MASTER AGREEMENT

Between

The Medical Society of Prince Edward Island

And

The Government of Prince Edward Island

And

Health PEI

April 1, 2010 - March 31, 2015

MASTER AGREEMENT

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SECTION A - GENERAL

ARTICLE A1 - PURPOSE OF AGREEMENT

A1.1 The parties to this Agreement share a desire to maintain and improve the high quality of service provided, so that the people of Prince Edward Island shall be well and effectively served. Accordingly, they are determined to maintain and foster an effective working relationship.

A1.2 The purpose of this Agreement is to establish a Tariff of Fees and other systems of payment for health services.

ARTICLE A2 - APPLICATION, DURATION AND AMENDMENTS

A2.1 This Agreement applies to and is binding upon the Government of Prince Edward Island, Health PEI, the Medical Society of Prince Edward Island and its constituent members.

A2.2 This Agreement shall be in force and effect for the period from April 1, 2010 to March 31, 2015, and shall remain in force and effect during the period of negotiation, mediation or interest arbitration carried out to achieve a new agreement.

A2.3 This Agreement constitutes the entire agreement between the parties, and no prior representations, undertakings or promises whatsoever, whether express or implied, shall form part of this Agreement**.**

A2.4 This Agreement may only be amended by mutual agreement, in writing, and no verbal agreements shall be required, permitted or recognized. Unless otherwise previously stipulated, alternate payment agreements shall coincide with the duration of this Agreement.

ARTICLE A3 - INTERPRETATION AND DEFINITIONS

A3.1 "Alternate Payment" means compensation provided for physician services on a basis other than fee for service. Alternate payments may include but are not limited to, sessional payments (hourly, daily, weekly or monthly rates), contract for service, and on-call remuneration.

A3.2 "Basic Health Services" means all services rendered by physicians that in the opinion of the Minister are medically required but do not include those listed in section (1) (d) (i) of the *Health Services Payment Act Regulations.*

A3.3 "Board" means the Board of Directors of Health PEI.

A3.4 "Clinical work incentive" means a method of additional compensation based upon the total value of an eligible physician's submitted and approved shadow billing claims.

A3.5 "Complement" means the complement of participating physicians for a region and/or the province approved by the Minister.

A3.6 "Consultation" means a request by one physician for an opinion from another physician competent to furnish advice where the patient's condition demands a further opinion.

A3.7 "Department" means the Department of Health and Wellness, which is authorized to act on behalf of the Minister.

A3.8 "Executive Director of Medical Affairs" means the position in Health PEI responsible for the administration and delivery of medical programs in the Province.

A3.9 "Employing Authority" or "Employer" means Health PEI established pursuant to the *Health Services Act*.

A3.10 "Full Time Salaried Physician" means a physician who works a regular schedule of hours as outlined in Article B5.1(a).

A3.11 "Family Physician" means a legally qualified medical practitioner who is not a specialist. The terms "Family Physician" and "General Practitioner" are interchangeable.

A3.12 "Government" means the Government of the Province of Prince Edward Island.

A3.13 "Health Services Payment Advisory Committee" means the provincial committee established under the provisions of the *Health Services Payment Act Regulations*.

A3.14 "Medical Director" means the individual assigned the administrative medical affairs of the respective hospitals or programs within the province.

A3.15 "Medical Society" means the Medical Society of Prince Edward Island, Canadian Medical Association, Prince Edward Island Division.

A3.16 "Minister" means the Minister of Health and Wellness.

A3.17 "On-Call" means a physician is required to be available to render service to or on behalf of a patient for a diagnosis or treatment at such locations as may be required in accordance with this Agreement, such as the home of the patient, at the doctor's office, at a hospital or at other health care institutions.

A3.18 "Part-Time Salaried Physician" means a physician who works less than full time hours, as outlined in section B5.1(a).

A3.19 "Physician" means a legally qualified medical practitioner who is entitled to practice medicine in Prince Edward Island pursuant to the *Medical Act*.

A3.20 "Sessional Fee" means a payment method other than fee for service that is based upon a time calculation.

A3.21 "Shadow Billing" means the process where physicians receiving alternate payment submit specially designated claims for the medical services provided to patients that result in no payment, subject to the clinical work incentive where applicable.

A3.22 "Specialist" means a legally qualified medical practitioner who is recognized as a specialist by the College of Physicians and Surgeons of Prince Edward Island.

A3.23 "Tariff" means a rate of fee for service payment as set out in the Tariff of Fees including the preamble to the Tariff of Fees, established pursuant to the *Health Services Payment Act* and this Agreement. The Tariff of Fees is attached hereto as Schedule "A".

A3.24 The term "he" shall be considered gender neutral throughout the document.

ARTICLE A4 - RECOGNITION

A4.1 The Government and Health PEI recognizes the Medical Society as the sole and exclusive bargaining agent for all of its members who are engaged in the practice of medicine in respect of all matters arising from this Agreement, including but not limited to fee for service and alternate payment.

A4.2 The Government and Health PEI and the Medical Society shall not negotiate with any other party with respect to matters covered by this Agreement.

A.4.3 The parties hereto or their designates and physicians, are prohibited from making written or verbal agreements which are in conflict with the terms of this Agreement. Any contractual arrangements between a Physician and Government or Health PEI related to the practice of medicine as defined in the *Medical Act* shall be provided to the Medical Society within thirty (30) days of signing.

A.4.5 (a) If the Government or Health PEI or their designates and a physician or physicians make a written or verbal agreement which is in conflict with the terms of this Agreement, such action shall automatically trigger a reopening of this Agreement at the Medical Society's sole option, for the purpose of negotiating the Article(s) which have been violated, and Articles A10 - Mediation and A11 - Interest Arbitration shall apply;

(b) For the purpose of this sub-article, notice to negotiate under sub-article A8.4(a) shall not apply; and

(c) The Article(s) found to be in conflict with the written or verbal agreement shall be separable from the remainder of this Agreement and all other Articles herein shall continue in full force and effect.

ARTICLE A5 - ADMINISTRATIVE AUTHORITY

A5.1 All the functions, rights, powers and authority of the Minister pursuant to the *Health Services Payment Act and Regulations*, which are not specifically abridged, delegated or modified by this Agreement are recognized by the Medical Society as being retained.

A5.2 All payments under this Agreement are subject to audit in accordance with the *Health Services Payment Act and Regulations*.

ARTICLE A6 - INFORMATION

A6.1 As soon as reasonably possible after the signing of this Agreement, Health PEI shall provide to all members of the Medical Society an electronic copy (in PDF format) of this Agreement, and upon request a printed and bound copy.

A6.2 Health PEI shall from time to time upon request provide identifiable physician payment data to the Medical Society for the sole purpose of enabling the Medical Society to represent physicians' interests. Such request shall be provided within fifteen (15) business days, or such other time as may be agreed upon by the parties.

A6.3 The Medical Society shall indemnify and save harmless the Government and Health PEI from any privacy complaints made by physicians or related liability that may arise from Health PEI's good faith provision of identifiable physician payment data to the Medical Society.

ARTICLE A7 - CORRESPONDENCE

A7.1 Correspondence from the Government and Health PEI to the Medical Society shall be addressed to a specified designate of the Medical Society and addressed to:

The Medical Society of Prince Edward Island
2 Myrtle Street
Stratford, PE
C1B 2W2

A7.2 Correspondence from the Medical Society to the Government and Health PEI shall be addressed to a specified designate of the Department or Health PEI and addressed to:

Department of Health and Wellness PO Box 2000 Charlottetown, PE C1A 7N8	Health PEI 16 Garfield St, PO Box 2000 Charlottetown, PE C1A 7N8

A7.3 Each party shall provide to the other a list of specified designates within thirty (30) days of the signing date of this Agreement.

A7.4 In the event that a dispute or matter involves a physician who is an employee of, or who provides a contract for service to the Department or Health PEI, the correspondence shall be addressed to the Department or Health PEI and copied to the Medical Society.

A7.5 In all cases, the parties may correspond by facsimile or email.

ARTICLE A8 - NEGOTIATIONS

A8.1 The parties to the negotiation of an agreement respecting physician compensation shall be the Medical Society and a Health Negotiation Committee appointed pursuant to the *Health Services Act*.

A8.2 The parties shall:

(a) not later than five months before the expiry date of any agreement in force, meet to determine the data and information that each should make available to the other;

(b) not later than four months before the expiry date of any agreement in force, meet to present and analyse the data and information that each has collected in accordance with clause (a); and

(c) prior to the commencement of formal negotiations, attempt to resolve as many issues as possible through mutual consultation.

A8.3 Neither party to an agreement shall change any term or condition therein unless the other party consents to the change or until a new agreement has been concluded by consultation, negotiation, mediation, or arbitration.

A8.4 (a) Not earlier than three (3) months preceding the expiry date of an agreement in force at the time either party may by notice in writing require the other party to commence negotiations with a view to the renewal or revision of an existing agreement or entering into a new agreement.

(b) The parties to an agreement may negotiate at any time by mutual consent.

A8.5 When one party has given notice under subsection A8.4(a) the parties shall, without delay, but in any case within fourteen (14) calendar days after the notice was given, meet or cause representatives on their behalf to meet and commence to negotiate with a view to the renewal or revision of an existing agreement or entering into a new agreement.

A8.6 Where the negotiations have been entered into under section A8.5, a party so negotiating shall not discontinue or withdraw from the negotiations on the ground that no notice, or improper or insufficient notice, has been given under section A8.4.

A8.7 An agreement remains in force until a new agreement is entered into to replace it.

ARTICLE A9 - GENERAL GRIEVANCE PROCEDURE

A9.1 The parties hereto recognize the benefit of dealing with disputes as quickly as possible, and shall make an earnest effort to settle such disputes promptly and fairly.

A9.2 (a) Where a dispute arises between a physician and Health PEI concerning the fee schedule, attached hereto as Schedule "A" to this Agreement, or any matter thereto as it applies to such physician, which cannot be satisfactorily resolved through discussion with the Executive Director of Medical Affairs or his designate, such dispute or matter shall be referred to the Health Services Payment Advisory Committee for a decision. If either party is dissatisfied with the decision of the Health Services Payment Advisory Committee, and following a review of the merits of the case, either party may, but is not obligated to, refer the dispute in writing to mediation and arbitration in accordance with Articles A10 and A12.

(b) Where a dispute arises between a salaried physician and Health PEI regarding the application, interpretation, or alleged violation of this Agreement, the matter shall be dealt with as outlined in Article B4.

(c) Where a dispute arises between a contract for service physician and Health PEI, regarding the application, interpretation or alleged violation of the particular contract for service between those parties arising from this Agreement, the matter may be referred by either party to mediation and arbitration in accordance with Articles A10 and A12.

(d) In all other circumstances, where a dispute arises between the Medical Society (acting on behalf of any of its members) and Health PEI regarding the application, interpretation, or alleged violation of this Agreement, such dispute may be referred to the Joint Consultation Committee to discuss and resolve the matter. If the dispute is not resolved, either party may refer the dispute in writing to mediation and arbitration in accordance with Articles A10 and A12.

A9.3 Communication between the parties shall be in writing at all stages.

ARTICLE A10 - MEDIATION

A10.1 Where notice to negotiate has been given under sub-article A8.4(a) and the parties have commenced negotiations and have reached an impasse, either party may request the assistance of a mediator. The parties shall attempt to select a mutually agreeable mediator between them. If the parties are unable to agree upon a mutually agreeable mediator within fifteen (15) calendar days, then either party may request the Minister responsible for the *Labour Act* in writing, to appoint a mediator to confer with the parties thereto to assist them in concluding an agreement, or a renewal or revision thereof and such request shall be accompanied by a statement of difficulties that have been encountered before the commencement or in the course of negotiations.

A10.2 The mediator appointed under sub-article A10.1 shall inquire into the matters in dispute and endeavour to bring about agreement between the parties.

A10.3 The mediator shall be paid such remuneration as the Minister responsible for the *Labour Act* determines and the mediator's fees and expenses shall be cost shared on a basis of 75% by Health PEI and 25% by the Medical Society, respectively.

A10.4 In the event a mediator is unable to resolve one or more of the matters within thirty (30) calendar days of the appointment of the said mediator, either party may thereafter, by serving written notice upon the other party, refer such a matter in dispute for resolution by interest arbitration or rights arbitration, as the case may be.

A10.5 In the event of a grievance dispute between the Medical Society and Health PEI, or a grievance dispute between a salaried physician, a contract for service physician or a physician receiving any other form of alternate payment, and Health PEI, as the case may be, the mediation process in this Article shall also be used.

ARTICLE A11 - INTEREST ARBITRATION

A11.1 The party giving notice shall, at the time of giving notice, name its appointee to the Board of Arbitration. The other party shall, within ten (10) calendar days of the receipt of such notice, name its appointee to the Board of Arbitration. The two appointees shall, within a further fifteen (15) calendar days, agree upon a chairperson for the Board of Arbitration.

A11.2 If either party fails to name its appointee within the time permitted, the Chief Justice of the Appeal Division of the Supreme Court of Prince Edward Island, upon the written request of the other party, shall meet and consult with the parties and then name such appointee. If the two appointees are unable to agree upon a chairperson within the time permitted, the Chief Justice, upon the written request of either party, shall meet and consult with the parties and then name the chairperson.

A11.3 No person who has a pecuniary interest in a matter before the Board of Arbitration, or is acting, or has acted within a period of two (2) years prior to the date notice has been served in accordance with sub-article A11.1 hereof, as solicitor, counsel, employee, agent, independent contractor or consultant to, or for, or on behalf of, either of the parties to this Agreement, or who is currently an employee of Health PEI, shall be eligible for appointment as a member of the Board of Arbitration. A person who is otherwise eligible shall not be disqualified solely as a result of having been the appointee of either party to a previous Board of Arbitration.

A11.4 Each party shall be responsible for its own costs, including the cost of its appointee to the Board of Arbitration. The parties shall be equally responsible for the costs and expenses of the chairperson.

A11.5 The Board of Arbitration shall have the power to determine its own procedure and shall not be bound by the formal rules of evidence, but shall give both parties the opportunity to submit full evidence and argument at a hearing. The hearing shall not be open to the public.

A11.6 The parties hereby express their mutual intentions that the arbitration proceedings shall be conducted in an expeditious manner, and that the deliberations of the Board of Arbitration shall be conducted with such due dispatch as is reasonably possible.

A11.7 When hearing a dispute, the Board of Arbitration shall have the jurisdiction to establish and settle any provisions of an agreement, which the parties have been unable to agree upon during negotiation or mediation.

A11.8 In making its decision, the Board of Arbitration shall consider and take into account any matter or factor, which it judges to be relevant based on the evidence submitted. In determining matters of funding the Board of Arbitration shall consider

(a) the fiscal policies of the Province;

(b) the ability of the Province to pay given the prevailing and anticipated economic conditions in the province;

(c) fair and reasonable compensation for physicians; and

(d) any other matter or factor which the Board of Arbitration judges to be relevant.

A11.9 The decision of the Board of Arbitration shall be the decision of a majority of its members. If there is no majority decision, the decision of the chairperson shall be deemed to be the decision of the Board of Arbitration. The Board of Arbitration shall make its decision and inform the parties thereof within thirty (30) calendar days from the completion of the hearing.

A11.10 Immediately upon receipt of the decision, the parties shall forthwith give effect to and implement such decision. In the event a question arises with respect to interpreting the decision, the Board of Arbitration shall remain seized of the matter and shall provide clarification to the parties as may be appropriate, but the Board of Arbitration shall not change its decision in any way.

A11.11 The decision of the Board of Arbitration shall be final and binding on the parties.

ARTICLE A12 - RIGHTS ARBITRATION

A12.1 If any difference arises out of the interpretation, application, operation or any contravention or alleged contravention of an agreement between the parties referenced in the preamble of this Agreement, or as to whether any such difference can be the subject of arbitration, the parties shall meet and attempt to resolve the difference. If the matter is not resolved either party may refer the dispute to mediation and then arbitration as provided for in this Agreement.

A12.2 When hearing a dispute arising out of any issue of interpretation, application, operation or any contravention or alleged contravention of an agreement, the Board of Arbitration shall have full remedial authority and shall order such remedy as may be just, but the Board of Arbitration shall have no jurisdiction to amend the provisions of such agreement.

ARTICLE A13 - RESPONSIBILITY FOR THE CONTINUANCE OF OPERATIONS

A13.1 Provided the parties have recourse to the dispute resolution mechanism provided for herein, the Medical Society shall not organize, incite, support or sanction a withdrawal of services, suspension or slow down of work, or any other interference with the business of the Province or Health PEI, and the Medical Society shall make all reasonable efforts to urge its members to refrain from such activities.

ARTICLE A14 - COMMITTEE STRUCTURES AND PURPOSES

A14.1 The Health Services Payment Advisory Committee

A committee created pursuant to the *Health Services Payment Act* and Regulations, of not less than three and not more than five physicians, who shall carry out the functions as listed in section 6 of the Regulations.

A14.2 The Physician Resource Planning Committee

(a) A committee created pursuant to sections 2.1 and 2.2 of the *Health Services Payment Act,* which assists the Minister in determining the appropriate number of,

and equitable distribution of, general and specialized physician services for the province, and discusses and provides advice regarding physician recruitment and retention strategy. In addition, the Committee shall make recommendations to the Minister on the physician complement.

(b) Where a practicing physician in Prince Edward Island or a Resident in medical training applies to Health PEI for financial assistance to complete additional training in a specialty of need within the Provincial Physician Resource Plan, Health PEI agrees to consult with the Physician Resource Planning Committee before finalizing its decision on each application.

A14.3 The Joint Consultation Committee

(a) A joint committee of the parties that meets at least on a quarterly basis and is co-chaired by a member from the Medical Society and a member of Health PEI. The Committee shall consist of eight (8) members, four (4) from each party. A quorum shall be five (5) with a minimum of two (2) representatives from each party. The function of the Committee shall be to review matters of mutual concern, such as but not limited to Preamble revisions and proposed new Fee Code items. In addition, the committee shall perform functions specifically referred to it by this Agreement.

(b) It is agreed that this Committee shall not have jurisdiction over the Tariff of Fees, or any alternate payment matters, or any matters of collective bargaining of this Agreement. The Committee shall not supersede the activities of any other committee of the Medical Society or Health PEI. The Committee shall not have the power to bind either the Medical Society or Health PEI to any decisions reached in their discussions. The Committee shall have the power to make recommendations to the Medical Society and Health PEI with respect to its discussions and conclusions.

ARTICLE A15 - SAVINGS CLAUSE

A15.1 If any article in this Agreement shall be found to be in conflict with any statute, such article shall be deemed null and void. However, such article shall be separable from the remainder of this Agreement, and all other articles herein shall continue in full force and effect. The parties to this Agreement shall negotiate a replacement for the article rendered null and void.

A15.2 In the event that the parties cannot reach mutual agreement, the matter in dispute under sub-article A15.1 shall be subject to mediation and interest arbitration proceedings.

ARTICLE A16 - DISCRIMINATION

A16.1 There shall be no discrimination practised by either party with respect to any physician on the basis of race, creed, colour, gender, sexual orientation, marital status, ethnic or national origin, age, disability or membership activity or lack of activity in the Medical Society.

ARTICLE A17 - ELECTION OF PAYMENT MODALITY

A17.1 Fee-for-service physicians shall be permitted to change to an alternate payment modality with the approval of Health PEI.

(a) Physicians who receive alternate payment shall have the right to convert to fee-for-service practice without restriction provided that eight (8) weeks of written notice is given to Health PEI.

(b) If Health PEI chooses not to retain the alternate payment physician (including a salaried physician who is converting to fee-for-service rather than resigning or retiring) the physician shall receive a payment equal to the amount of remuneration that the physician otherwise would have earned had the physician worked during the course of the eight (8) week period.

(c) If the alternate payment physician is not retained during the full notice period for reasons of just cause or non-performance of the work, as the case may be, the payment referred to in A17.1(b) shall not apply.

ARTICLE A18 - SHADOW BILLING

A18.1 All physicians receiving alternate payment shall shadow bill. Salaried physicians or physicians who are on a contract for service shall be provided with administrative support by Health PEI to effect the shadow billing.

A18.2 Any physician who shadow bills for any service shall only shadow bill for services performed by the physician personally.

SECTION B - SALARIED PHYSICIANS

ARTICLE B1 - APPLICATION OF SECTIONS A, C and D TO SALARIED PHYSICIANS

B.1 Sections A, C and D of this Agreement shall apply to salaried physicians, except where there is a conflict, the provisions of Section B shall prevail.

ARTICLE B2 - EMPLOYING AUTHORITY - MANAGEMENT RIGHTS

B2.1 All the functions, rights, powers and authority, which are not specifically abridged, delegated or modified by this Agreement are recognized by the Medical Society as being retained by Health PEI.

B2.2 These functions, rights, powers and authority shall not be exercised in a manner, which is inconsistent with the provisions of this Agreement, or in a manner that is arbitrary, discriminatory or in bad faith.

ARTICLE B3 - JOB DESCRIPTIONS

B3.1 Each salaried physician shall have a written job description. The Employing Authority shall establish the job description in consultation with the physician. The Employing Authority shall ensure that the job description is consistent with the information contained in the physician specific impact analysis.

B3.2 A job description shall contain:

(a) the job title;

(b) (i) the title of the physician's immediate supervisor(s) for administrative and clinical purposes;
(ii) where an immediate supervisor is not a physician, the salaried physician shall report to the Medical Director in regard to all clinical matters;

(c) a summary of the position's responsibilities;

(d) a description of the position's specific duties, including
(i) location of the physician's specific place(s) of work;
(ii) expected workload (to be determined on an individualized basis);
(iii) expected type and range of medical services to be provided;
(iv) expected on-call coverage; and
(v) any other related duties.

B3.3 A physician who accepts a salaried position shall not be permitted by an Employing Authority to commence employment unless both the physician and the Employing Authority have signed the contract of employment, which shall include the job description. For information purposes, a model contract of employment is attached as Appendix "A".

B3.4 The Employing Authority shall not make revisions to the physician's job description without thirty (30) days written notice, and discussion with the physician involved. Such discussion shall include consultation with medical department colleagues as may be appropriate. Differences of opinion may be referred to the Joint Consultation Committee for discussion and recommendation.

B3.5 Where a job description or other document confers certain rights, entitlements or benefits on a physician which are not covered by this Agreement, such rights, entitlements or benefits shall continue in full force and effect until such time as they are amended by negotiations.

ARTICLE B4 - GRIEVANCE PROCEDURE - SALARIED PHYSICIANS

B4.1 A grievance means a dispute between a salaried physician and the Employing Authority regarding the application, interpretation, or alleged violation of this Agreement.

B4.2 STEP ONE

Within ten (10) calendar days of an event giving rise to a grievance, a physician with the written approval of the Medical Society, shall submit the grievance in writing to the Employing Authority's designate. The written grievance shall state the facts giving rise to the alleged grievance, identify the provisions of the Agreement alleged to be in violation by specific reference, and state the contention of the physician with respect to these provisions, and shall also indicate the specific relief requested. The Employing Authority's designate shall reply in writing within ten (10) calendar days of receipt of the written grievance.

B4.3 STEP TWO

If the grievance is not resolved at step one, the Medical Society acting on behalf of the physician, may within ten (10) calendar days of receiving the written reply as required at step one, refer the grievance to the Joint Consultation Committee for resolution. The Joint Consultation Committee shall hear from both parties in an effort to resolve the grievance.

B4.4 STEP THREE

Failing satisfactory resolution of the grievance at step two, either the Medical Society or the Employing Authority may refer the grievance to mediation and/or arbitration in accordance with Articles A10 and A12.

B4.5 TIME LIMITS

The mandatory time limits specified in step one and step two may be extended by mutual agreement of the parties and shall be confirmed in writing.

B4.6 Unless dismissed or suspended by the Employing Authority, a physician shall continue to work in accordance with this Agreement until such time as the grievance is resolved.

B4.7 Replies to the grievance shall be in writing at all stages.

ARTICLE B5 - HOURS OF WORK

B5.1 (a) The normal hours of work shall be 37.5 hours per week to be provided between the hours of 8:00 a.m. and 8:00 p.m., Monday to Friday, unless otherwise agreed to between the physician and the Employing Authority.

(b) Notwithstanding Article B5.1(a), those salaried physicians who are, as of April 1, 2001, providing their normal hours of work between 8:00 a.m. and 6:00 p.m. Monday to Friday, shall continue such arrangement unless otherwise agreed to between the physician and Employing Authority.

(c) In consultation with each physician, the Employing Authority shall establish the work schedule/content for the normal hours of work in keeping with the service requirements of the Employing Authority. Revisions to such work schedule/content shall not be made unless there has been consultation between the physician and the Employing Authority.

(d) Salaried physicians shall not be permitted to bill fee-for-service during their normal hours of work as defined in sub articles 5.1(a) and (b).

B5.2 (a) For physicians not on-call, pre-approved hours worked in excess of 37.5 during this salaried period (the "overtime hours") may, at the physician's option, be taken as equivalent time off in lieu or paid additionally at the physician's then current hourly rate provided there has been prior consultation with the Employing Authority.

(b) Notwithstanding sub-article B5.2(a), a physician who, due to circumstances beyond his/her control, is unable to obtain pre-approval for overtime hours, shall provide a reasonable explanation for overtime hours such as, but not limited to,

the provision of urgent (e.g., infectious disease outbreaks) or emergent services, or where circumstances beyond a physician's control make it necessary to clear up an unavoidable backlog of work that, left undone, would compromise patient care or reasonable service delivery (e.g., a chronic unmanageable workload due to chronic unfilled physician vacancy(cies).

B5.3 (a) Physicians who share a call rota shall declare in writing to their respective Medical Director the same daily eight hour period, between 8 am and 8 pm, Monday to Friday, during which no fee-for-service on-call billing shall be permitted.

(b) Fee-for-service billing for on-call services shall be permitted outside of the declared period in sub-article B5.3(a) and paid at the physician's applicable specialty rate.

B5.4 When a physician is not on-call and is requested to see a special case outside of the normal salaried work day as defined in the job description, request for payment shall be processed as time in lieu or fee-for-service at the physician's option. A request for time in lieu shall include documentation of the time spent.

B5.5 Part-time physicians shall be paid pro rata salary, pension, vacation, statutory holidays and sick leave and receive pro rata continuing medical education (CME) benefits (as per Article B17). Part-time physicians shall receive fully paid benefits for life insurance, health care, dental, and long-term disability as such benefits apply to their base part-time salary.

ARTICLE B6 - WORKERS' COMPENSATION

B6.1 Workers' compensation coverage is provided to salaried physicians in accordance with the *Workers' Compensation Act and Regulations*.

B6.2 In cases of injury on duty, transportation to and from the nearest physician and/or hospital for appropriate medical care shall be provided by the Employing Authority.

ARTICLE B7 - SICK LEAVE

B7.1 Sick leave shall be provided in accordance with this article to enable salaried physicians to be absent during periods of illness from their regularly scheduled hours of work without loss of salary.

B7.2 Physicians shall accumulate sick leave benefits at the rate of 11.25 hours per month for each calendar month of continuous employment to a maximum accumulation 1612.5 hours.

B7.3 A physician appointed before the 16th of the month shall be eligible to accumulate full sick leave credits for that month.

B7.4 When an illness is caused due to the use of alcohol or other drugs and where the physician elects or is directed to undertake an approved treatment and rehabilitation program, the physician shall be granted sick leave with pay to the maximum of his/her available sick leave credits and long term disability benefits.

ARTICLE B8 - SPECIAL LEAVE

General Leave

B8.1 A physician shall be required to submit a written request for any leave of absence specifying the reason for such leave. Each request shall be considered on an individual basis and shall be at the discretion of the Employing Authority, in accordance with the terms of this Agreement or applicable legislation. Except in emergencies, such requests should be made at least four weeks in advance.

B8.2 Physicians granted leave of absence with pay shall be deemed to be continuously employed and shall retain their benefits and years of service and continue to accrue same during such leave of absence.

B8.3 Physicians granted leave of absence without pay shall be deemed to be continuously employed and shall retain their years of service accumulated to date for all purposes and shall be entitled to continue to access group insurance plans during a leave of absence subject to the terms and conditions of the contract(s) of insurance, but further years of service and benefits shall not accrue during such leave of absence.

Disability Leave

B8.4 Upon the expiry of sick leave, a physician who is eligible for LTD benefits shall be provided disability leave without pay for the period requested, up to a maximum of twelve (12) months. During the period of unpaid disability leave, the Employing Authority shall continue to pay group insurance premiums and the employer's share of pension contributions, provided the physician matches the contributions.

B8.5 Following the expiration of the twelve (12) month disability leave the physician shall be terminated from employment. If the physician is eligible and approved for Long Term Disability coverage pursuant to sub-article B19.3, the Employing Authority shall continue to pay the group insurance premiums and employer's share of pension contributions so long as the physician continues to be in receipt of LTD benefits.

Deferred Salary Plan

B8.6 A physician may apply for special leave of one year under the deferred salary plan administered by the Employing Authority. Under usual circumstances, this leave shall only be granted if a locum tenens physician is hired to replace the physician on such special leave. Leave of absence under a deferred salary plan must comply with the *Income Tax Act.*

ARTICLE B9 - VACATIONS

B9.1 A vacation year is the period beginning on the 1st day of April and ending on the 31st day of March of the following year.

B9.2 The following annual vacation entitlement shall be earned by a full-time physician:

(a) Four weeks' (20 working days) vacation with pay annually, during the first five years of medical practice in Canada or outside Canada but while under licensure by a Canadian jurisdictional authority. Vacation entitlement shall be earned at the rate of 1 ⅔ days per month.

(b) Five weeks' (25 working days) vacation with pay in the vacation year in which a physician completes his sixth year of medical practice in Canada or outside Canada but while under licensure by a Canadian jurisdictional authority, and yearly thereafter until the completion of 15 years of medical practice. Vacation entitlement shall be earned at the rate of 2 $^{1}/_{12}$ days per month.

(c) Six weeks' (30 working days) vacation with pay in the vacation year in which a physician completes his sixteenth year of medical practice in Canada or outside Canada but while under licensure by a Canadian jurisdictional authority, and yearly thereafter. Vacation entitlement shall be earned at the rate of 2 ½ days per month.

B9.3 (a) Vacation leave shall generally be taken in the vacation year in which it is earned. By mutual agreement with the Employing Authority, vacation may be taken in advance to a maximum of the vacation year's entitlement.

(b) Subject to this entire article, up to one year's entitlement of vacation may be carried over from one year to the next. Employees who make reasonable attempts to take their vacation during the year, but do not receive their requested vacation, shall be permitted to carry over or request a payout of their excess vacation. Employees' requests for vacation shall be in writing on the approved vacation leave form. The Employer shall respond to all requests on the same form. Employees shall retain copies of documents showing denied vacation requests.

(c) For employees who have at least one year of vacation entitlement in their vacation leave bank, the employees shall select their vacation prior to December 15th of each year. If the employee fails to select his/her vacation by December 15th, then the employer shall advise the employee of the dates of their vacation as selected by the employer, which will be taken before March 31st. If, for reasons beyond the control of the employee, the vacation as scheduled by the employer cannot be taken, then it shall be carried over in the employee's vacation bank or paid out to the employee at the employee's discretion.

(d) Employees who carried over more than the maximum entitlement at the end of the March 31, 2011 fiscal year shall have until March 31, 2014 to utilize their excess.

B9.4 For scheduling purposes, all requests for vacation leave shall be submitted to the Employing Authority for approval. If the physician is subsequently unable to take his earned vacation at the approved scheduled time because of a specific request in writing from the Employing Authority, then every effort shall be made by the employee and the Employing Authority to reschedule the vacation prior to the end of the vacation year.

B9.5 Vacation leave scheduling shall be determined on the basis of years employed in continuous full-time or part-time medical practice.

B9.6 In the event that inadequate staffing precludes the physician from taking vacation leave at the requested time, every effort shall be made by the Employing Authority to find suitable locum tenens coverage for the requested vacation period. A physician's approved vacation time shall not be denied by reason that the Employing Authority is unable to fund a locum physician

B9.7 Where a physician dies or leaves the position, the physician or his estate shall receive pay at the physician's then current rate of pay for any accumulated unused vacation leave.

ARTICLE B10 - STATUTORY HOLIDAYS

B10.1 A physician who is required to be on-call on a holiday shall receive a day off in lieu of the holiday, to be taken at a time mutually agreeable to the physician and the Employing Authority. Days off in lieu shall not be accumulated and must be used during the current fiscal year. All accrued holiday time will be paid out at the end of the fiscal year.

B10.2 Holidays are defined as New Year's Day, Islander Day, Good Friday, Easter Monday, Victoria Day, Canada Day, Labour Day, Thanksgiving Day, Remembrance Day, Christmas Day, Boxing Day and a floating holiday.

B10.3 A salaried physician on call on a statutory holiday shall be permitted to bill fee-for-service for services rendered outside the physician's regular hours of work. No fee for service billing shall otherwise be permitted.

ARTICLE B11 - MATERNITY / PATERNITY / PARENTAL LEAVE

B11.1 Maternity Leave

A physician who

(a) has been in the employment of the Employing Authority for a continuous period of twenty weeks or more;

(b) at least four weeks before the expected date of commencement of the leave, submits to the Employing Authority an application for maternity leave specifying the date of commencement and the date of termination of the leave; and

(c) provides the Employing Authority with a certificate of a qualified medical practitioner certifying that the physician is pregnant and specifying the estimated date of birth,

shall be granted up to seventeen continuous weeks of maternity leave without pay, commencing not more than eleven weeks immediately preceding the estimated date of birth. Sick leave shall be granted for allied conditions requiring hospitalization and confinement, where such confinement is supported by a certificate signed by a qualified medical practitioner. The Employing Authority reserves the right to have a physician examine the employee.

B11.2 Parental Leave

A physician who

(a) has been in the employment of the Employing Authority for a continuous period of twenty weeks or more;

(b) and who,
   (i) becomes the natural mother or father of a child,
   (ii) assumes actual care and custody of a child, for the purposes of adoption, or
   (iii) adopts or obtains legal guardianship of a child under the law of a province,

(c) and who, at least four weeks before the expected date of commencement of the leave, submits to the Employing Authority an application for parental leave specifying the date of commencement and the date of termination of the leave,

is entitled to and shall be granted, parental leave without pay for a continuous period of up to 35 weeks.

B11.3 Both Parents are Physicians

In the case where both parents are salaried physicians, the aggregate amount of maternity and parental leave in respect of the same event, shall not exceed 52 weeks.

B11.4 A full time physician mentioned in B11.1 or B11.2 who is subject to a waiting period of 10 days before receiving EI benefits shall receive leave with pay for the 10 day waiting period. This provision shall be prorated for part-time physicians based on paid hours in the previous twelve months.

B11.5 In the event that both parents are salaried physicians the total amount of time taken by either one or both parents under Article B 11.4 shall not exceed ten (10) days.

B11.6 When a physician decides to return to work after maternity or parental leave, she/he shall provide the Employing Authority with at least two (2) weeks notice.

B11.7 Birth or Adoption

A male physician upon request shall be granted one (1) day's leave with pay on the occasion of the birth of his child.

A physician shall be entitled to one (1) day's leave with pay on the adoption of a child or on the permanent placement of a foster child.

ARTICLE B12 - COMPASSIONATE LEAVE

B12.1 A physician may be granted compassionate leave on an as-required basis as approved by the Employer. Leave with pay for serious illness of the physician's immediate family may be approved by the Employer.

ARTICLE B13 - TRAVEL

B13.1 Travel allowances in accordance with the provincial rates, as determined from time to time by the Department of Finance and Municipal Affairs for provincial employees generally, shall be paid for physicians' travel on clinical or administrative business for the Employing Authority.

ARTICLE B14 - LOSS OF PERSONAL EFFECTS

B14.1 Where a physician, during the course of the physician's employment, because of the action of an inmate, patient, visitor or member of the public, suffers damage to or loss of eye glasses, false teeth, a watch, or other personal effects and/or professional

instruments usually carried with or worn by the physician in the performance of the physician's duties, including clothing, the Employing Authority shall pay to the physician in compensation for repairs or replacement an amount not exceeding $250 for any one item. All such incidents of loss of or damage to personal effects shall be reported in writing by the physician to the Employing Authority within two normal working days of the incident or discovery thereof.

ARTICLE B15 - TERMINATION OF EMPLOYMENT AND DISCIPLINE

Termination

B15.1 Physicians may retire upon reaching the age of 60.

B15.2 Any physician who has 10 or more years of service and attained the age of 55 years may retire at his own request or may be retired for just cause without loss of retirement benefits.

B15.3 Upon retirement, the physician shall receive a retirement allowance equal to five days' pay for each full year of continuous salaried service in the province, or portion thereof, to a maximum of 130 working days.

B15.4 Physicians shall give a minimum of eight weeks' notice of resignation and retirement of employment. If the Employing Authority chooses not to retain the physician in employment for the eight-week period after notice is received, the physician shall receive a payment equal to the amount of wages or salary that the physician would have earned had the physician worked during the course of the eight-week period.

B15.5 Physicians shall be expected on resignation and retirement to give a minimum of eight weeks' notice. Under exceptional circumstances, acceptance of less than eight weeks' notice shall be considered, and, if accepted, severance shall be equal to the notice period if the Employing Authority chooses not to retain the physician to the end of the notice period.

Discipline

B15.6 No salaried physician shall be disciplined by the Employing Authority except for just cause.

ARTICLE B16 - LIABILITY

B16.1 The physician agrees to maintain active individual membership with the Canadian Medical Protective Association (CMPA). Alternatively, the physician agrees to maintain individual professional malpractice liability insurance with limits of not less than $5,000,000 for any one occurrence. This insurance shall be with an insurer and in

a form acceptable to the Employing Authority, who shall have the right, but not the obligation to review this insurance to determine its acceptability. Acceptance by the Employing Authority of such insurance coverage shall not be construed as a waiver of any conditions of this Agreement. The physician shall provide the Employing Authority with a certificate of insurance evidencing such insurance.

B16.2 The physician shall pay CMPA dues or in the alternative, individual malpractice liability insurance as aforementioned. The Medical Society, upon receipt of evidence of payment shall provide reimbursement in accordance with Article D2 - CMPA Assistance.

B16.3 If an action or proceeding is brought against any physician for an alleged tort committed by him in the performance of his duties, the physician shall advise the Employing Authority immediately.

ARTICLE B17 - CONTINUING MEDICAL EDUCATION (CME)

B17.1 Physicians working full-time or part-time physicians working 0.6 FTE or more shall be provided with up to ten (10) paid working days' leave of absence per fiscal year for the purpose of attending approved educational seminars or courses. Physicians employed less than 0.6 FTE are entitled to five (5) days of paid leave of absence. There shall be no carryover of entitlement from year to year, except where a short-staffing situation has prevented the physician from taking his/her CME leave, or where the physician has received approval to undertake an unusually lengthy CME program.

B17.2 CME must be of potential professional benefit to the physician and it should relate to the physician's area of expertise. All CME requires prior approval by the physician's respective Medical Director. A minimum of four (4) weeks notice is required, however, exceptional circumstances shall be considered. Such approval shall not be unreasonably withheld.

B17.3 Where the Employing Authority requests a physician to upgrade his clinical skills for the purpose of undertaking new clinical responsibilities in practice, (e.g., expanded neonatology services), and the physician so agrees, the physician shall continue to receive his salary and benefits while upgrading his clinical skills and the Employing Authority shall reimburse the physician for all out-of-pocket costs in accordance with the Government's travel regulations and policies as approved from time to time by Treasury Board.

B17.4 Approval for this leave shall be subject to adequate staffing levels being in place during the period of absence. In the event that inadequate staffing would prevent the physician from attending a particular education leave, reasonable effort shall be made by the Employing Authority, in consultation with the physician, to obtain a locum tenens for the period of leave.

B17.5 A physician shall be reimbursed for CME expenses based on approval of receipts on the following basis:

(a) for a full-time or part-time general practitioner working 0.6 FTE or greater - up to $5,000 per annum;

(b) for a full-time or part-time specialist working 0.6 FTE or greater - up to $7,000 per annum;

(c) physicians working less than 0.6 FTE are eligible for one-half of the allowances in paragraphs (a) or (b) above;

(d) for the purpose of this article, "time worked" includes overtime hours worked;

(e) physicians beginning employment during a fiscal year shall have a pro-rated entitlement.

B17.6 The following CME expenses are eligible for reimbursement:

(a) registration fees;

(b) up to full-fare economy flight or other travel costs up to the equivalent full-fare economy rate;

(c) miscellaneous expenses associated with travel (e.g., taxis, tolls, etc.);

(d) meals as per approved Government travel policy;

(e) accommodations (unless otherwise approved, no greater than the hotel conference rate at CME site for duration of CME only); and

(f) books, journals, educational software and other CME materials may be purchased for CME purposes whether undertaken in PEI or at other approved sites.

B17.7 Electronic equipment is not eligible for reimbursement. If such equipment is required for the performance of work duties, associated costs should be discussed with the physician's respective Medical Director or designate.

ARTICLE B18 - SALARIES

B18.1 For the duration of this Agreement, the annual rates of pay for classifications shall be in accordance with the following salary scales, which shall include allowance for professional dues:

(a) Family Physicians

	Apr-01-10	Oct-01-11	Oct-01-12	Oct-01-13	Oct-01-14
Class I	138,982	140,233	142,317	144,402	147,320
Class II	143,384	144,675	146,826	148,978	151,990
Class III	149,985	151,334	153,583	155,832	158,980
Class IV	160,085	161,526	163,927	166,328	169,690

(i) Class IV is limited to a Family Physician who has a certificate of competency from a recognized educational program acceptable to Health PEI in Palliative Care, Geriatric Medicine, Oncology, Dermatology, Addictions or Pain Management, or who has the required equivalent experience as determined by the Employing Authority and who is required by the Employing Authority to have this level of competency or experience for the position.

(b) Specialists

	Apr-01-10	Oct-01-11	Oct-01-12	Oct-01-13	Oct-01-14
Class I	192,720	194,454	197,344	200,234	204,280
Class II	198,742	200,531	203,513	206,495	210,670
Class III	222,832	224,837	228,179	231,521	236,200
Class IV	281,193	287,014	296,716	306,418	320,000
Class V	281,193	290,014	304,716	319,418	340,000

(i) Class IV is limited to a specialist in Laboratory Medicine as certified by the Royal College of Physicians and Surgeons of Canada, or is otherwise recognized as a specialist in this field as determined by the College of

Physicians and Surgeons of Prince Edward Island, and who is required by the Employing Authority to have this level of competency for the position.

(ii) Class V is limited to a specialist in Radiation Oncology or Medical Oncology as certified by the Royal College of Physicians and Surgeons of Canada, or is otherwise recognized as a specialist in one of these fields as determined by the College of Physicians and Surgeons of Prince Edward Island, and who is required by the Employing Authority to have this level of competency for the position.

B18.2 A physician's annual rate of pay shall be adjusted to a specific step on the applicable scale as follows:

(a) A physician who is hired as a probationary employee shall not be paid at a starting rate higher than Class I. Such physician shall be paid at Class II following a nine hundred and seventy five (975) hour probationary period, subject to the physician's satisfactory performance.

(b) Advancement to Class III shall occur following nineteen hundred and fifty [1950] hours service at Class II, subject to the physician's satisfactory performance.

(c) Notwithstanding sub-article B18.2(b), a physician who is not CCFP or FRCP credentialed shall remain in Class II for a period of thirty nine hundred (3900) hours before being eligible to move to Class III.

B18.3 Notwithstanding the provisions of Article B18.2, Health PEI may place the new physician in a class greater than that provided for in Article B18.2 to reflect professional experience.

B18.4 The Employing Authority shall, prior to each anniversary date of a physician, review the performance of the employee. The physician concerned shall be given the opportunity to read the appraisal and attach his comments. The performance review shall be conducted by the Medical Director, Department Head and /or the physician's supervisor as determined by the Employing Authority.

B18.5 The Employing Authority shall notify the physician in writing when an increment is not granted. Such notice shall contain the reason for not granting the increment increase and shall be provided to the employee no later than the date on which the increment increase would otherwise have been due.

B18.6 The anniversary date of part-time physicians shall be on completion of one thousand nine hundred and fifty (1950) hours of work or paid leave. The computation of hours shall include overtime.

B18.7 All physicians listed in the Complement (which list shall be updated by the parties from time to time) who convert to salary from fee for service status shall be paid at Class III.

B.18.8 Excluding Specialists in Class IV and Class V, in addition to the applicable annual rate of pay, an employee shall be paid a clinical work incentive in accordance with Article C5.

ARTICLE B19 - PENSION AND BENEFIT COVERAGE

B19.1 Physicians who elected to remain in the Civil Service Superannuation Fund shall have their pension contributions matched by the Employer as authorized by the *Civil Service Superannuation Act*, subject to the maximum allowed by law.

B19.2 All other physicians shall designate their own RRSP account to which the Physician and Employer shall make contributions. The Physician shall contribute the equivalent of 9% of his/her base salary via payroll deduction, which shall not exceed 50% of the maximum permissible contribution provided for in the *Income Tax Act*. The Employer shall match that contribution.

B19.3 Physicians shall be enrolled in those group insurance benefit programs provided under the Public Sector Group Insurance Plan including basic group life insurance, basic health care, basic dental benefits, and basic long-term disability. Premiums for such coverage shall be fully paid by the Employing Authority.

ARTICLE B20 - COMPENSATION FOR UNINSURED SERVICES/THIRD PARTY BILLINGS PERFORMED BY SALARIED PHYSICIANS

B20.1 Salaried physicians are compensated by the Employing Authority for work they perform during the agreed hours of work. However, from time to time certain patients are examined/treated during such hours and the salaried physician is entitled to bill an uninsured patient or third party for such services, and shall not be required to work additional offset time for examining/treating uninsured patients. In such cases, the salaried physician may declare in writing, once in each fiscal year, that either of the following options shall apply:

(a) The salaried physician waives his entitlement to bill an uninsured patient or third party, and the Employing Authority submits the bill for such services and retains the fees; or

(b) The salaried physician retains the fees for such services, and must complete any associated documentation outside of his agreed hours of work

It is the intention of the parties that work on uninsured services shall be limited to those incidentally arising in the course of a physician's regular practice. Salaried physicians shall report to the Employer all payments received pursuant to this provision.

B20.2 Notwithstanding sub-article B20.1, in accordance with past practice, salaried pathologists who perform coroner's autopsies shall continue to receive and retain payment for such uninsured services performed during salaried hours, and shall not be required to work additional offset time.

ARTICLE B21 - ON-CALL DUTY (SALARIED SPECIALISTS ONLY)

B21.1 Subject to sub-article B21.5, or unless otherwise agreed, salaried specialists shall provide continuous comprehensive on-call coverage.

B21.2 (a) Salaried specialists who share a call rota shall declare in writing to their respective Medical Director the same daily eight hour period, between 8 am and 8 pm, Monday to Friday, during which no fee-for-service on-call billing shall be permitted.

(b) Fee-for-service billing for on-call services shall be permitted outside of the declared period in sub-article B21.2(a) and paid at the salaried specialist's applicable specialty rate.

B21.3 When a salaried specialist is not on-call and is requested to see a special case outside of the normal salaried work day as defined in the job description, request for payment shall be processed as time in lieu or fee-for-service at the physician's option. A request for time in lieu shall include documentation of the time spent.

B21.4 Subject to sub-article B21.2, salaried specialists compensated by fee-for-service payments for on-call duties shall be entitled to bill Health PEI on a fee-for-service basis, for services provided outside the declared salaried hours as determined by Article B21.2. Such billing shall be according to the fee-for-services tariff schedule. Physicians are responsible for submitting their own billings.

B21.5 A full-time salaried specialist shall not be required to be on-call more than an average of one day in three, except where coverage of vacation absences and continuing medical education (CME) leave is required. If the physician voluntarily agrees to more frequent on-call service, it shall be indicated in the job description. On-call service shall be no greater than one day in four for part-time salaried physicians who work at 0.6 FTE or less.

SECTION C - OTHER PHYSICIAN SERVICES

ARTICLE C1 - TARIFF OF FEES

C1.1 Health PEI shall pay physicians in accordance with the Tariff of Fees, attached hereto as Schedule "A", and Appendix "L" (New Fee Codes), for health services provided to entitled persons under the Health Services Payment Plan.

C1.2 If either party wishes to amend the Tariff of Fees, a request shall be made to the Joint Consultation Committee, which shall review the matter and make recommendation to the parties for an amendment to this Agreement. Ordinarily such amendments shall only be made twice a year, in April and October, and such amendments shall be made in the form of an addendum to this Agreement.

ARTICLE C2 - EMERGENCY DEPARTMENT (ED) SERVICES

C2.1 **ED Services - On-site Coverage**

Sessional fees and fee-for-service payments shall be payable for work performed at the Queen Elizabeth Hospital ("QEH"), Prince County Hospital ("PCH"), Kings County Memorial Hospital ("KCMH"), and Western Hospital ("WH") Emergency Departments. The number of funded hours of on-site coverage for each of these facilities, as of the signing of this Agreement, is listed in Appendix "E".

Funded hours for on-site coverage shall be paid by an hourly sessional fee which shall be billed using the site-specific fee code listed in the Tariff of Fees. Effective October 1, 2012, a premium of 8% shall apply for on-site coverage provided on weekends and statutory holidays.

C2.2 In addition to sessional fees, Emergency Department Physicians ("EDPs") and ED locum physicians shall be paid a percentage of the value of all submitted and approved shadow billing claims that have a service date on or after the following dates:

Apr-01-2010	Oct-01-2012	Oct-01-2013	Oct-01-2014
22%	24%	26%	28%

C2.3 The number of funded on-site coverage hours at each hospital is determined by taking into account patient volume and acuity of illness. The precise daily requirements for EDP coverage may vary from time to time according to patient volume and acuity of illness, and shall be determined by the Head of each Emergency Department (PCH and QEH) or applicable Medical Director (KCMH and WH) . All coverage hours actually provided in accordance with daily requirements shall be paid so long as the annual cost does not exceed the annual funding derived from the daily hours of on-site coverage as

approved by the Minister. For monitoring purposes, Health PEI shall provide quarterly reports to the Head of each Emergency Department or applicable Medical Director with respect to actual costs to date. In the event that the quarterly report indicates that there is an unused accumulation or an excess utilization of one hundred (100) funded hours or more, the Head of the Emergency Department or applicable Medical Director shall meet with the Joint Consultation Committee to discuss and determine any action required.

C2.4 If the workload in the Emergency Department warrants a change in the total number of funded on-site coverage hours at a hospital, then requests for a change in funded coverage hours and/or additions to the EDP complement shall be addressed in the usual manner through the Physician Resource Planning Committee.

C2.5 **Rural Hospital Incentive and On-Call Retainer**

(a) For the term of this Agreement, "rural hospital" shall mean Souris Hospital, Kings County Memorial Hospital (Montague), Stewart Memorial Hospital (Tyne Valley), Community Hospital (O'Leary), or Western Hospital (Alberton).

(b) Each permanent full-time physician whose principal place of practice is within the catchment area of a rural hospital shall receive an annual Rural Hospital Incentive, payable in equal monthly installments, provided the physician maintains active medical staff privileges at that hospital and participates equitably in the on-call rotation for that hospital.

(c) The annual Rural Hospital Incentive shall be:

(i) $5,000 for physicians practicing at a rural hospital with an emergency department where the physician is remunerated with the ED On-site sessional fee (or equivalent) defined in Article C2.1; or

(ii) $20,000 for physicians practicing at a rural hospital without an emergency department.

(d) Such incentive payments shall be pro-rated for permanent part-time physicians, and shall not apply to locum physicians. A physician may be eligible to receive only one of the above incentive payments.

(e) The Rural Hospital On-Call Retainer shall be paid to one (1) physician per rural hospital per twenty-four (24) hour period:

(i) using fee code 0040 for the provision of in-patient on-call services and after-hours emergency department on-call services at a rural hospital with a 24-hour Emergency Department; or

(ii) using fee code 0185 for the provision of in-patient on-call services at a rural hospital without a 24-hour emergency department.

(f) In addition to the Rural Hospital On-Call Retainer, physicians shall be paid fee-for-service for all approved claims for services rendered while on-call, which in the case of alternate pay physicians must be outside the physicians' regularly scheduled hours of work.

C2.6 In the event that Health PEI decides to fund certain on-site Emergency Department coverage at a hospital listed in sub-article C2.5, and the affected physicians through the Medical Society have been consulted and have agreed to provide such on-site coverage, then remuneration shall be in accordance with the sessional fees and fee-for-service payments set out in sub-articles C2.1 and C2.2.

C2.7 **Other Provisions Respecting Emergency Departments**

All of the following paragraphs apply at all times to services provided in the Emergency Departments at QEH and PCH**;** and to KCMH and WH between the hours of 8:00 a.m. and 10:00 p.m. (generally known as "Site 4 visits").

(a) All services (irrespective of type) provided outside an Emergency Department, i.e., non-site 4 visits, shall continue to be paid by Health PEI on a fee-for-service basis. For the purpose of this paragraph, "outside the Emergency Department" means any other location within the hospital or outside the hospital, including but not limited to a private medical clinic. For greater certainty, any emergency physician who bills fee-for-service outside an Emergency Department shall be paid at the full rate in the Tariff of Fees for all fee-for-service work that is rendered, shall not be regarded as a locum, and article C11 herein shall not apply. It is expected that such services shall primarily occur outside the EDP's scheduled shift duty.

(b) EDPs shall be entitled to retain all payments for third party billings and other uninsured services, including payments for medical reports. The documentation associated with these services, i.e. writing reports, must be completed outside sessional hours. EDPs shall not be required to work additional offset time for examining/treating uninsured patients. Sessional claims shall be submitted using current billing numbers and a hospital-specific sessional fee code.

(c) EDPs shall submit shadow billing claims, as required in Article A18 for all services provided to patients during their ER shifts. Except for those physicians who are salaried, the shadow billing claims shall be submitted, at physicians' own expense, using individual billing numbers.

(d) An EDP who occasionally provides primary care to patients in the Emergency Department outside of that physician's regular ER shift duty shall be paid by Health PEI on a fee-for-service basis, subject to the following:

(i) An EDP who covers an ER shift on a particular day shall not be entitled to bill fee-for-service for Site 4 visits provided on that same day. For the purpose of this Article, "same day" is defined as the 24-hour period commencing at 0001 hours during which the shift is worked. For shifts extending over 0001 hours, the day during which the FFS billing restriction applies, is the day in which the longest portion of the shift is worked.

(e) Scheduling of physicians for Emergency Department coverage shall be the responsibility of the Head of Emergency or Medical Director, as applicable, at each hospital.

(f) Each group of EDPs at QEH, PCH, KCMH and WH shall enter into a service coverage contract with Health PEI. The contract to be entered into is attached hereto as Appendix "D".

(g) If the workload in the Emergency Department warrants a change in the total hours of physician coverage, then requests for a change shall be addressed in the usual manner through the Physician Resource Planning Committee.

ARTICLE C3 - ON-CALL SERVICES

C3.1 (a) **On-Call Retainer (plus fee-for-service)** - Specialist or Other Physician As Applicable

One (1) specialist, or other physician as applicable, from each of the following clinical groups shall be entitled to a daily on-call retainer plus fee-for-service for providing twenty-four (24) hour coverage to each of the listed hospitals or provincial service, as the case may be:

Queen Elizabeth Hospital:
Internal Medicine, Pediatrics, General Surgery, Ob/Gyn, Anaesthesia, Surgical Assistant

Prince County Hospital:
Internal Medicine, Pediatrics, General Surgery, Ob/Gyn, Anaesthesia, Surgical Assistant

Provincial coverage:
Psychiatry, Radiology, ENT, Orthopedics, Ophthalmology, Plastic Surgery, Urology, Oncology, Palliative Care, Laboratory Medicine

(b) **On-Call Retainer (plus fee-for-service)** - Family Physicians

A daily on-call retainer plus fee-for-service shall be paid to Family Physicians providing on-call coverage at each of the following facilities:

(i) Queen Elizabeth Hospital and Prince County Hospital

- for in-patient coverage by one (1) physician per group per day. The on-call retainer fee will vary according to group size as listed in the Tariff of Fees. Claims for group coverage require a comment listing the names of the physicians in the group.

- for after-hours Hospitalist in-patient coverage by one (1) physician per hospitalist group per day. At the signing of this Agreement, there are two (2) hospitalist groups at the QEH and 1 hospitalist group at the PCH.

- for QEH Unit 9 (psychiatry) unaffiliated inpatient coverage by one (1) physician per day.

- for QEH Unit 7 (rehab) in-patient coverage by one (1) physician per day.

(ii) Souris Hospital and Stewart Memorial Hospital and Community Hospital and Kings County Memorial Hospital
- for in-patient coverage by one (1) physician per hospital per day.

(iii) Western Hospital
- for in-patient and after-hours Emergency Department coverage by one (1) physician per day.

(iv) Hillsborough Hospital and Mt. Herbert Addiction Services
- for in-patient coverage by one (1) physician per facility per day.

(v) Provincial Correctional Services
- for inmate coverage by one (1) physician per day.

(c) The daily retainer for each clinical group shall be paid according to a group-specific fee code as listed in the Tariff of Fees, and shall qualify for weekend and holiday premiums as listed in the Preamble to the Tariff of Fees.

(d) Payment of the retainer is contingent upon the following conditions being met:

(i) provision of twenty-four (24) hours per day, seven (7) days per week continuous coverage for each listed clinical group;

(ii) the clinical group commits to provide coverage for not less than a period of one (1) calendar month, except that in the event there are fewer than three (3) physicians practising in a particular clinical group, each physician must provide no less than one (1) day in three (3) coverage (i.e., a minimum of ten (10) days per month;

(iii) the physician is responsible to an emergency department, a hospital or a hospital unit, or other facility, as the case may be, and is available to respond to a request by hospital or facility staff to attend to a patient;

(iv) the physician's name appears on an established facility call schedule;

(v) the physician shall be entitled to bill fee-for-service in addition to the on-call retainer for all services rendered when on-call;

(vi) the physician is not otherwise compensated through another contractual arrangement for on-call coverage; and

(vii) in the event an on-call locum physician leaves the province early, the on-call retainer may be divided with another physician, provided a comment is added to the claim.

C3.2 **On-Call Per Diem (no fee-for-service)** - Salaried Physicians

(a) Salaried specialists who provide coverage in support of 24-hour emergency department service may elect, on an annual basis, to be compensated for on-call duties either by the on-call retainer plus fee-for-service set out in sub-article C3.1, or by an on-call alternate payment per diem of $500.00, effective April 1, 2010.

(b) A salaried Palliative Care specialist who provides coverage in support of 24-hour palliative service shall be compensated for on-call duties by an on-call alternate payment per diem of $400.00, effective April 1, 2010.

C3.3 **Salaried Medical Oncology specialists**

(a) Where a salaried medical oncology specialist provides "first on-call" coverage as set out in sub-articles B22.2(a) or (b), the provisions of Article B22 shall apply;

(b) Where a salaried medical oncology specialist backs up a GP Oncology Associate by providing "second on-call" coverage, the specialist shall be entitled to a retainer fee (fee code 0174) plus fee-for-service in accordance with sub-article B22.4.

C3.4 **Neurology On-Call Coverage**

Where a neurologist backs up an Internal Medicine specialist by providing "second on-call" coverage for neurology, the neurologist shall be entitled to a retainer fee (fee code 0503) plus fee-for-service.

C3.5 On-Call Coverage for Multiple Clinical Groups

In the event that a physician provides on-call coverage for more than one clinical group simultaneously, that physician shall be entitled to receive the on-call retainer or perdiem for each clinical group covered, provided the physician is qualified to practice in each specialty so covered.

C3.6 Weekend and Holiday Premiums for On-Call Coverage

When on-call coverage is required to be provided on weekends (from Saturday 08:00 hrs to Monday 08:00 hrs) and on holidays as designated in the Preamble to the Tariff of Fees, all on-call retainers and perdiems, as well as Hospitalist daily sessional fees, shall be paid at the applicable rate plus an add-on premium of twenty-five per cent (25%).

C3.7 Payment for Additional On-Call Coverage during Physician Shortages

In the event of a physician shortage for more than thirty (30) days in clinical groups of five (5) or less providing on-call coverage as outlined in sub-article C3.1(a), and the shortage is due to a vacancy in the approved complement or extended sick leave, Health PEI shall make every reasonable effort to fill the vacancy with either permanent or temporary locum physicians. If a physician is required to provide additional on-call coverage as a result of such physician shortage (i.e., is required to be on-call on those days that otherwise would have been covered by a locum), the physician shall be paid, in addition to the applicable on-call retainer or per diem, the same locum support payment ($150 per day at the signing of this Agreement) that otherwise would have been paid to a locum to provide the on-call coverage. Such additional payment shall not apply where the physician shortage is due to Continuing Medical Education or vacation leave.

C3.8 Hospital On-Call Response Fee

(a) A hospital On-Call Response Fee is intended to compensate on-call physicians for the disruption and inconvenience of having to respond emergently to the request of another physician or a charge nurse to provide service to a patient, which is not part of the on-call physician's normal routine, by returning to hospital after-hours (weekdays 18:00-08:00 and weekends/holidays 08:00-08:00).

(b) The hospital On-Call Response Fee for each clinical group shall be paid according to the fee code as listed in the Tariff of Fees, and shall qualify for weekend and holiday premiums as listed in the Preamble to the Tariff of Fees.

(c) This fee may be claimed only once per day on-call, and is payable in addition to the physician's usual On-Call Retainer Fee plus fee-for-service or On-Call Per Diem.

(d) For the purpose of this article, "hospital" is defined as: Queen Elizabeth Hospital, Prince County Hospital, Western Hospital, Community Hospital O'Leary, Stewart Memorial Hospital, Kings County Memorial Hospital, and Souris Hospital.

(e) Payment of this fee requires clear documentation on the patient's chart outlining the time the physician was called in, the nature of the patient's emergent problem and the medical necessity for the physician to be called back to personally attend to the patient. A comment is required on the claim identifying the patient seen, the person who requested the physician's return to hospital and the nature of the emergency.

(f) This fee is not payable if the physician has not been requested to return to hospital by another physician or a charge nurse, and is not payable if there is no medical necessity for the physician to attend to the request in person.

(g) For physicians such as obstetricians who remain on-site after-hours while on-call, this fee may be claimed only if called to personally attend to a patient's emergent problem.

C3.9 **Other Hospital Care Retention Payments**

(a) Each full-time fee-for-service Family Physician who maintains active medical staff privileges at either the Prince County Hospital or the Queen Elizabeth Hospital, and who participates in the provision of in-patient care shall receive an annual retention payment of $7,500.00, payable in equal biweekly installments. This retention payment shall be pro-rated for part-time physicians.

(b) Each full-time specialist in Internal Medicine who maintains active medical staff privileges at either the Prince County Hospital or the Queen Elizabeth Hospital, and who participates equitably in on-call coverage for a Critical Care Unit shall receive an annual retention payment of $36,400.00, payable in equal biweekly installments. This retention payment shall be pro-rated according to the proportion of Critical Care on-call coverage provided at each hospital.

An internist who provides more than his/her equal share of on-call coverage to a Critical Care Unit shall receive an additional retention payment in proportion to the additional days of on-call coverage that is provided by such physician in the event of a physician vacancy or vacancies which are not covered by a locum physician.

ARTICLE C4 - INDEPENDENT CONTRACTORS

C4.1 A physician who enters into a contract for services (ref. Appendix "B") with Health PEI (hereinafter an "independent contractor") shall be paid an hourly rate based upon the following calculation:

(a) Take the applicable annual salary for a similarly qualified General Practitioner or Specialist as set out in Article B18, add fifteen thousand dollars ($15,000) and divide the sum by 1,725.

Example: Specialist at Class III at April 1, 2010;

$222,832 + $15,000 = $237,832 divided by 1,725 = $137.87 per hour.

C4.2 In the event that an independent contractor's pre-existing contract for services provides for another hourly rate or other compensation that is greater than the hourly rate calculated by this article, such other hourly rate or other compensation shall continue to be payable by Health PEI until such time as the hourly rate calculated by this article is greater than the pre-existing hourly rate or other compensation.

C4.3 Excluding Specialists in Radiation Oncology, Medical Oncology or Laboratory Medicine, in addition to the applicable hourly rate of pay, an independent contractor shall be paid a clinical work incentive in accordance with Article C5.

C4.4 (a) Every contract for services entered into between an independent contractor and Health PEI shall set out maximum number of hours of work that are to be performed and remunerated under the contract for services.

(b) The physician shall submit a written invoice for actual hours worked on a monthly, quarterly or other period as may be specified in the contract for services, whereupon the Department shall pay the physician within thirty (30) days.

ARTICLE C5 - CLINICAL WORK INCENTIVE (Salary and Contract Physicians)

C5.1 Excluding specialists in Laboratory Medicine, Medical Oncology, and Radiation Oncology, in addition to the applicable salary or contract hourly rate of pay, salaried and contract physicians who are part of the approved complement shall be paid a clinical work incentive equal to a percentage of the value of their submitted and approved shadow billing claims that have a service date on or after the following dates:

Apr-01-2010	Oct-01-2012	Oct-01-2013	Oct-01-2014
10% or 22%	24%	26%	28%

C5.2 Effective April 1, 2010

(a) Where the total value of a physician's submitted and approved shadow billing claims is at least $18,750 per quarter ($75,000 per annum), pro-rated for part-time

physicians, the clinical work incentive shall equal 22% of the value of all submitted and approved shadow-billing claims for that three-month period.

(b) Where the total value of a physician's submitted and approved shadow billing claims is less than $18,750 per quarter ($75,000 per annum), pro-rated for part-time physicians, the clinical work incentive shall equal 10% of the value of all submitted and approved shadow-billing claims for that three-month period.

C5.3 Effective October 1, 2012

Payment of the clinical work incentive is contingent upon physicians meeting certain minimum expectations of a productive and efficient practice within their regular work hours. A productive and efficient practice is defined as the following (pro-rated for part-time physicians):

(a) Family Physicians other than those in salary Class IV as defined in Article B18.1

(i) $125,000 approved shadow billing amount per annum ($31,250 per quarter); and,
(ii) 3000 approved shadow billing claims per annum (750 per quarter)

(b) Family Physicians in salary Class IV as defined in Article B18.1

(i) $125,000 approved shadow billing amount per annum ($31,250 per quarter); and,
(ii) 200 initial consultation claims per annum (50 per quarter)

(c) Specialists - Category I
(Internal Medicine, Obstetrics, Pediatrics, Psychiatry, Physical Medicine)

(i) $160,000 approved shadow billing amount per annum ($40,000 per quarter); and,
(ii) 200 initial consultation claims per annum (50 per quarter)

(d) Specialists - Category II
(Dermatology, ENT, General Surgery, Plastic Surgery, Ophthalmology, Neurology)

(i) $160,000 approved shadow billing amount per annum ($40,000 per quarter); and,
(ii) 600 initial consultation claims per annum (150 per quarter)

C5.4 The thresholds set out above shall be pro-rated for physicians working part-time and those working greater than full-time hours (ie, overtime). Pro-ration shall exclude salaried/contract hours worked in a hospital where a top-up fee is paid instead of the usual Emergency Department or Hospitalist sessional fees.

C5.5 Physicians who meet the requisite threshold for a quarter shall be paid the clinical work incentive for that quarter. If a physician fails to meet the requisite threshold for a quarter, he/she shall not be paid the clinical work incentive for that quarter. However,

if the physician meets the annual thresholds, he/she shall be entitled to a reconsideration and reconciliation on the calendar year as a whole.

C5.6 Physicians working in Anesthesiology shall be entitled to the clinical work incentive without a requisite shadow-billing threshold.

C5.7 Physicians who have submitted all their shadow-billing claims for a quarter within 45 days following the end of that quarter shall be paid the amount owing within 90 days following the end of that quarter.

C5.8 The clinical work incentive shall not apply to locum physicians who are temporarily replacing a salaried or contract physician, but shall apply to long-term (6 months or more) locums.

ARTICLE C6 - LONG TERM CARE

C6.1 Each long term care facility in the province shall have a house physician. The house physician shall provide continuous coverage to the residents of the facility who do not have a personal physician. The house physician shall also provide service to residents who have a personal physician who cannot be reached. The house physician shall provide any required consulting services that the facility may require, including acting as a resource to committees of the facility.

C6.2 House Physicians shall be paid in the following manner:

(a) a standard administrative and on call fee per bed per annum (for providing twenty four (24) hour/seven (7) day per week coverage for each resident) of $300.00, effective April 1, 2010, based on the approved bed capacity of the Long Term Care Facility, to be paid in monthly installments (this amount includes provision for CME); and

(b) payment for medical services, either by

(i) fee-for-service, or

(ii) a standard medical services fee per bed per annum of $270.00, effective April 1, 2010, based on the approved bed capacity of the Long Term Care Facility, to be paid in monthly installments. If the House Physician elects this option, fee-for-service billing is not permitted, except for hospital inpatient services.

C6.3 (a) The long term care facilities and applicable bed counts are listed in Appendix “F”.

(b) The complexity and acuity level of patients (residents) in the Prince Edward Home (chronic under age 60 unit) and in the respite beds at the Sherwood Home

are greater as compared with the standard long term care facility. The bed count is therefore adjusted to recognize a weighting of 1.5 for each bed in the Prince Edward Home chronic under age 60 unit and the respite beds at Sherwood Home.

C6.4 It is the responsibility of the house physician, in consultation with the facility administration to ensure continuous call coverage.

C6.5 The contract for all Long Term Care Facility house physicians shall include the following (Ref. Appendix "C"):

- date/term of contract;
- identification of Health PEI as the contracting authority (or party responsible for supervising the clinical aspects at government facilities, or the Director of Nursing at private nursing homes);
- job description appended as a schedule to the contract;
- direct supervisor relative to LTC contracted responsibilities;
- if applicable, working hours , on-call rotation expectations, off-site response times;
- compensation in accordance with this Agreement;
- accountability and reporting requirements, i.e. shadow billing (not eligible for clinical work incentive), other reporting requirements as determined by management;
- ensuring continuous care coverage; and
- notice/termination requirements.

C6.6 Each house physician appointment is subject to an annual review conducted by the administration of the applicable Long Term Care Facility. The recruitment of a house physician or renewal of such physician's contract shall be the responsibility of the applicable Long Term Care Facility management. All such contracts shall be consistent with the provisions of this Agreement.

ARTICLE C7 - VISITING SPECIALISTS

C7.1 Eligible out of province Visiting Specialists shall be compensated as follows:

(a) Professional Fees

Options for payment modalities include the following:

(i) Fee-for-service, or
(ii) Sessional fee (fee code 9901), which is an hourly rate for clinical work.

The physician shall have the option to switch payment modalities once yearly

(b) Expense allowances for non-clinical time

(i) Reimbursement for air travel up to the full-fare economy rate (seven day advance booking is required); actual taxi costs and airport parking (receipts required); or

(ii) For use of a private vehicle per round trip from Halifax, Moncton or Saint John, reimbursement shall be in accordance with provincial travel allowance rates as determined from time to time by the Department of Finance and Municipal Affairs for provincial employees generally, plus reimbursement for the actual cost of road and bridge tolls;

(iii) For a visiting specialist who is required to provide a clinic in Summerside, reimbursement shall be in accordance with provincial travel allowance rates as determined from time to time by the Department of Finance and Municipal Affairs for provincial employees generally or reimbursement for a vehicle rental. Vehicle insurance is the visiting specialist's responsibility;

(iv) Reimbursement of $50.00 per hour shall be paid for actual travel time incurred between the visiting specialist's office and the Prince Edward Island work site.

(v) Reimbursement of required PEI licensure fees;

(vi) Reimbursement for accommodations shall be provided if pre-approved by Health PEI;

(vii) Reimbursement for meals as per Treasury Board out-of-province meal allowance; and

(viii) If allied health professionals accompany the Visiting Specialist, prior approval for travel and accommodation expenses must be obtained from the Executive Director of Medical Affairs or designate. Salaries of such allied health professionals shall not be covered by Health PEI.

ARTICLE C8 - CHIEF AND DEPUTY CHIEF HEALTH OFFICERS

C8.1 It is acknowledged that this Agreement applies to and covers physicians who provide services to the Government as the Chief Health Officer and/or the Deputy Chief Health Officer (the "Health Officer").

C8.2 Where the Health Officer is an employee, the annual salary (pro-rated for a part-time employee) shall be:

Apr-01-2010	Oct-01-2011	Oct-01-2012	Oct-01-2013	Oct-01-2014
$195,626	$199,147	$205,016	$210,884	$219,100

C8.3 Except for Article B18, Section B of this Agreement shall apply to a Health Officer who is an employee of the Department, subject to any pre-existing benefits that are greater than or in addition to the benefits provided under this Agreement.

C8.4 Subject to any pre-existing compensation (or reimbursement of expenses) that is greater than or in addition to the compensation provided under this Agreement, where the Health Officer is an independent contractor, compensation shall be in accordance with sub-article C4.1, summarized as follows:

April 1, 2010	($195,626 + $15,000)	divided by 1,725 hours	=	$122.10
October 1, 2011	($199,147 + $15,000)	divided by 1,725 hours	=	$124.14
October 1, 2012	($205,016 + $15,000)	divided by 1,725 hours	=	$127.55
October 1, 2013	($210,884 + $15,000)	divided by 1,725 hours	=	$130.95
October 1, 2014	($219,100 + $15,000)	divided by 1,725 hours	=	$135.71

C8.5 On-call compensation for a Health Officer shall be an on-call per diem of $325 (no fee-for-service).

ARTICLE C9 - HONORARIA

C9.1 An Honoraria program in accordance with Health PEI's honoraria policy, attached hereto as Appendix "J", shall continue, except that:

(a) Health PEI shall provide reimbursement directly to eligible physicians at the rate of one hundred and sixty ($160) dollars per hour, or part thereof in excess of fifteen (15) minutes, to a maximum of one thousand dollars ($1,000) per day;

(b) honoraria rates for the Chair of an approved committee shall be two hundred dollars ($200) per hour, or part thereof in excess of fifteen (15) minutes with a daily maximum of twelve hundred dollars ($1,200); and

(c) the Medical Society's Master Agreement Negotiating Committee is eligible for honoraria for actual time spent in negotiations with the Government Negotiating Team.

C9.2 Health PEI in issuing a payment to a physician shall indicate, with the payment, that it is made pursuant to the Master Agreement between the Department of Health and The Medical Society of Prince Edward Island.

C9.3 Health PEI shall provide a report to the Medical Society by March 31st of each year for the prior period ending December 31st detailing expenditure for honoraria including each physician's name, meetings attended and amount paid.

ARTICLE C10 - MEDICAL TRAINEE SPONSORSHIP

C10.1 Where a practicing physician in Prince Edward Island or a Resident in medical training applies to Health PEI for financial assistance to complete additional training in a specialty of need within the Provincial Physician Resource Plan, Health PEI agrees to consult with the Physician Resource Planning Committee before finalizing its decision on each application.

ARTICLE C11 - PARTIAL PAYMENT FOR PHYSICIANS OUTSIDE THE COMPLEMENT

C11.1 The Physician Resource Planning Committee makes recommendations to the Minister on the complement of each region, and the Medical Society acknowledges the Minister's authority to determine the complement of each region.

C11.2 Physicians in receipt of a billing number, on or after April 1, 1993, who are not part of the approved complement, shall be paid at 50% of the rates set out in the Tariff of Fees.

ARTICLE C12 - INTERNATIONAL CLASSIFICATION OF DISEASES CODING (ICD)

C12.1 Fee-for-service physicians utilize ICD-9 coding when submitting their claims to Health PEI. In the event that Health PEI requires physicians to utilize ICD-10 coding, Health PEI shall be responsible for the costs associated with having software vendors upgrade physicians' electronic billing software to conform to ICD-10 coding.

ARTICLE C13 - PATIENT ACCESS TO PHYSICIAN PROGRAM

C13.1 The goal of this program is to provide access to a family physician for those patients who are currently experiencing difficulty in obtaining a regular family physician.

C13.2 Health PEI shall provide a one-time fee of $150 each time that an eligible family physician accepts an eligible patient into his/her practice.

C13.3 For the purpose of this program, an "eligible patient" means a patient who is registered with the Provincial Patient Registry, excluding children under the age of six months whose custodial parent has a family physician.

C13.4 "Eligible Physician" means a physician who:

(a) is part of the provincial family physician complement,
(b) resides and carries on a family practice in Prince Edward Island,

(c) has and uses active hospital admitting and treatment privileges at a PEI hospital,
(d) has 1,200 or more active patients in his/her practice (pro-rated for a part-time physician), and/or
(e) has billed 4100 services (pro-rated for a part-time physician) annually from the following list of codes Monday - Friday between the hours of 8:00 am and 6:00 pm:

0100; 0103; 0105; 0110; 0112; 0113; 0115; 0118; 0121; 2228; 2229; 2230; 2231; 2501; 2502; 2505; 2507; and, 2508.

C13.5 For the purpose of this program, "active patient" means a patient who has received at least one medical service from an eligible physician in the previous 18-month period.

C13.6 For the purpose of determining ongoing eligibility under this program, the number of active patients and the number of applicable services shall be determined by Health PEI annually.

C13.7 When an eligible physician accepts an eligible patient into his/her practice, a patient-physician agreement must be entered into. The form and content of such agreement is attached as Appendix "H". The physician must submit a fully completed agreement each time this New Patient Fee is billed.

C13.8 The physician must provide the patient with at least one insured medical service in order to claim the New Patient Fee. No new patient fees shall be paid to a physician exceeding 2000 active patients unless given prior approval by Health PEI. Such approval shall be subject to a reasonable plan for access for patients, which may include use of alternate health care providers in a collaborative practice.

C13.9 Any patient who returns to the Provincial Patient Registry within 12 months of payment of a New Patient Fee shall trigger a recovery of the New Patient Fee. If the physician ceases practice within the province, or ceases to provide care for the new patient, within 12 months of claiming the New Patient Fee, the New Patient Fee must be repaid to Health PEI and may be set-off against other remuneration due to the physician.

C13.10 Family physicians who are paid under salary, contract, or fee-for-service are eligible and can retain 100% of the fee code. Locum physicians are not eligible for this program.

C13.11 Health PEI and the Medical Society shall review this program no later than January, 2013.

ARTICLE C14 - COLLABORATIVE FAMILY PRACTICE INCENTIVE PROGRAM

C14.1 Health PEI shall provide funding to the following maximum amounts for a Collaborative Family Practice Incentive Program for Family Physicians who collaborate with other practicing licensed health care professionals:

Year	Incremental New Funding	Cumulative New Funding
April 1, 2012 - March 31, 2013	$250,000	$250,000
April 1, 2013 - March 31, 2014	$100,000	$350,000
April 1, 2014 - March 31, 2015	$100,000	$450,000

C14.2 The goal of this program is to improve patient access to primary health care providers in the patient's Primary Health Care Network. Under this program:

(a) Family Physicians, regardless of usual payment modality, who have an approved plan to collaborate with other Family Physicians to ensure their patients have timely access to a physician and that medical services are provided to their patients when they are admitted to hospital will receive an incentive payment of $5,000 per year, paid in equal biweekly installments; and

(b) Family Physicians, regardless of usual payment modality, who have an approved plan to collaborate with other licensed health care professionals working in their Primary Health Care Network will receive an incentive payment of $5,000 per year, paid in equal biweekly installments.

(c) A locum physician is not eligible for incentive payments under this program.

(d) Applications for participation in this program shall be submitted to the Executive Director of Community Hospitals and Primary Care for approval, which shall include:

(i) the name of each physician who will participate in the collaborative group;
(ii) the locations of the included practices;
(iii) an operational plan for providing patients with timely access to their primary health care provider; and
(iv) if applicable, a plan to improve the health of the group's patients through collaboration with other licensed health care providers in the Primary Health Care Network.

C14.3 Health PEI shall provide a copy of each Collaborative Family Practice Agreement to the Medical Society.

C14.4. The Joint Consultation Committee shall review this program in the summer of 2014 and shall determine the use of any unspent funds in a manner that will meet the goal of this program.

SECTION D - NON-CLINICAL PROGRAM FUNDING

ARTICLE D1 - PHYSICIAN RETENTION PROGRAM

D1.1 A Physician Retention Program is established, effective October 1, 2012, in an effort to enhance the stability of physician services throughout the provincial health care system.

D1.2 On October 15th of each fiscal year, Health PEI shall remit to the Medical Society the sum of $500,000.

D1.3 On or before December 31st of each year after the establishment of this program, the Medical Society shall use this funding to pay an annual retention incentive of $2,000 to each eligible physician.

D1.4 An eligible physician is a physician who, as of December 31st of the previous calendar year has been an ordinary member of the Medical Society for the previous five years and received remuneration under the provisions of this Agreement, and who

(a) has been engaged to provide service by either Health PEI or the Government; and

(b) receives at least $20,000 in remuneration under this Agreement in the current calandar year.

D1.5 In consultation with the Joint Consultation Committee, the Medical Society shall be required to expend all the remaining funding for this program by increasing the otherwise approved retention incentive to eligible physicians.

D1.6 Within six (6) months following the Medical Society's fiscal year end, the Medical Society shall provide the following information to Health PEI:

(a) an audited report of actual expenditures for this program; and

(b) an annual report indicating the names of the physicians, by specialty, who received a payment under this program.

ARTICLE D2 - CMPA ASSISTANCE

D2.1 A rebate program in respect of Canadian Medical Protective Association ("CMPA") membership dues or other professional malpractice liability insurance premiums shall be continued for the duration of this Agreement and shall be administered by the Medical Society.

D2.2 Funding provided by Health PEI to the Medical Society for the purpose of the rebate program shall be used by the Medical Society to help offset the cost of CMPA membership dues or professional malpractice liability insurance premiums paid by physicians.

D2.3 Where a physician is not a CMPA member, the physician shall at all times hold a valid certificate of professional malpractice liability insurance with coverage of not less than $5,000,000 per claim.

D2.4 Health PEI shall provide annual funding to the Medical Society in the amounts of $600,000.

On April 15th and October 15th of each fiscal year, Health PEI shall pay the Medical Society the amount of $300,000.

D2.5 (a) Every member of the Medical Society, including locums, covered by this Master Agreement shall be entitled to participate in the rebate program. A physician shall be responsible for the first $1,000 of annual CMPA dues or insurance premiums. The difference between annual CMPA dues or insurance premiums and $1,000 shall be rebated by the Medical Society, subject to proration based upon the actual number of months in practice on PEI. In the case of a locum physician, the first $1,000 of CMPA dues or insurance premiums shall also be subject to such proration.

(b) Notwithstanding Article D2.5(a), the amount to be reimbursed by the Medical Society for professional malpractice liability insurance provided by another carrier (non-CMPA) shall not exceed the amount the physician would have been eligible for had the physician been enrolled in CMPA.

(c) Effective with the signing of this Agreement, the Medical Society shall provide an interim statement to Health PEI on August 15th and February 15th of each year, of the payments to be made to each physician. The Medical Society shall ensure that each physician is reimbursed for the rate class appropriate to each physician's actual provision of services on PEI. Prior to any payments being made, Health PEI will review the interim statement and inform the Medical Society within thirty (30) days of any rate class adjustments that may be required.

D2.6 The Medical Society shall provide Health PEI with a written statement detailing the distribution of the rebate program funds, including accumulated interest, administration fees and accumulated surplus, if any, by April 30th of each year for the immediately preceding calendar year.

D2.7 All program funds and investment interest earned thereon, if any, shall be held in trust by the Medical Society and used for the purpose set out in this article. Notwithstanding the foregoing the Medical Society shall have the right to deduct from rebate program

funds and retain an administration fee calculated as two per cent (2%) of the specific funding provided in sub-article D2.4.

D2.8 In the event that the rebate program experiences an accumulated surplus as at April 30, 2015, such surplus shall become the initial funding available to the Medical Society for the purpose of the rebate program in 2015/16.

D2.9 Where during the term of this Agreement additional physicians are added to the complement and commence practice on PEI, or locum physicians commence practice on PEI, CMPA dues or insurance premiums shall be rebated pursuant to sub-article D2.5. In the event that the "Trust Fund" does not have sufficient resources to meet the expenditures for CMPA dues or insurance premiums, Health PEI shall, on receipt of a detailed statement on April 30th and October 31st of each fiscal year by the Medical Society, provide additional funding to cover the shortfall.

ARTICLE D3 - CME AND CLINICAL SKILLS UPGRADE

Continuing Medical Education

D3.1 A Continuing Medical Education (CME) program shall be continued for the duration of this Agreement and shall be administered by the Medical Society.

D3.2 Health PEI shall provide annual dedicated funding to the Medical Society in the amounts of $140,000.

On April 15th and October 15th of each fiscal year, Health PEI shall pay the Medical Society $70,000.

D3.3 In the event that the funds provided are not expended, to a maximum of $10,000 in any one year, the unspent funds shall be carried forward by the Medical Society and applied to the program in the following year and shall be in addition to the specific funding provided in sub-article D3.2.

D3.4 Subject to the maximum of amount that may be carried forward and in consultation with the Joint Consultation Committee, the Medical Society shall be required to expend all other funding for this program by increasing the otherwise approved annual reimbursement to eligible physicians for CME expenses.

Clinical Skills Upgrade

D3.5 A Clinical Skills Upgrade Fund shall be continued for duration of this Agreement and shall be administered by the Medical Society.

D3.6 Health PEI shall provide dedicated annual funding to the Medical Society in the amounts of $30,000.

Health PEI shall pay the Medical Society the amount payable by April 15th of each fiscal year.

D3.7 In the event that the funds provided are not expended in any one year the unspent funds shall be carried forward by the Medical Society and applied to the program in the following year and shall be in addition to the specific funding provided in sub-article D3.6. If the unspent funds from year to year accumulate, the Medical Society may transfer any amount in excess of $30,000 to another support or benefit program under this Agreement, and shall advise the Joint Consultation Committee of such transfer.

Budgeting and Reporting requirements

D3.8 The Medical Society's CME Management Committee shall propose an annual CME and Clinical Skills Upgrade budget for prior approval by the Joint Consultation Committee. The budget shall include an amount for program administration not to exceed $40,000 per year.

D3.9 The Medical Society shall provide the following information to Health PEI:

(a) no later than November 15th of each year, an itemized annual budget indicating projected expenditures under the CME and Clinical Skills Upgrade programs;

(b) within six (6) months following the Medical Society's fiscal year end, an audited report of actual CME and Clinical Skills Upgrade program receipts and expenditures; and

(c) within six (6) months following the Medical Society's fiscal year end, an annual report indicating the number of physicians by specialty who participated in individual educational events funded under these programs.

ARTICLE D4 - SUMMER PROGRAM FOR MEDICAL STUDENTS

D4.1 The parties agree that the Medical Society's existing policy regarding support for the program for summer medical students shall continue. On May 1st of each fiscal year Health PEI shall pay to the Medical Society $40,000.

The maximum funding per student shall not exceed $8,000 for a 10-week period.

D4.2 The Medical Society shall provide a report to Health PEI by December 31st of each year for the year in which the program occurred, which provides:

(a) a summary of expenditures for support to each medical student;

(b) a summary of evaluations by medical students on their work experiences.

D4.3 In the event that the funds provided are not expended in any one year the balance shall be carried forward and applied to the program in the following year and shall be in addition to the specific funding provided in Article D4.1

D4.4 All interest earned on the Summer Program for Medical Students funds invested by the Medical Society shall be held in trust and used for the purpose set out in this article. Notwithstanding the foregoing the Medical Society shall have the right to deduct from rebate program funds and retain an administration fee calculated as two per cent (2%) of the funding amount provided by Health PEI in each fiscal year as per sub-article D4.1.

ARTICLE D5 - MD SUPPORT PROGRAM

D5.1 The parties agree that the Medical Society's existing program regarding assistance for physicians who are developing or experiencing difficulty n their professional or private lives shall continue. On May 1st of each fiscal year Health PEI shall pay to the Medical Society $7,385 each year.

D5.2 In the event that the funds provided are not expended in any one year the unspent funds shall be carried forward by the Medical Society and applied to the program in the following year and shall be in addition to the specific funding provided in sub-article D5.1. If the unspent funds from year to year accumulate, the Medical Society may transfer any amount in excess of $7,385 to another support or benefit program under this Agreement, and shall advise the Joint Consultation Committee of such transfer.

D5.3 All program funds and investment interest earned thereon, if any, shall be held in trust by the Medical Society and used for the purposes set out in this article. Notwithstanding the foregoing the Medical Society shall have the right to deduct from such program funds and retain an administration fee calculated as two per cent (2%) of the specific funding provided in sub-article D5.1.

D5.4 The Medical Society shall provide a confidential verbal report on the program to the Executive Director of Medical Affairs upon request from time to time.

ARTICLE D6 - MATERNITY/PARENTAL BENEFITS PROGRAM

D6.1 A Maternity/Parental Benefits Program shall be continued for the duration of this Agreement to provide partial income replacement for a physician parent who takes a temporary leave from practice in Prince Edward Island in relation to the birth/adoption of their child.

D6.2 Fee-for-service and alternate funded physicians shall be eligible for the program, which shall be designed and administered by the Medical Society generally in accordance

with the program described in Appendix "I" but subject to the specific criteria to be determined by the Medical Society,

D6.3 On May 1st of each fiscal year Health PEI shall fund the program by paying to the Medical Society $61,200 each year.

D6.4 In the event that the funds provided are not expended in any one year the unspent funds shall be carried forward by the Medical Society and applied to the program in the following year and shall be in addition to the specific funding provided in sub-article D6.3. If the unspent funds from year to year accumulate, the Medical Society may transfer any amount in excess of $61,200 to another support or benefit program under this Agreement, and shall advise the Joint Consultation Committee of such transfer.

D6.5 All program funds and investment interest earned thereon, if any, shall be held in trust by the Medical Society and used for the purposes set out in this article. Notwithstanding the foregoing the Medical Society shall have the right to deduct from such program funds and retain an administration fee calculated as two per cent (2%) of the specific funding provided in sub-article D6.3.

D6.6 The Medical Society shall provide a report to Health PEI by December 31st of each year for the year in which the program occurred which includes a summary of expenditures for each eligible physician.

IN WITNESS WHEREOF the parties have executed this Agreement by affixing hereto the signatures of their proper officers in that behalf.

DATED at Charlottetown, Prince Edward Island, this 14th day of December 2011.

On behalf of the Government
of the Province of Prince Edward Island

Witness

Hon. Doug Currie
Minister of Health and Wellness

On behalf of Health PEI

Witness

Chief Executive Officer

On behalf of the Medical Society
of the Province of Prince Edward Island

Witness

President

MEMORANDUM OF AGREEMENT

CHIEF CORONER AND DEPUTY CHIEF CORONER

Memorandum of Agreement

Between

The Office of the Attorney General

and

The Medical Society of PEI

This is to acknowledge that this Agreement applies to and covers physicians who provide services to the Government as Chief Coroner and Deputy Chief Coroner.

Effective October 1, 2010, the Chief Coroner shall be paid an annual stipend of $58,000.

The Coroner's Office shall provide on-call services to both the Eastern and Western regions of the province 24 hours per day 7 days per week. Remuneration for on-call coverage shall be $150.00 per day for each region.

APPENDIX A

CONTRACT OF EMPLOYMENT - SALARIED PHYSICIAN

THIS AGREEMENT MADE

BETWEEN: **Dr._____**

(the "Physician")

- and -

Health PEI

(the "Employer")

IN consideration of the covenants and conditions herein contained, the parties hereto agree that the Physician shall be employed upon the following basis.

1. The Physician shall assume all those responsibilities and diligently execute all those duties set out in the Job Description attached hereto.

2. The term of this employment shall be for continuous years, commencing on _____ subject to on-going satisfactory performance, and include an initial six-month period of probation.

3. The Physician shall be paid at salary class _____ on the basis of a 37.5 hour work week, performed between the hours of 8:00 a.m. and 8:00 p.m., at an annual salary before deductions as identified by the Master Agreement between the Medical Society of Prince Edward Island (the "Medical Society") and Health PEI (hereinafter the "Master Agreement"). Such salary shall be paid for the probationary period and shall be increased in accordance with the provisions of the Master Agreement.

4. The Employer shall make deductions from salary payable to the Physician as outlined in the Master Agreement and as required by any provincial or federal statute.

5. The Physician is entitled to an annual maximum of _____ weeks vacation leave as set out in the Master Agreement.

6. The Physician is entitled to the benefits listed below, in accordance with the Master Agreement, including but not limited to:

- Special Leave
- Sick Leave
- Statutory Holidays
- RRSP/Pension Plan contribution
- Long-Term Disability
- Health and Dental Plan
- Life Insurance
- Deferred Salary Plan
- Continuing Medical Education

7. The Physician certifies and agrees to provide written verification prior to execution of this Agreement that he/she is registered and licensed with the College of Physicians and Surgeons of PEI and is a member of the Medical Society.

8. Pursuant to the Master Agreement, the Physician shall:

   (a) agree to maintain active membership with the Canadian Medical Protective Association (CMPA) at his/her own expense. Acceptance by the Employer of such membership shall not be construed as a waiver of any conditions of this Agreement. The Physician shall provide the Employer with written evidence of CMPA membership;

   (b) agree to notify the Employer of any changes in CMPA membership;

   (c) participate equitably, including weekends and holidays, in an on-call schedule with individual commitment to be not more frequently than averaging a 1-in-3 call schedule (122 days/year);

   (d) co-operate in the development of an on-call/vacation schedule to be developed by the Physician and the Employer, and paid according to the provisions of the Master Agreement. The on-call obligation is detailed in the Job Description attached hereto; and

   (e) maintain active hospital privileges.

9. A professional work site and adequate support staff for regularly scheduled salaried hours of work shall be arranged by the Employer at no cost to the Physician.

10. The Physician shall participate in a shadow billing process as determined by Health PEI for the purpose of recording and monitoring patient care service activity at no cost to the Physician.

11. The Physician is subject to an annual performance review pursuant to the provisions of the Master Agreement.

12. The parties hereto are bound by the Master Agreement in effect from time to time between the Health PEI and the Medical Society and, in the event of a conflict between this or any other contract and the Master Agreement, the latter shall prevail.

13. The Employer recognizes the Medical Society as the sole and exclusive bargaining agent for all of its members who are engaged in the practice of medicine, including the Physician named herein.

14. The Employer acknowledges that the Physician is entitled to receive independent advice from the Medical Society. The Employer shall notify the Medical Society that it intends to make an offer of employment to the Physician, and the Employer shall make full disclosure of such offer to the Medical Society.

15. As an employee of the Employer, the Physician agrees to support and participate in planning that is aligned with the Health System Strategic Plans. This general obligation shall not limit the Physician's freedom of expression as an advocate for optimal patient care and for what the Physician believes to be in the best interest of the public health care system. It is further acknowledged that where the Physician is acting in the capacity of representative of his/her peers, such as but not limited to President of the Medical Staff, Chief of Staff, etc., the Physician shall have the right to express the views and concerns of physicians with respect to Health System Strategic Planning.

16. The Physician shall familiarize himself/herself with the content of the Employer's personnel policies and guidelines, and participate in training opportunities in relation thereto when offered by the Employer.

17. (a) In the event the Physician wishes to terminate this contract, he/she shall provide as much advance notice as is possible. In no case shall the notice be less than eight (8) weeks.
    (b) If the Employer wishes to terminate this contract, without cause, the Employer shall provide eight (8) weeks notice or pay in lieu thereof to the Physician.
    (c) The Employer shall be entitled to terminate this contract with just cause without notice.
    (d) Notice shall be deemed to have been given on the day of delivery in person, by facsimile, electronic communication, or on the mailing date of the notice, as the case may be.

IN WITNESS WHEREOF the parties hereto have executed this contract on the dates set out below.

SIGNED AND DELIVERED
in the presence of:

_____	_____	_____
WITNESS	**Physician**	DATE
_____	_____	_____
WITNESS	**Employer**	DATE

APPENDIX B

CONTRACT FOR SERVICES

THIS CONTRACT MADE

BETWEEN: **Dr._____**

(the "Physician")

- and -

Health PEI

WHEREAS Health PEI requires the services of the Physician to carry out the work described in Schedule "A" attached hereto;

AND WHEREAS the Physician has agreed to provide Health PEI with these services on certain terms and conditions;

NOW THEREFORE the parties agree that the terms and conditions of their business relationship are as follows:

INTERPRETATION

1. In this contract,

   "Master Agreement" means the Agreement entered into from time to time between Health PEI and the Medical Society of Prince Edward Island (the "Medical Society").

TERM

2. The term of this Contract shall commence on _____ and shall remain in effect until _____ unless earlier terminated in accordance with articles 17, 18 and 19 or extended by mutual agreement between the parties in writing.

SERVICES

3. The Physician shall perform the services, assume all those responsibilities and diligently execute all those duties described in Schedule "A" in a manner satisfactory to Health PEI.

4. If at any time during the term of this contract the Physician cannot perform any of the services described in Schedule "A", he/she shall notify Health PEI immediately.

5. The Physician shall apply for and maintain admitting privileges to the Prince Edward Island hospital(s) in which he/she may be required to perform services and Health PEI may require the Physician to provide in-patient care for his/her patients.

6. The Physician shall participate equitably, including weekends and holidays, in an on-call schedule for family physician/specialty services with individual commitment to be not more frequently than averaging a 1 in 3 call schedule (122 days/year). The Physician shall cooperate in the development of an on-call/vacation schedule to be developed by the Physician and Health PEI. Compensation for on-call services shall be in accordance with the Master Agreement.

7. The Physician shall, at no cost to the Physician, participate in a shadow billing process determined by Health PEI for the purpose of recording and monitoring patient care service activity.

8. Where the work is to be performed in Health PEI offices, the Physician for better co-ordination shall follow the same time schedule as applicable to employees of Health PEI, unless mutually agreed otherwise. Scheduling of the Physician's services, which require the assistance of Health PEI employees outside established regular working hours, requires prior agreement between the Physician and Health PEI.

9. Health PEI shall provide such support, direction, decisions and information as it deems necessary or appropriate under this contract, and may appoint a person to administer this contract.

ACCOUNTS AND PAYMENTS

10. The Physician shall be paid by Health PEI in accordance with the Master Agreement, in the following manner:

    (a) An hourly rate of $_____ as determined by Article C4 of the Master Agreement, for _____ hours of work each week;

    (b) Invoices for services rendered under this Agreement shall be submitted to the Physicians's respective Medical Director, or designate, for the hours worked during each bi-weekly period;

(c) Payment shall be made bi-weekly upon the receipt of invoices which have been authorized for payment by the Medical Director; and

(d) The Physician's aggregate compensation shall be determined by the applicable hourly rate/hours worked, clinical work incentive, on-call service coverage and other services the Physician may agree to provide from time to time.

INDEPENDENT CONTRACTOR

11. The Physician is an independent contractor and he/she is entitled to no other benefits or payment whatsoever other than those specified in this contract and the Master Agreement.

12. This contract does not create the relationship of employer and employee, or of principal and agent, between Health PEI and the Physician. The Physician shall have no authority to assume or create any obligation in the name of Health PEI, nor to bind Health PEI, in any manner unless such authorization is granted by Health PEI.

13. The physician shall be solely responsible for all deductions, taxes and remittances, and without limiting the generality of the foregoing, shall be responsible for all taxes and remittances payable to the Canada Revenue Agency. Any costs or expenses incurred by the Physician in complying with this article shall be borne by the Physician as a cost of doing business.

14. The Physician shall comply with all federal and provincial laws, which may have application to the services he/she performs under this contract.

LIABILITY AND INDEMNIFICATION

15. The Physician certifies and shall provide written verification prior to execution of this contract, that he/she is registered and licensed with the College of Physicians and Surgeons of PEI and is a member of the Medical Society.

16. The Physician shall:

(a) maintain active membership with the Canadian Medical Protective Association (CMPA) at his/her own expense. Acceptance by Health PEI of such membership shall not be construed as a waiver of any conditions of this contract. The Physician shall provide Health PEI with written evidence of CMPA membership;

(b) notify Health PEI of any changes in CMPA membership; and

(c) be solely responsible for any omission or negligent act of the Physician, and shall save harmless and indemnify Health PEI from and against all claims, liabilities, demands, actions, losses, expenses, costs or damages which Health PEI may suffer as a result of the negligence of the Physician in the performance or non-

performance of the services or the breach by the Physician of any material representation or condition of this contract, except to the extent that the Physician is performing administrative duties for Health PEI pursuant to this contract.

TERMINATION

17. If the Physician wishes to terminate this contract prior to its expiry date, he/she shall provide as much advance notice as is possible. In no case shall the notice be less than eight (8) weeks, unless otherwise agreed upon in writing at the time of signing of this contract.

18. If Health PEI wishes to terminate this contract prior to its expiry date, Health PEI shall provide eight (8) weeks of notice, or pay in lieu thereof to the Physician.

19. Health PEI may terminate this contract in writing without prior notice, if:

    (a) Health PEI reasonably believes that the Physician's conduct may threaten the safety of patients or staff;
    (b) the Physician becomes incapable of providing the services for any reason;
    (c) the Physician is convicted of an indictable offence;
    (d) the Physician fails to hold a valid licence from the College of Physicians and Surgeons of PEI to practice medicine, or is found guilty of professional misconduct by the College; or
    (e) the Physician fails to maintain liability/malpractice coverage with the Canadian Medical Protective Association or equivalent coverage with an insurance carrier satisfactory to Health PEI.

20. Notice shall be deemed to have been given on the day of delivery in person, by facsimile, electronic communication, or on the mailing date of the notice, as the case may be.

GENERAL

21. This contract shall not be assigned or subcontracted in whole or in part by the Physician without the prior written consent of Health PEI.

22. This contract shall be interpreted and applied in accordance with the laws and in the courts of the Province of Prince Edward Island.

23. This contract, including Schedule "A", constitutes and expresses the entire agreement between the parties hereto, and any amendment or addition thereto shall be in writing and signed by the respective parties.

24. The parties hereto are bound by the Master Agreement in effect from time to time between Health PEI and the Medical Society, and in the event of a conflict between this or any other contract and the Master Agreement, the latter shall prevail.

25. Health PEI recognizes the Medical Society as the sole and exclusive bargaining agent for all of its members who are engaged in the practice of medicine, including the Physician named herein.

26. Health PEI acknowledges that the Physician is entitled to receive independent advice from the Medical Society. Health PEI shall notify the Medical Society that it intends to enter into a contract for services with the Physician, and Health PEI shall make full disclosure of such contract to the Medical Society.

27. The headings are inserted in this contract for reference only and shall not form part of the contract.

IN WITNESS WHEREOF the parties hereto have executed this contract on the dates set out below.

SIGNED AND DELIVERED
in the presence of:

Witness	Physician	Date
Witness	Health PEI	Date

APPENDIX C

CONTRACT FOR SERVICES: LONG TERM CARE

THIS CONTRACT MADE

BETWEEN: **Dr._____**

(the " House Physician")

- and -

Health PEI

WHEREAS Health PEI requires the services of the House Physician to provide medical services to residents and advice to staff of the _____Long Term Care Facility;

AND WHEREAS the House Physician has agreed to provide Health PEI with these services on certain terms and conditions;

NOW THEREFORE the parties agree that the terms and conditions of their business relationship are as follows:

INTERPRETATION

1. In this contract,

   "Master Agreement" means the Agreement entered into from time to time between the Health PEI and the Medical Society of Prince Edward Island (the "Medical Society").

TERM

2. The term of this Contract shall commence on _____ and shall remain in effect until _____ unless earlier terminated in accordance with articles 17, 18 or 19, or extended by mutual agreement between the parties in writing.

SERVICES

3. The House Physician shall undertake the responsibility and diligently provide the services described in Schedule "A" attached hereto.

4. The House Physician shall provide continuous coverage to the residents of the Long Term Care Facility who do not have a personal physician, and also to residents who have a personal physician who cannot be reached or is otherwise unavailable.

5. The House Physician shall provide any required consulting services that the Long Term Care Facility may require, including acting as a resource to committees of the Facility and for ongoing resident medication reviews.

6. If at any time during the term of this contract the House Physician cannot perform any of the services described in Schedule "A", he/she shall notify Health PEI immediately and arrange for a replacement House Physician to perform the services. Where a House Physician has selected the option of a standard medical services fee (in lieu of the fee-for-service payment option) as set out in the Master Agreement, he/she shall continue to receive this payment during periods of his/her absence, and shall be solely responsible for paying the replacement House Physician for all services rendered. Where a House Physician has selected the fee-for-service payment option, the replacement House Physician shall also be paid on a fee-for-service basis.

7. Where a House Physician selects the option of a standard medical services fee (in lieu of fee-for-service) as set out in the Master Agreement, the physician shall participate in a shadow billing process determined by Health PEI for the purpose of recording and monitoring patient care service activity at the physician's expense.

8. Health PEI shall provide such support, direction, decisions and information as it deems necessary or appropriate under this contract, and shall appoint a person to administer this contract. Services provided under this contract are subject to an annual review.

ACCOUNTS AND PAYMENTS

9. The House Physician shall be paid by the Department in accordance with Article C1 of the Master Agreement, in the following manner:

   (a) a standard administrative and on call fee per bed per annum (for providing twenty four (24) hour/seven (7) day per week coverage for each resident) of $300.00 effective April 1, 2010, based on the approved bed capacity of the Long Term Care Facility, to be paid in monthly installments, (this amount includes provision for CME); and

   (b) payment for medical services, either by
      (i) fee-for-service, or

(ii) a standard medical services fee per bed per annum of $270.00 effective April 1, 2010, based on the approved bed capacity of the Long Term Care Facility, to be paid in monthly installments. If the House Physician elects this option, fee-for-service billing is not permitted, except for hospital inpatient services.

10. In the case of private nursing homes located outside of the municipality of the House Physician, he/she may seek remuneration for travel costs and travel time from the private Long Term Care Facility based on the Medical Society's guidelines for uninsured services.

INDEPENDENT CONTRACTOR

11. The House Physician is an independent contractor and he/she is entitled to no other benefits or payment whatsoever other than those specified in this contract and the Master Agreement.

12. This contract does not create the relationship of employer and employee, or of principal and agent, between Health PEI and the House Physician. The House Physician shall have no authority to assume or create any obligation in the name of Health PEI, nor to bind Health PEI, in any manner unless such authorization is granted by Health PEI.

13. The House Physician shall be solely responsible for all deductions, taxes and remittances, and without limiting the generality of the foregoing, shall be responsible for all taxes and remittances payable to the Canada Revenue Agency. Any costs or expenses incurred by the House Physician in complying with this article shall be borne by the House Physician as a cost of doing business.

14. The House Physician shall comply with all federal and provincial laws, which may have application to the services he/she performs under this contract.

LIABILITY AND INDEMNIFICATION

15. The House Physician certifies and shall provide written verification prior to execution of this contract that he/she is registered and licensed with the College of Physicians and Surgeons of PEI and is a member of the Medical Society.

16. The House Physician shall:

    (a) maintain active membership with the Canadian Medical Protective Association (CMPA) at his/her own expense. Acceptance by Health PEI of such membership shall not be construed as a waiver of any conditions of this contract. The House Physician shall provide Health PEI with written evidence of CMPA membership;

(b) notify Health PEI of any changes in CMPA membership; and

be solely responsible for any omission or negligent act of the House Physician, and shall save harmless and indemnify Health PEI from and against all claims, liabilities, demands, actions, losses, expenses, costs or damages which Health PEI may suffer as a result of the negligence of the House Physician in the performance or non-performance of the services or the breach by the House Physician of any material representation or condition of this contract, except to the extent that the House Physician is performing administrative duties for Health PEI pursuant to this contract.

TERMINATION

17. If the House Physician wishes to terminate this Contract prior to its expiry date, he/she shall provide as much advance notice as is possible. In no case shall the notice be less than eight (8) weeks, unless otherwise agreed upon in writing at the time of signing of this contract.

18. If Health PEI wishes to terminate this Contract prior to its expiry date, Health PEI shall provide eight (8) weeks of notice, or pay in lieu thereof to the House Physician.

19. Health PEI may terminate this contract in writing without prior notice, if:

    (a) Health PEI reasonably believes that the Physician's conduct may threaten the safety of patients or staff;
    (b) the Physician becomes incapable of providing the services for any reason;
    (c) the Physician is convicted of an indictable offence;
    (d) the Physician fails to hold a valid licence from the College of Physicians and Surgeons of PEI to practice medicine, or is found guilty of professional misconduct by the College; or
    (e) the Physician fails to maintain liability/malpractice coverage with the Canadian Medical Protective Association or equivalent coverage with an insurance carrier satisfactory to Health PEI.

20. Notice shall be deemed to have been given on the day of delivery in person, by facsimile, electronic communication, or on the mailing date of the notice, as the case may be.

GENERAL

21. Notwithstanding the provisions of Article 6, this Contract shall not be assigned or subcontracted in whole or in part by the House Physician without the prior written consent of Health PEI.

22. This Contract shall be interpreted and applied in accordance with the laws and in the courts of the Province of Prince Edward Island.

23. This Contract, including Schedule "A", constitutes and expresses the entire agreement between the parties hereto, and any amendment or addition thereto shall be in writing and signed by the respective parties.

24. The parties hereto are bound by the Master Agreement in effect from time to time between Health PEI and the Medical Society, and in the event of a conflict between this or any other contract and the Master Agreement, the latter shall prevail.

25. Health PEI recognizes the Medical Society as the sole and exclusive bargaining agent for all of its members who are engaged in the practice of medicine, including the House Physician named herein.

26. Health PEI acknowledges that the House Physician is entitled to receive independent advice from the Medical Society. Health PEI shall notify the Medical Society that it intends to enter into a contract for services with the House Physician, and Health PEI shall make full disclosure of such contract to the Medical Society.

27. The headings are inserted in this contract for reference only and shall not form part of the contract.

IN WITNESS WHEREOF the parties hereto have executed this contract on the dates set out below.

SIGNED AND DELIVERED
in the presence of

_____	_____	_____
Witness	House Physician	Date
_____	_____	_____
Witness	Health PEI	Date

SCHEDULE "A"

The House Physician's responsibilities shall be to:

a) provide twenty-four hour, seven days a week, "on call" coverage to the _____ _____ (name of facility);

b) provide a minimum average of one visit per week per facility;

c) maintain medical records on all residents/patients under his/her care in keeping with established standards;

d) notify the Chief Health Officer or his delegate of discovery of any communicable disease of which notice must be given under the Public Health Act and regulations;

e) perform a complete physical examination and medical history documentation on admission; thereafter, an annual physical examination would be required unless it is otherwise identified as not warranted; appropriate medical forms must be completed;

f) provide medical services when urgently required for residents with other attending physicians who are not available and have provided no alternate coverage;

g) provide consultation services when required by other attending physicians and collaborate with health care/community agencies (Acute Care, Mental Health, Home Care, Social Services, Pastoral Care, Addiction Services and Island Hospice Association, etc) in coordinating resident/patient care;

h) be involved in a multi disciplinary team approach to the development of and regular evaluation of resident/patient care plans;

i) perform weekly rounds, assess resident care issues, and provide medical services as required/requested;

j) provide advice regarding such things as stocked medications, narcotics, communicable diseases, and general public health issues such as flu shots, behavioral problem management, visitors;

k) evaluate and assess resident/patient drug profiles at least every three months;

l) comply with established standards of practice for geriatric care and long-term medical care, including those outlined by Accreditation Canada; and

m) ensure that a replacement physician acceptable to the facility is available.

NOTE: Any compensation for exceptional travel time or mileage shall remain the responsibility of the facility requiring the service.

APPENDIX D

EMERGENCY SERVICE COVERAGE AGREEMENT

THIS AGREEMENT dated the _____day of _____, 20__

BETWEEN:

Health PEI

-and-

_____
(all of the above Emergency Department Physicians,
any additions thereto or any deletions therefrom from time to time
are collectively known as the "Group")

THE PARTIES hereto agree as follows:

ARTICLE 1 - DURATION OF AGREEMENT

1.1 This Agreement shall be effective for the period from _____, 20__ to March 31, 20__, and shall remain in force and effect during the period of negotiation, mediation or interest arbitration carried out to achieve a new agreement.

1.2 Any Emergency Department Physician may withdraw from the Group and from this Agreement by giving ninety (90) days written notice of such withdrawal to the other members of the Group and to Health PEI.

ARTICLE 2 - SERVICES AND COMPENSATION

2.1 The Group shall provide 24-hour emergency medical coverage at the _____ Hospital in _____ in accordance with the rules and regulations of the Department of Emergency Medicine.

2.2 The Group and Health PEI shall be jointly responsible for maintaining and when necessary, recruiting physicians to fill the complement as approved by the Minister on recommendation by the Physician Resource Planning Committee. A new physician shall be mutually acceptable to both the Group and Health PEI.

2.3 It is acknowledged that the parties are bound by the Master Agreement entered into from time to time between the Government of Prince Edward Island, Health PEI and the Medical Society of Prince Edward Island.

2.4 Health PEI shall provide the Group with all emergency department resources, including but not limited to, all physical premises, facilities, plant, equipment, medical supplies, drugs, nursing, auxiliary and support staff, administrative and other services necessary for the due, proper and timely fulfillment by the Group of the coverage requirements.

ARTICLE 3 - CONTINUATION OF STATUS

3.1 (a) As professionals who are self-employed in the practice of emergency medicine, the Emergency Department Physicians are not employees of Health PEI, and each physician shall bear sole responsibility for the discharge of any professional liability, income tax liability and other liability imposed by law arising from such physician's professional work and any other business expenses arising from such professional work.

(b) For greater clarity, the group is not a partnership.

3.2 Each Emergency Department Physician shall maintain adequate medical liability coverage through the Canadian Medical Protective Association or equivalent medical liability insurer (ref. sub-article D2.3 of the Master Agreement between Health PEI and the PEI Medical Society).

3.3 The withdrawal or admittance of a physician to the Group shall not invalidate this Agreement.

3.4 The Emergency Department Physicians are severally liable under this Agreement.

3.5 If membership in the Group is altered through resignation or the addition of a new member:

(a) the physician leaving the group is absolved of the provisions of this Agreement; and

(b) the new physician shall be included in the Group upon signing the following statement:

I hereby acknowledge and accept the provisions of the _____ Hospital Emergency Service Coverage Agreement dated _____.

IN WITNESS WHEREOF the parties hereto have executed this Agreement on the date above written.

FOR THE GROUP:

Per: _____

Per: _____

Per: _____

Per: _____

Per: _____

Per: _____

Per: _____

Per: _____

HEALTH PEI:

Per: _____

Per: _____

I hereby acknowledge and accept the provisions of the _____ Hospital Emergency Service Coverage Agreement dated _____.

_____
Physician

_____
Date

_____
Health PEI

_____
Date

APPENDIX E

EMERGENCY DEPARTMENT ON-SITE COVERAGE FUNDED HOURS

The following is the funded hours of Emergency Department on-site coverage per day for each of the listed facilities:

Queen Elizabeth Hospital	48 hours
Prince County Hospital	38 hours
Kings County Memorial Hospital	14 hours
Western Hospital	14 hours

APPENDIX F

LONG TERM CARE FACILITIES and BED COUNT

The following list constitutes the Long Term Care facilities and applicable LTC bed count in the province, as of February 22, 2011:

(a) Standard Long Term Care facilities:

Government Facilities:	**LTC Beds** (incl. Respite)
Maplewood Manor	48
Margaret Stewart Ellis	25
Stewart Memorial	12
Wedgewood Manor	76
Summerset Manor	82
Riverview Manor	49
Colville Manor	52
Sherwood Home (14 + 2 respite @ 1.5 each)	17
Beach Grove Home	131

Private Nursing Homes:	**LTC Beds**
Garden Home	131
Atlantic Baptist Nursing Home	101
MacMillan Lodge	20
Clinton View Lodge	34
Whisperwood Villa	61 + 2 temporary
Gillis Lodge	49 + 19 temporary
Southshore Villa	31
Park West Lodge	15 + 1 temporary
Andrews of Summerside	10

(b) Non-Standard Long Term Care facility (Prince Edward Home):

Long Term Care	80
Respite	2
Palliative	8
Restorative	11
Chronic (under age 60)	27 (equivalent 41)

These bed numbers are subject to change by Health PEI during the term of this contract.

APPENDIX G

LOCUM TENENS POLICY

DEFINITION:

A locum tenens physician is a licensed physician who is substituting and providing services for another fully licensed physician (the resident physician) or providing temporary service in a vacant practice.

PURPOSE:

The purpose of a Locum Tenens arrangement is:

a) to allow existing resident physicians time off for vacation leave, CME and sick leave;
b) to provide temporary service in a vacant practice until a permanent replacement is approved.

PROCEDURE:

1. The locum physician shall have a temporary billing number or a permanent billing number if he/she is part of the existing physician complement. Both physicians must complete the Locum Tenens Information Form attached hereto as Schedule A. Only one of the two physicians is permitted to bill during the period of the locum (resident physician's number is deactivated).

2. The locum physician may be compensated either by fee-for-service or by alternate funding. Where alternate funding is the modality, the locum physician shall be paid at the rate for which he/she is qualified in accordance with Article B18 or C4, as the case may be. In addition, the locum shall be eligible for the same compensation for on-call services as is payable to the resident physician, including, but not limited to, on-call per diems and retainers, as the case may be.

3. Where a locum tenens is filling a vacancy or providing community-based on call the locum physician must work a minimum of one day to be eligible for travel and accommodation allowance.

4. Both physicians must include time of day as indicated on the application form (commence and/or cease, particularly for part days). Failure to do so could result in claims being rejected.

5. Recovery for overhead expenses, as applicable, is to be negotiated between the resident physician/clinic and the locum tenens physician.

SCHEDULE A

LOCUM TENENS
INFORMATION FORM

Surname First Name Initials Billing #

Name of Physician Being Temporarily Replaced Billing #

Date & Time Practice Commences: _____

Date & Time Practice Ceases: _____

Address of Temporary Practice: _____

_____

_____

Address Payment to be Forwarded to: _____

_____

_____

_____

Signature of Physician Being Replaced

DEPARTMENT OF HEALTH & WELLNESS
RECRUITMENT AND RETENTION SECRETARIAT POLICY

POLICY NAME: **LOCUM TENENS SUPPORT PROGRAM**

EFFECTIVE DATE: August 3, 2010

APPROVED BY: _____
Department of Health and Wellness

DEFINITION:

A locum tenens physician is a licensed physician who is substituting and providing temporary services for another fully licensed physician (the permanent physician) or providing temporary service in a vacant practice.

POLICY STATEMENT

In support of the Locum Tenens Policy outlined in the Master Agreement between the Medical Society of PEI and the Government of PEI, the Health Recruitment and Retention Secretariat and Medical Affairs have developed the following policy for the Locum Support Program:

1. Decisions regarding locum coverage requirements reside with the network/site Medical Director. The respective Medical Director will review a locum request to determine if it is appropriate and meets the policy outlined below. If the request is appropriate, he or she will approve it and forward it to the Recruitment & Retention Secretariat for final confirmation, support, and payment.

2. Permanent physicians may request locum coverage in the following instances only:

   2.1 There is at least a 1.0 full-time equivalent vacancy in the physician complement in the service area and the permanent physician will be absent from his/her practice for a 3-week period or greater;

   OR

   2.2 Permanent physicians are expected to coordinate vacations within their physician group, but in the event that two or more physicians must be away at the same time and there is a requirement of the permanent physician to provide coverage to the area emergency department, a locum may be requested and approved at the discretion of the respective network/site Medical Director.

   OR

2.3 There is no current vacancy in the physician complement in the service area; however, the permanent physician will be absent from his/her practice for more than a 4-week period for the following reasons: sick leave, special leave, paternity leave and maternity leave;

OR

2.4 The permanent physician is part of a specialty area consisting of three or fewer physicians for the service area. In these instances, the period of absence can be less than 3 weeks.

3. Locum physicians replacing a fee-for-service physician have the option of working under a fee-for-service or a contract-for-service arrangement.

   3.1 If the locum physician works on a contract-for-service basis, the permanent physician is eligible for subsidization for overhead costs at a regular rate set by the Division of Medical Affairs on April 1 of each year. This rate can be paid on a daily/weekly/or monthly basis.

   3.2 If the locum physician works on a fee-for-service basis, the permanent physician is responsible to negotiate a rate with the locum physician to cover the cost of office overhead, which is paid by the locum physician to the permanent physician.

4. In specialty areas with a complement of three (3) or fewer physicians in which a vacancy exists, a guaranteed minimum of $1,500 per weekend day will be offered to facilitate locum coverage. Recruitment and Retention Secretariat will provide $1,125 (if locum physician chooses on-call retainer plus fee for service) or $875 (if physician chooses on-call per diem only) toward the guaranteed minimum for each approved locum. Payment will be issued upon the submission of an invoice by the service area.

5. Requests for locum coverage by network/site Medical Directors should be made as far in advance as possible to allow for licensure. If the locum request meets the Locum Support Program criteria, Recruitment and Retention shall provide the site with a list of available locum physicians. The network/site must secure the locum service and the permanent physician must make contact with the locum physician. Recruitment and Retention Secretariat will provide C.V.'s, advice, support, and assistance to the network/site throughout the process of arranging the locum service.

6. Checklists have been developed for the permanent physician, locum physician, and administrative coordinators to ensure the process to finalize orientation, payment, licensing, work site arrangements and other details involved in preparing the locum physician to begin working is completed.

7. The Locum Support Program covers the following:

7.1 Return economy airfare up to a maximum of $2,000. In an extenuating circumstance, approval for an amount greater than $2,000 must be approved by the Manager of Recruitment and Retention. Travel by car will be reimbursed according to the current government mileage rates up to no more than the cost of one economy return air ticket. Bridge and road toll fees will be covered. Receipts are required.

7.2 Medical Society fees

7.3 College of Physicians and Surgeons of PEI licensure fees.

8. Daily Locum Support Stipend:

8.1 From October 1 to May 31 of each year, the locum physician is entitled to a stipend of $150 for each day worked to help offset accommodation and car rental costs. The total yearly maximum is $7,500 calculated on a fiscal year basis from April 1 to March 31 of each year. In an area of significant need, the maximum of $7500 may be exceeded. To be exceeded, the network/site Medical Director must seek approval from the Manager of Recruitment and Retention and the Director of Medical Affairs.

8.2 During peak tourism season, June 1 to September 30, the locum physician is entitled to a stipend of $200 for each day worked to offset accommodation and car rental costs. The total yearly maximum is $7,500 calculated on a fiscal year basis, from April 1 to March 31 of each year. In an area of significant need, the maximum of $7,500 may be exceeded. To be exceeded, the network/site Medical Director must seek approval from the Manager of Recruitment and Retention and the Director of Medical Affairs.

8.3 To obtain the stipend, the physician must complete the Locum Support Stipend Form, have the dates verified and signed by an individual designated by network/site, and send to the Recruitment and Retention Secretariat at the end of each month of the locum.

9. The Locum Support Program does NOT cover costs associated with the following:
- CMPA dues
- letters of good standing
- medical examinations
- work permits
- cell phones
- internet or satellite service
- meals
- cleaning fees
- travel time to and from the locum
- travel to and from work for the duration of the locum

10. Permanent Prince Edward Island Physicians who perform locum services are eligible for reimbursement from the Locum Support Program for in-province travel (as per Treasury Board policy) and accommodation costs, with receipts, to a total maximum of $150/day. Reimbursement for travel and accommodations cannot exceed $150 a day, except during the peak tourism season as described above in article 8.2. Island physicians providing locum services shall not be eligible for reimbursement for "travel time" to and from the locum.

11. In the event of a physician shortage for more than 30 days in clinical groups of 5 or fewer providing on-call coverage, the network/site physician shall be eligible for reimbursement according to clause C 3.7 of the Master Agreement.

PERMANENT PHYSICIAN SEEKING LOCUM
Locum Program Checklist

1. Ensure need for the locum is requested and approved through the network/site Medical Director who will forward request to the Recruitment and Retention Secretariat.

2. Complete the Locum Tenens Request Form and fax to the Montague Medicare Office at (902) 838-0940 once the locum is confirmed.

3. Work with network/site administrative coordinator to ensure a package of forms related to licensure and credentialing is forwarded to the locum.

4. Contact locum tenens physician and ensure dates are confirmed.

5. Ensure your administrative staff assist with billings for the locum physician.

6. If locum physician is billing fee-for-service for all services, make arrangement with locum physician for the coverage of overhead expenses.

7. If locum physician is on a contract-for-service, ensure the physician submits hours worked by fax to the Montague Medicare Office (902) 838-0940.

RECRUITMENT AND RETENTION SECRETARIAT
LOCUM SUPPORT STIPEND REQUEST FORM

The completion of this form is necessary for the processing of locum payments to all locum physicians. The payment will be received by separate cheque. For any assistance in completing this form, please call the Recruitment and Retention Secretariat at (902) 368-6302/620-3874

INVOICE FOR THE LOCUM STIPEND FOR THE MONTH OF _____

Invoice to: Locum Support Program, Recruitment and Retention Secretariat
Department of Health and Wellness, 16 Garfield Street
Charlottetown, PE C1A 7N8 **OR** Fax (902) 620-3072

Name of physician _____

Address _____

Please indicate dates (including hours) worked in the above month (or attach copy of sheet with dates and hours worked with approved signature):

	hrs.		hrs.		hrs.		hrs.
Day 1	_____	Day 9	_____	Day 17	_____	Day 25	_____
Day 2	_____	Day 10	_____	Day 18	_____	Day 26	_____
Day 3	_____	Day 11	_____	Day 19	_____	Day 27	_____
Day 4	_____	Day 12	_____	Day 20	_____	Day 28	_____
Day 5	_____	Day 13	_____	Day 21	_____	Day 29	_____
Day 6	_____	Day 14	_____	Day 22	_____	Day 30	_____
Day 7	_____	Day 15	_____	Day 23	_____	Day 31	_____
Day 8	_____	Day 16	_____	Day 24	_____		

Daily Stipend Claim of $150 X _____ days worked: (a) _____
From October 1 - May30

Daily Stipend Claim of $200 X _____ days worked: (b) _____
From June 1 - September 30

Travel Costs (attach receipts): _____

TOTAL AMOUNT PAYABLE **$ _____**

Note 1: Stipend allowance is subject to a maximum of $7,500 over a 12 month period (April 1 - March 31) to assist with travel and accommodation costs.

Signature of Locum Physician _____ Date_____

FOR OFFICE USE ONLY: (Must be legible or please print) Name

Date(s) worked verified by Network representative _____

APPENDIX H

PATIENT ACCESS TO PHYSICIAN PROGRAM AGREEMENT

I, _____ am registered with the Provincial Patient Registry for placement with a regular Family Physician.

I agree to accept Dr. _____ as my regular family physician in future.

Patient's Health Care # _____

Dependent's Health Care # _____

Dependent's Health Care # _____

Dependent's Health Care # _____

If you are new to Prince Edward Island and have not received a Personal Health Number(PHN), please call 1-800-321-5492 to register.

I am the legal guardian of the dependents lists above and so am authorized to sign this agreement on their behalf.

_____ _____

Patient's Signature Date

****

I agree to accept the patient(s) identified above into my family practice. If, for unforeseen reasons I will not be able to fulfill this commitment, I will inform Health PEI immediately.

_____ _____

Physician's Signature Date

EXPLANATORY NOTES ON PATIENT ACCESS TO PHYSICIAN PROGRAM

This program was established through agreement between the Medical Society of Prince Edward Island and Health PEI in an attempt to ensure Island residents have access to family physicians.

By signing this form, you are indicating that you intend to use a particular physician as your family physician. This form does not in any way restrict your ability to access services.

Legal guardians may sign this agreement on behalf of dependents under the age of 16 or individuals for whom they have been named as the legal guardian.

It is envisioned that patients may choose to see a family physician once or twice prior to committing to sign this form. If you have any questions about this program, please call the Patient Registry Office at 1-800-321-5492.

APPENDIX I

MATERNITY/PARENTAL BENEFITS PROGRAM

INFORMATION FOR PHYSICIANS

The Medical Society administers a Maternity/Parental Benefits Program for eligible physicians on Prince Edward Island. The Program provides partial income replacement for a physician parent who wants to take a temporary leave from PEI practice for the birth/adoption of a child. This Program is intended to financially assist physicians who suffer a loss of income because they provide little or no physician services during the period of leave. The program covers PEI physicians regardless their income modality (fee-for-service or alternate payment).

Am I eligible to claim?

If you have practiced medicine on PEI immediately prior to taking a leave of absence to care for a newborn or adopted child aged 5 or under, you are eligible to file a claim for benefits. These benefits are available to physicians who earned income directly or indirectly from Health PEI immediately prior to their leave for providing medical services and/or administrative duties. Applicants must have held a "Full" or "Full Time" license with the College of Physicians and Surgeons of PEI prior to the leave, and are required to continue to pay dues to the Medical Society. For greater clarity, these benefit programs are not available to physicians who, prior to the start of the parental leave, held a short-term or temporary license or served as a locum.

What benefits are available?

In general, you are eligible for up to 17 consecutive weeks of benefits as long as you have earned qualifying income for at least 17 weeks in the 12 months prior to your leave. If you have earned qualifying income for less than 17 weeks in the year prior to your leave, your maximum benefit period will be equal to the number of weeks you actually worked. You must take a minimum two weeks leave. In the event of a still birth, or death soon after birth, in cases of 19 or more weeks gestation, a compassionate benefit of up to one month is available to qualifying physicians.

Your parental leave claim period can begin as early as four weeks prior to the expected birth/adoption, but no later than six weeks after the baby's discharge from hospital or date of placement of your adopted child. Claimants must file an application for benefits within six months of the birth or adoption of a child. Thereafter, claims will not be accepted.

The amount of your weekly benefit is based on your qualifying income over the past year. It will be calculated as 60% of your average gross weekly earnings over the best six months of the 12 months (or portion thereof) immediately prior to your leave. However, the maximum gross benefit is $1,200 per week, regardless of your qualifying income. If you have worked less than six months in the past year, your qualifying income will be calculated on all weeks worked prior to the leave. Benefits will not be adjusted in the case of retroactive pay increases.

Can I earn other income while on leave?

While benefits are being paid, you may also receive up to $2,000 gross income per bi-weekly claim period from all other sources. Your weekly benefit will be reduced, dollar for dollar, if you receive more than $2,000 income from other sources during that bi-weekly claim period. Other sources of income include salary top-ups, vacation pay, fee-for-service remittance income, disability insurance benefits, etc. (Employment Insurance benefits are deducted from your weekly benefits under this Program.). However, any income you receive while on leave for services you provided *prior* to the start of your parental leave should **not** be reported. It does not affect your benefit under this program. Only income earned and received while on leave should be reported.

Can I share the leave with my spouse?

If both parents are physicians, they can *sequentially* share the 17 consecutive week benefit period if both take a leave of absence from their practice. The amount of benefit paid in any week will be based on the qualifying income of whichever parent is on leave at that time.

What else should I know?

Benefits are only payable to physicians who are resident on PEI during the benefit period. Relocation from the province will automatically terminate benefits.

Maternity/Parental benefits are taxable and the Medical Society is required to submit income taxes on your behalf. We automatically will submit taxes at the maximum rate. A T4A slip will be issued to you for income tax purposes.

How do I apply?

Contact Marlene Guignion at the Medical Society by calling 368-7303. You will be sent an Application for Benefits form. You must complete and return the Application form to establish your eligibility for benefit (the maximum weekly benefit you are eligible for and the maximum number of consecutive weeks that you may claim).

Thereafter, you will be sent a series of simple biweekly Claim forms. To be eligible to receive a benefit for each biweekly period, you must submit a Claim form to detail income you have earned and received from *all other sources* during the claim period. The Medical Society will calculate your benefit and send you a cheque two weeks following the end of each claim period.

What information does the Medical Society require?

You must begin your claim within 6 weeks of the adoption/discharge. To initiate your claim the Medical Society needs the following information, which you will be asked to provide on the Application for Benefits form:

- Identifying information about yourself
- Key dates affecting your maternity/parental leave
- Information on your qualifying income for each month during the 12 months prior to your leave
- Applications must be received within six months of the birth or adoption of a child (however, the actual leave must have begun no later than 6 weeks after the date of the birth or adoption).

In addition, for audit and verification purposes, you must agree to provide copies of relevant financial reports (e.g. income tax returns, Health PEI remittances, other employer remittances, etc.) upon our request.

Finally, you must submit proof of the birth/adoption, such as a physician's or hospital's report of the birth, or birth certificate/adoption certificate.

SAMPLE CALCULATIONS

1. Determination of Qualifying Income & Benefit Amount

Your benefit level is affected by your past gross income. You must report your monthly gross income on the application form so we can calculate your qualifying income. It will be calculated as 60% of your average gross weekly earnings over the best 6 of the 12 months (or portion thereof) immediately prior to your leave. However, the maximum benefit available to all claimants is $1,200 per week regardless of prior income.

Example

- Salaried physician who earned $12,000 gross income per month for all 12 months prior to the start of actual leave period.
- Gross income on best 6 months is 6 x $12,000 = $72,000.
- Qualifying income per week is $72,000 ÷ 26 weeks = $2,769
- 60% of qualifying income is .6 x $2,769 = 1,661.
- Benefit is maximized at $1,200 per week.

Example

- A fee-for-service physician worked only 8 months prior to start of actual leave. We use the gross income from the best 6 months: $10,000, $11,000, $12,200, $10,900, $9,200, $10,500.
- Total gross over best 6 months = $63,800.
- Qualifying income per week = $63,800 ÷ 26 weeks = $2,454
- 60% of qualifying income is .6 x $2,454 = $1,472
- Benefit is maximized at $1,200 per week.

2. Factors Which Can Change Your Benefit Amount

You are allowed to earn and receive a maximum of $2,000 of income per bi-weekly claim period from all other sources in addition to your maternity leave benefit. If you earn and receive more than that, the extra earnings are deducted dollar for dollar from your benefit.

Example

- Salaried physician is entitled to $1,200 per week from the Maternity/Parental Benefit Program.
- Physician also receives $417 a week for E.I. benefits.
- There is a reduction to the leave benefit equal to E.I. received.

Example

- Physician is entitled to $1,200 per week from the Maternity/Parental Benefits Program.
- Physician receives a substantial payout for delayed claims while on leave.
- There is no reduction to the leave benefit because the payout was for services provided before the parental leave period began. There is no need to report income for such services.

Example

- Physician is entitled to $1,200 per week from the Maternity/Parental Benefits Program.
- Physician decides to provide services during leave and subsequently earns and receives a $2,500 remittance for those services while still on leave. Physician will receive only a $1,900 benefit for the biweekly leave period because she/he exceeded the $2,000 bi-weekly maximum income from other sources by $500 ($2,500-$2,000 = $500).

Further Questions?

If you have any other questions or concerns about this Program please contact the Medical Society office.

APPENDIX J

HEALTH PEI
POLICIES AND PROCEDURES MANUAL

POLICY NAME: **PHYSICIAN HONORARIA POLICY**

EFFECTIVE DATE: April 1, 2001

APPROVED BY: _____
Health PEI

INTRODUCTION:

The Health PEI believes that a team-based approach is an effective means for problem-solving and developing solutions to the many issues in the delivery of the health care system.

In order to ensure active team member participation in this process, the Health PEI shall provide remuneration to physicians who are participating on approved committees/working groups. A schedule of meetings, approximate duration of the activities of the Committee, and budget shall be required in advance of approval.

1.0 INTERPRETATION/DEFINITIONS:

Committees shall be considered by the Health PEI on an individual basis. For the purpose of this policy and its implementation, the following definitions shall apply:

(a) "Chairperson" means the person appointed by the Health PEI to hold that position or to act as chairperson in the absence of the appointed chairperson

(b) "Committee" means all Provincial committees established by the Health PEI. This excludes those committees where physicians are required to participate as part of their usual medical staff functions or as a condition to having admitting privileges in that facility.

(c) "Honoraria" means rate of compensation paid to a person for attending a committee meeting or any other meeting the person is requested to attend, based on their capacity as chairperson or member of a committee.

2.0 APPROVAL PROCESS:

In order for a committee to qualify under the Honoraria Policy, it must satisfy one or more of the following criteria:

1) mandated by legislation, e.g., Health Services Payment Advisory Committee, Physician Resource Planning Committee;
2) arising from the Master Agreement between the Medical Society of P.E.I. and the Health PEI;
3) created by the Health PEI in response to a provincial issue;
4) in response to a regional request whereby decisions made would have a provincial impact;
5) a joint planning committee agreed to by the Health PEI and the Medical Society.

3.0 ELIGIBILITY FOR HONORARIA:

Honoraria shall be paid to all fee-for-service physicians who participate on approved committees. Salaried and alternately paid physicians shall only be paid an honoraria for committee participation outside of the scheduled contracted hours.

4.0 HONORARIA RATES:

As per Article C9 in the Master Agreement.

NOTE: Meeting time does not include travel time.

5.0 TRAVEL EXPENSES:

Mileage shall be paid at the approved Treasury Board rate. A minimum of 50 kilometers (return) must be traveled to be eligible for any reimbursement.

6.0 ADMINISTRATION:

Honoraria payments to physicians shall be made by the Health PEI on a quarterly basis (March, June, September, December). All Committee Resource persons shall submit their information to the Health PEI (Attention: Manager of Physician Services, Medical Services Division) within thirty (30) days after the end of the quarter.

APPENDIX K

CLINICAL WORK INCENTIVE THRESHOLD ALGORITHM

1. From Medicare billing data, determine the total shadow billing for each physician over the previous 3-month quarter using the following criteria:

   (a) Period equals previous 3-month quarter
   (b) Paid Amount equals $0.00
   (c) Approved Amount is greater than $0.00
   (d) Exclude the following specialty codes:
   - Code 17 - Radiation Oncology
   - Code 19 - Laboratory Medicine
   - Code 23 - Medical Oncology
   - Code 27 and 44 - ED On-site Sessional Shadow Billing
   - Code 40 - Long Term Care
   - Code 94 - Nursing
   - Code 95 - Nurse Practitioner

   (e) Report to include columns for Physician Number, Physician Name, Specialty Code, Approved Amount, Paid Amount, Total Records, Total Initial Consultations.

2. From the Employer's Payroll System and the Claims Payment System, determine the actual hours paid to each salaried and contract physician, respectively, in the pay periods ending in the previous 3-month quarter. Exclude salaried/contract hours worked in a hospital where a top-up fee is paid instead of the usual Emergency Department or Hospitalist sessional fees.

3. The proration of quarterly thresholds will be calculated as follows:

   Adjusted (prorated) quarterly threshold =

   $$\text{Basic Quarterly Threshold} \times \frac{\text{Total hours paid for pay periods ending in quarter}}{\text{Total pay periods ending in quarter} \times 75 \text{ hrs/pay period}}$$

4. The Basic Quarterly Threshold applies to both the approved shadow-billing dollar value threshold and the shadow-billing workload threshold (number of claims/consults), as provided in Article C5.

5. Physicians who are at or above the adjusted (prorated) thresholds for both dollar value and workload will be entitled to the clinical work incentive, which shall be the applicable percentage of the value of approved shadow-billing claims for that quarter.

APPENDIX L

NEW FEE CODES AND RE-DEFINED FEE CODES

The following is a list of all new fee codes and fee codes which have been redefined or reworded, which are now incorporated into the Tariff of Fees, attached hereto as Schedule "A".

New fee codes are flagged with an asterisk (*), and redefined fee codes are shown with the wording changes in the service descriptions in *italics*.

All new and substantively redefined fees listed here shall be effective as of January 1, 2012. Increases to all other fees listed in the Tariff of Fees shall be effective on October 1, 2011.

Description		Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
On-Call Services							
On-Call Retainer - Urban GP *group of 5 - 7*		**0019**	150.00	161.25	180.00	198.75	225.00
On-Call Retainer - Souris, Tyne Valley, *O'Leary, Montague* (per hospital)		**0185**	150.00	161.25	180.00	198.75	225.00
On-Call Retainer - *Alberton*		**0040**	260.00	260.00	260.00	260.00	260.00
On-Call Retainer - Coroner (East or West)	*	**0020**	150.00	150.00	150.00	150.00	150.00
On-Call Retainer - Corrections	*	**0030**	200.00	203.75	210.00	216.25	225.00
On-Call Response Fee	*	**0060**		50.00	80.00	110.00	150.00
Hospitalist Medicine							
Hospitalist *Type 1* daily sessional fee - *max. 21 beds*		**0107**	1,265.00	1,267.25	1,271.00	1,274.75	1,280.00
Hospitalist Type 1 daily sessional fee - max. 11 beds	*	**0102**		664.00	666.00	668.00	670.00
Hospitalist Type 2 daily sessional fee - max. 17 beds	*	**0101**	1,265.00	1,279.25	1,303.00	1,326.75	1,360.00
Hospitalist Type 2 daily sessional fee - max. 09 beds	*	**0037**		677.00	690.00	702.00	720.00
Hospitalist Type 1 sessional top-up fee (Salary Class I) - max. 21 beds	*	**0038**	595.51	592.33	587.01	581.70	574.26
Hospitalist Type 1 sessional top-up fee (Salary Class II) - max. 21 beds	*	**0039**	576.37	573.01	567.41	561.80	553.96
Hospitalist Type 1 sessional top-up fee (Salary Class III) - max. 21 beds	*	**0041**	547.70	544.06	538.03	532.00	523.57
Hospitalist Type 1 sessional top-up fee (Salary Class I) - max. 11 beds	*	**0042**		310.27	307.48	304.70	300.80
Hospitalist Type 1 sessional top-up fee (Salary Class II) - max. 11 beds	*	**0043**		300.15	297.21	294.28	290.17
Hospitalist Type 1 sessional top-up fee (Salary Class III) - max. 11 beds	*	**0044**		284.98	281.83	278.67	274.25
Hospitalist Type 2 sessional top-up fee (Salary Class I) - max. 17 beds	*	**0025**	595.51	604.33	619.01	633.70	654.26
Hospitalist Type 2 sessional top-up fee (Salary Class II) - max. 17 beds	*	**0026**	576.37	585.01	599.41	613.80	633.96
Hospitalist Type 2 sessional top-up fee (Salary Class III) - max. 17 beds	*	**0027**	547.70	556.06	570.03	584.00	603.57
Hospitalist Type 2 sessional top-up fee (Salary Class I) - max. 09 beds	*	**0045**		319.94	327.71	335.49	346.37
Hospitalist Type 2 sessional top-up fee (Salary Class II) - max. 09 beds	*	**0046**		309.71	317.33	324.95	335.62
Hospitalist Type 2 sessional top-up fee (Salary Class III) - max. 09 beds	*	**0047**		294.38	301.78	309.18	319.53
Emergency Medicine							
ER sessional top-up fee (Salary Class I)		**0005**	75.74	76.51	77.80	79.09	80.90
ER sessional top-up fee (Salary Class II)		**0006**	73.18	73.93	75.19	76.44	78.19
ER sessional top-up fee (Salary Class III)		**0007**	69.36	70.07	71.27	72.47	74.14
Emergency Procedural Sedation		**2011**	25.00	25.75	27.00	28.25	30.00

Description	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Palliative Care						
Palliative Care Unit Inpatient - initial visit *	**0163**		66.00	76.00	86.00	100.00
Palliative Care Unit Inpatient - daily care visit *	**0164**		37.25	41.00	44.75	50.00
Dermatology						
G.P. Dermatology consultation (designated physicians only) *	**0137**		75.00	76.50	78.00	80.00
Tele-Dermatology consultation *	**0350**		40.75	42.00	43.25	45.00
Telephone Services						
Telephone consultation - Pediatric *	**1120**		40.75	42.00	43.25	45.00
Telephone prescription renewal (1 or more per patient per month) *	**2019**		3.00	3.50	4.00	5.00
Neurology						
Electromyography (major) - examination of muscles of more than one region	**2149**	82.00	83.20	85.20	87.20	90.00
Electromyography (minor) - examination of muscles of a specific limb or region	**2150**	53.60	54.56	56.16	57.76	60.00
Nerve Conduction Studies, per nerve studied *(maximum 6 nerves)*	**2140**	28.52	28.82	29.32	29.82	30.52
Nerve entrapment evaluation (composite fee) *	**2166**		80.00	81.68	83.36	85.60
Dialysis Management						
Acute Dialysis - first treatment *	**2055**		585.00	585.00	585.00	585.00
Acute Dialysis - subsequent treatment (up to 2) *	**2056**		268.80	268.80	268.80	268.80
Chronic Dialysis - first treatment	**2135**	170.85	172.64	175.63	178.62	182.81
Chronic Dialysis - subsequent treatment (max. 3 per patient per week)	**2137**	102.50	74.00	74.00	74.00	74.00
Satellite Dialysis Management (per patient per week) *	**2058**		40.00	40.00	40.00	40.00
Dialysis catheter - tunneling and insertion *	**2038**		150.00	150.00	150.00	150.00
Dialysis catheter - removal and/or replacement *	**2039**		200.00	200.00	200.00	200.00
Gastroenterology						
Removal of rectal foreign body *	**2021**		72.25	76.00	79.75	85.00
Argon Coagulation of stomach or rectum - single or multiple (add-on fee) *	**2022**		75.00	76.58	78.15	80.25
Ileoscopy *	**2315**		57.50	70.00	82.50	100.00
Respirology						
Bronchoscopy with Transbronchial Lung Biopsy *- single lobe*	**4210**	196.00	198.06	201.49	204.92	209.72
Bronchoscopy with Transbronchial Lung Biopsy - each additional lobe *	**4212**		50.00	51.05	52.10	53.50
Bronchoscopy with Transbronchial Needle Aspiration (TBNA) of lymph nodes *	**4213**		198.06	201.49	204.92	209.72
Endobronchial Ultrasound (EBUS) *	**4214**		269.98	274.66	279.33	285.88
Cardiology						
Insertion - dual chamber pacemaker or ICD (Medical) *	**4781**		252.63	257.00	261.38	267.50
Insertion - dual chamber pacemaker or ICD (Surgical) *	**4782**		408.09	415.16	422.23	432.12
Reprogram *or Interrogate* pacemaker *(including ICD)*	**4776**	80.00	80.84	82.24	83.64	85.60
Critical Care						
Critical Care - *Days 2-30* inclusive, per day	**0597**	160.00	161.20	163.20	165.20	168.00
Critical Care - *Day 31* onward, per day	**0598**	80.00	80.60	81.60	82.60	84.00
Pediatric Critical Care - *Days 2-30* inclusive, per day	**1156**	160.00	161.20	163.20	165.20	168.00
Pediatric Critical Care - *Day 31* onward, per day	**1157**	80.00	80.60	81.60	82.60	84.00
Neonatal ICU Care - *Days 2-30* inclusive, per day	**1146**	165.00	166.50	169.00	171.50	175.00
Neonatal ICU Care - *Day 31* onward, per day	**1147**	110.00	110.90	112.40	113.90	116.00
Anesthesia Critical Care - *Days 2-30* inclusive, per day	**0297**	160.00	161.20	163.20	165.20	168.00

Description	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Anesthesia Critical Care - *Day 31* onward, per day	**0298**	80.00	80.60	81.60	82.60	84.00
Gynecology						
Laparoscopic Hysterectomy - total, abdominal or vaginal *	**6958**		526.79	535.91	545.03	557.80
Laparoscopic Hysterectomy - partial or subtotal, with or without adnexa *	**6959**		389.93	396.68	403.43	412.89
Omental Biopsy - single or multiple (add-on fee) *	**6631**		50.00	51.05	52.10	53.50
Conization of Cervix without D&C (LEEP) *	**6632**		60.00	61.26	62.52	64.20
Sacrospinous vault fixation *(add on)*	**6952**	95.00	96.00	97.66	99.32	101.65
Biopsy of Cervix - office procedure, *without colposcopy*	**6929**	30.85	31.17	31.71	32.25	33.01
Colposcopy *without biopsy*	**6934**	79.05	79.88	81.26	82.65	84.58
Colposcopy with biopsy (includes Pap) *	**6989**		111.05	112.98	114.90	117.59
Perineorrhaphy *(without rectocele repair)*	**6608**	129.75	131.11	133.38	135.65	138.83
Ophthalmology						
Optical Coherence Tomography (OCT) - *composite fee (max.. 4 per year)*	**2414**	57.05	57.65	58.65	59.65	61.04
Optical Coherence Tomography (OCT) - technical fee (max. 4 per year) *	**2417**		42.49	43.23	43.96	44.99
Optical Coherence Tomography (OCT) - professional fee (max. 4 per year) *	**2415**		15.16	15.42	15.68	16.05
IOL Master / Ocular Biometry - procedure only *	**2420**		38.30	38.96	39.62	40.55
IOL Master / Ocular Biometry - interpretation *	**2421**		19.39	20.20	21.01	22.15
Pneumatic Retinopexy *	**7259**		660.18	660.18	660.18	660.18
Pneumatic Retinopexy - repeat same eye within 30 days *	**7260**		330.09	330.09	330.09	330.09
Urology						
Intravesical Botox injections (1 or more) *	**8250**		202.10	205.60	209.10	214.00
Urethrolysis (includes cystoscopy) *	**8339**		350.00	357.35	364.70	374.50
Insertion of testicular prosthesis (Prior approval required *for age 18 yrs and over*)	**8507**	161.00	162.69	165.51	168.33	172.27
Radiology						
SPECT (nuclear scan tomography) - add-on fee *	**8799**		25.00	25.00	25.00	25.00
Radiation Oncology						
Radiation Oncology Consultation	**1760**	85.00	100.75	127.00	153.25	190.00
Radiation Oncology Follow-up visit	**1713**	19.35	21.70	25.61	29.52	35.00
Miscellaneous						
Autopsy - non-coroner's on *evenings and* weekends	**1900**	679.00	764.65	907.40	1,050.15	1,250.00
Tram Flap *- first surgeon*	**3097**	I.C.	I.C.	I.C.	I.C.	I.C.
Tram Flap - second surgeon	**9999**	I.C.	I.C.	I.C.	I.C.	I.C.
PAIN MANAGEMENT						
Chronic Pain Consultation	**0250**	85.00	87.70	92.20	96.70	103.00
Chronic Pain Follow-up visit	**0252**	33.00	33.30	33.80	34.30	35.00
Peripheral Nerve blocks						
Somatic *or peripheral nerve not specifically listed* - single	**2183**	36.00	36.60	37.60	38.60	40.00
Somatic *or peripheral nerve not specifically listed* - each additional *(to max. of 4)*	**2184**	18.00	18.30	18.80	19.30	20.00
Cervical plexus	**2186**	70.00	70.74	71.96	73.19	74.90
Brachial plexus	**2189**	60.00	60.63	61.68	62.73	64.20
Supraorbital branch of Ophthalmic Nerve (Trigeminal) *	**2450**		60.63	61.68	62.73	64.20
Infraorbital branch of Maxillary Nerve (Trigeminal)	**2188**	60.00	60.63	61.68	62.73	64.20
Mental branch of Mandibular Nerve (Trigeminal)	**2187**	60.00	60.63	61.68	62.73	64.20

Description	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Maxillary or Mandibular division of Trigeminal Nerve	**2206**	70.00	70.74	71.96	73.19	74.90
Therapeutic Seventh Cranial nerve block - unilateral	**2304**	42.00	42.44	43.18	43.91	44.94
Therapeutic Seventh Cranial nerve block - bilateral	**2305**	63.05	63.71	64.82	65.92	67.46
Other Cranial Nerve *	**2451**		60.63	61.68	62.73	64.20
Occipital Nerve	**2100**	31.05	32.39	34.63	36.87	40.00
Transverse Scapular Nerve *	**2452**		60.63	61.68	62.73	64.20
Intercostal Nerve - single *	**2453**		36.60	37.60	38.60	40.00
Intercostal Nerve - each additional (to max. of 4) *	**2454**		18.30	18.80	19.30	20.00
Paravertebral Nerve - single	**2210**	70.00	70.74	71.96	73.19	74.90
Paravertebral Nerve - each additional *(to max. of 4)*	**2211**	35.00	35.37	35.98	36.59	37.45
Ilioinguinal and/or Iliohypogastric Nerves *	**2455**		60.63	61.68	62.73	64.20
Sciatic Nerve	**2192**	60.00	60.63	61.68	62.73	64.20
Femoral Nerve *	**2456**		60.63	61.68	62.73	64.20
Obturator Nerve	**2193**	60.00	60.63	61.68	62.73	64.20
Pudendal Nerve	**2194**	50.00	60.63	61.68	62.73	64.20
Lateral Femoral Cutaneous Nerve	**2204**	70.00	70.00	70.00	70.00	70.00
Combined 3-in-1 block (femoral, obturator, lateral femoral cutaneous) *	**2457**		80.84	82.24	83.64	85.60
Fascia Iliaca Compartment block *	**2458**		60.63	61.68	62.73	64.20
Transversus Abdominis Plane (TAP) block - unilateral *	**2459**		30.32	30.84	31.37	32.10
Transversus Abdominis Plane (TAP) block - bilateral *	**2460**		50.02	50.89	51.75	52.97
Nerve block with fluoroscopic guidance (add on) *	**2461**		40.75	42.00	43.25	45.00
Nerve block with ultrasound guidance (add on) *	**2462**		25.75	27.00	28.25	30.00
Nerve block with alcohol or other sclerosing agent - add 50% (with comment) *						
Vertebral Facet Joint injections						
Vertebral Facet Joint injection - *with fluoroscopic guidance (single)*	**2533**	50.00	91.28	93.40	95.53	98.50
Vertebral Facet Joint injection - with fluoroscopic guidance (each additional, up to 6)*	**2463**		59.33	60.71	62.09	64.03
Vertebral Facet Joint injection - with ultrasound guidance (single) *	**2464**		76.28	78.40	80.53	83.50
Vertebral Facet Joint injection - with ultrasound guidance (each additional, up to 6).. *	**2465**		49.58	50.96	52.34	54.28
Sacroiliac Joint injections						
Sacroiliac Joint injection - with fluorscopic guidance (unilateral) *	**2466**		91.28	93.40	95.53	98.50
Sacroiliac Joint injection - with fluorscopic guidance (bilateral) *	**2467**		150.60	154.11	157.62	162.53
Nerve Root injections						
Diagnostic nerve root block - with fluoroscopic guidance (any number of sites) *	**2468**		161.68	164.48	167.28	171.20
Epidural injections						
Cervical epidural *injection - with fluoroscopic guidance*	**2531**	120.00	161.68	164.48	167.28	171.20
Thoracic epidural *injection - with fluoroscopic guidance*	**2532**	120.00	161.68	164.48	167.28	171.20
Lumbar epidural *injection - with fluoroscopic guidance*	**2524**	160.00	161.68	164.48	167.28	171.20
Caudal *epidural injection*	**2191**	65.00	65.68	66.82	67.96	69.55
Epidural - single injection	**2196**	80.00	80.84	82.24	83.64	85.60
Subarachnoid (diagnostic spinal)	**2195**	70.00	70.74	71.96	73.19	74.90
Sympathetic Nerve injections						
Cervical sympathetic or Stellate ganglion block	**2199**	100.00	101.05	102.80	104.55	107.00
Cervical sympathetic or Stellate ganglion block - *with U/S or fluoroscopic guidance* ..	**2208**	150.00	151.58	154.20	156.83	160.50
Thoracic, Lumbar, *Sacral* sympathetic block - *with fluoroscopic guidance*	**2205**	150.00	151.58	154.20	156.83	160.50
Lumbar sympathetic nerve block	**2185**	85.00	85.89	87.38	88.87	90.95

Description	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Ganglion/Plexus injections						
Presacral *(superior hypogastric plexus)* block	**2190**	60.00	60.63	61.68	62.73	64.20
Celiac, *splanchnic or hypogastric ganglion/*plexus block - *with fluoroscopic guidance*	**2197**	100.00	151.58	154.20	156.83	160.50
Trigeminal (Gasserian) ganglion block	**2198**	100.00	101.05	102.80	104.55	107.00
Trigeminal (Gasserian) ganglion block - *with fluoroscopic guidance*	**2202**	150.00	151.58	154.20	156.83	160.50
Spheno-palatine ganglion block - *with fluoroscopic guidance*	**2207**	70.00	151.58	154.20	156.83	160.50
Superior Laryngeal Nerve - *with fluoroscopic guidance*	**2209**	150.00	151.58	154.20	156.83	160.50
Other anesthetic injections						
IV Guanethidine/*Bier Block*	**2530**	100.00	101.05	102.80	104.55	107.00
Trigger point injection *(myoneural pain block)* with local anesthetic (one or more)	**2101**	20.00	20.21	20.56	20.91	21.40

SCHEDULE A

Schedule of Payments for Medical Services

April 1, 2010 - to - March 31, 2015

Health PEI
Medicare Office
PO Box 3000
Montague, PE C0A 1R0
(902) 838-0900

TARIFF OF FEES

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PREAMBLE TO THE TARIFF OF FEES

1. INTRODUCTION

The following outlines the policy of the Department of Health and Wellness of Prince Edward Island as implemented by Health PEI in the assessment of claims for basic health services provided to entitled persons under the *Hospitals Act* and *Health Services Payment Act* of Prince Edward Island. The assessment rules shall be subject to continual review and shall be amended from time to time by the Department in the light of experience in the operation of the P.E.I. Medical Insurance Plan, hereinafter referred to as "the Plan." In the event of a conflict between the assessment rules and this preamble, this preamble shall prevail.

The Preamble to the Tariff of Fees is deemed to form part of the regulations, but in the case of a conflict between any provision of the preamble, the regulations or the Act, the provision of the Act or the regulations shall prevail.

2. GENERAL CONSIDERATIONS

As a general overall policy, the Tariff of Fees should be applied in accordance with commonly established practices in the billing of patients prior to the introduction of the *Hospitals Act* and *Health Services Payment Act.*

The term "he" shall be considered gender neutral throughout the tariff.

Electronic Submission of Claims - All claims must be submitted in an electronic form within three (3) months from the date of the service.

3. ACCEPTANCE OF TARIFF

For the purpose of payment for services under the Plan, physicians shall claim 100% of the Tariff of Fees and the accepted claims shall be paid at the tariff established by the Department of Health in accordance with Section 4 (b) of the *Act*.

A participating physician may not charge an amount above the Tariff of Fees.

4. PARTICIPATION OF PHYSICIANS

All physicians practicing in Prince Edward Island are considered to be participating physicians under the Act, unless they opt out in accordance with Section 10.1(1)(2) of the Act. Consequently, accounts for basic health services provided to entitled persons are to be submitted to, and shall be paid by, Health PEI.

4.A. Election to Opt Out

A physician may opt out of the Plan by notice in writing to Health PEI as provided for under Section 10(1)(2) of the *Health Services Payment Act.*

4.B. Patient Claim Information

A physician who has elected to opt out is non-participating, and therefore cannot be paid by Health PEI directly for his services. He is required, however, to provide the resident with the required information, in a form acceptable to the Plan, for the resident to make a claim against Health PEI. The payment shall be made directly to the resident in an amount not exceeding the approved tariff for the insured service or, the amount of the physician's claim, whichever is the lesser.

4.C. Election to Participate

A physician may opt back into the Plan by application in writing to Health PEI as provided for under section 10(1)(2) of the Health Services Payment Act.

4.D. Selective Service(s) Opting Out

4.D.1 Procedure to Become Non-Participating Physician

Opted-in physicians may elect to opt out for any given patient for the total management of the condition under care, including any complications which may develop; for a series of services for which a composite fee applies, or for which the fees are inter-related, the physician would have to either opt in or opt out for the entire series of services.

4.D.2 Submission and Payment of Claims for Opted-Out Patients or Services

If the opted-in physician wishes to opt out for a particular patient or a particular service, he may, as at present, submit his claim to Health PEI on behalf of the patient. The patient shall then receive payment from Health PEI as per the Tariff of Fees and shall be responsible for additional fees from the opted out physician.

4.D.3 Notification by Participating Physician of Opted-Out Services

The following procedures must be strictly adhered to in the case of any patient of a participating physician for whom the physician has elected to opt out:

(i) The physician must inform the patient prior to the rendering of the service that he or she shall be billed directly for the service(s) being rendered;

(ii) The physician must sign the claim and report thereon the amount being charged to the patient, i.e. total amount charged.

5. MEDICAL NECESSITY

The Health Services Payment Act requires that only those services that are medically necessary shall be considered eligible for payment. If, in the opinion of the physician, a service is medically necessary, he may submit his claim for payment. Where a physician considers that a service rendered to an entitled person is not medically required, he may charge the patient for the service. Where Health PEI is in doubt as to the medical necessity of a service provided to an entitled person, the claim may be referred to the Health Services Payment Advisory Committee for a recommendation.

5.A. Services Rendered Without Medical Supervision

Health PEI shall consider for payment only those claims for services which are carried out by, or under the direction of, a physician. Services carried out under the direction of a physician shall be payable only if carried out in an office setting by an employee of the physician.

Fees are allowed to cover payment for professional services only and not the cost of materials or supplies used.

5.B. Delegated Functions

On a trial basis for the life of this agreement, the following fee codes may be billed at 66 ⅔ % of the Tariff of Fees when these services are delegated by a fee-for-service physician who is approved by Health PEI to bill for delegated services:

Fee codes 0113, 0123, 0115, 2228, 2229, 2230, 2231, 2501, 2505.

Approval of such arrangements shall be at the sole discretion of Health PEI and shall be limited to physicians who work 75% or greater on a fee-for-service basis. The visit is required to be documented on the patient's chart. The physician shall submit the bill at 66 ⅔ % of the standard rate with a notation in the comment section indicating that the service was delegated to another health professional employed by the physician.

6. INDEPENDENT CONSIDERATION (fee code 9999)

Independent Consideration shall be given under one of the following conditions:

(i) Where a fee is listed as Independent Consideration in the Tariff of Fees.
(ii) When requested by a physician (An explanatory note must accompany the claim).
(iii) When a service is claimed which is not listed in the Tariff of Fees.

For operative procedures, the anesthetic start and stop times must be recorded on the patient chart and on the claim.

7. EMERGENCY VISIT DEFINITION

An emergency visit refers to a situation where the demands of the patient and/or the physician's interpretation of the condition is such that he responds immediately at the sacrifice of regular office hours or routine medical practice. The need for immediate response is the intended controlling feature. Immediate attendance because of a personal choice or availability of physician is not considered an emergency visit. Urgent visits for acute or chronic conditions, which do not interfere with routine medical practice do not constitute an emergency visit. The premium fee (xx94) for emergency visits shall be added to the regular fee. Time of day must be indicated on the claim.

8. HEALTH PROMOTION COUNSELING (fee codes 2505, 2590)

Counseling patients and/or relatives in providing advice, encouragement, and direction for health care topics is an insured service. Included are lipid or dietary counseling, AIDS advice, smoking cessation, healthy heart advice, prenatal psychosocial assessment, allergy counseling, etc. Fee codes for counseling are not to be used in addition to office visit. This service is payable in blocks of fifteen (15) minutes or major portion thereof, and such time shall be recorded on the patient's chart.

9. OFFICE VISIT CODES

Office visit codes refer to services provided by a physician to a patient for diagnosis and/or treatment in the office, and shall generally be limited to one per physician per patient per day. In situations where two or more members of the same family attend a physician's office on the same day, each patient shall be treated as a separate individual for the purpose of claims submitted**.**

9.A. Consultation (fee codes xx60)

A consultation refers to an assessment, rendered at the written request of another physician or licensed health professional as approved by Health PEI, by a physician competent to provide advice when the patient's condition, due to its complexity, obscurity, or seriousness, necessitates an expert opinion.

The referral must be initiated by a Physician, or a Resident licensed by the College of Physicians and Surgeons of PEI, or a Nurse Practitioner, or other licensed health professional related to a specialist's field of practice, such as optometrist for ophthalmology, physiotherapist for orthopedic surgery, psychiatric nurse for psychiatry, and other similar referrals as approved by Health PEI. Consultation requests by patients, their representatives, or a third party acting on their behalf, do not qualify as consultations payable under the Plan.

No consultation fee shall be claimed unless the consultation has been specifically requested by the referring practitioner and unless a written report is rendered. The referring practitioner must

forward a written request for a consultation, which should include a description of the presenting complaint, the treatment undertaken (if any) and any relevant diagnostic test findings and patient information. The consulting physician must show the name of the referring practitioner in the appropriate section on his claim and must retain a copy of the written request for consultation, signed by the referring practitioner in the patient's chart. He must also submit his findings along with recommendations for further care, in writing, to the referring practitioner or family physician. Consultation claims for referrals from non-physicians must show "999" in the "referred by" field and a comment indicating the referring practitioner.

Discussion of a case by telephone or by letter between two physicians does not qualify as a consultation and is therefore not payable under the Plan, except if billed as a telephone consultation by an Internist, Pediatrician, Orthopedic Surgeon, or Out-of-Province specialist as per 11.C.1 and 11.C.2.

9.B. Consultation by a Family Physician (fee code 0160)

A consultation by a family physician requires that the consultant obtain a relevant history and perform a relevant physical examination, review pertinent x-ray films, laboratory or other data and submit his opinion and recommendation in writing to the referring physician or Nurse Practitioner. The patient should return to the referring physician or Nurse Practitioner for continuing care. The condition of the patient as justified by the diagnosis is the control mechanism for paying for such consults between family physicians. Trivial or minor problems shall result in the consult being reduced to an office visit or rejected on grounds of "not medically necessary." Information on the claim must substantiate necessity of consult between family physicians. A referral by a Nurse Practitioner to her collaborating physician shall not be considered a consultation.

9.C. Repeat Consultation (fee codes xx62)

A repeat consultation shall be a re-assessment for the same or related illness, or complication thereof, within 30 days of the initial consultation. A repeat consultation shall contain all the required elements of a consultation and implies that some interval care has been delivered by the referring practitioner prior to the request for a repeat consultation. Situations where a consulting physician requests a patient to return at a later date for an assessment does not qualify as a repeat consultation as there has been no written and signed referral by the attending practitioner.

9.D. Comprehensive Office Visit (fee codes xx10)

A comprehensive office visit is an in-depth evaluation of a patient necessitated by the seriousness, complexity, or obscurity of the patient's complaint(s) or medical condition. A comprehensive office visit shall comprise of a full history, which includes a history of the presenting complaint as well as past medical history, a full functional inquiry, a detailed examination of relevant body systems, a recommendation for treatment and all the relevant advice related to the presenting complaint. A detailed record of the findings and advice to the patient shall be considered part of the examination.

A comprehensive office visit may not be claimed within 30 days of a previous visit for the same complaint or medical condition. Visits provided within a 30-day period for the same condition or complication should be claimed as a limited office visit.

With regard to specialists,

(i) fee codes xx10 shall be billed where the patient has been initially referred for consultation and a subsequent visit relates to the same diagnosis, and

(ii) these visits can be billed to a maximum of four times within a twelve-month period. If additional such visits are required, a comment on the claim shall be required.

9.E. Limited Office Visit (fee codes xx13)

A limited office visit is a service rendered to a patient who presents with one or more complaints that require the physician to take a history of the presenting complaint(s), examine the affected part, region, or system, and provide a corresponding diagnosis and recommendation for treatment and/or care. The limited office visit is less involved than the comprehensive visit in terms of the functional inquiry, physical examination and documentation of the prior history, but shall require a minimum of 10 minutes of physician time.

A limited office visit may be claimed when the physician performs a limited assessment for a new condition or when monitoring or providing treatment of an established condition. Generally, payment shall be limited to no more than one office visit per patient per physician per day, except in cases where it is medically necessary in the physician's opinion to render a repeat office visit on the same day, and such medical necessity is documented both on the patient's chart, and as a comment on the electronic claims submission.

Office visit codes may not be claimed by a physician who has performed a major surgical procedure in the previous 30 days where the visit is related to the surgery performed. In the case of fractures and/or dislocations, the stated fee shall cover treatment including that related to the care of the fracture for a period of 45 days following the procedure**.**

9.F. Basic Office Visit (fee code 0123) - Family Physicians

A basic office visit is a service rendered by a family physician to a patient who presents with a relatively minor condition which requires only a brief problem-focused assessment, little or no physical examination, and less than 10 minutes of physician time.

9.G. Complete Re-examination by a Medical Specialist (fee codes xx63)

When a referred patient is seen in consultation for the first time and, when the nature and complexity of the referring problem requires a follow-up examination with complete re-examination, this shall be paid regardless of the interval between initial consultation and subsequent visit(s).

9.H. Annual Health Examination

An annual health examination for the detection of disease conditions at an early stage before symptoms appear is regarded as a basic health service and may be claimed only once in a calendar year. A diagnosis must not be indicated on a claim for an annual health exam. If a diagnosis is indicated, the physician should claim for a complete examination.

9.H.1 Procedures in Addition to Annual Health Examination

In addition to the fee for an annual health exam, physicians may bill for procedures related to health maintenance and disease prevention, such as venipuncture (2238 or 2239), urinalysis (2002 or 2003), injections (2009) such as flu shots and vitamin B12 shots, and pelvic exam or Pap test (2001 or 2008), all of which are payable in addition to an annual health exam, subject to the provisions of Section 5.A of this preamble. The insertion of an intra-uterine contraceptive device (Fee Code 6939) shall be paid at one-half the regular fee if inserted at the same time as an annual health exam.

9.I. Emergency Services in a Physician's Office

A physician who makes an unscheduled, non-elective, emergency visit to his office after regular office hours shall be entitled to claim the emergency office visit fee, providing a special trip to the office is necessary. The diagnosis/treatment/comment indicated on the claim must justify the service on an emergency basis. Time of visit must be specified on the claim. Additional patients seen during this special trip may be claimed at the normal office visit rate.

9.J. Continuing Care at a Specialist's Office

A specialist may charge his Specialty rates, as established in the tariff, when the patient is referred by a physician for continuing care. The service being rendered must be within the field in which the specialist is certified by the College of Physicians and Surgeons of Prince Edward Island, otherwise the Family Practice rate shall apply.

10. HOSPITAL VISIT CODES

Hospital visit codes are limited to medical services rendered to an entitled person formally admitted to hospital (including the inpatient Palliative Care Unit at the Prince Edward Home) for diagnostic tests and/or treatment. All initial visits, consultations and procedures must be supported by documentation. Routine daily visits by the attending physician need documentation only if the patient condition warrants.

10.A. Hospital Consultation

A hospital consultation refers to an assessment, rendered at the written request of another physician, by a physician competent to provide advice when the patient's condition, due to its complexity, obscurity, or seriousness, necessitates an expert opinion.

The referral must be initiated by a Physician, or a Resident licensed by the College of Physicians and Surgeons of PEI. Consultation requests by patients, their representatives, or a third party acting on their behalf, do not qualify as consultations payable under the Plan.

No consultation fee shall be claimed unless the consultation has been specifically requested by the referring physician and unless a written report is rendered. A written request for a consultation, signed by the referring physician, must appear on the patient's chart, on the emergency department record, or on the hospital order sheet. The consulting physician must show the name of the referring physician in the appropriate section on his claim, and must also document his findings, along with recommendations for further care, on the patient's chart.

Where a family physician maintains day-to-day responsibility for care, and requests only a consultation, the family physician shall charge on a per visit basis, and the consultant shall charge a consultant's fee.

Discussion of a case by telephone or by letter between two physicians does not qualify as a consultation and is therefore not payable under the Plan, except if billed as a telephone consultation by an Internist, Pediatrician, Orthopedic Surgeon, or Out-of-Province specialist as per 11.C.1 and 11.C.2.

10.A.1 Consultations Required by Hospitals

Consultations required by statute or hospital regulations are allowable benefits and are billable to the Plan.

10.A.2 Consultation by Specialist Prior to Intensive Care

(i) **Consultation Only**: Where a consultation is requested by the attending physician without transfer, the usual consultation fee shall be paid.

(ii) **Consultation and Transfer of Care**: Where a consultation is requested by the attending physician, and where, as a result of the findings of the consultation, the patient is subsequently transferred to the care of the consultant, both the consultant fee and subsequent daily visit fee shall be allowed.

(iii) **Transfer of Care**: Where the attending physician transfers a patient to the care of a consultant, but does not request a consultation, only the fee for visits shall be allowed. Where the transfer of care from a specialist to a physician in the same specialty occurs, only the fee for visits shall be allowed, unless the receiving physician has special skills required for the treatment of the patient.

10.B. Complete Examination in Hospital / Initial Hospital Visit (fee codes xx30)

A complete hospital examination cannot be billed by the attending physician until the physician has personally seen the patient and documented the History and Physical on the chart. Any daily hospital care, including acceptance of responsibility of care from the admitting physician prior to the complete examination, may be claimed as a subsequent hospital visit.

10.B.1 Initial Visit - Unaffiliated patient (fee code 0132)

An unassigned patient is a patient who does not have a regular family physician, or whose regular family physician does not have admitting privileges in the hospital where the patient has been admitted. This tariff cannot be claimed for newborns. This tariff also does not apply to patients whose regular family physician, with admitting privileges in the hospital where the patient is to be admitted, is temporarily unavailable due to vacation, illness, bereavement or CME, for less than four (4) weeks. This fee is payable in addition to the initial hospital visit fee. This fee code is applicable to family physicians only.

10.C. Other Hospital Visits

10.C.1 Concurrent Care

This refers to a situation where medical indication requires the services of more than one physician for adequate care of the patient on the same day. The physicians concerned shall have supplementary skills in different fields of practice, and each submits his separate account for the services rendered to the patient. Medical necessity for the requirement of multiple physicians must be established and noted on the claim and the patient chart.

Team procedures are not considered to be Concurrent Care when a team fee is listed in the Schedule of Fees.

10.C.2 Continuing Care and Supportive Care

(i) In medical cases of unusual severity, the responsibility for the day-to-day continuing care of the patient may be transferred from the attending physician to the consultant for a period of time. The consultant should charge, in addition to his consultation fee, his day-to-day continuing care on a per visit basis at the specialty rate listed for his specialty.

(ii) Supportive Care is defined as a Limited Visit provided by the family physician in a situation where the responsibility for the medical and surgical care of a registered hospital in-patient has temporarily been transferred to a consultant. Up to seven (7) visits can be claimed for supportive care while the patient is in hospital.

10.C.3 Directive Care

Directive care by a consultant may be claimed only in cases where the condition of the patient requires this special service and where the attending physician specifically requests the consultant to provide this service, and documents this request on the patient's chart. In such cases, both physicians may claim on a per visit basis.

10.C.4 Convalescent Care in Community Hospitals

During the period when patients are transferred to local community hospitals for convalescent care, the family physician may bill under fee codes 0145 and 0144 for the entire stay.

10.C.5 Intensive Care / Critical Care

Critical care fees (fee codes xx95, xx96, xx97, xx98, xx02) apply to the daily care of critically ill and potentially unstable patients who require intensive monitoring and treatment in a designated, approved intensive care area. Critical care fees include initial consultation and assessment and daily management of the patient, including the following procedures, as required: insertion of intravenous lines, arterial and central venous catheters, pressure infusion sets and pharmacological agents, securing and interpretation of blood gases, oximetry, endotracheal intubation, tracheal toilet, artificial ventilation and all necessary measures for respiratory support.

The following critical care services may be claimed in addition to the daily critical care fee codes: Swan-Ganz catheter insertion, transvenous pacemaker insertion, chest tube insertion, cardioversion, renal dialysis, and detention.

Critical care fees are payable to the physician in charge of the daily management of the patient. Other physicians who become involved in the patient’s care may charge the appropriate consultation, visit or procedure fees, including Concurrent Care as defined in 10.C.1.

Critical care fees do not apply when stable, non-critically ill patients are admitted to an intensive care area for cardiac rhythm monitoring or observation alone, or when patients who were critically ill no longer require intensive care, but remain in the intensive care area after a transfer order is written because of lack of beds elsewhere in the hospital. Critical care fees can be claimed one per 24-hour period up to and including the day the patient is medically suitable for transfer from the intensive care area. Intermediate/Progressive Care (fee code 0501) applies to the care of stabilized non-critically ill patients in an intensive care area, which may be an Intensive Care Unit, Coronary Care Unit, Progressive Care Unit, or Intermediate Care Unit.

Documentation including physical assessments, changes to patient symptoms, interpretation of necessary tests, and management plan on a daily basis is required to support billing these codes.

First day critical care codes require time of day when requesting after-hours premiums.

10.C.6 Visits Prior to Surgery

(a) Visit By a Surgeon Prior to Surgery

A visit by a surgeon other than a consultation within a day of the operation by the same surgeon for the same illness may not be claimed, as this is considered to be included in the surgical fee. However, consideration may be given in special cases where sufficient documentation is provided.

(b) Visit By Attending Physician Prior to Surgery

An attending physician may carry out hospital investigations prior to referring a patient to a Surgeon, and shall be entitled to submit claims for his services up to the time of referral. He shall only be entitled to submit claims beyond this time if he continues to be responsible for a condition not related to the surgery.

10.C.7 Visit Prior to Surgical Assist

A physician who submits a claim for a visit to an entitled person at home, in the office, or in the emergency department, and later on the same day assists at an operation, shall be allowed the fee for the visit in addition to the assistant's fee. The visit shall not be payable, however, if the physician concerned is also the surgeon performing the operation on the patient.

10.C.8 Multiple Physicians

A physician must indicate on his claim each day he has actually seen the patient in hospital. Generally, only one physician shall be paid for one hospital visit per patient per day. Any claim involving more than one hospital visit per day or the attendance of two physicians on the same day should be accompanied by an explanatory note.

In cases where a physician is temporarily replacing the attending physician, the attending physician shall not claim for the visits that are rendered by the replacement physician.

10.C.9 Discharge Fee

A hospital Discharge Fee may be claimed by the physician (either a family physician or a specialist when a patient is admitted for non-surgical hospitalization) who performs the activities in discharging a hospital in-patient. These activities include, as necessary, the completion of the patient’s chart, discharge summary, writing prescriptions for the patient, providing discharge instructions to the patient and arranging for follow-up care of the patient.

The fee is not payable where surgery or fracture care is provided in a hospital setting unless a patient is transferred to a family physician for follow-up care after surgery/fracture care. In this case, the family physician may claim the discharge fee if the family physician performs the

discharge duties. This fee cannot be claimed by the operating surgeon in association with any surgical code being billed, or for immediate post-partum care.

A hospital visit fee may be claimed in addition to the discharge fee where a hospital visit is provided on the same day.

10.D. Detention

10.D.1 Definition of Detention

"Detention Time" is defined as the time in excess of half an hour spent by the physician in actually examining or treating a patient; the time so spent constitutes detention time only when the time is spent by the physician exclusively, continuously, and when physically present with the patient in respect of whom detention time is charged. Detention is not restricted to services provided only in hospital. Detention does not apply when the time is spent doing procedures.

Detention does not commence until after the first half hour of service. In cases where consultations are billed for the same patient, detention does not begin until after the first 45 minutes for the specialty groups of internal medicine, pediatrics, psychiatry, palliative care, and physiatry. For all other specialty groups, detention starts 30 minutes after the beginning of the consultation. Claims submitted must include sufficient documentation and time spent justifying the charge for Detention. This service is payable in blocks of fifteen (15) minutes or major portion thereof.

10.D.2 Detention for Ambulance Transport of Patients

When a physician has accepted the responsibility of transporting a patient from one location to another, the physician shall be paid detention during time of travel from this location back to original site. Claims should have a comment record, indicating the length of time of the detention and any other information that would assist in adjudicating the claim.

10.D.3 Special Call Requiring Detention (fee codes xx76)
(Hospitalized inpatients only)

Where a consultation or a visit fee is charged and the physician is called back on the same day to provide further medical care, detention shall begin immediately.

Where a physician on duty in the Emergency Department is called to the floor to see/treat an inpatient, payment shall be made on a detention basis with actual time spent indicated on claim, and shall be payable in addition to the ER sessional rate. Time of day must also be indicated on the chart.

10.D.4 Special Detention - Radiology (fee code 8871)

Between 18:00 and 08:00 hours and on Saturdays, Sundays and holidays, detention for radiologists shall begin when the radiologist arrives at the hospital. If more than one patient is seen, detention may be claimed for the first patient only.

10.E. Hospital Emergency Department Visits

Physicians attending patients in the Emergency Department (ED) of a hospital shall claim under the appropriate ED code in the applicable section of the Tariff of Fees.

Emergency Department visits are categorized by both the time of day and the level of complexity of the encounter.

10.E.1 Time of Day

"Day" applies to visits between the hours of 08:00 and 18:00.
"Night" applies to visits between the hours of 18:00 and 08:00 the following day
"Weekend" applies to visits between the hours of 18:00 Friday and 08:00 Monday.

10.E.2 Level of Complexity

(a) Level I - Limited visit

A Level I Emergency Department visit (limited visit) is a service rendered to a patient who presents to the Emergency Department with a single condition requiring only a brief history of the presenting complaint, examination of the affected part, region or system, review of any required laboratory and/or imaging studies, and treatments.

(b) Level II - Comprehensive Visit

A Level II Emergency Department visit (comprehensive visit) is an in-depth evaluation of a patient necessitated by the seriousness, complexity, or obscurity of the patient's complaint(s) or medical condition. A comprehensive visit shall comprise of a full history, a full functional inquiry, and a detailed examination of relevant body systems. It shall also include a review of any required laboratory and/or imaging studies, and the initiation of appropriate treatment.

A comprehensive visit may also be claimed for those patients whose illness or injury requires prolonged observation, continuous therapy and/or multiple reassessment(s).

A comprehensive visit may be claimed, when appropriate, when a patient is seen in the Emergency Department for the first time that day by that physician. Return visits for the same condition on the same or following day by the same physician should be claimed as a limited visit.

Reassessment by physician on duty in the Emergency Department is the service provided when, at least two hours after the original assessment or re-assessment is completed (including appropriate investigation and treatment), a subsequent assessment indicates that further provision of care and/or investigation is required and performed. A maximum of three (3) reassessments may be claimed per patient per day with a maximum of two reassessments per physician per patient per day. A reassessment by the same physician shall be paid at the same rate as a limited visit. A reassessment by a different physician may be paid as a comprehensive visit if indicated, subject to appropriate documentation.

(c) Level III - Resuscitation/critical care visit

A Level III Emergency Department visit (resuscitation/critical care visit) pertains to the management of a life-threatening illness or injury which requires immediate evaluation and emergent intervention/treatment by the emergency physician. Emergency conditions necessitating Level III care would include resuscitation of cardiac arrest, multiple trauma, cardio-respiratory failure, shock, coma, cardiac arrhythmias with hemodynamic compromise, hypothermia, and other immediately life-threatening situations.

A resuscitation/critical care visit shall include an immediate crisis-related examination and the usual resuscitative interventions as required, such as defibrillation, cardioversion, intravenous lines, cutdowns, arterial and/or central venous catheters, arterial puncture for blood gases, insertion of nasogastric tubes with or without lavage, endotracheal intubation and tracheal toilet, and the use and monitoring by the emergency physician of pharmacologic agents such as inotropic, vasopressor, and thrombolytic drugs.

Payment for Level III care is based on the amount of time spent by the physician in constant attendance with a critically-ill patient in a life-threatening emergency situation. As in other detention-based care, after-hours premiums are applicable to Level III care.

Since emergency situations can occur anywhere in the hospital, resuscitation care is not restricted to emergency departments or emergency physicians, although it is expected that the physician in charge of the resuscitation shall normally be the physician on duty in the Emergency Department.

Because resuscitation situations often require the services of more than one physician at the same time, Level III care may be billed by up to three physicians per life-threatening emergency situation, when required. The attending physician shall document the need for more than one (1) physician.

10.E.3 Return Visits

When the patient has been discharged from the emergency department and returns the same day unexpectedly, another visit by a different physician may be claimed.

10.E.4 Multiple Physicians

The transfer of care between emergency physicians at the change of shift may generate a new visit fee, subject to appropriate documentation of an assessment.

10.E.5 Medical conditions treated in addition to minor surgical procedures

Patients may present, for example, with a laceration requiring suture repair and also require treatment of an unassociated, unrelated illness or injury. Both a visit fee (Level I, II, or III) and the procedural fee may be billed, and shall be paid in full.

Patients may also present with an emergency medical condition associated with a laceration (e.g. syncope with a scalp laceration or seizure disorder with a facial laceration). Again, both the appropriate visit fee (Level I, II, III) and a procedural fee may be billed, and shall be paid in full.

10.F Hospital In-patient Care of Unaffiliated ("orphan") Patients

An "unaffiliated" patient is a patient who does not have a regular family physician, or whose regular family physician does not have admitting privileges in the hospital where the patient has been admitted. This does not include patients whose regular family physician, with admitting privileges in the hospital where the patient is to be admitted, is temporarily unavailable due to vacation, illness, bereavement or CME, for less than four (4) weeks.

Upon admission to either the Prince County Hospital or the Queen Elizabeth Hospital, an unaffiliated patient will be assigned to the care of a Hospitalist physician. The Hospitalist shall provide comprehensive inpatient care for unaffiliated patients, including admission history and physical examination, daily medical management, participation in multi-disciplinary rounds and family conferences as needed, and discharge planning.

The Hospitalist will be responsible only for those unaffiliated patients for whom he/she is the attending physician. Thus, unaffiliated psychiatric patients admitted to the care of an attending psychiatrist at the QEH would not fall under the care of the Hospitalist; the medical care of these patients will be provided by other family physicians who are assigned to cover unaffiliated psychiatric inpatients at the QEH. Unaffiliated newborns may or may not fall under the care of the Hospitalist, depending upon the particular arrangements at each hospital.

Whereas some Hospitalist lines currently provide care for a mix of patients in all age groups with a variety of conditions, including medical, surgical and psychiatric, with various levels of acuity, other Hospitalist lines currently limit their practice to acutely ill adult medical patients only. In recognition of the different types of Hospitalist practice profile, two different types of Hospitalist shall be defined. Hospitalist Type 1 shall be defined by the provision of care to patients with a mixed variety of age groups, illnesses (medical, surgical, psychiatric, etc.) and acuity levels. Hospitalist Type 2 shall be defined by the provision of care to acute adult medical patients only. Type 1 Hospitalists shall be engaged on a 21-bed or 11-bed basis, and Type 2 Hospitalists shall

be engaged on a 17-bed or 9-bed basis. The type of Hospitalist which is utilized by a Health PEI hospital shall be as designated by the Director of Medical Affairs.

Each Hospitalist shall be paid a daily sessional fee for inpatient care of unaffiliated patients. The daily sessional fee shall be billed as a fee code which is specific to the type of Hospitalist and to the maximum number of beds for which the Hospitalist is engaged to manage:

Hospitalist Type 1 (Mixed Patient)

Fee Code 0107	maximum 21 beds
Fee Code 0102	maximum 11 beds

Hospitalist Type 2 (Acute Adult Medical)

Fee Code 0101	maximum 17 beds
Fee Code 0037	maximum 09 beds

Salaried physicians providing Hospitalist care shall be remunerated at the same sessional rate by billing a top-up fee equal to the difference between their daily salary (including benefits) and the Hospitalist sessional daily rate. Any inpatient care provided by a Hospitalist to unaffiliated patients in excess of his/her maximum patient load shall be remunerated by fee-for-service.

Overnight on-call coverage for Hospitalist inpatients between the hours of 18:00 and 08:00 hrs the following morning shall be remunerated by an on-call retainer (Fee Code 0108) plus fee-for-service for each Hospitalist group, as outlined in Section 11.D.2. A Hospitalist providing overnight on-call coverage for more than one Hospitalist group shall be entitled to receive an on-call retainer for each Hospitalist group covered. It is acknowledged that, even though on-call coverage may commence any time after 18:00 hrs, the normal daily duties of the Hospitalist may extend beyond this time, and each Hospitalist is expected to complete his/her daily duties prior to signing out to the Hospitalist on-call.

Any unaffiliated patients admitted after the maximum Hospitalist patient load (ie, maximum bed capacity) has been reached will be assigned to other family physicians. Remuneration for the care of these "overflow" unaffiliated patients shall be either by fee-for-service, or by a sessional daily rate, billed as Fee Code 0106, for each overflow unaffiliated patient. If a family physician chooses the latter option for any given unaffiliated patient, no fee-for-service claims may be billed by that physician for the care of that patient during the first five (5) weeks of the patient's hospital stay, following which billing will revert to regular fee-for-service rates (fee codes 0134 and 0135). Care of unaffiliated newborns may not be billed under Fee Code 0106.

Management and remuneration for the care of unaffiliated patients in the rural hospitals shall be the same as for the "overflow" unaffiliated patients at the Prince County and Queen Elizabeth Hospitals, as outlined above.

11. OTHER VISIT CODES

This category includes visit codes relating to visits in the Home, Long Term Care Institutions, Nursing Homes, etc.

11.A. Home Visit

Refers to services rendered other than at the physician's office and may include calls in which a patient is seen at the site of onset of illness or injury. Frequency of visits shall usually not exceed one per patient per day by the same physician except in unusual circumstances, in which case the physician should provide a suitable explanation on his claim.

11.A.1 Additional Patients Seen

Refers to an additional member of the same family, or person living in the same household or institution, examined and treated during a home visit.

11.A.2 Additional Fee for Emergency House Call (Fee codes xx25)

This fee applies between the hours of 08:00 and 18:00 only, in addition to the corresponding home visit or procedure.

11.B. Palliative Care

11.B.1 Palliative Care Consultation

A palliative care consultation must fulfill the normal requirements of a consultation, and include a psychosocial assessment, comprehensive review of pharmacotherapy, appropriate counseling and, where indicated, consideration of appropriate community services. A minimum of 45 minutes must be spent with the patient by a designated physician with recognized training and expertise in palliative care.

11.B.2 Repeat Palliative Care Consultation

A repeat Palliative Care Consultation shall be a reassessment for the same or related illness or complication thereof, within 30 days of the initial Palliative Care Consultation. A repeat consultation shall contain all the required elements of a Palliative Care Consultation and implies that some interval care has been delivered by the referring physician prior to the request for a repeat consultation. Situations where a consulting physician requests a patient to return at a later date for an assessment do not qualify as a repeat consultation as there has been no written and signed referral by the attending physician.

11.B.3 Palliative Care Telephone Call

Physicians may bill for telephone calls initiated by allied health professionals, in which the physician provides advice and direction regarding a palliative home care patient. The patient must be in a formal palliative home care program, and the claim must be supported by documentation on the patient's chart. Limit of three claims per patient per week.

11.B.4 Palliative Home Care Admission

This fee is applicable only to patients admitted to a formal palliative home care program. It is applicable anywhere in the Province and is not limited to designated palliative care physicians.

11.C Telephone Consultation

11.C.1 Telephone Consultation (Internal Medicine, Pediatrics, OOP Specialists)

This service is restricted to internists, pediatricians and out-of-province (OOP) specialists who provide telephone advice to physicians, and includes history review, history of presenting complaint, review of pertinent diagnostic data, discussion of patient condition/management, and advice to the referring physician, but without the consulting physician seeing the patient. Documentation must include a written submission of the consultant's opinion and recommendations to the referring physician. This service cannot be billed if the specialist sees the patient and bills a consultation within 3 days of the telephone consultation.

11.C.2 PACS Telephone Consultation (Orthopedics)

This service is restricted to orthopedic surgeons who provide PACS-based telephone advice to physicians, and includes history review, history of presenting complaint, direct review of PACS imaging studies, discussion of patient condition/management, and advice to the referring physician, but without the consulting physician seeing the patient. Documentation must include a written submission of the consultant's opinion and recommendations to the referring physician. This service cannot be billed if the orthopedic surgeon sees the patient and bills an orthopedic consultation within 3 days of the telephone consultation. Health PEI shall not be required to provide PACS outside the hospital.

11.C.3 Telephone Prescription Renewal

This service is billable when a physician is requested by a patient to communicate a prescription renewal by telephone, fax or email without seeing the patient. Documentation on the patient's chart must include the name of the pharmacy, as well as the drug, dose and amount prescribed. This service may not be billed if the physician sees the patient and bills for a visit within three (3) days of this service. A physician may bill for this service no more often than once per patient per month.

11.D On-Call Retainer Fees

11.D.1 Specialists and Surgical Assistants

One (1) specialist, or other physician as applicable, from each of the following clinical groups shall be entitled to a daily on-call retainer plus fee-for-service for providing twenty-four (24) hour coverage to each of the listed hospitals or provincial service, as the case may be:

Queen Elizabeth Hospital
Internal Medicine, General Surgery, Anesthesia, Pediatrics, Ob/Gyn, Surgical Assistant

Prince County Hospital
Internal Medicine, General Surgery, Anesthesia, Pediatrics, Ob/Gyn, Surgical Assistant

Provincial
ENT, Orthopedics, Ophthalmology, Urology, Plastic Surgery, Psychiatry, Radiology, Oncology, Laboratory Medicine, Palliative Care

11.D.2 Family Physicians

A daily on-call retainer plus fee-for-service shall be paid to Family Physicians providing on-call coverage at each of the following facilities:

Queen Elizabeth Hospital and Prince County Hospital

- fee codes 0015-0019 for in-patient coverage by one physician per group per day. The on-call retainer fee will vary according to group size as listed in the Tariff of Fees. Claims for group coverage require a comment listing the names of the physicians in the group.

- fee code 0108 for afterhours Hospitalist in-patient coverage by one physician per hospitalist group per day. There are currently two hospitalist groups at the QEH and one hospitalist group at the PCH.

- fee code 0199 for QEH Unit 9 (psychiatry) unaffiliated inpatient coverage by one physician per day.

- fee code 0147 for QEH Unit 7 (rehab) in-patient coverage by one physician per day.

Souris Hospital, Stewart Memorial Hospital, Community Hosptial, and Kings County Memorial Hospital

- fee code 0185 for in-patient coverage by one physician per hospital per day.

Western Hospital

- fee code 0040 for in-patient and after-hours Emergency Department coverage by one physician per day.

Hillsborough Hospital and Mt. Herbert Addiction Services

- fee codes 0197 and 0198 for in-patient coverage by one physician per facility per day.

Provincial Correctional Services

- fee code 0030 for inmate coverage by one physician per day.

11.D.3 Payment of Retainer

The daily retainer for each clinical group shall be paid according to a group-specific fee code as listed in the Tariff of Fees, and shall qualify for weekend and holiday premiums (see 12.B).

Payment of the on-call retainer is contingent upon the following conditions being met:

(i) provision of twenty-four (24) hours per day, seven (7) days per week continuous coverage for each listed clinical group;

(ii) the clinical group commits to provide coverage for not less than a period of one (1) calendar month, except that in the event there are fewer than three (3) physicians practising in a particular clinical group, each physician must provide no less than one (1) day in three (3) coverage (i.e., a minimum of ten (10) days per month);

(iii) the physician is responsible to an emergency department, a hospital or a hospital unit, or other facility, as the case may be, and is available to respond to a request by hospital or facility staff to attend to a patient emergency;

(iv) the physician's name appears on an established facility call schedule;

(v) the physician shall be entitled to bill fee-for-service in addition to the on-call retainer for all services rendered when on-call;

(vi) the physician is not otherwise compensated through another contractual arrangement for on-call coverage; and

(vii) in the event an on-call locum physician leaves the province early, the on-call retainer may be divided with another physician, provided a comment is added to the claim.

11.D.4 Salaried Medical Oncology specialists

Where a salaried medical oncology specialist backs up a GP Oncology Associate by providing "second on-call" coverage, the specialist shall be entitled to a retainer fee (Fee Code 0174) plus fee-for-service.

11.D.5 Neurology On-Call Coverage

Where a neurologist backs up an Internal Medicine specialist by providing "second on-call" coverage for neurology, the neurologist shall be entitled to a retainer fee (Fee Code 0503) plus fee-for-service.

11.D.6 On-Call Coverage for Multiple Clinical Groups

In the event that a physician is required to provide on-call coverage for more than one clinical group simultaneously, that physician shall be entitled to receive the on-call retainer or perdiem for each clinical group covered, provided the physician is qualified to practice in each specialty so covered.

11.D.7 Payment for Additional On-Call Coverage during Physician Shortages

In the event of a physician shortage for more than thirty (30) days, in clinical groups of five (5) or less as outlined in Section 11.D.1, and the shortage is due to a vacancy in the approved complement or extended sick leave, Health PEI shall make every reasonable effort to fill the vacancy with either permanent or temporary locum physicians. If a physician is required to provide additional on-call coverage as a result of such physician shortage (i.e., is required to be on-call on those days that otherwise would have been covered by a locum), the physician shall be paid, in addition to the applicable on-call retainer or per diem, the same locum support payment ($150 per day at the signing of this Agreement) that otherwise would have been paid to a locum to provide the on-call coverage. Such additional payment shall not apply where the physician shortage is due to Continuing Medical Education or vacation leave.

11.E **Hospital On-Call Response Fee** (fee code 0060)

A hospital On-Call Response Fee is intended to compensate on-call physicians for the disruption and inconvenience of having to respond emergently to the request of another physician or a charge nurse to provide service to a patient, which is not part of the on-call physician's normal routine, by returning to hospital after-hours (weekdays 18:00-08:00 and weekends/holidays 08:00-08:00

The hospital On-Call Response Fee for each clinical group shall be paid according to the fee code as listed in the Tariff of Fees, and shall qualify for weekend and holiday premiums as listed in the Preamble to the Tariff of Fees.

This fee may be claimed only once per day on-call, and is payable in addition to the physician's usual On-Call Retainer Fee plus fee-for-service or On-Call Perdiem.

For the purpose of this article, "hospital" is defined as: Queen Elizabeth Hospital, Prince County Hospital, Western Hospital, Community Hospital O'Leary, Stewart Memorial Hospital, Kings County Memorial Hospital, and Souris Hospital.

Payment of this fee requires clear documentation on the patient's chart outlining the time the physician was called in, the nature of the patient's emergent problem and the medical necessity for the physician to be called back to personally attend to the patient. A comment is required on the claim identifying the patient seen, the person who requested the physician's return to hospital and the nature of the emergency.

This fee is not payable if the physician has not been requested to return to hospital by another physician or a charge nurse, and is not payable if there is no medical necessity for the physician to attend to the request in person.

For physicians such as obstetricians who remain on-site after-hours while on-call, this fee may be claimed only if called to personally attend to a patient's emergent problem.

12. PREMIUM FEES

12.A After-Hours Premium

The following paragraphs show the charges applicable to physician services when provided on an emergency basis within defined hours. The rules regarding the application of After-Hours Premium for Emergency Services are as follows:

12A.1 Application of Premium

Where at least two thirds of a service rendered falls within a premium period, the premium rate applicable to that period shall apply for the entire service. In all other cases, the service must be billed at the lower rate.

12.A.2 Surgical Start Time

For billing purposes, the start time of surgical procedures is determined by the recorded anesthetic start time.

12.A.3 After-Hours Premium for Emergency Situations Only.

After hours premiums refer to emergency situations and are not to be billed when the time the service is rendered is for the convenience of the physician. For radiology services, the reading of the image must occur at the time of the emergency in order for the premium to apply.

Physicians are required to include on the comment record the date and time of the emergency situation. An E Indicator is required.

12.A.4 After-Hours Premium for Emergency Service (18:00-24:00)

Consultations, surgical procedures, assists for surgical procedures, deliveries, anaesthesia services, radiology services, resuscitation, home visits, community care facility visits, diagnostic

and therapeutic procedures, detention and other services rendered on an emergency basis during the hours of 18:00 to midnight shall be paid at normal fees plus 25%. Time and E indicator must be shown on claim.

12.A.5 After-Hours Premium for Emergency Service (24:00-08:00)

Consultations, surgical procedures, assists for surgical procedures, deliveries, anaesthesia services, radiology services, resuscitation, home visits, community care facility visits, diagnostic and therapeutic procedures, detention and other services rendered on an emergency basis during the hours of midnight to 08:00 shall be paid at normal fee plus 100%. Time and E indicator must be shown on claim.

12.A.6 After-Hours Premium for Emergency Service (08:00-18:00) (Saturdays, Sundays, Holidays)

Consultations, surgical procedures, assists for surgical procedures, deliveries, anesthesia services, radiology services, resuscitation, home visits, community care facility visits, diagnostic and therapeutic procedures, detention and other services rendered on an emergency basis during the hours 08:00 to 18:00 on Saturdays, Sundays and holidays shall be paid normal fees plus 25%. E indicator must be shown on claim.

12.B Weekend and Holiday Premium for On-Call Coverage

When on-call coverage is required to be provided on weekends (from Saturday 08:00 hrs to Monday 08:00 hrs) and on holidays as designated in the Preamble to the Tariff of Fees, all on-call retainers and perdiems shall be paid at the applicable rate plus an add-on premium of twenty-five per cent (25%). Effective 01-Oct-2012, Emergency Department sessional fees shall qualify for a weekend and holiday premium of 8%.

12.C. Weekend and Holiday Premium for Hospital Inpatient Visits

A premium of 25% shall apply to all hospital inpatient visits and Hospitalist daily sessional fees, provided on weekends and statutory holidays.

Applies to fee codes xx30, xx33, xx34, xx35, 0132, 0136, 0140, xx41, xx42, 0143, 0146, 0003, 0701, 0104, 0704, 0795, xx71, 0501, all critical care fee codes, hospitalist sessional fee codes

12.D. Geriatric Premium

A geriatric premium of 25% shall apply to all consultations, repeat consultations, office visits, home visits, ED visits and resuscitation provided to patients 75 years of age and over. This applies to Family Physicians and all other specialties.

Applies to fee codes xx60, xx62, xx10, xx11, xx13, xx21, xx24, xx80, xx81, xx90, xx91, xx86, xx87, xx68, xx69, 2231, 0512, 0563, 0123, 0812, 0182, 0183, 0184.

13. PSYCHIATRIC SERVICES

13.A. Psychotherapy

Psychotherapy is defined as a procedure carried out by a physician to treat mental, emotional and psychosomatic illness through a therapeutic relationship with the patient in an individual, group or family setting. Psychotherapy always entails continuing medical diagnostic evaluation and responsibility and may be carried out in conjunction with drugs and other treatment(s) (e.g. ECT). Psychotherapy assumes that the psychological and physical components of an illness are intertwined and that at any point in the disease process, psychological symptoms and signs may give rise to, substitute for, or run concurrently with physical symptoms and signs and vice versa.

This service is payable in blocks of fifteen (15) minutes or major portion thereof.

13.B. Certification for Admission to a Psychiatric Facility

Medical examinations required in connection with the certification of an entitled person to a mental institution or alcohol/drug treatment facility are acceptable as a benefit under the Plan (fee code 2800). A visit is not payable in addition to the certification examination. This fee code shall be subject to afterhours premiums, if indicated.

13.C. Limitation

Where a claim is submitted for psychotherapy provided to an entitled person, no claim shall be accepted for a subsequent visit by the same physician on the same day unless it is medically necessary or for an unrelated cause.

13.D. Psychotherapy Services in Hospital by Family Physician

A family physician may claim for psychotherapy in hospital**.**

13.E. Group Psychotherapy & Diagnostic/Therapeutic Interview

Billings must include PHN & DOB for each patient involved.

13.F. Hospital In-Patients under Attending Care of Psychiatrist

Fee code 0146 is payable to the family physician if a complete medical assessment is requested by the psychiatrist.

In addition, Supportive Care may be billed to a maximum of seven (7) visits during a hospital stay. The diagnosis may be the same or related for supportive care.

If the family physician is requested by the psychiatrist to see the patient for a physical condition, then Concurrent Care would apply (fee code 0142).

13.G. Case Management Conference

A Case Management Conference is a scheduled, multi-disciplinary meeting with other professionals for the purpose of discussing a treatment, management or intervention plan for the patient(s). The patient(s) and/or family members may or may not be present at the conference. This service is payable in blocks of fifteen (15) minutes or major portion thereof.

13.H. Diagnostic and Therapeutic Interview

A diagnostic and therapeutic interview is a scheduled interview with a patient and/or a patient's family or other persons who may have relevant information about the patient's circumstances for the purpose of obtaining a collateral history and discussing a treatment, management or intervention plan for the patient. The patient may or may not be present during the interview. This service is payable in blocks of fifteen (15) minutes or major portion thereof. This fee may be billed by psychiatry, pediatrics, internal medicine and family practice. This fee may also be billed by surgical specialties if the diagnosis is related to cancer.

13.I. Mental Health Crisis Care

Mental health crisis care is an unscheduled and unanticipated visit to a family physician by a patient who exhibits mental distress that requires immediate attention.

This service is payable in blocks of fifteen (15) minutes or major portion thereof.

14. SURGICAL SERVICES

The fee for surgical procedures shall include the customary pre and post-operative care as deemed necessary by the operating surgeon for a period of up to 30 days post-operatively or two office visits if necessary for the follow-up examination subsequent to discharge from hospital.

In cases where a surgeon is the primary physician responsible for critically-ill patients in an ICU, the surgeon shall be allowed to bill applicable Critical Care codes (0595-0598). However, these fees would not be applicable if another physician e.g. an internist is also charging Critical Care (0595-0598) rates. (Ref. Section 10.C.5.)

Laparoscopic procedures converted to open will not be paid in addition to surgical procedures as either Fee Code 5450 (Laparotomy) or Fee Code 5460 (Laparoscopy).

14.A. Pre-Operative Consultation and Investigation

A consultation by a surgeon which subsequently leads to surgery shall be paid in addition to the procedural fee, as long as the documentation requirements for consultations in Sections 9.A. or 10.A. are met.

In unusually complicated cases requiring prolonged preoperative care, visit fees may be claimed by the surgeon and must be accompanied by an adequate explanation.

14.B. Post-Operative Period

The normal post-operative period is deemed to be 30 days for all surgical procedures except fractures and dislocations where the normal post-operative period is 45 days.

14.C. Procedures During Visits

Surgical procedures performed in the course of a home visit may be charged in addition to the fee for the visit but if performed in connection with an office call, only procedure fees shall be charged if it was the primary reason for the visit. A procedural fee may be charged in addition to the office visit fee when the condition requiring the procedure was not the primary reason for the visit. Explanation must be provided clearly indicating there is no relationship between these two services.

14.D. Cosmetic Surgery (See PRIOR APPROVAL Section 30 & Preamble Appendix D)

14.E. SURGICAL PROCEDURES

14E.1 Role Codes

Role Codes #24, #25, #26 and #27 apply when the attending surgeon identifies the need for a qualified actively practicing second surgeon to assist in a procedure because of the second surgeon's expertise in a specific area. Prior approval is required for non-emergency cases, explaining the requirement for a second surgeon.

#10 Surgeon billing 100% of tariff

#11 Surgeon billing 65% of tariff - applies to surgeries performed by the same surgeon through different incisions under the same anaesthetic.

#12 Surgeon billing 50% of tariff - applies to surgeries performed by the same surgeon through the same incision under the same anaesthetic.

#21 Assistant billing 33% of surgeon's claim where **surgeon has billed 100%** of tariff (surgeon role #10).

#22 Assistant billing 33% of surgeon's claim where **surgeon has billed 65%** of tariff (surgeon role #11).

#23 Assistant billing 33% of surgeon's claim where **surgeon has billed 50%** of tariff (surgeon role #12).

#24 Assistant billing 75% of surgeon's claim where **surgeon has billed 100%** of tariff (surgeon role #10).

#25 Assistant billing 75% of surgeon's claim where **surgeon has billed 65**% of tariff (surgeon role #11).

#26 Assistant billing 75% of surgeon's claim where **surgeon has billed 50%** of tariff (surgeon role #12).

#27 Assistant billing 75% of surgeon's claim where an **intra-operative consultation** has occurred. (Ref 14.E.5.(c))

14.E.2 Similar Procedures Done Concurrently

When two similar procedures, e.g. sutures, are done at one time, the charge for the second procedure should be 50% of the listed fee, or as indicated in the schedule. When done at an interval under a separate anaesthetic, the full fee shall apply.

14.E.3 Multiple Procedures Through Same Incision

When more than one operative procedure is performed by the same surgeon through the same incision and under the same anaesthetic, the full fee shall be charged for the major procedure, and 50% the listed fee for the second procedure, except where such combined operations are specified in the schedule. This does not apply where an appendix or ovarian cyst is removed incidentally during an operation, for which no additional payment shall be made. Oophorectomy performed at the time of hysterectomy is billable only if ovarian pathology is present, at a rate of 25% for each ovary.

14.E.4 Multiple Procedures Through Separate Incisions

When procedures are done by one surgeon through separate incisions under one anaesthetic, the charge for the lesser procedure should be 65% of the listed fee.

14.E.5 Separate Surgeons

(a) Different Procedures

When different operative procedures are done by two different surgeons under the same anaesthetic for different conditions, the fee shall be 100% of the listed fee for each condition.

(b) Same Procedure

Where the attending surgeon identifies the need for a qualified actively practicing second surgeon to assist in a procedure because of the second surgeon's expertise in a specific area, the

second surgeon shall be paid at 75% of the attending surgeon's fee. Prior approval is required for non-emergency cases, explaining the requirement for a second surgeon.

(c) Intra-operative Consultations

When the attending physician identifies the need for a consultation from a qualified actively practicing second surgeon, during an operation in progress, the second surgeon shall be paid a separate consultation fee.

If the second surgeon assumes responsibility for the surgery, he shall be paid the surgical fee but not the consultation. The original surgeon shall be paid an assistant fee at 75% (Role Code #27). The original assistant (now the second assistant) shall continue to be paid at 33% (Role Code #21).

If the second surgeon becomes an assistant, the second surgeon shall be paid a separate consultation fee and an assistant's fee paid at 75% (Role code # 24). The original surgeon shall be paid for the operation at 100% (Role Code #10). The original assistant (now the second assistant) shall continue to be paid at 33% (Role Code #21).

If a second surgeon of a different specialty comes in and does his surgery, a consult will be paid.

14.E.6 Subsequent Operation

When a subsequent operation becomes necessary during the same hospitalization because of complications, or for a new or different condition developing during the same hospitalization, full fee shall be paid for procedures listed in the surgical schedule, which are performed because of complications.

14.E.7 Procedure Done in Stages

Where operative procedures are normally performed in stages, the full fee may be claimed for each procedure.

14.E.8 Pre-operative Diagnostic Procedures

Diagnostic procedures carried out prior to surgery shall be eligible for payment according to the Schedule.

14.E.9 Surgical Procedures Performed in Ambulatory Settings

Surgical procedures that can be safely and appropriately performed in an approved ambulatory setting (i.e., a hospital setting or a non-hospital setting approved by Health PEI) shall be paid at the same rate as if the procedure had been performed in a hospital operating room.

15. SURGICAL ASSISTANTS

15.A. Minor Surgical Procedure

The necessity of a surgical assistant for a minor surgical procedure shall be left to the discretion of the surgeon. On occasion, explanations may be required.

15.B Schedule of Rates

A surgical assistant shall render a separate claim for his services in accordance with the following:

(i) 33% of the fee listed for the procedure

(ii) When a second assistant is required by the surgeon, he may claim a fee as if he were the first assistant. Necessity of the second assistant must be indicated on the surgeon's claim and Health PEI has been assured that the requirement for a second assistant shall be a low frequency item

(iii) Surgical assists must be identified with Role Code No. 21, 22, 23, 24, 25, 26 or 27 as applicable on the claim

15.C. Concurrent Care Limitations

When an Assistant's fee is claimed, the physician may not claim for Concurrent or Supportive Care unless he is caring for a disease or condition not related to the surgical procedure at which he assisted.

16. VASCULAR SURGICAL PROCEDURES

16.A. Veins and Arteries

(i) Excision or repair procedures for arteries and veins include endarterectomy, thrombectomy and/or bypass graft.

(ii) Excision or repair procedures for arteries and veins include harvest of graft tissue, except where the harvest of graft tissue is beyond the normal parameters, which will be paid for as indicated.

(iii) Common femoral artery repair includes repair to the profunda femoris artery as far as the first major branch. If the repair extends beyond the first major branch of the profunda femoris artery, Fee Code 4652 may be claimed in addition. If added to another vascular procedure in the same incision/limb the fee will be paid at 50%.

(iv) Exposure of leg vessels for evaluation and re-vascularization - Fee Code 4643 may be claimed plus fee for sympathectomy or amputation, if required.

(v) Two distinct vascular procedures at same sitting, with same exposure, the second procedure will be paid at 50%.

(vi) Two distinct vascular or endovascular procedures via different exposures, the second procedure will be paid at 65%.

16.B. Harvesting

A surgeon may claim an add on fee when harvesting an arm vein, a superficial femoral vein or an opposite leg vein from the non-operative site.

16.C. Venous Wounds

During vascular procedures on venous wounds a laparotomy or thoracotomy will be paid at 50%, if required.

16.D. Arteriovenous Procedures

If an arteriovenous fistula is required as part of a vascular procedure, it shall be paid at 50% of the operation procedure.

16.E. Portal Hypertension

The fee for portal hypertension procedures shall include a splenectomy, as required.

16.F. Percutaneous Arterial Procedures

(i) Angiography for the renal mesenteric arch shall be paid per minor vessel, in addition to Fee Code 4635 – Arteriography Selective.

(ii) Multiple angioplasties are paid as one fee for each named vessel. If an angioplasty is required on a contiguous vessel it will be paid at 50%.

(iii) Operative arteriography will only be paid once per vessel per 24-hour period.

16.G. Aorto-iliac Procedures

(i) For aorto-iliac procedures, if a thoracotomy or laparotomy procedure is required, it shall be paid in addition to the operative procedure.

(ii) If re-vascularization is required for the removal of infected aortic graph stem and limbs, it will be paid in addition to the operative procedure at 50%.

16.H. Lower Limb Arterial Procedures

In cases of extended profundoplasty – first or second muscular branch – Fee Codes 4642 and 4652 may be claimed if it is the sole procedure. If done as a secondary procedure, it may be claimed at 50%.

17. FRACTURE CARE

17.A. Definitions

Open reduction shall mean the reduction of a fracture by an operative procedure and is intended to include exposure of the fracture site with fixation as indicated.

Closed reduction shall mean the reduction of a fracture by non-operative methods with the aid of local or general anesthesia.

No reduction shall mean treatment of a fracture by any method other than that designated above.

17. B. Composite Fee

The fees listed for fractures are intended to cover the treatment of the fracture including any necessary after care, e.g. physiotherapy supervision, exercises, cast changes, etc., for a period of forty five (45) days. Where aftercare cannot be provided by the initial surgeon, the subsequent treating physician is entitled to claim for a cast change when required.

17.C. Immobilization

Immobilization in a plaster cast or splint is not a prerequisite for claiming a fee for fractures.

17.D. Compound Fractures

The fee for compound fractures and/or compound dislocations shall be the fee for the appropriate fracture or dislocation plus 50%.

If an open reduction is performed, the fee for the open reduction shall apply.

17.E. Separate Surgeons

If different surgeons treat different fractures on the same patient at the same time, each surgeon shall be entitled to full fees for the initial fracture and 50% fees for subsequent fractures treated.

17.F. Repeated Closed Reductions

When repeated closed reductions are carried out by one surgeon for the same fracture, then the listed fee for that fracture shall apply to the first reduction and 50% for each subsequent

reduction. In cases where two closed reductions are done for one fracture, the tariff should be half the usual fee for the first reduction when done by the same surgeon. When the subsequent reduction is done by a different surgeon, the full fee should apply in each case.

17.G. Closed Reduction followed by Open Reduction

Where one surgeon performs a closed reduction of a fracture and later has to perform an open reduction, then the fee shall be 50% for the closed reduction and 100% for the open reduction.

17.H. Multiple Fractures

In multiple fractures, the fee for the major fracture requiring open reduction, plus 50% of the fee for the minor fractures requiring cast or closed reduction, shall apply.

17.I. Second Surgeon

When it becomes necessary for a second surgeon to perform a reduction, the full fee shall apply for this procedure. The first physician in this case shall be entitled to 100% of the fee for the closed reduction.

18. ANESTHESIA SERVICES

18.A. Anesthesia Fees

Anesthesia fees are payable only when the anesthetic is personally administered by a physician other than the surgeon, assistant surgeon or obstetrician and who remains in constant attendance during the procedure for the sole purpose of rendering an anesthetic service.

An anesthesia fee is for professional services only and includes:

18.B. Pre-Anesthesia Evaluation

Pre-anesthesia evaluation of the patient as an anesthetic risk, ordering of pre-medication as indicated, administration of all types of anesthesia, fluids or blood incidental to anesthesia or surgical procedure and immediate post-anesthetic supervision.

18.C. Supportive and Resuscitation Measures

Immediate supportive and resuscitation measures in the operating room and/or the recovery ward as indicated by the patient's condition.

18.D. Complication

Treatment of any complication arising from anesthesia within 48 hours.

18.E. Anesthesia Detention Fee

Anesthesia detention fees apply when an anesthetist is called and is personally present as a stand by to render anesthetic services**.**

18.F. Anesthesia for a Normal Delivery

Anesthesia for a normal delivery is an allowable service providing it was medically necessary in the opinion of the attending physician.

18.G. Anesthesia Outside Hospital

Claims for anesthetic services by a physician outside hospital shall be considered for payment only in an emergency or disaster situation.

18.H. Cancelled Surgery

This fee code (0266) is claimed when an anesthetist makes a pre-operative visit to a patient whose surgery is subsequently cancelled. If the anesthetist administers anesthesia within 7 days from the visit, this fee code is not payable; if anesthesia is administered by a different anesthetist, then the fee is payable.

18.I. Definition Beginning and End of Anesthesia

Anesthesia time begins, with the exception of ECT cases, ten (10) minutes prior to the patient's arrival in the operation room to allow for informed consent and preparation of equipment and ends when the anesthetist is no longer in personal attendance (when the patient may be safely placed under the customary post-operative supervision). Anesthesia time may extend for up to 30 minutes after the patient leaves the operating room.

19. OBSTETRICAL SERVICES

Obstetrical care includes initial visit, prenatal visits and necessary laboratory tests, delivery, post- partum care in hospital and postnatal visit. All composite obstetrical fees have been eliminated in favor of individual fees for services rendered.

19.A. Prenatal Visits

These are visits to a physician's office prior to delivery of the infant. These are usually monthly visits but may be more frequent in the last three months. Claims should be submitted on a regular basis and not held until delivery takes place.

19.B. Delivery

This usually refers to the time in hospital while labor proceeds to the delivery of the infant.

Where a failed operative (forceps) delivery leads to C-section by the same physician, the C-section fee code 6004 is payable at 100% and failed operation (forceps) delivery 6007 is payable at 50%.

Fee code 0004 is to be claimed if the general practitioner has attended a difficult labor and/or attended difficult delivery or cesarean section. This fee code may also be claimed and paid in full by a physician called on an emergency basis to attend a precipitous delivery prior to the arrival of the attending physician/obstetrician. In either case, the attending physician/obstetrician shall also be paid in full for attending at the delivery, unless the entire delivery has already been completed prior to the arrival of the attending physician/obstetrician.

19.C. In-Hospital Post-partum Care

This refers to the immediate care following delivery of the baby while the mother is still in hospital.

19.D. Postnatal Visit

This usually occurs about 6 weeks following the delivery and shall include a pelvic examination. Therefore, the postnatal period is defined as approximately 6 weeks.

19.E. Multiple Pregnancy

Second and additional deliveries shall be claimed at 100% of delivery fee.

19.F. Outpatient Assessment for Complications of Pregnancy/Labor

This tariff can be billed where a patient presents to hospital with a complication of pregnancy or labor after 20 weeks gestation by dates. An obstetrician may bill this tariff without a consultation request, provided the physician has not seen the patient within the prior 30 days. The service must include all the components of a major consultation with the appropriate chart documentation.

19.G. Obstetric Ultrasound

Obstetric Ultrasound may be billed by an obstetrician when performed in hospital to assess fetal viability once in the first trimester. It may be repeated after 12 weeks gestation to determine viability if examination by fetoscope or doppler fails to detect a fetal heart beat. It may be billed after 24 weeks gestation to assess fetal pelvic presentation and to locate the placenta. It may not be billed if an ultrasound is performed in Diagnostic Imaging for the same diagnosis on the same day.

19.H. Oxytocin Challenge Test

Oxytocin Challenge Test may be performed in the Labor and Delivery Unit by an Obstetrician to ascertain fetal well-being in a fetus who has reached the age of viability and shows signs of possible intrauterine compromise.

19. I. Scalp pH Monitoring

Scalp pH Monitoring may be performed in the Labor and Delivery Unit by an Obstetrician to help to assess the well-being of a fetus with a non-reassuring fetal heart tracing or other signs of possible intrauterine compromise in labor. Payment will be limited to 3 times per labor.

19. J. Biophysical Profile

Biophysical Profile Assessment may be performed by an Obstetrician to assess the well-being of a fetus. The examination may include ultrasonographic assessment of fetal breathing, fetal tone, fetal movement and amnionic fluid volume.

19.K Induction of Labor

Payment will not be made for ARM as the sole means of induction.

20. PEDIATRIC SERVICES

20.A. Newborn Care

Newborn care refers to routine care of a well baby during the first ten (10) days including complete examination and necessary parental advice.

Premature infant means an infant weighing 5 ½ lbs. (2500 grams) or less at birth.

Fee code 1136 applies to attendance at maternal delivery and shall include the consult. Fee code 1160, a pediatric consult, may not be billed on the same day as 1136 unless a comment is provided. Fee code 1136 may be billed in addition to fee codes 1145, 1148 or 1150 (Pediatric Intensive Care).

20.A.1 Pediatric Detention for Newborn Resuscitation

The Pediatric detention fee (1170) may be billed when a pediatrician is requested by an obstetrician to be physically present on stand-by in anticipation of rendering newborn resuscition services when a delivery occurs. This stand-by detention shall commence at the time the obstetrician specifies physical attendance is required and shall end once the delivery occurs and newborn resuscition (1136) begins.

20.B. Well Baby Care

Well baby care refers to periodic office visits to a maximum of nine visits of a healthy baby for routine supervision and development and any parental instructions required. Well baby care may be claimed only until the patient reaches his/her first birthday. Claims billed under well baby care after the first birthday shall be paid as office visits and a diagnosis shall be necessary.

20.C. Child Care

Pediatrics shall include the care of children up to their 16th birthday.

20.D. Patients 16 and over

Consultations for those patients 16 years of age and over shall be considered if accompanied by an explanation.

20.E. Pediatric Critical Care

Fee Code 1154 can be billed for pediatric patients who are ill enough to require critical care, which includes constant nursing care, continuous cardio-respiratory monitoring and intravenous therapy. This code can be billed regardless of whether the patient is in ICU or in a designated room on the pediatric floor with specialized nursing care. Appropriate documentation must be on the chart.

21. DIAGNOSTIC AND THERAPEUTIC PROCEDURES

When a Diagnostic and Therapeutic Procedure is claimed at the same time as a visit or consultation fee, both fees are payable in full, except when such procedure is the sole reason for the patient's attendance.

21.A. Provision of Surgical Dressing in Physician's Office

Change of Surgical Dressing in a physician's office may be claimed under Tariff of Fees fee code 2010 in Diagnostic and Therapeutic Procedures whether rendered by the physician or his staff.

21.B. Multiple Venepunctures

When a diagnostic test requires multiple venepunctures, up to five (5) venepunctures (fee code 2238) in one day may be billed if an appropriate comment is included.

21.C. Pelvic Examination

Pap smear with or without pelvic examination (fee code 2008) or pelvic examination only (fee code 2001) may be billed in conjunction with any visit other than an obstetrical or gynecological consultation.

21.D. Vaginal Pessary Fitting

This fee code may be billed by a Gynecologist, in addition to a consultation or visit fee, for a patient with pelvic relaxation problems. Subsequent follow-up visits after the initial fitting shall be paid as an office visit.

21.E. Urodynamic Studies

No more than four (4) urodynamic study fee codes may be billed per patient per visit.

21.F. Skin Lesions

Generally, removal of skin lesions for cosmetic purposes is not an insured service. However, the following conditions are insured services:

(i) The removal of malignant lesions or lesions recognized as presenting a significant risk of producing malignant lesions. Examples are neurofibromatosis (Von Recklinghausen's disease), keratoses in chronic dialysis patients.

(ii) The removal of non-malignant skin lesions, which because of their location or size, result in recurring bleeding or recurring infections not amenable to non-surgical management.

(iii) Fee Code 3046 (single or multiple) is limited to a maximum of three sittings per year for each individual patient per physician.

(iv) Excision Biopsy (fee code 3030) of skin lesions for the purpose of determination of pathology.

21.G. Injections

21.G.1. Injections of Vitamin B12 for Pernicious Anemia

Injections of B12 shall not be paid more frequently than once every four (4) weeks after the first two weeks of such treatment.

21.G.2. Subsequent Injections on the Same Visit

An additional amount shall not be allowed for subsequent injections on the same visit unless the patient develops a reaction at the time of the visit requiring further treatment. This is in accordance with the wording of the Tariff of Fees, fee code 2009.

21.G.3. Injection of Joints

Where two or more joints are injected on the same visit, 65% (as per surgical rules) of the usual fee shall be allowed for the second and subsequent procedures.

21.H Emergency Department Ultrasound

ED Ultrasound may be billed once per patient per physician per day by a physician appropriately trained in ED Ultrasound procedures.

21.I. Emergency Procedural Sedation

Procedural sedation is payable in addition to the procedure for which sedation is required, and applies to emergency procedures only.

21.J. Modified Sleep Apnea Study

Modified sleep apnea study will be limited to one per month per patient.

21.K Electromyography (EMG) and Nerve Conduction Studies

When referring to muscles of more than one region, or examination of a specific region, "region" is intended to mean one of the four following anatomic areas: head and neck, both upper limbs, both lower limbs, trunk (anterior and posterior).

When referring to nerve conduction studies, "per nerve studied" is intended to mean both the motor and sensory nerve conduction examination of a single nerve (mixed, motor, or sensory). Multiples may be claimed when another nerve (mixed, motor, or sensory) is examined and when separate nerve conduction studies of a major nerve branch are required, to a maximum of six (6) nerves.

Electrophysiological evaluation for nerve entrapment is a composite fee including conduction studies of one or more nerves suspected of being entrapped, together with EMG studies of the appropriate muscles as necessary.

21.L Dialysis Management

Remuneration for the management of patients receiving hemodialysis may be through direct patient contact in dialysis units in Charlottetown and Summerside, as well as through indirect distance supervision of patients in satellite dialysis units in Alberton and Souris.

Patients in Charlottetown and Summerside will receive directed care through regular physician contact in their respective dialysis units. Patients in Alberton and Souris will follow a satellite model unless directed care is mandated by specific patient issues. Satellite care includes phone and fax communication with nursing staff, prescription requests, monitoring of lab data, monthly teleconferences, liaison with other physicians, quarterly patient assessments, and other dialysis needs that may arise. It is assumed that patients receive dialysis three times weekly, and physicians are available 24 hours daily.

Direct physician management is care provided by the physician to the patient at the dialysis site on the day of treatment. Direct physician management of dialysis for acutely ill patients shall be payable using fee code 2055 for the initial acute treatment and fee code 2056 for up to two subsequent acute treatments. Direct physician management of dialysis for patients with chronic renal failure shall be payable using fee code 2135 for the initial treatment and fee code 2137 for all subsequent treatments, up to a maximum of three (3) treatments per patient per week. Satellite dialysis care (indirect distance supervision) shall be payable as a weekly management fee per patient using fee code 2058.

21.M Pain Management

Chronic Pain Consultation and Follow-up

Chronic pain management consultations and follow-up visits (fee codes 0250 and 0252) may be billed only by physicians designated by Health PEI as having additional recognized training and expertise in pain management.

Peripheral Nerve Blocks

Nerve blocks are eligible for payment only when rendered as an isolated service for diagnostic or therapeutic purposes. Nerve blocks administered as regional anesthesia prior to, during, immediately following a diagnostic, therapeutic or surgical procedure which the physician performs on the same patient are not eligible for payment. Local infiltration used as an anesthetic for any procedure is not eligible for payment. When a major plexus or peripheral nerve block is rendered, additional blocks of one or more nerves within the same nerve distribution are not eligible for payment.

Unless otherwise specified, all nerve block fee codes are for unilateral procedures only; if a bilateral block is performed, the second side is payable at 65% of the first.

Notwithstanding maximums applicable to individual nerve block services, there is an overall maximum of eight (8) per patient per day for any combination of nerve blocks. Nerve blocks beyond this overall maximum are not eligible for payment. Nerve blocks which are defined as a bilateral procedure are counted as two (2) services for the purpose of the overall daily maximum.

Peripheral nerve blocks with sclerosing solutions such as alcohol or phenol are payable as a 50% add-on premium to the peripheral nerve block fee, and require an explanatory comment on the claim.

Interventional Pain Injections

Interventional pain injections include injections into facet and sacroiliac joints, nerve roots, epidural and subarachnoid spaces, sympathetic nerve trunks and other deep nerve plexus/ganglia blocks rendered for the purpose of diagnosing the source of pain or developing a therapeutic treatment plan. Most of these injections are payable only when rendered with imaging guidance; in such cases, the imaging fees are included in the overall injection fee and are not payable separately. Interventional pain injections include the injection of contrast, medication and/or other solutions.

Interventional pain injections are only eligible for payment if documentation clearly describes:

- the procedure performed or, where image guidance is used, images of needle placement that clearly identify the site of injection and/or spread of contrast; and,
- the purpose of any diagnostic pain-related injection and the subsequent response to the procedure indicating a positive or negative result.

22. LABORATORY SERVICES

22.A. Autopsies

A complete autopsy consists of dissection of the chest, abdomen, and head. A limited autopsy consists of dissection of a particular region with exclusion of other areas (e.g., dissection of the chest and abdomen, with exclusion of the head).

22.B. Cytology

Cytology fees are applicable to those cases requiring diagnosis after screening by a cytotechnologist or those cases requiring screening by a pathologist as part of an accepted and recognized quality control program.

23. DIAGNOSTIC IMAGING SERVICES

23.A. MRI - Limitations

(i)	Cranial repeat sequence	- Fee Code 8976	- maximum of three repeats
	Thorax repeat sequence	- Fee Code 8981	- maximum of three repeats
	Abdomen repeat sequence	- Fee Code 8983	- maximum of three repeats
	Spine repeat sequence	- Fee Code 8989	- maximum of three repeats
(ii)	ENT repeat sequence	- Fee Code 8978	- maximum of three repeats plus GAD

(iii) Pelvis repeat sequence - Fee Code 8985 - maximum of four repeats plus GAD

(iv) Extremities repeat sequence - Fee Code 8987 - maximum of three repeats

24 PATIENT ACCESS TO PHYSICIAN PROGRAM

24.A Purpose

The goal of this program is to provide access to a family physician for those patients who are currently experiencing difficulty in obtaining a regular family physician.

Health PEI shall provide a one-time fee of $150 each time that an eligible family physician accepts an eligible patient into his/her practice.

24.B Eligibility

For the purpose of this program, an "eligible patient" means a patient who is registered with the Provincial Patient Registry, excluding children under the age of six months whose custodial parent has a family physician.

"Eligible Physician" means a physician who:

(i) is part of the provincial family physician complement,
(ii) resides and carries on a family practice in Prince Edward Island,
(iii) has and uses active hospital admitting and treatment privileges at a PEI hospital,
(iv) has 1,200 or more active patients in his/her practice (pro-rated for a part-time physician), and/or
(v) has billed 4100 services (pro-rated for a part-time physician) annually from the following list of codes Monday - Friday between the hours of 8:00 am and 6:00 pm:

0100; 0103; 0105; 0110; 0112; 0113; 0115; 0118; 0121;
2228; 2229; 2230; 2231; 2501; 2502; 2505; 2507; 2508.

For the purpose of this program, "active patient" means a patient who has received at least one medical service from an eligible physician in the previous 18-month period.

For the purpose of determining ongoing eligibility under this program, the number of active patients and the number of applicable services shall be determined by Health PEI annually.

Family physicians who are paid under salary, contract, or fee-for-service are eligible and can retain 100% of the fee code. Locum physicians are not eligible for this program.

24.C Implementation

When an eligible physician accepts an eligible patient into his/her practice, a patient-physician agreement must be entered into. The form and content of such agreement is attached as Preamble Appendix F. The physician must submit a fully completed agreement each time this New Patient Fee is billed. The New Patient Fee code is 0010.

The physician must provide the patient with at least one insured medical service in order to claim the New Patient Fee. No new patient fees shall be paid to a physician exceeding 2000 active patients unless given prior approval by Health PEI. Such approval shall be subject to a reasonable plan for access for patients, which may include use of alternate health care providers in a collaborative practice.

Any patient who returns to the Provincial Patient Registry within 12 months of payment of a New Patient Fee shall trigger a recovery of the New Patient Fee. If the physician ceases practice within the province, or ceases to provide care for the new patient, within 12 months of claiming the New Patient Fee, the New Patient Fee must be repaid to Health PEI and may be set-off against other remuneration due to the physician.

25. MISCELLANEOUS

25.A. Time Limit - Submission of Claims

Subsection 19.1 of the *Health Services Payment Act Regulations* states in part that "a physician who renders a basic health service to an entitled person shall submit his claim for service within three (3) months of the date on which the service was rendered in such form and manner as the Department may prescribe."

25.B. Time Limit - Surgical/Obstetrical Claims

The time period allowed before a surgical procedure becomes outdated for billing purposes shall begin on the date on which the major procedure was performed.

25.C. Time Limit - Claims on Extended Care Patients

Claims for services rendered to extended care patients and obstetrical patients should be submitted at appropriate intervals to ensure that no period greater than the allowable time elapses between the provision of a service and the date the corresponding claim is received at Health PEI.

25.D. Time Limit - Submission of Appeals

Physicians appealing a reduction or rejection of a claim also are required to submit their appeal prior to the expiry of the allowable time period from the date the claim appeared on a payment

statement. Failure to do so shall result in the appeal being declared "stale dated" and not reviewed.

25.E. Maximum Visit

When there are more than 10 non-hospital visits in 90 days to the same physician, a comment record is required to substantiate payment of the claim.

26. UNINSURED SERVICES / Examinations Requested by a Third Party

Section 1(d)(I) (D) of the *Health Services Payment Act Regulations* states that "examinations required in connection with employment, insurance, admission to an educational institution or camp, procurement of a passport or visa or legal proceedings, or any similar examination at the request of a third party are excluded as Basic Health Services."

Included in the above would be services and examinations rendered at the request of the following groups:

a. Insurance companies
b. Educational institutions
c. Employers
d. Youth groups, e.g. Scouts Canada, Cadet Services of Canada
e. Various summer camps
f. Office of the Attorney General - PEI (e.g., court requests, jury duty exemption)
g. Workers' Compensation Board of any province or territory
h. Veterans Affairs Canada (incl. RCMP)
i. Citizenship and Immigration - Canada - e.g., Visa Purposes
j. Federal, Provincial or Municipal Governments
k. Physical Examination For Adoption Purposes
l. Advice and Injection for Out of Country Travel
m. National Defense Canada
n. Group examination immunizations or inoculations unless such group, prior to administration of such examinations, immunizations or inoculations, received approval thereof by the Minister – Section 1(d)(i)(E) – *Health Services Payment Act*.

Claims for discussion of a patient's condition with another member of the family, other than for psychotherapy or diagnostic/therapeutic interview, shall not be accepted as an insured service.

27. HOLIDAYS

For the purpose of the Tariff of Fees, the following days are designated holidays:

a. New Year's Day
b. Islander Day

c. Good Friday
d. Easter Monday
e. Victoria Day
f. Canada Day
g. Labor Day
h. Thanksgiving
i. Remembrance Day
j. Christmas Day
k. Boxing Day
l. Christmas Eve Afternoon (12 noon)
m. Floating holiday
   - Lobster Carnival Day for Prince County
   - Gold Cup and Saucer Day for Queens & Kings Counties

When a statutory holiday falls on a Saturday or Sunday and when such statutory holiday is celebrated on a subsequent weekday, holiday rates shall apply for services rendered on an emergency basis on that designated weekday.

Holidays are considered to begin at 08:00 hrs on the day of the holiday (or designated holiday), and end at 08:00 hrs the following morning.

28. INTERPROVINCIAL RECIPROCAL BILLING OF MEDICAL CLAIMS

On April 1, 1988 a reciprocal billing arrangement for physician's medical claims came into effect between Prince Edward Island and all provinces and territories except Quebec.

The arrangement allows Prince Edward Island physicians to bill Health PEI directly for services rendered to eligible Canadian residents other than residents covered by the Quebec Plan.

29. WORKERS' COMPENSATION BOARD CLAIMS

Where a patient receives services for a WCB-related complaint and at the same visit, receives a service for an unrelated diagnosis, both services may be billed to the respective paying agencies.

30. PRIOR APPROVAL

All physician referrals made for non-emergency out-of-province/out-of-country physician or hospital services must receive prior approval from Health PEI. Prior approval is not necessary in the case of emergency transfers but an emergency out-of-province referral request must still be reported on a claim to Health PEI using the appropriate out-of-province referral fee code. Failure to obtain prior or emergency approval shall result in the patient/parent being held responsible for the total costs of the services. Schedule D outlines the policy/procedures for the out-of-province referral program. Such prior approval is valid for a period of one (1) year.

31. AUDIT PROCESS

An audit process is defined in the *Health Services Payment Act and Regulations* which charges Health PEI with the responsibility to ensure accountability for expenditures on basic health services.

32. ADMINISTRATIVE MEETINGS

A physician is eligible to claim an Administrative Meeting fee (fee code 0050) when the meeting meets the following criteria:

(a) The meeting is initiated or authorized by an individual to whom the physician is accountable, for example, a Medical Director or Health Care Network Manager;
(b) The meeting is planned in advance; and
(c) The discussions of the meeting are documented.

Up to two meetings per month are eligible for payment for workplace/unit staff meetings, for example, hospital department staff meetings and primary health care clinic staff meetings.

In addition, presentations for education sessions are eligible to be claimed as administrative meetings, provided the education sessions are part of the physician's duties and the sessions are being done at the direction of a supervisor. Preparation time to a maximum of four (4) hours may also be eligible.

Attendance at CME (professional development) and meetings with medical supply or pharmaceutical representatives are **not** eligible for this fee.

Any physician who receives an honorarium or an administrative stipend for such meetings is **not** eligible to claim the Administrative Meeting fee for these meetings.

Billing should be claimed as fee code 0050 per 15 minutes, using Provincial Health Number "01741230" and Diagnostic Code "V689". Time of day, time spent and comments are required on the claim, which should be billed as fee-for-service or shadow-billing, depending on the physician's payment modality at the time of the meeting.

Preamble APPENDIX A

TREATMENT LOCATIONS

Code	Facility
001	Queen Elizabeth Hospital
002	Hillsborough Hospital
003	Prince County Hospital
004	Western Hospital
005	King's County Memorial Hospital
006	Community Hospital
007	Souris Hospital
008	Stewart Memorial Hospital
009	Dr. Eric Found Centre
011	Addiction Services (Queen's County)
012	Addiction Services (Souris)
013	Addiction Services (Summerside)
014	Beach Grove Home
015	Prince Edward Home
016	Wedgewood Manor
017	Summerset Manor
018	Maplewood Manor
019	Colville Manor
020	Riverview Manor
021	Garden Home
022	Whisperwood Villa (Long Term Care)
023	Lennox Nursing Home
024	Parkwest Lodge
025	Atlantic Baptist Home
026	MacMillan Lodge
027	Sunset Lodge
028	Clinton View Lodge (Long Term Care)
029	Dr. John Gillis Lodge (Long Term Care)
030	South Shore Villa (Long Term Care)
031	Sherwood Home
032	Provincial Correctional Centre
033	Prince County Jail
034	PEI Youth Centre
035	Community Care Facilities
036	Margaret Stewart Ellis LTC (Community Hospital)
037	Long Term Care (Stewart Memorial Hospital)
038	Acute Care No Longer Required (Western Hospital)
039	Visiting Specialist (Prince County Hospital)
040	Visiting Specialist (Queen Elizabeth Hospital)
041	Patient's Home
042	Lady Slipper Villa
043	Acute Care No Longer Required (King's County)
044	Acute Care No Longer Required (Souris Hospital)
045	Whisperwood Villa (Community Care)
046	Clinton View Lodge (Community Care)
047	Dr. John Gillis Lodge (Community Care)
048	South Shore Villa (Community Care)
049	Salaried Physician Office (Souris)
150	Davis Lodge (Community Care)
151	Rev. Phillips Residence (Community Care)
152	Le Chez Nova (Community Care)
153	MacDonald Rest Home (Community Care)
154	MacEwen Mews (Community Care)
155	Miscouche Villa (Community Care)
156	Andrews Lodge - Charlottetown (Community Care)
157	The Valley Lodge (Community Care)
158	Corrigan Home (Community Care)
159	Corrigan Lodge (Community Care)
160	Langille House (Community Care)
161	MacQuaid Lodge (Community Care)
162	Old Rose Lodge (Community Care)
163	Riverview Rest Home (Community Care)
164	Rosewood Residence (Community Care)
165	MacKinnon Pines (Community Care)
166	Shady Rest (Community Care)
167	Bayview Lodge (Community Care)
168	Addiction Services (Montague)
169	Addiction Services (Alberton)
170	Andrews Lodge II (Summerside)
171	Richmond Centre
172	McGill Centre
173	Four Neighbourhoods Community Health Centre
174	Lacey House
175	Mental Health Clinic (Summerside)
176	Beechwood Family Health Centre (O'Leary)
177	Central Queens Health Centre (Hunter River)
178	Gulf Shore Family Health Centre
179	Polyclinic Night Clinic
180	Harbourside Family Health Centre (Summerside)
181	Smith Lodge
182	Boardwalk Professional Clinic
183	Salaried Physician Office (Montague)
184	Polyclinic
185	Parkdale Medical Centre
186	Addiction Services (Mt. Herbert)
187	Garfield Street
188	Sherwood Medical Centre
189	Andrews Lodge (Stratford)
190	Crapaud Wholeness Family Clinic
191	O'Leary Health Centre
192	Tyne Valley Health Centre
193	Eastern Kings Health Centre
194	Guardian Drug O'Leary Clinic
195	Murphy's Stratford Walk-in Clinic
951	King's County Medical Centre
952	Western Hospital Clinic
953	Charlottetown Area Health Centre
954	Summerside Medical Centre
955	Vogue Optical
956	Cornwall Medical Centre
957	Kensington Family Medical Centre
958	Stratford Medical Clinic
960	Dr. Hani Farag Office
961	Dr. Abdulrahem Laftah Office
962	Dr. Issam Habbi Office
963	Dr. Baldev Sethi Office
964	Dr. Phil Hansen Office
965	Dr. Chris Stewart Office
966	Dr. Gregory Mitton Office
967	Dr. Guy Boswall Office
968	Dr. Lloyd Molyneaux Office
969	Dr. Harold Molyneaux Office
970	Dr. Sterling Keizer Office
971	Dr. Trina Stewart Office

Preamble Appendix A - ***continued***

SERVICE SITES

CODE	SERVICE SITE (Facility Type)
01	OFFICE
02	HOME
03	HOSPITAL IN-PATIENT
04	HOSPTIAL OUT-PATIENT
05	OTHER OFFICE
06	DAY SURGERY
07	SPECIALTY CLINIC IN HOSPITAL
08	COMMUNITY CARE / NURSING HOME
09	OTHER SITE
10	A - UPEI CLINIC
11	D - DETOX CENTRE
12	F - FIRST PATIENT
13	I - IN-PATIENT RADIOLOGY
14	N - NIGHT CLINIC
15	O - OUT-PATIENT RADIOLOGY
16	P - PCH VISITING SPECIALIST
17	Q - QEH VISITING SPECIALIST
18	S - SATURDAY/SUNDAY OFFICE
19	X - RADIOLOGY
20	PROVIDER ANY FACILITY TYPE
21	E - EMERGENCY RADIOLOGY
27	WALK-IN CLINIC
101	PUBLIC DENTAL FACILITY
102	PRIVATE DENTAL FACILITY
103	PUBLIC HEALTH HYGEINIST

Preamble Appendix A - ***continued***

SPECIALTY CODES

Code	Specialty	Code	Specialty
01	General Practice	29	Pediatric Psychiatry
02	Anesthesia	30	Nephrology
03	Dermatology	31	Specialist (Shadow Billing)
04	General Surgery	32	Locum - Psychiatry (Shadow Billing)
05	Internal Medicine	33	Locum - Souris (Salaried Billing)
06	Neurosurgery	34	Locum - Montague (Salaried Billing)
07	Obstetrics & Gynecology	35	Locum - Queens Region (Salaried Billing)
08	Ophthalmology	36	Locum - P.C.H. (Salaried Billing)
09	Orthopedic Surgery	37	Locum - Alberton (Salaried Billing)
10	Otolaryngology	38	Locum - O'Leary (Salaried Billing)
11	Pediatrics	39	Locum - Tyne Valley (Salaried Billing)
12	Psychiatry	40	Long Term Care (Shadow Billing)
13	Urology	42	Pediatric Rheumatology
14	Dentistry	43	Medical Microbiology
15	Radiology	44	Emergency Medicine
16	Physical Medicine	45	Medical Oncology Clinical Associate
17	Radiation Oncology	46	Pain Management
18	Respirology	47	Palliative Care
19	Anatomic Pathology	48	Radiation Oncology Clinical Associate
20	Optometry	49	Hospitalist
21	Addictions	50	Pediatric Gastroenterology
22	Neurology	94	Nursing
23	Medical Oncology	95	Nurse Practitioner
24	Pediatric Cardiology	96	Dental Preventative
25	Neonatology	97	Plastic Surgery
26	Genetics/Metabolic diseases	98	All but Dental
27	ED On-Site Sessional Shadow Billing	99	G.P. and Eye Exams
28	Geriatric Medicine	100	Pharmacy

Preamble APPENDIX B

CLAIM MESSAGES

ID	DESCRIPTION
1	MORE THAN 3 MESSAGES
2	PROVIDER HAS NO ADMITTING PRIVILEGES
3	LOCUM COVERING ON TIME/DATE OF SERVICE
80	INCORRECT NUMBER OF SURFACES
81	SERVICE SAME DAY
82	MORE THAN 4 X-RAYS DURING YEAR
83	X-RAY LIMIT REACHED FOR YEAR
84	INVALID TREATMENT STATUS
85	NO MORE THAN ONE EXAM PER YEAR
86	PRIVATE DENTIST CLAIMING SEALANT FEE CODE
87	85% REDUCTION RATE
88	INCORRECT AGE FOR TOOTH AND FEE CODE
89	INCORRECT AGE FOR FEE CODE
90	PRIVATE DENTIST SHOULD NOT BE PAID
91	MORE THAN ONE SERVICE PER YEAR ON SAME TOOTH
92	EMERGENCY ON SAME DAY AS OTHER SERVICE
93	FILLING PERFORMED ON SAME DAY & TOOTH
94	INVALID SURFACES FOR FEE CODE
95	REGISTRATION FEE COLLECTED
96	FEE CODE DOESN'T MATCH TOOTH
97	TOOTH PREVIOUSLY EXTRACTED
98	CLAIM TOO OLD
99	INVALID QUADRANT/TOOTH
100	IN SUSPENSE - DATA CAPTURE
101	NEWBORN - WAITING FOR P.H.N.
102	RESIDENT NOT ELIGIBLE ON DATE OF SERVICE
103	NO HOUSEHOLD FOR RESIDENT
104	PROVIDER NOT ACTIVE ON DATE OF SERVICE
105	PROVIDER SPECIALTY NOT ELIGIBLE ON DATE
106	PROVIDER SPECIALTY NOT ON FEES RECORD
107	FACILITY TYPE NOT ON FEES RECORD
109	VALIDATION ATTEMPTS > 8
110	CLAIM IS ON HOLD - CLAIMS AUDITOR
111	NO LOT NUMBER FOR HOUSEHOLD
112	SERVICE DATE NOT SATURDAY OR SUNDAY
113	ELIGIBILITY SUSPENDED HEALTH ACT
114	PHYSICIAN NOT ELIGIBLE FOR PROGRAM
115	PATIENT NOT ON REGISTRY
151	DIAGNOSIS MISSING/NOT LEGIBLE
152	PROVIDER NUMBER MISSING
153	DATE OF SERVICE MISSING
154	TIME OF DAY MISSING ON CHART
155	TIME SPENT MISSING
156	FEE CODE MISSING
157	FEE CLAIMED MISSING
158	LETTER ON FILE @ MEDICAL ADVISOR
159	PERINATAL DEATH-NO P.H.N. ASSIGNED
160	REFERRING PROVIDER NAME MISSING
162	CANCEL-NO REPLY TO CORRESPONDENCE
163	FEE CODE CHANGED TO CORRESPOND WITH DIAGNOSIS
164	CLAIM VOID (PROVIDERS REQUEST)
165	EXPLANATION ON CLAIM,LOOK IT UP
166	SEE WRITTEN CORRESPONDENCE
167	RES# SUPPLIED,IGNORE SERVICE DATE
168	CLAIM CREATED,SEE ORIGINAL
169	PATIENT NOT REGISTERED
170	CLAIM MODIFIED BY PROV AUDITOR
171	BILLED TO WRONG RESIDENT
172	MEDICAL NECESSITY ESTABLISHED
173	ADVISED BY PROVIDER (PHONE OR COMMENT)
174	M.A.C. DECISION
176	COMMENT EXISTS/CLAIM APPROVED
177	ADDED ONLINE BY ADD NEW CLAIM SCREEN
178	RETROACTIVITY PAID MANUALLY
179	SERVICE DATE > RECEIVED DATE
180	CLAIM NUMBER.NOT IN ASSIGNED RANGE
181	NO CLAIM # RECORD FOR PRACTITIONER
182	MOVED FROM 51,52,53 TO 64 ZERO PAY
183	RESIDENT HAD INVAL OR TEMP S.I.N.
184	CLAIM TYPE 8,MAY BE NEWBORN
185	IN-PATIENT CLAIM SHOWS DIFFERENT DATES
186	SALARIED PHYSICIAN-PAY @ ZERO
187	CIHI QEH/PCH MISSING DATA
188	DISCHARGE-ADMIT NOT= DAYS STAY
189	CLAIM HAS BEEN SENT FOR M.A.D.
191	AMOUNT APPROVED REMOVED PAID IN ERROR
197	OUT OF PROVINCE LOCATION 213 CHOICE PROGRAM
198	OUT OF PROVINCE LOCATION 417 HOMEWOOD HEALTH
199	ORIGIN/BATCH# CHGD FROM PREVIOUS#
201	RESIDENT NUMBER NOT ON FILE
202	MISMATCH ON RESIDENT DATE OF BIRTH
203	MISMATCH ON RESIDENT SEX
204	PROVIDER NOT ON FILE
205	PROVIDER SPECIALTY DOES NOT AGREE

206 REFERRED TO NOT ON FILE
207 REFERRED BY NOT ON FILE
208 BILLING PROVIDER SAME AS REFERRED TO/BY
209 PAYEE NOT ON FILE
210 FEE CLAIMED NOT ON FILE
211 DIAGNOSTIC CODE NOT ON FILE
212 TREATMENT LOCATION NOT ON FILE
214 PROVIDER ROLE CORRECTED
215 INVALID DATE OF SERVICE
216 VERIFY DATE OF SERVICE (OVER 7 MONTHS)
217 CANCELLED SHOULD BE SHADOW BILLED
218 CLAIM ADDED BY ONLINE TRANSACTION
219 RESPONSIBILITY FOR PAYMENT NOT INDICATED
220 ADJUSTMENT MADE MANUALLY
221 ERROR MADE BY BILLING PROVINCE
222 BATCH NUMBER NOT VALID
223 COMMENT INDICATOR REQUIRED
224 EMERGENCY INDICATOR REQUIRED
225 PROVINCE CODE NOT VALID
226 DOS CHANGED TO PROCESS ADJUSTMENT
227 CLAIM ALREADY SENT FOR M.A.D
228 P.H.N.REQURIED FOR PAYMENT
230 NOT ADMITTING PROVIDER
231 CLAIM APPROVED RE O.R. CORRESPONDENCE
232 CLAIM NOT APPROVED RE O.R. CORRESPONDENCE
233 NOT APPROVED RE W.C.B LIST
234 PROVIDER NOT ON CALL
235 WORKING VISA EXPIRED
236 O.K. TO PAY REGISTRATION PROBLEM
237 SERVICE COUNT NE INDIVIDUAL CLAIMS
238 BILL UNDER ASSIGNED P.H.N.
500 SERVICES TOO FREQUENT SAME PROVIDER
501 SERVICES TOO FREQUENT DIFFERENT PROVIDER
502 AGE DOES NOT MATCH FEE CODE
503 PATIENT NOT FEMALE
504 PATIENT NOT MALE
505 SERVICE AFTER HOURS
506 TWO VISITS/CONSULTS + EXPLANATION
507 OTHER SERVICE SAME DAY EXAM
508 TWO EXAMINATIONS WITHIN SPAN
510 MORE THAN ONE INITIAL VISIT IN 30 DAYS
511 MORE THAN 10 VISITS
512 VISIT DURING HOSPITALIZATION
514 SERVICE PRIOR TO INITIAL HOSPITAL VISIT
515 INITAL HOSPITAL VISIT ON RE-ADMISSION
516 SERVICE SAME DAY AS HOME VISIT
517 SERVICE SAME DAY AS OUT PATIENT
518 OUTSIDE REGULAR HOURS
519 DOUBLE BILLING
520 ADDITIONAL SERVICE FOR NEWBORN
521 OVER TIME LIMIT
522 HOSPITAL VISIT BEING PAID
523 PREVIOUSLY PAID WITHIN 24 HRS
524 SERVICE SAME DAY AS ANAESTHESIA
525 NO SURGICAL SERVICE ON HISTORY
527 MAJOR CONSULTATION PREVIOUSLY PAID
528 REPEAT CONSULTATION PREVIOUSLY PAID
529 LIST 1 PROCEDURES BEING PAID
530 TWO EYE EXAMS
531 TWO LIST 2 PROCEDRES SAME DAY
532 AGE LIMIT-CHILD OVER 4 YEARS
533 CONSULTATION AND SURGERY < 200
534 TWO SURGICAL PROCEDURES
535 VISIT AFTER SURGERY
536 VISIT PRIOR TO SURGERY
537 DUAL ROLE IN SURGERY
538 NO CLAIM FROM SURGEON
539 FRACTURE PREVIOUSLY PAID
540 CLOSED FOLLOWED BY OPEN
541 SKULL CALIPER THEN SPINAL SURGY
542 PACEMAKER AND VISITS
543 INITAL VISIT AND CONSULTATION
545 CONSULT NOT PAYABLE INCLUDED IN COMPLETE
547 VISIT AFTER SURGERY-NOT PAYABLE
548 VISIT SAME DAY SURGICAL PROCEDURE
549 THERAPUTIC LIST 2 WITH SURGERY
550 ONLY TWO SESSIONS PER WEEK
551 VERIFY FEE CODE CLAIMED
552 ADJUST FEE CODE TO APPROVE
553 REFERRAL PENDING APPROVAL
554 APPROVED REFERRAL ON FILE
555 REJECTED REFERRAL ON FILE
556 NO REFERRAL ON FILE FOR SERVICE
559 CHART NUMBER CONTAINS NON-NUMERIC DATA
577 CLAIM PAID TWICE-CHECK HISTORY
578 CLAIM PUT TO HISTORY ONLY(ONLINE)
597 REQUIRES INDEPENDANT CONSIDERATION
598 ASSESSMENT ATTEMPTS > 8
599 CLAIM TO BE MANUALLY ASSESSED
601 INVALID FORMAT IN DATE OF BIRTH
602 SEX INDICATOR MUST BE M OR F
603 SPECIALTY CODE MUST BE 46388 OR 99
604 CORRUPT DATA IN RESIDENT NAME
605 ROLE CONTAINS CORRUPT DATA

606 INVALID FORMAT IN SERVICE DATE
607 HOUR OF DAY/SPENT MUST BE 44927
608 TIME OF DAY SPENT/MIN RANGE 21551
609 SERVICE COUNT CONTAINS INVALID DATA
610 SERVICE SITE CONTAINS INVALID DATA
611 REF TO/BY CONTAINS INVALID DATA
612 PAYMENT RESP CONTAINS INVALID DATA
613 EMERGENCY INDICATOR CONTAINS INVALID DATA
614 BATCH NUM CONTAINS CORRUPT DATA
615 I.C. INDICATOR CONTAINS INVALID DATA
616 FEE CODE CONTAINS INVALID DATA
617 DIAGNOSTIC CODE CONTAINS INVALID DATA
618 TREATMENT LOCATION CONTAINS INVALID DATA
619 O.P. REG# CONTAINS INVALID DATA
620 PROVINCE CODE FOR HOST INVALID DATA
621 UNABLE TO LOCATE/CONTACT PATIENT
622 NO STEP DOWN AVAILABLE
700 CLAIM PAID AT CHILDS RATE
701 CLAIM PAID AT NEWBORN RATE
702 FEE CODE ADJUSTED
703 AGE PROHIBITS THIS SERVICE
704 FEE CODE AND AMOUNT ADJUSTED
705 AFTER HOURS PREMIUM ADDED
706 TWO VISITS SAME DAY NOT PAYABLE
707 PAYMENT INCLUDED WITH SURGICAL FEE
708 PAID AT G.P.RATES NOT SPECIALTY
709 MAXIMUM 1 HEALTH EXAM PER YEAR
710 HEALTH EXAM NOT PAID-AGE FACTOR
711 ASSISTANTS FEE INCLUDES THIS SERVICE
712 WELL BABY CARE VISITS EXCEEDED
713 MAX TIME/SESSIONS EXCEEDED
714 PSYCHOTHERAPY PREVIOUSLY PAID
715 INTENSIVE CARE VISIT PREVIOUSLY PAID
717 VISIT/CONSULT PREVIOUSLY PAID
718 TOTAL NUMBER OF SERVICES EXCEEDED
719 CONVALESCENT CARE,ONLY IN COMMUNITY CARE FACILITY
720 INITIAL VISIT RULED REPEAT
721 PATIENT IN HOSPITAL ON SERVICE DATE
722 MEDICAL ADVISORS DECISION
723 PROCEDURE CONSIDERED SOLE PURPOSE FOR VISIT
724 SEX DOES NOT MATCH FEE CODE
725 NOT PAYABLE OUTSIDE OFFICE HOURS
726 BILATERAL PROCEDURES PAID AT 0.5
727 APPARENT DUPLICATE CLAIM
728 ANOTHER PROVIDER PAID SAME SERVCE
729 FEE CLAIMED EXCEEDS TARIFF AMOUNT
730 PAID CORRESPONDING TO SURGEONS CLAIM
731 FEE ADJUSTED TO SERVICES RENDERED
732 NUMBER OF VISITS EXCEEDED FIRST 35 DAYS
733 LIST 1 NOT PAYABLE IN ADDITION TO THIS SERVICE
734 REDUCED TO REPEAT CONSULTATION
735 CONSULT NOT PAYABLE WITH ANESTHESA
736 POST-OP VISITS
737 TEN VISITS EXCEEDED IN 90 DAYS EXPLANATION REQUIRED
738 CLAIM INELIGIBLE AFTER 6 MONTHS
740 RE-ADMITTED WITHIN TEN DAYS
741 PRIOR TO PATIENTS ELIGIBILITY DATE
742 PATIENT NOT REGISTERED
743 REFERRAL DENIED-SERVICE PROVIDED LOCALLY
744 PATIENT NO LONGER ELIGIBLE
745 WRITTEN CORRESPONDENCE ON FILE
746 D.V.A./ R.C.M.P./D.N.D RESPONSIBILITY
747 W.C.B. RESPONSIBILITY
748 REDUCED TO OFFICE VISIT RATE
749 NOT PAID WITHOUT EXPLANATION
750 NUMBER OF VISITS EXCEEDED 6th-13th WEEK
751 MAXIMUM FEE AFTER 13th WEEK
752 MAXIMUM SUPPORTIVE CARE(7 VISITS)
754 MAXIMUM DIRECTIVE CARE VISITS EXCEEDED
755 REPEAT OPERATION PAID AT LOWER RATE
756 PROVIDER SPECIALITY NOT ON FEES RECORD
757 CLOSED FOLLOWED BY OPEN REDUCTION @ 0.5
758 SEPARATE INCISION PAID AT 0.65
759 NOT INPATIENT ON DATE OF SERVICE
760 CONSULT/VISIT NOT PAID WITH PROCEDURE
761 PREVIOUS PAYMENT MADE ON THIS DATE
762 HEALTH EXAM-3rd PARTY UNINSURED
763 PROVIDER SPECIALITY DOES NOT AGREE
764 PROCESSING ERROR(CLAIM ADJUSTED)
765 HOST REGISTRATION NUMBER NOT VALID
766 PROVIDER NOT ELIGIBLE ON DATE OF SERVICE
767 AFTER HOURS PREMIUM NOT APPLICABLE
768 FACILITY TYPE NOT ON FEES RECORD
769 NO REPLY TO CORRESPONDENCE WITH PROVIDER
770 I.C.U. NOT PAYABLE AFTER 1st DAY
771 PAID AS CONVALESCENT CARE
772 NOT PAID WITH HEALTH/COMPLETE EXAM
773 CORRECTED RESIDENT INFORMATION
774 MISMATCH ON RESIDENT SURNAME
775 UNINSURED SERVICE
776 NOT PAYABLE WITHOUT PSYCH VISIT
777 FOR APPROVAL,RE-$AMOUNT APPROVED
778 HOSPITAL CODE 10 REQUIRED
779 EMERGENCY NOT INDICATED

780 CONSIDERED TRANSFERED,NOT CONSULT'
781 CONSIDERED INCIDENTAL SURGERY
782 MULTIPLE PROCEDURES-SAME INCISION, 0.5
783 ADMITTING PROVIDER BILLS TOTAL HOSPITAL CARE
784 MEDICAL NECESSITY NOT ESTABLISHED
785 SUPP CARE MAY APPLY-RESUBMIT
786 ROLE IN ERROR DUE TO SERVICE CATEGORY
787 CORRECTED CLAIM INFORMATION
788 DOES NOT AGREE WITH SURGEONS CLAIM
789 PLEASE VERIFY RESIDENT INFORMATION
790 FEE CODE CLAIMED CORRECTED
792 MULTIPLE PROCEDURES-REDUCED FEE
793 REFERRAL APPROVED
794 NOT COVERED BY W.C.B.
795 TIME OF DAY/SPENT NOT ON CLAIM
796 REFERRING PROVIDER NOT INDICATED
797 RETROACTIVE PAYMENT APPLIED
798 CLAIM IMPROPERLY COMPLETED
799 DIAGNOSTIC CODE NOT ON FILE
800 HOST REGISTRATION NUMBER NOT VALID
801 APPROVED REFERRAL ON FILE
802 SERVICE DEEMED EMERGENCY
803 NOT APPROVED-REFERRAL ON FILE
804 HOSPITAL LOCATION CODE INAPPROPRIATE
805 SERVICE DATE/COUNTS NOT =
806 DIAGNOSTIC CODE INAPPROPRIATE
807 PAID AT MAXIMUM WEEKLY RATE
808 QUE RESIDENT-BILL PROVINCE DIRECT
809 VISIT MUST BE BILLED PRIOR TO DETENTION
810 TIME AND/OR DAY INCORRECT
811 FACILITY TYPE DOESN`T MATCH ADMISSION/DISCHARGE
812 SERVICE DATE DOESN'T MATCH ADMISSION/DISCHARGE
813 FACILITY TYPE AND FACILITY MISMATCH
820 NO REFERRAL BUT WOULD BE APPROVED
821 NO REFERRAL QUESTIONABLE APPROVAL
822 NO REFERRAL WOULD NOT BE APPROVED
823 NOT ASSESSED.D.O.S.PRIOR TO 970701
825 REQUEST CANCELLED UNABLE TO ASSESS
826 NON-INSURED SERVICE
827 CONTRACT ADJUSTMENT FROM N.B.
828 IGNORE CLAIM-DUPLICATE SUBMISSION
829 PATIENT HAS VALID P.H.N FOR P.E.I.
830 CORRECTED PROVIDER SPECIALTY
831 $ APPROVED ADJUSTED TO ZERO
832 UNABLE TO LOCATE PATIENT
833 STUDENT OFF ISLAND
834 RESIDENT LEFT P.E.I.
835 RESIDENT COVERED BY ANOTHER PROVINCE
836 ADJUSTMENT MADE BY OTHER PROVINCE
837 FAMILY MEMBER A STUDENT
838 WAITING PERIOD - NEW PROVINCE
839 RESIDENT IN ELIGIBILITY STATUS 40
840 PATIENT UNDER CARE OF SPECIALIST
841 LACK OF INFORMATION PLEASE CLARIFY
842 SERVICE SITE/FEE CODE INCORRECT
843 DATE OF SERVICE INCONSISTENT
844 INSUFFICENT DOCUMENTATION
845 NO DOCUMENTATION AVAILABLE
846 PATIENT UNDER CARE OF GEN.PRACT.
847 SERVICE NOT AN EMERGENCY SITUATION
848 PATIENT WENT FROM OPD DIRECTLY ICU
849 PATIENT NOT SEEN BY PROVIDER ON THIS DATE
850 PATIENT OUT ON PASS
851 PATIENT IS DECEASED-AUDIT
852 TIME SPENT NOT INDICATED ON FILE
853 MONEY RETRIEVED MANUALLY
854 PAYMENT NOT REVERSED NO $ FOR PROVIDER
855 DOLLAR AMOUNT REDUCED BY CLAIMS AUDITOR
856 CLAIM ASSESSED BY CLAIMS AUDITOR
857 ADJUSTED TO APPROPRIATE FEE CODE
858 REFERRAL LETTER NOT AT SITE BILLED
859 TWO OR MORE PATIENTS SAME TIME NOT PAYABLE
860 APPEAL APPROVED BY MEDICAL ADVISOR
861 COMMENT HAS INSUFFICENT INFORMATION
862 SECOND DIAGNOSIS REQUIRED (M.A.)
863 CONFILCT WITH O.R. REPORT (M.A.)
864 PAYMENT IS INCLUDED IN PREVIOUS FEE CODE
865 PROVIDER NOT SESSIONAL AT TIME OF SERVICE
866 LONG TERM CARE PATIENT
867 PILOT PROGRAM CRITERIA NOT MET FOR PAYMENT
875 RESPONSIBILITY OF BILLING PROVINCE
876 CLAIM INELIGIBLE AFTER 3 MONTHS
877 PATHOLOGY REPORT REQUIRED
878 VERIFY AFTER HOURS PREMIUM
879 FACILITY INCORRECT
897 RETRO CLAIM COULD NOT BE MATCHED TO ORIGINAL CLAIM
900 *EMPTY*
901 CONSULT
902 CONSULT/INVESTIGATION
903 CONSULT/INVESTIGATION/TREATMENT
904 VERIFY HOST NUMBER
999 CLAIM CONVERTED FROM OLD SYSTEM
1000 CORRESPONDENCE NOT SENT BACK TO REFERRING PROVIDER
1001 MEDICAL ADVISORS DECISION WITH CLAIMS AUDITOR'S INPUT

1002	RESIDENT DECEASED
1003	PROVIDER OVER CAP
1004	O.R. REPORT NOT ON FILE
1005	PROVIDER BILLED PATIENT FOR SERVICE-PATIENT REIMBURSED
1006	CHECK ELIGIBILITY FOR P.E.I.
1007	RESIDENT ISSUED NEW P.H.N
1008	INFORMATION UPDATE NO PAYMENT ADJUSTED
1009	NO LETTER ON FILE
1010	CLAIM ON HOLD-ASSESSMENT
1011	PROCEDURE CODE NOT ON FILE
1012	PHN/FEE CODE/FACILITY MISMATCH
1013	SHOULD BE CLAIM TYPE 6
1014	NO FACILITY REQUIRED
1015	PATIENT U.S. RESIDENT
1016	PRIOR APPROVAL REQUIRED
1017	CLAIM ASSESSED RE: PREAMBLE TO THE TARIFF OF FEES
1018	VERIFY PROVIDER ROLE
1019	OOP PROVIDER SPECIALITY CODE NOT ON FILE
1020	SCALING AND/OR FLOURIDE NOT COVERED
1021	PAYMENT ADJUSTMENT ON PREVIOUSLY PAID CLAIM
1022	FEE CLAIMED DOES NOT EQUAL SERVICE COUNT
1023	FEE CLAIMED DOES NOT MATCH COMMENT
1025	MAXIMUM SUPPORTIVE CARE (7 VISITS)
1026	PATIENT NOT ON PROVINCIAL REGISTRY
1027	PHYSICIAN NOT ELIGIBLE FOR PILOT PROGRAM
1028	PATIENT NOT INDICATED ON PILOT PROGRAM
1029	NO PILOT PROGRAM APPLICATION AT REGISTRY OFFICE
1030	FEE FOR SERVICE NOT PAYABLE DURING CONTRACT/SALARY HOURS
1031	SERVICE NOT PROVIDED IN OFFICE

Preamble Appendix B - ***continued***

CLAIM STATUS

Code	Claim Status Description
11	To Process - Original Claim
12	To Process - Re-Edit Claim
21	In Suspense - Data Capture
22	In Suspense - Newborn
23	In Suspense - Hold Claim
24	In Suspense - Eligibility
25	In Suspense - Correction
31	In Error - Validation
35	In Error - Return To Provider
41	Pending Action - To Assess
42	Pending Action - To Review
43	Pending Action - To Review
44	Pending Action - To Adjust
45	Independent Consideration - MAC
46	Out of Province referral
47	Out of Province claim
51	To Pay
52	To Reverse
53	To Cancel
61	Settled - Paid
62	Settled - Reversed
63	Settled - Cancelled
64	Settled - History only
65	Cancelled History only

CLAIM TYPE

Code	Claim Type Description
1	In-Province - Pay Provider
2	In-Province - Pay Resident
3	In-Province - Hospital - In-Province Resident
4	In-Province - Hospital - OOP Resident
5	In-Province - Provider - OOP Resident
6	Out-Of-Province - Referral
7	Out-Of-Province - In-Patient
8	Out-Of-Province - Medical
9	Out-Of-Province - Out-Patient

Preamble APPENDIX C

NON-PATIENT SPECIFIC FEE CODE BILLING PARAMETERS

Service Description	Fee Code	Provincial Health No.	Diagnostic Code	Facility Type
On-Call Retainer (Queen Elizabeth Hospital)				
Anesthesia	0240	01696921	V85.1	3
Surgery	0440	01696947	V85.1	3
Internal Medicine	0540	01696962	V85.1	3
Ob/Gyn	0740	01696988	V85.1	3
Pediatrics	1140	01697036	V85.1	3
Surgical Assistant	0159	01853217	V85.1	3
Urban Family Physician - group of 1	0015	02155950	V85.1	3
Urban Family Physician - group of 2	0016	02155950	V85.1	3
Urban Family Physician - group of 3	0017	02155950	V85.1	3
Urban Family Physician - group of 4	0018	02155950	V85.1	3
Urban Family Physician - group of 5-7	0019	02155950	V85.1	3
Hospitalist	0108	01942804	V85.1	3
On-Call Retainer (Prince County Hospital)				
Anesthesia	0240	01696939	V85.1	3
Surgery	0440	01696954	V85.1	3
Internal Medicine	0540	01696970	V85.1	3
Ob/Gyn	0740	01696996	V85.1	3
Pediatrics	1140	02052959	V85.1	3
Surgical Assistant	0159	02175453	V85.1	3
Urban Family Physician - group of 1	0015	02175313	V85.1	3
Urban Family Physician - group of 2	0016	02175313	V85.1	3
Urban Family Physician - group of 3	0017	02175313	V85.1	3
Urban Family Physician - group of 4	0018	02175313	V85.1	3
Urban Family Physician - group of 5-7	0019	02175313	V85.1	3
Hospitalist	0108	02056851	V85.1	3
On-Call Retainer (Provincial)				
Ophthalmology	0840	01697002	V85.1	3
Orthopedics	0940	01697010	V85.1	3
ENT	1040	01697028	V85.1	3
Plastic Surgery	9740	01697069	V85.1	3
Psychiatry	1240	02155935	V85.1	3
Urology	1340	01697044	V85.1	3
Radiology	1540	01697051	V85.1	3
Laboratory Medicine	1940	02155836	V85.1	3
GP Oncology	0177	02155869	V85.1	3
GP Palliative Care	0179	02155877	V85.1	3

Service Description	Fee Code	Provincial Health No.	Diagnostic Code	Facility Type
On-Call Retainer (Other)				
Unaffiliated Psychiatric inpatient - QEH	0199	02082220	V85.1	3
Medical Officer Rehab Unit - QEH	0147	01663608	V85.1	3
Medical Officer Hillsborough Hospital	0197	02155885	V85.1	3
Medical Officer Addictions - Mt. Herbert	0198	02155893	V85.1	3
Ambulatory Detox Service - PCH & Western	0158	02175461	V85.1	3
Corrections	0030	02280519	V85.1	3
Coroner - East	0020	02455822	V85.1	3
Coroner - West	0020	02455830	V85.1	3
Oncology backup	0174	02155901	V85.1	3
Neurology backup	0503	02155927	V85.1	3
Rural Family Physician - Alberton	0040	02201085	V85.1	3
Rural Family Physician - O'Leary	0185	01530997	V85.1	3
Rural Family Physician - Tyne Valley	0185	01531003	V85.1	3
Rural Family Physician - Souris	0185	01530971	V85.1	3
Rural Family Physician - Montague	0185	02155943	V85.1	3
Hospitalist Sessional Fee (daily)				
Hospitalist Type 1 - max. 21 beds	0107	02056844	V85.1	3
Hospitalist Type 1 - max. 11 beds	0102	02056844	V85.1	3
Hospitalist Type 2 - max. 17 beds	0101	01942796	V85.1	3
Hospitalist Type 2 - max. 09 beds	0037	01942796	V85.1	3
Hospitalist Type 1 top-up Class I - 21 beds	0038	02056844	V85.1	3
Hospitalist Type 1 top-up Class II - 21 beds	0039	02056844	V85.1	3
Hospitalist Type 1 top-up Class III - 21 beds	0041	02056844	V85.1	3
Hospitalist Type 1 top-up Class I - 11 beds	0042	02056844	V85.1	3
Hospitalist Type 1 top-up Class II - 11 beds	0043	02056844	V85.1	3
Hospitalist Type 1 top-up Class III - 11 beds	0044	02056844	V85.1	3
Hospitalist Type 2 top-up Class I - 17 beds	0025	01942796	V85.1	3
Hospitalist Type 2 top-up Class II - 17 beds	0026	01942796	V85.1	3
Hospitalist Type 2 top-up Class III - 17 beds	0027	01942796	V85.1	3
Hospitalist Type 2 top-up Class I - 09 beds	0045	01942796	V85.1	3
Hospitalist Type 2 top-up Class II - 09 beds	0046	01942796	V85.1	3
Hospitalist Type 2 top-up Class III - 09 beds	0047	01942796	V85.1	3
ED Sessional Fee (hourly)				
ED Sessional Fee - Q.E.H.	0155	01533652	V85.0	4
ED Sessional Fee - P.C.H.	0156	01533660	V85.0	4
ED Sessional Fee - Kings County	0150	01530963	V85.0	4
ED Sessional Fee - Western	0152	01530989	V85.0	4
Administrative Meeting	0050	01741230	V68.9	

Preamble APPENDIX D

PRIOR APPROVAL

Prior approval is required from Health PEI before some surgical procedures are undertaken. Care should be exercised in ensuring such approval has been granted, before the surgery is undertaken.

The following is a general outline of services that may be covered under prior approval.

FACE AND NECK

1. Scar revision in exposed areas of the head and neck related to trauma, disease or surgery, unless the initial surgery was for cosmetic reasons only, hence uninsured.

2. Blepharoplasty of upper eyelids if there is encroachment of the visual axis.

3. Outstanding, protruding or congenitally deformed ears, under 18 years of age.

4. Rhinoplasty may be approved if the malformation significantly obstructs the nasal airway.

5. Conditions amenable to pulse dye laser treatment of the head and neck for which prior approval is necessary include:

    1) Pyogenic Granuloma
    2) Glomus tumors
    3) Lymphangiomas
    4) Port Wine Stains

OTHER BODY AREAS

1. Scar revision is insured if scars cause a functional disability, or if revision is part of a pre-planned staged reconstructive procedure. Scar revision is also approved if there is a history of post-operative complications.

2. With prior approval, augmentation mammoplasty is insured for congenital or post surgical amastia. If unilateral augmentation mammoplasty is approved for the above reasons then a balancing operation such as reduction or mastopexy may be approved for the opposite breast.

3. Reduction mammoplasty requires prior approval, and is payable only once in a patient's lifetime. A BMI of 27 or less is mandatory as is an estimate in excess of 500 grams to be removed from each breast reduction application.

4. After successful treatment of morbid obesity by gastroplasty, intestinal by-pass surgery or strict dietary control, a lipectomy/panniculectomy, may be approved, and is payable only once in a patient's lifetime.

   Candidates who qualify for morbid obesity procedures must have:

   a) Body mass index greater than 40
   b) Evidence that weight loss has been attempted through several other accepted forms of reduction therapy
   c) Existing medical conditions which are being aggravated as a result of excess body weight.

5. Circumcision less than one year of age.

Fee codes requiring prior approval:

DESCRIPTION	FEE CODE
Augmentation by prosthesis - Unilateral	3072
Male mastectomy (Benign)	3077
Removal of breast prosthesis	3079
Surgical Planing, face for acne, whole face	3080
Surgical Planing, single area, e.g. trauma scar	3081
Reduction - Mammoplasty - Unilateral	3082
Augmentation by prosthesis - Bilateral	3083
Rhinoplasty, with or without graft, and closure of septal perforation	4016
Gastric partition for morbid obesity	5233
Gastric partition plus all other procedures for morbid obesity	5234
Lipectomy, removal of panniculus	5456
Abortion - therapeutic	6010
Ptosis	7410
Ptosis - secondary repair	7411
Blepharoplasty	7430 and 7431
Repair - reconstruction of the ear with graft of skin or cartilage	7710
Penile prosthesis for impotence	8417
Insertion of Testicular prosthesis (for age 18 and over)	8507
TRAM Flap	3097

UNINSURED SERVICES

1. Otoplasty over the age of 18 years.

2. Reversal of vasectomy or tubal ligation.

3. Removal of tattoos.

4. Cosmetic surgery.

5. In vitro fertilization.

6. Simple lipoma, as well as warts, papillomata, keratosis, nevi, and moles - removal by any means. (Fee Codes 3039, 3041, 3042, 3043, 3044, 3045). For exceptions, please refer to Section 21.F of the Preamble to the Tariff of Fees.

7. Visits and injections related to upcoming out-of-country travel.

8. Sex reassignment surgery.

Preamble APPENDIX E

POLICY NAME: CRITERIA FOR OUT-OF-PROVINCE REFERRALS

EFFECTIVE DATE: April 1, 1995 POLICY #: REF 001

INTRODUCTION:

All referrals made to out-of-Province medical services and facilities must receive prior approval from the Department of Health. Failure to obtain this approval shall result in the patient being held fully responsible for the total costs of the services provided.

POLICY GUIDELINES:

1. *OUT-OF-PROVINCE (WITHIN CANADA)*

   i. Payment may be provided under the Plan for an eligible resident of Prince Edward Island to obtain in-patient and/or out-patient medical services outside the Province in the instances of extreme emergency or sudden illness (*) occurring while outside the Province.

   ii. All cases excluding extreme emergency or sudden illness require written approval from the Department of Health.

   iii. Prior written approval may be granted if after consult with a local specialist and in the opinion of a local general practitioner and/or specialist, adequate medical services are not available in Prince Edward Island.

   iv. Prior written approval may be granted if only one (1) consultant/specialist is available in Prince Edward Island in the specific medical specialty service required.

   v. Prior written approval may be granted if the required medical services are provided in Prince Edward Island but other extenuating circumstances exist. Such cases shall be reviewed by the Medical Director of the Department.

   vi. Eligible residents of Prince Edward Island requesting an out-of-Province referral for medical services by preference only shall not be approved.

   vii. Prior written approval must be obtained for out-of-Province treatment. This referral is effective for a 12 month period only providing the referral is for the same diagnosis and the same physician.

   viii. Payment shall not exceed the daily standard per diem rate as authorized by the Province where the hospital services are rendered.

2. *OUT OF COUNTRY*

i. Insured services may be provided under the Plan for an eligible resident of Prince Edward Island to obtain in-patient and/or out-patient medical services outside Canada if written prior approval is obtained from the Department.

ii. Prior written approval may be granted if after consult with a local specialist and in the opinion of a local general practitioner and/or specialist, adequate medical services are not available in Canada.

iii. Payment may be provided under the Plan for an eligible resident of Prince Edward Island to obtain in-patient and/or out-patient medical services outside Canada in the instances of extreme emergency or sudden illness occurring while outside the country.

In cases where the Medical Director's interpretation of policy is disputed, the case shall be referred to the Medical Advisory Committee of the Department of Health for adjudication.

(*)*Extreme emergency or sudden illness* *- a medical situation or occurrence of a serious nature, developing suddenly and unexpectedly, and demanding immediate medical attention.*

APPROVED: _____

REVIEW DATES: _____; _____; _____

POLICY NAME: CRITERIA FOR PAYMENT OF OUT-OF-PROVINCE REFERRALS

EFFECTIVE DATE: April 1, 1995 POLICY #: REF 004

INTRODUCTION:

The referral policy applies to those residents who request non-emergency or elective services. In these cases, the local physician advises and recommends a referral on behalf of the patient. The Department of Health determines whether or not it is a service that is pre-approved for payment.

POLICY GUIDELINES:

The criteria used to determine if the Department shall pay the out-of-Province cost is categorized into four groups. The decision to approve payment is based on:

i. If the service is not available locally (e.g., neurosurgery, cardiac surgery)
ii. If the resident has only one choice (e.g. dermatology)
iii. If there is inadequate service locally (e.g., neonatology)
iv. If there are justifiable extenuating circumstances.

1. Non-emergency services out-of-country are only approved for payment if two or more specialists document that the services is not available in Canada.

2. Residents who are approved for payment are notified by letter as well as those who were not approved for payment.

3. Residents who go out-of-Province knowing that the Department has not agreed to pay and who have been notified that they are responsible for costs are invoiced for the amount of the services provided. If a resident leaves the Province without a pre-approved referral for a service that is available locally, they shall be notified and billed for the services provided.

APPROVED: _____

REVIEW DATES: _____; _____; _____

_____; _____; _____

Preamble APPENDIX F

PATIENT ACCESS TO PHYSICIAN PROGRAM AGREEMENT

I, _____ am registered with the Provincial Patient Registry for placement with a regular Family Physician.

I agree to accept Dr. _____ as my regular family physician in future.

Patient's Health Care # _____

Dependent's Health Care # _____

Dependent's Health Care # _____

Dependent's Health Care # _____

If you are new to Prince Edward Island and have not received a Personal Health Number(PHN), please call 1-800-321-5492 to register.

I am the legal guardian of the dependents lists above and so am authorized to sign this agreement on their behalf.

_____ _____

Patient's Signature Date

****

I agree to accept the patient(s) identified above into my family practice. If, for unforeseen reasons I will not be able to fulfill this commitment, I will inform Health PEI immediately.

_____ _____

Physician's Signature Date

EXPLANATORY NOTES ON PATIENT ACCESS TO PHYSICIAN PROGRAM

This program was established through agreement between the Medical Society of Prince Edward Island and Health PEI in an attempt to ensure Island residents have access to family physicians.

By signing this form, you are indicating that you intend to use a particular physician as your family physician. This form does not in any way restrict your ability to access services.

Legal guardians may sign this agreement on behalf of dependents under the age of 16 or individuals for whom they have been named as the legal guardian.

It is envisioned that patients may choose to see a family physician once or twice prior to committing to sign this form. If you have any questions about this program, please call the Patient Registry Office at 1-800-321-5492.

TARIFF OF FEES

GENERAL PRACTICE

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

1. REFERRED CASES

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Consultation - **See Preamble 9.A, 9.B, 10.A**	0160	60.00	63.00	68.00	73.00	80.00
Repeat Consultation within 30 days - **See Preamble 9.C**	0162	30.00	31.50	34.00	36.50	40.00
G.P. Dermatology Consultation (designated physicians only)	0137		75.00	76.50	78.00	80.00

2. OFFICE VISITS

Comprehensive office visit - **See Preamble 9.D**	0110	55.25	55.96	57.15	58.34	60.00
Limited office visit - **See Preamble 9.E**	0113	33.00	33.30	33.80	34.30	35.00
Basic office visit - **See Preamble 9.F**	0123	28.00	28.00	28.00	28.00	28.00
Well baby care - **See Preamble 20.B**	0115	33.00	33.30	33.80	34.30	35.00
Annual Health Exam: - **See Preamble 9.H**						
Age 1-2	2228	33.00	33.30	33.80	34.30	35.00
Age 3-16	2229	33.00	33.30	33.80	34.30	35.00
Age 17-64	2230	35.00	36.50	39.00	41.50	45.00
Age 65+	2231	45.00	47.25	51.00	54.75	60.00
Emergency office visit at physician's home						
outside regular office hours including weekends and holidays						
- Day (08:00 - 18:00)	0112	19.35	21.70	25.61	29.52	35.00
- Night(18:00 - 08:00)	0114	32.85	33.17	33.71	34.25	35.00
Emergency office visit at physician's office						
outside regular office hours - **See Preamble 9.I**						
- Day (08:00 - 18:00) - Monday to Saturday	0118	19.35	21.70	25.61	29.52	35.00
- Sundays & Holidays	0120	19.35	21.70	25.61	29.52	35.00
- Night(18:00 - 08:00) - Monday to Thursday	0119	22.15	24.08	27.29	30.50	35.00
- Friday to Sunday, & Holidays	0116	32.15	32.58	33.29	34.00	35.00
Extra patients seen during emergency office visit	0113	33.00	33.30	33.80	34.30	35.00

3. HOSPITAL VISITS - In-Patient Services

Initial hospital visit - **See Preamble 10.B**	0130	60.00	66.00	76.00	86.00	100.00
Unaffiliated patient (add) - **See Preamble 10.B.1**	0132	60.00	62.25	66.00	69.75	75.00
Subsequent hospital visits						
First 5 weeks, per visit	0133	35.00	37.25	41.00	44.75	50.00
From 6th to 13th week inclusive, per visit	0134	20.00	21.50	24.00	26.50	30.00
After 13th week, per week	0135	20.00	21.50	24.00	26.50	30.00
Discharge fee - **See Preamble 10.C.9**	0136	25.00	27.25	31.00	34.75	40.00
Supportive care, per visit - **See Preamble 10.C.2**	0140	17.50	18.63	20.50	22.38	25.00
Concurrent care, per visit - **See Preamble 10.C.1**	0142	25.00	28.75	35.00	41.25	50.00
Continuing care, per visit - **See Preamble 10.C.2**	0143	35.00	37.25	41.00	44.75	50.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Convalescent care in community hospital						
- initial visit	0145	45.00	49.50	57.00	64.50	75.00
- subsequent visit	0144	18.00	22.80	30.80	38.80	50.00
History & Physical Examination for Dental care	0141	60.00	66.00	76.00	86.00	100.00
Complete assessment by a family physician of a patient under the attending care of a psychiatrist	0146	60.00	66.00	76.00	86.00	100.00

4. OBSTETRICAL CARE

Delivery only	0002	560.00	565.88	575.68	585.48	599.20
Assessment of Labor	0003	35.00	37.25	41.00	44.75	50.00
Attendance at complicated labor where patient is: referred for C-section or operative delivery(includes assistance at procedure) or, delivered precipitously by non-attending physician on emergency basis	0004	560.00	565.88	575.68	585.48	599.20
Initial prenatal visit	0100	55.25	55.96	57.15	58.34	60.00
Subsequent prenatal visit	0103	33.00	33.30	33.80	34.30	35.00
Postnatal visit	0105	33.00	33.30	33.80	34.30	35.00
Postpartum care visit (in-hospital)	0104	35.00	37.25	41.00	44.75	50.00
Neonatal Resuscitation (attendance at delivery for neonatal resuscitation)	0036	110.50	111.93	114.30	116.68	120.00

5. HOSPITAL EMERGENCY DEPARTMENT VISITS

Limited ED Visit (Level I visit) **- See Preamble 10.E.2(a)**						
- Day(08:00-18:00) - Monday to Friday	0180	28.50	28.95	29.70	30.45	31.50
- Saturday,Sunday,Holiday	0190	33.00	33.53	34.40	35.28	36.50
- Night(18:00-08:00) - Monday to Thursday	0181	37.25	37.81	38.75	39.69	41.00
- Friday,Saturday,Sunday,Holiday	0191	55.25	56.11	57.55	58.99	61.00
Comprehensive ED Visit (Level II visit) **- See Preamble 10.E.2(b)**						
- Day(08:00-18:00) - Monday to Friday	0186	52.00	52.83	54.20	55.58	57.50
- Saturday,Sunday,Holiday	0168	60.00	60.98	62.60	64.23	66.50
- Night(18:00-08:00) - Monday to Thursday	0187	70.00	71.13	73.00	74.88	77.50
- Friday,Saturday,Sunday,Holiday	0169	100.00	101.50	104.00	106.50	110.00
Resuscitation ED Visit (Level III visit) **- See Preamble 10.E.2(c)**						
- first 15 minutes	0182	90.00	91.50	94.00	96.50	100.00
- second 15 minutes	0183	45.00	45.75	47.00	48.25	50.00
- subsequent 15-minutes periods	0184	45.00	45.75	47.00	48.25	50.00
Additional fee allowed for strict emergency visit **- See Preamble 7**	0194	20.00	20.75	22.00	23.25	25.00
Complete examination in ED - patients age 55 yrs or over	0195	60.00	63.75	70.00	76.25	85.00
Care in the Emergency Department by a second physician (for a patient that has been in observation for over 8 hours) Claim requires a comment, time of day, and can only be billed once.	0196	35.00	37.25	41.00	44.75	50.00
Emergency Department coverage (hourly sessional rates)						
Kings County Hospital	0150	165.00	166.50	169.00	171.50	175.00
Western Hospital	0152	165.00	166.50	169.00	171.50	175.00
Queen Elizabeth Hospital	0155	165.00	166.50	169.00	171.50	175.00
Prince County Hospital	0156	165.00	166.50	169.00	171.50	175.00
ED sessional top-up fee (Salary Class I)	0005	75.74	76.51	77.80	79.09	80.90
ED sessional top-up fee (Salary Class II)	0006	73.18	73.93	75.19	76.44	78.19
ED sessional top-up fee (Salary Class III)	0007	69.36	70.07	71.27	72.47	74.14

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
6. ON-CALL RETAINERS - See Preamble 11.D						
Urban Family Physician (QEH & PCH) - per group of 1	0015	30.00	32.25	36.00	39.75	45.00
- per group of 2	0016	60.00	64.50	72.00	79.50	90.00
- per group of 3	0017	90.00	96.75	108.00	119.25	135.00
- per group of 4	0018	120.00	129.00	144.00	159.00	180.00
- per group of 5 - 7	0019	150.00	161.25	180.00	198.75	225.00
Rural Family Physician (per hospital) - Souris, Tyne Valley, O'Leary, Montague	0185	150.00	161.25	180.00	198.75	225.00
- Alberton	0040	260.00	260.00	260.00	260.00	260.00
Hospitalist (QEH & PCH)	0108	150.00	161.25	180.00	198.75	225.00
Unaffiliated Psychiatry inpatient coverage (QEH)	0199	150.00	161.25	180.00	198.75	225.00
Medical Officer Rehab Unit (QEH)	0147	200.00	203.75	210.00	216.25	225.00
Medical Officer Hillsborough Hospital	0197	200.00	203.75	210.00	216.25	225.00
Medical Officer Addictions Unit (Mt.Herbert)	0198	200.00	203.75	210.00	216.25	225.00
Ambulatory Detox Service (PCH & Western Hospital)	0158	50.00	57.50	70.00	82.50	100.00
GP Oncology (Provincial)	0177	300.00	300.00	300.00	300.00	300.00
GP Palliative Care (Provincial)	0179	300.00	300.00	300.00	300.00	300.00
Surgical Assistant (QEH & PCH)	0159	300.00	300.00	300.00	300.00	300.00
Corrections	0030	200.00	203.75	210.00	216.25	225.00
Coroner (East or West)	0020	150.00	150.00	150.00	150.00	150.00
7. HOSPITAL ON-CALL RESPONSE FEE - see Preamble 11.E	0060		50.00	80.00	110.00	150.00
8. DETENTION FEES - See Preamble 10.D.1						
Detention after first half hour (per 15 min.)	0170	40.00	40.75	42.00	43.25	45.00
Special call requiring detention(per 15 min.)**- See Preamble 10.D.3**	0176	40.00	40.75	42.00	43.25	45.00
NOTE: Ambulance transport to be billed as detention **- See Preamble 10.D.2**						
9. PSYCHIATRIC/COUNSELING SERVICES - See Preamble 13.						
NOTE: All psychiatric services are payable in blocks of 15 minutes or major portion thereof with a minimum of 15 min. service provided - not to apply on a day when visit fees are charged.						
Psychotherapy	2501	40.00	40.38	41.00	41.63	42.50
Group psychotherapy	2502	40.00	40.38	41.00	41.63	42.50
Member of Group Psychotherapy	2580	0.00	0.00	0.00	0.00	0.00
Psychotherapy by a General Practitioner in Hospital	2503	40.00	40.38	41.00	41.63	42.50
Mental Health Crisis Care **- See Preamble 13.I**	2508	40.00	40.38	41.00	41.63	42.50
Diagnostic and Therapeutic interview **- See Preamble 13.H**	2588	40.00	40.38	41.00	41.63	42.50
Case Management Conference **- See Preamble 13.G**	2507	40.00	40.38	41.00	41.63	42.50
Health Promotion counseling (max. 45 minutes) **- See Preamble 8**	2505	40.00	40.38	41.00	41.63	42.50
Prenatal Psychosocial Assessment (once/pregnancy - max.45 minutes)	2590	40.00	40.38	41.00	41.63	42.50
10. TELEPHONE PRESCRIPTION RENEWAL - See Preamble 11.C.3 (max. 1 per patient per month)	2019		3.00	3.50	4.00	5.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
11. HOME VISITS						
Home visit	0121	56.00	56.90	58.40	59.90	62.00
Each additional patient seen during home visit	0124	28.00	28.45	29.20	29.95	31.00
Additional fee allowed for emergency visit **- See Preamble 11.A.2**	0125	20.00	20.75	22.00	23.25	25.00
12. HOSPITALIST SERVICES - See Preamble 10.F						
Hospitalist Type 1 daily sessional fee - max. 21 beds	0107	1,265.00	1,267.25	1,271.00	1,274.75	1,280.00
Hospitalist Type 1 daily sessional fee - max. 11 beds	0102		664.00	666.00	668.00	670.00
Hospitalist Type 2 daily sessional fee - max. 17 beds	0101	1,265.00	1,279.25	1,303.00	1,326.75	1,360.00
Hospitalist Type 2 daily sessional fee - max. 09 beds	0037		677.00	690.00	702.00	720.00
Hospitalist Type 1 sessional top-up fee (Salary Class I) - max. 21 beds	0038	595.51	592.33	587.01	581.70	574.26
Hospitalist Type 1 sessional top-up fee (Salary Class II) - max. 21 beds	0039	576.37	573.01	567.41	561.80	553.96
Hospitalist Type 1 sessional top-up fee (Salary Class III) - max. 21 beds	0041	547.70	544.06	538.03	532.00	523.57
Hospitalist Type 1 sessional top-up fee (Salary Class I) - max. 11 beds	0042		310.27	307.48	304.70	300.80
Hospitalist Type 1 sessional top-up fee (Salary Class II) - max. 11 beds	0043		300.15	297.21	294.28	290.17
Hospitalist Type 1 sessional top-up fee (Salary Class III) - max. 11 beds	0044		284.98	281.83	278.67	274.25
Hospitalist Type 2 sessional top-up fee (Salary Class I) - max. 17 beds	0025	595.51	604.33	619.01	633.70	654.26
Hospitalist Type 2 sessional top-up fee (Salary Class II) - max. 17 beds	0026	576.37	585.01	599.41	613.80	633.96
Hospitalist Type 2 sessional top-up fee (Salary Class III) - max. 17 beds	0027	547.70	556.06	570.03	584.00	603.57
Hospitalist Type 2 sessional top-up fee (Salary Class I) - max. 09 beds	0045		319.94	327.71	335.49	346.37
Hospitalist Type 2 sessional top-up fee (Salary Class II) - max. 09 beds	0046		309.71	317.33	324.95	335.62
Hospitalist Type 2 sessional top-up fee (Salary Class III) - max. 09 beds	0047		294.38	301.78	309.18	319.53
Hospitalist on-call retainer (18:00-08:00 hrs daily)	0108	150.00	161.25	180.00	198.75	225.00
Hospitalist shadow billing code	0111	0.00	0.00	0.00	0.00	0.00
Hospitalist patient daily care	0106	68.00	69.80	72.80	75.80	80.00
This is a daily fee for Unaffiliated patient care when not covered by a hospitalist, in lieu of other daily fees.						
13. COMMUNITY CARE FACILITIES (includes nursing homes, manors)						
Visit	0127	45.70	47.10	49.42	51.75	55.00
Each additional patient	0129	22.85	23.55	24.71	25.87	27.50
14. PALLIATIVE CARE - See Preamble 11.B.						
These fees may be billed only by designated physicians with additional training in this specialty area.						
Palliative Care Consultation - G.P.	0148	122.40	128.04	137.44	146.84	160.00
- Specialist	2048	160.00	160.00	160.00	160.00	160.00
Repeat Palliative Care Consultation - G.P.	0167	61.20	64.02	68.72	73.42	80.00
- Specialist	2067	80.00	80.00	80.00	80.00	80.00
Palliative Care Unit Inpatient - initial visit	0163		66.00	76.00	86.00	100.00
Palliative Care Unit Inpatient - daily care visit	0164		37.25	41.00	44.75	50.00
Palliative Home Care Admission	0149	90.00	94.50	102.00	109.50	120.00
Palliative Home Care Visit	0173	72.00	72.45	73.20	73.95	75.00
Palliative Care telephone call (max. 3 claims/patient/wk)	0139	12.00	12.45	13.20	13.95	15.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
15. GERIATRIC CARE						
These fees may be billed only by designated physicians with additional training in this specialty area.						
Consultation	2860	122.40	128.04	137.44	146.84	160.00
Repeat Consultation (within 30 days)	2862	61.20	64.02	68.72	73.42	80.00
Follow-up Visit	2863	33.00	33.30	33.80	34.30	35.00
Home Care Visit	2821	56.00	58.85	63.60	68.35	75.00
Competency Assessment	2880	60.00	62.25	66.00	69.75	75.00
Diagnostic and Therapeutic Interview - **See Preamble 13.H**	2886	40.00	40.75	42.00	43.25	45.00
Case Management Conference - **See Preamble 13.G**	2807	40.00	40.75	42.00	43.25	45.00
Detention - **See Preamble 10.D.1**	2870	40.00	40.75	42.00	43.25	45.00
16. NEW PATIENT FEE - See Preamble 24	0010	150.00	150.00	150.00	150.00	150.00
17. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	28.00	29.80	32.80	35.80	40.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014

ANESTHESIA

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

1. CONSULTATION - See Preamble 9.A and 10.A	0260	85.00	87.70	92.20	96.70	103.00
2. SURGICAL ANESTHESIA - Sessional Fee						
First 30 minute block	0265	87.50	89.00	91.50	94.00	97.50
2nd, 3rd, 4th blocks of 30 minutes (per block)	0265	56.50	57.45	59.10	60.70	62.95
Each subsequent 15 minute block beyond 2 hours	0265	56.50	57.45	59.10	60.70	62.95
Charge for Cancelled Surgery **- See Preamble 18.H**	0266	90.00	91.50	94.00	96.50	100.00
3. FOLLOW-UP VISIT	0213	33.00	33.30	33.80	34.30	35.00
4. ANESTHESIA CRITICAL CARE - See Preamble 10.C.5						
Physician-in-Charge:						
Anesthesia Critical Care - 1st day, includes consult (90 minutes)	0296	275.00	277.25	281.00	284.75	290.00
Anesthesia Critical Care - Days 2-30 inclusive, per day	0297	160.00	161.20	163.20	165.20	168.00
Anesthesia Critical Care - Day 31 onward, per day	0298	80.00	80.60	81.60	82.60	84.00
Intensive Care Visit - per day	0271	85.00	87.25	91.00	94.75	100.00

The maximum time frame is indicated in brackets for first day fee codes. Additional time with the patient may be billed as detention with clear supporting documentation. All first day codes require time of day when requesting afterhours premiums.

Critical care fees include, as required, insertion of IV, central venous, and arterial lines, securing and interpretation of arterial blood gases, endotracheal intubation, artificial ventilation, and all necessary measures for respiratory support.

The following services are payable in addition to daily critical care fees:
- insertion of Swan-Ganz catheters,temporary pacemakers,and chest tubes, cardioversion, renal dialysis, and detention

These fees are not chargeable for patients admitted to an ICU/CCU area for convenience or for observation or monitoring of rhythm only.

5. DETENTION FEES - See Preamble 10.D.1 and 18.E						
Detention after first half hour (per 15 min.)	0270	40.00	40.75	42.00	43.25	45.00
Special call requiring detention(per 15 min.) **- See Preamble 10.D.3**	0276	40.00	40.75	42.00	43.25	45.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
6. ACUTE PAIN MANAGEMENT						
Epidural spinal block - Lumbar and Caudal	2520	65.00	66.50	69.00	71.50	75.00
Epidural spinal block (continuous)						
- consultation and institution	2521	200.00	203.00	208.00	213.00	220.00
- maintenance (per day)	2523	75.00	76.13	78.00	79.88	82.50
Acute Pain Service - initiation	0280	85.00	87.70	92.20	96.70	103.00
Patient-controlled analgesia (PCA) - maintenance	2534	25.00	25.38	26.00	26.63	27.50
Continuous Conduction Anesthesia (Epidural) for Obstetrics	2525	375.00	379.80	387.80	395.80	407.00
Composite fee includes consultation, catheter insertion, first dose, and maintenance						
Other Local/Regional Anesthesia - See Diag./Therapeutic Procedures						
7. CHRONIC PAIN MANAGEMENT						
These fees may be billed only by designated physicians with additional training in this specialty area.						
Chronic Pain consultation	0250	85.00	87.70	92.20	96.70	103.00
Chronic Pain follow-up visit	0252	33.00	33.30	33.80	34.30	35.00
8. ON-CALL RETAINER - Anesthesia (QEH & PCH)	0240	300.00	300.00	300.00	300.00	300.00
9. HOSPITAL ON-CALL RESPONSE FEE - see Preamble 11.E	0060		50.00	80.00	110.00	150.00
10. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	28.00	29.80	32.80	35.80	40.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014

DERMATOLOGY

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

1. REFERRED CASES

Consultation - **See Preamble 9.A and 10.A**	0360	85.00	87.70	92.20	96.70	103.00
Office, home or hospital						
Repeat Consultation within 30 days - **See Preamble 9.C**	0362	42.50	43.85	46.10	48.35	51.50
for same illness or complication thereof						

2. OFFICE VISITS - See Preamble 9.D and 9.E

Comprehensive Office Visit	0310	55.25	55.96	57.15	58.34	60.00
Initial Office Visit with regional exam	0311	33.00	33.30	33.80	34.30	35.00
Limited Office Visit	0313	33.00	33.30	33.80	34.30	35.00

3. HOSPITAL VISITS - In-Patient Services

Initial hospital visit	0330	60.00	66.00	76.00	86.00	100.00
Subsequent hospital visits						
First five weeks, per visit	0333	35.00	37.25	41.00	44.75	50.00
From 6th week to 13th week, per visit	0334	20.00	21.50	24.00	26.50	30.00
After 13th week, per week	0335	20.00	21.50	24.00	26.50	30.00
Continuing care	0341	35.00	37.25	41.00	44.75	50.00
Directive care	0342	35.00	37.25	41.00	44.75	50.00

4. INTENSIVE CARE VISIT - per day	0371	85.00	87.25	91.00	94.75	100.00

5. HOSPITAL EMERGENCY DEPARTMENT VISITS

Limited ED Visit (Level I visit) - **See Preamble 10.E.2(a)**						
- Day(08:00-18:00) - Monday to Friday	0380	28.50	28.95	29.70	30.45	31.50
- Saturday,Sunday,Holiday	0390	33.00	33.53	34.40	35.28	36.50
- Night(18:00-08:00) - Monday to Thursday	0381	37.25	37.81	38.75	39.69	41.00
- Friday,Saturday,Sunday,Holiday	0391	55.25	56.11	57.55	58.99	61.00
Comprehensive ED Visit (Level II visit) - **See Preamble 10.E.2(b)**						
- Day(08:00-18:00) - Monday to Friday	0386	52.00	52.83	54.20	55.58	57.50
- Saturday,Sunday,Holiday	0368	60.00	60.98	62.60	64.23	66.50
- Night(18:00-08:00) - Monday to Thursday	0387	70.00	71.13	73.00	74.88	77.50
- Friday,Saturday,Sunday,Holiday	0369	100.00	101.50	104.00	106.50	110.00
Additional fee allowed for strict emergency visit - **See Preamble 7**	0394	20.00	20.75	22.00	23.25	25.00

6. DETENTION FEES - See Preamble 10.D.1

Detention after first half hour (per 15 min.)	0370	40.00	40.75	42.00	43.25	45.00
Special call requiring detention(per 15 min.) - **See Preamble 10.D.3**	0376	40.00	40.75	42.00	43.25	45.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
7. TELEPHONE SERVICES						
Tele-Dermatology consultation	0350		40.75	42.00	43.25	45.00
Telephone Prescription Renewal (max. 1/patient/month) **- See Preamble 11.C.3**	2019		3.00	3.50	4.00	5.00
8. HOME VISITS (includes nursing homes, manors, etc.)						
Home visit	0321	56.00	56.90	58.40	59.90	62.00
Each additional patient	0324	28.00	28.45	29.20	29.95	31.00
Additional fee allowed for emergency visit **- See Preamble 11.A.2**	0325	20.00	20.75	22.00	23.25	25.00
9. SPECIAL PROCEDURES						
Ultraviolet Light Therapy - general or local application	0395	20.00	20.21	20.56	20.91	21.40
10. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	28.00	29.80	32.80	35.80	40.00

GENERAL SURGERY

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

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
1. REFERRED CASES						
Consultation - **See Preamble 9.A and 10.A**	0460	85.00	87.70	92.20	96.70	103.00
Office, home or hospital						
Repeat Consultation within 30 days - **See Preamble 9.C**	0462	42.50	43.85	46.10	48.35	51.50
for same illness or complication thereof						
2. OFFICE VISITS - See Preamble 9.D and 9.E						
Comprehensive Office Visit	0410	55.25	55.96	57.15	58.34	60.00
Initial Office Visit with regional exam	0411	33.00	33.30	33.80	34.30	35.00
Limited Office Visit	0413	33.00	33.30	33.80	34.30	35.00
3. HOSPITAL VISITS - In-Patient Services						
Initial hospital visit	0430	60.00	66.00	76.00	86.00	100.00
Subsequent hospital visits						
First five weeks, per visit	0433	35.00	37.25	41.00	44.75	50.00
From 6th week to 13th week, per visit	0434	20.00	21.50	24.00	26.50	30.00
After 13th week, per week	0435	20.00	21.50	24.00	26.50	30.00
Continuing care	0441	35.00	37.25	41.00	44.75	50.00
Directive care	0442	35.00	37.25	41.00	44.75	50.00
4. INTENSIVE CARE VISIT - per day	0471	85.00	87.25	91.00	94.75	100.00
5. HOSPITAL EMERGENCY DEPARTMENT VISITS						
Limited ED Visit (Level I visit) - **See Preamble 10.E.2(a)**						
- Day(08:00-18:00) - Monday to Friday	0480	28.50	28.95	29.70	30.45	31.50
- Saturday,Sunday,Holiday	0490	33.00	33.53	34.40	35.28	36.50
- Night(18:00-08:00) - Monday to Thursday	0481	37.25	37.81	38.75	39.69	41.00
- Friday,Saturday,Sunday,Holiday	0491	55.25	56.11	57.55	58.99	61.00
Comprehensive ED Visit (Level II visit) - **See Preamble 10.E.2(b)**						
- Day(08:00-18:00) - Monday to Friday	0486	52.00	52.83	54.20	55.58	57.50
- Saturday,Sunday,Holiday	0468	60.00	60.98	62.60	64.23	66.50
- Night(18:00-08:00) - Monday to Thursday	0487	70.00	71.13	73.00	74.88	77.50
- Friday,Saturday,Sunday,Holiday	0469	100.00	101.50	104.00	106.50	110.00
Resuscitation ED Visit (Level III visit) - **See Preamble 10.E.2(c)**						
- first 15 minutes	0182	90.00	91.50	94.00	96.50	100.00
- second 15 minutes	0183	45.00	45.75	47.00	48.25	50.00
- subsequent 15-minutes periods	0184	45.00	45.75	47.00	48.25	50.00
Additional fee allowed for strict emergency visit - **See Preamble 7**	0494	20.00	20.75	22.00	23.25	25.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
6. ON-CALL RETAINERS - General Surgery (QEH & PCH)	0440	300.00	300.00	300.00	300.00	300.00
- Plastic Surgery (Provincial)	9740	300.00	300.00	300.00	300.00	300.00
7. HOSPITAL ON-CALL RESPONSE FEE - see Preamble 11.E	0060		50.00	80.00	110.00	150.00
8. DETENTION FEES - See Preamble 10.D.1						
Detention after first half hour (per 15 min.)	0470	40.00	40.75	42.00	43.25	45.00
Special call requiring detention(per 15 min.)**- See Preamble 10.D.3**	0476	40.00	40.75	42.00	43.25	45.00
9. TELEPHONE PRESCRIPTION RENEWAL - See Preamble 11.C.3 (max. 1 per patient per month)	2019		3.00	3.50	4.00	5.00
10. HOME VISITS (includes nursing homes, manors, etc.)						
Home visit	0421	56.00	56.90	58.40	59.90	62.00
Each additional patient	0424	28.00	28.45	29.20	29.95	31.00
Additional fee allowed for emergency visit **-See Preamble 11.A.2**	0425	20.00	20.75	22.00	23.25	25.00
11. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	28.00	29.80	32.80	35.80	40.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014

INTERNAL MEDICINE

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

1. REFERRED CASES

Consultation - **See Preamble 9.A and 10.A**	0560	160.00	164.50	172.00	179.50	190.00
Office, home or hospital						
Repeat Consultation within 30 days - **See Preamble 9.C**	0562	80.00	82.25	86.00	89.75	95.00
for same illness or complication thereof						
Complete re-examination by a medical specialist **-See Preamble 9.G**	0563	64.80	65.58	66.88	68.18	70.00

2. OFFICE VISITS - See Preamble 9.D and 19.E

Comprehensive Office Visit	0510	64.80	65.58	66.88	68.18	70.00
Subsequent Office Visit with complete re-examination	0512	64.80	65.58	66.88	68.18	70.00
Limited Office Visit	0513	33.00	33.30	33.80	34.30	35.00

3. HOSPITAL VISITS - In-Patient Services

Initial hospital visit	0530	60.00	66.00	76.00	86.00	100.00
Subsequent hospital visits						
First five weeks, per visit	0533	35.00	37.25	41.00	44.75	50.00
From 6th week to 13th week, per visit	0534	20.00	21.50	24.00	26.50	30.00
After 13th week, per week	0535	20.00	21.50	24.00	26.50	30.00
Continuing care	0541	35.00	37.25	41.00	44.75	50.00
Directive care	0542	35.00	37.25	41.00	44.75	50.00

4. CRITICAL CARE - See Preamble 10.C.5

Physician-in-Charge:

Critical Care - 1st day, includes consultation (90 minutes)	0595	275.00	277.25	281.00	284.75	290.00
Critical Care - 1st day, consult within previous 10 days (45 min.)	0596	160.00	161.20	163.20	165.20	168.00
Critical Care - Days 2-30 inclusive, per day	0597	160.00	161.20	163.20	165.20	168.00
Critical Care - Day 31 onward, per day	0598	80.00	80.60	81.60	82.60	84.00
Intermediate/Progressive Care - per day	0501	120.00	121.80	124.80	127.80	132.00
Concurrent Critical Care - per day	0502	160.00	161.20	163.20	165.20	168.00

The maximum time frame is indicated in brackets for first day fee codes. Additional time with the patient may be billed as detention with clear supporting documentation. All first day codes require time of day when requesting afterhours premiums.

Critical care fees include, as required, insertion of IV, central venous, and arterial lines, securing and interpretation of arterial blood gases, endotracheal intubation, artificial ventilation, and all necessary measures for respiratory support.

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
The following services are payable in addition to daily critical care fees: - insertion of Swan-Ganz catheters,temporary pacemakers,and chest tubes, cardioversion, renal dialysis, and detention.						
These fees are not chargeable for patients admitted to an ICU/CCU area for convenience or for observation or monitoring of rhythm only.						
5. HOSPITAL EMERGENCY DEPARTMENT VISITS						
Limited ED Visit (Level I visit) - **See Preamble 10.E.2(a)**						
- Day(08:00-18:00) - Monday to Friday	0580	28.50	28.95	29.70	30.45	31.50
- Saturday,Sunday,Holiday	0590	33.00	33.53	34.40	35.28	36.50
- Night(18:00-08:00) - Monday to Thursday	0581	37.25	37.81	38.75	39.69	41.00
- Friday,Saturday,Sunday,Holiday	0591	55.25	56.11	57.55	58.99	61.00
Comprehensive ED Visit (Level II visit) - **See Preamble 10.E.2(b)**						
- Day(08:00-18:00) - Monday to Friday	0586	52.00	52.83	54.20	55.58	57.50
- Saturday,Sunday,Holiday	0568	60.00	60.98	62.60	64.23	66.50
- Night(18:00-08:00) - Monday to Thursday	0587	70.00	71.13	73.00	74.88	77.50
- Friday,Saturday,Sunday,Holiday	0569	100.00	101.50	104.00	106.50	110.00
Resuscitation ED Visit (Level III visit) - **See Preamble 10.E.2(c)**						
- first 15 minutes	0182	90.00	91.50	94.00	96.50	100.00
- second 15 minutes	0183	45.00	45.75	47.00	48.25	50.00
- subsequent 15-minutes periods	0184	45.00	45.75	47.00	48.25	50.00
Additional fee allowed for strict emergency visit - **See Preamble 7**	0594	20.00	20.75	22.00	23.25	25.00
6. ON-CALL RETAINERS - Internal Medicine (QEH & PCH)	0540	300.00	300.00	300.00	300.00	300.00
- Neurology (backup service)	0503	50.00	57.50	70.00	82.50	100.00
- Oncology (backup service)	0174	50.00	57.50	70.00	82.50	100.00
- Laboratory Medicine (Provincial)	1940	300.00	300.00	300.00	300.00	300.00
7. HOSPITAL ON-CALL RESPONSE FEE - see Preamble 11.E	0060		50.00	80.00	110.00	150.00
8. DETENTION FEES - See Preamble 10.D.1						
Detention after first half hour (per 15 min.)	0570	40.00	40.75	42.00	43.25	45.00
Special call requiring detention(per 15 min.) - **See Preamble 10.D.3**	0576	40.00	40.75	42.00	43.25	45.00
9. COUNSELING SERVICES - See Preamble 8 and 13						
All counseling services are payable in blocks of 15 minutes or major portion thereof - not to apply on a day when visit fees are charged						
Diagnostic and therapeutic interview - **See Preamble 13.H**	2586	50.00	50.75	52.00	53.25	55.00
Case Management Conference - **See Preamble 13.G**	2507	40.00	40.38	41.00	41.63	42.50
Health Promotion counseling (max. 45 minutes) - **See Preamble 8**	2505	40.00	40.38	41.00	41.63	42.50

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
10. TELEPHONE SERVICES						
Telephone Consultation - **see Preamble 11.C.1**	0550	40.00	40.75	42.00	43.25	45.00
Telephone Prescription Renewal (max. 1/patient/month) **- See Preamble 11.C.3**	2019		3.00	3.50	4.00	5.00
11. HOME VISITS (includes nursing homes, manors, etc.)						
Home visit	0521	56.00	56.90	58.40	59.90	62.00
Each additional patient	0524	28.00	28.45	29.20	29.95	31.00
Additional fee allowed for emergency visit **-See Preamble 11.A.2**	0525	20.00	20.75	22.00	23.25	25.00
12. SPECIAL PROCEDURES						
Pacemakers - see Fee Codes 4760-4776						
Stress tests and other procedures - see Diagnostic/Therapeutic Procedures						
13. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	28.00	29.80	32.80	35.80	40.00

OBSTETRICS AND GYNECOLOGY

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

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
1. REFERRED CASES						
Consultation - **See Preamble 9.A and 10.A**	0760	85.00	87.70	92.20	96.70	103.00
Office, home or hospital						
Repeat Consultation within 30 days - **See Preamble 9.C**	0762	42.50	43.85	46.10	48.35	51.50
for same illness or complication thereof						
Consultation - Reproductive Endocrinology	0764	85.00	87.70	92.20	96.70	103.00
Repeat Consultation - Reproductive Endocrinology	0765	42.50	43.85	46.10	48.35	51.50
2. OFFICE VISITS - See Preamble 9.D and 9.E						
Comprehensive Office Visit	0710	55.25	55.96	57.15	58.34	60.00
Initial Office Visit with regional exam	0711	33.00	33.30	33.80	34.30	35.00
Limited Office Visit	0713	33.00	33.30	33.80	34.30	35.00
Initial prenatal visit	0700	55.25	55.96	57.15	58.34	60.00
Subsequent prenatal visit	0703	33.00	33.30	33.80	34.30	35.00
Postnatal visit	0705	33.00	33.30	33.80	34.30	35.00
3. HOSPITAL VISITS - In-Patient Services						
Initial hospital visit	0730	60.00	66.00	76.00	86.00	100.00
Subsequent hospital visits						
First five weeks, per visit	0733	35.00	37.25	41.00	44.75	50.00
From 6th week to 13th week, per visit	0734	20.00	21.50	24.00	26.50	30.00
After 13th week, per week	0735	20.00	21.50	24.00	26.50	30.00
Continuing care	0741	35.00	37.25	41.00	44.75	50.00
Directive care	0742	35.00	37.25	41.00	44.75	50.00
Assessment of labour	0701	35.00	37.25	41.00	44.75	50.00
Postpartum visit	0704	35.00	37.25	41.00	44.75	50.00
4. INTENSIVE CARE VISIT - per day	0771	85.00	87.25	91.00	94.75	100.00
5. HOSPITAL EMERGENCY DEPARTMENT VISITS						
Limited ED Visit (Level I visit) - **See Preamble 10.E.2(a)**						
- Day(08:00-18:00) - Monday to Friday	0780	28.50	28.95	29.70	30.45	31.50
- Saturday,Sunday,Holiday	0790	33.00	33.53	34.40	35.28	36.50
- Night(18:00-08:00) - Monday to Thursday	0781	37.25	37.81	38.75	39.69	41.00
- Friday,Saturday,Sunday,Holiday	0791	55.25	56.11	57.55	58.99	61.00
Comprehensive ED Visit (Level II visit) - **See Preamble 10.E.2(b)**						
- Day(08:00-18:00) - Monday to Friday	0786	52.00	52.83	54.20	55.58	57.50
- Saturday,Sunday,Holiday	0768	60.00	60.98	62.60	64.23	66.50
- Night(18:00-08:00) - Monday to Thursday	0787	70.00	71.13	73.00	74.88	77.50
- Friday,Saturday,Sunday,Holiday	0769	100.00	101.50	104.00	106.50	110.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Additional fee allowed for strict emergency visit **- See Preamble 7**	0794	20.00	20.75	22.00	23.25	25.00
Outpatient assessment for complications of pregnancy/labor	0795	85.00	87.70	92.20	96.70	103.00
6. ON-CALL RETAINER - Obstetrics/Gynecology (QEH & PCH)	0740	300.00	300.00	300.00	300.00	300.00
7. HOSPITAL ON-CALL RESPONSE FEE - see Preamble 11.E	0060		50.00	80.00	110.00	150.00
8. DETENTION FEES - See Preamble 10.D.1						
Detention after first half hour (per 15 min.)	0770	40.00	40.75	42.00	43.25	45.00
Special call requiring detention(per 15 min.)**- See Preamble 10.D.3**	0776	40.00	40.75	42.00	43.25	45.00
9. TELEPHONE PRESCRIPTION RENEWAL - See Preamble 11.C.3 (max. 1 per patient per month)	2019		3.00	3.50	4.00	5.00
10. HOME VISITS (includes nursing homes, manors, etc.)						
Home visit	0721	56.00	56.90	58.40	59.90	62.00
Each additional patient	0724	28.00	28.45	29.20	29.95	31.00
Additional fee allowed for emergency visit **-See Preamble 11.A.2**	0725	20.00	20.75	22.00	23.25	25.00
11. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	28.00	29.80	32.80	35.80	40.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014

OPHTHALMOLOGY

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

1. REFERRED CASES

Consultation - **See Preamble 9.A and 10.A**	0860	85.00	87.70	92.20	96.70	103.00
Office, home or hospital						
Repeat Consultation within 30 days - **See Preamble 9.C**	0862	42.50	43.85	46.10	48.35	51.50
for same illness or complication thereof						

2. OFFICE VISITS - See Preamble 9.D and 9.E

Comprehensive Office Visit	0810	55.25	55.96	57.15	58.34	60.00
Initial Office Visit with regional exam	0811	33.00	33.30	33.80	34.30	35.00
Limited Office Visit	0813	33.00	33.30	33.80	34.30	35.00
Subsequent Office Visit with special tests	0812	55.00	55.75	57.00	58.25	60.00

3. HOSPITAL VISITS - In-Patient Services

Initial hospital visit	0830	60.00	66.00	76.00	86.00	100.00
Subsequent hospital visits						
First five weeks, per visit	0833	35.00	37.25	41.00	44.75	50.00
From 6th week to 13th week, per visit	0834	20.00	21.50	24.00	26.50	30.00
After 13th week, per week	0835	20.00	21.50	24.00	26.50	30.00
Continuing care	0841	35.00	37.25	41.00	44.75	50.00
Directive care	0842	35.00	37.25	41.00	44.75	50.00

4. INTENSIVE CARE VISIT - per day	0871	85.00	87.25	91.00	94.75	100.00

5. HOSPITAL EMERGENCY DEPARTMENT VISITS

Limited ED Visit (Level I visit) - **See Preamble 10.E.2(a)**						
- Day(08:00-18:00) - Monday to Friday	0880	28.50	28.95	29.70	30.45	31.50
- Saturday,Sunday,Holiday	0890	33.00	33.53	34.40	35.28	36.50
- Night(18:00-08:00) - Monday to Thursday	0881	37.25	37.81	38.75	39.69	41.00
- Friday,Saturday,Sunday,Holiday	0891	55.25	56.11	57.55	58.99	61.00
Comprehensive ED Visit (Level II visit) - **See Preamble 10.E.2(b)**						
- Day(08:00-18:00) - Monday to Friday	0886	52.00	52.83	54.20	55.58	57.50
- Saturday,Sunday,Holiday	0868	60.00	60.98	62.60	64.23	66.50
- Night(18:00-08:00) - Monday to Thursday	0887	70.00	71.13	73.00	74.88	77.50
- Friday,Saturday,Sunday,Holiday	0869	100.00	101.50	104.00	106.50	110.00
Additional fee allowed for strict emergency visit - **See Preamble 7**	0894	20.00	20.75	22.00	23.25	25.00
6. ON-CALL RETAINER - Ophthalmology (Provincial)	0840	300.00	300.00	300.00	300.00	300.00
7. HOSPITAL ON-CALL RESPONSE FEE - see Preamble 11.E	0060		50.00	80.00	110.00	150.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
8. DETENTION FEES - See Preamble Section 10.D.1						
Detention after first half hour (per 15 min.)	0870	40.00	40.75	42.00	43.25	45.00
Special call requiring detention(per 15 min.) **- See Preamble 10.D.3**	0876	40.00	40.75	42.00	43.25	45.00
9. TELEPHONE PRESCRIPTION RENEWAL - See Preamble 11.C.3 (max. 1 per patient per month)	2019		3.00	3.50	4.00	5.00
10. HOME VISITS (includes nursing homes, manors, etc.)						
Home visit	0821	56.00	56.90	58.40	59.90	62.00
Each additional patient	0824	28.00	28.45	29.20	29.95	31.00
Additional fee allowed for emergency visit **- See Preamble 11.A.2**	0825	20.00	20.75	22.00	23.25	25.00
11. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	28.00	29.80	32.80	35.80	40.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014

ORTHOPEDIC SURGERY

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

1. REFERRED CASES

Consultation - **See Preamble 9.A and 10.A**	0960	85.00	87.70	92.20	96.70	103.00
Office, home or hospital						
Repeat Consultation within 30 days - **See Preamble 9.C**	0962	42.50	43.85	46.10	48.35	51.50
for same illness or complication thereof						

2. OFFICE VISITS - See Preamble 9.D and 9.E

Comprehensive Office Visit	0910	55.25	55.96	57.15	58.34	60.00
Initial Office Visit with regional exam	0911	33.00	33.30	33.80	34.30	35.00
Limited Office Visit	0913	33.00	33.30	33.80	34.30	35.00

3. HOSPITAL VISITS - In-Patient Services

Initial hospital visit	0930	60.00	66.00	76.00	86.00	100.00
Subsequent hospital visits						
First five weeks, per visit	0933	35.00	37.25	41.00	44.75	50.00
From 6th week to 13th week, per visit	0934	20.00	21.50	24.00	26.50	30.00
After 13th week, per week	0935	20.00	21.50	24.00	26.50	30.00
Continuing care	0941	35.00	37.25	41.00	44.75	50.00
Directive care	0942	35.00	37.25	41.00	44.75	50.00

4. INTENSIVE CARE VISIT - per day	0971	85.00	87.25	91.00	94.75	100.00

5. HOSPITAL EMERGENCY DEPARTMENT VISITS

Limited ED Visit (Level I visit)- **See Preamble 10.E.2(a)**						
- Day(08:00-18:00) - Monday to Friday	0980	28.50	28.95	29.70	30.45	31.50
- Saturday,Sunday,Holiday	0990	33.00	33.53	34.40	35.28	36.50
- Night(18:00-08:00) - Monday to Thursday	0981	37.25	37.81	38.75	39.69	41.00
- Friday,Saturday,Sunday,Holiday	0991	55.25	56.11	57.55	58.99	61.00
Comprehensive ED Visit (Level II visit)- **See Preamble 10.E.2(b)**						
- Day(08:00-18:00) - Monday to Friday	0986	52.00	52.83	54.20	55.58	57.50
- Saturday,Sunday,Holiday	0968	60.00	60.98	62.60	64.23	66.50
- Night(18:00-08:00) - Monday to Thursday	0987	70.00	71.13	73.00	74.88	77.50
- Friday,Saturday,Sunday,Holiday	0969	100.00	101.50	104.00	106.50	110.00
Additional fee allowed for strict emergency visit - **See Preamble 7**	0994	20.00	20.75	22.00	23.25	25.00
6. ON-CALL RETAINER - Orthopedics (Provincial)	0940	300.00	300.00	300.00	300.00	300.00
7. HOSPITAL ON-CALL RESPONSE FEE - see Preamble 11.E	0060		50.00	80.00	110.00	150.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
8. DETENTION FEES - See Preamble 10.D.1						
Detention after first half hour (per 15 min.)	0970	40.00	40.75	42.00	43.25	45.00
Special call requiring detention(per 15 min.) **- See Preamble 10.D.3**	0976	40.00	40.75	42.00	43.25	45.00
9. TELEPHONE SERVICES						
PACS Telephone Consultation **- see Preamble 11.C.2**	0950	40.00	40.75	42.00	43.25	45.00
Telephone Prescription Renewal (max. 1/patient/month) **- See Preamble 11.C.3**	2019		3.00	3.50	4.00	5.00
10. HOME VISITS (includes nursing homes, manors, etc.)						
Home visit	0921	56.00	56.90	58.40	59.90	62.00
Each additional patient	0924	28.00	28.45	29.20	29.95	31.00
Additional fee allowed for emergency visit **-See Preamble 11.A.2**	0925	20.00	20.75	22.00	23.25	25.00
11. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	28.00	29.80	32.80	35.80	40.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014

OTOLARYNGOLOGY

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

1. REFERRED CASES

Consultation - **See Preamble 9.A and 10.A**	1060	85.00	87.70	92.20	96.70	103.00
Office, home or hospital						
Repeat Consultation within 30 days - **See Preamble 9.C**	1062	42.50	43.85	46.10	48.35	51.50
for same illness or complication thereof						

2. OFFICE VISITS - See Preamble 9.D and 9.E

Comprehensive Office Visit	1010	55.25	55.96	57.15	58.34	60.00
Initial Office Visit with regional exam	1011	33.00	33.30	33.80	34.30	35.00
Limited Office Visit	1013	33.00	33.30	33.80	34.30	35.00

3. HOSPITAL VISITS - In-Patient Services

Initial hospital visit	1030	60.00	66.00	76.00	86.00	100.00
Subsequent hospital visits						
First five weeks, per visit	1033	35.00	37.25	41.00	44.75	50.00
From 6th week to 13th week, per visit	1034	20.00	21.50	24.00	26.50	30.00
After 13th week, per week	1035	20.00	21.50	24.00	26.50	30.00
Continuing care	1041	35.00	37.25	41.00	44.75	50.00
Directive care	1042	35.00	37.25	41.00	44.75	50.00
4. INTENSIVE CARE VISIT - per day	1071	85.00	87.25	91.00	94.75	100.00

5. HOSPITAL EMERGENCY DEPARTMENT VISITS

Limited ED Visit (Level I visit) - **See Preamble 10.E.2(a)**						
- Day(08:00-18:00) - Monday to Friday	1080	28.50	28.95	29.70	30.45	31.50
- Saturday,Sunday,Holiday	1090	33.00	33.53	34.40	35.28	36.50
- Night(18:00-08:00) - Monday to Thursday	1081	37.25	37.81	38.75	39.69	41.00
- Friday,Saturday,Sunday,Holiday	1091	55.25	56.11	57.55	58.99	61.00
Comprehensive ED Visit (Level II visit) - **See Preamble 10.E.2(b)**						
- Day(08:00-18:00) - Monday to Friday	1086	52.00	52.83	54.20	55.58	57.50
- Saturday,Sunday,Holiday	1068	60.00	60.98	62.60	64.23	66.50
- Night(18:00-08:00) - Monday to Thursday	1087	70.00	71.13	73.00	74.88	77.50
- Friday,Saturday,Sunday,Holiday	1069	100.00	101.50	104.00	106.50	110.00
Additional fee allowed for strict emergency visit - **See Preamble 7**	1094	20.00	20.75	22.00	23.25	25.00
6. ON-CALL RETAINER - ENT(Provincial)	1040	300.00	300.00	300.00	300.00	300.00
7. HOSPITAL ON-CALL RESPONSE FEE - see Preamble 11.E	0060		50.00	80.00	110.00	150.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
8. DETENTION FEES - See Preamble 10.D.1						
Detention after first half hour (per 15 min.)	1070	40.00	40.75	42.00	43.25	45.00
Special call requiring detention(per 15 min.) **- See Preamble 10.D.3**	1076	40.00	40.75	42.00	43.25	45.00
9. TELEPHONE PRESCRIPTION RENEWAL - See Preamble 11.C.3 (max. 1 per patient per month)	2019		3.00	3.50	4.00	5.00
10. HOME VISITS (includes nursing homes, manors, etc.)						
Home visit	1021	56.00	56.90	58.40	59.90	62.00
Each additional patient	1024	28.00	28.45	29.20	29.95	31.00
Additional fee allowed for emergency visit **- See Preamble 11.A.2**	1025	20.00	20.75	22.00	23.25	25.00
11. SPECIAL PROCEDURES						
See Diagnostic & Therapeutic Procedures						
12. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	28.00	29.80	32.80	35.80	40.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014

PEDIATRICS

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

1. REFERRED CASES

Consultation - **See Preamble 9.A and 10.A**	1160	160.00	164.50	172.00	179.50	190.00
Office, home or hospital						
Repeat Consultation within 30 days - **See Preamble 9.C**	1162	80.00	82.25	86.00	89.75	95.00
for same illness or complication thereof						
Complete re-examination by a medical specialist **-See Preamble 9.G**	1163	64.80	65.58	66.88	68.18	70.00

2. OFFICE VISITS - See Preamble 9.D and 9.E

Comprehensive Office Visit	1110	64.80	65.58	66.88	68.18	70.00
Initial Office Visit with regional examination	1111	33.00	33.30	33.80	34.30	35.00
Subsequent Office Visit with complete re-examination	1112	64.80	65.58	66.88	68.18	70.00
Limited Office Visit	1113	33.00	33.30	33.80	34.30	35.00
Well baby care **- See Preamble 20.B**	1115	33.00	33.30	33.80	34.30	35.00

3. HOSPITAL VISITS - In-Patient Services

Initial hospital visit	1130	60.00	66.00	76.00	86.00	100.00
Subsequent hospital visits						
First five weeks, per visit	1133	35.00	37.25	41.00	44.75	50.00
From 6th week to 13th week, per visit	1134	20.00	21.50	24.00	26.50	30.00
After 13th week, per week	1135	20.00	21.50	24.00	26.50	30.00
Continuing care	1141	35.00	37.25	41.00	44.75	50.00
Directive care	1142	35.00	37.25	41.00	44.75	50.00
Attendance at maternal delivery +/- intubation **- See Preamble 20.A**	1136	110.50	111.93	114.30	116.68	120.00

Healthy Newborn

Hospital Visit fees apply

Ill Newborn

Initial hospital visit	1182	54.00	54.00	54.00	54.00	54.00
Subsequent hospital visits						
First five weeks, per visit	1183	11.55	11.55	11.55	11.55	11.55
From 6th week to 13th week, per visit (max.5 visits/week)	1184	10.50	10.50	10.50	10.50	10.50
After 13th week, per week	1185	14.50	14.50	14.50	14.50	14.50

Premature Newborn

Initial hospital visit	1137	75.75	75.75	75.75	75.75	75.75
Thereafter up to 3 weeks, per week	1138	64.45	64.45	64.45	64.45	64.45
After 3 weeks, per week	1139	32.45	32.45	32.45	32.45	32.45

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
4. PEDIATRIC CRITICAL CARE - See Preamble 10.C.5 and 20.E						
Physician-in-Charge:						
Pediatric Critical Care - 1st day, includes consult (90 minutes)	1154	275.00	277.25	281.00	284.75	290.00
Pediatric Critical Care - 1st day, consult in previous 10 days(45 min.)	1155	160.00	161.20	163.20	165.20	168.00
Pediatric Critical Care - Days 2-30 inclusive, per day	1156	160.00	161.20	163.20	165.20	168.00
Pediatric Critical Care - Day 31 onward, per day	1157	80.00	80.60	81.60	82.60	84.00
Intensive Care Visit - per day	1179	21.55	33.32	52.93	72.54	100.00

The maximum time frame is indicated in brackets for first day fee codes. Additional time with the patient may be billed as detention with clear supporting documentation. All first day codes require time of day when requesting afterhours premiums.

Critical care fees include, as required, insertion of IV, central venous, and arterial lines, securing and interpretation of arterial blood gases, endotracheal intubation, artificial ventilation, and all necessary measures for respiratory support.

The following services are payable in addition to daily critical care fees:
- insertion of Swan-Ganz catheters,temporary pacemakers,and chest tubes, cardioversion, renal dialysis, and detention.

These fees are not chargeable for patients admitted to an ICU/CCU area for convenience or for observation or monitoring of rhythm only.

5. NEONATAL INTENSIVE CARE*

Level A: Full life support including invasive monitoring, ventilatory support, and parenteral alimentation						
Neonatal ICU Care - 1st day, includes consult (120 minutes)	1145	330.00	333.00	338.00	343.00	350.00
Neonatal ICU Care - Days 2-30 inclusive, per day	1146	165.00	166.50	169.00	171.50	175.00
Neonatal ICU Care - Day 31 onward, per day	1147	110.00	110.90	112.40	113.90	116.00
Level B: Intensive Care including full monitoring both invasive and non-invasive, oxygen administration and intravenous therapy, but without ventilatory support.						
Neonatal ICU Care - 1st day, includes consult (90 minutes)	1148	215.00	218.75	225.00	231.25	240.00
Neonatal ICU Care - 2nd day onward, per day	1149	75.00	76.50	79.00	81.50	85.00
Level C: Intermediate care including oxygen administration, non-invasive monitoring and gavage feeding.						
Neonatal ICU Care - 1st day, includes consult (60 minutes)	1150	140.00	149.00	164.00	179.00	200.00
Neonatal ICU Care - 2nd day onward, per day	1151	60.00	61.50	64.00	66.50	70.00

The maximum time frame is indicated in brackets for first day fee codes. Additional time with the patient may be billed as detention with clear supporting documentation. All first day codes require time of day when requesting afterhours premiums.

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014

The above fees include the initial consultation or assessment and subsequent examinations of the patient and, as required, insertion of arterial, venous, C.V.P. or urinary catheters, intravenous lines, interpreting of blood gases, nasogastric tubes, pressure infusion sets and pharmaceutical agents, endotracheal intubation, tracheal toilet, artificial ventilation and all necessary measures for respiratory support.

If infant has been transferred from one level to another, in either direction, up or down, second day fees apply.

Regular visit and procedure fees will apply the day following termination of Neonatal Intensive Care.

If patient has been discharged from Unit more than 48 hours and is re-admitted to Unit 1st day rate applies again on day of re-admission.

The appropriate consultation, procedure and visit fees shall apply after stopping artificial respiration or special care.

*****Applicable to Pediatricians with special training in Neonatal Intensive Care.

6. HOSPITAL EMERGENCY DEPARTMENT VISITS

Limited ED Visit (Level I visit)**- See Preamble 10.E.2(a)**						
- Day(08:00-18:00) - Monday to Friday	1180	28.50	28.95	29.70	30.45	31.50
- Saturday,Sunday,Holiday	1190	33.00	33.53	34.40	35.28	36.50
- Night(18:00-08:00) - Monday to Thursday	1181	37.25	37.81	38.75	39.69	41.00
- Friday,Saturday,Sunday,Holiday	1191	55.25	56.11	57.55	58.99	61.00
Comprehensive ED Visit (Level II visit) **- See Preamble 10.E.2(b)**						
- Day(08:00-18:00) - Monday to Friday	1186	52.00	52.83	54.20	55.58	57.50
- Saturday,Sunday,Holiday	1168	60.00	60.98	62.60	64.23	66.50
- Night(18:00-08:00) - Monday to Thursday	1187	70.00	71.13	73.00	74.88	77.50
- Friday,Saturday,Sunday,Holiday	1169	100.00	101.50	104.00	106.50	110.00
Resuscitation ED Visit (Level III visit) **- See Preamble 10.E.2(c)**						
- first 15 minutes	0182	90.00	91.50	94.00	96.50	100.00
- second 15 minutes	0183	45.00	45.75	47.00	48.25	50.00
- subsequent 15-minutes periods	0184	45.00	45.75	47.00	48.25	50.00
Additional fee allowed for strict emergency visit **- See Preamble 7**	1194	20.00	20.75	22.00	23.25	25.00
7. ON-CALL RETAINER - Pediatrics (QEH & PCH)	1140	300.00	300.00	300.00	300.00	300.00
8. HOSPITAL ON-CALL RESPONSE FEE - see Preamble 11.E	0060		50.00	80.00	110.00	150.00

9. DETENTION FEES - See Preamble 10.D.1

Detention after first half hour (per 15 min.)	1170	40.00	40.75	42.00	43.25	45.00
Special call requiring detention(per 15 min.) **- See Preamble 10.D.3**	1176	40.00	40.75	42.00	43.25	45.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
10. COUNSELING SERVICES - See Preamble 8 and 13						
All counseling services are payable in blocks of 15 minutes or major portion thereof - not to apply on a day when visit fees are charged						
Health Promotion counseling (max. 45 minutes) **- See Preamble 8**	2505	40.00	40.38	41.00	41.63	42.50
Case Management Conference **- See Preamble 13.G**	2507	40.00	40.38	41.00	41.63	42.50
Diagnostic and therapeutic interview **- See Preamble 13.H** (includes genetic, drug, psychiatric, family counseling)	2586	50.00	50.75	52.00	53.25	55.00
11. TELEPHONE SERVICES						
Telephone Consultation **- see Preamble 11.C.1**	1120		40.75	42.00	43.25	45.00
Telephone Prescription Renewal (max. 1/patient/month) **- See Preamble 11.C.3**	2019		3.00	3.50	4.00	5.00
12. HOME VISITS (includes nursing homes, manors, etc.)						
Home visit	1121	56.00	56.90	58.40	59.90	62.00
Each additional patient	1124	28.00	28.45	29.20	29.95	31.00
Additional fee allowed for emergency visit **- See Preamble 11.A.2**	1125	20.00	20.75	22.00	23.25	25.00
13. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	28.00	29.80	32.80	35.80	40.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014

PSYCHIATRY

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

1. REFERRED CASES

Consultation - **See Preamble 9.A and 10.A**	1260	175.00	179.50	187.00	194.50	205.00
Office, home or hospital						
Repeat Consultation within 30 days - **See Preamble 9.C**	1262	87.50	89.75	93.50	97.25	102.50
for same illness or complication thereof						
Complete re-examination by a medical specialist **-See Preamble 9.G**	1263	64.80	65.58	66.88	68.18	70.00

2. OFFICE VISITS - See Preamble 9.D and 9.E

Comprehensive Office Visit	1210	64.80	65.58	66.88	68.18	70.00
Limited Office Visit	1213	33.00	33.30	33.80	34.30	35.00
Sessional fee - Member of Group	2582	0.00	0.00	0.00	0.00	0.00

3. HOSPITAL VISITS - In-Patient Services

Initial hospital visit	1230	60.00	66.00	76.00	86.00	100.00
Subsequent hospital visits						
First five weeks, per visit	1233	35.00	37.25	41.00	44.75	50.00
From 6th week to 13th week, per visit	1234	20.00	21.50	24.00	26.50	30.00
After 13th week, per week	1235	20.00	21.50	24.00	26.50	30.00
Continuing care	1241	35.00	37.25	41.00	44.75	50.00
Directive care	1242	35.00	37.25	41.00	44.75	50.00

4. PSYCHIATRIC SERVICES - See Preamble 13

All psychiatric services are payable in blocks of 15 minutes or major portion thereof with a minimum of 15 minutes service provided

Psychotherapy	2504	50.00	50.75	52.00	53.25	55.00
Group psychotherapy	2587	50.00	50.75	52.00	53.25	55.00
Member of Group Psychotherapy	2581	0.00	0.00	0.00	0.00	0.00
Diagnostic and/or Therapeutic interview	2586	50.00	50.75	52.00	53.25	55.00
Case Management Conference	2507	40.00	40.38	41.00	41.63	42.50

NOTE: In exceptionally long cases, psychiatrists should claim detention fees after 45 minutes.

5. HOSPITAL EMERGENCY DEPARTMENT VISITS

Limited ED Visit (Level I visit)- **See Preamble 10.E.2(a)**						
- Day(08:00-18:00) - Monday to Friday	1280	28.50	28.95	29.70	30.45	31.50
- Saturday,Sunday,Holiday	1290	33.00	33.53	34.40	35.28	36.50

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
- Night(18:00-08:00) - Monday to Thursday	1281	37.25	37.81	38.75	39.69	41.00
- Friday,Saturday,Sunday,Holiday	1291	55.25	56.11	57.55	58.99	61.00
Comprehensive ED Visit (Level II visit)**- See Preamble 10.E.2(b)**						
- Day(08:00-18:00) - Monday to Friday	1286	52.00	52.83	54.20	55.58	57.50
- Saturday,Sunday,Holiday	1268	60.00	60.98	62.60	64.23	66.50
- Night(18:00-08:00) - Monday to Thursday	1287	70.00	71.13	73.00	74.88	77.50
- Friday,Saturday,Sunday,Holiday	1269	100.00	101.50	104.00	106.50	110.00
Additional fee allowed for strict emergency visit **- See Preamble 7**	1294	20.00	20.75	22.00	23.25	25.00
6. ON-CALL RETAINER - Psychiatry (Provincial)	1240	300.00	300.00	300.00	300.00	300.00
7. HOSPITAL ON-CALL RESPONSE FEE - see Preamble 11.E	0060		50.00	80.00	110.00	150.00
8. DETENTION FEES - See Preamble 10.D.1						
Detention after first half hour (per 15 min.)	1270	40.00	40.75	42.00	43.25	45.00
Special call requiring detention(per 15 min.) **- See Preamble 10.D.3**	1276	40.00	40.75	42.00	43.25	45.00
9. TELEPHONE PRESCRIPTION RENEWAL - See Preamble 11.C.3 (max. 1 per patient per month)	2019		3.00	3.50	4.00	5.00
10. HOME VISITS (includes nursing homes, manors, etc.)						
Home visit	1221	56.00	56.90	58.40	59.90	62.00
Each additional patient	1224	28.00	28.45	29.20	29.95	31.00
Additional fee allowed for emergency visit **- See Preamble 11.A.2**	1225	20.00	20.75	22.00	23.25	25.00
11. SPECIAL PROCEDURES						
Phototherapy	2589	5.70	5.76	5.86	5.96	6.10
Electroconvulsive therapy - see Diagnostic/Therapeutic Procedures						
12. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	28.00	29.80	32.80	35.80	40.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014

UROLOGY

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

1. REFERRED CASES

Consultation - **See Preamble 9.A and 10.A**	1360	85.00	87.70	92.20	96.70	103.00
Office, home or hospital						
Repeat Consultation within 30 days - **See Preamble 9.C**	1362	42.50	43.85	46.10	48.35	51.50
for same illness or complication thereof						

2. OFFICE VISITS - See Preamble 9.D and 9.E

Comprehensive Office Visit	1310	55.25	55.96	57.15	58.34	60.00
Initial Office Visit with regional exam	1311	33.00	33.30	33.80	34.30	35.00
Limited Office Visit	1313	33.00	33.30	33.80	34.30	35.00

3. HOSPITAL VISITS - In-Patient Services

Initial hospital visit	1330	60.00	66.00	76.00	86.00	100.00
Subsequent hospital visits						
First five weeks, per visit	1333	35.00	37.25	41.00	44.75	50.00
From 6th week to 13th week, per visit	1334	20.00	21.50	24.00	26.50	30.00
After 13th week, per week	1335	20.00	21.50	24.00	26.50	30.00
Continuing care	1341	35.00	37.25	41.00	44.75	50.00
Directive care	1342	35.00	37.25	41.00	44.75	50.00

4. INTENSIVE CARE VISIT - per day	1371	85.00	87.25	91.00	94.75	100.00

5. HOSPITAL EMERGENCY DEPARTMENT VISITS

Limited ED Visit (Level I visit)- **See Preamble 10.E.2(a)**						
- Day(08:00-18:00) - Monday to Friday	1380	28.50	28.95	29.70	30.45	31.50
- Saturday,Sunday,Holiday	1390	33.00	33.53	34.40	35.28	36.50
- Night(18:00-08:00) - Monday to Thursday	1381	37.25	37.81	38.75	39.69	41.00
- Friday,Saturday,Sunday,Holiday	1391	55.25	56.11	57.55	58.99	61.00
Comprehensive ED Visit (Level II visit)- **See Preamble 10.E.2(b)**						
- Day(08:00-18:00) - Monday to Friday	1386	52.00	52.83	54.20	55.58	57.50
- Saturday,Sunday,Holiday	1368	60.00	60.98	62.60	64.23	66.50
- Night(18:00-08:00) - Monday to Thursday	1387	70.00	71.13	73.00	74.88	77.50
- Friday,Saturday,Sunday,Holiday	1369	100.00	101.50	104.00	106.50	110.00
Additional fee allowed for strict emergency visit - **See Preamble 7**	1394	20.00	20.75	22.00	23.25	25.00
6. ON CALL RETAINER - Urology (Provincial)	1340	300.00	300.00	300.00	300.00	300.00
7. HOSPITAL ON-CALL RESPONSE FEE - see Preamble 11.E	0060		50.00	80.00	110.00	150.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
8. DETENTION FEES - See Preamble 10.D.1						
Detention after first half hour (per 15 min.)	1370	40.00	40.75	42.00	43.25	45.00
Special call requiring detention(per 15 min.) **- See Preamble 10.D.3**	1376	40.00	40.75	42.00	43.25	45.00
9. TELEPHONE PRESCRIPTION RENEWAL - See Preamble 11.C.3 (max. 1 per patient per month)	2019		3.00	3.50	4.00	5.00
10. HOME VISITS (includes nursing homes, manors, etc.)						
Home visit	1321	56.00	56.90	58.40	59.90	62.00
Each additional patient	1324	28.00	28.45	29.20	29.95	31.00
Additional fee allowed for emergency visit **- See Preamble 11.A.2**	1325	20.00	20.75	22.00	23.25	25.00
11. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	28.00	29.80	32.80	35.80	40.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014

PHYSICAL MEDICINE

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

1. REFERRED CASES

Consultation - **See Preamble 9.A and 10.A**	1660	160.00	164.50	172.00	179.50	190.00
Office, home or hospital						
Repeat Consultation within 30 days - **See Preamble 9.C**	1662	80.00	82.25	86.00	89.75	95.00
for same illness or complication thereof						
Complete re-examination by a medical specialist **-See Preamble 9.G**	1663	64.80	65.58	66.88	68.18	70.00

2. OFFICE VISITS - See Preamble 9.D and 9.E

Comprehensive Office Visit	1610	64.80	65.58	66.88	68.18	70.00
Initial Office Visit with regional exam	1611	33.00	33.30	33.80	34.30	35.00
Limited Office Visit	1613	33.00	33.30	33.80	34.30	35.00

3. HOSPITAL VISITS - In-Patient Services

Initial hospital visit	1630	60.00	66.00	76.00	86.00	100.00
Subsequent hospital visits						
First five weeks, per visit	1633	35.00	37.25	41.00	44.75	50.00
From 6th week to 13th week, per visit	1634	20.00	21.50	24.00	26.50	30.00
After 13th week, per week	1635	20.00	21.50	24.00	26.50	30.00
Continuing care	1641	35.00	37.25	41.00	44.75	50.00
Directive care	1642	35.00	37.25	41.00	44.75	50.00

4. INTENSIVE CARE VISIT - per day	1671	85.00	87.25	91.00	94.75	100.00

5. HOSPITAL EMERGENCY DEPARTMENT VISITS

Limited ED Visit (Level I visit)**- See Preamble 10.E.2(a)**						
- Day(08:00-18:00) - Monday to Friday	1680	28.50	28.95	29.70	30.45	31.50
- Saturday,Sunday,Holiday	1690	33.00	33.53	34.40	35.28	36.50
- Night(18:00-08:00) - Monday to Thursday	1681	37.25	37.81	38.75	39.69	41.00
- Friday,Saturday,Sunday,Holiday	1691	55.25	56.11	57.55	58.99	61.00
Comprehensive ED Visit (Level II visit)**- See Preamble 10.E.2(b)**						
- Day(08:00-18:00) - Monday to Friday	1686	52.00	52.83	54.20	55.58	57.50
- Saturday,Sunday,Holiday	1668	60.00	60.98	62.60	64.23	66.50
- Night(18:00-08:00) - Monday to Thursday	1687	70.00	71.13	73.00	74.88	77.50
- Friday,Saturday,Sunday,Holiday	1669	100.00	101.50	104.00	106.50	110.00
Additional fee allowed for strict emergency visit **- See Preamble 7**	1694	20.00	20.75	22.00	23.25	25.00

6. DETENTION FEES - See Preamble 10.D.1

Detention after first half hour (per 15 min.)	1670	40.00	40.75	42.00	43.25	45.00
Special call requiring detention(per 15 min.) **- See Preamble 10.D.3**	1676	40.00	40.75	42.00	43.25	45.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
7. TELEPHONE PRESCRIPTION RENEWAL - See Preamble 11.C.3 (max. 1 per patient per month)	2019		3.00	3.50	4.00	5.00
8. HOME VISITS (includes nursing homes, manors, etc.)						
Home visit	1621	56.00	56.90	58.40	59.90	62.00
Each additional patient	1624	28.00	28.45	29.20	29.95	31.00
Additional fee allowed for emergency visit **- See Preamble 11.A.2**	1625	20.00	20.75	22.00	23.25	25.00
9. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	28.00	29.80	32.80	35.80	40.00

RADIATION ONCOLOGY

The listed fees are for the professional services of a certified therapeutic radiologist, the services of a specialist for the intra-cavitary or interstitial application of radium or sealed sources and the services of a specialist using non-sealed sources of radioisotopes in a laboratory authorized by the Atomic Energy Control Board of Canada. Other medical services to the patient are not included in these figures. The cost of material is additional.

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
1. CONSULTATIONS						
Consultation - **See Preamble 9.A and 10.A**	1760	85.00	100.75	127.00	153.25	190.00
Repeat Consultation within 30 days - **See Preamble 9.C**	1762	42.50	50.38	63.50	76.63	95.00
Follow-up visit at request of patient	1713	19.35	21.70	25.61	29.52	35.00
2. EXTERNAL THERAPY						
Treatment planning, dosage calculation and preparation of any special treatment device. (This is to apply only to malignant conditions treated radically.)	1715	36.50	36.50	36.50	36.50	36.50
Superficial therapy - x-ray under 100 K.V.P. per treatment visit	1716	6.85	6.85	6.85	6.85	6.85
Deep therapy - e.g. super voltage, Cobalt 60 or x-rays over 150 K.V.P. per treatment visit	1717	9.40	9.40	9.40	9.40	9.40
Preparation and application of Radium mould	1718	16.50	16.50	16.50	16.50	16.50
Application of Strontium 90 ophthalmic device	1719	8.40	8.40	8.40	8.40	8.40
Treatment planning for non malignant conditions	1720	22.75	22.75	22.75	22.75	22.75
3. INTERSTITIAL THERAPY						
Consultation and treatment planning fees as above.						
Interstitial insertion of Radium needles, Gold 98 grains or other sealed Radioisotopes.						
Biopsy as separate procedure	1725	182.60	182.60	182.60	182.60	182.60
4. INTRACAVITARY THERAPY						
Consultation and treatment planning fees as above.						
Radium insertion - per insertion	1730	157.70	157.70	157.70	157.70	157.70
Provision of radium in suitable containers and attendance in the operating room with advice and dosage calculation	1731	91.35	91.35	91.35	91.35	91.35
5. RADIOISOTOPE THERAPY						
Consultation and treatment planning fees as above (Treatment planning fee to apply to malignant conditions only)						

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Radioisotope therapy - carcinoma of thyroid (per course of Tx)	1735	74.65	74.65	74.65	74.65	74.65
Treatment for hyperthyroidism and/or cardiac disease (per course of Tx)	1736	54.90	54.90	54.90	54.90	54.90
Treatment for Polycythemia Vera with Page 33 (per course of Tx)	1737	44.75	44.75	44.75	44.75	44.75
6. RADIATION THERAPY (Shadow Billing)	2600	0.00	0.00	0.00	0.00	0.00
7. TELEPHONE PRESCRIPTION RENEWAL - See Preamble 11.C.3 (max. 1 per patient per month)	2019		3.00	3.50	4.00	5.00
8. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	28.00	29.80	32.80	35.80	40.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

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

Visit fee or consultation is payable in full in addition to a Diagnostic and Therapeutic Procedure except when such procedure is the sole reason for the patient's attendance.

These fees apply only when such procedures are carried out by or under the supervision of a physician.

Cost of medication used in any of these procedures is additional.

OFFICE LABORATORY PROCEDURES						
Urinalysis - complete (routine and microscopic)	2002	4.05	4.12	4.23	4.34	4.50
Urinalysis - partial	2003	2.05	2.08	2.13	2.18	2.25
Hemoglobin estimation	2004	3.75	3.79	3.85	3.91	4.00
Occult blood in stool	2005	2.05	2.08	2.13	2.18	2.25
Nasal smear for eosinophil	2006	3.75	3.79	3.85	3.91	4.00
ALLERGY SKIN TESTS						
Technical Component, per test (maximum 48 tests)	2349	0.65	0.66	0.67	0.68	0.70
Professional Component, per test (maximum 48 tests)	2359	0.15	0.16	0.17	0.18	0.20
Allergy counseling (billed as counseling fee 2505)						
ANTICOAGULATION THERAPY SUPERVISION (by telephone - per month)	2106	9.80	10.58	11.88	13.18	15.00
ARTHOGRAM - See Diagnostic Imaging						
ASPIRATIONS						
Lymph Node in neck	2050	22.75	22.99	23.39	23.79	24.34
Bladder	2107	30.00	31.50	34.00	36.50	40.00
Breast cyst	2108	20.00	21.50	24.00	26.50	30.00
Bursa	2109	25.00	25.26	25.70	26.14	26.75
Cisterna magna	2110	22.55	22.79	23.18	23.58	24.13
Duodenum	2111	37.50	37.89	38.55	39.21	40.13
Esophagus or stomach	2112	20.00	20.21	20.56	20.91	21.40
Hydrocele	2113	20.00	20.21	20.56	20.91	21.40
Joint	2114	25.00	26.50	29.00	31.50	35.00
Lumbar puncture	2115	75.00	78.75	85.00	91.25	100.00
Therapeutic Pericardiocentesis	2116	130.00	134.50	142.00	149.50	160.00
Subdural (tap)	2117	29.65	29.96	30.48	31.00	31.73
Subdural puncture(each additional tap)	2118	9.80	9.90	10.07	10.25	10.49
Thyroid cyst	2119	20.00	21.50	24.00	26.50	30.00
AUDIOMETRIC TESTS - See Otolaryngology						
AUTOPSY - non-coroner's autopsy on evenings and weekends	1900	679.00	764.65	907.40	1,050.15	1,250.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
BIOPSIES - see Needle Biopsies						
Breast Excisional Biopsy	3073	137.00	138.44	140.84	143.23	146.59
BLOOD TRANSFUSION						
Indirect Transfusions	2123	19.80	20.01	20.35	20.70	21.19
CARDIAC PROCEDURES						
Cardioversion only (one procedure to be billed per session)	2124	105.00	106.10	107.94	109.78	112.35
Selective percutaneous aortography - see Diagnostic Imaging						
Catheterization						
Catheterization of heart-right	2126	148.25	149.81	152.40	155.00	158.63
Hepatic wedge pressure	2127	98.80	99.84	101.57	103.30	105.72
Catheterization of heart-left	2128	197.70	199.78	203.24	206.70	211.54
Left ventricular puncture	2129	98.80	99.84	101.57	103.30	105.72
Phonocardiogram - Supervision and interpretation	2217	29.65	29.96	30.48	31.00	31.73
CERTIFICATION of patient to mental health or addictions facility	2800	40.00	40.42	41.12	41.82	42.80
CHEMOTHERAPY						
Administration of chemotherapy (includes Diagnostic/Therapeutic aspiration)	2215	49.35	50.95	53.61	56.27	60.00
IV administration of chemotherapy agent - per injection	2174	20.00	20.21	20.56	20.91	21.40
Additional injections of chemotherapy at time of init. injection	2264	9.85	9.95	10.13	10.30	10.54
Administration of chemotherapy into an Omaya Reservoir	2550	36.40	36.78	37.42	38.06	38.95
Intrathecal chemotherapy including diagnostic lumbar puncture	2551	58.20	68.97	86.92	104.87	130.00
Administration of sclerosing material via chest tube	2552	50.00	50.53	51.40	52.28	53.50
DIALYSIS for Renal Failure - See Preamble 21.L						
Acute Dialysis - first treatment	2055		585.00	585.00	585.00	585.00
Acute Dialysis - subsequent treatment (up to 2)	2056		268.80	268.80	268.80	268.80
Chronic Dialysis - first treatment	2135	170.85	172.64	175.63	178.62	182.81
Chronic Dialysis - subsequent treatment (maximum 3/week)	2137	102.50	74.00	74.00	74.00	74.00
Satellite Dialysis Management (per patient per week)	2058		40.00	40.00	40.00	40.00
Insertion of permanent peritoneal dialysis catheter	2132	145.20	146.72	149.27	151.81	155.36
Dialysis catheter - tunneling and insertion	2038		150.00	150.00	150.00	150.00
Dialysis catheter - removal and/or replacement	2039		200.00	200.00	200.00	200.00
DIAGNOSTIC IMAGING PROCEDURES						
Cystogram	2700	32.45	32.79	33.36	33.93	34.72
Arthogram	2701	32.45	32.79	33.36	33.93	34.72
Bronchogram	2702	43.20	43.65	44.41	45.17	46.22
Sialogram	2705	43.20	43.65	44.41	45.17	46.22
Hysterosalpingogram	2706	64.90	65.58	66.72	67.85	69.44
Percutaneous transhepatic cholangiogram	2708	75.75	76.55	77.87	79.20	81.05
Lymphogram	2709	108.15	109.29	111.18	113.07	115.72
Myelogram - Lumbar	2172	69.05	69.78	70.98	72.19	73.88
DRESSING CHANGE	2010	10.00	10.11	10.28	10.46	10.70
ED ULTRASOUND	2900	25.00	25.75	27.00	28.25	30.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
ELECTROCARDIOGRAM (ECG) & OTHER CARDIOLOGY STUDIES						
Note: Payment for interpretation of electrocardiograms made only to those physicians so qualified.						
ECG - Technical Component only	2257	10.00	10.11	10.28	10.46	10.70
ECG - procedure with interpretation in office	2142	20.00	20.21	20.56	20.91	21.40
ECG - procedure with interpretation in home	2143	25.05	25.31	25.75	26.19	26.80
ECG - Interpretation only	2145	10.00	10.11	10.28	10.46	10.70
Holter Monitoring	2144	48.00	48.50	49.34	50.18	51.36
Loop Event Recorder interpretation	4780	20.00	20.21	20.56	20.91	21.40
Stress Test	0599	80.00	80.84	82.24	83.64	85.60
Myocardial Perfusion (MIBI) Stress Test - exercise or pharmacologic (includes all injections, IV's, interpretation)	4754	100.00	101.05	102.80	104.55	107.00
Exercise tests: (The following fees refer to the professional component only)						
1. Simple progressive exercise tests at several work loads, with measurements of heart rate by ECG and of ventilation	2249	23.70	23.95	24.36	24.78	25.36
2. Exercise in a steady state at two or more work loads with measurements of heart rate by ECG, ventilation, VO, VCO, end tidal and mixed venous PCO2	2250	49.35	49.87	50.73	51.60	52.80
3. As above with calculation of cardiac output by respiratory gas technique	2251	79.00	79.83	81.21	82.59	84.53
ELECTROCONVULSIVE THERAPY (ECT)	2151	32.60	38.96	49.56	60.16	75.00
ELECTROENCEPHALOGRAM (EEG)						
EEG Interpretation only	2146	28.75	29.05	29.56	30.06	30.76
Insertion of sub-temporal needles (add)	2147	19.80	20.01	20.35	20.70	21.19
With activating Drugs, e.g. Metrazule (add)	2148	19.80	20.01	20.35	20.70	21.19
EMG & OTHER NEUROMUSCULAR STUDIES - see Preamble 21.K						
Electromyography (major) - examination of muscles of more than one region	2149	82.00	83.20	85.20	87.20	90.00
Electromyography (minor) - examination of muscles of a specific limb or region	2150	53.60	54.56	56.16	57.76	60.00
Nerve Conduction Studies, per nerve studied (maximum 6 nerves)	2140	28.52	28.82	29.32	29.82	30.52
Nerve entrapment evaluation (composite fee)	2166		80.00	81.68	83.36	85.60
Tensilon test	2269	21.25	21.47	21.85	22.22	22.74
ENDOCRINOLOGY AND METABOLISM						
ACTH Stimulation Test	2248	40.80	41.23	41.94	42.66	43.66
Insulin Hypoglycemia for Pituitary Function	2152	56.95	57.55	58.54	59.54	60.94
TRH Test	2153	28.45	28.75	29.25	29.74	30.44
GNRH (LHRH) Tests	2154	28.45	28.75	29.25	29.74	30.44
Combined calcium and pentagastrin	2155	68.35	69.07	70.26	71.46	73.13
Calcium or pentagastrin alone	2156	45.55	46.03	46.83	47.62	48.74
GASTROENTEROLOGY PROCEDURES						
Ambulatory 24 hour Esophageal Ph Monitoring	2309	30.80	31.12	31.66	32.20	32.96
Esophageal HCL drip test	2157	29.65	29.96	30.48	31.00	31.73
Esophageal Motility studies	2158	69.05	69.78	70.98	72.19	73.88
Esophageal variceal banding(includes esophagoscopy)	5166	260.00	262.73	267.28	271.83	278.20
Achalasia Botox injection	2167	60.00	60.63	61.68	62.73	64.20

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Gastro-esophageal tamponade	2159	49.35	50.95	53.61	56.27	60.00
Gastric lavage - diagnostic and emergency	2162	25.00	25.26	25.70	26.14	26.75
Gastroscopy - Diagnostic, biopsy, removal of foreign body	5218	180.20	182.09	185.25	188.40	192.81
- subsequent - within 45 days of initial procedure	5219	71.20	71.95	73.19	74.44	76.18
(IC for full fee may be given under exceptional circumstances)						
Peritoneal lavage	2255	75.00	75.79	77.10	78.41	80.25
Balloon stricture dilatation(incl. gastro/sigmoido/colonoscopy)	2237	247.00	249.59	253.92	258.24	264.29
Repeat balloon stricture dilatation within 30 days						
- with gastroscopy	2370	194.68	196.72	200.13	203.54	208.31
- with sigmoidoscopy	2371	148.50	150.06	152.66	155.26	158.90
- with colonoscopy of descending colon	2372	148.50	150.06	152.66	155.26	158.90
- with colonoscopy of descending & transverse colon	2373	173.50	175.32	178.36	181.39	185.65
- with colonoscopy of complete colon	2374	198.50	200.58	204.06	207.53	212.40
Fractional test - meal (samples and analysis)	2163	29.65	29.96	30.48	31.00	31.73
Proctoscopic exam	2007	11.05	12.39	14.63	16.87	20.00
Sigmoidoscopy - Rigid (with or without biopsy)	2235	35.00	37.25	41.00	44.75	50.00
Sigmoidoscopy - Flexible (with or without biopsy)	2242	70.00	72.25	76.00	79.75	85.00
Colonoscopy - descending colon	2310	50.00	57.50	70.00	82.50	100.00
Colonoscopy - descending & transverse colon	2320	100.00	109.00	124.00	139.00	160.00
Colonoscopy - complete colon	2260	150.00	161.25	180.00	198.75	225.00
Removal of polyp under colonoscopic examination - first polyp	2360	80.10	80.94	82.34	83.74	85.71
Plus 25% of the fee for each additional polyp (maximum of 5 polyps)						
Ileoscopy	2315		57.50	70.00	82.50	100.00
Removal of rectal foreign body	2021		72.25	76.00	79.75	85.00
Argon Coagulation of stomach or rectum - single or multiple (add-on fee)	2022		75.00	76.58	78.15	80.25
GYNECOLOGIC TESTS & PROCEDURES						
Pelvic Examination Only	2001	6.00	6.30	6.80	7.30	8.00
Pap Smear with/without Pelvic examination	2008	12.00	12.30	12.80	13.30	14.00
Pap Screening Clinic	2018	0.00	0.00	0.00	0.00	0.00
Insertion of Pessary	Visit Fee					
Vaginal Insufflation	Visit Fee					
Cryotherapy of cervix	2131	41.50	41.94	42.66	43.39	44.41
Fitting of diaphragm	6936	33.15	33.50	34.08	34.66	35.47
Vaginal Pessary - initial fitting	2605	15.00	15.16	15.42	15.68	16.05
INJECTIONS						
Injection - IM, SC, immunization (one or more)	2009	8.00	8.30	8.80	9.30	10.00
Hyposensitization/Allergy shot	2102	8.00	8.30	8.80	9.30	10.00
B.C.G. Vaccination, including necessary Tuberculin tests	2122	9.80	9.90	10.07	10.25	10.49
Vaccination with certificate	2243	16.00	16.17	16.45	16.73	17.12
Injection - IV	2165	12.00	12.45	13.20	13.95	15.00
Injection of medication - e.g. bursa, joint	2168	25.00	25.26	25.70	26.14	26.75
Injection of hemorrhoids, initial	2169	20.00	20.21	20.56	20.91	21.40
Injection of hemorrhoids, subsequent	2170	15.05	15.21	15.47	15.73	16.10
Injection for pruritus ani	2171	20.00	20.21	20.56	20.91	21.40
Injection - Ages 0 to 4 only - by cut down	2252	50.00	50.53	51.40	52.28	53.50
Injection - Ages 0 to 4 only - by scalp vein	2253	25.00	25.26	25.70	26.14	26.75
IV Iron infusion - total care	2410	50.00	50.53	51.40	52.28	53.50
Cryoprecipitate - includes preparation and administration	2015	20.25	20.46	20.82	21.17	21.67

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Intrathecal Epi-morph Injection	2307	57.50	58.10	59.11	60.12	61.53
Intravenous Pyelogram - after hours in Emergency Dept.	2265	35.00	35.37	35.98	36.59	37.45
Injection of medication into chest/abdominal cavities -see Paracentesis						
NEEDLE BIOPSY PROCEDURES						
Bone Marrow	2175	75.00	78.75	85.00	91.25	100.00
Kidney	2176	69.05	69.78	70.98	72.19	73.88
Liver	2177	75.00	75.79	77.10	78.41	80.25
Lung	2263	70.00	70.74	71.96	73.19	74.90
Lung - transbronchial	2268	116.20	117.42	119.45	121.49	124.33
Pleura	2178	39.65	40.07	40.76	41.45	42.43
Pericardium	2181	148.25	149.81	152.40	155.00	158.63
Prostate	2182	79.00	79.83	81.21	82.59	84.53
Synovial Tissue	2180	49.35	49.87	50.73	51.60	52.80
Thyroid	2259	22.75	26.84	33.65	40.46	50.00
NERVE BLOCKS and OTHER PAIN INJECTIONS - see Preamble 21.M						
Somatic or peripheral nerve not specifically listed - single	2183	36.00	36.60	37.60	38.60	40.00
- each additional (to max. of 4)	2184	18.00	18.30	18.80	19.30	20.00
Cervical plexus	2186	70.00	70.74	71.96	73.19	74.90
Brachial plexus	2189	60.00	60.63	61.68	62.73	64.20
Supraorbital branch of Ophthalmic Nerve (Trigeminal)	2450		60.63	61.68	62.73	64.20
Infraorbital branch of Maxillary Nerve (Trigeminal)	2188	60.00	60.63	61.68	62.73	64.20
Mental branch of Mandibular Nerve (Trigeminal)	2187	60.00	60.63	61.68	62.73	64.20
Maxillary or Mandibular division of Trigeminal Nerve	2206	70.00	70.74	71.96	73.19	74.90
Therapeutic Seventh Cranial nerve block - unilateral	2304	42.00	42.44	43.18	43.91	44.94
Therapeutic Seventh Cranial nerve block - bilateral	2305	63.05	63.71	64.82	65.92	67.46
Other Cranial Nerve	2451		60.63	61.68	62.73	64.20
Occipital Nerve	2100	31.05	32.39	34.63	36.87	40.00
Transverse Scapular Nerve	2452		60.63	61.68	62.73	64.20
Intercostal Nerve - single	2453		36.60	37.60	38.60	40.00
Intercostal Nerve - each additional (to max. of 4)	2454		18.30	18.80	19.30	20.00
Paravertebral Nerve - single	2210	70.00	70.74	71.96	73.19	74.90
Paravertebral Nerve - each additional (to max. of 4)	2211	35.00	35.37	35.98	36.59	37.45
Ilioinguinal and/or Iliohypogastric Nerves	2455		60.63	61.68	62.73	64.20
Sciatic Nerve	2192	60.00	60.63	61.68	62.73	64.20
Femoral Nerve	2456		60.63	61.68	62.73	64.20
Obturator Nerve	2193	60.00	60.63	61.68	62.73	64.20
Pudendal Nerve	2194	50.00	60.63	61.68	62.73	64.20
Lateral Femoral Cutaneous Nerve	2204	70.00	70.00	70.00	70.00	70.00
Combined 3-in-1 block (femoral, obturator, lateral femoral cutaneous)	2457		80.84	82.24	83.64	85.60
Fascia Iliaca Compartment block	2458		60.63	61.68	62.73	64.20
Transversus Abdominis Plane (TAP) block - unilateral	2459		30.32	30.84	31.37	32.10
Transversus Abdominis Plane (TAP) block - bilateral	2460		50.02	50.89	51.75	52.97
Nerve block with fluoroscopic guidance (add on)	2461		40.75	42.00	43.25	45.00
Nerve block with ultrasound guidance (add on)	2462		25.75	27.00	28.25	30.00

Nerve block with alcohol or other sclerosing agent - add 50% (with comment)

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Vertebral Facet Joint injections						
- with fluoroscopic guidance - single	2533	50.00	91.28	93.40	95.53	98.50
- each additional, up to 6	2463		59.33	60.71	62.09	64.03
- with ultrasound guidance - single	2464		76.28	78.40	80.53	83.50
- each additional, up to 6	2465		49.58	50.96	52.34	54.28
Sacroiliac Joint injection with fluorscopic guidance - unilateral	2466		91.28	93.40	95.53	98.50
- bilateral	2467		150.60	154.11	157.62	162.53
Diagnostic nerve root block with fluoroscopic guidance (any number of sites)	2468		161.68	164.48	167.28	171.20
Epidural injections						
Cervical epidural injection with fluoroscopic guidance	2531	120.00	161.68	164.48	167.28	171.20
Thoracic epidural injection with fluoroscopic guidance	2532	120.00	161.68	164.48	167.28	171.20
Lumbar epidural injection with fluoroscopic guidance	2524	160.00	161.68	164.48	167.28	171.20
Caudal epidural injection	2191	65.00	65.68	66.82	67.96	69.55
Epidural - single injection	2196	80.00	80.84	82.24	83.64	85.60
Subarachnoid (diagnostic spinal)	2195	70.00	70.74	71.96	73.19	74.90
Sympathetic Nerve injections						
Cervical sympathetic or Stellate ganglion block	2199	100.00	101.05	102.80	104.55	107.00
- with U/S or fluoroscopic guidance	2208	150.00	151.58	154.20	156.83	160.50
Thoracic, Lumbar, Sacral sympathetic block with fluoroscopic guidance	2205	150.00	151.58	154.20	156.83	160.50
Lumbar sympathetic nerve block	2185	85.00	85.89	87.38	88.87	90.95
Ganglion/Plexus injections						
Presacral (superior hypogastric plexus) block	2190	60.00	60.63	61.68	62.73	64.20
Celiac, splanchnic, hypogastric ganglion/plexus block w/ fluoro guidance	2197	100.00	151.58	154.20	156.83	160.50
Trigeminal (Gasserian) ganglion block	2198	100.00	101.05	102.80	104.55	107.00
- with fluoroscopic guidance	2202	150.00	151.58	154.20	156.83	160.50
Spheno-palatine ganglion block with fluoroscopic guidance	2207	70.00	151.58	154.20	156.83	160.50
Superior Laryngeal Nerve with fluoroscopic guidance	2209	150.00	151.58	154.20	156.83	160.50
IV Guanethidine/Bier Block	2530	100.00	101.05	102.80	104.55	107.00
Trigger point injection (myoneural pain block) with local anesthetic (one or more)	2101	20.00	20.21	20.56	20.91	21.40
OBSTETRIC TESTS & PROCEDURES						
Ultrasound procedures by Obstetrician	2606	57.00	57.60	58.60	59.59	60.99
Insertion of Intrauterine Pressure Catheter (IUPC)	2601	47.50	48.00	48.83	49.66	50.83
Oxytocin Challenge Test	2602	30.00	30.32	30.84	31.37	32.10
Scalp Ph Sampling (maximum of 2)	2603	62.00	62.65	63.74	64.82	66.34
Biophysical Profile	2604	57.00	57.60	58.60	59.59	60.99
OPHTHALMIC TESTS						
Annual Diabetic Retinopathy Photographic Screening	2308	10.50	10.61	10.79	10.98	11.24
Anterior stromal puncture corneal erosion	2303	53.35	53.91	54.84	55.78	57.08
Intravitreol Injection of Eye	2306	200.00	202.10	205.60	209.10	214.00
Visual Fields with a Goldman perimeter	2258	38.15	38.55	39.22	39.89	40.82
Visual Field interpretation	2408	15.00	15.16	15.42	15.68	16.05

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Ultrasound - procedure only	8887	37.90	38.30	38.96	39.62	40.55
Ultrasound - interpretation	8889	18.90	19.39	20.20	21.01	22.15
Fluorescein / Digital Angiography	7510	57.05	57.65	58.65	59.65	61.04
Optical Coherence Tomography (OCT) - composite fee (max. 4/year)	2414	57.05	57.65	58.65	59.65	61.04
Optical Coherence Tomography (OCT) - technical fee (max. 4/year)	2417		42.49	43.23	43.96	44.99
Optical Coherence Tomography (OCT) - professional fee (max. 4/year)	2415		15.16	15.42	15.68	16.05
Heidelberg Retina Tomography (HRT) - nonscreening (max.4/year)	2413	15.00	17.25	21.00	24.75	30.00
Pachymetry - one or both eyes (only once per patient lifetime)	2412	10.00	10.30	10.80	11.30	12.00
IOL Master / Ocular Biometry - procedure only	2420		38.30	38.96	39.62	40.55
IOL Master / Ocular Biometry - interpretation	2421		19.39	20.20	21.01	22.15
OTOLARYNGOLOGY TESTS & PROCEDURES						
Impedance audiometry	1095	21.22	21.44	21.81	22.19	22.71
Complete hearing test (incl.audiometry, tuning fork, speech test)	2540	37.36	37.75	38.41	39.06	39.98
Cerumen removal (unilateral or bilateral)	2000	10.00	10.30	10.80	11.30	12.00
Microdebridement in office	1099	25.60	25.87	26.32	26.76	27.39
Vestibular function tests	2541	21.55	21.78	22.15	22.53	23.06
Modified Sleep study	2549	40.00	40.42	41.12	41.82	42.80
Emergency Cricothyrotomy	2901	200.00	202.10	205.60	209.10	214.00
Change of Tracheostomy Tube	Visit Fee					
PARACENTESIS (Thoracic or Abdominal)						
Diagnostic aspiration	2213	30.00	33.00	38.00	43.00	50.00
Therapeutic aspiration (including diagnostic sample)	2214	50.00	52.25	56.00	59.75	65.00
PROCEDURAL SEDATION (Emergency)	2011	25.00	25.75	27.00	28.25	30.00
PULMONARY FUNCTION STUDIES						
1. Evaluation and interpretation of results of complete pulmonary function study, (i.e. ventilation, lung volumes, and pulmonary diffusing capacity) with or without other studies	2218	50.00	50.53	51.40	52.28	53.50
2. Evaluation and Interpretation of:						
(a) Maximum breathing capacity or peak flow study	2219	10.75	10.86	11.05	11.24	11.50
(b) Pulmonary diffusion capacity	2220	19.80	20.01	20.35	20.70	21.19
(c) Pulmonary pressure tracings only	2222	10.75	10.86	11.05	11.24	11.50
(d) Lung volume determination	2223	21.05	21.27	21.64	22.01	22.52
(e) Vital capacity and timed unit capacity	2247	10.75	10.86	11.05	11.24	11.50
Methacholine challenge	2245	67.50	68.21	69.39	70.57	72.23
RHEUMATOLOGY AND PHYSICAL MEDICINE						
Uric acid crystals	2233	5.95	6.01	6.12	6.22	6.37
Mucin clot	2234	2.00	2.02	2.06	2.09	2.14
STERILITY INVESTIGATION						
Male, sperm cell count and morphology	2236	9.80	9.90	10.07	10.25	10.49
Female - see Gynecology						
SWEAT TEST	2261	31.80	32.13	32.69	33.25	34.03

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
VENIPUNCTURE						
Venipuncture - infant or child under 6 years	2239	20.00	20.21	20.56	20.91	21.40
Venipuncture - adult or child 6 years or older	2238	8.00	8.30	8.80	9.30	10.00
Venipuncture - femoral vein puncture	2240	20.00	20.21	20.56	20.91	21.40
Venipuncture - jugular vein puncture	2241	20.00	20.21	20.56	20.91	21.40
IV Start on Pediatric patient(under 6 yrs)	2232	40.00	40.42	41.12	41.82	42.80
Central I.V. Line Insertion	2254	100.00	103.00	108.00	113.00	120.00
Central Venous Pressure - placement of catheter	2244	50.00	50.53	51.40	52.28	53.50
Swan-Ganz Catheter	2262	160.00	161.68	164.48	167.28	171.20
Therapeutic phlebotomy	2266	19.80	20.01	20.35	20.70	21.19
Umbilical vessel catheterization	2256	72.05	72.81	74.07	75.33	77.09
Arterial puncture for blood gases	2400	20.00	20.21	20.56	20.91	21.40
Arterial cannulation (Arterial Line insertion)	4599	50.00	51.50	54.00	56.50	60.00
UROLOGICAL TESTS & PROCEDURES						
Cystometrogram	2246	30.00	30.32	30.84	31.37	32.10
Urodynamic Studies:						
Urine Flow rate determination	2267	12.00	12.13	12.34	12.55	12.84
Urethral pressure profile or leak pressure test	2276	20.00	20.21	20.56	20.91	21.40
Electromyography	2278	20.00	20.21	20.56	20.91	21.40
Pressure flow study	2284	20.00	20.21	20.56	20.91	21.40
Videourodynamic assessment	2290	20.00	20.21	20.56	20.91	21.40
Periurethral collagen injection	2292	150.00	151.58	154.20	156.83	160.50
Intravenous Pyelogram - after hours in Emergency Dept	2265	35.00	35.37	35.98	36.59	37.45
Prostatic massage	Visit Fee					
Insertion of urinary catheter (transurethral)	2902	30.00	30.75	32.00	33.25	35.00
Aspiration of corpus cavernosum for priapism	2903	60.00	60.63	61.68	62.73	64.20
Reduction of paraphimosis, including dorsal slit	2904	50.00	50.53	51.40	52.28	53.50

VASCULAR LAB DIAGNOSTIC PROCEDURES

Extracranial cerebrovascular assessment:						
Bilateral carotid and/or subclavian and/or vertebral arteries						
Doppler scan or B scan – *technical component*	2270	40.65	41.08	41.79	42.50	43.50
– *professional component*	2271	22.85	23.09	23.49	23.89	24.45
Frequency analysis – *technical component*	2272	40.65	41.08	41.79	42.50	43.50
– *professional component*	2273	22.85	23.09	23.49	23.89	24.45
Frequency analysis plus scan – *technical component*	2274	61.05	61.69	62.76	63.83	65.32
– *professional component*	2275	34.35	34.71	35.31	35.91	36.75
Peripheral arterial evaluation:						
(not to be billed routinely w/ above cerebrovascular assessment)						
Doppler scan or B scan	2277	15.35	15.51	15.78	16.05	16.42
Frequency analysis	2279	12.70	12.83	13.06	13.28	13.59
Frequency analysis plus scan – *technical component*	2280	29.25	29.56	30.07	30.58	31.30
– *professional component*	2281	24.10	24.35	24.77	25.20	25.79
Venous assessment:						
Bilateral femoral, popliteal, post/ant tibial veins – *technical component*	2282	6.40	6.47	6.58	6.69	6.85
– *professional component*	2283	10.20	10.31	10.49	10.66	10.91
(not chargeable during surgery or during post-op stay in hospital)						
Ankle pressure determination – *professional component*	2285	8.35	8.44	8.58	8.73	8.93
(not chargeable during surgery or during post-op stay in hospital)						
Ankle pressure measurements w/ segmental pressure +/- Doppler recordings -- *tech*	2286	19.20	19.40	19.74	20.07	20.54
-- *prof.*	2287	22.85	23.09	23.49	23.89	24.45
Ankle pressure measurements with exercise or tourniquet hyperemia						
induced velocity changes, added to the above – *technical component*	2288	7.05	7.12	7.25	7.37	7.54
– *professional component*	2289	10.85	10.96	11.15	11.34	11.61
Penile pressure recordings - two or more pressures – *professional component*	2291	7.60	7.68	7.81	7.95	8.13
Strain gauge plethysmography (venous capacitance and venous outflow) – *prof*	2293	5.70	5.76	5.86	5.96	6.10
Periorbital studies for reversed flow in carotid system						
by Doppler or by photo plethysmography – *technical component*	2294	12.70	12.83	13.06	13.28	13.59
– *professional component*	2295	13.95	14.10	14.34	14.58	14.93
Venous Refilling Time – *technical component*	2296	11.55	11.67	11.87	12.08	12.36
– *professional component*	2297	5.70	5.76	5.86	5.96	6.10

*Professional and technical components are only payable when qualified physicians provide both components.

OFFICE VASCULAR DIAGNOSTIC PROCEDURES

Ultrasound assessment of cerebral circulation						
with segmental pressures and analysis of wave forms – *composite fee.*	2300	44.45	44.92	45.69	46.47	47.56
(technical and professional components)						
Ultrasound assessment of cerebral circulation						
plus periorbital flow studies – *composite fee.*	2301	44.45	44.92	45.69	46.47	47.56
(technical and professional components)						

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014

OPERATIONS ON THE INTEGUMENTARY SYSTEM

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

SKIN AND SUBCUTANEOUS TISSUE

Incision

Abscess						
Subcutan.boil, infected cyst, superficial lymphadenitis, paronychia, felon, etc.						
- Local anesthetic	3000	35.00	35.37	35.98	36.59	37.45
- General anesthetic	3001	43.20	43.65	44.41	45.17	46.22
Carbuncle - neck, complete care	3002	86.45	87.36	88.87	90.38	92.50
Perianal or pilonidal - local anesthetic	3003	40.00	40.42	41.12	41.82	42.80
- general anesthetic, complete care	3004	64.90	65.58	66.72	67.85	69.44
Ischio-rectal - simple incision - local anesthetic	3005	40.00	40.42	41.12	41.82	42.80
- Unroofing - complete care	3006	129.75	131.11	133.38	135.65	138.83
Palmar and plantar space infections, tenosynovitis						
- general or regional - complete care	3007	129.75	131.11	133.38	135.65	138.83
Hematoma - local anesthetic	3008	35.00	35.37	35.98	36.59	37.45
- general anesthetic -depending on size, complicating factors	3009	43.20	43.65	44.41	45.17	46.22
Tongue-tie release - infant	Visit Fee					
- child - local anesthetic	3010	13.25	13.39	13.62	13.85	14.18
- general anesthetic	3011	43.20	43.65	44.41	45.17	46.22
Removal of foreign body or fibroma - local anesthetic	3012	40.00	40.42	41.12	41.82	42.80
- general anesthetic	3013	I.C.	I.C.	I.C.	I.C.	I.C.

Note: Pre and Post-operative care for the above at visit fees
unless otherwise specified.

Excision

*Excision Biopsy	3030	42.00	42.44	43.18	43.91	44.94
Carcinoma of skin, excision, - simple	3031	75.75	76.55	77.87	79.20	81.05
- complicated, depending on site, etc.	3032	I.C.	I.C.	I.C.	I.C.	I.C.
*Pilonidal Cyst - simple excision or marsupialisation	3033	205.80	207.96	211.56	215.16	220.21
*Sebaceous Cyst - face or neck	3034	42.00	42.44	43.18	43.91	44.94
- other areas	3035	38.00	38.40	39.06	39.73	40.66
Fingernail or Toenail Removal - Simple	3036	45.00	45.47	46.26	47.05	48.15
Resection of portion of nail, nail bed and matrix	3037	48.00	48.50	49.34	50.18	51.36
Radical removal of nail	3038	108.15	109.29	111.18	113.07	115.72
(includes destruction of nail bed, shortening of phalanx if necessary)						

*Note: Pre and Post-operative care for the above at visit fees
unless otherwise specified.

Lipoma - simple removal, local anesthetic	3039	43.20	43.65	44.41	45.17	46.22
- complicated,large or involving deeper structures	3040	I.C.	I.C.	I.C.	I.C.	I.C.
Neuroma - simple, subcutaneous, local anesthetic	3041	43.20	43.65	44.41	45.17	46.22

Warts, incl. papillomatosis, keratosis, nevi, moles, pyogenic granuloma
- removal by use of medical methods ..... Visit Fee

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Benign skin lesion - cryotherapy, initial visit (1 or more)	3042	24.75	25.01	25.44	25.88	26.48
- cryotherapy, subsequent visit (1 or more)	3043	10.90	11.01	11.21	11.40	11.66
Warts, including papillomata, keratosis, nevi, moles, pyogenic granuloma						
- curettage or electrocautery (1 or more)	3044	24.70	25.50	26.82	28.15	30.00
- simple excision (1 or more)	3045	30.85	31.17	31.71	32.25	33.01
Plantar warts - cryotherapy, curettage, or electrocautery (1 or more)	3046	28.00	28.30	28.80	29.30	30.00
(maximum of 3 sittings per year per patient per physician)						
- surgical excision	3047	55.25	55.83	56.80	57.76	59.12
Introduction						
Implantation of hormone pellets **(Prior approval required)**	3049	32.45	32.79	33.36	33.93	34.72
Suture						
Simple wounds or lacerations	3050	50.00	51.50	54.00	56.50	60.00
Complicated, extensive lacerations	3051	I.C.	I.C.	I.C.	I.C.	I.C.
Repair						
Thermal burns - simple small burns, office dressing	Visit Fee					
Extensive burns - requiring debridement, grafts, etc.	3052	I.C.	I.C.	I.C.	I.C.	I.C.
Skin Graft						
The fee would depend on the size and location of the area grafted and the type of graft. Additional procedures other than skin grafting are extra, tendon grafts, inlay grafts, etc. Local tissue shift advancement: rotation, transposition, Z plasty, etc. will depend on the site and size.						
Small skin graft, with or without skin graft for secondary defect	3053	200.00	202.10	205.60	209.10	214.00
Eyebrow, eyelid, lip, ear, nose	3054	257.20	259.90	264.40	268.90	275.20
Large flap, i.e. for decubitus ulcer	3055	378.35	382.32	388.94	395.56	404.83
Flaps from a distance, direct, small,(eg.cross finger flap) to incl.staging	3056	257.20	259.90	264.40	268.90	275.20
Flaps from a distance - direct, large,(eg.cross leg flap) initial stage	3057	463.05	467.91	476.02	484.12	495.46
- further staging, per stage - 50% of						
- indirect, - major stage per operation	3058	324.40	327.81	333.48	339.16	347.11
- minor stage per operation	3059	162.25	163.95	166.79	169.63	173.61
Longer stage with skin graft	3060	324.40	327.81	333.48	339.16	347.11
Delay of tube or pedicle	3061	75.75	76.55	77.87	79.20	81.05
Full thickness grafts						
Eyelid, nose, lips	3062	257.20	259.90	264.40	268.90	275.20
Finger tip	3063	108.15	109.29	111.18	113.07	115.72
Volar/palm	3064	162.25	163.95	166.79	169.63	173.61
Island graft	3065	432.55	437.09	444.66	452.23	462.83
Split thickness grafts						
- very small, very minor, e.g. trauma	3066	100.00	101.05	102.80	104.55	107.00
- minor to medium sized areas, e.g. varicose ulcer, breast	3067	162.25	163.95	166.79	169.63	173.61
- intermediate large area trunk, legs	3068	257.20	259.90	264.40	268.90	275.20
- major large areas extensive but thickness grafting	3069	378.35	382.32	388.94	395.56	404.83
Destruction						
Surgical planing - face for acne, whole face **(Prior approval)**	3080	216.10	218.37	222.15	225.93	231.23
- single area, eg.trauma scar **(Prior approval)**	3081	75.75	76.55	77.87	79.20	81.05
Sweat gland excision - axillary, inguinal, perineal (unilateral)	4915	215.00	217.26	221.02	224.78	230.05
- with skin graft(s) and/or rotation flap(s)	4916	315.00	318.31	323.82	329.33	337.05

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
MALIGNANT SKIN LESIONS (incl. biopsy of each lesion - 1 or more)						
Deep Cryotherapy						
Face or Neck						
- Single lesion	3087	72.80	73.56	74.84	76.11	77.90
- Two lesions	3088	119.65	120.91	123.00	125.09	128.03
- Three or more lesions	3089	227.60	229.99	233.97	237.96	243.53
Other Areas						
- Single lesion	3090	58.05	58.66	59.68	60.69	62.11
- Two lesions	3091	95.75	96.76	98.43	100.11	102.45
- Three or more lesions	3092	191.25	193.26	196.61	199.95	204.64

OPERATIONS ON THE BREAST

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

Incision						
Drainage of intramammary abscess, single or multiple (includes pre and post-operative care)	3070	86.45	87.36	88.87	90.38	92.50
- Repeat incision	3071	86.45	87.36	88.87	90.38	92.50
Aspiration of breast cyst	2108	20.00	21.50	24.00	26.50	30.00
Excision						
Mastectomy - simple	3074	298.35	301.48	306.70	311.92	319.23
- Lumpectomy	3086	247.00	249.59	253.92	258.24	264.29
- segmental with Axillary Dissection	3084	618.80	625.30	636.13	646.96	662.12
- radical or modified radical	3075	618.80	625.30	636.13	646.96	662.12
- radical with skin graft	3076	566.10	572.04	581.95	591.86	605.73
- male simple **(Prior approval required)**	3077	129.75	131.11	133.38	135.65	138.83
- partial or resection of duct papilloma for bleeding (incl. removal of fistula abscess/underlying aerolar tissue)	3078	129.75	131.11	133.38	135.65	138.83
Insertion of breast tissue expander	3093	205.00	207.15	210.74	214.33	219.35
Percutaneous inflation of tissue expanders (per visit)	3096	22.60	22.84	23.23	23.63	24.18
Removal of breast tissue expander - general anesthetic	3094	73.80	74.57	75.87	77.16	78.97
- local anesthetic	3095	36.90	37.29	37.93	38.58	39.48
Removal of breast tissue expander at time of subsequent surgery		nil	nil	nil	nil	nil
Mammoplasty - augmentation, by prosthesis-unilateral **(Prior approval)**	3072	262.15	264.90	269.49	274.08	280.50
- augmentation ,by prosthesis-bilateral **(Prior approval)**	3083	432.55	437.09	444.66	452.23	462.83
- reduction - unilateral **(Prior approval required)**	3082	420.00	424.41	431.76	439.11	449.40
Removal of breast prosthesis **(Prior approval required)**	3079	75.75	76.55	77.87	79.20	81.05
- with capsulotomy	3098	100.00	101.05	102.80	104.55	107.00
- with capsulectomy	3099	175.00	176.84	179.90	182.96	187.25
Needle Biopsy - Breast	3085	84.00	84.88	86.35	87.82	89.88
Sentinel node biopsy	4805	221.00	223.32	227.19	231.06	236.47
Tram Flap - first surgeon **(Prior approval required)**	3097	I.C.	I.C.	I.C.	I.C.	I.C.
- second surgeon	9999	I.C.	I.C.	I.C.	I.C.	I.C.

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

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

APPLICATION OF CASTS - Not requiring an anesthetic and not associated with initial fractures or initial dislocations.

Finger	3100	29.85	30.16	30.69	31.21	31.94
Arm or leg	3101	38.35	40.10	43.01	45.92	50.00
Shoulder spica	3102	54.00	54.57	55.51	56.46	57.78
Head and torso	3103	108.15	109.29	111.18	113.07	115.72
Body cast (torso)	3104	86.45	87.36	88.87	90.38	92.50
Hip spica, single	3105	75.75	76.55	77.87	79.20	81.05
Removal of plaster (not continuity of treatment)	3106	35.70	36.07	36.70	37.32	38.20
Unna boot	3107	21.55	21.78	22.15	22.53	23.06

APPLICATION OF CORRECTIVE SPLINTS - Arthritic & spastic deformities not associated with fractures or dislocations.

Upper limb - hand and wrist	3108	32.45	32.79	33.36	33.93	34.72
- elbow	3109	32.45	32.79	33.36	33.93	34.72
- shoulder	3110	43.20	43.65	44.41	45.17	46.22
Lower limb - whole leg	3111	43.20	43.65	44.41	45.17	46.22
- below knee	3112	32.45	32.79	33.36	33.93	34.72
Neck	3113	32.45	32.79	33.36	33.93	34.72

INTRODUCTION

Injection of medication into bursa, ganglion or joints - see 2168
(including preliminary aspiration - medications not included)

BONES

INCISION

Incision for osteomyelitis

Hand and foot - osteomyelitis						
Phalanx	3150	54.00	54.57	55.51	56.46	57.78
Metacarpal or metatarsal	3151	108.15	109.29	111.18	113.07	115.72
Carpus or tarsus	3152	108.15	109.29	111.18	113.07	115.72
Humerus - acute osteomyelitis						
Incision and drainage	3153	162.25	163.95	166.79	169.63	173.61
Saucerization	3154	270.25	273.09	277.82	282.55	289.17
Secondary closure	3155	162.25	163.95	166.79	169.63	173.61
Humerus - chronic osteomyelitis						
Sequestrectomy, simple	3156	162.25	163.95	166.79	169.63	173.61
Saucerization and bone chips where necessary	3157	324.40	327.81	333.48	339.16	347.11
Secondary closure	3158	162.25	163.95	166.79	169.63	173.61
Radius or ulna - acute osteomyelitis						
Incision and drainage	3159	162.25	163.95	166.79	169.63	173.61
Saucerization	3160	270.25	273.09	277.82	282.55	289.17
Secondary closure	3161	162.25	163.95	166.79	169.63	173.61

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Radius or ulna - chronic osteomyelitis						
Sequestrectomy, simple	3162	162.25	163.95	166.79	169.63	173.61
Saucerization and bone chips where necessary	3163	324.40	327.81	333.48	339.16	347.11
Secondary closure	3164	162.25	163.95	166.79	169.63	173.61
Tibia - acute osteomyelitis						
Incision and drainage	3165	162.25	163.95	166.79	169.63	173.61
Tibia - chronic osteomyelitis						
Sequestrectomy, simple	3167	216.10	218.37	222.15	225.93	231.23
Saucerization and bone chips where necessary	3168	324.40	327.81	333.48	339.16	347.11
Secondary closure	3169	162.25	163.95	166.79	169.63	173.61
Femur - acute osteomyelitis						
Incision and drainage	3170	216.10	218.37	222.15	225.93	231.23
Saucerization	3171	378.35	382.32	388.94	395.56	404.83
Femur - chronic osteomyelitis						
Sequestrectomy, simple	3172	216.10	218.37	222.15	225.93	231.23
Saucerization and bone chips where necessary	3173	378.35	382.32	388.94	395.56	404.83
Secondary closure	3174	162.25	163.95	166.79	169.63	173.61
Pelvis - osteomyelitis						
Sequestrectomy, simple	3175	270.25	273.09	277.82	282.55	289.17
Other, depending on extent of operation	3176	I.C.	I.C.	I.C.	I.C.	I.C.
Vertebra - acute osteomyelitis						
Incision and drainage	3177	216.10	218.37	222.15	225.93	231.23
Saucerization and bone chips where necessary	3178	432.55	437.09	444.66	452.23	462.83
Secondary closure	3179	162.25	163.95	166.79	169.63	173.61
Vertebra - chronic osteomyelitis						
Sequestrectomy, simple	3180	216.10	218.37	222.15	225.93	231.23
Saucerization and/or bone graft	3181	378.35	382.32	388.94	395.56	404.83
Skull - osteomyelitis	3182	I.C.	I.C.	I.C.	I.C.	I.C.
Transection of Bone (Osteotomy)						
Phalanx, metacarpal, metatarsal	3183	162.25	163.95	166.79	169.63	173.61
Radius, ulna, fibula	3184	270.25	273.09	277.82	282.55	289.17
Humerus, tibia	3185	353.50	357.21	363.40	369.58	378.25
Femur, neck or shaft	3186	540.65	546.33	555.79	565.25	578.50
Spine	3187	I.C.	I.C.	I.C.	I.C.	I.C.
Incision for removal of bone plates, screws, and other appliances used for fixation because of complications						
- local anesthesia	3188	110.95	112.11	114.06	116.00	118.72
- general anesthesia	3189	177.15	179.01	182.11	185.21	189.55
EXCISION						
Bone Tumor, depending on site and extent	3190	I.C.	I.C.	I.C.	I.C.	I.C.
Bone Biopsy						
Vertebra - x-ray control	3191	216.10	218.37	222.15	225.93	231.23
- open	3192	308.70	311.94	317.34	322.75	330.31
Other - punch, simple	3193	108.15	109.29	111.18	113.07	115.72
- punch, x-ray control	3194	162.25	163.95	166.79	169.63	173.61
- open	3195	162.25	163.95	166.79	169.63	173.61

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Skull						
Maxilla, with or without exenteration of orbit and skin graft	3196	617.45	623.93	634.74	645.54	660.67
Mandible	3197	411.60	415.92	423.12	430.33	440.41
Upper Extremity						
Carpal bone (1 or more)	3199	257.15	259.85	264.35	268.85	275.15
Radius - styloid	3200	216.10	218.37	222.15	225.93	231.23
- head	3201	216.10	218.37	222.15	225.93	231.23
- head with replacement	3202	324.40	327.81	333.48	339.16	347.11
Ulna - lower end	3203	205.80	207.96	211.56	215.16	220.21
- olecranon and fascial repair	3205	324.40	327.81	333.48	339.16	347.11
Humerus - head	3206	411.60	415.92	423.12	430.33	440.41
- head with replacement	3207	514.60	520.00	529.01	538.01	550.62
- exostosis	3208	205.80	207.96	211.56	215.16	220.21
- tumor - simple excision	3209	270.25	273.09	277.82	282.55	289.17
- excision and bone graft	3210	432.55	437.09	444.66	452.23	462.83
- excision resection and reconstruction	3211	I.C.	I.C.	I.C.	I.C.	I.C.
Acromion and/or outer end of clavicle	3212	216.10	218.37	222.15	225.93	231.23
Lower extremity						
Foot bones - proximal phalanx	3213	162.25	163.95	166.79	169.63	173.61
- tumor of phalanx, excision and replacement	3214	257.20	259.90	264.40	268.90	275.20
- sesamoid	3215	205.80	207.96	211.56	215.16	220.21
- bunion - exostectomy only - unilateral	3216	188.55	190.53	193.83	197.13	201.75
- bilateral	3217	194.55	196.59	200.00	203.40	208.17
- Keller	3218	257.20	259.90	264.40	268.90	275.20
- scaphoid, accessory	3219	205.80	207.96	211.56	215.16	220.21
- tarsal bar	3220	257.20	259.90	264.40	268.90	275.20
- calcaneal spur, exostosis	3221	162.25	163.95	166.79	169.63	173.61
- os calcis or talus	3222	308.70	311.94	317.34	322.75	330.31
- metatarsal head	3223	162.25	163.95	166.79	169.63	173.61
- each additional	3224	54.00	54.57	55.51	56.46	57.78
Tibia - exostosis	3225	216.10	218.37	222.15	225.93	231.23
- tumor (see humerus)						
Patella - excision with reconstruction	3226	308.70	311.94	317.34	322.75	330.31
- excision with prosthesis	3227	432.55	437.09	444.66	452.23	462.83
Femur - exostosis	3228	216.10	218.37	222.15	225.93	231.23
- head and neck	3229	432.55	437.09	444.66	452.23	462.83
- tumor (see humerus)						
Trunk						
Cervical rib - complete removal	3230	514.60	520.00	529.01	538.01	550.62
REPAIR, MANIPULATION AND RECONSTRUCTION						
Grafts of Bone - see fractures						
Lengthening of Bone						
- Tibia	3232	514.60	520.00	529.01	538.01	550.62
- Femur	3233	617.45	623.93	634.74	645.54	660.67
Shortening of Bone						
- Femur, Tibia, Humerus	3234	514.60	520.00	529.01	538.01	550.62
- metatarsal - one	3235	257.20	259.90	264.40	268.90	275.20
- more than one	3236	360.20	363.98	370.29	376.59	385.41

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Reconstruction of Chest						
- Pectus excavatum - infant	3242	270.25	273.09	277.82	282.55	289.17
- other than infant	3243	540.65	546.33	555.79	565.25	578.50
Scapulopexy - congenital evaluation	3244	432.55	437.09	444.66	452.23	462.83
- winged scapula	3245	432.55	437.09	444.66	452.23	462.83
Reconstruction of foot (Joplin, McBride, Lapitus, etc.)						
eg. osteotomy and/or tendon transfers, etc.						
- Unilateral	3246	356.90	360.65	366.89	373.14	381.88
- Bilateral	3247	540.65	546.33	555.79	565.25	578.50
Exostectomy and arthrodesis, metacarpophalangeal joint						
- Unilateral	3248	308.70	311.94	317.34	322.75	330.31
- Bilateral	3249	486.50	491.61	500.12	508.64	520.56
Bone graft (paid at 100% in addition to other procedure)	3258	126.05	127.37	129.58	131.79	134.87

FRACTURES

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

Upper Extremity

Phalanx (finger/thumb)						
- No reduction	3300	45.70	46.18	46.98	47.78	48.90
- Closed reduction	3301	88.25	89.18	90.72	92.27	94.43
- Open reduction	3302	162.25	163.95	166.79	169.63	173.61
Metacarpal						
- No reduction (1 or more)	3303	45.70	46.18	46.98	47.78	48.90
- Reduction with or without extension	3304	106.45	107.57	109.43	111.29	113.90
- Open reduction	3305	205.80	207.96	211.56	215.16	220.21
Bennett's Fracture/Dislocation						
- No reduction	3306	54.00	54.57	55.51	56.46	57.78
- Reduction with external pin fixation	3544	140.60	142.08	144.54	147.00	150.44
- Reduction with or without extension	3307	118.95	120.20	122.28	124.36	127.28
- Open reduction	3308	216.10	218.37	222.15	225.93	231.23
Carpus (excluding Scaphoid)						
- Closed reduction	3309	118.95	120.20	122.28	124.36	127.28
- Open reduction (1 or more)	3310	205.80	207.96	211.56	215.16	220.21
Scaphoid						
- Closed reduction	3311	119.40	120.65	122.74	124.83	127.76
- Excision	3312	205.80	207.96	211.56	215.16	220.21
- Bone graft or replacement	3313	411.60	415.92	423.12	430.33	440.41
Radial Head						
- Closed reduction of head	3314	135.40	136.82	139.19	141.56	144.88
- Excision or open reduction of head	3315	205.80	207.96	211.56	215.16	220.21
Radius and Ulna - Colles						
- No reduction, cast	3316	82.25	83.11	84.55	85.99	88.01
- Closed reduction	3317	143.90	145.41	147.93	150.45	153.97
- Open reduction	3318	308.70	311.94	317.34	322.75	330.31
Radius and Ulna - Shafts						
- No reduction	3319	82.25	83.11	84.55	85.99	88.01
- Closed reduction	3320	190.10	192.10	195.42	198.75	203.41
- Open reduction	3321	378.35	382.32	388.94	395.56	404.83

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Radius and Ulna - Monteggia						
- Closed reduction	3323	226.40	228.78	232.74	236.70	242.25
- Open reduction	3324	360.20	363.98	370.29	376.59	385.41
Radius or Ulna						
- No reduction, cast	3326	82.25	83.11	84.55	85.99	88.01
- Closed reduction	3327	162.25	163.95	166.79	169.63	173.61
- Open reduction	3328	257.20	259.90	264.40	268.90	275.20
Olecranon						
- No reduction, cast	3330	86.45	87.36	88.87	90.38	92.50
- Closed reduction	3331	162.25	163.95	166.79	169.63	173.61
- Open reduction	3332	257.20	259.90	264.40	268.90	275.20
Humerus - Epicondyle(medial or lateral)						
- Closed reduction	3333	191.10	193.11	196.45	199.80	204.48
- Open reduction	3334	257.20	259.90	264.40	268.90	275.20
Humerus - Supra or transcondylar						
- No reduction	3335	101.00	102.06	103.83	105.60	108.07
- Closed reduction	3336	237.70	240.20	244.36	248.52	254.34
- Open reduction	3337	324.40	327.81	333.48	339.16	347.11
Humerus - Shaft						
- No reduction	3338	118.95	120.20	122.28	124.36	127.28
- Closed reduction	3339	226.40	228.78	232.74	236.70	242.25
- Open reduction	3340	360.20	363.98	370.29	376.59	385.41
Humerus - Neck or Tuberosity						
- No reduction	3342	118.95	120.20	122.28	124.36	127.28
- Closed reduction	3343	226.40	228.78	232.74	236.70	242.25
- Open reduction	3344	378.35	382.32	388.94	395.56	404.83
Lower Extremity						
Phalanx (toe)						
- No reduction	3345	43.20	43.65	44.41	45.17	46.22
- Closed reduction	3346	75.75	76.55	77.87	79.20	81.05
- Open reduction	3347	162.25	163.95	166.79	169.63	173.61
Metatarsal (1 or more)						
- No reduction	3348	54.00	54.57	55.51	56.46	57.78
- Closed reduction	3349	86.45	87.36	88.87	90.38	92.50
- Open reduction	3350	205.80	207.96	211.56	215.16	220.21
Tarsus (excluding Os Calcis) (1 or more)						
- No reduction	3351	110.75	111.91	113.85	115.79	118.50
- Closed reduction	3352	178.45	180.32	183.45	186.57	190.94
- Open reduction	3353	308.70	311.94	317.34	322.75	330.31
Os Calcis						
- No reduction - no cast	3354	99.95	101.00	102.75	104.50	106.95
- cast	3355	108.15	109.29	111.18	113.07	115.72
- Closed reduction (manipulation)	3356	247.00	249.59	253.92	258.24	264.29
- Open reduction	3357	308.70	311.94	317.34	322.75	330.31
- Open reduction, primary arthrodesis	3358	411.60	415.92	423.12	430.33	440.41
Ankle Fracture or Fracture/Dislocation						
- No reduction	3359	86.45	87.36	88.87	90.38	92.50
- Closed reduction	3360	226.40	228.78	232.74	236.70	242.25

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
- Open reduction - medial malleolus	3361	257.20	259.90	264.40	268.90	275.20
- bi or trimalleolar	3362	360.20	363.98	370.29	376.59	385.41
Tibia with or without Fibula						
- No reduction	3363	154.65	156.27	158.98	161.69	165.48
- Closed reduction	3364	244.60	247.17	251.45	255.73	261.72
- Open reduction	3365	378.35	382.32	388.94	395.56	404.83
Fibula Only						
- No reduction	3367	75.75	76.55	77.87	79.20	81.05
- Closed reduction	3368	108.15	109.29	111.18	113.07	115.72
- Open reduction	3369	216.10	218.37	222.15	225.93	231.23
Patella						
- No reduction	3370	86.45	87.36	88.87	90.38	92.50
- Closed reduction	3371	108.15	109.29	111.18	113.07	115.72
- Open reduction - by suture	3372	308.70	311.94	317.34	322.75	330.31
- excision	3373	308.70	311.94	317.34	322.75	330.31
Femur - Shaft or Transcondylar						
- No reduction, cast	3374	182.30	184.21	187.40	190.59	195.06
- Closed reduction - child	3375	270.25	273.09	277.82	282.55	289.17
- adult	3376	378.35	382.32	388.94	395.56	404.83
- Open reduction	3377	480.80	485.85	494.26	502.68	514.46
Femur - Neck or Intertrochanteric						
- No reduction	3379	216.10	218.37	222.15	225.93	231.23
- Closed reduction	3380	324.40	327.81	333.48	339.16	347.11
- Open reduction, pin and/or plate	3381	591.10	597.31	607.65	618.00	632.48
- Prosthesis	3382	628.75	635.35	646.36	657.36	672.76
Spine						
Spinous or transverse process, facet, etc.	3383	108.15	109.29	111.18	113.07	115.72
Vertebral body fracture/dislocation, without cord injury						
- Supervision, bed rest only	Visit Fee					
- Skull calipers, visit fee plus	3385	108.15	109.29	111.18	113.07	115.72
- Closed reduction, +/- anesthetic, cast, frame, brace, etc	3384	257.20	259.90	264.40	268.90	275.20
- Open reduction +/- internal fixation	3386	617.45	623.93	634.74	645.54	660.67
- Open reduction/fusion	3387	648.50	655.31	666.66	678.01	693.90
- Open reduction/fusion, with Neurosurgeon (each surgeon)	3388	486.50	491.61	500.12	508.64	520.56
Vertebral body fracture/dislocation, with cord injury						
- No operation	Visit Fee					
- Skull calipers, visit fee plus	3389	108.15	109.29	111.18	113.07	115.72
- Closed reduction under Anesthesia	3390	514.60	520.00	529.01	538.01	550.62
- Open reduction +/- internal fixation	3391	756.80	764.75	777.99	791.23	809.78
- Open reduction/fusion	3392	756.80	764.75	777.99	791.23	809.78
- Open reduction/fusion, with Neurosurgeon (each surgeon)	3393	514.60	520.00	529.01	538.01	550.62
- Open reduction with decompression of cord or nerve roots	3394	720.30	727.86	740.47	753.07	770.72
Sacrum						
- Complete care	3395	54.00	54.57	55.51	56.46	57.78
Coccyx						
- No reduction, complete care	3396	54.00	54.57	55.51	56.46	57.78
- Excision	3397	205.80	207.96	211.56	215.16	220.21

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Trunk						
Clavicle						
- No reduction - child (age 15 years or less)	3398	59.70	60.33	61.37	62.42	63.88
- adult	3399	64.90	65.58	66.72	67.85	69.44
- Closed reduction - child (age 15 years or less)	3400	110.75	111.91	113.85	115.79	118.50
- adult	3401	110.75	111.91	113.85	115.79	118.50
- Open reduction	3402	216.10	218.37	222.15	225.93	231.23
Scapula - body, neck or glenoid						
- No reduction	3404	59.70	60.33	61.37	62.42	63.88
- Closed reduction	3405	108.15	109.29	111.18	113.07	115.72
Sternum						
- No reduction	3406	54.00	54.57	55.51	56.46	57.78
- Closed reduction	3407	108.15	109.29	111.18	113.07	115.72
- Open reduction	3408	216.10	218.37	222.15	225.93	231.23
Ribs						
- Uncomplicated - 3 ribs or less	3409	32.45	32.79	33.36	33.93	34.72
- each additional	3410	10.85	10.96	11.15	11.34	11.61
- Complicated, requiring special treatment	3411	I.C.	I.C.	I.C.	I.C.	I.C.
Pelvis						
- No reduction - bed rest and supervision	3412	19.35	19.55	19.89	20.23	20.70
- manipulation and control	3413	324.40	327.81	333.48	339.16	347.11
- Open reduction	3414	I.C.	I.C.	I.C.	I.C.	I.C.
Head						
Nasal Bones						
- No reduction	3415	32.45	32.79	33.36	33.93	34.72
- Closed reduction - local anaesthetic	3416	80.35	81.19	82.60	84.01	85.97
- general anaesthetic	3417	108.15	109.29	111.18	113.07	115.72
- Open reduction, rhinoplastic method	3418	216.10	218.37	222.15	225.93	231.23
Mandible						
- No reduction, no wiring of teeth	3419	54.00	54.57	55.51	56.46	57.78
- Closed reduction, including wiring of teeth	3420	216.10	218.37	222.15	225.93	231.23
- Open reduction, unilateral or bilateral skeletal fixation	3421	324.40	327.81	333.48	339.16	347.11
Maxilla - Malar bone						
- Reduction by direction of forceps	3423	108.15	109.29	111.18	113.07	115.72
- Open reduction	3424	216.10	218.37	222.15	225.93	231.23
Complicated mid-face	3425	I.C.	I.C.	I.C.	I.C.	I.C.
Skull - No reduction, complete care, simple or compound	Visit Fee					

JOINTS

INCISION (Arthrotomy)

Wrist, elbow, shoulder, ankle	3500	216.10	218.37	222.15	225.93	231.23
Knee - exploratory and/or removal loose body	3501	257.20	259.90	264.40	268.90	275.20
- Meniscus/debridement, compartment	3502	396.80	400.97	407.91	414.85	424.58
Hip - exploratory and/or removal loose body	3503	411.60	415.92	423.12	430.33	440.41

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
EXCISION						
Capsulectomy - Synovectomy - Debridement						
Elbow, wrist	3504	324.40	327.81	333.48	339.16	347.11
Shoulder	3505	432.55	437.09	444.66	452.23	462.83
Hip	3506	514.60	520.00	529.01	538.01	550.62
Knee	3507	432.55	437.09	444.66	452.23	462.83
Fingers, toes - one or more joints	3508	162.25	163.95	166.79	169.63	173.61
Neurectomy						
Elbow, knee	3509	308.70	311.94	317.34	322.75	330.31
Hip	3510	378.35	382.32	388.94	395.56	404.83
Chondrectomy						
Knee - menisectomy	3512	308.70	311.94	317.34	322.75	330.31
- Baker's cyst	3513	162.25	163.95	166.79	169.63	173.61
Intervertebral Discs						
Excision of intervertebral disc - lumbar						
- single	3514	514.60	520.00	529.01	538.01	550.62
- bilateral, recurrent or multiple	3515	648.50	655.31	666.66	678.01	693.90
Excision of intervertebral disc with fusion						
- one surgeon	3519	756.80	764.75	777.99	791.23	809.78
- two surgeons, each	3520	486.50	491.61	500.12	508.64	520.56
RECONSTRUCTION						
Arthroplasty - all types						
Interphalangeal, Metacarpophalangeal	3521	216.10	218.37	222.15	225.93	231.23
Hand, reconstruction of rheumatoid joints, multiple	3522	514.60	520.00	529.01	538.01	550.62
Wrist, ankle	3523	411.60	415.92	423.12	430.33	440.41
Elbow, knee	3524	432.55	489.64	584.79	679.94	813.15
Acromio, or sternoclavicular	3525	270.25	273.09	277.82	282.55	289.17
Shoulder	3550	656.40	708.10	794.26	880.42	1,001.04
Foot - Hallux rigidus	3526	216.10	218.37	222.15	225.93	231.23
- Keller operation	3528	257.20	259.90	264.40	268.90	275.20
Hip - Cup arthroplasty	3529	648.50	655.31	666.66	678.01	693.90
- Total arthroplasty	3530	806.05	814.51	828.62	842.73	862.47
Hip arthroplasty - resurfacing	3250	935.55	945.37	961.75	978.12	1,001.04
Conversion of Moores prosthesis to total hip	3255	1,010.15	1,020.76	1,038.43	1,056.11	1,080.86
Revision of total hip	3256	1,263.90	1,277.17	1,299.29	1,321.41	1,352.37
Total knee	3251	759.95	767.93	781.23	794.53	813.15
Revision of total knee	3257	1,162.90	1,175.11	1,195.46	1,215.81	1,244.30
Removal of total knee, without replacement, w/insertion of spacer	3259	I.C.	I.C.	I.C.	I.C.	I.C.
Total ankle	3252	664.15	671.12	682.75	694.37	710.64
Arthroplasty	3253	162.25	163.95	166.79	169.63	173.61
Arthrodesis						
Finger, thumb	3531	216.10	218.37	222.15	225.93	231.23
Wrist, elbow, ankle	3532	411.60	415.92	423.12	430.33	440.41
Shoulder, knee, sacroiliac	3533	514.60	520.00	529.01	538.01	550.62
Hip	3534	648.50	655.31	666.66	678.01	693.90
Foot - toe, one joint	3535	364.65	368.48	374.86	381.24	390.18
- toe, multiple joints	3536	32.45	32.79	33.36	33.93	34.72
- mid-tarsal, sub-talar, triple, etc	3537	411.60	415.92	423.12	430.33	440.41

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
- pan-talar, one stage	3538	540.65	546.33	555.79	565.25	578.50
- congenital club foot, fusions and tendon transfers	3539	514.60	520.00	529.01	538.01	550.62
Spinal Column fusion - one or two spaces	3540	617.45	623.93	634.74	645.54	660.67
- more than two spaces	3541	756.80	764.75	777.99	791.23	809.78
Chemonucleolysis - incl. placement of needle, injection (per disc)	3545	242.25	244.79	249.03	253.27	259.21
ARTHROSCOPY						
Diagnostic Arthroscopy - all joints	3254	176.50	178.35	181.44	184.53	188.86
(including instrumentation, lavage and biopsy)						
Surgical Procedures with or without Arthroscopy (all joints)						
Lateral/medial retinacular release	3848	181.75	183.66	186.84	190.02	194.47
Synovectomy - 1 compartment	3542	308.70	311.94	317.34	322.75	330.31
- 2 or more compartments	3507	432.55	437.09	444.66	452.23	462.83
Menisectomy/debridement - 1 compartment	3502	396.80	400.97	407.91	414.85	424.58
- 2 or more compartments	3547	494.70	499.89	508.55	517.21	529.33
Reduction & pinning of intra-articular fragments	3548	308.70	311.94	317.34	322.75	330.31
Meniscal repair (medial or lateral)	3549	308.70	311.94	317.34	322.75	330.31

All above arthroscopy fees are mutually exclusive for the same joint
(eg. cannot do both debridement and synovectomy on the same joint)
Diagnostic fee will not be paid in addition to procedure for the same leg.
When 2 or more joints being done, the 2nd procedure will be paid at 65%.
Tissue from arthroscopic synovectomy requires pathology.

DISLOCATIONS

Upper Extremity

Finger and Thumb						
- Closed reduction, one	3600	54.00	54.57	55.51	56.46	57.78
- Open reduction	3601	162.25	163.95	166.79	169.63	173.61
Metacarpophalangeal						
- Closed reduction, one	3602	60.80	61.44	62.50	63.57	65.06
- Open reduction	3603	162.25	163.95	166.79	169.63	173.61
Wrist and Carpal Bones						
- Closed reduction	3604	162.25	163.95	166.79	169.63	173.61
- Open reduction	3605	308.70	311.94	317.34	322.75	330.31
Elbow						
- Closed reduction	3606	171.55	173.35	176.35	179.36	183.56
- Open reduction	3607	308.70	311.94	317.34	322.75	330.31
- Dislocation of head of radius	3546	46.45	46.94	47.75	48.56	49.70
Shoulder						
- Closed reduction	3608	113.30	114.49	116.47	118.46	121.23
- Open reduction	3609	378.35	382.32	388.94	395.56	404.83
- Recurrent dislocations, repair, all types	3610	452.75	457.50	465.43	473.35	484.44
Acromioclavicular						
- Closed reduction	3611	64.90	65.58	66.72	67.85	69.44
- Open reduction	3612	270.25	273.09	277.82	282.55	289.17
Sternoclavicular						
- Closed reduction	3613	59.40	60.02	61.06	62.10	63.56
- Open reduction	3614	216.10	218.37	222.15	225.93	231.23

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Lower Extremity						
Toe, Interphalangeal						
- Closed reduction	3615	32.45	32.79	33.36	33.93	34.72
- Open reduction	3616	162.25	163.95	166.79	169.63	173.61
Metatarsophalangeal						
- Closed reduction	3617	60.80	61.44	62.50	63.57	65.06
- Open reduction	3618	162.25	163.95	166.79	169.63	173.61
Tarsus						
- Closed reduction	3619	135.40	136.82	139.19	141.56	144.88
- Open reduction	3620	270.25	273.09	277.82	282.55	289.17
Ankle, Subluxation						
- Closed reduction with or without general anesthetic	3621	165.80	167.54	170.44	173.34	177.41
- Open reduction	3622	308.70	311.94	317.34	322.75	330.31
- Repair or recurrent subluxation	3623	411.60	415.92	423.12	430.33	440.41
Knee						
- Closed reduction	3624	191.10	193.11	196.45	199.80	204.48
- Simple reduction	3625	378.35	382.32	388.94	395.56	404.83
- Open reduction/reconstruction of ligaments, medial collateral, lateral collateral and/or cruciates +/- menisectomy	3647	486.50	491.61	500.12	508.64	520.56
Patella						
- Closed reduction, with or without anesthetic	3626	75.75	76.55	77.87	79.20	81.05
- Open reduction for recurrent dislocation	3627	324.40	327.81	333.48	339.16	347.11
- Open reduction/reconstruction of ligaments, medial collateral, lateral collateral and/or cruciates +/- menisectomy	3648	486.50	491.61	500.12	508.64	520.56
Hip						
Anterior or Posterior Dislocation						
- Closed reduction with or without anesthetic	3628	191.10	193.11	196.45	199.80	204.48
- Open reduction	3629	378.35	382.32	388.94	395.56	404.83
Central Dislocation						
- Closed reduction with or without anesthetic	3630	216.10	218.37	222.15	225.93	231.23
- Open reduction	3631	432.55	437.09	444.66	452.23	462.83
Congenital Dislocation						
Closed reduction with or without anesthetic						
- unilateral	3632	162.25	163.95	166.79	169.63	173.61
- repeat manipulation and plaster	3633	75.75	76.55	77.87	79.20	81.05
Simple or rotation osteotomy	3634	432.55	437.09	444.66	452.23	462.83
Acetabuloplasty	3635	540.65	546.33	555.79	565.25	578.50
Spine						
Intervertebral						
- Closed reduction, correction spica	3636	216.10	218.37	222.15	225.93	231.23
- Open reduction	3637	411.60	415.92	423.12	430.33	440.41
- Open reduction/fusion, cervical spine, +/- cord injury	3638	668.90	675.92	687.63	699.33	715.72
- Open reduction/fusion, thoracic/lumbar, +/- cord injury	3639	648.50	655.31	666.66	678.01	693.90
Sacrococcygeal						
- Non-operative	Visit Fee					
- Open reduction - removal of coccyx	3640	216.10	218.37	222.15	225.93	231.23
Temporomandibular						
- Closed reduction	3641	47.35	47.85	48.68	49.50	50.66
- Open reduction	3642	216.10	218.37	222.15	225.93	231.23

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
MANIPULATION						
Manipulation of Joints under General Anesthesia						
- Wrist, elbow, ankle	3643	32.45	32.79	33.36	33.93	34.72
- Shoulder, knee, hip	3644	54.00	54.57	55.51	56.46	57.78
Congenital foot deformity, club-foot, +/- anesthetic						
Dennis Brown's splints	3645	21.55	21.78	22.15	22.53	23.06
Manipulation and cast, single	3646	32.45	32.79	33.36	33.93	34.72
BURSAE						
Incision						
Removal of calcium	3701	216.10	218.37	222.15	225.93	231.23
Excision						
Olecranon, prepatellar bursae	3702	162.25	163.95	166.79	169.63	173.61
Humero-radial	3703	162.25	163.95	166.79	169.63	173.61
Sub-acromial	3704	216.10	218.37	222.15	225.93	231.23
Sub-trochanteric	3705	257.20	259.90	264.40	268.90	275.20
Biopsy						
Superficial bursa	3706	32.45	32.79	33.36	33.93	34.72
MUSCLES						
Incision						
Removal of foreign body, general anesthetic						
- Simple	3750	54.00	54.57	55.51	56.46	57.78
- Complicated e.g. gunshot wound	3751	I.C.	I.C.	I.C.	I.C.	I.C.
Release or cutting of muscle (myotomy) - Tennis Elbow	3754	162.25	163.95	166.79	169.63	173.61
Excision						
Biopsy, independent procedure	3755	54.00	54.57	55.51	56.46	57.78
Resection of muscle	3756	I.C.	I.C.	I.C.	I.C.	I.C.
Local excision of lesion of muscle	3757	75.75	76.55	77.87	79.20	81.05
Repair						
Manipulation and injection, tennis elbow	3758	32.45	32.79	33.36	33.93	34.72
Quadricepsplasty	3760	378.35	382.32	388.94	395.56	404.83
TENDONS, TENDON SHEATHS, FASCIA						
Incision						
Exploration of tendon or tendon sheath	3800	129.75	131.11	133.38	135.65	138.83
Tenosynovitis, finger	3801	129.75	131.11	133.38	135.65	138.83
Trigger finger, release	3802	129.75	131.11	133.38	135.65	138.83
Exploration of fascia	3803	153.80	155.41	158.11	160.80	164.57
Drainage of tendon sheath	3804	129.75	131.11	133.38	135.65	138.83
Tenotomy (closed)						
Toe - single	3805	32.45	32.79	33.36	33.93	34.72
- multiple	3806	54.00	54.57	55.51	56.46	57.78
Plantar fascia	3807	54.00	54.57	55.51	56.46	57.78
Hip adductors	3808	54.00	54.57	55.51	56.46	57.78
Tendo-Achilles	3809	54.00	54.57	55.51	56.46	57.78

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Excision						
Ganglion, tendon sheath or joint	3810	129.70	131.06	133.33	135.60	138.78
DeQuervian's (Wrist)	3811	259.40	262.12	266.66	271.20	277.56
Tendon sheath for tuberculosis	3812	324.40	327.81	333.48	339.16	347.11
Fascia for Dupuytren's - partial	3813	216.10	218.37	222.15	225.93	231.23
- complete	3814	378.35	382.32	388.94	395.56	404.83
Xanthoma	3815	108.15	109.29	111.18	113.07	115.72
Repair						
Tenoplasty, shortening, lengthening, etc.						
- one tendon, one location	3816	216.10	218.37	222.15	225.93	231.23
- two or more	3817	270.25	273.09	277.82	282.55	289.17
Tendon graft						
- Hand, Wrist - single	3818	411.60	415.92	423.12	430.33	440.41
- two or more	3819	514.60	520.00	529.01	538.01	550.62
- other location	3820	409.30	413.60	420.76	427.92	437.95
Fasciotomy						
- Lengthening of ileo-tibial band - unilateral	3821	205.80	207.96	211.56	215.16	220.21
- Decompression of carpal tunnel	5968	216.10	218.37	222.15	225.93	231.23
Transplant of tendon, transposition						
- Hand, Forearm - single	3823	216.10	218.37	222.15	225.93	231.23
- multiple	3824	378.35	382.32	388.94	395.56	404.83
- Shoulder - pectoralis minor	3825	216.10	218.37	222.15	225.93	231.23
- trapezius	3826	360.20	363.98	370.29	376.59	385.41
- Foot, Ankle - single	3827	216.10	218.37	222.15	225.93	231.23
- multiple	3828	378.35	382.32	388.94	395.56	404.83
- Knee - transposition of tendons	3829	324.40	327.81	333.48	339.16	347.11
- Foot - tenodesis	3830	216.10	218.37	222.15	225.93	231.23
Repair of mallet finger - closed	3831	55.25	55.83	56.80	57.76	59.12
- operative	3832	162.25	163.95	166.79	169.63	173.61
Tenoplasty - Achilles, biceps, or quadriceps tendon	3847	257.20	259.90	264.40	268.90	275.20
Suture						
Tenorrhaphy, tendon suture						
Finger, hand, wrist, foot, ankle						
Extensor tendon - partially severed	3849	150.00	151.58	154.20	156.83	160.50
- single	3833	162.25	163.95	166.79	169.63	173.61
- each subsequent	3834	75.00	75.79	77.10	78.41	80.25
Flexor tendon - single	3835	250.00	252.63	257.00	261.38	267.50
- each subsequent	3836	125.00	126.31	128.50	130.69	133.75
Achilles, biceps, quadriceps	3837	270.25	273.09	277.82	282.55	289.17
Reconstruction (fascia and ligaments)						
Shoulder - rotator cuff tear	3838	360.20	363.98	370.29	376.59	385.41
- late repair	3839	432.55	437.09	444.66	452.23	462.83
- acromioplasty only	3840	324.40	327.81	333.48	339.16	347.11
Acromioclavicular, sternoclavicular - early repair(see Dislocations)						
- late repair	3841	360.20	363.98	370.29	376.59	385.41
Elbow, wrist, ankle - early repair	3842	216.10	218.37	222.15	225.93	231.23
- late repair	3843	378.35	382.32	388.94	395.56	404.83
Knee - early repair	3844	324.40	327.81	333.48	339.16	347.11
- late repair	3845	475.80	480.80	489.12	497.45	509.11
Metacarpophalangeal - early or late	3846	162.25	163.95	166.79	169.63	173.61

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
AMPUTATION						
Upper Extremity						
Through phalanx	3900	75.00	75.79	77.10	78.41	80.25
Through metacarpal or M.P. joint	3901	108.15	109.29	111.18	113.07	115.72
Of hand - through all metacarpals	3902	270.25	273.09	277.82	282.55	289.17
Through radius and ulna	3903	324.40	327.81	333.48	339.16	347.11
Through humerus	3904	324.40	327.81	333.48	339.16	347.11
At shoulder	3905	378.35	382.32	388.94	395.56	404.83
Fore quarter	3906	514.60	520.00	529.01	538.01	550.62
Lower Extremity						
Through phalanx	3907	75.75	76.55	77.87	79.20	81.05
Through metatarsal or M.P. joint	3908	108.15	109.29	111.18	113.07	115.72
Transmetatarsal	3909	257.20	259.90	264.40	268.90	275.20
Symes	3910	308.70	311.94	317.34	322.75	330.31
Through tibia and fibula	3911	324.40	327.81	333.48	339.16	347.11
At knee - Gritti - Stokes or Callander	3912	324.40	327.81	333.48	339.16	347.11
Through femur	3913	324.40	327.81	333.48	339.16	347.11
At hip	3914	617.45	623.93	634.74	645.54	660.67
Hind quarter	3915	756.80	764.75	777.99	791.23	809.78
Hemipelvectomy	3916	756.80	764.75	777.99	791.23	809.78

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014

OPERATIONS ON THE RESPIRATORY SYSTEM

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NOSE

Incision						
Drainage of nasal abscess, complete care	4000	55.25	55.83	56.80	57.76	59.12
Drainage of septal abscess, complete care	4001	86.45	87.36	88.87	90.38	92.50
Excision						
Biopsy of soft tissue	4002	50.00	50.53	51.40	52.28	53.50
Nasal Polypi						
- Unilateral - local anesthetic	4003	32.45	32.79	33.36	33.93	34.72
- general anesthetic	4004	54.00	54.57	55.51	56.46	57.78
- Bilateral - local anesthetic	4005	54.00	54.57	55.51	56.46	57.78
- general anesthetic	4006	108.15	109.29	111.18	113.07	115.72
Excision of choanal polyp	4007	75.75	76.55	77.87	79.20	81.05
Excision of skin of nose for rhinophyma - uncomplicated	4009	75.75	76.55	77.87	79.20	81.05
Septectomy, submucous resection	4010	216.10	218.37	222.15	225.93	231.23
Septectomy, submucous resection - including septoplasty	4011	270.25	273.09	277.82	282.55	289.17
Turbinectomy - complete or partial	4012	43.20	43.65	44.41	45.17	46.22
- Submucosal turbinectomy	4013	I.C.	I.C.	I.C.	I.C.	I.C.
Endoscopy						
Rhinoscopy with removal of foreign body in nose	4014	35.00	35.37	35.98	36.59	37.45
- under general Anesthesia	4015	43.20	43.65	44.41	45.17	46.22
Repair						
Rhinoplasty, and closure of septal perforation						
Complete with or without grafts **(Prior approval required)**	4016	635.85	642.53	653.65	664.78	680.36
Nasal septal button insertion	7907	91.23	92.19	93.78	95.38	97.62
Lysis of nasal adhesions	7908	110.50	111.66	113.59	115.53	118.24
Destruction						
Infraction of turbinate, unilateral or bilateral	4019	21.55	21.78	22.15	22.53	23.06
Cauterization of turbinates - unilateral	4020	32.45	32.79	33.36	33.93	34.72
- bilateral	4021	54.00	54.57	55.51	56.46	57.78
Manipulation						
Control of primary nasal hemorrhage (Epistaxis)						
- With cauterization of nasal septum	4022	21.55	21.78	22.15	22.53	23.06
- With anterior nasal packing	4023	50.00	50.53	51.40	52.28	53.50
- With posterior nasal packing	4024	85.00	85.89	87.38	88.87	90.95
Control of secondary hemorrhage same as above	4025	75.75	76.55	77.87	79.20	81.05
Epistaxis control by ligation of ethmoidal arteries	7905	108.15	109.29	111.18	113.07	115.72
Epistaxis control by ligation of maxillary arteries	7906	420.33	424.74	432.10	439.46	449.75
Catheterization of Eustachian Tube for infiltration of middle ear	4026	10.85	10.96	11.15	11.34	11.61

SINUSES

Incision

Sinusotomy, sinusectomy, as indicated

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Maxillary sinusotomy - intranasal (unilateral)	4027	129.75	131.11	133.38	135.65	138.83
- radical, Caldwell-Luc (unilateral)	4028	308.70	311.94	317.34	322.75	330.31
Frontal Trephine and sinusectomy	4029	162.25	163.95	166.79	169.63	173.61
- Radical	4030	514.60	520.00	529.01	538.01	550.62
External fronto-ethmoidal with sphenoid if necessary	4031	162.25	163.95	166.79	169.63	173.61
Ethmoidal - intranasal (unilateral)	4032	162.25	163.95	166.79	169.63	173.61
Intranasal ethmoidectomy - anterior only	7909	160.65	162.34	165.15	167.96	171.90
- anterior and posterior	7910	262.00	264.75	269.34	273.92	280.34
Sphenoidal - intranasal	4033	216.10	218.37	222.15	225.93	231.23
Introduction						
Lavage - maxillary	4034	21.55	21.78	22.15	22.53	23.06
- frontal	4035	43.20	43.65	44.41	45.17	46.22
- sphenoidal	4036	43.20	43.65	44.41	45.17	46.22
Suture						
Closure of antro-oral fistula	4037	324.40	327.81	333.48	339.16	347.11
Examination under general Anesthesia of the post-nasal space	4040	42.30	42.74	43.48	44.22	45.26
Submucous Diathermy of the turbinates (Bilateral)	4041	56.95	57.55	58.54	59.54	60.94
LARYNX						
Excision						
Laryngectomy - partial (laryngo-fissure)	4100	432.55	437.09	444.66	452.23	462.83
- total	4101	648.50	655.31	666.66	678.01	693.90
Introduction						
Intubation of larynx (Independent procedure)	4104	50.00	51.50	54.00	56.50	60.00
Endoscopy						
Laryngoscopy, direct - without biopsy (only 1 procedure paid per session)	4105	65.00	68.00	73.00	78.00	85.00
- with biopsy	4106	86.45	89.23	93.87	98.51	105.00
Laryngoscopy with removal of foreign body	4107	165.50	170.68	179.30	187.93	200.00
Laryngoscopy with removal of benign growth	4108	205.80	212.43	223.48	234.53	250.00
Laryngoscopy, indirect - with biopsy	4109	43.20	49.47	59.92	70.37	85.00
Repair						
Laryngoplasty, plastic operation on larynx	4110	I.C.	I.C.	I.C.	I.C.	I.C.
Arytenoidopexy (King or Kelly)	4111	411.60	415.92	423.12	430.33	440.41
TRACHEA AND BRONCHI						
Incision						
Tracheostomy	4200	205.80	207.96	211.56	215.16	220.21
Endoscopy						
Bronchoscopy, diagnostic. (1 procedure paid per session)	4201	142.35	143.84	146.34	148.83	152.31
- With biopsy	4202	142.35	143.84	146.34	148.83	152.31
- With insertion of radioactive substance	4203	142.35	143.84	146.34	148.83	152.31
- With removal of foreign body	4204	205.80	207.96	211.56	215.16	220.21
- With excision of tumor	4205	205.80	207.96	211.56	215.16	220.21
Broncho-esophagoscopy +/- biopsy (1 procedure paid/session)	4206	194.55	196.59	200.00	203.40	208.17
Quadroscopy	4209	187.90	189.87	193.16	196.45	201.05
Includes direct laryngoscopy, esophagoscopy, examination of the post nasal space and bronchoscopy.						
Bronchoscopy with Transbronchial lung biopsy - single lobe	4210	196.10	198.06	201.49	204.92	209.72
- each additional lobe	4212		50.00	51.05	52.10	53.50
Bronchoscopy with Transbronchial Needle Aspiration (TBNA) of lymph nodes	4213		198.06	201.49	204.92	209.72

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Endobronchial Ultrasound (EBUS)	4214		269.98	274.66	279.33	285.88
Endoscopy through tracheostomy	4211	50.00	50.53	51.40	52.28	53.50
Suture						
Tracheorrhapy - suture of external wound in trachea	4207	162.25	163.95	166.79	169.63	173.61
Closure of tracheostomy or tracheal fistula	4208	162.25	163.95	166.79	169.63	173.61
LUNGS AND PLEURA						
Incision						
Thoracocentesis						
- Closed drainage - operation and after care (chest tube)	4400	176.80	178.66	181.75	184.84	189.18
- Open drainage - Rib resection and drainage	4401	265.20	267.98	272.63	277.27	283.76
Drainage of lung abscess	4402	389.15	393.24	400.05	406.86	416.39
Exploratory thoracotomy or removal of foreign body	4403	389.15	393.24	400.05	406.86	416.39
Biopsy of pleura or lung	4404	442.00	446.64	454.38	462.11	472.94
Needle biopsy of pleura	2178	39.65	40.07	40.76	41.45	42.43
Excision						
Pneumonectomy	4406	884.00	893.28	908.75	924.22	945.88
Lobectomy	4407	850.85	859.78	874.67	889.56	910.41
Lobectomy and segmental resection	4408	756.80	764.75	777.99	791.23	809.78
Segmental resection	4409	756.80	764.75	777.99	791.23	809.78
Wedge resection	4410	530.40	535.97	545.25	554.53	567.53
Pleurectomy - pleural decortication	4411	618.80	625.30	636.13	646.96	662.12
- with bullous emphysema	4412	617.45	623.93	634.74	645.54	660.67
Thoracoscopy	4413	221.00	223.32	227.19	231.06	236.47
CHEST WALL AND MEDIASTINUM						
Incision						
Mediastinotomy with drainage	4300	432.55	437.09	444.66	452.23	462.83
Reconstruction						
Pectus excavatum - infant	3242	270.25	273.09	277.82	282.55	289.17
- other than infant	3243	540.65	546.33	555.79	565.25	578.50
Excision						
Chest wall tumor involving ribs/cartilage, and reconstruction of chest wall	4302	685.10	692.29	704.28	716.27	733.06
Mediastinal tumor	4303	540.65	546.33	555.79	565.25	578.50
Transaxillary resection 1st rib	4313	508.30	513.64	522.53	531.43	543.88
Surgical Collapse						
Thoracoplasty - one stage	4305	411.60	415.92	423.12	430.33	440.41
- multi-stage, each	4306	259.40	262.12	266.66	271.20	277.56
Pneumolysis - intrapleural	4308	194.55	196.59	200.00	203.40	208.17
- extrapleural	4309	324.40	327.81	333.48	339.16	347.11
Apicolysis - extrafascial (Sembs)	4310	324.40	327.81	333.48	339.16	347.11
- extrapleural	4311	324.40	327.81	333.48	339.16	347.11
Mediastinoscopy	4304	265.20	267.98	272.63	277.27	283.76

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

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VEINS

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Varicose Veins and Ulcers						
Injection of varicose veins - single	4511	10.85	10.96	11.15	11.34	11.61
- multiple at same sitting	4512	46.45	46.94	47.75	48.56	49.70
Sclerotherapy, comprehensive, on referred patients (one leg)	4529	116.20	117.42	119.45	121.49	124.33
Ligation - multiple, one leg	4513	129.75	131.11	133.38	135.65	138.83
Ligation - saphenofemoral or saphenopopliteal junction (one leg)	4514	129.75	131.11	133.38	135.65	138.83
Ligation and stripping of stab avulsions (one leg)						
- Long saphenous vein	4515	216.10	218.37	222.15	225.93	231.23
- with multiple low ligation & excision-ligation of perforators	4516	270.25	273.09	277.82	282.55	289.17
- Short saphenous vein	4517	108.15	109.29	111.18	113.07	115.72
Excision of venous stasis ulcer, and skin graft	4521	216.10	218.37	222.15	225.93	231.23
- with ligation and stripping of stab avulsions (one leg)	4519	324.40	327.81	333.48	339.16	347.11
Subfascial control of perforators, open or by SEPS	4522	324.40	327.81	333.48	339.16	347.11
- with stripping of stab avulsions	4523	432.55	437.09	444.66	452.23	462.83
Recurrent or complicated varicose veins	4518	381.70	385.71	392.39	399.07	408.42
Venous Thrombectomy						
Iliac or femoral vein thrombectomy	4524	514.60	520.00	529.01	538.01	550.62
Interruption of vena cava - transvenous IVC filter	4655	260.00	262.73	267.28	271.83	278.20
Vein Harvesting						
Harvest arm vein (add)	4656	99.28	100.32	102.06	103.80	106.23
Harvest superficial femoral vein (add)	4657	99.28	100.32	102.06	103.80	106.23
Harvest opposite leg vein (add)	4658	82.62	83.49	84.93	86.38	88.40
Venous Wounds						
Suture repair wound of major vein	4528	278.70	281.63	286.50	291.38	298.21
Repair lacerated major vein (eg. femoral, popliteal, subclavian, brachial), or microscopic repair of digital vein	4530	254.34	257.01	261.46	265.91	272.14
- by patch	4531	397.80	401.98	408.94	415.90	425.65
- by vein graft	4532	529.04	534.59	543.85	553.11	566.07
Arteriovenous Procedures						
Repair of AV anomaly	4533	389.15	393.24	400.05	406.86	416.39
Creation of AV fistula	4505	389.15	393.24	400.05	406.86	416.39
Closure/obliteration of AV fistula	4527	61.90	62.55	63.63	64.72	66.23
Portal Hypertension						
Portocaval shunt	4501	756.80	764.75	777.99	791.23	809.78
Distal splenorenal shunt	4525	927.80	937.54	953.78	970.01	992.75
Mesocaval shunt	4503	720.30	727.86	740.47	753.07	770.72
Esopho-gastric devasularization and esophageal transection, (including reanastomosis and splenectomy)	4534	718.52	726.06	738.64	751.21	768.82
Other Venous Procedures						
Venogram	4500	54.05	54.62	55.56	56.51	57.83
Ligation - Jugular vein, internal	4506	162.25	163.95	166.79	169.63	173.61
Ligation - Inferior vena cava, ligation or placation	4508	432.55	437.09	444.66	452.23	462.83

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Ligation - Saphenous	4510	54.00	54.57	55.51	56.46	57.78
Superior vena cava bypass graft	4526	557.45	563.30	573.06	582.81	596.47
Venous anastomosis - Splenorenal	4502	756.80	764.75	777.99	791.23	809.78

ARTERIES

Percutaneous Vascular Procedures						
Arterial cannulation	4599	50.00	51.50	54.00	56.50	60.00
Angiography						
- Carotid	4630	108.15	109.29	111.18	113.07	115.72
- Femoral - unilateral	4631	54.00	54.57	55.51	56.46	57.78
- bilateral	4632	86.45	87.36	88.87	90.38	92.50
- Aortography	4633	108.15	109.29	111.18	113.07	115.72
- Arteriography, selective	4635	108.15	109.29	111.18	113.07	115.72
- Renal Mesenteric arch - per major vessel (add)	4538	20.00	20.21	20.56	20.91	21.40
Operative arteriography - one or more (add)	4536	54.00	54.57	55.51	56.46	57.78
Exposure of major artery for aortography	4634	162.25	163.95	166.79	169.63	173.61
Arterial cannulation for aortography	4636	54.00	54.57	55.51	56.46	57.78
Dilatations and Stents						
Dilatation/Stent of Iliac artery - unilateral	4537	250.46	253.09	257.47	261.86	267.99
Vascular stent (add)	4535	63.80	64.47	65.59	66.70	68.27
Arterial Wounds						
Suture of lacerated major artery of limb	4671	253.48	256.14	260.58	265.01	271.22
Repair of lacerated major artery of limb, or microscopic repair of digital artery (including patch angioplasty)	4670	398.92	403.11	410.09	417.07	426.84
Brachiocephalic Procedures						
Carotid body tumor	4627	648.50	655.31	666.66	678.01	693.90
- with graft	4628	702.75	710.13	722.43	734.73	751.94
- with vessel bypass	4629	756.80	764.75	777.99	791.23	809.78
Carotid endarterectomy	5652	648.50	655.31	666.66	678.01	693.90
- with patch graft	5653	756.80	764.75	777.99	791.23	809.78
- with graft and by-pass shunt	5654	864.95	874.03	889.17	904.31	925.50
Aneurysm repair						
- Carotid	4660	656.56	663.45	674.94	686.43	702.52
- Subclavian	4661	693.88	701.17	713.31	725.45	742.45
- Axillary or Brachial - synthetic graft	4663	540.65	546.33	555.79	565.25	578.50
- vein graft	4664	648.50	655.31	666.66	678.01	693.90
Brachiocephalic arterial bypass with autogenous vein graft	4662	525.24	530.76	539.95	549.14	562.01
- includes Carotid-subclavian, Carotid-axillary, Axillo-axillary, Axillo-brachial, Brachio-distal						
Aorto-Iliac Procedures						
Thoracic aortic aneurysm repair - without bypass with hypothermia	4606	756.80	764.75	777.99	791.23	809.78
- with by-pass	4607	973.05	983.27	1,000.30	1,017.32	1,041.16
Thoraco-abdominal aneurysm repair	4665	1,547.00	1,563.24	1,590.32	1,617.39	1,655.29
- with rupture	4666	1,690.65	1,708.40	1,737.99	1,767.57	1,809.00
Abdominal aortic aneurysm repair	4608	864.95	874.03	889.17	904.31	925.50
- with rupture	4609	973.05	983.27	1,000.30	1,017.32	1,041.16
- Aortic Bifurcation graft	4617	1,064.80	1,075.98	1,094.61	1,113.25	1,139.34
- Reimplantation of inferior mesenteric artery (add)	4654	130.05	131.42	133.69	135.97	139.15

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Thromboendarterectomy	4618	648.50	655.31	666.66	678.01	693.90
Endarterectomy of aorta and/or aortic bifurcation	4619	756.80	764.75	777.99	791.23	809.78
Pelvic aneurysm repair - ligation exclusion	4667	362.50	366.31	372.65	378.99	387.88
- with graft	4668	563.55	569.47	579.33	589.19	603.00
Ilio-femoral bypass	4669	586.00	592.15	602.41	612.66	627.02
Total removal of infected aortic graft (stem and limbs)	4672	734.68	742.39	755.25	768.11	786.11
Partial removal of infected aortic graft (one limb only)	4673	275.20	278.09	282.91	287.72	294.46
Closure of duodenal fistula (add)	4674	101.64	102.71	104.49	106.26	108.75
Visceral Artery Repairs						
Superior mesenteric, celiac, renal, hepatic:						
- Aneurysm repair or bypass for obstruction	4675	454.00	458.77	466.71	474.66	485.78
- Endarterectomy or graft	4676	540.00	545.67	555.12	564.57	577.80
- By-pass to additional artery	4677	I.C.	I.C.	I.C.	I.C.	I.C.
Embolectomy - Mesenteric	4624	450.00	454.73	462.60	470.48	481.50
- Renal	4625	540.65	546.33	555.79	565.25	578.50
Lower Limb Arterial Procedures						
Femoro-popliteal or femoro-femoral or axillo-femoral bypass						
- synthetic graft	4620	540.65	546.33	555.79	565.25	578.50
- vein graft	4621	648.50	655.31	666.66	678.01	693.90
Femoro-distal bypass(eg.anterior or posterial tibial)	4644	702.75	710.13	722.43	734.73	751.94
In situ peripheral vein procedure (add)	4653	247.65	250.25	254.58	258.92	264.99
Femoral or popliteal endarterectomy	4659	607.68	614.06	624.70	635.33	650.22
Peripheral aneurysm repair - lower limb (eg.femoral,popliteal)	4651	605.75	612.11	622.71	633.31	648.15
Peripheral false aneurysm repair	4650	655.25	662.13	673.60	685.06	701.12
Arterioplasty of lower limb artery or vein graft						
- Femoral	4637	324.40	327.81	333.48	339.16	347.11
- Iliac	4638	324.40	327.81	333.48	339.16	347.11
Embolectomy/thrombectomy - Iliac or femoral artery	4623	432.55	437.09	444.66	452.23	462.83
- Transfemoral (bilateral)	4622	648.50	655.31	666.66	678.01	693.90
Limb fasciotomy for ischemia - single	4678	134.47	135.88	138.24	140.59	143.88
- multiple	4679	256.16	258.85	263.33	267.82	274.09
Secondary closure of fasciotomy	4680	77.88	78.70	80.06	81.42	83.33
Composite graft, combining 2 or more conduits (add)	4681	106.72	107.84	109.71	111.58	114.19
Extended profundoplasty						
- to first major branch	4642	432.55	437.09	444.66	452.23	462.83
- to second major branch	4652	572.80	578.81	588.84	598.86	612.90
Exposure of leg vessels for inspection/evaluation, per exposure	4643	108.15	109.29	111.18	113.07	115.72
Sympathectomy						
Transcervical	5980	432.55	437.09	444.66	452.23	462.83
Transaxillary	5981	449.65	454.37	462.24	470.11	481.13
Translumbar	5983	341.80	345.39	351.37	357.35	365.73
Other Vascular Procedures						
Transcervical or transaxillary resection of 1st rib	4313	508.30	513.64	522.53	531.43	543.88
Temporal artery biopsy	4682	75.75	76.55	77.87	79.20	81.05
Closure of lymphatic fistula groin	4683	165.84	167.58	170.48	173.39	177.45
Re-operation after 1 month for failed vascular graft (add)	4684	278.96	281.89	286.77	291.65	298.49
Arteriotomy	4600	75.75	76.55	77.87	79.20	81.05
Transection of artery - peripheral	4603	162.25	163.95	166.79	169.63	173.61
- intra-abdominal or intra-thoracic	4604	216.10	218.37	222.15	225.93	231.23

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Ligation carotid, neck - simple	4639	162.25	163.95	166.79	169.63	173.61
Ligation anterior ethmoid artery for epistaxis	4641	108.15	109.29	111.18	113.07	115.72
HEART AND PERICARDIUM						
Incision						
Atrial or ventricular puncture	4700	43.20	43.65	44.41	45.17	46.22
Biopsy of pericardium - by needle	2181	148.25	149.81	152.40	155.00	158.63
- by thoracotomy	4702	324.40	327.81	333.48	339.16	347.11
Cardiotomy with exploration	4703	540.65	546.33	555.79	565.25	578.50
- with removal of foreign body or tumor	4704	540.65	546.33	555.79	565.25	578.50
- By closed technique	4705	648.50	655.31	666.66	678.01	693.90
- By open technique without bypass	4706	756.80	764.75	777.99	791.23	809.78
- By open technique with bypass	4707	864.95	874.03	889.17	904.31	925.50
Excision						
Pericardiectomy - partial	4708	432.55	437.09	444.66	452.23	462.83
- sub-total	4709	648.50	655.31	666.66	678.01	693.90
Introduction						
Catheterization of heart - right	2126	148.25	149.81	152.40	155.00	158.63
- Hepatic wedge pressure	2127	98.80	99.84	101.57	103.30	105.72
Catheterization of heart - left	2128	197.70	199.78	203.24	206.70	211.54
- insertion of catheter pacemaker	4716	216.10	218.37	222.15	225.93	231.23
Insertion of Portacath	4714	234.00	236.46	240.55	244.65	250.38
Removal of Portacath	4715	204.75	206.90	210.48	214.07	219.08
Insertion of Hickman catheter	4717	142.35	143.84	146.34	148.83	152.31
Removal of Hickman catheter	4713	73.07	73.84	75.12	76.39	78.18
Insertion of Loop recorder	4778	100.00	101.05	102.80	104.55	107.00
Removal of Loop recorder	4779	50.00	50.53	51.40	52.28	53.50
Repair						
Patent ductus arteriosus	4718	540.65	546.33	555.79	565.25	578.50
Pulmonary Stenosis - Open heart - without bypass	4738	756.80	764.75	777.99	791.23	809.78
Pericardial insufflation with powder	4747	324.40	327.81	333.48	339.16	347.11
Suture of wound (heart)	4752	540.65	546.33	555.79	565.25	578.50
Open Cardiac Massage	4753	216.10	218.37	222.15	225.93	231.23
Includes fee for thoracotomy and cardiac massage in addition to fee for operation during which arrest occurred						
PACEMAKER PROCEDURES						
Temporary catheter pacemaker						
Insertion (incl.repositioning w/in 24 hrs) - medical fee	4770	173.95	175.78	178.82	181.86	186.13
- surgical fee	4760	232.10	234.54	238.60	242.66	248.35
- composite fee	4766	307.60	310.83	316.21	321.60	329.13
Repositioning after 24 hrs - medical fee	4771	70.20	70.94	72.17	73.39	75.11
- surgical fee	4761	87.85	88.77	90.31	91.85	94.00
- composite fee	4767	123.00	124.29	126.44	128.60	131.61
Replace - medical fee	4772	116.25	117.47	119.51	121.54	124.39
- surgical fee	4762	175.75	177.60	180.67	183.75	188.05
- composite fee	4768	246.10	248.68	252.99	257.30	263.33

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Permanent pacemaker						
Insertion (epicardial) - medical fee	4773	170.55	172.34	175.33	178.31	182.49
- surgical fee	4769	470.75	475.69	483.93	492.17	503.70
Insertion (transvenous) - medical fee	4777	250.00	252.63	257.00	261.38	267.50
- surgical fee	4763	336.95	340.49	346.38	352.28	360.54
Insertion (dual chamber or ICD) - medical fee	4781		252.63	257.00	261.38	267.50
- surgical fee	4782		408.09	415.16	422.23	432.12
Reposition/replace wire - medical fee	4774	116.25	117.47	119.51	121.54	124.39
- surgical fee	4764	175.75	177.60	180.67	183.75	188.05
Reposition/replace power source - medical fee	4775	116.25	117.47	119.51	121.54	124.39
- surgical fee	4765	232.10	234.54	238.60	242.66	248.35
Reprogram or interrogate pacemaker (including ICD) - medical fee	4776	80.00	80.84	82.24	83.64	85.60

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014

OPERATIONS ON THE HEMATIC AND LYMPHATIC SYSTEMS

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

SPLEEN and BONE MARROW						
Excision						
Splenectomy	4802	552.50	558.30	567.97	577.64	591.18
Biopsy of Marrow, as Independent Procedure						
- Aspiration, needle or punch	2175	75.00	78.75	85.00	91.25	100.00
- Bone button	4804	64.90	65.58	66.72	67.85	69.44
LYMPH CHANNELS						
Excision						
Cystic hygroma	4900	389.15	393.24	400.05	406.86	416.39
Lymphedema						
- Kondolean	4901	389.15	393.24	400.05	406.86	416.39
- Radical Sleeve Excision	4902	648.50	655.31	666.66	678.01	693.90
- Lymphangiogram	4903	194.55	196.59	200.00	203.40	208.17
Excision of Lymph Glands						
Tumor, suprahyoid - unilateral	4904	331.50	334.98	340.78	346.58	354.71
- bilateral	4905	486.50	491.61	500.12	508.64	520.56
Radical neck dissection	4906	648.50	655.31	666.66	678.01	693.90
Dissection of inguinal glands	4907	324.40	327.81	333.48	339.16	347.11
Radical dissection of axillary glands	4908	409.50	413.80	420.97	428.13	438.17
Radical dissection of inguinal glands, including iliac glands	4909	432.55	437.09	444.66	452.23	462.83
Radical dissection of inguinal glands and iliac glands, bilateral	4910	491.35	496.51	505.11	513.71	525.74
Fine Needle Biopsy - cervical, axillary, inguinal	4809	50.95	51.48	52.38	53.27	54.52
Lymph gland Biopsy - cervical, axillary, inguinal	4911	77.20	78.01	79.36	80.71	82.60
- Scalene	4912	137.00	138.44	140.84	143.23	146.59
- Complicated biopsy	4913	I.C.	I.C.	I.C.	I.C.	I.C.
- Sentinel Node biopsy	4805	221.00	223.32	227.19	231.06	236.47
Laparotomy for lymphoma staging	4914	540.65	546.33	555.79	565.25	578.50
Sweat gland excision - axillary, inguinal, perineal (unilateral)	4915	215.00	217.26	221.02	224.78	230.05
- with skin graft(s) and/or rotation flap(s)	4916	315.00	318.31	323.82	329.33	337.05

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014

OPERATIONS ON THE DIGESTIVE SYSTEM

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

MOUTH						
Incision						
Drainage of Ludwig's Angina, complete care	5000	108.15	109.29	111.18	113.07	115.72
Excision						
Biopsy	5001	50.00	50.53	51.40	52.28	53.50
Excision of - simple lesion	5002	43.20	43.65	44.41	45.17	46.22
- leukoplakia, limited	5003	64.90	65.58	66.72	67.85	69.44
Excision of ranula of dermoid cyst	5005	129.75	131.11	133.38	135.65	138.83
Local excision CA floor of mouth, mandible, alveolar margin, or buccal mucosa	5006	194.55	196.59	200.00	203.40	208.17
- With hemimandibulectomy	5007	432.55	437.09	444.66	452.23	462.83
- Either of above combined with unilateral neck dissection	5008	756.80	764.75	777.99	791.23	809.78
Suture						
Closure of antero-oral fistula with flap	5010	324.40	327.81	333.48	339.16	347.11
Closure of antero-oral fistula with radical antrotomy	5011	378.35	382.32	388.94	395.56	404.83
LIPS						
Excision						
Biopsy	5020	50.00	50.53	51.40	52.28	53.50
Lip Shave	5021	129.75	131.11	133.38	135.65	138.83
Excision of simple lesion	5022	64.90	65.58	66.72	67.85	69.44
V-excision for carcinoma	5023	198.90	200.99	204.47	207.95	212.82
- plus radical neck dissection	5024	702.75	710.13	722.43	734.73	751.94
Excision one half lip - plus reconstruction	5025	324.40	327.81	333.48	339.16	347.11
- plus radical neck dissection	5026	756.80	764.75	777.99	791.23	809.78
Total excision of lip	5027	432.55	437.09	444.66	452.23	462.83
- plus radical neck dissection	5028	756.80	764.75	777.99	791.23	809.78
Repair						
Harelip - unilateral	5029	324.40	327.81	333.48	339.16	347.11
TONGUE						
Excision						
Biopsy	5040	50.00	50.53	51.40	52.28	53.50
Local excision of simple tumor	5041	108.15	109.29	111.18	113.07	115.72
Hemiglossectomy	5042	324.40	327.81	333.48	339.16	347.11
- plus radical neck dissection	5043	756.80	764.75	777.99	791.23	809.78
Total glossectomy	5044	389.15	393.24	400.05	406.86	416.39
- plus radical neck dissection	5045	756.80	764.75	777.99	791.23	809.78
Repair						
Minor lacerations	5047	50.00	50.53	51.40	52.28	53.50
TEETH AND GUMS						
Incision						
Drainage of alveolar abscess - general anesthetic	5060	43.20	43.65	44.41	45.17	46.22

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Excision						
Biopsy of gum	5061	50.00	50.53	51.40	52.28	53.50
Mucous cyst	5063	43.20	43.65	44.41	45.17	46.22
Suture						
Suture of gum, secondary	5064	50.00	50.53	51.40	52.28	53.50
PALATE AND UVULA						
Incision						
Palate abscess	5080	75.00	75.79	77.10	78.41	80.25
Excision						
Uvulectomy - independent procedure	5081	43.20	43.65	44.41	45.17	46.22
Biopsy	5082	43.20	43.65	44.41	45.17	46.22
Excision of simple lesion	5083	64.90	65.58	66.72	67.85	69.44
Excision of malignant lesion (with reconstruction)	5084	302.75	305.93	311.23	316.53	323.94
Suture						
Suture of palate wound	5086	32.45	32.79	33.36	33.93	34.72
Uvulopalatopharyngoplasty (includes tonsillectomy, partial palatectomy and pharyngoplasty)	5087	248.65	251.26	255.61	259.96	266.06
SALIVARY GLANDS AND DUCTS						
Incision						
Sialolithotomy - local anesthetic	5100	32.45	32.79	33.36	33.93	34.72
- general anesthetic - simple	5102	64.90	65.58	66.72	67.85	69.44
- complicated	5103	194.55	196.59	200.00	203.40	208.17
Excision						
Submandibular gland	5104	259.40	262.12	266.66	271.20	277.56
Parotid gland - Superficial parotidectomy	5105	566.30	572.25	582.16	592.07	605.94
- Total parotidectomy	5106	718.25	725.79	738.36	750.93	768.53
- plus unilateral radical neck dissection	5107	756.80	764.75	777.99	791.23	809.78
Repair						
Plastic repair of salivary duct	5108	270.25	273.09	277.82	282.55	289.17
Dilation of salivary duct (independent procedure)	5109	43.20	43.65	44.41	45.17	46.22
Probing						
Catheterization for Sialogram	5111	43.20	43.65	44.41	45.17	46.22
RADICAL NECK DISSECTION						
A composite resection of the head and neck for malignancy, neck dissection with reconstruction utilizing local or distant flaps	5112	1,922.10	1,942.28	1,975.92	2,009.56	2,056.65
A composite fee which includes elevation of free island skin and bone flap and closure of defect; preparation of microvascular recipient site for free island skin and bone flap immediately following ablative surgery and when recipient vessels are in the site of ablation; and transplanation of free island skin and bone flap with microvascular anastomosis(es) and bone fixation	5113	1,940.80	1,961.18	1,995.14	2,029.11	2,076.66

* NOTE in most cases this procedure will require 8 hours or more.
Where a procedure requires less than 8 hours, independent consideration will be considered.

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
PHARYNX, ADENOIDS AND TONSILS						
Incision						
Biopsy of Pharynx	5120	77.35	78.16	79.52	80.87	82.76
Drainage of retropharyngeal abscess						
- internal approach	5121	54.00	54.57	55.51	56.46	57.78
- external approach	5122	162.25	163.95	166.79	169.63	173.61
Drainage of peritonsillar abscess, operation only	5123	75.00	75.79	77.10	78.41	80.25
Excision						
Branchial cyst	5124	331.50	334.98	340.78	346.58	354.71
Sinus	5125	432.55	437.09	444.66	452.23	462.83
Pharyngo-esophageal diverticulum	5126	540.65	546.33	555.79	565.25	578.50
Thyroglossal duct cyst	5127	270.25	273.09	277.82	282.55	289.17
Cyst and sinus	5128	389.15	393.24	400.05	406.86	416.39
Tonsillectomy with or without adenoidectomy						
- Under age 16	5129	162.00	163.70	166.54	169.37	173.34
- Adult	5130	162.00	163.70	166.54	169.37	173.34
Excision of Tonsil tag - unilateral	5131	86.45	87.36	88.87	90.38	92.50
Excision of Lingual tonsil (independent procedure)	5132	86.45	87.36	88.87	90.38	92.50
Adenoidectomy without tonsillectomy	5138	54.00	54.57	55.51	56.46	57.78
Post-tonsillectomy/adenoidectomy hemorrage control (same surgeon)	7911	66.30	67.00	68.16	69.32	70.94
Post-tonsillectomy/adenoidectomy hemorrage control (different surgeon)	7912	121.55	122.83	124.95	127.08	130.06
Repair						
Choanal atresia	5133	540.65	546.33	555.79	565.25	578.50
Pouch-Back Flap (Pharyngeal)	5134	486.50	491.61	500.12	508.64	520.56
Suture of exterior wound or injury of pharynx	5136	I.C.	I.C.	I.C.	I.C.	I.C.
Removal of Foreign Body - pharynx	5137	75.00	75.79	77.10	78.41	80.25
ESOPHAGUS						
Incision						
Cervical esophagotomy	5140	324.40	327.81	333.48	339.16	347.11
Thoracic esophagotomy	5141	432.55	437.09	444.66	452.23	462.83
Esophagomyotomy	5142	540.65	546.33	555.79	565.25	578.50
Excision						
Intrathoracic diverticulum	5143	518.95	524.40	533.48	542.56	555.28
Extrathoracic diverticulum - one stage	5144	432.55	437.09	444.66	452.23	462.83
Resection of esophagus - primary anastomosis	5145	756.80	764.75	777.99	791.23	809.78
- With replacement by jejunum, colon, or stomach						
- 1st surgeon	5146	864.95	874.03	889.17	904.31	925.50
- 2nd surgeon	5147	216.10	218.37	222.15	225.93	231.23
Esophago-gastrectomy	5148	864.95	874.03	889.17	904.31	925.50
Esophageal bypass with colon or jejunum	5149	756.80	764.75	777.99	791.23	809.78
Endoscopy						
Esophagoscopy - with or without biopsy (only 1 procedure paid per session)	5150	129.75	134.29	141.85	149.41	160.00
- with removal of foreign body	5151	216.10	218.19	221.66	225.14	230.00
Esophago-bronchoscopy (only 1 procedure paid per session)	5152	194.55	196.59	200.00	203.40	208.17
Esophago-gastroscopy w/Elder-Palmer or similar(only 1 procedure per session)	5153	162.25	163.95	166.79	169.63	173.61

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Repair						
Esophagoplasty (repair of stricture)	5155	648.50	655.31	666.66	678.01	693.90
Esophageal Hiatus Hernia						
- Abdominal approach	5156	540.65	546.33	555.79	565.25	578.50
- Abdominal approach plus cholecystectomy, if indicated	5157	648.50	655.31	666.66	678.01	693.90
- Transthoracic approach	5158	540.65	546.33	555.79	565.25	578.50
Repair of hiatal hernia plus esophagoplasty	5175	756.80	764.75	777.99	791.23	809.78
Fundoplication with or without hiatal hernia repair	5176	540.65	546.33	555.79	565.25	578.50
Ruptured esophagus	5159	518.95	524.40	533.48	542.56	555.28
- Cervical drainage	5160	378.35	382.32	388.94	395.56	404.83
Esophago-gastrostomy	5161	756.80	764.75	777.99	791.23	809.78
Esophago-duodenostomy or jejunostomy	5162	756.80	764.75	777.99	791.23	809.78
Closure of esophageal-tracheal fistula	5163	756.80	764.75	777.99	791.23	809.78
Esophagotomy with ligation of varices	5164	518.95	524.40	533.48	542.56	555.28
Injection of Esophageal varices or bleeding ulcer w/ Esophagoscopy						
- initial	5165	259.40	262.12	266.66	271.20	277.56
- repeat, within 30 days	5177	194.75	196.79	200.20	203.61	208.38
Banding of Esophageal varices (with Esophagoscopy)						
- initial	5166	260.00	262.73	267.28	271.83	278.20
- repeat, within 30 days	5178	194.75	196.79	200.20	203.61	208.38
Gastro-esophageal tamponade	2159	49.35	50.95	53.61	56.27	60.00
Introduction of Mousseau-Barbin tube	5167	324.40	327.81	333.48	339.16	347.11
Dilation						
Indirect						
- Active - with or without guiding string	5168	54.00	54.57	55.51	56.46	57.78
- Passive - using mercury filled tubes	5169	21.55	21.78	22.15	22.53	23.06
With Esophagoscopy						
- Initial	5172	247.00	249.59	253.92	258.24	264.29
- Repeat	5173	64.90	65.58	66.72	67.85	69.44
Dilation of esophagus with fluoroscopic control	5174	75.75	76.55	77.87	79.20	81.05

STOMACH

Incision						
Gastrotomy with removal of tumor or foreign body	5200	324.40	327.81	333.48	339.16	347.11
Pyloromyotomy (Ramstedt's)	5201	464.10	468.97	477.09	485.22	496.59
Simple tube gastrostomy	5202	324.40	327.81	333.48	339.16	347.11
Percutaneous Endoscopic Gastrostomy (PEG)	5240	199.35	201.44	204.93	208.42	213.30
Excision						
Biopsy - by gastroscopy	5204	194.55	196.59	200.00	203.40	208.17
- by gastrotomy	5205	324.40	327.81	333.48	339.16	347.11
Gastrectomy						
- Wedge resection for ulcer	5207	408.85	413.14	420.30	427.45	437.47
- Partial, or subtotal	5208	672.75	679.81	691.59	703.36	719.84
- Plus repair of hiatus hernia	5209	756.80	764.75	777.99	791.23	809.78
- After previous gastro-enterostomy or partial gastrectomy	5210	756.80	764.75	777.99	791.23	809.78
- Antrectomy or subtotal - plus vagotomy	5211	756.80	764.75	777.99	791.23	809.78
- Total Gastrectomy	5212	864.95	874.03	889.17	904.31	925.50
Excision of gastroduodenal lesion (recurrent ulcer)	5213	756.80	764.75	777.99	791.23	809.78
- plus vagotomy	5214	864.95	874.03	889.17	904.31	925.50

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Excision of gastrojejunal lesion (recurrent ulcer)	5215	756.80	764.75	777.99	791.23	809.78
Any of the above, plus cholecystectomy (add)	5217	108.15	109.29	111.18	113.07	115.72
Endoscopy						
Gastroscopy - Diagnostic, biopsy, removal of foreign body	5218	180.20	182.09	185.25	188.40	192.81
- subsequent - within 45 days of initial procedure	5219	71.20	71.95	73.19	74.44	76.18
(IC for full fee may be given under exceptional circumstances)						
Repair						
Pyloroplasty	5220	397.80	401.98	408.94	415.90	425.65
- Pyloroplasty plus vagotomy	5221	514.60	520.00	529.01	538.01	550.62
Gastroduodenostomy, gastrojejunostomy, or gastrogastrostomy	5222	397.80	401.98	408.94	415.90	425.65
- Either of the above plus vagotomy	5223	540.65	546.33	555.79	565.25	578.50
Pyloroplasty or gastroenterostomy with vagotomy and hiatal hernia	5224	648.50	655.31	666.66	678.01	693.90
Vagotomy alone	5225	389.15	393.24	400.05	406.86	416.39
Any of the above plus cholecystectomy (add)	5226	108.15	109.29	111.18	113.07	115.72
Suture						
Closure of gastrostomy or other external fistula of stomach	5227	259.40	262.12	266.66	271.20	277.56
Closure of perforated ulcer or wound of stomach	5228	397.80	401.98	408.94	415.90	425.65
Closure of gastro-colic or gastro-jejunocolic fistula,						
- one stage	5229	756.80	764.75	777.99	791.23	809.78
- two stages, including colostomy	5230	756.80	764.75	777.99	791.23	809.78
Gastric cooling	5231	129.75	131.11	133.38	135.65	138.83
Highly Selective Vagotomy	5232	636.35	643.03	654.17	665.30	680.89
Gastric partition for morbid obesity **(Prior approval required)**	5233	I.C.	I.C.	I.C.	I.C.	I.C.
Gastric partition + all other procedures for morbid obesity **(Prior approval)**	5234	I.C.	I.C.	I.C.	I.C.	I.C.
E.R.C.P.(Endoscopic Retrograde Cholangio-Pancreatography)						
Standard E.R.C.P.	5235	229.05	231.46	235.46	239.47	245.08
E.R.C.P. Biopsy (Additional)	5236	11.65	11.77	11.98	12.18	12.47
E.R.C.P. on a bilroth II	5237	192.80	194.82	198.20	201.57	206.30
E.R.C.P. with biliary tract dilatation	5241	297.00	300.12	305.32	310.51	317.79
E.R.C.P. with sphincterotomy	5238	345.50	349.13	355.17	361.22	369.69
E.R.C.P. Stent placement (Additional)	5239	63.05	63.71	64.82	65.92	67.46
INTESTINES (EXCEPT RECTUM)						
Incision						
Ileostomy for ulcerative colitis	5250	389.15	393.24	400.05	406.86	416.39
Ileostomy or jejunostomy (with tube)	5251	270.25	273.09	277.82	282.55	289.17
1st stage Mikulicz	5252	389.15	393.24	400.05	406.86	416.39
Colostomy	5253	415.35	419.71	426.98	434.25	444.42
- Revision of colostomy for stenosis	5278	129.75	131.11	133.38	135.65	138.83
Cecostomy, as single procedure	5255	270.25	273.09	277.82	282.55	289.17
Enterotomy or colostomy	5256	397.80	401.98	408.94	415.90	425.65
- with operative sigmoidoscopy	5257	432.55	437.09	444.66	452.23	462.83
- multiple with operative sigmoidoscopy	5258	540.65	546.33	555.79	565.25	578.50
Excision						
Biopsy by intubation	5259	64.90	65.58	66.72	67.85	69.44
Local excision of lesion of small intestine incl. duodenal diverticulum	5260	442.00	446.64	454.38	462.11	472.94
Enterectomy with Anastomosis						

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Small Intestine						
- Duodenectomy	5261	530.40	535.97	545.25	554.53	567.53
- Other	5262	530.40	535.97	545.25	554.53	567.53
Small and Large Intestine						
- Terminal ileum, caecum	5263	663.00	669.96	681.56	693.17	709.41
- Terminal ileum, caecum, ascending colon	5264	663.00	669.96	681.56	693.17	709.41
Large Intestine						
- Segmental colectomy	5265	663.00	672.09	687.24	702.38	723.59
- Hemicolectomy, right or left	5266	676.25	683.35	695.19	707.02	723.59
- Total colectomy without perineal resection	5267	994.50	1,004.94	1,022.35	1,039.75	1,064.12
- Total colectomy with ileostomy and abdomino-perineal resection						
- single team	5268	965.25	975.39	992.28	1,009.17	1,032.82
- two team - 1st surgeon	5269	893.25	902.63	918.26	933.89	955.78
- 1st assistant	5270	259.40	262.12	266.66	271.20	277.56
- 2nd assistant	5271	194.55	196.59	200.00	203.40	208.17
Intestinal Obstruction						
- without resection	5272	552.50	558.30	567.97	577.64	591.18
- with resection	5273	663.00	669.96	681.56	693.17	709.41
- Entero-enterostomy	5275	397.80	401.98	408.94	415.90	425.65
- Duodenal atresia, duodeno-jejunostomy	5276	432.55	437.09	444.66	452.23	462.83
Multiple stage procedures, preliminary colostomy, bowel resection, closure of colostomy, etc., to be paid at fee listed for each procedure.						
Repair						
Fecal fistula, radical with resection	5277	594.70	600.94	611.35	621.76	636.33
Revision of ileostomy or colostomy	5278	129.75	131.11	133.38	135.65	138.83
Closure of perforation	5279	346.30	349.94	356.00	362.06	370.54
Closure of perforation with colostomy	5280	432.55	437.09	444.66	452.23	462.83
Cecopexy or sigmoidopexy, independent operation	5281	324.40	327.81	333.48	339.16	347.11
Suture						
Closure of enterostomy plus resection	5282	442.00	446.64	454.38	462.11	472.94
Closure of colostomy	5283	442.00	446.64	454.38	462.11	472.94
Plication of small intestine for adhesions	5284	486.50	491.61	500.12	508.64	520.56
Manipulation						
Dilation of enterostomy, colostomy, etc.						
- with anesthetic	5285	43.20	43.65	44.41	45.17	46.22
- without anesthetic	Visit Fee					
E.E.A. Stapler	5286	52.55	53.10	54.02	54.94	56.23

MECKEL'S DIVERTICULUM AND THE MESENTERY

Excision						
Meckel's diverticulum	5287	324.40	327.81	333.48	339.16	347.11
Local excision of lesion or mesentery	5288	324.40	327.81	333.48	339.16	347.11
Resection of mesentery	5289	324.40	327.81	333.48	339.16	347.11
Mesenteric cyst	5290	324.40	327.81	333.48	339.16	347.11

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
APPENDIX						
Incision						
Drainage of abscess, complete care	5300	270.25	273.09	277.82	282.55	289.17
Excision						
Appendectomy	5301	386.75	390.81	397.58	404.35	413.82
- With gross perforation and peritonitis	5302	519.35	524.80	533.89	542.98	555.70
- With removal of Meckel's Diverticulum	5303	335.00	338.52	344.38	350.24	358.45
RECTUM						
Incision						
Proctotomy - with drainage (perirectal abscess)	5322	129.75	131.11	133.38	135.65	138.83
Pelvic abscess - drainage	5323	162.25	163.95	166.79	169.63	173.61
Excision						
Proctectomy						
- Anterior resection of rectum	5324	994.50	1,004.94	1,022.35	1,039.75	1,064.12
- Perineal resection of rectum	5325	518.95	524.40	533.48	542.56	555.28
- Abdomino-perineal resection plus colostomy						
- Single team	5326	994.50	1,004.94	1,022.35	1,039.75	1,064.12
- Two team - 1st surgeon	5327	936.00	945.83	962.21	978.59	1,001.52
- 1st assistant	5328	442.00	446.64	454.38	462.11	472.94
- 2nd assistant	5329	298.35	301.48	306.70	311.92	319.23
Hartmann's procedure	5330	607.75	625.13	654.09	683.04	723.59
Reanastomosis following Hartmann's procedure	5331	556.00	561.84	571.57	581.30	594.92
Rectal polyp - low, excision or cauterization	5336	64.90	65.58	66.72	67.85	69.44
- upper rectum and sigmoid through sigmoidoscope	5337	132.60	133.99	136.31	138.63	141.88
Biopsy of recto-sigmoid for Hirschprung's disease	5338	86.45	87.36	88.87	90.38	92.50
Electro-coagulation of rectal carcinoma						
- initial	5358	216.10	218.37	222.15	225.93	231.23
- repeat	5359	108.15	109.29	111.18	113.07	115.72
Repair						
Proctostomy	5339	324.40	327.81	333.48	339.16	347.11
Proctopexy - abdominal route	5340	389.15	393.24	400.05	406.86	416.39
Rectal prolapse						
- Excision of mucous membrane	5341	216.10	218.37	222.15	225.93	231.23
- Perineal repair, major	5342	389.15	393.24	400.05	406.86	416.39
- Abdominal approach	5343	518.95	524.40	533.48	542.56	555.28
- Thiersch wire procedure	5344	129.75	131.11	133.38	135.65	138.83
Suture of Rectum						
- External approach	5345	259.40	262.12	266.66	271.20	277.56
- Intraperitoneal approach	5346	432.55	437.09	444.66	452.23	462.83
Closure of Fistula						
- Recto-vaginal	5347	432.55	437.09	444.66	452.23	462.83
- Recto-vesical	5348	432.55	437.09	444.66	452.23	462.83
ANUS						
Clamping of internal hemorrhoid - per haemorrhoid	5349	66.30	67.00	68.16	69.32	70.94
Incision						
Thrombosed haemorrhoid						
- Local anesthetic	5350	40.00	40.42	41.12	41.82	42.80
- General anesthetic	5351	54.00	54.57	55.51	56.46	57.78

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Excision						
Local excision of anal lesion (fissure, malignancy)	5352	129.75	131.11	133.38	135.65	138.83
Hemorrhoidectomy, with or without sigmoidoscopy	5353	198.90	200.99	204.47	207.95	212.82
Anal polyp, hemorrhoidal tags	5354	66.30	67.00	68.16	69.32	70.94
Fistula-in-ano - low level	5355	198.90	200.99	204.47	207.95	212.82
- high level with division of internal sphincter	5356	397.80	401.98	408.94	415.90	425.65
Biopsy, independent operation, general anesthetic	5357	43.20	43.65	44.41	45.17	46.22
Introduction						
Hemorrhoid injection - initial	2169	20.00	20.21	20.56	20.91	21.40
- subsequent	2170	15.05	15.21	15.47	15.73	16.10
Injection for pruritus ani or anal fissure	2171	20.00	20.21	20.56	20.91	21.40
Repair						
Excision of scar, for stenosis	5361	129.75	131.11	133.38	135.65	138.83
Anaplasty for stenosis	5362	259.40	262.12	266.66	271.20	277.56
Repair of anal sphincter	5363	324.40	327.81	333.48	339.16	347.11
- Repair of anal sphincter and anorectal ring	5364	324.40	327.81	333.48	339.16	347.11
Repair of Imperforate Anus/Membranous obstruction of anus	5365	129.75	131.11	133.38	135.65	138.83
Destruction						
Cauterization of fissure	5371	25.00	25.26	25.70	26.14	26.75
Electro-dessication of condylomata	5372	75.00	75.79	77.10	78.41	80.25
Manipulation						
Dilation of anal sphincter under general anesthetic (independent procedure)	5373	21.55	21.78	22.15	22.53	23.06
Anoscopy	5374	10.85	11.47	12.51	13.55	15.00
Partial Lateral internal sphincterotomy	5375	191.00	193.01	196.35	199.69	204.37
LIVER						
Incision						
Hepatotomy						
- Drainage of abscess or cyst	5381	389.15	393.24	400.05	406.86	416.39
- Removal of foreign body	5382	389.15	393.24	400.05	406.86	416.39
- Incision and packing of wound	5383	389.15	393.24	400.05	406.86	416.39
Excision						
Hepatectomy						
- Local excision of lesion	5384	389.15	393.24	400.05	406.86	416.39
- Partial Resection of liver (partial hepatectomy or lobectomy)	5385	864.95	874.03	889.17	904.31	925.50
Biopsy - needle	2177	75.00	75.79	77.10	78.41	80.25
Repair						
Suture of liver wound/rupture	5388	I.C.	I.C.	I.C.	I.C.	I.C.
BILIARY TRACT						
Incision						
Cholecystostomy	5390	324.40	327.81	333.48	339.16	347.11
Cholecysto-enterostomy	5391	389.15	393.24	400.05	406.86	416.39
Cholecysto-enterostomy plus enteroenterostomy	5392	432.55	437.09	444.66	452.23	462.83
Cholecystogastrostomy	5393	389.15	393.24	400.05	406.86	416.39
Choledochoduodenostomy	5394	540.65	546.33	555.79	565.25	578.50
Common duct exploration	5395	518.95	524.40	533.48	542.56	555.28
Common duct exploration with duodenotomy, sphincterotomy	5396	648.50	655.31	666.66	678.01	693.90

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Excision						
Choledochectomy	5398	648.50	655.31	666.66	678.01	693.90
Excision of Ampulla of Vater	5399	594.70	600.94	611.35	621.76	636.33
Cholecystectomy	5400	519.35	527.70	541.61	555.52	575.00
- with operative cholangiogram	5401	574.60	580.63	590.69	600.74	614.82
Cholecystectomy and exploration of bile duct	5402	607.75	614.13	624.77	635.40	650.29
- with operative cholangiogram	5403	663.00	669.96	681.56	693.17	709.41
Cholecystectomy and exploration of bile ducts plus duodenotomy	5404	648.50	655.31	666.66	678.01	693.90
Repair						
Surgical reconstruction of common bile duct	5405	864.95	874.03	889.17	904.31	925.50
Suture						
Closure of fistula	5406	594.70	600.94	611.35	621.76	636.33
PANCREAS						
Incision						
Pancreatotomy	5410	432.55	437.09	444.66	452.23	462.83
Pancreatic abscess or cyst	5411	432.55	437.09	444.66	452.23	462.83
Excision						
Pancreatectomy						
- Local Excision of lesion	5414	518.95	524.40	533.48	542.56	555.28
- Partial - resection of tail	5415	518.95	524.40	533.48	542.56	555.28
Pancreatico-duodenal resection (Whipple type operation)	5416	864.95	874.03	889.17	904.31	925.50
Excision pancreatic cyst	5417	518.95	524.40	533.48	542.56	555.28
Repair						
Pancreatico - gastrostomy	5418	518.95	524.40	533.48	542.56	555.28
- duodenostomy	5419	518.95	524.40	533.48	542.56	555.28
- jejunostomy	5420	518.95	524.40	533.48	542.56	555.28
Marsupialization of cyst	5421	432.55	437.09	444.66	452.23	462.83
ABDOMEN, PERITONEUM AND OMENTUM						
Incision						
Laparotomy, with or without biopsy	5450	386.75	390.81	397.58	404.35	413.82
Peritoneal abscess						
- Drainage of subphrenic abscess	5451	389.15	393.24	400.05	406.86	416.39
- Intra-abdominal abscess, other	5452	397.80	401.98	408.94	415.90	425.65
Drainage of abdominal wall abscess						
- general anesthetic, complete care	5480	64.90	65.58	66.72	67.85	69.44
Removal of foreign body, abdominal wall - gun shot	5453	I.C.	I.C.	I.C.	I.C.	I.C.
Excision						
Desmoid tumor, depending on extent	5454	I.C.	I.C.	I.C.	I.C.	I.C.
Lipectomy, removal of panniculus **(Prior approval required)**	5456	324.40	327.81	333.48	339.16	347.11
Retroperitoneal tumor	5457	518.95	524.40	533.48	542.56	555.28
Mesenteric cyst	5458	324.40	327.81	333.48	339.16	347.11
Endoscopy						
Peritoneoscopy (laparoscopy)	5460	194.50	196.54	199.95	203.35	208.12
Repair						
Herniotomy and Herniorrhaphy						
- Inguinal or femoral, single	5461	309.40	312.65	318.06	323.48	331.06
- Inguinal - single with hydrocele	5462	353.60	357.31	363.50	369.69	378.35

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
- Inguinal and femoral - same side	5463	324.40	327.81	333.48	339.16	347.11
- Sliding hernia	5464	324.40	327.81	333.48	339.16	347.11
- Inguinal or femoral repair by prosthesis or graft	5465	353.60	357.31	363.50	369.69	378.35
Recurrent hernia	5466	442.00	446.64	454.38	462.11	472.94
- Recurrent hernia repair by prosthesis or graft	5467	464.10	468.97	477.09	485.22	496.59
Umbilical hernia - adult	5468	331.50	334.98	340.78	346.58	354.71
- child	5469	205.80	207.96	211.56	215.16	220.21
Enterocele, infant	5470	324.40	327.81	333.48	339.16	347.11
Omphalocoele	5471	432.55	437.09	444.66	452.23	462.83
Diaphragmatic hernia	5472	540.65	546.33	555.79	565.25	578.50
- with prosthesis	5473	594.70	600.94	611.35	621.76	636.33
Incisional or ventral hernia - repair by suture	5474	442.00	446.64	454.38	462.11	472.94
- repair by prosthesis	5475	468.00	472.91	481.10	489.29	500.76
Epigastric hernia	5476	309.40	312.65	318.06	323.48	331.06
Strangulated or Incarcerated Hernia						
- without resection	5477	324.40	327.81	333.48	339.16	347.11
- with resection	5478	585.00	591.14	601.38	611.62	625.95
Suture						
Secondary closure for evisceration	5479	254.15	256.82	261.27	265.71	271.94

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014

OPERATIONS ON THE ENDOCRINE SYSTEM

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

THYROID GLAND

Incision						
Abscess, complete care	5500	129.75	131.11	133.38	135.65	138.83
Excision						
Biopsy - needle (core)	5501	43.20	43.65	44.41	45.17	46.22
- surgical	5502	259.40	262.12	266.66	271.20	277.56
Thyroidectomy						
- Bilateral total thyroidectomy	5503	594.70	600.94	611.35	621.76	636.33
- Total lobectomy	5504	497.25	502.47	511.17	519.87	532.06
- Total lobectomy plus subtotal lobectomy	5505	486.50	491.61	500.12	508.64	520.56
- Sub-total bilateral thyroidectomy	5506	432.55	437.09	444.66	452.23	462.83
- Partial lobectomy	5507	389.15	393.24	400.05	406.86	416.39
Excision of solitary nodule	5508	259.40	262.12	266.66	271.20	277.56
If one of the following procedures carried out with either of the above add:						
- Unilateral limited node dissection	5509	129.75	131.11	133.38	135.65	138.83
- Bilateral limited node dissection	5510	259.40	262.12	266.66	271.20	277.56
- Radical neck dissection unilateral	5511	324.40	327.81	333.48	339.16	347.11

PARATHYROID, THYMUS AND ADRENAL GLANDS

Excision						
Parathyroidectomy - for hyperplasia	5550	594.70	600.94	611.35	621.76	636.33
- parathyroid tumor	5551	518.95	524.40	533.48	542.56	555.28
- if sternal splitting required	5552	648.50	655.31	666.66	678.01	693.90
Thymectomy	5553	648.50	655.31	666.66	678.01	693.90
Adrenal exploration - unilateral	5554	324.40	327.81	333.48	339.16	347.11
Adrenalectomy - unilateral	5555	540.65	546.33	555.79	565.25	578.50

OPERATIONS ON THE NERVOUS SYSTEM

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

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Diagnostic Procedures						
Lumbar puncture	2115	75.00	78.75	85.00	91.25	100.00
Subdural puncture - first	2117	29.65	29.96	30.48	31.00	31.73
- each additional	2118	9.80	9.90	10.07	10.25	10.49
Myelogram - Lumbar	2172	69.05	69.78	70.98	72.19	73.88
Arteriography						
- carotid or vertebral (percutaneous)	4630	108.15	109.29	111.18	113.07	115.72
- carotid or vertebral (cutdown,brachial)	4634	162.25	163.95	166.79	169.63	173.61
- aortic arch study (percutaneous)	4633	108.15	109.29	111.18	113.07	115.72
- aortic arch study (cutdown,brachial)	4634	162.25	163.95	166.79	169.63	173.61
Vascular Procedures						
Carotid endarterectomy	5652	648.50	655.31	666.66	678.01	693.90
- with patch graft	5653	756.80	764.75	777.99	791.23	809.78
- with graft and by-pass shunt	5654	864.95	874.03	889.17	904.31	925.50
Trauma						
Scalp laceration						
- simple uncomplicated	3050	50.00	51.50	54.00	56.50	60.00
- extensive, multiple or complicated	3051	I.C.	I.C.	I.C.	I.C.	I.C.
Head Injury (closed) - initial examination & recommendations	5702	60.00	60.63	61.68	62.73	64.20
Skull fracture						
- Non-operative - same as in Head Injury, closed						
- Decompressive Craniotomy						
- Temporal	5710	432.55	437.09	444.66	452.23	462.83
- Subtemporal	5711	648.50	655.31	666.66	678.01	693.90
Extradural hematoma - surgical management	5716	594.70	600.94	611.35	621.76	636.33
Subdural hematoma - with burr holes	5717	594.70	600.94	611.35	621.76	636.33
Vertebral body fracture/dislocation, without cord injury						
Supervision, bed rest only	Visit Fee					
Skull calipers, - visit fee plus	3385	108.15	109.29	111.18	113.07	115.72
Closed reduction, +/- anesthetic, cast, frame, brace, etc.	3384	257.20	259.90	264.40	268.90	275.20
Open reduction with or without internal fixation	3386	617.45	623.93	634.74	645.54	660.67
Open reduction and fusion	3387	648.50	655.31	666.66	678.01	693.90
Open reduction/fusion with Orthopedic surgeon -each surgeon	3388	486.50	491.61	500.12	508.64	520.56
Vertebral body fracture/dislocation, with cord injury						
No operation	Visit Fee					
Skull Calipers, - visit fee plus	3389	108.15	109.29	111.18	113.07	115.72
Closed reduction under Anesthesia	3390	514.60	520.00	529.01	538.01	550.62
Open reduction with or without internal fixation	3391	756.80	764.75	777.99	791.23	809.78
Open reduction and fusion	3392	756.80	764.75	777.99	791.23	809.78
Open reduction/fusion with Orthopaedic surgeon -each surgeon	3393	514.60	520.00	529.01	538.01	550.62
Open reduction and decompression of cord or nerve roots	3394	720.30	727.86	740.47	753.07	770.72

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Brain						
Craniotomy						
- Burr hole and aspiration	5859	540.65	546.33	555.79	565.25	578.50
Spinal Cord						
Laminectomy						
- For excision of neoplasm, hematoma, vascular anomaly, constrictive pachy-meningitis of spinal cord or nerve roots	5900	756.80	764.75	777.99	791.23	809.78
- For decompression of spinal cord or cauda equine	5902	648.50	655.31	666.66	678.01	693.90
- For treatment of extradural abscess	5903	648.50	655.31	666.66	678.01	693.90
Discs						
Lumbar						
- Unilateral	3514	514.60	520.00	529.01	538.01	550.62
- Bilateral, multiple or recurrent	3515	648.50	655.31	666.66	678.01	693.90
Excision of disc with fusion - one surgeon	3519	756.80	764.75	777.99	791.23	809.78
- two surgeons, each	3520	486.50	491.61	500.12	508.64	520.56
Peripheral Nerves						
Exploration of major nerve (median,ulnar,radial,sciatic,etc) +/- neurolysis	5963	216.10	218.37	222.15	225.93	231.23
Removal tumor major peripheral nerve	5964	324.40	327.81	333.48	339.16	347.11
Suture major peripheral nerve	5965	324.40	327.81	333.48	339.16	347.11
Suture small peripheral nerve (digital)	5967	162.25	163.95	166.79	169.63	173.61
Decompression median nerve at wrist (carpal tunnel syndrome)	5968	216.10	218.37	222.15	225.93	231.23
Decompression ulnar nerve at elbow (cubital tunnel syndrome)	5969	216.10	218.37	222.15	225.93	231.23
Transposition of ulnar nerve at elbow	5970	270.25	273.09	277.82	282.55	289.17
Morton's Neuroma, excision	5973	216.10	218.37	222.15	225.93	231.23
Sympathectomy						
- Cervical	5980	432.55	437.09	444.66	452.23	462.83
- Cervicodorsal	5981	449.65	454.37	462.24	470.11	481.13
- Lumbar	5983	341.80	345.39	351.37	357.35	365.73

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OPERATIONS ON THE FEMALE REPRODUCTIVE SYSTEM

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

OBSTETRICAL CARE

Initial prenatal visit	0700	55.25	55.96	57.15	58.34	60.00
Assessment of labour	0701	35.00	37.25	41.00	44.75	50.00
This fee can only be billed once for the period of the assessment. Not applicable if the same physician delivers within 24 hours. Time of day is required.						
Prenatal visit in office	0703	33.00	33.30	33.80	34.30	35.00
Postnatal visit in office	0705	33.00	33.30	33.80	34.30	35.00
Post-partum visit in hospital	0704	35.00	37.25	41.00	44.75	50.00

OBSTETRICAL OPERATIONS

Vaginal Delivery - non-operative	6001	560.00	565.88	575.68	585.48	599.20
Caesarean Section - procedure and post-operative care	6004	560.00	565.88	575.68	585.48	599.20
- Sterilization at time of C-Section, hysterotomy, laparotomy,etc	6005	70.75	71.49	72.73	73.97	75.70
- Caesarean Hysterectomy, subtotal or total	6006	742.15	749.94	762.93	775.92	794.10
Operative delivery other than Caesarean section	6007	560.00	565.88	575.68	585.48	599.20
Surgical or medical induction of labour, consultation/procedure	6008	68.55	69.27	70.47	71.67	73.35
Abortion - complete, under 20 weeks	Visit Fee					
- incomplete, including D & C	6009	138.80	140.26	142.69	145.12	148.52
- therapeutic **(Prior approval required)**	6010	151.20	152.79	155.43	158.08	161.78
Missed abortion, with or without intra-uterine hypertonic solution	6012	151.20	152.79	155.43	158.08	161.78
Repair of third degree laceration, consultation/procedure (includes evacuation of vaginal hematoma and repair)	6013	110.50	111.66	113.59	115.53	118.24
**Retained placenta removal, consultation/procedure	6014	110.50	111.66	113.59	115.53	118.24
Ectopic pregnancy	6015	336.45	339.98	345.87	351.76	360.00
Suture of incompetent cervix during pregnancy	6016	190.95	192.95	196.30	199.64	204.32
Sterilization - postpartum (in addition to obstetrical fee)	6017	257.20	259.90	264.40	268.90	275.20
Amniocentesis	6019	50.90	51.43	52.33	53.22	54.46
Abortion incomplete without Anesthesia or D&C (in hospital)	6021	75.75	76.55	77.87	79.20	81.05
Post coital testing	6025	34.15	34.51	35.11	35.70	36.54
Post-partum vaginal hematoma - evacuation/suture (gen.anesth.)	6947	105.00	106.10	107.94	109.78	112.35
Perineal/Vaginal/Cervical laceration - repair(general anesthesia)	6948	95.00	96.00	97.66	99.32	101.65
Post-partum hemorrhage - surgical management (eg. vessel ligation, compression sutures)	6953	386.75	390.81	397.58	404.35	413.82

**Chargeable by an obstetrician on his own patient when the services of an anesthetist is required.

Fetal Monitoring

Consultation/interpretation of fetal monitoring records	6022	43.20	43.65	44.41	45.17	46.22
External cephalic version with or without tocolysis	6024	121.45	122.73	124.85	126.98	129.95
Ultrasound procedures by Obstetrician	2606	57.00	57.60	58.60	59.59	60.99
Insertion of Intrauterine Pressure Catheter (IUPC)	2601	47.50	48.00	48.83	49.66	50.83
Oxytocin Challenge Test	2602	30.00	30.32	30.84	31.37	32.10

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Scalp Ph Sampling (maximum of 2)	2603	62.00	62.65	63.74	64.82	66.34
Biophysical Profile	2604	57.00	57.60	58.60	59.59	60.99
VULVA						
Incision						
Hymenectomy	6500	54.00	54.57	55.51	56.46	57.78
Abscess of vulva, Bartholin or Skene's gland						
- complete care	6501	55.25	55.83	56.80	57.76	59.12
- Marsupialization or cautery	6502	65.45	66.14	67.28	68.43	70.03
Excision						
Vulvectomy - simple	6503	259.40	262.12	266.66	271.20	277.56
Cyst of Bartholin's gland	6506	132.60	133.99	136.31	138.63	141.88
Condylomata	6508	110.50	111.66	113.59	115.53	118.24
VAGINA						
Incision						
Colpotomy, posterior, drainage or needling	6600	86.45	87.36	88.87	90.38	92.50
Excision						
Local excision of cyst	6601	154.70	156.32	159.03	161.74	165.53
Repair						
Cystocele or Rectocele	6602	215.75	218.02	221.79	225.57	230.85
Cystocele and Rectocele	6603	372.00	375.91	382.42	388.93	398.04
Cystocele, Rectocele and prolapse (Fothergill)	6604	432.55	437.09	444.66	452.23	462.83
Cystocele, Rectocele and excision of cervical stump	6605	432.55	437.09	444.66	452.23	462.83
Paravaginal repair of cystocele	6803	205.00	207.15	210.74	214.33	219.35
Vaginal vault prolapse (post-hysterectomy,vaginal or abdominal)	6606	436.75	441.34	448.98	456.62	467.32
Rectocele and repair of anal sphincter	6607	370.40	374.29	380.77	387.25	396.33
Perineorrhaphy (without rectocele repair)	6608	129.75	131.11	133.38	135.65	138.83
Repair of double vagina	6611	194.55	196.59	200.00	203.40	208.17
Closure of fistula - vesico-vaginal	6612	432.55	437.09	444.66	452.23	462.83
- recto-vaginal	6613	432.55	437.09	444.66	452.23	462.83
- uretero-vaginal	6614	518.95	524.40	533.48	542.56	555.28
Urethral caruncle or prolapse of mucosa	6615	86.45	87.36	88.87	90.38	92.50
Enterocele	6616	395.55	399.70	406.63	413.55	423.24
Retropubic operation for incontinence (Marchetti)	6617	370.40	374.29	380.77	387.25	396.33
Operations for stress incontinence - vaginal	6618	331.50	334.98	340.78	346.58	354.71
- abdominal	6619	442.00	446.64	454.38	462.11	472.94
- combined	6620	663.00	669.96	681.56	693.17	709.41
Transvaginal Tape (TVT) procedure (including cystoscopy)	6639	470.00	474.94	483.16	491.39	502.90
Colposacropexy	6951	558.00	563.86	573.62	583.39	597.06
Sacrospinous vault fixation (add on fee)	6952	95.00	96.00	97.66	99.32	101.65
Manipulation						
Examination +/- dilation - general anesthesia(independent operation)	6622	75.75	76.55	77.87	79.20	81.05
UTERUS AND CERVIX						
Excision						
Diagnostic curettage	6901	103.00	104.08	105.88	107.69	110.21
Myomectomy	6902	370.65	374.54	381.03	387.51	396.60

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Hysterectomy - total, abdominal or vaginal	6903	417.05	421.43	428.73	436.03	446.24
- with cystocele or rectocele repair	6900	560.00	565.88	575.68	585.48	599.20
- with cystocele and rectocele repair	6933	660.00	666.93	678.48	690.03	706.20
Hysterectomy - partial or subtotal, with or without adnexae	6905	308.70	311.94	317.34	322.75	330.31
- with rectocele and/or cystocele repair	6906	411.60	415.92	423.12	430.33	440.41
Laparoscopic Hysterectomy - total, abdominal or vaginal	6958		526.79	535.91	545.03	557.80
Laparoscopic Hysterectomy - partial or subtotal, with or without adnexa	6959		389.93	396.68	403.43	412.89
Septate uterus	6908	411.60	415.92	423.12	430.33	440.41
Cervical polyp, without D&C	6909	31.15	31.48	32.02	32.57	33.33
Amputation of cervix	6910	185.25	187.20	190.44	193.68	198.22
Cervical stump - vaginal	6911	247.00	249.59	253.92	258.24	264.29
- abdominal	6912	308.70	311.94	317.34	322.75	330.31
Biopsy of cervix - independent operation with general anesthesia	6913	51.95	52.50	53.40	54.31	55.59
Introduction						
Insufflation, Rubin's test and D&C	6916	108.15	109.29	111.18	113.07	115.72
Insufflation and endometrial biopsy	6917	64.90	65.58	66.72	67.85	69.44
Hysterosalpingogram	6918	78.10	78.92	80.29	81.65	83.57
I.U.C.D. insertion	6919	70.70	71.44	72.68	73.92	75.65
I.U.C.D. insertion at annual health exam	6939	25.70	25.97	26.42	26.87	27.50
Repair						
Hysteropexy (uterine suspension)	6920	257.20	259.90	264.40	268.90	275.20
- with rectocele and cystocele repair	6922	411.60	415.92	423.12	430.33	440.41
Cervix with or without biopsy	6923	185.25	187.20	190.44	193.68	198.22
Incompetent cervix - any suture repair	6924	154.35	155.97	158.67	161.37	165.15
Repair of inversion of uterus - operative	6925	370.40	374.29	380.77	387.25	396.33
- manual	6926	154.35	155.97	158.67	161.37	165.15
Electro-cautery of cervix - office procedure	6928	32.45	32.79	33.36	33.93	34.72
Biopsy of cervix - office procedure (without colposcopy)	6929	30.85	31.17	31.71	32.25	33.01
Conization of cervix - with D&C	6930	162.25	163.95	166.79	169.63	173.61
- without D&C (LEEP)	6632		60.00	61.26	62.52	64.20
Endometrial biopsy	6931	42.00	42.44	43.18	43.91	44.94
Injection of fissure in ano	6932	21.55	21.78	22.15	22.53	23.06
Colposcopy - without biopsy	6934	79.05	79.88	81.26	82.65	84.58
- with biopsy (includes Pap)	6989		111.05	112.98	114.90	117.59
Artificial insemination	6935	43.20	43.65	44.41	45.17	46.22
Vaporization of endometriosis & treatment of pelvic pain, (including all associated procedures)	6937	320.35	323.71	329.32	334.93	342.77
Surgical procedure for infertility involving tubal blockage at cornua	6938	640.70	647.43	658.64	669.85	685.55
Hysteroscopy - diagnostic	6945	135.00	136.42	138.78	141.14	144.45
- therapeutic, with D&C, +/-polyp removal	6946	188.00	189.97	193.26	196.55	201.16
Endometrial ablation (+/- D&C; +/- hysteroscopy)	6942	380.15	384.14	390.79	397.45	406.76
Hysteroscopic resection of endometrial tumor	6949	420.00	424.41	431.76	439.11	449.40
Omentectomy, infra-colic and infra-gastric	6630	181.80	183.71	186.89	190.07	194.53
Omental biopsy - single or multiple (add-on fee)	6631		50.00	51.05	52.10	53.50
Staging laparotomy for gynecological CA including total hysterectomy/bilateral salpingoophorectomy, bilateral selective pelvic lymphadenectomies, omental biopsies, selective periaortic lymphadenectomy, pelvic washings.	6950	803.45	811.89	825.95	840.01	859.69

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
FALLOPIAN TUBES						
Peritoneoscopy (Laparoscopy)	5460	194.50	196.54	199.95	203.35	208.12
Excision						
Salpingectomy and Salpingo-oophorectomy	6700	323.65	327.05	332.71	338.38	346.31
Repair						
Tubal plastic operation	6701	360.20	363.98	370.29	376.59	385.41
Sterilization	6702	257.20	259.90	264.40	268.90	275.20
Lysis of adhesion	6704	311.60	314.87	320.32	325.78	333.41
Infertility investigation with tubal insufflation	6705	210.50	212.71	216.39	220.08	225.24
Follicular tracking by ultrasound	6710	77.20	78.01	79.36	80.71	82.60
OVARY						
Excision						
Ovarian cyst	6800	308.70	311.94	317.34	322.75	330.31
Paraovarian cyst	6801	308.70	311.94	317.34	322.75	330.31
Oophorocystectomy	6802	308.70	311.94	317.34	322.75	330.31

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014

OPERATIONS ON THE EYE

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Examination under general Anesthesia with or without intubation	7000	54.00	54.57	55.51	56.46	57.78

EYEBALL

Incision						
Goniotomy	7002	324.40	327.81	333.48	339.16	347.11
Excision						
Enucleation	7003	270.25	273.09	277.82	282.55	289.17
- with prosthesis implant	7004	324.40	327.81	333.48	339.16	347.11
Repair						
Evisceration	7005	270.25	273.09	277.82	282.55	289.17
- with implant	7006	324.40	327.81	333.48	339.16	347.11
Removal intraocular foreign body	7007	360.20	363.98	370.29	376.59	385.41

CORNEA

Incision						
Paracentesis	7050	51.35	51.89	52.79	53.69	54.94
Removal embedded foreign body						
- Local anesthetic	7051	35.00	35.37	35.98	36.59	37.45
- General anesthetic	7052	51.35	51.89	52.79	53.69	54.94
Excision						
Keratectomy	7053	324.40	327.81	333.48	339.16	347.11
Excision of dermoid	7054	162.25	163.95	166.79	169.63	173.61
Repair						
Corneal transplant						
- penetrating	7058	668.90	675.92	687.63	699.33	715.72
- Lamellar	7059	514.60	520.00	529.01	538.01	550.62
Suture penetrating wound						
- with excision of iris	7060	324.40	327.81	333.48	339.16	347.11
- without excision of iris	7061	216.10	218.37	222.15	225.93	231.23
Removal of corneal sutures in O.R	7062	49.80	50.32	51.19	52.07	53.29
Corneal retrieval	7063	131.35	132.73	135.03	137.33	140.54
Bandage Contact Lens	7511	83.45	84.33	85.79	87.25	89.29

SCLERA

Excision						
Sclerectomy	7102	360.20	363.98	370.29	376.59	385.41
Suture						
All penetrating wounds	7103	324.40	327.81	333.48	339.16	347.11

IRIS AND CILIARY BODY

Incision						
*Iridectomy	7150	257.20	259.90	264.40	268.90	275.20
Iridencleisis	7151	324.40	327.81	333.48	339.16	347.11
Division of anterior synechia following penetrating keratoplasty	7152	162.25	163.95	166.79	169.63	173.61

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Destruction						
Diathermy of Ciliary body	7153	216.10	218.37	222.15	225.93	231.23
Anterior chamber open evacuation of clot	7156	324.40	327.81	333.48	339.16	347.11
Iridencysis	7160	318.35	321.69	327.26	332.83	340.63
Trabeculoplasty	7161	336.70	340.24	346.13	352.02	360.27
Anterior Vitrectomy	7162	300.55	303.71	308.97	314.23	321.59

*Note - Fee applies to laser as well as surgical iridectomy.
Repeat procedure not payable within 30 days.

LENS

Incision						
Capsulotomy	7202	205.80	207.96	211.56	215.16	220.21
Excision						
Cataract						
- Senile	7203	458.35	463.16	471.18	479.20	490.43
- Congenital	7204	484.40	489.49	497.96	506.44	518.31
- Traumatic	7205	484.40	489.49	497.96	506.44	518.31
Extraction of dislocated lens	7206	484.40	489.49	497.96	506.44	518.31
Severance of Vitreous Strands (Yag Laser)	7208	156.35	157.99	160.73	163.46	167.29
Cataract Extraction with Intra-ocular Lens Insertion	7210	555.55	555.55	555.55	555.55	555.55
Secondary Lens Insertion	7211	333.05	336.55	342.38	348.20	356.36
Reposition of Intra-ocular Lens	7212	159.05	160.72	163.50	166.29	170.18
Removal of Intra-ocular Lens	7213	279.90	282.84	287.74	292.64	299.49

RETINA

Re-attachment of retina and choroid						
- Simple coagulation (diathermy)	7250	432.55	437.09	444.66	452.23	462.83
- Photocoagulation	7251	411.60	415.92	423.12	430.33	440.41
- Cryopexy	7252	411.60	415.92	423.12	430.33	440.41
- Non-circling tube or buckle procedures, including operations in which silicone is implanted to produce a non-permanent small choroidal elevation	7253	648.50	655.31	666.66	678.01	693.90
- For circling tube, as a first operation	7254	648.50	655.31	666.66	678.01	693.90
- Previously untreated retinal detachments, including scleral resection	7255	648.50	655.31	666.66	678.01	693.90
- Secondary operations after an unsuccessful operation or for a fresh detachment after a previously successful operation, including an encircling tube	7256	864.95	874.03	889.17	904.31	925.50
Pneumatic Retinopexy	7259		660.18	660.18	660.18	660.18
- repeat same eye within 30 days	7260		330.09	330.09	330.09	330.09
Independent Procedures						
- Photocoagulation	7257	257.20	259.90	264.40	268.90	275.20
- Cryopexy	7258	257.20	259.90	264.40	268.90	275.20
Fluorescein / Digital Angiography	7510	57.05	57.65	58.65	59.65	61.04

EXTRAOCULAR MUSCLES

Repair						
Strabismus Procedures						
- one or more than one muscle, one or both eyes	7300	308.70	311.94	317.34	322.75	330.31
- subsequent operation by same surgeon within 6 months	7301	162.25	163.95	166.79	169.63	173.61

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
- Adjustable Suture Technique	7302	318.35	321.69	327.26	332.83	340.63
ORBIT						
Incision						
Drainage of abscess	7350	216.10	218.37	222.15	225.93	231.23
Lateral orbiotomy, Kronlein procedure	7351	540.65	546.33	555.79	565.25	578.50
Excision						
Tumor - orbital	7352	378.35	382.32	388.94	395.56	404.83
- lacrimal gland	7353	378.35	382.32	388.94	395.56	404.83
Exenterations, with or without major plastic repair	7354	432.55	437.09	444.66	452.23	462.83
Biopsy	7355	108.15	109.29	111.18	113.07	115.72
Repair						
Orbital fracture, open reduction rim wall fracture (zygomatic fract/disloc)	7356	324.40	327.81	333.48	339.16	347.11
Blowout fracture of floor	7357	378.35	382.32	388.94	395.56	404.83
Secondary repair of blowout fracture by combined or orbital approach	7358	594.70	600.94	611.35	621.76	636.33
EYELIDS						
Incision						
Drainage of abscess - local anesthetic	7400	35.00	35.37	35.98	36.59	37.45
Excision						
Chalazion - single or multiple - complete care						
- local anesthetic	7402	43.40	43.86	44.62	45.37	46.44
- general anesthetic	7403	54.00	54.57	55.51	56.46	57.78
Epilation by Hyfurcator, electrolysis	7404	21.55	21.78	22.15	22.53	23.06
Lid Tumors						
- very minor	7405	32.45	32.79	33.36	33.93	34.72
- minor	7406	154.35	155.97	158.67	161.37	165.15
- intermediate	7407	270.25	273.09	277.82	282.55	289.17
- major	7408	378.35	382.32	388.94	395.56	404.83
- extensive major	7409	540.65	546.33	555.79	565.25	578.50
Repair						
Ptosis **(Prior approval required)**	7410	324.40	327.81	333.48	339.16	347.11
- secondary repair **(Prior approval required)**	7411	540.65	546.33	555.79	565.25	578.50
Blepharoplasty **(Prior approval required)**						
- excision of skin, with or without muscle, per lid	7430	133.25	134.65	136.98	139.31	142.58
- with removal of orbital fat, +/-lid fold reconstruction/graft	7431	174.00	175.83	178.87	181.92	186.18
Districhiasis - unilateral	7412	324.40	327.81	333.48	339.16	347.11
Trichiasis, surgical repair by transplantation	7413	I.C.	I.C.	I.C.	I.C.	I.C.
Entropion, other than Zeigler puncture	7414	325.00	328.41	334.10	339.79	347.75
Ectropion, other than Zeigler puncture	7415	324.40	327.81	333.48	339.16	347.11
Laceration, full thickness, including margin						
- less than 2cm	7421	162.25	163.95	166.79	169.63	173.61
- greater than 2cm	7417	324.40	327.81	333.48	339.16	347.11
Suture						
Tarsorrhaphy	7418	108.15	109.29	111.18	113.07	115.72
Double adhesion	7419	162.25	163.95	166.79	169.63	173.61
Treatment of Trichiasis by electrolysis in the O.R. or by laser oblation of hair follicles	7420	49.80	50.32	51.19	52.07	53.29

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
CONJUNCTIVA						
Removal of foreign body - office call fee						
Excision						
Pterygium - unilateral with conjunctival autograph	7450	210.00	212.21	215.88	219.56	224.70
Peritomy - unilateral	7451	75.75	76.55	77.87	79.20	81.05
Biopsy	7452	32.45	32.79	33.36	33.93	34.72
Repair						
Plastic repair - depending on extent	7453	I.C.	I.C.	I.C.	I.C.	I.C.
LACRIMAL TRACT						
Incision						
Daryocystotomy - general anesthetic	7500	54.00	54.57	55.51	56.46	57.78
Excision						
Dacryocystectomy	7502	270.25	273.09	277.82	282.55	289.17
Introduction						
Catheterization or irrigation of duct	Visit Fee					
Repair						
Lacerated canaliculus	7503	216.10	218.37	222.15	225.93	231.23
Dacrocystorrhinostomy	7504	432.55	437.09	444.66	452.23	462.83
Manipulation						
Dilation of punctum	Visit Fee					
Probing and dilation of duct - Office precedure	Visit Fee					
- General anesthetic - initial or repeat, unilateral or bilateral	7505	54.00	57.15	62.40	67.65	75.00
Three snip procedure for ectropion of the lower lacrimal punctums (bilateral)	7512	61.95	62.60	63.68	64.77	66.29

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014

OPERATIONS ON THE EAR

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

EXTERNAL EAR

Incision						
Drainage of abscess or hematoma of auricle or external ear canal						
- local anesthetic	7700	75.00	75.79	77.10	78.41	80.25
- general anesthetic	7701	54.00	54.57	55.51	56.46	57.78
Excision						
Biopsy of ear	7702	75.00	75.79	77.10	78.41	80.25
Local excision of lesion on ear	7703	54.00	54.57	55.51	56.46	57.78
Partial excision of ear	7704	162.25	163.95	166.79	169.63	173.61
Complete excision or amputation of ear	7705	216.10	218.37	222.15	225.93	231.23
Radical excision of malignant lesion of external ear canal	7706	432.55	437.09	444.66	452.23	462.83
Excision of pre-auricular sinus, simple - local anesthetic	7720	76.23	77.03	78.36	79.70	81.57
- general anesthetic	7721	152.46	154.06	156.73	159.40	163.13
Excision of ear canal Exostosis - single	7913	282.41	285.38	290.32	295.26	302.18
- multiple	7914	497.25	502.47	511.17	519.87	532.06
Endoscopy						
Removal of foreign body from external ear canal						
- simple	7707	35.00	35.37	35.98	36.59	37.45
- under general anesthetic	7708	54.00	54.57	55.51	56.46	57.78
Repair						
Reconstruction of ear with graft of skin/cartilage **(Prior approval required)**	7710	I.C.	I.C.	I.C.	I.C.	I.C.
Construction of ear canal for congenital atresia	7711	756.80	764.75	777.99	791.23	809.78
Removal of plastic drainage tubes	7712	19.35	19.55	19.89	20.23	20.70
Removal of plastic drainage tubes under general anesthetic	7713	48.10	48.61	49.45	50.29	51.47
Fibreoptic endoscopy	7714	18.20	18.39	18.71	19.03	19.47

MIDDLE EAR

Incision						
Myringotomy (without after care) - local anesthetic	7800	32.45	32.79	33.36	33.93	34.72
- general anesthetic	7801	64.90	65.58	66.72	67.85	69.44
Myringotomy (operative Microscope) and insertion of prosthesis	7802	103.00	104.08	105.88	107.69	110.21
Aspiration of serous otitis	7803	21.55	21.78	22.15	22.53	23.06
Excision						
Mastoidectomy - simple, unilateral	7804	324.40	327.81	333.48	339.16	347.11
- Radical or modified radical, unilateral	7805	540.65	546.33	555.79	565.25	578.50
Removal of middle ear polyp by snare (not including post-op care)	7806	43.20	43.65	44.41	45.17	46.22
Repair						
Revision of radical mastoid cavity	7807	540.65	546.33	555.79	565.25	578.50
Stapes mobilization	7808	540.65	546.33	555.79	565.25	578.50
Stapedectomy	7809	756.80	764.75	777.99	791.23	809.78
Myringoplasty	7811	324.40	327.81	333.48	339.16	347.11
Tympanoplasty	7812	617.45	623.93	634.74	645.54	660.67
Facial nerve decompression	7813	540.65	546.33	555.79	565.25	578.50
Facial nerve graft	7814	648.50	655.31	666.66	678.01	693.90

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Middle ear exploration	7815	324.40	327.81	333.48	339.16	347.11
Cleaning of mastoid cavity	7915	64.41	65.09	66.21	67.34	68.92
INTERNAL EAR						
Excision						
Labyrinthectomy	7901	648.50	655.31	666.66	678.01	693.90
Meatoplasty (may be claimed in addition to a mastoidectomy)	7902	110.45	111.61	113.54	115.48	118.18

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014

OPERATIONS ON THE URINARY SYSTEM

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

KIDNEY AND PERINEPHRIUM

Incision						
Drainage of Kidney abscess, including excision of carbuncle	8000	324.40	327.81	333.48	339.16	347.11
Drainage of perinephric abscess	8001	216.10	218.37	222.15	225.93	231.23
Adrenal exploration, unilateral	8002	324.40	327.81	333.48	339.16	347.11
Renal exploration	8003	324.40	327.81	333.48	339.16	347.11
Nephrostomy	8004	378.35	382.32	388.94	395.56	404.83
Transection of aberrant renal vessel	8006	378.35	382.32	388.94	395.56	404.83
- Secondary operation - additional	8007	108.15	109.29	111.18	113.07	115.72
Pyelolithotomy	8009	378.35	382.32	388.94	395.56	404.83
- Removal of Staghorn calculus	8030	606.90	613.27	623.89	634.51	649.38
Excision						
Adrenalectomy, unilateral	8011	540.65	546.33	555.79	565.25	578.50
Functional tumors (pheochromocytoma)	8012	540.65	546.33	555.79	565.25	578.50
Renal cyst	8013	378.35	382.32	388.94	395.56	404.83
Heminephrectomy	8014	518.95	524.40	533.48	542.56	555.28
- Secondary operation - additional	8015	108.15	109.29	111.18	113.07	115.72
Nephrectomy						
- Ectopic	8016	432.55	437.09	444.66	452.23	462.83
- Lumbar	8017	454.05	458.82	466.76	474.71	485.83
- Transperitoneal	8018	432.55	437.09	444.66	452.23	462.83
- Thoraco-abdominal	8019	648.50	655.31	666.66	678.01	693.90
- Radical nephrectomy - lumbar or thoraco-abdominal	8020	617.45	623.93	634.74	645.54	660.67
- Nephro-ureterectomy	8021	540.65	546.33	555.79	565.25	578.50
- Nephro-ureterectomy with resection of uretero-vesical junction	8022	648.50	655.31	666.66	678.01	693.90
- Secondary operation - additional	8023	108.15	109.29	111.18	113.07	115.72
Donor nephrectomy - unilateral or bilateral	8031	433.45	438.00	445.59	453.17	463.79
Open renal biopsy	8024	324.40	327.81	333.48	339.16	347.11
Needle Biopsy	2176	69.05	69.78	70.98	72.19	73.88
Partial removal and reconstruction of kidney for Renal CA	8010	617.45	623.93	634.74	645.54	660.67
Repair						
Pyeloureteroplasty	8025	486.50	491.61	500.12	508.64	520.56
Nephropexy	8026	324.40	327.81	333.48	339.16	347.11
Symphysiotomy for horseshoe kidney +/- nephropexy & assoc.procedures	8028	518.95	524.40	533.48	542.56	555.28
Renal auto-transplantation	8032	836.05	844.83	859.46	874.09	894.57
Suture						
Ruptured or lacerated kidney - repair or removal	8029	432.55	437.09	444.66	452.23	462.83

URETER

Incision						
Peri-ureteral abscess	8100	216.10	218.37	222.15	225.93	231.23

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Ureterotomy						
- Upper two-thirds	8102	389.15	393.24	400.05	406.86	416.39
- Lower one-third	8103	454.05	458.82	466.76	474.71	485.83
Ureterotomy where ureter has been previously opened						
- Upper two-thirds	8125	412.50	416.83	424.05	431.27	441.38
- Lower one-third	8126	473.15	478.12	486.40	494.68	506.27
Excision						
Ureterectomy	8104	378.35	382.32	388.94	395.56	404.83
- including ureterovesical junction	8105	432.55	437.09	444.66	452.23	462.83
Repair						
Ureterovesical anastomosis, reimplantation	8106	518.95	524.40	533.48	542.56	555.28
Uretero-ileal conduit	8107	648.50	655.31	666.66	678.01	693.90
Uretero-ileal conduit with total cystectomy	8108	973.05	983.27	1,000.30	1,017.32	1,041.16
Uretero-colic anastomosis or transplant	8109	486.50	491.61	500.12	508.64	520.56
- with cystectomy, one stage	8110	778.35	786.52	800.14	813.76	832.83
- with cystectomy, and colostomy	8111	908.05	917.58	933.48	949.37	971.61
Ileo-ureteral substitution	8112	648.50	655.31	666.66	678.01	693.90
Uretero-ureterostomy	8113	540.65	546.33	555.79	565.25	578.50
Ureterostomy,cutaneous-unilateral	8114	324.40	327.81	333.48	339.16	347.11
Uretero-vaginal fistula	8115	518.95	524.40	533.48	542.56	555.28
Ureterolysis for peri-ureteral fibrosis, unilateral	8116	432.55	437.09	444.66	452.23	462.83
Spontaneous or traumataic rupture or transection						
- Immediate - upper two thirds	8118	378.35	382.32	388.94	395.56	404.83
- lower one-third	8119	432.55	437.09	444.66	452.23	462.83
- Late repair - upper two-thirds	8120	432.55	437.09	444.66	452.23	462.83
- lower one-third	8121	486.50	491.61	500.12	508.64	520.56
Bladder flap (BOARI) to include re-implantation of ureter	8127	464.50	469.38	477.51	485.63	497.02
Revision of ureteral-ileal anastomosis	8128	406.50	410.77	417.88	425.00	434.96
Partial resection and revision of ileal conduit	8129	371.70	375.60	382.11	388.61	397.72
Endoscopic procedures						
Calibration and/or dilation (one or both sides)	8122	95.00	96.00	97.66	99.32	101.65
Endoscopic removal of calculus +/- ureteral meatotomy (Basket extraction)	8123	275.00	277.89	282.70	287.51	294.25
Manipulation only, stone not removed	8124	160.00	161.68	164.48	167.28	171.20
Insertion of ureteral stent	8199	260.00	262.73	267.28	271.83	278.20
BLADDER						
Endoscopy - Cystoscopy						
Diagnostic - with or without catheterization of ureters, collection of ureteral specimens of urine, intravenous function test, but not including subsequent hospital care	8200	95.00	96.00	97.66	99.32	101.65
- With biopsy (transurethral)	8202	160.00	161.68	164.48	167.28	171.20
- With electrocoagulation of tumor - single	8203	160.00	161.68	164.48	167.28	171.20
- multiple	8204	200.00	202.10	205.60	209.10	214.00
- With urethral dilation	8205	95.00	97.25	101.00	104.75	110.00
- With bladder dilation	8206	160.00	161.68	164.48	167.28	171.20
- With electrocoagulation of Hunner's ulcers	8207	160.00	161.68	164.48	167.28	171.20
- With electro-excision of tumor(s) including base & adjacent muscle						
- single	8208	288.20	291.23	296.27	301.31	308.37
- multiple	8209	420.00	424.41	431.76	439.11	449.40
- With electrosurgical ureteral meatotomy	8211	180.00	181.89	185.04	188.19	192.60

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- With removal of foreign body or calculus	8212	200.00	202.10	205.60	209.10	214.00
- With litholapaxy, visual or tactile and removal of fragments	8214	247.00	249.59	253.92	258.24	264.29
- With urethral meatotomy and plastic repair	8215	160.00	161.68	164.48	167.28	171.20
- With insertion of ureteral stent	8199	260.00	262.73	267.28	271.83	278.20
- With brush biopsy of the ureter and renal pelvis	8198	200.00	202.10	205.60	209.10	214.00
- With retrograde pyelogram	8242	86.45	87.36	88.87	90.38	92.50
- Wtih intravesical Botox injections (1 or more)	8250		202.10	205.60	209.10	214.00
Incision						
Cystotomy or cystostomy	8216	162.25	163.95	166.79	169.63	173.61
Cystotomy or cystostomy and electro-coagulation of tumor	8217	324.40	327.81	333.48	339.16	347.11
Cystotomy with trochar and cannula and insertion of tube	8218	108.15	109.29	111.18	113.07	115.72
Cystolithotomy	8219	216.10	218.37	222.15	225.93	231.23
Excision						
Cystectomy, partial - for atony	8223	432.55	437.09	444.66	452.23	462.83
- for tumor or diverticulum	8224	486.50	491.61	500.12	508.64	520.56
- with reimplantation of ureter	8225	540.65	546.33	555.79	565.25	578.50
Cystectomy, complete without transplant	8226	540.65	546.33	555.79	565.25	578.50
Cystectomy, complete with colocystoplasty	8227	864.95	874.03	889.17	904.31	925.50
- Second surgeon	8228	216.10	218.37	222.15	225.93	231.23
Excision of urachus and repair of bladder	8229	270.25	273.09	277.82	282.55	289.17
Therapeutic pelvic & retroperitoneal lymphadenectomy for bladder cancer	8243	609.75	616.15	626.82	637.49	652.43
Repair						
Extrophy						
- primary closure	8230	324.40	327.81	333.48	339.16	347.11
- urinary diversion for bladder extrophy and excision of ectopic bladder and repair of abdominal wall	8231	864.95	874.03	889.17	904.31	925.50
- excision of bladder and repair of abdominal wall	8232	324.40	327.81	333.48	339.16	347.11
Repair of ruptured bladder	8233	389.15	393.24	400.05	406.86	416.39
Ileocystoplasty or colocystoplasty	8234	648.50	655.31	666.66	678.01	693.90
Closure of fistula						
- external,suprapubic	8239	259.40	262.12	266.66	271.20	277.56
- Vesicovaginal-transvesical approach	8240	518.95	524.40	533.48	542.56	555.28
- Vesicorectal or vesicosigmoid	8241	432.55	437.09	444.66	452.23	462.83
URETHRA						
Endoscopy						
Biopsy including endoscopy	8300	86.45	87.36	88.87	90.38	92.50
Internal urethrotomy	8301	129.75	131.11	133.38	135.65	138.83
Removal of foreign body or calculus	8302	162.25	163.95	166.79	169.63	173.61
Meatal extraction of foreign body	8303	35.00	35.37	35.98	36.59	37.45
Incision						
Urethrotomy - external	8304	259.40	262.12	266.66	271.20	277.56
Cold Knife (visual) internal urethrotomy	8197	214.00	216.25	219.99	223.74	228.98
Meatotomy and plastic repair	8305	75.75	76.55	77.87	79.20	81.05
Periurethral abscess	8308	54.00	54.57	55.51	56.46	57.78
External sphincterotomy (transurethral)	8335	303.45	306.64	311.95	317.26	324.69
Excision						
Caruncle	8309	75.75	76.55	77.87	79.20	81.05
- with cystoscopy	8310	129.75	131.11	133.38	135.65	138.83
Urethral papilloma, single or multiple	8311	129.75	131.11	133.38	135.65	138.83

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Prolapse	8312	86.45	87.36	88.87	90.38	92.50
- with cystoscopy	8313	129.75	131.11	133.38	135.65	138.83
Stricture - one stage with diversion	8314	389.15	393.24	400.05	406.86	416.39
- two stage - first stage	8315	194.55	196.59	200.00	203.40	208.17
- second stage	8316	389.15	393.24	400.05	406.86	416.39
Diverticulectomy - male or female	8317	270.25	273.09	277.82	282.55	289.17
Posterior urethral valve - by endoscopy	8318	108.15	109.29	111.18	113.07	115.72
- open operation	8319	270.25	273.09	277.82	282.55	289.17
Biopsy	8320	32.45	32.79	33.36	33.93	34.72
Urethrectomy	8334	400.00	404.20	411.20	418.20	428.00
Repair						
Urethral sling	8321	324.40	327.81	333.48	339.16	347.11
Urethrovesical suspension for stress incontinence	8322	389.15	393.24	400.05	406.86	416.39
Urethrovesical suspension with partial cystectomy or vesicopexy	8323	518.95	524.40	533.48	542.56	555.28
Transvaginal Tape (TVT) procedure (including cystoscopy)	6639	470.00	474.94	483.16	491.39	502.90
Urethrolysis (includes cystoscopy)	8339		350.00	357.35	364.70	374.50
Suture						
Rupture - anterior urethra (diversion of urine extra)	8324	259.40	262.12	266.66	271.20	277.56
- posterior urethra - immediate repair	8325	454.05	458.82	466.76	474.71	485.83
- late repair	8326	594.70	600.94	611.35	621.76	636.33
Recto-urethral fistula	8328	432.55	437.09	444.66	452.23	462.83
- with colostomy	8329	540.65	546.33	555.79	565.25	578.50
Urethro-cutaneous fistula	8333	259.40	262.12	266.66	271.20	277.56
Manipulation						
Dilation of stricture - local anesthetic	8330	21.55	21.78	22.15	22.53	23.06
- general anesthetic	8331	54.00	54.57	55.51	56.46	57.78
- filiforms and followers	8332	39.15	39.56	40.25	40.93	41.89
Insertion of artificial urinary sphincter	8336	600.00	606.30	616.80	627.30	642.00
PERCUTANEOUS PROCEDURES						
Percutaneous Renal & Upper Ureteric procedures						
Renal/Upper ureteral stone removal - single stone						
- without electrohydraulic or ultrasonic lithotripsy	8592	467.50	472.41	480.59	488.77	500.23
- with electrohydraulic and/or ultrasonic lithotripsy	8593	560.95	566.84	576.66	586.47	600.22
Renal/Upper ureteral stone removal - multiple stones or staghorn						
- without electrohydraulic or ultrasonic lithrotripsy	8594	560.95	566.84	576.66	586.47	600.22
- with electrohydraulic and/or ultrasonic lithotripsy	8595	747.85	755.70	768.79	781.88	800.20
Repeat through original access within one week for any of the above	8596	374.05	377.98	384.52	391.07	400.23
Percutaneous nephrostomy	8597	149.65	151.22	153.84	156.46	160.13
Percutaneous endopyeloplasty for UPJ obstruction/stenosis	8033	259.40	262.12	266.66	271.20	277.56
Percutaneous Lower Ureteric procedures						
Ureteroscopy only	8588	94.35	95.34	96.99	98.64	100.95
Ureteroscopy with electrohydraulic and/or ultrasonic lithotripsy	8598	560.95	566.84	576.66	586.47	600.22
Ureteroscopy plus basket	8599	467.50	472.41	480.59	488.77	500.23
Extracorporeal Shockwave Lithotripsy (ESWL)						
ESWL - one side, one stone	8040	360.00	363.78	370.08	376.38	385.20
ESWL - one side, multiple stones	8041	540.00	545.67	555.12	564.57	577.80
ESWL - bilateral stones, one stone per side	8042	600.00	606.30	616.80	627.30	642.00
ESWL - bilateral stones, multiple stones per side	8043	875.00	884.19	899.50	914.81	936.25

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014

OPERATIONS ON THE MALE REPRODUCTIVE SYSTEM

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PENIS						
Incision						
Split of prepuce - newborn	8400	10.85	10.96	11.15	11.34	11.61
- child or infant	8401	12.00	12.13	12.34	12.55	12.84
- adult	8402	24.00	24.25	24.67	25.09	25.68
Excision						
Circumcision - infant over 10 days or child under 12 years	8404	129.49	130.85	133.12	135.38	138.55
- adult	8405	129.07	130.43	132.68	134.94	138.10
Condylomata	8406	54.00	54.57	55.51	56.46	57.78
Biopsy	8407	43.20	43.65	44.41	45.17	46.22
Amputation						
- Partial	8408	194.55	196.59	200.00	203.40	208.17
- Partial with inguinal glands dissection - 1 or 2 stages	8409	518.95	524.40	533.48	542.56	555.28
- Total with inguinal and femoral glands dissection - 1 or 2 stages	8410	648.50	655.31	666.66	678.01	693.90
Repair						
Epispadias	8411	324.40	327.81	333.48	339.16	347.11
Hypospadias - including urinary diversion						
- Chordee repair	8412	216.10	218.37	222.15	225.93	231.23
Plastic reconstruction urethra, penile - one stage	8413	324.40	327.81	333.48	339.16	347.11
- two stage	8414	432.55	437.09	444.66	452.23	462.83
Plastic reconstruction penoscrotal or perineal - one stage	8415	432.55	437.09	444.66	452.23	462.83
- two stage	8416	540.65	546.33	555.79	565.25	578.50
Penile prosthesis for impotence **(Prior approval required)**	8417	306.55	309.77	315.13	320.50	328.01
Insertion of hydraulic penile prosthesis	8420	375.45	379.39	385.96	392.53	401.73
Removal of infected penile prosthesis	8422	250.00	252.63	257.00	261.38	267.50
Excision of Peyronie's plaque	8418	195.10	197.15	200.56	203.98	208.76
Nesbitt procedure for Peyronie's disease	8337	540.00	545.67	555.12	564.57	577.80
Intracorporeal injections of vasoactive substances for impotence (Dx & Tx)	8419	14.50	14.65	14.91	15.16	15.52
TESTES						
Incision						
Abscess	8500	54.00	54.57	55.51	56.46	57.78
Excision						
Orchidectomy, unilateral	8501	194.55	196.59	200.00	203.40	208.17
Biopsy - single	8502	54.00	54.57	55.51	56.46	57.78
- with vasography	8503	108.15	109.29	111.18	113.07	115.72
Radical orchidectomy for malignancy - unilateral	8508	300.00	303.15	308.40	313.65	321.00
Repair						
Orchidopexy or exploration, unilateral	8504	370.40	374.29	380.77	387.25	396.33
Reduction of torsion of testis or appendix testis and repair	8505	194.55	196.59	200.00	203.40	208.17
Ruptured testicle	8506	194.55	196.59	200.00	203.40	208.17
Insertion of testicular prosthesis **(Prior approval required for age 18 yrs & over)**	8507	161.00	162.69	165.51	168.33	172.27
Retroperitoneal lymphadenectomy for testicular cancer	8421	I.C.	I.C.	I.C.	I.C.	I.C.

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
EPIDIDYMIS						
Incision						
Abscess	8510	54.00	54.57	55.51	56.46	57.78
Excision						
Spermatocele	8511	194.55	196.59	200.00	203.40	208.17
Epididymectomy, unilateral	8512	194.55	196.59	200.00	203.40	208.17
Anastomosis, epididymovasostomy, unilateral	8513	194.55	196.59	200.00	203.40	208.17
TUNICA VAGINALIS						
Excision						
Hydrocele - unilateral	8520	185.25	187.20	190.44	193.68	198.22
Hydrocele - aspiration	8521	21.55	21.78	22.15	22.53	23.06
SCROTUM						
Incision						
Abscess or hematocele	8530	54.00	54.57	55.51	56.46	57.78
Exploration, unilateral	8531	129.75	131.11	133.38	135.65	138.83
Excision						
Minor lesions, e.g. sebaceous cysts, fibromata, etc	3035	38.00	38.40	39.06	39.73	40.66
Resection of scrotum	8533	216.10	218.37	222.15	225.93	231.23
Suture						
Trauma - laceration, depending on extent and complications	8534	I.C.	I.C.	I.C.	I.C.	I.C.
VAS DEFERENS						
Vasography, single procedure	8540	54.00	54.57	55.51	56.46	57.78
Suture						
Ligation, bilateral (vasectomy)	8543	132.00	133.39	135.70	138.01	141.24
SPERMATIC CORD						
Excision						
Varicocele, unilateral	8550	194.55	196.59	200.00	203.40	208.17
Hydrocele, unilateral	8551	194.55	196.59	200.00	203.40	208.17
SEMINAL VESICLES						
Incision						
Abscess	8560	108.15	109.29	111.18	113.07	115.72
Excision						
Vesiculectomy	8561	540.65	546.33	555.79	565.25	578.50
PROSTATE						
Incision						
Biopsy - perineal open operation	8572	216.10	218.37	222.15	225.93	231.23
- needle, perineal	2182	79.00	79.83	81.21	82.59	84.53
- needle, perineal with cystoscopy	8574	129.75	131.11	133.38	135.65	138.83
- ultrasound guided transrectal (1 billing per procedure)	8582	115.00	117.25	121.00	124.75	130.00
Excision						
Prostatectomy						
Radical prostatovesiculectomy	8577	778.35	786.52	800.14	813.76	832.83

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Suprapubic - one stage or two stages	8578	518.95	524.40	533.48	542.56	555.28
- with diverticulectomy	8579	648.50	655.31	666.66	678.01	693.90
- with partial cystectomy for atony of bladder	8580	648.50	655.31	666.66	678.01	693.90
Retropubic - simple	8581	514.60	520.00	529.01	538.01	550.62
Staging pelvic lymphadenectomy for Carcinoma of prostate	8591	306.55	309.77	315.13	320.50	328.01
Endoscopy						
Transurethral electro-resection (TURP)	8584	514.60	520.00	529.01	538.01	550.62
Resection of bladder neck - adult	8587	324.40	327.81	333.48	339.16	347.11
Change of suprapubic tube	8590	21.55	21.78	22.15	22.53	23.06

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014

DIAGNOSTIC IMAGING

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

These are the fees for consultation between the Certified Diagnostic Radiologist and the referring physician, supervision of x-ray service, fluoroscopy, interpretation of radiographs and fluoroscopic findings. This does not include special procedural fees listed separately in the schedule.

NOTE: Fees for Clinical procedures related to x-ray examination are listed under 'Special Procedural Fee' or under the appropriate Specialty section.

NOTE: Where cine or videotape is used, fee is to be increased by 25%.

NOTE: Non-certified Radiologists are paid at 75% of following fees.

ON-CALL RETAINER - Radiology (Provincial)	1540	300.00	300.00	300.00	300.00	300.00
HOSPITAL ON-CALL RESPONSE FEE - see Preamble 11.E	0060		50.00	80.00	110.00	150.00
ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	28.00	29.80	32.80	35.80	40.00
ADDITIONAL FEE FOR EMERGENCY STUDIES	8859	23.15	23.39	23.80	24.20	24.77
FLUOROSCOPY - per 15 minute block	8860	40.00	40.75	42.00	43.25	45.00
SPECIAL DETENTION - per 15 minute block	8871	40.00	40.75	42.00	43.25	45.00

PLAIN FILMS

HEAD AND NECK

Eye for foreign body	8600	7.30	7.38	7.50	7.63	7.81
Eye for localization additional	8601	19.55	19.76	20.10	20.44	20.92
Optic Foramina	8602	7.30	7.38	7.50	7.63	7.81
Facial bones	8603	10.85	10.96	11.15	11.34	11.61
Mandible	8604	7.30	7.38	7.50	7.63	7.81
Mastoids necessary added views	8605	10.70	10.81	11.00	11.19	11.45
Neck for soft tissues	8606	8.05	8.13	8.28	8.42	8.61
Nasal bones	8607	9.90	10.00	10.18	10.35	10.59
Salivary gland region	8608	7.30	7.38	7.50	7.63	7.81
Sella turcica	8609	5.95	6.01	6.12	6.22	6.37
Sinuses paranasal	8610	9.45	9.55	9.71	9.88	10.11
Skull - routine views	8611	11.00	11.12	11.31	11.50	11.77
Skull - special additional views	8612	5.95	6.01	6.12	6.22	6.37
Teeth - up to half set	8613	5.95	6.01	6.12	6.22	6.37
Teeth - full set	8614	9.85	9.95	10.13	10.30	10.54
Temperomandibular joint	8615	7.80	7.88	8.02	8.15	8.35
Internal auditory meati	8616	9.85	9.95	10.13	10.30	10.54

SPINE AND PELVIS

Cervical spine - routine views	8620	10.75	10.86	11.05	11.24	11.50
Cervical spine - with special added views	8621	12.70	12.83	13.06	13.28	13.59
Thoracic spine	8622	8.80	8.89	9.05	9.20	9.42

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Lumbar spine - routine views	8623	10.75	10.86	11.05	11.24	11.50
Lumbar spine - with special added views	8624	11.75	11.87	12.08	12.28	12.57
Sacrum and/or coccyx	8625	7.30	7.38	7.50	7.63	7.81
Pelvis	8626	8.05	8.13	8.28	8.42	8.61
S.I. Joints	8627	8.05	8.13	8.28	8.42	8.61
Complete spine scoliosis series	8628	18.55	18.74	19.07	19.39	19.85
Ribs each side	8629	7.35	7.43	7.56	7.68	7.86
Sternum	8630	7.30	7.38	7.50	7.63	7.81
EXTREMITIES						
Clavicle	8635	8.15	8.24	8.38	8.52	8.72
Sternoclavicular joints	8636	7.30	7.38	7.50	7.63	7.81
Shoulder	8637	8.15	8.24	8.38	8.52	8.72
Scapula	8638	7.30	7.38	7.50	7.63	7.81
Humerus	8639	8.15	8.24	8.38	8.52	8.72
Elbow	8640	8.15	8.24	8.38	8.52	8.72
Forearm	8641	8.15	8.24	8.38	8.52	8.72
Wrist	8642	8.00	8.08	8.22	8.36	8.56
Hand	8643	8.00	8.08	8.22	8.36	8.56
Finger	8644	3.85	3.89	3.96	4.03	4.12
Acromioclavicular joints with weights	8645	9.85	9.95	10.13	10.30	10.54
Hip	8646	8.05	8.13	8.28	8.42	8.61
Hip pinning - interpretation	8647	8.20	8.29	8.43	8.57	8.77
Hip pinning - supervision and interpretation	8648	29.20	29.51	30.02	30.53	31.24
Femur	8649	8.05	8.13	8.28	8.42	8.61
Orthoroentgenogram	8650	8.70	8.79	8.94	9.10	9.31
Knee	8651	8.25	8.34	8.48	8.63	8.83
Tibia & Fibula	8652	8.15	8.24	8.38	8.52	8.72
Ankle	8653	8.00	8.08	8.22	8.36	8.56
Calcaneus	8654	8.00	8.08	8.22	8.36	8.56
Foot	8655	8.00	8.08	8.22	8.36	8.56
Toe	8656	3.85	3.89	3.96	4.03	4.12
Bone age determination	8657	9.85	9.95	10.13	10.30	10.54
Metastatic series: chest, skull, spine, pelvis & thorax	8658	19.55	19.76	20.10	20.44	20.92
Metabolic bone survey: skull,mandible,hands,knees,abdomen,thorax,pelvis	8659	19.55	19.76	20.10	20.44	20.92
All long bones (additional to metastatic series)	8660	4.65	4.70	4.78	4.86	4.98
Special additional views of extremity	8661	3.40	3.44	3.50	3.55	3.64
Feet - weight bearing	8662	6.20	6.27	6.37	6.48	6.63
CHEST						
Single view	8665	6.05	6.11	6.22	6.33	6.47
Multiple views	8666	10.80	10.91	11.10	11.29	11.56
Fluoroscopy only	8667	11.75	11.87	12.08	12.28	12.57
ABDOMEN						
Survey film	8670	7.35	7.43	7.56	7.68	7.86
Multiple films	8671	10.75	10.86	11.05	11.24	11.50
G.I.TRACT						
Barium swallow - pharynx & esophagus	8675	23.25	23.49	23.90	24.31	24.88

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Upper G.I. series - esophagus, stomach & duodenum	8676	35.90	36.28	36.91	37.53	38.41
Upper G.I. series & small bowel study	8677	50.15	50.68	51.55	52.43	53.66
Colon - barium only	8678	26.50	26.78	27.24	27.71	28.36
Colon - double contrast	8679	37.50	37.89	38.55	39.21	40.13
Cholecystogram	8680	8.70	8.79	8.94	9.10	9.31
T-tube cholangiogram (fluoroscopy additional)	8681	14.65	14.80	15.06	15.32	15.68
Operative cholangiogram	8682	9.85	9.95	10.13	10.30	10.54
Percutaneous transhepatic cholangiogram (interpretation only)	8684	19.55	19.76	20.10	20.44	20.92
- Fluoroscopy additional	8685	9.85	9.95	10.13	10.30	10.54
Hypotonic duodenogram	8686	23.25	23.49	23.90	24.31	24.88
Insertion of a catheter in duodenum for small bowel enema						
- procedure	8688	50.30	50.83	51.71	52.59	53.82
- interpretation	8689	8.50	8.59	8.74	8.89	9.10
G.U. TRACT						
Survey film	8690	4.65	4.70	4.78	4.86	4.98
Retrograde pyelogram	8691	8.70	8.79	8.94	9.10	9.31
Intravenous pyelogram (excluding injection fee)	8692	29.75	30.06	30.58	31.10	31.83
Pyelogram special technique - hypertensive	8695	24.40	24.66	25.08	25.51	26.11
Stress or voiding cystogram	8696	19.55	19.76	20.10	20.44	20.92
Stress or voiding cystogram with urethrogram	8697	23.25	23.49	23.90	24.31	24.88
Urethrogram and/or cystogram (interpretation)	8698	8.70	8.79	8.94	9.10	9.31
T-tube pyelogram (fluoroscopy additional)	8700	8.70	8.79	8.94	9.10	9.31
Renal cystography	8701	11.60	11.72	11.92	12.13	12.41
Retrograde pyelogram - procedure	8702	28.70	29.00	29.50	30.01	30.71
Nephrostogram - procedure	8703	28.70	29.00	29.50	30.01	30.71
- interpretation	8704	8.50	8.59	8.74	8.89	9.10
Catheter Cystourethrogram (CUG)	8711	22.85	23.09	23.49	23.89	24.45
OBSTETRICS AND GYNECOLOGY						
Survey films	8705	4.70	4.75	4.83	4.91	5.03
Hysterosalpingogram	8708	17.60	17.78	18.09	18.40	18.83
VASCULAR						
Peripheral Arteriography & Venography						
- Unilateral	8715	15.60	15.76	16.04	16.31	16.69
- Bilateral	8716	21.65	21.88	22.26	22.64	23.17
Aortography	8717	38.90	39.31	39.99	40.67	41.62
- Each selective examination in addition to aortography	8718	23.25	23.49	23.90	24.31	24.88
Translumbar aortogram	8721	18.45	18.64	18.97	19.29	19.74
Arch aortogram	8727	29.20	29.51	30.02	30.53	31.24
Splenoportogram	8728	23.25	23.49	23.90	24.31	24.88
Lymphangiogram	8729	23.25	23.49	23.90	24.31	24.88
Selective angiography	8730	29.20	29.51	30.02	30.53	31.24
Carotid arteriogram - unilateral	8731	29.20	29.51	30.02	30.53	31.24
- bilateral	8734	38.90	39.31	39.99	40.67	41.62
SPECIAL EXAMINATIONS						
Loopogram	8744	37.25	37.64	38.29	38.94	39.86
Arthrogram	8745	23.25	23.49	23.90	24.31	24.88

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Fistula or sinus with contrast medium (excluding fluoroscopy)	8749	11.75	11.87	12.08	12.28	12.57
Laminography, Planography, Tomography (excluding plane film studies)						
- One plane	8750	17.95	18.14	18.45	18.77	19.21
- Two planes	8751	24.40	24.66	25.08	25.51	26.11
Mammography Screening (bilateral)	8739	14.30	16.45	20.02	23.60	28.60
Mammography - unilateral	8740	15.05	15.21	15.47	15.73	16.10
- bilateral	8741	36.00	36.38	37.01	37.64	38.52
- additional views	8742	3.60	3.64	3.70	3.76	3.85
- tumor localization	8790	140.80	142.28	144.74	147.21	150.66
Stereotactic Breast Biopsy	8743	138.00	139.45	141.86	144.28	147.66
Myelogram - Lumbar	8754	23.25	23.49	23.90	24.31	24.88
- Dorsal	8755	18.45	18.64	18.97	19.29	19.74
- Cervical	8756	18.45	18.64	18.97	19.29	19.74
- Complete	8757	38.60	39.01	39.68	40.36	41.30
Sialogram	8759	11.75	11.87	12.08	12.28	12.57
Fluoroscopy only	8762	11.75	11.87	12.08	12.28	12.57
Interpretation of submitted films	8763	11.75	11.87	12.08	12.28	12.57
ULTRA SOUND PROCEDURES						
B Mode Scan (interpretation) - pelvic	8766	41.31	41.74	42.47	43.19	44.20
B Mode Scan (interpretation) - abdominal	8791	51.31	51.85	52.75	53.64	54.90
B Mode Scan (obstetrics)	8767	48.21	48.72	49.56	50.40	51.58
M Mode Scan interpretation	8768	55.00	55.58	56.54	57.50	58.85
Doppler Interpretation	8769	50.00	50.53	51.40	52.28	53.50
Ultrasonography (procedures done by radiologist)	8770	77.20	78.01	79.36	80.71	82.60
Sonohysterogram - composite fee	8793	85.00	85.89	87.38	88.87	90.95

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC IMAGING EXAMINATIONS

1. These procedural fees are intended to cover compensation for the professional service or placing an instrument and introducing contrast media (except oral or rectal administration for study of the alimentary tract).

2. The same fee may be charged for similar services associated with diagnostic physiological studies of non-radiological nature e.g. catheterization for physiological sampling or the transmission of pressure, sound or electrical waves. In such cases, separate fees are listed for the performance of the physiological studies and their interpretation.

Peripheral angiogram	4630	108.15	109.29	111.18	113.07	115.72
Thoracic or abdominal angiogram - see Vascular fee schedule						
Myelogram - Lumbar	2172	69.05	69.78	70.98	72.19	73.88
Cystogram	2700	32.45	32.79	33.36	33.93	34.72
Arthrogram	2701	32.45	32.79	33.36	33.93	34.72
Bronchogram	2702	43.20	43.65	44.41	45.17	46.22
Sialogram	2705	43.20	43.65	44.41	45.17	46.22
Hysterosalpingogram	2706	64.90	65.58	66.72	67.85	69.44
Percutaneous transhepatic cholangiogram	2708	75.75	76.55	77.87	79.20	81.05
Lymphogram	2709	108.15	109.29	111.18	113.07	115.72

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Percutaneous Procedures						
Percutaneous aspiration of renal cyst under imaging guidance	8771	89.30	90.24	91.80	93.36	95.55
Percutaneous aspiration of renal cyst with sclerosing injection	8772	111.60	112.77	114.72	116.68	119.41
Percutaneous biopsy of solid masses using ultrasound or fluoroscopy	8773	111.60	112.77	114.72	116.68	119.41
Percutaneous nephrostomy tube insertion under ultrasound or fluoroscopy	8774	178.70	180.58	183.70	186.83	191.21
Percutaneous diagnostic tap of fluid collection	8775	89.30	90.24	91.80	93.36	95.55
Percutaneous insertion drainage tube into fluid collection (excl.nephrostomy)	8776	134.05	135.46	137.80	140.15	143.43
Aspiration of renal cyst	8777	111.60	112.77	114.72	116.68	119.41
Percutaneous biliary drainage	8778	260.00	262.73	267.28	271.83	278.20
Change of biliary drainage catheter	8779	90.00	90.95	92.52	94.10	96.30
Biliary stricture dilatation/stent	8780	130.00	131.37	133.64	135.92	139.10
Angiography						
Arch aortogram	8900	106.10	107.21	109.07	110.93	113.53
- One selective off arch	8901	52.95	53.51	54.43	55.36	56.66
- Two selective off arch	8902	106.10	107.21	109.07	110.93	113.53
Abdominal aortogram	8903	106.10	107.21	109.07	110.93	113.53
- One selective off aorta	8904	52.95	53.51	54.43	55.36	56.66
- Two selective off aorta	8905	106.10	107.21	109.07	110.93	113.53
Femoral arteriogram - unilateral	8906	52.95	53.51	54.43	55.36	56.66
- bilateral	8907	84.70	85.59	87.07	88.55	90.63
Arteriogram - Selective	8908	106.10	107.21	109.07	110.93	113.53
Percutaneous needle aspiration biopsy	8909	110.40	111.56	113.49	115.42	118.13
Percutaneous transhepatic cholangiogram	8910	67.80	68.51	69.70	70.88	72.55
Arterial embolization (includes arteriogram)	8911	155.95	157.59	160.32	163.05	166.87
Renins I.V.C.	8912	55.20	55.78	56.75	57.71	59.06
Splenoportogram	8913	66.25	66.95	68.11	69.26	70.89
Biopsy or renal cyst puncture	8914	88.30	89.23	90.77	92.32	94.48
Lymphangiogram - unilateral	8915	190.85	192.85	196.19	199.53	204.21
- bilateral	8916	286.10	289.10	294.11	299.12	306.13
Angioplasty	8917	220.90	223.22	227.09	230.95	236.36
Inferior venacavagram	8918	55.20	55.78	56.75	57.71	59.06
Femoral arteriogram papaverine injection with pressure measurement	8919	68.60	69.32	70.52	71.72	73.40
Myocardial Perfusion Imaging - rest and stress incl.all assoc. IVs,injections,image manipulations & interpretation)	8794	89.00	89.93	91.49	93.05	95.23
NUCLEAR MEDICINE SCANS						
THYROID						
Uptake studies, single or multiple within 2 weeks	8800	27.80	28.09	28.58	29.06	29.75
Uptake plus scan	8801	46.30	46.79	47.60	48.41	49.54
Perchlorate flush	8802	23.15	23.39	23.80	24.20	24.77
Radioactive MIBG scan	8813	54.65	55.22	56.18	57.14	58.48
BLOOD VOLUME						
Plasma volume	8803	15.50	15.66	15.93	16.21	16.59
Red cell volume	8804	15.50	15.66	15.93	16.21	16.59
Repeated plasma volume studies, each	8805	7.80	7.88	8.02	8.15	8.35
Plasma iron clearance and turnover	8806	23.15	23.39	23.80	24.20	24.77
Iron red cell utilization	8807	23.15	23.39	23.80	24.20	24.77

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Red cell survival	8808	30.85	31.17	31.71	32.25	33.01
Sequestration studies	8809	30.85	31.17	31.71	32.25	33.01
Electrolyte spaces	8810	30.85	31.17	31.71	32.25	33.01
Other complex tests	8811	I.C.	I.C.	I.C.	I.C.	I.C.
RENAL FUNCTION						
Pertechnetate Scan	8812	23.25	23.49	23.90	24.31	24.88
Hippuran renogram	8815	27.80	28.09	28.58	29.06	29.75
Renal scan	8816	23.15	23.39	23.80	24.20	24.77
Combination of scan with renogram	8817	46.30	46.79	47.60	48.41	49.54
Other radioactive materials - uptake and clearance	8818	15.50	15.66	15.93	16.21	16.59
Vascular studies using radionuclides	8819	27.80	28.09	28.58	29.06	29.75
Other complex tests	8820	I.C.	I.C.	I.C.	I.C.	I.C.
GASTROINTESTINAL TRACT						
Schilling test	8825	18.60	18.80	19.12	19.45	19.90
Schilling test - repeat after intrinsic factor	8826	9.35	9.45	9.61	9.78	10.00
Liver scan	8828	37.00	37.39	38.04	38.68	39.59
Abdominal scan for ectopic gastric mucosa	8830	37.00	37.39	38.04	38.68	39.59
HIDA scan	8834	55.50	56.08	57.05	58.03	59.39
Gastric emptying study	8814	45.60	46.08	46.88	47.67	48.79
CIRCULATORY SYSTEM						
Spleen scan	8835	37.00	37.39	38.04	38.68	39.59
Cardiac scan	8836	30.85	31.17	31.71	32.25	33.01
Cardiac output	8837	39.19	39.60	40.29	40.97	41.93
Circulation time	8838	15.50	15.66	15.93	16.21	16.59
RESPIRATORY SYSTEM						
Lung scan - ventilation or perfusion	8840	46.25	46.74	47.55	48.35	49.49
- ventilation and perfusion on same day	8841	74.10	74.88	76.17	77.47	79.29
Pulmonary aspiration test	8842	38.00	38.40	39.06	39.73	40.66
SKELETAL SYSTEM						
Bone tumor scans	8850	66.70	67.40	68.57	69.73	71.37
Metabolic studies	8851	30.85	31.17	31.71	32.25	33.01
Bone Densitometry	8852	25.20	25.46	25.91	26.35	26.96
OTHER SYSTEMS						
Gallium 67 for abscess localization	8856	46.30	46.79	47.60	48.41	49.54
Parathyroid scan	8857	46.25	46.74	47.55	48.35	49.49

For multiple isotopes as in liver and pancreas, or lung and liver -
→ Use fee for one study + 50%.

Where electronic memory or data storage and playback is used
and the material studied later for additional information -
→ 50% is added to the fee

SPECT (nuclear scan tomography) - add-on fee	8799		25.00	25.00	25.00	25.00

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
COMPUTED TOMOGRAPHY (CT)						
HEAD - without IV contrast	8925	75.90	76.70	78.03	79.35	81.21
- with IV contrast	8926	85.40	86.30	87.79	89.29	91.38
- with and without IV contrast	8927	107.25	108.38	110.25	112.13	114.76
COMPLEX HEAD* - without IV contrast	8928	75.40	76.19	77.51	78.83	80.68
- with IV contrast	8929	88.05	88.97	90.52	92.06	94.21
- with and without IV contrast	8930	100.60	101.66	103.42	105.18	107.64
*Complex Head CT Scans are meant to be multiplaner (multidirectional) head CT Scans - To include one or more of the following areas: Pituitary Fossa, Posterior Fossa, Internal Auditory Meati, Orbits and related structures, the Temporal bone and its contents and the Tempero Mandibular joints. 8925, 8926 & 8927 not to be billed in addition to those fees for complex head studies.						
NECK - without IV contrast	8931	50.20	50.73	51.61	52.48	53.71
- with IV contrast	8932	75.40	76.19	77.51	78.83	80.68
- with and without IV contrast	8933	88.05	88.97	90.52	92.06	94.21
THORAX - without IV contrast	8934	95.00	96.00	97.66	99.32	101.65
- with IV contrast	8935	97.50	98.52	100.23	101.94	104.33
- with and without IV contrast	8936	109.70	110.85	112.77	114.69	117.38
ABDOMEN - without IV contrast	8937	100.60	101.66	103.42	105.18	107.64
- with IV contrast	8938	102.95	104.03	105.83	107.63	110.16
- with and without IV contrast	8939	114.20	115.40	117.40	119.40	122.19
PELVIS - without IV contrast	8940	100.60	101.66	103.42	105.18	107.64
- with IV contrast	8941	102.95	104.03	105.83	107.63	110.16
- with and without IV contrast	8942	114.20	115.40	117.40	119.40	122.19
EXTREMITIES (one or more) - without IV contrast	8943	50.20	50.73	51.61	52.48	53.71
- with IV contrast	8944	75.40	76.19	77.51	78.83	80.68
- with and without IV contrast	8945	88.05	88.97	90.52	92.06	94.21
SPINE - without IV contrast	8946	100.60	101.66	103.42	105.18	107.64
- with IV contrast	8947	102.95	104.03	105.83	107.63	110.16
- with and without IV contrast	8948	114.20	115.40	117.40	119.40	122.19
CT Guidance of Biopsy	8949	36.20	36.58	37.21	37.85	38.73
CT Scan Aborted	8950	12.75	12.88	13.11	13.33	13.64

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
MAGNETIC RESONANCE IMAGING (MRI)						
HEAD						
Cranial Multisection SE	8975	73.10	73.87	75.15	76.43	78.22
Cranial Repeat, sequence (maximum of 3 repeats)	8976	36.00	36.38	37.01	37.64	38.52
E.N.T.						
ENT Multisection SE	8977	73.10	73.87	75.15	76.43	78.22
ENT Repeat, sequence (maximum of 3 repeats + GAD)	8978	36.00	36.38	37.01	37.64	38.52
THORAX						
Thorax Multisection SE	8979	84.30	85.19	86.66	88.14	90.20
MRI Gating*	8980	25.30	25.57	26.01	26.45	27.07
Thorax Repeat, sequence (maximum of 3 repeats)	8981	42.20	42.64	43.38	44.12	45.15
ABDOMEN						
Abdomen Multisection SE	8982	84.30	85.19	86.66	88.14	90.20
Abdomen Repeat, sequence (maximum of 3 repeats)	8983	42.20	42.64	43.38	44.12	45.15
PELVIS						
Pelvis Multisection SE	8984	84.30	85.19	86.66	88.14	90.20
Pelvis Repeat, sequence (maximum of 4 repeats + GAD)	8985	42.20	42.64	43.38	44.12	45.15
EXTREMITIES						
Extremities Multisection SE	8986	73.10	73.87	75.15	76.43	78.22
Extremities Repeat, sequence (maximum of 3 repeats)	8987	36.00	36.38	37.01	37.64	38.52
SPINE						
Spine(one segment) Multisection SE	8988	67.50	68.21	69.39	70.57	72.23
Spine(one segment) Repeat, sequence (maximum of 3 repeats)	8989	33.70	34.05	34.64	35.23	36.06
MRI Enhancement*(gadolinium) - includes injection/infusion	8990	40.00	40.42	41.12	41.82	42.80
Spectroscopy* - includes injection/infusion	8991	40.00	40.42	41.12	41.82	42.80
Three Dimensional MRI acquisition sequence*, including post-processing (minimum of 60 slices; maximum 1 per patient per day)	8992	62.75	63.41	64.51	65.61	67.14

(* indicates another fee code will be billed with these fee codes)

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014

OUT-OF-PROVINCE REFERRAL FEE CODES

The Out-of-Province Referral Fee Codes are matched to the Department's criteria for approval. The approval criteria were developed in consultation with the P.E.I. Medical Society. Physicians should utilize one of the following fee codes for each out-of-province referral, depending on the reason for the referral:

1) "The insured (in Prince Edward Island)medical and/or hospital service is not available within the province".

Service Not Available - Consultation	9401	0.00	0.00	0.00	0.00	0.00
Service Not Available - Consultation/Investigation	9402	0.00	0.00	0.00	0.00	0.00
Service Not Available - Consultation/Investigation/Treatment	9403	0.00	0.00	0.00	0.00	0.00

2) There exists within Prince Edward Island only 1 medical practitioner in the required specialty".

Only One Specialist - Consultation	9404	0.00	0.00	0.00	0.00	0.00
Only One Specialist - Consultation/Investigation	9405	0.00	0.00	0.00	0.00	0.00
Only One Specialist - Consultation/Investigation/Treatment	9406	0.00	0.00	0.00	0.00	0.00

3) In the opinion of a Prince Edward Island physician and the Medical Director of the Department of Health and Social Services, adequate service is not available within the province".

Adequate Service Not Available* - Consultation	9407	0.00	0.00	0.00	0.00	0.00
Adequate Service Not Available* - Consultation/Investigation	9408	0.00	0.00	0.00	0.00	0.00
Adequate Service Not Available* - Consultation/Investigation/Treatment	9409	0.00	0.00	0.00	0.00	0.00

4) In the opinion of the Medical Director of the Department of Health and Social Services extenuating circumstances exist and are documented that permit services to be provided in another province or territory".

Extenuating Circumstances* - Consultation	9410	0.00	0.00	0.00	0.00	0.00
Extenuating Circumstances* - Consultation/Investigation	9411	0.00	0.00	0.00	0.00	0.00
Extenuating Circumstances* - Consultation/Investigation/Treatment	9412	0.00	0.00	0.00	0.00	0.00

***SUPPORTING DOCUMENTATION/COMMENT MUST BE PROVIDED**

VISITING SPECIALIST SESSIONAL RATE (per hour)	9901	157.25	159.91	164.35	168.79	175.00
INDEPENDENT CONSIDERATION	9999	I.C.	I.C.	I.C.	I.C.	I.C.

Time of day, time spent and comment required.

TARIFF OF FEES

FEE CODE INDEX

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
0002	OBS - DELIVERY ONLY	560.00	565.88	575.68	585.48	599.20
0003	ASSESSMENT OF LABOUR (G.P.)	35.00	37.25	41.00	44.75	50.00
0004	ATTEND. COMPLICATED LABOR/DELIVERY & ASSIST AT C/S	560.00	565.88	575.68	585.48	599.20
0005	ED SESSIONAL TOP-UP FEE FOR GP SALARY LEVEL 1	75.74	76.51	77.80	79.09	80.90
0006	ED SESSIONAL TOP-UP FEE FOR GP SALARY LEVEL 2	73.18	73.93	75.18	76.44	78.19
0007	ED SESSIONAL TOP-UP FEE FOR GP SALARY LEVEL 3	69.36	70.08	71.27	72.47	74.14
0010	NEW PATIENT FEE (G.P.)	150.00	150.00	150.00	150.00	150.00
0015	ONCALL RETAINER - URBAN GP GROUP OF 1	30.00	32.25	36.00	39.75	45.00
0016	ONCALL RETAINER - URBAN GP GROUP OF 2	60.00	64.50	72.00	79.50	90.00
0017	ONCALL RETAINER - URBAN GP GROUP OF 3	90.00	96.75	108.00	119.25	135.00
0018	ONCALL RETAINER - URBAN GP GROUP OF 4	120.00	129.00	144.00	159.00	180.00
0019	ONCALL RETAINER - URBAN GP GROUP OF 5 - 7	150.00	161.25	180.00	198.75	225.00
0020	ON-CALL RETAINER - CORONER (EAST OR WEST)	150.00	150.00	150.00	150.00	150.00
0025	HOSPITALIST TYPE 2 TOP-UP (SALARY LEVEL 1) - 17 BEDS	595.51	604.33	619.01	633.70	654.26
0026	HOSPITALIST TYPE 2 TOP-UP (SALARY LEVEL 2) - 17 BEDS	576.37	585.01	599.41	613.80	633.96
0027	HOSPITALIST TYPE 2 TOP-UP (SALARY LEVEL 3) - 17 BEDS	547.70	556.06	570.03	584.00	603.57
0030	ON-CALL RETAINER - CORRECTIONS	200.00	203.75	210.00	216.25	225.00
0036	ATTENDING DELIVERY FOR NEONATAL RESUSC	110.50	111.93	114.30	116.68	120.00
0037	HOSPITALIST TYPE 2 DAILY SESSIONAL FEE - 09 BEDS		677.00	690.00	702.00	720.00
0038	HOSPITALIST TYPE 1 TOP-UP (SALARY LEVEL 1) - 21 BEDS	595.51	592.33	587.01	581.70	574.26
0039	HOSPITALIST TYPE 1 TOP-UP (SALARY LEVEL 2) - 21 BEDS	576.37	573.01	567.41	561.80	553.96
0040	ON-CALL RETAINER - ALBERTON	260.00	260.00	260.00	260.00	260.00
0041	HOSPITALIST TYPE 1 TOP-UP (SALARY LEVEL 3) - 21 BEDS	547.70	544.06	538.03	532.00	523.57
0042	HOSPITALIST TYPE 1 TOP-UP (SALARY LEVEL 1) - 11 BEDS		310.27	307.48	304.70	300.80
0043	HOSPITALIST TYPE 1 TOP-UP (SALARY LEVEL 2) - 11 BEDS		300.15	297.21	294.28	290.17
0044	HOSPITALIST TYPE 1 TOP-UP (SALARY LEVEL 3) - 11 BEDS		284.98	281.83	278.67	274.25
0045	HOSPITALIST TYPE 2 TOP-UP (SALARY LEVEL 1) - 09 BEDS		319.94	327.71	335.49	346.37
0046	HOSPITALIST TYPE 2 TOP-UP (SALARY LEVEL 2) - 09 BEDS		309.71	317.33	324.95	335.62
0047	HOSPITALIST TYPE 2 TOP-UP (SALARY LEVEL 3) - 09 BEDS		294.38	301.78	309.18	319.53
0050	ADMINISTRATIVE MEETING	28.00	29.80	32.80	35.80	40.00
0060	HOSPITAL ON-CALL RESPONSE FEE		50.00	80.00	110.00	150.00
0100	OBS-INITIAL VISIT	55.25	55.96	57.15	58.34	60.00
0101	HOSPITALIST TYPE 2 DAILY SESSIONAL FEE - 17 BEDS	1,265.00	1,279.25	1,303.00	1,326.75	1,360.00
0102	HOSPITALIST TYPE 1 DAILY SESSIONAL FEE - 11 BEDS		664.00	666.00	668.00	670.00
0103	OBS-PRENATAL VISIT	33.00	33.30	33.80	34.30	35.00
0104	OBS-IN HOSPITAL DAILY CARE	35.00	37.25	41.00	44.75	50.00
0105	OBS-POST NATAL VISIT	33.00	33.30	33.80	34.30	35.00
0106	HOSPITALIST ALL HOSPITALS	68.00	69.80	72.80	75.80	80.00
0107	HOSPITALIST TYPE 1 DAILY SESSIONAL FEE - 21 BEDS	1,265.00	1,267.25	1,271.00	1,274.75	1,280.00
0108	HOSPITALIST ON-CALL RETAINER	150.00	161.25	180.00	198.75	225.00
0110	COMPREHENSIVE OFFICE VISIT	55.25	55.96	57.15	58.34	60.00
0111	HOSPITALIST SHADOW	0.00	0.00	0.00	0.00	0.00
0112	EMERGENCY VISIT - PROVIDERS HOME - DAY	19.35	21.70	25.61	29.52	35.00
0113	LIMITED OFFICE VISIT	33.00	33.30	33.80	34.30	35.00
0114	EMERGENCY VISIT - PROVIDERS HOME - NIGHT	32.85	33.17	33.71	34.25	35.00
0115	WELL BABY CARE	33.00	33.30	33.80	34.30	35.00
0116	EMERGENCY.CALL 6PM-8AM SUNDAY OR HOLIDAYS	32.15	32.58	33.29	34.00	35.00
0118	EMERGENCY OFFICE CALL - DAY	19.35	21.70	25.61	29.52	35.00
0119	EMERGENCY OFFICE CALL - NIGHT	22.15	24.08	27.29	30.50	35.00
0120	EMERGENCY OFFICE VISIT - SUNDAY,HOLIDAYS	19.35	21.70	25.61	29.52	35.00
0121	HOME DAY VISIT	56.00	56.90	58.40	59.90	62.00

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
0123	BASIC OFFICE VISIT (G.P.)	28.00	28.00	28.00	28.00	28.00
0124	HOME VISIT - ADDITIONAL FAMILY MEMBER	28.00	28.45	29.20	29.95	31.00
0125	ADDITIONAL FEE FOR STRICT EMERGENCY	20.00	20.75	22.00	23.25	25.00
0127	DAY VISIT-8AM-9PM-NURSING HOME,ETC	45.70	47.10	49.42	51.75	55.00
0129	EACH ADDITIONAL PATIENT NURSING HOME "ETC"	22.85	23.55	24.71	25.87	27.50
0130	INITIAL HOSPITAL VISIT (DAY)	60.00	66.00	76.00	86.00	100.00
0132	INITIAL HOSPITAL VISIT- ORPHAN PATIENT	60.00	62.25	66.00	69.75	75.00
0133	SUBSEQUENT HOSPITAL VISIT (1st-5th WEEKS)	35.00	37.25	41.00	44.75	50.00
0134	SUBSEQUENT HOSPITAL VISIT (6-13th WEEKS)	20.00	21.50	24.00	26.50	30.00
0135	SUBSEQUENT HOSPITAL VISIT (AFTER 13th WEEK)	20.00	21.50	24.00	26.50	30.00
0136	HOSPITAL DISCHARGE FEE	25.00	27.25	31.00	34.75	40.00
0137	G.P. DERMATOLOGY CONSULTATION		75.00	76.50	78.00	80.00
0139	PALLIATIVE CARE - TELEPHONE CALL	12.00	12.45	13.20	13.95	15.00
0140	SUPPORTIVE CARE	17.50	18.63	20.50	22.38	25.00
0141	HISTORY/PHYSICAL FOR DENTAL	60.00	66.00	76.00	86.00	100.00
0142	CONCURRENT CARE	25.00	28.75	35.00	41.25	50.00
0143	CONTINUING CARE	35.00	37.25	41.00	44.75	50.00
0144	CONVALESC CARE SUBSEQUENT VISIT	18.00	22.80	30.80	38.80	50.00
0145	CONVALESCENT CARE INITIAL VISIT	45.00	49.50	57.00	64.50	75.00
0146	EXAM BY GP REQUEST BY PSYCHIATRIST	60.00	66.00	76.00	86.00	100.00
0147	MEDICAL OFFICER Q.E.H. REHAB	200.00	203.75	210.00	216.25	225.00
0148	COMPREHENSIVE PALLIATIVE CARE CONSULT - GP	122.40	128.04	137.44	146.84	160.00
0149	PALLIATIVE HOME CARE ADMISSION	90.00	94.50	102.00	109.50	120.00
0150	ED SESSIONAL FEE - KINGS COUNTY HOSPITAL	165.00	166.50	169.00	171.50	175.00
0152	ED SESSIONAL FEE - WESTERN HOSPITAL	165.00	166.50	169.00	171.50	175.00
0155	ED SESSIONAL FEE - QUEEN ELIZABETH HOSPITAL	165.00	166.50	169.00	171.50	175.00
0156	ED SESSIONAL FEE - PRINCE COUNTY HOSPITAL	165.00	166.50	169.00	171.50	175.00
0158	AMBULATORY DETOX SERVICE	50.00	57.50	70.00	82.50	100.00
0159	ON-CALL RETAINER FOR SURGICAL ASSISTANT	300.00	300.00	300.00	300.00	300.00
0160	G.P. CONSULTATION	60.00	63.00	68.00	73.00	80.00
0162	G.P. REPEAT CONSULTATION	30.00	31.50	34.00	36.50	40.00
0163	PALLIATIVE CARE INPATIENT - INITIAL VISIT		66.00	76.00	86.00	100.00
0164	PALLIATIVE CARE INPATIENT - SUBSEQUENT VISIT		37.25	41.00	44.75	50.00
0167	REPEAT PALLIATIVE CARE CONSULTATION - GP	61.20	64.02	68.72	73.42	80.00
0168	COMPREHENSIVE ED VISIT - SAT,SUN,HOLIDAY (DAY)	60.00	60.98	62.60	64.23	66.50
0169	COMPREHENSIVE ED VISIT - FRI,SAT,SUN,HOLI (NIGHT)	100.00	101.50	104.00	106.50	110.00
0170	DETENTION	40.00	40.75	42.00	43.25	45.00
0173	PALLIATIVE HOME CARE VISIT	72.00	72.45	73.20	73.95	75.00
0174	ONCALL RETAINER - ONCOLOGY BACKUP	50.00	57.50	70.00	82.50	100.00
0176	DETENTION-SPECIAL CALL	40.00	40.75	42.00	43.25	45.00
0177	ONCALL RETAINER - GP ONCOLOGY	300.00	300.00	300.00	300.00	300.00
0179	ONCALL RETAINER - GP PALLIATIVE	300.00	300.00	300.00	300.00	300.00
0180	LIMITED ED VISIT - MON-FRI (DAY)	28.50	28.95	29.70	30.45	31.50
0181	LIMITED ED VISIT - MON-THURS (NIGHT)	37.25	37.81	38.75	39.69	41.00
0182	RESUSCITATION/15 MIN	90.00	91.50	94.00	96.50	100.00
0183	RESUSCITATION-SECOND 15 MIN	45.00	45.75	47.00	48.25	50.00
0184	RESUS.SUBSEQUENT 15 MIN PERIOD	45.00	45.75	47.00	48.25	50.00
0185	ON-CALL RETAINER - SOURIS, STEWART, O'LEARY, KCMH	150.00	161.25	180.00	198.75	225.00
0186	COMPREHENSIVE ED VISIT - MON-FRI (DAY)	52.00	52.83	54.20	55.58	57.50
0187	COMPREHENSIVE ED VISIT - MON-THURS (NIGHT)	70.00	71.13	73.00	74.88	77.50
0190	LIMITED ED VISIT - SAT,SUN,HOLIDAY (DAY)	33.00	33.53	34.40	35.28	36.50
0191	LIMITED ED VISIT - FRI,SAT,SUN,HOLIDAY (NIGHT)	55.25	56.11	57.55	58.99	61.00
0194	OUT-PATIENT - ADDITIONAL FEE	20.00	20.75	22.00	23.25	25.00
0195	COMPLETE EXAM-OUT-PATIENT-55 YRS AND OVER	60.00	63.75	70.00	76.25	85.00
0196	OBSERVATION (OUT-PATIENT- OVER 8 HOURS)	35.00	37.25	41.00	44.75	50.00
0197	ONCALL RETAINER - HILLSBOROUGH	200.00	203.75	210.00	216.25	225.00
0198	ONCALL RETAINER - MT.HERBERT	200.00	203.75	210.00	216.25	225.00

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
0199	ONCALL RETAINER - GP PSYCHIATRY	150.00	161.25	180.00	198.75	225.00
0213	ANESTHESIA-FOLLOW-UP VISIT	33.00	33.30	33.80	34.30	35.00
0240	RETAINER ANESTHESIA Q.E.H. AND P.C.H.	300.00	300.00	300.00	300.00	300.00
0250	CHRONIC PAIN CONSULTATION	85.00	87.70	92.20	96.70	103.00
0252	CHRONIC PAIN FOLLOW-UP VISIT	33.00	33.30	33.80	34.30	35.00
0260	ANESTHESIA-CONSULTATION	85.00	87.70	92.20	96.70	103.00
0265	ANESTHESIA SESSIONAL FEE - FIRST 30 MIN. BLOCK	87.50	89.00	91.50	94.00	97.50
0266	CANCELLED SURGERY	90.00	91.50	94.00	96.50	100.00
0270	ANESTHESIA (DETENTION)	40.00	40.75	42.00	43.25	45.00
0271	ANESTHESIA-INTENSIVE CARE	85.00	87.25	91.00	94.75	100.00
0276	ANESTHESIA (DETENTION-SPECIAL)	40.00	40.75	42.00	43.25	45.00
0280	ACUTE PAIN SERVICE - INITIATION	85.00	87.70	92.20	96.70	103.00
0296	FIRST DAY/INTENSIVE RESPIRATORY CARE	275.00	277.25	281.00	284.75	290.00
0297	ANESTHESIA CRIT. CARE - DAY 2-30 INCL, PER DAY	160.00	161.20	163.20	165.20	168.00
0298	ANESTHESIA CRIT. CARE - DAY 31 ONWARD, PER DAY	80.00	80.60	81.60	82.60	84.00
0310	COMPREHENSIVE OFFICE VISIT	55.25	55.96	57.15	58.34	60.00
0311	INITIAL OFFICE VISIT WITH REGIONAL EXAM	33.00	33.30	33.80	34.30	35.00
0313	LIMITED OFFICE VISIT	33.00	33.30	33.80	34.30	35.00
0321	DAY HOME VISIT-MONDAY TO SATURDAY	56.00	56.90	58.40	59.90	62.00
0324	HOME VISIT-ADDITIONAL FAMILY MEMBER	28.00	28.45	29.20	29.95	31.00
0325	ADDITIONAL FEE FOR STRICT EMERGENCY	20.00	20.75	22.00	23.25	25.00
0330	INITIAL HOSPITAL VISIT	60.00	66.00	76.00	86.00	100.00
0333	SUBSEQUENT HOSPITAL VISITS (1ST 5 WEEKS)	35.00	37.25	41.00	44.75	50.00
0334	SUBSEQUENT HOSPITAL VISITS (6-13 WEEK)	20.00	21.50	24.00	26.50	30.00
0335	SUBSEQUENT HOSPITAL VISITS (AFTER 13th WEEK)	20.00	21.50	24.00	26.50	30.00
0341	CONTINUING CARE	35.00	37.25	41.00	44.75	50.00
0342	DIRECTIVE CARE	35.00	37.25	41.00	44.75	50.00
0350	TELE-DERMATOLOGY CONSULTATION		40.75	42.00	43.25	45.00
0360	CONSULTATION-INITIAL	85.00	87.70	92.20	96.70	103.00
0362	CONSULTATION-SUBSEQUENT	42.50	43.85	46.10	48.35	51.50
0368	COMPREHENSIVE ED VISIT - SAT,SUN,HOLIDAY (DAY)	60.00	60.98	62.60	64.23	66.50
0369	COMPREHENSIVE ED VISIT - FRI,SAT,SUN,HOLI (NIGHT)	100.00	101.50	104.00	106.50	110.00
0370	DETENTION	40.00	40.75	42.00	43.25	45.00
0371	INTENSIVE CARE	85.00	87.25	91.00	94.75	100.00
0376	DETENTION-SPECIAL CARE	40.00	40.75	42.00	43.25	45.00
0380	LIMITED ED VISIT - MON-FRI (DAY)	28.50	28.95	29.70	30.45	31.50
0381	LIMITED ED VISIT - MON-THURS (NIGHT)	37.25	37.81	38.75	39.69	41.00
0386	COMPREHENSIVE ED VISIT - MON-FRI (DAY)	52.00	52.83	54.20	55.58	57.50
0387	COMPREHENSIVE ED VISIT - MON-THURS (NIGHT)	70.00	71.13	73.00	74.88	77.50
0390	LIMITED ED VISIT - SAT,SUN,HOLIDAY (DAY)	33.00	33.53	34.40	35.28	36.50
0391	LIMITED ED VISIT - FRI,SAT,SUN,HOLIDAY (NIGHT)	55.25	56.11	57.55	58.99	61.00
0394	OUT-PT-ADDITIONAL FEE FOR STRICT EMERGENCY	20.00	20.75	22.00	23.25	25.00
0395	ULTRAVIOLET LIGHT THERAPY	20.00	20.21	20.56	20.91	21.40
0410	COMPREHENSIVE OFFICE VISIT	55.25	55.96	57.15	58.34	60.00
0411	INITIAL OFFICE VISIT WITH REGIONAL EXAM	33.00	33.30	33.80	34.30	35.00
0413	LIMITED OFFICE VISIT	33.00	33.30	33.80	34.30	35.00
0421	DAY HOME VISIT - MONDAY TO SUNDAY	56.00	56.90	58.40	59.90	62.00
0424	HOME VISIT - ADDITIONAL FAMILY MEMBER	28.00	28.45	29.20	29.95	31.00
0425	ADDITIONAL FEE FOR STRICT EMERGENCY	20.00	20.75	22.00	23.25	25.00
0430	INITIAL HOSPITAL VISIT	60.00	66.00	76.00	86.00	100.00
0433	SUBSEQUENT HOSPITAL VISITS (1st 5 WEEKS)	35.00	37.25	41.00	44.75	50.00
0434	SUBSEQUENT HOSPITAL VISITS (6-13th WEEK)	20.00	21.50	24.00	26.50	30.00
0435	SUBSEQUENT HOSPIRAL VISITS (AFTER 13th WEEK)	20.00	21.50	24.00	26.50	30.00
0440	RETAINER SURGERY Q.E.H. AND P.C.H.	300.00	300.00	300.00	300.00	300.00
0441	CONTINUING CARE	35.00	37.25	41.00	44.75	50.00
0442	DIRECTIVE CARE	35.00	37.25	41.00	44.75	50.00
0460	CONSULTATION-INITIAL	85.00	87.70	92.20	96.70	103.00

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
0462	CONSULTATION-SUBSEQUENT	42.50	43.85	46.10	48.35	51.50
0468	COMPREHENSIVE ED VISIT - SAT,SUN,HOLIDAY (DAY)	60.00	60.98	62.60	64.23	66.50
0469	COMPREHENSIVE ED VISIT - FRI,SAT,SUN,HOLI (NIGHT)	100.00	101.50	104.00	106.50	110.00
0470	DETENTION	40.00	40.75	42.00	43.25	45.00
0471	INTENSIVE CARE	85.00	87.25	91.00	94.75	100.00
0476	DETENTION-SPECIAL CALL	40.00	40.75	42.00	43.25	45.00
0480	LIMITED ED VISIT - MON-FRI (DAY)	28.50	28.95	29.70	30.45	31.50
0481	LIMITED ED VISIT - MON-THURS (NIGHT)	37.25	37.81	38.75	39.69	41.00
0486	COMPREHENSIVE ED VISIT - MON-FRI (DAY)	52.00	52.83	54.20	55.58	57.50
0487	COMPREHENSIVE ED VISIT - MON-THURS (NIGHT)	70.00	71.13	73.00	74.88	77.50
0490	LIMITED ED VISIT - SAT,SUN,HOLIDAY (DAY)	33.00	33.53	34.40	35.28	36.50
0491	LIMITED ED VISIT - FRI,SAT,SUN,HOLIDAY (NIGHT)	55.25	56.11	57.55	58.99	61.00
0494	OUT-PT-ADDITIONAL FEE FOR STRICT EMERGENCY	20.00	20.75	22.00	23.25	25.00
0501	INTERMEDIATE/PROGRESSIVE CARE	120.00	121.80	124.80	127.80	132.00
0502	CONCURRENT CARE/DAY	160.00	161.20	163.20	165.20	168.00
0503	ONCALL RETAINER - NEUROLOGY	50.00	57.50	70.00	82.50	100.00
0510	INITIAL OFFICE VISIT WITH COMPLETE EXAM	64.80	65.58	66.88	68.18	70.00
0512	REPEAT OFFICE VISIT WITH COMPLETE EXAM	64.80	65.58	66.88	68.18	70.00
0513	LIMITED OFFICE VISIT	33.00	33.30	33.80	34.30	35.00
0521	DAY HOME VISIT - MONDAY TO SUNDAY	56.00	56.90	58.40	59.90	62.00
0524	HOME VISIT-ADDITIONAL FAMILY MEMBER	28.00	28.45	29.20	29.95	31.00
0525	ADDITIONAL FEE FOR STRICT EMERGENCY	20.00	20.75	22.00	23.25	25.00
0530	INITIAL HOSPITAL VISIT	60.00	66.00	76.00	86.00	100.00
0533	SUBSEQUENT HOSPITAL VISITS - 1st 5 WEEKS	35.00	37.25	41.00	44.75	50.00
0534	SUBSEQUENT HOSPITAL VISITS - 6-13th WEEK	20.00	21.50	24.00	26.50	30.00
0535	SUBSEQUENT HOSPITAL VISITS - AFTER 13th WEEK	20.00	21.50	24.00	26.50	30.00
0540	RETAINER INTERNAL MEDICINE Q.E.H. AND P.C.H	300.00	300.00	300.00	300.00	300.00
0541	CONTINUING CARE	35.00	37.25	41.00	44.75	50.00
0542	DIRECTIVE CARE	35.00	37.25	41.00	44.75	50.00
0550	TELEPHONE CONSULT - INTERNIST	40.00	40.75	42.00	43.25	45.00
0560	CONSULTATION-INITIAL	160.00	164.50	172.00	179.50	190.00
0562	CONSULTATION-SUBSEQUENT	80.00	82.25	86.00	89.75	95.00
0563	CONSULTATION-COMPLETE RE EXAM	64.80	65.58	66.88	68.18	70.00
0568	COMPREHENSIVE ED VISIT - SAT,SUN,HOLIDAY (DAY)	60.00	60.98	62.60	64.23	66.50
0569	COMPREHENSIVE ED VISIT - FRI,SAT,SUN,HOLI (NIGHT)	100.00	101.50	104.00	106.50	110.00
0570	DETENTION	40.00	40.75	42.00	43.25	45.00
0576	DETENTION-SPECIAL CALL	40.00	40.75	42.00	43.25	45.00
0580	LIMITED ED VISIT - MON-FRI (DAY)	28.50	28.95	29.70	30.45	31.50
0581	LIMITED ED VISIT - MON-THURS (NIGHT)	37.25	37.81	38.75	39.69	41.00
0586	COMPREHENSIVE ED VISIT - MON-FRI (DAY)	52.00	52.83	54.20	55.58	57.50
0587	COMPREHENSIVE ED VISIT - MON-THURS (NIGHT)	70.00	71.13	73.00	74.88	77.50
0590	LIMITED ED VISIT - SAT,SUN,HOLIDAY (DAY)	33.00	33.53	34.40	35.28	36.50
0591	LIMITED ED VISIT - FRI,SAT,SUN,HOLIDAY (NIGHT)	55.25	56.11	57.55	58.99	61.00
0594	ADDITIONAL FEE FOR STRICT EMERGENCY	20.00	20.75	22.00	23.25	25.00
0595	PHYSICIAN IN CHARGE/CRITICAL CARE	275.00	277.25	281.00	284.75	290.00
0596	INTENSIVE RESPIRATORY CARE(1st DAY)	160.00	161.20	163.20	165.20	168.00
0597	CRITICAL CARE - DAY 2-30 INCLUSIVE, PER DAY	160.00	161.20	163.20	165.20	168.00
0598	CRITICAL CARE - DAY 31 ONWARD, PER DAY	80.00	80.60	81.60	82.60	84.00
0599	STRESS TEST	80.00	80.84	82.24	83.64	85.60
0700	OBS INITIAL VISIT	55.25	55.96	57.15	58.34	60.00
0701	ASSESSMENT OF LABOUR (OB/GYN)	35.00	37.25	41.00	44.75	50.00
0703	OBS PRENATAL VISIT	33.00	33.30	33.80	34.30	35.00
0704	IN HOSPITAL DAILY CARE	35.00	37.25	41.00	44.75	50.00
0705	OBS-POST NATAL VISIT	33.00	33.30	33.80	34.30	35.00
0710	COMPREHENSIVE OFFICE VISIT	55.25	55.96	57.15	58.34	60.00
0711	INITIAL OFFICE VISIT WITH REGIONAL	33.00	33.30	33.80	34.30	35.00
0713	LIMITED OFFICE VISIT	33.00	33.30	33.80	34.30	35.00

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
0721	DAY HOME VISIT - MONDAY TO SUNDAY	56.00	56.90	58.40	59.90	62.00
0724	HOME VISIT-ADDITIONAL FAMILY MEMBER	28.00	28.45	29.20	29.95	31.00
0725	ADDITIONAL FEE FOR STRICT EMERGENCY	20.00	20.75	22.00	23.25	25.00
0730	INITIAL HOSPITAL VISIT	60.00	66.00	76.00	86.00	100.00
0733	SUBSEQUENT HOSPITAL VISITS - 1st 6 WEEKS	35.00	37.25	41.00	44.75	50.00
0734	SUBSEQUENT HOSPITAL VISITS 6th-13th WEEK'S	20.00	21.50	24.00	26.50	30.00
0735	SUBSEQUENT HOSPITAL VISITS/AFTER 13th WEEK	20.00	21.50	24.00	26.50	30.00
0740	RETAINER OBS/GYN Q.E.H. AND P.C.H.	300.00	300.00	300.00	300.00	300.00
0741	CONTINUING CARE	35.00	37.25	41.00	44.75	50.00
0742	DIRECTIVE CARE	35.00	37.25	41.00	44.75	50.00
0760	CONSULTATION-INITIAL	85.00	87.70	92.20	96.70	103.00
0762	CONSULTATION-SUBSEQUENT	42.50	43.85	46.10	48.35	51.50
0764	CONSULTATION-REPRODUCTIVE ENDOCRINOLOGY	85.00	87.70	92.20	96.70	103.00
0765	REPEAT CONSULT REPRODUCTIVE ENDOCRINOLOGY	42.50	43.85	46.10	48.35	51.50
0768	COMPREHENSIVE ED VISIT - SAT,SUN,HOLIDAY (DAY)	60.00	60.98	62.60	64.23	66.50
0769	COMPREHENSIVE ED VISIT - FRI,SAT,SUN,HOLI (NIGHT)	100.00	101.50	104.00	106.50	110.00
0770	DETENTION	40.00	40.75	42.00	43.25	45.00
0771	INTENSIVE CARE	85.00	87.25	91.00	94.75	100.00
0776	DETENTION-SPECIAL CALL	40.00	40.75	42.00	43.25	45.00
0780	LIMITED ED VISIT - MON-FRI (DAY)	28.50	28.95	29.70	30.45	31.50
0781	LIMITED ED VISIT - MON-THURS (NIGHT)	37.25	37.81	38.75	39.69	41.00
0786	COMPREHENSIVE ED VISIT - MON-FRI (DAY)	52.00	52.83	54.20	55.58	57.50
0787	COMPREHENSIVE ED VISIT - MON-THURS (NIGHT)	70.00	71.13	73.00	74.88	77.50
0790	LIMITED ED VISIT - SAT,SUN,HOLIDAY (DAY)	33.00	33.53	34.40	35.28	36.50
0791	LIMITED ED VISIT - FRI,SAT,SUN,HOLIDAY (NIGHT)	55.25	56.11	57.55	58.99	61.00
0794	OUT-PT-ADDITIONAL FEE FOR STRICT EMERGENCY	20.00	20.75	22.00	23.25	25.00
0795	OUT-PT ASSESSMENT FOR COMPLIC PREG/LABOR	85.00	87.70	92.20	96.70	103.00
0810	COMPREHENSIVE OFFICE VISIT	55.25	55.96	57.15	58.34	60.00
0811	INITIAL OFFICE VISIT WITH REGIONAL EXAM	33.00	33.30	33.80	34.30	35.00
0812	SUBSEQUENT VISIT FOR SPECIAL TESTS	55.00	55.75	57.00	58.25	60.00
0813	LIMITED OFFICE VISIT	33.00	33.30	33.80	34.30	35.00
0821	DAY HOME VISIT - MONDAY TO SUNDAY	56.00	56.90	58.40	59.90	62.00
0824	HOME VISIT-ADDITIONAL FAMILY MEMBER	28.00	28.45	29.20	29.95	31.00
0825	ADDITIONAL FEE FOR STRICT EMERGENCY	20.00	20.75	22.00	23.25	25.00
0830	INITIAL HOSPITAL VISIT	60.00	66.00	76.00	86.00	100.00
0833	SUBSEQUENT HOSPITAL VISITS - 1st 5 WEEKS	35.00	37.25	41.00	44.75	50.00
0834	SUBSEQUENT HOSPITAL VISITS 6-13th WEEK	20.00	21.50	24.00	26.50	30.00
0835	SUBSEQUENT HOSPITAL VISITS AFTER 13th WEEK	20.00	21.50	24.00	26.50	30.00
0840	RETAINER OPHTHALMOLOGY Q.E.H.	300.00	300.00	300.00	300.00	300.00
0841	CONTINUING CARE	35.00	37.25	41.00	44.75	50.00
0842	DIRECTIVE CARE	35.00	37.25	41.00	44.75	50.00
0860	CONSULTATION-INITIAL	85.00	87.70	92.20	96.70	103.00
0862	CONSULTATION-SUBSEQUENT	42.50	43.85	46.10	48.35	51.50
0868	COMPREHENSIVE ED VISIT - SAT,SUN,HOLIDAY (DAY)	60.00	60.98	62.60	64.23	66.50
0869	COMPREHENSIVE ED VISIT - FRI,SAT,SUN,HOLI (NIGHT)	100.00	101.50	104.00	106.50	110.00
0870	DETENTION	40.00	40.75	42.00	43.25	45.00
0871	INTENSIVE CARE	85.00	87.25	91.00	94.75	100.00
0876	DETENTION-SPECIAL CALL	40.00	40.75	42.00	43.25	45.00
0880	LIMITED ED VISIT - MON-FRI (DAY)	28.50	28.95	29.70	30.45	31.50
0881	LIMITED ED VISIT - MON-THURS (NIGHT)	37.25	37.81	38.75	39.69	41.00
0886	COMPREHENSIVE ED VISIT - MON-FRI (DAY)	52.00	52.83	54.20	55.58	57.50
0887	COMPREHENSIVE ED VISIT - MON-THURS (NIGHT)	70.00	71.13	73.00	74.88	77.50
0890	LIMITED ED VISIT - SAT,SUN,HOLIDAY (DAY)	33.00	33.53	34.40	35.28	36.50
0891	LIMITED ED VISIT - FRI,SAT,SUN,HOLIDAY (NIGHT)	55.25	56.11	57.55	58.99	61.00
0894	OUT-PT-ADDITIONAL FEE FOR STRICT EMERGENCY	20.00	20.75	22.00	23.25	25.00
0910	COMPREHENSIVE OFFICE VISIT	55.25	55.96	57.15	58.34	60.00
0911	INITIAL OFFICE VISIT WITH REGIONAL EXAM	33.00	33.30	33.80	34.30	35.00

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
0913	LIMITED OFFICE VISIT	33.00	33.30	33.80	34.30	35.00
0921	DAY HOME VISIT - MONDAY TO SUNDAY	56.00	56.90	58.40	59.90	62.00
0924	HOME VISIT-ADDITIONAL FAMILY MEMBER	28.00	28.45	29.20	29.95	31.00
0925	ADDITIONAL FEE FOR STRICT EMERGENCY	20.00	20.75	22.00	23.25	25.00
0930	INITIAL HOSPITAL VISIT	60.00	66.00	76.00	86.00	100.00
0933	SUBSEQUENT HOSPITAL VISITS 1st 5 WEEKS	35.00	37.25	41.00	44.75	50.00
0934	SUBSEQUENT HOSPITAL VISITS 6-13th WEEK	20.00	21.50	24.00	26.50	30.00
0935	SUBSEQUENT HOSPITAL VISITS AFTER 13th WEEK	20.00	21.50	24.00	26.50	30.00
0940	RETAINER ORTHOPEDICS Q.E.H.	300.00	300.00	300.00	300.00	300.00
0941	CONTINUING CARE	35.00	37.25	41.00	44.75	50.00
0942	DIRECTIVE CARE	35.00	37.25	41.00	44.75	50.00
0950	PACS TELEPHONE CONSULTATION	40.00	40.75	42.00	43.25	45.00
0960	CONSULTATION-INITIAL	85.00	87.70	92.20	96.70	103.00
0962	CONSULTATION-SUBSEQUENT	42.50	43.85	46.10	48.35	51.50
0968	COMPREHENSIVE ED VISIT - SAT,SUN,HOLIDAY (DAY)	60.00	60.98	62.60	64.23	66.50
0969	COMPREHENSIVE ED VISIT - FRI,SAT,SUN,HOLI (NIGHT)	100.00	101.50	104.00	106.50	110.00
0970	DETENTION	40.00	40.75	42.00	43.25	45.00
0971	INTENSIVE CARE	85.00	87.25	91.00	94.75	100.00
0976	DETENTION-SPECIAL CALL	40.00	40.75	42.00	43.25	45.00
0980	LIMITED ED VISIT - MON-FRI (DAY)	28.50	28.95	29.70	30.45	31.50
0981	LIMITED ED VISIT - MON-THURS (NIGHT)	37.25	37.81	38.75	39.69	41.00
0986	COMPREHENSIVE ED VISIT - MON-FRI (DAY)	52.00	52.83	54.20	55.58	57.50
0987	COMPREHENSIVE ED VISIT - MON-THURS (NIGHT)	70.00	71.13	73.00	74.88	77.50
0990	LIMITED ED VISIT - SAT,SUN,HOLIDAY (DAY)	33.00	33.53	34.40	35.28	36.50
0991	LIMITED ED VISIT - FRI,SAT,SUN,HOLIDAY (NIGHT)	55.25	56.11	57.55	58.99	61.00
0994	OUT-PATIENT-ADDITIONAL FEE STRICT EMERGENCY	20.00	20.75	22.00	23.25	25.00
1010	COMPREHENSIVE OFFICE VISIT	55.25	55.96	57.15	58.34	60.00
1011	INITIAL OFFICE VISIT WITH REGIONAL EXAM	33.00	33.30	33.80	34.30	35.00
1013	LIMITED OFFICE VISIT	33.00	33.30	33.80	34.30	35.00
1021	DAY HOME VISIT	56.00	56.90	58.40	59.90	62.00
1024	HOME VISIT-ADDITIONAL FAMILY MEMBER	28.00	28.45	29.20	29.95	31.00
1025	ADDITIONAL FEE FOR STRICT EMERGENCY	20.00	20.75	22.00	23.25	25.00
1030	INITIAL HOSPITAL VISIT	60.00	66.00	76.00	86.00	100.00
1033	SUBSEQUENT HOSPITAL VISITS 1st 5 WEEKS	35.00	37.25	41.00	44.75	50.00
1034	SUBSEQUENT HOSPITAL VISITS 6-13th WEEK	20.00	21.50	24.00	26.50	30.00
1035	SUBSEQUENT HOSPITAL VISITS AFTER 13th WEEK	20.00	21.50	24.00	26.50	30.00
1040	RETAINER ENT PROVINCIAL	300.00	300.00	300.00	300.00	300.00
1041	CONTINUING CARE	35.00	37.25	41.00	44.75	50.00
1042	DIRECTIVE CARE	35.00	37.25	41.00	44.75	50.00
1060	CONSULTATION-INITIAL	85.00	87.70	92.20	96.70	103.00
1062	CONSULTATION-SUBSEQUENT	42.50	43.85	46.10	48.35	51.50
1068	COMPREHENSIVE ED VISIT - SAT,SUN,HOLIDAY (DAY)	60.00	60.98	62.60	64.23	66.50
1069	COMPREHENSIVE ED VISIT - FRI,SAT,SUN,HOLI (NIGHT)	100.00	101.50	104.00	106.50	110.00
1070	DETENTION	40.00	40.75	42.00	43.25	45.00
1071	INTENSIVE CARE	85.00	87.25	91.00	94.75	100.00
1076	DETENTION-SPECIAL CALL	40.00	40.75	42.00	43.25	45.00
1080	LIMITED ED VISIT - MON-FRI (DAY)	28.50	28.95	29.70	30.45	31.50
1081	LIMITED ED VISIT - MON-THURS (NIGHT)	37.25	37.81	38.75	39.69	41.00
1086	COMPREHENSIVE ED VISIT - MON-FRI (DAY)	52.00	52.83	54.20	55.58	57.50
1087	COMPREHENSIVE ED VISIT - MON-THURS (NIGHT)	70.00	71.13	73.00	74.88	77.50
1090	LIMITED ED VISIT - SAT,SUN,HOLIDAY (DAY)	33.00	33.53	34.40	35.28	36.50
1091	LIMITED ED VISIT - FRI,SAT,SUN,HOLIDAY (NIGHT)	55.25	56.11	57.55	58.99	61.00
1094	OUT-PT-ADDITIONAL FEE FOR STRICT EMERGENCY	20.00	20.75	22.00	23.25	25.00
1095	IMPEDENCE AUDIOMETRY	21.22	21.44	21.81	22.19	22.71
1099	MICRODEBRIDEMENT	25.60	25.87	26.32	26.76	27.39
1110	INITIAL OFFICE VISIT WITH COMPLETE EXAM	64.80	65.58	66.88	68.18	70.00
1111	INITIAL OFFICE VISIT WITH REGIONAL EXAM	33.00	33.30	33.80	34.30	35.00

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
1112	SUBSEQUENT OFFICE VISIT WITH COMPLETE	64.80	65.58	66.88	68.18	70.00
1113	LIMITED OFFICE VISIT	33.00	33.30	33.80	34.30	35.00
1115	WELL BABY CARE	33.00	33.30	33.80	34.30	35.00
1120	TELEPHONE CONSULTATION - PEDIATRIC		40.75	42.00	43.25	45.00
1121	DAY HOME VISIT	56.00	56.90	58.40	59.90	62.00
1124	HOME VISIT-ADDITIONAL FAMILY MEMBER	28.00	28.45	29.20	29.95	31.00
1125	ADDITIONAL FEE FOR STRICT EMERGENCY	20.00	20.75	22.00	23.25	25.00
1130	INITIAL HOSPITAL VISIT DAY	60.00	66.00	76.00	86.00	100.00
1133	SUBSEQUENT HOSPITAL VISITS 1st 5 WEEKS	35.00	37.25	41.00	44.75	50.00
1134	SUBSEQUENT HOSPITAL VISITS 6-13th WEEK	20.00	21.50	24.00	26.50	30.00
1135	SUBSEQUENT HOSPITAL VISITS AFTER 13th WEEK	20.00	21.50	24.00	26.50	30.00
1136	ATTENDANCE AT MATERNAL DELIVERY	110.50	111.93	114.30	116.68	120.00
1137	PREMATURE CARE - INITIAL VISIT	75.75	75.75	75.75	75.75	75.75
1138	PREMATURE CARE-SUB UP TO 3 WEEKS	64.45	64.45	64.45	64.45	64.45
1139	PREMATURE CARE-SUB AFTER 3 WEEKS	32.45	32.45	32.45	32.45	32.45
1140	RETAINER PEDIATRICS Q.E.H.	300.00	300.00	300.00	300.00	300.00
1141	CONTINUING CARE	35.00	37.25	41.00	44.75	50.00
1142	DIRECTIVE CARE	35.00	37.25	41.00	44.75	50.00
1145	NEONATAL I.C.U.(1st DAY) LEVEL A	330.00	333.00	338.00	343.00	350.00
1146	NEONATAL I.C.U.(DAY 2-30 INCL) LEVEL A	165.00	166.50	169.00	171.50	175.00
1147	NEONATAL I.C.U. (DAY 31 ONWARD) LEVEL A	110.00	110.90	112.40	113.90	116.00
1148	NEONATAL I.C.U.(1st DAY) LEVEL B	215.00	218.75	225.00	231.25	240.00
1149	NEONATAL I.C.U.(2nd DAY ONWARD) LEVEL B	75.00	76.50	79.00	81.50	85.00
1150	NEONATAL I.C.U.(1st DAY) LEVEL C	140.00	149.00	164.00	179.00	200.00
1151	NEONATAL I.C.U.(2nd DAY ONWARD) LEVEL C	60.00	61.50	64.00	66.50	70.00
1154	PEDIATRIC CONSULT ICU 1st DAY	275.00	277.25	281.00	284.75	290.00
1155	PEDIATRIC INTENSIVE CARE 1st DAY	160.00	161.20	163.20	165.20	168.00
1156	PEDIATRIC CRIT. CARE (DAY 2-30 INCL), PER DAY	160.00	161.20	163.20	165.20	168.00
1157	PEDIATRIC CRIT. CARE (DAY 31 ONWARD) PER DAY	80.00	80.60	81.60	82.60	84.00
1160	CONSULTATION-INITIAL	160.00	164.50	172.00	179.50	190.00
1162	CONSULTATION-SUBSEQUENT	80.00	82.25	86.00	89.75	95.00
1163	CONSULTATION-COMPLETE RE-EXAM	64.80	65.58	66.88	68.18	70.00
1168	COMPREHENSIVE ED VISIT - SAT,SUN,HOLIDAY (DAY)	60.00	60.98	62.60	64.23	66.50
1169	COMPREHENSIVE ED VISIT - FRI,SAT,SUN,HOLI (NIGHT)	100.00	101.50	104.00	106.50	110.00
1170	DETENTION	40.00	40.75	42.00	43.25	45.00
1176	DETENTION-SPECIAL CALL	40.00	40.75	42.00	43.25	45.00
1179	INTENSIVE CARE	21.55	33.32	52.93	72.54	100.00
1180	LIMITED ED VISIT - MON-FRI (DAY)	28.50	28.95	29.70	30.45	31.50
1181	LIMITED ED VISIT - MON-THURS (NIGHT)	37.25	37.81	38.75	39.69	41.00
1182	ILL NEWBORN-INITIAL HOSPITAL VISIT	54.00	54.00	54.00	54.00	54.00
1183	ILL NEWBORN-SUBSEQUENT VISITS 1st 5 WEEKS	11.55	11.55	11.55	11.55	11.55
1184	ILL NEWBORN-SUBSEQUENT VISITS 6-13 WEEK	10.50	10.50	10.50	10.50	10.50
1185	ILL NEWBORN AFTER 13th WEEK	14.50	14.50	14.50	14.50	14.50
1186	COMPREHENSIVE ED VISIT - MON-FRI (DAY)	52.00	52.83	54.20	55.58	57.50
1187	COMPREHENSIVE ED VISIT - MON-THURS (NIGHT)	70.00	71.13	73.00	74.88	77.50
1190	LIMITED ED VISIT - SAT,SUN,HOLIDAY (DAY)	33.00	33.53	34.40	35.28	36.50
1191	LIMITED ED VISIT - FRI,SAT,SUN,HOLIDAY (NIGHT)	55.25	56.11	57.55	58.99	61.00
1194	ADDITIONAL FEE FOR STRICT EMERGENCY	20.00	20.75	22.00	23.25	25.00
1210	INITIAL OFFICE VISIT WITH COMPLETE EXAM	64.80	65.58	66.88	68.18	70.00
1213	LIMITED OFFICE VISIT	33.00	33.30	33.80	34.30	35.00
1221	DAY HOME VISIT - MONDAY TO FRIDAY	56.00	56.90	58.40	59.90	62.00
1224	HOME VISIT-ADDITIONAL FAMILY MEMBER	28.00	28.45	29.20	29.95	31.00
1225	ADDITIONAL FEE FOR STRICT EMERGENCY	20.00	20.75	22.00	23.25	25.00
1230	INITIAL HOSPITAL VISIT	60.00	66.00	76.00	86.00	100.00
1233	SUBSEQUENT HOSPITAL VISITS 1st 5 WEEKS	35.00	37.25	41.00	44.75	50.00
1234	SUBSEQUENT VISIT - 6-13th WEEK	20.00	21.50	24.00	26.50	30.00
1235	SUBSEQUENT VISITS AFTER 13th WEEK	20.00	21.50	24.00	26.50	30.00

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
1240	ONCALL RETAINER - PSYCHIATRY	300.00	300.00	300.00	300.00	300.00
1241	CONTINUING CARE	35.00	37.25	41.00	44.75	50.00
1242	DIRECTIVE CARE	35.00	37.25	41.00	44.75	50.00
1260	CONSULTATION-INITIAL	175.00	179.50	187.00	194.50	205.00
1262	CONSULTATION-SUBSEQUENT	87.50	89.75	93.50	97.25	102.50
1263	CONSULTATION-COMPLETE RE-EXAM	64.80	65.58	66.88	68.18	70.00
1268	COMPREHENSIVE ED VISIT - SAT,SUN,HOLIDAY (DAY)	60.00	60.98	62.60	64.23	66.50
1269	COMPREHENSIVE ED VISIT - FRI,SAT,SUN,HOLI (NIGHT)	100.00	101.50	104.00	106.50	110.00
1270	DETENTION	40.00	40.75	42.00	43.25	45.00
1276	DETENTION-SPECIAL CALL	40.00	40.75	42.00	43.25	45.00
1280	LIMITED ED VISIT - MON-FRI (DAY)	28.50	28.95	29.70	30.45	31.50
1281	LIMITED ED VISIT - MON-THURS (NIGHT)	37.25	37.81	38.75	39.69	41.00
1286	COMPREHENSIVE ED VISIT - MON-FRI (DAY)	52.00	52.83	54.20	55.58	57.50
1287	COMPREHENSIVE ED VISIT - MON-THURS (NIGHT)	70.00	71.13	73.00	74.88	77.50
1290	LIMITED ED VISIT - SAT,SUN,HOLIDAY (DAY)	33.00	33.53	34.40	35.28	36.50
1291	LIMITED ED VISIT - FRI,SAT,SUN,HOLIDAY (NIGHT)	55.25	56.11	57.55	58.99	61.00
1294	ADDITIONAL FEE FOR STRICT EMERGENCY	20.00	20.75	22.00	23.25	25.00
1310	COMPREHENSIVE OFFICE VISIT	55.25	55.96	57.15	58.34	60.00
1311	INITIAL OFFICE VISIT WITH REGIONAL EXAM	33.00	33.30	33.80	34.30	35.00
1313	LIMITED OFFICE VISIT	33.00	33.30	33.80	34.30	35.00
1321	DAY HOME VISIT - MONDAY TO SUNDAY	56.00	56.90	58.40	59.90	62.00
1324	HOME VISIT-ADDITIONAL FAMILY MEMBER	28.00	28.45	29.20	29.95	31.00
1325	ADDITIONAL FEE FOR STRICT EMERGENCY	20.00	20.75	22.00	23.25	25.00
1330	INITIAL HOSPITAL VISIT	60.00	66.00	76.00	86.00	100.00
1333	SUBSEQUENT HOSPITAL VISITS 1st 5 WEEKS	35.00	37.25	41.00	44.75	50.00
1334	SUBSEQUENT HOSPITAL VISITS 6-13 WEEKS	20.00	21.50	24.00	26.50	30.00
1335	SUBSEQUENT HOSPITAL VISITS AFTER 13th WEEK	20.00	21.50	24.00	26.50	30.00
1340	RETAINER UROLOGY Q.E.H.	300.00	300.00	300.00	300.00	300.00
1341	CONTINUING CARE	35.00	37.25	41.00	44.75	50.00
1342	DIRECTIVE CARE	35.00	37.25	41.00	44.75	50.00
1360	CONSULTATION-INITIAL	85.00	87.70	92.20	96.70	103.00
1362	CONSULTATION-SUBSEQUENT	42.50	43.85	46.10	48.35	51.50
1368	COMPREHENSIVE ED VISIT - SAT,SUN,HOLIDAY (DAY)	60.00	60.98	62.60	64.23	66.50
1369	COMPREHENSIVE ED VISIT - FRI,SAT,SUN,HOLI (NIGHT)	100.00	101.50	104.00	106.50	110.00
1370	DETENTION	40.00	40.75	42.00	43.25	45.00
1371	INTENSIVE CARE	85.00	87.25	91.00	94.75	100.00
1376	DETENTION-SPECIAL CALL	40.00	40.75	42.00	43.25	45.00
1380	LIMITED ED VISIT - MON-FRI (DAY)	28.50	28.95	29.70	30.45	31.50
1381	LIMITED ED VISIT - MON-THURS (NIGHT)	37.25	37.81	38.75	39.69	41.00
1386	COMPREHENSIVE ED VISIT - MON-FRI (DAY)	52.00	52.83	54.20	55.58	57.50
1387	COMPREHENSIVE ED VISIT - MON-THURS (NIGHT)	70.00	71.13	73.00	74.88	77.50
1390	LIMITED ED VISIT - SAT,SUN,HOLIDAY (DAY)	33.00	33.53	34.40	35.28	36.50
1391	LIMITED ED VISIT - FRI,SAT,SUN,HOLIDAY (NIGHT)	55.25	56.11	57.55	58.99	61.00
1394	OUT-PT ADDITIONAL FEE FOR STRICT EMERGENCY	20.00	20.75	22.00	23.25	25.00
1540	RETAINER RADIOLOGY QEH	300.00	300.00	300.00	300.00	300.00
1610	INITIAL OFFICE VISIT WITH COMPLETE EXAM	64.80	65.58	66.88	68.18	70.00
1611	INITIAL OFFICE VISIT WITH REGIONAL EXAM	33.00	33.30	33.80	34.30	35.00
1613	LIMITED OFFICE VISIT	33.00	33.30	33.80	34.30	35.00
1621	DAY HOME VISIT	56.00	56.90	58.40	59.90	62.00
1624	HOME VISIT-ADDITIONAL FAMILY MEMBERS	28.00	28.45	29.20	29.95	31.00
1625	ADDITIONAL FEE FOR STRICT EMERGENCY	20.00	20.75	22.00	23.25	25.00
1630	INITIAL HOSPITAL VISIT	60.00	66.00	76.00	86.00	100.00
1633	SUBSEQUENT HOSPITAL VISIT-1st 5 WEEKS	35.00	37.25	41.00	44.75	50.00
1634	SUBSEQUENT HOSPITAL VISIT 6-13th WEEK	20.00	21.50	24.00	26.50	30.00
1635	SUBSEQUENT HOSPITAL VISIT - AFTER 13th WEEK	20.00	21.50	24.00	26.50	30.00
1641	CONTINUING CARE	35.00	37.25	41.00	44.75	50.00
1642	DIRECTIVE CARE	35.00	37.25	41.00	44.75	50.00

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
1660	CONSULTATION-INITIAL	160.00	164.50	172.00	179.50	190.00
1662	CONSULTATION-SUBSEQUENT	80.00	82.25	86.00	89.75	95.00
1663	CONSULTATION-COMPLETE RE-EXAM	64.80	65.58	66.88	68.18	70.00
1668	COMPREHENSIVE ED VISIT - SAT,SUN,HOLIDAY (DAY)	60.00	60.98	62.60	64.23	66.50
1669	COMPREHENSIVE ED VISIT - FRI,SAT,SUN,HOLI (NIGHT)	100.00	101.50	104.00	106.50	110.00
1670	DETENTION	40.00	40.75	42.00	43.25	45.00
1671	INTENSIVE CARE	85.00	87.25	91.00	94.75	100.00
1676	DETENTION-SPECIAL CALL	40.00	40.75	42.00	43.25	45.00
1680	LIMITED ED VISIT - MON-FRI (DAY)	28.50	28.95	29.70	30.45	31.50
1681	LIMITED ED VISIT - MON-THURS (NIGHT)	37.25	37.81	38.75	39.69	41.00
1686	COMPREHENSIVE ED VISIT - MON-FRI (DAY)	52.00	52.83	54.20	55.58	57.50
1687	COMPREHENSIVE ED VISIT - MON-THURS (NIGHT)	70.00	71.13	73.00	74.88	77.50
1690	LIMITED ED VISIT - SAT,SUN,HOLIDAY (DAY)	33.00	33.53	34.40	35.28	36.50
1691	LIMITED ED VISIT - FRI,SAT,SUN,HOLIDAY (NIGHT)	55.25	56.11	57.55	58.99	61.00
1694	OUT-PT ADDITIONAL FEE FOR STRICT EMERGENCY	20.00	20.75	22.00	23.25	25.00
1713	RADIATION ONCOLOGY FOLLOW-UP VISIT	19.35	21.70	25.61	29.52	35.00
1715	ONCOLOGY-TREATMENT PLANNING	36.50	36.50	36.50	36.50	36.50
1716	ONCOLOGY-SUPERFICIAL THERAPY	6.85	6.85	6.85	6.85	6.85
1717	ONCOLOGY-DEEP THERAPY	9.40	9.40	9.40	9.40	9.40
1718	RADIUM MOULD	16.50	16.50	16.50	16.50	16.50
1719	ONCOLOGY-OPTHALMIC DEVICE	8.40	8.40	8.40	8.40	8.40
1720	TREATMENT PLANNING FOR NON MALIG CONDITION	22.75	22.75	22.75	22.75	22.75
1725	ONCOLOGY BIOPSY (INTERSTITAL THERAPY)	182.60	182.60	182.60	182.60	182.60
1730	RADIUM INSERTION	157.70	157.70	157.70	157.70	157.70
1731	RADIUM PROVISION-OPERATING ROOM	91.35	91.35	91.35	91.35	91.35
1735	RADIOISOTOPE THERAPY-CARCINOMA OF THYROID	74.65	74.65	74.65	74.65	74.65
1736	TREATMENT OF HYPERTHYROIDISM	54.90	54.90	54.90	54.90	54.90
1737	TREATMENT OF POLYCYTHEMIA VERA	44.75	44.75	44.75	44.75	44.75
1760	RADIATION ONCOLOGY CONSULTATION	85.00	100.75	127.00	153.25	190.00
1762	REPEAT CONSULTATION	42.50	50.38	63.50	76.63	95.00
1900	AUTOPSY - NON-CORONERS (EVENINGS & WEEKENDS)	679.00	764.65	907.40	1,050.15	1,250.00
1940	ONCALL RETAINER - LABORATORY	300.00	300.00	300.00	300.00	300.00
2000	CERUMEN REMOVAL	10.00	10.30	10.80	11.30	12.00
2001	PELVIC EXAM	6.00	6.30	6.80	7.30	8.00
2002	URINALYSIS	4.05	4.12	4.23	4.34	4.50
2003	PARTIAL EXAMINATION	2.05	2.08	2.13	2.18	2.25
2004	HAEMAGLOBIN	3.75	3.79	3.85	3.91	4.00
2005	OCCULT BLOOD IN STOOL	2.05	2.08	2.13	2.18	2.25
2006	NASAL SMEAR FOR EOSINOPHILS	3.75	3.79	3.85	3.91	4.00
2007	PROCTOSCOPIC EXAM	11.05	12.39	14.63	16.87	20.00
2008	PAP SMEAR WITH OR WITHOUT PELVIC EXAM	12.00	12.30	12.80	13.30	14.00
2009	INJECTION OTHER THAN ALLERGY	8.00	8.30	8.80	9.30	10.00
2010	CHANGE OF DRESSING	10.00	10.11	10.28	10.46	10.70
2011	EMERGENCY PROCEDURAL SEDATION	25.00	25.75	27.00	28.25	30.00
2015	CRYOPRECIPITATE	20.25	20.46	20.82	21.17	21.67
2018	PAP SCREENING CLINIC	0.00	0.00	0.00	0.00	0.00
2019	TELEPHONE PRESCRIPTION RENEWAL		3.00	3.50	4.00	5.00
2021	REMOVAL OF RECTAL FOREIGN BODY		72.25	76.00	79.75	85.00
2022	ARGON COAG. STOMACH OR RECTUM (ADD-ON FEE)		75.00	76.58	78.15	80.25
2038	DIALYSIS CATHETER - TUNNELING AND INSERTION		150.00	150.00	150.00	150.00
2039	DIALYSIS CATHETER - REMOVAL AND/OR REPLACEMENT		200.00	200.00	200.00	200.00
2048	COMPREHENS PALLIATIVE CARE CONSULT-SPECIALIST	160.00	160.00	160.00	160.00	160.00
2050	ASPIRATION OF LYMPH NODE IN NECK	22.75	22.99	23.39	23.79	24.34
2055	ACUTE DIALYSIS - FIRST TREATMENT		585.00	585.00	585.00	585.00
2056	ACUTE DIALYSIS - SUBSEQUENT TREATMENT (UP TO 2)		268.80	268.80	268.80	268.80
2058	SATELLITE DIALYSIS MANAGEMENT (PER PATIENT / WEEK)		40.00	40.00	40.00	40.00
2067	REPEAT PALLIATIVE CARE CONSULT-SPECIALIST	80.00	80.00	80.00	80.00	80.00

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
2100	OCCIPITAL NERVE BLOCK	31.05	32.39	34.63	36.87	40.00
2101	TRIGGER POINT INJECTION (ONE OR MORE)	20.00	20.21	20.56	20.91	21.40
2102	HYPOSENSITIZATION-SUBSEQUENT VISITS	8.00	8.30	8.80	9.30	10.00
2106	SUPERVISION OF ANTI-COAGULENT THERAPY	9.80	10.58	11.88	13.18	15.00
2107	ASPIRATION-BLADDER	30.00	31.50	34.00	36.50	40.00
2108	ASPIRATION-BREAST CYST	20.00	21.50	24.00	26.50	30.00
2109	ASPIRATION-BURSA	25.00	25.26	25.70	26.14	26.75
2110	ASPIRATION-CISTERNA MAGNA	22.55	22.79	23.18	23.58	24.13
2111	ASPIRATION-DUODENUM	37.50	37.89	38.55	39.21	40.13
2112	ASPIRATION-ESOPHAGUS/STOMACH	20.00	20.21	20.56	20.91	21.40
2113	ASPIRATION-HYDROCELE	20.00	20.21	20.56	20.91	21.40
2114	ASPIRATION-JOINT	25.00	26.50	29.00	31.50	35.00
2115	LUMBAR PUNCTURE	75.00	78.75	85.00	91.25	100.00
2116	PERICARDIOCENTESIS	130.00	134.50	142.00	149.50	160.00
2117	SUBDURAL TAP	29.65	29.96	30.48	31.00	31.73
2118	SUBDURAL PUNCTURE-EACH ADDITIONAL	9.80	9.90	10.07	10.25	10.49
2119	ASPIRATION-THYROID CYST	20.00	21.50	24.00	26.50	30.00
2122	B.C.G. VACCINATION	9.80	9.90	10.07	10.25	10.49
2123	BLOOD TRANSFUSION	19.80	20.01	20.35	20.70	21.19
2124	CARDIOVERSION	105.00	106.10	107.94	109.78	112.35
2126	SELECTIVE CORONARY ANGIOGRPHY OF HEART-RIGHT	148.25	149.81	152.40	155.00	158.63
2127	HEPATIC-WEDGE PRESSURE	98.80	99.84	101.57	103.30	105.72
2128	HEPATIC-WEDGE PRESSURE OF HEART LEFT	197.70	199.78	203.24	206.70	211.54
2129	LEFT VENTRICULAR PUNCTURE	98.80	99.84	101.57	103.30	105.72
2131	CRYOTHERAPY OF CERVIX	41.50	41.94	42.66	43.39	44.41
2132	INSERTION-PERM PERITONEAL DIALYSIS CATHETER	145.20	146.72	149.27	151.81	155.36
2135	CHRONIC DIALYSIS - FIRST TREATMENT	170.85	172.64	175.63	178.62	182.81
2137	CHRONIC DIALYSIS - SUBSEQUENT TREATMENT	102.50	74.00	74.00	74.00	74.00
2140	NERVE CONDUCTION STUDIES, PER NERVE, (MAX. 6)	28.52	28.82	29.32	29.82	30.52
2142	ECG INTERPRETATION IN OFFICE	20.00	20.21	20.56	20.91	21.40
2143	ECG (HOME)	25.05	25.31	25.75	26.19	26.80
2144	HOLTER MONITORING	48.00	48.50	49.34	50.18	51.36
2145	ECG-INTERPRETATION ONLY	10.00	10.11	10.28	10.46	10.70
2146	EEG INTERPRETATION ONLY	28.75	29.05	29.56	30.06	30.76
2147	EEG - INSERTION SUBTEMPORAL NEEDLES	19.80	20.01	20.35	20.70	21.19
2148	EEG ACTIVATING DRUGS	19.80	20.01	20.35	20.70	21.19
2149	EMG (MAJOR) - MUSCLES OF MORE THAN ONE REGION	82.00	83.20	85.20	87.20	90.00
2150	EMG (MINOR) - MUSCLES OF A SPECIFIC LIMB OR REGION	53.60	54.56	56.16	57.76	60.00
2151	ELECTROCONVULSIVE THERAPY	32.60	38.96	49.56	60.16	75.00
2152	INSULIN HYPOGLYCEMIA/PITUITARY FUNCTION	56.95	57.55	58.54	59.54	60.94
2153	TRH TEST	28.45	28.75	29.25	29.74	30.44
2154	GNRH(LHRH) TEST	28.45	28.75	29.25	29.74	30.44
2155	CALCIUM AND PENTAGASTRIN	68.35	69.07	70.26	71.46	73.13
2156	CALCIUM OR PENTAGASTRIN ALONE	45.55	46.03	46.83	47.62	48.74
2157	HCL DRIP TEST (ESOPHAGUS)	29.65	29.96	30.48	31.00	31.73
2158	MOTILITY STUDIES (ESOPHAGUS)	69.05	69.78	70.98	72.19	73.88
2159	GASTRO-ESOPHAGEAL TAMPONADE	49.35	50.95	53.61	56.27	60.00
2162	GASTRIC LAVAGE	25.00	25.26	25.70	26.14	26.75
2163	GASTRO-ENTEROLOGY FRACTIONAL TEST-MEAL	29.65	29.96	30.48	31.00	31.73
2165	INJECTION-INTRAVENOUS	12.00	12.45	13.20	13.95	15.00
2166	NERVE ENTRAPMENT EVALUATION (COMPOSITE FEE)		80.00	81.68	83.36	85.60
2167	ACHALASIA BOTOX INJECTION	60.00	60.63	61.68	62.73	64.20
2168	INJECTION MEDICATION-BURSA JOINT,ETC.	25.00	25.26	25.70	26.14	26.75
2169	INJECTION HEMORRHOIDS-INITIAL	20.00	20.21	20.56	20.91	21.40
2170	INJECTION HEMORRHOIDS SUBSEQUENT	15.05	15.21	15.47	15.73	16.10
2171	INJECTION OF PRURITIS ANI	20.00	20.21	20.56	20.91	21.40
2172	MYELOGRAM-LUMBAR	69.05	69.78	70.98	72.19	73.88

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
2174	IV ADMIN OF CHEMOTHERAPY AGENT-PER INJECTION	20.00	20.21	20.56	20.91	21.40
2175	BONE MARROW (NEEDLE BIOPSY)	75.00	78.75	85.00	91.25	100.00
2176	KIDNEY-NEEDLE BIOPSY	69.05	69.78	70.98	72.19	73.88
2177	LIVER-NEEDLE BIOPSY	75.00	75.79	77.10	78.41	80.25
2178	PLEURA-NEEDLE BIOPSY	39.65	40.07	40.76	41.45	42.43
2180	SYNOVIAL TISSUE-NEEDLE BIOPSY	49.35	49.87	50.73	51.60	52.80
2181	PERICARDIUM-NEEDLE BIOPSY	148.25	149.81	152.40	155.00	158.63
2182	PROSTATE-NEEDLE BIOPSY	79.00	79.83	81.21	82.59	84.53
2183	SOMATIC OR PERIPHERAL NERVE BLOCK - SINGLE	36.00	36.60	37.60	38.60	40.00
2184	SOMATIC/ PERIPH. NERVE BLOCK - ADDITIONAL (MAX. 4)	18.00	18.30	18.80	19.30	20.00
2185	LUMBAR SYMPATHETIC NERVE BLOCK	85.00	85.89	87.38	88.87	90.95
2186	CERVICAL PLEXUS BLOCK	70.00	70.74	71.96	73.19	74.90
2187	MENTAL BRANCH MANDIBULAR NERVE	60.00	60.63	61.68	62.73	64.20
2188	INFRAORBITAL BRANCH MAXILLARY NERVE	60.00	60.63	61.68	62.73	64.20
2189	BRACHIAL PLEXUS BLOCK	60.00	60.63	61.68	62.73	64.20
2190	PRESACRAL (SUPERIOR HYPOGASTRIC PLEXUS) BLOCK	60.00	60.63	61.68	62.73	64.20
2191	CAUDAL EPIDURAL INJECTION	65.00	65.68	66.82	67.96	69.55
2192	SCIATIC NERVE BLOCK	60.00	60.63	61.68	62.73	64.20
2193	OBTURATOR NERVE BLOCK	60.00	60.63	61.68	62.73	64.20
2194	PUDENDAL NERVE BLOCK	50.00	60.63	61.68	62.73	64.20
2195	SUBARACHNOID (DIAGNOSTIC SPINAL) BLOCK	70.00	70.74	71.96	73.19	74.90
2196	EPIDURAL - SINGLE INJECTION	80.00	80.84	82.24	83.64	85.60
2197	CELIAC/HYPOGASTRIC PLEXUS BLOCK - FLUORO GUIDED	100.00	151.58	154.20	156.83	160.50
2198	TRIGEMINAL (GASSERIAN) GANGLION BLOCK	100.00	101.05	102.80	104.55	107.00
2199	CERVICAL SYMPATHETIC OR STELLATE GANGLION BLOCK	100.00	101.05	102.80	104.55	107.00
2202	GASSERIAN GANGLION BLOCK - FLUORO GUIDED	150.00	151.58	154.20	156.83	160.50
2204	LATERAL FEMORAL CUTANEOUS NERVE BLOCK	70.00	70.00	70.00	70.00	70.00
2205	THORAC/LUMBAR/SACRAL SYMPATH BLOCK -FLUOR GUIDED	150.00	151.58	154.20	156.83	160.50
2206	MAXILLARY / MANDIBULAR DIVISION TRIGEMINAL NERVE	70.00	70.74	71.96	73.19	74.90
2207	SPHENO-PALATINE GANGLION BLOCK - FLUORO GUIDED	70.00	151.58	154.20	156.83	160.50
2208	STELLATE GANGLION BLOCK - U/S OR FLUORO GUIDED	150.00	151.58	154.20	156.83	160.50
2209	SUPERIOR LARYNGEAL NERVE BLOCK - FLUORO GUIDED	150.00	151.58	154.20	156.83	160.50
2210	PARAVERTEBRAL NERVE BLOCK - SINGLE	70.00	70.74	71.96	73.19	74.90
2211	PARAVERTEBRAL NERVE BLOCK - ADDITIONAL (MAX. 4)	35.00	35.37	35.98	36.59	37.45
2213	PARACENTESIS-THORACIC OR ABDO ASPIRATION	30.00	33.00	38.00	43.00	50.00
2214	THERAPEUTIC ASPIRATION	50.00	52.25	56.00	59.75	65.00
2215	ADMINISTRATION OF CHEMOTHERAPY	49.35	50.95	53.61	56.27	60.00
2217	PHONOCARDIOGRAM	29.65	29.96	30.48	31.00	31.73
2218	ROUTINE SURVEY-PULMONARY FUNCTION	50.00	50.53	51.40	52.28	53.50
2219	INDIVIDUAL TESTS-MAXIMUM BREATHING CAPACITY	10.75	10.86	11.05	11.24	11.50
2220	PULMONARY DIFFUSING CAPACITY	19.80	20.01	20.35	20.70	21.19
2222	INTERPRETATION PRESSURE TRACINGS	10.75	10.86	11.05	11.24	11.50
2223	LUNG CAPACITY DETERMINATIONS	21.05	21.27	21.64	22.01	22.52
2228	ANNUAL HEALTH EXAM 1-2 YEARS	33.00	33.30	33.80	34.30	35.00
2229	ANNUAL HEALTH EXAM 3-16 YEARS	33.00	33.30	33.80	34.30	35.00
2230	ANNUAL HEALTH EXAM 17-64 YEARS	35.00	36.50	39.00	41.50	45.00
2231	ANNUAL HEALTH EXAM 65 YEARS PLUS	45.00	47.25	51.00	54.75	60.00
2232	IV START ON PEDIATRIC PATIENT	40.00	40.42	41.12	41.82	42.80
2233	URIC ACID CRYSTALS	5.95	6.01	6.12	6.22	6.37
2234	MUCIN CLOT	2.00	2.02	2.06	2.09	2.14
2235	SIGMOIDOSOCOPIC	35.00	37.25	41.00	44.75	50.00
2236	STERILITY INVESTIGATION-MALE	9.80	9.90	10.07	10.25	10.49
2237	BALLOON STRCT.DILAT-INC GSCPY,SSCPY OR CSCPY	247.00	249.59	253.92	258.24	264.29
2238	VENIPUNCTURE	8.00	8.30	8.80	9.30	10.00
2239	VENIPUNCTURE INFANT OR CHILD UNDER SIX	20.00	20.21	20.56	20.91	21.40
2240	FEMORAL VEIN PUNCTURE	20.00	20.21	20.56	20.91	21.40
2241	JUGULAR VEIN PUNCTURE	20.00	20.21	20.56	20.91	21.40

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
2242	SIGMOIDOSCOPY-FLEXIBLE (W/ OR W/OUT BIOPSY)	70.00	72.25	76.00	79.75	85.00
2243	VACCINATION	16.00	16.17	16.45	16.73	17.12
2244	CENTRAL VENOUS PRESSURE	50.00	50.53	51.40	52.28	53.50
2245	METACHOLINE CHALLENGE	67.50	68.21	69.39	70.57	72.23
2246	CYSTOMETROGRAM	30.00	30.32	30.84	31.37	32.10
2247	VITAL CAPACITY AND TIMED UNIT CAPACITY	10.75	10.86	11.05	11.24	11.50
2248	ACTH STIMULATION TEST	40.80	41.23	41.94	42.66	43.66
2249	SIMPLE PROGRESSIVE EXERCISE TESTS	23.70	23.95	24.36	24.78	25.36
2250	EXERCISE IN A STEADY STATE	49.35	49.87	50.73	51.60	52.80
2251	EXERCISE IN A STEADY STATE	79.00	79.83	81.21	82.59	84.53
2252	INJECTIONS BY CUTDOWN-AGES 0-4 YRS	50.00	50.53	51.40	52.28	53.50
2253	INJECTIONS BY SCALP VEIN	25.00	25.26	25.70	26.14	26.75
2254	CENTRAL IV LINE INSERTION	100.00	103.00	108.00	113.00	120.00
2255	PERITONEAL LAVAGE	75.00	75.79	77.10	78.41	80.25
2256	UMBILICAL VESSEL CATHETERIZATION	72.05	72.81	74.07	75.33	77.09
2257	ECG-TECHNICAL COMPONENT	10.00	10.11	10.28	10.46	10.70
2258	VISUAL FIELDS-GOLDMAN PERIMETER	38.15	38.55	39.22	39.89	40.82
2259	ASPIRATION BIOPSY/THYROID	22.75	26.84	33.65	40.46	50.00
2260	COLONSCOPY OF COMPLETE COLON	150.00	161.25	180.00	198.75	225.00
2261	SWEAT TEST	31.80	32.13	32.69	33.25	34.03
2262	SWAN'S GANZ CATHETER	160.00	161.68	164.48	167.28	171.20
2263	NEEDLE BIOPSY-LUNG	70.00	70.74	71.96	73.19	74.90
2264	ADDITIONAL INJECTION OF CHEMOTHERAPY	9.85	9.95	10.13	10.30	10.54
2265	I.V.PYLEOGRAM IN O.P.D.	35.00	35.37	35.98	36.59	37.45
2266	THERAPEUTIC PHLEBOTOMY	19.80	20.01	20.35	20.70	21.19
2267	URINE FLOW RATE DETERMINATION	12.00	12.13	12.34	12.55	12.84
2268	NEEDLE BIOPSY LUNG	116.20	117.42	119.45	121.49	124.33
2269	TENSILON TEST	21.25	21.47	21.85	22.22	22.74
2270	DOPPLER SCAN OR B SCAN TECHNICAL COMPONENT	40.65	41.08	41.79	42.50	43.50
2271	DOPPLER SCAN OR B SCAN PROFESSIONAL COMPNENT	22.85	23.09	23.49	23.89	24.45
2272	FREQUENCY ANALYSIS TECHNICAL COMPONENT	40.65	41.08	41.79	42.50	43.50
2273	FREQUENCY ANALYSIS PROFESSIONAL COMPONENT	22.85	23.09	23.49	23.89	24.45
2274	FREQUENCY ANALYSIS PLUS SCAN TECH COMPONENT	61.05	61.69	62.76	63.83	65.32
2275	FREQUENCY ANALYSIS PLUS SCAN PROF COMPONENT	34.35	34.71	35.31	35.91	36.75
2276	URETHRAL PRESSURE PROFILE OR LEAK PRESS TEST	20.00	20.21	20.56	20.91	21.40
2277	DOPPLER SCAN OR B SCAN	15.35	15.51	15.78	16.05	16.42
2278	ELECTROMYOGRAPHY	20.00	20.21	20.56	20.91	21.40
2279	FREQUENCY ANALYSIS	12.70	12.83	13.06	13.28	13.59
2280	FREQUENCY ANALYSIS PLUS SCAN TECHN COMPNENT	29.25	29.56	30.07	30.58	31.30
2281	FREQUENCY ANALYSIS PLUS SCAN PROF COMPONENT	24.10	24.35	24.77	25.20	25.79
2282	VENOUS ASSESSMENT TECHNICAL COMPONENT	6.40	6.47	6.58	6.69	6.85
2283	VENOUS ASSESSMENT PROFESSIONAL COMPONENT	10.20	10.31	10.49	10.66	10.91
2284	PRESSURE/FLOW STUDY	20.00	20.21	20.56	20.91	21.40
2285	ANKLE PRESSURE DETERMINATION	8.35	8.44	8.58	8.73	8.93
2286	ANKLE PRESS MEAS/DOPPLER RECRD TECH COMPNENT	19.20	19.40	19.74	20.07	20.54
2287	ANKLE PRESS MEAS/DOPPLER RECRD PROF COMPNENT	22.85	23.09	23.49	23.89	24.45
2288	ANKLE PRESS/EXERCISE-HYPEREMIA TECH COMPNENT	7.05	7.12	7.25	7.37	7.54
2289	ANKLE PRESS/EXERCISE-HYPEREMIA PROF COMPNENT	10.85	10.96	11.15	11.34	11.61
2290	VIDEOURODYNAMIC ASSESSMENT	20.00	20.21	20.56	20.91	21.40
2291	PENILE PRESSURE RECORD-TWO OR MORE	7.60	7.68	7.81	7.95	8.13
2292	PERI-URETHRAL COLLAGEN INJECTN INCL CYSTSCPY	150.00	151.58	154.20	156.83	160.50
2293	STRAIN GAUGE PLETHYSMOGRAPHY	5.70	5.76	5.86	5.96	6.10
2294	PERIORBITAL STUDIES BY DOPPLER TECH COMPONENT	12.70	12.83	13.06	13.28	13.59
2295	PERIORBITAL STUDIES BY DOPPLER PROF COMPONENT	13.95	14.10	14.34	14.58	14.93
2296	VENOUS REFILLING TIME TECHNICAL COMPONENT	11.55	11.67	11.87	12.08	12.36
2297	VENOUS REFILLING TIME PROFESSIONAL COMPONENT	5.70	5.76	5.86	5.96	6.10
2300	ULTRASOUND ASSESS OF CEREBRAL CIRCULATION	44.45	44.92	45.69	46.47	47.56

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
2301	ULTRASOUND ASSESSMENT-PLUS PERIORBITAL FLOW	44.45	44.92	45.69	46.47	47.56
2303	STROMAL PUNCTURE CORNEAL EROSION-ANTERIOR	53.35	53.91	54.84	55.78	57.08
2304	SEVENTH CRANIAL NERVE BLOCK - UNILATERAL	42.00	42.44	43.18	43.91	44.94
2305	SEVENTH CRANIAL NERVE BLOCK - BILATERAL	63.05	63.71	64.82	65.92	67.46
2306	INTRAVITREOL INJECTION OF EYE	200.00	202.10	205.60	209.10	214.00
2307	INTRATHECAL EPI-MORPH INJECTION	57.50	58.10	59.11	60.12	61.53
2308	ANNUAL DIABETIC RETINOPATHY	10.50	10.61	10.79	10.98	11.24
2309	AMBULATORY 24 HOUR ESOPHEGAL PH MONITORING	30.80	31.12	31.66	32.20	32.96
2310	COLONOSCOPY DESCENDING COLON	50.00	57.50	70.00	82.50	100.00
2315	ILEOSCOPY		57.50	70.00	82.50	100.00
2320	COLONOSCOPY DESCENDING & TRANSVERSE COLON	100.00	109.00	124.00	139.00	160.00
2349	ALLERGY TEST TECHNICAL COMPONENT	0.65	0.66	0.67	0.68	0.70
2359	ALLERGY TEST PROFESSIONAL COMPONENT	0.15	0.16	0.17	0.18	0.20
2360	REMOVAL POLYP/COLONOSCOPIC EXAM	80.10	80.94	82.34	83.74	85.71
2370	REPT BALLOON STRIC.DILAT.W/IN 30 DYS-INCL GSCPY	194.68	196.72	200.13	203.54	208.31
2371	INCLUDES SIGMOIDOSCOPY	148.50	150.06	152.66	155.26	158.90
2372	INCLUDES COLONOSCOPY DESCENDING COLON	148.50	150.06	152.66	155.26	158.90
2373	INCLUDES COLONSCPY DECSND&TRANSVERSE COLON	173.50	175.32	178.36	181.39	185.65
2374	INCLUDES COLONOSCOPY COMPLETE COLON	198.50	200.58	204.06	207.53	212.40
2400	ARTERIAL PUNCTURE FOR BLOOD GASES	20.00	20.21	20.56	20.91	21.40
2408	VISUAL FIELD INTERPRETATION	15.00	15.16	15.42	15.68	16.05
2410	IV IRON INFUSION-TOTAL CARE	50.00	50.53	51.40	52.28	53.50
2412	PACHYMETRY	10.00	10.30	10.80	11.30	12.00
2413	HEIDELBERG RETINA TOMOGRAPHY	15.00	17.25	21.00	24.75	30.00
2414	OPTICAL COHERENCE TOMOGRAPHY - COMPOSITE FEE	57.05	57.65	58.65	59.65	61.04
2415	OPTICAL COHERENCE TOMOGRAPHY - PROFESSIONAL FEE		15.16	15.42	15.68	16.05
2417	OPTICAL COHERENCE TOMOGRAPHY - TECHNICAL FEE		42.49	43.23	43.96	44.99
2420	IOL MASTER / OCULAR BIOMETRY - PROCEDURE ONLY		38.30	38.96	39.62	40.55
2421	IOL MASTER / OCULAR BIOMETRY - INTERPRETATION		19.39	20.20	21.01	22.15
2450	SUPRAORBITAL BRANCH OPHTHALMIC NERVE BLOCK		60.63	61.68	62.73	64.20
2451	OTHER CRANIAL NERVE BLOCK		60.63	61.68	62.73	64.20
2452	TRANSVERSE SCAPULAR NERVE BLOCK		60.63	61.68	62.73	64.20
2453	INTERCOSTAL NERVE BLOCK - SINGLE		36.60	37.60	38.60	40.00
2454	INTERCOSTAL NERVE BLOCK - ADDITIONAL (MAX. 4)		18.30	18.80	19.30	20.00
2455	ILIOINGUINAL AND/OR ILIOHYPOGASTRIC NERVE BLOCK		60.63	61.68	62.73	64.20
2456	FEMORAL NERVE BLOCK		60.63	61.68	62.73	64.20
2457	3-IN-1 BLOCK (FEM, OBTURATOR, LAT FEM CUTANEOUS)		80.84	82.24	83.64	85.60
2458	FASCIA ILIACA COMPARTMENT BLOCK		60.63	61.68	62.73	64.20
2459	TRANSVERSUS ABDOMINIS PLANE BLOCK - UNILAT		30.32	30.84	31.37	32.10
2460	TRANSVERSUS ABDOMINIS PLANE BLOCK - BILAT		50.02	50.89	51.75	52.97
2461	NERVE BLOCK W/ FLUOROSCOPIC GUIDANCE (ADD ON)		40.75	42.00	43.25	45.00
2462	NERVE BLOCK W/ ULTRASOUND GUIDANCE (ADD ON)		25.75	27.00	28.25	30.00
2463	FACET JOINT INJECTION - FLUORO GUIDED -ADD'L, MAX. 6		59.33	60.71	62.09	64.03
2464	FACET JOINT INJECTION - U/S GUIDED (SINGLE)		76.28	78.40	80.53	83.50
2465	FACET JOINT INJECTION - U/S GUIDED -ADD'L, MAX. 6		49.58	50.96	52.34	54.28
2466	SACROILIAC JOINT INJECTION - FLUORO GUIDED -UNILAT		91.28	93.40	95.53	98.50
2467	SACROILIAC JOINT INJECTION - FLUORO GUIDED -BILAT		150.60	154.11	157.62	162.53
2468	DIAGNOSTIC NERVE ROOT BLOCK - FLUORO GUIDED -ANY #		161.68	164.48	167.28	171.20
2501	PSYCHOTHERAPY-GENERAL PRACTITIONER	40.00	40.38	41.00	41.63	42.50
2502	GROUP PSYCHOTHERAPY-GENERAL PRACTITIONER	40.00	40.38	41.00	41.63	42.50
2503	PSYCHOTHERAPY BY A GP -IN HOSPITAL	40.00	40.38	41.00	41.63	42.50
2504	PSYCHOTHERAPY-PSYCHIATRIST	50.00	50.75	52.00	53.25	55.00
2505	HEALTH PROMOTION COUNSELLING	40.00	40.38	41.00	41.63	42.50
2507	CASE MANAGEMENT PER 15 MINUTES	40.00	40.38	41.00	41.63	42.50
2508	MENTAL HEALTH CRISIS CARE-GP-PER 15 MINUTES	40.00	40.38	41.00	41.63	42.50
2520	EPIDURAL SPINAL BLOCK	65.00	66.50	69.00	71.50	75.00
2521	EPIDURAL SPINAL BLOCK (CONTINUOUS)	200.00	203.00	208.00	213.00	220.00

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
2523	EPIDURAL SPINAL BLOCK MAXIMUM ONE PER DAY	75.00	76.13	78.00	79.88	82.50
2524	LUMBAR EPIDURAL INJECTION - FLUORO GUIDED	160.00	161.68	164.48	167.28	171.20
2525	CATHETER FOR ANALYGESIA/FIRST DOSE	375.00	379.80	387.80	395.80	407.00
2530	IV GUANETHIDINE OR BIER BLOCK	100.00	101.05	102.80	104.55	107.00
2531	CERVICAL EPIDURAL INJECTION - FLUORO GUIDED	120.00	161.68	164.48	167.28	171.20
2532	THORACIC EPIDURAL INJECTION - FLUORO GUIDED	120.00	161.68	164.48	167.28	171.20
2533	FACET JOINT INJECTION - FLUORO GUIDED (SINGLE)	50.00	91.28	93.40	95.53	98.50
2534	PATIENT CONTROLLED ANALGESIA-MAINTENANCE	25.00	25.38	26.00	26.63	27.50
2540	AUDIOMETRY-TUNING FORK AND SPEECH TEST	37.36	37.75	38.41	39.06	39.98
2541	VESTIBULAR FUNCTION TESTS	21.55	21.78	22.15	22.53	23.06
2549	MODIFIED SLEEP STUDY	40.00	40.42	41.12	41.82	42.80
2550	ADMIN OF CHEMOTHERAPY IN OMAYA RESERVOIR	36.40	36.78	37.42	38.06	38.95
2551	INTRATHECAL CHEMOTHRPY INCL LUMBAR PNCTURE	58.20	68.97	86.92	104.87	130.00
2552	ADMIN OF SELEROSING MATERIAL VIA CHEST TUBE	50.00	50.53	51.40	52.28	53.50
2580	MEMBER OF GROUP PSYCHOTHERAPY (G P)	0.00	0.00	0.00	0.00	0.00
2581	MEMBER OF GROUP PSYCHOTHERAPY (SP)	0.00	0.00	0.00	0.00	0.00
2582	MEMBER OF SESSIONAL SERVICE	0.00	0.00	0.00	0.00	0.00
2586	DIAGNOSTIC/THERAPEUTIC INTERVIEW-RELATIVES	50.00	50.75	52.00	53.25	55.00
2587	GROUP PSYCHOTHERAPY	50.00	50.75	52.00	53.25	55.00
2588	DIAGNOSTIC/THERAPEUTIC INTERVIEW	40.00	40.38	41.00	41.63	42.50
2589	PHOTOTHERAPY	5.70	5.76	5.86	5.96	6.10
2590	PRENATAL PSYCHOSOCIAL ASSESSMENT	40.00	40.38	41.00	41.63	42.50
2600	RADIATION THERAPY	0.00	0.00	0.00	0.00	0.00
2601	INSERTION OF IUPC	47.50	48.00	48.83	49.66	50.83
2602	OXYTOCIN CHALLENGE TEST	30.00	30.32	30.84	31.37	32.10
2603	SCALP PH SAMPLING	62.00	62.65	63.74	64.82	66.34
2604	BIOPHYSICAL PROFILE	57.00	57.60	58.60	59.59	60.99
2605	VAGINAL PESSARY FITTING(INITIAL)	15.00	15.16	15.42	15.68	16.05
2606	ULTRASOUND PROCEDURES - OBSTETRICIAN	57.00	57.60	58.60	59.59	60.99
2700	CYSTOGRAM	32.45	32.79	33.36	33.93	34.72
2701	ARTHROGRAM	32.45	32.79	33.36	33.93	34.72
2702	BRONCHOGRAM	43.20	43.65	44.41	45.17	46.22
2705	SIALOGRAM	43.20	43.65	44.41	45.17	46.22
2706	HYSTEROSALPINGOGRAM	64.90	65.58	66.72	67.85	69.44
2708	PERCUTANEOUS TRANSHEP CHOLANGIOGRAM	75.75	76.55	77.87	79.20	81.05
2709	LYMPHOGRAM	108.15	109.29	111.18	113.07	115.72
2800	ADMISSION EXAM TO ALCOHOL OR MENTAL FACILITY	40.00	40.42	41.12	41.82	42.80
2807	CASE MANAGEMENT-GERIATRIC MEDICINE	40.00	40.75	42.00	43.25	45.00
2821	HOME VISIT-GERIATRIC MEDICINE	56.00	58.85	63.60	68.35	75.00
2860	CONSULTATION-GERIATRIC MEDICINE	122.40	128.04	137.44	146.84	160.00
2862	REPEAT CONSULT W/IN 30 DAYS-GERIATRIC MEDICINE	61.20	64.02	68.72	73.42	80.00
2863	FOLLOW UP VISIT-GERIATRIC MEDICINE	33.00	33.30	33.80	34.30	35.00
2870	DETENTION-GERIATRIC MEDICINE	40.00	40.75	42.00	43.25	45.00
2880	COMPENTENCY ASSESSMENT-GERIATRIC MEDICINE	60.00	62.25	66.00	69.75	75.00
2886	DIAG.&THERA. INTERVIEW-GERIATRIC MEDICINE	40.00	40.75	42.00	43.25	45.00
2900	ED ULTRASOUND	25.00	25.75	27.00	28.25	30.00
2901	EMERGENCY CRICOTHYROTOMY	200.00	202.10	205.60	209.10	214.00
2902	URINARY CATHETER - TRANSURETHRAL	30.00	30.75	32.00	33.25	35.00
2903	ASPIRATION FOR PRIAPISM	60.00	60.63	61.68	62.73	64.20
2904	PARAPHIMOSIS REDUCTION	50.00	50.53	51.40	52.28	53.50
3000	ABSCESS-LOCAL ANAESTHETIC	35.00	35.37	35.98	36.59	37.45
3001	ABSCESS-GENERAL ANAESTHETIC	43.20	43.65	44.41	45.17	46.22
3002	CARBUNCLE-COMPLETE CARE	86.45	87.36	88.87	90.38	92.50
3003	PERIANAL OR PILONIDAL-LOCAL	40.00	40.42	41.12	41.82	42.80
3004	PERIANAL OR PILONIDAL-GEN ANAES	64.90	65.58	66.72	67.85	69.44
3005	ISCHIORECTAL-SIMPLE INCISION W/ LOCL ANESTHETIC	40.00	40.42	41.12	41.82	42.80
3006	UNROOFING-COMPLETE CARE	129.75	131.11	133.38	135.65	138.83

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
3007	PALMAR AND PLANTAR SPACE INFECTIONS	129.75	131.11	133.38	135.65	138.83
3008	HAEMATOMA-LOCAL	35.00	35.37	35.98	36.59	37.45
3009	HAEMATOMA-GENERAL ANAESTHETIC	43.20	43.65	44.41	45.17	46.22
3010	TONGUE TIE-LOCAL	13.25	13.39	13.62	13.85	14.18
3011	TONGUE TIE-GENERAL	43.20	43.65	44.41	45.17	46.22
3012	REMOVAL OF FOREIGN BODY OR FIBROMA	40.00	40.42	41.12	41.82	42.80
3013	REMOVAL OF FOREIGN BODY-GENERAL ANAESTHETIC	I.C.	I.C.	I.C.	I.C.	I.C.
3030	BIOPSY	42.00	42.44	43.18	43.91	44.94
3031	CARCINOMA OF SKIN	75.75	76.55	77.87	79.20	81.05
3032	CARCINOMA-COMPLICATED	I.C.	I.C.	I.C.	I.C.	I.C.
3033	CYST-PILONIDAL	205.80	207.96	211.56	215.16	220.21
3034	CYST-SEBACEOUS (FACE OR NECK)	42.00	42.44	43.18	43.91	44.94
3035	CYST-SEBACEOUS (OTHER AREAS)	38.00	38.40	39.06	39.73	40.66
3036	REMOVAL OF FINGER OR TOE NAIL	45.00	45.47	46.26	47.05	48.15
3037	RESECTION OF NAIL-BED AND MATRIX	48.00	48.50	49.34	50.18	51.36
3038	RADICAL REMOVAL OF NAIL	108.15	109.29	111.18	113.07	115.72
3039	LIPOMA-SIMPLE (LOCAL)	43.20	43.65	44.41	45.17	46.22
3040	LIPOMA-COMPLICATED	I.C.	I.C.	I.C.	I.C.	I.C.
3041	NEUROMA-SIMPLE	43.20	43.65	44.41	45.17	46.22
3042	BENIGN SKIN LESION-INITAL CRYOTHERAPY	24.75	25.01	25.44	25.88	26.48
3043	BENIGN SKIN LESION-SUBSEQUENT CRYOTHERAPY	10.90	11.01	11.21	11.40	11.66
3044	WARTS-CURETTAGE OR ELECTROCAUTERY	24.70	25.50	26.82	28.15	30.00
3045	WARTS-SIMPLE EXCISION	30.85	31.17	31.71	32.25	33.01
3046	PLANTAR WART-CURETTAGE	28.00	28.30	28.80	29.30	30.00
3047	PLANTAR WART-SURGICAL EXCISION	55.25	55.83	56.80	57.76	59.12
3049	IMPLANTATION OF HORMONE PELLETS	32.45	32.79	33.36	33.93	34.72
3050	SUTURE-SIMPLE WOUNDS OR LACERATIONS	50.00	51.50	54.00	56.50	60.00
3051	SUTURE-COMPLICATED LACERATIONS	I.C.	I.C.	I.C.	I.C.	I.C.
3052	EXTENSIVE BURNS (REPAIR)	I.C.	I.C.	I.C.	I.C.	I.C.
3053	SKIN GRAFT-SMALL	200.00	202.10	205.60	209.10	214.00
3054	SKIN GRAFT-EYE BROW,LID,EAR,NOSE	257.20	259.90	264.40	268.90	275.20
3055	SKIN GRAFT-LARGE	378.35	382.32	388.94	395.56	404.83
3056	CROSS FINGER FLAP	257.20	259.90	264.40	268.90	275.20
3057	CROSS LEG FLAP	463.05	467.91	476.02	484.12	495.46
3058	INDIRECT SKIN GRAFT-MAJOR	324.40	327.81	333.48	339.16	347.11
3059	INDIRECT SKIN GRAFT-MINOR	162.25	163.95	166.79	169.63	173.61
3060	LONGER STAGE WITH SKIN GRAFT	324.40	327.81	333.48	339.16	347.11
3061	DELAY OF TUBE OR PEDICLE	75.75	76.55	77.87	79.20	81.05
3062	FULL GRAFTS-EYELID, NOSE,LIPS	257.20	259.90	264.40	268.90	275.20
3063	FULL GRAFTS-FINGER TIP	108.15	109.29	111.18	113.07	115.72
3064	FULL GRAFTS-VOLAR PALM	162.25	163.95	166.79	169.63	173.61
3065	FULL GRAFTS-ISLAND GRAFT	432.55	437.09	444.66	452.23	462.83
3066	SPLIT THICKNESS GRAFT-MINOR	100.00	101.05	102.80	104.55	107.00
3067	SPLIT THICKNESS GRAFTS-MINOR TO MEDIUM	162.25	163.95	166.79	169.63	173.61
3068	SPLIT SKIN GRAFTS-INTERMEDIATE AREA	257.20	259.90	264.40	268.90	275.20
3069	SPLIT THICKNESS GRAFTS-MAJOR GRAFT	378.35	382.32	388.94	395.56	404.83
3070	DRAINAGE OF INTRAMAMMARY ABSCESS	86.45	87.36	88.87	90.38	92.50
3071	REPEAT INCISION	86.45	87.36	88.87	90.38	92.50
3072	AUGUMENT PROSTHESIS UNILATERAL	262.15	264.90	269.49	274.08	280.50
3073	EXCISIONAL BIOPSY	137.00	138.44	140.84	143.23	146.59
3074	MASTECTOMY-SIMPLE	298.35	301.48	306.70	311.92	319.23
3075	MASTECTOMY-RADICAL	618.80	625.30	636.13	646.96	662.12
3076	MASTECTOMY-RADICAL WITH SKIN GRAFT	566.10	572.04	581.95	591.86	605.73
3077	MASTECTOMY-MALE,SIMPLE	129.75	131.11	133.38	135.65	138.83
3078	MASTECTOMY-PARTIAL OR RESECTION	129.75	131.11	133.38	135.65	138.83
3079	REMOVAL OF BREAST PROSTHESIS	75.75	76.55	77.87	79.20	81.05
3080	SURGICAL PLANING-FACE	216.10	218.37	222.15	225.93	231.23

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
3081	SINGLE AREA-SURGICAL PLANING	75.75	76.55	77.87	79.20	81.05
3082	MAMMOPLASTY-UNILATERAL	420.00	424.41	431.76	439.11	449.40
3083	AUGMENTATION PROSTHESIS-BILATERAL	432.55	437.09	444.66	452.23	462.83
3084	SEGMENTAL MASTECTOMY	618.80	625.30	636.13	646.96	662.12
3085	BIOPSY-NEEDLE BREAST	84.00	84.88	86.35	87.82	89.88
3086	LUMPECTOMY	247.00	249.59	253.92	258.24	264.29
3087	CRYOTHERAPY-FACE/NECK SINGLE LESION	72.80	73.56	74.84	76.11	77.90
3088	CRYOTHERAPY-FACE/NECK 2 LESIONS	119.65	120.91	123.00	125.09	128.03
3089	CRYOTHERAPY-FACE/NECK 3 OR MORE LESIONS	227.60	229.99	233.97	237.96	243.53
3090	CRYOTHERAPY-OTHER AREAS 1 LESION	58.05	58.66	59.68	60.69	62.11
3091	CRYOTHERAPY-OTHER AREAS 2 LESIONS	95.75	96.76	98.43	100.11	102.45
3092	CRYOTHERAPY-OTHER AREAS 3 OR MORE LEISONS	191.25	193.26	196.61	199.95	204.64
3093	INSERTION OF BREAST TISSUE EXPANDER	205.00	207.15	210.74	214.33	219.35
3094	REMOVAL BREAST TISSUE EXPANDER - GEN ANESTH	73.80	74.57	75.87	77.16	78.97
3095	REMOVAL BREAST TISSUE EXPANDER - LOCL ANESTH	36.90	37.29	37.93	38.58	39.48
3096	PERCUTAN INFLATION TISSUE EXPANDER - PER VISIT	22.60	22.84	23.23	23.63	24.18
3097	TRAM FLAP - FIRST SURGEON	I.C.	I.C.	I.C.	I.C.	I.C.
3098	REMOVAL BREAST PROSTHESIS WITH CAPSULOTOMY	100.00	101.05	102.80	104.55	107.00
3099	REMOVAL BREAST PROSTHESIS WITH CAPSULECTOMY	175.00	176.84	179.90	182.96	187.25
3100	CORRECTIVE SPLINTS FINGER	29.85	30.16	30.69	31.21	31.94
3101	ARM OR LEG	38.35	40.10	43.01	45.92	50.00
3102	SHOULDER SPICA	54.00	54.57	55.51	56.46	57.78
3103	HEAD AND TORSO	108.15	109.29	111.18	113.07	115.72
3104	BODY CAST (TORSO)	86.45	87.36	88.87	90.38	92.50
3105	HIP SPICA, SINGLE	75.75	76.55	77.87	79.20	81.05
3106	REMOVAL OF PLASTER	35.70	36.07	36.70	37.32	38.20
3107	UNNA BOOT	21.55	21.78	22.15	22.53	23.06
3108	CORRECTIVE SPLINTS-HAND AND WRIST	32.45	32.79	33.36	33.93	34.72
3109	CORRECTIVE SPLINTS-ELBOW	32.45	32.79	33.36	33.93	34.72
3110	SHOULDER	43.20	43.65	44.41	45.17	46.22
3111	CORRECTIVE SPLINTS-WHOLE LEG	43.20	43.65	44.41	45.17	46.22
3112	CORRECTIVE SPLINTS-BELOW KNEE	32.45	32.79	33.36	33.93	34.72
3113	CORRECTIVE SPLINTS-NECK	32.45	32.79	33.36	33.93	34.72
3150	PHALANX	54.00	54.57	55.51	56.46	57.78
3151	METACARPAL OR METATRSAL	108.15	109.29	111.18	113.07	115.72
3152	CARPUS OR TARSUS	108.15	109.29	111.18	113.07	115.72
3153	HUMERUS-INCISION AND DRAINAGE	162.25	163.95	166.79	169.63	173.61
3154	HUMERUS-SAUCERIZATION	270.25	273.09	277.82	282.55	289.17
3155	HUMERUS-SECONDARY CLOSURE	162.25	163.95	166.79	169.63	173.61
3156	HUMERUS-SEQUESTRECTOMY,SIMPLE	162.25	163.95	166.79	169.63	173.61
3157	HUMERUS-SAUCERIZATION AND BONE CHIPS	324.40	327.81	333.48	339.16	347.11
3158	HUMERUS (CHRONIC)-SECONDARY CLOSURE	162.25	163.95	166.79	169.63	173.61
3159	RADIUS OR ULNA (ACUTE-INCISION AND DRAINAGE)	162.25	163.95	166.79	169.63	173.61
3160	RADIUS OR ULNA(ACUTE)-SAUCERIZATION	270.25	273.09	277.82	282.55	289.17
3161	RADIUS/ULNA (ACUTE-SECONDARY CLOSURE)	162.25	163.95	166.79	169.63	173.61
3162	RADIUS/ULNA(CHRONIC)-SEQUESTRECTOMY,SIMPLE	162.25	163.95	166.79	169.63	173.61
3163	RADIUS/ULNA(CHRONIC)-SAUCERIZATN & BONE CHPS	324.40	327.81	333.48	339.16	347.11
3164	RADIUS/ULNA(CHRONIC)-SECONDARY CLOSURE	162.25	163.95	166.79	169.63	173.61
3165	TIBIA(ACUTE)-INCISION AND DRAINAGE	162.25	163.95	166.79	169.63	173.61
3167	TIBIA(CHRONIC)-SEQUESTRECTOMY,SIMPLE	216.10	218.37	222.15	225.93	231.23
3168	TIBIA(CHRONIC)-SAUCERIZATN & BONE CHIPS	324.40	327.81	333.48	339.16	347.11
3169	TIBIA(CHRONIC)-SECONDARY CLOSURE	162.25	163.95	166.79	169.63	173.61
3170	FEMUR(ACUTE)-INCISION AND DRAINAGE	216.10	218.37	222.15	225.93	231.23
3171	FEMUS (ACUTE)-SAUCERIZATION	378.35	382.32	388.94	395.56	404.83
3172	FEMUR(CHRONIC)-SEQUESTRECTOMY-SIMPLE	216.10	218.37	222.15	225.93	231.23
3173	FEMUR(CHRONIC)-SAUCERIZATION AND BONE CHIPS	378.35	382.32	388.94	395.56	404.83
3174	FEMUR(CHRONIC)-SECONDARY CLOSURE	162.25	163.95	166.79	169.63	173.61

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
3175	PELVIS-SEQUESTRECTOMY,SIMPLE	270.25	273.09	277.82	282.55	289.17
3176	PELVIS-OTHER	I.C.	I.C.	I.C.	I.C.	I.C.
3177	VERTEBRA(ACUTE)-INCISION AND DRAINAGE	216.10	218.37	222.15	225.93	231.23
3178	VERTEBRA(ACUTE)-SAUCERIZATION AND BONE CHIPS	432.55	437.09	444.66	452.23	462.83
3179	VERTEBRA (ACUTE)-SECONDARY CLOSURE	162.25	163.95	166.79	169.63	173.61
3180	VERTEBRA(CHRONIC)-SEQUESTRECTOMY- SIMPLE	216.10	218.37	222.15	225.93	231.23
3181	VERTEBRA(CHRONIC)SAUCERIZATN +/OR BONE GRAFT	378.35	382.32	388.94	395.56	404.83
3182	SKULL, OSTEOMYELITIS	I.C.	I.C.	I.C.	I.C.	I.C.
3183	PHALANX, METACARPAL, METATARSAL	162.25	163.95	166.79	169.63	173.61
3184	RADIUS, ULNA, FIBULA	270.25	273.09	277.82	282.55	289.17
3185	HUMERUS, TIBIA	353.50	357.21	363.40	369.58	378.25
3186	FEMUR, NECK OR SHAFT	540.65	546.33	555.79	565.25	578.50
3187	SPINE	I.C.	I.C.	I.C.	I.C.	I.C.
3188	INCIS-REMOVAL BONE PLATES-LOCAL	110.95	112.11	114.06	116.00	118.72
3189	INCIS-REMOVE BONE PLATES-GENERAL	177.15	179.01	182.11	185.21	189.55
3190	BONE TUMOR	I.C.	I.C.	I.C.	I.C.	I.C.
3191	BONE BIOPSY-VERTEBRA,X-RAY CONTROL	216.10	218.37	222.15	225.93	231.23
3192	BONE BIOPSY-VERTEBRA,OPEN	308.70	311.94	317.34	322.75	330.31
3193	BONE BIOPSY-OPEN, PUNCH, SIMPLE	108.15	109.29	111.18	113.07	115.72
3194	BONE BIOP-OTHER,PUNCH,X-RAY CONTROL	162.25	163.95	166.79	169.63	173.61
3195	BONE BIOPSY-OTHER,OPEN	162.25	163.95	166.79	169.63	173.61
3196	MAXILLA	617.45	623.93	634.74	645.54	660.67
3197	MANDIBLE	411.60	415.92	423.12	430.33	440.41
3199	UPPER EXTREMITY-CARPAL BONE(S)	257.15	259.85	264.35	268.85	275.15
3200	UPPER EXTREMITY-RADIUS-STYLOID	216.10	218.37	222.15	225.93	231.23
3201	UPPER EXTREMITY-RADIUS HEAD	216.10	218.37	222.15	225.93	231.23
3202	RADIUS-HEAD WITH REPLACEMENT	324.40	327.81	333.48	339.16	347.11
3203	UPPER EXTREMITY,ULNA-LOWER END	205.80	207.96	211.56	215.16	220.21
3205	ULNA,OLECRANON AND FACIAL REPAIR	324.40	327.81	333.48	339.16	347.11
3206	HUMERUS-HEAD	411.60	415.92	423.12	430.33	440.41
3207	HUMERUS-HEAD WITH REPLACEMENT	514.60	520.00	529.01	538.01	550.62
3208	HUMERUS-EXOSTOSIS	205.80	207.96	211.56	215.16	220.21
3209	HUMERUS-TUMOR SIMPLE EXCISION	270.25	273.09	277.82	282.55	289.17
3210	HUMERUS-TUMOR,EXCISION AND BONE GRAFT	432.55	437.09	444.66	452.23	462.83
3211	HUMERUS-TUMOR,RECONSTRUCTION	I.C.	I.C.	I.C.	I.C.	I.C.
3212	ACROMION OR OUTER END OF CLAVICLE	216.10	218.37	222.15	225.93	231.23
3213	EXCISION-FOOTBONES,PROXIMAL PHALANX	162.25	163.95	166.79	169.63	173.61
3214	EXCISION AND REPLACEMENT OF TUMOR OF PHALANX	257.20	259.90	264.40	268.90	275.20
3215	FOOT BONES,SESAMOIDS	205.80	207.96	211.56	215.16	220.21
3216	BUNION-EXOSTECTOMY UNILATERAL	188.55	190.53	193.83	197.13	201.75
3217	BUNION-EXOSTECTOMY BILATERAL	194.55	196.59	200.00	203.40	208.17
3218	FOOTBONES-KELLER	257.20	259.90	264.40	268.90	275.20
3219	FOOTBONES-SCAPHOID	205.80	207.96	211.56	215.16	220.21
3220	FOOTBONES-TARSAL BAR	257.20	259.90	264.40	268.90	275.20
3221	FOOTBONES-CALCANEAL SPUR,EXOSTOSIS	162.25	163.95	166.79	169.63	173.61
3222	FOOT BONES-OS CALCIS OR TALUS	308.70	311.94	317.34	322.75	330.31
3223	FOOTBONES-METATARSAL HEAD	162.25	163.95	166.79	169.63	173.61
3224	FOOTBONES-EACH ADDITIONAL	54.00	54.57	55.51	56.46	57.78
3225	TIBIA-EXOSTOSIS	216.10	218.37	222.15	225.93	231.23
3226	PATELLA,EXCISION-RECONSTRUCTION	308.70	311.94	317.34	322.75	330.31
3227	PATELLA,EXCISION-PROSTHESIS	432.55	437.09	444.66	452.23	462.83
3228	FEMUR,EXOSTOSIS	216.10	218.37	222.15	225.93	231.23
3229	FEMUR,HEAD AND NECK	432.55	437.09	444.66	452.23	462.83
3230	TRUNK-CERVICAL RIB,COMPLETE REMOVAL	514.60	520.00	529.01	538.01	550.62
3232	LENGHTHENING OF BONE-TIBIA	514.60	520.00	529.01	538.01	550.62
3233	LENGTHENING OF BONE-FEMUR	617.45	623.93	634.74	645.54	660.67
3234	SHORTENING BONE-TIBIA,FEMUR,HUMERUS	514.60	520.00	529.01	538.01	550.62

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
3235	SHORTENING OF BONE-METATARSAL(ONE)	257.20	259.90	264.40	268.90	275.20
3236	SHORTNING BONE-METATRSL,MORE THAN 1	360.20	363.98	370.29	376.59	385.41
3242	RECONSTRUCT CHEST-PECTUS EXCAVATUM (INFANT)	270.25	273.09	277.82	282.55	289.17
3243	RECONSTRCT CHEST-PECT EXCAVATUM (NON-INFNT)	540.65	546.33	555.79	565.25	578.50
3244	SCAPULOPEXY-CONGENITAL ELEVATION	432.55	437.09	444.66	452.23	462.83
3245	SCAPULOPEXY-WINGED SCAPULA	432.55	437.09	444.66	452.23	462.83
3246	RECONSTRUCTION OF FOOT-UNILATERAL	356.90	360.65	366.89	373.14	381.88
3247	RECONSTRUCTION OF FOOT-BILATERAL	540.65	546.33	555.79	565.25	578.50
3248	METACARPOPHALANGEAL JOINT-UNILATRAL	308.70	311.94	317.34	322.75	330.31
3249	METACARPOPHALANGEAL JOINT-BILATERAL	486.50	491.61	500.12	508.64	520.56
3250	HIP ARTHROPLASTY-RESURFACING	935.55	945.37	961.75	978.12	1,001.04
3251	TOTAL KNEE	759.95	767.93	781.23	794.53	813.15
3252	TOTAL ANKLE	664.15	671.12	682.75	694.37	710.64
3253	ARTHROPLASTY	162.25	163.95	166.79	169.63	173.61
3254	DIAGNOSTIC ARTHROSCPY ALL JOINTS	176.50	178.35	181.44	184.53	188.86
3255	CONVERSION OF MOORES PROSTHESIS TO TOTAL HIP	1,010.15	1,020.76	1,038.43	1,056.11	1,080.86
3256	REVISION OF TOTAL HIP	1,263.90	1,277.17	1,299.29	1,321.41	1,352.37
3257	REVISION OF TOTAL KNEE	1,162.90	1,175.11	1,195.46	1,215.81	1,244.30
3258	BONE GRAFT (NOT ASS WITH ACUTE FRACTURE	126.05	127.37	129.58	131.79	134.87
3259	REMOV TOTL KNEE, W/O REPLCMNT, W/ INSRT SPACER	I.C.	I.C.	I.C.	I.C.	I.C.
3300	PHALANX-NO REDUCTION	45.70	46.18	46.98	47.78	48.90
3301	PHALANX-CLOSED REDUCTION	88.25	89.18	90.72	92.27	94.43
3302	PHALANX-OPEN REDUCTION	162.25	163.95	166.79	169.63	173.61
3303	METACARPAL-NO REDUCTION (ONE/MORE)	45.70	46.18	46.98	47.78	48.90
3304	METACARPAL-REDUCTION	106.45	107.57	109.43	111.29	113.90
3305	METACARPAL-OPEN REDUCTION	205.80	207.96	211.56	215.16	220.21
3306	BENNETT'S FRACTURE(DISLOCATION)-NO REDUCTION	54.00	54.57	55.51	56.46	57.78
3307	BENNETT'S FRACTURE(DISLOCATION)-REDUCTION	118.95	120.20	122.28	124.36	127.28
3308	BENNETT'S FRACTURE-OPEN REDUCTION	216.10	218.37	222.15	225.93	231.23
3309	CARPUS-CLOSED REDUCTION,ONE OR MORE	118.95	120.20	122.28	124.36	127.28
3310	CARPUS-OPEN REDUCTION,ONE OR MORE	205.80	207.96	211.56	215.16	220.21
3311	SCAPHOID-CLOSED REDUCTION	119.40	120.65	122.74	124.83	127.76
3312	SCAPHOID-EXCISION	205.80	207.96	211.56	215.16	220.21
3313	SCAPHOID-BONE GRAFT OR REPLACEMENT	411.60	415.92	423.12	430.33	440.41
3314	RADIUS-CLOSED REDUCTION OF HEAD	135.40	136.82	139.19	141.56	144.88
3315	RADIUS-EXCISION OR OPEN REDUCTION OF HEAD	205.80	207.96	211.56	215.16	220.21
3316	RADIUS AND ULNA-COLLES-NO REDUCTION-CAST	82.25	83.11	84.55	85.99	88.01
3317	RADIUS AND ULNA,COLLES-CLOSED REDUCTION	143.90	145.41	147.93	150.45	153.97
3318	RADIUS AND ULNA-COLLES,OPEN REDUCTION	308.70	311.94	317.34	322.75	330.31
3319	RADIUS AND ULNA,SHAFTS-NO REDUCTION	82.25	83.11	84.55	85.99	88.01
3320	RADIUS AND ULNA,SHAFTS-CLOSED REDUCTION	190.10	192.10	195.42	198.75	203.41
3321	RADIUS AND ULNA,SHAFTS-OPEN REDUCTION	378.35	382.32	388.94	395.56	404.83
3323	MONTEGGIA-CLOSED REDUCTION	226.40	228.78	232.74	236.70	242.25
3324	MONTEGGIA OPEN REDUCTION	360.20	363.98	370.29	376.59	385.41
3326	RADIUS OR ULNA-NO REDUCTION,CAST	82.25	83.11	84.55	85.99	88.01
3327	RADIUS OR ULNA-CLOSED REDUCTION	162.25	163.95	166.79	169.63	173.61
3328	RADIUS OR ULNA-OPEN REDUCTION	257.20	259.90	264.40	268.90	275.20
3330	OLECRANON-NO REDUCTION,CAST	86.45	87.36	88.87	90.38	92.50
3331	OLECRANON-CLOSED REDUCTION	162.25	163.95	166.79	169.63	173.61
3332	OLECRANON-OPEN REDUCTION	257.20	259.90	264.40	268.90	275.20
3333	HUMERUS-EPICONDYLE,CLOSED REDUCTION	191.10	193.11	196.45	199.80	204.48
3334	HUMERUS-EPICONDYLE,OPEN REDUCTION	257.20	259.90	264.40	268.90	275.20
3335	SUPRA OR TRANSCONDYLAR-NO REDUCTION	101.00	102.06	103.83	105.60	108.07
3336	SUPRA OR TRANSCONDYLAR-CLOSE REDUCTION	237.70	240.20	244.36	248.52	254.34
3337	SUPRA OR TRANSCONDYLAR-OPEN REDUCTION	324.40	327.81	333.48	339.16	347.11
3338	SHAFT-NO REDUCTION	118.95	120.20	122.28	124.36	127.28
3339	SHAFT-CLOSED REDUCTION	226.40	228.78	232.74	236.70	242.25

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3340	SHAFT-OPEN REDUCTION	360.20	363.98	370.29	376.59	385.41
3342	NECK OR TUBEROSITY-NO REDUCTION	118.95	120.20	122.28	124.36	127.28
3343	NECK OR TUBEROSITY-CLOSED REDUCTION	226.40	228.78	232.74	236.70	242.25
3344	NECK OR TUBEROSITY-OPEN REDUCTION	378.35	382.32	388.94	395.56	404.83
3345	PHALANX-NO REDUCTION	43.20	43.65	44.41	45.17	46.22
3346	PHALANX-CLOSED REDUCTION	75.75	76.55	77.87	79.20	81.05
3347	PHALANX-OPEN REDUCTION	162.25	163.95	166.79	169.63	173.61
3348	METATARSAL-NO REDUCTION,ONE OR MORE	54.00	54.57	55.51	56.46	57.78
3349	METATARSAL-CLOSED REDUCTION	86.45	87.36	88.87	90.38	92.50
3350	METATARSAL-OPEN REDUCTION	205.80	207.96	211.56	215.16	220.21
3351	TARSUS-NO REDUCTION-ONE OR MORE	110.75	111.91	113.85	115.79	118.50
3352	TARSUS-CLOSED REDUCTION	178.45	180.32	183.45	186.57	190.94
3353	TARSUS-OPEN REDUCTION	308.70	311.94	317.34	322.75	330.31
3354	OS CALCIS-NO REDUCTION, NO CAST	99.95	101.00	102.75	104.50	106.95
3355	OS CALCIS-NO REDUCTION,CAST	108.15	109.29	111.18	113.07	115.72
3356	OS CALCIS-CLOSED REDUCTION	247.00	249.59	253.92	258.24	264.29
3357	OS CALCIS-OPEN REDUCTION	308.70	311.94	317.34	322.75	330.31
3358	OS CALCIS-OPEN REDUCTION PRIMARY ARTHRODESIS	411.60	415.92	423.12	430.33	440.41
3359	ANKLE FRACTURE-NO REDUCTION	86.45	87.36	88.87	90.38	92.50
3360	ANKLE FRACTURE-CLOSED REDUCTION	226.40	228.78	232.74	236.70	242.25
3361	ANKLE-OPEN REDUCTION-MEDIAL MALLEOLUS	257.20	259.90	264.40	268.90	275.20
3362	ANKLE-OPEN REDUCTION BI OR TRIMALLEAOLAR	360.20	363.98	370.29	376.59	385.41
3363	TIBIA-NO REDUCTION	154.65	156.27	158.98	161.69	165.48
3364	TIBIA-CLOSED REDUCTION	244.60	247.17	251.45	255.73	261.72
3365	TIBIA-OPEN REDUCTION	378.35	382.32	388.94	395.56	404.83
3367	FIBULA-NO REDUCTION	75.75	76.55	77.87	79.20	81.05
3368	FIBULA-CLOSED REDUCTION	108.15	109.29	111.18	113.07	115.72
3369	FIBULA-OPEN REDUCTION	216.10	218.37	222.15	225.93	231.23
3370	PATELLA-NO REDUCTION	86.45	87.36	88.87	90.38	92.50
3371	PATELLA-CLOSED REDUCTION	108.15	109.29	111.18	113.07	115.72
3372	PATELLA-OPEN REDUCTION BY SUTURE	308.70	311.94	317.34	322.75	330.31
3373	PATELLA-OPEN REDUCTION BY EXCISION	308.70	311.94	317.34	322.75	330.31
3374	FEMUR,SHAFT OR TRANS-NO REDUCTION,CAST	182.30	184.21	187.40	190.59	195.06
3375	FEMUR,CLOSED REDUCTION-CHILD	270.25	273.09	277.82	282.55	289.17
3376	FEMUR,CLOSED REDUCTION-ADULT	378.35	382.32	388.94	395.56	404.83
3377	FEMUR-OPEN REDUCTION	480.80	485.85	494.26	502.68	514.46
3379	NECK-NO REDUCTION	216.10	218.37	222.15	225.93	231.23
3380	NECK-CLOSED REDUCTION	324.40	327.81	333.48	339.16	347.11
3381	NECK OPEN REDUCTION,PIN AND/OR PLATE	591.10	597.31	607.65	618.00	632.48
3382	NECK-PROSTHESIS	628.75	635.35	646.36	657.36	672.76
3383	SPINE-FRACTURE-SPINOUS/TRANSVERSE	108.15	109.29	111.18	113.07	115.72
3384	SPINE-CLOSED REDUCTION	257.20	259.90	264.40	268.90	275.20
3385	SPINE-SKULL CALIPERS	108.15	109.29	111.18	113.07	115.72
3386	SPINE-OPEN REDUCTION	617.45	623.93	634.74	645.54	660.67
3387	SPINE-OPEN REDUCTION WITH FUSION	648.50	655.31	666.66	678.01	693.90
3388	SPINE-OPEN AND FUSION WITH CORD INJURY	486.50	491.61	500.12	508.64	520.56
3389	SKULL CALIPERS	108.15	109.29	111.18	113.07	115.72
3390	SPINE-CLOSED REDUCTION UNDER ANAES	514.60	520.00	529.01	538.01	550.62
3391	SPINE-OPEN REDUCTION	756.80	764.75	777.99	791.23	809.78
3392	SPINE-OPEN REDUCTION WITH FUSION	756.80	764.75	777.99	791.23	809.78
3393	SPINE-OPEN REDUCTION AND FUSION-EACH SURGERY	514.60	520.00	529.01	538.01	550.62
3394	SPINE-OPEN,DECOMPRESSION OF CORD	720.30	727.86	740.47	753.07	770.72
3395	SACRUM-COMPLETE CARE	54.00	54.57	55.51	56.46	57.78
3396	COCCYX-NO REDUCTION-COMPLETE CARE	54.00	54.57	55.51	56.46	57.78
3397	COCCYX-EXCISION	205.80	207.96	211.56	215.16	220.21
3398	CLAVICLE-NO REDUCTION -CHILD	59.70	60.33	61.37	62.42	63.88
3399	CLAVICLE-NO REDUCTION-ADULT	64.90	65.58	66.72	67.85	69.44

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
3400	CLAVICLE-CLOSED REDUCTION-CHILD	110.75	111.91	113.85	115.79	118.50
3401	CLAVICLE-CLOSED REDUCTION-ADULT	110.75	111.91	113.85	115.79	118.50
3402	CLAVICLE-OPEN REDUCTION	216.10	218.37	222.15	225.93	231.23
3404	SCAPULA-NO REDUCTION	59.70	60.33	61.37	62.42	63.88
3405	SCAPULA-CLOSED REDUCTION	108.15	109.29	111.18	113.07	115.72
3406	STERNUM-NO REDUCTION	54.00	54.57	55.51	56.46	57.78
3407	STERNUM-CLOSED REDUCTION	108.15	109.29	111.18	113.07	115.72
3408	STERNUM-OPEN REDUCTION	216.10	218.37	222.15	225.93	231.23
3409	RIBS-UNCOMPLICATED(THREE OR LESS)	32.45	32.79	33.36	33.93	34.72
3410	RIBS-EACH ADDITIONAL (OVER 3)	10.85	10.96	11.15	11.34	11.61
3411	RIBS-COMPLICATED	I.C.	I.C.	I.C.	I.C.	I.C.
3412	PELVIS-NO REDUCTION	19.35	19.55	19.89	20.23	20.70
3413	PELVIS-NO REDUCTION	324.40	327.81	333.48	339.16	347.11
3414	PELVIS-OPEN REDUCTION	I.C.	I.C.	I.C.	I.C.	I.C.
3415	NASAL BONES-NO REDUCTION	32.45	32.79	33.36	33.93	34.72
3416	NASAL BONES-CLOSED,LOCAL	80.35	81.19	82.60	84.01	85.97
3417	NASAL BONES-CLOSED,GENERAL	108.15	109.29	111.18	113.07	115.72
3418	NASAL BONES-OPEN	216.10	218.37	222.15	225.93	231.23
3419	MANDIBLE-NO REDUCTION	54.00	54.57	55.51	56.46	57.78
3420	MANDIBLE-CLOSED REDUCTION	216.10	218.37	222.15	225.93	231.23
3421	MANDIBLE-OPEN	324.40	327.81	333.48	339.16	347.11
3423	MAXILLA-REDUCTION BY DIRECTION-FORCEPS	108.15	109.29	111.18	113.07	115.72
3424	MAXILLA-OPEN REDUCTION	216.10	218.37	222.15	225.93	231.23
3425	MAXILLA-COMPLICATED	I.C.	I.C.	I.C.	I.C.	I.C.
3500	ARTHROTOMY-WRIST,ELBOW,SHOULDER,ANKLE	216.10	218.37	222.15	225.93	231.23
3501	ARTHROTOMY-KNEE EXPLORATORY	257.20	259.90	264.40	268.90	275.20
3502	MENIS/DEB ICOMPARTMENT	396.80	400.97	407.91	414.85	424.58
3503	ARTHROTOMY-HIP EXPLORATORY	411.60	415.92	423.12	430.33	440.41
3504	CAPSULECTOMY-ELBOW,WRIST	324.40	327.81	333.48	339.16	347.11
3505	CAPSULECTOMY-SHOULDER	432.55	437.09	444.66	452.23	462.83
3506	CAPSULECTOMY-HIP	514.60	520.00	529.01	538.01	550.62
3507	SYNOVECTOMY 2 OR MORE COMPARTMENTS	432.55	437.09	444.66	452.23	462.83
3508	CAPSULECTOMY-FINGERS,TOES	162.25	163.95	166.79	169.63	173.61
3509	NEURECTOMY-ELBOW,KNEE	308.70	311.94	317.34	322.75	330.31
3510	NEURECTOMY-HIP	378.35	382.32	388.94	395.56	404.83
3512	CHONDRECTOMY-KNEE MENISECTOMY	308.70	311.94	317.34	322.75	330.31
3513	CHRONDRECTOMY-BAKER'S CYST (KNEE)	162.25	163.95	166.79	169.63	173.61
3514	EXCISION OF INTERVERTEBRAL DISC	514.60	520.00	529.01	538.01	550.62
3515	EXCIS-INTERVERT DISC,BILATERAL MULTPLE	648.50	655.31	666.66	678.01	693.90
3519	FUSION-ONE SURGEON	756.80	764.75	777.99	791.23	809.78
3520	FUSION-TWO SURGEONS	486.50	491.61	500.12	508.64	520.56
3521	INTERPHALANGEAL,METACARPOPHALANGEAL	216.10	218.37	222.15	225.93	231.23
3522	HAND,RECONSTRUCT-RHEUMATOID JOINTS	514.60	520.00	529.01	538.01	550.62
3523	ARTHOPLASTY-WRIST,ANKLE	411.60	415.92	423.12	430.33	440.41
3524	ARTHOPLASTY-SHOULDER,ELBOW,KNEE	432.55	489.64	584.79	679.94	813.15
3525	ACROMIO OR STERNOCLAVICULAR	270.25	273.09	277.82	282.55	289.17
3526	FOOT-HALLUX RIGIDUS	216.10	218.37	222.15	225.93	231.23
3528	FOOT-KELLER OPERATION	257.20	259.90	264.40	268.90	275.20
3529	HIP-CUP ARTHROPLASTY	648.50	655.31	666.66	678.01	693.90
3530	HIP-TOTAL ARTHROPLASTY	806.05	814.51	828.62	842.73	862.47
3531	ARTHRODESIS-FINGER,THUMB	216.10	218.37	222.15	225.93	231.23
3532	ARTHRODESIS-WRIST,ELBOW,ANKLE	411.60	415.92	423.12	430.33	440.41
3533	ARTHRODESIS-SHOULDER,KNEE,SACROILIC	514.60	520.00	529.01	538.01	550.62
3534	ARTHRODESIS-HIP	648.50	655.31	666.66	678.01	693.90
3535	ARTHRODESIS-FOOT,TOE, ONE JOINT	364.65	368.48	374.86	381.24	390.18
3536	ARTHRODESIS-FOOT,TOE,MULTIPLE JOINT	32.45	32.79	33.36	33.93	34.72
3537	ARTHRODESIS-FOOT MID-TARSAL	411.60	415.92	423.12	430.33	440.41

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3538	ARTHRODESIS-FOOT PAN TALER	540.65	546.33	555.79	565.25	578.50
3539	ARTHRODESIS-CONGENITAL CLUB FOOT	514.60	520.00	529.01	538.01	550.62
3540	SPINAL COLUMN FUSION-ONE OR TWO SPACES	617.45	623.93	634.74	645.54	660.67
3541	SPINAL COLUMN.FUSION MORE THAN 2 SPACE	756.80	764.75	777.99	791.23	809.78
3542	SYNOVECTOMY 1 COMPARTMENT	308.70	311.94	317.34	322.75	330.31
3544	REDUCTION WITH EXTERNAL PIN FIX	140.60	142.08	144.54	147.00	150.44
3545	CHEMONUCLEOLYSIS INCL NEEDL & INJECTN PER DISC	242.25	244.79	249.03	253.27	259.21
3546	DISLOCATION OF HEAD OF RADIUS	46.45	46.94	47.75	48.56	49.70
3547	MENISECTOMY/DEBRIDMNT 2 OR MORE COMPRTMNTS	494.70	499.89	508.55	517.21	529.33
3548	REDUCTN+PINNING INTRA-ARTICULAR FRAGMENTS	308.70	311.94	317.34	322.75	330.31
3549	MENISCAL REPAIR (MEDIAL OR LATERAL)	308.70	311.94	317.34	322.75	330.31
3550	SHOULDER ARTHROPLASTY	656.40	708.10	794.26	880.42	1,001.04
3600	FINGER AND THUMB-CLOSED REDUCTION,ONE	54.00	54.57	55.51	56.46	57.78
3601	FINGER AND THUMB-OPEN REDUCTION	162.25	163.95	166.79	169.63	173.61
3602	METACARPOPHALANGEAL-CLOSE REDUCTION	60.80	61.44	62.50	63.57	65.06
3603	METCARPOPHALANGEAL-OPEN REDUCTION	162.25	163.95	166.79	169.63	173.61
3604	WRIST AND CARPAL BONES-CLOSED REDUCTION	162.25	163.95	166.79	169.63	173.61
3605	WRIST AND CARPAL BONES-OPEN REDUCTION	308.70	311.94	317.34	322.75	330.31
3606	ELBOW-CLOSED REDUCTION	171.55	173.35	176.35	179.36	183.56
3607	ELBOW-OPEN REDUCTION	308.70	311.94	317.34	322.75	330.31
3608	SHOULDER-CLOSED REDUCTION	113.30	114.49	116.47	118.46	121.23
3609	SHOULDER-OPEN REDUCTION	378.35	382.32	388.94	395.56	404.83
3610	SHOULDER-RECURRENT DISLOCATIONS	452.75	457.50	465.43	473.35	484.44
3611	ACROMIOCLAVICULAR-CLOSED REDUCTION	64.90	65.58	66.72	67.85	69.44
3612	ACROMIOCLAVICULAR-OPEN REDUCTION	270.25	273.09	277.82	282.55	289.17
3613	STERNOCLAVICULAR-CLOSED REDUCTION	59.40	60.02	61.06	62.10	63.56
3614	STERNOCLAVICULAR-OPEN REDUCTION	216.10	218.37	222.15	225.93	231.23
3615	TOE,INTERPHALANGEAL-CLOSED REDUCTION	32.45	32.79	33.36	33.93	34.72
3616	TOE,INTERPHALANGEAL-OPEN REDUCTION	162.25	163.95	166.79	169.63	173.61
3617	METATARSOPHALANGEAL-CLOSE REDUCTION	60.80	61.44	62.50	63.57	65.06
3618	METATARSOPHALANGEAL-OPEN REDUCTION	162.25	163.95	166.79	169.63	173.61
3619	TARSAL-CLOSED REDUCTION	135.40	136.82	139.19	141.56	144.88
3620	TARSAL-OPEN REDUCTION	270.25	273.09	277.82	282.55	289.17
3621	ANKLE-CLOSED REDUCTION	165.80	167.54	170.44	173.34	177.41
3622	ANKLE-OPEN REDUCTION	308.70	311.94	317.34	322.75	330.31
3623	ANKLE REPAIR-RECURRENT SUBLUXATION	411.60	415.92	423.12	430.33	440.41
3624	KNEE-CLOSED REDUCTION	191.10	193.11	196.45	199.80	204.48
3625	KNEE-SIMPLE REDUCTION	378.35	382.32	388.94	395.56	404.83
3626	PATELLA-CLOSED REDUCTION	75.75	76.55	77.87	79.20	81.05
3627	PATELLA-OPEN REDUCTN FOR RECURR DISLOCATION	324.40	327.81	333.48	339.16	347.11
3628	HIP-CLOSED REDUCTION	191.10	193.11	196.45	199.80	204.48
3629	HIP-OPEN REDUCTION	378.35	382.32	388.94	395.56	404.83
3630	HIP-CENTRAL DISLOCATION-CLOSED REDUCTION	216.10	218.37	222.15	225.93	231.23
3631	HIP-CENTRAL DISLOCATION-OPEN REDUCTION	432.55	437.09	444.66	452.23	462.83
3632	HIP-CONGENITAL DISLOCATION-CLOSED UNILATERAL	162.25	163.95	166.79	169.63	173.61
3633	HIP-CONGEN DISLOCN-REPEAT MANIPUL+PLASTER	75.75	76.55	77.87	79.20	81.05
3634	HIP-CONGENITAL DISLOCATION-OSTEOTOMY	432.55	437.09	444.66	452.23	462.83
3635	HIP-CONGENITAL DISLOCATION-ACETABULOPLASTY	540.65	546.33	555.79	565.25	578.50
3636	SPINE-INTERVERTEBRAL-CLOSED REDUCTION	216.10	218.37	222.15	225.93	231.23
3637	SPINE-INTERVERTEBRAL-OPEN REDUCTION	411.60	415.92	423.12	430.33	440.41
3638	OPEN REDUCTION-FUSION CERVICAL SPINE	668.90	675.92	687.63	699.33	715.72
3639	OPEN REDUCTION-FUSION,THORACIC AND LUMBAR	648.50	655.31	666.66	678.01	693.90
3640	SACROCOCCYGEAL-OPEN REDUCTION	216.10	218.37	222.15	225.93	231.23
3641	TEMPOROMANDIBULAR-CLOSED REDUCTION	47.35	47.85	48.68	49.50	50.66
3642	TEMPOROMANDIBULAR-OPEN REDUCTION	216.10	218.37	222.15	225.93	231.23
3643	MANIPULATION OF WRIST,ELBOW,ANKLE	32.45	32.79	33.36	33.93	34.72
3644	MANIPULATION OF SHOULDER,KNEE,HIP	54.00	54.57	55.51	56.46	57.78

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3645	CONGENITAL FOOT DENNIS BROWN SPLINTS	21.55	21.78	22.15	22.53	23.06
3646	CONGENITAL FOOT MANIPULATION AND CAST	32.45	32.79	33.36	33.93	34.72
3647	KNEE-OPEN REDUCTION-RECONSTRUCT LIGAMENTS	486.50	491.61	500.12	508.64	520.56
3648	PATELLA-OPEN REDUCTN-RECONSTRUCT LIGAMENTS	486.50	491.61	500.12	508.64	520.56
3701	BURSA-INCISION,REMOVAL OF CALCIUM	216.10	218.37	222.15	225.93	231.23
3702	BURSA,EXCISION OLECRANON	162.25	163.95	166.79	169.63	173.61
3703	BURSA-EXCISION HUMERO-RADIAL	162.25	163.95	166.79	169.63	173.61
3704	BURSA-EXCISION-SUB-ACROMIAL	216.10	218.37	222.15	225.93	231.23
3705	BURSA-EXCISION-SUB TROCHANTERIC	257.20	259.90	264.40	268.90	275.20
3706	BIOPSY-SUPERFICIAL BURSA	32.45	32.79	33.36	33.93	34.72
3750	MUSCLES-REMOVAL OF FOREIGN BODY	54.00	54.57	55.51	56.46	57.78
3751	MUSCLE-COMPLICATED REMOVAL FOREIGN BODY	I.C.	I.C.	I.C.	I.C.	I.C.
3754	TENNIS ELBOW	162.25	163.95	166.79	169.63	173.61
3755	MUSCLE BIOPSY	54.00	54.57	55.51	56.46	57.78
3756	RESECTION OF MUSCLE	I.C.	I.C.	I.C.	I.C.	I.C.
3757	LOCAL EXCISION OF LESION OF MUSCLE	75.75	76.55	77.87	79.20	81.05
3758	MANIPULATION AND INJECTION-TENNIS ELBOW	32.45	32.79	33.36	33.93	34.72
3760	QUADRICEPSPLASTY	378.35	382.32	388.94	395.56	404.83
3800	EXPLORATION OF TENDON/TENDON SHEATH	129.75	131.11	133.38	135.65	138.83
3801	TENOSYNOVITIS,FINGER	129.75	131.11	133.38	135.65	138.83
3802	TRIGGER FINGER-RELEASE	129.75	131.11	133.38	135.65	138.83
3803	EXPLORATION OF FASCIA	153.80	155.41	158.11	160.80	164.57
3804	DRAINAGE OF TENDON SHEATH	129.75	131.11	133.38	135.65	138.83
3805	TENOTOMY-TOE,SINGULAR	32.45	32.79	33.36	33.93	34.72
3806	TENOTOMY-TOE,MULTIPLE	54.00	54.57	55.51	56.46	57.78
3807	TENOTOMY-PLANTAR FASCIA	54.00	54.57	55.51	56.46	57.78
3808	TENOTOMY-HIP ADDUCTORS	54.00	54.57	55.51	56.46	57.78
3809	TENOTOMY-TENDO ACHILLES	54.00	54.57	55.51	56.46	57.78
3810	GANGLION-TENDON SHEATH OR JOINT	129.70	131.06	133.33	135.60	138.78
3811	BAKER'S CYST-DEQUERVAINS	259.40	262.12	266.66	271.20	277.56
3812	TENDON SHEATH FOR TUBERCULOSIS	324.40	327.81	333.48	339.16	347.11
3813	FASCIA FOR DUPUYTREN'S-PARTIAL	216.10	218.37	222.15	225.93	231.23
3814	FASCIA FOR DUPUYTREN'S-COMPLETE	378.35	382.32	388.94	395.56	404.83
3815	XANTHOMA	108.15	109.29	111.18	113.07	115.72
3816	TENOPLASTY-ONE TENDON	216.10	218.37	222.15	225.93	231.23
3817	TENOPLASTY-TWO OR MORE TENDONS	270.25	273.09	277.82	282.55	289.17
3818	TENDON GRAFT-WRIST OR HAND-SINGLE	411.60	415.92	423.12	430.33	440.41
3819	TENDON GRAFT-WRIST/HAND-TWO AND GREATER	514.60	520.00	529.01	538.01	550.62
3820	TENDON GRAFT-OTHER LOCATION	409.30	413.60	420.76	427.92	437.95
3821	FASCIOTOMY	205.80	207.96	211.56	215.16	220.21
3823	TENDON TRANSPLANT-HAND,FOREARM-SINGLE	216.10	218.37	222.15	225.93	231.23
3824	TENDON TRANSPLANT-HAND,FOREARM-MULTIPLE	378.35	382.32	388.94	395.56	404.83
3825	SHOULDER-PECTORALIS MINOR	216.10	218.37	222.15	225.93	231.23
3826	TENDON TRANS SHOULDER TRAPEZIUS	360.20	363.98	370.29	376.59	385.41
3827	TENDON TRANSPLANT-FOOT,ANKLE,SINGLE	216.10	218.37	222.15	225.93	231.23
3828	TENDON TRANSPLANT-FOOT,ANKLE-MULTIPLE	378.35	382.32	388.94	395.56	404.83
3829	KNEE-TRANSPOSITION OF TENDONS	324.40	327.81	333.48	339.16	347.11
3830	FOOT-TENDODESIS	216.10	218.37	222.15	225.93	231.23
3831	REPAIR OF MALLET FINGER-CLOSED	55.25	55.83	56.80	57.76	59.12
3832	REPAIR OF MALLET FINGER-OPERATIVE	162.25	163.95	166.79	169.63	173.61
3833	SUTURE-EXTENSOR TENDON-SINGLE	162.25	163.95	166.79	169.63	173.61
3834	SUTURE-EXTENSOR TENDON EACH SUBSEQUENT	75.00	75.79	77.10	78.41	80.25
3835	SUTURE-FLEXOR TENDON-SINGLE	250.00	252.63	257.00	261.38	267.50
3836	SUTURE-FLEXOR TENDON EACH SUBSEQUENT	125.00	126.31	128.50	130.69	133.75
3837	SUTURE-ACHILLES,BICEPS,QUADRICEPS	270.25	273.09	277.82	282.55	289.17
3838	FASCIA AND LIGAMENTS-SHOULDER CUFF TEAR	360.20	363.98	370.29	376.59	385.41
3839	FASCIA AND LIGAMENTS-SHOULDER-LATE REPAIR	432.55	437.09	444.66	452.23	462.83

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
3840	RECONSTRUCTION OF SHOULDER ACROMIOPLASTY	324.40	327.81	333.48	339.16	347.11
3841	ACROMIOCLAVICULAR/STERNOCLAVICULAR	360.20	363.98	370.29	376.59	385.41
3842	ELBOW,WRIST,ANKLE-EARLY REPAIR	216.10	218.37	222.15	225.93	231.23
3843	ELBOW,WRIST,ANKLE-LATE REPAIR	378.35	382.32	388.94	395.56	404.83
3844	KNEE-EARLY REPAIR	324.40	327.81	333.48	339.16	347.11
3845	KNEE-LATE REPAIR	475.80	480.80	489.12	497.45	509.11
3846	METACARPOPHALANGEAL-EARLY OR LATER	162.25	163.95	166.79	169.63	173.61
3847	TENOPLASTY-ACHILLES BICEPS/QUADRICEPS TENDON	257.20	259.90	264.40	268.90	275.20
3848	LATERAL/MEDIAL RETNACULAR RELEASE	181.75	183.66	186.84	190.02	194.47
3849	EXTENSOR TENDOR-PARTIALLY SEVERED	150.00	151.58	154.20	156.83	160.50
3900	AMPUTATION-UP EXTREMITY THROUGH PHALANX	75.00	75.79	77.10	78.41	80.25
3901	AMPUTATION THROUGH METACARPAL OR MP JOINT	108.15	109.29	111.18	113.07	115.72
3902	AMPUTATION HAND-THROUGH ALL METACARPALS	270.25	273.09	277.82	282.55	289.17
3903	AMPUTN UP EXTREMITY THROUGH RADIUS AND ULNA	324.40	327.81	333.48	339.16	347.11
3904	AMPUTATION UP EXTREMITY THROUGH HUMERUS	324.40	327.81	333.48	339.16	347.11
3905	AMPUTATION UPPER EXTREMITY AT SHOULDER	378.35	382.32	388.94	395.56	404.83
3906	AMPUTATION UPPER EXTREMITY,FORE QUARTER	514.60	520.00	529.01	538.01	550.62
3907	AMPUTN-LOWER EXTREMITY THROUGH PHALANX	75.75	76.55	77.87	79.20	81.05
3908	AMPUTATION THROUGH METATARSAL OR MP JOINT	108.15	109.29	111.18	113.07	115.72
3909	AMPUTATION-LOWER-TRANSMETATARSAL	257.20	259.90	264.40	268.90	275.20
3910	AMPUTATION-LOWER-SYMES	308.70	311.94	317.34	322.75	330.31
3911	AMPUTATION-LOWER-THROUGH TIBIA AND FIBULA	324.40	327.81	333.48	339.16	347.11
3912	AMPUTATION-LOWER-AT KNEE	324.40	327.81	333.48	339.16	347.11
3913	AMPUTATION-LOWER-THROUGH FEMUR	324.40	327.81	333.48	339.16	347.11
3914	AMPUTATION-LOWER-AT HIP	617.45	623.93	634.74	645.54	660.67
3915	AMPUTATION-LOWER-HIND QUARTER	756.80	764.75	777.99	791.23	809.78
3916	AMPUTATION-LOWER-HEMIPELVECTOMY	756.80	764.75	777.99	791.23	809.78
4000	NOSE-NASAL ABSCESS	55.25	55.83	56.80	57.76	59.12
4001	NOSE-SEPTAL ABSCESS	86.45	87.36	88.87	90.38	92.50
4002	BIOPSY OF SOFT TISSUE	50.00	50.53	51.40	52.28	53.50
4003	NASAL POLYPI-UNILATERAL LOCAL	32.45	32.79	33.36	33.93	34.72
4004	NASAL POLYPI-UNILATERAL GENERAL	54.00	54.57	55.51	56.46	57.78
4005	NASAL POLYPI-BILATERAL LOCAL	54.00	54.57	55.51	56.46	57.78
4006	NASAL POLYPI-BILATERAL GENERAL	108.15	109.29	111.18	113.07	115.72
4007	EXCISION OF CHOANAL POLYP	75.75	76.55	77.87	79.20	81.05
4009	EXCISION-NOSE SKIN-RHINOPHYMA,UNCOMPLICATED	75.75	76.55	77.87	79.20	81.05
4010	SEPTECTOMY	216.10	218.37	222.15	225.93	231.23
4011	SEPTECTOMY INCLUDING SEPTOPLASTY	270.25	273.09	277.82	282.55	289.17
4012	TURBINECTOMY	43.20	43.65	44.41	45.17	46.22
4013	SUBMUCOSAL TURBINECTOMY	I.C.	I.C.	I.C.	I.C.	I.C.
4014	RHINOSCOPY-REMOVAL FOREIGN BODY-NOSE	35.00	35.37	35.98	36.59	37.45
4015	RHINOSCOPY-GENERAL ANESTHETIC	43.20	43.65	44.41	45.17	46.22
4016	RHINOPLASTY/CLOSURE SEPTAL PERFORATION	635.85	642.53	653.65	664.78	680.36
4019	INFRACTION OF TURBINATE	21.55	21.78	22.15	22.53	23.06
4020	CAUTERIZATION TURBINATES-UNILATERAL	32.45	32.79	33.36	33.93	34.72
4021	CAUTERIZATION TURBINATES-BILATERAL	54.00	54.57	55.51	56.46	57.78
4022	NASAL HEMORRHAGE-CAUTERIZ NASAL SEPTUM	21.55	21.78	22.15	22.53	23.06
4023	NASAL HEMORRHAGE-ANTERIOR NASAL PACKING	50.00	50.53	51.40	52.28	53.50
4024	NASAL HEMORRHAGE-POSTERIOR NASAL PACKING	85.00	85.89	87.38	88.87	90.95
4025	CONTROL OF SECONDARY HEMORRHAGE	75.75	76.55	77.87	79.20	81.05
4026	CATHETERIZATION OF EUSTACHIAN TUBE	10.85	10.96	11.15	11.34	11.61
4027	SINUSOTOMY-MAXILLARY,INTRANASAL-UNILATERAL	129.75	131.11	133.38	135.65	138.83
4028	SINUSOTOMY-RADICAL-UNILATERAL	308.70	311.94	317.34	322.75	330.31
4029	FRONTAL TREPHINE AND SINUSECTOMY	162.25	163.95	166.79	169.63	173.61
4030	FRONTAL-RADICAL	514.60	520.00	529.01	538.01	550.62
4031	FRONTAL-EXTERNAL FRONTO-ETHMOIDAL	162.25	163.95	166.79	169.63	173.61
4032	ETHMOIDAL-INTRANASAL,UNILATERAL	162.25	163.95	166.79	169.63	173.61

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
4033	SPHENOIDAL-INTRANASAL	216.10	218.37	222.15	225.93	231.23
4034	LAVAGE-MAXILLARY	21.55	21.78	22.15	22.53	23.06
4035	LAVAGE-FRONTAL	43.20	43.65	44.41	45.17	46.22
4036	LAVAGE-SPHENOIDAL	43.20	43.65	44.41	45.17	46.22
4037	SUTURE-CLOSURE ANTRO-ORAL FISTULA	324.40	327.81	333.48	339.16	347.11
4040	EXAM POST-NASAL SPACE UNDER GEN ANAESTHESIA	42.30	42.74	43.48	44.22	45.26
4041	SUBMUCUS DIATHERMY/TURBINATES	56.95	57.55	58.54	59.54	60.94
4100	LARYNGECTOMY-PARTIAL	432.55	437.09	444.66	452.23	462.83
4101	LARYNGECTOMY-TOTAL	648.50	655.31	666.66	678.01	693.90
4104	INTUBATION OF LARYNX	50.00	51.50	54.00	56.50	60.00
4105	LARYNGOSCOPY-DIRECT	65.00	68.00	73.00	78.00	85.00
4106	LARYNGOSCOPY-DIRECT WITH BIOPSY	86.45	89.23	93.87	98.51	105.00
4107	LARYNGOSCOPY-REMOVAL FOREIGN BODY	165.50	170.68	179.30	187.93	200.00
4108	LARYNGOSCOPY-REMOVAL BENIGN GROWTH	205.80	212.43	223.48	234.53	250.00
4109	LARYNGOSCOPY-INDIRECT WITH BIOPSY	43.20	49.47	59.92	70.37	85.00
4110	LARYNGOPLASTY	I.C.	I.C.	I.C.	I.C.	I.C.
4111	ARYTENOIDOPEXY	411.60	415.92	423.12	430.33	440.41
4200	TRACHEOSTOMY	205.80	207.96	211.56	215.16	220.21
4201	BRONCHOSCOPY-DIAGNOSTIC	142.35	143.84	146.34	148.83	152.31
4202	BRONCHOSCOPY WITH BIOPSY	142.35	143.84	146.34	148.83	152.31
4203	BRONCHOSCPY-INSERT RADIOACTIVE SUBSTANCE	142.35	143.84	146.34	148.83	152.31
4204	BRONCHOSCOPY-REMOVAL FOREIGN BODY	205.80	207.96	211.56	215.16	220.21
4205	BRONCHOSCOPY WITH EXCISION TUMOR	205.80	207.96	211.56	215.16	220.21
4206	BRONCHO-ESOPHAGOSCOPY	194.55	196.59	200.00	203.40	208.17
4207	TRACHEORRHAPY	162.25	163.95	166.79	169.63	173.61
4208	CLOSE TRACHEOSTOMY/TRACHEAL FISTULA	162.25	163.95	166.79	169.63	173.61
4209	QUADROSCOPY	187.90	189.87	193.16	196.45	201.05
4210	BRONCHOSCOPY W/ TRANSBRONCH LUNG BX -SINGLE LOBE	196.10	198.06	201.49	204.92	209.72
4211	ENDOSCOPY THROUGH TRACHEOSTOMY	50.00	50.53	51.40	52.28	53.50
4212	BRONCHOSCOPY +TRANSBRONCH LUNG BX -ADD'L LOBE		50.00	51.05	52.10	53.50
4213	BRONCHOSC'PY +TRANSBRONCH NEEDLE ASPIRAT'N NODES		198.06	201.49	204.92	209.72
4214	ENDOBRONCHIAL ULTRASOUND (EBUS)		269.98	274.66	279.33	285.88
4300	MEDIASTINOTOMY	432.55	437.09	444.66	452.23	462.83
4302	CHEST WALL TUMOR	685.10	692.29	704.28	716.27	733.06
4303	MEDIASTINAL TUMOR	540.65	546.33	555.79	565.25	578.50
4304	MEDIASTINOSCOPY	265.20	267.98	272.63	277.27	283.76
4305	THORACOPLASTY-ONE STAGE	411.60	415.92	423.12	430.33	440.41
4306	THORACOPLASTY-MULTI-STAGE	259.40	262.12	266.66	271.20	277.56
4308	PNEUMOLYSIS-INTRAPLEURAL	194.55	196.59	200.00	203.40	208.17
4309	PNEUMOLYSIS-EXTRAPLEURAL	324.40	327.81	333.48	339.16	347.11
4310	APICOLYSIS-EXTRAFASCIAL	324.40	327.81	333.48	339.16	347.11
4311	APICOLYSIS-EXTRAPLEURAL	324.40	327.81	333.48	339.16	347.11
4313	TRANSAXILLARY-RESECTION 1ST RIB	508.30	513.64	522.53	531.43	543.88
4400	THORACOTOMY-CLOSED DRAINAGE	176.80	178.66	181.75	184.84	189.18
4401	THORACOTOMY-RIB RESECTION	265.20	267.98	272.63	277.27	283.76
4402	THORACOTOMY-DRAINAGE LUNG ABCESS	389.15	393.24	400.05	406.86	416.39
4403	EXPLORATORY THORACOTOMY	389.15	393.24	400.05	406.86	416.39
4404	BIOPSY OF PLEURA OR LUNG	442.00	446.64	454.38	462.11	472.94
4406	PNEUMONECTOMY	884.00	893.28	908.75	924.22	945.88
4407	LOBECTOMY	850.85	859.78	874.67	889.56	910.41
4408	LOBECTOMY WITH SEGMENTAL RESECTION	756.80	764.75	777.99	791.23	809.78
4409	SEGMENTAL RESECTION	756.80	764.75	777.99	791.23	809.78
4410	WEDGE RESECTION	530.40	535.97	545.25	554.53	567.53
4411	PLEURECTOMY-PLEURAL DECORTICATION	618.80	625.30	636.13	646.96	662.12
4412	PLEURECTOMY-WITH BULLOUS EMPHYSEMA	617.45	623.93	634.74	645.54	660.67
4413	THORACOSCOPY	221.00	223.32	227.19	231.06	236.47
4500	VENOGRAM	54.05	54.62	55.56	56.51	57.83

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
4501	VENOUS ANASTOMOSIS-PORTO CAVAL SHUNT	756.80	764.75	777.99	791.23	809.78
4502	VENOUS ANASTOMOSIS-SPLENO RENAL SHUNT	756.80	764.75	777.99	791.23	809.78
4503	VENOUS ANASTOMOSIS-MESO CAVAL SHUNT	720.30	727.86	740.47	753.07	770.72
4505	CREATION OF A-V FISTULA	389.15	393.24	400.05	406.86	416.39
4506	JUGULAR VEIN,INTERNAL	162.25	163.95	166.79	169.63	173.61
4508	INFERIOR VENA CAVA-LIGATION OR PLICATION	432.55	437.09	444.66	452.23	462.83
4510	SAPHENOUS	54.00	54.57	55.51	56.46	57.78
4511	INJECTION-SINGLE	10.85	10.96	11.15	11.34	11.61
4512	INJECTION-MULTIPLE AT SAME SITTING	46.45	46.94	47.75	48.56	49.70
4513	LIGATION,MULTIPLE-ONE LEG	129.75	131.11	133.38	135.65	138.83
4514	LIGAT SAPHENO-FEM OR SAPHEN-POP JUNCT (ONE LEG)	129.75	131.11	133.38	135.65	138.83
4515	LONG SAPHEN LIGAT/STRIPPING STAB AVULS (ONE LEG)	216.10	218.37	222.15	225.93	231.23
4516	MULT LOW LIGATION &EXCISN LIGATN-PERFORAORS	270.25	273.09	277.82	282.55	289.17
4517	SHORT SAPHENOUS LIGATION/ STRIPPING (ONE LEG)	108.15	109.29	111.18	113.07	115.72
4518	RECURRENT OR COMPLICATED VARICOSE VEINS	381.70	385.71	392.39	399.07	408.42
4519	EXCISION ULCER,LIGAT/STRIPPING/SKIN GRAFT(ONE LEG)	324.40	327.81	333.48	339.16	347.11
4521	EXCISION STASIS ULCER AND SKIN GRAFT	216.10	218.37	222.15	225.93	231.23
4522	SUB-FASCIAL LIGATION	324.40	327.81	333.48	339.16	347.11
4523	SUB FASCIAL LIGATION-STRIPPING VEIN	432.55	437.09	444.66	452.23	462.83
4524	TROMBECTOMY,ILIAC OR FEMORAL	514.60	520.00	529.01	538.01	550.62
4525	DISTAL SPLENORENAL SHUNT	927.80	937.54	953.78	970.01	992.75
4526	SUPERIOR VENA CAVA BYPASS GRAFT	557.45	563.30	573.06	582.81	596.47
4527	OBLITERATION OF AV FISTULA	61.90	62.55	63.63	64.72	66.23
4528	SUTURE-A MAJOR VEIN REPAIR	278.70	281.63	286.50	291.38	298.21
4529	SCLEROTHERAPY COMPREHENSIVE (ONE LEG)	116.20	117.42	119.45	121.49	124.33
4530	REPAIR MAJOR VEIN OR MICROREPAIR DIGITAL VEIN	254.34	257.01	261.46	265.91	272.14
4531	REPAIR MAJOR VEIN BY PATCH	397.80	401.98	408.94	415.90	425.65
4532	REPAIR MAJOR VEIN BY VEIN GRAFT	529.04	534.59	543.85	553.11	566.07
4533	REPAIR A-V ANOMALY	389.15	393.24	400.05	406.86	416.39
4534	ESOPH DEVASC/TRANSECTION/REANASTOMOSIS W/SPLENECTOM	718.52	726.06	738.64	751.21	768.82
4535	VASCULAR STENT (ADD)	63.80	64.47	65.59	66.70	68.27
4536	OPERATIVE ARTERIOGRAM-ONE OR MORE (ADD)	54.00	54.57	55.51	56.46	57.78
4537	DILATION/STENT ILIAC ARTERY - UNILATERAL	250.46	253.09	257.47	261.86	267.99
4538	ANGIOGRAPHY-RENAL/MESENTERIC-PER VESSEL (ADD)	20.00	20.21	20.56	20.91	21.40
4599	ARTERIAL CANNULATION	50.00	51.50	54.00	56.50	60.00
4600	ARTERIOTOMY	75.75	76.55	77.87	79.20	81.05
4603	TRANSECTION OF ARTERY	162.25	163.95	166.79	169.63	173.61
4604	INTRA-ABDOMINAL OR INTRA-THORACIC	216.10	218.37	222.15	225.93	231.23
4606	THORACIC AORTA WITHOUT BYPASS	756.80	764.75	777.99	791.23	809.78
4607	THORACIC AORTA-WITH BYPASS	973.05	983.27	1,000.30	1,017.32	1,041.16
4608	ABDOMINAL AORTA	864.95	874.03	889.17	904.31	925.50
4609	ABDOMINAL AORTA WITH RUPTURE	973.05	983.27	1,000.30	1,017.32	1,041.16
4617	AORTA-BIFURCATION GRAFT	1,064.80	1,075.98	1,094.61	1,113.25	1,139.34
4618	THROMBOENDARTERECTOMY	648.50	655.31	666.66	678.01	693.90
4619	THROMBOENDARTERECTOMY OF AORTA/BIFURCATION	756.80	764.75	777.99	791.23	809.78
4620	FEM/POP, FEM/FEM, AXILLO/FEM - SYNTHETIC GRAFT	540.65	546.33	555.79	565.25	578.50
4621	FEM/POP, FEM/FEM, AXILLO/FEM - AUTOGEN.VEIN GRAFT	648.50	655.31	666.66	678.01	693.90
4622	EMBOLECTOMY-AORTIC/TRANSFEMORAL - BILAT.	648.50	655.31	666.66	678.01	693.90
4623	EMBOLECTOMY-ILIAC OR FEMORAL	432.55	437.09	444.66	452.23	462.83
4624	MESENTERIC EMBOLECTOMY	450.00	454.73	462.60	470.48	481.50
4625	EMBOLECTOMY-RENAL	540.65	546.33	555.79	565.25	578.50
4627	CAROTID BODY TUMOR	648.50	655.31	666.66	678.01	693.90
4628	CAROTID BODY TUMOR WITH GRAFT	702.75	710.13	722.43	734.73	751.94
4629	CAROTID BODY TUMOR-VESSEL BYPASS	756.80	764.75	777.99	791.23	809.78
4630	ARTERIOGRAPHY CAROTID	108.15	109.29	111.18	113.07	115.72
4631	ARTERIOGRAPHY-FEMORAL UNILATERAL	54.00	54.57	55.51	56.46	57.78
4632	ARTERIOGRAPHY-FEMORAL BILATERAL	86.45	87.36	88.87	90.38	92.50

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
4633	AORTOGRAPHY-PERCUTANEOUS	108.15	109.29	111.18	113.07	115.72
4634	AORTOGRAPHY-EXPOSURE MAJOR ARTERY	162.25	163.95	166.79	169.63	173.61
4635	ARTERIOGRAPHY-SELECTIVE	108.15	109.29	111.18	113.07	115.72
4636	AORTOGRAPHY-ARTERIAL CANNULATION	54.00	54.57	55.51	56.46	57.78
4637	ARTERIOPLASTY-FEMORAL	324.40	327.81	333.48	339.16	347.11
4638	ARTERIOPLASTY-ILIAC	324.40	327.81	333.48	339.16	347.11
4639	SUTURE-LIGATION CAROTID,NECK-SIMPLE	162.25	163.95	166.79	169.63	173.61
4641	LIGATION ANTERIOR ETHMOID ARTERY	108.15	109.29	111.18	113.07	115.72
4642	PROFUNDOPLASTY- TO FIRST MAJOR BRANCH	432.55	437.09	444.66	452.23	462.83
4643	EXPOSURE OF LEG VESSELS	108.15	109.29	111.18	113.07	115.72
4644	FEMORAL ANTERIOR OR POSTERIOR TIBIAL BYPASS	702.75	710.13	722.43	734.73	751.94
4650	REPAIR OF FALSE ANEURYSM	655.25	662.13	673.60	685.06	701.12
4651	REPAIR OF POPLITEAL OR FEMORAL ANEURYSM	605.75	612.11	622.71	633.31	648.15
4652	EXTENDED PROFUNDOPLASTY- TO 2ND MAJOR BRANCH	572.80	578.81	588.84	598.86	612.90
4653	IN-SITU PERIPHERAL VEIN GRAFT PROCEDURE (ADD)	247.65	250.25	254.58	258.92	264.99
4654	REIMPLANT INFERIOR MESENTERIC ARTERY (ADD)	130.05	131.42	133.69	135.97	139.15
4655	INTERRUPT VENA CAVA - TRANSVENOUS IVC FILTER	260.00	262.73	267.28	271.83	278.20
4656	HARVEST ARM VEIN (ADD)	99.28	100.32	102.06	103.80	106.23
4657	HARVEST SUP.FEM. VEIN (ADD)	99.28	100.32	102.06	103.80	106.23
4658	HARVEST OPPOSITE LEG VEIN (ADD)	82.62	83.49	84.93	86.38	88.40
4659	ENDARTERECTOMY - FEMORAL OR POPLITEAL	607.68	614.06	624.70	635.33	650.22
4660	CAROTID ANEURYSM REPAIR	656.56	663.45	674.94	686.43	702.52
4661	SUBCLAVIAN ANEURYSM REPAIR	693.88	701.17	713.31	725.45	742.45
4662	BRACHIOCEPHALIC ARTERIAL BYPASS	525.24	530.76	539.95	549.14	562.01
4663	AXILLARY/BRACHIAL ANEURYSM REPAIR - SYNTHETIC	540.65	546.33	555.79	565.25	578.50
4664	AXILLARY/BRACHIAL ANEURYSM REPAIR - VEIN	648.50	655.31	666.66	678.01	693.90
4665	THORACO-ABDOMINAL ANEURYSM REPAIR	1,547.00	1,563.24	1,590.32	1,617.39	1,655.29
4666	THORACO-ABDOMINAL ANEURYSM REPAIR (RUPTURED)	1,690.65	1,708.40	1,737.99	1,767.57	1,809.00
4667	PELVIC ANEURYSM REPAIR - LIGATION	362.50	366.31	372.65	378.99	387.88
4668	PELVIC ANEURYSM REPAIR - GRAFT	563.55	569.47	579.33	589.19	603.00
4669	ILIO-FEMORAL BYPASS	586.00	592.15	602.41	612.66	627.02
4670	REPAIR LACERATION MAJOR ARTERY OR MICRO DIGITAL	398.92	403.11	410.09	417.07	426.84
4671	SUTURE LACERATION MAJOR ARTERY LIMB	253.48	256.14	260.58	265.01	271.22
4672	TOTAL REMOVAL INFECTED AORTIC GRAFT	734.68	742.39	755.25	768.11	786.11
4673	PARTIAL REMOVAL INFECTED AORTIC GRAFT	275.20	278.09	282.91	287.72	294.46
4674	CLOSURE DUODENAL FISTULA (ADD)	101.64	102.71	104.49	106.26	108.75
4675	VISCERAL ARTERY ANEURYSM REPAIR OR BYPASS	454.00	458.77	466.71	474.66	485.78
4676	VISCERAL ARTERY ENDARTERECTOMY OR GRAFT	540.00	545.67	555.12	564.57	577.80
4677	VISCERAL ARTERY BYPASS TO ADDITIONAL ARTERY	I.C.	I.C.	I.C.	I.C.	I.C.
4678	LIMB FASCIOTOMY FOR ISCHEMIA (SINGLE)	134.47	135.88	138.24	140.59	143.88
4679	LIMB FASCIOTOMY FOR ISCHEMIA (MULTIPLE)	256.16	258.85	263.33	267.82	274.09
4680	LIMB FASCIOTOMY SECONDARY CLOSURE	77.88	78.70	80.06	81.42	83.33
4681	COMPOSITE GRAFT (ADD)	106.72	107.84	109.71	111.58	114.19
4682	TEMPORAL ARTERY BIOPSY	75.75	76.55	77.87	79.20	81.05
4683	CLOSURE LYMPHATIC FISTULA OF GROIN	165.84	167.58	170.48	173.39	177.45
4684	REPEAT PROCED. AFTER FOR FAILED GRAFT (ADD)	278.96	281.89	286.77	291.65	298.49
4700	ATRIAL OR VENTRICULAR PUNCTURE	43.20	43.65	44.41	45.17	46.22
4702	BIOPSY OF PERICARDIUM	324.40	327.81	333.48	339.16	347.11
4703	CARDIOTOMY WITH EXPLORATION	540.65	546.33	555.79	565.25	578.50
4704	CARDIOTOMY-REMOVAL FOREIGN BODY OR TUMOR	540.65	546.33	555.79	565.25	578.50
4705	CARDIOTOMY BY CLOSED TECHNIQUE	648.50	655.31	666.66	678.01	693.90
4706	CARDIOTOMY BY OPEN TECHNIQUE	756.80	764.75	777.99	791.23	809.78
4707	CARDIOTOMY BY OPEN TECHNIQUE-BYPASS	864.95	874.03	889.17	904.31	925.50
4708	PERICARDIECTOMY-PARTIAL	432.55	437.09	444.66	452.23	462.83
4709	PERICARDIECTOMY-SUBTOTAL	648.50	655.31	666.66	678.01	693.90
4713	REMOVAL HICKMAN CATHETER	73.07	73.84	75.12	76.39	78.18
4714	INSERTION OF PORTACATH	234.00	236.46	240.55	244.65	250.38

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
4715	REMOVAL OF PORTACATH	204.75	206.90	210.48	214.07	219.08
4716	CATHERIZATION OF CATHETER PACEMAKER	216.10	218.37	222.15	225.93	231.23
4717	HICKMAN CATHETER	142.35	143.84	146.34	148.83	152.31
4718	PATENT DUCTUS ARTERIOSUS	540.65	546.33	555.79	565.25	578.50
4738	PULMONARY STENOSIS-OPEN HEART	756.80	764.75	777.99	791.23	809.78
4747	PERICARDIAL INSUFFLATION-POWDER	324.40	327.81	333.48	339.16	347.11
4752	SUTURE OF WOUND	540.65	546.33	555.79	565.25	578.50
4753	CARDIAC MASSAGE	216.10	218.37	222.15	225.93	231.23
4754	NUCLEAR (MIBI) STRESS TESTING	100.00	101.05	102.80	104.55	107.00
4760	INSERTION TEMPORARY CATHETER PACEMAKER	232.10	234.54	238.60	242.66	248.35
4761	REPOSITION TEMPORARY CATHETER PACEMAKER	87.85	88.77	90.31	91.85	94.00
4762	REPLACE TEMPORARY CATHETER PACEMAKER	175.75	177.60	180.67	183.75	188.05
4763	INSERTION OF PERMANENT PACEMAKER	336.95	340.49	346.38	352.28	360.54
4764	REPOSITION PERMANENT PACEMAKER WIRE	175.75	177.60	180.67	183.75	188.05
4765	REPOSITIONING POWER SOURCE	232.10	234.54	238.60	242.66	248.35
4766	INSERTION TEMPORARY CATHETER PACEMAKER	307.60	310.83	316.21	321.60	329.13
4767	REPOSITION TEMPORARY CATHETER PACEMAKER	123.00	124.29	126.44	128.60	131.61
4768	REPLACE TEMPORARY CATHETER PACEMAKER	246.10	248.68	252.99	257.30	263.33
4769	INSERTION PERMANENT PACEMAKER/EPICARDIAL	470.75	475.69	483.93	492.17	503.70
4770	INSERTION TEMPORARY CATHETER PACEMAKER	173.95	175.78	178.82	181.86	186.13
4771	REPOSITION TEMPORARY CATHETER PACEMAKER	70.20	70.94	72.17	73.39	75.11
4772	REPLACE TEMPORARY CATHETER PACEMAKER	116.25	117.47	119.51	121.54	124.39
4773	INSERTION PERMANENT PACEMAKER	170.55	172.34	175.33	178.31	182.49
4774	REPOSITION PERMANENT PACEMAKER WIRE	116.25	117.47	119.51	121.54	124.39
4775	REPOSITIONING POWER SOURCE	116.25	117.47	119.51	121.54	124.39
4776	REPROGRAM OR INTERROGATE PACEMAKER (INCL. ICD)	80.00	80.84	82.24	83.64	85.60
4777	INSERTION PERM PACEMAKER/INTRAVENOU	250.00	252.63	257.00	261.38	267.50
4778	INSERTION OF LOOP RECORDER	100.00	101.05	102.80	104.55	107.00
4779	REMOVAL OF LOOP RECORDER	50.00	50.53	51.40	52.28	53.50
4780	LOOP RECORDER INTERPRETATION	20.00	20.21	20.56	20.91	21.40
4781	INSERTION - DUAL CHAMBER PACEMAKER / ICD -MEDICAL		252.63	257.00	261.38	267.50
4782	INSERTION - DUAL CHAMBER PACEMAKER / ICD -SURGICAL		408.09	415.16	422.23	432.12
4802	SPLENECTOMY	552.50	558.30	567.97	577.64	591.18
4804	BONE BUTTON	64.90	65.58	66.72	67.85	69.44
4805	SENTINEL NODE BIPOSY	221.00	223.32	227.19	231.06	236.47
4809	FINE NEEDLE BPSY CERV, AXILL OR INGUINAL NODES	50.95	51.48	52.38	53.27	54.52
4900	CYSTIC HYGROMA	389.15	393.24	400.05	406.86	416.39
4901	KONDOLEON	389.15	393.24	400.05	406.86	416.39
4902	RADICAL SLEEVE EXCISION	648.50	655.31	666.66	678.01	693.90
4903	LYMPHANIGIOGRAM	194.55	196.59	200.00	203.40	208.17
4904	SUPRAHYOID-UNILATERAL	331.50	334.98	340.78	346.58	354.71
4905	SUPRAHYOID-BILATERAL	486.50	491.61	500.12	508.64	520.56
4906	RADICAL NECK DISSECTION	648.50	655.31	666.66	678.01	693.90
4907	DISSECTION OF INGUINAL GLANDS	324.40	327.81	333.48	339.16	347.11
4908	RADICAL DISSECTION-AXILLARY GLANDS	409.50	413.80	420.97	428.13	438.17
4909	RADICAL DISSECTION-INGUINAL AND ILIAC GLANDS	432.55	437.09	444.66	452.23	462.83
4910	RADICAL DISSECTN-INGUINAL &ILIAC GLANDS-BILAT	491.35	496.51	505.11	513.71	525.74
4911	BIOPSY-CERVICAL,AXILLARY,INGUINAL	77.20	78.01	79.36	80.71	82.60
4912	SCALENE	137.00	138.44	140.84	143.23	146.59
4913	COMPLICATED BIOPSY	I.C.	I.C.	I.C.	I.C.	I.C.
4914	LAPAROTOMY	540.65	546.33	555.79	565.25	578.50
4915	EXCISN-INGUIN,PERINL,OR AXILL SWEAT GLNDS-UNIL	215.00	217.26	221.02	224.78	230.05
4916	WITH SKIN GRAFT(S) AND/OR ROTATION FLAP(S)	315.00	318.31	323.82	329.33	337.05
5000	DRAINAGE OF LUDWIG'S ANGINA	108.15	109.29	111.18	113.07	115.72
5001	MOUTH BIOPSY	50.00	50.53	51.40	52.28	53.50
5002	MOUTH-EXCISION OF SIMPLE LESION	43.20	43.65	44.41	45.17	46.22
5003	MOUTH-LEUKOPLAKIA, LIMITED	64.90	65.58	66.72	67.85	69.44

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
5005	EXCISION OF RANULA OF DERMOID CYST	129.75	131.11	133.38	135.65	138.83
5006	LOCL EXCISN-CA MOUTH, MANDB ALVEOL MARGIN	194.55	196.59	200.00	203.40	208.17
5007	LOCAL EXCISN-CA MOUTH, W/ HEMIMANDIBLCTOMY	432.55	437.09	444.66	452.23	462.83
5008	LOCAL EXCISN-CA -UNILATERAL NECK DISSECTION	756.80	764.75	777.99	791.23	809.78
5010	CLOSURE OF ANTRO-ORAL FISTULA WITH FLAP	324.40	327.81	333.48	339.16	347.11
5011	CLOSE ANTRO-ORAL FISTULA W/ RADICL ANTROTOMY	378.35	382.32	388.94	395.56	404.83
5020	LIP BIOPSY	50.00	50.53	51.40	52.28	53.50
5021	LIP SHAVE	129.75	131.11	133.38	135.65	138.83
5022	LIP-EXCISION OF SIMPLE LESION	64.90	65.58	66.72	67.85	69.44
5023	V-EXCISION FOR CARCINOMA	198.90	200.99	204.47	207.95	212.82
5024	V-EXCISION CA AND RADICLE NECK DISSECTION	702.75	710.13	722.43	734.73	751.94
5025	ONE HALF LIP PLUS RECONSTRUCTION	324.40	327.81	333.48	339.16	347.11
5026	ONE HALF LIP PLUS RADICLE NECK DISSECTION	756.80	764.75	777.99	791.23	809.78
5027	TOTAL EXCISION OF LIP	432.55	437.09	444.66	452.23	462.83
5028	TOTAL LIP EXCISION PLUS RADICLE NECK DISSECTION	756.80	764.75	777.99	791.23	809.78
5029	HARE LIP-UNILATERAL	324.40	327.81	333.48	339.16	347.11
5040	TONGUE BIOPSY	50.00	50.53	51.40	52.28	53.50
5041	TONGUE-LOCAL EXCISION SIMPLE TUMOR	108.15	109.29	111.18	113.07	115.72
5042	HEMIGLOSSECTOMY	324.40	327.81	333.48	339.16	347.11
5043	HEMIGLOSSECTOMY AND RADICAL NECK DISSECTION	756.80	764.75	777.99	791.23	809.78
5044	TOTAL GLOSSECTOMY	389.15	393.24	400.05	406.86	416.39
5045	TOTAL GLOSSECTOMY + RADICAL NECK DISSECTION	756.80	764.75	777.99	791.23	809.78
5047	SUTURE MINOR TONGUE LACERATIONS	50.00	50.53	51.40	52.28	53.50
5060	DRAINAGE OF ALVEOLAR ABSCESS	43.20	43.65	44.41	45.17	46.22
5061	BIOPSY OF GUM	50.00	50.53	51.40	52.28	53.50
5063	MUCOUS CYST	43.20	43.65	44.41	45.17	46.22
5064	SUTURE OF GUM	50.00	50.53	51.40	52.28	53.50
5080	PALATE ABSCESS	75.00	75.79	77.10	78.41	80.25
5081	UVULECTOMY	43.20	43.65	44.41	45.17	46.22
5082	PALATE AND UVULA-BIOPSY	43.20	43.65	44.41	45.17	46.22
5083	PALATE AND UVULA-EXCISION SIMPLE LESION	64.90	65.58	66.72	67.85	69.44
5084	PLATE AND UVULA-EXCISION OF MALIGNANT LESION	302.75	305.93	311.23	316.53	323.94
5086	SUTURE OF PALATE WOUND	32.45	32.79	33.36	33.93	34.72
5087	UVULOPALATOPHARYNGOPLASTY	248.65	251.26	255.61	259.96	266.06
5100	SIALOLITHOTOMY -LOCAL	32.45	32.79	33.36	33.93	34.72
5102	SIALOLITHOTOMY-GENERAL ANAESTHETIC	64.90	65.58	66.72	67.85	69.44
5103	SIALOLITHOTOMY-COMPLICATED	194.55	196.59	200.00	203.40	208.17
5104	SUBMANDIBULAR GLAND-EXCISION	259.40	262.12	266.66	271.20	277.56
5105	PAROTID GLAND-SUPERFICIAL PAROTIDECTMY	566.30	572.25	582.16	592.07	605.94
5106	TOTAL PAROTIDECTOMY	718.25	725.79	738.36	750.93	768.53
5107	TOTAL PAROTIDECTOMY + UNILAT NECK DISSECTION	756.80	764.75	777.99	791.23	809.78
5108	PLASTIC REPAIR OF DUCT	270.25	273.09	277.82	282.55	289.17
5109	DILATION OF DUCT	43.20	43.65	44.41	45.17	46.22
5111	CATHETERIZATION-SIALOGRAM	43.20	43.65	44.41	45.17	46.22
5112	RADICAL NECK DISECTION	1,922.10	1,942.28	1,975.92	2,009.56	2,056.65
5113	COMPOSITE FEE RADICAL NECK DISSECTION	1,940.80	1,961.18	1,995.14	2,029.11	2,076.66
5120	BIOPSY OF PHARNYX	77.35	78.16	79.52	80.87	82.76
5121	DRAIN RETROPHARYNGEAL ABSCESS-INTERNAL	54.00	54.57	55.51	56.46	57.78
5122	DRAIN RETROPHARYNGEAL ABSCESS-EXTERNAL	162.25	163.95	166.79	169.63	173.61
5123	DRAINAGE OF PERITONSILLAR ABSCESS	75.00	75.79	77.10	78.41	80.25
5124	BRANCHIAL CYST	331.50	334.98	340.78	346.58	354.71
5125	EXCISION-SINUS	432.55	437.09	444.66	452.23	462.83
5126	PHARYNGO-OESOPHAGEAL DIVERTICULUM	540.65	546.33	555.79	565.25	578.50
5127	THYROGLOSSAL DUCT CYST	270.25	273.09	277.82	282.55	289.17
5128	CYST AND SINUS	389.15	393.24	400.05	406.86	416.39
5129	TONSILLECTOMY	162.00	163.70	166.54	169.37	173.34
5130	TONSILLECTOMY-ADULT	162.00	163.70	166.54	169.37	173.34

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
5131	EXCISION OF TONSIL TAG-UNILATERAL	86.45	87.36	88.87	90.38	92.50
5132	EXCISION OF LINGUAL TONSIL	86.45	87.36	88.87	90.38	92.50
5133	CHOANAL ATRESIA	540.65	546.33	555.79	565.25	578.50
5134	PUCH-BACK FLAP	486.50	491.61	500.12	508.64	520.56
5136	SUTURE OF EXTERNAL WOUND OF PHARNYX	I.C.	I.C.	I.C.	I.C.	I.C.
5137	REMOVAL OF FOREIGN BODY-PHARNYX	75.00	75.79	77.10	78.41	80.25
5138	ADENOIDECTOMY	54.00	54.57	55.51	56.46	57.78
5140	CERVICAL OESOPHAGOTOMY	324.40	327.81	333.48	339.16	347.11
5141	THORACIC OESOPHAGOTOMY	432.55	437.09	444.66	452.23	462.83
5142	OESOPHAGOMYOTOMY	540.65	546.33	555.79	565.25	578.50
5143	INTRATHORACIC DIVERTICULUM	518.95	524.40	533.48	542.56	555.28
5144	EXTRATHORACIC DIVERTICULUM	432.55	437.09	444.66	452.23	462.83
5145	RESECTION OF OESOPHAGUS	756.80	764.75	777.99	791.23	809.78
5146	RESECTION ESOPHAGUS-REPLACEMENT-1ST SURGEON	864.95	874.03	889.17	904.31	925.50
5147	RESECTION ESOPHAGUS-REPLACEMENT-2ND SURGEON	216.10	218.37	222.15	225.93	231.23
5148	ESOPHAGO-GASTRECTOMY	864.95	874.03	889.17	904.31	925.50
5149	ESOPHAGEAL BYPASS	756.80	764.75	777.99	791.23	809.78
5150	ESOPHAGOSCOPY	129.75	134.29	141.85	149.41	160.00
5151	ESOPHAGOSCOPY-REMOVE FOREIGN BODY	216.10	218.19	221.66	225.14	230.00
5152	ESOPHAGO-BRONCHOSCOPY	194.55	196.59	200.00	203.40	208.17
5153	ESOPHAGO-GASTROSCOPY-ELDER-PALMER	162.25	163.95	166.79	169.63	173.61
5155	ESOPHAGOPLASTY	648.50	655.31	666.66	678.01	693.90
5156	ESOPHAGEAL HIATUS HERNIA-ABDO APPROACH	540.65	546.33	555.79	565.25	578.50
5157	ESOPHAGEAL HIATUS HERNIA-ABDO+CHOECCYSTOMY	648.50	655.31	666.66	678.01	693.90
5158	ESOPHAGEAL ILIATUS HERNIA-TRANSTHORAC APPRCH	540.65	546.33	555.79	565.25	578.50
5159	RUPTURED OESOPHAGUS	518.95	524.40	533.48	542.56	555.28
5160	RUPTURED OESOPHAGUS-CERVICAL DRAIN	378.35	382.32	388.94	395.56	404.83
5161	ESOPHAGO-GASTROSTOMY	756.80	764.75	777.99	791.23	809.78
5162	ESOPHAGO-DUODENOSTOMY	756.80	764.75	777.99	791.23	809.78
5163	CLOSURE OF OESOPHAGEAL	756.80	764.75	777.99	791.23	809.78
5164	ESOPHAGOTOMY WITH LIGATION VARICES	518.95	524.40	533.48	542.56	555.28
5165	ESOPHAGEAL VARICES-INITIAL	259.40	262.12	266.66	271.20	277.56
5166	ESOPHAGEAL VARICEAL BANDING (ESOPHAGOSCOPY)	260.00	262.73	267.28	271.83	278.20
5167	INTRODUCTION OF MOUSSEAU-BARBIN TUBE	324.40	327.81	333.48	339.16	347.11
5168	DILATION-ACTIVE	54.00	54.57	55.51	56.46	57.78
5169	DILATION-PASSIVE-MERCURY FILLED TUBES	21.55	21.78	22.15	22.53	23.06
5172	DILATION WITH OSOPHAGOSCOPY-INITIAL	247.00	249.59	253.92	258.24	264.29
5173	DILATION OF OEXOPHAGOSCOPY-REPEAT	64.90	65.58	66.72	67.85	69.44
5174	DILATION OF OESOPHAGUS	75.75	76.55	77.87	79.20	81.05
5175	REPAIR OF HIATAL HERNIA	756.80	764.75	777.99	791.23	809.78
5176	FUNDOPLICATION +/- HIATAL HERNIA REPAIR	540.65	546.33	555.79	565.25	578.50
5177	INJECTN-ESOPH VARIC-REP W/IN 30 DY-INCL ESPHSCPY	194.75	196.79	200.20	203.61	208.38
5178	ESOPH VARIC BANDG-REP W/IN 30 DYS-INCL ESPHSCPY	194.75	196.79	200.20	203.61	208.38
5200	GASTROTOMY	324.40	327.81	333.48	339.16	347.11
5201	PYLOROMYOTOMY	464.10	468.97	477.09	485.22	496.59
5202	SIMPLE TUBE GASTROSTOMY	324.40	327.81	333.48	339.16	347.11
5204	BIOPSY BY GASTROSCOPY	194.55	196.59	200.00	203.40	208.17
5205	BIOPSY BY GASTROTOMY	324.40	327.81	333.48	339.16	347.11
5207	WEDGE RESECTION FOR ULCER	408.85	413.14	420.30	427.45	437.47
5208	GASTRECTOMY-PARTIAL	672.75	679.81	691.59	703.36	719.84
5209	GASTRECTOMY AND REPAIR HIATUS HERNIA	756.80	764.75	777.99	791.23	809.78
5210	AFTER GASTRECTOMY	756.80	764.75	777.99	791.23	809.78
5211	ANTRECTOMY	756.80	764.75	777.99	791.23	809.78
5212	TOTAL GASTRECTOMY	864.95	874.03	889.17	904.31	925.50
5213	EXCISION OF GASTRODUODENAL LESION	756.80	764.75	777.99	791.23	809.78
5214	EXCISE GASTRODUODENAL LESION AND VAGOTOMY	864.95	874.03	889.17	904.31	925.50
5215	EXCISION OF GASTROJEJUNAL LESION	756.80	764.75	777.99	791.23	809.78

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
5217	GASTRECTMY-EXCISION LESION & CHOLECTYSTOMY	108.15	109.29	111.18	113.07	115.72
5218	GASTROSCPY-DIAGNOS BIOPSY-REMOVAL FB	180.20	182.09	185.25	188.40	192.81
5219	GASTROSCOPY-SUBSEQUENT	71.20	71.95	73.19	74.44	76.18
5220	PYLOROPLASTY	397.80	401.98	408.94	415.90	425.65
5221	PYLOROPLASTY AND VAGOTOMY	514.60	520.00	529.01	538.01	550.62
5222	GASTRODUODENOSTOMY OR OTHER	397.80	401.98	408.94	415.90	425.65
5223	VAGOTOMY PLUS	540.65	546.33	555.79	565.25	578.50
5224	PYLORPLSTY GASTROENTSTMY W/VAGTMY & H.HERN	648.50	655.31	666.66	678.01	693.90
5225	VAGOTOMY ALONE	389.15	393.24	400.05	406.86	416.39
5226	CHOLECTYSTECTOMY PLUS OTHERS	108.15	109.29	111.18	113.07	115.72
5227	CLOSURE OF GASTROSTOMY	259.40	262.12	266.66	271.20	277.56
5228	CLOSURE OF PERFORATED ULCER	397.80	401.98	408.94	415.90	425.65
5229	CLOSURE OF GASTRO-COLIC FISTULA	756.80	764.75	777.99	791.23	809.78
5230	CLOSURE OF GASTRO-COLIC-TWO STAGES	756.80	764.75	777.99	791.23	809.78
5231	GASTRIC COOLING	129.75	131.11	133.38	135.65	138.83
5232	HIGHLY SELECTIVE VAGOTOMY	636.35	643.03	654.17	665.30	680.89
5233	GASTRIC PARTITION/MORBID OBESITY	I.C.	I.C.	I.C.	I.C.	I.C.
5234	GASTRIC PARTIT+OTH PRCEDURES FOR MORB OBESITY	I.C.	I.C.	I.C.	I.C.	I.C.
5235	STANDARD E.R.C.P.	229.05	231.46	235.46	239.47	245.08
5236	BIOPSY AT TIME OF PROCEDURE	11.65	11.77	11.98	12.18	12.47
5237	E.R.C.P. ON A BILROTH II	192.80	194.82	198.20	201.57	206.30
5238	E.R.C.P. WITH SPINCTEROTOMY	345.50	349.13	355.17	361.22	369.69
5239	PLACEMENT OF STENT AT E.R.C.P.	63.05	63.71	64.82	65.92	67.46
5240	PERCUTANEOUS ENDOSCOPIC GASTROSTOMY (PEG)	199.35	201.44	204.93	208.42	213.30
5241	ERCP WITH BILIARY DILATATION	297.00	300.12	305.32	310.51	317.79
5250	ILEOSTOMY FOR ULCERATIVE COLITIS	389.15	393.24	400.05	406.86	416.39
5251	ILEOSTOMY FOR JEJUNOSCOMY	270.25	273.09	277.82	282.55	289.17
5252	1st STAGE MICHULIEZ	389.15	393.24	400.05	406.86	416.39
5253	COLOSTOMY	415.35	419.71	426.98	434.25	444.42
5255	CECOSTOMY	270.25	273.09	277.82	282.55	289.17
5256	ENTEROTOMY OR COLOTOMY	397.80	401.98	408.94	415.90	425.65
5257	ENTEROTOMY/COLOTOMY AND SIGMOIDOSCOPY	432.55	437.09	444.66	452.23	462.83
5258	MULTIPLE ENTEROTOMY AND SIGMOIDOSCOPY	540.65	546.33	555.79	565.25	578.50
5259	INTESTINES-BIOPSY	64.90	65.58	66.72	67.85	69.44
5260	LOCAL EXCISION OF LESION	442.00	446.64	454.38	462.11	472.94
5261	DUODENECTOMY	530.40	535.97	545.25	554.53	567.53
5262	ENTERECTOMY-OTHER	530.40	535.97	545.25	554.53	567.53
5263	TERMINAL ILEUM AND CAECUM	663.00	669.96	681.56	693.17	709.41
5264	TERMINAL ILEUM, CAECUM AND ASCENDING COLON	663.00	669.96	681.56	693.17	709.41
5265	SEGMENTAL	663.00	672.09	687.24	702.38	723.59
5266	HEMICOLECTOMY	676.25	683.35	695.19	707.02	723.59
5267	TOTAL COLECTOMY	994.50	1,004.94	1,022.35	1,039.75	1,064.12
5268	TOT COLCTMY W/ILEOSTMY/ABD PERI RSXN SNGL TM	965.25	975.39	992.28	1,009.17	1,032.82
5269	TOT COLCTMY W/ILEOSTMY/ABD PERI RSXN 1ST SRGN	893.25	902.63	918.26	933.89	955.78
5270	TOT COLCTMY W/ILEOSTMY/ABD PERI RSXN 1ST ASST	259.40	262.12	266.66	271.20	277.56
5271	TOT COLCTMY W/ILEOSTMY/ABD PERI RSXN 2ND ASST	194.55	196.59	200.00	203.40	208.17
5272	INTESTINAL OBSTRUCTION NO RESECTION	552.50	558.30	567.97	577.64	591.18
5273	INTESTINAL OBSTRUCTION AND RESECTION	663.00	669.96	681.56	693.17	709.41
5275	ENTERO-ENTEROSTOMY	397.80	401.98	408.94	415.90	425.65
5276	DUODENAL ATRESIA,DUDENO-JEJUNOSTOMY	432.55	437.09	444.66	452.23	462.83
5277	FECAL FISTULA-RADICAL RESECTION	594.70	600.94	611.35	621.76	636.33
5278	REVISION OF ILEOSTOMY OR COLOSTOMY	129.75	131.11	133.38	135.65	138.83
5279	CLOSURE OF PERFORATION	346.30	349.94	356.00	362.06	370.54
5280	CLOSURE PERFORATION WITH COLOSTOMY	432.55	437.09	444.66	452.23	462.83
5281	CECOPEXY OR SIGMOIDOPEXY	324.40	327.81	333.48	339.16	347.11
5282	CLOSURE OF ENTEROSTOMY	442.00	446.64	454.38	462.11	472.94
5283	CLOSURE OF COLOSTOMY	442.00	446.64	454.38	462.11	472.94

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
5284	PLICATION SMALL INTESTINE FOR ADHESION	486.50	491.61	500.12	508.64	520.56
5285	DILATION ENTEROSTOMY,ETC.ANAESTHET	43.20	43.65	44.41	45.17	46.22
5286	E.E.A.STAPLER	52.55	53.10	54.02	54.94	56.23
5287	MECKEL'S DIVERTICULUM	324.40	327.81	333.48	339.16	347.11
5288	LOCAL EXCISION OF LESION,MESENTERY	324.40	327.81	333.48	339.16	347.11
5289	RESECTION OF MESENTERY	324.40	327.81	333.48	339.16	347.11
5290	MESENTERIC CYST	324.40	327.81	333.48	339.16	347.11
5300	DRAINAGE OF APPENDIX ABCESS	270.25	273.09	277.82	282.55	289.17
5301	APPENDECTOMY	386.75	390.81	397.58	404.35	413.82
5302	APPENDECTOMY W/ GROSS PERFOR AND PERITONITIS	519.35	524.80	533.89	542.98	555.70
5303	APPNDCTMY,REMOVE MECKEL'S DIVERTCLM	335.00	338.52	344.38	350.24	358.45
5322	PROCTOTOMY WITH DRAINAGE	129.75	131.11	133.38	135.65	138.83
5323	PELVIC ABSCESS	162.25	163.95	166.79	169.63	173.61
5324	PROCTECTOMY-ANTERIOR RESECTION RECTUM	994.50	1,004.94	1,022.35	1,039.75	1,064.12
5325	PROCTECTOMY-PERINEAL RESECTION RECTUM	518.95	524.40	533.48	542.56	555.28
5326	ABDO-PERINEAL RSXN+COLOSTOMY-SINGLE TEAM	994.50	1,004.94	1,022.35	1,039.75	1,064.12
5327	ABDO-PERINAL RSXN+COLOSTOMY-2 TEAM 1ST SURG	936.00	945.83	962.21	978.59	1,001.52
5328	ABDO-PERI RSXN+COLOSTOMY-2 TEAM 1ST SURG ASST	442.00	446.64	454.38	462.11	472.94
5329	ABDO-PERI RSXN+COLOSTOMY-2 TEAM 2ND SURGEON	298.35	301.48	306.70	311.92	319.23
5330	HARTMAN PROCEDURE	607.75	625.13	654.09	683.04	723.59
5331	REANASTOMOSIS FOLLOWING HARTMAN PROCEDURE	556.00	561.84	571.57	581.30	594.92
5336	RECTAL POLYP	64.90	65.58	66.72	67.85	69.44
5337	RECTAL POLYP-THROUGH SIGMOIDOSCOPE	132.60	133.99	136.31	138.63	141.88
5338	BIOPSY,RECTO-SIGMOID-HIRSCHPRUNG'S	86.45	87.36	88.87	90.38	92.50
5339	PROCTOSTOMY	324.40	327.81	333.48	339.16	347.11
5340	PROCTOPEXY-ABDOMINAL ROUTE	389.15	393.24	400.05	406.86	416.39
5341	RECTAL PROLAPSE-EXCISE MUCOUS MEMBRANE	216.10	218.37	222.15	225.93	231.23
5342	RECTAL PROLAPSE-PERINEAL REPAIR MAJOR	389.15	393.24	400.05	406.86	416.39
5343	RECTAL PROLAPSE-ABDOMINAL APPROACH	518.95	524.40	533.48	542.56	555.28
5344	RECTAL PROLAPSE-THIERSCH WIRE PROCEDURE	129.75	131.11	133.38	135.65	138.83
5345	SUTURE-EXTERNAL APPROACH	259.40	262.12	266.66	271.20	277.56
5346	SUTURE INTRAPERITONEAL APPROACH	432.55	437.09	444.66	452.23	462.83
5347	CLOSURE OF FISTULA-RECTO-VAGINAL	432.55	437.09	444.66	452.23	462.83
5348	CLOSURE OF FISTULA-RECTO-VESICAL	432.55	437.09	444.66	452.23	462.83
5349	CLAMPING OF INTERNAL HEMORRHOID-PER HEMORH	66.30	67.00	68.16	69.32	70.94
5350	THROMBOSED HEMORRHOID	40.00	40.42	41.12	41.82	42.80
5351	THROMBOSED HEMORRHOID-GENERAL	54.00	54.57	55.51	56.46	57.78
5352	LOCAL EXCISION OF LESION	129.75	131.11	133.38	135.65	138.83
5353	HAEMORRHOIDECTOMY	198.90	200.99	204.47	207.95	212.82
5354	ANAL POLYP-HEMORRHOIDIAL TAGS	66.30	67.00	68.16	69.32	70.94
5355	FISTULA-IN-ANO,LOW LEVEL	198.90	200.99	204.47	207.95	212.82
5356	FISTULA-IN-ANO,HIGH LEVEL	397.80	401.98	408.94	415.90	425.65
5357	ANUS BIOPSY-GENERAL	43.20	43.65	44.41	45.17	46.22
5358	ELECTROCOAG RECTAL CARCINOMA-INITAL	216.10	218.37	222.15	225.93	231.23
5359	ELECTRO COAGULATION RECTAL CA-REPEAT	108.15	109.29	111.18	113.07	115.72
5361	EXCISION OF SCAR, FOR STENOSIS	129.75	131.11	133.38	135.65	138.83
5362	ANOPLASTY FOR STENOSIS	259.40	262.12	266.66	271.20	277.56
5363	REPAIR OF ANAL SPHINCTER	324.40	327.81	333.48	339.16	347.11
5364	REPAIR OF SPHINCTER AND ANORECTAL RING	324.40	327.81	333.48	339.16	347.11
5365	MEMBRANOUS OBSTRUCTION OF ANUS	129.75	131.11	133.38	135.65	138.83
5371	CAUTERIZATION OF FISSURE	25.00	25.26	25.70	26.14	26.75
5372	ELECTRO DESSICATION OF CONDYLOMATA	75.00	75.79	77.10	78.41	80.25
5373	DILATION OF ANAL SPHINCTER	21.55	21.78	22.15	22.53	23.06
5374	ANOSCOPY	10.85	11.47	12.51	13.55	15.00
5375	PARTIAL LATERAL SPHINCTEROTOMY	191.00	193.01	196.35	199.69	204.37
5381	DRAINAGE OF ABSCESS -LIVER	389.15	393.24	400.05	406.86	416.39
5382	REMOVAL OF FOREIGN BODY -LIVER	389.15	393.24	400.05	406.86	416.39

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
5383	INCISION AND PACKING OF LIVER WOUND	389.15	393.24	400.05	406.86	416.39
5384	HEPATECTOMY-LOCAL EXCISION,LESION	389.15	393.24	400.05	406.86	416.39
5385	RESECTION OF LIVER	864.95	874.03	889.17	904.31	925.50
5388	SUTURE OF RUPTURE OR WOUND -LIVER	I.C.	I.C.	I.C.	I.C.	I.C.
5390	CHOLECYSTOSTOMY	324.40	327.81	333.48	339.16	347.11
5391	CHOLECYSTENTEROSTOMY	389.15	393.24	400.05	406.86	416.39
5392	CHOLECYSTENTEROSTMY AND ENTRORSTMY	432.55	437.09	444.66	452.23	462.83
5393	CHOLECYSTOGASTROSTOMY	389.15	393.24	400.05	406.86	416.39
5394	CHOLEDOCHODUODENOSTOMY	540.65	546.33	555.79	565.25	578.50
5395	COMMON DUCT EXPLORATION	518.95	524.40	533.48	542.56	555.28
5396	COMMON DUCT EXPLOR W/ DUODOTMY SPHNCTRTMY	648.50	655.31	666.66	678.01	693.90
5398	CHOLEDOCHECTOMY	648.50	655.31	666.66	678.01	693.90
5399	EXCISION OF AMPULLA OF VATER	594.70	600.94	611.35	621.76	636.33
5400	CHOLECYSTOMY	519.35	527.70	541.61	555.52	575.00
5401	CHOLECYSTOMY-OPERATIVE CHOLANGIOGRM	574.60	580.63	590.69	600.74	614.82
5402	CHOLECYSTECTOMY AND EXPLORATION BILE DUCT	607.75	614.13	624.77	635.40	650.29
5403	CHOLECYSTMY-EXPLOR BILE DUCT+CHLANGIOGRAM	663.00	669.96	681.56	693.17	709.41
5404	CHOLECYSTECTOMY WITH DUODENOTOMY	648.50	655.31	666.66	678.01	693.90
5405	SURGICAL RECONSTRCTION COMMON BILE DUCT	864.95	874.03	889.17	904.31	925.50
5406	SUTURE-CLOSURE OF FISTULA	594.70	600.94	611.35	621.76	636.33
5410	PANCREATOTOMY	432.55	437.09	444.66	452.23	462.83
5411	PANCREATIC ABSCESS	432.55	437.09	444.66	452.23	462.83
5414	LOCAL EXCISION OF LESION	518.95	524.40	533.48	542.56	555.28
5415	PARTIAL PANCREATECTOMY	518.95	524.40	533.48	542.56	555.28
5416	PANCREATICO-DUODENAL RESECTION	864.95	874.03	889.17	904.31	925.50
5417	EXCISION PANCREATIC CYST	518.95	524.40	533.48	542.56	555.28
5418	PANCREATICO-GASTROSTOMY	518.95	524.40	533.48	542.56	555.28
5419	PANCREATICO-DUODENOSTOMY	518.95	524.40	533.48	542.56	555.28
5420	PANCREATICO-JEJUNOSTOMY	518.95	524.40	533.48	542.56	555.28
5421	MARSUPIALIZATION OF CYST	432.55	437.09	444.66	452.23	462.83
5450	LAPAROTOMY	386.75	390.81	397.58	404.35	413.82
5451	DRAINAGE OF SUBPHRENIC ABCESS	389.15	393.24	400.05	406.86	416.39
5452	INTRA-ABDOMINAL ABCESS	397.80	401.98	408.94	415.90	425.65
5453	REMOVAL OF FOREIGN BODY-GUN SHOT	I.C.	I.C.	I.C.	I.C.	I.C.
5454	DESMOID TUMOR	I.C.	I.C.	I.C.	I.C.	I.C.
5456	LIPECTOMY	324.40	327.81	333.48	339.16	347.11
5457	RETROPERITONEAL TUMOR	518.95	524.40	533.48	542.56	555.28
5458	MESENTERIC CYST	324.40	327.81	333.48	339.16	347.11
5460	PERITONEOSCOPY	194.50	196.54	199.95	203.35	208.12
5461	HERNIOTOMY+HERNIORRHAPY-INGUINAL/FEMORAL	309.40	312.65	318.06	323.48	331.06
5462	HERNIOTOMY AND HERNIORRHAPHY-INGUINAL	353.60	357.31	363.50	369.69	378.35
5463	HERNIOTMY+HERNIORRPHY-INGUINL/FEM-SAME SIDE	324.40	327.81	333.48	339.16	347.11
5464	SLIDING HERNIA	324.40	327.81	333.48	339.16	347.11
5465	INGUINAL/FEMORAL REPAIR-PROSTHESIS	353.60	357.31	363.50	369.69	378.35
5466	RECURRENT HERNIA	442.00	446.64	454.38	462.11	472.94
5467	RECUR HERNIA REPAIR-PROSTHES/GRAFT	464.10	468.97	477.09	485.22	496.59
5468	UMBILICAL HERNIA	331.50	334.98	340.78	346.58	354.71
5469	UMBILICAL HERNIA-CHILD	205.80	207.96	211.56	215.16	220.21
5470	ENTEROCELE-INFANT	324.40	327.81	333.48	339.16	347.11
5471	OMPHALOCELE-INFANT	432.55	437.09	444.66	452.23	462.83
5472	DIAPHRAGMATIC HERNIA	540.65	546.33	555.79	565.25	578.50
5473	DIAPHRAGMATIC HERNIA WITH PROSTHES	594.70	600.94	611.35	621.76	636.33
5474	INCISION/VENTRAL REPAIR BY SUTURE	442.00	446.64	454.38	462.11	472.94
5475	INCISION/VENTRAL REPAIR BY PROSTHESIS	468.00	472.91	481.10	489.29	500.76
5476	EPIGASTRIC HERNIA	309.40	312.65	318.06	323.48	331.06
5477	STRANGULATED SUTURE	324.40	327.81	333.48	339.16	347.11
5478	STRANGULATED SUTURE WITH RESECTION	585.00	591.14	601.38	611.62	625.95

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
5479	SECONDARY CLOSURE FOR EVISCERATION	254.15	256.82	261.27	265.71	271.94
5480	DRAINAGE OF ABDOMINAL WALL ABCESS	64.90	65.58	66.72	67.85	69.44
5500	THYROID GLAND-ABSCESS	129.75	131.11	133.38	135.65	138.83
5501	THYROID GLAND-BIOPSY	43.20	43.65	44.41	45.17	46.22
5502	THYROID GLAND BIOPSY-SURGICAL	259.40	262.12	266.66	271.20	277.56
5503	BILATERAL TOTAL THYROIDECTOMY	594.70	600.94	611.35	621.76	636.33
5504	TOTAL LOBECTOMY	497.25	502.47	511.17	519.87	532.06
5505	TOTAL LOBECTOMY AND SUBTOTAL LOBECTMY	486.50	491.61	500.12	508.64	520.56
5506	SUB-TOTAL BILATERAL THYROIDECTOMY	432.55	437.09	444.66	452.23	462.83
5507	PARTIAL LOBECTOMY	389.15	393.24	400.05	406.86	416.39
5508	EXCISION OF SOLITARY NODULE	259.40	262.12	266.66	271.20	277.56
5509	UNILATERAL LIMITED NODE DISSECTION	129.75	131.11	133.38	135.65	138.83
5510	BILATERAL LIMITED NODE DISSECTION	259.40	262.12	266.66	271.20	277.56
5511	RADICAL NECK DISSECTION UNILATERAL	324.40	327.81	333.48	339.16	347.11
5550	PARATHYROIDECTOMY FOR HYPERPLASIA	594.70	600.94	611.35	621.76	636.33
5551	PARATHYROID TUMOR	518.95	524.40	533.48	542.56	555.28
5552	PARATHYROID TUMOR-STERNAL SPLITTING REQUIRED	648.50	655.31	666.66	678.01	693.90
5553	THYMECTOMY	648.50	655.31	666.66	678.01	693.90
5554	ADRENAL EXPLORATION-UNILATEAL	324.40	327.81	333.48	339.16	347.11
5555	ADRENALECTOMY-UNILATERAL	540.65	546.33	555.79	565.25	578.50
5652	CAROTID ENDARTERECTOMY	648.50	655.31	666.66	678.01	693.90
5653	CAROTID ENDARTERECTOMY-PATCH GRAFT	756.80	764.75	777.99	791.23	809.78
5654	CAROTID ENDARTERECTOMY-GRAFT+BY PASS SHUNT	864.95	874.03	889.17	904.31	925.50
5702	HEAD INJURY	60.00	60.63	61.68	62.73	64.20
5710	DECOMPRESSIVE CRANIECTOMY-SUBTEMPORAL	432.55	437.09	444.66	452.23	462.83
5711	DECOMPRESSIVE CRANIECTOMY-SUBTEMPORAL	648.50	655.31	666.66	678.01	693.90
5716	MENINGES-EXTRADURAL	594.70	600.94	611.35	621.76	636.33
5717	MENINGES-SUBDURAL WITH BURR HOLES	594.70	600.94	611.35	621.76	636.33
5859	BURR HOLE AND ASPIRATION	540.65	546.33	555.79	565.25	578.50
5900	LAMINECTOMY FOR EXCISION	756.80	764.75	777.99	791.23	809.78
5902	LAMINECTOMY-DECOMPRESS SPINAL CORD	648.50	655.31	666.66	678.01	693.90
5903	LAMINECTOMY-EXTRADURAL ABSCESS	648.50	655.31	666.66	678.01	693.90
5963	EXPLORATION OF MAJOR NERVE	216.10	218.37	222.15	225.93	231.23
5964	REMOVAL TUMOR MAJOR PERIPHERAL NERVE	324.40	327.81	333.48	339.16	347.11
5965	SUTURE MAJOR PERIPHERAL NERVE	324.40	327.81	333.48	339.16	347.11
5967	SUTURE SMALL PERIPHERAL NERVE	162.25	163.95	166.79	169.63	173.61
5968	DECOMPRESSION MEDIAN NERVE AT WRIST	216.10	218.37	222.15	225.93	231.23
5969	DECOMPRESSION ULNAR NERVE AT ELBOW	216.10	218.37	222.15	225.93	231.23
5970	TRANSPOSITION OF ULNAR NERVE	270.25	273.09	277.82	282.55	289.17
5973	MORTON'S NEUROMA	216.10	218.37	222.15	225.93	231.23
5980	SYMPATHECTOMY-CERVICAL	432.55	437.09	444.66	452.23	462.83
5981	SYMPATHECTOMY-CERVICODORSAL	449.65	454.37	462.24	470.11	481.13
5983	SYMPATHECTOMY-LUMBAR	341.80	345.39	351.37	357.35	365.73
6001	DELIVERY	560.00	565.88	575.68	585.48	599.20
6004	CAESARIAN SECTION-PROCEDURE AND POSTOP	560.00	565.88	575.68	585.48	599.20
6005	STERILIZ AT TIME OF C/SXN,HYST,LAPAROTMY ETC.	70.75	71.49	72.73	73.97	75.70
6006	CAESARIAN HYSTERECTOMY-SUBTOTAL OR TOTAL	742.15	749.94	762.93	775.92	794.10
6007	OPERATIVE DELIVRY NOT CAESARIAN,C&P	560.00	565.88	575.68	585.48	599.20
6008	SURGICAL/MEDICAL INDUCTION-LABOUR	68.55	69.27	70.47	71.67	73.35
6009	ABORTION-INCOMPLETE INCLUDING D&C	138.80	140.26	142.69	145.12	148.52
6010	ABORTION-THERAPEUTIC	151.20	152.79	155.43	158.08	161.78
6012	MISSED ABORT+/-I.U.HYPERTONIC SOLUTION	151.20	152.79	155.43	158.08	161.78
6013	REPAIR THIRD DEGREE LACN CONSULT+PROCEDURE	110.50	111.66	113.59	115.53	118.24
6014	RETAINED PLACENTA REMOVAL-CONSULT+PROCED	110.50	111.66	113.59	115.53	118.24
6015	ECTOPIC PREGNANCY	336.45	339.98	345.87	351.76	360.00
6016	SUTURE INCOMPETENT CERVIX IN PREGNANCY	190.95	192.95	196.30	199.64	204.32
6017	STERILZATION-POST PARTUM	257.20	259.90	264.40	268.90	275.20

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
6019	AMNIOCENTESIS	50.90	51.43	52.33	53.22	54.46
6021	ABORTION-INCOMPLETE	75.75	76.55	77.87	79.20	81.05
6022	CONSULT+INTERPRET FETAL MONITORING RECORDS	43.20	43.65	44.41	45.17	46.22
6024	FETAL MONITORING,UNDER TOCOLYSIS	121.45	122.73	124.85	126.98	129.95
6025	POST COITAL TESTING	34.15	34.51	35.11	35.70	36.54
6500	HYMENECTOMY	54.00	54.57	55.51	56.46	57.78
6501	ABSCESS OF VULVA	55.25	55.83	56.80	57.76	59.12
6502	MARSUPIALIZATION OR CAUTERY	65.45	66.14	67.28	68.43	70.03
6503	VULVECTOMY-SIMPLE	259.40	262.12	266.66	271.20	277.56
6506	CYST OF BARTHOLIN'S GLAND	132.60	133.99	136.31	138.63	141.88
6508	CONDYLOMATA	110.50	111.66	113.59	115.53	118.24
6600	COLPOTOMY	86.45	87.36	88.87	90.38	92.50
6601	LOCAL EXCISION OF VAGINAL CYST	154.70	156.32	159.03	161.74	165.53
6602	CYSTOCELE OR RECTOCELE	215.75	218.02	221.79	225.57	230.85
6603	CYSTOCELE AND RECTOCELE	372.00	375.91	382.42	388.93	398.04
6604	CYSTOCELE,RECTOCELE AND PROLAPSE	432.55	437.09	444.66	452.23	462.83
6605	CYSTOCELE, RECTOCELE + EXCISION CERVICAL STUMP	432.55	437.09	444.66	452.23	462.83
6606	VAGINAL VAULT-PROLAPSE	436.75	441.34	448.98	456.62	467.32
6607	RECTOCELE AND REPAIR ANAL SPHINCTER	370.40	374.29	380.77	387.25	396.33
6608	PERINEORRHAPHY (WITHOUT RECTOCELE REPAIR)	129.75	131.11	133.38	135.65	138.83
6611	REPAIR OF DOUBLE VAGINA	194.55	196.59	200.00	203.40	208.17
6612	CLOSURE OF FISTULA-VESICO VAGINAL	432.55	437.09	444.66	452.23	462.83
6613	CLOSURE OF FISTULA-RECTOVAGINAL	432.55	437.09	444.66	452.23	462.83
6614	CLOSURE OF FISTULA-URETERO VAGINAL	518.95	524.40	533.48	542.56	555.28
6615	URETHRAL CARUNCLE-PROLAPSE-MUCOSA	86.45	87.36	88.87	90.38	92.50
6616	ENTEROCELE	395.55	399.70	406.63	413.55	423.24
6617	RETROPUBIC OPERATION-INCONTINENCE	370.40	374.29	380.77	387.25	396.33
6618	OPERATIONS FOR STRESS INCONTINENCE-VAGINAL	331.50	334.98	340.78	346.58	354.71
6619	OPERATIONS FOR STRESS INCONTINENCE-ABDOMINAL	442.00	446.64	454.38	462.11	472.94
6620	OPERATIONS FOR STRESS INCONTINENCE-COMBINED	663.00	669.96	681.56	693.17	709.41
6622	ENDOSCOPY-EXAM AND/OR DILATION	75.75	76.55	77.87	79.20	81.05
6630	INFRACOLIC / INFRAGASTRIC OMENTECTOMY	181.80	183.71	186.89	190.07	194.53
6631	OMENTAL BIOPSY - SINGLE OR MULTIPLE (ADD-ON)		50.00	51.05	52.10	53.50
6632	CONIZATION OF CERVIX WITHOUT D&C (LEEP)		60.00	61.26	62.52	64.20
6639	TRANSVAGINAL TAPE (TVT) PROCED INCL CYSTOSCPY	470.00	474.94	483.16	491.39	502.90
6700	SALPINGECTMY AND SALPINGO OOPHORECTMY	323.65	327.05	332.71	338.38	346.31
6701	TUBAL PLASTIC-OPERATION	360.20	363.98	370.29	376.59	385.41
6702	STERILZATION	257.20	259.90	264.40	268.90	275.20
6704	LYSIS OF ADHESION	311.60	314.87	320.32	325.78	333.41
6705	INFERTILITY INVESTIGATION	210.50	212.71	216.39	220.08	225.24
6710	FOLLICULAR TRACKING BY ULTRASOUND	77.20	78.01	79.36	80.71	82.60
6800	EXCISION OF OVARIAN CYST	308.70	311.94	317.34	322.75	330.31
6801	EXCISION OF PARAOVARIAN CYST	308.70	311.94	317.34	322.75	330.31
6802	OOPHOROCYSTECTOMY	308.70	311.94	317.34	322.75	330.31
6803	PARAVAGINAL REPAIR OF CYSTOCELE	205.00	207.15	210.74	214.33	219.35
6900	HYSTERECTOMY W/ CYSTOCELE OR RECTOCELE REPAIR	560.00	565.88	575.68	585.48	599.20
6901	D&C	103.00	104.08	105.88	107.69	110.21
6902	MYOMECTOMY	370.65	374.54	381.03	387.51	396.60
6903	HYSTERECTOMY	417.05	421.43	428.73	436.03	446.24
6905	HYSTERECTOMY-PARTIAL	308.70	311.94	317.34	322.75	330.31
6906	HYSTERECTOMY-PARTIAL WITH RECT/CYS	411.60	415.92	423.12	430.33	440.41
6908	SEPTATE UTERUS	411.60	415.92	423.12	430.33	440.41
6909	CERVICAL POLYP	31.15	31.48	32.02	32.57	33.33
6910	AMPUTATION OF CERVIX	185.25	187.20	190.44	193.68	198.22
6911	CERVICAL STUMP-VAGINAL	247.00	249.59	253.92	258.24	264.29
6912	CERVICAL STUMP-ABDOMINAL	308.70	311.94	317.34	322.75	330.31
6913	BIOPSY OF CERVIX	51.95	52.50	53.40	54.31	55.59

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
6916	INSUFFLATION-RUBIN'S TEST AND D&C	108.15	109.29	111.18	113.07	115.72
6917	INSUFFLATION AND ENDOMETRIAL BIOPSY	64.90	65.58	66.72	67.85	69.44
6918	HYSTEROSALPINGOGRAM	78.10	78.92	80.29	81.65	83.57
6919	IUCD	70.70	71.44	72.68	73.92	75.65
6920	HYSTEROPEXY	257.20	259.90	264.40	268.90	275.20
6922	HYSTEROPEXY-RECTOCELE AND CYSTOCELE	411.60	415.92	423.12	430.33	440.41
6923	CERVIX WITH/WITHOUT BIOPSY	185.25	187.20	190.44	193.68	198.22
6924	INCOMPETENT CERVIX	154.35	155.97	158.67	161.37	165.15
6925	REPAIR INVERSTION OF UTERUS-OPERATIVE	370.40	374.29	380.77	387.25	396.33
6926	REPAIR INVERSION OF UTERUS-MANUAL	154.35	155.97	158.67	161.37	165.15
6928	ELECTRO-CAUTERY OF CERVIX	32.45	32.79	33.36	33.93	34.72
6929	BIOPSY OF CERVIX - OFFICE PROCED W/OUT COLPOSCOPY	30.85	31.17	31.71	32.25	33.01
6930	D&C AND CONIZATION OF CERVIX	162.25	163.95	166.79	169.63	173.61
6931	ENDOMETRIAL BIOPSY	42.00	42.44	43.18	43.91	44.94
6932	INJECTION OF FISSURE IN ANO	21.55	21.78	22.15	22.53	23.06
6933	HYSTERECTOMY W/ CYSTOCELE AND RECTOCELE REPAIR	660.00	666.93	678.48	690.03	706.20
6934	COLPOSCOPY WITHOUT BIOPSY	79.05	79.88	81.26	82.65	84.58
6935	ARTIFICIAL INSEMINATION	43.20	43.65	44.41	45.17	46.22
6936	FITTING OF DIAPHRAGM	33.15	33.50	34.08	34.66	35.47
6937	VAPORIZATION ENDOMETRIOSIS	320.35	323.71	329.32	334.93	342.77
6938	INFERTILITY/TUBAL BLOCKAGE/CORNUA	640.70	647.43	658.64	669.85	685.55
6939	IUCD INSERTED DURING ANNUAL EXAM	25.70	25.97	26.42	26.87	27.50
6942	ENDOMETRIAL ABLATION+/- D&C, +/- HYSTEROSCOPY	380.15	384.14	390.79	397.45	406.76
6945	DIAGNOSTIC HYSTEROSCOPY	135.00	136.42	138.78	141.14	144.45
6946	THERAPEUTIC HYSTEROSCOPY	188.00	189.97	193.26	196.55	201.16
6947	VAGINAL HEMATOMA (GENERAL ANESTHESIA)	105.00	106.10	107.94	109.78	112.35
6948	VAGINAL/CERVICAL LACERATION (GEN.ANESTH)	95.00	96.00	97.66	99.32	101.65
6949	HYSTEROSCOPY RSXN ENDOMETRIAL TUMOR	420.00	424.41	431.76	439.11	449.40
6950	STAGING LAPAROTMY GYNEC CA INCL HYSTX/SALPX	803.45	811.89	825.95	840.01	859.69
6951	COLPOSACROPEXY	558.00	563.86	573.62	583.39	597.06
6952	SACROSPINOUS VAULT FIXATION (ADD ON)	95.00	96.00	97.66	99.32	101.65
6953	POSTPARTUM HEMORRAGE (SURGICAL MGMT)	386.75	390.81	397.58	404.35	413.82
6958	LAPAROSCOPIC HYSTERECTOMY - TOTAL, ABDO OR VAG		526.79	535.91	545.03	557.80
6959	LAPAROSCOPIC HYSTERECTOMY - SUBTOTAL, +/-ADNEXA		389.93	396.68	403.43	412.89
6989	COLPOSCOPY WITH BIOPSY (INCLUDES PAP)		111.05	112.98	114.90	117.59
7000	EYE EXAM UNDER GENERAL ANAESTHESIA	54.00	54.57	55.51	56.46	57.78
7002	GONIOTOMY	324.40	327.81	333.48	339.16	347.11
7003	ENUCLEATION	270.25	273.09	277.82	282.55	289.17
7004	ENUCLEATION WITH PROSTHESIS IMPLANT	324.40	327.81	333.48	339.16	347.11
7005	EVISCERATION	270.25	273.09	277.82	282.55	289.17
7006	EVISCERATION WITH IMPLANT	324.40	327.81	333.48	339.16	347.11
7007	REMOVAL INTRAOCULAR FOREIGN BODY	360.20	363.98	370.29	376.59	385.41
7050	PARACENTESIS	51.35	51.89	52.79	53.69	54.94
7051	REMOVAL FOREIGN BODY LOCAL - EYE	35.00	35.37	35.98	36.59	37.45
7052	REMOVAL FOREIGN BODY-GENERAL - EYE	51.35	51.89	52.79	53.69	54.94
7053	KERATECTOMY	324.40	327.81	333.48	339.16	347.11
7054	EXCISION OF DERMOID	162.25	163.95	166.79	169.63	173.61
7058	CORNEAL TRANSPLANT-PENETRATING	668.90	675.92	687.63	699.33	715.72
7059	CORNEAL TRANSPLANT-LAMELLAR	514.60	520.00	529.01	538.01	550.62
7060	SUTURE WITH EXCISION OF IRIS	324.40	327.81	333.48	339.16	347.11
7061	SUTURE WITHOUT EXCISION OF IRIS	216.10	218.37	222.15	225.93	231.23
7062	REMOVAL OF CORNEAL SUTURES	49.80	50.32	51.19	52.07	53.29
7063	CORNEAL RETRIEVAL	131.35	132.73	135.03	137.33	140.54
7102	SCLERECTOMY	360.20	363.98	370.29	376.59	385.41
7103	SUTURE-ALL PENETRATING WOUNDS	324.40	327.81	333.48	339.16	347.11
7150	IRIDECTOMY	257.20	259.90	264.40	268.90	275.20
7151	IRIDENCLEISIS	324.40	327.81	333.48	339.16	347.11

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
7152	DIVISION OF ANTERIOR SYNECHIA	162.25	163.95	166.79	169.63	173.61
7153	CRYOTHERAPY OF CILIARY BODY	216.10	218.37	222.15	225.93	231.23
7156	ANTERIOR CHAMBER OPEN EVACUATION OF CLOT	324.40	327.81	333.48	339.16	347.11
7160	IRIDENCLESIS	318.35	321.69	327.26	332.83	340.63
7161	TRABECULOPLASTY	336.70	340.24	346.13	352.02	360.27
7162	ANTERIOR VITRECTOMY	300.55	303.71	308.97	314.23	321.59
7202	CAPSULOTOMY	205.80	207.96	211.56	215.16	220.21
7203	CATARACT-SENILE	458.35	463.16	471.18	479.20	490.43
7204	CATARACT-CONGENITAL	484.40	489.49	497.96	506.44	518.31
7205	CATARACT-TRAUMATIC	484.40	489.49	497.96	506.44	518.31
7206	CATARACT-EXTRACT-DISLOCATED LENS	484.40	489.49	497.96	506.44	518.31
7208	SEVERANCE OF VITREOUS STRANDS	156.35	157.99	160.73	163.46	167.29
7210	CATARACT EXTRACT-INTRA-OCULAR LENS	555.55	555.55	555.55	555.55	555.55
7211	SECONDARY LENS INSERTION	333.05	336.55	342.38	348.20	356.36
7212	REPOSITION INTRA-OCULAR LENS	159.05	160.72	163.50	166.29	170.18
7213	REMOVAL-INTRA-OCULAR LENS	279.90	282.84	287.74	292.64	299.49
7250	RE-ATTACH OF RETINA AND CHOROID -SIMPLE	432.55	437.09	444.66	452.23	462.83
7251	RE-ATTACH OF RETINA & CHOROID -PHOTOCOAGULATION	411.60	415.92	423.12	430.33	440.41
7252	CRYOPEXY	411.60	415.92	423.12	430.33	440.41
7253	NON-CIRCLING TUBE OR BUCKLE PROCED	648.50	655.31	666.66	678.01	693.90
7254	CIRCLING TUBE-1ST OPERATION	648.50	655.31	666.66	678.01	693.90
7255	UNTREATED RETINAL DETACHMENTS	648.50	655.31	666.66	678.01	693.90
7256	SECONDARY OPERATION FOR DETACHMENT	864.95	874.03	889.17	904.31	925.50
7257	PHOTOCOAGULATION-INDEPENDENT PROCED	257.20	259.90	264.40	268.90	275.20
7258	CRYOPEXY-INDEPENDENT PROCEDURE	257.20	259.90	264.40	268.90	275.20
7259	PNEUMATIC RETINOPEXY		660.18	660.18	660.18	660.18
7260	PNEUMATIC RETINOPEXY -REPEAT SAME EYE W/IN 30 DAYS		330.09	330.09	330.09	330.09
7300	STRABISMUS PROCEDURES	308.70	311.94	317.34	322.75	330.31
7301	STRABISMUS PROCED-SUB OPERATIONS	162.25	163.95	166.79	169.63	173.61
7302	STRABISMUS SURGERY	318.35	321.69	327.26	332.83	340.63
7350	DRAINAGE OF ABSCESS-ORBIT	216.10	218.37	222.15	225.93	231.23
7351	LATERAL ORBIOTOMY-KRONLEIN PROCED	540.65	546.33	555.79	565.25	578.50
7352	TUMOR-ORBITAL	378.35	382.32	388.94	395.56	404.83
7353	TUMOR-LACRIMAL GLAND	378.35	382.32	388.94	395.56	404.83
7354	EXENTERATIONS	432.55	437.09	444.66	452.23	462.83
7355	ORBIT BIOPSY	108.15	109.29	111.18	113.07	115.72
7356	ORBITAL FRACTURE	324.40	327.81	333.48	339.16	347.11
7357	BLOWOUT FRACTURE OF FLOOR	378.35	382.32	388.94	395.56	404.83
7358	SECONDARY REPAIR OF BLOWOUT FRACTURE	594.70	600.94	611.35	621.76	636.33
7400	DRAINAGE OF EYELID ABSCESS-LOCAL	35.00	35.37	35.98	36.59	37.45
7402	CHALAZION-LOCAL	43.40	43.86	44.62	45.37	46.44
7403	CHALAZION-GENERAL	54.00	54.57	55.51	56.46	57.78
7404	EPILATION BY HYFRECOTOR	21.55	21.78	22.15	22.53	23.06
7405	LID TUMORS-VERY MINOR	32.45	32.79	33.36	33.93	34.72
7406	LID TUMORS-MINOR	154.35	155.97	158.67	161.37	165.15
7407	LID TUMORS-INTERMEDIATE	270.25	273.09	277.82	282.55	289.17
7408	LID TUMORS-MAJOR	378.35	382.32	388.94	395.56	404.83
7409	LID TUMORS-EXTENSIVE	540.65	546.33	555.79	565.25	578.50
7410	PTOSIS	324.40	327.81	333.48	339.16	347.11
7411	PTOSIS-SECONDARY REPAIR	540.65	546.33	555.79	565.25	578.50
7412	DISTRICHIASIS-UNILATERAL	324.40	327.81	333.48	339.16	347.11
7413	TRICHIASIS	I.C.	I.C.	I.C.	I.C.	I.C.
7414	ENTROPION	325.00	328.41	334.10	339.79	347.75
7415	ECTROPION	324.40	327.81	333.48	339.16	347.11
7417	LACERATION	324.40	327.81	333.48	339.16	347.11
7418	SUTURE-TARSORRHAPHY	108.15	109.29	111.18	113.07	115.72
7419	DOUBLE ADHESION	162.25	163.95	166.79	169.63	173.61

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
7420	TREATMENT OF TRICHIASIS	49.80	50.32	51.19	52.07	53.29
7421	EYELID REPAIR LACERATION (LESS THAN 2CM)	162.25	163.95	166.79	169.63	173.61
7430	BLEPHAROPLSTY-EXCISN SKIN+/-MUSCLE-PER LID	133.25	134.65	136.98	139.31	142.58
7431	PLUS REMOV ORB FAT+/-LID FOLD RECONSTR OR GRFT	174.00	175.83	178.87	181.92	186.18
7450	PTERYGIUM-UNILATERAL	210.00	212.21	215.88	219.56	224.70
7451	PERITOMY	75.75	76.55	77.87	79.20	81.05
7452	CONJUNCTIVA BIOPSY	32.45	32.79	33.36	33.93	34.72
7453	CONJUNCTIVA-PLASTIC REPAIR	I.C.	I.C.	I.C.	I.C.	I.C.
7500	DACRYOCYSTOTOMY	54.00	54.57	55.51	56.46	57.78
7502	DACRYOCYSTECTOMY	270.25	273.09	277.82	282.55	289.17
7503	LACERATED CANALICULUS	216.10	218.37	222.15	225.93	231.23
7504	DACROCYSTORHINOSTOMY	432.55	437.09	444.66	452.23	462.83
7505	PROBING AND DILATION OF DUCT-GENERAL	54.00	57.15	62.40	67.65	75.00
7510	FLUORESCEIN / DIGITAL ANGIOGRAM	57.05	57.65	58.65	59.65	61.04
7511	BANDAGE CONTACT LENS	83.45	84.33	85.79	87.25	89.29
7512	THREE-SNIP PROCEDURE	61.95	62.60	63.68	64.77	66.29
7700	DRAIN ABSCESS OR HEMATOMA-LOCAL	75.00	75.79	77.10	78.41	80.25
7701	DRAIN ABSCESS OR HEMATOMA-GENERAL	54.00	54.57	55.51	56.46	57.78
7702	BIOPSY OF EAR	75.00	75.79	77.10	78.41	80.25
7703	LOCAL EXCISION-LESION ON EAR	54.00	54.57	55.51	56.46	57.78
7704	PARTIAL EXCISION OF EAR	162.25	163.95	166.79	169.63	173.61
7705	COMPLETE EXCISION OF EAR	216.10	218.37	222.15	225.93	231.23
7706	RADICAL EXCISION-MALIGNANT LESION	432.55	437.09	444.66	452.23	462.83
7707	REMOVAL OF FOREIGN BODY-SIMPLE	35.00	35.37	35.98	36.59	37.45
7708	REMOVAL OF FOREIGN BODY-GENERAL	54.00	54.57	55.51	56.46	57.78
7710	RECONSTRUCTION OF EAR/SKIN GRAFT	I.C.	I.C.	I.C.	I.C.	I.C.
7711	CONSTRUCTION OF EAR CANAL	756.80	764.75	777.99	791.23	809.78
7712	REMOVAL OF PLASTIC DRAINAGE TUBES	19.35	19.55	19.89	20.23	20.70
7713	REMOVAL OF DRAINAGE TUBE-GENERAL	48.10	48.61	49.45	50.29	51.47
7714	FIBREOPTIC ENDOSCOPY	18.20	18.39	18.71	19.03	19.47
7720	EXCISN PRE-AURICULAR SINUS-SIMPLE-LOC ANES	76.23	77.03	78.36	79.70	81.57
7721	EXCISN PRE-AURICULAR SINUS-GEN ANESTHETIC	152.46	154.06	156.73	159.40	163.13
7800	MYRINGOTOMY-LOCAL	32.45	32.79	33.36	33.93	34.72
7801	MYRINGOTOMY-GENERAL	64.90	65.58	66.72	67.85	69.44
7802	MYRINGOTOMY AND INSERTION OF PROSTHES	103.00	104.08	105.88	107.69	110.21
7803	ASPIRATION FOR SEROUS OTITIS	21.55	21.78	22.15	22.53	23.06
7804	MASTOIDECTOMY-SIMPLE-UNILATERAL	324.40	327.81	333.48	339.16	347.11
7805	RADICAL MASTOIDECTOMY-UNILATERAL	540.65	546.33	555.79	565.25	578.50
7806	REMOVAL MIDDLE EAR POLYP BY SNARE	43.20	43.65	44.41	45.17	46.22
7807	REVISION OF RADICAL MASTOID CAVITY	540.65	546.33	555.79	565.25	578.50
7808	STAPES MOBILIZATION	540.65	546.33	555.79	565.25	578.50
7809	STAPEDECTOMY	756.80	764.75	777.99	791.23	809.78
7811	MYRINGOPLASTY	324.40	327.81	333.48	339.16	347.11
7812	TYMPANOPLASTY	617.45	623.93	634.74	645.54	660.67
7813	FACIAL NERVE DECOMPRESSION	540.65	546.33	555.79	565.25	578.50
7814	FACIAL NERVE GRAFT	648.50	655.31	666.66	678.01	693.90
7815	MIDDLE EAR EXPLORATION	324.40	327.81	333.48	339.16	347.11
7901	LABYRINTHECTOMY-EXCISION	648.50	655.31	666.66	678.01	693.90
7902	MEATOPLASTY	110.45	111.61	113.54	115.48	118.18
7905	ETHMOIDAL ARTERY LIGATION FOR EPISTAXIS	108.15	109.29	111.18	113.07	115.72
7906	MAXILLARY ARTERY LIGATION FOR EPISTAXIS	420.33	424.74	432.10	439.46	449.75
7907	NASAL SEPTAL BUTTON INSERTION	91.23	92.19	93.78	95.38	97.62
7908	LYSIS OF NASAL ADHESIONS	110.50	111.66	113.59	115.53	118.24
7909	INTRANASAL ETHMOIDECTOMY(ANTERIOR)	160.65	162.34	165.15	167.96	171.90
7910	INTRANASAL ETHMOIDECTOMY(ANT.+POST.)	262.00	264.75	269.34	273.92	280.34
7911	POST-TONSIL/ADENOIDECTOMY BLEED(SAME SURGEON)	66.30	67.00	68.16	69.32	70.94
7912	POST-TONSIL/ADENOIDECTOMY BLEED(DIFF SURGEON)	121.55	122.83	124.95	127.08	130.06

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
7913	EXCISION EAR CANAL EXOSTOSIS (SINGLE)	282.41	285.38	290.32	295.26	302.18
7914	EXCISION EAR CANAL EXOSTOSIS (MULTIPLE)	497.25	502.47	511.17	519.87	532.06
7915	MASTOID CAVITY CLEANING	64.41	65.09	66.21	67.34	68.92
8000	DRAINAGE OF KIDNEY ABSCESS	324.40	327.81	333.48	339.16	347.11
8001	DRAINAGE OF PERINEPHRIC ABSCESS	216.10	218.37	222.15	225.93	231.23
8002	ADRENAL EXPLORATION-UNILATERAL	324.40	327.81	333.48	339.16	347.11
8003	RENAL EXPLORATION	324.40	327.81	333.48	339.16	347.11
8004	NEPHROSTOMY	378.35	382.32	388.94	395.56	404.83
8006	TRANSECTION ABERRANT RENAL VESSEL	378.35	382.32	388.94	395.56	404.83
8007	SECONDARY OPERATION-ADDITIONAL	108.15	109.29	111.18	113.07	115.72
8009	PYELOITHOTOMY	378.35	382.32	388.94	395.56	404.83
8010	PARTIAL NEPHRECTOMY/RECONSTRUCTION FOR CA	617.45	623.93	634.74	645.54	660.67
8011	ADRENALECTOMY-UNILATERAL	540.65	546.33	555.79	565.25	578.50
8012	FUNCTIONAL TUMORS	540.65	546.33	555.79	565.25	578.50
8013	RENAL CYST	378.35	382.32	388.94	395.56	404.83
8014	HEMINEPHRECTOMY	518.95	524.40	533.48	542.56	555.28
8015	SECONDARY OPERATION-ADDITIONAL	108.15	109.29	111.18	113.07	115.72
8016	NEPHRECTOMY-ECTOPIC	432.55	437.09	444.66	452.23	462.83
8017	LUMBAR	454.05	458.82	466.76	474.71	485.83
8018	TRANSPERITONEAL	432.55	437.09	444.66	452.23	462.83
8019	TRANSPERITONEAL-THORACO-ABDOMINAL	648.50	655.31	666.66	678.01	693.90
8020	RADICAL NEPHRECTOMY	617.45	623.93	634.74	645.54	660.67
8021	NEPHRO-URETERECTOMY	540.65	546.33	555.79	565.25	578.50
8022	NEPHRO-URETERECTOMY WITH RESECTION	648.50	655.31	666.66	678.01	693.90
8023	NEPHRO-URETERECTOMY-SECONDARY OPER	108.15	109.29	111.18	113.07	115.72
8024	OPEN RENAL BIOPSY	324.40	327.81	333.48	339.16	347.11
8025	PYELOURETOPLASTY	486.50	491.61	500.12	508.64	520.56
8026	NEPHROPEXY	324.40	327.81	333.48	339.16	347.11
8028	SYMPHYSIOTOMY	518.95	524.40	533.48	542.56	555.28
8029	SUTURE RUPTURED KIDNEY	432.55	437.09	444.66	452.23	462.83
8030	REMOVAL OF STAGHORN CALCULUS	606.90	613.27	623.89	634.51	649.38
8031	DONOR NEPHRECTOMY-UNILATERAL OR BILATERAL	433.45	438.00	445.59	453.17	463.79
8032	RENAL AUTO TRANSPLANTATION	836.05	844.83	859.46	874.09	894.57
8033	PERCUT ENDOPYELOPLSTY FOR UPJ OBSTRUCTION	259.40	262.12	266.66	271.20	277.56
8040	ESWL - ONE SIDE, ONE STONE	360.00	363.78	370.08	376.38	385.20
8041	ESWL - ONE SIDE, MULTIPLE STONES	540.00	545.67	555.12	564.57	577.80
8042	ESWL - BILATERAL, ONE STONE PER SIDE	600.00	606.30	616.80	627.30	642.00
8043	ESWL - BILATERAL, MULTIPLE STONES PER SIDE	875.00	884.19	899.50	914.81	936.25
8100	PERI-URETERAL ABSCESS	216.10	218.37	222.15	225.93	231.23
8102	URETEROTOMY-UPPER TWO THIRDS	389.15	393.24	400.05	406.86	416.39
8103	URETEROTOMY-LOWER ONE THIRD	454.05	458.82	466.76	474.71	485.83
8104	URETERECTOMY	378.35	382.32	388.94	395.56	404.83
8105	URETERECTOMY-URETEROVESICAL JUNCTION	432.55	437.09	444.66	452.23	462.83
8106	URETEROVESICAL ANASTOMOSIS	518.95	524.40	533.48	542.56	555.28
8107	URETERO-ILEAL CONDUIT	648.50	655.31	666.66	678.01	693.90
8108	URETERO-ILEAL COND-TOTAL CYSTECT	973.05	983.27	1,000.30	1,017.32	1,041.16
8109	URETERO-COLIC ANASTOMOSIS	486.50	491.61	500.12	508.64	520.56
8110	URETERO-COLIC ANASTOMOSIS-CYSTECT	778.35	786.52	800.14	813.76	832.83
8111	URET-COLIC ANASTOMOSIS-CYSTECTMY+COLOSTMY	908.05	917.58	933.48	949.37	971.61
8112	ILEO-URETERAL SUBSTITUTION	648.50	655.31	666.66	678.01	693.90
8113	URETERO-URETEROSTOMY	540.65	546.33	555.79	565.25	578.50
8114	URETEROSTOMY-CUTANEOUS UNILATERAL	324.40	327.81	333.48	339.16	347.11
8115	URETERO-VAGINAL FISTURE	518.95	524.40	533.48	542.56	555.28
8116	URETEROLYSIS PERI-URETERAL FIBROSIS-UNILAT	432.55	437.09	444.66	452.23	462.83
8118	SPONTANEOUS RUPTURE IMMEDIATE-UPPER	378.35	382.32	388.94	395.56	404.83
8119	SPONTANEOUS RUPTURE-IMMEDIATE LOWER	432.55	437.09	444.66	452.23	462.83
8120	SPONTANEOUS RUPTURE-LATE REPAIR-UP	432.55	437.09	444.66	452.23	462.83

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
8121	SPONTANEOUS RUPTURE-LATE REPAIR-LOW	486.50	491.61	500.12	508.64	520.56
8122	ENDOSCOPIC PROCEDURES-CALIBRATION/DILATION	95.00	96.00	97.66	99.32	101.65
8123	ENDOSCOPIC REMOVAL OF CALCULUS	275.00	277.89	282.70	287.51	294.25
8124	ENDOSCOPIC PROCEDURES-MANIPULATION ONLY	160.00	161.68	164.48	167.28	171.20
8125	URETEROTOMY-UPPER TWO THIRDS	412.50	416.83	424.05	431.27	441.38
8126	URETEROTOMY-LOWER ONE THIRD	473.15	478.12	486.40	494.68	506.27
8127	BLADDER FLAP (BOARI) INCL REIMPLANT	464.50	469.38	477.51	485.63	497.02
8128	REVISION OF URETERAL-ILEAL ANASTOMOSIS	406.50	410.77	417.88	425.00	434.96
8129	PARTIAL RESECTION+REVISION OF ILEAL CONDUIT	371.70	375.60	382.11	388.61	397.72
8197	COLD KNIFE (VISUAL) INTERNAL URETHROTOMY	214.00	216.25	219.99	223.74	228.98
8198	BRUSH BIOPSY OF URETER/RENAL PELVIS	200.00	202.10	205.60	209.10	214.00
8199	ENDOSCOPY WITH INSERT URETERAL STNT	260.00	262.73	267.28	271.83	278.20
8200	ENDOSCOPY-CYSTOSCOPY-DIAGNOSTIC	95.00	96.00	97.66	99.32	101.65
8202	ENDOSCOPY-CYSTOSCOPY WITH BIOPSY	160.00	161.68	164.48	167.28	171.20
8203	ENDOSCOPY-CYSTOSCOPY-ELECTROCOAG TUMOR	160.00	161.68	164.48	167.28	171.20
8204	ENDOSCPY-CYSTOSCPY-ELECTROCOAG TUMOR MULT	200.00	202.10	205.60	209.10	214.00
8205	ENDOSCOPY-CYSTOSCOPY-URETHRAL DILATION	95.00	97.25	101.00	104.75	110.00
8206	ENDOSCOPY-CYSTOSCOPY-BLADDER DILATION	160.00	161.68	164.48	167.28	171.20
8207	ENDOSCPY-CYSTOSCPY-COAGULATN HUNNER ULCER	160.00	161.68	164.48	167.28	171.20
8208	ENDOSCPY-CYSTOSCPY-ELCTROCOAG-EXCISN TUMOR	288.20	291.23	296.27	301.31	308.37
8209	ENDSCPY-CYSTO-ELCTROCOAG/EXCSN TUMOR MULT	420.00	424.41	431.76	439.11	449.40
8211	ELECTROSURGICAL URETERAL METOTOMY	180.00	181.89	185.04	188.19	192.60
8212	ENDOSCOPY-CYSTOSCOPY-REMOVAL FOREIGN BODY	200.00	202.10	205.60	209.10	214.00
8214	ENDOSCOPY/CYSTOSCOPY-LITHOPLAPAXY	247.00	249.59	253.92	258.24	264.29
8215	URETHRAL MEATOTOMY AND PLASTIC REPAIR	160.00	161.68	164.48	167.28	171.20
8216	CYSTOTOMY OR CYSTOSTOMY	162.25	163.95	166.79	169.63	173.61
8217	CYSTOT/CYSTOS AND ELCTRCGLTN TUMOR	324.40	327.81	333.48	339.16	347.11
8218	CYSTOTOMY WITH TROCHAR AND CANNULA	108.15	109.29	111.18	113.07	115.72
8219	CYSTOLITHOTOMY	216.10	218.37	222.15	225.93	231.23
8223	CYSTECTOMY-PARTIAL	432.55	437.09	444.66	452.23	462.83
8224	CYSTECTOMY FOR TUMOR DIVERTICULUM	486.50	491.61	500.12	508.64	520.56
8225	CYSTECTOMY-REIMPLANTATION OF URETER	540.65	546.33	555.79	565.25	578.50
8226	COMPLETE CYSTECTOMY	540.65	546.33	555.79	565.25	578.50
8227	CYSTECTOMY WITH COLOCYSTOPLASTY	864.95	874.03	889.17	904.31	925.50
8228	CYSTECTOMY-COLOCYSTOPLASTY-2ND SURGERY	216.10	218.37	222.15	225.93	231.23
8229	EXCISION URACHUS AND REPAIR BLADDER	270.25	273.09	277.82	282.55	289.17
8230	EXTROPHY	324.40	327.81	333.48	339.16	347.11
8231	EXTROPHY-URINARY DIVERSION & EXCIS	864.95	874.03	889.17	904.31	925.50
8232	EXTROPHY-EXCSN BLADDER+REPAIR BLADDER WALL	324.40	327.81	333.48	339.16	347.11
8233	REPAIR OF RUPTURED BLADDER	389.15	393.24	400.05	406.86	416.39
8234	ILEOCYSTOPLASTY	648.50	655.31	666.66	678.01	693.90
8239	CLOSURE FISTULA,EXTERNAL-SUPRAPUBIC	259.40	262.12	266.66	271.20	277.56
8240	VESICOVAGINAL-TRANSVESICAL APPROACH	518.95	524.40	533.48	542.56	555.28
8241	VESICORECTAL OR VESICOSIGMOID	432.55	437.09	444.66	452.23	462.83
8242	CYSTOSCOPY-RETROGRAPHY PYELOGRAM	86.45	87.36	88.87	90.38	92.50
8243	PEVIC AND RETROPERITONEAL LYMPH CANCER	609.75	616.15	626.82	637.49	652.43
8250	INTRAVESICAL BOTOX INJECTIONS (1 OR MORE)		202.10	205.60	209.10	214.00
8300	BIOPSY INCLUDING ENDOSCOPY	86.45	87.36	88.87	90.38	92.50
8301	INTERNAL URETHROTOMY	129.75	131.11	133.38	135.65	138.83
8302	REMOVAL OF FOREIGN BODY	162.25	163.95	166.79	169.63	173.61
8303	MEATAL EXTRACTION OF FOREIGN BODY	35.00	35.37	35.98	36.59	37.45
8304	URETHROTOMY-EXTERNAL	259.40	262.12	266.66	271.20	277.56
8305	MEATOTOMY AND PLASTIC REPAIR	75.75	76.55	77.87	79.20	81.05
8308	PERIURETHRAL ABSCESS	54.00	54.57	55.51	56.46	57.78
8309	CARUNCLE	75.75	76.55	77.87	79.20	81.05
8310	CARUNCLE INCLUDING CYSTOSCOPY	129.75	131.11	133.38	135.65	138.83
8311	URETHRAL PAPILLOMA	129.75	131.11	133.38	135.65	138.83

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
8312	PROLAPSE	86.45	87.36	88.87	90.38	92.50
8313	PROLAPSE WITH CYSTOSCOPY	129.75	131.11	133.38	135.65	138.83
8314	STRICTURE-ONE STAGE	389.15	393.24	400.05	406.86	416.39
8315	STRICTURE-TWO STAGE (1ST STAGE)	194.55	196.59	200.00	203.40	208.17
8316	STRICTURE-SECOND STAGE	389.15	393.24	400.05	406.86	416.39
8317	DIVERTICULECTOMY	270.25	273.09	277.82	282.55	289.17
8318	POSTERIOR URETHRAL VALVE-ENDOSCOPY	108.15	109.29	111.18	113.07	115.72
8319	POST URETHRAL VALVE-OPEN OPERATION	270.25	273.09	277.82	282.55	289.17
8320	BIOPSY-EXCISION	32.45	32.79	33.36	33.93	34.72
8321	URETHRAL SLING	324.40	327.81	333.48	339.16	347.11
8322	URETHROVESICAL SUSPENSION-STRESS INCONINENCY	389.15	393.24	400.05	406.86	416.39
8323	URETHRVESIC SUSPNSN+PARTL CYSTECTMY/VESCPXY	518.95	524.40	533.48	542.56	555.28
8324	SUTURE-RUPTURE OF ANTERIOR URETHRA	259.40	262.12	266.66	271.20	277.56
8325	SUTURE-POST URETHRA-IMMEDIATE REPAIR	454.05	458.82	466.76	474.71	485.83
8326	SUTURE-POST URETHRA-LATE REPAIR	594.70	600.94	611.35	621.76	636.33
8328	RECTO-URETHRAL FISTULA	432.55	437.09	444.66	452.23	462.83
8329	RECTO-URETHRAL FISTULA-COLOSTOMY	540.65	546.33	555.79	565.25	578.50
8330	DILATION OF STRICTURE LOCAL	21.55	21.78	22.15	22.53	23.06
8331	DILATION OF STRICTURE-GENERAL	54.00	54.57	55.51	56.46	57.78
8332	DILATION STRICTURE-FILLFORMS AND FOLLOWERS	39.15	39.56	40.25	40.93	41.89
8333	SUTURE URETHROCUTANEOUS FISTULA	259.40	262.12	266.66	271.20	277.56
8334	URETHRECTOMY	400.00	404.20	411.20	418.20	428.00
8335	EXTERNAL SPINCTEROTOMY (TRANSURETHL)	303.45	306.64	311.95	317.26	324.69
8336	INSERTION OF ARTIFICIAL URINARY SPHINCTER	600.00	606.30	616.80	627.30	642.00
8337	NESBITT PROCEDURE FOR PEYRONIE'S DISEASE	540.00	545.67	555.12	564.57	577.80
8339	URETHROLYSIS (INCLUDES CYSTOSCOPY)		350.00	357.35	364.70	374.50
8400	SPLIT OF PREPUCE-NEWBORN	10.85	10.96	11.15	11.34	11.61
8401	SPLIT OF PREPUCE-CHILD	12.00	12.13	12.34	12.55	12.84
8402	SPLIT OF PREPUCE-ADULT	24.00	24.25	24.67	25.09	25.68
8404	CIRCUMCISION-CHILD UNDER 12	129.49	130.85	133.12	135.38	138.55
8405	CIRCUMCISION-ADULT	129.07	130.43	132.68	134.94	138.10
8406	CONDYLOMATA	54.00	54.57	55.51	56.46	57.78
8407	BIOPSY-PENIS	43.20	43.65	44.41	45.17	46.22
8408	PARTIAL AMPUTATION OF PENIS	194.55	196.59	200.00	203.40	208.17
8409	PARTIAL AMPUTATION-PENIS AND INGUINAL GLANDS	518.95	524.40	533.48	542.56	555.28
8410	TOTAL AMPUTATION PENIS AND INGUINAL GLANDS	648.50	655.31	666.66	678.01	693.90
8411	EPISPADIUS	324.40	327.81	333.48	339.16	347.11
8412	HYPOSPADIUS-CHRORDEE REPAIR	216.10	218.37	222.15	225.93	231.23
8413	PLASTIC RECONTRUCTION URETHRE-ONE STAGE	324.40	327.81	333.48	339.16	347.11
8414	PLASTIC RECONTRUCTION URETHRA-TWO STAGE	432.55	437.09	444.66	452.23	462.83
8415	PLASTIC RECONTRUCTION PENOSCROTAL-1ST STAGE	432.55	437.09	444.66	452.23	462.83
8416	PLASTIC RECONTRUCTION PENOSCROTAL 2ND STAGE	540.65	546.33	555.79	565.25	578.50
8417	PENILE PROSTHESIS FOR IMPOTENCE	306.55	309.77	315.13	320.50	328.01
8418	EXCISION OF PEYRONIE'S PLAQUE	195.10	197.15	200.56	203.98	208.76
8419	INJECTION SUBSTANCE IMPOTENCE THERAPY	14.50	14.65	14.91	15.16	15.52
8420	INSERTION OF HYDRAULIC PENILE PROSTHESIS	375.45	379.39	385.96	392.53	401.73
8421	RETROPERITONEL LYMPHADENECTOMY TESTIC CA	I.C.	I.C.	I.C.	I.C.	I.C.
8422	REMOVAL OF INFECTED PENILE PROSTHESIS	250.00	252.63	257.00	261.38	267.50
8500	TESTES ABSCESS	54.00	54.57	55.51	56.46	57.78
8501	ORCHIDECTOMY-UNILATERAL	194.55	196.59	200.00	203.40	208.17
8502	TESTES BIOPSY-SINGLE	54.00	54.57	55.51	56.46	57.78
8503	TESTES BIOPSY WITH VASOGRAPHY	108.15	109.29	111.18	113.07	115.72
8504	ORCHIDOPEXY	370.40	374.29	380.77	387.25	396.33
8505	REDUCT TORSION OR APPENDIX TESTIS	194.55	196.59	200.00	203.40	208.17
8506	RUPTURED TESTICLE	194.55	196.59	200.00	203.40	208.17
8507	INSERTION OF TESTICULAR PROSTHESIS	161.00	162.69	165.51	168.33	172.27
8508	RADICAL ORCHIECTOMY FOR CA-UNILATERAL	300.00	303.15	308.40	313.65	321.00

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
8510	EPIDIDYMIS-ABSCESS	54.00	54.57	55.51	56.46	57.78
8511	SPERMATOCELE	194.55	196.59	200.00	203.40	208.17
8512	EPIDIDYMECTOMY-UNILATERAL	194.55	196.59	200.00	203.40	208.17
8513	ANASTOMOSIS-EPIDIDYMOVASOSTOMY UNILATERAL	194.55	196.59	200.00	203.40	208.17
8520	HYDROCELE-UNILATERAL	185.25	187.20	190.44	193.68	198.22
8521	HYDROCELE-ASPIRATION	21.55	21.78	22.15	22.53	23.06
8530	SCROTOM ABSCESS	54.00	54.57	55.51	56.46	57.78
8531	SCROTUM EXPLORATION-UNILATERAL	129.75	131.11	133.38	135.65	138.83
8533	RESECTION OF SCROTUM	216.10	218.37	222.15	225.93	231.23
8534	SUTURE-INTEGUMENTARY SYSTEM	I.C.	I.C.	I.C.	I.C.	I.C.
8540	VASOGRAPHY	54.00	54.57	55.51	56.46	57.78
8543	SUTURE-LIGATION-BILATERAL	132.00	133.39	135.70	138.01	141.24
8550	VARICOCELE-SINGLE	194.55	196.59	200.00	203.40	208.17
8551	HYDROCELE-SPERMATIC CORD	194.55	196.59	200.00	203.40	208.17
8560	SEMINAL VESICLES-ABSCESS	108.15	109.29	111.18	113.07	115.72
8561	VESICULECTOMY	540.65	546.33	555.79	565.25	578.50
8572	PROSTATE BIOPSY PERINEAL	216.10	218.37	222.15	225.93	231.23
8574	PROSTATE BIOPSY-NEEDLE	129.75	131.11	133.38	135.65	138.83
8577	RADICAL PROSTATOVESICULECTOMY	778.35	786.52	800.14	813.76	832.83
8578	PROSTATECTOMY-SUBRAPUBIC	518.95	524.40	533.48	542.56	555.28
8579	SUPRAPUBIC WITH DIVETICULECTOMY	648.50	655.31	666.66	678.01	693.90
8580	SUPRAPUBIC WITH PARTIAL CYSTECTOMY	648.50	655.31	666.66	678.01	693.90
8581	PROSTATECTOMY-RETROPUBIC-SIMPLE	514.60	520.00	529.01	538.01	550.62
8582	PROSTATE BIOPSY - U/S GUIDED TRANSRECT	115.00	117.25	121.00	124.75	130.00
8584	TRANSURETHRAL ELECTRORESECTION	514.60	520.00	529.01	538.01	550.62
8587	RESECTION OF BLADDER NECK-ADULT	324.40	327.81	333.48	339.16	347.11
8588	URETEROSCOPY ONLY	94.35	95.34	96.99	98.64	100.95
8590	CHANGE OF SUPRAPUBIC TUBE	21.55	21.78	22.15	22.53	23.06
8591	LYMPHADENECTOMY FOR CANCER OF PROSTATE	306.55	309.77	315.13	320.50	328.01
8592	URETERAL/RENAL STONE REMOVAL SINGLE	467.50	472.41	480.59	488.77	500.23
8593	URET STONE REMOV ELECHYDROLIC U/S LITHTRPSY	560.95	566.84	576.66	586.47	600.22
8594	RENAL/UPPER URETERAL STONE REMOVAL	560.95	566.84	576.66	586.47	600.22
8595	RENAL/UP URET WITH ELECRO/ULTRA	747.85	755.70	768.79	781.88	800.20
8596	REPEAT ORIG ABSCESS WITH ONE WEEK	374.05	377.98	384.52	391.07	400.23
8597	PERCUTANEOUS NEPHROSTOMY	149.65	151.22	153.84	156.46	160.13
8598	URETEROSCOPY WITH ULTRA/ELECT LITH	560.95	566.84	576.66	586.47	600.22
8599	URETEROSCOPY PLUS BASKET	467.50	472.41	480.59	488.77	500.23
8600	EYE FOR FOREIGN BODY	7.30	7.38	7.50	7.63	7.81
8601	EYE FOR LOCALIZATION ADDITIONAL	19.55	19.76	20.10	20.44	20.92
8602	OPTIC FORAMINA	7.30	7.38	7.50	7.63	7.81
8603	FACIAL BONES	10.85	10.96	11.15	11.34	11.61
8604	MANDIBLE	7.30	7.38	7.50	7.63	7.81
8605	MASTOIDS	10.70	10.81	11.00	11.19	11.45
8606	NECK-FOR SOFT TISSUES	8.05	8.13	8.28	8.42	8.61
8607	NASAL BONES	9.90	10.00	10.18	10.35	10.59
8608	SALIVARY GLAND REGION	7.30	7.38	7.50	7.63	7.81
8609	SELLA TURCICA	5.95	6.01	6.12	6.22	6.37
8610	SINUSES-PARANASAL	9.45	9.55	9.71	9.88	10.11
8611	SKULL-ROUTINE VIEWS	11.00	11.12	11.31	11.50	11.77
8612	SKULL-SPECIAL ADDITIONAL VIEWS	5.95	6.01	6.12	6.22	6.37
8613	TEETH UP TO HALF SET	5.95	6.01	6.12	6.22	6.37
8614	TEETH-FULL SET	9.85	9.95	10.13	10.30	10.54
8615	TEMPEROMANDIBULAR JOINT	7.80	7.88	8.02	8.15	8.35
8616	INTERNAL AUDITORY MEATI	9.85	9.95	10.13	10.30	10.54
8620	CERVICAL SPINE-ROUTINE	10.75	10.86	11.05	11.24	11.50
8621	CERVICAL SPINE WITH SPECIAL VIEWS	12.70	12.83	13.06	13.28	13.59
8622	THORACIC SPINE	8.80	8.89	9.05	9.20	9.42

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
8623	LUMBAR SPINE-ROUTINE	10.75	10.86	11.05	11.24	11.50
8624	LUMBAR SPINE-SPECIAL VIEWS	11.75	11.87	12.08	12.28	12.57
8625	SACRUM AND/OR COCCYX	7.30	7.38	7.50	7.63	7.81
8626	PELVIS	8.05	8.13	8.28	8.42	8.61
8627	S.I. JOINTS	8.05	8.13	8.28	8.42	8.61
8628	COMPLETE SPINE SCOLIOSIS SERIES	18.55	18.74	19.07	19.39	19.85
8629	RIBS-EACH SIDE	7.35	7.43	7.56	7.68	7.86
8630	STERNUM	7.30	7.38	7.50	7.63	7.81
8635	CLAVICLE	8.15	8.24	8.38	8.52	8.72
8636	STEROCLAVICULAR JOINTS	7.30	7.38	7.50	7.63	7.81
8637	SHOULDER	8.15	8.24	8.38	8.52	8.72
8638	SCAPULA	7.30	7.38	7.50	7.63	7.81
8639	HUMERUS	8.15	8.24	8.38	8.52	8.72
8640	ELBOW	8.15	8.24	8.38	8.52	8.72
8641	FOREARM	8.15	8.24	8.38	8.52	8.72
8642	WRIST	8.00	8.08	8.22	8.36	8.56
8643	HAND	8.00	8.08	8.22	8.36	8.56
8644	FINGER	3.85	3.89	3.96	4.03	4.12
8645	ACROMIOCLAVICULAR JOINTS WITH WGHTS	9.85	9.95	10.13	10.30	10.54
8646	HIP	8.05	8.13	8.28	8.42	8.61
8647	HIP PINNING-INTERPRETATION	8.20	8.29	8.43	8.57	8.77
8648	HIP PINNING-SUPERVISION AND INTERPRETATION	29.20	29.51	30.02	30.53	31.24
8649	FEMUR	8.05	8.13	8.28	8.42	8.61
8650	ORTHOROENTGENOGRAM	8.70	8.79	8.94	9.10	9.31
8651	KNEE	8.25	8.34	8.48	8.63	8.83
8652	TIBIA AND FIBULA	8.15	8.24	8.38	8.52	8.72
8653	ANKLE	8.00	8.08	8.22	8.36	8.56
8654	CALCANEUS	8.00	8.08	8.22	8.36	8.56
8655	FOOT	8.00	8.08	8.22	8.36	8.56
8656	TOE	3.85	3.89	3.96	4.03	4.12
8657	BONE AGE DETERMINATION	9.85	9.95	10.13	10.30	10.54
8658	METASTATIC SERIES	19.55	19.76	20.10	20.44	20.92
8659	METABOLIC BONE SURVEY	19.55	19.76	20.10	20.44	20.92
8660	ALL LONG BONES	4.65	4.70	4.78	4.86	4.98
8661	SPECIAL ADDITIONAL VIEWS OF EXTREMITY	3.40	3.44	3.50	3.55	3.64
8662	FEET-WEIGHT BEARING	6.20	6.27	6.37	6.48	6.63
8665	CHEST-SINGLE VIEW	6.05	6.11	6.22	6.33	6.47
8666	CHEST-MULTIPLE VIEWS	10.80	10.91	11.10	11.29	11.56
8667	CHEST FLUOROSCOPY ONLY	11.75	11.87	12.08	12.28	12.57
8670	ABDOMEN-SURVEY FILM	7.35	7.43	7.56	7.68	7.86
8671	ABDOMEN-MULTIPLE FILMS	10.75	10.86	11.05	11.24	11.50
8675	BARIUM SWALLOW	23.25	23.49	23.90	24.31	24.88
8676	STOMACH AND DUODENUM	35.90	36.28	36.91	37.53	38.41
8677	UPPER G.I SERIES AND SMALL BOWEL STUDY	50.15	50.68	51.55	52.43	53.66
8678	COLON-BARIUM ONLY	26.50	26.78	27.24	27.71	28.36
8679	COLON-DOUBLE CONTRAST	37.50	37.89	38.55	39.21	40.13
8680	CHOLECYSTOGRAM	8.70	8.79	8.94	9.10	9.31
8681	T-TUBE CHOLANGIOGRAM	14.65	14.80	15.06	15.32	15.68
8682	OPERATIVE CHOLANGIOGRAM	9.85	9.95	10.13	10.30	10.54
8684	P.T. CHOLANGIOGRAM-INTERPRETATION	19.55	19.76	20.10	20.44	20.92
8685	P.T. CHOLANGIOGRAM-FLUROSCOPY ADDITIONAL	9.85	9.95	10.13	10.30	10.54
8686	HYPOTONIC DUODENOGRAM	23.25	23.49	23.90	24.31	24.88
8688	INSERT CATH DUODENUM/SM BOWEL ENEMA/PROCED	50.30	50.83	51.71	52.59	53.82
8689	INSERT CATH DUODEN/SM BOWEL ENEMA/INTERPRET	8.50	8.59	8.74	8.89	9.10
8690	G.U. TRACT-SURVEY FILM	4.65	4.70	4.78	4.86	4.98
8691	RETROGRADE PYELOGRAM	8.70	8.79	8.94	9.10	9.31
8692	INTRAVENOUS PYELOGRAM	29.75	30.06	30.58	31.10	31.83

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
8695	PYELOGRAM-HYPERTENSIVE	24.40	24.66	25.08	25.51	26.11
8696	STRESS OR VOIDING CYSTOGRAM	19.55	19.76	20.10	20.44	20.92
8697	STRESS/VOIDING CYSTOGRAM-URETHROGRM	23.25	23.49	23.90	24.31	24.88
8698	URETHROGRAM+/-CYSTOGRAM-INTERPRETATION	8.70	8.79	8.94	9.10	9.31
8700	T-TUBE PYELOGRAM	8.70	8.79	8.94	9.10	9.31
8701	RENAL CYSTOGRAPHY	11.60	11.72	11.92	12.13	12.41
8702	RETROGRADE PYELOGRAM-PROCEDURE	28.70	29.00	29.50	30.01	30.71
8703	NEPHROSTOGRAM- PROCEDURE	28.70	29.00	29.50	30.01	30.71
8704	NEPHROSTOGRAM- INTERPRETATION	8.50	8.59	8.74	8.89	9.10
8705	OBSTETRICS AND GYNAECOLOGY-SURVEY FILMS	4.70	4.75	4.83	4.91	5.03
8708	HYSTEROSALPINOGRAM	17.60	17.78	18.09	18.40	18.83
8711	CATHETER CUG	22.85	23.09	23.49	23.89	24.45
8715	PERI ARTERIOGRAPHY AND VENOGRPHY-UNILATERAL	15.60	15.76	16.04	16.31	16.69
8716	PERI ARTERIOGRAPHY AND VENOGRPHY-BILATERAL	21.65	21.88	22.26	22.64	23.17
8717	AORTOGRAPHY	38.90	39.31	39.99	40.67	41.62
8718	EACH SELECT EXAM IN AD TO AORTOGRPY	23.25	23.49	23.90	24.31	24.88
8721	TRANSLUMBAR AORTOGRAM	18.45	18.64	18.97	19.29	19.74
8727	ARCH AORTOGRAM	29.20	29.51	30.02	30.53	31.24
8728	SPLENOPORTOGRAM	23.25	23.49	23.90	24.31	24.88
8729	LYMPHANGIOGRAM	23.25	23.49	23.90	24.31	24.88
8730	SELECTIVE ANGIOGRAPHY	29.20	29.51	30.02	30.53	31.24
8731	CAROTID ARTERIOGRAM-UNILATERAL	29.20	29.51	30.02	30.53	31.24
8734	CAROTID ARTERIOGRAM-BILATERAL	38.90	39.31	39.99	40.67	41.62
8739	MAMMOGRAPHY SCREENING BILATERAL EX	14.30	16.45	20.02	23.60	28.60
8740	MAMMOGRAPHY-UNILATERAL	15.05	15.21	15.47	15.73	16.10
8741	MAMMOGRAPHY-BILATERAL	36.00	36.38	37.01	37.64	38.52
8742	MAMMOGRAPHY-ADDITIONAL VIEWS	3.60	3.64	3.70	3.76	3.85
8743	STEREOTACTIC BREAST BIOPSY	138.00	139.45	141.86	144.28	147.66
8744	LOOPOGRAM	37.25	37.64	38.29	38.94	39.86
8745	ARTHROGRAM	23.25	23.49	23.90	24.31	24.88
8749	FISTULA OR SINUS WITH CONTRAST MED	11.75	11.87	12.08	12.28	12.57
8750	LAMINOGRPHY,PLANOGRPHY,TOMOGRPHY-1 PLANE	17.95	18.14	18.45	18.77	19.21
8751	LAMINOGRPHY,PLANOGRPHY,TOMOGRPHY-2 PLANES	24.40	24.66	25.08	25.51	26.11
8754	MYELOGRAM-LUMBAR	23.25	23.49	23.90	24.31	24.88
8755	MYELOGRAM-DORSAL	18.45	18.64	18.97	19.29	19.74
8756	MYELOGRAM-CERVICAL	18.45	18.64	18.97	19.29	19.74
8757	MYELOGRAM-COMPLETE	38.60	39.01	39.68	40.36	41.30
8759	SIALOGRAM	11.75	11.87	12.08	12.28	12.57
8762	FLUOROSCOPY ONLY	11.75	11.87	12.08	12.28	12.57
8763	INTERPRETATION OF SUBMITTED FILMS	11.75	11.87	12.08	12.28	12.57
8766	ULTRASOUND B MODE - PELVIC	41.31	41.74	42.47	43.19	44.20
8767	ULTRASOUND B MODE - OBSTETRICAL	48.21	48.72	49.56	50.40	51.58
8768	M MODE INTERPRETATION-ULTRA SOUND	55.00	55.58	56.54	57.50	58.85
8769	DOPPLER INTERPRETATION	50.00	50.53	51.40	52.28	53.50
8770	ULTRASONOGRAPHY	77.20	78.01	79.36	80.71	82.60
8771	PERCUTANEOUS ASP RENAL CYST/IMAGING	89.30	90.24	91.80	93.36	95.55
8772	PERCUTANEOUS ASP RENAL CYST/SCLEROS	111.60	112.77	114.72	116.68	119.41
8773	PERCUTANEOUS BIOPSY US/FLUOROSCOPY	111.60	112.77	114.72	116.68	119.41
8774	PERCUTANEOUS NEPHROSTOMY TURE INSE	178.70	180.58	183.70	186.83	191.21
8775	PERCUTANEOUS DIAGNOSTIC TAP	89.30	90.24	91.80	93.36	95.55
8776	PERCUTANEOUS INSERT DRAINAGE TUBE	134.05	135.46	137.80	140.15	143.43
8777	ASPIRATION RENAL CYST	111.60	112.77	114.72	116.68	119.41
8778	PERCUTANEOUS BILIARY DRAINAGE	260.00	262.73	267.28	271.83	278.20
8779	CHANGE OF BILIARY DRAINAGE CATHETER	90.00	90.95	92.52	94.10	96.30
8780	BILIARY STRICTURE DILATION/STENTING	130.00	131.37	133.64	135.92	139.10
8790	TUMOR LOCALIZATION	140.80	142.28	144.74	147.21	150.66
8791	ULTRASOUND B MODE - ABDOMINAL	51.31	51.85	52.75	53.64	54.90

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
8793	SONOHYSTEROGRAM - COMPOSITE FEE	85.00	85.89	87.38	88.87	90.95
8794	MYOCARDIAL PERFUSION IMAGING - REST AND STRESS	89.00	89.93	91.49	93.05	95.23
8799	SPECT (NUCLEAR SCAN TOMOGRAPHY) - ADD-ON FEE		25.00	25.00	25.00	25.00
8800	THYROID UPTAKE STUDIES	27.80	28.09	28.58	29.06	29.75
8801	THYROID UPTAKE PLUS SCAN	46.30	46.79	47.60	48.41	49.54
8802	THYROID PERCHLORATE FLUSH	23.15	23.39	23.80	24.20	24.77
8803	PLASMA VOLUME	15.50	15.66	15.93	16.21	16.59
8804	RED CELL VOLUME	15.50	15.66	15.93	16.21	16.59
8805	REPEAT PLASMA VOL STUDIES,EACH	7.80	7.88	8.02	8.15	8.35
8806	PLASMA IRON CLEARANCE AND TURNOVER	23.15	23.39	23.80	24.20	24.77
8807	IRON RED CELL UTILIZATION	23.15	23.39	23.80	24.20	24.77
8808	RED CELL SURVIVAL	30.85	31.17	31.71	32.25	33.01
8809	SEQUESTRATION STUDIES	30.85	31.17	31.71	32.25	33.01
8810	ELECTROLYTE SPACES	30.85	31.17	31.71	32.25	33.01
8811	OTHER COMPLEX TESTS (BLOOD VOL)	I.C.	I.C.	I.C.	I.C.	I.C.
8812	PERTECHNETATE SCAN	23.25	23.49	23.90	24.31	24.88
8813	RADIOACTIVE MIBG SCAN	54.65	55.22	56.18	57.14	58.48
8814	GASTRIC EMPTYING STUDY	45.60	46.08	46.88	47.67	48.79
8815	HIPPURAN RENOGRAM	27.80	28.09	28.58	29.06	29.75
8816	RENAL SCAN	23.15	23.39	23.80	24.20	24.77
8817	COMBO-SCAN WITH RENOGRAM	46.30	46.79	47.60	48.41	49.54
8818	OTHER RADIOACTIVE MATER-UPTAKE / CLEARANCE	15.50	15.66	15.93	16.21	16.59
8819	VASCULAR STUDIES USING RADIONUCLIDS	27.80	28.09	28.58	29.06	29.75
8820	OTHER COMPLEX TESTS (RENAL FUNCTION)	I.C.	I.C.	I.C.	I.C.	I.C.
8825	SCHILLING TEST	18.60	18.80	19.12	19.45	19.90
8826	SCHILLING TEST-REPEAT	9.35	9.45	9.61	9.78	10.00
8828	LIVER SCAN	37.00	37.39	38.04	38.68	39.59
8830	ABDOMINAL SCAN FOR ECTOPIC GASTRIC MUCOSA	37.00	37.39	38.04	38.68	39.59
8834	HIDA SCAN	55.50	56.08	57.05	58.03	59.39
8835	SPLEEN SCAN	37.00	37.39	38.04	38.68	39.59
8836	CARDIAC SCAN	30.85	31.17	31.71	32.25	33.01
8837	CARDIAC OUTPUT	39.19	39.60	40.29	40.97	41.93
8838	CIRCULATION TIME	15.50	15.66	15.93	16.21	16.59
8840	LUNG SCAN-VENT OR PERFUSION	46.25	46.74	47.55	48.35	49.49
8841	LUNG SCAN-VENT & PERF ON SAME DAY	74.10	74.88	76.17	77.47	79.29
8842	PULMONARY ASPIRATION TEST	38.00	38.40	39.06	39.73	40.66
8850	BONE TUMOR SCANS	66.70	67.40	68.57	69.73	71.37
8851	METABOLIC STUDIES	30.85	31.17	31.71	32.25	33.01
8852	BONE DENSITOMETRY	25.20	25.46	25.91	26.35	26.96
8856	GALLIUM 67-ABCESS LOCALIZATION X	46.30	46.79	47.60	48.41	49.54
8857	PARATHYROID SCAN	46.25	46.74	47.55	48.35	49.49
8859	ADDITIONAL FOR EMERGENCY STUDIES X	23.15	23.39	23.80	24.20	24.77
8860	FLUOROSCOPY-PER 15 MIN	40.00	40.75	42.00	43.25	45.00
8871	DETENTION FEE PER 15 MIN BEGINNING	40.00	40.75	42.00	43.25	45.00
8887	B MODE PROCEDURE-INTERPRETATION	37.90	38.30	38.96	39.62	40.55
8889	A MODE PROCEDURE/INTERPRETATION	18.90	19.39	20.20	21.01	22.15
8900	ARCH AORTOGRAM	106.10	107.21	109.07	110.93	113.53
8901	ANGIOGRAPHY ONE SELECTIVE OFF ARCH	52.95	53.51	54.43	55.36	56.66
8902	ANGIOGRAPHY TWO SELECTIVE OFF ARCH	106.10	107.21	109.07	110.93	113.53
8903	ABDOMINAL AORTOGRAM	106.10	107.21	109.07	110.93	113.53
8904	ANGIOGRAPHY ONE SELECTIVE OFF AORTA	52.95	53.51	54.43	55.36	56.66
8905	ANGIOGRAPHY TWO SELECTIVE OFF AORTA	106.10	107.21	109.07	110.93	113.53
8906	FEMORAL ARTERIOGRAM	52.95	53.51	54.43	55.36	56.66
8907	BILATERAL FEMORAL ARTERIOGRAM	84.70	85.59	87.07	88.55	90.63
8908	ARTERIOGRAM SELECTIVE	106.10	107.21	109.07	110.93	113.53
8909	PERCUTANEOUS NEEDLE ASPIRATION BIO	110.40	111.56	113.49	115.42	118.13
8910	PERCUTANEOUS TRANSHEPATIC CHOLANGI	67.80	68.51	69.70	70.88	72.55

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
8911	ARTERIAL EMBOLIZATION	155.95	157.59	160.32	163.05	166.87
8912	RENNINS I V C	55.20	55.78	56.75	57.71	59.06
8913	SPLENOPORTOGRAM	66.25	66.95	68.11	69.26	70.89
8914	BIOPSY/RENAL CYST PUNCTURE	88.30	89.23	90.77	92.32	94.48
8915	LYMPHANGIOGRAM UNILATERAL	190.85	192.85	196.19	199.53	204.21
8916	LYMPHANGIOGRAM BILATERAL	286.10	289.10	294.11	299.12	306.13
8917	LYMPHANGIOGRAM ANGIOPLASTY	220.90	223.22	227.09	230.95	236.36
8918	LYMPHANGIOGRAM INF VENA CAVA	55.20	55.78	56.75	57.71	59.06
8919	FEMORAL ARTERIOGRAM PAPAVERINE INJECTION	68.60	69.32	70.52	71.72	73.40
8925	HEAD-WITHOUT IV CONTRAST	75.90	76.70	78.03	79.35	81.21
8926	HEAD-WITH IV CONTRAST	85.40	86.30	87.79	89.29	91.38
8927	HEAD-WITH AND WITHOUT IV CONTRAST	107.25	108.38	110.25	112.13	114.76
8928	COMPLEX HEAD-WITHOUT IV CONTRAST	75.40	76.19	77.51	78.83	80.68
8929	COMPLEX HEAD-WITH IV CONTRAST	88.05	88.97	90.52	92.06	94.21
8930	COMPLEX HEAD-WITH/WITHOUT IV CONTRAST	100.60	101.66	103.42	105.18	107.64
8931	NECK-WITHOUT IV CONTRAST	50.20	50.73	51.61	52.48	53.71
8932	NECK-WITH IV CONTRAST	75.40	76.19	77.51	78.83	80.68
8933	NECK-WITH/WITHOUT IV CONTRAST	88.05	88.97	90.52	92.06	94.21
8934	THORAX-WITHOUT IV CONTRAST	95.00	96.00	97.66	99.32	101.65
8935	THORAX-WITH IV CONTRAST	97.50	98.52	100.23	101.94	104.33
8936	THORAX-WITH/WITHOUT IV CONTRAST	109.70	110.85	112.77	114.69	117.38
8937	ABDOMEN-WITHOUT IV CONTRAST	100.60	101.66	103.42	105.18	107.64
8938	ABDOMEN-WITH IV CONTRAST	102.95	104.03	105.83	107.63	110.16
8939	ABDOMEN-WITH/WITHOUT IV CONTRAST	114.20	115.40	117.40	119.40	122.19
8940	PELVIS-WITHOUT IV CONTRAST	100.60	101.66	103.42	105.18	107.64
8941	PELVIS-WITH IV CONTRAST	102.95	104.03	105.83	107.63	110.16
8942	PELVIS-WITH/WITHOUT IV CONTRAST	114.20	115.40	117.40	119.40	122.19
8943	EXTREMITIES/ONE/MORE/WITHOUT IV CONTRAST	50.20	50.73	51.61	52.48	53.71
8944	EXTREMITIES/ONE/MORE/WITH IV CONTRAST	75.40	76.19	77.51	78.83	80.68
8945	EXTREMITIES/ONE/MORE/WITH/OUT IV CONTRAST	88.05	88.97	90.52	92.06	94.21
8946	SPINE-WITHOUT IV CONTRAST	100.60	101.66	103.42	105.18	107.64
8947	SPINE-WITH IV CONTRAST	102.95	104.03	105.83	107.63	110.16
8948	SPINE-WITH/WITHOUT IV CONTRAST	114.20	115.40	117.40	119.40	122.19
8949	CT GUIDANCE OF BIOPSY	36.20	36.58	37.21	37.85	38.73
8950	SCAN ABORTED	12.75	12.88	13.11	13.33	13.64
8975	CRANIAL - MULTI-SLICE SCOUT SEQUENCE	73.10	73.87	75.15	76.43	78.22
8976	CRANIAL - ADDITIONAL SEQUENCE	36.00	36.38	37.01	37.64	38.52
8977	ENT - MULTI-SLICE SCOUT SEQUENCE	73.10	73.87	75.15	76.43	78.22
8978	ENT - ADDITIONAL SEQUENCE	36.00	36.38	37.01	37.64	38.52
8979	THORAX - MULTI-SLICE SCOUT SEQUENCE	84.30	85.19	86.66	88.14	90.20
8980	MRI GATING	25.30	25.57	26.01	26.45	27.07
8981	THORAX - ADDITIONAL SEQUENCE	42.20	42.64	43.38	44.12	45.15
8982	ABDOMEN - MULTI-SLICE SCOUT SEQUENCE	84.30	85.19	86.66	88.14	90.20
8983	ABDOMEN - ADDITIONAL SEQUENCE	42.20	42.64	43.38	44.12	45.15
8984	PELVIS - MULTI-SLICE SCOUT SEQUENCE	84.30	85.19	86.66	88.14	90.20
8985	PELVIS - ADDITIONAL SEQUENCE	42.20	42.64	43.38	44.12	45.15
8986	EXTREMITY - MULTI-SLICE SCOUT SEQUENCE	73.10	73.87	75.15	76.43	78.22
8987	EXTREMITY - ADDITIONAL SEQUENCE	36.00	36.38	37.01	37.64	38.52
8988	SPINE - MULTI-SLICE SCOUT SEQUENCE	67.50	68.21	69.39	70.57	72.23
8989	SPINE - ADDITIONAL SEQUENCE	33.70	34.05	34.64	35.23	36.06
8990	MRI ENHANCEMENT (GADOLINIUM)	40.00	40.42	41.12	41.82	42.80
8991	SPECTROSCOPY	40.00	40.42	41.12	41.82	42.80
8992	3D	62.75	63.41	64.51	65.61	67.14
9000	ERUPTED TOOTH					
9001	RESIDUAL ROOTS					
9002	RESIDUAL ROOTS-COMPLICATED					
9003	IMPACTED TEETH					

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
9004	IMPACTED TEETH-DIFFICULT					
9010	ALVEOPLASTY					
9011	GINGIVOPLASTY					
9020	SUCULUS DEEPENING AND RIDGE CONSTRUCTION					
9021	SUCULUS DEEP RIDGE CONSTRUCTION-GRAFT					
9025	EXPOSURE TOOTH-ORTHO TREATMENT					
9026	EXPOSURE TOOTH WITH ORTHO ATTACHMNT					
9030	CLOSURE INTRA-ORAL LACERATION-LOCAL					
9031	CLOSURE INTRA ORAL LACERATION-GENERAL					
9032	CLOSURE LACERATIONS-DEBRIDEMENT					
9040	ANTERIOR TOOTH-ROOT RESECTION					
9041	ROOT RESECTION-POSTERIOR TOOTH					
9045	ABSCESS-INTRAORAL					
9046	ABSCESS-EXTRAORAL					
9047	SEQUESTRECTOMY					
9048	SEQUESTRECTOMY WITH SAUCERIZATION					
9060	SIMPLE INTERDENTAL WIRING MANDIBLE					
9061	MAND FRACTURE-COMPOUND FIX BY PINNING					
9062	MAXILLARY FRACTURE RADICAL ANSTROSTOMY					
9063	MAXILLARY FRACTURE-COMPOUND					
9064	MALAR FRACTURE-SIMPLE ELEVATION					
9065	MALAR FRACTURE-OPEN REDUCTION PINNING					
9066	MALAR FRACT-OPEN REDUCTN, ANTROS AND PACKING					
9067	MAJOR FRACTURE IN MIDDLE THIRD FACE					
9068	ALVEOLAR FRACTURE					
9069	INCISION OF BONE PLATES, REMOVAL MANDIBULAR WIRES					
9080	INTRA-ORAL CYSTS-LESS THAN 2.0 CM.					
9081	INTRA-ORAL CYSTS GREATER THAN 2 CM.					
9082	INTRA-ORAL CYSTS-COMPLICATED					
9090	INTRA-ORAL BIOPSY SOFT TISSUE					
9091	INTRA-ORAL BIOPSY-BONE					
9095	INTRA-ORAL TUMORS LESS THAN 2 CM.					
9096	INTRA ORAL TUMORS GREATER THAN 2CM.					
9100	REMOVAL ROOT/FOREIGN BODY-MAX ANTRUM					
9110	CLOSURE OF ANTRA-ORAL FISTULA					
9120	TEMPORO-MANDIBLE DISLOCATION-CLOSED					
9121	TEMPORO-MANDIBLE DISLOCATION,OPEN					
9130	SIALOLITHOTOMY-SIMPLE					
9131	SIALOLITHOTOMY-COMPLICATED					
9140	EXCISION OF RANULA					
9150	PROGNATHISM					
9152	PROGNATHISM-TWO SURGEONS					
9155	MICROGNATHISM					
9156	MICROGNATHISM (TWO SURGEONS)					
9158	MICROGNATHISM-BONE GRAFT					
9160	CONDYLECTOMY-WITHOUT FIXATION					
9162	CONDYLECTOMY-FIXATION					
9170	ALCOHOL NERVE BLOCK					
9175	AVULSION OF NERVE					
9176	REPAIR/CLOSURE ORAL/NASAL FISTULA W/BONE GRFT					
9177	REPAIR/CLOSURE ORAL/NASL FISTULA W/O BONE GRFT					
9178	SEGMENTAL OSTEOTOMY					
9179	ALVEOLAR RIDGE RECONSTRUCTION					
9180	ALVEOLAR RIDGE RECONSTRUCTION					
9181	ARTHROPLASTY-EMINOPLASTY					
9182	ARTHROPLASTY-CONDYLECTOMY					
9183	ARTHROPLASTY-MENISECTOMY					

Code	Description	Apr-1-10	Oct-1-11	Oct-1-12	Oct-1-13	Oct-1-14
9184	ARTHROPLASTY-PLICATION OF MENISCUS					
9185	ORTHOGNATHIC SURGERY TREATMENT PLAN					
9200	CONSULTATION- ORAL SURGEON					
9202	ONCALL RETAINER FEE DENTAL					
9401	SERVICE NOT AVAILABLE LOCALLY CONSULT	0.00	0.00	0.00	0.00	0.00
9402	SERVICE NOT AVAIL LOC CONSULT/INVESIGATION	0.00	0.00	0.00	0.00	0.00
9403	SERVICE NOT AVAIL LOC CONSULT/INVESTIG/TRTMNT	0.00	0.00	0.00	0.00	0.00
9404	ONE SPECIALIST CONSULT	0.00	0.00	0.00	0.00	0.00
9405	ONE SPECIALIST CONSULT/INVESTIGATION	0.00	0.00	0.00	0.00	0.00
9406	ONE SPECIALIST CONSULT/INVESTIG/TREATMENT	0.00	0.00	0.00	0.00	0.00
9407	ADEQUATE SERVICE NOT AVAILABLE CONSULT	0.00	0.00	0.00	0.00	0.00
9408	ADEQUATE SERVICE NOT AVAIL CONSULT/INVESTIG	0.00	0.00	0.00	0.00	0.00
9409	ADEQUATE SERV NOT AVAIL CONSLT/INVSTG/TRTMNT	0.00	0.00	0.00	0.00	0.00
9410	EXTENUATING CIRCUMSTANCES CONSULT	0.00	0.00	0.00	0.00	0.00
9411	EXTENUATING CIRCUMSTANCES CONSULT INVESTIG	0.00	0.00	0.00	0.00	0.00
9412	EXTENUATG CIRCMSTNC CONSULT/INVESTIG/TRTMNT	0.00	0.00	0.00	0.00	0.00
9740	RETAINER PLASTIC SURGERY Q.E.H.	300.00	300.00	300.00	300.00	300.00
9801	SPECIALIST CLINIC PATIENT	0.00	0.00	0.00	0.00	0.00
9901	VISITING SPECIALIST (PER HOUR)	157.25	159.91	164.35	168.79	175.00
9903	ALTERNATE PROVIDER	0.00	0.00	0.00	0.00	0.00
9904	PHYSICIAN AND ALTERNATE	0.00	0.00	0.00	0.00	0.00
9977	IN PROVINCE IN PATIENT	0.00	0.00	0.00	0.00	0.00
9988	OUT OF PROVINCE FEE CODE	0.00	0.00	0.00	0.00	0.00
9999	INDEPENDANT CONSIDERATION	0.00	0.00	0.00	0.00	0.00

AGREEMENT TO AMEND THE MASTER AGREEMENT

BETWEEN: **The Medical Society of Prince Edward Island**

AND: **The Government of Prince Edward Island**

AND: **Health PEI**

WHEREAS the parties entered into a Master Agreement dated December 14, 2011;

AND WHEREAS Article A8.3 of the Master Agreement provides for the parties to amend terms or conditions of the Master Agreement upon mutual consent and agreement;

AND WHEREAS the parties have agreed to make certain amendments to the Master Agreement:

NOW THEREFORE the parties agree as follows:

Joint Consultation Meeting - January 26, 2012

1. **Article 11.E** of the Tariff Preamble shall be amended to include Hillsborough Hospital in the article definition of "hospital" to read as follows:

   For the purpose of this article, "hospital" is defined as: Queen Elizabeth Hospital, Prince County Hospital, Western Hospital, Community Hospital O'Leary, Stewart Memorial Hospital, Kings County Memorial Hospital, Souris Hospital and Hillsborough Hospital.

2. **Tariff 9.A** **Consultations** - (The following shall be added to the end of the Second Paragraph:)

   Family physicians can take referrals from allied health professionals for unaffiliated patients

3. **Preamble APPENDIX A - Treatment Locations** - Shall be amended by adding the following locations:

955 Belvedere Eye Clinic
972 Hove Family Physician Clinic - Alberton
973 Tignish Medical Center
974 Linden Avenue Medical Center
975 Singh/Dhillon Office

and current code/facility of 970 - Dr. Sterling Keizer Office be amended as follows:

970 Dr. Sterling Keizer/Dr. Heather Keizer Office

4. **Tariff 12.C - Weekend and Holiday Premium for Hospital Inpatient Visits** shall be amended by adding fee codes as follows:

Adding Fee Codes 0163 and 0164 (Palliative Care).

Joint Consultation Committee Meeting - May 3, 2012

5. **Article 11.C.1** of the Tariff Preamble shall be amended to include Palliative Care Physicians to read as follows:

Telephone Consultation (Internal Medicine, Pediatrics, OOP Specialists and Palliative Care Physicians)

6. **Sub-Article C5.3(b)(ii)** shall be amended to read as follows:

200 initial consultation claims per annum which includes eligible telephone consultations (50 per quarter)

7. **Sub-Article C5.3(c)(ii)** shall be amended to read as follows:

200 initial consultation claims per annum, which includes eligible telephone consultations (50 per quarter)

8. **Article C13.5** of the Master Agreement shall be amended to change the definition of "active patient" as follows:

> For the purpose of this program, "active patient" means a patient who has received at least one medical service from an eligible physician in the previous 36-month period.

DATED at Charlottetown, Prince Edward Island, this 22 day of June, 2012.

MEDICAL SOCIETY OF PRINCE EDWARD ISLAND

Per: _____

GOVERNMENT OF PRINCE EDWARD ISLAND

Per: _____

HEALTH PEI

Per: _____

AGREEMENT TO AMEND THE MASTER AGREEMENT

BETWEEN: **The Medical Society of Prince Edward Island**

AND: **The Government of Prince Edward Island**

AND: **Health PEI**

WHEREAS the parties entered into a Master Agreement dated December 14, 2011;

AND WHEREAS Article A8.3 of the Master Agreement provides for the parties to amend terms or conditions of the Master Agreement upon mutual consent and agreement;

AND WHEREAS the parties have agreed to make certain amendments to the Master Agreement:

NOW THEREFORE the parties agree as follows:

Joint Consultation Meeting - November 29, 2012

1. **SECTION A - GENERAL**
   Section A shall be amended by adding Article A19 entitled 'Protection for Physicians Undertaking Military Service' which reads:

   > "Health PEI shall grant leave of absence of not more than fifty-two (52) weeks without pay to a physician who requests leave for the purpose of taking Reserve Military training or activation for operational reasons with the Canadian Forces. This physician's position in the complement shall be protected and available upon return from active duty."

2. **SECTION C - OTHER PHYSICIAN SERVICES**

   Article C 5.3 (a) shall be amended to read as follows:

   (a) "Family Physicians in Salary Classes I, II, III and Family physicians in Salary Class IV who practice addictions and oncology
      - (i) $125,000 approved shadow billing amount per annum ($31,250) per quarter) and,
      - (ii) 3000 approved shadow billing claims per annum (750 per quarter)

Article C5.3 (b) shall be amended to read as follows:

(b) "Family Physicians in Salary Class IV as defined in Article B18.1 who practice Dermatology, Geriatrics, Pain Management or Palliative care medicine
- (i) $125,000 approved shadow billing amount per annum ($31,250) per quarter) and,
- (ii) 200 initial consultation claims, which includes eligible telephone consultations, per annum (50 per quarter).

DATED at Charlottetown, Prince Edward Island, this 27th day of February, 2013.

MEDICAL SOCIETY OF PRINCE EDWARD ISLAND

Per: _____

GOVERNMENT OF PRINCE EDWARD ISLAND

Per: _____

HEALTH PEI

Per: _____

AGREEMENT TO AMEND THE MASTER AGREEMENT

BETWEEN: **The Medical Society of Prince Edward Island**

AND: **The Government of Prince Edward Island**

AND: **Health PEI**

WHEREAS the parties entered into a Master Agreement dated December 14, 2011;

AND WHEREAS Article A8.3 of the Master Agreement provides for the parties to amend terms or conditions of the Master Agreement upon mutual consent and agreement;

AND WHEREAS the parties have agreed to make certain amendments to the Master Agreement:

NOW THEREFORE the parties agree as follows:

Joint Consultation Meeting - February 7, 2013

1. **ARTICLE D1 - PHYSICIAN RETENTION PROGRAM**
   Article D1 shall be amended by adding sub-article Dl.7 as follows:

   "All program funds and investment interest earned thereon, if any, shall be held in trust by the Medical Society and used for the purpose set out in this Article. Notwithstanding the foregoing, the Medical Society shall have the right to deduct from rebate program funds and retain an administration fee calculated as two percent (2%) of the specific funding provided in sub-article D1.2."

2. **TARIFF 11.C - TELEPHONE CONSULTATION**
   Sub-Article 11.C.1 of the Tariff shall be amended as follows:

   "**11.C.1 Telephone Consultation (Internal Medicine, Pediatrics, OOP Specialists and Palliative Care Physicians)**

   This service is restricted to internists, pediatricians, out-of-province (OOP) specialists and Palliative Care Physicians who provide telephone advice to physicians, and includes history review, history of presenting complaint, review of pertinent diagnostic data, discussion of patient condition/management, and advice to the referring physician, but without the consulting physician seeing the patient. Documentation must include a written submission of the consultant's opinion and recommendations to the referring physician. This service cannot be billed if the specialist sees the patient and bills a consultation within 3 days of the telephone consultation."

3. TARIFF OF FEES - PALLIATIVE CARE

Palliative Care of the Master Agreement Tariff of Fees (page 67) shall be amended by adding the following:

	Fee Code	Apr-01, 2010	Oct-01, 2011	Oct-01, 2012	Oct-01, 2013	Oct-01, 2014
Palliative Care Telephone Consultations	0165	40.00	40.75	42.00	43.25	45.00

DATED at Charlottetown, Prince Edward Island, this 19th day of April, 2013.

MEDICAL SOCIETY OF PRINCE EDWARD ISLAND

Per: _____

GOVERNMENT OF PRINCE EDWARD ISLAND

Per: _____

HEALTH PEI

Per: _____

AGREEMENT TO AMEND THE MASTER AGREEMENT

BETWEEN: **The Medical Society of Prince Edward Island**

AND: **The Government of Prince Edward Island**

AND: **Health PEI**

WHEREAS the parties entered into a Master Agreement dated December 14, 2011;

AND WHEREAS Article A8.3 of the Master Agreement provides for the parties to amend terms or conditions of the Master Agreement upon mutual consent and agreement;

AND WHEREAS the parties have agreed to make certain amendments to the Master Agreement:

NOW THEREFORE the parties agree as follows:

As Agreed At Joint Consultation Meeting - November 4, 2013

1. SECTION C - OTHER PHYSICIAN SERVICES
ARTICLE C2 - EMERGENCY DEPARTMENT (ED) SERVICES
Sub-Article C2.5 Rural Hospital Incentive and On-Call Retainer (page 29)

Sub-Article C2.5(a) shall be amended by deleting *Stewart Memorial Hospital*, so that the sub-article reads as follows:

"For the term of this Agreement, "rural hospital" shall mean Souris Hospital, Kings County Memorial Hospital (Montague), Community Hospital (O'Leary), or Western Hospital (Alberton)."

Sub-Article C2.5(e) shall be deleted and replaced as follows:

"The Rural Hospital On-Call Retainer shall be paid to one (1) physician per rural hospital per twenty-four (24) hour period using fee code 0185 for the provision of in-patient on-call services at a rural hospital without a 24-hour emergency department."

Sub-Article C2.7 - Other Provisions Respecting Emergency Departments (page 30)

Sub-Article C2.7 shall be amended to reflect Western Hospital's emergency department hours are between 8:00a.m. and 8:00 p.m. so that the article reads as follows:

"All of the following paragraphs apply at all times to services provided in the Emergency Departments at QEH and PCH; at KCMH between the hours of 8:00 a.m. and 10:00 p.m. and at Western Hospital between the hours of 8:00 a.m. and 8:00 p.m. (generally known as "Site 4 visits)."

Sub-Article C2.7(f) shall be amended by deleting *KCMH* and *WH* so that the sub-article reads as follows:

"Each group of EDPs at QEH and PCH shall enter into a service coverage contract with Health PEI. The contract to be entered into is attached hereto as Appendix "D".

2. **ARTICLE C3 - ON CALL SERVICES (page 31)**
Sub-Article C3.1(b) On-Call Retainer (Plus Fee-For-Service) - Family Physicians

Sub-Article C3.1(b)(ii) shall be amended by deleting *Stewart Memorial Hospital* and adding *Western Hospital*, so that the sub-article reads as follows:

"Souris Hospital and Western Hospital and Community Hospital and Kings County Memorial Hospital
- for in-patient coverage by one (1) physician per hospital per day."

Article C3.1(b)(iii) shall be deleted.

3. **APPENDIX E - EMERGENCY DEPARTMENT ON-SITE COVERAGE FUNDED HOURS (page 70)**

Appendix E shall be amended to reflect Western Hospital's funded hours have changed from 14 to 12, so that the appendix reads as follows:

"Western Hospital 12 hours"

4. APPENDIX F - LONG TERM CARE FACILITIES and BED COUNT (page 71)

Appendix F(a) shall be amended to reflect the long term care beds at Steward Memorial have increase from 12 to 23, so that the Appendix reads as follows:

(a) Standard Long Term Care facilities

Government Facilities	LTC Beds (incl. Respite)
Stewart Memorial Manor (21 + 2 respite)	23

5. PREAMBLE TO THE TARIFF OF FEES
11 - OTHER VISIT CODES

11.D.2 - Family Physicians (Tariff - 19)

Sub-Article 11.D.2 of the Tariff shall be amended by:

A.) deleting *Stewart Memorial Hospital* and adding *Western Hospital* so that the sub-article reads as follows:

"Souris Hospital, Community Hospital, Kings County Memorial Hospital, and Western Hospital
- fee code 0185 for in-patient by one physician per hospital per day."

B.) deleting:
"Western Hospital
- fee code 0040 for in-patient and after-hours Emergency Department coverage by one physician per day."

11.E - Hospital On-Call Response Fee (Fee Code 0060) (Tariff - 21)

Paragraph 4 shall be amended by deleting *Stewart Memorial Hospital* so that the paragraph reads as follows:

"For the purpose of this article, "hospital" is defined as: Queen Elizabeth Hospital, Prince County Hospital, Western Hospital, Community Hospital O'Leary, Kings County Memorial Hospital, Souris Hospital, and Hillsborough Hospital."

Section 11.F shall be added to the Preamble to the Tariff of Fees as follows:

11.F Online Medical Control

11.F.1 Retainer Fee

On-Line Medical Control allows registered nurses and paramedics to speak directly with a physician when advice is needed regarding patients presenting at a Collaborative Emergency Center (CEC) or patients being attended in the field by Island EMS.

On-Line Medical Control will be provided by a designated group of physicians who have knowledge and understanding of the full scope of practice of paramedics and nurses who care for patients at a CEC or function as Island EMS patient care providers. One physician from the group shall be entitled to a daily on-call retainer for providing coverage to respond to calls from CEC or Island EMS in a twenty-four (24) hour period.

11.F.2 Telephone Advice (CEC and EMS)

This service is restricted to Physicians who provide telephone advice to CEC nurses and paramedics working at a CEC and paramedics in the field with patients. It involves a discussion of the patient's condition and management and documentation of the Physician's opinion and recommendations to the nurse or paramedic.

Documentation must include a summary of the physician's opinion and recommendations to the nurse or paramedic. Any telephone advice provided to CEC or Island EMS staff during a patient encounter will be paid a fee per patient encounter, subject to after hours and weekend/holiday premiums. If a Physician is working at an emergency department while on call, then the telephone fee is to be shadow billed.

Section 11.G shall be added to the Preamble to the Tariff of Fees as follows:

11.G - Nurse Practitioner Collaboration (Tariff - 22)

Family physicians, regardless of the communication mode (one-on-one, telephone, text, Blackberry messaging (BBM), fax) who have signed an agreement to collaborate with a Nurse Practitioner(s) (NP(s)) may bill for blocks of 10 minutes or major portion thereof for time spent collaborating with NP(s) on treatment, management, or intervention plans for patients.

12. PREMIUM FEES

12.A.4 After-Hours Premium for Emergency Service (18:00-24:00)

Sub-Article 12.A.4 of the Tariff shall be amended by adding *on-line medical control* so that sub-article 12.A.4 reads as follows:

Consultations, surgical procedures, assists for surgical procedures, deliveries, anaesthesia services, radiology services, resuscitation, home visits, community care facility visits, diagnostic and therapeutic procedures, detention, on-line medical control and other services rendered on an emergency basis during the hours of 18:00 to midnight shall be paid at normal fees plus 25%. Time and E indicator must be shown on claim.

12.A.5 After-Hours Premium for Emergency Service (24:00-08:00)

Sub-Article 12.A.5 of the Tariff shall be amended by adding *on-line medical control* so that sub-article 12.A.5 reads as follows:

Consultations, surgical procedures, assists for surgical procedures, deliveries, anaesthesia services, radiology services, resuscitation, home visits, community care facility visits, diagnostic and therapeutic procedures, detention, on-line medical control and other services rendered on an emergency basis during the hours of midnight to 08:00 shall be paid at normal fees plus 100%. Time and E indicator must be shown on claim.

12.A.6 After-Hours Premium for Emergency Service (08:00-18:00) (Saturdays, Sundays, Holidays)

Sub-Article 12.A.6 of the Tariff shall be amended by adding *on-line medical control* so that sub-article 12.A.6 reads as follows:

Consultations, surgical procedures, assists for surgical procedures, deliveries, anaesthesia services, radiology services, resuscitation, home visits, community care facility visits, diagnostic and therapeutic procedures, detention, on-line medical control and other services rendered on an emergency basis during the hours of 0:800 to18:00 on Saturdays, Sundays, and holidays shall be paid at normal fees plus 25%. Time and E indicator must be shown on claim.

19.G. Obstetric Ultrasound - Tariff - 34

19.G shall be amended by adding *In Hospital* to the title line to read as follows:

"19.G Obstetric Ultrasound In Hospital"

6. Preamble APPENDIX A

TREATMENT LOCATIONS **(Tariff - 46)**

Appendix A shall be amended by deleting the following:

Code	Facility
008	Stewart Memorial Hospital

Appendix A shall be amended by deleting *037 Long Term Care (Stewart Memorial Hospital)* and adding *037 Long Term Care (Stewart Memorial Manor).*

7. TARIFF OF FEES

GENERAL PRACTICE
Section 3 - HOSPITAL VISITS - In-Patient Services (Tariff - 64)

Tariff of Fees Section 3 (Tariff - 64) shall be amended by:

A.) deleting the following:

Convalescent care in community hospital

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Initial Visit	0145	45.00	49.50	57.00	64.50	75.00
Subsequent Visit	0144	18.00	22.80	30.80	38.80	50.00

B.) adding the following:

Extended care hospital beds - See Preamble 10.C.4

	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Initial Visit	0145	45.00	49.50	57.00	64.50	75.00
Subsequent Visit						
- First 5 weeks, per visit	0144	18.00	22.80	30.80	38.80	50.00
- 6th -13th week inclusive per visit	0055				26.50	30.00
- After 13th week, per week	0056				26.50	30.00

8. TARIFF OF FEES

6. ON-CALL RETAINERS

Tariff of Fees, Section 6 **(Tariff - 66)** shall be amended as follows:

A.) For Fee Code 0185, delete *Tyne Valley* and add *Alberton*, so that the tariff reads as follows:

"Rural Family Physician (per hospital) - Souris, Alberton, O'Leary, Montague"

B) Delete the entire line pertaining to Fee Code 0040 and the fee code becomes inactive.

C) Add On-line Medical Control as follows:

	Fee Code	Oct-01 2013	Oct-01 2014
On-Line Medical Control	0090	216.25	225.00

13. COMMUNITY CARE FACILITIES (includes nursing homes, manors)

Tariff of Fees, Section 13 **(Tariff - 67)** shall be amended by adding *and other long term care facilities* so that the title reads as follows:

"13. COMMUNITY CARE FACILITIES (includes nursing homes, manors, and other long term care facilities)."

TARIFF OF FEES (Tariff - 68) shall be amended by adding the following Articles:

"18. ON-LINE MEDICAL CONTROL - see Preamble 11.F"

	Fee Code	Oct-01 2013	Oct-01 2014
CEC - Telephone Consultation	0071	40.00	41.60
EMS - Telephone Consultation	0072	40.00	41.60

"19. NURSE PRACTIONER COLLABORATION- see Preamble 11.G"

	Fee Code	Oct-01 2013	Oct-01 2014
Nurse Practitioner Collaboration (per 10 min.)	2510	27.75	28.33

All amendments in this agreement are effective November 4, 2013.

DATED at Charlottetown, Prince Edward Island, this 18th day of November, 2013.

MEDICAL SOCIETY OF PRINCE EDWARD ISLAND

Per: _____

GOVERNMENT OF PRINCE EDWARD ISLAND

Per: Doug Currie

HEALTH PEI

Per: _____

AGREEMENT TO AMEND THE MASTER AGREEMENT

BETWEEN: **The Medical Society of Prince Edward Island**

AND: **The Government of Prince Edward Island**

AND: **Health PEI**

WHEREAS the parties entered into a Master Agreement dated December 14, 2011;

AND WHEREAS Article A8.3 of the Master Agreement provides for the parties to amend terms or conditions of the Master Agreement upon mutual consent and agreement;

AND WHEREAS the parties have agreed to make certain amendments to the Master Agreement:

NOW THEREFORE the parties agree as follows:

As Approved by Electronic Poll conducted between November 5 – December 9, 2013

TARIFF OF FEES – PREAMBLE – SECTION 10
Sub-Article C.4 shall be amended by deleting and replacing as follows:

10.C.4 – Extended Care Hospital Beds
During the period when patients are admitted or transferred to a community hospital (KCMH and Western) or an extended care hospital (Souris and Community Hospital O'Leary) for extended care, the family physician may bill under fee codes 0145, 0144, 0055 and 0056 as outlined in the TARIFF OF FEES. Extended care patients are those who have been designated as convalescent, restorative, palliative or alternative level of care (ALC) awaiting placement for a long term care or community care bed. Hospital visit fees cannot be claimed for individuals who are admitted for respite services.

This Amendment is effective November 4, 2013.

DATED at Charlottetown, Prince Edward Island, this 23rd day of December, 2013.

MEDICAL SOCIETY OF PRINCE EDWARD ISLAND

Per: _____

GOVERNMENT OF PRINCE EDWARD ISLAND

Per: _____

HEALTH PEI

Per: _____

AGREEMENT TO AMEND THE MASTER AGREEMENT

BETWEEN: **The Medical Society of Prince Edward Island**

AND: **The Government of Prince Edward Island**

AND: **Health PEI**

WHEREAS the parties entered into a Master Agreement dated December 14, 2011;

AND WHEREAS Article A8.3 of the Master Agreement provides for the parties to amend terms or conditions of the Master Agreement upon mutual consent and agreement;

AND WHEREAS the parties have agreed to make certain amendments to the Master Agreement:

NOW THEREFORE the parties agree as follows:

Joint Consultation Meeting - May 2, 2014

1. APPENDIX F - LONG TERM CARE FACILITIES AND BED COUNT

TO (a) Standard Long Term Care facilities:

	Private Nursing Homes:	LTC Beds (incl. Respite)
ADD	**The Mount**	**30 (when fully operational)**

2. APPENDIX A (Preamble) - TREATMENT LOCATIONS

ADD	Code	Facility
	998	**The Mount**

DATED at Charlottetown, Prince Edward Island, this 29th day of October, 2014.

MEDICAL SOCIETY OF PRINCE EDWARD ISLAND

Per: _____

GOVERNMENT OF PRINCE EDWARD ISLAND

Per: _____

HEALTH PEI

Per: _____

AGREEMENT TO AMEND THE MASTER AGREEMENT

BETWEEN: **The Medical Society of Prince Edward Island**

AND: **The Government of Prince Edward Island**

AND: **Health PEI**

WHEREAS the parties entered into a Master Agreement dated December 14, 2011;

AND WHEREAS Article A8.3 of the Master Agreement provides for the parties to amend terms or conditions of the Master Agreement upon mutual consent and agreement;

AND WHEREAS the parties have agreed to make certain amendments to the Master Agreement:

NOW THEREFORE the parties agree as follows:

Joint Consultation Meeting - July 4, 2014

1. APPENDIX K - CLINICAL WORK INCENTIVE THRESHOLD ALGORITHM :

Appendix K of the Master Agreement shall be amended with the addition of 6. As follows:

6. For the purposes of shadow billing consultation threshold, "initial consultations" are:

(i) all fee codes which are identified as initial consultations in accordance with the Master Agreement Preamble 9.A. (codes xx60), plus

(ii) fee code 0148 which is identified as an initial consultation in accordance with the Master Agreement Preamble 11.B.1, plus

(iii) fee code 0250 which is identified as an initial consultation for chronic pain in accordance with Master Agreement Preamble 21.M, plus

(iv) fee codes 0550, 1120, and 0165 which are identified as telephone consultations for Internal Medicine, Pediatrics and Palliative Care in accordance with Master Agreement Preamble 11.C.1, plus

(v) for Psychiatry, for in-patient hospital services only, fee code 1263 - complete re-examination by a medical specialist, plus

(vi) for Pediatric physicians only, fee code 1136 - attendance at maternal delivery +/- intubation, plus

(vii) for Internal Medicine and Pediatric physicians, the following fee codes where attendance at the first day of admission to an ICU or NICU also includes a consultation: 0595, 1145, 1148, 1150, 1154, plus

(viii) for Obstetric/Gynocology physicians, fee code 0700 - initial prenatal visit, plus

(ix) for Obstetric/Gynocology physicians, fee code 0795 - outpatient assessment for complication of pregnancy/labor.

Note: Item 6(v) is effective December 1, 2013 and the inclusion of this fee code as an "initial consultation" for the purposes of the Clinical Work Incentive will be re-assessed in March 2015.

Joint Consultation Meeting - May 2, 2014

2. TARIFF 19.A

Tariff 19.A - Page 33 of the Master Agreement Tariff will be amended as follows:

19.A These are visits to a physician's office prior to delivery of the infant. These are usually monthly visits but may be more frequent in the last three months. Claims should be submitted on a regular basis and not held until delivery takes place. A specialist may claim an initial prenatal visit as fee code 0700, or 0760 if the patient was referred, but not both.

3. ARTICLE B9 - VACATIONS

Article B9.3(d) will be amended as follows:

(d) Employees who carried over more than the maximum entitlement at the end of the March 31, 2011 fiscal year shall have until March 31, 2015 to utilize their excess.

DATED at Charlottetown, Prince Edward Island, this 29th day of October, 2014.

MEDICAL SOCIETY OF PRINCE EDWARD ISLAND

Per: _____

GOVERNMENT OF PRINCE EDWARD ISLAND

Per: _____

HEALTH PEI

Per: _____

AGREEMENT TO AMEND THE MASTER AGREEMENT

BETWEEN: **The Medical Society of Prince Edward Island**

AND: **The Government of Prince Edward Island**

AND: **Health PEI**

WHEREAS the parties entered into a Master Agreement dated December 14, 2011;

AND WHEREAS Article A8.3 of the Master Agreement provides for the parties to amend terms or conditions of the Master Agreement upon mutual consent and agreement;

AND WHEREAS the parties have agreed to make certain amendments to the Master Agreement:

NOW THEREFORE the parties agree as follows:

As Approved by Electronic Poll of JCC conducted between August 29 – September 2, 2014

PREAMBLE TO THE TARIFF OF FEES

SECTION 18 Anesthesia Services

Section 18 of the Tariff of Fees Preamble is amended to include sub-sections 18.J Acute Pain Service Initiation and 18.K Follow-Up Visit as follows:

18. J Acute Pain Service Initiation

Fee code 0280 is payable when a qualified physician initiates an acute pain service involving patient-controlled analgesia (PCA) and other acute pain modalities such as indwelling nerve catheters, to a patient admitted to hospital. The service must include all the components of a major consultation with the appropriate chart documentation. This does not require a consultation request from another physician.

This fee code involves an assessment of the patient in order to determine the acute pain control modality most appropriate for that patient, and includes the initial management of the acute pain service. Daily maintenance of PCA is payable as fee code 2534, which may not be billed on the same day as fee code 0280. Any procedures performed for acute pain management are payable in addition to these service fees.

Fee code 0280 is not payable to the same physician in addition to a consultation (fee code 0260) or other composite fees, which include consultation (i.e. fee codes 2521, 2525, 0296) where the reason for the consultation is for the purpose of initiation of acute pain management service. However, where a pre-operative consultation has been provided prior to the administration of an anesthetic, the anesthetist may bill fee codes 0280 and 2534 for post-operative acute pain management.

Any major interventions or complications, which require another physician to attend the patient, may be billed as a 0260 consultation or detention, as appropriate.

18.K Follow Up Visit

This fee code (0213) can be billed in situations where, subsequent to an initial consultation by the anesthetist, a patient has returned for a re-assessment of the patient's readiness for the anesthetic services required to perform the planned surgical procedure(s). The follow up visit shall require a minimum of 10 minutes of physician time.

A follow up visit may also be claimed when an anesthetist provides treatment of a complication arising from anesthesia more than 48 hours after surgery.

This Amendment is effective September 2, 2014.

DATED at Charlottetown, Prince Edward Island, this 29th day of October, 2014.

MEDICAL SOCIETY OF PRINCE EDWARD ISLAND

Per: _____

GOVERNMENT OF PRINCE EDWARD ISLAND

Per: _____

HEALTH PEI

Per: _____

AGREEMENT TO AMEND THE MASTER AGREEMENT

BETWEEN: **The Medical Society of Prince Edward Island**

AND: **The Government of Prince Edward Island**

AND: **Health PEI**

WHEREAS the parties entered into a Master Agreement dated December 14, 2011;

AND WHEREAS Article A8.3 of the Master Agreement provides for the parties to amend terms or conditions of the Master Agreement upon mutual consent and agreement;

AND WHEREAS the parties have agreed to make certain amendments to the Master Agreement:

NOW THEREFORE the parties agree as follows:

Joint Consultation Meeting - May 1 2015

1. **ARTICLE B9 - VACATIONS**
   Article B9.3(d) will be amended as follows:

   (d) Employees who carried over more than the maximum entitlement at the end of the March 31, 2011 fiscal year, shall have until March 31, 2016 to utilize their excess.

DATED at Charlottetown, Prince Edward Island this 23 day of July, 2015.

MEDICAL SOCIETY OF PRINCE EDWARD ISLAND

Per: _____

GOVERNMENT OF PRINCE EDWARD ISLAND

Per: _____

HEALTH PEI

Per: _____

AGREEMENT TO AMEND THE MASTER AGREEMENT

BETWEEN: **The Medical Society of Prince Edward Island**

AND: **The Government of Prince Edward Island**

AND: **Health PEI**

WHEREAS the parties entered into a Master Agreement dated December 14, 2011;

AND WHEREAS Article A8.3 of the Master Agreement provides for the parties to amend terms or conditions of the Master Agreement upon mutual consent and agreement;

AND WHEREAS the parties have agreed to make certain amendments to the Master Agreement:

NOW THEREFORE the parties agree as follows:

As Agreed at Joint Consultation Committee Meeting – July 3, 2015

TARIFF 11.C Telephone Consultation
Amended as follows:

11.C.1 Telephone Consultation (Internal Medicine, Pediatrics, Palliative Care, Prenatal Care and OOP Specialists)

This service is restricted to internists, pediatricians, palliative care physicians and out-of-province (OOP) specialists who provide telephone advice to physicians. This service is also restricted to obstetricians who provide telephone advice to physicians and nurse practitioners in relation to prenatal care. It also applies to internists who provide telephone advice to remote patient monitoring (RPM) registered nurses. This service includes history review, history of presenting complaint, review of pertinent diagnostic data, discussion of patient condition/management, and advice to the referring physician, but without the consulting physician seeing the patient. Documentation must include a written submission of the consultant's opinion and recommendations to the referring physician. This service cannot be billed if the specialist sees the patient and bills a consultation within 3 days of the telephone consultation.

Amendments to Master Agreement
July, 2015

TARIFF OF FEES – Page 79

9. TELEPHONE PRESCRIPTION RENEWAL (See Preamble 11.C.3 – Amended as Follows:

9. TELEPHONE SERVICES	Fee Code	Apr-01 2010	Oct-01 2011	Oct-01 2012	Oct-01 2013	Oct-01 2014
Telephone Consultation – See Preamble 11.C.1 for Prenatal Care	0750					45.00
Telephone Prescription Renewal (Max. 1/patient/month) – See Preamble 11.C.3	2019		3.00	3.50	4.00	5.00

DATED at Charlottetown, Prince Edward Island, this 10th day of August, 2015.

MEDICAL SOCIETY OF PRINCE EDWARD ISLAND

Per: _____

GOVERNMENT OF PRINCE EDWARD ISLAND

Per: Doug Currie

HEALTH PEI

Per: _____