PHYSICIAN SERVICES AGREEMENT

Between

The Medical Society of Prince Edward Island

And

The Government of Prince Edward Island

And

Health PEI

April 1, 2024, to March 31, 2029

PHYSICIAN SERVICES AGREEMENT

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Section A - GENERAL

ARTICLE A1 - PRINCIPLES & PURPOSE OF AGREEMENT

In the spirit of Reconciliation, we acknowledge that the land upon which we work is unceded Mi'kmaq territory. Epekwitk (Prince Edward Island), Mi'kma'ki, is covered by the historic Treaties of Peace and Friendship. We pay our respects to the Indigenous Mi'kmaq People who have occupied this Island for over 12,000 years; past, present and future." The parties agree they have a role to play to advance positive change in the health care experiences of Indigenous patients, families, communities and Nations."

A1.1 The Parties to this Agreement share a desire to maintain and improve the high quality of health services delivered in Prince Edward Island. Accordingly, they are determined to maintain and foster an effective working relationship.

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

A1.3 The terms of this Agreement were guided by the following principles:

(a) All Parties trust the intentions of one another, and specifically;
   (i) Trust that Health PEI and Government are making health service delivery decisions in the best interests of Islanders, the Physicians covered by this Agreement and stakeholders.
   (ii) Trust that Physicians use their professionalism and clinical judgement to make the best decisions for their patients.

(b) Meaningful and respectful collaboration and consultation between Physicians, MSPEI, Health PEI and Government are essential to building a strong and sustainable health care system.

(c) Prince Edward Island's health care system is predominately a rural medical care system. This concept must be at the forefront of how we manage our health system and support Physicians.

(d) The Agreement supports an equitable, diverse and inclusive medical profession and work environment and all Parties make a commitment to review issues through an equity, diversity and inclusiveness lens going forward.

(e) The Agreement seeks to create opportunities to improve patient access to the appropriate provider at the appropriate time.

(f) "Care is care". Whether direct or indirect patient care, team collaboration or an administrative function, the effort extended to care for a patient is valued.

(g) The Agreement provides flexibility and agility, where possible, so Health PEI and Physicians can be responsive to unforeseen system and medical profession needs.

(h) The Agreement strives for simplicity in how Physicians are paid for their services.

(i) The Agreement must be fair, transparent, and consistently applied, wherever possible.

A1.4 The Parties agree to commit to meaningful consultation on any fundamental or transformational changes to the operations of healthcare in PEI which may significantly impact Physicians. For the purpose of this section, "meaningful consultation" means Health PEI will ensure concerns and input of Physicians are represented by MSPEI and considered. For greater certainty, issues requiring meaningful consultation include, but are not limited to:

(a) Any fundamental or transformational change decision affecting Physicians and delivery of physician services;
(b) New or amended health policies that impact how Physicians deliver care;
(c) Any changes to Medical Staff By-Laws and rules which affect delivery of healthcare by Physicians;
(d) Substantial quality and cost improvement opportunities; and
(e) Substantial quality improvement projects including quality assurance projects identified by any facility or Health PEI.

A1.5 (a) The Health PEI Physician Services Operating Guide ("Operating Guide") will be developed after the implementation of this Agreement by the Parties with meaningful consultation from MSPEI and made available to all Physicians. It is acknowledged and agreed that the development of the Operating Guide will require input of the Implementation Management Team ("IMT") and Executive Committee ("EC"). Ongoing dialogue through the IMT Process including meaningful consultation with MSPEI, will also be required throughout the life of the Operating Guide.

(b) The Operating Guide will support this Agreement in its operationalization and provide Health PEI's Management Team, Physicians and MSPEI with transparent and consistent guidance on how health services will be delivered. It will provide guidance on:

- Physician resource allocation;
- Accessing equipment and infrastructure;
- Accessing additional supports (i.e., staff);
- Developing provincial and other health service delivery models;
- On-call rotas;
- Physician accountability standards and key performance indicators (e.g., patient panel size)
- Adding new specialties or services to the system;
- Medical leadership roles, responsibilities and contact information;
- Establishing locum rates, and
- Other such matters as may be determined by Health PEI.

(c) In the event of a dispute between a Physician and Health PEI as to whether the contents of the Operating Guide are consistent with this Agreement, or whether Health PEI is acting fairly and reasonably in the exercise of its management

prerogatives, the dispute must first be attempted to be resolved through the appropriate leader in the Medical Affairs Office's Physician Leadership Team. If a dispute cannot be resolved through the appropriate Physician Leader, it may be referred to the IMT, and then the EC for resolution.

A1.6 When a committee is appointed by Health PEI or the Government to consider any fundamental or transformational changes to the operations of healthcare in Prince Edward Island which may significantly impact Physicians, the committee shall invite representation from MSPEI.

A1.7 All the above processes are to be operationalized through the provisions of the IMT and the EC Process as set out in Article A13.2.

ARTICLE A2 - APPLICATION, DURATION AND AMENDMENTS

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

A2.2 The Master Agreement expiring March 31, 2024 ("Master Agreement") shall remain in full force and effect for the period April 1, 2024, to March 31, 2025. However, upon signing of this Agreement, the IMT and EC shall commence their work under Article 13.2 of this Agreement and assume the functions of the Joint Consultation Committee ("JCC") as per Article A14.2(a) of the Master Agreement.

A2.3 For the period April 1, 2025, to March 31, 2029 the entirety of this Agreement shall be in full force and effect including during the period of negotiation, mediation or interest arbitration carried out to achieve a new agreement.

A2.4 This Agreement constitutes the entire agreement between the Parties, and no prior representations, undertakings or promises whatsoever, whether express or implied, shall form part of this Agreement.

A2.5 This Agreement may only be amended in accordance with Article A13.2. Unless otherwise stipulated, Alternate Payment agreements shall align with the duration of this Agreement.

ARTICLE A3 - INTERPRETATION AND DEFINITIONS

A3.0 "Academic Physician" means a Physician, with respect to their clinical practice, who has entered into an arrangement with Health PEI to provide medical services while holding an academic appointment.

A3.1 "Agreement" means the Agreement and the Preamble and Tariff of Fees appended at Schedule A.

A3.2 "Alternate Payment" means compensation provided for Physician services on a basis other than fee for service. Alternate payments may include, but are not limited to, salary, contract for service, sessional payments (hourly, daily, weekly, or monthly rates), and on-call remuneration.

A3.3 "Associate Physician" means a Physician employed by Health PEI pursuant to a contractual arrangement as outlined in Article B6, and holds associate registration under the *Medical Practitioner Regulations*, PEI Reg EC843/21.

A3.4 "Chief Medical Officer" means the most senior medical leader in Health PEI and is accountable to the Chief Executive Officer of Health PEI for any Medical Staff matters arising from the organization of the Medical Staff or operation of Health PEI.

A3.5 "Clinical Education" means medical education that takes place in any clinical setting provided by medical faculty that is concurrent with providing direct patient care.

A3.6 "Contract for Service Physician" means a Physician who is an independent contractor of Health PEI, pursuant to a contract for services as outlined in Article B8.

A3.7 "Department" means the department of the Medical Affairs Office's physician leadership structure.

A3.8 "Department of Health and Wellness" means the Department of Health and Wellness, which is authorized to act on behalf of the Minister.

A3.9 "Executive Committee" means the tripartite oversight committee established pursuant to Article A13.2(a) of this Agreement.

A3.10 "Fee for Service Physician" means a Physician who has an arrangement with Health PEI for payment on a fee-for-service basis as outlined in Article B13.1.

A3.11 "Full Time Salaried Physician" means a Physician who works a regular schedule of hours as outlined in Article B6.4.

A3.12 "Government" means the Government of the Province of Prince Edward Island, as represented by the Minister of Health and Wellness.

A3.13 "Implementation Management Team" means the team established by the Executive Committee pursuant to Article A13.2(b) and the Memorandum of Understanding attached to this Agreement.

A3.14 "Locum Physician" means a Physician fulfilling a temporary vacancy who has an arrangement with Health PEI for payment on a clinical locum rate established in the Operational Guide.

A3.15 "Medical Society" means the Medical Society of Prince Edward Island.

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

A3.17 "On-Call" means a Physician who is required to be available for a 24-hour period to render service to, or on behalf of, a patient for a diagnosis or treatment.

A3.18 "Part-Time Salaried Physician" means a Physician who works less than full time hours, as outlined in Article B6.4.

A3.19 "Physician" means a legally qualified medical practitioner who is entitled to practice medicine in Prince Edward Island pursuant to the *Regulated Health Professions Act, RSPEI 1988, c R-10.1*. and who has an arrangement with Health PEI or Government.

A3.20 "Probationary Employee" means a Physician to whom Section B applies who has not completed their probationary period as defined in Article B6.10.

A3.21 "Rural Hospital" means Souris Hospital, Kings County Memorial Hospital (Montague), Community Hospital (O'Leary), or Western Hospital (Alberton).

A3.22 "Salaried Physician" means a Physician employed by Health PEI pursuant to a contractual arrangement.

A3.23 "Sessional Fee" means a payment method other than fee for service that is based upon a time calculation.

A3.24 "Sessional Physician" means a Physician who is paid as either a Hospitalist, Emergency Department Physician, or Closed ICU Physician under this Agreement and is responsible to provide group coverage in accordance with a Services Coverage Agreement as outlined in Article B12.

A3.25 "Shadow Billing" means the process where Physicians receiving alternate payment submit specially designated claims for the medical services provided to patients that result in no payment.

A3.26 "Tariff" means the Preamble and the rate of fee for service payment as set out in the Tariff of Fees established pursuant to the *Health Services Payment Act* and this Agreement. The Tariff of Fees is attached hereto as Schedule "A". For clarity, all fees for services that are rendered by a Physician pursuant to this agreement shall be deemed included in the Tariff.

ARTICLE A4 - RECOGNITION

A4.1 The Government and Health PEI recognizes the Medical Society as the sole an exclusive bargaining agent for physicians who are licensed with the College of Physicians and Surgeons of Prince Edward Island, including Associate Physicians and Academic Physicians, who are engaged in the practice of medicine in respect of all matters arising from this Agreement, including fee for service and alternate payment. The Coroners, Chief Public Health Officer and Deputy Chief Public Health Office are bound by this Agreement on the terms as set out in the respective Memorandums of Agreement attached hereto. For greater clarity, Academic Physicians are those physicians who have academic appointments and who are permitted by Health PEI to provide medical services. They shall be governed by this Agreement as it relates to the clinical services they provide.

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

A4.3 Physicians are prohibited from making written or verbal agreements which are in conflict with the terms of this Agreement.

ARTICLE A5 - ADMINISTRATIVE AUTHORITY

A5.1 All the functions, rights, powers, and authority which are not specifically abridged, delegated, or modified by this Agreement are recognized by the Medical Society as being retained by Health PEI.

A5.2 These functions, rights, powers, and authority of Health PEI shall not be exercised in a manner which is inconsistent with the provisions of this Agreement, or in a manner that is arbitrary, discriminatory or in bad faith.

A5.3 All payments under this Agreement are subject to audit in accordance with the *Health Services Payment Act* and *Regulations*.

ARTICLE A6 - INFORMATION

A6.1 As soon as reasonably possible after the signing of this Agreement, Health PEI shall work with the Medical Society to provide to all members of the Medical Society an electronic copy (in PDF format) of this Agreement and shall provide the Medical Society with a maximum of 35 printed and bound copies of this Agreement.

A6.2 On a quarterly basis, and from time to time upon request, Health PEI shall provide identifiable Physician payment data to the Medical Society for the sole purpose of enabling the Medical Society to represent Physicians' interests. Between quarterly reports, Health PEI shall respond to reasonable data requests within fifteen (15) business days of the request, or at such other time as may be agreed upon by the Parties. Such data shall be transferred in electronic form.

A6.3 Health PEI shall provide the Medical Society access to relevant Physician Services data (excluding identifiable personal health information) as reported through other electronic medical systems (i.e., Cerner and Telus Collaborative Health Record). Data sharing must meet all provincial and federal privacy requirements.

A6.4 The Medical Society shall indemnify and save harmless the Government and Health PEI from any privacy complaints made by Physicians or the public or related liability that may arise from Health PEI's good faith provision of identifiable Physician payment and health services data to the Medical Society only as it relates to information provided in A6.3.

ARTICLE A7 - SHADOW BILLING

A7.1 All Physicians receiving Alternate Payment shall perform Shadow Billing. Any Physician receiving Alternate Payment who fails to provide Shadow Billing may be required to convert to fee-for-service at the discretion of Health PEI in those circumstances.

(a) Salaried or Contract-for-Service Physicians shall be provided with administrative support by Health PEI to provide Shadow Billing.
(b) Any Physician who provides Shadow Billing for any service shall only provide Shadow Billing for services performed personally by the Physician.

A7.2 The foregoing shall apply until March 31, 2025, and may be extended by the Parties agreement through the IMT.

A7.3 The IMT is tasked with creating a plan to minimize what and how services are tracked with a goal to reduce overall administrative burden.

ARTICLE A8 - CORRESPONDENCE

A8.1 Correspondence from the Government and Health PEI to the Medical Society shall be addressed to a specified designate of the Medical Society and addressed to:

The Medical Society of Prince Edward Island
PO Box 40009
RPO West Royalty
Charlottetown, PE
C1E 0J2
c/o Chief Executive Officer

A8.2 Correspondence from the Medical Society to the Government and Health PEI shall be addressed to a specified designate of the Department or Health PEI and addressed to:

Department of Health and Wellness
PO Box 2000
Charlottetown, PE
C1A 7N8
c/o Deputy Minister of Health and Wellness

Health PEI
16 Garfield St, PO Box 2000
Charlottetown, PE
C1A 7N8
c/o Chief Executive Officer

A8.3 In all cases, the Parties may correspond by email.

ARTICLE A9 - NEGOTIATIONS

A9.1 The Parties to the negotiation of an agreement respecting Physician compensation and other matters shall be the Medical Society and a Health Negotiation Committee appointed pursuant to the *Health Services Act*.

A9.2 The Parties shall:

(a) not later than five months before the expiry date of any agreement in force, meet to determine the data and information that each should make available to the other;
(b) not later than four months before the expiry date of any agreement in force, meet to present and analyse the data and information that each has collected in accordance with clause (a); and
(c) prior to the commencement of formal negotiations, attempt to resolve as many issues as possible through mutual consultation.

A9.3 No party to this Agreement shall change any term or condition therein unless the other party consents to the change or until a new agreement has been concluded by consultation, negotiation, mediation, or arbitration.

A9.4 (a) Not earlier than three (3) months preceding the expiry date of an agreement in force at the time either party may by notice in writing require the other party to commence negotiations with a view to the renewal or revision of an existing agreement or entering into a new agreement.

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

A9.5 When one party has given notice under this Article, the Parties shall, without delay, but in any case within fourteen (14) calendar days after the notice was given, meet or cause representatives on their behalf to meet and commence to negotiate with a view to the renewal or revision of an existing agreement or entering into a new agreement.

A9.6 Where the negotiations have been entered into under this Article, a Party so negotiating shall not discontinue or withdraw from the negotiations on the ground that no notice, or improper or insufficient notice, has been given under this Article.

A9.7 An agreement remains in force until a new agreement is entered into to replace it.

ARTICLE A10 - DISPUTE RESOLUTION PROCEDURES

A10.1 The Parties hereto recognize the benefit of dealing with disputes as quickly as possible and shall make an earnest effort to settle such disputes promptly and fairly. The Parties agree that before formal dispute resolution procedures are resorted to, the Parties must attempt to resolve disputes through the appropriate leader in the Physician Leadership structure and Medical Affairs. If a dispute is unable to be resolved informally, any Party can proceed with the dispute resolution procedures outlined in this Article.

A10.2 General Disputes

(a) Failing resolution through the internal management structure outlined in Article A10.1, and subject to Article A10.3 ("Fee Disputes") or Article A10.4 ("Audits"), the following disputes are to be addressed under this Article:

(i) Between Health PEI and a Physician engaged by Health PEI on any matter including, but not limited to, disputes regarding the application, interpretation or alleged violation of this Agreement or of the particular contract between the Physician and Health PEI; or

(ii) Between the Medical Society (acting on behalf of any of its members or in a policy dispute) and Health PEI on any matter regarding the application, interpretation, or alleged violation of this Agreement.

(b) Only a Party may refer a dispute to the IMT.

(c) If appropriate, the IMT may recommend voluntary conciliation to facilitate a discussion(s) between the Physician(s) and the Physician Leader.

(d) If the dispute is not resolved by the IMT, then a Party may refer the matter to the EC for a decision.

(e) If the dispute is not resolved through the EC, a Party may refer the matter to arbitration. When hearing a dispute arising out of any issue of interpretation, application, operation or any contravention or alleged contravention of an agreement, the Arbitrator shall have full remedial authority and shall order such remedy as may be just, but the Arbitrator shall have no jurisdiction to amend the provisions of this Agreement.

(f) With the exception only of any face-to-face communications, all communications in respect of disputes and matters being addressed under Article A10 shall be in writing at all stages.

(g) Where a dispute under this Article is referred to arbitration, the EC shall attempt to select a mutually agreeable arbitrator between them. If the EC is unable to agree upon an arbitrator within fifteen (15) calendar days, then either party may request that the Chief Justice of the Appeal Division of the Supreme Court of Prince Edward Island appoint an arbitrator for the Parties.

A10.3 Fee Disputes

(a) It is a principle of the Parties that all Physicians are to be trusted to bill properly. Where Health PEI disputes a claim for payment made under the *Health Services Payment Act*, Health PEI will make the payment to the Physician and then discuss the matter with the Physician and may conduct such inquiries or investigations as may be considered necessary. If Health PEI determines it has paid moneys in excess of the correct amount under any claim, Health PEI may withhold future claims or recover moneys from the Physician in the amount of the overpayment, in accordance with the *Health Services Payment Act* and *Regulations.*

(b) Except in the case of an audit, where a fee dispute arises between a Physician and Health PEI concerning a claim for payment or other issue pursuant to the Tariff of Fees the Physician shall, within three months of the claim being rejected, initially seek to resolve the issue through the claim appeal process.

(c) Where a dispute or matter referenced in subsection (a) cannot be satisfactorily resolved through the claim appeal process, the Physician may request through the Medical Society in writing for a review by the IMT. If agreed by the Medical Society, the IMT shall review the matter(s) in dispute and shall attempt to resolve the dispute within 30 calendar days of request by the Medical Society for a review.

(d) If the matter is not resolved by the IMT, then the matter may be referred to EC for a decision. If the EC is not able to reach a decision, the EC shall refer the matter to the Health Services Payment Advisory Committee ("HSPAC").

(e) In any case where the Physician is dissatisfied with the decision of the IMT and/or EC, they may choose to refer the matter to HSPAC.

A10.4 Audits

(a) In the case of an audit conducted in accordance with the *Health Services Payment Act* and *Regulations*, the Physician may enter into discussions with Health PEI to resolve the dispute. Every effort will be made to conclude this discussion process within 90 days of the date of the first communication to the Physician.

If still not resolved, the matter may be addressed in accordance with the *Health Services Payment Act* and *Regulations*.

ARTICLE A11 - INTEREST ARBITRATION

A11.1 In the event that either Party determines that a revised PSA is not able to be reached following the expiry of the Agreement or in accordance with the Re-opener MOU, attached hereto, then the Parties agree that Interest Arbitration is the sole method of dispute resolution. The Party giving notice of their desire to resolve the dispute through interest arbitration shall, at the time of giving notice, name its appointee to the Board of Arbitration. The other Party shall, within ten (10) calendar days of the receipt of such notice, name its appointee to the Board of Arbitration. The two appointees shall, within a further fifteen (15) calendar days, agree upon a chairperson for the Board of Arbitration.

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

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

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

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

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

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

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

(a) the fiscal policies of Government;

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

(c) fair and reasonable compensation for Physicians; and

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

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

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

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

ARTICLE A12 - RESPONSIBILITY FOR THE CONTINUANCE OF OPERATIONS

A12.1 Provided the Parties have recourse to the dispute resolution mechanism provided for herein, the Medical Society shall not organize, incite, support or sanction a withdrawal of services, suspension or slowdown of work, or any other interference with the business of the Government or Health PEI, and the Medical Society shall make all reasonable efforts to urge its members to refrain from such activities.

ARTICLE A13 - COMMITTEE STRUCTURES AND PURPOSES

A13.1 Legislated Committees

The following Committees are established pursuant to legislation and report and make recommendations directly to the Minister and include Physician representation:

(a) **The Health Services Payment Advisory Committee** ("HSPAC")

A committee created pursuant to the *Health Services Payment Act* RSPEI 1988, c H-2 and *Health Services Payment Act Regulations*, PEI Reg EC499/13, the functions of which include, but are not limited to, reviewing and making recommendations to the Minister with respect to Physician claims for payment, and advising the Minister on matters affecting the effective and efficient administration of the Health Services Payment Plan.

(b) **The Physician Resource Planning Committee** ("PRPC")

A committee created pursuant to sections 2.1 and 2.2 of the *Health Services Payment Act*, RSPEI 1988, c H-2, which assists the Minister in determining the appropriate number and equitable distribution of general and specialized Physician services for the province, and discusses and provides advice regarding Physician recruitment and retention strategy. In addition, the Committee shall make recommendations to the Minister on the Physician complement.

If such committees are amended by legislation, the Parties agree to adhere to the applicable legislative processes.

A13.2 Physician Services Agreement Committees

(a) **Executive Committee ("EC")**

(i) **Purpose**

a. The Parties recognize that the landscape for the effective, efficient delivery of robust healthcare to Islanders faces numerous ongoing challenges and needs to be capable of addressing these challenges and changing rapidly as is needed and appropriate.
b. The Parties agree to continue to pursue an interest based collaborative approach to joint problem solving as being an integral to the successful implementation of the Agreement.
c. The Parties will ensure the effective and efficient implementation and administration of the Agreement and ensure the oversight of the role and responsibility of Physicians in the medical system.

EC is a tripartite oversight committee comprised of representatives of the three Parties.

The EC has the sole authority upon mutual agreement to amend the PSA as required to support the enhanced management of the health care system as it relates to the interest of the Parties.

(ii) **Functions**

The functions of EC in cooperation, consultation and collaboration with the IMT, established by a Memorandum of Agreement attached hereto, shall be to ensure that the IMT succeeds in the following:

a. Design sound processes, policies and structures to support the Agreement being a flexible, viable and living document;
b. Ensure timely implementation of the PSA;
c. Ensure the key enablers required to support the Agreement are actioned;
d. Nurture and implement the required culture for change management, communication and education arising from the evolution of the Agreement;
e. Evaluate the programming and components of the Agreement;
f. Ensure due process is followed for all elements of the Agreement within its mandate, including fund allocation/management, introduction of new fee codes, issues management and dispute resolution;
g. Make recommendations to the Parties respecting matters arising from carrying out its functions;
h. Discuss and action matters of mutual interest arising during the life of this Agreement;

i. Discuss and action recommendations from IMT and the Parties upon any proposed revisions, amendments, additions, or deletions to the PSA, the Preamble and the Tariff of Fees;
j. Review and accept or make recommendations to the Parties respecting the implementation of any recommendations from IMT;
k. Perform those dispute resolution functions as listed in Article A10;
l. Communicate decisions of general interest, including billing interpretation issues, to the Parties to disseminate to their members or stakeholders, as appropriate;
m. Engage in any such other functions that IMT or the Parties may, by written agreement, refer to it;
n. During the term of this Agreement, the IMT shall have the authority to make recommendations to EC regarding amendments to the Tariff of Fees and Preamble and the recommendations ultimately endorsed by EC.

(iii) **Membership**

EC will be comprised of four (4) members being the CEO of the Medical Society, the CEO of Health PEI, the CMO of Health PEI and the Deputy Minister of the Department of Health and Wellness, or their designate at the level of Assistant Deputy Minister, or above. A member may appoint a designate/proxy *pro tem*, if, as and when required.

For all matters that go to vote, each party has one (1) vote regardless of the number of attendees. Unanimity is required for any formal decision to make any modification to the PSA.

There will be an annual rotating chair from the Parties for the purpose of calling meetings, minute taking, etc.

EC will meet at least on a quarterly basis or more often as required to provide direction to the IMT and to ensure satisfactory progress of the implementation of the PSA as directed from time to time by the EC.

(b) **Implementation Management Team ("IMT")**

The EC will be supported by a tri-partite IMT which is responsible to fulfill the above functions on behalf of the EC. IMT's Leadership Team will be accountable to the Executive Committee. It will have a representative appointed from each party. In addition, the IMT shall be the first point of contact for disputes and attempt to resolve any dispute that arises with the interpretation, implementation or administration of the PSA. Matters that cannot be resolved shall be referred to the EC and are subject to Article A10.

ARTICLE A14 - SAVINGS CLAUSE

A14.1 If any article in this Agreement shall be found to be in conflict with any statute, such article shall be deemed null and void. However, such article shall be separable from the remainder of this Agreement, and all other articles herein shall continue in full force and effect. The Parties to this Agreement shall negotiate a replacement for the article rendered null and void.

ARTICLE A15 - DISCRIMINATION

A15.1 There shall be no discrimination practised by either party with respect to any Physician on the basis of age, colour, creed, disability, ethnic or national origin, family status, gender expression, gender identity, marital status, political belief, race, religion, sex, sexual orientation, source of income or membership activity in the Medical Society.

ARTICLE A16 - PROTECTION FOR PHYSICIANS UNDERTAKING MILITARY SERVICE

A16.1 Health PEI shall grant leave of absence of no more than fifty-two (52) weeks without pay to a Physician who requests leave for the purpose of taking Reserve Military training or activation for operational reasons with the Canadian Forces. The Physician's position in the complement shall be protected and available upon return from active duty.

ARTICLE A17 - PATIENT MEDICAL HOMES

A17.1 The Parties agree to administer this Agreement in a manner that supports the Patient Medical Home model by enabling recruitment and retention to practice environments that are safe, collaborative, and sustainable.

ARTICLE A18 - INSURANCE AND LIABILITY

A18.1 The Physician agrees to maintain active individual membership with the Canadian Medical Protective Association (CMPA). Alternatively, the Physician agrees to maintain individual professional malpractice liability insurance with limits of not less than $10,000,000 for any one occurrence. This insurance shall be with an insurer and in a form acceptable to Health PEI, who shall have the right, but not the obligation to review this insurance to determine its acceptability. Acceptance by Health PEI of such insurance coverage shall not be construed as a waiver of any conditions of this Agreement. The Physician shall provide Health PEI with a certificate of insurance evidencing such insurance.

A18.2 The Physician shall pay CMPA dues or in the alternative, individual malpractice liability insurance as aforementioned. The Medical Society, upon receipt of evidence of payment shall provide reimbursement in accordance with Article C3.6 (CMPA Assistance).

A18.3 If an action or proceeding is brought against any Physician for an alleged tort committed by them in the performance of their duties, the Physician shall advise Health PEI immediately.

SECTION B - TERMS & REMUNERATION

ARTICLE B1 - PHYSICIAN CONTRACTS

B1.1 New Salaried Physicians will sign a letter of offer or a letter of confirmation reflecting the services they are providing, in accordance with this Agreement.

B1.2 New Contract for Service Physicians will sign contracts in the form attached as Appendix A as applicable, reflecting the services they are providing.

B1.3 New Fee-for-Service Physicians shall sign a letter of offer or a letter of confirmation stipulating the range of medical services, the delivery model and the geographic area or region where the fee-for-service work will be performed.

B1.4 New Associate Physicians will sign a letter of offer or a letter of confirmation reflecting the services they are providing, in accordance with this Agreement.

B1.5 No Physician will be permitted by Health PEI to commence employment/services unless both the Physician and Health PEI have signed the contract of employment, letter of offer or letter of confirmation, as applicable, which will include the job description or description of duties.

B1.6 Health PEI acknowledges that the Physician is entitled to receive independent advice from the Medical Society. Health PEI shall notify the Medical Society that it intends to make an offer of employment to the Physician, and Health PEI shall make full disclosure of such offer to the Medical Society in advance of signing by the Physician.

B1.7 Health PEI may revise the Physician's job description or description of duties by providing thirty (30) days' written notice, and discussion with the Physician involved. The Medical Society will be advised before any revised description is presented to any Physician and will be provided with any revised description when completed. Any revisions must be reasonable and based on operational requirements. If the Physician does not agree with the revisions, they may refer the matter to the dispute resolution mechanisms pursuant to Article A10.

B1.8 When a Physician employed by Health PEI agrees upon signing a contract to support and participate in planning that is aligned with the Health System Strategic Plans, this does not limit the Physician's freedom of expression as an advocate for optimal patient care and for what the Physician believes to be in the best interest of the public health care system. It is further acknowledged that where the Physician is acting in the capacity of representative of their peers, such as but not limited to President of the Medical Staff, Chief of Staff, etc., the Physician shall have the right to express the views and concerns of physicians with respect to Health System Strategic Planning.

ARTICLE B2 - ELECTION OF PAY MODALITY

B2.1 Fee-for-Service Physicians shall be permitted to change to an Alternate Payment modality with the prior approval of Health PEI.

B2.2 Physicians who receive Alternate Payment have the right to convert to fee-for-service practice provided that eight (8) weeks of written notice is given to Health PEI, and provided that the Physician continues the same range of medical services within the same delivery model and geographic area where the Alternate Payment services were performed.

B2.3 If Health PEI chooses not to retain the Alternate Payment Physician (including a Salaried Physician who is converting to fee-for-service rather than resigning or retiring) the Physician will receive a payment equal to the amount of remuneration that the physician otherwise would have earned had the Physician worked during the course of the eight (8) week period.

B2.4 If the Alternate Payment Physician is not retained during the full notice period for reasons of just cause or non-performance of the work, as the case may be, the payment referred to in Article B2.3 will not apply.

B2.5 To convert from Alternate Payment modality to fee-for-service practice both the Physician and Health PEI must sign a fee-for-service letter of confirmation. Such letter shall stipulate the geographic area and the range of medical services for the Physician. The geographic area and the range of services will be consistent with the Physician's work within the immediately preceding 12-month period.

B2.6 Physicians who convert to fee-for-service pursuant to this Article are subject to Article B13.

ARTICLE B3 - MULTIPLE PAYMENT MODALITIES

B3.1 Physicians who are authorized to work in an Alternate Payment model (sessional, contract-for-service or salary) are permitted to bill fee-for-service for work performed in the following circumstances:

(a) They have prior authorization of Health PEI (which will not be unreasonably withheld) and the work performed is:
   (i) outside of the Physician's description of duties as set out in their arrangement with Health PEI; and
   (ii) outside of the Physician's weekly scheduled hours as set out in their arrangement with Health PEI.

(b) They have prior authorization of Health PEI to bill fee-for-services on specific terms.

(c) They are performing work outside their Alternate Payment hours in the following areas:
   (i) on-call services;
   (ii) hospital inpatient services; or
   (iii) services provided to patients in their home, nursing home or community care facility.

(d) They are performing work as an Emergency Medicine, Hospitalist Medicine or Closed ICU Physician outside of their Department but within any other location of the hospital.

B3.2 Where the additional work falls within a Physician's description of duties, the Physician may be eligible for overtime as set out in this Agreement.

B3.3 Failure to obtain prior written authorization from Health PEI, when required under this Article, for such fee-for-service work performed in a manner inconsistent with their letter of offer or confirmation letter shall result in the Physician being paid at 50% of the rates set out in the Tariff of Fees for such work.

B3.4 Where a Physician takes approved vacation from their salaried position, the Physician may provide other clinical or administrative services to fill an organizational need on a fee-for-service basis, provided they obtain written authorization from Health PEI before performing these services. Such authorization shall not be unreasonably withheld. For clarity, a Physician cannot bill fee-for-service while on approved vacation if the services provided are considered part of their salaried position from which the Physician took the vacation.

ARTICLE B4 - PAID HOURS SUBMISSION

B4.1 Physicians must submit their hours worked for payment as set out in the Operating Guide in accordance with their chosen pay modality.

Overtime

B4.2 At the discretion of Health PEI, and based on operational need, Health PEI may pre-approve overtime for Alternate Payment Physicians not on-call.

B4.3 For Salaried Physicians, "Overtime Hours" will be hours worked in excess of 37.5 during this salaried period. Overtime Hours will be taken as equivalent time off in lieu, subject to operational needs. In the event it is not possible to take time off in lieu, the overtime hours may be paid to the Physician at the Physician's then current hourly rate.

B4.4 For Contract for Service Physicians, in cases where the Physician has exceeded their annual maximum hours in a given year, the Contract for Service Physician shall seek written approval from Health PEI to continue to provide and submit for clinical services. In such cases, the Contract for Service Physician shall be permitted to continue to be remunerated by hourly rate.

B4.5 Subject to an emergency situation, all overtime must be pre-approved.

B4.6 Any claim for unapproved overtime must be submitted to Health PEI and must contain a full description of the emergency situation which required overtime.

ARTICLE B5 - PAYMENT BY MEDICARE

B5.1 All claims submitted to Medicare that meet the requirements of the *Health Services Payment Act* and the Tariff shall be paid within 90 days of submission. All accounts submitted are subject to audit and repayment as required by the *Health Services Payment Act*.

ARTICLE B6 - SALARIED AND ASSOCIATE PHYSICIAN TERMS

B6.1 (a) The following Article B6 applies only to Salaried Physicians and Associate Physicians.

(b) Salaried Physicians and Associate Physicians are employees of Health PEI pursuant to a contractual arrangement.

(c) Except as otherwise expressly stated, the term "Physician" in Article B6 means "Salaried Physicians" and "Associate Physicians".

B6.2 Health PEI shall, at no cost to the Physician, arrange for a professional work site and sufficient support staff to enable an efficient and productive practice during regularly scheduled salaried hours of work.

Job Description

B6.3 Each Physician shall have a written job description. Such job description shall contain:

(a) the job title;
(b) the Physician Leader to whom the physician will report for clinical and administrative purposes;
(c) a summary of the position's responsibilities;
(d) a description of the position's specific duties, including:
    (i) location of the physician's specific place(s) of work;
    (ii) expected workload (to be determined on an individualized basis);
    (iii) expected type and range of medical services to be provided;
    (iv) expected on-call coverage and/or inpatient requirements as per the Agreement, if applicable;
    (v) any other related duties.

Work Schedule and Services

B6.4 The normal hours of work for a Physician shall be 37.5 hours per week/1950 hours per year, typically Monday to Friday unless otherwise agreed to between the Physician and Health PEI.

B6.5 In consultation with each Salaried Physician, Health PEI will establish a work schedule and services required of the Salaried Physician. Services must be based on system need, as determined by Health PEI. Revisions to work schedules and required services must be documented in consultation between the Salaried Physician and Health PEI.

B6.6 For Associate Physicians, Health PEI will establish the work schedule/content for the normal hours of work in keeping with the service requirements of Health PEI and in coordination with the Supervising Physician and the Associate Physician. Revisions to

such work schedule/content shall be made with agreement between the Supervising Physician, Associate Physician, and Health PEI.

On-Call during Statutory Holidays

B6.7 A Physician who is required to be on-call on a statutory holiday shall receive a day off in lieu of the holiday, to be taken at a time mutually agreeable to the Physician and Health PEI. Days off in lieu shall not be accumulated and must be used during the current fiscal year. All accrued holiday time will be paid out at the end of the fiscal year.

B6.8 A Physician who provides on-call services during a statutory holiday shall be permitted to bill fee-for-service for services rendered during the holiday.

B6.9 Statutory holidays are as defined in Article C1.29.

Probationary Period

B6.10 A Physician hired after the signing of this Agreement shall be hired as probationary employee and shall be subject to a "probationary period" of the lesser of nine hundred seventy five (975) working hours or one year.

B6.11 Health PEI shall review a probationary employee's performance at least one time prior to the completion of their probationary period. The probationary employee shall be given the opportunity to read the appraisal and attach their comments prior to completion of the probationary period. The performance review shall be conducted by the applicable Physician Leader, as determined by Health PEI.

B6.12 The probationary period may be extended by a maximum of two hundred fifty (250) working hours, provided such extension is considered necessary by Health PEI. A written notice of the extension and a copy of a written performance appraisal, with reasons for the extension, shall be given to the physician and the Medical Society prior to the expiry of the initial probationary period.

Discipline

B6.13 No Physician who has successfully completed their probationary period shall be disciplined by Health PEI except for just cause.

Termination by Physician

B6.14 In the event the Physician wishes to terminate their employment with Health PEI, they are to provide as much advance notice as is possible. A minimum of eight (8) weeks is required.

Termination by Employer

B6.15 If Health PEI wishes to terminate a Physician's employment, without cause, Health PEI will provide the following advance notice, or pay in lieu thereof, to the Physician:

(1) a Physician with less than four years of continuous employment, eight (8) weeks' notice; or

(2) a Physician with four or more years of continuous employment, two (2) weeks' notice for each full year of service, to a maximum of thirty (30) weeks' notice. A partial year of service in the final year shall be pro-rated.

B6.16 Health PEI is entitled to terminate a Physician's employment with just cause without notice.

B6.17 Notice is deemed to have been given on the day of delivery in person, by facsimile, electronic communication, or on the mailing date of the notice, as the case may be.

ARTICLE B7 - SUPERVISING PHYSICIAN

B7.1 (a) The Primary Supervising Physician who is supervising an Associate Physician is eligible to bill the physician supervision fee code (0053) as per the Tariff of Fees. Payment for supervision is limited to the first six (6) months of employment with Health PEI for new Associate Physicians being assigned to a Supervising Physician. Supervision may be shared by a group of physicians, and only one physician is eligible to bill per day.

(b) If an Associate Physician moves to a new role in the system, the new Primary Supervising Physician (or group) is eligible for the supervision fee code (0053) for an additional three (3) months to support the Associate Physician in transitioning to the new role.

ARTICLE B8 - CONTRACT-FOR-SERVICE TERMS

B8.1 (a) The following Article B8 applies only to Contract for Service Physicians.

(b) A Contract for Service Physician is an independent contractor of Health PEI, pursuant to a contract for services (Appendix "A") which includes a description of duties for which they have been engaged to provide.

Hours of Work

B8.2 Every contract for service entered into between a Contract for Service Physician and Health PEI shall set out maximum number of hours of work that are to be performed and remunerated under the contract for service.

B8.3 The normal hours of work for a Contract for Service Physician shall be 1725 hours per year, typically Monday to Friday unless otherwise agreed to between the Physician and Health PEI.

Additional Hours

B8.4 Contract for Service Physicians shall submit a written invoice for actual hours worked on a monthly, quarterly or other period as may be specified in the contract for services, whereupon Health PEI shall pay the Physician within thirty (30) days.

B8.5 The following will account for the contract for service in lieu of benefits amounts:

Apr 1, 2025	Apr 1, 2026	Apr 1, 2027	Oct 1, 2027	Apr 1, 2028	Oct 1, 2028
$23,000.00	$23,000.00	$23,230.00	$23,462.30	$23,696.92	$23,933.89

ARTICLE B9 - PERFORMANCE EVALUATION

B9.1 (a) The following Article B9 applies only to Salaried Physicians, Contract for Service Physicians and Associate Physicians.

(b) Except as otherwise expressly stated, the term "Physician" in Article B9 means Salaried Physicians, Contract for Service Physicians and Associate Physicians.

B9.2 The Parties acknowledge and agree that Government and Health PEI have a desire to hold Physicians accountable for the alternate payment they receive in lieu of traditional fee-for-service piece work.

B9.3 At the discretion of Health PEI, the performance and accountability of Physicians will be evaluated on the basis of Health PEI's Employee Performance & Development Policy and upon a variety of factors, (also referred to as Key Performance Indicators), which could include, but are not limited to, the following:

(a) Alignment with panel policy

(b) Number of consults

(c) Access (e.g., 3rd next available appointment, same-day appointment or consult wait-times).

B9.4 Defining key performance indicators and the approach and methodology to data collection and reporting will be documented in the Operational Guide and endorsed by the Implementation Management Team.

B9.5 If a Physician's performance falls below standards acceptable to Health PEI, certain remedial actions may be taken, including (but not limited to) placing the Physician on probation or, for Salaried Physicians and Contract for Service Physicians, requiring the Physician to reduce their FTE or convert to fee-for-service payment modality as determined by Health PEI.

ARTICLE B10 - PERIODIC REVIEWS

B10.1 All Physicians shall be subject to periodic reviews.

ARTICLE B11 - TARIFF OF FEES

B11.1 Health PEI shall pay Physicians in accordance with the Tariff of Fees, attached hereto as Schedule "A", for health services provided to entitled persons under the Health Services Payment Plan.

ARTICLE B12 - SESSIONAL TERMS

B12.1 A Sessional Physician is responsible to provide group coverage in accordance with a Services Coverage Agreement with Health PEI as set out in Appendices C - F.

ARTICLE B13 - FEE-FOR-SERVICE TERMS

B13.1 A Fee-for-Service Physician is an independent contractor who has an arrangement with Health PEI for payment on a fee-for-service basis.

ARTICLE B14 - REMUNERATION

B14.1 As determined in accordance with this Agreement, the rates of pay for Physicians will be in accordance with the pay levels outlined in each sub-article below.

Longitudinal Family Medicine Specialist ("LFM Specialist")

B14.2 (a) The Longitudinal Family Medicine Specialist ("LFM Specialist") rate will apply where:

(i) The Physician works a minimum of 0.6 FTE dedicated to a LFM primary care setting, which may include inpatient care and rural emergency department care; and

(ii) The Physician has a patient panel and/or is participating in a Patient Medical Home.

(b) A LFM Specialist may select to provide focused family medicine work as approved by Health PEI and will be remunerated at the LFM Specialist rate.

(c) The following is the pay level for an LFM Specialist:

	Apr 1, 2025	Apr 1, 2026	Apr 1, 2027	Oct 1, 2027	Apr 1, 2028	Oct 1, 2028
Annual Salary	$325,455.00	$325,455.00	$328,709.55	$331,996.65	$335,316.61	$338,669.78
Salaried Hourly Rate	$166.90	$166.90	$168.57	$170.25	$171.96	$173.68
Contract for Service Hourly Rate	$202.00	$202.00	$204.02	$206.06	$208.12	$210.21

Patient Panel Incentive Program

B14.3 (a) The Patient Panel Incentive Program ("Program") is designed to remunerate those LFM Specialists who affiliate patients to their practice and/or Patient Medical Home beyond their assigned panel benchmark. The Program is not intended to supplement income for those LFM Specialists who reduce their FTE which has the effect of qualifying for the incentive.

(b) Eligibility

(i) The Program only applies to Contract for Service and Salaried LFM Specialists who work a minimum of 0.8 FTE and dedicate a minimum of 0.6 FTE to LFM services, as described below.

a. For LFM Specialists hired before the signing of this Agreement, LFM Services (and accordingly the services upon which the Physician's LFM FTE is calculated) are services provided in the primary care setting and may include inpatient care, palliative care, MAID, SHORS, addictions care medicine, family practice anesthesia, family medicine obstetrics, unaffiliated prenatal care and emergency services.

b. For LFM Specialists hired after signing of this Agreement, LFM Services (and accordingly the services upon which the Physician's LFM FTE is calculated) are services provided in the primary care setting and may include inpatient care and rural emergency medicine.

(ii) LFM Specialists must use the Provincial EMR.

(c) Reassessment of Eligibility after Change in FTE Status

If a Physician successfully obtains approval from Health PEI to change their FTE as an LFM Specialist, their eligibility for the Program will be critically reassessed and a decision rendered by Health PEI. For clarity, this is to prevent Physicians from modifying practice profiles to enhance financial gain under the Panel Policy Incentive Program.

(d) Panel Size Calculation for Purpose of Program

(i) A LFM Specialist's patient panel size will be validated annually using a methodology in accordance with Health PEI's Panel Policy and Patient Medical Home Panel Policy ("Panel Policy") and endorsed by the IMT and documented in the Operational Guide.

(ii) Where a LFM Specialist does not agree with the findings of the panel validation process in relation to their patient panel count, they may use the dispute resolution process as set out in Article A10.

(e) Payment

Payment under the Program is calculated in the following manner:

(i) The payment will be made annually, following a patient panel validation process in accordance with Panel Policy.

(ii) Physicians who establish to Health PEI under the patient panel validation process that they are exceeding the Panel Policy expectations (based on an annual review of data) will receive an annual payment as outlined below:

Key Performance Indicator*	**Incentive***
❑ Adherence to Panel Policy ❑ Same day access target **AND**	
❑ 100 patients over Panel Policy	$10,000
❑ 200 patients over Panel Policy	$20,000
❑ 300 patients over Panel Policy	$30,000
❑ 400 patients over Panel Policy	$40,000
❑ 500 patients over Panel Policy	$50,000
❑ 600 patients over Panel Policy	$60,000

*Based on 1 FTE in Longitudinal Family Medicine. Panel increment and incentive value is prorated for Physicians working below 1.0 FTE.

Longitudinal Family Medicine Retention Payments

B14.4 In-patient Retention: QEH and PCH

(a) Each full-time fee-for-service LFM Specialist who maintains active medical staff privileges at either the Prince County Hospital or the Queen Elizabeth Hospital, and who participates in the provision of in-patient care shall receive an annual retention payment of $7,500, payable in equal biweekly installments. This retention payment shall be pro-rated for part-time physicians.

B14.5 Rural Hospital Inpatient On-Call Retainer Incentive

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

(b) The annual Rural Hospital Incentive will be:

(i) $5,000 for LFM Specialists practicing at a rural hospital with an emergency department where the LFM Specialist is remunerated by the ED hourly rate defined in Article B15.3; or

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

(c) Such incentive payments shall be pro-rated for permanent part-time LFM Specialists and shall not apply to Locum Physicians. An LFM Specialist may be eligible to receive only one of the above incentive payments.

B14.6 Focused Family Medicine Specialist

(a) The Focused Family Medicine Specialist ("FFM Specialist") rate will apply when the following criteria are met:

(i) the majority of the Physician's time is not dedicated to a LFM setting;

(ii) the Physician does not have a patient panel and/or is not participating in a Patient Medical Home; and,

(iii) the Physician's area of focus includes, but is not limited to, one or a combination of the below subspecialties:

- Palliative Care
- MAID
- SHORS
- Addictions Medicine
- Pain Management
- Sports Medicine
- Geriatrics (consulting with provincial program)
- Dermatology
- Family Medicine Obstetrics
- Clinical Associates – Medical Oncology
- Home Care
- Surgical Assists
- Family Medicine Relief
- Primary Care Access Clinics (PCAC)
- Walk In Clinic /Virtual Platforms for Unaffiliated

The following is the pay level for a FFM Specialist:

	Apr 1, 2025	Apr 1, 2026	Apr 1, 2027	Oct 1, 2027	Apr 1, 2028	Oct 1, 2028
Annual Salary	$296,127.00	$296,127.00	$299,088.27	$302,079.15	$305,099.94	$308,150.94
Salaried Hourly Rate	$151.86	$151.86	$153.38	$154.91	$156.46	$158.03
Contract for Service Hourly Rate	$185.00	$185.00	$186.85	$188.72	$190.61	$192.51

B14.7 Surgical Assists

(a) Physicians who provide surgical assists as a secondary service (i.e., are actively working in their own specialty) will bill the appropriate hourly rate according to Tariff.

(b) Physicians who no longer practice their specialty and provide a focused surgical assist service will be paid the Family Focused Medicine hourly rate in accordance with Article B14.6(b).

B14.8 Associate Physician Salary

(a) The following is the annual salary for a full-time Associate Physician:

	Apr 1, 2025	Apr 1, 2026	Apr 1, 2027	Oct 1, 2027	Apr 1, 2028	Oct 1, 2028
Annual Salary	$162,727.50	$162,727.50	$164,354.78	$165,998.32	$167,658.31	$169,334.89
Salaried Hourly Rate	$83.45	$83.45	$84.28	$85.13	$85.98	$86.84

B14.9 All Other Specialists

(a) The following is the pay level for Group 1 Specialists: Laboratory Medicine, Radiation Oncology, Medical Oncology and Hematology Specialists:

	Apr 1, 2025	Apr 1, 2026	Apr 1, 2027	Oct 1, 2027	Apr 1, 2028	Oct 1, 2028
Annual Salary	$437,580.00	$437,580.00	$441,955.80	$446,375.36	$450,839.11	$455,347.50
Salaried Hourly Rate	$224.40	$224.40	$226.64	$228.91	$231.20	$233.51
Contract for Service Hourly Rate	$267.00	$267.00	$269.67	$272.37	$275.09	$277.84

(b) The following is the pay level for Group 2 Specialists: All other specialties not previously listed above in sub-article (a):

	Apr 1, 2025	Apr 1, 2026	Apr 1, 2027	Oct 1, 2027	Apr 1, 2028	Oct 1, 2028
Annual Salary	$377,208.00	$377,208.00	$380,980.08	$384,789.88	$388,637.78	$392,524.16
Salaried Hourly Rate	$193.44	$193.44	$195.37	$197.33	$199.30	$201.29
Contract for Service Hourly Rate	$232.00	$232.00	$234.32	$236.67	$239.03	$241.42

ARTICLE B15 - SESSIONAL TERMS

B15.1 For Sessional Physicians, Health PEI, in consultation with the Provincial Department Heads and applicable Medical Directors will determine the funded hours and lines in each Emergency Department, Hospitalist Service, and the number of beds in a Closed ICU and will be outlined in the Operational Guide.

B15.2 Each Sessional Physician shall be paid the applicable rate as set out in the sub-articles below.

B15.3 Emergency Medicine Services

(a) Emergency Department Physician ("EDP") are those Physicians who are engaged to work and scheduled by Health PEI's Provincial Emergency Medicine Physician Leader to provide emergency department services at one of Health PEI's designated Emergency Departments.

(b) An EDP engaged by the Provincial Department Head of Emergency Medicine to provide medical services within a Health PEI Emergency Department will be paid an hourly sessional fee which shall be billed using time-window specific fee codes listed in the Tariff of Fees.

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

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

(i) An EDP who covers an ER shift on a particular day shall not be entitled to bill fee-for-service for Site 4 visits provided on that same day without prior authorization from Health PEI.

(ii) For the purpose of this sub-article, "same day" is defined as the 24-hour period commencing at 00:01 hours during which the shift is worked. For shifts extending over 00:01 hours, the day during which the FFS billing restriction applies, is the day in which the longest portion of the shift is worked.

(e) The following is the hourly pay levels for an EDP:

	Apr 1, 2025	Apr 1, 2026	Apr 1, 2027	Oct 1, 2027	Apr 1, 2028	Oct 1, 2028
Weekday Day Hourly Rate 08:00-17:59	$225.00	$225.00	$227.25	$229.52	$231.82	$234.14
Weekday Evening Hourly Rate 18:00-23:59	$281.25	$281.25	$284.06	$286.90	$289.77	$292.67
Weekend/Holiday Day and Evening Hourly Rate	$337.50	$337.50	$340.88	$344.28	$347.73	$351.20
Night Hourly Rate 24:00-07:59	$450.00	$450.00	$454.50	$459.05	$463.64	$468.27

(f) EDPs will bill for the hours worked in each shift window. It is recognized that an EDP's shift may be spread in multiple shift windows. The shift windows will be as follows:

Shift Window	Applicable Hours
Day	0800-1759
Evening	1800-2359
Overnight	0000-0759

B15.4 Option to Design New Payment Model

(a) Through the ED Provincial Department Head, the ED physician group may opt to work with the IMT to design a new payment model to help achieve desired patient access and Key Performance Indicators desired by both the physicians and system for recommendation and approval by EC.

(b) A new payment model must work within the existing funds allocated to emergency services through this Agreement.

B15.5 Hospitalist Medicine Services

(a) A Hospitalist Medicine Physician ("Hospitalist Physician") is a Physician who is engaged and scheduled by Health PEI Provincial Hospitalist Medicine Physician Leader to provide hospitalist services at an acute care facility. A Hospitalist Physician shall provide comprehensive inpatient care for patients assigned to them, including admission history and physical examination, daily medical management, participation in multi-disciplinary rounds and family conferences as needed, and discharge planning.

(b) Each group of Hospitalist Physicians shall enter into a Hospital Service Coverage Agreement with Health PEI as set out in Appendix E. Each Hospitalist Physician shall be paid an hourly sessional fee.

(c) The following is the hourly pay level for a Hospitalist Physician:

	Apr 1, 2025	Apr 1, 2026	Apr 1, 2027	Oct 1, 2027	Apr 1, 2028	Oct 1, 2028
Hourly Rate	$202.00	$202.00	$204.02	$206.06	$208.12	$210.20

(d) Each Hospitalist Physician shall bill the hourly rate for any hours worked between 0800 and 1700 hours daily to a maximum of 8 hours daily.

B15.6 Closed ICU

(a) Closed ICU Physicians are those Physicians who are engaged to work and are scheduled by Health PEI's Provincial Department Head of Medicine to provide medical services to critically ill patients who require intensive monitoring and treatment in a critical care setting.

(b) Each group of Closed ICU Physicians shall enter into a Closed ICU Coverage Agreement with Health PEI as set out in Appendix F.

(c) Each day, one Closed ICU Physician shall be paid a daily sessional fee for the admission and management of patients in the Closed ICU as set out below.

(d) The daily rates are based on a per bed rate. The daily rate will be adjusted if bed count changes per facility.

(e) The following is the daily sessional fee for a Closed ICU Physician based on a 10-bed Closed ICU:

	Apr 1, 2025	Apr 1, 2026	Apr 1, 2027	Oct 1, 2027	Apr 1, 2028	Oct 1, 2028
Daily Sessional Rate	$4500.00	$4500.00	$4545.00	$4590.45	$4636.35	$4682.72
Based on per bed rate	$450	$450	$454.50	$459.05	$463.63	$468.27

(f) A Closed ICU Physician shall limit competing clinical duties and, in any event, shall not perform routine elective consultations, clinics or investigations while designated to provide daytime coverage for critically ill patients in the Closed ICU. Refer to the Tariff of Fees for exceptions.

ARTICLE B16 - LONG TERM CARE

B16.1 Each contracted LTC physician will sign a contract as outlined in Appendix B.

B16.2 Each Long Term Care Facility ("LTC Facility") in the Province shall have either a full-service contracted Long Term Care Physician ("LTC Physician") or collaborating contracted LTC Physician who works collaboratively with a Nurse Practitioner at the facility.

B16.3 The contracted LTC Physician shall provide, either directly as a full-service contracted LTC Physician or collaboratively with a Nurse Practitioner as a collaborating contracted LTC Physician;

(a) continuous coverage to the residents of the facility who do not have a personal physician;

(b) service to residents who have a personal physician who cannot be reached; and

(c) any required consulting services that the facility may require, including acting as a resource to committees of the facility.

B16.4 Contracted LTC Physicians shall be remunerated in the following manner:

(a) full-service contracted LTC Physicians shall be paid a standard LTC stipend of $1,000.00 per bed per annum, based on the approved bed capacity of the LTC Facility, to be paid in bi-weekly installments, for the provision of comprehensive LTC medical services (in lieu of fee-for-service billings, except as noted in Article B16.4(d) and twenty-four (24) hour/seven (7) day per week on-call coverage for each resident.

(b) collaborating contracted LTC Physicians shall be paid a standard LTC stipend of $570.00 per bed per annum, based on the approved bed capacity of the LTC Facility, to be paid in bi-weekly installments, for the provision of LTC medical services (in lieu of fee-for-service billings, except as noted in Article B16.4(d) through collaboration with a Nurse Practitioner.

(c) physicians providing on-call coverage in support of LTC Nurse Practitioners shall be paid an LTC Back-up On-call Retainer of $200.00 per day (fee code 6003), which shall qualify for the standard weekend/holiday premium of 25% (see Preamble 12.B).

(d) in addition to the above-noted standard LTC stipends, any services that must be provided emergently afterhours (weekdays 18:00-08:00 and weekends 08:00-08:00) at the explicit request of LTC staff shall be paid on a fee-for-service basis, as follows:

(i) **LTC On-Call Response Fee** (fee code 9360)
This fee is intended to compensate on-call contracted LTC Physicians and physicians billing the LTC Backup On-call Retainer for the disruption and inconvenience of having to respond emergently to the request of LTC staff to provide in-person emergent service to a resident, which is not part of the on-call physician's normal routine. This fee shall qualify for the standard weekend/holiday premium (see Preamble 12.B), may be claimed more than once per on-call day, and is payable in addition to any medical services provided.

(ii) **LTC Afterhours Detention Fee** (fee code 1870)
In addition to the LTC On-Call Response Fee, this fee is payable when the on-call contracted LTC Physician or physician billing the LTC Backup On-call Retainer is called in emergently to provide medical services to a resident, in lieu of other visit or procedure fees. It is payable in blocks of 15 minutes, or major portion thereof, commencing immediately when the physician sees the resident, and qualifies for both afterhours (weekdays 18:00-08:00) and weekend/holiday (08:00-08:00) premiums (see Preamble 12.B).

(e) Payment of the LTC On-Call Response Fee and the LTC Afterhours Detention Fee requires clear documentation on the resident's chart outlining:
(i) The time the physician was called in
(ii) Time spent with the resident
(iii) The nature of the resident's emergent problem
(iv) The medical necessity for the physician to be called to personally attend to the resident
(v) Name of the resident seen
(vi) Name of the person who requested the physician's presence

B16.5 It is the responsibility of the contracted LTC Physician to ensure continuous call coverage, in conjunction with the facility administration.

B16.6 The LTC facilities and applicable bed counts are listed in the Operational Guide.

B16.7 Each contracted LTC physician appointment is subject to a periodic review conducted by Health PEI Medical Affairs. The hiring of a contracted LTC physician or renewal of such Physician's contract shall be the responsibility of Health PEI Medical Affairs. All such contracts shall be consistent with the provisions of this Agreement.

ARTICLE B17 - PREMIUM PAY RATE

B17.1 At Health PEI's discretion and with prior approval, a premium hourly rate may be applied to specific work in order to meet an operational need of the healthcare system. The intent of using a premium hourly rate is to support Health PEI in stabilizing services and responding to unforeseen system needs. Premium hourly rates will be paid at 25% of the hourly/sessional rate for the applicable specialty.

ARTICLE B18 - ON-CALL

B18.1 Health PEI is moving to a tiered on-call program to be flexible, agile, and responsive to the expectations and needs of managing a 24/7, predominately rural, health-care system.

B18.2 Day-to-day operationalization of the process set out herein will be specified in the Operating Guide.

B18.3 Tier 1 Physicians On-Call Retainer (plus fee-for-service)

(a) Tier 1 on-call coverage covers the following specialties who will be paid an on-call retainer in accordance with the Tariff ("Tier I Physician Group"):

- Anesthesia (by facility)
- Critical Care PCU (by facility)
- Critical Care ICU (by facility)
- General Internal Medicine (by facility)
- Psychiatry: General (provincial)
- Psychiatry Inpatient (by facility)
- Obstetrics and Gynecology (by facility)
- Orthopedics (provincial)
- General Surgery (by facility)
- Surgical Assists (by facility)
- Pediatrics (by facility)
- NICU (provincial)

B18.4 Tier 2 Physicians On-Call Retainer (plus fee-for-service)

(a) All Call Groups not listed as a Tier 1 Physician Group are considered a Tier 2 Physician Group (except Family Medicine Specialist and Hospitalist Inpatients, see: Article B18.5) and will be paid an on-call retainer in accordance with the Tariff.
(b) Tier 2 Physician Groups are established at the discretion of Health PEI.
(c) Services rendered during the on-call period outside of salaried or contract hours (as applicable) will be paid fee-for-service according to the Tariff of Fees.

B18.5 Family Medicine/Hospitalists On-Call Retainer (plus fee-for-service)

(a) An on-call retainer will be paid to Family Physicians and Hospitalist Physicians providing on-call coverage to inpatients according to the Tariff of Fees. Facilities and call groups are determined by Health PEI.
(b) Services rendered during the on-call period outside of salaried or contract hours (as applicable) will be paid fee-for-service according to the Tariff of Fees.

B18.6 Back-up On-Call Coverage

(a) Physicians providing "back-up on-call" as defined in the Operational Guide are entitled to the fee code as listed in the Tariff.
(b) The implementation of the foresaid shall be in accordance with the Operating Guide.

B18.7 On-Call Coverage for Multiple Clinical Groups

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

B18.8 Additional On-call during Physician Shortages

(a) With the approval and at the discretion of Health PEI, when a Physician performs additional on-call they will be paid a 100% add-on fee on their applicable on-call retainer as per the Tariff of Fees, subject to weekend and holiday premiums.

(b) The add-on fee is applied to the on-call retainer where a Physician performs additional on-call in the following circumstances:
    (i) The Physician is part of a clinical group providing on-call coverage approved by Health PEI except those on-call groups outlined in Article B18.8(c);
    (ii) The on-call group is reduced in size for more than 30 days with no arrangements made for on-call to be otherwise covered, i.e., locum, off-Island support;
    (iii) The group is reduced by a minimum of one FTE of funded positions; and
    (iv) When applicable, active recruitment is underway to fill a vacancy.

(c) The add-on fee shall not apply where physician vacancy is due to Continuing Medical Education or vacation leave. Further, the add-on fee will not apply to:

(i) hospitalist overflow;
(ii) backup on-call;
(iii) individual Physicians who request and/or choose to do additional on-call within the approved and funded complement;
(iv) off Island specialists providing on call services remotely; or
(v) Family Physicians who provide inpatient services at an acute care facility with a formalized hospitalist program.

(d) Where a clinical group has members who have been permitted by Health PEI to be removed from the call schedule, Health PEI will work with the clinical group to come to an agreed upon base in which to calculate additional on-call work.

(e) Health PEI Medical Affairs will work with Department Heads to establish the base in which to calculate additional on-call to be published in the Operational Guide.

B18.9 Exceptional Physician Shortages

(a) With the approval and at discretion of Health PEI, in province physicians may be paid the applicable locum fees, as set out in the Tariff, for additional clinical work performed in addition to the physician's regular on-call services when the following criteria are met:

(i) The clinical group is reduced in size by at least 40% of its funded FTE due to vacancies for a period of at least three months.

(b) Such locum payment will not apply where the physician vacancy is due to Continuing Medical Education or vacation leave. Further, Locum payment will not apply to:

(i) hospitalist overflow;
(ii) back up on-call;
(iii) off-Island specialists providing services remotely; or
(iv) Family Physicians who provide inpatient services at an acute care facility with a formalized hospitalist program.

(c) Physicians may be paid under either Article B18.8 or B18.9 but not both.

B18.10 On-Call Frequency

(a) Unless otherwise approved by Health PEI, the Physician shall participate equitably, including weekends and holidays, in an on-call schedule.
(b) On-call frequency is determined by Department based on the call group size. No call group should be expected to do more than 1 in 3 on-call (back-up call excluded).
(c) It is recognized that Health PEI should strive to ensure there are sufficient physicians to support 1 in 5 on-call for Tier 1 call groups.

B18.11 Post On-Call Time Off

(a) Tier 1 Physician Groups providing on call services are to work with their Provincial Department Head to determine the need and establish the process and protocol for scheduling mornings of post-call days with the goal of ensuring the health and safety of Physician and patients. Every effort should be made to plan for and minimize the disruption of patient care. Whenever possible, non-direct patient care services should be provided.
(b) There will be no impact on a Physician's salary for a Physician who is receiving post-call scheduled time off in accordance with sub-article (a).
(c) Salaried and Contract for Service Physicians may not bill fee-for-service on a scheduled post-call day off.
(d) Fee-for-Service Physicians who determine it to be unsafe to provide patient care on post-call mornings, are encouraged to schedule clinic accordingly.
(e) Health PEI may grant other specialties access to post on-call, as deemed appropriate.

ARTICLE B19 - INCOME STABILITY

B19.1 In recognition that circumstances may occur beyond a Fee-for-Service, Contract for Service and Sessional Physician's control and may impact their ability to earn the anticipated income, the following income stability support will be provided.

B19.2 Catastrophic Event

(a) When a catastrophic event occurs that prevents a Physician from being able to go to work and their financial stability is at risk, Health PEI may introduce its Catastrophic Event Income Stability Program to Fee-for-Service Contract for Service and Sessional Physicians. A catastrophic event will be declared by Health PEI based on an event that has caused sudden and great harm or destruction to a facility or service area preventing physicians from being able to work.

(b) The program only applies to events that prevent physicians from working in Health PEI facilities and is not intended to respond to catastrophic events that prevent a fee for service physician from working in their private facility.

(c) Physicians may shift to being paid temporarily at the hourly rate designated to their specialty.

(d) Eligible Physicians must be approved by Health PEI and be willing to work where the system requires the physician during the time in which they are benefitting from the program.

(e) For clarity, income stability is not designed to make a physician financially whole (or to financially gain) and does not intend to support;

  (i) Physician illness;

  (ii) Inability for physician to retain own community-based staff, or their private facility has issues that forces them to close; or

  (iii) Predicted/expected Operating Room slowdowns (i.e., summer).

ARTICLE B20 - LOCUM PHYSICIANS

B20.1 Physicians serving as Locum Physicians will have clinical rates established by Health PEI, endorsed by the IMT. This allows Health PEI to be responsive to the competitive locum recruitment market.

B20.2 Health PEI has the full discretion and responsibility to provide additional monetary or otherwise support outside of the clinical rates to be competitive in the locum recruitment market.

B20.3 Physicians who work within PEI and have an established permanent role with Health PEI may also locum in areas outside of their core role, job description, and, or current primary place of work (i.e., facility) when there is operational need by Health PEI.

ARTICLE B21 - VISITING SPECIALISTS

B21.1 Eligible out of province Visiting Specialists shall be compensated as follows:

(a) Provision of Professional Fees

(b) Options for payment modalities include the following:

(i) Fee-for-service, or

(ii) Sessional fee (fee code 9901), which is an hourly rate for clinical work.

The Visiting Physician shall have the option to switch payment modalities once yearly.

ARTICLE B22 - HONORARIA

B22.1 An Honoraria program in accordance with Health PEI's honoraria policy, attached hereto as Appendix "G", shall continue, except that:

(a) Subject to Article B22.1(c), Health PEI shall provide reimbursement directly to eligible Physicians at the rate of two hundred twenty ($220) dollars per hour, or part thereof in excess of fifteen (15) minutes, to a maximum of one thousand three hundred twenty dollars ($1,320) per day;

(b) The Medical Society's Physician Services Agreement Negotiating Committee is eligible for honoraria for actual time spent in negotiations with the Government Negotiating Team.

(c) Any claim for an honoraria incurred prior to April 1, 2025 will be determined in accordance with the prior Master Agreement which expired on March 31, 2024.

B22.2 Health PEI in issuing a payment to a physician shall indicate, with the payment, that it is made pursuant to the Physician Services Agreement between the Department of Health and The Medical Society of Prince Edward Island.

B22.3 Health PEI shall provide a report to the Medical Society by March 31st of each year for the prior period ending December 31st detailing expenditure for honoraria including each physician's name, meetings attended and amount paid.

ARTICLE B23 - PARTIAL PAYMENT FOR PHYSICIANS ACTING OUTSIDE LETTER OF OFFER OR CONFIRMATION LETTER

B23.1 Physicians in receipt of a billing number, on or after April 1, 1993, who act in a manner inconsistent with their letter of offer or confirmation letter from Health PEI, shall be paid at 50% of the rates set out in the Tariff of Fees for any work done without approval from Health PEI.

SECTION C - BENEFITS & PROGRAMS

ARTICLE C1 - SALARIED BENEFITS

C1.1 The following Article C1 shall apply only to Salaried Physicians and Associate Physicians who for the purpose of this Article are referred to as "Physicians", except as expressly stated otherwise.

Worker's Compensation

C1.2 Workers' compensation coverage is provided to Physicians in accordance with the *Workers' Compensation Act, Regulations* and *Policies*.

Sick Leave

C1.3 Sick leave shall be provided in accordance with this Article to enable Physicians to be absent during periods of illness from their regularly scheduled hours of work without loss of salary.

C1.4 Physicians shall accumulate sick leave benefits at the rate of 11.25 hours per month for each calendar month of continuous employment to a maximum accumulation 1612.5 hours.

C1.5 Physicians appointed before the 16th of the month shall be eligible to accumulate full sick leave credits for that month.

C1.6 Whenever possible, medical appointments should be booked during scheduled time off. When not possible, sick leave may be used.

General Leave

C1.7 Physicians shall be required to submit a written request for any leave of absence specifying the reason for such leave. Each request shall be considered on an individual basis and shall be at the discretion of Health PEI, in accordance with the terms of this Agreement or applicable legislation. Except in emergencies, such requests should be made at least four weeks in advance.

C1.8 Physicians granted leave of absence with pay shall be deemed to be continuously employed and shall retain their benefits and years of service and continue to accrue same during such leave of absence.

C1.9 Physicians granted leave of absence without pay shall be deemed to be continuously employed and shall retain their years of service accumulated to date for all purposes and shall be entitled to continue to access group insurance plans during a leave of absence subject to the terms and conditions of the contract(s) of insurance, but further years of service and benefits shall not accrue during such leave of absence.

Disability Leave

C1.10 (a) Upon the expiry of sick leave, a Physician who is eligible for Long Term Disability (LTD) benefits shall be provided disability leave without pay for the period requested, up to a maximum of twelve (12) months. During the period of unpaid disability leave, Health PEI shall continue to pay group insurance premiums and the employer's share of pension contributions, provided the Physicians matches the contributions.

(b) Following the expiration of the twelve (12) month disability leave the Physicians shall be terminated from employment. If the Physicians is eligible and approved for Long Term Disability coverage pursuant to this Article, Health PEI shall continue to pay the group insurance premiums and employer's share of pension contributions so long as the Physicians continues to be in receipt of LTD benefits.

Deferred Salary Plan

C1.11 Physicians may apply for special leave of one year under the deferred salary plan administered by Health PEI. Under usual circumstances, this leave shall only be granted if a Locum Physician is hired to replace the Salaried Physician on such special leave. Leave should not be unreasonably withheld. Leave of absence under a deferred salary plan must comply with the *Income Tax Act.* Once leave has been granted, it can not later be revoked, unless agreed by the Physician.

Family Illness Leave

C1.12 Where time off is required to attend the needs of a member of their immediate family during illness, the Physician shall be granted up to 75 hours per fiscal year.

(a) For the purpose of this Article, "immediate family" means:

(i) the Physician's spouse and dependent children;
(ii) the Physician's parents;
(iii) any other relative residing in the same household.

(b) In the case of illness of a parent, spouse, sibling, or child, compassionate leave with pay may be granted at the discretion of the Physician Leader for up to an additional three (3) days and shall not be unreasonably withheld.
(c) Whenever possible, medical appointments for family members should be booked during scheduled time off. When not possible, Family Illness Leave may be used.

Bereavement Leave

C1.13 In the event of the death of a Physician's family member, the Physician may be granted up to five (5) days paid leave and an additional two (2) days may be authorized for travelling time. A part-time Physician is permitted four (4) days paid leave if scheduled to work during that time.

C1.14 A family member includes: partner (including common law), child, stepchild, grandchild, parent (or guardian/foster), grandparent, great grandparent, sibling, in-law parent or sibling, or a person permanently residing in the Physician's home.

Continuing Medical Education (CME) Leave

C1.15 Physicians working 0.6 FTE or more shall be provided with up to seventy-five (75) hours paid leave of absence per fiscal year for the purpose of attending approved CME. Physicians employed less than 0.6 FTE are entitled to thirty-seven and one half (37.5) hours paid leave of absence. There shall be no carryover of entitlement from year to year, except where a short-staffing situation has prevented the Physicians from taking their CME leave, or where the Physician has received approval to undertake an unusually lengthy CME program.

C1.16 (a) Physicians shall be entitled to claim such paid leave of absence for their actual time spent attending CME. In order to claim a full day (7.5 hours) of CME leave, a Physician must attend a minimum of five (5) hours of CME in that day. Time spent on CME that is less than five (5) hours in any one day shall be credited on a per hour basis. Proof of the CME must be provided.

(b) Subject to subparagraph (a), time spent away from work to attend CME, which is not certified by the organizers of the event as CME time, shall be taken as vacation.

(c) For travel to CME events outside of the province, a Physician shall be entitled to claim up to a maximum of fifteen (15) hours of CME leave per CME program.

C1.17 Where Health PEI requests a Physician to upgrade their clinical skills for the purpose of undertaking new clinical responsibilities in practice, (e.g., expanded neonatology services), and the Physician so agrees, the Physician shall continue to receive their salary and benefits while upgrading their clinical skills and Health PEI shall reimburse the Physician for all out-of-pocket costs in accordance with the Government's travel regulations and policies as approved from time to time by Treasury Board.

C1.18 Approval for this leave shall be subject to adequate staffing levels being in place during the period of absence. In the event that inadequate staffing would prevent the Physician from attending a particular education leave, reasonable effort shall be made by Health PEI, in consultation with the Physician, to obtain a locum for the period of leave.

Vacations

C1.19 A vacation year is the period beginning on the 1st day of April and ending on the 31st day of March of the following year.

C1.20 The annual vacation entitlement of a full-time Physician is six weeks' (30 working days) vacation with pay. Vacation entitlement shall be earned at the rate of 2 ½ days per month. Physicians working less than full-time shall earn vacation entitlement on a pro-rata basis at the same accrual rate.

C1.21 (a) Vacation leave shall generally be taken in the vacation year in which it is earned. By mutual agreement with Health PEI, vacation may be taken in advance to a maximum of the vacation year's entitlement.

(b) Subject to this entire Article, up to one year's entitlement of vacation may be carried over from one year to the next. Employees who make reasonable attempts to take their vacation during the year, but do not receive approval for their requested vacation, shall be permitted to carry over or request a payout of their excess vacation. Employees' requests for vacation shall be in writing to their Physician Leader.

C1.22 For scheduling purposes, all requests for vacation leave must be made in advance and shall be submitted to Health PEI for approval prior to taking the vacation leave requested. For summer vacation requests, Physicians should submit requests by April 15th to ensure staffing needs are met and vacations shall be approved between May 1st and May 15th.

C1.23 To ensure there is sufficient Physician coverage, vacation approvals/ scheduling will be at the discretion of the Medical Director/Department Head. Years of employment, advance notice provided by the Physician for leave and the nature of the leave may all be considered when granting vacation.

C1.24 Health PEI shall make every effort to advise the Physician regarding approval or denial of vacation leave requests as soon as possible in advance of the requested leave date(s).

C1.25 In the event that inadequate staffing precludes the Physician from taking vacation leave at the requested time, every effort shall be made by Health PEI to find suitable locum coverage for the requested vacation period.

C1.26 Physicians shall not be precluded from taking approved vacation leave by reason that Health PEI is unable to find a Locum Physician.

C1.27 Where a Physician dies or leaves the position, the Physician or their estate shall receive pay at the Physician's then current rate of pay for any accumulated unused vacation leave.

Statutory Holidays

C1.28 A Physician who is required to be on-call on a holiday shall receive a day off in lieu of the holiday, to be taken at a time mutually agreeable to the Physician and Health PEI. Days off in lieu shall not be accumulated and must be used during the current fiscal year. All accrued holiday time will be paid out at the end of the fiscal year.

C1.29 (a) Holidays are defined as:

New Year's Day	National Truth and Reconciliation Day
Islander Day	Thanksgiving Day
Good Friday	Remembrance Day
Easter Monday	Christmas Eve After 12-noon
Victoria Day	Boxing Day
Canada Day	Christmas Day
Labour Day	A Floating holiday to be used at the Physician's discretion.

(b) A Physician may choose to exchange up to two of the above statutory days for up to two days they wish to be off subject to the prior approval of their Physician Leader.

Maternity/Paternity/Parental Leave

C1.30 Eligibility for maternity/paternity and parental leave is set out below. The Physician is entitled to participate in the Maternity/Parental Benefits Program as set out under Article C2 below.

C1.31 A Physician who:

(a) has been in the employment of Health PEI for a continuous period of twenty (20) weeks or more; and

(b) at least four (4) weeks before the expected date of commencement of the leave, submits to Health PEI an application for maternity leave specifying the date of commencement and the date of termination of the leave; and

shall be granted up to twenty-six (26) continuous weeks of maternity leave without pay, commencing not more than thirteen (13) weeks immediately preceding the estimated date of birth. Sick leave shall be granted for allied conditions requiring hospitalization and/or confinement. A medical certificate signed by a qualified medical practitioner may be requested.

Parental Leave

C1.32 A Physician who:

(a) has been in the employment of Health PEI for a continuous period of twenty (20) weeks or more,

(b) and who;

(i) becomes the natural mother or father of a child; or

(ii) assumes actual care and custody of a child, for the purposes of adoption; or

(iii) adopts or obtains legal guardianship of a child under the law of a province,

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

is entitled to and shall be granted, parental leave without pay for a continuous period of up to sixty-two (62) weeks.

Both Parents are Salaried or Associate Physicians

C1.33 In the case where both parents are Physicians the aggregate amount of maternity and parental leave in respect of the same event, shall not exceed seventy-eight (78) weeks.

C1.34 A full time Physician is subject to a waiting period of one (1) week before receiving EI benefits shall receive leave with pay for the one (1) week waiting period. This provision shall be prorated for part-time Physicians based on paid hours in the previous twelve months.

C1.35 In the event that both parents are Physicians the total amount of time taken by either one or both parents under Article C1.34 shall not exceed one (1) week.

C1.36 When a Physician decides to return to work after maternity or parental leave, they shall provide Health PEI with at least two (2) weeks' notice.

Birth or Adoption

C1.37 (a) A non-birth parent who is a Physician upon request shall be granted one (1) day's leave with pay on the occasion of the birth of the Physician's child.

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

Travel

C1.38 Travel allowances in accordance with the provincial rates, as determined from time to time by the Department of Finance for provincial employees generally, shall be paid for Physicians' travel on clinical or administrative business for Health PEI.

Loss of Personal Effects

C1.39 Where a Physician, during the course of the Physician's employment, because of the action of an inmate, patient, visitor or member of the public, suffers damage to personal effects and/or professional instruments. Health PEI shall pay to the Physician in compensation for repairs or replacement an amount not exceeding $250 for any one item. All such incidents of loss of or damage to personal effects shall be reported in writing by the Physician to Health PEI within two normal working days of the incident or discovery thereof.

Retirement

C1.40 For the purpose of this Article:

(a) "retirement" shall mean ceasing practice on Prince Edward Island in any pay modality, but will not include providing periodic medical services with the express written consent of Health PEI.

(b) "continuous service" shall not be interrupted by any approved absences, such as maternity leave, parental leave, or sabbatical. However, it shall be considered interrupted by any period of conversion to a different pay modality.

C1.41 A Physician must provide written notice to Health PEI of their election to retire to qualify for a retirement allowance under this Article.

C1.42 Any Physician who has 10 or more years of continuous service as a salaried Physician for Health PEI and has attained the age of 55 years shall, upon retirement, receive a retirement allowance equal to five days' pay for each full year of continuous salaried service in the province, to a maximum of 130 working days. Periods of part-time service during the years of continuous service shall be paid out on a pro-rata basis.

C1.43 Physicians shall give a minimum of eight (8) weeks' notice of resignation and retirement of employment. If Health PEI chooses not to retain the Physician in employment for the eight-week period after notice is received, the Physician shall receive a payment equal to the amount of wages or salary that the Physician would have earned had the Physician worked during the course of the eight-week period.

C1.44 Physicians shall be expected on resignation and retirement to give a minimum of eight weeks' notice. Under exceptional circumstances, acceptance of less than eight weeks' notice shall be considered, and, if accepted, severance shall be equal to the notice period if Health PEI chooses not to retain the Physician to the end of the notice period.

Pensions and Benefits Coverage

C1.45 Physicians who elected to remain in the Civil Service Superannuation Fund or desire to join shall have their pension contributions matched by Health PEI as authorized by the *Public Sector Pension Plan Act*, subject to the maximum allowed by law. The foregoing is subject to the rules of the Fund.

C1.46 Only Physicians who have opted out of Article C1.45 shall designate their own RRSP account to which the Physician and Health PEI shall make contributions. The Physician shall contribute the equivalent of 9% of their base salary via payroll deduction, which shall not exceed 50% of the maximum permissible contribution provided for in the *Income Tax Act*. Health PEI shall match that contribution.

C1.47 Physicians shall be enrolled in those group insurance benefit programs provided under the Public Sector Group Insurance Plan including basic group life insurance, basic health care, basic dental benefits, and basic long-term disability. Premiums for such coverage shall be fully paid by Health PEI.

ARTICLE C2 - BENEFITS OF GENERAL APPLICATION

C2.1 The following benefits and programs Article C2 applies to Fee-for-Service, Contract-for-Service Physicians, Sessional Associate and Salaried Physicians, except as otherwise stated.

C2.2 A medical practitioner who is licensed to practice in Prince Edward Island under the Atlantic Registry and whose home College is not Prince Edward Island is entitled to compensation for insured medical services as applicable in this PSA. A Physician practicing in the Atlantic Registry, where the Medical Society is not their primary association is not entitled to any other benefit or compensation under this Agreement.

Medical Society Funding and Reporting

C2.3 Except as otherwise specified herein, in each fiscal year, Health PEI shall provide annual funding ("Annual Amount") to the Medical Society, for programs administered by the Medical Society as set out below, in two (2) equal installments, on April 15th and October 15th.

C2.4 Except as otherwise specified herein, the Medical Society shall provide reports based on audited financial statements to Health PEI on all programs administered by the Medical Society no later than June 30th of each year, which includes a summary of expenditure for each eligible Physician for the year in which the program occurred, surplus, accumulated interest, accumulated surpluses, as applicable based on the Program.

Continuing Medical Education

C2.5 A Continuing Medical Education Program ("CME") shall be available for all permanent Physicians and shall be administered by the Medical Society.

C2.6 No later than April 15th of each fiscal year, the Medical Society will invoice Health PEI for the sum of $5,000 per Physician who (a) as of December 31st of the previous calendar year has been a full member of the Medical Society and received remuneration under the provisions of this Agreement, and who (b) has been engaged to provide service by either Health PEI or the Department of Health and Wellness.

C2.7 In the event that the funds provided are not expended, to a maximum of $10,000 in any year, the unspent funds shall be carried forward by the Medical Society and applied to the program in the following year and shall be in addition to the specific funding provided in Article C2.3.

Maternity/Parental Benefits Program (Payment and/or Top Up)

C2.8 A Maternity/Parental Benefits Program shall be continued for the duration of this Agreement to provide partial income replacement for a Physician parent who takes a temporary leave from practice in Prince Edward Island in relation to the birth/adoption of their child.

C2.9 All Physicians shall be eligible for the Program, which shall be designed and administered by the Medical Society.

C2.10 Health PEI shall fund the program by paying to the Medical Society $539,300 each year.

C2.11 In the event that the funds provided are not expended in any one year the unspent funds shall be carried forward by the Medical Society and applied to the program in the following year and shall be in addition to the specific funding provided in Article C2.3. If the unspent funds from year to year accumulate, the Medical Society may transfer any amount in excess of $100,000 to another support or benefit program under this Agreement and shall advise the EC of such transfer.

C2.12 All program funds and investment interest earned thereon, if any, shall be held in trust by the Medical Society and used for the purposes set out in this article.

ARTICLE C3 - NON-CLINICAL PROGRAMS AND FUNDING

C3.1 The following Article C3 applies to all Physicians under this Agreement.

CMPA Assistance

C3.2 A rebate program in respect of Canadian Medical Protective Association ("CMPA") premiums or other professional malpractice liability insurance premiums shall be administered by the Medical Society in accordance with this Article for the duration of this Agreement.

C3.3 Funding provided by Health PEI to the Medical Society for the purpose of the rebate program shall be used by the Medical Society to help offset the cost of CMPA premiums or other professional malpractice liability insurance premiums paid by Physicians.

C3.4 Where a Physician is not a CMPA member, the Physician shall at all times hold a valid certificate of professional malpractice liability insurance with coverage of not less than $10,000,000 per claim.

C3.5 (a) In each calendar year, Health PEI shall provide annual funding ("Annual Amount") to the Medical Society, pursuant to Article C2.3, in two (2) equal installments, on April 15th and October 15th.

(b) The Parties shall determine the Annual Amount for that calendar year by multiplying $2,419.35 by the number of Physicians who paid CMPA premiums in that calendar year.

(c) If the Annual Amount paid by Health PEI pursuant to Article C3.5(b) combined with the total Deductible Amount paid by Physicians, pursuant to Article C3.6(a), in a calendar year is less than the total cost of premiums paid by Physicians to CMPA in that calendar year, the Parties shall each contribute to the shortfall as follows:

(i) Health PEI shall pay 75% of the shortfall, and
(ii) members of the Medical Society shall pay the remaining 25% of the shortfall.

For the purpose of this Article, the methodology for any payment under Article C3.5(c)(ii) by the Physicians shall be determined exclusively by the Medical Society.

C3.6 (a) Every member of the Medical Society, including locums, covered by this Agreement shall be entitled to participate in the rebate program. A Physician shall be responsible for the first $1,500 of annual CMPA premiums or other professional malpractice liability insurance premiums. The difference between annual CMPA premiums or other professional malpractice liability insurance premiums and $1,500 shall be rebated by the Medical Society, subject to proration based upon the actual number of months in practice on PEI. In the case of a locum Physician, the first $1,500 of CMPA premiums or other professional malpractice liability insurance premiums shall also be subject to such proration.

(b) Notwithstanding Article C3.6(a), the amount to be reimbursed by the Medical Society for professional malpractice liability insurance provided by another carrier (non-CMPA) shall not exceed the amount the Physician would have been eligible for had the Physician been enrolled in CMPA.

(c) Effective with the signing of this Agreement, the Medical Society shall provide an interim statement to Health PEI on July 31st and January 31st of each year, of the payments to be made to each Physician. The Medical Society shall ensure that each Physician is reimbursed for the rate class appropriate to each Physician's actual provision of services on PEI. Prior to any payments being made, Health PEI will review the interim statement and inform the Medical Society within thirty (30) days of any rate class adjustments that may be required.

C3.7 All program funds and investment interest earned thereon, if any, shall be held in trust by the Medical Society and used for the purpose set out in this article.

C3.8 In the event the rebate program experiences an accumulated surplus as of April 30th of any year, such surplus shall become the initial funding available to the Medical Society for the purpose of the rebate program in the following year.

C3.9 In the event the "Trust Fund" does not have sufficient resources to meet the expenditures for CMPA premiums or other professional malpractice liability insurance premiums, Health PEI shall, on receipt of a detailed statement on August 31st and February 28th of each year from the Medical Society, provide additional funding to cover the shortfall pursuant to Article C3.5(c).

Healthy Physician Workforce

C3.10 To demonstrate their mutual commitment and shared responsibility for ensuring Prince Edward Island has a healthy and vibrant physician workforce, Health PEI and Government agree to fund, and the Medical Society agrees to develop and operate, a Healthy Physician Workforce Program, the programming for which will address Physician Health, Physician Leadership Development and Engagement, and Physician Practice Support and Management.

C3.11 Health PEI agrees to pay the Medical Society $600,000 annually to fund the Healthy Physician Workforce Program in accordance with Article C2.3.

C3.12 In the event that the funds paid to the Medical Society in respect of the Healthy Physician Workforce Program, or any portion thereof, are not expended in the fiscal year in which they are provided, the Parties agree the unspent funds shall be carried forward by the Medical Society in addition to the annual payment contemplated in the sub-article above.

C3.13 The Parties agree the Medical Society shall be entitled to utilize the funds to engage external trainers, consultants or other service providers and/or to employ staff within the Medical Society to support the development and operation of the above-noted programs.

C3.14 The Parties agree the IMT will work together, in an open, transparent and collaborative way, to consider the individual and systemic factors, from all stakeholder perspectives, that negatively affect the health of PEI's physician workforce, all with a view to identifying priorities for the management and development of a comprehensive Healthy Physician Workforce strategy that enhances physicians' well-being, engagement, leadership, integration and overall sense of personal and professional fulfillment, and elevates the quality of patient care and health system operations. Further, the IMT will ensure that the Healthy Physician Workforce Program takes into consideration and complements, where appropriate, with existing Health PEI policies, programs and structures.

C3.15 With oversight by the IMT, the Medical Society shall be responsible for evaluating and reporting on the Healthy Physician Workforce Programs. Reporting should include an overview of the programs offered, usage and the evaluation results, in addition to the expenditures and surpluses as required in Article C3.12.

Physician Clinical Orientation

C3.16 In the event that a Physician new to practice is required to work solo in a hospital-based clinical environment, a colleague of the same specialty may join that Physician for up to three shifts to provide support and orientation to the work environment. The orienting Physician will bill their designated hourly rate for all hours spent orienting the new Physician. The Physician Leader in the designated area will advise Medical Affairs when a new Physician chooses to utilize this program.

C3.17 The intent of this program is to support Physicians who are working in a solo clinical environment and will not benefit from the collegial support extended in team-based environments (e.g., Emergency Departments staffed by one Physician).

C3.18 For groups where multiple Physicians work side-by-side, it is expected experienced colleagues will be collegial and extend support and guidance to the newest members of their team.

Physician Retention Program

C3.19 A Physician Retention Program was established to enhance the stability of physician services throughout the provincial health care system.

C3.20 Health PEI shall remit to the Medical Society the sum of $500,000 annually in accordance with Article C2.3.

C3.21 On or before December 31st of each year after the establishment of this program, the Medical Society shall use this funding to pay an annual retention incentive to each eligible Physician.

C3.22 An eligible Physician is a Physician who, as of December 31st of the previous calendar year has been a full member of the Medical Society and received remuneration under the provisions of this Agreement, and who:

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

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

C3.23 The Medical Society shall be required to equally divide all of the funding for this program between all eligible Physicians.

ARTICLE C4 - NON CLINICAL PROGRAMS FOR FEE FOR SERVICE

Overhead Stipend Program

C4.1 An Overhead Stipend will be provided to eligible Fee-for-Service Physicians by December 31 of each calendar year to acknowledge the costs associated with running a medical practice.

C4.2 The Overhead Stipend Program is provided to Fee-for-Service Physicians who are responsible, personally or through a corporate structure, for the overhead costs of their physical space and staff compensation and have not been otherwise subsidized by Health PEI and Government. In addition, eligible Physicians must meet the following criteria:

(a) be a full member of the Medical Society of PEI;

(b) be engaged to provide service by either Health PEI or the Government,

(c) be remunerated through the terms of this Agreement,

(d) have permanent status (i.e., not a locum), and

(e) have received at least $100,000 in remuneration under this Agreement in the previous fiscal year (April 1 – March 31).

C4.3 No later than October 15th of each fiscal year, the Medical Society will invoice Health PEI for the sum of $25,000 per Physician who meets the eligibility criteria above.

Medical Society's PSA Management and Member Benefits Administration

C4.4 For reasons set out in the MOU establishing the IMT, it is acknowledged that the Medical Society will be taking on an expanded role under this Agreement and therefore, will require additional resources.

C4.5 The Medical Society is also responsible for administering the following member benefit programs under this Agreement:

(a) Retention

(b) Parental Leave

(c) CME

(d) Overhead support

(e) CMPA rebate

(f) Healthy Physician Workforce

C4.6 To support PSA Management and Member Benefits Administration, an annual payment of $750,000 in accordance with Article C2.3 will be transferred to the Medical Society.

C4.7 No additional monies shall be paid by HPEI to cover the Medical Society's expenses in delivering these programs.

C4.8 It is expressly understood and agreed that the foregoing monies shall be spent on the above noted programs and other matters within the mandate of the IMT and shall not be expended on other matters including litigation, arbitration or other legal matters.

International Classification of Diseases Coding ("ICD")

C4.9 Fee-for-service Physicians utilize ICD-9 coding when submitting their claims to Health PEI. In the event that Health PEI requires Physicians to utilize ICD-10 coding, Health PEI shall be responsible for the costs associated with having software vendors upgrade Physicians' electronic billing software to conform to ICD-10 coding.

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

DATED at Charlottetown, Prince Edward Island, this _10th_day of October, 2024.

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

__Erin Butler_____
Witness

_____
Minister of Health and Wellness

DATED at Charlottetown, Prince Edward Island, this 9th day of October, 2024.

On behalf of Health PEI

Kandice MacNevin
_____
Witness

_____
Chief Executive Officer

DATED at Charlottetown, Prince Edward Island, this 9th day of October, 2024.

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

_____
Witness

_____
President

Chief and Deputy Chief Health Officers

Memorandum of Agreement

Between

Department of Health and Wellness

and

The Medical Society of PEI

This is to acknowledge that this Agreement applies to and covers Physicians who provide services to the Government as Chief Public Health Officer and/or as Deputy Chief Health Public Officer (collectively, "Health Officer").

Where the Health Officer is an employee, the annual salary (pro-rated for part-time employee) shall be in the amount paid to Group 2 Specialist salary under Article B14.9(b).

Section C of the Physician Services Agreement shall apply to a Health Officer who is an employee of the Department, subject to any pre-existing benefits that are greater than or in addition to the benefits provided under this Agreement.

Subject to any pre-existing compensation (or reimbursement of expenses) that is greater than or in addition to the compensation provided under this Agreement, where the Health Officer is an independent contractor, compensation shall be in accordance the contract-for-service hourly rate for Group 2 Specialists as set out in Article B14.9(b).

On-call retainer for a Health Officer shall be in the amount paid to Tier 2 Physicians.

Chief Coroner and Deputy Chief Coroner

Memorandum of Agreement

Between

The Office of the Attorney General

And

The Medical Society of PEI

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

Effective April 1, 2025, the Chief Coroner will be paid at an hourly rate equivalent to the Family Focused Medicine Hourly rate (Article B14.6).

The Coroner's Office shall provide on-call services to both the Eastern and Western regions of the province 24-hours per day seven-days a week. Remuneration for on-call coverage will be billed as fee code 0020 of the Tariff of Fees per day for each region.

Implementation Management Team

Memorandum of Agreement

Between

MEDICAL SOCIETY OF PRINCE EDWARD ISLAND

("MSPEI")

HEALTH PEI

("HPEI")

AND

GOVERNMENT OF PRINCE EDWARD ISLAND,
as represented by the Minister of Health and Wellness,

(the "Minister")

(individually a "Party" and collectively the "Parties")

1. **RECITALS**

WHEREAS:

a) The Parties are committed to working together to ensure a new vision of how physician services are operationalized and delivered in a timely manner under the new Physician Services Agreement ("PSA") to meet the pressing health care needs of the citizens of Prince Edward Island.

b) The PSA is fundamentally different from previous agreements in many aspects, including but not limited to, compensation, benefits, programs and overall design and will require significant time and resources to support the implementation, adaptation and ongoing evaluation of the new PSA.

c) It is the mutual interest and desire of the Parties to establish a collaborative team to remove / manage roadblocks and carry out the timely and flexible implementation that is fundamental to the success of the new PSA. To that end, the Parties have agreed to create a Team: the Physician Services Agreement Implementation Management Team ("IMT").

d) The Parties have agreed to execute this Memorandum of Understanding now to provide for the most timely and fulsome implementation of the PSA.

2. IMPLEMENTATION MANAGEMENT TEAM ("IMT")

a) The IMT is established with one (1) representative from each of MSPEI, HPEI and the Minister. The Parties agree that the following positions will serve as representatives on the IMT:
   i. MSPEI – Senior Representative designated by MSPEI
   ii. HPEI – Senior Representation designated by Health PEI
   iii. Minister - Senior representative to be designated by the Department of Health and Wellness from the Health Innovation Division.

b) The IMT reports to the Executive Committee established by the PSA ("EC") quarterly or more often as required.

c) IMT shall meet at the request of any Party.

3. SCOPE OF WORK

IMT's focus will be to provide investigation, research, feedback, advice and recommendations to EC in the following areas:

- Create an environment where all issues concerning the role, responsibilities and opportunities of Physicians within the health care system shall be addressed and resolved;
- Oversight and implementation of all the elements of the PSA and to create further necessary changes required;
- Introduce the required change management, education and communications including supporting all interested parties through the change (Department Heads, Medicare, Administrators, and Physicians);
- Create an evaluation plan and dashboards to ensure the Parties are achieving desired outcomes and make necessary changes as required;
- Recommend formal contract amendments and fee changes to the EC for approval.
- Create solutions for changes that arose during negotiations but did not have sufficient data or information for decision:
    - Review of fee tariff to address gender and other inequities;
    - Simplify the fee tariff for chronic renal therapy on a cost-neutral basis; and
    - Remuneration model for Critical Transport Program, should data illustrate need
- Create and implement a process to be responsive to unforeseen system needs;
- Name and work with all parts of the health-care system to put in place the necessary enablers to support the next contract negotiations (i.e., measurement & reporting, identifying key performance indicators, performance reviews and extensive fee review);

- Ensure the key enablers required to support the PSA are actioned and to identify and remove / manage "roadblocks";
- Ensuring all elements of the PSA within EC's mandate are completed, including fund allocation/management, introduction of new fee codes, revision or removal of outdated fee codes, issues management and any dispute resolution matters referred to it;
- Making proactive recommendations to EC respecting matters arising from carrying out its functions;
- Considering and advising upon matters of mutual interest arising during the life of the PSA;
- Establish working groups and, if authorized by the Parties, to engage third party contractors and/or consultants as deemed necessary or advisable to investigate issues of importance to the ongoing implementation and operation of this Agreement, including but not limited to such issues as may be jointly referred to EC by the Parties;
- Discussing and making recommendations to EC upon any proposed revisions, amendments, additions, or deletions to the PSA, the Preamble and the Tariff of Fees; and
- Engage in carrying out such functions that EC may, by written direction, refer to it.

4. **APPROACH**

IMT shall make recommendations to the Parties via the EC on matters within IMT's mandate.

IMT's recommendations will be in writing and consensus-based. No modification of the PSA shall be recommended to the Parties via EC that does not have the approval by consensus of the IMT. The final decision of any changes to the PSA is that of the EC.

In attempting to reach consensus on any IMT recommendation, IMT members will use principles as outlined in A1.3 of the PSA.

5. **RESOURCES**

a) HPEI and the Minister will fund / second a Project Manager together with administrative support as may be required from time to time to assist the IMT in carrying out its scope of work.

b) The Project Manager will:
   - serve as a resource person to and report to the IMT as directed;
   - be seconded from or provided by the Government of Prince Edward Island;
   - have full access to all information, data and to the employees of the Government of PEI, HPEI or MSPEI as required to fulfill its functions and in accordance with all applicable laws; and
   - assist in execution of the IMT's scope of work as directed by the IMT.

c) The Parties agree that the utilization of internal resources (excluding Physicians) which are facilitated by the IMT whenever necessary shall be without fee to the Parties. This does not include previously agreed to payments made to MSPEI for the administration of various PSA programs.

d) With prior approval of the Parties, the IMT may contract out for services that are not readily available to or from HPEI, the Minister or MSPEI and any such costs will be shared in a manner determined by the Parties.

e) EC may recommend programs, alternative or new programs for consideration by the IMT.

PSA Reopener

MEMORANDUM OF UNDERSTANDING

MEDICAL SOCIETY OF PRINCE EDWARD ISLAND

("MSPEI")

HEALTH PEI

("HPEI")

AND

GOVERNMENT OF PRINCE EDWARD ISLAND,
as represented by the Minister of Health and Wellness,

(the "Minister")

(individually a "Party" and collectively the "Parties")

The Parties agree that the effective implementation and operation of the IMT and EC is fundamental to the success of this PSA. In this regard the Parties are fundamentally committed to its success.

In the event that either Party should reasonably conclude that the IMT/EC is fundamentally failing to work as in a manner consistent with the contemplated intent of the Parties then either Party may declare its desire for the PSA to terminate effective March 31/27 and the Parties shall reopen the PSA in accordance with the following terms and conditions:

1. The dissatisfied Party shall give notice to the other Party on or before Dec 31/26 of their intention to enter into a renegotiation of the PSA effective April 1/27.
2. The only matter open for discussion is the effective implementation and operation of the IMT/ET and its alleged materially adverse effect and impact on the day-to-day operation of the PSA.
3. Specifically, and for clarity, monetary increases in 27/28 or 28/29 along with any other financial matters are not a subject of the reopener negotiation between the Parties.
4. The Parties shall agree on the appointment of a mediator /arbitrator to meet with the Parties in an attempt to resolve the issues in dispute. The Parties agree to cooperate with the Mediator /Arbitrator in an attempt to resolve all the issues related to the matters in dispute. The Mediator/ Arbitrator shall meet as they may determine and shall continue the mediation process until they determine and shall

continue the mediation process until they determine that Mediation is no longer feasible.

5. Once the Mediator concludes mediation the Mediator shall convert into an Arbitrator and shall decide the issues without hearing further from the Parties and shall decide on the matter. The Decision of the Arbitrator is final and binding.
6. In the event the Parties are unable to agree on the appointment of a Mediator/Arbitrator then the matter shall be referred to the Chief Justice of the PEI Court of Appeal for the appointment. Each Parties shall submit three (3) names to the Chief Justice for consideration.

All of the foregoing is for the purpose of reopening the PSA and it is strictly limited to the fundamental failure in the reasonable opinion of any Party as to the IMT/EC operation under the PSA. Other regular disputes between the Parties with respect to the regular operation of the IMT/EC shall be resolved by the IMT/EC and in the event of any failure to arrive at an agreement, the dispute shall be resolved by the regular grievance arbitration process as set out in Article A10.

UPEI Medical School

MEMORANDUM OF UNDERSTANDING

MEDICAL SOCIETY OF PRINCE EDWARD ISLAND

("MSPEI")

HEALTH PEI

("HPEI")

AND

GOVERNMENT OF PRINCE EDWARD ISLAND,
as represented by the Minister of Health and Wellness,

(the "Minister")

(individually a "Party" and collectively the "Parties")

Whereas the Parties agree to provide clinical services to facilitate medical education services for the UPEI Faculty of Medicine ("Medical School").

Whereas the Parties agree that all Physicians who provide Clinical Education must have a signed letter of offer from Health PEI, be a member of the College of Physicians and Surgeons of PEI and be members of MSPEI and bound to the provisions of this Physician Services Agreement ("PSA").

Whereas the Parties agree that eventually the PSA will need to be amended to accommodate all of the principles set out in these recitals and elsewhere in this Memorandum of Understanding.

Therefore, the Parties agree as follows:

1. The Parties agree that this MOU is only the commencement of the discussions and agreement of the Parties and may be modified as necessary and must include the participation of the Medical School in any future agreement.

2. All terms and conditions of the employment and engagement of all Physicians who provide clinical services to Health PEI and educational services to the Medical School shall be bound by the provisions of the PSA.

3. All Physicians who have agreed to provide clinical education must have:
    a. a signed letter of offer from Health PEI to provide clinical services;
    b. be a member of the College of Physicians and Surgeons of PEI; and
    c. be members of MSPEI and bound to the provisions of this Physician Services Agreement ("PSA").

    For further clarity, all Physicians who provide clinical education services must provide clinical services to patients in PEI in accordance with their agreement with Health PEI.

4. The Parties recognize and agree that during the term of the PSA, if necessary, the PSA will be modified to facilitate inclusion of Academic/Clinical physicians into the PSA. The Parties agree to maintain the principles that were utilized in arriving at the PSA including the principles of 'an hour is an hour', 'care is care' and similar principles to ensure the Physicians who provide services to the Medical School will not experience a reduction in hourly rate.

5. The Parties agree that the services provided in the educational environment shall be managed by the Medical School whilst all clinical services shall be in accordance with the PSA and governed in accordance with the processes and procedures set out therein and in applicable legislation and regulations.

APPENDIX A - CONTRACT FOR SERVICES

CONTRACT FOR SERVICES
(General)

THIS CONTRACT MADE

BETWEEN: **Dr.**_____

(the "Physician")

- and -

Health PEI

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

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

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

INTERPRETATION

1. In this Contract,

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

TERM

2. The term of this Contract shall commence on _____ and shall remain in effect until terminated in accordance with Paragraphs 21, 22 and 23 of this Contract.

SERVICES

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

4. If at any time during the term of this contract the Physician cannot perform the services as agreed upon herein, they shall notify Health PEI immediately.

5. The Physician shall apply for and maintain admitting privileges at the hospital(s) in which they may be required to perform services and Health PEI may require the Physician to provide in-patient care for their patients.

6. The Physician shall be subject to Health PEI Medical Staff Bylaws, Rules and Regulations, copies of which shall be made available to the Physician.

7. Unless otherwise approved by Health PEI, the Physician shall participate equitably, including weekends and holidays, in an on-call schedule for family physician/specialty services with individual commitment to be not more frequently than averaging a 1 in 3 call schedule (122 days/year). The Physician shall cooperate in the development of an on-call/vacation schedule to be developed by the Physician and Health PEI. Compensation for on-call services shall be in accordance with the Physician Services Agreement. The on-call obligation, if applicable, is detailed in the Schedule "A" attached hereto.

8. Health PEI shall, at no cost to the Physician, arrange for a professional work site and sufficient support staff to enable an efficient and productive practice.

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

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

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

12. The Physician shall participate in an annual services review to ensure the Physician is operating in accordance with this Contract and applicable provisions of the Physician Services Agreement.

ACCOUNTS AND PAYMENTS

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

    (a) An hourly rate of $_____ as determined in Article B14 of the Physician Services Agreement, for _____ hours of work each week;
    (b) Invoices for services rendered under this Contract shall be submitted to the Physician's respective Physician Leader, or designate, for the hours worked during each bi-weekly period;
    (c) Payment shall be made bi-weekly upon the receipt of invoices which have been authorized for payment by the Physician Leader; and
    (d) A submission for hours in excess of the agreed upon hours shall be subject to Article B4 of the Physician Services Agreement.
    (e) The Physician's aggregate compensation shall be determined by the applicable hourly rate and hours worked, on-call service coverage and other services the Physician may agree to provide from time to time.

14. If the Physician has satisfied all the conditions set out in this Contract and the Physician Services Agreement, the Physician may be paid on a fee-for-service basis for services performed outside their regular work schedule, but only in accordance with Article B3 of the Physician Services Agreement.

INDEPENDENT CONTRACTOR

15. The Physician is an independent contractor and they are entitled to no other benefits or payment whatsoever other than those specified in this Contract and the Physician Services Agreement.

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

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

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

LIABILITY AND INDEMNIFICATION

19. The Physician certifies, and agrees to provide written verification prior to execution of this Contract, that they are registered and licensed with the College of Physicians and Surgeons of PEI and is a member of the Medical Society.

20. The Physician shall:

    (a) maintain active membership with the Canadian Medical Protective Association (CMPA) in accordance with the Physician Services Agreement. Acceptance by Health PEI of such membership shall not be construed as a waiver of any conditions of this Contract. The Physician shall provide Health PEI with written evidence of CMPA membership;

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

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

TERMINATION

21. Either Party may terminate this Contract by providing Health PEI with 90 days advance notice in writing.

22. Health PEI may terminate this Contract, without prior notice, only for fundamental breach of the Contract.

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

GENERAL

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

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

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

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

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

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

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

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

SIGNED AND DELIVERED
in the presence of:

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

APPENDIX B - CONTRACT FOR SERVICES: LONG TERM CARE (LTC)

CONTRACT FOR SERVICES: LONG TERM CARE (LTC)

THIS CONTRACT MADE

BETWEEN: **Dr._____**

(the "Contracted LTC Physician")

- and -

Health PEI

WHEREAS Health PEI requires the services of a full-service Contracted LTC Physician to provide medical services to residents and advice to staff, or the services of a collaborating Contracted LTC Physician to provide medical services in conjunction with LTC Nurse Practitioners to residents and advice to staff at the _____ LTC Facility (the "Facility");

AND WHEREAS the Contracted LTC Physician has agreed to provide Health PEI with

_____

(*select one*: full-service medical services OR collaborating medical services in conjunction with LTC Nurse Practitioners) and advice to LCT staff, on certain terms and conditions;

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

INTERPRETATION

1. In this Contract,

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

TERM

2. The term of this Contract shall commence on _____ and shall remain in effect until _____ unless earlier terminated in accordance with articles 15, 16 or 17, or extended by mutual agreement between the parties in writing.

SERVICES

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

4. The Contracted LTC Physician shall provide _____ (*select one*: direct OR in collaboration with a Nurse Practitioner) continuous coverage to the residents of the LTC Facility who do not have a personal physician, and also to residents who have a personal physician who cannot be reached or is otherwise unavailable.

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

6. If at any time during the term of this contract the Contracted LTC Physician cannot perform any of the services described in Schedule "A" attached hereto, they shall notify Health PEI immediately and in conjunction with Health PEI arrange for a replacement Physician to perform the services. The Contracted LTC Physician shall continue to receive the LTC Stipend set out in Paragraph 8 during their temporary absence, and shall be solely responsible for paying the replacement Physician for the same LTC Stipend in their absence.

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

ACCOUNTS AND PAYMENTS

8. The Contracted LTC Physician shall be remunerated by Health PEI in accordance with Article B16 of the Physician Services Agreement, in the following manner:

   (a) a full-service Contracted LTC Physician shall be paid a standard LTC stipend of $1,000.00 per bed per annum, based on the approved bed capacity of the Long Term Care Facility, to be paid in bi-weekly installments, for the provision of comprehensive LTC medical services (in lieu of fee-for-service billings, except as noted in paragraph 8. (d)) and twenty-four (24) hour/seven (7) day per week on-call coverage for each resident;

   (b) a collaborating Contracted LTC Physician shall be paid a standard LTC stipend of $570.00 per bed per annum, based on the approved bed capacity of the Long Term Care Facility, to be paid in bi-weekly installments, for the provision of LTC medical services(in lieu of fee-for-service billings, except as noted in paragraph 8. (d)) through collaboration with a Nurse Practitioner;

(c) physicians providing on-call coverage in support of LTC Nurse Practitioners shall by paid an LTC Back-up On-call Retainer of $200.00 per day (fee code 6003), which shall qualify for the standard weekend/holiday premium of 25% (see Preamble 12.B);

(d) in addition to the above-noted standard LTC stipends, any services that must be provided emergently afterhours (weekdays 18:00-08:00 and weekends 08:00-08:00) at the explicit request of LTC staff shall be paid on a fee-for-service basis, as follows:

(i) LTC On-Call Response Fee (fee code 9360)

This fee is intended to compensate on-call Contracted LTC Physicians and physicians billing the LTC Backup On-call Retainer for the disruption and inconvenience of having to respond emergently to the request of LTC staff to provide in-person emergent service to a resident, which is not part of the on-call physician's normal routine. This fee shall qualify for the standard weekend/holiday premium (see Preamble 12.B), may be claimed more than once per on-call day, and is payable in addition to any medical services provided.

(ii) LTC Afterhours Detention Fee (fee code 1870)

In addition to the LTC On-Call Response Fee, this fee is payable when the on-call Contracted LTC Physicians or physician billing the LTC Backup On-call Retainer is called in emergently to provide medical services to a resident, in lieu of other visit or procedure fees. It is payable in blocks of 15 minutes, or major portion thereof, commencing immediately when the physician sees the resident, and qualifies for both afterhours (weekdays 18:00-08:00) and weekend/holiday (08:00-08:00) premiums (see Preamble 12.B).

Payment of the LTC On-Call Response Fee and the LTC Afterhours Detention Fee requires clear documentation on the resident's chart outlining the time the physician was called in, time spent with the resident, the nature of the resident's emergent problem and the medical necessity for the physician to be called to personally attend to the resident. Time of service and time spent with the resident must be shown on the claim.

INDEPENDENT CONTRACTOR

9. The Contracted LTC Physician is an independent contractor and they are entitled to no other benefits or payment whatsoever other than those specified in this contract and the Physician Services Agreement.

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

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

12. The Contracted LTC Physician shall comply with all federal and provincial laws, which may have application to the services they perform under this contract.

LIABILITY AND INDEMNIFICATION

13. The Contracted LTC Physician certifies and shall provide written verification prior to execution of this contract that they are registered and licensed with the College of Physicians and Surgeons of Prince Edward Island and are a member of the Medical Society.

14. The Contracted LTC Physician shall:

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

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

TERMINATION

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

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

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

    (a) Health PEI reasonably believes that the Physician's conduct may threaten the safety of patients or staff;

    (b) the Physician becomes incapable of providing the services for any reason;

    (c) the Physician is convicted of an indictable offence;

    (d) the Physician fails to hold a valid license from the College of Physicians and Surgeons of PEI to practice medicine, or is found guilty of professional misconduct by the College; or

    (e) the Physician fails to maintain liability/malpractice coverage with the Canadian Medical Protective Association or equivalent coverage with an insurance carrier satisfactory to Health PEI.

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

GENERAL

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

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

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

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

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

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

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

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

SIGNED AND DELIVERED
in the presence of

_____	_____	_____
Witness	Contracted LTC Physician	Date
_____	_____	_____
Witness	Health PEI	Date

APPENDIX C - EMERGENCY SERVICE COVERAGE AGREEMENT (PCH & QEH)

EMERGENCY SERVICE COVERAGE AGREEMENT
(Prince County Hospital or Queen Elizabeth Hospital)

THIS AGREEMENT dated the _____day of _____, 20__

BETWEEN:

Health PEI

-and-

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

THE PARTIES hereto agree as follows:

ARTICLE 1 - DURATION OF AGREEMENT

1.1 This Agreement shall commence on the effective date of the Physician Services Agreement between Health PEI and the Medical Society of Prince Edward Island, and shall remain in effect for the term of the Physician Services Agreement. This Agreement shall be renewed for a further term unless either party provides 180 days written notice in advance of the expiry date of the Physician Services Agreement.

ARTICLE 2 - SERVICES AND COMPENSATION

2.1 The Group shall provide continuous 24-hour Emergency Department medical coverage at the _____ Hospital in _____.

2.2 Health PEI shall fund the provision of this coverage in accordance with Article B15.3 of the Physician Services Agreement, based on the funded hours per facility as defined in the Operational Guide. Coverage hours may be increased from time to time if needed and mutually agreed by Health PEI and the Group.

2.3 The Group and Health PEI shall be jointly responsible for maintaining and, when necessary, recruiting physicians to adequately staff the Emergency Department to the funded hours.

2.4 Any new physician joining the Group shall be mutually acceptable to both the Group and Health PEI, shall be a member of the Group, and shall be bound by the terms of this Agreement.

2.5 Any physician may withdraw from the Group and from this Agreement by giving ninety (90) days written notice of such withdrawal to the other members of the Group and to Health PEI. A physician leaving the group is absolved of the provisions of this Agreement.

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

2.7 The Group shall, in consultation with individual physicians, determine the schedule for the Group to adequately staff the Emergency Department to the funded hours, and shall make the physician schedule available to Health PEI.

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

2.9 Health PEI may provide such support, direction and information as it deems necessary under this Agreement.

ARTICLE 3 - INDEPENDENT CONTRACTORS

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

3.2 For greater clarity, the group is not a partnership.

3.3 The Emergency Department Physicians are severally liable, and not jointly liable, under this Agreement.

3.4 Each Emergency Department Physician shall maintain adequate medical liability coverage through the Canadian Medical Protective Association or equivalent medical liability insurer as outlined in Article A18.1 of the Agreement.

ARTICLE 4 - GENERAL

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

4.2 Health PEI recognizes the Medical Society as the sole and exclusive bargaining agent for all of its members who are engaged in the practice of medicine, including the physicians who are signatory to this Agreement.

4.3 Health PEI acknowledges that the Group members are entitled to receive independent advice from the Medical Society. Health PEI shall make full disclosure of any offer of engagement to MSPEI, and shall provide MSPEI a copy such offer of engagement in advance of signing by a new Group member.

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

_____ _____

MSPEI (approved as to form) **Date**

THE GROUP: **HEALTH PEI:**

Per: _____ Per: _____

Per: _____ Per: _____

Per: _____

Per: _____

Per: _____

Per: _____

Per: _____

Per: _____

APPENDIX D - EMERGENCY SERVICE COVERAGE AGREEMENT (KCMH & WH)

EMERGENCY SERVICE COVERAGE AGREEMENT
(Kings County Memorial Hospital or Western Hospital)

THIS AGREEMENT dated the _____day of _____, 20__

BETWEEN:

Health PEI

-and-

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

THE PARTIES hereto agree as follows:

ARTICLE 1 - DURATION OF AGREEMENT

1.1 This Agreement shall commence on the effective date of the Physician Services Agreement between Health PEI and the Medical Society of Prince Edward Island, and shall remain in effect for the term of the Physician Services Agreement. This Agreement shall be renewed for a further term unless either party provides 180 days written notice in advance of the expiry date of the Physician Services Agreement.

ARTICLE 2 - SERVICES AND COMPENSATION

2.1 The Group shall provide ___-hour Emergency Department medical coverage at the _____ Hospital in _____.

2.2 Health PEI shall fund the provision of this coverage in accordance with Article B15.3 of the Physician Services Agreement, based on the funded hours per facility as defined in the Operational Guide. Coverage hours may be increased from time to time if needed and mutually agreed by Health PEI and the Group.

2.3 The Group and Health PEI shall be jointly responsible for maintaining and, when necessary, recruiting physicians to adequately staff the Emergency Department to the funded hours.

2.4 Any new physician joining the Group shall be mutually acceptable to both the Group and Health PEI, shall be a member of the Group, and shall be bound by the terms of this Agreement.

2.5 Any physician may withdraw from the Group and from this Agreement by giving ninety (90) days written notice of such withdrawal to the other members of the Group and to Health PEI. A physician leaving the group is absolved of the provisions of this Agreement.

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

2.7 The Group shall, in consultation with individual physicians, determine the schedule for the Group to adequately staff the Emergency Department to the funded hours, and shall make the physician schedule available to Health PEI.

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

2.9 Health PEI may provide such support, direction and information as it deems necessary under this Agreement.

ARTICLE 3 - INDEPENDENT CONTRACTORS

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

3.2 For greater clarity, the group is not a partnership.

3.3 The Emergency Department Physicians are severally liable, and not jointly liable, under this Agreement.

3.4 Each Emergency Department Physician shall maintain adequate medical liability coverage through the Canadian Medical Protective Association or equivalent medical liability insurer as outlined in Article A18.1 of the Agreement.

ARTICLE 4 - GENERAL

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

4.2 Health PEI recognizes the Medical Society as the sole and exclusive bargaining agent for all of its members who are engaged in the practice of medicine, including the physicians who are signatory to this Agreement.

4.3 Health PEI acknowledges that the Group members are entitled to receive independent advice from the Medical Society. Health PEI shall make full disclosure of any offer of engagement to MSPEI, and shall provide MSPEI a copy such offer of engagement in advance of signing by a new Group member.

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

_____	_____
MSPEI (approved as to form)	**Date**

THE GROUP:	**HEALTH PEI:**
Per: _____	Per: _____
Per: _____	Per: _____
Per: _____	
Per: _____	
Per: _____	
Per: _____	
Per: _____	
Per: _____	

APPENDIX E - HOSPITALIST SERVICE COVERAGE AGREEMENT (PCH & QEH)

HOSPITALIST SERVICE COVERAGE AGREEMENT
(Prince County Hospital and Queen Elizabeth Hospital)

THIS AGREEMENT dated the _____day of _____, 20__

BETWEEN:

Health PEI

-and-

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

THE PARTIES hereto agree as follows:

ARTICLE 1 - DURATION OF AGREEMENT

1.1 This Agreement shall commence on the effective date of the Physician Services Agreement between Health PEI and the Medical Society of Prince Edward Island, and shall remain in effect for the term of the Physician Services Agreement. This Agreement shall be renewed for a further term unless either party provides 180 days written notice in advance of the expiry date of the Physician Services Agreement.

ARTICLE 2 - SERVICES AND COMPENSATION

2.1 In accordance with Article B15 of the Physician Services Agreement, the Group shall provide continuous hospital inpatient medical coverage for unaffiliated patients at the _____ Hospital in _____.

2.2 Health PEI shall fund the provision of this Hospitalist Service in accordance with Article B15 of the Physician Services Agreement, based on the funded lines per facility as defined in the Operational Guide.

2.3 The Group and Health PEI shall be jointly responsible for maintaining and, when necessary, recruiting physicians to adequately staff the Hospitalist Service to the funded lines. The Group shall also be responsible for recruiting physicians for the standby role pursuant to Article B15.

2.4 Any new physician joining the Group shall be mutually acceptable to both the Group and Health PEI, shall be a member of the Group, and shall be bound by the terms of this Agreement.

2.5 Any physician may withdraw from the Group and from this Agreement by giving ninety (90) days written notice of such withdrawal to the other members of the Group and to Health PEI. A physician leaving the group is absolved of the provisions of this Agreement.

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

2.7 The Group shall, in consultation with individual physicians, determine the schedule for the Group to adequately staff the Hospitalist Service to the funded lines, and shall make the physician schedule available to Health PEI.

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

2.9 Health PEI may provide such support, direction and information as it deems necessary under this Agreement.

ARTICLE 3 - INDEPENDENT CONTRACTORS

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

3.2 For greater clarity, the group is not a partnership.

3.3 The Hospitalist Physicians are severally liable, and not jointly liable, under this Agreement.

3.4 Each Hospitalist Physician shall maintain adequate medical liability coverage through the Canadian Medical Protective Association or equivalent medical liability insurer as outlined in Article A18.1 of the Agreement.

ARTICLE 4 - GENERAL

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

4.2 Health PEI recognizes the Medical Society as the sole and exclusive bargaining agent for all of its members who are engaged in the practice of medicine, including the physicians who are signatory to this Agreement.

4.3 Health PEI acknowledges that the Group members are entitled to receive independent advice from the Medical Society. Health PEI shall make full disclosure of any offer of engagement to MSPEI, and shall provide MSPEI a copy of any individual physician contract in advance of signing by a new Group member.

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

_____	_____
MSPEI (approved as to form)	**Date**
THE GROUP:	**HEALTH PEI:**
Per: _____	Per: _____
Per: _____	Per: _____
Per: _____	
Per: _____	
Per: _____	
Per: _____	
Per: _____	
Per: _____	

APPENDIX F - CLOSED ICU COVERAGE AGREEMENT (PCH & QEH)

CLOSED ICU COVERAGE AGREEMENT
(Prince County Hospital and Queen Elizabeth Hospital)

THIS AGREEMENT dated the _____day of _____, 20__

BETWEEN:

Health PEI

-and-

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

THE PARTIES hereto agree as follows:

ARTICLE 1 - DURATION OF AGREEMENT

1.1 This Agreement shall commence on the effective date of the Physician Services Agreement between Health PEI and the Medical Society of Prince Edward Island, and shall remain in effect for the term of the Physician Services Agreement. This Agreement shall be renewed for a further term unless either party provides 180 days written notice in advance of the expiry date of the Physician Services Agreement.

ARTICLE 2 - SERVICES AND COMPENSATION

2.1 In accordance with Article B15.6 of the Physician Services Agreement, the Group shall provide continuous hospital ICU coverage at the _____ Hospital in _____.

2.2 Health PEI shall fund the provision of this Closed ICU Service in accordance with Article B15.6 of the Physician Services Agreement, based on the funded beds per facility as defined in the Operational Guide.

2.3 The Group and Health PEI shall be jointly responsible for maintaining and, when necessary, recruiting physicians to adequately staff the Closed ICU Service to the funded lines. The Group shall also be responsible for recruiting physicians for the standby role pursuant to Article B15.6.

2.4 Any new physician joining the Group shall be mutually acceptable to both the Group and Health PEI, shall be a member of the Group, and shall be bound by the terms of this Agreement.

2.5 Any physician may withdraw from the Group and from this Agreement by giving ninety (90) days written notice of such withdrawal to the other members of the Group and to Health PEI. A physician leaving the group is absolved of the provisions of this Agreement.

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

2.7 The Group shall, in consultation with individual physicians, determine the schedule for the Group to adequately staff the Closed ICU Service to the funded lines, and shall make the physician schedule available to Health PEI.

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

2.9 Health PEI may provide such support, direction and information as it deems necessary under this Agreement.

ARTICLE 3 - INDEPENDENT CONTRACTORS

3.1 Excluding members of the Group who are salaried physicians, as professionals who are self-employed in the practice of ICUt medicine, the ICUPhysicians are not employees of Health PEI, and each physician shall bear sole responsibility for the discharge of any professional liability, income tax liability and other liability imposed by law arising from such physician's professional work and any other business expenses arising from such professional work.

3.2 For greater clarity, the group is not a partnership.

3.3 The ICU Physicians are severally liable, and not jointly liable, under this Agreement.

3.4 Each ICU Physician shall maintain adequate medical liability coverage through the Canadian Medical Protective Association or equivalent medical liability insurer as outlined in Article A18.1 of the Agreement.

ARTICLE 4 - GENERAL

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

4.2 Health PEI recognizes the Medical Society as the sole and exclusive bargaining agent for all of its members who are engaged in the practice of medicine, including the physicians who are signatory to this Agreement.

4.3 Health PEI acknowledges that the Group members are entitled to receive independent advice from the Medical Society. Health PEI shall make full disclosure of any offer of engagement to MSPEI, and shall provide MSPEI a copy of any individual physician contract in advance of signing by a new Group member.

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

_____	_____
MSPEI (approved as to form)	**Date**
THE GROUP:	**HEALTH PEI:**
Per: _____	Per: _____
Per: _____	Per: _____
Per: _____	
Per: _____	
Per: _____	
Per: _____	
Per: _____	
Per: _____	

APPENDIX G - HONORARIA POLICY

"For Information Only"

HEALTH PEI
POLICIES AND PROCEDURES MANUAL

POLICY NAME:	PHYSICIAN HONORARIA POLICY
EFFECTIVE DATE:	April 1, 2001
APPROVED BY:	_____
	Health PEI

INTRODUCTION:

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

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

1.0 INTERPRETATION/DEFINITIONS:

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

a. "Chairperson" means the person appointed by Health PEI to hold that position or to act as chairperson in the absence of the appointed chairperson
b. "Committee" means all Provincial committees established by Health PEI. This excludes those committees where physicians are required to participate as part of their usual medical staff functions or as a condition to having admitting privileges in that facility.
c. "Honoraria" means rate of compensation paid to a person for attending a committee meeting or any other meeting the person is requested to attend, based on their capacity as chairperson or member of a committee.

2.0 APPROVAL PROCESS:

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

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

3.0 ELIGIBILITY FOR HONORARIA:

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

4.0 HONORARIA RATES:

As per Article B22 in the Master Agreement.

NOTE: Meeting time does not include travel time.

5.0 TRAVEL EXPENSES:

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

6.0 ADMINISTRATION:

Honoraria payments to physicians shall be made by Health PEI on a quarterly basis (March, June, September, December). Physicians shall submit their invoice, using the form attached hereto, to Health PEI (Attention: Executive Director, Medical Affairs) within thirty (30) days after the end of the quarter.

PHYSICIAN HONORARIUM PAYMENT FORM

Honoraria payments to eligible physicians shall be made by Health PEI on a quarterly basis (March, June, September, December). To receive honoraria payments, physicians must submit their invoice using this form to Health PEI (Attention: Manager of Physician Services, Medical Services Division) within 30 days after the end of the quarter.

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

Honorarium amount: Health PEI shall provide reimbursement directly to eligible physicians at the rate $220/hour, or part thereof in excess of 15 minutes, to a maximum of $1,320/day.

Travel: Honoraria will be paid for meeting time only, not travel time. Mileage claims in excess of 50 km (return trip) are eligible for reimbursement at approved Treasury Board rates, as determined on a monthly basis.

Physician Name: _____ Employee ID: _____

Address: _____

Committee Name	Meeting Date	Start Time	End Time	Honorarium Amount	Travel Distance
			Total	**$**	**km**

Prepared By: _____ Date Prepared: _____

Approved By: _____ Date Approved: _____

_____

FOR OFFICE USE ONLY:

Mileage rate: $ _____/km Travel reimbursement: $ _____

TARIFF OF FEES

Schedule of Payments for Medical Services

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PREAMBLE TO THE TARIFF OF FEES

1. INTRODUCTION

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

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

2. GENERAL CONSIDERATIONS

The Preamble and how it is used and implemented is guided by the following principles.

a. All Parties trust the intentions of one another, and specifically:
    i) Trust that Health PEI and Government are making health service delivery decisions in the best interests of Islanders, the Physicians covered by this Agreement and stakeholders.
    ii) Trust that Physicians use their professionalism and clinical judgement to make the best decisions for their patients.
b. Meaningful and respectful collaboration and consultation between Physicians, MSPEI, Health PEI and Government is essential to building a strong and sustainable health care system.
c. Prince Edward Island's health care system is predominately a rural medical care system. This concept must be at the forefront of how we manage our health system and support Physicians.
d. The Agreement supports an equitable, diverse, and inclusive medical profession and work environment and all Parties make a commitment to review issues through an equity, diversity and inclusiveness lens going forward.
e. The Agreement seeks to create opportunities to improve patient access to the appropriate provider at the appropriate time.
f. "Care is care." Whether direct or indirect patient care, team collaboration or an administrative function, the effort extended to care for a patient is valued.
g. The Agreement provides flexibility and agility, where possible, so Health PEI and Physicians can be responsive to unforeseen system and medical profession needs.
h. The Agreement strives for simplicity in how Physicians are paid for their services.
i. The Agreement must be fair, transparent, and consistently applied, wherever possible.

2.A Virtual Care

The Parties recognize that the delivery of healthcare through the use of virtual care is evolving. In the interest of keeping pace with such virtual care technologies, the Parties agree that virtual care may be utilized through technologies and programs when approved by Health PEI.

Virtual care services are only billable for medically necessary services that can be safely and competently delivered through approved virtual care technologies.

Physicians providing medical advice by virtual (video, phone, text, approved online platforms), must record all interactions in the patient's chart, including the discussion of the clinical problem and the medical advice provided.

2.B Supporting Documentation

In general, it is expected that documentation will be on a patient's chart that supports claims for services. If such documentation is absent, the claim may not be paid. In particular, documentation must support that the services provided meet the criteria and/or requirements which are specified in this Preamble and Tariff and so the claim is eligible for payment.

Physicians are expected to follow best practice in documentation and recordkeeping.

The requirement for time-related fee codes are as follows:

- Fee codes which are affected by time of day must be supported by a start time documented on the patient's chart.
- Fee codes which are affected by the time spent providing the service must be supported by documentation of time spent on the patient's chart.
- Fee codes, which are affected by both time of day and time spent, require documentation of both start time and time spent on the patient's chart.

Note that time-based fee codes are those codes for which Physician bills for services based on 'blocks of time' or where there is a minimum time requirement specified in the Preamble or Tariff.

2.C Time of Day

For the purposes of this preamble and billing:

"Day" applies to visits between the hours of 08:00 and 17:59

"Evening" applies to visits between the hours 18:00 and 23:59

"Night" applies to visits between the hours of 24:00and 7:59 the following day

"Weekend" applies to visits between the hours of 08:00 Saturday and 08:00 Monday except for ER visits which start at 18:00 Friday.

2.D Electronic Submission of Claims

All claims must be submitted in an electronic form.

2.D.1 Time Limit - Submission of Claims

Subsection 19.1 of the *Health Services Payment Act Regulations* states in part that "a physician who renders a basic health service to an entitled person shall submit his claim for service within three (3) months of the date on which the service was rendered in such form and manner as the Department may prescribe."

2.D.2 Time Limit - Submission of Appeals

Physicians appealing a reduction or rejection of a claim also are required to submit their appeal within three (3) months from the date the claim appeared on a payment statement. Failure to do so will result in the appeal being declared "stale dated" and not reviewed.

3. ACCEPTANCE OF TARIFF

For the purpose of payment for services under the Plan, Physicians approved by Health PEI to provide services in Prince Edward Island, will claim 100% of the Tariff of Fees, except as expressed in Article B 23.1 of the Physicians Services Agreement, and the accepted claims shall be paid at the tariff established by the Department of Health in accordance with Section 4 (b) of the *Act*.

A participating Physician must hold a valid billing number authorizing the holder to claim payments under the Plan and may not charge an amount above the Tariff of Fees.

4. PARTICIPATION OF PHYSICIANS

All substantiated claims in respect to basic health services provided to entitled persons are to be submitted to and shall be paid by Health PEI in accordance with section 11 and 12 of the Act.

4.A Withdrawal from Plan

A Physician may withdraw from the Plan by providing at least 30 days' notice in writing to Health PEI as provided for under Section 27 of the *Health Services Payment Act Regulations.*

4.B Patient Claim Information

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

4.C Readmission to the Plan

A Physician may seek to be readmitted into the Plan by application in writing to Health PEI as provided for under section 30 of the Health Services Payment Act Regulations.

4.D Selective Service(s) Opting Out

4.D.1 Selective Option Out of the Plan

In accordance with section 10.1 of the Act, Participation Physicians may elect to opt out of the Plan for any given patient for the total management of the condition under care, including any complications which may develop; for a series of services for which a composite fee applies, or for which the fees are inter-related, the Physician would have to either opt in or opt out for the entire series of services.

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

If the opted-in Physician wishes to opt out for a particular patient or a particular service, they may, as at present, submit their claim to Health PEI on behalf of the patient. An entitled person shall then receive payment from Health PEI for substantiated claims in respect to basic health services as per the Tariff of Fees but shall be responsible for any additional fees charged by the opted-out Physician.

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

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

i. The Physician must inform the patient prior to the rendering of the service that they shall be billed directly for the service(s) being rendered;

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

5. MEDICAL NECESSITY

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

6. DELEGATION OF SERVICES

6.A Services Rendered Without Medical Supervision

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

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

6.B Delegated Functions

The following fee codes may be billed at a percentage of the Tariff of Fees as specified in this Preamble when the following services are delegated by a fee-for-service Physician who is approved by Health PEI to bill for delegated services and are within the scope of practice of the delegate:

- Comprehensive Office Visit (Fee Code 1810)
- Limited Office Visit (Fee Code 1813)
- Time-based office visits (Fee Codes 2501, 2507, 2588)
- Procedure codes: (Fee Codes 2000, 2001, 2008, 2009, 2019, 3042)

The delegated functions percentage rate to be applied to the designated fee codes shall be 75%. Approval of such arrangements shall be at the sole discretion of Health PEI and shall be limited to Physicians who work 75% or greater on a fee-for-service basis. The visit is required to be documented on the patient's chart.

The Physician shall submit the bill at the listed percentage of the standard rate. Role Code #28 must be used for all delegated services for which a fee-for-service Physician is submitting a claim.

7. INDEPENDENT CONSIDERATION (fee code 9999)

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

(i) Where a fee is listed as Independent Consideration in the Tariff of Fees.

(ii) When requested by a physician (An explanatory note must accompany the claim).

(iii) When a service is claimed which is not listed in the Tariff of Fees, following a process that is agreed to by MSPEI and HPEI.

For clarity, the per minute rate when billing Independent Consideration is $3.65.

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

8. VISIT CODES

8.A Consultation

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

Consultation requests by patients, their representatives, or a third party acting on their behalf, do not qualify as consultations payable under the Plan. For family physicians, a consultation fee can only be billed when the physician is not the most responsible provider for the patient. A consult may not be billed more than once in 30 days for the same problem by the same Physician. The consulting physician must send their recommendations to the referring practitioner and retain a copy in their chart, as well as a copy of the written referral request.

Special designation is required for family physicians to bill the following consults:
Palliative Care, Addictions, Geriatrics, Dermatology, Chronic Pain Management

Consultations longer than 30 minutes may be eligible for detention (Preamble 9.D.2). Exceptions are Pain Management, Addictions, Palliative Care, Geriatrics, Internal Medicine, Pediatrics, Physiatry, Psychiatry which must exceed 45 minutes to qualify.

8.B Limited or Telephone Consultation

This service is billable for two-way communication (in person, telephone or virtual) between a Referring Physician (or Health PEI-approved licensed health professional) and a Consulting Physician regarding the assessment and management of a patient without the Consulting Physician having to see the patient. The Consulting Physician will provide their expert opinion upon hearing the request.

All interactions must be documented in the patient’s chart or in a consulting letter to the referring practitioner, including the referring practitioner’s request, the discussion of the clinical problem, the medical advice given and the change in the patient’s treatment and/or management, if necessary.

This service is billable by the Consulting Physician only if they have provided an opinion and/or recommendation for patient treatment and/or management and documented the interaction. This service cannot be billed if the Consulting Physician sees the patient and bills a consultation within three days of the limited consultation.

This service is billable by the Referring Physician for participating in the discussion and documenting the discussion on the patient’s medical record.

8.C On-Line Medical Control Consultation

This service is restricted to Physicians who provide telephone advice to CEC nurses and paramedics working at a CEC and paramedics in the field with patients. It involves a discussion of the patient's condition and management, and documentation of the physician's opinion and recommendations to the nurse or paramedic.Any telephone advice provided to CEC or Island EMS staff during a patient encounter will be paid a fee per patient encounter, subject to afterhours and weekend/holiday premiums. If the physician is working in an emergency department while on-call, the fee shall be paid at full tariff rate.

8.D Consultations in Hospital

In regard to consultations in hospital:

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

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

iii. **Transfer of Care (no consultation)**: Where the attending physician transfers a patient to the care of a consultant, but does not request a consultation, only the fee for visits shall be allowed. Where the transfer of care from a specialist to a physician in the same specialty occurs, only the fee for visits shall be allowed, unless the receiving physician has special skills required for the treatment of the patient.

8.E Comprehensive Visit

A comprehensive visit is an in-depth evaluation of a patient necessitated by the seriousness, complexity, or obscurity of the patient's complaint(s) or medical condition.
A detailed record of the findings and advice to the patient shall be considered part of the visit. Examples include (but are not limited to):

- In-depth comprehensive office visit
- Subsequent office visit with complete re-exam
- Multi-issue office visit
- Initial prenatal visit
- New patient intake visit
- Complete re-exam after consultation
- Complex chronic disease management
- Initial evaluation of undifferentiated problem
- Emergency Visit Level II

A comprehensive visit may not be claimed within 30 days of a previous visit for the same complaint or medical condition. Visits provided within a 30-day period for the same condition or complication should be claimed as a limited visit. Within an Emergency Department, the 30-day rule does not apply and return visits for the same condition on the same or following day by the same Physician should be claimed as a limited visit.

8.F Ophthalmology Office Visit with Special Tests

Fee code 0812 Office Visit with Special Tests includes the following tests as part of the visit:

- Tonometry
- Gonioscopy
- Indirect ophthalmoscopy
- 3-mirror fundoscopy
- Slit lamp Biomicroscopy

These tests would be covered for both eyes within the visit.

8.G Limited Visit

A limited visit is a service rendered to a patient who presents with one or more complaints and is less involved than the comprehensive visit. A limited visit may be claimed when the Physician performs a focused assessment for a new condition or when monitoring or providing treatment of an established condition.

This care may be provided in the Physician's office, at the patient's home, virtually (by phone, video, or text), at a walk-in clinic, the Emergency Department or other similar access clinic.

Examples include (but are not limited to):

- Limited office visit
- Subsequent prenatal visit
- Well baby visit
- Follow-up visit
- Non homebound patient (home visit)
- Additional patient (after the first) during homebound visit
- Emergency Visit Level I

In regard to follow-up visits after a surgical procedure (including orthopedic procedures), follow-up visits can only be billed after 14 days following the procedure.

8.H Emergency Department Visits

Reassessment by Physician on duty in the Emergency Department is the service provided when, at least two hours after the original assessment or re-assessment is completed (including appropriate investigation and treatment), a subsequent assessment indicates that further provision of care and/or investigation is required and performed. A reassessment by the same Physician shall be paid at the same rate as a limited visit. A reassessment by a different Physician may be paid as a comprehensive visit if indicated, subject to appropriate documentation.

8.I Resuscitation/Critical Care Visit

A Resuscitation/Critical Care Visit pertains to the management of a life-threatening illness or injury which requires immediate evaluation and emergent intervention/treatment. Emergency conditions necessitating this service would include (but are not limited to) resuscitation of cardiac arrest, multiple traumas, cardio-respiratory failure, shock, coma, cardiac arrhythmias with hemodynamic compromise, hypothermia, and other immediately life-threatening situations.

A Resuscitation/Critical Care Visit shall include an immediate crisis-related examination and the usual resuscitative interventions as required, such as defibrillation, cardioversion, intravenous lines, cutdowns, arterial and/or central venous catheters, arterial puncture for blood gases, insertion of nasogastric tubes with or without lavage, endotracheal intubation and tracheal toilet, and the use and monitoring by the emergency Physician of pharmacologic agents such as inotropic, vasopressor, and thrombolytic drugs.

Payment for this service is based on the amount of time spent by the Physician in constant attendance with a critically ill patient in a life-threatening emergency situation. As in other detention-based care, after-hours premiums are applicable.

Because resuscitation situations often require the services of more than one Physician at the same time, this service may be billed by up to three Physicians per life-threatening emergency situation, when required. The attending Physician shall document on the patient record the need for more than one (1) Physician.

8.J Homebound Patient Visit

Refers to services rendered to a homebound patient at the request of the patient or the patient's representative. A homebound patient visit (fee code 1821) may only be claimed when the patient's condition or situation justifies the service and the patient is considered homebound, as defined by one or more of the following conditions and documented on the patient's record:

- Leaving home isn't recommended because of the patient's condition
- Leaving home takes a considerable and taxing effort

8.K Diagnostic and Therapeutic Interview Visit

A diagnostic and therapeutic interview visit is a scheduled visit with a patient and/or a patient's family or other persons who may have relevant information about the patient's circumstances for the purpose of obtaining a collateral history and discussing a treatment, management, or intervention plan for the patient. The patient may or may not be present during the visit. This service is payable in blocks of fifteen (15) minutes or a major portion thereof, with a minimum of fifteen (15) minutes of service. Such time shall be recorded on the patient's chart.

Physicians cannot submit a claim for this service during the same encounter for which visit fees are claimed. If this fee is claimed on the same day as a visit fee, the Physician must document both encounters.

This fee may be billed by psychiatry, pediatrics, internal medicine, physical medicine, and family medicine specialist physicians. This fee may also be billed by surgical specialties if the diagnosis is related to cancer.

8.L Long Term Care and Community Care Visits

Long Term Care and Community Care visits shall be redefined as follows:

Long Term Care (LTC) and Community Care visits shall be payable for physician services provided to residents of these facilities. Fee code 1827 applies to the first resident seen; fee code 1828 applies to each additional resident seen at the same location on the same day. These fee codes qualify for after-hours premiums.

Contracted LTC Physicians shall be paid a standard LTC stipend for the provision of comprehensive LTC medical services in lieu of LTC Visit fee codes 1827 and 1828.

8.M Medical Assistance in Dying

Fee code 1899 is used to compensate a Physicians for time spent providing MAiD services. It includes, but is not limited to, the time spent engaging the patient in a discussion of their diagnosis, prognosis, and treatment options, discussing the availability of palliative care for terminally ill patients, assessment of patient for MAiD criteria, arrangement for additional assessors, and procedure time.

This service is payable in blocks of fifteen (15) minutes or a major portion thereof, with a minimum of fifteen (15) minutes of service. Such time shall be recorded on the patient's chart.

Physicians cannot submit a claim for this service during the same encounter for which visit fees are claimed. If this fee is claimed on the same day as a visit fee, the Physician must document both encounters.

8.N Off Site Visit

Offsite Visit refers to a service rendered to a patient at a site other than the patient's home, the Physician's office or clinic, hospital or other institution, and may include calls in which a patient is seen at the site of onset of illness or injury, for example, on the street or at a sports arena. An offsite visit should be billed as fee code 1829.

9. FACILITY VISIT CODES

Hospital visit codes are limited to medical services rendered to an entitled person formally admitted to hospital (including the inpatient Palliative Care Unit and Addictions) for diagnostic tests and/or treatment. All hospital visits, consultations and procedures must be supported by documentation.

9.A Hospital Care

9.A.1 Hospital Admission

This visit (fee code 1830) is for the initial daily hospital care visit, including History and Physical, care plan and orders, and applies whether the patient is affiliated or unaffiliated.

For clarity, this includes but is not limited to the following services:

- Initial Hospital Visit
- Sick or Premature Newborn Initial Visit
- Complete Medical Assessment on Psychiatry Patient
- History & Physical for Dental Surgery
- Initial Visit for Extended Care and Palliative Care Inpatient/Home Care patients

9.A.2 Daily Hospital Care – Most Responsible Physician (MRP)

This fee code (1833) is for all subsequent hospital visits made by the Most Responsible Physician (MRP). If billed more than one in one day, the Physician must document on the patient's chart the medical necessity of the additional visits. When a Physician is called back in to see an inpatient for a second time on the same day, they may bill detention.

Post-operative Daily Hospital Care visits within 14 days of surgery are not payable to the Operating Surgeon, with the exception of post-partum care.

For clarity, this includes but is not limited to the following services:

- All Subsequent Hospital Visits regardless of duration of stay
- Assessment of Labour
- Post Partum Hospital Visit
- Sick and Premature Newborn Subsequent Visits
- Extended and Palliative Care Subsequent Inpatient Visits
- Unaffiliated Daily Care Visits

9.A.3 Hospital Care – Additional Physician

i. Services from an additional Physician, other than the MRP, may be billed on the same patient/same day (fee code 1841). Documentation must substantiate the requirement for services from the additional Physician.
For clarity, this includes but is not limited to the following services:
   - Daily Hospital Care Visit Additional Physician
   - Concurrent Care by Family Physician
   - Continuing Care by Consultant
   - Directive Care by Consultant

   If billed more than once in one day, the Physician must document on the patient's chart the medical necessity of the additional visits. Services from an additional Physician, other than the MRP, may be billed on the same patient/same day. Documentation must substantiate the requirement for services from the additional Physician.

   Post-operative Daily Hospital Care visits within 14 days of surgery are not payable to the Operating Surgeon.

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

9.A.4 Hospital Discharge

A hospital Discharge Fee (add-on fee code 0136) may be claimed by the Physician who performs the activities in discharging a hospital in-patient. These activities include, as necessary, the completion of the patient's chart, discharge summary, writing prescriptions for the patient, providing discharge instructions to the patient, and arranging for follow-up care of the patient. The Hospital Discharge fee may be claimed in addition to a Daily Hospital Care fee if both are performed on the same day.

The fee is not payable where surgery or fracture care is provided in a hospital setting unless a patient is transferred to a non-operating Physician for follow-up care after surgery/fracture care. In this case, that Physician may claim the discharge fee if the Family Physician performs the discharge duties. This fee cannot be claimed by the operating Surgeon in association with any surgical code being billed, or for immediate post-partum care.

It is possible for a Physician to claim for the Hospital Admission and Hospital Discharge fees on the same day for a patient. More than one Physician may bill for hospital care provided specialized care is required and documentation is provided in the patient's chart.

9.B Intensive Care / Critical Care

9.B.1 Critical Care

Critical care fees (fee codes 0595, 0596, 0597, 0598, 0502) apply to the daily care of critically ill and potentially unstable patients who require intensive monitoring and treatment in a designated, approved intensive care area. The above critical care fee codes include initial consultation and assessment and daily management of the patient, including the following procedures, as required: insertion of intravenous lines, arterial and central venous catheters, urinary catheters, pressure infusion sets and pharmacological agents, securing and interpretation of blood gases, oximetry, nasogastric tubes, endotracheal intubation, tracheal toilet, artificial ventilation and all necessary measures for respiratory support.

The following critical care services may be claimed in addition to the daily critical care fee codes as appropriate within the physician's chosen pay modality: Swan-Ganz catheter insertion, transvenous pacemaker insertion, chest tube insertion, cardioversion, bronchoscopy, endoscopy, surgical pacemaker insertion, pacemaker interrogation, renal dialysis, and detention.

Critical care fees are payable to the Physician in charge of the daily management of the patient. Other Physicians who become involved in the patient's care may charge the appropriate consultation, visit or procedure fees including concurrent critical care (fee code 0502).

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

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

First day critical care codes require time of day when requesting after-hours premiums. Detention may be billed in relation to first day critical care when the time spent with the patient exceeds the specific time maximums noted in the tariff for the first day critical care by the specialist. Clear supporting documentation on the additional time requirements must be present on the patient chart.

9.B.2 Closed ICU

Designated Physicians to work in a Closed ICU will be paid a daily sessional fee, billed as Fee Code 2080 or, for salaried Physicians on weekdays, as an equivalent top-up sessional fee code. These sessional fees must be billed under Specialty Code 53.

Closed ICU Physicians are required to shadow bill all Closed ICU critical care fee codes, including detention, for services provided to Closed ICU patients during day coverage while on duty based on established fee codes and billing parameters set out in Preamble 9.B.1. Shadow billing for Closed ICU patients will be flagged using Specialty Code 54.

The following critical care services may be claimed by an on-duty Closed ICU Physician, on a fee-for-service basis, in addition to the daily sessional fee (using the Physician's usual specialty code): Swan-Ganz catheter insertion, transvenous pacemaker insertion, bronchoscopy, endoscopy, surgical pacemaker insertion, pacemaker interrogation and renal dialysis, along with any other services which require specialized skills and are not generally considered part of usual critical care procedures, provided such services have been approved by Health PEI to be provided on a fee-for-service basis in addition to the daily sessional fee.

For greater clarity, routine elective services are not payable to the Closed ICU Physician while designated to be on critical care duty.

Critical care daily sessional fees for the Closed ICU, and any allowable fee for service critical care services provided to patients admitted to the Closed ICU are payable to the on-duty Closed ICU Physician in charge of the daily management of the patient. Other Physicians who become involved in the patient's care may charge the appropriate consultation, visit or procedure fees including concurrent critical care (fee code 0502).

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

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

9.C Visits Prior to Surgery

9.C.1 Visit by a Surgeon Prior to Surgery

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

9.C.2 Visit by Attending Physician Prior to Surgery

An Attending Physician may carry out hospital investigations prior to referring a patient to a Surgeon and shall be entitled to submit claims for their services up to the time of referral. They shall only be entitled to submit claims beyond this time if they continue to be responsible for a condition not related to the surgery.

9.C.3 Visit Prior to Surgical Assist

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

9.D Detention

9.D.1 Definition of Detention

Detention is defined as a time-based service applicable in a number of situations. Detention is billable in time blocks of 15 minutes or a major portion thereof. When billing detention, other fee codes may not be billed during the same time. Claims submitted must include detention time spent. Detention is not restricted to services provided only in hospital. Detention does not apply when the time is spent doing procedures.

9.D.2 Application of Detention

Detention may be billed under the following scenarios:

- Time in excess of half an hour spent by the Physician in examining, treating, or consulting a patient.
- For the specialty groups of internal medicine, pediatrics, psychiatry, palliative care, pain management, geriatric care, addictions and physiatry detention may apply after the first 45 minutes.
- Time spent when a Physician has been called in to a hospital to provide a service to a patient and there is an operational delay. Detention does not apply when the Physician chooses to stay on-site for their own convenience.
- When a Physician is required to be personally present, as a stand-by, to render services.
- When a Physician has accepted the responsibility of transporting a patient from one location to another, the Physician shall be paid detention during time of travel from this location back to original site. Claims should have a comment record, indicating the length of time of the detention.
- Where a Physician on duty in the Emergency Department is called to the floor to assess/treat an inpatient, payment shall be made on a detention basis with actual time spent indicated on claim and shall be payable in addition to the ER sessional rate. In the case of inpatient resuscitation, resuscitation fees apply instead of detention. Time of day must also be indicated on the chart.
- When a Physician is called to see an in-patient for a second or subsequent visit, detention shall begin immediately.
- When the LTC Physician is called in emergently to provide medical services to an LTC resident, payable in lieu of other visit, or procedure fees.

9.E Hospitalist Medicine Service

Hospitalist Medicine Services shall be in accordance with Article B15.5 of the Physician Services Agreement. In accordance with Article B15.5, Hospitalists shall be paid an hourly sessional fee (fee code 1801) to provide comprehensive inpatient care for patients assigned to them, including admission history and physical examination, daily medical management, participation in multi-disciplinary rounds and family conferences as needed, and discharge planning.

Salaried Focused Family Physicians providing Hospitalist Medicine Services shall be remunerated at the same sessional rate by billing a top-up fee equal to the difference between their hourly salary (including benefits) and the Hospitalist sessional hourly rate (fee code 0028).

10. OTHER VISIT CODES

10.A Non-Face-to-Face Care

10.A.1 Physician-to-Patient Electronic Communication

This service is billable unscheduled two-way communication with a patient (i.e., telephone, secure email or secure text services as approved by Health PEI).

All interactions must be recorded in the patient's chart, including the discussion of the clinical problem and the medical advice provided. A claim for service includes all secure email/text communication with respect to the clinical issue at hand.

This fee code (1895) is not payable for prescription renewals, anti-coagulation therapy by email or text or notification/booking of appointments or referrals. This fee code is not payable on the same day as a visit or service fee by the same Physician for the same patient.

10.A.2 Collaborative Care

This service is billable when a Physician is requested to provide advice on a patient by an allied healthcare professional recognized by Health PEI. This fee code (0097) is intended to compensate the Physician for the time they take to share their medical expertise in caring for a patient. All interactions must be recorded in the patient's chart, including the advice given to the health-care professional.

The following exclusions apply to the Collaboration fee code:

- Allied health care personnel for dentists and chiropractors;
- Prescription renewals, clarification of illegible prescriptions, switching to generic form of drug, and cannot be billed in with Telephone Prescription Renewal;
- Collaboration completed by other members of the care team on behalf of the Physician (the Physician must be directly involved in the collaboration interaction for it to be billed).

10.A.3 Telephone Prescription Renewal

This service is billable when a Physician is requested by a patient to communicate a prescription renewal by electronic medical record, telephone, fax, or email without seeing the patient.

Documentation on the patient's chart must include the name of the pharmacy, as well as the drug, dose and amount prescribed. This service may not be billed if the Physician sees the patient and bills for a visit within three (3) days of this service.

10.A.4 Indirect/Administrative Care

Available only to Fee for Service Physicians, Clinical Administration (fee code 1896) is a time-based service which may be billed for the indirect administrative work such as completing forms, charting, or navigating the healthcare system on behalf of the patient.

Administrative meetings with staff are not eligible to be billed under this fee code nor is work for uninsured services.

This fee may be billed an average of 5 hours per week, up to a maximum of 230 hours per year (pro-rated to FTE). This does not apply to salary, contract, or sessional physicians or those who provide surgical assists exclusively.

10.A.5 Case Management Conference

A Case Management Conference is a scheduled, multi-disciplinary meeting with other professionals for the purpose of discussing a treatment, management, or intervention plan for the patient(s). The patient(s) and/or family members may or may not be present at the conference. This service is payable in blocks of fifteen (15) minutes or a major portion thereof, with a minimum of 15 minutes of service.

Physicians may not submit a claim for this service during the same encounter for which visit fees are claimed. If this fee is claimed on the same day as a visit fee, the Physician must document both encounters.

11. On-Call Services

11.A On-Call Retainer Fees

11.A.1 Payment of Retainer

The daily retainer for each clinical group shall be paid according to a fee code as listed in the Tariff of Fees and shall qualify for weekend and holiday premiums (see Preamble 12.B).

Payment of the on-call retainer is contingent upon the following conditions being met:

- the Physician shall be entitled to bill fee-for-service in addition to the on-call retainer for all services rendered when on-call, except if services are provided during salaried/contract hours;
- the Physician is not otherwise compensated through another contractual arrangement for on-call coverage;
- in the event an on-call locum Physician leaves the province early, the on-call retainer may be divided with another Physician, provided a comment is added to the claim; and
- any Physician scheduled to receive an on-call retainer who is unavailable or does not respond when called or paged, shall not be entitled to receive the on-call retainer payment.

11.A.2 On-Call Coverage for Multiple Clinical Groups

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

11.A.3 Payment for Additional On-Call Coverage during Physician Shortages

Where a Physician performs additional on-call (in accordance with Article B18.8) a Physician will be paid a 100% add on fee on their applicable on-call retainer as per the Fee Tariff, subject to weekend and holiday premiums (either fee code 9345 or 9350 or 0078 based on the Specialty)
The premium does not apply where the additional on-call is a result of a Physician vacancy is due to Continuing Medical Education or vacation leave.

The additional on-call premium will not apply to:

- hospitalist overflow;
- backup on-call;
- individual Physicians who request and/or choose to do additional on-call within the approved and funded complement;
- off Island specialists providing on call services remotely; or
- Family Physicians who provide in-patient services at an acute care facility with a formalized hospitalist program

11.B On-Call Response Fees

11.B.1 On-Call Response Fee

An On-Call Response Fee is intended to compensate on-call Physicians for the disruption and inconvenience of having to respond emergently to the request of another Physician or a charge nurse to provide service to a patient, which is not part of the on-call Physician's normal routine, by returning to a Health PEI approved healthcare facility after-hours (weekdays 18:00-08:00 and weekends/holidays 08:00-08:00) and shall qualify for weekend and holiday premiums.

This fee may be claimed more than once per day on-call and is payable in addition to the Physician's usual On-Call Retainer Fee plus fee-for-service.

Payment of this fee requires clear documentation on the patient's chart outlining the time the Physician was called in, the nature of the patient's emergent problem and the medical necessity for the Physician to be called back to personally attend to the patient.

This fee is not payable if the Physician has not been requested to return to a Health PEI approved healthcare facility by another Physician or a charge nurse and is not payable if there is no medical necessity for the Physician to attend to the request in person.

11.B.2 On-Call Response Fee: Extraordinary Circumstances

A Physician not scheduled to be on call may bill the on-call response should they be requested to come to a facility due to a situation where the Physician on-call requires additional assistance as a result of unusually high patient demands. A comment is required on the necessity for back-up support.

12. PREMIUM FEES

12.A After-Hours Premium

The rules regarding the application of After-Hours Premiums are as follows:

12.A.1 Application of Premium

For fee codes that are subject to after-hours premiums, where at least two thirds of a service rendered falls within a premium period, the premium rate applicable to that period shall apply for the entire service. In all other cases, the service must be billed at the non-premium rate.

12.A.2 Surgical Start Time

For billing purposes, the start time of surgical procedures is determined by the recorded anesthetic start time.

12.A.3 After-Hours Premium for Emergency Situations Only

After hours premiums refer to emergency service and are not to be billed when the time the service is rendered is for the convenience of the Physician. For radiology services, the reading of the image must occur at the time of the emergency in order for the premium to apply.

Physicians are required to include the date and time of the emergency service. An E Indicator is required.

12.A.4 After-Hours Premium for Emergency Service (18:00-24:00)

Consultations, surgical procedures, assists for surgical procedures, deliveries, anaesthesia services, radiology services, resuscitation, homebound patient visits, community care facility visits, long term care facility visits, diagnostic and therapeutic procedures, detention, on-line medical control, assessment of labour, and other services rendered on an emergency basis during the hours of 18:00 to midnight shall be paid at normal fees plus 25%.

Time and E indicator must be shown on claim.

12.A.5 After-Hours Premium for Emergency Service (24:00-08:00)

Consultations, surgical procedures, assists for surgical procedures, deliveries, anaesthesia services, radiology services, resuscitation, homebound patient visits, community care facility visits, long term care facility visits, diagnostic and therapeutic procedures, detention, on-line medical control, assessment of labour, and other services rendered on an emergency basis during the hours of midnight to 08:00 shall be paid at normal fee plus 100%.

Time and E indicator must be shown on claim.

12.A.6 After-Hours Premium for Emergency Service (08:00-18:00) (Saturday, Sunday, Holiday)

Consultations, surgical procedures, assists for surgical procedures, deliveries, anesthesia services, radiology services, resuscitation, homebound patient visits, community care facility visits, long term care facility visits, diagnostic and therapeutic procedures, detention, on-line medical control, assessment of labour, and other services rendered on an emergency basis during the hours 08:00 to 18:00 on Saturdays, Sundays and holidays shall be paid normal fees plus 25%. E indicator must be shown on claim.

12.B Weekend and Holiday Premium for On-Call Coverage

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

12.C Weekend and Holiday Premium for Hospital Inpatient Visits

A premium of 25% shall apply to all hospital inpatient visits and Hospitalist hourly sessional fees, and ICU Physician sessional fees, provided on weekends and statutory holidays.

12.D Geriatric Premium

A geriatric premium of 25% shall apply to all consultations, repeat consultations, office visits, home visits, ED visits and resuscitation provided to patients 75 years of age and over. This applies to all specialties.

A premium of 16.5% shall apply to all Critical Care 1st Day fees provided to patients 75 years of age and over to account for the 25% Geriatric Premium on the consultation portion of Critical Care 1st Day fees. Applies to fee codes 0595 and 0596.

12.E Child and Adolescent Psychiatry Premium

A premium of 25% shall apply to the following services provided by a Psychiatrist: psychiatric consultations, repeat consultations, office visits, home visits, and ED visits provided to patients 18 years of age and younger.

13. PSYCHIATRIC SERVICES

13.A Psychotherapy

Psychotherapy is defined as a procedure carried out by a Physician to treat mental, emotional and psychosomatic illness through a therapeutic relationship with the patient in an individual, group or family setting. Psychotherapy always entails continuing medical diagnostic evaluation and responsibility and may be carried out in conjunction with drugs and other treatment(s) (e.g., ECT). Psychotherapy assumes that the psychological and physical components of an illness are intertwined and that at any point in the disease process, psychological symptoms and signs may give rise to, substitute for, or run concurrently with physical symptoms and signs and vice versa.

This service is payable in blocks of fifteen (15) minutes or a major portion thereof, with a minimum of fifteen (15) minutes of service. Such time shall be recorded on the patient's chart. Physicians cannot submit a claim for this service during the same encounter for which visit fees are claimed. If this fee is claimed on the same day as a visit fee, the Physician must document both encounters.

13.B Hospital Psychiatric Care

Hospital Psychiatric Care is a time-based fee for in-patient care provided by a Psychiatrist in an acute care facility (fee code 1803). This service is payable in blocks of fifteen (15) minutes or a major portion thereof, with a minimum of fifteen (15) minutes of service. Such time shall be recorded on the patient's chart. Physicians cannot submit a claim for this service during the same encounter for which visit fees are claimed. If this fee is claimed on the same day as a visit fee, the Physician must document both encounters.

For clarity, the Hospital Psychiatric Care fee code replaces in-hospital Psychotherapy (2504) and in-hospital Diagnostic and Therapeutic (2586) performed by Psychiatrists.

13.C Certification for Admission to a Psychiatric Facility

Medical examinations required in connection with the certification of an entitled person to a mental institution are acceptable as a benefit under the Plan (fee code 2800). A visit is not payable in addition to the certification examination. This fee code shall be subject to afterhours premiums, if indicated.

13.D Group Psychotherapy

Billings must include PHN & DOB for each patient involved. This service is payable in blocks of fifteen (15) minutes or a major portion thereof, with a minimum of fifteen (15) minutes of service. Such time shall be recorded on the patient's chart. Physicians cannot submit a claim for this service during the same encounter for which visit fees are claimed. If this fee is claimed on the same day as a visit fee, the Physician must document both encounters.

14. SURGICAL SERVICES

The fee for surgical procedures shall include the customary pre and post-operative care as deemed necessary by the operating Surgeon for a period of up to 14 days post-operatively or two office visits if necessary for the follow-up examination subsequent to discharge from hospital.

In cases where a Surgeon is the primary Physician responsible for critically ill patients in an ICU, the Surgeon shall be allowed to bill applicable Critical Care codes (0595-0598). However, these fees would not be applicable if another Physician e.g., an Internist is also charging Critical Care (0595-0598) rates. (Ref. Section 9.B.1.)

Laparoscopic procedures converted to open will not be paid in addition to surgical procedures as either Fee Code 5450 (Laparotomy) or Fee Code 5460 (Laparoscopy).

14.A Pre-Operative Consultation and Investigation

A consultation by a Surgeon which subsequently leads to surgery shall be paid in addition to the procedural fee, as long as the documentation requirements for consultations in Sections 8.A and 8.D.

In unusually complicated cases requiring prolonged preoperative care, visit fees may be claimed by the Surgeon and must be accompanied by an adequate explanation in the patient's record.

14.B Post-Operative Period

The normal post-operative period is deemed to be 14 days for all surgical procedures including fractures and dislocations.

14.C Procedures During Visits

A procedural fee may be charged in addition to the visit fee when the procedure was not the primary reason for the visit.

14.D Cosmetic Surgery

See PRIOR APPROVAL Section 27 & Preamble Appendix D

14.E SURGICAL PROCEDURES

14.E.1 Role Codes

#10 Surgeon billing 100% of tariff
#11 Surgeon billing 65% of tariff - applies to surgeries performed by the same Surgeon through different incisions under the same anaesthetic.
#12 Surgeon billing 50% of tariff - applies to surgeries performed by the same Surgeon through the same incision under the same anaesthetic.
Role Codes #24, #25, #26, #27, #50 and #51 apply when the attending Surgeon identifies the need for a qualified actively practicing second Surgeon to assist in a procedure because of the second Surgeon's expertise in a specific area. Prior approval is required for non-emergency cases, explaining the requirement for a second Surgeon.
#24 Assistant billing 75% of Surgeon's claim where **Surgeon has billed 100%** of tariff (Surgeon role #10).
#25 Assistant billing 75% of Surgeon's claim where **Surgeon has billed 65**% of tariff (Surgeon role #11).
#26 Assistant billing 75% of Surgeon's claim where **Surgeon has billed 50%** of tariff (Surgeon role #12).
#27 Assistant billing 75% of Surgeon's claim where an **intra-operative consultation** has occurred. (Ref 14.E.5.(c))

Role Codes #46, #47, #50, #51 apply to Advanced Laparoscopic surgeries performed on the stomach (fee codes 5207-5234), the intestines (fee codes 5250-5290), the rectum (fee codes 5322-5348) and effective April 01, 2022, the kidney (fee codes 8010, 8011, 8019, 8021, 8022, 8025).

#46 Surgeon billing 125% of tariff
#47 Surgeon billing 62.5% of tariff - applies to surgeries performed by the same Surgeon through the same incision under the same anaesthetic.
#50 Assistant billing 75% of Surgeon's claim where **Surgeon has billed 125%** of tariff (Surgeon role #46).
#51 Assistant billing 75% of Surgeon's claim where **Surgeon has billed 62.5%** of tariff (Surgeon role #47).

14.E.2 Similar Procedures Done Concurrently

When two similar procedures, e.g., sutures, are done at one time, the charge for the second procedure should be 50% of the listed fee, or as indicated in the schedule. When done at an interval under a separate anesthetic, the full fee shall apply.

14.E.3 Multiple Procedures Through Same Incision

When more than one operative procedure is performed by the same Surgeon through the same incision and under the same anesthetic, the full fee shall be charged for the major procedure, and 50% the listed fee for the second procedure, except where such combined operations are specified in the schedule. This does not apply where an appendix or ovarian cyst is removed incidentally during an operation, for which no additional payment shall be made.

14.E.4 Multiple Procedures Through Separate Incisions

When procedures are done by one Surgeon through separate incisions under one anesthetic, the charge for the lesser procedure should be 65% of the listed fee.

14.E.5 Separate Surgeons

(a) Different Procedures

When different operative procedures are done by two different Surgeons under the same anaesthetic for different conditions, the fee shall be 100% of the listed fee for each condition.

(b) Intra-operative Consultations

When the attending Physician identifies the need for a consultation from a qualified actively practicing second Surgeon, during an operation in progress, the second Surgeon shall be paid a separate consultation fee.

If the second Surgeon assumes responsibility for the surgery, they shall be paid the surgical fee but not the consultation. The original Surgeon shall be paid the assistant fee at 75% (Role Code #27) . The original Assistant, now second Assistant shall continue to be paid at the Assistant hourly rate.

If the second Surgeon becomes the Assistant, then the second Surgeon shall be paid a separate consultation fee and the assistant fee at 75% (Role Code #24). The original Surgeon payment shall not change. The original Assistant, now second Assistant, shall continue to be paid at the Assistant hourly rate.

14.E.6 Subsequent Operation

When a subsequent operation becomes necessary during the same hospitalization because of complications, or for a new or different condition developing during the same hospitalization, full fee shall be paid for procedures listed in the surgical schedule, which are performed because of complications.

14.E.7 Procedure Done in Stages

Where operative procedures are normally performed in stages, the full fee may be claimed for each procedure.

14.E.8 Pre-operative Diagnostic Procedures

Diagnostic procedures carried out prior to surgery shall be eligible for payment according to the Schedule.

14.E.9 Surgical Procedures Performed in Ambulatory Settings

Surgical procedures that can be safely and appropriately performed in an approved ambulatory setting (i.e., a hospital setting, or a non-hospital setting approved by Health PEI) shall be paid at the same rate as if the procedure had been performed in a hospital operating room.

14.E.10 Surgical Procedures for Morbidly Obese Patients

A surgical Obesity Premium may be claimed for designated major surgical procedures performed on the neck, peritoneal cavity, pelvis, retroperitoneum, hip, or knee of patients with a Body Mass Index (BMI) of 40 or higher. This premium may be claimed by the Surgeon only once per surgical session, in addition to the regular surgical fee, for major surgical procedures performed in a hospital operating room using an open technique for the neck, hip, and knee, or an open or laparoscopic technique for the peritoneal cavity, pelvis, and retroperitoneum. This premium is billed as fee code 0074 and must be supported by documentation of the BMI on the patient's medical record.

The Surgical Obesity Premium may not be claimed for bariatric surgical procedures, nor for procedures limited to the skin or subcutaneous tissues, nor for procedures performed under local anesthesia or conscious sedation, nor for procedures consisting of aspiration, needle biopsy, dilation, endoscopy, cautery, ablation, or catheterization.

14.E.11 Advanced Laparoscopic Surgery

A premium of 25% may be claimed for advanced laparoscopic surgical procedures, specifically, surgery on the stomach (fee codes 5207-5234), the intestines (fee codes 5250-5290), the rectum (fee codes 5322-5348), and the kidney (fee codes 8010, 8011, 8019, 8021, 8022, 8025). This premium is claimed by billing for the procedure using Role Codes #46 and #47.

14.E.12 Sudden Cancellation of Surgery

In the event that surgery is cancelled due to an issue that was outside of the Physician's control or as a result of a health-system issue that prevented the surgery from proceeding (i.e., shortage of allied health-care professions or O.R. space). This fee code shall only apply when the surgery was cancelled with less than 24-hour notice, providing insufficient notification for other direct patient care work to be scheduled. With the exception of the Indirect/Administrative Care Fee code, no other fee for service may be billed during this time. This fee code applies to all fee-for-service Physicians impacted by cancellation (i.e., Surgeon, Anesthesiologist and Surgical Assistant). This code is not eligible if the surgery was cancelled due to the Physicians' unavailability (i.e., illness) or a patient related cancellation.

15. SURGICAL ASSISTANTS

15.A Minor Surgical Procedure

The necessity of a Surgical Assistant for a minor surgical procedure shall be left to the discretion of the Surgeon. On occasion, explanations may be required.

15.B Schedule of Rates

A routine Surgical Assist will be paid based on the most appropriate time-based Surgical Assist fee code in the Tariff.

- Fee Code 9367 – Longitudinal Family Medicine Specialist Physicians
- Fee Code 9368 – *All Specialists other than Longitudinal Family Medicine Specialist and Focused Family Medicine Specialist Physicians*
- Fee Code 9369 – All other physicians

The payable time begins when the anesthesia time starts and ends when the Surgical Assist is no longer required to personally attend the patient.

When the attending Surgeon identifies the need for a qualified actively practicing second Surgeon to assist in a procedure because of the second Surgeon's expertise in a specific area. Prior approval is required for non-emergency cases, explaining the requirement for a second Surgeon. In this case the assisting Surgeon may bill 75% of the Surgeon's fees, using role codes 24, 25, 26, 27, 50, 51. If prior approval is not granted, the second Surgeon should bill the appropriate time-based fee code for routine surgical assist.

16. VASCULAR SURGICAL PROCEDURES

16.A Veins and Arteries

i. Excision or repair procedures for arteries and veins include endarterectomy, thrombectomy and/or bypass graft.

ii. Excision or repair procedures for arteries and veins include harvest of graft tissue, except where the harvest of graft tissue is beyond the normal parameters, which will be paid for as indicated.

iii. Common femoral artery repair includes repair to the profunda femoris artery as far as the first major branch. If the repair extends beyond the first major branch of the profunda femoris artery, Fee Code 4652 may be claimed in addition. If added to another vascular procedure in the same incision/limb the fee will be paid at 50%.

iv. Exposure of leg vessels for evaluation and re-vascularization - Fee Code 4643 may be claimed plus fee for sympathectomy or amputation, if required.

v. Two distinct vascular procedures at same sitting, with same exposure, the second procedure will be paid at 50%.

vi. Two distinct vascular or endovascular procedures via different exposures, the second procedure will be paid at 65%.

16.B Harvesting

A Surgeon may claim an add on fee when harvesting an arm vein, a superficial femoral vein or an opposite leg vein from the non-operative site.

16.C Venous Wounds

During vascular procedures on venous wounds a laparotomy or thoracotomy will be paid at 50%, if required.

16.D Arteriovenous Procedures

If an arteriovenous fistula is required as part of a vascular procedure, it shall be paid at 50% of the operation procedure.

16.E Portal Hypertension

The fee for portal hypertension procedures shall include a splenectomy, as required.

16.F Percutaneous Arterial Procedures

(i) Angiography for the renal mesenteric arch shall be paid per minor vessel, in addition to Fee Code 4635 – Arteriography Selective.

(ii) Multiple angioplasties are paid as one fee for each named vessel. If an angioplasty is required on a contiguous vessel, it will be paid at 50%.

(iii) Operative arteriography will only be paid once per vessel per 24-hour period.

16.G Aorto-iliac Procedures

(i) For aorto-iliac procedures, if a thoracotomy or laparotomy procedure is required, it shall be paid in addition to the operative procedure.

(ii) If re-vascularization is required for the removal of infected aortic graph stem and limbs, it will be paid in addition to the operative procedure at 50%.

16.H Lower Limb Arterial Procedures

In cases of extended profundoplasty – first or second muscular branch – Fee Codes 4642 and 4652 may be claimed if it is the sole procedure. If done as a secondary procedure, it may be claimed at 50%.

17. FRACTURE CARE

17.A Definitions

Open reduction shall mean the reduction of a fracture by an operative procedure and is intended to include exposure of the fracture site with fixation as indicated.

Closed reduction shall mean the reduction of a fracture by non-operative methods with the aid of local or general anesthesia.
No reduction shall mean treatment of a fracture by any method other than that designated above.

17.B Composite Fee

The fees listed for fractures are intended to cover the treatment of the fracture including any necessary after-care, e.g., physiotherapy supervision, exercises, cast changes, etc., for a period of fourteen (14) days. Where aftercare cannot be provided by the initial Surgeon, the subsequent treating Physician is entitled to claim for a cast change when required.

17.C Immobilization

Immobilization in a plaster cast or splint is not a prerequisite for claiming a fee for fractures.

17.D Compound Fractures

The fee for compound fractures and/or compound dislocations shall be the fee for the appropriate fracture or dislocation plus 50%.

If an open reduction is performed, the fee for the open reduction shall apply instead.

17.E Separate Surgeons

If different Surgeons treat different fractures on the same patient at the same time, each Surgeon shall be entitled to full fees for the initial fracture and 50% fees for subsequent fractures treated.

17.F Repeated Closed Reductions

When repeated closed reductions are carried out by one Surgeon for the same fracture, then the listed fee for that fracture shall apply to the first reduction and 50% for each subsequent reduction. In cases where two closed reductions are done for one fracture, the tariff should be half the usual fee for the first reduction when done by the same Surgeon. When the subsequent reduction is done by a different Surgeon, the full fee should apply in each case.

17.G Closed Reduction followed by Open Reduction

Where one Surgeon performs a closed reduction of a fracture and later has to perform an open reduction, then the fee shall be 50% for the closed reduction and 100% for the open reduction.

17.H Multiple Fractures

In multiple fractures, the fee for the major fracture requiring open reduction, plus 50% of the fee for the minor fractures requiring cast or closed reduction, shall apply.

17.I Second Surgeon

When it becomes necessary for a second Surgeon to perform a reduction, the full fee shall apply for this procedure. The first Physician in this case shall be entitled to 100% of the fee for the closed reduction.

18. ANESTHESIA SERVICES

18.A Anesthesia Fees

Anesthesia fees are payable only when the anesthetic is personally administered by a Physician other than the Surgeon, Assistant Surgeon or Obstetrician and who remains in constant attendance during the procedure for the sole purpose of rendering an anesthetic service.

An anesthesia fee is for professional services only and includes:

Pre-anesthesia evaluation of the patient as an anesthetic risk, ordering of pre-medication as indicated, administration of all types of anesthesia, fluids or blood incidental to anesthesia or surgical procedure and immediate post-anesthetic supervision.

Immediate supportive and resuscitation measures in the operating room and/or the recovery ward as indicated by the patient's condition.

Treatment of any complication arising from anesthesia within 48 hours.

18.B Anesthesia for a Normal Delivery

Fee code 2525 (Continuous Conduction Anesthesia (Epidural) for Obstetrics) is a composite fee that includes consultation, catheter insertion, first dose, and maintenance.

18.C Anesthesia Outside Hospital

Claims for anesthetic services by a physician outside hospital shall be considered for payment only in an emergency or disaster situation unless otherwise approved by Health PEI.

18.D Definition Beginning and End of Anesthesia

Anesthesia time begins, with the exception of ECT cases, ten (10) minutes prior to the patient’s arrival in the operation room to allow for informed consent and preparation of equipment and ends when the Anesthetist is no longer in personal attendance (when the patient may be safely placed under the customary post-operative supervision). Anesthesia time may extend for up to 30 minutes after the patient leaves the operating room.

18.E Acute Pain Service Initiation

Fee code 0280 is payable when a qualified Physician initiates an acute pain service involving patient-controlled analgesia (PCA) and other acute pain modalities such as indwelling nerve catheters, to a patient admitted to hospital. The service must include all the components of a major consultation with the appropriate chart documentation. This does not require a consultation request from another Physician.

This fee code involves an assessment of the patient in order to determine the acute pain control modality most appropriate for that patient and includes the initial management of the acute pain service. Daily maintenance of PCA is payable as fee code 2534, which may not be billed on the same day as fee code 0280. Any procedures performed for acute pain management are payable in addition to these service fees.

Fee code 0280 is not payable to the same Physician in addition to a consultation or other composite fees, which include consultation (i.e., fee codes 2521, 2525, 0595) where the reason for the consultation is for the purpose of initiation of acute pain management service. However, where a pre-operative consultation has been provided prior to the administration of an anesthetic, the Anesthetist may bill fee codes 0280 and 2534 for post-operative acute pain management.

Any major interventions or complications, which require another Physician to attend the patient, may be billed as a consultation or detention, as appropriate.

18.F Anesthesia – Cancelled Surgery

This fee code (0266) is claimed when an Anesthetist makes a pre-operative visit to a patient whose surgery is subsequently cancelled. If the Anesthetist administers anesthesia within 7 days from the visit, this fee code is not payable; if anesthesia is administered by a different Anesthetist, then the fee is payable. This fee code cannot be billed in addition to sudden cancellation of surgery fee code (9375).

18.G Surgical Procedures for Morbidly Obese Patients

An Anesthesia Obesity Premium may be claimed for major surgical procedures performed on patients with a Body Mass Index (BMI) of 40 or higher. This premium may be claimed by Anesthesiologist only once per surgical session, in addition to the regular anesthesia fee, for major surgical procedures performed in a hospital operating room where the surgery is done under general, spinal, or epidural anesthesia. This premium is billed as fee code 0075 and must be supported by documentation of the BMI on the patient's medical record.

The Anesthesia Obesity Premium may not be claimed for procedures performed under local anesthesia or conscious sedation.

19. OBSTETRICAL SERVICES

Obstetrical care includes initial visit, prenatal visits and necessary laboratory tests, delivery, post-partum care in hospital and postnatal visit. All composite obstetrical fees have been eliminated in favor of individual fees for services rendered.

19.A Prenatal Visits

These are visits to a Physician's office prior to delivery of the infant. A Physician may claim an initial prenatal visit as consultation if the patient was referred, otherwise may bill a comprehensive visit.

19.B Hospital Assessment for Complications of Pregnancy or Complications of Labor

This tariff can be billed where a patient presents to hospital with a complication of pregnancy or labor after 20 weeks gestation by dates. An Obstetrician may bill this tariff without a consultation request. The service must include all the components of a major consultation with the appropriate chart documentation. A patient who returns the same day may be billed as a new encounter.

This fee code (0795) is only billable once per patient per encounter. Reassessment by the same Physician after two hours must be billed under a limited visit code.

19.C Labor Management Fee

Management of a patient in active labor who has been admitted to Labor & Delivery with a diagnosis of labor. This fee code (0720) can only be billed once per day per Physician and is subject to after-hours premiums and can be billed in addition to procedures related to labour and delivery, such as induction of labor, IUPC insertion, fetal scalp sampling, pudendal blocks, ultrasounds in labor, the actual delivery, repair of third degree lacerations, and manual delivery of the placenta.

19.D Delivery

The delivery includes delivery of the infant, placenta, and standard recovery management.

Where a failed operative (forceps) delivery leads to C-section by the same Physician, the C-section fee code 6004 is payable at 100% and failed operation (forceps) delivery 6007 is payable at 50%.

Fee code 0004 is to be claimed if the Family Medicine Physician has attended a complicated labor where the patient is referred to cesarean section or operative delivery. The fee code includes assistance with the referred procedure. This fee code may also be claimed and paid in full by a Physician called on an emergency basis to attend a precipitous delivery prior to the arrival of the attending Physician/Obstetrician. In either case, the attending Physician/Obstetrician shall also be paid in full for attending at the delivery, unless the entire delivery has already been completed prior to the arrival of the attending Physician/Obstetrician.

19.E In-Hospital Post-partum Care

This refers to the immediate care following delivery of the baby while the mother is still in hospital and may be billed regardless of the method of delivery.

19.F Multiple Pregnancy

Second and additional deliveries shall be claimed at 100% of delivery fee.

19.G Obstetric Ultrasound in Hospital

Obstetric Ultrasound may be billed by an Obstetrician as clinically appropriate. It may not be billed if an ultrasound is performed in Diagnostic Imaging for the same diagnosis on the same day.

19.H Induction of Labor

Induction of labour is defined as cervical ripening (mechanical or prostaglandin) and/or initiation of oxytocin infusion, for the purpose of labour induction. It is billable in outpatient and inpatients, and once per 24-hour period.

20. PEDIATRIC SERVICES

20.A Standby for Resuscitation and Attendance at Maternal Delivery

The detention fee may be billed when a Pediatrician is requested by an Obstetrician to be physically present on stand-by in anticipation of rendering newborn resuscitation services when a delivery occurs. This stand-by detention shall commence at the time the Obstetrician specifies physical attendance is required and shall end once the delivery occurs and newborn resuscitation (1136) begins.
Fee code 1136 applies to attendance at maternal delivery and shall include the consult. A pediatric consult may not be billed on the same day as 1136 unless a comment is provided. Fee code 1136 may be billed in addition to Critical Care fee codes.

20.B Pediatric Age Limits

Pediatrics age ranges shall generally include the care of children up to their 16th birthday.

Consultations for those patients 16 years of age and over shall document the need on the patient's chart.

20.C Pediatric Critical Care

Pediatric critical care fee codes can be billed for pediatric patients who are ill enough to require critical care, which includes constant nursing care, continuous cardio-respiratory monitoring and intravenous therapy. This code can be billed regardless of whether the patient is in ICU or in a designated room on the pediatric floor with specialized nursing care. Appropriate documentation must be on the chart.

20.D Neonatal Intensive Care (NICU)

If an infant has been transferred from one NICU level to another, in either direction, up or down, second day fees apply. Regular visit and procedure fees will apply the day following discharge from the NICU. If the patient has been discharged from the Unit more than 48 hours and is readmitted to Unit; 1st day rate applies again on day of re-admission.

The appropriate consultation, procedure and visit fees shall apply after stopping artificial respiration or special care.

21. DIAGNOSTIC AND THERAPEUTIC PROCEDURES

When a Diagnostic and Therapeutic Procedure is claimed at the same time as a visit or consultation fee, both fees are payable in full, except when such procedure is the sole reason for the patient's attendance.

21.A Pelvic Examination

Pap smear +/- HPV testing with or without pelvic examination (fee code 2008) or pelvic examination only (fee code 2001) may be billed in conjunction with any visit other than an obstetrical or gynecological consultation.

21.B Vaginal Pessary Fitting

This fee code may be billed, in addition to a consultation or visit fee, for a patient with pelvic relaxation problems. Subsequent follow-up visits after the initial fitting shall be paid as a limited visit.

21.C Skin Lesions

Generally, removal of skin lesions for cosmetic purposes is not an insured service. However, the following conditions are insured services:

i. The removal of malignant lesions or lesions recognized as presenting a significant risk of producing malignant lesions. Examples are neurofibromatosis (Von Recklinghausen's disease), keratoses in chronic dialysis patients.

ii. The removal of non-malignant skin lesions, which because of their location or size, result in recurring bleeding or recurring infections not amenable to non-surgical management.

iii. *Plantar Wart (single or multiple) - cryotherapy, curettage, or electrocautery (fee code 3046*).

iv. Excision Biopsy (fee code 3030) of skin lesions for the purpose of determination of pathology.

21.D Injections

21.D.1 Subsequent Injections on the Same Visit

An additional amount shall not be allowed for subsequent injections on the same visit unless the patient develops a reaction at the time of the visit requiring further treatment.

21.D.2 Injection of Joints

Where two or more joints are injected on the same visit, 65% (as per surgical rules) of the usual fee shall be allowed for the second and subsequent procedures.

21.D.3 Immunization Reporting

Physicians are able to bill for patient immunization injections using fee code 2009 and can only be billed once per patient visit.

Pursuant to the Immunization Regulations of the *PEI Public Health Act*, Physicians must submit to the Chief Public Health Officer (CPHO) quarterly reports of all immunizations provided to individuals on PEI. To provide physicians with the option of electronically reporting immunizations to the CPHO, with all associated data elements, the following zero-dollar immunization fee codes have been established, with the associated ICD9 diagnostic codes to be used:

0081 Immunization - Influenza(ICD9 diagnostic code V04.8)
0082 Immunization - Pneumococcal (ICD9 diagnostic code V06.6)
0083 Immunization - Tetanus/pertussis (Tdap) (ICD9 diagnostic code V06.3)
0084 Immunization - Hepatitis A/B (ICD9 diagnostic code V05.3)
0085 Immunization - Varicella zoster (ICD9 diagnostic code V04.89)

For those Physicians who wish to file their immunization reports electronically via the claims payment system, in addition to submitting a claim for fee code 2009, the physician must also submit a $0 claim for each of the immunizations administered using applicable fee code listed above.

If Physicians choose to report their immunization manually (i.e., paper filing), the Physician is responsible for ensuring they utilize the forms prepared by the CPHO and providing all required data elements specified on the forms.

21.E Emergency Department and Critical Care Ultrasound

ED and Critical Care Ultrasound may be billed once per patient per physician per day by a Physician appropriately trained in ED and Critical Care Ultrasound procedures.

21.F Emergency Procedural Sedation

Procedural sedation is payable in addition to the procedure for which sedation is required and applies to emergency procedures only.

21.G Electromyography (EMG) and Nerve Conduction Studies

When referring to muscles of more than one region, or examination of a specific region, “region” is intended to mean one of the four following anatomic areas: head and neck, both upper limbs, both lower limbs, trunk (anterior and posterior).

When referring to nerve conduction studies, “per nerve studied” is intended to mean both the motor and sensory nerve conduction examination of a single nerve (mixed, motor, or sensory). Multiples may be claimed when another nerve (mixed, motor, or sensory) is examined and when separate nerve conduction studies of a major nerve branch are required, to a maximum of six (6) nerves.

Electrophysiological evaluation for nerve entrapment is a composite fee including conduction studies of one or more nerves suspected of being entrapped, together with EMG studies of the appropriate muscles as necessary.

21.H Dialysis Management

Remuneration for the management of patients receiving hemodialysis may be through direct patient contact in dialysis units in Charlottetown and Summerside, as well as through indirect distance supervision of patients in satellite dialysis units in Alberton and Souris.

Patients in Charlottetown and Summerside will receive directed care through regular Physician contact in their respective dialysis units. Patients in Alberton and Souris will follow a satellite model unless directed care is mandated by specific patient issues. Satellite care includes phone and fax communication with nursing staff, prescription requests, monitoring of lab data, monthly teleconferences, liaison with other Physicians, quarterly patient assessments, and other dialysis needs that may arise. It is assumed that patients receive dialysis three times weekly, and Physicians are available 24 hours daily.

Direct physician management is care provided by the Physician to the patient at the dialysis site on the day of treatment. Direct physician management of dialysis for acutely ill patients shall be payable using fee code 2055 for the initial acute treatment and fee code 2056 for up to two subsequent acute treatments. Direct physician management of dialysis for patients with chronic renal failure shall be payable using fee code 2135 for the initial treatment and fee code 2137 for all subsequent treatments, up to a maximum of three (3) treatments per patient per week, unless medical necessity requires additional treatments, in which case a comment must appear on the claim. Satellite dialysis care (indirect distance supervision) shall be payable as a weekly management fee per patient using fee code 2058.

21.I Pain Management

21.I.1 Peripheral Nerve Blocks

Nerve blocks are eligible for payment only when rendered as an isolated service for diagnostic or therapeutic purposes. Nerve blocks administered as regional anesthesia prior to, during, immediately following a diagnostic, therapeutic or surgical procedure which the physician performs on the same patient are not eligible for payment. Local infiltration used as an anesthetic for any procedure is not eligible for payment. When a major plexus or peripheral nerve block is rendered, additional blocks of one or more nerves within the same nerve distribution are not eligible for payment.

Unless otherwise specified, all nerve block fee codes are for unilateral procedures only; if a bilateral block is performed, the second side is payable at 65% of the first.

Notwithstanding maximums applicable to individual nerve block services, there is an overall maximum of eight (8) per patient per day for any combination of nerve blocks. Nerve blocks beyond this overall maximum are not eligible for payment. Nerve blocks which are defined as a bilateral procedure are counted as two (2) services for the purpose of the overall daily maximum.

Peripheral nerve blocks with sclerosing solutions such as alcohol or phenol are payable as a 50% add-on premium to the peripheral nerve block fee and require an explanatory comment on the claim.

21.I.2 Interventional Pain Injections

Interventional pain injections include injections into facet and sacroiliac joints, nerve roots, epidural and subarachnoid spaces, sympathetic nerve trunks and other deep nerve plexus/ganglia blocks rendered for the purpose of diagnosing the source of pain or developing a therapeutic treatment plan. Most of these injections are payable only when rendered with imaging guidance; in such cases, the imaging fees are included in the overall injection fee and are not payable separately. Interventional pain injections include the injection of contrast, medication and/or other solutions.

Interventional pain injections are only eligible for payment if documentation clearly describes:

- the procedure performed or, where image guidance is used, images of needle placement that clearly identify the site of injection and/or spread of contrast; and,
- the purpose of any diagnostic pain-related injection and the subsequent response to the procedure indicating a positive or negative result.

21.J Echocardiography

Payment for interpretation of echocardiograms shall be made only to those Physicians so qualified. Afterhours and weekend Emergency Premiums for echocardiograms will require a comment on the claim indicating the need for an emergent echocardiogram. Cine fee is not billable in addition to echocardiogram fee codes.

21.J.1 Complete Transthoracic Echocardiogram

Complete transthoracic echocardiogram (TTE) includes interpretation of M-mode, Doppler, 2-D, and 3-D images. No additional fee for technical procedure complete by Physician. If a complete TTE is not required, then a limited TTE should be billed.

21.J.2 Limited Transthoracic Echocardiogram

Limited transthoracic echocardiogram (TTE) includes interpretation of repeat TTE with limited images, with diagnoses including, but not limited to, reassessment of pericardial effusion, thrombus, vegetation.

21.J.3 Transesophageal Echocardiogram

Complete transesophageal echocardiogram (TEE) includes interpretation of M-mode, Doppler, 2-D, and 3-D images. If a complete TEE is not required, then a limited TEE should be billed. TEE includes sedation, insertion of esophageal transducer and interpretation of images.

21.J.4 Stress Echocardiogram

Stress echocardiogram includes both a stress test (either exercise or dobutamine) and either a complete TTE if no prior echo or limited TTE if prior echo. Fee includes the treadmill fee or injection of dobutamine.

21.J.5 Contrast Echocardiogram

Contrast echocardiogram includes a limited TTE with injection of IV contrast agent or agitated/bubble saline (add-on fee).

21.J.6 Echo-Directed Pericardiocentesis

Echo-directed pericardiocentesis should be billed as a combination of Limited TEE (fee code 8784) and Pericardiocentesis (fee code 2116). If the assistance of a second physician with additional expertise is required, that physician may also bill for the Pericardiocentesis (fee code 2116).

22. DIAGNOSTIC IMAGING SERVICES

22.A MRI - Limitations

(i) Cranial repeat sequence - Fee Code 8976 - maximum of three repeats
Thorax repeat sequence - Fee Code 8981 - maximum of three repeats
Abdomen repeat sequence - Fee Code 8983 - maximum of three repeats
Spine repeat sequence - Fee Code 8989 - maximum of three repeats

(ii) ENT repeat sequence - Fee Code 8978 - maximum of three repeats plus GAD

(iii) Pelvis repeat sequence - Fee Code 8985 - maximum of four repeats plus GAD

(iv) Extremities repeat sequence - Fee Code 8987 - maximum of three repeats

22.B CT Complex Head

Complex Head CT scans are meant to be multiplanar (multidirectional) head CT Scans - To include one or more of the following areas: Pituitary Fossa, Posterior Fossa, Internal Auditory Meati, Orbits and related structures, the Temporal bone and its contents and the Temporo- Mandibular joints. CT Complex Head may be billed in addition to CT Head on same day if reported as separate studies.

22.C Ultrasound Cine/Video

Add-on fee code 8765 for interpretation of Ultrasound Cine/Video may only be billed for fee codes 8766, 8767, 8769, and 8791. Findings on cine/video must be documented in the report.

22.D Transvaginal Ultrasound

Fee code 8792 for interpretation of Pelvic Ultrasound with Transvaginal Scan must include interpretation and documentation of both the pelvic and the transvaginal scan.

22.E CT Extremities

CT scan of more than one extremity may be billed on the same patient on the same day, but each exam requires a separate report. Technical protocols for joint replacement planning excluded.

23. UNINSURED SERVICES / EXAMINATIONS REQUEST BY A THIRD PARTY

Section 1(d)(I) (D) of the *Health Services Payment Act Regulations* states that "examinations required in connection with employment, insurance, admission to an educational institution or camp, procurement of a passport or visa or legal proceedings, or any similar examination at the request of a third party are excluded as Basic Health Services."

Included in the above would be services and examinations rendered at the request of the following groups:

- Insurance companies
- Educational institutions
- Employers
- Youth groups, e.g., Scouts Canada, Cadet Services of Canada
- Various summer camps
- Office of the Attorney General - PEI (e.g., court requests, jury duty exemption)
- Workers' Compensation Board of any province or territory
- Veterans Affairs Canada (incl. RCMP)
- Citizenship and Immigration - Canada - e.g., Visa Purposes
- Federal, Provincial or Municipal Governments
- Physical Examination for Adoption Purposes
- Advice and Injection for Out of Country Travel
- National Defense Canada
- Group examination immunizations or inoculations unless such group, prior to administration of such examinations, immunizations, or inoculations, received approval thereof by the Minister – Section 1(d)(i)(E) – *Health Services Payment Act*.

Claims for discussion of a patient's condition with another member of the family, other than for psychotherapy, case conference management or diagnostic/therapeutic interview, shall not be accepted as an insured service.

24. HOLIDAYS

For the purpose of the Tariff of Fees, the following days are designated holidays:

- New Year's Day
- Islander Day
- Good Friday
- Easter Monday
- Victoria Day
- Canada Day
- Labour Day
- National Truth and Reconciliation Day
- Thanksgiving
- Remembrance Day
- Christmas Eve After 12 noon
- Christmas Day
- Boxing Day
- Floating holiday
    - Friday of Summerside Lobster Festival week (or in the absence of the festival, the 2nd Friday in July) for Prince County
    - Gold Cup and Saucer Day for Queens & Kings Counties

When a statutory holiday falls on a Saturday or Sunday and when such statutory holiday is celebrated on a subsequent weekday, holiday rates shall apply for services rendered on an emergency basis on that designated weekday.

Holidays are considered to begin at 08:00 hrs. on the day of the holiday (or designated holiday), and end at 08:00 hrs. the following morning.

25. INTERPROVINCIAL RECIPROCAL BILLING OF MEDICAL CLAIMS

On April 1, 1988, a reciprocal billing arrangement for Physician's medical claims came into effect between Prince Edward Island and all provinces and territories except Quebec.

The arrangement allows Prince Edward Island physicians to bill Health PEI directly for services rendered to eligible Canadian residents other than residents covered by the Quebec Plan.

26. WORKERS' COMPENSATION BOARD CLAIMS

Where a patient receives services for a WCB-related complaint and at the same visit, receives a service for an unrelated diagnosis, both services may be billed to the respective paying agencies.

27. PRIOR APPROVAL

All Physician referrals made for non-emergency out-of-province/out-of-country Physician or hospital services must receive prior approval from Health PEI. Prior approval is not necessary in the case of emergency transfers, but an emergency out-of-province referral request must still be reported on a claim to Health PEI using the appropriate out-of-province referral fee code. Failure to obtain prior or emergency approval shall result in the patient/parent being held responsible for the total costs of the services.

Preamble Appendix D outlines the policy/procedures for the out-of-province referral program. Such prior approval is valid for a period of one (1) year.

28. AUDIT PROCESS

An audit process is defined in the *Health Services Payment Act and Regulations* which charges Health PEI with the responsibility to ensure accountability for expenditures on basic health services.

29. ADMINISTRATIVE MEETINGS

A Physician is eligible to claim an Administrative Meeting fee (fee code 0050) when the meeting meets the following criteria:

- The meeting is initiated or authorized by an individual to whom the Physician is accountable;
- The meeting is planned in advance; and
- The discussions of the meeting are documented.

Up to two meetings per month are eligible for payment for workplace/unit staff meetings, for example, hospital department staff meetings and primary health care clinic staff meetings.

In addition, presentations for education sessions are eligible to be claimed as administrative meetings, provided the education sessions are part of the Physician's duties, and the sessions are being done at the direction of a supervisor. Preparation time up to a maximum of four (4) hours may also be eligible.

Attendance at CME (professional development) and meetings with medical supply or pharmaceutical representatives are **not** eligible for this fee.

Any Physician who receives an honorarium or an administrative stipend for such meetings is **not** eligible to claim the Administrative Meeting fee for these meetings.

Billing should be claimed as fee code 0050 per 15 minutes, or major portion thereof, using Provincial Health Number "01741230" and Diagnostic Code "V689". Time of day, time spent, and comments are required on the claim, which should be billed as fee-for-service or shadow-billing, depending on the Physician's payment modality at the time of the meeting.

30. PHYSICIAN SUPERVISION

A Physician who is designated upon request of Health PEI to supervise the clinical work of another Physician (including an Associate Physician or Physician Assistant) is eligible to claim a daily supervision stipend (fee code 0053) for the approved period of supervision. This excludes supervision of residents and students (medical and nursing).

Regarding providing supervision to either an Associate Physician or Physician Assistant, the Primary Supervising Physician who is supervising an Associate Physician is eligible to bill the physician supervision fee code (0053) per day as per the Tariff of Fees. Payment for supervision is limited to the first six (6) months of employment with Health PEI for new Associate Physicians being assigned to a Supervising Physician. Supervision may be shared by a group of physicians, and only one physician is eligible to bill per day.

If an Associate Physician moves to a new role in the system, the new Primary Supervising Physician (or group) is eligible for the supervision fee code (0053) for an additional three (3) months to support the Associate Physician in transitioning to the new role.

31. TRANSITIONAL PROVISION

Claims for services or procedures during the period April 1, 2024, to March 31, 2025, will be determined based on the Preamble to the Tariff contents in the prior Master Agreement that expired on March 31, 2024.

APPENDIX A - Medicare Codes

TREATMENT LOCATIONS

ID	FACILITY DESCRIPTION
1	Queen Elizabeth Hospital
2	Hillsborough Hospital
3	Prince County Hospital
4	Western Hospital
5	King's County Memorial Hospital
6	Community Hospital
7	Souris Hospital
8	Stewart Memorial Hospital
9	Dr. Eric Found Centre
11	Addiction Services - Queen's County
12	Addiction Services - Souris
13	Addiction Services - Summerside
14	Beach Grove Home
15	Prince Edward Home
16	Wedgewood Manor
17	Summerset Manor
18	Maplewood Manor
19	Colville Manor
20	Riverview Manor
21	Garden Home
22	Whisperwood Villa - Long Term Care
23	Lennox Nursing Home
24	Parkwest Lodge
25	Atlantic Baptist Home
26	MacMillan Lodge
27	Sunset Lodge
28	Clinton View Lodge - Long Term
29	Dr. John Gillis Lodge - Long Term
30	South Shore Villa - Long Term 31
32	Provincial Correctional Centre
33	Prince County Jail
34	Youth Centre
35	Community Care Facilities
36	Margaret Stewart Ellis - Community Hospital
37	Stewart Memorial Home
38	Acute Care No Longer Required Western
39	Visiting Specialist - Prince County
40	Visiting Specialist - Queen's County
41	Patients Home
42	Lady Slipper Villa
43	Acute Care No Longer Required King's County
44	Acute Care No Longer Required Souris Hospital
45	Whisperwood Villa - Community Care
46	Clinton View Lodge - Community Care
47	Dr. John Gillis Lodge - Community Care
48	South Shore Villa - Community Care
49	Salaried Physician Office - Souris
150	Davis Lodge
151	Rev. Phillips Res.
152	Le Chez Nous
153	MacDonald Rest Home
154	MacEwen Mews
155	Miscouche Villa
156	Andrews Lodge - Charlottetown (Community Care)
157	The Valley Lodge
158	Corrigan Home
159	Corrigan Lodge/Bevan Lodge
160	Langille House
161	MacQuaid Lodge
162	Old Rose Lodge
163	Riverview Rest Home
164	Rosewood Residence
165	MacKinnon Pines
166	French Creek Lodge
167	Bayview Lodge
168	Addiction Services - Montague
169	Addiction Services - Alberton
170	Andrews Lodge2 - Summerside
171	Richmond Centre
172	McGill Centre
173	Four Neighborhoods Community Health Centre
174	Lacey House
175	Mental Health Clinic - Summerside
176	Beechwood Family Health Centre - O'Leary
177	Central Queens Health Centre - Hunter River
178	Gulf Shore Family Health Centre
179	Polyclinic Night Clinic
180	Harbourside Family Health Centre - Summerside
181	Smith Lodge
182	Boardwalk Professional Clinic
183	Salaried Physician Office - Montague
184	Polyclinic
185	Parkdale Medical Centre
186	Mt. Herbert
187	Garfield Street
188	Sherwood Medical Centre

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ID	FACILITY DESCRIPTION
189	Andrews Lodge - Stratford
190	Crapaud Wholeness Family Clinic
191	O'Leary Health Centre
192	Tyne Valley Health Centre
193	Eastern Kings Health Centre
194	Guardian Drug O'Leary Clinic
195	Murphy's Stratford Clinic
196	Physician's Home
197	Queens Home Care Office
198	Dr. Christie Nichols - Home Based Care
946	Campos Dr. Alfredo Office
947	Dr. Paul Phelan (Summerside)
948	Morell Walk-In Clinic
951	Kings County Medical Centre
952	Western Hospital Clinic
953	Charlottetown Area Health Centre
954	Summerside Medical Centre
955	Belvedere Eye Clinic
956	Cornwall Medical Centre
957	Kensington Health Centre
958	Stratford Medical Clinic
959	Crapaud Wholeness Family Clinic
960	Farag Dr. Hani Office
961	Laftah Dr. Abdulrahem Office
962	Habbi Dr. Issam Office
963	Sethi Dr. Baldev Office
964	Hansen Dr. Phil Office
965	Stewart Dr. Chris Office
966	Mitton Dr. Gregory Office
967	Boswall Dr. Guy/Dr. Andrew Office
968	Molyneaux Dr. Lloyd Office
969	Molyneaux Dr. Harold Office
970	Keizer Drs. Sterling/Heather Office
971	Stewart Dr. Trina Office
972	Hove Family Physician Clinic - Alberton
973	Tignish Health Centre
974	Linden Ave Medical Centre
975	Singh/Dhillon Drs. Office
976	Stewart Dr. David I - South Shore Pharmacy
977	East Prince Health Centre - Summerside
978	Murphy's Community Centre
979	Parkhill Place - Summerside
980	Park Lane Medical Clinic
981	Geneva Villa - Charlottetown
982	Perrin's Marina Villa - Montague
983	Lennox Island Health Centre - Lennox Island
984	Abegweit First Nation Mi'kmaq Wellness Centre - Scotchfort
985	Flu Clinic - Various Locations
986	Charlottetown Civic Centre
987	Kensington Community Care Centre
988	West Prince Family Health Clinic
989	Stamper Residence

ID	FACILITY DESCRIPTION
990	Charlotte Residence
991	Tignish Seniors Home Care Co-op Ltd
992	Sharpe Dr. Jonathan Office
993	Seaside Medical Center - Souris
994	Murray River Health Centre
995	Spring Park National Walk-in Clinic
996	Dr. Jaggi Rao Office - Alberta
997	Ground Ambulance Service
998	The Mount (Long Term Care)
1000	Sea Isle Medical (Summerside)
1001	Queen Street Medical Centre
1002	Superstore Summerside Walk-In Clinic
1003	Holland College Charlottetown Centre
1004	Provincial Palliative Care Centre
1005	Optometrist - Burke & Associates
1006	Optometrist - Vogue Optical Summerside
1007	Optometrist - Summerside Vision Clinic
1008	Optometrist - Belvedere Vision Centre
1009	Optometrist - Family Vision Centre
1010	Optometrist - Charlottetown Vision Care
1011	Optometrist - Dr. Kelly D. Bowes & Assoc.
1012	Optometrist - Dr. Catherine Arsenault
1013	Optometrist - Dr. Alanna Stetson
1014	Optometrist - Dr. Kristine Giddings
1015	Optometrist - Dr. Murray Rusk
1016	Optometrist - Prince County Eye Clinic
1017	Optometrist - West Prince Eye Clinic
1018	UPEI
1019	Cornwall Dental Clinic
1020	Chances Family Centre
1021	Optometrist - Dr. Kelly Bowes & Associates - Alberton
1022	Optometrist - Island Optical and Eye Care - Charlottetown
1023	Optometrist - Dr. Jinks - Montague
1024	Dynamic Fitness
1025	QEH In-Hospital Dental Services
1026	PCH In-Hospital Dental Services
1027	Optometrist - In Focus Eye Care
1028	Dr. Naqvi Clinic Summerside
1029	Adolescent Day Treatment Centre Charlottetown
1030	Spears, Dr. Ben Office
1031	SHORS (Women's Wellness Program) - PCH
1032	Crapaud Walk-In Clinic
1033	Cornwall Health Centre - Murphy's
1034	Cancer Treatment Centre - QEH
1035	Prince Home Care Office
1036	Upper-Level Walk-In Clinic - O'Leary
1037	MacLellan Dr. Darcy Office
1038	Brackley Stables Transition Home
1040	QEH Closed ICU

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ID	FACILITY DESCRIPTION
1041	SHORS (Women's Wellness Program) - The Mount
1042	Best Dr. William Office
1043	Wellington Medical Centre
1044	Queens County - COVID-19 Assessment Clinic
1045	Prince County - COVID-19 Assessment Clinic
1046	Optometrist - Fyidoctors Charlottetown
1047	Kinlock Medical Centre
1048	Dr. Visser - Summerside
1049	Cherian Dr. Anil K. - Office
1050	Virtual Care
1051	Operational Stress Injury Clinic (OSI)
1052	Slemon Park Health Centre
1053	Ojuawo Dr. Akin - Office
1054	Murphy's Pharmacy Kensington - Walk-in
1055	OFFSITE Office
1056	Community Outreach Centre
1057	Mental Health Clinic - Montague
1058	Dr. Brianne Lewis Obstetrics & Gynecology Practice
1059	Dr. Paul Ellis Dentistry Inc.
1060	The Willows - O'Leary
2014	IWK In-Hospital Dental Services

SERVICE SITE (FACILITY) TYPES

CODE	SITE DESCRIPTION
1	OFFICE
2	HOME VISIT
3	INPATIENT
4	OUTPATIENT
5	OTHER OFFICE
6	DAY SURGERY
7	SPECIALITY CLINIC
8	COMMUNITY CARE FACILITY
9	OTHER SITE
10	A - U.P.E. I.
11	D - DETOX CENTERS
12	F - FIRST PATIENT
13	I - INPATIENT RADIOLOGY
14	N - NIGHT CLINIC
15	O - OUTPATIENT RADIOLOGY
16	P - VISITING SPECIALIST PRINCE COUNTY HOSPITAL
17	Q - VISITING SPECIALIST Q.E.H.
18	S - SATURDAY/SUNDAY OFFICE
19	X - RADIOLOGY
20	PROVIDER ANY FACILITY TYPE
21	E- RADIOLOGY EMERGENCY
27	WALK-IN CLINIC
28	VIRTUAL CARE
101	PUBLIC DENTAL FACILITY
102	PRIVATE DENTAL FACILITY
103	PUBLIC HEALTH HYGIENIST

SPECIALTY CODES

CODE	SPECIALTY
01	GENERAL PRACTICE
02	ANAESTHESIA
03	DERMATOLOGY
04	GENERAL SURGERY
05	INTERNAL MEDICINE
06	NEUROSURGERY
07	OBSTETS/GYNECOLOGY
08	OPHTHALMOLOGY
09	ORTHOPEDIC SURGERY
10	OTOLARYNGOLOGY
11	PAEDIATRICS
12	PSYCHIATRY
13	UROLOGY
14	DENTAL
15	RADIOLOGY
16	PHYSICAL MEDICINE
17	THERAPEUTIC RADIATION
18	RESPIRATORY DISEASES
19	ANATOMIC PATHOLOGY
20	OPTOMETRIST
21	ALCOHOL/DRUG TREATMENT
22	NEUROLOGY
23	MEDICAL ONCOLOGY
24	PAEDIATRIC CARDIOLOGY
25	NEONATOLOGY
26	GENETICS/METABOLIC
27	ED ON-SITE SESSIONAL SHADOW BILLING
28	GERIATRIC MEDICINE
29	PEDIATRICS PSYCHIATRY
30	NEPHROLOGY
31	SPECIALIST (Shadow Billing)
32	PSYCHIATRY LOCUM (Shadow Billing)
33	SOURIS LOCUM PHYSICIAN (Salaried Billing)
34	KINGS CO. LOCUM PHYSICIAN (Salaried Billing)
35	QUEENS REGION LOCUM PHYSICIAN (Salaried Billing)
36	PCH LOCUM PHYSICIAN (Salaried Billing)
37	WESTERN LOCUM PHYSICIAN (Salaried Billing)
38	COMMUNITY LOCUM PHYSICIAN (Salaried Billing)
39	STEWART MEMORIAL PHYSICIAN (Salaried Billing)
40	LONG TERM CARE (Shadow Billing)
42	PEDIATRIC RHEUMATOLOGIST
43	MEDICAL MICROBIOLOGIST
44	EMERGENCY MEDICINE
45	MEDICAL ONCOLOGY CLIN ASSOC
46	PAIN MANAGEMENT
47	PALLIATIVE CARE
48	RAD ONCOLOGY CLIN ASSOC
49	HOSPITALIST
50	PAEDIATRIC GASTROENTEROLOGY
51	IMMUNOLOGY & ALLERGY
52	TELE HEALTH GP - MAPLE CORP
53	QEH CLOSED ICU
54	QEH CLOSED ICU (Shadow Billing)
55	TELE-HEALTH - ED (Fee for Service)
56	TELE-HEALTH MAPLE CORP - Virtual Care (FFS)
57	PHYSICIAN ASSISTANT
ID	DESCRIPTION
58	ASSOCIATE PHYSICIAN
89	COVID-19 (Shadow Billing)
93	MIDWIFERY
94	NURSING
95	NURSE PRACTITIONER
96	DENTAL PREVENTATIVE
97	PLASTIC SURGERY
98	ALL BUT DENTAL
99	G.P. AND EYE EXAMS
100	PHARMACIST
111	ADHD
1001	ORAL SURGERY
1002	PEDIATRIC DENTIST
1003	ENDODONTIST
1004	PERIODONTIST
1005	ORTHODONTIST
1006	DENTURIST
1007	DENTAL HYGIENIST

APPENDIX B - Claim Messages, Codes, & Types

CLAIM MESSAGES

ID	DESCRIPTION
1	MORE THAN 03 MESSAGES
2	PROVIDER HAS NO ADMITTING PRIVILEGES
3	LOCUM COVERING ON TIME/DATE OF SERVICE
40	OUTPATIENT VISIT CANNOT OVERLAP WITH INPATIENT PERIOD AT THE SAME FACILITY
41	INPATIENT VISIT CANNOT OVERLAP WITH AN OUTPATIENT SERVICE AT THE SAME FACILITY
43	DUPLICATE OUTPATIENT CLAIM
44	INVALID HOSPITAL NUMBER
45	PROCEDURE CODE AND/OR DATE MISSING
46	PROCEDURE DATE MUST EQUAL SERVICE DATE
47	NO HIGH COST PROCEDURE OR DATE
48	RECIPROCAL EXCLUSION
49	INVALID SERVICE CODE
50	DUPLICATE INPATIENT CLAIM
51	INCORRECT SERVICE CHARGE
52	MANUALLY ASSESS, UNABLE TO PRICE PROCEDURE
53	SIMILAR HIGH COST PROCEDURES ON THE SAME DATE, MAX TWO PER DAY
54	APPLY WELL NEWBORN RATE
78	REGISTRATION PAID
79	80/20 RULE APPLIED
80	INCORRECT NUMBER OF SURFACES
81	SERVICE SAME DAY
82	MORE THAN 4 X-RAYS DURING YEAR
83	X-RAY LIMIT REACHED FOR YEAR
84	INVALID TREATMENT STATUS
85	MAX 1 EXAM PER YR\REG NOT DUE
86	PRIVATE DENTIST CLAIMING SEALANT FEE CODE
87	85% REDUCTION RATE
88	INCORRECT AGE FOR TOOTH AND FEE CODE
89	INCORRECT AGE FOR FEE CODE
90	PROCEDURE NOT COVERED IN PRIVATE OFFICE
91	MORE THAN ONE SERVICE PER YEAR ON SAME TOOTH
92	EMERGENCY ON SAME DAY AS OTHER SERVICE
93	FILLING PERFORMED ON SAME DAY & TOOTH
94	INVALID SURFACES FOR FEE CODE
95	REGISTRATION FEE COLLECTED
96	FEE CODE DOESN'T MATCH TOOTH
97	TOOTH PREVIOUSLY EXTRACTED
98	CLAIM TOO OLD
99	INVALID QUADRANT/TOOTH
100	IN SUSPENSE - DATA CAPTURE
101	NEWBORN - WAITING FOR P.H.N.
102	RESIDENT NOT ELIGIBLE ON DATE OF SERVICE
103	NO HOUSEHOLD FOR RESIDENT
104	PROVIDER NOT ACTIVE ON DATE OF SERVICE
105	PROVIDER SPECIALTY NOT ELIGIBLE ON DATE
106	PROVIDER SPECIALTY NOT ON FEES RECORD
107	FACILITY TYPE NOT ON FEES RECORD
109	VALIDATION ATTEMPTS > 8
110	CLAIM IS ON HOLD - CLAIMS AUDITOR
111	NO LOT NUMBER FOR HOUSEHOLD
112	SERVICE DATE NOT SATURDAY OR SUNDAY
113	ELIGIBILITY SUSPENDED HEALTH ACT
114	PHYSICIAN NOT ELIGIBLE FOR PROGRAM
115	PATIENT NOT ON REGISTRY
118	DISCHARGE-ADMIT NOT = DAYS STAY
151	DIAGNOSIS MISSING/NOT LEGIBLE
152	PROVIDER NUMBER MISSING
153	DATE OF SERVICE MISSING
154	TIME OF DAY MISSING ON CHART
155	TIME SPENT MISSING
156	FEE CODE MISSING
157	FEE CLAIMED MISSING
158	LETTER ON FILE @ MEDICAL ADVISOR
159	PERINATAL DEATH-NO P.H.N. ASSIGNED
160	REFERRING PROVIDER NAME MISSING
162	CANCEL-NO REPLY TO CORRESPONDENCE
163	FEE CODE CHANGED TO CORRESPOND WITH DIAGNOSIS
164	CLAIM VOID (PROVIDERS REQUEST)
165	EXPLANATION ON CLAIM,LOOK IT UP
166	SEE WRITTEN CORRESPONDENCE
167	RES# SUPPLIED,IGNORE SERVICE DATE
168	CLAIM CREATED,SEE ORIGINAL
169	PATIENT NOT REGISTERED
170	CLAIM MODIFIED BY PROV AUDITOR
171	BILLED TO WRONG RESIDENT
172	MEDICAL NECESSITY ESTABLISHED
173	ADVISED BY PROVIDER (PHONE OR COMMENT)
174	HEALTH SERVICES PAYMENT ADVISORY DECISION
175	POSSIBLE DUPLICATE CLAIM (PARENT/BABY)
176	COMMENT EXISTS/CLAIM APPROVED
177	ADDED ONLINE BY ADD NEW CLAIM SCREEN
178	RETROACTIVITY PAID MANUALLY
179	SERVICE DATE > RECEIVED DATE
180	CLAIM NUMBER.NOT IN ASSIGNED RANGE
181	NO CLAIM # RECORD FOR PRACTITIONER
182	MOVED FROM 51,52,53 TO 64 ZERO PAY
183	RESIDENT HAD INVAL OR TEMP S.I.N.
184	CLAIM TYPE 8, MAY BE NEWBORN

185 IN-PATIENT CLAIM SHOWS DIFFERENT DATES
186 SALARIED PHYSICIAN-PAY @ ZERO
187 CIHI QEH/PCH MISSING DATA
188 DISCHARGE-ADMIT NOT= DAYS STAY
189 CLAIM HAS BEEN SENT FOR M.A.D.
191 AMOUNT APPROVED REMOVED PAID IN ERROR
197 OUT OF PROVINCE LOCATION 213 CHOICE PROGRAM
198 OUT OF PROVINCE LOCATION 417 HOMEWOOD HEALTH
199 ORIGIN/BATCH# CHGD FROM PREVIOUS#
201 RESIDENT NUMBER NOT ON FILE
202 MISMATCH ON RESIDENT DATE OF BIRTH
203 MISMATCH ON RESIDENT SEX
204 PROVIDER NOT ON FILE
205 PROVIDER SPECIALTY DOES NOT AGREE
206 REFERRED TO NOT ON FILE
207 REFERRED BY NOT ON FILE
208 BILLING PROVIDER SAME AS REFERRED TO/BY
209 PAYEE NOT ON FILE
210 FEE CLAIMED NOT ON FILE
211 DIAGNOSTIC CODE NOT ON FILE
212 TREATMENT LOCATION NOT ON FILE
214 PROVIDER ROLE CORRECTED
215 INVALID DATE OF SERVICE
216 VERIFY DATE OF SERVICE (OVER 7 MONTHS)
217 CANCELLED SHOULD BE SHADOW BILLED
218 CLAIM ADDED BY ONLINE TRANSACTION
219 RESPONSIBILITY FOR PAYMENT NOT INDICATED
220 ADJUSTMENT MADE MANUALLY
221 ERROR MADE BY BILLING PROVINCE
222 BATCH NUMBER NOT VALID
223 COMMENT INDICATOR REQUIRED
224 EMERGENCY INDICATOR REQUIRED
225 PROVINCE CODE NOT VALID
226 DOS CHANGED TO PROCESS ADJUSTMENT
227 CLAIM ALREADY SENT FOR M.A.D
228 P.H.N.REQURIED FOR PAYMENT
230 NOT ADMITTING PROVIDER
231 CLAIM APPROVED RE O.R. CORRESPONDENCE
232 CLAIM NOT APPROVED RE O.R. CORRESPONDENCE
233 NOT APPROVED RE W.C.B LIST
234 PROVIDER NOT ON CALL
235 WORKING VISA EXPIRED
236 O.K. TO PAY REGISTRATION PROBLEM
237 SERVICE COUNT NE INDIVIDUAL CLAIMS
238 BILL UNDER ASSIGNED P.H.N.
500 SERVICES TOO FREQUENT SAME PROVIDER
501 SERVICES TOO FREQUENT DIFFERENT PROVIDER
502 AGE DOES NOT MATCH FEE CODE
503 PATIENT NOT FEMALE
504 PATIENT NOT MALE
505 SERVICE AFTER HOURS
506 TWO VISITS/CONSULTS + EXPLANATION
507 OTHER SERVICE SAME DAY EXAM
508 TWO EXAMINATIONS WITHIN SPAN
510 MORE THAN ONE INITIAL VISIT IN 30 DAYS
511 MORE THAN 10 VISITS
512 VISIT DURING HOSPITALIZATION
514 SERVICE PRIOR TO INITIAL HOSPITAL VISIT
515 INITAL HOSPITAL VISIT ON RE-ADMISSION
516 SERVICE SAME DAY AS HOME VISIT
517 SERVICE SAME DAY AS OUTPATIENT
518 OUTSIDE REGULAR HOURS
519 DOUBLE BILLING
520 ADDITIONAL SERVICE FOR NEWBORN
521 OVER TIME LIMIT
522 HOSPITAL VISIT BEING PAID
523 PREVIOUSLY PAID WITHIN 24 HRS
524 SERVICE SAME DAY AS ANAESTHESIA
525 NO SURGICAL SERVICE ON HISTORY
527 MAJOR CONSULTATION PREVIOUSLY PAID
528 REPEAT CONSULTATION PREVIOUSLY PAID
529 LIST 1 PROCEDURES BEING PAID
530 TWO EYE EXAMS
531 TWO LIST 2 PROCEDRES SAME DAY
532 AGE LIMIT-CHILD OVER 4 YEARS
533 CONSULTATION AND SURGERY < 200.00
534 TWO SURGICAL PROCEDURES
535 VISIT AFTER SURGERY
536 VISIT PRIOR TO SURGERY
537 DUAL ROLE IN SURGERY
538 NO CLAIM FROM SURGEON
539 FRACTURE PREVIOUSLY PAID
540 CLOSED FOLLOWED BY OPEN
541 SKULL CALIPER THEN SPINAL SURGY
542 PACEMAKER AND VISITS
543 INITAL VISIT AND CONSULTATION
545 CONSULT NOT PAYABLE INCLUDED IN COMPLETE
547 VISIT AFTER SURGERY-NOT PAYABLE
548 VISIT SAME DAY SURGICAL PROCEDURE
549 THERAPUTIC LIST 2 WITH SURGERY
550 ONLY TWO SESSIONS PER WEEK
551 VERIFY FEE CODE CLAIMED
552 ADJUST FEE CODE TO APPROVE 553 REFERRAL PENDING APPROVAL
553 REFERRAL PENDING APPROVAL
554 APPROVED REFERRAL ON FILE
555 REJECTED REFERRAL ON FILE
556 NO REFERRAL ON FILE FOR SERVICE
559 CHART NUMBER CONTAINS NON-NUMERIC DATA
577 CLAIM PAID TWICE-CHECK HISTORY
578 CLAIM PUT TO HISTORY ONLY(ONLINE)
597 REQUIRES INDEPENDANT CONSIDERATION
598 ASSESSMENT ATTEMPTS > 8
599 CLAIM TO BE MANUALLY ASSESSED
601 INVALID FORMAT IN DATE OF BIRTH
602 SEX INDICATOR MUST BE "M" OR "F"
603 SPECIALTY CODE MUST BE 01-27 OR 99
604 CORRUPT DATA IN RESIDENT NAME
605 ROLE CONTAINS CORRUPT DATA
606 INVALID FORMAT IN SERVICE DATE
607 HOUR OF DAY/SPENT MUST BE 01-23

608 TIME OF DAY SPENT/MIN RANGE 01-59
609 SERVICE COUNT CONTAINS INVALID DATA
610 SERVICE SITE CONTAINS INVALID DATA
611 REF TO/BY CONTAINS INVALID DATA
612 PAYMENT RESP CONTAINS INVALID DATA
613 EMERGENCY INDICATOR CONTAINS INVALID DATA
614 BATCH NUM CONTAINS CORRUPT DATA
615 I.C. INDICATOR CONTAINS INVALID DATA
616 FEE CODE CONTAINS INVALID DATA
617 DIAGNOSTIC CODE CONTAINS INVALID DATA
618 TREATMENT LOCATION CONTAINS INVALID DATA
619 O.P. REG# CONTAINS INVALID DATA
620 PROVINCE CODE FOR HOST INVALID DATA
621 UNABLE TO LOCATE/CONTACT PATIENT
622 NO STEP DOWN AVAILABLE
700 CLAIM PAID AT CHILDS RATE
701 CLAIM PAID AT NEWBORN RATE
702 FEE CODE ADJUSTED
703 AGE PROHIBITS THIS SERVICE
704 FEE CODE AND AMOUNT ADJUSTED
705 AFTER HOURS PREMIUM ADDED
706 TWO VISITS SAME DAY NOT PAYABLE
707 PAYMENT INCLUDED WITH SURGICAL FEE
708 PAID AT G.P.RATES NOT SPECIALTY
709 MAXIMUM 1 HEALTH EXAM PER YEAR
710 HEALTH EXAM NOT PAID - AGE FACTOR
711 ASSISTANTS FEE INCLUDES THIS SERVICE
712 WELL BABY CARE VISITS EXCEEDED
713 MAX TIME/SESSIONS EXCEEDED
714 PSYCHOTHERAPY PREVIOUSLY PAID
715 INTENSIVE CARE VISIT PREVIOUSLY PAID
717 VISIT/CONSULT PREVIOUSLY PAID
718 TOTAL NUMBER OF SERVICES EXCEEDED
719 CONVALESCENT CARE, ONLY IN COMMUNITY CARE FACILITY
720 INITIAL VISIT RULED REPEAT
721 PATIENT IN HOSPITAL ON SERVICE DATE
722 MEDICAL AFFAIRS DECISION
723 PROCEDURE CONSIDERED SOLE PURPOSE FOR VISIT
724 SEX DOES NOT MATCH FEE CODE
725 NOT PAYABLE OUTSIDE OFFICE HOURS
726 BILATERAL PROCEDURES PAID AT 50%
727 APPARENT DUPLICATE CLAIM
728 ANOTHER PROVIDER PAID SAME SERVCE
729 FEE CLAIMED EXCEEDS TARIFF AMOUNT
730 PAID CORRESPONDING TO SURGEONS CLAIM
731 FEE ADJUSTED TO SERVICES RENDERED
732 NUMBER OF VISITS EXCEEDED FIRST 35 DAYS
733 LIST 1 NOT PAYABLE IN ADDITION TO THIS SERVICE
734 REDUCED TO REPEAT CONSULTATION
735 CONSULT NOT PAYABLE WITH ANESTHESA
736 POST-OP VISITS
737 TEN VISITS EXCEEDED IN 90 DAYS EXPLANATION REQUIRED
738 CLAIM INELIGIBLE AFTER 6 MONTHS
740 RE-ADMITTED WITHIN TEN DAYS
741 PRIOR TO PATIENTS ELIGIBILITY DATE
742 PATIENT NOT REGISTERED
743 REFERRAL DENIED-SERVICE PROVIDED LOCALLY
744 PATIENT NO LONGER ELIGIBLE
745 WRITTEN CORRESPONDENCE ON FILE
746 D.V.A./ R.C.M.P./D.N.D. RESPONSIBILITY
747 W.C.B. RESPONSIBILITY
748 REDUCED TO OFFICE VISIT RATE
749 NOT PAID WITHOUT EXPLANATION
750 NUMBER OF VISITS EXCEEDED 6th-13th WEEK
751 MAXIMUM FEE AFTER 13th WEEK
752 MAXIMUM SUPPORTIVE CARE (7 VISITS)
754 MAXIMUM DIRECTIVE CARE VISITS EXCEEDED
755 REPEAT OPERATION PAID AT LOWER RATE
756 PROVIDER SPECIALITY NOT ON FEES RECORD
757 CLOSED FOLLOWED BY OPEN REDUCTION @ 50%
758 SEPARATE INCISION PAID AT 65%
759 NOT INPATIENT ON DATE OF SERVICE
760 CONSULT/VISIT NOT PAID WITH PROCEDURE
761 PREVIOUS PAYMENT MADE ON THIS DATE
762 HEALTH EXAM-3rd PARTY UNINSURED
763 PROVIDER SPECIALITY DOES NOT AGREE
764 PROCESSING ERROR (CLAIM ADJUSTED)
765 HOST REGISTRATION NUMBER NOT VALID
766 PROVIDER NOT ELIGIBLE ON DATE OF SERVICE
767 AFTER HOURS PREMIUM NOT APPLICABLE
768 FACILITY TYPE NOT ON FEES RECORD
769 NO REPLY TO CORRESPONDENCE WITH PROVIDER
770 I.C.U. NOT PAYABLE AFTER 1st DAY
771 PAID AS CONVALESCENT/EXTENDED CARE
772 NOT PAID WITH HEALTH/COMPLETE EXAM
773 CORRECTED RESIDENT INFORMATION
774 MISMATCH ON RESIDENT SURNAME
775 UNINSURED SERVICE
776 NOT PAYABLE WITHOUT PSYCH VISIT
777 FOR APPROVAL, RE-$AMOUNT APPROVED
778 HOSPITAL CODE "010" REQUIRED
779 EMERGENCY NOT INDICATED
780 CONSIDERED TRANSFERED, NOT CONSULT
781 CONSIDERED INCIDENTAL SURGERY
782 MULTIPLE PROCEDURES-SAME INCISION, 50%
783 ADMITTING PROVIDER BILLS TOTAL HOSPITAL CARE
784 MEDICAL NECESSITY NOT ESTABLISHED
785 SUPP CARE MAY APPLY-RESUBMIT
786 ROLE IN ERROR DUE TO SERVICE CATEGORY
787 CORRECTED CLAIM INFORMATION
788 DOES NOT AGREE WITH SURGEONS CLAIM
789 PLEASE VERIFY RESIDENT INFORMATION
790 FEE CODE CLAIMED CORRECTED
792 MULTIPLE PROCEDURES-REDUCED FEE
793 REFERRAL APPROVED
794 NOT COVERED BY W.C.B.
795 TIME OF DAY/SPENT NOT ON CLAIM
796 REFERRING PROVIDER NOT INDICATED

797 RETRO AMOUNT HAS BEEN APPLIED TO THE ORIGINAL CLAIM
798 CLAIM IMPROPERLY COMPLETED
799 DIAGNOSTIC CODE NOT ON FILE
800 HOST REGISTRATION NUMBER NOT VALID
801 APPROVED REFERRAL ON FILE
802 SERVICE DEEMED EMERGENCY
803 NOT APPROVED-REFERRAL ON FILE
804 HOSPITAL LOCATION CODE INAPPROPRIATE
805 SERVICE DATE/COUNTS NOT =
806 DIAGNOSTIC CODE INAPPROPRIATE
807 PAID AT MAXIMUM WEEKLY RATE
808 QUE RESIDENT-BILL PROVINCE DIRECT
809 VISIT WITH TIME OF DAY MUST BE BILLED PRIOR TO DETENTION
810 TIME AND/OR DAY INCORRECT
811 FACILITY TYPE DOESN`T MATCH ADMISSION/DISCHARGE
812 SERVICE DATE DOESN'T MATCH ADMISSION/DISCHARGE
813 FACILITY TYPE AND FACILITY MISMATCH
820 NO REFERRAL BUT WOULD BE APPROVED
821 NO REFERRAL QUESTIONABLE APPROVAL
822 NO REFERRAL WOULD NOT BE APPROVED
823 NOT ASSESSED.D.O.S. PRIOR TO 970701
825 REQUEST CANCELLED UNABLE TO ASSESS
826 NON-INSURED SERVICE
827 CONTRACT ADJUSTMENT FROM N.B.
828 IGNORE CLAIM-DUPLICATE SUBMISSION
829 PATIENT HAS VALID P.H.N FOR P.E.I.
830 CORRECTED PROVIDER SPECIALTY
831 $ APPROVED ADJUSTED TO ZERO
832 UNABLE TO LOCATE PATIENT
833 STUDENT OFF ISLAND
834 RESIDENT LEFT P.E.I.
835 RESIDENT COVERED BY ANOTHER PROVINCE
836 ADJUSTMENT MADE BY OTHER PROVINCE
837 FAMILY MEMBER A STUDENT
838 WAITING PERIOD - NEW PROVINCE
839 RESIDENT IN ELIGIBILITY STATUS 40
840 PATIENT UNDER CARE OF SPECIALIST
841 LACK OF INFORMATION PLEASE CLARIFY
842 SERVICE SITE/FEE CODE INCORRECT
843 DATE OF SERVICE INCONSISTENT
844 INSUFFICENT DOCUMENTATION
845 NO DOCUMENTATION AVAILABLE
846 PATIENT UNDER CARE OF GEN.PRACT.
847 SERVICE NOT AN EMERGENCY SITUATION
848 PATIENT WENT FROM OPD DIRECTLY ICU
849 PATIENT NOT SEEN BY PROVIDER ON THIS DATE
850 PATIENT OUT ON PASS
851 PATIENT IS DECEASED-AUDIT
852 TIME SPENT NOT INDICATED ON FILE
853 MONEY RETRIEVED MANUALLY
854 PAYMENT NOT REVERSED NO $ FOR PROVIDER
855 DOLLAR AMOUNT REDUCED BY CLAIMS AUDITOR
856 CLAIM ASSESSED BY CLAIMS AUDITOR
857 ADJUSTED TO APPROPRIATE FEE CODE
858 REFERRAL LETTER NOT AT SITE BILLED
859 TWO OR MORE PATIENTS SAME TIME NOT PAYABLE
860 APPEAL APPROVED BY MEDICAL ADVISOR
861 COMMENT HAS INSUFFICENT INFORMATION
862 THREE/MORE DISTINCT DIAG REQUIRED (M.A. 9.D.1)
863 CONFILCT WITH O.R. REPORT (M.A.)
864 PAYMENT IS INCLUDED IN PREVIOUS FEE CODE
865 PROVIDER NOT SESSIONAL AT TIME OF SERVICE
866 LONG TERM CARE PATIENT
867 PILOT PROGRAM CRITERIA NOT MET FOR PAYMENT
875 RESPONSIBILITY OF BILLING PROVINCE
876 CLAIM INELIGIBLE AFTER 3 MONTHS
877 PATHOLOGY REPORT REQUIRED
878 VERIFY AFTER HOURS PREMIUM
879 FACILITY INCORRECT
897 RETRO CLAIM COULD NOT BE ATTACHED TO ORIGINAL CLAIM
900 *EMPTY*
901 CONSULT
902 CONSULT/INVESTIGATION
903 CONSULT/INVESTIGATION/TREATMENT
904 VERIFY HOST NUMBER
911 NO ACTIVE DECLARATION FOUND - PRIVATE INSURANCE MAY EXIST
999 CLAIM CONVERTED FROM OLD SYSTEM
1000 CORRESPONDENCE NOT SENT BACK TO REFERRING PROVIDER
1001 MEDICAL ADVISORS DECISION WITH CLAIMS AUDITOR'S INPUT
1002 RESIDENT DECEASED
1003 PROVIDER OVER CAP
1004 O.R. REPORT NOT ON FILE
1005 PROVIDER BILLED PATIENT FOR SERVICE-PATIENT REIMBURSED
1006 CHECK ELIGIBILITY FOR P.E.I.
1007 RESIDENT ISSUED NEW P.H.N.
1008 INFORMATION UPDATE NO PAYMENT ADJUSTED
1009 NO LETTER ON FILE
1010 CLAIM ON HOLD-ASSESSMENT
1011 PROCEDURE CODE NOT ON FILE
1012 PHN/FEE CODE/FACILITY MISMATCH
1013 SHOULD BE CLAIM TYPE 06
1014 NO FACILITY REQUIRED
1015 PATIENT U.S. RESIDENT
1016 PRIOR APPROVAL REQUIRED
1017 CLAIM ASSESSED RE: PREAMBLE TO THE TARIFF OF FEES
1018 VERIFY PROVIDER ROLE
1019 OOP PROVIDER SPECIALITY CODE NOT ON FILE
1020 SCALING AND/OR FLOURIDE NOT COVERED
1021 PAYMENT ADJUSTMENT ON PREVIOUSLY PAID CLAIM
1022 FEE CLAIMED DOES NOT EQUAL SERVICE COUNT
1023 FEE CLAIMED DOES NOT MATCH COMMENT
1025 MAXIMUM SUPPORTIVE CARE (7 VISITS)
1026 PATIENT NOT ON PROVINCIAL PATIENT REGISTRY
1027 PHYSICIAN NOT ELIGIBLE FOR PILOT PROGRAM

1028	PATIENT NOT INDICATED ON PILOT PROGRAM APPLICATION
1029	NO PILOT PROGRAM APPLICATION AT REGISTRY OFFICE
1030	FEE FOR SERVICE NOT PAYABLE DURING CONTRACT/SALARY HOURS
1031	SERVICE NOT PROVIDED IN OFFICE
1032	ADJUSTMENT GRANTED BY OTHER PROVINCE
1033	ADJUSTMENT DENIED BY OTHER PROVINCE
7861	1-ROLE IN ERROR DUE TO SERVICE CATAGORY
7862	2-ROLE IN ERROR DUE TO SERVICE CATAGORY
7863	3-ROLE IN ERROR DUE TO SERVICE CATAGORY
7900	CLAIMED AT LESS THAN CURRENT TARIFF RATE

CLAIM STATUS CODES

CODE	CLAIM STATUS DESCRIPTION
11	TO PROCESS - ORIGINAL CLAIM
12	TO PROCESS - RE-EDIT CLAIMS
21	IN SUSPENSE - DATA CAPTURE
22	IN SUSPENSE – NEWBORN
23	IN SUSPENSE - CLAIM HOLD
24	IN SUSPENSE – ELIGIBILITY
25	IN SUSPENSE – CORRECTION
31	IN ERROR – VALIDATION
35	IN ERROR - RETURN TO PROVIDER
41	PENDING ACTION - TO ASSESS
42	PENDING ACTION - TO REVIEW
43	PENDING ACTION - TO REVIEW
44	PENDING ACTION - TO ADJUST
45	IC MAC - IC MAC
46	OP REF - OP REF
47	OP CLM - OP CLM
51	TO PAY - TO PAY
52	TO PAY – REVERSE
53	TO PAY – CANCEL
61	SETTLED – PAID
62	SETTLED – REVERSED
63	SETTLED – CANCELLED
64	SETTLED - HISTORY ONLY
65	HISTORY - HIST

CLAIM TYPES

ID	DESCRIPTION
1	IN-PROVINCE PAY PROVIDER
2	IN-PROVINCE PAY RESIDENT
3	IN-PROVINCE HOSPITAL IN-PROVINCE RESIDENT
4	IN-PROVINCE HOSPITAL OOP RESIDENT
5	IN-PROVINCE PROVIDER OOP RESIDENT
6	OUT-OF-PROVINCE PAY REFERRALS
7	OUT-OF-PROVINCE IN-PATIENT CLAIMS
8	OUT-OF-PROVINCE MEDICAL CLAIMS
9	OUT-OF-PROVINCE OUT-PATIENT CLAIMS
13	DENTAL – CDANet

APPENDIX C - NON-PATIENT SPECIFIC FEE CODE BILLING PARAMETERS

Service Description		Fee Code	Provincial Health #	Diagnostic Code	Facility Type
ON-CALL RETAINERS - See Preamble 11. A					
On-Call Retainer (Queen Elizabeth Hospital)					
Tier 1					
On-Call Retainer - Surgical Assistant		0159	01853217	V85.1	3
On-Call Retainer - Anesthesia		0240	01696921	V85.1	3
On-Call Retainer - General Surgery		0440	01696947	V85.1	3
On-Call Retainer - Internal Medicine		0540	01696962	V85.1	3
On-Call Retainer - Ob/Gyn		0740	01696988	V85.1	3
On-Call Retainer - Pediatrics		1140	01697036	V85.1	3
On-Call Retainer - NICU		1100	01697036	V85.1	3
On-Call Retainer - Closed ICU		0505	03822715	V85.1	3
On-Call Retainer - PCU		0520	03822780	V85.1	3
On-Call Retainer - Psychiatry Inpatients		1239	03822723	V85.1	3
Tier 2					
On-Call Retainer - Rehab Unit		0147	01663608	V85.1	3
On-Call Retainer - Unaffiliated Family Medicine Psychiatry inpatient		0199	02082220	V85.1	3
Hospitalist					
Hospitalist (Full-Line)		0108	01942804	V85.1	3
Hospitalist (Half-Line)		0034	01942804	V85.1	3
Family Practice (inpatients)					
Urban Family Physician	- per group of 1	0015	02155950	V85.1	3
	- per group of 2	0016	02155950	V85.1	3
	- per group of 3	0017	02155950	V85.1	3
	- per group of 4	0018	02155950	V85.1	3
	- per group of 5	0019	02155950	V85.1	3
	- per group of 6	0021	02155950	V85.1	3
	- per group of 7	0022	02155950	V85.1	3
	- per group of 8	0023	02155950	V85.1	3
	- per group of 9	0024	02155950	V85.1	3
	- per group of 10	0014	02155950	V85.1	3
On-Call Retainer (Prince County Hospital)					
Tier 1					
On-Call Retainer - Surgical Assistant		0159	02175453	V85.1	3
On-Call Retainer - Anesthesia		0240	01696939	V85.1	3
On-Call Retainer - General Surgery		0440	01696954	V85.1	3
On-Call Retainer - Internal Medicine		0540	01696970	V85.1	3
On-Call Retainer - Ob/Gyn		0740	01696996	V85.1	3
On-Call Retainer - Pediatrics		1140	02052959	V85.1	3
On-Call Retainer - NICU		1100	03822749	V85.1	3
On-Call Retainer - Closed ICU		0505	03822756	V85.1	3
On-Call Retainer - PCU		0520	03822764	V85.1	3
On-Call Retainer - Psychiatry Inpatients		1239	03822772	V85.1	3
Tier 2					
On-Call Retainer - Unaffiliated Family Medicine Psychiatry inpatient		0199	3493830	V85.1	3
Hospitalist					
Hospitalist (Full-Line)		0108	02056851	V85.1	3
Hospitalist (Half-Line)		0034	02056851	V85.1	3

Service Description		Fee Code	Provincial Health #	Diagnostic Code	Facility Type
On-Call Retainer (Prince County Hospital) (cont.)					
Family Practice (inpatients)					
Urban Family Physician	- per group of 1	0015	02175313	V85.1	3
	- per group of 2	0016	02175313	V85.1	3
	- per group of 3	0017	02175313	V85.1	3
	- per group of 4	0018	02175313	V85.1	3
	- per group of 5	0019	02175313	V85.1	3
	- per group of 6	0021	02175313	V85.1	3
	- per group of 7	0022	02175313	V85.1	3
	- per group of 8	0023	02175313	V85.1	3
	- per group of 9	0024	02175313	V85.1	3
	- per group of 10	0014	02175313	V85.1	3
On-Call Retainer (Provincial)					
Tier 1					
On-Call Retainer - Orthopedics		0940	01697010	V85.1	3
On-Call Retainer - Psychiatry		1240	02155935	V85.1	3
Tier 2					
On-Call Retainer - Nephrology		0549	02498186	V85.1	3
On-Call Retainer - Ophthalmology		0840	01697002	V85.1	3
On-Call Retainer - Otolaryngology		1040	01697028	V85.1	3
On-Call Retainer - Urology		1340	01697044	V85.1	3
On-Call Retainer - Radiology		1540	01697051	V85.1	3
On-Call Retainer - Laboratory Medicine		1940	02155836	V85.1	3
On-Call Retainer - Medical Microbiology		4340	03518834	V85.1	3
On-Call Retainer - Medical Oncology		2390	02155901	V85.1	3
On-Call Retainer - Radiation Oncology		4840	02898989	V85.1	3
On-Call Retainer - Plastic Surgery		9740	01697069	V85.1	3
On-Call Retainer - Family Medicine Oncology		0177	02155869	V85.1	3
On-Call Retainer - Family Medicine Palliative Care		0179	02155877	V85.1	3
On-Call Retainer - Family Medicine Hillsborough Hospital		0197	02155885	V85.1	3
On-Call Retainer - Addictions (Mt. Herbert)		0198	02155893	V85.1	3
On-Call Retainer - On-Line Medical Control		0090	02611861	V85.1	4
On-Call Retainer - Critical Care Transport		0089	03822798	V85.1	3
On-Call Retainer - Critical Lab Reports		0088	03822806	V85.1	3
On-Call Retainer (Other)					
On-Call Retainer - Psychiatry Inpatients - Hillsborough Hospital		1239	03822814	V85.1	3
On-Call Retainer - Corrections		0030	02280519	V85.1	3
On-Call Retainer - Coroner East		0020	02455822	V85.1	3
On-Call Retainer - Coroner West		0020	02455830	V85.1	3
On-Call Retainer - Ambulatory Detox Service - PCH & Western		0158	02175461	V85.1	3
On-Call Retainer - Rural Family Physician - Souris		0185	01530971	V85.1	3
On-Call Retainer - Rural Family Physician - O'Leary		0185	01530997	V85.1	3
On-Call Retainer - Rural Family Physician - Alberton		0175	02201085	V85.1	3
On-Call Retainer - Rural Family Physician - Montague		0175	02155943	V85.1	3
On-Call Retainer - Backup					
On-Call Retainer - Hospitalist (backup) - Overflow Unaffil. Patients (QEH)		0066	01942796	V85.1	3
On-Call Retainer - Neurology (backup)		0503	02155927	V85.1	3
On-Call Retainer - Oncology (backup)		0174	02155901	V85.1	3
On-Call Retainer - Neonatology (backup)		1101	01697036	V85.1	3
On-Call Retainer - Closed ICU (backup)		2087	03104577	V85.1	3
On-Call Retainer - LTC (backup)		6003	03614112	V85.1	8
On-Call Retainer - ED Night shift (backup)		9366	03822822	V85.1	3
On-Call Retainer - Radiology (backup)		1547	03822830	V85.1	3

Service Description	Fee Code	Provincial Health #	Diagnostic Code	Facility Type
Additional On-Call - See Preamble 11.A.3				
Additional On-Call (add-on) - Tier 1	9345	03822848	V85.1	3
Additional On-Call (add-on) - Tier 2	9350	03822855	V85.1	3
Additional On-Call (add-on) - Family Practice (inpatient with no hospitalist coverage)	0078	03822863	V85.1	3
HOSPITALIST SERVICES				
Hospitalist sessional fee (per hour) - QEH	1801	03822889	V85.1	3
Hospitalist sessional fee (Focused Family Medicine salary top-up) - QEH	0028	03822897	V85.1	3
Hospitalist sessional fee (per hour) - PCH	1801	03822905	V85.1	3
Hospitalist sessional fee (Focused Family Medicine salary top-up) - PCH	0028	03822913	V85.1	3
ED PHYSICIAN SERVICES (May bill for services provided in each time window)				
QEH				
ED hourly sessional fee - Weekday Day (08:00-17:59) QEH	9308	01533652	V85.0	4
ED hourly sessional fee - Weekday Evening (18:00-23:59) QEH	9318	01533652	V85.1	4
ED hourly sessional fee - Weekend/Holiday (08:00-23:59) QEH	9320	01533652	V85.1	4
ED hourly sessional fee - Night (24:00-07:59) QEH	9324	01533652	V85.1	4
ED hourly sessional fee - salary top-up (Weekday Day) QEH	9310	01533652	V85.1	4
PCH				
ED hourly sessional fee - Weekday Day (08:00-17:59) PCH	9308	01533660	V85.0	4
ED hourly sessional fee - Weekday Evening (18:00-23:59) PCH	9318	01533660	V85.1	4
ED hourly sessional fee - Weekend/Holiday (08:00-23:59) PCH	9320	01533660	V85.1	4
ED hourly sessional fee - Night (24:00-07:59) PCH	9324	01533660	V85.1	4
ED hourly sessional fee - salary top-up (Weekday Day) PCH	9310	01533660	V85.1	4
ED hourly sessional fee - Weekday Day (08:00-17:59) PCH	9308	01533660	V85.0	4
WESTERN HOSPITAL				
ED hourly sessional fee - Weekday Day (08:00-17:59) Western	9308	01530989	V85.0	4
ED hourly sessional fee - Weekday Evening (18:00-23:59) Western	9318	01530989	V85.1	4
ED hourly sessional fee - Weekend/Holiday (08:00-23:59) Western	9320	01530989	V85.1	4
ED hourly sessional fee - salary top-up (Weekday Day) Western	9310	01530989	V85.1	4
KINGS COUNTY				
ED hourly sessional fee - Weekday Day (08:00-17:59) Kings County	9308	01530963	V85.0	4
ED hourly sessional fee - Weekday Evening (18:00-23:59) Kings County	9318	01530963	V85.1	4
ED hourly sessional fee - Weekend/Holiday (08:00-23:59) Kings County	9320	01530963	V85.1	4
ED hourly sessional fee - salary top-up (Weekday Day) Kings County	9310	01530963	V85.1	4
CLOSED ICU PHYSICIAN (designated) - See Preamble 9.B.2				
Closed ICU Sessional fee (daily rate)	2080	03104577	V85.1	3
Closed ICU Sessional fee (salary top-up)	2083	03104577	V85.1	3
Closed ICU Sessional fee (overflow rate per bed)	2088	03104577	V85.1	3
ADMINISTRATIVE MEETING (per 15 minutes) - See Preamble 29	0050	01741230	V68.9	
PHYSICIAN SUPERVISION STIPEND (per day) - See Preamble 30	0053	03216587	V85.1	3

APPENDIX D - PRIOR APPROVAL

Prior approval is required from Health PEI before some surgical procedures are undertaken. Care should be exercised in ensuring such approval has been granted before the surgery is undertaken.

The following is a general outline of services that may be covered under prior approval.

FACE & NECK

i. Scar revision in exposed areas of the head and neck related to trauma, disease or surgery, unless the initial surgery was for cosmetic reasons only, hence uninsured.
ii. Blepharoplasty of upper eyelids if there is encroachment of the visual axis.
iii. Outstanding, protruding or congenitally deformed ears, under 18 years of age.
iv. Rhinoplasty may be approved if the malformation significantly obstructs the nasal airway.
v. Conditions amenable to pulse dye laser treatment of the head and neck for which prior approval is necessary include:
    a. Pyogenic Granuloma
    b. Glomus tumors
    c. Lymphangiomas
    d. Port Wine Stains

OTHER BODY AREAS

i. Scar revision is insured if scars cause a functional disability, or if revision is part of a preplanned staged reconstructive procedure. Scar revision is also approved if there is a history of post-operative complications.
ii. With prior approval, augmentation mammoplasty is insured for congenital or post-surgical amastia. If unilateral augmentation mammoplasty is approved for the above reasons, then a balancing operation such as reduction or mastopexy may be approved for the opposite breast. For clarity, post-surgical breast cancer patients seeking augmentation by prosthesis-bilateral (fee code 3083) or unilateral (fee code 3072) are not required to seek prior approval, however a comment is required on the claim to indicate post-surgical breast cancer patient
iii. Reduction mammoplasty requires prior approval and is payable only once in a patient's lifetime. An estimate in excess of 500 grams is to be removed from each breast reduction application.
iv. After successful treatment of morbid obesity by gastroplasty, intestinal by-pass surgery or strict dietary control, a lipectomy/panniculectomy, may be approved, and is payable only once in a patient's lifetime. Candidates who qualify for morbid obesity procedures must have:
    a. Body mass index greater than 40
    b. Evidence that weight loss has been attempted through several other accepted forms of reduction therapy
    c. Existing medical conditions which are being aggravated as a result of excess body weight.
v. Circumcision less than one year of age.

FEE CODES REQUIRING PRIOR APPROVAL:

DESCRIPTION	FEE CODE
Augmentation by prosthesis - Unilateral	3072
Male mastectomy (Benign)	3077
Removal of breast prosthesis	3079
Surgical Planing, face for acne, whole face	3080
Surgical Planing, single area, e.g., trauma scar	3081
Reduction - Mammoplasty - Unilateral	3082
Reduction - Mammoplasty - Multilateral	3048
Augmentation by prosthesis - Bilateral	3083
Rhinoplasty, with or without graft, and closure of septal perforation	4016
Gastric partition for morbid obesity	5233
Gastric partition plus all other procedures for morbid obesity	5234
Lipectomy, removal of panniculus	5456
Ptosis	7410
Ptosis - secondary repair	7411
Blepharoplasty - excision of skin, with or without muscle	7430
Blepharoplasty - with removal of orbital fat, +/- lid fold reconstruction/graft	7431
Repair - reconstruction of the ear with graft of skin or cartilage	7710
Penile prosthesis for impotence	8417
Insertion of Testicular prosthesis (for age 18 and over)	8507
TRAM Flap	3097

UNINSURED SERVICES

i. Otoplasty over the age of 18 years.
ii. Reversal of vasectomy or tubal ligation.
iii. Removal of tattoos.
iv. Cosmetic surgery.
v. In vitro fertilization.
vi. Simple lipoma, as well as warts, papillomata, keratosis, nevi, and moles - removal by any means. (Fee Codes 3039, 3041, 3042, 3043, 3044, 3045). For exceptions, please refer to **Section 21.C** of the Preamble to the Tariff of Fees.
vii. Visits and injections related to upcoming out-of-country travel.

APPENDIX E - CRITERIA FOR OUT OF PROVINCE REFERRALS

HPEI Policy and Procedures Manual

CRITERIA FOR OUT-OF-PROVINCE REFERRALS

Health PEI			POLICY & PROCEDURES
Applies To:	Out-of-Province Referral Program		
Monitoring:	Manager of Physician Services		
Date:	Effective:	April 1, 1995	
	Next Review:	**January 2023**	

Approving Authority: Executive Director of Medical Affairs

Authorized Signature: _____

Record of Decision	Approving Body:	Executive Director of Medical Affairs
	Meeting Date:	

HPEI Policy and Procedures Manual

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Date:	Effective:	April 1, 1995	
	Next Review:	**January 2023**	

This is a CONTROLLED document. Any copies of this document appearing in paper form should always be checked against the electronic version prior to use.

1.0 POLICY

1.1 Referrals for Out-of-Province (OOP) medical services must receive prior approval from the OOP Referral Program. Failure to obtain prior approval for medical services may result in the patient being held responsible for the cost of the services provided.

Exception: Payment under the Hospital and Medical Services Insurance Plan (the Plan) may be provided without prior approval for an eligible resident of Prince Edward Island to obtain in-patient and/or out-patient medical services outside the province (within Canada), or outside of Canada, for an **emergency or sudden illness.**

1.2 OOP referrals for medical services that are granted prior approval receive funding under the Hospital and Medical Services Insurance Plan for the cost of the initial referral and subsequent treatment deemed clinically necessary by the consulting physician for the referring clinical indication or diagnosis. This includes, but is not limited to, initial consultation, treatment/interventions, and follow-up care that **is effective for 12 months.**

2.0 DEFINITIONS

Emergency or Sudden Illness:	A medical situation or occurrence of a serious nature, developing suddenly and unexpectedly and demanding immediate medical attention.
Out-of-Province Referral for Medical Services	A written request made by a PEI physician to refer a patient to an out of province physician for a specific clinical indication or diagnosis, including but not limited to initial consultation, treatment, and follow-up care that is deemed medically necessary by the consulting physician.
PEI Eligible Resident:	Anyone who is legally entitled to remain in Canada, and who makes his or her home, and is ordinarily present on an annual basis for at least six months plus a day in Prince Edward Island and possesses a valid PEI Health Card.
Prior Approval:	Approval that must be obtained from the Out of Province Health Services Coordinator at Health PEI before a resident of Prince Edward Island leaves the province for medical treatment.

3.0 PURPOSE/SCOPE

To outline the criteria used to determine approval for out-of-province referrals for medical services.

4.0 APPLICATION

4.1 This policy applies to the Out-of-Province Referral Program, Health PEI.

4.2 Out-of-Province (OOP) medical services and facilities can include services within Canada and Out-of-Country (OOC).

5.0 PROCEDURES

5.1 Out-of-Province (Within Canada) Services

(a) Prior written approval for out-of-province referrals may be granted if:

- After consultation with a local specialist and in the opinion of a local general practitioner and/or specialist, adequate medical services are **not** available in Prince Edward Island.
- Only one (1) consultant/specialist is available in Prince Edward Island in the specific medical specialty service required.
- The required medical services are provided in Prince Edward Island but other extenuating circumstances exist. Such cases may be reviewed by the Executive Director of Medical Affairs & Legal Services (or designate).

(b) Eligible residents of Prince Edward Island requesting an out-of-province physician referral for medical services for reasons of personal preference only may **not** be approved.

Note: Payment for hospital services rendered outside the province do not exceed the daily standard per diem rate as authorized by the Government of PEI.

5.2 Out of Country Services

(a) Insured health services may be provided under the Plan for an eligible resident of Prince Edward Island to obtain in-patient and/or out-patient medical services outside Canada if written prior approval is obtained from Health PEI.

(b) Prior written approval may be granted if, after consult with a local specialist and in the opinion of a local general practitioner and/or specialist, adequate medical services are not available within Canada.

6.0 MONITORING

6.1 The Executive Director of Medical Affairs and Legal Services is responsible for ensuring this policy is reviewed every three years as per the organization's policy review cycle and standards.

6.2 The Manager of Physician Services is responsible for monitoring this policy.

6.3 As required, the Out-of-Province Health Services Coordinator in consultation with the Manager of Physician Services may initiate and request amendments to this policy.

7.0 REFERENCES

Related Documents

N/A

References

N/A

Appendices

N/A

8.0 STAKEHOLDER REVIEW

Group/Committee	Dates of Review
Medical Affairs	December 2019
Provincial Services, Long Term Care and Hospital Services East	December 2019

9.0 REVIEW HISTORY

Review Dates:

July 1995	July 2001	July 2007
July 2015	December 2019	

APPENDIX F - CRITERIA FOR PAYMENT OF OUT OF PROVINCE REFERRALS

PEI Policy and Procedures Manual

CRITERIA FOR PAYMENT OF OUT-OF-PROVINCE REFERRALS

	Health PEI		**POLICY & PROCEDURES**
Applies To:	Out-of-Province Referral Program		
Monitoring:	Manager of Physician Services		
Date:	Effective:	April 1, 1995	
	Next Review:	**February 2023**	

Approving Authority: Executive Director of Medical Affairs

Authorized Signature: _____

Record of Decision	Approving Body:	Executive Director of Medical Affairs
	Meeting Date:	

Policy and Procedures Manual

CRITERIA FOR PAYMENT OF OUT-OF-PROVINCE REFERRALS

Health PEI			POLICY & PROCEDURES
Applies To:	Out-of-Province Referral Program		
Monitoring:	Manager of Physician Services		
Approving Authority:	Executive Director of Medical Affairs		
Date:	Effective:	April 1, 1995	
	Next Review:	**February 2023**	

This is a CONTROLLED document. Any copies of this document appearing in paper form should always be checked against the electronic version prior to use.

10.0 POLICY

10.1 For residents requesting out-of-province (OOP) non-emergent or elective services, the Health PEI OOP program reviews the local physician recommendation and referral and bases the decision to pre-approve for payment on the following criteria:

(a) If the service is not available locally (e.g., neurosurgery, cardiac surgery);
(b) If the resident has only one choice (e.g., one specialist in the specialty)
(c) If an adequate service is not available
(d) If there are extenuating circumstances

11.0 DEFINITIONS

Prior Approval:	Approval that must be obtained from the Out-of-Province Physician Coordinator at Health PEI before a resident of Prince Edward Island leaves the province for medical treatment

12.0 PURPOSE/SCOPE

The purpose of this policy is to determine under what conditions costs for out-of-province referrals will be paid.

13.0 APPLICATION

This policy applies to the Out-of-Province (OOP) Referral Program, Health PEI.

14.0 PROCEDURES

14.1 Residents with referrals approved for payment are notified by letter, as well as those residents who were not approved for payment.

14.2 Residents who go out-of-province on their own, or who have been advised Health PEI has not agreed to pay, may be responsible for costs incurred while out-of-province.

15.0 MONITORING

15.1 The Manager of Physician Services is responsible for monitoring the policy and ensuring it is reviewed according to Health PEI's policy review cycle and standards every three years.

15.2 The OOP Physician Referral Coordinator in consultation with the Manager of Physician Services may initiate required amendments to the policy.

REFERENCES

Related Documents

Master Agreement Between the Medical Society of Prince Edward Island and the Government of Prince Edward Island and Health PEI

References

N/A

Appendices

Appendix A – Out-of-Province Referral Fee Codes

Appendix B – Out-of-Province Location Codes

16.0 STAKEHOLDER REVIEW

Group/Committee	Dates of Review
Medical Affairs & Legal Services	Fall 2019
Provincial Services, Long Term Care and Hospital Services East	*January 2020*

17.0 REVIEW HISTORY

Review Dates:

July 1995	July 2001	July 2007
July 2015	January 2020	

APPENDIX A

Out-of-Province Referral Fee Codes

The Out-of-Province Referral Fee Codes are matched to Health PEI's criteria for approval. The approval criteria were developed in consultation with the P.E.I. Medical Society. Physicians should utilize one of the following fee codes for each out-of-province referral, depending on the reason for the referral:

(i) *"The insured (in Prince Edward Island) medical and/or hospital service is not available within the province".*

9401	Service Not Available	Consultation
9402	Service Not Available	Consult./Investigation
9403	Service Not Available	Consult./Investigation/Treatment

(ii) *"There exists within Prince Edward Island only 1 medical practitioner in the required specialty".*

9404	Only One Specialist	Consultation
9405	Only One Specialist	Consultation/Investigation
9406	Only One Specialist	Consult./Investigation/Treatment

(iii) *"In the opinion of a Prince Edward Island physician and the Medical Consultant of Health PEI, adequate service is not available within the province".*

*9407	Adequate Service Not Available	Consultation
*9408	Adequate Service Not Available	Consultation/Investigation
*9409	Adequate Service Not Available	Consult./Investigation/Treatment

(iv) *"In the opinion of the Medical Consultant of Health PEI, extenuating circumstances exist and are documented that permit services to be provided in another province or territory".*

*9410	Extenuating Circumstances	Consultation
*9411	Extenuating Circumstances	Consultation/Investigation
*9412	Extenuating Circumstances	Consult./Investigation/Treatment

Supporting documentation must be provided.

APPENDIX B

Out-of-Province Location Code

CODE	LOCATION
050	NEW BRUNSWICK
051	MONCTON GENERAL
052	DR. GEO.L. DUMONT
053	ST. JOHN REGIONAL
054	DR.E. CHALMERS
055	BEAUSEJOUR
056	ST. JOHN HOSTEL
099	NEW BRUNSWICK
100	NEWFOUNDLAND
149	NEWFOUNDLAND
200	NOVA SCOTIA
201	HIGHLAND VIEW
202	HALIFAX N.S.
203	I. W. K.
204	VICTORIA GENERAL *
205	WOMEN CLINIC
206	HALIFAX INFIR'Y *
207	CAMP HILL HOSP *
208	GRACE MATERNITY
209	HALIFAX CIVIC
210	DARTMOUTH GENERAL
211	POINT PLEASANT
212	CANCER TREATMENT
213	CHOICES PROGRAM
214	QE2 HALIFAX
299	NOVA SCOTIA
300	QUEBEC
301	MONTREAL PQ
302	SHRINERS HOSP
303	INST OF CARDIOLIGY
304	ROYAL VICTORIA
305	MCGILL HOSPITAL
306	QUEBEC CITY
307	LAVAL
308	INST CARD QC
309	MONTERAL GENERALY
310	MONTERAL CHILDS
311	MONTERAL NEUROL
399	QUEBEC
400	ONTARIO
401	TORONTO
402	CLARKE INST PSY
403	DONWOOD INST
404	HOSP SICK CHILD
405	EASTERN GENERAL
406	SUNNYBROOK MED
407	TORONTO GENERAL

CODE	LOCATION
408	LYNDHURST HOSPY
409	SHOULDICE HOSP
410	PRINCES MARGARET
411	ST. MICHAELS
412	MOUNT SINAI
413	THE WELLSELEY
414	VICTORIA
415	UNIVERSITY HOSP
416	PARKWOOD HOSP
417	HOMEWOOD
418	BELLWOOD
499	ONTARIO
500	MANITOBA
599	MANITOBA
600	SASKATEWAN
699	SASKATEWAN
700	ALBERTA
799	ALBERTA
800	BRITSH COLUMBIA
850	YUKON
875	NORTH WEST TERRITORIES
885	NUNAVUT
900	UNITED STATES
902	U.S.A.
903	U.S NORTH EAST
904	U.S. SOUTH EAST
905	U.S. NORTH CENT
906	U.S. MID CENTRL
907	U.S. SOUTH CENT
908	U.S. NORTH WEST
909	U.S. SOUTH WEST
950	FOREIGN COUNTRY
999	OTHER THAN PROV

*PART OF QEII HEALTH SCIENCES CENTRE

TARIFF OF FEES

	Fee Code	1-Apr 2025	1-Apr 2027	1-Oct 2027	1-Apr 2028	1-Oct 2028
VISITS & SERVICES						
These fees cannot be correctly interpreted without reference to the Preamble.						
1. CONSULTATIONS - See Preamble 8.A						
Consultation (Psychiatry)	1260	298.00	300.98	303.99	307.03	310.10
Consultation (Medical) - **see below for "Medical" inclusions**	1460	248.00	250.48	252.98	255.51	258.07
Consultation (Surgical) - **see below for "Surgical" inclusions**	1860	140.00	141.40	142.81	144.24	145.68
Consultation (Family Physician)	0160	120.00	121.20	122.41	123.64	124.87
Repeat Consultation within 30 days (Psychiatry)	1262	149.00	150.49	151.99	153.51	155.05
Repeat Consultation within 30 days (Medical)	1462	124.00	125.24	126.49	127.76	129.03
Repeat Consultation within 30 days (Surgical)	1862	70.00	70.70	71.41	72.12	72.84
Repeat Consultation within 30 days (Family Physician)	0162	60.00	60.60	61.21	61.82	62.44
"**Medical**" includes Internal Medicine, Pediatrics, Physical Medicine, Geriatrics, Oncology, Palliative Care, Addictions, Chronic Pain Mgmt. "**Surgical**" includes Anesthesia, Dermatology, General Surgery, ObGyn, Ophthalmology, Orthopedics, Otolaryngology, Urology.						
Limited or Telephone Consultation (Consulting Specialist) - **See Preamble 8.B**	1850	100.00	101.00	102.01	103.03	104.06
Limited or Telephone Consultation (Consulting Family Physician) - **See Preamble 8.B**	0128	55.00	55.55	56.11	56.67	57.23
Limited or Telephone Consultation (Referring Physician) - **See Preamble 8.B**	1851	55.00	55.55	56.11	56.67	57.23
Limited or Telephone Consultation (OLMC) - **See Preamble 8.C**	1872	55.00	55.55	56.11	56.67	57.23
2. OFFICE VISITS						
Comprehensive office visit - **See Preamble 8.E**	1810	100.00	101.00	102.01	103.03	104.06
Limited office visit - **See Preamble 8.G**	1813	50.00	50.50	51.01	51.52	52.03
Subsequent office visit with Special Tests (Ophthalmology) - **See Preamble 8.F**	0812	72.41	73.14	73.87	74.61	75.35
3. HOSPITAL VISITS - In-Patient Services						
Hospital Admission - **See Preamble 9.A.1**	1830	150.00	151.50	153.02	154.55	156.09
Hospital Daily Care (MRP) - **See Preamble 9.A.2**	1833	100.00	101.00	102.01	103.03	104.06
Hospital Daily Care (additional physician) - **See Preamble 9.A.3**	1841	100.00	101.00	102.01	103.03	104.06
Hospital Discharge fee (add-on) - **See Preamble 9.A.4**	0136	75.00	75.75	76.51	77.27	78.05
Hospital Supportive care visit - **See Preamble 9.A.3**	0140	50.00	50.50	51.01	51.52	52.03
Hospitalist Services						
Hospitalist sessional fee - (per hour)	1801	202.00	204.02	206.06	208.12	210.20
Hospitalist sessional fee - (Focused Family Medicine salary top-up)	0028	17.00	17.17	17.34	17.51	17.69
Hospitalist shadow billing code	0111	0.00	0.00	0.00	0.00	0.00

	Fee Code	1-Apr 2025	1-Apr 2027	1-Oct 2027	1-Apr 2028	1-Oct 2028
4. HOME, OFFSITE, LONG TERM CARE VISITS						
Homebound patient visit - **See Preamble 8.J**	1821	110.00	111.10	112.21	113.33	114.47
Home visit for non-Homebound patient - **See Preamble 8.G**	1826	50.00	50.50	51.01	51.52	52.03
Each additional patient seen during home visit - **See Preamble 8.G**	1824	50.00	50.50	51.01	51.52	52.03
Additional fee allowed for emergency home visit	1825	31.17	31.49	31.80	32.12	32.44
Offsite visit - **See Preamble 8.N**	1829	50.00	50.50	51.01	51.52	52.03
LTC and Community Care Visit - first resident - **See Preamble 8.L**	1827	100.00	101.00	102.01	103.03	104.06
LTC and Community Care Visit - each additional resident - **See Preamble 8.L**	1828	50.00	50.50	51.01	51.52	52.03
5. DETENTION FEES (per 15-min block) - See Preamble 9.D	1870	55.00	55.55	56.11	56.67	57.23
6. PSYCHOTHERAPY - (all fees per 15-min block)						
Family Medicine						
Psychotherapy (in office) - **See Preamble 13.A**	2501	55.00	55.55	56.11	56.67	57.23
Psychotherapy (in hospital) - **See Preamble 13.A**	2503	55.00	55.55	56.11	56.67	57.23
Group psychotherapy - **See Preamble 13.D**	2502	55.00	55.55	56.11	56.67	57.23
Member of Group Psychotherapy	2580	0.00	0.00	0.00	0.00	0.00
Psychiatry						
Psychotherapy (in office) - **See Preamble 13.A**	2504	68.59	69.27	69.96	70.66	71.37
Group psychotherapy - **See Preamble 13.D**	2587	68.59	69.27	69.96	70.66	71.37
Member of Group Psychotherapy	2581	0.00	0.00	0.00	0.00	0.00
Hospital Inpatient Psychiatric Care - **See Preamble 13.B**	1803	81.12	81.93	82.75	83.58	84.41
7. NON-FACE-TO-FACE SERVICES						
Physician-to-Patient Electronic Communication - **See Preamble 10.A.1**	1895	30.00	30.30	30.60	30.91	31.22
Collaborative Care - **See Preamble 10.A.2**	0097	30.00	30.30	30.60	30.91	31.22
Telephone Prescription Renewal - **See Preamble 10.A.3**	2019	15.00	15.15	15.30	15.45	15.61
Indirect / Administrative Care (per 15 minutes) - **See Preamble 10.A.4**	1896	55.00	55.55	56.11	56.67	57.23
Case Management Conference (per 15 min) - **See Preamble 10.A.5**	2507	55.00	55.55	56.11	56.67	57.23
Diagnostic & Therapeutic interview (per 15 min) - Family Medicine - **See Preamble 8.K**	2588	55.00	55.55	56.11	56.67	57.23
Diagnostic & Therapeutic interview (per 15 min) - Specialist - - **See Preamble 8.K**	2586	68.59	69.27	69.96	70.66	71.37
8. HOSPITAL CRITICAL CARE						
Closed ICU Physician (designated) - **See Preamble 9.B.2**						
Closed ICU Sessional fee (daily rate)	2080	4,500.00	4,545.00	4,590.45	4,636.35	4,682.72
Closed ICU Sessional fee (salary top-up)	2083	2,760.00	2,787.60	2,815.48	2,843.63	2,872.07
Closed ICU Sessional fee (overflow rate per bed)	2088	450.00	454.50	459.05	463.64	468.27
Physician-in-Charge - See Preamble 9.B and 20.C						
Critical Care - 1st day, includes consultation (90 minutes)	0595	361.61	365.23	368.88	372.57	376.30
Critical Care - 1st day, consult within previous 10 days (45 min.)	0596	209.48	211.58	213.69	215.83	217.99
Critical Care - Days 2-30 inclusive, per day	0597	209.48	211.58	213.69	215.83	217.99
Critical Care - Day 31 onward, per day	0598	104.74	105.79	106.85	107.92	108.99
Intermediate/Progressive Care - per day	0501	225.00	227.25	229.52	231.82	234.14
Concurrent Critical Care - per day	0502	209.48	211.58	213.69	215.83	217.99
Intensive Care Visit - per day	1871	124.70	125.94	127.20	128.47	129.76

	Fee Code	1-Apr 2025	1-Apr 2027	1-Oct 2027	1-Apr 2028	1-Oct 2028
9. NEONATAL INTENSIVE CARE - See Preamble 9.B.1 and 20.D						
Level A: Full life support including invasive monitoring, ventilatory support, and parenteral alimentation						
Neonatal ICU Care - 1st day, includes consult (120 minutes)	1145	436.44	440.80	445.21	449.66	454.16
Neonatal ICU Care - Days 2-30 inclusive, per day	1146	218.22	220.40	222.60	224.83	227.08
Neonatal ICU Care - Day 31 onward, per day	1147	144.65	146.10	147.56	149.03	150.52
Level B: Intensive Care including full monitoring both invasive and non-invasive, oxygen administration and intravenous therapy, but without ventilatory support.						
Neonatal ICU Care - 1st day, includes consult (90 minutes)	1148	299.27	302.26	305.28	308.33	311.42
Neonatal ICU Care - 2nd day onward, per day	1149	106.00	107.06	108.13	109.21	110.30
Level C: Intermediate care including oxygen administration, non-invasive monitoring and gavage feeding.						
Neonatal ICU Care - 1st day, includes consult (60 minutes)	1150	249.39	251.89	254.40	256.95	259.52
Neonatal ICU Care - 2nd day onward, per day	1151	87.29	88.16	89.04	89.93	90.83
10. EMERGENCY DEPARTMENT VISITS - See Preamble 8.E, 8.G, 8.H, 8.I						
Limited ED Visits						
Limited ED Visit – Day (08:00-17:59) - Mon to Fri	1880	50.00	50.50	51.01	51.52	52.03
Limited ED Visit – Day (08:00-17:59) - Sat, Sun, Holiday	1890	62.50	63.13	63.76	64.39	65.04
Limited ED Visit – Night (18:00-07:59) - Mon to Fri	1881	62.50	63.13	63.76	64.39	65.04
Limited ED Visit – Night (18:00-07:59) - Sat, Sun, Holiday	1891	75.00	75.75	76.51	77.27	78.05
Comprehensive ED Visits						
Comprehensive ED Visit- Day (08:00-17:59) - Mon to Fri	1886	100.00	101.00	102.01	103.03	104.06
Comprehensive ED Visit- Day (08:00-17:59) - Sat, Sun, Holiday	1868	125.00	126.25	127.51	128.79	130.08
Comprehensive ED Visit - Night (18:00-07:59) - Mon to Fri	1887	125.00	126.25	127.51	128.79	130.08
Comprehensive ED Visit - Night (18:00-07:59) - Sat, Sun, Holiday	1869	150.00	151.50	153.02	154.55	156.09
Resuscitation ED Visits						
Resuscitation ED Visit - first 15 minute block	0182	150.00	151.50	153.02	154.55	156.09
Resuscitation ED Visit - subsequent 15- minute blocks	0183	75.00	75.75	76.51	77.27	78.05
ED Physician Services						
(May bill for services provided in each time window)						
ED hourly sessional fee - Weekday Day (08:00-17:59)	9308	225.00	227.25	229.52	231.82	234.14
ED hourly sessional fee - Weekday Evening (18:00-23:59)	9318	281.25	284.06	286.90	289.77	292.67
ED hourly sessional fee - Weekend/Holiday (08:00-23:59)	9320	337.50	340.88	344.28	347.73	351.20
ED hourly sessional fee - Night (24:00-07:59)	9324	450.00	454.50	459.05	463.64	468.27
ED hourly sessional fee - Salary top-up (Weekday Day)	9310	23.00	23.23	23.46	23.70	23.94

	Fee Code	1-Apr 2025	1-Apr 2027	1-Oct 2027	1-Apr 2028	1-Oct 2028
11. ON-CALL RETAINERS - See Preamble 11.A						
On-Call Retainer - Tier 1						
On-Call Retainer - Surgical Assistant (QEH & PCH)	0159	600.00	600.00	600.00	600.00	600.00
On-Call Retainer - Anesthesia (QEH, PCH)	0240	600.00	600.00	600.00	600.00	600.00
On-Call Retainer - General Surgery (QEH, PCH)	0440	600.00	600.00	600.00	600.00	600.00
On-Call Retainer - Internal Medicine (QEH, PCH)	0540	600.00	600.00	600.00	600.00	600.00
On-Call Retainer - Ob/Gyn (QEH, PCH)	0740	600.00	600.00	600.00	600.00	600.00
On-Call Retainer - Orthopedics (provincial)	0940	600.00	600.00	600.00	600.00	600.00
On-Call Retainer - Pediatrics (QEH, PCH)	1140	600.00	600.00	600.00	600.00	600.00
On-Call Retainer - NICU (provincial)	1100	600.00	600.00	600.00	600.00	600.00
On-Call Retainer - Psychiatry (provincial)	1240	600.00	600.00	600.00	600.00	600.00
On-Call Retainer - Closed ICU (QEH, PCH)	0505	600.00	600.00	600.00	600.00	600.00
On-Call Retainer - PCU (QEH, PCH)	0520	600.00	600.00	600.00	600.00	600.00
On-Call Retainer - Psychiatry Inpatients (QEH, PCH, HH)	1239	600.00	600.00	600.00	600.00	600.00
On-Call Retainer - Tier 2						
On-Call Retainer - Nephrology	0549	400.00	400.00	400.00	400.00	400.00
On-Call Retainer - Ophthalmology	0840	400.00	400.00	400.00	400.00	400.00
On-Call Retainer - Otolaryngology	1040	400.00	400.00	400.00	400.00	400.00
On-Call Retainer - Urology	1340	400.00	400.00	400.00	400.00	400.00
On-Call Retainer - Radiology	1540	400.00	400.00	400.00	400.00	400.00
On-Call Retainer - Laboratory Medicine	1940	400.00	400.00	400.00	400.00	400.00
On-Call Retainer - Medical Microbiology	4340	400.00	400.00	400.00	400.00	400.00
On-Call Retainer - Medical Oncology	2390	400.00	400.00	400.00	400.00	400.00
On-Call Retainer - Radiation Oncology	4840	400.00	400.00	400.00	400.00	400.00
On-Call Retainer - Plastic Surgery	9740	400.00	400.00	400.00	400.00	400.00
On-Call Retainer - Rehab Unit (QEH)	0147	400.00	400.00	400.00	400.00	400.00
On-Call Retainer - Ambulatory Detox Service (PCH, Western)	0158	400.00	400.00	400.00	400.00	400.00
On-Call Retainer - Family Medicine Oncology (provincial)	0177	400.00	400.00	400.00	400.00	400.00
On-Call Retainer - Family Medicine Palliative Care (provincial)	0179	400.00	400.00	400.00	400.00	400.00
On-Call Retainer - Family Medicine Hillsborough Hospital	0197	400.00	400.00	400.00	400.00	400.00
On-Call Retainer - Addictions (Mt. Herbert)	0198	400.00	400.00	400.00	400.00	400.00
On-Call Retainer - Unaffil. Fam Med Psychiatry inpatient (QEH)	0199	400.00	400.00	400.00	400.00	400.00
On-Call Retainer - Corrections	0030	400.00	400.00	400.00	400.00	400.00
On-Call Retainer - Coroner (East or West)	0020	400.00	400.00	400.00	400.00	400.00
On-Call Retainer - On-Line Medical Control (provincial)	0090	400.00	400.00	400.00	400.00	400.00
On-Call Retainer - Critical Care Transport (provincial)	0089	400.00	400.00	400.00	400.00	400.00
On-Call Retainer - Critical Lab Reports (provincial)	0088	400.00	400.00	400.00	400.00	400.00
On-Call Retainer - Backup						
On-Call Retainer - Hospitalist (backup) – Overflow Unaffiliated Patients (QEH)	0066	200.00	200.00	200.00	200.00	200.00
On-Call Retainer - Neurology (backup)	0503	200.00	200.00	200.00	200.00	200.00
On-Call Retainer - Oncology (backup)	0174	200.00	200.00	200.00	200.00	200.00
On-Call Retainer - Neonatology (backup)	1101	200.00	200.00	200.00	200.00	200.00
On-Call Retainer - Closed ICU (backup)	2087	200.00	200.00	200.00	200.00	200.00
On-Call Retainer - LTC (backup)	6003	200.00	200.00	200.00	200.00	200.00
On-Call Retainer - ED Night shift (backup)	9366	200.00	200.00	200.00	200.00	200.00
On-Call Retainer - Radiology (backup)	1547	200.00	200.00	200.00	200.00	200.00
On-Call Retainer - Hospitalist Line						
On-Call Retainer - Hospitalist (Full-Line)	0108	400.00	400.00	400.00	400.00	400.00
On-Call Retainer - Hospitalist (Half-Line)	0034	200.00	200.00	200.00	200.00	200.00

	Fee Code	1-Apr 2025	1-Apr 2027	1-Oct 2027	1-Apr 2028	1-Oct 2028
On-Call Retainer - Family Practice (inpatients)						
On-Call Retainer - Urban Family Physician (QEH & PCH)						
- per group of 1	0015	80.00	80.00	80.00	80.00	80.00
- per group of 2	0016	160.00	160.00	160.00	160.00	160.00
- per group of 3	0017	240.00	240.00	240.00	240.00	240.00
- per group of 4	0018	320.00	320.00	320.00	320.00	320.00
- per group of 5	0019	400.00	400.00	400.00	400.00	400.00
- per group of 6	0021	480.00	480.00	480.00	480.00	480.00
- per group of 7	0022	560.00	560.00	560.00	560.00	560.00
- per group of 8	0023	640.00	640.00	640.00	640.00	640.00
- per group of 9	0024	720.00	720.00	720.00	720.00	720.00
- per group of 10	0014	800.00	800.00	800.00	800.00	800.00
On-Call Retainer - Rural Family Physician (per hospital)						
- Souris, O'Leary	0185	400.00	400.00	400.00	400.00	400.00
- Alberton,-Montague	0175	800.00	800.00	800.00	800.00	800.00
12. ADDITIONAL ON-CALL - See Preamble 11.A.3						
Additional On-Call (add-on) - Tier 1	9345	600.00	600.00	600.00	600.00	600.00
Additional On-Call (add-on) - Tier 2	9350	400.00	400.00	400.00	400.00	400.00
Additional On-Call (add-on) - Family Practice (inpatient with no hospitalist coverage)	0078	400.00	400.00	400.00	400.00	400.00
13. ON-CALL RESPONSE FEE - See Preamble 11.B.1 and 11.B.2	9360	185.00	186.85	188.72	190.61	192.51
14. ADMINISTRATIVE MEETING (per 15 min) - See Preamble 29	0050	55.00	55.55	56.11	56.67	57.23
15. MAiD (per 15-min block) - See Preamble 8.M	1899	55.00	55.55	56.11	56.67	57.23
16. PHYSICIAN SUPERVISION STIPEND (per day) - See Preamble 30	0053	220.00	222.20	224.42	226.67	228.93
17. VISITING SPECIALIST Sessional Rate (per hour)	9901	218.22	220.40	222.60	224.83	227.08
18. OBSTETRICAL CARE						
Assessment of Labor - Family Physician	0003	100.00	101.00	102.01	103.03	104.06
Assessment of Labor - Ob/Gyn	0701	100.00	101.00	102.01	103.03	104.06
Hospital Assessment for Complications of Pregnancy/Labor - See Preamble 19.B	0795	140.00	141.40	142.81	144.24	145.68
Labor Management Fee - See Preamble 19.C	0720	200.00	202.00	204.02	206.06	208.12
Attendance at delivery for neonatal resusc. - Family Physician	0036	150.00	151.50	153.02	154.55	156.09
Attendance at delivery for neonatal resusc. - Pediatrics - See Preamble 20.A	1136	150.00	151.50	153.02	154.55	156.09

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19. ANESTHESIA SERVICES						
Surgical Anesthesia sessional fees						
First 2 hours - per 30-minute block	0265	160.00	161.60	163.22	164.85	166.50
Each subsequent 15-minute block beyond 2 hours	0264	80.00	80.80	81.61	82.42	83.25
Cancelled Surgery - See Preamble 18.F	0266	124.70	125.94	127.20	128.47	129.76
Sudden Cancellation of Surgery (Anesthesia) - **See Preamble 14.E.12**	9375	348.00	351.48	354.99	358.54	362.13
Acute Pain Management						
Epidural spinal block - Lumbar and Caudal	2520	93.52	94.46	95.40	96.36	97.32
Epidural spinal block (continuous)						
- consultation and institution	2521	274.33	277.07	279.84	282.64	285.47
- maintenance (per day)	2523	102.87	103.90	104.94	105.99	107.05
Acute Pain Service - initiation - **See Preamble 18.E**	0280	140.00	141.40	142.81	144.24	145.68
Patient-controlled analgesia (PCA) - maintenance	2534	34.29	34.63	34.98	35.33	35.68
Continuous Conduction Anesthesia (Epidural) - Obstetrics - **See Preamble 18.B**	2525	507.52	512.59	517.72	522.90	528.13
Other Local/Regional Anesthesia - **See Diag./Therapeutic Procedures**						
20. SURGICAL SERVICES						
Surgical Assist rates (per 15-minute block)						
Longitudinal Family Medicine Specialist	9367	50.50	51.01	51.52	52.03	52.55
All Specialists (other than Family Medicine and Focused Family Medicine)	9368	58.00	58.58	59.17	59.76	60.36
All other Physicians	9369	46.25	46.71	47.18	47.65	48.13
Sudden Cancellation of Surgery fee - See Preamble 14. E.12						
Surgeon	9370	348.00	351.48	354.99	358.54	362.13
Anesthetist	9375	348.00	351.48	354.99	358.54	362.13
Surgical Assistant	9380	277.50	280.28	283.08	285.91	288.77
21. PHOTOTHERAPY						
Ultraviolet Light Therapy - Dermatology	0395	24.49	24.73	24.98	25.23	25.48
Phototherapy - Psychiatry	2589	7.60	7.68	7.75	7.83	7.91

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RADIATION ONCOLOGY						
The listed fees are for the professional services of a certified therapeutic radiologist, the services of a specialist for the intra-cavitary or interstitial application of radium or sealed sources and the services of a specialist using non-sealed sources of radioisotopes in a laboratory authorized by the Atomic Energy Control Board of Canada. Other medical services to the patient are not included in these figures. The cost of material is additional.						
1. EXTERNAL THERAPY						
Treatment planning, dosage calculation and preparation of any special treatment device. (This is to apply only to malignant conditions treated radically.)	1715	45.52	45.97	46.43	46.90	47.37
Superficial therapy - x-ray under 100 K.V.P. per treatment visit	1716	8.54	8.62	8.71	8.79	8.88
Deep therapy - e.g., super voltage, Cobalt 60 or x-rays over 150 K.V.P. per visit	1717	11.73	11.84	11.96	12.08	12.20
Preparation and application of Radium mold	1718	20.57	20.78	20.98	21.19	21.41
Application of Strontium 90 ophthalmic device	1719	10.48	10.59	10.69	10.80	10.91
Treatment planning for non-malignant conditions	1720	28.37	28.65	28.94	29.23	29.52
2. INTERSTITIAL THERAPY						
Consultation and treatment planning fees as above. Interstitial insertion of Radium needles, Gold 98 grains or other sealed Radioisotopes.						
Biopsy as separate procedure	1725	227.69	229.97	232.27	234.59	236.93
3. INTRACAVITARY THERAPY						
Consultation and treatment planning fees as above.						
Radium insertion - per insertion	1730	196.65	198.61	200.60	202.61	204.63
Provision of radium in suitable containers and attendance in the operating room with advice and dosage calculation	1731	113.91	115.04	116.19	117.36	118.53
4. RADIOISOTOPE THERAPY						
Consultation and treatment planning fees as above (Treatment planning fee to apply to malignant conditions only)						
Radioisotope therapy - carcinoma of thyroid (per course of Tx)	1735	93.09	94.02	94.96	95.91	96.87
Treatment for hyperthyroidism and/or cardiac disease (per course of Tx)	1736	68.46	69.15	69.84	70.54	71.24
Treatment for Polycythemia Vera with Page 33 (per course of Tx)	1737	55.80	56.36	56.92	57.49	58.07
5. RADIATION THERAPY (Shadow Billing)	2600	0.00	0.00	0.00	0.00	0.00

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DIAGNOSTIC AND THERAPEUTIC PROCEDURES						
These fees cannot be correctly interpreted without reference to Preamble.						
See Preamble 21 and Preamble 6.A Cost of medication used in any of these procedures is additional.						
OFFICE LABORATORY PROCEDURES						
Urinalysis - complete (routine and microscopic)	2002	5.61	5.67	5.72	5.78	5.84
Urinalysis - partial	2003	2.81	2.83	2.86	2.89	2.92
Hemoglobin estimation	2004	4.98	5.03	5.08	5.13	5.19
Occult blood in stool	2005	2.81	2.83	2.86	2.89	2.92
Nasal smear for eosinophil	2006	4.98	5.03	5.08	5.13	5.19
ALLERGY SKIN TESTS						
Technical Component, per test (maximum 48 tests)	2349	0.88	0.89	0.90	0.91	0.92
Professional Component, per test (maximum 48 tests)	2359	0.25	0.26	0.26	0.26	0.26
ANTICOAGULATION THERAPY SUPERVISION (by telephone - per month)	2106	18.70	18.89	19.08	19.27	19.46
ARTHOGRAM - See Diagnostic Imaging						
ASPIRATIONS						
Lymph Node in neck	2050	30.35	30.65	30.96	31.27	31.58
Bladder	2107	49.87	50.37	50.88	51.39	51.90
Breast cyst	2108	37.41	37.79	38.16	38.54	38.93
Bursa	2109	33.35	33.69	34.02	34.36	34.71
Cisterna magna	2110	30.10	30.40	30.70	31.01	31.32
Duodenum	2111	50.05	50.55	51.06	51.57	52.08
Esophagus or stomach	2112	26.69	26.95	27.22	27.49	27.77
Hydrocele	2113	26.69	26.95	27.22	27.49	27.77
Joint	2114	43.65	44.08	44.53	44.97	45.42
Lumbar puncture	2115	124.70	125.94	127.20	128.47	129.76
Therapeutic Pericardiocentesis	2116	199.52	201.51	203.53	205.56	207.62
Subdural (tap)	2117	39.57	39.96	40.36	40.77	41.17
Subdural puncture(each additional tap)	2118	13.08	13.21	13.34	13.48	13.61
Thyroid cyst	2119	37.41	37.79	38.16	38.54	38.93
AUDIOMETRIC TESTS - See Otolaryngology						
AUTOPSY - non-coroner's autopsy on evenings and weekends	1900	1,558.70	1,574.29	1,590.03	1,605.93	1,621.99
BIOPSIES - See Needle Biopsies						
Breast Excisional Biopsy	3073	193.01	194.94	196.89	198.85	200.84
BLOOD TRANSFUSION						
Indirect Transfusions	2123	26.42	26.69	26.95	27.22	27.49

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CARDIAC PROCEDURES						
Cardioversion only (one procedure to be billed per session)	2124	140.10	141.50	142.91	144.34	145.78
Selective percutaneous aortography - see Diagnostic Imaging						
Catheterization						
-Catheterization of heart-right	2126	197.81	199.79	201.79	203.81	205.85
-Hepatic wedge pressure	2127	131.84	133.15	134.48	135.83	137.19
-Catheterization of heart-left	2128	263.78	266.42	269.08	271.77	274.49
Left ventricular puncture	2129	131.84	133.15	134.48	135.83	137.19
Phonocardiogram - Supervision and interpretation	2217	39.57	39.96	40.36	40.77	41.17
CERTIFICATION						
of patient to mental health or addictions facility	2800	53.37	53.91	54.44	54.99	55.54
CHEMOTHERAPY						
Administration of chemotherapy						
(includes Diagnostic/Therapeutic aspiration)	2215	74.82	75.57	76.33	77.09	77.86
IV administration of chemotherapy agent - per injection	2174	26.69	26.95	27.22	27.49	27.77
Additional injections of chemotherapy at time of init. injection	2264	13.15	13.28	13.41	13.54	13.68
Administration of chemotherapy into an Omaya Reservoir	2550	48.58	49.06	49.55	50.05	50.55
Intrathecal chemotherapy						
(including diagnostic lumbar puncture)	2551	162.11	163.73	165.37	167.02	168.69
Administration of sclerosing material via chest tube	2552	66.72	67.38	68.06	68.74	69.42
DIALYSIS for Renal Failure - See Preamble 21.H						
Acute Dialysis - first treatment	2055	729.48	736.77	744.14	751.58	759.10
Acute Dialysis - subsequent treatment (up to 2)	2056	335.18	338.53	341.92	345.34	348.79
Chronic Dialysis - first treatment	2135	227.95	230.23	232.53	234.86	237.21
Chronic Dialysis - subsequent treatment - **See Preamble 21.H**	2137	92.28	93.20	94.13	95.08	96.03
Satellite Dialysis Management (per patient per week)	2058	49.87	50.37	50.88	51.39	51.90
Insertion of permanent peritoneal dialysis catheter						
(open or laparoscopic)	2132	373.32	377.05	380.82	384.63	388.48
Removal of permanent peritoneal dialysis catheter						
(open or laparoscopic)	2133	325.11	328.36	331.64	334.96	338.31
Dialysis catheter - tunneling and insertion	2038	187.04	188.91	190.80	192.71	194.64
Dialysis catheter - removal and/or replacement	2039	249.39	251.89	254.40	256.95	259.52
DIAGNOSTIC IMAGING PROCEDURES						
Cystogram	2700	42.85	43.27	43.71	44.14	44.58
Arthrogram	2701	42.85	43.27	43.71	44.14	44.58
Bronchogram	2702	57.04	57.61	58.18	58.76	59.35
Sialogram	2705	57.04	57.61	58.18	58.76	59.35
Hysterosalpingogram	2706	85.69	86.55	87.41	88.29	89.17
Percutaneous transhepatic cholangiogram	2708	100.01	101.01	102.02	103.04	104.07
Lymphogram	2709	142.80	144.23	145.67	147.13	148.60
Myelogram - Lumbar	2172	91.18	92.09	93.01	93.94	94.88
DRESSING CHANGE	2010	23.98	24.22	24.46	24.71	24.95

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ECHOCARDIOGRAPHY - See Preamble 21.J						
Note: Payment for interpretation of echocardiograms made only to those physicians so qualified.						
Transthoracic Echocardiogram (TTE) - complete	8781	246.81	249.28	251.77	254.29	256.83
Transthoracic Echocardiogram (TTE) - limited	8782	99.00	99.99	100.99	102.00	103.02
Transesophageal Echocardiogram (TEE) - complete	8783	323.81	327.05	330.32	333.62	336.95
Transesophageal Echocardiogram (TEE) - limited	8784	176.00	177.76	179.54	181.33	183.15
Stress Echocardiogram - complete	8785	359.41	363.01	366.64	370.30	374.01
Stress Echocardiogram - limited	8786	211.61	213.72	215.86	218.02	220.20
Echocardiogram contrast injection (add-on)	8787	26.69	26.95	27.22	27.49	27.77
ED AND CRITICAL CARE ULTRASOUND - See Preamble 21.E	2900	37.41	37.79	38.16	38.54	38.93
ELECTROCARDIOGRAM (ECG) & OTHER CARDIOLOGY STUDIES						
Note: Payment for interpretation of electrocardiograms made only to those physicians so qualified.						
ECG - Technical Component only	2257	13.34	13.48	13.61	13.75	13.88
ECG - procedure with interpretation in office	2142	26.69	26.95	27.22	27.49	27.77
ECG - procedure with interpretation in home	2143	33.42	33.75	34.09	34.43	34.77
ECG - Interpretation only	2145	14.08	14.22	14.36	14.51	14.65
Holter Monitoring	2144	67.56	68.24	68.92	69.61	70.31
Loop Event Recorder interpretation	4780	28.16	28.44	28.73	29.01	29.30
Stress Test	0599	112.61	113.73	114.87	116.02	117.18
Myocardial Perfusion (MIBI) Stress Test (exercise or pharmacologic) (includes all injections, IV's, interpretation)	4754	140.77	142.17	143.60	145.03	146.48
Exercise tests						
(The following fees refer to the professional component only)						
1. Simple progressive exercise tests at several workloads, with measurements of heart rate by ECG and of ventilation	2249	31.61	31.93	32.25	32.57	32.90
2. Exercise in a steady state at two or more work loads with measurements of heart rate by ECG, ventilation, VO, VCO, end tidal and mixed venous PCO2	2250	65.84	66.49	67.16	67.83	68.51
3. As above with calculation of cardiac output by respiratory gas technique	2251	105.40	106.46	107.52	108.60	109.68
ELECTROCONVULSIVE THERAPY (ECT)	2151	93.52	94.46	95.40	96.36	97.32
ELECTROENCEPHALOGRAM (EEG)						
EEG Interpretation only	2146	47.12	47.60	48.07	48.55	49.04
Insertion of sub-temporal needles (add)	2147	26.42	26.69	26.95	27.22	27.49
With activating Drugs, e.g., Metrazule (add)	2148	26.42	26.69	26.95	27.22	27.49
Sleep EEG Interpretation only	2125	84.71	85.56	86.41	87.28	88.15
EMG & OTHER NEUROMUSCULAR STUDIES See Preamble 21.G						
Electromyography (major) - examination of muscles of more than one region	2149	112.22	113.34	114.48	115.62	116.78
Electromyography (minor) - examination of muscles of a specific limb or region	2150	74.82	75.57	76.33	77.09	77.86
Nerve Conduction Studies, per nerve studied (maximum 6 nerves)	2140	38.06	38.44	38.83	39.21	39.61
Nerve entrapment evaluation (composite fee)	2166	106.73	107.80	108.88	109.97	111.07
Tensilon test	2269	28.36	28.64	28.93	29.22	29.51

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ENDOCRINOLOGY AND METABOLISM						
ACTH Stimulation Test	2248	54.45	54.99	55.54	56.10	56.66
Insulin Hypoglycemia for Pituitary Function	2152	75.99	76.75	77.52	78.29	79.07
TRH Test	2153	37.96	38.34	38.72	39.11	39.50
GNRH (LHRH) Tests	2154	37.96	38.34	38.72	39.11	39.50
Combined calcium and pentagastrin	2155	91.20	92.11	93.03	93.96	94.90
Calcium or pentagastrin alone	2156	60.78	61.38	62.00	62.62	63.24
GASTROENTEROLOGY PROCEDURES						
Ambulatory 24-hour Esophageal pH Monitoring	2309	41.11	41.52	41.93	42.35	42.78
Esophageal HCL drip test	2157	39.57	39.96	40.36	40.77	41.17
Esophageal Motility studies	2158	92.14	93.06	93.99	94.93	95.88
Esophageal variceal banding (includes esophagoscopy)	5166	343.31	346.74	350.21	353.71	357.25
Achalasia Botox injection	2167	80.06	80.86	81.67	82.48	83.31
Gastro-esophageal tamponade	2159	74.82	75.57	76.33	77.09	77.86
Gastric lavage - diagnostic and emergency	2162	33.35	33.69	34.02	34.36	34.71
Gastroscopy - Diagnostic, biopsy, removal of foreign body	5218	237.93	240.31	242.71	245.14	247.59
- subsequent - within 45 days of initial procedure	5219	94.01	94.95	95.90	96.85	97.82
(IC for full fee may be given under exceptional circumstances)						
Peritoneal lavage	2255	100.07	101.07	102.08	103.10	104.13
Balloon stricture dilation (incl. gastro/sigmoido/colonoscopy)	2237	329.56	332.86	336.18	339.55	342.94
Repeat balloon stricture dilation within 30 days						
- with gastroscopy	2370	259.75	262.35	264.98	267.62	270.30
- with sigmoidoscopy	2371	198.14	200.12	202.13	204.15	206.19
- with colonoscopy of descending colon	2372	198.14	200.12	202.13	204.15	206.19
- with colonoscopy of descending & transverse colon	2373	231.51	233.82	236.16	238.52	240.91
- with colonoscopy of complete colon	2374	264.86	267.51	270.18	272.88	275.61
Fractional test - meal (samples and analysis)	2163	39.57	39.96	40.36	40.77	41.17
Proctoscopic exam	2007	24.94	25.19	25.44	25.69	25.95
Sigmoidoscopy - Rigid (with or without biopsy)	2235	62.35	62.97	63.60	64.24	64.88
Sigmoidoscopy - Flexible (with or without biopsy)	2242	106.00	107.06	108.13	109.21	110.30
Colonoscopy - descending colon (with or without biopsy)	2310	124.70	125.94	127.20	128.47	129.76
Colonoscopy - descending & transverse colon						
(with or without biopsy)	2320	199.52	201.51	203.53	205.56	207.62
Colonoscopy - complete colon (with or without biopsy)	2260	264.00	266.64	269.31	272.00	274.72
Removal of polyp under colonoscopic examination - first polyp	2360	126.50	127.77	129.04	130.33	131.64
- each of the next 4 polyps	2361	44.00	44.44	44.88	45.33	45.79
- each polyp after 5 polyps	2362	22.00	22.22	22.44	22.67	22.89
Dysplasia screening in inflam. bowel dis.						
(≥ 28 biopsies, 4 quadrants, q10cm)	2311	61.89	62.50	63.13	63.76	64.40
Endosopic Mucosal Resection (EMR) polyps ≥ 2 cm requiring						
piecemeal rsxn	2312	192.50	194.43	196.37	198.33	200.32
Endoluminal Stent - esophageal	2313	198.00	199.98	201.98	204.00	206.04
- gastroduodenal	2314	198.00	199.98	201.98	204.00	206.04
- colonic	2316	198.00	199.98	201.98	204.00	206.04
Endosopic removal of foreign body in GI tract	2317	80.08	80.88	81.69	82.51	83.33
Terminal Ileal Intubation						
(not for routine screening of asymptomatic patients)	2318	40.54	40.94	41.35	41.76	42.18
Ileoscopy	2315	124.70	125.94	127.20	128.47	129.76
Removal of rectal foreign body	2021	106.00	107.06	108.13	109.21	110.30
Argon Coagulation of stomach or rectum						
- single or multiple (add-on fee)	2022	100.07	101.07	102.08	103.10	104.13

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GYNECOLOGIC TESTS & PROCEDURES						
Pelvic Examination Only	2001	9.98	10.08	10.18	10.28	10.38
Pap Smear or HPV testing with/without Pelvic examination	2008	17.46	17.63	17.81	17.99	18.17
Pap Screening Clinic	2018	0.00	0.00	0.00	0.00	0.00
Cryotherapy of cervix	2131	55.39	55.94	56.50	57.06	57.63
Fitting of diaphragm	6936	44.23	44.67	45.12	45.57	46.03
Vaginal Pessary - initial fitting	2605	86.46	87.32	88.20	89.08	89.97
Insertion of Pessary (paid as Visit Fee only)						
Vaginal Insufflation (paid as Visit Fee only)						
IMMUNIZATION REPORTING - See Preamble 21.D.3						
Immunization - Influenza (reporting only)	0081	0.00	0.00	0.00	0.00	0.00
Immunization - Pneumococcal (reporting only)	0082	0.00	0.00	0.00	0.00	0.00
Immunization - Tetanus/Pertussis (reporting only)	0083	0.00	0.00	0.00	0.00	0.00
Immunization - Hepatitis A/B (reporting only)	0084	0.00	0.00	0.00	0.00	0.00
Immunization - Varicella zoster (reporting only)	0085	0.00	0.00	0.00	0.00	0.00
INJECTIONS						
Injection - IM, SC, immunization (one or more)	2009	12.47	12.60	12.72	12.85	12.98
Hyposensitization/Allergy shot	2102	12.47	12.60	12.72	12.85	12.98
B.C.G. Vaccination, including necessary Tuberculin tests	2122	13.08	13.21	13.34	13.48	13.61
Vaccination with certificate	2243	21.34	21.55	21.77	21.99	22.21
Injection - IV	2165	18.70	18.89	19.08	19.27	19.46
Injection of medication - e.g., bursa, joint	2168	35.97	36.33	36.69	37.06	37.43
Injection of hemorrhoids, initial	2169	26.69	26.95	27.22	27.49	27.77
Injection of hemorrhoids, subsequent	2170	20.08	20.28	20.48	20.68	20.89
Injection for pruritus ani	2171	26.69	26.95	27.22	27.49	27.77
Injection - Ages 0 to 4 only - by cut down	2252	66.72	67.38	68.06	68.74	69.42
Injection - Ages 0 to 4 only - by scalp vein	2253	33.35	33.69	34.02	34.36	34.71
IV Iron infusion - total care	2410	66.72	67.38	68.06	68.74	69.42
Cryoprecipitate - includes preparation and administration	2015	27.03	27.30	27.57	27.85	28.12
Intrathecal Epi-morph Injection	2307	76.73	77.49	78.27	79.05	79.84
Intravenous Pyelogram - after hours in Emergency Dept	2265	46.71	47.17	47.64	48.12	48.60
Injection of medication into chest/abdominal cavities -see Paracentesis						
MORBID OBESITY PREMIUMS						
Morbid Obesity Premium (Surgery) - **See Preamble 14.E.10**	0074	119.90	121.10	122.31	123.53	124.77
Morbid Obesity Premium (Anesthesia) - **See Preamble 18.G**	0075	119.90	121.10	122.31	123.53	124.77
NEEDLE BIOPSY PROCEDURES						
Bone Marrow	2175	124.70	125.94	127.20	128.47	129.76
Kidney	2176	92.14	93.06	93.99	94.93	95.88
Liver	2177	100.07	101.07	102.08	103.10	104.13
Lung	2263	93.40	94.34	95.28	96.23	97.19
Lung - transbronchial	2268	155.03	156.58	158.15	159.73	161.33
Pleura	2178	52.91	53.44	53.97	54.51	55.06
Pericardium	2181	197.81	199.79	201.79	203.81	205.85
Prostate	2182	104.31	105.36	106.41	107.47	108.55
Synovial Tissue	2180	65.84	66.49	67.16	67.83	68.51
Thyroid	2259	62.35	62.97	63.60	64.24	64.88

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NERVE BLOCKS and OTHER PAIN INJECTIONS						
See Preamble 21.I						
Somatic or peripheral nerve not specifically listed:						
- single	2183	49.87	50.37	50.88	51.39	51.90
- each additional (to max. of 4)	2184	24.94	25.19	25.44	25.69	25.95
Cervical plexus	2186	93.40	94.34	95.28	96.23	97.19
Brachial plexus	2189	80.06	80.86	81.67	82.48	83.31
Supraorbital branch of Ophthalmic Nerve (Trigeminal)	2450	80.06	80.86	81.67	82.48	83.31
Infraorbital branch of Maxillary Nerve (Trigeminal)	2188	80.06	80.86	81.67	82.48	83.31
Mental branch of Mandibular Nerve (Trigeminal)	2187	80.06	80.86	81.67	82.48	83.31
Maxillary or Mandibular division of Trigeminal Nerve	2206	93.40	94.34	95.28	96.23	97.19
Therapeutic Seventh Cranial nerve block - unilateral	2304	56.05	56.61	57.17	57.74	58.32
Therapeutic Seventh Cranial nerve block - bilateral	2305	84.12	84.96	85.81	86.67	87.53
Other Cranial Nerve	2451	80.06	80.86	81.67	82.48	83.31
Occipital Nerve	2100	49.87	50.37	50.88	51.39	51.90
Transverse Scapular Nerve	2452	80.06	80.86	81.67	82.48	83.31
Intercostal Nerve - single	2453	49.87	50.37	50.88	51.39	51.90
Intercostal Nerve - each additional (to max. of 4)	2454	24.94	25.19	25.44	25.69	25.95
Paravertebral Nerve - single	2210	93.40	94.34	95.28	96.23	97.19
Paravertebral Nerve - single - injection for chronic pain	2470	49.87	50.37	50.88	51.39	51.90
Paravertebral Nerve - each additional (to max. of 4)	2211	46.71	47.17	47.64	48.12	48.60
Paravertebral Nerve - each additional (to max. of 4) - injection for chronic pain	2471	24.94	25.19	25.44	25.69	25.95
Ilioinguinal and/or Iliohypogastric Nerves	2455	80.06	80.86	81.67	82.48	83.31
Sciatic Nerve	2192	80.06	80.86	81.67	82.48	83.31
Sciatic Nerve - injection for chronic pain	2472	49.87	50.37	50.88	51.39	51.90
Femoral Nerve	2456	80.06	80.86	81.67	82.48	83.31
Obturator Nerve	2193	80.06	80.86	81.67	82.48	83.31
Pudendal Nerve	2194	80.06	80.86	81.67	82.48	83.31
Lateral Femoral Cutaneous Nerve	2204	87.29	88.16	89.04	89.93	90.83
Combined 3-in-1 block (femoral, obturator, lateral femoral cutaneous)	2457	106.73	107.80	108.88	109.97	111.07
Fascia Iliaca Compartment block	2458	80.06	80.86	81.67	82.48	83.31
Transversus Abdominis Plane (TAP) block - unilateral	2459	40.02	40.42	40.82	41.23	41.64
Transversus Abdominis Plane (TAP) block - bilateral	2460	66.06	66.72	67.38	68.06	68.74
Nerve block with fluoroscopic guidance (add on)	2461	56.11	56.67	57.24	57.81	58.39
Nerve block with ultrasound guidance (add on)	2462	37.41	37.79	38.16	38.54	38.93
Nerve block with alcohol or other sclerosing agent - add 50% (with comment)						
Vertebral Facet Joint injections						
with fluoroscopic guidance						
- single	2533	122.83	124.05	125.29	126.55	127.81
- each additional, up to 6	2463	79.84	80.64	81.44	82.26	83.08
with ultrasound guidance						
- single	2464	104.13	105.17	106.22	107.28	108.35
- each additional, up to 6	2465	67.68	68.36	69.04	69.73	70.43
Sacroiliac Joint injection with fluoroscopic guidance						
- unilateral	2466	122.83	124.05	125.29	126.55	127.81
- bilateral	2467	202.66	204.69	206.74	208.80	210.89
Sacroiliac Joint injection with ultrasound guidance						
- unilateral	2476	104.13	105.17	106.22	107.28	108.35
- bilateral	2477	171.81	173.53	175.26	177.01	178.78
Diagnostic nerve root block with fluoroscopic guidance (any number of sites)	2468	213.48	215.61	217.77	219.95	222.15

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Epidural injections						
Cervical epidural injection with fluoroscopic guidance	2531	213.48	215.61	217.77	219.95	222.15
Thoracic epidural injection with fluoroscopic guidance	2532	213.48	215.61	217.77	219.95	222.15
Lumbar epidural injection with fluoroscopic guidance	2524	213.48	215.61	217.77	219.95	222.15
Caudal epidural injection	2191	86.72	87.59	88.47	89.35	90.25
Epidural - single injection	2196	106.73	107.80	108.88	109.97	111.07
Subarachnoid (diagnostic spinal)	2195	93.40	94.34	95.28	96.23	97.19
Sympathetic Nerve injections						
Cervical sympathetic or Stellate ganglion block	2199	133.43	134.76	136.11	137.47	138.85
- with U/S or fluoroscopic guidance	2208	200.13	202.14	204.16	206.20	208.26
Thoracic, Lumbar, Sacral sympathetic block						
- with fluoroscopic guidance	2205	200.13	202.14	204.16	206.20	208.26
Lumbar sympathetic nerve block	2185	113.41	114.54	115.69	116.85	118.01
Ganglion/Plexus injections						
Presacral (superior hypogastric plexus) block	2190	80.06	80.86	81.67	82.48	83.31
Celiac, splanchnic, hypogastric ganglion/plexus block						
- with fluoroscopic guidance	2197	200.13	202.14	204.16	206.20	208.26
Trigeminal (Gasserian) ganglion block	2198	133.43	134.76	136.11	137.47	138.85
- with fluoroscopic guidance	2202	200.13	202.14	204.16	206.20	208.26
Spheno-palatine ganglion block with fluoroscopic guidance	2207	200.13	202.14	204.16	206.20	208.26
Superior Laryngeal Nerve with fluoroscopic guidance	2209	200.13	202.14	204.16	206.20	208.26
IV Guanethidine/Bier Block	2530	133.43	134.76	136.11	137.47	138.85
Trigger point injection (myoneural pain block)						
- with local anesthetic (one or more)	2101	26.69	26.95	27.22	27.49	27.77
OBSTETRIC TESTS & PROCEDURES						
Ultrasound procedures by Obstetrician	2606	76.05	76.81	77.58	78.36	79.14
Insertion of Intrauterine Pressure Catheter (IUPC)	2601	63.38	64.02	64.66	65.30	65.96
Oxytocin Challenge Test	2602	40.02	40.42	40.82	41.23	41.64
Scalp pH Sampling (maximum of 2)	2603	82.72	83.55	84.38	85.23	86.08
Biophysical Profile	2604	76.05	76.81	77.58	78.36	79.14
OPHTHALMIC TESTS						
Annual Diabetic Retinopathy Photographic Screening	2308	14.01	14.15	14.30	14.44	14.58
Anterior stromal puncture corneal erosion	2303	71.17	71.88	72.60	73.33	74.06
Intravitreol Injection of Eye	2306	245.99	248.45	250.94	253.45	255.98
Visual Fields with a Goldman perimeter	2258	50.90	51.41	51.92	52.44	52.96
Visual Field interpretation	2408	20.01	20.21	20.41	20.62	20.82
Ultrasound - procedure only	8887	50.57	51.07	51.58	52.10	52.62
Ultrasound - interpretation	8889	27.62	27.90	28.18	28.46	28.74
Fluorescein / Digital Angiography	7510	76.11	76.87	77.64	78.42	79.20
Optical Coherence Tomography (OCT)						
- composite fee (max. 4/year)	2414	76.11	76.87	77.64	78.42	79.20
Optical Coherence Tomography (OCT)						
- technical fee (max. 4/year)	2417	56.10	56.66	57.23	57.80	58.38
Optical Coherence Tomography (OCT)						
- professional fee (max. 4/year)	2415	20.01	20.21	20.41	20.62	20.82
Heidelberg Retina Tomography (HRT)						
- nonscreening (max.4/year)	2413	37.41	37.79	38.16	38.54	38.93
Pachymetry - one or both eyes (only once per patient lifetime)	2412	14.96	15.11	15.26	15.41	15.57
IOL Master / Ocular Biometry - procedure only	2420	50.57	51.07	51.58	52.10	52.62
IOL Master / Ocular Biometry - interpretation	2421	27.62	27.90	28.18	28.46	28.74
Injection for Blepharospasm						
- unilateral (max. 5/year)	2319	56.05	56.61	57.17	57.74	58.32
- bilateral (max. 5/year)	2329	84.12	84.96	85.81	86.67	87.53

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OTOLARYNGOLOGY TESTS & PROCEDURES						
Impedance audiometry	1095	28.33	28.61	28.89	29.18	29.48
Complete hearing test (incl.audiometry, tuning fork, speech test)	2540	49.85	50.35	50.85	51.36	51.88
Cerumen removal (unilateral or bilateral)	2000	14.96	15.11	15.26	15.41	15.57
Microdebridement in office	1099	34.16	34.50	34.84	35.19	35.54
Vestibular function tests	2541	28.75	29.04	29.33	29.63	29.92
Modified Sleep study	2549	53.37	53.91	54.44	54.99	55.54
Emergency Cricothyrotomy	2901	266.85	269.52	272.21	274.93	277.68
Intratympanic injection	2545	75.90	76.66	77.43	78.20	78.98
Change of Tracheostomy Tube (paid as Visit Fee only)						
PARACENTESIS (Thoracic or Abdominal)						
Diagnostic aspiration	2213	62.35	62.97	63.60	64.24	64.88
Therapeutic aspiration (including diagnostic sample)	2214	81.05	81.86	82.68	83.50	84.34
PROCEDURAL SEDATION (Emergency)	2011	75.00	75.75	76.51	77.27	78.05
PULMONARY FUNCTION STUDIES						
1. Evaluation and interpretation of results of complete pulmonary function study (i.e., ventilation, lung volumes, and pulmonary diffusing capacity) with or without other studies	2218	66.72	67.38	68.06	68.74	69.42
2. Evaluation and Interpretation of:						
(a) Maximum breathing capacity or peak flow study	2219	14.34	14.49	14.63	14.78	14.93
(b) Pulmonary diffusion capacity	2220	26.42	26.69	26.95	27.22	27.49
(c) Pulmonary pressure tracings only	2222	14.34	14.49	14.63	14.78	14.93
(d) Lung volume determination	2223	28.08	28.36	28.65	28.93	29.22
(e) Vital capacity and timed unit capacity	2247	14.34	14.49	14.63	14.78	14.93
Methacholine challenge	2245	90.07	90.97	91.88	92.80	93.73
RHEUMATOLOGY AND PHYSICAL MEDICINE						
Uric acid crystals	2233	7.94	8.02	8.10	8.18	8.26
Mucin clot	2234	2.67	2.70	2.73	2.75	2.78
STERILITY INVESTIGATION						
Male, sperm cell count and morphology	2236	13.08	13.21	13.34	13.48	13.61
Female - see Gynecology						
SWEAT TEST	2261	42.44	42.86	43.29	43.72	44.16
VENIPUNCTURE						
Venipuncture - infant or child under 6 years	2239	26.69	26.95	27.22	27.49	27.77
Venipuncture - adult or child 6 years or older	2238	13.19	13.32	13.45	13.59	13.72
Venipuncture - femoral vein puncture	2240	26.69	26.95	27.22	27.49	27.77
Venipuncture - jugular vein puncture	2241	26.69	26.95	27.22	27.49	27.77
IV Start on Pediatric patient (under 6 years)	2232	53.37	53.91	54.44	54.99	55.54
Central I.V. Line Insertion	2254	149.63	151.13	152.64	154.17	155.71
Central Venous Pressure - placement of catheter	2244	66.72	67.38	68.06	68.74	69.42
Swan-Ganz Catheter	2262	213.48	215.61	217.77	219.95	222.15
Therapeutic phlebotomy	2266	26.42	26.69	26.95	27.22	27.49
Umbilical vessel catheterization	2256	96.13	97.09	98.06	99.04	100.03
Arterial puncture for blood gases	2400	26.69	26.95	27.22	27.49	27.77
Arterial cannulation (Arterial Line insertion)	4599	74.04	74.78	75.53	76.28	77.05

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UROLOGICAL TESTS & PROCEDURES						
Cystometrogram	2246	40.02	40.42	40.82	41.23	41.64
Urodynamic Studies:						
- Urine Flow rate determination	2267	16.01	16.17	16.33	16.49	16.65
- Urethral pressure profile or leak pressure test	2276	26.69	26.95	27.22	27.49	27.77
- Electromyography	2278	26.69	26.95	27.22	27.49	27.77
- Pressure flow study	2284	26.69	26.95	27.22	27.49	27.77
- Videourodynamic assessment	2290	26.69	26.95	27.22	27.49	27.77
Periurethral collagen injection	2292	200.13	202.14	204.16	206.20	208.26
Intravenous Pyelogram - after hours in Emergency Dept	2265	46.71	47.17	47.64	48.12	48.60
Prostatic massage (paid as Visit Fee only)						
Insertion of urinary catheter (transurethral)	2902	43.65	44.08	44.53	44.97	45.42
Aspiration of corpus cavernosum for priapism	2903	80.06	80.86	81.67	82.48	83.31
Reduction of paraphimosis, including dorsal slit	2904	66.72	67.38	68.06	68.74	69.42
VASCULAR LAB DIAGNOSTIC PROCEDURES						
Extracranial cerebrovascular assessment						
Bilateral carotid and/or subclavian and/or vertebral arteries						
Doppler scan or B scan - technical component	2270	54.24	54.78	55.33	55.88	56.44
- professional component	2271	30.49	30.80	31.10	31.42	31.73
Frequency analysis - technical component	2272	54.24	54.78	55.33	55.88	56.44
- professional component	2273	30.49	30.80	31.10	31.42	31.73
Frequency analysis plus scan - technical component	2274	81.44	82.26	83.08	83.91	84.75
- professional component	2275	45.83	46.28	46.75	47.21	47.69
Peripheral arterial evaluation						
(not to be billed routinely w/ above cerebrovascular assess.)						
Doppler scan or B scan	2277	20.48	20.69	20.89	21.10	21.31
Frequency analysis	2279	16.94	17.11	17.28	17.45	17.63
Frequency analysis plus scan - technical component	2280	39.03	39.42	39.81	40.21	40.61
- professional component	2281	32.15	32.47	32.80	33.13	33.46
Venous assessment						
Bilateral femoral, popliteal, post/ant tibial veins						
- technical component	2282	8.54	8.62	8.71	8.79	8.88
- professional component	2283	13.61	13.74	13.88	14.02	14.16
(not chargeable during surgery or during post-op stay in hospital)						
Ankle pressure determination - professional component	2285	11.14	11.25	11.37	11.48	11.60
(not chargeable during surgery or during post-op stay in hospital)						
Ankle pressure measurements w/ segmental pressure +/-						
Doppler recordings - technical component	2286	25.61	25.86	26.12	26.38	26.65
- professional component	2287	30.49	30.80	31.10	31.42	31.73
Ankle pressure measurements with exercise or tourniquet hyperemia						
induced velocity changes, added to the above						
- technical component	2288	9.41	9.50	9.59	9.69	9.79
- professional component	2289	14.48	14.62	14.77	14.91	15.06
Penile pressure recordings - two or more pressures						
- professional component	2291	10.14	10.24	10.35	10.45	10.55
Strain gauge plethysmography						
(venous capacitance and venous outflow) - prof	2293	7.60	7.68	7.75	7.83	7.91

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Venous assessment (cont.)						
Periorbital studies for reversed flow in carotid system by Doppler or by photo plethysmography - technical component	2294	16.94	17.11	17.28	17.45	17.63
- professional component	2295	18.62	18.81	19.00	19.19	19.38
Venous Refilling Time - technical component	2296	15.41	15.57	15.72	15.88	16.04
- professional component	2297	7.60	7.68	7.75	7.83	7.91
*Professional and technical components are only payable when qualified physicians provide both components						
OFFICE VASCULAR DIAGNOSTIC PROCEDURES						
Ultrasound assessment of cerebral circulation with segmental pressures and analysis of wave forms - composite fee (technical and professional components)	2300	59.30	59.89	60.49	61.10	61.71
Ultrasound assessment of cerebral circulation plus periorbital flow studies - composite fee. (technical and professional components)	2301	59.30	59.89	60.49	61.10	61.71

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OPERATIONS ON THE INTEGUMENTARY SYSTEM						
These fees cannot be correctly interpreted without reference to the Preamble.						
SKIN AND SUBCUTANEOUS TISSUE						
Incision						
Abscess						
Subcutaneous boil, infected cyst, superficial lymphadenitis, paronychia, felon, etc.						
- Local anesthetic	3000	46.21	46.67	47.14	47.61	48.09
- General anesthetic	3001	57.04	57.61	58.18	58.76	59.35
Carbuncle - neck, complete care	3002	114.15	115.29	116.44	117.61	118.78
- Perianal or pilonidal - local anesthetic	3003	71.19	71.90	72.62	73.35	74.08
- general anesthetic, complete care	3004	85.69	86.55	87.41	88.29	89.17
- Ischio-rectal - simple incision - local anesthetic	3005	71.19	71.90	72.62	73.35	74.08
- unroofing - complete care	3006	171.31	173.03	174.76	176.50	178.27
Palmar and plantar space infections, tenosynovitis - general or regional - complete care	3007	171.31	173.03	174.76	176.50	178.27
Hematoma - local anesthetic	3008	46.21	46.67	47.14	47.61	48.09
- general anesthetic (depending on size, complicating factors)	3009	57.04	57.61	58.18	58.76	59.35
Tongue-tie release - infant (paid as Visit Fee only)						
- child - local anesthetic	3010	17.50	17.68	17.85	18.03	18.21
- general anesthetic	3011	57.04	57.61	58.18	58.76	59.35
Removal of foreign body or fibroma - local anesthetic	3012	59.32	59.92	60.52	61.12	61.73
- general anesthetic	3013	I.C.	I.C.	I.C.	I.C.	I.C.
Note: Pre and Post-operative care for the above at visit fees unless otherwise specified.						
Excision						
*Excision Biopsy	3030	59.32	59.92	60.52	61.12	61.73
Carcinoma of skin, excision - simple	3031	100.01	101.01	102.02	103.04	104.07
- complicated, depending on site, etc.	3032	I.C.	I.C.	I.C.	I.C.	I.C.
*Pilonidal Cyst - simple excision or marsupialisation	3033	271.74	274.46	277.21	279.98	282.78
*Sebaceous Cyst - face or neck	3034	118.66	119.84	121.04	122.25	123.47
- other areas	3035	88.99	89.88	90.78	91.69	92.60
Fingernail or Toenail Removal - Simple	3036	88.99	89.88	90.78	91.69	92.60
Resection of portion of nail, nail bed and matrix	3037	88.99	89.88	90.78	91.69	92.60
Radical removal of nail (includes destruction of nail bed, shortening of phalanx if necessary)	3038	177.98	179.76	181.56	183.37	185.21
*Note: Pre and Post-operative care for the above at visit fees unless otherwise specified.						
Lipoma - simple removal, local anesthetic	3039	88.99	89.88	90.78	91.69	92.60
- complicated, large or involving deeper structures	3040	I.C.	I.C.	I.C.	I.C.	I.C.
Neuroma - simple, subcutaneous, local anesthetic	3041	57.04	57.61	58.18	58.76	59.35
Warts, incl. papillomatosis, keratosis, nevi, moles, pyogenic granuloma - removal by use of medical methods (paid as Visit Fee only)						
Benign skin lesion - cryotherapy, initial visit (1 or more)	3042	32.68	33.01	33.34	33.67	34.01
- cryotherapy, subsequent visit (1 or more)	3043	14.39	14.53	14.68	14.82	14.97
Warts, including papillomata, keratosis, nevi, moles, pyogenic granuloma						
- curettage or electrocautery (1 or more)	3044	37.02	37.39	37.76	38.14	38.52
- simple excision (1 or more)	3045	40.73	41.14	41.55	41.97	42.39

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SKIN AND SUBCUTANEOUS TISSUE, Excision (cont.)						
Plantar warts						
- cryotherapy, curettage, or Electrocautery (1 or more)	3046	37.02	37.39	37.76	38.14	38.52
- surgical excision	3047	72.95	73.68	74.42	75.16	75.91
Introduction						
Insertion of hormone or contraceptive subcut. Implants (post-op visit fees allowed)	3049	60.92	61.53	62.14	62.76	63.39
Removal of hormone or contraceptive subcut. Implants (post-op visit fees allowed)	3019	97.42	98.39	99.37	100.37	101.37
Suture						
Simple wounds or lacerations	3050	88.99	89.88	90.78	91.69	92.60
Complicated, extensive lacerations	3051	I.C.	I.C.	I.C.	I.C.	I.C.
Repair						
Thermal burns - simple small burns, office dressing (paid as Visit Fee only)						
Extensive burns - requiring debridement, grafts, etc.	3052	I.C.	I.C.	I.C.	I.C.	I.C.
Skin Graft						
The fee would depend on the size and location of the area grafted and type of graft.						
Additional procedures other than skin grafting are extra						
- tendon grafts, inlay grafts,etc						
Local tissue shift advancement: rotation, transposition, Z-plasty,etc. will depend on the site and size.						
Small skin graft, with or w/o skin graft for secondary defect	3053	264.08	266.72	269.38	272.08	274.80
Eyebrow, eyelid, lip, ear, nose	3054	339.60	343.00	346.43	349.89	353.39
Large flap, i.e., for decubitus ulcer	3055	499.57	504.56	509.61	514.70	519.85
Flaps from a distance, direct, small, (e.g., cross finger flap) to incl.staging	3056	339.60	343.00	346.43	349.89	353.39
Flaps from a distance, direct, large, (e.g., cross leg flap)						
- initial stage	3057	611.40	617.52	623.69	629.93	636.23
further staging, per stage - 50% of						
- indirect - major stage per operation	3058	428.33	432.61	436.94	441.31	445.72
- minor stage per operation	3059	214.24	216.38	218.54	220.73	222.93
Longer stage with skin graft	3060	428.33	432.61	436.94	441.31	445.72
Delay of tube or pedicle	3061	100.01	101.01	102.02	103.04	104.07
Full thickness grafts						
Eyelid, nose, lips	3062	339.60	343.00	346.43	349.89	353.39
Fingertip	3063	142.80	144.23	145.67	147.13	148.60
Volar/palm	3064	214.24	216.38	218.54	220.73	222.93
Island graft	3065	571.13	576.84	582.61	588.44	594.32
Split thickness grafts						
- very small, very minor, e.g., trauma	3066	132.04	133.36	134.70	136.05	137.41
- minor to medium sized areas, e.g., varicose ulcer, breast	3067	214.24	216.38	218.54	220.73	222.93
- intermediate large area trunk, legs	3068	339.60	343.00	346.43	349.89	353.39
- major large areas extensive but thickness grafting	3069	499.57	504.56	509.61	514.70	519.85

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Destruction						
Surgical planing - face for acne, whole face **(Prior approval)**	3080	285.34	288.19	291.08	293.99	296.93
- single area, e.g., trauma scar **(Prior approval)**	3081	100.01	101.01	102.02	103.04	104.07
Sweat gland excision - axillary, inguinal, perineal (unilateral)	4915	283.88	286.72	289.58	292.48	295.40
- with skin graft(s) and/or rotation flap(s)	4916	415.92	420.08	424.28	428.52	432.81
MALIGNANT SKIN LESIONS (incl. biopsy of each lesion - 1 or more)						
Deep Cryotherapy						
Face or Neck						
- Single lesion	3087	96.13	97.09	98.06	99.04	100.03
- Two lesions	3088	157.99	159.57	161.17	162.78	164.41
- Three or more lesions	3089	300.52	303.53	306.56	309.63	312.72
Other Areas						
- Single lesion	3090	76.64	77.40	78.18	78.96	79.75
- Two lesions	3091	126.42	127.69	128.96	130.25	131.56
- Three or more lesions	3092	252.54	255.06	257.61	260.19	262.79

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OPERATIONS ON THE BREAST						
These fees cannot be correctly interpreted without reference to the Preamble.						
Incision						
Drainage of intramammary abscess, single or multiple (includes pre and post-operative care)	3070	121.79	123.01	124.24	125.48	126.74
- Repeat incision	3071	121.79	123.01	124.24	125.48	126.74
Aspiration of breast cyst	2108	37.41	37.79	38.16	38.54	38.93
Excision						
Mastectomy - simple	3074	420.31	424.51	428.76	433.05	437.38
- Lumpectomy	3086	347.96	351.44	354.96	358.51	362.09
- segmental with Axillary Dissection	3084	871.77	880.49	889.29	898.19	907.17
- radical or modified radical	3075	871.77	880.49	889.29	898.19	907.17
- radical with skin graft	3076	797.53	805.51	813.56	821.70	829.92
- male simple **(Prior approval required)**	3077	182.79	184.61	186.46	188.33	190.21
- partial or resection of duct papilloma for bleeding (incl. removal of fistula abscess/underlying aerolar tissue)	3078	182.79	184.61	186.46	188.33	190.21
Insertion of breast tissue expander	3093	270.68	273.38	276.12	278.88	281.67
Percutaneous inflation of tissue expanders (per visit)	3096	29.84	30.14	30.44	30.75	31.05
Removal of breast tissue expander - general anesthetic	3094	97.45	98.42	99.41	100.40	101.41
- local anesthetic	3095	48.72	49.21	49.70	50.20	50.70
Removal of breast tissue expander at time of subsequent surgery						
Mammoplasty						
- augmentation, by prosthesis-unilateral **(Prior approval)**	3072	346.14	349.60	353.09	356.63	360.19
- augmentation, by prosthesis-bilateral **(Prior approval)**	3083	571.13	576.84	582.61	588.44	594.32
- reduction – unilateral **(Prior approval required)**	3082	653.68	660.21	666.81	673.48	680.22
- reduction – bilateral **(Prior approval required)**	3048	1,078.56	1,089.35	1,100.24	1,111.24	1,122.35
Removal of breast prosthesis **(Prior approval required)**	3079	100.01	101.01	102.02	103.04	104.07
- with capsulotomy	3098	132.04	133.36	134.70	136.05	137.41
- with capsulectomy	3099	231.07	233.38	235.71	238.07	240.45
Needle Biopsy - Breast	3085	118.34	119.52	120.72	121.92	123.14
Sentinel node biopsy	4805	364.76	368.41	372.09	375.81	379.57
Tram Flap - first surgeon **(Prior approval required)**	3097	I.C.	I.C.	I.C.	I.C.	I.C.
- second surgeon	9999	I.C.	I.C.	I.C.	I.C.	I.C.

	Fee Code	1-Apr 2025	1-Apr 2027	1-Oct 2027	1-Apr 2028	1-Oct 2028
OPERATIONS ON THE MUSCULOSKELETAL SYSTEM						
These fees cannot be correctly interpreted without reference to the Preamble.						
APPLICATION OF CASTS - Not requiring an anesthetic and not associated with initial fractures or initial dislocations.						
Finger	3100	39.41	39.81	40.21	40.61	41.01
Arm or leg	3101	61.70	62.32	62.94	63.57	64.20
Shoulder spica	3102	71.30	72.02	72.74	73.46	74.20
Head and torso	3103	142.80	144.23	145.67	147.13	148.60
Body cast (torso)	3104	114.15	115.29	116.44	117.61	118.78
Hip spica, single	3105	100.01	101.01	102.02	103.04	104.07
Removal of plaster (not continuity of treatment)	3106	47.15	47.62	48.09	48.57	49.06
Unna boot	3107	28.46	28.74	29.03	29.32	29.61
APPLICATION OF CORRECTIVE SPLINTS - Arthritic & spastic deformities not associated with fractures or dislocations.						
Upper limb - hand and wrist	3108	42.85	43.27	43.71	44.14	44.58
- elbow	3109	42.85	43.27	43.71	44.14	44.58
- shoulder	3110	57.04	57.61	58.18	58.76	59.35
Lower limb - whole leg	3111	57.04	57.61	58.18	58.76	59.35
- below knee	3112	42.85	43.27	43.71	44.14	44.58
Neck	3113	42.85	43.27	43.71	44.14	44.58
INTRODUCTION						
Injection of medication into bursa, ganglion or joints **See 2168** (including preliminary aspiration - medications not included)						
BONES						
INCISION						
Incision for osteomyelitis						
Hand and foot - osteomyelitis						
Phalanx	3150	71.30	72.02	72.74	73.46	74.20
Metacarpal or metatarsal	3151	142.80	144.23	145.67	147.13	148.60
Carpus or tarsus	3152	142.80	144.23	145.67	147.13	148.60
Humerus - acute osteomyelitis						
Incision and drainage	3153	214.24	216.38	218.54	220.73	222.93
Saucerization	3154	356.84	360.41	364.01	367.65	371.33
Secondary closure	3155	214.24	216.38	218.54	220.73	222.93
Humerus - chronic osteomyelitis						
Sequestrectomy, simple	3156	214.24	216.38	218.54	220.73	222.93
Saucerization and bone chips where necessary	3157	428.33	432.61	436.94	441.31	445.72
Secondary closure	3158	214.24	216.38	218.54	220.73	222.93
Radius or ulna - acute osteomyelitis						
Incision and drainage	3159	214.24	216.38	218.54	220.73	222.93
Saucerization	3160	356.84	360.41	364.01	367.65	371.33
Secondary closure	3161	214.24	216.38	218.54	220.73	222.93
Radius or ulna - chronic osteomyelitis						
Sequestrectomy, simple	3162	214.24	216.38	218.54	220.73	222.93
Saucerization and bone chips where necessary	3163	428.33	432.61	436.94	441.31	445.72
Secondary closure	3164	214.24	216.38	218.54	220.73	222.93

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INCISION (cont.)						
Tibia - acute osteomyelitis						
Incision and drainage	3165	214.24	216.38	218.54	220.73	222.93
Tibia - chronic osteomyelitis						
Sequestrectomy, simple	3167	285.34	288.19	291.08	293.99	296.93
Saucerization and bone chips where necessary	3168	428.33	432.61	436.94	441.31	445.72
Secondary closure	3169	214.24	216.38	218.54	220.73	222.93
Femur - acute osteomyelitis						
Incision and drainage	3170	285.34	288.19	291.08	293.99	296.93
Saucerization	3171	499.57	504.56	509.61	514.70	519.85
Femur - chronic osteomyelitis						
Sequestrectomy, simple	3172	285.34	288.19	291.08	293.99	296.93
Saucerization and bone chips where necessary	3173	499.57	504.56	509.61	514.70	519.85
Secondary closure	3174	214.24	216.38	218.54	220.73	222.93
Pelvis - osteomyelitis						
Sequestrectomy, simple	3175	356.84	360.41	364.01	367.65	371.33
Other, depending on extent of operation	3176	I.C.	I.C.	I.C.	I.C.	I.C.
Vertebra - acute osteomyelitis						
Incision and drainage	3177	285.34	288.19	291.08	293.99	296.93
Saucerization and bone chips where necessary	3178	571.13	576.84	582.61	588.44	594.32
Secondary closure	3179	214.24	216.38	218.54	220.73	222.93
Vertebra - chronic osteomyelitis						
Sequestrectomy, simple	3180	285.34	288.19	291.08	293.99	296.93
Saucerization and/or bone graft	3181	499.57	504.56	509.61	514.70	519.85
Skull - osteomyelitis	3182	I.C.	I.C.	I.C.	I.C.	I.C.
Transection of Bone (Osteotomy)						
Phalanx, metacarpal, metatarsal	3183	214.24	216.38	218.54	220.73	222.93
Radius, ulna, fibula	3184	356.84	360.41	364.01	367.65	371.33
Humerus, tibia	3185	466.76	471.43	476.14	480.91	485.72
Femur, neck or shaft	3186	713.88	721.02	728.23	735.51	742.86
Spine	3187	I.C.	I.C.	I.C.	I.C.	I.C.
Incision for removal of bone plates, screws, and other appliances used for fixation because of complications						
- local anesthesia	3188	146.50	147.96	149.44	150.94	152.45
- general anesthesia	3189	233.90	236.24	238.61	240.99	243.40
EXCISION						
Bone Tumor, depending on site and extent	3190	I.C.	I.C.	I.C.	I.C.	I.C.
Bone Biopsy						
Vertebra - x-ray control	3191	285.34	288.19	291.08	293.99	296.93
- open	3192	407.61	411.68	415.80	419.96	424.16
Other - punch, simple	3193	142.80	144.23	145.67	147.13	148.60
- punch, x-ray control	3194	214.24	216.38	218.54	220.73	222.93
- open	3195	214.24	216.38	218.54	220.73	222.93
SKULL						
Maxilla, with or without exenteration of orbit and skin graft	3196	815.28	823.43	831.66	839.98	848.38
Mandible	3197	543.48	548.91	554.40	559.94	565.54

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EXCISION (cont.)						
UPPER EXTREMITY						
Carpal bone (1 or more)	3199	339.55	342.94	346.37	349.84	353.34
Radius - styloid	3200	285.34	288.19	291.08	293.99	296.93
- head	3201	285.34	288.19	291.08	293.99	296.93
- head with replacement	3202	428.33	432.61	436.94	441.31	445.72
Ulna - lower end	3203	271.74	274.46	277.21	279.98	282.78
- olecranon and fascial repair	3205	428.33	432.61	436.94	441.31	445.72
Humerus - head	3206	543.48	548.91	554.40	559.94	565.54
- head with replacement	3207	679.47	686.26	693.13	700.06	707.06
- exostosis	3208	271.74	274.46	277.21	279.98	282.78
- tumor - simple excision	3209	356.84	360.41	364.01	367.65	371.33
- excision and bone graft	3210	571.13	576.84	582.61	588.44	594.32
- excision resection and reconstruction	3211	I.C.	I.C.	I.C.	I.C.	I.C.
Acromion and/or outer end of clavicle	3212	285.34	288.19	291.08	293.99	296.93
LOWER EXTREMITY						
Foot bones - proximal phalanx	3213	214.24	216.38	218.54	220.73	222.93
- tumor of phalanx, excision and replacement	3214	339.60	343.00	346.43	349.89	353.39
- sesamoid	3215	271.74	274.46	277.21	279.98	282.78
- bunion - exostectomy only - unilateral	3216	248.96	251.45	253.97	256.51	259.07
- bilateral	3217	256.88	259.45	262.05	264.67	267.31
- Keller	3218	339.60	343.00	346.43	349.89	353.39
- scaphoid, accessory	3219	271.74	274.46	277.21	279.98	282.78
- tarsal bar	3220	339.60	343.00	346.43	349.89	353.39
- calcaneal spur, exostosis	3221	214.24	216.38	218.54	220.73	222.93
- os calcis or talus	3222	407.61	411.68	415.80	419.96	424.16
- metatarsal head	3223	214.24	216.38	218.54	220.73	222.93
- each additional	3224	71.30	72.02	72.74	73.46	74.20
Tibia - exostosis	3225	285.34	288.19	291.08	293.99	296.93
- tumor (see humerus)						
Patella - excision with reconstruction	3226	407.61	411.68	415.80	419.96	424.16
- excision with prosthesis	3227	571.13	576.84	582.61	588.44	594.32
Femur - exostosis	3228	285.34	288.19	291.08	293.99	296.93
- head and neck	3229	571.13	576.84	582.61	588.44	594.32
- tumor (see humerus)						
TRUNK						
Cervical rib - complete removal	3230	679.47	686.26	693.13	700.06	707.06
REPAIR, MANIPULATION AND RECONSTRUCTION						
Grafts of Bone - see fractures						
Lengthening of Bone						
Tibia	3232	679.47	686.26	693.13	700.06	707.06
Femur	3233	815.28	823.43	831.66	839.98	848.38
Shortening of Bone						
Femur, Tibia, Humerus	3234	679.47	686.26	693.13	700.06	707.06
metatarsal - one	3235	339.60	343.00	346.43	349.89	353.39
- more than one	3236	475.61	480.36	485.17	490.02	494.92
Reconstruction of Chest						
- Pectus excavatum - infant	3242	356.84	360.41	364.01	367.65	371.33
- other than infant	3243	713.88	721.02	728.23	735.51	742.86
Scapulopexy - congenital evaluation	3244	571.13	576.84	582.61	588.44	594.32
- winged scapula	3245	571.13	576.84	582.61	588.44	594.32
Reconstruction of foot (Joplin, McBride, Lapitus, etc.)						
e.g., osteotomy and/or tendon transfers, etc.						
Unilateral	3246	471.25	475.96	480.72	485.53	490.39
Bilateral	3247	713.88	721.02	728.23	735.51	742.86

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Exostectomy and arthrodesis, metacarpophalangeal joint						
Unilateral	3248	407.61	411.68	415.80	419.96	424.16
Bilateral	3249	642.38	648.80	655.29	661.84	668.46
Bone graft (paid at 100% in addition to other procedure)	3258	166.43	168.09	169.78	171.47	173.19
FRACTURES						
These fees cannot be correctly interpreted without reference to the Preamble.						
UPPER EXTREMITIES						
Phalanx (finger/thumb)						
No reduction	3300	60.35	60.95	61.56	62.17	62.80
Closed reduction	3301	116.53	117.70	118.88	120.07	121.27
Open reduction	3302	214.24	216.38	218.54	220.73	222.93
Metacarpal						
No reduction (1 or more)	3303	60.35	60.95	61.56	62.17	62.80
Reduction with or without extension	3304	140.56	141.96	143.38	144.82	146.27
Open reduction	3305	271.74	274.46	277.21	279.98	282.78
Bennett's Fracture/Dislocation						
No reduction	3306	71.30	72.02	72.74	73.46	74.20
Reduction with external pin fixation	3544	185.65	187.50	189.38	191.27	193.19
Reduction with or without extension	3307	157.07	158.64	160.23	161.83	163.45
Open reduction	3308	285.34	288.19	291.08	293.99	296.93
Carpus (excluding Scaphoid)						
Closed reduction	3309	157.07	158.64	160.23	161.83	163.45
Open reduction (1 or more)	3310	271.74	274.46	277.21	279.98	282.78
Scaphoid						
Closed reduction	3311	157.65	159.23	160.82	162.43	164.05
Excision	3312	271.74	274.46	277.21	279.98	282.78
Bone graft or replacement	3313	543.48	548.91	554.40	559.94	565.54
Radial Head						
Closed reduction of head	3314	178.79	180.58	182.39	184.21	186.05
Excision or open reduction of head	3315	271.74	274.46	277.21	279.98	282.78
Radius and Ulna - Colles						
No reduction, cast	3316	108.60	109.69	110.79	111.89	113.01
Closed reduction	3317	190.00	191.90	193.82	195.76	197.72
Open reduction	3318	407.61	411.68	415.80	419.96	424.16
Radius and Ulna - Shafts						
No reduction	3319	108.60	109.69	110.79	111.89	113.01
Closed reduction	3320	251.02	253.53	256.07	258.63	261.21
Open reduction	3321	499.57	504.56	509.61	514.70	519.85
Radius and Ulna - Monteggia						
Closed reduction	3323	298.94	301.93	304.94	307.99	311.07
Open reduction	3324	475.61	480.36	485.17	490.02	494.92
Radius or Ulna						
No reduction, cast	3326	108.60	109.69	110.79	111.89	113.01
Closed reduction	3327	214.24	216.38	218.54	220.73	222.93
Open reduction	3328	339.60	343.00	346.43	349.89	353.39
Olecranon						
No reduction, cast	3330	114.15	115.29	116.44	117.61	118.78
Closed reduction	3331	214.24	216.38	218.54	220.73	222.93
Open reduction	3332	339.60	343.00	346.43	349.89	353.39
Humerus - Epicondyle (medial or lateral)						
Closed reduction	3333	252.33	254.85	257.40	259.97	262.57
Open reduction	3334	339.60	343.00	346.43	349.89	353.39

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UPPER EXTREMITIES (cont.)						
Humerus - Supra or transcondylar						
No reduction	3335	133.35	134.69	136.03	137.39	138.77
Closed reduction	3336	313.85	316.99	320.16	323.36	326.60
Open reduction	3337	428.33	432.61	436.94	441.31	445.72
Humerus - Shaft						
No reduction	3338	157.07	158.64	160.23	161.83	163.45
Closed reduction	3339	298.94	301.93	304.94	307.99	311.07
Open reduction	3340	475.61	480.36	485.17	490.02	494.92
Revision of open reduction	3482	699.52	706.52	713.58	720.72	727.93
Intramedullary nail	3341	849.49	857.98	866.56	875.23	883.98
Humerus - Neck or Tuberosity						
No reduction	3342	157.07	158.64	160.23	161.83	163.45
Closed reduction	3343	298.94	301.93	304.94	307.99	311.07
Open reduction	3344	499.57	504.56	509.61	514.70	519.85
LOWER EXTREMITY						
Phalanx (toe)						
No reduction	3345	57.04	57.61	58.18	58.76	59.35
Closed reduction	3346	100.01	101.01	102.02	103.04	104.07
Open reduction	3347	214.24	216.38	218.54	220.73	222.93
Metatarsal (1 or more)						
No reduction	3348	71.30	72.02	72.74	73.46	74.20
Closed reduction	3349	114.15	115.29	116.44	117.61	118.78
Open reduction	3350	271.74	274.46	277.21	279.98	282.78
Tarsus (excluding Os Calcis) (1 or more)						
No reduction	3351	146.23	147.70	149.17	150.67	152.17
Closed reduction	3352	235.62	237.98	240.36	242.76	245.19
Open reduction	3353	407.61	411.68	415.80	419.96	424.16
Os Calcis						
No reduction - no cast	3354	131.98	133.30	134.63	135.98	137.34
- cast	3355	142.80	144.23	145.67	147.13	148.60
Closed reduction (manipulation)	3356	326.14	329.40	332.69	336.02	339.38
Open reduction	3357	407.61	411.68	415.80	419.96	424.16
Open reduction, primary arthrodesis	3358	543.48	548.91	554.40	559.94	565.54
Ankle Fracture or Fracture/Dislocation						
No reduction	3359	114.15	115.29	116.44	117.61	118.78
Closed reduction	3360	298.94	301.93	304.94	307.99	311.07
Open reduction - medial malleolus	3361	339.60	343.00	346.43	349.89	353.39
- bi or trimalleolar	3362	475.61	480.36	485.17	490.02	494.92
Revision of open reduction (bi or trimalleolar)	3483	699.52	706.52	713.58	720.72	727.93
Tibia with or without Fibula						
No reduction	3363	204.20	206.25	208.31	210.39	212.50
Closed reduction	3364	322.97	326.20	329.46	332.76	336.08
Open reduction	3365	499.57	504.56	509.61	514.70	519.85
Revision of open reduction	3486	734.77	742.11	749.54	757.03	764.60
Intramedullary nail	3366	732.40	739.73	747.12	754.59	762.14
Revision of intramedullary nail	3487	1,098.60	1,109.59	1,120.68	1,131.89	1,143.21
Fibula Only						
No reduction	3367	100.01	101.01	102.02	103.04	104.07
Closed reduction	3368	142.80	144.23	145.67	147.13	148.60
Open reduction	3369	285.34	288.19	291.08	293.99	296.93

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LOWER EXTREMITY (cont.)						
Patella						
No reduction	3370	114.15	115.29	116.44	117.61	118.78
Closed reduction	3371	142.80	144.23	145.67	147.13	148.60
Open reduction - by suture	3372	407.61	411.68	415.80	419.96	424.16
- excision	3373	407.61	411.68	415.80	419.96	424.16
Femur - Shaft or Transcondylar						
No reduction, cast	3374	240.70	243.11	245.54	248.00	250.48
Closed reduction - child	3375	356.84	360.41	364.01	367.65	371.33
- adult	3376	499.57	504.56	509.61	514.70	519.85
Open reduction	3377	634.85	641.20	647.61	654.09	660.63
Revision of open reduction	3488	933.76	943.09	952.53	962.05	971.67
Intramedullary nail	3378	850.06	858.56	867.14	875.82	884.57
Revision of intramedullary nail	3489	1,275.09	1,287.84	1,300.72	1,313.72	1,326.86
Femur - Neck or Intertrochanteric						
No reduction	3379	285.34	288.19	291.08	293.99	296.93
Closed reduction	3380	428.33	432.61	436.94	441.31	445.72
Open reduction, pin and/or plate	3381	780.49	788.30	796.18	804.14	812.19
Prosthesis	3382	830.19	838.49	846.88	855.35	863.90
Intramedullary nail	3403	854.12	862.66	871.28	880.00	888.80
Revision of intramedullary nail	3484	1,281.18	1,293.99	1,306.93	1,320.00	1,333.20
SPINE						
Spinous or transverse process, facet, etc.	3383	142.80	144.23	145.67	147.13	148.60
Vertebral body fracture/dislocation, without cord injury						
Supervision, bed rest only (paid as Visit Fee only)						
Skull calipers, visit fee plus	3385	142.80	144.23	145.67	147.13	148.60
Closed reduction, +/- anesthetic, cast, frame, brace, etc.	3384	339.60	343.00	346.43	349.89	353.39
Open reduction +/- internal fixation	3386	815.28	823.43	831.66	839.98	848.38
Open reduction/fusion	3387	856.28	864.85	873.50	882.23	891.05
Open reduction/fusion, with Neurosurgeon (each surgeon)	3388	642.38	648.80	655.29	661.84	668.46
Vertebral body fracture/dislocation, with cord injury						
No operation (paid as Visit Fee only)						
Skull calipers, visit fee plus	3389	142.80	144.23	145.67	147.13	148.60
Closed reduction under Anesthesia	3390	679.47	686.26	693.13	700.06	707.06
Open reduction +/- internal fixation	3391	999.27	1,009.27	1,019.36	1,029.55	1,039.85
Open reduction/fusion	3392	999.27	1,009.27	1,019.36	1,029.55	1,039.85
Open reduction/fusion, with Neurosurgeon (each surgeon)	3393	679.47	686.26	693.13	700.06	707.06
Open reduction with decompression of cord or nerve roots	3394	951.08	960.59	970.20	979.90	989.70
Sacrum						
Complete care	3395	71.30	72.02	72.74	73.46	74.20
Coccyx						
No reduction, complete care	3396	71.30	72.02	72.74	73.46	74.20
Excision	3397	271.74	274.46	277.21	279.98	282.78
TRUNK						
Clavicle						
No reduction - child (age 15 years or less)	3398	78.84	79.63	80.42	81.23	82.04
- adult	3399	85.69	86.55	87.41	88.29	89.17
Closed reduction - child (age 15 years or less)	3400	146.23	147.70	149.17	150.67	152.17
- adult	3401	146.23	147.70	149.17	150.67	152.17
Open reduction	3402	285.34	288.19	291.08	293.99	296.93
Revision of open reduction	3499	419.68	423.88	428.12	432.40	436.72
Scapula - body, neck or glenoid						
No reduction	3404	78.84	79.63	80.42	81.23	82.04
Closed reduction	3405	142.80	144.23	145.67	147.13	148.60

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TRUNK (cont.)						
Sternum						
No reduction	3406	71.30	72.02	72.74	73.46	74.20
Closed reduction	3407	142.80	144.23	145.67	147.13	148.60
Open reduction	3408	285.34	288.19	291.08	293.99	296.93
Ribs						
Uncomplicated - 3 ribs or less	3409	42.85	43.27	43.71	44.14	44.58
- each additional	3410	14.32	14.47	14.61	14.76	14.90
Complicated, requiring special treatment	3411	I.C.	I.C.	I.C.	I.C.	I.C.
Pelvis						
No reduction - bed rest and supervision	3412	25.54	25.80	26.06	26.32	26.58
- manipulation and control	3413	428.33	432.61	436.94	441.31	445.72
Open reduction	3414	I.C.	I.C.	I.C.	I.C.	I.C.
HEAD						
Nasal Bones						
No reduction	3415	42.85	43.27	43.71	44.14	44.58
Closed reduction - local anaesthetic	3416	106.10	107.16	108.23	109.31	110.40
- general anaesthetic	3417	142.80	144.23	145.67	147.13	148.60
Open reduction, rhinoplastic method	3418	285.34	288.19	291.08	293.99	296.93
Mandible						
No reduction, no wiring of teeth	3419	71.30	72.02	72.74	73.46	74.20
Closed reduction, including wiring of teeth	3420	285.34	288.19	291.08	293.99	296.93
Open reduction, unilateral or bilateral skeletal fixation	3421	428.33	432.61	436.94	441.31	445.72
Maxilla - Malar bone						
Reduction by direction of forceps	3423	142.80	144.23	145.67	147.13	148.60
Open reduction	3424	285.34	288.19	291.08	293.99	296.93
Complicated mid-face	3425	I.C.	I.C.	I.C.	I.C.	I.C.
Skull - No reduction, complete care, simple or compound (paid as Visit Fee only)						
JOINTS						
INCISION (Arthrotomy)						
Wrist, elbow, shoulder, ankle	3500	285.34	288.19	291.08	293.99	296.93
Knee - exploratory and/or removal loose body	3501	339.60	343.00	346.43	349.89	353.39
- Meniscus/debridement, compartment	3502	523.93	529.17	534.46	539.81	545.20
Hip - exploratory and/or removal loose body	3503	543.48	548.91	554.40	559.94	565.54
EXCISION						
Capsulectomy - Synovectomy - Debridement						
Elbow, wrist	3504	428.33	432.61	436.94	441.31	445.72
Shoulder	3505	571.13	576.84	582.61	588.44	594.32
Hip	3506	679.47	686.26	693.13	700.06	707.06
Knee	3507	571.13	576.84	582.61	588.44	594.32
Fingers, toes - one or more joints	3508	214.24	216.38	218.54	220.73	222.93
Neurectomy						
Elbow, knee	3509	407.61	411.68	415.80	419.96	424.16
Hip	3510	499.57	504.56	509.61	514.70	519.85
Chondrectomy						
Knee - menisectomy	3512	407.61	411.68	415.80	419.96	424.16
- Baker's cyst	3513	214.24	216.38	218.54	220.73	222.93
Intervertebral Discs						
Excision of intervertebral disc - lumbar						
single	3514	679.47	686.26	693.13	700.06	707.06
bilateral, recurrent or multiple	3515	856.28	864.85	873.50	882.23	891.05
Excision of intervertebral disc with fusion						
one surgeon	3519	999.27	1,009.27	1,019.36	1,029.55	1,039.85
two surgeons, each	3520	642.38	648.80	655.29	661.84	668.46

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RECONSTRUCTION						
Arthroplasty - all types						
Interphalangeal, Metacarpophalangeal	3521	285.34	288.19	291.08	293.99	296.93
Interphalangeal, Metacarpophalangeal - revision	3551	419.68	423.88	428.12	432.40	436.72
Hand, reconstruction of rheumatoid joints, multiple	3522	679.47	686.26	693.13	700.06	707.06
Hand, reconstruction of rheumatoid joints, multiple - revision	3552	999.37	1,009.37	1,019.46	1,029.65	1,039.95
Wrist, ankle	3523	543.48	548.91	554.40	559.94	565.54
Wrist, ankle - revision	3553	799.35	807.34	815.41	823.57	831.80
Elbow, knee	3524	1,003.44	1,013.48	1,023.61	1,033.85	1,044.19
Elbow, knee - revision	3554	1,475.88	1,490.64	1,505.55	1,520.60	1,535.81
Acromio, or sternoclavicular	3525	356.84	360.41	364.01	367.65	371.33
Shoulder	3550	1,235.30	1,247.65	1,260.13	1,272.73	1,285.46
Shoulder - revision	3580	1,816.88	1,835.05	1,853.40	1,871.93	1,890.65
Foot - Hallux rigidus	3526	285.34	288.19	291.08	293.99	296.93
- Keller operation	3528	339.60	343.00	346.43	349.89	353.39
Hip - Cup arthroplasty	3529	856.28	864.85	873.50	882.23	891.05
- Total arthroplasty	3530	1,064.31	1,074.95	1,085.70	1,096.55	1,107.52
Hip arthroplasty - resurfacing	3250	1,235.30	1,247.65	1,260.13	1,272.73	1,285.46
Conversion of Moores prosthesis to total hip	3255	1,333.79	1,347.13	1,360.60	1,374.21	1,387.95
Revision of total hip	3256	1,668.83	1,685.52	1,702.38	1,719.40	1,736.59
Total knee	3251	1,003.44	1,013.48	1,023.61	1,033.85	1,044.19
Revision of total knee	3257	1,535.48	1,550.83	1,566.34	1,582.01	1,597.83
Removal of total knee, without replacement, w/insertion of spacer	3259	I.C.	I.C.	I.C.	I.C.	I.C.
Total ankle	3252	1,348.19	1,361.67	1,375.29	1,389.04	1,402.94
Total ankle - revision	3582	2,022.30	2,042.52	2,062.94	2,083.57	2,104.41
Arthroplasty	3253	214.24	216.38	218.54	220.73	222.93
Arthrodesis						
Finger, thumb	3531	285.34	288.19	291.08	293.99	296.93
Wrist, elbow	3532	543.48	548.91	554.40	559.94	565.54
Ankle (includes bone graft)	3527	830.29	838.59	846.98	855.45	864.00
Shoulder, knee, sacroiliac	3533	679.47	686.26	693.13	700.06	707.06
Hip	3534	856.28	864.85	873.50	882.23	891.05
Foot - toe, one joint	3535	481.49	486.31	491.17	496.08	501.04
- toe,one joint - revision	3565	708.18	715.26	722.41	729.64	736.93
- toe, multiple joints	3536	42.85	43.27	43.71	44.14	44.58
- mid-tarsal, sub-talar, triple, etc	3537	543.48	548.91	554.40	559.94	565.54
- mid-tarsal, sub-talar, triple, etc - revision	3567	799.35	807.34	815.41	823.57	831.80
- pan-talar, one stage	3538	713.88	721.02	728.23	735.51	742.86
- congenital club foot, fusions and tendon transfers	3539	679.47	686.26	693.13	700.06	707.06
Spinal Column fusion - one or two spaces	3540	815.28	823.43	831.66	839.98	848.38
- more than two spaces	3541	999.27	1,009.27	1,019.36	1,029.55	1,039.85
Chemonucleolysis - incl. placement of needle, - injection (per disc)	3545	319.87	323.07	326.30	329.56	332.86

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ARTHROSCOPY						
Diagnostic Arthroscopy - all joints (except hip) (including instrumentation, lavage and biopsy)	3254	233.05	235.38	237.73	240.11	242.51
Surgical Procedures with or without Arthroscopy (all joints)						
Lateral/medial retinacular release	3848	239.98	242.38	244.80	247.25	249.72
Synovectomy - 1 compartment	3542	407.61	411.68	415.80	419.96	424.16
- 2 or more compartments	3507	571.13	576.84	582.61	588.44	594.32
Menisectomy/debridement - 1 compartment	3502	523.93	529.17	534.46	539.81	545.20
- 2 or more compartments	3547	653.19	659.72	666.32	672.98	679.71
Reduction & pinning of intra-articular fragments	3548	407.61	411.68	415.80	419.96	424.16
Meniscal repair (medial or lateral)	3549	407.61	411.68	415.80	419.96	424.16
All above arthroscopy fees are mutually exclusive for the same joint (e.g., cannot do both debridement and synovectomy on the same joint) Diagnostic fee will not be paid in addition to procedure for the same leg. When 2 or more joints being done, the 2nd procedure will be paid at 65%. Tissue from arthroscopic synovectomy requires pathology.						
Hip Arthroscopy - Primary procedures: (maximum 1 primary procedure)						
Diagnostic hip arthroscopy	3260	858.00	866.58	875.25	884.00	892.84
Therapeutic hip arthroscopy (debridement, removal of loose bodies)	3261	715.00	722.15	729.37	736.67	744.03
Excision of labrum	3262	858.00	866.58	875.25	884.00	892.84
Repair of labrum	3263	975.26	985.01	994.86	1,004.81	1,014.86
Reconstruction of labrum with allograft	3264	1,144.00	1,155.44	1,166.99	1,178.66	1,190.45
Osteoplasty of femoral head	3265	975.26	985.01	994.86	1,004.81	1,014.86
Osteoplasty of acetabular rim	3266	975.26	985.01	994.86	1,004.81	1,014.86
Repair of hip abductors	3267	975.26	985.01	994.86	1,004.81	1,014.86
Trochanteric bursectomy and resection of trochanter	3268	975.26	985.01	994.86	1,004.81	1,014.86
Hip Arthroscopy - Secondary procedures: (maximum 2 add-ons)						
Excision of labrum (add-on)	3270	110.11	111.21	112.32	113.45	114.58
Repair of labrum (add on)	3271	286.00	288.86	291.75	294.67	297.61
Reconstruction of labrum with allograft (add-on)	3272	429.00	433.29	437.62	442.00	446.42
Osteoplasty of femoral head (add-on)	3273	286.00	288.86	291.75	294.67	297.61
Osteoplasty of acetabular rim (add-on)	3274	286.00	288.86	291.75	294.67	297.61
Release of psoas tendon (add-on)	3275	110.11	111.21	112.32	113.45	114.58
Trochanteric bursectomy, release of fascia, resection of trochanter (add-on)	3276	286.00	288.86	291.75	294.67	297.61
DISLOCATIONS						
UPPER EXTREMITY						
Finger and Thumb						
Closed reduction, one	3600	71.30	72.02	72.74	73.46	74.20
Open reduction	3601	214.24	216.38	218.54	220.73	222.93
Metacarpophalangeal						
Closed reduction, one	3602	80.28	81.08	81.89	82.71	83.54
Open reduction	3603	214.24	216.38	218.54	220.73	222.93
Wrist and Carpal Bones						
Closed reduction	3604	214.24	216.38	218.54	220.73	222.93
Open reduction	3605	407.61	411.68	415.80	419.96	424.16
Elbow						
Closed reduction	3606	226.51	228.78	231.06	233.38	235.71
Open reduction	3607	407.61	411.68	415.80	419.96	424.16
Dislocation of head of radius	3546	61.34	61.95	62.57	63.19	63.83

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DISLOCATIONS, UPPER EXTREMITY (cont.)						
Shoulder						
Closed reduction	3608	149.60	151.10	152.61	154.13	155.67
Open reduction	3609	499.57	504.56	509.61	514.70	519.85
Recurrent dislocations, repair, all types	3610	597.81	603.78	609.82	615.92	622.08
Acromioclavicular						
Closed reduction	3611	85.69	86.55	87.41	88.29	89.17
Open reduction	3612	356.84	360.41	364.01	367.65	371.33
Sternoclavicular						
Closed reduction	3613	78.43	79.21	80.01	80.81	81.61
Open reduction	3614	285.34	288.19	291.08	293.99	296.93
LOWER EXTREMITY						
Toe, Interphalangeal						
Closed reduction	3615	42.85	43.27	43.71	44.14	44.58
Open reduction	3616	214.24	216.38	218.54	220.73	222.93
Metatarsophalangeal						
Closed reduction	3617	80.28	81.08	81.89	82.71	83.54
Open reduction	3618	214.24	216.38	218.54	220.73	222.93
Tarsus						
Closed reduction	3619	178.79	180.58	182.39	184.21	186.05
Open reduction	3620	356.84	360.41	364.01	367.65	371.33
Ankle, Subluxation						
Closed reduction with or without general anesthetic	3621	218.93	221.12	223.33	225.57	227.82
Open reduction	3622	407.61	411.68	415.80	419.96	424.16
Repair or recurrent subluxation	3623	543.48	548.91	554.40	559.94	565.54
Knee						
Closed reduction	3624	252.33	254.85	257.40	259.97	262.57
Simple reduction	3625	499.57	504.56	509.61	514.70	519.85
Open reduction/reconstruction of ligaments, medial collateral, lateral collateral and/or cruciates +/- menisectomy	3647	642.38	648.80	655.29	661.84	668.46
Patella						
Closed reduction, with or without anesthetic	3626	100.01	101.01	102.02	103.04	104.07
Open reduction for recurrent dislocation	3627	428.33	432.61	436.94	441.31	445.72
Open reduction/reconstruction of ligaments, medial collateral, lateral collateral and/or cruciates +/- menisectomy	3648	642.38	648.80	655.29	661.84	668.46
HIP						
Anterior or Posterior Dislocation						
Closed reduction with or without anesthetic	3628	252.33	254.85	257.40	259.97	262.57
Open reduction	3629	499.57	504.56	509.61	514.70	519.85
Central Dislocation						
Closed reduction with or without anesthetic	3630	285.34	288.19	291.08	293.99	296.93
Open reduction	3631	571.13	576.84	582.61	588.44	594.32
Congenital Dislocation						
Closed reduction with or without anesthetic - unilateral	3632	214.24	216.38	218.54	220.73	222.93
- repeat manipulation and plaster	3633	100.01	101.01	102.02	103.04	104.07
Simple or rotation osteotomy	3634	571.13	576.84	582.61	588.44	594.32
Acetabuloplasty	3635	713.88	721.02	728.23	735.51	742.86

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SPINE						
Intervertebral						
Closed reduction, correction spica	3636	285.34	288.19	291.08	293.99	296.93
Open reduction	3637	543.48	548.91	554.40	559.94	565.54
Open reduction/fusion, cervical spine, +/- cord injury	3638	883.21	892.04	900.96	909.97	919.07
Open reduction/fusion, thoracic/lumbar, +/- cord injury	3639	856.28	864.85	873.50	882.23	891.05
Sacrococcygeal						
Non-operative (paid as Visit Fee only)						
Open reduction - removal of coccyx	3640	285.34	288.19	291.08	293.99	296.93
Temporomandibular						
Closed reduction	3641	62.52	63.15	63.78	64.42	65.06
Open reduction	3642	285.34	288.19	291.08	293.99	296.93
Manipulation						
Manipulation of Joints under General Anesthesia						
- Wrist, elbow, ankle	3643	42.85	43.27	43.71	44.14	44.58
- Shoulder, knee, hip	3644	71.30	72.02	72.74	73.46	74.20
Congenital foot deformity, club-foot, +/- anesthetic						
Dennis Brown's splints	3645	28.46	28.74	29.03	29.32	29.61
Manipulation and cast, single	3646	42.85	43.27	43.71	44.14	44.58
BURSAE						
Incision						
Removal of calcium	3701	285.34	288.19	291.08	293.99	296.93
Excision						
Olecranon, prepatellar bursae	3702	214.24	216.38	218.54	220.73	222.93
Humero-radial	3703	214.24	216.38	218.54	220.73	222.93
Sub-acromial	3704	285.34	288.19	291.08	293.99	296.93
Sub-trochanteric	3705	339.60	343.00	346.43	349.89	353.39
Biopsy						
Superficial bursa	3706	42.85	43.27	43.71	44.14	44.58
MUSCLES						
Incision						
Removal of foreign body, general anesthetic						
- Simple	3750	71.30	72.02	72.74	73.46	74.20
- Complicated e.g., gunshot wound	3751	I.C.	I.C.	I.C.	I.C.	I.C.
Release or cutting of muscle (myotomy) - Tennis Elbow	3754	214.24	216.38	218.54	220.73	222.93
Excision						
Biopsy, independent procedure	3755	71.30	72.02	72.74	73.46	74.20
Resection of muscle	3756	I.C.	I.C.	I.C.	I.C.	I.C.
Local excision of lesion of muscle	3757	100.01	101.01	102.02	103.04	104.07
Repair						
Manipulation and injection, tennis elbow	3758	42.85	43.27	43.71	44.14	44.58
Quadricepsplasty	3760	499.57	504.56	509.61	514.70	519.85
TENDONS, TENDON SHEATHS, FASCIA						
Incision						
Exploration of tendon or tendon sheath	3800	171.31	173.03	174.76	176.50	178.27
Tenosynovitis, finger	3801	171.31	173.03	174.76	176.50	178.27
Trigger finger, release	3802	171.31	173.03	174.76	176.50	178.27
Exploration of fascia	3803	203.08	205.11	207.16	209.24	211.33
Drainage of tendon sheath	3804	171.31	173.03	174.76	176.50	178.27
Tenotomy (closed) - Toe - single	3805	42.85	43.27	43.71	44.14	44.58
- Toe - multiple	3806	71.30	72.02	72.74	73.46	74.20
- Plantar fascia	3807	71.30	72.02	72.74	73.46	74.20
- Hip adductors	3808	71.30	72.02	72.74	73.46	74.20
- Tendo-Achilles	3809	71.30	72.02	72.74	73.46	74.20

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Excision						
Ganglion, tendon sheath or joint	3810	171.26	172.97	174.70	176.45	178.21
DeQuervian's (Wrist)	3811	342.51	345.93	349.39	352.89	356.41
Tendon sheath for tuberculosis	3812	428.33	432.61	436.94	441.31	445.72
Fascia for Dupuytren's - partial	3813	285.34	288.19	291.08	293.99	296.93
- complete	3814	499.57	504.56	509.61	514.70	519.85
Xanthoma	3815	142.80	144.23	145.67	147.13	148.60
Repair						
Tenoplasty, shortening, lengthening, etc.						
- one tendon, one location	3816	285.34	288.19	291.08	293.99	296.93
- two or more	3817	356.84	360.41	364.01	367.65	371.33
Tendon graft						
- Hand, Wrist - single	3818	543.48	548.91	554.40	559.94	565.54
- two or more	3819	679.47	686.26	693.13	700.06	707.06
- other location	3820	540.44	545.85	551.30	556.82	562.39
Fasciotomy						
- Lengthening of ileo-tibial band - unilateral	3821	271.74	274.46	277.21	279.98	282.78
- Decompression of carpal tunnel	5968	285.34	288.19	291.08	293.99	296.93
Transplant of tendon, transposition						
- Hand, Forearm - single	3823	285.34	288.19	291.08	293.99	296.93
- multiple	3824	499.57	504.56	509.61	514.70	519.85
- Shoulder - pectoralis minor	3825	285.34	288.19	291.08	293.99	296.93
- trapezius	3826	475.61	480.36	485.17	490.02	494.92
- Foot, Ankle - single	3827	285.34	288.19	291.08	293.99	296.93
- multiple	3828	499.57	504.56	509.61	514.70	519.85
- Knee - transposition of tendons	3829	428.33	432.61	436.94	441.31	445.72
- Foot - tenodesis	3830	285.34	288.19	291.08	293.99	296.93
Repair of mallet finger - closed	3831	72.95	73.68	74.42	75.16	75.91
- operative	3832	214.24	216.38	218.54	220.73	222.93
Tenoplasty - Achilles, biceps, or quadriceps tendon	3847	339.60	343.00	346.43	349.89	353.39
Suture						
Tenorrhaphy, tendon suture						
Finger, hand, wrist, foot, ankle						
Extensor tendon - partially severed	3849	198.06	200.04	202.04	204.06	206.10
- single	3833	214.24	216.38	218.54	220.73	222.93
- each subsequent	3834	99.03	100.02	101.02	102.03	103.05
Flexor tendon - single	3835	330.10	333.40	336.73	340.10	343.50
- each subsequent	3836	165.04	166.69	168.36	170.04	171.75
Achilles, biceps, quadriceps	3837	356.84	360.41	364.01	367.65	371.33
Reconstruction (fascia and ligaments)						
Shoulder - rotator cuff tear	3838	475.61	480.36	485.17	490.02	494.92
- rotator cuff tear - revision	3868	699.52	706.52	713.58	720.72	727.93
- late repair	3839	571.13	576.84	582.61	588.44	594.32
- late repair - revision	3869	840.04	848.44	856.92	865.49	874.15
- acromioplasty only	3840	428.33	432.61	436.94	441.31	445.72
Acromioclavicular, sternoclavicular - early repair (see Dislocations)						
- late repair	3841	475.61	480.36	485.17	490.02	494.92
Elbow, wrist, ankle - early repair	3842	285.34	288.19	291.08	293.99	296.93
- late repair	3843	499.57	504.56	509.61	514.70	519.85
Knee - early repair	3844	428.33	432.61	436.94	441.31	445.72
- late repair	3845	628.24	634.53	640.87	647.28	653.75
- late repair - revision	3875	924.03	933.27	942.61	952.03	961.55
Metacarpophalangeal - early or late	3846	214.24	216.38	218.54	220.73	222.93

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AMPUTATION						
Upper Extremity						
Through phalanx	3900	99.03	100.02	101.02	102.03	103.05
Through metacarpal or M.P. joint	3901	142.80	144.23	145.67	147.13	148.60
Of hand - through all metacarpals	3902	356.84	360.41	364.01	367.65	371.33
Through radius and ulna	3903	428.33	432.61	436.94	441.31	445.72
Through humerus	3904	428.33	432.61	436.94	441.31	445.72
At shoulder	3905	499.57	504.56	509.61	514.70	519.85
Fore quarter	3906	679.47	686.26	693.13	700.06	707.06
Lower Extremity						
Through phalanx	3907	213.72	215.86	218.01	220.19	222.40
Through metatarsal or M.P. joint	3908	353.40	356.93	360.50	364.11	367.75
Transmetatarsal	3909	582.25	588.07	593.96	599.89	605.89
Symes	3910	748.17	755.65	763.20	770.84	778.54
Through tibia and fibula	3911	756.32	763.88	771.52	779.23	787.03
At knee - Gritti - Stokes or Callander	3912	756.32	763.88	771.52	779.23	787.03
Through femur	3913	756.32	763.88	771.52	779.23	787.03
At hip	3914	1,112.83	1,123.95	1,135.19	1,146.55	1,158.01
Hind quarter	3915	1,716.33	1,733.49	1,750.83	1,768.34	1,786.02
Hemipelvectomy	3916	1,716.33	1,733.49	1,750.83	1,768.34	1,786.02

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OPERATIONS ON THE RESPIRATORY SYSTEM						
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NOSE						
Incision						
Drainage of nasal abscess, complete care	4000	72.95	73.68	74.42	75.16	75.91
Drainage of septal abscess, complete care	4001	114.15	115.29	116.44	117.61	118.78
Excision						
Biopsy of soft tissue	4002	66.02	66.68	67.35	68.02	68.70
Nasal Polypi						
- Unilateral - local anesthetic	4003	42.85	43.27	43.71	44.14	44.58
- general anesthetic	4004	71.30	72.02	72.74	73.46	74.20
- Bilateral - local anesthetic	4005	71.30	72.02	72.74	73.46	74.20
- general anesthetic	4006	142.80	144.23	145.67	147.13	148.60
Excision of choanal polyp	4007	100.01	101.01	102.02	103.04	104.07
Excision of skin of nose for rhinophyma - uncomplicated	4009	100.01	101.01	102.02	103.04	104.07
Septectomy, submucous resection	4010	285.34	288.19	291.08	293.99	296.93
Septectomy, submucous resection - including septoplasty	4011	356.84	360.41	364.01	367.65	371.33
Turbinectomy - complete or partial	4012	57.04	57.61	58.18	58.76	59.35
- Submucosal turbinectomy	4013	I.C.	I.C.	I.C.	I.C.	I.C.
Endoscopy						
Rhinoscopy with removal of foreign body in nose	4014	46.21	46.67	47.14	47.61	48.09
- under general Anesthesia	4015	57.04	57.61	58.18	58.76	59.35
Repair						
Rhinoplasty, and closure of septal perforation						
Complete with or without grafts **(Prior approval required)**	4016	839.56	847.96	856.44	865.00	873.65
Nasal septal button insertion	7907	120.46	121.67	122.88	124.11	125.35
Lysis of nasal adhesions	7908	145.92	147.37	148.85	150.34	151.84
Destruction						
Infraction of turbinate, unilateral or bilateral	4019	28.46	28.74	29.03	29.32	29.61
Cauterization of turbinates - unilateral	4020	42.85	43.27	43.71	44.14	44.58
- bilateral	4021	71.30	72.02	72.74	73.46	74.20
Manipulation						
Control of primary nasal hemorrhage (Epistaxis)						
- With cauterization of nasal septum	4022	28.46	28.74	29.03	29.32	29.61
- With anterior nasal packing	4023	66.02	66.68	67.35	68.02	68.70
- With posterior nasal packing	4024	112.23	113.36	114.49	115.63	116.79
Control of secondary hemorrhage same as above	4025	100.01	101.01	102.02	103.04	104.07
Epistaxis control by ligation of ethmoidal arteries	7905	142.80	144.23	145.67	147.13	148.60
Epistaxis control by ligation of maxillary arteries	7906	554.99	560.54	566.15	571.81	577.53
Catheterization of Eustachian Tube for infiltration of mid ear	4026	14.32	14.47	14.61	14.76	14.90

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SINUSES						
Incision						
Sinusotomy, sinusectomy, as indicated						
Maxillary sinusotomy - intranasal (unilateral)	4027	171.31	173.03	174.76	176.50	178.27
- radical, Caldwell-Luc (unilateral)	4028	407.61	411.68	415.80	419.96	424.16
Frontal Trephine and sinusectomy	4029	214.24	216.38	218.54	220.73	222.93
- Radical	4030	679.47	686.26	693.13	700.06	707.06
External fronto-ethmoidal with sphenoid if necessary	4031	214.24	216.38	218.54	220.73	222.93
Ethmoidal - intranasal (unilateral)	4032	214.24	216.38	218.54	220.73	222.93
Intranasal ethmoidectomy - anterior only	7909	212.14	214.26	216.40	218.56	220.75
- anterior and posterior	7910	345.94	349.40	352.89	356.42	359.99
Sphenoidal - intranasal	4033	285.34	288.19	291.08	293.99	296.93
Introduction						
Lavage - maxillary	4034	28.46	28.74	29.03	29.32	29.61
- frontal	4035	57.04	57.61	58.18	58.76	59.35
- sphenoidal	4036	57.04	57.61	58.18	58.76	59.35
Suture						
Closure of antro-oral fistula	4037	428.33	432.61	436.94	441.31	445.72
Examination under general Anesthesia of the post-nasal space	4040	55.85	56.41	56.97	57.54	58.11
Submucous Diathermy of the turbinates (Bilateral)	4041	75.21	75.96	76.72	77.49	78.26
LARYNX						
Excision						
Laryngectomy - partial (laryngo-fissure)	4100	571.13	576.84	582.61	588.44	594.32
- total	4101	856.28	864.85	873.50	882.23	891.05
Introduction						
Intubation of larynx (Independent procedure)	4104	74.04	74.78	75.53	76.28	77.05
Endoscopy						
Laryngoscopy, direct - without biopsy (only 1 procedure paid per session)	4105	104.90	105.94	107.00	108.07	109.16
- with biopsy	4106	129.57	130.86	132.17	133.50	134.83
Laryngoscopy with removal of foreign body	4107	246.81	249.28	251.77	254.29	256.83
Laryngoscopy with removal of benign growth	4108	308.51	311.59	314.71	317.85	321.03
Laryngoscopy, indirect - with biopsy	4109	104.90	105.94	107.00	108.07	109.16
Repair						
Laryngoplasty, plastic operation on larynx	4110	I.C.	I.C.	I.C.	I.C.	I.C.
Arytenoidopexy (King or Kelly)	4111	543.48	548.91	554.40	559.94	565.54
TRACHEA AND BRONCHI						
Incision						
Tracheostomy	4200	271.74	274.46	277.21	279.98	282.78
Endoscopy						
Bronchoscopy, diagnostic. (1 procedure paid per session)	4201	266.97	269.64	272.34	275.06	277.81
- With biopsy	4202	266.97	269.64	272.34	275.06	277.81
- With insertion of radioactive substance	4203	266.97	269.64	272.34	275.06	277.81
- With removal of foreign body	4204	271.74	274.46	277.21	279.98	282.78
- With excision of tumor	4205	271.74	274.46	277.21	279.98	282.78
Broncho-esophagoscopy +/- biopsy (1 procedure paid/session)	4206	256.88	259.45	262.05	264.67	267.31
Quadroscopy (Includes direct laryngoscopy, esophagoscopy, examination of the post nasal space and bronchoscopy.)	4209	266.97	269.64	272.34	275.06	277.81
Bronchoscopy with Transbronchial lung biopsy						
- single lobe	4210	258.80	261.38	264.00	266.64	269.31
- each additional lobe	4212	66.02	66.68	67.35	68.02	68.70

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TRACHEA AND BRONCHI, Endoscopy (cont.)						
Bronchoscopy with Transbronchial Needle Aspiration (TBNA) of lymph nodes	4213	258.80	261.38	264.00	266.64	269.31
Endobronchial Ultrasound (EBUS)	4214	352.78	356.31	359.87	363.47	367.11
Endoscopy through tracheostomy	4211	66.02	66.68	67.35	68.02	68.70
Suture						
Tracheorrhapy - suture of external wound in trachea	4207	214.24	216.38	218.54	220.73	222.93
Closure of tracheostomy or tracheal fistula	4208	214.24	216.38	218.54	220.73	222.93
LUNGS AND PLEURA						
Incision						
Thoracocentesis						
- Closed drainage - operation and after care (chest tube)	4400	233.45	235.79	238.15	240.53	242.93
- Open drainage - Rib resection and drainage	4401	350.16	353.66	357.20	360.77	364.38
Drainage of lung abscess	4402	513.83	518.97	524.16	529.40	534.70
Exploratory thoracotomy or removal of foreign body	4403	513.83	518.97	524.16	529.40	534.70
Biopsy of pleura or lung	4404	583.62	589.45	595.35	601.30	607.31
Needle biopsy of pleura	2178	52.91	53.44	53.97	54.51	55.06
Excision						
Pneumonectomy	4406	1,167.23	1,178.90	1,190.69	1,202.60	1,214.63
Lobectomy	4407	1,123.46	1,134.70	1,146.04	1,157.51	1,169.08
Lobectomy and segmental resection	4408	999.27	1,009.27	1,019.36	1,029.55	1,039.85
Segmental resection	4409	999.27	1,009.27	1,019.36	1,029.55	1,039.85
Wedge resection	4410	700.34	707.34	714.41	721.56	728.77
Pleurectomy - pleural decortication	4411	817.06	825.23	833.48	841.82	850.23
- with bullous emphysema	4412	815.28	823.43	831.66	839.98	848.38
Thoracoscopy	4413	291.81	294.73	297.67	300.65	303.66
CHEST WALL AND MEDIASTINUM						
Incision						
Mediastinotomy with drainage	4300	571.13	576.84	582.61	588.44	594.32
Reconstruction						
Pectus excavatum - infant	3242	356.84	360.41	364.01	367.65	371.33
- other than infant	3243	713.88	721.02	728.23	735.51	742.86
Excision						
Chest wall tumor involving ribs/cartilage, and reconstruction of chest wall	4302	904.61	913.65	922.79	932.02	941.34
Mediastinal tumor	4303	713.88	721.02	728.23	735.51	742.86
Transaxillary resection 1st rib	4313	671.17	677.88	684.66	691.50	698.42
Surgical Collapse						
Thoracoplasty - one stage	4305	543.48	548.91	554.40	559.94	565.54
- multi-stage, each	4306	342.51	345.93	349.39	352.89	356.41
Pneumolysis - intrapleural	4308	256.88	259.45	262.05	264.67	267.31
- extrapleural	4309	428.33	432.61	436.94	441.31	445.72
Apicolysis - extrafascial (Sembs)	4310	428.33	432.61	436.94	441.31	445.72
- extrapleural	4311	428.33	432.61	436.94	441.31	445.72
Mediastinoscopy	4304	350.16	353.66	357.20	360.77	364.38

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OPERATIONS ON THE CARDIOVASCULAR SYSTEM						
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VEINS						
Varicose Veins and Ulcers						
Injection of varicose veins - single	4511	14.32	14.47	14.61	14.76	14.90
- multiple at same sitting	4512	61.34	61.95	62.57	63.19	63.83
Sclerotherapy, comprehensive, on referred patients (one leg)	4529	153.42	154.95	156.50	158.07	159.65
Ligation - multiple, one leg	4513	171.31	173.03	174.76	176.50	178.27
Ligation - saphenofemoral or saphenopopliteal junction (one leg)	4514	171.31	173.03	174.76	176.50	178.27
Ligation and stripping of stab avulsions (one leg)						
- Long saphenous vein	4515	285.34	288.19	291.08	293.99	296.93
- with multiple low ligation & excision-ligation of perforators	4516	356.84	360.41	364.01	367.65	371.33
- Short saphenous vein	4517	142.80	144.23	145.67	147.13	148.60
Excision of venous stasis ulcer, and skin graft	4521	285.34	288.19	291.08	293.99	296.93
- with ligation and stripping of stab avulsions (one leg)	4519	428.33	432.61	436.94	441.31	445.72
Subfascial control of perforators, open or by SEPS	4522	428.33	432.61	436.94	441.31	445.72
- with stripping of stab avulsions	4523	571.13	576.84	582.61	588.44	594.32
Recurrent or complicated varicose veins	4518	504.00	509.04	514.13	519.27	524.46
Venous Thrombectomy						
Iliac or femoral vein thrombectomy	4524	679.47	686.26	693.13	700.06	707.06
Interruption of vena cava - transvenous IVC filter	4655	343.31	346.74	350.21	353.71	357.25
Vein Harvesting						
Harvest arm vein (add)	4656	131.09	132.40	133.72	135.06	136.41
Harvest superficial femoral vein (add)	4657	131.09	132.40	133.72	135.06	136.41
Harvest opposite leg vein (add)	4658	109.09	110.18	111.28	112.39	113.52
Venous Wounds						
Suture repair wound of major vein	4528	367.99	371.67	375.39	379.14	382.94
Repair lacerated major vein (e.g., femoral, popliteal, subclavian, brachial), or microscopic repair of digital vein	4530	335.83	339.19	342.58	346.01	349.47
- by patch	4531	525.26	530.51	535.82	541.18	546.59
- by vein graft	4532	698.53	705.52	712.57	719.70	726.90
Arteriovenous Procedures						
Repair of AV anomaly	4533	513.83	518.97	524.16	529.40	534.70
Creation of AV fistula	4505	513.83	518.97	524.16	529.40	534.70
Closure/obliteration of AV fistula	4527	81.73	82.55	83.37	84.21	85.05
Portal Hypertension						
Portocaval shunt	4501	999.27	1,009.27	1,019.36	1,029.55	1,039.85
Distal splenorenal shunt	4525	1,225.07	1,237.32	1,249.69	1,262.19	1,274.81
Mesocaval shunt	4503	951.08	960.59	970.20	979.90	989.70
Esopho-gastric devasularization and esophageal transection, (including reanastomosis and splenectomy)	4534	948.73	958.22	967.80	977.48	987.25
Other Venous Procedures						
Venogram	4500	71.36	72.07	72.79	73.52	74.25
Ligation - Jugular vein, internal	4506	214.24	216.38	218.54	220.73	222.93
Ligation - Inferior vena cava, ligation or placation	4508	571.13	576.84	582.61	588.44	594.32
Ligation - Saphenous	4510	71.30	72.02	72.74	73.46	74.20
Superior vena cava bypass graft	4526	736.05	743.41	750.85	758.36	765.94
Venous anastomosis - Splenorenal	4502	999.27	1,009.27	1,019.36	1,029.55	1,039.85

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ARTERIES						
Percutaneous Vascular Procedures						
Arterial cannulation	4599	74.04	74.78	75.53	76.28	77.05
Angiography						
- Carotid	4630	142.80	144.23	145.67	147.13	148.60
- Femoral - unilateral	4631	71.30	72.02	72.74	73.46	74.20
- bilateral	4632	114.15	115.29	116.44	117.61	118.78
- Aortography	4633	142.80	144.23	145.67	147.13	148.60
- Arteriography, selective	4635	142.80	144.23	145.67	147.13	148.60
- Renal Mesenteric arch - per major vessel (add)	4538	26.41	26.68	26.94	27.21	27.48
Operative arteriography - one or more (add)	4536	71.30	72.02	72.74	73.46	74.20
Exposure of major artery for aortography	4634	214.24	216.38	218.54	220.73	222.93
Arterial cannulation for aortography	4636	71.30	72.02	72.74	73.46	74.20
Dilations and Stents						
Dilation/Stent of Iliac artery - unilateral	4537	330.70	334.01	337.35	340.72	344.13
Vascular stent (add)	4535	84.25	85.09	85.94	86.80	87.67
Arterial Wounds						
Suture of lacerated major artery of limb	4671	334.69	338.03	341.41	344.83	348.28
Repair of lacerated major artery of limb, or microscopic repair of digital artery (including patch angioplasty)	4670	526.72	531.99	537.31	542.68	548.11
Brachiocephalic Procedures						
Carotid body tumor	4627	856.28	864.85	873.50	882.23	891.05
- with graft	4628	927.91	937.18	946.56	956.02	965.58
- with vessel bypass	4629	999.27	1,009.27	1,019.36	1,029.55	1,039.85
Carotid endarterectomy	5652	856.28	864.85	873.50	882.23	891.05
- with patch graft	5653	999.27	1,009.27	1,019.36	1,029.55	1,039.85
- with graft and by-pass shunt	5654	1,142.08	1,153.50	1,165.03	1,176.68	1,188.45
Aneurysm repair						
- Carotid	4660	866.92	875.59	884.35	893.19	902.12
- Subclavian	4661	916.19	925.35	934.61	943.95	953.39
- Axillary or Brachial - synthetic graft	4663	713.88	721.02	728.23	735.51	742.86
- vein graft	4664	856.28	864.85	873.50	882.23	891.05
Brachiocephalic arterial bypass with autogenous vein graft (Includes Carotid-subclavian, Carotid-axillary, Axillo-axillary, Axillo-brachial, Brachio-distal)	4662	693.53	700.46	707.47	714.54	721.69
Aorto-Iliac Procedures						
Thoracic aortic aneurysm repair						
- without bypass with hypothermia	4606	999.27	1,009.27	1,019.36	1,029.55	1,039.85
- with by-pass	4607	1,284.81	1,297.66	1,310.64	1,323.74	1,336.98
Thoraco-abdominal aneurysm repair	4665	2,042.65	2,063.07	2,083.70	2,104.54	2,125.58
- with rupture	4666	2,232.33	2,254.65	2,277.20	2,299.97	2,322.97
Abdominal aortic aneurysm repair	4608	1,142.08	1,153.50	1,165.03	1,176.68	1,188.45
- with rupture	4609	1,284.81	1,297.66	1,310.64	1,323.74	1,336.98
- Aortic Bifurcation graft	4617	1,405.95	1,420.01	1,434.21	1,448.56	1,463.04
- Reimplantation of inferior mesenteric artery (add)	4654	171.72	173.44	175.17	176.92	178.69
Thromboendarterectomy	4618	856.28	864.85	873.50	882.23	891.05
Endarterectomy of aorta and/or aortic bifurcation	4619	999.27	1,009.27	1,019.36	1,029.55	1,039.85
Pelvic aneurysm repair - ligation exclusion	4667	478.65	483.44	488.27	493.16	498.09
- with graft	4668	744.11	751.55	759.06	766.65	774.32
Ilio-femoral bypass	4669	773.75	781.49	789.30	797.20	805.17
Total removal of infected aortic graft (stem and limbs)	4672	970.07	979.77	989.57	999.46	1,009.46
Partial removal of infected aortic graft (one limb only)	4673	363.37	367.01	370.68	374.38	378.13
Closure of duodenal fistula (add)	4674	134.20	135.54	136.90	138.27	139.65

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Visceral Artery Repairs						
Superior mesenteric, celiac, renal, hepatic:						
- Aneurysm repair or bypass for obstruction	4675	599.46	605.45	611.51	617.62	623.80
- Endarterectomy or graft	4676	713.01	720.14	727.34	734.61	741.96
- By-pass to additional artery	4677	I.C.	I.C.	I.C.	I.C.	I.C.
Embolectomy - Mesenteric	4624	594.18	600.12	606.12	612.18	618.30
- Renal	4625	713.88	721.02	728.23	735.51	742.86
Lower Limb Arterial Procedures						
Femoro-popliteal or femoro-femoral or axillo-femoral bypass						
- synthetic graft	4620	713.88	721.02	728.23	735.51	742.86
- vein graft	4621	856.28	864.85	873.50	882.23	891.05
Femoro-distal bypass (e.g., anterior or posterial tibial)	4644	927.91	937.18	946.56	956.02	965.58
In situ peripheral vein procedure (add)	4653	327.00	330.27	333.57	336.91	340.27
Femoral or popliteal endarterectomy	4659	802.38	810.41	818.51	826.70	834.96
Peripheral aneurysm repair - lower limb						
(e.g., femoral, popliteal)	4651	799.83	807.83	815.91	824.07	832.31
Peripheral false aneurysm repair	4650	865.18	873.83	882.57	891.40	900.31
Arterioplasty of lower limb artery or vein graft						
- Femoral	4637	428.33	432.61	436.94	441.31	445.72
- Iliac	4638	428.33	432.61	436.94	441.31	445.72
Embolectomy/thrombectomy - Iliac or femoral artery	4623	571.13	576.84	582.61	588.44	594.32
- Transfemoral (bilateral)	4622	856.28	864.85	873.50	882.23	891.05
Limb fasciotomy for ischemia - single	4678	177.55	179.33	181.12	182.93	184.76
- multiple	4679	338.23	341.61	345.03	348.48	351.96
Secondary closure of fasciotomy	4680	102.83	103.86	104.89	105.94	107.00
Composite graft, combining 2 or more conduits (add)	4681	140.91	142.32	143.74	145.18	146.63
Extended profundoplasty						
- to first major branch	4642	571.13	576.84	582.61	588.44	594.32
- to second major branch	4652	756.33	763.89	771.53	779.24	787.04
Exposure of leg vessels for inspection/evaluation,						
- per exposure	4643	142.80	144.23	145.67	147.13	148.60
Sympathectomy						
Transcervical	5980	571.13	576.84	582.61	588.44	594.32
Transaxillary	5981	593.73	599.66	605.66	611.72	617.83
Translumbar	5983	451.32	455.83	460.39	464.99	469.64
Other Vascular Procedures						
Transcervical or transaxillary resection of 1st rib	4313	671.17	677.88	684.66	691.50	698.42
Temporal artery biopsy	4682	100.01	101.01	102.02	103.04	104.07
Closure of lymphatic fistula groin	4683	218.98	221.17	223.38	225.61	227.87
Re-operation after 1 month for failed vascular graft (add)	4684	368.35	372.03	375.75	379.51	383.30
Arteriotomy	4600	100.01	101.01	102.02	103.04	104.07
Transection of artery - peripheral	4603	214.24	216.38	218.54	220.73	222.93
- intra-abdominal or intra-thoracic	4604	285.34	288.19	291.08	293.99	296.93
Ligation carotid, neck - simple	4639	214.24	216.38	218.54	220.73	222.93
Ligation anterior ethmoid artery for epistaxis	4641	142.80	144.23	145.67	147.13	148.60
HEART AND PERICARDIUM						
Incision						
Atrial or ventricular puncture	4700	57.04	57.61	58.18	58.76	59.35
Biopsy of pericardium - by needle	2181	197.81	199.79	201.79	203.81	205.85
- by thoracotomy	4702	428.33	432.61	436.94	441.31	445.72
Cardiotomy with exploration	4703	713.88	721.02	728.23	735.51	742.86
- with removal of foreign body or tumor	4704	713.88	721.02	728.23	735.51	742.86
- By closed technique	4705	856.28	864.85	873.50	882.23	891.05
- By open technique without bypass	4706	999.27	1,009.27	1,019.36	1,029.55	1,039.85
- By open technique with bypass	4707	1,142.08	1,153.50	1,165.03	1,176.68	1,188.45

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Excision						
Pericardiectomy - partial	4708	571.13	576.84	582.61	588.44	594.32
- sub-total	4709	856.28	864.85	873.50	882.23	891.05
Introduction						
Catheterization of heart - right	2126	197.81	199.79	201.79	203.81	205.85
- Hepatic wedge pressure	2127	131.84	133.15	134.48	135.83	137.19
Catheterization of heart - left	2128	263.78	266.42	269.08	271.77	274.49
- insertion of catheter pacemaker	4716	285.34	288.19	291.08	293.99	296.93
Insertion of Portacath	4714	308.98	312.07	315.19	318.34	321.52
Removal of Portacath	4715	270.35	273.05	275.78	278.54	281.32
Insertion of Hickman catheter	4717	187.95	189.83	191.72	193.64	195.58
Removal of Hickman catheter	4713	96.48	97.45	98.42	99.40	100.40
Insertion of Loop recorder (surgeon or internist)	4778	132.04	133.36	134.70	136.05	137.41
Removal of Loop recorder	4779	66.02	66.68	67.35	68.02	68.70
Repair						
Patent ductus arteriosus	4718	713.88	721.02	728.23	735.51	742.86
Pulmonary Stenosis - Open heart - without bypass	4738	999.27	1,009.27	1,019.36	1,029.55	1,039.85
Pericardial insufflation with powder	4747	428.33	432.61	436.94	441.31	445.72
Suture of wound (heart)	4752	713.88	721.02	728.23	735.51	742.86
Open Cardiac Massage	4753	285.34	288.19	291.08	293.99	296.93
(Includes fee for thoracotomy and cardiac massage in addition to fee for operation during which arrest occurred)						
PACEMAKER PROCEDURES						
Temporary Catheter Pacemaker						
Insertion (incl.repositioning w/in 24 hrs) - medical fee	4770	244.88	247.33	249.80	252.30	254.83
- surgical fee	4760	326.72	329.99	333.29	336.62	339.99
- composite fee	4766	433.00	437.33	441.71	446.12	450.59
Repositioning after 24 hrs - medical fee	4771	98.81	99.80	100.80	101.81	102.83
- surgical fee	4761	123.66	124.90	126.15	127.41	128.68
- composite fee	4767	173.14	174.87	176.62	178.39	180.17
Replace - medical fee	4772	163.66	165.29	166.95	168.62	170.30
- surgical fee	4762	247.40	249.88	252.37	254.90	257.45
- composite fee	4768	346.43	349.90	353.40	356.93	360.50
Permanent Pacemaker						
Insertion (epicardial) - medical fee	4773	240.09	242.49	244.91	247.36	249.83
- surgical fee	4769	662.67	669.30	675.99	682.75	689.58
Insertion (transvenous) - medical fee	4777	351.92	355.44	359.00	362.59	366.21
- surgical fee	4763	474.32	479.06	483.85	488.69	493.58
Insertion (dual chamber or ICD) - medical fee	4781	351.92	355.44	359.00	362.59	366.21
- surgical fee	4782	568.49	574.18	579.92	585.72	591.57
Reposition/replace wire - medical fee	4774	163.66	165.29	166.95	168.62	170.30
- surgical fee	4764	247.40	249.88	252.37	254.90	257.45
Reposition/replace power source - medical fee	4775	163.66	165.29	166.95	168.62	170.30
- surgical fee	4765	326.72	329.99	333.29	336.62	339.99
Reprogram or interrogate pacemaker (including ICD) - medical fee	4776	112.61	113.73	114.87	116.02	117.18

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OPERATIONS ON THE HEMATIC AND LYMPHATIC SYSTEMS						
These fees cannot be correctly interpreted without reference to the Preamble.						
SPLEEN and BONE MARROW						
Excision						
Splenectomy	4802	729.53	736.83	744.19	751.64	759.15
Biopsy of Marrow, as Independent Procedure						
- Aspiration, needle or punch	2175	124.70	125.94	127.20	128.47	129.76
- Bone button	4804	85.69	86.55	87.41	88.29	89.17
LYMPH CHANNELS						
Excision						
Cystic hygroma	4900	513.83	518.97	524.16	529.40	534.70
Lymphedema						
- Kondolean	4901	513.83	518.97	524.16	529.40	534.70
- Radical Sleeve Excision	4902	856.28	864.85	873.50	882.23	891.05
- Lymphangiogram	4903	256.88	259.45	262.05	264.67	267.31
Excision of Lymph Glands						
Tumor, suprahyoid - unilateral	4904	437.72	442.10	446.52	450.99	455.50
- bilateral	4905	642.38	648.80	655.29	661.84	668.46
Radical neck dissection	4906	856.28	864.85	873.50	882.23	891.05
Dissection of inguinal glands	4907	428.33	432.61	436.94	441.31	445.72
Radical dissection of axillary glands	4908	540.72	546.12	551.58	557.10	562.67
Radical dissection of inguinal glands, including iliac glands	4909	571.13	576.84	582.61	588.44	594.32
Radical dissection of inguinal glands and iliac glands, bilateral	4910	648.77	655.26	661.81	668.43	675.11
Fine Needle Biopsy - cervical, axillary, inguinal	4809	67.28	67.95	68.63	69.31	70.01
Lymph gland Biopsy - cervical, axillary, inguinal	4911	118.66	119.84	121.04	122.25	123.47
- Scalene	4912	180.90	182.70	184.53	186.38	188.24
- Complicated biopsy	4913	I.C.	I.C.	I.C.	I.C.	I.C.
- Sentinel Node biopsy	4805	364.76	368.41	372.09	375.81	379.57
Laparotomy for lymphoma staging	4914	713.88	721.02	728.23	735.51	742.86
Sweat gland excision - axillary, inguinal, perineal (unilateral)	4915	283.88	286.72	289.58	292.48	295.40
- with skin graft(s) and/or rotation flap(s)	4916	415.92	420.08	424.28	428.52	432.81

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OPERATIONS ON THE DIGESTIVE SYSTEM						
These fees cannot be correctly interpreted without reference to the Preamble.						
MOUTH						
Incision						
Drainage of Ludwig's Angina, complete care	5000	142.80	144.23	145.67	147.13	148.60
Excision						
Biopsy	5001	66.02	66.68	67.35	68.02	68.70
Excision of - simple lesion	5002	57.04	57.61	58.18	58.76	59.35
- leukoplakia, limited	5003	85.69	86.55	87.41	88.29	89.17
Excision of ranula of dermoid cyst	5005	171.31	173.03	174.76	176.50	178.27
Local excision CA floor of mouth, mandible, alveolar margin, or buccal mucosa	5006	256.88	259.45	262.05	264.67	267.31
- With hemimandibulectomy	5007	571.13	576.84	582.61	588.44	594.32
- Either of above combined with unilateral neck dissection	5008	999.27	1,009.27	1,019.36	1,029.55	1,039.85
Suture						
Closure of antero-oral fistula with flap	5010	428.33	432.61	436.94	441.31	445.72
Closure of antero-oral fistula with radical antrotomy	5011	499.57	504.56	509.61	514.70	519.85
LIPS						
Excision						
Biopsy	5020	66.02	66.68	67.35	68.02	68.70
Lip Shave	5021	171.31	173.03	174.76	176.50	178.27
Excision of simple lesion	5022	118.66	119.84	121.04	122.25	123.47
V-excision for carcinoma	5023	262.61	265.24	267.89	270.57	273.28
- plus radical neck dissection	5024	927.91	937.18	946.56	956.02	965.58
Excision one half lip - plus reconstruction	5025	428.33	432.61	436.94	441.31	445.72
- plus radical neck dissection	5026	999.27	1,009.27	1,019.36	1,029.55	1,039.85
Total excision of lip	5027	571.13	576.84	582.61	588.44	594.32
- plus radical neck dissection	5028	999.27	1,009.27	1,019.36	1,029.55	1,039.85
Repair						
Harelip - unilateral	5029	428.33	432.61	436.94	441.31	445.72
TONGUE						
Excision						
Biopsy	5040	66.02	66.68	67.35	68.02	68.70
Local excision of simple tumor	5041	148.32	149.81	151.31	152.82	154.35
Hemiglossectomy	5042	428.33	432.61	436.94	441.31	445.72
- plus radical neck dissection	5043	999.27	1,009.27	1,019.36	1,029.55	1,039.85
Total glossectomy	5044	513.83	518.97	524.16	529.40	534.70
- plus radical neck dissection	5045	999.27	1,009.27	1,019.36	1,029.55	1,039.85
Repair						
Minor lacerations	5047	66.02	66.68	67.35	68.02	68.70
TEETH AND GUMS						
Incision						
Drainage of alveolar abscess - general anesthetic	5060	57.04	57.61	58.18	58.76	59.35
Excision						
Biopsy of gum	5061	66.02	66.68	67.35	68.02	68.70
Mucous cyst	5063	57.04	57.61	58.18	58.76	59.35
Suture						
Suture of gum, secondary	5064	66.02	66.68	67.35	68.02	68.70

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PALATE AND UVULA						
Incision						
Palate abscess	5080	99.03	100.02	101.02	102.03	103.05
Excision						
Uvulectomy - independent procedure	5081	57.04	57.61	58.18	58.76	59.35
Biopsy	5082	57.04	57.61	58.18	58.76	59.35
Excision of simple lesion	5083	85.69	86.55	87.41	88.29	89.17
Excision of malignant lesion (with reconstruction)	5084	399.75	403.75	407.79	411.86	415.98
Suture						
Suture of palate wound	5086	42.85	43.27	43.71	44.14	44.58
Uvulopalatopharyngoplasty (includes tonsillectomy, partial palatectomy and pharyngoplasty)	5087	328.32	331.60	334.92	338.27	341.65
SALIVARY GLANDS AND DUCTS						
Incision						
Sialolithotomy - local anesthetic	5100	42.85	43.27	43.71	44.14	44.58
- general anesthetic - simple	5102	85.69	86.55	87.41	88.29	89.17
- complicated	5103	256.88	259.45	262.05	264.67	267.31
Excision						
Submandibular gland	5104	342.51	345.93	349.39	352.89	356.41
Parotid gland - Superficial parotidectomy	5105	747.74	755.21	762.77	770.39	778.10
- Total parotidectomy	5106	948.38	957.86	967.44	977.11	986.88
- plus unilateral radical neck dissection	5107	999.27	1,009.27	1,019.36	1,029.55	1,039.85
Repair						
Plastic repair of salivary duct	5108	356.84	360.41	364.01	367.65	371.33
Dilation of salivary duct (independent procedure)	5109	57.04	57.61	58.18	58.76	59.35
Probing						
Catheterization for Sialogram	5111	57.04	57.61	58.18	58.76	59.35
RADICAL NECK DISSECTION						
A composite resection of the head and neck for malignancy, neck dissection with reconstruction utilizing local or distant flaps	5112	2,537.94	2,563.32	2,588.95	2,614.84	2,640.99
A composite fee which includes elevation of free island skin and bone flap and closure of defect; preparation of microvascular recipient site for free island skin and bone flap immediately following ablative surgery and when recipient vessels are in the site of ablation; and transplanation of free island skin and bone flap with microvascular anastomosis(es) and bone fixation	5113	2,562.63	2,588.25	2,614.13	2,640.28	2,666.68
* NOTE, in most cases this procedure will require 8 hours or more. Where a procedure requires less than 8 hours, independent consideration will be considered.						
PHARYNX, ADENOIDS AND TONSILS						
Incision						
Biopsy of Pharynx	5120	102.12	103.15	104.18	105.22	106.27
Drainage of retropharyngeal abscess						
- internal approach	5121	71.30	72.02	72.74	73.46	74.20
- external approach	5122	214.24	216.38	218.54	220.73	222.93
Drainage of peritonsillar abscess, operation only	5123	99.03	100.02	101.02	102.03	103.05

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Excision						
Branchial cyst	5124	437.72	442.10	446.52	450.99	455.50
Sinus	5125	571.13	576.84	582.61	588.44	594.32
Pharyngo-esophageal diverticulum	5126	713.88	721.02	728.23	735.51	742.86
Thyroglossal duct cyst	5127	356.84	360.41	364.01	367.65	371.33
Cyst and sinus	5128	513.83	518.97	524.16	529.40	534.70
Tonsillectomy with or without adenoidectomy						
- Under age 16	5129	249.17	251.66	254.18	256.72	259.29
- Adult	5130	249.17	251.66	254.18	256.72	259.29
Excision of Tonsil tag - unilateral	5131	114.15	115.29	116.44	117.61	118.78
Excision of Lingual tonsil (independent procedure)	5132	114.15	115.29	116.44	117.61	118.78
Adenoidectomy without tonsillectomy	5138	71.30	72.02	72.74	73.46	74.20
Post-tonsillectomy/adenoidectomy hemorrage control (same surgeon)	7911	87.55	88.42	89.31	90.20	91.10
Post-tonsillectomy/adenoidectomy hemorrage control (different surgeon)	7912	160.49	162.09	163.72	165.35	167.01
Repair						
Choanal atresia	5133	713.88	721.02	728.23	735.51	742.86
Pouch-Back Flap (Pharyngeal)	5134	642.38	648.80	655.29	661.84	668.46
Suture of exterior wound or injury of pharynx	5136	I.C.	I.C.	I.C.	I.C.	I.C.
Removal of Foreign Body - pharynx	5137	99.03	100.02	101.02	102.03	103.05
ESOPHAGUS						
Incision						
Cervical esophagotomy	5140	428.33	432.61	436.94	441.31	445.72
Thoracic esophagotomy	5141	571.13	576.84	582.61	588.44	594.32
Esophagomyotomy	5142	713.88	721.02	728.23	735.51	742.86
Excision						
Intrathoracic diverticulum	5143	685.22	692.08	699.00	705.99	713.05
Extrathoracic diverticulum - one stage	5144	571.13	576.84	582.61	588.44	594.32
Resection of esophagus - primary anastomosis	5145	999.27	1,009.27	1,019.36	1,029.55	1,039.85
- With replacement by jejunum, colon, or stomach						
- 1st surgeon	5146	1,142.08	1,153.50	1,165.03	1,176.68	1,188.45
- 2nd surgeon	5147	285.34	288.19	291.08	293.99	296.93
Esophago-gastrectomy	5148	1,142.08	1,153.50	1,165.03	1,176.68	1,188.45
Esophageal bypass with colon or jejunum	5149	999.27	1,009.27	1,019.36	1,029.55	1,039.85
Endoscopy						
Esophagoscopy						
- with or without biopsy (only 1 procedure paid per session)	5150	197.44	199.41	201.41	203.42	205.46
- with removal of foreign body	5151	283.82	286.66	289.53	292.42	295.35
Esophago-bronchoscopy (only 1 procedure paid per session)	5152	256.88	259.45	262.05	264.67	267.31
Esophago-gastroscopy w/Elder-Palmer or similar (only 1 procedure per session)	5153	214.24	216.38	218.54	220.73	222.93
Repair						
Esophagoplasty (repair of stricture)	5155	856.28	864.85	873.50	882.23	891.05
Esophageal Hiatus Hernia						
- Abdominal approach	5156	713.88	721.02	728.23	735.51	742.86
- Abdominal approach plus cholecystectomy, if indicated	5157	856.28	864.85	873.50	882.23	891.05
- Transthoracic approach	5158	713.88	721.02	728.23	735.51	742.86
Repair of hiatal hernia plus esophagoplasty	5175	999.27	1,009.27	1,019.36	1,029.55	1,039.85
Fundoplication with or without hiatal hernia repair	5176	713.88	721.02	728.23	735.51	742.86
Ruptured esophagus	5159	685.22	692.08	699.00	705.99	713.05
- Cervical drainage	5160	499.57	504.56	509.61	514.70	519.85
Esophago-gastrostomy	5161	999.27	1,009.27	1,019.36	1,029.55	1,039.85
Esophago-duodenostomy or jejunostomy	5162	999.27	1,009.27	1,019.36	1,029.55	1,039.85

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ESOPHAGUS, Repair (cont.)						
Closure of esophageal-tracheal fistula	5163	999.27	1,009.27	1,019.36	1,029.55	1,039.85
Esophagotomy with ligation of varices	5164	685.22	692.08	699.00	705.99	713.05
Injection of Esophageal varices or bleeding ulcer w/ Esophagoscopy						
- initial	5165	342.51	345.93	349.39	352.89	356.41
- repeat, within 30 days	5177	257.15	259.72	262.32	264.94	267.59
Banding of Esophageal varices (with Esophagoscopy)						
- initial	5166	343.31	346.74	350.21	353.71	357.25
- repeat, within 30 days	5178	257.15	259.72	262.32	264.94	267.59
Gastro-esophageal tamponade	2159	74.82	75.57	76.33	77.09	77.86
Introduction of Mousseau-Barbin tube	5167	428.33	432.61	436.94	441.31	445.72
Dilation						
Indirect						
- Active - with or without guiding string	5168	71.30	72.02	72.74	73.46	74.20
- Passive - using mercury filled tubes	5169	28.46	28.74	29.03	29.32	29.61
With Esophagoscopy						
- Initial	5172	326.14	329.40	332.69	336.02	339.38
- Repeat	5173	85.69	86.55	87.41	88.29	89.17
Dilation of esophagus with fluoroscopic control	5174	100.01	101.01	102.02	103.04	104.07
STOMACH						
Incision						
Gastrotomy with removal of tumor or foreign body	5200	428.33	432.61	436.94	441.31	445.72
Pyloromyotomy (Ramstedt's)	5201	612.80	618.93	625.12	631.37	637.68
Simple tube gastrostomy	5202	428.33	432.61	436.94	441.31	445.72
Percutaneous Endoscopic Gastrostomy (PEG)	5240	263.21	265.84	268.50	271.18	273.90
Excision						
Biopsy - by gastroscopy	5204	256.88	259.45	262.05	264.67	267.31
- by gastrotomy	5205	428.33	432.61	436.94	441.31	445.72
Gastrectomy						
- Wedge resection for ulcer	5207	539.85	545.25	550.70	556.20	561.77
- Partial, or subtotal	5208	888.28	897.17	906.14	915.20	924.35
- Plus repair of hiatus hernia	5209	999.27	1,009.27	1,019.36	1,029.55	1,039.85
- After previous gastro-enterostomy or partial gastrectomy	5210	999.27	1,009.27	1,019.36	1,029.55	1,039.85
- Antrectomy or subtotal - plus vagotomy	5211	999.27	1,009.27	1,019.36	1,029.55	1,039.85
- Total Gastrectomy	5212	1,142.08	1,153.50	1,165.03	1,176.68	1,188.45
Excision of gastroduodenal lesion (recurrent ulcer)	5213	999.27	1,009.27	1,019.36	1,029.55	1,039.85
- plus vagotomy	5214	1,142.08	1,153.50	1,165.03	1,176.68	1,188.45
Excision of gastrojejunal lesion (recurrent ulcer)	5215	999.27	1,009.27	1,019.36	1,029.55	1,039.85
Any of the above, plus cholecystectomy (add)	5217	142.80	144.23	145.67	147.13	148.60
Endoscopy						
Gastroscopy - Diagnostic, biopsy, removal of foreign body	5218	237.93	240.31	242.71	245.14	247.59
- subsequent - within 45 days of initial procedure	5219	94.01	94.95	95.90	96.85	97.82
(IC for full fee may be given under exceptional circumstances)						
Repair						
Pyloroplasty	5220	525.26	530.51	535.82	541.18	546.59
- Pyloroplasty plus vagotomy	5221	679.47	686.26	693.13	700.06	707.06
Gastroduodenostomy, gastrojejunostomy, or gastrogastrostomy	5222	525.26	530.51	535.82	541.18	546.59
- Either of the above plus vagotomy	5223	713.88	721.02	728.23	735.51	742.86
Pyloroplasty or gastroenterostomy with vagotomy and hiatal hernia	5224	856.28	864.85	873.50	882.23	891.05
Vagotomy alone	5225	513.83	518.97	524.16	529.40	534.70
Any of the above plus cholecystectomy (add)	5226	142.80	144.23	145.67	147.13	148.60

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Suture						
Closure of gastrostomy or other external fistula of stomach	5227	342.51	345.93	349.39	352.89	356.41
Closure of perforated ulcer or wound of stomach	5228	525.26	530.51	535.82	541.18	546.59
Closure of gastro-colic or gastro-jejunocolic fistula,						
- one stage	5229	999.27	1,009.27	1,019.36	1,029.55	1,039.85
- two stages, including colostomy	5230	999.27	1,009.27	1,019.36	1,029.55	1,039.85
Gastric cooling	5231	171.31	173.03	174.76	176.50	178.27
Highly Selective Vagotomy	5232	840.24	848.64	857.12	865.69	874.35
Gastric partition for morbid obesity **(Prior approval required)**	5233	I.C.	I.C.	I.C.	I.C.	I.C.
Gastric partition + all other procedures for morbid obesity **(Prior approval)**	5234	I.C.	I.C.	I.C.	I.C.	I.C.
E.R.C.P. (ENDOSCOPIC RETROGRADE CHOLANGIO-PANCREATOGRAPHY)						
Standard E.R.C.P.	5235	302.42	305.45	308.50	311.59	314.70
E.R.C.P. Biopsy (Additional)	5236	15.39	15.54	15.70	15.86	16.01
E.R.C.P. on a bilroth II	5237	254.57	257.12	259.69	262.29	264.91
E.R.C.P. with biliary tract dilation	5241	392.15	396.07	400.03	404.03	408.07
E.R.C.P. with sphincterotomy	5238	456.20	460.77	465.37	470.03	474.73
E.R.C.P. with sphincterotomy+balloon dilation						
- complex stones or stent placement	5242	487.47	492.34	497.26	502.24	507.26
E.R.C.P. Stent placement (Additional)	5239	83.25	84.08	84.92	85.77	86.63
INTESTINES (EXCEPT RECTUM)						
Incision						
Ileostomy for ulcerative colitis	5250	548.23	553.71	559.25	564.84	570.49
Ileostomy or jejunostomy (with tube)	5251	380.73	384.54	388.38	392.27	396.19
1st stage Mikulicz	5252	548.23	553.71	559.25	564.84	570.49
Colostomy	5253	585.13	590.99	596.90	602.86	608.89
- Revision of colostomy for stenosis	5278	182.79	184.61	186.46	188.33	190.21
Cecostomy, as single procedure	5255	380.73	384.54	388.38	392.27	396.19
Enterotomy or colostomy	5256	560.43	566.03	571.69	577.41	583.18
- with operative sigmoidoscopy	5257	609.38	615.47	621.63	627.84	634.12
- multiple with operative sigmoidoscopy	5258	761.67	769.29	776.98	784.75	792.60
Excision						
Biopsy by intubation	5259	91.42	92.34	93.26	94.19	95.13
Local excision of lesion of small intestine incl. duodenal diverticulum	5260	622.69	628.91	635.20	641.56	647.97
Enterectomy with Anastomosis						
Small Intestine						
- Duodenectomy	5261	747.23	754.70	762.25	769.87	777.57
- Other	5262	747.23	754.70	762.25	769.87	777.57
Small and Large Intestine						
- Terminal ileum, caecum	5263	934.03	943.37	952.81	962.33	971.96
- Terminal ileum, caecum, ascending colon	5264	934.03	943.37	952.81	962.33	971.96
Large Intestine						
- Segmental colectomy	5265	952.71	962.24	971.86	981.58	991.39
- Hemicolectomy, right or left	5266	952.71	962.24	971.86	981.58	991.39
- Total colectomy without perineal resection	5267	1,401.06	1,415.07	1,429.22	1,443.51	1,457.95
- Total colectomy with ileostomy and abdomino-perineal resection						
- single team	5268	1,359.84	1,373.44	1,387.17	1,401.05	1,415.06
- two team - 1st surgeon	5269	1,258.41	1,271.00	1,283.71	1,296.54	1,309.51
- 1st assistant	5270	365.44	369.10	372.79	376.52	380.28
- 2nd assistant	5271	274.08	276.82	279.58	282.38	285.20

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INTESTINES (EXCEPT RECTUM), Excision (cont.)						
Intestinal Obstruction						
- without resection	5272	778.37	786.15	794.02	801.96	809.98
- with resection	5273	934.03	943.37	952.81	962.33	971.96
- Entero-enterostomy	5275	560.43	566.03	571.69	577.41	583.18
- Duodenal atresia, duodeno-jejunostomy	5276	609.38	615.47	621.63	627.84	634.12
Multiple stage procedures, preliminary colostomy, bowel resection, closure of colostomy, etc., to be paid at fee listed for each procedure.						
Repair						
Fecal fistula, radical with resection	5277	837.82	846.19	854.66	863.20	871.83
Revision of ileostomy or colostomy	5278	182.79	184.61	186.46	188.33	190.21
Closure of perforation	5279	487.86	492.74	497.67	502.64	507.67
Closure of perforation with colostomy	5280	609.38	615.47	621.63	627.84	634.12
Cecopexy or sigmoidopexy, independent operation	5281	457.02	461.59	466.20	470.87	475.57
Suture						
Closure of enterostomy plus resection	5282	622.69	628.91	635.20	641.56	647.97
Closure of colostomy	5283	622.69	628.91	635.20	641.56	647.97
Plication of small intestine for adhesions	5284	685.39	692.24	699.16	706.16	713.22
Manipulation						
Dilation of enterostomy, colostomy, etc.						
- with anesthetic	5285	60.86	61.47	62.09	62.71	63.33
- without anesthetic (paid as Visit Fee only)						
E.E.A. Stapler	5286	74.03	74.77	75.52	76.27	77.04
MECKEL'S DIVERTICULUM AND THE MESENTERY						
Excision						
Meckel's diverticulum	5287	457.02	461.59	466.20	470.87	475.57
Local excision of lesion or mesentery	5288	457.02	461.59	466.20	470.87	475.57
Resection of mesentery	5289	457.02	461.59	466.20	470.87	475.57
Mesenteric cyst	5290	457.02	461.59	466.20	470.87	475.57
APPENDIX						
Incision						
Drainage of abscess, complete care	5300	380.73	384.54	388.38	392.27	396.19
Excision						
Appendectomy	5301	544.85	550.30	555.80	561.36	566.98
- With gross perforation and peritonitis	5302	731.65	738.97	746.36	753.82	761.36
- With removal of Meckel's Diverticulum	5303	471.96	476.67	481.44	486.26	491.12
RECTUM						
Incision						
Proctotomy - with drainage (perirectal abscess)	5322	182.79	184.61	186.46	188.33	190.21
Pelvic abscess - drainage	5323	228.58	230.87	233.17	235.51	237.86
Excision						
Proctectomy						
- Anterior resection of rectum	5324	1,401.06	1,415.07	1,429.22	1,443.51	1,457.95
- Perineal resection of rectum	5325	731.10	738.42	745.80	753.26	760.79
- Abdomino-perineal resection plus colostomy						
- Single team	5326	1,401.06	1,415.07	1,429.22	1,443.51	1,457.95
- Two team - 1st surgeon	5327	1,318.64	1,331.82	1,345.14	1,358.59	1,372.18
- 1st assistant	5328	622.69	628.91	635.20	641.56	647.97
- 2nd assistant	5329	420.31	424.51	428.76	433.05	437.38
Hartmann's procedure	5330	952.71	962.24	971.86	981.58	991.39
Reanastomosis following Hartmann's procedure	5331	783.29	791.12	799.03	807.02	815.09

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RECTUM, Excision (cont.)						
Rectal polyp						
- low, excision or cauterization	5336	91.42	92.34	93.26	94.19	95.13
- upper rectum and sigmoid through sigmoidoscope	5337	186.80	188.67	190.56	192.46	194.39
Biopsy of recto-sigmoid for Hirschprung's disease	5338	121.79	123.01	124.24	125.48	126.74
Electro-coagulation of rectal carcinoma						
- initial	5358	304.45	307.49	310.57	313.67	316.81
- repeat	5359	152.36	153.88	155.42	156.98	158.55
Repair						
Proctostomy	5339	457.02	461.59	466.20	470.87	475.57
Proctopexy - abdominal route	5340	548.23	553.71	559.25	564.84	570.49
Rectal prolapse						
- Excision of mucous membrane	5341	304.45	307.49	310.57	313.67	316.81
- Perineal repair, major	5342	548.23	553.71	559.25	564.84	570.49
- Abdominal approach	5343	731.10	738.42	745.80	753.26	760.79
- Thiersch wire procedure	5344	182.79	184.61	186.46	188.33	190.21
Suture of Rectum						
- External approach	5345	365.44	369.10	372.79	376.52	380.28
- Intraperitoneal approach	5346	609.38	615.47	621.63	627.84	634.12
Closure of Fistula						
- Recto-vaginal	5347	609.38	615.47	621.63	627.84	634.12
- Recto-vesical	5348	609.38	615.47	621.63	627.84	634.12
ANUS						
Clamping of internal hemorrhoid - per haemorrhoid	5349	87.55	88.42	89.31	90.20	91.10
Incision						
Thrombosed haemorrhoid						
- Local anesthetic	5350	52.81	53.34	53.87	54.41	54.96
- General anesthetic	5351	71.30	72.02	72.74	73.46	74.20
Excision						
Local excision of anal lesion (fissure, malignancy)	5352	171.31	173.03	174.76	176.50	178.27
Hemorrhoidectomy, with or without sigmoidoscopy	5353	262.61	265.24	267.89	270.57	273.28
Anal polyp, hemorrhoidal tags	5354	87.55	88.42	89.31	90.20	91.10
Fistula-in-ano - low level	5355	262.61	265.24	267.89	270.57	273.28
- high level with division of internal sphincter	5356	525.26	530.51	535.82	541.18	546.59
Biopsy, independent operation, general anesthetic	5357	57.04	57.61	58.18	58.76	59.35
Introduction						
Hemorrhoid injection - initial	2169	26.69	26.95	27.22	27.49	27.77
- subsequent	2170	20.08	20.28	20.48	20.68	20.89
Injection for pruritus ani or anal fissure	2171	26.69	26.95	27.22	27.49	27.77
Repair						
Excision of scar, for stenosis	5361	171.31	173.03	174.76	176.50	178.27
Anaplasty for stenosis	5362	342.51	345.93	349.39	352.89	356.41
Repair of anal sphincter	5363	428.33	432.61	436.94	441.31	445.72
Repair of anal sphincter and anorectal ring	5364	428.33	432.61	436.94	441.31	445.72
Repair of Imperforate Anus/Membranous obstruction of anus	5365	171.31	173.03	174.76	176.50	178.27
Destruction						
Cauterization of fissure	5371	33.01	33.34	33.67	34.01	34.35
Electro-dessication of condylomata	5372	99.03	100.02	101.02	102.03	103.05
Manipulation						
Dilation of anal sphincter under general anesthetic (independent procedure)	5373	28.46	28.74	29.03	29.32	29.61
Anoscopy	5374	18.51	18.70	18.89	19.07	19.26
Partial Lateral internal sphincterotomy	5375	252.19	254.71	257.25	259.83	262.43

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LIVER						
Incision						
Hepatotomy						
- Drainage of abscess or cyst	5381	513.83	518.97	524.16	529.40	534.70
- Removal of foreign body	5382	513.83	518.97	524.16	529.40	534.70
- Incision and packing of wound	5383	513.83	518.97	524.16	529.40	534.70
Excision						
Hepatectomy						
- Local excision of lesion	5384	513.83	518.97	524.16	529.40	534.70
- Partial Resection of liver (partial hepatectomy or lobectomy)	5385	1,142.08	1,153.50	1,165.03	1,176.68	1,188.45
Biopsy - needle	2177	100.07	101.07	102.08	103.10	104.13
Repair						
Suture of liver wound/rupture	5388	I.C.	I.C.	I.C.	I.C.	I.C.
BILIARY TRACT						
Incision						
Cholecystostomy	5390	428.33	432.61	436.94	441.31	445.72
Cholecysto-enterostomy	5391	513.83	518.97	524.16	529.40	534.70
Cholecysto-enterostomy plus enteroenterostomy	5392	571.13	576.84	582.61	588.44	594.32
Cholecystogastrostomy	5393	513.83	518.97	524.16	529.40	534.70
Choledochoduodenostomy	5394	713.88	721.02	728.23	735.51	742.86
Common duct exploration	5395	685.22	692.08	699.00	705.99	713.05
Common duct exploration with duodenotomy, sphincterotomy	5396	856.28	864.85	873.50	882.23	891.05
Excision						
Choledochectomy	5398	856.28	864.85	873.50	882.23	891.05
Excision of Ampulla of Vater	5399	785.24	793.09	801.02	809.03	817.12
Cholecystectomy	5400	709.56	716.65	723.82	731.06	738.37
- with operative cholangiogram	5401	758.69	766.28	773.94	781.68	789.50
Cholecystectomy and exploration of bile duct	5402	802.46	810.49	818.59	826.78	835.04
- with operative cholangiogram	5403	875.42	884.18	893.02	901.95	910.97
Cholecystectomy and exploration of bile ducts plus duodenotomy	5404	856.28	864.85	873.50	882.23	891.05
Repair						
Surgical reconstruction of common bile duct	5405	1,142.08	1,153.50	1,165.03	1,176.68	1,188.45
Suture						
Closure of fistula	5406	785.24	793.09	801.02	809.03	817.12
PANCREAS						
Incision						
Pancreatotomy	5410	571.13	576.84	582.61	588.44	594.32
Pancreatic abscess or cyst	5411	571.13	576.84	582.61	588.44	594.32
Excision						
Pancreatectomy						
- Local Excision of lesion	5414	685.22	692.08	699.00	705.99	713.05
- Partial - resection of tail	5415	685.22	692.08	699.00	705.99	713.05
Pancreatico-duodenal resection (Whipple type operation)	5416	1,142.08	1,153.50	1,165.03	1,176.68	1,188.45
Excision pancreatic cyst	5417	685.22	692.08	699.00	705.99	713.05
Repair						
Pancreatico - gastrostomy	5418	685.22	692.08	699.00	705.99	713.05
- duodenostomy	5419	685.22	692.08	699.00	705.99	713.05
- jejunostomy	5420	685.22	692.08	699.00	705.99	713.05
Marsupialization of cyst	5421	571.13	576.84	582.61	588.44	594.32

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ABDOMEN, PERITONEUM AND OMENTUM						
Incision						
Laparotomy, with or without biopsy	5450	510.65	515.76	520.92	526.13	531.39
Peritoneal abscess						
- Drainage of subphrenic abscess	5451	513.83	518.97	524.16	529.40	534.70
- Intra-abdominal abscess, other	5452	525.26	530.51	535.82	541.18	546.59
Drainage of abdominal wall abscess						
- general anesthetic, complete care	5480	85.69	86.55	87.41	88.29	89.17
Removal of foreign body, abdominal wall - gun shot	5453	I.C.	I.C.	I.C.	I.C.	I.C.
Excision						
Desmoid tumor, depending on extent	5454	I.C.	I.C.	I.C.	I.C.	I.C.
Lipectomy, removal of panniculus **(Prior approval required)**	5456	428.33	432.61	436.94	441.31	445.72
Retroperitoneal tumor	5457	685.22	692.08	699.00	705.99	713.05
Mesenteric cyst	5458	428.33	432.61	436.94	441.31	445.72
Endoscopy						
Peritoneoscopy (laparoscopy)	5460	256.82	259.39	261.98	264.60	267.24
Repair						
Herniotomy and Herniorrhaphy						
- Inguinal or femoral, single	5461	408.53	412.61	416.74	420.91	425.12
- Inguinal - single with hydrocele	5462	466.88	471.55	476.27	481.03	485.84
- Inguinal and femoral - same side	5463	428.33	432.61	436.94	441.31	445.72
- Sliding hernia	5464	428.33	432.61	436.94	441.31	445.72
- Inguinal or femoral repair by prosthesis or graft	5465	466.88	471.55	476.27	481.03	485.84
Recurrent hernia	5466	583.62	589.45	595.35	601.30	607.31
- Recurrent hernia repair by prosthesis or graft	5467	612.80	618.93	625.12	631.37	637.68
Umbilical hernia - adult	5468	437.72	442.10	446.52	450.99	455.50
- child	5469	271.74	274.46	277.21	279.98	282.78
Enterocele, infant	5470	428.33	432.61	436.94	441.31	445.72
Omphalocoele	5471	571.13	576.84	582.61	588.44	594.32
Diaphragmatic hernia	5472	713.88	721.02	728.23	735.51	742.86
- with prosthesis	5473	785.24	793.09	801.02	809.03	817.12
Incisional or ventral hernia - repair by suture	5474	583.62	589.45	595.35	601.30	607.31
- repair by prosthesis	5475	617.95	624.13	630.37	636.67	643.04
Epigastric hernia	5476	408.53	412.61	416.74	420.91	425.12
Strangulated or Incarcerated Hernia						
- without resection	5477	428.33	432.61	436.94	441.31	445.72
- with resection	5478	772.43	780.16	787.96	795.84	803.79
Suture						
Secondary closure for evisceration	5479	335.58	338.93	342.32	345.75	349.20

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OPERATIONS ON THE ENDOCRINE SYSTEM						
These fees cannot be correctly interpreted without reference to the Preamble.						
THYROID GLAND						
Incision						
Abscess, complete care	5500	171.31	173.03	174.76	176.50	178.27
Excision						
Biopsy - needle (core)	5501	57.04	57.61	58.18	58.76	59.35
- surgical	5502	342.51	345.93	349.39	352.89	356.41
Thyroidectomy						
- Bilateral total thyroidectomy	5503	785.24	793.09	801.02	809.03	817.12
- Total lobectomy	5504	656.57	663.13	669.77	676.46	683.23
- Total lobectomy plus subtotal lobectomy	5505	642.38	648.80	655.29	661.84	668.46
- Sub-total bilateral thyroidectomy	5506	571.13	576.84	582.61	588.44	594.32
- Partial lobectomy	5507	513.83	518.97	524.16	529.40	534.70
Excision of solitary nodule	5508	342.51	345.93	349.39	352.89	356.41
If one of the following procedures is carried out with either of the above add:						
- Unilateral limited node dissection	5509	171.31	173.03	174.76	176.50	178.27
- Bilateral limited node dissection	5510	342.51	345.93	349.39	352.89	356.41
- Radical neck dissection unilateral	5511	428.33	432.61	436.94	441.31	445.72
PARATHYROID, THYMUS AND ADRENAL GLANDS						
Excision						
Parathyroidectomy - for hyperplasia	5550	785.24	793.09	801.02	809.03	817.12
- parathyroid tumor	5551	685.22	692.08	699.00	705.99	713.05
- if sternal splitting required	5552	856.28	864.85	873.50	882.23	891.05
Thymectomy	5553	856.28	864.85	873.50	882.23	891.05
Adrenal exploration - unilateral	5554	428.33	432.61	436.94	441.31	445.72
Adrenalectomy - unilateral	5555	713.88	721.02	728.23	735.51	742.86

	Fee Code	1-Apr 2025	1-Apr 2027	1-Oct 2027	1-Apr 2028	1-Oct 2028
OPERATIONS ON THE NERVOUS SYSTEM						
These fees cannot be correctly interpreted without reference to the Preamble.						
Diagnostic Procedures						
Lumbar puncture	2115	124.70	125.94	127.20	128.47	129.76
Subdural puncture - first	2117	39.57	39.96	40.36	40.77	41.17
- each additional	2118	13.08	13.21	13.34	13.48	13.61
Myelogram - Lumbar	2172	91.18	92.09	93.01	93.94	94.88
Arteriography						
- carotid or vertebral (percutaneous)	4630	142.80	144.23	145.67	147.13	148.60
- carotid or vertebral (cutdown, brachial)	4634	214.24	216.38	218.54	220.73	222.93
- aortic arch study (percutaneous)	4633	142.80	144.23	145.67	147.13	148.60
- aortic arch study (cutdown, brachial)	4634	214.24	216.38	218.54	220.73	222.93
Vascular Procedures						
Carotid endarterectomy	5652	856.28	864.85	873.50	882.23	891.05
- with patch graft	5653	999.27	1,009.27	1,019.36	1,029.55	1,039.85
- with graft and by-pass shunt	5654	1,142.08	1,153.50	1,165.03	1,176.68	1,188.45
Trauma						
Scalp laceration						
- simple uncomplicated	3050	88.99	89.88	90.78	91.69	92.60
- extensive, multiple or complicated	3051	I.C.	I.C.	I.C.	I.C.	I.C.
Head Injury (closed) - initial examination & recommendations	5702	79.22	80.01	80.81	81.62	82.44
Skull fracture						
- Non-operative - same as in Head Injury, closed						
- Decompressive Craniotomy						
- Temporal	5710	571.13	576.84	582.61	588.44	594.32
- Subtemporal	5711	856.28	864.85	873.50	882.23	891.05
Extradural hematoma - surgical management	5716	785.24	793.09	801.02	809.03	817.12
Subdural hematoma - with burr holes	5717	785.24	793.09	801.02	809.03	817.12
Vertebral body fracture/dislocation, without cord injury						
Supervision, bed rest only (paid as Visit Fee only)						
Skull calipers, - visit fee plus	3385	142.80	144.23	145.67	147.13	148.60
Closed reduction, +/- anesthetic, cast, frame, brace, etc.	3384	339.60	343.00	346.43	349.89	353.39
Open reduction with or without internal fixation	3386	815.28	823.43	831.66	839.98	848.38
Open reduction and fusion	3387	856.28	864.85	873.50	882.23	891.05
Open reduction/fusion with Orthopedic surgeon each surgeon	3388	642.38	648.80	655.29	661.84	668.46
Vertebral body fracture/dislocation, with cord injury						
No operation (paid as Visit Fee only)						
Skull Calipers, - visit fee plus	3389	142.80	144.23	145.67	147.13	148.60
Closed reduction under Anesthesia	3390	679.47	686.26	693.13	700.06	707.06
Open reduction with or without internal fixation	3391	999.27	1,009.27	1,019.36	1,029.55	1,039.85
Open reduction and fusion	3392	999.27	1,009.27	1,019.36	1,029.55	1,039.85
Open reduction/fusion with Orthopaedic surgeon						
- each surgeon	3393	679.47	686.26	693.13	700.06	707.06
Open reduction and decompression of cord or nerve roots	3394	951.08	960.59	970.20	979.90	989.70
BRAIN						
Craniotomy						
Burr hole and aspiration	5859	713.88	721.02	728.23	735.51	742.86

	Fee Code	1-Apr 2025	1-Apr 2027	1-Oct 2027	1-Apr 2028	1-Oct 2028
SPINAL CORD						
Laminectomy						
For excision of neoplasm, hematoma, vascular anomaly, constrictive pachy-meningitis of spinal cord or nerve roots	5900	999.27	1,009.27	1,019.36	1,029.55	1,039.85
For decompression of spinal cord or cauda equine	5902	856.28	864.85	873.50	882.23	891.05
For treatment of extradural abscess	5903	856.28	864.85	873.50	882.23	891.05
DISCS						
Lumbar						
- Unilateral	3514	679.47	686.26	693.13	700.06	707.06
- Bilateral, multiple or recurrent	3515	856.28	864.85	873.50	882.23	891.05
Excision of disc with fusion - one surgeon	3519	999.27	1,009.27	1,019.36	1,029.55	1,039.85
- two surgeons, each	3520	642.38	648.80	655.29	661.84	668.46
PERIPHERAL NERVES						
Exploration of major nerve (median,ulnar,radial,sciatic,etc) +/- neurolysis	5963	285.34	288.19	291.08	293.99	296.93
Removal tumor major peripheral nerve	5964	428.33	432.61	436.94	441.31	445.72
Suture major peripheral nerve	5965	428.33	432.61	436.94	441.31	445.72
Suture small peripheral nerve (digital)	5967	214.24	216.38	218.54	220.73	222.93
Decompression median nerve at wrist (carpal tunnel syndrome)	5968	285.34	288.19	291.08	293.99	296.93
Decompression ulnar nerve at elbow (cubital tunnel syndrome)	5969	285.34	288.19	291.08	293.99	296.93
Transposition of ulnar nerve at elbow	5970	356.84	360.41	364.01	367.65	371.33
Morton's Neuroma, excision	5973	285.34	288.19	291.08	293.99	296.93
Sympathectomy						
Cervical	5980	571.13	576.84	582.61	588.44	594.32
Cervicodorsal	5981	593.73	599.66	605.66	611.72	617.83
Lumbar	5983	451.32	455.83	460.39	464.99	469.64

	Fee Code	1-Apr 2025	1-Apr 2027	1-Oct 2027	1-Apr 2028	1-Oct 2028
OPERATIONS ON THE FEMALE REPRODUCTIVE SYSTEM						
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OBSTETRICAL OPERATIONS						
Vaginal Delivery - Family Physician	0002	739.42	746.81	754.28	761.83	769.44
Attendance at complicated labor/ precipitous delivery (F.P.) - See Preamble 19.D	0004	739.42	746.81	754.28	761.83	769.44
Vaginal Delivery - non-operative	6001	739.42	746.81	754.28	761.83	769.44
Caesarean Section - procedure only	6004	739.42	746.81	754.28	761.83	769.44
Tubal ligation at time of C-Section, hysterotomy, laparotomy,etc	6005	93.41	94.35	95.29	96.24	97.20
- Caesarean Hysterectomy, subtotal or total	6006	979.92	989.72	999.62	1,009.62	1,019.71
Operative delivery other than Caesarean section	6007	739.42	746.81	754.28	761.83	769.44
Surgical or medical induction of labour, consultation/procedure	6008	90.51	91.41	92.33	93.25	94.18
Abortion - complete, under 20 weeks (paid as Visit Fee only)						
- incomplete, including D & C	6009	199.64	201.64	203.65	205.69	207.75
- therapeutic	6010	199.64	201.64	203.65	205.69	207.75
Missed abortion, with or without intra-uterine hypertonic solution	6012	199.64	201.64	203.65	205.69	207.75
Repair of third degree laceration, consultation/procedure (includes evacuation of vaginal hematoma and repair)	6013	145.92	147.37	148.85	150.34	151.84
**Retained placenta removal, consultation/procedure	6014	145.92	147.37	148.85	150.34	151.84
Ectopic pregnancy	6015	444.25	448.69	453.18	457.71	462.28
Suture of incompetent cervix during pregnancy	6016	252.13	254.65	257.20	259.77	262.37
Sterilization - postpartum (in addition to obstetrical fee)	6017	339.60	343.00	346.43	349.89	353.39
Amniocentesis	6019	67.21	67.88	68.56	69.25	69.94
Abortion incomplete without Anesthesia or D&C (in hospital)	6021	100.01	101.01	102.02	103.04	104.07
Post coital testing	6025	45.09	45.54	46.00	46.46	46.92
Post-partum vaginal hematoma - evacuation/suture (gen.anesth.)	6947	138.63	140.02	141.42	142.83	144.26
Perineal/Vaginal/Cervical laceration – repair (general anesthesia)	6948	125.44	126.70	127.97	129.25	130.54
Post-partum hemorrhage - surgical management (e.g., vessel ligation, compression sutures)	6953	510.65	515.76	520.92	526.13	531.39
**Chargeable by an obstetrician on his own patient when the services of an anesthetist is required.						
FETAL MONITORING						
Consultation/interpretation of fetal monitoring records	6022	57.04	57.61	58.18	58.76	59.35
External cephalic version with or without tocolysis	6024	160.36	161.96	163.58	165.22	166.87
Ultrasound procedures by Obstetrician	2606	76.05	76.81	77.58	78.36	79.14
Insertion of Intrauterine Pressure Catheter (IUPC)	2601	63.38	64.02	64.66	65.30	65.96
Oxytocin Challenge Test	2602	40.02	40.42	40.82	41.23	41.64
Scalp pH Sampling (maximum of 2)	2603	82.72	83.55	84.38	85.23	86.08
Biophysical Profile	2604	76.05	76.81	77.58	78.36	79.14

	Fee Code	1-Apr 2025	1-Apr 2027	1-Oct 2027	1-Apr 2028	1-Oct 2028
VULVA						
Incision						
Hymenectomy	6500	71.30	72.02	72.74	73.46	74.20
Abscess of vulva, Bartholin or Skene's gland						
- complete care	6501	72.95	73.68	74.42	75.16	75.91
- Marsupialization or cautery	6502	86.42	87.28	88.15	89.03	89.92
Excision						
Vulvectomy - simple	6503	342.51	345.93	349.39	352.89	356.41
Cyst of Bartholin's gland	6506	175.09	176.84	178.61	180.39	182.20
Condylomata	6508	145.92	147.37	148.85	150.34	151.84
VAGINA						
Incision						
Colpotomy, posterior, drainage or needling	6600	114.15	115.29	116.44	117.61	118.78
Excision						
Local excision of cyst	6601	204.27	206.31	208.38	210.46	212.56
Repair						
Cystocele or Rectocele	6602	284.87	287.72	290.59	293.50	296.43
Cystocele and Rectocele	6603	491.18	496.09	501.06	506.07	511.13
Cystocele, Rectocele and prolapse (Fothergill)	6604	571.13	576.84	582.61	588.44	594.32
Cystocele, Rectocele and excision of cervical stump	6605	571.13	576.84	582.61	588.44	594.32
Paravaginal repair of cystocele	6803	270.68	273.38	276.12	278.88	281.67
Vaginal vault prolapse						
(post-hysterectomy, vaginal or abdominal)	6606	576.68	582.44	588.27	594.15	600.09
Rectocele and repair of anal sphincter	6607	489.07	493.96	498.90	503.89	508.93
Perineorrhaphy (without rectocele repair)	6608	171.31	173.03	174.76	176.50	178.27
Repair of double vagina	6611	256.88	259.45	262.05	264.67	267.31
Closure of fistula - vesico-vaginal	6612	571.13	576.84	582.61	588.44	594.32
- recto-vaginal	6613	571.13	576.84	582.61	588.44	594.32
- uretero-vaginal	6614	685.22	692.08	699.00	705.99	713.05
Urethral caruncle or prolapse of mucosa	6615	114.15	115.29	116.44	117.61	118.78
Enterocele	6616	522.28	527.50	532.78	538.11	543.49
Retropubic operation for incontinence (Marchetti)	6617	489.07	493.96	498.90	503.89	508.93
Operations for stress incontinence - vaginal	6618	437.72	442.10	446.52	450.99	455.50
- abdominal	6619	583.62	589.45	595.35	601.30	607.31
- combined	6620	875.42	884.18	893.02	901.95	910.97
Transvaginal Tape (TVT) procedure (including cystoscopy)	6639	620.59	626.79	633.06	639.39	645.79
Colposacropexy	6951	736.78	744.15	751.59	759.11	766.70
Sacrospinous vault fixation (add on fee)	6952	125.44	126.70	127.97	129.25	130.54
Manipulation						
Examination +/- dilation - general anesthesia						
(independent operation)	6622	100.01	101.01	102.02	103.04	104.07

	Fee Code	1-Apr 2025	1-Apr 2027	1-Oct 2027	1-Apr 2028	1-Oct 2028
UTERUS AND CERVIX						
Excision						
Diagnostic curettage	6901	136.00	137.36	138.74	140.13	141.53
Myomectomy	6902	489.40	494.30	499.24	504.23	509.27
Hysterectomy - total, abdominal or vaginal	6903	724.24	731.48	738.80	746.19	753.65
- with cystocele or rectocele repair	6900	739.42	746.81	754.28	761.83	769.44
- with cystocele and rectocele repair	6933	871.46	880.18	888.98	897.87	906.85
Hysterectomy - partial or subtotal, with or without adnexae	6905	635.75	642.10	648.52	655.01	661.56
- with rectocele and/or cystocele repair	6906	543.48	548.91	554.40	559.94	565.54
Laparoscopic Hysterectomy - total, abdominal or vaginal	6958	905.30	914.35	923.50	932.73	942.06
Laparoscopic Hysterectomy - partial or subtotal, - w. or w/o adnexa	6959	794.68	802.63	810.66	818.76	826.95
Septate uterus	6908	543.48	548.91	554.40	559.94	565.54
Cervical polyp, without D&C	6909	41.13	41.54	41.96	42.38	42.80
Amputation of cervix	6910	244.61	247.05	249.52	252.02	254.54
Cervical stump - vaginal	6911	326.14	329.40	332.69	336.02	339.38
- abdominal	6912	407.61	411.68	415.80	419.96	424.16
Biopsy of cervix - independent operation w. general anesthesia	6913	68.60	69.28	69.97	70.67	71.38
Introduction						
Insufflation, Rubin's test and D&C	6916	142.80	144.23	145.67	147.13	148.60
Insufflation and endometrial biopsy	6917	118.66	119.84	121.04	122.25	123.47
Hysterosalpingogram	6918	103.13	104.16	105.20	106.25	107.31
I.U.C.D. insertion	6919	118.66	119.84	121.04	122.25	123.47
I.U.C.D. insertion at annual health exam	6939	33.94	34.27	34.62	34.96	35.31
Repair						
Hysteropexy (uterine suspension)	6920	339.60	343.00	346.43	349.89	353.39
- with rectocele and cystocele repair	6922	543.48	548.91	554.40	559.94	565.54
Cervix with or without biopsy	6923	244.61	247.05	249.52	252.02	254.54
Incompetent cervix - any suture repair	6924	203.80	205.83	207.89	209.97	212.07
Repair of inversion of uterus - operative	6925	489.07	493.96	498.90	503.89	508.93
- manual	6926	203.80	205.83	207.89	209.97	212.07
Electro-cautery of cervix - office procedure	6928	42.85	43.27	43.71	44.14	44.58
Biopsy of cervix - office procedure (without colposcopy)	6929	40.73	41.14	41.55	41.97	42.39
Conization of cervix - with D&C	6930	214.24	216.38	218.54	220.73	222.93
- without D&C (LEEP)	6632	79.22	80.01	80.81	81.62	82.44
Endometrial biopsy	6931	55.46	56.02	56.58	57.14	57.71
Injection of fissure in ano	6932	28.46	28.74	29.03	29.32	29.61
Colposcopy - without biopsy	6934	104.37	105.41	106.47	107.53	108.61
- with biopsy (includes Pap)	6989	145.10	146.55	148.02	149.50	150.99
Artificial insemination	6935	57.04	57.61	58.18	58.76	59.35
Vaporization of endometriosis & treatment of pelvic pain (including all associated procedures)	6937	422.98	427.21	431.48	435.80	440.16
Surgical procedure for infertility involving tubal blockage at cornua	6938	845.98	854.44	862.98	871.61	880.33
Hysteroscopy - diagnostic	6945	178.26	180.04	181.84	183.66	185.49
- therapeutic, with D&C, +/-polyp removal	6946	248.24	250.72	253.23	255.76	258.32
Endometrial ablation (+/- D&C; +/- hysteroscopy)	6942	501.95	506.97	512.04	517.16	522.33
Hysteroscopic resection of endometrial tumor	6949	554.57	560.11	565.71	571.37	577.08
Omentectomy, infra-colic and infra-gastric	6630	240.05	242.45	244.88	247.33	249.80
Omental biopsy - single or multiple (add-on fee)	6631	66.02	66.68	67.35	68.02	68.70
Staging laparotomy for gynecological CA (including total hysterectomy/bilateral salpingoophorectomy, bilateral selective pelvic lymphadenectomies, omental biopsies, selective periaortic lymphadenectomy, pelvic washings.)	6950	1,060.87	1,071.48	1,082.20	1,093.02	1,103.95

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FALLOPIAN TUBES						
Peritoneoscopy (Laparoscopy)	5460	256.82	259.39	261.98	264.60	267.24
Excision						
Salpingectomy - unilateral	6700	427.35	431.62	435.94	440.30	444.70
Repair						
Tubal plastic operation	6701	475.61	480.36	485.17	490.02	494.92
Sterilization	6702	339.60	343.00	346.43	349.89	353.39
Lysis of adhesion	6704	411.43	415.55	419.70	423.90	428.14
Infertility investigation with tubal insufflation	6705	277.95	280.73	283.53	286.37	289.23
Follicular tracking by ultrasound	6710	101.93	102.95	103.97	105.01	106.06
OVARY						
Excision						
Ovarian cyst	6800	407.61	411.68	415.80	419.96	424.16
Paraovarian cyst	6801	407.61	411.68	415.80	419.96	424.16
Oophorocystectomy	6802	407.61	411.68	415.80	419.96	424.16

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OPERATIONS ON THE EYE						
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Examination under general Anesthesia with or without intubation	7000	71.30	72.02	72.74	73.46	74.20
EYEBALL						
Incision						
Goniotomy	7002	428.33	432.61	436.94	441.31	445.72
Excision						
Enucleation	7003	356.84	360.41	364.01	367.65	371.33
- with prosthesis implant	7004	428.33	432.61	436.94	441.31	445.72
Repair						
Evisceration	7005	356.84	360.41	364.01	367.65	371.33
- with implant	7006	428.33	432.61	436.94	441.31	445.72
Removal intraocular foreign body	7007	475.61	480.36	485.17	490.02	494.92
CORNEA						
Incision						
Paracentesis	7050	67.80	68.48	69.17	69.86	70.56
Removal embedded foreign body						
- Local anesthetic	7051	46.21	46.67	47.14	47.61	48.09
- General anesthetic	7052	67.80	68.48	69.17	69.86	70.56
Excision						
Keratectomy	7053	428.33	432.61	436.94	441.31	445.72
Excision of dermoid	7054	214.24	216.38	218.54	220.73	222.93
Repair						
Corneal transplant						
- penetrating	7058	883.21	892.04	900.96	909.97	919.07
- Lamellar	7059	679.47	686.26	693.13	700.06	707.06
Suture						
penetrating wound - with excision of iris	7060	428.33	432.61	436.94	441.31	445.72
- without excision of iris	7061	285.34	288.19	291.08	293.99	296.93
Removal of corneal sutures in O.R	7062	65.76	66.42	67.08	67.75	68.43
Corneal retrieval	7063	173.43	175.16	176.91	178.68	180.47
Bandage Contact Lens	7511	110.19	111.29	112.40	113.53	114.66
SCLERA						
Excision						
Sclerectomy	7102	475.61	480.36	485.17	490.02	494.92
Suture						
All penetrating wounds	7103	428.33	432.61	436.94	441.31	445.72
IRIS AND CILIARY BODY						
Incision						
*Iridectomy	7150	339.60	343.00	346.43	349.89	353.39
Iridencleisis	7151	428.33	432.61	436.94	441.31	445.72
Division of anterior synechia following penetrating keratoplasty	7152	214.24	216.38	218.54	220.73	222.93
Destruction						
Diathermy of Ciliary body	7153	285.34	288.19	291.08	293.99	296.93
Anterior chamber open evacuation of clot	7156	428.33	432.61	436.94	441.31	445.72
Iridencysis	7160	420.34	424.55	428.79	433.08	437.41

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IRIS AND CILIARY BODY, Destruction (cont.)						
Trabeculoplasty	7161	444.58	449.02	453.51	458.05	462.63
Anterior Vitrectomy	7162	396.85	400.82	404.82	408.87	412.96
Placement of Glaucoma Shunt	7241	964.48	974.12	983.87	993.70	1,003.64
Trabeculectomy with anti-metabolites	7245	852.90	861.42	870.04	878.74	887.53
*****Note - Fee applies to laser as well as surgical iridectomy. Repeat procedure not payable within 30 days.						
LENS						
Incision						
Capsulotomy	7202	271.74	274.46	277.21	279.98	282.78
Excision						
Cataract						
- Senile	7203	605.20	611.25	617.36	623.54	629.77
- Congenital	7204	639.60	645.99	652.45	658.98	665.57
- Traumatic	7205	639.60	645.99	652.45	658.98	665.57
Extraction of dislocated lens	7206	639.60	645.99	652.45	658.98	665.57
Severance of Vitreous Strands (Yag Laser)	7208	206.44	208.50	210.59	212.69	214.82
Cataract Extraction with Intra-ocular Lens Insertion	7210	611.11	617.22	623.39	629.62	635.92
Secondary Lens Insertion	7211	439.75	444.14	448.59	453.07	457.60
Reposition of Intra-ocular Lens	7212	210.01	212.11	214.23	216.38	218.54
Removal of Intra-ocular Lens	7213	369.58	373.27	377.01	380.78	384.58
RETINA						
Re-attachment of retina and choroid						
- Simple coagulation (diathermy)	7250	571.13	576.84	582.61	588.44	594.32
- Photocoagulation	7251	543.48	548.91	554.40	559.94	565.54
- Cryopexy	7252	543.48	548.91	554.40	559.94	565.54
- Non-circling tube or buckle procedures, including						
- Scleral buckling procedure for retinal detachment	7253	878.82	887.61	896.49	905.45	914.51
- Secondary operations after an unsuccessful operation or for a fresh detachment after a previously successful operation, including an encircling tube	7256	1,142.08	1,153.50	1,165.03	1,176.68	1,188.45
Pneumatic Retinopexy	7259	814.67	822.82	831.05	839.36	847.75
- repeat same eye within 30 days	7260	407.33	411.40	415.52	419.67	423.87
Independent Procedures						
- Photocoagulation	7257	339.60	343.00	346.43	349.89	353.39
- Cryopexy	7258	339.60	343.00	346.43	349.89	353.39
Fluorescein / Digital Angiography	7510	76.11	76.87	77.64	78.42	79.20
Posterior Vitrectomy	7242	1,021.74	1,031.95	1,042.27	1,052.69	1,063.22
Vitreous Exchange (add-on fee)	7243	173.72	175.46	177.21	178.99	180.78
Epiretinal membrane peel	7244	578.60	584.39	590.23	596.13	602.09
EXTRAOCULAR MUSCLES						
Repair						
Strabismus Procedures						
- one or more than one muscle, one or both eyes	7300	563.61	569.24	574.94	580.68	586.49
- subsequent operation by same surgeon within 6 months	7301	326.30	329.57	332.86	336.19	339.55
- Adjustable Suture Technique	7302	420.34	424.55	428.79	433.08	437.41
ORBIT						
Incision						
Drainage of abscess	7350	285.34	288.19	291.08	293.99	296.93
Lateral orbiotomy, Kronlein procedure	7351	713.88	721.02	728.23	735.51	742.86

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Excision						
Tumor - orbital	7352	499.57	504.56	509.61	514.70	519.85
- lacrimal gland	7353	499.57	504.56	509.61	514.70	519.85
Exenterations, with or without major plastic repair	7354	571.13	576.84	582.61	588.44	594.32
Biopsy	7355	142.80	144.23	145.67	147.13	148.60
Repair						
Orbital fracture, open reduction rim wall fracture (zygomatic fract/disloc)	7356	428.33	432.61	436.94	441.31	445.72
Blowout fracture of floor	7357	499.57	504.56	509.61	514.70	519.85
Secondary repair of blowout fracture by combined or orbital approach	7358	785.24	793.09	801.02	809.03	817.12
EYELIDS						
Incision						
Drainage of abscess - local anesthetic	7400	46.21	46.67	47.14	47.61	48.09
Excision						
Chalazion - single or multiple - complete care						
- local anesthetic	7402	57.31	57.88	58.46	59.05	59.64
- general anesthetic	7403	71.30	72.02	72.74	73.46	74.20
Epilation by Hyfurcator, electrolysis	7404	28.46	28.74	29.03	29.32	29.61
Lid Tumors						
- very minor	7405	42.85	43.27	43.71	44.14	44.58
- minor	7406	203.80	205.83	207.89	209.97	212.07
- intermediate	7407	356.84	360.41	364.01	367.65	371.33
- major	7408	499.57	504.56	509.61	514.70	519.85
- extensive major	7409	713.88	721.02	728.23	735.51	742.86
Repair						
Ptosis **(Prior approval required)**	7410	428.33	432.61	436.94	441.31	445.72
- secondary repair **(Prior approval required)**	7411	713.88	721.02	728.23	735.51	742.86
Blepharoplasty **(Prior approval required)**						
- excision of skin, with or without muscle, per lid	7430	175.95	177.70	179.48	181.28	183.09
- with removal of orbital fat, +/-lid fold reconstruction/graft	7431	229.76	232.05	234.38	236.72	239.09
Districhiasis - unilateral	7412	428.33	432.61	436.94	441.31	445.72
Trichiasis, surgical repair by transplantation	7413	I.C.	I.C.	I.C.	I.C.	I.C.
Entropion, other than Zeigler puncture	7414	429.13	433.42	437.76	442.14	446.56
Ectropion, other than Zeigler puncture	7415	428.33	432.61	436.94	441.31	445.72
Laceration, full thickness, including margin						
- less than 2cm	7421	214.24	216.38	218.54	220.73	222.93
- greater than 2cm	7417	428.33	432.61	436.94	441.31	445.72
Suture						
Tarsorrhaphy	7418	142.80	144.23	145.67	147.13	148.60
Double adhesion	7419	214.24	216.38	218.54	220.73	222.93
Treatment of Trichiasis by electrolysis in the O.R. or by laser oblation of hair follicles	7420	65.76	66.42	67.08	67.75	68.43
CONJUNCTIVA						
Removal of foreign body - office call fee						
Excision						
Pterygium - unilateral with conjunctival autograph	7450	277.29	280.06	282.86	285.69	288.55
Peritomy - unilateral	7451	100.01	101.01	102.02	103.04	104.07
Biopsy	7452	42.85	43.27	43.71	44.14	44.58
Repair						
Plastic repair - depending on extent	7453	I.C.	I.C.	I.C.	I.C.	I.C.

	Fee Code	1-Apr 2025	1-Apr 2027	1-Oct 2027	1-Apr 2028	1-Oct 2028
LACRIMAL TRACT						
Incision						
Daryocystotomy - general anesthetic	7500	71.30	72.02	72.74	73.46	74.20
Excision						
Dacryocystectomy	7502	356.84	360.41	364.01	367.65	371.33
Introduction						
Catheterization or irrigation of duct (paid as Visit Fee only)						
Repair						
Lacerated canaliculus	7503	285.34	288.19	291.08	293.99	296.93
Dacrocystorrhinostomy	7504	571.13	576.84	582.61	588.44	594.32
Manipulation						
Dilation of punctum (paid as Visit Fee only)						
Probing and dilation of duct - Office procedure (paid as Visit Fee only)						
General anesthetic - initial or repeat, unilateral or bilateral	7505	92.55	93.48	94.41	95.36	96.31
Three snip procedure for ectropion of the lower lacrimal punctums (bilateral)	7512	81.80	82.61	83.44	84.27	85.12

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OPERATIONS ON THE EAR						
These fees cannot be correctly interpreted without reference to the Preamble.						
EXTERNAL EAR						
Incision						
Drainage of abscess or hematoma of auricle or external ear canal						
- local anesthetic	7700	99.03	100.02	101.02	102.03	103.05
- general anesthetic	7701	71.30	72.02	72.74	73.46	74.20
Excision						
Biopsy of ear	7702	118.66	119.84	121.04	122.25	123.47
Local excision of lesion on ear	7703	71.30	72.02	72.74	73.46	74.20
Partial excision of ear	7704	214.24	216.38	218.54	220.73	222.93
Complete excision or amputation of ear	7705	285.34	288.19	291.08	293.99	296.93
Radical excision of malignant lesion of external ear canal	7706	571.13	576.84	582.61	588.44	594.32
Excision of pre-auricular sinus, simple - local anesthetic	7720	100.65	101.66	102.67	103.70	104.74
- general anesthetic	7721	201.31	203.32	205.36	207.41	209.49
Excision of ear canal Exostosis - single	7913	372.90	376.63	380.40	384.20	388.04
- multiple	7914	656.57	663.13	669.77	676.46	683.23
Endoscopy						
Removal of foreign body from external ear canal - simple	7707	46.21	46.67	47.14	47.61	48.09
- under general anesthetic	7708	71.30	72.02	72.74	73.46	74.20
Repair						
Reconstruction of ear with graft of skin/cartilage **(Prior approval required)**	7710	I.C.	I.C.	I.C.	I.C.	I.C.
Construction of ear canal for congenital atresia	7711	999.27	1,009.27	1,019.36	1,029.55	1,039.85
Removal of plastic drainage tubes	7712	25.54	25.80	26.06	26.32	26.58
Removal of plastic drainage tubes under general anesthetic	7713	63.51	64.15	64.79	65.44	66.09
Fibreoptic endoscopy	7714	35.60	35.95	36.31	36.67	37.04
MIDDLE EAR						
Incision						
Myringotomy (without after care) - local anesthetic	7800	42.85	43.27	43.71	44.14	44.58
- general anesthetic	7801	85.69	86.55	87.41	88.29	89.17
Myringotomy (operative Microscope) and insertion of prosthesis	7802	136.00	137.36	138.74	140.13	141.53
Aspiration of serous otitis	7803	28.46	28.74	29.03	29.32	29.61
Excision						
Mastoidectomy - simple, unilateral	7804	428.33	432.61	436.94	441.31	445.72
- Radical or modified radical, unilateral	7805	713.88	721.02	728.23	735.51	742.86
Removal of middle ear polyp by snare (not including post-op care)	7806	57.04	57.61	58.18	58.76	59.35
Repair						
Revision of radical mastoid cavity	7807	713.88	721.02	728.23	735.51	742.86
Stapes mobilization	7808	713.88	721.02	728.23	735.51	742.86
Stapedectomy	7809	999.27	1,009.27	1,019.36	1,029.55	1,039.85
Myringoplasty	7811	428.33	432.61	436.94	441.31	445.72
Tympanoplasty	7812	815.28	823.43	831.66	839.98	848.38
Facial nerve decompression	7813	713.88	721.02	728.23	735.51	742.86
Facial nerve graft	7814	856.28	864.85	873.50	882.23	891.05
Middle ear exploration	7815	428.33	432.61	436.94	441.31	445.72
Cleaning of mastoid cavity	7915	85.05	85.90	86.76	87.63	88.51
INTERNAL EAR						
Excision						
Labyrinthectomy	7901	856.28	864.85	873.50	882.23	891.05
Meatoplasty (may be claimed in addition to a mastoidectomy)	7902	145.84	147.30	148.77	150.26	151.76

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OPERATIONS ON THE URINARY SYSTEM						
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KIDNEY AND PERINEPHRIUM						
Incision						
Drainage of Kidney abscess, including excision of carbuncle	8000	428.33	432.61	436.94	441.31	445.72
Drainage of perinephric abscess	8001	285.34	288.19	291.08	293.99	296.93
Adrenal exploration, unilateral	8002	428.33	432.61	436.94	441.31	445.72
Renal exploration	8003	428.33	432.61	436.94	441.31	445.72
Nephrostomy	8004	499.57	504.56	509.61	514.70	519.85
Transection of aberrant renal vessel	8006	499.57	504.56	509.61	514.70	519.85
- Secondary operation - additional	8007	142.80	144.23	145.67	147.13	148.60
Pyelolithotomy	8009	499.57	504.56	509.61	514.70	519.85
- Removal of Staghorn calculus	8030	801.35	809.36	817.46	825.63	833.89
Excision						
Adrenalectomy, unilateral	8011	713.88	721.02	728.23	735.51	742.86
Functional tumors (pheochromocytoma)	8012	713.88	721.02	728.23	735.51	742.86
Renal cyst	8013	499.57	504.56	509.61	514.70	519.85
Heminephrectomy	8014	685.22	692.08	699.00	705.99	713.05
- Secondary operation - additional	8015	142.80	144.23	145.67	147.13	148.60
Nephrectomy						
- Ectopic	8016	571.13	576.84	582.61	588.44	594.32
- Lumbar	8017	599.52	605.52	611.57	617.69	623.86
- Transperitoneal	8018	571.13	576.84	582.61	588.44	594.32
- Thoraco-abdominal	8019	856.28	864.85	873.50	882.23	891.05
- Radical nephrectomy - lumbar or thoraco-abdominal	8020	815.28	823.43	831.66	839.98	848.38
- Nephro-ureterectomy	8021	713.88	721.02	728.23	735.51	742.86
- Nephro-ureterectomy with resection of uretero-vesical junction	8022	856.28	864.85	873.50	882.23	891.05
- Secondary operation - additional	8023	142.80	144.23	145.67	147.13	148.60
Donor nephrectomy - unilateral or bilateral	8031	572.32	578.04	583.82	589.66	595.56
Open renal biopsy	8024	428.33	432.61	436.94	441.31	445.72
Needle Biopsy	2176	92.14	93.06	93.99	94.93	95.88
Partial removal and reconstruction of kidney for Renal CA	8010	815.28	823.43	831.66	839.98	848.38
Repair						
Pyeloureteroplasty	8025	642.38	648.80	655.29	661.84	668.46
Nephropexy	8026	428.33	432.61	436.94	441.31	445.72
Symphysiotomy for horseshoe kidney +/- nephropexy & assoc. procedures	8028	685.22	692.08	699.00	705.99	713.05
Renal auto-transplantation	8032	1,103.91	1,114.94	1,126.09	1,137.35	1,148.73
Suture						
Ruptured or lacerated kidney - repair or removal	8029	571.13	576.84	582.61	588.44	594.32
URETER						
Incision						
Peri-ureteral abscess	8100	285.34	288.19	291.08	293.99	296.93
Ureterotomy						
- Upper two-thirds	8102	513.83	518.97	524.16	529.40	534.70
- Lower one-third	8103	599.52	605.52	611.57	617.69	623.86
Ureterotomy where ureter has been previously opened						
- Upper two-thirds	8125	544.68	550.12	555.62	561.18	566.79
- Lower one-third	8126	624.75	630.99	637.30	643.68	650.11

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Excision						
Ureterectomy	8104	499.57	504.56	509.61	514.70	519.85
- including ureterovesical junction	8105	571.13	576.84	582.61	588.44	594.32
Repair						
Ureterovesical anastomosis, reimplantation	8106	685.22	692.08	699.00	705.99	713.05
Uretero-ileal conduit	8107	856.28	864.85	873.50	882.23	891.05
Uretero-ileal conduit with total cystectomy	8108	1,284.81	1,297.66	1,310.64	1,323.74	1,336.98
Uretero-colic anastomosis or transplant	8109	642.38	648.80	655.29	661.84	668.46
- with cystectomy, one stage	8110	1,027.72	1,038.00	1,048.38	1,058.86	1,069.45
- with cystectomy, and colostomy	8111	1,198.98	1,210.97	1,223.08	1,235.31	1,247.66
Ileo-ureteral substitution	8112	856.28	864.85	873.50	882.23	891.05
Uretero-ureterostomy	8113	713.88	721.02	728.23	735.51	742.86
Ureterostomy,cutaneous-unilateral	8114	428.33	432.61	436.94	441.31	445.72
Uretero-vaginal fistula	8115	685.22	692.08	699.00	705.99	713.05
Ureterolysis for peri-ureteral fibrosis, unilateral	8116	571.13	576.84	582.61	588.44	594.32
Spontaneous or traumataic rupture or transection						
- Immediate - upper two thirds	8118	499.57	504.56	509.61	514.70	519.85
- lower one-third	8119	571.13	576.84	582.61	588.44	594.32
- Late repair - upper two-thirds	8120	571.13	576.84	582.61	588.44	594.32
- lower one-third	8121	642.38	648.80	655.29	661.84	668.46
Bladder flap (BOARI) to include re-implantation of ureter	8127	613.33	619.46	625.65	631.91	638.23
Revision of ureteral-ileal anastomosis	8128	536.75	542.11	547.53	553.01	558.54
Partial resection and revision of ileal conduit	8129	490.80	495.71	500.66	505.67	510.73
Endoscopic procedures						
Calibration and/or dilation (one or both sides)	8122	125.44	126.70	127.97	129.25	130.54
Endoscopic removal of calculus +/- ureteral meatotomy (Basket extraction)	8123	363.11	366.74	370.41	374.11	377.85
Manipulation only, stone not removed	8124	211.27	213.38	215.51	217.67	219.84
Insertion of ureteral stent	8199	343.31	346.74	350.21	353.71	357.25
BLADDER						
Endoscopy - Cystoscopy						
Diagnostic - with or without catheterization of ureters, collection of ureteral specimens of urine, intravenous function test, but not including subsequent hospital care	8200	125.44	126.70	127.97	129.25	130.54
With biopsy (transurethral)	8202	211.27	213.38	215.51	217.67	219.84
With electrocoagulation of tumor - single	8203	211.27	213.38	215.51	217.67	219.84
- multiple	8204	264.08	266.72	269.38	272.08	274.80
With urethral dilation	8205	135.74	137.10	138.47	139.85	141.25
With bladder dilation	8206	211.27	213.38	215.51	217.67	219.84
With electrocoagulation of Hunner's ulcers	8207	211.27	213.38	215.51	217.67	219.84
With electro-excision of tumor(s) including base & adjacent muscle						
- single	8208	380.52	384.33	388.17	392.05	395.97
- multiple	8209	554.57	560.11	565.71	571.37	577.08
With electrosurgical ureteral meatotomy	8211	237.67	240.04	242.44	244.87	247.32
With removal of foreign body or calculus	8212	264.08	266.72	269.38	272.08	274.80
With litholapaxy, visual or tactile and removal of fragments	8214	326.14	329.40	332.69	336.02	339.38
With urethral meatotomy and plastic repair	8215	211.27	213.38	215.51	217.67	219.84
With insertion of ureteral stent	8199	343.31	346.74	350.21	353.71	357.25
With brush biopsy of the ureter and renal pelvis	8198	264.08	266.72	269.38	272.08	274.80
With retrograde pyelogram	8242	160.18	161.78	163.40	165.04	166.69
With intravesical Botox injections (1 or more)	8250	264.08	266.72	269.38	272.08	274.80

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Incision						
Cystotomy or cystostomy	8216	214.24	216.38	218.54	220.73	222.93
Cystotomy or cystostomy and electro-coagulation of tumor	8217	428.33	432.61	436.94	441.31	445.72
Cystotomy with trochar and cannula and insertion of tube	8218	142.80	144.23	145.67	147.13	148.60
Cystolithotomy	8219	285.34	288.19	291.08	293.99	296.93
Excision						
Cystectomy, partial - for atony	8223	571.13	576.84	582.61	588.44	594.32
- for tumor or diverticulum	8224	642.38	648.80	655.29	661.84	668.46
- with reimplantation of ureter	8225	713.88	721.02	728.23	735.51	742.86
Cystectomy, complete without transplant	8226	713.88	721.02	728.23	735.51	742.86
Cystectomy, complete with colocystoplasty	8227	1,142.08	1,153.50	1,165.03	1,176.68	1,188.45
- Second surgeon	8228	285.34	288.19	291.08	293.99	296.93
Excision of urachus and repair of bladder	8229	356.84	360.41	364.01	367.65	371.33
Therapeutic pelvic & retroperitoneal lymphadenectomy for bladder cancer	8243	805.11	813.16	821.29	829.51	837.80
Repair						
Extrophy						
- primary closure	8230	428.33	432.61	436.94	441.31	445.72
- urinary diversion for bladder extrophy and excision of ectopic bladder and repair of abdominal wall	8231	1,142.08	1,153.50	1,165.03	1,176.68	1,188.45
- excision of bladder and repair of abdominal wall	8232	428.33	432.61	436.94	441.31	445.72
Repair of ruptured bladder	8233	513.83	518.97	524.16	529.40	534.70
Ileocystoplasty or colocystoplasty	8234	856.28	864.85	873.50	882.23	891.05
Closure of fistula						
- external, suprapubic	8239	342.51	345.93	349.39	352.89	356.41
- Vesicovaginal-transvesical approach	8240	685.22	692.08	699.00	705.99	713.05
- Vesicorectal or vesicosigmoid	8241	571.13	576.84	582.61	588.44	594.32
URETHRA						
Endoscopy						
Biopsy including endoscopy	8300	114.15	115.29	116.44	117.61	118.78
Internal urethrotomy	8301	171.31	173.03	174.76	176.50	178.27
Removal of foreign body or calculus	8302	214.24	216.38	218.54	220.73	222.93
Meatal extraction of foreign body	8303	46.21	46.67	47.14	47.61	48.09
Incision						
Urethrotomy - external	8304	342.51	345.93	349.39	352.89	356.41
Cold Knife (visual) internal urethrotomy	8197	282.57	285.39	288.25	291.13	294.04
Meatotomy and plastic repair	8305	100.01	101.01	102.02	103.04	104.07
Periurethral abscess	8308	71.30	72.02	72.74	73.46	74.20
External sphincterotomy (transurethral)	8335	400.68	404.68	408.73	412.82	416.94
Excision						
Caruncle	8309	100.01	101.01	102.02	103.04	104.07
- with cystoscopy	8310	171.31	173.03	174.76	176.50	178.27
Urethral papilloma, single or multiple	8311	171.31	173.03	174.76	176.50	178.27
Prolapse	8312	114.15	115.29	116.44	117.61	118.78
- with cystoscopy	8313	171.31	173.03	174.76	176.50	178.27
Stricture - one stage with diversion	8314	513.83	518.97	524.16	529.40	534.70
- two stage - first stage	8315	256.88	259.45	262.05	264.67	267.31
- second stage	8316	513.83	518.97	524.16	529.40	534.70
Diverticulectomy - male or female	8317	356.84	360.41	364.01	367.65	371.33
Posterior urethral valve - by endoscopy	8318	142.80	144.23	145.67	147.13	148.60
- open operation	8319	356.84	360.41	364.01	367.65	371.33
Biopsy	8320	42.85	43.27	43.71	44.14	44.58
Urethrectomy	8334	528.15	533.44	538.77	544.16	549.60

	Fee Code	1-Apr 2025	1-Apr 2027	1-Oct 2027	1-Apr 2028	1-Oct 2028
Repair						
Urethral sling	8321	428.33	432.61	436.94	441.31	445.72
Urethrovesical suspension for stress incontinence	8322	513.83	518.97	524.16	529.40	534.70
Urethrovesical suspension with partial cystectomy or vesicopexy	8323	685.22	692.08	699.00	705.99	713.05
Transvaginal Tape (TVT) procedure (including cystoscopy)	6639	620.59	626.79	633.06	639.39	645.79
Urethrolysis (includes cystoscopy)	8339	462.14	466.76	471.43	476.15	480.91
Suture						
Rupture - anterior urethra (diversion of urine extra)	8324	342.51	345.93	349.39	352.89	356.41
- posterior urethra - immediate repair	8325	599.52	605.52	611.57	617.69	623.86
- late repair	8326	785.24	793.09	801.02	809.03	817.12
Recto-urethral fistula	8328	571.13	576.84	582.61	588.44	594.32
- with colostomy	8329	713.88	721.02	728.23	735.51	742.86
Urethro-cutaneous fistula	8333	342.51	345.93	349.39	352.89	356.41
Manipulation						
Dilation of stricture - local anesthetic	8330	28.46	28.74	29.03	29.32	29.61
- general anesthetic	8331	71.30	72.02	72.74	73.46	74.20
- filiforms and followers	8332	51.70	52.22	52.74	53.27	53.80
Insertion of artificial urinary sphincter	8336	792.23	800.15	808.15	816.24	824.40
PERCUTANEOUS PROCEDURES						
Percutaneous Renal & Upper Ureteric procedures						
Renal/Upper ureteral stone removal - single stone						
- without electrohydraulic or ultrasonic lithotripsy	8592	617.29	623.46	629.69	635.99	642.35
- with electrohydraulic and/or ultrasonic lithotripsy	8593	740.69	748.09	755.57	763.13	770.76
Renal/Upper ureteral stone removal - multiple stones or staghorn						
- without electrohydraulic or ultrasonic lithrotripsy	8594	740.69	748.09	755.57	763.13	770.76
- with electrohydraulic and/or ultrasonic lithotripsy	8595	987.46	997.33	1,007.31	1,017.38	1,027.55
Repeat through original access within one week for any of the above	8596	493.89	498.83	503.82	508.85	513.94
Percutaneous nephrostomy	8597	197.60	199.58	201.58	203.59	205.63
Percutaneous endopyeloplasty for UPJ obstruction/stenosis	8033	342.51	345.93	349.39	352.89	356.41
Percutaneous Lower Ureteric procedures						
Ureteroscopy only	8588	320.36	323.57	326.80	330.07	333.37
Ureteroscopy with electrohydraulic and/or ultrasonic lithotripsy	8598	740.69	748.09	755.57	763.13	770.76
Ureteroscopy plus basket	8599	617.29	623.46	629.69	635.99	642.35
Extracorporeal Shockwave Lithotripsy (ESWL)						
ESWL - one side, one stone	8040	475.34	480.10	484.90	489.75	494.64
ESWL - one side, multiple stones	8041	713.01	720.14	727.34	734.61	741.96
ESWL - bilateral stones, one stone per side	8042	792.23	800.15	808.15	816.24	824.40
ESWL - bilateral stones, multiple stones per side	8043	1,155.34	1,166.89	1,178.56	1,190.35	1,202.25

	Fee Code	1-Apr 2025	1-Apr 2027	1-Oct 2027	1-Apr 2028	1-Oct 2028
OPERATIONS ON THE MALE REPRODUCTIVE SYSTEM						
PENIS						
Incision						
Split of prepuce - newborn	8400	14.32	14.47	14.61	14.76	14.90
- child or infant	8401	15.84	16.00	16.16	16.32	16.48
- adult	8402	31.69	32.01	32.33	32.65	32.98
Excision						
Circumcision - infant over 10 days or child under 12 years	8404	207.65	209.72	211.82	213.94	216.08
- adult	8405	207.65	209.72	211.82	213.94	216.08
Condylomata	8406	71.30	72.02	72.74	73.46	74.20
Biopsy	8407	57.04	57.61	58.18	58.76	59.35
Amputation						
- Partial	8408	256.88	259.45	262.05	264.67	267.31
- Partial with inguinal glands dissection - 1 or 2 stages	8409	685.22	692.08	699.00	705.99	713.05
- Total w. inguinal and femoral glands dissection 1 or 2 stages	8410	856.28	864.85	873.50	882.23	891.05
Repair						
Epispadias	8411	428.33	432.61	436.94	441.31	445.72
Hypospadias - including urinary diversion						
- Chordee repair	8412	285.34	288.19	291.08	293.99	296.93
Plastic reconstruction urethra, penile - one stage	8413	428.33	432.61	436.94	441.31	445.72
- two stage	8414	571.13	576.84	582.61	588.44	594.32
Plastic reconstruction penoscrotal or perineal - one stage	8415	571.13	576.84	582.61	588.44	594.32
- two stage	8416	713.88	721.02	728.23	735.51	742.86
Penile prosthesis for impotence **(Prior approval required)**	8417	404.77	408.81	412.90	417.03	421.20
Insertion of hydraulic penile prosthesis	8420	495.74	500.69	505.70	510.76	515.87
Removal of infected penile prosthesis	8422	330.10	333.40	336.73	340.10	343.50
Excision of Peyronie's plaque	8418	257.61	260.19	262.79	265.41	268.07
Nesbitt procedure for Peyronie's disease	8337	713.01	720.14	727.34	734.61	741.96
Intracorporeal injections of vasoactive substances for impotence (Dx & Tx)	8419	19.15	19.34	19.54	19.73	19.93
TESTES						
Incision						
Abscess	8500	71.30	72.02	72.74	73.46	74.20
Excision						
Orchidectomy, unilateral	8501	256.88	259.45	262.05	264.67	267.31
Biopsy - single	8502	71.30	72.02	72.74	73.46	74.20
- with vasography	8503	142.80	144.23	145.67	147.13	148.60
Radical orchidectomy for malignancy - unilateral	8508	396.12	400.08	404.08	408.12	412.21
Repair						
Orchidopexy or exploration, unilateral	8504	489.07	493.96	498.90	503.89	508.93
Reduction of torsion of testis or appendix testis and repair	8505	256.88	259.45	262.05	264.67	267.31
Ruptured testicle	8506	256.88	259.45	262.05	264.67	267.31
Insertion of testicular prosthesis						
(Prior approval required for age 18 yrs & over)	8507	212.59	214.71	216.86	219.03	221.22
Retroperitoneal lymphadenectomy for testicular cancer	8421	I.C.	I.C.	I.C.	I.C.	I.C.
EPIDIDYMIS						
Incision						
Abscess	8510	71.30	72.02	72.74	73.46	74.20
Excision						
Spermatocele	8511	256.88	259.45	262.05	264.67	267.31
Epididymectomy, unilateral	8512	256.88	259.45	262.05	264.67	267.31
Anastomosis, epididymovasostomy, unilateral	8513	256.88	259.45	262.05	264.67	267.31

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TUNICA VAGINALIS						
Excision						
Hydrocele - unilateral	8520	244.61	247.05	249.52	252.02	254.54
Hydrocele - aspiration	8521	28.46	28.74	29.03	29.32	29.61
SCROTUM						
Incision						
Abscess or hematocele	8530	71.30	72.02	72.74	73.46	74.20
Exploration, unilateral	8531	171.31	173.03	174.76	176.50	178.27
Excision						
Minor lesions, e.g., sebaceous cysts, fibromata, etc.	3035	88.99	89.88	90.78	91.69	92.60
Resection of scrotum	8533	285.34	288.19	291.08	293.99	296.93
Suture						
Trauma - laceration, depending on extent and complications	8534	I.C.	I.C.	I.C.	I.C.	I.C.
VAS DEFERENS						
Vasography, single procedure	8540	71.30	72.02	72.74	73.46	74.20
Suture						
Ligation, bilateral (vasectomy)	8543	189.85	191.75	193.66	195.60	197.56
SPERMATIC CORD						
Excision						
Varicocele, unilateral	8550	256.88	259.45	262.05	264.67	267.31
Hydrocele, unilateral	8551	256.88	259.45	262.05	264.67	267.31
SEMINAL VESICLES						
Incision						
Abscess	8560	142.80	144.23	145.67	147.13	148.60
Excision						
Vesiculectomy	8561	713.88	721.02	728.23	735.51	742.86
PROSTATE						
Incision						
Biopsy - perineal open operation	8572	285.34	288.19	291.08	293.99	296.93
- needle, perineal	2182	104.31	105.36	106.41	107.47	108.55
- needle, perineal with cystoscopy	8574	171.31	173.03	174.76	176.50	178.27
- ultrasound guided transrectal (1 billing per procedure)	8582	160.42	162.03	163.65	165.29	166.94
Excision						
Prostatectomy						
Radical prostatovesiculectomy	8577	1,027.72	1,038.00	1,048.38	1,058.86	1,069.45
Suprapubic - one stage or two stages	8578	685.22	692.08	699.00	705.99	713.05
- with diverticulectomy	8579	856.28	864.85	873.50	882.23	891.05
- with partial cystectomy for atony of bladder	8580	856.28	864.85	873.50	882.23	891.05
Retropubic - simple	8581	679.47	686.26	693.13	700.06	707.06
Staging pelvic lymphadenectomy for Carcinoma of prostate	8591	404.77	408.81	412.90	417.03	421.20
Endoscopy						
Transurethral electro-resection (TURP)	8584	679.47	686.26	693.13	700.06	707.06
Resection of bladder neck - adult	8587	428.33	432.61	436.94	441.31	445.72
Change of suprapubic tube	8590	28.46	28.74	29.03	29.32	29.61

	Fee Code	1-Apr 2025	1-Apr 2027	1-Oct 2027	1-Apr 2028	1-Oct 2028
DIAGNOSTIC IMAGING						
These fees cannot be correctly interpreted without reference to the Preamble.						
These are the fees for consultation between the Certified Diagnostic Radiologist and the referring physician, supervision of x-ray service, fluoroscopy, interpretation of radiographs and fluoroscopic findings. This does not include special procedural fees listed separately in the schedule.						
NOTE: Fees for Clinical procedures related to x-ray examination are listed under 'Special Procedural Fee' or under the appropriate Specialty section.						
NOTE: Except for fee codes 8765, 8766, 8767, 8769, 8791, where cine or videotape is used, fee is to be increased by 25%.						
ON-CALL RETAINER - Radiology (Prov.) **See Preamble 11.A.1**	1540	400.00	400.00	400.00	400.00	400.00
Additional On-Call add-on fee - **See Preamble 11.A.3**	1545	400.00	400.00	400.00	400.00	400.00
ON-CALL RETAINER - Radiology (Backup)	1547	200.00	200.00	200.00	200.00	200.00
HOSPITAL ON-CALL RESPONSE FEE - See Preamble 11.B.1	9360	185.00	186.85	188.72	190.61	192.51
ADMINISTRATIVE MEETING - See Preamble 29 (per 15 min)	0050	55.00	55.55	56.11	56.67	57.23
ADDITIONAL FEE FOR EMERGENCY STUDIES	8859	30.57	30.87	31.18	31.50	31.81
FLUOROSCOPY - per 15 minute block	8860	55.00	55.55	56.11	56.67	57.23
SPECIAL DETENTION - per 15 minute block	8871	55.00	55.55	56.11	56.67	57.23
PLAIN FILMS						
HEAD AND NECK						
Eye for foreign body	8600	9.64	9.73	9.83	9.93	10.03
Eye for localization additional	8601	25.82	26.08	26.34	26.60	26.87
Optic Foramina	8602	9.64	9.73	9.83	9.93	10.03
Facial bones	8603	14.32	14.47	14.61	14.76	14.90
Mandible	8604	9.64	9.73	9.83	9.93	10.03
Mastoids necessary added views	8605	14.14	14.28	14.42	14.56	14.71
Neck for soft tissues	8606	10.62	10.72	10.83	10.94	11.05
Nasal bones	8607	13.07	13.20	13.33	13.46	13.60
Salivary gland region	8608	9.64	9.73	9.83	9.93	10.03
Sella turcica	8609	7.85	7.93	8.01	8.09	8.17
Sinuses paranasal	8610	12.47	12.60	12.72	12.85	12.98
Skull - routine views	8611	14.52	14.67	14.81	14.96	15.11
Skull - special additional views	8612	7.85	7.93	8.01	8.09	8.17
Teeth - up to half set	8613	7.85	7.93	8.01	8.09	8.17
Teeth - full set	8614	13.00	13.13	13.26	13.40	13.53
Temperomandibular joint	8615	10.30	10.40	10.50	10.61	10.71
Internal auditory meati	8616	13.00	13.13	13.26	13.40	13.53
SPINE AND PELVIS						
Cervical spine - routine views	8620	14.19	14.33	14.48	14.62	14.77
Cervical spine - with special added views	8621	16.76	16.93	17.10	17.27	17.44
Thoracic spine	8622	11.63	11.74	11.86	11.98	12.10
Lumbar spine - routine views	8623	14.19	14.33	14.48	14.62	14.77
Lumbar spine - with special added views	8624	15.51	15.67	15.82	15.98	16.14
Sacrum and/or coccyx	8625	9.64	9.73	9.83	9.93	10.03
Pelvis	8626	10.62	10.72	10.83	10.94	11.05
S.I. Joints	8627	10.62	10.72	10.83	10.94	11.05
Complete spine scoliosis series	8628	24.49	24.73	24.98	25.23	25.48
Ribs each side	8629	9.69	9.79	9.89	9.98	10.08
Sternum	8630	9.64	9.73	9.83	9.93	10.03

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EXTREMITIES						
Clavicle	8635	10.76	10.87	10.97	11.08	11.19
Sternoclavicular joints	8636	9.64	9.73	9.83	9.93	10.03
Shoulder	8637	10.76	10.87	10.97	11.08	11.19
Scapula	8638	9.64	9.73	9.83	9.93	10.03
Humerus	8639	10.76	10.87	10.97	11.08	11.19
Elbow	8640	10.76	10.87	10.97	11.08	11.19
Forearm	8641	10.76	10.87	10.97	11.08	11.19
Wrist	8642	10.56	10.67	10.77	10.88	10.99
Hand	8643	10.56	10.67	10.77	10.88	10.99
Finger	8644	5.08	5.13	5.18	5.24	5.29
Acromioclavicular joints with weights	8645	13.00	13.13	13.26	13.40	13.53
Hip	8646	10.62	10.72	10.83	10.94	11.05
Hip pinning - interpretation	8647	10.82	10.93	11.04	11.15	11.26
Hip pinning - supervision and interpretation	8648	38.56	38.94	39.33	39.72	40.12
Femur	8649	10.62	10.72	10.83	10.94	11.05
Orthoroentgenogram	8650	11.48	11.60	11.71	11.83	11.95
Knee	8651	10.89	11.00	11.11	11.22	11.33
Tibia & Fibula	8652	10.76	10.87	10.97	11.08	11.19
Ankle	8653	10.56	10.67	10.77	10.88	10.99
Calcaneus	8654	10.56	10.67	10.77	10.88	10.99
Foot	8655	10.56	10.67	10.77	10.88	10.99
Toe	8656	5.08	5.13	5.18	5.24	5.29
Bone age determination	8657	13.00	13.13	13.26	13.40	13.53
Metastatic series: chest, skull, spine, pelvis & thorax	8658	25.82	26.08	26.34	26.60	26.87
Metabolic bone survey: skull, mandible, hands, knees, abdomen, thorax, pelvis	8659	25.82	26.08	26.34	26.60	26.87
All long bones (additional to metastatic series)	8660	6.15	6.21	6.27	6.34	6.40
Special additional views of extremity	8661	4.50	4.54	4.59	4.64	4.68
Feet - weight bearing	8662	8.18	8.27	8.35	8.43	8.52
CHEST						
Single view	8665	7.99	8.07	8.15	8.23	8.31
Multiple views	8666	14.27	14.41	14.55	14.70	14.85
Fluoroscopy only	8667	15.51	15.67	15.82	15.98	16.14
ABDOMEN						
Survey film	8670	9.69	9.79	9.89	9.98	10.08
Multiple films	8671	14.19	14.33	14.48	14.62	14.77
G.I. TRACT						
Barium swallow - pharynx & esophagus	8675	30.71	31.02	31.33	31.64	31.96
Upper G.I. series - esophagus, stomach & duodenum	8676	47.40	47.87	48.35	48.84	49.32
Upper G.I. series & small bowel study	8677	66.22	66.88	67.55	68.23	68.91
Colon - barium only	8678	34.99	35.34	35.69	36.05	36.41
Colon - double contrast	8679	49.52	50.02	50.52	51.02	51.53
Cholecystogram	8680	11.48	11.60	11.71	11.83	11.95
T-tube cholangiogram (fluoroscopy additional)	8681	19.35	19.54	19.74	19.94	20.13
Operative cholangiogram	8682	13.00	13.13	13.26	13.40	13.53
Percutaneous transhepatic cholangiogram (interpretation only)	8684	25.82	26.08	26.34	26.60	26.87
- Fluoroscopy additional	8685	13.00	13.13	13.26	13.40	13.53
Hypotonic duodenogram	8686	30.71	31.02	31.33	31.64	31.96
Insertion of a catheter in duodenum for small bowel enema						
- procedure	8688	66.41	67.07	67.74	68.42	69.10
- interpretation	8689	11.22	11.33	11.45	11.56	11.68

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G.U. TRACT						
Survey film	8690	6.15	6.21	6.27	6.34	6.40
Retrograde pyelogram	8691	11.48	11.60	11.71	11.83	11.95
Intravenous pyelogram (excluding injection fee)	8692	39.27	39.66	40.06	40.46	40.86
Pyelogram special technique - hypertensive	8695	32.22	32.54	32.87	33.20	33.53
Stress or voiding cystogram	8696	25.82	26.08	26.34	26.60	26.87
Stress or voiding cystogram with urethrogram	8697	30.71	31.02	31.33	31.64	31.96
Urethrogram and/or cystogram (interpretation)	8698	11.48	11.60	11.71	11.83	11.95
T-tube pyelogram (fluoroscopy additional)	8700	11.48	11.60	11.71	11.83	11.95
Renal cystography	8701	15.32	15.48	15.63	15.79	15.95
Retrograde pyelogram - procedure	8702	37.90	38.27	38.66	39.04	39.43
Nephrostogram - procedure	8703	37.90	38.27	38.66	39.04	39.43
- interpretation	8704	11.22	11.33	11.45	11.56	11.68
Catheter Cystourethrogram (CUG)	8711	30.17	30.47	30.78	31.09	31.40
OBSTETRICS AND GYNECOLOGY						
Survey films	8705	6.20	6.27	6.33	6.39	6.46
Hysterosalpingogram	8708	23.23	23.46	23.70	23.94	24.18
VASCULAR						
Peripheral Arteriography & Venography - Unilateral	8715	20.60	20.81	21.02	21.23	21.44
- Bilateral	8716	28.60	28.89	29.17	29.47	29.76
Aortography	8717	51.36	51.87	52.39	52.92	53.44
- Each selective examination in addition to aortography	8718	30.71	31.02	31.33	31.64	31.96
Translumbar aortogram	8721	24.37	24.61	24.85	25.10	25.35
Arch aortogram	8727	38.56	38.94	39.33	39.72	40.12
Splenoportogram	8728	30.71	31.02	31.33	31.64	31.96
Lymphangiogram	8729	30.71	31.02	31.33	31.64	31.96
Selective angiography	8730	38.56	38.94	39.33	39.72	40.12
Carotid arteriogram - unilateral	8731	38.56	38.94	39.33	39.72	40.12
- bilateral	8734	51.36	51.87	52.39	52.92	53.44
SPECIAL EXAMINATIONS						
Loopogram	8744	49.18	49.67	50.17	50.67	51.18
Arthrogram	8745	30.71	31.02	31.33	31.64	31.96
Fistula or sinus with contrast medium (excluding fluoroscopy)	8749	15.51	15.67	15.82	15.98	16.14
Laminography, Planography, Tomography (excluding plane film studies)						
- One plane	8750	23.71	23.94	24.18	24.42	24.67
- Two planes	8751	32.22	32.54	32.87	33.20	33.53
Mammography Screening (bilateral)	8739	35.29	35.64	36.00	36.36	36.72
Mammography - unilateral	8740	19.87	20.06	20.27	20.47	20.67
- bilateral	8741	47.53	48.01	48.49	48.97	49.46
- additional views	8742	4.74	4.79	4.84	4.88	4.93
- tumor localization	8790	185.92	187.78	189.66	191.56	193.47
Breast Tomosynthesis (add-on) - unilateral	8788	14.74	14.89	15.04	15.19	15.34
- bilateral	8789	29.48	29.77	30.07	30.37	30.68
Stereotactic Breast Biopsy	8743	182.22	184.04	185.88	187.74	189.61
Myelogram - Lumbar	8754	30.71	31.02	31.33	31.64	31.96
- Dorsal	8755	24.37	24.61	24.85	25.10	25.35
- Cervical	8756	24.37	24.61	24.85	25.10	25.35
- Complete	8757	50.96	51.47	51.99	52.51	53.03
Sialogram	8759	15.51	15.67	15.82	15.98	16.14
Fluoroscopy only	8762	15.51	15.67	15.82	15.98	16.14
Interpretation of submitted films	8763	15.51	15.67	15.82	15.98	16.14

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ULTRA SOUND PROCEDURES						
B Mode Scan (interpretation) - pelvic	8766	54.55	55.09	55.65	56.20	56.76
B Mode Scan (interpretation) - pelvic with transvaginal scan **See Preamble 22.D**	8792	78.74	79.53	80.32	81.12	81.94
B Mode Scan (interpretation) - abdominal	8791	67.75	68.43	69.11	69.80	70.50
B Mode Scan (obstetrics)						
- single gestation	8767	63.65	64.28	64.93	65.57	66.23
- twin gestation > 13 weeks	8760	111.39	112.50	113.62	114.76	115.91
- multiple (3 or more) gestation >13 weeks	8761	159.12	160.71	162.31	163.94	165.58
M Mode Scan interpretation	8768	77.42	78.19	78.97	79.76	80.56
Doppler Interpretation	8769	70.39	71.09	71.80	72.52	73.25
Ultrasonography (procedures done by radiologist)	8770	101.93	102.95	103.97	105.01	106.06
Sonohysterogram - composite fee	8793	112.23	113.36	114.49	115.63	116.79
Cine/Video interpretation (add-on) - **see Preamble 22.C**	8765	16.12	16.28	16.44	16.60	16.77

	Fee Code	1-Apr 2025	1-Apr 2027	1-Oct 2027	1-Apr 2028	1-Oct 2028
CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC IMAGING EXAMINATIONS						
1. These procedural fees are intended to cover compensation for the professional service or placing an instrument and introducing contrast media (except oral or rectal administration for study of the alimentary tract).						
2. The same fee may be charged for similar services associated with diagnostic physiological studies of non-radiological nature e.g., catheterization for physiological sampling or the transmission of pressure, sound or electrical waves. In such cases, separate fees are listed for the performance of the physiological studies and their interpretation.						
Peripheral angiogram	4630	142.80	144.23	145.67	147.13	148.60
Thoracic or abdominal angiogram - see Vascular fee schedule						
Myelogram - Lumbar	2172	91.18	92.09	93.01	93.94	94.88
Cystogram	2700	42.85	43.27	43.71	44.14	44.58
Arthrogram	2701	42.85	43.27	43.71	44.14	44.58
Bronchogram	2702	57.04	57.61	58.18	58.76	59.35
Sialogram	2705	57.04	57.61	58.18	58.76	59.35
Hysterosalpingogram	2706	85.69	86.55	87.41	88.29	89.17
Percutaneous transhepatic cholangiogram	2708	100.01	101.01	102.02	103.04	104.07
Lymphogram	2709	142.80	144.23	145.67	147.13	148.60
Percutaneous Procedures						
Percutaneous aspiration of renal cyst under imaging guidance	8771	117.91	119.09	120.28	121.48	122.70
Percutaneous aspiration of renal cyst with sclerosing injection	8772	147.36	148.83	150.32	151.82	153.34
Percutaneous biopsy of solid masses using ultrasound or fluoroscopy	8773	147.36	148.83	150.32	151.82	153.34
Percutaneous nephrostomy tube insertion under ultrasound or fluoroscopy	8774	235.96	238.32	240.70	243.11	245.54
Percutaneous diagnostic tap of fluid collection	8775	117.91	119.09	120.28	121.48	122.70
Percutaneous insertion drainage tube into fluid collection (excl. nephrostomy)	8776	177.00	178.77	180.56	182.36	184.19
Aspiration of renal cyst	8777	147.36	148.83	150.32	151.82	153.34
Percutaneous biliary drainage	8778	343.31	346.74	350.21	353.71	357.25
Change of biliary drainage catheter	8779	118.83	120.02	121.22	122.43	123.66
Biliary stricture dilation/stent	8780	171.64	173.36	175.09	176.84	178.61
Angiography						
Arch aortogram	8900	140.10	141.50	142.91	144.34	145.78
- One selective off arch	8901	69.93	70.63	71.33	72.05	72.77
- Two selective off arch	8902	140.10	141.50	142.91	144.34	145.78
Abdominal aortogram	8903	140.10	141.50	142.91	144.34	145.78
- One selective off aorta	8904	69.93	70.63	71.33	72.05	72.77
- Two selective off aorta	8905	140.10	141.50	142.91	144.34	145.78
Femoral arteriogram - unilateral	8906	69.93	70.63	71.33	72.05	72.77
- bilateral	8907	111.85	112.97	114.10	115.24	116.39
Arteriogram - Selective	8908	140.10	141.50	142.91	144.34	145.78
Percutaneous needle aspiration biopsy	8909	145.78	147.24	148.71	150.20	151.70
Percutaneous transhepatic cholangiogram	8910	89.53	90.42	91.33	92.24	93.16
Arterial embolization (includes arteriogram)	8911	205.91	207.97	210.05	212.15	214.27
Renins I.V.C.	8912	72.88	73.60	74.34	75.08	75.83

	Fee Code	1-Apr 2025	1-Apr 2027	1-Oct 2027	1-Apr 2028	1-Oct 2028
Angiography (cont.)						
Splenoportogram	8913	87.48	88.36	89.24	90.13	91.04
Biopsy or renal cyst puncture	8914	116.59	117.75	118.93	120.12	121.32
Lymphangiogram - unilateral	8915	252.00	254.52	257.06	259.63	262.23
- bilateral	8916	377.77	381.55	385.37	389.22	393.11
Angioplasty	8917	291.67	294.58	297.53	300.50	303.51
Inferior venacavagram	8918	72.88	73.60	74.34	75.08	75.83
Femoral arteriogram papaverine injection with pressure measurement	8919	90.59	91.49	92.41	93.33	94.26
Myocardial Perfusion Imaging - rest and stress (incl.all assoc. IVs,injections,image manipulations & interpretation)	8794	117.51	118.69	119.88	121.07	122.28
NUCLEAR MEDICINE SCANS						
THYROID						
Uptake studies, single or multiple within 2 weeks	8800	36.71	37.07	37.44	37.82	38.20
Uptake plus scan	8801	61.13	61.74	62.36	62.98	63.61
Perchlorate flush	8802	30.57	30.87	31.18	31.50	31.81
Radioactive MIBG scan	8813	72.17	72.89	73.62	74.36	75.10
BLOOD VOLUME						
Plasma volume	8803	20.47	20.68	20.88	21.09	21.30
Red cell volume	8804	20.47	20.68	20.88	21.09	21.30
Repeated plasma volume studies, each	8805	10.30	10.40	10.50	10.61	10.71
Plasma iron clearance and turnover	8806	30.57	30.87	31.18	31.50	31.81
Iron red cell utilization	8807	30.57	30.87	31.18	31.50	31.81
Red cell survival	8808	40.73	41.14	41.55	41.97	42.39
Sequestration studies	8809	40.73	41.14	41.55	41.97	42.39
Electrolyte spaces	8810	40.73	41.14	41.55	41.97	42.39
Other complex tests	8811	I.C.	I.C.	I.C.	I.C.	I.C.
RENAL FUNCTION						
Pertechnetate Scan	8812	30.71	31.02	31.33	31.64	31.96
Hippuran renogram	8815	36.71	37.07	37.44	37.82	38.20
Renal scan	8816	30.57	30.87	31.18	31.50	31.81
Combination of scan with renogram	8817	61.13	61.74	62.36	62.98	63.61
Other radioactive materials - uptake and clearance	8818	20.47	20.68	20.88	21.09	21.30
Vascular studies using radionuclides	8819	36.71	37.07	37.44	37.82	38.20
Other complex tests	8820	I.C.	I.C.	I.C.	I.C.	I.C.
GASTROINTESTINAL TRACT						
Schilling test	8825	24.56	24.81	25.06	25.31	25.56
Schilling test - repeat after intrinsic factor	8826	12.34	12.47	12.59	12.72	12.84
Liver scan	8828	48.85	49.34	49.83	50.33	50.83
Abdominal scan for ectopic gastric mucosa	8830	48.85	49.34	49.83	50.33	50.83
HIDA scan	8834	73.29	74.03	74.77	75.51	76.27
Gastric emptying study	8814	60.20	60.81	61.41	62.03	62.65
CIRCULATORY SYSTEM						
Spleen scan	8835	48.85	49.34	49.83	50.33	50.83
Cardiac scan	8836	40.73	41.14	41.55	41.97	42.39
Cardiac output	8837	51.74	52.26	52.78	53.31	53.85
Circulation time	8838	20.47	20.68	20.88	21.09	21.30
RESPIRATORY SYSTEM						
Lung scan - ventilation or perfusion	8840	61.07	61.68	62.30	62.92	63.55
- ventilation and perfusion on same day	8841	97.85	98.82	99.81	100.81	101.82
Pulmonary aspiration test	8842	50.18	50.68	51.19	51.70	52.22

	Fee Code	1-Apr 2025	1-Apr 2027	1-Oct 2027	1-Apr 2028	1-Oct 2028
SKELETAL SYSTEM						
Bone tumor scans	8850	88.07	88.95	89.84	90.73	91.64
Metabolic studies	8851	40.73	41.14	41.55	41.97	42.39
Bone Densitometry	8852	33.28	33.61	33.94	34.28	34.63
OTHER SYSTEMS						
Gallium 67 for abscess localization	8856	61.13	61.74	62.36	62.98	63.61
Parathyroid scan	8857	61.07	61.68	62.30	62.92	63.55
For multiple isotopes as in liver and pancreas, or lung and liver - Use fee for one study + 50%.						
Where electronic memory or data storage and playback is used and the material studied later for additional information - 50% is added to the fee						
SPECT (nuclear scan tomography) - add-on fee	8799	30.86	31.16	31.48	31.79	32.11
COMPUTED TOMOGRAPHY (CT)						
HEAD						
without IV contrast	8925	100.22	101.22	102.24	103.26	104.29
with IV contrast	8926	112.77	113.90	115.04	116.19	117.35
with and without IV contrast	8927	141.61	143.03	144.46	145.91	147.36
COMPLEX HEAD* - See Preamble 22.B						
without IV contrast	8928	99.56	100.56	101.56	102.58	103.60
with IV contrast	8929	116.26	117.42	118.60	119.78	120.98
with and without IV contrast	8930	132.84	134.16	135.51	136.86	138.23
NECK						
without IV contrast	8931	66.29	66.95	67.62	68.29	68.98
with IV contrast	8932	99.56	100.56	101.56	102.58	103.60
with and without IV contrast	8933	116.26	117.42	118.60	119.78	120.98
THORAX						
without IV contrast	8934	125.44	126.70	127.97	129.25	130.54
with IV contrast	8935	128.74	130.03	131.33	132.65	133.97
with and without IV contrast	8936	144.86	146.31	147.77	149.25	150.74
ABDOMEN						
without IV contrast	8937	132.84	134.16	135.51	136.86	138.23
with IV contrast	8938	135.94	137.30	138.67	140.06	141.46
with and without IV contrast	8939	150.79	152.30	153.82	155.36	156.91
PELVIS						
without IV contrast	8940	132.84	134.16	135.51	136.86	138.23
with IV contrast	8941	135.94	137.30	138.67	140.06	141.46
with and without IV contrast	8942	150.79	152.30	153.82	155.36	156.91
EXTREMITIES						
without IV contrast	8943	66.29	66.95	67.62	68.29	68.98
with IV contrast	8944	99.56	100.56	101.56	102.58	103.60
with and without IV contrast	8945	116.26	117.42	118.60	119.78	120.98
SPINE						
without IV contrast	8946	132.84	134.16	135.51	136.86	138.23
with IV contrast	8947	135.94	137.30	138.67	140.06	141.46
with and without IV contrast	8948	150.79	152.30	153.82	155.36	156.91
CT Guidance of Biopsy	8949	47.80	48.27	48.76	49.24	49.74
CT Scan Aborted	8950	16.84	17.01	17.18	17.35	17.52
MAGNETIC RESONANCE IMAGING (MRI)						

	Fee Code	1-Apr 2025	1-Apr 2027	1-Oct 2027	1-Apr 2028	1-Oct 2028
HEAD						
Cranial Multisection SE	8975	96.53	97.49	98.47	99.45	100.44
Cranial Repeat, sequence (maximum of 3 repeats)	8976	47.53	48.01	48.49	48.97	49.46
E.N.T.						
ENT Multisection SE	8977	96.53	97.49	98.47	99.45	100.44
ENT Repeat, sequence (maximum of 3 repeats + GAD)	8978	47.53	48.01	48.49	48.97	49.46
THORAX						
Thorax Multisection SE	8979	111.31	112.42	113.55	114.68	115.83
MRI Gating*	8980	33.40	33.73	34.07	34.41	34.75
Thorax Repeat, sequence (maximum of 3 repeats)	8981	55.72	56.27	56.83	57.40	57.98
ABDOMEN						
Abdomen Multisection SE	8982	111.31	112.42	113.55	114.68	115.83
Abdomen Repeat, sequence (maximum of 3 repeats)	8983	55.72	56.27	56.83	57.40	57.98
PELVIS						
Pelvis Multisection SE	8984	111.31	112.42	113.55	114.68	115.83
Pelvis Repeat, sequence (maximum of 4 repeats + GAD)	8985	55.72	56.27	56.83	57.40	57.98
EXTREMITIES						
Extremities Multisection SE	8986	96.53	97.49	98.47	99.45	100.44
Extremities Repeat, sequence (maximum of 3 repeats)	8987	47.53	48.01	48.49	48.97	49.46
SPINE						
Spine (one segment) Multisection SE	8988	89.13	90.02	90.92	91.83	92.75
Spine (one segment) Repeat, sequence (maximum of 3 repeats)	8989	44.50	44.94	45.39	45.84	46.30
MRI Enhancement*(gadolinium) - includes injection/infusion	8990	52.81	53.34	53.87	54.41	54.96
Spectroscopy* - includes injection/infusion	8991	52.81	53.34	53.87	54.41	54.96
Three Dimensional MRI acquisition sequence*, including post-processing (minimum of 60 slices; maximum 1 per patient per day)	8992	82.85	83.68	84.52	85.36	86.22

* indicates another fee code will be billed with these fee codes

OUT-OF-PROVINCE REFERRAL FEE CODES

	Fee Code	1-Apr 2025	1-Apr 2027	1-Oct 2027	1-Apr 2028	1-Oct 2028
The Out-of-Province Referral Fee Codes are matched to the Department's criteria for approval. The approval criteria were developed in consultation with the P.E.I. Medical Society. Physicians should utilize one of the following fee codes for each out-of-province referral, depending on the reason for the referral:						
1) "The insured (in Prince Edward Island) medical and/or hospital service is not available within the province".						
Service Not Available - Consultation	9401	0.00	0.00	0.00	0.00	0.00
Service Not Available - Consultation/Investigation	9402	0.00	0.00	0.00	0.00	0.00
Service Not Available - Consultation/Investigation/Treatment	9403	0.00	0.00	0.00	0.00	0.00
2) There exists within Prince Edward Island only 1 medical practitioner in the required specialty".						
Only One Specialist - Consultation	9404	0.00	0.00	0.00	0.00	0.00
Only One Specialist - Consultation/Investigation	9405	0.00	0.00	0.00	0.00	0.00
Only One Specialist - Consultation/Investigation/Treatment	9406	0.00	0.00	0.00	0.00	0.00
3) In the opinion of a Prince Edward Island physician and the Medical Director of the Department of Health and Social Services, adequate service is not available within the province".						
Adequate Service Not Available* - Consultation	9407	0.00	0.00	0.00	0.00	0.00
Adequate Service Not Available* - Consultation/Investigation	9408	0.00	0.00	0.00	0.00	0.00
Adequate Service Not Available* - Consultation/Investigation/Treatment	9409	0.00	0.00	0.00	0.00	0.00
4) In the opinion of the Medical Director of the Department of Health and Social Services extenuating circumstances exist and are documented that permit services to be provided in another province or territory".						
Extenuating Circumstances* - Consultation	9410	0.00	0.00	0.00	0.00	0.00
Extenuating Circumstances* - Consultation/Investigation	9411	0.00	0.00	0.00	0.00	0.00
Extenuating Circumstances* - Consultation/Investigation/Treatment	9412	0.00	0.00	0.00	0.00	0.00
***SUPPORTING DOCUMENTATION/COMMENT MUST BE PROVIDED**						
VISITING SPECIALIST SESSIONAL RATE (per hour)	9901	218.22	220.40	222.60	224.83	227.08
INDEPENDENT CONSIDERATION **Time of day, time spent and comment required.**	9999	I.C.	I.C.	I.C.	I.C.	I.C.