Medical

Procedure List

As Of

14 March 2025

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

I. CERTAIN DIAGNOSTIC AND THERAPEUTIC PROCEDURES

01 NONOPERATIVE ENDOSCOPY

01.0 Nonoperative endoscopy of respiratory tract

01.01 Rhinoscopy

	BASE	ANE
01.01A Sinus endoscopy, professional component	52.43 V	106.73
NOTE: May not be claimed with HSC 01.03.		
01.01B Sinus endoscopy, technical	61.79	
NOTE: May not be claimed with HSC 01.03.		
01.03 Direct laryngoscopy	71.68 V	113.05
NOTE: May not be claimed with HSC 01.01A.		

01.04 Other nonoperative laryngoscopy

01.04A Video laryngeal stroboscopy	107.30	

01.05 Pharyngoscopy

01.05A Nasendoscopy	127.38	113.05
NOTE: Payable only for the assessment of velopharyngeal incompetence.		
01.09 Other nonoperative bronchoscopy	132.62 V	158.50

NOTE:
1. No additional benefit for aspiration.
2. May be claimed in addition to HSC 43.96E and 45.88A.
3. For a repeat, during the same hospitalization, benefit will be reduced. Refer to Price List.
4. For patients aged 12 months or younger, the procedural benefit varies. Refer to the Price List; modifier L1.

01.1 Nonoperative endoscopy of upper gastrointestinal tract

01.12 Other nonoperative esophagoscopy

01.12A Functional endoscopic esophageal study	149.76	
01.12B Other nonoperative esophagoscopy, rigid	108.67	129.72
01.14 Other nonoperative gastroscopy	113.99	135.53
Esophagogastroscopy		

NOTE:
1. HSCs 11.02, 12.12B, 12.13A, 13.99AF, 54.21C, 54.21D, 54.21E, 54.91A, 54.91C, 54.92E, 54.99A, 55.1 B, 55.41A, 55.41B, 56.34A, 56.99A and 58.39B may be claimed in addition.
2. Benefit includes biopsies.

01.16 Other nonoperative endoscopy of small intestine

01.16A Small bowel capsule endoscopy, interpretation, per 15 minutes or major portion thereof	57.00	
NOTE: A maximum of 2 1/2 hours may be claimed.		
01.16B Balloon (single or double) enteroscopy, rectal route	341.98	113.05
NOTE: May be claimed in addition to HSCs 01.16C, 56.34A, 57.13A, 57.13B, 57.21A and 58.99C.		

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

01 NONOPERATIVE ENDOSCOPY (cont'd)

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

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

		BASE	ANE
01.16C	Balloon (single or double) enteroscopy, oral route	341.98	113.05
	NOTE: May be claimed in addition to HSCs 01.16B, 56.34A, 57.13A, 57.13B, 57.21A and 58.99C.		

01.2 Nonoperative endoscopy of lower gastrointestinal tract

01.22	Other nonoperative colonoscopy	188.49	113.05
	NOTE: 1. HSCs 13.99AE, 57.13A, 57.13B, 57.21A, 57.21B, 57.21C and 58.99C may be claimed in addition. 2. Benefit includes biopsies. 3. Benefit includes the removal of diminutive polyps that are 5mm or less in size. 4. Refer to HSCs 01.22A, 01.22B and 01.22C for screening.		
01.22A	Other nonoperative colonoscopy for screening of high risk patients	188.49	112.95
	NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99C may be claimed in addition. 2. Benefit includes biopsies. 3. Benefit includes the removal of diminutive polyps that are 5mm or less in size. 4. May be claimed for screening purposes for those patients that have been considered to be of high risk for colon cancer. 5. High risk is defined as an individual that has a strong family history of colorectal cancer with multiple individuals affected but no genetic syndrome identified, family history of Hereditary Non-Polyposis Colorectal Cancer or a personal history of inflammatory bowel disease. 6. May be claimed once every year.		
01.22B	Other nonoperative colonoscopy for screening of moderate risk patients . . .	188.49	112.95
	NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99C may be claimed in addition. 2. Benefit includes biopsies. 3. Benefit includes the removal of diminutive polyps that are 5mm or less in size. 4. May be claimed for screening purposes for those patients that have been considered to be of moderate risk for colon cancer. 5. Moderate risk is defined as an individual who has one or more first degree relatives with colorectal cancer or personal history of colorectal adenomatous polyps. 6. May be claimed once every 5 years.		

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

01 NONOPERATIVE ENDOSCOPY (cont'd)

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

	BASE	ANE
01.22C Other nonoperative colonoscopy for screening of average risk patients. . . .	188.49	112.95
NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99C may be claimed in addition. 2. Benefit includes biopsies. 3. Benefit includes the removal of diminutive polyps that are 5mm or less in size. 4. May be claimed for screening purposes for those patients that have been considered to be of average risk for colon cancer. 5. Average risk is defined as an individual that is asymptomatic and aged 50 to 74 years. 6. May be claimed once every 10 years.		

01.24 Other nonoperative proctosigmoidoscopy

01.24A Rigid proctosigmoidoscopy	53.13 V	113.05
NOTE: 1. HSC 58.99D may be claimed in addition. 2. Benefit includes biopsies and/or polypectomies.		
01.24B Flexible proctosigmoidoscopy, diagnostic only	74.92 V	112.95
NOTE: 1. HSCs 13.99AE, 57.13A, 57.13B, 57.21A, 57.21B, 57.21C, 58.99C, and 58.99D may be claimed in addition. 2. Benefit includes biopsies. 3. Benefit includes the removal of diminutive polyps that are 5mm or less in size.		
01.24BA Flexible proctosigmoidoscopy for screening of patients considered to be of high risk for colon cancer due to a family history of Familial Adenomatous Polyposis (FAP)	79.69 V	112.95
NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C and 58.99D may be claimed in addition. 2. Benefit includes biopsies. 3. Benefit includes the removal of diminutive polyps that are 5mm or less in size. 4. May be claimed once every year beginning at the age of 10.		
01.24BB Flexible proctosigmoidoscopy for screening of patients who are considered to be of average risk for colon cancer	79.69 V	111.71
NOTE: 1. HSCs 57.13A, 57.21A, 57.21B, 57.21C, and 58.99D may be claimed in addition. 2. Benefit includes biopsies. 3. Benefit includes the removal of diminutive polyps that are 5mm or less in size. 4. Average risk is defined as an individual who is asymptomatic and aged 50 to 74 years. 5. May be claimed once every 5 years.		

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

01 NONOPERATIVE ENDOSCOPY (cont'd)

01.3 Other nonoperative endoscopy

		BASE	ANE
01.32	Otoscopy NOTE: May only be claimed when performed under general anesthesia.	28.76	113.05
01.34	Cystoscopy NOTE: 1. Includes urethral dilation and/or meatotomy. 2. May be claimed in addition to HSCs 03.22A, 03.22B and 03.22C for video urodynamics. 3. May not be claimed with HSC 03.25.	87.03	111.81

02 DIAGNOSTIC RADIOLOGY AND RELATED TECHNIQUES

Radiology Section - Please See Section X

02.7 Other x-ray

02.75 Other computerized axial tomography

02.75A	Anesthetic for CAT scan or MRI	158.50	158.50

02.8 Diagnostic ultrasound

02.82 Diagnostic ultrasound of heart

02.82A	Comprehensive diagnostic trans-esophageal echocardiography NOTE: 1. Benefit includes 2D, M-mode, Doppler, 3D acquisition and post-processing and bubble study if indicated. 2. May be claimed in addition to HSC 13.72A. 3. May be claimed in addition to a visit or a consultation. 4. May not be claimed for services provided intraoperatively.	288.82	156.76

02.83 Other diagnostic ultrasound of thorax

02.83A	Intravascular ultrasound (IVUS), additional benefit NOTE: May only be claimed in addition to HSCs 48.98A, 48.98B, 48.92A, 49.96A, 49.98B, 51.59D, 51.59E and 51.59F.	124.28	89.81
02.83B	Endobronchial Ultrasonography (EBUS)	165.55	127.18

02.84 Diagnostic ultrasound of digestive system

02.84A	Endoscopic ultrasound of esophageal or gastric lesions	199.49	135.53
02.84B	Endoscopic ultrasound of rectal lesions	85.49 V	112.95
02.84C	Small bowel ultrasound NOTE: 1. May only be claimed by gastroenterologists (Skill GAST). 2. May only be claimed for services provided in a location that is not an AHS regional or contracted facility.	30.00	

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

03 CLINICAL EVALUATION AND EXAMINATION

03.0 Diagnostic interview and evaluation or consultation

03.01 Diagnostic interview and evaluation, unqualified

	BASE	ANE
03.01AD Advice to a patient or their agent (agent as defined in the Personal Directives Act) via telephone, secure email or videoconference	20.00	

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

03.01 Diagnostic interview and evaluation, unqualified

03.01MT Completion of a Physician Report form under the Mandatory Testing and Disclosure Act	66.77	

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

03.01AA After hours time premium	BY ASSESS	

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

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

	BASE	ANE
03.01NG Patient care advice to paramedic - pre hospital patch, Mobile Integrated Healthcare Unit paramedic, assisted living/designated assisted living and lodge staff, active treatment facility worker for hospital in-patient, long term care worker for patients in a long term care facility, nurse practitioner, hospice worker, home care worker, midwife or public health nurse weekdays 0700 to 1700 hours, provided via telephone or other telecommunication methods, in relation to the care and treatment of a patient	18.44	
NOTE: Refer to notes following HSC 03.01NI.		
03.01NH Patient care advice to paramedic - pre hospital patch, Mobile Integrated Healthcare Unit paramedic, assisted living/designated assisted living and lodge staff, active treatment facility worker for hospital in-patient, long		

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

	BASE	ANE
term care worker for patients in a long term care facility, nurse practitioner, hospice worker, home care worker, midwife or public health nurse weekdays 1700 to 2200 hours, weekends and statutory holidays, 0700 to 2200 hours, provided via telephone or other telecommunication methods, in relation to the care and treatment of a patient	21.79	

NOTE: Refer to notes following HSC 03.01NI.

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

	BASE	ANE
03.01NI Patient care advice to paramedic - pre hospital patch, Mobile Integrated Healthcare Unit paramedic, assisted living/designated assisted living and lodge staff, active treatment facility worker for hospital in-patient, long term care worker for patients in a long term care facility, nurse practitioner, hospice worker, home care worker, midwife or public health nurse any day 2200 to 0700 hours, provided via telephone or other telecommunication methods, in relation to the care and treatment of a patient	25.14	

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

BASE ANE

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

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

	BASE	ANE
03.01NJ Patient care advice to active treatment facility worker in relation to a patient receiving outpatient IV medication day treatment, weekdays 0700 to 1700 hours	32.47	
NOTE: Refer to the notes following HSC 03.01NL.		
03.01NK Patient care advice to active treatment facility worker in relation to a patient receiving outpatient IV medication day treatment, weekdays 1700 to 2200 hours, weekends and statutory holidays 0700 to 2200 hours	40.59	
NOTE: Refer to the notes following HSC 03.01NL.		
03.01NL Patient care advice to active treatment facility worker in relation to a patient receiving outpatient IV medication day treatment, any day 2200 to 0700 hours	48.71	

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

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

	BASE	ANE
03.01NM Patient care advice to a pharmacist provided via telephone or other telecommunication methods in relation to the care and treatment of a patient	18.44	

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

03.01B Patient care advice provided to community mental health care workers, child protection workers, group home staff, or educational personnel weekdays 0700 to 1700 hours in relation to the care and treatment of a patient receiving community mental health care services under the Alberta community mental health care program.	18.44	V

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

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

	BASE	ANE
03.01BA Patient care advice provided to community mental health care workers, child protection workers, group home staff, or educational personnel weekdays 1700 to 2200 hours, weekends and statutory holidays 0700 to 2200 hours in relation to the care and treatment of a patient receiving community mental health care services under the Alberta community mental health care program.	21.79 V	
NOTE: Refer to notes following 03.01BB for further information.		
03.01BB Patient care advice provided to community mental health care workers, child protection workers, group home staff, or educational personnel any day 2200 to 0700 hours in relation to the care and treatment of a patient receiving community mental health care services under the Alberta community mental health care program.	25.14 V	
NOTE: 1. HSCs 03.01B, 03.01BA, 03.01BB are to be claimed using the Personal Health Number of the patient.		
2. May only be claimed when the request for advice is initiated by the community mental health care worker, child protection worker, group home staff, or educational personnel.		
3. May be claimed: -for advice provided in person or via telephone or other telecommunication methods. -in addition to visits or other services provided on the same day by the same physician.		
4. A maximum of two (any combination of HSC 03.01B, 03.01BA, 03.01BB) claims may be claimed per patient, per physician, per day.		
5. Documentation of the request and advice must be recorded by both the physician and the community mental health care worker in their respective patient records.		
03.01C Telehealth assistance service	34.32 V	
NOTE: 1. May only be claimed if the physician is required to be present at the referring site to assist with essential physical assessment without which the consultant service would be ineffective.		
2. May be claimed in addition to other services provided in an emergency situation.		

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

		BASE	ANE
03.01J	Assessment of an unrelated condition in association with a Workers' Compensation service	25.14	
	NOTE: May only be claimed when services are provided for an unrelated illness or injury in conjunction with a WCB-related service, including visits.		
03.01N	Management of anticoagulant therapy to include ordering necessary blood tests, interpreting results, adjusting the anticoagulant dosage as required	18.44	
	NOTE: 1. May only be claimed twice per calendar month, per patient, regardless of whether the same or different physician provides the service. 2. May only be claimed in months where advice has been given regarding dosage. 3. May be claimed in addition to visits or other services provided on the same day by the same physician. 4. May not be claimed for hospital inpatients or hospital outpatients. 5. Documentation of the communication must be recorded.		

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

	BASE	ANE
03.01O Physician or Nurse Practitioner to Physician secure E-Consultation, consultant	68.99	

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

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

		BASE	ANE
03.01R	Physician to Physician secure E-Consultation, referring physician	35.53	

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

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

	BASE	ANE
03.01S Physician to patient secure electronic communication	20.00	

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

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

	BASE	ANE
03.01T Physician to patient secure videoconference	20.00	

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

03.01LG Physician to physician or podiatric surgeon telephone or telehealth videoconference or secure videoconference consultation, referring physician, weekdays 0700 to 1700 hours	35.20	

NOTE: Refer to notes following HSC 03.01LI.

03.01LH Physician to physician or podiatric surgeon telephone or telehealth videoconference or secure videoconference consultation, referring physician, weekdays 1700 to 2200 hours, weekends and statutory holidays 0700 to 2200 hours	38.55	

NOTE: Refer to notes following HSC 03.01LI.

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

	BASE	ANE
03.01LI Physician to physician or podiatric surgeon telephone or telehealth videoconference or secure videoconference consultation, referring physician, any day 2200 to 0700 hours	41.90	

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

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

	BASE	ANE
03.01LJ Physician, nurse practitioner, midwife or podiatric surgeon to physician telephone or telehealth videoconference or secure videoconference consultation, consultant, weekdays 0700 to 1700 hours . . . . . NOTE: Refer to notes following HSC 03.01LL.	78.12	
03.01LK Physician, nurse practitioner, midwife or podiatric surgeon to physician telephone or telehealth videoconference or secure videoconference consultation, consultant, weekdays 1700 to 2200 hours, weekends and statutory holidays 0700 to 2200 hours . . . . . NOTE: Refer to notes following HSC 03.01LL.	115.65	

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

	BASE	ANE
03.01LL Physician, nurse practitioner, midwife or podiatric surgeon to physician telephone or telehealth videoconference or secure videoconference consultation, consultant, any day 2200 to 0700 hours	136.49	

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

BASE ANE

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

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

	BASE	ANE
03.01LM Patient care advice to active treatment facility worker or nurse practitioner in relation to the obstetrical outpatient, weekdays 0700 - 1700 hours	18.44	
NOTE: Refer to the notes following HSC 03.01LO.		
03.01LN Patient care advice to active treatment facility worker or nurse practitioner in relation to the obstetrical outpatient, weekdays 1700 - 2200 hours, weekends and statutory holidays 0700 - 2200 hours	26.16	
NOTE: Refer to the notes following HSC 03.01LO.		
03.01LO Patient care advice to active treatment facility worker or nurse practitioner in relation to the obstetrical outpatient, any day 2200 - 0700 hours	30.87	

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

03.01LT Online medical control (OLMC) - Telephone calls from EMS practitioners on site to OLMC physicians on duty weekdays 0700 - 1700 hours	27.90	
NOTE: Refer to the notes following HSC 03.01LV		
03.01LU Online medical control (OLMC) - Telephone calls from EMS practitioners on site to OLMC physicians on duty weekdays 1700 - 2200 hours, weekends and statutory holidays 0700 - 2200 hours	34.87	
NOTE: Refer to the notes following HSC 03.01LV.		

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

	BASE	ANE
03.01LV Online medical control (OLMC) - Telephone calls from EMS practitioners on site to OLMC physicians on duty any day 2200 - 0700 hours	38.78	

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

03.02 Diagnostic interview and evaluation, described as brief

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

03.03 Diagnostic interview and evaluation, described as limited

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

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

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

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

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

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

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

03.03B Prenatal visit - in office.	38.99	
03.03BZ Prenatal visit - out of office.	38.99	
03.03C Routine post-natal office examination	38.99	

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

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

	BASE	ANE
03.03D Hospital visits	43.50 V	

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

03.03DF Visit to hospital in-patient in association with a callback	45.83 V	

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

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

	BASE	ANE
03.03DG Complex pediatric hospital visit per full 15 minutes	102.08	

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

03.03AO Transfer of care of hospital in-patient	95.63 V	

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

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

	BASE	ANE
03.03AU Transfer of care of hospital in-patient or out-patient to operating physician	133.85 V	
NOTE: 1. May only be claimed by general surgery, orthopedics, urology, and neurosurgery. 2. May only be claimed when a consultation for the patient has already been claimed by another physician of the same specialty. 3. May be claimed in addition to a procedure on the same date of service.		
03.03AT Patient admission at the request of an internal medicine specialist triage physician	202.94	
NOTE: 1. May only be claimed by internal medicine at the time the patient is seen. 2. May be claimed on the date of transfer by the receiving physician when admitting the patient. 3. May not be claimed in addition to any other visit or consultation on the same date of service by the same physician. 4. Callbacks and HSC 03.03DF at a separate encounter for the same date of service by the same or different physician may be claimed in addition.		
03.03AR Urgent or priority attendance on hospital inpatient or long term care inpatient, at request of facility staff when physician is already on site. .	50.28	
NOTE: 1. May only be claimed by the patient's physician of record, or by physicians working as part of an on-call rotation. 2. May not be claimed by physician extenders. 3. May only be claimed for direct attendance with the patient.		
03.03E Periodic chronic care visit to a long term care patient	40.23 V	
NOTE: 1. May be claimed once per calendar week if no other visit precedes in the same calendar week for the same patient by the same physician. 2. HSC 03.03EA and special callbacks (HSCs 03.03AR, 03.03KA, 03.03LA, 03.03MC, 03.03MD) may be claimed subsequent to a 03.03E in the same calendar week for the same patient by the same physician. 3. HSC 03.03D may be claimed for palliative care or inter-current illness.		
03.03EA Visit to long term care patient in association with a special callback (HSC 03.03KA, 03.03LA, 03.03MC, 03.03MD)	70.39 V	

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

	BASE	ANE
03.03F Repeat office visit or scheduled outpatient visit in a regional facility, referred cases only - in office.	32.65 V	
03.03FA Prolonged repeat office or scheduled outpatient visit in a regional facility, referred cases only, full 15 minutes or portion thereof for the first call when only one call is claimed	17.44 V	

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

03.03FT Prolonged repeat virtual visit or scheduled outpatient visit via telephone or secure videoconference, referred cases only, full 15 minutes or portion thereof for the first call when only one call is claimed	17.44 V	

NOTE: 1. May only be claimed in addition to HSC 03.03FV when the service exceeds 30 minutes.
2. May only be claimed by pediatrics (including subspecialties) and clinical immunology and allergy for patients 18 years of age and under, or by cardiology, endocrinology/metabolism, gastroenterology, infectious diseases, internal medicine, hematology, medical genetics, medical oncology, neurology, physiatry, respiratory medicine, rheumatology, urology and vascular surgery (no age restriction).
3. The patient's record must include a detailed summary of all services provided including time spent and start and stop times.
4. Time spent on administrative tasks cannot be claimed.
5. May not be claimed on the same day as an in-person visit or consultation service by the same physician for the same patient.

03.03FZ Repeat office visit or scheduled outpatient visit in a regional facility, referred cases only - out of office.	32.65 V	
03.03FV Repeat office visit or scheduled outpatient visit, referred cases only via telephone or secure videoconference.	32.65 V	

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

		BASE	ANE
	NOTE: 1. At a minimum a physician must complete a limited assessment of a patient's condition requiring a history related to the presenting problems, appropriate records, and advice to the patient. The total physician time spent providing patient care activities must last a minimum of 10 minutes. If the total physician time spent on patient management activities on the same day is less than 10 minutes the services must be claimed using HSC 03.01AD. 2. May only be claimed if the service is personally rendered by the physician. 3. The patient's record must include a detailed summary of all services provided including time spent and start and stop times. 4. Time spent on administrative tasks cannot be claimed. 5. May not be claimed on the same day as HSC 03.01AD, 03.01S, 03.01T, 03.03CV, 03.05JR, 03.08CV, 08.19CV, 08.19CW or 08.19CX by the same physician for the same patient. 6. May not be claimed on the same day as an in-person visit or consultation service by the same physician for the same patient.		
03.03H	Chronic poliomyelitis cases, monthly fee	89.11	
03.03J	Anesthetist hospital visit, unrelated to anesthetic	27.42	
	NOTE: Supervising a respiratory problem as an example Anesthetist specialty restriction.		
03.03KA	Special callback to hospital emergency/outpatient department, AACC, UCC, auxiliary hospital or nursing home, when specially called from home or office, weekday, (0700-1700 hours)	80.45	
	NOTE: Refer to the notes following HSC 03.03MD.		
03.03LA	Special callback to hospital emergency/outpatient department, AACC, UCC, auxiliary hospital or nursing home, when specially called from home or office, weekdays 1700-2200 hours, weekends and statutory holidays 0700-2200 hours	120.68	
	NOTE: Refer to the notes following HSC 03.03MD.		
03.03MC	Special callback to hospital emergency/outpatient department, AACC, UCC, auxiliary hospital or nursing home, when specially called from home or office, any day (2200-2400 hours)	160.90	
	NOTE: Refer to the notes following HSC 03.03MD.		
03.03MD	Special callback to hospital emergency/outpatient department, AACC, UCC, auxiliary hospital or nursing home, when specially called from home or office, any day (2400-0700 hours)	160.90	

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

	BASE	ANE

NOTE: 1. For hospital emergency/outpatient department, AACC, UCC refer to GR 15.3.
2. For auxiliary hospital and nursing home visits, refer to the following notes:
- Benefits for HSCs 03.03KA, 03.03LA, 03.03MC, 03.03MD may only be claimed when the physician is requested to attend a patient, by the patient, the patient's relatives or a health care provider of the facility involved in managing the patients care.
- HSC 03.03EA may be claimed in addition to a special callback to an auxiliary hospital or nursing home.
- HSC 03.03D may be claimed for palliative care or acute inter-current illness.
- HSC 03.03DF may only be claimed where HSC 03.03D has been claimed for palliative care or acute inter-current illness in an auxiliary hospital or nursing home. Special callback benefits (03.03KA, 03.03LA, 03.03MC, 03.03MD) may be claimed in addition.
- Benefits for HSCs 03.03KA, 03.03LA, 03.03MC, 03.03MD are payable based on the time at which the encounter commences.
- The physician responds to such a call from outside the auxiliary hospital or nursing home, on an unscheduled basis.
- The patient is attended on a priority basis.
- Special callback benefits (HSCs 03.05N, 03.05P, 03.05QA, 03.05QB, 03.05R) may not be claimed in addition.
3. HSCs 03.05CN, 03.05DN, 03.05EN, 03.04FB, 03.04GB and 03.04HB may be claimed in addition by emergency physicians (skill EMSP) when the service is provided in a non-rotation duty hospital with less than 25,000 visits to the emergency room per year.

03.03ME	Special call to closed office, weekdays (0000-2400)	60.34

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

03.03MF	Special call to closed office, weekends and statutory holidays (0000-2400) .	60.34

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

		BASE	ANE
	NOTE: 1. When a physician must travel to his/her office which is closed, with no staff in attendance. 2. A maximum of ten (10) per weekend day or statutory holiday, per physician may be claimed. 3. Subsequent patients seen may be claimed under code 03.02A, 03.03A, 03.04A or the appropriate procedural code.		
Home Visits			
03.03N	Home visit - first patient	38.19	V
	NOTE: At a minimum, a physician must complete a limited assessment of a patient's condition requiring a history related to the presenting problems, an examination of the relevant body systems, appropriate records, and advice to the patient.		
03.03P	Home visit - second/subsequent patients	14.00	V
	NOTE: At a minimum, a physician must complete a limited assessment of a patient's condition requiring a history related to the presenting problems, an examination of the relevant body systems, appropriate records, and advice to the patient.		
03.03Q	Home visit - repeat visit same day	14.00	V
03.03R	Broker home visit	30.17	
	NOTE: 1. Broker means an intermediary (agent or company) who provides a contact point for patients wishing to arrange for a home visit from a physician. 2. Broker home visit means a home visit arranged by an intermediary (agent or company).		
03.03NA	Home visit to patients residing in Assisted Living, Designated Assisted Living (DAL), group homes, seniors lodges or personal care home, first patient	90.51	

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

	BASE	ANE
NOTE: 1. A maximum of one visit per day, per facility may be claimed. For the subsequent patient seen in the same facility on the same date of service, see HSC 03.03NB. 2. If a special call for attendance is made for a second visit on the same date of service, a second 03.03NA may be submitted with supporting information. 3. Modifiers OFEV, OFEVWK, OFNTAM or OFNTPM may only be claimed if a special call for attendance is received and the physician attends within 24 hours of receiving the call. 4. If the facility provides a room for the physician to see the patient, an appropriate visit (03.02A, 03.03A or 03.04A) should be billed instead. 5. At a minimum, a physician must complete a limited assessment of a patient's condition requiring a history related to the presenting problems, an examination of the relevant body systems, appropriate records, and advice to the patient.		
03.03NB Home visit to patients residing in Assisted Living, Designated Assisted Living (DAL), group homes, seniors lodges or personal care home, second/subsequent patients	55.53	
NOTE: 1. A maximum of one visit per day, per facility, per patient may be claimed. 2. If a special call for attendance is made for a second visit on the same date of service, a second 03.03NB may be submitted with supporting information. 3. If the facility provides a room for the physician to see the patient, an appropriate visit (03.02A, 03.03A or 03.04A) should be billed instead. 4. At a minimum, a physician must complete a limited assessment of a patient's condition requiring a history related to the presenting problems, an examination of the relevant body systems, appropriate records, and advice to the patient.		

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

03.04 Diagnostic interview and evaluation, described as comprehensive

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

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

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

	BASE	ANE
03.04AZ Comprehensive assessment of a patient's condition requiring a complete history, a complete physical examination appropriate to the physician's specialty, an appropriate record and advice to the patient - out of office.	40.14 V	
NOTE: 1. This may be used for an annual medical examination within the limitations of GR 4.6.1. 2. Complete physical examination shall include examination of each organ system of the body, except in psychiatry, dermatology and the surgical specialties. "Complete physical examination" shall encompass all those organ systems which customarily and usually are the standard complete examination prevailing within the practice of the respective specialty. What is customary and usual may be judged by peer review. 3. Benefit includes the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient.		
03.04F Comprehensive visit in an emergency department, weekday, 0700-1700 hours . .	102.50	
NOTE: Refer to the notes following 03.04H.		
03.04FA Comprehensive visit in an AACC or UCC, weekday 0700-1700 hours	95.40	
NOTE: Refer to the notes following HSC 03.04HA.		
03.04FB Non-rotation duty, comprehensive visit in an emergency department, weekday, 0700-1700 hours	110.62	
NOTE: 1. Refer to notes under HSC 03.04HB.		
03.04G Comprehensive visit in an emergency department, weekdays 1700-2200 hours, weekends and statutory holidays 0700-2200 hours	102.50	
NOTE: Refer to the notes following HSC 03.04H.		
03.04GA Comprehensive visit in an AACC or UCC, weekdays 1700-2200 hours, weekends and statutory holidays 0700-2200 hours	95.40	
NOTE: Refer to the notes following HSC 03.04HA.		
03.04GB Non-rotation duty, comprehensive visit in an emergency department, weekdays 1700-2200 hours, weekends and statutory holidays 0700-2200 hours	110.62	
NOTE: 1. Refer to notes under HSC 03.04HB.		

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

	BASE	ANE
03.04H Comprehensive visit in emergency department, 2200-0700 hours	102.50	
NOTE: 1. HSCs 03.04F, 03.04G, 03.04H may only be claimed by emergency medicine physicians, full time emergency room physicians, general practitioners or pediatricians working a rotation duty shift in an emergency department with 24 hour on-site coverage or by physicians who are providing first call coverage in an emergency department that has greater than 25,000 visits to the emergency room per year. 2. HSCs 03.04F, 03.04G, 03.04H may be claimed for those patients whose illness/injury requires prolonged observation, continuous therapy and multiple reassessments as described in GR 4.2.7 or for female patients requiring an internal examination because of obstetrical problems or gynecological bleeding.		
03.04HA Comprehensive visit in an AACC or UCC, 2200-0700 hours	95.40	
NOTE: 1. HSCs 03.04FA, 03.04GA, 03.04HA may only be claimed by physicians working a rotation duty shift in an AACC or UCC. 2. HSCs 03.04FA, 03.04GA, 03.04HA may be claimed for those patients whose illness/injury requires prolonged observation, continuous therapy and multiple reassessments as described in GR 4.2.7 or for female patients requiring an internal examination because of obstetrical problems or gynecological bleeding.		
03.04HB Non-rotation duty, comprehensive visit in emergency department, 2200-0700 hours	110.62	
NOTE: 1. HSCs 03.04FB, 03.04GB and 03.04HB may only be claimed by emergency medicine physicians (skill EMSP) working a non-rotation duty shift in a non-rotation duty emergency department that has less than 25,000 visits to the emergency room per year. 2. HSCs 03.04FB, 03.04GB and 03.04HB may be claimed for those patients whose illness/injury requires prolonged observation, continuous therapy and multiple reassessments as described in GR 4.2.7 or for female patients requiring an internal examination because of obstetrical problems or gynecological bleeding.		
03.04B Initial prenatal visit requiring complete history and physical examination .	110.62	
NOTE: 1. May not be charged within 90 days of another comprehensive visit or consultation. 2. May only be claimed once per pregnancy. 3. Includes a full history, examination, initiation of the prenatal record and advice to the patient.		
03.04C Hospital admission	34.37 V	

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

		BASE	ANE
03.04D	Long term care admission (Nursing Home/Auxiliary Hospital or a long term care bed in a general hospital)	117.32	
03.04I	Comprehensive visit, including completion of form, required for admission to a regional health authority addiction residential treatment centre	130.73	
03.04E	Emergency home visit and admission to a hospital and hospital visit on the same day	35.99	V

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

	BASE	ANE
03.04K Comprehensive geriatric assessment, first full 90 minutes	331.86	

NOTE:
1. If the assessment is less than 90 minutes, then HSC 03.04A, 03.04AZ, 03.08A or 03.08AZ should be claimed.
2. May only be claimed in an AHS regional facility or AHS/Contracted partner run geriatric program(s) or community clinic where a PCN multi-disciplinary team is contributing to the assessment.
3. May only be claimed for patients aged 65 years or older.
4. May only be claimed by general practitioners, internal medicine specialists or geriatric medicine specialists.
5. May only be claimed once per patient per year.
6. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List, to a maximum of 7 calls.
7. Assessment must include the following components:
   a) Medical includes but is not limited to a complete physical examination, a problem list, co morbidity conditions and disease severity, a medication review and nutritional status.
   b) Functional includes but is not limited to a review of basic activities of daily living, instrumental activities of daily living, activity/exercise status, gait, balance and assessment of senior falls.
   c) Cognitive/psychological includes but is not limited to review of mental status, administration of the Mini Mental State Examination (MMSE) and mood/depression testing through Geriatric Depression Scale (GDS) or other relevant appropriate mental health examinations.
   d) Social includes but is not limited to a review of informal support needs and assets, care resource eligibility and a financial assessment.
   e) Environmental includes but is not limited to a review of current living situation, home safety and transportation.
8. Evidence that all components in note 7 were completed must be documented in the patient's records. This includes physician notes and copies of the MMSE and GDS or other relevant appropriate mental health examinations.

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

		BASE	ANE
03.04M	Pre-operative history and physical examination in relation to an insured service	110.62	
	NOTE: 1. May only be claimed when an examination and a standard form for pre-operative assessment have been completed. 2. A copy of the form must be retained in the patient's chart. 3. May not be claimed in addition to a surgical assist (SA, SAQS, SSOS) for the same patient by the same physician. 4. HSC 03.04M may not be claimed for a pre operative physical examination when the request is for a cataract procedure (HSC 27.72A) that will not require the use of a general anesthetic.		
03.04N	Comprehensive evaluation including completion of forms to determine capacity as defined by the Personal Directives Act (PDA) (RSA 2007 s9(2)(a))	204.48	
	Note: 1. Benefit includes witnessing the agents' or service providers' assessment. 2. May be claimed to determine lack of capacity or to determine that capacity has been regained.		
03.04O	Follow-up care of patient with functioning renal transplant - first year . .	100.95 V	
	NOTE: 1. May only be claimed 4 times per patient within the first 12 months following a renal transplant. 2. Should the required number of visits for the patient exceed four in the first year following a renal transplant, subsequent visits may be submitted using the appropriate visit HSC. 3. May only be claimed by physicians with GNSG or NEPH skill codes.		
03.04P	Follow-up care of patient with functioning renal transplant - second and subsequent years	100.95 V	
	NOTE: 1. May only be claimed 4 times per patient per year for the second and subsequent years following a renal transplant. 2. Should the required number of visits exceed four within a given post-transplant year (beginning on the date of transplantation), subsequent visits may be submitted using the appropriate visit HSC. 3. May only be claimed by physicians with GNSG or NEPH skill codes.		
03.04Q	Post surgical cancer surveillance examination	110.62	

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

	BASE	ANE

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

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

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

	BASE	ANE
03.04R Pre-surgical planning and patient navigation visit	79.69 V	

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

03.05 Other diagnostic interview and evaluation

03.05A Intensive care unit visit per 15 minutes	58.32	

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

03.03AI Transfer of care of intensive care patient	166.25	

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

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

03.05 Other diagnostic interview and evaluation (cont'd)

	BASE	ANE
03.05B Trauma care visit	106.26	
NOTE: 1. Trauma care visit includes daily visit, review of blood work, laboratory and x-ray results, and management of care with co-ordination of required consultations. The first day of trauma care may be claimed using HSC 13.99GA. 2. May only be claimed by the co-ordinating surgical specialist. 3. May not be claimed in addition to a major surgical procedure performed by the same (trauma) physician. 4. May only be claimed for referred cases. 5. A maximum of 6 HSC 03.05B (one for each hospital day) may be claimed for care delivered following the trauma admission (HSC 13.99GA). 6. Daily hospital visits for those trauma patients requiring care past seven days, should be claimed using HSC 03.03D beginning on the eighth day and onwards. 7. May be claimed in addition to care provided by intensivists.		
03.05CN Non-rotation duty, emergency/outpatient department, AACC or UCC, 0700-1700 hours	40.23	
NOTE: Refer to note following HSC 03.05EN.		
03.05DN Non-rotation duty, emergency/outpatient department, AACC or UCC, weekday, 1700-2200 hours or on Saturday, Sunday, statutory holiday, 0700-2200 hours .	40.23	
NOTE: Refer to note following HSC 03.05EN.		
03.05EN Non-rotation duty, emergency/outpatient department, AACC or UCC, 2200-0700 hours	40.23	
NOTE: HSCs 03.05CN, 03.05DN and 03.05EN may only be claimed by emergency medicine physicians (skill EMSP).		
03.05CR Rotation duty, emergency department, 0700-1700 hours	29.19	
NOTE: Refer to the note following 03.05ER.		
03.05DR Rotation duty, emergency department, weekdays 1700-2200 hours, weekends and statutory holidays 0700-2200 hours	29.19	
NOTE: Refer to the note following HSC 03.05ER.		
03.05ER Rotation duty, emergency department, 2200-0700 hours	29.19	
NOTE: HSCs 03.05CR, 03.05DR and 03.05ER may only be claimed by physicians who are on-site and working a scheduled rotation duty shift in an emergency department, or are providing first call coverage in an emergency department with greater than 25,000 visits per year.		
03.05FR Rotation duty, AACC or UCC, 0700-1700 hours	32.78	

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

03.05 Other diagnostic interview and evaluation (cont'd)

	BASE	ANE
NOTE: Refer to the notes following HSC 03.05HR.		
03.05GR Rotation duty, AACC or UCC, weekdays 1700-2200 hours, weekends and statutory holidays 0700-2200 hours	32.78	
NOTE: Refer to the notes following HSC 03.05HR.		
03.05HR Rotation duty, AACC or UCC, 2200-0700 hours	32.78	
NOTE: HSCs 03.05FR, 03.05GR and 03.05HR may only be claimed by physicians who are on-site and working in an AACC or UCC.		

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

03.05 Other diagnostic interview and evaluation (cont'd)

	BASE	ANE
03.05F Follow-up care of a patient remaining in an emergency department awaiting further evaluation, treatment, and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician, weekday, 0700 to 1700 hours	29.38	
NOTE: Refer to the notes following HSC 03.05FB.		
03.05FA Follow-up care of a patient remaining in an emergency department awaiting further evaluation, treatment and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician, weekday, 1700 to 2200 hours, weekend and statutory holiday, 0700 to 2200 hours	29.38	
NOTE: Refer to the notes following HSC 03.05FB.		
03.05FB Follow-up care of a patient remaining in an emergency department awaiting further evaluation, treatment and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician, any day, 2200 to 0700 hours	29.38	
NOTE: 1. HSCs 03.05F, 03.05FA and 03.05FB may not be claimed on the same shift by the physician who provided the initial assessment. 2. HSCs 03.05F, 03.05FA and 03.05FB may only be claimed once per patient per emergency room shift. 3. HSCs 03.05F, 03.05FA and 03.05FB may only be claimed by physicians on rotation duty in an emergency department, or providing first call coverage in an emergency department with greater than 25,000 visits per year. 4. Should the patient remain in the emergency room awaiting an in-patient bed after admission to hospital, HSCs 03.05F, 03.05FA and 03.05FB may not be claimed by the emergency room physician.		
03.05FC Follow-up care of a patient remaining in an AACC or UCC awaiting further evaluation, treatment, transfer to another facility, or requiring extended care by a physician, weekday, 0700 to 1700 hours	37.21	
NOTE: Refer to the notes following HSC 03.05FE.		
03.05FD Follow-up care of a patient remaining in an AACC or UCC awaiting further evaluation, treatment, transfer to another facility, or requiring extended care by a physician, weekday, 1700 to 2200 hours, weekend and statutory holiday, 0700 to 2200 hours	37.21	
NOTE: Refer to the notes following HSC 03.05FE.		

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

03.05 Other diagnostic interview and evaluation (cont'd)

	BASE	ANE
03.05FE Follow-up care of a patient remaining in an AACC or UCC awaiting further evaluation, treatment, transfer to another facility, or requiring extended care by a physician, any day, 2200 to 0700 hours	37.21	
NOTE: 1. HSCs 03.05FC, 03.05FD and 03.05FE may not be claimed on the same shift by the physician who provided the initial assessment. 2. HSCs 03.05FC, 03.05FD and 03.05FE may only be claimed once per patient per shift. 3. HSCs 03.05FC, 03.05FD and 03.05FE may only be claimed by physicians on rotation duty in an AACC or UCC.		
03.05FF Follow-up care of a patient remaining in a non-rotation duty emergency department after awaiting further evaluation, treatment, and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician, 0700 - 1700 hours, weekdays	37.21	
NOTE: Refer to the notes following HSC 03.05FH.		
03.05FG Follow-up care of a patient remaining in a non-rotation duty emergency department after awaiting further evaluation, treatment, and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician 1700 - 2200 hours, weekday, 0700 - 2200 hours weekend and statutory holiday	37.21	
NOTE: Refer to the notes following HSC 03.05FH.		
03.05FH Follow-up care of a patient remaining in a non-rotation duty emergency department after awaiting further evaluation, treatment, and/or waiting for a bed, transfer to another facility, or requiring extended care by a physician 2200 to 0700 hours any day	37.21	
NOTE: 1. May only be claimed by the same physician who provided the initial assessment when a second call for attendance has been made by staff or another physician. 2. May be claimed by a different physician who is taking over care of the patient.		
03.05G Initial assessment of newborn	70.39 V	
03.05GA Care of healthy newborn in hospital (subsequent days)	56.32 V	
NOTE: May only be claimed when no other visit service has been provided on that day, regardless of physician.		

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

03.05 Other diagnostic interview and evaluation (cont'd)

	BASE	ANE
03.05JA Formal, scheduled, multiple health discipline team conference, full 15 minutes or major portion thereof for the first call when only one call is claimed . . . . . With para-medical personnel regarding the provision of health care where social and other issues are involved NOTE: 1. May be claimed when the conference involves the physician and one or more allied health professionals. 2. May be claimed by more than one physician where circumstances warrant (text will be required). 3. May be claimed to a maximum of 12 calls or 3 hours per year (April 1 to March 31), per patient, per physician.	44.92	
03.05JD Formal, scheduled, multiple health discipline team conference for purposes to include care planning, care plan review, annual integrated care conference, patient management, related to a patient in a continuing care facility where the facility or program, as outlined in the Continuing Care Health Service Standards, is responsible for patient care, full 5 minutes or major portion thereof for the first call when only one call is claimed, to a maximum of 12 units per hour	15.08	
03.05JE Formal, scheduled review of patient medication (multiple patients) for patients in continuing care facilities where the facility or program, as outlined in the Continuing Care Health Service Standards is responsible for medication management, by the physician most responsible for the patient's care . . . . . NOTE: Refer to the notes following HSC 03.05JF.	15.08	
03.05JF Second physician attendance where required at a formal, scheduled review of patient medication (multiple patients) for patients in continuing care facilities where the facility or program, as outlined in the Continuing Care Health Service Standards, is responsible for medication management on behalf of a specific patient . . . . . NOTE: 1. HSCs 03.05JE and 03.05JF may only be claimed by physicians present during and directly involved in the medication review. 2. HSCs 03.05JE and 03.05JF are to be claimed using the Personal Health Number of the patient, naming the personnel, agencies or organizations involved. 3. Each physician involved in a patient conference may claim for patient services using HSCs 03.05JE or 03.05JF per patient, to a maximum of 6 patients in a 30-minute period. 4. HSC 03.05JF may be claimed when the physician most responsible for the patient's care has submitted a claim under HSC 03.05JE.	15.08	

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

03.05 Other diagnostic interview and evaluation (cont'd)

	BASE	ANE
03.05JB Formal, scheduled family conference relating to a specific patient, per 15 minutes or major portion thereof	54.97	
NOTE: 1. May not be claimed at the same encounter as a visit. 2. May be claimed to a maximum of 12 calls or 3 hours per year (April 1 to March 31), per patient, per physician.		
03.05JG Formal, scheduled family conference relating to a deceased child, per 15 minutes or major portion thereof	52.08	
NOTE: 1. This service is to be claimed using the Personal Health Number (PHN) of the parent or legal guardian. 2. May only be claimed for children 18 years of age and under at the time of death. 3. Supporting information identifying the name and PHN of the child must be submitted. 4. May only be claimed by pediatrics (including subspecialties) or by medical genetics.		
03.05JC Family conference relating to acute care facility in-patient or registered emergency or out-patient, or auxiliary hospital, nursing home patient, AACC or UCC patient, per 15 minutes or major portion thereof	44.92	
NOTE: 1. Intended specifically for patients whose condition warrants periodic family conferences. 2. May be claimed to a maximum of 12 calls or 3 hours per year (April 1 to March 31), per patient, per physician.		
03.05JH Family conference via telephone, in regards to a community patient	32.68	
NOTE: 1. This service is to be claimed using the Personal Health Number of the patient. 2. May be claimed in situations where: a) location or mobility factors of family members at the time of the call preclude in person meetings. b) communication about a patient's condition or to gather collateral information that is relative to patient management and care activities. 3. May not be claimed for: a) relaying results for lab or diagnostics. b) arranging follow up care. 4. Documentation of the communication to be maintained in the patient record. 5. May be claimed in the pre and post-operative periods.		

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

03.05 Other diagnostic interview and evaluation (cont'd)

	BASE	ANE
03.05JP Family conference via telephone relating to acute care facility in-patient or registered emergency or out-patient, or auxiliary hospital, nursing home patient, hospice patient, AACC or UCC patient	43.58	

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

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

03.05 Other diagnostic interview and evaluation (cont'd)

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

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

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

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

03.05K Formal, scheduled, team/family conference full 30 minutes or major portion thereof for the first call when only one call is claimed	120.82	

NOTE: May only be claimed by physiatrists.

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

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

03.05 Other diagnostic interview and evaluation (cont'd)

	BASE	ANE
community agencies, on behalf of a specific patient, full 15 minutes or major portion thereof for the first call when only one call is claimed . . . NOTE: This service is to be claimed in the name of the patient by the physician most responsible for the patient.	44.92	
03.05U Second and subsequent physician attendance at formal, scheduled, professional interview relating to the care and treatment of a palliative care patient with other physicians, family and/or direct therapeutic supervision of allied health professionals or community agencies, on behalf of a specific patient, full 15 minutes or major portion thereof for the first call when only one call is claimed . . . . . . NOTE: This service is to be claimed in the name of the patient.	30.17	
03.05V Formal, scheduled, professional interview relating to the care and treatment of a patient with chronic pain with other physicians, and/or direct therapeutic supervision of allied health professionals or community agencies, on behalf of a specific patient, per 15 minutes . . . . . . NOTE: 1. This service is to be claimed by the physician most responsible for the patient where the physician spends a minimum of 30 minutes with medical and/or para-medical personnel regarding the management of chronic pain. 2. In those situations where the physician is not part of a comprehensive, coordinated, interdisciplinary chronic pain program, the patient must have been initially assessed at an interdisciplinary chronic pain program, the name of which must be identified in the patient's chart when the patient is referred back to the home community for ongoing treatment.	41.99	
03.05W Second and subsequent physician attendance at a formal, scheduled, professional interview relating to the care and treatment of a patient with chronic pain with other physicians, family, and/or direct therapeutic supervision of allied health professionals or community agencies, on behalf of a specific patient, per 15 minutes . . . . . . NOTE: 1. This service is to be claimed in the name of the patient. 2. In those situations where the physician is not part of a comprehensive, coordinated, interdisciplinary chronic pain program, the patient must have been initially assessed at an interdisciplinary chronic pain program, the name of which must be identified in the patient's chart when the patient is referred back to the home community for ongoing treatment.	27.39	

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

03.05 Other diagnostic interview and evaluation (cont'd)

	BASE	ANE
03.05X Formal, scheduled, professional interview with relative(s) relating to the care and treatment of a patient with chronic pain on behalf of a specific patient, full 15 minutes or major portion thereof for the first call when only one call is claimed	54.97	
NOTE: 1. This service is to be claimed in the name of the patient. 2. In those situations where the physician is not part of a comprehensive, coordinated, interdisciplinary chronic pain program, the patient must have been initially assessed at an interdisciplinary chronic pain program, the name of which must be identified in the patient's chart when the patient is referred back to the home community for ongoing treatment.		
03.05JM Formal, scheduled, professional conference related to the care and treatment of multiple patients undergoing rehabilitation therapy including those with chronic pain with other physician(s), allied health professionals, educational, correctional and other community agencies on behalf of a specific patient provided by the physiatrist most responsible for the patient's care per full 5 minutes to a maximum of 6 units in a 30 minute period	20.14	
NOTE: Refer to the notes following HSC 03.05JN.		
03.05JN Second and subsequent physician attendance at a formal, scheduled, professional conference related to the care and treatment of multiple patients undergoing rehabilitation therapy including those with chronic pain, when discussion occurs on behalf of a specific patient per full 5 minutes to a maximum of 6 units in a 30 minute period	15.08	
NOTE: 1. HSC 03.05JM may only be claimed by Physiatry. 2. HSC 03.05JN may be claimed by any physician that is participating in the conference. 3. HSCs 03.05JM and 03.05JN are to be claimed using the Personal Health Number of the patient. 4. HSC 03.05JN may be claimed when the physician most responsible for the patient's care has submitted a claim under 03.05JM.		

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

03.05 Other diagnostic interview and evaluation (cont'd)

		BASE	ANE
03.05Y	Formal, scheduled, professional interview, case conference with other physicians and/or direct therapeutic supervision of allied health professionals, educational or other community agencies on behalf of a specific patient, provided by the physician most responsible for the patient's care.	104.16	
	NOTE: 1. May not be claimed unless the physician has seen the patient and been directly involved in the patient's care. 2. May only be claimed by: - pediatricians (including subspecialties) for patients 18 years of age and under - medical geneticists and psychiatrists (no age restriction) when a minimum of 30 minutes has been spent. 3. A maximum benefit of 3 hours applies per session. 4. A maximum benefit of 6 hours per patient, per physician, per benefit year, applies. 5. This service is to be claimed using the Personal Health Number of the patient. 6. HSC 03.03D may be claimed on the same day.		
03.05YM	Second and subsequent physician attendance at a formal, scheduled, professional interview, case conference on behalf of a specific patient 18 years of age and under, full 15 minutes or major portion thereof for the first call when only one call is claimed	52.08	
	NOTE: May only be claimed when the physician most responsible for the patient's care has submitted a claim under HSC 03.05Y.		

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

03.05 Other diagnostic interview and evaluation (cont'd)

	BASE	ANE
03.05JJ Professional communication/discussion with allied health professionals, educational or other community agencies on behalf of a specific patient, full 5 minutes or major portion thereof for the first call when only one call is claimed	34.79	

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

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

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

4. A maximum benefit of 60 minutes or 12 calls per physician, per week, applies.
5. This service is to be claimed using the Personal Health Number of the patient.
6. Documentation of the communication must be recorded in the patient record.

03.05JK Pediatric conference with parents/guardians of patients, without the patient (child) being present	62.50	

NOTE: 1. May only be claimed by: pediatricians (including subspecialties) for patients 18 years of age and under, or by medical geneticists (no age restriction).
2. A maximum of two conferences may be claimed per patient, per physician, per calendar year.
3. May not be claimed on the same day as a visit.

03.05LA Group session, multiple patients, per patient where a physician is involved in providing care and teaching to patients in attendance	16.76	

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

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

03.05 Other diagnostic interview and evaluation (cont'd)

	BASE	ANE
03.05LB Group teaching session for patients and/or family members with chronic pain, previous amputation, stroke, brain injury, concussion, spinal cord injury, or other neuromusculoskeletal condition, first 45 minutes or major portion thereof for the first call when only one call is claimed . . . . . NOTE: May not be claimed for preparation time.	254.73	
03.05M Supportive care visit . . . . . NOTE: May be claimed to a maximum of four visits per patient hospitalization.	30.17	
03.05MA Supportive care visit by pediatrics (including subspecialties) for patients 18 years of age and under, or by medical genetics (no age restriction) . . . NOTE: A maximum of one visit per week, per physician, may be claimed.	41.67	
03.05I Direct care, reassessment, education and/or general counselling of a patient requiring palliative care, per 15 minutes or portion thereof - in office or a patient's home . . . . . NOTE: For palliative care services provided in the patient's home, the subdivision (SUBD) modifier may only be claimed when a special call has been made on behalf of the patient and the physician responds within a 24 hour period from the time of the call. The time of the initial call as well as the time of the service must be documented in patient's record.	54.97	
03.05IZ Direct care, reassessment, education and/or general counselling of a patient requiring palliative care per 15 minutes or portion thereof - out of office.	54.97	
03.05O Direct management, reassessment, education and/or general counselling of a patient with chronic pain, per 15 minutes or portion thereof . . . . . NOTE: In those situations where the physician is not part of a comprehensive, coordinated, interdisciplinary chronic pain program, the patient must have been initially assessed at an interdisciplinary chronic pain program, the name of which must be identified in the patient's chart when the patient is referred back to the home community for ongoing treatment.	44.90 V	
03.05N Special callback to hospital inpatient, when specially called from home or office, weekdays, (0700 - 1700 hours) . . . . . NOTE: Refer to notes following 03.05R for further information.	75.97	
03.05P Special callback to hospital inpatient, weekday, (1700 - 2200 hours) . . . . NOTE: Refer to notes following 03.05R for further information.	113.94	
03.05QA Special callback to hospital inpatient, (2200-2400 hours) . . . . . NOTE: Refer to notes following 03.05R.	151.92	

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

03.05 Other diagnostic interview and evaluation (cont'd)

	BASE	ANE
03.05QB Special callback to hospital inpatient, (2400-0700 hours)	151.92	

NOTE: Refer to notes following 03.05R.

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

03.05 Other diagnostic interview and evaluation (cont'd)

	BASE	ANE
03.05R Special callback to hospital inpatient, weekends and statutory holidays 0700-2200 hours	113.94	

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

03.05Z Non-psychiatric insured medical services	45.12 V	

03.07 Consultation, described as limited

03.07A Minor consultation - in office	42.52 V	

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

03.07AZ Minor consultation - out of office	42.52 V	

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

03.07B Repeat consultation	40.23 V	
03.07C Repeat obstetrical consultation	64.98	

03.08 Consultation, described as comprehensive

03.08A Comprehensive consultation - in office	80.00 V	

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

03.08AZ Comprehensive consultation - out of office	80.00 V	

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

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

03.08 Consultation, described as comprehensive (cont'd)

	BASE	ANE
03.08CV Comprehensive consultation via telephone or secure videoconference	80.00 V	
NOTE: 1. May only be claimed if the service is personally rendered by the physician. 2. The patient's record must include a detailed summary of all services provided including time spent and start and stop times. 3. Time spent on administrative tasks cannot be claimed. 4. May not be claimed on the same day as HSC 03.01AD, 03.01S, 03.01T, 03.03CV, 03.03FV, 03.05JR, 08.19CV, 08.19CW or 08.19CX by the same physician for the same patient. 5. May not be claimed on the same day as an in-person visit or consultation service by the same physician for the same patient.		
03.08B Obstetrical consultation - in office	97.47	
03.08BZ Obstetrical consultation - out of office	97.47	
03.08M Extended uro-gynecology, pediatric gynecological, gyne-oncology, reproductive endocrinology or perinatology consultation, per 15 minutes or major portion thereof	42.24	
NOTE: May only be claimed in addition to HSC 03.08A, 03.08AZ, 03.08B or 03.08BZ when the consultation exceeds 30 minutes.		
03.08C Formal major neuro-otolaryngological consultation	126.47	
NOTE: May only be claimed by physicians who have neurotology (NEOT) certification or dual neurology/otolaryngology specialities.		

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

03.08 Consultation, described as comprehensive (cont'd)

		BASE	ANE
03.08F	Formal, comprehensive consultation, for a patient with chronic pain, full 60 minutes or major portion thereof for the first call when only one call is claimed . . . . . NOTE: The physician must be part of a comprehensive, coordinated, interdisciplinary chronic pain program as defined in GR 4.2.5.	182.62	
03.08J	Prolonged consultation or hospital admission by pediatrics (including subspecialties) and clinical immunology and allergy for patients 18 years of age and under, or by medical genetics (no age restriction), full 15 minutes or portion thereof for the first call when only one call is claimed - in office. . . . . NOTE: May only be claimed: - in addition to HSC 03.08A, 03.08AZ and 03.04C after 30 minutes; - in addition to HSC 03.07A, 03.07AZ, and 03.07B after 20 minutes.	62.50	
03.08JV	Prolonged consultation via telephone or secure videoconference by pediatrics (including subspecialties) and clinical immunology and allergy for patients 18 years of age and under, or by medical genetics (no age restriction), full 15 minutes or portion thereof for the first call when only one call is claimed. . . . . NOTE: 1. May only be claimed in addition to HSC 03.08CV when the service exceeds 30 minutes. 2. The patient's record must include a detailed summary of all services provided including time spent and start and stop times. 3. Time spent on administrative tasks cannot be claimed. 4. May not be claimed on the same day as an in-person visit or consultation service by the same physician for the same patient.	62.50	
03.08JZ	Prolonged consultation or hospital admission by pediatrics (including subspecialties) and clinical immunology and allergy for patients 18 years of age and under, or by medical genetics (no age restriction), full 15 minutes or portion thereof for the first call when only one call is claimed - out of office. . . . . NOTE: May only be claimed: - in addition to HSC 03.08A, 03.08AZ and 03.04C after 30 minutes; - in addition to HSC 03.07A, 03.07AZ, and 03.07B after 20 minutes.	62.50	
03.08I	Prolonged cardiology, clinical immunology, endocrinology/metabolism, gastroenterology, hematology, infectious diseases, internal medicine, nephrology, physiatry, medical oncology, neurology, respiratory medicine or rheumatology consultation or visit, full 15 minutes or major portion thereof for the first call when only one call is claimed - in office. . . . NOTE: May only be claimed in addition to HSCs 03.04A, 03.04AZ, 03.04C, 03.07B, 03.08A, and 03.08AZ when these services exceed 30 minutes.	40.24 V	

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

03.08 Consultation, described as comprehensive (cont'd)

	BASE	ANE
03.08IV Prolonged cardiology, clinical immunology, endocrinology/metabolism, gastroenterology, hematology, infectious diseases, internal medicine, nephrology, physiatry, medical oncology, neurology, respiratory medicine or rheumatology consultation via telephone or secure videoconference, full 15 minutes or major portion thereof for the first call when only one call is claimed.	40.24 V	
NOTE: 1. May only be claimed in addition to HSC 03.08CV when the service exceeds 30 minutes. 2. The patient's record must include a detailed summary of all services provided including time spent and start and stop times. 3. Time spent on administrative tasks cannot be claimed. 4. May not be claimed on the same day as an in-person visit or consultation service by the same physician for the same patient.		
03.08IZ Prolonged cardiology, clinical immunology, endocrinology/metabolism, gastroenterology, hematology, infectious diseases, internal medicine, nephrology, physiatry, medical oncology, neurology, respiratory medicine or rheumatology consultation or visit, full 15 minutes or major portion thereof for the first call when only one call is claimed - out of office.	40.24 V	
NOTE: May only be claimed in addition to HSCs 03.04A, 03.04AZ, 03.04C, 03.07B, 03.08A, and 03.08AZ when these services exceed 30 minutes.		
03.08H Formal major neuro- ophthalmology consultation, including complex consultations of orbit or oncology	233.94	
NOTE: HSC 03.08H will be payable only to physicians who have been approved by the CPSA to provide these services.		
03.08K Otolaryngological oncology consultation for patients with complex invasive malignancies of the head and neck	126.47	
NOTE: 1. May only be claimed for patients with: - malignant mucosal disease of the upper aerodigestive tract, excluding salivary gland, thyroid and skin malignancy or - malignant disease of the facial bones, sinuses or skull base or, - head and neck sarcomas and other rare malignancies requiring significantly invasive surgery of the head and neck. 2. May only be claimed by physicians having at least one year's post-residency training in head and neck oncology.		
03.08L Prolonged anesthesia consultation, per full 5 minutes	15.19	

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

03.08 Consultation, described as comprehensive (cont'd)

	BASE	ANE
NOTE: 1. May only be claimed by physicians with an anesthesia specialty. 2. May only be claimed in addition to HSC 03.08A or 03.08AZ for consultations exceeding 30 minutes. 3. A maximum of six five-minute units may be claimed. 4. May not be claimed for chronic pain consultations.		
03.08NZ Consultation for interventional radiology procedures only	160.35	
NOTE: 1. May not be claimed on the same date of service as a procedure by the same physician. 2. Referral must be made by written request by a non-radiologist physician. 3. May only be claimed in an active treatment facility. 4. May only be claimed when the patient is referred for an interventional radiological procedure which requires extensive discussion and review of data that must be documented in the patient's medical record. 5. A repeat consultation may not be claimed for the same condition, for the same patient within 6 months. 6. May not be claimed for musculoskeletal injections, simple biopsies or aspirations or in situations where a consultation is not warranted. 7. May not be claimed for the routine task of obtaining an informed consent.		

03.09 Consultation, described as other

03.09A Prenatal consultation for fetal assessment	196.49	
NOTE: 1. May only be claimed by pediatricians (including subspecialties), medical geneticists, or pediatric otolaryngologists. 2. To be claimed under the maternal number.		
03.09B Teleophthalmology consultation for examination, evaluation and interpretation of stereoscopic digital retinal imaging using store and forward technology	74.41	
NOTE: Benefit includes written recommendation to the primary care physician for follow up and management.		

03.1 Measurements and manual examinations of nervous system and sense organs

03.11 Vision screening examination

03.11A Visual assessment for patients presenting with acute visual disturbances or painful eye(s)	102.50	

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

03.11 Vision screening examination (cont'd)

	BASE	ANE
Note: 1. Assessment must include anterior and posterior chamber examinations, examination of retina, and may include pressure assessment if necessary. 2. May not be claimed for conditions or procedures related to obvious conjunctivitis, allergic conjunctival conditions, stye, eye lid conditions, foreign body or other similar conditions.		
03.12 Tonometry		
03.12A Intraocular pressure measurement, unilateral or bilateral	26.24	
03.16 Electroencephalogram		
03.16A Electroencephalogram, technical	92.99	113.05
03.16B Electroencephalogram, interpretation	58.04	
03.16C Video/EEG telemetry, review and interpretation, first full 30 minutes or major portion thereof for the first call when only one call is claimed . . .	126.63	
NOTE: 1. May not be claimed concurrently with other services. 2. Each subsequent 15 minutes, or major portion thereof, is payable at the rate specified on the Price List.		

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

03.16 Electroencephalogram (cont'd)

	BASE	ANE
03.16D Stereo/EEG (SEEG) intracranial telemetry, review and interpretation, first full 30 minutes or major portion thereof for the first call when only one call is claimed	156.45	
NOTE: 1. May not be claimed concurrently with other services. 2. Each subsequent 15 minutes, or major portion thereof, is payable at the rate specified on the Price List after the first full 30 minutes has elapsed.		

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

03.19C Evoked potential, somatosensory, bilateral median nerve and bilateral legs, interpretation	36.17	
03.19D Sleep polygraph studies for apnea and SIDS, interpretation	105.17	
NOTE: Pediatric specialty restriction.		

03.2 Measurements and manual examinations of genitourinary system

03.21 Urinary manometry

03.21A Upper urinary tract flow studies	170.18	134.04
NOTE: 1. Includes interpretation. 2. Includes cystoscopy.		

03.22 Cystometrogram

03.22A Performance of uroflowometry interpretation and/or assessment of post-void residual by bladder scanner or catheterization	34.76 V	111.71
NOTE: May not be claimed with HSC 03.25.		
03.22B Urodynamics	151.00 V	111.71
NOTE: 1. Benefit includes cystometrogram and pressure flow study performance and interpretation. 2. May be claimed in addition to a visit or a consultation. 3. May be claimed in addition to HSC 01.34. 4. May not be claimed with HSC 03.25.		
03.22C Male or female video-urodynamics	177.00	111.81
NOTE: 1. Benefit includes cystometrogram and pressure flow study performance and radiologic assessment with cystogram and interpretation. 2. May be claimed in addition to a visit or a consultation. 3. May be claimed in addition to HSC 01.34. 4. May not be claimed with HSC 03.25.		

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.2 Measurements and manual examinations of genitourinary system (cont'd)
03.25 Urethral pressure profile (UPP)

		BASE	ANE
03.25	Urethral pressure profile (UPP)	69.33 V	111.71
	NOTE: 1. Includes interpretation. 2. Includes cystoscopy. 3. May not be claimed with HSCs 01.34, 03.22A, 03.22B or 03.22C.		

03.26 Gynecological examination

03.26	Gynecological examination	100.72	113.05
	NOTE: May only be claimed when performed under general anesthesia.		

03.29 Other nonoperative genitourinary system measurements and examinations

03.29A	Urethral and bladder testing for urinary incontinence in the female	16.24

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

03.37A	Vital capacity	10.87
03.37B	Timed vital capacity	9.41

03.38 Other nonoperative respiratory measurements

03.38A	Pulmonary function tests, flow volume loops, interpretation	13.36
03.38B	Pulmonary function tests, closing volumes, before and after bronchodilators, interpretation	12.04
03.38C	Spirometry	51.17
	NOTE: 1. Benefit includes maximum breathing capacity, vital capacity, tidal volume, inspiratory and expiratory reserve volume. 2. When bronchodilators are administered, the benefit includes both the administration and the cost of the bronchodilator.	
03.38D	Vitalometry, alone	16.20
03.38E	Vitalometry, before and after bronchodilators	17.87
	NOTE: Includes vital capacity and timed vital capacity.	
03.38F	Flow-volume loop measurement before and after bronchodilator only, technical	39.88
03.38G	Flow-volume loop measurement before bronchodilator only, technical	22.95
03.38H	Lung volumes, diffusing capacities, mixing efficiency and alveolar C02 interpretation	32.17
03.38K	Lung compliance	64.71
03.38M	Residual lung volume	31.60
03.38N	Carbon monoxide diffusion capacity, at rest	34.80
03.38P	Oxygen saturation (ear oximetry with exercise)	15.99
03.38Q	Inhalation challenge test, technical, including interpretation	223.67

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

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

03.38 Other nonoperative respiratory measurements (cont'd)

		BASE	ANE
03.38R	Interpretation of diagnostic procedures involving vitalometry	13.54	
03.38S	Body, plethysmography, technical	34.80	
03.38T	Body, plethysmography, interpretation	19.00	
03.38X	Asthma exercise test utilizing treadmill or bicycle ergometer	150.50	

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

03.39 Other nonoperative measurements and examinations

03.39A	24-hour ambulatory blood pressure monitoring (ABPM), interpretation	10.55	

NOTE: May only be claimed by internal medicine specialists.

03.39B	24-hour ambulatory blood pressure monitoring(ABPM), technical	71.43	

NOTE: May only be claimed by internal medicine specialists.

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.4 Cardiac stress tests and pacemaker checks

03.41 Cardiovascular stress test using treadmill

	BASE	ANE
03.41A Maximal stress electrocardiogram, with or without pulse oximetry, technical only	33.26	
NOTE: 1. Utilizing bicycle ergometer or treadmill. 2. Includes resting electrocardiograms before and after the procedure.		
03.41B Interpretation	20.66	
03.41C Continuous personal physician monitoring, with or without pulse oximetry	61.27	
NOTE: 1. Utilizing bicycle ergometer or treadmill. 2. Benefit includes resting electrocardiograms before and after the procedure.		
03.41D Intravenous dipyridamole administration for thallium imaging, professional component only	90.76	

03.44 Other cardiovascular stress test

03.44A Physician personal and continuous monitoring during the provision of dobutamine infusion for the purposes of pharmacologic stress imaging	185.11	
NOTE: Benefit does not include electrocardiograms.		

03.45 Artificial pacemaker rate check

03.45A Routine artificial pacemaker and ICD function check by a physician	17.94	
NOTE: May only be claimed for remote interpretation.		
03.45B Complex artificial pacemaker and ICD function check	45.07	
NOTE: 1. May only be claimed for remote interpretation in cases where the physician spends at least 15 minutes interpreting data due to complex issues arising from implanted device i.e. syncope, shocks etc. 2. May not be claimed for time spent setting up transmission or for difficulties in transmitting or receiving information.		

03.5 Other cardiac function tests

03.52 Other electrocardiogram

03.52A Electrocardiogram, technical	24.62	
03.52B Electrocardiogram, interpretation	9.83	
03.52C Tape ECG - ambulatory ECG monitoring record (greater than 12 hours and up to 48 hours), technical	30.24	
03.52D Tape ECG - ambulatory ECG monitoring record (greater than 12 hours and up to 48 hours), interpretation	31.50	
03.52E Tape ECG - ambulatory ECG monitoring record (greater than 48 hours), technical	30.24	
03.52F Tape ECG - ambulatory ECG monitoring record (greater than 48 Hours), interpretation	31.50	

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.5 Other cardiac function tests (cont'd)

03.55 Phonocardiogram with EKG lead

	BASE	ANE
03.55A Phonocardiogram with EKG lead, technical	21.79	
03.55B Phonocardiogram with EKG lead, interpretation	10.77	

03.56 Carotid pulse tracing with EKG lead

03.56A Non-invasive cardiac study, technical	25.22	
03.56B Non-invasive cardiac study, interpretation	35.08	

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

03.6 Other cardiovascular measurements

03.63 Implantable Loop Recorder, insertion or removal	224.05	150.73

NOTE: May not be claimed with HSC 49.84.

03.7 General physical examination

03.7 A Examination of stillborn . . . . . 70.39 V

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

03.7 BA Medical Assistance in Dying - Determination Phase, full 15 minutes or major portion thereof for the first call when only one call is claimed 70.39

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

03.7 BB Medical Assistance in Dying - Action Phase, full 15 minutes or major portion thereof for the first call when only one call is claimed 70.39

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

03 CLINICAL EVALUATION AND EXAMINATION (cont'd)

03.7 General physical examination (cont'd)

	BASE	ANE
NOTE: 1. May only be claimed for patient management for Medical Assistance in Dying. 2. Services related to the Action Phase include: a. patient visit and assessment, b. Pharmacy visit, c. Communication with other health care providers, d. Review and administration of medication, e. Coordination of procedure, and f. Completion of appropriate documents and forms. 3. All services must be provided in accordance with the CPSA standards for Medical Assistance in Dying. 4. May not be claimed in addition to a visit, consultation or assessment. 5. May not be claimed for travel time. 6. The total time spent during the Action Phase may be calculated on a cumulative basis over the course of several hours or several days. 7. The patient's record must include a detailed summary of all services provided including a summary of time spent per day per activity.		
03.7 BC Medical Assistance in Dying - Care After Death Phase, full 15 minutes or portion thereof for the first call when only one call is claimed	70.39	
NOTE: 1. May only be claimed for patient management for Medical Assistance in Dying. 2. Services related to the Care After Death Phase include: a. Reporting of event; b. Post event arrangements and, c. Completion of appropriate documents and forms. 3. All services must be provided in accordance with the CPSA standards for Medical Assistance in Dying. 4. May not be claimed for travel time. 5. The total time spent during the Care After Death Phase may be calculated on a cumulative basis over the course of several hours or several days. 6. The patient's record must include a detailed summary of all services provided including a summary of time spent per day per activity.		

06 NUCLEAR MEDICINE

06.3 Other therapeutic radiology and nuclear medicine

06.35 Injection or instillation of radioisotopes

06.35A Intracavitary or interstitial administration radioactive gold (Au198) or radioactive colloidal chromic phosphate	134.45	

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

06 NUCLEAR MEDICINE (cont'd)

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

	BASE	ANE
06.35B Injection of radioactive phosphorus (P32) for polycythemia rubra vera, leukemia, bone metastases, etc.	79.79	
06.39 Other radiotherapeutic procedure		
06.39A Administration radioactive iodine - hyperthyroidism	71.10	
06.39B Administration radioactive iodine for ablation of normal thyroid gland, thyroid remnant or cancer of the thyroid	131.76	

07 PHYSICAL MEDICINE, REHABILITATION, AND RELATED PROCEDURES

07.0 Diagnostic physical medicine
07.09 Other diagnostic physical medicine procedures

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

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

07.27A Manipulation of major joint(s) or spine	175.80	113.05
NOTE: May only be claimed when performed under general anesthesia.		
07.27B Manipulation of minor joint(s) or examination	26.37	112.95
NOTE: May only be claimed when performed under general anesthesia.		

07.29 Other forcible correction of deformity

07.29A Metatarsus varus, manipulation and plaster, per closed treatment	131.85 V	112.95
NOTE: May be claimed for club hand.		
07.29B Manipulation and application of Dennis Brown splints, direct, with adhesive strapping	35.16	

07.4 Skeletal traction and other traction

07.4 A Halo traction	175.80	
That for scoliosis		

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

07.51A Body jacket	176.68	
07.51C Turnbuckle, localiser jacket	263.71	
That for scoliosis		

07.53 Application of other cast

07.53A Shoulder, hip, spica	175.80	

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

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

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

07.53 Application of other cast (cont'd)

	BASE	ANE
07.53B Upper extremity, excluding finger	50.28	
07.53C Finger	30.17	
07.53D Lower extremity	50.28	
07.53E Wedging of cast	47.54	
07.53H Application of fibreglass cast, upper limb, excluding finger	50.28	

NOTE: Refer to notes following 07.53J.

07.53J Application of fibreglass cast, lower limb	50.28	

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

07.54 Application of splint

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

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

07.56 Application of pressure dressing

07.56A Unna's boot	10.72	

07.57 Application of other wound dressing

07.57A Initial treatment - minor burn	40.23 V	
07.57B Subsequent treatment - minor burns - dressing and/or debridement	60.34	

08 DIAGNOSTIC AND THERAPEUTIC PSYCHOLOGY AND PSYCHIATRY

08.1 Psychiatric evaluations, interviews, and consultations

08.11 Psychiatric mental status determination

08.11A Requiring complete mental status examination and investigation, first full 30 minutes or major portion thereof for the first call when only one call is claimed	45.05 V	

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

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

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

	BASE	ANE
NOTE: 1. May only be claimed for the initial visit. 2. When visit does not require complete examination and investigation, the appropriate office visit HSC should be claimed. 3. HSCs 08.19GA, 08.19GZ or 08.19GB may not be claimed at the same encounter. The total time spent providing the non-referred first visit must be claimed using the applicable non-referred first visit code.		
08.11B Evidence from a psychiatrist at a Review Panel on behalf of a specific patient, as required under section 37(3) of the Mental Health Act, per 15 minutes or portion thereof	50.33	
NOTE: 1. This service is to be claimed using the Personal Health Number of the patient. 2. May only be claimed by a psychiatrist or a generalist in mental health. 3. Time spent completing and reviewing relevant forms and documents may be claimed using this code. Time spent may occur on a separate date of service as the hearing, and must be recorded on a session by session basis in the patient record. A maximum of 30 minutes of preparation time may be claimed. 4. Benefit does not include travel time.		
08.11C For complex patient, requiring complete mental status examination and investigation, first full 30 minutes or major portion thereof for the first call when only one call is claimed	187.90	
NOTE: 1. May only be claimed for the initial visit. 2. May only be claimed by psychiatrists. 3. May only be claimed when the patient meets the criteria outlined in note 4 and the score is identified in the patient's chart at least once every six months. 4. Complex patient is defined as: a. An adult with a Global Assessment of Function (GAF) score of 40 or less. b. A child with a Children's Global Assessment of Function (CGAS) score of 41 or less. 5. HSCs 08.19GA, 08.19GZ, or 08.19GB may not be claimed at the same encounter. The total time spent providing the non-referred first visit must be claimed using the applicable non-referred first visit code.		

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

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

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

08.12 Psychiatric commitment evaluation

	BASE	ANE
08.12A Certification under the Mental Health Act	58.93	
NOTE: 1. For the completion of forms under the Mental Health Act. 2. May not be claimed for completion of forms that are covered by other health service codes.		

08.19 Other psychiatric evaluation and interview

08.19A Formal major psychiatric consultation, first full 30 minutes or major portion thereof for the first call when only one call is claimed - in office.	54.21	V
NOTE: 1. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List after the first full 30 minutes has elapsed. 2. HSCs 08.19GA, 08.19GZ or 08.19GB may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code.		
08.19AZ Formal major psychiatric consultation, first full 30 minutes or major portion thereof for the first call when only one call is claimed - out of office.	54.21	V
NOTE: 1. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List after the first full 30 minutes has elapsed. 2. HSCs 08.19GA, 08.19GB or 08.19GZ may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code.		
08.19AA Formal major psychiatric consultation for a patient referred by a registered: occupational therapist, psychologist, community based psychiatric nurse, social worker or speech language pathologist, first full 30 minutes or major portion thereof for the first call when only one call is claimed	189.58	
NOTE: 1. May be claimed when a patient is referred to a psychiatrist by a registered: occupational therapist, psychologist, community based psychiatric nurse, social worker or speech language pathologist and the provisions that apply to consultations under GRs 4.3, 4.4 and 4.6 are met. 2. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List after the first full 30 minutes has elapsed. 3. HSCs 08.19GA, 08.19GZ or 08.19GB may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code.		

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

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

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

08.19 Other psychiatric evaluation and interview (cont'd)

	BASE	ANE
08.19CX Formal major psychiatric consultation via telephone or secure videoconference, first full 30 minutes or major portion thereof for the first call when only one call is claimed	54.21 V	

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

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

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

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

08.19 Other psychiatric evaluation and interview (cont'd)

	BASE	ANE
08.19B Minor psychiatric consultation, full 15 minutes or major portion thereof for the first call when only one call is claimed . . . . . NOTE: HSCs 08.19GA, 08.19GZ, or 08.19GB may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code.	45.05 V	
08.19BB Minor psychiatric consultation for a patient referred by a registered: occupational therapist, psychologist, community based psychiatric nurse, social worker or speech language pathologist, full 15 minutes or major portion thereof for the first call when only one call is claimed . . . . . NOTE: 1. May be claimed when a patient is referred to a psychiatrist by a registered: occupational therapist, psychologist, community based psychiatric nurse, social worker or speech language pathologist and the provisions that apply to consultations under GRs 4.3, 4.4 and 4.6 are met. 2. HSCs 08.19GA, 08.19GZ, or 08.19GB may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code.	53.13	
08.19C Repeat psychiatric consultation, per full 30 minutes or major portion thereof for the first call when only one call is claimed . . . . . NOTE: HSCs 08.19GA, 08.19GB or 08.19GZ may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code.	45.05 V	
08.19CC Repeat psychiatric consultation for a patient referred by a registered: occupational therapist, psychologist, community based psychiatric nurse, social worker or speech language pathologist, per full 30 minutes or major portion thereof for the first call when only one call is claimed . . . . . NOTE: 1. May be claimed when a patient is referred to a psychiatrist by a registered: occupational therapist, psychologist, community based psychiatric nurse, social worker or speech language pathologist and the provisions that apply to consultations under GRs 4.3, 4.4 and 4.6 are met. 2. HSCs 08.19GA, 08.19GZ or 08.19GB may not be claimed at the same encounter. The total time spent providing the consultation must be claimed using the applicable consultation code.	150.44	

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

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

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

08.19 Other psychiatric evaluation and interview (cont'd)

		BASE	ANE
08.19D	Professional interview with relative(s) in connection with the management of a patient with a psychiatric disorder, but without the patient being present during the interview, per 15 minutes or major portion thereof . . .	52.08 V	
	NOTE: 1. This service is to be claimed using the Personal Health Number of the patient. 2. The relationship of the patient to the person interviewed, must be indicated. 3. The maximum benefit to be claimed by a physician other than a psychiatrist, pediatrician, or a generalist mental health is 2 hours per patient, per benefit year.		
08.19F	Formal, scheduled, professional conference related to the care and treatment of a psychiatric patient with other physician(s), and/or direct therapeutic supervision of, allied health professionals, educational, correctional and other community agencies on behalf of a specific patient, provided by the physician most responsible for the patient's care, per 15 minutes or major portion thereof	44.92 V	
	NOTE: Refer to notes following 08.19H		
08.19H	Second and subsequent physician attendance at a formal, scheduled, professional conference related to the care and treatment of a psychiatric patient, on behalf of a specific patient, per 15 minutes or major portion thereof	30.17 V	
	NOTE: 1. 08.19F and 08.19H may only be claimed by general practice physicians, generalists in Mental Health, pediatricians, psychiatrists and specialists in Mental Health. 2. 08.19F and 08.19H are to be claimed using the Personal Health Number of the patient, naming the personnel, agencies or organizations involved. 3. 08.19H may be claimed when the physician most responsible for the patient's care has submitted a claim under 08.19F.		
08.19J	Formal, scheduled, professional conference related to the care and treatment of multiple psychiatric patients with other physician(s), allied health professionals, educational, correctional and other community agencies on behalf of a specific patient, provided by the physician most responsible for the patient's care	28.52	
	NOTE: Refer to notes following 08.19K.		

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

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

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

08.19 Other psychiatric evaluation and interview (cont'd)

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

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

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

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

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

08.19 Other psychiatric evaluation and interview (cont'd)

		BASE	ANE
08.19L	Issuance, development and documentation of a Community Treatment Order (CTO) as defined by the Mental Health Act including all activities and services that are directly related to the CTO initiation and development, per full 15 minutes	50.28 V	

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

08.19M	Second physician involved in the issuance, development and documentation of a CTO, per full 15 minutes	50.28 V	

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

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

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

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

08.19 Other psychiatric evaluation and interview (cont'd)

	BASE	ANE
08.19N Renewal, amendments, cancellation or expiry of a CTO as well as necessary work involved in the completion of an apprehension order, examination on apprehension, written statement or non-compliance report, per full 15 minutes	47.65 V	

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

08.19G Direct contact with an individual patient for psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or general psychiatric counselling, per 15 minutes or major portion thereof - in office. . . . . 50.28 V

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

08.19GA Direct contact with a patient for psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or psychiatric counseling, per 15 minutes or major portion thereof - in office. . . . . 45.70 V

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

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

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

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

08.19 Other psychiatric evaluation and interview (cont'd)

	BASE	ANE
08.19GB Direct contact with a complex patient for psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or psychiatric counseling, per 15 minutes or major portion thereof	48.79 V	

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

08.19GV Telephone or secure videoconference with a complex patient for psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or psychiatric counseling, per 15 minutes or major portion thereof	48.79 V	

NOTE:
1. May only be claimed by a psychiatrist or a generalist in mental health.
2. The patient's record must include a detailed summary of all services provided including time spent and start and stop times.
3. Only time spent communicating with the patient and/or the parent/guardian of a patient child can be claimed as part of the service. Time spent on administrative tasks cannot be claimed.
4. May not be claimed on the same day as a virtual visit or consultation by the same physician for the same patient.
5. May not be claimed on the same day as an in-person visit or consultation service by the same physician for the same patient.
6. May only be claimed when the patient meets the criteria outlined in note 7 and the score is identified in the patient's chart at least once every six months.
7. Complex patient is defined as:
   a. An adult with a Global Assessment of Function (GAF) score of 40 or less.
   b. A child with a Children's Global Assessment of Function (CGAS) score of 41 or less.

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

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

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

08.19 Other psychiatric evaluation and interview (cont'd)

	BASE	ANE
08.19GZ Direct contact with an individual patient for psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or psychiatric counselling, per 15 minutes or major portion thereof - out of office.	45.70 V	
NOTE: 1. May be claimed: -if the intent of the session is the therapy of one individual patient, whether or not more than one person is involved in the session. -when a physician assessment has established (during the same or previous visit) that the patient is suffering from a psychiatric disorder. 2. For treatment of non-psychiatric disorders, the appropriate office visit health service code should be claimed. 3. May not be claimed at the same encounter as HSCs 08.11A, 08.11C, 08.19A, 08.19AA, 08.19B, 08.19BB, 08.19C, 08.19CC or 08.19AZ.		
08.19CV Telephone or secure videoconference with a patient for psychiatric treatment (including medical psychotherapy and medication prescription), psychiatric reassessment, patient education and/or psychiatric counseling, per 15 minutes or major portion thereof	45.70 V	
NOTE: 1. May only be claimed by a psychiatrist (PSYC), a generalist in Mental Health (GNMH) or by a specialist in Mental Health (SPMH). 2. May be claimed for both referred and non-referred patients with psychiatric disorders. 3. The patient's record must include a detailed summary of all services provided including time spent and start and stop times. 4. Only time spent communicating with the patient and/or the parent/guardian of a patient child can be claimed as part of the service. Time spent on administrative tasks cannot be claimed. 5. May not be claimed on the same day as other virtual care services or other in-person visit or consultation services by the same physician for the same patient.		
08.19CW Telephone or secure videoconference with a patient for scheduled psychiatric treatment or for a palliative care or a chronic pain visit by an eligible physician, per 15 minutes or major portion thereof.	50.28 V	

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

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

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

08.19 Other psychiatric evaluation and interview (cont'd)

	BASE	ANE

Note: 1. When services other than psychiatric treatment, palliative care or chronic pain services are delivered, the most appropriate health service code (e.g., 03.03CV) should be claimed.
2. May be claimed by any physician for palliative care. Palliative care is defined as care given to a patient with a terminal disease such as cancer, AIDS or advanced neurologic disease. Palliative care involves active ongoing multi-disciplinary team care.
3. May be claimed by any physician that is part of an interdisciplinary chronic pain program for a chronic pain visit. A chronic pain visit is defined as pain which persists past the normal time of healing, is associated with protracted illness or is a severe symptom of a recurring condition. A chronic pain visit must be part of a comprehensive, coordinated, interdisciplinary program as defined in General Rule 4.2.5. A physician must be able to demonstrate that they have appropriate chronic pain training and experience.
4. The patient's record must include a detailed summary of all services provided including time spent and start and stop times.
5. Only time spent communicating with the patient and/or the parent/guardian of a patient child can be claimed as part of the service. Time spent on administrative tasks cannot be claimed.
6. May not be claimed on the same day as other virtual care services or other in-person visit or consultation services by the same physician for the same patient.

08.3 Psychiatric drug and shock therapy

08.38	Other electroconvulsive therapy (ECT), per treatment	63.02 V	111.71

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

08.4 Other psychiatric therapeutic procedures

08.44 Group therapy

08.44A	Group psychotherapy, where all members of the group are receiving therapy in the session, full 15 minutes or major portion thereof for the first call when only one call is claimed	44.92 V	

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

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

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

	BASE	ANE

NOTE: 1. May be claimed by a physician other than a psychiatrist only when a physician assessment has established (during the same or a previous visit) that the patient is suffering from a psychiatric disorder.
2. For treatment of non-psychiatric disorders, the appropriate office visit HSC should be claimed.
3. Group therapy services for patients 18 years of age or younger may be claimed using HSC 08.44C or 08.44D.
4. May be claimed by a general practitioner (GP) or a generalist in mental health (GNMH) when providing services in the capacity of the second or subsequent physician for psychotherapy of complex groups (HSC 08.44D).

08.44AV Group psychotherapy via telephone or secure videoconference, where all members of the group are receiving therapy in the session, full 15 minutes or major portion thereof for the first call when only one call is claimed . 44.92 V

NOTE: 1. May only be claimed by a physician other than a psychiatrist when a physician assessment has established (during the same or a previous visit) that the patient is suffering from a psychiatric disorder.
2. For treatment of non-psychiatric disorders, the appropriate HSC should be claimed.
3. Virtual group therapy services for patients 18 years of age or younger may be claimed using HSC 08.44CV or 08.44DV.
4. The patient's record must include a detailed summary of all services provided including time spent and start and stop times.
5. Only time spent communicating with the patients can be claimed as part of the service. Time spent on administrative tasks cannot be claimed.

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

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

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

	BASE	ANE
08.44B Second and subsequent physician attendance at group psychotherapy, where all members of the group are receiving therapy in the session, full 15 minutes or major portion thereof for the first call when only one call is claimed	73.26 V	
NOTE: 1. May only be claimed by a psychiatrist. 2. Group therapy services for patients 18 years of age or younger may be claimed using HSC 08.44C or 08.44D.		
08.44BV Second and subsequent physician attendance at group psychotherapy via telephone or secure videoconference, where all members of the group are receiving therapy in the session, full 15 minutes or major portion thereof for the first call when only one call is claimed	44.92 V	
NOTE: 1. May only be claimed by general practice physicians, generalists in mental health and psychiatrists. 2. Virtual group therapy services for patients 18 years of age or younger may be claimed using HSC 08.44CV or 08.44DV. 3. The patient's record must include a detailed summary of all services provided including time spent and start and stop times. 4. Only time spent communicating with the patients can be claimed as part of the service. Time spent on administrative tasks cannot be claimed.		
08.44C Group psychotherapy, complex group, where all members of the group are receiving therapy in the session, full 15 minutes or major portion thereof for the first call when only one call is claimed	82.21	
NOTE: 1. May only be claimed by a psychiatrist. 2. May only be claimed for groups where one or more of the members has a significant personality disorder. 3. May be claimed for group therapy sessions for patients 18 years of age or younger.		
08.44CV Group psychotherapy via telephone or secure videoconference, complex group, where all members of the group are receiving therapy in the session, full 15 minutes or major portion thereof for the first call when only one call is claimed	82.21	

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

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

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

	BASE	ANE
NOTE: 1. May only be claimed by a psychiatrist. 2. May only be claimed for groups where one or more of the members has a significant personality disorder. 3. May be claimed for virtual group therapy sessions for patients 18 years of age or younger. 4. The patient's record must include a detailed summary of all services provided including time spent and start and stop times. 5. Only time spent communicating with the patients can be claimed as part of the service. Time spent on administrative tasks cannot be claimed.		
08.44D Second and subsequent physician attendance at complex group psychotherapy, where all members of the group are receiving therapy in the session, full 15 minutes or major portion thereof for the first call when only one call is claimed	82.21	
NOTE: 1. May only be claimed by a psychiatrist. 2. May only be claimed for groups where one or more of the members has a significant personality disorder. 3. May be claimed for group therapy sessions for patients 18 years or younger.		
08.44DV Second and subsequent physician attendance at complex group psychotherapy via telephone or secure videoconference, where all members of the group are receiving therapy in the session, full 15 minutes or major portion thereof for the first call when only one call is claimed.	82.21	
NOTE 1. May only be claimed by a psychiatrist. 2. May only be claimed for groups where one or more of the members has a significant personality disorder. 3. May be claimed for virtual group therapy sessions for patients 18 years or younger. 4. The patient's record must include a detailed summary of all services provided including time spent and start and stop times. 5. Only time spent communicating with the patients can be claimed as part of the service. Time spent on administrative tasks cannot be claimed.		

08.45 Family Therapy

08.45 Assessment or therapy of a family, requiring comprehensive psychiatric or family systems evaluation, first full 45 minutes or major portion thereof for the first call when only one call is claimed - in office.	60.20 V	

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

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

08.4 Other psychiatric therapeutic procedures (cont'd)

08.45 Family Therapy (cont'd)

	BASE	ANE
NOTE: 1. May only be claimed: - when the purpose of the visit is to provide psychiatric assessment or therapy to deal with systemic issues in the family unit; - by general practice physicians, generalists in Mental Health, pediatricians (including subspecialties) and psychiatrists. 2. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List after the first full 45 minutes has elapsed.		
08.45V Assessment or therapy of a family via telephone or secure videoconference, requiring comprehensive psychiatric or family systems evaluation, first full 45 minutes or major portion thereof for the first call when only one call is claimed.	60.20 V	
NOTE: 1. May only be claimed: - when the purpose of the visit is to provide psychiatric assessment or therapy to deal with systemic issues in the family unit; - by general practice physicians, generalists in Mental Health, pediatricians (including subspecialties) and psychiatrists. 2. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List after the first full 45 minutes has elapsed. 3. The patient's record must include a detailed summary of all services provided including time spent and start and stop times. 4. Only time spent communicating with the patient and/or the parent/guardian of a patient child can be claimed as part of the service. Time spent on administrative tasks cannot be claimed.		

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

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

08.4 Other psychiatric therapeutic procedures (cont'd)
08.45 Family Therapy (cont'd)

	BASE	ANE
08.45A Complex assessment or therapy of a family, requiring comprehensive psychiatric or family systems evaluation, first full 45 minutes or major portion thereof for the first call when only one call is claimed	205.24	
NOTE: 1. May only be claimed by psychiatrists. 2. May only be claimed for family therapy where one or more members of the family has a significant personality disorder. 3. May only be claimed when the purpose of the visit is to provide psychiatric assessment or therapy to deal with systemic issues in the family unit. 4. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List after the first full 45 minutes has elapsed.		
08.45AV Complex assessment or therapy of a family via telephone or secure videoconference, requiring comprehensive psychiatric or family systems evaluation, first full 45 minutes or major portion thereof for the first call when only one call is claimed	205.24	
NOTE: 1. May only be claimed by psychiatrists. 2. May only be claimed for family therapy where one or more members of the family has a significant personality disorder. 3. May only be claimed when the purpose of the virtual visit is to provide psychiatric assessment or therapy to deal with systemic issues in the family unit. 4. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List after the first full 45 minutes has elapsed. 5. The patient's record must include a detailed summary of all services provided including time spent and start and stop times. 6. Only time spent communicating with the patient and/or the parent/guardian of a patient child can be claimed as part of the service. Time spent on administrative tasks cannot be claimed.		
08.45Z Assessment or therapy of a family, requiring comprehensive psychiatric or family systems evaluation, first full 45 minutes or major portion thereof for the first call when only one call is claimed_- out of office.	60.20 V	

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

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

08.4 Other psychiatric therapeutic procedures (cont'd)
08.45 Family Therapy (cont'd)

	BASE	ANE

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

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

09 OPHTHALMOLOGICAL AND OTOLOGICAL DIAGNOSIS AND TREATMENT

09.0 General and subjective eye examination
09.01 Limited eye examination

09.01A	Biomicroscopy (slit lamp examination)	26.24
09.01B	Gonioscopy	26.24
09.01C	Orthoptic analysis, interpretation	34.87
09.01E	Orthoptic analysis, technical (may include Hess screen)	34.18
09.01F	Complete oculo-visual examination	36.95

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

09.02 Comprehensive eye examination

09.02A	Inpatient examination for retinopathy of prematurity in infants or non-accidental trauma	158.14

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

09.02B	Anterior chamber depth measurement	1.55
09.02D	Community or outpatient retinopathy examination of prematurity in infants	110.84

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

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

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

09.0 General and subjective eye examination (cont'd)

09.02 Comprehensive eye examination (cont'd)

	BASE	ANE
09.02E Amblyopia evaluation for patients nine years of age and younger	53.00	
09.04 Eye examination under anesthesia NOTE: May not be claimed when topical anesthesia only is used.	290.05	113.05

09.05 Visual field study

09.05A Full threshold perimetric examination, technical	40.05	
09.05B Full threshold perimetric examination, interpretation	34.36	

09.06 Colour vision study

09.06A Color vision test, interpretation and technical	15.88	

09.07 Dark adaptation study

09.07C Bilateral dark adaptation study - technical and interpretation	15.88	

09.1 Examinations of form and structure of eye

09.11 Photography of fundus oculi

09.11A Bilateral specular microscopy for corneal graft patients only - technical	15.88	
09.11B Bilateral specular microscopy for corneal graft patients only - interpretation	15.88	
09.11C Potential acuity measurement (PAM) NOTE: May not be claimed in addition to HSC 09.13G.	15.88	

09.12 Fluorescein angiography or angioscopy of eye

09.12A Intravenous fluorescein angiography (IVFA), interpretation NOTE: 1. May not be claimed with HSC 13.59C. 2. Benefit includes both eyes.	68.54	
09.12B Intravenous fluorescein angiography (IVFA), technical	161.77	

09.13 Ultrasound study of eye

09.13C Assessment of serial ocular ultrasonography measurements to evaluate change in tumour dimensions NOTE: Refer to notes following 09.13D for further information.	107.90	
09.13D Ocular ultrasonography, for intraocular pathology, interpretation NOTE: HSCs 09.13C and 09.13D may only be claimed by an ophthalmologist.	141.40	
09.13E Optical coherence tomography (OCT), for the diagnosis and management of ocular pathology, interpretation NOTE: May not be claimed for routine examinations or routine screening.	26.41	

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

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

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

09.13 Ultrasound study of eye (cont'd)

	BASE	ANE
09.13F Optical coherence tomography (OCT), for the diagnosis and management of ocular pathology, technical	20.72	
NOTE: May not be claimed for routine examinations or routine screening.		
09.13G Bilateral biometry for cataract surgery, technical	50.59	
NOTE: May only be claimed once every 5 years.		
09.13H Bilateral biometry for cataract surgery, interpretation	34.36	
NOTE: May only be claimed once every 5 years.		
09.13I Yearly bilateral biometry for myopic progression in children under 18 years of age, technical.	30.00	
NOTE: 1. May only be claimed for patients with a refractive error of -3D or worse. The refractive error must be recorded in the patients' chart.		
2. Benefit rate includes both eyes.		
09.13J Yearly bilateral biometry for myopic progression in children under 18 years of age, interpretation.	12.00	
NOTE: Refer to notes on HSC 09.13I for further information.		

09.2 Objective functional tests of eye

09.21 Electroretinogram (ERG)

09.21A Electroretinogram (ERG), technical	56.46	
09.21B Electroretinogram (ERG), interpretation	67.85	

09.23 Visual evoked potential (VEP)

09.23A Visual evoked potential (VEP), technical	44.02	
09.23B Visual evoked potential (VEP), interpretation	29.00	

09.24 Electronystagmogram (ENG)

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

09.26 Tonography, provocative tests, and other glaucoma testing

09.26A Diurnal tension curve	58.35	
NOTE: Minimum 4 intraocular pressures separated by a minimum of 2 hours each.		
09.26D Bilateral corneal pachymetry	15.88	

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

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

09.2 Objective functional tests of eye (cont'd)

09.26 Tonography, provocative tests, and other glaucoma testing (cont'd)

	BASE	ANE
NOTE: 1. May only be claimed once every five years. 2. Billable only in non-refractive conditions. Excludes (Lasik and PRK).		

09.4 Nonoperative procedures related to hearing

09.41 Audiometry

09.41A Impedance audiometry/tympanometry, technical	9.13	
NOTE: Includes acoustic reflexes and hard copy of results.		
09.41B Interpretation	16.89	
NOTE: Only one 09.41B fee, per patient, should be claimed, regardless of the number of tests performed per day.		

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

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

09.4 Nonoperative procedures related to hearing (cont'd)

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

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

09.46 Other auditory and vestibular function tests

09.46A	Auditory evoked potential, interpretation	26.21	
09.46B	Particle repositioning maneuver for benign positional vertigo (Epley maneuver) NOTE: May only be claimed by physicians who have neurotology (NEOT) certification or a specialty in neurology or otolaryngology.	92.23	

09.49 Other nonoperative procedures related to hearing

09.49A	Automatic tympanometry NOTE: Includes the technical and professional component.	2.28	

10 NONOPERATIVE INTUBATION, IRRIGATION, AND MANIPULATION PROCEDURES

10.0 Nonoperative intubation of respiratory and gastrointestinal tracts

10.04	Endotracheal intubation for aspiration of sputum NOTE: May not be claimed with 13.62A.	34.01	
10.04B	Intubation performed in an emergency room, AACC or UCC NOTE: 1. May only be claimed when performed in an emergency room, AACC or UCC. 2. May not be claimed in addition to HSC 10.04 or 13.99E when performed by the same physician. 3. May be claimed in addition to visits or other services provided on the same day by the same physician.	106.61	

10.08 Insertion of (naso-)intestinal tube

10.08A	Intubation for selective duodenography or small bowel studies	39.03	

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

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

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

10.16 Insertion of other vaginal pessary

		BASE	ANE
10.16A	Pessary fitting NOTE: May be claimed in addition to a visit or consultation.	88.76	
10.16B	Pessary removal, adjustment and/or reinsertion NOTE: 1. May not be claimed in addition to HSC 10.16A. 2. May be claimed in addition to a visit or consultation.	13.47	

10.2 Other nonoperative dilation and manipulation procedures

10.23	Dilation of anal sphincter NOTE: 1. May only be claimed when performed under anesthesia. 2. HSC 61.63A may not be claimed in addition.	53.13 V	113.05
10.25	Therapeutic distention of bladder	34.81 V	113.05

10.3 Nonoperative alimentary tract irrigation, cleaning and local instillation

10.33 Gastric lavage

10.33A	Gastric lavage	45.88	
10.33B	Gastric cytology washings	41.04	
10.35	Gastric gavage	43.66	

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

10.55 Irrigation of other indwelling urinary catheter

10.55A	Bladder irrigation	52.22	112.95

10.56 Other genitourinary instillation

10.56A	Bladder instillation of chemotherapeutic agents NOTE: Includes catheterization and visit.	52.22	

11 REPLACEMENT AND REMOVAL OF THERAPEUTIC APPLIANCES

11.0 Nonoperative replacement of gastrointestinal appliances

11.02	Replacement of gastrostomy tube NOTE: May only be claimed in addition to 01.14.	47.82	111.81
11.02A	Replacement of gastrostomy tube without gastroscopy NOTE: May only be claimed when performed under general anesthesia or procedural sedation, otherwise a visit health service code applies.	143.35	113.05

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

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

11.2 Other nonoperative replacement

11.23 Replacement of tracheostomy tube

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

11.7 Nonoperative removal of therapeutic device from genital system

11.71 Removal of intrauterine contraceptive device (IUD)

11.71A Removal of intrauterine contraceptive device (IUD)	37.24 V	113.05
NOTE: May be claimed in addition to a visit or consultation.		

11.8 Other nonoperative removal of therapeutic device

11.81 Removal of peritoneal drainage device

11.81A Excision of indwelling intraperitoneal dialysis catheter with subcutaneous tunnel	116.88 V	150.73

12 NONOPERATIVE REMOVAL OF FOREIGN BODY

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

12.01 Removal of intraluminal foreign body from nose without incision	50.28 V	113.05
12.03 Removal of Intraluminal foreign body from larynx without incision	145.76	112.95
NOTE: Includes laryngoscopy.		
12.05 Removal of Intraluminal foreign body from bronchus without incision	400.00	171.67
NOTE: Includes bronchoscopy.		

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

12.12 Removal of intraluminal foreign body from esophagus without incision

12.12A Via rigid esophagoscopy	439.23	150.73
12.12B Via flexible esophagogastroscopy	113.99	111.81
NOTE: May only be claimed in addition to 01.14.		

12.13 Removal of intraluminal foreign body from stomach without incision

12.13A Via esophagogastroscopy	113.99	111.81
NOTE: May only be claimed in addition to 01.14.		

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

12 NONOPERATIVE REMOVAL OF FOREIGN BODY (cont'd)

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

		BASE	ANE
12.21	Removal of intraluminal foreign body from ear without incision	50.28 V	112.95
12.23	Removal of intraluminal foreign body from vagina without incision NOTE: For examination under general anesthetic, refer to 03.26.	86.82	112.95
12.24	Removal of intraluminal foreign body from urethra without incision NOTE: May not be claimed in addition to 03.26.	124.18 V	113.05

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

12.31	Removal of non-penetrating foreign body from eye without incision	40.23 V	112.95

13 OTHER NONOPERATIVE PROCEDURES

13.4 Injection or infusion of other therapeutic or prophylactic substance

13.4 A	Scalp vein transfusion or infusion	40.23

13.42 Immunization for allergy

13.42A	Desensitization treatments with allergy serums NOTE: 1. When performed by physician or under physician supervision. 2. A maximum of one office visit per month may be claimed for reassessment of the patient in lieu of a claim for desensitizing injection. 3. Benefit includes cost of all material other than allergy serum. 4. Only one benefit may be claimed per treatment regardless of number of injections given.	24.14

13.5 Other injection or infusion of other therapeutic or prophylactic substance

13.53 Injection of steroid

13.53A	Intranasal injection of steroid	10.89
13.53B	Intralesional injection(s) of steroid NOTE: May not be claimed in addition to HSCs 16.89B, 16.89C or 16.89D.	22.73

13.55 Injection or infusion of cancer chemotherapeutic substance NEC

13.55A	Chemotherapy That for treatment of malignant disease	81.18

13.57 Iontophoresis

13.57A	Iontophoresis, ionization or gluing of corneal ulcer	21.24

13.59 Injection or infusion of therapeutic or prophylactic substance NEC

13.59A	Intramuscular or subcutaneous injections	10.73

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

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

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

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

		BASE	ANE
	NOTE: 1. May be claimed in addition to a visit or a consultation. 2. May not be claimed for injection of allergy serum.		
13.59B	Intravenous injections	13.40	
13.59C	Initiation of intravenous NOTE: 1. Sole procedure only and may not be claimed in addition to a radiology service. 2. May be claimed in addition to a visit or a consultation providing the purpose of the visit is not for the initiation of the intravenous. 3. May be claimed only when performed by a physician where suitable qualified nursing personnel are unavailable.	31.13	
13.59D	Intracorporeal injection of penis NOTE: 1. Includes visit. 2. Limit of one per patient, per physician. 3. Repeat visits, refer to 03.03A or 03.03AZ. 4. Includes patient teaching for self injection and observation.	69.63	
13.59E	Injection of Botulinum A Toxin For spasmodic torticollis	164.22	113.05
13.59F	Follow up injection of Botulinum A Toxin for spasmodic torticollis	85.08	
13.59K	Injection of Botulinum A Toxin For treatment of spasticity due to upper motor neuron injury or disease NOTE: 1. Single benefit applies regardless of the number of injections or limbs injected. 2. May only be claimed for purposes such as improving gait, reduction of pain, improving upper limb function. 3. May be claimed for initial and follow-up or repeat injections at a later date. 4. May not be claimed with 07.09A or 07.09B.	163.11	113.05
13.59H	Local infiltration of tissue NOTE: May not be claimed with any other procedure at the same encounter by the same or different physician except for HSC 95.94C.	25.34	
13.59J	Injection with local anesthetic of myofascial trigger points NOTE: 1. A maximum of three calls applies. 2. May not be claimed in addition to HSCs 16.89B, 16.89C or 16.89D.	20.88	
13.59L	Botulinum toxin injection for treatment of sialorrhea NOTE: May only be claimed by Otolaryngology/Neurology specialists.	67.57 V	112.95

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

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

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

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

		BASE	ANE
13.59N	Injection of Botulinum A Toxin for anal fissure	79.69 V	113.05
	NOTE: May be claimed in addition to a visit or a consultation.		
13.59M	Injection of therapeutic substance for lower urinary tract dysfunction . . .	348.13	112.95
	NOTE: 1. Benefit includes cystoscopy. 2. May only be claimed by urology, obstetrics and gynecology.		
13.59O	Injections of Botulinum A Toxin for the prophylaxis of chronic migraine headaches for eligible patients 18-65 years of age	100.91 V	113.05
	NOTE: 1. Eligible patients will have suffered headache activity for greater than 15 days per month with each episode lasting four or more hours for three consecutive months prior to the initial treatment. 2. Follow up treatment may be claimed in 12 week intervals. 3. Only one call may be claimed regardless of the number of injections performed. 4. May be claimed in addition to a visit or a consultation.		
13.59V	Immunization and administration of COVID-19 vaccine	25.00	

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

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

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

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

	BASE	ANE

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

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

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

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

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

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

	BASE	ANE

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

13.6 Respiratory therapy

13.62 Other mechanical assistance to respiration

13.62A Ventilatory support, in Intensive Care Unit (ICU) 98.19

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

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

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

13.7 Conversion of cardiac rhythm
13.72 Other electric countershock of heart

	BASE	ANE
13.72A Cardioversion	103.28	113.05
NOTE: 1. May only be claimed for electrical conversion. 2. May not be claimed with electrophysiology studies.		

13.8 Miscellaneous physical procedures
13.82 Ultraviolet light therapy

13.82A Psoralen ultraviolet A treatment, ultraviolet B or narrow-band ultraviolet B treatment	21.40

13.9 Other miscellaneous diagnostic and therapeutic procedures
13.99 Other miscellaneous diagnostic and therapeutic procedures NEC

13.99AG Application of neurological navigation unit, with intracranial intracerebral localization by neurosurgical probe or instrument	535.40
13.99BA Periodic Papanicolaou Smear for patients between the ages of 21 and 69	30.17
NOTE: 1. Two Papanicolaou smears may be claimed per patient, per physician, per year (April 1 of one year to March 31 of the following year). Additional claims may be submitted with supporting information. 2. May be claimed in addition to a visit or consultation. 3. When clinically indicated, Papanicolaou smears may be claimed for those patients not meeting the age requirements. In those instances, text must be submitted explaining the specific circumstance. 4. May not be claimed at the same encounter as HSC 13.99BD or 13.99BE.	
13.99BE Pelvic examination using a speculum requiring swab(s) and/or sample(s) collection	30.17
NOTE: 1. May be claimed with a visit or consultation. 2. May not be claimed at the same encounter as HSC 13.99BA or 13.99BD.	
13.99BD Anal Papanicolaou Smear	18.10
NOTE: 1. Two Anal Papanicolaou smears may be claimed per patient, per physician, per year (April 1 of one year to March 31 of the following year). Additional claims may be submitted with supporting information. 2. May be claimed in addition to a visit or consultation. 3. May not be claimed at the same encounter as HSC 13.99BA or 13.99BE.	
13.99BB Needle biopsy of other superficial organs	65.44 V

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

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

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

		BASE	ANE
13.99CC	Assessment of distal circulation by peripheral Doppler	75.26	
	NOTE: 1. May only be claimed by vascular surgeons and by general surgeons with additional training in vascular surgery. 2. If performing arterial and venous assessments, a second call may be claimed.		
13.99DD	Non-surgical reduction of abdominal or inguinal hernia	63.08	111.71
	NOTE: 1. May be claimed in addition to a visit or consultation at the same encounter. 2. May only be claimed in an emergency room, AACC or UCC.		
13.99AE	Placement of colonic stent, additional benefit	170.99	167.71
	NOTE: May only be claimed in addition to HSCs 01.22 and 01.24B.		
13.99AF	Placement of duodenal stent via gastroscope, additional benefit	170.99	167.71
	NOTE: May only be claimed in addition to HSCs 01.14 or 64.97A.		
13.99A	Hemodialysis treatment, unstable patient	114.63	
	For assessment and management of an unstable patient undergoing hemodialysis treatment where the physician attends and assesses or changes the treatment at the time of the visit		
13.99B	Hemodialysis treatment, stable patient	42.32	
	For assessment and management of a stable patient with chronic renal failure		
	NOTE: May only be claimed when the patient is seen while receiving hemodialysis. If the patient is seen when they are not receiving hemodialysis, the appropriate visit HSC should be claimed.		
13.99C	Assessment and management of an unstable patient with acute/chronic renal failure treated by peritoneal dialysis	114.63	
13.99D	Assessment and management of a stable patient with chronic renal failure treated by peritoneal dialysis	45.85	
13.99AA	Assessment and management of a patient undergoing therapeutic plasmapheresis	114.63	
	NOTE: 1. A benefit for central line placement or umbilical vein catheter, if required, may be claimed in addition. 2. May not be claimed for blood transfusion.		

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

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

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

	BASE	ANE
13.99AB Dialysis therapy, any modality, in the intensive care unit	145.40	

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

13.99O Management of dialysis patients on home dialysis or receiving treatment in a remote hemodialysis unit (per week)	97.41	

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

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

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

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

	BASE	ANE
13.99OA Management of patient on hemodialysis or peritoneal dialysis (per week) . .	132.26	

NOTE:
1. May only be claimed by nephrologists and pediatric nephrologists.
2. May not be claimed in addition to HSC 13.99B or 13.99D within the same calendar week.
3. May be claimed once per patient within the same calendar if not preceded by any visit except those outlined in
4. HSCs 03.03AR, 03.03DF and special callback benefits (HSC 03.03KA, 03.03LA, 03.03MC, 03.03MD, 03.05N, 03.05P, 03 03.05QB, 03.05R) may be claimed within the same calenda for the same patient by the same physician.
5. Other HSCs (03.08A, 03.08AZ, 03.07B, 03.04A, 03.04AZ, 03.03A, 03.03AZ, 03.03F, 03.03FZ) may not be claimed in the same calendar week for the same patient by any nephrologist. Exceptions to this include consultation and visit HSCs that are related to assessment for kidney/kidney-pancreas transplantation, which may be claimed within the same calendar week by nephrologists with special interest or training in transplantation. For the exceptions, supporting text must be submitted.
6. The physician must be actively involved in the management of the patient's care in order to claim.

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

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

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

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

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

Emergency Services

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

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

13.99EC	Resuscitation, per 15 minutes or major portion thereof for the second and subsequent physician actively participating and providing assistance to the primary physician at a resuscitation	87.70	

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

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

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

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

Emergency Services (cont'd)

	BASE	ANE
13.99EB Medical Emergency Team Co-ordination by lead physician, per full 15 minutes or major portion thereof	98.08	

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

13.99F Neonatal resuscitation	82.80	

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

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

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

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

Emergency Services (cont'd)

	BASE	ANE
13.99GA Trauma assessment, multiple trauma, severely injured patient	366.59	

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

13.99H Critical care of severely ill or injured patient in a hospital emergency department requiring major treatment intervention(s), per 15 minutes	58.65	

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

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

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

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

Emergency Services (cont'd)

	BASE	ANE
13.99HA Critical care of severely ill or injured patient in an AACC or UCC department, or requiring major treatment intervention, per 15 minutes . . .	63.69	

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

13.99I Hyperbaric oxygen therapy detention time, full 15 minutes or major portion thereof for the first call when only one call is claimed	50.28	

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

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

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

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

Emergency Services (cont'd)

		BASE	ANE
13.99J	Medical emergency detention time, per 15 minutes	63.69	

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

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

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

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

Emergency Services (cont'd)

	BASE	ANE
13.99JA Management of complex labour, per 15 minutes	55.23	

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

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

NOTE: Refer to the notes following HSC 13.99KB.

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

NOTE: Refer to the notes following HSC 13.99KB.

13.99KB Ambulance detention time, full 15 minutes or major portion thereof, any day, 2200 - 0700 hours	142.65	

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

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

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

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

Emergency Services (cont'd)

		BASE	ANE
13.99L	Donor maintenance, prior to cadaveric harvesting of organs, per 15 minutes . NOTE: 1. To be claimed using the Personal Health Number of the donor. 2. Payable for direct attendance by the physician. 3. Total time to be determined on a cumulative basis.	57.29	
13.99M	Donor maintenance during cadaveric organ harvesting, first full 35 minutes . NOTE: Each subsequent full 5 minutes may be claimed at the rate specified on the Price List.	158.03	
13.99AD	Application of image guided surgery system for sinus and skull base surgery, additional benefit	112.77	
13.99V	Examination and crisis counselling for sexual/physical abuse, full 15 minutes or major portion thereof for the first call when only one call is claimed . . . . . NOTE: 1. A maximum of 16 calls may be claimed. 2. Time taken for forensic evidence is not to be included in total time.	59.17	
13.99UM	Pre-lung transplant, assessment . . . . . NOTE: May only be claimed by Pediatric, Internal Medicine and Respiratory Medicine specialists.	573.58	
13.99VM	Post-lung transplant, inpatient care, per day . . . . . NOTE: 1. May only be claimed by Pediatric, Internal Medicine and Respiratory Medicine specialists. 2. Daily fee includes all visit services provided including callbacks during a 24-hour period. 3. A maximum of 30 days may be claimed.	114.75	
13.99W	Pre-liver transplant, assessment . . . . . NOTE: May only be claimed by Pediatric and Internal Medicine specialists.	507.35	

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

13 OTHER NONOPERATIVE PROCEDURES (cont'd)

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

Emergency Services (cont'd)

		BASE	ANE
13.99X	Post-liver transplant, inpatient care, per day	85.23	
	NOTE: 1. May only be claimed by Pediatric and Internal Medicine specialists. 2. Daily fee includes all visit services provided including callbacks during a 24-hour period. 3. A maximum of 30 days may be claimed.		
13.99Y	Renal transplant care, day one	484.96	
13.99Z	Day two and three, per day	290.98	
	NOTE: The daily fee for 13.99Y and 13.99Z, includes all visit services including callbacks during a 24 hour period.		
13.99AZ	Medical pre-transplant assessment, pancreas or islet cell transplantation .	726.62	
	NOTE: 1. May only be claimed for out of province patients. 2. May only be claimed by endocrinologists. 3. To include all services relating to the pre-transplant assessment for patients undergoing pancreatic or islet cell transplantation.		

II. OPERATIONS ON THE NERVOUS SYSTEM

14 INCISION AND EXCISION OF SKULL, BRAIN AND CEREBRAL MENINGES

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

14.0 Cranial puncture

14.09 Other cranial puncture

		BASE	ANE
14.09A	Drainage of ventricle or cyst through existing burr holes	96.37 V	112.95
14.09B	Aspiration of intracranial abscess	935.61	187.66

14.1 Craniotomy and craniectomy

14.13 Other craniotomy

14.13A	With exploration, burr holes	401.55	188.43
14.13B	Craniotomy or craniectomy with exploration	1,070.80	358.00
14.13C	Evacuation of epidural hematoma, abscess or fluid collection	1,338.50	430.23
14.13D	Decompressive craniectomy including hemicraniectomy	1,472.35	471.05
14.13E	Exploration of posterior fossa NOTE: Includes that with rhizotomy.	1,180.56	343.35
14.13F	Intracranial endoscopy via skull base, neurosurgical component	2,231.28	1,684.52
14.13G	Intracranial endoscopy via cranial vault, neurosurgical component	1,338.50	1,015.25

14.14 Other craniectomy

14.14A	For osteomyelitis	535.40	339.16
14.14B	For neoplasm of skull	1,070.80	339.16
14.14C	With exploration	803.10	358.01
14.14D	For sub-temporal decompression	622.40	223.59

14.2 Incision of brain and cerebral meninges

14.21 Incision of cerebral meninges

14.21B	Evacuation of subdural hematoma, abscess or fluid collection	1,673.13	520.81

14.22 Lobotomy and tractotomy

14.22A	Resection of brain tissue for epilepsy, including lobectomy, tractotomy and corpus callostomy	3,346.25	1,087.96

14.29 Other incision of brain

14.29A	Resection of disrupted brain tissue	2,007.75	471.05
14.29B	Evacuation of intraparenchymal hematoma, abcess or fluid collection	2,275.45	508.74

14.3 Operations on thalamus and globus pallidus (including ansa and cingulus)

14.3 A	A Stereotactic ablation or stimulation of subcortical structures for functional indications, including thalamus and globus pallidus	1,379.99	379.49
14.3 B	Other stereotactic procedure, including application of stereotactic frame or frameless stereotaxy	2,275.45	391.32

14.4 Other excision or destruction of brain and meninges

14.41 Excision of lesion or tissue of cerebral meninges

14.41A	Craniotomy/craniectomy with repair of leptomeningeal cyst	2,007.75	589.76
14.42	Hemispherectomy	2,877.78	786.33

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

14 INCISION AND EXCISION OF SKULL, BRAIN AND CEREBRAL MENINGES

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

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

14.49 Other excision or destruction of lesion or tissue of brain

Craniotomy/craniectomy with:

		BASE	ANE
14.49A	Cerebral biopsy	1,338.50	433.37
14.49B	Removal of tumor of cerebellopontine angle	1,895.32	849.33
14.49C	Resection of intracranial intra-axial tumor, supratentorial	3,346.25	792.55
14.49D	Removal or surgical correction of intracranial lesion, transclival approach	3,480.10	1,067.47
14.49E	Craniotomy/craniectomy with removal of extra-axial tumor with or without microsurgical dissection	4,684.75	1,106.71
14.49F	Cortical exploration and resection for epilepsy	2,677.00	659.49
14.49G	With insertion of electrodes (epidural, subdural, or intraparenchymal) for epilepsy	1,338.50	489.88
14.49H	Resection of skull base tumor, neurosurgical component NOTE: For otolaryngological component, refer to Price List.	3,164.07 V	885.59
14.49J	Extended skull base craniotomy including anterior, middle or posterior fossa approaches, neurosurgical component NOTE: For otolaryngological component, refer to Price List.	3,008.80 V	849.33
14.49K	Radiosurgery method for cranial or spinal lesion, neurosurgical component	4,684.75	1,094.48

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

14.82	Biopsy of brain That by twist drill or burr hole	962.38	277.01
14.85B	Injection of contrast media, via burr holes	305.18	134.04

14.88 Other invasive diagnostic procedures on brain and cerebral meninges

14.88A	Electrocortography or microelectrode cellular recording, full 15 minutes or major portion thereof for the first call when only one call is claimed	81.65	
14.88B	Insertion of special electrodes for epilepsy	65.59	

15 OTHER OPERATIONS ON SKULL, BRAIN, AND CEREBRAL MENINGES

15.0 Cranioplasty

15.01 Opening of cranial suture

15.01A	Craniectomy for craniostenosis, single suture	1,338.50	301.47

15.02 Elevation of skull fracture fragments

15.02A	Skull fracture, depressed, dura intact	1,338.50	339.65
15.02B	Skull fracture, with laceration of brain	1,673.13	395.68
15.02C	Skull fracture, with paranasal sinus involvement	1,090.59	415.63

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

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

15.0 Cranioplasty (cont'd)

15.06 Other cranial osteoplasty

		BASE	ANE
15.06A	Cranioplasty, or cranial vault repair NOTE: Benefit includes synthetic implant or plate fixation.	1,003.88	430.23
15.06B	Craniofacial reconstruction, for congenital deformity, full 60 minutes or major portion thereof for the first call when only one call is claimed	649.16	

15.1 Repair of cerebral meninges

15.12 Other repair of cerebral meninges

15.12A	Craniotomy and repair of C.S.F. fistula	1,081.17	397.56
15.12B	Repair of cranial meningo-encephalocoele	983.46	316.25
15.12C	Intracranial duraplasty with graft	271.72	206.01

15.2 Ventriculostomy

15.2 A	Ventriculostomy including insertion of cerebrospinal fluid (CSF) reservoir system	1,003.88	508.74

15.3 Extracranial ventricular shunt

15.3	Extracranial ventricular shunt	1,338.50	611.38

15.4 Revision of ventricular shunt

15.4	Revision of ventricular shunt	1,338.50	294.37

15.9 Other operations on skull, brain, and cerebral meninges

15.93 Implantation of intracranial neurostimulator

15.93A	Internalization or minor repairs to leads, control unit, battery or battery replacement for deep brain stimulator or epidural electrodes	401.55	113.05
15.93B	Insertion, requiring stereotactic procedures	1,396.06	433.70
15.93C	Revision, requiring stereotactic procedures NOTE: May not be claimed within 90 days subsequent to 15.93B.	936.95	325.28

15.94 Insertion of intracranial pressure monitor

15.94A	Insertion of intracranial pressure monitoring device with recording	325.26	150.73
15.94B	ICP and/or CSF monitoring in ICU, daily benefit NOTE: 1. May be claimed for the monitoring and manipulation of the physiologic parameter of intracranial or cerebrospinal fluid pressure through an indwelling temporary catheter. 2. May only be claimed once per 24 hour period for any ventilated patient, irrespective of the number of physicians providing care. 3. May be claimed in association with other ICU services. 4. When a procedure and 03.05A are provided during the same encounter, only the greater benefit may be claimed. 5. Time spent performing this procedure should be excluded from cumulative 03.05A time spent with the patient per day.	62.21	

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

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

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

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

		BASE	ANE
15.99A	Application of skull tongs	200.78	111.71
	NOTE: May be claimed in addition to a consultation.		

16 OPERATIONS ON SPINAL CORD AND SPINAL CANAL STRUCTURES

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

16.0 Exploration and decompression of spinal canal

16.09 Other exploration and decompression of spinal canal

16.09F	Laminectomy with microsurgical exploration of spinal cord	2,007.75	960.96
	For syringomyelia and shunting		
	NOTE: Instrumentation may be claimed in addition.		
16.09G	Laminectomy, with microsurgical exploration of cervico-medullary junction .	2,677.00	1,341.65
	For syringomyelia or Arnold-Chiari malformation		
	NOTE: Instrumentation may be claimed in addition.		
16.09J	Repeat decompression, cervical, thoracic or lumbar spine	1,265.79	527.58
16.09N	Intervertebral fusion, thoracic & lumbar spine only (anterior lumbar intervertebral fusion (ALIF), posterior lumbar intervertebral fusion (PLIF), translateral lumbar intervertebral fusion (TLIF), or lateral lumbar interbody fusion (LLIF))	1,318.53	471.05
	NOTE: 1. Instrumentation may be claimed in addition.		
	2. Additional levels may be claimed at the rate specified on the Price List; a maximum benefit of five calls applies.		

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

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

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

		BASE	ANE
16.09O	Laminoplasty or decompression (cervical/thoracic/lumbar)	1,211.34	339.16
	NOTE: 1. Only 1 benefit may be claimed regardless of the number of levels. 2. Instrumentation may be claimed in addition.		
16.09P	Anterolateral or posterolateral decompression of spine, not simple discectomy or laminectomy	1,111.96	566.10

16.1 Division of intraspinal nerve root

16.1 A	Cervical or thoracic dorsal root entry zone myelolysis	2,018.48	795.11
16.1 B	Cervical, laminectomy with cordotomy or rhizotomy	1,239.45	361.41
	NOTE: Instrumentation may be claimed in addition.		
16.1 C	Thoracic or lumbar, laminectomy with cordotomy or rhizotomy	861.33	312.74
	NOTE: Instrumentation may be claimed in addition.		
16.1 D	Lumbar/sacral, laminectomy with selective posterior rhizotomy	2,409.30	921.62
	NOTE: Instrumentation may be claimed in addition.		

16.2 Chordotomy

16.2 A	Longitudinal myelotomy	990.49	277.01
16.2 B	Percutaneous	619.57	

16.3 Excision or destruction of lesion of spinal cord and spinal meninges

Thoracic or lumbar laminectomy

16.3 A	With removal of tumor	1,673.06	395.69
	NOTE: Instrumentation may be claimed in addition.		
16.3 B	With removal of intradural tumor or arteriovenous malformation	3,145.48	395.69
	NOTE: Instrumentation may be claimed in addition.		

Cervical laminectomy

16.3 C	With removal of tumor	1,673.13	464.66
	NOTE: Instrumentation may be claimed in addition.		
16.3 D	With removal of intradural tumor or arteriovenous malformation	2,677.00	471.05
	NOTE: Instrumentation may be claimed in addition.		

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

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

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

		BASE	ANE
16.3 E	Excision of spinal or paraspinal tumor	1,644.00	782.64
	NOTE: 1. Benefit is for the neurosurgical component, when an orthopedic surgeon claims 93.05D.		
	2. Instrumentation may be claimed in addition.		
16.3 F	Repair of lipomeningomyelocele with excision of intra-medullary lipoma	2,677.00	1,011.99

16.4 Plastic operations on spinal cord and spinal meninges

16.42 Repair of (spinal) myelomeningocele

16.42A	Plastic repair of meningocoele or myelocoele	1,338.50	282.64

16.43 Repair of vertebral fracture

16.43D	Repair of spine fracture/dislocation, posterior (cervical, thoracic, lumbar) Open reduction internal fixation, instrumentation and graft	1,582.24	546.44
16.43E	Repair of spine fracture/dislocation, posterior (cervical, thoracic, lumbar) Open reduction internal fixation segmental wiring and graft	966.92	325.27

16.49 Other repair and plastic operation on spinal cord structures

16.49A	Laminectomy (thoracic or lumbar) with repair of diastematomyelia	1,935.50	650.55
	NOTE: Instrumentation may be claimed in addition.		
16.49B	Laminectomy cervicothoracic, 2 levels or less	1,318.53	471.05
	NOTE: Instrumentation may be claimed in addition.		
16.49C	Laminectomy cervicothoracic, more than 2 levels	1,626.19	565.27
	NOTE: Instrumentation may be claimed in addition.		
16.49D	Laminectomy lumbar, for stenosis, 2 levels or less	966.92	339.16
	NOTE: Instrumentation may be claimed in addition.		

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

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

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

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

	BASE	ANE
16.49E Laminectomy lumbar, for stenosis, more than 2 levels	1,318.53	471.05
NOTE: Instrumentation may be claimed in addition.		
16.49F Dural repair	197.78	111.71
16.49G Duralplasty	331.43	111.71

16.5 Freeing of adhesions of spinal cord and nerve roots

16.5 A Laminectomy (thoracic or lumbar) with release of tethered spinal cord	2,275.45	942.13
NOTE: Instrumentation may be claimed in addition.		

16.8 Invasive diagnostic procedures on spinal cord and spinal canal structures

16.81 Spinal tap

16.81A Spinal tap for diagnosis or imaging studies	128.09	
NOTE: 1. May not be claimed in addition to HSC 50.98B or 50.99C.		
2. May be claimed in addition to a visit or consultation.		

16.83 Contrast myelogram

16.83A Lumbar, thoracic, cervical or complete	58.73	113.05
16.83B Supine myelography	33.23	
NOTE: May be claimed in addition to 16.83A.		
16.83C Cisternal or posterior fossa injection	112.44	134.04

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

16.89A Injection for discogram	96.21	
NOTE: May not be claimed in addition to an operative procedure.		
16.89B Percutaneous facet joint injection - Cervical	107.03	
NOTE: Refer to notes following HSC 16.89D.		
16.89C Percutaneous facet joint injection - Thoracic	107.03	
NOTE: Refer to notes following HSC 16.89D.		
16.89D Percutaneous facet joint injection - Lumbar/Sacral	107.03	

NOTE:
1. A maximum of four calls may be made per patient, per day regardless of level (HSCs 16.89B, 16.89C or 16.89D).
2. A maximum of twelve calls may be claimed per patient, per benefit year regardless of level (HSCs 16.89B, 16.89C or 16.89D).
3. HSCs 16.89B, 16.89C and 16.89D may not be claimed in addition to HSCs 13.53B, 13.59J, 92.78B or 92.78C.
4. HSCs X 55 or X 56 may only be claimed in addition to HSCs 16.89B, 16.89C or 16.89D once per year, per patient.

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

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

16.9 Other operations on spinal cord and canal structures
16.91 Injection of anesthetic into spinal canal for analgesia

		BASE	ANE
16.91A	Epidural/regional catheter insertion for pain control management, including set up and initial injection	106.74	
	NOTE: Refer to notes following 16.91B		
16.91B	Follow up encounter for pain control management subsequent to continuous epidural/regional catheter insertion for pain management	42.69	
	NOTE: 1. 16.91A and 16.91B may not be claimed: - for labour and delivery - in addition to an anesthetic for the same encounter. 2. A maximum of four 16.91B may be claimed per physician, per patient, per day, which may include: - up to two claims for regularly scheduled encounters, and - a maximum of two claims for unscheduled encounters. 3. Surcharge benefits may be claimed for unscheduled encounters in accordance with GR 15.		
16.91C	Epidural catheter insertion for labour analgesia including set-up and initial injection	106.74	
	NOTE: Refer to notes following 16.91G for further information.		
16.91G	Epidural analgesia for labour and delivery, monitoring and/or top-up/adjustment, each additional full 5 minutes, per patient	16.93	
	NOTE: 1. May be claimed by an on-site physician when immediately available or when called to monitor or reassess the patient or top-up/adjust analgesia. 2. HSC 16.91G may not be claimed for the same patient until 35 minutes has elapsed from the time of the initiation of the HSC 16.91C recognizing that HSC 16.91C represents a full 30 minutes. 3. Concurrent billing for overlapping time for separate patient encounters/services may not be claimed. 4. Anesthetic benefits for a vaginal delivery by the same or a different physician may not be claimed in addition to HSCs 16.91C or 16.91G. 5. HSC 16.91F may be claimed for attendance at a forceps/vacuum delivery, vaginal breech delivery or vaginal delivery multiple birth, where an epidural was previously established by the same or different physician. 6. Listed anesthetic benefits for Cesarean section may be claimed in addition but not concurrently with HSC 16.91G, see Note 3. 7. A maximum of one surcharge benefit (SURC) for HSC 16.91G may be claimed per physician, per patient, if applicable, in accordance with GR 15.		

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

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

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

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

	BASE	ANE
16.91F Attendance at forceps/vacuum delivery, vaginal breech delivery or vaginal delivery multiple birth, where epidural was previously established	106.74	
NOTE: 1. May only be claimed when the physician is specially called and remains in attendance for the delivery. 2. May not be claimed if the delivery is by Caesarean section.		
16.92 Injection of other agent into spinal canal		
16.92A Implantation of intrathecal morphine infusion system	891.05	
16.92B Differential spinal block	340.25	
16.93 Insertion or replacement of spinal neurostimulator		
16.93A Implantation of epidural stimulator for intractable pain	1,003.88	263.79
16.93B Revision of epidural stimulator for intractable pain	1,003.88	244.96
NOTE: May not be claimed within 90 days subsequent to 16.93A.		
16.95 Spinal blood patch		
16.95A Epidural blood patch	111.47	
16.99 Other operations on spinal cord and spinal canal structures NEC		
16.99A Epidural injection of steroids	113.21	

17 OPERATIONS ON CRANIAL AND PERIPHERAL NERVES

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

17.02 Acoustic neurotomy		
17.02A Trans-labyrinthine resection of acoustic neuroma	1,023.95	354.04
17.02B Middle fossa approach for acoustic neuroma	1,252.84	411.04
17.03 Division of trigeminal nerve		
17.03A Trigeminal rhizotomy	1,003.88	282.64
17.05 Other incision of cranial and peripheral nerves		
Exploration of peripheral nerve (post traumatic neuropraxia)		
17.05A Major, proximal to mid palm	272.65	169.57
17.05B Minor, distal to mid palm	168.78	113.05
17.08 Other excision or avulsion of cranial and peripheral nerves		
17.08A Morton's neuroma, excision	175.80	113.05
17.08B Excision of neuroma on peripheral nerve	285.45	150.73
17.08C Obturator neurectomy	238.21	134.04
17.08D Avulsion of supra-orbital or infra-orbital nerves	210.74	111.71
17.08E Avulsion of suboccipital nerve	199.56	111.71
17.08F Differential section of facial nerve	396.76	178.71

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

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

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

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

	BASE	ANE
17.08H Trans-labyrinthine section of eight nerve	699.60	339.56
17.08J Transantral vidian neurectomy	347.91	180.72
17.08K Retrolabyrinthine selective vestibular neurectomy	2,917.93 V	786.33
NOTE: 1. Includes intraoperative electrodiagnostic monitoring. 2. For otolaryngological component - refer to Price List.		

17.1 Destruction of cranial and peripheral nerves

17.1 A Injection of alcohol, Trigeminal	168.57	112.95

17.2 Suture of cranial and peripheral nerves

17.2 A Peripheral nerve repair - major	233.70	169.57
17.2 B Peripheral nerve repair - minor	194.75	113.05
Microsurgical anastomosis of intracranial portion of cranial nerve		
17.2 C Without graft, to include craniotomy	1,634.31	596.35
NOTE: With other intracranial procedures, price will be modified, refer to Price List.		

17.3 Freeing of adhesions and decompression of cranial and peripheral nerves

17.31 Decompression of trigeminal nerve root

17.31A Craniotomy with microvascular decompression of cranial nerve V (Trigeminal)	2,007.75	584.12

17.32 Other cranial nerve decompression

17.32A Facial nerve decompression	678.93	316.79
NOTE: May not be claimed in addition to HSCs 52.31A, 52.31B, 52.31C or 52.31D by the same or different physician at the same encounter.		
17.32B Craniotomy with microvascular decompression of cranial nerve VII (facial nerve)	2,007.75	560.20
17.32C Facial nerve decompression with insertion of graft	703.13	280.09
17.33 Release of carpal tunnel	285.63	113.05
NOTE: May not be claimed in addition to HSC 17.39C.		

17.39 Other peripheral nerve or ganglion decompression or freeing of adhesions

17.39A Neurolysis, external and interfascicular release of nerve from scar tissue	428.45	207.27

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

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

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

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

		BASE	ANE
17.39B	Major nerve exploration	395.56	169.57
	NOTE: 1. May not be claimed for the release of carpal tunnel (HSC 17.33) or procedures/diagnostic conditions related to carpal tunnel. 2. May not be claimed in addition to HSC 17.39C.		
17.39C	Release ulnar nerve (includes transposition)	394.99	169.57
	NOTE: May not be claimed with HSCs 17.5 A, 17.33 or 17.39B.		
17.39D	Brachial plexus exploration, full 60 minutes or major portion thereof for the first call when only one call is claimed	649.16	207.27
	NOTE: 1. May not be claimed with other procedures. 2. Each subsequent 15 minutes, or major portion thereof, is payable at the rate specified on the Price List after the first full 60 minutes has elapsed.		
17.39E	Neurolysis, lateral cutaneous nerve of thigh, minor	103.70 V	112.95
17.39F	Decompression recurrent laryngeal nerve	278.05	151.90
	NOTE: May only be claimed in addition to thyroid surgery (HSCs 19.3 A or 19.3 B) when the nerve is encased in malignant disease or in repeat thyroid procedures.		

17.4 Cranial or peripheral nerve graft

	Microsurgical anastomosis of intracranial portion of cranial nerve		
17.4 A	With graft to include craniotomy	1,467.89	661.24
	NOTE: With other intracranial procedures, price will be modified, refer to Price List.		
	Peripheral nerve reconstruction utilizing microsurgical technique		
17.4 B	Minor, single cable	415.46	298.17
17.4 C	Major, multiple cables	1,038.66	527.59

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

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

17.5 Transposition of cranial and peripheral nerves

	BASE	ANE
17.5 A Transposition of peripheral neuroma	284.90	142.97
NOTE: May not be claimed with 17.39C.		
17.5 D Submuscular ulnar nerve transposition	527.41	188.43

17.6 Other cranial or peripheral neuroplasty

17.61 Anastomosis of cranial or peripheral nerve

17.61A Spino facial or facio hypoglossal anastomosis	571.26	223.38
17.61B Peripheral repair using microsurgical technique, primary	415.46	169.57

17.63 Repair of old traumatic injury of cranial and peripheral nerves

17.63A Peripheral repair using microsurgical technique, secondary	519.33	223.59

17.7 Injection into peripheral nerve

17.71 Peripheral nerve injection, unqualified

17.71A Local block(s) of somatic nerve(s)	26.07	
NOTE: May not be claimed with any other procedure at the same encounter by the same or different physician except for HSC 95.94C.		
17.71B Femoral nerve block - injection with or without ultrasound	60.66	
NOTE: 1. May not be claimed for services related to chronic pain management or treatment. 2. May not be claimed in addition to any other anesthetic services by the same physician. 3. May be claimed in addition to a visit or consultation by the same physician. 4. May not be billed with a visit if another physician has provided and claimed a visit on the same date of service in the same location.		

17.8 Invasive diagnostic procedures on peripheral nervous system

17.81 Biopsy of peripheral nerve or ganglion

17.81A Sural nerve biopsy	105.53 V	113.05
17.81B Fascicular nerve biopsy, with operating microscope	224.35	111.81

17.89 Other invasive diagnostic procedures on cranial and peripheral nerves

17.89A Intraoperative neural electrodiagnostic monitoring	240.93	
NOTE: 1. One fee only payable per sitting irrespective of the number of nerves involved. 2. May be claimed in addition to items 16.1A, 16.1D, 16.3B, 16.3D, 16.5A 16.49A and 16.09F.		

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

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

17.9 Other operations on cranial and peripheral nerves

17.92 Implantation or replacement of peripheral neurostimulator

	BASE	ANE
17.92A Sacral nerve root stimulator, peripheral nerve evaluation, first full 30 minutes or major portion thereof for the first call when only one call is claimed	136.45	113.05
NOTE: 1. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List after the first full 30 minutes has elapsed. 2. The anesthetic rate for HSC 17.92A may not be claimed in addition to an anesthetic rate for any other service.		
17.92B Sacral nerve root stimulator, implantation of pulse generator, first full 30 minutes or major portion thereof for the first call when only one call is claimed	131.36	113.05
NOTE: 1. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List after the first full 30 minutes has elapsed. 2. The anesthetic rate for HSC 17.92B may not be claimed in addition to an anesthetic rate for any other service.		
17.92C Sacral nerve root stimulator, first or second stage (permanent implant), first full 60 minutes or major portion thereof for the first call when only one call is claimed	522.19	113.05
NOTE: 1. Each subsequent 15 minutes, or major portion thereof, may be claimed at the rate specified on the Price List after the first full 60 minutes has elapsed. 2. The anesthetic rate for HSC 17.92C may not be claimed in addition to an anesthetic rate for any other service.		

18 OPERATIONS ON SYMPATHETIC NERVES OR GANGLIA

18.1 Sympathectomy

18.13 Lumbar sympathectomy

18.13A Thoracic or thoracolumbar	525.20	298.15
18.13B Lumbar	443.80	187.66
18.14 Presacral sympathectomy Presacral neurectomy	316.85	142.97

18.2 Injection into sympathetic nerve or ganglion

18.22 Injection of neurolytic agent into sympathetic nerve

18.22A With sclerosing agents (alcohol)	126.35	
18.22B Celiac plexus ganglion block, with sclerosing agents (alcohol or phenol)	133.62	

18.29 Other injection into sympathetic nerve or ganglion

18.29A Chemical sympathectomy under fluoroscopic or CT control	200.54	

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

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

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

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

		BASE	ANE
18.29B	Lumbar sympathetic block	108.58	
18.29C	Stellate ganglion block	107.77	
18.29D	Sphenopalatine ganglion block	112.11	
18.29E	Paravertebral block	107.03	

NOTE:
1. When claimed for a diagnostic branch block of a spinal facet joint, one call may be claimed for each individual joint blocked. For example, L4/5 and L5/S1 on the right is two calls. L4/5 and L5/S1 bilaterally is four joints; therefore four calls.
2. Up to three calls may be claimed per side when nerves for that number of joints are blocked, for a maximum of six calls.
3. The first joint (cervical, thoracic, or lumbar) for Diagnostic medial branch block(s) requires two needle placements, each additional contiguous joint requires one additional needle placement.
4. Branch blocks of a spinal facet joint may only be claimed for diagnostic procedures, not for therapeutic use.
5. May not be used in place of HSCs 16.89B, 16.89C, or 16.89D for facet joint injections when the limits for HSC 16.89 have otherwise been reached.
6. Fluoroscopy HSC (X107A) may only be submitted for the first call.

18.29EA	Sacroiliac block	107.03	

NOTE:
1. May only be claimed for a diagnostic branch block of a sacroiliac joint, one call may be claimed for each individual joint blocked.
2. Two calls may be claimed for bilateral sacroiliac joints. Refer to Price List.
3. When claimed in addition to HSC 18.29E on the same date of service, only one benefit for HSC X107A may be claimed.

18.29F	Radiofrequency ablation of the facet joint medial branch nerves, using fluoroscopic guidance	469.85	

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

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

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

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

	BASE	ANE
NOTE: 1. One call applies for each individual spinal facet joint treated. For example, L4/5 and L5/S1 on the right is two calls. L4/5 and L5/S1 bilaterally is four joints, therefore four calls. 2. Up to three calls may be claimed per side when nerves for that number of joints are ablated, for a maximum of six calls bilaterally. 3. HSC 18.29E or 18.29EA may not be claimed on the same day. 4. When claimed in addition to HSC 18.29FA on the same date of service, only one benefit for HSC X107A may be claimed.		
18.29FA Radiofrequency ablation of the sacroiliac joint lateral branch nerves, using fluoroscopic guidance	704.78	
NOTE: 1. Two calls may be claimed for bilateral sacroiliac joints. Refer to Price List. 2. When claimed in addition to HSC 18.29F on the same date of service, only one benefit for HSC X107A may be claimed. 3. HSC 18.29E or 18.29EA may not be claimed on the same day.		
18.29G Genicular nerve(s) block	107.03	
NOTE: 1. Benefit includes all nerves blocked in the same knee on the same date of service. 2. Two calls may be claimed for bilateral services and will be paid at the rate identified in the Price List. 3. Fluoroscopy HSC X107A may only be claimed once per encounter. 4. HSC 18.29GA may not be claimed on the same date of service by the same or different physician.		
18.29GA Radiofrequency ablation of genicular nerve(s)	325.00	
NOTE: 1. Benefit includes all nerves ablated in the same knee on the same date of service. 2. Two calls may be claimed for bilateral services and will be paid at the rate identified in the Price List. 3. Fluoroscopy HSC X107A may only be claimed once per encounter. 4. HSC 18.29G may not be claimed on the same date of service by the same or different physician. 5. A maximum of 4 HSC 18.29GAs may be claimed per patient per calendar year or twice per knee per patient per calendar year.		

III. OPERATIONS ON THE ENDOCRINE SYSTEM

19 OPERATIONS ON THYROID AND PARATHYROID GLANDS

19.0 Incision of thyroid field

19.09 Other incision of thyroid field

		BASE	ANE
19.09A	Exploration of the neck for penetrating injury, first hour of operating time NOTE: 1. May only be claimed for trauma patients. 2. Other procedures may be claimed in addition but the time spent in performing them may not be included in the time claimed for this procedure. 3. Each subsequent 15 minutes or major portion thereof may be claimed at the rate specified on the Price List. 4. A maximum of three hours may be claimed.	398.47	324.89

19.1 Unilateral thyroid lobectomy

19.1	Total thyroid lobectomy	720.15	320.33

19.3 Complete thyroidectomy

19.3 A	Total thyroidectomy	1,328.23	527.59
19.3 B	Total thyroidectomy with formal neck dissection	1,760.99	734.85

19.6 Excision of thyroglossal duct or tract

19.6 A	Thyroglossal duct excision	427.81	188.43
19.6 B	Recurrent thyroglossal duct excision	638.29	263.79

19.7 Parathyroidectomy

19.7 A	Parathyroidectomy NOTE: Benefit for a re-operation; use modifier REANE or REOP; refer to the Price List.	1,227.26	640.65
19.7 B	Parathyroidectomy with mediastinal exploration NOTE: May not be claimed in addition to HSC 20.73.	1,593.88	697.17

19.8 Invasive diagnostic procedures on thyroid and parathyroid glands

19.81	Percutaneous (needle) biopsy of thyroid	67.23 V	112.95

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

20 OPERATIONS ON OTHER ENDOCRINE GLANDS

		BASE	ANE
20.1	Partial adrenalectomy		
20.12	Unilateral adrenalectomy	1,041.33	362.31
20.12A	Unilateral laparoscopic adrenalectomy	1,285.81	588.73
20.5	Hypophysectomy		
20.54	Total excision of pituitary gland, transfrontal approach	1,888.89	661.24
20.55	Total excision of pituitary gland, transsphenoidal approach		
20.55A	Total excision of pituitary gland, transsphenoidal approach NOTE: 1. Also applies to transethmoidal approach.	1,212.67	521.75
20.55B	Transphenoidal or transethmoidal hypophysectomy, Neurosurgical component	1,338.50	428.60
20.7	Thymectomy		
20.73	Total excision of thymus NOTE: May not be claimed in addition to HSC 19.7 B.	1,050.41	343.34

IV. OPERATIONS ON THE EYES

21 OPERATIONS ON LACRIMAL APPARATUS

21.3 Manipulation of lacrimal passage (tract)

21.31 Dilation of lacrimal punctum

		BASE	ANE
21.31A	Diagnostic irrigation of nasolacrimal duct, office procedure, per eye	31.59	
21.31B	Probing and irrigation of nasolacrimal duct for patients 18 years of age and under	263.63	113.05
	NOTE: 1. May only be claimed when performed in an operating room, day surgery or non hospital surgical facility. 2. Benefit rate includes both eyes.		

21.32 Probing of lacrimal canaliculi

21.32B	Catheterization of nasolacrimal duct	158.14	111.71
	NOTE: May be claimed when performed at the same time as 21.71.		
21.32C	Unilateral probing with intubation of nasolacrimal duct	290.05	113.05
21.32D	Replacement of Jones/bypass lacrimal tube, per eye	232.56	176.50

21.4 Incision of lacrimal sac and passage

21.41	Incision of lacrimal sac Drainage of lacrimal sac	79.07 V	111.71
21.42	Snip incision of lacrimal punctum	79.07 V	111.71

21.6 Repair of canaliculus and punctum

21.69 Other repair of canaliculus and punctum

21.69A	Non-surgical closure of punctum, insertion of punctual plugs, per eye	26.41 V	111.71
21.69B	Lacerated canaliculi repair	579.92	131.89
	NOTE: Benefit includes intubation.		
21.69C	Surgical closure of punctum, not punctal plugs, per eye	79.07 V	111.71

21.7 Fistulization of lacrimal tract to nasal cavity

21.71	Dacryocystorhinostomy (DCR) NOTE: May not be claimed in addition to HSCs 33.01A, 33.51B, 33.76C, 34.54A and 34.89A.	632.58	167.71
21.72	Conjunctivocystorhinostomy	685.24	171.67

22 OPERATIONS ON EYELIDS

22.1 Excision of lesion or tissue of eyelid

22.13 Other excision of single lesion of eyelid

22.13A	Excision of eyelid lesion requiring pathology analysis	158.14	111.81
	NOTE: Single fee applies regardless of whether the upper or lower or both eyelids of same eye are involved. If second eye needs to be done, the fee for the second eye may be claimed at 75%.		

IV. OPERATIONS ON THE EYES (cont'd)

22 OPERATIONS ON EYELIDS (cont'd)

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

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

		BASE	ANE
22.13B	Chalazion - surgical removal	121.20 V	113.05
	NOTE: May be claimed in addition to a visit or consultation.		
22.13C	Non cosmetic excision of benign tumor of eyelid not requiring pathology analysis, for functional reasons including obstruction of visual axis, tearing, inflammation or lid malposition	80.64 V	112.95
	NOTE: For services requiring pathology analysis see HSC 22.13A.		

22.3 Correction of entropion or ectropion

22.32A	Major full thickness repair of lid involving eyelid margin entropion, ectropion, trauma or tumor)	465.11	126.50

22.39 Other correction of entropion or ectropion

22.39A	Non full thickness lid procedure for entropion, ectropion or lid repair . .	318.53	113.05

22.4 Correction of blepharoptosis

22.4 A	Eyelid ptosis repair requiring surgery on eyelid retractors - muller, levator, frontalis and/or lower lid equivalent	728.57	153.59

22.5 Blepharorrhaphy

22.5 A	Simple suture	144.33 V	111.81
	NOTE: Single fee applies regardless of whether the upper or lower or both eyelids of same eye are involved. If second eye needs to be done, the fee for the second eye may be claimed at 75%.		
22.5 B	Surgical tarsorrhaphy	316.29	111.71
	Not to be used for botox		

22.51 Functional blepharoplasty - upper eyelid - without cosmetic intent

22.51A	Functional blepharoplasty - upper eyelid - without cosmetic intent	395.53	153.59
	NOTE: May only be claimed for patients where at least half the pupil is covered by the skin of the upper eyelids. Sufficient evidence to support this must be documented in the patient record.		

22.6 Other repair of eyelid

22.62 Rhytidectomy of eyelid

22.62A	Lower/upper repair of redundant skin	196.00	112.95
	NOTE: Single fee applies regardless of whether the upper or lower or both eyelids of same eye are involved. If second eye needs to be done, the fee for the second eye may be claimed at 75%.		

IV. OPERATIONS ON THE EYES (cont'd)

22 OPERATIONS ON EYELIDS (cont'd)

22.6 Other repair of eyelid (cont'd)

22.69 Other eyelid repair

	BASE	ANE
22.69B Major full thickness lid repair with flap or graft	930.05	244.96
NOTE: Single fee applies regardless of whether the upper or lower or both eyelids of same eye are involved. If second eye needs to be done, the fee for the second eye may be claimed at 75%.		

22.7 Epilation of eyelid

22.71 Electrosurgical epilation requiring injection of anesthesia	142.26	

22.8 Invasive diagnostic procedures on eyelid

22.81 Biopsy of eyelid	81.38 V	111.71
NOTE: Single fee applies regardless of whether the upper or lower or both eyelids of same eye are involved. If second eye needs to be done, the fee for the second eye may be claimed at 75%.		

23 OPERATIONS ON OCULAR MUSCLES OR TENDONS

23.9 Other operations on ocular muscles or tendons

23.99 Other operations on ocular muscles or tendons NEC

23.99A Strabismus repair, one muscle	711.82	169.57
NOTE: 1. Subsequent muscles, regardless if the same or different eye, are paid at a reduced rate as indicated in the Price List to a maximum benefit of five.		
2. The add on fee applies once only per eye for a re-operation.		
23.99C Strabismus repair, adjustable suture technique, additional benefit	368.95	111.71
NOTE: 1. May only be claimed in addition to HSC 23.99A.		
2. Single benefit applies regardless of the number of adjustable sutures used.		
23.99D Injection of Botulinum A Toxin	130.59	
For strabismus, blepharospasm or hemifacial spasm		
NOTE: May be claimed in addition to a visit or consultation.		

24 OPERATIONS ON CONJUNCTIVA

24.1 Other incision of conjunctiva

24.1 A Peritomy	158.14	111.71
NOTE: May not be claimed in addition to any other procedure on the same date of service.		

IV. OPERATIONS ON THE EYES (cont'd)

24 OPERATIONS ON CONJUNCTIVA (cont'd)

	BASE	ANE
24.2 Excision or destruction of lesion or tissue of conjunctiva		
24.22 Excision of lesion or tissue of conjunctiva		
24.22A Conjunctival biopsy or simple tumor excision with pathology analysis	131.90 V	113.05
24.3 Conjunctivoplasty		
24.31 Reconstruction of conjunctival cul-de-sac with buccal mucous membrane graft		
24.31A Reconstruction of conjunctival fornix with graft	930.05	180.72
24.32 Other reconstruction of conjunctival cul-de-sac		
24.32A Other reconstruction of conjunctival fornix	465.11	186.34
24.35 Conjunctival flap		
24.35A Conjunctival flap for corneal ulcer	465.11	113.05
24.5 Suture of conjunctiva		
24.5 Suture of conjunctiva	158.14 V	111.71
NOTE: May not be claimed in addition to other procedures at the same encounter.		
24.89 Other invasive diagnostic procedures on conjunctiva Allergy testing		
24.89A Conjunctival test, per test	7.96	
NOTE: 1. A maximum of 15 calls may be claimed per patient, per benefit year except when the patient has been referred to a specialist in which case the specialist may also claim a maximum of 15 calls.		
2. Benefits do not include the cost of materials.		
24.89B Diagnostic conjunctival scraping	18.65	
24.9 Other operations on conjunctiva		
24.91 Subconjunctival injection	36.95	
NOTE: 1. May not be claimed in addition to other procedures at the same encounter.		
2. May not be claimed for injection of local anesthetics.		

25 OPERATIONS ON CORNEA

25.1 Incision of cornea		
25.1 A Removal of corneal foreign body	40.92 V	112.95
25.2 Excision of pterygium		
25.21 Excision or transposition of pterygium with graft		
25.21A Excision of pterygium with graft	465.11	150.73

IV. OPERATIONS ON THE EYES (cont'd)

25 OPERATIONS ON CORNEA (cont'd)

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

	BASE	ANE
25.29 Other excision of pterygium		
25.29A Excision of pterygium without graft	171.44	113.05
25.3 Excision or destruction of other lesion or tissue of cornea		
25.39 Other removal or destruction of corneal lesion		
25.39A Excision of corneal dermoid	206.31	144.57
25.39B Malignant tumor of cornea	516.91	151.90
25.39C Superficial keratectomy	314.22	125.10
25.39D Phototherapeutic keratectomy - for corneal scar, epithelial irregularity or amblyogenic refractive error	465.11	
NOTE: May not be claimed for routine refractive purposes.		
25.4 Suture of cornea		
25.4 A Traumatic corneal wound repair that with sutures	1,033.29	113.05
25.5 Corneal transplant		
25.53 Lamellar keratoplasty (with homograft)		
25.53A Anterior lamellar keratoplasty with graft	930.05	226.10
25.53B Deep anterior lamellar keratoplasty with graft	1,394.82	301.47
25.53C Endothelial keratoplasty	1,033.29	301.47
25.55 Penetrating keratoplasty (with homograft)		
25.55A Penetrating keratoplasty	1,291.57	301.47
25.6 Other repair of cornea		
25.63 Keratoprosthesis	1,550.03	294.87
25.69 Other repair of cornea		
25.69A Therapeutic corneal cross-linking examination for progressing cases of keratoconus or pellucid marginal degeneration, per eye	1,278.28	153.59

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

IV. OPERATIONS ON THE EYES (cont'd)

25 OPERATIONS ON CORNEA (cont'd)

25.8 Invasive diagnostic procedures on cornea
25.81 Scraping of cornea for smear or culture

	BASE	ANE
25.81A Diagnostic corneal scraping	18.65	

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

26.2 Operations for the relief of intraocular tension

26.2 B Glaucoma implant procedures with reservoir shunts	1,241.68	320.33

26.25 Trabeculectomy ab externo

26.25B Trabeculectomy or major revision of trabeculectomy	981.67	226.10

26.29 Other relief of intraocular circulation

26.29A Ab-interno angle surgery (stent, trabectome or similar) for adult open-angle glaucoma	474.43	226.10
26.29B Transcleral drainage of choroidal hemorrhages or subretinal fluid	344.43	261.39

26.3 Facilitation of intraocular circulation

26.34 Trabeculotomy ab externo

26.34A Argon laser trabeculoplasty, selective laser trabeculoplasty, iridoplasty, goniopuncture	421.78	320.09

26.4 Excision or destruction of lesion of iris, ciliary body, and sclera

26.45 Excision of lesions of ciliary body	1,808.31	285.95

26.5 Other iridectomy or iridotomy
26.52 Other iridotomy

26.52A Peripheral iridotomy - laser NOTE: May not be claimed for capsulotomy.	316.29	135.53

26.53 Iridectomy (basal)

26.53A Surgical iridectomy	516.73	167.71

26.6 Iridoplasty
26.62 Freeing of other anterior synechiae

26.62A Freeing of angle closure synechiae under gonioscopy	230.66	111.81

26.69 Other iridoplasty

26.69A Iridodialysis, repair	516.91	153.59

26.7 Scleroplasty

26.71 Suture of complicated (traumatic) laceration of sclera with or without laceration to cornea	1,550.03	181.14

26.79 Other scleroplasty

26.79A Scleroplasty/scleral resection	961.99	279.52

IV. OPERATIONS ON THE EYES (cont'd)

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

	BASE	ANE
26.9 Other operations on iris, ciliary body, sclera, and anterior chamber		
26.91 Aspiration of anterior chamber		
26.91A Aspiration or tap of anterior chamber through new wound	113.77 V	111.71
26.91B Anterior chamber washout for hyphema	413.32	125.10
26.97 Other operations on sclera		
26.97B Placement of radioactive plaque with suturing to sclera	836.99	
26.98 Other operations on anterior chamber		
26.98B Ciliary body ablation	594.25	223.59

27 OPERATIONS ON LENS

27.3 Discission of lens and capsulotomy		
27.3 C Yttrium Aluminium Garnet (YAG) laser capsulotomy NOTE: Two calls may be claimed for bilateral services.	210.80	111.71
27.4 Intracapsular extraction of lens		
27.4 A Intracapsular extraction of lens with or without intraocular lens	775.01	205.53
27.5 Extracapsular extraction of lens		
27.5 A Pediatric cataract extraction May only be claimed for children 6 years of age and under	1,033.29	282.63
27.5 B Extracapsular cataract extraction - non phacoemulsification - with or without intraocular lens	775.01	207.83
27.7 Insertion of prosthetic lens		
27.7 A Entry into anterior chamber for manipulation, repositioning of lens fragment, IOL or foreign body	344.43	112.95
27.7 C Remove, replace or repositioning of subluxed or dislocated intraocular lens (IOL) or secondary insertion of posterior chamber intraocular lens with or without suturing	729.09	207.27
27.7 D Removal, replace or repositioning of posteriorly dislocated pseudophakos, with secondary suturing	1,027.25	285.95
27.72 Insertion of intraocular lens prosthesis with cataract extraction, one stage		
27.72A Phacoemulsification cataract extraction, anterior approach, with or without insertion of intraocular lens	409.96	100.73
27.73 Secondary insertion of intraocular lens prosthesis		
27.73A Secondary insertion of anterior chamber intraocular lens, includes peripheral iridectomy	681.27	189.74

IV. OPERATIONS ON THE EYES (cont'd)

27 OPERATIONS ON LENS (cont'd)

27.9 Other operations on lens

27.99 Other operations on lens NEC

	BASE	ANE
27.99A Dislocated lens, removal	769.14	205.53

28 OPERATIONS ON RETINA, CHOROID, AND VITREOUS

28.2 Scleral buckling with implant

28.2 B Segmental retinal repair	928.15	282.63
28.2 C Scleral buckling and encircling tubing	997.38	320.33
28.2 D Removal of scleral buckle material	697.49	529.34

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

28.4 Other operations for repair of retina

28.4 A Light coagulation or cryopexy - posterior segment (repair of retinal tears)	427.65	111.71
28.4 B Light coagulation or cryopexy with drainage of subretinal fluids	864.62	223.38

28.5 Excision or destruction of lesion of retina or choroid

28.5 A Posterior segment cryopexy or focal or grid laser	427.65	111.71
28.5 B Cryopexy or laser treatment for retinopathy of prematurity	782.95	126.50

28.54 Destruction of lesion of retina or choroid by unspecified photocoagulation

28.54A Panretinal photocoagulation	579.92	111.71

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

28.7 Operations on vitreous

28.71 Removal of vitreous, anterior approach (partial)

28.71A Anterior vitrectomy using automated vitrector at the time of anterior segment surgery (complex cataract, trauma, keratoplasty, glaucoma filtering procedure)	344.43	169.57

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

28.72 Removal of vitreous, other approach

28.72A Aspiration/washout of vitreous cavity with replacement	516.91	153.59
28.72B Posterior total vitrectomy with 2 or 3 port infusion and cutting device	990.30	320.33
28.72C Posterior capsulotomy when performed with posterior vitrectomy	105.49	80.06

28.73 Injection of vitreous substitute

28.73A Pneumatic retinopexy - includes cryopexy, and/or laser, and/or gas injection, and/or paracentesis, and/or fluid drainage	526.40	399.50

IV. OPERATIONS ON THE EYES (cont'd)

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

28.7 Operations on vitreous (cont'd)

28.73 Injection of vitreous substitute (cont'd)

	BASE	ANE
28.73B Addition or removal of gas or air injection	150.38	
NOTE: Payable within 60 days following scleral buckling (HSC 28.2 C) or pneumatic retinopexy (HSC 28.73A).		

28.74 Discission of vitreous strands

28.74B Stripping of premacular membrane associated with vitrectomy	1,311.77	393.17

28.79 Other operations on vitreous

28.79B Intravitreal injection for drug delivery	112.00	111.71
28.79C Aspiration of vitreous for diagnostic purposes with or without intravitreal injection for drug delivery	238.08	180.69
NOTE: May not be claimed for injecting anti Vascular Endothelial Growth Factor (VEGF) medications.		

28.8 Invasive diagnostic procedures on retina, choroid, and vitreous

28.8 A Eye tumor localization or planning of plaque placement	310.07 V	111.71

28.81 Biopsy of retina, choroid, and vitreous

28.81A Biopsy of retina or choroid including intraoperative laser	516.73	111.71

29 OPERATIONS ON ORBIT AND EYEBALL

29.0 Orbitotomy

29.0 A Orbitotomy - exploration and/or biopsy	529.34	150.73
29.0 B Orbitotomy for decompression	930.05	339.16
NOTE: A second, third or fourth call may be claimed at the rate specified on the Price List.		
29.0 C Orbitotomy - incision and drainage of abscess	462.85	112.95

29.01 Orbitotomy with frontal approach

29.01A Removal of anterior orbital tumor including lacrimal gland biopsy if performed	697.49	150.73

29.02 Orbitotomy with lateral approach

29.02A Complicated orbital reconstruction or tumor excision - first 90 minutes	1,704.89	411.04

29.2 Evisceration of eyeball

29.21 Removal of ocular contents with implant into scleral shell

29.21A Evisceration with or without implant	930.05	169.57

IV. OPERATIONS ON THE EYES (cont'd)

29 OPERATIONS ON ORBIT AND EYEBALL (cont'd)

29.2 Evisceration of eyeball (cont'd)

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

	BASE	ANE
29.29 Other evisceration of eyeball	708.39	134.04

29.3 Removal of eyeball

29.31 Enucleation of eyeball with implant into tenon's capsule with attachment of muscles

29.31A Enucleation with or without implant into tenon's capsule with attachment of extra ocular muscles	1,162.43	169.57

29.4 Exenteration of orbital contents

29.4 A Exenteration of orbital contents with or without flap graft	1,445.06	207.83

29.5 Insertion of ocular or orbital implant

29.55 Other reinsertion of ocular implant

29.55A Replacement of socket implant or dermal fat graft to socket	874.80	144.57

29.9 Other operations on orbit or eyeball

29.91 Retrobulbar injection of therapeutic agent	131.90	

29.99 Other operations on eye, unspecified structure or type

29.99A Removal of intraocular foreign body	516.91	162.64

V. OPERATIONS ON THE EARS

30 OPERATIONS ON EXTERNAL EAR

	BASE	ANE
30.1 Excision or destruction of lesion of external ear		
30.1 A Removal of osteoma of ear canal	184.46	113.05
30.11 Excision of preauricular sinus		
30.11A Excision of preauricular sinus, primary	154.32	113.05
30.11B Secondary excision of preauricular sinus	328.73	171.67
30.19 Excision or destruction of other lesion of external ear		
30.19A Aural polyp removal	26.94 V	111.71
30.19B Excision of accessory auricle	112.69 V	112.95
30.3 Suture of (traumatic) laceration of external ear		
30.3 A Post traumatic major ear reconstruction	411.81	226.10
30.4 Surgical correction of prominent ear		
30.4 A Otoplasty NOTE: Patient under 19 years of age.	467.40	150.73
30.6 Other plastic repair of external ear		
30.61 Construction of auricle of ear		
30.61A Major ear reconstruction, cartilage graft and flap or skin graft, per 60 minutes or major portion thereof for the first call when only one call is claimed NOTE: Refer to notes following HSC 30.61B.	649.16	1,030.04
30.61B Major ear reconstruction, cartilage graft, per 60 minutes or major portion thereof for the first call when only one call is claimed NOTE: 1. HSCs 30.61A and 30.61B may not be claimed with other procedures. 2. Benefits for HSCs 30.61A and 30.61B include harvesting and preparation of cartilage.	649.16	668.63
30.8 Invasive diagnostic procedures on external ear		
30.81 Biopsy of external ear		
30.81A Punch biopsy	30.17	
30.9 Other operations on external ear		
30.9 A Closure of post-auricular fistula	126.68 V	111.71

31 RECONSTRUCTIVE OPERATIONS ON MIDDLE EAR

31.0 Stapes mobilization		
31.0 Stapes mobilization	336.95	180.72
31.1 Stapedectomy		
31.1 A Stapedectomy, stapedoplasty or fenestration of oval window	718.65	226.10
31.19 Other stapedectomy		
31.19A Laser stapedotomy	934.15	607.62

V. OPERATIONS ON THE EARS (cont'd)

31 RECONSTRUCTIVE OPERATIONS ON MIDDLE EAR (cont'd)

		BASE	ANE
31.3	Other operations on ossicular chain		
31.3 A	Ossicular reconstruction	743.31	395.68
31.4	Myringoplasty		
31.4	Myringoplasty Tympanoplasty	489.91	188.43
31.5	Other tympanoplasty		
31.5 A	Tympanoplasty with antrotomy	561.59	244.96
31.9	Other repair of middle ear		
31.9 A	Excision of glomus tumors, trans-tympanotomy approach	499.95	171.67

32 OTHER OPERATIONS ON MIDDLE AND INNER EAR

		BASE	ANE
32.0	Myringotomy		
32.01	Myringotomy with insertion of tube		
32.01A	Myringotomy With insertion of tube NOTE: Single anesthetic benefit applies regardless of whether the procedure is performed bilaterally.	62.09 V	113.05
32.1	Removal of tympanostomy tube		
32.1	Removal of tympanostomy tube NOTE: 1. May be claimed when performed under anesthesia. 2. If under local anesthesia, claim the appropriate office visit.	70.31 V	153.59
32.2	Incision of mastoid and middle ear		
32.21	Incision of mastoid		
32.21A	For removal of foreign body	115.21 V	111.71
32.23	Incision of middle ear		
32.23A	Tympanotomy (exploratory) elevation of tympanomeatal flap	122.36 V	150.73
32.3	Mastoidectomy		
32.31	Simple mastoidectomy	310.93	153.59
32.32	Radical mastoidectomy		
32.32A	Radical or modified mastoidectomy	690.34	207.27
32.32B	Radical or modified radical mastoidectomy, with tympanoplasty	935.98	301.47
32.39	Other mastoidectomy		
32.39A	Antrotomy	105.01 V	111.71
32.39B	Repair of atresia of ear, incomplete	373.94	198.79

V. OPERATIONS ON THE EARS (cont'd)

32 OTHER OPERATIONS ON MIDDLE AND INNER EAR (cont'd)

32.3 Mastoidectomy (cont'd)

32.39 Other mastoidectomy (cont'd)

		BASE	ANE
32.39C	Repair of atresia of ear, complete	808.60	339.16
32.79B	Excision of glomus tumors, including resection of jugular bulb, internal jugular vein and sigmoid sinus	1,202.16	452.21
32.79G	Labyrinth destruction, destruction of vestibular organ by cryotherapy	352.48	187.66
32.79H	Labyrinth destruction, chemical	504.52	180.72

32.8 Invasive diagnostic procedures on middle and inner ear

32.81 Electrocochleography 127.84
Promontory stimulation test
NOTE: Includes the technical and professional components.

32.9 Other operations on middle and inner ear and eustachian tube

32.95 Implantation of electro-magnetic hearing aid

32.95A Ear implant intracochlear, multiple or single channel 1,247.82 508.74
NOTE: A second call may be claimed at 75%, for bilateral ear implants.

32.96 Other operations on middle and inner ear

32.96A Debridement of mastoid cavities and/or repair of small perforation under microscopy 27.39
NOTE: May not be claimed for removal of cerumen

32.96B Debridement of mastoid cavities and/or repair of small perforation under microscopy 93.14 188.42
NOTE: 1. May not be claimed for removal of cerumen.
2. May only be claimed when performed as a sole procedure and under general or regional anesthesia excluding topical anesthesia techniques.

VI. OPERATIONS ON THE NOSE, MOUTH,AND PHARYNX

33 OPERATIONS ON NOSE

33.0 Control of epistaxis

33.01 Control of epistaxis by anterior nasal packing

	BASE	ANE
33.01A Control of epistaxis by anterior nasal packing with or without cautery	101.25	

NOTE: 1. Benefit includes visit.
2. May not be claimed in addition to HSC 21.71.

33.02 Control of epistaxis by posterior (and anterior) packing

33.02A Control of epistaxis by posterior and anterior packing	250.00	113.05

33.03 Control of epistaxis by cauterization (and packing)

33.03A Control of epistaxis by cautery	57.92 V	

NOTE: 1. Benefit includes visit.
2. A repeat performed within 14 days is payable at a reduced rate. Refer to Price List.

33.04 Control of epistaxis by ligation of ethmoidal arteries	280.79	113.05
33.05 Control of epistaxis by (transantral) ligation of the maxillary artery	505.89	169.57

33.1 Incision of nose

33.1 A Lateral rhinotomy/sublabial	291.30	144.57

33.2 Excision or destruction of lesion of nose

33.21 Excision of lesion of nose, unqualified

33.21A Cauterization of nasal turbinate	25.92	
33.21B Dermoid cyst	211.22	150.73

33.22 Local excision or destruction of intranasal lesion

33.22A Nasal polyp removal	89.03 V	104.13
33.22B Mucosal biopsy	58.42 V	112.95

NOTE: A maximum of three calls may be claimed.

33.3 Resection of nose

33.3 A Rhinophyma	323.71	216.84
33.3 B Rhinophyma with graft	502.23	232.32
33.4 C Septoplasty	331.93 V	124.96

NOTE: Benefit will be reduced if rhinoplasty is claimed by a second surgeon. Refer to Price List.

33.5 Turbinectomy

33.51 Turbinectomy by diathermy or cryosurgery

33.51A Submucosal diathermy of nasal turbinate	77.16 V	109.34
33.51B Other methods	96.79 V	109.34

NOTE: 1. Includes that with steroid injections.
2. May not be claimed in addition to HSC 21.71.

VI. OPERATIONS ON THE NOSE, MOUTH,AND PHARYNX (cont'd)

33 OPERATIONS ON NOSE (cont'd)

33.6 Reduction of nasal fracture
33.61 Reduction (closed) of nasal fracture

	BASE	ANE
33.61A Fracture intra-nasal reduction and splinting	129.83 V	112.95
33.62 Open reduction of nasal fracture		
33.62A And mini-plate fixation	519.33	189.74
33.62B Mini-plate fixation via coronal approach	1,142.53	607.62
33.7 Repair and plastic operations on the nose		
33.73 Rhinoplasty with implantation of inert material		
33.73A Silicone elastomer implant	182.63	125.10
33.74 Rhinoplasty with bone or cartilage graft		
33.74A Composite graft	428.18	180.72
NOTE: Composite graft claimed for reconstruction of full thickness alar or columellar defects.		
33.76 Other rhinoplasty or septoplasty		
33.76A Tip revision	224.64	130.17
33.76B Hump removal	180.80	153.59
33.76C Infracture	189.48	151.90
NOTE: May not be claimed in addition to HSC 21.71.		
33.76D Hump removal and infracture	246.68	153.59
33.76E Complete (hump removal, infracture and tip revision)	444.71	189.74
33.76F Complete rhinoplasty and S.M.R. (1 surgeon)	505.89	207.83
33.76G Repair of nasal septum perforation	339.24	144.57
33.76H Repeat reconstructive rhinoplasty following previous complete rhinoplasty	658.38	325.28
NOTE: May be claimed only when there is a history of a previous 33.76E.		
33.9 Other operations on nose		
33.99 Other operations on nose NEC		
33.99A Choanal atresia, intranasal	387.63	144.57
33.99B Choanal atresia, transpalatine	580.31	162.64

34 OPERATIONS ON NASAL SINUSES

34.0 Puncture of nasal sinus		
34.0 A Puncture and irrigation of maxillary sinus	24.20 V	109.34
34.1 Intranasal antrotomy		
34.1 A Intranasal antrostomy	96.34 V	104.13
34.2 External maxillary antrotomy		
34.2 A Caldwell Luc (radical)	310.93	180.72
34.2 B Caldwell Luc and closure of antra-oral fistula	419.59	171.67
34.21 Radical Maxillary antrotomy		
34.21A With obliteration by abdominal fat graft	415.94	214.45

VI. OPERATIONS ON THE NOSE, MOUTH,AND PHARYNX (cont'd)

34 OPERATIONS ON NASAL SINUSES (cont'd)

34.3 Frontal sinusotomy and sinusectomy
34.32 Frontal sinusectomy

		BASE	ANE
34.32A	Trephine	240.62	111.71
34.32B	Intranasal	440.60	151.90
34.32C	External (Lynch or Howarth type)	674.36	178.71
34.32D	Osteoplastic flap with obliteration by fat or bone graft	1,024.56	325.28

34.5 Other nasal sinusectomy
34.54 Ethmoidectomy

34.54A	Intranasal	246.55	104.13
	NOTE: May not be claimed in addition to HSC 21.71.		
34.54B	External	298.85	169.78
34.54C	Transantral	184.91	107.23
	NOTE: May be claimed in addition to 34.2 A.		

34.55 Sphenoidectomy

34.55A	Intranasal	184.91	104.13
34.55B	Transantral	100.45	35.74
	NOTE: May be claimed in addition to 34.2 A.		

34.8 Invasive diagnostic procedures on nasal sinus
34.89 Other invasive diagnostic procedures on nasal sinuses

34.89A	Sinus endoscopy with polypectomy	92.23 V	112.95
	NOTE: May not be claimed in addition to HSC 21.71.		

35 REMOVAL AND RESTORATION OF TEETH

35.0 Forceps extraction of tooth (multiple) (single)

35.0 A	Dental extraction/treatment	67.51 V
	NOTE: May be claimed when performed by a physician on an emergency basis or when required as part of surgical repair of fractured mandible.	

36 OTHER OPERATIONS ON TEETH, GUMS AND ALVEOLI

36.9 Other dental operations
36.99 Other dental operations NEC

36.99AA	Anesthetic fee for extensive dental rehabilitation treatment	149.93

VI. OPERATIONS ON THE NOSE, MOUTH,AND PHARYNX (cont'd)

36 OTHER OPERATIONS ON TEETH, GUMS AND ALVEOLI (cont'd)

36.9 Other dental operations (cont'd)
36.99 Other dental operations NEC (cont'd)

	BASE	ANE
NOTE: 1. May only be claimed when the conditions described in GRs 10.2 and 10.3 are met. 2. May only be claimed for dental rehabilitation for children 17 years and under when the scheduled length of the rehabilitation treatment is at least 60 minutes. 3. The extraction of wisdom teeth or any routine dental treatment alone is not considered to be extensive dental rehabilitation.		
36.99F Surgical assistant for dental surgery performed by oral surgeons	148.79	

37 OPERATIONS ON TONGUE

37.1 Partial glossectomy		
37.1 A Partial glossectomy	252.94	158.44
37.1 B Hemiglossectomy	396.31	277.28
37.2 Complete glossectomy		
37.2 Complete glossectomy	915.89	356.90
37.8 Invasive diagnostic procedures on tongue		
37.81 Needle biopsy of tongue	39.27 V	111.71
37.82 Other biopsy of tongue		
37.82A Biopsy of tongue	40.64 V	111.81
NOTE: A maximum of three calls may be claimed.		
37.82B Punch biopsy of tongue	29.68	
37.9 Other operations on tongue		
37.91 Lingual frenotomy		
37.91A Release of simple tongue tie, clipping	60.34	111.71
37.91B Release of complex tongue tie	205.00	131.89
That requiring Z plasty closure		

38 OPERATIONS ON SALIVARY GLANDS AND DUCTS

38.0 Incision of salivary gland or duct		
38.0 A Removal salivary gland calculus	108.67 V	112.95
38.2 Sialoadenectomy		
38.21 Sialoadenectomy, unqualified		
38.21A Submandibular gland	410.46	171.67
NOTE: Two calls may be claimed for bilateral services.		

VI. OPERATIONS ON THE NOSE, MOUTH,AND PHARYNX (cont'd)

38 OPERATIONS ON SALIVARY GLANDS AND DUCTS (cont'd)

38.2 Sialoadenectomy (cont'd)

38.22 Partial sialoadenectomy
Parotidectomy

	BASE	ANE
38.22A Subtotal with preservation of facial nerve	710.43	282.63
38.22B Subtotal repeat with preservation of facial nerve	983.01	397.56
38.22C Subtotal without preservation of facial nerve	147.02	111.71

38.23 Complete sialoadenectomy
Parotidectomy

38.23A Total with preservation of facial nerve	1,486.61	527.59
38.23B Total without preservation of facial nerve	1,041.91	393.17

NOTE: Two calls may be claimed for bilateral services.

38.8 Invasive diagnostic procedures on salivary gland or duct
38.89 Other operations on salivary gland or duct NEC

38.89A Sublingual mucosal biopsy	42.00 V	112.95

NOTE: A maximum of three calls may be claimed.

38.89B Injection of contrast material for sialography	58.73	

39 OTHER OPERATIONS ON MOUTH AND FACE

39.2 Excision of lesion or tissue of palate
39.21 Local excision or destruction of lesion or tissue of palate

39.21A Biopsy of palate	40.64 V	113.05

NOTE: A maximum of three calls may be claimed.

39.5 Palatoplasty
39.52 Correction of cleft palate

39.52A Primary palate repair (alveolar cleft)	638.26	226.45
39.52B Primary palate repair with bone graft (alveolar cleft)	1,038.66	452.88

NOTE: Includes harvesting.

39.52C Secondary palate repair	647.88	216.84
39.52D Secondary palate repair with intravelar veloplasty	1,038.66	475.52

39.53 Revision of cleft palate repair

39.53A Repeat palate reconstruction	779.00	376.85

39.6 Operations on uvula
39.62 Excision of uvula

39.62A Biopsy of uvula	40.64 V	113.05

NOTE: A maximum of three calls may be claimed.

VI. OPERATIONS ON THE NOSE, MOUTH,AND PHARYNX (cont'd)

39 OTHER OPERATIONS ON MOUTH AND FACE (cont'd)

39.8 Invasive diagnostic procedures on oral cavity
39.83 Biopsy of unspecified structure of mouth

		BASE	ANE
39.83A	Incisional biopsy of mouth	40.64 V	113.05
	NOTE: A maximum of three calls may be claimed.		

39.9 Other operations on mouth and face
39.91 Labial frenotomy

39.91B	Labial frenotomy	60.34	112.95
	That for clipping of frenulum of lip		
39.91C	Labial frenotomy	227.32	144.57
	That for release of frenulum of lip requiring Z plasty closure		

39.99 Other operations on oral cavity

39.99A	Removal of complicated leukoplakia	BY ASSESS	

40 OPERATIONS ON TONSILS AND ADENOIDS

40.0 Incision and drainage of tonsil and peritonsillar structures

40.0	Incision and drainage of tonsil and peritonsillar structures	132.35	158.50

40.1 Tonsillectomy without adenoidectomy

40.1	Tonsillectomy for patient 14 years of age and over	364.80	207.27
	NOTE: May be claimed in addition to HSC 40.5.		
40.1 A	Tonsillectomy for patient under 14 years of age	292.21	204.97
	NOTE: May be claimed in addition to HSC 40.5.		

40.5 Adenoidectomy without tonsillectomy

40.5	Adenoidectomy	82.64 V	187.66
	NOTE: May be claimed in addition to HSC 40.1 or 40.1 A.		

40.7 Control of hemorrhage after tonsillectomy and adenoidectomy

40.7	Control of hemorrhage after tonsillectomy and adenoidectomy	224.64	294.37

40.9 Other operations on tonsils and adenoids
40.92 Excision of lesion of tonsil and adenoid

40.92A	Biopsy of tonsil	40.64 V	111.81
	NOTE: A maximum of three calls may be claimed.		

41 OPERATIONS ON PHARYNX

41.0 Pharyngotomy

41.0 A	Midline, Trotter	466.16	207.83

VI. OPERATIONS ON THE NOSE, MOUTH,AND PHARYNX (cont'd)

41 OPERATIONS ON PHARYNX (cont'd)

41.0 Pharyngotomy (cont'd)

		BASE	ANE
41.0 B	Lateral	656.56	262.04
41.0 C	Transhyoid	421.42	189.74

41.1 Excision of branchial cleft cyst or vestiges

41.1	Excision of branchial cleft cyst or vestiges	364.35	169.57

41.2 Excision or destruction of lesion or tissue of pharynx

41.21	Cricopharyngeal myotomy	278.05	171.67

41.29 Other excision or destruction of lesion or tissue of pharynx

41.29A	Biopsy of nasopharynx under local anesthetic	63.46	
41.29B	Biopsy or examination of nasopharynx NOTE: May only be claimed when performed under general anesthesia.	127.84	112.95
41.29C	Excision nasopharyngeal tumor, via oropharynx	193.59	144.57
41.29D	Excision nasopharyngeal tumor, transpalatine approach	391.29	207.27

41.3 Plastic operation on pharynx

41.3 A	Pharyngoplasty	436.94	207.27
41.3 B	Repair of nasopharyngeal stenosis	347.91	198.79
41.3 D	Laser assisted uvulopalatoplasty (LAUP) NOTE: This benefit is only payable in cases with a proven diagnosis of obstructive sleep apnea, from an accredited sleep laboratory.	436.94	187.66

41.4 Other repair of pharynx

41.42	Closure of branchial cleft fistula Excision of branchial sinus or fistula	395.85	207.27

VII. OPERATIONS ON THE RESPIRATORY SYSTEM

42 EXCISION OF LARYNX

	BASE	ANE
42.0 Excision or destruction of lesion or tissue of larynx		
42.09 Other excision or destruction of lesion or tissue of larynx		
42.09A Removal of benign tumor to include laryngoscopy	154.32	112.95
42.09B Suspension, laryngoscopy	252.94	158.50
42.09C Glottic stenosis repair	436.94	339.65
42.09D Removal of complicated lesion from larynx or trachea	330.10	158.50
That with suspension laryngoscopy and laser NOTE: Limited to laryngeal papillomatosis, cancer of larynx or trachea or other lesions requiring a minimum of 30 minutes of laser treatment.		
42.1 Hemilaryngectomy (anterior) (lateral)		
42.1 Hemilaryngectomy (anterior) (lateral)	712.26	271.06
42.3 Complete laryngectomy		
42.3 A Laryngectomy	972.51	395.69
42.3 B Laryngopharyngectomy	1,296.22	397.56
42.3 C Laryngopharyngectomy with reconstruction of phonatory mechanism - one stage	1,130.48	614.43

43 OTHER OPERATIONS ON LARYNX AND TRACHEA

43.0 Injection of larynx		
43.0 A Laryngeal injection of material excluding Botulinum A Toxin	291.30	186.34
43.0 B Injection of Botulinum A Toxin, for spastic dysphonia NOTE: HSC 01.03 may be claimed in addition.	110.95	
43.1 Temporary tracheostomy		
43.1 A Tracheostomy NOTE: May not be claimed when performed in association with any of the laryngectomy services.	393.16	181.14
43.1 B Emergency cricothyroidotomy	221.54	
43.3 Other incision of larynx or trachea		
43.3 A Thyrotomy (laryngofissure)	419.59	263.79
43.3 B Tracheal fenestration	278.05	111.81
43.3 C Rigid laser bronchoscopy for removal of tracheal mass NOTE: Repeats within the 30 day post operative period may not be claimed except by anesthesia who may claim either the listed rate or the time release rate.	1,309.86	783.78
43.5 Repair of larynx		
43.54 Repair of laryngeal fracture NOTE: Includes that with insertion of laryngeal strut.	535.56	294.86
43.59 Other repair of larynx		
43.59A Arytenoidopexy or arytenoidectomy	419.59	243.96

VII. OPERATIONS ON THE RESPIRATORY SYSTEM (cont'd)

43 OTHER OPERATIONS ON LARYNX AND TRACHEA (cont'd)

43.5 Repair of larynx (cont'd)

43.59 Other repair of larynx (cont'd)

	BASE	ANE
43.59B Meurman operation	352.48	187.66
43.59C Repair of supraglottic stenosis	908.59	452.88

43.6 Repair and plastic operations on trachea

43.63 Closure of other fistula of trachea

43.63A Tracheo esophageal fistulectomy	684.41	343.35
43.63B Transcervical repair of fistula	689.89	263.79
43.63C Trans-thoracic repair of fistula	885.04	354.05

43.65 Construction of artificial larynx and reconstruction of trachea (with graft)

43.65C Secondary larynx tracheoesophageal puncture and valve insertion NOTE: May be claimed 30 days or more after laryngectomy.	419.59	250.20

43.69 Other repair and plastic operations on trachea

43.69A Infraglottic stenosis repair	908.59	452.88

43.8 Invasive diagnostic procedures on larynx and trachea

43.81 Biopsy of larynx NOTE: Includes laryngoscopy.	136.52	113.05
43.82 Biopsy of trachea NOTE: Includes bronchoscopy or laryngoscopy.	130.56	111.71

43.9 Other operations on larynx and trachea

43.95 Other operations on larynx

43.95A Laryngeal dilation NOTE: Includes laryngoscopy.	125.10 V	111.71

43.96 Other operations on trachea

43.96A Tracheal or bronchial dilatation with rigid or flexible bronchoscope and balloon (balloon bronchoplasty) NOTE: 1. The anesthetic rate for 43.96A may not be claimed in addition to an anesthetic rate for any other service. 2. Benefit includes bronchoscopy.	209.75	282.63
43.96B Electrosection and dilatation of tracheal or bronchial web stenosis NOTE: 1. The anesthetic rate for 43.96B may not be claimed in addition to an anesthetic rate for any other service. 2. Benefit includes bronchoscopy.	305.22	282.63

VII. OPERATIONS ON THE RESPIRATORY SYSTEM (cont'd)

43 OTHER OPERATIONS ON LARYNX AND TRACHEA (cont'd)

43.9 Other operations on larynx and trachea (cont'd)

43.96 Other operations on trachea (cont'd)

	BASE	ANE
43.96C Placement of self-expandable metal endotracheal or endobronchial stent	273.71	271.06
NOTE: 1. The anesthetic rate for 43.96C may not be claimed in addition to an anesthetic rate for any other service. 2. Benefit includes bronchoscopy.		
43.96D Placement of silicone endotracheal or endobronchial stent under general anesthetic	276.54	271.07
NOTE: 1. The anesthetic rate for 43.96D may not be claimed in addition to an anesthetic rate for any other service. 2. Benefit includes bronchoscopy.		
43.96E Placement of intratracheal or intrabronchial brachytherapy catheter, additional benefit	68.98	
NOTE: May only be claimed in addition to 01.09.		

44 EXCISION OF BRONCHUS AND LUNG

44.0 Local excision or destruction of lesion or tissue of bronchus

44.01 Endoscopic excision or destruction of lesion or tissue of bronchus	214.46	144.57
That with removal of tumor		
NOTE: Includes bronchoscopy.		

44.09 Other local excision or destruction of lesion or tissue of bronchus

44.09A Bronchotomy for removal of tumor	630.24	285.95

44.1 Other excision of bronchus

44.19 Other excision of bronchus	1,418.05	745.37
Resection (wide sleeve) of bronchus		

44.2 Local excision or destruction of lesion or tissue of lung

44.21 Plication of emphysematous bleb	787.80	391.32
Blebectomy		

44.22 Endoscopic excision or destruction of lesion or tissue of lung

44.22A With laser resections	495.70	150.73
NOTE: 1. Includes bronchoscopy. 2. Includes subsequent resections within 30 days.		

44.3 Segmental resection of lung (basilar)(superior)

44.3 A Segmental resection of lung (basilar) (superior)	1,050.41	489.88
44.3 B Wedge resection of lung or open lung biopsy	787.80	362.31

44.4 Lobectomy of lung

44.4 A Lobectomy of lung	1,050.41	543.46

VII. OPERATIONS ON THE RESPIRATORY SYSTEM (cont'd)

44 EXCISION OF BRONCHUS AND LUNG (cont'd)

		BASE	ANE
44.4	Lobectomy of lung (cont'd)		
44.4 B	Bilobectomy	1,260.49	701.97
44.4 C	Sleeve lobectomy	1,418.05	714.85
44.5	Complete pneumonectomy		
44.5 A	Pneumonectomy, complete	1,050.41	566.10
44.5 B	Completion pneumonectomy	1,259.25	500.40
44.5 C	Sleeve pneumonectomy	1,878.57	714.85

45 OTHER OPERATIONS ON BRONCHUS AND LUNG

45.0	Incision of bronchus		
45.0 A	Bronchotomy for removal of foreign body	692.47	285.95
45.1	Incision of lung		
45.1 A	Drainage, lung abscess	429.72	196.59
45.1 B	Pneumonotomy, removal of foreign body	687.76	279.52
45.4	Repair and plastic operations on bronchus and lung		
45.42	Closure of bronchial fistula		
45.42A	Repair bronchopleural fistula, post surgical	627.30	625.50
45.43	Other repair and plastic operation on bronchus Bronchoplasty	525.20	277.01
45.5	Lung transplant		
45.5 A	Lung transplant With recipient pneumonectomy NOTE: 1. May be claimed with HSC 49.5 A. 2. When performed as a bilateral procedure and/or when claimed in addition to HSC 49.5A, the procedural benefit may be claimed at 100% for both lungs. This does not apply to the anesthetic rate.	4,988.90	1,421.23
45.5 B	Donor pneumonectomy	1,929.89	375.28
45.6	Combined heart-lung transplantation		
45.6 B	Donor heart/lung resection	2,411.51	740.92
45.8	Invasive diagnostic procedures on bronchus and lung		
45.81	Biopsy of bronchus by bronchoscopy		
45.81A	Biopsy of bronchus	117.01 V	111.71
45.83	Percutaneous (needle) biopsy of lung	69.94 V	111.71
45.84	Other biopsy of lung		
45.84A	Aspiration or trephine lung biopsy under fluoroscopic guidance	102.78 V	134.04
45.84B	Diagnostic lung biopsy performed with other thoracic surgery as a planned procedure	117.65	53.61

VII. OPERATIONS ON THE RESPIRATORY SYSTEM (cont'd)

45 OTHER OPERATIONS ON BRONCHUS AND LUNG (cont'd)

45.8 Invasive diagnostic procedures on bronchus and lung (cont'd)

45.86 Other contrast bronchogram

	BASE	ANE
45.86A Instillation of opaque material	54.96	111.71

45.88 Other invasive diagnostic procedures on lung

45.88A Trans-bronchial biopsy of lung, additional benefit	87.29	62.55

NOTE: 1. May only be claimed in addition to HSC 01.09.
2. Two calls may be claimed for bilateral services (right and left lung).

46 OPERATIONS ON CHEST WALL, PLEURA, MEDIASTINUM, AND DIAPHRAGM

46.0 Incision of chest wall and pleura

46.02 Exploratory thoracotomy	409.10	226.10

46.03 Reopening of recent thoracotomy site

NOTE: 1. Patient must have left both operating room suite and post anesthetic (recovery) room.
2. Redo modifier does NOT apply to these services.

46.03A Reoperation for bleeding following thoracic surgery	383.83	249.08
46.03B Rewiring of sternum, irrigation or debridement of mediastinum with removal of intracardiac lines	626.91	263.79

46.04 Insertion of intercostal catheter (with water seal) for drainage

46.04A Tube thoracostomy For conditions other than empyema or effusion	90.80	112.95
46.04B Tube thoracostomy For empyema or effusion	116.30 V	113.05
46.04C Installation of thrombolytics into pleural space for lysis of complex pleural adhesions	43.27	

46.09 Other incision of pleura

46.09A Open drainage, includes rib resection	267.84	142.97
46.09B Placement of tunneled pleural catheter	206.93 V	158.98
46.09C Removal of tunneled pleural catheter	116.63 V	113.05

46.1 Incision of mediastinum

46.1 A With removal of foreign body from mediastinum	753.46	354.05
46.1 B Anterior mediastinotomy (Chamberlain)	315.12	169.57

46.2 Excision or destruction of lesion or tissue of mediastinum

46.2 A Mediastinotomy with removal of cyst or tumor	787.65	354.05

46.3 Excision or destruction of lesion of chest wall

46.3 A Resection of chest wall, minor (one rib)	315.12	188.43

VII. OPERATIONS ON THE RESPIRATORY SYSTEM (cont'd)

46 OPERATIONS ON CHEST WALL, PLEURA, MEDIASTINUM, AND DIAPHRAGM (cont'd)

46.3 Excision or destruction of lesion of chest wall (cont'd)

	BASE	ANE
46.3 B Resection of chest wall, major (two ribs or more)	629.95	320.33
46.3 C Resection of chest wall, major with prosthesis	1,050.41	339.16

46.4 Pleurectomy

46.41 Decortication of lung

46.41A Partial, total, at least one lobe	735.28	362.31

NOTE: Bilateral procedures may be claimed using 2 calls. Refer to Price List.

46.49 Other excision of pleura

46.49A Pleurectomy, parietal	420.16	362.31

46.5 Scarification of pleura

46.5 A Thoracoscopy with poudrage and catheter drainage	105.04	134.04

46.6 Repair of chest wall

46.64 Repair of pectus deformity

46.64A Minor	219.04	271.72
46.64B Major	738.50	384.95

46.8 Invasive diagnostic procedures on chest wall, pleura, mediastinum and diaphragm

46.81 Thoracoscopy

46.81A Transpleural	105.04	111.71

NOTE: Includes biopsy.

46.82 Mediastinoscopy	262.60	150.73

46.84 Pleural biopsy

46.84A Needle biopsy of pleura	65.30 V	111.71

46.88 Other invasive diagnostic procedures on chest wall, pleura and diaphragm

46.88A Insertion of catheters and injection of dye	50.60	

That for sinograms or fistulograms, single or multiple studies

46.9 Other operations on thorax

46.91 Thoracentesis	65.69 V	

NOTE: A repeat performed within 31 days is payable at a reduced rate. Refer to Price List.

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM

47 OPERATIONS ON VALVES AND SEPTA OF HEART

		BASE	ANE
47.0	**Closed heart valvotomy**		
47.02	**Closed heart valvotomy, mitral valve**		
47.02A	Closed heart valvotomy, mitral valve	1,752.18	571.87
47.02B	Percutaneous mitral valvuloplasty	1,312.82	
	NOTE: Includes related catheterization procedures performed at the same time.		
47.02C	Mitral valve repair through mini thoracotomy	2,287.96	1,031.89
47.03	**Closed heart valvotomy, aortic valve**		
47.03A	Percutaneous aortic valvuloplasty	980.24	600.82
	NOTE: Includes related catheterization procedures performed at the same time.		
47.04	Closed heart valvotomy, pulmonary valve	1,122.02	724.61
47.1	**Open heart valvuloplasty without replacement**		
47.12	**Open heart valvuloplasty of mitral valve, without replacement**		
47.12A	Open heart valvuloplasty of mitral valve, without replacement	1,715.97	716.02
47.12B	Reconstruction	2,205.59	1,031.89
47.13	**Open heart valvuloplasty of aortic valve, without replacement**		
47.13A	Open heart valvuloplasty of aortic valve, without replacement	1,715.97	679.11
47.13B	Reconstruction aortic valve	2,205.59	1,031.89
47.13C	Valvulotomy	1,815.50 V	965.04
	NOTE: Age modifier required, refer to Price List.		
47.14	**Open heart valvuloplasty of tricuspid valve, without replacement**		
47.14A	Open heart valvuloplasty of tricuspid valve, without replacement	1,715.97	679.11
47.14B	Reconstruction tricuspid valve	2,205.59	1,031.89
47.15	**Open heart valvuloplasty of pulmonary valve, without replacement**		
47.15A	Open heart valvuloplasty of pulmonary valve, without replacement	1,608.44	679.11
47.15B	Reconstruction pulmonary valve	2,205.59	1,067.47
47.15C	Valvulotomy pulmonary valve	1,837.23 V	947.19
	NOTE: Age modifier required, refer to Price List.		
47.2	**Valvuloplasty with replacement of heart valve**		
47.23	**Other replacement of mitral valve**		
47.23A	Mitral valve replacement	1,881.85	678.92
47.23B	Mitral valve replacement through mini thoracotomy	2,287.96	1,031.89
47.25	**Other replacement of aortic valve**		
47.25A	Stented aortic valve replacement	1,881.85	708.07
47.25C	Stentless aortic valve replacement	3,131.07	1,018.67
47.25B	Valve conduit repair or replacement of the aortic valve and ascending aorta with reimplantation of the coronary arteries	3,064.72	1,030.04
	Associated with non-ruptured aortic aneurysm		
47.25D	Valve conduit repair or replacement of aortic valve and ascending aorta with reimplantation of the coronary arteries	4,243.02	1,707.96
	Associated with ruptured aortic aneurysm or aortic dissection		

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

47 OPERATIONS ON VALVES AND SEPTA OF HEART (cont'd)

47.2 Valvuloplasty with replacement of heart valve (cont'd)

47.25 Other replacement of aortic valve (cont'd)

	BASE	ANE
47.25E Transcatheter aortic valve replacement (TAVR)	1,724.17	708.07

47.27 Other replacement of tricuspid valve

47.27A Tricuspid valve replacement	1,881.85	678.92

47.29 Other replacement of pulmonary valve

47.29A Pulmonary valve replacement	1,881.85	678.92
47.29B Transcatheter pulmonary valve replacement	2,100.51	1,628.29

47.3 Operations on structures adjacent to valves

47.39 Operations on other structures adjacent to valves of heart

47.39A Repair of sinus of valsalva That for aneurysm/fistula	1,715.97	679.11

47.4 Production of septal defect in heart

47.42 Enlargement of existing atrial septal defect

47.42A Balloon atrial septostomy NOTE: May be claimed in addition to cardiac catheterization.	276.57	151.90

47.5 Repair of atrial and ventricular septa with prosthesis

47.54 Repair of ventricular septal defect with prosthesis

47.54A Septation of single ventricle	2,205.59	947.19
47.54B Closure of VSD with prosthesis	1,960.78	947.19

47.55 Repair of endocardial cushion defect with prosthesis

47.55A Atrial ventricular canal	2,205.59	957.76
47.55B Primum atrial septal defect to include mitral valve reconstruction	1,960.78	957.76
47.55C Sinus venosus ASD plus partial anomalous pulmonary venous drainage	1,960.78	947.19

47.7 Other and unspecified repair of atrial and ventricular septa

47.72 Other and unspecified repair of atrial septal defect

47.72A Closure of atrial septal defect (secundum)	1,593.56	875.70
47.72B Closure of ASD NOTE: May be claimed when performed with another procedure.	427.85	111.71
47.72C Percutaneous closure, atrial septal defect NOTE: 1. Benefit includes other angiograms and cardiac catheterizations performed on the same date of service. 2. May not be claimed in association with angiocardiography (HSC 48.92A, 48.98A, 48.98B) or trans-esophageal echocardiography (HSC 02.82A). 3. For each additional occlusion device, refer to Price List. 4. Role modifier ASIC may be claimed for assistance by a second interventional cardiologist.	1,225.30	584.12

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

47 OPERATIONS ON VALVES AND SEPTA OF HEART (cont'd)

		BASE	ANE
47.8	Total repair of certain congenital cardiac anomalies		
47.81	Total repair of tetralogy of Fallot	1,960.78	947.20
47.82	Total repair of total anomalous pulmonary venous connection	2,205.59	947.19
47.83	Total repair of truncus arteriosus		
47.83A	Total repair of truncus arteriosus	2,047.72	975.83
47.83B	Closure of aortopulmonary window	1,960.78	947.19
47.84	Total correction of transposition of great vessels NEC		
47.84A	Arterial switch procedure for transposition of great vessels including repair of ASD	2,696.36	1,280.97
47.9	Other operations on valves and septa of heart		
47.91	Interatrial transposition of venous return		
47.91A	Atrial switch procedure for transposition of great vessels	2,047.72	947.20
47.92	Creation of conduit between right ventricle and pulmonary artery		
47.92A	Correction of pulmonary atresia for subpulmonic stenosis	2,205.59	947.19
47.92B	Remodelling of outflow tract to right ventricle	2,205.59	947.19
47.92C	Removal of pulmonary artery banding and reconstruction of pulmonary artery	2,205.59	947.19
47.93	Creation of conduit between left ventricle and aorta		
47.93A	Remodelling of outflow tract to left ventricle For subaortic membrane/band/perivalvular abscess/cavity/severe distortion/hypoplasia	2,205.59	947.19
47.93B	Remodeling of outflow tract to left ventricle For asymmetric septal hypertrophy	2,676.91	1,075.94
47.95	Other operations on septa of heart		
47.95A	Excision of intraatrial membrane Cor triatriatum	1,960.78	947.19

48 OPERATIONS ON VESSELS OF HEART

48.0	Removal of coronary artery obstruction		
48.0 A	Endarterectomy NOTE: A maximum of four calls may be claimed.	306.59	111.71
48.1	Bypass anastomosis for heart revascularization		
48.12	Aortocoronary bypass of one coronary artery	1,593.56	607.07
48.12A	Aortocoronary bypass of one coronary artery without cardiopulmonary bypass.	2,042.00	821.59
48.13	Aortocoronary bypass of two coronary arteries	1,869.26	670.59
48.13A	Aortocoronary bypass of two coronary arteries without cardiopulmonary bypass	2,317.70	839.28
48.14	Aortocoronary bypass of three coronary arteries	2,144.96	782.02
48.14A	Aortocoronary bypass of three coronary arteries without cardiopulmonary bypass	2,594.55	981.95

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

48 OPERATIONS ON VESSELS OF HEART (cont'd)

48.1 Bypass anastomosis for heart revascularization (cont'd)

48.15 Aortocoronary bypass of four or more coronary arteries

		BASE	ANE
48.15A	Of four coronary arteries	2,421.81	838.24
48.15E	Aortocoronary bypass of four coronary arteries without cardiopulmonary bypass	2,690.64	1,150.14
48.15B	Of five coronary arteries	2,697.50	942.12
48.15F	Aortocoronary bypass of five coronary arteries without cardiopulmonary bypass	2,949.18	1,085.27
48.15C	Of six coronary arteries	2,973.20	993.90
48.15G	Aortocoronary bypass of six coronary arteries without cardiopulmonary bypass	3,389.61	1,209.81
48.15D	Of seven coronary arteries	3,016.68	1,103.06
48.15H	Aortocoronary bypass of seven coronary arteries without cardiopulmonary bypass	3,663.02	1,298.77

48.19 Other bypass anastomosis for heart revascularization

48.19A	Preparation of the internal mammary/gastroepiploic artery for coronary artery bypass grafting, additional benefit NOTE: A maximum of three calls applies.	306.59	111.71

48.9 Other operations on vessels of heart

48.92 Angiocardiography, unqualified

48.92A	Selective angiocardiogram NOTE: May be claimed in addition to cardiac catheterization.	91.02	

48.98 Other coronary arteriography

DEFINITION: Cannulation and angiography of the right and left coronary arteries.

48.98A	Selective angiography of aortocoronary vein bypass graft, per graft Note: May not be claimed in addition to HSCs 50.91D or 50.91E.	105.03	
48.98B	Coronary angiography NOTE: May not be claimed in addition to HSCs 50.91D or 50.91E.	288.82	

49 OTHER OPERATIONS ON HEART AND PERICARDIUM

49.0 Pericardiocentesis

49.0	Pericardiocentesis NOTE: If a repeat service occurs within 14 days, benefit will be modified, refer to Price List.	332.58 V	113.05

49.1 Cardiotomy and pericardiotomy

49.12	Cardiotomy	576.57	321.69
49.12B	Cardiotomy with infarctectomy and reconstruction of ventricular wall For post-infarction, ventricular rupture or repair of ventricular septal defect	3,013.24	1,494.46

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

49 OTHER OPERATIONS ON HEART AND PERICARDIUM (cont'd)

49.1 Cardiotomy and pericardiotomy (cont'd)

49.13 Pericardiotomy

	BASE	ANE
49.13A Drainage, repair and insufflation	322.22	280.09

49.2 Pericardiectomy

49.2 A Parietal pericardiectomy	974.67	724.61
49.2 B Visceral pericardiectomy for chronic pericardial constriction	3,220.30	1,672.37

49.3 Excision of lesion of heart

49.31 Excision of aneurysm of heart	1,715.97	750.59
49.39 Excision of other lesion of heart	1,715.97	679.11
49.39B Removal of atrial tumor or other lesion within or on the left or right atrium	1,715.97	947.19
49.39C Removal of ventricular tumor with reconstruction of ventricular wall	3,013.24	1,018.67

49.4 Repair of heart and pericardium

49.4 A Cardiorrhaphy	539.96	294.86
49.4 B Suture of (traumatic) laceration of heart	1,715.97	686.70
49.4 C Coronary arterioplasty, additional benefit	375.23	151.90

49.5 Heart transplantation

49.5 A Heart transplantation, including recipient cardiectomy NOTE: For heart/lung transplantation, may be claimed with HSC 45.5 A.	5,366.41	1,707.96
49.5 B Donor cardiectomy	1,929.89	428.92

49.6 Implantation of heart assist system

49.61 Implant of pulsation balloon

49.61A Graft placement for intra aortic balloon pumping including removal	488.48	196.59
49.61B Percutaneous insertion of intra aortic balloon pump to include removal NOTE: When performed in conjunction with other procedures fee will be modified, refer to Price List.	245.06 V	

49.62 Implantation of other heart assist system

49.62A Implantation of left or right ventricular assist device, temporary	1,164.57	566.10
49.62B Implantation of left or right ventricular assist device, permanent	5,256.59	2,544.14

49.64 Removal of heart assist system

49.64A Removal of permanent left ventricular assist device or right ventricular assist device	3,220.30	1,672.37

49.7 Implantation of cardiac pacemaker system

49.7 A Insertion of AV sequential pacemaker	560.14	244.96
49.7 F Insertion of AV sequential pacemaker, two lead	533.88	244.96
49.7 G Insertion of AV sequential pacemaker, 3 lead	883.97	489.88
49.7 H Insertion of AV sequential pacemaker, 4 lead	1,193.79	536.13
49.7 J Implantation of automatic internal cardioverter defibrillator - single RV lead	558.39	475.52

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

49 OTHER OPERATIONS ON HEART AND PERICARDIUM (cont'd)

49.7 Implantation of cardiac pacemaker system (cont'd)

	BASE	ANE
49.7 JA Single chamber (right ventricular) implantable cardioverter defibrillator, insertion and testing	1,039.75	801.27
NOTE: 1. May only be claimed by cardiologists or thoracic surgeons. 2. May not be claimed in addition to electrophysiology studies (HSCs 49.98AA through 49.98Y).		
49.7 K Implantation of automatic internal cardioverter defibrillator - atrial and right ventricular lead	913.72	588.73
49.7 KA Dual chamber implantable cardioverter defibrillator insertion and testing	1,302.32	987.59
NOTE: 1. May only be claimed by cardiologists or thoracic surgeons. 2. May not be claimed in addition to electrophysiology studies (HSCs 49.98AA through 49.98Y).		
49.7 L Implantation of automatic internal cardioverter defibrillator - right ventricular and left ventricular lead	906.72	588.73
49.7 LA Cardiac resynchronization defibrillator insertion without atrial lead and testing	1,739.93	987.59
NOTE: 1. May only be claimed by cardiologists or thoracic surgeons. 2. May not be claimed in addition to electrophysiology studies (HSCs 49.98AA through 49.98Y).		
49.7 M Implantation of automatic internal cardioverter defibrillator - atrial, right ventricular and left ventricular leads	1,172.79	724.61
49.7 MA Cardiac resynchronization defibrillator insertion and testing	1,995.49	1,484.05
NOTE: 1. May only be claimed by cardiologists or thoracic surgeons. 2. May not be claimed in addition to electrophysiology studies (HSCs 49.98AA through 49.98Y).		
49.7 N Percutaneous venoplasty for lead placement	596.90	465.85
NOTE: 1. May only be claimed by cardiologists or thoracic surgeons. 2. May be claimed in addition to HSCs 49.7 A, 49.7 F, 49.7 G, 49.7 H, 49.7 JA, 49.7 KA, 49.7 LA and 49.7 MA.		
49.7 C Transthoracic pacemaker	851.12	301.47
49.7 D Transvenous pacemaker, permanent	329.08	169.57
49.7 E Subxiphoid epicardial pacemaker	669.23	226.10
49.73 Implantation of endocardial electrodes		
49.73A Temporary right heart catheter pacemaker	131.28	
NOTE: Claims for temporary insertion of a pacemaker in conjunction with other cardiac procedures are included.		
49.8 Removal or replacement of implanted cardiac pacemaker		
49.81 Replacement of myocardial electrodes	227.56	144.57
49.82 Replacement of endocardial electrodes		
49.82A Replacement of endocardial electrodes	210.05	150.73
49.82B Replacement of temporary right heart catheter pacemaker	99.77 V	111.71

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

49 OTHER OPERATIONS ON HEART AND PERICARDIUM (cont'd)

49.8 Removal or replacement of implanted cardiac pacemaker (cont'd)

49.83 Replacement of pulse generator

	BASE	ANE
49.83A Adjustment of pacemaker	50.76 V	
49.84 Replacement of battery		
49.84 Replacement of battery	213.55	150.73
49.84B Replacement of automatic internal cardioverter defibrillator battery	502.37	282.63
49.85 Removal of myocardial electrodes		
49.85 Removal of myocardial electrode, per electrode, with or without new lead or pacemaker insertion	225.36	142.97
49.86 Removal of endocardial electrodes		
49.86 Removal of endocardial electrode, per electrode, with or without new lead or pacemaker insertion	227.56	144.57
49.86B Lead extraction requiring use of extractor sheath, per lead	2,030.50	982.93
49.87 Removal of cardiac pacemaker system without replacement		
49.87A Removal of pacemaker from site other than new implant site	224.05	113.05
49.87B Removal of automatic internal cardioverter defibrillator from site other than new implant site	294.07	126.50
49.9 Other operations on heart and pericardium		
49.9 A Open heart surgery, not elsewhere classified	1,715.97	768.47
49.91 Open chest cardiac massage	304.60	
49.93 Biopsy of heart		
49.93A Percutaneous right ventricular endomycardial biopsy	299.32	
NOTE: May be claimed in addition to cardiac catheterization.		
49.95 Right cardiac catheterization		
DEFINITION: Insertion and placement of a catheter into the right heart, to include the recording of oxygen saturations, by whatever methods, and the recording of pressures.		
49.95A Right cardiac catheterization with fluoroscopy	201.30	203.79
NOTE: May not be claimed in addition to HSCs 50.94D and 50.95A.		

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

49 OTHER OPERATIONS ON HEART AND PERICARDIUM (cont'd)

49.9 Other operations on heart and pericardium (cont'd)

49.96 Left cardiac catheterization
DEFINITION: Insertion and placement of a catheter into the left heart, by whatever route, to include the recording of oxygen saturations, by whatever methods, and the recording of pressures.

		BASE	ANE
49.96A	Left cardiac catheterization with fluoroscopy	266.07	
49.96B	Trans-septal heart catheterization with fluoroscopy DEFINITION: Insertion and placement of the catheter into the left atrium by puncture of the fossa Ovalis. NOTE: May not be claimed in addition to HSCs 49.98AA, 49.98AB and 49.98AC.	315.08	

49.98 Other invasive diagnostic procedures on heart and pericardium

49.98B	Pharmacological manipulation of physiological function and recording thereof NOTE: 1. May be claimed in addition to cardiac catheterization. 2. May only be claimed once per day, per patient, per physician.	62.21	
49.98C	Physical manipulation of physiological function and recording thereof NOTE: 1. May be claimed in addition to cardiac catheterization. 2. May only be claimed once per day, per patient, per physician.	62.21	
49.98D	Electrical manipulation of physiological function and recording thereof NOTE: 1. May be claimed in addition to cardiac catheterization. 2. May only be claimed once per day, per patient, per physician.	62.21	
49.98E	Cardiac mapping and surgical control (with or without use of cryoprobe of ventricular or supraventricular tachycardia) NOTE: May be claimed when performed in association with 48.98P by another physician.	2,445.69	885.49
49.98X	Surgical treatment of atrial fibrillation (Cox-Maze procedure)	3,088.75	1,672.37

Electrophysiology Studies:

49.98AA	Diagnostic Electrophysiological (EP) study with or without Drug challenge AV node ablation or defibrillation testing NOTE: 1. May not be claimed in addition to HSC 49.96B. 2. Refer to the notes following 49.98Y.	665.16	
49.98AB	Complex ablation of arrhythmic substrate(s) NOTE: 1. May not be claimed in addition to HSC 49.96B. 2. Refer to the notes following 49.98Y.	2,223.04	
49.98AC	Standard ablation of arrhythmic substrate NOTE: 1. May not be claimed in addition to HSC 49.96B. 2. Refer to the notes following 49.98Y.	1,225.30	

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

49 OTHER OPERATIONS ON HEART AND PERICARDIUM (cont'd)

49.9 Other operations on heart and pericardium (cont'd)

Electrophysiology Studies: (cont'd)

		BASE	ANE
49.98P	Intra-operative electrophysiologic studies	539.13	
	NOTE: 1. May be claimed in addition to elements of electrophysiologic study. 2. Refer to the notes following 49.98Y.		
49.98Q	Noninvasive evaluation of cardiac pacemaker implanted for clinical bradyarrhythmia	54.26	
	NOTE: Refer to the notes following 49.98Y.		
49.98R	Implanted for treatment of tachyarrhythmia	122.53	
	NOTE: Refer to the notes following 49.98Y.		
49.98S	Interrogation of implanted cardioverter/defibrillator device	54.26	
	NOTE: Refer to the notes following 49.98Y.		
49.98T	Interpretation of transtelephonic ECG or rhythm strip	10.85	
	NOTE: Refer to the notes following 49.98Y.		
49.98U	Tilt table testing for evaluation of syncope (includes pharmacologic manipulation plus intra-arterial BP monitoring)	326.12	
	NOTE: Refer to the notes following 49.98Y.		
49.98Y	Cardioversion	66.52	
	NOTE: 1. These are not to be claimed in association with HSCs outside of the electrophysiology studies (EPS) section. 2. These may only be claimed when performed in a hospital. 3. HSC 49.98Y may only be claimed when performed with EPS HSCs (49.98AA through 49.98U). When it is not performed with EPS, then HSC 13.72A should be claimed.		
49.98W	Second operator at complicated EP studies per 15 minutes or major portion thereof	48.58	
49.99A	Transesophageal echocardiography guidance for percutaneous procedures, per 30 minutes or major portion thereof	137.08	
	NOTE: 1. May not be claimed in addition to HSC 02.82A. 2. May not be claimed by the surgeon.		
49.99AA	Intraoperative trans-esophageal echocardiography, procedure and interpretation	137.08	
	NOTE: May not be claimed by the surgeon if performed intraoperatively.		

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

50 INCISION, EXCISION, AND OCCLUSION OF VESSELS

50.0 Incision of vessel (embolectomy, exploration, thrombectomy)

50.01 Incision of intracranial vessels

	BASE	ANE
50.01A Intracranial arteriotomy under micro dissection	2,288.22	704.77
50.03 Incision of upper limb vessels		
50.03A Venous thrombectomy	345.34	226.10
50.03B Embolectomy or arteriothrombectomy	496.03	226.10
50.04 Incision of aorta		
50.04A Embolectomy or arteriothrombectomy	592.05	214.45
50.05 Incision of other thoracic vessels		
50.05A Pulmonary embolectomy (acute)	1,558.38	822.08
50.06 Incision of abdominal arteries		
50.06A Embolectomy or arteriothrombectomy	1,128.92	263.79
50.07 Incision of abdominal veins		
50.07A Venous thrombectomy	348.13	196.59
50.08 Incision of lower limb vessels		
50.08A Embolectomy or arteriothrombectomy of femoral arteries	752.61	226.10
50.08AA Embolectomy or arteriothrombectomy of popliteal/tibial arteries	1,003.48	567.49
50.08B Venous thrombectomy	356.14	207.83
50.09 Incision of vessel, unspecified site		
50.09A Embolectomy or arteriothrombectomy	579.39	207.83
50.09B Venous thrombectomy	595.38	196.59

50.1 Endarterectomy

50.12 Endarterectomy of other vessels of head and neck		
50.12A Carotid endarterectomy	1,598.34	384.95
50.12B Carotid endarterectomy with patch repair	1,505.22	815.18
50.12C Carotid subclavian reconstruction - any method	1,505.22	567.49
50.12D Carotid-carotid reconstruction - any method	1,505.22	1,190.00
50.14 Endarterectomy, aorta	1,123.81	250.20
50.15 Endarterectomy of other thoracic vessels		
50.15A Pulmonary endarterectomy and embolectomy (chronic)	5,366.41	2,806.44
50.16 Endarterectomy of abdominal arteries		
50.16A Iliac	1,379.79	252.99
50.18 Endarterectomy of lower limb vessels		
50.18A Femoral-profundoplasty	1,003.48	317.01

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

50 INCISION, EXCISION, AND OCCLUSION OF VESSELS (cont'd)

50.2 Resection of vessel with anastomosis
50.24 Resection of aorta with anastomosis

		BASE	ANE
50.24A	Coarctation repair	1,210.33 V	905.75
	NOTE: For pediatric repair, refer to Price List.		
50.24B	Correction of aortic vascular ring	880.86	307.21
	Includes ligation of patent ductus arteriosus (PDA)		

50.3 Resection of vessel with replacement
50.32 Resection of head and neck vessels with replacement
NOTE: If full Y graft, increase anesthetic fee by 1/3. Additional payment applies only to Aneurysm or A.V. fistula, peripheral or visceral.

50.32A	Traumatic injury with graft	1,504.25	343.35
50.32B	Resection of aneurysm with graft	1,602.78	464.65
50.32C	Excision of AV fistula	757.88	505.98

50.33 Resection of upper limb vessels with replacement

50.33A	Traumatic injury with graft	1,028.57	384.95
50.33B	Resection of aneurysm with graft	777.70	505.98
50.33C	Excision of AV fistula	743.81	471.05

50.34 Resection of aorta with replacement

50.34A	Coarctation repair	1,248.06 V	1,079.41
	NOTE: For pediatric repair, refer to Price List.		
50.34B	Replacement of aortic arch	3,064.72	1,067.47
	For aneurysm or occlusion		
50.34K	Replacement of aortic arch	4,243.02	1,651.01
	For ruptured aneurysm, aortic dissection or traumatic injury		
50.34KA	Endovascular repair of aortic arch for aneurysm	2,960.27	1,067.47
	NOTE: May not be claimed in addition to HSC 51.3 B.		
50.34KB	Endovascular repair of aortic arch for ruptured aneurysm, dissection or traumatic injury	4,264.80	1,651.01
	NOTE: May not be claimed in addition to HSC 51.3 B.		
50.34C	Correction of interrupted aortic arch	2,180.43	1,050.45
50.34D	Resection of thoracic aortic aneurysm	1,348.75	701.97
50.34DA	Endovascular repair of thoracic aneurysm	2,157.49	1,938.64
	NOTE: May not be claimed in addition to HSC 51.3 B.		
50.34L	Resection or repair of thoracic aortic aneurysm	2,291.39	1,187.34
	For ruptured aneurysm, dissection or traumatic injury		
50.34LA	Endovascular repair of thoracic aneurysm for rupture, dissection or traumatic injury	2,724.46	1,672.03
	NOTE: May not be claimed in addition to HSC 51.3 B.		

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

50 INCISION, EXCISION, AND OCCLUSION OF VESSELS (cont'd)

50.3 Resection of vessel with replacement (cont'd)

50.34 Resection of aorta with replacement (cont'd)

	BASE	ANE
50.34E Resection of thoraco-abdominal aneurysm	4,555.16	1,938.64
50.34F Resection of abdominal aortic aneurysm, straight tube graft	1,756.10	1,077.73
50.34FA Endovascular repair of abdominal aortic aneurysm (Tube graft)	1,756.10	1,077.73
NOTE: May not be claimed in addition to HSC 51.3 B.		
50.34G Resection of abdominal aortic aneurysm, reconstruction with aortic bi-iliac or aorto-bi-femoral graft	2,458.53	1,508.83
50.34GA Endovascular abdominal aortic aneurysm repair (Bifurcated iliac)	2,458.53	1,508.83
NOTE: May not be claimed in addition to HSC 51.3 B.		
50.34H Resection of ruptured aortic aneurysm, straight tube graft	2,508.71	1,539.62
50.34HA Endovascular repair of ruptured abdominal aortic aneurysm (Tube graft)	2,508.71	1,539.62
NOTE: May not be claimed in addition to HSC 51.3 B.		
50.34J Resection of ruptured aortic aneurysm, aorto-bi-iliac or bi-femoral graft	3,211.15	1,970.71
50.34JA Endovascular repair of ruptured abdominal aortic aneurysm (Bifurcated graft)	3,211.15	1,970.71
NOTE: May not be claimed in addition to HSC 51.3 B.		

50.35 Resection of other thoracic vessels with replacement

50.35A Traumatic injury with graft	689.98	307.21
50.35B Aneurysm with graft	699.37	469.86
50.35C Excision of AV fistula	685.14	464.65

50.36 Resection of abdominal arteries with replacement

50.36A Traumatic injury with graft	1,148.87	289.13
50.36B Aneurysm with graft	1,555.16	505.98
50.36C Excision of AV fistula	739.96	464.65

50.37 Resection of abdominal veins with replacement

50.37A Traumatic injury with graft	1,214.26	303.80
50.37B Aneurysm with graft	782.15	446.79
50.37C Excision of AV fistula	747.50	446.79

50.38 Resection of lower limb vessels with replacement

50.38A Traumatic injury with graft	767.66	361.42
50.38B Aneurysm with graft	1,053.66	527.59
50.38C Excision of AV fistula	1,344.46	500.40

50.39 Resection of vessels of unspecified site with replacement

50.39A Traumatic injury with graft	830.93	285.95
50.39B Aneurysm with graft	647.25	527.59
50.39C Excision of AV fistula	822.79	498.15

50.4 Ligation and stripping of varicose veins

50.4 A Saphenous ligation	83.80 V	113.05

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

50 INCISION, EXCISION, AND OCCLUSION OF VESSELS (cont'd)

50.4 Ligation and stripping of varicose veins (cont'd)

	BASE	ANE
50.4 B Ligation and stripping of long saphenous vein	376.31	150.73
50.4 C Ligation and stripping of long and short saphenous veins	435.66	226.10
50.4 D Ligation and stripping of short saphenous vein	232.94	113.05
50.4 F Radical multiple ligation of incompetent communicating veins of lower leg (extrafascial ligation or Cockett procedure, subfascial ligation) excludes stripping of long saphenous vein	501.74	226.10

50.5 Other excision of vessels

50.51 Other excision of intracranial vessels

50.51A Surgical treatment of intracranial arterio-venous malformation NOTE: Includes craniotomy.	3,618.45	678.33

50.53 Other excision of upper limb vessels

50.53A Excision of congenital or traumatic peripheral AV fistula	492.33	216.84

50.58 Other excision of lower limb vessels

50.58A Preparation of autogenous saphenous vein for graft NOTE: May not be claimed with HSCs 48.12, 48.13, 48.14, 48.15A, 48.15B, 48.15C and 48.15D.	215.85	125.10
50.58B Excision of congenital or traumatic peripheral AV fistula	492.33	226.10
50.58C Harvest of alternative autogenous conduit (radial artery, brachio-cephalic vein, superficial femoral vein, hypogastric artery), additional benefit NOTE: 1. Benefit excludes harvest/preparation of vein for dialysis access. 2. May not be claimed with HSCs 48.12, 48.13, 48.14, 48.15A, 48.15B, 48.15C and 48.15D.	588.79	111.71

50.59 Other excision of vessels, unspecified site

50.59A Excision of congenital or traumatic peripheral AV fistula	493.36	226.10

50.6 Plication or other interruption of vena cava

50.6 A Ligation or plication of vena cava	363.55	169.78
50.6 B Percutaneous insertion of intravascular filter NOTE: Includes contrast studies.	451.31	169.78

50.7 Other surgical occlusion of vessels

50.71 Other surgical occlusion of intracranial vessels

50.71A Repair of carotid-cavernous sinus fistula	1,763.50	596.35
50.71B Exploration of cavernous sinus Includes that with removal or surgical correction of lesion(s)	3,041.34	1,067.47
50.71C Balloon embolization of caroticocavernous fistula Includes intraoperative angiograms	846.97	

50.72 Other surgical occlusion of head and neck vessels

50.72A External carotid artery ligation	220.54	111.71

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

50 INCISION, EXCISION, AND OCCLUSION OF VESSELS (cont'd)

50.7 Other surgical occlusion of vessels (cont'd)

50.72 Other surgical occlusion of head and neck vessels (cont'd)

		BASE	ANE
50.72B	Ligation of carotid artery That for intracranial aneurysm	483.76	204.96
50.72C	Internal jugular vein ligation	121.85	112.95

50.75 Other surgical occlusion of thoracic vessels

50.75A	Ligation or division of shunt in conjunction with a major procedure	673.80	268.07
50.75B	Pulmonary artery banding	673.80	358.00
50.75C	Ligation of patent ductus arteriosus	673.80	385.28
50.75D	Ligation of patent ductus in association with congenital heart surgery	122.41	111.71

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

50 INCISION, EXCISION, AND OCCLUSION OF VESSELS (cont'd)

50.7 Other surgical occlusion of vessels (cont'd)

50.75 Other surgical occlusion of thoracic vessels (cont'd)

	BASE	ANE
50.75E Percutaneous, transvascular closure of patent ductus arteriosus with umbrella	812.20	554.01
NOTE: Includes all associated catheterizations performed during the same sitting, includes pressure and oxygen saturation measurements, angiography and management of intra-procedural complications.		
50.76 Other surgical occlusion of abdominal arteries		
50.76A Ligation, iliac artery ligation	337.89	142.97
50.77 Other surgical occlusion of abdominal veins		
50.77A Ligation, abdominal veins	292.21	178.71
50.78 Other surgical occlusion of lower limb vessels		
50.78A Superficial femoral vein ligation	301.04	111.71
50.79 Other surgical occlusion of vessels, site unspecified		
50.79A Vascular occlusion by catheter, to include intraoperative angiograms, per vessel	412.67	169.57
NOTE: 1. A single call applies regardless of the number of lesions treated within a single vessel. 2. Multiple calls may only be claimed when multiple vessels are treated.		

50.8 Selective angiography using contrast material

NOTE: 1. A separate angiographic procedure can be billed whenever repositioning or exchange of a catheter is required to obtain an additional angiographic study of a different region of the same vessel, or to obtain selective or superselective injection of a different artery or vein. It may also be claimed when there is multiple site venous sampling that requires repositioning or exchange of a catheter.
2. For each additional selective injection, refer to Price List. Maximums apply.

50.81 Angiography of cerebral vessels		
50.81A Selective arterial injection	208.65	
50.81B Direct arterial injection, carotid artery	106.26	113.05
50.81C Direct arterial injection, vertebral artery	107.42	112.95
50.81D Direct arterial injection, carotid artery, requiring cutdown	235.82	178.71
50.81E Retrograde brachial injection	105.03	
50.82 Aortography		
50.82A Trans-arterial catheter injection	201.30	
50.82B Direct trans-lumbar injection	117.64	111.81

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

50 INCISION, EXCISION, AND OCCLUSION OF VESSELS (cont'd)

50.8 Selective angiography using contrast material (cont'd)

50.83 Angiography of pulmonary vessels

	BASE	ANE
50.83A Main pulmonary artery or selective arterial injection	166.29	
50.84 Angiography of other intrathoracic vessels		
50.84A Superior vena cavography via SVC catheter	183.92	
50.84B Selective arterial injection	148.79	
50.84C Selective venous injection	122.53	
50.87 Angiography of other intra-abdominal vessels		
50.87A Selective arterial injection	208.65	
50.87B Inferior vena cavography via IVC catheter	208.65	
50.87C Selective venous injection	208.65	
50.88 Angiography of femoral vessels		
50.88A Selective arterial injection	199.63	
50.89 Angiography of other vessels NEC		
50.89A Peripheral artery, direct arterial injection	35.01	113.05
50.89B Peripheral venography direct injection, any area	27.82	
50.89C Peripheral venography cutdown and direct injection	42.01	
50.89D Selective arterial injection of unspecified site	35.01	
50.89E Selective venous injection of unspecified site	208.10	

50.9 Other invasive procedures on vessels

50.91 Arterial catheterization		
50.91B Peripheral artery, cutdown	152.15	
50.91C Placement of indwelling vascular catheter in the hepatic artery for infusion therapy, includes correction of anomalous circulation when indicated	120.79	241.27
50.91D Radial arterial line access NOTE: May not be claimed in addition to HSCs 48.98A, 48.98B, 51.59A, 51.59B, 51.59D, 51.59E and 51.59F.	54.54	
50.91E Femoral arterial line access Note: May not be claimed in addition to HSCs 48.98A, 48.98B, 51.59A 51.59B, 51.59D, 51.59E and 51.59F.	54.44	
50.93 Other venous catheterization		
50.93A Percutaneous insertion of catheter into blood vessel NOTE: For hemodialysis or hemoperfusion.	162.29	150.73
50.94 Central venous pressure monitoring		
50.94B Insertion of a tunnelled central line in an infant	352.64	112.95

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

50 INCISION, EXCISION, AND OCCLUSION OF VESSELS (cont'd)

50.9 Other invasive procedures on vessels (cont'd)

50.94 Central venous pressure monitoring (cont'd)

	BASE	ANE
NOTE: May only be claimed for infants of up to 5 kg or a post conceptual age of less than 60 weeks		

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

50 INCISION, EXCISION, AND OCCLUSION OF VESSELS (cont'd)

50.9 Other invasive procedures on vessels (cont'd)

50.94 Central venous pressure monitoring (cont'd)

		BASE	ANE
50.94D	Introduction of central venous catheter, with or without ultrasound guidance NOTE: May not be claimed in addition to HSC 49.95A.	67.83 V	144.57
50.94E	Introduction of catheter into peripheral vein, requiring ultrasound guidance NOTE: May not be claimed for routine venous access or initiation of intravenous.	68.20 V	144.57

50.95 Other circulatory monitoring

50.95A	Insertion of flow directed (Swan Ganz) catheter, and all monitoring thereof NOTE: May not be claimed in addition to HSC 49.95A.	113.78	151.90
50.95B	Cardiac output studies NOTE: 1. Claimable by whatever method. 2. One per day per patient. 3. May be claimed in addition to cardiac catheterization.	105.00	
50.96	Venous cutdown	39.80	

50.97 Biopsy of blood vessel

50.97A	Biopsy of temporal artery	73.95 V	113.05

50.98 Other puncture of artery

50.98A	For blood/gas analysis	17.12	

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

50 INCISION, EXCISION, AND OCCLUSION OF VESSELS (cont'd)

50.9 Other invasive procedures on vessels (cont'd)

50.98 Other puncture of artery (cont'd)

		BASE	ANE
50.98B	Arterial access procedure	83.33	
	NOTE: 1. May only be claimed: -for hospital inpatients under the age of 3 years. -where the procedure requires physician involvement due to a previously failed attempt or when suitable qualified personnel are unavailable. 2. May be claimed in addition to a hospital visit or consultation. 3. An unscheduled service modifier may not be claimed if a hospital visit or consultation is claimed. 4. May not be claimed in addition to 16.81A or 50.99C.		

50.99 Other puncture of vein

50.99A	Obtaining laboratory specimen (blood)	17.04	
	NOTE: 1. May only be claimed for services provided to out of province Canadian residents. 2. May be claimed by the facility responsible for the collection and referral of the specimen, if no examination is carried out on the specimen by the referring facility. 3. May not be claimed by non-laboratory facilities in urban and metropolitan areas.		
50.99B	Insertion of long dwelling intravascular catheter requiring subcutaneous tunnel	232.22	148.91
50.99F	Removal and reinsertion of long dwelling intravascular catheter requiring subcutaneous tunnel under general anesthesia	435.66	244.96
50.99G	Removal of long dwelling intravascular catheter requiring subcutaneous tunnel under general anesthesia	159.39	113.05
50.99C	Venous access procedure	83.33	
	NOTE: 1. May only be claimed: -for hospital inpatients under the age of 3 years. -where the procedure requires physician involvement due to a previously failed attempt or when suitable qualified personnel are unavailable. 2. May be claimed in addition to a hospital visit or consultation. 3. An unscheduled service modifier may not be claimed if a hospital visit or consultation is claimed. 4. May not be claimed in addition to 16.81A or 50.98B.		
50.99D	Phlebotomy	52.29	
	NOTE: 1. May only be claimed for hospital inpatients under the age of 2 years. 2. May be claimed in addition to a hospital visit or consultation.		

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

50 INCISION, EXCISION, AND OCCLUSION OF VESSELS (cont'd)

50.9 Other invasive procedures on vessels (cont'd)

50.99 Other puncture of vein (cont'd)

	BASE	ANE
50.99E Peripheral embolectomy or endarterectomy, additional benefit	205.71	111.71
NOTE: 1. May only be claimed in association with other vascular surgery through the same arteriotomy. 2. A single call applies regardless of the number of embolectomies or endarterectomies provided in the same vessel. 3. Multiple calls may only be claimed when multiple vessels are treated.		

51 OTHER OPERATIONS ON VESSELS

51.0 Systemic to pulmonary artery shunt		
51.0 A Anastomosis, pulmonary, aortic, subclavian or superior vena cava	734.44	584.12
51.1 Intra-abdominal venous anastomosis		
51.1 A Porto-systemic shunt	1,154.93	414.53
51.2 Other shunt or vascular bypass		
51.21 Caval-pulmonary artery anastomosis		
51.21A Repair or correction of tricuspid atresia	2,186.05	1,018.66
51.21B Anastomosis of pulmonary artery to systemic venous atrium (with or without conduit)	2,575.10	1,209.81
51.21C Bidirectional cavopulmonary anastamosis	2,575.10	1,209.81
51.22 Aorta-subclavian-carotid bypass		
51.22A Aorta-great vessel bypass - distal anastomosis	1,776.60	1,388.34
NOTE: If multiple anastomoses are performed, refer to price list.		
51.24 Aorta-renal bypass		
51.24A Renal artery reconstruction	652.26	405.00
51.24B Aorto-renal or aorto-visceral reconstruction for occlusive disease or aneurysm	1,254.35	508.74
NOTE: May not be claimed with other services performed at the same operative encounter.		
51.25 Aorta iliac-femoral bypass		
51.25A Aorta femoral	1,733.59	898.72
51.25B Aorta-bifemoral	2,458.53	1,508.83
51.26 Other intra-abdominal shunt or bypass		
51.26A Visceral artery reconstruction, any method	657.28	362.31

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

51 OTHER OPERATIONS ON VESSELS (cont'd)

51.2 Other shunt or vascular bypass (cont'd)

51.27 Arteriovenostomy for renal dialysis

	BASE	ANE
51.27A Creation of AV fistula	528.32	188.43

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

51 OTHER OPERATIONS ON VESSELS (cont'd)

51.2 Other shunt or vascular bypass (cont'd)

51.28 Extracranial-intracranial (ED-IC) vascular bypass

	BASE	ANE
51.28A Intracranial arterial bypass	3,346.25	1,162.99
NOTE: Includes vein graft harvesting.		
51.29 Other (peripheral) shunt or bypass		
51.29A Femoral-popliteal	1,354.70	362.31
51.29C Femoral-tibial	1,605.57	430.23
51.29D Axillo-femoral	1,292.13	317.01
51.29E Femoro-femoral	1,204.18	282.63
51.29F Prosthetic graft for vascular access	464.46	188.43
51.29G Superficial femoral to greater saphenous shunt	702.44	232.32
51.3 Suture of vessel		
51.3 A Repair of traumatic injury to major vessels, trunk	665.94	317.01
51.3 B Repair to peripheral vessels, traumatic injury	759.69	294.37
NOTE: May not be claimed in addition to HSCs 50.34DA, 50.34FA, 50.34GA, 50.34HA, 50.34JA, 50.34KA, 50.34KB and 50.34LA.		
51.3 C Repair of thoracic aortic injury	1,348.75	560.20
51.4 Revision of vascular procedure		
51.43 Removal of arteriovenous shunt for renal dialysis	70.54 V	113.05
51.49 Other revision of vascular procedure		
51.49B Excision of arteriovenous graft	275.21	149.07
51.49C Repair of aorto-enteric fistula, or removal of infected aortic graft, with extra anatomic bypass	BY ASSESS	
51.5 Other repair of vessels		
51.51 Clipping of intracranial aneurysm		
51.51A Surgical treatment of intracranial aneurysm includes craniotomy	2,736.05	815.18
51.52 Other repair of aneurysm		
51.52A Ultrasound assisted percutaneous thrombosis of an arterial aneurysm	195.13	
51.53 Repair of arteriovenous fistula		
51.53A Ligation and division, AV fistula	117.12 V	112.95
51.53B Ultrasound assisted percutaneous thrombosis of an arterial fistula	140.49	
51.58 Repair of blood vessel with unspecified type of patch graft		
51.58A Patch angioplasty - popliteal/tibial artery	1,128.92	815.18
51.58B Patch angioplasty - upper extremity vessel	612.12	815.18

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

51 OTHER OPERATIONS ON VESSELS (cont'd)

51.5 Other repair of vessels (cont'd)

51.59 Other repair of blood vessel NEC

		BASE	ANE
51.59A	Open transluminal angioplasty	424.05	216.84
	NOTE: 1. Benefit includes intra-operative angiography. 2. Benefit will be reduced when performed in association with another vascular procedure; refer to Price List. 3. May not be claimed in addition to HSCs 50.91D or 50.91E.		
51.59B	Percutaneous transluminal angioplasty, excluding coronary vessels	548.68	153.59
	NOTE: 1. May not be claimed in addition to HSCs 50.91D or 50.91E. 2. A single call applies regardless of the number of angioplasties provided in the same vessel. 3. Multiple calls may only be claimed when multiple vessels are treated.		
51.59D	Percutaneous transluminal coronary angioplasty with associated diagnostic angiogram	1,164.04	361.42
	NOTE: 1. May be claimed when the diagnostic angiogram is intended to determine appropriate treatment of the patient's coronary anatomy and is immediately followed by a coronary angioplasty by the same cardiologist. 2. Benefit includes other angiograms performed on the same date of service. 3. For each additional coronary vessel, refer to Price List. 4. Role modifier ASIC may be claimed for assistance at coronary angioplasty by a second interventional cardiologist. 5. May not be claimed in addition to HSCs 50.91D or 50.91E.		
51.59E	Percutaneous transluminal coronary angioplasty without associated angiogram	901.47	357.43
	NOTE: 1. Patient will have had a previous angiogram to determine appropriate treatment. 2. May be claimed where the diagnosis has been determined and the patient's need for angioplasty has been established before the date of the procedure. 3. Coronary angiography may not be claimed on the same date of service by the same or different physician. 4. For each additional coronary vessel, refer to Price List. 5. Role modifier ASIC may be claimed for assistance at coronary angioplasty by a second interventional cardiologist. 6. May not be claimed in addition to HSCs 50.91D or 50.91E.		

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

51 OTHER OPERATIONS ON VESSELS (cont'd)

51.5 Other repair of vessels (cont'd)

51.59 Other repair of blood vessel NEC (cont'd)

		BASE	ANE
51.59F	Percutaneous transluminal coronary angioplasty without associated angiogram	866.46	357.43
	NOTE: 1. May be claimed when another physician has performed the angiogram on the same date of service which established the need for the angioplasty and has claimed 48.98B for the coronary angiogram. 2. Coronary angiography (48.98B) may not be claimed by the same physician on the same date of service. 3. For each additional coronary vessel, refer to Price List. 4. Role modifier ASIC may be claimed for assistance at coronary angiography by a second interventional cardiologist when medically required. 5. May not be claimed in addition to HSCs 50.91D or 50.91E.		
51.59G	Device assisted percutaneous coronary intervention including but not exclusive to rotoblation, retrograde total occlusions and clot aspiration devices, additional benefit	194.30	
	NOTE: May only be claimed in addition to HSCs 51.59D, 51.59E and 51.59F.		

51.6 Extracorporeal circulation and procedures auxiliary to open heart surgery

51.61 Extracorporeal circulation auxiliary to open heart surgery

51.61A	For open heart surgery	620.04	223.38
51.61B	For other procedures not connected with open heart surgery	430.14	243.96
51.61C	Percutaneous cardiopulmonary bypass	464.46	111.71
	NOTE: 1. May be claimed in addition to concomitant procedure fees. 2. Benefit includes care, removal and hemostasis.		
51.61D	Hypothermic circulatory arrest for open heart surgery	441.58	116.17

51.65 Extracorporeal membrane oxygenation (ECMO)

51.65A	Priming of oxygenator	156.73	
51.65B	Sedation for cannulation/decannulation	171.16	
	NOTE: May not be claimed by the same physician who is claiming anesthetic services for HSCs 51.65A, 51.65C or 51.65D.		
51.65C	Arterial and venous cannulation	719.56	
51.65D	Arterial and venous decannulation	480.47	
	NOTE: Includes repair of vessels.		

51.8 Operations on carotid body and other vascular bodies

51.8 A	Resection of carotid body tumor	1,379.79	1,090.84

VIII. OPERATIONS ON THE CARDIOVASCULAR SYSTEM (cont'd)

51 OTHER OPERATIONS ON VESSELS (cont'd)

51.9 Other operations on vessels

51.92 Injection of sclerosing agent or solution into vein

		BASE	ANE
51.92A	Varicose vein, single injection	14.08	
	NOTE: 1. Sclerotherapy for asymptomatic varicose veins is not an insured service. 2. At any one visit, a maximum of three HSC 51.92B may be claimed in addition to a 51.92A. 3. A maximum of six HSC 51.92A and eighteen 51.92B may be claimed per benefit year. 4. May be claimed in addition to a visit or a consultation.		
51.92B	Varicose vein, additional injection	7.37	
	NOTE: Refer to notes following 51.92A.		

51.98 Control of hemorrhage, not otherwise specified

51.98A	Reoperation for bleeding following cardiac surgery	511.36	249.08
	NOTE: Patient must have left both operating room suite and post anesthetic (recovery) room.		

51.99 Other operations on vessels NEC

51.99A	Percutaneous removal or attempted removal of intravascular foreign bodies	417.69	188.43
51.99B	Percutaneous removal or lysis of embolus or thrombus in any vessel	451.31	188.43
	NOTE: Includes angiography performed during the procedure.		

IX. OPERATIONS ON THE HEMIC AND LYMPHATIC SYSTEMS

52 OPERATIONS ON LYMPHATIC SYSTEM

		BASE	ANE
52.0	Incision of lymphatic structure		
52.0 A	Drainage, deep cervical abscess	310.93	113.05
52.1	Simple excision of lymphatic structure		
52.1 A	Biopsy, superficial lymph node	52.93 V	113.05
52.1 B	Cystic hygroma, full 60 minutes or major portion thereof for the first call when only one call is claimed	270.96	150.73
52.11	Excision of deep cervical lymph node (with excision of scalene fat pad)		
52.11A	Excision deep cervical lymph node	166.15	113.05
52.11B	Scalene fat pad excision	265.65	113.05
52.12	Excision of internal mammary lymph node	151.98	112.95
52.13	Excision of axillary lymph node	184.88	113.05
52.14	Excision of inguinal lymph node That for tissue cross matching purposes	169.24	113.05
52.2	Regional lymph node excision		
52.2	Regional lymph node excision That for TB etc NOTE: May not be claimed in addition to HSCs 55.8 B, 55.9 AA and 63.69A.	253.15	113.05
52.3	Radical excision of cervical lymph nodes		
52.31	Radical neck dissection, unqualified		
52.31A	Limited neck dissection (suprahyoid) NOTE: HSCs 17.32A or 98.51F may not be claimed in addition, by the same or different physician at the same encounter.	397.22	188.43
52.31B	Modified neck dissection with preservation of either one or two of the non-lymphatic structures, (e.g., sternocleidomastoid muscle, jugular vein or spinal accessory nerve), unilateral including removal of all neck lymph nodes NOTE: 1. May not be claimed with HSCs 50.72C or 95.14E. 2. HSCs 17.32A or 98.51F may not be claimed in addition, by the same or different physician at the same encounter.	1,087.17	469.86
52.31C	Functional or selective neck dissection with preservation of all non-lymphatic structures, (e.g., sternocleidomastoid muscle, jugular vein, spinal accessory nerve), unilateral, including removal of three or more nodal levels in the neck	1,539.57	621.80

IX. OPERATIONS ON THE HEMIC AND LYMPHATIC SYSTEMS (cont'd)

52 OPERATIONS ON LYMPHATIC SYSTEM (cont'd)

52.3 Radical excision of cervical lymph nodes (cont'd)
52.31 Radical neck dissection, unqualified (cont'd)

	BASE	ANE

NOTE: 1. May not be claimed with HSCs 50.72C or 95.14E
2. HSCs 17.32A or 98.51F may not be claimed in addition, by the same or different physician at the same encounter.

IX. OPERATIONS ON THE HEMIC AND LYMPHATIC SYSTEMS (cont'd)

52 OPERATIONS ON LYMPHATIC SYSTEM (cont'd)

52.3 Radical excision of cervical lymph nodes (cont'd)
52.31 Radical neck dissection, unqualified (cont'd)

	BASE	ANE
52.31D Extended neck dissection Removal of all neck lymph nodes and some non-lymphatic structures other than spinal accessory nerve, sternocleidomastoid muscle, or jugular vein. These structures may include the scalene muscle, deep neck muscles, hypoglossal nerve, carotid artery extensive resection of skin, etc, all related to or required because of tumor invasion of those structures NOTE: 1. May not be claimed with HSCs 50.72A, 50.72C, 95.14C, 95.14E. 2. HSCs 17.32A or 98.51F may not be claimed in addition, by the same or different physician at the same encounter.	1,884.29	433.37

52.4 Radical excision of other lymph nodes

52.42 Radical excision of axillary lymph nodes	690.68	207.27

52.43 Radical excision of peri-aortic lymph nodes

52.43A Radical Retroperitoneal lymph node dissection, thoracoabdominal or transperitoneal	751.20	571.87
52.43B Open retroperitoneal node dissection, thoracoabdominal or transperitoneal, for testicular cancer	2,436.89	632.47

52.45 Radical groin dissection

52.45A Radical inguinal lymph node dissection	563.17	188.43

52.49 Radical excision of other lymph nodes

52.49A Radical mediastinal node dissection	BY ASSESS	
52.49B Popliteal resection	460.12	187.66
52.49C Pelvic lymphadenectomy for gynecological malignancy	516.58	226.45
52.49D Pelvic lymphadenectomy That for carcinoma of the prostate or bladder	435.16	204.97

52.8 Invasive diagnostic procedures on lymphatic structures
52.85 Other lymphangiogram

52.85A Injection, any area	154.94	

52.89 Other invasive diagnostic procedures on lymphatic structures

52.89A Staging laparotomy NOTE: Includes splenectomy.	1,003.27	414.53
52.89C Sentinel node biopsy for skin and other cancers	377.22	150.73

IX. OPERATIONS ON THE HEMIC AND LYMPHATIC SYSTEMS (cont'd)

53 OPERATIONS ON BONE MARROW AND SPLEEN

53.3 Splenectomy

		BASE	ANE
53.34	Total splenectomy of a normal sized spleen	844.76	362.31
	NOTE: 1. A normal sized spleen is defined as 20 cms or less for patients 12 years of age and older and less than 12 cms for patients younger than 12 years of age. 2. Benefits may not be claimed for incidential splenectomies.		
53.34A	Splenectomy for massive splenomegaly	1,689.51	1,242.49
	NOTE: 1. Massive splenomegaly is defined as greater than 20 cms or at least 12 cms for patients 12 years of age and younger. 2. Size must be confirmed by pre-operative imaging.		

53.4 Other operations on bone marrow

53.42 Injection into bone marrow

53.42A	Intraosseous cannulation	60.49	

53.5 Other operations on spleen

53.51 Excision of accessory spleen

53.51A	Resection of accessory spleen	908.51	346.20
	NOTE: 1. Benefit will be paid at 100% when only procedure performed. 2. When performed with HSC 53.34, benefit will be paid as ADD. Refer to Price List.		

53.53 Repair and plastic operations on spleen

53.53A	Spleen - rupture with repair	749.12	354.05
	NOTE: May not be claimed for incidental repair.		

53.8 Invasive diagnostic procedures on bone marrow and spleen

53.81 Biopsy of bone marrow

53.81A	Aspiration biopsy of bone marrow	56.82	
53.81B	Needle biopsy of bone marrow	56.82 V	113.05

53.83 Aspiration biopsy of spleen

53.83A	Needle biopsy of spleen	119.78 V	111.71

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION

54 OPERATIONS ON ESOPHAGUS

	BASE	ANE
54.0 Esophagotomy		
54.09 Other incision of esophagus		
54.09A Esophagotomy for removal of foreign body, cervical	610.51	244.96
54.09B Esophagotomy for removal of foreign body, transthoracic	807.19	250.21
54.1 Esophagostomy		
54.12 Cervical esophagostomy	472.68	241.27
54.21B Removal of tumor via rigid esophagoscopy	203.15	126.50
54.21C With palliative bipolar electrocoagulation for obstructive esophageal cancer NOTE: May only be claimed in addition to 01.14.	113.99	111.81
54.21D With electrocautery or injection hemostasis for esophageal hemorrhage NOTE: 1. May only be claimed in addition to 01.14. 2. Single benefit applies regardless of the number of sites or applications.	136.79	111.81
54.21E With esophageal polypectomy(s) NOTE: May only be claimed in addition to 01.14.	62.73	111.81
54.22 Local excision of esophageal diverticulum		
54.22A Esophagotomy for removal of diverticulum, cervical	569.81	244.96
54.22B Esophagotomy for removal of diverticulum, transthoracic	690.68	271.07
54.29 Other local excision of other lesion or tissue of esophagus		
54.29A Esophagotomy for removal of tumor, cervical	582.21	207.83
54.3 Excision of esophagus		
54.32 Partial esophagectomy		
54.32A Resection with primary anastomosis	1,105.09	475.52
54.33 Total esophagectomy		
54.33A Total esophagectomy	1,260.49	543.46
54.33B Total esophagectomy with immediate interposition of hollow viscus	2,100.81	1,036.95
54.6 Esophagomyotomy		
54.6 Esophagomyotomy NOTE: May not be claimed with 54.76A, 65.7B, 65.8B or 65.8C.	891.04	376.84
54.7 Other repair of esophagus		
54.76 Esophagogastroplasty		
54.76A Esophagogastric reconstruction for complex foregut procedure	1,489.47	508.74
54.79 Other repair of esophagus NEC		
54.79A Primary repair of esophageal atresia and tracheoesophageal fistula	2,343.00	1,030.04
54.79B Reconstruction of esophagus by interposition of hollow viscus	1,380.18	546.44

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

54 OPERATIONS ON ESOPHAGUS (cont'd)

54.8 Invasive diagnostic procedures on esophagus

54.89 Other invasive diagnostic procedures on esophagus

		BASE	ANE
54.89A	Esophageal pH monitoring, 24 hours	85.49	
54.89B	Measurement of esophageal motility using triple lumen tube	113.99	
54.89D	Esophageal motility study and pH monitoring of distal esophagus, technical	38.44	
54.89E	Esophageal motility study and pH monitoring of the distal esophagus, interpretation	34.20	
54.89F	Acid infusion test (Berstein test)	34.20	

54.9 Other operations on esophagus

54.91 Injection or ligation of esophageal varices

54.91A	Sclerotherapy, additional benefit. NOTE: May only be claimed in addition to HSC 01.14.	113.99	26.80
54.91B	Trans-esophageal ligation of varicosites (through abdomen or chest)	676.91	277.01
54.91C	Banding, additional benefit NOTE: May only be claimed in addition to HSC 01.14.	113.99	111.71

54.92 Dilation of esophagus

54.92A	Rupture of inferior gastroesophageal sphincter by pneumatic bag That for achalasia	170.99	
54.92B	Dilation by sound or bougie, without endoscopy	51.85	
54.92C	Dilation by sound or bougie, via rigid esophagoscopy, initial	147.93	113.05
54.92D	Dilation by sound or bougie, via rigid esophagoscopy, repeat NOTE: Repeat service should be claimed if provided within 14 days of initial.	104.46 V	113.05
54.92E	Dilation by sound or bougie, or esophageal balloon, additional benefit NOTE: May only be claimed in addition to HSC 01.14.	102.59	111.81

54.99 Other operations on esophagus NEC

54.99A	Esophageal stent placement, additional benefit NOTE: May only be claimed in addition to HSC 01.14.	170.99	142.97

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

55 INCISION AND EXCISION OF STOMACH

		BASE	ANE
55.1	Temporary gastrostomy		
55.1 A	Temporary gastrostomy	568.38	188.43
	NOTE: 1. Fee will be paid at 100% when only procedure performed. 2. With other abdominal or gastrointestinal procedures refer to Price List, fee will be paid as ADD or ADD2.		
55.1 B	Percutaneous endoscopic gastrostomy, additional benefit	113.99	111.71
	NOTE: May only be claimed in addition to HSC 01.14.		
55.2	Permanent gastrostomy		
55.2 A	Surgical gastrostomy	531.29	207.27
	NOTE: 1. Benefit will be paid at 100% when only procedure performed. 2. When performed with other abdominal or gastrointestinal procedures, benefit will be paid as ADD or ADD2. Refer to Price List.		
55.3	Pyloromyotomy		
55.3	Pyloromyotomy Ramstedt	517.85	271.72
55.4	Local excision or destruction of lesion or tissue of stomach		
55.41	Endoscopic excision or destruction of lesion or tissue of stomach		
55.41A	Endoscopic excision or destruction of lesion or tissue of stomach (tumor)	103.02	111.81
	NOTE: May only be claimed in addition to 01.14.		
55.41B	Endoscopic gastric polypectomy(s)	47.47	111.81
	NOTE: May only be claimed in addition to 01.14.		
55.43	Other local excision of lesion or tissue of stomach		
55.43A	Gastrotomy for tumor, foreign body	531.29	244.96
55.8	Other partial gastrectomy		
55.8 A	Sub-total	818.14	452.88
	NOTE: May be claimed in addition to HSC 66.83.		
55.8 B	Radical sub-total	1,647.01	543.46
	NOTE: 1. May be claimed in addition to HSC 66.83. 2. May not be claimed in addition to HSCs 52.2, 56.2, 57.7 and 66.3 A.		
55.9	Total gastrectomy		
55.9 A	Total gastrectomy	1,466.37	588.73
	NOTE: May be claimed in addition to HSC 66.83.		

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

55 INCISION AND EXCISION OF STOMACH (cont'd)

55.9 Total gastrectomy (cont'd)

	BASE	ANE
55.9 AA Total gastrectomy for malignancy	2,204.87	588.73
NOTE: May not be claimed with HSCs 52.2, 52.43A, 55.9 A, 56.2, 57.7 and 66.3 A.		
55.99 Other total gastrectomy		
55.99A Thoraco abdominal esophagogastrectomy	1,936.45	996.32
NOTE: May be claimed in addition to HSC 66.83.		

56 OTHER OPERATIONS ON STOMACH

56.0 Vagotomy

56.02 Truncal vagotomy

56.02A Truncal vagotomy, transthoracic or abdominal	262.60	223.38

56.03 Selective vagotomy

56.03A Selective vagotomy	872.89	312.74
56.03B For denervation of parietal cells	876.88	316.78

56.1 Pyloroplasty

56.1 Pyloroplasty	524.15	298.17

56.2 Gastroenterostomy (without gastrectomy)

56.2 Gastroenterostomy (without gastrectomy)	743.81	376.84
NOTE: May not be claimed with HSCs 55.8 B, 55.9 AA, 64.3, 64.43A, 64.49A or 64.7.		

56.3 Control of hemorrhage and suture of ulcer of stomach or duodenum

56.34 Endoscopic control of gastric or duodenal bleeding

56.34A Endoscopic control of gastric or duodenal bleeding with electrocautery or injection hemostasis	136.79	111.81
NOTE: 1. May only be claimed in addition to HSCs 01.14, 01.16B and 01.16C.		
2. Single benefit applies per route (oral or rectal).		

56.39 Other control of hemorrhage of stomach or duodenum

56.39A Suture or other surgical control of bleeding or perforated gastric or duodenal ulcer	908.51	580.90

56.4 Revision of gastric anastomosis

56.4 A Gastrectomy revision with or without resection	1,689.51	508.74
NOTE: May not be claimed in addition to HSC 66.4 A.		

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

56 OTHER OPERATIONS ON STOMACH (cont'd)

56.9 Other operations on stomach

56.93 Gastric partitioning for obesity

	BASE	ANE
56.93A Roux-en-Y Gastric Bypass NOTE: May not be claimed in addition to any other procedure except HSC 65.7 A.	1,700.14	1,072.83
56.93B Adjustable gastric band fill NOTE: 1. A repeat is payable at a reduced rate; refer to the Price List. 2. A maximum of four repeat fills may be claimed per patient, per physician, per calendar year.	159.39 V	
56.93C Sleeve gastrectomy for obesity NOTE: May not be claimed in addition to HSC 66.83.	1,046.65	694.18
56.93D Removal of gastric band NOTE: May not be claimed in addition to HSCs 56.93E, 66.4 A and 66.83.	717.25	541.78
56.93E Port revision or replacement NOTE: May not be claimed in addition to HSC 56.93D.	377.22	150.73
56.93F Placement of gastric band including port placement	871.32	562.99

56.99 Other operations on stomach NEC

56.99A Balloon dilatation of upper gastrointestinal stricture (stomach, duodenum or jejunum) NOTE: 1. May only be claimed in addition to 01.14. 2. A repeat performed within 90 days is payable at 50%.	91.19	89.35

57 INCISION, EXCISION AND ANASTOMOSIS OF INTESTINE

57.0 Enterotomy

57.0 A Removal of foreign body or tumor	637.55	262.04

57.03 Other incisions of small intestine

57.03A Intestinal lengthening, Serial transverse enteroplasty procedure (STEP)	2,434.77	1,495.60

57.04 Incision of large intestine

57.04A Colotomy with removal of foreign body or tumor	637.55	282.63

57.1 Local excision or destruction of lesion or tissue of small intestine

57.12 Other local excision or destruction of lesion or tissue of duodenum

57.12A Diverticulectomy of duodenum	610.99	214.45
57.12B Duodenal diverticulum with choledochostomy	813.15	312.74

57.13 Endoscopic excision or destruction of lesion or tissue of small intestine except duodenum

57.13A Bipolar electrocoagulation/heater probe hemostasis or endoclip placement or argon plasma coagulation for bleeding lesions of the colon following an		

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

57 INCISION, EXCISION AND ANASTOMOSIS OF INTESTINE (cont'd)

57.1 Local excision or destruction of lesion or tissue of small intestine (cont'd)

57.13 Endoscopic excision or destruction of lesion or tissue of small intestine except duodenum (cont'd)

	BASE	ANE
initial procedure at a separate encounter, additional benefit	136.79	111.81
NOTE: 1. May only be claimed in addition to HSCs 01.16B, 01.16C, 01.22, 01.22A, 01.22B, 01.22C, 01.24B, 01.24BA and 01.24BB. 2. May only be claimed in situations where the patient has post-polypectomy bleeding following an initial procedure and must undergo a repeat procedure to manage post-polypectomy bleeding. 3. May not be claimed for services provided at the same encounter as the initial polypectomy.		
57.13B Hemostasis of the colon via bipolar electrocoagulation/heater probe hemostasis, injection or endoclip placement or argon plasma coagulation for bleeding lesions of the colon that are not related to post polypectomy bleeds including but not limited to diverticulum bleeds, radiation enteritis, ulceration of the colon, additional benefit	138.85	111.81
NOTE: 1. May only be claimed in addition to HSCs 01.16B, 01.16C, 01.22, and 01.24B. 2. May not be claimed for prophylactic clip placement.		

57.14 Local excision of lesion or tissue of small intestine, except duodenum

57.14A Meckel's diverticulum resection	531.29	282.63

57.2 Local excision or destruction of lesion or tissue of large intestine

57.21 Endoscopic excision or destruction of lesion or tissue of large intestine

57.21A Polypectomy of large intestine, additional benefit	85.49	111.71

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

57 INCISION, EXCISION AND ANASTOMOSIS OF INTESTINE (cont'd)

57.2 Local excision or destruction of lesion or tissue of large intestine (cont'd)

57.21 Endoscopic excision or destruction of lesion or tissue of large intestine (cont'd)

BASE ANE

NOTE:
1. May only be claimed for the removal of polyps that are greater than 5mm in size.
2. May only be claimed with HSCs 01.16B, 01.16C, 01.22, 01.22A, 01.22B, 01.22C, 01.24B, 01.24BA and 01.24BB and when the removal of a colonic mucosal lesion is performed using a polypectomy snare (with or without electrocautery)or a hot biopsy forceps.
3. May be claimed in addition to HSC 57.21C if polyps are removed from different sites.
4. May not be claimed when a regular biopsy forceps is used to remove a diminutive polyp without electrocautery, even if multiple passes are required.
5. Benefit includes placement of clips at the time of polypectomy.
6. Each additional polyp may be claimed at the rate specified on the Price List; a maximum benefit of six calls applies.

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

57 INCISION, EXCISION AND ANASTOMOSIS OF INTESTINE (cont'd)

57.2 Local excision or destruction of lesion or tissue of large intestine (cont'd)

57.21 Endoscopic excision or destruction of lesion or tissue of large intestine (cont'd)

	BASE	ANE
57.21B Injection hemostasis, additional benefit	94.18	111.81

For vascular abnormalities of colon

NOTE: 1. May not be claimed for control of bleeding, following polypectomies.
2. Maximum of one per sitting irrespective of the number of sites involved.
3. May only be claimed in addition to HSCs 01.22, 01.22A, 01.22B, 01.22C, 01.24B, 01.24BA and 01.24BB.
4. May be claimed in addition to HSC 57.21C if polyps are removed from a different site.

57.21C Removal of sessile polyp, additional benefit	175.00	149.07

NOTE: 1. May only be claimed for polyps greater than 2 cms in size requiring submucosal injection and piecemeal resection.
2. May only be claimed in addition to HSCs 01.22, 01.22A, 01.22B, 01.22C, 01.24B, 01.24BA and 01.24BB.
3. May be claimed in addition to HSC 57.21A if polyps are removed from different sites.
4. May not be claimed for pedunculated polyps.
5. Benefit includes placement of clips at the time of polypectomy.
6. A maximum of two calls applies.

57.4 Other excision of small intestine

57.42 Other partial resection of small intestine

57.42A Small bowel resection	717.25	362.31

NOTE: 1. May only be claimed with HSC 57.59A when two anastomoses are performed.
2. May only be claimed with HSC 60.52B when two discontinuous areas are resected and two anastomoses are performed.
3. May not be claimed in addition to HSCs 57.7 or 63.12B.

57.42B Massive resection, over 60%	1,062.59	376.84

NOTE: May not be claimed with HSCs 60.52A or 60.52B.

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

57 INCISION, EXCISION AND ANASTOMOSIS OF INTESTINE (cont'd)

57.5 Partial excision of large intestine

57.59 Other partial excision of large intestine

	BASE	ANE
57.59A Partial or segmental colectomy	1,030.71	762.54
NOTE: 1. Benefit includes right hemicolectomy, left hemicolectomy, sigmoid colectomy or extended right hemicolectomy. 2. More than one call may be claimed if two or more anastomoses are performed. 3. May only be claimed with HSC 60.52B when two discontinuous areas are resected and two anastomoses are performed. 4. May not be claimed with HSC 60.52A or 63.12B.		

57.6 Total colectomy

57.6 A Total colectomy with or without ileostomy	1,344.17	670.59
NOTE: Refer to the note following HSC 57.6 E.		
57.6 B Total proctocolectomy with ileostomy	1,498.25	602.96
NOTE: Refer to the note following HSC 57.6 E.		
57.6 C Total proctocolectomy with continent ileostomy	1,754.35	686.70
NOTE: Refer to the note following HSC 57.6 E.		
57.6 D Total proctocolectomy with diverting ileostomy, ileo-anal pouch and ileo-anal anastomosis	2,438.64	697.17
NOTE: Refer to the note following HSC 57.6 E.		
57.6 E Creation of ileo-anal pouch and ileo-anal anastomosis following previous total colectomy	1,657.63	602.96
NOTE: HSCs 57.6 A through 57.6 E may not be claimed in addition to HSCs 60.52A or 60.52B.		
57.6 F Colon j pouch or coloplasty construction, additional benefit	154.07	113.05
NOTE: May only be claimed in addition to HSC 60.52B.		

57.7 Small to small intestinal anastomosis

57.7 Small to small intestinal anastomosis	743.81	282.63
NOTE: 1. May be claimed for ileostomy closure and/or stricturoplasty. 2. May not be claimed in addition to HSCs 55.8 B, 55.9 AA, 57.42A or 63.69A.		

57.8 Other anastomosis of intestine

57.82 Anastomosis of small intestine to rectal stump

57.82A Reanastomosis of colon following Hartman procedure	1,030.71	414.53

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

57 INCISION, EXCISION AND ANASTOMOSIS OF INTESTINE (cont'd)

57.8 Other anastomosis of intestine (cont'd)
57.85 Anastomosis of anus

	BASE	ANE
57.85A Completion of perianal portion of anastomosis	154.07	124.95
NOTE: 1. This benefit is for the second surgeon. 2. May not be claimed in addition to any other procedures by the same physician at the same encounter.		

57.9 Invasive diagnostic procedures on intestine
57.92 Other biopsy of small intestine

57.92A Crosby capsule, jejunal biopsy	85.01 V	134.04
NOTE: For under 13 years of age, refer to Price List.		

58 OTHER OPERATIONS ON INTESTINE

58.1 Colostomy
58.11 Colostomy, unqualified

58.11A Colostomy	451.60	244.96
NOTE: May be claimed when a temporary or permanent colostomy is performed regardless of the type, i.e. loop or end colostomy.		

58.12 Temporary colostomy

58.12A Cecostomy	451.60	150.73
NOTE: When only procedure performed.		
58.13C Mitrofanoff antegrade continence enema	696.25	271.06

58.3 Other enterostomy
58.39 Other enterostomy NEC

58.39A Enterostomy primary procedure	605.67	244.96
NOTE: 1. Fee will be paid at 100% when only procedure performed. 2. With other abdominal or gastrointestinal procedures refer to Price List, fee will be paid as ADD or ADD2. 3. To a maximum of two per operation.		
58.39B Percutaneous endoscopic jejunostomy	97.41	111.81
NOTE: May only be claimed in addition to 01.14.		
58.39C Intra-operative placement of small bowel feeding tube, additional benefit	100.95	111.71

58.4 Revision of intestinal stoma
58.42 Revision of stoma of small intestine

58.42A Ileostomy revision	531.29	263.79
NOTE: Includes laparotomy and lysis of adhesions.		

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

58 OTHER OPERATIONS ON INTESTINE (cont'd)

58.4 Revision of intestinal stoma (cont'd)

58.44 Other revision of stoma of large intestine

		BASE	ANE
58.44A	Colostomy revision	584.42	263.79
	NOTE: Includes laparotomy and lysis of adhesions.		

58.7 Other repair of intestine

58.73	Other suture of small intestine, except duodenum	610.99	358.00
	NOTE: 1. May not be claimed for incidental bowel perforations.		
	2. May not be claimed in addition to HSC 63.12B.		

58.75 Suture of large intestine

58.75A	Suture of large or small intestine	717.25	358.00
	NOTE: 1. May not be claimed for incidental bowel perforations.		
	2. May not be claimed in addition to HSC 63.12B.		

58.8 Intra-abdominal manipulation of intestine

58.81 Intra-abdominal manipulation of intestine, unqualified

58.81A	Any form of obstruction without resection	717.25	362.31
58.81B	Any form of obstruction with enterotomy decompression	876.63	430.23
58.81C	Any form of obstruction with resection	1,073.21	451.92
	NOTE: May not be claimed with HSCs 60.52A or 60.52B.		
58.81D	Neonatal intestinal obstruction, atresia or meconium ileus	1,955.16	814.98

58.9 Other operations on intestines

58.99 Other operations on intestines NEC

58.99B	Decompression of sigmoid volvulus (trans-rectal)	170.99	112.95
58.99C	Balloon dilatation of lower gastrointestinal (ileum or colonic) stricture	91.19	89.35
	NOTE: 1. May only be claimed in addition to HSCs 01.16B, 01.16C, 01.22, 01.22A, 01.22B, 01.22C and 01.24B.		
	2. A repeat performed within 90 days is payable at 50%.		
58.99D	Balloon dilatation of lower gastrointestinal (ileum or colonic) stricture in association with sigmoidoscopy	64.66	89.35
	NOTE: 1. May only be claimed in addition to HSCs 01.24A, 01.24B, 01.24BA and 01.24BB.		
	2. A repeat performed within 90 days is payable at 50%.		
58.99E	Intraoperative colonic lavage	154.07	
	NOTE: May only be claimed in addition to HSCs 57.59A, 57.6 A, 57.6 B, 57.6 C, 57.6 D, 57.6 E, 57.82A, 58.81A, 58.81B, 58.81C, 60.39A, 60.4 A, 60.4 B, 60.52A, 60.52B, 60.54, 60.59A and 60.59B.		

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

58 OTHER OPERATIONS ON INTESTINE (cont'd)

58.9 Other operations on intestines (cont'd)
58.99 Other operations on intestines NEC (cont'd)

	BASE	ANE
58.99F Manual disimpaction of stool	100.00 V	113.05
NOTE: May be claimed in addition to a visit or consultation.		

59 OPERATIONS ON APPENDIX

59.0 Appendectomy

59.0 A Appendectomy with or without abscess	531.29	188.43
NOTE: May not be claimed for incidental appendectomies.		

60 OPERATIONS ON RECTUM AND PERIRECTAL TISSUE

No additional benefits for sigmoidoscopy

60.2 Local excision or destruction of lesion or tissue of rectum

60.24 Local excision of rectal lesion or tissue

60.24C Rectal polyp including villous adenoma, per 30 minutes or major portion thereof	313.46	150.73
NOTE: A maximum of three hours may be claimed.		

60.3 Pull-through resection of rectum
60.39 Other pull-through resection of rectum

60.39A Imperforated anus, abdominal perineal repair	1,264.48	397.56

60.4 Abdominoperineal resection of rectum

60.4 A Abdominal-perineal resection	1,657.63	520.81
NOTE: This benefit is for the abdominal surgeon.		
60.4 B Perineal portion of abdomino-perineal resection	478.16	
NOTE: 1. May be claimed by the same or different physician regardless of who performed the abdominal portion of the surgery. 2. May only be claimed in addition to HSCs 57.6 B, 60.4 A and 60.52B		

60.5 Other resection of rectum
60.52 Other anterior resection

60.52A Anterior segmental resection, rectosigmoid	1,110.40	520.81
NOTE: May not be claimed in addition to HSCs 57.42B, 57.59A, 57.6 A, 57.6 B, 57.6 C, 57.6 D, 57.6 E and 58.81C.		

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

60 OPERATIONS ON RECTUM AND PERIRECTAL TISSUE
No additional benefits for sigmoidoscopy (cont'd)

60.5 Other resection of rectum (cont'd)
60.52 Other anterior resection (cont'd)

	BASE	ANE
60.52B Total mesorectal excision	1,657.63	520.81
NOTE: 1. May only be claimed for rectal neoplasms (benign and or malignant tumors), or inflammatory bowel disease. 2. May not be claimed in addition to HSCs 57.6 A, 57.6 B, 57.6 C, 57.6 D, 57.6 E and 58.81C. 3. HSCs 57.42A and 57.59A may only be claimed in addition when two discontinuous areas are resected and two anastomoses are performed. 4. May be claimed in addition to HSC 57.6 F.		
60.54 Duhamel resection	1,030.71	397.56

60.59 Other resection of rectum NEC

60.59A Perineal resection of rectum	717.25	320.33
60.59B Full thickness transanal or trans-sphincteric resection of rectum	956.33	395.68

60.6 Repair of rectum

60.65 Abdominal protopexy

60.65 Abdominal proctopexy	1,030.71	301.47
NOTE: May be claimed in addition to HSC 60.52A.		

60.66 Other proctopexy

60.66A Rectal prolapse (massive) perineal approach	531.29	188.43

60.7 Incision or excision of perirectal tissue or lesion
60.71 Incision of perirectal tissue

60.71B Incision, excision or drainage of perirectal tissue, lesion or abscess	297.52	113.05
NOTE: May only be claimed when performed under general anesthesia.		

60.8 Invasive diagnostic procedures on rectum and perirectal tissue
60.82 Other biopsy of rectum

60.82C Rectal biopsy for Hirschsprung's disease	154.07 V	113.05

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

60 OPERATIONS ON RECTUM AND PERIRECTAL TISSUE
No additional benefits for sigmoidoscopy (cont'd)

60.8 Invasive diagnostic procedures on rectum and perirectal tissue (cont'd)

60.89 Other invasive diagnostic procedures on rectum and perirectal tissue

		BASE	ANE
60.89A	Rectal motility studies	81.84	

61 OPERATIONS ON ANUS
NOTE: No additional payment for sigmoidoscopy

61.0 Incision or excision of perianal tissue

61.01 Incision of perianal abscess

61.01A	Ano-rectal abscess	96.81 V	113.05
61.01B	Ischiorectal abscess	217.83	113.05
61.03	Excision of perianal skin tags	66.30	

61.2 Local excision or destruction of other lesion or tissue of anus

61.2 A	Anal fissurectomy NOTE: May be claimed with 61.4 A.	132.82	113.05

61.29 Other local excision or destruction of other lesion or tissue of anus

61.29B	Local excision or destruction of lesion, tissue or polyp of anus NOTE: A maximum of six calls may be claimed.	79.69 V	113.05

61.3 Procedures on hemorrhoids

61.36 Excision of hemorrhoids

61.36A	Hemorrhoidectomy Includes related ano-rectal procedures	313.46	113.05

61.37 Evacuation of thrombosed hemorrhoids

61.37A	Incision or excision	60.34 V	112.95

61.39 Other procedures on hemorrhoids

61.39B	Scarification procedure on hemorrhoids NOTE: May be claimed for any local treatment on hemorrhoids, i.e. banding, injection etc.	79.69 V	113.05

61.4 Division of anal sphincter

61.4 Sphincterotomy

61.4 A	Anoplasty or lateral sphincterotomy NOTE: May be claimed with HSC 61.2 A.	313.46	113.05

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

61 OPERATIONS ON ANUS
NOTE: No additional payment for sigmoidoscopy (cont'd)

61.6 Repair of anus

61.63 Closure of anal fistula

	BASE	ANE
61.63A Anal fistulotomy and other procedures for anal fistula	292.21	113.05
NOTE: 1. Benefit includes insertion of seton, fibrin glue injection, anal fistula plug insertion, ligation of intersphincteric fistula tract. 2. Maximum of three calls may be claimed per encounter. 3. Second and third calls may not be claimed unless treatment is performed on documented separate internal openings for each call at the same encounter. 4. HSC 10.23 may not be claimed in addition.		
61.69 Other repair of anus and anal sphincter		
61.69B Imperforate anus, plastic repair	472.85	207.83

62 OPERATIONS ON LIVER

62.1 Local excision or destruction of lesion or tissue of liver

62.12 Partial hepatectomy

62.12A Biopsy with laparotomy	531.29	226.10
62.12B Liver biopsy in conjunction with other open or laparoscopic abdominal procedure, additional benefit	132.82	62.55
NOTE: May not be claimed for needle biopsy.		
62.12C Partial resection of liver	1,328.23	543.46
NOTE: 1. May not be claimed for wedge biopsy. 2. May not be claimed in addition to HSCs 62.2 B, 63.12B or 63.69A.		

62.2 Lobectomy of liver

62.2 A Lobectomy of liver (living donor)	4,122.83	1,622.63
NOTE: Benefit includes back table preparation.		
62.2 B Lobectomy of liver - 4 or more hepatic segments	2,656.47	837.82
NOTE: May not be claimed in addition to HSCs 62.12C, 63.12B or 63.69A.		

62.3 Total hepatectomy

62.3 A Recipient	2,390.82	
NOTE: The anesthetic fee for recipient hepatectomy is included in the anesthetic fee for hepatic transplantation.		
62.3 B Donor	2,874.30	697.17

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

62 OPERATIONS ON LIVER (cont'd)

62.4 Liver transplant

		BASE	ANE
62.4	Liver transplant	5,047.28	3,042.30

62.5 Repair of liver

62.51	Suture of liver	531.29	316.79
	That for (traumatic) laceration		

62.8 Invasive diagnostic procedures on liver

62.81 Percutaneous biopsy of liver

62.81A	Needle biopsy of liver	119.78 V	113.05

62.82 Other biopsy of liver

62.82A	Transjugular liver biopsy	235.70	135.53

63 OPERATIONS ON GALLBLADDER AND BILIARY TRACT

63.0 Cholecystotomy and cholecystostomy

63.09 Other cholecystotomy and cholecystostomy

63.09A	Cholecystostomy	499.22	207.27

63.1 Cholecystectomy

63.12 Total cholecystectomy

63.12A	Open surgical cholecystectomy	743.81	320.33
	NOTE: 1. May not be claimed for laparoscopic cholecystectomy.		
63.12B	Cholecystectomy with closure of fistula to duodenum or colon	1,328.23	376.84
	Note: May not be claimed in addition to HSCs 57.42A, 57.59A, 58.73, 58.75A, 62.12C or 62.2 B.		
63.12D	Transduodenal sphincteroplasty with cholecystectomy	1,599.25	540.39
63.12E	Choledocho-enterostomy with cholecystectomy	1,588.57	487.93
63.14	Laparoscopic cholecystectomy	531.29	319.68
	NOTE: May not be claimed for open surgical cholecystectomy.		

63.2 Anastomosis of gallbladder or bile duct

63.22	Anastomosis of gallbladder to intestine	862.78	277.01
	NOTE: Refer to the note following HSC 63.27.		
63.27	Anastomosis of hepatic duct to gastrointestinal tract	1,779.83	614.42
	NOTE: HSCs 63.22 and 63.27 may not be claimed in addition to HSCs 63.41, 63.69A, 64.3, 64.43A, 64.49A or 64.7.		

63.4 Other incision of bile duct

63.41	Incision of common duct	1,168.84	358.00

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

63 OPERATIONS ON GALLBLADDER AND BILIARY TRACT (cont'd)

63.4 Other incision of bile duct (cont'd)

	BASE	ANE
NOTE: May not be claimed in addition to HSCs 63.22 or 63.27.		
63.6 Repair of bile ducts		
63.69 Repair of other bile ducts		
63.69A Resection and reconstruction of common bile duct including secondary plastic repair and all anastomoses	3,187.76	640.65
NOTE: May not be claimed in addition to HSCs 52.2, 57.7, 62.12C, 62.2 B, 63.22 or 63.27.		
63.8 Other operations on biliary ducts and operations on sphincter of Oddi		
63.86 Endoscopic sphincterotomy and papillotomy		
63.86A Billary sphincteroplasty, dilation of the ampulla of Vater	113.99	89.35
NOTE: May only be claimed in addition to 64.97A.		
63.87 Endoscopic insertion of nasobiliary drainage tube	51.13	
NOTE: 1. May not be claimed in association with 63.88. 2. May only be claimed in addition to 64.97A.		
63.88 Endoscopic pancreatic stent placement or insertion of stent into bile duct, additional benefit	113.99	
NOTE: 1. May not be claimed in addition to HSC 63.87. 2. May only be claimed in addition to HSC 64.97A.		
63.89 Other operations on sphincter of Oddi		
63.89A Transduodenal sphincteroplasty	1,328.36	361.42
63.9 Other operations on biliary tract		
63.90 Endoscopic removal of calculus (calculi) from biliary tract		
63.90A Mechanical stone lithotripsy	113.99	
63.90B Stone extraction	57.00	
NOTE: 1. May not be claimed in association with each other. 2. May be claimed in addition to 64.97A.		
63.96 Intra-operative or intravenous cholangiogram or percutaneous hepatic cholangiogram		
63.96A Intra-operative injection of contrast media for cholangiogram	106.26	
63.96B Percutaneous trans-hepatic cholangiography	129.83	113.05
63.99 Other operations on biliary tract NEC		
63.99A Percutaneous removal or attempted removal of retained biliary tract stone(s)	243.43	112.95

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

63 OPERATIONS ON GALLBLADDER AND BILIARY TRACT (cont'd)

63.9 Other operations on biliary tract (cont'd)

63.99 Other operations on biliary tract NEC (cont'd)

	BASE	ANE
63.99B Percutaneous biliary tract drainage, including transhepatic cholangiography, full 60 minutes or major portion thereof	273.57	
NOTE: Each subsequent 15 minutes, or major portion thereof after the first full 60 minutes has elapsed, is payable at the rate specified on the Price List; a maximum benefit applies.		
63.99C Biliary lithotripsy for impacted distal common bile duct stone	348.13 V	
NOTE: 1. Only one benefit may be claimed regardless of the number of calculi.		
2. Physician in continuous attendance.		
3. Includes injection of dye contrast material.		
4. Includes injection of sedation when required.		
5. Repeat within 42 days - refer to Price List.		
63.99D Biliary drain exchange	89.64	142.97

64 OPERATIONS ON PANCREAS

64.0 Pancreatotomy

64.09 Other pancreatotomy

64.09A Pancreatic abscess, drainage	1,461.06	498.16
64.3 Internal drainage of pancreatic cyst	1,330.16	376.84
Pancreatico-cystoenterostomy		
NOTE: May not be claimed with HSCs 56.2, 63.22, 63.27 and 64.7.		

64.4 Partial pancreatectomy

64.43 Radical subtotal pancreatectomy

64.43A Pancreatectomy 95% resection	2,252.68	810.22
NOTE: 1. May be claimed in addition to HSC 66.83.		
2. May not be claimed with HSCs 56.2, 63.22, 63.27 and 64.7.		

64.49 Other partial pancreatectomy

64.49A Other partial pancreatectomy - with or without splenectomy	1,593.88	452.88
NOTE: 1. May be claimed in addition to HSC 66.83.		
2. May not be claimed with HSCs 56.2, 63.22, 63.27 and 64.7.		

64.6 Radical pancreaticoduodenectomy

64.6 A Whipple/ pancreaticoduodenectomy	4,122.83	2,632.26

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

64 OPERATIONS ON PANCREAS (cont'd)

		BASE	ANE
64.6	Radical pancreaticoduodenectomy (cont'd)		
	NOTE: 1. Benefit includes all portions of the reconstruction, i.e., biliary, gastric and pancreatic anastomosis, cholecystectomy and regional lymph node dissection and other standard steps in the procedure. 2. May not be claimed in addition to any other procedure at the same encounter.		
64.7	Anastomosis of pancreas (duct)		
64.7	Anastomosis of pancreas (duct)	1,593.88	433.37
	Pancreatico-enterostomy		
	NOTE: May not be claimed with HSCs 56.2, 63.22, 63.27, 64.3, 64.43A or 64.49A.		
64.8	Transplant of pancreas		
64.81	Pancreatic transplant, unqualified		
64.81A	Pancreatic transplant and back table preparation	3,012.43	2,059.11
64.81B	Donor pancreas removal	988.21	913.08
	NOTE: To be claimed under the donor PHN.		
64.9	Other operations on pancreas		
64.95	Aspiration biopsy of pancreas		
64.95A	Needle biopsy of pancreas	113.99 V	112.95
64.97	Contrast pancreatogram		
64.97A	Endoscopic retrograde cholangiopancreatography (ERCP)	262.18	169.57
	NOTE: May be claimed in addition to HSCs 13.99AF, 63.86A, 63.87, 63.88, 63.90A, and 63.90B.		
65.04	Repair of femoral hernia		
65.04A	Repair of femoral hernia	451.60	150.73
65.04C	Incarcerated femoral	451.60	188.43
65.1	Repair of inguinofemoral hernia with graft or prosthesis (unilateral)		
65.1 A	Repair of recurrent inguinal or femoral hernia, including mesh if used	664.12	274.77
65.1 B	Repair of inguinal or femoral hernia, including mesh	451.60	274.77
65.11	Repair of inguinal hernia, unqualified, with graft or prosthesis		
65.11A	Repair of inguinal hernia - with or without incarceration, obstruction or strangulation, includes the use of mesh if used	451.60	149.12
65.4	Repair of umbilical hernia		
65.4 A	Repair of omphalocele	499.42	271.72
65.4 B	Omphalocele, staged	658.80	285.95

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

64 OPERATIONS ON PANCREAS (cont'd)

65.4 Repair of umbilical hernia (cont'd)

65.49 Other repair of umbilical hernia

	BASE	ANE
65.49A Repair of umbilical and/or epigastric hernia	377.22 V	150.73

NOTE: 1. Benefit for child under 11 years of age, refer to Price List.
2. Two calls may be claimed at 100% where both umbilical and epigastric hernias are repaired.

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

64 OPERATIONS ON PANCREAS (cont'd)

65.6 Repair of other hernia of anterior abdominal wall with graft or prosthesis

65.61 Repair of incisional hernia with graft or prosthesis

		BASE	ANE
65.61A	Repair of incisional hernia including mesh, if used	860.69	444.36
	NOTE: 1. Refer to Price List for benefit when performed in conjunction with other abdominal procedures. 2. May not be claimed in conjunction with bowel obstruction HSCs 58.81A, 58.81B, or 58.81C. 3. A second call may only be claimed if a non-contiguous site requires repair. 4. HSC 66.4 A may not be claimed in addition. 5. Not for recurrent inguinal hernias.		

65.7 Repair of diaphragmatic hernia (abdominal approach)

65.7 A	Repair of diaphragmatic hernia, abdominal approach, acquired	685.37	263.79
	NOTE: When performed with HSCs 56.93A or 56.93C, the benefit will be paid as ADD. Refer to the Price List.		
65.7 B	Anti-reflux procedure	844.76	430.23
65.7 D	Repair of congenital diaphragmatic hernia for infant 14 days of age and younger	1,955.16	1,246.42

65.8 Repair of diaphragmatic hernia, thoracic approach

65.8 Repair of diaphragmatic hernia

65.8 A	Thoracic approach, congenital or acquired	945.36	252.99
65.8 B	Anti-reflux procedure	842.53	358.00
65.9 C	Repair of paraesophageal hernia, greater than 50% of stomach, intrathoracic, either abdominal or thoracic approach, confirmed by pre-operative imaging	1,689.51	1,242.49
65.9 D	Parastomal hernia repair (includes revision and/or relocation of ileostotomy/colostomy and the incision hernia repair)	1,333.55	1,004.90
	NOTE: 1. May only be claimed in instances where the stoma has been re-sited. 2. May not be claimed in addition to other hernia repair procedures or bowel resection procedures. 3. Includes laparotomy and lysis of adhesions.		
65.9 E	Repair of diaphragmatic hernia, abdominal or thoracic approach, anti-reflux procedure	1,710.76	599.64
	That for recurrent esophagitis, following a previous repair		

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

66 OTHER OPERATIONS ON ABDOMINAL REGION

66.1 Laparotomy

66.19 Other laparotomy

		BASE	ANE
66.19A	Other laparotomy	394.31	203.79
	NOTE: May not be claimed for hernia repair or in addition to hernia repair HSCs (65 series).		
66.19B	Drainage of intraperitoneal abscess, including subphrenic and pelvic	499.42	317.01
66.19C	Transabdominal approach to the spine	314.69	375.28
	NOTE: Benefit is for the general surgeon when a spinal procedure is performed by a second operator.		
66.19D	Laparotomy for trauma patients, first 60 minutes	435.66	328.52
	NOTE: 1. Benefit includes exploration of hematoma(s), Kockerization of duodenum, lesser sac and control of minor bleeding as well as other explorations for injury in trauma patients. 2. Each subsequent 15 minutes or major portion thereof may be claimed at the rate specified on the Price List. 3. Other procedures may be claimed in addition but the time spent in performing them may not be included in the time claimed for this procedure. 4. A maximum of three hours may be claimed. 5. HSC 66.67A may be claimed in addition.		
66.19E	Intraperitoneal Chemotherapy	510.04	317.01

66.3 Excision or destruction of lesion or tissue of peritoneum

66.3 A	Omentectomy, for abdominal malignancy, additional benefit	276.16	62.55
	NOTE: May be claimed in addition to the primary procedure performed, except for HSCs 55.8 B and 55.9 AA.		
66.3 B	Retroperitoneal tumor, excision	731.01	339.65
66.3 C	Retroperitoneal tumor, biopsy	563.17	226.10

66.4 Freeing of peritoneal adhesions

66.4 A	Lysis of adhesions	79.69	
	NOTE: 1. May only be claimed when a full 15 minutes has been spent on adhesions. Each subsequent 15 minutes or major portion thereof may be claimed at the rate specified in the Price List. 2. May not be claimed in addition to procedures billed with REDO modifier(s). 3. May not be claimed in addition to HSCs 58.42A, 58.44A, 58.81A, 58.81B, 58.81C, 65.61A, 71.02 and 81.29C. 4. Benefit includes time spent on lysis of adhesions in the retroperitoneum.		

66.5 Suture of abdominal wall and peritoneum

66.51 Reclosure of post-operative disruption of abdominal wall

66.51A	Post-operative closure or delayed primary closure abdominal wall	531.29	244.96

X. OPERATIONS ON THE DIGESTIVE SYSTEM AND ABDOMINAL REGION (cont'd)

66 OTHER OPERATIONS ON ABDOMINAL REGION (cont'd)

66.5 Suture of abdominal wall and peritoneum (cont'd)
66.51 Reclosure of post-operative disruption of abdominal wall (cont'd)

		BASE	ANE
66.51B	Superficial	123.45	113.05
66.52	Delayed closure of granulating abdominal wound	127.51	112.95
66.63	Repair of gastroschisis	642.86	271.72

66.67 Other repair of mesentery

66.67A	Mesenteric tear repair, additional benefit NOTE: 1. May not be claimed for incidental repair. 2. May only be claimed in addition to HSC 66.19D.	79.69	

66.8 Invasive diagnostic procedures of abdominal region
66.82 Biopsy of peritoneum

66.82A	Retroperitoneal mass biopsy	119.78 V	113.05
66.83	Laparoscopy Diagnostic, with or without biopsy NOTE: 1. May not be claimed in addition to other procedures if the laparoscopy is an integral part of the procedure with the exception of HSCs 62.12B, 81.09, 82.63 or 83.2 B, which may be claimed at 100%. 2. May be claimed in addition to HSCs 55.8 A, 55.8 B, 55.9 A, 55.99A, 64.43A, 64.49A. 3. May not be claimed in addition to HSC 56.93D.	228.93	150.73

66.89 Other invasive diagnostic procedure on abdominal region

66.89A	Peritoneal lavage For diagnosis of intra-abdominal bleeding after blunt abdominal trauma	47.82	
66.89B	Instillation or injection of contrast media for loopogram	32.46	
66.89C	Insertion of catheters and injection of dye That for sinograms or fistulograms, single or multiple studies	50.23	

66.9 Other operations in abdominal region
66.91 Percutaneous abdominal paracentesis

66.91A	Paracentesis	55.25	
66.91B	Percutaneous catheter drainage of deep abscess That in body cavity, requiring CT or ultrasound localization	278.20	113.05
66.91C	Replacement of percutaneous catheter for drainage of deep abscess in body cavity	89.64	113.05
66.94	Creation of peritoneovascular shunt	457.77	260.88

66.98 Peritoneal dialysis

66.98A	Insertion of indwelling intraperitoneal dialysis catheter NOTE: Not payable in addition to omentectomy.	201.89	150.73

XI. OPERATIONS ON THE URINARY TRACT

67 OPERATIONS ON KIDNEY

67.0 Nephrotomy and Nephrostomy

67.01 Nephrotomy

		BASE	ANE
67.01A	Renal exploration	348.13	153.59
	NOTE: Includes that with renal biopsy or renal cyst.		
67.01B	Renal exploration to include nephrostomy	348.13	234.91
67.02	Nephrostomy Percutaneous	241.11	

67.1 Pyelotomy and Pyelostomy

67.11 Pyelotomy

67.11A	Extended pyelolithotomy with infundibulolithotomy	870.32	298.17
67.11B	Removal of renal calculus and/or tumor Percutaneous, ureteroscopic or open surgery approach. NOTE: 1. Benefit includes cystoscopy and retrograde pyelogram and all related operative procedures for removal of stone and / or tumor performed during the same hospital admission. 2. For a repeat percutaneous or ureteroscopic procedure during the same hospitalization, benefit will be reduced. Refer to Price List. 3. Two calls may only be claimed for bilateral removal of Calculus and / or tumor.	870.32	244.96

67.12 Pyelostomy

67.12A	Cutaneous	348.13	198.79

67.3 Partial nephrectomy

67.3 A	Open partial nephrectomy	1,810.29	317.01
67.3 B	Laparoscopic partial nephrectomy	1,827.67	1,404.48

67.4 Total nephrectomy

67.4 A	Nephroureterectomy and excision of bladder cuff	1,740.64	471.05
67.4 B	Donor, cadaver unilateral/bilateral	685.37	
67.4 C	Donor, live NOTE: Includes perfusion and arrangements for shipping.	1,404.20	301.47
67.4 D	Laparoscopic live donor nephrectomy	1,827.67	686.70

67.41 Total nephrectomy (unilateral)

67.41A	Total nephrectomy	1,014.77	282.63
67.41B	Radical nephrectomy thoraco-abdominal or transperitoneal Includes complete peri and paranephric tissue	1,740.64	407.60
67.41C	Laparoscopic radical nephrectomy	1,740.64	928.39
67.41D	Radical nephrectomy with removal of suprahepatic tumor thrombus	2,785.02	1,057.38

XI. OPERATIONS ON THE URINARY TRACT (cont'd)

67 OPERATIONS ON KIDNEY (cont'd)

		BASE	ANE
67.5	**Transplant of kidney**		
67.59	**Other kidney transplantation**		
67.59A	Renal transplantation (homo, hetero, auto)	1,705.45	656.67
	NOTE: 1. Includes intra-operative renal biopsy. 2. May not be claimed in addition to HSCs 68.72A or 68.72C.		
67.6	**Nephropexy**		
67.6	Nephropexy	174.06	144.57
67.7	**Other repair of kidney**		
67.71	Suture of kidney That for (traumatic) laceration	641.60	285.95
67.72	Closure of nephrostomy and pyelostomy	678.85	250.21
67.75	Symphysiotomy of horseshoe kidney	694.79	196.59
67.79	**Other repair of kidney NEC**		
67.79A	Pyeloplasty	696.25	301.47
67.79B	Laparoscopic pyeloplasty	1,392.51	951.04
67.8	**Invasive diagnostic procedures on kidney**		
67.81	Percutaneous biopsy of kidney	114.37 V	113.05
67.83	Nephroscopy	156.66	112.95
67.86	Retrograde pyelogram NOTE: 1. Includes cystoscopy. 2. Only one call may be claimed whether unilateral or bilateral.	139.25 V	113.05
67.87	**Percutaneous pyelogram**		
67.87A	Percutaneous injection of contrast media into renal pelvis under CT or ultrasound guidance for antegrade pyelography	135.24	111.71
67.89	**Other invasive diagnostic procedures on kidney**		
67.89A	Instillation or injection of contrast media for nephrostogram NOTE: 1. May be claimed by the surgeon who performed the surgery only when the service is provided after the 14 day post-operative period. 2. Benefit for injection of opaque media without intubation being required is included in X77A and X77B.	32.46	
67.9	**Other operations on kidney**		
67.93	Replacement of nephrostomy tube NOTE: May be claimed by the surgeon who performed the surgery only when the service is provided after the 14 day post-operative period.	34.78	111.71

XI. OPERATIONS ON THE URINARY TRACT (cont'd)

67 OPERATIONS ON KIDNEY (cont'd)

67.9 Other operations on kidney (cont'd)

67.96 Other injection into kidney of therapeutic substance acting locally

	BASE	ANE
67.96A Aspiration/injection of renal cyst	74.96 V	111.71

67.99 Other operations on kidney NEC

67.99A Renal bivalve and multiple selected nephrotomies That for stag horn calculus NOTE: Includes renal hypothermia and selective segmental renal artery dissection and occlusion.	1,392.51	428.92

68 OPERATIONS ON URETER

68.0 Transurethral clearance of ureter and renal pelvis

68.0 A Endoscopic removal of ureteral calculus (basket extraction)	174.06	113.05

68.1 Ureteral meatotomy

68.1 Ureteral meatotomy	87.03 V	113.05

68.2 Ureterotomy

68.2 A Removal of calculus and/or tumor from ureter Percutaneous, ureteroscopic or open surgery approach. NOTE: 1. Benefit includes cystoscopy and retrograde pyelogram and all related operative procedures for removal of stone and / or tumor performed during the same hospital admission. 2. For a repeat percutaneous or ureteroscopic procedure during the same hospitalization, benefit will be reduced. Refer to Price List. 3. Two calls may only be claimed for bilateral removal of Calculus and / or tumor.	522.19	244.96

68.3 Ureterectomy

68.3 Ureterectomy	522.19	153.59

68.32 Partial ureterectomy

68.32A Ureteroureterostomy, ipsilateral	696.25	263.79
68.32B Excision or incision of ureterocoele	87.03 V	111.71

68.4 Cutaneous ureteroileostomy

68.41 Formation of cutaneous ureteroileostomy

68.41A Ureteral transplant to ileal conduit	522.19	271.06
68.41B Reimplantation of ureter to ileal conduit	696.25	358.00
68.41C Uretero-ileo-cutaneous conduit to include entero-enterostomy and ileostomy	1,218.45	339.56

68.5 Other external urinary diversion

68.51 Formation of other cutaneous ureterostomy	348.13	198.79

XI. OPERATIONS ON THE URINARY TRACT (cont'd)

68 OPERATIONS ON URETER (cont'd)

	BASE	ANE
68.6 Urinary diversion to intestine		
68.62 Other urinary diversion to intestine		
68.62A Uretero-sigmoid-cutaneous conduit	696.25	358.01
68.62C Continent urinary diversion That with uretero-ileal anastomosis	1,392.51	489.88
68.7 Other anastomosis or bypass of ureter		
68.72 Ureteroneocystostomy		
68.72A Ureteroneocystostomy NOTE: May not be claimed in addition to HSC 67.59A.	609.22	260.88
68.72B Ureteroneocystostomy plus excision ureterocoele	609.22	339.56
68.72C Ureteroneocystostomy with bladder flap NOTE: May not be claimed in addition to HSC 67.59A.	696.25	301.47
68.72D Ureteroneocystostomy and simultaneous longitudinal ureterectomy and ureteroplasty	696.25	301.47
68.73 Transureteroureterostomy	647.52	259.14
68.8 Repair of ureter		
68.83 Closure of ureterostomy		
68.83A Closure of cutaneous ureterostomy	348.13	144.57
68.9 Other operations on ureter		
68.95 Ureteroscopy NOTE: 1. Includes cystoscopy. 2. Only one call may be claimed whether unilateral or bilateral.	261.10	169.57
68.99 Other operations on ureter NEC		
68.99A Insertion of double "J" stent NOTE: Includes cystoscopy.	174.06	113.05
68.99B Removal of double "J" stent NOTE: Includes cystoscopy.	121.84	113.05

69 OPERATIONS ON URINARY BLADDER

69.0 Transurethral clearance of bladder		
69.0 A Removal of vesical calculus	261.10	150.73
69.0 B Foreign body removal	261.10	113.05
69.1 Cystotomy and cystostomy		
69.11 Percutaneous aspiration of bladder	27.05	
69.13 Other cystotomy		
69.13A Removal of foreign body from bladder through open cystotomy	348.13	113.05

XI. OPERATIONS ON THE URINARY TRACT (cont'd)

69 OPERATIONS ON URINARY BLADDER (cont'd)

69.1 Cystotomy and cystostomy (cont'd)

69.13 Other cystotomy (cont'd)

	BASE	ANE
69.13B Removal of vesical calculus, suprapubic approach	348.13	150.73
69.13C Open (suprapubic)	261.10	113.05
69.13D Trocar and tube	63.17 V	113.05

69.14 Cystostomy

69.14A Vesicostomy	348.13	207.27

69.2 Transurethral excision or destruction of lesion or tissue of bladder

69.29 Other transurethral excision or destruction of lesion or tissue of bladder

69.29A Bladder lesion or small tumor	121.84 V	113.05
69.29B Moderate sized tumor	348.13	113.05
That for less than 30 minutes of resecting		
69.29C Large or multiple tumors	522.19	226.10
That for more than 30 minutes		

69.3 Other excision or destruction of lesion or tissue of bladder

69.31 Excision of urachus	348.13	188.43

69.39 Open excision or destruction of other lesion or tissue of bladder

69.39A Suprapubic excision or fulguration of bladder tumors	266.12	171.67
69.39B Diverticulectomy of bladder	522.19	153.59

69.4 Partial cystectomy

69.4 A Partial cystectomy	346.66	169.57
69.4 B With reimplantation of ureters	870.32	225.88

69.5 Total cystectomy

69.5 A Total cystectomy	497.08	214.45
69.51 Radical cystectomy	1,392.51	792.55
That with total prostatectomy, seminal vesiculectomy or hysterectomy		

69.6 Reconstruction of urinary bladder

69.6 A Entero-cystoplasty	870.32	343.35

69.7 Other repair of urinary bladder

69.71 Suture of bladder	522.19	188.43
That for (traumatic) laceration		

69.73 Repair of other fistula of bladder

69.73A Vesicovaginal fistula repair	696.25	188.43
69.73B Rectovesical fistula, resection	425.03	205.54

NOTE: 1. Benefit will be paid at 100% when only procedure performed.
2. When performed with other procedures, benefit will be paid as ADD. Refer to Price List.

XI. OPERATIONS ON THE URINARY TRACT (cont'd)

69 OPERATIONS ON URINARY BLADDER (cont'd)

69.7 Other repair of urinary bladder (cont'd)

69.73 Repair of other fistula of bladder (cont'd)

	BASE	ANE
69.73C Vesicovaginal fistula, transvesical repair	783.29	263.79

69.74 Cystourethroplasty and plastic repair of bladder neck

69.74A Plastic repair of bladder neck	348.13	188.43
69.74B Insertion artificial external sphincter - to include urethrosphincteroplasty	1,009.57	527.59
69.74C Revision of artificial urinary bladder sphincter	696.25	169.57
69.74D Ligation of bladder neck for incontinence	609.22	225.88

69.8 Invasive diagnostic procedures on bladder

69.83 Cystogram and cystourethrogram

69.83A Voiding	34.81 V	111.81
NOTE: May be claimed in addition to HSCs 03.22A, 03.22B and 03.22C.		
69.83B Retrograde urethrography	34.81 V	111.81

69.9 Other operations on bladder

69.91 Sphincterotomy of bladder	261.10	151.90
69.94 Insertion of indwelling urinary catheter	52.22	
NOTE: May not be claimed in association with another procedure.		

70 OPERATIONS ON URETHRA

70.0 External urethrotomy

70.0 A Perineal urethrostomy (solo procedure)	261.10	142.97
NOTE: May be claimed in addition to HSC 72.1 D.		

70.1 Urethral meatotomy (external)

70.1 Urethral meatotomy (external)	87.03 V	113.05

70.2 Excision or destruction of urethral lesion or tissue

70.2 A Excision or cautery of caruncle	86.69 V	113.05
70.2 B Caruncle or prolapse of urethral mucosa, fulguration or excision	120.60 V	113.05
70.2 C Urethral diverticulum, excision	261.10	150.73
70.2 D Radical urethrectomy, male	348.13	142.97
70.2 E Radical urethrectomy, female	174.06	112.95
70.2 F Transurethral resection of prostatic valves	348.13	153.59
70.2 G Transvesical resection of prostatic valves	348.13	142.97
70.2 H Transurethral fulguration of urethral condyloma acuminata	87.03 V	112.95

70.3 Repair of urethra

70.31 Suture of urethra

70.31A Urethral rupture, cystotomy and perineal repair	435.16	207.83

XI. OPERATIONS ON THE URINARY TRACT (cont'd)

70 OPERATIONS ON URETHRA (cont'd)

70.3 Repair of urethra (cont'd)

70.33 Closure of other fistula of urethra

		BASE	ANE
70.33A	Urethral fistula repair	261.10	144.57
70.33B	Repair of urethrovaginal fistula	348.13	142.97

70.39 Other repair of urethra

70.39A	Suprapubic exploration for ruptured urethra, cystotomy and catheter	348.13	198.79

70.4 Freeing of stricture of urethra

70.4 A	Repair, infrasphincteric, one stage NOTE: May only be claimed by Obstetrics and Gynecology.	581.56	226.10
70.4 F	Internal urethrotomy	87.03 V	113.05
70.4 G	Internal urethrotomy endoscopic	174.06	113.05
70.4 H	Anastomotic stricture repair	1,044.38	633.57
70.4 I	One stage reconstruction of anterior urethra with tissue transfer	1,566.57	1,075.94
70.4 J	Posterior reconstruction (urethral distraction defect after pelvic fracture)	1,566.57	1,017.49
70.4 K	First stage urethral reconstruction (complex structures with fibrosis, fistulae or significant loss of urethra)	1,305.48	913.08
70.4 L	Second stage urethral reconstruction (may only be claimed after first stage reconstruction)	1,305.48	913.08

70.5 Dilation of urethra

70.5 A	Male NOTE: Repeat service should be claimed if provided within 31 days of initial.	52.22 V	113.05
70.5 B	Female	17.41	112.95

71 OTHER OPERATIONS ON URINARY TRACT

71.0 Dissection of retroperitoneal tissue

71.02	Ureterolysis with freeing or repositioning of ureter for retroperitoneal fibrosis	454.85	160.83
71.02A	Ureterolysis for malignancy NOTE: 1. Claimable for ureterolysis performed during malignant gynecologic surgery where there is extensive retroperitoneal dissection. 2. May be claimed with HSCs 66.3B, 66.3C, 81.99A, 52.49C, 52.89A, 52.89C, 52.43A, 57.42A, 60.52A and 69.4A 3. May not be claimed in association with HSC 83.9 A, when HSC 83.9 A is billed alone.	162.45	159.89

71.4 Suprapubic sling operation

71.4 A	Fascia lata sling operation NOTE: An additional benefit of 100% may be claimed for a repeat by using modifier REPT.	448.35	263.79

XI. OPERATIONS ON THE URINARY TRACT (cont'd)

71 OTHER OPERATIONS ON URINARY TRACT (cont'd)

71.4 Suprapubic sling operation (cont'd)

		BASE	ANE
71.4 B	Vaginal portion, combined sub-urethral sling procedure, when performed by two surgeons	341.14	358.00

NOTE: 1. HSC 82.64A may not be claimed in addition.
2. When performed as a second or subsequent procedure through the same incision, the procedural rate should be claimed at 50% using modifier LVP50. Anesthetic claims using ANE for second and subsequent procedures should use the LVP75 modifier.
3. An additional benefit of 100% may be claimed for a repeat by using modifier REPT.

XI. OPERATIONS ON THE URINARY TRACT (cont'd)

71 OTHER OPERATIONS ON URINARY TRACT (cont'd)

71.4 Suprapubic sling operation (cont'd)

	BASE	ANE
71.4 C Abdominal portion, combined sub-urethral sling procedure, when performed by two surgeons	558.81	358.00

NOTE: 1. HSC 82.64A may not be claimed in addition.
2. When performed as a second or subsequent procedure through the same incision, the procedural rate should be claimed at 50% using modifier LVP50. Anesthetic claims using ANE for second and subsequent procedures should use the LVP75 modifier.
3. An additional benefit of 100% may be claimed for a repeat by using modifier REPT.

71.7 Other repair of urinary (stress) incontinence

71.7 A Anterior urethropexy	422.36	169.57
NOTE: An additional benefit of 50% may be claimed for a repeat by using modifier REPT.		
71.7 B Repeat repair of urinary (stress) incontinence	578.31	226.10
After failed previous stress incontinence surgery		
71.7 C Correction of male incontinence	609.22	263.79
With or without simple prosthesis		

71.8 Ureteral catheterization

71.8 Ureteral catheterization	139.25	113.05

NOTE: 1. Includes cystoscopy and renal function tests.
2. Only one call may be claimed whether unilateral or bilateral.

71.9 Other operations on urinary system

71.95 Replacement of cystostomy tube	52.22	111.71

71.96 Ultrasonic fragmentation of urinary stones

71.96A Extra-corporeal Shock Wave Lithotripsy (ESWL)	348.13 V	
That for upper urinary tract calculi		

NOTE: 1. Only one benefit may be claimed regardless of the number of calculi treated on one side.
2. Physician in continuous attendance.
3. Includes injection of dye contrast material.
4. Includes injection of sedation when required.
5. Repeat within 42 days, refer to Price List.
6. Cystoscopy and retrograde pyelography performed at the same encounter may be claimed.
7. Bilateral calculi may be claimed for the second side, refer to Price List.

XII. OPERATIONS ON THE MALE GENITAL ORGANS

72 OPERATIONS ON PROSTATE AND SEMINAL VESICLES

		BASE	ANE
72.0	**Incision of prostate**		
72.0 A	Perineal drainage of prostatic abscess	260.40	111.71
72.1	**Transurethral prostatectomy**		
72.1 A	Transurethral prostatectomy NOTE: May not be claimed in addition to HSC 72.1 C.	522.19	226.10
72.1 B	Repeat transurethral resection of prostate or bladder neck contracture NOTE: 1. May only be claimed before one year, by the same operator. 2. May not be claimed during the same hospital admission.	261.10	226.10
72.1 C	Photoselective vaporization of the prostate NOTE: May not be claimed with HSC 72.1 A.	783.29	360.10
72.1 D	Laser enucleation and morcellation of prostate NOTE: 1. For bladder outlet obstruction secondary to benign prostate hypertrophy. 2. May only be claimed for prostates 60cc or greater. 3. May not be claimed when GreenLight Laser is used.	1,114.01	357.99
72.2	**Suprapubic prostatectomy**		
72.2	Suprapubic prostatectomy	696.25	226.10
72.3	**Retropubic prostatectomy**		
72.3	Retropubic prostatectomy	696.25	226.10
72.4	**Radical prostatectomy**		
72.4	Radical prostatectomy With prostatovesiculectomy NOTE: Benefits for 69.74A may not be claimed in addition.	1,247.97	339.16
72.4 A	Laparoscopic radical prostatectomy NOTE: Benefits for 69.74A may not be claimed in addition.	2,038.29	1,018.97
72.5	**Other prostatectomy**		
72.52	Perineal prostatectomy	696.25	223.59
72.52A	Cryosurgery of prostate	1,044.38	670.83
72.9	**Invasive diagnostic procedures on prostate and seminal vesicles**		
72.91	Needle biopsy of prostate	85.01 V	113.05
72.92	**Other biopsy of prostate**		
72.92A	Open perineal biopsy of prostate	242.99	111.71

XII. OPERATIONS ON THE MALE GENITAL ORGANS (cont'd)

73 OPERATIONS ON SCROTUM AND TUNICA VAGINALIS

		BASE	ANE
73.0	Incision of scrotum and tunica vaginalis		
73.0 A	Incision and drainage, deep scrotal abscess	174.06	113.05
73.1	Excision of hydrocele (of tunica vaginalis)		
73.1 A	Radical cure	261.10	112.95
73.1 B	Repair of communicating hydrocele	375.98	188.43
73.2	Excision or destruction of lesion or tissue of scrotum		
73.2 A	Laser therapy	43.91	111.71
	NOTE: Excludes condylomata accuminata - refer to 98.12S, 98.12T, 98.12U.		
73.2 B	Scrotectomy	348.13	144.57
73.9	Other operations on scrotum and tunica vaginalis		
73.91	Percutaneous aspiration of tunica vaginalis	46.08	
	Hydrocele - aspiration		

74 OPERATIONS ON TESTES

74.2	Unilateral orchiectomy		
74.2 A	Unilateral orchiectomy	174.06	113.05
74.2 B	Radical	348.13	169.57
	Includes complete removal of cord to internal ring		
74.4	Orchiopexy		
74.4 A	Orchiopexy	435.16	169.57
74.4 B	Inguinal exploration for cryptorchidism	207.20	113.05
	Includes that with orchidectomy		
74.4 C	Retroperitoneal exploration for cryptorchid testicle	387.84	169.57
	Includes that with orchidectomy, via inguinal approach		
74.4 D	Testicular fixation	174.06	112.95
74.4 E	Laparoscopic Orchidopexy	870.32	577.66
74.8	Invasive diagnostic procedures on testes		
74.82	Other biopsy of testes		
74.82A	Testicular biopsy	87.03 V	113.05

75 OPERATIONS ON SPERMATIC CORD, EPIDIDYMIS, AND VAS DEFERENS

75.0	Excision of varicocele and hydrocele of spermatic cord		
75.0	Excision of varicocele and hydrocele of spermatic cord	261.10	113.05
75.1	Excision of cyst of epididymis		
75.1 A	Excision of sperm granuloma or spermatocele	208.88	113.05
75.3	Epididymectomy		
75.3	Epididymectomy	261.10	113.05

XII. OPERATIONS ON THE MALE GENITAL ORGANS (cont'd)

75 OPERATIONS ON SPERMATIC CORD, EPIDIDYMIS, AND VAS DEFERENS (cont'd)

75.4 Repair of spermatic cord and epididymis

	BASE	ANE
75.42 Reduction of torsion of testes or spermatic cord	435.16	113.05

XII. OPERATIONS ON THE MALE GENITAL ORGANS (cont'd)

75 OPERATIONS ON SPERMATIC CORD, EPIDIDYMIS, AND VAS DEFERENS (cont'd)

	BASE	ANE
75.6 Vasectomy and ligation of vas deferens		
75.64 Vasectomy (complete) (partial)	187.72	113.05
NOTE: May not be claimed if vasectomy is subsequent to a previous reversal. If a repeat procedure is required due to a previously failed attempt, supporting documentation must be provided.		
75.8 Invasive diagnostic procedures on spermatic cord, epididymis, and vas deferens		
75.83 Contrast Vasogram		
75.83A Injection of contrast for vasography	87.03	111.71

76 OPERATIONS ON PENIS

76.0 Circumcision		
76.0 Circumcision	261.10	113.05
NOTE: Routine newborn circumcisions are not an insured service.		
76.1 Local excision or destruction of lesion of penis		
76.1 A Laser therapy	87.03	112.95
NOTE: Excludes condylomata accuminata - refer to 98.12S, 98.12T, 98.12U.		
76.2 Amputation of penis		
76.2 A Partial	348.13	169.57
76.2 B Radical	522.19	207.27
76.2 C Radical, with unilateral gland dissection	870.32	241.27
76.2 D Radical, with bilateral lymphadenectomy	1,218.45	343.35
76.3 Repair and plastic operations on penis		
76.32 Release of chordee		
76.32A Correction of chordee without hypospadias	348.13	150.73
76.32B Correction of chordee with grafting	696.25	282.63
76.33 Repair of epispadias or hypospadias		
76.33A Hypospadias, first stage	261.10	169.57
76.33B Hypospadias, second stage	435.16	207.27
76.33C Hypospadias, one stage repair combining urethroplasty and chordee correction	1,044.38	301.47
76.39 Other repair of penis		
76.39A Repair of penile fracture	348.13	150.73
76.8 Invasive diagnostic procedures on penis		
76.89 Other invasive diagnostic procedures on penis		
76.89A Injection of contrast media for corpus cavernosogram	38.29	

XII. OPERATIONS ON THE MALE GENITAL ORGANS (cont'd)

76 OPERATIONS ON PENIS (cont'd)

76.9 Other operations on male genital organs
76.91 Dorsal or lateral slit of prepuce

	BASE	ANE
76.91A Without circumcision	87.03 V	113.05
NOTE: May not be claimed with 76.0.		
76.95 Insertion or replacement of internal prosthesis of penis		
76.95A Without scrotal pump or abdominal reservoir	522.19	282.63
76.95B With abdominal and scrotal reservoir and inflatable prosthesis	800.69	451.77
76.97 Other operations on penis		
76.97A Corpus-cavernosis to greater saphenous shunt or corpus spongiosis shunt	348.13	289.13

XIII OPERATIONS ON THE FEMALE GENITAL ORGANS

77 OPERATIONS ON OVARY

77.9 Other operations on ovary
77.99 Other operations on ovary NEC

77.99A Ovarian carcinoma, debulking, additional benefit	152.70	62.55
NOTE: May not be claimed in addition to HSC 66.3 A.		

78 OPERATIONS ON FALLOPIAN TUBES
78.5 Other salpingectomy
78.52 Salpingectomy

78.52C Surgical treatment of ectopic pregnancy	396.37	207.27
78.7 Insufflation of fallopian tube		
78.7 A Patency determination of fallopian tube(s)	19.49 V	111.71
NOTE: A repeat performed within the same day is payable at a reduced rate. Refer to Price List.		
78.9 Other operations on fallopian tubes		
78.99 Other operations on fallopian tubes NEC		
78.99B Other tubal sterilization, any method	230.67	150.73
NOTE: May not be claimed if sterilization is subsequent to a previous reversal. If a repeat procedure is required due to a previously failed attempt, supporting documentation must be provided.		

79 OPERATIONS ON CERVIX

79.1 Conization of cervix

79.1 A Cone biopsy	162.45	113.05
NOTE: Includes D & C		

XIII OPERATIONS ON THE FEMALE GENITAL ORGANS (cont'd)

79 OPERATIONS ON CERVIX (cont'd)

79.2 Other excision or destruction of lesion or tissue of cervix

		BASE	ANE
79.22	Destruction of lesion of cervix by cauterization	45.48	
	NOTE: 1. Benefit includes biopsy. 2. May be claimed in addition to a visit or consultation.		
79.23	Destruction of lesion of cervix by cryosurgery		
79.23A	Cryotherapy	44.86	
	NOTE: 1. Benefit includes biopsy. 2. May be claimed in addition to a visit or consultation.		
79.29	Other excision or destruction of lesion or tissue of cervix NEC		
79.29C	By CO2 laser therapy For cervical interepithelial neoplasia	149.45	113.05
79.29D	Loop electrical excision procedure (LEEP) For cervical interepithelial neoplasia	149.45	113.05
79.29E	Biopsy of cervix	45.48 V	
	NOTE: May not be claimed with any other procedure.		
79.3	Amputation of cervix		
79.3 E	Excision of cervical stump, abdominal or vaginal approach	425.61	188.43
79.4	Repair of internal cervical os		
79.4 C	Suturing of cervix, encircling suture For cervical incompetence, elective	178.69	113.05
	NOTE: May be claimed in addition to a visit or consultation.		
79.4 D	Suturing of cervix, emergency cerclage after cervix has been effaced or opened	240.42	169.57
	NOTE: May be claimed in addition to a consultation or visit.		

80 OTHER INCISION AND EXCISION OF UTERUS

80.1 Excision or destruction of lesion or tissue of uterus

80.19	Other excision or destruction of lesion of uterus		
80.19A	Correction of congenital abnormalities	308.65	150.73
80.19B	Myomectomy, vaginal	308.65	150.73
80.19C	Myomectomy, abdominal	357.38	169.57
80.19D	Endometrial ablation by hysteroscopic method to include roller ball or resectoscope	441.85	207.27
	NOTE: 1. Benefit includes hysteroscopy. 2. Benefit includes insertion of a laminaria tent if required by same or different physician.		

XIII OPERATIONS ON THE FEMALE GENITAL ORGANS (cont'd)

80 OTHER INCISION AND EXCISION OF UTERUS (cont'd)

80.1 Excision or destruction of lesion or tissue of uterus (cont'd)
80.19 Other excision or destruction of lesion of uterus (cont'd)

	BASE	ANE
80.19E Endometrial ablation by any non-hysteroscopic method (eg. microwave, thermablate, etc.)	230.67	113.05
NOTE: May not be claimed in addition to HSC 80.81.		
80.8 Invasive diagnostic procedures on uterus and supports		
80.81 Hysteroscopy	146.20	113.05
NOTE: 1. Benefit includes biopsy.		
2. May not be claimed in addition to HSCs 80.19D or 80.19E.		
80.83 Uterine biopsy		
80.83B Endometrial biopsy	45.48 V	112.95
80.85 Opaque dye contrast hysterosalpingography		
80.85A Hysterosalpingogram insufflation or injection of opaque material	90.97	111.71
80.85B Pneumohysterosalpingogram	71.48 V	111.71

81 OTHER OPERATIONS ON UTERUS AND SUPPORTS

81.0 Dilation and curettage (of uterus)		
81.01 Dilation and curettage following delivery or abortion		
81.01D D & C for missed abortion or following delivery	155.95	113.05
NOTE: May be claimed in addition to a consultation.		
81.09 Other dilation and curettage	155.95	113.05
NOTE: 1. Benefit includes biopsy or polypectomy.		
2. May be claimed in addition to a consultation.		
81.2 Excision or destruction of lesion or tissue of uterine supports		
81.29 Other excision or destruction of lesion or tissue of uterine supports		
81.29B Laparotomy, to include conservation procedures for endometriosis	389.87	188.43
81.29C Laparoscopy, for conservative procedures for endometriosis and/or lysis of adhesions first full 15 minutes of operating time or major portion thereof for the first call when only one call is claimed	211.18	134.04
NOTE: 1. Each subsequent 15 minutes, or major portion thereof, is payable at the rate specified on the Price List after the first full 15 minutes has elapsed.		
2. May not be claimed in addition to HSCs 86.9 C or 86.9 D.		

XIII OPERATIONS ON THE FEMALE GENITAL ORGANS (cont'd)

81 OTHER OPERATIONS ON UTERUS AND SUPPORTS (cont'd)

81.5 Repair of uterus
81.51 Suture of uterus

	BASE	ANE
81.51A Repair due to injury NOTE: Excludes obstetrical trauma.	383.37	169.57
81.8 Insertion of intra-uterine contraceptive device		
81.8 Insertion of intra-uterine contraceptive device NOTE: May be claimed in addition to a visit or consultation.	71.48 V	
81.9 Other operations on uterus, cervix, and supporting structures		
81.91 Insertion of therapeutic device into uterus		
81.91A Radium insertion - each insertion NOTE: 1. May be claimed in addition to a visit or consultation. 2. May not be claimed with any other procedure.	142.95	113.05
81.96 Removal of cerclage material from cervix NOTE: 1. May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery. 2. May be claimed in addition to a visit or consultation.	58.48 V	113.05
81.99 Other operations on cervix and uterus		
81.99A Hysterectomy, any method NOTE: If pelvic lymphadenectomy is performed for cancer, HSC 52.49C may be claimed in addition.	666.03	207.22
81.99AA Removal of fallopian tubes at the same time as hysterectomy for risk reduction for ovarian cancer, additional benefit NOTE: The benefit is for the removal of one or both fallopian tubes at the time of the hysterectomy.	100.72	
81.99C Laparoscopic radical hysterectomy and bilateral radical lymph node dissection	2,089.06	1,168.69

82 OPERATIONS ON VAGINA AND CUL-DE-SAC

82.1 Incision of vagina and cul-de-sac		
82.12 Colpotomy or culdotomy		
82.12A Diagnostic	80.45 V	111.71
82.12B Therapeutic	100.72 V	112.95
82.12C With D & C	110.46 V	111.71
82.12D Drainage pelvic abscess NOTE: May only be claimed when performed under general anesthesia.	281.63	113.05
82.14 Other vaginotomy		
82.14D Other vaginotomy	139.70 V	113.05

XIII OPERATIONS ON THE FEMALE GENITAL ORGANS (cont'd)

82 OPERATIONS ON VAGINA AND CUL-DE-SAC (cont'd)

82.1 Incision of vagina and cul-de-sac (cont'd)

82.14 Other vaginotomy (cont'd)

	BASE	ANE
NOTE: 1. May be claimed in addition to a visit or consultation. 2. May not be claimed with any other procedure.		

82.3 Obliteration and total excision of vagina

82.3 A LeFort operation	279.41	113.05
82.3 B Colpectomy For carcinoma	568.56	316.79

82.4 Repair of cystocele and rectocele

82.41 Repair of cystocele

82.41A Repair of cystocele NOTE: An additional benefit of 50% may be claimed for a repeat by using modifier REPT.	337.89	113.05

82.42 Repair of rectocele

82.42A Rectocele repair NOTE: An additional benefit of 50% may be claimed for a repeat by using modifier REPT.	337.89	113.05

82.5 Vaginal construction and reconstruction

82.51 Vaginal construction, Abbe, McIndoe, Williams

82.51A Plastic correction of congenital absence	532.82	243.96

82.6 Other repair of vagina

82.61 Suture of vagina

82.61A Repair of non-obstetrical laceration NOTE: 1. May only be claimed when performed under general anesthesia. 2. May be claimed in addition to a consultation. 3. May not be claimed with any other procedure.	142.95	113.05

82.62 Repair of fistula of vagina

82.62A Rectovaginal fistula repair	409.10	180.72
82.63 Hymenorrhaphy NOTE: 1. May be claimed in addition to a consultation. 2. HSC 66.83 may be claimed in addition.	146.20	113.05

82.64 Vaginal suspension and fixation

82.64A Vaginal vault suspension, additional benefit	276.16	106.20

XIII OPERATIONS ON THE FEMALE GENITAL ORGANS (cont'd)

82 OPERATIONS ON VAGINA AND CUL-DE-SAC (cont'd)

82.6 Other repair of vagina (cont'd)

82.64 Vaginal suspension and fixation (cont'd)

		BASE	ANE
	NOTE: 1. May only be claimed in addition to HSCs 81.99A, 81.99C, 82.41A, 82.42A and 82.69B. 2. An additional benefit of 100% may be claimed for a repeat by using modifier REPT.		
82.64B	Other vaginal vault suspension, sacrospinous, ileo-coccygeal	471.09	335.41
	NOTE: 1. When performed as a second or subsequent procedure through the same incsision, the procedural rate should be claimed at 50% using modifier LVP50. Anesthetic claims using ANE for second and subsequent procedures should use the LVP75 modifier. 2. An additional benefit of 100% may be claimed for a repeat by using modifier REPT.		

XIII OPERATIONS ON THE FEMALE GENITAL ORGANS (cont'd)

82 OPERATIONS ON VAGINA AND CUL-DE-SAC (cont'd)

82.6 Other repair of vagina (cont'd)

82.69 Other repair of vagina NEC

	BASE	ANE
82.69B Enterocoele repair	337.89	149.07
NOTE: An additional benefit of 100% may be claimed for a repeat by using modifier REPT.		
82.69C Insertion of prosthetic mesh	68.23	
NOTE: May only be claimed in addition to HSCs 71.4 A, 71.4 B, 71.4 C, 71.7 A, 71.7 B, 81.99A, 82.3 A, 82.41A, 82.42A, 82.64B, 82.69B, 82.69D, 82.7 A.		
82.69D Paravaginal repair	425.61	242.25
NOTE: 1. When performed as a second or subsequent procedure through the same incision, the procedural rate should be claimed at 50% using modifier LVP50. Anesthetic claims using ANE for second and subsequent procedures should use the LVP75 modifier. 2. An additional benefit of 100% may be claimed for a repeat by using modifier REPT.		
82.69E Excision of mesh or graft material (vaginal or abdominal approach) per full 15 minutes	207.14	153.70
NOTE: Each subsequent 15 minutes, or major portion thereof, is payable at the rate specified on the Price List after the first full 15 minutes has elapsed.		

82.7 Obliteration of vagina vault

82.7 A Abdominal sacrocolpopexy	666.03	226.10
NOTE: An additional benefit of 100% may be claimed for a repeat by using modifier REPT.		

82.8 Invasive diagnostic procedures on vagina and cul-de-sac

82.81 Culdoscopy/Colposcopy

82.81A Colposcopy	45.48 V	112.95
NOTE: 1. Includes biopsy. 2. Repeat within 90 days, refer to Price List.		

82.9 Other operations on vagina and cul-de-sac

82.91 Other operations on vagina

82.91A Biopsy of vagina	45.48 V	113.05
NOTE: A maximum of three calls applies.		

XIII OPERATIONS ON THE FEMALE GENITAL ORGANS (cont'd)

83 OPERATIONS ON VULVA AND PERINEUM

83.0 Incision of vulva and perineum

83.09 Other incision of vulva and perineum

	BASE	ANE
83.09A Perineal abscess, I & D, marsupialization	146.20	113.05

NOTE: 1. May be claimed in addition to a visit or consultation.
2. May not be claimed with any other procedure.

83.1 Operations on Bartholin's gland

83.19A Operations on Bartholin's gland	146.20	113.05

NOTE: 1. May be claimed in addition to a consultation.
2. May not be claimed with any other procedure.

83.2 Other local excision or destruction of vulva and perineum

83.2 B Other local excision or destruction of vulva and perineum	146.20	113.05

NOTE: 1. May not be claimed for condylomata accuminata; refer to HSCs 98.12S, 98.12T, 98.12U.
2. May be claimed in addition to a visit or consultation.
3. May be claimed in addition to HSC 66.83.

83.4 Radical vulvectomy

83.4 A Radical vulvectomy	419.11	226.10
83.4 B Radical vulvectomy with gland dissection	867.46	301.47

83.5 Other vulvectomy

83.5 A Labial reduction or large vulvar resection	172.19	113.05

83.6 Repair of vulva and perineum

83.61 Suture of vulva and perineum	146.20	113.05

Perineorrhaphy

NOTE: 1. May not be claimed with any other procedure.
2. May be claimed in addition to a visit or consultation.

83.69 Other repair of vulva and perineum

83.69B Repair of old 3rd degree laceration	308.65	150.73
83.69C Repair of vulvar or vaginal hematoma	152.70	113.05

NOTE: 1. May be claimed in addition to a consultation.
2. May not be claimed with any other procedure.

83.7 Other operations on vulva

83.7 A Biopsy of vulva	45.48 V	113.05

NOTE: A maximum of three calls applies.

XIII OPERATIONS ON THE FEMALE GENITAL ORGANS (cont'd)

83 OPERATIONS ON VULVA AND PERINEUM (cont'd)

83.6 Repair of vulva and perineum (cont'd)

83.9 Other operations on female genital organs NEC

	BASE	ANE
83.9 A Operations on the adnexa, any method	393.12	169.57

NOTE:
1. May be claimed with HSCs 71.7 A, 82.7 A and 81.99A.
2. May not be claimed in association with a hysterectomy for the removal of fallopian tubes alone. Removal of fallopian tubes for ovarian cancer risk reduction, at the same time as a hysterectomy, should be claimed using HSC 81.99AA.
3. May not be claimed for sterilization.
4. When performed as a second or subsequent procedure through the same incision, the procedural rate should be claimed at 50% using modifier LVP50. Anesthetic claims using ANE for second and subsequent procedures should use the LVP75 modifier.

XIV OBSTETRIC PROCEDURES

84 FORCEPS EXTRACTION AND OTHER INSTRUMENTAL DELIVERY

84.2 Mid forceps delivery

84.21 Mid forceps delivery with episiotomy

	BASE	ANE
84.21D Assisted delivery, forceps, vacuum with or without rotation, mid or lower cavity	144.58	62.55

NOTE: May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery.

85 OTHER PROCEDURES INDUCING OR ASSISTING DELIVERY

85.5 Medical induction of labour

	BASE	ANE
85.5 A Medical induction	120.21	

NOTE:
1. May only be claimed when a physician has assessed the patient prior to the induction and monitors the patient's progress subsequent to the induction.
2. A maximum of two per 24 hour period to a maximum of four per pregnancy may be claimed unless the patient is transferred to another facility for a higher level of care.
3. If the patient is transferred to another facility for a higher level of care, the receiving physician may also claim a maximum of two per 24 hour period to a maximum of four per pregnancy.
4. May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery.

XIV OBSTETRIC PROCEDURES (cont'd)

85 OTHER PROCEDURES INDUCING OR ASSISTING DELIVERY (cont'd)

85.6 Manually assisted delivery

		BASE	ANE
85.69B	Management of shoulder dystocia NOTE: 1. May only be claimed when one of the recognized maneuvers for correction of the situation is employed. 2. May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery.	133.54	89.35
85.69C	Manually assisted delivery (breech presentation, manually or forceps assisted) NOTE: May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery.	198.18	62.55

85.9 Other operations assisting delivery

85.91 External version

85.91	External version Cephalic NOTE: 1. Service must be provided in hospital with level II & III obstetrical units. 2. Ultrasound must be available. 3. Immediate access to OR for Cesarean Section must be available. 4. May only be claimed by specialists or physicians with special accreditation by CPSA. 5. Gestation age must be 37 weeks or greater.	159.20	124.96

86 CESAREAN SECTION AND REMOVAL OF FETUS

86.3 Removal of intraperitoneal embryo

86.3	Removal of intraperitoneal embryo	503.58	226.10

86.4 Other removal of embryo

86.41	Hysterotomy to terminate pregnancy	243.67	142.97

86.9 Cesarean section of unspecified type

86.9 B	Cesarean hysterectomy	1,039.65	362.31
86.9 C	Elective Cesarean section, any approach NOTE: May not be claimed in addition to HSC 81.29C.	513.33	270.74
86.9 D	Cesarean section of unspecified type following trial of labour for any reason NOTE: May not be claimed in addition to HSC 81.29C.	718.01	293.64

XIV OBSTETRIC PROCEDURES (cont'd)

87 OTHER OBSTETRIC OPERATIONS

87.0 Intra-amniotic injection for termination of pregnancy

		BASE	ANE
87.0 A	A Termination of pregnancy between 13 and 20 weeks for medical or genetic reasons using potent prostaglandins or for termination of ectopic pregnancy using methotrexate by any route.	159.20	
	NOTE: 1. Includes the insertion of a laminaria tent if required. 2. A D & C or surgical treatment if required within 14 days should be claimed under HSC 81.09 or 78.52C.		

87.2 Other termination of pregnancy

87.29 Other termination of pregnancy NEC

87.29A	Suction curettage or dilation and curettage for termination of pregnancy . .	155.95	111.71
	NOTE: May only be claimed when performed in an active treatment hospital or by a physician approved to perform the procedure by the CPSA when performed in an accredited non-hospital surgical facility.		
87.29B	Termination of pregnancy, dilatation and evacuation (D&E) termination where imaging report confirms fetus is 12 weeks size or greater	269.66	204.97
	NOTE: 1. May be claimed for termination of viable or non-viable pregnancy. 2. May only be claimed when performed in an active treatment hospital or by a physician approved to perform the procedure by the CPSA when performed in an accredited non-hospital surgical facility.		

87.3 Amniocentesis

87.3	Amniocentesis	103.97	
	NOTE: When performed for a twin pregnancy, refer to Price List.		

87.4 Intrauterine transfusion

87.4	Intrauterine transfusion	393.12	180.72

87.5 Other intrauterine operations on fetus and amnion

87.53 Fetal blood sampling and biopsy

87.53A	Fetal scalp sampling	42.24	
	NOTE: May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery.		
87.53B	Percutaneous umbilical blood sampling (Cordocentesis)	266.41	

XIV OBSTETRIC PROCEDURES (cont'd)

87 OTHER OBSTETRIC OPERATIONS (cont'd)

87.5 Other intrauterine operations on fetus and amnion (cont'd)

87.54 Fetal monitoring, unqualified

	BASE	ANE
87.54A Interpretation of non-stress test	16.24	
NOTE: May not be claimed if labour has commenced.		
87.54B Interpretation and supervision of continuous fetal monitoring (includes application of internal electrode)	63.41	
NOTE: 1. May be claimed: - for continuous monitoring by either internal or external electrical means. - at 100% in addition to delivery benefits regardless of who performs the delivery. 2. May only be claimed in situations of suspected fetal or maternal compromise requiring greater than usual physician supervision. 3. May only be claimed once per hospitalization unless the patient is transferred to another physician or facility for a higher level of care.		

87.55 Other diagnostic procedures on fetus and amnion

87.55A Chorionic villus sampling	113.71	111.71

87.6 Removal of retained placenta

87.6 Removal of retained placenta	113.71 V	131.89
Manual removal of retained placenta and membranes		
NOTE: 1. May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery. 2. May be claimed in addition to a consultation.		

87.7 Repair of obstetric laceration of uterus

87.72 Repair of obstetric laceration of cervix

87.72A Repair of extensive laceration of cervix	113.71 V	144.57
NOTE: 1. May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery. 2. May be claimed in addition to a consultation.		

87.8 Repair of other obstetric lacerations

87.82 Repair of obstetric laceration of sphincter ani	113.71 V	149.07
NOTE: 1. May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery. 2. May be claimed in addition to a consultation.		

XIV OBSTETRIC PROCEDURES (cont'd)

87 OTHER OBSTETRIC OPERATIONS (cont'd)

87.8 Repair of other obstetric lacerations (cont'd)

87.89 Repair of other obstetric lacerations NEC

	BASE	ANE
87.89A Repair of obstetrical laceration involving rectal mucosa	126.71 V	144.57
NOTE: 1. May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery. 2. May be claimed in addition to a consultation.		
87.89B Repair of extensive vaginal laceration	113.71 V	150.73
NOTE: 1. May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery. 2. A second call may only be claimed if a non-contiguous site requires suturing. 3. A maximum of two calls applies. 4. May be claimed in addition to a consultation.		

87.9 Other obstetric operations

87.91 Evacuation of incisional hematoma	38.99 V	113.05
NOTE: 1. May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery. 2. May be claimed in addition to a visit or consultation.		
87.92 Evacuation of other hematoma of vulva or vagina	113.71 V	112.95
NOTE: 1. May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery. 2. May be claimed in addition to a consultation.		

XIV OBSTETRIC PROCEDURES (cont'd)

87 OTHER OBSTETRIC OPERATIONS (cont'd)

87.9 Other obstetric operations (cont'd)

87.93 Surgical correction of inverted uterus

		BASE	ANE
87.93A	Replacement of inverted uterus, abdominal approach	422.36	187.66
	NOTE: 1. May only be claimed when performed under general anesthesia. 2. May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery.		

87.94 Manual replacement of inverted uterus

87.94C	Manual replacement of inverted uterus	139.70	142.97
	NOTE: May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery.		

87.98 Delivery NEC

87.98A	Vaginal delivery	471.09	178.71
87.98B	Management of labour and attempted delivery	479.35	189.74
	NOTE: 1. The benefit includes all usual hospital care associated with the confinement and provided by the referring physician. 2. May be claimed by the referring physician, when the referring physician intended to conduct the delivery, provided the following conditions are met: - the referring physician attended the patient during labour and provided assessment of the progress of the labour, both initial and ongoing; - there is a documented complication warranting the referral, such as fetal distress or dysfunctional labour (failure to progress), and - the referring physician remains in attendance and assists the consultant; or - where the physician must transfer the patient to another facility because of either fetal or maternal indications and delivery occurs within 24 hours of transfer. 3. The same physician may not claim both the delivery and management of labour and attempted delivery.		
87.98C	Vaginal delivery following trial of labour after previous cesarean section	718.01	189.74
87.98D	Multiple birth, vaginal delivery (for each additional newborn)	159.20	62.55
	NOTE: May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery.		

XIV OBSTETRIC PROCEDURES (cont'd)

87 OTHER OBSTETRIC OPERATIONS (cont'd)

87.9 Other obstetric operations (cont'd)

87.98 Delivery NEC (cont'd)

	BASE	ANE
87.98E Delivery detention time, may be claimed per full 15 minutes after the first full 30 minutes has elapsed	88.99	

NOTE:
1. May only be claimed when a physician is specifically requested by the physician intending to perform a delivery and no other service may be claimed for that attendance.
2. May be claimed following the first 30 minutes after the physician has arrived for the attendance at delivery.
3. Services following delivery may be claimed in addition, e.g., care of healthy newborn (HSC 03.05G), neonatal resuscitation (HSC 13.99F), resuscitation (HSC 13.99E), etc.
4. This service is only billable when physician attendance on behalf of the baby is required.
5. If the mother is transferred to another hospital prior to the delivery, the physician may claim for the time spent providing the service to a maximum of 3 calls (60 minutes) of HSC 87.98E with text.

87.99 Other obstetric operations NEC

87.99A Non-surgical management of post partum hemorrhage	96.17	

NOTE:
1. May be claimed at 100% in addition to delivery benefits regardless of who performs the delivery.
2. May be claimed in addition to a consultation.

87.99AA Surgical management of severe post partum hemorrhage including but not limited to the use of an intrauterine balloon device or suturing encircling the uterus	162.45	227.11
87.99B Selective fetal reduction	149.45	111.71

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

88 OPERATIONS ON FACIAL BONES AND JOINTS

	BASE	ANE
88.0 (Closed) reduction of facial fractures		
88.02 (Closed) reduction of malar and zygomatic fracture		
88.02A Hook or temporal elevation	246.68	113.05
88.02B Hook or temporal elevation and antral packing	207.73	142.97
88.03 (Closed) reduction of maxillary fracture		
88.03A With external fixation	350.55	180.72
88.04 (Closed) reduction of mandibular fracture		
88.04A With external fixation	350.55	188.43
88.04B Multiple fractures, with external fixation	402.48	361.42
88.1 Open reduction of facial fractures		
88.12 Open reduction of malar and zygomatic fracture		
88.12A Fixation	337.56	162.64
88.12B With mini-plate fixation of fractured zygoma, malar, one plate	519.33	464.65
88.12C With mini-plate fixation of fractured zygoma, malar, more than one plate	649.16	614.93
88.12D With mini-plate fixation of fractured zygoma, malar, via coronal approach	1,142.53	822.08
88.13 Open reduction of maxillary fracture		
88.13A With suspension	441.43	242.25
88.13B With mini-plate fixation, one side only	519.33	303.80
88.13C With mini-plate fixation, both sides	1,090.59	689.45
88.14 Open reduction of mandibular fracture		
88.14A With internal fixation, single	376.51	415.64
88.14B Single and interdental fixation with splint	532.31	487.93
88.14C Multiple and interdental fixation with splint	636.18	518.28
88.14D Mini-plate fixation of fractured mandible, one plate or lag screws	740.05	508.74
88.14E With mini-plate fixation of fractured mandible, more than one plate or lag screws in more than one fracture	1,116.56	697.17
88.16 Open reduction of orbital fracture		
88.16A Orbital floor fracture NOTE: May not be claimed in addition to item 98.79A.	571.26	207.27
88.16B Mini-plate fixation of fractured supraorbital ridge via coronal approach	1,246.39	831.27
88.19 Open reduction of other facial fracture		
88.19A With mini-plate fixation of fractured frontal bone via coronal approach	1,246.39	661.24
88.4 Partial ostectomy of facial bone, except mandible		
88.4 A Resection of maxilla	1,103.54	433.70
88.5 Excision and reconstruction of mandible		
88.51 Partial ostectomy, mandible		
88.51A Segmental resection	328.28	153.59
88.51B Hemiresection	487.62	205.53

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

88 OPERATIONS ON FACIAL BONES AND JOINTS (cont'd)

		BASE	ANE
88.6	Temporomandibular arthroplasty		
88.6 A	Temporomandibular arthroplasty	485.34	205.54
88.6 B	Temporomandibular arthrotomy NOTE: Includes menisectomy.	363.43	144.57
88.7	Other facial bone repair and osteoplasty		
88.76	Reconstruction of mandible without associated resection Bone graft mandible	597.23	204.97
88.9	Other operations on facial bones and joints		
88.92	Closed reduction of temporomandibular dislocation	70.58 V	112.95
88.99	Other operations on facial bones and joints NEC Osseointegrated cranio-facial reconstruction NOTE: May only be claimed following surgery for cancer or trauma or to patients with congenital anomalies.		
88.99A	One or two fixtures, first stage	775.27	428.92
88.99B	One or two fixtures, second stage	580.31	357.43
88.99C	Three fixtures, first stage	1,025.68	696.99
88.99D	Three fixtures, second stage	839.24	451.77
88.99E	Four or more fixtures, first stage	1,324.29	867.39
88.99F	Four or more fixtures, second stage	1,025.68	661.24

89 INCISION, EXCISION, AND DIVISION OF OTHER BONES

89.0	Sequestrectomy		
89.0 A	Radical surgical debridement of sternum NOTE: 1. Includes insertion of irrigation and drainage catheters. 2. Includes with or without closure of sternum.	773.33	358.00
89.0 B	Reconstruction of sternum using plates and screws NOTE: May not be claimed for closure of sternum for routine cardiac procedures.	1,070.98	374.78
89.03	Sequestrectomy, carpals and metacarpals	230.06	112.95
89.08	Sequestrectomy, other specified site		
89.08B	Phalanx	228.51	113.05
89.09	Sequestrectomy, unspecified site		
89.09A	Large bone	439.44	207.27
89.1	Other incision of bone without division		
89.12	Other incision of bone without division, radius and ulna		
89.12A	Olecranon excision	263.71	144.57
89.12B	Radial head or neck excision	263.71	169.57
89.19	Other incision of bone without division, unspecified site		
89.19A	Incision and drainage subperiosteal abscess	263.71	112.95

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

89 INCISION, EXCISION, AND DIVISION OF OTHER BONES (cont'd)

89.2 Wedge osteotomy
NOTE: Benefits for HSCs 89.20A to 89.26A include fixation

		BASE	ANE
89.20	Wedge osteotomy, scapula, clavicle, and thorax (ribs and sternum)		
89.20A	Clavicle	439.51	113.05
89.21	Wedge osteotomy humerus	703.22	169.57
89.22	Wedge osteotomy, radius and ulna		
89.22A	Radius	703.22	150.73
89.22B	Ulna	527.41	150.73
89.23	Osteotomy, carpal bones, phalanx or metacarpals (including fixation)	389.50	113.05
89.24	Wedge osteotomy, femur	1,054.82	226.10
89.26	Wedge osteotomy, tibia and fibula		
89.26A	Tibia	879.02	188.43
89.36	Osteotomy, tibia		
89.36A	Mal-united fracture, dislocation, ankle	879.02	226.10
89.36C	Osteotomy, fibula (including fixation)	263.71	113.05
89.37	Other division of bone, tarsals and metatarsals		
89.37A	Osteotomy, calcaneum or talus	527.41	169.57
89.37B	Osteotomy, Lesser bone of foot	263.71	113.05
89.38	Other division of bone, other specified site		
89.38B	Osteotomy, pelvis (including fixation)	1,054.82	282.63
89.38C	Osteotomy for kyphosis correction, posterior cervical spine	1,634.32	536.13
89.38D	Osteotomy spine, posterior thoracolumbar	791.12	279.52
89.38E	Subtraction/decancellation posterior osteotomy, lumbar	1,758.04	678.33
89.38F	Anterior release, thoracolumbar, multilevel	1,318.53	465.85
89.38G	Periacetabular osteotomy	2,637.06	923.28
89.4	Excision of bunion (bunionectomy)		
89.41	Bunionectomy with soft tissue correction and osteotomy of the first metatarsal		
89.41A	Bunionectomy with distal osteotomy of the first metatarsal or proximal phalanx	395.56	188.43
89.41B	Bunionectomy with proximal osteotomy first metatarsal	791.12	282.63
	NOTE: May not be claimed with other osteotomy services on the first metatarsal.		
89.42	Bunionectomy with soft tissue correction and arthrodesis		
89.42A	Bunionectomy with soft tissue correction	263.71	113.05
89.5	Local excision of lesion or tissue of bone		
89.53	Local excision of lesion or tissue of bone, metacarpal		
89.53A	Excision of tumor	347.95	113.05

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

89 INCISION, EXCISION, AND DIVISION OF OTHER BONES (cont'd)

89.5 Local excision of lesion or tissue of bone (cont'd)

89.57 Local excision of lesion or tissue of bone, tarsals and metatarsals

	BASE	ANE
89.57B Local excision of lesion or tissue of bone, tarsals and metatarsals, sequestrectomy or saucerization	175.80	113.05

89.58 Local excision of lesion or tissue of bone, phalanx

89.58A Tumor	347.95	113.05
89.58B Saucerization	194.75	112.95

89.59 Local excision of lesion or tissue of bone, unspecified site

89.59A Biopsy bone tumor, superficial	131.85 V	113.05
89.59B Percutaneous, biopsy bone tumor, deep	139.10	113.05
89.59F Local excision or saucerization, large bone	439.51	207.27
89.59G Open biopsy bone tumor, first full 30 minutes or major portion thereof for the first call when only one call is claimed	197.78	113.05

NOTE: 1. May not be claimed with other procedures.
2. Each subsequent 15 minutes, or major portion thereof, is payable at the rate specified on the Price List after the first full 30 minutes has elapsed.

89.6 Excision of bone for graft

Allograft harvesting from cadaver for bone bank

89.6 A Major, may include hemipelvis, long bone and joint articulation	459.62	
89.6 C Harvesting of autologous bone That for grafting by a second surgeon for immediate insertion	213.05	

89.7 Other partial ostectomy

89.78 Other partial ostectomy (specified site)

89.78D Odontoidectomy, transoral approach	2,365.77	625.50
89.78E Temporal bone, subtotal resection That for malignant disease	2,781.92	469.86
89.78H Vertebrectomy cervical, partial	802.27	584.12

NOTE: 1. Benefit includes discectomy(s).
2. Fusion, bone graft harvesting and/or plating may be claimed in addition.

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

89 INCISION, EXCISION, AND DIVISION OF OTHER BONES (cont'd)

89.7 Other partial ostectomy (cont'd)
89.78 Other partial ostectomy (specified site) (cont'd)

		BASE	ANE
89.78I	Vertebrectomy cervical, total, one level NOTE: 1. Benefit includes discectomy(s). 2. Fusion, bone graft harvesting and/or plating may be claimed in addition.	1,582.24	716.02
89.78L	Vertebrectomy cervical, total, two levels NOTE: 1. Benefit includes discectomy(s). 2. Fusion, bone graft harvesting and/or plating may be claimed in addition.	1,360.83	1,087.96
89.78M	Vertebrectomy cervical, total, three levels NOTE: 1. Benefit includes discectomy(s). 2. Fusion, bone graft harvesting and/or plating may be claimed in addition.	1,637.57	1,263.17
89.78N	Vertebrectomy cervical, total, four levels NOTE: 1. Benefit includes discectomy(s). 2. Fusion, bone graft harvesting and/or plating may be claimed in addition.	2,609.11	1,387.71
89.78J	Vertebrectomy, partial, thoracolumbar NOTE: 1. Benefit includes discectomy(s). 2. Fusion, bone graft harvesting and/or plating may be claimed in addition.	879.02	686.70
89.78K	Vertebrectomy, total, thoracolumbar, one level NOTE: 1. Benefit includes discectomy(s). 2. Fusion, bone graft harvesting and/or plating may be claimed in addition.	1,780.02	829.06
89.78P	Vertebrectomy, total, thoracolumbar, two levels NOTE: 1. Benefit includes discectomy(s). 2. Fusion, bone graft harvesting and/or plating may be claimed in addition.	2,130.63	1,446.94
89.78Q	Vertebrectomy, total, thoracolumbar, three levels NOTE: 1. Benefit includes discectomy(s). 2. Fusion, bone graft harvesting and/or plating may be claimed in addition.	1,493.96	1,547.85
89.78R	Vertebrectomy, total, thoracolumbar, four levels NOTE: 1. Benefit includes discectomy(s). 2. Fusion, bone graft harvesting and/or plating may be claimed in addition.	2,474.15	1,921.45
89.78S	Anterior cervical plating, 2 vertebrae	643.44	428.92

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

89 INCISION, EXCISION, AND DIVISION OF OTHER BONES (cont'd)

89.7 Other partial ostectomy (cont'd)
89.78 Other partial ostectomy (specified site) (cont'd)

	BASE	ANE
89.78T Anterior cervical plating, 3 vertebrae	703.22	428.92
89.78U Anterior cervical plating, 4 vertebrae	894.42	428.92
89.78V Anterior cervical plating, 5 vertebrae	813.97	428.92
89.78W Anterior thoracolumbar plating, 2 vertebrae	773.54	428.92
89.78X Anterior thoracolumbar plating, 3 vertebrae	813.97	428.92
89.78Y Anterior thoracolumbar plating, 4 vertebrae	896.60	428.92

89.8 Total ostectomy
89.85 Total patellectomy 439.51 167.71

89.88 Total ostectomy (specified site)
89.88A Coccygectomy 445.11 113.05

89.89 Complete ostectomy, unspecified site
89.89B Radical or wide en-bloc resection of bone or soft tissue tumor of limb and limb salvage reconstruction, full 60 minutes or major portion thereof for the first call when only one call is claimed 527.41
NOTE: Each subsequent 15 minutes, or major portion thereof, is payable at the rate specified on the Price List after the first full 60 minutes has elapsed.

89.9 Biopsy of bone
89.98 Biopsy of bone, other specified site
89.98A Needle biopsy of vertebral body or disc 139.10 113.05

90 OTHER OPERATIONS ON BONES EXCEPT FACIAL BONES

90.0 Bone graft
NOTE: Benefits for 90.00A to 90.08A include harvesting and fixation

90.00 Bone graft, scapula, clavicle, and thorax (ribs or sternum)
90.00A Clavicle 351.61 188.43

90.01 Bone graft, humerus 527.41 226.10

90.02 Bone graft, radius and ulna
90.02B Radius 351.61 180.72
90.02C Ulna 351.61 180.72

90.03 Bone graft, carpals and metacarpals
90.03A Carpal scaphoid 597.23 169.57
90.03B Bone graft metacarpal or phalanx 337.56 111.71
90.03C Carpal, vascularized 1,038.66 376.84

90.04 Bone graft, femur 527.41 301.47

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

90 OTHER OPERATIONS ON BONES EXCEPT FACIAL BONES (cont'd)

90.0 Bone graft (cont'd)

90.05 Bone graft, patella

	BASE	ANE
90.05A Articular osteochondral graft in the knee	791.12	282.63

90.06 Bone graft, tibia and fibula

90.06A Tibia	351.61	226.10
90.06B Medial malleolus	263.71	180.72

90.07 Bone graft, tarsals and metatarsals

90.07A Calcaneum	527.41	196.59
90.07B Metatarsals	351.61	113.05

90.08 Bone graft, other specified site

90.08A Phalanges	263.71	111.71
90.08B Ilioplasty, repair iliac crest defect following bone graft harvest	87.90	

NOTE: Benefit includes repair with autograft, allograft, or bone cement.

90.09 Bone graft, unspecified site

90.09A Preparation of allograft bone from bone bank, for insertion, including spinal cage insertion	131.85	

NOTE: 1. For spinal surgery, may be claimed only once regardless of the number of levels.
2. May be claimed with 90.09B or 90.09C if autogenous bone is harvested.

90.09B Harvest autogenous bone graft, iliac crest or different bone through a different incision	263.71	

NOTE: May not be claimed in association with HSC 90.00A to 90.08A inclusive.

90.09C Harvest autogenous bone graft, different bone	131.85	

NOTE: May not be claimed in association with HSC 90.00A to 90.08A inclusive.

90.2 Epiphyseal stapling

90.2 A Epiphyseal stapling, One side	351.61	150.73

90.3 Other change in bone length

90.32 Other change in bone length, radius and ulna

90.32A Shortening of radius	389.50	142.97
90.32B Shortening of ulna	351.61	150.73

90.34 Other change in bone length, femur

90.34A Femur, (shortening)	1,054.82	320.33
90.34B Femur, (lengthening)	949.34	361.42

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

90 OTHER OPERATIONS ON BONES EXCEPT FACIAL BONES (cont'd)

90.3 Other change in bone length (cont'd)

90.39 Other change in bone length, unspecified site

	BASE	ANE
90.39A Incremental lengthening or deformity correction using external fixation device, full 60 minutes or major portion thereof for the first call when only one call is claimed	527.41	487.93
NOTE: Each subsequent 15 minutes, or major portion thereof, is payable at the rate specified on the Price List after the first full 60 minutes has elapsed.		

90.4 Other repair or plastic operation on bone

90.40 Other repair or plastic operation on bone, scapula, clavicle, and thorax (ribs and sternum)

90.40A Congenital elevation scapula, scapulopexy	703.22	196.59
90.40B Vertical expandable prosthetic titanium rib (VEPTR) surgical insertion for scoliosis or other thoracic deficiency syndrome	3,516.08	1,487.80
90.40C Vertical expandable prosthetic titanium rib (VEPTR) lengthening procedure	1,547.08	659.49

90.5 Internal fixation of bone (without fracture reduction)

90.5 A Odontoid screw fixation	1,626.19	565.27
90.5 B C1 - C2 facet screw fixation and posterior tension band	2,621.99	810.22

90.6 Removal of internal fixation device

90.6 D Removal of external fixation device	175.80	113.05
NOTE: May only be claimed when performed in a hospital operating theatre or non-hospital surgical suite		
90.6 E Removal of hardware under local anesthetic	87.90	
NOTE: Regardless of the number of pieces of hardware removed, only one call may be claimed per site.		
90.6 F Removal of hardware, excluding external fixator devices, first full 30 minutes or major portion thereof for the first call when only one call is claimed	197.78	113.05
NOTE: 1. May only be claimed when performed in a hospital operating theatre or non-hospital surgical suite.		
2. Each subsequent 15 minutes, or major portion thereof, is payable at the rate specified on the Price List after the first full 30 minutes has elapsed.		

91 REDUCTION OF FRACTURE AND DISLOCATION

91.0 Closed reduction of fracture (without internal fixation)

91.00 Closed reduction of fracture, humerus

91.00A Surgical neck	120.09	
91.00B Surgical neck with anesthesia and manipulation	174.00	113.05

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

91 REDUCTION OF FRACTURE AND DISLOCATION (cont'd)

91.0 Closed reduction of fracture (without internal fixation) (cont'd)

91.00 Closed reduction of fracture, humerus (cont'd)

		BASE	ANE
91.00C	Shaft	183.82	112.95
91.00D	Supracondylar	214.92	113.05
91.00E	Supracondylar, traction or external skeletal fixation	527.41	150.73
91.00F	Elbow, one or more bones	120.09	113.05

91.01 Closed reduction of fracture, radius and ulna

91.01A	Radius head, not requiring anesthesia	77.10	
91.01B	Radius head with manipulation and anesthesia	90.51	113.05
91.01C	Radius, shaft	109.07	113.05
91.01D	Ulna, shaft	117.29	113.05
91.01E	Monteggia	175.80	188.43
91.01F	Colles	140.34	113.05
91.01G	CR fracture, Colles with pin fixation	351.61	113.05
91.01H	Styloid process radius	88.32 V	111.81
91.01J	Styloid, ulna	46.51 V	111.71
91.01K	Undisplaced	78.12	
91.01L	Greenstick	117.29	112.95
91.01M	Closed reduction of fracture, radius and ulna, displaced	183.82	113.05

91.02 Closed reduction of fracture, carpals and metacarpals

91.02A	Metacarpal	87.48 V	113.05
91.02B	Bennett's	117.29	111.71
91.02C	Carpals, excluding scaphoid	120.09	112.95
91.02D	Scaphoid	140.34	111.71

91.03 Closed reduction of fracture, phalanges of hand

91.03A	Phalanx	84.99 V	113.05
91.03B	Simple distal phalanx	42.78 V	113.05

91.04 Closed reduction of fracture (without internal fixation), femur

91.04A	Femur (Intertrochanteric, undisplaced)	183.82	
91.04B	Intertrochanteric, femur, skeletal traction	424.02	204.97
91.04C	Shaft	407.88 V	204.97

NOTE: For under 10 years of age, refer to Price List.

91.04E	Closed reduction femoral shaft fracture, patient under 10 years of age	527.41	188.43

NOTE: 1. Benefit includes application of hip spica.
2. May only be claimed when performed in a hospital operating theatre or non-hospital surgical suite.

91.05 Closed reduction of fracture, tibia and fibula

91.05A	Tibia, plateau, traction	237.74	113.05
91.05B	Tibia, shaft, with or without fibula	235.29 V	113.05

NOTE: For under 10 years of age, refer to Price List.

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

91 REDUCTION OF FRACTURE AND DISLOCATION (cont'd)

91.0 Closed reduction of fracture (without internal fixation) (cont'd)

91.05 Closed reduction of fracture, tibia and fibula (cont'd)

		BASE	ANE
91.05K	Closed reduction of tibia	351.61	113.05
	NOTE: May only be claimed when performed in a hospital operating theatre or non-hospital surgical suite.		
91.05C	Medial malleolus, without displacement of astragalus	117.23	112.95
91.05D	Medial or lateral malleolus with displacement of astragalus	164.16	111.71
91.05E	Fibula, shaft	117.29 V	111.71
	NOTE: May be claimed in addition to 91.05C.		
91.05F	Ankle, bi-malleolar	237.74	113.05
91.05G	Ankle, tri-malleolar	237.74	188.43
91.05H	Lateral malleolus	114.96 V	112.95
	NOTE: May not be claimed in addition to 91.05C.		

91.06 Closed reduction of fracture (without internal fixation), tarsals and metatarsals

91.06A	Talus	140.87	111.81
91.06B	Calcaneus	120.09	112.95
91.06C	Calcaneus, external skeletal fixation	527.41	144.57
91.06D	Metatarsal	89.35 V	113.05
91.06E	Other tarsal bone(s)	117.29 V	111.71
	NOTE: A second call may only be claimed when a fracture in the second foot is reduced.		

91.07 Closed reduction of fracture, phalanges of foot

91.07A	Phalanx or phalanges	58.64 V	111.71

91.08 Closed reduction of fracture (without internal fixation), other specified bone

91.08B	Scapula	67.69 V	111.71
91.08L	External fixation, pelvis	791.12	339.65
	NOTE: Benefit includes closed reduction		
91.08G	Central dislocation of hip, displaced, skeletal traction	175.80	169.57
91.08J	Sacrum	49.02	

91.09 Closed reduction of fracture (without internal fixation) unspecified bone

91.09A	Diaphyseal bone external fixation with possible metaphyseal fixation	527.41	188.43
	NOTE: This will include complex cases such as a severe tibial plateau fracture that can not be treated with internal fixation.		
91.09B	Closed reduction and pinning of distal radius metaphyseal fractures	270.14	188.43

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

91 REDUCTION OF FRACTURE AND DISLOCATION (cont'd)

	BASE	ANE
91.1 Closed reduction of fracture with internal fixation		
91.10 Closed reduction of fracture with internal fixation, humerus		
91.10A Closed reduction and percutaneous pinning proximal humeral fracture	527.41	188.43
91.12 Closed reduction of fracture with internal fixation, carpals and metacarpals		
91.12A Metacarpal	259.67	113.05
91.13 Closed reduction of fracture with internal fixation, phalange of hand		
91.13A Phalanx	285.63	113.05
91.14 Closed reduction of fracture with internal fixation, femur		
91.14A Neck	791.12	271.72
91.14B With insertion of intramedullary nail	879.02	294.37
91.14C With insertion of locking intramedullary nail	1,054.82	339.65
91.15 Closed reduction of fracture with internal fixation, tibia and fibula		
91.15A Closed reduction of fracture, tibia and fibula with insertion of intramedullary nail	659.27	188.43
91.15B Closed reduction of fracture, tibia and fibula with insertion of locking intramedullary nail	857.04	226.10
91.2 Open reduction of fracture (without internal fixation)		
91.22 Open reduction of fracture (without internal fixation), carpals and metacarpals		
91.22A Open reduction without internal fixation of carpal	415.46	169.57
91.22B Open reduction without internal fixation of metacarpal	227.99	112.95
91.23 Open reduction of fracture (without internal fixation) phalanges of hand		
91.23A Phalanx	203.62	113.05
91.23B Bennett's	305.37	144.57
91.3 Open reduction of fracture with internal fixation		
91.30 Open reduction of fracture with internal fixation, humerus		
91.30A Elbow (medial or lateral condyles)	527.41	169.57
91.30B Surgical neck	659.27	169.57
91.30C Shaft	659.27	169.57
91.30D Supracondylar	659.27	207.27
91.30F ORIF complex intercondylar distal humeral fracture (T-type, more than 2 articular fragments)	1,186.68	414.53
91.30G ORIF simple intercondylar distal humeral fracture, 2 articular fragments	703.22	263.79
91.30H ORIF complex proximal humeral fracture (3-4 part) including hemiarthroplasty	1,186.68	414.53
NOTE: This code may not be used for primary shoulder hemiarthroplasty for arthritis.		

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

91 REDUCTION OF FRACTURE AND DISLOCATION (cont'd)

91.3 Open reduction of fracture with internal fixation (cont'd)

91.30 Open reduction of fracture with internal fixation, humerus (cont'd)

	BASE	ANE
91.30I ORIF glenoid fracture, excluding bony Bankart lesion repair(s)	593.34	282.63

91.31 Open reduction of fracture with internal fixation, radius and ulna

91.31B Radius shaft	351.61	150.73
91.31C Ulna shaft	351.61	150.73
91.31D ORIF of fracture, Colles (extra-articular)	527.41	150.73
91.31E Monteggia	527.41	207.27
91.31F Olecranon	351.61	150.73
91.31G ORIF complex distal radial fracture (comminuted, intra-articular), not percutaneous	879.02	320.33
91.31H ORIF Galeazzi fracture	527.41	188.43
91.31J ORIF radial head/neck or replacement radial head arthroplasty	527.41	188.43
91.31K Open reduction, complex comminuted fracture, proximal ulna	615.31	358.00

91.32 Open reduction of fracture with internal fixation, carpals and metacarpals

91.32A Metacarpal	350.55	113.05
91.32D ORIF scaphoid and carpal bones	671.03	188.43

91.33 Open reduction of fracture with internal fixation, phalanges of hand

91.33A Phalanx(s)	363.53	113.05
91.33B ORIF intra-articular or Bennett's fracture	376.51	150.73

91.34 Open reduction of fracture with internal fixation, femur

91.34A Inter-trochanteric	791.12	271.72
91.34B Bicondylar, supracondylar fracture, T-shaped	1,186.68	475.52
91.34C Supracondylar fracture	879.02	475.52
91.34D Fracture femoral condyle	527.41	249.08
91.34E Femur, neck	791.12	271.72
91.34F ORIF femoral head fracture	879.02	384.95
91.34G ORIF femoral shaft fracture	879.02	384.95
91.34H ORIF subtrochanteric femur fracture	1,054.82	452.88

91.35 Open reduction of fracture with internal fixation, tibia and fibula

91.35A Tibial plateau	791.12	188.43
91.35B Tibia	593.34	188.43
91.35C Medial malleolus	263.71	150.73
91.35D ORIF of fracture, Fibula, shaft	307.66	150.73
91.35G ORIF, Tibial plateau - bicondylar fracture (T type, comminuted, displaced)	1,186.68	376.84
91.35H ORIF of fracture, Lateral malleolus	307.66	150.73
91.35K ORIF tibial plafond (2 intra-articular fragments)	791.12	282.63
91.35L ORIF comminuted tibial plafond (more than 2 intra-articular fragments)	1,186.68	414.53
91.35M ORIF posterior malleolus	175.80	113.05
91.35N Syndesmosis screw insertion	219.76	393.17

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

91 REDUCTION OF FRACTURE AND DISLOCATION (cont'd)

91.3 Open reduction of fracture with internal fixation (cont'd)

91.36 Open reduction of fracture with internal fixation, tarsals and metatarsals

		BASE	ANE
91.36A	Talus	791.12	188.43
91.36B	ORIF of fracture, Calcaneus	966.92	188.43
91.36I	ORIF intra-articular comminuted calcaneus fracture more than three intra-articular parts	1,186.68	913.86
91.36C	ORIF of fracture, other tarsal bone, including navicular bone	659.27	150.73
91.36D	ORIF of fracture, Metatarsal	263.71	135.53
91.36E	ORIF Lisfranc fracture dislocation	593.34	207.27
91.36G	ORIF Lisfranc fracture dislocation, 3 or more dislocations	791.12	527.59
91.36H	Talar fracture, complex	966.92	670.83

NOTE: May only be claimed for repairs of 2 of either:
-Body fracture (s)
-Neck fracture or
-lateral process fractures.

91.37 Open reduction of fracture with internal fixation, phalanges of foot

91.37A	Toe	175.80	113.05

91.38 Open reduction of fracture with internal fixation, other specified bone

91.38A	Clavicle	596.46	113.05
91.38B	Scapula	527.41	144.57
91.38D	ORIF, Acetabulum - simple wall (anterior/posterior)	1,054.82	376.84
91.38F	Patella	395.56	169.57
91.38H	ORIF pubic symphysis or iliac wing	791.12	282.63
91.38J	ORIF complex, acetabular (column) fracture	2,109.65	905.75
91.38K	ORIF sacroiliac joint	1,054.82	376.84

91.4 (Closed) reduction of separated (slipped) epiphysis

91.44 (Closed) reduction of separated (slipped) epiphysis (femur)

91.44B	Upper femoral, internal fixation	879.02	226.10

91.7 Closed reduction of dislocation of joint
For those not listed - claim a visit.

91.70 Closed reduction of dislocation of shoulder

91.70A	Primary	82.00 V	113.05
91.70B	Recurrent	82.00 V	112.95
91.71	Closed reduction of dislocation of elbow	90.51 V	113.05

NOTE: May not be claimed for dislocated radial head.

91.72	Closed reduction of dislocation of wrist	96.28	113.05

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

91 REDUCTION OF FRACTURE AND DISLOCATION (cont'd)

91.7 Closed reduction of dislocation of joint (cont'd)

91.73 Closed reduction of dislocation of hand and finger

	BASE	ANE
91.73A Carpo-metacarpal	62.48 V	112.95
91.73B MP or IP joint	53.40 V	111.81

91.74 Closed reduction of dislocation of hip

91.74A Closed reduction of dislocation of hip	183.82	113.05
91.74B Closed reduction of developmental hip dislocation	791.12	207.27
NOTE: May only be claimed when performed under general anesthetic.		

91.75 Closed reduction of dislocation of knee

91.75A Tibio-femoral	165.44	112.95
91.75B Closed reduction of patellar dislocation	89.35	111.71
NOTE: 1. May be claimed in addition to a visit or consultation at the same encounter.		
2. May only be claimed in an emergency room, AACC or UCC.		
91.76 Closed reduction of dislocation of ankle	145.83	112.95

91.77 Closed reduction of dislocation of foot and toe

91.77A Tarsus	129.41	113.05
91.77B Metatarsal	65.00 V	111.71
91.77C Toes	37.21 V	111.71

91.78 Closed reduction of dislocation of other specified sites

91.78A Sterno-clavicular	58.71 V	112.95
91.78B Acromio-clavicular	91.20 V	111.71
91.78C Neck simple, with anesthetic	141.33	111.71
91.78D Vertebra fracture, fracture dislocation, Halo traction, total care	527.41	
NOTE: Includes total care.		

91.8 Open reduction of dislocation of joint

91.80 Open reduction of acute dislocation of shoulder, less than 21 days after injury	659.27	226.10
91.80A Open reduction of chronic dislocation of shoulder, more than 21 days after injury	879.02	689.45
91.81 Open reduction of dislocation of elbow	659.27	188.43

91.82 Open reduction of dislocation of wrist

91.82A ORIF, Carpal Dislocation	659.27	150.73

91.83 Open reduction of dislocation of hand and finger

91.83A Carpo-metacarpal	310.95	113.05

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

91 REDUCTION OF FRACTURE AND DISLOCATION (cont'd)

91.8 Open reduction of dislocation of joint (cont'd)

91.83 Open reduction of dislocation of hand and finger (cont'd)

	BASE	ANE
91.83B MP or IP joint	312.12	113.05
91.84 Open reduction of dislocation of hip		
91.84A Open reduction of dislocation of hip NOTE: May be claimed in addition to 89.38B.	659.27	282.63
91.84C Open reduction of developmental hip dislocation	1,054.82	225.88
91.84D Repeat open reduction of developmental dislocation of hip NOTE: May not be claimed within 14 days of a 91.84C.	1,582.24	524.06
91.85 Open reduction of dislocation of knee		
91.85A Tibio-femoral	351.61	207.27
91.86 Open reduction of dislocation of ankle	263.71	188.43
91.87 Open reduction of dislocation of foot and toe		
91.87A Tarsus	263.71	188.43
91.87B Metatarsal	195.14	135.53
91.87C Toe	175.80	113.05
91.88 Open reduction of dislocation of other specified sites		
91.88A Sterno-clavicular	527.41	169.57
91.88B Open reduction of dislocation acromio-clavicular, acute repair, less than 6 weeks from date of injury	351.61	169.57
91.88C Open reduction of dislocation acromio-clavicular chronic repair, greater than 6 weeks from date of injury	395.56	282.63

91.9 Other or unspecified operations on bone injuries NEC

91.90 Other or unspecified operations on bone injuries NEC, humerus

91.90A Open or closed reduction of fracture, humerus with insertion of intermedullary locking-nail	857.04	244.96

92 INCISION AND EXCISION OF JOINT STRUCTURES

92.1 Other arthrotomy

NOTE: Benefits 92.10 through 92.19A (except 92.13) may not be claimed with other procedures on the same joint.

92.10 Arthrotomy, shoulder	395.56	169.57

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

92 INCISION AND EXCISION OF JOINT STRUCTURES (cont'd)

92.1 Other arthrotomy (cont'd)
NOTE: Benefits 92.10 through 92.19A (except 92.13) may not be claimed with other procedures on the same joint. (cont'd)

		BASE	ANE
92.11	Arthrotomy, elbow	351.61	150.73
92.12	Arthrotomy, wrist	420.66	113.05
92.13	Arthrotomy, hand and finger	148.01	111.81
92.14	Arthrotomy, hip	527.41	207.27
92.15	Arthrotomy, knee NOTE: May not be claimed with other procedures on the same joint.	351.61	113.05
92.16	Arthrotomy, ankle	351.61	150.73

92.19 Other arthrotomy, unspecified site

92.19A	Arthrotomy of any joint, not elsewhere classified NOTE: May not be claimed with other procedures on the same joint.	263.71	113.05

92.3 Excision (or destruction) of certain specified joint structures
92.31 Excision or destruction of intervertebral disc

92.31C	Cervical discectomy with fusion, Neurosurgical component	1,037.34	316.78
92.31D	Cervical discectomy with fusion, Orthopedic component	639.93	316.78
92.31E	Anterior cervical discectomy and fusion, one level	1,384.00	857.82
92.31M	Anterior cervical discectomy and fusion, two levels NOTE: 1. Benefit includes discectomy(s). 2. Bone graft harvesting and/or plating may be claimed in addition.	1,555.93	1,075.94
92.31N	Anterior cervical discectomy and fusion, three levels NOTE: 1. Benefit includes discectomy(s). 2. Bone graft harvesting and/or plating may be claimed in addition.	1,765.93	1,331.82
92.31P	Anterior cervical discectomy and fusion, four levels NOTE: 1. Benefit includes discectomy(s). 2. Bone graft harvesting and/or plating may be claimed in addition.	2,007.75	1,439.20
92.31Q	Microscopic assisted discectomy	1,132.37	452.21
92.31R	Artificial disc replacement, cervical disc	1,714.09	678.33
92.31S	Artificial disc replacement, lumbar disc	1,933.84	732.72
92.31F	Thoracic disc, anterior approach	1,290.33	415.63
92.31H	Cervical laminectomy for discectomy NOTE: 1. Benefit includes discectomy. 2. Instrumentation may be claimed in addition.	1,070.80	321.69
92.31J	Posterolateral fusion, lumbar, 2 levels or less	703.22	223.59
92.31K	Posterolateral fusion, lumbar, more than 2 levels	922.97	312.74

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

92 INCISION AND EXCISION OF JOINT STRUCTURES (cont'd)

92.3 Excision (or destruction) of certain specified joint structures (cont'd)
92.31 Excision or destruction of intervertebral disc (cont'd)

	BASE	ANE
92.31L Cervical/lumbar discectomy without fusion	791.12	339.16

92.32 Excision of semilunar cartilage of knee
NOTE: Benefits 92.32B through 92.32D may not be claimed with other procedures on the same knee.

92.32B Arthroscopy knee, including menisectomy	351.61	169.57
92.32C Meniscal repair	571.36	169.57
92.32D Arthroscopy knee, including non-reconstructive procedures (loose body, plica, etc.)	351.61	150.73

92.4 Synovectomy
NOTE: 1. 92.40 to 92.46 inclusive may only be claimed for total synovectomy.
2. Partial synovectomy is considered to be an incidental procedure and may not be claimed.

92.40 Synovectomy, shoulder NOTE: May not be claimed in addition to HSCs 93.81A, 93.81B or 93.96E.	527.41	189.74
92.41 Synovectomy, elbow NOTE: May not be claimed in addition to HSCs 93.96D or 93.96E.	527.41	162.64
92.42 Synovectomy, wrist NOTE: May not be claimed in addition to HSCs 93.87C, 93.96D or 93.96E.	337.56	149.07

92.43 Synovectomy, hand and finger

92.43A MP joint or IP joint	207.73	112.95
92.44 Synovectomy, hip NOTE: May not be claimed in addition to HSCs 93.59A, 93.69B, 93.69C or 93.96E.	659.27	196.59
92.45 Synovectomy, knee NOTE: May not be claimed in addition to HSCs 93.41A or 93.96E.	527.41	207.27
92.46 Synovectomy, ankle NOTE: May not be claimed in addition to HSCs 93.96D or 93.96E.	527.41	142.97

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

92 INCISION AND EXCISION OF JOINT STRUCTURES (cont'd)

92.5 Other local excision or destruction of lesion of joint
92.5 Bursotomy

		BASE	ANE
92.5 B	Synovial biopsy	244.78	111.71
	NOTE: May not be claimed with other procedures on the same joint.		

92.7 Contrast arthrogram

Injection for

92.70	Shoulder	58.73 V
92.71	Elbow	58.73 V
92.72	Wrist	58.73 V
92.74	Hip	58.73 V
92.75	Knee	58.73 V
92.76	Ankle	58.73 V

92.78 Contrast arthrogram, other specified site

92.78A	Temporomandibular joint	58.73
92.78B	Facet joint in spine	58.73
	NOTE: May not be claimed in addition to HSCs 16.89B, 16.89C or 16.89D.	
92.78C	Contrast arthrogram, unspecified site	58.73 V
	NOTE: 1. May not be claimed in addition to HSCs 16.89B, 16.89C or 16.89D. 2. May be claimed in addition to HSC 95.94C.	

92.8 Arthroscopy

92.8 A	Arthroscopy diagnostic-knee, shoulder, elbow, wrist, ankle	307.66	113.05
	NOTE: May not be claimed when a subsequent therapeutic open or arthroscopic procedure is performed in the same body cavity.		
92.8 B	Arthroscopy, hip-diagnostic	527.41	188.43
	NOTE: May not be claimed when a subsequent therapeutic open or arthroscopic procedure is performed in the same body cavity.		
92.8 C	Arthroscopy, hip, therapeutic intervention, including debridement/drilling, etc.	747.17	263.79
92.8 D	Arthroscopy, (wrist, elbow, ankle, shoulder, knee) therapeutic intervention, including debridement/drilling, etc.	527.41	188.43
	NOTE: May not be billed in addition to HSCs 92.32B, 92.32C or 92.32D.		

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

93 REPAIR AND PLASTIC OPERATIONS ON JOINT STRUCTURES

93.0 Spinal fusion

93.01 Atlas-axis spinal fusion

	BASE	ANE
93.01A Foramen magnum, decompression and occiput-cervical: exploration, open reduction, internal fixation, and fusion with autogenous bone	2,677.00	979.81
93.01B Occipital cervical fusion with instrumentation	2,637.06	923.28

93.02 Other cervical spinal fusion

93.02A 2 vertebrae	615.52	279.52
93.02B 3 - 5 vertebrae	675.19	316.79

93.05 Other dorsolumbar spinal fusion

93.05D Instrumentation of spine following decompression	1,209.03	376.84
93.05E Instrumentation of spine following excision of spinal or paraspinal tumor	1,269.84	708.09

93.06 Lumbar spinal fusion

93.06A Spine fusion and disc Transabdominal NOTE: This benefit is for the spinal procedure when the abdominal approach was performed by a second operator.	672.45	375.28

93.09 Other spinal fusion

93.09B Arthrodesis sacro-iliac or instrumentation sacrum to pelvis	879.02	207.83
93.09C Percutaneous sacroiliac joint fixation	791.12	282.63
93.09E Scoliosis correction (anterior or posterior more than 5 levels)	3,516.08	1,487.80
93.09D Instrumentation of dorsolumbar and cervical spine with or without fusion, posterior, 2 vertebrae	1,023.18	447.21
93.09F Instrumentation of dorsolumbar and cervical spine with or without fusion, posterior, 3 vertebrae	1,199.86	508.74
93.09G Instrumentation of dorsolumbar and cervical spine with or without fusion, posterior, 4 vertebrae	1,371.27	584.12
93.09H Instrumentation of dorsolumbar and cervical spine with or without fusion, posterior, 5 vertebrae	1,547.08	659.49

93.1 Arthrodesis of foot and ankle

93.11 Ankle fusion

93.11A Ankle fusion	966.92	216.84

93.12 Triple arthrodesis (and stripping)

93.12A Single hindfoot joint fusion or syndesmosis fusion	580.15	207.83
93.12B Double hindfoot joint fusion	773.54	252.99
93.12C Triple hindfoot joint fusion	966.92	325.28

93.13 Subtalar fusion

93.13A Arthrodesis of subtalar joint with bone block lengthening	773.54	343.35

93.14 Midtarsal fusion

93.14 Midtarsal fusion	527.41	188.43

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

93 REPAIR AND PLASTIC OPERATIONS ON JOINT STRUCTURES (cont'd)

93.1 Arthrodesis of foot and ankle (cont'd)

93.14 Midtarsal fusion (cont'd)

		BASE	ANE
	NOTE: 1. A second call may only be claimed when a midtarsal joint in the other foot is fused. 2. Additional midtarsal fusions in the same foot may be claimed under 93.14A.		
93.14A	Each additional midtarsal fusion	79.11	111.71
	NOTE: 1. May only be claimed with 93.14. 2. A maximum benefit of 4 calls applies to each foot.		
93.16	Metatarsophalangeal fusion		
93.16A	MP joint great toe	351.61	135.53
93.18	Other fusion of toe		
93.18A	IP joint great toe	175.80	135.53
93.18B	Other toe joints	175.80	135.53
93.2	Arthrodesis of other joints		
93.21	Arthrodesis of hip	1,758.04	303.79
93.22	Arthrodesis of knee	1,054.82	223.59
93.23	Arthrodesis of shoulder	1,770.92	252.99
93.24	Arthrodesis of elbow	1,054.82	198.79
93.25	Carporadial fusion	879.02	207.27
93.26	Metacarpocarpal fusion	532.69	207.27
93.26A	Intercarpal fusion	791.12	282.63
93.27	Metacarpophalangeal fusion	467.72	112.95
93.28	Interphalangeal fusion Arthrodesis or tenodesis	407.66	113.05
93.3	Arthroplasty of foot and toe		
93.39	Other arthroplasty of foot and toe		
93.39B	Other toes, excision metatarsal head, Hoffmann's procedure NOTE: Benefit includes hammer toes, single joint.	175.80	113.05
93.39C	Arthroplasty great toe, MP joint NOTE: Includes bunionectomy.	263.71	150.73

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

93 REPAIR AND PLASTIC OPERATIONS ON JOINT STRUCTURES (cont'd)

93.4 Arthroplasty of knee and ankle

93.41 Total knee replacement (geomedic)(polycentric)

		BASE	ANE
93.41A	Total knee arthroplasty, including hemiarthroplasty	1,054.82	451.92
	NOTE: 1. May not be claimed in addition to HSC 92.45. 2. Benefit includes cancellous bone grafting of minor femoral and tibial cysts.		

93.44 Patellar stabilization

93.44A	Reconstruction, patellar tendon transplant for recurrent dislocation patella	527.41	207.27

93.45 Other repair of the cruciate ligaments

93.45A	Anterior cruciate ligament reconstruction with bone - patellar tendon graft	879.02	358.00
93.45B	Early repair knee cruciate ligament, less than 14 days	527.41	188.43
93.45C	Anterior cruciate ligament reconstruction with meniscectomy	966.92	376.84
93.45D	Anterior cruciate ligament reconstruction with meniscal repair	1,318.53	414.53
93.45E	Revision anterior cruciate ligament reconstruction	1,186.68	433.37
93.45F	Revision anterior cruciate ligament reconstruction with meniscal repair	1,318.53	632.47
93.45J	Revision anterior cruciate ligament reconstruction with meniscectomy	1,230.63	527.59
93.45G	Posterior cruciate ligament reconstruction	1,230.63	379.49
93.45H	Posterior cruciate ligament reconstruction with meniscal repair	1,362.48	777.05
93.45K	Revision posterior cruciate ligament reconstruction with meniscectomy	1,230.63	679.11

93.47 Other repair of knee

93.47A	Early repair, knee, collateral ligament, less than 14 days	439.51	169.57
93.47C	Reconstruction of collateral ligament, knee, late repair, more than 14 days	747.17	244.96

93.49 Other repair of ankle

93.49A	Reconstruction ligament(s) ankle, early repair less than 14 days	351.61	162.64
93.49B	Reconstruction ligament(s) ankle, late repair, more than 14 days	527.41	226.10
93.49C	Arthroplasty, ankle	527.41	188.43

93.5 Total hip replacement

93.59 Other total hip replacement

93.59A	Total hip arthroplasty	1,054.82	451.92
	NOTE: 1. May not be claimed in addition to HSC 92.44. 2. Benefit includes screw placement in the acetabulum and bone grafting minor acetabular cysts.		

93.6 Other arthroplasty of hip

93.6 A	Resection arthroplasty of hip	791.12	282.63
93.6 B	Surgical hip dislocation with trochanteric flip, osteochondroplasty labral repair	1,582.24	565.27

93.69 Other repair of hip

93.69A	Congenital dislocation of hip with acetabuloplasty or iliac osteotomy, or shelf	1,582.24	320.33
93.69B	Hemiarthroplasty hip with uncemented prosthesis	791.12	294.37

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

93 REPAIR AND PLASTIC OPERATIONS ON JOINT STRUCTURES (cont'd)

93.6 Other arthroplasty of hip (cont'd)

93.69 Other repair of hip (cont'd)

		BASE	ANE
	NOTE: May not be claimed in addition to HSC 92.44.		
93.69C	Hemiarthroplasty hip with cemented prosthesis	843.86	362.31
	NOTE: May not be claimed in addition to HSC 92.44.		

93.7 Arthroplasty of hand and finger

93.71 Arthroplasty of hand and finger with synthetic prosthesis

93.71A	Resection arthroplasty MP or IP joint, single	350.55	113.05
93.71C	Reconstruction of collateral ligament and/or the volar plate of the MP or IP joint	350.55	150.73
93.71D	Total finger joint arthroplasty (replacement with synthetic joint)	441.43	169.57

93.8 Arthroplasty of upper extremity, except hand

93.8 A	Acromio-clavicular or sterno-clavicular	395.56	226.10

93.81 Arthroplasty of shoulder with synthetic prosthesis

93.81A	Total joint arthroplasty of shoulder (glenoid and humeral replacement)	1,054.82	320.33
	NOTE: May not be claimed in addition to HSC 92.40.		
93.81B	Hemiarthroplasty of shoulder with synthetic prosthesis	843.86	320.33
	NOTE: May not be claimed with HSCs 92.40, 93.83D, 95.65B, 93.83H or 91.30H.		

93.83 Other repair of shoulder

93.83B	Repair recurrent sterno-clavicular, acromioclavicular dislocation with tendon graft from different site	835.07	188.43
93.83C	Posterior shoulder instability repair	703.22	282.63
	NOTE: May not be claimed in association with 93.83D or 95.65B.		
93.83D	Bankart repair or capsular shift for anterior instability	703.22	263.79
93.83E	Superior Labrum Anterior-Posterior (SLAP) repair (reattachment of the biceps anchor utilizing an anchoring device)	593.34	207.27
93.83F	Bankart repair (reattachment of the labrum to the rim of the glenoid) plus Superior Labrum Anterior-Posterior (SLAP) repair (reattachment of the biceps anchor utilizing an anchoring device)	835.07	301.47
93.83G	Other shoulder instability repair not elsewhere listed	593.34	198.79
	NOTE: May not be billed in association with 93.83D or 95.65B.		
93.83H	Rotator cuff repair, including tendon transfer	527.41	188.43
	NOTE: May not be claimed with 95.65B except where tendon transfers are performed through a different incision and do not involve rotator cuff muscles.		
93.83I	Rotator cuff repair, with Superior Labrum Anterior-Posterior (SLAP) or Bankart repair, including tendon transfer	879.02	320.33

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

93 REPAIR AND PLASTIC OPERATIONS ON JOINT STRUCTURES (cont'd)

93.8 Arthroplasty of upper extremity, except hand (cont'd)

93.83 Other repair of shoulder (cont'd)

	BASE	ANE
NOTE: May not be claimed with 95.65B except where tendon transfers are performed through a different incision and do not involve rotator cuff muscles.		
93.83N Revision rotator cuff repair, including tendon transfer	1,054.82	376.84
NOTE: May not be claimed with 95.65B except where tendon transfers are performed through a different incision and do not involve rotator cuff muscles.		
93.83O Circumferential repair glenoid labrum	1,054.82	524.06

93.84 Arthroplasty of elbow with synthetic prosthesis

93.84A Arthroplasty of elbow with synthetic prosthesis/fascial graft	1,054.82	298.17

93.85 Other repair of elbow

93.85A Arthroplasty elbow	527.41	226.10
NOTE: May not be billed in association with 92.41.		

93.87 Other repair of wrist

93.87A Arthroplasty distal radio-ulnar joint, including resection soft tissue interposition technique or resection fusion technique	351.61	144.57
93.87B Arthroplasty of wrist - excision single carpal bone with or without insertion of synthetic prosthesis	503.27	188.43
93.87C Total arthroplasty of wrist using synthetic prosthesis	697.94	234.91
NOTE: May not be claimed in addition to HSCs 92.42.		
93.87E Resection arthroplasty of wrist (proximal row carpectomy)	879.02	320.33
93.87J Triangulo fibrocartilage complex repair, arthroscopic or open	637.29	244.96
93.87K Wrist ligament reconstruction (including scapholunate or lunotriquetral ligament)	637.29	244.96

93.9 Other operations on joints

93.91 Arthrocentesis

93.91A Joint aspiration, injection, hip	37.48 V	113.05
NOTE: Refer to notes following 93.91B.		
93.91B Joint aspiration, injection, other joints	19.98 V	113.05
NOTE: 1. HSCs 93.91A and 93.91B may be claimed in addition to a visit or a consultation.		
2. A second call may only be claimed for HSCs 93.91A and 93.91B when a second joint is either aspirated and/or injected.		
3. HSCs 93.91A and 93.91B may be claimed in addition to HSC 95.94C.		

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

93 REPAIR AND PLASTIC OPERATIONS ON JOINT STRUCTURES (cont'd)

93.9 Other operations on joints (cont'd)

93.96 Other repair of joint

		BASE	ANE
93.96L	Ligament repair, elbow, acute, less than 14 days	351.61	376.84
93.96B	Reconstruction, elbow single ligament, more than 14 days	527.41	188.43
93.96C	Reconstruction, elbow two ligaments, more than 14 days	879.02	320.33
93.96D	Primary total joint arthroplasty (ankle, elbow, wrist) NOTE: May not be claimed in addition to HSCs 92.41, 92.42 or 92.46.	1,054.82	376.84
93.96E	Primary total joint arthroplasty with major reconstruction including structural allograft, protrusio ring/custom implant (hip, knee, ankle, shoulder, elbow, wrist) NOTE: May not be claimed in addition to HSCs 92.40, 92.41, 92.42, 92.44, 92.45 or 92.46.	1,371.27	588.33
93.96F	Revision total joint arthroplasty - Bearing change only or patellar revision	1,230.63	414.53
93.96G	Removal components insertion spacer (Prostalac or equivalent)	1,582.24	656.67
93.96H	Revision total joint arthroplasty single side (excluding patellar revision)	1,476.75	634.02
93.96I	Revision total joint arthroplasty both sides	1,687.72	724.61
93.96J	Revision total joint arthroplasty with major reconstruction one side including structural allograft/protrusio ring/ custom implant	2,109.65	905.75
93.96K	Revision total joint arthroplasty with major reconstruction both sides including structural allograft/protrusio ring/custom implant	2,637.06	1,127.11

94 OPERATIONS ON MUSCLE, TENDON, FASCIA AND BURSA OF HAND

94.0 Incision of muscle, tendon, fascia and bursa of hand

94.01 Incision of tendon sheath of hand

94.01A	Incision of tendon sheath of hand	155.80	113.05
94.01B	Incision and drainage of tendon sheath of hand	194.75	113.05
94.04	Incision and drainage of palmar and thenar space	95.25 V	112.95

94.2 Excision of lesion of muscle, tendon and fascia of hand

94.21 Excision of lesion of sheath tendon of hand

94.21A	Ganglion of hand	181.77	113.05

94.3 Other excision of muscle, tendon and fascia of hand

94.35 Other excision of fascia of hand

94.35A	Radical fasciectomy for Dupuytren's contracture	363.53	188.43
94.35B	Partial fasciectomy for Dupuytren's contracture	337.56	150.73

94.4 Suture of muscle, tendon and fascia of hand
NOTE: For second and subsequent tendon repairs, claim 50% (flexor or extensor).

94.42 Delayed suture of flexor tendon of hand

94.42A	Secondary repair, flexor	480.38	188.43

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

94 OPERATIONS ON MUSCLE, TENDON, FASCIA AND BURSA OF HAND (cont'd)

94.4 Suture of muscle, tendon and fascia of hand (cont'd)

94.43 Delayed suture of other tendon of hand

	BASE	ANE
94.43A Secondary repair, extensor	298.61	150.73
94.44 Other suture of flexor tendon of hand		
94.44A Primary repair, flexor	389.50	188.43
94.45 Other suture of other tendon of hand		
94.45A Primary repair, extensor	244.09	113.05
94.5 Transplantation of muscle and tendon of hand		
94.55 Other transfer or transplantation of tendon of hand	454.41	169.57
94.6 Reconstruction of thumb		
94.61 Pollicization (operation) with neurovascular bundle carryover Thumb reconstruction	1,194.46	280.09
94.7 Plastic operations on muscle, tendon, and fascia of hand with graft or implant		
94.71 Tendon pulley reconstruction		
94.71A Hand	246.68	150.73
94.72 Plastic operation on hand with graft of tendon		
94.72A Flexor or extensor, tendon graft	571.26	263.79
94.72B First stage of tendon graft using alloplastic spacer	386.90	282.63
94.8 Other plastic operations on hand		
94.82 Other change in length of muscle, tendon, and fascia of hand		
94.82A Tendon lengthening or shortening	263.71	144.57
94.85 Repair of mallet finger	147.49	144.57
94.9 Other operations on muscle, tendon, fascia, and bursa of hand		
94.91 Freeing of adhesions of muscle, tendon, fascia and bursa of hand		
94.91A Tenolysis	285.63	113.05
94.91B Tenolysis following flexor tendon graft	558.18	198.79

95 OPERATIONS ON MUSCLES, TENDONS, FASCIA AND BURSA, EXCEPT HAND

95.0 Incision of muscle, tendon, fascia and bursa		
95.01 Incision of tendon sheath		
95.01B Incision of tendon sheath, stenosing tenosynovitis or excision tendon sheath tumor	155.80	112.95
95.02 Myotomy		
95.02A Myotomy That for removal of foreign body	117.29 V	111.81

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

95 OPERATIONS ON MUSCLES, TENDONS, FASCIA AND BURSA, EXCEPT HAND (cont'd)

95.0 Incision of muscle, tendon, fascia and bursa (cont'd)

95.02 Myotomy (cont'd)

	BASE	ANE
95.03 Bursotomy	27.73 V	111.71
NOTE: May not be claimed for percutaneous aspiration of bursa.		
95.09 Incision of other soft tissue		
95.09A Removal of deep foreign body, with or without imaging, full 15 minutes of operating time or major portion thereof for the first call when only one call is claimed	120.09	113.05
NOTE: Each subsequent 15 minutes, or major portion thereof, is payable at the rate specified on the Price List after the first full 15 minutes has elapsed; a maximum benefit applies.		
95.1 Division of muscle, tendon and fascia		
95.12 Adductor tenotomy of hip	307.66	111.81
95.13 Other tenotomy		
95.13A Hip flexor release	351.61	198.79
95.13B Proximal hamstring release	351.61	223.38
95.14 Myotomy for division		
95.14A Thoracic outlet, release or rib resection	1,098.12	244.96
95.14B Thoracic outlet, release or rib resection, repeat	853.12	375.28
95.14C Scalenus anterior division	237.26	134.04
95.14D Scalenus anterior with cervical rib resection	377.75	196.59
95.14E Sterno-mastoid	319.62	169.57
That for congenital torticollis		
95.15 Fasciotomy for division		
95.15A Fasciotomy of all compartments in one extremity in one limb segment (arm, forearm, hand, buttock, thigh, leg, foot)	527.41	169.57
NOTE: Only one call per limb segment may be claimed regardless of the number of incisions.		
95.15B Plantar fasciotomy	263.71	149.07
95.15C Division ilio-tibial band, distal end	263.71	111.81
95.15F Plantar fasciectomy, partial	337.56	113.05
95.15G Plantar fasciectomy, complete	703.22	223.59
95.19 Division of other soft tissue		
95.19A Release or sever operation for Erbs palsy	448.18	198.79
NOTE: Includes that with osteotomy of humerus.		
95.2 Excision of lesion of muscle, tendon, fascia, and bursa		
95.29 Excision of lesion of other soft tissue		
95.29A Baker's cyst	527.41	188.43

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

95 OPERATIONS ON MUSCLES, TENDONS, FASCIA AND BURSA, EXCEPT HAND (cont'd)

	BASE	ANE
95.2 Excision of lesion of muscle, tendon, fascia, and bursa (cont'd)		
95.29 Excision of lesion of other soft tissue (cont'd)		
95.29B Excision ganglion	140.79	113.05
95.3 Other excision of muscle, tendon, and fascia		
95.32 Other excision of tendon		
95.32A Excision tendon sheaths forearm, wrist, tubercular or other granuloma	357.61	188.43
95.32B Tenosynovectomy wrist	532.76	188.43
95.4 Excision of bursa		
95.4 A Olecranon, prepatellar	175.80	113.05
95.4 B Excision of bursa, Ischial, trochanteric	175.80	150.73
95.5 Suture of muscles, tendon, and fascia		
95.54 Other suture of tendon		
95.54A Primary repair of tendo achilles, less than 14 days	439.51	150.73
95.54B Primary repair, extensor, less than 14 days	263.71	113.05
95.54C Primary repair, flexor, less than 14 days	263.71	188.43
95.54D Reconstruction of tendo achilles, more than 14 days	659.27	244.96
95.54E Quadriceps or patellar tendon repair	527.41	188.43
95.54F Other suture of tendon, primary repair, extensor, greater than 14 days	395.56	397.56
95.54G Other suture of tendon, primary repair, flexor, greater than 14 days	395.56	397.56
95.6 Reconstruction of muscle and tendon		
95.65 Other transfer or transplantation of tendon		
95.65B About shoulder	703.22	207.27
95.65C About elbow	703.22	188.43
95.65D About hip	703.22	282.63
95.65E About knee	527.41	207.27
95.65F Distal knee	527.41	162.64
95.65G Distal Elbow	527.41	169.57
95.66 Other transfer or transplantation of muscle		
95.66B Muscle slide of the forearm	703.22	150.73
95.7 Other plastic operations on muscles, tendon and fascia		
95.71 Tendon pulley reconstruction		
95.71A Tendon graft for pulley reconstruction	246.68	142.97
95.71B Repair recurrent dislocation peroneal tendons	527.41	169.57
95.72 Plastic operation with graft of tendon		
95.72A Silastic rod first stage tendon graft	428.45	144.57
95.72B Flexor or extensor tendon graft	519.33	263.79
95.75 Release of clubfoot NEC		
95.75A Metatarsus varus or club hand, medial or posterior release	527.41	188.43
95.75B Metatarsus varus or club hand, medial and posterior release	1,054.82	263.79

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

95 OPERATIONS ON MUSCLES, TENDONS, FASCIA AND BURSA, EXCEPT HAND (cont'd)

		BASE	ANE
95.76	Other change in length of muscle, tendon, and fascia		
95.76A	Tendon lengthening or shortening	263.71	150.73
95.76B	Repeat posteriomedial release of foot	1,582.24	508.74
95.76C	Myotendinous lengthening or gastrosoleus slide	395.56	113.05
95.77	Other plastic operations on tendon		
95.77A	Biceps tenodesis, including tendon transfer NOTE: May not be billed in association with 95.65B	219.76	111.81
95.78	Other plastic operations on muscle		
95.78A	Quadricepsplasty	703.22	207.27
95.78B	Distal biceps/triceps, primary repair (less than 14 days)	703.22	263.79
95.78C	Distal biceps/triceps, late repair (more than 14 days)	879.02	320.33
95.8	Invasive diagnostic procedures on muscle, tendon, fascia and bursa		
95.81	Biopsy of muscle, tendon, fascia and bursa		
95.81A	Biopsy of muscle	77.28 V	113.05
95.9	Other operations on muscle, tendon, fascia, and bursa		
95.91	Freeing of adhesions of muscle, tendon, fascia, and bursa		
95.91A	Tenolysis	228.61	113.05
95.91B	Tenolysis following flexor tendon graft	439.51	196.59
95.91C	Subacromial decompression, including bursectomy NOTE: May not be billed in association with 95.65B.	329.63	111.81
95.93	Injection/aspiration of therapeutic substance into bursa Subacromial NOTE: 1. A second call may only be claimed when the second bursa is either aspirated and/or injected. 2. May be claimed in addition to HSC 95.94C.	18.16 V	111.71

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

95 OPERATIONS ON MUSCLES, TENDONS, FASCIA AND BURSA, EXCEPT HAND (cont'd)

95.9 Other operations on muscle, tendon, fascia, and bursa (cont'd)

95.94 Injection of therapeutic substance into other soft tissue

	BASE	ANE
95.94A Injection with local anesthetic of myofascial trigger points combined with a spray and stretch technique	70.39	
NOTE: 1. A minimum of 30 minutes of stretching per call is required at the time of the injection. 2. A maximum of 8 calls may be claimed per physician per day.		
95.94B Intravaginal trigger point injection(s)	97.47	
NOTE: 1. Benefit includes a general gynecological examination and concurrent specialized physiotherapy. 2. When only an injection is provided, refer to 13.59J.		
95.94C Ultrasound guidance during injection of soft tissue (trigger point), peripheral nerve, muscle, tendon, ligament, bursa or joint, additional benefit	61.25	
NOTE: 1. May only be claimed by Physical Medicine and Rehabilitation. 2. May only be claimed with HSCs 13.59H, 13.59J, 16.89B, 16.89D, 16.99A, 17.71A, 92.78C, 93.91A, 93.91B, 95.93 and 95.96A.		

95.96 Aspiration of other soft tissue

95.96A Other bursae, tendon sheaths, ganglion of wrist or ankle, aspiration, injection	13.35 V	112.95
NOTE: 1. A second call may only be claimed when a second bursa, tendon sheath or ganglion is either aspirated and/or injected. 2. May be claimed in addition to HSC 95.94C.		

95.99 Other operations on muscle, tendon, fascia, and bursa NEC

95.99A Open reconstruction of congenital vertical talus	901.00	259.13

96 OTHER OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

96.0 Amputation of upper limb

96.01 Amputation and disarticulation of finger(s), except thumb

96.01A Finger, one	207.73	113.05
96.01B Amputation and disarticulation of finger, through MP joint	201.50	150.73

96.02 Amputation and disarticulation of thumb

96.02A Amputation and disarticulation of thumb, distal to MP joint	183.84	150.73
96.02B Amputation and disarticulation of thumb, through MP joint	201.50	149.07

96.03 Amputation through hand

96.03A Metacarpal, entire ray	311.60	112.95

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

96 OTHER OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

96.0 Amputation of upper limb (cont'd)

96.03 Amputation through hand (cont'd)

		BASE	ANE
96.03B	Through metacarpal or MP joint	215.52	111.71
96.04	Disarticulation of wrist	659.27	112.95
96.05	Amputation through forearm	659.27	171.67
96.06	Disarticulation of elbow or amputation through humerus	659.27	188.43
96.07	Disarticulation of shoulder	879.02	223.38
96.08	Interthoracoscapular amputation	1,758.04	225.88

96.1 Amputation of lower limb

96.11 Amputation and disarticulation of toe(s)

96.11A	Toe, one	175.80	113.05

96.12 Amputation and disarticulation of foot

96.12A	Metatarsal - whole ray	263.71	113.05
96.12B	Transmetatarsal	527.41	135.53
	NOTE: 1. One call may be claimed per foot regardless of the number of metatarsals that are removed. 2. Two calls may only be claimed for bilateral procedures.		
96.12C	Mid-tarsal	527.41	112.95
96.13	Amputation and disarticulation of ankle Symes, Pirogoff	892.57	379.49
96.14	Amputation of lower leg Below knee	791.12	188.43
96.15	Amputation of thigh or disarticulation of knee Supracondylar Thigh through femur	791.12	167.71
96.16	Disarticulation of hip	1,054.82	294.86
96.17	Abdominopelvic amputation or hindquarter amputation	2,637.06	1,031.89

96.2 Revision of amputation stump

96.2 A	Finger	195.49	113.05

96.3 Reattachment of extremity

96.3 A	Reattachment of extremity involving microsurgical technique, full 60 minutes or major portion thereof for the first call when only one call is claimed (includes preparation of severed part)	649.16	

XV. OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

96 OTHER OPERATIONS ON THE MUSCULOSKELETAL SYSTEM (cont'd)

96.3 Reattachment of extremity (cont'd)

	BASE	ANE

NOTE: Second surgeon (microsurgical) with a role modifier, refer to Price List.

XVI. OPERATIONS ON THE BREAST

97 OPERATIONS ON THE BREAST

97.1 Excision or destruction of lesion or tissue of breast

97.11 Local excision of lesion of breast

	BASE	ANE
97.11A Directed breast biopsy following mammography needle localization	297.52	113.05
97.11B Breast biopsy and/or local excision of lesion(s)	170.40	113.05
NOTE: May not be claimed for skin biopsy of the breast.		
97.11C Breast clip placement, professional	88.10	
NOTE: 1. May be claimed when clip is inserted at the time of the biopsy, post-biopsy or in de novo settings. 2. Benefit rate does not include the cost of the biopsy marker. 3. May be claimed in addition to 97.11A, 97.11B, 97.81 and 97.82A.		

97.12 (Unilateral) complete mastectomy

97.12A Without removal of nodes or muscle	451.60	207.27
97.12B Total mastectomy with formal axillary node dissection and/or sentinal node biopsy, with or without removal of pectoral muscles	844.76	320.33

97.2 Other excision or destruction of breast tissue

97.21 (Unilateral) subcutaneous mastectomy with implantation of prosthesis

97.21A Skin sparing mastectomy when performed for reconstruction	998.83	731.45

97.22 Other (unilateral) subcutaneous mastectomy

97.22A With retention of areola and nipple	493.36	226.10
NOTE: 1. Transgender patients who meet the criteria for Alberta's Final Stage Gender Reassignment Surgery are eligible for this procedure in the context of female-to-male gender reassignment. 2. Approval is required by Alberta Health prior to completing the procedure.		

97.27 Resection of quadrant of breast

97.27A Segmental resection	371.91	113.05
97.27B Segmental resection with sentinel node biopsy	637.55	320.33
NOTE: When claimed in addition to HSC 52.42, the benefit will be paid at LVP50.		

97.29 Other excision of breast tissue NEC

97.29A Simple mastectomy, includes that for gynecomastia	388.68	150.73
NOTE: 1. May only be claimed for: -pediatric gynecomastia (i.e. below the age of 18), -symptomatic gynecomastia such as breast pain, -prophylactic mastectomies for patients who are breast cancer gene positive or have a strong family history of breast cancer. 2. For cases other than those involving malignancies.		

XVI. OPERATIONS ON THE BREAST (cont'd)

97 OPERATIONS ON THE BREAST (cont'd)

		BASE	ANE
97.3	**Reduction mammoplasty**		
97.31	Unilateral reduction mammoplasty	519.33	226.10
	NOTE: 1. May only be claimed if mammary hypertrophy is causing physical symptoms including, but not limited to back pain, shoulder pain or paresthesias of the arms. 2. Except in unusual circumstances, the expected weight of breast tissue to be removed should be in excess of 300g. 3. May be billed if being done as a 'balancing procedure' such as to compensate for breast changes in the contralateral breast due to breast cancer treatment or to correct gross congenital/developmental asymmetry.		
97.4	**Augmentation mammoplasty**		
97.43	Unilateral augmentation mammoplasty by implant or graft prosthesis	493.36	188.43
	NOTE: 1. Payable only for congenital aplasia, hypoplasia, post-mastectomy or for transgender patients who meet the criteria of Alberta's Final Stage Gender Reassignment Surgery in the context of male-to-female gender reassignment. 2. Patients who have been diagnosed with gender dysphoria are eligible for this procedure in the context of male-to-female gender reassignment if the following criteria are met: Negligible breast development despite adequate hormone therapy for a least one year; or, hormone therapy is medically contraindicated. Approval is required by Alberta Health prior to completing the procedure.		
97.5	**Mastopexy (post mastectomy)**		
97.5	Mastopexy (Post mastectomy)	350.55	150.73
97.7	**Other repair and plastic operations on breast**		
97.77	Other repair or reconstruction of nipple	376.51	188.43
97.8	**Invasive diagnostic procedures on breast**		
97.81	Percutaneous (needle) biopsy of breast	45.21 V	112.95
97.82	**Other biopsy of breast**		
97.82A	Percutaneous stereotactic core breast biopsy	89.64	
97.83	**Contrast mammary ductogram**		
97.83A	Catheterization of mammary duct and injection of contrast media	50.23	
97.89	**Other invasive diagnostic procedures on breast**		
97.89A	Needle localization under mammographic control, single lesion	49.84	
97.89B	Injection of contrast media into cyst of breast	50.23	
97.9	**Other operations on the breast**		
97.95	Insertion of tissue expander for breast reconstruction	493.36	150.73

XVI. OPERATIONS ON THE BREAST (cont'd)

97 OPERATIONS ON THE BREAST (cont'd)

97.9 Other operations on the breast (cont'd)

		BASE	ANE
	NOTE: Bilateral procedures may be claimed using 2 calls.		
97.96	Removal of tissue expander for breast reconstruction . . . . . NOTE: 1. When removal is the only procedure performed and not part of another procedure. 2. Bilateral procedures may be claimed using 2 calls.	141.26 V	112.95
97.99	Other operations on the breast NEC		
97.99A	Mammary capsulectomy	300.69	113.05

XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE

98.0 Incision of skin and subcutaneous tissue

98.01 Tattooing or insertion into skin and subcutaneous tissue

		BASE	ANE
98.01A	Implantation of subdermal contraceptive implant	63.69	111.71
	NOTE: May be claimed in addition to a visit or a consultation.		

98.03 Other incision with drainage of skin and subcutaneous tissue

98.03A	Incision and drainage of abscess or hematoma, subcutaneous or submucous . .	16.69 V	113.05
	NOTE: May be claimed in addition to a visit or a consultation.		
98.03B	Incision and drainage of abscess, deep, unspecified site	BY ASSESS	113.05
98.03C	Aspiration of hematoma	20.11	
98.03D	Abscess requiring procedural sedation and extensive drainage and packing . .	100.49	
	NOTE: May only be claimed when performed in an emergency room, AACC or UCC.		
98.03E	Aspiration of seroma	138.14	126.35

98.04 Incision with removal of foreign body of skin and subcutaneous tissue

98.04A	Incision with removal of foreign body of skin and subcutaneous tissue under anesthesia	36.87 V	135.53
98.04B	Incision with removal of foreign body of skin and subcutaneous tissue without anesthesia	24.81	
98.04C	Removal of subdermal contraceptive implant	55.03	111.71

98.1 Excision of skin and subcutaneous tissue

98.11 Debridement of wound or infected tissue

NOTE: Only one of HSCs 98.11A to 98.11F may be claimed per functional or non-functional anatomical area as defined in GRs 7.1.1 and 7.1.2 with the exception of paired structures which may be claimed as two.

98.11A	Non-functional area, up to 32 total square cms	110.62	207.27
98.11B	Non-functional area, over 32 and up to 64 total square cms	224.25	207.27
98.11C	Non-functional area, over 64 total square cms	415.46	226.10
98.11D	Functional area, up to 32 total square cms	138.34	112.95
98.11E	Functional area, over 32 and up to 64 total square cms	291.30	113.05
98.11F	Functional area, over 64 total square cms	668.93	223.88

98.12 Local excision or destruction of lesion or tissue of skin and subcutaneous tissue

98.12A	Excisional biopsy, skin	44.39 V	113.05
	NOTE: A maximum of three calls may be claimed.		
98.12B	Excisional biopsy, skin of face	56.93 V	113.05
	NOTE: A maximum of three calls may be claimed.		

XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98.1 Excision of skin and subcutaneous tissue (cont'd)

98.12 Local excision or destruction of lesion or tissue of skin and subcutaneous tissue (cont'd)

		BASE	ANE
98.12C	Removal of sebaceous cyst NOTE: 1. May be claimed in addition to a visit or a consultation. 2. A maximum of 3 calls may be claimed.	38.56 V	113.05
98.12D	Bilateral excision, apocrine glands, major	322.52	169.57
98.12E	Excision, apocrine glands, minor That for suppurative hydradenitis	106.76 V	112.95
98.12F	Excision and graft, apocrine glands That for suppurative hydradenitis	345.67	188.42
98.12G	Laser treatment of cutaneous vascular tumors	69.52 V	113.05
98.12H	Excision of soft tissue tumor(s) (subcutaneous) full 30 minutes of operating time or major portion thereof for the first call when only one call is claimed NOTE: 1. For sebaceous cyst removal see HSC 98.12C. 2. After the first full 30 minutes has elapsed, each subsequent 15 minutes or major portion thereof, is payable at the rate specified in the Price List; a maximum benefit applies.	96.09 V	113.05

Warts or Keratoses

NOTE: 1. Items 98.12J, 98.12K and 98.12L may only be claimed for the following: genital warts; plantar warts; precancerous skin lesions, e.g., actinic keratoses; seborrhoeic keratoses which are irritated and treatment is medically required; warts in immuno-deficient patients or immuno-suppressed patients; or molluscum contagiosum.
2. The treatment of common warts or keratoses is an uninsured service.

98.12J	Removal or excision, first lesion NOTE: 1. May be claimed in addition to a visit or a consultation. 2. A maximum of four calls may be claimed.	19.23 V	113.05
98.12K	Removal by fulguration, first lesion NOTE: A maximum of six calls may be claimed.	24.85 V	113.05
98.12L	Non-surgical treatment (cryotherapy, chemotherapy), warts or keratoses NOTE: May be claimed in addition to a visit or consultation.	13.84	
98.12M	Removal of pigmented benign nevus, excluding face	36.87 V	112.95
98.12N	Removal of pigmented benign nevus of the face	56.99 V	112.95
98.12P	Removal of complicated naevi	BY ASSESS	

XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

Warts or Keratoses (cont'd)
NOTE: 1. Items 98.12J, 98.12K and 98.12L may only be claimed for the following: genital warts; plantar warts; precancerous skin lesions, e.g., actinic keratoses; seborrhoeic keratoses which are irritated and treatment is medically required; warts in immuno-deficient patients or immuno-suppressed patients; or molluscum contagiosum.
2. The treatment of common warts or keratoses is an uninsured service. (cont'd)

		BASE	ANE
	Multiple dysplastic or localized carcinomatous lesions of the skin		
98.12Q	Removal of any atypical or neoplastic lesion(s) - any method excluding cryotherapy for actinic keratoses	38.94 V	111.81
	Example: Multiple dysplastic naevi syndrome, multiple basal and/or squamous cell carcinomas		
	NOTE: A maximum of five calls may be claimed.		
98.12R	Removal of first plantar wart	36.87 V	111.71
	NOTE: 1. May be claimed in addition to a consultation. 2. For non-surgical treatment, see HSC 98.12L. 3. A maximum of three calls may be claimed.		
	Condylomata acuminata		
98.12S	Non surgical treatment, cryotherapy	40.23	
98.12T	Removal of minor condylomata acuminata without general anesthetic by any surgical method	50.70	
98.12U	Removal of major condylomata acuminata under general anesthetic	143.45	113.05
98.12VA	Laser resurfacing of scars including burn scars, non-functional area, up to 32 total square cms	143.85	207.27
	NOTE: May only be claimed for services provided under general anesthetic within a hospital facility.		
98.12VB	Laser resurfacing of scars including burn scars, non-functional area, over 32 and up to 64 total square cms	240.45	207.27
	NOTE: May only be claimed for services provided under general anesthetic within a hospital facility.		
98.12VC	Laser resurfacing of scars including burn scars, non-functional area, over 64 and up to 100 total square cms	373.40	226.10
	NOTE: May only be claimed for services provided under general anesthetic within a hospital facility.		

XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

	BASE	ANE
98.12VD Laser resurfacing of scars including burn scars, non-functional area, over 100 total square cms	534.39	226.10
NOTE: May only be claimed for services provided under general anesthetic within a hospital facility.		
98.12VE Laser resurfacing of scars including burn scars, functional area, up to 32 total square cms	186.96	112.95
NOTE: May only be claimed for services provided under general anesthetic within a hospital facility.		
98.12VF Laser resurfacing of scars including burn scars, functional area, over 32 and up to 64 total square cms	320.43	113.05
NOTE: May only be claimed for services provided under general anesthetic within a hospital facility.		
98.12VG Laser resurfacing of scars including burn scars, functional area, over 64 total square cms	534.39	223.88
NOTE: May only be claimed for services provided under general anesthetic within a hospital facility.		
98.13 Radical excision of skin lesion		
98.13A Melanoma, excision, excluding face	238.06	113.05
98.13B Excision of large malignant facial lesion with primary closure	213.52	169.57
Excision of contracted and/or unstable scar and application of skin graft		
98.13C Up to 32 square cms	88.94	225.88
98.13D Over 32 and up to 64 square cms	308.10	225.88
98.13E Over 64 and up to 100 square cms	549.06	244.96
98.14 Excision of pilonidal sinus or cyst		
98.14A Pilonidal cyst - excision or marsupialization	249.71	150.73
98.2 Suture of skin and subcutaneous tissue		
98.22 Suture of skin and subcutaneous tissue of other sites		
98.22A Laceration, face, up to 2.5 cms (1 unit) or body, up to 5 cms (1 unit)	60.34 V	111.81
NOTE: See 98.22B for further notes and for lacerations exceeding the lengths listed above.		

XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98.2 Suture of skin and subcutaneous tissue (cont'd)
98.22 Suture of skin and subcutaneous tissue of other sites (cont'd)

		BASE	ANE
98.22B	Laceration, face, over 2.5 cms (1 unit) and/or body, over 5 cms (1 unit) . . For each layer or unit, refer to Price List	63.69 V	112.95

NOTE: The following applies to HSCs 98.22A and 98.22B.
1. Benefit includes primary closure of wound by any method excluding adhesive tape skin closure or simple bandaging, normal wound care follow-up and suture removal.
2. Where the laceration is treated with the use of adhesive tape skin closure or simple bandaging, a visit should be claimed.
3. Where multiple lacerations are repaired, use the combined length.
4. May only be claimed when the laceration is a result of a trauma either minor or major.
5. May not be claimed in addition to an elective procedure.

98.4 Free skin graft

98.44 Full thickness skin graft to other sites
NOTE: Includes closure of donor defect. Dorsum of hand, palm of hand and web space of hand are considered separate sites.

98.44A	Up to 32 square cms	224.75	113.05
98.44B	Over 32 square cms	571.26	188.43

98.49 Other free skin graft to other sites
Non-functional areas split thickness skin grafts
NOTE: 1. Refer to GRs 7.1.1 through 7.2.2.
2. Only one of HSCs 98.49A to 98.49G may be claimed per anatomical area as defined in GRs 7.1.1 and GR 7.1.2 with the exception of paired structures which may be claimed as two.

98.49A	Non-functional split thickness skin graft, up to 32 total square cms . . . . NOTE: Refer to the notes following HSC 98.49D.	112.69 V	144.57
98.49B	Non-functional split thickness skin graft over 32 and up to 64 total square cms . . . . . NOTE: Refer to the notes following HSC 98.49D.	167.22	156.20

XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98.4 Free skin graft (cont'd)

98.49 Other free skin graft to other sites
Non-functional areas split thickness skin grafts
NOTE: 1. Refer to GRs 7.1.1 through 7.2.2.
2. Only one of HSCs 98.49A to 98.49G may be claimed per anatomical area as defined in GRs 7.1.1 and GR 7.1.2 with the exception of paired structures which may be claimed as two. (cont'd)

		BASE	ANE
98.49C	Non-functional split thickness skin graft over 64 and up to 100 total square cms . . . . . NOTE: Refer to the notes following HSC 98.49D.	363.53	260.31
98.49D	Non-functional split thickness skin graft over 100 total square cms . . . . NOTE: 1. For grafts over 100 square cms, only one HSC 98.49D may be claimed per anatomical area. 2. Refer to GRs 7.1.1 through 7.2.2 for explanation of functional and non-functional areas. 3. Only one of HSCs 98.49A, 98.49B, 98.49C or 98.49D may be claimed per anatomical area unless it is for a paired structure. 4. If several grafts of less than 100 sq cms are performed in the same anatomical area, the maximum that may be claimed is one HSC 98.49D.	493.36	330.63
	Functional area split thickness skin grafts		
98.49E	Functional split thickness skin graft up to 32 total square cms	155.80	145.76
98.49F	Functional split thickness skin graft over 32 and up to 64 total square cms	217.60	187.43
98.49G	Functional split thickness skin graft 64 and to 100 total square cms	432.08	312.39
98.49N	Functional split thickness skin graft over 100 total square cms	571.26	354.05
	Mucosal Grafts		
98.49L	Mucosal grafts up to 32 square cms	233.25	111.71
98.49M	Mucosal grafts over 32 square cms . . . . . NOTE: Benefits payable for 98.49L, 98.49M include closures of donor defect.	342.91	178.71

XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98.5 Flap or pedicle graft

NOTE: 1. Functional areas includes the following anatomical areas: Head, neck, axillae, elbow, wrist, hand, groin, perineum, hip, knee, ankle, foot and includes coverage of exposed vital structures (bone, tendon, major vessel, nerve)
2. Flaps (HSCs 98.53,98.5A,98.51A,98.51B) for functional areas are designated by FNCAR modifier, add 50% to total benefit.
3. Flap size 5-10 cms or double Z-plasty designated by 2ZPL modifier, add 25% to benefit.
4. Flap size greater than 10 cms or triple Z-plasty designated by 3ZPL modifier, add 50% to benefit.
5. Composite tissue resection (includes bone) designated by CMPRSC modifier, add 25% to benefit.
6. Only one modifier (CMPRSC, FNCAR, 2ZPL, 3ZPL) may be claimed per flap.

		BASE	ANE
98.5 A	Rotation or transposition flap	331.23	207.27
98.51	Flap or pedicle graft, unqualified		
98.51A	Major flap of single tissue (e.g. fasciocutaneous or muscle) with axial blood supply	779.00	358.00
	NOTE: 1. Local block of somatic nerve or infiltration of tissue may not be claimed post-operatively. 2. A claim may not be submitted for infiltration into the tissue expander in the post-operative period.		
98.51B	Composite compound flap using two or more of the following: skin, muscle, bone: with axial blood supply	1,251.93	489.88
98.51E	Free flaps involving microsurgical technique and neuro-vascular hook-up, for head and neck reconstruction, or for procedures related to head and neck reconstruction, full 60 minutes or major portion thereof for the first call when only one call is claimed	481.69	
	NOTE: The total time claimed for HSC 98.51E may only reflect the time spent providing micro surgery and may not include time spent providing other services.		
98.51F	Free flaps involving microsurgical technique and neuro-vascular hook-up, for procedures not related to head and neck reconstruction, full 60 minutes or major portion thereof for the first call when only one call is claimed	649.16	
	NOTE: 1. May not be claimed in addition to HSCs 52.31A, 52.31B, 52.31C or 52.31D by the same or different physician at the same encounter. 2. The total time claimed for HSC 98.51F may only reflect the time spent providing micro surgery and may not include time spent providing other services.		
98.52	Cutting and preparation of flap or pedicle graft		
98.52A	Less than 2 cms	132.27	113.05

XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98.5 Flap or pedicle graft

NOTE: 1. Functional areas includes the following anatomical areas: Head, neck, axillae, elbow, wrist, hand, groin, perineum, hip, knee, ankle, foot and includes coverage of exposed vital structures (bone, tendon, major vessel, nerve)
2. Flaps (HSCs 98.53,98.5A,98.51A,98.51B) for functional areas are designated by FNCAR modifier, add 50% to total benefit.
3. Flap size 5-10 cms or double Z-plasty designated by 2ZPL modifier, add 25% to benefit.
4. Flap size greater than 10 cms or triple Z-plasty designated by 3ZPL modifier, add 50% to benefit.
5. Composite tissue resection (includes bone) designated by CMPRSC modifier, add 25% to benefit.
6. Only one modifier (CMPRSC, FNCAR, 2ZPL, 3ZPL) may be claimed per flap. (cont'd)

98.52 Cutting and preparation of flap or pedicle graft (cont'd)

		BASE	ANE
98.52B	Less than 2 cms (delay)	138.11	111.71
98.52C	2-5 cms	424.81	204.97
98.52D	2-5 cms (delay)	224.21	111.71
98.52E	Greater than 5 cms	479.54	260.88
98.52F	Greater than 5 cms (delay)	259.50	111.71
98.53	Advancement of flap or pedicle graft (no donor defect)	196.38	111.81

98.55 Attachment of flap or pedicle graft to other sites

98.55A	Less than 2 cms (insetting)	103.69	111.71
98.55B	2-5 cms (insetting)	285.37	142.97
98.55C	Greater than 5 cms (insetting)	341.11	169.78

98.56 Revision of flap or pedicle graft

98.56A	Less than 2 cms (revision)	157.78	111.71
98.56B	2-5 cms (revision)	252.47	167.71
98.56C	Greater than 5 cms (revision)	389.25	207.27

98.6 Plastic operations on lip and external mouth

98.6 A	Simple excision of carcinoma of lip	105.93 V	112.95
98.6 B	Major excision of carcinoma of lip	156.33	149.07
98.6 C	Leukoplakia wedge resection	120.54 V	112.95
98.6 D	Leukoplakia vermilionectomy	219.61	144.57
98.6 E	Leukoplakia vermilionectomy and wedge resection	318.23	178.71
98.6 G	Major excision and plastic repair	BY ASSESS	207.27
	Primary reconstruction of cleft lip and palate		
98.6 H	Unilateral	649.16	263.79
	NOTE: If bilateral lip done staged, claim 98.6H per stage.		
98.6 J	Bilateral, done at one operative sitting	779.00	358.00
98.6 K	Repair of cleft nose deformity at time of primary lip repair	1,191.86	376.84

XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98.6 Plastic operations on lip and external mouth (cont'd)

		BASE	ANE
	NOTE: Includes fee for lip repairs.		
	Secondary reconstruction of cleft lip and palate		
98.6 L	Revision of one of mucosa, skin, muscle, nostril floor	194.75	111.81
98.6 M	Revision of two of mucosa, skin, muscle, nostril floor	311.60	150.73
98.6 N	Complete lip reconstruction	623.20	358.00
98.6 P	Abbe flap	501.09	214.44
98.6 R	Major, reconstruction of cleft lip and nasal deformity	662.15	298.17

98.7 Other repair and reconstruction of skin and subcutaneous tissue

98.71 Correction of syndactyly

NOTE: Grafts are paid per anatomic functional area

98.71A	With local flaps	462.20	135.53
98.71B	With flap and graft reconstruction	558.28	207.27
98.71C	Post-traumatic excision of scar and skin graft	558.28	207.27
98.71D	Vandenbos procedure NOTE: A single call applies per digit treated.	110.62	
98.72	Facial rhytidectomy That for facial palsy NOTE: One side only.	600.91	263.79

98.73 Repair for facial weakness

98.73A	Fascial-sling for facial palsy (static)	446.07	207.83
98.73B	Dynamic facial sling	706.82	312.74

98.74 Size reduction plastic operation

98.74A	Major panniculectomy	649.16	520.81

98.79 Other repair and reconstruction of skin and subcutaneous tissue NEC

NOTE: 1. Fee includes harvesting and insertion.
2. Grafting to the nasal tip and tip rhinoplasty may not be claimed together.
3. Grafting to the nasal dorsum and dorsal rhinoplasty may not be claimed together.

Transplantation of autogenous tissues other than skin

98.79A	Auricular cartilage, costal cartilage or bone graft, to nose, orbit, forehead, etc.	458.86	226.10
98.79B	Septal cartilage	220.53	111.71

Allograft/ Prosthetic

98.79C	Insertion of bone/cartilage/prosthetic graft	316.90	160.83

98.8 Invasive diagnostic procedures on skin and subcutaneous tissue

98.8 A	Skin test, e.g. tuberculin	9.05	

XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98.8 Invasive diagnostic procedures on skin and subcutaneous tissue (cont'd)

98.81 Biopsy of skin and subcutaneous tissue

	BASE	ANE
98.81A Biopsy, skin	38.94 V	113.05
NOTE: A maximum of three calls may be claimed.		
98.81B Punch biopsy	20.11	

98.89 Other invasive diagnostic procedures on skin and subcutaneous tissue

98.89A Skin tests, intradermal or prick, on children under five years, carried out by a physician, per test	4.17	
NOTE: Refer to the notes following 98.89F.		
98.89B Passive transfer test, per test	5.08	
NOTE: Refer to the notes following 98.89F.		
98.89C Skin tests, stinging insects	62.99	
NOTE: Refer to the notes following 98.89F.		
98.89D Skin test, patch, per test	1.68	
NOTE: Refer to the notes following 98.89F.		
98.89E Skin test, airborne allergens, intradermal or prick, per test	2.27	
NOTE: Refer to the notes following 98.89F.		
98.89F Skin test, food allergens, intradermal or prick, per test	2.27	
NOTE: 1. A maximum per benefit year as specified on the Price List applies to 98.89A, 98.89B, 98.89C, 98.89D, 98.89E and 98.89F.		
2. A second set of tests (98.89A, 98.89B, 98.89C, 98.89D, 98.89E, 98.89F) may be claimed only by a specialist for a patient who is referred.		
3. Benefits do not include the cost of materials.		
98.89G Provocative testing for suspected sensitivity to local anesthetic, food, antibiotic, vaccine or venom	160.36	
NOTE: 1. Requiring constant supervision by a physician for a duration of one hour or more.		
2. May only be claimed once per benefit year per patient except when the patient is referred to a specialist in which case the specialist may also claim.		
98.89H Photo test or photopatch test set of four	36.30	

98.9 Other operations on skin and subcutaneous tissue

98.92 Chemosurgery of skin

98.92C Full face	117.33	142.97

XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98.9 Other operations on skin and subcutaneous tissue (cont'd)

98.92 Chemosurgery of skin (cont'd)

		BASE	ANE
	NOTE: 1. May only be claimed for medium and deep chemical peels. Superficial peels including glycolic peels and liquid nitrogen should be claimed under HSC 98.99AA. 2. May only be claimed by dermatology.		
98.92D	Nipple/areola tattooing following repair or reconstruction . . . . . NOTE: May only be claimed when performed by a physician.	296.02	
98.92E	Technical component for nipple tattooing (staff, equipment, consumables) associated with 98.92D when performed by a physician . . . . . NOTE: May not be claimed when the procedure is performed in the hospital.	148.01	
98.92F	Photodynamic therapy for actinic keratosis or superficial basal cell carcinoma of full face, chest, or hand(s) . . . . . NOTE: 1. May only be claimed when the full face, full chest, or full hand(s) are treated. 2. May only be claimed by a dermatologist. 3. Three calls may only be claimed when treatment includes the full face, full chest or hand(s). Refer to price list.	202.65	

98.93 Dermabrasion

98.93A	Less than 1/4 of face . . . . . NOTE: May only be claimed when performed in an operating or day surgery room in an active treatment facility.	61.80 V	111.71
98.93B	Between 1/4 and 1/2 of face . . . . . NOTE: May only be claimed when performed in an operating or day surgery room in an active treatment facility.	118.85 V	111.71

98.96 Removal of nail, nailbed, or nailfold

98.96A	Wedge excision	63.69 V	113.05
98.96B	Radical excision	83.80 V	112.95
98.96C	Wedge excision with plastic repair, one side of nail	70.39 V	113.05
98.96D	Wedge excision with plastic repair, two sides of nail	77.10 V	144.57

98.98 Insertion of tissue expanders

98.98A	Insertion of tissue expanders	493.36	144.57
98.98B	Removal of tissue expanders . . . . . NOTE: When removal is the only procedure performed and not part of another procedure.	78.94 V	111.71

98.99 Other operations on skin and subcutaneous tissue NEC

98.99AA	Acne surgery . . . . . For incision and drainage and/or cryotherapy of cysts; and superficial peels for acne including liquid nitrogen and glycolic peels	30.40	

XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98.99 Other operations on skin and subcutaneous tissue NEC (cont'd)

	BASE	ANE
Tangential excision of skin cancer, microscopically controlled		
98.99B Initial excision	207.73	150.73

XVII. OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98 OPERATIONS ON SKIN AND SUBCUTANEOUS TISSUE (cont'd)

98.99 Other operations on skin and subcutaneous tissue NEC (cont'd)

		BASE	ANE
98.99C	One or more extra cuts, additional benefit	181.77	111.71

NOTE:
1. HSCs 98.99B and 98.99C refer to recognized techniques in which the excised tissue is appropriately marked, oriented and mapped by the surgeon in such a way as to anatomically locate residual malignant cells, if any, in the corresponding sector of the tumor bed.
2. HSCs 98.99B and 98.99C may only be claimed when a certified pathologist has confirmed the diagnosis from a prior biopsy.
3. HSCs 98.99B and 98.99C may only be claimed once whether or not the excision of the lesion extends to the subsequent day.

Moh's microscopically controlled excision

98.99D	Initial cut, including debulking	329.83	
98.99E	One or more additional cuts, extra	286.22	
98.99F	Special overhead and technical component, additional benefit	283.83	

NOTE:
1. HSC 98.99D may only be claimed by physicians who have been approved to provide these services by the CPSA.
2. HSC 98.99D may only be claimed when a certified pathologist has confirmed the diagnosis from a prior biopsy.
3. HSCs 98.99E and 98.99F may only be claimed once, whether or not excision of the lesion extends to the subsequent day.
4. HSC 98.99F may not be claimed if the surgery is performed in a hospital setting.
5. Closure of the resulting defect by undermining the advancement flaps is included in the above benefits. If more complicated closure is medically necessary, claim as an additional procedure under the appropriate graft HSC.

XVIII. PROCEDURES NOT ELSEWHERE CLASSIFIED

99 PROCEDURES NOT ELSEWHERE CLASSIFIED

99.0 Ill-defined operations

99.09 Surgical procedures NOS

		BASE	ANE
99.09A	Unlisted Procedures, Nervous System	BY ASSESS	
99.09B	Unlisted Procedures, Endocrine System	BY ASSESS	
99.09C	Unlisted Procedures, Eyes	BY ASSESS	
99.09D	Unlisted Procedures, Ears	BY ASSESS	
99.09E	Unlisted Procedures, Nose, mouth and pharynx	BY ASSESS	
99.09F	Unlisted Procedures, Respiratory system	BY ASSESS	
99.09G	Unlisted Procedures, Cardiovascular system	BY ASSESS	
99.09H	Unlisted Procedures, Hemic and Lymphatic system	BY ASSESS	
99.09J	Unlisted Procedures, Digestive system and abdominal repair	BY ASSESS	
99.09K	Unlisted Procedures, Urinary tract	BY ASSESS	
99.09L	Unlisted Procedures, Male genital organs	BY ASSESS	
99.09M	Unlisted Procedures, Female genital organs	BY ASSESS	
99.09N	Unlisted Procedures, Obstetric procedures	BY ASSESS	
99.09P	Unlisted Procedures, Musculoskeletal system	BY ASSESS	
99.09Q	Unlisted Procedures, Breast	BY ASSESS	
99.09R	Unlisted Procedures, Skin and subcutaneous tissue	BY ASSESS	
99.09U	Unlisted Procedures, Certain Diagnostic and Therapeutic Procedures	BY ASSESS	
99.09V	Unlisted Procedures, Radiology	BY ASSESS	

LABORATORY AND PATHOLOGY

HEMATOLOGY

NOTE: Unusual multiple charges for the same laboratory service should be submitted with an explanation

Hematology - General

		BASE	ANE
E 1	Complete blood count (hemoglobin, white blood count, differential, platelet count, eosinophil count and either red blood count or hematocrit, with no additional charge for indices) - by any method.	18.53	
	NOTE: 1. Includes check by pathologist or hemopathologist if required. 2. No combination of those items which constitute a complete blood count shall be billed in excess of a complete blood count.		
E 29	Blood smear by special request of referring physician Claim only an E1 (CBC) if the test results are not outside the laboratory's criteria for referring the smear to a pathologist for review	51.44	
E 13	Bone marrow - interpretation of smear by pathologist or hematopathologist	80.71	
E400	Eosinophil count - direct	7.10	
E 7	Hematocrit	5.53	
E 2	Hemoglobin	5.53	
E404	Hemosiderin stain on blood, bone marrow or urine smear	10.28	
E 23	Malaria or other parasite	17.08	
E 3	Red blood cell count by electronic counting	5.53	
E 8	Reticulocyte count	10.47	
E 6	Sedimentation rate	3.94	
E 4	White blood cell count	5.53	
E 5	White blood cell - differential count	9.00	

Hematology - Special

E 9	Acid hemolysis test	27.20	
E 10	Ascorbic test for red cell enzyme deficiency	17.08	
E 11	Autohemolysis with glucose and ATP	50.24	
E 16	Cold hemolysins (Donath-Landsteiner)	17.08	
E427	Fetal hemoglobin cell count (Kleihauer)	27.20	
E 18	Fetal hemoglobin by denaturation	17.08	
E 19	Fragility test	47.91	
E429	Heinz body (in vitro)	14.10	
E460	Hemoglobin hybridization in identification of abnormal hemoglobins	62.12	
E517	Hemoglobin, unstable by heat stability	29.45	
E 22	Leukocyte alkaline phosphatase (L.A.P.)	20.24	
E 24	P.N.H. screen	13.77	
E520	Platelet aggregation per aggregating agent NOTE: Up to three agents, maximums apply refer to Price List.	19.64	
E 25	Red cell G-6-PD (quantitative)	56.97	
E 26	Red cell pyruvate kinase (quantitative)	56.97	
E366	Schilling test - with or without intrinsic factor	67.25	
E 27	Sickle cell identification	11.27	

LABORATORY AND PATHOLOGY (cont'd)

HEMATOLOGY (cont'd)

Hematology - Coagulation, Hemostasis

		BASE	ANE
E 30	Bleeding time	7.27	
E 32	Circulating anticoagulant	20.24	
E 33	Clot retraction	11.70	
E 31	Clotting time (Lee-White)	6.14	
E 36	Contact activation	27.20	
E405	Factor VIII (A.H.G.) assay	68.06	
E406	Factor IX (P.T.C.) assay	68.06	
E 34	Factor XI - identification of defect (P.T.A.)	47.91	
E 35	Factor XII - identification of defect (Hageman)	47.91	
E 38	Fibrinogen Qualitative (eg. fibrindex)	12.99	
E 37	Fibrinogen Quantitative - chemical	33.63	
E464	Fibrinogen split products	18.19	
E 17	Fibrinolysin (dilute whole blood clot lysis)	13.77	
E 40	Platelet adhesiveness	33.21	
E 41	Platelet count	13.62	
E 42	Prothrombin consumption test	27.20	
E 43	Prothrombin time	14.74	
E428	Stypven time	17.08	
E 45	Thromboplastin generation test - full identification of defect	68.06	
E 44	Thromboplastin generation test - screening	29.58	
E 46	Thromboplastin time - partial	17.08	

Immunohematology

E 51	ABO grouping	8.23	
E 49	Antibody identification including antiglobulin test, warm and cold phase but not elution or absorption	41.95	
E468	Donor antibody screen, per donor, per day, including antiglobulin test	23.10	
E 48	Antiglobulin test, direct or indirect or both, when not part of a cross match, includes negative and positive control	10.61	
E 50	Cross match, per patient, per set-up, includes antiglobulin test as well as grouping	47.92	
E 21	Leukoagglutinins (qualitative)	33.21	
E434	Leukoagglutinins (quantitative)	100.50	
E435	Platelet antibodies, modification of complement fixation	100.49	
E472	Preparation of cryoprecipitate - per unit (not including collection)	43.10	
E469	Preparation of packed red cells - per patient, per day (not including collection)	15.00	
E471	Preparation of platelet concentrate (minimum of eight donors) (not including collection)	87.04	
E432	R.B.C. absorption and elution studies	84.25	
E433	R.B.C. elution only	50.23	
E 52	Rh groupings, per antigen	8.23	
E436	Red blood cell antibody titration, warm or cold, saline and/or antiglobulin test	27.20	

LABORATORY AND PATHOLOGY (cont'd)

CHEMISTRY

Chemistry - Routine blood

		BASE	ANE
E 55	Acetone	23.11	
E 79	Acetylcholinesterase (red cells)	33.21	
E515	Alanine aminotransferase (ALT)	15.00	
E473	Aldolase	20.73	
E475	Alpha 1 antitrypsin	37.98	
E551M	Alpha fetoprotein	59.34	
E 57	Amino acid (total)	18.20	
E 58	Ammonia	23.10	
E 59	Amylase	20.73	
E 60	Ascorbic acid	23.11	
E 62	Bilirubin - total and fractionation (conjugated)	14.27	
E 63	Bilirubin - total - without fractionation	9.65	
E 68	Calcium	18.51	
E 81	Carbon dioxide (C02)	6.38	
E 70	Carbon monoxide (quantitative)	27.07	
E551J	Carcinoembryonic antigen (CEA)	59.34	
E 72	Carotene	23.10	
E 75	Ceruloplasmin (quantitative)	27.20	
E 76	Chloride	6.38	
E 77	Cholesterol total	16.33	
E519	Cholesterol, high density lipoprotein (HDL) fraction	32.81	
E 79A	Cholinesterase (serum) total	33.21	
E 79B	Cholinesterase (serum) isoenzyme fractionation	35.24	
E525	Chromatography (blood) by column	68.06	
E422	Chromatography (blood), gas per specimen, per injection	68.06	
E524	Chromatography (blood), liquid per specimen, per injection	68.43	
E526	Chromatography (blood), thin layer qualitative, per plate	30.38	
E560	C-1 Esterase Inhibitor	37.98	
E492	Complement 3, serum	37.98	
E494	Complement 4, serum	37.98	
E495	Complement, total (hemolytic assay)	46.30	
E 84	Creatinine	11.40	
E 86	Cryoprotein per fraction	9.00	
E420	Creatine kinase (CK)	17.08	
E420A	Creatine kinase (CK) isoenzyme fractionation	35.63	
E425	D-Xylose tolerance	33.21	
E150E	Enzyme, serum otherwise not listed	20.87	
E 88	Fatty acid (total)	20.24	
E550D	Ferritin	59.34	
E401A	Folic acid, red cell	41.96	
E 90	Galactose tolerance - I.V.	49.06	
E 92	Glucose - fasting	10.47	
E 92D	Glucose - spot	10.47	
E 92E	Glucose - two hour P.C.	10.47	
E 93	Glucose - stick test	3.62	
E 94	Glucose tolerance - includes urines as required, four or more specimens	47.08	
E 92B	Glucose - Gestational Diabetic screen	14.88	
E 54	Haptoglobins	33.21	

LABORATORY AND PATHOLOGY (cont'd)

CHEMISTRY (cont'd)

Chemistry - Routine blood (cont'd)

		BASE	ANE
E 96	Hemoglobin (plasma) quantitative	17.86	
E 97A	Hemoglobin electrophoresis, together with quantitation of abnormal hemoglobin by scanning or elution	64.47	
E503	Hemoglobin A2 by chromatography	68.06	
E512	Heavy metals, each	29.46	
E 98	Immunoelectrophoresis (1 membrane)	44.69	
E 98A	Additional slides to a maximum of two	22.15	
E 99	Immunoglobulin quantitation of IgG, IgA, and IgM, inclusive	70.41	
E 99A	Immunoglobulin quantitation of any of IgG, IgA, IgM, IgD each	23.10	
E550X	IgE (immunoglobulin E)	59.34	
E103	Iron - serum and iron binding capacity	29.99	
E104	Lactic acid or lactate	36.01	
E105	Lactic dehydrogenase (LD)	20.73	
E106	LD Isoenzyme fractionation	35.64	
E107	Lipase	18.51	
E504	Lithium	22.32	
E111	Magnesium	17.08	
E114	Methemalbumin (Schumm test)	7.10	
E150	Multi-channel analysis	25.18	
E116	Osmolarity	13.77	
E119	pH of blood	17.08	
E119A	pCO2	17.86	
E121A	pO2	17.08	
E122	Phenylalanine - chemical quantitative	17.08	
E123D	Phosphatase acid	20.73	
E123	Phosphatase alkaline	20.65	
E123B	Phosphatase alkaline, isoenzyme fractionation	35.64	
E124	Phospholipids	17.08	
E125	Phosphorus, inorganic	14.10	
E127	Potassium	6.38	
E128	Proteins - total only	10.28	
E130	Proteins - electrophoresis	25.50	
E527	Protoporphyrin, free (red cell)	41.55	
E528	Pyruvic acid or pyruvate	36.00	
E552	Radioimmunoassay specify	BY ASSESS	
E137	Sodium	6.38	
E529	Transferrin, quantitative	26.61	
E142	Triglyceride	16.33	
E144	Urea	12.05	
E145	Uric acid	11.69	
E146	Vitamin A tolerance - includes vitamin A (4 specimens)	90.17	
E147	Vitamin A	23.10	
E148	Vitamin B 12	46.30	

Chemistry - Routine urine

E151	Urinalysis routine examination - including exam of centrifuged sediment	7.11	

NOTE: Item E152, item E153, or item E222 shall not be submitted for a service rendered on the same day as item E151.

LABORATORY AND PATHOLOGY (cont'd)

CHEMISTRY (cont'd)

Chemistry - Routine urine (cont'd)

		BASE	ANE
E152	Urinalysis without microscopic examination of centrifuged sediment	3.62	
E153	Microscopic examination, alone	3.62	
E157	Amino acids - total (chemical)	23.11	
E158	Amino acids - paper chromatography screening	23.11	
E159	Amino acids - chromatography (semi-quantitative) (includes sugars)	39.98	
E162	Amylase	20.73	
E163	Ascorbic acid (quantitative)	23.11	
E169	Calcium (quantitative)	20.73	
E291	Calculus analysis (qualitative)	23.10	
E479	Calculus analysis by infra-red spectroscopy or x-ray diffraction	24.99	
E480	Calculus - infra-red scan - interpretation of	12.05	
E172A	Chlorides (quantitative)	10.28	
E505	Chromatography, gas, per specimen, per injection	68.06	
E521	Chromatography, liquid - per specimen - per injection	68.06	
E522	Chromatography by column	68.06	
E523	Chromatography, thin layer - qualitative, per plate	30.38	
E181	Concentration test only	3.49	
E203	Concentration test with osmolality	25.65	
E182	Coproporphyrin (quantitative)	23.10	
E183	Coproporphyrin (qualitative)	11.28	
E178	Creatinine (quantitative)	11.69	
E179	Creatinine clearance test	27.20	
E530	Cystine, quantitative	60.91	
E184	Cystine (screening)	11.28	
E481	Delta-aminolevulinic acid	43.10	
E189	Glucose (quantitative)	11.70	
E190	Heavy metals, each	29.45	
E531	Homogentisic acid, qualitative	12.99	
E532	Hydroxyproline, quantitative	60.91	
E518	Immunoelectrophoresis or immunofixation, including dialysis concentration	84.66	
E198	Melanin	23.10	
E200	Myoglobin	33.21	
E533	Mucopolysaccharides, qualitative	17.86	
E202	Osmolality	13.77	
E483	Oxalate	25.00	
E205	Phenylpyruvic acid (qualitative) (P.K.U.)	3.49	
E206	Phosphorus	14.10	
E207	Porphobilinogen (qualitative)	7.10	
E208	Porphyrins (quantitative)	17.08	
E209	Potassium (quantitative)	18.34	
E188	Protein electrophoresis	40.76	
E210	Protein (quantitative) 24 hour	18.51	
E513	Radioimmunoassay	58.54	
E213	Serotonin - quantitative	27.20	
E214	Serotonin - qualitative	7.10	
E215	Sodium (quantitative)	17.23	
E175	Sugars - chromatography, screening	13.77	
E175A	Sugars - chromatography, semi-quantitative	39.98	
E219	Urea clearance	27.20	

LABORATORY AND PATHOLOGY (cont'd)

CHEMISTRY (cont'd)

Chemistry - Routine urine (cont'd)

		BASE	ANE
E224	Uric acid	11.69	
E221	Urobilinogen - quantitative	18.20	
E222	Urobilinogen - qualitative	7.10	
E223	Uroporphyrin (quantitative)	23.10	

Chemistry - Endocrine blood

E551K	Adrenocorticotropin (ACTH)	59.34	
E551N	Androstenedione	59.34	
E550K	Human chorionic gonadotropin, beta sub-unit	59.34	
E487	Cortisol	62.12	
E551F	Dihydroepiandrosterone F. (DHEAS)	59.34	
E550A	Estradiol	59.34	
E550B	Estrogen, total	59.34	
E550E	Follicle stimulating hormone (F.S.H.)	59.34	
E551D	Gastrin	59.34	
E550M	Human growth hormone, (H.G.H.) (maximum of two for function test)	59.35	
E551Q	17 Hydroxyprogesterone	59.34	
E550N	Insulin (maximum of six for function test)	59.34	
E550P	Luteinizing hormone, (L.H.)	59.34	
E551E	Parathormone	96.54	
E550Q	Progesterone	59.34	
E550R	Prolactin (maximum of 2 for function test)	59.34	
E551G	Renin (per test, maximum of two)	83.87	
E550S	Testosterone	59.34	
E550U	T-4 (thyroxine)	1.60	
E350	T3 uptake	1.60	
E353	T4 corrected for abnormal thyroid binding protein	1.60	
E550W	Total T-3 (tri-iodothyronine)	47.84	
E750	Sensitive thyroid stimulating hormone (s-T.S.H)	47.84	
E751	Free Tri-iodothyronine (FT3)	30.57	
E752	Free thyroxine (FT4)	30.57	

Chemistry - Endocrine urine

E225	Aldosterone	169.35	
E226	Catecholamines	50.23	
E489	Metanaphrine	46.30	
E411	Pregnancy test	12.05	
E234	Pregnanediol or pregnanetriol	50.23	
E235	Pregnanediol and pregnanetriol	84.25	
E486	Urinary free cortisol	62.12	
E603	Urine beta HCG	19.94	
E237	V.M.A. - quantitative	50.23	
E238	V.M.A. Screening	13.77	

Chemistry - Therapeutic drug monitoring and toxicology

E 56	Alcohol (Ethanol) - blood	23.11	

LABORATORY AND PATHOLOGY (cont'd)

CHEMISTRY (cont'd)

Chemistry - Therapeutic drug monitoring and toxicology (cont'd)

		BASE	ANE
E 56D	Alcohol (Ethanol) - urine	23.11	
E 61	Barbiturates - blood	47.91	
E164	Barbiturates - urine - quantitative	47.91	
E165	Barbiturates - urine - qualitative	10.28	
E 65	Bromide (quantitative)	13.77	
E516M	Carbamazepine (quantitative)	37.98	
E550	Digoxin	59.34	
E516A	Diphenylhydantoin (phenytoin) (quantitative)	37.59	
E516G	Drug assay - (not to be used if specific fee code for drug assayed exists in schedule) specify (quantitative)	47.91	
E516	Ethosuximide (quantitative)	40.76	
E516N	N-acetylprocainamide (quantitative)	40.76	
E501	Narcotic drug screen urine - suspect drug specified	23.10	
E516B	Phenobarbitone (quantitative)	38.77	
E204	Phenothiazine tranquilizers - urine (screen)	11.28	
E516D	Primidone (quantitative)	40.76	
E516E	Procainamide (quantitative)	40.76	
E516F	Quinidine (quantitative)	40.76	
E135	Salicylates - blood	20.08	
E212	Salicylates - urine	20.09	
E516J	Theophylline (quantitative)	37.20	
E516K	Valproic acid (quantitative)	47.91	

Other body fluids (amniotic, cerebrospinal, serous, synovial, etc)

E 56B	Alcohol (Ethanol) - Gastric fluid	23.10	
E426	Bilirubin	17.08	
E409	Cell count	6.00	
E239A	Chloride	10.28	
E511	Crystal identification by polarizing microscopy	10.61	
E307	Eosinophils - sputum or nasal secretions	7.10	
E294	Gastric analysis - single specimen	7.10	
E295	Gastric analysis - with histamine	20.24	
E536	Gastric contents - gas or liquid chromatography, per specimen, per injection	68.06	
E537	Gastric contents, thin layer chromatography, qualitative, per plate	30.38	
E241	Glucose	10.47	
E242	Protein	10.28	
E243	Protein electrophoresis	40.76	
E305	Semen analysis, including sperm count	33.63	
E305B	Semen - examination for presence of sperm only	10.28	
E305A	Sperm agglutination test	68.06	
E309A	Sweat chloride test including collection of specimen	33.21	

Feces

E245	Fat, total	58.54	
E248	Occult blood, diagnostic only	8.23	

LABORATORY AND PATHOLOGY (cont'd)

CHEMISTRY (cont'd)

Feces (cont'd)

		BASE	ANE
E248A	Occult blood, for screening of average risk patients NOTE: 1. Average risk is defined as an individual that is 50 years of age or older with no personal history of colorectal adenomatous polyps, no personal history of inflammatory bowel disease and no family history of colorectal cancer. 2. May be claimed once every year.	8.23	
E534	PH (feces)	26.61	
E250	Trypsin (semi-quantitative)	11.28	
E251	Urobilinogen (quantitative)	27.07	

Bacteriology

E253	Antibiotic level, estimation of	20.24	
E256	Autogenous vaccine, preparation of	32.03	
E272	Bacteruria screening test	7.10	
E258B	Bacterial culture including, when necessary, indentification, sensitivity and quantitation Only one bacterial culture may be billed per specimen	35.31	
E261	Culture - Tuberculosis - atypical or Mycobacterium tuberculosis	33.21	
E264	Darkfield microscopy - identification of Treponema, Borrelia, etc	47.91	
E263	Microscopic examination for parasites with concentration methods	26.10	
E263A	Microscopic examination of smear for M. tuberculosis or atypical mycobacteria	26.10	
E262	Microscopic identification (Gram-stain without culture, worm identification, ecto parasites, (eg. scabies, ticks), hairs, scales, smear, film preparations)	7.44	
E269	Phage typing per organism	33.21	
E265	Trophozoites - amoeba in stool - direct examination	17.08	
E262A	Wet mount and/or hanging drop preparations (e.g. Trichomonas vaginalis, Campylobacteria, etc.)	7.44	
E280	Examination of stool for cryptosporidium including stain and concentration	25.96	

Mycology

E274	Culture, fungal and identify	23.10	
E273	Smear - (KOH) preparation and examination	10.28	
E275	Yeast identification - serological or by chlamydiospores	10.28	

Serology

E288	Antibody screen by immunofluorescence antibody, other than antinuclear, per antibody, (up to maximum of three)	33.21	
E288A	Antibody, titre of, identified in E288 screen as positive (maximum of three different antibodies)	66.45	
E550Y	Anti DNA	59.34	
E287	Antinuclear antibodies by fluorescence, screen, e.g. Fluorescence (FANA), Peroxidase, Other methodology	33.21	

LABORATORY AND PATHOLOGY (cont'd)

CHEMISTRY (cont'd)

Serology (cont'd)

		BASE	ANE
E287A	Antinuclear antibody titre if screen positive (not to be claimed in addition to screen)	66.45	
E304	Antinuclear antibody - latex antinuclear nucleoprotein test	10.28	
E278	ASOT - antistreptolysin 'O' titre (ASO)	17.08	
E277	Serologic identification - antibodies, using up to four antigens, e.g. Agglutination, Complement fixation, Enzyme immunoassay	17.08	
E286	Bovine milk antibodies	27.20	
E410	C. reactive protein	10.28	
E279	Cold agglutinins with titre	13.77	
E293	Glutin antibodies	27.20	
E303	Rheumatoid factor qualitative	10.28	
E562	Rheumatoid factor quantitative	30.70	
E283	Serological test for syphilis (S.T.S.)	17.08	
E299	Thyroglobulin - antithyroglobulin antibodies	50.24	
E299A	Thyroid antibodies - microsomal antibodies	50.24	
E300	Thyroid antibodies - screening test, e.g. latex	17.08	
E508	Toxoplasmosis, IgG or IgM	29.45	

Viruses/Rickettsia/Chlamydia

E602	Chlamydia/viral culture e.g. Herpes	39.99	
E601	Direct fluorescent or special staining examination of specimens for chlamydia, viral inclusions	23.10	
E550F	Hepatitis A virus antibody, per antibody (maximum of 2)	43.39	
E550G	Hepatitis B virus antibody, per antibody (maximum of 2)	43.39	
E550J	Hepatitis B virus antigen, per antigen (maximum of 2)	43.39	
E298	Infectious mononucleosis - immunologic screen	10.28	
E281	Infectious mononucleosis heterophile agglutination with absorption (see also E-298)	28.20	
E553	Rubella - screen or semi-quantitative	18.82	
E554	Rubella IgM antibody - quantitative	24.35	
E499	Viral serology - hemagglutination inhibition test	18.51	
E496	Viral serology - complement fixation test, single antigen	29.46	
E497	Viral serology - complement fixation test, 5 to 7 antigens	80.71	
E498	Repeat viral complement fixation test, (convalescent) - 5 to 7 antigens	57.79	

Cytopathology

E310	Breast cytopathology (processing, examination and interpretation)	23.87	
E314	C.S.F. cytopathology (processing, examination and interpretation)	33.21	
E311	Cervical cytopathology (processing, examination and interpretation)	22.61	
E312	Gastric or colon washings for cytopathology (collection only)	27.20	
E317	Gastric or colon wash cytopathology (excluding collection) (processing, examination and interpretation)	33.21	
E297	Inclusion bodies	17.08	
E301	Karyotype determination by tissue culture	338.64	
E538	Needle aspiration cytopathology (processing, examination and interpretation)	73.19	
E318	Oral cytopathology (processing, examination and interpretation)	23.87	

LABORATORY AND PATHOLOGY (cont'd)

CHEMISTRY (cont'd)

Cytopathology (cont'd)

		BASE	ANE
E320	Serous fluid cytopathology (processing, examination and interpretation)	33.21	
E319	Sex chromatin determination (vaginal or oral)	33.21	
E313	Spermatozoa, cytopathological examination on fomites or invasion test	33.21	
E321	Sputum or bronchial wash cytopathology (processing, examination and interpretation)	48.27	
E323	Urine cytopathology (processing, examination and interpretation)	33.21	
E324	Vaginal cytopathology for hormonal status (maturation index plus interpretation)	22.32	

Histopathology

E493	Antigen identification in tissue biopsy by immunologic techniques, per antigen, maximum of three	66.45	
E450	Electron microscopy of biopsy specimen with report	424.10	
E315	Frozen section and quick report	58.54	
E322	Tissue, gross and microscopic examination with report	80.71	

Pulmonary Function

E333	Blood gas studies - includes serial blood, pH, C02 and oxygen content studies (5 estimations of each) and alveolar air, oxygen and carbon dioxide analysis (3 estimations of each)	253.99	
E336	Determination of blood gases, pH, pCO2, pO2	33.21	
E337	Urea breath test (C-13) for Helicobacter pylori	81.13	

RADIOISOTOPE TESTS - IN VIVO

Thyroid Function - Isotopes 131 or 125

E346	Thyroid uptake	55.79	
E347	Thyroid uptake and scan	90.99	
E349	T.S.H. stimulation test (exclusive of T.S.H cost)	83.06	
E351	Thyroid suppression test	67.25	

Blood studies and hemopoietic function

E354	Red cell survival	132.54	
E355	Red cell volume	68.83	
E356	Plasma iron turnover	83.06	
E356A	Radioactive iron (59) binding capacity determination	23.25	
E357	Plasma iron red cell utilization	123.83	
E359	Red cell survival and splenic sequestration	299.89	
E358	Survey sites of erythropoiesis	299.89	
E360	Plasma volume (direct)	83.06	

Gastrointestinal studies

E367	1131 triolein studies	83.06	
E368	1131 oleic acid study	83.07	
E369	Gastrointestinal blood loss (quantitative) (include survival)	231.80	

LABORATORY AND PATHOLOGY (cont'd)

RADIOISOTOPE TESTS - IN VIVO (cont'd)

Gastrointestinal studies (cont'd)

		BASE	ANE
E370	Localization gastrointestinal tract bleeding	332.32	
E371	Protein losing enteropathy	249.25	

Miscellaneous procedures

E500	Unlisted procedures	BY ASSESS	
E500A	Unlisted procedures (out of province referral to Canadian Laboratories)	BY ASSESS	
E500B	Unlisted procedures (out of Canada referrals)	BY ASSESS	

LABORATORY AND PATHOLOGY

F 7	Interpretation of karyotype	50.11	

DIAGNOSTIC RADIOLOGY

NOTE: 1. As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.
2. An additional 30% of the benefit applies to patients 12 years of age and younger, for some diagnostic radiology HSCs. Refer to Price List.

Head

X 1	Skull NOTE: 1. May not be claimed in addition to HSC X 4.	54.87	
X 2	Skull (including stereos)	69.16	
X 4	Facial bones NOTE: May not be claimed in addition to HSC X 1.	54.87	
X 5	Mandible	45.98	
X 6	Nasal bones	41.34	
X 6A	Adenoids or nasopharynx	32.46	
X 7	Mastoids	62.60	
X 8	Sinuses - paranasal	54.87	
X 9	Temporo-mandibular joints	59.89	
X 10	Sella turcica	45.98	
X 12	Orbit - for foreign body	45.98	
X 13	Orbit - for foreign body localization	92.35	
X 13A	Optic foramina	69.16	
X 14A	Dacryocystography	59.89	
X 15	Salivary duct for calculus	45.98	
X 16	Sialography	66.46	
X 17	Tooth (single)	12.16	
X 18	Teeth (half set)	31.76	
X 19	Teeth (complete)	47.53	

DIAGNOSTIC RADIOLOGY

NOTE: 1. As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.
2. An additional 30% of the benefit applies to patients 12 years of age and younger, for some diagnostic radiology HSCs. Refer to Price List. (cont'd)

Chest

		BASE	ANE
X 20	Chest - single view	34.39	
X 20A	Chest - single view - interpretation only	18.55	
X 21	Chest - multiple views	42.89	
X 21A	Thoracic inlet views	66.07	
X 22	Ribs	43.28	
X 23	Chest - fluoroscopy	28.21	
	Pre-breast biopsy needle localization under mammographic control		
X 27A	Single lesion	108.96	
X 27B	Multiple lesions	168.08	
	NOTE: X26 or X27 not payable for the same date of service.		
X 25	Chest - cardiac fluoroscopy including P.A., lateral and oblique views with barium in esophagus	86.17	
X 26	Mammography (one breast)	111.67	
	NOTE: May not be claimed in addition to HSCs X105 or X105A.		
X 26A	Mammoductography	101.62	
	NOTE: May not be claimed in addition to HSC X105A.		
X 26B	Mammocystography	97.37	
	NOTE: May not be claimed in addition to HSC X105A.		
	Automated stereotactic-guided large core biopsy (LNCB)		
X 26C	Percutaneous stereotactic core breast biopsy imaging guidance	301.39	
	NOTE: May not be claimed in addition to HSC X105A.		
X 27	Mammography (both breasts)	172.04	
	NOTE: May not be claimed in addition to HSCs X105 or X105A.		
X 27C	Screening mammography (age 40 to 44 years inclusive)	131.37	
	NOTE: Refer to notes following X 27G for further information.		
X 27D	Screening mammography (age 45 to 74 years inclusive)	131.37	
	NOTE: Refer to notes following X 27G for further information.		

DIAGNOSTIC RADIOLOGY

NOTE: 1. As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.
2. An additional 30% of the benefit applies to patients 12 years of age and younger, for some diagnostic radiology HSCs. Refer to Price List. (cont'd)

Chest (cont'd)

Automated stereotactic-guided large core biopsy (LNCB) (cont'd)

		BASE	ANE
X 27E	Screening mammography (age 75 years and over)	131.37	
	NOTE: 1. Refer to notes under X27G for further information.		
X 27F	Diagnostic mammography, supplementary views	56.25	
	Taken within 90 days of X27C, X27D, X27E		
	NOTE: 1. May be self-referred.		
	2. May not be claimed in addition to HSCs X26, X27 or X105A.		
X 27G	Screening mammography for patients with the following conditions: implants, augmentation, mammoplasty, and when determined appropriate for screening by a radiologist and/or primary care physician, with the following conditions: post intervention (e.g. biopsy, excision, etc.)	172.04	
	NOTE: 1. Benefits for HSCs X27C, X27D and X27E include patient education. A visit benefit may not be claimed in conjunction with these services by the radiologist performing the screening mammogram or by a different radiologist in conjunction with the same radiological examination.		
	2. Only one Screen Test or fee-for-service benefit may be claimed every calendar year.		
	3. HSCs X27C and X27E must be referred initially. Subsequent referrals are not required. HSC X27D does not require a referral.		
	4. HSCs X27C, X27D or X27E may not be claimed subsequent to HSC X27 within the same calendar year.		
	5. Supplementary views, refer to HSC X27F.		
	6. HSCs X27C, X27D, X27E, X27F (related to mammography work up), X27G, and TOMO modifier require submission of data to the Alberta Breast Cancer Screening Program through either the Alberta Society of Radiologists or the Alberta Health Services' Screening Programs.		
	7. HSCs X27C, X27D, X27E, and X27G may not be claimed in addition to HSCs X105 or X105A.		
	8. Required data submitted to the Alberta Breast Cancer Screening Program or results communication cannot be claimed as 03.01S, 03.01T or 03.05JR.		
X 28	Sternum and/or sterno-clavicular joint	41.34	

DIAGNOSTIC RADIOLOGY

NOTE: 1. As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.
2. An additional 30% of the benefit applies to patients 12 years of age and younger, for some diagnostic radiology HSCs. Refer to Price List. (cont'd)

Upper extremity

		BASE	ANE
X 29	Finger	23.96	
X 30	Hand	37.48	
X 31	Wrist or carpal bone (or wrist and hand)	37.48	
X 31A	Carpal tunnel view, additional benefit	13.14	
X 32	Radius and ulna	39.41	
X 33	Elbow	36.71	
X 34	Humerus	36.71	
X 35	Clavicle	36.71	
X 36	Shoulder girdle	49.46	
X 36A	Scapula	46.75	
X 37	Arthrogram - any upper extremity joint	109.35	

Lower extremity

X 38	Toe	23.96	
X 39	Foot	37.40	
X 40	Ankle	40.18	
X 41	Os calcis	35.16	
X 42	Tibia and fibula	39.41	
X 43	Knee	45.75	
	NOTE: May not be claimed in addition to HSCs X 54A and X 54B.		
	Skyline or tunnel view of knee		
X 43A	Additional benefit	13.14	
X 43B	Both views, additional benefit	21.25	
X 44	Arthrogram - any lower extremity joint	109.74	
X 45	Femur or thigh	39.95	
X 46	Femur, including hip and knee	92.35	
X 47	Hip	47.53	
	NOTE: May not be claimed in addition to HSCs X 54A and X 54B.		
X 48	Hip - arthrogram	109.35	
X 50	Hip pinning with fluoroscopy	79.60	
X 51	Pelvis	47.53	
	NOTE: May not be claimed in addition to HSCs X 54A and X 54B.		
X 52	Pelvis and one hip	59.89	
	NOTE: May not be claimed in addition to HSCs X 54A and X 54B.		
X 53	Pelvis and both hips	76.12	
	NOTE: May not be claimed in addition to HSCs X 54A and X 54B.		

DIAGNOSTIC RADIOLOGY

NOTE: 1. As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.
2. An additional 30% of the benefit applies to patients 12 years of age and younger, for some diagnostic radiology HSCs. Refer to Price List. (cont'd)

Lower extremity (cont'd)

Skyline or tunnel view of knee (cont'd)

		BASE	ANE
X 54	Sacro-iliac joints	54.48	
	NOTE: May not be claimed in addition to HSCs X 54A and X 54B.		

Stress views of a limb
Additional benefit

X 54A	- unilateral	13.91	
	NOTE: Refer to the note following HSC X 54B.		
X 54B	- bilateral	21.25	
	NOTE: HSCs X 54A and X 54B may not be claimed in addition to HSCs X 43, X 47, X 51, X 52, X 53, X 54, X 55, X 56, X 57, X 57A, X 58, X 58A, X 58B, X 58D, X 58E, X 59, X 60, X 61, X 62, X 63, X 64, and X 65.		

Spine

X 55	Spine, one area	62.21	
	NOTE: 1. May not be claimed in addition to HSCs X 54A and X 54B. 2. May only be claimed in addition to HSCs 16.89B, 16.89C or 16.89D once per year, per patient.		
X 56	Spine, one area - with obliques	83.46	
	NOTE: 1. May not be claimed in addition to HSCs X 54A and X 54B. 2. May only be claimed in addition to HSCs 16.89B, 16.89C or 16.89D once per year, per patient.		

DIAGNOSTIC RADIOLOGY

NOTE: 1. As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.
2. An additional 30% of the benefit applies to patients 12 years of age and younger, for some diagnostic radiology HSCs. Refer to Price List. (cont'd)

Spine (cont'd)

		BASE	ANE
X 57	Two areas NOTE: May not be claimed in addition to HSCs X 54A and X 54B.	107.80	
X 57A	Two areas (of the spine) with obliques of each area NOTE: May not be claimed in addition to HSCs X 54A and X 54B.	155.72	
X 58E	More than two areas (of the spine) with obliques of each area NOTE: May not be claimed in addition to HSCs X 54A and X 54B.	222.56	
X 58	Complete spine NOTE: May not be claimed in addition to HSCs X 54A and X 54B.	144.51	
	Flexion and extension or lateral bending views of the spine. Additional benefit		
X 58A	- flexion and extension NOTE: May not be claimed in addition to HSCs X 54A and X 54B.	15.07	
X 58B	- lateral bending NOTE: May not be claimed in addition to HSCs X 54A and X 54B.	15.07	
X 58D	flexion, extension and lateral bending NOTE: 1. HSCs X 58A, X 58B and X 58D may not be claimed in addition to HSCs X 54A and X 54B. 2. HSCs X58A, X58B and X58D may be claimed in addition to HSCs X55, X56, X57, X57A, X58 and X58E.	23.18	
X 59	Lumbo sacral spine and pelvis NOTE: May not be claimed in addition to HSCs X 54A and X 54B.	99.69	
X 60	Lumbo sacral spine and sacro-iliac joints NOTE: May not be claimed in addition to HSCs X 54A and X 54B.	83.46	
X 61	Lumbo sacral spine and pelvis and sacro-iliac joints NOTE: May not be claimed in addition to HSCs X 54A and X 54B.	110.89	
X 62	Lumbo sacral spine and one hip NOTE: May not be claimed in addition to HSCs X 54A and X 54B.	110.89	
X 63	Lumbo sacral spine and both hips NOTE: May not be claimed in addition to HSCs X 54A and X 54B.	138.33	
X 64	Lumbo sacral spine, pelvis and one hip	127.90	

DIAGNOSTIC RADIOLOGY

NOTE: 1. As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.
2. An additional 30% of the benefit applies to patients 12 years of age and younger, for some diagnostic radiology HSCs. Refer to Price List. (cont'd)

Spine (cont'd)

Flexion and extension or lateral bending views of the spine.
Additional benefit (cont'd)

		BASE	ANE
	NOTE: May not be claimed in addition to HSCs X 54A and X 54B.		
X 65	Lumbo sacral spine, pelvis and both hips	138.33	
	NOTE: May not be claimed in addition to HSCs X 54A and X 54B.		
X 66	Myelogram, x-ray and fluoroscopy	107.42	
X 66A	Cervical or thoracic myelogram with fluoroscopy	118.62	
X 67	Discography	129.06	

Genito urinary

X 68	Kidney, ureters, bladder (K.U.B.)	41.34	
	NOTE: May not be claimed in addition to HSCs X 98, X 99 or X100.		
X 69	Cystography	39.80	
X 70	Urethrography	35.16	
X 71	Excretory pyelography (includes injections of material)	109.74	
X 73	Retrograde pyelogram	66.46	
X 77A	Nephrostogram with fluoroscopy, unilateral	98.92	
X 77B	Nephrostogram with fluoroscopy, bilateral	148.76	
X 80	Hystero-salpingography (with or without fluoroscopy) (instillation of medium, see 80.85A	92.35	

Gastrointestinal tract

X 81	Esophagus with fluoroscopy	107.80	
X 82	Stomach and duodenum with fluoroscopy	147.22	
X 82A	Double contrast examination of stomach - additional fee to X 82 and X 84	17.39	
X 84	Stomach, duodenum and small bowel follow through and with fluoroscopy (includes follow-up film taken next day if necessary)	178.51	
X 85	Small bowel only with fluoroscopy	107.80	
X 85B	Small bowel studies including fluoroscopy following selective intubation and administration of cholinergic drugs (enteroclysis)	187.79	
X 86	Colon (with fluoroscopy and films)	107.80	
	NOTE: May not be claimed in addition to HSCs X 87 or X 88.		
X 87	Colon (with fluoroscopy and films) combined with air contrast examination	146.83	
	NOTE: May not be claimed in addition to HSCs X 86 or X 88.		
X 88	Colon - separate air contrast (fluoroscopy and films)	146.83	

DIAGNOSTIC RADIOLOGY

NOTE: 1. As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.
2. An additional 30% of the benefit applies to patients 12 years of age and younger, for some diagnostic radiology HSCs. Refer to Price List. (cont'd)

Gastrointestinal tract (cont'd)

	BASE	ANE
NOTE: May not be claimed in addition to HSCs X 86 or X 87.		

DIAGNOSTIC RADIOLOGY

NOTE: 1. As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.
2. An additional 30% of the benefit applies to patients 12 years of age and younger, for some diagnostic radiology HSCs. Refer to Price List. (cont'd)

Gastrointestinal tract (cont'd)

		BASE	ANE
X 88A	Barium enema for the reduction of intussusception	250.77	
	NOTE: If any of the above procedures (HSCs X 81 through X 88A) are performed without fluoroscopy, the NOFLSP modifier should be applied. The benefit rate will be adjusted according to the Price List.		
X 94	Trans-hepatic percutaneous cholangiography . . . . . (instillation, see 63.96)	173.88	
X 94B	Hepatic venogram - hepatic wedge pressure	176.97	
X 95	Operative cholangiogram (includes cost of contrast media)	67.23	
X 96	T-tube cholangiogram (includes injection and cost of contrast material) . .	105.87	
X 97	Splenoportography (excludes injection of contrast media)	155.33	
X 98	Abdomen - single view	41.34	
	NOTE: May not be claimed in addition to HSCs X 68, X 99 or X100.		
X 99	Abdomen - multiple views	59.89	
	NOTE: May not be claimed in addition to HSCs X 68, X 98 or X100.		
X100	Abdomen for obstruction or perforation	69.16	
	NOTE: May not be claimed in addition to HSCs X 68, X 98 or X 99.		

Skeletal survey for secondary neoplasms, etc.

X102	Skull, shoulder, chest, spine and pelvis	140.26	
X103	Chest, spine and pelvis	93.89	
X104	Plus all long bones - additional	51.00	

Special techniques

X105	Planogram (tomogram, laminogram) - including stereos and fluoroscopy when necessary - any area	119.01	
	NOTE: May not be claimed in addition to HSCs X 26, X 27, X 27C, X 27D, X 27E or X 27G.		
X105A	Multi-directional tomography, any area	241.88	
	NOTE: May not be claimed in addition to HSCs X 26, X 26A, X 26B, X 26C, X 27, X 27C, X 27D, X 27E, X 27F or X 27G.		
X106	Scanogram (including stereos and fluoroscopy)	120.17	
X107	Fluoroscopy of a joint with image intensification (including spot films) . .	69.55	
X107A	Fluoroscopy performed during special diagnostic or therapeutic procedures, including biopsy, endoscopy, intubation, pacemaker insertion and		

DIAGNOSTIC RADIOLOGY

NOTE: 1. As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.
2. An additional 30% of the benefit applies to patients 12 years of age and younger, for some diagnostic radiology HSCs. Refer to Price List. (cont'd)

Special techniques (cont'd)

	BASE	ANE
bougienage, etc.	197.83	

DIAGNOSTIC RADIOLOGY

NOTE: 1. As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.
2. An additional 30% of the benefit applies to patients 12 years of age and younger, for some diagnostic radiology HSCs. Refer to Price List. (cont'd)

Special techniques (cont'd)

		BASE	ANE
X128	Bone mineral content determination dual photon absorptiometry with or without vertebral fracture assessment (VFA)	142.19	

NOTE: 1. May only be claimed once every two years from the date of the last service.
2. For patients that are at high risk or have conditions that require more frequent assessments, text describing the circumstances will be required.
3. May only be claimed for patients 50 years of age or older unless the patient is referred by a Endocrinology/Metabolism, Gastroenterology, General Surgery, Internal Medicine, Nephrology, Orthopedic, Pediatric (including sub-specialties), Physical Medicine and Rehabilitation or Rheumatology specialist.
4. Nurse Practitioners and physicians that are part of Cancer Control Alberta may refer for patients under 50 years of age who are at high risk of bone density loss. Text is required on both the referral and the claim to indicate the patient's risk.

Heart

X108	Guidance of right heart catheterization	222.95	
X109	Guidance of left heart catheterization	222.95	
X110	Guidance combined left and right	330.37	

NOTE: If angiography is done at the same time, see subsequent items for appropriate charge.

X111	Guidance of pacemaker	222.95	
X111A	Guidance of extracardiac vascular catheterization without angiography	222.95	

ANGIOGRAPHY

NOTE: If cine, video or automatic rapid film changer are used, add 50%, refer to Price List.

Peripheral

X112	Artery or vein	77.67	
X113	Lymphangiography - unilateral	93.51	
X114	Lymphangiography - bilateral	140.26	

DIAGNOSTIC RADIOLOGY

NOTE: 1. As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.
2. An additional 30% of the benefit applies to patients 12 years of age and younger, for some diagnostic radiology HSCs. Refer to Price List. (cont'd)

ANGIOGRAPHY (cont'd)

Abdominal

		BASE	ANE
X115	Abdominal angiography	135.24	
X116	Selective abdominal angiography	193.97	
X117	Combined abdominal and selective abdominal	270.48	

Thoracic

X118	Thoracic angiography	135.24	
X119	Selective thoracic angiography	193.97	
X120	Combined thoracic and selective thoracic	270.48	
X121	Inferior or superior vena cavography	135.24	
X122	Angiocardiography	290.18	
X123	Pulmonary angiography	193.97	

Head and neck

X124	Cerebral - unilateral	116.30	
X125	Cerebral - bilateral	212.13	

NUCLEAR MEDICINE

Thyroid studies

X140	Thyroid scan	104.33	

Liver studies

X151	Liver scan	146.06	
X151A	Combined liver and spleen scan	209.43	
X151B	Dynamic liver and/or spleen scan including static views	312.59	
X153	Whole body scanning	502.70	

Cardiac studies

X170	Thallium myocardial perfusion imaging (rest study)	321.87	
X171	Thallium myocardial perfusion imaging (rest and exercise)	448.11	
X172	Gated cardiac imaging (rest study)	248.56	
X173	Gated cardiac imaging (rest and exercise)	427.10	

Brain studies

X156	Brain scan	190.49	

DIAGNOSTIC RADIOLOGY

NOTE: 1. As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.
2. An additional 30% of the benefit applies to patients 12 years of age and younger, for some diagnostic radiology HSCs. Refer to Price List. (cont'd)

NUCLEAR MEDICINE (cont'd)

Bone studies

		BASE	ANE
X157	Bone scan	418.46	

Lung studies

X158	Lung scan	209.43	
X158A	Lung scan with unilateral venogram (to include injection of radionuclide)	312.59	
X158B	Lung scan with bilateral venogram (to include injection of radionuclide)	339.25	
X158D	Xenon ventilation imaging	199.38	

Spleen studies

X159	Splenic scan	209.43	

Gastrointestinal studies

X174	Gastrointestinal imaging	241.88	

Adrenal imaging

X175	M.I.B.G. (I-131) adrenal imaging	477.58	
X176	M.I.B.G. (I-123) adrenal imaging	145.67	

Miscellaneous

X160	Heart, aorta, or great vessel scan	190.49	
X161	Dynamic heart imaging	248.84	
X162	Glomerular filtration rate	171.95	
X163	Dynamic renal transplant imaging studies	381.37	
X164	Renal flow studies	131.76	
X165	Cisternography	381.37	
X166	Dynamic brain studies (including static views)	284.77	
X167	Radionuclide cystography	137.56	
X168	Radionuclide dacrocystogram	110.89	
X169	Radionuclide venogram, unilateral (to include injection of radionuclide)	124.81	
X169A	Radionuclide venogram, bilateral (to include injection of radionuclide)	151.47	
X255	Renogram	120.55	
X256	Renal scan	120.55	

DIAGNOSTIC RADIOLOGY

NOTE: 1. As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.
2. An additional 30% of the benefit applies to patients 12 years of age and younger, for some diagnostic radiology HSCs. Refer to Price List. (cont'd)

DIAGNOSTIC ULTRASOUND

NOTE: 1. An additional 30% of the benefit applies to patients 12 years of age and younger, except for HSCs X325, X326 and X327.
2. Ultrasound benefits include Doppler colour mapping.
3. Quantitative spectral analysis with directional flow and/or Doppler measurements (HSC X337) may be claimed in addition to ultrasound services except for HSCs X304, X306A, X306B, X323, X331, X332 and X333.
4. Where notes indicate HSCs may not be claimed in addition to X301-X338, this refers to being claimed by the same or different physician in the same location on the same day.

Head and neck

		BASE	ANE
X301	Ultrasound, thyroid or parathyroid	128.28	
	NOTE: May not be claimed with X302, X303, and X338.		
X302	Ultrasound, salivary gland(s)	112.44	
	NOTE: May not be claimed in addition to HSCs X301 or X303.		
X303	Ultrasound, head and/or neck, soft tissue	112.44	
	NOTE: 1. Benefit includes any and all soft tissue head and neck including salivary gland(s), thyroid or parathyroid if performed. 2. May not be claimed in addition to HSCs X301 or X302. 3. Benefit includes unilateral or bilateral neck masses. 4. Max one call.		
X304	Ultrasound, carotid and/or vertebral artery, bilateral study	230.68	
	NOTE: May not be claimed in addition to HSC X337.		

Thorax

X305	Ultrasound, thorax (chest wall or pleura)	85.01	
	NOTE: Two calls may only be claimed for bilateral ultrasound.		

DIAGNOSTIC RADIOLOGY

NOTE: 1. As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.
2. An additional 30% of the benefit applies to patients 12 years of age and younger, for some diagnostic radiology HSCs. Refer to Price List. (cont'd)

DIAGNOSTIC ULTRASOUND

NOTE: 1. An additional 30% of the benefit applies to patients 12 years of age and younger, except for HSCs X325, X326 and X327.
2. Ultrasound benefits include Doppler colour mapping.
3. Quantitative spectral analysis with directional flow and/or Doppler measurements (HSC X337) may be claimed in addition to ultrasound services except for HSCs X304, X306A, X306B, X323, X331, X332 and X333.
4. Where notes indicate HSCs may not be claimed in addition to X301-X338, this refers to being claimed by the same or different physician in the same location on the same day. (cont'd)

Thorax (cont'd)

		BASE	ANE
X306A	Complex Complete Echocardiogram	250.31	

NOTE: 1. A complex complete echocardiogram includes all elements of an X306B, where the study is performed to confirm, assess, diagnose or follow-up on a patient that has, or previously had any of the following:
-pericardial disease, cardiomyopathy
-valve repair and/or valve replacement
-ventricular assist devices
-moderate or worse left ventricular systolic dysfunction (ASE guideline reference LVEF equal or less than 40%)
-vegetation, thrombus or cardiac mass
-moderate or worse valvular stenosis or regurgitation (ASE guideline references-specifically excludes mild to moderate)
-congenital heart disease (repaired or unrepaired; excludes patent foramen ovale unless bubble study is requested or indicated
2. Also payable in cases where the performance and interpretation of contrast injection (agitated saline or echo contrast), or stress echocardiography are completed.
3. Benefit includes rescanning (i.e. image acquisition) by a qualified physician, if performed.
4. In the rare case where a specific view or Doppler signal is unavailable, the reason shall be documented in the patient's record.
5. May not be claimed in addition to HSCs X307, X323 and X337.

DIAGNOSTIC RADIOLOGY

NOTE: 1. As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.
2. An additional 30% of the benefit applies to patients 12 years of age and younger, for some diagnostic radiology HSCs. Refer to Price List. (cont'd)

DIAGNOSTIC ULTRASOUND

NOTE: 1. An additional 30% of the benefit applies to patients 12 years of age and younger, except for HSCs X325, X326 and X327.
2. Ultrasound benefits include Doppler colour mapping.
3. Quantitative spectral analysis with directional flow and/or Doppler measurements (HSC X337) may be claimed in addition to ultrasound services except for HSCs X304, X306A, X306B, X323, X331, X332 and X333.
4. Where notes indicate HSCs may not be claimed in addition to X301-X338, this refers to being claimed by the same or different physician in the same location on the same day. (cont'd)

Thorax (cont'd)

		BASE	ANE
X306B	Non Complex Complete Echocardiogram	229.31	
	A study of all the relevant cardiac structures and functions of all the chambers, valves, septae, pericardium and great vessels from multiple views, complemented by Doppler examination of every cardiac valve, the atrial and ventricular septa for antegrade and retrograde flow. NOTE: May not be claimed in addition to HSCs X307, X323 and X337.		
X307	Ultrasound, heart, Echocardiogram, limited	61.27	
	NOTE: May not be claimed in addition to HSCs X306A or X306B.		
X308	Ultrasound, breast, including axilla	126.74	
	NOTE: 1. Two calls may only be claimed for bilateral ultrasound. 2. May not be claimed with HSC X309. 3. Ultrasounds completed due to dense breast tissue require submission of data to the Alberta Breast Cancer Screening Program through either the Alberta Society of Radiologists or the Alberta Health Services' Screening Programs.		
X309	Ultrasound, axilla	73.03	
	NOTE: 1. Two calls may only be claimed for bilateral ultrasound. 2. May not be claimed with HSC X308.		

Abdomen and Retroperitoneum

X310	Ultrasound, abdominal, complete or at least two abdominal organs	171.68	

DIAGNOSTIC RADIOLOGY

NOTE: 1. As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.
2. An additional 30% of the benefit applies to patients 12 years of age and younger, for some diagnostic radiology HSCs. Refer to Price List. (cont'd)

DIAGNOSTIC ULTRASOUND

NOTE: 1. An additional 30% of the benefit applies to patients 12 years of age and younger, except for HSCs X325, X326 and X327.
2. Ultrasound benefits include Doppler colour mapping.
3. Quantitative spectral analysis with directional flow and/or Doppler measurements (HSC X337) may be claimed in addition to ultrasound services except for HSCs X304, X306A, X306B, X323, X331, X332 and X333.
4. Where notes indicate HSCs may not be claimed in addition to X301-X338, this refers to being claimed by the same or different physician in the same location on the same day. (cont'd)

Abdomen and Retroperitoneum (cont'd)

		BASE	ANE
	NOTE: May not be claimed in addition to HSCs X311 and X312.		
X311	Ultrasound, kidneys, ureters and bladder	138.72	
	NOTE: 1. Benefit includes any pre-void, post-void and/or jets. 2. May not be claimed in addition to HSCs X310, X312, X314, X315, X316 and X328.		
X312	Ultrasound, abdominal, single organ study, limited or follow up	110.51	
	NOTE: 1. For two or more organs on the same day, claim HSC X310. 2. May not be claimed in addition to HSC X310, X311 and X316.		
X313	Ultrasound, abdominal wall, or appendix study	112.83	
	NOTE: Supporting text is required when a third call is claimed.		
X313A	Ultrasound, inguinal hernia	112.83	
	NOTE: 1. May only be claimed when the referral is supplied by a urologist (UROL) or general surgeon (GNSG). For pediatric patients, a general practitioner (GP), general surgeon (GNSG), pediatrician (PED), urologist (UROL) or pediatric general surgeon (PDSG) may also make referrals.		

DIAGNOSTIC RADIOLOGY

NOTE: 1. As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.
2. An additional 30% of the benefit applies to patients 12 years of age and younger, for some diagnostic radiology HSCs. Refer to Price List. (cont'd)

DIAGNOSTIC ULTRASOUND

NOTE: 1. An additional 30% of the benefit applies to patients 12 years of age and younger, except for HSCs X325, X326 and X327.
2. Ultrasound benefits include Doppler colour mapping.
3. Quantitative spectral analysis with directional flow and/or Doppler measurements (HSC X337) may be claimed in addition to ultrasound services except for HSCs X304, X306A, X306B, X323, X331, X332 and X333.
4. Where notes indicate HSCs may not be claimed in addition to X301-X338, this refers to being claimed by the same or different physician in the same location on the same day. (cont'd)

Obstetrics, Gynecology and Female Pelvis

NOTE: Female pelvic ultrasound exams (HSCs X314, X315, X316 and X324) may only be claimed in addition to any obstetrical ultrasound exams for different diagnosis.

		BASE	ANE
X314	Ultrasound, pelvis, female, including endo-vaginal (EV) scan . . . . . NOTE: May not be claimed in addition to HSCs X311, X315, X316, X318, X319 and X324.	195.90	
X315	Ultrasound, pelvis, female, transvesical scan . . . . . NOTE: May not be claimed in addition to HSCs X311, X314, X316 and X324.	127.51	
X316	Ultrasound, urinary bladder, female . . . . . NOTE: 1. Benefit includes any pre-void, post-void and/or jets. 2. May not be claimed in addition to HSCs X311, X312, X314, X315 and X324.	102.01	
X317	Ultrasound, obstetrical, first trimester, excluding detailed fetal assessment or nuchal translucency measurement . . . . . NOTE: 1. An additional 50% of the benefit may be claimed for each additional fetus. 2. May not be claimed in addition to HSCs X318, X319, X320, X321, X322 and X324.	119.78	
X318	Ultrasound, obstetrical, first trimester, excluding detailed fetal assessment or nuchal translucency measurement	175.42	

DIAGNOSTIC RADIOLOGY

NOTE: 1. As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.
2. An additional 30% of the benefit applies to patients 12 years of age and younger, for some diagnostic radiology HSCs. Refer to Price List. (cont'd)

DIAGNOSTIC ULTRASOUND

NOTE: 1. An additional 30% of the benefit applies to patients 12 years of age and younger, except for HSCs X325, X326 and X327.
2. Ultrasound benefits include Doppler colour mapping.
3. Quantitative spectral analysis with directional flow and/or Doppler measurements (HSC X337) may be claimed in addition to ultrasound services except for HSCs X304, X306A, X306B, X323, X331, X332 and X333.
4. Where notes indicate HSCs may not be claimed in addition to X301-X338, this refers to being claimed by the same or different physician in the same location on the same day. (cont'd)

Obstetrics, Gynecology and Female Pelvis

NOTE: Female pelvic ultrasound exams (HSCs X314, X315, X316 and X324) may only be claimed in addition to any obstetrical ultrasound exams for different diagnosis. (cont'd)

		BASE	ANE

NOTE: 1. Benefit includes endo-vaginal (EV) scan, if performed.
2. An additional 50% of the benefit may be claimed for each additional fetus.
3. May not be claimed in addition to HSCs X314, X317, X319, X320, X321, X322 and X324.

DIAGNOSTIC RADIOLOGY

NOTE: 1. As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.
2. An additional 30% of the benefit applies to patients 12 years of age and younger, for some diagnostic radiology HSCs. Refer to Price List. (cont'd)

DIAGNOSTIC ULTRASOUND

NOTE: 1. An additional 30% of the benefit applies to patients 12 years of age and younger, except for HSCs X325, X326 and X327.
2. Ultrasound benefits include Doppler colour mapping.
3. Quantitative spectral analysis with directional flow and/or Doppler measurements (HSC X337) may be claimed in addition to ultrasound services except for HSCs X304, X306A, X306B, X323, X331, X332 and X333.
4. Where notes indicate HSCs may not be claimed in addition to X301-X338, this refers to being claimed by the same or different physician in the same location on the same day. (cont'd)

Obstetrics, Gynecology and Female Pelvis

NOTE: Female pelvic ultrasound exams (HSCs X314, X315, X316 and X324) may only be claimed in addition to any obstetrical ultrasound exams for different diagnosis. (cont'd)

		BASE	ANE
X319	Ultrasound, obstetrical, first trimester/early fetal screening	207.11	
	NOTE: 1. Benefit includes detailed fetal assessment, nuchal translucency measurement and endo-vaginal (EV) scan, if performed. 2. An additional 100% of the benefit may be claimed for each additional fetus. 3. May not be claimed in addition to HSCs X314, X317, X318, X320, X321, X322 and X324.		
X320	Ultrasound, obstetrical, second or third trimester, general fetal assessment	172.72	
	NOTE: 1. Benefit includes fetal measurements and placental localization. 2. An additional 100% of the benefit may be claimed for each additional fetus. 3. May not be claimed in addition to HSCs X317, X318, X319 and X321.		
X321	Ultrasound, obstetrical, second or third trimester, high risk - for example, significant maternal disease (i.e. diabetes), fetal anomaly, fetal markers, Intrauterine Growth Retardation (IUGR), oligohydramnios, growth discordance in twins, suspected fetal anemia, genetics, fetal therapy . . .	200.92	

DIAGNOSTIC RADIOLOGY

NOTE: 1. As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.
2. An additional 30% of the benefit applies to patients 12 years of age and younger, for some diagnostic radiology HSCs. Refer to Price List. (cont'd)

DIAGNOSTIC ULTRASOUND

NOTE: 1. An additional 30% of the benefit applies to patients 12 years of age and younger, except for HSCs X325, X326 and X327.
2. Ultrasound benefits include Doppler colour mapping.
3. Quantitative spectral analysis with directional flow and/or Doppler measurements (HSC X337) may be claimed in addition to ultrasound services except for HSCs X304, X306A, X306B, X323, X331, X332 and X333.
4. Where notes indicate HSCs may not be claimed in addition to X301-X338, this refers to being claimed by the same or different physician in the same location on the same day. (cont'd)

Obstetrics, Gynecology and Female Pelvis

NOTE: Female pelvic ultrasound exams (HSCs X314, X315, X316 and X324) may only be claimed in addition to any obstetrical ultrasound exams for different diagnosis. (cont'd)

		BASE	ANE
	NOTE: 1. Benefit includes fetal measurements, placental localization, colour Doppler and cord Doppler. 2. An additional 100% of the benefit may be claimed for each additional fetus. 3. May not be claimed in addition to HSCs X317, X318, X319 and X320.		

DIAGNOSTIC RADIOLOGY

NOTE: 1. As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.
2. An additional 30% of the benefit applies to patients 12 years of age and younger, for some diagnostic radiology HSCs. Refer to Price List. (cont'd)

DIAGNOSTIC ULTRASOUND

NOTE: 1. An additional 30% of the benefit applies to patients 12 years of age and younger, except for HSCs X325, X326 and X327.
2. Ultrasound benefits include Doppler colour mapping.
3. Quantitative spectral analysis with directional flow and/or Doppler measurements (HSC X337) may be claimed in addition to ultrasound services except for HSCs X304, X306A, X306B, X323, X331, X332 and X333.
4. Where notes indicate HSCs may not be claimed in addition to X301-X338, this refers to being claimed by the same or different physician in the same location on the same day. (cont'd)

Obstetrics, Gynecology and Female Pelvis

NOTE: Female pelvic ultrasound exams (HSCs X314, X315, X316 and X324) may only be claimed in addition to any obstetrical ultrasound exams for different diagnosis. (cont'd)

		BASE	ANE
X322	Ultrasound, obstetrical, biophysical profile, third trimester only	108.96	
	NOTE: 1. May not be claimed with HSCs X317, X318 and X319. 2. An additional 100% of the benefit may be claimed for each additional fetus.		
X323	Ultrasound, heart (Echocardiogram), fetal, complete study	271.25	
	NOTE: 1. May not be claimed in addition to HSCs X306A, X306B and X337. 2. An additional 100% of the benefit may be claimed for each additional fetus.		
X324	Ultrasound, pelvis, female, translabial or endo-vaginal (EV), additional benefit	68.49	
	NOTE: 1. A maximum of one may be claimed per patient, per physician, per day. 2. May not be claimed in addition to HSCs X314, X315, X316, X317, X318 and X319.		

Pediatrics

X325	Ultrasound head, pediatric scan through open fontanel	164.22	
X326	Ultrasound, hips, bilateral, pediatric, newborn to 16 years of age	166.15	
X327	Ultrasound, spine, pediatric, newborn to 16 years of age	200.92	

DIAGNOSTIC RADIOLOGY

NOTE: 1. As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.
2. An additional 30% of the benefit applies to patients 12 years of age and younger, for some diagnostic radiology HSCs. Refer to Price List. (cont'd)

DIAGNOSTIC ULTRASOUND

NOTE: 1. An additional 30% of the benefit applies to patients 12 years of age and younger, except for HSCs X325, X326 and X327.
2. Ultrasound benefits include Doppler colour mapping.
3. Quantitative spectral analysis with directional flow and/or Doppler measurements (HSC X337) may be claimed in addition to ultrasound services except for HSCs X304, X306A, X306B, X323, X331, X332 and X333.
4. Where notes indicate HSCs may not be claimed in addition to X301-X338, this refers to being claimed by the same or different physician in the same location on the same day. (cont'd)

Male Genitourinary Tract

		BASE	ANE
X328	Ultrasound, pelvis, male	127.51	
	NOTE: 1. Benefit includes bladder, any pre-void, post-void and/or jets. 2. May not be claimed in addition to HSC X311.		
X329	Ultrasound, prostate, transrectal	139.49	
X330	Ultrasound, scrotal	127.51	
	NOTE: May not be claimed in addition to HSC X337.		

Peripheral Vascular System

NOTE: These HSCs can be claimed on any combination of limbs as determined by clinical evaluation.

X331	Ultrasound, arterial screening, peripheral	91.02	
	NOTE: May not be claimed in addition to HSC X337.		
X332	Ultrasound, arterial complete mapping, peripheral	161.90	
	NOTE: May not be claimed in addition to HSC X337.		
X333	Ultrasound, venous, peripheral	127.51	
	NOTE: May not be claimed in addition to HSC X337.		

DIAGNOSTIC RADIOLOGY

NOTE: 1. As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.
2. An additional 30% of the benefit applies to patients 12 years of age and younger, for some diagnostic radiology HSCs. Refer to Price List. (cont'd)

DIAGNOSTIC ULTRASOUND

NOTE: 1. An additional 30% of the benefit applies to patients 12 years of age and younger, except for HSCs X325, X326 and X327.
2. Ultrasound benefits include Doppler colour mapping.
3. Quantitative spectral analysis with directional flow and/or Doppler measurements (HSC X337) may be claimed in addition to ultrasound services except for HSCs X304, X306A, X306B, X323, X331, X332 and X333.
4. Where notes indicate HSCs may not be claimed in addition to X301-X338, this refers to being claimed by the same or different physician in the same location on the same day. (cont'd)

Peripheral Vascular System

NOTE: These HSCs can be claimed on any combination of limbs as determined by clinical evaluation. (cont'd)

		BASE	ANE
X334	Ultrasound, other than shoulder including joints, tendons, ligaments, muscles, single anatomic site	117.08	
	NOTE: 1. A maximum of two anatomical areas may be claimed per patient, per physician, per day. 2. May not be claimed in addition to HSC X337.		
X335	Ultrasound shoulder, dedicated rotator cuff and bicep	144.51	
	NOTE: 1. Two calls may only be claimed for bilateral ultrasound. 2. May not be claimed in addition to HSC X337.		

Miscellaneous

X337	Doppler, quantitative spectral analysis with directional flow and/or Doppler measurements (e.g. renal artery, portal venous system, resistivity index, etc.), additional benefit	46.75	
	NOTE: May not be billed in addition to HSCs X304, X306A, X306B, X323, X330, X331, X332, X333, X334 and X335 when services are provided by the same or different physician in the same facility on the same day.		
X338	Ultrasound, limited soft-tissue study, site unspecified, any single site, not organ related	74.19	

DIAGNOSTIC RADIOLOGY

NOTE: 1. As stated in G.R. 11.1.1, claims for services in the Diagnostic Radiology section will not be payable unless the physician has been approved by the CPSA to provide those services.
2. An additional 30% of the benefit applies to patients 12 years of age and younger, for some diagnostic radiology HSCs. Refer to Price List. (cont'd)

DIAGNOSTIC ULTRASOUND

NOTE: 1. An additional 30% of the benefit applies to patients 12 years of age and younger, except for HSCs X325, X326 and X327.
2. Ultrasound benefits include Doppler colour mapping.
3. Quantitative spectral analysis with directional flow and/or Doppler measurements (HSC X337) may be claimed in addition to ultrasound services except for HSCs X304, X306A, X306B, X323, X331, X332 and X333.
4. Where notes indicate HSCs may not be claimed in addition to X301-X338, this refers to being claimed by the same or different physician in the same location on the same day. (cont'd)

Miscellaneous (cont'd)

	BASE	ANE

NOTE: 1. A maximum of two anatomical areas may be claimed per patient, per physician, per day.
2. May not be claimed in addition to HSC X301.

THERAPEUTIC RADIOLOGY

X-ray therapy

			BASE	ANE
Y	1	Superficial x-ray therapy excluding cancer, per sitting - one area	16.61	
Y	2	Multiple areas treated at one sitting - not to exceed	33.59	
Y	3	Superficial x-ray therapy, cancer	BY ASSESS	113.05