaging, full 15 minutes of operating time or major portion thereof for the first call when only one call is claimed | 120.09 | 110.53 |
| | NOTE: Each subsequent 15 minutes, or major portion thereof, is payable at the rate specified on the Price List after the first full 15 minutes has elapsed; a maximum benefit applies. | | |

95.1 Division of muscle, tendon and fascia

| | | | |
|---|---|---|---|
| 95.12 | Adductor tenotomy of hip | 307.66 | 109.31 |

95.13 Other tenotomy

| | | | |
|---|---|---|---|
| 95.13A | Hip flexor release | 351.61 | 194.35 |
| 95.13B | Proximal hamstring release | 351.61 | 218.39 |

95.14 Myotomy for division

| | | | |
|---|---|---|---|
| 95.14A | Thoracic outlet, release or rib resection | 1,046.33 | 239.49 |
| 95.14B | Thoracic outlet, release or rib resection, repeat | 844.22 | 366.90 |
| 95.14C | Scalenus anterior division | 234.79 | 131.04 |
| 95.14D | Scalenus anterior with cervical rib resection | 373.81 | 192.20 |
| 95.14E | Sterno-mastoid | 316.45 | 165.79 |
| | That for congenital torticollis | | |

95.15 Fasciotomy for division

| | | | |
|---|---|---|---|
| 95.15A | Fasciotomy of all compartments in one extremity in one limb segment (arm, forearm, hand, buttock, thigh, leg, foot) | 527.41 | 165.79 |
| | NOTE: Only one call per limb segment may be claimed regardless of the number of incisions. | | |
| 95.15B | Plantar fasciotomy | 263.71 | 145.74 |
| 95.15C | Division ilio-tibial band, distal end | 263.71 | 109.31 |
| 95.15F | Plantar fasciectomy, partial | 351.61 | 110.53 |
| 95.15G | Plantar fasciectomy, complete | 703.22 | 218.60 |

95.19 Division of other soft tissue

| | | | |
|---|---|---|---|
| 95.19A | Release or sever operation for Erbs palsy | 445.96 | 194.35 |
| | NOTE: Includes that with osteotomy of humerus. | | |

95.2 Excision of lesion of muscle, tendon, fascia, and bursa

95.29 Excision of lesion of other soft tissue

| | | | |
|---|---|---|---|
| 95.29A | Baker's cyst | 527.41 | 184.21 |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

95 OPERATIONS ON MUSCLES, TENDONS, FASCIA AND BURSA, EXCEPT HAND (cont'd)

| | BASE | ANE |
|---|---|---|
| 95.2 Excision of lesion of muscle, tendon, fascia, and bursa (cont'd) | | |
| 95.29 Excision of lesion of other soft tissue (cont'd) | | |
| 95.29B Excision ganglion | 133.12 | 110.53 |
| 95.3 Other excision of muscle, tendon, and fascia | | |
| 95.32 Other excision of tendon | | |
| 95.32A Excision tendon sheaths forearm, wrist, tubercular or other granuloma | 354.27 | 184.21 |
| 95.32B Tenosynovectomy wrist | 532.76 | 184.21 |
| 95.4 Excision of bursa | | |
| 95.4 A Olecranon, prepatellar | 175.80 | 110.53 |
| 95.4 B Excision of bursa, Ischial, trochanteric | 175.80 | 147.37 |
| 95.5 Suture of muscles, tendon, and fascia | | |
| 95.54 Other suture of tendon | | |
| 95.54A Primary repair of tendo achilles, less than 14 days | 439.51 | 147.37 |
| 95.54B Primary repair, extensor, less than 14 days | 263.71 | 110.53 |
| 95.54C Primary repair, flexor, less than 14 days | 263.71 | 184.21 |
| 95.54D Reconstruction of tendo achilles, more than 14 days | 659.27 | 239.49 |
| 95.54E Quadriceps or patellar tendon repair | 527.41 | 184.21 |
| 95.54F Other suture of tendon, primary repair, extensor, greater than 14 days | 395.56 | 388.68 |
| 95.54G Other suture of tendon, primary repair, flexor, greater than 14 days | 395.56 | 388.68 |
| 95.6 Reconstruction of muscle and tendon | | |
| 95.65 Other transfer or transplantation of tendon | | |
| 95.65B About shoulder | 703.22 | 202.64 |
| 95.65C About elbow | 703.22 | 184.21 |
| 95.65D About hip | 703.22 | 276.32 |
| 95.65E About knee | 527.41 | 202.64 |
| 95.65F Distal knee | 527.41 | 159.01 |
| 95.65G Distal Elbow | 520.08 | 165.79 |
| 95.66 Other transfer or transplantation of muscle | | |
| 95.66B Muscle slide of the forearm | 703.22 | 147.37 |
| 95.7 Other plastic operations on muscles, tendon and fascia | | |
| 95.71 Tendon pulley reconstruction | | |
| 95.71A Tendon graft for pulley reconstruction | 266.34 | 139.77 |
| 95.71B Repair recurrent dislocation peroneal tendons | 527.41 | 165.79 |
| 95.72 Plastic operation with graft of tendon | | |
| 95.72A Silastic rod first stage tendon graft | 427.55 | 141.34 |
| 95.72B Flexor or extensor tendon graft | 518.25 | 257.90 |
| 95.75 Release of clubfoot NEC | | |
| 95.75A Metatarsus varus or club hand, medial or posterior release | 527.41 | 184.21 |
| 95.75B Metatarsus varus or club hand, medial and posterior release | 1,054.82 | 257.90 |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

95 OPERATIONS ON MUSCLES, TENDONS, FASCIA AND BURSA, EXCEPT HAND (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 95.76 | Other change in length of muscle, tendon, and fascia | | |
| 95.76A | Tendon lengthening or shortening | 263.71 | 147.37 |
| 95.76B | Repeat posteriomedial release of foot | 1,582.24 | 497.38 |
| 95.76C | Myotendinous lengthening or gastrosoleus slide | 395.56 | 110.53 |
| 95.77 | Other plastic operations on tendon | | |
| 95.77A | Biceps tenodesis, including tendon transfer<br>NOTE: May not be billed in association with 95.65B | 219.76 | 109.31 |
| 95.78 | Other plastic operations on muscle | | |
| 95.78A | Quadricepsplasty | 703.22 | 202.64 |
| 95.78B | Distal biceps/triceps, primary repair (less than 14 days) | 703.22 | 257.90 |
| 95.78C | Distal biceps/triceps, late repair (more than 14 days) | 879.02 | 313.17 |
| 95.8 | Invasive diagnostic procedures on muscle, tendon, fascia and bursa | | |
| 95.81 | Biopsy of muscle, tendon, fascia and bursa | | |
| 95.81A | Biopsy of muscle | 77.07 V | 110.53 |
| 95.9 | Other operations on muscle, tendon, fascia, and bursa | | |
| 95.91 | Freeing of adhesions of muscle, tendon, fascia, and bursa | | |
| 95.91A | Tenolysis | 175.80 | 110.53 |
| 95.91B | Tenolysis following flexor tendon graft | 439.51 | 192.20 |
| 95.91C | Subacromial decompression, including bursectomy<br>NOTE: May not be billed in association with 95.65B. | 329.63 | 109.31 |
| 95.93 | Injection/aspiration of therapeutic substance into bursa<br>Subacromial<br>NOTE: 1. A second call may only be claimed when the second bursa is either aspirated and/or injected.<br>2. May be claimed in addition to HSC 95.94C. | 18.11 V | 109.21 |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

95 OPERATIONS ON MUSCLES, TENDONS, FASCIA AND BURSA, EXCEPT HAND (cont'd)

95.9 Other operations on muscle, tendon, fascia, and bursa (cont'd)

95.94 Injection of therapeutic substance into other soft tissue

| | BASE | ANE |
|---|---|---|
| 95.94A Injection with local anesthetic of myofascial trigger points combined with a spray and stretch technique | 66.56 | |
| NOTE: 1. A minimum of 30 minutes of stretching per call is required at the time of the injection. 2. A maximum of 8 calls may be claimed per physician per day. | | |
| 95.94B Intravaginal trigger point injection(s) | 92.55 | |
| NOTE: 1. Benefit includes a general gynecological examination and concurrent specialized physiotherapy. 2. When only an injection is provided, refer to 13.59J. | | |
| 95.94C Ultrasound guidance during injection of soft tissue (trigger point), peripheral nerve, muscle, tendon, ligament, bursa or joint, additional benefit | 59.02 | |
| NOTE: 1. May only be claimed by Physical Medicine and Rehabilitation. 2. May only be claimed with HSCs 13.59H, 13.59J, 16.89B, 16.89D, 16.99A, 17.71A, 92.78C, 93.91A, 93.91B, 95.93 and 95.96A. | | |

95.96 Aspiration of other soft tissue

| | | |
|---|---|---|
| 95.96A Other bursae, tendon sheaths, ganglion of wrist or ankle, aspiration, injection | 13.26 V | 110.43 |
| NOTE: 1. A second call may only be claimed when a second bursa, tendon sheath or ganglion is either aspirated and/or injected. 2. May be claimed in addition to HSC 95.94C. | | |

95.99 Other operations on muscle, tendon, fascia, and bursa NEC

| | | |
|---|---|---|
| 95.99A Open reconstruction of congenital vertical talus | 901.00 | 253.34 |

96 OTHER OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

96.0 Amputation of upper limb

96.01 Amputation and disarticulation of finger(s), except thumb

| | | |
|---|---|---|
| 96.01A Finger, one | 207.30 | 110.53 |
| 96.01B Amputation and disarticulation of finger, through MP joint | 201.08 | 147.37 |

96.02 Amputation and disarticulation of thumb

| | | |
|---|---|---|
| 96.02A Amputation and disarticulation of thumb, distal to MP joint | 183.46 | 147.37 |
| 96.02B Amputation and disarticulation of thumb, through MP joint | 201.08 | 145.74 |

96.03 Amputation through hand

| | | |
|---|---|---|
| 96.03A Metacarpal, entire ray | 310.95 | 110.43 |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

96 OTHER OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

96.0 Amputation of upper limb (cont'd)

96.03 Amputation through hand (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 96.03B | Through metacarpal or MP joint | 215.07 | 109.21 |
| 96.04 | Disarticulation of wrist | 659.27 | 110.43 |
| 96.05 | Amputation through forearm | 659.27 | 167.83 |
| 96.06 | Disarticulation of elbow or amputation through humerus | 659.27 | 184.21 |
| 96.07 | Disarticulation of shoulder | 879.02 | 218.39 |
| 96.08 | Interthoracoscapular amputation | 1,773.64 | 220.84 |

96.1 Amputation of lower limb

96.11 Amputation and disarticulation of toe(s)

| | | | |
|---|---|---|---|
| 96.11A | Toe, one | 175.80 | 110.53 |

96.12 Amputation and disarticulation of foot

| | | | |
|---|---|---|---|
| 96.12A | Metatarsal - whole ray | 263.71 | 110.53 |
| 96.12B | Transmetatarsal | 527.41 | 132.51 |

NOTE: 1. One call may be claimed per foot regardless of the number of metatarsals that are removed.
2. Two calls may only be claimed for bilateral procedures.

| | | | |
|---|---|---|---|
| 96.12C | Mid-tarsal | 527.41 | 110.43 |
| 96.13 | Amputation and disarticulation of ankle<br>Symes, Pirogoff | 879.02 | 371.01 |
| 96.14 | Amputation of lower leg<br>Below knee | 791.12 | 184.21 |
| 96.15 | Amputation of thigh or disarticulation of knee<br>Supracondylar Thigh through femur | 791.12 | 163.96 |
| 96.16 | Disarticulation of hip | 1,054.82 | 288.28 |
| 96.17 | Abdominopelvic amputation or hindquarter amputation | 2,637.06 | 1,008.83 |

96.2 Revision of amputation stump

| | | | |
|---|---|---|---|
| 96.2 A | Finger | 195.38 | 110.53 |

96.3 Reattachment of extremity

| | | | |
|---|---|---|---|
| 96.3 A | Reattachment of extremity involving microsurgical technique, full 60 minutes or major portion thereof for the first call when only one call is claimed (includes preparation of severed part) | 647.81 | |

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

96 OTHER OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

96.3 Reattachment of extremity (cont'd)

| | BASE | ANE |
|---|---|---|
| NOTE: Second surgeon (microsurgical) with a role modifier, refer to Price List. | | |

## XVI. OPERATIONS ON THE BREAST

### 97 OPERATIONS ON THE BREAST

#### 97.1 Excision or destruction of lesion or tissue of breast

##### 97.11 Local excision of lesion of breast

| | BASE | ANE |
|---|---|---|
| 97.11A Directed breast biopsy following mammography needle localization | 295.81 | 110.53 |
| 97.11B Breast biopsy and/or local excision of lesion(s) | 169.95 | 110.53 |

##### 97.12 (Unilateral) complete mastectomy

| | | |
|---|---|---|
| 97.12A Without removal of nodes or muscle | 448.99 | 202.64 |
| 97.12B Total mastectomy with formal axillary node dissection and/or sentinal node biopsy, with or without removal of pectoral muscles | 839.88 | 313.17 |

#### 97.2 Other excision or destruction of breast tissue

##### 97.21 (Unilateral) subcutaneous mastectomy with implantation of prosthesis

| | | |
|---|---|---|
| 97.21A Skin sparing mastectomy when performed for reconstruction | 993.06 | 715.11 |

##### 97.22 Other (unilateral) subcutaneous mastectomy

| | | |
|---|---|---|
| 97.22A With retention of areola and nipple | 492.33 | 221.05 |

NOTE: 1. Transgender patients who meet the criteria for Alberta's Final Stage Gender Reassignment Surgery are eligible for this procedure in the context of female-to-male gender reassignment.
2. Approval is required by Alberta Health prior to completing the procedure.

##### 97.27 Resection of quadrant of breast

| | | |
|---|---|---|
| 97.27A Segmental resection | 369.76 | 110.53 |
| 97.27B Segmental resection with sentinel node biopsy | 633.87 | 313.17 |

NOTE: When claimed in addition to HSC 52.42, the benefit will be paid at LVP50.

##### 97.29 Other excision of breast tissue NEC

| | | |
|---|---|---|
| 97.29A Simple mastectomy, includes that for gynecomastia | 388.68 | 147.37 |

NOTE: 1. May only be claimed for:
-pediatric gynecomastia (i.e. below the age of 18),
-symptomatic gynecomastia such as breast pain,
-prophylactic mastectomies for patients who are breast cancer gene positive or have a strong family history of breast cancer.
2. For cases other than those involving malignancies.

#### 97.3 Reduction mammoplasty

| | | |
|---|---|---|
| 97.31 Unilateral reduction mammoplasty | 518.25 | 221.05 |

XVI. OPERATIONS ON THE BREAST (cont'd)

97 OPERATIONS ON THE BREAST (cont'd)

97.3 Reduction mammoplasty (cont'd)

| | BASE | ANE |
|---|---|---|
| NOTE: 1. May only be claimed if mammary hypertrophy is causing physical symptoms including, but not limited to back pain, shoulder pain or paresthesias of the arms. 2. Except in unusual circumstances, the expected weight of breast tissue to be removed should be in excess of 300g. 3. May be billed if being done as a 'balancing procedure' such as to compensate for breast changes in the contralateral breast due to breast cancer treatment or to correct gross congenital/developmental asymmetry. | | |

97.4 Augmentation mammoplasty

| | | | |
|---|---|---|---|
| 97.43 | Unilateral augmentation mammoplasty by implant or graft prosthesis | 492.33 | 184.21 |
| | NOTE: 1. Payable only for congenital aplasia, hypoplasia, post-mastectomy or for transgender patients who meet the criteria of Alberta's Final Stage Gender Reassignment Surgery in the context of male-to-female gender reassignment. 2. Patients who have been diagnosed with gender dysphoria are eligible for this procedure in the context of male-to-female gender reassignment if the following criteria are met: Negligible breast development despite adequate hormone therapy for a least one year; or, hormone therapy is medically contraindicated. Approval is required by Alberta Health prior to completing the procedure. | | |

97.5 Mastopexy (post mastectomy)

| | | | |
|---|---|---|---|
| 97.5 | Mastopexy (Post mastectomy) | 349.82 | 147.37 |

97.7 Other repair and plastic operations on breast

| | | | |
|---|---|---|---|
| 97.77 | Other repair or reconstruction of nipple | 375.73 | 184.21 |

97.8 Invasive diagnostic procedures on breast

| | | | |
|---|---|---|---|
| 97.81 | Percutaneous (needle) biopsy of breast | 45.09 V | 110.43 |
| 97.82 | Other biopsy of breast | | |
| 97.82A | Percutaneous stereotactic core breast biopsy | 89.41 | |
| 97.83 | Contrast mammary ductogram | | |
| 97.83A | Catheterization of mammary duct and injection of contrast media | 50.10 | |
| 97.89 | Other invasive diagnostic procedures on breast | | |
| 97.89A | Needle localization under mammographic control, single lesion | 49.71 | |
| 97.89B | Injection of contrast media into cyst of breast | 50.10 | |

97.9 Other operations on the breast

| | | | |
|---|---|---|---|
| 97.95 | Insertion of tissue expander for breast reconstruction | 492.33 | 147.37 |

XVI. OPERATIONS ON THE BREAST (cont'd)

97 OPERATIONS ON THE BREAST (cont'd)

97.9 Other operations on the breast (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| | NOTE: Bilateral procedures may be claimed using 2 calls. | | |
| 97.96 | Removal of tissue expander for breast reconstruction . . . . . | 140.96 V | 110.43 |
| | NOTE: 1. When removal is the only procedure performed and not part of another procedure.<br>2. Bilateral procedures may be claimed using 2 calls. | | |
| 97.99 | Other operations on the breast NEC | | |
| 97.99A | Mammary capsulectomy . . . . . | 300.06 | 110.53 |

## XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE

### 98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE

#### 98.0 Incision of skin and subcutaneous tissue

##### 98.01 Tattooing or insertion into skin and subcutaneous tissue

| | | BASE | ANE |
|---|---|---|---|
| 98.01A | Implantation of subdermal contraceptive implant | 60.70 | 109.21 |

##### 98.03 Other incision with drainage of skin and subcutaneous tissue

| | | | |
|---|---|---|---|
| 98.03A | Incision and drainage of abscess or hematoma, subcutaneous or submucous<br>NOTE: May be claimed in addition to a visit or a consultation. | 22.87 V | 110.53 |
| 98.03B | Incision and drainage of abscess, deep, unspecified site | BY ASSESS | 110.53 |
| 98.03C | Aspiration of hematoma | 19.02 | |
| 98.03D | Abscess requiring procedural sedation and extensive drainage and packing<br>NOTE: May only be claimed when performed in an emergency room, AACC or UCC. | 100.49 | |
| 98.03E | Aspiration of seroma | 137.34 | 123.53 |

##### 98.04 Incision with removal of foreign body of skin and subcutaneous tissue

| | | | |
|---|---|---|---|
| 98.04A | Incision with removal of foreign body of skin and subcutaneous tissue under anesthesia | 39.36 V | 132.51 |
| 98.04B | Incision with removal of foreign body of skin and subcutaneous tissue without anesthesia | 23.45 | |
| 98.04C | Removal of subdermal contraceptive implant | 75.47 | 109.21 |

#### 98.1 Excision of skin and subcutaneous tissue

##### 98.11 Debridement of wound or infected tissue

NOTE: Only one of HSCs 98.11A to 98.11F may be claimed per functional or non-functional anatomical area as defined in GRs 7.1.1 and 7.1.2 with the exception of paired structures which may be claimed as two.

| | | | |
|---|---|---|---|
| 98.11A | Non-functional area, up to 32 total square cms | 104.92 | 202.64 |
| 98.11B | Non-functional area, over 32 and up to 64 total square cms | 221.47 | 202.64 |
| 98.11C | Non-functional area, over 64 total square cms | 414.60 | 221.05 |
| 98.11D | Functional area, up to 32 total square cms | 138.34 | 110.43 |
| 98.11E | Functional area, over 32 and up to 64 total square cms | 291.30 | 110.53 |
| 98.11F | Functional area, over 64 total square cms | 668.93 | 218.88 |

##### 98.12 Local excision or destruction of lesion or tissue of skin and subcutaneous tissue

| | | | |
|---|---|---|---|
| 98.12A | Excisional biopsy, skin<br>NOTE: A maximum of three calls may be claimed. | 42.30 V | 110.53 |
| 98.12B | Excisional biopsy, skin of face<br>NOTE: A maximum of three calls may be claimed. | 54.25 V | 110.53 |

XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98.1 Excision of skin and subcutaneous tissue (cont'd)

98.12 Local excision or destruction of lesion or tissue of skin and subcutaneous tissue (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 98.12C | Removal of sebaceous cyst . . . . . | 38.17 V | 110.53 |
| | NOTE: 1. May be claimed in addition to a visit or a consultation. 2. A maximum of 3 calls may be claimed. | | |
| 98.12D | Bilateral excision, apocrine glands, major . . . . . | 355.86 | 165.79 |
| 98.12E | Excision, apocrine glands, minor . . . . . | 105.65 V | 110.43 |
| | That for suppurative hydradenitis | | |
| 98.12F | Excision and graft, apocrine glands . . . . . | 340.37 | 184.21 |
| | That for suppurative hydradenitis | | |
| 98.12G | Laser treatment of cutaneous vascular tumors . . . . . | 66.23 V | 110.53 |
| 98.12H | Excision of soft tissue tumor(s) (subcutaneous) full 30 minutes of operating time or major portion thereof for the first call when only one call is claimed . . . . . | 95.09 V | 110.53 |
| | NOTE: 1. For sebaceous cyst removal see HSC 98.12C. 2. After the first full 30 minutes has elapsed, each subsequent 15 minutes or major portion thereof, is payable at the rate specified in the Price List; a maximum benefit applies. | | |

Warts or Keratoses

NOTE: 1. Items 98.12J, 98.12K and 98.12L may only be claimed for the following: genital warts; plantar warts; precancerous skin lesions, e.g., actinic keratoses; seborrhoeic keratoses which are irritated and treatment is medically required; warts in immuno-deficient patients or immuno-suppressed patients; or molluscum contagiosum.
2. The treatment of common warts or keratoses is an uninsured service.

| | | | |
|---|---|---|---|
| 98.12J | Removal or excision, first lesion . . . . . | 19.02 V | 110.53 |
| | NOTE: 1. May be claimed in addition to a visit or a consultation. 2. A maximum of four calls may be claimed. | | |
| 98.12K | Removal by fulguration, first lesion . . . . . | 24.15 V | 110.53 |
| | NOTE: A maximum of six calls may be claimed. | | |
| 98.12L | Non-surgical treatment (cryotherapy, chemotherapy), warts or keratoses . . . | 14.92 | |
| | NOTE: May be claimed in addition to a visit or consultation. | | |
| 98.12M | Removal of pigmented benign nevus, excluding face . . . . . | 34.87 V | 110.43 |
| 98.12N | Removal of pigmented benign nevus of the face . . . . . | 53.88 V | 110.43 |
| 98.12P | Removal of complicated naevi . . . . . | BY ASSESS | |

XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

Warts or Keratoses (cont'd)
NOTE: 1. Items 98.12J, 98.12K and 98.12L may only be claimed for the following: genital warts; plantar warts; precancerous skin lesions, e.g., actinic keratoses; seborrhoeic keratoses which are irritated and treatment is medically required; warts in immuno-deficient patients or immuno-suppressed patients; or molluscum contagiosum.
2. The treatment of common warts or keratoses is an uninsured service. (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| | Multiple dysplastic or localized carcinomatous lesions of the skin | | |
| 98.12Q | Removal of any atypical or neoplastic lesion(s) - any method excluding cryotherapy for actinic keratoses . . . . . | 37.11 V | 109.31 |
| | Example: Multiple dysplastic naevi syndrome, multiple basal and/or squamous cell carcinomas | | |
| | NOTE: A maximum of five calls may be claimed. | | |
| 98.12R | Removal of first plantar wart . . . . . | 34.87 V | 109.21 |
| | NOTE: 1. May be claimed in addition to a consultation. | | |
| | 2. For non-surgical treatment, see HSC 98.12L. | | |
| | 3. A maximum of three calls may be claimed. | | |
| | Condylomata acuminata | | |
| 98.12S | Non surgical treatment, cryotherapy . . . . . | 38.03 | |
| 98.12T | Removal of minor condylomata acuminata without general anesthetic by any surgical method . . . . . | 48.31 | |
| 98.12U | Removal of major condylomata acuminata under general anesthetic . . . . . | 135.75 | 110.53 |
| 98.12VA | Laser resurfacing of scars including burn scars, non-functional area, up to 32 total square cms . . . . . | 143.55 | 202.64 |
| | NOTE: May only be claimed for services provided under general anesthetic within a hospital facility. | | |
| 98.12VB | Laser resurfacing of scars including burn scars, non-functional area, over 32 and up to 64 total square cms . . . . . | 239.95 | 202.64 |
| | NOTE: May only be claimed for services provided under general anesthetic within a hospital facility. | | |
| 98.12VC | Laser resurfacing of scars including burn scars, non-functional area, over 64 and up to 100 total square cms . . . . . | 372.62 | 221.05 |
| | NOTE: May only be claimed for services provided under general anesthetic within a hospital facility. | | |

XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

| | BASE | ANE |
|---|---|---|
| 98.12VD Laser resurfacing of scars including burn scars, non-functional area, over 100 total square cms | 533.27 | 221.05 |
| NOTE: May only be claimed for services provided under general anesthetic within a hospital facility. | | |
| 98.12VE Laser resurfacing of scars including burn scars, functional area, up to 32 total square cms | 186.57 | 110.43 |
| NOTE: May only be claimed for services provided under general anesthetic within a hospital facility. | | |
| 98.12VF Laser resurfacing of scars including burn scars, functional area, over 32 and up to 64 total square cms | 319.76 | 110.53 |
| NOTE: May only be claimed for services provided under general anesthetic within a hospital facility. | | |
| 98.12VG Laser resurfacing of scars including burn scars, functional area, over 64 total square cms | 533.27 | 218.88 |
| NOTE: May only be claimed for services provided under general anesthetic within a hospital facility. | | |
| 98.13 Radical excision of skin lesion | | |
| 98.13A Melanoma, excision, excluding face | 226.79 | 110.53 |
| 98.13B Excision of large malignant facial lesion with primary closure | 203.40 | 165.79 |
| Excision of contracted and/or unstable scar and application of skin graft | | |
| 98.13C Up to 32 square cms | 84.72 | 220.84 |
| 98.13D Over 32 and up to 64 square cms | 299.18 | 220.84 |
| 98.13E Over 64 and up to 100 square cms | 546.33 | 239.49 |
| 98.14 Excision of pilonidal sinus or cyst | | |
| 98.14A Pilonidal cyst - excision or marsupialization | 248.27 | 147.37 |
| 98.2 Suture of skin and subcutaneous tissue | | |
| 98.22 Suture of skin and subcutaneous tissue of other sites | | |
| 98.22A Laceration, face, up to 2.5 cms (1 unit) or body, up to 5 cms (1 unit) | 57.05 V | 109.31 |
| NOTE: See 98.22B for further notes and for lacerations exceeding the lengths listed above. | | |

XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98.2 Suture of skin and subcutaneous tissue (cont'd)

98.22 Suture of skin and subcutaneous tissue of other sites (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 98.22B | Laceration, face, over 2.5 cms (1 unit) and/or body, over 5 cms (1 unit) . . For each layer or unit, refer to Price List | 60.22 | 110.43 |

NOTE: The following applies to HSCs 98.22A and 98.22B.
1. Benefit includes primary closure of wound by any method excluding adhesive tape skin closure or simple bandaging, normal wound care follow-up and suture removal.
2. Where the laceration is treated with the use of adhesive tape skin closure or simple bandaging, a visit should be claimed.
3. Where multiple lacerations are repaired, use the combined length.
4. May only be claimed when the laceration is a result of a trauma either minor or major.
5. May not be claimed in addition to an elective procedure.

98.4 Free skin graft

98.44 Full thickness skin graft to other sites

NOTE: Includes closure of donor defect. Dorsum of hand, palm of hand and web space of hand are considered separate sites.

| | | | |
|---|---|---|---|
| 98.44A | Up to 32 square cms . . . . . | 214.11 | 110.53 |
| 98.44B | Over 32 square cms . . . . . | 570.07 | 184.21 |

98.49 Other free skin graft to other sites

Non-functional areas split thickness skin grafts

NOTE: 1. Refer to GRs 7.1.1 through 7.2.2.
2. Only one of HSCs 98.49A to 98.49G may be claimed per anatomical area as defined in GRs 7.1.1 and GR 7.1.2 with the exception of paired structures which may be claimed as two.

| | | | |
|---|---|---|---|
| 98.49A | Non-functional split thickness skin graft, up to 32 total square cms . . . . NOTE: Refer to the notes following HSC 98.49D. | 112.46 V | 141.34 |
| 98.49B | Non-functional split thickness skin graft over 32 and up to 64 total square cms . . . . . NOTE: Refer to the notes following HSC 98.49D. | 166.87 | 152.70 |

XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98.4 Free skin graft (cont'd)

98.49 Other free skin graft to other sites
Non-functional areas split thickness skin grafts
NOTE: 1. Refer to GRs 7.1.1 through 7.2.2.
2. Only one of HSCs 98.49A to 98.49G may be claimed per anatomical area as defined in GRs 7.1.1 and GR 7.1.2 with the exception of paired structures which may be claimed as two. (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 98.49C | Non-functional split thickness skin graft over 64 and up to 100 total square cms<br>NOTE: Refer to the notes following HSC 98.49D. | 362.77 | 254.50 |
| 98.49D | Non-functional split thickness skin graft over 100 total square cms<br>NOTE:<br>1. For grafts over 100 square cms, only one HSC 98.49D may be claimed per anatomical area.<br>2. Refer to GRs 7.1.1 through 7.2.2 for explanation of functional and non-functional areas.<br>3. Only one of HSCs 98.49A, 98.49B, 98.49C or 98.49D may be claimed per anatomical area unless it is for a paired structure.<br>4. If several grafts of less than 100 sq cms are performed in the same anatomical area, the maximum that may be claimed is one HSC 98.49D. | 492.33 | 323.24 |
| | Functional area split thickness skin grafts | | |
| 98.49E | Functional split thickness skin graft up to 32 total square cms | 155.47 | 142.51 |
| 98.49F | Functional split thickness skin graft over 32 and up to 64 total square cms | 217.14 | 183.25 |
| 98.49G | Functional split thickness skin graft 64 and to 100 total square cms | 431.18 | 305.41 |
| 98.49N | Functional split thickness skin graft over 100 total square cms | 570.07 | 346.13 |
| | Mucosal Grafts | | |
| 98.49L | Mucosal grafts up to 32 square cms | 229.42 | 109.21 |
| 98.49M | Mucosal grafts over 32 square cms<br>NOTE: Benefits payable for 98.49L, 98.49M include closures of donor defect. | 337.56 | 174.72 |

XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98.5 Flap or pedicle graft

NOTE: 1. Functional areas includes the following anatomical areas: Head, neck, axillae, elbow, wrist, hand, groin, perineum, hip, knee, ankle, foot and includes coverage of exposed vital structures (bone, tendon, major vessel, nerve)
2. Flaps (HSCs 98.53,98.5A,98.51A,98.51B) for functional areas are designated by FNCAR modifier, add 50% to total benefit.
3. Flap size 5-10 cms or double Z-plasty designated by 2ZPL modifier, add 25% to benefit.
4. Flap size greater than 10 cms or triple Z-plasty designated by 3ZPL modifier, add 50% to benefit.
5. Composite tissue resection (includes bone) designated by CMPRSC modifier, add 25% to benefit.
6. Only one modifier (CMPRSC, FNCAR, 2ZPL, 3ZPL) may be claimed per flap.

| | | BASE | ANE |
|---|---|---|---|
| 98.5 A | Rotation or transposition flap | 331.23 | 202.64 |
| 98.51 | Flap or pedicle graft, unqualified | | |
| 98.51A | Major flap of single tissue (e.g. fasciocutaneous or muscle) with axial blood supply | 777.37 | 350.01 |
| | NOTE: 1. Local block of somatic nerve or infiltration of tissue may not be claimed post-operatively. 2. A claim may not be submitted for infiltration into the tissue expander in the post-operative period. | | |
| 98.51B | Composite compound flap using two or more of the following: skin, muscle, bone: with axial blood supply | 1,243.79 | 478.95 |
| 98.51E | Free flaps involving microsurgical technique and neuro-vascular hook-up, for head and neck reconstruction, or for procedures related to head and neck reconstruction, full 60 minutes or major portion thereof for the first call when only one call is claimed | 481.69 | |
| | NOTE: The total time claimed for HSC 98.51E may only reflect the time spent providing micro surgery and may not include time spent providing other services. | | |
| 98.51F | Free flaps involving microsurgical technique and neuro-vascular hook-up, for procedures not related to head and neck reconstruction, full 60 minutes or major portion thereof for the first call when only one call is claimed | 647.81 | |
| | NOTE: 1. May not be claimed in addition to HSCs 52.31A, 52.31B, 52.31C or 52.31D by the same or different physician at the same encounter. 2. The total time claimed for HSC 98.51F may only reflect the time spent providing micro surgery and may not include time spent providing other services. | | |
| 98.52 | Cutting and preparation of flap or pedicle graft | | |
| 98.52A | Less than 2 cms | 130.81 | 110.53 |

XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98.5 Flap or pedicle graft

NOTE: 1. Functional areas includes the following anatomical areas: Head, neck, axillae, elbow, wrist, hand, groin, perineum, hip, knee, ankle, foot and includes coverage of exposed vital structures (bone, tendon, major vessel, nerve)
2. Flaps (HSCs 98.53,98.5A,98.51A,98.51B) for functional areas are designated by FNCAR modifier, add 50% to total benefit.
3. Flap size 5-10 cms or double Z-plasty designated by 2ZPL modifier, add 25% to benefit.
4. Flap size greater than 10 cms or triple Z-plasty designated by 3ZPL modifier, add 50% to benefit.
5. Composite tissue resection (includes bone) designated by CMPRSC modifier, add 25% to benefit.
6. Only one modifier (CMPRSC, FNCAR, 2ZPL, 3ZPL) may be claimed per flap. (cont'd)

98.52 Cutting and preparation of flap or pedicle graft (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 98.52B | Less than 2 cms (delay) | 136.58 | 109.21 |
| 98.52C | 2-5 cms | 420.10 | 200.39 |
| 98.52D | 2-5 cms (delay) | 223.09 | 109.21 |
| 98.52E | Greater than 5 cms | 474.22 | 255.05 |
| 98.52F | Greater than 5 cms (delay) | 259.12 | 109.21 |
| 98.53 | Advancement of flap or pedicle graft (no donor defect) | 194.34 | 109.31 |

98.55 Attachment of flap or pedicle graft to other sites

| | | | |
|---|---|---|---|
| 98.55A | Less than 2 cms (insetting) | 102.54 | 109.21 |
| 98.55B | 2-5 cms (insetting) | 282.20 | 139.77 |
| 98.55C | Greater than 5 cms (insetting) | 337.33 | 165.98 |

98.56 Revision of flap or pedicle graft

| | | | |
|---|---|---|---|
| 98.56A | Less than 2 cms (revision) | 158.84 | 109.21 |
| 98.56B | 2-5 cms (revision) | 252.47 | 163.96 |
| 98.56C | Greater than 5 cms (revision) | 388.68 | 202.64 |

98.6 Plastic operations on lip and external mouth

| | | | |
|---|---|---|---|
| 98.6 A | Simple excision of carcinoma of lip | 100.79 V | 110.43 |
| 98.6 B | Major excision of carcinoma of lip | 155.24 | 145.74 |
| 98.6 C | Leukoplakia wedge resection | 120.54 V | 110.43 |
| 98.6 D | Leukoplakia vermilionectomy | 219.61 | 141.34 |
| 98.6 E | Leukoplakia vermilionectomy and wedge resection | 306.54 | 174.72 |
| 98.6 G | Major excision and plastic repair | BY ASSESS | 202.64 |
| | Primary reconstruction of cleft lip and palate | | |
| 98.6 H | Unilateral | 647.81 | 257.90 |
| | NOTE: If bilateral lip done staged, claim 98.6H per stage. | | |
| 98.6 J | Bilateral, done at one operative sitting | 777.37 | 350.01 |
| 98.6 K | Repair of cleft nose deformity at time of primary lip repair | 1,189.37 | 368.43 |

XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98.6 Plastic operations on lip and external mouth (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| | NOTE: Includes fee for lip repairs. | | |
| | Secondary reconstruction of cleft lip and palate | | |
| 98.6 L | Revision of one of mucosa, skin, muscle, nostril floor | 194.34 | 109.31 |
| 98.6 M | Revision of two of mucosa, skin, muscle, nostril floor | 310.95 | 147.37 |
| 98.6 N | Complete lip reconstruction | 621.89 | 350.01 |
| 98.6 P | Abbe flap | 497.60 | 209.65 |
| 98.6 R | Major, reconstruction of cleft lip and nasal deformity | 660.76 | 291.50 |
| 98.7 | Other repair and reconstruction of skin and subcutaneous tissue | | |
| 98.71 | Correction of syndactyly | | |
| | NOTE: Grafts are paid per anatomic functional area | | |
| 98.71A | With local flaps | 461.24 | 132.51 |
| 98.71B | With flap and graft reconstruction | 557.11 | 202.64 |
| 98.71C | Post-traumatic excision of scar and skin graft | 557.11 | 202.64 |
| 98.72 | Facial rhytidectomy | 600.91 | 257.90 |
| | That for facial palsy | | |
| | NOTE: One side only. | | |
| 98.73 | Repair for facial weakness | | |
| 98.73A | Fascial-sling for facial palsy (static) | 446.07 | 203.18 |
| 98.73B | Dynamic facial sling | 673.35 | 305.76 |
| 98.74 | Size reduction plastic operation | | |
| 98.74A | Major panniculectomy | 667.55 | 509.18 |
| 98.79 | Other repair and reconstruction of skin and subcutaneous tissue NEC | | |
| | NOTE: 1. Fee includes harvesting and insertion. | | |
| | 2. Grafting to the nasal tip and tip rhinoplasty may not be claimed together. | | |
| | 3. Grafting to the nasal dorsum and dorsal rhinoplasty may not be claimed together. | | |
| | Transplantation of autogenous tissues other than skin | | |
| 98.79A | Auricular cartilage, costal cartilage or bone graft, to nose, orbit, forehead, etc. | 458.86 | 221.05 |
| 98.79B | Septal cartilage | 220.53 | 109.21 |
| | Allograft/ Prosthetic | | |
| 98.79C | Insertion of bone/cartilage/prosthetic graft | 307.92 | 157.25 |
| 98.8 | Invasive diagnostic procedures on skin and subcutaneous tissue | | |
| 98.8 A | Skin test, e.g. tuberculin | 8.56 | |

XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98.8 Invasive diagnostic procedures on skin and subcutaneous tissue (cont'd)

98.81 Biopsy of skin and subcutaneous tissue

| | | BASE | | ANE |
|---|---|---|---|---|
| 98.81A | Biopsy, skin<br>NOTE: A maximum of three calls may be claimed. | 37.11 | V | 110.53 |
| 98.81B | Punch biopsy | 21.59 | | |

98.89 Other invasive diagnostic procedures on skin and subcutaneous tissue

| | | | | |
|---|---|---|---|---|
| 98.89A | Skin tests, intradermal or prick, on children under five years, carried out by a physician, per test<br>NOTE: Refer to the notes following 98.89F. | 2.97 | | |
| 98.89B | Passive transfer test, per test<br>NOTE: Refer to the notes following 98.89F. | 4.97 | | |
| 98.89C | Skin tests, stinging insects<br>NOTE: Refer to the notes following 98.89F. | 52.77 | | |
| 98.89D | Skin test, patch, per test<br>NOTE: Refer to the notes following 98.89F. | 1.67 | | |
| 98.89E | Skin test, airborne allergens, intradermal or prick, per test<br>NOTE: Refer to the notes following 98.89F. | 2.23 | | |
| 98.89F | Skin test, food allergens, intradermal or prick, per test<br>NOTE: 1. A maximum per benefit year as specified on the Price List applies to 98.89A, 98.89B, 98.89C, 98.89D, 98.89E and 98.89F.<br>2. A second set of tests (98.89A, 98.89B, 98.89C, 98.89D, 98.89E, 98.89F) may be claimed only by a specialist for a patient who is referred.<br>3. Benefits do not include the cost of materials. | 2.23 | | |
| 98.89G | Provocative testing for suspected sensitivity to local anesthetic, food, antibiotic, vaccine or venom<br>NOTE: 1. Requiring constant supervision by a physician for a duration of one hour or more.<br>2. May only be claimed once per benefit year per patient except when the patient is referred to a specialist in which case the specialist may also claim. | 160.36 | | |
| 98.89H | Photo test or photopatch test set of four | 35.91 | | |

98.9 Other operations on skin and subcutaneous tissue

98.92 Chemosurgery of skin

| | | | | |
|---|---|---|---|---|
| 98.92C | Full face | 160.93 | | 139.77 |

XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98.9 Other operations on skin and subcutaneous tissue (cont'd)

98.92 Chemosurgery of skin (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| | NOTE: 1. May only be claimed for medium and deep chemical peels. Superficial peels including glycolic peels and liquid nitrogen should be claimed under HSC 98.99AA. 2. May only be claimed by dermatology. | | |
| 98.92D | Nipple/areola tattooing following repair or reconstruction | 295.40 | |
| | NOTE: May only be claimed when performed by a physician. | | |
| 98.92E | Technical component for nipple tattooing (staff, equipment, consumables) associated with 98.92D when performed by a physician | 147.70 | |
| | NOTE: May not be claimed when the procedure is performed in the hospital. | | |
| 98.92F | Photodynamic therapy for actinic keratosis or superficial basal cell carcinoma of full face, chest, or hand(s) | 193.06 | |
| | NOTE: 1. May only be claimed when the full face, full chest, or full hand(s) are treated. 2. May only be claimed by a dermatologist. | | |

98.93 Dermabrasion

| | | | |
|---|---|---|---|
| 98.93A | Less than 1/4 of face | 60.64 V | 109.21 |
| | NOTE: May only be claimed when performed in an operating or day surgery room in an active treatment facility. | | |
| 98.93B | Between 1/4 and 1/2 of face | 117.08 V | 109.21 |
| | NOTE: May only be claimed when performed in an operating or day surgery room in an active treatment facility. | | |

98.96 Removal of nail, nailbed, or nailfold

| | | | |
|---|---|---|---|
| 98.96A | Wedge excision | 60.22 V | 110.53 |
| 98.96B | Radical excision | 79.24 V | 110.43 |
| 98.96C | Wedge excision with plastic repair, one side of nail | 66.56 V | 110.53 |
| 98.96D | Wedge excision with plastic repair, two sides of nail | 72.90 V | 141.34 |

98.98 Insertion of tissue expanders

| | | | |
|---|---|---|---|
| 98.98A | Insertion of tissue expanders | 492.33 | 141.34 |
| 98.98B | Removal of tissue expanders | 77.13 V | 109.21 |
| | NOTE: When removal is the only procedure performed and not part of another procedure. | | |

98.99 Other operations on skin and subcutaneous tissue NEC

| | | | |
|---|---|---|---|
| 98.99AA | Acne surgery | 30.40 | |
| | For incision and drainage and/or cryotherapy of cysts; and superficial peels for acne including liquid nitrogen and glycolic peels | | |

Tangential excision of skin cancer, microscopically controlled

| | | | |
|---|---|---|---|
| 98.99B | Initial excision | 207.30 | 147.37 |

XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98.99 Other operations on skin and subcutaneous tissue NEC (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| 98.99C | One or more extra cuts, additional benefit | 181.39 | 109.21 |

NOTE:
1. HSCs 98.99B and 98.99C refer to recognized techniques in which the excised tissue is appropriately marked, oriented and mapped by the surgeon in such a way as to anatomically locate residual malignant cells, if any, in the corresponding sector of the tumor bed.
2. HSCs 98.99B and 98.99C may only be claimed when a certified pathologist has confirmed the diagnosis from a prior biopsy.
3. HSCs 98.99B and 98.99C may only be claimed once whether or not the excision of the lesion extends to the subsequent day.

Moh's microscopically controlled excision

| | | |
|---|---|---|
| 98.99D | Initial cut, including debulking | 314.20 |
| 98.99E | One or more additional cuts, extra | 272.65 |
| 98.99F | Special overhead and technical component, additional benefit | 270.38 |

NOTE:
1. HSC 98.99D may only be claimed by physicians who have been approved to provide these services by the CPSA.
2. HSC 98.99D may only be claimed when a certified pathologist has confirmed the diagnosis from a prior biopsy.
3. HSCs 98.99E and 98.99F may only be claimed once, whether or not excision of the lesion extends to the subsequent day.
4. HSC 98.99F may not be claimed if the surgery is performed in a hospital setting.
5. Closure of the resulting defect by undermining the advancement flaps is included in the above benefits. If more complicated closure is medically necessary, claim as an additional procedure under the appropriate graft HSC.

## XVIII. PROCEDURES NOT ELSEWHERE CLASSIFIED

### 99 PROCEDURES NOT ELSEWHERE CLASSIFIED

#### 99.0 Ill-defined operations

##### 99.09 Surgical procedures NOS

| | | BASE | ANE |
|---|---|---|---|
| 99.09A | Unlisted Procedures, Nervous System | BY ASSESS | |
| 99.09B | Unlisted Procedures, Endocrine System | BY ASSESS | |
| 99.09C | Unlisted Procedures, Eyes | BY ASSESS | |
| 99.09D | Unlisted Procedures, Ears | BY ASSESS | |
| 99.09E | Unlisted Procedures, Nose, mouth and pharynx | BY ASSESS | |
| 99.09F | Unlisted Procedures, Respiratory system | BY ASSESS | |
| 99.09G | Unlisted Procedures, Cardiovascular system | BY ASSESS | |
| 99.09H | Unlisted Procedures, Hemic and Lymphatic system | BY ASSESS | |
| 99.09J | Unlisted Procedures, Digestive system and abdominal repair | BY ASSESS | |
| 99.09K | Unlisted Procedures, Urinary tract | BY ASSESS | |
| 99.09L | Unlisted Procedures, Male genital organs | BY ASSESS | |
| 99.09M | Unlisted Procedures, Female genital organs | BY ASSESS | |
| 99.09N | Unlisted Procedures, Obstetric procedures | BY ASSESS | |
| 99.09P | Unlisted Procedures, Musculoskeletal system | BY ASSESS | |
| 99.09Q | Unlisted Procedures, Breast | BY ASSESS | |
| 99.09R | Unlisted Procedures, Skin and subcutaneous tissue | BY ASSESS | |
| 99.09U | Unlisted Procedures, Certain Diagnostic and Therapeutic Procedures | BY ASSESS | |
| 99.09V | Unlisted Procedures, Radiology | BY ASSESS | |

LABORATORY AND PATHOLOGY

HEMATOLOGY

NOTE: Unusual multiple charges for the same laboratory service should be submitted with an explanation

Hematology - General

| | | BASE | ANE |
|---|---|---|---|
| E 1 | Complete blood count (hemoglobin, white blood count, differential, platelet count, eosinophil count and either red blood count or hematocrit, with no additional charge for indices) - by any method. | 18.32 | |
| | NOTE: 1. Includes check by pathologist or hemopathologist if required.<br>2. No combination of those items which constitute a complete blood count shall be billed in excess of a complete blood count. | | |
| E 29 | Blood smear by special request of referring physician<br>Claim only an E1 (CBC) if the test results are not outside the laboratory's criteria for referring the smear to a pathologist for review | 50.82 | |
| E 13 | Bone marrow - interpretation of smear by pathologist or hematopathologist | 79.75 | |
| E400 | Eosinophil count - direct | 7.02 | |
| E 7 | Hematocrit | 5.46 | |
| E 2 | Hemoglobin | 5.46 | |
| E404 | Hemosiderin stain on blood, bone marrow or urine smear | 10.15 | |
| E 23 | Malaria or other parasite | 16.88 | |
| E 3 | Red blood cell count by electronic counting | 5.46 | |
| E 8 | Reticulocyte count | 10.34 | |
| E 6 | Sedimentation rate | 3.90 | |
| E 4 | White blood cell count | 5.46 | |
| E 5 | White blood cell - differential count | 8.90 | |

Hematology - Special

| | | | |
|---|---|---|---|
| E 9 | Acid hemolysis test | 26.89 | |
| E 10 | Ascorbic test for red cell enzyme deficiency | 16.88 | |
| E 11 | Autohemolysis with glucose and ATP | 49.64 | |
| E 16 | Cold hemolysins (Donath-Landsteiner) | 16.88 | |
| E427 | Fetal hemoglobin cell count (Kleihauer) | 26.89 | |
| E 18 | Fetal hemoglobin by denaturation | 16.88 | |
| E 19 | Fragility test | 47.33 | |
| E429 | Heinz body (in vitro) | 13.93 | |
| E460 | Hemoglobin hybridization in identification of abnormal hemoglobins | 61.38 | |
| E517 | Hemoglobin, unstable by heat stability | 29.10 | |
| E 22 | Leukocyte alkaline phosphatase (L.A.P.) | 20.00 | |
| E 24 | P.N.H. screen | 13.60 | |
| E520 | Platelet aggregation per aggregating agent<br>NOTE: Up to three agents, maximums apply refer to Price List. | 19.40 | |
| E 25 | Red cell G-6-PD (quantitative) | 56.29 | |
| E 26 | Red cell pyruvate kinase (quantitative) | 56.29 | |
| E366 | Schilling test - with or without intrinsic factor | 66.46 | |
| E 27 | Sickle cell identification | 11.13 | |

LABORATORY AND PATHOLOGY (cont'd)

HEMATOLOGY (cont'd)

Hematology - Coagulation, Hemostasis

| | | BASE | ANE |
|---|---|---|---|
| E 30 | Bleeding time | 7.17 | |
| E 32 | Circulating anticoagulant | 20.00 | |
| E 33 | Clot retraction | 11.56 | |
| E 31 | Clotting time (Lee-White) | 6.07 | |
| E 36 | Contact activation | 26.89 | |
| E405 | Factor VIII (A.H.G.) assay | 67.24 | |
| E406 | Factor IX (P.T.C.) assay | 67.24 | |
| E 34 | Factor XI - identification of defect (P.T.A.) | 47.33 | |
| E 35 | Factor XII - identification of defect (Hageman) | 47.33 | |
| E 38 | Fibrinogen Qualitative (eg. fibrindex) | 12.84 | |
| E 37 | Fibrinogen Quantitative - chemical | 33.22 | |
| E464 | Fibrinogen split products | 17.98 | |
| E 17 | Fibrinolysin (dilute whole blood clot lysis) | 13.60 | |
| E 40 | Platelet adhesiveness | 32.82 | |
| E 41 | Platelet count | 13.45 | |
| E 42 | Prothrombin consumption test | 26.89 | |
| E 43 | Prothrombin time | 14.57 | |
| E428 | Stypven time | 16.88 | |
| E 45 | Thromboplastin generation test - full identification of defect | 67.24 | |
| E 44 | Thromboplastin generation test - screening | 29.23 | |
| E 46 | Thromboplastin time - partial | 16.88 | |

Immunohematology

| | | | |
|---|---|---|---|
| E 51 | ABO grouping | 8.13 | |
| E 49 | Antibody identification including antiglobulin test, warm and cold phase but not elution or absorption | 41.44 | |
| E468 | Donor antibody screen, per donor, per day, including antiglobulin test | 22.83 | |
| E 48 | Antiglobulin test, direct or indirect or both, when not part of a cross match, includes negative and positive control | 10.48 | |
| E 50 | Cross match, per patient, per set-up, includes antiglobulin test as well as grouping | 47.34 | |
| E 21 | Leukoagglutinins (qualitative) | 32.82 | |
| E434 | Leukoagglutinins (quantitative) | 99.30 | |
| E435 | Platelet antibodies, modification of complement fixation | 99.29 | |
| E472 | Preparation of cryoprecipitate - per unit (not including collection) | 42.59 | |
| E469 | Preparation of packed red cells - per patient, per day (not including collection) | 14.83 | |
| E471 | Preparation of platelet concentrate (minimum of eight donors) (not including collection) | 86.01 | |
| E432 | R.B.C. absorption and elution studies | 83.25 | |
| E433 | R.B.C. elution only | 49.63 | |
| E 52 | Rh groupings, per antigen | 8.13 | |
| E436 | Red blood cell antibody titration, warm or cold, saline and/or antiglobulin test | 26.89 | |

LABORATORY AND PATHOLOGY (cont'd)

CHEMISTRY

Chemistry - Routine blood

| | | BASE | ANE |
|---|---|---|---|
| E 55 | Acetone | 22.84 | |
| E 79 | Acetylcholinesterase (red cells) | 32.82 | |
| E515 | Alanine aminotransferase (ALT) | 14.83 | |
| E473 | Aldolase | 20.49 | |
| E475 | Alpha 1 antitrypsin | 37.53 | |
| E551M | Alpha fetoprotein | 58.63 | |
| E 57 | Amino acid (total) | 17.99 | |
| E 58 | Ammonia | 22.83 | |
| E 59 | Amylase | 20.49 | |
| E 60 | Ascorbic acid | 22.84 | |
| E 62 | Bilirubin - total and fractionation (conjugated) | 14.10 | |
| E 63 | Bilirubin - total - without fractionation | 9.54 | |
| E 68 | Calcium | 18.30 | |
| E 81 | Carbon dioxide (C02) | 6.31 | |
| E 70 | Carbon monoxide (quantitative) | 26.76 | |
| E551J | Carcinoembryonic antigen (CEA) | 58.63 | |
| E 72 | Carotene | 22.83 | |
| E 75 | Ceruloplasmin (quantitative) | 26.89 | |
| E 76 | Chloride | 6.31 | |
| E 77 | Cholesterol total | 16.13 | |
| E519 | Cholesterol, high density lipoprotein (HDL) fraction | 32.43 | |
| E 79A | Cholinesterase (serum) total | 32.82 | |
| E 79B | Cholinesterase (serum) isoenzyme fractionation | 34.83 | |
| E525 | Chromatography (blood) by column | 67.24 | |
| E422 | Chromatography (blood), gas per specimen, per injection | 67.24 | |
| E524 | Chromatography (blood), liquid per specimen, per injection | 67.61 | |
| E526 | Chromatography (blood), thin layer qualitative, per plate | 30.01 | |
| E560 | C-1 Esterase Inhibitor | 37.53 | |
| E492 | Complement 3, serum | 37.53 | |
| E494 | Complement 4, serum | 37.53 | |
| E495 | Complement, total (hemolytic assay) | 45.75 | |
| E 84 | Creatinine | 11.26 | |
| E 86 | Cryoprotein per fraction | 8.90 | |
| E420 | Creatine kinase (CK) | 16.88 | |
| E420A | Creatine kinase (CK) isoenzyme fractionation | 35.21 | |
| E425 | D-Xylose tolerance | 32.82 | |
| E150E | Enzyme, serum otherwise not listed | 20.63 | |
| E 88 | Fatty acid (total) | 20.00 | |
| E550D | Ferritin | 58.63 | |
| E401A | Folic acid, red cell | 41.45 | |
| E 90 | Galactose tolerance - I.V. | 48.48 | |
| E 92 | Glucose - fasting | 10.34 | |
| E 92D | Glucose - spot | 10.34 | |
| E 92E | Glucose - two hour P.C. | 10.34 | |
| E 93 | Glucose - stick test | 3.58 | |
| E 94 | Glucose tolerance - includes urines as required, four or more specimens | 46.53 | |
| E 92B | Glucose - Gestational Diabetic screen | 14.71 | |
| E 54 | Haptoglobins | 32.82 | |

LABORATORY AND PATHOLOGY (cont'd)

CHEMISTRY (cont'd)

Chemistry - Routine blood (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| E 96 | Hemoglobin (plasma) quantitative | 17.65 | |
| E 97A | Hemoglobin electrophoresis, together with quantitation of abnormal hemoglobin by scanning or elution | 63.71 | |
| E503 | Hemoglobin A2 by chromatography | 67.24 | |
| E512 | Heavy metals, each | 29.11 | |
| E 98 | Immunoelectrophoresis (1 membrane) | 44.16 | |
| E 98A | Additional slides to a maximum of two | 21.88 | |
| E 99 | Immunoglobulin quantitation of IgG, IgA, and IgM, inclusive | 69.57 | |
| E 99A | Immunoglobulin quantitation of any of IgG, IgA, IgM, IgD each | 22.83 | |
| E550X | IgE (immunoglobulin E) | 58.63 | |
| E103 | Iron - serum and iron binding capacity | 29.64 | |
| E104 | Lactic acid or lactate | 35.58 | |
| E105 | Lactic dehydrogenase (LD) | 20.49 | |
| E106 | LD Isoenzyme fractionation | 35.22 | |
| E107 | Lipase | 18.30 | |
| E504 | Lithium | 22.05 | |
| E111 | Magnesium | 16.88 | |
| E114 | Methemalbumin (Schumm test) | 7.02 | |
| E150 | Multi-channel analysis | 24.88 | |
| E116 | Osmolarity | 13.60 | |
| E119 | pH of blood | 16.88 | |
| E119A | pCO2 | 17.65 | |
| E121A | pO2 | 16.88 | |
| E122 | Phenylalanine - chemical quantitative | 16.88 | |
| E123D | Phosphatase acid | 20.49 | |
| E123 | Phosphatase alkaline | 20.41 | |
| E123B | Phosphatase alkaline, isoenzyme fractionation | 35.22 | |
| E124 | Phospholipids | 16.88 | |
| E125 | Phosphorus, inorganic | 13.93 | |
| E127 | Potassium | 6.31 | |
| E128 | Proteins - total only | 10.15 | |
| E130 | Proteins - electrophoresis | 25.19 | |
| E527 | Protoporphyrin, free (red cell) | 41.06 | |
| E528 | Pyruvic acid or pyruvate | 35.57 | |
| E552 | Radioimmunoassay specify | BY ASSESS | |
| E137 | Sodium | 6.31 | |
| E529 | Transferrin, quantitative | 26.30 | |
| E142 | Triglyceride | 16.13 | |
| E144 | Urea | 11.91 | |
| E145 | Uric acid | 11.55 | |
| E146 | Vitamin A tolerance - includes vitamin A (4 specimens) | 89.10 | |
| E147 | Vitamin A | 22.83 | |
| E148 | Vitamin B 12 | 45.75 | |

Chemistry - Routine urine

| | | | |
|---|---|---|---|
| E151 | Urinalysis routine examination - including exam of centrifuged sediment | 7.03 | |

NOTE: Item E152, item E153, or item E222 shall not be submitted for a service rendered on the same day as item E151.

LABORATORY AND PATHOLOGY (cont'd)

CHEMISTRY (cont'd)

Chemistry - Routine urine (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| E152 | Urinalysis without microscopic examination of centrifuged sediment | 3.58 | |
| E153 | Microscopic examination, alone | 3.58 | |
| E157 | Amino acids - total (chemical) | 22.84 | |
| E158 | Amino acids - paper chromatography screening | 22.84 | |
| E159 | Amino acids - chromatography (semi-quantitative) (includes sugars) | 39.50 | |
| E162 | Amylase | 20.49 | |
| E163 | Ascorbic acid (quantitative) | 22.84 | |
| E169 | Calcium (quantitative) | 20.49 | |
| E291 | Calculus analysis (qualitative) | 22.83 | |
| E479 | Calculus analysis by infra-red spectroscopy or x-ray diffraction | 24.69 | |
| E480 | Calculus - infra-red scan - interpretation of | 11.91 | |
| E172A | Chlorides (quantitative) | 10.15 | |
| E505 | Chromatography, gas, per specimen, per injection | 67.24 | |
| E521 | Chromatography, liquid - per specimen - per injection | 67.24 | |
| E522 | Chromatography by column | 67.24 | |
| E523 | Chromatography, thin layer - qualitative, per plate | 30.01 | |
| E181 | Concentration test only | 3.45 | |
| E203 | Concentration test with osmolality | 25.34 | |
| E182 | Coproporphyrin (quantitative) | 22.83 | |
| E183 | Coproporphyrin (qualitative) | 11.14 | |
| E178 | Creatinine (quantitative) | 11.55 | |
| E179 | Creatinine clearance test | 26.89 | |
| E530 | Cystine, quantitative | 60.19 | |
| E184 | Cystine (screening) | 11.14 | |
| E481 | Delta-aminolevulinic acid | 42.59 | |
| E189 | Glucose (quantitative) | 11.56 | |
| E190 | Heavy metals, each | 29.10 | |
| E531 | Homogentisic acid, qualitative | 12.84 | |
| E532 | Hydroxyproline, quantitative | 60.19 | |
| E518 | Immunoelectrophoresis or immunofixation, including dialysis concentration | 83.65 | |
| E198 | Melanin | 22.83 | |
| E200 | Myoglobin | 32.82 | |
| E533 | Mucopolysaccharides, qualitative | 17.65 | |
| E202 | Osmolality | 13.60 | |
| E483 | Oxalate | 24.70 | |
| E205 | Phenylpyruvic acid (qualitative) (P.K.U.) | 3.45 | |
| E206 | Phosphorus | 13.93 | |
| E207 | Porphobilinogen (qualitative) | 7.02 | |
| E208 | Porphyrins (quantitative) | 16.88 | |
| E209 | Potassium (quantitative) | 18.13 | |
| E188 | Protein electrophoresis | 40.28 | |
| E210 | Protein (quantitative) 24 hour | 18.30 | |
| E513 | Radioimmunoassay | 57.85 | |
| E213 | Serotonin - quantitative | 26.89 | |
| E214 | Serotonin - qualitative | 7.02 | |
| E215 | Sodium (quantitative) | 17.02 | |
| E175 | Sugars - chromatography, screening | 13.60 | |
| E175A | Sugars - chromatography, semi-quantitative | 39.50 | |
| E219 | Urea clearance | 26.89 | |

LABORATORY AND PATHOLOGY (cont'd)

CHEMISTRY (cont'd)

Chemistry - Routine urine (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| E224 | Uric acid | 11.55 | |
| E221 | Urobilinogen - quantitative | 17.99 | |
| E222 | Urobilinogen - qualitative | 7.02 | |
| E223 | Uroporphyrin (quantitative) | 22.83 | |

Chemistry - Endocrine blood

| | | | |
|---|---|---|---|
| E551K | Adrenocorticotropin (ACTH) | 58.63 | |
| E551N | Androstenedione | 58.63 | |
| E550K | Human chorionic gonadotropin, beta sub-unit | 58.63 | |
| E487 | Cortisol | 61.38 | |
| E551F | Dihydroepiandrosterone F. (DHEAS) | 58.63 | |
| E550A | Estradiol | 58.63 | |
| E550B | Estrogen, total | 58.63 | |
| E550E | Follicle stimulating hormone (F.S.H.) | 58.63 | |
| E551D | Gastrin | 58.63 | |
| E550M | Human growth hormone, (H.G.H.) (maximum of two for function test) | 58.64 | |
| E551Q | 17 Hydroxyprogesterone | 58.63 | |
| E550N | Insulin (maximum of six for function test) | 58.63 | |
| E550P | Luteinizing hormone, (L.H.) | 58.63 | |
| E551E | Parathormone | 95.39 | |
| E550Q | Progesterone | 58.63 | |
| E550R | Prolactin (maximum of 2 for function test) | 58.63 | |
| E551G | Renin (per test, maximum of two) | 82.87 | |
| E550S | Testosterone | 58.63 | |
| E550U | T-4 (thyroxine) | 1.57 | |
| E350 | T3 uptake | 1.57 | |
| E353 | T4 corrected for abnormal thyroid binding protein | 1.57 | |
| E550W | Total T-3 (tri-iodothyronine) | 47.26 | |
| E750 | Sensitive thyroid stimulating hormone (s-T.S.H) | 47.26 | |
| E751 | Free Tri-iodothyronine (FT3) | 30.20 | |
| E752 | Free thyroxine (FT4) | 30.20 | |

Chemistry - Endocrine urine

| | | | |
|---|---|---|---|
| E225 | Aldosterone | 167.33 | |
| E226 | Catecholamines | 49.63 | |
| E489 | Metanaphrine | 45.75 | |
| E411 | Pregnancy test | 11.91 | |
| E234 | Pregnanediol or pregnanetriol | 49.63 | |
| E235 | Pregnanediol and pregnanetriol | 83.25 | |
| E486 | Urinary free cortisol | 61.38 | |
| E603 | Urine beta HCG | 19.70 | |
| E237 | V.M.A. - quantitative | 49.63 | |
| E238 | V.M.A. Screening | 13.60 | |

Chemistry - Therapeutic drug monitoring and toxicology

| | | | |
|---|---|---|---|
| E 56 | Alcohol (Ethanol) - blood | 22.84 | |

LABORATORY AND PATHOLOGY (cont'd)

CHEMISTRY (cont'd)

Chemistry - Therapeutic drug monitoring and toxicology (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| E 56D | Alcohol (Ethanol) - urine | 22.84 | |
| E 61 | Barbiturates - blood | 47.33 | |
| E164 | Barbiturates - urine - quantitative | 47.33 | |
| E165 | Barbiturates - urine - qualitative | 10.15 | |
| E 65 | Bromide (quantitative) | 13.60 | |
| E516M | Carbamazepine (quantitative) | 37.53 | |
| E550 | Digoxin | 58.63 | |
| E516A | Diphenylhydantoin (phenytoin) (quantitative) | 37.14 | |
| E516G | Drug assay - (not to be used if specific fee code for drug assayed exists in schedule) specify (quantitative) | 47.33 | |
| E516 | Ethosuximide (quantitative) | 40.28 | |
| E516N | N-acetylprocainamide (quantitative) | 40.28 | |
| E501 | Narcotic drug screen urine - suspect drug specified | 22.83 | |
| E516B | Phenobarbitone (quantitative) | 38.31 | |
| E204 | Phenothiazine tranquilizers - urine (screen) | 11.14 | |
| E516D | Primidone (quantitative) | 40.28 | |
| E516E | Procainamide (quantitative) | 40.28 | |
| E516F | Quinidine (quantitative) | 40.28 | |
| E135 | Salicylates - blood | 19.84 | |
| E212 | Salicylates - urine | 19.85 | |
| E516J | Theophylline (quantitative) | 36.76 | |
| E516K | Valproic acid (quantitative) | 47.33 | |

Other body fluids (amniotic, cerebrospinal, serous, synovial, etc)

| | | | |
|---|---|---|---|
| E 56B | Alcohol (Ethanol) - Gastric fluid | 22.83 | |
| E426 | Bilirubin | 16.88 | |
| E409 | Cell count | 5.93 | |
| E239A | Chloride | 10.15 | |
| E511 | Crystal identification by polarizing microscopy | 10.48 | |
| E307 | Eosinophils - sputum or nasal secretions | 7.02 | |
| E294 | Gastric analysis - single specimen | 7.02 | |
| E295 | Gastric analysis - with histamine | 20.00 | |
| E536 | Gastric contents - gas or liquid chromatography, per specimen, per injection | 67.24 | |
| E537 | Gastric contents, thin layer chromatography, qualitative, per plate | 30.01 | |
| E241 | Glucose | 10.34 | |
| E242 | Protein | 10.15 | |
| E243 | Protein electrophoresis | 40.28 | |
| E305 | Semen analysis, including sperm count | 33.22 | |
| E305B | Semen - examination for presence of sperm only | 10.15 | |
| E305A | Sperm agglutination test | 67.24 | |
| E309A | Sweat chloride test including collection of specimen | 32.82 | |

Feces

| | | | |
|---|---|---|---|
| E245 | Fat, total | 57.85 | |
| E248 | Occult blood, diagnostic only | 8.13 | |

LABORATORY AND PATHOLOGY (cont'd)

CHEMISTRY (cont'd)

Feces (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| E248A | Occult blood, for screening of average risk patients | 8.13 | |
| | NOTE: 1. Average risk is defined as an individual that is 50 years of age or older with no personal history of colorectal adenomatous polyps, no personal history of inflammatory bowel disease and no family history of colorectal cancer. 2. May be claimed once every year. | | |
| E534 | PH (feces) | 26.30 | |
| E250 | Trypsin (semi-quantitative) | 11.14 | |
| E251 | Urobilinogen (quantitative) | 26.76 | |

Bacteriology

| | | | |
|---|---|---|---|
| E253 | Antibiotic level, estimation of | 20.00 | |
| E256 | Autogenous vaccine, preparation of | 31.65 | |
| E272 | Bacteruria screening test | 7.02 | |
| E258B | Bacterial culture including, when necessary, indentification, sensitivity and quantitation | 34.89 | |
| | Only one bacterial culture may be billed per specimen | | |
| E261 | Culture - Tuberculosis - atypical or Mycobacterium tuberculosis | 32.82 | |
| E264 | Darkfield microscopy - identification of Treponema, Borrelia, etc | 47.33 | |
| E263 | Microscopic examination for parasites with concentration methods | 25.79 | |
| E263A | Microscopic examination of smear for M. tuberculosis or atypical mycobacteria | 25.79 | |
| E262 | Microscopic identification (Gram-stain without culture, worm identification, ecto parasites, (eg. scabies, ticks), hairs, scales, smear, film preparations) | 7.34 | |
| E269 | Phage typing per organism | 32.82 | |
| E265 | Trophozoites - amoeba in stool - direct examination | 16.88 | |
| E262A | Wet mount and/or hanging drop preparations (e.g. Trichomonas vaginalis, Campylobacteria, etc.) | 7.34 | |
| E280 | Examination of stool for cryptosporidium including stain and concentration | 25.65 | |

Mycology

| | | | |
|---|---|---|---|
| E274 | Culture, fungal and identify | 22.83 | |
| E273 | Smear - (KOH) preparation and examination | 10.15 | |
| E275 | Yeast identification - serological or by chlamydiospores | 10.15 | |

Serology

| | | | |
|---|---|---|---|
| E288 | Antibody screen by immunofluorescence antibody, other than antinuclear, per antibody, (up to maximum of three) | 32.82 | |
| E288A | Antibody, titre of, identified in E288 screen as positive (maximum of three different antibodies) | 65.66 | |
| E550Y | Anti DNA | 58.63 | |
| E287 | Antinuclear antibodies by fluorescence, screen, e.g. Fluorescence (FANA), Peroxidase, Other methodology | 32.82 | |

LABORATORY AND PATHOLOGY (cont'd)

CHEMISTRY (cont'd)

Serology (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| E287A | Antinuclear antibody titre if screen positive (not to be claimed in addition to screen) | 65.66 | |
| E304 | Antinuclear antibody - latex antinuclear nucleoprotein test | 10.15 | |
| E278 | ASOT - antistreptolysin 'O' titre (ASO) | 16.88 | |
| E277 | Serologic identification - antibodies, using up to four antigens, e.g. Agglutination, Complement fixation, Enzyme immunoassay | 16.88 | |
| E286 | Bovine milk antibodies | 26.89 | |
| E410 | C. reactive protein | 10.15 | |
| E279 | Cold agglutinins with titre | 13.60 | |
| E293 | Glutin antibodies | 26.89 | |
| E303 | Rheumatoid factor qualitative | 10.15 | |
| E562 | Rheumatoid factor quantitative | 30.33 | |
| E283 | Serological test for syphilis (S.T.S.) | 16.88 | |
| E299 | Thyroglobulin - antithyroglobulin antibodies | 49.64 | |
| E299A | Thyroid antibodies - microsomal antibodies | 49.64 | |
| E300 | Thyroid antibodies - screening test, e.g. latex | 16.88 | |
| E508 | Toxoplasmosis, IgG or IgM | 29.10 | |

Viruses/Rickettsia/Chlamydia

| | | | |
|---|---|---|---|
| E602 | Chlamydia/viral culture e.g. Herpes | 39.51 | |
| E601 | Direct fluorescent or special staining examination of specimens for chlamydia, viral inclusions | 22.83 | |
| E550F | Hepatitis A virus antibody, per antibody (maximum of 2) | 42.87 | |
| E550G | Hepatitis B virus antibody, per antibody (maximum of 2) | 42.87 | |
| E550J | Hepatitis B virus antigen, per antigen (maximum of 2) | 42.87 | |
| E298 | Infectious mononucleosis - immunologic screen | 10.15 | |
| E281 | Infectious mononucleosis heterophile agglutination with absorption (see also E-298) | 27.86 | |
| E553 | Rubella - screen or semi-quantitative | 18.59 | |
| E554 | Rubella IgM antibody - quantitative | 24.07 | |
| E499 | Viral serology - hemagglutination inhibition test | 18.30 | |
| E496 | Viral serology - complement fixation test, single antigen | 29.11 | |
| E497 | Viral serology - complement fixation test, 5 to 7 antigens | 79.75 | |
| E498 | Repeat viral complement fixation test, (convalescent) - 5 to 7 antigens | 57.10 | |

Cytopathology

| | | | |
|---|---|---|---|
| E310 | Breast cytopathology (processing, examination and interpretation) | 23.59 | |
| E314 | C.S.F. cytopathology (processing, examination and interpretation) | 32.82 | |
| E311 | Cervical cytopathology (processing, examination and interpretation) | 22.34 | |
| E312 | Gastric or colon washings for cytopathology (collection only) | 26.89 | |
| E317 | Gastric or colon wash cytopathology (excluding collection) (processing, examination and interpretation) | 32.82 | |
| E297 | Inclusion bodies | 16.88 | |
| E301 | Karyotype determination by tissue culture | 334.61 | |
| E538 | Needle aspiration cytopathology (processing, examination and interpretation) | 72.32 | |
| E318 | Oral cytopathology (processing, examination and interpretation) | 23.59 | |

LABORATORY AND PATHOLOGY (cont'd)

CHEMISTRY (cont'd)

Cytopathology (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| E320 | Serous fluid cytopathology (processing, examination and interpretation) | 32.82 | |
| E319 | Sex chromatin determination (vaginal or oral) | 32.82 | |
| E313 | Spermatozoa, cytopathological examination on fomites or invasion test | 32.82 | |
| E321 | Sputum or bronchial wash cytopathology (processing, examination and interpretation) | 47.69 | |
| E323 | Urine cytopathology (processing, examination and interpretation) | 32.82 | |
| E324 | Vaginal cytopathology for hormonal status (maturation index plus interpretation) | 22.05 | |

Histopathology

| | | | |
|---|---|---|---|
| E493 | Antigen identification in tissue biopsy by immunologic techniques, per antigen, maximum of three | 65.66 | |
| E450 | Electron microscopy of biopsy specimen with report | 419.05 | |
| E315 | Frozen section and quick report | 57.85 | |
| E322 | Tissue, gross and microscopic examination with report | 79.75 | |

Pulmonary Function

| | | | |
|---|---|---|---|
| E333 | Blood gas studies - includes serial blood, pH, C02 and oxygen content studies (5 estimations of each) and alveolar air, oxygen and carbon dioxide analysis (3 estimations of each) | 250.96 | |
| E336 | Determination of blood gases, pH, pCO2, pO2 | 32.82 | |
| E337 | Urea breath test (C-13) for Helicobacter pylori | 80.17 | |

RADIOISOTOPE TESTS - IN VIVO

Thyroid Function - Isotopes 131 or 125

| | | | |
|---|---|---|---|
| E346 | Thyroid uptake | 55.13 | |
| E347 | Thyroid uptake and scan | 89.91 | |
| E349 | T.S.H. stimulation test (exclusive of T.S.H cost) | 82.07 | |
| E351 | Thyroid suppression test | 66.46 | |

Blood studies and hemopoietic function

| | | | |
|---|---|---|---|
| E354 | Red cell survival | 130.96 | |
| E355 | Red cell volume | 68.01 | |
| E356 | Plasma iron turnover | 82.07 | |
| E356A | Radioactive iron (59) binding capacity determination | 22.97 | |
| E357 | Plasma iron red cell utilization | 122.36 | |
| E359 | Red cell survival and splenic sequestration | 296.31 | |
| E358 | Survey sites of erythropoiesis | 296.31 | |
| E360 | Plasma volume (direct) | 82.07 | |

Gastrointestinal studies

| | | | |
|---|---|---|---|
| E367 | 1131 triolein studies | 82.07 | |
| E368 | 1131 oleic acid study | 82.08 | |
| E369 | Gastrointestinal blood loss (quantitative) (include survival) | 229.04 | |

LABORATORY AND PATHOLOGY (cont'd)

RADIOISOTOPE TESTS - IN VIVO (cont'd)

Gastrointestinal studies (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| E370 | Localization gastrointestinal tract bleeding | 328.36 | |
| E371 | Protein losing enteropathy | 246.28 | |

Miscellaneous procedures

| | | | |
|---|---|---|---|
| E500 | Unlisted procedures | BY ASSESS | |
| E500A | Unlisted procedures (out of province referral to Canadian Laboratories) | BY ASSESS | |
| E500B | Unlisted procedures (out of Canada referrals) | BY ASSESS | |

LABORATORY AND PATHOLOGY

| | | | |
|---|---|---|---|
| F 7 | Interpretation of karyotype | 49.60 | |

DIAGNOSTIC RADIOLOGY

NOTE: As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.

Head

| | | | |
|---|---|---|---|
| X 1 | Skull<br>NOTE: 1. May not be claimed in addition to HSC X 4. | 54.72 | |
| X 2 | Skull (including stereos) | 68.98 | |
| X 4 | Facial bones<br>NOTE: May not be claimed in addition to HSC X 1. | 54.72 | |
| X 5 | Mandible | 45.86 | |
| X 6 | Nasal bones | 45.86 | |
| X 6A | Adenoids or nasopharynx | 36.23 | |
| X 7 | Mastoids | 68.98 | |
| X 8 | Sinuses - paranasal | 54.72 | |
| X 9 | Temporo-mandibular joints | 54.72 | |
| X 10 | Sella turcica | 45.86 | |
| X 12 | Orbit - for foreign body | 45.86 | |
| X 13 | Orbit - for foreign body localization | 92.10 | |
| X 13A | Optic foramina | 68.98 | |
| X 14A | Dacryocystography | 59.73 | |
| X 15 | Salivary duct for calculus | 45.86 | |
| X 16 | Sialography | 66.28 | |
| X 17 | Tooth (single) | 11.95 | |
| X 18 | Teeth (half set) | 31.22 | |
| X 19 | Teeth (complete) | 47.40 | |

Chest

| | | | |
|---|---|---|---|
| X 20 | Chest - single view | 30.44 | |

DIAGNOSTIC RADIOLOGY

NOTE: As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services. (cont'd)

Chest (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| X 20A | Chest - single view - interpretation only | 18.50 | |
| X 21 | Chest - multiple views | 38.92 | |
| X 21A | Thoracic inlet views | 73.61 | |
| X 22 | Ribs | 48.17 | |
| X 23 | Chest - fluoroscopy | 28.13 | |
| | Pre-breast biopsy needle localization under mammographic control | | |
| X 27A | Single lesion | 108.29 | |
| X 27B | Multiple lesions | 167.25 | |
| | NOTE: X26 or X27 not payable for the same date of service. | | |
| X 25 | Chest - cardiac fluoroscopy including P.A., lateral and oblique views with barium in esophagus | 85.94 | |
| X 26 | Mammography (one breast) | 106.36 | |
| | NOTE: May not be claimed in addition to HSCs X105 or X105A. | | |
| X 26A | Mammoductography | 100.97 | |
| | NOTE: May not be claimed in addition to HSC X105A. | | |
| X 26B | Mammocystography | 97.11 | |
| | NOTE: May not be claimed in addition to HSC X105A. | | |
| | Automated stereotactic-guided large core biopsy (LNCB) | | |
| X 26C | Percutaneous stereotactic core breast biopsy imaging guidance | 274.00 | |
| | NOTE: May not be claimed in addition to HSC X105A. | | |
| X 27 | Mammography (both breasts) | 164.94 | |
| | NOTE: May not be claimed in addition to HSCs X105 or X105A. | | |
| X 27C | Screening mammography (age 40 to 49 years inclusive) | 124.86 | |
| | NOTE: Refer to notes following X27E for further information. | | |
| X 27D | Screening mammography (age 50 to 74 years inclusive) | 124.86 | |
| | NOTE: Refer to notes following X27E for further information. | | |

DIAGNOSTIC RADIOLOGY

NOTE: As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services. (cont'd)

Chest (cont'd)

Automated stereotactic-guided large core biopsy (LNCB) (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| X 27E | Screening mammography (age 75 years and over) . . . . . | 124.86 | |

NOTE:
1. Benefits for X27C, X27D and X27E include patient education. A visit benefit may not be claimed in conjunction with these services by the radiologist performing the screening mammogram or by a different radiologist in conjunction with the same radiological examination.
2. Only one Screen Test or fee-for-service benefit may be claimed every calendar year.
3. X27C and X27E must be referred initially. Subsequent yearly referrals are not required. X27D does not require a referral.
4. X27C, X27D or X27E may not be claimed subsequent to X27 within the same calendar year.
5. Supplementary views, refer to X27F.
6. X27C, X27D and X27E require submission of data to the Alberta Breast Cancer Screening Program through either the Alberta Society of Radiologists or the Alberta Health Services' Screening Programs.
7. X27C, X27D or X27E may not be claimed in addition to HSCs X105 or X105A.

DIAGNOSTIC RADIOLOGY

NOTE: As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services. (cont'd)

Chest (cont'd)

Automated stereotactic-guided large core biopsy (LNCB) (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| X 27F | Diagnostic mammography, supplementary views<br>Taken within 90 days of X27C, X27D, X27E<br>NOTE: 1. May be self-referred.<br>2. May not be claimed in addition to HSCs X26, X27 or X105A. | 40.08 | |
| X 27G | Screening mammography for patients with the following conditions: implants, augmentation, mammoplasty, and when determined appropriate for screening by a radiologist and/or primary care physician, with the following conditions: post intervention (e.g. biopsy, excision, etc.)<br>NOTE: May not be claimed in addition to HSCs X105 or X105A. | 164.94 | |
| X 28 | Sternum and/or sterno-clavicular joint | 45.86 | |

Upper extremity

| | | | |
|---|---|---|---|
| X 29 | Finger | 20.81 | |
| X 30 | Hand | 32.37 | |
| X 31 | Wrist or carpal bone (or wrist and hand) | 37.00 | |
| X 31A | Carpal tunnel view, additional benefit | 11.95 | |
| X 32 | Radius and ulna | 36.61 | |
| X 33 | Elbow | 33.14 | |
| X 34 | Humerus | 36.61 | |
| X 35 | Clavicle | 36.61 | |
| X 36 | Shoulder girdle | 54.72 | |
| X 36A | Scapula | 46.63 | |
| X 37 | Arthrogram - any upper extremity joint | 109.06 | |

Lower extremity

| | | | |
|---|---|---|---|
| X 38 | Toe | 20.81 | |
| X 39 | Foot | 32.37 | |
| X 40 | Ankle | 37.00 | |
| X 41 | Os calcis | 31.99 | |
| X 42 | Tibia and fibula | 36.61 | |
| X 43 | Knee<br>NOTE: May not be claimed in addition to HSCs X 54A and X 54B. | 42.01 | |

Skyline or tunnel view of knee

| | | | |
|---|---|---|---|
| X 43A | Additional benefit | 13.87 | |
| X 43B | Both views, additional benefit | 21.20 | |
| X 44 | Arthrogram - any lower extremity joint | 109.45 | |
| X 45 | Femur or thigh | 36.61 | |

DIAGNOSTIC RADIOLOGY

NOTE: As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services. (cont'd)

Lower extremity (cont'd)

Skyline or tunnel view of knee (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| X 46 | Femur, including hip and knee | 92.10 | |
| X 47 | Hip | 47.40 | |
| | NOTE: May not be claimed in addition to HSCs X 54A and X 54B. | | |
| X 48 | Hip - arthrogram | 109.06 | |
| X 50 | Hip pinning with fluoroscopy | 79.39 | |
| X 51 | Pelvis | 47.40 | |
| | NOTE: May not be claimed in addition to HSCs X 54A and X 54B. | | |
| X 52 | Pelvis and one hip | 61.27 | |
| | NOTE: May not be claimed in addition to HSCs X 54A and X 54B. | | |
| X 53 | Pelvis and both hips | 69.37 | |
| | NOTE: May not be claimed in addition to HSCs X 54A and X 54B. | | |
| X 54 | Sacro-iliac joints | 60.50 | |
| | NOTE: May not be claimed in addition to HSCs X 54A and X 54B. | | |

Stress views of a limb
Additional benefit

| | | | |
|---|---|---|---|
| X 54A | - unilateral | 13.87 | |
| | NOTE: Refer to the note following HSC X 54B. | | |
| X 54B | - bilateral | 21.20 | |
| | NOTE: HSCs X 54A and X 54B may not be claimed in addition to HSCs X 43, X 47, X 51, X 52, X 53, X 54, X 55, X 56, X 57, X 57A, X 58, X 58A, X 58B, X 58D, X 58E, X 59, X 60, X 61, X 62, X 63, X 64, and X 65. | | |

Spine

| | | | |
|---|---|---|---|
| X 55 | Spine, one area | 68.98 | |
| | NOTE: 1. May not be claimed in addition to HSCs X 54A and X 54B. 2. May only be claimed in addition to HSCs 16.89B, 16.89C or 16.89D once per year, per patient. | | |
| X 56 | Spine, one area - with obliques | 83.24 | |
| | NOTE: 1. May not be claimed in addition to HSCs X 54A and X 54B. 2. May only be claimed in addition to HSCs 16.89B, 16.89C or 16.89D once per year, per patient. | | |

DIAGNOSTIC RADIOLOGY

NOTE: As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services. (cont'd)

Spine (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| X 57 | Two areas<br>NOTE: May not be claimed in addition to HSCs X 54A and X 54B. | 114.46 | |
| X 57A | Two areas (of the spine) with obliques of each area<br>NOTE: May not be claimed in addition to HSCs X 54A and X 54B. | 164.17 | |
| X 58E | More than two areas (of the spine) with obliques of each area<br>NOTE: May not be claimed in addition to HSCs X 54A and X 54B. | 247.03 | |
| X 58 | Complete spine<br>NOTE: May not be claimed in addition to HSCs X 54A and X 54B. | 160.32 | |
| | Flexion and extension or lateral bending views of the spine. | | |
| | Additional benefit | | |
| X 58A | - flexion and extension<br>NOTE: May not be claimed in addition to HSCs X 54A and X 54B. | 13.87 | |
| X 58B | - lateral bending<br>NOTE: May not be claimed in addition to HSCs X 54A and X 54B. | 13.87 | |
| X 58D | flexion, extension and lateral bending<br>NOTE: 1. HSCs X 58A, X 58B and X 58D may not be claimed in addition to HSCs X 54A and X 54B.<br>2. HSCs X58A, X58B and X58D may be claimed in addition to HSCs X55, X56, X57, X57A, X58 and X58E. | 21.20 | |
| X 59 | Lumbo sacral spine and pelvis<br>NOTE: May not be claimed in addition to HSCs X 54A and X 54B. | 110.60 | |
| X 60 | Lumbo sacral spine and sacro-iliac joints<br>NOTE: May not be claimed in addition to HSCs X 54A and X 54B. | 83.24 | |
| X 61 | Lumbo sacral spine and pelvis and sacro-iliac joints<br>NOTE: May not be claimed in addition to HSCs X 54A and X 54B. | 110.60 | |
| X 62 | Lumbo sacral spine and one hip<br>NOTE: May not be claimed in addition to HSCs X 54A and X 54B. | 110.60 | |
| X 63 | Lumbo sacral spine and both hips<br>NOTE: May not be claimed in addition to HSCs X 54A and X 54B. | 137.96 | |
| X 64 | Lumbo sacral spine, pelvis and one hip<br>NOTE: May not be claimed in addition to HSCs X 54A and X 54B. | 127.56 | |
| X 65 | Lumbo sacral spine, pelvis and both hips | 137.96 | |

DIAGNOSTIC RADIOLOGY

NOTE: As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services. (cont'd)

Spine (cont'd)

Flexion and extension or lateral bending views of the spine.
Additional benefit (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| | NOTE: May not be claimed in addition to HSCs X 54A and X 54B. | | |
| X 66 | Myelogram, x-ray and fluoroscopy | 107.13 | |
| X 66A | Cervical or thoracic myelogram with fluoroscopy | 118.31 | |
| X 67 | Discography | 128.72 | |

Genito urinary

| | | | |
|---|---|---|---|
| X 68 | Kidney, ureters, bladder (K.U.B.) | 45.86 | |
| | NOTE: May not be claimed in addition to HSCs X 98, X 99 or X100. | | |
| X 69 | Cystography | 39.69 | |
| X 70 | Urethrography | 35.07 | |
| X 71 | Excretory pyelography (includes injections of material) | 109.45 | |
| X 73 | Retrograde pyelogram | 66.28 | |
| X 77A | Nephrostogram with fluoroscopy, unilateral | 98.66 | |
| X 77B | Nephrostogram with fluoroscopy, bilateral | 148.37 | |
| X 80 | Hystero-salpingography (with or without fluoroscopy) (instillation of medium, see 80.85A | 92.10 | |

Gastrointestinal tract

| | | | |
|---|---|---|---|
| X 81 | Esophagus with fluoroscopy | 107.52 | |
| X 82 | Stomach and duodenum with fluoroscopy | 146.83 | |
| X 82A | Double contrast examination of stomach - additional fee to X 82 and X 84 | 17.34 | |
| X 84 | Stomach, duodenum and small bowel follow through and with fluoroscopy (includes follow-up film taken next day if necessary) | 178.04 | |
| X 85 | Small bowel only with fluoroscopy | 107.52 | |
| X 85B | Small bowel studies including fluoroscopy following selective intubation and administration of cholinergic drugs (enteroclysis) | 187.29 | |
| X 86 | Colon (with fluoroscopy and films) | 107.52 | |
| | NOTE: May not be claimed in addition to HSCs X 87 or X 88. | | |
| X 87 | Colon (with fluoroscopy and films) combined with air contrast examination | 146.44 | |
| | NOTE: May not be claimed in addition to HSCs X 86 or X 88. | | |
| X 88 | Colon - separate air contrast (fluoroscopy and films) | 146.44 | |
| | NOTE: May not be claimed in addition to HSCs X 86 or X 87. | | |

DIAGNOSTIC RADIOLOGY

NOTE: As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services. (cont'd)

Gastrointestinal tract (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| X 88A | Barium enema for the reduction of intussusception . . . . . | 250.11 | |
| | NOTE: If any of the above procedures (HSCs X81 through X88A) are performed without fluoroscopy the benefit should be reduced by $10.92. | | |
| X 94 | Trans-hepatic percutaneous cholangiography . . . . . | 173.42 | |
| | (instillation, see 63.96) | | |
| X 94B | Hepatic venogram - hepatic wedge pressure . . . . . | 176.50 | |
| X 95 | Operative cholangiogram (includes cost of contrast media) . . . . . | 67.06 | |
| X 96 | T-tube cholangiogram (includes injection and cost of contrast material) . . | 105.59 | |
| X 97 | Splenoportography (excludes injection of contrast media) . . . . . | 154.92 | |
| X 98 | Abdomen - single view . . . . . | 41.24 | |
| | NOTE: May not be claimed in addition to HSCs X 68, X 99 or X100. | | |
| X 99 | Abdomen - multiple views . . . . . | 54.72 | |
| | NOTE: May not be claimed in addition to HSCs X 68, X 98 or X100. | | |
| X100 | Abdomen for obstruction or perforation . . . . . | 68.98 | |
| | NOTE: May not be claimed in addition to HSCs X 68, X 98 or X 99. | | |

Skeletal survey for secondary neoplasms, etc.

| | | | |
|---|---|---|---|
| X102 | Skull, shoulder, chest, spine and pelvis . . . . . | 137.96 | |
| X103 | Chest, spine and pelvis . . . . . | 92.10 | |
| X104 | Plus all long bones - additional . . . . . | 45.86 | |

Special techniques

| | | | |
|---|---|---|---|
| X105 | Planogram (tomogram, laminogram) - including stereos and fluoroscopy when necessary - any area . . . . . | 118.70 | |
| | NOTE: May not be claimed in addition to HSCs X 26, X 27, X 27C, X 27D, X 27E or X 27G. | | |
| X105A | Multi-directional tomography, any area . . . . . | 241.24 | |
| | NOTE: May not be claimed in addition to HSCs X 26, X 26A, X 26B, X 26C, X 27, X 27C, X 27D, X 27E, X 27F or X 27G. | | |
| X106 | Scanogram (including stereos and fluoroscopy) . . . . . | 119.85 | |
| X107 | Fluoroscopy of a joint with image intensification (including spot films) . . | 69.37 | |
| X107A | Fluoroscopy performed during special diagnostic or therapeutic procedures, including biopsy, endoscopy, intubation, pacemaker insertion and bougienage, etc. . . . . | 197.31 | |

## DIAGNOSTIC RADIOLOGY

NOTE: As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services. (cont'd)

Special techniques (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| X128 | Bone mineral content determination dual photon absorptiometry with or without vertebral fracture assessment (VFA) | 141.82 | |

NOTE:
1. May only be claimed once every two years from the date of the last service.
2. For patients that are at high risk or have conditions that require more frequent assessments, text describing the circumstances will be required.
3. May only be claimed for patients 50 years of age or older unless the patient is referred by a Endocrinology/Metabolism, Gastroenterology, General Surgery, Internal Medicine, Nephrology, Orthopedic, Pediatric (including sub-specialties), Physical Medicine and Rehabilitation or Rheumatology specialist.
4. Nurse Practitioners and physicians that are part of Cancer Control Alberta may refer for patients under 50 years of age who are at high risk of bone density loss. Text is required on both the referral and the claim to indicate the patient's risk.

Heart

| | | |
|---|---|---|
| X108 | Guidance of right heart catheterization | 222.36 |
| X109 | Guidance of left heart catheterization | 222.36 |
| X110 | Guidance combined left and right | 329.50 |

NOTE: If angiography is done at the same time, see subsequent items for appropriate charge.

| | | |
|---|---|---|
| X111 | Guidance of pacemaker | 222.36 |
| X111A | Guidance of extracardiac vascular catheterization without angiography | 222.36 |

## ANGIOGRAPHY

NOTE: If cine, video or automatic rapid film changer are used, add 50%, refer to Price List.

Peripheral

| | | |
|---|---|---|
| X112 | Artery or vein | 77.46 |
| X113 | Lymphangiography - unilateral | 93.26 |
| X114 | Lymphangiography - bilateral | 139.89 |

Abdominal

| | | |
|---|---|---|
| X115 | Abdominal angiography | 134.88 |
| X116 | Selective abdominal angiography | 193.46 |

DIAGNOSTIC RADIOLOGY

NOTE: As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services. (cont'd)

ANGIOGRAPHY (cont'd)

Abdominal (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| X117 | Combined abdominal and selective abdominal | 269.76 | |

Thoracic

| | | | |
|---|---|---|---|
| X118 | Thoracic angiography | 134.88 | |
| X119 | Selective thoracic angiography | 193.46 | |
| X120 | Combined thoracic and selective thoracic | 269.76 | |
| X121 | Inferior or superior vena cavography | 134.88 | |
| X122 | Angiocardiography | 289.42 | |
| X123 | Pulmonary angiography | 193.46 | |

Head and neck

| | | | |
|---|---|---|---|
| X124 | Cerebral - unilateral | 116.00 | |
| X125 | Cerebral - bilateral | 211.57 | |

NUCLEAR MEDICINE

Thyroid studies

| | | | |
|---|---|---|---|
| X140 | Thyroid scan | 104.05 | |

Liver studies

| | | | |
|---|---|---|---|
| X151 | Liver scan | 145.67 | |
| X151A | Combined liver and spleen scan | 208.87 | |
| X151B | Dynamic liver and/or spleen scan including static views | 311.77 | |
| X153 | Whole body scanning | 501.37 | |

Cardiac studies

| | | | |
|---|---|---|---|
| X170 | Thallium myocardial perfusion imaging (rest study) | 321.02 | |
| X171 | Thallium myocardial perfusion imaging (rest and exercise) | 448.00 | |
| X172 | Gated cardiac imaging (rest study) | 248.50 | |
| X173 | Gated cardiac imaging (rest and exercise) | 426.61 | |

Brain studies

| | | | |
|---|---|---|---|
| X156 | Brain scan | 189.99 | |

Bone studies

| | | | |
|---|---|---|---|
| X157 | Bone scan | 417.36 | |

DIAGNOSTIC RADIOLOGY

NOTE: As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services. (cont'd)

NUCLEAR MEDICINE (cont'd)

Lung studies

| | | BASE | ANE |
|---|---|---|---|
| X158 | Lung scan | 208.87 | |
| X158A | Lung scan with unilateral venogram (to include injection of radionuclide) | 311.77 | |
| X158B | Lung scan with bilateral venogram (to include injection of radionuclide) | 338.36 | |
| X158D | Xenon ventilation imaging | 198.85 | |

Spleen studies

| | | | |
|---|---|---|---|
| X159 | Splenic scan | 208.87 | |

Gastrointestinal studies

| | | | |
|---|---|---|---|
| X174 | Gastrointestinal imaging | 241.24 | |

Adrenal imaging

| | | | |
|---|---|---|---|
| X175 | M.I.B.G. (I-131) adrenal imaging | 476.32 | |
| X176 | M.I.B.G. (I-123) adrenal imaging | 145.29 | |

Miscellaneous

| | | | |
|---|---|---|---|
| X160 | Heart, aorta, or great vessel scan | 189.99 | |
| X161 | Dynamic heart imaging | 248.18 | |
| X162 | Glomerular filtration rate | 171.49 | |
| X163 | Dynamic renal transplant imaging studies | 380.37 | |
| X164 | Renal flow studies | 131.41 | |
| X165 | Cisternography | 380.37 | |
| X166 | Dynamic brain studies (including static views) | 284.02 | |
| X167 | Radionuclide cystography | 137.19 | |
| X168 | Radionuclide dacrocystogram | 110.60 | |
| X169 | Radionuclide venogram, unilateral (to include injection of radionuclide) | 124.48 | |
| X169A | Radionuclide venogram, bilateral (to include injection of radionuclide) | 151.07 | |
| X255 | Renogram | 120.24 | |
| X256 | Renal scan | 120.24 | |

DIAGNOSTIC RADIOLOGY

NOTE: As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services. (cont'd)

DIAGNOSTIC ULTRASOUND

NOTE: 1. An additional 30% of the benefit applies to patients 12 years of age and younger, except for HSCs X325, X326 and X327.
2. Ultrasound benefits include Doppler colour mapping.
3. Quantitative spectral analysis with directional flow and/or Doppler measurements (HSC X337) may be claimed in addition to ultrasound services except for HSCs X304, X306A, X306B, X323, X331, X332 and X333.
4. Where notes indicate HSCs may not be claimed in addition to X301-X338, this refers to being claimed by the same or different physician in the same location on the same day.

Head and neck

| | | BASE | ANE |
|---|---|---|---|
| X301 | Ultrasound, thyroid or parathyroid . . . . . | 102.90 | |
| | NOTE: May not be claimed with X302, X303, and X338. | | |
| X302 | Ultrasound, salivary gland(s) . . . . . | 102.90 | |
| | NOTE: May not be claimed in addition to HSCs X301 or X303. | | |
| X303 | Ultrasound, head and/or neck, soft tissue . . . . . | 103.28 | |
| | NOTE: 1. Benefit includes any and all soft tissue head and neck including salivary gland(s), thyroid or parathyroid if performed.<br>2. May not be claimed in addition to HSCs X301 or X302.<br>3. Benefit includes unilateral or bilateral neck masses.<br>4. Max one call. | | |
| X304 | Ultrasound, carotid and/or vertebral artery, bilateral study . . . . . | 254.73 | |
| | NOTE: May not be claimed in addition to HSC X337. | | |

Thorax

| | | | |
|---|---|---|---|
| X305 | Ultrasound, thorax (chest wall or pleura) . . . . . | 84.78 | |
| | NOTE: Two calls may only be claimed for bilateral ultrasound. | | |

DIAGNOSTIC RADIOLOGY

NOTE: As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services. (cont'd)

DIAGNOSTIC ULTRASOUND

NOTE: 1. An additional 30% of the benefit applies to patients 12 years of age and younger, except for HSCs X325, X326 and X327.
2. Ultrasound benefits include Doppler colour mapping.
3. Quantitative spectral analysis with directional flow and/or Doppler measurements (HSC X337) may be claimed in addition to ultrasound services except for HSCs X304, X306A, X306B, X323, X331, X332 and X333.
4. Where notes indicate HSCs may not be claimed in addition to X301-X338, this refers to being claimed by the same or different physician in the same location on the same day. (cont'd)

Thorax (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| X306A | Complex Complete Echocardiogram . . . . . | 250.25 | |

NOTE: 1. A complex complete echocardiogram includes all elements of an X306B, where the study is performed to confirm, assess, diagnose or follow-up on a patient that has, or previously had any of the following:
-pericardial disease, cardiomyopathy
-valve repair and/or valve replacement
-ventricular assist devices
-moderate or worse left ventricular systolic dysfunction (ASE guideline reference LVEF equal or less than 40%)
-vegetation, thrombus or cardiac mass
-moderate or worse valvular stenosis or regurgitation (ASE guideline references-specifically excludes mild to moderate)
-congenital heart disease (repaired or unrepaired; excludes patient foramen ovale unless bubble study is requested or indicated
2. Also payable in cases where the performance and interpretation of contrast injection (agitated saline or echo contrast), or stress echocardiography are completed.
3. Benefit includes rescanning (i.e. image acquisition) by a qualified physician, if performed.
4. In the rare case where a specific view or Doppler signal is unavailable, the reason shall be documented in the patient's record.
5. May not be claimed in addition to HSCs X307, X323 and X337.

DIAGNOSTIC RADIOLOGY

NOTE: As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services. (cont'd)

DIAGNOSTIC ULTRASOUND

NOTE: 1. An additional 30% of the benefit applies to patients 12 years of age and younger, except for HSCs X325, X326 and X327.
2. Ultrasound benefits include Doppler colour mapping.
3. Quantitative spectral analysis with directional flow and/or Doppler measurements (HSC X337) may be claimed in addition to ultrasound services except for HSCs X304, X306A, X306B, X323, X331, X332 and X333.
4. Where notes indicate HSCs may not be claimed in addition to X301-X338, this refers to being claimed by the same or different physician in the same location on the same day. (cont'd)

Thorax (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| X306B | Non Complex Complete Echocardiogram . . . . . A study of all the relevant cardiac structures and functions of all the chambers, valves, septae, pericardium and great vessels from multiple views, complemented by Doppler examination of every cardiac valve, the atrial and ventricular septa for antegrade and retrograde flow. NOTE: May not be claimed in addition to HSCs X307, X323 and X337. | 230.00 | |
| X307 | Ultrasound, heart, Echocardiogram, limited . . . . . NOTE: May not be claimed in addition to HSCs X306A or X306B. | 59.99 | |
| X308 | Ultrasound, breast, including axilla . . . . . NOTE: 1. Two calls may only be claimed for bilateral ultrasound. 2. May not be claimed with HSC X309. | 133.34 | |
| X309 | Ultrasound, axilla . . . . . NOTE: 1. Two calls may only be claimed for bilateral ultrasound. 2. May not be claimed with HSC X308. | 65.90 | |

Abdomen and Retroperitoneum

| | | | |
|---|---|---|---|
| X310 | Ultrasound, abdominal, complete or at least two abdominal organs . . . . . NOTE: May not be claimed in addition to HSCs X311 and X312. | 200.39 | |
| X311 | Ultrasound, kidneys, ureters and bladder . . . . . NOTE: 1. Benefit includes any pre-void, post-void and/or jets. 2. May not be claimed in addition to HSCs X310, X312, X314, X315, X316 and X328. | 173.03 | |
| X312 | Ultrasound, abdominal, single organ study, limited or follow up . . . . . | 102.90 | |

DIAGNOSTIC RADIOLOGY

NOTE: As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services. (cont'd)

DIAGNOSTIC ULTRASOUND

NOTE: 1. An additional 30% of the benefit applies to patients 12 years of age and younger, except for HSCs X325, X326 and X327.
2. Ultrasound benefits include Doppler colour mapping.
3. Quantitative spectral analysis with directional flow and/or Doppler measurements (HSC X337) may be claimed in addition to ultrasound services except for HSCs X304, X306A, X306B, X323, X331, X332 and X333.
4. Where notes indicate HSCs may not be claimed in addition to X301-X338, this refers to being claimed by the same or different physician in the same location on the same day. (cont'd)

Abdomen and Retroperitoneum (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| | NOTE: 1. For two or more organs on the same day, claim HSC X310.<br>2. May not be claimed in addition to HSC X310, X311 and X316. | | |
| X313 | Ultrasound, abdominal wall, or appendix study . . . . . | 102.90 | |
| | NOTE: Supporting text is required when a third call is claimed. | | |
| X313A | Ultrasound, inguinal hernia . . . . . | 102.90 | |
| | NOTE: 1. May only be claimed when the referral is supplied by a urologist (UROL) or general surgeon (GNSG). For pediatric patients, a general practitioner (GP), general surgeon (GNSG), pediatrician (PED), urologist (UROL) or pediatric general surgeon (PDSG) may also make referrals. | | |

## DIAGNOSTIC RADIOLOGY

NOTE: As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services. (cont'd)

### DIAGNOSTIC ULTRASOUND

NOTE:
1. An additional 30% of the benefit applies to patients 12 years of age and younger, except for HSCs X325, X326 and X327.
2. Ultrasound benefits include Doppler colour mapping.
3. Quantitative spectral analysis with directional flow and/or Doppler measurements (HSC X337) may be claimed in addition to ultrasound services except for HSCs X304, X306A, X306B, X323, X331, X332 and X333.
4. Where notes indicate HSCs may not be claimed in addition to X301-X338, this refers to being claimed by the same or different physician in the same location on the same day. (cont'd)

Obstetrics, Gynecology and Female Pelvis

NOTE: Female pelvic ultrasound exams (HSCs X314, X315, X316 and X324) may only be claimed in addition to any obstetrical ultrasound exams for different diagnosis.

| | | BASE | ANE |
|---|---|---|---|
| X314 | Ultrasound, pelvis, female, including endo-vaginal (EV) scan . . . . . | 176.12 | |
| | NOTE: May not be claimed in addition to HSCs X311, X315, X316, X318, X319 and X324. | | |
| X315 | Ultrasound, pelvis, female, transvesical scan . . . . . | 127.17 | |
| | NOTE: May not be claimed in addition to HSCs X311, X314, X316 and X324. | | |
| X316 | Ultrasound, urinary bladder, female . . . . . | 127.17 | |
| | NOTE: 1. Benefit includes any pre-void, post-void and/or jets.<br>2. May not be claimed in addition to HSCs X311, X312, X314, X315 and X324. | | |
| X317 | Ultrasound, obstetrical, first trimester, excluding detailed fetal assessment or nuchal translucency measurement . . . . . | 109.06 | |
| | NOTE: 1. An additional 50% of the benefit may be claimed for each additional fetus.<br>2. May not be claimed in addition to HSCs X318, X319, X320, X321, X322 and X324. | | |
| X318 | Ultrasound, obstetrical, first trimester, excluding detailed fetal assessment or nuchal translucency measurement . . . . . | 157.62 | |
| | NOTE: 1. Benefit includes endo-vaginal (EV) scan, if performed.<br>2. An additional 50% of the benefit may be claimed for each additional fetus.<br>3. May not be claimed in addition to HSCs X314, X317, X319, X320, X321, X322 and X324. | | |

## DIAGNOSTIC RADIOLOGY

NOTE: As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services. (cont'd)

### DIAGNOSTIC ULTRASOUND

NOTE: 1. An additional 30% of the benefit applies to patients 12 years of age and younger, except for HSCs X325, X326 and X327.
2. Ultrasound benefits include Doppler colour mapping.
3. Quantitative spectral analysis with directional flow and/or Doppler measurements (HSC X337) may be claimed in addition to ultrasound services except for HSCs X304, X306A, X306B, X323, X331, X332 and X333.
4. Where notes indicate HSCs may not be claimed in addition to X301-X338, this refers to being claimed by the same or different physician in the same location on the same day. (cont'd)

Obstetrics, Gynecology and Female Pelvis

NOTE: Female pelvic ultrasound exams (HSCs X314, X315, X316 and X324) may only be claimed in addition to any obstetrical ultrasound exams for different diagnosis. (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| X319 | Ultrasound, obstetrical, first trimester/early fetal screening . . . . . | 206.56 | |
| | NOTE: 1. Benefit includes detailed fetal assessment, nuchal translucency measurement and endo-vaginal (EV) scan, if performed.<br>2. An additional 100% of the benefit may be claimed for each additional fetus.<br>3. May not be claimed in addition to HSCs X314, X317, X318, X320, X321, X322 and X324. | | |
| X320 | Ultrasound, obstetrical, second or third trimester, general fetal assessment | 157.62 | |
| | NOTE: 1. Benefit includes fetal measurements and placental localization.<br>2. An additional 100% of the benefit may be claimed for each additional fetus.<br>3. May not be claimed in addition to HSCs X317, X318, X319 and X321. | | |
| X321 | Ultrasound, obstetrical, second or third trimester, high risk - for example, significant maternal disease (i.e. diabetes), fetal anomaly, fetal markers, Intrauterine Growth Retardation (IUGR), oligohydramnios, growth discordance in twins, suspected fetal anemia, genetics, fetal therapy . . . | 198.90 | |
| | NOTE: 1. Benefit includes fetal measurements, placental localization, colour Doppler and cord Doppler.<br>2. An additional 100% of the benefit may be claimed for each additional fetus.<br>3. May not be claimed in addition to HSCs X317, X318, X319 and X320. | | |

## DIAGNOSTIC RADIOLOGY

NOTE: As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services. (cont'd)

### DIAGNOSTIC ULTRASOUND

NOTE: 1. An additional 30% of the benefit applies to patients 12 years of age and younger, except for HSCs X325, X326 and X327.
2. Ultrasound benefits include Doppler colour mapping.
3. Quantitative spectral analysis with directional flow and/or Doppler measurements (HSC X337) may be claimed in addition to ultrasound services except for HSCs X304, X306A, X306B, X323, X331, X332 and X333.
4. Where notes indicate HSCs may not be claimed in addition to X301-X338, this refers to being claimed by the same or different physician in the same location on the same day. (cont'd)

Obstetrics, Gynecology and Female Pelvis

NOTE: Female pelvic ultrasound exams (HSCs X314, X315, X316 and X324) may only be claimed in addition to any obstetrical ultrasound exams for different diagnosis. (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| X322 | Ultrasound, obstetrical, biophysical profile, third trimester only . . . . . | 104.89 | |
| | NOTE: 1. May not be claimed with HSCs X317, X318 and X319.<br>2. An additional 100% of the benefit may be claimed for each additional fetus. | | |
| X323 | Ultrasound, heart (Echocardiogram), fetal, complete study . . . . . | 266.68 | |
| | NOTE: 1. May not be claimed in addition to HSCs X306A, X306B and X337.<br>2. An additional 100% of the benefit may be claimed for each additional fetus. | | |
| X324 | Ultrasound, pelvis, female, translabial or endo-vaginal (EV), additional benefit . . . . . | 66.67 | |
| | NOTE: 1. A maximum of one may be claimed per patient, per physician, per day.<br>2. May not be claimed in addition to HSCs X314, X315, X316, X317, X318 and X319. | | |

Pediatrics

| | | | |
|---|---|---|---|
| X325 | Ultrasound head, pediatric scan through open fontanel . . . . . | 163.78 | |
| X326 | Ultrasound, hips, bilateral, pediatric, newborn to 16 years of age . . . . . | 157.62 | |
| X327 | Ultrasound, spine, pediatric, newborn to 16 years of age . . . . . | 200.39 | |

DIAGNOSTIC RADIOLOGY

NOTE: As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services. (cont'd)

DIAGNOSTIC ULTRASOUND

NOTE: 1. An additional 30% of the benefit applies to patients 12 years of age and younger, except for HSCs X325, X326 and X327.
2. Ultrasound benefits include Doppler colour mapping.
3. Quantitative spectral analysis with directional flow and/or Doppler measurements (HSC X337) may be claimed in addition to ultrasound services except for HSCs X304, X306A, X306B, X323, X331, X332 and X333.
4. Where notes indicate HSCs may not be claimed in addition to X301-X338, this refers to being claimed by the same or different physician in the same location on the same day. (cont'd)

Male Genitourinary Tract

| | | BASE | ANE |
|---|---|---|---|
| X328 | Ultrasound, pelvis, male | 127.17 | |
| | NOTE: 1. Benefit includes bladder, any pre-void, post-void and/or jets. 2. May not be claimed in addition to HSC X311. | | |
| X329 | Ultrasound, prostate, transrectal | 127.17 | |
| X330 | Ultrasound, scrotal | 127.17 | |
| | NOTE: May not be claimed in addition to HSC X337. | | |

Peripheral Vascular System

NOTE: These HSCs can be claimed on any combination of limbs as determined by clinical evaluation.

| | | | |
|---|---|---|---|
| X331 | Ultrasound, arterial screening, peripheral | 84.78 | |
| | NOTE: May not be claimed in addition to HSC X337. | | |
| X332 | Ultrasound, arterial complete mapping, peripheral | 161.47 | |
| | NOTE: May not be claimed in addition to HSC X337. | | |
| X333 | Ultrasound, venous, peripheral | 127.17 | |
| | NOTE: May not be claimed in addition to HSC X337. | | |

## DIAGNOSTIC RADIOLOGY

NOTE: As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services. (cont'd)

### DIAGNOSTIC ULTRASOUND

NOTE:
1. An additional 30% of the benefit applies to patients 12 years of age and younger, except for HSCs X325, X326 and X327.
2. Ultrasound benefits include Doppler colour mapping.
3. Quantitative spectral analysis with directional flow and/or Doppler measurements (HSC X337) may be claimed in addition to ultrasound services except for HSCs X304, X306A, X306B, X323, X331, X332 and X333.
4. Where notes indicate HSCs may not be claimed in addition to X301-X338, this refers to being claimed by the same or different physician in the same location on the same day. (cont'd)

#### Peripheral Vascular System

NOTE: These HSCs can be claimed on any combination of limbs as determined by clinical evaluation. (cont'd)

| | | BASE | ANE |
|---|---|---|---|
| X334 | Ultrasound, other than shoulder including joints, tendons, ligaments, muscles, single anatomic site . . . . . | 115.23 | |
| | NOTE: 1. A maximum of two anatomical areas may be claimed per patient, per physician, per day.<br>2. May not be claimed in addition to HSC X337. | | |
| X335 | Ultrasound shoulder, dedicated rotator cuff and bicep . . . . . | 160.32 | |
| | NOTE: 1. Two calls may only be claimed for bilateral ultrasound.<br>2. May not be claimed in addition to HSC X337. | | |

#### Miscellaneous

| | | | |
|---|---|---|---|
| X337 | Doppler, quantitative spectral analysis with directional flow and/or Doppler measurements (e.g. renal artery, portal venous system, resistivity index, etc.), additional benefit . . . . . | 42.39 | |
| | NOTE: May not be billed in addition to HSCs X304, X306A, X306B, X323, X330, X331, X332, X333, X334 and X335 when services are provided by the same or different physician in the same facility on the same day. | | |
| X338 | Ultrasound, limited soft-tissue study, site unspecified, any single site, not organ related . . . . . | 66.67 | |
| | NOTE: 1. A maximum of two anatomical areas may be claimed per patient, per physician, per day.<br>2. May not be claimed in addition to HSC X301. | | |

## THERAPEUTIC RADIOLOGY

### X-ray therapy

| | | | BASE | ANE |
|---|---|---|---|---|
| Y | 1 | Superficial x-ray therapy excluding cancer, per sitting - one area | 16.57 | |
| Y | 2 | Multiple areas treated at one sitting - not to exceed | 33.14 | |
| Y | 3 | Superficial x-ray therapy, cancer | BY ASSESS | 110.53 |