

Payment Schedule For Yukon

April 1, 2009

**INSURED
HEALTH
SERVICES**

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PREAMBLE

Complete understanding of the following paragraphs is essential to proper interpretation of the Guide

1. SETTING OF FEES

(a) Yukon Health Care Insurance Plan:

Fees payable by the Yukon Health Care Insurance Plan (YHCIP) are subject to negotiation between the Government of Yukon and the Yukon Medical Association. The description of fee items and their respective dollar values form part of the Yukon Health Care Insurance Plan Act regulations. The YHCIP/YMA Liaison Committee is responsible for resolving issues of interpretation and making recommendations regarding new fee items, amendments to existing items and re-evaluation of existing items.

No fee above or in addition to this prescribed schedule may be charged to either YHCIP or to the patient in the case of insured services provided to insured persons.

If there is not a fee included in this schedule for a particular service, the account may be submitted to YHCIP with a copy of the operative report or a letter outlining the reason for the charge. In such cases a Fee Item Number may be designated by taking the first digit of item in the applicable section, and adding the digits 999 (i.e. General Surgery 7999 - Obstetrics 4999).

Individual medical practitioners have the right to communicate directly with the Medical Advisor to the YHCIP or the President of the YMA on any fee matter, giving details of the reason for their method of billing or dispute.

(b) Yukon Workers' Compensation Health & Safety Board:

Fees payable by Workers' Compensation Board (YWCHSB) are subject to separate negotiations between the YWCHSB and the YMA. Specific items directly related to YWCHSB are found in the Non-Insured Fee Guide. Disputed fees and fees not found in the fee book will be handled by direct communication with the Executive Director of YWCHSB and/or President of the YMA.

(c) Private Billing:

All fees in the attached guide shall be used in private practice. If the doctor intends to charge a higher fee because of unusual circumstances, this fee should, whenever possible, be arranged with the patient before the service is rendered.

If smaller charges are required because of the patient's reduced circumstances, the listed fee should be quoted, followed by the charge actually being made. This will prevent the public from gaining a false impression of the necessary level of professional charges from these exceptional cases.

If the patient's financial circumstances are unusual, and other doctors have been called in attendance, it is the responsibility of the attending physician to acquaint his/her colleagues of such circumstances. Each doctor concerned in the care of the patient shall give or send to the patient or their agent a statement showing his/her own professional services. An itemized statement should be supplied on request.

2. GROUP PRACTICE

If fees are collected by an organized clinic or medical partnership, then the total itemized fee should be submitted to the patient or his agent. Members of such a group shall be considered as individual physicians, each charging for his/her own services.

3. INCLUSIVE FEES

Inclusive fees (e.g. surgical operations) are intended to provide for the planning and carrying out of operative procedures and cover pre-operative care, operation and postoperative care. (See also preamble 10 and 11.)

When services other than those above can be shown to have been required, because of serious, complications or coincidental illness, the doctor rendering the service, whether he/she is charging the inclusive fee or not, may charge an additional sum commensurate with the extra service rendered.

4. CONSULTATION

This is defined as a request by a doctor for a second opinion on a case he/she has examined and with which he/she has encountered some difficulty. It includes the initial services of a consultant and additional visits necessary to enable him/her to prepare and render his/her report. Subsequent consultations may be sought by the original doctor from the same or other consultants. No consultation should be charged to the patient or their payment agency unless it was requested by the attending doctor.

5. CONTINUING CARE BY CONSULTANT

This may follow consultation at the request of the referring doctor if the complexities of the case are such that its management should remain for a time in the hands of the consultant. In such circumstances, the consultant will charge for his/her consultation and continuing care according to the Fees pertaining to his/her specialty.

Should the referring doctor consider that continuing consultant care of his/her patient is still necessary after six months, he/she should review the case and re-refer for continuing care only. (NOTE: Otherwise future services will be paid at general practitioner rates. Also see Fee Code 3333 Page 2.) When a referral takes place, it must be made clear by the referring doctor to all concerned that the major responsibility for the case has been transferred, and the referring doctor may not charge for the case until, or unless, the full responsibility is returned to him/her, except that for a patient in hospital, he/she may charge supportive care where the patient's condition warrants it. (See Preamble 10 (b) (i)).

6. DIRECTIVE OR CONCURRENT CARE BY A CONSULTANT

For those medical cases where the medical indications are of such complexity that concurrent services of more than one physician are required for the adequate care of patient, subsequent visits should be claimed by each physician as required for that care. To facilitate payment, relevant clinic records should accompany claims, and independent consideration will be given.

7. MULTIPLE SERVICE

- (a) When the performance of a minor therapeutic or diagnostic procedure (e.g. intramuscular or intravenous injection or taking a specimen from the patient) is the purpose of the doctors' attendance in the office, hospital or on a house call, the charge made will be that listed for the procedure only.
- (b) Therapeutic and diagnostic procedures performed consequent to a visit or consultation shall be billed in addition to the visit or consultation (see preamble 13).

8. MISCELLANEOUS FEES NOT INCLUDED IN THE GUIDE AND DISPUTED FEES

See Preamble 1.

9. HOSPITAL CARE

Routine in-patient care can be billed at the rate of one visit per day. Exceptions to this protocol are consultations, ICU care, concurrent care, long-term care, supportive care, procedural fees and new conditions requiring immediate assessment. (See Preamble 5, 6, 10(a), 10(b), 14, 15 & 20). Another exception is admission to hospital prior to 0800 hours when a second visit that day can be billed.

10. OPERATIVE SURGICAL BILLING

(a) General

The surgeon's responsibility for any case under his/her care, referred or not, includes usual preoperative preparation of up to one month's duration, operation, and routine postoperative follow-up, including removal of sutures and care of the operative wound. These services are included in the surgical fee. The normal post operative period is considered to be 42 days for all surgical procedures. Management of serious or unusual post-operative complications may be billed as separate items.

When a surgical assistant is necessary, surgical assistant's fees are to be billed as separate items.

(b) Referred Surgical Cases

If a requested consultation is followed by a surgical or diagnostic procedure performed by the same physician, the consultation charges are in addition to the scheduled operative fee. The family or referring doctor may charge for necessary care for a referred case quite apart from the surgical fee as follows:

- (i) Supportive Care - non-surgical care including liaison with the family, reassurance of the patient, etc. while the patient is hospitalized. The referring doctor may charge one hospital visit for every two- (2) days hospitalized during the first ten- (10) days of hospitalization and, thereafter, one visit every five- (5) days hospitalized.
- (ii) Convalescent Care - visits by the patient to the family doctor following discharge from hospital. Up to one visit a week until convalescence is completed may be billed.
- (iii) Concurrent Care - see Preamble 6.

(c) Surgery by a Visiting Doctor

The surgical fee will be indivisible at all times. If a surgeon operates outside his/her geographical areas, and because of this he/she is unable to carry out the post-operative care, the physician who performs this service for the patient should make a separate charge to the patient. The charges may be made on the basis of daily care while in hospital up to fourteen (14) days postoperatively and thereafter on the basis of the supportive care formula. No charge should be made for patients in a metropolitan area or within 20 miles of the surgeon's office or usual hospital.

(d) Operation Only

When billing YHCIP or YWCB fee items marked "operation only", the pre and post-operative calls can be charged. If the procedure is the sole reason for the visit, the visit fee should not be charged in addition to the procedural fee. Fee items classified "operation only" do not preclude proper referral of the patient.

(e) Cosmetic Surgery

Cosmetic Surgery is defined as any procedure done primarily to change the external appearance of an anatomically and physiologically normal person aged 19 and over. The surgeon must obtain prior authorization for such procedures in ANY case when dealing with a payment agency.

11. OPERATIVE SURGICAL FEES

- (a) When two similar procedures (e.g. bilateral herniorrhaphy) are done at the same time, the charge for the second procedure should be 50% of the listed fee. When done under separate anaesthetics at staged intervals, the full fee should be charged for each operation.
- (b) When two different elective procedures are done through separate incisions at the same time (e.g. herniorrhaphy and varicose veins), the charge for the lesser procedure should be 50% of the fee.
- (c) When two procedures are done through the same incision the lesser procedure should be charged at 50%. (NOTE: Incidental appendectomy is not to be billed in addition to the abdominal surgery)
- (d) When two different emergency procedures are done through separate incisions under the same anaesthetic, each procedure shall be charged at the full listed fee.

- (e) An emergency operation followed by a definite surgical procedure (e.g. cholecystotomy followed by cholecystectomy at a later date) should be charged as the full listed fee in each instance.
- (f) When two procedures are done by two physicians in different fields utilizing the same anaesthetic, each procedure shall be charged for at the full listed fee, except as stated for team procedures (e.g. laminectomy and fusion).
- (g) Certified surgical assistant:
Where an operative assistant is required, he/she would ordinarily be a non-specialist. However, in certain selective instances of unusual technical difficulties, the services of a certified surgical assistant may be necessary. In only these instances should the fee for specialist assistant be applied.
- (h) Where two surgeons, specialists in different fields, perform major surgical procedures under the same anaesthetic, except where 7019 is indicated, each surgeon may charge an assistant fee for assisting the other.
- (i) Where the completion of two or more different procedures are required and could be completed by one physician, but two physicians of the same specialty complete the procedures; the total surgical fee billed may not exceed the equivalent if done by one physician and one assistant.

12. FRACTURES, ETC.

- (a) When multiple procedures for multiple fractures and/or soft tissue injuries are done by the same surgeon, the full fee for the major procedure shall be charged and 50% for all subsequent procedures. In cases of dissociated injuries of which the presence of one impedes the progress of another or in the cases of multiple major fractures (e.g. a fractured femur and tibia in the same limb), a full fee for each may be charged provided that adequate clinical evidence to support this charge is rendered with the account.
- (b) Compound fracture - up to 50% extra may be charged.
- (c) Open reduction of fracture or dislocation when necessary - 50% extra may be charged except when a special fee is listed.
- (d) Where a closed reduction of a fracture is followed within (4) four weeks by an open reduction the greater fee will be paid in full and the lesser fee at 50%.
- (e) Inclusive fees for fractures include the necessary application of casting, when applied before the expiry of the post-operative period (See paragraph 10(a)).
- (f) Open reduction of old malunited fracture - 25% extra may be added to the fee for open reduction of the equivalent new fracture.
- (g) External Skeletal Fixation with closed reduction - 25% above closed reduction fee may be charged. External fixation of an open fracture 25% above the open reduction fee (see Preamble)
- (h) Any secondary amputation, excision or disarticulation may be charged at 50% of the listed fee for the primary procedure, whenever performed.
- (i) Failed Procedure Requiring Remanipulation
 - (i) Remanipulation by same surgeon within four weeks, no charge.
 - (ii) Remanipulation by a consultant surgeon should be charged at the full fee for the procedure.
 - (iii) Where a patient is referred to a consultant and remanipulation is required, the attending physician who performed the initial or original attempt to reduce the fracture should charge 50% of the fee for the procedure he performed.

13. DIAGNOSTIC PROCEDURES

Special fees are listed for Diagnostic Procedures when performed in conjunction with another service. These fees are procedural fees only, and the fee for opinion, whether given as a consultation or as an office visit, will be charged in addition to the procedural fee. If the procedure augments a consultation, the consultant will indicate whether it was a major or limited consultation. If the procedure is done at a time different than the original visit, no fee other than the procedure fee should be billed for the second visit.

Diagnostic procedural fees may be charged in addition to fees for surgical procedures. The surgical fee includes only those services detailed in Paragraph 10. If two diagnostic procedures are done at the same time, whether in office or in hospital, the lesser should be billed at 50% of the listed fee. Repeat procedures done at separate times will be listed as separate procedural fees.

14. LONG-STAY HOSPITAL AND NURSING HOME CARE

Accounts for long-stay, serious illness in acute care hospitals may be charged in full for a period up to thirty days. Care beyond this period may be charged up to two hospital visits per week, when such visits are necessary.

Accounts for long-term nursing home (or other similar institutions) cases may be charged up to one visit every two weeks. When patient is acutely ill charge fee-for service, when such visits are necessary. Charges in excess of these should be accompanied by an explanatory letter.

15. PREMATURE CARE IN HOSPITAL

Charge in accordance with clause 14. Payment agencies shall pay accounts for supportive or directive care as outlined in clauses 5 and 6 in addition to one attending physician while newborn is hospitalized and considered premature as defined in clause 17.

16. DIAGNOSTIC ROENTGENOLOGY

Multiple examinations of areas on the same side of the body may be charged as the sum total of the individual items.

17. AGE CATEGORIES

Age categories are defined as follows:

Premature baby: under 2,500 grams

Neonate: under 28 days

Infant: 28 days to 1 year

Child: 1 year to 16 years

18. EXPERIMENTAL MEDICINE

Costs of medical services (such as examinations by physicians, laboratory procedures, other diagnostic procedures, etc.) which are primarily related to research or experimentation are not the responsibility of the patient or the Yukon Health Care Insurance Plan. Only those reasonable costs customarily related to routine and accepted care of a patient's problem are considered to be insured services by the Yukon Health Care Insurance Plan.

Grants are available from a number of funding agencies to defray the extra costs associated with clinical research and experimentation.

19. COUNSELLING

The following definitions apply:

- (i) Counselling is the lengthy discussion (minimum of 20 minutes) with the patient, parent or relative about a difficult and complex medical condition. Routine advice, for example birth control advice or explaining pathophysiology, is a normal part of therapeutic intervention and, as such, is part of the visit or service fee and should not be billed as counselling regardless of duration of visit.
- (ii) Psychotherapy is a medical act by which a physician, through sessions of verbal or other communication, explores and attempts to influence the behavior of a psychiatrically disordered patient with the objective of reducing his disability.

NOTE: YHCIP and the YMA have agreed to pay item 0120 on the basis of a limit of six (6) visits per twelve month period per patient for counselling a complex medical condition. Up to three (3) visits per patient per year are permitted for counselling related to smoking cessation or weight management. Subsequent visits should be billed at the appropriate office visit fee. The twelve month period starts April 1st each year.

20. INTENSIVE AND CORONARY CARE UNITS

- (a) The responsibility for a patient in an I.C.U. or C.C.U. lies with the patient's attending physician unless he/she specifically requests continuing consultative care.
- (b) When there is a doctor in charge of an I.C.U. or C.C.U., he/she is entitled to charge a patient or their agent for those services which he/she is specifically requested to provide by the attending physician or consultant in charge.
- (c) When a patient requires multiple consultations, a consultation fee may be charged by each consultant. Continuing care by a consultant or consultants must be clearly requested by the attending physician in charge. Any patient admitted to an I.C.U. or C.C.U. is considered to be critically ill and therefore the attending physician who is coordinating the consultative services is entitled to charge up to three visits daily. Payments for additional visits will be considered when detailed case summary is provided.
- (d) Where a consultant or consultants are requested to see a patient or provide continuing care, the fee(s) shall relate the responsibility each consultant bears to the patient's treatment.
- (e) Intensive Care billings (0138) may apply for care on wards other than in formal Intensive Care Units, e.g. newborn nursery, paediatric ward, outpost hospitals prior to transfer, etc.

21. BALANCE BILL

Means the amount of the difference between the payment made by Yukon Health Care Insurance Plan for an insured service and the fee charged by the physician for that service.

22. DIFFERENTIAL BILLING FOR NON-REFERRED PATIENTS

Means the difference between the fee payable to the general practitioner and the fee payable to the specialist for YHCIP insured services. This amount may be billed by the specialist directly to the patient.

23. EXTRA BILL

Means an amount for an insured service over the fee for that service listed herein under "YHCIP and YWCHSB fees."

24. FEES FOR INDIVIDUAL PRACTITIONERS

After review, by the appropriate Committee, the Association may recommend to the Yukon Health Care Insurance Plan adjustments in fees to be paid to individual practitioners.

25. VENEPUNCTURE AND DISPATCH

(Fee Item 0012) - this is the only fee applicable for taking blood specimens and is to apply to those situations where a single service is provided by an unassociated facility or person. Where a specimen is taken by a laboratory and dispatched to another unassociated laboratory, the original laboratory may charge fee item 0012 only when it does not perform another laboratory procedure using that specimen.

26. ACCOMPANYING PATIENTS

When it is medically essential that a physician accompanies a patient to a distant hospital, charges should be made under fee item 0095, plus travel expenses, meals, accommodation and incidentals at the prevailing government rates.

27. PREFIXED FEE ITEMS

B designates services included in visit fee. For an isolated service see clause 7 preamble.
T designates fee items approved on a temporary basis awaiting further information.

28. MISSED APPOINTMENTS

The charging for missed appointments is at the discretion of each physician. Such charges should not be submitted to the Yukon Health Care Insurance Plan.

29. MICROSURGERY

Means operating with the use of an operating microscope.

30. STATUTORY HOLIDAYS

- New Year's Day
- Heritage Day
- Good Friday
- Easter Monday
- Victoria Day
- Canada Day
- Discovery Day
- Labour Day
- Thanksgiving Day
- Remembrance Day
- Christmas Day
- Boxing Day

FOR BILLING PURPOSES ONLY

The next working day will be used when the stat falls on a Saturday or Sunday.

31. RURAL PREMIUM

A premium of five per cent (5%) applies to all fee codes billed by physicians in all Yukon communities except for Whitehorse.

32. AGE PREMIUM

Effective January 1, 2009 for newborns and up to 1 year of age, and for patients age 60 and older, a premium of ten per cent (10%) applies to all consultations rendered by specialist and to General Practice fee codes 0100, 0101,0109,0120,0121,0122,0123,0108,1100,1101 and 1109.

GENERAL SERVICES

YHCIP Anaes
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YWCHSB Unit

These fees cannot be correctly interpreted without reference to the Preamble.
No additional visit fee should be charged unless extra service is rendered.
Letter B designates services included in visit fee.

INJECTIONS

B 0010 Intramuscular medications	14.20	
B 0011 Intravenous medications	19.10	
B 0012 Venepuncture and dispatch of specimen to laboratory, when no other charge is made (See Preamble Clause 25)	14.20	
B 0013 Intra-arterial medications	28.30	
0014 Intra-articular medications by injection - hip (initial injection)	39.40	
0015 - tendons, bursae and all other joints	28.20	
0016 Intrathecal medications by injection	48.40	
0020 Trigger point injection (maximum 2 per sitting)	13.30	

BLOOD TRANSFUSIONS

0017 Venesection of central venous catheter	47.80	
0018 Insertion of indwelling arterial line	47.80	
0019 Venesection of polycythemia for phlebotomy	47.80	
0024 Vein dissection for intravenous therapy (not paid in the immediate pre and post-operative phase of surgery)	72.20	

DIALYSIS FEES

Acute Renal Failure (Hemodialysis)

0350 Blood Dialysis - physician in charge	981.90	
0351 Repeat Blood Dialysis - physician in charge	368.20	
NOTE: Maximum number of repeat dialysis on one patient is four (4). Thereafter, bill as chronic renal failure under fee code 0358.		
0352 Blood Dialysis - fee for cut down by surgeon to be charged in addition to fee code 0350 or 351.	245.10	
NOTE: When fee code 0350 or 0351 are charged there should be no charge under fee code 0310, 0308 or 0081.		

Acute Renal Failure (Peritoneal Dialysis)

0355 Dialysis (initial) to include consultation and two (2) weeks care	733.60	
0308 Subsequent hospital visits (paragraph 15 applies)	36.10	
0356 Re-insertion of peritoneal catheter after 10 days from initial insertion	96.30	
NOTE: fee code 0081 not to be charged in addition to fee code 0355. Where an initial peritoneal dialysis is performed and for various reasons hemodialysis initiated within next forty eight (48) hours, the subsequent service should be charged under fee code 0358 plus fee code 0356 for the inserton of catheter.		

Chronic Renal Failure (a) Hemodialysis:

7239 Insertion of new A.V. Bypass (no consultation charged)	467.20	2+T
0358 Performance of Hemodialysis - fee to include supervision of the procedure, history, physical examination, appropriate adjustment of solutions, and other problems during dialysis for each dialysis.	96.30	
7598 Removal of Hemodialysis shunt	116.80	
360 Cannula declotting when performed by attending physician	72.20	

GENERAL SERVICES

	YHCIP and YWCHSB	Anaes Proc. Unit
Chronic Renal Failure (b) Peritoneal Dialysis:		
7599 Insertion of permanent catheter, procedural fee only	348.90	2+T
0323 Performance of initial peritoneal dialysis to include consultation and two (2) weeks care	740.00	
0359 Performance of each Peritoneal Dialysis thereafter - fee to include supervision of procedure, history, physical examination, appropriate adjustments of solutions and any other problem that may arise during dialysis.	96.30	
NOTE:		
(i) Other situations requiring medical care such as bacteremias, etc. to be covered by fee code 0081 and always to be accompanied by a letter of explanation.		
(ii) If a period greater than three (3) months elapses since last dialysis, then charge as an initial fee code 0355.		
0361 Supervision of home dialysis - per week	123.80	
NOTE: fee code 0361 covers all services per week necessary for home or limited care dialysis and includes consultations and visits of all types. Should a patient take ill with a condition totally unrelated to renal care or require hospitalization for any reason, then other appropriate fee codes may be charged in lieu of fee code 0361.		
 IMMUNIZATION, SKIN TESTS		
B 0030 Diagnostic skin tests (Schick, Dick, T.B., and Frei)	9.60	
B 0034 Subcutaneous injections, including desensitization treatments, immunization, oral polio vaccine, etc. (maximum per sitting 3)	9.60	
 MISCELLANEOUS		
0040 Stomach Lavage and Gavage	47.80	
B 0041 Ultrasound treatments	10.20	
B 0045 Manipulation therapy without anaesthesia	21.70	
3333 Referral to Specialist when patient not seen	.00	
0043 Monitoring Anticoagulant Therapy		
This fee code is intended to be billed for those occasions outside of the office visit when the physician reviews and monitors the lab results and medication of a patient.		10.00
0050 Nurse initiated home care calls to a maximum of one call per patient per day.		33.40
This fee code is for Nurse initiated communications by telephone, facsimile or email to a maximum of one communication per patient per day. Communications must be initiated by the nurse and direction received from the physician must be incorporated in the patient's chart. Communications handled by physicians' staff are not billable. Communications to renew prescriptions are not billable. Premiums are not payable in conjunction with this fee.		
0049 Telephone calls initiated by Community Nurse Practitioners to Physicians providing scheduled emergency coverage in the Hospital. Physicians resident in communities outside Whitehorse are eligible for those calls received from Nurse Practitioners in communities other than the physician's community of residence.		34.00
Premiums not payable in conjunction with this fee.		
T 4450 HPV Study test.		30.00
T 9450 HPV Study Survey		20.00
*T9450 requires submission of T4450 to be valid.		

EMERGENCY SERVICES

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WCHSB Unit

EMERGENCY CARE

Prolonged emergency procedures requiring bedside attention. When surgery is performed by the same physician, after prolonged emergency care, he/she may charge both the emergency care fee and the surgical fee.

When a second or third physician is required for the emergency care of an acutely ill patient requiring continuous bedside care item 0081 is applicable.

- A) *Fee item 0081 to be used for billing for the active treatment of acutely ill patients whom one cannot leave. The fee is not for standby time such as waiting for laboratory results nor is it for detention care such as repeat examinations of a patient on the same day or treatment of extensive lacerations.*
- B) *Fee item 0081 may be billed in addition to a consultation, but where a consultation fee is charged, this consultation fee will constitute the fee for the first half hour.*

In excess of 2 units will be assessed by the Medical Advisor on the basis of a written report.

0081 Per half hour or major portion thereof

116.90

ACUTE CARE DETENTION FEE

To be billed when, as the result of an acute medical circumstance, the lack of a physician in attendance would likely result in a significant risk to the patient's health. This fee is for services when emergency care is not required yet the physician should not leave the patient unattended. This is not to cover time waiting for lab or xray results, consultations, etc. In excess of 2 units will be assessed by the Medical Advisor on the basis of a written report. This fee is inclusive of all other services.

0082 Per half hour or major portion thereof

93.20

PERSONAL OR FAMILY CRISIS INTERVENTION FEE

Applies to situations where the attending physician is called upon to provide continuous medical assistance at the exclusion of all other services in periods of personal or family crisis caused by rape, sudden bereavement, suicidal behaviour or acute psychosis. In excess of 2 units will be assessed by the Medical Advisor on the basis of a written report.

0083 Per half hour or major portion thereof

84.60

IN-TERRITORY MEDIVAC ON-CALL

To be billed by the scheduled physician on call to provide medical services to patients who require transportation by air ambulance within the territory. To be billed when the scheduled physician is on call in a 24-hour period. The first and second Medivac performed within the territory constitutes one unit. If the physician is on call but is not required to provide services one unit is payable. When the scheduled physician performs a third in-territory medivac in a 24-hour period then 2 x 0084 is to be billed. The third unit shall be sent with an accompanying letter of explanation to Insured Health Services. When submitting a claim for payment the physician shall include the patient's name and the destination on the diagnosis line if a medivac

0084 Per Unit

722.00

EMERGENCY SERVICES

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OUT-OF-TERRITORY MEDICAL EVACUATION

To be billed by the family physician (if available) to provide medical services to patients who require transportation by air ambulance out of the territory. South bound Medivac - two units. If returning from out of territory necessitates loss of scheduled work time - one additional unit. Physicians can apply for .5 of a unit for second patient on the same medivac with supporting documentation to the Medical Advisor.

0095 Per Unit 925.40

EMERGENCY VISIT PREMIUM

NOTE: To be charged in addition to visit or procedural fee.

** Based on time seen by physician.*

0150 Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care 40.60

0151 Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care 120.40

NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays

0152 Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care 139.60

Hospital Emergency Department Premium (When located in hospital and called to emergency)

0153 Evening (1800 - 2259) premium when located at or called to the hospital emergency department from within the hospital 19.30

NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays

0154 Night (2300 - 0759) premium when located at or called to the hospital emergency department from within the hospital 84.70

LEVEL I ON-CALL COVERAGE

**Physicians must meet the criteria as per section 7 of the Memorandum of Understanding to bill for on-call remuneration.*

0240 GENERAL SURGERY, OBSTETRICS/GYNAECOLOGY, PEDIATRICS ON-CALL: 25.00/hr

To be charged by a certified specialist when the specialist is available to provide services as required at Whitehorse General Hospital.

Call coverage shall be 24 hours a day, 365 days a year, which may be satisfied through the use of locums.

Paid per 24 hour period 8 am to 8 am.

Maximum payable is \$600.00 per 24 hour period

0540 ANAESTHETIST ON-CALL (Certified or non-certified): 25.00/hr

To be charged by the scheduled anaesthetist on-call when the anaesthetist is available to provide anaesthetic services as requires at Whitehorse General Hospital. Per Hour.

0440 COMMUNITY (DAWSON CITY AND WATSON LAKE) PHYSICIAN ON-CALL: 25.00/hr

To be charged when the scheduled physician on-call is available to provide services as required.

Call coverage shall be 24 hours a day, 365 days a year which may be satisfied through the use of locums.

Per 24 hour period 8 am to 8 am.

Maximum payment is \$600.00 per 24 hour period

EMERGENCY SERVICES

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LEVEL II ON-CALL COVERAGE

**Physicians must meet the criteria as per section 7 of the Memorandum of Understanding to bill for on-call remuneration.*

0140	SECOND ON CALL AT WHITEHORSE GENERAL HOSPITAL EMERGENCY ROOM To be charged by the scheduled second on call physician when the physician is available to provide emergency services as required. Per hour	19.79/hr
0141	DOCTOR OF THE DAY Doctor of the Day and Emergency Department on call coverage at Whitehorse General Paid per day for each on call service. The day cannot be divided into hourly services. <i>Please note this fee code is billed to PHN 002-833-663</i>	475.00
0270	INTERNAL MEDICINE, PSYCHIATRY, PAEDIATRICS, WATSON LAKE AND DAWSON CITY On-call coverage of less than 365 days a year is acceptable however, in order to participate each physician must commit to a minimum of 1 in 3 days of on-call coverage.	475.00/day

SUPPLEMENTAL ON CALL EMERGENCY FEES

Please note these fee codes are billed to PHN 002-833-655

0145	Billable as a base fee in addition to visit fees, procedural fees and time premiums 0800-2300	45.00/hour
0146	Billable as a base fee in addition to visit fees, procedural fees and time premiums 2301-0759	85.00/hour

DIAGNOSTIC PROCEDURES

YHCIP Anaes
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YWCHSB Unit

These fees cannot be correctly interpreted without reference to the Preamble.

PROCEDURES INVOLVING VISUALIZATION BY INSTRUMENTATION

0700 Bronchoscopy or bronchofibroscopy	142.40	4+T
0701 Direct laryngoscopy	71.50	5+T
0702 Bronchoscopy with biopsy	236.50	4+T
0703 Culdoscopy or Open Colpotomy	236.70	1+T
0704 Cystoscopy to include dilatation and panendoscopy	130.00	1+T
0705 Cystoscopy with catheterization of ureters (with kidney function test and injection of solution for pyelogram to include dilation and panendoscopy)	142.40	1+T
0706 Esophagoscopy with biopsy	236.50	3+T
0707 Gastroscopy including esophagoscopy	189.60	3+T
0709 Esophagoscopy	142.40	3+T
0710 Mediastinoscopy or anterior mediastinotomy (combined 50% extra)	236.70	4+T
0711 Gastric biopsy	59.70	3+T
0713 Arthroscopic examination under general anaesthetic	236.50	2+T
-hip joint	236.50	3+T
NOTE: 50% if followed by surgery under the same anaesthetic		
0714 Sigmoidoscopy	59.70	1+T
0715 Sigmoidoscopy with biopsy	71.50	1+T
0716 Flexible sigmoidoscopy	118.60	1+T
0718 Gonioscopy	24.00	1+T

PROCEDURES UTILIZING RADIOLOGICAL EQUIPMENT

The following fees are separate from the fees for the radiological part of this examination and should be charged by the attending physician or by the radiologist who performs the procedure, e.g. instrumentation or injection of contrast material.

0720 Air encephalogram	165.50	3+T
0721 Myelogram	71.50	2+T
0723 Sialogram - per duct	71.50	2+T
0724 Presacral air insufflation	71.50	2+T
0725 Perirenal air insufflation	71.50	2+T
0726 Arthrogram	71.50	2+T
0727 Salpingogram	118.60	2+T
0728 Orthodiagram	24.00	2+T
0729 Fluoroscopy of chest by Internist or Paediatrician	24.00	1+T
0730 Catheterization of bronchi for bronchogram.	47.10	4+T
NOTE: When performed in conjunction with a Bronchoscopy (fee code 0700 or 0701) both fees are to be paid in full		
0731 Duodenal Biopsy	165.50	3+T
0732 Voiding cysto-urethrogram	24.00	1+T
0733 Venogram, Intraosseous or Intravenous	47.10	2+T
0734 Lymphangiography or Lymphography - surgical component (see fee code 8614)	236.70	1+T
0735 Laryngogram	47.10	1+T
0736 Bronchial brushing in conjunction with Bronchoscopy (Bronchoscopy extra)	142.40	4+T
0737 Bronchial brushing in conjunction with bronchogram (bronchogram extra)	71.50	4+T

DIAGNOSTIC PROCEDURES

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THERAPUTIC PROCEDURES UTILIZING RADIOLOGICAL EQUIPMENT

0738	Removal of biliary calculi by Burhenne technique	331.90	4+T
0980	Trans-hepatic biliary drainage procedure	486.70	3+T
0983	Percutaneous abdominal abscess drainage by catheter insertion	330.20	2+T
0984	Exchange of previously inserted catheter for percutaneous or biliary drainage	115.50	1+T

NEEDLE BIOPSY PROCEDURES

These biopsies include only those done by needle. Biopsies involving the incision of skin or mucous membrane or involving total or partial removal of a lesion are regarded as surgical procedures, i.e. biopsy of breast, brain, larynx, skin, facial skin, lymph nodes, prostate, etc.

0739	Percutaneous lung or mediastinal biopsy	165.50	2+T
0740	Liver biopsy	118.60	2+T
0741	Splenic biopsy	118.60	2+T
0742	Renal biopsy	165.50	2+T
0744	Thyroid biopsy	94.90	1+T
0745	Peripheral or subcutaneous lymph node biopsy	24.00	1+T
0747	Prostate biopsy	47.10	1+T
0748	Bone biopsy	71.50	1+T
0749	Parietal pleural, including thoracentesis	94.90	1+T
0766	Breast biopsy	94.90	1+T

PUNCTURE PROCEDURES FOR OBTAINING BODY FLUIDS

(when performed for diagnostic purposes)

0750	Lumbar puncture	47.10	1+T
0751	Pericardial puncture	94.90	3+T
0752	Cisternal puncture	71.50	2+T
0753	Marrow aspiration	71.50	1+T
0754	Subdural tapping in infant	49.90	2+T
0755	Artery puncture	14.00	1+T
0756	Joint aspiration - hip	35.40	1+T
0757	- other joints	24.00	1+T
0758	Pneumoperitoneum	47.10	1+T
0759	Paracentesis (thoracic) or transtracheal aspiration	47.10	2+T
0760	Paracentesis (abdominal)	47.10	1+T
0761	Cyst or bursa aspiration (to include breast)	24.00	1+T

ALLERGY, PATCH AND PHOTOPATCH TESTS

0762	Scratch test - per antigen	2.60	
0763	- Children under 5 years of age - per antigen	4.60	
0764	Intracutaneous test - per test	4.60	
0767	Patch testing (extra) (annual maximum, 30 tests) per test	2.60	
0768	Photopatch test - per test	9.60	

EXAMINATION UNDER ANAESTHESIA

(when done as independent procedure)

0770	Pelvic examination under anaesthesia	47.10	1+T
0771	Retinal examination under anaesthesia	47.10	3+T
0772	Nasopharyngeal examination under anaesthesia	47.10	3+T

DIAGNOSTIC PROCEDURES

	YHCIP and YWCHSB	Anaes Proc. Unit
GYNAECOLOGICAL		
0775 Hydrotubation	118.20	
0776 Fetal scalp sampling - initial sample	47.10	
0777 - subsequent samples	24.00	
0778 Laparoscopy	236.70	4+T
0779 Amnioscopy	47.10	
0781 Rubin's Test	47.10	
0782 Needle aspiration of Pouch of Douglas	47.10	1+T
0783 Huhner's Test	47.10	
0784 Cervix punch biopsy	24.00	1+T
0785 Endometrial biopsy	71.50	1+T
0786 Pelvic examination with needle aspiration of Pouch of Douglas under anaesthesia when not followed by a surgical procedure by the same surgeon	94.90	1+T
0787 Transabdominal amniocentesis (assessment of multi-gestation can be billed at 50% for each additional fetus)	71.50	2+T
0788 Colposcopy with biopsy and curettage	61.10	1+T
0789 Colposcopy	40.80	
0790 Hysteroscopy (simple)	119.90	2+T
UROLOGICAL		
0795 Biopsy of penis	47.10	2+T
0796 Cystometrogram	47.10	
0773 Sphincterometry (in addition to cystometrogram)	47.10	
0802 Urethrogram	117.70	2+T
0792 Cysto-ureterogram - technical fee	24.00	2+T
0793 professional fee	11.40	
MISCELLANEOUS		
0794 Peritoneal lavage	189.60	1+T
CARDIOVASCULAR PROCEDURES		
0801 Intra-arterial cannulation (with multiple aspirations)	47.10	
0831 Swans-Ganz catheter insertion	236.50	5+T
NOTE: When catheter is inserted as part of anaesthetic procedure the fee code 0831 would be payable at 50%		
ELECTRODIAGNOSIS		
<i>Items under Intensity duration Curve-each muscle.</i>		
<i>Electromyograph - each muscle.</i>		
<i>Motor nerve conduction study - each nerve.</i>		
<i>Sensory nerve conduction study - each nerve.</i>		
<i>Tetanic stimulation test - each muscle.</i>		
0904 Schedule A-extensive examination (8 or more)	198.70	
0905 Schedule B-limited examination (4 - 7 items)	132.50	
0906 Schedule C-short examination (1-3 items)	73.20	
0907 Endoscopic flexible or rigid examinations of the nose and nasopharnx (procedure only)	43.50	3+T
0908 procedure and biopsy	74.90	3+T
0909 Flexible fiberoptic nasopharyngolaryngoscopy	55.10	3+T
0922 Electrodiagnostic component of the decamethonium edrophonium test for myasthenia gravis, inclusive of tetanic stimulation tests.	67.20	
0923 Technical fee for electrodiagnostic testing	33.40	

DIAGNOSTIC PROCEDURES

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PULMONARY INVESTIGATIVE AND FUNCTION STUDIES

0928 Simple Screening Spirometry with FVC, FEV(i) and FEV(i)/FVC ratio using a portable apparatus without bronchodilators	24.50
0929 - before and after bronchodilators. Exercise Studies: NOTE: No more than one exercise study item may be billed for a single patient on any one day without written explanation	38.50
0950 Progressive Exercise Test with at least three workloads, measuring ventilation and electrocardiographic monitoring -professional fee	46.40
0951 - technical fee	69.80
0952 Ventilation at rest and exercise with blood gas analysis but without expired gas analysis - professional fee	57.80
0953 - technical fee	92.50
0954 Exercise in a steady state at two or more workloads with measurements of ventilation, O ₂ and CO ₂ exchange, and electrocardiographic monitoring - professional fee	96.60
0955 - technical fee	96.60
0956 Exercise in a steady state at two or more workloads with measurements of ventilation, O ₂ and CO ₂ exchange, electrocardiographic monitoring, arterial blood gases, measurement of A _a gradients and physiological dead space - professional fee	115.70
0957 - technical fee	115.70
0958 Testing for exercise induced asthma by serial flow measurements - professional fee	46.40
0959 - technical fee	69.80
0962 Expired gas analysis to measure mixed venous CO ₂ - professional fee	7.00

GENERAL PRACTICE

YHCIP and YWCHSB Anaes Proc. Unit

These fees cannot be correctly interpreted without reference to the Preamble.

1100	Visit (in emergency department at Whitehorse General Hospital)	40.10
0100	Visit (in or out of office): For any condition(s) requiring partial or regional examination and history to include pronouncement of death and health supervision of infant up to and including one year of age	40.10
1101	Complete examination (in emergency department at Whitehorse General Hospital)	88.10
0101	Complete examination (in and out of office): For any condition requiring a complete physical examination and detailed history NOTE: A complete physical examination shall include a complete and detailed history and detailed physical examination with special attention to local examination where clinically indicated, adequate recording of findings and, if necessary, discussion with patient. The above should include complaints, history of the present and past illness, family history, personal history, functional inquiry, physical examination, differential diagnosis, and provisional diagnosis. A minimum of 20 minutes in patient contact is considered necessary to use this fee.	88.10
1109	Second extensive examination (in emergency department at Whitehorse General Hospital)	51.00
0109	For a situation when a second extensive examination is required, the second complaint should be more than passing significance. Both complaints or diagnoses should be recorded on the claim card. Can also be used for "well woman" annual check ie; blood pressure, pap, breast exam and related health counselling.	51.00
0110	Consultation (in and out of office): To include history and physical examination, review of x-rays and laboratory findings and written report	129.70
0112	Limited General Practitioner Consult (in or out of office): To include a brief history and focused examination, review of xrays and laboratory findings with a written report	64.90
0116	Admission to ICU for critically ill patients (not routine or post anaesthetic) requiring immediate complete examination, investigation and close monitoring of condition	152.60

HOME VISITS

0103	First patient	84.30
0104	Extra patients seen during same house call NOTE: Home visits can also be used when a non emergency visit is provided at a place other than the normal health care facility (i.e. place of work, sporting event, etc.).	45.00

HOSPITAL VISITS

0108	Visit (see Preamble 14)	51.50
0128	Supportive Care (see Preamble 10 (B) (i) and 5)	51.50
0138	ICU Visit (see Preamble 20 (C))	57.20
0148	Long Stay Hospital and Nursing Home care (see Preamble 14). To be billed when seeing a patient while already at nursing home or on regular rounds.	57.60

NURSING HOME VISITS

0114	To be billed when the physician is called by the nursing home to see patient.	68.40
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GENERAL PRACTICE

YHCIP and
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CHRONIC DISEASE MANAGEMENT

- T 1120 Flat Fee for Group Visits: 250.00
Group visits will consist of a minimum of three patients and a minimum time requirement of one hour per visit, to include time spent for preparation and follow up. The physician may elect to split larger groups into smaller more manageable groups of a minimum of three patients.
Claims for remuneration are to be submitted to Insured Health Services under the Personal Health Number (PHN) 002-798-049 and the patient name Chronic, Disease.
- T 0111 Shadow Billing:
A second temporary fee code has been established to track the group visits on a per patient basis. The physician shall "shadow bill" under the patient's Personal Health Number (PHN). There is no dollar value attached to this fee code as it has been established for tracking purposes only. For each patient the physician sees in the group visit a claim is to be completed and submitted to Insured Health Services.

MISCELLANEOUS

- 0115 Complex laboratory or x-ray studies performed by physician when such studies are beyond the scope of a local available support staff (e.g. skull or spine xrays taken by outpost physician) 38.00
- 0117 Interpretation of electrocardiogram by non-internist 4.90
- 0118 Attendance at birth if specifically requested by surgeon for care of baby only 73.30
- 0119 Routine care of newborn in hospital. 73.30
NOTE: If a newborn becomes ill and requires care beyond routine then the physician shall bill routine hospital visits from day of birth and not bill 0119. Physiologic jaundice requiring only phototherapy is considered routine newborn care.
- 0120 Prolonged visit for counselling a complex medical condition 88.00
(minimum time per visit - 20 minutes)
NOTE: Payment agencies will pay up to (6) visits per patient per fiscal year (starting April 01, 2009), will be paid for counselling a complex medical condition and up to three (3) visits per patient per year for counselling related to smoking cessation or weight management.
- 0121 Psychotherapy - up to 30 minutes 66.70
- 0122 Psychotherapy - 31 to 45 minutes 100.50
- 0123 Psychotherapy - over 45 minutes 134.00
- 0124 Nurse Referred G.P. Consultation: 129.70
This fee item is for the referral from an outpost nurse to a Whitehorse physician for in depth consultation. The GP must, by way of return letter, outline the results of a complete history and physical, a tentative diagnosis, all laboratory investigations undertaken, with results if available, and all therapeutic measures advised. In addition the GP should outline several alternatives of treatment to be attempted before re-evacuation for assessment if indicated.
- T 0125 New Patient Program - Pilot Project: 200.00
Payment for accepting patients into practice retroactive to April 01, 2004.
One time payment for each new patient that a family physician accepts into his/her practice.
Completion of New Patient Form with signatures from both the family physician and patient are required for payment. A copy of this form is required with the claim for payment. Payable once for each YHCIP health care number.

GENERAL PRACTICE

	YHCIP and YWCHSB	Anaes Proc. Unit
<p>0126 Stand-By Service: To be paid when a physician is requested to stand-by to possibly provide an immediate service pending the results of another service by another physician (i.e. possible surgical assist pending arthroscopy or gastroscopy results, or possible general anaesthesia pending failed local or regional anaesthetic, etc.). In excess of 2 units will be assessed by the Medical Advisor on the basis of a written report. Per half hour or major portion thereof</p>	38.30	
<p>0129 Cancer Chemotherapy Visit: To include the administration of multiple parenteral chemotherapeutic agents, history and physical examination as necessary to document disease status, counselling of patient and/or family, review of pertinent laboratory and radiologic data, venesection and institution of an intravenous line. This service not to be billed more than once every 28 days (time taken must be in excess of 1 hour).</p>	156.90	
<p>0130 Limited Cancer Chemotherapy Visit: To include the administration of single or multiple parenteral chemotherapeutic agents, history and physical examination as necessary to document disease status, counselling of patient and/or family, review of pertinent laboratory and radiological data, venesection and institution of an intra-venous line. NOTE: This item is not to be billed more than once every 7 days. Neither is it to be billed for routine administration of 5 Flourouracil as a single agent.</p>	78.40	

TELEMEDICINE

YHCIP Anaes
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Physicians should submit billings to Insured Health Services using the telemedicine codes listed below for any conditions requiring preparations of a telemedicine transmission.

In addition to the patient exam a family practitioner may charge an additional equivalency to an office visit if they are actually sending the transmission.

Specialists will be paid the regular major or minor consultation fee (as if the patient were physically present with the specialist.) Consult letter to follow in each instance.

<p>2600 Telemedicine Transmission or Review: For any condition(s) requiring partial or regional examination and history. (2600 to be billed when sending or replying to a telemedicine transmission.)</p>	<p>40.30</p>
<p>2601 Detailed Telemedicine Transmission or Review and Reply: For any condition requiring a complete review of examination and detailed history. NOTE: A complete review of examination shall include complaints, history of the present and past illness, pertinent family history, functional inquiry, differential diagnosis, and provisional diagnosis. A minimum of 20 minutes of the physicians time should be spent for review and reply of transmission.</p>	<p>80.40</p>
<p>2602 Telemedicine Consultation: To include review of history, review applicable x-rays and laboratory findings and a written report. A minimum of 30 minutes of the physicians time should be spent for review and reply of transmission.</p>	<p>130.30</p>
<p>2603 Dermatology Consultation Review and Reply</p>	<p>99.80</p>
<p>2699 In circumstances where an inordinate amount of time is required of any physician in management of a clinical problem utilizing the telemedicine modality, that physician may claim by billing under fee code 2699. A brief explanation should accompany the billing. In the rare event emergency consultations via telemedicine are required, they will be paid as per the current administrative guidelines for premium fees, etc.</p>	<p>.00</p>

ANAESTHESIA PREAMBLE

1. The tariff is for all types of anaesthesia. The fee is for the professional services, including ordering preanaesthetic medication, administering anaesthesia, immediate post-anaesthetic supportive measures to include necessary post-anaesthetic visits and follow-up; but does not include cost of material used.
2. Total anaesthetic fee, the dollar value, is determined by multiplying a unit value of \$30.70 for YHCIP and YWCHSB billings by the number of units applicable. Please note the anaesthesia time units, Fee Codes 1054 and 1063 were adjusted April 1st 2009 to 33.50 per unit.
Units are divided into three categories:
 - a) Anaesthetic evaluation unit
 - b) Procedural fee unit
 - c) Time unit

The anaesthetic evaluation unit compensates for the professional assessment of a patient and will be applied when a pre-operative assessment has been done whether or not an anaesthetic is administered.

The procedural unit is listed opposite many diagnostic and surgical procedures. It is a modifying factor to compensate for the anaesthetic service rendered. When presenting accounts to a payment agency, the code number and description for the diagnostic or surgical fee item should be stated on the claim card.

The time unit compensates for the time involvement in the total anaesthetic service. Anaesthesia time begins when the anaesthetist is first in attendance with the patient for the purpose of creating the anaesthetic state and ends when he/she is no longer in personal attendance (when the patient may be safely placed under customary post-operative supervision). When presenting accounts to a payment agency the time the anaesthetic commenced and the time it ended should be stated on the claim card. One additional unit may be charged at the beginning of each daily slate to allow for in-depth security check on anaesthetic machines.

3. When multiple or bilateral procedures are done during the same anaesthetic, the procedural units shall be the number listed for the procedure carrying the greatest number of units;
e.g. thoracic approach to hiatus hernia repair – procedural units as limited for thoracotomy, i.e. 10.
4. When the following modifying factors are utilized by a Certified Anaesthetist in the administration of an anaesthetic, charge additional for:
 - a) Induced hypothermia
 - b) Controlled hypotension
 - c) Pump oxygenator
 - d) Prone position
 - e) Sitting position for intracranial or vertebral surgery
5. Where unusual detention with the patient before or after anaesthesia is essential for the safety and welfare of such patient, the necessary time will be compensated on the same basis as indicated for the anaesthetic time.
6. Where the attendance of the anaesthetist is requested by the patient's other medical attendants for the sole purpose of monitoring or special supportive care, and where the anaesthetist is in constant attendance, the fee shall be 4 units plus time.

ANAESTHESIA PREAMBLE

7. Anaesthetist's continuous attendance by request at any procedure for possible resuscitation and/or complementary anaesthesia, will be charged for the time of such attendance at the same rate as for administration of anaesthesia for the procedure.
8. Payment of Two Anaesthetists:
Where two anaesthetists are medically required in the interest of the patient both may charge a full fee. When billing a payment agency support need for charges with a written statement.
9. Payment of Anaesthesia when performed by the Surgeons:
When a surgeon is required to administer an anaesthetic in addition to performing a surgical procedure it is recommended that a charge NOT be made for the anaesthesia in addition to the procedure performed. In emergency situations it may be necessary for the surgeon to act as the anaesthetist; a charge for such service should be accompanied by a written explanation of the circumstance by the surgeon concerned when billing payment
10. Anaesthetic Fees Not Included in the Schedule:
Such fees shall be computed in equity with the procedures of similar anaesthetic responsibility, difficulty, and skill. When submitting an account to a payment agency use fee item 1999 and state the reason for the charge.
The foregoing also applies to anaesthetic procedural units for surgical or diagnostic procedures charged under a miscellaneous 999 number (see Clause 8, page 2 of the Preamble).
11. Epidural Anaesthesia for Obstetrics:
 - a) Evaluation unit
 - b) Procedural unit
 - c) Time units

ANAESTHESIA

YHCIP and YWCHSB Anaes Proc. Unit

EMERGENCY VISIT PREMIUM

**Based on time seen by physician*

0250	Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	52.20	
0251	Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays.	143.30	
0252	Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: The above fees to be charged by certified specialist only. Premiums for non-certified anaesthetist are listed under General Practice (fee code 0150, 0151, and 0152)	167.70	
1015	Consultation by a Certified Specialist in Anaesthesia: To include complete history and physical examination for a systemic disturbance which is a threat to life, either by itself or in association with proposed anaesthesia and surgery, review of x-ray and laboratory findings and written report. If followed by an anaesthetic, the consultation is to be charged in addition to the total anaesthetic fee.	30.70	7
1014	Repeat or Limited Consultation: To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant or where in the judgment of the consultant the consultative service does not warrant a full consultative fee.	30.70	4
1017	Assessment and initiation of treatment of a non-anaesthetic complication when such services are requested and a degree of urgency exists	30.70	3
1009	Dental Anaesthesia (certified anaesthetists) (anaesthetic evaluation, extra)	30.70	2
1010	Non-certified Dental anaesthesia (anaesthetic evaluation, extra)	30.70	1+T
1051	Routine anaesthetic evaluation - certified anaesthetist	30.70	3
1025	Complicated Pre-Anaesthetic Check (non-certified): To include complete history and physical examination for systemic disturbance which is a threat to life, either by itself or in association with proposed anaesthesia fee code includes complete exam, history, review of xray and laboratory findings. If the anaesthetic is administered by the same anaesthetist fee code 1052 does not apply.	30.70	3
1052	Non-certified anaesthetist	30.70	2
1053	Procedural fee (units as listed opposite diagnostic or surgical procedure)	30.70	
1054	Time, for each 15 minutes or fraction thereof (Less than 2 hour duration)	33.50	1
1063	Time, 2 hours or more duration for each 10 minutes or fraction thereof	33.50	1
1055	Monitoring or special supportive care (neither anaesthetic evaluation units nor resuscitative care apply) - applies to cadaverous kidney donor	30.70	4+T

MODIFYING FACTORS

1056	Induced hypothermia	30.70	5
1057	Controlled hypotension	30.70	5
1058	Pump oxygenator	30.70	5
1059	Prone position	30.70	1
1064	Patient over 70 years of age	30.70	1
1065	Patient under 1 year of age	30.70	1
1066	Sitting position for intracranial or vertebral surgery	30.70	8
1068	Neonates (under 28 days)	30.70	5

ANAESTHESIA

YHCIP Anaes
and Proc.
YWCHSB Unit

DIAGNOSTIC AND THERAPEUTIC ANAESTHESIA FEE ITEMS

The anaesthetic fee is for professional services (excluding cost of materials). Anaesthetic evaluation units to be charged in addition to procedural units as listed. No time units will be charged, except for Epidurals. Consultations, when requested, will be charged in addition. Nerve block fees are also for diagnostic or therapeutic anaesthetic techniques when surgery is not involved. When surgical, obstetrical or diagnostic procedures are involved the nerve block anaesthetic procedural units do not apply except for Epidurals.

NERVE BLOCKS

Somatic Nerves

1020 Nerve roots (maximum 4 units per sitting) per root	30.70	1
1022 Nerve plexus	30.70	3
1023 Peripheral nerves - (maximum 3 units per sitting) per nerve	30.70	1
1030 Epidural or Caudal Block - lumbar	30.70	5+T
1038 Nerve root and facet blocks - cervical (maximum 12 units per sitting)	30.70	4
1039 Nerve root and facet blocks - thoracic (maximum 9 units per sitting)	30.70	3
1031 Repeat injections of Caudal or Epidural Block (if via previously inserted catheter, anaesthetic evaluation applies to fee code 1030 only) Remuneration of time only payable after 30 minutes. Time spent up to and including 30 minutes is inclusive of anaesthetic	30.70	2
1032 Subdural (spinal) Block	30.70	3
1033 Repeat injections of Subdural (spinal) Block (if via previously inserted catheter, anaesthetic evaluation applies to fee code 1032 only)	30.70	2

Sympathetic Nerves

1036 Thoracic Epidural Block	30.70	6+T
1040 Stellate Ganglion	30.70	2
1042 Paravertebral	30.70	3
1044 Coeliac Ganglion Block	30.70	5
1045 Injection of Alcohol, Phenol, or other Sclerosing Agent into: Nerve Sheath, Plexus, Ganglion	30.70	9

INTRAVENOUS PROCEDURES

Injection intravenously of procaine, vasodilators, curare, decamethonium, or other drugs, for diagnostic or therapeutic indications.

1060 - First injection	30.70	2
1061 - Subsequent injections (anaesthetic evaluation applies to fee code 1060 only)	30.70	2

ANAESTHESIA

YHCIP and YWCHSB Anaes Proc. Unit

RESUSCITATIVE PROCEDURES BY ANAESTHETIST

- (a) When followed by an anaesthetic, include in anaesthetic time.
 (b) When an isolated service, apply fee item 0081.
 (c) Prolonged resuscitation or respiratory control or assistance with or without apnoeic technique (asthmatics, crushed chests, respiratory failure or infection, etc.)
 Anaesthetic evaluation does NOT apply.
 (d) Resuscitative procedures by Anaesthetist to include both ventilator care and By-Level Positive Airway Pressure (BYPAP).

1078 -first day	30.70	6+T
1079 -second and third day	30.70	4+T
1081 - fourth to twenty-first day, per day	30.70	2+T
1083 - twenty-second to forty-second day, per day	30.70	1+T
1085 - seventh to fourteenth week, per day	30.70	3+T
1087 - thereafter, per month	30.70	5+T
1089 Resuscitation of a seriously depressed neonate at the request of the attending physician (anaesthetic evaluation does NOT apply)	30.70	4
1091 Intubation	30.70	5
1092 Awake fibre-optic intubation	30.70	3

ACUTE PAIN MANAGEMENT

1016 Consultation by a certified specialist in anaesthesia for assessment of the patient for chronic pain, to include review of relevant history and physical examination, x-ray and laboratory findings, and a written report	30.70	6
1013 Consultation by a certified specialist in anaesthesia: Assessment of the patient for post operative acute pain management within 24 hours following the end of surgery, to include review of the relevant history and physical examination, x-ray and laboratory findings, and a written report	30.70	4
1011 Follow-up visit for chronic pain control in the office by a certified specialist in anaesthesia	30.70	2
1012 Pain management acute or chronic in the hospital by non-certified anaesthetist (maximum of two visits per day or letter of explanation)	30.70	1.5
1019 Pain management acute or chronic in the hospital by certified anaesthetist (maximum of two visits per day or letter of explanation)	30.70	2.5

DERMATOLOGY

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These fees cannot be correctly interpreted without reference to the Preamble.

REFERRED CASES

0210 Consultation: To include history, and dermatological examination, with review of any previous x-ray and laboratory findings and written report	102.00
0211 Treatment, as under fee code 0216, other than excision, with consultation	28.60
0214 Repeat or Limited Consultation: To apply where a consultation is repeated for the same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee (laboratory test and biopsy, when necessary, extra)	71.20
0215 Dermatological Biopsy	37.50
Continuing Care by Consultant:	
0204 Directive care	28.60
0207 Subsequent office visit	28.60
0208 Subsequent hospital visit	28.60
0209 Subsequent home visit	70.30

EMERGENCY VISIT PREMIUM

**Based on time seen by physician*

0250 Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	52.20
0251 Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	143.30
0252 Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	167.70

SPECIAL EXAMINATIONS

0206 For primary systemic diseases with cutaneous manifestations, to include complete history and physical examination, review of x-ray and laboratory findings, and a written report	236.30
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SPECIAL THERAPY

0216 Forms of treatment other than excision, such as removal of haemangiomas and warts with electrosurgery, cryotherapy initial visit	57.00
0217 - subsequent visit	28.60
0218 Curettage and electrosurgery of skin carcinoma proven histopathologically	165.80
0219 -each additional lesion (maximum charge \$155.80)	82.60

OPHTHALMOLOGY

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* See fee code 2012

REFERRED CASES

2010 Consultation:	127.70
To include history, eye examination, review of previous x-rays and laboratory findings and any or all of measurement for refractive error, ophthalmoscopy, biomicroscopy, tonometry, eye balance test keratometry where indicated and necessary to prepare a written report.	
2011 Repeat or Limited Consultation:	69.90
To apply where a consultation is repeated for the same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	
2012 Special Consultation:	163.90
To apply when an ophthalmologist, neurologist, paediatric neurologist or neurosurgeon refers a patient to an ophthalmologist for special examination, or when an ophthalmologist refers a patient to another ophthalmologist where a decision regarding medical or surgical treatment is complicated and requires extra consideration, judgment and implementation of specialized knowledge and experience. This item should include any or all eye examinations marked with an asterisk when indicated and necessary to prepare a written note.	
NOTE: Where referred for emergency surgery and surgery is performed within 3 days from date consultation is requested - charge fee code 2010	
Continuing Care by Consultant:	
2007 Subsequent office visit	44.70
2008 Subsequent hospital visit	23.40
2009 Subsequent home visit	70.30

EMERGENCY VISIT PREMIUM

**Based on time seen by physician*

0250 Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	52.20
0251 Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	143.30
NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	
0252 Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	167.70

OPHTHALMOLOGY

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EYE EXAMINATIONS

Included in consultation or visit fee when applicable.

NOTE: When two or more examinations are performed by specialist ophthalmologist on the same subsequent visit, the major examination is to be charged in full and the lesser examinations to be charged at 50% UP TO A MAXIMUM OF THREE EXAMINATIONS.

Do not bill professional or technical fee to Insured Health Services. BILL TOTAL FEE ONLY.

2015	Eye examination to include measurement of refractive error, ophthalmoscopy, and any or all biomicroscopy, tonometry, eye balance test, keratometry, where indicated. NOTE: May be charged by non-specialist, or by an Optometrist under the supervision of an Ophthalmologist.	82.00	
* 2020	Ophthalmo-dynamometry	57.70	
2041	Limited visual field examination, ie. tangent screen, autoplot, arc perimeter, or single level automated test such as octopus program 3 or 7 or equivalent - may be billed by Optometrist	57.70	
2639	Ophthalmic ultrasound A scan for determination of axial length (to be billed only if proceeds to lens implant surgery)	92.40	
	Computerized retinal fibre layer photography and neuro-retinal rim assessment (OCT)	90.00	
2068	-Professional fee	30.00	
2069	-technical fee	60.00	
2042	Quantitative perimetry examination: one of: (a) full field manual perimetry such as 2 or 3 isopters on Goldman perimeter or equivalent, with spot checks between isopters and kinetic plotting of scotomata; or (b) limited area manual static threshold perimetry such as 2 or 3 half-meridians at 2 degrees intervals to 30 degrees from fixation or 30 to 50 static threshold points in any arrangement; or (c) automated testing at 2 or 3 threshold related luminance levels (such as OCTOPUS program 33 or 34 or equivalent); or (d) automated testing of periphery only (such as OCTOPUS program 41 or equivalent) NOTE: Item 2042 includes 2041	55.50	
*2017	Oculo-motor function tests	37.50	
*2018	Biomicroscopy (inclusive of visit)	28.10	
*2019	Tonometry	28.10	
*2022	Provocative test for glaucoma	37.50	
2025	Fluorescein angiography of retina with interpretation	186.00	
2026-	professional fee	44.80	
2027-	technical fee	141.20	
*2029	Dynamic Fluorescein Angioscopy	70.30	
2035	Colour vision assessment (anomaloscope, Farnsworth Hue)	70.30	
2036-	professional fee	45.60	
2037-	technical fee	24.90	
*2038	Keratometry	23.40	
2039	Fundus photography (limitations-glaucomatous disc changes, tumor progression and potentially progressive retinal disease) - may be billed by Optometrist	23.40	
2040	Retinoscopy, keratometry, tonometry, indirect funduscopy, fundus photography and prosthetic fitting under general anaesthetic	194.50	3+T
2048	Exophthalmometry	19.30	
2046	Gonioscopy (for one or both eyes)	17.70	
2047	Dacryocystogram	93.60	
2049	Potentiometry	45.20	

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SPECIAL THERAPY

2109	Injections - subconjunctival	42.20	
2075	Botulinum toxin injection for entropion	102.54	

LACRIMAL APPARATUS

2120	Punctum dilation and syringing sac (operation only)	45.40	3+T
2118	Two or three snip procedure	89.10	3+T
2121	Duct probing - under general anaesthesia (operation only)	168.60	3+T
2122	- under local anaesthesia (operation only)	42.20	3+T
2123	Insertion of Quickert tube	200.50	3+T
2129	Insertion of Lester Jones tube	533.30	3+T
2124	Dacryocystostomy -under general anaesthesia (operation only)	147.90	3+T
2119	- under local anaesthesia (operation only)	42.40	
2125	Dacryocystectomy - under local anaesthesia	527.20	3+T
2126	Dacryocystorhinostomy	1054.20	3+T
2127	Repair of canaliculi	682.50	3+T
2128	Surgical excision of lacrimal gland	527.20	3+T

ORBIT

2132	Retrobulbar injection of alcohol	168.50	2+T
2133	Enucleation or evisceration	682.50	4+T
2134	Complicated implant (Allan or Iowa)	844.60	4+T
2136	Exploration and/or biopsy of orbit	421.50	4+T
2137	Exploration and decompression (Kronlein)	1054.20	4+T
2139	- anterior orbital tumor	422.30	4+T
2141	Excision of posterior orbital tumor by anterolateral approach	1339.40	6+T
2143	Lateral orbitotomy with decompression, fat dissection and down-fracture into maxillary sinus	1367.40	4+T

EYE LIDS

2130	Blepharoplasty, simple, non-cosmetic	262.90	3+T
2131	Blepharoplasty, complicated, non-cosmetic	569.20	3+T
2146	Trichiasis - epilation - forceps	42.20	3+T
2147	- electric	45.40	3+T
2148	Cryotherapy of eyelids for trichiasis or tumor	167.30	3+T
2149	Meibomian gland evacuation	42.20	1+T
2150	Chalazion excision	105.50	3+T
2151	Repair of conjunctiva	114.20	1+T
2152	Tarsorrhaphy	234.00	3+T
2153	Ectropion, Entropion, Ziegler or simple procedure	114.20	3+T
2154	- complicated, including neoplasms and plastic repair	632.20	3+T
2155	Ptosis repair - orbicularis sling - using synthetic material	403.75	3+T
2156	Excision of tumors of lid margins or conjunctiva - benign	117.10	3+T
2157	Excision of benign tumor of lids	68.50	3+T
2158	Fasanella Servat	376.30	3+T
2159	- orbicularis sling - using autologous fascia lata	910.40	3+T
2160	- levator resection	910.40	3+T
2166	Lid elevation and scleral graft for lower lid retraction	622.00	3+T
2100	Graded muellerectomy with levator recession under local anaesthesia	622.00	3+T
2107	Repair of eyelid margin defect requiring layered closure	403.75	

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EYE MUSCLES

2161	Strabismus - one or two muscles	702.40	3+T
2162	- three or more muscles	910.40	3+T
2163	- complicated re-operation	1054.20	4+T
2164	- adjustable suture surgery	1054.20	

CORNEA AND SCLERA

2167	Cautery or cryotherapy of corneal ulcer	68.20	3+T
2170	Removal of imbedded corneal foreign body (operation only)	33.20	
2171	Pterygium or limbus tumor excision	227.20	3+T
2172	Gunderson type flap	682.30	3+T
2173	Keratoplasty - lamellar	1312.20	3+T
2175	- penetrating	1581.30	4+T
2168	- Complicated re-operation	1850.60	4+T

NOTE: Fee code 2168, 2173, 2175 includes all suture removals after 42 days

2174	Suture of cornea and/or sclera with or without iridectomy - simple	819.50	4+T
2169	- complicated	1312.20	4+T
2176	Posterior sclerotomy with or without insufflation of anterior chamber	262.90	4+T
2165	Sclerokeratectomy with mucous membrane graft	973.10	4+T
2050	Contact lens bandage unilateral	109.60	
2199	Pterygium excision with mucous membrane graft	500.00	4+T
2200	Complicated pterygium excision (re-operation) of cancer excision, with mucus membrane graft.	600.00	4+T

Note: Record of previous pterygium surgical excision (operative report or referral letter) must be available upon request.

INTRAOCULAR

2181	Foreign body intraocular-magnetic extraction	1054.20	4+T
2182	non-magnetic (including enucleation, if necessary)	1365.60	4+T
2177	Glaucoma - peripheral iridectomy	702.60	4+T
2178	- filtering procedures	936.90	4+T
2179	- combined (complicated)	1054.20	4+T
2180	- goniotomy	843.60	4+T
2183	- repeat within 3 months	682.60	4+T
2184	- cyclodialysis	632.50	4+T
2185	- cyclodiathermy or cryotherapy	549.00	4+T
2186	- repeat within 3 months	262.90	4+T
2187	- microsurgical (trabeculectomy or trabeculotomy)	1054.20	4+T
2189	Iridocyclectomy via scleral flap dissection	1096.50	4+T
2188	Cataract - linear extraction, congenital, traumatic or senile	714.10	4+T
2191	- capsulotomy, needling or discission - initial	422.30	4+T
2193	- subsequent	140.80	4+T
2190	Primary intraocular lens implant to include repositioning of lens within the 42 day post- operative period - extra	229.60	4+T
2192	secondary intraocular lens implant to include repositioning of lens within the 42 day post- operative period	898.20	4+T
2196	Surgical repositioning of implant lens	362.60	4+T

NOTE: For non-surgical repositioning, use visit fees

2197	Surgical evacuation of hyphema	975.90	4+T
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2198	Anterior vitrectomy NOTE: fee code 2198 is intended for cases of vast complication requiring removal of membranes from the anterior segment as a result of prior surgery or injury. It is not intended in conjunction with elective cataract removal and/or primary lens implantation.	560.40	4+T
2090	Vitreous paracentesis	280.50	4+T
2091	Anterior chamber paracentesis	233.40	4+T
2092	Vitreous biopsy	373.70	4+T

RETINAL DETACHMENT

2195	Diathermy or cryopexy	910.40	5+T
2194	Buckling procedure NOTE: Repeat procedures full fee	1581.60	5+T

PHOTOCOAGULATION OR CRYOPEXY FOR TREATMENT OF OCULAR PROBLEMS OTHER THAN RETINAL DETACHMENT USING PORTABLE YAG LASER

2114	Yag laser, per eye - professional fee	255.40	
2115	Yag laser, per eye - technical fee	160.70	
2116	Panretinal photocoagulation - defined as greater than 700 burns (Maximum fee for one eye for any 6 month period)	1360.80	4+T
2117	Photocoagulation of second eye during course of treatment of first eye	365.80	4+T

OPTOMETRY

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These fees cannot be correctly interpreted without reference to the Preamble
Note: These fees have been established in the absence of a resident Ophthalmologist.

EYE TESTING

These fees are only billable by an Optometrist

Emergency Visit Premium

The Hospital Visit premium is to be charged in addition to fee guide fees.

Please note the fee is for consultation purposes only and is not intended to include the transfer of care

0253	Daytime (0800-1759)	30.50
0254	Evening (1800-2259) Note: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays.	83.50
0255	Night (2300-0759) premiums to be charged when one must leave home, office or hospital to render urgent or emergency care.	97.70
2215	Problem based eye testing that may include <u>measurement</u> of refractive error, ophthalmoscopy, and any or all biomicroscopy, tonometry, eye balance test, keratometry where indicated. NOTE: This fee is billable for medically required testing including ocular disease, trauma or injury; systemic diseases associated with significant ocular risk including but not limited to diabetes, wet macular degeneration and glaucoma; and medications associated with significant risk.	105.00
2217	Surgical follow up	75.00
2218	Dilated Fundus Examination	45.00
2219	Non surgical follow up	75.00
2019	Tonometry	28.10
2041	Limited visual field examination .i.e. tangent screen, autoplot, arc perimeter, or single level automated test such as octopus program 3 or 7 equivalent	57.70
2039	Fundus photography (limitations - glaucomatous disc changes, tumor progression and potentially progressive retinal disease)	23.40
	Computerized retinal fibre layer photography and neuro-retinal rim assessment (OCT)	90.00
2068	Professional fee	30.00
2069	technical fee	60.00

OTOLARYNGOLOGY

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REFERRED CASES

2510	Consultation: To include history, detailed examination of the ear, nose and throat, review of x-ray and laboratory findings and written report	89.10
2511	Consultation including Audiogram (AC and BC), when performed in conjunction with consultation	112.90
2514	Repeat or Limited Consultation: To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	70.30
Continuing Care by Consultant:		
2507	Subsequent office visit	23.40
2508	Subsequent hospital visit	23.40
2509	Subsequent home visit	70.30

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250	Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	52.20
0251	Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	143.30
0252	Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	167.70

SPECIAL EXAMINATIONS

The following fees, except for fee codes 9520 and 2521, apply when these special otolaryngological examinations are carried out by/or under the supervision of a certified otolaryngologist.

NOTE: When two or more special examinations are performed by a specialist otolaryngologist on the same subsequent visit, the major examination is to be charged in full and the lesser examinations to be charged at 50% UP TO A MAXIMUM OF THREE EXAMINATIONS, (not to include an audiogram (AB or BC) if done as part of a consultation). No charge will be made for an office visit in addition to these special examinations when examination is done as an adjunct to a consultation.

Hearing Tests

9520	Audiogram - pure tone (AC and BC)	32.50
2521	Audiogram - speech (SRT, PB, MCL)	32.50
2522	Audiogram - SISI	32.50
2523	Audiogram - tone decay	32.50
9525	Tympanogram (Impedance test)	32.50
2531	Impedance test, including contralateral reflex	46.80
2533	Play audiometry	46.80
2534	Free field audiometry	46.80
2536	Brain stem evoked response audiometry	100.90

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Vestibular Tests

2526 Cold Calorics Test	23.40	
2527 Bithermal Test	46.80	
2528 E.N.G. (Electronystagmography)	94.10	

NOTE: To control the total cost involved in extensive patient investigation the following recommendation applies: Vestibular tests performed on a subsequent visit should have a maximum fee limitation equal to the value of fee code 2528 to be paid directly in lieu of return visit.

Functional Tests:

2529 Lombard	32.50	
2530 Stenger	46.80	
2537 Alternate binaural loudness balance test	34.20	

Miscellaneous Tests:

2535 Maxillary Sinus Endoscopy via canine fossa, with or without biopsy	177.10	3+T
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EAR

Removal of foreign body or aerating tubes from ear - simple	per visit	
2201- requiring general anaesthetic (operation only)	116.90	1+T
2208 Mastoid antrotomy (infants)	472.40	3+T
2206 Removal of ear canal osteoma (operation only)	116.90	1+T
2209 Removal of obstructing exostosis of ear canal	702.60	3+T
2210 Paracentesis of the ear drum (operation only)	70.30	1+T
2220 Removal of aural polyp (operation only)	116.90	1+T
2232 Facial nerve decompression involving vertical portion only	1170.90	4+T
2240 Labyrinthectomy - destructive (any type)	702.60	4+T
2243 Repair bony atresia external ear canal - complete atresia	1405.70	3+T
2244 - partial atresia	702.60	3+T
2247 Simple mastoidectomy	702.60	3+T
2248 Radical mastoidectomy	1138.70	4+T
2249 Stapes - reconstruction	1024.50	3+T
2250 Stapes - mobilization of	702.60	3+T
2251 Myringoplasty repair of drum without exploration of middle ear	351.70	3+T
2252 Tympanoplasty - without ossicular chain reconstruction (repair of ear drum as well as inspection of middle ear by means of a tympanotomy)	820.30	3+T
2264 - with ossicular chain reconstruction	938.60	3+T
2253 - with complete exenteration	1407.90	3+T
2265 - with partial mastoid exenteration	1054.20	3+T
2263 Trans-tympanic polyneurectomy	702.60	3+T
2257 Homograft tympanic membrane - tympanoplasty	1326.10	3+T
2254 Myringotomy with insertion of aerating tube (operation only)	116.90	1+T
2255 Exploratory tympanotomy	455.30	2+T
2266 Paper patch application to TM perforation	71.90	1+T
2256 Subarachnoid endolymphatic shunt (any procedure)	1407.90	6+T
2259 Excision of glomus by tympanotomy approach	938.60	3+T
2260 Excision of glomus (where extensive dissection is required)	1407.90	4+T
2267 Conchal cartilage graft	820.30	3+T

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NOSE AND SINUS

	Removal of foreign body from nose - simple	per visit	
2298	Cryosurgical treatments of turbinates- unilateral	248.60	3+T
2299	Cryosurgical treatments of turbinates- bilateral	340.70	3+T
2301	- Complicated with anaesthetic	116.90	2+T
2303	Cauterization of septum - electric	46.80	3+T
2304	Turbinectomy - unilateral	159.70	3+T
2305	- bilateral	239.50	3+T
2306	Submucous resection of septum	469.60	3+T
2307	Nasal antral window - single	237.60	3+T
2308	- double	340.70	3+T
2309	Radical antrostomy	682.00	3+T
2310	- with closure of alveolar fistula	910.40	4+T
2311	Intranasal ethmoidectomy to include polypectomy - complete one side	682.00	3+T
2312	- complete two sides	910.40	3+T
2313	Partial ethmoidectomy to include polypectomy - anterior and middle	344.60	3+T
2314	- bilateral	453.80	3+T
2315	External radical fronto-ethmoidectomy	1022.70	4+T
2316	External radical frontal operation	910.40	3+T
2317	Electrocoagulation of turbinates - one side	94.10	3+T
2318	- both sides	140.80	3+T
2319	Trephining frontal sinus	351.50	3+T
2320	Sphenoidectomy (intranasal)	469.60	3+T
2322	Removal of nasal polypi - unilateral	163.90	3+T
2323	- bilateral	246.00	3+T
2324	Antral lavage - unilateral	35.20	3+T
2325	- bilateral Choanal atresia - definitive repair of	52.90	3+T
2326	- unilateral	702.40	3+T
2327	- bilateral Choanal atresia - perforation of	1054.20	4+T
2328	- unilateral	234.30	3+T
2329	- bilateral	350.40	4+T
2330	Submucous turbinectomy - unilateral	234.30	3+T
2331	- bilateral	350.40	3+T
	Lateral rhinotomy and excision of tumour		
2332	- benign	819.50	3+T
2333	- malignant	1054.20	3+T
2334	Transantral ethmoidectomy	938.60	3+T
2335	Transantral ligation, internal maxillary artery	819.50	6+T
2337	Ligation of anterior and posterior ethmoid arteries	585.10	6+T
2338	Removal of angiofibroma - nasal pharynx	1407.90	6+T
2342	Maxillectomy with exenteration of ethmoid	1407.90	5+T
2339	Palatal fenestration	469.60	3+T
2343	Septal reconstruction	703.70	3+T
2344	Posterior nasal packing (operation only)	117.30	3+T
2345	Drainage of abscess or haematoma of septum (operation only)	117.30	3+T
6121	Nasal fracture - simple reduction	117.30	3+T
6122	- reduction and external splinting	234.30	3+T
6123	- comminuted nasal fractures - transosseous wire plate fixation	469.60	3+T
2348	Operative closure of oral nasal fistula	703.70	3+T
2349	Operative closure of nasal septal perforation	703.70	3+T

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RHINOPLASTY

2350	Removal of hump	350.40	3+T
2351	Nasal refracture requiring lateral osteotomies	703.70	3+T
2352	Reconstruction of nasal tip, ala and columella	819.50	3+T
2354	Complete rhinoplasty with SMR to include nasal hump removal, nasal refracture and reconstruction of nasal tip without skin grafting	1173.20	3+T

THROAT

2400	Incision of peritonsillar abscess (operation only)	70.30	4+T
2401	Tonsils and adenoids - child (to include neonate)	234.30	4+T
2402	- adult	328.30	4+T
2403	Tonsillectomy under local anaesthesia	350.40	4+T
2404	Adenoidectomy - office visits extra, apart from usual one pre and one post-operative visit	117.30	4+T
2405	Retropharyngeal abscess	117.30	4+T
2406	- requiring lateral pharyngotomy	469.60	4+T
2407	Tracheostomy (operation only)	301.30	5+T
2408	Removal of tumor from larynx or trachea	453.80	5+T
2409	Uvulo-palato-pharyngoplasty for severe obstructive sleep apnea confirmed by polysomnogram, with or without tonsillectomy	568.40	5+T
2412	Biopsy of larynx and/or cauterization (including laryngoscopy)	234.30	5+T
2413	Operative control of post-tonsillectomy or post-adenoidectomy hemorrhage requiring local or general anaesthetic	187.80	6+T
2415	Esophagoscopy with removal of foreign body	328.30	3+T
2416	Dilation of oesophagus	117.30	2+T
2417	- repeat within one month	70.30	2+T
2420	Dilation of trachea	117.30	5+T
2421	- repeat within one month	70.30	5+T
2422	Tracheostomy Tube Change (operation only) to be billed in addition to office visit	13.80	
2425	Arytenoidectomy	938.60	5+T
2426	Bronchoscopy with removal of foreign body	569.20	6+T
2427	Microlaryngoscopy	140.80	5+T
2428	Microlaryngoscopy with biopsy of larynx and/or cauterization	305.10	5+T
2429	Microlaryngoscopy and removal of tumor from larynx or trachea	522.50	5+T
2433	Vocal cord implant - injection	585.10	5+T
2434	- external approach	1054.70	5+T
2438	rans-oral cricopharyngeal myotomy	782.10	5+T

INTERNAL MEDICINE

YHCIP
and
YWCHSB Anaes
Proc.
Unit

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

0310	Consultation: To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report	236.30
0312	Repeat or Limited Consultation: Where a consultation for same illness is repeated within six (6) months of the last visit by the consultant or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	117.90
0314	Prolonged visit for counselling (maximum four (4) per year applies to Insured Health Services and YWCHSB only)	84.40
Continuing Care by Consultant		
0306	Directive care	46.80
0307	Subsequent office visit	46.80
0308	Subsequent hospital visit	36.10
0309	Subsequent home visit	70.30

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250	Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	52.20
0251	Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	143.30
0252	Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	167.70

EXAMINATIONS BY CERTIFIED INTERNIST

9316	Electrocardiogram and interpretation- in office by internist - each	46.70	
9317	Electrocardiogram and interpretation - in home by internist - each	71.30	
0318	Electrocardiogram - professional fee	23.40	
9401	- technical fee	29.80	
0322	Internists' part in cardioangiogram, per hour or fraction thereof	94.10	
0325	Cardioversion NOTE: The procedural fee does not include the consultation fee or follow-up daily visits. If more than one cardioversion is performed on any patient in a single day, this is to be treated as a special case and a written report should accompany the account	165.90	6+T
Single Chamber permanent programmable pacemaker testing			
0326	- professional fee	49.50	
0353	- technical fee	24.80	
Dual Chamber permanent programmable pacemaker testing			
0328	- professional fee	74.40	
0354	- technical fee	49.50	

INTERNAL MEDICINE

	YHCIP and YWCHSB	Anaes Proc. Unit
Polarcardiography and interpretation		
0327 - professional fee	79.40	
9427 - technical fee	85.40	
0330 Temporary right ventricular pacemaker catheter placement, using external battery pack (internist or other qualified physicians)	331.60	4+T
0332 Pacemaker standby and/or placement of the endocardial catheter	165.90	4+T
0333 Generator placement and venous cutdown	544.10	4+T
0334 Graded exercise test (performance and interpretation)	142.30	
0335 - professional fee	91.50	
0336 - technical fee	50.70	
<p>NOTE: This test involves controlled graduated exercise levels by the use of either a bicycle or treadmill ergometer with continuous electrocardiographic monitoring during and after exercise. At least two exercise work levels must be measured, exclusive of a warm-up period, and reproducible exercise and post-exercise records must be obtained. When only one level of exercise testing is performed, then the same fee as for a Master Two-Step should apply.</p>		
<p>When a 23 lead cardiogram is done on the same day as the graded exercise test, it is included in fee code 0334. A graded exercise tolerance test may be repeated once within one year to assess functional capacity of patient after recovery from coronary by-pass surgery and to assess the affect of therapy where exercise has produced a serious ventricular rhythm disturbance.</p>		
<p>In all other circumstances, where graded exercise tests are repeated within one year a letter of explanation for the need will accompany the account to the payment agency except in conjunction with thallium myocardial scans where a graded exercise test may be performed and charged with each scan.</p>		
0337 Replacement transfusion - hepatic failure to include two weeks care after transfusion NOTE: Consultation and necessary hospital visits prior to initial transfusion, extra	591.10	
0338 Plasmapheresis - therapeutic	234.30	
0340 Scanning of 8 hour electrocardiogram	140.80	
0341 - professional fee	90.60	
0342 - technical fee	50.20	
0343 Cardiac Screening (maximum 3 a month within manufacturer's guarantee and one a week beyond manufacturer's guarantee)	9.60	
0344 - professional fee	4.60	
0345 - technical fee	4.60	

INTERNAL MEDICINE

	YHCIP and YWCHSB	Anaes Proc. Unit
Scanning of 24 hour electrocardiogram		
0347 - professional fee	138.50	
0348 - technical fee for ECG	52.20	
0349 - technical fee for scanning	93.90	
Level I: Requires a recorder capable of recording all beats and transmitting this information to a scanner which is capable of analyzing and printing every beat and also performing edited trend analysis, and/or edited graphic or alpha-numeric hourly summary of data		
0363 Level II: Requires a recorder capable of recording all beats and transmitting this information to a scanner which is capable of analyzing and printing every beat and also performing unedited trend analysis, and/or unedited graphic or alpha-numeric hourly summary of data	70.60	
0364 Level III: Requires a recorder capable of recording only a portion of each minute, or a pre-determined time period after an abnormal complex is sensed The scanner of this record is capable of analyzing the data and printing all beats in the pre-determined time period and analyzing the ST segment, heart rate and ectopic beat frequency	46.80	
0365 Level IIII: a) Requires a recorder capable of recording beats for only a portion of a minute and feeding this information into a scanner through an adaptor that feeds the information to the standard ECG machine b) Requires a recorder capable of recording all beats and feeding the information into an alpha-numeric device which prints an hourly maximum R-R intervals, premature beats, and ventricular complexes of abnormal width	23.50	
0372 Measurement of Bone Mineral content in vivo using photon absorptiometry Intracardiac Electrophysiological Mapping	79.70	
0366 - initial study	1343.60	
0367 - restudy	269.20	
0368 Esophageal or intra-atrial electrophysiological study	201.10	
Chemotherapy		
0382 Cancer Chemotherapy visit: To include the administration of multiple parenteral chemotherapeutic agents, history and physical examination as necessary to document disease status, counselling of patient and/or family, review of pertinent laboratory and radiologic data, venesection and institution of an intravenous line. This service will not be billed more than once every twenty-eight days (time taken must be in excess of 1 hour).	160.80	
0383 Limited Cancer Chemotherapy visit: To include the administration of single or multiple parenteral chemotherapeutic agents, history and physical examination as necessary to document disease status, counselling patient and/or family, review of pertinent laboratory and radiologic data, venesection and institution of an intravenous line. NOTE: This item is not to be billed more than once every seven days. Neither is it to be billed for routine administration of 5-fluorouracil as a single agent.	80.30	

RHEUMATOLOGY

YHCIP
and
YWCHSB Anaes
Proc.
Unit

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

3310	Consultation: To consist of examination, review of history, laboratory, x-ray findings and additional visit necessary to render a written report	244.30
3312	Repeat Limited Consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgement of the consultant, the consultative services do not warrant a full consultative fee	122.40
3314	Prolonged visit for counselling	87.20
Continuing Care By Consultant		
3307	Subsequent office visit	48.50

NEUROLOGY

YHCIP
and
YWCHSB Anaes
Proc.
Unit

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

0410	Consultation: To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report	236.30
0411	Repeat or Limited Consultation: Where a consultation for the same illness is repeated within six (6) months of the last service by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	118.10
Continuing Care by Consultant:		
0406	Directive care	46.80
0407	Subsequent office visit	46.80
0408	Subsequent hospital visit	35.80
0409	Subsequent home visit	70.30

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250	Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	52.20
0251	Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hour of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	143.30
0252	Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	167.70

BOTULINUM TOXIN INJECTIONS

**These fees are only billable by Neurologist*

0473	Botulinum Toxin Injection for Blepharospasm associated with dystonia (including benign essential blepharospasm) or VII nerve disorders -unilateral or bilateral	192.90
0424	Botulinum Toxin Injection only applicable to Cervical Dystonia (spasmodic torticollis); adductor spasmodic dysphonia, jaw-closing oro-mandibular dystonia or hemifacial spasm, dynamic equines foot deformity due to spasticity in paediatric cerebral palsy patients, focal spasticity including the treatment of upper limb spasticity associated with strokes in adults	225.20

NEUROSURGERY

YHCIP
and
YWCHSB Anaes
Proc.
Unit

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

3010	Consultation: To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report	140.80	
3011	Repeat or Limited Consultation: Where a consultation for the same illness is repeated within six (6) months of the last service by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	70.30	
Continuing Care by Consultant:			
3007	Subsequent office visit	23.40	
3008	Subsequent hospital visit	35.20	
3009	Subsequent home visit	70.30	

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250	Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	52.20	
0251	Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	143.30	
0252	Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	167.70	

CRANIAL NERVES

3101	Supra or intra orbital nerve avulsion	161.10	3+T
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TRAUMA

3111	Elevation of simple depressed skull fracture	898.40	5+T
3112	Elevation of compound depressed skull fracture	1476.70	6+T
3113	Elevation of compound depressed skull fracture with repair of dura, debridement of cerebral laceration and sinuses	1639.30	6+T
3115	Exploration of subdural space for chronic subdural hematoma - unilateral or bilateral	1054.20	6+T
3116	Craniotomy for evacuation of intracranial hematoma (cerebral sub-dural, extradural or abscess)	1725.80	8+T
3118	Craniotomy for repair of CSF leak	1642.50	8+T
3119	Craniotomy for microvascular decompression of cranial nerve	2107.70	8+T

CEREBRAL PROCEDURES

3126	Re-opening or removal of bone flap	674.10	6+T
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EXTRA-CRANIAL VASCULAR PROCEDURES

7237	Carotid endarterectomy	1251.60	8+T
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NEUROSURGERY

YHCIP
and
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Unit

SPINAL

3165	Insertion of intracranial pressure monitoring device (operation only)	482.90	6+T
3167	Insertion of skull tongs (operation only)	234.30	4+T
3173	-in conjunction with orthopaedic surgeon (operation only)	1047.90	6+T

PERIPHERAL NERVE

3191	Minor, digital, primary suture or secondary	350.40	2+T
3192	Repair of palmar nerve	350.40	2+T
3193	Major, primary suture	703.70	2+T
3195	Exploration of peripheral nerve and neurolysis	469.60	2+T
3196	Exploration, mobilization and transposition	579.10	2+T
3198	Neurectomy of major nerve	350.40	2+T
3200	Secondary suture including transposition	938.60	3+T
3201	Secondary suture of major nerve	813.60	3+T
3204	Hypoglossal facial anastomosis	813.60	4+T
3205	Nerve graft	703.70	3+T
7751	Cervical or dorsal sympathectomy	860.40	5+T
7753	Lumbo-dorsal sympathectomy and splanchnic neurectomy - unilateral	860.40	7+T

MISCELLANEOUS

3211	Muscle biopsy	117.30	
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OBSTETRICS AND GYNAECOLOGY

YHCIP
and
YWCHSB Anaes
Proc.
Unit

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

4010 Consultation:	165.90
To include complete history and gynaecological examination, review of x-ray and laboratory findings, if required, and written report or consultation during labour	
4012 Repeat or Limited Consultation:	76.70
To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	
Continuing Care by Consultant:	
4007 Subsequent office visit	50.30
4008 Subsequent hospital visit	46.40
4009 Subsequent home visit	76.70

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250 Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	52.20
0251 Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	143.30
0252 Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	167.70

OBSTETRICAL PROCEDURES

4020 Emergency obstetric consultation including complicated vaginal surgery	353.20	4+T
4021 Emergency obstetric consultation including complicated delivery NOTE: This is the maximum fee for emergency obstetric consultation	546.60	4+T
4022 Repair of complete separation of external sphincter (operation only) (Third degree tear)	186.10	3+T
4023 Repair of extensive cervical and/or vaginal lacerations (operation only)	186.10	3+T
4090 Prenatal visit - complete examination This fee is billable once by each physician who renders the service to the same patient	88.50	
4091 - subsequent examination	41.10	
4092 Initial Pregnancy Counselling minimum time per visit 20 mins This fee is billable by one or more physicians to a maximum of three times per patient.	90.20	
4100 Extraordinary events during labor maternal (eg. fetal distress, antepartum hemorrhage, fever) where immediate assessment of the patient by the physician is required and the physician is specifically called by the nurse. This is not to be billed for routine monitoring of the laboring patient and must include call back time.	41.10	
4108 Delivery only (50% extra for each additional neonate delivery) NOTE: For consideration of premiums, the time of delivery shall be the time of the birth of the newborn	636.10	
4109 Post-natal care of mother in hospital	94.30	
4110 Six weeks post-partum check of mother plus pap smear NOTE: (If IUD is inserted, 50% of fee code 4540 may be charged in addition)	78.00	

OBSTETRICS AND GYNAECOLOGY

	YHCIP and YWCHSB	Anaes Proc. Unit
4105 Caesarean section	706.30	5+T
4106 Caesarean hysterectomy	797.30	8+T
4111 Therapeutic abortion (vaginal) - by whatever means - less than 12 weeks gestation (operation only)	234.30	1+T
4112 - 12 weeks gestation or over	453.80	1+T
4113 Obstetrical assist - to be billed in complicated delivery by the family physician who supervised the labour when the neonate was delivered by a consultant. *This shall cover the first stage and 2 hours of the second stage of labour	491.10	
4117 Curettage for post-partum hemorrhage or retained placenta	234.00	3+T
4118 Induction or stimulation of labour by oxytocin intravenous drip, where constant attendance by the physician in attendance is required - per half hour; maximum 10 hours	95.50	
4119 Inpatient or outpatient insertion of prostaglandin vaginal gel for ripening and/or induction of labor	41.10	
4120 External cephalic version	60.40	
4199 MANAGEMENT OF PROLONGED SECOND STAGE: This item is billable in addition to fee code 4108 or 4113 after the second stage of labour exceeds 2 hours (may begin at transitional stage of 8 cm). The physician must be in personal attendance for duration of second stage. Both start and end time is required on the claim submission. In excess of 2 units will be assessed by the Medical Advisor on the basis of a written report. Per half hour or major portion thereof	95.50	
4299 MANAGEMENT OF PROLONGED THIRD STAGE: This item is billable after the third stage exceeds 45 minutes for such reasons as postpartum hemorrhage, manual removal of retained placenta or extensive vaginal laceration. It is not payable if fee code 4022, 4023 or 4428 is billed. The physician must be in personal attendance for the duration of the third stage. Both start and end time is required on the claim submission. In excess of 2 units will be assessed by the Medical Advisor on the basis of a written report. Per half hour or major portion thereof	95.50	
4399 Obstetrical Case management Fee Billable in addition to visit fees, procedural fees and time premiums. This item may be billed only once per obstetrical case by the patients primary care physician who remains available for the purpose of labour and delivery.	850.00	

ABDOMINAL OPERATIONS

4200 Hysterectomy - subtotal	819.70	5+T
4201 - total	938.60	5+T
4202 - vaginal	938.60	4+T
4203 - Myomectomy	703.60	5+T
4204 Abdominal hysterotomy with or without sterilization	703.60	5+T
4205 Removal of ectopic pregnancy, abdominal or vaginal route	703.60	5+T
4206 Suspension of uterus	585.10	4+T
4207 Removal of ovarian cysts and/or salpingectomy	585.10	5+T
4208 Removal of complicated pelvic disease	1173.20	6+T
4209 Abdominal excision of cervical stump	938.60	3+T
4213 Sterilization by abdominal or vaginal route	453.80	4+T
4214 Tuboplasty for infertility, including microsurgical salpingo-ovariolysis (unilateral or bilateral) NOTE: not payable following previous surgical sterilization and should not be billed to the payment agency	819.70	5+T
4215 Wedge resection of ovaries	703.60	5+T
4217 Post-operative hemorrhage (intra-abdominal management)	469.60	6+T

OBSTETRICS AND GYNAECOLOGY

YHCIP
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YWCHSB Anaes
Proc.
Unit

OPERATIONS ON THE VULVA

4300	Incision of hymen (operation only)	70.30	1+T
4301	Excision or marsupialization of a Bartholin's cyst	234.30	1+T
4302	Incision and drainage of Bartholin's abscess (operation only)	70.30	1+T
4303	Excision of hydrocele or canal of Nuck	350.40	1+T
4304	Urethral caruncle - cautery or excision in hospital	117.30	1+T
4305	Venereal warts, cautery or excision (not for application of phodophyllin) (operation only)	46.80	
4306	Excision of venereal warts under general anaesthesia in hospital	234.30	1+T
4309	Varicocele of labium	234.30	1+T
4312	Resection of labia minora	234.30	1+T
4315	Biopsy of vulva	70.30	1+T

OPERATIONS ON THE VAGINA

4401	Repair of recto-vaginal fistula	938.10	3+T
4403	Colpotomy - open	117.30	1+T
4402	Colpotomy with drainage pelvic abscess	234.30	1+T
4404	Removal of vaginal inclusion cyst	70.30	1+T
4405	Removal of other vaginal cyst	350.40	1+T
4406	Operation for removal of vaginal septum	234.30	1+T
4408	Vault prolapse following hysterectomy	938.60	4+T
4409	Excision of cervical stump with anterior and posterior repair	819.70	3+T
4410	Post-operative hemorrhage - vaginal management requiring anaesthesia	234.30	5+T

PLASTIC OPERATIONS OF GENITAL PROLAPSE

4420	Repair of cystocele	585.10	2+T
4421	Repair of rectocele	585.10	2+T
4422	Repair of enterocele	819.70	2+T
4423	Repair of cystocele and rectocele combined	819.70	2+T
4425	Vaginal hysterectomy with complete repair	1289.10	4+T
4426	Repair of cystocele or rectocele with abdominal hysterectomy or laparotomy	1289.10	4+T
4427	LeFort's operation	585.10	2+T
4428	Primary repair of fourth degree perineal laceration	223.20	2+T
4429	Repair of old third degree perineal laceration	703.60	2+T
4432	Repeat vaginal plastic procedure (additional fee)	234.30	2+T
4431	Retropubic operation for urinary incontinence (Burch Procedure)	819.70	2+T

VAGINAL OPERATIONS ON THE CERVIX AND UTERUS

4500	Dilation of cervix and curettage (prenatal and pre-operative visits extra)	187.80	1+T
4502	Repair of cervix	234.30	1+T
4503	Cryosurgery of cervix	190.70	1+T
4505	Removal of cervical polyp in office	46.80	
4506	Removal of cervical polyp with dilation and curettage (pre-operative visits extra)	187.80	1+T
4508	Biopsy of cervix under general anaesthesia	117.30	1+T
4510	Biopsy of cervix with dilation and curettage - total (pre-operative visits extra)	187.80	1+T
4513	Vaginal repair of vesico-vaginal fistula	938.10	3+T
4514	Repair of incompetent cervical os	469.60	2+T
4515	Removal of buried cervical ligature under anaesthesia	117.30	2+T
4218	Hysteroscopic endometrial resection and ablation	451.70	2+T

OBSTETRICS AND GYNAECOLOGY

	YHCIP and YWCHSB	Anaes Proc. Unit
4528 Laparoscopic excision of endometriosis to include transection of uterosacral liagaments This fee is not to be billed in addition to fee code 4529	453.80	4+T
4529 Cauterization of endometriosis at laparoscopy or laparotomy	70.30	
4530 Cauterization of cervix under general anaesthesia	94.10	1+T
4531 Cauterization of cervix with dilation and curettage (pre-operative visits extra)	187.80	1+T
4533 Electric cauterization of cervix in office	36.60	
4536 Dilation and curettage with cone biopsy of cervix for abnormal cytology under general anaesthesia	328.30	2+T
4540 Insertion of intrauterine contraceptive device (IUD) or Laminaria tent(s) (operation only)	41.60	1+T
4541 Retrieval of lost or retained IUD via intrauterine hook, curettage or forceps (operation only)	68.00	
4545 Artificial insemination (operation only)	70.30	
4550 Vaginal removal of cervical stump - open peritoneum	469.60	3+T

MISCELLANEOUS

4610 Obstetric/Gynaecology ultrasound (professional fee) (assessment of multi-gestation can be billed at 50% for each additional fetus)	76.70	
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ORTHOPAEDICS

YHCIP
and
YWCHSB Anaes
Proc.
Unit

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

5010	Consultation: (In office or hospital) To include a history and physical examination, review of x-ray and laboratory findings, and a written report	128.10
5012	Repeat or Limited Consultation: To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	70.30
5015	Orthopaedic special consultation: Extended consult for complex problems (ie., oncology, complex trauma, adult cerebral palsy etc.), when requested by another Orthopaedic Surgeon, Neurosurgeon, Plastic Surgeon or Rehabilitation Physician. Includes history, physical examination, review of x-rays and written report	256.50
Continuing Care by Consultant:		
5007	Subsequent office visit	36.60
5008	Subsequent hospital visit	23.40
5009	Subsequent home visit	70.30

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250	Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	52.20
0251	Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	143.30
0252	Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	167.70

FRACTURES

Upper Extremity

	Per Visit	Per Visit
Finger phalanx or metacarpal - not requiring reduction		
5201 Finger phalanx, requiring reduction	187.70	1+T
5203 Metacarpal, requiring reduction	187.70	1+T
5225 Distal phalanges - open reduction and wiring - first	350.40	2+T
5226 - each additional (extra)	187.70	2+T
5227 Other than distal phalanges - open reduction and wiring - first	585.10	2+T
5228 - each additional (extra)	281.60	2+T
5229 Crush injury of hand with multiple fractures - closed reduction	350.40	2+T
5206 - open reduction NOTE: To include wiring if applicable	585.10	2+T
5205 Base of 1st metacarpal (Bennett's)	281.60	2+T
5207 Scaphoid (intra-articular)	344.00	2+T
5209 Radius and/or ulna at wrist - requiring reduction	303.40	2+T
5210 - greenstick requiring reduction	162.70	1+T
5211 Radius or ulna shaft, closed reduction	281.60	2+T
5212 Radius and ulna shaft, complete displacement requiring closed reduction	585.10	2+T
5213 Head of radius - closed reduction	234.30	2+T
5214 Resection head of radius	469.60	2+T

ORTHOPAEDICS

	YHCIP and YWCHSB	Anaes Proc. Unit
5215 Olecranon - closed reduction	234.30	2+T
5216 Olecranon and humeral epicondyles	350.40	2+T
5217 Humerus shaft - requiring reduction	350.40	2+T
5219 - open reduction	350.40	2+T
5220 Supracondylar (humerus)	585.10	2+T
5221 Surgical neck of humerus - requiring reduction	350.40	2+T
5222 Clavicle - child	.00	
5224 - adult	187.70	1+T
5223 - open reduction	281.60	2+T
5231 Intercondylar (humerus)	819.60	2+T
5232 Intercondylar (humerus) - not requiring reduction	585.10	
Chest		
Sternum		
Ribs - single or multiple		
Spine		
5233 Spine - non-operative management of unstable fracture	703.60	4+T
5230 Coccyx - operative	281.60	4+T
Pelvis		
5235 Simple - without displacement	.00	
5236 Non-operative management of unstable and complicated fracture	703.60	4+T
Lower Extremity		
5238 Femur	469.60	4+T
- neck or intertrochanteric (including slipped epiphysis)		
- closed reduction with fixation		
5239 Femur - neck or intertrochanteric-operative	1173.20	5+T
5240 Femur - shaft or supracondylar	350.40	4+T
- closed reduction with or without anaesthetic		
- infant		
5241 - child	585.10	4+T
5242 - adult	819.60	2+T
5243 Femur - shaft - open reduction	1173.20	5+T
5249 - supracondylar - open reduction	1173.20	5+T
5246 Vastus medialis advancement	469.60	4+T
5247 Patella - simple - closed reduction	234.30	2+T
5248 - excision or open reduction, including wiring	469.60	2+T
5250 Stapling of proximal tibial and distal femoral epiphyses	819.70	2+T
5251 Tibial condyles - (plateau) not requiring reduction	234.30	
5252 - (plateau) requiring reduction	469.60	2+T
5253 Tibia shaft closed reduction	585.10	2+T
5244 - open reduction	938.60	3+T
5254 Tibia - medial malleolus	234.30	2+T
5255 Tibia and fibula bimalleolar or trimalleolar	469.60	2+T
5256 Surgery for dislocating patella	703.60	2+T
- involving plication of medial capsule plus transposition of patellar tendon		
5257 Quadriceps myoplasty	703.60	3+T
5266 Crush injury of foot with multiple fractures - closed reduction	350.40	2+T
5267 - open reduction	585.10	2+T
5270 Fibula - malleolus - closed reduction	350.40	2+T
5271 Fibula - shaft or malleolus - not requiring reduction	162.70	
5272 Os calcis - closed reduction	350.40	2+T
5273 Fracture - neck of talus	350.40	2+T
5274 Tarsal bones - closed reduction	234.30	2+T
5275 Metatarsal bone - closed reduction - one	162.70	2+T
5276 - two or more	234.30	2+T

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DISLOCATIONS

5300	Reduction of dislocation other than shoulder without anaesthetic	46.70	
5301	Temporo-mandibular joint - dislocation - closed reduction	117.30	1+T
5303	Clavicle - acromio-clavicular - requiring open reduction	703.60	2+T
5304	Shoulder - closed initial reduction	162.70	1+T
5305	- closed recurring reduction	117.30	1+T
5306	- open reduction to recurrent - Bankart	1190.80	3+T
5307	Elbow - closed reduction	162.70	1+T
5308	Carpal bones - closed reduction (Lunate)	162.70	1+T
5309	- open reduction	469.60	2+T
5310	Metacarpophalangeal or interphalangeal joint - closed reduction	70.60	1+T
5311	- open reduction	281.60	2+T
5312	Hip - closed reduction	469.60	2+T
5313	Patella - closed reduction	117.30	1+T
5314	Knee - open primary repair of ruptured ligaments (with or without meniscectomy)	819.60	3+T
5315	Ankle - closed reduction	234.30	2+T
5316	Astragalus - closed reduction	234.30	2+T
5317	Metatarsal bone - closed reduction	70.60	1+T
5318	Toe - closed reduction	70.60	1+T
5319	Vertebra - closed reduction	469.60	4+T
5320	Congenital dislocation of hip- closed reduction	585.10	4+T
5321	- open reduction	1054.20	6+T

FRACTURE-DISLOCATIONS

5400	Hip - central, anterior or posterior: - closed reduction	703.60	2+T
5401	- open reduction	1173.20	4+T
5402	Vertebra - closed reduction	703.60	4+T
5403	- open reduction with internal fixation or fusion	1407.90	6+T
5404	Astragalus - closed reduction	469.60	2+T
5405	- open reduction	703.60	2+T
5406	Carpus - closed reduction	350.40	1+T
5407	- open reduction	469.60	2+T
5408	Monteggia fracture - dislocation of elbow - closed reduction	585.10	2+T
5409	- open reduction	819.60	2+T
5410	Head of humerus - closed reduction	585.10	2+T
5411	- open reduction	819.60	2+T
5412	Dislocated elbow with fractured epicondyles - closed reduction	385.10	1+T
5413	- open reduction	529.00	2+T
5414	Ankle - closed reduction	469.60	2+T
5415	- open reduction	703.60	2+T

AMPUTATIONS

Upper Extremity			
5420	Disarticulation - interscapulo-thoracic	1173.20	5+T
5421	Shoulder disarticulation	938.60	4+T
5422	Upper arm	585.10	3+T
5423	Forearm	585.10	3+T
5424	Hand	585.10	2+T
5425	Transmetacarpal	350.40	2+T
5426	Finger - any joint or phalanx	234.30	2+T

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Lower Extremity

5430	Disarticulation - interpelvic-abdominal	1795.60	6+T
5431	Disarticulation - hip	1173.20	6+T
5432	Thigh (all levels) including knee	703.60	4+T
5433	Leg	585.10	4+T
5434	Ankle - Syme, Pirogoff	703.60	2+T
5435	Foot - mid or trans-metatarsal	469.60	2+T
5436	Metatarsal - with toe	234.30	2+T
5437	Toe - any joint or phalanx	94.10	2+T
5438	Secondary closure for amputations up to 50% of original fee not to exceed	350.40	2+T

OSTEOTOMY AND EXCISION

5460	Minor bones, eg. phalanges, metatarsals	234.30	2+T
5461	Major bones, eg. tibia, humerus	703.60	2+T
5462	Subtrochanteric of femur (McMurray)	1407.90	4+T
5473	Innominate osteotomy (Salter)	934.00	6+T
5463	Phalangectomy - Hammer Toe	164.30	2+T
5464	Osteomyelitis - Saucerization, muscle flap or bone graft	938.60	3+T
5465	- saucerization and sequestrectomy	703.60	3+T
5467	- incision subperiosteal abscess	117.30	2+T
5474	Decompression of acute osteomyelitis	700.20	3+T
5468	Local excision of bone tumor - benign Local excision of bone tumor - malignant - bill under fee code 5999	469.60	3+T
5469	Local excision of bone spur	117.30	1+T
5470	Excision of acromion or outer end of clavicle	585.10	2+T
5471	Excision of clavicle	585.10	3+T
5472	Excision accessory tarsal scaphoid (Kidner)	469.60	2+T

ARTHROTOMY

(including removal of loose or foreign bodies, including osteochondritic disease, if necessary).

5501	Wrist, elbow, ankle or tarsal	350.40	2+T
5502	Hip	469.60	4+T
5508	Shoulder	469.60	2+T
5503	Knee	350.40	3+T
5504	Knee, transarthroscopic meniscectomy	747.20	3+T
5505	Knee (meniscectomy)	469.60	3+T
5506	Stripping of lateral epicondyle for tennis elbow	350.40	2+T
5507	Pes anserinus transfer	469.60	2+T
5511	Fixation of osteochondral fragments with bone graft peg	585.10	3+T

ARTHROPLASTY

5522	Interphalangeal or metacarpophalangeal - capsulotomy, arthroplasty and arthrodesis	350.40	2+T
5514	Metatarsal phalangeal joint - silastic	469.60	2+T
5528	Obliteration nail bed - great toe (Zadic)	234.30	2+T
5529	Total hip prosthesis	2111.60	6+T
5525	Metatarso-phalangeal (Keller, McBride)	350.40	2+T
5526	Mitchell osteotomy - unilateral	469.60	2+T
5527	- bilateral	703.60	2+T
5513	Glenohumeral - total shoulder	1516.20	7+T
5524	Total knee joint replacement	1748.90	5+T

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ARTHRODESIS

5530	Knee, shoulder, elbow, ankle	1286.20	3+T
5531	Hip	1642.20	6+T
5532	Sacroiliac	813.60	6+T
5533	Wrist	813.60	2+T
5538	Foot - subtalar, mid-tarsal, triple, Grice-Green	813.60	2+T
5539	Interphalangeal or metacarpophalangeal	350.40	2+T

FASCIAL REPAIRS

5544	Meniscal Reattachment	480.40	2+T
5554	Major knee ligament reconstruction - medial or lateral sides	1190.80	3+T
5555	- medial and lateral sides	1783.90	3+T
5553	Patellar shaving	469.60	2+T

TENODESIS BONE GRAFTING

5560	Femur - neck	938.60	4+T
5561	Shaft	1173.20	3+T
5562	Tibia	938.60	3+T
5563	Humerus	938.60	2+T
5564	Radius and ulna	938.60	2+T
5565	Radius or ulna	585.10	2+T
5566	Metacarpal, Phalanx	469.60	2+T
5568	Tibial or fibular malleolus	585.10	2+T
5572	Scaphoid	585.10	2+T
5571	Bone graft-clavicle	938.60	2+T
5573	Harvesting of live bone for grafting (in conjunction with open reduction), extra	451.60	2+T

PLASTER CASTS IN NON-FRACTURE CASES AND FOR FRACTURES NOT REDUCED

Initial application of cast to be charged in addition to visit fee. If assessment including x-ray are required for subsequent recasting, then visit and cast fee allowed. If only minimal reassessment prior to recasting is required, cast fee only should apply.

See also clause 12 (C) of Preamble

5580	Finger or toe	23.40	
5581	Short arm (elbow to hand)	35.50	
5583	Long arm (axilla to hand)	46.80	
5584	Shoulder spica	117.30	
5585	Ankle (foot to midleg)	46.80	
5586	Knee (foot to thigh)	46.80	
5587	Walking cast	46.80	
5588	Hip spica - unilateral	117.30	
5589	- bilateral	140.80	
5590	Body - shoulder to hips	117.30	2+T
5591	Body - including head (Minerva)	164.30	2+T
5592	Petrie abduction cast	140.80	
5593	Cast brace for fractured femur	433.10	

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MISCELLANEOUS

5600	Manipulation of any joint under general anaesthetic other than for dislocation or fracture (operation only) - Casting extra at 100%	117.30	2+T
5601	Irrigation of joint	46.80	1+T
5604	Application of Denis-Browne Splint with adhesive tape	46.80	
5607	Removal pins and screws (operation only)	228.60	2+T
5608	Removal of plates, intramedullary rods	350.40	2+T
5612	Bone biopsy - open	164.30	2+T
5613	Reconstruction of rheumatoid hand joints multiple eg. synovectomy, intrinsic release, repositioning of extensor tendons, each hand: Fee for service at any one operative session - up to	1877.00	3+T
5614	Forefoot reconstruction - per individual items up to maximum of	819.70	3+T
5615	Finger joint prosthesis - first joint	350.40	2+T
5616	- subsequent joints same sitting	172.00	2+T
5620	Synovectomy of hand joint	469.60	2+T
5621	Intrinsic release	469.60	2+T
5625	Orthopaedic interpretation of submitted x-ray films	46.60	
5626	Synovectomy of flexor or extensor tendons in wrist or hand for rheumatoid disease	703.60	2+T
5627	Iliopsoas transplant	1282.80	4+T
5629	Synovectomy of knee joint	938.60	3+T
5630	Closed digital tenotomy - first	164.30	1+T
5631	- each additional	23.40	1+T
5632	Digital neuroma excision	234.30	1+T
5633	Epiphyseal arrest, femur and/or tibia	703.60	2+T
5634	Jones tenosuspension	469.60	2+T
5635	Tendon Achilles	436.10	2+T
5637	Proximal hamstring release Resection volar carpal ligament - see fee code 3195	469.60	2+T
5640	Rotator cuff tear repair	1190.80	3+T
5642	Skeletal traction	140.80	1+T
5646	Reconstruction lateral ligaments of ankle	703.60	2+T
5643	Halo skeletal traction	469.60	4+T

PAEDIATRICS

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REFERRED CASES

0510	Consultation:	234.30
	To consist of an examination, review of history, laboratory, x-ray findings and additional visits necessary to render a written report	
0512	Repeat or Limited Consultation:	117.30
	Where a formal consultation for the same illness is repeated within six (6) months of the last visit by the consultant or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	
0514	Prolonged visit for counselling	117.30
	NOTE: Insured Health Services and YWCHSB will pay up to four such visits per year (see clause 19 of the Preamble)	
Continuing Care by Consultant		
0506	Directive care	51.90
0507	Subsequent office visit	64.10
0508	Subsequent hospital visit	51.40
0509	Subsequent home visit	70.60

NOTE: For premature care or intensive care of a newborn see clause 15 and 20 of the preamble.

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250	Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	52.20
0251	Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	143.30
	NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	
0252	Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent emergency care	167.70

SPECIAL PROCEDURES

0522	Emotionally disturbed child and/or FAS reporting:	406.60
	Diagnostic interviews or examination, including mental status and treatment recommendation, assessment of parents, guardian or other relatives and written report	
0525	Insertion of intra-arterial infusion line in infants - extra to consultation	96.90
0524	Exchange transfusion - procedural fee	604.20
	NOTE:	
	(i) Charge full fee for all repeat transfusions	
	(ii) Normally an assistant for exchange transfusion is not required. However, in those exceptional cases when one is required, a letter of explanation of need must accompany the account to the payment agency.	
0526	Insertion of intravenous infusion line in children under 5 years	72.90
	- extra to consultation	
0527	Electrocardiogram and interpretation in office by a paediatrician - each	48.30
0528	Electrocardiogram and interpretation in home by a paediatrician - each	72.90
0529	Electrocardiogram - professional fee	18.80

PAEDIATRICS

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9401 - technical fee	29.80	
0530 Graded exercise test - technical fee	35.20	
0535 - professional fee	66.60	
NOTE: The note following fee codes 0335 and 0336 in the Internal Medicine Section of this guide applies to fee codes 0530 and 0535		
Electrocardiogram and interpretation for children under 2 years of age:		
0533 - professional fee Paediatrician only	18.80	
0534 - technical fee Paediatrician only	53.70	
Chemotherapy:		
0582 Cancer Chemotherapy visit:	160.80	
To include the administration of multiple parenteral chemotherapeutic agents, history and physical examination as necessary to document disease status, counselling of patient and/or family, review of pertinent laboratory and radiologic data, venesection and institution of an intravenous line. This service not to be billed more than once every twenty-eight days (time taken must be in excess of 1 hour)		
0583 Limited Cancer Chemotherapy visit:	80.30	
To include the administration of single or multiple parenteral chemotherapeutic agents, history and physical examination as necessary to document disease status, counselling patient and/or family, review of pertinent laboratory and radiologic data, venesection and institution of an intravenous line.		
NOTE: This item is not to be billed more than once every seven days. Neither is it to be billed for routine administration of 5-fluorouracil as a single agent		

PSYCHIATRY

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REFERRED CASES

Consultations: (office, home or hospital)

0610 Individual:	249.50
Diagnostic interviews or examination, including history, mental status and treatment recommendation, with written report	
0622 Emotionally disturbed child:	406.60
Diagnostic interviews or examination, including mental status and treatment recommendation, assessment of parents, guardian or other relatives and written report	
0623 Multiple disturbed family (3 or more members)	406.60
simultaneous diagnostic interviews or examination, including mental status of the members, their interactions and written report	
0624 Evaluation interview with family member or guardian without presence of patient	90.20
- per 1/2 hour session	

Repeat or Limited Consultation:

(If a formal consultation for same illness is repeated within six (6) months of the last visit by the consultant, or in the judgment of the consultant the consultative service does not warrant a full consult).

0625 Individual (see fee code 0610)	112.30
0626 Emotionally disturbed child (see fee code 0622)	203.20
0627 Multiple disturbed family (see fee code 0623)	203.20

Continuing Care by Consultant

0607 Office visit	50.50
to include services such as chemotherapy management and/or minimal psychotherapy	
0608 Hospital visit	52.20
0609 Home visit	79.10

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250 Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	52.20
0251 Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	143.30
NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	
0252 Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent emergency care	167.70

PSYCHOTHERAPY

0630 Individual per 1/2 hour	97.00
0631 Individual per 3/4 hour	141.00
0632 Individual per 1 hour	186.70
0633 Family - two or more family members (conjoint therapy) per 1/2 hour	110.20
0635 Family - two or more family members (conjoint therapy) per 3/4 hour	165.50
0636 Family - two or more family members (conjoint therapy) per 1 hour	220.40
NOTE: Where a psychotherapy session extends beyond one (1) hour in a day, a written explanation of need is required by the payment agencies such as out-of-town patient, emergency or like situations	
0637 Group therapy (session runs from 1 1/2 to 2 hours) per patient	42.30

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REFERRED CASES

6010	Consultation: To include complete history and physical examination, review of x-ray and laboratory findings, if required, and a written report	139.40	
6012	Repeat or Limited Consultation: To apply where a consultation is repeated for same condition within six (6) months of last visit by the consultant or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	70.60	
Continuing Care by Consultant:			
6007	Subsequent office visit	36.60	
6008	Subsequent hospital visit	23.40	
6009	Subsequent home visit	70.60	

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250	Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	52.20	
0251	Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	143.30	
0252	Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	167.70	

SKIN GRAFTS

NOTE: Additional procedures, other than skin grafts are extra; e.g. bone or tendon grafts, inlay grafts, etc.

Local Tissue Shifts: (Advancements, rotations, transpositions "Z" plasty, etc.)

6019	Single or multiple flaps under 2 cm. in diameter used in repair of a defect (except for special areas as in fee code 6024)	231.40	1+T
6020	Single	463.00	2+T
6021	- with free skin graft to secondary defect	579.10	2+T
6022	Multiple	923.10	2+T
6023	- with free skin graft to secondary defect	1032.50	2+T
6024	Eyebrow, eyelid, lip, ear, nose - single	579.10	3+T
6025	- two stages	923.10	3+T
6026	Arterial Island Flap	688.50	2+T
Flaps from a Distance: Direct (2 stages)			
6030	Upper extremity	923.10	2+T
6031	- with free skin graft to secondary defect	1157.50	2+T
6032	Lower extremity (plaster cast included) NOTE: Further stages at 50% of appropriate fee	1392.30	2+T
Indirect - tubes, jumps:			
6033	Major stage - per operation	688.50	4+T
6034	Minor stage - per operation	453.80	3+T
6036	Minor stage with free skin graft - per operation	688.50	3+T
6035	Delaying tube or pedicle	139.40	3+T

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FREE SKIN GRAFTS: (including mucosa)

*Note: In the case of a free skin graft, where a donor is necessary - plastic surgeon
-additional 25% of appropriate grafting fee.*

Full thickness grafts

6041	Eyelid, nose, lips, ear	688.50	2+T
6043	Finger tip	187.70	2+T
6040	Finger more than one phalanx	579.10	2+T
6044	Sole or palm	579.10	2+T
6045	Toe pulp graft	234.30	2+T

Split thickness grafts: Non-functional areas:

(total area treated, whether at one operation or at staged intervals).

6046	- less than 6.5 square cm.	115.70	2+T
6047	- 6.5 square cm. to 65 square cm.	234.30	2+T
6048	- 65 square cm. to 650 square cm.	463.00	2+T
6049	For each 6.5 square cm. over 650 square cm. Refrigerated graft - 50% of appropriate fee	9.70	3+T

Split thickness grafts: Functional Areas:

NOTE: Multiple operations to functional areas

- see Preamble paragraph 11(a)

6051	Finger tip	184.30	2+T
6050	Regions of - Major joints and hands - early	688.50	2+T
6058	Regions of - Major joints and hands - late with scar excision graft	938.60	2+T
6052	Head and neck - 65 square cm. or less	463.00	3+T
6053	- in excess of 65 square cm.	688.50	3+T
6054	- in excess of 195 square cm.	1626.80	3+T

Cavity Grafting:

6055	Eye socket	782.10	3+T
6056	- with mucosa	1157.50	3+T
6057	Nose	688.50	3+T
6060	Mouth	938.60	3+T
6061	Lining pedicle flaps	463.00	3+T
6062	Bone cavity over 7.4 cm. or more in diameter in large bone eg. Femur	688.50	4+T
6065	- up to 7.5 cm. in diameter in large bone	469.60	3+T
6064	- in small bone, eg. hand or foot	347.30	2+T

Tumors of Skin - removal requiring skin graft:

6070	If area involved less than 6.5 square cm.	115.70	2+T
6071	- 6.5 square cm. to 65 square cm.	231.50	2+T
6072	- 65 square cm. to 650 square cm.	463.00	3+T
6073	- for each 6.5 square cm. over 650 square cm.	4.60	3+T

Tumors of skin - removal not requiring skin graft:

6069	Excision of benign tumor of skin or subcutaneous tissue or small scar - face	115.70	3+T
7034	- additional lesions removed at the same sitting (maximum per sitting - five) each	23.40	
7035	Excision of benign tumor of skin or subcutaneous tissue or small scar	78.50	1+T
7036	Localized carcinoma of skin, proven histopathologically	117.30	1+T
7037	Excision of large (over 7.5 cm.) benign tumor of skin or subcutaneous tissue where general anaesthetic or regional block is necessary	164.30	2+T
7038	Removal of major benign tumor requiring extensive dissection (accompanied by written report to payment agencies)	703.70	2+T

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INJURIES

Wounds - simple:

7030	Minor laceration or foreign body requiring local anaesthesia (operation only)	72.10	
7031	Minor laceration or foreign body requiring general anaesthesia (operation only)	72.10	1+T
7032	Extensive laceration (bill if total length of all skin lacerations exceed 15 cm.)	168.10	2+T

Wounds - avulsed and complicated:

6075	Lips and eyelids	469.60	3+T
6076	Nose and ear	469.60	3+T
6077	Complicated lacerations of the scalp, cheek and neck	469.60	3+T

BURNS

(with or without general anaesthesia - per operation)

General Care - severe only:

6083	- first hour	115.70	2+T
6084	- subsequent hour (per hour)	69.50	2+T

Local Care

	- Minor burns	69.50	
6078	- dressing (in hospital care only)	46.80	4+T
6079	- surgical debridement - for each 5% of body surface	69.50	5+T
6080	- subsequent debridements - for each 5% of body surface (includes dressing)	34.70	5+T

Surgical excision of burnt tissue prior to immediate skin grafting:

6081	- for first 5% of body surface	231.40	5+T
6082	- for each subsequent 5% of body surface	115.70	5+T

OSTEOMYELITIS

5464	Saucerization, muscle flap or bone graft	938.60	2+T
5465	Saucerization and sequestrectomy	703.60	2+T
5467	Incision subperiosteal abscess	117.30	2+T

BIOPSY

7021	Biopsy of skin or mucosa	70.60	
7022	Biopsy of facial area	70.60	

Note: Punch or shave biopsies not to be charged under fee code 7021, 7022

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REGIONAL MANDIBULO-FACIAL

Fracture-Mandible

6240	Interdental and intermaxillary wiring	585.10	6+T
6241	Wiring and Gunning splints	703.60	6+T
6242	Open reduction - unilateral	703.60	6+T
6243	- bilateral	1054.20	6+T
6244	Open reduction and intermaxillary wiring - unilateral	819.60	6+T
6245	- bilateral	1173.20	6+T
6246	Removal of sutures, intra-oral splints, etc. under general anaesthesia	164.30	4+T

Fracture-Maxilla (Central mid-third):

6250	Le Fort I - (Horizontal fractures)	1173.20	6+T
6251	Le Fort II - (Pyramidal fractures)	1173.20	6+T
6252	Le Fort III - (Cranio-facial disjunction)	1173.20	6+T
6253	Open reduction and internal or external craniomaxillary wire suspension with or without intermaxillary fixation	1173.20	6+T

Fracture-Zygomatic (Lateral mid-third):

Zygomatico-maxillary (including Orbital Floor)

6260	Temporal elevation	234.30	3+T
6261	Open reduction and interosseous wiring (to include antral packing where necessary)	938.70	4+T
6262	Reduction via transantral approach and antral packing	234.30	4+T

Zygomatic Arch:

6265	Temporal elevation	234.30	3+T
6266	Open reduction and interosseous wiring	585.10	4+T

Orbital Floor Fractures: (Blow-out fractures)

6270	Open reduction (to include antral packing where necessary)	819.60	4+T
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Fracture - Alveolus:

6271	Alveolar fracture with one tooth extraction	164.30	3+T
6272	- each additional tooth	46.70	3+T
6273	Arch bar fixation of teeth	469.60	3+T

Temporo-Mandibular Joint:

5301	Dislocation - closed reduction	117.30	3+T
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Mandibular Resection:

6291	Tumors - enucleation, partial or complete resection	694.40	4+T
6292	- with bone graft	1045.00	4+T
7500	Resection of mandible	703.70	5+T
6293	Bone graft to jaw or face - autologous	938.70	4+T
6294	- non-autologous	703.60	4+T

Osteotomies:

6314	Canthopexy	938.70	3+T
6304	Malar Maxillary	1595.60	6+T
6305	Mandibular - for prognathism, micrognathism, malocclusion, etc. - unilateral with intermaxillary fixation	907.10	6+T
6306	- bilateral with intermaxillary fixation	1376.70	6+T
6307	Premaxillary set back	1141.80	6+T
6308	Mandibular osteotomy with rigid internal fixation - unilateral	1141.80	6+T
6309	- bilateral	1595.60	6+T

PLASTIC SURGERY

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CHEEKS

6111	Facial paralysis-static stings - unilateral	1023.10	3+T
6112	Abrasive surgery - less than one quarter of face	115.70	3+T
6113	- between one quarter and one half of face	347.30	3+T
6114	- full face	688.20	3+T
7525	Salivary fistula - plastic to Stenson's duct	703.60	4+T

NOSE

Rhinoplasty:			
2350	Removal of hump	350.40	3+T
2351	Nasal refracture requiring lateral osteotomies	703.70	3+T
2352	Reconstruction of nasal tip, ala and columella	819.50	3+T
6118	Bone graft to nose - autologous	938.70	3+T
6119	- non-autologous	694.40	3+T
2354	Complete rhinoplasty with submucous resection to include nasal hump removal, nasal refracture and reconstruction of nasal tip - without skin grafting	1173.20	3+T
6115	Forehead rhinoplasty - 2 operations NOTE: Partial forehead rhinoplasties charge under fee code 6020 and 6021	1392.30	3+T
6116	Composite graft	579.10	3+T
6117	Rhinophyma	463.00	3+T
Fractures:			
6121	Simple reduction	117.30	3+T
6122	Reduction and splinting	234.30	3+T
6123	Comminuted nasal fractures - transosseous wire plate fixation	469.60	3+T
6124	Naso-orbital fractures - open reduction and interosseous wiring or transosseous wire plate fixation	703.60	3+T

EARS

6131	Outstanding ears - unilateral otoplasty	463.00	3+T
6132	Microtia or loss of ear-partial - per stage	463.00	3+T
6133	- total - major stage	694.40	3+T
6134	- total - minor stage	463.00	3+T
6130	Accessory auricle	231.40	3+T
6135	Preauricular sinus - simple	278.50	3+T
6180	- complicated	463.00	3+T

MOUTH

7720	Lip shave - vermillionectomy	469.60	3+T
6137	Full lip thickness transfer by rotation flap	938.60	4+T
6140	Wedge resection of lip, vermillion	162.70	3+T
6141	Wedge resection of lip - to sulcus	347.30	3+T
6142	Pharyngoplasty of pharyngeal flap	813.60	6+T

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ORBIT

6153	Bone graft to orbit - autologous	938.60	4+T
6154	- non-autologous implant	694.40	4+T
2153	Ectropion-Entropion-Ziegler or simple procedure	114.20	3+T
2154	- complicated, including neoplasms and plastic repair	632.20	3+T
2159	Ptosis repair - orbicularis sling - using autologous fascia lata	910.40	3+T
2160	- levator resection	910.40	3+T
6148	Direct flat to eyebrow - first stage	694.40	3+T
6149	- Second stage	347.30	3+T

GENITALIA

Hypospadias, excluding urethrostomy

8274	- First stage, chordee	469.60	2+T
8275	- Second stage, (penile)	703.60	2+T
8276	- penoscrotal	938.60	2+T
8277	Epispadias - plastic repair	938.60	2+T

TRUNK

Note: See Preamble regarding cosmetic surgery

6151	Decubitus ulcers - excision and treatment of bone, rotation flaps and skin grafts to secondary defect	1047.90	4+T
6155	- with flap procedure, mobilization of umbilicus and repair of umbilical hernia NOTE: Only medically required procedures should be billed to the payment agency (accompanied by an explanation of the medical requirement)	935.90	4+T
6157	Nipple-areolar reconstruction	653.70	2+T
6158	Myocutaneous flap - involving major muscle rotated on its neurovascular pedicle	1284.40	5+T
6164	Prosthetic breast replacement in unilateral agenesis or following mastectomy -unilateral	579.10	3+T
6165	- bilateral	935.90	3+T

LEG

7216	Lymphedema of limbs - excision and grafting - entire leg	1407.90	3+T
7217	- entire lower extremity	2111.80	3+T
6167	Treatment of lymphedema using the Thompson procedure - upper extremity forearm	694.40	4+T
6168	- arm (Total of \$1,091.10 whether one or two stages)	463.00	4+T
6169	- lower extremity leg	1157.50	4+T
6170	- thigh (Total of \$2,182.20 whether one or two stages)	1157.50	4+T

PLASTIC SURGERY

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HAND

6171	Syndactyly - local flaps - first cleft	463.00	2+T
6172	- with skin graft, first cleft	694.40	2+T
6173	Direct flap to finger - 2 stages	578.70	2+T

Amputations:

5425	Transmetacarpal	350.40	2+T
5426	Finger, any joint or phalanx	234.30	2+T

Bone Grafting:

5566	Metacarpal, phalanx	469.60	2+T
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Fractures:

5203	Metacarpal, requiring reduction	187.70	1+T
5225	Distal phalanges - open reduction and wiring - first	350.40	1+T
5226	- each additional (extra)	187.70	1+T
5227	Other than distal phalanges - open reduction and wiring - first	585.10	1+T
5228	- each additional (extra)	281.60	1+T

Joints - Inter or Metacarpophalangeal:

5522	Capsulotomy, arthroplasty and arthrodesis	350.40	2+T
5613	Reconstruction of rheumatoid hand joints - multiple eg. synovectomy, intrinsic release repositioning of extensor tendons, each hand - fee for service, at any one operative session - up to	1877.00	3+T

5615	Finger joint prosthesis - first joint	350.40	2+T
5616	- subsequent joints same sitting - each	172.00	2+T
5620	Synovectomy of hand joint	469.60	2+T
5621	Intrinsic release	469.60	2+T
5626	Synovectomy of flexor or extensor tendons in wrist and hand for rheumatoid disease	703.60	2+T
5629	Synovectomy of knee joint	938.60	2+T

Hand Infections:

6197	Acute tenosynovitis-finger (operation only)	234.30	2+T
6198	- ulnar or radial bursa (operation only)	234.30	2+T
7046	Web space abscess (operation only)	70.30	2+T
7047	- under general anaesthetic (operation only)	117.30	2+T
7049	Mid palmar, thenar and dorsal subaponeurotic space abscess (operation only)	117.30	2+T

Nerves:

3191	Peripheral nerve - minor, digital, primary suture or secondary	350.40	2+T
3192	- repair of palmar nerve	350.40	2+T
3193	- major, primary suture	703.70	3+T
3195	- exploration of peripheral nerve and neurolysis	469.60	2+T
6156	Transplant of neuroma	347.30	2+T

MISCELLANEOUS

Meningocele:

6166	Excision of axillary sweat glands for hyperhidrosis - unilateral	694.40	4+T
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GENERAL SURGERY

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These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

7010 Consultation:	162.80
To include complete history and physical examination, review of x-ray and laboratory findings, if required, and a written report	
7012 Repeat or Limited Consultation:	89.90
To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	
Continuing Care by Consultant:	
7007 Subsequent office visit	36.60
7008 Subsequent hospital visit	46.40
7009 Subsequent home visit	76.70

EMERGENCY VISIT PREMIUM

**Based on time seen by physician*

0250 Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	52.20
0251 Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	143.30
0252 Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	167.70

SURGICAL ASSISTANT

**Payment will be based upon the total dollars billed by the surgeon, excluding diagnostics.*

NOTE: For consideration of premiums, the time of the surgical assist shall correspond to that of the start time of the first procedure.

7015 Operation fee - less than \$184.70	102.30
7016 - \$184.71 to \$567.10 inclusive	177.30
7017 - \$567.11 to \$956.60 inclusive	229.30
7018 - over \$956.61	309.00
7014 Time, after 2 hours or more of continuous surgical assistance for one patient, each 15 minutes or fraction thereof NOTE: (i) When a second assistant in surgery is requested by the Surgeon-in-Chief there should be adequate written explanation on the claim card and the charge should be in accordance with the fee for the first assistant. (ii) In those rare situations where an assistant is required for minor surgery, a detailed explanation of need must accompany the claim to the payment agency. (iii) Where an assistant at surgery assists at two operations in different areas performed by the same or different surgeon(s) under one anaesthetic, he/she may charge a separate assistant fee for each operation, except for bilateral procedures.	33.30
7019 Certified Surgical Assistant - where it is necessary for one certified surgeon to assist another certified surgeon	398.50
7020 Surgeon's part in cardioangiogram - per hour or fraction thereof	94.10

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GENERAL

Biopsy:

7021 Biopsy of skin or mucosa 70.60 1+T
NOTE: Punch or shave biopsies not to be charged under fee code 7021, 7022
(see fee code 0215)

7022 Biopsy of facial area 70.60 2+T

7023 Excision biopsy of lymph glands for malignancy under general anaesthetic 117.30 1+T

7024 Scalene gland biopsy 234.30 3+T

7025 Temporal artery biopsy 117.30 2+T

Abscess:

7026 Opening superficial abscess, including furuncle (operation only) 39.40 1+T

7027 Deep abscess, including carbuncle requiring general anaesthesia (operation only) 117.30 1+T

Lacerations or foreign bodies:

7030 Minor laceration or foreign body requiring local anaesthesia (operation only) 72.10

7031 Minor laceration or foreign body requiring general anaesthesia (operation only) 72.10 1+T

7032 Extensive laceration (bill if total length of all skin lacerations exceed 15 c.m.) 168.10 2+T

NOTE: For very extensive lacerations of face see Plastic Surgery Section

Skin:

7035 Excision of benign tumor of skin or subcutaneous tissue or small scar 78.50 1+T

7034 - additional lesions removed at the same sitting (maximum five per sitting) each 23.40 1+T

7036 Localized carcinoma of skin, proven histopathologically 117.30 1+T

Soft Tissue Tumor:

7037 Excision of large (over 7.5 cm.) benign tumor of skin or subcutaneous tissue where
general anaesthesia or regional block is necessary 164.30 2+T

7038 Removal of major benign tumor requiring extensive dissection 703.70 2+T
(accompanied by written report to payment agency)

INFECTIONS OF HAND AND FOOT

7044 Paronychia (operation only) 46.80 1+T

7045 Anterior closed space abscess (operation only) 46.80 1+T

7046 Web space abscess (operation only) 70.30 2+T

7047 - under general anaesthetic (operation only) 117.30 2+T

7049 Mid palmar, thenar and dorsal subaponeurotic space abscess (operation only) 117.30 1+T

7050 Removal of nail - simple (operation only) 46.80 1+T

7052 - with destruction of nail bed 94.10 1+T

7053 - complete with shortening of phalanx 234.40 2+T

7051 Wedge excision of one nail 70.60 1+T

BURSAE, SYNOVIAL CYSTS AND GANGLIA

7054 Excision of prepatellar, olecranon or trochanteric 234.40 2+T

7055 Ganglia - of the wrist 234.40 1+T

7056 - of tendon sheath joint 350.40 1+T

7057 - compound 703.60 1+T

7058 - popliteal cyst - radical removal 469.60 2+T

GENERAL SURGERY

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TENDONS

7060	Flexor - primary or secondary repair	585.10	2+T
7061	- each additional	234.30	2+T
7062	Tendon Achilles	350.40	2+T
7063	Extensor - primary or secondary repair	350.40	2+T
7064	- each additional	164.30	2+T
7065	Silastic Rod prior to Tendon Grafting	703.60	1+T
7066	Silastic Pulley and Underlay	117.30	1+T
7067	Tendon graft	1054.20	2+T
7068	Tenoplasty - tenodesis, tenovaginitis, shortening or lengthening, stenosing tenosynovitis - 1 tendon any location	350.40	2+T
7069	- 2 or more tendons	585.10	2+T
7070	Tendon transplant - single	469.60	3+T
7071	- each additional (extra) Section of transverse carpal ligament (bill under fee code 3195)	305.10	2+T
7077	Plantar fasciectomy	585.10	2+T
7078	Extensive palmar fasciectomy involving one or more digits (Dupuytren's)	703.60	2+T
7084	- with skin grafting NOTE: Localized charge under fee code 7037	951.00	2+T
7085	Tenolysis	585.10	2+T
7086	-each additional to a maximum of three extra	234.30	2+T

TENOTOMY

7073	Tenotomy - congenital torticollis	234.40	3+T
7074	- resection Section of transverse carpal ligament (bill under fee code 3195)	469.60	3+T
7081	Anterior scalenotomy	350.40	2+T

VENOUS SYSTEM

7100	Vein Eraser - first vein	46.70	
7101	- each subsequent vein	23.40	
7102	Varicose veins, injection, each visit	23.40	
7104	- injection with elevation, sponge rubber compression and bandaging (operation only)	78.50	1+T
Varicose Veins and Perforators:			
7107	High ligation, long saphenous	290.00	2+T
7108	Stripping long saphenous	482.10	2+T
7109	Stripping short saphenous	265.40	2+T
7110	Multiple ligations and stripping tributaries (3-5 incisions)	200.50	2+T
7111	Multiple ligations and stripping tributaries (6 or more incisions)	345.30	2+T
7112	Ligation of 2 or more perforators or partial fasciotomy with or without multiple ligations	361.40	2+T
7113	Complete fasciotomy, with or without multiple ligations	641.60	2+T

GENERAL SURGERY

	YHCIP and YWCHSB	Anaes Proc. Unit
<i>RECURRENT VARICOSE VEINS</i>		
7117 Re-exploration of groin and/or popliteal fossa	602.10	2+T
7118 Multiple ligations, strippings and perforators, re-exploration of groin and/or popliteal fossa	913.40	3+T
7119 Multiple ligations, strippings, re-exploration of groin and complete fasciotomy	1188.50	3+T
7120 Excision of ulcer and grafting - add full fee to venous procedures (operation only)	240.80	3+T
7123 Ligation of femoral vein	399.10	2+T
7124 Ligation of fenestration of inferior vena cava	938.60	5+T
7125 Thrombectomy for acute ilio-femoral thrombophlebitis	1173.20	5+T
Portal Hypertension:		
7128 Spleno-renal shunt	1751.90	8+T
7129 Porto-caval shunt	1751.90	8+T
Intra-Venous Catheters:		
7132 Jugulo-caval Holter Lifeline (operation only)	234.30	2+T
7133 - under 3 months of age or 3 kg weight	469.60	4+T
7134 Peritoneal Venous Shunt for ascites	703.30	6+T
Excision and Grafting:		
7216 Lymphedema of limbs - entire leg	1407.90	3+T
7217 - entire lower extremity	2111.80	3+T
Incision:		
7229 Thrombectomy with or without angioplasty	1054.20	5+T
7230 Embolectomy - trunk or both extremities	1173.20	5+T
7231 Embolectomy - one side	844.60	5+T
Bypass graft (synthetic) and/or Thromboendarterectomy:		
7233 - Innominate	1470.30	5+T
7234 - Subclavian	1407.90	5+T
7237 - Carotid	1251.60	8+T
7232 - Aorta and/or iliac - unilateral	1407.90	9+T
7235 - bilateral	1642.50	9+T
7240 - Aorto-femoral or ilio-femoral - unilateral	1642.50	9+T
7243 - bilateral	1877.00	9+T
7244 - Superior mesenteric	1595.60	7+T
7245 - Renal	1517.40	7+T
7242 - Anterior or posterior tibial or peroneal	1406.40	5+T
7226 - Axillo-femoral - unilateral	1407.90	7+T
7227 - bilateral	1642.50	7+T
7274 - Femoro-femoral crossover	1173.20	5+T
7238 - Femoral (common or superficial endarterectomy)	1032.50	5+T
7246 - Femoral-popliteal (synthetic)	1360.80	5+T
7275 - Femoral-popliteal (endarterectomy)	1282.80	5+T
7248 Venous crossover graft for iliac obstruction	1173.20	5+T
Bypass Graft (autogenous vein)		
7261 - superior mesenteric	1517.40	7+T
7262 - renal	1517.40	7+T
7263 - aorta	1642.50	9+T
7264 - iliac	1642.50	8+T
7265 - femoral	1360.80	5+T
7266 - popliteal	1360.80	5+T
7276 - anterior, posterior tibial or peroneal	1595.60	5+T
7277 - Femoro-femoral crossover	1314.00	7+T
7278 - Axillo-femoral - unilateral	1564.30	7+T
7267 - 2nd operator, synchronous combined bypass graft - extremities	585.10	
7247 - trunk	585.10	

NOTE: fee code 7267 and 7247 provide operative report by second operator when requested from payment agency

GENERAL SURGERY

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Excision:

7250	Arteriovenous aneurysm	938.70	9+T
7252	Abdominal aneurysm, with grafting	1877.00	9+T
7254	Ruptured aneurysm, with grafting	2221.30	10+T
7281	Resection of abdominal aneurysm with associated femoral dissection, one or both sides (extra fee to be added to procedure)	234.30	9+T

NOTE: Peripheral aneurysm - charge associated by-pass graft procedure

Suture:

7270	Repair injury of major vessel in extremity - suture	703.60	6+T
7271	- graft	1173.20	6+T
7269	Repair injury of major vessel in trunk - suture	1392.30	6+T
7273	- graft	1857.60	9+T
7272	Ligation of carotid artery	469.60	5+T
7283	Re-dissection of groin (after 21 days), extra	210.50	4+T

NOTE: Not to be charged when billing for a complete repeat procedure

LYMPHATIC SYSTEM

7360	Splenectomy	938.70	6+T
7361	TB Glands - radical removal	469.60	4+T
7362	Radical axillary dissection	813.60	3+T
7363	Radical femoral, inguinal and iliac dissection	938.70	5+T
7365	Isolated limb perfusion to include groin dissection and laparotomy	1642.50	5+T
7366	Laparotomy and staging of lymphoma to include splenectomy	1383.80	6+T
7367	Repair of laceration or rupture of spleen by suture	938.70	6+T

BREAST

7488	Microdochectomy	234.30	2+T
7489	Biopsy or removal of simple tumor or segmental resection	187.80	2+T
7490	Mastectomy - simple	469.60	3+T
7491	Mastectomy - radical or modified	1110.60	3+T
7492	Mastectomy - radical with skin graft	1219.70	3+T
7493	Triple biopsy of breast for cancer	469.60	2+T
7496	Double biopsy of breast for cancer	234.30	2+T
7494	Radical mastectomy with triple biopsy	1345.10	3+T
7495	Radical mastectomy with triple biopsy and skin graft closure	1470.30	3+T
7497	Biopsy or segmental resection of non-palpable breast lesion with pre and intra-operative radiological localization	305.10	2+T
7498	Mastectomy subcutaneous, female - unilateral	700.20	3+T
6164	Prosthetic breast replacement following mastectomy - unilateral	579.10	3+T
6165	- bilateral	935.90	3+T

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DIGESTIVE SYSTEM

Jaws:

7500 Resection of mandible 703.70 5+T

Pharynx:

7511 Excision of pharyngo-esophageal diverticulum 938.60 6+T

7512 Excision of congenital cyst/fistula from neck 703.60 4+T

Salivary Glands:

7520 Sialolithotomy - simple, in duct 117.30 3+T

7521 - complicated, in gland 350.40 3+T

7522 Local excision parotid tumor 234.30 3+T

7527 Subtotal parotidectomy with complete facial nerve dissection 1289.10 4+T

7523 Total parotidectomy with nerve dissection for malignancy or deep lobe tumor 1407.90 4+T

7524 Excision of submandibular gland 469.60 4+T

7525 Salivary fistula - plastic to Stenson's duct 703.60 4+T

7526 Dilatation of salivary duct (operation only) 46.70 3+T

Esophagus:

7529 Esophagectomy - upper 2/3 to include esophagostomy and gastrostomy 1877.00 8+T

7530 Esophago-gastrectomy-combined thoraco-abdominal 2111.60 8+T

7531 Cervical esophagostomy and division of tracheoesophageal fistula with gastrostomy 1407.90 8+T

7532 Plastic operation for cardiospasm - Heller 1173.20 8+T

7533 Esophageal diverticulum - intrathoracic resection 1173.20 8+T

7534 Correction of esophageal atresia with closure of tracheoesophageal fistula 2111.60 8+T

7535 Replacement of esophagus with intestine 2346.40 8+T

7536 Direct ligation of esophageal varices 1289.10 7+T

7537 Ruptured esophagus - transthoracic repair 1173.20 8+T

7538 - cervical drainage 766.40 4+T

7539 Insertion of celestin tube 813.60 4+T

7540 - sountar type tube 350.40 1+T

7541 Intramural tumor of esophagus 1289.10 6+T

7542 Esophageal replacement performed as a team procedure - first operator 2064.90 8+T

7543 - second operator 829.20

7544 Brusque pneumatic esophageal dilatation (operation only) 195.40 3+T

7545 - repeat within one month (operation only) 97.70 3+T

7546 Sclerosing of esophageal varices to include endoscopy (operation only) 316.00 3+T

7547 Bougie dilatation (operation only) 117.30 3+T

7555 Zenkers Diverticulotomy 623.40 5+T

ABDOMEN

Trauma fee items are to be charged in cases of blunt and/or penetrating abdominal injury.

They do not apply to incidental intraoperative injury to abdominal structures.

Trauma:

7430 Diagnostic peritoneal lavage (catheter) 150.80 1+T

7431 Repair diaphragmatic injury 1179.90 8+T

7432 Laparotomy in the trauma patient 629.30 5+T

7433 Laparotomy to include removal of injured spleen 945.20 7+T

7434 Laparotomy to include splenic repair 945.20 7+T

7435 Repair of lacerations to stomach 839.80 7+T

7436 Exploration and mobilization of duodenum and pancreas 945.20 7+T

7437 Repair of laceration of duodenum 1258.70 7+T

7438 Resection and debridement of duodenal injury, to include duodenal diverticulisation where indicated 1574.30 7+T

7439 Repair liver laceration 945.20 8+T

GENERAL SURGERY

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7440	1102.80	8+T
7441	1258.70	8+T
7442	1889.80	9+T
7443	1258.70	8+T
7445	839.80	7+T
7446	945.20	7+T
7447	839.80	7+T
7448	1258.70	7+T
7449	1258.70	7+T
7450	787.40	7+T
7451	418.70	8+T
7452	1258.70	7+T
7453	615.10	5+T
7454	1392.30	6+T
Incision:		
7587	744.60	5+T
7597	469.60	6+T
7600	585.10	5+T
7601	766.40	5+T
7602	46.70	
7603	469.60	5+T
Hernia:		
7592	703.60	2+T
7604	703.60	3+T
7605	594.20	2+T
7606	703.60	2+T
7607	1110.60	5+T
7608	766.40	2+T
7609	876.10	2+T
7568	876.10	3+T
7610	469.60	4+T
7611	703.60	2+T
7612	344.00	2+T
7613	453.80	2+T
7614	703.90	7+T
7615	938.60	7+T
7616	1282.80	6+T
7593	1517.50	6+T
7594	1329.90	9+T
7595	1407.90	8+T
7596	234.30	2+T
Stomach Incision:		
7617	703.60	5+T
7618	938.60	6+T
7625	938.60	8+T
7578	1110.60	5+T
7619	703.60	5+T

GENERAL SURGERY

	YHCIP and YWCHSB	Anaes Proc. Unit
Stomach Excision:		
7620 Total gastrectomy	2093.30	6+T
7621 Subtotal gastrectomy	1345.10	6+T
7622 - with vagotomy	1454.70	6+T
7623 Revision gastrectomy after previous gastrectomy with or without vagotomy	1751.90	6+T
7624 Emergency gastrectomy for continued hemorrhage (with operative report)	1751.90	7+T
7574 Gastric polypectomy to include gastroscopy (operation only)	368.40	5+T
Stomach Suture:		
7626 Pyloroplasty	703.60	5+T
7627 Gastrojejunostomy	751.00	5+T
7628 Gastrojejunostomy or pyloroplasty with vagotomy, with or without gastrostomy	1110.60	5+T
7629 Emergency gastrojejunostomy or pyloroplasty with vagotomy and suture of bleeder for continued hemorrhage	1407.90	7+T
7630 Gastrostomy - simple	376.30	5+T
7631 - with living tube	819.60	5+T
7632 Repair of perforated peptic ulcer, wound or injury to stomach	819.60	6+T
7633 Closure of gastrojejuno colic fistula	1986.40	5+T
Intestine Incision:		
7634 Enterotomy or colotomy (single)	751.00	5+T
7635 Multiple colotomy with operative sigmoidoscopy	1001.50	5+T
Intestine Excision:		
7636 Resection of small intestine with anastomosis	1048.00	5+T
7637 Hemicolectomy - right	1345.10	6+T
7591 - left	1407.90	6+T
7638 Anterior resection of rectosigmoid for carcinoma with or without protective colostomy	1642.50	6+T
7639 Limited resection of colon	1219.80	6+T
7640 Total colectomy with ileoproctostomy	1751.90	6+T
7642 Bowel resection without anastomosis and with ileostomy	1194.10	5+T
7641 Total proctocolectomy with perineal excision of rectum and ileostomy	2346.50	7+T
7589 - synchronous - abdominal portion	2049.00	7+T
7590 - synchronous - perineal portion	585.10	7+T
7643 Enteroenterostomy	766.50	5+T
7644 Enterostomy or caecostomy	469.60	5+T
7570 Colo-colostomy or enterocolostomy	1048.20	6+T
NOTE: fee code 7570 applies to unprepared, non-resectable bowel obstruction. In all other instances fee code 7643 applies		
7645 Colostomy - loop	530.30	5+T
7588 - end	585.10	5+T
7646 Closure of colostomy without resection	585.10	4+T
7647 Closure of colostomy with resection and anastomosis	876.10	5+T
7648 Revision of colostomy, ileostomy - simple incision of scar, etc.	350.40	4+T
7649 Revision of colostomy, ileostomy - radical	585.10	5+T
7650 Intestinal obstruction resection of bands	876.10	5+T
7651 Reduction of volvulus, intussusception or internal hernia	813.60	5+T
7575 Kock intra-abdominal pouch with continent ileostomy	1752.00	6+T
Intestine Suture:		
7653 Atresia of the small bowel	1282.80	6+T
7654 Intestinal obstruction - plication or insertion of intraluminal tube	1001.50	5+T
7655 Excision of Meckel's diverticulum	641.50	4+T
7656 Appendectomy	531.80	4+T
7657 Appendectomy - perforated with abscess or generalized peritonitis	766.50	5+T
7658 Exteriorisation of large bowel lesion (carcinoma, perforation, etc.)	938.60	5+T

GENERAL SURGERY

	YHCIP and YWCHSB	Anaes Proc. Unit
Rectum Excision:		
7660 Rectal drainage of pelvic abscess	350.40	2+T
7661 Hartmann resection	1283.00	7+T
7659 Reconstruction Hartmann with or without protective colostomy	1173.20	7+T
7662 Abdomino-perineal resection	1877.00	7+T
7663 Synchronous combined abdomino-perineal resection - abdominal portion	1642.50	7+T
7664 - perineal portion	585.10	7+T
7665 Full thickness rectal biopsy for Hirschsprung's Disease	234.30	2+T
7670 Pull-through procedure for Hirschsprung's Disease	1877.00	7+T
7576 Pull through procedure - Second operator	585.10	
7667 Rectal prolapse - perineal approach	469.60	5+T
7668 Excision or fulguration of rectal or sigmoidal tumors to include operative sigmoidoscopy - small - less than 1 cm.	117.30	2+T
7669 - medium - 1 to 2.5 cm.	164.30	2+T
7673 - large - greater than 2.5 cm.	350.40	2+T
Rectum Repair:		
7671 Anal stricture plastic repair	703.60	2+T
7672 Complete rectal prolapse - abdominal or perineal approach	1054.20	5+T
7580 Trans-sacral (Kraske) resection	813.60	5+T
7581 Colonoscopy with flexible colonoscope	422.30	2+T
7582 - biopsy	469.60	2+T
7583 - removal polyp	703.60	2+T
7584 Fulguration rectal carcinoma - palliative	350.40	2+T
7585 - radical (with operative report)	585.10	2+T
7586 - repeat	234.30	2+T
Anus Incision:		
7675 Fistula-in-ano - submucous	234.30	2+T
7676 - submuscular	531.80	2+T
7677 - multiple (with operative report)	703.60	2+T
7678 Incision and drainage of superficial perianal abscess (operation only)	117.30	1+T
7679 Ischio-rectal abscess (operation only)	164.30	2+T
7666 Anus incision (fistula-in-ano second stage), division of sphincter after placement of seton	204.50	2+T
Anus Excision:		
7681 Fissurectomy with or without sphincterotomy under general anaesthetic (operation only)	234.30	2+T
7683 Hemorrhoidectomy with or without sigmoidoscopy	409.60	2+T
7688 Hemorrhoids - elastic band ligation (operation only)	81.40	1+T
7682 - additional band, same sitting (operation only) Note: Maximum sittings chargeable per year five (5)	52.60	1+T
7684 Enucleation of external thrombotic haemorrhoid	58.70	1+T
7685 Pilonidal sinus-excision or marsupialization	469.60	2+T
7686 Anal polyp	70.60	1+T
7687 Anal fissure excision under local anaesthesia	117.30	
7689 Anal dilation - (operation only)	117.30	1+T
7697 Excision sacrococcygeal teratoma	1642.50	6+T
7674 Fulguration anal condylomata - simple	117.30	1+T
7680 - complicated (with operative report) and laboratory findings, if required, and a written report	234.30	1+T

GENERAL SURGERY

	YHCIP and YWCHSB	Anaes Proc. Unit
Anus Repair:		
7690 Anoplasty for imperforate anus	938.60	4+T
7691 Imperforate anus - simple incision	46.80	1+T
7692 Repair major ano-rectal anomalies with concurrent urogenital malformations via sacral approach	1407.90	7+T
Liver:		
7693 Drainage of hepatic abscess	766.50	6+T
7694 Ruptured liver - repair by suture	922.60	8+T
7695 - thoracoabdominal approach with suture	1406.30	8+T
7696 Resection of liver - hepatic lobectomy-total	2111.80	8+T
7775 - partial	938.60	8+T
Biliary Tract:		
7757 Biliary tract endoscopy	195.40	2+T
7698 Cholecystostomy	703.60	5+T
7699 Cholecystectomy	938.60	5+T
7764 Cholangiography - operative, extra	96.60	
7701 Choledochostomy	1095.20	5+T
7769 Duodenotomy and sphincteroplasty	969.30	5+T
7703 Choledochoduodenostomy	1407.09	6+T
7705 Choledochojejunostomy	1552.50	6+T
7706 Cholecystoenterostomy	703.60	6+T
7704 Surgical reconstruction for stricture or congenital atresia	1642.50	6+T
7719 Resection of carcinoma of common bile duct - middle and lower	1752.10	6+T
7737 - upper	1986.40	6+T
7776 Repair of cholecystoenteric fistula	969.30	5+T
7777 U-tube insertion for common bile duct malignancy	1163.60	5+T
7573 Endoscopic papillotomy (Ampulla of Vater) to include retrograde pancreatography (0809) (operation only)	777.00	5+T
Pancreas:		
7711 Drainage of pseudocyst - cystogastrostomy	1054.20	5+T
7733 - Roux-en-Y	1329.70	5+T
7712 Pancreatico-duodenectomy (Whipple)	2346.50	7+T
7713 Partial pancreatectomy	1235.60	7+T
7714 Pancreaticojejunostomy	1642.50	7+T
7710 Pancreatogram with or without sphincterotomy done in conjunction with any of the biliary or pancreatic surgical procedures - extra	117.30	5+T
7734 Pancreatitis - acute - gastrostomy, jejunostomy, cholecystostomy	1054.20	4+T
7722 Percutaneous biopsy of pancreas - operation only	195.40	2+T

GENERAL SURGERY

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HEAD AND NECK

7735	Tongue tie - under general anaesthetic	164.30	3+T
7736	Local excision tongue - under general anaesthetic	234.30	3+T
7738	Excision cystic hygroma	938.60	3+T
7720	Lip shave - vermillionectomy	469.60	3+T
7721	Glossectomy - partial for carcinoma	703.60	6+T
7723	Alveolectomy	350.40	3+T
7724	Transpalatal maxillectomy, ethmoidectomy and sphenoidectomy	1407.90	5+T
7725	Maxillectomy	1407.90	5+T
7726	- with exenteration of orbit and skin graft	1877.00	5+T
7739	Transoral maxillectomy with skin graft	1642.50	5+T
7749	Partial maxillectomy for malignancy -fenestration	938.60	5+T
7727	Composite resection -tongue, mandible, radical neck dissection and tracheotomy (3 months post-op care)	2346.50	7+T
7728	Resection mandible, floor of mouth, suprahyoid dissection and tracheostomy - malignancy	1407.90	7+T
7729	Laryngo-pharyngo-esophagectomy - primary excision only	2346.50	6+T
7730	Radical neck dissection	1407.90	6+T
7731	Partial unilateral neck dissection	469.60	5+T
7766	Unilateral radical neck plus contralateral suprahyoid dissection	1642.50	5+T
7767	Suprahyoid neck dissection for malignancy	469.60	5+T
7768	Excision tuberculosis lymph nodes neck (with operative report)	469.60	4+T
7796	Excision neurogenic neoplasm neck	938.60	5+T
7771	Picking operation - metastatic neck nodes for thyroid carcinoma (with operative report)	703.60	5+T

ENDOCRINE SYSTEM

7740	Thyroid biopsy - open	234.30	4+T
7741	Local excision thyroid lesion	585.10	4+T
7742	Thyroidectomy - subtotal bilateral or total unilateral	938.60	4+T
7743	- bilateral total for malignancy	1329.90	4+T
7759	- Graves' disease	1173.20	4+T
7758	Recurrent thyroidectomy (after 6 weeks from previous operation)	1155.60	4+T
7745	Parathyroidectomy	1173.20	4+T
7744	Subtotal parathyroidectomy	1080.70	4+T
7748	Parathyroidectomy with sternal split	1642.50	6+T
7746	Adrenalectomy - unilateral extra peritoneal approach	938.60	8+T
7747	- unilateral or bilateral - intraperitoneal approach	1407.90	8+T

SYMPATHECTOMY

7750	Lumbar sympathectomy - unilateral	703.60	4+T
7751	Cervical sympathectomy - unilateral	860.40	5+T
7754	Lumbar sympathectomy with abdominal procedure - unilateral (extra)	234.30	
7755	- bilateral (extra)	469.60	
7752	Preganglionic sympathectomy, upper dorsal region - unilateral	860.40	7+T
7753	Lumbo-dorsal sympathectomy and splanchnic neurectomy - unilateral	860.40	7+T

GENERAL SURGERY

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ORGAN TRANSPLANTS - Kidney Implantation of Kidney Graft

7760	Urologist	1642.50	7+T
7761	Vascular surgeon	1642.50	7+T
Removal of Donor Kidney			
7762	From cadaver with necessary kidney preservation	469.60	7+T
7763	From living donor	938.60	7+T
NOTE:			
(i) Anaesthetist and Nephrologist charge fee for service.			
(ii) A certified surgical assistant will be required with billing under fee code 7019			

RENAL DIALYSIS

7239	Insertion of new A-V bypass (no consultation charged)	467.20	4+T
7187	Creation of internal arteriovenous fistula	700.20	4+T
7186	Thrombectomy of arteriovenous fistula	657.00	3+T
7598	Removal of hemodialysis shunt	116.80	2+T
7599	Insertion of permanent catheter	348.90	3+T
7579	A-V Shunt with Bovine Graft	938.60	4+T
7577	Removal by dissection of chronic peritoneal catheter (operation only)	210.50	3+T
NOTE: Removal of Tenchov-type chronic peritoneal catheter not requiring surgical dissection - use visit fees.			

CARDIO-THORACIC SURGERY

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Unit

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

7810 Consultation:	136.50	
To include complete history and physical examination, review of x-ray and laboratory findings, if required, and a written report		
7812 Repeat or Limited Consultation:	76.70	
To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee		
Continuing Care by Consultant:		
7807 Subsequent office visit	36.60	
7808 Subsequent hospital visit	23.40	
7809 Subsequent home visit	76.70	

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250 Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	52.20	
0251 Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	143.30	
NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays		
0252 Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	167.70	

ARTERIAL SYSTEM

7825 Resecting aneurysms in conjunction with another procedure	453.80	10+T
7828 Repair of aortic injury (thoracic)	2418.40	10+T
7829 Repair of traumatic injury of major intrathoracic vessels	1347.80	10+T

HEART AND MEDIASTINUM

Heart:		
7843 Endocardial pacemaker (ventricular)	782.10	4+T
7847 Endocardial pacemaker (Atrial A-V sequential)	775.20	4+T
7953 Double lead endocardial pacemaker	775.20	4+T
7952 Electronic monitoring of pacing and pacemaker function	137.70	
7844 Implantation or replacement of pulse generator for cardiac pacing	344.00	4+T
7845 Repair, replacement, adjustment of electrode	344.00	4+T
NOTE: For implantation of temporary pacemaker see fee code 0330		
7846 Surgical treatment of cardiac arrest by cardiac massage (operation only)	453.80	11+T
NOTE: To be supported by letter. Paragraphs 11(b) and 11(d) of the Preamble will apply		
Mediastinum:		
7921 Mediastinal cyst or tumor	1251.60	8+T
7922 Thymectomy	897.60	8+T

CARDIO-THORACIC SURGERY

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RESPIRATORY SYSTEM

Pleura and Lung:

7924	Decompression of traumatic pneumothorax (operation only)	70.60	4+T
7925	Artificial pneumothorax	46.70	4+T
7926	Closed drainage of chest (operation only)	234.40	4+T
7927	Rib resection for empyema	688.20	6+T
7928	Exploratory thoracotomy with or without biopsy or removal of foreign body	782.10	8+T
7929	Decortication of lung	1125.90	8+T
7930	Pleurectomy	708.30	8+T
7931	Closure of pleurostomy following long term management of empyema with rib section	708.30	6+T
7932	Segmental resection of lung (including operative report)	1360.80	8+T
7933	Lobectomy	1251.60	8+T
7934	Pneumonectomy	1673.80	9+T
7935	Thoracotomy including wedge resection	782.10	8+T
7936	Drainage of lung abscess - operation only	688.20	8+T
7938	Closure of bronchopleural fistula	1372.10	10+T
7939	Repair of ruptured bronchus	1372.10	9+T

Ribs and Chest Wall:

7941	Thoracoplasty	688.20	6+T
7945	Cervical rib resection	688.20	5+T
7946	Intrathoracic tumor - without lung involvement	891.90	5+T
7948	Trans-axillary resection of first rib	803.50	5+T
7955	Tracheal resection	1372.10	10+T
7956	- with laryngeal release, extra	678.00	10+T
7957	- with hilar release, extra	678.00	10+T
7958	Chest wall tumor with rib resection	940.80	6+T

MECHANICAL DEVICES

7960	Intra-aortic balloon insertion, removal and care	963.20	
	NOTE: For an isolated procedure (anaesthetic procedural units)	963.20	10+T

UROLOGY

YHCIP
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These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

8010 Consultation:	136.50
To include complete history and physical examination, review of x-ray and laboratory findings, if required, and a written report	
8012 Repeat or Limited Consultation:	76.70
To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	
Continuing Care by Consultant:	
8007 Subsequent office visit	36.60
8008 Subsequent hospital visit	23.40
8009 Subsequent home visit	76.70

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250 Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	52.20
0251 Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	143.30
NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	
0252 Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	167.70

KIDNEY AND PERINEPHRIUM

8100 Drainage of perinephric abscess	469.60	5+T
8101 Exploration of renal and perirenal tissues	703.60	5+T
8102 Nephrotomy or nephrostomy	892.00	5+T
8103 Pyelotomy or pyelostomy	892.00	5+T
8117 Nephrolithotomy and/or pyelolithotomy	892.00	5+T
8118 Nephrolithotomy or pyelolithotomy with x-ray control with or without nephroscopy	1173.20	5+T
8119 Nephrolithotomy or pyelolithotomy with renal cooling, with or without x-ray control, with or without nephroscopy	1282.80	6+T
8104 Hemi-nephrectomy or partial nephrectomy	938.60	5+T
8105 Nephrectomy	892.00	5+T
8106 - ectopic kidney	892.00	5+T
8107 - transperitoneal	892.00	5+T
8108 - thoracoabdominal	1407.90	8+T
8109 - radical with gland dissection	1047.90	6+T
8110 Nephrourecterectomy to include bladder cuff	1329.70	6+T
8111 Excision of stenosed renal artery with reimplantation or bypass homograft	1407.90	8+T
8112 Open renal biopsy (as independent procedure)	469.60	5+T
8113 Symphysiotomy and nephropexy or nephrectomy in horseshoe kidney	1047.90	5+T
8114 Pyeloplasty including management of aberrant vessels and nephropexy	912.80	5+T
8115 Nephropexy	892.00	5+T
8116 Ruptured or lacerated kidney-repair or removal	938.60	4+T

UROLOGY

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URETER

8149	Ureterotomy/ureterolithotomy - upper ureter	813.60	5+T
8150	- lower ureter	892.00	5+T
8151	Ureterotomy or removal of stump	892.00	5+T
8152	Uretero-vesical reanastomosis - unilateral	813.60	5+T
8148	- bilateral	1407.90	5+T
8156	Ureteroureterostomy	1173.20	5+T
8157	Uretero-cutaneous anastomosis - unilateral	703.60	5+T
8158	Ureteral sigmoid anastomosis - bilateral	938.60	5+T
8159	Ureterolysis	938.60	5+T
8160	Reconstruction lower segment ureter by bladder flap	1047.90	5+T
8161	Transurethral manipulation of ureteral calculus with recovery of calculus	469.60	3+T
8162	Ureteroplasty	938.60	5+T
8163	Uretero-vesical anastomosis in the presence of ureterocele or ureteral duplication	1173.20	5+T

URINARY DIVERSION AND CYSTECTOMY

8170	Preparation of intestinal segment and reanastomosis	938.60	5+T
8171	Transplantation of ureters to an intestinal segment	703.60	6+T
8172	Cystectomy (isolated procedure)	1407.90	6+T
8173	Radical cystectomy with pelvic lymphadenectomy (isolated procedure)	1642.50	7+T
8174	Preparation of intestinal segment, reanastomosis and ureteral transplantation (same surgeon)	1642.50	6+T
8175	Cystectomy and ureteral transplantation (same surgeon)	1407.90	6+T
8176	Radical cystectomy and ureteral transplantation (same surgeon)	1642.50	7+T
8177	Preparation of intestinal segment, ureteral transplantation and cystectomy (same surgeon)	2346.50	6+T
8178	Preparation of intestinal segment, ureteral transplantation with radical cystectomy	2580.90	7+T
8179	Mobilization of bladder and anastomosis to intestinal segment	703.60	6+T
8180	Mobilization of bladder and anastomosis plus preparation of intestinal segment (same surgeon)	1642.50	6+T
8181	Ileoplasty or colocystoplasty	1282.80	6+T

BLADDER

8200	Cystoscopy with fulguration or for operative control of post-prostatectomy hemorrhage	234.40	2+T
8201	Cystostomy	469.60	2+T
8202	Cystostomy by trochar	117.30	1+T
8203	Cystolithotomy	469.60	2+T
8204	Cystectomy-partial for tumor or diverticulum	938.60	5+T
8207	Ruptured bladder repair	813.60	5+T
8210	Differential renal function studies	234.40	
Endoscopy:			
8250	Transurethral resection of bladder or urethral tumor and adjacent muscle and electrocoagulation as necessary	688.20	3+T
8251	Transurethral resection bladder neck, female	469.60	3+T
8252	Transurethral removal of vesical or urethral foreign body	469.60	3+T
8253	Y-V vesical neck plasty	797.60	4+T
8254	Litholapaxy and removal of fragments	407.10	2+T
8255	Closure of fistula - suprapubic, vesico- vaginal, vesico-rectal or vesico-sigmoid	938.60	5+T
8256	Transurethral resection of external urinary sphincter	469.60	3+T

UROLOGY

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URETHRA

8260	Urethrotomy, external or internal	350.40	2+T
8261	Urethrostomy	350.40	2+T
8262	Meatotomy and plastic repair (operation only)	46.70	1+T
8263	Urethrectomy - total	703.60	3+T
8264	Stricture of urethra - office dilation (operation only)	35.50	
8265	- dilation in hospital, isolated procedure with anaesthesia (operation only)	46.70	1+T
8266	- first stage plastic repair (excluding urethrostomy)	469.60	3+T
8259	- first stage plastic repair requiring pedicle graft	1173.20	3+T
8267	- second stage plastic repair (excluding urethrostomy)	469.60	3+T
8268	Urethral diverticulectomy, male or female	469.60	2+T
8269	TUR posterior urethral valves	469.60	2+T
8270	Transurethral removal of foreign body or calculus	469.60	3+T
4431	Retropubic operation for urinary incontinence	819.70	4+T
8272	Urethral fistula (penile excision)	350.40	2+T
8273	Abdominal repair of vesico-vaginal fistula	938.60	5+T
8274	Hypospadias excluding urethrostomy - 1st stage chordee	469.60	2+T
8275	- Second stage (penile)	703.60	2+T
8276	- penoscrotal	938.60	2+T
8277	- epispadias plastic repair	938.60	2+T
8278	Suprapubic cystostomy and primary repair of urethra	938.60	3+T
8279	Prolapse of urethra - repair	469.60	2+T
8280	Urethral caruncle - excision, including cystoscopy	234.40	2+T

PENIS

8300	Priapism: sapheno-cavernous shunt	813.60	2+T
8301	Dorsal slit	46.80	1+T
8303	Circumcision - child	94.10	1+T
	NOTE: Routine circumcision of the newborn for non-medical reasons is not a benefit under Insured Health Services		
8304	- adult	234.40	1+T
8305	Simple amputation of penis	375.20	2+T
8299	Radical amputation of penis	813.60	2+T
8306	Clitoridectomy	187.80	2+T
8308	Excision of femoral and inguinal glands with or without iliac glands - unilateral	1407.90	4+T
8309	- bilateral	2111.80	4+T
8307	Excision of Peyronies plaque, with replacement graft (tissue or synthetic)	785.30	2+T
8296	Penile prosthesis (eg. small carrion) insertion following traumatic or surgical injury	690.00	3+T
8363	Revision of penile prosthesis	465.60	3+T
	(includes removal, correction of any mechanical failure, and replacement)		
	NOTE: In cases in which impotence is not the direct result of surgery or trauma, prior authorization should be obtained from Insured Health Services		

UROLOGY

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PROSTATE

8310	Open prostatic biopsy - perineal or retropubic prostatectomy (including meatoplasty, dorsal slit, urethral dilation, panendoscopy, cystoscopy, retrograde pyelography, vasectomy, or bladder-neck surgery done while patient is under anaesthetic for the prostatectomy)	469.60	3+T
8311	- perineal, suprapubic, retropubic, prostate, seminal, urethral approaches	1125.90	5+T
8314	- radical perineal retropubic prostate- seminal vesiculectomy NOTE: No charge for repeat prostatectomies done within a period of three months by the same operator, except where radical prostatectomy is required subsequently for cancer	1173.20	7+T
8315	Perineal incision of prostate with drainage of abscess	469.60	2+T
8316	Prostatic massage	18.80	
8317	Anti-incontinence procedure (Kaufman)	1173.20	4+T
8318	Radical prostatectomy to include lymphadectomy	1585.50	7+T

TESTIS

8320	Hydrocele or spermatocele - aspiration	46.80	
8321	Orchidectomy - unilateral	234.40	2+T
8322	Orchidopexy - one or two stages	688.20	2+T
8323	Exploration of scrotal contents - unilateral	234.40	2+T
8324	Exploration of undescended testicle, without orchidopexy	469.60	2+T
8328	Recurrent undescended testis	775.20	2+T
8325	Reduction of torsion of testis and spermatic cord, repair - bilateral	469.60	2+T
8326	Ruptured testicle - repair	350.40	2+T
8327	Biopsy of testis	117.30	2+T

EPIDIDYMIS

8339	Male venereal warts, cautery or excision (not for application of podophyllin) (operation only)	46.80	
8340	Abscess, incision, complete care	234.40	1+T
8341	Spermatocele or hydrocele - excision	391.30	2+T
8342	Epididymectomy - unilateral	350.40	2+T
8344	Vasogram - bilateral	234.40	2+T
8345	Vasectomy - bilateral	234.40	2+T
8346	Varicocele - resection	350.40	2+T
8347	Avulsion of penile skin and scrotum - repair	938.60	2+T
8348	Investigation of sterility in the male, including complete examination of male genitalia, prostatic fluid, serology and written report	70.60	
8349	Retroperitoneal lymphadenectomy for carcinoma of testis	1173.20	4+T
8350	Urethro-vesical neck plasty for congenital incontinence	1173.20	4+T
8351	Excision extrophied bladder and plastic repair abdominal wall	1173.20	4+T
8352	- with ureterosigmoidostomy	1407.90	5+T
8353	Plastic repair of extrophy and plastic repair of bladder with skin	1517.40	5+T

DIAGNOSTIC ROENTGENOLOGY

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(Applicable in full for Certified Radiologists and at 75% for all other physicians)

HEAD AND NECK

8500	Skull - routine	75.70
8501	Skull - special studies additional	50.50
8502	Ventriculogram or encephalogram (not including procedural fee)	177.10
8503	Paranasal sinuses	77.90
8504	Facial bones - orbit	77.90
8505	Nasal bones	50.50
8506	Mastoids	75.70
8507	Mandible	50.50
8508	Temporomandibular joints	54.50
8509	Salivary gland region	50.50
8510	Sialogram	75.70
8511	Eye - for foreign body	50.50
8512	For foreign body localization - additional	67.70
8513	Dacrocystogram	50.50
8514	Nasopharynx and/or soft tissue, neck - single lateral view	25.60
8515	Laryngogram (excluding procedural fee) Teeth - bitewing or routine dental	75.70
8516	- single film	23.50
8517	- full series	102.80

NOTE: When less than a full series is performed, individual films may be charged up to the fee for a full series

UPPER EXTREMITY

8520	Shoulder Girdle	50.50
8521	Humerus	50.50
8522	Elbow	50.50
8523	Forearm	50.50
8524	Wrist	50.50
8525	Hand (any part)	50.50
8526	Special requested views in upper extremity	24.90

LOWER EXTREMITY

8530	Hip	50.50
8531	Femur	50.50
8532	Knee	50.50
8533	Tibia and Fibula	50.50
8534	Ankle	50.50
8535	Foot (any part)	50.50
8536	Leg length films - any method	50.50
8537	Special requested additional views for lower extremity	24.90

DIAGNOSTIC ROENTGENOLOGY

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SPINE AND PELVIS

8540	Cervical spine	72.60
8541	Thoracic spine	72.60
8542	Lumbar spine	122.90
8543	Sacrum and coccyx	72.60
8549	Spine - requested additional views (flexion, bending views, etc.) NOTE: Fee code 8549 is not intended to cover normal projections	50.50
8544	Pelvis	50.50
8545	Sacro-iliac joints	54.50
8546	Scoliosis films - single AP or lateral - 14 x 36 film taken at 6 feet	72.60
8547	Pelvis and additional requested views ie. sacroiliac joints, hip, etc.	67.70
8548	Myelogram and/or posterior fossa positive contrast (excluding procedural fee)	136.00

CHEST

8550	Thoracic viscera	50.50
8551	Thoracic inlet	50.50
8552	- additional requested views	24.90
8553	Fluoroscopy, when requested	34.30
8554	Ribs - one side	50.50
8555	Ribs - both sides	75.70
8556	Sternum or sternoclavicular joints	50.50
8557	Sternum and sternoclavicular joints	75.70
8558	Bronchogram, excluding preliminary films (excluding procedural fees) - one side	126.60
8559	- both sides	174.70

ABDOMEN

8570	Abdomen	50.50
8571	Abdomen, multiple views	75.70

GASTRO-INTESTINAL TRACTS

8572	Esophagus, only	87.30
8573	Esophagus, stomach and duodenum	126.60
8574	Small bowel	126.60
8576	Colon or double contrast air studies	126.60
8577	Hypotonic duodenography	126.60
8578	Pancreatography (excluding procedural fee)	75.70
8579	Glucagon assisted contrast study (in addition to routine fee)	54.40

GALLBLADDER

8580	Oral cholecystogram	75.70
8581	Intravenous cholangiogram	110.60
8582	Operative cholangiogram (transhepatic also)	75.70
8583	Direct post-operative cholangiogram	75.70
8584	Removal of biliary calculi by Burhenne technique or equivalent including necessary cholangiogram and fluoroscopy (excluding procedural fee)	93.80

DIAGNOSTIC ROENTGENOLOGY

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GENITO-URINARY SYSTEM

8590	K.U.B.	50.50
8591	Pyelogram - intravenous	109.00
8592	IVP-special studies, ie. rapid sequence, drip infusion	149.60
8593	Pyelogram - retrograde	75.70
8594	Intravenous pyelogram with voiding cystourethrogram	151.60
8595	Cystogram or retrograde urethrogram (not including catheterization)	75.70
8596	Hysterosalpingogram (excluding injection)	126.60
8597	Pelvimetry	101.40
8598	Placentogram (with or without contrast)	75.70
8599	Voiding cystourethrogram	126.60

MISCELLANEOUS

8600	Cine study-50% added to the fee for region studied	.00
8601	Radiographic study of sinus, fistula, etc with contrast media, including injection and fluoroscopy, if necessary	75.70
8602	Body section radiography - applies to all tomographic procedures (including polytomography when done in one plan) per plane series, including orthopantogram	113.70
8603	Bone age - whatever method	50.50
8604	Bone survey - first anatomical area	50.50
8605	- each subsequent anatomical area	24.90
8606	Arthrogram, shoulder (excluding injection of contrast)	50.50
8607	Arthrogram, hip (excluding injection of contrast)	50.50
8608	Arthrogram, knee (excluding injection of contrast)	109.00
8609	Arthrogram, ankle (excluding injection of contrast)	50.50
8610	Mammography - unilateral	75.70
8611	- bilateral	126.60
8612	Xeromammography - unilateral	116.40
8613	- bilateral	187.50
8614	Lymphangiogram - one extremity	101.40
8615	Cerebral angiography - unilateral	177.10
8616	- bilateral	280.40
8617	Peripheral angiography (arteriography and venography) - unilateral	101.40
8618	- bilateral for trauma	151.60
8619	Orbital venography	116.40
8620	Aortography (aortography plus peripheral angiography)	256.60
8621	Cerebral stereotaxy	202.50
8622	Cerebral stereotaxy - radiologistt present additional	24.90
8623	Retroperitoneal gas insufflation	126.60

The entry "Thoracic or abdominal angiogram" is intended to include the following:

Ascending Lumbar	Angiocardiogram
Coronary arteriogram	Celiac arteriogram
Bronchial arteriogram	Cavogram
Mediastinal angiogram	Renal arteriogram
Mesenteric arteriogram	Pelvic arteriogram
Pulmonary arteriogram	Splenoportogram
Superior or inferior vena	Lumbar aortogram
Pelvic venogram, etc.	Retrograde aortogram
Ilio-femoral arteriogram	Thoracic aortogram

DIAGNOSTIC ROENTGENOLOGY

	YHCIP and YWCHSB	Anaes Proc. Unit
8624 Thoracic or abdominal angiogram (Cine or videotape surcharge not applicable) - using single film - non-selective	101.40	
8625 - selective	24.90	
8626 - using multiple sequential views - non-selective	194.20	
8627 - selective	177.10	
8628 Interpretation of submitted films - per examination NOTE: This item to be charged only in those situations where a third party requests a second written radiological opinion	24.90	
8629 Radiologist in attendance for fluoroscopy for various clinical procedures (ie. small bowel biopsy; insertion of pacemaker, etc.)	24.90	
8630 Percutaneous transluminal angioplasty	456.20	

COMPUTERIZED TOMOGRAPHY

8690 Head scan - without contrast	70.60	
8691 - with contrast	98.50	
8692 - double scan or 2 planes	127.40	
8693 Body scan - one region without contrast	141.20	
8694 - one region with contrast	156.00	
8695 - double scan or 2 regions	213.40	

DIAGNOSTIC ULTRASOUND

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HEAD AND NECK

0916	Echoencephalography - midline A mode	35.10
8640	Echoencephalography - complete (midline and ventricular size)	62.40
8641	Ophthalmic B scan - immersion technique	249.50
2639	Ophthalmic ultrasound A scan for determination of axial length (to be billed only if patient proceeds to lens implant surgery)	92.40
8642	Thyroid B scan	90.20

HEART

8643	Echocardiography - M mode	212.70
8638	Echocardiography - real time	161.10
8661	Echocardiography - combined two dimensional real time and M mode	225.10
8644	Ultrasonically guided pericardiocentesis	188.10

THORAX

8645	B scan	188.10
8646	Ultrasonically guided thoracentesis	188.10
8647	B scan for breast mass - per breast	62.40

ABDOMEN

8648	Abdominal B scan for liver, pancreas, mass, aortic, aneurysm, etc.	188.10
8649	Renal B scan	188.10
8650	Ultrasonically guided biopsy or cyst puncture	188.10

OBSTETRIC AND GYNAECOLOGY

8651	Obstetrical B scan - 20 weeks gestation or over	178.00
8652	B scan IUD localization	75.00
8653	Non-obstetrical pelvic B scan	188.10
8654	Ultrasonically guided amniocentesis	188.10

BRAIN

8659	B scan	135.30
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EXTREMITIES

8658	B scan - cyst or mass	85.40
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DOPPLER STUDIES

NOTE: The Doppler Vascular listings are applicable to hospital based accredited and approved ultrasound vascular studies laboratories only.

8656	Assessment of ventricular arterial shunt	37.00
Peripheral Arterial:		
8664	Resting arterial assessment: To include multiple wave form and/or segmental pressure analysis, calculation and ankle/arm index	88.00

DIAGNOSTIC ULTRASOUND

	YHCIP and YWCHSB	Anaes Proc. Unit
8665 Treadmill stress examination with or without ECG monitoring: To include sequential post stress measurement and calculations - with monitoring physician present	156.00	
8666 - without monitoring physician present	105.70	
8667 Reactive hyperemia with sequential pressures	66.40	
8668 Vasopastic assessment: To include digital pressures and/or plethysmography - cold and hot stress responses and/or multiple extremity wave form analysis	105.70	
8669 Sympathetic tone response: To include resting arterial assessment plus plethysmograph and/or impedance monitoring and/or digital wave forms, response to Valsalva maneuvers or other stimuli	64.60	
Peripheral Venous:		
8670 Laboratory assessment of deep venous thrombosis: To include determination of venous sounds at multiple sites, response to standard compression maneuvers with documentation of sounds and responses	64.60	
8671 Laboratory assessment of venous hypertension and venous reflux, delineation of incomplete perforators	64.60	
Extracranial:		
8672 Carotid imaging: To include delineation of extra cranial vessels on both sides of the neck - ultrasound imaging	108.60	
8673 - ultrasonic arteriography plotting	103.60	
8674 - continuous wave audioangiography with or without wave forms	40.50	
8675 - spectrum analysis	64.60	
8676 - duplex scan, ie. ultrasonic image and placement, doppler flow assessment	160.00	
8677 Periorbital assessments; either oculoplethysmograph (OPG) or photoplethysmography (PPG), and/or doppler directional determination with extra-cranial artery compression	64.60	
8678 Subclavian or vertebral assessment including assessment of subclavian steal: To include directional doppler determination of flow direction in vertebral arteries with or without arm compression and other maneuvers	88.00	

THERAPEUTIC ROENTGENOLOGY

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MALIGNANT DISEASE

Consultation in therapy for malignant lesion should include complete history and examination, review of x-ray and laboratory findings, routine urine and blood studies and written report.

8712 - skin	48.20
8711 - if biopsy is included	72.90
8710 Hemapoietic, reproductive (male or female), urinary, gastrointestinal or nervous system	96.90

X-RAY RADIATION

8715 Where an incomplete course of x-ray therapy or cobalt therapy is given, per treatment	24.10
8716 Multiple therapy, each additional port	11.90

NON-MALIGNANT DISEASE

8786 First treatment, including consultation and written report to referring physician	72.90
8787 - subsequent treatment	36.20

LABORATORY PROCEDURE (Short List)

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Tests performed in physicians' offices that are accepted for payment by Insured Health Services.

9000 Hemoglobin - other methods	4.60
9003 Hematocrit - micro or macro	4.60
9005 Hematology profile (automatic to include HGB, WCT, HCT, RBC indices) NOTE: When all components of the hematology profile (fee code 9005) are normal, a white count differential (fee code 9012) is not required and will not be performed unless medically required and specifically requested by a physician	18.20
9007 Hemoglobin - cyanmethemoglobin method	9.60
9011 White blood cell count only	9.60
9012 Differential white cell count	14.20
9031 Sedimentation rate	7.20
9066 Latex test	17.20
9074 Mono test	17.00
9077 Anti-nuclear factor	71.60
9101 Simple stained smear	11.60
9104 Urine culture	18.80
9106 Throat culture	14.90
9110 Secretion smear for eosinophils	11.60
9111 Examination for pinworm ova	9.60
9113 Direct examination for cutaneous fungus - KOH preparation	11.60
9115 Trichomonas and/or Candida (direct exam)	7.20
9119 Candida culture	8.80
9125 Serological tests 1 to 3 antigens	46.80
9126 Serological tests 4 or more antigens	70.80
9195 Lithium	23.90
9209 Potassium	18.80
9219 Dextrostix	4.60
9220 Glucose determination by reflectometer	8.50
9221 Glucose determination by reflectometer following ingestion of predetermined amount of glucose containing solution	13.00
9234 Occult blood	9.60
9366 Complete urine analysis	9.60
9349 Immunological gonadotrophin (pregnancy test)	23.50
9364 Microscopic examination on centrifuged specimen of urine	7.10
9365 Routine screening urinalysis (to include sugar, protein, blood, pH, bile and ketones or any part thereof)	2.60
9429 Seminal examination for presence or absence of sperm	23.50
9436 Fern test	9.60
9827 T3	42.70
9830 T4	51.70
9242 Serum uric-acid	30.50

YUKON DENTAL FEES

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SURGICAL REMOVAL OF TEETH

8504 Orthopan x-ray	77.90
9940 Erupted first tooth	48.00
9941 Each additional	24.00
9943 Soft tissue impaction	92.00
9944 Bony impaction (partial)	165.00
9945 Complete bony impaction	245.00
9950 Alveoloplasty	75.00
9987 Sulcus deepening and ridge construction per arch	393.00
9951 Exposure of tooth for orthodontic treatment	145.00
9984 Treatment of traumatic injuries of soft tissue with the mouth	97.00
9948 Root resection	172.00
9955 Incision and drainage of abscess of dental origin	54.00
9983 Frenectomy	170.00
9970 Closed reduction of fracture of mandible and maxilla	435.00
9966 Excision of intraoral cysts - small	218.00
9967 - large	411.00
9954 Intraoral biopsy - soft tissue	72.00
9969 - bony tissue	144.00
9960 Excision of benign intraoral tumors, under 1 cm.	210.00
9961 Excision of benign intraoral tumors, over 1 cm.	411.00
9964 Removal of root or foreign body from maxillary antrum	319.00
9965 Repair and closure of antro-oral fistula	259.00
9973 Closed reduction of temporomandibular dislocation	110.00
9958 Sialolithotomy	109.00
0110 Consultation written (at hospital)	129.70