

Payment Schedule For Yukon

April 1, 2011

**INSURED
HEALTH
SERVICES**

Table Of Contents

<i>PREAMBLE</i>	1
<i>GENERAL SERVICES</i>	8
<i>EMERGENCY SERVICES</i>	10
<i>DIAGNOSTIC PROCEDURES</i>	13
<i>GENERAL PRACTICE</i>	17
<i>TELEMEDICINE</i>	20
<i>ANAESTHESIA PREAMBLE</i>	21
<i>ANAESTHESIA</i>	23
<i>DERMATOLOGY</i>	26
<i>OPHTHALMOLOGY</i>	27
<i>OPTOMETRY</i>	32
<i>OTOLARYNGOLOGY</i>	33
<i>INTERNAL MEDICINE</i>	37
<i>RHEUMATOLOGY</i>	40
<i>NEUROLOGY</i>	41
<i>NEUROSURGERY</i>	42
<i>OBSTETRICS AND GYNAECOLOGY</i>	44
<i>ORTHOPAEDICS</i>	48
<i>PAEDIATRICS</i>	55
<i>PSYCHIATRY</i>	57
<i>PLASTIC SURGERY</i>	58
<i>GENERAL SURGERY</i>	65
<i>CARDIO-THORACIC SURGERY</i>	78
<i>UROLOGY</i>	80
<i>DIAGNOSTIC ROENTGENOLOGY</i>	84
<i>DIAGNOSTIC ULTRASOUND</i>	88
<i>THERAPEUTIC ROENTGENOLOGY</i>	90
<i>LABORATORY PROCEDURE (Short List)</i>	91
<i>YUKON DENTAL FEES</i>	92

PREAMBLE

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

1. SETTING OF FEES

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

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

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

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

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

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

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

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

2. GROUP PRACTICE

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

3. INCLUSIVE FEES

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

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

4. CONSULTATION

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

5. CONTINUING CARE BY CONSULTANT

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

Should the referring doctor consider that continuing consultant care of his/her patient is still necessary after six months, he/she should review the case and re-refer for continuing care only. (NOTE: Otherwise future services will be paid at general practitioner rates. Also see Fee Code 3333 Page 9.) When a referral takes place, it must be made clear by the referring doctor to all concerned that the major responsibility for the case has been transferred, and the referring doctor may not charge for the case until, or unless, the full responsibility is returned to him/her, except that for a patient in hospital, he/she may charge supportive care where the patient's condition warrants it. (See Preamble 10 (b) (i)).

6. DIRECTIVE OR CONCURRENT CARE BY A CONSULTANT

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

7. MULTIPLE SERVICE

(a) When the performance of a minor therapeutic or diagnostic procedure (e.g. intramuscular or intravenous injection or taking a specimen from the patient) is the purpose of the doctors' attendance in the office, hospital or on a house call, the charge made will be that listed for the procedure only.

(b) Therapeutic and diagnostic procedures performed consequent to a visit or consultation shall be billed in addition to the visit or consultation (see preamble 13).

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

See Preamble 1.

9. HOSPITAL CARE

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

10. OPERATIVE SURGICAL BILLING

(a) General

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

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

(b) Referred Surgical Cases

If a requested consultation is followed by a surgical or diagnostic procedure performed by the same physician, the consultation charges are in addition to the scheduled operative fee.

The family or referring doctor may charge for necessary care for a referred case quite apart from the surgical fee as follows:

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

(c) Surgery by a Visiting Doctor

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

(d) Operation Only

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

(e) Cosmetic Surgery

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

11. OPERATIVE SURGICAL FEES

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

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

12. FRACTURES, ETC.

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

13. DIAGNOSTIC PROCEDURES

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

Diagnostic procedural fees may be charged in addition to fees for surgical procedures. The surgical fee includes only those services detailed in Paragraph 10.

If two diagnostic procedures are done at the same time, whether in office or in hospital, the lesser should be billed at 50% of the listed fee. Repeat procedures done at separate times will be listed as separate procedural fees.

14. LONG-STAY HOSPITAL AND NURSING HOME CARE

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

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

15. PREMATURE CARE IN HOSPITAL

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

16. DIAGNOSTIC ROENTGENOLOGY

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

17. AGE CATEGORIES

Age categories are defined as follows:

Premature baby: under 2,500 grams

Neonate: under 28 days

Infant: 28 days to 1 year

Child: 1 year to 16 years

18. EXPERIMENTAL MEDICINE

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

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

19. COUNSELLING

The following definitions apply:

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

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

20. INTENSIVE AND CORONARY CARE UNITS

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

21. BALANCE BILL

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

22. DIFFERENTIAL BILLING FOR NON-REFERRED PATIENTS

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

23. EXTRA BILL

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

24. FEES FOR INDIVIDUAL PRACTITIONERS

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

25. VENEPUNCTURE AND DISPATCH

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

26. ACCOMPANYING PATIENTS

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

27. PREFIXED FEE ITEMS

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

28. MISSED APPOINTMENTS

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

29. MICROSURGERY

Means operating with the use of an operating microscope.

30. STATUTORY HOLIDAYS

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

FOR BILLING PURPOSES ONLY

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

31. RURAL PREMIUM

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

32. AGE PREMIUM

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

GENERAL SERVICES

YHCIP / Anaes /
YWCHSB Proc Unit

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

INJECTIONS

B 0010 Intramuscular medications	15.00
B 0011 Intravenous medications	20.30
B 0012 Venepuncture and dispatch of specimen to laboratory, when no other charge is made (see Preamble Clause 25)	15.00
B 0013 Intra-arterial medications	30.00
0014 Intra-articular medications by injection - hip (initial injection)	41.80
0015 Intra-articular medications by injection - tendons, bursae and all other joints	29.90
0016 Intrathecal medications by injection	51.40
0020 Trigger point injection (maximum 2 per sitting)	14.10

BLOOD TRANSFUSIONS

0017 Venesection of central venous catheter	50.70
0018 Insertion of indwelling arterial line	50.70
0019 Venesection of polycythemia for phlebotomy	50.70
0024 Vein dissection for intravenous therapy (not paid in the immediate pre and post-operative phase of surgery)	76.60

DIALYSIS FEES

Acute Renal Failure (Hemodialysis)

0350 Blood Dialysis - physician in charge	1041.70
0351 Repeat Blood Dialysis - physician in charge NOTE: Maximum number of repeat dialysis on one patient is four (4). Thereafter, bill as chronic renal failure under fee code 0358.	390.60
0352 Blood Dialysis - fee for cut down by surgeon to be charged in addition to fee code 0350 or 351. NOTE: When fee code 0350 or 0351 are charged there should be no charge under fee code 0310, 0308 or 0081.	260.10

Acute Renal Failure (Peritoneal Dialysis)

0355 Dialysis (initial) to include consultation and two (2) weeks care	778.30
0308 Subsequent hospital visits (paragraph 15 applies)	38.30
0356 Re-insertion of peritoneal catheter after 10 days from initial insertion NOTE: fee code 0081 not to be charged in addition to fee code 0355. Where an initial peritoneal dialysis is performed and for various reasons hemodialysis initiated within next forty eight (48) hours, the subsequent service should be charged under fee code 0358 plus fee code 0356 for the insertion of catheter.	102.20

Chronic Renal Failure (a) Hemodialysis:

7239 Insertion of new A.V. Bypass (no consultation charged)	495.60	2+T
0358 Performance of Hemodialysis - fee to include supervision of the procedure, history, physical examination, appropriate adjustment of solutions, and other problems during dialysis for each dialysis.	102.20	
7598 Removal of Hemodialysis shunt	123.90	
0360 Cannula declotting when performed by attending physician	76.60	

GENERAL SERVICES

YHCIP / Anaes /
YWCHSB Proc Unit

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

Chronic Renal Failure (b) Peritoneal Dialysis:

7599	Insertion of permanent catheter, procedural fee only	370.20	2+T
0323	Performance of initial peritoneal dialysis to include consultation and two (2) weeks care	785.10	
0359	Performance of each Peritoneal Dialysis thereafter - fee to include supervision of procedure, history, physical examination, appropriate adjustments of solutions and any other problem that may arise during dialysis.	102.20	
	NOTE:		
	(i) Other situations requiring medical care such as bacteremias, etc. to be covered by fee code 0081 and always to be accompanied by a letter of explanation.		
	(ii) If a period greater than three (3) months elapses since last dialysis, then charge as an initial fee code 0355.		
0361	Supervision of home dialysis - per week	131.30	
	NOTE:		
	Fee code 0361 covers all services per week necessary for home or limited care dialysis and includes consultations and visits of all types.		
	Should a patient take ill with a condition totally unrelated to renal care or require hospitalization for any reason, then other appropriate fee codes may be charged in lieu of fee code 0361.		

IMMUNIZATION, SKIN TESTS

B 0030	Diagnostic skin tests (Schick, Dick, T.B., and Frei)	10.20	
B 0034	Subcutaneous injections, including desensitization treatments, immunization, oral polio vaccine, etc. (maximum per sitting 3)	10.20	

MISCELLANEOUS

0040	Stomach Lavage and Gavage	50.70	
B 0041	Ultrasound treatments	10.80	
B 0045	Manipulation therapy without anaesthesia	23.10	
3333	Referral to Specialist when patient not seen	0	
0043	Monitoring Anticoagulant Therapy	10.60	
	This fee code is intended to be billed for those occasions outside of the office visit when the physician reviews and monitors the lab results and medication of a patient.		
0050	Nurse initiated calls to a maximum of one call per patient per day.	35.40	
	This fee code is for Nurse initiated communications by telephone, facsimile or email to a maximum of one communication per patient per day.		
	Communications must be initiated by the nurse and direction received from the physician must be incorporated in the patient's chart.		
	Communications handled by physicians' staff are not billable.		
	Communications to renew prescriptions are not billable.		
	Premiums are not payable in conjunction with this fee.		
0049	Telephone calls initiated by Community Nurse Practitioners to Physicians providing scheduled emergency coverage in the Hospital. Physicians resident in communities outside Whitehorse are eligible for those calls received from Nurse Practitioners in communities other than the physician's community of residence. Premiums not payable in conjunction with this fee.	36.10	

EMERGENCY SERVICES

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble

FOCUS BASED PORTABLE ULTRASOUND

Performed by someone other than a radiologist in an accredited hospital.

Note: This service is included in fee codes 0081 Emergency Care and 0082 Acute Care Detention Fee. This fee is payable for services provided exclusively in an accredited hospital to those service providers who have achieved competency through specific training in the use of portable ultrasound. Proof of training may be requested by Insured Health Services.

0089 Focus based portable ultrasound by non-radiologist in an accredited hospital 25.80

EMERGENCY CARE

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

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

A) *Fee item 0081 to be used for billing for the active treatment of acutely ill patients whom one cannot leave. The fee is not for standby time such as waiting for laboratory results nor is it for detention care such as repeat examinations of a patient on the same day or treatment of extensive lacerations.*

B) *Fee item 0081 may be billed in addition to a consultation, but where a consultation fee is charged, this consultation fee will constitute the fee for the first half hour.*

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

0081 Per half hour or major portion thereof 124.00

ACUTE CARE DETENTION FEE

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

0082 Per half hour or major portion thereof 98.90

PERSONAL OR FAMILY CRISIS INTERVENTION FEE

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

0083 Per half hour or major portion thereof 89.70

EMERGENCY SERVICES

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble

IN-TERRITORY MEDIVAC ON-CALL

To be billed by the scheduled physician on call to provide medical services to patients who require transportation by air ambulance within the territory. To be billed when the scheduled physician is on call in a 24-hour period. The first and second Medivac performed within the territory constitutes one unit. If the physician is on call but is not required to provide services one unit is payable. When the scheduled physician performs a third in-territory medivac in a 24-hour period then 2 x 0084 is to be billed. The third unit shall be sent with an accompanying letter of explanation to Insured Health Services. When submitting a claim for payment the physician shall include the patient's name and the destination on the diagnosis line if a medivac is performed. Please use PHN 002-629-111 when billing this fee item.

0084 Per Unit 766.00

OUT-OF-TERRITORY MEDICAL EVACUATION

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

0095 Per Unit 981.80

EMERGENCY VISIT PREMIUM

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

Based on time seen by physician.

0150 Daytime (0800 - 1759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care 43.10

0151 Evening (1800 - 2259) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care 127.70
NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays

0152 Night (2300 - 0759) premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care 148.10

Hospital Emergency Department Premium

(When located in hospital and called to emergency)

0153 Evening (1800 - 2259) premium when located at or called to the hospital emergency department from within the hospital 20.50
NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays

0154 Night (2300 - 0759) premium when located at or called to the hospital emergency department from within the hospital 89.80

EMERGENCY SERVICES

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble

LEVEL I ON CALL COVERAGE

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

- | | |
|---|-----------|
| 0240 GENERAL SURGERY, OBSTETRICS/GYNAECOLOGY, PAEDIATRICS ON-CALL:
To be charged by a certified specialist when the specialist is available to provide services as required at Whitehorse General Hospital.
Per 24 hour period 8 am to 8 am
Maximum payable is \$655.20 per 24 hour period.
Please use PHN 003-787-801 when billing this fee item. | 27.30 /hr |
| 0540 ANAESTHETIST ON-CALL (Certified or non-certified) :
To be charged by the scheduled anaesthetist on-call when the anaesthetist is available to provide anaesthetic services as required at Whitehorse General Hospital.
Per Hour.
Please use PHN 003-221-009 when billing this fee item. | 27.30 /hr |
| 0440 COMMUNITY (DAWSON CITY AND WATSON LAKE) PHYSICIAN ON-CALL:
To be charged when the scheduled physician on-call is available to provide services as required.
Call coverage shall be 24 hours a day, 365 days a year which may be satisfied through the use of locums.
Per 24 hour period 8 am to 8 pm.
Maximum payment is \$655.20 per 24 hour period.
Please use PHN 003-750-106 when billing this fee item. | 27.30 /hr |

LEVEL II ON CALL COVERAGE

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

- | | |
|---|-------------|
| 0140 SECOND ON-CALL AT WHITEHORSE GENERAL HOSPITAL EMERGENCY ROOM
To be charged by the scheduled second on-call physician when the physician is available to provide emergency services as required.
Per Hour.
Please use PHN 003-202-108 when billing this fee item. | 21.60/hr |
| 0141 DOCTOR OF THE DAY
Doctor of the Day and Emergency Department on call coverage at Whitehorse General Hospital
Paid per day for each on call service.
The day cannot be divided into hourly services.
This fee code is to be billed to PHN 002-833-663 | 519.40 |
| 0270 INTERNAL MEDICINE, PAEDIATRICS, WATSON LAKE AND DAWSON CITY
On-call coverage of less than 365 days a year is acceptable; however, in order to participate, each physician must commit to a minimum of 1 in 3 days of on-call
Please use PHN 003-133-105 when billing this fee item. | 519.40 /day |

SUPPLEMENTAL ON CALL EMERGENCY FEES

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

- | | |
|--|----------|
| 0145 Billable as a base fee in addition to visit fees, procedural fees and time premiums
0800-2300 | 49.20/hr |
| 0146 Billable as a base fee in addition to visit fees, procedural fees and time premiums
2301-0759 | 92.90/hr |

DIAGNOSTIC PROCEDURES

YHCIP / Anaes /
YWCHSB Proc Unit

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

PROCEDURES INVOLVING VISUALIZATION BY INSTRUMENTATION

0700 Bronchoscopy or bronchofibroscopy	151.10	4+T
0701 Direct laryngoscopy	75.80	5+T
0702 Bronchoscopy with biopsy	250.90	4+T
0703 Culdoscopy or Open Colpotomy	251.10	1+T
0704 Cystoscopy to include dilatation and panendoscopy	137.90	1+T
0705 Cystoscopy with catheterization of ureters (with kidney function test and injection of solution for pyelogram to include dilation and panendoscopy)	151.10	1+T
0706 Esophagoscopy with biopsy	250.90	3+T
0707 Gastroscopy including esophagoscopy	201.20	3+T
0709 Esophagoscopy	151.10	3+T
0710 Mediastinoscopy or anterior mediastinotomy (combined 50% extra)	251.10	4+T
0711 Gastric biopsy	63.30	3+T
0713 Arthroscopic examination under general anaesthetic	250.90	2+T
Arthroscopic examination under general anaesthetic - hip joint	250.90	3+T
NOTE: 50% if followed by surgery under the same anaesthetic		
0714 Sigmoidoscopy	63.30	1+T
0715 Sigmoidoscopy with biopsy	75.80	1+T
0716 Flexible sigmoidoscopy	125.90	1+T
0718 Gonioscopy	25.40	1+T

PROCEDURES UTILIZING RADIOLOGICAL EQUIPMENT

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

0720 Air encephalogram	175.60	3+T
0721 Myelogram	75.80	2+T
0723 Sialogram - per duct	75.80	2+T
0724 Presacral air insufflation	75.80	2+T
0725 Perirenal air insufflation	75.80	2+T
0726 Arthrogram	75.80	2+T
0727 Salpingogram	125.90	2+T
0728 Orthodiagram	25.40	2+T
0729 Fluoroscopy of chest by Internist or Paediatrician	25.40	1+T
0730 Catheterization of bronchi for bronchogram.	50.00	4+T
NOTE: When performed in conjunction with a Bronchoscopy (fee code 0700 or 0701) both fees are to be paid in full		
0731 Duodenal Biopsy	175.60	3+T
0732 Voiding cysto-urethrogram	25.40	1+T
0733 Venogram, Intraosseous or Intravenous	50.00	2+T
0734 Lymphangiography or Lymphography - surgical component (see fee code 8614)	251.10	1+T
0735 Laryngogram	50.00	1+T
0736 Bronchial brushing in conjunction with Bronchoscopy (Bronchoscopy extra)	151.10	4+T
0737 Bronchial brushing in conjunction with Bronchogram (Bronchogram extra)	75.80	4+T

DIAGNOSTIC PROCEDURES

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble

THERAPEUTIC PROCEDURES UTILIZING RADIOLOGICAL EQUIPMENT

0738 Removal of biliary calculi by Burhenne technique	352.20	4+T
0980 Trans-hepatic biliary drainage procedure	516.30	3+T
0983 Percutaneous abdominal abscess drainage by catheter insertion	350.30	2+T
0984 Exchange of previously inserted catheter for percutaneous or biliary drainage	122.60	1+T

NEEDLE BIOPSY PROCEDURES

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

0739 Percutaneous lung or mediastinal biopsy	175.60	2+T
0740 Liver biopsy	125.90	2+T
0741 Splenic biopsy	125.90	2+T
0742 Renal biopsy	175.60	2+T
0744 Thyroid biopsy	100.60	1+T
0745 Peripheral or subcutaneous lymph node biopsy	25.40	1+T
0747 Prostate biopsy	50.00	1+T
0748 Bone biopsy	75.80	1+T
0749 Parietal pleural, including thoracentesis	100.60	1+T
0766 Breast biopsy	100.60	1+T

PUNCTURE PROCEDURES FOR OBTAINING BODY FLUIDS

(when performed for diagnostic purposes)

0750 Lumbar puncture	50.00	1+T
0751 Pericardial puncture	100.60	3+T
0752 Cisternal puncture	75.80	2+T
0753 Marrow aspiration	75.80	1+T
0754 Subdural tapping in infant	52.90	2+T
0755 Artery puncture	14.80	1+T
0756 Joint aspiration - (not in addition to fee code 0014 or 0015) - hip	37.60	1+T
0757 Joint aspiration - other joints	25.40	1+T
0758 Pneumoperitoneum	50.00	1+T
0759 Paracentesis (thoracic) or transtracheal aspiration	50.00	2+T
0760 Paracentesis (abdominal)	50.00	1+T
0761 Cyst or bursa aspiration (to include breast)	25.40	1+T

ALLERGY, PATCH AND PHOTOPATCH TESTS

0762 Scratch test - per antigen	2.80	
0763 Scratch test - Children under 5 years of age - per antigen	4.80	
0764 Intracutaneous test - per test	4.80	
0767 Patch testing (extra) (annual maximum, 30 tests) per test	2.80	
0768 Photopatch test - per test	10.20	

DIAGNOSTIC PROCEDURES

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble

EXAMINATION UNDER ANAESTHESIA

(when done as independent procedure)

0770 Pelvic examination under anaesthesia	50.00	1+T
0771 Retinal examination under anaesthesia	50.00	3+T
0772 Nasopharyngeal examination under anaesthesia	50.00	3+T

GYNAECOLOGICAL

0775 Hydrotubation	125.40	
0776 Fetal scalp sampling - initial sample	50.00	
0777 Fetal scalp sampling - subsequent samples	25.40	
0778 Laparoscopy	251.10	4+T
0779 Amnioscopy	50.00	
0781 Rubin's Test	50.00	
0782 Needle aspiration of Pouch of Douglas	50.00	1+T
0783 Huhner's Test	50.00	
0784 Cervix punch biopsy	25.40	1+T
0785 Endometrial biopsy	75.80	1+T
0786 Pelvic examination with needle aspiration of Pouch of Douglas under anaesthesia when not followed by a surgical procedure by the same surgeon	100.60	1+T
0787 Transabdominal amniocentesis (assessment of multi-gestation can be billed at 50% for each additional fetus)	75.80	2+T
0788 Colposcopy with biopsy and curettage	64.80	1+T
0789 Colposcopy	43.30	
0790 Hysteroscopy (simple)	127.20	2+T

UROLOGICAL

0795 Biopsy of penis	50.00	2+T
0796 Cystometrogram	50.00	
0773 Sphincterometry (in addition to cystometrogram)	50.00	
0802 Urethrogram	124.80	2+T
0792 Cysto-ureterogram - technical fee	25.40	2+T
0793 Cysto-ureterogram - professional fee	12.10	

MISCELLANEOUS

0794 Peritoneal lavage	201.20	1+T
------------------------	--------	-----

CARDIOVASCULAR PROCEDURES

0801 Intra-arterial cannulation (with multiple aspirations)	50.00	
0831 Swans-Ganz catheter insertion	250.90	5+T

NOTE: When catheter is inserted as part of anaesthetic procedure the fee code 0831 would be payable at 50%

DIAGNOSTIC PROCEDURES

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble

ELECTRODIAGNOSIS

Items under Intensity duration Curve-each muscle.

Electromyograph - each muscle.

Motor nerve conduction study - each nerve.

Sensory nerve conduction study - each nerve.

Tetanic stimulation test - each muscle.

0904	Schedule A - extensive examination (8 or more items)	210.80	
0905	Schedule B - limited examination (4 - 7 items)	140.60	
0906	Schedule C - short examination (1 - 3 items)	77.70	
0907	Endoscopic flexible or rigid examinations of the nose and nasopharnx - procedure only	46.10	3+T
0908	Endoscopic flexible or rigid examinations of the nose and nasopharnx - procedure and biopsy	79.40	3+T
0909	Flexible fiberoptic nasopharyngolaryngoscopy	58.50	3+T
0922	Electrodiagnostic component of the decamethonium edrophonium test for myasthenia gravis, inclusive of tetanic stimulation tests.	71.30	
0923	Technical fee for electrodiagnostic testing	35.40	

PULMONARY INVESTIGATIVE AND FUNCTION STUDIES

0928	Simple Screening Spirometry with FVC, FEV(i) and FEV(i)/FVC ratio using a portable apparatus - without bronchodilators	26.00	
0929	Simple Screening Spirometry with FVC, FEV(i) and FEV(i)/FVC ratio using a portable apparatus - before and after bronchodilators.	40.90	
	Exercise Studies:		
	NOTE: No more than one exercise study item may be billed for a single patient on any one day without written explanation		
0950	Progressive Exercise Test with at least three workloads, measuring ventilation and electrocardiographic monitoring - professional fee	49.20	
0951	Progressive Exercise Test with at least three workloads, measuring ventilation and electrocardiographic monitoring - technical fee	74.10	
0952	Ventilation at rest and exercise with blood gas analysis but without expired gas analysis - professional fee	61.30	
0953	Ventilation at rest and exercise with blood gas analysis but without expired gas analysis - technical fee	98.20	
0954	Exercise in a steady state at two or more workloads with measurements of ventilation, O ₂ and CO ₂ exchange, and electrocardiographic monitoring - professional fee	102.50	
0955	Exercise in a steady state at two or more workloads with measurements of ventilation, O ₂ and CO ₂ exchange, and electrocardiographic monitoring - technical fee	102.50	
0956	Exercise in a steady state at two or more workloads with measurements of ventilation, O ₂ and CO ₂ exchange, electrocardiographic monitoring, arterial blood gases, measurement of Aa gradients and physiological dead space - professional fee	122.80	
0957	Exercise in a steady state at two or more workloads with measurements of ventilation, O ₂ and CO ₂ exchange, electrocardiographic monitoring, arterial blood gases, measurement of Aa gradients and physiological dead space - technical fee	122.80	
0958	Testing for exercise induced asthma by serial flow measurements - professional fee	49.20	
0959	Testing for exercise induced asthma by serial flow measurements - technical fee	74.10	
0960	Ear oximetry to measure arterial O ₂ saturation - professional fee	10.70	
0962	Expired gas analysis to measure mixed venous CO ₂ - professional fee	7.40	

GENERAL PRACTICE

YHCIP / Anaes /
YWCHSB Proc Unit

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

1100	Visit (in emergency department at Whitehorse General Hospital)	42.50
0100	Visit (in or out of office): For any condition(s) requiring partial or regional examination and history to include pronouncement of death and health supervision of infant up to and including one year of age	42.50
1101	Complete examination (in emergency department at Whitehorse General Hospital)	93.40
0101	Complete examination (in and out of office): For any condition requiring a complete physical examination and detailed history NOTE: A complete physical examination shall include a complete and detailed history and detailed physical examination with special attention to local examination where clinically indicated, adequate recording of findings and, if necessary, discussion with patient. The above should include complaints, history of the present and past illness, family history, personal history, functional inquiry, physical examination, differential diagnosis, and provisional diagnosis. A minimum of 20 minutes in patient contact is considered necessary to use this fee.	93.40
1109	Second extensive examination (in emergency department at Whitehorse General Hospital)	54.10
0109	For a situation when a second extensive examination is required, the second complaint should be more than passing significance. Both complaints or diagnoses should be recorded on the claim card. Can also be used for "well woman" annual check ie; blood pressure, pap, breast exam and related health counselling.	54.10
0110	Consultation (in and out of office): To include history and physical examination, review of x-rays and laboratory findings and written report	137.60
0112	Limited General Practitioner Consult (in or out of office): To include a brief history and focused examination, review of x-rays and laboratory findings with a written report	68.80
0116	Admission to ICU for critically ill patients (not routine or post anaesthetic) requiring immediate complete examination, investigation and close monitoring of condition	161.90
1108	Palliative Care per half hour	212.20

HOME VISITS

0103	Home Visit - First patient	89.40
0104	Home Visit - Extra patients seen during same house call NOTE: Home visits can also be used when a non emergency visit is provided at a place other than the normal health care facility (i.e. place of work, sporting event, etc.).	47.80

HOSPITAL VISITS

0108	Visit (see Preamble 14)	54.60
0128	Supportive Care (see Preamble 5 and 10 (b) (i))	54.60
0138	ICU Visit (see Preamble 20 (c))	60.70
0148	Long Stay Hospital and Nursing Home care (see Preamble 14). To be billed when seeing a patient while already at nursing home or on regular rounds.	61.10

GENERAL PRACTICE

YHCIP / Anaes /
YWCHSB Proc Unit

NURSING HOME VISITS

0114 To be billed when the physician is called by the nursing home to see patient. 72.60

CHRONIC DISEASE MANAGEMENT

T 1120 Flat Fee for Group Visits: 250.00

Group visits will consist of a minimum of three patients and a minimum time requirement of one hour per visit, to include time spent for preparation and follow up. The physician may elect to split larger groups into smaller more manageable groups of a minimum of three patients.

Claims for remuneration are to be submitted to Insured Health Services under the Personal Health Number:

PHN 002-798-049 and the patient name Chronic, Disease.

T 0111 Shadow Billing: 0

A second temporary fee code has been established to track the group visits on a per patient basis. The physician shall "shadow bill" under the patient's Personal Health Number (PHN). There is no dollar value attached to this fee code as it has been established for tracking purposes only. For each patient the physician sees during the group visit, a claim is to be completed and submitted to Insured Health Services.

MISCELLANEOUS

0115 Complex laboratory or x-ray studies performed by physician when such studies are beyond the scope of a local available support staff (e.g. skull or spine x-rays taken by outpost physician) 41.50

0117 Interpretation of electrocardiogram by non-internist 5.20

0118 Attendance at birth if specifically requested by surgeon for care of baby only 77.80

0119 Routine care of newborn in hospital. 77.80

NOTE: If a newborn becomes ill and requires care beyond routine then the physician shall bill routine hospital visits from day of birth and not bill 0119. Physiologic jaundice requiring only phototherapy is considered routine newborn care.

0120 Prolonged visit for counselling a complex medical condition (minimum time per visit - 20 minutes) 93.30

NOTE: Payment agencies will pay up to (6) visits per patient per fiscal year (starting April 01) will be paid for counselling a complex medical condition and up to 3 visits per year for counselling related to smoking cessation or weight management.

0121 Psychotherapy - up to 30 minutes 70.80

0122 Psychotherapy - 31 to 45 minutes 106.60

0123 Psychotherapy - over 45 minutes 142.10

0124 Nurse Referred G.P. Consultation: 137.60

This fee item is for the referral from an outpost nurse to a Whitehorse physician for in depth consultation. The GP must, by way of return letter, outline the results of a complete history and physical, a tentative diagnosis, all laboratory investigations undertaken, with results if available, and all therapeutic measures advised. In addition the GP should outline several alternatives of treatment to be attempted before re-evacuation for assessment if indicated.

GENERAL PRACTICE

	YHCIP / Anaes / YWCHSB Proc Unit
<p>T 0125 New Patient Program: One time payment for each new patient that a family physician accepts into his/her practice. Completion of New Patient Form with signatures from both the family physician and patient are required for payment. A copy of this form is required with the claim for payment. Payable once for each YHCIP health care number.</p>	200.00
<p>0126 Stand-By Service: To be paid when a physician is requested to stand-by to possibly provide an immediate service pending the results of another service by another physician (i.e. possible surgical assist pending arthroscopy or gastroscopy results, or possible general anaesthesia pending failed local or regional anaesthetic, etc.). In excess of 2 units will be assessed by the Medical Advisor on the basis of a written report. Per half hour or major portion thereof</p>	40.60
<p>0129 Cancer Chemotherapy Visit: May include the administration of multiple parenteral chemotherapeutic agents, to include history and physical examination as necessary to document disease status, counselling of patient and/or family, review of pertinent laboratory and radiologic data, venesection and institution of an intravenous line. This service not to be billed more than once every 28 days (time taken must be in excess of 1 hour).</p>	166.40
<p>0130 Limited Cancer Chemotherapy Visit: May include the administration of single or multiple parenteral chemotherapeutic agents, to include history and physical examination as necessary to document disease status, counselling of patient and/or family, review of pertinent laboratory and radiological data, venesection and institution of an intra-venous line. NOTE: This item is not to be billed more than once every 7 days. Neither is it to be billed for routine administration of 5 Flourouracil as a single agent.</p>	83.20

TELEMEDICINE

YHCIP / Anaes /
YWCHSB Proc Unit

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

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

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

TELEMEDICINE

2600	Telemedicine Transmission or Review: For any condition(s) requiring partial or regional examination and history. (2600 to be billed when sending or replying to a telemedicine transmission.)	42.70
2601	Detailed Telemedicine Transmission or Review and Reply: For any condition requiring a complete review of examination and detailed history. NOTE: A complete review of examination shall include complaints, history of the present and past illness, pertinent family history, functional inquiry, differential diagnosis, and provisional diagnosis. A minimum of 20 minutes of the physicians time should be spent for review and reply of transmission.	85.30
2602	Telemedicine Consultation: To include review of history, review applicable x-rays and laboratory findings and a written report. A minimum of 30 minutes of the physicians time should be spent for review and reply of transmission.	138.20
2603	Dermatology Consultation Review and Reply	105.90
2699	In circumstances where an inordinate amount of time is required of any physician in management of a clinical problem utilizing the telemedicine modality, that physician may claim by billing under fee code 2699. A brief explanation should accompany the billing.	0

In the rare event emergency consultations via telemedicine are required, they will be paid as per the current administrative guidelines for premium fees, etc.

ANAESTHESIA PREAMBLE

1. The tariff is for all types of anaesthesia. The fee is for the professional services, including ordering preanaesthetic medication, administering anaesthesia, immediate post-anaesthetic supportive measures to include necessary post-anaesthetic visits and follow-up; but does not include cost of material used.
2. Total anaesthetic fee is determined by multiplying a unit value of \$32.50 for YHCIP and YWCHSB billings by the number of units applicable. Please note the anaesthesia time units, Fee Codes 1054 and 1063 as of April 1st, 2011 are \$35.50.
Units are divided into three categories:
 - a) Anaesthetic evaluation unit
 - b) Procedural fee unit
 - c) Time unit

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

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

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

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

ANAESTHESIA PREAMBLE

6. Where the attendance of the anaesthetist is requested by the patient's other medical attendants for the sole purpose of monitoring or special supportive care, and where the anaesthetist is in constant attendance, the fee shall be 4 units plus time.
7. Anaesthetist's continuous attendance by request at any procedure for possible resuscitation and/or complementary anaesthesia, will be charged for the time of such attendance at the same rate as for administration of anaesthesia for the procedure.
8. **Payment of Two Anaesthetists:**
Where two anaesthetists are medically required in the interest of the patient both may charge a full fee.
When billing a payment agency support need for charges with a written statement.
9. **Payment of Anaesthesia when performed by the Surgeons:**
When a surgeon is required to administer an anaesthetic in addition to performing a surgical procedure it is recommended that a charge NOT be made for the anaesthesia in addition to the procedure performed. In emergency situations it may be necessary for the surgeon to act as the anaesthetist; a charge for such service should be accompanied by a written explanation of the circumstance by the surgeon concerned when billing payment
10. **Anaesthetic Fees Not Included in the Schedule:**
Such fees shall be computed in equity with the procedures of similar anaesthetic responsibility, difficulty, and skill. When submitting an account to a payment agency use fee item 1999 and state the reason for the charge. The foregoing also applies to anaesthetic procedural units for surgical or diagnostic procedures charged under a miscellaneous 999 number (see Clause 8, page 2 of the Preamble).
11. **Epidural Anaesthesia for Obstetrics:**
 - a) Evaluation unit
 - b) Procedural unit
 - c) Time units

ANAESTHESIA

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble

EMERGENCY VISIT PREMIUM

Based on time seen by physician

0250	Daytime (0800 - 1759): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care.	55.40	
0251	Evening (1800 - 2259): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	152.00	
0252	Night (2300 - 0759): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care Note: The above fees to be charged by a certified specialist only. Premiums for non-certified anaesthetist are listed under General Practice (fee codes 0150, 0151, and 0152)	177.90	
1015	Consultation by a Certified Specialist in Anaesthesia: To include complete history and physical examination for a systemic disturbance which is a threat to life, either by itself or in association with proposed anaesthesia and surgery, review of x-ray and laboratory findings and written report. If followed by an anaesthetic, the consultation is to be charged in addition to the total anaesthetic fee.	32.50	7
1014	Repeat or Limited Consultation: To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant or where in the judgment of the consultant the consultative service does not warrant a full consultative fee.	32.50	4
1017	Assessment and initiation of treatment of a non-anaesthetic complication when such services are requested and a degree of urgency exists	32.50	3
1009	Dental Anaesthesia (certified anaesthetists) (anaesthetic evaluation, extra)	32.50	2
1010	Non-certified Dental Anaesthesia (anaesthetic evaluation, extra)	32.50	1+T
1051	Routine anaesthetic evaluation - certified anaesthetist	32.50	3
1025	Complicated Pre-Anaesthetic Check (non-certified): To include complete history and physical examination for systemic disturbance which is a threat to life, either by itself or in association with proposed anaesthesia fee code includes complete exam, history, review of xray and laboratory findings. If the anaesthetic is administered by the same anaesthetist fee code 1052 does not apply.	32.50	3
1052	Non-certified anaesthetist	32.50	2
1053	Procedural fee (units as listed opposite diagnostic or surgical procedure)	32.50	
1054	Time, for each 15 minutes or fraction thereof (Less than 2 hour duration)	35.50	1
1063	Time, 2 hours or more duration for each 10 minutes or fraction thereof	35.50	1
1055	Monitoring or special supportive care (neither anaesthetic evaluation units nor resuscitative care apply) - applies to cadaverous kidney donor	32.50	4+T

MODIFYING FACTORS

1056	Induced hypothermia	32.50	5
1057	Controlled hypotension	32.50	5
1058	Pump oxygenator	32.50	5
1059	Prone position	32.50	1

ANAESTHESIA

	YHCIP / YWCHSB	Anaes / Proc Unit
1064 Patient over 70 years of age	32.50	1
1065 Patient under 1 year of age	32.50	1
1066 Sitting position for intracranial or vertebral surgery	32.50	8
1068 Neonates (under 28 days)	32.50	5

DIAGNOSTIC AND THERAPEUTIC ANAESTHESIA FEE ITEMS

The anaesthetic fee is for professional services (excluding cost of materials).

Anaesthetic evaluation units to be charged in addition to procedural units as listed.

No time units will be charged, except for Epidurals.

Consultations, when requested, will be charged in addition.

Nerve block fees are also for diagnostic or therapeutic anaesthetic techniques when surgery is not involved.

When surgical, obstetrical or diagnostic procedures are involved the nerve block anaesthetic procedural units do not apply except for Epidurals.

NERVE BLOCKS

Somatic Nerves

1020 Nerve roots (maximum 4 units per sitting) per root	32.50	1
1022 Nerve plexus	32.50	3
1023 Peripheral nerves - (maximum 3 units per sitting) per nerve	32.50	1
1030 Epidural or Caudal Block - lumbar	32.50	5+T
1038 Nerve root and facet blocks - cervical (maximum 12 units per sitting)	32.50	4
1039 Nerve root and facet blocks - thoracic (maximum 9 units per sitting)	32.50	3
1031 Repeat injections of Caudal or Epidural Block (if via previously inserted catheter, anaesthetic evaluation applies to fee code 1030 only). Remuneration of time only payable after 30 minutes. Time spent up to and including 30 minutes is inclusive of anaesthetic units.	32.50	2
1032 Subdural (spinal) Block	32.50	3
1033 Repeat injections of Subdural (spinal) Block (if via previously inserted catheter, anaesthetic evaluation applies to fee code 1032 only)	32.50	2

Sympathetic Nerves

1036 Thoracic Epidural Block	32.50	6+T
1040 Stellate Ganglion	32.50	2
1042 Paravertebral	32.50	3
1044 Coeliac Ganglion Block	32.50	5
1045 Injection of Alcohol, Phenol, or other Sclerosing Agent into: Nerve Sheath, Plexus, Ganglion	32.50	9

INTRAVENOUS PROCEDURES

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

1060 First injection	32.50	2
1061 Subsequent injections (anaesthetic evaluation applies to fee code 1060 only)	32.50	2

ANAESTHESIA

YHCIP / Anaes /
YWCHSB Proc Unit

RESUSCITATIVE PROCEDURES BY ANAESTHETIST

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

1078	First day - Resuscitative Procedures	32.50	6+T
1079	Second and third day - Resuscitative Procedures	32.50	4+T
1081	Fourth to twenty-first day - Resuscitative Procedures, per day	32.50	2+T
1083	Twenty-second to forty-second day - Resuscitative Procedures, per day	32.50	1+T
1085	Seventh to fourteenth week - Resuscitative Procedures, per day	32.50	3+T
1087	After fourteenth week - Resuscitative Procedures, per month	32.50	5+T
1089	Resuscitation of a seriously depressed neonate at the request of the attending physician (anaesthetic evaluation does NOT apply)	32.50	4
1091	Intubation	32.50	5
1092	Awake fibre-optic intubation	32.50	3

ACUTE PAIN MANAGEMENT

1016	Consultation by a certified specialist in anaesthesia for assessment of the patient for chronic pain, to include review of relevant history and physical examination, x-ray and laboratory findings, and a written report	32.50	6
1013	Consultation by a certified specialist in anaesthesia: Assessment of the patient for post operative acute pain management within 24 hours following the end of surgery, to include review of the relevant history and physical examination, x-ray and laboratory findings, and a written report	32.50	4
1011	Follow-up visit for chronic pain control in the office by a certified specialist in anaesthesia	32.50	2
1012	Pain management acute or chronic in the hospital by non-certified anaesthetist (maximum of two visits per day or letter of explanation)	32.50	1.5
1019	Pain management acute or chronic in the hospital by certified anaesthetist (maximum of two visits per day or letter of explanation)	32.50	2.5

DERMATOLOGY

YHCIP / Anaes /
YWCHSB Proc Unit

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

REFERRED CASES

0210 Consultation:	108.30
To include history, and dermatological examination, with review of any previous x-ray and laboratory findings and written report	
0211 Treatment, as under fee code 0216, other than excision, with consultation	30.40
0214 Repeat or Limited Consultation:	75.50
To apply where a consultation is repeated for the same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee (laboratory test and biopsy, when necessary, extra)	
0215 Dermatological Biopsy	39.80
Continuing Care by Consultant:	
0204 Directive care	30.40
0207 Subsequent office visit	30.40
0208 Subsequent hospital visit	30.40
0209 Subsequent home visit	74.60

EMERGENCY VISIT PREMIUM

Based on time seen by physician

0250 Daytime (0800 - 1759):	55.40
Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	
0251 Evening (1800 - 2259):	152.00
Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	
0252 Night (2300 - 0759):	177.90
Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	

SPECIAL EXAMINATIONS

0206 For primary systemic diseases with cutaneous manifestations:	250.70
To include complete history and physical examination, review of x-ray and laboratory findings, and a written report	

SPECIAL THERAPY

0216 Forms of treatment other than excision, such as removal of haemangiomas and warts with electrosurgery, cryotherapy - initial visit	60.50
0217 Forms of treatment other than excision, such as removal of haemangiomas and warts with electrosurgery, cryotherapy - subsequent visit	30.40
0218 Curettage and electrosurgery of skin carcinoma proven histopathologically	175.90
0219 Curettage and electrosurgery of skin carcinoma proven histopathologically - each additional lesion (maximum charge \$175.40)	87.70

OPHTHALMOLOGY

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble

* Please note fee code 2012

REFERRED CASES

2010 Consultation: 135.40

To include history, eye examination, review of previous x-rays and laboratory findings and any or all of measurement for refractive error, ophthalmoscopy, biomicroscopy, tonometry, eye balance test keratometry where indicated and necessary to prepare a written report.

2011 Repeat or Limited Consultation: 74.20

To apply where a consultation is repeated for the same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee

2012 Special Consultation: 173.90

To apply when an ophthalmologist, neurologist, paediatric neurologist or neurosurgeon refers a patient to an ophthalmologist for special examination, or when an ophthalmologist refers a patient to another ophthalmologist where a decision regarding medical or surgical treatment is complicated and requires extra consideration, judgment and implementation of specialized knowledge and experience. This item should include any or all eye examinations marked with an asterisk when indicated and necessary to prepare a written note.

NOTE: Where referred for emergency surgery and surgery is performed within 3 days from date consultation is requested - charge fee code 2010

Continuing Care by Consultant:

2007 Subsequent office visit 47.40

2008 Subsequent hospital visit 24.80

2009 Subsequent home visit 74.60

EMERGENCY VISIT PREMIUM

Based on time seen by physician

0250 Daytime (0800 - 1759): 55.40

Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care

0251 Evening (1800 - 2259): 152.00

Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care

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

0252 Night (2300 - 0759): 177.90

Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care

OPHTHALMOLOGY

YHCIP / Anaes /
YWCHSB Proc Unit

EYE EXAMINATIONS

Included in consultation or visit fee when applicable.

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

Do not bill professional or technical fee to Insured Health Services.

BILL TOTAL FEE ONLY.

2015	Eye examination to include measurement of refractive error, ophthalmoscopy, and any or all biomicroscopy, tonometry, eye balance test, keratometry, where indicated. NOTE: May be charged by non-specialist, or by an Optometrist under the supervision of an Ophthalmologist	87.00
* 2020	Ophthalmo-dynamometry	61.20
2041	Limited visual field examination, ie. tangent screen, autoplots, arc perimeter, or single level automated test such as octopus program 3 or 7 or equivalent - may be billed by Optometrist	61.20
2639	Ophthalmic ultrasound A scan for determination of axial length (to be billed only if patient proceeds to lens implant surgery)	98.10
2068	Computerized retinal fibre layer photography and neuro-retinal rim assessment (OCT) - Professional fee	31.80
2069	Computerized retinal fibre layer photography and neuro-retinal rim assessment (OCT) - Technical fee	63.70
2042	Quantitative perimetry examination: one of: (a) full field manual perimetry such as 2 or 3 isopters on Goldman perimeter or equivalent, with spot checks between isopters and kinetic plotting of scotomata; or (b) limited area manual static threshold perimetry such as 2 or 3 half-meridians at 2 degrees intervals to 30 degrees from fixation or 30 to 50 static threshold points in any arrangement; or (c) automated testing at 2 or 3 threshold related luminance levels (such as OCTOPUS program 33 or 34 or equivalent); or (d) automated testing of periphery only (such as OCTOPUS program 41 or equivalent) NOTE: Item 2042 includes 2041	58.90
* 2017	Oculo-motor function tests	39.80
* 2018	Biomicroscopy (inclusive of visit)	29.80
* 2019	Tonometry	29.80
* 2022	Provocative test for glaucoma	39.80
2025	Fluorescein angiography of retina with interpretation	197.30
2026	Fluorescein angiography of retina with interpretation - Professional fee	47.50
2027	Fluorescein angiography of retina with interpretation - Technical fee	149.80
* 2029	Dynamic Fluorescein Angioscopy	74.60
2035	Colour vision assessment (anomaloscope, Farnsworth Hue)	74.60
2036	Colour vision assessment (anomaloscope, Farnsworth Hue) - Professional fee	48.40
2037	Colour vision assessment (anomaloscope, Farnsworth Hue) - Technical fee	26.40
* 2038	Keratometry	24.80

OPHTHALMOLOGY

	YHCIP / YWCHSB	Anaes / Proc Unit
2039 Fundus photography (limitations-glaucomatous disc changes, tumor progression and potentially progressive retinal disease) - may be billed by Optometrist	24.80	
2040 Retinoscopy, keratometry, tonometry, indirect fundoscopy, fundus photography and prosthetic fitting under general anaesthetic	206.30	3+T
2048 Exophthalmometry	20.50	
2046 Gonioscopy (for one or both eyes)	18.70	
2047 Dacryocystogram	99.30	
2049 Potentiometry	48.00	
SPECIAL THERAPY		
2109 Injections - subconjunctival	44.80	
2075 Botulinum toxin injection for entropion	108.80	
2073 Botulinum toxin injection for blepharospasm associated with dystonia (including benign essential blepharospasm) or VII nerve disorders in patients 12 years of age or older - unilateral or bilateral	204.70	
LACRIMAL APPARATUS		
2120 Punctum dilation and syringing sac (operation only)	48.20	3+T
2118 Two or three snip procedure	94.60	3+T
2121 Duct probing - under general anaesthesia (operation only)	178.90	3+T
2122 Duct probing - under local anaesthesia (operation only)	44.80	3+T
2123 Insertion of Quickert tube	212.70	3+T
2129 Insertion of Lester Jones tube	565.80	3+T
2124 Dacryocystostomy - under general anaesthesia (operation only)	156.90	3+T
2119 Dacryocystostomy - under local anaesthesia (operation only)	45.00	
2125 Dacryocystectomy - under local anaesthesia	559.30	3+T
2126 Dacryocystorhinostomy	1118.40	3+T
2127 Repair of canaliculi	724.10	3+T
2128 Surgical excision of lacrimal gland	559.30	3+T
ORBIT		
2132 Retrobulbar injection of alcohol	178.80	2+T
2133 Enucleation or evisceration	724.10	4+T
2134 Complicated implant (Allan or Iowa)	896.00	4+T
2136 Exploration and/or biopsy of orbit	447.10	4+T
2137 Exploration and decompression (Kronlein)	1118.40	4+T
2139 - anterior orbital tumor	448.10	4+T
2141 Excision of posterior orbital tumor by anterolateral approach	1421.00	6+T
2143 Lateral orbitotomy with decompression, fat dissection and down-fracture into maxillary sinus	1450.70	4+T
EYE LIDS		
2130 Blepharoplasty, simple, non-cosmetic	278.90	3+T
2131 Blepharoplasty, complicated, non-cosmetic	603.90	3+T
2146 Trichiasis - epilation - forceps	44.80	3+T
2147 Trichiasis - epilation - electric	48.20	3+T
2148 Cryotherapy of eyelids for trichiasis or tumor	177.50	3+T
2149 Meibomian gland evacuation	44.80	1+T
2150 Chalazion excision	112.00	3+T

OPHTHALMOLOGY

	YHCIP / YWCHSB	Anaes / Proc Unit
2151 Repair of conjunctiva	121.10	1+T
2152 Tarsorrhaphy	248.20	3+T
2153 Ectropion, Entropion, Ziegler or simple procedure	121.10	3+T
2154 Ectropion, Entropion - complicated, including neoplasms and plastic repair	670.70	3+T
2155 Ptosis repair - orbicularis sling - using synthetic material	428.40	3+T
2156 Excision of tumors of lid margins or conjunctiva - benign	124.20	3+T
2157 Excision of benign tumor of lids	72.70	3+T
2158 Fasanella Servat	399.20	3+T
2159 Ptosis repair - orbicularis sling - using autologous fascia lata	965.80	3+T
2160 Ptosis repair - levator resection	965.80	3+T
2166 Lid elevation and scleral graft for lower lid retraction	659.90	3+T
2100 Graded muellerectomy with levator recession under local anaesthesia	659.90	3+T
2107 Repair of eyelid margin defect requiring layered closure	428.40	

EYE MUSCLES

2161 Strabismus - one or two muscles	745.20	3+T
2162 Strabismus - three or more muscles	965.80	3+T
2163 Strabismus - complicated re-operation	1118.40	4+T
2164 Strabismus - adjustable suture surgery	1118.40	

CORNEA AND SCLERA

2167 Cautery or cryotherapy of corneal ulcer	72.30	3+T
2170 Removal of imbedded corneal foreign body (operation only)	35.20	
2171 Pterygium or limbus tumor excision	241.00	3+T
2172 Gunderson type flap	723.90	3+T
2173 Keratoplasty - lamellar	1392.10	3+T
2175 Keratoplasty - penetrating	1677.60	4+T
2168 Keratoplasty - complicated re-operation	1963.30	4+T
NOTE: Fee code 2168, 2173, 2175 includes all suture removals after 42 days		
2174 Suture of cornea and/or sclera with or without iridectomy - simple	869.40	4+T
2169 Suture of cornea and/or sclera with or without iridectomy - complicated	1392.10	4+T
2176 Posterior sclerotomy with or without insufflation of anterior chamber	278.90	4+T
2165 Sclerokeratectomy with mucous membrane graft	1032.40	4+T
2050 Contact lens bandage - unilateral	116.30	
2199 Pterygium excision with mucous membrane graft	530.50	4+T
2200 Complicated pterygium excision (re-operation) of cancer excision, with mucous membrane graft.	636.50	4+T

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

INTRAOCULAR

2181 Foreign body intraocular - magnetic extraction	1118.40	4+T
2182 Foreign body intraocular - non-magnetic (including enucleation, if necessary)	1448.80	4+T
2177 Glaucoma - peripheral iridectomy	745.40	4+T
2178 Glaucoma - filtering procedures	994.00	4+T
2179 Glaucoma - combined (complicated)	1118.40	4+T

OPHTHALMOLOGY

	YHCIP / YWCHSB	Anaes / Proc Unit
2180 Glaucoma - goniotomy	895.00	4+T
2183 Glaucoma - repeat within 3 months	724.20	4+T
2184 Glaucoma - cyclodialysis	671.00	4+T
2185 Glaucoma - cyclodiathermy or cryotherapy	582.50	4+T
2186 Glaucoma - repeat within 3 months	278.90	4+T
2187 Glaucoma - microsurgical (trabeculectomy or trabeculotomy)	1118.40	4+T
2189 Iridocyclectomy via scleral flap dissection	1163.30	4+T
2188 Cataract - linear extraction, congenital, traumatic or senile	757.60	4+T
2191 Cataract - capsulotomy, needling or discission - initial	448.10	4+T
2193 Cataract - capsulotomy, needling or discission - subsequent	149.40	4+T
2190 Primary intraocular lens implant to include repositioning of lens within the 42 day post-operative period - extra	243.60	4+T
2192 Secondary intraocular lens implant to include repositioning of lens within the 42 day post-operative period	952.90	4+T
2196 Surgical repositioning of implant lens NOTE: For non-surgical repositioning, use visit fees	384.70	4+T
2197 Surgical evacuation of hyphema	1035.40	4+T
2198 Anterior vitrectomy NOTE: fee code 2198 is intended for cases of vast complication requiring removal of membranes from the anterior segment as a result of prior surgery or injury. It is not intended in conjunction with elective cataract removal and/or primary lens implantation.	594.50	4+T
2090 Intravitreal injection of antibiotics and/or vitreous paracentesis	297.60	4+T
2091 Anterior chamber paracentesis	247.60	4+T
2092 Vitreous biopsy	396.40	4+T

RETINAL DETACHMENT

2195 Diathermy or cryopexy	965.80	5+T
2194 Buckling procedure NOTE: Repeat procedures full fee	1677.90	5+T

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

2114 Yag laser, per eye - Professional fee	271.00	
2115 Yag laser, per eye - Technical fee	170.50	
2116 Panretinal photocoagulation - defined as greater than 700 burns. Maximum fee for one eye for any 6 month period	1443.60	4+T
2117 Photocoagulation of second eye during course of treatment of first eye	388.10	4+T

OPTOMETRY

YHCIP / Anaes /
YWCHSB Proc Unit

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

EYE TESTING

These fees are billable by an Optometrist.

Emergency Visit Premium

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

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

0253	Daytime (0800 - 1759)	30.50
0254	Evening (1800-2259) Note: This fee to be charged during the hours of 0800 to 2259 on Saturday, Sunday and Statutory Holidays.	83.50
0255	Night (2300-0759) Premiums to be charged when one must leave home, office or hospital to render urgent or emergency care.	97.50
2215	Problem based eye testing that may include measurement of refractive error, ophthalmoscopy, and any or all biomicroscopy, tonometry, eye balance test, keratometry where indicated. Note: This fee is billable for medically required testing including ocular disease, trauma or injury; systemic diseases associated with significant ocular risk including, but not limited to, diabetes, wet macular degeneration and glaucoma; and medications associated with significant risk.	105.00
2217	Surgical follow up	75.00
2218	Dilated Fundus Examination	45.00
2219	Non surgical follow up	75.00
2019	Tonometry	29.80
2041	Limited visual field examination: ie. Tangent screen, autoplot, arc perimeter, or single level automated test such as octopus program 3 or 7 equivalent.	61.20
2039	Fundus photography (limitations-glaucomatous disc changes, tumor progression and potentially progressive retinal disease) - may be billed by Optometrist	24.80
Computerized retinal fibre layer photography and neuro-retinal rim assessment (OCT)		
2068	Computerized retinal fibre layer photography and neuro-retinal rim assessment (OCT) - Professional fee	31.80
2069	Computerized retinal fibre layer photography and neuro-retinal rim assessment (OCT) - Technical fee	63.70

OTOLARYNGOLOGY

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

2510 Consultation: To include history, detailed examination of the ear, nose and throat, review of x-ray and laboratory findings and written report	94.60
2511 Consultation including Audiogram (AC and BC): when performed in conjunction with consultation	119.80
2514 Repeat or Limited Consultation: To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	74.60

Continuing Care by Consultant:

2507 Subsequent office visit - Continuing Care	24.80
2508 Subsequent hospital visit - Continuing Care	24.80
2509 Subsequent home visit - Continuing Care	74.60

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250 Daytime (0800 - 1759): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	55.40
0251 Evening (1800 - 2259): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	152.00
0252 Night (2300 - 0759): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	177.90

SPECIAL EXAMINATIONS

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

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

Hearing Tests

9520 Audiogram - pure tone (AC and BC)	34.50
2521 Audiogram - speech (SRT, PB, MCL)	34.50
2522 Audiogram - SISI	34.50
2523 Audiogram - tone decay	34.50
9525 Tympanogram (Impedance test)	34.50
2531 Impedance test, including contralateral reflex	49.60
2533 Play audiometry	49.60
2534 Free field audiometry	49.60
2536 Brain stem evoked response audiometry	107.00

OTOLARYNGOLOGY

YHCIP / Anaes /
YWCHSB Proc Unit

Vestibular Tests

2526	Cold Calorics Test	24.80
2527	Bithermal Test	49.60
2528	Electronystagmography (ENG)	99.80

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

Functional Tests:

2529	Lombard	34.50
2530	Stenger	49.60
2537	Alternate binaural loudness balance test	36.30

Miscellaneous Tests:

2535	Maxillary Sinus Endoscopy via canine fossa, with or without biopsy	187.90	3+T
------	--	--------	-----

EAR

		Per Visit	
2201	Removal of foreign body or aerating tubes from ear - simple	124.00	1+T
	Removal of foreign body or aerating tubes from ear - requiring general anaesthetic (operation only)		
2208	Mastoid antrotomy (infants)	501.20	3+T
2206	Removal of ear canal osteoma (operation only)	124.00	1+T
2209	Removal of obstructing exostosis of ear canal	745.40	3+T
2210	Paracentesis of the ear drum (operation only)	74.60	1+T
2220	Removal of aural polyp (operation only)	124.00	1+T
2232	Facial nerve decompression involving vertical portion only	1242.20	4+T
2240	Labyrinthectomy - destructive (any type)	745.40	4+T
2243	Repair bony atresia external ear canal - complete atresia	1491.30	3+T
2244	Repair bony atresia external ear canal - partial atresia	745.40	3+T
2247	Simple mastoidectomy	745.40	3+T
2248	Radical mastoidectomy	1208.10	4+T
2249	Stapes - reconstruction	1086.90	3+T
2250	Stapes - mobilization of	745.40	3+T
2251	Myringoplasty repair of drum without exploration of middle ear	373.20	3+T
2252	Tympanoplasty - without ossicular chain reconstruction (repair of ear drum as well as inspection of middle ear by means of a tympanotomy)	870.20	3+T
2264	Tympanoplasty - with ossicular chain reconstruction	995.80	3+T
2253	Tympanoplasty - with complete exenteration	1493.60	3+T
2265	Tympanoplasty - with partial mastoid exenteration	1118.40	3+T
2263	Trans-tympanic polyneurectomy	745.40	3+T
2257	Homograft tympanic membrane - tympanoplasty	1406.90	3+T
2254	Myringotomy with insertion of aerating tube (operation only)	124.00	1+T
2255	Exploratory tympanotomy	483.10	2+T
2266	Paper patch application to TM perforation	76.30	1+T
2256	Subarachnoid endolymphatic shunt (any procedure)	1493.60	6+T
2259	Excision of glomus by tympanotomy approach	995.80	3+T
2260	Excision of glomus (where extensive dissection is required)	1493.60	4+T
2267	Conchal cartilage graft	870.20	3+T

OTOLARYNGOLOGY

YHCIP / Anaes /
YWCHSB Proc Unit

NOSE AND SINUS

	Per Visit	
Removal of foreign body from nose - simple	263.80	3+T
2298 Cryosurgical treatments of turbinates - unilateral	361.40	3+T
2299 Cryosurgical treatments of turbinates - bilateral	124.00	2+T
2301 Removal of foreign body from nose - Complicated with anaesthetic	49.60	3+T
2303 Cauterization of septum - chemical	49.60	3+T
Cauterization of septum - electric	169.40	3+T
2304 Turbinectomy - unilateral	254.10	3+T
2305 Turbinectomy - bilateral	498.20	3+T
2306 Submucous resection of septum	252.00	3+T
2307 Nasal antral window - single	361.40	3+T
2308 Nasal antral window - double	723.60	3+T
2309 Radical antrostomy	965.80	4+T
2310 Radical antrostomy - with closure of alveolar fistula	723.60	3+T
2311 Intranasal ethmoidectomy to include polypectomy - complete one side	965.80	3+T
2312 Intranasal ethmoidectomy to include polypectomy - complete two sides	365.50	3+T
2313 Partial ethmoidectomy to include polypectomy - anterior and middle	481.40	3+T
2314 Partial ethmoidectomy to include polypectomy - bilateral	1085.00	4+T
2315 External radical fronto-ethmoidectomy	965.80	3+T
2316 External radical frontal operation	99.80	3+T
2317 Electrocoagulation of turbinates - one side	149.40	3+T
2318 Electrocoagulation of turbinates - both sides	372.90	3+T
2319 Trephining frontal sinus	498.20	3+T
2320 Sphenoidectomy (intranasal)	173.90	3+T
2322 Removal of nasal polypi - unilateral	261.00	3+T
2323 Removal of nasal polypi - bilateral	37.40	3+T
2324 Antral lavage - unilateral	56.10	3+T
2325 Antral lavage - bilateral	745.20	3+T
2326 Choanal atresia - definitive repair of	745.20	3+T
2327 Choanal atresia, definitive repair of: - unilateral	1118.40	4+T
2328 Choanal atresia, definitive repair of:- bilateral	248.50	3+T
2329 Choanal atresia; perforation of: - unilateral	371.70	4+T
2330 Choanal atresia; perforation of: - bilateral	248.50	3+T
2331 Submucous turbinectomy - unilateral	371.70	3+T
2331 Submucous turbinectomy - bilateral		
Lateral rhinotomy and excision of tumour		
2332 Lateral rhinotomy and excision of tumour - benign	869.40	3+T
2333 Lateral rhinotomy and excision of tumour - malignant	1118.40	3+T
2334 Transantral ethmoidectomy	995.80	3+T
2335 Transantral ligation, internal maxillary artery	869.40	6+T
2337 Ligation of anterior and posterior ethmoid arteries	620.80	6+T
2338 Removal of angiofibroma - nasal pharynx	1493.60	6+T

OTOLARYNGOLOGY

	YHCIP / YWCHSB	Anaes / Proc Unit
2342 Maxillectomy with exenteration of ethmoid	1493.60	5+T
2339 Palatal fenestration	498.20	3+T
2343 Septal reconstruction	746.50	3+T
2344 Posterior nasal packing (operation only)	124.40	3+T
2345 Drainage of abscess or haematoma of septum (operation only)	124.40	3+T
6121 Nasal fracture - simple reduction	124.40	3+T
6122 Nasal fracture - reduction and external splinting	248.50	3+T
6123 Nasal fracture - comminuted nasal fractures - transosseous wire plate fixation	498.20	3+T
2348 Operative closure of oral nasal fistula	746.50	3+T
2349 Operative closure of nasal septal perforation	746.50	3+T

RHINOPLASTY

2350 Removal of hump	371.70	3+T
2351 Nasal refracture requiring lateral osteotomies	746.50	3+T
2352 Reconstruction of nasal tip, ala and columella	869.40	3+T
2354 Complete rhinoplasty with SMR to include nasal hump removal, nasal refracture and reconstruction of nasal tip without skin grafting	1244.70	3+T

THROAT

2400 Incision of peritonsillar abscess (operation only)	74.60	4+T
2401 Tonsils and adenoids - child (to include neonate)	248.50	4+T
2402 Tonsils and adenoids - adult	348.20	4+T
2403 Tonsillectomy under local anaesthesia	371.70	4+T
2404 Adenoidectomy - office visits extra, apart from usual one pre and one post-operative visit	124.40	4+T
2405 Retropharyngeal abscess	124.40	4+T
2406 Retropharyngeal abscess or hematoma - requiring lateral pharyngotomy	498.20	4+T
2407 Tracheostomy (operation only)	319.60	5+T
2408 Removal of tumor from larynx or trachea	481.40	5+T
2409 Uvulo-palato-pharyngoplasty for severe obstructive sleep apnea confirmed by polysomnogram, with or without tonsillectomy	603.10	5+T
2412 Biopsy of larynx and/or cauterization (including laryngoscopy)	248.50	5+T
2413 Operative control of post-tonsillectomy or post-adenoidectomy hemorrhage requiring local or general anaesthetic	199.20	6+T
2415 Esophagoscopy with removal of foreign body	348.20	3+T
2416 Dilatation of oesophagus	124.40	2+T
2417 Dilatation of oesophagus - repeat within one month	74.60	2+T
2420 Dilatation of trachea	124.40	5+T
2421 Dilatation of trachea - repeat within one month	74.60	5+T
2422 Tracheostomy Tube Change (operation only) to be billed in addition to office visit	14.60	
2425 Arytenoidectomy	995.80	5+T
2426 Bronchoscopy with removal of foreign body	603.90	6+T
2427 Microlaryngoscopy	149.40	5+T
2428 Microlaryngoscopy with biopsy of larynx and/or cauterization	323.70	5+T
2429 Microlaryngoscopy and removal of tumor from larynx or trachea	554.30	5+T
2433 Vocal cord implant - injection	620.80	5+T
2434 Vocal cord implant - external approach	1118.90	5+T
2438 Trans-oral cricopharyngeal myotomy	829.80	5+T

INTERNAL MEDICINE

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

0310	Consultation: To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report	250.70
0312	Repeat or Limited Consultation: Where a consultation for same illness is repeated within six (6) months of the last visit by the consultant or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	125.00
0314	Prolonged visit for counselling (maximum four (4) per year applies to Insured Health Services and YWCHSB only)	89.50

Continuing Care by Consultant

0306	Directive care - Continuing Care	49.60
0307	Subsequent office visit - Continuing Care	49.60
0308	Subsequent hospital visit - Continuing Care	38.30
0309	Subsequent home visit - Continuing Care	74.60

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250	Daytime (0800 - 1759): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	55.40
0251	Evening (1800 - 2259): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	152.00
0252	Night (2300 - 0759): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	177.90

EXAMINATIONS BY CERTIFIED INTERNIST

9316	Electrocardiogram and interpretation- in office by internist - each	49.50	
9317	Electrocardiogram and interpretation - in home by internist - each	75.60	
0318	Electrocardiogram - professional fee	24.80	
9401	Electrocardiogram - technical fee	31.60	
0322	Internists' part in cardioangiogram, per hour or fraction thereof	99.80	
0325	Cardioversion NOTE: The procedural fee does not include the consultation fee or follow-up daily visits. If more than one cardioversion is performed on any patient in a single day, this is to be treated as a special case and a written report should accompany the account	176.00	6+T
0326	Single Chamber permanent programmable pacemaker testing - professional fee	52.50	
0353	Single Chamber permanent programmable pacemaker testing - technical fee	26.30	
0328	Dual Chamber permanent programmable pacemaker testing - professional fee	78.90	
0354	Dual Chamber permanent programmable pacemaker testing - technical fee	52.50	

INTERNAL MEDICINE

	YHCIP / YWCHSB	Anaes / Proc Unit
Scanning of 8 hour electrocardiogram		
0327 Polarcardiography and interpretation - professional fee	84.30	
9427 Polarcardiography and interpretation - technical fee	90.60	
0330 Temporary right ventricular pacemaker catheter placement, using external battery pack - internist or other qualified physicians	351.70	4+T
0332 Pacemaker standby and/or placement of the endocardial catheter	176.00	4+T
0333 Generator placement and venous cutdown	577.20	4+T
0334 Graded exercise test (performance and interpretation)	151.00	
0335 Graded exercise test (performance and interpretation) - professional fee	97.00	
0336 Graded exercise test (performance and interpretation) - technical fee	53.80	
NOTE: This test involves controlled graduated exercise levels by the use of either a bicycle or treadmill ergometer with continuous electrocardiographic monitoring during and after exercise. At least two exercise work levels must be measured, exclusive of a warm-up period, and reproducible exercise and post-exercise records must be obtained. When only one level of exercise testing is performed, then the same fee as for a Master Two-Step should apply.		
When a 23 lead cardiogram is done on the same day as the graded exercise test, it is included in fee code 0334. A graded exercise tolerance test may be repeated once within one year to assess functional capacity of patient after recovery from coronary by-pass surgery and to assess the affect of therapy where exercise has produced a serious ventricular rhythm disturbance.		
In all other circumstances, where graded exercise tests are repeated within one year a letter of explanation for the need will accompany the account to the payment agency except in conjunction with thallium myocardial scans where a graded exercise test may be performed and charged with each scan.		
0337 Replacement transfusion - hepatic failure to include two weeks care after transfusion NOTE: Consultation and necessary hospital visits prior to initial transfusion, extra	627.10	
0338 Plasmapheresis - therapeutic	248.50	
0340 Scanning of 8 hour electrocardiogram	149.40	
0341 Scanning of 8 hour electrocardiogram - professional fee	96.10	
0342 Scanning of 8 hour electrocardiogram - technical fee	53.30	
0343 Cardiac Screening (maximum 3 a month within manufacturer's guarantee and one a week beyond manufacturer's guarantee)	10.20	
0344 Cardiac Screening - professional fee	4.80	
0345 Cardiac Screening - technical fee	4.80	
Scanning of 24 hour electrocardiogram		
0347 Scanning of 24 hour electrocardiogram - professional fee	147.00	
0348 Scanning of 24 hour electrocardiogram - technical fee for ECG	55.40	
0349 Scanning of 24 hour electrocardiogram - technical fee for scanning Level I: Requires a recorder capable of recording all beats and transmitting this information to a scanner which is capable of analyzing and printing every beat and also performing edited trend analysis, and/or edited graphic or alpha-numeric hourly summary of data	99.60	

INTERNAL MEDICINE

YHCIP / Anaes /
YWCHSB Proc Unit
74.90

0363 Scanning of 24 hour electrocardiogram - technical fee for scanning
Level II:
Requires a recorder capable of recording all beats and transmitting this information to a scanner which is capable of analyzing and printing every beat and also performing unedited trend analysis, and/or unedited graphic or alpha-numeric hourly summary of data

0364 Scanning of 24 hour electrocardiogram - technical fee for scanning
Level III:
Requires a recorder capable of recording only a portion of each minute, or a pre-determined time period after an abnormal complex is sensed The scanner of this record is capable of analyzing the data and printing all beats in the pre-determined time period and analyzing the ST segment, heart rate and ectopic beat frequency

0365 Scanning of 24 hour electrocardiogram - technical fee for scanning
Level IV:
a) Requires a recorder capable of recording beats for only a portion of a minute and feeding this information into a scanner through an adaptor that feeds the information to the standard ECG machine

b) Requires a recorder capable of recording all beats and feeding the information into an alpha-numeric device which prints an hourly maximum R-R intervals, premature beats, and ventricular complexes of abnormal width

0372 Measurement of Bone Mineral content in vivo using photon absorptiometry 84.60

Intracardiac Electrophysiological Mapping

0366 Intracardiac Electrophysiological Mapping - initial study 1425.40

0367 Intracardiac Electrophysiological Mapping - restudy 285.60

0368 Esophageal or intra-atrial electrophysiological study 213.30

Chemotherapy

0382 Cancer Chemotherapy visit: 170.60
To include the administration of multiple parenteral chemotherapeutic agents, history and physical examination as necessary to document disease status, counselling of patient and/or family, review of pertinent laboratory and radiologic data, venesection and institution of an intravenous line. This service will not be billed more than once every twenty-eight days (time taken must be in excess of 1 hour).

0383 Limited Cancer Chemotherapy visit: 85.20
To include the administration of single or multiple parenteral chemotherapeutic agents, history and physical examination as necessary to document disease status, counselling patient and/or family, review of pertinent laboratory and radiologic data, venesection and institution of an intravenous line.
NOTE: This item is not to be billed more than once every seven days. Neither is it to be billed for routine administration of 5-fluorouracil as a single agent.

RHEUMATOLOGY

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

3310 Consultation: To consist of examination, review of history, laboratory, x-ray findings and additional visit necessary to render a written report	259.10
3312 Repeat Limited Consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant, the consultative services do not warrant a full consultative fee	129.90
3314 Prolonged visit for counselling	92.50
Continuing Care by Consultant	
3307 Subsequent office visit	69.40

NEUROLOGY

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

0410 Consultation:	250.70
To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report	
0411 Repeat or Limited Consultation:	125.20
Where a consultation for the same illness is repeated within six (6) months of the last service by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	

Continuing Care by Consultant:

0406 Directive care	49.60
0407 Subsequent office visit	49.60
0408 Subsequent hospital visit	38.00
0409 Subsequent home visit	74.60

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250 Daytime (0800 - 1759):	55.40
Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	
0251 Evening (1800 - 2259):	152.00
Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hour of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	
0252 Night (2300 - 0759):	177.90
Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	

BOTULINUM TOXIN INJECTIONS

These fees are only billable by a Neurologist

0473 Botulinum Toxin Injection for Blepharospasm associated with dystonia (including benign essential blepharospasm) or VII nerve disorders - unilateral or bilateral	204.70
0424 Botulinum Toxin Injection only applicable to Cervical Dystonia (spasmodic torticollis); adductor spasmodic dystonia, jaw-closing oro-mandibular dystonia or hemifacial spasm, dynamic equines foot deformity due to spasticity in paediatric cerebral palsy patients, focal spasticity including the treatment of upper limb spasticity associated with strokes in adults	239.00

NEUROSURGERY

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

3010	Consultation: To consist of examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report	149.40	
3011	Repeat or Limited Consultation: Where a consultation for the same illness is repeated within six (6) months of the last service by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	74.60	

Continuing Care by Consultant:

3007	Subsequent office visit	24.80	
3008	Subsequent hospital visit	37.40	
3009	Subsequent home visit	74.60	

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250	Daytime (0800 - 1759): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	55.40	
0251	Evening (1800 - 2259): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	152.00	
0252	Night (2300 - 0759): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	177.90	

CRANIAL NERVES

3101	Supra or intra orbital nerve avulsion	170.90	3+T
-------------	---------------------------------------	--------	-----

TRAUMA

3111	Elevation of simple depressed skull fracture	953.20	5+T
3112	Elevation of compound depressed skull fracture	1566.60	6+T
3113	Elevation of compound depressed skull fracture with repair of dura, debridement of cerebral laceration and sinuses	1739.20	6+T
3115	Exploration of subdural space for chronic subdural hematoma - unilateral or bilateral	1118.40	6+T
3116	Craniotomy for evacuation of intracranial hematoma (cerebral sub-dural, extradural or abscess)	1830.90	8+T
3118	Craniotomy for repair of CSF leak	1742.60	8+T
3119	Craniotomy for microvascular decompression of cranial nerve	2236.00	8+T

CEREBRAL PROCEDURES

3126	Re-opening or removal of bone flap	715.10	6+T
-------------	------------------------------------	--------	-----

NEUROSURGERY

YHCIP / Anaes /
YWCHSB Proc Unit

EXTRA-CRANIAL VASCULAR PROCEDURES

7237 Carotid endarterectomy 1327.80 8+T

SPINAL

3165 Insertion of intracranial pressure monitoring device (operation only) 512.30 6+T

3167 Insertion of skull tongs (operation only) 248.50 4+T

3173 Fracture of spine with cord injury - open reduction and fusion - in conjunction with orthopaedic surgeon (operation only) 1111.70 6+T

PERIPHERAL NERVE

3191 Minor, digital, primary suture or secondary 371.70 2+T

3192 Repair of palmar nerve 371.70 2+T

3193 Major, primary suture 746.50 2+T

3195 Exploration of peripheral nerve and neurolysis 498.20 2+T

3196 Exploration, mobilization and transposition 614.40 2+T

3198 Neurectomy of major nerve 371.70 2+T

3200 Secondary suture including transposition 995.80 3+T

3201 Secondary suture of major nerve 863.10 3+T

3204 Hypoglossal facial anastomosis 863.10 4+T

3205 Nerve graft 746.50 3+T

7751 Cervical or dorsal sympathectomy 912.80 5+T

7753 Lumbo-dorsal sympathectomy and splanchnic neurectomy - unilateral 912.80 7+T

MISCELLANEOUS

3211 Muscle biopsy 124.40

OBSTETRICS AND GYNAECOLOGY

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

4010 Consultation: To include complete history and gynaecological examination, review of x-ray and laboratory findings, if required, and written report or consultation during labour	176.00
4012 Repeat or Limited Consultation: To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative services do not warrant a full consultative fee	81.40

Continuing Care by Consultant:

4007 Subsequent office visit	53.40
4008 Subsequent hospital visit	49.20
4009 Subsequent home visit	81.40

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250 Daytime (0800 - 1759): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	55.40
0251 Evening (1800 - 2259): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	152.00
0252 Night (2300 - 0759): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	177.90

OBSTETRICAL PROCEDURES

4020 Emergency obstetric consultation including complicated vaginal surgery	374.70	4+T
4021 Emergency obstetric consultation including complicated delivery NOTE: This is the maximum fee for emergency obstetric consultation	579.90	4+T
4022 Repair of complete separation of external sphincter (operation only) (Third degree tear)	197.50	3+T
4023 Repair of extensive cervical and/or vaginal lacerations (operation only)	197.50	3+T
4090 Prenatal visit - complete examination This fee is billable once by each physician who renders the service to the same patient.	93.90	
4091 Prenatal visit - subsequent examination	43.60	
4092 Initial Pregnancy Counselling minimum time per visit 20 minutes This fee is billable by one or more physicians to a maximum of three times per patient	95.70	
4100 Extraordinary events during labor (eg. fetal distress, antepartum hemorrhage, maternal fever) where immediate assessment of the patient by the physician is required and the physician is specifically called by the nurse. This is not to be billed for routine monitoring of the laboring patient and must include call back time.	43.60	

OBSTETRICS AND GYNAECOLOGY

	YHCIP / YWCHSB	Anaes / Proc Unit
4108 Delivery only (50% extra for each additional neonate delivery) NOTE: For consideration of premiums, the time of delivery shall be the time of the birth of the newborn	674.90	
4109 Post-natal care of mother in hospital	100.00	
4110 Six weeks post-partum check of mother plus pap smear NOTE: (If IUD is inserted, 50% of fee code 4540 may be charged in addition)	82.70	
4105 Caesarean section	749.30	5+T
4106 Caesarean hysterectomy	845.80	8+T
4111 Therapeutic abortion (vaginal) - by whatever means - less than 12 weeks gestation (operation only)	248.50	1+T
4112 Therapeutic abortion (vaginal) - by whatever means - 12 weeks gestation or over	481.40	1+T
4113 Obstetrical assist - to be billed in complicated delivery by the family physician who supervised the labour when the neonate was delivered by a consultant. *This shall cover the first stage and 2 hours of the second stage of labour	521.00	
4117 Curettage for post-partum hemorrhage or retained placenta	248.20	3+T
4118 Induction or stimulation of labour by oxytocin intravenous drip, where constant attendance by the physician in attendance is required - per half hour; maximum 10 hours	101.40	
4119 Inpatient or outpatient insertion of prostaglandin vaginal gel for ripening and/or induction of labor	43.60	
4120 External cephalic version	64.10	
4199 MANAGEMENT OF PROLONGED SECOND STAGE: This item is billable in addition to fee code 4108 or 4113 after the second stage of labour exceeds 2 hours (may begin at transitional stage of 8 cm). The physician must be in personal attendance for duration of second stage. Both start and end time is required on the claim submission. In excess of 2 units will be assessed by the Medical Advisor on the basis of a written report. Per half hour or major portion thereof	101.40	
4299 MANAGEMENT OF PROLONGED THIRD STAGE: This item is billable after the third stage exceeds 45 minutes for such reasons as postpartum hemorrhage, manual removal of retained placenta or extensive vaginal laceration. It is not payable if fee code 4022, 4023 or 4428 is billed. The physician must be in personal attendance for the duration of the third stage. Both start and end time is required on the claim submission. In excess of 2 units will be assessed by the Medical Advisor on the basis of a written report. Per half hour or major portion thereof	101.40	
4399 Obstetrical Case Management Fee Billable in addition to visit fees, procedural fees and time premiums. This item may be billed only once per obstetrical case by the patients primary care physician who remains available for the purpose of labour and delivery.	901.80	

ABDOMINAL OPERATIONS

4200 Hysterectomy - subtotal	869.60	5+T
4201 Hysterectomy - total	995.80	5+T
4202 Hysterectomy - vaginal	995.80	4+T
4203 Myomectomy	746.40	5+T
4204 Abdominal hysterotomy with or without sterilization	746.40	5+T
4205 Removal of ectopic pregnancy, abdominal or vaginal route	746.40	5+T
4206 Suspension of uterus	620.80	4+T

OBSTETRICS AND GYNAECOLOGY

	YHCIP / YWCHSB	Anaes / Proc Unit
4207 Removal of ovarian cysts and/or salpingectomy	620.80	5+T
4208 Removal of complicated pelvic disease	1244.70	6+T
4209 Abdominal excision of cervical stump	995.80	3+T
4214 Tuboplasty for infertility, including microsurgical salpingo-ovariolysis - unilateral or bilateral	869.60	5+T
NOTE: Not payable following previous surgical sterilization and should not be billed to the payment agency		
4213 Sterilization by abdominal or vaginal route	481.40	4+T
4215 Wedge resection of ovaries	746.40	5+T
4217 Post-operative hemorrhage (intra-abdominal management)	498.20	5+T

OPERATIONS ON THE VULVA

4300 Incision of hymen (operation only)	74.60	1+T
4301 Excision or marsupialization of a Bartholin's cyst	248.50	1+T
4302 Incision and drainage of Bartholin's abscess (operation only)	74.60	1+T
4303 Excision of hydrocele or canal of Nuck	371.70	1+T
4304 Urethral caruncle - cautery or excision in hospital	124.40	1+T
4305 Venereal warts, cautery or excision (not for application of phodophyllin) (operation only)	49.60	
4306 Excision of venereal warts under general anaesthesia in hospital	248.50	1+T
4309 Varicocele of labium	248.50	1+T
4312 Resection of labia minora	248.50	1+T
4315 Biopsy of vulva	74.60	1+T

OPERATIONS ON THE VAGINA

4401 Repair of recto-vaginal fistula	995.20	3+T
4403 Colpotomy - open	124.40	1+T
4402 Colpotomy with drainage pelvic abscess	248.50	1+T
4404 Removal of vaginal inclusion cyst	74.60	1+T
4405 Removal of other vaginal cyst	371.70	1+T
4406 Operation for removal of vaginal septum	248.50	1+T
4408 Vault prolapse following hysterectomy	995.80	4+T
4409 Excision of cervical stump with anterior and posterior repair	869.60	3+T
4410 Post-operative hemorrhage - vaginal management requiring anaesthesia	248.50	5+T

PLASTIC OPERATIONS OF GENITAL PROLAPSE

4420 Repair of cystocele	620.80	2+T
4421 Repair of rectocele	620.80	2+T
4422 Repair of enterocele	869.60	2+T
4423 Repair of cystocele and rectocele combined	869.60	2+T
4425 Vaginal hysterectomy with complete repair	1367.60	4+T
4426 Repair of cystocele or rectocele with abdominal hysterectomy or laparotomy	1367.60	4+T
4427 LeFort's operation	620.80	2+T
4428 Primary repair of fourth degree perineal laceration	236.80	2+T
4429 Repair of old third degree perineal laceration	746.40	2+T
4432 Repeat vaginal plastic procedure (additional fee)	248.50	2+T
4431 Retropubic operation for urinary incontinence (Burch Procedure)	869.60	2+T

OBSTETRICS AND GYNAECOLOGY

YHCIP / Anaes /
YWCHSB Proc Unit

VAGINAL OPERATIONS ON THE CERVIX AND UTERUS

4500	Dilation of cervix and curettage (prenatal and pre-operative visits extra)	199.20	1+T
4502	Repair of cervix	248.50	1+T
4503	Cryosurgery of cervix	202.30	1+T
4505	Removal of cervical polyp in office	49.60	
4506	Removal of cervical polyp with dilation and curettage (pre-operative visits extra)	199.20	1+T
4508	Biopsy of cervix under general anaesthesia	124.40	1+T
4510	Biopsy of cervix with dilation and curettage - total (pre-operative visits extra)	199.20	1+T
4513	Vaginal repair of vesico-vaginal fistula	995.20	3+T
4514	Repair of incompetent cervical os	498.20	2+T
4515	Removal of buried cervical ligature under anaesthesia	124.40	2+T
4218	Hysteroscopic endometrial resection and ablation	479.30	2+T
4528	Laparoscopic excision of endometriosis to include transection of uterosacral ligaments. This fee is not to be billed in addition to fee code 4529	481.40	4+T
4529	Cauterization of endometriosis at laparoscopy or laparotomy	74.60	
4530	Cauterization of cervix under general anaesthesia	99.80	1+T
4531	Cauterization of cervix with dilation and curettage (pre-operative visits extra)	199.20	1+T
4533	Electric cauterization of cervix in office	38.80	
4536	Dilation and curettage with cone biopsy of cervix for abnormal cytology under general anaesthesia	348.20	2+T
4540	Insertion of intrauterine contraceptive device (IUD) or Laminaria tent(s) (operation only)	44.10	1+T
4541	Retrieval of lost or retained IUD via intrauterine hook, curettage or forceps (operation only)	72.10	
4545	Artificial insemination (operation only)	74.60	
4550	Vaginal removal of cervical stump - open peritoneum	498.20	3+T

MISCELLANEOUS

4610	Obstetric/Gynaecology ultrasound - professional fee (assessment of multi-gestation can be billed at 50% for each additional fetus)	81.40	
------	---	-------	--

ORTHOPAEDICS

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

5010 Consultation: (In office or hospital) To include a history and physical examination, review of x-ray and laboratory findings, and a written report	135.90
5012 Repeat or Limited Consultation: To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	74.60
5015 Orthopaedic special consultation: Extended consult for complex problems (ie. oncology, complex trauma, adult cerebral palsy etc.), when requested by another Orthopaedic Surgeon, Neurosurgeon, Plastic Surgeon or Rehabilitation Physician. Includes history, physical examination, review of x-rays and written report	272.10

Continuing Care by Consultant:

5007 Subsequent office visit	38.80
5008 Subsequent hospital visit	24.80
5009 Subsequent home visit	74.60

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250 Daytime (0800 - 1759): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	55.40
0251 Evening (1800 - 2259): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	152.00
0252 Night (2300 - 0759): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	177.90

FRACTURES

Upper Extremity

` Finger phalanx or metacarpal - not requiring reduction	Per Visit	
5201 Finger phalanx - requiring reduction	199.10	1+T
5203 Metacarpal - requiring reduction	199.10	1+T
5225 Distal phalanges - open reduction and wiring - first	371.70	2+T
5226 Distal phalanges - open reduction and wiring - each additional (extra)	199.10	2+T
5227 Other than distal phalanges - open reduction and wiring - first	620.80	2+T
5228 Other than distal phalanges - open reduction and wiring - each additional (extra)	298.70	2+T
5229 Crush injury of hand with multiple fractures - closed reduction	371.70	2+T
5206 Crush injury of hand with multiple fractures - open reduction NOTE: To include wiring if applicable	620.80	2+T
5205 Base of 1st metacarpal (Bennett's) Carpal bones - one or more	298.70 Per Visit	2+T

ORTHOPAEDICS

	YHCIP / YWCHSB	Anaes / Proc Unit
5207 Scaphoid (intra-articular)	364.90	2+T
5209 Radius and/or ulna at wrist - requiring reduction	321.90	2+T
Radius and/or ulna at wrist - not requiring reduction	Per Visit	
5210 Radius and/or ulna - greenstick requiring reduction	172.60	1+T
5211 Radius or ulna shaft - closed reduction	298.70	2+T
5212 Radius and ulna shaft - complete displacement requiring closed reduction	620.80	2+T
5213 Head of radius - closed reduction	248.50	2+T
5214 Resection head of radius	498.20	2+T
5215 Olecranon - closed reduction	248.50	2+T
5216 Olecranon and humeral epicondyles	371.70	2+T
5217 Humerus shaft - requiring reduction	371.70	2+T
Humerus shaft - tuberosity or condyle - not requiring reduction	Per Visit	
5219 Humerus shaft - open reduction	371.70	2+T
5220 Supracondylar (humerus) - requiring reduction	620.80	2+T
Supracondylar (humerus) - not requiring reduction	620.80	
5221 Surgical neck of humerus - requiring reduction	371.70	2+T
Surgical neck of humerus - not requiring reduction	371.70	
Scapula	371.70	
5222 Clavicle - child	0	
5224 Clavicle - adult	199.10	1+T
5223 Clavicle - open reduction	298.70	2+T
5231 Intercondylar (humerus)	869.50	2+T
5232 Intercondylar (humerus) - not requiring reduction	620.80	
Chest		
Sternum		
Ribs - single or multiple		
Spine		
5233 Spine - non-operative management of unstable fracture	746.40	4+T
5230 Coccyx - operative	298.70	4+T
Pelvis		
5235 Simple - without displacement	0	
5236 Non-operative management of unstable and complicated fracture	746.40	4+T
Lower Extremity		
5238 Femur - neck or intertrochanteric (including slipped epiphysis) - closed reduction with fixation	498.20	4+T
5239 Femur - neck or intertrochanteric-operative	1244.70	5+T
5240 Femur - shaft or supracondylar - closed reduction with or without anaesthetic - infant	371.70	4+T
5241 - child	620.80	4+T
5242 - adult	869.50	2+T
5243 Femur - shaft - open reduction	1244.70	5+T
5249 - supracondylar - open reduction	1244.70	5+T
5246 Vastus medialis advancement	498.20	4+T
5247 Patella - simple - closed reduction	248.50	2+T
5248 - excision or open reduction, including wiring	498.20	2+T

ORTHOPAEDICS

	YHCIP / YWCHSB	Anaes / Proc Unit
5250 Stapling of proximal tibial and distal femoral epiphyses	869.60	2+T
5251 Tibial condyles - (plateau) not requiring reduction	248.50	
5252 - (plateau) requiring reduction	498.20	2+T
5253 Tibia shaft closed reduction	620.80	2+T
- Tibia shaft not requiring reduction	620.80	
5244 - open reduction	995.80	3+T
5254 Tibia - medial malleolus	248.50	2+T
5255 Tibia and fibula bimalleolar or trimalleolar	498.20	2+T
5256 Surgery for dislocating patella - involving plication of medial capsule plus transposition of patellar tendon	746.40	2+T
5257 Quadriceps myoplasty	746.40	3+T
5266 Crush injury of foot with multiple fractures - closed reduction	371.70	2+T
5267 Crush injury of foot with multiple fractures - open reduction	620.80	2+T
5270 Fibula - malleolus - closed reduction	371.70	2+T
5271 Fibula - shaft or malleolus - not requiring reduction	172.60	
5272 Os calcis - closed reduction	371.70	2+T
5273 Fracture - neck of talus	371.70	2+T
5274 Tarsal bones - closed reduction	248.50	2+T
not requiring reduction	248.50	
5275 Metatarsal bone - closed reduction - one	172.60	2+T
5276 Metatarsal bone - closed reduction - two or more	248.50	2+T

DISLOCATIONS

5300 Reduction of dislocation other than shoulder without anaesthetic	49.50	
5301 Temporo-mandibular joint - dislocation - closed reduction	124.40	1+T
Clavicle, sterno-clavicular, acromio-clavicular - closed reduction	124.40	
5303 Clavicle - acromio-clavicular - requiring open reduction	746.40	2+T
5304 Shoulder - closed initial reduction	172.60	1+T
5305 Shoulder - closed recurring reduction	124.40	1+T
5306 Shoulder- open reduction to recurrent - Bankart	1263.30	3+T
5307 Elbow - closed reduction	172.60	1+T
5308 Carpal bones - closed reduction (Lunate)	172.60	1+T
5309 Carpal bones - open reduction	498.20	2+T
5310 Metacarpophalangeal or interphalangeal joint - closed reduction	74.90	1+T
5311 Metacarpophalangeal or interphalangeal joint - open reduction	298.70	2+T
5312 Hip - closed reduction	498.20	2+T
5313 Patella - closed reduction	124.40	1+T
5314 Knee - open primary repair of ruptured ligaments (with or without meniscectomy)	869.50	3+T
5315 Ankle - closed reduction	248.50	2+T
5316 Astragalus - closed reduction	248.50	2+T
5317 Metatarsal bone - closed reduction	74.90	1+T
5318 Toe - closed reduction	74.90	1+T
5319 Vertebra - closed reduction	498.20	4+T
5320 Congenital dislocation of hip - closed reduction	620.80	4+T
5321 Congenital dislocation of hip - open reduction	1118.40	6+T

ORTHOPAEDICS

YHCIP / Anaes /
YWCHSB Proc Unit

FRACTURE-DISLOCATIONS

5400 Hip - central, anterior or posterior: - closed reduction	746.40	2+T
5401 Hip - central, anterior or posterior - open reduction	1244.70	4+T
5402 Vertebra - closed reduction	746.40	4+T
5403 Vertebra - open reduction with internal fixation or fusion	1493.60	6+T
5404 Astragalus - closed reduction	498.20	2+T
5405 Astragalus - open reduction	746.40	2+T
5406 Carpus - closed reduction	371.70	1+T
5407 Carpus - open reduction	498.20	2+T
5408 Monteggia fracture - dislocation of elbow - closed reduction	620.80	2+T
5409 Monteggia fracture - dislocation of elbow - open reduction	869.50	2+T
5410 Head of humerus - closed reduction	620.80	2+T
5411 Head of humerus - open reduction	869.50	2+T
5412 Dislocated elbow with fractured epicondyles - closed reduction	408.60	1+T
5413 Dislocated elbow with fractured epicondyles - open reduction	561.20	2+T
5414 Ankle - closed reduction	498.20	2+T
5415 Ankle - open reduction	746.40	2+T

AMPUTATIONS

Upper Extremity

5420 Disarticulation - interscapulo-thoracic	1244.70	5+T
5421 Shoulder disarticulation	995.80	4+T
5422 Upper arm	620.80	3+T
5423 Forearm	620.80	3+T
5424 Hand	620.80	2+T
5425 Transmetacarpal	371.70	2+T
5426 Finger - any joint or phalanx	248.50	2+T

Lower Extremity

5430 Disarticulation - interpelvic-abdominal	1905.00	6+T
5431 Disarticulation - hip	1244.70	6+T
5432 Thigh (all levels) including knee	746.40	4+T
5433 Leg	620.80	4+T
5434 Ankle - Syme, Pirogoff	746.40	2+T
5435 Foot - mid or trans-metatarsal	498.20	2+T
5436 Metatarsal - with toe	248.50	2+T
5437 Toe - any joint or phalanx	99.80	2+T
5438 Secondary closure for amputations up to 50% of original fee not to exceed	371.70	2+T

OSTEOTOMY AND EXCISION

5460 Minor bones, eg. phalanges, metatarsals	248.50	2+T
5461 Major bones, eg. tibia, humerus	746.40	2+T
5462 Subtrochanteric of femur (McMurray)	1493.60	4+T
5473 Innominate osteotomy (Salter)	990.90	6+T

ORTHOPAEDICS

	YHCIP / YWCHSB	Anaes / Proc Unit
5463 Phalangectomy - Hammer Toe	174.30	2+T
5464 Osteomyelitis - Saucerization, muscle flap or bone graft	995.80	3+T
5465 Osteomyelitis - saucerization and sequestrectomy	746.40	3+T
5467 Osteomyelitis - incision subperiosteal abscess	124.40	2+T
5474 Decompression of acute osteomyelitis	742.80	3+T
5468 Local excision of bone tumor - benign	498.20	3+T
Local excision of bone tumor - malignant - bill under fee code 5999		
5469 Local excision of bone spur	124.40	1+T
5470 Excision of acromion or outer end of clavicle	620.80	2+T
5471 Excision of clavicle	620.80	3+T
5472 Excision accessory tarsal scaphoid (Kidner)	498.20	2+T

ARTHROTOMY

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

5501 Wrist, elbow, ankle or tarsal	371.70	2+T
5502 Hip	498.20	4+T
5508 Shoulder	498.20	2+T
5503 Knee	371.70	3+T
5504 Knee, transarthroscopic meniscectomy	792.70	3+T
5505 Knee (meniscectomy)	498.20	3+T
5506 Stripping of lateral epicondyle for tennis elbow	371.70	2+T
5507 Pes anserinus transfer	498.20	2+T
5511 Fixation of osteochondral fragments with bone graft peg	620.80	3+T

ARTHROPLASTY

5522 Interphalangeal or metacarpophalangeal - capsulotomy, arthroplasty and arthrodesis	371.70	2+T
5514 Metatarsal phalangeal joint - silastic	498.20	2+T
5528 Obliteration nail bed - great toe (Zadic)	248.50	2+T
5529 Total hip prosthesis	2240.10	6+T
5525 Metatarso-phalangeal (Keller, McBride)	371.70	2+T
5526 Mitchell osteotomy - unilateral	498.20	2+T
5527 Mitchell osteotomy - bilateral	746.40	2+T
5513 Glenohumeral - total shoulder	1608.60	7+T
5524 Total knee joint replacement	1855.40	5+T

ARTHRODESIS

5530 Knee, shoulder, elbow, ankle	1364.50	3+T
5531 Hip	1742.20	6+T
5532 Sacroiliac	863.10	6+T
5533 Wrist	863.10	2+T
5538 Foot - subtalar, mid-tarsal, triple, Grice-Green	863.10	2+T
5539 Interphalangeal or metacarpophalangeal	371.70	2+T

ORTHOPAEDICS

YHCIP / Anaes /
YWCHSB Proc Unit

FASCIAL REPAIRS

5544 Meniscal Reattachment	509.60	2+T
5554 Major knee ligament reconstruction - medial or lateral sides	1263.30	3+T
5555 Major knee ligament reconstruction - medial and lateral sides	1892.50	3+T
5553 Patellar shaving	498.20	2+T

TENODESIS BONE GRAFTING

5560 Femur - neck	995.80	4+T
5561 Shaft	1244.70	3+T
5562 Tibia	995.80	3+T
5563 Humerus	995.80	2+T
5564 Radius and ulna	995.80	2+T
5565 Radius or ulna	620.80	2+T
5566 Metacarpal, Phalanx	498.20	2+T
5568 Tibial or fibular malleolus	620.80	2+T
5572 Scaphoid	620.80	2+T
5571 Bone graft-clavicle	995.80	2+T
5573 Harvesting of live bone for grafting (in conjunction with open reduction), extra	479.10	2+T

PLASTER CASTS IN NON-FRACTURE CASES AND FOR FRACTURES NOT

REDUCED *Initial application of cast to be charged in addition to visit fee. If assessment including x-ray are required for subsequent recasting, then visit and cast fee allowed. If only minimal reassessment prior to recasting is required, cast fee only should apply. See also clause 12 (C) of Preamble.*

5580 Finger or toe	24.80	
5581 Short arm (elbow to hand)	37.70	
5583 Long arm (axilla to hand)	49.60	
5584 Shoulder spica	124.40	
5585 Ankle (foot to midleg)	49.60	
5586 Knee (foot to thigh)	49.60	
5587 Walking cast	49.60	
5588 Hip spica - unilateral	124.40	
5589 Hip spica - bilateral	149.40	
5590 Body - shoulder to hips	124.40	2+T
5591 Body - including head (Minerva)	174.30	2+T
5592 Petrie abduction cast	149.40	
5593 Cast brace for fractured femur	459.50	

ORTHOPAEDICS

YHCIP / Anaes /
YWCHSB Proc Unit

MISCELLANEOUS

5600 Manipulation of any joint under general anaesthetic other than for dislocation or fracture (operation only) - Casting extra at 100%	124.40	2+T
5601 Irrigation of joint	49.60	1+T
5604 Application of Denis-Browne Splint with adhesive tape	49.60	
5607 Removal pins and screws (operation only)	242.60	2+T
5608 Removal of plates, intramedullary rods	371.70	2+T
5612 Bone biopsy - open	174.30	2+T
5613 Reconstruction of rheumatoid hand joints multiple eg. synovectomy, intrinsic release, repositioning of extensor tendons, each hand: Fee for service at any one operative session - up to	1991.30	3+T
5614 Forefoot reconstruction - per individual items up to maximum of	869.60	3+T
5615 Finger joint prosthesis - first joint	371.70	2+T
5616 Finger joint prosthesis - subsequent joints same sitting	182.50	2+T
5620 Synovectomy of hand joint	498.20	2+T
5621 Intrinsic release	498.20	2+T
5625 Orthopaedic interpretation of submitted x-ray films	49.40	
5626 Synovectomy of flexor or extensor tendons in wrist or hand for rheumatoid	746.40	2+T
5627 Iliopsoas transplant	1360.90	4+T
5629 Synovectomy of knee joint	995.80	3+T
5630 Closed digital tenotomy - first	174.30	1+T
5631 Closed digital tenotomy - each additional	24.80	1+T
5632 Digital neuroma excision	248.50	1+T
5633 Epiphyseal arrest, femur and/or tibia	746.40	2+T
5634 Jones tenosuspension	498.20	2+T
5635 Tendon achilles	462.70	2+T
5637 Proximal hamstring release	498.20	2+T
Resection volar carpal ligament - see fee code 3195		
5640 Rotator cuff tear repair	1263.30	3+T
5642 Skeletal traction	149.40	1+T
5646 Reconstruction lateral ligaments of ankle	746.40	2+T
5643 Halo skeletal traction	498.20	4+T

PAEDIATRICS

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

0510 Consultation:	248.50
To consist of an examination, review of history, laboratory, x-ray findings and additional visits necessary to render a written report	
0512 Repeat or Limited Consultation:	124.40
Where a formal consultation for the same illness is repeated within six (6) months of the last visit by the consultant or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	
0514 Prolonged visit for counselling	124.40
NOTE: Insured Health Services and YWCHSB will pay up to four such visits per year (see clause 19 of the Preamble)	
0550 Extended Consultation - exceeding 50 minutes	268.50
To consist of an examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report	
Note:	
i) Applicable to patients with chronic and complex medical needs.	
li) Not payable in addition to 0510, 0511, 0512, or 0551.	
iii) Start and end times must be submitted with claim and must be recorded in the patient's chart.	
0551 Extended Consultation - exceeding 60 minutes	332.90
To consist of an examination, review of history, laboratory, x-ray findings, and additional visits necessary to render a written report	
Note:	
i) Applicable to patients with chronic and complex medical needs.	
li) Not payable in addition to 0510, 0511, 0512 or 0551.	
iii) Start and end times must be submitted with claim and must be recorded in the patient's chart.	
Continuing Care by Consultant	
0506 Directive care	55.10
0507 Subsequent office visit	68.00
0508 Subsequent hospital visit	54.50
0509 Subsequent home visit	74.90

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

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250 Daytime (0800 - 1759):	55.40
Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	
0251 Evening (1800 - 2259):	152.00
Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	
NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	
0252 Night (2300 - 0759):	177.90
Premium to be charged only when one must immediately leave home, office or hospital to render urgent emergency care	

PAEDIATRICS

YHCIP / Anaes /
YWCHSB Proc Unit

SPECIAL PROCEDURES

0522	Emotionally disturbed child and/or FAS reporting: Diagnostic interviews or examination, including mental status and treatment recommendation, assessment of parents, guardian or other relatives and written report	431.40
0525	Insertion of intra-arterial infusion line in infants - extra to consultation	102.80
0524	Exchange transfusion - procedural fee	641.00
	NOTE: (i) Charge full fee for all repeat transfusions (ii) Normally an assistant for exchange transfusion is not required. However, in those exceptional cases when one is required, a letter of explanation of need must accompany the account to the payment agency.	
0526	Insertion of intravenous infusion line in children under 5 years - extra to consultation	77.40
0527	Electrocardiogram and interpretation in office by a paediatrician - each	51.20
0528	Electrocardiogram and interpretation in home by a paediatrician - each	77.40
0529	Electrocardiogram - professional fee	20.00
9401	Electrocardiogram - technical fee	31.60
0530	Graded exercise test - technical fee	37.40
0535	Graded exercise test - professional fee	70.70
	NOTE: The note following fee codes 0335 and 0336 in the Internal Medicine Section of this guide applies to fee codes 0530 and 0535	
Electrocardiogram and interpretation for children under 2 years of age:		
0533	Graded exercise test - professional fee Paediatrician only	20.00
0534	Graded exercise test - technical fee Paediatrician only	57.00
Chemotherapy:		
0582	Cancer Chemotherapy visit: To include the administration of multiple parenteral chemotherapeutic agents, history and physical examination as necessary to document disease status, counselling of patient and/or family, review of pertinent laboratory and radiologic data, venesection and institution of an intravenous line. This service not to be billed more than once every twenty-eight days (time taken must be in excess of 1 hour)	170.60
0583	Limited Cancer Chemotherapy visit: To include the administration of single or multiple parenteral chemotherapeutic agents, history and physical examination as necessary to document disease status, counselling patient and/or family, review of pertinent laboratory and radiologic data, venesection and institution of an intravenous line. NOTE: This item is not to be billed more than once every seven days. Neither is it to be billed for routine administration of 5-fluorouracil as a single agent	85.20

PSYCHIATRY

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

Consultations: (office, home or hospital)

0610	Individual: Diagnostic interviews or examination, including history, mental status and treatment recommendation, with written report	264.70
0622	Emotionally disturbed child: Diagnostic interviews or examination, including mental status and treatment recommendation, assessment of parents, guardian or other relatives and written report	431.40
0623	Multiple disturbed family (3 or more members) simultaneous diagnostic interviews or examination, including mental status of the members, their interactions and written report	431.40
0624	Evaluation interview with family member or guardian without presence of patient	95.70

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

0625	Individual (see fee code 0610)	119.20
0626	Emotionally disturbed child (see fee code 0622)	215.60
0627	Multiple disturbed family (see fee code 0623)	215.60

Continuing Care by Consultant

0607	Office visit to include services such as chemotherapy management and/or minimal psychotherapy	53.60
0608	Hospital visit	55.40
0609	Home visit	83.90

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250	Daytime (0800 - 1759): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	55.40
0251	Evening (1800 - 2259): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	152.00
0252	Night (2300 - 0759): Premium to be charged only when one must immediately leave home, office or hospital to render urgent emergency care	177.90

PSYCHOTHERAPY

0630	Individual per 1/2 hour	102.90
0631	Individual per 3/4 hour	149.60
0632	Individual per 1 hour	198.10
0633	Family - two or more family members (conjoint therapy) per 1/2 hour	116.90
0635	Family - two or more family members (conjoint therapy) per 3/4 hour	175.60
0636	Family - two or more family members (conjoint therapy) per 1 hour NOTE: Where a psychotherapy session extends beyond one (1) hour in a day, a written explanation of need is required by the payment agencies such as out-of-town patient, emergency or like situations	233.80
0637	Group therapy (session runs from 1 1/2 to 2 hours) per patient	44.90

PLASTIC SURGERY

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

6010	Consultation: To include complete history and physical examination, review of x-ray and laboratory findings, if required, and a written report	147.90	
6012	Repeat or Limited Consultation: To apply where a consultation is repeated for same condition within six (6) months of last visit by the consultant or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	74.90	

Continuing Care by Consultant:

6007	Subsequent office visit	38.80	
6008	Subsequent hospital visit	24.80	
6009	Subsequent home visit	74.90	

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250	Daytime (0800 - 1759): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	55.40	
0251	Evening (1800 - 2259): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	152.00	
0252	Night (2300 - 0759): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	177.90	

SKIN GRAFTS

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

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

6019	Single or multiple flaps under 2 cm. in diameter used in repair of a defect(except for special areas as in fee code 6024)	245.40	1+T
6020	Single Skin Graft	491.20	2+T
6021	Single Skin Graft - with free skin graft to secondary defect	614.40	2+T
6022	Multiple Skin Graft	979.30	2+T
6023	Multiple Skin Graft - with free skin graft to secondary defect	1095.40	2+T
6024	Eyebrow, eyelid, lip, ear, nose - single	614.40	3+T
6025	Eyebrow, eyelid, lip, ear, nose - two stages	979.30	3+T
6026	Arterial Island Flap	730.50	2+T

Flaps from a Distance: Direct (2 stages)

6030	Upper extremity	979.30	2+T
6031	Upper extremity - with free skin graft to secondary defect	1228.00	2+T
6032	Lower extremity (plaster cast included)	1477.10	2+T

NOTE: Further stages at 50% of appropriate fee

PLASTIC SURGERY

YHCIP / Anaes /
YWCHSB Proc Unit

Indirect - tubes, jumps:

6033 Major stage - per operation	730.50	4+T
6034 Minor stage - per operation	481.40	3+T
6036 Minor stage with free skin graft - per operation	730.50	3+T
6035 Delaying tube or pedicle	147.90	3+T

FREE SKIN GRAFTS: (including mucosa)

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

Full thickness grafts

6041 Eyelid, nose, lips, ear	730.50	2+T
6043 Finger tip	199.10	2+T
6040 Finger more than one phalanx	614.40	2+T
6044 Sole or palm	614.40	2+T
6045 Toe pulp graft	248.50	2+T

Split thickness grafts: Non-functional areas:

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

6046 Split thickness graft - less than 6.5 square cm.	122.80	2+T
6047 Split thickness graft - 6.5 square cm. to 65 square cm.	248.50	2+T
6048 Split thickness graft - 65 square cm. to 650 square cm.	491.20	2+T
6049 Split thickness graft - for each 6.5 square cm. over 650 square cm. Refrigerated graft - 50% of appropriate fee	10.30	3+T

Split thickness grafts: Functional Areas:

NOTE: Multiple operations to functional areas - see Preamble paragraph 11(a)

6051 Split thickness graft - Finger tip	195.50	2+T
6050 Split thickness graft - Regions of - Major joints and hands - early	730.50	2+T
6058 Split thickness graft - Regions of - Major joints and hands - late with scar excision graft	995.80	2+T
6052 Split thickness graft - Head and neck - 65 square cm. or less	491.20	3+T
6053 Split thickness graft - Head and neck - in excess of 65 square cm.	730.50	3+T
6054 Split thickness graft - Head and neck - in excess of 195 square cm.	1725.90	3+T

Cavity Grafting:

6055 Cavity graft - Eye socket	829.80	3+T
6056 Cavity graft - Eye socket - with mucosa	1228.00	3+T
6057 Cavity graft - Nose	730.50	3+T
6060 Cavity graft - Mouth	995.80	3+T
6061 Cavity graft - Lining pedicle flaps	491.20	3+T
6062 Cavity graft - Bone cavity over 7.4 cm. or more in diameter in large bone eg. Femur	730.50	4+T
6065 Cavity graft - Bone cavity - up to 7.5 cm. in diameter in large bone	498.20	3+T
6064 Cavity graft - Bone cavity - in small bone, eg. hand or foot	368.40	2+T

Tumors of Skin - removal requiring skin graft:

6070 If area involved less than 6.5 square cm.	122.80	2+T
6071 - 6.5 square cm. to 65 square cm.	245.60	2+T
6072 - 65 square cm. to 650 square cm.	491.20	3+T
6073 - for each 6.5 square cm. over 650 square cm.	4.80	3+T

PLASTIC SURGERY

	YHCIP / YWCHSB	Anaes / Proc Unit
Tumors of skin - removal not requiring skin graft:		
6069 Excision of benign tumor of skin or subcutaneous tissue or small scar - face	122.80	3+T
7034 Excision of benign tumor of skin or subcutaneous tissue or small scar - additional lesions removed at the same sitting (maximum per sitting - five) each	24.80	
7035 Excision of benign tumor of skin or subcutaneous tissue or small scar	83.30	1+T
7036 Localized carcinoma of skin, proven histopathologically	124.40	1+T
7037 Excision of large (over 7.5 cm.) benign tumor of skin or subcutaneous tissue where general anaesthetic or regional block is necessary	174.30	2+T
7038 Removal of major benign tumor requiring extensive dissection (accompanied by written report to payment agencies)	746.50	2+T

INJURIES

Wounds - simple:

7030 Minor laceration or foreign body requiring local anaesthesia (operation only)	76.50	
7031 Minor laceration or foreign body requiring general anaesthesia (operation only)	76.50	1+T
7032 Extensive laceration (bill if total length of all skin lacerations exceed 15 cm.)	178.30	2+T

Wounds - avulsed and complicated:

6075 Lips and eyelids	498.20	3+T
6076 Nose and ear	498.20	3+T
6077 Complicated lacerations of the scalp, cheek and neck	498.20	3+T

BURNS

(with or without general anaesthesia - per operation)

General Care - severe only:

6083 - first hour	122.80	2+T
6084 - subsequent hour (per hour)	73.70	2+T

Local Care

- Minor burns	Per Visit	
6078 - dressing (in hospital care only)	49.60	4+T
6079 - surgical debridement - for each 5% of body surface	73.70	5+T
6080 - subsequent debridements - for each 5% of body surface (includes dressing)	36.80	5+T

Surgical excision of burnt tissue prior to immediate skin grafting:

6081 - for first 5% of body surface	245.40	5+T
6082 - for each subsequent 5% of body surface	122.80	5+T

OSTEOMYELITIS

5464 Saucerization, muscle flap or bone graft	995.80	2+T
5465 Saucerization and sequestrectomy	746.40	2+T
5467 Incision subperiosteal abscess	124.40	2+T

BIOPSY

7021 Biopsy of skin or mucosa	74.90	
7022 Biopsy of facial area	74.90	

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

PLASTIC SURGERY

YHCIP / Anaes /
YWCHSB Proc Unit

REGIONAL MANDIBULO-FACIAL

Fracture-Mandible

6240	Interdental and intermaxillary wiring	620.80	6+T
6241	Wiring and Gunning splints	746.40	6+T
6242	Open reduction - unilateral	746.40	6+T
6243	Open reduction - bilateral	1118.40	6+T
6244	Open reduction and intermaxillary wiring - unilateral	869.50	6+T
6245	Open reduction and intermaxillary wiring - bilateral	1244.70	6+T
6246	Removal of sutures, intra-oral splints, etc. under general anaesthesia	174.30	4+T

Fracture-Maxilla (Central mid-third):

6250	Le Fort I - (Horizontal fractures)	1244.70	6+T
6251	Le Fort II - (Pyramidal fractures)	1244.70	6+T
6252	Le Fort III - (Cranio-facial disjunction)	1244.70	6+T
6253	Open reduction and internal or external craniomaxillary wire suspension with or without intermaxillary fixation	1244.70	6+T

Fracture-Zygomatic (Lateral mid-third):

Zygomatoco-maxillary (including Orbital Floor)

6260	Temporal elevation	248.50	3+T
6261	Open reduction and interosseous wiring (to include antral packing where necessary)	995.90	4+T
6262	Reduction via transantral approach and antral packing	248.50	4+T

Zygomatic Arch:

6265	Temporal elevation	248.50	3+T
6266	Open reduction and interosseous wiring	620.80	4+T

Orbital Floor Fractures: (Blow-out fractures)

6270	Open reduction (to include antral packing where necessary)	869.50	4+T
------	--	--------	-----

Fracture - Alveolus:

6271	Alveolar fracture with one tooth extraction	174.30	3+T
6272	Alveolar fracture - each additional tooth extraction	49.50	3+T
6273	Arch bar fixation of teeth	498.20	3+T

Temporo-Mandibular Joint:

5301	Dislocation - closed reduction	124.40	3+T
------	--------------------------------	--------	-----

Mandibular Resection:

6291	Tumors - enucleation, partial or complete resection	736.70	4+T
6292	Tumors - enucleation, partial or complete resectio - with bone graft	1108.70	4+T
7500	Resection of mandible	746.50	5+T
6293	Bone graft to jaw or face - autologous	995.90	4+T
6294	Bone graft to jaw or face - non-autologous	746.40	4+T

Osteotomies:

6314	Canthopexy	995.90	3+T
6304	Malar Maxillary	1692.80	6+T
6305	Mandibular - for prognathism, micrognathism, malocclusion, etc. - unilateral with intermaxillary fixation	962.30	6+T

PLASTIC SURGERY

	YHCIP / YWCHSB	Anaes / Proc Unit
6306 Mandibular - for prognathism, micrognathism, malocclusion, etc. - bilateral with intermaxillary fixation	1460.50	6+T
6307 Premaxillary set back	1211.40	6+T
6308 Mandibular osteotomy with rigid internal fixation - unilateral	1211.40	6+T
6309 Mandibular osteotomy with rigid internal fixation - bilateral	1692.80	6+T

CHEEKS

6111 Facial paralysis-static stings - unilateral	1085.40	3+T
6112 Abrasive surgery - less than one quarter of face	122.80	3+T
6113 Abrasive surgery - between one quarter and one half of face	368.40	3+T
6114 Abrasive surgery - full face	730.10	3+T
7525 Salivary fistula - plastic to Stenson's duct	746.40	4+T

NOSE

Rhinoplasty:

2350 Removal of hump	371.70	3+T
2351 Nasal refracture requiring lateral osteotomies	746.50	3+T
2352 Reconstruction of nasal tip, ala and columella	869.40	3+T
6118 Bone graft to nose - autologous	995.90	3+T
6119 Bone graft to nose - non-autologous	736.70	3+T
2354 Complete rhinoplasty with submucous resection to include nasal hump removal, nasal refracture and reconstruction of nasal tip - without skin grafting	1252.00	3+T
6115 Forehead rhinoplasty - 2 operations NOTE: Partial forehead rhinoplasties charge under fee code 6020 and 6021	1477.10	3+T
6116 Composite graft	614.40	3+T
6117 Rhinophyma	491.20	3+T

Fractures:

6121 Simple reduction	124.40	3+T
6122 Reduction and splinting	248.50	3+T
6123 Comminuted nasal fractures - transosseous wire plate fixation	498.20	3+T
6124 Naso-orbital fractures - open reduction and interosseous wiring or transosseous wire plate fixation	746.40	3+T

EARS

6131 Outstanding ears - unilateral otoplasty	491.20	3+T
6132 Microtia or loss of ear -partial - per stage	491.20	3+T
6133 Microtia or loss of ear - total - major stage	736.70	3+T
6134 Microtia or loss of ear - total - minor stage	491.20	3+T
6130 Accessory auricle	245.40	3+T
6135 Preauricular sinus - simple	295.50	3+T
6180 Preauricular sinus - complicated	491.20	3+T

MOUTH

7720 Lip shave - vermilionectomy	498.20	3+T
6137 Full lip thickness transfer by rotation flap	995.80	4+T
6140 Wedge resection of lip, vermilion	172.60	3+T

PLASTIC SURGERY

	YHCIP / YWCHSB	Anaes / Proc Unit
6141 Wedge resection of lip - to sulcus	368.40	3+T
6142 Pharyngoplasty of pharyngeal flap	863.10	6+T
ORBIT		
6153 Bone graft to orbit - autologous	995.80	4+T
6154 Bone graft to orbit - non-autologous implant	736.70	4+T
2153 Ectropion-Entropion-Ziegler or simple procedure	121.10	3+T
2154 Ectropion-Entropion - complicated, including neoplasms and plastic repair	670.70	3+T
2159 Ptosis repair - orbicularis sling - using autologous fascia lata	965.80	3+T
2160 Ptosis repair - levator resection	965.80	3+T
6148 Direct flat to eyebrow - first stage	736.70	3+T
6149 Direct flat to eyebrow - Second stage	368.40	3+T
GENITALIA		
8274 Hypospadias - excluding urethrostomy - First stage, chordee	498.20	2+T
8275 Hypospadias - excluding urethrostomy - Second stage, (penile)	746.40	2+T
8276 Hypospadias - excluding urethrostomy - penoscrotal	995.80	2+T
8277 Epispadias - plastic repair	995.80	2+T
TRUNK		
<i>Note: See Preamble regarding cosmetic surgery</i>		
6151 Decubitus ulcers - excision and treatment of bone, rotation flaps and skin grafts to secondary defect	1111.70	4+T
6155 Mobilization of umbilicus and repair of umbilical hernia - with flap procedure, NOTE: Only medically required procedures should be billed to the payment agency (accompanied by an explanation of the medical requirement)	992.90	4+T
6157 Nipple-areolar reconstruction	693.50	2+T
6158 Myocutaneous flap - involving major muscle rotated on its neurovascular pedicle	1362.60	5+T
6164 Prosthetic breast replacement in unilateral agenesis or following mastectomy - unilateral	614.40	3+T
6165 Prosthetic breast replacement in unilateral agenesis or following mastectomy - bilateral	992.90	3+T
LEG		
7216 Lymphoedema of limbs - excision and grafting - entire leg	1493.60	3+T
7217 Lymphoedema of limbs - excision and grafting - entire lower extremity	2240.50	3+T
6167 Treatment of lymphedema using the Thompson procedure - upper extremity forearm	736.70	4+T
6168 Treatment of lymphedema - arm (Total of \$1,228.00 whether one or two stages)	491.20	4+T
6169 Treatment of lymphedema - lower extremity leg	1228.00	4+T
6170 Treatment of lymphedema - thigh (Total of \$2,456.00 whether one or two stages)	1228.00	4+T
HAND		
6171 Syndactyly - local flaps - first cleft	491.20	2+T
6172 Syndactyly - with skin graft, first cleft	736.70	2+T
6173 Direct flap to finger - 2 stages	614.00	2+T

PLASTIC SURGERY

	YHCIP / YWCHSB	Anaes / Proc Unit
Amputations:		
5425 Transmetacarpal	371.70	2+T
5426 Finger, any joint or phalanx	248.50	2+T
Bone Grafting:		
5566 Metacarpal, phalanx	498.20	2+T
Fractures:		
5203 Metacarpal - requiring reduction	199.10	1+T
5225 Distal phalanges - open reduction and wiring - first	371.70	1+T
5226 Distal phalanges - open reduction and wiring - each additional (extra)	199.10	1+T
5227 Other than distal phalanges - open reduction and wiring - first	620.80	1+T
5228 Other than distal phalanges - open reduction and wiring - each additional (extra)	298.70	1+T
Joints - Inter or Metacarpophalangeal:		
5522 Capsulotomy, arthroplasty and arthrodesis	371.70	2+T
5613 Reconstruction of rheumatoid hand joints - multiple eg. synovectomy, intrinsic release repositioning of extensor tendons, each hand - fee for service, at any one operative session - up to	1991.30	3+T
5615 Finger joint prosthesis - first joint	371.70	2+T
5616 Finger joint prosthesis - subsequent joints same sitting - each	182.50	2+T
5620 Synovectomy of hand joint	498.20	2+T
5621 Intrinsic release	498.20	2+T
5626 Synovectomy of flexor or extensor tendons in wrist and hand for rheumatoid disease	746.40	2+T
5629 Synovectomy of knee joint	995.80	2+T
Hand Infections:		
6197 Acute tenosynovitis - finger (operation only)	248.50	2+T
6198 Acute tenosynovitis - ulnar or radial bursa (operation only)	248.50	2+T
7046 Web space abscess (operation only)	74.60	2+T
7047 Web space abscess - under general anaesthetic	124.40	2+T
7049 Mid palmar, thenar and dorsal subaponeurotic space abscess (operation only)	124.40	2+T
Nerves:		
3191 Peripheral nerve - minor, digital, primary suture or secondary	371.70	2+T
3192 Repair of palmar nerve	371.70	2+T
3193 Major, primary suture	746.50	3+T
3195 Exploration of peripheral nerve and neurolysis	498.20	2+T
6156 Transplant of neuroma	368.40	2+T
MISCELLANEOUS		
Meningocele:		
6166 Excision of axillary sweat glands for hyperhidrosis - unilateral	736.70	4+T

GENERAL SURGERY

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

7010 Consultation:	To include complete history and physical examination, review of x-ray and laboratory findings, if required, and a written report	172.70
7012 Repeat or Limited Consultation:	To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	95.40

Continuing Care by Consultant:

7007 Subsequent office visit		38.80
7008 Subsequent hospital visit		49.20
7009 Subsequent home visit		81.40

EMERGENCY VISIT PREMIUM

**Based on time seen by physician*

0250 Daytime (0800 - 1759):	Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	55.40
0251 Evening (1800 - 2259):	Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	152.00
0252 Night (2300 - 0759):	Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	177.90

SURGICAL ASSISTANT

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

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

7015 Operation fee - less than \$196.00		108.60
7016 Operation fee - \$196.01 to \$601.60 inclusive		188.10
7017 Operation fee - \$601.61 to \$1014.90 inclusive		243.30
7018 Operation fee - \$1014.91 and over		327.80

GENERAL SURGERY

YHCIP / Anaes /
YWCHSB Proc Unit

7014 Time, after 2 hours or more of continuous surgical assistance for one patient, each 15 minutes or fraction thereof 35.30

NOTE:

- (i) When a second assistant in surgery is requested by the Surgeon-in-Chief there should be adequate written explanation on the claim card and the charge should be in accordance with the fee for the first assistant.
- (ii) In those rare situations where an assistant is required for minor surgery, a detailed explanation of need must accompany the claim to the payment agency.
- (iii) Where an assistant at surgery assists at two clearly separate operations in different areas (ie. Foot and abdomen) performed by the same or different surgeon(s) under one anaesthetic, he/she may charge a separate assistant fee for each operation, except for bilateral procedures.

7019 Certified Surgical Assistant - where it is necessary for one certified surgeon to assist another certified surgeon 422.80

7020 Surgeon's part in cardioangiogram - per hour or fraction thereof 99.80

GENERAL

Biopsy:

7021	Biopsy of skin or mucosa NOTE: Punch or shave biopsies not to be charged under fee code 7021, 7022 (see fee code 0215)	74.90	1+T
7022	Biopsy of facial area	74.90	2+T
7023	Excision biopsy of lymph glands for malignancy under general anaesthetic	124.40	1+T
7024	Scalene gland biopsy	248.50	3+T
7025	Temporal artery biopsy	124.40	2+T

Abscess:

7026	Opening superficial abscess, including furuncle (operation only)	41.80	1+T
7027	Deep abscess, including carbuncle requiring general anaesthesia (operation only)	124.40	1+T

Lacerations or foreign bodies:

7030	Minor laceration or foreign body requiring local anaesthesia (operation only)	76.50	
7031	Minor laceration or foreign body requiring general anaesthesia (operation only)	76.50	1+T
7032	Extensive laceration (bill if total length of all skin lacerations exceed 15 c.m.) NOTE: For very extensive lacerations of face see Plastic Surgery Section	178.30	2+T

Skin:

7035	Excision of benign tumor of skin or subcutaneous tissue or small scar	83.30	1+T
7034	Excision of benign tumor of skin or subcutaneous tissue or small scar - additional lesions removed at the same sitting (maximum five per sitting) each Minor burns	24.80 24.80	1+T
7036	Localized carcinoma of skin, proven histopathologically	124.40	1+T

Soft Tissue Tumor:

7037	Excision of large (over 7.5 cm.) benign tumor of skin or subcutaneous tissue where general anaesthesia or regional block is necessary	174.30	2+T
7038	Removal of major benign tumor requiring extensive dissection (accompanied by written report to payment agency)	746.50	2+T

GENERAL SURGERY

YHCIP / Anaes /
YWCHSB Proc Unit

INFECTIONS OF HAND AND FOOT

7044 Paronychia (operation only)	49.60	1+T
7045 Anterior closed space abscess (operation only)	49.60	1+T
7046 Web space abscess (operation only)	74.60	2+T
7047 Web space abscess - under general anaesthetic	124.40	2+T
7049 Mid palmar, thenar and dorsal subaponeurotic space abscess (operation only)	124.40	1+T
7050 Removal of nail - simple (operation only)	49.60	1+T
7052 Removal of nail - with destruction of nail bed	99.80	1+T
7053 Removal of nail - complete with shortening of phalanx	248.60	2+T
7051 Wedge excision of one nail	74.90	1+T

BURSAE, SYNOVIAL CYSTS AND GANGLIA

7054 Excision of prepatellar, olecranon or trochanteric	248.60	2+T
7055 Excision Ganglia - of the wrist	248.60	1+T
7056 Excision of tendon sheath joint	371.70	1+T
7057 Excision - compound	746.40	1+T
7058 Excision - popliteal cyst - radical removal	498.20	2+T

TENDONS

7060 Flexor - primary or secondary repair	620.80	2+T
7061 Flexor repair - each additional	248.50	2+T
7062 Tendon achilles	371.70	2+T
7063 Extensor - primary or secondary repair	371.70	2+T
7064 Extensor repair - each additional	174.30	2+T
7065 Silastic Rod prior to Tendon Grafting	746.40	1+T
7066 Silastic Pulley and Underlay	124.40	1+T
7067 Tendon graft	1118.40	2+T
7068 Tenoplasty - tenodesis, tenovaginitis, shortening or lengthening, stenosing tenosynovitis - 1 tendon any location	371.70	2+T
7069 Tenoplasty - 2 or more tendons	620.80	2+T
7070 Tendon transplant - single	498.20	3+T
7071 Tendon transplant - each additional (extra) section of transverse carpal ligament (bill under fee code 3195)	323.70	2+T
7077 Plantar fasciectomy	620.80	2+T
7078 Extensive palmar fasciectomy involving one or more digits (Dupytrens)	746.40	2+T
7084 Extensive palmar fasciectomy involving one or more digits (Dupytrens) - with skin grafting NOTE: Localized charge under fee code 7037	1008.90	2+T
7085 Tenolysis	620.80	2+T
7086 Tenolysis - each additional to a maximum of three extra	248.50	2+T

TENOTOMY

7073 Tenotomy - congenital torticollis	248.60	3+T
7074 Tenotomy - resection Section of transverse carpal ligament (bill under fee code 3195)	498.20	3+T
7081 Anterior scalenotomy	371.70	2+T

GENERAL SURGERY

YHCIP / Anaes /
YWCHSB Proc Unit

VENOUS SYSTEM

7100 Vein Eraser - first vein	49.50	
7101 Vein Eraser - each subsequent vein	24.80	
7102 Varicose veins, injection, each visit	24.80	
7104 Varicose veins - injection with elevation, sponge rubber compression and bandaging (operation only)	83.30	1+T

Varicose Veins and Perforators:

7107 High ligation, long saphenous	307.70	2+T
7108 Stripping long saphenous	511.50	2+T
7109 Stripping short saphenous	281.60	2+T
7110 Multiple ligations and stripping tributaries (3-5 incisions)	212.70	2+T
7111 Multiple ligations and stripping tributaries (6 or more incisions)	366.40	2+T
7112 Ligation of 2 or more perforators or partial fasciotomy with or without multiple ligations	383.40	2+T
7113 Complete fasciotomy, with or without multiple ligations	680.60	2+T

RECURRENT VARICOSE VEINS

7117 Re-exploration of groin and/or popliteal fossa	638.80	2+T
7118 Multiple ligations, strippings and perforators, re-exploration of groin and/or popliteal fossa	969.00	3+T
7119 Multiple ligations, strippings, re-exploration of groin and complete fasciotomy	1260.90	3+T
7120 Excision of ulcer and grafting - add full fee to venous procedures (operation only)	255.40	3+T
7123 Ligation of femoral vein	423.40	2+T
7124 Ligation of fenestration of inferior vena cava	995.80	5+T
7125 Thrombectomy for acute ilio-femoral thrombophlebitis	1244.70	5+T

Portal Hypertension:

7128 Spleno-renal shunt	1858.60	8+T
7129 Porto-caval shunt	1858.60	8+T

Intra-Venous Catheters:

7132 Jugulo-caval Holter Lifeline (operation only)	248.50	2+T
7133 Jugulo-caval Holter Lifeline (operation only) - under 3 months of age or 3 kg weight	498.20	4+T
7134 Peritoneal Venous Shunt for ascites	746.10	6+T

Excision and Grafting:

7216 Lymphedema of limbs - entire leg	1493.60	3+T
7217 - entire lower extremity	2240.50	3+T

Incision:

7229 Thrombectomy with or without angioplasty	1118.40	5+T
7230 Embolectomy - trunk or both extremities	1244.70	5+T
7231 Embolectomy - one side	896.00	5+T

Bypass graft (synthetic) and/or Thromboendarterectomy:

7233 - Innominate	1559.80	5+T
7234 - Subclavian	1493.60	5+T
7237 - Carotid	1327.80	8+T
7232 - Aorta and/or iliac - unilateral	1493.60	9+T
7235 - bilateral	1742.60	9+T

GENERAL SURGERY

	YHCIP / YWCHSB	Anaes / Proc Unit
7240 - Aorto-femoral or ilio-femoral - unilateral	1742.60	9+T
7243 - bilateral	1991.30	9+T
7244 - Superior mesenteric	1692.80	7+T
7245 - Renal	1609.80	7+T
7242 - Anterior or posterior tibial or peroneal	1492.10	5+T
7226 - Axillo-femoral - unilateral	1493.60	7+T
7227 - bilateral	1742.60	7+T
7274 - Femoro-femoral crossover	1244.70	5+T
7238 - Femoral (common or superficial endarterectomy)	1095.40	5+T
7246 - Femoral-popliteal (synthetic)	1443.60	5+T
7275 - Femoral-popliteal (endarterectomy)	1360.90	5+T
7248 - Venous crossover graft for iliac obstruction	1244.70	5+T
Bypass Graft (autogenous vein)		
7261 - superior mesenteric	1609.80	7+T
7262 - renal	1609.80	7+T
7263 - aorta	1742.60	9+T
7264 - iliac	1742.60	8+T
7265 - femoral	1443.60	5+T
7266 - popliteal	1443.60	5+T
7276 - anterior, posterior tibial or peroneal	1692.80	5+T
7277 - Femoro-femoral crossover	1394.00	7+T
7278 - Axillo-femoral - unilateral	1659.50	7+T
7267 - 2nd operator, synchronous combined bypass graft - extremities	620.80	
7247 - trunk	620.80	
NOTE: fee code 7267 and 7247 provide operative report by second operator when requested from payment agency		
Excision:		
7250 Arteriovenous aneurysm	995.90	9+T
7252 Abdominal aneurysm, with grafting	1991.30	9+T
7254 Ruptured aneurysm, with grafting	2356.50	10+T
7281 Resection of abdominal aneurysm with associated femoral dissection, one or both sides (extra fee to be added to procedure)	248.50	9+T
NOTE: Peripheral aneurysm - charge associated by-pass graft procedure		
Suture:		
7270 Repair injury of major vessel in extremity - suture	746.40	6+T
7271 Repair injury of major vessel in extremity - graft	1244.70	6+T
7269 Repair injury of major vessel in trunk - suture	1477.10	6+T
7273 Repair injury of major vessel in trunk - graft	1970.70	9+T
7272 Ligation of carotid artery	498.20	5+T
7283 Re-dissection of groin (after 21 days), extra	223.30	4+T

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

LYMPHATIC SYSTEM

7360 Splenectomy	995.90	6+T
7361 TB Glands - radical removal	498.20	4+T
7362 Radical axillary dissection	863.10	3+T
7363 Radical femoral, inguinal and iliac dissection	995.90	5+T
7365 Isolated limb perfusion to include groin dissection and laparotomy	1742.60	5+T
7366 Laparotomy and staging of lymphoma to include splenectomy	1468.10	6+T
7367 Repair of laceration or rupture of spleen by suture	995.90	6+T

GENERAL SURGERY

YHCIP / Anaes /
YWCHSB Proc Unit

BREAST

7488	Microdocheotomy	248.50	2+T
7489	Biopsy or removal of simple tumor or segmental resection	199.20	2+T
7490	Mastectomy - simple	498.20	3+T
7491	Mastectomy - radical or modified	1178.20	3+T
7492	Mastectomy - radical with skin graft	1294.00	3+T
7493	Triple biopsy of breast for cancer	498.20	2+T
7496	Double biopsy of breast for cancer	248.50	2+T
7494	Radical mastectomy with triple biopsy	1427.10	3+T
7495	Radical mastectomy with triple biopsy and skin graft closure	1559.80	3+T
7497	Biopsy or segmental resection of non-palpable breast lesion with pre and intra-operative radiological localization	323.70	2+T
7498	Mastectomy subcutaneous, female - unilateral	742.80	3+T
6164	Prosthetic breast replacement following mastectomy - unilateral	614.40	3+T
6165	Prosthetic breast replacement following mastectomy - bilateral	992.90	3+T

DIGESTIVE SYSTEM

Jaws:

7500	Resection of mandible	746.50	5+T
------	-----------------------	--------	-----

Pharynx:

7511	Excision of pharyngo-esophageal diverticulum	995.80	6+T
7512	Excision of congenital cyst/fistula from neck	746.40	4+T

Salivary Glands:

7520	Sialolithotomy - simple, in duct	124.40	3+T
7521	Sialolithotomy - complicated, in gland	371.70	3+T
7522	Local excision parotid tumor	248.50	3+T
7527	Subtotal parotidectomy with complete facial nerve dissection	1367.60	4+T
7523	Total parotidectomy with nerve dissection for malignancy or deep lobe tumor	1493.60	4+T
7524	Excision of submandibular gland	498.20	4+T
7525	Salivary fistula - plastic to Stenson's duct	746.40	4+T
7526	Dilation of salivary duct (operation only)	49.50	3+T

Esophagus:

7529	Esophagectomy - upper 2/3 to include esophagostomy and gastrostomy	1991.30	8+T
7530	Esophago-gastrectomy-combined thoraco-abdominal	2240.10	8+T
7531	Cervical esophagostomy and division of tracheoesophageal fistula with gastrostomy	1493.60	8+T
7532	Plastic operation for cardiospasm - Heller	1244.70	8+T
7533	Esophageal diverticulum - intrathoracic resection	1244.70	8+T

GENERAL SURGERY

	YHCIP / YWCHSB	Anaes / Proc Unit
7534 Correction of esophageal atresia with closure of tracheoesophageal fistula	2240.10	8+T
7535 Replacement of esophagus with intestine	2489.30	8+T
7536 Direct ligation of esophageal varices	1367.60	7+T
7537 Ruptured esophagus - transthoracic repair	1244.70	8+T
7538 Ruptured esophagus - cervical drainage	813.10	4+T
7539 Insertion of celestin tube	863.10	4+T
7540 Insertion of souttar type tube	371.70	1+T
7541 Intramural tumor of esophagus	1367.60	6+T
7542 Esophageal replacement performed as a team procedure - first operator	2196.60	8+T
7543 Esophageal replacement performed as a team procedure - second operator	879.70	
7544 Brusque pneumatic esophageal dilation (operation only)	207.30	3+T
7545 Brusque pneumatic esophageal dilation - repeat within one month (operation)	103.60	3+T
7546 Sclerosing of esophageal varices to include endoscopy (operation only)	335.30	3+T
7547 Bougie dilation (operation only)	124.40	3+T
7555 Zenkers Diverticulotomy	661.40	5+T

ABDOMEN

Trauma fee items are to be charged in cases of blunt and/or penetrating abdominal injury. They do not apply to incidental intraoperative injury to abdominal structures.

Trauma:

7430 Diagnostic peritoneal lavage (catheter)	160.00	1+T
7431 Repair diaphragmatic injury	1251.80	8+T
7432 Laparotomy in the trauma patient	667.60	5+T
7433 Laparotomy to include removal of injured spleen	1002.80	7+T
7434 Laparotomy to include splenic repair	1002.80	7+T
7435 Repair of lacerations to stomach	891.00	7+T
7436 Exploration and mobilization of duodenum and pancreas	1002.80	7+T
7437 Repair of laceration of duodenum	1335.40	7+T
7438 Resection and debridement of duodenal injury, to include duodenal diverticulisation where indicated	1670.10	7+T
7439 Repair liver laceration	1002.80	8+T
7440 Resectional debridement of liver	1170.00	8+T
7441 Hepatic artery ligation, to include resectional debridement where indicated	1335.40	8+T
7442 Hepatic lobectomy for trauma	2004.90	9+T
7443 Resection of distal pancreas for trauma	1335.40	8+T
7445 Repair of lacerations to small bowel	891.00	7+T
7446 Resection of injured small bowel	1002.80	7+T
7447 Repair of mesenteric injury	891.00	7+T
7448 Repair of colonic injury with or without colostomy	1335.40	7+T
7449 Resection of colonic injury	1335.40	7+T
7450 Exteriorization of colonic injury	835.30	7+T
7451 Thoracic extension of abdominal incision, extra	444.20	8+T
7452 Repair of extra peritoneal rectum with or without colostomy	1335.40	7+T
7453 Repair of bladder injury	652.60	5+T
7454 Repair of injury to major vessel	1477.10	6+T

GENERAL SURGERY

	YHCIP / YWCHSB	Anaes / Proc Unit
Incision:		
7587 Laparotomy requiring extensive examination and colostomy (with operative report)	789.90	5+T
7597 Post-operative hemorrhage - intra-abdominal management	498.20	6+T
7600 Exploratory laparotomy with/without biopsy	620.80	5+T
7601 Intra-abdominal abscess including intrahepatic	813.10	5+T
7602 Pneumoperitoneum-therapeutic (operation only)	49.50	
7603 Resuture abdominal wound evisceration	498.20	5+T
Hernia:		
7592 Inguinal - child - bilateral	746.40	2+T
7604 Hernia - with emergency repair	746.40	3+T
7605 Inguinal or femoral	630.40	2+T
7606 Inguinal or femoral - recurrent	746.40	2+T
7607 Inguinal or femoral - with bowel resection	1178.20	5+T
7608 Ventral, incisional - repair by suture	813.10	2+T
7609 Ventral, incisional - repair by prosthesis	929.50	2+T
7568 Ventral, incisional - emergency repair	929.50	3+T
7610 Epigastric	498.20	4+T
7611 Umbilical - adult to include lipectomy if necessary	746.40	2+T
7612 Umbilical - infant and neonate	364.90	2+T
7613 Umbilical - child	481.40	2+T
7614 Omphalocele - temporary repair	746.80	7+T
7615 Omphalocele - permanent repair	995.80	7+T
7616 Diaphragmatic or hiatal to include vagotomy and drainage procedures where indicated (with operative report)	1360.90	6+T
7593 Diaphragmatic or hiatal to include vagotomy and drainage procedures where indicated - recurrent (with operative report)	1609.90	6+T
7594 Diaphragmatic hernia - neonatal	1410.90	9+T
7595 Diaphragmatic hernia - traumatic	1493.60	8+T
Reduction of incarcerated hernia non-operative	1493.60	
7596 Hernia - incisional - repair following laparotomy (with operative report) extra	248.50	2+T
Stomach Incision:		
7617 Congenital pyloric stenosis - Ramstedt operation	746.40	5+T
7618 Vagotomy - abdominal	995.80	6+T
7625 Vagotomy - thoracic	995.80	8+T
7578 Highly selective vagotomy	1178.20	5+T
7619 Gastrotomy for removal of foreign body, etc.	746.40	5+T
Stomach Excision:		
7620 Total gastrectomy	2220.80	6+T
7621 Subtotal gastrectomy	1427.10	6+T
7622 Subtotal gastrectomy - with vagotomy	1543.20	6+T
7623 Revision gastrectomy after previous gastrectomy with or without vagotomy	1858.60	6+T
7624 Emergency gastrectomy for continued hemorrhage (with operative report)	1858.60	7+T
7574 Gastric polypectomy to include gastroscopy (operation only)	390.90	5+T

GENERAL SURGERY

	YHCIP / YWCHSB	Anaes / Proc Unit
Stomach Suture:		
7626 Pyloroplasty	746.40	5+T
7627 Gastrojejunostomy	796.70	5+T
7628 Gastrojejunostomy or pyloroplasty with vagotomy, with or without gastrostomy	1178.20	5+T
7629 Emergency gastrojejunostomy or pyloroplasty with vagotomy and suture of bleeder for continued hemorrhage	1493.60	7+T
7630 Gastrostomy - simple	399.20	5+T
7631 Gastrostomy - with living tube	869.50	5+T
7632 Repair of perforated peptic ulcer, wound or injury to stomach	869.50	6+T
7633 Closure of gastrojejuno colic fistula	2107.40	5+T
Intestine Incision:		
7634 Enterotomy or colotomy (single)	796.70	5+T
7635 Multiple colotomy with operative sigmoidoscopy	1062.40	5+T
Intestine Excision:		
7636 Resection of small intestine with anastomosis	1111.80	5+T
7637 Hemicolectomy - right	1427.10	6+T
7591 Hemicolectomy - left	1493.60	6+T
7638 Anterior resection of rectosigmoid for carcinoma with or without protective colostomy	1742.60	6+T
7639 Limited resection of colon	1294.10	6+T
7640 Total colectomy with ileoproctostomy	1858.60	6+T
7642 Bowel resection without anastomosis and with ileostomy	1266.80	5+T
7641 Total proctocolectomy with perineal excision of rectum and ileostomy	2489.40	7+T
7589 Proctocolectomy - synchronous - abdominal portion	2173.80	7+T
7590 Proctocolectomy - synchronous - perineal portion	620.80	7+T
7643 Enteroenterostomy	813.20	5+T
7644 Enterostomy or caecostomy	498.20	5+T
7570 Colo-colostomy or enterocolostomy	1112.00	6+T
NOTE: fee code 7570 applies to unprepared, non-resectable bowel obstruction. In all other instances fee code 7643 applies		
7645 Colostomy - loop	562.60	5+T
7588 Colostomy - end	620.80	5+T
7646 Closure of colostomy without resection	620.80	4+T
7647 Closure of colostomy with resection and anastomosis	929.50	5+T
7648 Revision of colostomy, ileostomy - simple incision of scar, etc.	371.70	4+T
7649 Revision of colostomy, ileostomy - radical	620.80	5+T
7650 Intestinal obstruction resection of bands	929.50	5+T
7651 Reduction of volvulus, intussusception or internal hernia	863.10	5+T
7575 Kock intra-abdominal pouch with continent ileostomy	1858.70	6+T
Intestine Suture:		
7653 Atresia of the small bowel	1360.90	6+T
7654 Intestinal obstruction - plication or insertion of intraluminal tube	1062.40	5+T
7655 Excision of Meckel's diverticulum	680.50	4+T
7656 Appendectomy	564.20	4+T
7657 Appendectomy - perforated with abscess or generalized peritonitis	813.20	5+T
7658 Exteriorisation of large bowel lesion (carcinoma, perforation, etc.)	995.80	5+T

GENERAL SURGERY

	YHCIP / YWCHSB	Anaes / Proc Unit
Rectum Excision:		
7660 Rectal drainage of pelvic abscess	371.70	2+T
7661 Hartmann resection	1361.10	7+T
7659 Reconstruction Hartmann with or without protective colostomy	1244.70	7+T
7662 Abdomino-perineal resection	1991.30	7+T
7663 Synchronous combined abdomino-perineal resection - abdominal portion	1742.60	7+T
7664 Synchronous combined abdomino-perineal resection - perineal portion	620.80	7+T
7665 Full thickness rectal biopsy for Hirschsprung's Disease	248.50	2+T
7670 Pull-through procedure for Hirschsprung's Disease	1991.30	7+T
7576 Pull through procedure - Second operator	620.80	
7667 Rectal prolapse - perineal approach	498.20	5+T
7668 Excision or fulguration of rectal or sigmoidal tumors to include operative sigmoidoscopy - small - less than 1 cm.	124.40	2+T
7669 Excision or fulguration of rectal or sigmoidal tumors to include operative sigmoidoscopy - medium - 1 to 2.5 cm.	174.30	2+T
7673 Excision or fulguration of rectal or sigmoidal tumors to include operative sigmoidoscopy - large - greater than 2.5 cm.	371.70	2+T
Rectum Repair:		
7671 Anal stricture plastic repair	746.40	2+T
7672 Complete rectal prolapse - abdominal or perineal approach	1118.40	5+T
7580 Trans-sacral (Kraske) resection	863.10	5+T
7581 Colonoscopy with flexible colonoscope	448.10	2+T
7582 Colonoscopy with flexible colonoscope - biopsy	498.20	2+T
7583 Colonoscopy with flexible colonoscope - removal polyp	746.40	2+T
7584 Fulguration rectal carcinoma - palliative	371.70	2+T
7585 Fulguration rectal carcinoma - radical (with operative report)	620.80	2+T
7586 Fulguration rectal carcinoma - repeat	248.50	2+T
Anus Incision:		
7675 Fistula-in-ano - submucous	248.50	2+T
7676 Fistula-in-ano - submuscular	564.20	2+T
7677 Fistula-in-ano - multiple (with operative report)	746.40	2+T
7678 Incision and drainage of superficial perianal abscess (operation only)	124.40	1+T
7679 Ischio-rectal abscess (operation only)	174.30	2+T
7666 Anus incision (fistula-in-ano second stage), division of sphincter after placement of seton	216.90	2+T
Anus Excision:		
7681 Fissurectomy with or without sphincterotomy under general anaesthetic (operation only)	248.50	2+T
Injection of hemorrhoids	248.50	
7683 Hemorrhoidectomy with or without sigmoidoscopy	434.60	2+T
7688 Hemorrhoids - elastic band ligation (operation only)	86.30	1+T
7682 Hemorrhoids - elastic band ligation - additional band, same sitting Note: Maximum sittings chargeable per year five (5)	55.80	1+T
7684 Enucleation of external thrombotic hemorrhoid	62.30	1+T

GENERAL SURGERY

	YHCIP / YWCHSB	Anaes / Proc Unit
7685 Pilonidal sinus-excision or marsupialization	498.20	2+T
7686 Anal polyp	74.90	1+T
7687 Anal fissure excision under local anaesthesia	124.40	
7689 Anal dilation - (operation only)	124.40	1+T
7697 Excision sacrococcygeal teratoma	1742.60	6+T
7674 Fulguration anal condylomata - simple	124.40	1+T
7680 Fulguration anal condylomata - complicated (with operative report) and laboratory findings, if required, and a written report	248.50	1+T
Anus Repair:		
7690 Anoplasty for imperforate anus	995.80	4+T
7691 Imperforate anus - simple incision	49.60	1+T
7692 Repair major ano-rectal anomalies with concurrent urogenital malformations via sacral approach	1493.60	7+T
Liver:		
7693 Drainage of hepatic abscess	813.20	6+T
7694 Ruptured liver - repair by suture	978.80	8+T
7695 Ruptured liver - thoracoabdominal approach with suture	1492.00	8+T
7696 Resection of liver - hepatic lobectomy - total	2240.50	8+T
7775 Resection of liver - hepatic lobectomy - partial	995.80	8+T
Biliary Tract:		
7757 Biliary tract endoscopy	207.30	2+T
7698 Cholecystostomy	746.40	5+T
7699 Cholecystectomy	995.80	5+T
7764 Cholangiography - operative, extra	102.50	
7701 Choledochostomy	1161.90	5+T
7769 Duodenotomy and sphincteroplasty	1028.40	5+T
7703 Choledochoduodenostomy	1493.60	6+T
7705 Choledochojejunostomy	1647.10	6+T
7706 Cholecystoenterostomy	746.40	6+T
7704 Surgical reconstruction for stricture or congenital atresia	1742.60	6+T
7719 Resection of carcinoma of common bile duct - middle and lower	1858.80	6+T
7737 Resection of carcinoma of common bile duct - upper	2107.40	6+T
7776 Repair of cholecystoenteric fistula	1028.40	5+T
7777 U-tube insertion for common bile duct malignancy	1234.50	5+T
7573 Endoscopic papillotomy (Ampulla of Vater) to include retrograde pancreatography (0809) (operation only)	824.30	5+T
Pancreas:		
7711 Drainage of pseudocyst - cystogastrostomy	1118.40	5+T
7733 Drainage of pseudocyst - Roux-en-Y	1410.70	5+T
7712 Pancreatico-duodenectomy (Whipple)	2489.40	7+T
7713 Partial pancreatectomy	1310.90	7+T
7714 Pancreaticojejunostomy	1742.60	7+T
7710 Pancreatogram with or without sphincterotomy done in conjunction with any of the biliary or pancreatic surgical procedures - extra	124.40	5+T
7734 Pancreatitis - acute - gastrostomy, jejunostomy, cholecystostomy	1118.40	4+T
7722 Percutaneous biopsy of pancreas - operation only	207.30	2+T

GENERAL SURGERY

YHCIP / Anaes /
YWCHSB Proc Unit

HEAD AND NECK

7735	Tongue tie - under general anaesthetic	174.30	3+T
7736	Local excision tongue - under general anaesthetic	248.50	3+T
7738	Excision cystic hygroma	995.80	3+T
7720	Lip shave - vermilionectomy	498.20	3+T
7721	Glossectomy - partial for carcinoma	746.40	6+T
7723	Alveolectomy	371.70	3+T
7724	Transpalatal maxillectomy, ethmoidectomy and sphenoidectomy	1493.60	5+T
7725	Maxillectomy	1493.60	5+T
7726	Maxillectomy - with exenteration of orbit and skin graft	1991.30	5+T
7739	Transoral maxillectomy with skin graft	1742.60	5+T
7749	Partial maxillectomy for malignancy -fenestration	995.80	5+T
7727	Composite resection -tongue, mandible, radical neck dissection and tracheotomy	2489.40	7+T
7728	Resection mandible, floor of mouth, suprahyoid dissection and tracheostomy - malignancy	1493.60	7+T
7729	Laryngo-pharyngo-esophagectomy - primary excision only	2489.40	6+T
7730	Radical neck dissection	1493.60	6+T
7731	Partial unilateral neck dissection	498.20	5+T
7766	Unilateral radical neck plus contralateral suprahyoid dissection	1742.60	5+T
7767	Suprahyoid neck dissection for malignancy	498.20	5+T
7768	Excision tuberculosis lymph nodes neck (with operative report)	498.20	4+T
7796	Excision neurogenic neoplasm neck	995.80	5+T
7771	Picking operation - metastatic neck nodes for thyroid carcinoma (with operative report)	746.40	5+T

ENDOCRINE SYSTEM

7740	Thyroid biopsy - open	248.50	4+T
7741	Local excision thyroid lesion	620.80	4+T
7742	Thyroidectomy - subtotal bilateral or total unilateral	995.80	4+T
7743	Thyroidectomy - bilateral total for malignancy	1410.90	4+T
7759	Thyroidectomy - Graves' disease	1244.70	4+T
7758	Recurrent thyroidectomy (after 6 weeks from previous operation)	1226.00	4+T
7745	Parathyroidectomy	1244.70	4+T
7744	Subtotal parathyroidectomy	1146.50	4+T
7748	Parathyroidectomy with sternal split	1742.60	6+T
7746	Adrenalectomy - unilateral extra peritoneal approach	995.80	8+T
7747	Adrenalectomy - unilateral or bilateral - intraperitoneal approach	1493.60	8+T

SYMPATHECTOMY

7750	Lumbar sympathectomy - unilateral	746.40	4+T
7751	Cervical sympathectomy - unilateral	912.80	5+T
7754	Lumbar sympathectomy with abdominal procedure - unilateral (extra)	248.50	
7755	Lumbar sympathectomy with abdominal procedure - bilateral (extra)	498.20	
7752	Preganglionic sympathectomy, upper dorsal region - unilateral	912.80	7+T
7753	Lumbo-dorsal sympathectomy and splanchnic neurectomy - unilateral	912.80	7+T

GENERAL SURGERY

YHCIP / Anaes /
YWCHSB Proc Unit

ORGAN TRANSPLANTS - Kidney Implantation of Kidney Graft

7760 Urologist	1742.60	7+T
7761 Vascular surgeon	1742.60	7+T
7762 Removal of donor kidney from cadaver with necessary kidney preservation	498.20	7+T
7763 Removal of donor kidney from living donor	995.80	7+T
NOTE:		
(i) Anaesthetist and Nephrologist charge fee for service.		
(ii) A certified surgical assistant will be required with billing under fee code 7019		

RENAL DIALYSIS

7239 Insertion of new A-V bypass (no consultation charged)	495.60	4+T
7187 Creation of internal arteriovenous fistula	742.80	4+T
7186 Thrombectomy of arteriovenous fistula	697.00	3+T
7598 Removal of hemodialysis shunt	123.90	2+T
7599 Insertion of permanent catheter	370.20	3+T
7579 A-V Shunt with Bovine Graft	995.80	4+T
7577 Removal by dissection of chronic peritoneal catheter (operation only)	223.30	3+T
NOTE: Removal of Tenchov-type chronic peritoneal catheter not requiring surgical dissection - use visit fees.		

CARDIO-THORACIC SURGERY

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

7810 Consultation:	To include complete history and physical examination, review of x-ray and laboratory findings, if required, and a written report	144.80
7812 Repeat or Limited Consultation:	To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	81.40

Continuing Care by Consultant:

7807 Subsequent office visit		38.80
7808 Subsequent hospital visit		24.80
7809 Subsequent home visit		81.40

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250 Daytime (0800 - 1759):	Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	55.40
0251 Evening (1800 - 2259):	Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	152.00
0252 Night (2300 - 0759):	Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	177.90

ARTERIAL SYSTEM

7825 Resecting aneurysms in conjunction with another procedure		481.40	10+T
7828 Repair of aortic injury (thoracic)		2565.70	10+T
7829 Repair of traumatic injury of major intrathoracic vessels		1429.80	10+T

HEART AND MEDIASTINUM

Heart:

7843 Endocardial pacemaker (ventricular)		829.80	4+T
7847 Endocardial pacemaker (Atrial A-V sequential)		822.50	4+T
7953 Double lead endocardial pacemaker		822.50	4+T
7952 Electronic monitoring of pacing and pacemaker function		146.10	
7844 Implantation or replacement of pulse generator for cardiac pacing		364.90	4+T
7845 Repair, replacement, adjustment of electrode		364.90	4+T
NOTE: For implantation of temporary pacemaker see fee code 0330			
7846 Surgical treatment of cardiac arrest by cardiac massage (operation only)		481.40	11+T
NOTE: To be supported by letter. Paragraphs 11(b) and 11(d) of the Preamble will apply			

CARDIO-THORACIC SURGERY

YHCIP / Anaes /
YWCHSB Proc Unit

Mediastinum:

7921 Mediastinal cyst or tumor	1327.80	8+T
7922 Thymectomy	952.20	8+T

RESPIRATORY SYSTEM

Pleura and Lung:

7924 Decompression of traumatic pneumothorax (operation only)	74.90	4+T
7925 Artificial pneumothorax	49.50	4+T
7926 Closed drainage of chest (operation only)	248.60	4+T
7927 Rib resection for empyema	730.10	6+T
7928 Exploratory thoracotomy with or without biopsy or removal of foreign body	829.80	8+T
7929 Decortication of lung	1194.50	8+T
7930 Pleurectomy	751.40	8+T
7931 Closure of pleurostomy following long term management of empyema with rib section	751.40	6+T
7932 Segmental resection of lung (including operative report)	1443.60	8+T
7933 Lobectomy	1327.80	8+T
7934 Pneumonectomy	1775.70	9+T
7935 Thoracotomy including wedge resection	829.80	8+T
7936 Drainage of lung abscess - operation only	730.10	8+T
7938 Closure of bronchopleural fistula	1455.70	10+T
7939 Repair of ruptured bronchus	1455.70	9+T

Ribs and Chest Wall:

7941 Thoracoplasty	730.10	6+T
7945 Cervical rib resection	730.10	5+T
7946 Intrathoracic tumor - without lung involvement	946.30	5+T
7948 Trans-axillary resection of first rib	852.40	5+T
7955 Tracheal resection	1455.70	10+T
7956 - with laryngeal release, extra	719.20	10+T
7957 - with hilar release, extra	719.20	10+T
7958 Chest wall tumor with rib resection	998.10	6+T

MECHANICAL DEVICES

7960 Intra-aortic balloon insertion, removal and care	1021.90	
NOTE: For an isolated procedure (anaesthetic procedural units)	1021.90	10+T

UROLOGY

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble

REFERRED CASES

8010	Consultation: To include complete history and physical examination, review of x-ray and laboratory findings, if required, and a written report	144.80	
8012	Repeat or Limited Consultation: To apply where a consultation is repeated for same condition within six (6) months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	81.40	

Continuing Care by Consultant:

8007	Subsequent office visit	38.80	
8008	Subsequent hospital visit	24.80	
8009	Subsequent home visit	81.40	

EMERGENCY VISIT PREMIUM

**Based on time seen by physician.*

0250	Daytime (0800 - 1759): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	55.40	
0251	Evening (1800 - 2259): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care NOTE: This fee to be charged during the hours of 0800 and 2259 on Saturday, Sunday and Statutory Holidays	152.00	
0252	Night (2300 - 0759): Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care Premium to be charged only when one must immediately leave home, office or hospital to render urgent or emergency care	177.90	

KIDNEY AND PERINEPHRIUM

8100	Drainage of perinephric abscess	498.20	5+T
8101	Exploration of renal and perirenal tissues	746.40	5+T
8102	Nephrotomy or nephrostomy	946.40	5+T
8103	Pyelotomy or pyelostomy	946.40	5+T
8117	Nephrolithotomy and/or pyelolithotomy	946.40	5+T
8118	Nephrolithotomy or pyelolithotomy with x-ray control with or without nephroscopy	1244.70	5+T
8119	Nephrolithotomy or pyelolithotomy with renal cooling, with or without x-ray control, with or without nephroscopy	1360.90	6+T
8104	Hemi-nephrectomy or partial nephrectomy	995.80	5+T
8105	Nephrectomy	946.40	5+T
8106	- ectopic kidney	946.40	5+T
8107	- transperitoneal	946.40	5+T
8108	- thoracoabdominal	1493.60	8+T
8109	- radical with gland dissection	1111.70	6+T
8110	Nephrourecterectomy to include bladder cuff	1410.70	6+T
8111	Excision of stenosed renal artery with reimplantation or bypass homograft	1493.60	8+T

UROLOGY

	YHCIP / YWCHSB	Anaes / Proc Unit
8112 Open renal biopsy (as independent procedure)	498.20	5+T
8113 Symphysiotomy and nephropexy or nephrectomy in horseshoe kidney	1111.70	5+T
8114 Pyeloplasty including management of aberrant vessels and nephropexy	968.40	5+T
8115 Nephropexy	946.40	5+T
8116 Ruptured or lacerated kidney-repair or removal	995.80	4+T

URETER

8149 Ureterotomy/ureterolithotomy - upper ureter	863.10	5+T
8150 Ureterotomy/ureterolithotomy - lower ureter	946.40	5+T
8151 Ureterotomy or removal of stump	946.40	5+T
8152 Uretero-vesical reanastomosis - unilateral	863.10	5+T
8148 Uretero-vesical reanastomosis - bilateral	1493.60	5+T
8156 Ureteroureterostomy	1244.70	5+T
8157 Uretero-cutaneous anastomosis - unilateral	746.40	5+T
8158 Ureteral sigmoid anastomosis - bilateral	995.80	5+T
8159 Ureterolysis	995.80	5+T
8160 Reconstruction lower segment ureter by bladder flap	1111.70	5+T
8161 Transurethral manipulation of ureteral calculus with recovery of calculus	498.20	3+T
8162 Ureteroplasty	995.80	5+T
8163 Uretero-vesical anastomosis in the presence of ureterocele or ureteral duplication	1244.70	5+T

URINARY DIVERSION AND CYSTECTOMY

8170 Preparation of intestinal segment and reanastomosis	995.80	5+T
8171 Transplantation of ureters to an intestinal segment	746.40	6+T
8172 Cystectomy (isolated procedure)	1493.60	6+T
8173 Radical cystectomy with pelvic lymphadenectomy (isolated procedure)	1742.60	7+T
8174 Preparation of intestinal segment, reanastomosis and ureteral transplantation (same surgeon)	1742.60	6+T
8175 Cystectomy and ureteral transplantation (same surgeon)	1493.60	6+T
8176 Radical cystectomy and ureteral transplantation (same surgeon)	1742.60	7+T
8177 Preparation of intestinal segment, ureteral transplantation and cystectomy (same surgeon)	2489.40	6+T
8178 Preparation of intestinal segment, ureteral transplantation with radical cystectomy	2738.00	7+T
8179 Mobilization of bladder and anastomosis to intestinal segment	746.40	6+T
8180 Mobilization of bladder and anastomosis plus preparation of intestinal segment (same surgeon)	1742.60	6+T
8181 Ileoplasty or colocystoplasty	1360.90	6+T

BLADDER

8200 Cystoscopy with fulguration or for operative control of post-prostatectomy hemorrhage	248.60	2+T
8201 Cystostomy	498.20	2+T
8202 Cystostomy by trochar	124.40	1+T
8203 Cystolithotomy	498.20	2+T
8204 Cystectomy-partial for tumor or diverticulum	995.80	5+T
8207 Ruptured bladder repair	863.10	5+T
8210 Differential renal function studies	248.60	

UROLOGY

	YHCIP / YWCHSB	Anaes / Proc Unit
Endoscopy:		
8250 Transurethral resection of bladder or urethral tumor and adjacent muscle and electrocoagulation as necessary	730.10	3+T
8251 Transurethral resection bladder neck, female	498.20	3+T
8252 Transurethral removal of vesical or urethral foreign body	498.20	3+T
8253 Y-V vesical neck plasty	846.10	4+T
8254 Litholapaxy and removal of fragments	431.90	2+T
8255 Closure of fistula - suprapubic, vesico- vaginal, vesico-rectal or vesico-sigmoid	995.80	5+T
8256 Transurethral resection of external urinary sphincter	498.20	3+T
URETHRA		
8260 Urethrotomy, external or internal	371.70	2+T
8261 Urethrostomy	371.70	2+T
8262 Meatotomy and plastic repair (operation only)	49.50	1+T
8263 Urethrectomy - total	746.40	3+T
8264 Stricture of urethra - office dilation (operation only)	37.70	
8265 Urethra - dilation in hospital, isolated procedure with anaesthesia (operation only)	49.50	1+T
8266 Urethra - first stage plastic repair (excluding urethrostomy)	498.20	3+T
8259 Urethra - first stage plastic repair requiring pedicle graft	1244.70	3+T
8267 Urethra - second stage plastic repair (excluding urethrostomy)	498.20	3+T
8268 Urethral diverticulectomy, male or female	498.20	2+T
8269 Transurethral resection (TUR) posterior urethral valves	498.20	2+T
8270 Transurethral removal of foreign body or calculus	498.20	3+T
4431 Retropubic operation for urinary incontinence	869.60	4+T
8272 Urethral fistula (penile excision)	371.70	2+T
8273 Abdominal repair of vesico-vaginal fistula	995.80	5+T
8274 Hypospadias - excluding urethrostomy - 1st stage chordee	498.20	2+T
8275 Hypospadias - excluding urethrostomy - Second stage, (penile)	746.40	2+T
8276 Hypospadias - excluding urethrostomy - penoscrotal	995.80	2+T
8277 Epispadias - plastic repair	995.80	2+T
8278 Suprapubic cystostomy and primary repair of urethra	995.80	3+T
8279 Prolapse of urethra - repair	498.20	2+T
8280 Urethral caruncle - excision, including cystoscopy	248.60	2+T
PENIS		
8300 Priapism: sapheno-cavernous shunt	863.10	2+T
8301 Dorsal slit	49.60	1+T
8303 Circumcision - child	99.80	1+T
NOTE: Routine circumcision of the newborn for non-medical reasons is not a benefit under Insured Health Services		
8304 Circumcision - adult	248.60	1+T
8305 Simple amputation of penis	398.10	2+T
8299 Radical amputation of penis	863.10	2+T
8306 Clitoridectomy	199.20	2+T
8308 Excision of femoral and inguinal glands with or without iliac glands - unilateral	1493.60	4+T
8309 Excision of femoral and inguinal glands with or without iliac glands - bilateral	2240.50	4+T
8307 Excision of Peyronies plaque, with replacement graft (tissue or synthetic)	833.20	2+T
8296 Penile prosthesis (eg. small carrion) insertion following traumatic or surgical injury	732.00	3+T
8363 Revision of penile prosthesis (includes removal, correction of any mechanical failure, and replacement)	494.00	3+T
NOTE: In cases in which impotence is not the direct result of surgery or trauma, prior authorization should be obtained from Insured Health Services		

UROLOGY

YHCIP / Anaes /
YWCHSB Proc Unit

PROSTATE

8310	Open prostatic biopsy - perineal or retropubic prostatectomy (including meatoplasty, dorsal slit, urethral dilation, panendoscopy, cystoscopy, retrograde pyelography, vasectomy, or bladder-neck surgery done while patient is under anaesthetic for the prostatectomy)	498.20	3+T
8311	Prostatectomy - perineal, suprapubic, retropubic, and transurethral approaches	1194.50	5+T
8314	Prostatectomy - radical perineal retropubic prostate seminal vesiculectomy NOTE: No charge for repeat prostatectomies done within a period of three months by the same operator, except where radical prostatectomy is required subsequently for cancer	1244.70	7+T
8315	Perineal incision of prostate with drainage of abscess	498.20	2+T
8316	Prostatic massage	20.00	
8317	Anti-incontinence procedure (Kaufman)	1244.70	4+T
8318	Radical prostatectomy to include lymphadectomy	1682.10	7+T

TESTIS

8320	Hydrocele or spermatocele - aspiration	49.60	
8321	Orchidectomy - unilateral	248.60	2+T
8322	Orchidopexy - one or two stages	730.10	2+T
8323	Exploration of scrotal contents - unilateral	248.60	2+T
8324	Exploration of undescended testicle, without orchidopexy	498.20	2+T
8328	Recurrent undescended testis	822.50	2+T
8325	Reduction of torsion of testis and spermatic cord, repair - bilateral	498.20	2+T
8326	Ruptured testicle - repair	371.70	2+T
8327	Biopsy of testis	124.40	2+T

EPIDIDYMIS

8339	Male venereal warts, cauterly or excision (not for application of podophyllin) (operation only)	49.60	
8340	Abscess, incision, complete care	248.60	1+T
8341	Spermatocele or hydrocele - excision	415.10	2+T
8342	Epididymectomy - unilateral	371.70	2+T
8344	Vasogram - bilateral	248.60	2+T
8345	Vasectomy - bilateral	248.60	2+T
8346	Varicocele - resection	371.70	2+T
8347	Avulsion of penile skin and scrotum - repair	995.80	2+T
8348	Investigation of sterility in the male, including complete examination of male genitalia, prostatic fluid, serology and written report	74.90	
8349	Retroperitoneal lymphadenectomy for carcinoma of testis	1244.70	4+T
8350	Urethro-vesical neck plasty for congenital incontinence	1244.70	4+T
8351	Excision extrophied bladder and plastic repair abdominal wall	1244.70	4+T
8352	Excision extrophied bladder and plastic repair abdominal wall - with ureterosigmoidostomy	1493.60	5+T
8353	Plastic repair of extrophy and plastic repair of bladder with skin	1609.80	5+T

DIAGNOSTIC ROENTGENOLOGY

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble
(Applicable in full for Certified Radiologists and at 75% for all other physicians)

HEAD AND NECK

8500	Skull - routine	80.30
8501	Skull - special studies additional	53.60
8502	Ventriculogram or encephalogram (not including procedural fee)	187.90
8503	Paranasal sinuses	82.60
8504	Facial bones - orbit	82.60
8505	Nasal bones	53.60
8506	Mastoids	80.30
8507	Mandible	53.60
8508	Temporomandibular joints	57.80
8509	Salivary gland region	53.60
8510	Sialogram	80.30
8511	Eye - for foreign body	53.60
8512	For foreign body localization - additional	71.80
8513	Dacrocystogram	53.60
8514	Nasopharynx and/or soft tissue, neck - single lateral view	27.20
8515	Laryngogram (excluding procedural fee)	80.30
8516	Teeth - bitewing or routine dental - single film	24.90
8517	Teeth - bitewing or routine dental - full series	109.10

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

UPPER EXTREMITY

8520	Shoulder Girdle	53.60
8521	Humerus	53.60
8522	Elbow	53.60
8523	Forearm	53.60
8524	Wrist	53.60
8525	Hand (any part)	53.60
8526	Special requested views in upper extremity	26.40

LOWER EXTREMITY

8530	Hip	53.60
8531	Femur	53.60
8532	Knee	53.60
8533	Tibia and Fibula	53.60
8534	Ankle	53.60
8535	Foot (any part)	53.60
8536	Leg length films - any method	53.60
8537	Special requested additional views for lower extremity	26.40

SPINE AND PELVIS

8540	Cervical spine	77.00
8541	Thoracic spine	77.00
8542	Lumbar spine	130.40
8543	Sacrum and coccyx	77.00
8549	Spine - requested additional views (flexion, bending views, etc.)	53.60

NOTE: Fee code 8549 is not intended to cover normal projections

DIAGNOSTIC ROENTGENOLOGY

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble
(Applicable in full for Certified Radiologists and at 75% for all other physicians)

8544 Pelvis	53.60
8545 Sacro-iliac joints	57.80
8546 Scoliosis films - single AP or lateral - 14 x 36 film taken at 6 feet	77.00
8547 Pelvis and additional requested views ie. sacroiliac joints, hip, etc.	71.80
8548 Myelogram and/or posterior fossa positive contrast (excluding procedural fee)	144.30

CHEST

8550 Thoracic viscera	53.60
8551 Thoracic inlet	53.60
8552 Thoracic inlet - additional requested views	26.40
8553 Fluoroscopy, when requested	36.40
8554 Ribs - one side	53.60
8555 Ribs - both sides	80.30
8556 Sternum or sternoclavicular joints	53.60
8557 Sternum and sternoclavicular joints	80.30
8558 Bronchogram, excluding preliminary films (excluding procedural fees) - one side	134.30
8559 Bronchogram, excluding preliminary films (excluding procedural fees) - both sides	185.30

ABDOMEN

8570 Abdomen	53.60
8571 Abdomen, multiple views	80.30

GASTRO-INTESTINAL TRACTS

8572 Esophagus, only	92.60
8573 Esophagus, stomach and duodenum	134.30
8574 Small bowel	134.30
8576 Colon or double contrast air studies	134.30
8577 Hypotonic duodenography	134.30
8578 Pancreatography (excluding procedural fee)	80.30
8579 Glucagon assisted contrast study (in addition to routine fee)	57.70

GALLBLADDER

8580 Oral cholecystogram	80.30
8581 Intravenous cholangiogram	117.30
8582 Operative cholangiogram (transhepatic also)	80.30
8583 Direct post-operative cholangiogram	80.30
8584 Removal of biliary calculi by Burhenne technique or equivalent including necessary cholangiogram and fluoroscopy (excluding procedural fee)	99.50

GENITO-URINARY SYSTEM

8590 Kidney, Ureter and Bladder (K.U.B.)	53.60
8591 Pyelogram - intravenous	115.70
8592 IVP-special studies, ie. rapid sequence, drip infusion	158.70
8593 Pyelogram - retrograde	80.30
8594 Intravenous pyelogram with voiding cystourethrogram	160.80
8595 Cystogram or retrograde urethrogram (not including catheterization)	80.30
8596 Hysterosalpingogram (excluding injection)	134.30
8597 Pelvimetry	107.50
8598 Placentogram (with or without contrast)	80.30
8599 Voiding cystourethrogram	134.30

DIAGNOSTIC ROENTGENOLOGY

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble
(Applicable in full for Certified Radiologists and at 75% for all other physicians)

MISCELLANEOUS

8600 Cine study-50% added to the fee for region studied	0
8601 Radiographic study of sinus, fistula, etc with contrast media, including injection and fluoroscopy, if necessary	80.30
8602 Body section radiography - applies to all tomographic procedures (including polytomography when done in one plan) per plane series, including orthopantogram	120.60
8603 Bone age - whatever method	53.60
8604 Bone survey - first anatomical area	53.60
8605 Bone survey - each subsequent anatomical area	26.40
8606 Arthrogram - shoulder (excluding injection of contrast)	53.60
8607 Arthrogram - hip (excluding injection of contrast)	53.60
8608 Arthrogram - knee (excluding injection of contrast)	115.70
8609 Arthrogram - ankle (excluding injection of contrast)	53.60
8610 Mammography - unilateral	80.30
8611 Mammography - bilateral	134.30
8612 Xeromammography - unilateral	123.50
8613 Xeromammography - bilateral	198.90
8614 Lymphangiogram - one extremity	107.50
8615 Cerebral angiography - unilateral	187.90
8616 Cerebral angiography - bilateral	297.50
8617 Peripheral angiography (arteriography and venography) - unilateral	107.50
8618 Peripheral angiography (arteriography and venography) - bilateral for trauma	160.80
8619 Orbital venography	123.50
8620 Aortography (aortography plus peripheral angiography)	272.20
8621 Cerebral stereotaxy	214.90
8622 Cerebral stereotaxy - radiologist present additional	26.40
8623 Retroperitoneal gas insufflation	134.30

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

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

DIAGNOSTIC ROENTGENOLOGY

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble
(Applicable in full for Certified Radiologists and at 75% for all other physicians)

8624 Thoracic or abdominal angiogram (Cine or videotape surcharge not applicable) - using single film - non-selective	107.50
8625 Thoracic or abdominal angiogram (Cine or videotape surcharge not applicable) - using single film - selective	26.40
8626 Thoracic or abdominal angiogram (Cine or videotape surcharge not applicable) - using multiple sequential views - non-selective	206.00
8627 Thoracic or abdominal angiogram (Cine or videotape surcharge not applicable) - using multiple sequential views - selective	187.90
8628 Interpretation of submitted films - per examination NOTE: This item to be charged only in those situations where a third party requests a second written radiological opinion	26.40
8629 Radiologist in attendance for fluoroscopy for various clinical procedures (ie. small bowel biopsy; insertion of pacemaker, etc.)	26.40
8630 Percutaneous transluminal angioplasty	484.00

COMPUTERIZED TOMOGRAPHY

8690 Head scan - without contrast	74.90
8691 Head scan - with contrast	104.50
8692 Head scan - double scan or 2 planes	135.10
8693 Body scan - one region without contrast	149.80
8694 Body scan - one region with contrast	165.50
8695 Body scan - double scan or 2 regions	226.40

DIAGNOSTIC ULTRASOUND

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble

HEAD AND NECK

0916	Echoencephalography - midline A mode	37.30
8640	Echoencephalography - complete (midline and ventricular size)	66.20
8641	B scan - Ophthalmic - immersion technique	264.70
2639	Ophthalmic ultrasound A scan for determination of axial length (to be billed only if patient proceeds to lens implant surgery)	98.10
8642	B scan - Thyroid	95.70

HEART

8643	Echocardiography - M mode	225.70
8638	Echocardiography - real time	170.90
8661	Echocardiography - combined two dimensional real time and M mode	238.90
8644	Ultrasonically guided pericardiocentesis	199.50

THORAX

8645	B scan	199.50
8646	Ultrasonically guided thoracentesis	199.50
8647	B scan for breast mass - per breast	66.20

ABDOMEN

8648	B scan - Abdominal - for liver, pancreas, mass, aortic, aneurysm, etc.	199.50
8649	B scan - Renal	199.50
8650	Ultrasonically guided biopsy or cyst puncture	199.50

OBSTETRIC AND GYNAECOLOGY

8651	B scan - Obstetrical - 20 weeks gestation or over	188.80
8652	B scan - IUD localization	79.60
8653	B scan - Non-obstetrical pelvic	199.50
8654	Ultrasonically guided amniocentesis	199.50

BRAIN

8659	B scan - Brain	143.60
------	----------------	--------

EXTREMITIES

8658	B scan - Extremities - cyst or mass	90.60
------	-------------------------------------	-------

DOPPLER STUDIES

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

8656	Assessment of ventricular arterial shunt	39.20
------	--	-------

Peripheral Arterial:

8664	Resting arterial assessment: To include multiple wave form and/or segmental pressure analysis, calculation and ankle/arm index	93.30
------	--	-------

DIAGNOSTIC ULTRASOUND

YHCIP / Anaes /
YWCHSB Proc Unit

These fees cannot be correctly interpreted without reference to the Preamble

8665	Treadmill stress examination with or without ECG monitoring: To include sequential post stress measurement and calculations - with monitoring physician present	165.50
8666	Treadmill stress examination with or without ECG monitoring: To include sequential post stress measurement and calculations - without monitoring physician present	112.20
8667	Reactive hyperemia with sequential pressures	70.50
8668	Vasopastic assessment: To include digital pressures and/or plethysmography - cold and hot stress responses and/or multiple extremity wave form analysis	112.20
8669	Sympathetic tone response: To include resting arterial assessment plus plethysmograph and/or impedance monitoring and/or digital wave forms, response to Valsalva maneuvers or other stimuli	68.50
Peripheral Venous:		
8670	Laboratory assessment of deep venous thrombosis: To include determination of venous sounds at multiple sites, response to standard compression maneuvers with documentation of sounds and responses	68.50
8671	Laboratory assessment of venous hypertension and venous reflux, delineation of incomplete perforators	68.50
Extracranial:		
8672	Carotid imaging: To include delineation of extra cranial vessels on both sides of the neck - ultrasound imaging	115.30
8673	- ultrasonic arteriography plotting	109.90
8674	- continuous wave audioangiography with or without wave forms	43.00
8675	- spectrum analysis	68.50
8676	Carotid imaging - duplex scan, ie. ultrasonic image and placement, doppler flow assessment	169.70
8677	Periorbital assessments; either oculoplethysmograph (OPG) or photoplethysmography (PPG), and/or doppler directional determination with extra-cranial artery compression maneuvers	68.50
8678	Subclavian or vertebral assessment including assessment of subclavian steal: To include directional doppler determination of flow direction in vertebral arteries with or without arm compression and other maneuvers	93.30

THERAPEUTIC ROENTGENOLOGY

YHCIP / Anaes /
YWCHSB Proc Unit

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

MALIGNANT DISEASE

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

8712 Consultation malignant disease of the skin	51.10
8711 Consultation malignant disease of the skin - if biopsy is included	77.40
8710 Hemapoietic, reproductive (male or female), urinary, gastrointestinal or nervous system	102.80

X-RAY RADIATION

8715 Where an incomplete course of x-ray therapy or cobalt therapy is given, per treatment	25.50
8716 Multiple therapy, each additional portion	12.70

NON-MALIGNANT DISEASE

8786 Consultation - non-malignant disease - first treatment - including consultation and written report to referring physician	77.40
8787 Consultation - non-malignant disease - subsequent treatment - including consultation and written report to referring physician	38.40

LABORATORY PROCEDURE (Short List)

YHCIP / Anaes /
YWCHSB Proc Unit

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

9000 Hemoglobin - other methods	4.80
9003 Hematocrit - micro or macro	4.80
9005 Hematology profile (automatic to include HGB, WCT, HCT, RBC indices) NOTE: When all components of the hematology profile (fee code 9005) are normal, a white count differential (fee code 9012) is not required and will not be performed unless medically required and specifically requested by a physician	19.30
9007 Hemoglobin - cyanmethemoglobin method	10.20
9011 White blood cell count only	10.20
9012 Differential white cell count	15.00
9031 Sedimentation rate	7.60
9066 Latex test	18.20
9074 Mono test	18.00
9077 Anti-nuclear factor	75.90
9101 Simple stained smear	12.30
9104 Urine culture	20.00
9106 Throat culture	15.80
9110 Secretion smear for eosinophils	12.30
9111 Examination for pinworm ova	10.20
9113 Direct examination for cutaneous fungus - KOH preparation	12.30
9115 Trichomonas and/or Candida (direct exam)	7.60
9119 Candida culture	9.40
9125 Serological tests 1 to 3 antigens	49.60
9126 Serological tests 4 or more antigens	75.10
9195 Lithium	25.30
9209 Potassium	20.00
9219 Dextrostix	4.80
9220 Glucose determination by reflectometer	9.10
9221 Glucose determination by reflectometer following ingestion of predetermined amount of glucose containing solution	13.80
9234 Occult blood	10.20
9366 Complete urine analysis	10.20
9349 Immunological gonadotrophin (pregnancy test)	24.90
9364 Microscopic examination on centrifuged specimen of urine	7.50
9365 Routine screening urinalysis (to include sugar, protein, blood, pH, bile and ketones or any part thereof)	2.80
9429 Seminal examination for presence or absence of sperm	24.90
9436 Fern test	10.20
9827 Thyroid Function Test - Total T3	45.30
9830 Thyroid Function Test - Total T4	54.90
9242 Serum uric-acid	32.30

YUKON DENTAL FEES

YHCIP / Anaes /
YWCHSB Proc Unit

SURGICAL REMOVAL OF TEETH

8504	Orthopan x-ray	82.60
9940	Erupted first tooth	48.00
9941	Each additional	24.00
9943	Soft tissue impaction	92.00
9944	Bony impaction (partial)	165.00
9945	Complete bony impaction	245.00
9950	Alveoplasty	75.00
9987	Sulcus deepening and ridge construction per arch	393.00
9951	Exposure of tooth for orthodontic treatment	145.00
9984	Treatment of traumatic injuries of soft tissue with the mouth	97.00
9948	Root resection	172.00
9955	Incision and drainage of abscess of dental origin	54.00
9983	Frenectomy	170.00
9970	Closed reduction of fracture of mandible and maxilla	435.00
9966	Excision of intraoral cysts - small	218.00
9967	Excision of intraoral cysts - large	411.00
9954	Intraoral biopsy - soft tissue	72.00
9969	Intraoral biopsy - bony tissue	144.00
9960	Excision of benign intraoral tumors, under 1 cm.	210.00
9961	Excision of benign intraoral tumors, over 1 cm.	411.00
9964	Removal of root or foreign body from maxillary antrum	319.00
9965	Repair and closure of antro-oral fistula	259.00
9973	Closed reduction of temporomandibular dislocation	110.00
9958	Sialolithotomy	109.00
0110	Consultation written (at hospital)	137.60