MANITOBA
PHYSICIAN'S MANUAL

April 1, 2024

Issued by:
The Minister of Health
manitoba.ca/health/manual

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INTRODUCTION

The Manitoba Physician's Manual is the schedule of fees payable to physicians for insured medical services provided to insured persons enrolled with the Manitoba Health Services Insurance Plan or covered under Interprovincial Reciprocal Billing Agreements, as negotiated between Manitoba and Doctors Manitoba and forming part of the Physician Services Agreement.

The Rules of Application provide the terms and conditions under which fees are to be submitted for payment and provide direction to assist physicians to bill appropriately for insured medical services and for Manitoba Health to pay for insured medical services.

All fee tariffs listed in the Manual, unless specific exceptions are identified, include various additional elements of the medical services in the listed fees, beyond the wording of the tariff. For example, it is presumed that every tariff includes any inquiry of the patient or other source, including review of ongoing medical records, necessary to arrive at an opinion as to the nature and history of the patient's condition. Physicians should ensure their charting in the patient record provides sufficient information and detail to support the tariff being claimed.

Manitoba Health and Doctors Manitoba will continue to provide information and support to physicians on the requirements of the fee tariffs.

LEGISLATION AND REGULATIONS

The legislation governing payment for insured medical services is *The Health Services Insurance Act* (HSIA) (C.C.S.M. c. H35 (gov.mb.ca)) with authority provided under *Section 74* as follows:

Agreements on Medical Fees and Payments

The Minister, with the approval of the Lieutenant Governor in Council, and notwithstanding that it is not an incorporated association, the Manitoba Medical Association (now known as Doctors Manitoba), through its officers, may enter into an agreement respecting all matters relevant to:

(a) A schedule of fees to be paid by the minister to medical practitioners in respect of medical services rendered to insured persons;

(b) Terms and conditions relating to the application of the schedule of fees in respect of medical services rendered to insured persons; and

(c) Methods of payment to medical practitioners of benefits payable in respect of medical services rendered to insured persons.

Medical Services Insurance Regulation

"Insured medical services" means all personal healthcare services provided to an insured person by a medical practitioner that are medically required and are not excluded under *The Excluded Services Regulation* made under the Act (Regulation 46/93 under *The Health Services Insurance Act*)

Entitlement to insured medical services

An insured person is entitled as a benefit under the Act to payment of insured medical services paid by the Minister in accordance with this regulation.

Amount payable for medical services in Manitoba

Where an insured medical service is provided in Manitoba, the benefit payable is the amount prescribed in the *Payments for Insured Medical Services Regulation* under the Act.

Payments for Insured Medical Services Regulation

Amounts payable

The amounts payable by the Minister for insured medical services provided are the amounts set out in the Manual.

CONTACT INFORMATION

PRACTITIONER REGISTRY/USER SITE MAINTENANCE

practitionerregistry@gov.mb.ca

204-788-2567 or 204-786-7225

Practitioner Registry staff at Manitoba Health provide assistance and information in relation to the following:

- Registration of new physicians with Manitoba Health
- Issuance of billing numbers for claims submission to Manitoba Health
- Payment cycles and claim form information
- Locum tenens registration with Manitoba Health
- Electronic funds transfer (EFT) maintenance, including the processing of changes to banking information
- Letter of Agreement (LOA) required for electronic claim submission
- Set up, testing, maintenance and closure of electronic User Sites for electronic claims submission.
- Notification of medical billing software Vendor or Service Bureau changes
- To obtain a listing of software Vendors and Service Bureaus who currently have sites submitting claims to Manitoba Health
- Issuance and maintenance of Safenet token (FOB) for access to EPiCS and iREG
- Notification of address change
- Registration of laboratory and x-ray facilities

CLAIMS UNIT—CLAIMS ENQUIRY

Physicians and their administrative staff are encouraged to regularly check the claims processing solution website for information and updates related to the processing of fee-for service claims: http://www.gov.mb.ca/health/claims/index.html

Telephone inquiries may be directed to:

204-786-7355

Claims Unit staff provide assistance and information to physicians and billing staff on:

- Remittance Advice statements
- Explanation of Benefits (EOB) codes
- Benefit codes (tariffs) in the Physician's Manual
- Diagnostic Codes (ICD-9-CM)
- Claims data requirements
- Pended, reduced or rejected claims
- Applications for prior approval of elective/plastic reconstructive surgery

REGISTRATION/CLIENT SERVICES

http://www.gov.mb.ca/health/claims/index.html

www.echartmanitoba.ca

204-786-7101 or 1-800-392-1207

Registration/Client Services staff at Manitoba Health should be contacted for information and assistance with following:

- New residents applying for coverage under the Provincial Health Plan
- Requests for new Health Cards
- Reporting of births and deaths
- Reporting of changes or correction to patient address, marital status, etc.
- Personal Health Identification Number (PHIN)
    - The PHIN is a mandatory field on all claims. If the PHIN is not correctly entered on the claim when it is submitted to Manitoba Health, it will be automatically rejected.
    - iREG and eChart are two applications that are available to practitioners in Manitoba. Both applications offer different benefits that may have value for the physicians practice.
    - Physicians who would like to have more information about eChart should contact Manitoba e-Health at www.echartmanitoba.ca
    - For more information about iREG, see the iREG release package on the WebLink applications main page or call Practitioner Registry at 204-788-2567.
    - For practitioner offices that do not have eChart or iREG access, a 529 Form can be submitted to Manitoba Health by fax to request patient information, including PHIN. Please contact Registration/Client Services staff at 204-786-7101 or 1-800-392-1207 for further information.

SHARED HEALTH SERVICE DESK

servicedesk@sharedhealthmb.ca

204-940-8500 or toll-free at 1-866-999-9698

Service Desk staff may be contacted for assistance with the following:

- Uploading claims submission files to Manitoba Health
- Password resets (mainframe as well as iREG)
- Trouble-shooting for connection issues with EPiCS or WebLink

CLAIMS SUBMISSION AND PAYMENT PROCEDURES

The Manitoba Physician's Manual is an integral part of the negotiated Physician Services Agreement between and Doctors Manitoba regarding compensation for fee-for-service physicians. The most current version of the manual can be found on Manitoba Health's website at http://www.manitoba.ca/health/manual.

CLAIMS PROCESSING SUMMARY (SEE PARTS I-VII FOR DETAILS)

1. Claims for insured services must be submitted to Manitoba Health electronically. Paper claims will only be accepted in exceptional circumstances, with prior approval of Manitoba Health.
2. Electronic funds transfers for the payment of claims will be made by Manitoba Health twice monthly.
3. All physicians are encouraged to submit claims on a weekly basis or at more frequent intervals to avoid late claim submissions.
4. All claims MUST be submitted within six (6) months of the date of the service. When required and requested, supporting documentation must be submitted within six (6) months from the date of request.
5. Physicians should review their Remittance Advice provided by Manitoba Health, including Explanation of Benefits (EOB) codes, to ensure they reconcile their remittance in a timely manner, and understand any changes in payment made.
6. Pending Claims, including By-Report claims, will be processed by Manitoba Health within six months of the date of submission of all information required to process the claim. Manitoba Health may request additional information to assess these claims. Provisional claims and By-Report claims must include a report when the claim is submitted. Where this occurs, Manitoba Health will have six months from receipt of the additional information to process the claim.
7. If the claim is not adjudicated within six months of submission of all information required to process the claim, the physician should discuss the claim with Doctors Manitoba. Doctors Manitoba may refer the claim to the Joint Physician Services Agreement Committee. If the matter is not resolved within 120 days of referral to the Joint Physician Services Agreement Committee, Doctors Manitoba may refer the matter to arbitration through the provisions of the dispute resolution process set out in Part VII below.
8. After reviewing the Remittance Advice, including EOB codes, if a physician disagrees with an assessment and/or payment of a claim, they may query the claim within six months of the date on the Remittance Advice.
9. Claims that require a correction to the initial claim must be electronically submitted with the necessary corrections noted in the EOB within six months from the date of the service. A query should not be submitted for claims that require a correction.
10. Manitoba Health shall respond to all queries received within 90 days of receipt. Duplicate queries and multiple submissions of the same query will not be reviewed. If a claim is denied or amended, Manitoba Health shall respond to the query by providing an explanation of the denial or amendment.
11. If Manitoba Health does not respond to the query within 90 days of receipt, or if the physician is not satisfied with the response to the query, the physician should discuss the claim with Doctors Manitoba. Doctors Manitoba may refer the claim to the Joint Physician Services Agreement Committee. If the matter is not resolved within 120 days of referral to the Joint Physician Services Agreement Committee, Doctors Manitoba may refer the matter to arbitration through the provisions of the dispute resolution process set out in Part VII below.
12. Notwithstanding the above, the informal dispute resolution process is not mandatory and either Doctors Manitoba or Manitoba Health may opt to refer any dispute directly to an arbitration board at any time.

PART I—BILLING AND PROVISION OF SERVICES

The assessment and payment of physician claims is based on appropriate tariffs being claimed for insured services, and appropriate billing practices being followed.

The following principles apply to claims submitted to Manitoba Health.

1. Insured service claims may only be made for services rendered personally by the physician.
2. A physician will not claim for services rendered to members of his or her own family, or for services rendered to the physician except in urgent or emergent circumstances.
3. A physician will advise a patient, or a person responsible for the patient, of any financial obligation, including with respect to any uninsured service or portion of a service, that may be involved in the patient's care.
4. Physicians should exercise care when billing multiple agencies (e.g. Manitoba Health and another agency such as an insurance company, or the Workers Compensation Board of Manitoba) for multiple services provided during the same visit. Generally two agencies may not be billed for the same service. If the physician is uncertain he/she may wish to contact Manitoba Health and/or Doctors Manitoba to obtain billing advice before submitting such a claim.

PART II—METHOD OF CLAIMS SUBMISSION

All fee-for-service claims must be submitted electronically. EPiCS (Electronic Practitioner integrated Claims Submission) is the method used to transmit files from the practitioners billing software directly to Manitoba Health.

The submission of paper claims is only permitted with the prior approval of Manitoba Health.

For information regarding the set-up or testing of a new User Site for electronic claim submission, please contact Practitioner Registry at 204-788-2567.

Operative reports are not routinely required for the assessment of claims. However, operative reports and/or supporting documentation are required for the processing of provisional claims (except as otherwise agreed to by Manitoba Health and Doctors Manitoba), By-report claims, claims requiring a special report, billing errors, billing discrepancies involving incorrect dates of service, incorrect tariffs, incorrect patients, etc. Additional information may also be required to ensure that physicians' claims are adjudicated in a consistent and fair manner.

PAYMENT CYCLE

Manitoba Health adjudicates fee-for-service claims on a continual basis and claims can be submitted by practitioners on a daily basis. Payments to practitioners are made by electronic funds transfer (EFT) twice monthly, at mid-month (15th) and month end. There are two (2) cut-off dates per month for each bi-weekly run of the payment system. A complete list of cut-off dates for each pay period is available at http://www.gov.mb.ca/health/claims/index.html or by calling the Shared Health Service desk by phone at 204-940-8500 or toll-free at 1-866-999-9698, or by e-mail at servicedesk@sharedhealthmb.ca.

SIX (6) MONTH DEADLINE FOR SUBMISSION OF CLAIMS

Manitoba Health provides benefits for insured medical services in accordance with the *The Health Services Insurance Act* and its regulations.

Section 4(2) of the *Medical Services Insurance Regulation* 49/93 states:

> **Payment to doctor**
>
> 4(2) *A medical practitioner who provides an insured medical service to an insured person, and who has not made an election under subsection 91(1) of the Act, shall submit to the minister:*
>
> ***(a) a claim for the service within six months from the date on which the service was provided in the form and manner required by the minister;*** *and*

> *(b) such further information respecting the service in a form and manner as may be required by the minister.*

Claims received by Manitoba Health more than 6 months after the service date will be rejected with Explanation of Benefits (EOB) code ***"C2". This claim was refused as this service was not submitted with six (6) months from the date on which the service was rendered.***

The *Medical Services Insurance Regulation* does provide for possible extension of the 6-month deadline for claim submissions, in extenuating circumstances:

> *4(3) The minister may extend the time referred to in subsection (2) if in the minister's opinion there are extenuating circumstances that prevented the filing of the claim within the six month period.*

Physicians seeking an extension to the 6-month claims submission deadline are required to make the request in writing and include detailed information regarding the extenuating circumstance that prevented the submission of the claim to Manitoba Health in accordance with the legislation, and addressed as follows:

Director
Insured Benefits, Insurance Division
Manitoba Health
3rd Floor, 300 Carlton Street
Winnipeg, MB R3B 3M9

Reciprocal Billing for Non-Manitoba Residents (Canadians)

Interprovincial Reciprocal Billing Agreements between the provinces and territories allow physicians to submit claims to Manitoba Health for most services provided to out-of-province (Canadian) patients (except for Quebec residents).

Physicians should submit their claims for insured services provided to any Canadian resident (except for patients from Quebec) to Manitoba Health for processing at the rates in the Manitoba Physician's Manual.

Carefully check the patient's health card to ensure that their coverage has not expired, as some provincial health plans issue renewable, rather than lifetime health registration numbers.

If a patient does not present a valid health card, the patient can be considered uninsured and billed directly for all services. The patient may then seek reimbursement from their private insurer or, if they have valid coverage, from their home province's insurance plan.

Quebec does not participate in the inter-provincial reciprocal medical billing agreements. If a physician provides insured services to a Quebec resident, their billing options are as follows.

- Bill the Quebec resident directly. The resident can then seek reimbursement from the Quebec Health Plan; or
- Bill the "The Régie de l'assurance maladie" (contact information can be found at http://www.ramq.gouv.qc.ca/en/courrier/index.shtml). The physician will also be paid the applicable Quebec rates for the services rendered. The physician will also need to ensure the Quebec resident's health care card is valid.

Patient Eligibility (Coverage under Provincial Health Plan)

The following information is a general outline. For more specific information, please refer to *The Health Services Insurance Act* and its regulations, or contact our office at 204-786-7101.

Manitoba Health issues registration certificates ("Health Cards") to families and single persons eighteen (18) years of age and older. Manitobans have been instructed (through brochures, etc.) to present their Health Cards when seeking services insured under the Provincial Health Plan, however, in the event a patient cannot provide you with their Personal Health Identification Number (PHIN), please direct them to contact Registration/Client Services at 204-786-7101 or 1-800-392-1207 to obtain information on applying for provincial health coverage or to obtain a new Health Card.

Persons Not Eligible

Tourists, transients, visitors and other persons temporarily in Manitoba are not considered residents pursuant to *The Health Services Insurance Act* and, therefore are not eligible for coverage under the Provincial Health Plan.

PART III—REMITTANCE ADVICE

The Remittance Advice statement is the electronic information that Manitoba Health provides each pay period (at mid-month and month end) to assist physicians with reconciling their claims in their practice management systems.

The Remittance Advice statement includes Explanation of Benefits (EOB) codes that explain any changes in payment made by Manitoba Health. IT IS THE RESPONSIBILITY OF THE PHYSICIAN TO REVIEW EOB CODES and reconcile each Remittance Advice statement on a timely basis.

The remittance file is available for download from Manitoba Health beginning on the 3rd business day after the claim submission cut-off date until the following cut-off date. Each remittance file must be downloaded by the billing staff. A complete list of cut-off dates can be found at http://www.gov.mb.ca/health/claims/index.html or by contacting the Digital Shared Service Desk at 204-940-8500, toll free on 1-866-999-9698, or by email at servicedesk@sharedhealthmb.ca.

The Remittance Advice statement has two (2) parts, a listing of "processed claims" and a listing of "pending claims." The decision regarding the information the physician wishes to extract from the remittance file is made by the physician and their billing software vendor or service bureau. The list below shows the type of information that Manitoba Health reports back to the providers on the "processed claims" file each pay period. If there are items in the list below that the physician would like to see on their reports, they may contact their vendor directly.

- User Number
- User Name
- Physician Number
- Patient's Surname
- Patient's Initial
- Patient's Given Name
- Gender
- Manitoba Health Registration Number
- Manitoba Health Personal Health Identification Number (PHIN)
- Manitoba Health Microfilm Number
- Claim Number (assigned by your billing software)
- Health Identification number for reciprocal/non-resident claims
- Year of Birth
- Non-Resident Birth Date
- Physician Payment Option
- Explanation of Benefits (EOB) codes
- Incorporated Indicator
- Referring Physician Number
- Interest Amount
- Hospital Number
- Service Date (YYMMDD)
- Tariff (benefit code or benefit catalogue item)
- Prefix

- Number of Services
- Province Code for reciprocal/non-resident claims
- Fee Submitted
- Fee Assessed
- Manual Code
- Location of Service
- Medical Records Number, Clinic Number, or Physician's Patient Number

PENDING CLAIMS (EOB "77")

Some claims submitted with a particular tariff (benefit code or benefit catalogue item) and/or involving a Rule of Application in the Physician's Manual may require manual assessment by Manitoba Health claims staff.

While in process, the claim will continue to appear on each Remittance Advice statement under the *"Listing of Pending Claims"* with EOB code **"77" Pending benefit catalogue item.**

In some cases, the claim may show as pending without final adjudication for several pay periods. **Please do not resubmit or query claims listed as pending.** This includes claims that have not fully been adjudicated. It is important to wait until the entire claim has been processed. Manitoba Health will not respond to queries of claims that are pending. Pending claims will be listed as a "processed claim" on a future Remittance Advice once they have been adjudicated.

Questions regarding Remittance Advice may be directed to Claims Enquiry at 204-786-7355.

PART IV—FEE DIFFERENTIALS

Definitions

1. General

"locum tenens" is a physician who enters into an arrangement whereby he or she provides medical services on behalf of an absentee physician on a temporary basis. (For additional information regarding payments for services provided by Locum Tenens physicians, contact Practitioner Registry at 204-788-2567).

"northern Manitoba" means that part of Manitoba north of the 53rd parallel of latitude.

"remote Manitoba Communities" means those communities in Manitoba described as one of:

i) north of the 53rd parallel of latitude, not the cities of Flin Flon, The Pas, or Thompson, or,

ii) communities in Manitoba without year-round road access

"rural Manitoba and remote communities" means that part of Manitoba south of the 53rd parallel of latitude except the city of Winnipeg and the city of Brandon.

"**remote communities**" means all communities designated as remote communities.

Fees

2. The fees set out in the Schedule, titled "Physician's Manual", are benefits payable under *The Manitoba Health Services Insurance Act* with respect to the cost of insured medical services.

Fee Differentials

3. In addition to the amount set out in the Schedule, the Minister shall pay the percentage set out in Column I of the following Table for each medical service provided by a physician in the location set out opposite in Column II.

Table	
Column I	**Column II**
35%	Remote Communities
25%	Northern Manitoba
5%	Rural Manitoba
5%	City of Brandon
0%	City of Winnipeg
0%	Outside Manitoba

4. In addition to the amount set out in the Schedule, the Minister shall pay the following percentage corresponding to the location of the physician and location of the patient for each virtual service provided.

   The associated alpha-codes should be submitted along with a virtual claim in the rural fee differential field.

		Patient Location			
		Winnipeg	Brandon/Rural	Northern	Remote
Physician Location	Winnipeg	0%	M=2.5%	P=12.5%	Q=17.5%
	Brandon/Rural	S=2.5%	T=5%	U=15%	V=20%
	Northern	H=12.5%	X=15%	Y=25%	Z=30%
	Remote	D=17.5%	F=20%	G=30%	A=35%

PART V—INTEREST

If an electronic claim is not paid with thirty (30) days of receipt of the claim by Manitoba Health, or a paper claim is not paid within sixty (60) days of receipt of the claim by Manitoba Health, provided the claim has included all required information as set out in the Physician's Manual, interest shall be paid on the outstanding amount of the claim until the date of actual payment, and rate of interest per annum shall be:

i) for the period January 1 to June 30 in each year, the prime lending rate of the Bank of Canada as that rate stood on January 1 of that year, plus 1%; and

ii) for the period April 1 to December 31 in each year, the prime lending rate of the Bank of Canada as that rate stood on April 1 of that year, plus 1%, compounded annually.

Where a physician submits a formal query about the disposition of a claim, and the claim is adjusted in such a manner that the payment ultimately exceeds the amount, if any, originally paid by Manitoba Health, interest at the rate set out above shall be payable on the difference from thirty (30) days after receipt of the claim by Manitoba Health in the event of an electronic claim, and sixty (60) days after receipt of the claim by Manitoba Health in the event of a paper claim, to the actual date of payment.

PART VI—BY REPORT

It is not possible to list every variation of a procedure in the Physician's Manual. Some procedures may vary from minor to major and cannot be listed with a definite benefit, and will require assessment.

In order to correctly assess a fee tariff number designated as ***By Report***, the assessor must have complete information. This may be provided on the claim, operative report, a separate letter, or on a ***By Report*** form.

There are several factors which will assist in assessment, e.g., the size of the lesion, the area involved, complications and the time required to perform the procedure. Where possible, the claimant may relate the service to an existing tariff number ("E"

entered under Split Indicator field) of similar complexity which carries a definite benefit or may suggest a suitable benefit. If you are in disagreement with an assessment, please refer to the appeal mechanism listed below.

PART VII—DISPUTES

Informal Resolution of Disputes

The assessment of a claim is not necessarily final and is always subject to appeal. It should be recognized, however, that an unsatisfactory assessment may result from a misunderstanding or a lack of information. An initial contact with the medical assessor may resolve the assessment to the physician's satisfaction. Medical Assessors may be reached by telephone by contacting 204-786-7170.

Where a physician disagrees with the assessment and/or payment of a claim the physician must file a query within six months from the Remittance Advice Statement date on which the claim was processed. Manitoba Health shall respond to queries within 90 days of receipt. Where the claim is not paid in full, Manitoba Health shall provide details of the reasons for the denial or amendment of the claim. In the event the physician is not satisfied with the response, the physician should discuss the claim with Doctors Manitoba. Doctors Manitoba may refer the claim to the Joint Physician Services Agreement Committee. If the matter is not resolved within 120 days of referral to the Joint Physician Services Agreement Committee, Doctors Manitoba may refer the matter to arbitration through the provisions of the dispute resolution process set out in Part VII below.

Notwithstanding the above, the informal dispute resolution process is not mandatory and either Doctors Manitoba or Manitoba Health may opt to refer any dispute directly to an arbitration board at any time.

Referral to Arbitration

Where a dispute arises between a physician and Manitoba Health concerning the application of the Physician's Manual or any matter relating thereto as it applies to such physician which cannot be satisfactorily resolved on an informal basis, the physician or Doctors Manitoba (acting on behalf of the physician) or Manitoba Health may refer the dispute to Arbitration for a decision by providing written notice to the other party.

Where the dispute arises out of an audit, the physician or Doctors Manitoba must refer the dispute to arbitration within 90 days of the receipt of notice of the determination of Manitoba Health. Manitoba Health may not recover payments until the time for the referral to dispute resolution has elapsed or, if the matter is referred to dispute resolution, until the dispute is resolved through an arbitration decision or agreement of the parties.

After notice is given, the party shall refer the dispute to a Chairperson, selected on a rotating basis from a list of no less than six lawyers agreed to by Manitoba Health and Doctors Manitoba. The list of agreed upon Chairpersons may, from time to time, be modified by agreement of the parties. If the Minister and Doctors Manitoba cannot agree upon at least six Chairpersons, either party may ask the Joint Physician Services Agreement Committee to choose Chairpersons.

The Chairperson shall request the positions of the physician and Manitoba Health in writing, and such positions shall be provided to the Chairperson within thirty (30) days of the request having been made.

Where the amount in dispute exceeds $10,000, the arbitration shall be heard by a Board composed of five (5) members: The Chairperson, two nominees appointed by the physician or Doctors Manitoba and two nominees appointed by Manitoba Health. At least one of the two nominees for each of Manitoba Health and Doctors Manitoba shall be a physician. The Chairperson shall be selected on a rotating basis from a list of lawyers agreed to by Manitoba Health and Doctors Manitoba. The list of agreed upon Chairpersons may, from time to time, be modified by the agreement of the parties.

All nominees shall be appointed within thirty (30) days of the referral to the Chairperson. If either party fails to name any or all of its appointees to the Board within thirty (30) calendar days the party shall be deemed to have forfeited its right to appoint such nominee and the process shall proceed with a panel of less than five (5).

Where the amount in dispute is $10,000 or less, the dispute shall be heard by the Chairperson acting as a sole arbitrator unless the parties agree otherwise.

No person who has a pecuniary interest in the matter at issue or who is acting or has acted in the past three (3) years as solicitor, counsel, employee, agent, independent contractor or consultant to or on behalf of Manitoba Health or Doctors Manitoba, is eligible for appointment to the Board.

The sole arbitrator or Board constituted hereunder shall have the power to determine its own procedures and shall have the power to receive and accept such evidence and information as it sees fit, whether admissible in a Court of Law or not; and the Board shall give full opportunity to the parties to present evidence, make submissions, and to be heard. The sole arbitrator or Board shall have full remedial authority and shall order such remedy as may be just, but it shall have no authority to amend this Regulation or the provisions of the Physician Services Agreement respecting fee-for-service physicians between the Minister and Doctors Manitoba, or as amended from time to time.

The arbitration award in regard to the specific matter(s) referred to it shall be made within thirty (30) days of completion of the hearing respecting the matter(s), or within such longer period of time as the parties may mutually agree upon.

The decision of a majority of the members of the Board shall be the decision of the Board. In the event the Board consists of an even number of people and a majority decision cannot be rendered by the Board, the decision of the Chairperson shall be the decision of the Board.

Except as provided herein, an arbitration decision is final and binding, and shall not be appealed to or reviewed by any court or removed by certiorari.

Each party shall be responsible for any approved and agreed to costs and expenses of its appointee to such Board and the approved and agreed to costs and expenses of the Chairperson shall be shared equally between the parties.

The time limits specified in the arbitration procedure may be extended by the mutual agreement of the parties.

RULES OF APPLICATION

1—VISIT OR EXAMINATION

A ***Visit or Examination*** is the service by a physician to a patient for diagnosis and/or treatment and may take place in office, home, hospital or elsewhere. A claim for a visit or examination may also be made in exceptional circumstances such as where a third party is involved on a By Report basis.

Discussions (including counseling) with a patient or others concerned (e.g. family) regarding a patient's condition(s) or related matters are included in the patient's visit fee and/or the procedure or treatment carried out on the patient except as otherwise provided for in the Physician's Manual.

If discussions (including counseling) occur during a psychotherapy visit and involve a patient together with a third party, the time charged for the psychotherapy visit should be the total time spent with the patient and the third party and the claims should be made out in the name of the patient.

If the situation with respect to the patient requires a separate visit by a third party–by formal appointment for a minimum of fifteen (15) minutes duration–under exceptional circumstances the physician may charge a separate visit under the patient's name.

Tariffs specifically for discussion (including counseling) such as tariff 8474 "Case Management Conference" and tariff 8473 "Patient Care Family Conference" may be claimed where appropriate in accordance with their rules. See General Schedule Case Management Conference or General Schedule Patient Care Family Conference.

In exceptional circumstances: See Rule 55.

2—SPECIALIST

A ***Specialist*** (for the purposes of application of the Schedule of Benefits) shall be defined as a physician whose name is in the specialist register of The College of Physicians and Surgeons of Manitoba and shall be paid according to the listed benefit in the Schedule of Benefits for that specialty.

A ***Specialist*** is permitted to do and shall be paid for a procedure outside his specialty.

Where there is no "office and hospital visit" page for that specialty or where the procedure has been done by a specialist which is not listed in the "office and hospital visit" page of that specialty, payment will be made according to the general practice schedule except tariffs specifically mentioned elsewhere in the general schedule.

3—SPECIAL CALL/SPECIAL CALL RULE OF APPLICATION 3

Whenever a physician is required to make a special trip, over and above the physician's regular routine, to attend a patient, a ***Special Call*** benefit may be claimed in addition to the benefits listed for assessment and/or procedural medical services (except as listed below). Only one (1) ***Special Call*** per response is applicable.

A ***Special Call*** must be initiated by someone other than the physician (except when services are rendered outside the hospital) and requires the physician to travel from one location to another (not within the same building complex) to attend the patient.

A ***Special Call*** benefit will be paid even if the patient is deceased, on the arrival of the physician called, or, if the patient has left the premises prior to the physician's arrival provided the physician was not unreasonably tardy.

Subject to the Exclusions listed below, all ***Special Call*** benefits may be claimed under the following tariffs:

8561	For special calls made to a patient's home	52.93
8598	For special calls made to the emergency department or O.P.D. of a hospital	54.86
8566	For special calls made in obstetrics	54.86
8567	For special calls made in non-elective surgical cases, in the postoperative period.	54.86
8563	All other special calls not covered under tariffs 8561, 8566, 8567 or 8598 (including, but not limited to, special calls made to personal care homes and to attend to registered hospital patients, subject to Exclusion (a) below) may be claimed under this tariff.	54.86

EXCLUSIONS

Special Call benefits do not apply under the following circumstances:

a) Care to registered hospital patients during the physician's regular daily round.

b) Regularly scheduled daily office appointments.

c) Scheduled N.F.A. medical services.

d) Routine care provided to patients in personal care homes.

e) Scheduled routine in-patient surgical activity.

f) Where the physician is already in the hospital.

g) All elective surgery both pre and postoperative.

h) In obstetrical care, on the day of the performance of an elective caesarean section.

4—COMPLETE HISTORY AND PHYSICAL EXAMINATION

A ***Complete History and Physical Examination*** is a service that will vary from specialty to specialty. In the case of regional specialties, the service may comprise only a full history of the presenting complaint, inquiry concerning and detailed examination of the affected part, region or system, as needed to make a diagnosis, exclude disease and/or assess function, a complete record and advice to the patient. In case of general practitioners, the service is defined with tariff 8540.

5—REGIONAL HISTORY AND EXAMINATION

A ***Regional History and Examination*** is the service rendered to a patient who consults the physician for a condition—usually relatively minor—which does not require as full an assessment as described under "Complete History and Physical Examination."

6—SUBSEQUENT VISIT

A ***Subsequent Visit*** is one that follows either a complete or regional history and examination by the same physician, for the same condition within a period of sixty (60) days; i.e., if the patient has been seen by the same doctor within any sixty (60) day period for the same condition, only a subsequent visit may be claimed for any visit following the initial visit. However, in the case of certain illnesses, for example the continuing management of a chronic illness, when the physician deems it necessary to do a more extensive examination such as a complete physical examination or a regional or a reassessment within the sixty (60) day period, a claim for such a visit may be allowed but only by ***Special Report***.

7—CONSULTATION (AMENDED APRIL 1, 2015)

A ***Consultation*** is the situation in which a physician, registered nurse (extended practice), optometrist, dentist/oral surgeon, or audiologist, after an appropriate examination of the patient, requests in writing the opinion of a consultant physician because:

a) The physician, registered nurse (extended practice), optometrist, dentist/oral surgeon, or audiologist, requires medical advice regarding the diagnosis, prognosis, treatment and/or management of the patient's medical condition; or

b) The patient or the patient's substitute decision maker requests another medical opinion.

Note: *In the case of a request for an opinion from an optometrist, dentist/oral surgeon or audiologist, a consultation may only be claimed where reference is made to optometrists and/or dentists/oral surgeons and/or audiologists in the consultation tariff(s) on the visit page applicable to the claimant.*

8—CONSULTATION (AMENDED OCTOBER 1, 2008)

A ***Consultation*** shall consist of a history and physical examination of the patient regarding the specific medical condition, a review of diagnostic data and the provision of a written opinion with findings and recommendations as to treatment and management of the condition, to the physician, registered nurse (extended practice), optometrist or dentist/oral surgeon who requested the consultation. The consultation may include the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient.

9—TREATMENT/PROCEDURES PERFORMED BY A CONSULTANT (AMENDED OCTOBER 1, 2008)

Where the consultant physician is required to perform any necessary medical services following the consultation, including where those services are performed prior to the patient being returned to the care of the physician, registered nurse (extended practice), optometrist or dental/oral surgeon who requested the consultation, in addition to the fee for the consultation, payment for such medical services shall be made in accordance with the Physician's Manual.

10—SUBSEQUENT CONSULTATIONS (AMENDED OCTOBER 1, 2008)

A consultation in respect to the same patient concerning the same, similar or related medical condition may only be claimed once within a twelve (12) consecutive month period by the same consultant physician.

11—DELETED (OCTOBER 1, 2008)

12—HOSPITAL CARE

Hospital Care applies to the care of registered bed patients formally admitted to hospital, benefits for which are listed on the Visit Pages, and are claimable from the date of admission to the date of medical discharge by the attending physician. Only one (1) visit per day, per patient, will be paid for in-hospital care regardless of the necessity of multiple visits on the same day. Whenever a visit to an in-patient necessitates a special trip, however, as defined in Rule 3, a ***Special Call*** benefit will also apply.

After the date of medical discharge, visits will be claimable on a per visit basis according to the Rules of Application governing chronic care.

13—SUPPORTIVE CARE

Supportive Care is the situation where the responsibility for the medical and surgical care of the patient in hospital has temporarily been transferred from the family or referring doctor to a consultant, but it remains necessary and/or desirable for the family or referring doctor to visit the patient for purposes of reassurance, liaison with the family, etc. The fee for each visit by the referring doctor will be the same as for hospital visits and will be limited to three (3) visits per week. Claims for supportive care will be paid only when a ***Special Report*** is submitted to justify the necessity of this service.

14—CONCOMITANT CARE

Concomitant care may be claimed when:

a) the complexities of the case require the continued attendance of more than one (1) physician, with supplementary skills in different fields of practice, on a patient in hospital, and

b) such care is requested by the referring physician.

Claims for ***Concomitant Care*** are subject to the provisions of Rules 47 and 48.

15—DELETED (APRIL 1, 2005)

16—PERSONAL CARE HOME CARE

Personal Care Home Care is defined as care by a physician of a patient or a resident in a personal care home insured under "*The Manitoba Health Services Insurance Act*."

Visits shall be paid as follows:

a) Benefits listed under tariff 8511 (Chronic Care) in the General Schedule shall apply for a routine visit to a chronic care patient in such an institution to examine, assess or evaluate the patient's condition, and give advice as necessary to the patient and/or the nursing staff concerning management of the patient.

b) A visit to a patient with an "acute illness", which occurs during the physician's routine attendance at the institution, shall be paid as an office visit appropriate to each bloc of practice.

For the purpose of this Rule, "acute illness" is defined as an illness of such a nature that the physician would likely have been requested to make a special trip to visit the patient, were the physician not scheduled for a routine attendance at the institution on the day the illness arises.

For the purpose of this Rule:

i) an illness which is chronic, or

ii) an "acute illness", which has previously been diagnosed by the physician but is not in an acute phase at the time of the subsequent visit, does not qualify as an "acute illness."

A claim for a visit to a patient with an "acute illness," which occurs during a routine attendance at the institution, must include the words "acute illness" as well as a brief explanation of the nature of the illness.

c) When a physician is required to make a special trip to the institution to visit a patient, the visit shall be paid as an office visit appropriate to each bloc of practice, and the appropriate ***Special Call*** benefit shall be paid.

17—Pelvic Examinations (Amended October 1, 2023)

a) A pelvic examination provided to a patient who is not pregnant is usually comprised of the following elements, where indicated:

- Performance of visual inspection of the vulva and perineum;
- Insertion of speculum into the vagina to inspect the vault and cervix;
- Bimanual examination of the uterus and ovaries, and
- Conduction of pelvic-rectal examination.

b) A comprehensive pelvic examination provided to a pregnant patient who is presenting with a concern that may be unrelated to the pregnancy, is usually comprised of the following elements, where indicated:

- Performance of visual inspection of the vulva and perineum;
- Insertion of speculum into the vagina to inspect the vault and cervix;
- Bimanual examination of the uterus;
- Conduction of pelvic-rectal examination.

17(c) - Deleted (October 1, 2023)

17(d) - Deleted (October 1, 2023)

17(e) - Deleted (October 1, 2023)

18—Chronic Care

Chronic Care is defined as care of a patient in the Extended Treatment Unit of a hospital as designated by Manitoba Health.

Where a patient is transferred to a new physician in an extended treatment hospital, the new physician may claim a Complete History and Physical Examination if the service is performed in addition to any other services to which the physician may be entitled.

In surgical cases, where a patient is transferred to an extended care hospital following surgery, the three (3) week postoperative period which applies to the care of the patient by the surgeon does not apply to the physician caring for the patient in the extended care hospital.

Benefits listed for the situations outlined above apply to the physician who will be attending the patient following surgery and do not affect those benefits listed for surgical tariffs. The three (3) week definition will still apply to the surgeon attending the patient during that period.

19—Premature Baby Care

Premature Baby Care is the care of a baby weighing 5 ½ lbs (2500 gms.) or less, at birth, or with a gestational age of less than thirty-seven (37) weeks.

20—CHILD/INFANT/NEWBORN (AMENDED APRIL 1, 2019)

Wherever used in these Rules of Application and Schedule of Benefits ***child***, is defined as a patient who has not reached his/her sixteenth (16^{th}) birthday, excepting where noted otherwise.

Whenever used in these Rules of Application and Schedule of Benefits ***baby*** or ***infant,*** is defined as a patient under two (2) years of age.

Whenever used in these Rules of Application and Schedule of Benefits ***newborn,*** is defined as a patient under 28 days.

SURGICAL RULES

21—ASTERISKED PROCEDURE

A tariff followed by an ***asterisk*** means that the fee is for the procedure alone. The usual management of the case and follow-up care will be paid in addition.

22—INDEPENDENT PROCEDURE

Certain of the listed procedures are commonly carried out as an integral part of a total service, and as such no separate fee should be charged. When such a procedure is carried out as a separate entity, not immediately related to other services, the indicated fee for "independent procedure" is applicable.

23—BENEFITS FOR MAJOR SURGICAL SERVICES

Benefits for Major Surgical Services include three (3) weeks postoperative care (also See Rules 29 and 31). Where the patient's condition requires prolonged hospital care in itself, and where an incidental surgical service is interposed, appropriate hospital care benefits may be claimed but such claims must be accompanied by a ***Special Report***.

24—PREOPERATIVE CARE

Preoperative Care of normal duration after admission to hospital for Elective surgery is included in the benefits listed for the surgical service. Where medical complications/conditions result in unduly long preoperative stay, claims for daily visits up to the time of surgery may be made by ***Special Report*** which must describe the complication, condition and treatment required to justify the delay in the surgery.

25—MULTIPLE SURGICAL SERVICES–SAME INCISION

The fee for ***Multiple Surgical Services***, performed through the same incision by the same surgeon or his/her assistant, utilizing the same anesthetic, shall be paid at 100% for the highest value service and only 75% for the lesser value service(s).

26—MULTIPLE SURGICAL SERVICES–SEPARATE INCISIONS

When two (2) or more **distinct *Surgical Services*** are performed by the same surgeon or his/her assistant, and through separate incisions, but utilizing the same anesthetic, 100% of the fee for the highest value service and only 75% of the fee for the lesser value service(s) shall be paid.

27—MULTIPLE SURGICAL SERVICES PERFORMED BY DIFFERENT SURGEONS

When two or more **distinct *Surgical Services*** are performed through separate incisions, but utilizing the same anesthetic, by two different surgeons in different fields of practice and with different skills, the fee for each service shall be paid at 100%.

28—Bilateral Surgical Services

Fees for ***Bilateral Surgical Services***, performed in separate hospital admissions or at separate operative sessions, will be paid at a 100% of the fee for each side. When performed during the same operative session, utilizing the same anesthetic, 100% of the fee for the first side and 75% of the fee for the second side shall be paid.

29—Additional Surgical Services

Benefits for ***Additional Surgical Services*** which are performed within three (3) weeks of, but not directly related to a preceding surgery, shall be paid at 100% of the fee. Payments for additional surgical services resulting from complications related to the preceding surgery will be based on the nature of the service performed, and its relation to the prior surgery, and on the submission of a ***Special Report***.

30—Two Surgeons

When ***Two Surgeons*** are involved in the management of a surgical case, by prior agreement between the surgeons, the total fee may be apportioned in relation to the responsibility taken and the work done. Each surgeon should send in his/her own claim showing the agreed apportionment to each surgeon.

31—Postoperative Surgical Care

Postoperative Surgical Care is the responsibility of the surgeon. If a postoperative patient is transferred to the care of another physician, that physician may claim for the services rendered, and benefits paid to this physician may be deducted from payment made to the surgeon up to a maximum of 15% of the surgeon's fee.

32—Surgical Assistant

A ***Surgical Assistant*** is defined as a physician who assists the operating surgeon through the duration of the operation. Assistants' benefits will be provided only when medical necessity justifies the need for an assistant in respect to the primary procedure performed during the operation. When a claim is made by a surgical assistant, no additional claim should be made for supportive care by the assistant for the postoperative period. If concomitant care is rendered by the assistant, appropriate claims may be made in addition to that for surgical assistance. In multiple surgical procedures, benefits will be provided to the assistant based on the total of all benefits paid to the principal surgeon (i.e. the total of all benefits for all procedures performed by the principal surgeon throughout the duration of the operation, including those procedures for which there is no medical necessity for the presence of a surgical assistant).

When a second surgical assistant is required, benefits listed in the General Schedule for surgical assistance will also apply to the second assistant, and shall also be based on the total of all benefits paid to the principle surgeon as note above.

33—Obstetrics (Amended April 1, 2019)

a) ***Pre-natal care*** includes a comprehensive pre-natal assessment, follow-up pre-natal visits, which would generally occur at four (4) week intervals to twenty-eight (28) weeks, followed by visits every second week to thirty-six (36) weeks, then weekly until delivery. However, complicated pregnancies may require additional visits.

b) A ***comprehensive pre-natal assessment*** (8400) includes a full patient history, an inquiry into and examination of all relevant parts or systems, a comprehensive pelvic examination, completion of the pre-natal record and advice to the patient. All other pre-natal visits (8401), as well as post-natal visit (8402) include the necessary history, examination, appropriate record and advice to the patient. All pre-natal visits include pregnancy related counselling in the form of providing advice to the patient or the patient's representative(s).

c) The ***comprehensive pre-natal assessment*** (8400) generally should be about 20 minutes or longer in duration. The pre-natal visit (8401), as well as the post-natal visit (8402) generally should be about 10 minutes in duration, otherwise tariff 8509 (General Practice) or 8530 (Obstetrics & Gynaecology) should be claimed.

d) If during the course of the pregnancy the pre-natal care of the patient is transferred from a general practitioner to either a specialist in obstetrics and gynaecology or a general practitioner with additional training in obstetrics, the receiving physician may claim a comprehensive pre-natal assessment (8400) upon the initiation of their care.

e) Other than during the pre-natal or post-natal visit, the physician may charge for all visits for conditions unrelated to the pregnancy, under the appropriate fee items listed elsewhere.

f) A post-natal visit (8402) may only be billed once following delivery. The post-natal period is usually considered as 6 weeks (42 days) following delivery. However, complicated pregnancies may require additional visits which should be claimed under the appropriate office, home or hospital visit tariffs.

g) Necessary laboratory investigations, routine urinalysis and haemoglobin estimations, etc., are payable in addition to the benefits for obstetrical care.

h) Benefits listed under the headings ***Induction of Labour and Management of Complications of Labour*** will be paid in addition to other obstetrical care benefits as outlined in the manual. A physician may claim for more than one complication of the first and second stage of labour.

i) Benefits for complications of the third and fourth stage of labour may be claimed by either the physician who performed the delivery or another physician that is called in specifically for these complications. One or more of tariffs 4843, 4844, 4845, 4846, and 4847 may be claimed.

j) Serious complications that require hospitalization prior to delivery are not included in the benefits provided for obstetrical care. Such complications will be paid for at the scheduled benefits if substantiated by ***Special Report***.

k) If during the course of labour the attending physician calls a consultant to perform the delivery or caesarean section because complications have arisen, the attending physician may claim either tariff 4824, 4825 or 4826, in addition to the pre- and post-natal visits.

34—Fractures

Benefits listed for fractures are intended to include the application of casts, and are for full care for a period of three (3) weeks, but do not include the cost of materials.

35—Fractures Requiring No Reduction

Fees for ***Fractures Requiring No Reduction*** will be provided on a “Fee for Service” (F/S) basis, e.g. visits, application of casts, etc. The fee in these circumstances shall not exceed the fee for closed reduction of the corresponding fracture.

36—Multiple Fractures

For ***Multiple Fractures*** benefits will be based on 100% of the scheduled fee for the major fracture (the one with the highest benefit) plus 100% of those listed for other fracture(s).

In complicated cases with many fractures, lacerations, cut tendons, nerves and arteries, etc., the total benefit should be determined in relation to the work done. Claims for such cases will require a ***Detailed Report*** giving operating details and time, etc.

37—Two Closed Reductions

In cases where ***Two Closed Reductions*** are done for one fracture by different physicians, benefits will be provided at 85% of those listed for the first reduction, as well as 100% of those for the final reduction.

38—Revision of a Closed Reduction

Where a ***Revision of a Closed Reduction*** is required within three (3) weeks of the original reduction by the same physician, claims for the revision will not be paid.

39—Closed Reduction

Where a ***Closed Reduction is Followed By an Open Reduction***, by the same or different physician(s), benefits will be based on 85% of those listed for the closed reduction and 100% of those for the open reduction.

40—Open Reduction is Followed by a Second Open Reduction

Where an ***Open Reduction is Followed by a Second Open Reduction*** by the same physician within the three (3) week period, 100% of the listed benefit will be paid for the first open reduction and 75% for the second reduction. The circumstances of the second requirement must be given by ***Special Report*** to justify this assessment.

41—Compound Fractures

Fees for ***Compound Fractures*** requiring closed reduction may be higher than the fees for simple fractures requiring closed reduction, as shown in the fee schedule.

42—Open Reduction (Amended April 15, 2019)

Open Reduction of compound or closed shaft fractures requiring reconstruction procedures, skin shifts, or with neurovascular damage requiring reconstruction, etc. by the same surgeon, may be provided at a fee greater than the scheduled fee when justified by a ***Special Report***.

An additional 25% of the listed fracture benefit may be claimed by an orthopaedic surgeon for open reduction of a fracture with a demonstrated radiographic non-union after 16 weeks from the date of the initial fracture.

43—Secondary Amputation or Excision

Fees for any ***Secondary Amputation or Excision*** will be provided at 50% of the scheduled fee, unless otherwise specified in the Schedule of Benefits.

44—Dialysis

Benefits for ***Acute Renal Failure*** outlined in the schedule apply to the first four (4) weeks of management, and include the care of such medical complications as septicemia, cannula clotting, cardiac monitoring, mechanically assisted ventilation, etc.

Benefits for surgical procedures such as cannula revision, bronchoscopy and tracheostomy will be paid separately as provided in the schedule. Should dialysis be required beyond four (4) weeks, benefits will be the same as for repeat dialysis for chronic renal failure.

45—Chronic Renal Failure

When patients with ***Chronic Renal Failure*** are admitted for complications, benefits for hospital stay will be the same as for any other medical admission and may be in addition to repeat dialysis.

46—Deputizing

When a doctor knows that they are ***deputizing*** for another doctor and has access to the patient's file and all the information they need to give temporary care to the patient on behalf of their colleague, they should consider their services a continuation of the care and claim for a subsequent visit.

However, should the doctor feel that because they have not the record of the patient or have difficulty in properly assessing the patient, or is confronted with a new problem, a statement from them on the claim card will justify payment for an initial visit as a new patient.

GUIDELINES ON CONCOMITANT CARE

When the complexities of the case require the continued attendance of more than one physician, with supplementary skills in different fields of practice, on a patient in hospital, each doctor may charge fees subject to the following interpretations.

47—CONCOMITANT CARE

That where surgery is performed, concomitant care shall not be charged for the care and treatment of usual or often encountered complications. Such "usual" complications are called minor and include those listed below, and the like. For these complications, the reasonable competence of the doctor is expected and concomitant care should not be expected.

This list is not intended to be exhaustive, but rather to indicate the type of condition on which a charge should not be based.

Complications of the Procedure:

a) Postoperative bleeding

b) Gastrointestinal states; states including nausea and vomiting

c) Postoperative hemorrhagic shock

d) Urinary retention

e) Cerebral edema

Complications of Site of Procedure:

a) Wound infections

b) Wound rupture

Complications of Immobility and Sequelae:

a) Thrombophlebitis

b) Pressure excoriations of skin

c) Bronchitis, pneumonitis

d) Atelectasis

e) Mild diabetic imbalance

48—CONCOMITANT CARE/MAJOR ADDITIONAL DIAGNOSES

That where surgery is performed and where there are "major additional diagnoses" as set out below, and the like, and where the referring doctor requests continued assistance with management of the case, concomitant care fees should equal that of the appropriate visit fee followed by the concomitant care fee.

Fees for concomitant care should be charged for only if the additional physician's services are not within the same field of practice.

The following is a list of complications wherein a doctor of reasonable competence may need assistance in management and where concomitant care could be expected. This list is not intended to be exhaustive but rather to indicate the type of condition on which a charge could be made:

a) Disorders of Consciousness

   i) Cerebro vascular episode—thrombotic, embolic or hemorrhagic

   ii) Associated with electrolytic imbalance

   iii) Associated with shock

iv) Associated with convulsive disorder

b) Pulmonary embolus—attended by shock or heart failure

c) Acute myocardial infarction

d) Cardiac Failure

i) Pulmonary edema

ii) Congestive heart failure

iii) Cardiac arrest

e) Hepatic failure

i) Pre-coma or coma

f) Renal Failure

i) Acute renal failure—renal shutdown

ii) Chronic renal failure

g) Serious cardiac arrhythmias

i) Ventricular tachycardia, atrial flutter

ii) Arial tachycardia with block, heart block, etc.

h) Shock

i) Cardiogenic and bacteremic

i) Septicemia with or without shock

j) Adrenal insufficiency and pituitary insufficiency

k) Diabetes (discovered postop)

i) Balancing after surgery

l) Severe drug reactions or severe reactions to blood transfusions (i.e. associated with anaphylaxis, shock, anemia or renal shutdown)

m) Infections

i) Meningitis

ii) Bacterial endocarditis

n) Respiratory Failure

i) Respiratory acidosis

ii) Respiratory arrest

o) Blood dyscrasis

p) Acute confusional states

q) Total parenteral nutrition (TPN)

r) Psychiatric disorders

If concomitant care is rendered by the surgical assistant, appropriate claims may be made in addition to that for surgical assistance—Rule of Application 32.

49—DELETED (APRIL 1, 2007)

50—DELETED (APRIL 1, 2007

51—DELETED (APRIL 1, 2007)

52—DELETED (APRIL 1, 2007)

53—DELETED (APRIL 1, 2007)

54—DELETED (APRIL 1, 2007)

55—EXTRAORDINARY CIRCUMSTANCE

Notwithstanding the above rules and conditions that apply, extraordinary circumstances will be given special consideration, if substantiated ***By Report***.

56—PROVISIONAL TARIFFS

A tariff preceded by a tilde (~) is a provisional tariff. A provisional tariff means that the particular service is under evaluation for a period of time not to exceed eighteen (18) months from its effective date. Payment for claims shall be made in accordance with the same Rules of Application that apply to permanent tariffs. In addition to the normal requirements for submitting a claim as set out in ***Claims Submission and Payment Procedure—Part III Instructions for Completion of Claim Forms,*** for surgical procedures an operative report and for non-surgical services a descriptive report, including the length of time for the procedure or service, must be submitted with any claim for a provisional tariff. The reports may be reviewed by Manitoba Health and Doctors Manitoba as part of the evaluation of the provisional tariff. At the end of the evaluation period the tariff shall either become a permanent tariff or amended/deleted upon the agreement of Manitoba Health and Doctors Manitoba.

57—MINIMUM FEE UNDER GENERAL ANESTHESIA

The minimum benefit for procedures performed with general anesthesia shall be $72.80 notwithstanding that a lesser benefit or no benefit at all, may be listed for the procedure performed without general anesthetic.

58—REGISTERED NURSE (EXTENDED PRACTICE)

A Registered Nurse (Extended Practice) (for the purposes of application of the Schedule of Benefits) shall be defined as a registered nurse whose name is registered on the register of registered nurses (extended practice) of The College of Registered Nurses of Manitoba.

59—CLINICAL ASSISTANT

A Clinical Assistant or a Physician Assistant (for the purposes of application of the Schedule of Benefits) shall be defined as a clinical assistant or physician assistant whose name is registered in the clinical assistant or physician assistant register of The College of Physicians and Surgeons of Manitoba in accordance with The Regulated Health Professionals Act and its regulations.

60—Head and Neck Surgery (Amended October 1, 2023)

When any two of direct laryngoscopy, esophagoscopy with or without gastro-duodenoscopy, bronchoscopy, nasopharyngoscopy are rendered at the same sitting then both services are payable at 100% of the listed benefit. If any three (3) or more are rendered at the same time sitting service shall be claimed under tariff 2130.

61—Technical Fees

Technical fees are not payable for those services provided in either a hospital setting or publicly funded facility, unless Manitoba Health and Doctors Manitoba have otherwise agreed in writing.

62—Virtual Medicine Visit Services – Definition

1) A Virtual Medicine Visit is a medical service provided to a patient by a physician by telephone or video. Telephone means synchronous audio-only communication (no visualization); and video means 2-way synchronous video-conference (audio and video visualization).

2) For the purposes of claiming Virtual Medicine Visits, continuing patient relationship means:

i) The physician has provided at least one insured service for the patient in the preceding 24 months; or

ii) The patient is on the panel of another physician within the same practice group who has provided at least one insured service to the patient in the preceding 24 months and the physician has access to the patient's electronic medical record; or,

iii) The physician is providing services through a contractual arrangement with Manitoba, a Health Authority or under the Physician Services Agreement including but not limited to Specialist On-Call coverage or coverage of a Rural or Northern ED; or,

iv) The patient has been referred to the physician from another health care provider or health care service in Manitoba; or,

v) The virtual medicine visit is for the purpose of psychiatric care or psychotherapy.

3) Virtual Medicine Visits may be claimed subject to the following:

a) Services must be personally rendered by the physician, i.e., no claim may be made for a virtual medicine visit in which only a physician proxy, e.g., nurse or clerk, participates.

b) Maximum of one virtual visit per patient per day may be claimed.

c) The patient and the physician must both be located in Manitoba at the time of service, except where otherwise authorized by the Provincial CMO or designate.

d) After Hours Premiums may only be claimed when there is a continuing patient relationship as described above and the visit is an urgent or emergent service.

e) Medical services provided must be documented and such documentation may be requested by Manitoba, to support the claim submitted.

f) Geographical fee differentials shall apply in addition. The geographical fee differential shall be determined by the average of the fee differential applicable to the patient's location and applicable to the physician's location.

g) Where, during the course of the virtual visit, it is determined an in-patient assessment is necessary, the physician may bill a Basic or Intermediate virtual visit as appropriate. The subsequent in person visit may be billed at the appropriate in-person examination tariff in addition.

63— VISIT ON THE SAME DAY OF PROCEDURE

Where a visit has been provided in the previous 90 days, a visit may only be claimed on the same day as a procedure, by the same physician, for the same diagnosis, without the requirement for a Special Report as per rule of application 24, in circumstances where:

1) The visit on the day of procedure occurs in an emergency room or urgent care centre; or
2) The patient is less than 16 years of age; or
3) The procedure is related to cancer treatment or surveillance; or
4) The procedure is not pre-scheduled; or
5) The procedure is an asterisked procedure.

For greater certainty, “visit” includes all in-person assessments on the visit pages including extended visits, complete examinations, and regional visits.

ANESTHESIA

See Section C Anesthesia.

VISITS/EXAMINATIONS—INTERNAL MEDICINE (01)

These benefits cannot be correctly interpreted without reference to the Rules of Application.[1]

OFFICE, HOME VISITS

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time 134.92

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination.....112.42

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time 86.16

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6.....71.80

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty (30) minutes of patient/physician contact time 70.86

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8403 Regional History and Examination or Subsequent Visit.....59.05

[1] The above tariffs and benefits can also be claimed by those physicians who are Fellows of the Royal College of Physicians and Surgeons of Canada in Community Medicine and whose names are on the specialist register of The College of Physicians and Surgeons of Manitoba (Rule 2).

8626 Extended Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10–
Child minimum of forty-five (45) minutes of patient/physician contact time 221.94

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10 ..... 184.96

8416 Midwifery Assessment & Report—See General Schedule

CONTINUING PATIENT CARE MANAGEMENT BY MEDICAL SPECIALISTS

8700 Continuing patient care management, supplement add to visit fee..... 30.00

Notes: *1) May be claimed in addition to an in-person visit tariff excluding consultations.*

2) Maximum of four (4) supplements may be claimed per patient per 12-month period.

3) Patient must have an established diagnosis of one or more of the following diseases. The applicable ICD codes are available for review here.

i. Advanced HIV
ii. HIV with opportunistic infection
iii. HIV in pregnancy
iv. Diabetes mellitus, including complications
v. Coagulation defects (e.g., haemophillia, other deficiencies)
vi. Purpura, thrombocytopenia, other haemorrhagic conditions
vii. Senile dementia, presenile dementia
viii. Child psychoses or autism
ix. Parkinson's Disease
x. Multiple Sclerosis
xi. Cerebral Palsy
xii. Epilepsy
xiii. Chronic Bronchitis
xiv. Emphysema
xv. Asthma, Allergic Bronchitis
xvi. Pulmonary Fibrosis
xvii. Regional Enteritis; Crohn's Disease
xviii. Ulcerative Colitis
xix. Cirrhosis of the Liver
xx. Chronic Renal Failure, Uremia
xxi. Systemic Lupus Erythematosus
xxii. Inflammatory Myositis
xxiii. Complex Psoriasis
xxiv. Vasculitis
xxv. Scleroderma
xxvi. Sarcoidosis
xxvii. Rheumatoid Arthritis

xxviii. *Adult Onset Still's Disease*
xxix. *Systemic Juvenile Inflammatory Arthritis*
xxx. *Ankylosing Spondylitis*
xxxi. *Psoriatic Arthritis*
xxxii. *Reactive Arthritis*
xxxiii. *Enteropathic Arthritis*

VIRTUAL VISITS

8340 Episodic virtual visit by phone.....20.40

8321 Virtual visit by telephone or video.....59.05

8535 Virtual consultation by telephone or video.....184.96

8447 Comprehensive Virtual Assessment by telephone or video.....112.42

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time.....134.92

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination.....112.42

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time.....86.16

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 71.80

8626 Extended Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10–
Child minimum of forty-five (45) minutes of patient/physician contact time 221.94

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10 ..... 184.96

8664 Extended Consultation—Unassigned Patient–Child minimum of forty-five (45)
minutes of patient/physician contact time 276.13

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8595 Consultation—Unassigned Patient 230.10

Note: *"Unassigned Patient" means a patient who requires assessment by an Internal Medicine Specialist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 10 inclusive apply.*

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty
(30) minutes of patient/physician contact time 70.86

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8510 Regional History Examination, or Subsequent Visit 74.08

8520 Hospital Care—per day 42.92

8526 Clinical Teaching Unit (CTU) patient care supplement–per day 41.22

Note: *1) May be claimed by the CTU attending physician for each patient admitted to a CTU designated by Manitoba Health.*

2) Tariff 8520 and/or other applicable visit/examination services are payable in addition.

CONCOMITANT CARE

8524 Concomitant Care—per day.....42.92

CHRONIC CARE—SEE GENERAL SCHEDULE

NEUROLOGY (01-1)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time 127.18

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination 105.98

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time 86.82

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 72.37

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty (30) minutes of patient/physician contact time 70.02

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8403 Regional History and Examination or Subsequent Visit 58.37

8492 Comprehensive Cognitive Assessment 231.88

Note: *This assessment includes the following:*

- *Extensive testing, direct patient contact (minimum 1 ½ hours).*
- *Interpretation of tests (minimum ½ hour) and report to referring physician.*

8494 Follow–up Comprehensive Cognitive Assessment 115.96

- *Reassessment and retesting, behavioural function tests.*
- *Six (6) to twelve (12) months after 8492.*

Note: *A consultation or other visit fee may be claimed in addition to 8492 or 8494 on the same day.*

8626 Extended Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10–
Child minimum of forty-five (45) minutes of patient/physician contact time.....235.05

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation (including by Dentist/Oral Surgeon or by Optometrist)—See Rules 7 to 10 .....195.87

CONTINUING PATIENT CARE MANAGEMENT BY MEDICAL SPECIALISTS

8700 Continuing patient care management, supplement add to visit fee 30.00

Notes: *1) May be claimed in addition to an in-person visit tariff excluding consultations.*

2) Maximum of four (4) supplements may be claimed per patient per 12-month period.

3) Patient must have an established diagnosis of one or more of the following diseases. The applicable ICD codes are available for review here.

i. Advanced HIV
ii. HIV with opportunistic infection
iii. HIV in pregnancy
iv. Diabetes mellitus, including complications
v. Coagulation defects (e.g., haemophillia, other deficiencies)
vi. Purpura, thrombocytopenia, other haemorrhagic conditions
vii. Senile dementia, presenile dementia
viii. Child psychoses or autism
ix. Parkinson's Disease
x. Multiple Sclerosis
xi. Cerebral Palsy
xii. Epilepsy
xiii. Chronic Bronchitis
xiv. Emphysema
xv. Asthma, Allergic Bronchitis
xvi. Pulmonary Fibrosis
xvii. Regional Enteritis; Crohn's Disease
xviii. Ulcerative Colitis
xix. Cirrhosis of the Liver
xx. Chronic Renal Failure, Uremia
xxi. Systemic Lupus Erythematosus

xxii. *Inflammatory Myositis*
xxiii. *Complex Psoriasis*
xxiv. *Vasculitis*
xxv. *Scleroderma*
xxvi. *Sarcoidosis*
xxvii. *Rheumatoid Arthritis*
xxviii. *Adult Onset Still's Disease*
xxix. *Systemic Juvenile Inflammatory Arthritis*
xxx. *Ankylosing Spondylitis*
xxxi. *Psoriatic Arthritis*
xxxii. *Reactive Arthritis*
xxxiii. *Enteropathic Arthritis*

VIRTUAL VISITS

8340 Episodic virtual visit by phone 20.40

8321 Virtual visit by telephone or video 58.37

8535 Virtual consultation by telephone or video..... 195.87

8447 Comprehensive Virtual Assessment by telephone or video 105.98

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time 127.18

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination 105.98

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time..... 86.82

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 72.37

8626 Extended Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10–
Child minimum of forty-five (45) minutes of patient/physician contact time 235.05

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation (including by Dentist/Oral Surgeon or by Optometrist)—See Rules 7 to 10 ..... 195.87

8664 Extended Consultation—Unassigned Patient–Child minimum of forty-five (45) minutes of patient/physician contact time 291.09

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8595 Consultation—Unassigned Patient 242.56

Note: *"Unassigned Patient" means a patient who requires assessment by a Neurologist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 10 inclusive apply.*

8490 Initial Assessment of patient with hyperacute stroke symptoms and/or signs 331.25

Note: *1) Includes determination of the hyperacute stroke period and recommendation with regard to the administration of tPA and/ or interventional endovascular therapy (EVT).*

2) Includes a review of CT scan/Radiologist report and/or other diagnostic tests as appropriate.

3) *Tariff rate payable for the first thirty (30) minute period. After thirty (30) minutes tariffs 8573 and 8574 may be claimed.*

4) *May not be claimed in addition to 8550, 8595, 8540, 8480 or 8551 on the same day.*

5) *Tariff 8510 may be claimed on the same day, same patient, where the physician is required to return to provide additional assessments.*

6) *The time of service must be submitted on the claim.*

8551 Assessment of a patient with hyper-acute stroke for consideration of interventional endovascular therapy (EVT)..... 327.96

Note: 1) *Tariff 8551 may only be claimed by a neurologist who performs an assessment on a patient who has been transported from another hospital to HSC, and who has already had an initial hyper-acute stroke assessment (tariff 8490 or 8485).*

2) *Includes verification of the hyper-acute stroke period and recommendation with regard to the interventional EVT.*

3) *The Neurologist must be available at the time of patient arrival and provide rapid clinical assessment on arrival, determination if further imaging is needed, assessment of imaging as required, managing patient care, and disposition post computed tomography angiography (CTA) and/or post EVT.*

4) *Includes review of CT scan/Radiologist report and/or other diagnostic tests as appropriate.*

5) *May not be claimed in addition to 8550, 8595, 8540, 8480 or 8490 on the same day.*

6) *Tariff 8510 may be claimed on the same day same patient, where the physician is required to return to provide additional assessment.*

7) *Tariff 8490 may not be claimed for the same patient on the same day by another physician at the same facility.*

8) *Tariff 8551 is payable for the first thirty (30) minutes. After thirty (30) minutes tariffs 8573 and 8574 may be claimed. The time of service must be submitted on the claim.*

9) *Maximum one tariff 8551 may be claimed per patient per day.*

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty (30) minutes of patient/physician contact time..... 70.02

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8510 Regional History and Examination, or Subsequent Visit 67.32

8520 Hospital Care—per day 45.52

CONCOMITANT CARE

8524 Concomitant Care—per day.....45.52

CHRONIC CARE—SEE GENERAL SCHEDULE

GERIATRIC MEDICINE (01-2)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time 146.19

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination 121.84

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time 99.37

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 82.82

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty (30) minutes of patient/physician contact time 86.16

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8403 Regional History and Examination or Subsequent Visit 71.80

8620 Extended Consultation—(including requests by Geriatric Program Assessment Team GPAT)—See Rules 7 to 10–minimum of forty-five (45) minutes of patient/physician contact time 271.09

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.*

8550 Consultation (including requests by Geriatric Program Assessment Team GPAT)—See Rules 7 to 10.....225.88

8436 Geriatric Social Interview 52.87

A Geriatric Social Interview is defined as an interview by a Geriatrician with an individual who has close knowledge of, or association with, a patient.

Note:

1) The person being interviewed may include, but is not limited to, a spouse, member of the family, community nurse, teacher, member of the clergy or social worker.

2) Tariff rate is payable for the first full fifteen (15) minutes and for each additional fifteen (15) minutes or major portion thereof. The start and end time of the interview must be denoted on the patient chart and the medical claim.

3) Interview must be on a one-to-one basis between the Geriatrician and the person being interviewed, and must take place in person, except in circumstances described in note 9. The patient shall not be present during the interview.

4) The tariff must be billed in the name of the patient. The Geriatrician must document the name of the person interviewed and their knowledge of, or association with, the patient.

5) Maximum one (1) hour may be claimed per interview.

6) Maximum of four (4) hours per patient may be claimed within any twelve (12) month period.

7) Additional Geriatric Social Interviews may be claimed by written report.

8) Tariff 8436 may be billed for interviews conducted by the Geriatrician, by telephone, in circumstances where all of the following conditions are met:

a) The patient is experiencing a health crisis, and has presented to an emergency department, hospital, or mental health facility that is designated by Manitoba for the purposes of claiming this tariff; and,

b) Timely communication with the family member or close acquaintances is essential to the patient care and/or management; and,

c) The location or mobility factors of interviewees at the time of the call preclude in-person meetings (these circumstances must be denoted in the patient chart); and,

d) The purpose of the interview is not to relay lab or diagnostic results.

9) *Tariff 8436 may be claimed only by a physician holding certification as a Geriatrician with the Royal College of Physicians and Surgeons of Canada or as designated by the Internal Medicine Program Lead.*

8614 Interpretation of comprehensive cognitive assessment results (minimum ½ hour of physician time) and reporting to referring physician. May be claimed in addition to a visit tariff 104.05

8615 Geriatric Specialty Support–initiated by an allied health professional or another physician requesting advice regarding a complex or comorbid geriatric condition, which is provided by the Geriatrician on a priority basis within twelve (12) hours by telephone for a patient under geriatric care, per fifteen (15) minutes or major portion thereof, maximum of thirty (30) minutes 36.88

Note: 1) *The Geriatrician must document the service, including the time when the advice was requested, and the time the call was made.*

2) *A maximum of seventy-five (75) minutes are claimable per patient per week.*

3) *Tariffs 8000 and 8001 may not be claimed for the same patient during the same day as 8615.*

CONTINUING PATIENT CARE MANAGEMENT BY MEDICAL SPECIALISTS

8700 Continuing patient care management, supplement add to visit fee..... 30.00

Notes: 1) *May be claimed in addition to an in-person visit tariff excluding consultations.*

2) *Maximum of four (4) supplements may be claimed per patient per 12-month period.*

3) *Patient must have an established diagnosis of one or more of the following diseases. The applicable ICD codes are available for review here.*

i. *Advanced HIV*
ii. *HIV with opportunistic infection*
iii. *HIV in pregnancy*
iv. *Diabetes mellitus, including complications*
v. *Coagulation defects (e.g., haemophillia, other deficiencies)*
vi. *Purpura, thrombocytopenia, other haemorrhagic conditions*
vii. *Senile dementia, presenile dementia*
viii. *Child psychoses or autism*
ix. *Parkinson's Disease*
x. *Multiple Sclerosis*
xi. *Cerebral Palsy*
xii. *Epilepsy*
xiii. *Chronic Bronchitis*
xiv. *Emphysema*
xv. *Asthma, Allergic Bronchitis*
xvi. *Pulmonary Fibrosis*
xvii. *Regional Enteritis; Crohn's Disease*
xviii. *Ulcerative Colitis*
xix. *Cirrhosis of the Liver*
xx. *Chronic Renal Failure, Uremia*
xxi. *Systemic Lupus Erythematosus*
xxii. *Inflammatory Myositis*

xxiii. *Complex Psoriasis*
xxiv. *Vasculitis*
xxv. *Scleroderma*
xxvi. *Sarcoidosis*
xxvii. *Rheumatoid Arthritis*
xxviii. *Adult Onset Still's Disease*
xxix. *Systemic Juvenile Inflammatory Arthritis*
xxx. *Ankylosing Spondylitis*
xxxi. *Psoriatic Arthritis*
xxxii. *Reactive Arthritis*
xxxiii. *Enteropathic Arthritis*

VIRTUAL VISITS

8340 Episodic virtual visit by phone.....20.40

8321 Virtual visit by telephone or video.....71.80

8535 Virtual consultation by telephone or video.....225.88

8447 Comprehensive Virtual Assessment by telephone or video.....121.84

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time.....146.19

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination.....121.84

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time 99.37

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 82.82

8620 Extended Consultation—(including requests by Geriatric Program Assessment Team GPAT)—See Rules 7 to 10–minimum of forty-five (45) minutes of patient/physician contact time 271.09

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.*

8550 Consultation (including requests by Geriatric Program Assessment Team GPAT)—See Rules 7 to 10 ..... 225.88

8436 Geriatric Social Interview 52.87

A Geriatric Social Interview is defined as an interview by a Geriatrician with an individual who has close knowledge of, or association with, a patient.

Note:

1) *The person being interviewed may include, but is not limited to, a spouse, member of the family, community nurse, teacher, member of the clergy or social worker.*

2) *Tariff rate is payable for the first full fifteen (15) minutes and for each additional fifteen (15) minutes or major portion thereof. The start and end time of the interview must be denoted on the patient chart and the medical claim.*

3) *Interview must be on a one-to-one basis between the Geriatrician and the person being interviewed, and must take place in person, except in circumstances described in note 9. The patient shall not be present during the interview.*

4) *The tariff must be billed in the name of the patient. The Geriatrician must document the name of the person interviewed and their knowledge of, or association with, the patient.*

5) *Maximum one (1) hour may be claimed per interview.*

6) *Maximum of four (4) hours per patient may be claimed within any twelve (12) month period.*

7) *Additional Geriatric Social Interviews may be claimed by written report.*

8) *Tariff 8436 may be billed for interviews conducted by the Geriatrician, by telephone, in circumstances where all of the following conditions are met:*

a) *The patient is experiencing a health crisis, and has presented to an emergency department, hospital, or mental health facility that is designated by Manitoba for the purposes of claiming this tariff; and,*

b) *Timely communication with the family member or close acquaintances is essential to the patient care and/or management; and,*

c) *The location or mobility factors of interviewees at the time of the call preclude in-person meetings (these circumstances must be denoted in the patient chart); and,*

d) *The purpose of the interview is not to relay lab or diagnostic results.*

9) *Tariff 8436 may be claimed only by a physician holding certification as a Geriatrician with the Royal College of Physicians and Surgeons of Canada or as designated by the Internal Medicine Program Lead.*

8614 Interpretation of comprehensive cognitive assessment results (minimum ½ hour of physician time) and reporting to referring physician. May be claimed in addition to a visit tariff.....104.05

8615 Geriatric Specialty Support–initiated by an allied health professional or another physician requesting advice regarding a complex or comorbid geriatric condition, which is provided by the Geriatrician on a priority basis within twelve (12) hours by telephone for a patient under geriatric care, per fifteen (15) minutes or major portion thereof, maximum of thirty (30) minutes 36.88

Note: 1) *The Geriatrician must document the service, including the time when the advice was requested, and the time the call was made.*

2) *A maximum of seventy-five (75) minutes are claimable per patient per week.*

3) *Tariffs 8000 and 8001 may not be claimed for the same patient during the same day as 8615.*

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty (30) minutes of patient/physician contact time.....86.16

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8510 Regional History and Examination, or Subsequent Visit 77.31

8520 Hospital Care—per day.....55.60

CONCOMITANT CARE

8524 Concomitant Care—per day.....55.60

CHRONIC CARE—SEE GENERAL SCHEDULE

RHEUMATOLOGY MEDICINE (01-3)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time 134.92

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination 112.42

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time 87.40

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 72.84

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty (30) minutes of patient/physician contact time 64.35

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8403 Regional History and Examination or Subsequent Visit 53.62

8626 Extended Consultation—See Rules 7 to 10–Child minimum of forty-five (45) minutes of patient/physician contact time 233.63

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation—See Rules 7 to 10.....194.68

CONTINUING PATIENT CARE MANAGEMENT BY MEDICAL SPECIALISTS

8700 Continuing patient care management, supplement add to visit fee 30.00

Notes: *1) May be claimed in addition to an in-person visit tariff excluding consultations.*

2) Maximum of four (4) supplements may be claimed per patient per 12-month period.

3) Patient must have an established diagnosis of one or more of the following diseases. The applicable ICD codes are available for review here.

i. Advanced HIV
ii. HIV with opportunistic infection
iii. HIV in pregnancy
iv. Diabetes mellitus, including complications
v. Coagulation defects (e.g., haemophillia, other deficiencies)
vi. Purpura, thrombocytopenia, other haemorrhagic conditions
vii. Senile dementia, presenile dementia
viii. Child psychoses or autism
ix. Parkinson's Disease
x. Multiple Sclerosis
xi. Cerebral Palsy
xii. Epilepsy
xiii. Chronic Bronchitis
xiv. Emphysema
xv. Asthma, Allergic Bronchitis
xvi. Pulmonary Fibrosis
xvii. Regional Enteritis; Crohn's Disease
xviii. Ulcerative Colitis
xix. Cirrhosis of the Liver
xx. Chronic Renal Failure, Uremia
xxi. Systemic Lupus Erythematosus
xxii. Inflammatory Myositis
xxiii. Complex Psoriasis
xxiv. Vasculitis
xxv. Scleroderma
xxvi. Sarcoidosis
xxvii. Rheumatoid Arthritis
xxviii. Adult Onset Still's Disease
xxix. Systemic Juvenile Inflammatory Arthritis
xxx. Ankylosing Spondylitis
xxxi. Psoriatic Arthritis
xxxii. Reactive Arthritis
xxxiii. Enteropathic Arthritis

VIRTUAL VISITS

8340 Episodic virtual visit by phone 20.40

8321 Virtual visit by telephone or video 53.62

8535 Virtual consultation by telephone or video..... 194.68

8447 Comprehensive Virtual Assessment by telephone or video 112.42

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time 134.92

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination 112.42

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time..... 87.40

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 72.84

8626 Extended Consultation—See Rules 7 to 10–Child minimum of forty-five (45) minutes of patient/physician contact time 233.63

Note: *1) Patient must be under eighteen (18) years of age.*

2) *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.*

8550 Consultation—See Rules 7 to 10 ..... 194.68

8664 Extended Consultation—Unassigned Patient–Child minimum of forty-five (45) minutes of patient/physician contact time 290.65

Note: 1) *Patient must be under eighteen (18) years of age.*

2) *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.*

8595 Consultation—Unassigned Patient 242.22

Note: *"Unassigned Patient" means a patient who requires assessment by a Rheumatologist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 10 inclusive apply.*

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty (30) minutes of patient/physician contact time 64.35

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8510 Regional History and Examination, or Subsequent Visit 61.80

8520 Hospital Care—per day 42.82

8526 Clinical Teaching Unit (CTU) patient care supplement–per day 25.76

Note: 1) *May be claimed by the CTU attending physician for each patient admitted to a CTU designated by Manitoba Health.*

2) *Tariff 8520 and/or other applicable visit/examination services are payable in addition.*

CONCOMITANT CARE

8524 Concomitant Care—per day 42.82

CHRONIC CARE—SEE GENERAL SCHEDULE

CARDIOLOGY (01-4)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time 114.47

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination.....95.41

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time 97.33

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6.....81.09

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty (30) minutes of patient/physician contact time 72.05

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8403 Regional History and Examination or Subsequent Visit.....60.05

8626 Extended Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10–
Child minimum of forty-five (45) minutes of patient/physician contact time 217.23

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10 ..... 181.04

CONTINUING PATIENT CARE MANAGEMENT BY MEDICAL SPECIALISTS

8700 Continuing patient care management, supplement add to visit fee..... 30.00

Notes: *1) May be claimed in addition to an in-person visit tariff excluding consultations.*

2) Maximum of four (4) supplements may be claimed per patient per 12-month period.

3) Patient must have an established diagnosis of one or more of the following diseases. The applicable ICD codes are available for review here.

i. Advanced HIV
ii. HIV with opportunistic infection
iii. HIV in pregnancy
iv. Diabetes mellitus, including complications
v. Coagulation defects (e.g., haemophillia, other deficiencies)
vi. Purpura, thrombocytopenia, other haemorrhagic conditions
vii. Senile dementia, presenile dementia
viii. Child psychoses or autism
ix. Parkinson's Disease
x. Multiple Sclerosis
xi. Cerebral Palsy
xii. Epilepsy
xiii. Chronic Bronchitis
xiv. Emphysema
xv. Asthma, Allergic Bronchitis
xvi. Pulmonary Fibrosis
xvii. Regional Enteritis; Crohn's Disease
xviii. Ulcerative Colitis
xix. Cirrhosis of the Liver
xx. Chronic Renal Failure, Uremia
xxi. Systemic Lupus Erythematosus
xxii. Inflammatory Myositis
xxiii. Complex Psoriasis
xxiv. Vasculitis
xxv. Scleroderma
xxvi. Sarcoidosis
xxvii. Rheumatoid Arthritis
xxviii. Adult Onset Still's Disease
xxix. Systemic Juvenile Inflammatory Arthritis

xxx. *Ankylosing Spondylitis*
xxxi. *Psoriatic Arthritis*
xxxii. *Reactive Arthritis*
xxxiii. *Enteropathic Arthritis*

VIRTUAL VISITS

8340 Episodic virtual visit by phone 20.40

8321 Virtual visit by telephone or video 60.05

8535 Virtual consultation by telephone or video 181.04

8447 Comprehensive Virtual Assessment by telephone or video 95.41

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time 114.47

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination 95.41

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time 97.33

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 81.09

8626 Extended Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10–
Child minimum of forty-five (45) minutes of patient/physician contact time 217.23

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10 ..... 181.04

8664 Extended Consultation—Unassigned Patient–Child minimum of forty-five (45)
minutes of patient/physician contact time 266.03

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8595 Consultation—Unassigned Patient 221.68

Note: *"Unassigned Patient" means a patient who requires assessment by a Cardiologist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 10 inclusive apply.*

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty
(30) minutes of patient/physician contact time 72.05

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8510 Regional History and Examination, or Subsequent Visit 72.05

8520 Hospital Care—per day 57.10

8526 Clinical Teaching Unit (CTU) patient care supplement–per day 26.01

Note: *1) May be claimed by the CTU attending physician for each patient admitted to a CTU designated by Manitoba Health.*

2) Tariff 8520 and/or other applicable visit/examination services are payable in addition.

CONCOMITANT CARE

8524 Concomitant Care—per day.....57.10

CHRONIC CARE—SEE GENERAL SCHEDULE

GASTROENTEROLOGY (01-5)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time 107.84

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination 89.87

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time 81.03

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 67.50

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty (30) minutes of patient/physician contact time 72.07

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8403 Regional History and Examination or Subsequent Visit 60.06

8626 Extended Consultation—See Rules 7 to 10–Child minimum of forty-five (45) minutes of patient/physician contact time 220.04

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation—See Rules 7 to 10.....183.38

CONTINUING PATIENT CARE MANAGEMENT BY MEDICAL SPECIALISTS

8700 Continuing patient care management, supplement add to visit fee 30.00

Notes: *1) May be claimed in addition to an in-person visit tariff excluding consultations.*

2) Maximum of four (4) supplements may be claimed per patient per 12-month period.

3) Patient must have an established diagnosis of one or more of the following diseases. The applicable ICD codes are available for review here.

i. Advanced HIV
ii. HIV with opportunistic infection
iii. HIV in pregnancy
iv. Diabetes mellitus, including complications
v. Coagulation defects (e.g., haemophillia, other deficiencies)
vi. Purpura, thrombocytopenia, other haemorrhagic conditions
vii. Senile dementia, presenile dementia
viii. Child psychoses or autism
ix. Parkinson's Disease
x. Multiple Sclerosis
xi. Cerebral Palsy
xii. Epilepsy
xiii. Chronic Bronchitis
xiv. Emphysema
xv. Asthma, Allergic Bronchitis
xvi. Pulmonary Fibrosis
xvii. Regional Enteritis; Crohn's Disease
xviii. Ulcerative Colitis
xix. Cirrhosis of the Liver
xx. Chronic Renal Failure, Uremia
xxi. Systemic Lupus Erythematosus
xxii. Inflammatory Myositis
xxiii. Complex Psoriasis
xxiv. Vasculitis
xxv. Scleroderma
xxvi. Sarcoidosis
xxvii. Rheumatoid Arthritis
xxviii. Adult Onset Still's Disease
xxix. Systemic Juvenile Inflammatory Arthritis
xxx. Ankylosing Spondylitis
xxxi. Psoriatic Arthritis
xxxii. Reactive Arthritis
xxxiii. Enteropathic Arthritis

VIRTUAL VISITS

8340 Episodic virtual visit by phone 20.40

8321 Virtual visit by telephone or video 60.06

8535 Virtual consultation by telephone or video 183.38

8447 Comprehensive Virtual Assessment by telephone or video 89.87

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time 107.84

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination 89.87

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time 81.03

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 67.50

8626 Extended Consultation—See Rules 7 to 10–Child minimum of forty-five (45) minutes of patient/physician contact time 220.04

Note: *1) Patient must be under eighteen (18) years of age.*

2) *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.*

8550 Consultation—See Rules 7 to 10 ..... 183.38

8664 Extended Consultation—Unassigned Patient–Child minimum of forty-five (45) minutes of patient/physician contact time 271.53

Note: 1) *Patient must be under eighteen (18) years of age.*

2) *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.*

8595 Consultation—Unassigned Patient 226.28

Note: *"Unassigned Patient" means a patient who requires assessment by a Gastroenterologist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 10 inclusive apply.*

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty (30) minutes of patient/physician contact time 72.07

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8510 Regional History and Examination, or Subsequent Visit 67.50

8520 Hospital Care—per day 45.30

8526 Clinical Teaching Unit (CTU) patient care supplement–per day 25.76

Note: 1) *May be claimed by the CTU attending physician for each patient admitted to a CTU designated by Manitoba Health.*

2) *Tariff 8520 and/or other applicable visit/examination services are payable in addition.*

CONCOMITANT CARE

8524 Concomitant Care—per day 45.30

CHRONIC CARE—SEE GENERAL SCHEDULE

NEPHROLOGY (01-6)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time 141.41

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination.....117.83

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time 92.36

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6.....76.96

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty (30) minutes of patient/physician contact time 92.35

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8403 Regional History and Examination or Subsequent Visit.....76.95

8626 Extended Consultation—See Rules 7 to 10–Child minimum of forty-five (45) minutes of patient/physician contact time 237.23

Note: *1) Patient must be under eighteen (18) years of age.*

2) *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.*

8550 Consultation—See Rules 7 to 10 ..... 197.70

CONTINUING PATIENT CARE MANAGEMENT BY MEDICAL SPECIALISTS

8700 Continuing patient care management, supplement add to visit fee 30.00

Notes: 1) *May be claimed in addition to an in-person visit tariff excluding consultations.*

2) *Maximum of four (4) supplements may be claimed per patient per 12-month period.*

3) *Patient must have an established diagnosis of one or more of the following diseases. The applicable ICD codes are available for review here.*

i. *Advanced HIV*
ii. *HIV with opportunistic infection*
iii. *HIV in pregnancy*
iv. *Diabetes mellitus, including complications*
v. *Coagulation defects (e.g., haemophillia, other deficiencies)*
vi. *Purpura, thrombocytopenia, other haemorrhagic conditions*
vii. *Senile dementia, presenile dementia*
viii. *Child psychoses or autism*
ix. *Parkinson's Disease*
x. *Multiple Sclerosis*
xi. *Cerebral Palsy*
xii. *Epilepsy*
xiii. *Chronic Bronchitis*
xiv. *Emphysema*
xv. *Asthma, Allergic Bronchitis*
xvi. *Pulmonary Fibrosis*
xvii. *Regional Enteritis; Crohn's Disease*
xviii. *Ulcerative Colitis*
xix. *Cirrhosis of the Liver*
xx. *Chronic Renal Failure, Uremia*
xxi. *Systemic Lupus Erythematosus*
xxii. *Inflammatory Myositis*
xxiii. *Complex Psoriasis*
xxiv. *Vasculitis*
xxv. *Scleroderma*
xxvi. *Sarcoidosis*
xxvii. *Rheumatoid Arthritis*
xxviii. *Adult Onset Still's Disease*
xxix. *Systemic Juvenile Inflammatory Arthritis*
xxx. *Ankylosing Spondylitis*
xxxi. *Psoriatic Arthritis*
xxxii. *Reactive Arthritis*
xxxiii. *Enteropathic Arthritis*

VIRTUAL VISITS

8340 Episodic virtual visit by phone 20.40

8321 Virtual visit by telephone or video 76.95

8535 Virtual consultation by telephone or video 197.70

8447 Comprehensive Virtual Assessment by telephone or video 117.83

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time 141.41

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination 117.83

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time 92.36

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 76.96

8626 Extended Consultation—See Rules 7 to 10–Child minimum of forty-five (45) minutes of patient/physician contact time 237.23

Note: *1) Patient must be under eighteen (18) years of age.*

2) *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.*

8550 Consultation—See Rules 7 to 10 ..... 197.70

8664 Extended Consultation—Unassigned Patient–Child minimum of forty-five (45) minutes of patient/physician contact time 295.64

Note: 1) *Patient must be under eighteen (18) years of age.*

2) *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.*

8595 Consultation—Unassigned Patient 246.37

Note: *"Unassigned Patient" means a patient who requires assessment by a Nephrologist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months Rules of Application 7 to 10 inclusive apply.*

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty (30) minutes of patient/physician contact time 92.35

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8510 Regional History and Examination, or Subsequent Visit 76.95

8520 Hospital Care—per day 53.69

8526 Clinical Teaching Unit (CTU) patient care supplement–per day 41.22

Note: 1) *May be claimed by the CTU attending physician for each patient admitted to a CTU designated by Manitoba Health.*

2) *Tariff 8520 and/or other applicable visit/examination services are payable in addition.*

CONCOMITANT CARE

8524 Concomitant Care—per day 53.69

CHRONIC CARE—SEE GENERAL SCHEDULE

ALLERGY & CLINICAL IMMUNOLOGY (01-7)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time 135.35

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination 112.78

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time 85.78

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 71.48

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty (30) minutes of patient/physician contact time 70.54

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8403 Regional History and Examination or Subsequent Visit 58.79

8626 Extended Consultation—See Rules 7 to 10–Child minimum of forty-five (45) minutes of patient/physician contact time 222.83

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation—See Rules 7 to 10.....185.68

CONTINUING PATIENT CARE MANAGEMENT BY MEDICAL SPECIALISTS

8700 Continuing patient care management, supplement add to visit fee 30.00

Notes: *1) May be claimed in addition to an in-person visit tariff excluding consultations.*

2) Maximum of four (4) supplements may be claimed per patient per 12-month period.

3) Patient must have an established diagnosis of one or more of the following diseases. The applicable ICD codes are available for review here.

i. Advanced HIV
ii. HIV with opportunistic infection
iii. HIV in pregnancy
iv. Diabetes mellitus, including complications
v. Coagulation defects (e.g., haemophillia, other deficiencies)
vi. Purpura, thrombocytopenia, other haemorrhagic conditions
vii. Senile dementia, presenile dementia
viii. Child psychoses or autism
ix. Parkinson's Disease
x. Multiple Sclerosis
xi. Cerebral Palsy
xii. Epilepsy
xiii. Chronic Bronchitis
xiv. Emphysema
xv. Asthma, Allergic Bronchitis
xvi. Pulmonary Fibrosis
xvii. Regional Enteritis; Crohn's Disease
xviii. Ulcerative Colitis
xix. Cirrhosis of the Liver
xx. Chronic Renal Failure, Uremia
xxi. Systemic Lupus Erythematosus
xxii. Inflammatory Myositis
xxiii. Complex Psoriasis
xxiv. Vasculitis
xxv. Scleroderma
xxvi. Sarcoidosis
xxvii. Rheumatoid Arthritis
xxviii. Adult Onset Still's Disease
xxix. Systemic Juvenile Inflammatory Arthritis

xxx. Ankylosing Spondylitis
xxxi. Psoriatic Arthritis
xxxii. Reactive Arthritis
xxxiii. Enteropathic Arthritis

VIRTUAL VISITS

8340 Episodic virtual visit by phone 20.40

8321 Virtual visit by telephone or video 58.79

8535 Virtual consultation by telephone or video 185.68

8447 Comprehensive Virtual Assessment by telephone or video 112.78

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time 135.35

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination 112.78

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time 85.78

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 71.48

8626 Extended Consultation—See Rules 7 to 10–Child minimum of forty-five (45) minutes of patient/physician contact time 222.83

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation—See Rules 7 to 10 ..... 185.68

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty (30) minutes of patient/physician contact time 70.54

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8510 Regional History and Examination, or Subsequent Visit 73.98

8520 Hospital Care—per day 42.97

CONCOMITANT CARE

8524 Concomitant Care—per day 42.97

CHRONIC CARE—SEE GENERAL SCHEDULE

MEDICAL GENETICS (01-8)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time 126.10

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination 105.07

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time 114.92

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 95.78

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty (30) minutes of patient/physician contact time 83.76

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8403 Regional History and Examination or Subsequent Visit 69.82

8408 Review and interpretation of genetic information for patients seen exclusively by a genetic counsellor.....43.62

Note: *1) Includes the interpretation of pertinent pedigrees (which must contain a comprehensive ancestral history), and/or cytogenetic, biochemical or molecular genetic reports.*

2) Services shall be documented in the patient's record as required by the College of Physicians & Surgeons of Manitoba, and such documentation is required, upon request by Manitoba Health, to support the claim submitted. The patient's record must include a note that the genetic information was reviewed by a medical geneticist.

8626 Extended Consultation—See Rules 7 to 10–Child minimum of forty-five (45) minutes of patient/physician contact time.....264.40

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation—See Rules 7 to 10.....220.34

8416 Midwifery Assessment & Report—See General Schedule

CONTINUING PATIENT CARE MANAGEMENT BY MEDICAL SPECIALISTS

8700 Continuing patient care management, supplement add to visit fee 30.00

Notes: *1) May be claimed in addition to an in-person visit tariff excluding consultations.*

2) Maximum of four (4) supplements may be claimed per patient per 12-month period.

3) Patient must have an established diagnosis of one or more of the following diseases. The applicable ICD codes are available for review here.

i. Advanced HIV
ii. HIV with opportunistic infection
iii. HIV in pregnancy
iv. Diabetes mellitus, including complications
v. Coagulation defects (e.g., haemophillia, other deficiencies)
vi. Purpura, thrombocytopenia, other haemorrhagic conditions
vii. Senile dementia, presenile dementia
viii. Child psychoses or autism
ix. Parkinson's Disease
x. Multiple Sclerosis
xi. Cerebral Palsy
xii. Epilepsy
xiii. Chronic Bronchitis
xiv. Emphysema
xv. Asthma, Allergic Bronchitis
xvi. Pulmonary Fibrosis

xvii. *Regional Enteritis; Crohn's Disease*
xviii. *Ulcerative Colitis*
xix. *Cirrhosis of the Liver*
xx. *Chronic Renal Failure, Uremia*
xxi. *Systemic Lupus Erythematosus*
xxii. *Inflammatory Myositis*
xxiii. *Complex Psoriasis*
xxiv. *Vasculitis*
xxv. *Scleroderma*
xxvi. *Sarcoidosis*
xxvii. *Rheumatoid Arthritis*
xxviii. *Adult Onset Still's Disease*
xxix. *Systemic Juvenile Inflammatory Arthritis*
xxx. *Ankylosing Spondylitis*
xxxi. *Psoriatic Arthritis*
xxxii. *Reactive Arthritis*
xxxiii. *Enteropathic Arthritis*

VIRTUAL VISITS

8340 Episodic virtual visit by phone 20.40

8321 Virtual visit by telephone or video 69.82

8535 Virtual consultation by telephone or video 220.34

8447 Comprehensive Virtual Assessment by telephone or video 105.07

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time 126.10

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination 105.07

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time 114.92

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 .....95.78

8626 Extended Consultation—See Rules 7 to 10–Child minimum of forty-five (45) minutes of patient/physician contact time 264.40

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation—See Rules 7 to 10 .....220.34

8664 Extended Consultation—Unassigned Patient–Child minimum of forty-five (45) minutes of patient/physician contact time 319.74

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8595 Consultation—Unassigned Patient 266.45

Note: *"Unassigned Patient" means a patient who requires assessment by a Genetics Specialist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 10 inclusive apply.*

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty (30) minutes of patient/physician contact time 83.76

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8510 Regional History and Examination, or Subsequent Visit 81.52

8520 Hospital Care—per day 42.57

CONCOMITANT CARE

8524 Concomitant Care—per day 42.57

CHRONIC CARE—SEE GENERAL SCHEDULE

ENDOCRINOLOGY (13-1)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time 134.92

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination.....112.42

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time 86.16

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6.....71.80

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty (30) minutes of patient/physician contact time 70.86

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8403 Regional History and Examination or Subsequent Visit.....59.05

8626 Extended Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10–
Child minimum of forty-five (45) minutes of patient/physician contact time 221.94

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10 ..... 184.96

8416 Midwifery Assessment & Report—See General Schedule

CONTINUING PATIENT CARE MANAGEMENT BY MEDICAL SPECIALISTS

8700 Continuing patient care management, supplement add to visit fee..... 30.00

Notes: *1) May be claimed in addition to an in-person visit tariff excluding consultations.*

2) Maximum of four (4) supplements may be claimed per patient per 12-month period.

3) Patient must have an established diagnosis of one or more of the following diseases. The applicable ICD codes are available for review here.

i. Advanced HIV
ii. HIV with opportunistic infection
iii. HIV in pregnancy
iv. Diabetes mellitus, including complications
v. Coagulation defects (e.g., haemophillia, other deficiencies)
vi. Purpura, thrombocytopenia, other haemorrhagic conditions
vii. Senile dementia, presenile dementia
viii. Child psychoses or autism
ix. Parkinson's Disease
x. Multiple Sclerosis
xi. Cerebral Palsy
xii. Epilepsy
xiii. Chronic Bronchitis
xiv. Emphysema
xv. Asthma, Allergic Bronchitis
xvi. Pulmonary Fibrosis
xvii. Regional Enteritis; Crohn's Disease
xviii. Ulcerative Colitis
xix. Cirrhosis of the Liver
xx. Chronic Renal Failure, Uremia
xxi. Systemic Lupus Erythematosus
xxii. Inflammatory Myositis
xxiii. Complex Psoriasis
xxiv. Vasculitis
xxv. Scleroderma
xxvi. Sarcoidosis
xxvii. Rheumatoid Arthritis

xxviii. *Adult Onset Still's Disease*
xxix. *Systemic Juvenile Inflammatory Arthritis*
xxx. *Ankylosing Spondylitis*
xxxi. *Psoriatic Arthritis*
xxxii. *Reactive Arthritis*
xxxiii. *Enteropathic Arthritis*

VIRTUAL VISITS

8340 Episodic virtual visit by phone 20.40

8321 Virtual visit by telephone or video 59.05

8535 Virtual consultation by telephone or video 184.96

8447 Comprehensive Virtual Assessment by telephone or video 112.42

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time 134.92

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination 112.42

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time 86.16

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 71.80

8626 Extended Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10–
Child minimum of forty-five (45) minutes of patient/physician contact time 221.94

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10 ..... 184.96

8664 Extended Consultation—Unassigned Patient–Child minimum of forty-five (45)
minutes of patient/physician contact time 276.13

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8595 Consultation—Unassigned Patient 230.10

Note: *"Unassigned Patient" means a patient who requires assessment by a Endocrinologist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 10 inclusive apply.*

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty
(30) minutes of patient/physician contact time 70.86

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8510 Regional History and Examination, or Subsequent Visit 74.08

8520 Hospital Care—per day 42.92

8526 Clinical Teaching Unit (CTU) patient care supplement–per day 41.22

Note: *1) May be claimed by the CTU attending physician for each patient admitted to a CTU designated by Manitoba Health.*

2) Tariff 8520 and/or other applicable visit/examination services are payable in addition.

CONCOMITANT CARE

8524 Concomitant Care—per day.....42.92

CHRONIC CARE—SEE GENERAL SCHEDULE

INFECTIOUS DISEASE (13-3)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time 134.92

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination 112.42

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time 86.16

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 71.80

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty (30) minutes of patient/physician contact time 70.86

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8403 Regional History and Examination or Subsequent Visit 59.05

8626 Extended Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10–
Child minimum of forty-five (45) minutes of patient/physician contact time.....221.94

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10.....184.96

8416 Midwifery Assessment & Report—See General Schedule

CONTINUING PATIENT CARE MANAGEMENT BY MEDICAL SPECIALISTS

8700 Continuing patient care management, supplement add to visit fee 30.00

Notes: *1) May be claimed in addition to an in-person visit tariff excluding consultations.*

2) Maximum of four (4) supplements may be claimed per patient per 12-month period.

3) Patient must have an established diagnosis of one or more of the following diseases. The applicable ICD codes are available for review here.

i. Advanced HIV
ii. HIV with opportunistic infection
iii. HIV in pregnancy
iv. Diabetes mellitus, including complications
v. Coagulation defects (e.g., haemophillia, other deficiencies)
vi. Purpura, thrombocytopenia, other haemorrhagic conditions
vii. Senile dementia, presenile dementia
viii. Child psychoses or autism
ix. Parkinson's Disease
x. Multiple Sclerosis
xi. Cerebral Palsy
xii. Epilepsy
xiii. Chronic Bronchitis
xiv. Emphysema
xv. Asthma, Allergic Bronchitis
xvi. Pulmonary Fibrosis
xvii. Regional Enteritis; Crohn's Disease
xviii. Ulcerative Colitis
xix. Cirrhosis of the Liver
xx. Chronic Renal Failure, Uremia
xxi. Systemic Lupus Erythematosus
xxii. Inflammatory Myositis
xxiii. Complex Psoriasis
xxiv. Vasculitis
xxv. Scleroderma
xxvi. Sarcoidosis
xxvii. Rheumatoid Arthritis

xxviii. *Adult Onset Still's Disease*
xxix. *Systemic Juvenile Inflammatory Arthritis*
xxx. *Ankylosing Spondylitis*
xxxi. *Psoriatic Arthritis*
xxxii. *Reactive Arthritis*
xxxiii. *Enteropathic Arthritis*

VIRTUAL VISITS

8340 Episodic virtual visit by phone 20.40

8321 Virtual visit by telephone or video 59.05

8535 Virtual consultation by telephone or video..... 184.96

8447 Comprehensive Virtual Assessment by telephone or video 112.42

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time 134.92

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination 112.42

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time..... 86.16

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 71.80

8626 Extended Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10–
Child minimum of forty-five (45) minutes of patient/physician contact time 221.94

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10 ..... 184.96

8664 Extended Consultation—Unassigned Patient–Child minimum of forty-five (45)
minutes of patient/physician contact time 276.13

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8595 Consultation—Unassigned Patient 230.10

Note: *"Unassigned Patient" means a patient who requires assessment by a Infectious Disease Specialist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 10 inclusive apply.*

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty
(30) minutes of patient/physician contact time 70.86

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8510 Regional History and Examination, or Subsequent Visit 74.08

8520 Hospital Care—per day 42.92

8526 Clinical Teaching Unit (CTU) patient care supplement–per day 41.22

Note: *1) May be claimed by the CTU attending physician for each patient admitted to a CTU designated by Manitoba Health.*

2) Tariff 8520 and/or other applicable visit/examination services are payable in addition.

CONCOMITANT CARE

8524 Concomitant Care—per day 42.92

CHRONIC CARE—SEE GENERAL SCHEDULE

RESPIROLOGY (13-4)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time 134.92

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination.....112.42

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time 86.16

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6.....71.80

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty (30) minutes of patient/physician contact time 70.86

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8403 Regional History and Examination or Subsequent Visit.....59.05

8626 Extended Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10–
Child minimum of forty-five (45) minutes of patient/physician contact time 221.94

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10 ..... 184.96

8416 Midwifery Assessment & Report—See General Schedule

CONTINUING PATIENT CARE MANAGEMENT BY MEDICAL SPECIALISTS

8700 Continuing patient care management, supplement add to visit fee..... 30.00

Notes: *1) May be claimed in addition to an in-person visit tariff excluding consultations.*

2) Maximum of four (4) supplements may be claimed per patient per 12-month period.

3) Patient must have an established diagnosis of one or more of the following diseases. The applicable ICD codes are available for review here.

i. Advanced HIV
ii. HIV with opportunistic infection
iii. HIV in pregnancy
iv. Diabetes mellitus, including complications
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vi. Purpura, thrombocytopenia, other haemorrhagic conditions
vii. Senile dementia, presenile dementia
viii. Child psychoses or autism
ix. Parkinson's Disease
x. Multiple Sclerosis
xi. Cerebral Palsy
xii. Epilepsy
xiii. Chronic Bronchitis
xiv. Emphysema
xv. Asthma, Allergic Bronchitis
xvi. Pulmonary Fibrosis
xvii. Regional Enteritis; Crohn's Disease
xviii. Ulcerative Colitis
xix. Cirrhosis of the Liver
xx. Chronic Renal Failure, Uremia
xxi. Systemic Lupus Erythematosus
xxii. Inflammatory Myositis
xxiii. Complex Psoriasis
xxiv. Vasculitis
xxv. Scleroderma
xxvi. Sarcoidosis
xxvii. Rheumatoid Arthritis

xxviii. *Adult Onset Still's Disease*
xxix. *Systemic Juvenile Inflammatory Arthritis*
xxx. *Ankylosing Spondylitis*
xxxi. *Psoriatic Arthritis*
xxxii. *Reactive Arthritis*
xxxiii. *Enteropathic Arthritis*

VIRTUAL VISITS

8340 Episodic virtual visit by phone 20.40

8321 Virtual visit by telephone or video 59.05

8535 Virtual consultation by telephone or video 184.96

8447 Comprehensive Virtual Assessment by telephone or video 112.42

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time 134.92

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination 112.42

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time 86.16

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 71.80

8626 Extended Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10–
Child minimum of forty-five (45) minutes of patient/physician contact time 221.94

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10 ..... 184.96

8664 Extended Consultation—Unassigned Patient–Child minimum of forty-five (45)
minutes of patient/physician contact time 276.13

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8595 Consultation—Unassigned Patient 230.10

Note: *"Unassigned Patient" means a patient who requires assessment by a Respirologist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 10 inclusive apply.*

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty
(30) minutes of patient/physician contact time 70.86

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8510 Regional History and Examination, or Subsequent Visit 74.08

8520 Hospital Care—per day 42.92

8526 Clinical Teaching Unit (CTU) patient care supplement–per day 41.22

Note: *1) May be claimed by the CTU attending physician for each patient admitted to a CTU designated by Manitoba Health.*

2) *Tariff 8520 and/or other applicable visit/examination services are payable in addition.*

CONCOMITANT CARE

8524 Concomitant Care—per day.....42.92

CHRONIC CARE—SEE GENERAL SCHEDULE

PAEDIATRICS (02)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination 101.53

Notes: *1) Tariff 9795 (cytological smears for cancer screening) may be claimed in addition to tariff 8540, where appropriate.*

2) Tariff 8448 may be claimed in addition to 8540 where a pelvic examination is provided. See Rule 17 for full description.

8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10 ..... 187.81

8416 Midwifery Assessment and Report—See General Schedule

8582 Paediatric/Adolescent Behavioural Therapy, per fifteen (15) minute period or major portion thereof [minimum duration—thirty (30) minutes, maximum duration—ninety (90) minutes] 76.53

Note: *This tariff is claimable only by Paediatricians with appropriate training or experience in adolescent medicine as may be agreed upon from time to time by Doctors Manitoba and Manitoba Health.*

8529 Regional Intermediate Visit—Regional or Subsequent Visit or Well Baby Care 58.43

Notes: *1) A Regional Intermediate Visit for a problem specific Assessment is a service provided to a patient which shall be comprised of:*

- *A history of the presenting complaint(s);*
- *An examination of the parts or systems related to the presenting complaint(s);*
- *A review of all pertinent investigations;*
- *A complete written record and advice to the patient.*

2) The visit shall be a minimum of ten (10) minutes of physician time.

3) Tariff 9795 (cytological smears for cancer screening) may be claimed in addition to tariff 8529, where appropriate.

4) Tariff 8448 may be claimed in addition to 8529 where a pelvic examination is provided. See Rule 17 for full description.

~8644 Extended Visit 80.00

Note: *An extended visit is to assess two or more distinct complaints or problems from the patient, and shall be comprised of:*

- *A history of the presenting two or more complaints;*
- *An examination of the parts or systems related to the presenting complaints;*
- *A review of all pertinent investigations;*
- *A complete written record and advice to the patient;*
- *The visit shall be a minimum of twenty (20) minutes of physician time.*

8509 Regional Basic Visit—Regional or Subsequent Visit 50.52

Note: *A Regional Basic Visit is a service rendered to a patient who consults the physician for a condition—usually relatively minor. The assessment of the patient's condition is problem focused and little or no physical examination is included.*

Note: *Generally, less than ten (10) minutes of physician time is required.*

8448 Pelvic Examination, add—See Rule 17 for full tariff description 20.40

8415 Extended Visit, time based premium, add 20%

Notes: *1) Tariff 8415 is claimable in addition to tariff 8540 where a minimum of forty-five (45) minutes of direct patient/physician contact time occurs.*

2) Tariff 8415 is claimable in addition to tariff 8529 where a minimum of thirty (30) minutes of direct patient/physician contact time occurs.

3) Tariff 8415 is claimable in addition to tariff 8550 where a minimum of forty-five (45) minutes of direct patient/physician contact time occurs, and the patient is under 18 years of age.

4) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

VIRTUAL VISITS

8340 Episodic virtual visit by phone 20.40

8345 Basic virtual visit by telephone or video 49.53

Note: *Generally, less than ten (10) minutes of physician time is required.*

8321 Intermediate virtual visit by telephone or video 58.43

Note: *The visit shall be a minimum of ten (10) minutes of physician time.*

8535 Virtual consultation by telephone or video 187.81

8447 Comprehensive Virtual Assessment by telephone or video 101.53

~8350 Extended virtual visit by video 80.00

Note: *An extended visit is to assess two or more distinct complaints or problems from the patient, and shall be comprised of:*

- *A history of the presenting two or more complaints;*
- *An examination of the parts or systems related to the presenting complaints;*
- *A review of all pertinent investigations;*
- *A complete written record and advice to the patient;*
- *The visit shall be a minimum of twenty (20) minutes of physician time.*
- *Start and stop times must be included on the claim.*

Notes: *1) When 8345, or 8321 is provided by telephone the service must be part of a continuing patient relationship as described in Rule of Application 62.*

2) 8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.

3) 8340 shall be limited to patients with no known history with the physician.

EXTENDED CLINIC HOURS PREMIUM

5530 Extended clinic hours 0600-0800 (6:00 a.m. – 8:00 a.m) or 1700 to 2359 hours (5:00 p.m to 11:59 p.m) add.....20% to payable fee
On weekdays, excluding Saturday, Sunday and designated Holidays (see Note 5 below).

5531 Extended clinic hours 0701 to 2359 (7:01 a.m. to 11:59 p.m) add on Saturday, Sunday and designated Holidays (see Note 5 below).....20% to payable fee

Extended clinic hour premiums shall apply to all medical services commencing between the hours set out above provided that:

I. The clinic maintains at least 8 hours of regular office hours within 0800-1700 Monday Friday (For example, 0800-1600, or 0830-1630, or 0900-1700); and,

II.The extended clinic hours are advertised to the public or the clinic's own patients and the patient has the option for in person availability.

Notes: *1) An extended clinic hours premium may not be claimed for a patient scheduled to be seen before the extended hours period.*

2) The time the service commences must be entered on the claim.

3) 5530 or 5531 may not be claimed with tariffs 5555, 5553, 5550, 5556, 5557 and 5558.

4) Tariffs 8000, 8001, 8002, 8003, 8005 and annual management tariffs such as but not limited to CDM and CCM tariffs, are not eligible for the extended clinic hours premium.

5) Designated Holidays include: New Year's Day, Louis Riel Day, Good Friday, Easter Monday, Victoria Day, Canada Day, Terry Fox Day, Labour Day, National Day for Truth and Reconciliation, Thanksgiving Day, Remembrance Day, Christmas Day and Boxing Day.
If any of these days fall on a Saturday or Sunday, the day will be observed as stated on the Manitoba Health CPS website at: https://www.gov.mb.ca/health/claims/providers.html

Paediatrician to Psychiatrist telephone consultation:

8009 Referring Physician 15.85

Note: *1) Payable for two-way telephone communication regarding assessment, opinion, next step advice, and recommendations as to the management and/or treatment of a patient.*

2) 8009 is payable only when a corresponding 8007 or 8008 is completed by the Psychiatrist.

3) Includes discussion of pertinent family/patient history, history of presenting complaint, and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.

4) Advice and resulting care plan must be recorded in the patient chart. Any care plan resulting from the advice must be recorded in the patient chart of the Paediatrician.

5) Limited to one (1) claim per patient per Paediatrician per day.

6) Not payable where the sole purpose of the call is to:

a) Book an appointment;

b) Arrange for a transfer of care that occurs within 24 hours;

c) Arrange for an expedited consultation or procedure within 24 hours; or

d) Arrange a hospital bed for the patient.

7) Advice given by the Psychiatrist must take place within the specified number of hours of the Paediatrician's first contact with the Psychiatrist and must be physician to physician. Not payable for written communication.

8) Claim must include date and time of initiating contact from the Paediatrician and start and end time of the telephone conversation where consultative expertise is given.

Complex Pediatric Patients Clinic

8648 Complex Paediatric Patient Assessment per fifteen (15) minutes or major portion thereof 76.53

Note: *1) Limited to Complex Care pediatricians as designated by Provincial CMO or a designate.*

2) May not be claimed with other visit or consultation service on the same day.

3) This tariff is applicable to children ages 17 and under, and includes, but is not limited to, the following services:

a) History taking;

b) Assessment;

c) Collateral contacts (e.g., parents, social workers, speech pathologists, other health care professionals, teachers, etc.) by way of meetings, receipt/writing or correspondence or telephone calls.

d) Preparation of assessment report.

Child Developmental Assessment Including High Risk Neonatal Program

8552 Developmental assessment and report per fifteen (15) minute period or major portion thereof..... 76.53

Note: *This tariff is applicable to children ages 17 and under, and includes, but is not limited to, the following services:*

- *history taking;*
- *assessment;*
- *collateral contacts (e.g., parents, social workers, speech pathologists, other health care professionals, teachers, etc.) by way of meetings, receipt/writing or correspondence or telephone calls;*
- *preparation of assessment report.*

Note: *If a physical examination of the child is conducted in conjunction with the assessment, the appropriate visit fee may be claimed in addition to this tariff.*

Assessments within 60 days of a previous developmental assessment and report 8552 shall be claimed under tariff 8404 ***By Report****; and Assessments after 60 days shall be submitted using tariff 8552 in aggregate* ***By Report****.*

8404 Complete or extensive re-assessment and report within 60 days per fifteen (15) minute period or major portion thereof—***By Report*** 76.53

8555 Parent interview and counselling related to a previous developmental assessment, per fifteen (15) minute period or major portion thereof 76.53

8558 Behaviour therapy conducted subsequent to a developmental assessment, per fifteen (15) minute period or major portion thereof 76.53

8439 Virtual Child Developmental Assessment..... 76.53

Note: *Tariffs 8552, 8404, 8555, 8558 and 8439 may be claimed by a physician who is agreed by Manitoba Health and Doctors Manitoba to be adequately trained in developmental paediatrics.*

Child Developmental Assessment Re: Feeding

8560 Initial Feeding Assessment and Report per fifteen (15) minute period or major portion thereof..... 76.53

Note: *This tariff is applicable to children ages 17 and under, and includes, but is not limited to, the following services:*

- *history taking;*
- *feeding observation;*
- *assessment;*
- *review of the diet record;*
- *preparation of assessment report.*

Note: *If a physical examination of the child is conducted in conjunction with the assessment, the appropriate visit fee may be claimed in addition to this tariff.*

8562 Attendance during Swallowing Studies in Hospital Radiology Department, per fifteen (15) minute period or major portion thereof [maximum sixty (60) minutes per study may be claimed]. 76.53

Note: *This includes participation by the Developmental Paediatrician in the interpretation of the radiographic studies.*

8564 Feeding reassessment following initial feeding assessment and report, per fifteen (15) minute period or major portion thereof [maximum sixty (60) minutes per patient per month may be claimed]. Additional units may be claimed ***By Report***. 69.48

8597 Feeding Case Management per fifteen (15) minute period or major portion thereof.....55.24

Note: *Includes the review of the assessment and progress of the child and/or the provision of advice on medication or ongoing therapy with a collateral professional by way of meetings, receipt/writing of correspondence or telephone calls.*

Note: *Tariffs 8560, 8562, 8564 and 8597 may only be claimed by a Developmental Paediatrician who is agreed by Manitoba Health and Doctors Manitoba to be adequately trained in feeding disorders.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

The Hospital Care Premium also applies to tariffs 8529 and 8509 for urgent/emergent services provided in the Emergency Department.

8540 Complete History and Physical Examination.....101.53

Notes: *1) Tariff 9795 (cytological smears for cancer screening) may be claimed in addition to tariff 8540, where appropriate.*

2) Tariff 8448 may be claimed in addition to 8540 where a pelvic examination is provided. See Rule 17 for full description.

8595 Consultation—Unassigned Patient.....233.67

Note: *"Unassigned Patient" means a patient who requires assessment by a Paediatric Specialist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 10 inclusive apply.*

8664 Extended Consultation—Unassigned Patient–Child minimum of forty-five (45) minutes of patient/physician contact time 277.62

Note: *1) Patient must be under eighteen (18) years of age.*

2) *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.*

8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10 ..... 187.81

8510 Regional History and Examination, or Subsequent Visit 64.57

Notes: 1) *Tariff 9795 (cytological smears for cancer screening) may be claimed in addition to tariff 8510, where appropriate.*

2) *Tariff 8448 may be claimed in addition to 8510 where a pelvic examination is provided. See Rule 17 for full description.*

8448 Pelvic Examination, add—See Rule 17 for full tariff description 20.40

8415 Extended Visit, time based premium, add 20%

Notes: 1) *Tariff 8415 is claimable in addition to tariff 8540 where a minimum of forty-five (45) minutes of direct patient/physician contact time occurs.*

2) *Tariff 8415 is claimable in addition to tariff 8510 where a minimum of thirty (30) minutes of direct patient/physician contact time occurs.*

3) *Tariff 8415 is claimable in addition to tariff 8550 where a minimum of forty-five (45) minutes of direct patient/physician contact time occurs, and the patient is under 18 years of age.*

4) *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.*

Paediatrician to Psychiatrist telephone consultation:

8009 Referring Physician 15.85

Note: 1) *Payable for two-way telephone communication regarding assessment, opinion, next step advice, and recommendations as to the management and/or treatment of a patient.*

2) *8009 is payable only when a corresponding 8007 or 8008 is completed by the Psychiatrist.*

3) *Includes discussion of pertinent family/patient history, history of presenting complaint, and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.*

4) *Advice and resulting care plan must be recorded in the patient chart. Any care plan resulting from the advice must be recorded in the patient chart of the Paediatrician.*

5) *Limited to one (1) claim per patient per Paediatrician per day.*

6) *Not payable where the sole purpose of the call is to:*

   a) *Book an appointment;*

   b) *Arrange for a transfer of care that occurs within 24 hours;*

   c) *Arrange for an expedited consultation or procedure within 24 hours; or*

   d) *Arrange a hospital bed for the patient.*

7) *Advice given by the Psychiatrist must take place within the specified number of hours of the Paediatrician's first contact with the Psychiatrist and must be physician to physician. Not payable for written communication.*

8) *Claim must include date and time of initiating contact from the Paediatrician and start and end time of the telephone conversation where consultative expertise is given.*

8520 Hospital Care—per day 43.06

8526 Clinical Teaching Unit (CTU) patient care supplement–per day 26.01

Note: 1) *May be claimed by the CTU attending physician for each patient admitted to a CTU designated by Manitoba Health.*

2) *Tariff 8520 and/or other applicable visit/examination services are payable in addition.*

8412 Neonatal/Paediatric Supportive Care—per day 32.69

Note: 1) *Tariff 8412 includes:*

   i) *Ongoing monitoring of the patient's condition to ensure continuity of patient care;*

   ii) *Meeting or communicating with patient's family or caregivers, details to be noted in the patient's chart or communicated to the Attending Neonatologist or Paediatric Intensivist;*

   iii) *Meeting or communicating with the Attending Neonatologist or Paediatric Intensivist;*

   iv) *Advice regarding discharge planning and follow-up.*

2) *Tariff 8412 may be claimed by only one Paediatrician per day for supportive care of a newborn/paediatric patient admitted to the NICU or PICU at Children's Hospital, the Combined Neonatal Unit at St. Boniface General Hospital or the Intermediate Care Nursery at Women's Hospital (the Units).*

3) *May be claimed from the date of admission to the date of discharge from the Unit. No other visit or hospital care tariff may be claimed by the Paediatrician during this period.*

4) *Rule of Application 13 does not apply.*

5) *May not be claimed on the same day as tariffs 8473 Patient Care Family Conference or 8474 Case Management Conference.*

8413 Supportive Care Visits by Paediatricians 32.69

Note: *1) Tariff 8413 may only be claimed once per day per patient to a maximum of three (3) supportive care visits per seven (7) day period. No other tariff may be claimed while the patient remains in the unit.*

*2) Post discharge services, including office or home visits provided within the seven days of a tariff 8413 claim, must be submitted **By Report**.*

3) Applicable to closed units at Children's Hospital.

4) May not be claimed for the same patient on the same day as tariff 8412 Neonatal/Paediatric Supportive Care per day, tariff 8474 Case Management Conference or tariff 8473 Patient Care Family Conference.

5) Includes ongoing monitoring of the patient's condition to ensure continuity of patient care.

6) Includes meeting or communicating with patient's family or caregivers, details to be noted in the patient's chart or communicated to the physician of record.

7) Includes meeting or communicating with the physician of record.

8) Includes advice regarding discharge planning and follow-up.

CONCOMITANT CARE

8524 Concomitant Care—per day 43.06

NEONATAL AND PAEDIATRIC INTENSIVE, COMPREHENSIVE CRITICAL CARE AND VENTILATORY SUPPORT FEE SCHEDULE

Preamble

This fee schedule is intended to be used by physicians who provide direct Neonatal and Paediatric Intensive Care, Comprehensive Care, Critical Care and Ventilator Support to critically ill and unstable neonatal and Paediatric patients.

It is recognized that more than one physician may manage complicated problems when a patient is critically ill. The daily rate is payable, per patient, to the physician providing care.

When claiming under this fee schedule, no other critical care tariff codes may be claimed by the physician.

It is recognized that specialists other than Paediatricians or neonatologists may be called upon to provide care. For example, this may include nephrology management of dialysis, neurologic opinion and treatment, infectious disease review and management of complicated infections. In some intensive care units, parenteral nutrition may be prescribed by a physician who is not a Paediatrician or neonatologist or an anaesthesiologist may be called in to insert a difficult arterial line. In such cases, physicians may bill in accordance with the services provided.

This schedule does not preclude family physicians billing daily hospital visits where appropriate for infants over 28 days of age.

After Hours Premiums and Special Call

After Hours premiums and ***Special Call*** benefits do not apply when claims are made under this Fee Schedule.

Patient Re-Admittance

Where a patient is discharged from the Neonatal, Comprehensive, Critical Care, or Ventilatory Support Units, but is re-admitted within 48 hours, the second day rates shall be charged.

Where the patient is re-admitted more than 48 hours after discharge, first day rates shall be charged.

Change of Neonatal Acuity Level

Where a patient changes acuity level (up or down), then the appropriate second day rate shall be charged.

Transfer of Patient from One Hospital to Another

Where critically ill patients are transferred from one hospital to another the original intensive care team may bill for the day of the patient's transfer. First day rates shall apply to the receiving intensive care teams where more than two hours bedside care is provided.

Physicians required to be in attendance during the transporting of a patient may claim in accordance with the Physician's Manual.

Designated Intensive Care Areas

Neonatal Care, Comprehensive Care, Critical Care and Ventilatory Support fees may be claimed when patients receive care in a Neonatal Intensive Care Unit (NICU) or Paediatric Intensive Care Unit (PICU) or other designated area of a hospital where one to one nursing care is being provided.

Duration

This fee schedule shall be effective from April 1, 1998. The duration of this agreement shall be consistent with the fee-for-service agreement between the Province of Manitoba and Doctors Manitoba subject to determination under the Interest Arbitration Agreement.

Other

This schedule does not apply to non-ventilated stable patients admitted to a special care unit for routine postoperative care.

Fees for NICU Level A, B and C may be claimed for pre-operative and/or postoperative patients requiring NICU admission. However, if where the patient is transferred directly from an Operating Room or a Recovery Room to the NICU, intensive care tariffs should be claimed commencing with the second day rate of the appropriate level.

In cases where resuscitation and stabilization have been accomplished before the patient is transferred to the NICU/PICU, the payment will begin at the appropriate second day rate.

NEONATAL INTENSIVE CARE

These fees apply to physicians providing intensive care to neonate patients (from birth until first discharged from hospital or, following discharge, up to and including 28 days of age).

Included in these daily composite fees are the initial consultation or assessment, subsequent visits and examinations as required in any given day. Also included, but not limited to, are the insertion of arterial, venous, CVP or urinary catheters, intravenous lines, interpretation of blood gases, insertion of nasogastric tubes, infusion of pharmaceutical agents including TPN, endotracheal intubation and artificial ventilation and all other necessary respiratory support.

There are three levels of neonatal intensive care depending on the procedures performed.

Level A Infants requiring artificial Ventilation, full invasive monitoring and parenteral alimentation if necessary.

8300	Day 1	607.29
8301	Day 2 – 10, per day	209.82
8302	Day 11 onwards, per day	191.71

Level B Infants requiring full monitoring, both invasive and IV therapy or parenteral alimentation, but without ventilatory support.

8303	Day 1	276.04
8304	Day 2 – 10, per day	135.58
8305	Day 11 onwards, per day	135.58

Level C Infants requiring oxygen administration and/or non-invasive monitoring, and/or gavage feeding.

8306 Day 1 ..... 171.37

8307 Day 2 – 10, per day..... 85.68

8308 Day 11 onwards, per day 85.68

COMPREHENSIVE CARE

These fees apply to physicians who provide both, critical care and ventilatory support to infants (non-neonate patients who have been discharged from hospital and are over the age of 28 days), children and adolescents (under age 18). These fees include, but are not limited to, initial consultation and assessment and subsequent examinations of the patient, family counseling, endotracheal intubation, tracheal toilet, artificial ventilation and all necessary measures for respiratory support, emergency resuscitation, insertion of intravenous lines, cutdowns, arterial and/or venous catheters, pressure infusion sets and pharmacological agents, insertion of C.V. P. lines, defibrillation, cardioversion and usual resuscitative measures, insertion of urinary catheters and nasogastric tubes, securing and interpretation of blood gases, intracranial pressure monitoring interpretation and assessment when indicated (excluding insertion of ICP measuring device).

Note: *Separate billable intervention may be claimed for:*

- *Insertion of chest tube for closed drainage (tariff code 2157).*
- *Bilateral at same sitting (tariff code 2156).*
- *Swan-Ganz Catherization: Cardiac catherization, right heart (tariff code 2303).*

8309 Day 1 ..... 386.49

8310 Day 2 – 10, per day..... 235.73

8311 Day 11 onwards, per day 115.26

CRITICAL CARE—(WITHOUT VENTILATOR SUPPORT)

These fees apply to physicians who provide critical care to infants (non neonate patients who have been discharged from hospital and are over the age of 28 days), children and adolescents (under age 18). It includes, but is not limited to initial consultation and assessment, family counseling, emergency resuscitation, intra-venous lines, cutdowns, pressure infusion set and pharmacological agents, insertion of arterial C.V.P or urinary catheters and nasogastric tubes, defibrillation, cardioversion and usual resuscitative measures, securing and interpretation of laboratory tests, oximetry, transcutaneous blood gases and intracranial pressure monitoring interpretation and assessment when indicated (excluding insertion if ICP measuring device).

Where ventilatory support only is provided, claims should be made under Ventilatory Support and Critical Care fees shall not apply.

Note: *Separate billable intervention may be claimed for:*

- *Insertion of chest tube for closed drainage (tariff code 2157).*
- *Bilateral at same sitting (tariff code 2156).*
- *Swan Ganz Catherization: Cardiac catherization, right heart (tariff code 2303).*

8312 Day 1 ..... 259.66

8313 Day 2 – 10, per day..... 161.74

8314 Day 11 onwards, per day 66.23

VENTILATORY SUPPORT

These fees apply to physicians who provide ventilatory support to infants (non-neonate patients who have been discharged from hospital and are over the age of 28 days), children and adolescents (under age 18). It includes, but is not limited to initial consultation and assessment, family counseling, endotracheal intubation with positive pressure ventilation, insertion of intravenous lines, cutdowns, pressure infusion, insertion of arterial and C.V. lines, tracheal toilet, use of artificial ventilator and all necessary measures for its supervision, obtaining and the interpretation of blood gases, oximetry, end tidal CO^2, transcutaneous blood gas application and assessment and maximum inspiratory pressure monitoring and non-invasive metabolic measurements.

Note: *Separate billable intervention may be claimed for:*

- *Insertion of chest tube for closed drainage (tariff code 2157).*
- *Bilateral at same sitting (tariff code 2156).*
- *Swan Ganz Catherization: Cardiac catherization, right heart (tariff code 2303).*

8315 Day 1 ..... 231.88

8316 Day 2 – 10, per day 104.94

8317 Day 11 onwards, per day 86.11

PSYCHIATRY (03)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

PSYCHIATRY GENERAL

- In addition to the visit codes, Psychiatry services are classified as:
  - individual psychotherapy;
  - group psychotherapy;
  - patient care family conference;
  - electroconvulsive therapy (ECT);
  - psychiatric care;
  - child and youth management conference; and
  - psychiatric social interview
- Only specialists in psychiatry are eligible to submit claims in respect of "Psychiatry" services under this part.
- More than one psychiatrist may submit claims for psychiatry services for the same patient on the same day.
- Psychotherapy is a procedure for the treatment of mental, emotional and/or psychosomatic illness by means of a professional relationship between a psychiatrist and a patient, carried out through a series of prearranged medical services.
- Psychotherapy is undertaken to remove, modify or retard existing symptoms, or attenuate or reverse disturbed patterns of behaviour and to promote the patient's positive personality growth and development.
- Psychotherapy procedures include direct patient contact by a psychiatrist for the purpose of evaluation, diagnosis, physical and/or drug treatment, patient education, general psychiatric counseling and documentation in the patient's record.
- A psychiatrist may submit claims for individual psychotherapy, group psychotherapy, patient care family conference, psychiatric social interview and/or a child and youth management conference—for the same patient on the same day.
- Individual psychotherapy and psychiatric care cannot be claimed for the same patient on the same day by the same psychiatrist.
- Individual or group psychotherapy cannot be claimed for the same patient on the same day as ECT.
- A psychiatrist may submit claims for ECT and psychiatric care, a patient care family conference, psychiatric social interview and/or child youth management conference for the same patient on the same day.
- Psychoanalysis is an excluded service and cannot be claimed.
- Psychiatry services shall be documented in the patient's record as required by the College of Physicians and Surgeons of Manitoba, and such documentation is required to support the claim submitted to Manitoba Health.

OFFICE, HOME VISITS

8503	Complete History and Psychiatric Examination—adult	151.94
8504	Complete History and Psychiatric Examination—child	207.13

Note: *Patient must be under eighteen (18) years of age.*

8429 Complete History and Psychiatric Examination – Geriatric patient.....207.13

Note: *1) The patient must be at least seventy (70) years of age or have suspected or confirmed neurocognitive conditions (including but not limited to temporal lobe dementia, dementia, etc.).*

2) Tariff 8429 may be claimed only by a physician holding certification as a geriatric psychiatrist with the Royal College of Physicians and Surgeons of Canada or as designated by Shared Health, or an RHA Mental Health Program.

8530 Regional History and Examination, or Subsequent Visit.....49.62

8624 Extended Consultation—See Rules 7 to 10–Geriatric (age 70 and older) minimum of forty-five (45) minutes of patient/physician contact time.....358.34

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.*

8622 Consultation—geriatric patient—See Rules 7 to 10.....298.64

Note: *1) The patient must be at least seventy (70) years of age.*

2) Tariff 8622 may be claimed only by a physician holding certification as a geriatric psychiatrist with the Royal College of Physicians and Surgeons of Canada or as designated by the WRHA Mental Health Program.

8625 Extended Consultation—See Rules 7 to 10–Adult minimum of forty-five (45) minutes of patient/physician contact time.....278.68

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.*

8553 Consultation—adult—See Rules 7 to 10.....232.23

8626 Extended Consultation—See Rules 7 to 10–Child minimum of forty-five (45) minutes of patient/physician contact time.....358.34

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8554 Consultation—child—See Rules 7 to 10 ..... 298.64

Note: *Patient must be under eighteen (18) years of age.*

VIRTUAL VISITS

8340 Episodic virtual visit by phone 20.40

8321 Intermediate virtual visit by telephone or video 49.62

8535 Virtual consultation by telephone or video 232.23

8521 Consultation – child (less than 18), or geriatric (70 or older) 298.64

8447 Comprehensive Virtual Assessment by telephone or video 151.94

8533 Psychotherapy performed by a psychiatrist 60.79

8786 Psychiatric care 76.13

8668 Group (2−4) psychotherapy performed by a psychiatrist 69.92

8669 Group (5+) psychotherapy performed by a psychiatrist 68.68

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

COMMUNITY PSYCHIATRIC CARE FOR ACUTE MENTAL HEALTH PATIENTS

Community psychiatric care following patient discharge from acute mental health inpatient care.

8417 First 14 days post discharge, add 20%

8418 15 to 183 days post discharge, add 10%

8419 Urgent Community Psychiatric Follow-up, add to consultation fee 30%

Notes: *1) 8417 and 8418 are payable in addition to all services provided to patients in office, at home or virtually, including consultations, visits, psychiatric and psychological care and conferences.*

2) 8419 is only eligible for payment when the psychiatrist providing the urgent community psychiatric follow-up:

a) Renders a consultation service to an out-patient on an urgent basis during the four (4) week period immediately following discharge where the patient was a hospital in-patient for treatment of a psychiatric condition; and,

b) Did not provide services to the same patient during the same psychiatric hospital admission.

3) 8419 is limited to a maximum of one per physician per patient per 12 month period.

4) 8419 is not claimable with 8417 or 8418.

8466 Psychiatry Intake Registry Consultation to Primary Care Provider–Adult—See Rules 7 to 10 .....307.38

8467 Psychiatry Intake Registry Consultation to Primary Care Provider–Child—See Rules 7 to 10 (Patient under the age of 18) 378.34

8468 Psychiatry Intake Registry Consultation to Primary Care Provider–Geriatric—See Rules 7 to 10 (Patient at least 70 years of age).....378.34

Notes: *1) The Psychiatry Intake Registry must be located in and managed by the applicable Regional Health Authority(s) (RHAs).*

2) Claimable by psychiatrists approved by the applicable RHA.

3) Payable for patients referred to the Registry by a primary care provider, who must receive the consultation report.

4) The consultation must be scheduled through the RHA's Psychiatry Intake Registry. Each Psychiatry Intake Registry must establish written policies regarding patient eligibility for psychiatric consultations in order for these tariffs to be billable.

5) Psychiatrists must meet the following requirements to claim these tariffs.

a) At least one (1) hour consultation time must be reserved by the psychiatrist on a weekly basis and communicated to applicable Registry administrators to provide timely access to consultation appointments and reserved consultation dates and times for Psychiatry Intake patients.

b) Patients must be accepted and seen by psychiatrists in the order they are disseminated by the Registry, except in urgent circumstances.

8706 Extended Psychiatry Intake Registry Originated Consultation to Primary Care Provider–Geriatric (age 70 and older) minimum of forty-five (45) minutes of patient/physician contact time.....453.99

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.*

8707 Extended Psychiatry Intake Registry Originated Consultation to Primary Care Provider–Adult minimum of forty-five (45) minutes of patient/physician contact time 368.87

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.*

8708 Extended Psychiatry Intake Registry Originated Consultation to Primary Care Provider–Child minimum of forty-five (45) minutes of patient/physician contact time 453.99

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8472 Child and Youth Management Conference 61.24

A Child and Youth Management Conference is defined as a conference between a psychiatrist and allied health professionals, educators, peace officers, correctional workers or appropriate community workers to share information to better manage a patient's care.

Note:

- *The patient must be twenty (20) years of age or younger.*
- *In hospital "physician-with-physician" patient care conferences are excluded.*
- *The conference must be a formal scheduled conference.*
- *Tariff rate is payable for the first full fifteen (15) minute period and for each additional fifteen (15) minutes or major portion thereof.*
- *Maximum of one (1) hour may be claimed per conference.*
- *Maximum of six (6) hours per patient may be claimed within any twelve (12) month period.*
- *The tariff must be claimed in the name of the patient.*
- *Additional Child and Youth Management conferences may be claimed by written report.*

8475 Psychiatry—Patient Care Family Conference.....55.61

A Patient Care Family Conference is defined as a formal scheduled conference between the Psychiatrist and relative(s) or guardian(s) relating to the care and treatment of a patient with a psychiatric disorder

Note:

- *A patient Care Family Conference may include, but is not limited to, discussions about the condition and care of a patient with serious and complex psychiatric problems. It may include the assessment of the need for care from other providers and/or community agencies.*
- *Patient may or may not be present at the Patient Care Family Conference.*
- *Tariff rate is payable for the first full fifteen (15) minute period and for each additional fifteen (15) minutes or major portion thereof.*
- *The service must be claimed in the name of the patient.*
- *Maximum of one (1) hour may be claimed per Patient Care Family Conference.*
- *Maximum of four (4) hours may be claimed per patient within any twelve (12) month period.*
- *Additional Patient Care Family Conference may be claimed by written report.*

8476 Psychiatric Social Interview.....59.86

A Psychiatric Social Interview is defined as an interview by a Psychiatrist with an individual who has close knowledge of, or association with, a patient.

Note:

1) *The person being interviewed may include, but is not limited to, a spouse, member of the family, community psychiatric nurse, teacher, member of the clergy or social worker.*
2) *Tariff rate is payable for the first full fifteen (15) minutes and for each additional fifteen (15) minutes or major portion thereof. The start and end time of the interview must be denoted on the patient chart and the medical claim.*
3) *Interview must be on a one-to-one basis between the Psychiatrist and the person being interviewed, and must take place in person, except in circumstances described in note 9. The patient shall not be present during the interview.*
4) *In hospital "physician-with-physician" patient care conferences are excluded.*
5) *The tariff must be billed in the name of the patient. The Psychiatrist must document the name of the person interviewed and their knowledge of, or association with, the patient.*
6) *Maximum one (1) hour may be claimed per interview.*
7) *Maximum of four (4) hours per patient may be claimed within any twelve (12) month period.*
8) *Additional Psychiatric Social Interviews may be claimed by written report.*

9) *Tariff 8476 may be billed for interviews conducted by the Psychiatrist, by telephone, in circumstances where all of the following conditions are met:*

   a) *The patient is experiencing a mental health crisis, and has presented to an emergency department, hospital, or mental health facility that is designated by Manitoba for the purposes of claiming this tariff; and,*

   b) *Timely communication with the family member or close acquaintances is essential to the patient care and/or management; and,*

   c) *The location or mobility factors of interviewees at the time of the call preclude in-person meetings (these circumstances must be denoted in the patient chart); and,*

   d) *The purpose of the interview is not to relay lab or diagnostic results.*

Psychiatrist to General Practitioner, Paediatrician or RN (EP) telephone consultation:

8007 Consulting Psychiatrist, direct physician to physician or physician to RN (EP) telephone response within two (2) hours of referring General Practitioner's, Paediatrician's or RN (EP)'s request 62.43

8008 Consulting Psychiatrist, direct physician to physician or physician to RN (EP) telephone response within forty-eight (48) hours of referring General Practitioner's, Paediatrician's or RN (EP)'s request 49.43

Note: 1) *Payable to a Psychiatrist for a two-way telephone communication, initiated at the request of a General Practitioner, Paediatrician or RN (EP) regarding the assessment, opinion, next step advice and recommendations as to the management and/or treatment of a patient.*

2) *Includes discussion of pertinent family/patient history, history of presenting complaint, and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.*

3) *A record of the response and advice must be maintained by the Psychiatrist.*

4) *Limited to one claim per patient per day.*

5) *Not payable where the sole purpose of the call is to:*

   a) *Book an appointment;*

   b) *Arrange for a transfer of care that occurs within 24 hours;*

   c) *Arrange for an expedited consultation or procedure within 24 hours; or*

   d) *Arrange a hospital bed for the patient.*

6) *Advice given by the Psychiatrist must take place within the specified number of hours of the General Practitioner's, Paediatrician's or RN (EP)'s first contact with the Psychiatrist and must be physician to physician or physician to RN (EP). Not payable for written communication.*

7) *Claim must include date and time of initiating contact from the General Practitioner, Paediatrician or RN (EP) and start and end time of telephone conversation where consultative expertise is given.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8503 Complete History and Psychiatric Examination—adult.....151.94

8504 Complete History and Psychiatric Examination—child.....207.13

Note: *Patient must be under eighteen (18) years of age.*

8429 Complete History and Psychiatric Examination – Geriatric patient.....207.13

Note: *1) The patient must be at least seventy (70) years of age or have suspected or confirmed neurocognitive conditions (including but not limited to temporal lobe dementia, dementia, etc.).*

2) Tariff 8429 may be claimed only by a physician holding certification as a geriatric psychiatrist with the Royal College of Physicians and Surgeons of Canada or as designated by Shared Health, or an RHA Mental Health Program.

8510 Regional History and Examination, or Subsequent Visit.....49.62

8624 Extended Consultation—See Rules 7 to 10–Geriatric (age 70 and older) minimum of forty-five (45) minutes of patient/physician contact time.....358.34

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.*

8622 Consultation—geriatric patient—See Rules 7 to 10.....298.64

Note: *1) The patient must be at least seventy (70) years of age.*

2) Tariff 8622 may be claimed only by a physician holding certification as a geriatric psychiatrist with the Royal College of Physicians and Surgeons of Canada or as designated by the WRHA Mental Health Program.

8625 Extended Consultation—See Rules 7 to 10–Adult minimum of forty-five (45) minutes of patient/physician contact time.....278.68

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.*

8553 Consultation—adult—See Rules 7 to 10 ..... 232.23

8626 Extended Consultation—See Rules 7 to 10–Child minimum of forty-five (45) minutes of patient/physician contact time 358.34

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8554 Consultation—child—See Rules 7 to 10 ..... 298.64

Note: *Patient must be under eighteen (18) years of age.*

8662 Extended Consultation—Unassigned Patient–Geriatric (age 70 and older) minimum of forty-five (45) minutes of patient/physician contact time 420.18

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.*

8623 Consultation—Unassigned Patient–Geriatric—See Rules 7 to 10 ..... 350.16

Note: *1) The patient must be at least seventy (70) years of age.*

2) Tariff 8623 may be claimed only by a physician holding certification as a geriatric psychiatrist with the Royal College of Physicians and Surgeons of Canada or as designated by the WRHA Mental Health Program.

8663 Extended Consultation—Unassigned Patient–Adult minimum of forty-five (45) minutes of patient/physician contact time 340.47

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.*

8595 Consultation—Unassigned Patient—adult 283.71

8664 Extended Consultation—Unassigned Patient–Child minimum of forty-five (45) minutes of patient/physician contact time 420.18

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8596 Consultation—Unassigned Patient—child 350.16

Note: *1) "Unassigned Patient" means a patient who requires assessment by a Psychiatrist, who has not rendered a Complete History and Physical Examination (tariff 8503 or 8504), or Consultation service (tariff 8553, 8554, 8595 or 8596) or Intake Registry tariff or Geriatric Consultation to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 10 inclusive apply.*

2) Patient must be under eighteen (18) years of age.

8466 Psychiatry Intake Registry Consultation to Primary Care Provider–Adult—See Rules 7 to 10 ..... 307.38

8467 Psychiatry Intake Registry Consultation to Primary Care Provider–Child—See Rules 7 to 10 (Patient under the age of 18) 378.34

8468 Psychiatry Intake Registry Consultation to Primary Care Provider–Geriatric—See Rules 7 to 10 (Patient at least 70 years of age) 378.34

Note: *1) The Psychiatry Intake Registry must be located in and managed by the applicable Regional Health Authority(s) (RHAs).*

2) Claimable by psychiatrists approved by the applicable RHA.

3) Payable for patients referred to the Registry by a primary care provider, who must receive the consultation report.

4) The consultation must be scheduled through the RHA's Psychiatry Intake Registry. Each Psychiatry Intake Registry must establish written policies regarding patient eligibility for psychiatric consultations in order for these tariffs to be billable.

5) Psychiatrists must meet the following requirements to claim these tariffs.

a) At least one (1) hour consultation time must be reserved by the psychiatrist on a weekly basis and communicated to applicable Registry administrators to provide timely access to consultation appointments and reserved consultation dates and times for Psychiatry Intake patients.

b) Patients must be accepted and seen by psychiatrists in the order they are disseminated by the Registry, except in urgent circumstances.

8706 Extended Psychiatry Intake Registry Originated Consultation to Primary Care Provider–Geriatric (age 70 and older) minimum of forty-five (45) minutes of patient/physician contact time 453.99

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.*

8707 Extended Psychiatry Intake Registry Originated Consultation to Primary Care Provider–Adult minimum of forty-five (45) minutes of patient/physician contact time 368.87

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.*

8708 Extended Psychiatry Intake Registry Originated Consultation to Primary Care Provider–Child minimum of forty-five (45) minutes of patient/physician contact time 453.99

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8520 Hospital Care—per day 39.70

Note: *For patients participating in hospital day care programs the physician is to claim the appropriate visit or therapy fee only for those days when the physician actually provides a direct service to the patient.*

8443 Psychiatric inpatient care – patient care supplement – per day 28.56

Notes: *1) May be claimed by the attending psychiatrist for each patient admitted to an acute psychiatric unit/bed.*

2) Tariff 8520 and/or other applicable visit/examination services are payable in addition.

CONCOMITANT CARE

8524 Concomitant Care—per day 35.47

PSYCHOTHERAPY (WITH OR WITHOUT INTRAVENOUS DRUGS)

8581 Individual 60.79

Note: *1) Tariff rate is payable for each of the first two full fifteen(15) minute periods and for each additional fifteen (15) minute period or major portion thereof.*

2) A minimum of a full thirty (30) minute period and a maximum of ninety (90) minutes may be claimed per patient per day.

3) Where psychotherapy sessions with a patient extend beyond two and one-half (2 ½) hours in any seven (7) day period, a written report is required.

Group psychotherapy is defined as the treatment of two or more patients together in a session, and may include members of a family group.

8444 Group of two (2)—four (4) patients 69.62

8446 Group of five (5) or more patients.....68.65

Note: *1) Tariff rate is payable for each of the first two full fifteen (15) minute periods and for each additional fifteen (15) minute period or major portion thereof.*

2) A minimum of a full thirty (30) minute period and a maximum of ninety (90) minutes may be claimed per day.

3) Where group psychotherapy session(s) extend beyond these limits, a written report is required.

4) The total fee listed for the group is divided by the number of patients in the group and billed for each separate claim.

ELECTROCONVULSIVE THERAPY

8588 Electroconvulsive Therapy (ECT).....101.51

PSYCHIATRIC CARE

Psychiatric care means the provision of individual psychotherapy services that may or may not be prearranged.

8584 Individual 76.13

Note: *1) A minimum of a full fifteen (15) minute period and a maximum of thirty (30) minutes may be claimed per patient per day.*

2) Tariff rate is payable for the first full fifteen (15) minute period and for the second fifteen (15) minutes or major portion thereof.

8488 Enhanced Psychiatric Treatments 28.61

Enhanced psychiatric treatment administration and monitoring-single agent or modality requiring less than 1 hour to infuse or treat – per session.

Notes: *1) To be eligible to bill 8488, the physician, treatment drug, instrument must be deemed eligible by the Provincial CMO or a designate. They include ketamine (IV, oral and nasal), and rTMS.*

2) *For the initial administration of the treatment when calibration, mapping, dosage or setup services are provided by the psychiatrist, 2 units (total) of 8488 may be claimed for the session.*

3) *When bedside attendance is required by the psychiatrist, 2 units (total) of 8488 may be claimed for that session.*

4) *For all other sessions, where the psychiatrist provides monitoring and stand-by services, 1 unit of 8488 may be claimed for that session.*

8489 Repetitive Transcranial Magnetic Stimulation rTMS- technical component per session 37.49

Notes: 1) *8489 may be claimed if the equipment is owned, and the staff are employed by the physician. The equipment model must be approved by Provincial CMO or a designate.*

2) *8489 may be claimed in addition to 8488.*

3) *Max one 8489 may be claimed per sitting.*

Psychiatrist to General Practitioner, Paediatrician or RN (EP) telephone consultation:

8007 Consulting Psychiatrist, direct physician to physician or physician to RN (EP) telephone response within two (2) hours of referring General Practitioner's, Paediatrician's or RN (EP)'s request 62.43

8008 Consulting Psychiatrist, direct physician to physician or physician to RN (EP) telephone response within forty-eight (48) hours of referring General Practitioner's, Paediatrician's or RN (EP)'s request 49.43

Note: 1) *Payable to a Psychiatrist for a two-way telephone communication, initiated at the request of a General Practitioner, Paediatrician or RN (EP) regarding the assessment, opinion, next step advice and recommendations as to the management and/or treatment of a patient.*

2) *Includes discussion of pertinent family/patient history, history of presenting complaint, and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.*

3) *A record of the response and advice must be maintained by the Psychiatrist.*

4) *Limited to one claim per patient per day.*

5) *Not payable where the sole purpose of the call is to:*

a) *Book an appointment;*

b) *Arrange for a transfer of care that occurs within 24 hours;*

c) *Arrange for an expedited consultation or procedure within 24 hours; or*

d) *Arrange a hospital bed for the patient.*

6) *Advice given by the Psychiatrist must take place within the specified number of hours of the General Practitioner's, Paediatrician's or RN (EP)'s first contact with the Psychiatrist and must be physician to physician or physician to RN (EP). Not payable for written communication.*

7) Claim must include date and time of initiating contact from the General Practitioner, Paediatrician or RN (EP) and start and end time of telephone conversation where consultative expertise is given.

GENERAL SURGERY (04-1)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination 62.02

8403 Regional History and Examination or Subsequent Visit 33.09

8626 Extended Consultation—See Rules 7 to 10–Child minimum of forty-five (45) minutes of patient/physician contact time 163.85

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation—See Rules 7 to 10 ..... 136.57

VIRTUAL VISITS

8340 Episodic virtual visit by phone 20.40

8321 Virtual visit by telephone or video 33.09

8535 Virtual consultation by telephone or video 136.57

8447 Comprehensive Virtual Assessment by telephone or video 62.02

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8540 Complete History and Physical Examination.....62.02

8626 Extended Consultation—See Rules 7 to 10–Child minimum of forty-five (45) minutes of patient/physician contact time.....163.85

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation—See Rules 7 to 10.....136.57

8664 Extended Consultation—Unassigned Patient–Child minimum of forty-five (45) minutes of patient/physician contact time.....226.61

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8595 Consultation—Unassigned Patient.....188.83

Note: *"Unassigned Patient" means a patient who requires assessment by a General Surgeon Specialist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 10 inclusive apply.*

8510 Regional History and Examination, or Subsequent Visit.....33.24

8520 Hospital Care—per day.....35.22

CONCOMITANT CARE

8524 Concomitant Care—per day.....35.22

CHRONIC CARE—SEE GENERAL SCHEDULE

CARDIAC SURGERY (04-2)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination.....71.27

8403 Regional History and Examination or Subsequent Visit.....33.09

8626 Extended Consultation—See Rules 7 to 10–Child minimum of forty-five (45) minutes of patient/physician contact time.....184.25

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation—See Rules 7 to 10.....159.51

VIRTUAL VISITS

8340 Episodic virtual visit by phone.....20.40

8321 Virtual visit by telephone or video.....33.09

8654 Thoracic Aortic Disease Virtual Clinic Visit.....32.77

8535 Virtual consultation by telephone or video.....159.51

8447 Comprehensive Virtual Assessment by telephone or video.....71.27

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8540 Complete History and Physical Examination 71.27

8626 Extended Consultation—See Rules 7 to 10–Child minimum of forty-five (45) minutes of patient/physician contact time 184.25

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation—See Rules 7 to 10 ..... 159.51

8664 Extended Consultation—Unassigned Patient–Child minimum of forty-five (45) minutes of patient/physician contact time 243.43

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8595 Consultation—Unassigned Patient 210.72

Note: *"Unassigned Patient" means a patient who requires assessment by a Cardiovascular Surgeon, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 10 inclusive apply.*

8510 Regional History and Examination, or Subsequent Visit 32.57

8520 Hospital Care—per day 39.40

CONCOMITANT CARE

8524 Concomitant Care—per day 39.40

CHRONIC CARE—SEE GENERAL SCHEDULE

PLASTIC & RECONSTRUCTIVE SURGERY (04-3)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination 67.11

8530 Subsequent Visit 46.41

8626 Extended Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10–
Child minimum of forty-five (45) minutes of patient/physician contact time 150.49

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10 ..... 100.41

VIRTUAL VISITS

8340 Episodic virtual visit by phone 20.40

8321 Virtual visit by telephone or video 46.41

8535 Virtual consultation by telephone or video 100.41

8447 Comprehensive Virtual Assessment by telephone or video 67.11

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8540 Complete History and Physical Examination.....67.11

8626 Extended Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10–
Child minimum of forty-five (45) minutes of patient/physician contact time.....150.49

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10.....100.41

8520 Hospital Care—per day.....34.65

CONCOMITANT CARE

8524 Concomitant Care—per day.....34.65

CHRONIC CARE—SEE GENERAL SCHEDULE

UROLOGY (04-4)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination 62.95

8403 Regional History and Examination or Subsequent Visit 41.41

8626 Extended Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10–
Child minimum of forty-five (45) minutes of patient/physician contact time 112.87

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10 ..... 97.56

VIRTUAL VISITS

8340 Episodic virtual visit by phone 20.40

8321 Virtual visit by telephone or video 41.41

8535 Virtual consultation by telephone or video 97.56

8447 Comprehensive Virtual Assessment by telephone or video 62.95

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8540 Complete History and Physical Examination.....62.95

8626 Extended Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10–
Child minimum of forty-five (45) minutes of patient/physician contact time.....112.87

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10.....97.56

8510 Regional History and Examination, or Subsequent Visit 48.07

8520 Hospital Care—per day.....33.45

CONCOMITANT CARE

8524 Concomitant Care—per day.....33.45

CHRONIC CARE—SEE GENERAL SCHEDULE

ORTHOPAEDIC SURGERY (04-5)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination 56.29

8403 Regional History and Examination or Subsequent Visit 36.19

8626 Extended Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10–
Child minimum of forty-five (45) minutes of patient/physician contact time 122.55

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10 ..... 102.14

8440 Orthopaedic Spinal Consultation 249.05

Note: *1) This tariff may be claimed by Orthopaedic and Neurological Surgeons recognized by the Manitoba Orthopaedic Society or the Division of Neurosurgeons, University of Manitoba, and the WRHA Medical Director, Surgery Program, as having appropriate training in spinal surgery.*

2) The visit shall be a minimum of forty (40) minutes of physician time.

3) The physician time shall be documented in the patient's record.

4) Rules of Application 7to 10 apply. In addition, the consultation must include a complete neurological assessment and review of all appropriate imaging and laboratory results and be consistent with the following Guidelines—Orthopaedic Spinal Consultation:

Guideline—Orthopaedic Spinal Consultation

Goal

To provide a thorough history and physical examination of the spine and related structures with interpretation of the appropriate radiographs. With this information the surgeon will formulate a treatment plan and follow up recommendation.

Consultation Format

The format of a consultation is generally divided into the headings of: history, physical examination, radiography, conclusion and plan. Within each heading the basic feature will be outlined as follows:

History

Identification of the entrance complaint, characteristics of the pain (e.g., duration, quality, type, exacerbating and relieving factors, radiation of pain, treatment response), constitutional symptoms, bladder and bowel function, symptoms of spinal instability, symptoms of claudication, radicular or myelopathic symptoms, change in posture, change in fitting of clothing, history of inflammatory arthropathy, past spinal surgery, reviews of systems related to presenting problem, and social history.

Physical Examination

Evaluation of gait, frontal and sagittal alignment, range of motion of the cervical, thoracic and lumbar spine (flexion, extension, rotation and lateral bending), tenderness of the spine, examination of proximal joints to the line, neurologic examination including motor and sensory function, deep tendon reflexes, upper motor neuron signs, peripheral vascular exam, rectal exam if indicated. Special tests: Straight leg raise, crossed straight leg raise, Lasegue sign, Hoffman's sign, Babinski sign.

Radiology

Evaluation and interpretation of relevant imaging including plain x-rays lateral, flexion/extension views, AP lateral bending films, nuclear medicine imaging, MRI, CT/myelogram (include date of exam and facility performed), documentation of measured progression of deformity, most recent films should be no older than one year or less than six months when there has been a recent change in symptoms in a paediatric patient.

Conclusion

This is a summary of finding in history, in physical and radiography with a diagnosis of the problem and a special emphasis on a defined treatment plan, ordering the further investigation if warranted and follow up recommendation particularly for chronic non surgical cases.

8441* Distance Management of an Injured Orthopaedic Patient.....69.35

Note: *1) This tariff may be claimed by an Orthopaedic Surgeon (whose name appears in the specialist register of the College of Physicians and Surgeons of Manitoba).*

2) This tariff is for written advice to the referring physician on the management of a case based upon review of patient files and x-rays by an Orthopaedic Surgeon.

3) Payable once per case only.

4) The referring physician who initiates the request must be situated outside the city of Winnipeg (includes St. Norbert).

*5) The Orthopaedic Surgeon who receives the request must be situated in Manitoba in a community **other than** where the referring physician is situated.*

6) After hour premiums may be claimed only for urgent/emergent cases.

7) Tariff 8001 may not be claimed in addition for same patient, same condition.

8) Telehealth may not be claimed in addition for same patient, same condition.

VIRTUAL VISITS

8340 Episodic virtual visit by phone.....20.40

8321 Virtual visit by telephone or video.....36.19

8535 Virtual consultation by telephone or video.....102.14

8447 Comprehensive Virtual Assessment by telephone or video.....56.29

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8540 Complete History and Physical Examination 56.29

8626 Extended Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10–Child minimum of forty-five (45) minutes of patient/physician contact time 122.55

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10 ..... 102.14

8664 Extended Consultation—Unassigned Patient–Child minimum of forty-five (45) minutes of patient/physician contact time 172.96

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8595 Consultation—Unassigned Patient 144.13

Note: *"Unassigned Patient" means a patient who requires assessment by an Orthopaedic Specialist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550, 8595 or 8440) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 10 inclusive apply.*

8510 Regional History and Examination, or Subsequent Visit 36.69

8520 Hospital Care—per day 33.21

CONCOMITANT CARE

8524 Concomitant Care—per day 33.21

CHRONIC CARE—SEE GENERAL SCHEDULE

NEUROLOGICAL SURGERY (04-6)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination 67.93

8403 Regional History and Examination or Subsequent Visit 39.71

8626 Extended Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10–
Child minimum of forty-five (45) minutes of patient/physician contact time 166.83

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10 ..... 139.05

8440 Orthopaedic Spinal Consultation 248.37

Note: *1) This tariff may be claimed by Orthopaedic and Neurological Surgeons recognized by the Manitoba Orthopaedic Society or the Division of Neurosurgeons, University of Manitoba, and the WRHA Medical Director, Surgery Program, as having appropriate training in spinal surgery.*

2) The visit shall be a minimum of forty (40) minutes of physician time.

3) The physician time shall be documented in the patient's record.

4) Rules of Application 7 to 10 apply. In addition, the consultation must include a complete neurological assessment and review of all appropriate imaging and laboratory results and be consistent with the following Guidelines—Orthopaedic Spinal Consultation:

Guideline

Orthopaedic Spinal physical examination of the spine and related Consultation

Goal

To provide a thorough history and physical examination of the spine and related structures with interpretation of the appropriate radiographs. With this information the surgeon will formulate a treatment plan and follow up recommendation.

Consultation Format

The format of a consultation is generally divided into the headings of: history, physical examination, radiography, conclusion and plan. Within each heading the basic feature will be outlined as follows:

History

Identification of the entrance complaint, characteristics of the pain (e.g., duration, quality, type, exacerbating and relieving factors, radiation of pain, treatment response), constitutional symptoms, bladder and bowel function, symptoms of spinal instability, symptoms of claudication, radicular or myelopathic symptoms, change in posture, change in fitting of clothing, history of inflammatory arthropathy, past spinal surgery, reviews of systems related to presenting problem, and social history.

Physical Examination

Evaluation of gait, frontal and sagittal alignment, range of motion of the cervical, thoracic and lumbar spine (flexion, extension, rotation and lateral bending), tenderness of the spine, examination of proximal joints to the line, neurologic examination including motor and sensory function, deep tendon reflexes, upper motor neuron signs, peripheral vascular exam, rectal exam if indicated. Special tests: Straight leg raise, crossed straight leg raise, Lasegue sign, Hoffman's sign, Babinski sign.

Radiology

Evaluation and interpretation of relevant imaging including plain x-rays lateral, flexion/extension views, AP lateral bending films, nuclear medicine imaging, MRI, CT/myelogram (include date of exam and facility performed), documentation of measured progression of deformity, most recent films should be no older than one year or less than six months when there has been a recent change in symptoms in a paediatric patient.

Conclusion

This is a summary of finding in history, in physical and radiography with a diagnosis of the problem and a special emphasis on a defined treatment plan, ordering the further investigation if warranted and follow up recommendation particularly for chronic non surgical cases.

VIRTUAL VISITS

8340 Episodic virtual visit by phone.....20.40

8321 Virtual visit by telephone or video.....39.71

8535 Virtual consultation by telephone or video.....139.05

8447 Comprehensive Virtual Assessment by telephone or video.....67.93

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8540 Complete History and Physical Examination.....67.93

8626 Extended Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10–
Child minimum of forty-five (45) minutes of patient/physician contact time.....166.83

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10 ..... 139.05

8510 Regional History and Examination, or Subsequent Visit 39.71

8520 Hospital Care—per day 39.64

CONCOMITANT CARE

8524 Concomitant Care—per day 39.64

CHRONIC CARE—SEE GENERAL SCHEDULE

OPHTHALMOLOGY (05-1)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8543 Complete History and Ocular Examination, including refraction and other necessary tests (other than those listed as Special Diagnostic Ocular Tests in the Ocular Section) 90.40

8505 Regional History and Examination of the Eye 54.60

8530 Subsequent Visit 44.86

8666 Extended Consultation (including by Optometrist), including refraction and other necessary tests (other than those listed as Special Diagnostic Ocular Tests in the Ocular Section)—See Rules 7 to 10–minimum of forty-five (45) minutes of patient and physician time 151.50

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8556 Consultation (including by Optometrist), including refraction and other necessary tests (other than those listed as Special Diagnostic Ocular Tests in the Ocular Section)—See Rules 7 to 10 ..... 113.07

8449 Extended Ophthalmology Consultation for the Assessment and/or Treatment of Uveitis—See Rules 7 to 10 ..... 155.09

Note: *1) This tariff may be claimed by Ophthalmologists with successful completion of formal subspecialty fellowship training in Uveitis in a nationally recognized program and only when the patient has been referred by an Ophthalmologist or other specialist.*

2) The visit shall be a minimum of forty-five (45) minutes of face to face time between the physician and the patient.

3) The face-to-face time must be documented in the patient's record. Face-to-face time is defined as only that time that the physician spends face-to-face with the patient. Non face-to-face time in which the physician spends time before or after the face-to-face time performing such tasks as reviewing records and tests, arranging for further services and communicating with other professionals or the patient in writing or by telephone is included in the consultation fee.

VIRTUAL VISITS

8340 Episodic virtual visit by phone 20.40

8321 Virtual visit by telephone or video 54.60

8535 Virtual consultation by telephone or video 113.07

8447 Comprehensive Virtual Assessment by telephone or video 90.40

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8543 Complete History and Ocular Examination, including refraction and other necessary tests (other than those listed in Special Diagnostic Ocular Tests in the Ocular Section) 90.40

8666 Extended Consultation (including by Optometrist), including refraction and other necessary tests (other than those listed as Special Diagnostic Ocular Tests in the Ocular Section)—See Rules 7 to 10–minimum of forty-five (45) minutes of patient and physician time 151.50

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8556 Consultation (including by Optometrist), including refraction and other necessary tests (other than those listed as Special Diagnostic Ocular Tests in the Ocular Section)—See Rules 7 to 10 ..... 113.07

8510 Regional History and Examination of the Eye, or Subsequent Visit 42.45

8520 Hospital Care—per day 33.01

CONCOMITANT CARE

8524 Concomitant Care—per day 33.01

CHRONIC CARE—SEE GENERAL SCHEDULE

OTORHINOLARYNGOLOGY (05-2)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8544 Complete History and ENT Examination, including screening audiogram when necessary 66.33

8403 Regional History and Examination or Subsequent Visit 41.04

8667 Extended Consultation–Child (including by Dentist/Oral Surgeon/Audiologist) including screen audiogram when necessary—See Rules 7 to 10–minimum of forty-five (45) minutes of patient/physician contact time..... 113.94

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8557 Consultation (including by Dentist/Oral Surgeon/Audiologist), including screening audiogram when necessary—See Rules 7 to 10 ..... 96.46

8660 Neuro-otologic Consultation – see Rules 7 to 10 ..... 123.62

Note: *1) 8660 shall include a comprehensive history and physical examination.*

2) 8660 may only be claimed by a physician with Neurotologic Fellowship training, as approved by Head of the WRHA or Shared Health Otolaryngology program.

3) 8660 may be claimed by a physician only when dealing with complex conditions of the ear and how they relate to the central nervous system. Patient indications include severe hearing impairment, complex skull-based tumors, and non-surgical vestibular conditions. Regular otology consultation tariff 8557 should be billed where this is not indicated.

VIRTUAL VISITS

8340 Episodic virtual visit by phone 20.40

8321 Virtual visit by telephone or video 41.04

8535 Virtual consultation by telephone or video..... 96.46

8447 Comprehensive Virtual Assessment by telephone or video 66.33

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8544 Complete History and ENT Examination, including screening audiogram when necessary 66.33

8512 Regional History and Examination, or Subsequent Visit 39.75

8667 Extended Consultation–Child (including by Dentist/Oral Surgeon/Audiologist) including screen audiogram when necessary—See Rules 7 to 10–minimum of forty-five (45) minutes of patient/physician contact time 113.94

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8557 Consultation (including by Dentist/Oral Surgeon/Audiologist), including screening audiogram when necessary—See Rules 7 to 10 .....96.46

8660 Neuro-otologic Consultation – see Rules 7 to 10 .....123.62

Note: *1) 8660 shall include a comprehensive history and physical examination.*

2) 8660 may only be claimed by a physician with Neurotologic Fellowship training, as approved by Head of the WRHA or Shared Health Otolaryngology program.

3) 8660 may be claimed by a physician only when dealing with complex conditions of the ear and how they relate to the central nervous system. Patient indications include severe hearing impairment, complex skull-based tumors, and non-surgical vestibular conditions. Regular otology consultation tariff 8557 should be billed where this is not indicated.

8410 Voice Clinic Consultation includes full voice history, physical examination of relevant parts, analysis of voice testing data, consultation with recognized speech pathologist, video laryngeal and stroboscopic examination, development of treatment plan and advice 306.21

8411 Subsequent Voice Consultation includes the necessary history and physical examination, analysis of voice testing data, repeat video and/or stroboscopic examination. 76.53

8520 Hospital Care—per day 44.48

CONCOMITANT CARE

8524 Concomitant Care—per day 44.48

CHRONIC CARE—SEE GENERAL SCHEDULE

DERMATOLOGY (06)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8704 Extended Complete History and Dermatological Examination, minimum of forty-five (45) minutes of patient/physician contact time 79.84

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Dermatological Examination.....53.95

8705 Extended Subsequent Visit, minimum of thirty (30) minutes of patient/physician contact time 39.94

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8530 Subsequent Visit.....34.04

8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10 .....83.52

Note: *Where a primary care physician refers a patient to a dermatologist with respect to warts or molluscum contagiosum, and the warts or molluscum contagiosum are treated by the dermatologist:*

- *The dermatologist shall bill the appropriate visit fee(s) under either tariff 8540 or 8530, whichever is applicable;*
- *The dermatologist shall NOT bill for a consultation under tariff 8550;*
- *Where a biopsy is provided, the dermatologist shall be entitled to bill under tariff 0171;*
- *The dermatologist shall be entitled to bill under the appropriate tariff for the treatment rendered.*

8452 Complex Consultation requested by Physician or Dentist/Oral Surgeon 160.13

Note: *1) The visit shall be a minimum of thirty (30) minutes of physician time.*

2) Rules of Application 7 to 10 inclusive apply.

3) This tariff may be claimed for services provided to an in-patient, a patient in an Emergency Department or a resident of a Personal Care Home.

CONTINUING PATIENT CARE MANAGEMENT BY MEDICAL SPECIALISTS

8700 Continuing patient care management, supplement add to visit fee..... 30.00

Notes: *1) May be claimed in addition to an in-person visit tariff excluding consultations.*

2) Maximum of four (4) supplements may be claimed per patient per 12-month period.

3) Patient must have an established diagnosis of one or more of the following diseases. The applicable ICD codes are available for review here.

i. Advanced HIV
ii. HIV with opportunistic infection
iii. HIV in pregnancy
iv. Diabetes mellitus, including complications
v. Coagulation defects (e.g., haemophillia, other deficiencies)
vi. Purpura, thrombocytopenia, other haemorrhagic conditions
vii. Senile dementia, presenile dementia
viii. Child psychoses or autism
ix. Parkinson's Disease
x. Multiple Sclerosis
xi. Cerebral Palsy
xii. Epilepsy
xiii. Chronic Bronchitis
xiv. Emphysema
xv. Asthma, Allergic Bronchitis
xvi. Pulmonary Fibrosis
xvii. Regional Enteritis; Crohn's Disease
xviii. Ulcerative Colitis
xix. Cirrhosis of the Liver
xx. Chronic Renal Failure, Uremia
xxi. Systemic Lupus Erythematosus
xxii. Inflammatory Myositis
xxiii. Complex Psoriasis
xxiv. Vasculitis
xxv. Scleroderma
xxvi. Sarcoidosis
xxvii. Rheumatoid Arthritis
xxviii. Adult Onset Still's Disease
xxix. Systemic Juvenile Inflammatory Arthritis
xxx. Ankylosing Spondylitis
xxxi. Psoriatic Arthritis
xxxii. Reactive Arthritis
xxxiii. Enteropathic Arthritis

VIRTUAL VISITS

8340 Episodic virtual visit by phone 20.40

8321 Virtual visit by telephone or video 34.04

8535 Virtual consultation by telephone or video..... 83.52

8447 Comprehensive Virtual Assessment by telephone or video 53.95

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8704 Extended Complete History and Dermatological Examination, minimum of forty-five (45) minutes of patient/physician contact time 79.84

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Dermatological Examination.....53.95

8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10 .....83.52

8452 Complex Consultation requested by Physician or Dentist/Oral Surgeon 160.13

Note: *1) The visit shall be a minimum of thirty (30) minutes of physician time.*

2) Rules of Application 7 to 10 inclusive apply.

3) This tariff may be claimed for services provided to an in-patient, a patient in an Emergency Department or a resident of a Personal Care Home.

8520 Hospital Care—per day 38.66

CONCOMITANT CARE

8524 Concomitant Care—per day 38.66

CHRONIC CARE—SEE GENERAL SCHEDULE

RADIOLOGY (07, 07-1, 07-2, 07-6)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8540 Complete History and Physical Examination 90.02

8510 Regional History and Examination, or Subsequent Visit 39.43

8594 Complete History and Physical Examination—Unassigned patient 136.90

Notes: *1) "Unassigned patient" generally means that no ongoing physician-patient relationship exists. Specifically:*

2) This tariff may be claimed by a radiologist who performs a Complete History and Physical Examination of a patient to assess whether admission to hospital is appropriate or to admit the patient to hospital under the care of that physician, so long as that physician has not claimed tariff 8540 in respect of that patient within the last 12 consecutive months prior to the assessment or admission. This tariff is to be claimed in lieu of tariff 8540.

8520 Hospital Care—per day 39.43

8524 Concomitant Care—per day 39.43

8550 Consultation 86.05

Note: *A radiology consultation may be claimed following a written request from a physician for a radiologist's opinion regarding the advisability of performing a radiological procedure.*

It shall consist of such examination of the patient when necessary and if appropriate and a discussion of the risks and limitations of the proposed procedure shall occur. A written or dictated report shall be provided to the referring physician.

A consultation may be claimed in addition to any services and/or procedures provided to the patient during or following the consultation.

OBSTETRICS AND GYNAECOLOGY (09)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination.....61.97

Notes: *1) Tariff 9795 (cytological smears for cancer screening) may be claimed in addition to tariff 8540, where appropriate.*

2) Tariff 8448 may be claimed in addition to 8540 where a pelvic examination is provided. See Rule 17 for full description.

8465 Extended Visit, time based premium, add..... 20%

Notes: *1) Tarif 8465 is claimable in addition to 8540 where a minimum of forty-five (45) minutes of direct patient/physician contact time occurs.*

2) Tarif 8465 is claimable in addition to 8505 where a minimum of thirty (30) minutes of direct patient/physician contact time occurs.

3) Tarif 8465 is claimable in addition to 8550 where a minimum of forty-five (45) minutes of direct patient/physician contact time occurs , and the patient is under eighteen 18 years of age.

4) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8459 Mature Women's Health Assessment (or, Assessment for active/symptomatic perimenopause and menopause).....90.02

Notes: *1) 8459 includes a patient history, an inquiry into and examination of all relevant parts or systems, and advice to the patient.*

2) 8459 may be claimed for patients who are experiencing symptoms of perimenopause or menopause, and who require an assessment of symptoms, complications, interactions that could stem from perimenopause or menopause.

3) If a physician is consulted strictly for active presentations of perimenopause or menopause, practitioners may claim the consultation tariff for those services when a consultation is provided.

4) 8459 may be claimed on any day after another visit or consultation, notwithstanding Rule of Application 6.

8505 Regional History and Examination 45.33

Notes: *1) Tariff 9795 (cytological smears for cancer screening) may be claimed in addition to tariff 8505, where appropriate..*

2) Tariff 8448 may be claimed in addition to 8505 where a pelvic examination is provided. See Rule 17 for full description.

8448 Pelvic Examination, add—See Rule 17 for full tariff description 20.40

8530 Subsequent Visit 37.04

8550 Consultation—See Rules 7 to 10 ..... 102.33

8416 Midwifery Assessment & Report—See General Schedule

8400 Comprehensive pre-natal assessment 88.70

8401 Pre-natal visit 38.60

8402 Post-natal visit 38.66

VIRTUAL VISITS

8340 Episodic virtual visit by phone 20.40

8321 Virtual visit by telephone or video 45.33

8535 Virtual consultation by telephone or video 102.33

8447 Comprehensive Virtual Assessment by telephone or video 61.97

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

OBSTETRICAL CARE—SEE OBSTETRICAL BENEFITS/FEMALE GENITAL SECTION

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8540 Complete History and Physical Examination 61.97

Notes: *1) Tariff 9795 (cytological smears for cancer screening) may be claimed in addition to tariff 8540, where appropriate.*

2) Tariff 8448 may be claimed in addition to 8540 where a pelvic examination is provided. See Rule 17 for full description.

8465 Extended Visit, time based premium, add 20%

Notes: *1) Tarif 8465 is claimable in addition to 8540 where a minimum of forty-five (45) minutes of direct patient/physician contact time occurs.*

2) Tarif 8465 is claimable in addition to 8505 where a minimum of thirty (30) minutes of direct patient/physician contact time occurs.

3) Tarif 8465 is claimable in addition to 8550 where a minimum of forty-five (45) minutes of direct patient/physician contact time occurs,, and the patient is under eighteen 18 years of age.

4) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8459 Mature Women's Health Assessment (or, Assessment for active/symptomatic perimenopause and menopause).....90.02

Notes: *1) 8459 includes a patient history, an inquiry into and examination of all relevant parts or systems, and advice to the patient.*

2) 8459 may be claimed for patients who are experiencing symptoms of perimenopause or menopause, and who require an assessment of symptoms, complications, interactions that could stem from perimenopause or menopause.

2) If a physician is consulted strictly for active presentations of perimenopause or menopause, practitioners may claim the consultation tariff for those services when a consultation is provided.

2) 8459 may be claimed on any day after another visit or consultation, notwithstanding Rule of Application 6.

8550 Consultation—See Rules 7 to 10.....102.33

8510 Regional History and Examination, or Subsequent Visit.....38.11

Notes: *1) Tariff 9795 (cytological smears for cancer screening) may be claimed in addition to tariff 8510, where appropriate.*

2) Tariff 8448 may be claimed in addition to 8510 where a pelvic examination is provided. See Rule 17 for full description.

8520 Hospital Care—per day.....35.11

CONCOMITANT CARE

8524 Concomitant Care—per day.....35.11

CHRONIC CARE—SEE GENERAL SCHEDULE

ANESTHESIOLOGY (10)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination 62.29

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 38.66

8403 Regional History and Examination or Subsequent Visit 33.39

8550 Consultation—See Section C

8416 Midwifery Assessment & Report—See General Schedule

VIRTUAL VISITS

8340 Episodic virtual visit by phone 20.40

8321 Virtual visit by telephone or video 33.39

8535 Virtual consultation by telephone or video 159.34

8447 Comprehensive Virtual Assessment by telephone or video 62.29

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8540 Complete History and Physical Examination 62.29

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 38.66

8550 Consultation—See Section C

8510 Regional History and Examination, or Subsequent Visit 39.38

8508 Pre-anesthetic evaluation leading to delay in surgery—See Section C

8520 Hospital Care—per day 37.83

CONCOMITANT CARE

8524 Concomitant Care—per day 37.83

GENERAL PRACTICE (11)

These benefits cannot be correctly interpreted without reference to the Rules of Application.
10% will automatically be applied to tariffs 8540, 8529, 8510, 8442, 8321, ~8640 or ~8350 for patients between the ages of 65 to 69 years.
20% will automatically be applied to tariffs 8540, 8529, 8510, 8442, 8321, ~8640 or ~8350 for patients 70 years of age or older.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination.....90.02

Notes: *1) This is a service provided to a patient, which will usually comprise of:*

- *A full patient history;*
- *An inquiry into and an examination of all relevant parts or systems required to make a diagnosis or differential diagnosis;*
- *A review of results of investigations ordered by the physician;*
- *A complete written or electronic record; and*
- *Advice to the patient during the visit, and/or later by telephone, if appropriate.*
- *Where medically indicated, a return visit to advise the patient may be claimed. Abnormal test results generally require a follow-up visit.*

2) Tariff 9795 (cytological smears for cancer screening) may be claimed in addition to tariff 8540, where appropriate.

3) Tariff 8448 may be claimed in addition to 8540 where a pelvic examination is provided. See Rule 17 for full description.

8459 Mature Women's Health Assessment (or, Assessment for active/symptomatic perimenopause and menopause).....90.02

Notes: *1) 8459 includes a patient history, an inquiry into and examination of all relevant parts or systems, and advice to the patient.*

2) 8459 may be claimed for patients who are experiencing symptoms of perimenopause or menopause, and who require an assessment of symptoms, complications, interactions that could stem from perimenopause or menopause.

3) If a physician is consulted strictly for active presentations of perimenopause or menopause, practitioners may claim the consultation tariff for those services when a consultation is provided.

4) 8459 may be claimed on any day after another visit or consultation, notwithstanding Rule of Application 6.

8529 Regional Intermediate Visit—Regional or Subsequent Visit or Well Baby Care 39.43

Notes: *1) A Regional Intermediate Visit for a problem specific Assessment is a service provided to a patient which shall be comprised of:*

- *A history of the presenting complaint(s);*
- *An examination of the parts or systems related to the presenting complaint(s);*
- *A review of all pertinent investigations;*
- *A complete written record and advice to the patient.*

2) The visit shall be a minimum of ten (10) minutes of physician time or the patient is over 65 years of age.

3) Tariff 9795 (cytological smears for cancer screening) may be claimed in addition to tariff 8529, where appropriate.

4) Tariff 8448 may be claimed in addition to 8529 where a pelvic examination is provided. See Rule 17 for full description.

~8640 Extended Visit 70.00

Notes: *1) An extended visit is to assess two or more distinct complaints or problems from the patient, and shall be comprised of:*

- *A history of the presenting two or more complaints;*
- *An examination of the parts or systems related to the presenting complaints;*
- *A review of all pertinent investigations;*
- *A complete written record and advice to the patient;*
- *The visit shall be a minimum of twenty (20) minutes of physician time.*

2) If applicable, an age premium will automaticallybe applied to tariff ~8640.

8509 Regional Basic Visit—Regional or Subsequent Visit 28.15

Note: *A Regional Basic Visit is a service rendered to a patient who consults the physician for a condition—usually relatively minor. The assessment of the patient's condition is problem focused and little or no physical examination is included.*

Note: *Generally, less than ten (10) minutes of physician time is required.*

8448 Pelvic Examination, add—See Rule 17 for full tariff description 20.40

8400 Comprehensive pre-natal assessment 88.92

8401 Pre-natal visit 38.81

8402 Post-natal visit 38.81

8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10 ..... 99.20

8445 Consultation by physician with certificate in Addictions Medicine or physicians approved by Provincial CMO or a designate—See Rules 7 to 10 ..... 160.21

8617 Geriatric Consultation (by physician with certificate in Care of the Elderly)—See Rules 7 to 10 ..... 160.21

8516 Anesthetic consultation 159.34

Note: *For other anesthetic services—See Section C*

8416 Midwifery Assessment & Report—See General Schedule

CARE OF THE ELDERLY (COE)

8656 Interpretation of comprehensive cognitive assessment results (minimum ½ hour of physician time) and reporting to referring physician. May be claimed in addition to a visit tariff.....104.05

8657 Care of the Elderly (COE) Geriatric Specialty Support- initiated by an allied health professional or another physician requesting advice regarding a complex or comorbid geriatric condition, which is provided by the COE physician on a priority basis within twelve (12) hours by telephone for a patient under geriatric care, per fifteen (15) minutes or major portion thereof, maximum of thirty (30) minutes.....36.88

Notes: *1) The Care of the Elderly physician must document the service, including the time when the advice was requested, and the time the call was made.*

2) A maximum of seventy-five (75) minutes are claimable per patient per week.

3) Tariffs 8000 and 8001 may not be claimed for the same patient during the same day as tariff 8657.

8658 Extended Care of the Elderly (COE) Consultation- (including requests by Geriatric Program Assessment Team GPAT) – See Rules 7 to 10 – minimum of forty-five (45) minutes of patient/physician contact time.....271.09

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.*

Note: *Tariffs 8656, 8657, and 8658 shall be limited to physicians with a certificate in Care of the Elderly or physicians approved by the Provincial CMO or Designate.*

VIRTUAL VISITS

8340 Episodic virtual visit by phone.....20.40

8345 Basic virtual visit by telephone or video.....28.15

Note: *Generally, less than ten (10) minutes of physician time is required.*

8321 Intermediate virtual visit by telephone or video.....39.43

Note: *The visit shall be a minimum of ten (10) minutes of physician time or the patient is over 65 years of age.*

8535 Virtual consultation by telephone or video.....99.20

8637 Virtual Geriatric Consultation.....157.07

8638 Virtual Anesthetic Consultation.....159.34

8442 Comprehensive Virtual Assessment by telephone or video.....90.02

~8350 Extended virtual visit by video.....70.00

Notes: *1) An extended visit is to assess two or more distinct complaints or problems from the patient, and shall be compromised of:*

- *A history of the presenting two or more complaints;*
- *An examination of the parts or systems related to the presenting complaints;*
- *A review of all pertinent investigations;*
- *A complete written record and advice to the patient;*
- *The visit shall be a minimum of twenty (20) minutes of physician time.*
- *Start and stop times must be included on the claim.*

2) *If applicable, an age premium will automatically be applied to tariff ~8350.*

3) *When 8345, or 8321 is provided by telephone the service must be part of a continuing patient relationship as described in Rule of Application 62.*

4) *8442 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

5) *8340 shall be limited to patients with no known history with the physician.*

FAMILY MEDICINE PLUS

Preamble

Family Medicine Plus recognizes the skill, expertise, and continuity of care provided by family medicine physicians providing ongoing care to their patients. Family physicians working within teams and within a patient's medical Home Clinic ensures high quality primary care is provided to Manitoba patients. Family Medicine Plus is composed of four elements:

1. **Primary Care Enrolled Panel Management** provides support to physicians who manage a panel of enrolled patients, for whom the physician is responsible for their ongoing primary care.
2. **Comprehensive Chronic Disease Care** provides ongoing support to physicians who care for enrolled patients with specified Chronic Diseases.
3. **Newborn and Infant Enrolment** provides support and incentive for physicians to bring young Manitobans into their enrolled panel to provide primary care.
4. **Indirect Clinical Services** provides support for physicians who support the delivery of care to their enrolled panel of patients outside of conventional fee for service visits.

Family Medicine Plus tariffs may only be claimed for enrolled patients on the claiming physician's Home Clinic panel. "Enrolled patient" means a patient whom the family physician has reached an understanding to be the patient's most responsible provider and is responsible for their ongoing primary care.

Home Clinic Enrolment must be denoted in the EMR and communicated to Manitoba Health in a format compatible with Manitoba Health's information system and delivered securely through: (a) web based enrolment portal (Home Clinic Portal), or (b) via data extracts compatible with Manitoba Health's information system and delivered securely, through a secure electronic interface from the EMR on a monthly basis.

Family Medicine Plus tariffs may only be claimed by physicians who provide ongoing, comprehensive primary care to enrolled patients and have provided Manitoba Health the location of the clinic (address and contact information), and number and type of practitioners providing services at that location.

Newborn and Infant Enrolment

8180 Newborn and infant acceptance of ongoing care, under age 2 .....100.00

Notes: *1) Tariff 8180 may only be claimed once per patient (lifetime maximum), upon enrolment into the physician's panel.*

2) To claim tariff 8180, the physician must provide a medical service to the patient in the preceding twenty-four (24) months.

3) Tariff 8180 may be claimed in addition to a visit.

Primary Care Enrolled Panel Management

8181 Patient age, 0 - 16 years 7.50

8182 Patient age, 17 - 49 years 3.75

8183 Patient age, 50 - 64 years 12.50

8184 Patient age, 65 - 74 years 18.75

8185 Patient age, 75 years or greater 25.00

Notes: *1) Tariffs 8181 – 8185 are claimable once per three-month time period for a patient enrolled on the physician's panel. The three-month time periods are defined as: April 1 to June 30, July 1 to September 30, October 1 to December 31 and January 1 to March 31.*

2) A physician may claim one of the following tariffs: 8181, 8182, 8183, 8184, or 8185 per enrolled patient.

Comprehensive Chronic Disease Care

Primary care for an enrolled patient with:

8186 One chronic disease in the Medical Cluster Group 32.50

8187 Two chronic diseases in separate clusters within the Medical Cluster Group.....43.75

8188 Three chronic diseases in separate clusters within the Medical Cluster Group.....51.25

8189 Four or more chronic diseases in separate clusters within the Medical Cluster Group 56.25

8190 A chronic disease in the Mental Health Cluster 30.00

Notes: *1) Tariffs 8186 – 8190 are claimable once per three-month time period for a patient enrolled on the physician's panel. The three-month time periods are defined as: April 1 to June 30, July 1 to September 30, October 1 to December 31 and January 1 to March 31.*

2) A physician may claim one of the following tariffs: 8186, 8187, 8188, or 8189 where applicable and additionally may claim tariff 8190 where applicable.

3) For the purpose of claiming tariffs 8186, 8187, 8188, 8189 or 8190, the chronic disease clusters and disease groupings are included in the Chronic Disease Clusters table, below. Applicable ICD codes for the Chronic Diseases are available for review here.

4) In order to claim tariff 8186, 8187, 8188, 8189 or 8190 the physician, an allied health member of their clinic, or another physician providing coverage to the physician must provide a medical service to the patient in the preceding twenty-four (24) months.

5) The physician or member of their team must provide:

i) Medical services consistent with the applicable indicators in the Manitoba Primary Care Quality Indicators Guide (version 4.0 or such other version(s) as agreed to by the parties). https://www.gov.mb.ca/health/primarycare/providers/pin/docs/mpcqig.pdf

ii) Ongoing coordination with other health care providers respecting management of patient condition(s) and patient care plan; and

iii) Ongoing communication with patient, monitoring of patient condition(s) and patient care plan.

6) Family Medicine Plus tariffs may not be claimed in combination with Chronic Disease Management Tariffs: 8431, 8432, 8433, 8434, or 8435.

7) Claims for additional services rendered to a patient on the physician's enrolled panel (e.g., visits) may be made in addition.

8) The services must be documented in the EMR and communicated to Manitoba Health via data extracts compatible with Manitoba Health's information system and delivered securely, either (a) through a secure electronic interface (EMR extract) on a monthly basis, or (b) on an encrypted electronic device (e.g. CD or flash drive), on a quarterly basis (commencing on April 1 of each year), within 15 calendar days of the end of each quarter.

9) The physician shall provide care based on current standards and shall maintain competency to manage these patients, or shall be practicing in a multi-disciplinary team based care environment that develops common care plans and collectively cares for a patient population in a primary care setting.

10) In addition to medication management, the physician, or a member of their team, where required, must:

i) Provide ongoing screening and monitoring of the patient's condition using validated screening/diagnostic tools including identifying risk status.

ii) Make brief interventions, as required, helping patient identify goals and treatment readiness, and identify risky behaviours. Such interventions may require additional visit or services as applicable.

iii) Develop, review and manage patient care plans including management of co-morbidities, on an on-going basis.

iv) Make appropriate referrals/consultations.

Indirect Clinical Services

8191 Indirect Clinical Services provided to the physician's enrolled panel of patients, per full 15 minutes, to a maximum of 12 units per week, subject to the below maximum..... 42.76

Notes: *1) The physician may claim up to 30 minutes per calendar week, for each 250 patients on their panel. A calendar week is defined as Sunday to Saturday. Example, a physician with an enrolled panel of 1,300 patients shall be eligible for: 1,300 / 250 = 5.2 = 5 30-minute blocks, or 10 units of 8191 per calendar week.*

2) The physician shall be limited to maximum of three (3) hours (or 12 units) of Indirect Clinical service per calendar week.

3) The physician shall have provided primary care services to their enrolled panel of patients during the calendar week that they are claiming Indirect Clinical services.

4) The physician may claim for time spent on Indirect Clinical Services, which are patient-specific services provided when the patient is not present. This includes:

i) Documentation of patient interactions and charting.

ii) Review of results: labs, imaging, consultations, and other reports .
iii) Preparing referrals and requisitions, excluding-consultation.
iv) Chart review.
v) Care coordination, and care planning.
vi) Clinical teaching arising from direct patient care for the following learners: medical students, residents, nurses/nursing students, nurse practitioners/nurse practitioner students and midwives/midwifery students.
vii) Reviewing and analyzing clinically related information/research directly related to the needs of a particular patient (e.g. investigating particular diagnostic and therapeutic interventions).
viii) Completion of clinically required forms, reports and medical certificates of death. This excludes services requested or required by a third party for other than medical requirements, such as insurance forms and reports, medical-legal letters and reports, insurance/industrial examinations, and physical fitness examinations for school/camp.

Chronic Disease Clusters

Medical Cluster Group	Included Diseases
Cardiac Disease Cluster	Hypertension Coronary Artery Disease Chronic Heart Failure
Endocrine Disease Cluster	Diabetes
Respiratory Disease Cluster	Asthma Chronic Obstructive Pulmonary Disorder
Sexually Transmitted and Blood Borne Infections (STBBI) Cluster	HIV (active management) HIV (prevention, including PrEP) Hepatitis (active management) Syphilis (active management)
Substance Use Disorder Cluster	Excludes SUD diagnosis associated with caffeine or tobacco
Mental Health Cluster	**Included Diseases**
Mental Health Cluster	Depression Anxiety ADHD/ ADD Bipolar Disorder Borderline Personality Disorder Schizophrenia

EXTENDED CLINIC HOURS PREMIUM

5530 Extended clinic hours 0600-0800 (6:00 a.m. – 8:00 a.m) or 1700 to 2359 hours (5:00 p.m to 11:59 p.m) add. ..... 20% to payable fee
On weekdays, excluding Saturday, Sunday and designated Holidays (see Note 5 below).

5531 Extended clinic hours 0701 to 2359 (7:01 a.m. to 11:59 p.m) add on Saturday, Sunday and designated Holidays (see Note 5 below).....20% to payable fee

Extended clinic hour premiums shall apply to all medical services commencing between the hours set out above provided that:

I. The clinic maintains at least 8 hours of regular office hours within 0800-1700 Monday Friday (For example, 0800-1600, or 0830-1630, or 0900-1700); and,

II.The extended clinic hours are advertised to the public or the clinic's own patients and the patient has the option for in person availability.

Notes: *1) An extended clinic hours premium may not be claimed for a patient scheduled to be seen before the extended hours period.*

2) The time the service commences must be entered on the claim.

3) 5530 or 5531 may not be claimed with tariffs 5555, 5553, 5550, 5556, 5557 and 5558.

4) Tariffs 8000, 8001, 8002, 8003, 8005 and annual management tariffs such as but not limited to CDM and CCM tariffs, are not eligible for the extended clinic hours premium.

5) Designated Holidays include: New Year's Day, Louis Riel Day, Good Friday, Easter Monday, Victoria Day, Canada Day, Terry Fox Day, Labour Day, National Day for Truth and Reconciliation, Thanksgiving Day, Remembrance Day, Christmas Day and Boxing Day.
If any of these days fall on a Saturday or Sunday, the day will be observed as stated on the Manitoba Health CPS website at:
https://www.gov.mb.ca/health/claims/providers.html

General Practitioner to psychiatrist telephone consultation:

8006 Referring General Practitioner..... 15.85

Note: *1) Payable for two-way telephone communication regarding assessment, opinion, next step advice, and recommendations as to the management and/or treatment of a patient.*

2) 8006 is payable only when a corresponding 8007 or 8008 is completed by the psychiatrist.

3) Includes discussion of pertinent family/patient history, history of presenting complaint, and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.

4) Advice and resulting care plan must be recorded in the patient chart. Any care plan resulting from the advice must be recorded in the patient chart of the General Practitioner.

5) Limited to one claim per patient per General Practitioner physician per day.

6) Not payable where the sole purpose of the call is to:

a) Book an appointment;

b) Arrange for a transfer of care that occurs within 24 hours;

c) Arrange for an expedited consultation or procedure within 24 hours; or

d) Arrange a hospital bed for the patient.

7) Advice given by the psychiatrist must take place within the specified number of hours of the General Practitioner's first contact with the psychiatrist and must be physician to physician. Not payable for written communication.

8) Claim must include date and time of initiating contact from the General Practitioner and start and end time of the telephone conversation where consultative expertise is given.

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

The Hospital Care Premium also applies to tariffs 8529 and 8509 for urgent/emergent services provided in the Emergency Department.

8540 Complete History and Physical Examination.....90.02

Notes: *1) This is a service provided to a patient, which will usually comprise of:*

- *A full patient history;*
- *An inquiry into and an examination of all relevant parts or systems required to make a diagnosis or differential diagnosis;*
- *A review of results of investigations ordered by the physician;*
- *A complete written or electronic record; and*
- *Advice to the patient during the visit, and/or later by telephone, if appropriate.*
- *Where medically indicated, a return visit to advise the patient may be claimed. Abnormal test results generally require a follow-up visit.*

2) Tariff 9795 (cytological smears for cancer screening) may be claimed in addition to tariff 8540, where appropriate.

3) Tariff 8448 may be claimed in addition to 8540 where a pelvic examination is provided. See Rule 17 for full description.

8459 Mature Women's Health Assessment (or, Assessment for active/symptomatic perimenopause and menopause).....90.02

Notes: *1) 8459 includes a patient history, an inquiry into and examination of all relevant parts or systems, and advice to the patient.*

2) *8459 may be claimed for patients who are experiencing symptoms of perimenopause or menopause, and who require an assessment of symptoms, complications, interactions that could stem from perimenopause or menopause.*

2) *If a physician is consulted strictly for active presentations of perimenopause or menopause, practitioners may claim the consultation tariff for those services when a consultation is provided.*

2) *8459 may be claimed on any day after another visit or consultation, notwithstanding Rule of Application 6.*

8510 Regional History and Examination, or Subsequent Visit 39.43

Notes: 1) *Tariff 9795 (cytological smears for cancer screening) may be claimed in addition to tariff 8510, where appropriate.*

2) *Tariff 8448 may be claimed in addition to 8510 where a pelvic examination is provided. See Rule 17 for full description.*

8448 Pelvic Examination, add—See Rule 17 for full tariff description 20.40

8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10 ..... 99.20

8445 Consultation by physician with certificate in Addictions Medicine or physicians approved by Provincial CMO or a designate—See Rules 7 to 10 ..... 160.21

8617 Geriatric Consultation (by physician with certificate in Care of the Elderly)—See Rules 7 to 10 ..... 160.21

8594 Complete History and Physical Examination—Unassigned patient 136.90

Notes: 1) *"Unassigned patient" generally means that no ongoing physician-patient relationship exists. Specifically:*

2) *This tariff may be claimed by a general practitioner who performs a Complete History and Physical Examination of a patient to assess whether admission to hospital is appropriate or to admit the patient to hospital under the care of that physician, so long as that physician has not claimed tariff 8540 in respect of that patient within the last 12 consecutive months prior to the assessment or admission. This tariff is to be claimed in lieu of tariff 8540.*

3) *Where the patient has a regular family physician, and where another physician, who is part of the regular family physician's call group, performs a Complete History and Physical Examination prior to the patient's admission to hospital, this tariff may not be claimed if the patient's regular family physician has claimed tariff 8540, in respect of that patient within the last 12 consecutive months prior to the patient's admission to hospital.*

4) *The limitation in Note 3 does not apply to a physician who has agreed to be "Doctor of the Day".*

General Practitioner to psychiatrist telephone consultation:

8006 Referring General Practitioner 15.85

Note: 1) *Payable for two-way telephone communication regarding assessment, opinion, next step advice, and recommendations as to the management and/or treatment of a patient.*

2) *8006 is payable only when a corresponding 8007 or 8008 is completed by the psychiatrist.*

3) *Includes discussion of pertinent family/patient history, history of presenting complaint, and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.*

4) *Advice and resulting care plan must be recorded in the patient chart. Any care plan resulting from the advice must be recorded in the patient chart of the General Practitioner.*

5) *Limited to one claim per patient per General Practitioner physician per day.*

6) *Not payable where the sole purpose of the call is to:*

   a) *Book an appointment;*

   b) *Arrange for a transfer of care that occurs within 24 hours;*

   c) *Arrange for an expedited consultation or procedure within 24 hours; or*

   d) *Arrange a hospital bed for the patient.*

7) *Advice given by the psychiatrist must take place within the specified number of hours of the General Practitioner's first contact with the psychiatrist and must be physician to physician. Not payable for written communication.*

8) *Claim must include date and time of initiating contact from the General Practitioner and start and end time of the telephone conversation where consultative expertise is given.*

8520 Hospital Care—per day 39.43

8526 Clinical Teaching Unit (CTU) patient care supplement – per day 15.65

Note: 1) *May be claimed by the CTU attending physician for each patient admitted to a CTU designated by Manitoba Health.*

2) *Tariff 8520 and/or other applicable visit/examination services are payable in addition.*

3) *Only one (1) physician may claim tariff 8526, one service per patient per day.*

CONCOMITANT CARE

8524 Concomitant Care—per day 39.43

CHRONIC CARE—SEE GENERAL SCHEDULE

CHRONIC DISEASE MANAGEMENT

8431 Annual management of Diabetes, including development of patient care plan..... 45.57

Note: *1) Applicable only for patients with confirmed diagnosis of Diabetes.*

2) Tariff 8431 is payable only to the general practice physician who has provided the majority of the patient's ongoing comprehensive care in relation to the active management of Diabetes during the preceding twelve (12) months.

3) Tariff 8431 may only be billed upon provision of the following services:

i) Blood pressure measurement;

ii) Foot examination or management of documented peripheral neuropathy;

iii) Fundoscopic examination or referral for a fundoscopic examination;

iv) Full fasting lipid profile screening (for patients from 18 years of age to 74 years of age);

v) HGB A1C test;

vi) Nephropathy screening;

vii) Obesity/overweight screening;

viii) Ongoing coordination with other allied health care providers respecting management of patient condition and patient care plan as appropriate;

ix) Ongoing communication with patient, monitoring of patient condition and patient care plan as appropriate.

4) Tariff 8431 may only be billed once per patient during any twelve (12) month period.

5) The services in Note 3) must be documented and provided to Manitoba Health either a) by an electronic medical record compatible with Manitoba Health's information system or b) by completing Manitoba Health's patient care treatment form which shall be forwarded to Manitoba Health either electronically or by fax.

6) Claims for additional services rendered to a patient (e.g., visits) may be made in addition to this tariff.

8432 Annual management of Asthma, including development of patient care plan 20.25

Note: *1) Applicable only for patients with confirmed diagnosis of Asthma.*

2) Tariff 8432 is payable only to the general practice physician who has provided the majority of the patient's ongoing comprehensive care in relation to the active management of Asthma during the preceding twelve (12) months.

3) Tariff 8432 may only be billed upon provision of the following services:

i) Development and review of Asthma Action Plan form;

ii) Ongoing coordination with other allied health care providers respecting management of patient condition and patient care plan as appropriate;

iii) Ongoing communication with patient, monitoring of patient condition and patient care plan as appropriate.

4) Tariff 8432 may only be billed once per patient during any twelve (12) month period.

5) The services in Note 3) must be documented and provided to Manitoba Health either a) by an electronic medical record compatible with Manitoba Health's information system or b) where available, by completing Manitoba Health's patient care treatment form which shall be forwarded to Manitoba Health either electronically or by fax.

6) Claims for additional services rendered to a patient (e.g., visits) may be made in addition to this tariff.

8433 Annual management of Congestive Heart Failure, including development of patient care plan 45.57

Note: *1) Applicable only for patients with confirmed diagnosis of Congestive Heart Failure.*

2) Tariff 8433 is payable only to the general practice physician who has provided the majority of the patient's ongoing comprehensive care in relation to the active management of Congestive Heart Failure during the preceding twelve (12) months.

3) Tariff 8433 may only be billed upon provision of the following services:

i) Blood pressure measurement;

ii) Fasting blood sugar test (for patients who do not have diabetes);

iii) Full fasting lipid profile screening (for patients from 18 years of age to 74 years of age);

iv) Management of ACE inhibitor or ARB use;

v) Obesity/overweight screening;

vi) Ongoing coordination with other allied health care providers respecting management of patient condition and patient care plan as appropriate;

vii) Ongoing communication with patient, monitoring of patient condition and patient care plan as appropriate.

4) Tariff 8433 may only be claimed once per patient during any twelve (12) month period.

5) The services in Note 3) must be documented and provided to Manitoba Health either a) by an electronic medical record compatible with Manitoba Health's information system or b) by completing Manitoba Health's patient care treatment form which shall be forwarded to Manitoba Health either electronically or by fax.

6) Claims for additional services rendered to a patient (e.g., visits) may be made in addition to this tariff.

8434 Annual management of Coronary Artery Disease, including development of patient care plan 45.57

Note: *1) Applicable only for patients with confirmed diagnosis of Coronary Artery Disease.*

2) Tariff 8434 is payable only to the general practice physician who has provided the majority of the patient's ongoing comprehensive care in relation to the active management of Coronary Artery Disease during the preceding twelve (12) months.

3) Tariff 8434 may only be billed upon provision of the following services:

i) Blood pressure measurement;

ii) Fasting blood sugar test (for patients who do not have diabetes);

iii) Full fasting lipid profile screening (for patients from 18 years of age to 74 years of age);

iv) Management of beta blocking medication (for patients from 18 to 74 years of age, who have had an acute myocardial infarction, do not have asthma and have been prescribed with a beta blocking medication);

v) Obesity/overweight screening;

vi) Lipid reduction counselling (for patients from 18 to 74 years of age, with LDL levels greater than 2.0 mmol/L or prescribed with lipid lowering medication;

vii) Ongoing coordination with other allied health care providers respecting management of patient condition and patient care plan as appropriate;

viii) Ongoing communication with patient, monitoring of patient condition and patient care plan as appropriate.

4) Tariff 8434 may only be claimed once per patient during any twelve (12) month period.

5) The services in Note 3) must be documented and provided to Manitoba Health either a) by an electronic medical record compatible with Manitoba Health's information system or b) by completing Manitoba Health's patient care treatment form which shall be forwarded to Manitoba Health either electronically or by fax.

6) Claims for additional services rendered to a patient (e.g., visits) may be made in addition to this tariff.

8435 Annual management of Hypertension, including development of patient care plan 45.57

Note: *1) Applicable only for patients with confirmed diagnosis of Hypertension.*

2) Tariff 8435 is payable only to the general practice physician who has provided the majority of the patient's ongoing comprehensive care in relation to the active management of Hypertension during the preceding twelve (12) months.

3) Tariff 8435 may only be billed upon provision of the following services:

i) Blood pressure measurement;

ii) Fasting blood sugar test (for patients who do not have diabetes);

iii) Full fasting lipid profile screening (for patients from 18 years of age to 74 years of age);

iv) Obesity/overweight screening;

v) Test to detect renal dysfunction (serum creatine);

vi) *Ongoing coordination with other allied health care providers respecting management of patient condition and patient care plan as appropriate;*

vii) *Ongoing communication with patient, monitoring of patient condition and patient care plan as appropriate.*

4) *Tariff 8435 may only be billed once per patient during any twelve (12) month period.*

5) *The services in Note 3) must be documented and provided to Manitoba Health either a) by an electronic medical record compatible with Manitoba Health's information system or b) by completing Manitoba Health's patient care treatment form which shall be forwarded to Manitoba Health either electronically or by fax.*

6) *Claims for additional services rendered to a patient (e.g., visits) may be made in addition to this tariff.*

Comprehensive Care

8454 Annual management of primary care for a patient between 50-74 years of age without a chronic disease 15.19

8455 Annual management of primary care for a patient 75 years of age and over without a chronic disease 20.25

8456 Annual management of primary care for a patient diagnosed with one chronic disease 60.75

8457 Annual management of primary care for a patient diagnosed with two chronic diseases.....106.32

8458 Annual management of primary care for a patient diagnosed with three or more chronic diseases.....151.89

Note: 1) *Tariffs may only be claimed for enrolled patients. "Enrolled patient" means a patient with whom a physician, or his/her team, has reached an agreement to be the patient's most responsible primary care provider. Enrollment must be denoted in the EMR and communicated to Manitoba Health in a format compatible with Manitoba Health's information system and delivered securely through (a) one of the mechanisms referenced in Note 8, or (b) a web based enrollment portal.*

2) *Tariffs may only be claimed by physicians who provide comprehensive care to enrolled patients and have provided Manitoba Health, Seniors and Active Living the location of the clinic (address and contact information), and number and type of practitioners providing services at that location.*

3) *Tariffs are payable only to the physician who has provided the patient ongoing comprehensive primary care during the preceding twelve (12) months.*

4) *Physician or member of his/her team must provide:*

i) *Medical services consistent with the applicable indicators in the Manitoba Primary Care Quality Indicators Guide (version 3.0 or such other version(s) as agreed to by the parties).*

https://www.gov.mb.ca/health/primarycare/providers/pin/docs/mpcqig.pdf

Services shall be documented in the EMR.

ii) Ongoing coordination with other health care providers respecting management of patient condition(s) and patient care plan; and

iii) Ongoing communication with patient, monitoring of patient condition(s) and patient care plan.

5) Tariffs 8456, 8457 and 8458 may only be claimed once per patient during any twelve (12) month period and cannot be claimed in combination with any other Comprehensive Care Tariff or Chronic Disease Management Tariff.

6) Claims for additional services rendered to an enrolled patient (e.g., visits) may be made in addition.

7) Physicians must use an EMR and services must be documented in such EMR.

8) The services in Note 4(i) must be documented in the EMR and communicated to Manitoba Health via data extracts compatible with Manitoba Health's information system and delivered securely, either (a) through a secure electronic interface (EMR extract) on a monthly basis, or (b) on an encrypted electronic device (e.g. CD or flash drive), on a quarterly basis (commencing on April 1 of each year), within 15 calendar days of the end of each quarter.

9) For the purpose of 8456, 8457 and 8458 a "chronic disease" shall be Diabetes, Asthma/COPD, Congestive Heart Failure, Hypertension, Coronary Artery Disease, and effective September 1, 2020, Moderate Major Depressive Disorder/Moderate Generalized Anxiety/Substance Use Disorder (SUD).

10) Where a patient has more than one of Moderate Major Depressive Disorder/Moderate Generalized Anxiety/Substance Use Disorder (SUD), only one (1) Chronic Disease may be claimed.

11) To initially qualify to claim for Moderate Major Depressive Disorder, Moderate Generalized Anxiety Disorder or SUD ("the Disorders") the patient shall have a minimum of one of the following:

i) Two or more physician/provider visits/services with a diagnosis of one or more of the Disorders in the 1 year prior to the claim date of service. It is not required that such visits/services are provided by the physician claiming CCM; or,

ii) One or more encounter with health care facilities (such as; hospitals, emergency room/department, Addictions Foundation Manitoba (AFM), Crisis Response Centers, Co-Occurring Mental Health and Substance Use Disorders (CODI) Outreach Program at Health Sciences Centre, RAAM Clinics) with a diagnosis of one or more of the Disorders within the 2 years prior to the CCM claim's date of service.

12) For the purposes of this tariff SUD excludes diagnoses for SUD associated with caffeine, cannabinoids and tobacco.

13) The Physician shall provide care based on current standards and shall maintain competency to manage these patients, or shall be practicing in a multi-disciplinary team based care environment that develops common care plans and collectively cares for a patient population in a primary care setting.

14) *In addition to medication management, the Physician or a member of their team, where required, must:*

   a) *Provide ongoing screening and monitoring of the Disorder using validated screening/diagnostic tools including identifying risk status;*

   b) *Make brief interventions, as required, helping patient identify goals and treatment readiness, and identify risky behaviours. Such interventions may require additional visit or services as applicable;*

   c) *Develop, review and manage patient care plans including management of co-morbidities, on an on-going basis;*

   d) *Make appropriate referrals/consultations, which in the case of SUD may include referral to brief therapy or additional treatment such as buprenorphine-naloxone, methadone, naltrexone, opioids or opioid agonist therapy [OAT].*

EMERGENCY MEDICINE (11-3)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540	Complete History and Physical Examination	90.02
8599	Regional or Subsequest Visit	39.43
8550	Consultation—See Rules 7 to 10	130.89

VIRTUAL VISITS

8340	Episodic virtual visit by phone	20.40
8321	Virtual visit by telephone or video	39.43
8535	Virtual consultation by telephone or video	130.89
8447	Comprehensive Virtual Assessment by telephone or video	90.02

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

HOSPITAL CARE

8540	Complete History and Physical Examination	90.02
8599	Regional or Subsequent Visit	39.43
8550	Consultation—See Rules 7 to 10	130.89

PHYSICAL MEDICINE AND REHABILITATION (12)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time 120.30

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination.....100.24

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time 112.95

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6.....94.11

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty (30) minutes of patient/physician contact time 90.11

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8403 Regional History and Examination or Subsequent Visit.....75.07

8626 Extended Consultation—See Rules 7 to 10–Child minimum of forty-five (45) minutes of patient/physician contact time 248.68

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation—See Rules 7 to 10..... 207.23

8483 Physiatry Family Conference 50.28

A Physiatry Family Conference is a formal scheduled conference between a physiatrist, the patient's family, guardians or caregivers with or without allied health personnel.

Note:
- *A Physiatry Family Conference may include, but is not limited to, discussions regarding the condition and care of the patient with serious and complex problems, including catastrophic or terminal illness, developmental and/or multiple handicap disorders, and chronic pain.*
- *This tariff may also be claimed for a meeting involving the discharge of a patient, including the assessment of the need for care from other providers and/or community agencies.*
- *Patient may or may not be present at the Physiatry Family Conference.*
- *Tariff rate is payable for the first full fifteen (15) minute period and for each additional fifteen (15) minutes or major portion thereof.*
- *The service shall be claimed in the name of the patient.*
- *A physiatrist may claim a maximum of three (3) hours of Patient Care Family Conferences per patient within any twelve (12) month period.*
- *Additional Physiatry Care Family Conferences may be claimed by written report.*

8484 Physiatry Community Conference..... 48.37

A Physiatry Community Conference is a formal scheduled conference between a physiatrist, community representative (e.g., teacher, workplace manager) with or without other allied health professional(s) to review and share information in order to better manage care and resolve physical rehabilitation issues for patients returning to the community.

Note:
- *The patient may or may not be present.*
- *Tariff rate is payable for the first full fifteen (15) minute period and for each additional fifteen (15) minutes or major portion thereof.*
- *Maximum of three (3) hours of Physiatry Community Conferences per patient may be claimed in any twelve (12) month period.*
- *Additional Physiatry Community Conferences may be claimed by written report.*

CONTINUING PATIENT CARE MANAGEMENT BY MEDICAL SPECIALISTS

8700 Continuing patient care management, supplement add to visit fee 30.00

Notes: *1) May be claimed in addition to an in-person visit tariff excluding consultations.*

2) Maximum of four (4) supplements may be claimed per patient per 12-month period.

3) Patient must have an established diagnosis of one or more of the following diseases. The applicable ICD codes are available for review here.

i. Advanced HIV
ii. HIV with opportunistic infection
iii. HIV in pregnancy
iv. Diabetes mellitus, including complications
v. Coagulation defects (e.g., haemophillia, other deficiencies)
vi. Purpura, thrombocytopenia, other haemorrhagic conditions
vii. Senile dementia, presenile dementia
viii. Child psychoses or autism
ix. Parkinson's Disease
x. Multiple Sclerosis
xi. Cerebral Palsy
xii. Epilepsy
xiii. Chronic Bronchitis
xiv. Emphysema
xv. Asthma, Allergic Bronchitis
xvi. Pulmonary Fibrosis
xvii. Regional Enteritis; Crohn's Disease
xviii. Ulcerative Colitis
xix. Cirrhosis of the Liver
xx. Chronic Renal Failure, Uremia
xxi. Systemic Lupus Erythematosus
xxii. Inflammatory Myositis
xxiii. Complex Psoriasis
xxiv. Vasculitis
xxv. Scleroderma
xxvi. Sarcoidosis
xxvii. Rheumatoid Arthritis
xxviii. Adult Onset Still's Disease
xxix. Systemic Juvenile Inflammatory Arthritis
xxx. Ankylosing Spondylitis
xxxi. Psoriatic Arthritis
xxxii. Reactive Arthritis
xxxiii. Enteropathic Arthritis

VIRTUAL VISITS

8340 Episodic virtual visit by phone.....20.40

8321 Virtual visit by telephone or video.....75.07

8535 Virtual consultation by telephone or video 207.23

8447 Comprehensive Virtual Assessment by telephone or video 100.24

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8645 Extended Complete History and Physical Examination, minimum of forty-five (45) minutes of patient/physician contact time 120.30

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8540 Complete History and Physical Examination 100.24

8646 Extended Complete or extensive re-examination for same illness, minimum of thirty (30) minutes of patient/physician contact time 112.95

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 94.11

8626 Extended Consultation—See Rules 7 to 10–Child minimum of forty-five (45) minutes of patient/physician contact time 248.68

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation—See Rules 7 to 10 ..... 207.23

8664 Extended Consultation—Unassigned Patient–Child minimum of forty-five (45) minutes of patient/physician contact time 293.71

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8595 Consultation—Unassigned Patient.....249.62

Note: *"Unassigned Patient" means a patient who requires assessment by a Physical Medicine and Rehabilitation Specialist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 10 inclusive apply*

8477 Physiatry Team Management Conference.....48.69

A Physiatry Team Management Conference is a formal scheduled conference between a physiatrist and allied health professional(s) to review and share information in order to better manage care and establish physical rehabilitation goals for their patients, per fifteen (15) minutes or major portion thereof.

Note:

- *Tariff 8477 covers all patients reviewed at the conference;*
- *The formally scheduled conference must be conducted in the hospital (office and home visits are excluded);*
- *Patients reviewed may include outpatients or registered bed patients;*
- *A minimum of four (4) patients must be reviewed per scheduled conference;*
- *Patient may or may not be present during their own review;*
- *Allied health professionals includes, but is not limited to home care coordinators, nurses, VON, public health nurses, psychiatric nurses, mental health workers, nurses located in northern nursing stations, occupational therapists, physiotherapists, respiratory therapists and ambulance paramedics;*
- *Allied health professionals* ***does not*** *include physicians;*
- *Maximum of one (1) Physiatry Team Management Conference per calendar week per physician;*
- *Maximum of three (3) hours per conference may be claimed;*
- *Additional Physiatry Team Management Conferences may be claimed by written report;*
- *Only the organizing physiatrist may submit claims for the Team Management Conference;*
- *The total fee listed for the group is divided by the number of patients in the group and billed for each patient on a separate claim;*
- *The Team Management Conference must be documented in the patient's records.*

8647 Extended Regional History & Examination or Subsequent Visit, minimum of thirty (30) minutes of patient/physician contact time 90.11

Note: *Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not included time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards time for the purposes of an extended visit.*

8510 Regional History and Examination, or Subsequent Visit 73.35

8520 Hospital Care—per day 40.46

CONCOMITANT CARE

8524 Concomitant Care—per day 40.46

CHRONIC CARE—SEE GENERAL SCHEDULE

VASCULAR SURGERY (14-1)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination....72.79

8403 Regional History and Examination or Subsequent Visit....33.76

8626 Extended Consultation—See Rules 7 to 10–Child minimum of forty-five (45) minutes of patient/physician contact time....179.52

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation—See Rules 7 to 10....141.77

VIRTUAL VISITS

8340 Episodic virtual visit by phone....20.40

8321 Virtual visit by telephone or video....33.76

8535 Virtual consultation by telephone or video....141.77

8447 Comprehensive Virtual Assessment by telephone or video....72.79

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8540 Complete History and Physical Examination....72.79

8626 Extended Consultation—See Rules 7 to 10–Child minimum of forty-five (45) minutes of patient/physician contact time....179.52

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation—See Rules 7 to 10 ..... 141.77

8664 Extended Consultation—Unassigned Patient–Child minimum of forty-five (45) minutes of patient/physician contact time 223.04

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8595 Consultation—Unassigned Patient 191.51

Note: *"Unassigned Patient" means a patient who requires assessment by a Vascular Surgeon, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 10 inclusive apply.*

8510 Regional History and Examination, or Subsequent Visit 33.93

8520 Hospital Care—per day 33.76

CONCOMITANT CARE

8524 Concomitant Care—per day 33.76

CHRONIC CARE—SEE GENERAL SCHEDULE

THORACIC SURGERY (14-2)

These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination 76.06

8403 Regional History and Examination or Subsequent Visit 40.52

8626 Extended Consultation—See Rules 7 to 10–Child minimum of forty-five (45) minutes of patient/physician contact time 175.86

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation—See Rules 7 to 10 ..... 149.47

VIRTUAL VISITS

8340 Episodic virtual visit by phone 20.40

8321 Virtual visit by telephone or video 40.52

8535 Virtual consultation by telephone or video 149.47

8447 Comprehensive Virtual Assessment by telephone or video 76.06

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8540 Complete History and Physical Examination 76.06

8626 Extended Consultation—See Rules 7 to 10–Child minimum of forty-five (45) minutes of patient/physician contact time 175.86

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8550 Consultation—See Rules 7 to 10 ..... 149.47

8664 Extended Consultation—Unassigned Patient–Child minimum of forty-five (45) minutes of patient/physician contact time 221.70

Note: *1) Patient must be under eighteen (18) years of age.*

2) Patient/physician contact time must be documented with start and stop times on the patient's record. Patient/physician contact time is defined as time the physician spends directly in the presence of the patient for the purposes of examination, discussion and/or explanation. It does not include time spent reviewing records or tests, or arranging for further services or communication with others, either in writing or by telephone. Time spent performing procedures for which another tariff is claimable may not be counted towards contact time for the purposes of an extended visit.

8595 Consultation—Unassigned Patient 188.46

Note: *"Unassigned Patient" means a patient who requires assessment by a Thoracic Surgeon, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 10 inclusive apply.*

8510 Regional History and Examination, or Subsequent Visit 40.52

8520 Hospital Care—per day 33.76

CONCOMITANT CARE

8524 Concomitant Care—per day 33.76

CHRONIC CARE—SEE GENERAL SCHEDULE

MALIGNANT DISEASE SPECIALIST (15)

These benefits cannot be correctly interpreted without reference to the Rules of Application[2]

OFFICE, HOME VISITS

8540 Complete History and Physical Examination.....112.42

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6.....71.80

8536 Complete or extensive re-examination of a cancer patient.....66.85

These patients are defined as those who have had or are presently receiving any of the following treatments: radiation, chemotherapy (either parenteral or oral), hormonal therapy, vaccine immunotherapy, or other biological cancer therapies and are at risk for recurrence.

Tariff 8536 may be claimed every twenty-one (21) days. In the event the patient is seen again within any twenty-one (21) day period, the physician shall claim tariff 8403—Regional History and Examination or Subsequent Visit.

A claim for tariff 8403 within a twenty-one (21) day period does not preclude a physician from claiming tariff 8536 for further visits.

Example

Physician provides care on Day 1, Day 15, Day 22.

Physician is eligible to claim as follows:

Day 1—8536

Day 15—8403

Day 22—8536

8403 Regional History and Examination or Subsequent Visit.....59.05

8550 Consultation—See Rules 7 to 10.....184.96

VIRTUAL VISITS

8340 Episodic virtual visit by phone.....20.40

8321 Virtual visit by telephone or video.....59.05

8535 Virtual consultation by telephone or video.....184.96

8447 Comprehensive Virtual Assessment by telephone or video.....112.42

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

[2] The above tariffs and benefits may be claimed by physicians recognized by the College of Physicians and Surgeons of Manitoba as having specialist qualifications in a relevant field who have in addition been designated by Cancer Care Manitoba as eligible.

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8540 Complete History and Physical Examination 112.42

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ..... 71.80

8550 Consultation—See Rules 7 to 10 ..... 184.96

8595 Consultation—Unassigned Patient 230.09

Note: *"Unassigned Patient" means a patient who requires assessment by a Malignant Disease Specialist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 10 inclusive apply.*

8510 Regional History and Examination, or Subsequent Visit 74.08

8520 Hospital Care—per day 42.92

CONCOMITANT CARE

8524 Concomitant Care—per day 42.92

RADIATION ONCOLOGY SPECIALIST (15-8)

These benefits cannot be correctly interpreted without reference to the Rules of Application.[3]

OFFICE, HOME VISITS

8540 Complete History and Physical Examination.....111.64

8536 Complete or extensive re-examination of a cancer patient.....65.73

These patients are defined as those who have had or are presently receiving any of the following treatments: radiation, chemotherapy (either parenteral or oral), hormonal therapy, vaccine immunotherapy, or other biological cancer therapies and are at risk for recurrence.

Tariff 8536 may be claimed every twenty-one (21) days. In the event the patient is seen again within any twenty-one (21) day period, the physician shall claim tariff 8403—Regional History and Examination or Subsequent Visit.

A claim for tariff 8403 within a twenty-one (21) day period does not preclude a physician from claiming tariff 8536 for further visits.

Example

Physician provides care on Day 1, Day 15, Day 22. Physician is eligible to claim as follows:

Day 1—8536

Day 15—8403

Day 22—8536

8403 Regional History and Examination or Subsequent Visit.....58.47

8550 Consultation—See Rules 7 to 10.....182.29

VIRTUAL VISITS

8340 Episodic virtual visit by phone.....20.40

8321 Virtual visit by telephone or video.....58.47

8535 Virtual consultation by telephone or video.....182.29

8447 Comprehensive Virtual Assessment by telephone or video.....111.64

Note: *8447 may only be provided as part of a Continuing Patient Relationship as described in Rule of Application 62.*

SPECIAL CALL—SEE GENERAL SCHEDULE

[3] The above tariffs and benefits may be claimed by physicians recognized by the College of Physicians and Surgeons of Manitoba as having specialist qualifications in a relevant field who have in addition been designated by Cancer Care Manitoba as eligible.

HOSPITAL CARE

Hospital Care Premium

A 15% premium will automatically be applied to the following tariffs, 8300, 8301, 8302, 8303, 8304, 8305, 8306, 8307, 8308, 8409, 8410, 8411, 8412, 8413, 8444, 8445, 8446, 8452, 8466, 8467, 8468, 8477, 8490, 8502, 8503, 8504, 8508, 8510, 8512, 8520, 8524, 8526, 8536, 8540, 8543, 8544, 8550, 8551, 8553, 8554, 8556, 8557, 8581, 8584, 8594, 8595, 8596, 8599, 8614, 8615, 8617, 8620, 8622, 8623, 8624, 8625, 8626, 8635, 8645, 8646, 8647, 8660, 8662, 8663, 8664, 8667, 8704, 8706, 8707, 8708, 8732 and 8733 when rendered for services provided in a hospital in-patient setting or an Emergency Department.

8540 Complete History and Physical Examination 111.64

8550 Consultation—See Rules 7 to 10 ..... 182.29

8595 Consultation—Unassigned Patient 226.80

Note: *"Unassigned Patient" means a patient who requires assessment by a Radiation Oncologist, who has not rendered a Complete History and Physical Examination (tariff 8540) or Consultation service (tariff 8550 or tariff 8595) to that patient within the last twelve (12) consecutive months. Rules of Application 7 to 10 inclusive apply.*

8510 Regional History and Examination, or Subsequent Visit 73.25

8520 Hospital Care—per day 42.49

These benefits cannot be correctly interpreted without reference to the Rules of Application.[4]

CONCOMITANT CARE

8524 Concomitant Care—per day 42.49

RADIOTHERAPY—TELETHERAPY

Note: *1) Tariffs 7232, 7233, 7234 and 7235 are for the entire course of Radiotherapy including all mould room visits, simulator/clinical set-up attendance, radiation treatment planning, adjustments to the radiation prescription including but not limited to booster doses and shrinking fields, and on-radiation out-patient medical management.*

2) When a Radiotherapy Teletherapy patient requires emergency care during the course of treatment, after hours premiums and/or special calls may be claimed in addition. No services that relate to the course of treatment (including visits, patient care family conferences, case management conferences, telephone/facsimile/email communications) may be claimed in addition except as noted below.

3) Tariffs 7232, 7233, 7234 and 7235 are claimable by and payable to only one (1) radiation oncologist for the entire course of treatment.

4) Should the level of treatment change before the course of treatment is complete, the Radiation Oncologists shall be paid at the rate of the highest level.

[4] The above tariffs and benefits may be claimed by physicians recognized by the College of Physicians and Surgeons of Manitoba as having specialist qualifications in a relevant field who have in addition been designated by Cancer Care Manitoba as eligible.

5) *A course of treatment shall be considered six (6) weeks commencing on the date of the initial treatment.*

6) *Where the Radiation Oncologist has admitted the patient to hospital, tariff 8520 may be claimed in addition to 7232, 7233, 7234 and 7235 during the six (6) week course of treatment.*

7) *Where the Radiation Oncologist provides concomitant care, tariff 8524 may be claimed in addition to 7232, 7233, 7234 and 7235 during the six (6) week course of treatment.*

7232 Simple Radiation Treatment Management (Level 1) 221.85

Note: *All simple cases that do not meet the criteria for Levels 2-4 such as clinical set-ups and simulations for photons and/or electrons and all unplanned cases.*

7233 Intermediate Radiation Treatment Management (Level 2) 385.92

Note: *Must include one or more of the following components:*

- *Standard 2-D planning on one contour*
- *Simulation using contrast material*
- *Extended SSD*
- *Simulation with standard shielding*
- *Complex clinical set-ups including custom wax/Pb cut-out*

7234 Complex Radiation Treatment Management (Level 3).....701.00

Note: *Must include one or more of the following components:*

- *Any 3-D planning case that does not meet the criteria for Level 4.*
- *Cranial-spinal radiation*
- *CT/MR/PET fusion*
- *Hemi-body radiation planning*
- *Custom shielding*
- *Requirement of compensators including dynamic wedges and 2 field IMRT*
- *Requirement of custom immobilization devices*

7235 Extensive Radiation Treatment Management (Level 4).....835.65

Note: *Must include one or more of the following components:*

- *Pediatric radiation therapy*
- *Total skin electron treatment*
- *Total body irradiation*
- *Intensity modulated radiation therapy (IMRT) with more than 2 fields*

RADIOTHERAPY—BRACHYTHERAPY

7244 Tandem and Colpostats (Cervix or Uterus)—per treatment.....248.18

7245	Vaginal Vault—per treatment	124.14
7246	Oesophagus—per treatment	131.19
7247	Lung—Placement of catheters and first treatment	248.18
7248	Lung—Subsequent treatments	124.14
7249	Interstitial application of sealed radioisotope—Placement of catheters in OR including planning and first treatment	546.63
7250	Interstitial application of sealed radioisotope—Single catheter implant	248.18
7251	Interstitial—Subsequent treatments, any number	248.18
7252	Plaque or Mould—First application	77.42
7253	Plaque or Mould—Subsequent treatments	77.42
7254	Prostate—Seed Implant	248.18
7255	Intravascular Brachytherapy—peripheral artery	248.18
7256	Intravascular Brachytherapy—cardiac	248.18
7279	Brachytherapy Biliary Ducts	284.23

GENERAL SCHEDULE

AFTER HOURS PREMIUMS

5555 1700 to 2359 hours (5:00 p.m. to 11:59 p.m.), add ..... 50% to payable fee
On weekdays, excluding Saturday, Sunday and Holidays (see Note 7 below)

5553 2400 to 0700 hours (Midnight to 7:00 a.m.), add..... 75% to payable fee
Seven days per week

5550 0701 to 2359 hours (7:01 a.m. to 11:59 p.m.), add ..... 50% to payable fee
On Saturday, Sunday and Holidays (see Note 7 below)

After Hours Premiums shall apply to all urgent or emergent medical services commencing between the hours set out above, except as follows:

Any physician receiving "on-call" or any other form of non fee-for-service remuneration during this time period. This exception does not apply to any physician who receives non fee-for-service remuneration pursuant to an agreement to which Manitoba Health is a party if the agreement specifically provides that the physician is entitled to submit fee-for-service claims.

- Obstetrical fees if labour is induced by medical and/or surgical means by the same physician, unless the reason for the induction is fetal distress, diabetes, premature rupture of the membrane, severe pre-eclampsia—hypertension, abruption or other medically necessary reason ***By Report***.
- Full or part-time emergency physicians and on-site practitioners providing coverage in drop-in emergency clinics or hospital emergency rooms. For the purpose of this exclusion, drop-in emergency clinics include drop-in/walk-in clinics which maintain regular hours of operation that fall within the periods of time specified in the After Hours Premiums tariffs.
- During or after a "shift" by emergency or other physicians who have elected or are required to be physically or continuously present in the Emergency Department.
- Laboratory services or interpretation of test results, unless provided under urgent or emergent circumstances on-site.
- Interpretation of diagnostic imaging unless provided by a radiologist under urgent or emergent circumstances.
- Anticoagulant monitoring under tariff 8002.
- Telephone/Facsimile/Email Communications—EDS Approval under tariff 8003.

Services deemed to be urgent or emergent include, but are not limited to:

- Non-elective surgery/procedures
- Obstetrical deliveries
- Clinical procedures associated with diagnostic radiological examinations, e.g., angiography
- Detention in ambulance
- Emergent psychiatric cases
- Services rendered to an "unassigned" patient coincident with an assessment for admission or admission to hospital
- Examination of newborn at the time of birth by physician who attended the birth or examination of newborn on weekend/holiday.
- Renal Transplant Services (Tariffs 5871, 5872, 5873, 5898, 5895, 5896, 5897)

Note: *1) For obstetrical deliveries, including caesarean sections, the time of delivery shall be used to determine the applicable After Hours Premium period for the delivery and all services rendered in conjunction with the delivery. For greater certainty, these services include tariffs listed under the headings Induction of Labour, Management of Complications of First and Second Stages of Labour, and Management of Complications of Third and Fourth Stages of Labour, as well as tariffs 4824 and 4826.*

The time of delivery must be entered on the claim.

(For tariff 4825, determine After Hours Premiums in accordance with note 3 below)

2) For operative procedures, the time the patient enters the operating theatre shall be used to determine the applicable After Hours Premium period and must be entered on the claim.

3) For all other services not covered by notes 1 and 2 the time the service commences shall be used to determine the applicable After Hours Premium period and must be entered on the claim.

4) Provided the service is urgent or emergent, After Hours Premiums are payable for all medical services listed in the Physician's Manual (including tariff 8000 and tariff 8001) except as set out above and except for services identified in the physician's Manual as specifically excluded from After Hours Premiums.

5) Provided the service is an urgent or emergent medical service, After Hours Premiums are payable for services rendered regardless of location, including services in a Personal Care Home, Physician's Office, Patient's home, Hospital, Hospital Emergency Department and Out-Patient Department, except as set out above.

6) Claims for services rendered in a physician's office must include the words "urgent/emergent" on the claim. In addition, if the ICD code included on the claim is not clearly demonstrative of the urgent/emergent nature of the service, the claim should include a brief comment to demonstrate the urgent/emergent nature of the service.

7) For donor related services, management of rejection crisis and recipient related services Day 1, the time the service commences shall be used to determine the applicable After-Hours Premium period and must be entered on the claim. For recipient related services on Day 2 and Day 3, 0800 shall be considered commencement time.

8) Designated Holidays include: New Year's Day, Louis Riel Day, Good Friday, Easter Monday, Victoria Day, Canada Day, August Civic Holiday, Labour Day, National Day for Truth and Reconciliation, Thanksgiving Day, Remembrance Day, Christmas Day and Boxing Day.

If any of these days fall on a Saturday or Sunday, the day will be observed as stated in the Physician's newsletter.

SPECIAL CALL/SPECIAL CALL RULE OF APPLICATION 3

Whenever a physician is required to make a special trip, over and above the physician's regular routine, to attend a patient, a **Special Call** benefit may be claimed in addition to the benefits listed for assessment and/or procedural medical services (except as listed below). Only one (1) **Special Call** per response is applicable.

A **Special Call** must be initiated by someone other than the physician (except when services are rendered outside the hospital) and requires the physician to travel from one (1) location to another (not within the same building complex) to attend the patient.

A **Special Call** benefit will be paid even if the patient is deceased, on the arrival of the physician called, or, if the patient has left the premises prior to the physician's arrival provided the physician was not unreasonably tardy.

Subject to the Exclusions listed below, all **Special Call** benefits may be claimed under the following tariffs:

8561	For special calls made to a patient's home	52.93
8598	For special calls made to the emergency department or O.P.D. of a hospital	54.86
8566	For special calls made in obstetrics	54.86
8567	For special calls made in non-elective surgical cases, in the postoperative period.	54.86
8563	All other special calls not covered under tariffs 8561, 8566, 8567 or 8598 (including, but not limited to, special calls made to personal care homes and to attend to registered hospital patients, subject to Exclusion 1 below) may be claimed under this tariff.	54.86

Exclusions:

Special Call benefits do not apply under the following circumstances:

1. Care to registered hospital patients during the physician's regular daily round.
2. Regularly scheduled daily office appointments.
3. Scheduled N.F.A. medical services.
4. Routine care provided to patients in personal care homes.
5. Scheduled routine in-patient surgical activity.
6. Where the physician is already in the hospital.
7. All elective surgery both pre and postoperative.
8. In obstetrical care, on the day of the performance of an elective caesarean section.

DETENTION AND TRANSPORT—CRITICALLY ILL PATIENT

Detention time means the doctor is detained with and providing care to a critically ill patient for at least half an hour. Detention time does not apply where the physician is detained when doing procedures such as fractures or operations, or for the purpose of waiting for reports of X-rays or the laboratory.

It implies the presence of the physician at the bedside of the patient whose condition is critical and requires constant attention beyond the scope of the staff or family.

At the termination of the critical period, as indicated by the physician being able to leave the patient in the care of the staff or family, detention time no longer applies for subsequent visits on that day or subsequent days. Unless a new crisis develops, an ordinary visit should be sufficient to adjust orders so that the patient can continue to be cared for by the staff.

Should a new crisis develop or some unusual care require further detention time on the same day or subsequent days, a ***Special Report*** must be submitted to claim these tariffs.

Transport means the physician is in transport with and providing all aspects of care to a critically ill patient, during the patient's ambulance transfer to a hospital. No examinations or procedures may be claimed in addition to transport services.

No examinations or procedures may be claimed during the time of detention or transport.

8572 Detention and care at the bedside of a critically ill patient for the first half hour, when no procedural benefit applies. After this, tariff 8573 applies 88.44

8573 Detention and care at the bedside of a critically ill patient beyond the half hour in 8572, when no procedural benefit applies. Per additional fifteen (15) minute period (or major portion thereof) 44.25

8574 Special consideration in exceptional circumstances and prolonged detention ..... ***By Report***

8565 Trip (without patient), preceding or following ambulance transfer of a critically ill patient, per fifteen (15) minute period (or major portion thereof) 21.62

Note: *1) An appropriate examination/visit tariff may be claimed in lieu of 8572.*

2) The start and end time for providing the services, shall be documented on the claim.

8630 Ambulance transport and care of a critically ill patient being transferred to a hospital who requires continuous monitoring and care by a physician, per each fifteen (15) minute period (or major portion thereof) 51.92

DETENTION AND TRANSPORT BY AIR AMBULANCE—CRITICALLY ILL PATIENT

Detention time means the physician is detained with and providing care to a critically ill air ambulance patient.

8632 Detention and care of a critically ill patient, during air ambulance transport to hospital, per fifteen (15) minute period (or major portion thereof) 53.00

Note: *1) Tariff 8632 includes all related communications with a paramedic and other health care providers regarding the care and treatment of the patient during transport.*

2) Tariff 8632 services shall be documented in the patient's record and shall indicate the authority (e.g. Lifeflight or RHA Department/Program) who requested a physician for transport.

3) Tariff 8632 is only claimable if the physician is not being otherwise remunerated pursuant to other agreements.

INTER-FACILITY TRANSFER

8331 Initial review of patient following patient transfer between healthcare facilities.....51.00

Notes: *1) Not eligible to be claimed for transfers between St. Boniface Hospital, Grace Hospital and Health Sciences Centre.*

2) A complete examination or unassigned complete examination may be claimed within 24 hours of transfer.

3) After hours premiums may be claimed in addition where the physician reviews the chart and/or visits the patient during the after hours period.

4) 8331 may be claimed in all rural Hospitals, Community hospitals and Long-Term Care facilities.

RESUSCITATION—BY NON-ANESTHETISTS (OR BY ANESTHETISTS OUTSIDE THE OPERATING ROOM)

2556 Cardio-respiratory resuscitation including cardiac arrest, for the first half-hour 185.44

2565 For each additional fifteen (15) minute period or portion thereof.....64.95

MEDICAL MANAGEMENT OF ECTOPIC PREGNANCY

8426 Medical management of ectopic pregnancy, including examination, assessment, the taking of cytological smears for cancer screening–cervix, management and monitoring of patients taking Methotrexate. This service may include ordering blood tests, interpreting results, inquiring into possible complications and adjusting the dosage as necessary.....227.16

Note: *1) Tariff 9795 (cytological smears for cancer screening) may not be claimed in addition to tariff 8426.*

2) Follow up care to tariff 8426 to be billed under Regional Examination.

3) Includes telephone/facsimile/email communications with other physicians or health care providers regarding the patient.

8428 Medical management of early pregnancy failure/elective pregnancy termination, including examination, assessment, the taking of cytological smears for cancer screening–cervix, management and monitoring of patients taking cytotoxic and/or prostglandin medications (e.g. Methotrexate/Misoprostol). This service may include administration of the medication, ordering blood tests, interpreting results, inquiring into possible complications and adjusting dosage(s) as necessary.....176.16

Note: *1) Tariff 9795 (cytological smears for cancer screening) may not be claimed in addition to tariff 8428.*

2) Follow up care to tariff 8428 to be billed under Regional Examination.

3) Includes telephone/facsimile/email communications with other physicians or health care providers regarding the patient.

8427 Rural and remote medical termination – Virtual management of early pregnancy failure/elective pregnancy termination, management and monitoring of patients taking cytotoxic and/or prostglandin medications (e.g. Methotrexate/Misoprostol). This service may include administration of the medication, ordering blood tests, interpreting results, inquiring into possible complications and adjusting dosage(s) as necessary.....176.16

Note: *1) Follow up care to 8427 to be billed under Regional Examination.*

2) *Includes telephone/facsimile/email communications with other physicians or health care providers regarding the patient.*

COMMUNITY-BASED CLINICAL SERVICES

2651 Procedural sedation by physician 51.00

0800 Simple reduction, e.g., radial head 76.50

0252* Removal of sutures and/or staples from lacerations or surgical incisions of any length by any physician 17.85

Note: *Surgical Rules apply.*

1004 Incarcerated ring removal 25.50

0436 Dressing for wounds not due to burns 35.70

0479 Debridement of wounds not on lower extremity 71.40

0070 Local anesthesia for pediatric patients (tariff 40000 not eligible in addition) 15.30

5350 Ring and/or hematoma block 25.50

8464 Administration of Flourescein drops for corneal abrasion 15.30

8469 Administration of Inhalation medication (Ventolin) for acute asthma presentation 51.00

ADDICTIONS MEDICINE IN THE COMMUNITY

8375 Assessment for Induction of Opioids Agonist Treatment (OAT) for Opioid Use Disorder – per 15 minutes or greater portion thereof 45.90

Initial assessment requires complete medical history, substance use history and appropriate targeted physical examination. If assessment and induction are done on the same day, withdrawal assessment using COWS or SOWS and administration of first dose of OAT are included.

Notes: 1) *Payable to a maximum of 4 units per patient/per day/per intended induction.*

2) *Payable only to the physician who intends to provide or share management of the patient's OAT induction for opioid use disorder.*

3) *Start time must be entered in both the billing claim and patient's chart.*

4) *No other visit fees are billable on the same day except 8376, RACE tariffs and conferences. 8376, RACE tariffs and conferences are payable in addition to 8375 only when not performed concurrently.*

5) *Payable for assessment for change of OAT with induction to a different medication.*

6) *May not be repeated within 30 days by the same physician.*

7) *This service is payable only for physician time spent on patient assessment (and on administration of first dose of OAT if provided same day).*

8376 Management of OAT Induction for opioid use disorder 25.50

This fee is payable for individual interactions with the patient during the first three days of OAT induction for opioid use disorder within the limits described in the following notes.

Notes: *1) Billable in addition to 8375, or a same day visit or consultation fee (in-person, telephone or video conference) when not performed concurrently.*

2) Billable up to 3 times on day of first dose of OAT.

3) Billable up to 2 times on day 2 of OAT induction.

4) Billable once only on day 3 of OAT induction.

5) May be provided in-person, by telephone, or by video conference.

6) May be billed when delegated to a nurse employed within, the eligible physician practice.

7) Start time must be entered in both the billing claim and patient's chart.

8377 Management of ongoing maintenance Opioid Agonist Treatment for Opioid Use Disorder.....28.56

Notes: *1) The physician does not necessarily have to have direct face-to-face contact with the patient for this fee to be paid.*

2) 8377 is the only fee payable for any medically necessary service associated with maintenance opioid agonist treatment for opioid use disorder. This includes but is not limited to the following:

- *At least one visit (in person, telephone, or video conference) per month with the patient after induction/stabilization on opioid agonist treatment is complete.*
- *At least one in-person visit with the patient every 90 days. Exceptions to the criterion will be considered on an individual basis.*
- *Supervised urine drug screening and interpretation of results.*
- *Simple advice/communication with other allied care providers involved in the patients OAT.*

3) Claims for treatment of co-morbid medical conditions, including psychiatric diagnoses other than substance use disorder, are billable using the applicable visit fees. Counselling and visit fees related only to substance use disorder are not payable in addition.

4) This fee is payable once per week per patient regardless of the number of services per week for management of OAT maintenance.

5) After hours premiums are not payable in addition.

6) Eligibility to submit claims for this tariff is limited to physicians who are actively supervising the patient's continuing use of opioid agonist medications for treatment of opioid use disorder.

7) This payment stops when the patient stops opioid agonist treatment.

8378 Point of Care (POC) Testing for opioid agonist treatment.....13.26

Notes: *1) Restricted to patients in opioid agonist treatment.*

2) Maximum billable: 26 per annum, per patient.

3) Confirmatory testing (reanalyzing a specimen which is positive on the initial POC test using a different analytic method) is expensive and seldom necessary once a patient is in treatment for opioid use disorder. Accordingly, confirmatory testing should be utilized only when medically necessary and when a confirmed result would have a significant impact on patient management.

4) *This tariff includes the adulteration test.*

5) *Only POC urine testing kits that have met Health Canada Standards are to be used.*

8379 Point of Care (POC) testing for amphetamines, benzodiazepines, buprenorphine/naloxone, cocaine metabolites, methadone metabolites, opioids and oxycodone 13.77

Notes: *1) Not billable for patients in opioid agonist treatment.*

2) Maximum billable: 26 per annum, per patient:

3) Confirmatory testing (reanalyzing a specimen which is positive on the initial POC test using a different analytic cmethod) is expensive and seldom necessary once a patient is in treatment for opioid use disorder. Accordingly, confirmatory testing should be utilized only when medically necessary and when a confirmed result would have a significant impact on patient management.

4) This tariff includes the adulteration test.

5) Only POC urine testing kits that have met Health Canada Standards are to be used.

TELEPHONE/FACSIMILE/EMAIL COMMUNICATIONS

8000 Telephone/Facsimile/Email Communications initiated by other health care providers 16.58

This tariff may be claimed for the following categories of telephone, facsimile and email communications:

1) Communications initiated by other health care providers, who are responsible for and/or assigned to the care of:

i) a patient receiving home care;

ii) a patient in a personal care home;

iii) a paneled patient at home or in hospital who is awaiting placement in a personal care home;

iv) a patient in a special care home, (in-patient or out-patient), e.g., St. Amant Centre, Manitoba Developmental Centre;

v) a chronic care patient in an extended care facility, (in-patient or out-patient) e.g., Deer Lodge Centre Extended Treatment Unit;

vi) a patient presenting at a northern nursing station;

vii) a patient registered in the Manitoba Home Nutrition Program;

viii) a patient registered in the Manitoba Home IV program;

ix) an infant receiving a home visit by a Public Health Nurse in a recognized RHA post-natal program;

x) a patient receiving care at a Quick Care Clinic;

xi) a patient receiving care at River Ridge Transitional Care, or

xii) a patient registered in the Sleep Disorders Centre Program.

Note: *Other health care providers includes, but is not limited to:*

i) Home care coordinator;

ii) Nurses;

iii) VON;

iv) Public health nurses;

v) Psychiatric nurses;

vi) Mental health workers;

vii) Nurses located in northern nurses' stations;

viii) Occupational therapists;

ix) Physiotherapists;

x) Respiratory therapists;

xi) Ambulance paramedics;

xii) Clinical Assistants.

2) Communications initiated by midwives following a Midwifery Assessment and Report by the physician.

General Notes:

1) The claim must include the name and position of the person who initiated the communication, the name of the patient concerned, and the time of day the communication was completed.

2) Claims for communications respecting patients receiving home care must include the words "home care" on the claim.

3) Where more than one patient is discussed in a single communication, a claim may be submitted with respect to each patient discussed.

4) Claims for more than one communication per patient per day should be submitted on a single claim.

5) A maximum of five (5) communications per patient per seven–day week may be claimed.

6) No claim may be made until the physician responds to the medical inquiry made by the other health care provider, or midwife who initiated the communication.

7) Except as set out above, no claim may be made for communications regarding patients in hospital receiving acute care.

8) No claim may be made for communications in which only a physician proxy, e.g., nurse or clerk, participates.

9) After Hour Premiums may not be claimed in addition, except for urgent or emergent communications.

10) Services shall be documented in the patient's record as required by the College of Physicians and Surgeons of Manitoba, and such documentation is required, upon request by Manitoba Health, to support the claim submitted.

8001 Telephone/Facsimile/Email communications to a physician initiated by another physician , RN (EP) or designated allied health provider 25.50

Note: *1) This tariff may be claimed by:*

i) A Physician for communications from another physician, RN (EP) or designated allied health provider regarding a patient who is receiving medical care from the Physician or RN (EP) who initiated the communication;

ii) A General Practitioner with expertise in Addictions Medicine, Palliative Care, Care of the Elderly, Anesthesia or Obstetrics, from a Specialist, General Practitioner or RN (EP) regarding a patient who is receiving medical care from the practitioner who initiated the communication.

iii) A General Practitioner or Specialist (Internal Medicine, Neurologist, Cardiologist, Plastic Surgeon, Urologist, Orthopaedic Surgeon, Neurosurgeon, Otolaryngologist or Dermatologist) from a Dentist/Oral Surgeon regarding a patient who is receiving medical care from the Dentist/Oral Surgeon who initiated the communication.

iv) An Ophthalmologist for communications from an Optometrist.

v) An Otolaryngologist for communications from an Audiologist.

2) Tariff 8001 may not be claimed on the same day as 8355 Telephone/Video Conference Consultant Physician or 8356 Telephone/Video Conference Referring Physician.

3) No claim may be made until the Physician responds to the medical inquiry made by the Physician or RN (EP) who initiated the communication.

4) No claim may be made where only a proxy for the Physician, e.g., nurse or clerk, communicates with the Physician or RN (EP) who initiated the communication.

5) No claim may be made where the sole purpose of the communication is to arrange a hospital bed for the patient.

6) A maximum of one (1) claim per patient per day may be made per physician.

7) Where more than one (1) patient is discussed in a single communication, a claim may be submitted with respect to each patient discussed.

8) The claim must include the name of the Physician or RN (EP) who initiated the communication, the name of the patient concerned, and the time of day the communication was completed.

9) After Hours Premiums may not be claimed in addition, except for urgent or emergent communications.

10) Services shall be documented in the patient's record as required by the College of Physicians and Surgeons of Manitoba, and such documentation is required, upon request by Manitoba Health to support the claim submitted.

8005 Telephone/Facsimile/Email Communications initiated by pharmacists 16.58

This tariff may be claimed for the following categories of telephone, facsimile and email communications:

1) Communications initiated by pharmacists where the communication is regarding the renewal of a patient's prescription(s).

i) This service is not to be used as a routine practice or to authorize repeat prescriptions for which long-term repeats would more properly have been authorized at the time of writing the initial prescription.

ii) No claim may be made for the same day the physician provides other medical services to the patient.

iii) *No claim may be made where the primary purpose of the communication is to clarify, decipher or interpret the physician's handwriting and/or written instructions.*

iv) *A maximum of one (1) communication per patient per day may be claimed, regardless of the number of prescription renewals discussed with the pharmacist.*

v) *Claims must include the words "prescription renewal".*

2) *Communications initiated by pharmacists where the pharmacist is assigned to the care of the patient (e.g., scheduled medication review in a personal care home or special care home which subsequently requires discussion with a physician).*

i) *Claims for more than one communication per patient per day should be submitted on a single claim.*

General Notes:

1) *The claim must include the name and position of the person who initiated the communication, the name of the patient concerned, and the time of day the communication was completed.*

2) *Where more than one patient is discussed in a single communication, a claim may be submitted with respect to each patient discussed.*

3) *A maximum of five (5) communications per patient per seven-day week may be claimed.*

4) *No claim may be made until the physician responds to the medical inquiry made by the pharmacist who initiated the communication.*

5) *No claim may be made for communications in which only a physician proxy, e.g., nurse or clerk, participates.*

6) *After Hour Premiums may not be claimed in addition, except for urgent or emergent communications.*

7) *Services shall be documented in the patient's record as required by the College of Physicians and Surgeons of Manitoba, and such documentation is required, upon request by Manitoba Health, to support the claim submitted.*

8002 Monitoring anticoagulant therapy–by telephone, facsimile or email, per calendar month 18.08

Note: 1) *Service includes monitoring the condition of a patient receiving anticoagulant therapy including ordering blood tests, interpreting results, inquiry into possible complications and adjusting the dosage of the anticoagulant therapy.*

2) *Claims for additional services rendered to a patient (e.g., visits) may be made in addition to this tariff.*

3) *Services shall be documented in the patient's record as required by the College of Physicians and Surgeons of Manitoba, and such documentation is required, upon request by Manitoba Health, to support the claim submitted.*

8003 Telephone/Facsimile/Email Communications–EDS Approval 16.58

This tariff may be claimed for telephone, facsimile or email communications incidental to applications for drug coverage pursuant to Part 3 of the Prescription Drugs Cost Assistance Act, specified Drugs Regulation (Exception Drug Status approval).

Note: *1) A maximum of five (5) communications per patient per thirty (30) day period may be claimed.*

2) Only one (1) claim per communication may be made.

3) No claim may be made for communications in which only a physician proxy, e.g., nurse or clerk participates.

4) Claims for more than one (1) communication per patient per day should be submitted on a single claim.

5) Services shall be documented in the patient's record as required by the College of Physicians and Surgeons of Manitoba, and such documentation is required, upon request by Manitoba Health, to support the claim submitted.

8004 Monitoring of clozapine 16.38

Note: *1) This tariff is payable for the responsibility of monitoring patients taking clozapine (including, but not limited to, Apo-clozapine, Clozaril and Gen-clozapine). This service may include ordering blood tests, interpreting results, inquiring into possible complications and adjusting the dosage as necessary.*

2) Payment of this tariff is limited to one (1) physician per patient per calendar month.

3) This tariff is limited to a maximum of one (1) claim per patient per calendar month.

4) Claims for additional services rendered to a patient (e.g. visits) may be made in addition to this tariff.

8355 Telephone/Videoconference communications to a consultant initiated by another physician, RN (EP), Physician Assistant (PA), Clinical Assistant (CA), midwife or designated allied health provider – Consultant Physician 51.00

8356 Telephone/Videoconference communications to a Consultant Physician – Referring Physician 25.50

Tariff 8355 and 8356 may be claimed by:

i) A Specialist for communications from a Specialist, General Practitioner, RN (EP), Physician Assistant (PA), Clinical Assistant (CA), or midwife regarding a patient who is receiving medical care from the Physician or RN (EP) who initiated the communication; and

ii) A General Practitioner for communications from a General Practitioner, RN (EP) Physician Assistant (PA), Clinical Assistant (CA), or midwife regarding a patient who is receiving medical care from the Physician or RN (EP) who initiated the communication.

iii) A General Practitioner with expertise in Addictions Medicine, Palliative Care, Care of the Elderly, Anesthesia or Obstetrics, from a Specialist, General Practitioner or RN (EP) regarding a patient who is receiving medical care from the practitioner who initiated the communication.

iv) A General Practitioner or Specialist (Internal Medicine, Neurologist, Cardiologist, Plastic Surgeon, Urologist, Orthopaedic Surgeon, Neurosurgeon, Otolaryngologist or Dermatologist) from a Dentist/Oral Surgeon regarding a patient who is receiving medical care from the Dentist/Oral Surgeon who initiated the communication.

v) An Ophthalmologist for communications from an Optometrist.

vi) An Otolaryngologist for communications from an Audiologist.

vii) The consultant may not claim a major consultation or procedure for the same patient for the same condition within 24 hours unless the patient was transferred from an outside facility and advice was given on management of that patient prior to transfer.

viii) May only be claimed when the consultant has provided an opinion and recommendation for patient treatment, and management after reviewing pertinent family/patient history of the presenting complaint, and discussion of the patients condition and management after reviewing laboratory and other data where indicated.

ix) The purpose of the call is to seek the advice of a physician more experienced in treating a presenting problem. It is the expectation that the referring physician, nurse practitioner, midwife or podiatric surgeon will continue to care for the patient.

x) May not be claimed for situations where the purpose of the call is to:

- *Arrange for an expedited consultation or procedure within 24 hours except when the conditions are met.*
- *Arrange for laboratory or diagnostic investigations.*
- *Discuss or inform the referring physician or podiatric surgeon of results of diagnostic investigations.*

xi) A maximum of any two 8355, 8356 claims may be claimed per patient, per physician per day.

xii) Documentation must be recorded by both the referring physician, RN (EP) or designated allied health provider and the consultant in their respective records.

xiii) Physician billing 8355 can not be the supervising physician of the Physician Assistant (PA) or Clinical Assistant (CA).

CASE MANAGEMENT CONFERENCE

		GENERAL PRACTITIONER	SPECIALIST
8474	Case Management Conference	41.28	40.47

A Case Management Conference is a conference between the physician in charge of the patient's care and allied health professionals, educators, correctional workers, appropriate community workers or other physician(s) to share information to better manage a patient's care.

Note: *1) The conference must be a formal scheduled conference pertaining to one named patient.*

2) *This tariff may not be claimed with respect to additional patients discussed on an impromptu basis during the course of a conference or for patients discussed during regular or grand rounds. However, consecutive formal scheduled conferences, each pertaining to one named patient, are permitted.*

3) *Tariff rate is payable for the first full fifteen (15) minute period spent discussing one named patient and for each additional fifteen (15) minute period or major portion thereof spent discussing that same named patient.*

4) *Maximum of one (1) hour may be claimed per conference.*

5) *A physician may claim a maximum of three (3) Case Management Conferences per patient, per year.*

6) *The claim must include the name of the physician in charge of the patient's care, the time the conference took place, the location of the conference and the names of all persons in attendance at the conference. This information must also be documented in the patient's chart.*

7) *All physicians in charge of or involved with the patient's care in attendance at the conference may submit a claim.*

8) *For Psychiatrists and Physical Medicine Specialists, see appropriate visit pages.*

SHARED CARE CONFERENCE

8650 Shared Care Conference 59.27

A Shared Care Conference is defined as a conference between a psychiatrist and other physicians, allied health professionals, educators, or appropriate community workers to share information to better manage a patient's care.

Notes: 1) *Tariff 8650 is payable for the first full fifteen (15) minute period and for each additional fifteen (15) minutes or major portion thereof.*

2) *Maximum of six (6) hours per patient may be claimed within any twelve (12) month period.*

3) *Additional Shared Care Conferences may be claimed **By Report**.*

4) *Maximum of one (1) hour may be claimed per conference.*

5) *The tariff must be claimed in the name of the patient.*

6) *Only the psychiatrist who is most responsible for the care of the patient and whose active participation in the Shared Conference is documented may claim the tariff.*

7) *The General Practitioner most responsible for the care of the patient and whose active participation in the Shared Care Conference is documented may claim the tariff.*

8) *Any other physicians participating in the Shared Care Conference may claim **By Report.***

9) *In hospital "physician-with-physician" patient care conferences are excluded.*

10) *The conference must be a formal scheduled conference.*

ACUTE PSYCHIATRIC PATIENT CASE TRANSITION CONFERENCE

8453 Acute Psychiatric Patient Case Transition Conference 52.43

An Acute Psychiatric Patient Case Transition Conference is defined as a conference between a psychiatrist, other psychiatrists, and/or other physicians and allied health providers for the purpose of managing the care of acute mental health patients into, through, and out of facilities.

Notes: *1) Tariff 8453 may be claimed for Conferences that take place within 2 weeks of a patient's admission or discharge from a mental health inpatient facility.*

2) Tariff 8453 is payable for each fifteen (15) minutes or major portion thereof.

3) Maximum of six (6) hours per patient may be claimed within any twelve (12) month period.

4) Additional Acute Psychiatric Patient Case Transition Conferences may be claimed By Report.

5) Maximum of one (1) hour may be claimed per conference.

6) The tariff must be claimed in the name of the patient.

7) Psychiatrists most responsible for the care of the patient in each outgoing, incoming or community setting may claim 8453 for their active participation in the conference.

8) The General Practitioner or Pediatrician most responsible for the care of the patient and whose active participation in the Conference is documented may claim the tariff.

9) Any other physicians participating in the Conference may claim By Report.

10) The Conference must be formally scheduled, and can occur in person, via telemedicine, or remotely.

PATIENT CARE FAMILY CONFERENCE

		GENERAL PRACTITIONER	SPECIALIST
8473	Patient Care Family Conference	41.28	40.47

A Patient Care Family Conference may include, but is not limited to, discussions about the condition and care of a patient with serious and complex problems, a catastrophic or terminal illness, developmental and multiple handicap disorders, or chronic pain. It may include the assessment of the need of care from other providers and/or community agencies.

Note: *1) Patient may or may not be present at the Patient Care Family Conference.*

2) The session must relate to the care and treatment of the patient.

*3) Maximum of twelve (12) fifteen-minute sessions per patient per year. Additional conferences may be claimed **By Report**.*

4) Maximum of sixty (60) minutes may be claimed per conference.

5) Tariff rate is payable for the first full fifteen (15) minute period and for each additional fifteen (15) minute period or major portion thereof.

6) Services must be claimed in the name of the patient.

7) *Physician may claim either Palliative Care Counselling tariff or Patient Care Family Conference, but not both.*

8) *Services shall be documented in the patient's record as required by the College of Physicians and Surgeons of Manitoba, and such documentation is required, upon request by Manitoba Health, to support the claim submitted.*

9) *For Psychiatrists and Physical Medicine Specialists, see appropriate visit pages.*

10) *No claim may be made for a service, including a visit, rendered during the same period of time, or any portion thereof, in respect to which the physician submits a claim under this tariff, but nothing shall prevent a claim being made for a service, including a visit, rendered either immediately preceding, or immediately following, the period of time in respect to which the physician submits a claim under this tariff.*

MANITOBA HOME NUTRITION PATIENT CARE CONFERENCE

8493 Manitoba Home Nutrition Patient Care Conference..... 41.28

Note:

1) *A Manitoba Home Nutrition Patient Conference is a formal scheduled conference relating to the care and treatment of a patient registered in the Manitoba Home Nutrition Program.*

2) *The conference shall include a pre-assessment team conference with allied health professionals and a post-assessment conference with patient's family and/or other care givers.*

3) *The patient is not present at the pre-assessment team conference and may or may not be present at the post assessment family conference.*

4) *Maximum of twelve (12) conferences per patient per year. Additional conferences may be claimed **By Report**.*

5) *The total time for the conference shall be claimed.*

6) *Maximum of sixty (60) minutes per conference.*

7) *Tariff rate is payable for the first full fifteen (15) minute period and for each additional fifteen (15) minute period or major portion thereof.*

8) *Services must be claimed in the name of the patient.*

9) *Services shall be documented in the patient's record as required by the College of Physicians and Surgeons of Manitoba, and such documentation is required, upon request by Manitoba Health, to support the claim submitted.*

10) *An appropriate visit tariff for the physical examination of the patient may be claimed in addition to the conference.*

8491 Weekly retainer for management of home Total Parenteral Nutrition (TPN) patient 51.51

Note:

1) *Patient must be registered in the Manitoba Home Nutrition Program and receiving TPN at home.*

2) *Includes all TPN related email/fax/phone communications with allied health personnel.*

3) *Tariffs 8000 or 8001 may not be claimed in respect of communications regarding TPN for this patient.*

4) *Tariff 8493 may not be claimed for the same patient within any seven (7) day period of billing tariff 8491.*

5) *Services shall be documented in the patient's record as required by the College of Physicians and Surgeons of Manitoba, and such documentation is required, upon request by Manitoba Health to support the claim submitted.*

PSYCHOTHERAPY

Psychotherapy (with or without intravenous drugs)

Note: *These benefits apply to services of physicians who are not certified specialists in Psychiatry and apply only when it has been determined during a regular office visit that a course of psychiatric treatment is necessary.*

8580 Individual 41.28

Note: 1) *Tariff rate is payable for each of the first two (2) full fifteen (15) minute periods and for each additional fifteen (15) minute period or major portion thereof.*

2) *A minimum of a full thirty (30) minute period and a maximum of ninety (90) minutes may be claimed per patient per day.*

3) *Where psychotherapy sessions with a patient extend beyond two and one-half (2½) hours in any seven (7) day period, a written report is required.*

Group psychotherapy is defined as the treatment of two (2) or more patients together in a session, and may include members of a family group.

8589 Group [two (2) or more patients] 43.45

Note: 1) *Tariff rate is payable for each of the first two (2) full fifteen (15) minute periods and for each additional fifteen (15) minute period or major portion thereof.*

2) *A minimum of a full thirty (30) minute period and a maximum of ninety (90) minutes may be claimed per group per day.*

3) *Where group psychotherapy session(s) extend beyond these limits, a written report is required.*

4) *The total fee listed for the group is divided by the number of patients in the group and billed for each patient on a separate claim.*

Virtual Care

8655 Virtual psychotherapy by telephone or video.....41.28

8675 Virtual Group Psychotherapy two or more patients by telephone or video.....42.84

ELECTROCONVULSIVE THERAPY

8587 Electroconvulsive Therapy (ECT) 55.68

Note: *1) These benefits apply to services of physicians who are not certified specialists in Psychiatry*

2) In-patient (ECT); no additional benefit shall be provided for hospital care on days the (ECT) is given except under exceptional circumstances.

PALLIATIVE CARE

8585 Palliative Care Counselling 41.28

Palliative care is the care of a patient after the decision has been made that there will be no aggressive treatment of the underlying disease process and that care is to be directed to maintaining comfort of the patient until death occurs.

The palliative care counselling tariff code applies to physicians who provide counselling to a patient with a terminal disease such as cancer, AIDS or advanced neurological disease and/or counselling to that patient's family. The goal of palliative care is achievement of the best possible quality of life for people for whom cure is no longer possible.

Specifically,

- A patient or family member may request a counselling session with the physician because of specialized management of a patient with terminal illness.
- Counselling session may be with the patient, with the patient and the family, or with the family without the patient present.
- Palliative care counselling generally is provided during a period not greater than three (3) months prior to death. Where circumstances require a longer duration of palliative care, this may be claimed ***By Report***.
- Tariff rate is payable for the first full fifteen (15) minute period and for each additional fifteen (15) minute period or major portion thereof.
- Counselling beyond one (1) hour must be submitted ***By Report***.

MEDICAL ASSISTANCE IN DYING

8635 Medical assistance in dying, assessment, counselling, examination and administration, per fifteen (15) minutes or major portion thereof 52.84

Note: *1) Tariff 8635 is for all services directly related to medical assistance in dying in accordance with any College of Physicians and Surgeons of Manitoba Standard of Practice related to medical assistance in dying services including but are not limited to:*

i) History taking;

ii) Assessment including examination and/or review of relevant medical history;

iii) Conferences with the patient, family members, the Administering Practitioner, the Independent Assessing Practitioner members of the Provincial MAID Clinical Services Team or other health care professionals;

iv) Reviewing and writing medical reports or other correspondence. Telephone calls;

v) Counselling of patient and/or family;

vi) Assessment of decision making capacity and consent;

vii) Arranging referrals/consultations to physicians and other health care professionals;

viii) Administrative tasks including completing forms and reports including documentation in the patient's medical record;

2) The start and end time for providing the services shall be documented on the claim.

3) Services unrelated to medical assistance in dying provided by the Administering Physician, the Independent Assessor or any other physician including visits or examinations related to the ongoing treatment or care of the patient may be claimed in addition to 8635.

4) All claims shall include one of the following remarks indicating the nature of the service provided;

i) clinical services or assessment (to indicate clinical services, medical assessment, assessments of decision making capacity and consent, etc.);

ii) counselling (may include person and/or family);

iii) administrative (may include arranging referrals, consultations, review of documentation, completion of forms and reports, conferences etc.).

Where remarks are provided descriptive reports are not required.

5) May be claimed by the administering physicians, independent assessing physician or by a member of the Provincial MAID Clinical Services Team as determined by the CMO of Shared Health.

6) In circumstances where up to three physicians are required to attend to the provision of MAID, the second and third physician in attendance must include a remark on their claims that the attendance of additional physician(s) was required or requested.

CHRONIC CARE

8511 Chronic Care, per visit 41.77
See Rule 18

Virtual Care

8527 Chronic Care virtual visit by telephone or video.....41.77

SEXUAL ASSAULT

~8665 Sexual Assault Services – Assessment & Related Services, per fifteen (15) minutes or major portion thereof 57.95

Note: *1) Tariff ~8665 is for all services related to sexual assault assessment in accordance with any Manitoba Standard of Practice which may include some but not all and are not limited to:*

i) History taking;

ii) Assessment including physical examination and/or review of relevant medical history;

iii) Counselling;

iv) Conferences with the patient, family members, or the other health care professionals;

v) Reviewing and writing medical reports or other correspondence;

vi) Telephone calls;

vii) Arranging referrals/consultations to physicians and other health care professionals;

viii) Administrative tasks including completing forms and reports including documentation in the patient's medical record;

ix) Where appropriate, forensic evidence collection;

x) Initial discussion with law enforcement

2) When applicable, After Hours premiums are payable in addition to the service. For the purpose of claiming after-hours premiums ~8665 is deemed to be an urgent or emergent service.

3) When applicable, Special call tariffs are payable in addition to ~8665.

4) In circumstances where up to two physicians are required to attend to the provision of sexual assault services, the second physician in attendance must include a remark on their claim(s) that the attendance of an additional physician was required or requested.

5) Services provided in addition to sexual assault services, by the attending physician or any other physicians including visits or examinations related to their ongoing treatment or care of the patient may be claimed in addition to ~8665.

BLOOD ALCOHOL SAMPLING

8577 Blood alcohol sampling 30.29

Note: *This benefit covers the following:*

1) a) Assessment to determine that obtaining a sample is safe.

b) Assessment of the patient's ability to consent to the procedure.

c) Completing the police form.

d) Taking the sample, labelling the specimen and recording the event on the patient's hospital record.

2) a) Where the usual criteria as described in the Physician's Manual are met, the physician may claim a special call.

b) Only where medical indications exist may the physician also claim appropriate examination and treatment tariffs (e.g., repairing lacerations).

COMPLETE EYE EXAMINATION

8543 Complete eye examination and refraction by a physician other than a specialist in Ophthalmology.....62.22

WELL BABY CARE

8523 Well Baby Care by a physician other than a Paediatrician or a General Practitioner.....35.83

APPLICATION/ASSESSMENT FOR LONG TERM CARE

8541 Complete History and Physical Examination for the purpose of assessing the patient and completion of the Application/Assessment for Long Term Care 137.34

8542 Regional or Subsequent Visit for the purpose of assessing the patient and completion of the Application/Assessment for Long Term Care.....83.44

COMMUNITY–BASED PRACTICE SUPPORT

8380* Community-Based Practice Supplement.....3.57

Note: *1) 8380 may be claimed in addition to an office/home visit where practice expenses are directly incurred by the physician.*

2) 8380 may not be claimed in relation to services performed at a hospital or other publicly funded facility or a facility on contract with a Health Authority to perform insured services.

3) A maximum of 50 claims for tariff 8380 may be claimed in any twenty-four (24) hour period.

4) After Hours Premiums may not be claimed in addition to a Community Based Practice Supplement.

5) Community Based Practice Supplements are not payable in addition to virtual visit tariffs.

6) Extended Clinic Hours Premiums are not payable on the Community Based Practice Supplement.

7) 8380 may be claimed for all PCH visits where the physician maintains a community based practice.

8) Tariff 8380 may be claimed in addition to tariff 8511.

TRAY FEES

0001 Major Tray Fee.....29.38

May only be claimed in addition to tariffs 0104, 0105, 0107, 0108, 0109, 0110, 0111, 0112, 0113, 0116, 0117, 0118, 0119, 0120, 0171, 0222, 0223 0230, 0250, 0251, 0253, 0257, 0286, 0295, 0437, 0439, 0440, 0441, 0447, 0519, 0520, 0521, 0523, 1017, 1511, 1519, 1535, 1536, 1552, 1553, 1574, 1935, 1967, 1970, 1971, 2030, 2031, 2070, 2071, 2074, 2753, 2781, 2783, 2819, 2881, 2921, 2981, 3283, 3311, 3313, 3315, 3317, 3320, 3323, 3324, 3340, 3357, 3365, 3377, 3930, 3934, 4111, 4122, 4241, 4305, 4421, 4432, 4434, 4471, 4475, 4477, 4482, 4611, 4612, 4613, 4675, 4676, 4677, 4678, 5235, 5751, 5753, 9860 and 9861 when the service is rendered in the **physician's office.**

0003 Minor Tray Fee 14.75

May only be claimed in addition to tariffs 0106, 0329, 0430, 1049, 3285, 3310, 3392, 3395, 3396, 3397, 3401, 3433, 3434, 4031, 4033, 4035, 4191, 4403, 4405, 4411, 4430, 4431, 4433, 4472, 4476, 4908, 4910, 5445, 5446, 5702, 5703, 5741, 5742, 5744, 5961 5980, and 7875 when the service is rendered in the **physician's office.**

Note: *Tray Fee tariffs 0001 and 0003 are claimable only in instances where expenses are directly incurred by the physician for medical/surgical supplies. Tray Fee tariffs are not claimable in relation to services performed at a hospital, personal care home or other publically funded facility or a facility on contract with a Regional Health Authority to perform such insured services.*

0005 Endoscopic Tray Fee 193.80

May only be claimed in addition to tariffs 1949, 3055, 3065, 3095, 3121, 3122, 3123, 3185, 3186, 3187, 3189, 3926, 3927, 3928, 3929, 3931, 3932, 3933, 3939, 4636 and 4647 when the service is rendered in the **physician's office.**

Note: *Tray Fee tariff 0005 is claimable only in instances where expenses are directly incurred by the physician for medical/surgical supplies. Tray Fee tariff 0005 is not claimable in relation to services performed at a hospital, personal care home or other publically funded facility or a facility on contract with a Regional Health Authority to perform such insured services.*

MORBIDLY OBESE PATIENTS: BMI SUPPLEMENTS

One (1) Surgical BMI Supplement is payable to physicians in addition to the amount eligible for payment for the surgical procedures. One (1) Anesthetic BMI Premium is payable in addition to the amount eligible for anesthesia services.

Surgical BMI Supplement

0021 BMI Supplement (Group A), add 66.96

Tariff 0021 may only be claimed in addition to tariffs 0510, 1050, 1410, 1436, 2116, 2423, 2632, 2633, 3103, 3119, 3134, 3203, 3207, 3251, 3285, 3426, 3566, 3572, 3574, 3663, 3805, 3807, 3819, 3866, 3906, 3909, 4521, 4561, 4562, 4605, 4608, 4619, 4816 and 4832.

0022 BMI Supplement (Group B), add 118.47

Tariff 0022 may only be claimed in addition to tariffs 0770, 0865, 0868, 0870, 0872, 0874, 0884, 1101, 1149, 1334, 1423, 1424, 1425, 1440, 1470, 1471, 2152, 2158, 2425, 2431, 2530, 2532, 2621, 2629, 2640, 2646, 2675, 2676, 3101, 3105, 3112, 3118, 3120, 3131, 3133, 3135, 3137, 3141, 3142, 3153, 3161, 3162, 3166, 3171, 3191, 3193, 3194, 3195, 3201, 3204, 3206, 3208, 3209, 3221, 3225, 3226, 3227, 3228, 3231, 3235, 3241, 3261, 3262, 3263, 3286, 3297, 3321, 3325, 3326, 3328, 3331, 3333, 3335, 3471, 3472, 3481, 3503, 3504, 3515, 3526, 3544, 3565, 3571, 3573, 3575, 3577, 3594, 3631, 3633, 3635, 3636, 3646, 3651, 3661, 3664, 3666, 3734, 3811, 3812, 3826, 3827, 3845, 3846, 3851, 3857, 3858, 3861, 3880, 3881, 3884, 3885, 3901, 3907, 3908, 3911, 3912, 3920, 3922, 3924, 3960, 3961, 3965, 3966, 3967, 3968, 3970, 3972, 3974, 4118, 4202, 4316, 4318, 4444, 4445, 4479, 4498, 4545, 4551, 4571, 4581, 4583, 4585, 4606, 4614, 4618, 4694, 4695, 4696, 4701, 4800, 4811, 4812, 4911, 4912 and 4994.

0023 BMI Supplement (Group C), add 190.59

Tariff 0023 may only be claimed in addition to tariffs 0771, 0772, 0773, 0879, 1414, 1415, 1416, 1417, 1418, 1419, 1420, 1422, 1426, 1745, 1748, 2051, 2052, 2080, 2427, 2435, 2458, 2475, 2485, 2496, 2500, 2501, 2506, 2507, 2510, 2511, 2515, 2516, 2520, 2524, 2525, 2531, 2533, 2535, 2572, 2578, 2580, 2587, 2601, 2647, 2648, 2652, 2665, 2666, 2671, 2674, 3040, 3068, 3079, 3114, 3115, 3117, 3172, 3174, 3175, 3179, 3180, 3183, 3205, 3224, 3288, 3289, 3290, 3292, 3298, 3329, 3464, 3493, 3495, 3496, 3516, 3518, 3520, 3522, 3524, 3528, 3541, 3542, 3546, 3547, 3567, 3568, 3580, 3660, 3707, 3708, 3709, 3710, 3809, 3813, 3815, 3816, 3817, 3821, 3822, 3823, 3824, 3825, 3831, 3833, 3841, 3871, 3874, 3876, 3877, 3878, 3887, 3921, 3923, 3936, 3952, 3953, 3955, 3969, 4146, 4313, 4319, 4914, 4971, 4988, 4990, 5881, 5884, 5885, 5886 and 5887.

0024 BMI Supplement (Group D), add.....339.97

Tariff 0024 may only be claimed in addition to tariffs 0774, 1421, 2455, 2457, 2509, 2513, 2517, 2579, 2585, 2588, 2713, 2715, 2716, 2717, 2718, 2722, 2723, 2724, 2725, 2788, 2790, 3041, 3046, 3067, 3069, 3181, 3182, 3184, 3491, 3492, 3494, 3550, 3551, 3552, 3600, 3810, 3814, 3995, 4320 and 5883.

Note: *1) A BMI Supplement may be claimed where the patient has a BMI of greater than forty (40) or, where pregnant, the patient has a BMI of greater than forty-five (45) or, where the patient is under eighteen (18) years of age and is above the 97th percentile for BMI on an approved pediatric growth curve.*

2) The patient's BMI, height and weight must be recorded in the operative report and in the claim submission.

3) One (1) BMI Supplement may be claimed per patient per day per primary physician.

Anesthetic BMI Premium

0050 BMI Premium, add to anesthetic procedures only 25%

Notes: *1) Tariff 0050 may be claimed where the patient has a BMI of greater than forty (40) or, where pregnant, the patient has a BMI of greater than forty-five (45) or, where the patient is under eighteen (18) years of age and is above the 97th percentile for BMI on an approved pediatric growth curve.*

2) The patient's BMI, height and weight must be recorded in the operative report or anesthetic record and in the claim submission.

3) 0050 is only payable in addition to:

1. *Anesthetic Procedural Services listed in Appendix A.*
2. *Special Invasive Anesthetic services.*
3. *The following tariffs listed in Appendix B: 5311, 5319, 4877.*

4) 0050 is not payable in addition to: Visits including consultations, pre-anesthetic evaluations, and post-operative care, tariffs listed in Appendix B except where specifically referenced above, Chronic Pain management, and Acute Pain Services.

LAPAROSCOPIC SURGERY

UNIT VALUE

3540 Laparoscopic surgery, add..... 25%

***Note**: 1.) Tariff 3540 is eligible to be claimed in addition to the following tariffs: 2601, 2652, 3068, 3069, 3076, 3078, 3079,3112, 3114, 3115, 3117, 3133, 3135, 3137,3140, 3141, 3162, 3171, 3172, 3174, 3175, 3179, 3180, 3181, 3182, 3184, 3191, 3193, 3194, 3195, 3205, 3206, 3207, 3209, 3221, 3224, 3225, 3226, 3231, 3241, 3251, 3288, 3289, 3290, 3292, 3325, 3326, 3329, 3464, 3491, 3492, 3494, 3550, 3631, 3632, 3635, 3636, 3707, 3708, 3710, 4545, 4571, 4581, 4583, 4610, 4811, 4988, 4989, 4990 .*

***Note:** 2.) Tariff 3572 or tariff 3574 may not be claimed in addition to 3540.*

INTRA-OPERATIVE LYSIS OF ADHESIONS

3500	Lysis of Adhesions, first full 30 minutes	218.79	22.750
3501	Lysis of Adhesions, each additional 15 minutes, or major portion thereof	109.40	

***Notes:** 1) Tariffs 3500 and 3501 are claimable when provided with surgical services found in sections I, J, K, M, N, and O.*

2) The following information must be clearly denoted in the operative report:

i) Total time of the surgical case, and

ii) Total time spent performing lysis of adhesions.

3) 3500 and 3501 shall be paid at 100% when provided in conjunction with additional surgical services.

MIDWIFERY ASSESSMENT AND REPORT

- A Midwifery Assessment and Report is the situation in which a midwife, after an appropriate examination of the patient, requests in writing the opinion of a physician because the midwife requires medical advice regarding the diagnosis, prognosis, treatment and/or management of the patient's medical condition or because the patient or the patient's substitute decision maker requests another medical opinion.
- A Midwifery Assessment and Report shall consist of a history and physical examination of the patient regarding the specific medical condition, a review of diagnostic data and the provision of a written opinion with findings and recommendations as to treatment and management of the condition, to the midwife who requested the Assessment and Report. The Assessment and Report may include the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient.
- Where the physician is required to perform any necessary medical services following the Assessment and Report, including where those services are performed prior to the patient being returned to the care of the midwife who requested the Assessment and Report, in addition to the fee for the Assessment and Report, payment for such medical services shall be made in accordance with the Physician's Manual.
- Midwives may request a Midwifery Assessment and Report from General Practitioners, Obstetricians, Paediatricians, Medical Geneticists, Internal Medicine physicians and Anesthesiologists.
- The tariff shall be billed in the name of the patient.
- A Midwifery Assessment and Report may be claimed by physicians in the blocs of practice set out below, under Tariff **8416**:

Eligible Blocs:

Internal Medicine $184.96

Medical Genetics $220.34

Endocrinology $184.96

Infectious Disease $184.96

Respirology $184.96

Paediatrics $187.81

Obstetrics $102.33

Anesthesia $159.56

General Practice $99.20

TELEMEDICINE

Definitions

"Telemedicine service" is a medical service provided to a patient presenting at an approved telemedicine site, through the recording of visual images and transmission of those images to receiving physician at an approved telemedicine site. Telemedicine services shall only be provided at the following approved sites within Manitoba.

Exceptions will only be made with prior approval from Manitoba Health.

- Facilities designated as a Hospital
- Nursing Stations
- Personal Care Homes

"Live telemedicine service" is a telemedicine service utilizing a direct interactive video link with a patient.

"Store and forward telemedicine service" is a telemedicine service utilizing the recording, storing and subsequent transmission to a receiving physician of visual images.

Rules of Application

Receiving Physicians

For live telemedicine services, a receiving physician shall claim tariff 8480, which tariff shall have a benefit rate equal to the consultation benefit rate for the physician's bloc of practice.

For store and forward telemedicine services, a receiving physician shall claim tariff 8481, which tariff shall have a benefit rate equal to the regional history and examination or subsequent visit benefit rate for the physician's bloc of practice.

Where a receiving physician, after having provided a telemedicine service to a patient, decides he/she must examine the patient in person, the physician may claim a complete examination fee for the in-person examination, notwithstanding that the in-person examination has been provided within sixty (60) days of the telemedicine service.

Where a telemedicine service is interrupted for technical reasons, and is not able to be resumed within a reasonable period of time, and is therefore not able to be completed.

1) The receiving physician shall be entitled to claim ***By Report*** for the telemedicine service which he/she began to provide prior to the interruption, to the same effect as if the provision of the service had been completed.
2) Where a subsequent telemedicine service is provided to the patient for the same condition by the physician, the physician shall be entitled to claim ***By Report*** for the second telemedicine service, notwithstanding that the second telemedicine service has been provided within sixty (60) days of the initial telemedicine service.
3) Where a subsequent in-person service is provided to the patient for the same condition by the physician, the physician shall be entitled to claim ***By Report*** a complete examination fee for the in-person service, notwithstanding that the in-person service, has been provided within sixty (60) days of the telemedicine service.

Assisting Physicians

Where a physician is required to be present with the patient to assist with essential physical/psychiatric assessment, the assisting physician shall claim tariff 8482.

For other services rendered by the assisting physician, either prior to or subsequent to the telemedicine service, the appropriate tariff codes may be claimed.

Psychiatry

A Psychiatrist shall claim tariff 8480 for a live telemedicine service, unless the service which is provided is individual psychotherapy, in which case tariff 8479 shall be claimed, or psychiatric care, in which case tariff 8478 shall be claimed. Except by prior approval of Manitoba Health, group psychotherapy shall not be provided via telemedicine service.

Radiology

Radiologists who interpret diagnostic images received via store and forward telemedicine services shall be paid at the same rate as is currently paid for equivalent hard film examinations. Where a radiologist interprets a diagnostic image received via a store and forward telemedicine service, no claim may be made for the interpretation of the same image received on hard film.

General

After hours premiums may be claimed in relation to live telemedicine services when provided in urgent or emergent situations.

Special call fees may be claimed in relation to live telemedicine services in accordance with the Rule of Application relating to special calls.

After hours premiums and special call fees may not be claimed in relation to store and forward telemedicine services.

8480	Live Telemedicine Service —Receiving Physician	Claim rate equal to consultation rate for receiving physician's bloc of practice.
8479	Live Telemedicine Service —Individual Psychotherapy —Receiving Psychiatrist	Claim rate equal to individual psychotherapy (psychiatry rate).
8478	Live Telemedicine Service —Psychiatric Care —Receiving Psychiatrist	Claim rate equal to psychiatric care rate.
8481	Store and Forward Telemedicine Service —Receiving Physician	Claim rate equal to appropriate regional history and examination rate for receiving physician's bloc of practice.

Note: *1) Dermatology; Plastic & Reconstructive Surgery; Psychiatry claim rate equal to subsequent visit rate.*

2) Obstetrics and Gynaecology claim rate equal to 8505 rate.

3) Paediatrics or General Practice claim rate equal to 8529 rate.

8482 Telemedicine Service (live or store and forward)—Assisting Physician per fifteen (15) minute period or major portion thereof.....36.35

Note: *Maximum of one (1) hour per telemedicine service except* ***By Report***

TELESTROKE

8485 Initial Assessment of patient with hyperacute stroke symptoms and/or signs by a Neurologist providing Telemedicine Telestroke services to the Hyper Acute Stroke Service.....331.25

Note: *1) Includes determination of the hyperacute stroke period and recommendation with regard to the administration of tPA and/or eligibility for (EVT) assessment at HSC.*

2) Includes a review of CT scan/Radiologist report and/or other diagnostic tests as appropriate.

3) May not be claimed in addition to 8550, 8595 or 8540.

4) *In the event that a subsequent live telemedicine service is provided, tariff 8480 may be claimed. No other visit or hospital care tariffs may be claimed.*

5) *The time of service must be submitted on the claim.*

8486 Follow-up Telephone/Facsimile/Email communications by the Neurologist providing Telestroke services to the Hyper Acute Stroke Service 22.05

Note: 1) *This tariff may be only claimed within twenty-four (24) hours of the provision of the service described by tariff 8485.*

2) *This tariff may be claimed by a Neurologist for direct communication with a Specialist or General Practitioner regarding a patient for whom 8485 was claimed.*

3) *The claim must include the name of the Physician who initiated the communication, the name of the patient concerned and the time of day the communication was completed.*

4) *Services shall be documented in the patient's record as required by the College of Physicians and Surgeons of Manitoba, and such documentation is required, upon request by Manitoba Health to support the claim submitted.*

E-CONSULTATIONS

8627 eConsultation, consultant services per fifteen minutes or portion thereof 61.20

Notes: 1) *8627 includes review of the specific medical request and any accompanying diagnostic data and communication to the referring physicians with recommendations as to treatment and management of patient.*

2) *Response must be provided within seven days of request.*

3) *A visit or consultation by the consultant may not be claimed on the same day as 8627.*

4) *Limited to physicians participating in a recognized Provincial eConsultation service.*

5) *Rules of Application 7 – 10 do not apply.*

8628 Referring physician 28.15

Note: *A visit or consultation may be claimed on the same day as 8628.*

PSORALEN ULTRA VIOLET A TREATMENT

9885 P.U.V.A., each treatment.....48.76

9886 professional component.....18.14

9887 technical component.....21.93

Note: *Includes follow-up visits on same day.*

THERAPEUTIC PLASMAPHERESIS BY CELL SEPARATOR

Note: *This service is to be claimed only by one (1) physician at a time and only by one (1) of the designated physicians approved by (WRHA, Head (or designate) of Department of Medicine). This service is to be claimed only when used for conditions approved for plasmapheresis by The College of Physicians and Surgeons of Manitoba.*

After a year without plasmapheresis, a patient's next plasmapheresis can be claimed as an initial or first service.

2605* First 129.81

2606* Second to fifth.....102.09

2607* Sixth or more, each 63.20

DIABETIC CARE

8575 Insulin pump instruction (individual) per fifteen (15) minute period.....27.71

8576 Diabetes self-care group teaching session per fifteen (15) minute period.....27.71

Note: *1) A "group" must consist of:*

i) two (2) or more patients, each with diagnosed diabetes, or

ii) one (1) patient with diagnosed diabetes, who is accompanied by a family member(s) or other caregiver(s).

2) The total fee for the group teaching session must be divided by the number of patients with diabetes in the group and billed for each patient on a separate claim.

3) Tariff rate is payable for the first full fifteen (15) minute period and for each additional fifteen (15) minute period or major portion thereof.

4) Tariff rate is payable per group teaching session, regardless of the number of individuals present in the group.

5) The claim must include the time the teaching session took place and the names of all patients and family members/caregivers in attendance.

6) A claim may be made for another service, including a visit, provided on the same day as the diabetes self-care group teaching session, so long as such other service is provided either prior to, or following, the period of time covered by the teaching session.

8487 Local Centre Dialysis Unit (LCDU) Patient–Weekly stipend for the medical management of a patient in the LCDU by the local centre physician..... 67.27

LCDUs are currently in place at the following locations:

Bethesda Regional Health Centre, Boundary Trails Health Centre, Berens River Renal Health Centre, Dauphin Regional Health Centre, Flin Flon General Hospital, Gimli Hospital, Hodgson Area Renal Health Centre, Island Lake Regional Renal Unit, Lakeshore General Hospital, Norway House Hospital, Pine Falls General Hospital, Portage District General Hospital, Swan Valley Health Centre, Selkirk & District General Hospital, The Pas Health Complex, Thompson General Hospital.

Note: *1) The weekly stipend is intended to compensate the local centre physician for the medical management of an LCDU patient during the regular operating hours of the unit.*

2) Tariff 8487 may be billed once per patient per week regardless of the number of times the patient attends the unit during the week.

3) Claims for all non-dialysis medical services rendered to an LCDU patient, including Special Calls and After Hours Premiums, will be paid in addition to this tariff.

THERAPEUTIC INJECTIONS AND IMMUNIZATIONS

These benefits under this section are for the procedure alone and not for the management of the case. Where therapeutic injections or immunizations are provided in a community-based clinic, physicians may bill when the service is provided by a staff member employed and paid by the physician and competent to perform the service.

THERAPEUTIC INJECTIONS

No visit benefit will be paid in addition to the following procedures if the patient's visit is for the procedure alone.

8954 Intramuscular or subcutaneous 11.80

8957* Intravenous (injection) 11.80

Note: *When a physician performs a venipuncture and injects medication, the service may be claimed under tariff 8957.*

Injecting medication into I.V. tubing by a physician or staff person is not claimable.

2560 Intravenous therapy, establishment 33.20

Note: *This fee may not normally be charged by a physician who has charged for a visit or anesthetic that day or a block fee for a surgical procedure. It may be claimed only by a physician with special experience (example—anesthetist) who is requested to perform the procedure because of exceptional technical difficulties.*

2563 Arterial Puncture, for therapeutic injection of medicine 13.72

2300* for blood withdrawal 17.70

8952* Infiltration analgesia 11.80

Note: *This does not apply to injections of local Anesthesia for the purpose of repairs or excisions where the local is injected for absorption into or proximal to the area. It applies only to the injection of analgesic agents into a large area to relieve spasm, e.g., lumbar muscles, or other substances into painful areas of neuritis, etc.*

2446 Blood-exchange transfusion for erythroblastosis 248.76

2562 Infiltration of tissues for trigger point 16.44

DIAGNOSTIC AND THERAPEUTIC ANESTHETIC PROCEDURES

Therapeutic Procedures

8950 Epidural injection of autologous blood, any site 110.65

2596 Anesthesia for emergency relief of acute upper airway (above the carnia) obstruction (excluding choanal atresia) 265.56

2597 Intubation not associated with an anesthetic service 110.65

2618 Controlled hypothermia and/or pump oxygenation in non-cardiac anesthesia 177.04

2567 Autonomic blockade by pharmacologic or major neuraxial technique to minimize blood loss or facilitate surgery. A sustained mean blood pressure below 60 mmHg is required to bill this tariff. 132.78

2649 Nerve block by primary surgeon, per injection, add 15.86

Injection Tendon Sheath, Ligaments

1046 Single injections 22.13

1047 Multiple injections, regardless of number 33.20

1048 IV injections for diagnosis and/or therapeutic management of pain syndromes 44.26

2566 IV sympathetic blockade 132.78

Intra-Articular Injections

1055 Intra-Articular injections with fluoroscopic control 99.59

Note: *1) This procedural fee is intended to cover the procedural portion of the service including the placing of an instrument into the joint space and introducing local anesthetic and/or contrast media and/or steroids and/or other analgesic/diagnostic agents under fluoroscopic control.*

2) When two (2) or more intra-articular injections are performed on the same patient on the same day by the same physician, 100% of the unit value shall be paid for the first injection and 75% for each additional injection.

Local Anesthesia

40000 Local injections to anesthetize an area through absorption by area nerves. 3.97
This includes anesthetic injected directly into desired area or injected proximally for absorption into nerves supplying the area, (e.g. “ring anesthesia” in a finger proximal to the area; but does not include specific nerve blocks.) **This excludes topical anesthesia.**

CHEMOTHERAPY (COMMUNITY CANCER CARE PROGRAM NETWORK—SEE TARIFF 8409)

Chemical/Biological Intravenous Cancer Therapy

2610* This tariff applies to either of the following clinical circumstances: 39.25

1) *Intravenous single agent chemotherapy where **all** of the following criteria apply:*

   a) *duration of administration of the agent itself, or administration of the agent in combination with other agents requires one (1) hour or less;*

   b) *dosage administered is within the conventional range;*

   c) *potential for extravasation, cardiovascular or allergic reactions is normally low. (Examples of these single agents include, but are not limited to 5-FU, methotrexate, cyclophosphamide, fludarabine, Ara-C, and bleomycin subsequent to first dose).*

2) *Administration of biological agents, including vaccines, antibodies, interferons and other cytokines, administered subsequent to the first dose, except where documented allergic or other serious reactions have occurred with the first dose and the patient remains at risk of subsequent reactions.*

2611* This tariff applies to either of the following clinical circumstances: 8.39

1) *Administration of each additional agent that meets the criteria for tariff 2610.*

2) *Administration of leucovorin, when administered with 5-FU for chemopotentiation.*

2613* This tariff applies to each of the following clinical circumstances: 82.01

1) *Administration of single or multiple agent requiring greater than one (1) and less than six (6) hours to infuse, where continuous cardiovascular monitoring is not normally required (e.g., platinum compounds).*

2) *Administration of single or multiple agent where one (1) or more agents have the potential to cause serious extravasation, cardiovascular or allergic reactions but where continuous cardiovascular monitoring is not normally required (e.g., anthracyclines, etoposide, vinca alkaloids, first dose bleomycin).*

3) *First time administration of biological agents (vaccines, antibodies, interferons and cytokines), where the risk of allergic reaction is, by reason of being the first dose, unknown.*

4) *Subsequent doses of biological therapy where, because of a previously documented serious adverse reaction (e.g., bronchospasm, hypotension, anaphylaxis, severe urticaria) the patient remains at high risk for further serious adverse reactions requiring antihistamines and/or corticosteroid or other recognized adjunctive antidote therapy.*

2614* This tariff applies to each of the following clinical circumstances: 114.97

1) *Administration of single or multiple agents requiring greater than six (6) hours at one time to infuse.*

2) *Single or multiple agents administered more frequently than once within a 24-hour period (e.g., Ara-C, etoposide and cis-platin).*

3) *Administration of any agent administered at a dose 25% or greater than the usually administered dose (e.g., Ara-C, cyclophosphamide, nitrosourea).*

4) *Administration of any agent requiring a specific antidote to prevent serious toxicity or death (e.g., methotrexate at doses requiring leucovorin; ifosfamide requiring mesna; anthracyclines requiring dexrazoxane to prevent or stabilize low cardiac function (LVEF<50%).*

5) *Administration of any agent routinely requiring both premedication to prevent serious allergic reactions and continuous cardiovascular monitoring, regardless of the duration of administration (e.g., Taxol; Taxotere).*

Note: *Where treatments that fall under tariff 2614 are administered consecutively for more than one (1) day, tariff 2614 shall be claimed on the first day of treatment and tariff 2613 shall be claimed on subsequent days of the treatment cycle (e.g., ifosfamide/mesna daily x 5 days).*

2224* Administration of chemotherapy, including aspiration, thoracentesis and sample 72.94

3905* Chemotherapeutic instillations in bladder, per instillation, to include necessary catheterization (Professional Fee Only) 62.07

2226 Subcutaneous or intramuscular injection of a luteinizing hormone-releasing hormone (LHRH) agonist or antagonist for prostate or breast cancer 51.77

Note: 1) *This tariff may be claimed by:*

a) *physicians participating in a recognized Community Cancer Care Program Network (CCPN); or*

b) *physicians in rural areas where there is no cancer treatment clinic, as approved by Cancer Care Manitoba.*

2228 Subcutaneous or intramuscular injection of a luteinizing hormone-releasing hormone (LHRH) agonist or antagonist for prostate or breast cancer 51.77

Note: *This tariff may be claimed by physicians practicing in Winnipeg as approved by Cancer Care Manitoba.*

5063* Intrathecal antineoplastic chemotherapy by cisternal route 88.08

5061* Intrathecal antineoplastic chemotherapy by lumbar route 88.08

8405 Monitoring of oral anti-cancer agents 27.71

Note: *1) Tariff 8405 is payable for the responsibility of monitoring patients taking oral anti-cancer agents. This service may include ordering blood tests, interpreting results, inquiring into possible complications and adjusting the dosage as necessary.*

2) This tariff may be claimed by physicians designated as specialists in Medical Oncology, Hematology and Pediatric Oncology/Hematology by the College of Physicians and Surgeons of Manitoba or physicians approved by Cancer Care Manitoba for supervision/monitoring of anti-cancer agents.

3) Maximum of one (1) claim per patient per twenty-one (21) day period.

4) Claims for additional services rendered to a patient (e.g. visits) may be made in addition to this tariff.

5) Payable only for cytotoxic anti-cancer agents or targeted therapies.

6) If both oral and intravenous agents are administered at the same sitting, payment for the intravenous agent shall be Tariff 2611.

8409 Complete or extensive re-examination of a cancer patient.....59.06

These patients are defined as those who have had or are presently receiving any of the following treatments: radiation, chemotherapy, (either parenteral or oral), hormonal therapy, vaccine immunotherapy, or other biological cancer therapies and are at risk for recurrence.

Tariff 8409 may be claimed every twenty-one (21) days. In the event the patient is seen again within any twenty-one (21) day period, the physician shall claim the appropriate subsequent visit tariff from their visit page.

A claim for a subsequent visit within a twenty-one (21) day period does not preclude a physician from claiming tariff 8409 for further visits.

For example: Physician provides care on Day 1, Day 15, Day 22. Physician is eligible to claim as follows:

- Day 1—8409
- Day 15—subsequent visit
- Day 22—8409

Note: *1) This tariff may be claimed by:*

a) physicians participating in a recognized Community Cancer Care Program Network (CCPN); or

b) physicians in rural areas where there is no cancer treatment clinic, as approved by Cancer Care Manitoba.

2) This tariff may only be claimed by physicians designated as eligible by Cancer Care Manitoba.

3) Physicians may continue to claim the appropriate visit tariff when conducting an initial or subsequent examination on a cancer patient.

4) Physicians eligible to claim tariff 8409 may also claim the chemotherapy tariffs listed under the heading "Chemical/Biological Intravenous Cancer Therapy" in the General Schedule of the Physician's Manual.

Immunizations

Immunizations are an excluded service for purposes of travel, employment and emigration, and may only be claimed if the injection is for a publicly funded vaccine administered in accordance with the eligibility criteria as is determined from time to time by the Communicable Disease Control Branch of Manitoba Health. The eligibility criteria for most publicly funded vaccines can be found on Manitoba Health's website at www.gov.mb.ca/health/publichealth/cdc/index.html

ACTIVE IMMUNIZING AGENTS

BCG–Bacillus Calmette–Guérin

8731 single dose 11.80

COVID–19

8161 Moderna XBB.1.5 Vaccine (12+ years of age) 11.80

8162 Moderna XBB.1.5 – 0.1 mg/ml (6 months – 11 years of age) 11.80

8163 Novavax XBB.1.5 COVID-19 ..... 11.80

8160 Pfizer XBB.1.5 Vaccine (12+ years of age) 11.80

8165 Pfizer Pediatric XBB.1.5 Vaccine (5-11 years of age) 11.80

8166 Pfizer Infant XBB.1.5 Vaccine (6 months-4 years of age) 11.80

DTaP–IPV–Hib–Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio Virus, Haemophilus influenza type b paediatric

8802 single dose 11.80

HA–Hepatitis A

8904 single dose 11.80

HAHB–Hepatitis A and B

8899 single dose 11.80

HB–Hepatitis B

8913 single dose 11.80

Hib–Haemophilus influenzae type b

8901 single dose 11.80

HPV–9–Human Papillomavirus type 6, 11, 16, 18, 31, 33, 45, 52, 58

8971 single dose 11.80

Inf(s)–Influenza–seasonal

8791 single dose 11.80

Inf-Influenza-High Dose

8775 single dose 11.80

Inf ITN–Influenza–Intranasal

8969 single dose 11.80

IPV–Inactivated Polio Virus

8931 single dose 11.80

Men–B–Multicomponent Meningococcal B

8970 single dose....11.80

Men–C–C–Meningococcal C Conjugate

8685 single dose....11.80

Men–C–ACWY–135–Meningococcal–Conjugate ACWY

8990 single dose....11.80

MMR–Measles, Mumps, Rubella

8670 single dose....11.80

MMRV–Measles–Mumps–Rubella–Varicella

8671 single dose....11.80

Pneu–C–13–Pneumococcal Conjugate–13–valent

8896 single dose....11.80

Pneu-P-23 – Pneumococcal Polysaccharide-23-Valent

8961 single dose....11.80

PNEU-C-15 – Pneumococcal Conjugate-15-Valent

8222 single dose....11.80

PNEU-C-20 – Pneumococcal Conjugate-20-Valent

8223 single dose....11.80

Rab–Rabies–post–exposure

8751 single dose....11.80

Rab–Rabies Vaccine–pre–exposure

8761 single dose....11.80

Rota–1 (Rotavirus monovalent)

8897 single dose....11.80

Rota–5 (Rotavirus pentavalent)

8778 single dose....11.80

Smallpox/Monkeypox

8699 single dose....11.80

Td–Tetanus, Diphtheria–adult

8651 single dose....11.80

TdaP–Tetanus, Diphtheria, accellular Pertussis–adult

8907 single dose....11.80

Tdap–IPV–Tet–dipth–Apertussis–Ipolio

8964 single dose....11.80

Var–Varicella

8674 single dose....11.80

PASSIVE IMMUNIZING AGENTS

BAtx–Botulism Antitoxin

8910 single dose 11.80

DAtx–Diphtheria Antitoxin

8928 single dose 11.80

HBIg–Hepatitis B Immunoglobulin

8916 single dose 11.80

Ig–Immune globulin (human)

8920 single dose 11.80

RabIg–Rabies Immunoglobulin

8768 single dose 11.80

TIg–Tetanus Immunoglobulin

8690 single dose 11.80

VarIg–Varicella Immunoglobulin

8672 single dose 11.80

OTHER IMMUNIZING AGENTS

Other Immunizing Agents

8800 other active or passive immunizing agents not listed above, single dose 11.80

ALLERGY

The benefits under this section are for the procedure alone and not for the management of the case.

Allergy Tests as an aid in the diagnosis of disease states, if read and interpreted by a physician.

9860* Comprehensive Allergy Investigation.....113.48

Note: *1) Includes all investigations necessary to assess the role of allergy in contributing to a patient's illness(es).*

2) Investigation may include appropriate skin testing with inhalants, foods, stinging insect venoms, chemicals and/or drugs.

*3) Tariff 9860 may only be claimed once for the same patient by the same physician in a twelve (12) consecutive month period. (Exceptional circumstances will be considered on a "**By Report**" basis).*

4) Tariff 9861 may be claimed for the same patient by the same physician within the twelve (12) consecutive month period.

9861* Limited Allergy Investigation.....42.96

Note: *1) Includes investigations required to assess a specific allergic condition such as drug allergy, limited food allergies, contact reactions.*

*2) Tariff 9861 may only be claimed twice for the same patient by the same physician in a twelve (12) consecutive month period. (Exceptional circumstances will be considered on a "**By Report**" basis).*

9871* Intradermal tests, including tuberculin Mantoux tests, (excluding the Tine test), Shick, fungal and other skin tests, per ten (10) tests.....22.06

9872* minimum.....19.30

9875* Patch tests, per one (1) test.....2.47

9876* minimum.....7.19

9867* Epicutaneous tests, per ten (10) (to a maximum of twenty (20).....19.99

DESENSITIZATION

9865* Per treatment visit [one (1) or more injection(s)].....24.03

9864* Single and casual visit [one (1) or more injection(s)].....25.56

Note: *Office visits will be paid in addition to the allergy injection **only** when the doctor has to examine the patient, and provides explanation on the claim card.*

INGESTANT AND INJECTION CHALLENGES

Note: *Challenges are to be administered in an appropriate clinical setting **with full resuscitation equipment available**, and performed by administration of incremental oral or subcutaneous doses of a substance which has the potential for inducing a systemic reaction as suggested by history and/or in vivo or in vitro testing for allergen-specific IgE.*

9817* per fifteen (15) minutes or major portion thereof, to a maximum of three (3) hours per day per patient.....28.02

VENOM IMMUNOTHERAPY

Note: *Subsequent to an initial major assessment (consultation) and appropriate epicutaneous and/or intradermal testing, the patient may receive incremental dose venom immunotherapy (rush or modified rush).*

9818* per injection to a maximum of six (6) injections per day 18.36

9862* for maintenance venom immunotherapy, per injection, to a maximum of two (2) per day 18.72

9863* Sting challenge with a live venomous stinging insect per quarter hour 24.23

Note: *Tariff 9863 is to be claimed for this service **only** when performed in a hospital emergency room or an intensive care setting with appropriate precautions including vascular access and electrocardiograph monitoring.*

SURGICAL ASSISTANT

A Surgical Assistant is defined as a physician who assists the operating surgeon throughout the duration of the operation. Assistants' benefits will be provided only when medical necessity justifies the need for an assistant in respect to the primary procedure performed during the operation. When a claim is made by a surgical assistant, no additional claim should be made for supportive care by the assistant for the postoperative period. If concomitant care is rendered by the assistant, appropriate claims may be made in addition to that for surgical assistance. In cases where multiple surgical procedures are provided, the surgical assistant's benefits will be calculated based on the total of all procedural benefits paid to the principal surgeon (ie. the total of all benefits for all procedures performed by the principal surgeon throughout the duration of the operation, including those procedures for which there is no medical necessity for the presence of a surgical assistant.)

When a second surgical assistant is required, benefits listed in the General Schedule for surgical assistance will also apply to the second assistant, and shall also be based on the total of all benefits paid to the principal surgeon as noted above."

Surgical assistant service benefits provided by a General Practitioner shall be calculated at a rate of 40% of the total value of procedural benefits paid to the principal surgeon.

Surgical assistant service benefits provided by a Specialist shall be calculated at a rate of 60% of the total value of procedural benefits paid to the principal surgeon.

ANESTHESIA

TABLE OF CONTENTS

PART I—GENERAL PROVISIONS

Anesthetists shall continue to be eligible to bill fee-for-service for all other services not expressly covered by this Agreement, in accordance with the Manitoba Physician's Manual, being an integral part of the fee-for service Agreement in effect from time to time between the parties.

PART II—RULES OF APPLICATION FOR ANESTHESIA SERVICES

Unless otherwise expressly stated herein, in the event of a conflict between the Rules of Application in this Part and the general Rules of Application contained in the Physician's Manual, the Rules in this Part shall prevail.

1. DEFINITIONS

a) "Anesthetist" means a medical practitioner who is enrolled on the Specialist Register of the College of Physicians and Surgeons of Manitoba and whose registration is so defined

or

a medical practitioner with privileges to administer anesthesia as determined by the College of Physicians and Surgeons of Manitoba (commonly referred to as either a non-specialist anesthetist or general practitioner anesthetist).

b) All anesthetists are entitled to submit claims for all anesthetic services, including modifiers and premiums, in accordance with these Rules of Application and accompanying appendices.

c) "Unit value" means the particular unit rating of an anesthetic service.

d) "Unit value rate" means the remuneration payable for the provision of one (1) anesthetic unit. The unit value rate is two dollars and twenty one and three tenths cents ($2.213).

e) "Anesthetic services" means the various services provided by an anesthetist, including but not limited to, anesthetic procedural services.

f) "Scheduled slate" means anesthetic procedural services provided in an operating room or designated location between 0700 hours (7:00 a.m.) and 1600 hours (4:00 p.m.) Monday to Friday inclusive.

2. ANESTHETIC PROCEDURAL SERVICES

a) Anesthetic procedural services and applicable unit values are listed in Appendix A. These services include the administration of the anesthetic and the necessary anesthesia care during the procedure, including intubation and/or turning, and regular monitoring services.

b) Anesthetic procedural services are time based. Anesthetic time shall be calculated in fifteen (15) minute periods or portion thereof.

c) Anesthetic procedural services have been evaluated and rated on the basis of complexity and intensity. There are five different levels of complexity/intensity with respect to anesthetic services. The least complex/intense services are assigned a complexity/intensity rating of one (1), and the most complex/intensive services are assigned a rating of five (5).

d) Each of the five levels of complexity/intensity are assigned a number of units (the unit value) per fifteen (15) minute periods or portion thereof as follows:

Level of Complexity/ Intensity	Unit Value [per fifteen (15) minute period or portion thereof]
1	20.000
2	21.375
3	22.750
4	25.500
5	26.875

e) An anesthetic procedural service shall be deemed to have commenced with the attendance of the anesthetist for the purpose of administering an anesthetic or providing monitored care. The anesthetic service shall be deemed to have ceased when the anesthetist has transferred the care of the patient.

3. Pre–Anesthetic Evaluation

a) Tariff **8515** is for a pre-anesthetic evaluation. This is a service provided by an anesthetist and is comprised of a focused patient history, examination of the patient and review of the patient's records for the purposes of:

i) anesthetic risk stratification,

ii) optimizing fitness for surgery and anesthesia, and

iii) explaining the anesthetic service(s) to the patient.

b) Tariff **8515** shall be claimed in conjunction with other anesthetic services, except as otherwise noted. This tariff may only be claimed once per patient per calendar day by the same anesthetist.

c) Tariff **8515** may be claimed notwithstanding a patient's prior attendance at a pre-operative anesthesia clinic, services for which are payable in accordance with Rules of Application for Anesthesia Services 12.

d) Tariff **8515** shall not be claimed where the same anesthetist has provided an anesthetic consultation within seventy-two (72) hours of the provision of the anesthetic service.

e) The unit value of tariff **8515** is twelve (12) units. Payment is based on the listed unit value of the service regardless of the time required for the evaluation.

f) Where a pre-anesthetic evaluation is completed and there is a delay in surgery, tariff **8508** shall be claimed instead of tariff **8515**. The unit value of tariff **8508** is twenty-five (25) units. Payment is based on the unit value regardless of the time required.

4. Anesthetic Procedural Modifiers

a) Tariffs **2615**, **2616**, **2600** and **2617** are anesthetic procedural modifiers that may be claimed, where the clinical circumstances warrant, in addition to Anesthetic Procedural Services listed in Appendix A, Diagnostic and Therapeutic Anesthetic Procedures listed in Appendix B and Monitored Anesthetic Care Rules of Application for Anesthesia Services 7.

b) Anesthetic procedural modifiers are not time based. Payment is based on the listed unit value of the service regardless of the time required.

c) Anesthetic procedural modifiers may not be claimed in conjunction with the following services: Consultations, Visits, Resuscitation, Critical Care, Chronic Pain Management or Acute Pain Services.

d) Anesthetic procedural modifier **2617** may be claimed in addition to either **2615**, **2616** or **2600**, where the clinical circumstances warrant.

e) The unit values of the anesthetic procedural modifiers are as follows:

2615 Neonates (less than 44 gestational weeks and/or 2500 grams or less) ..... 70 units

2616 Patients over 70 years of age ..... 10 units

2600 Patients under one year of age (not to be billed in addition to tariff **2615**) ..... 60 units

2617 Patient entering the operating room with hemodynamic instability requiring blood transfusion and/or vasopressor administration and with respiratory insufficiency requiring endotracheal intubation and requiring intraoperative red blood cell salvage (Cell Saver), operated by primary anesthetist ..... 50 units

Note: *2617 may not be claimed when the anesthetist on-call for Cell Saver attends as a second anesthetist to a surgical service. Secondary anesthetist benefits may be claimed.*

5. Diagnostic and Therapeutic Anesthetic Procedures

a) Diagnostic and therapeutic anesthetic procedures include nerve blocks and intravenous procedures, and are used to determine the cause of pain and to provide relief of pain through treatment.

b) Diagnostic and therapeutic anesthetic procedures are not time based. Payment is based on the listed unit value of the service regardless of the time required, except for tariff **5113**.

c) Diagnostic and therapeutic anesthetic procedures are listed in Appendix B with the exception of tariff **5113**.

d) Subject to Rules of Application for Anesthesia Services 6 d) iii) and 6 e) iii), tariff **8515** pre-anesthetic evaluation may be claimed in addition to diagnostic and therapeutic anesthetic procedures.

e) Tariff **5113** is Titration of a Long-Term Percutaneous Catheter. This is a service provided by an anesthetist for the titration of medication and monitoring of effectiveness and side effects following the insertion of a long-term percutaneous catheter. The unit value of tariff **5113** is twenty (20) units per fifteen (15) minute period or portion thereof.

6. Chronic Pain Management Services

a) Chronic Pain Management Clinics designated by Manitoba Health are:

Chronic Pain Management Clinics	Funded Sessions Per Year
Chronic Pain Clinics in the City of Winnipeg	925
Brandon Regional Health Centre Chronic Pain Clinic	125
Selkirk Hospital Chronic Pain Clinic	125

b) A session means eight (8) hours.

c) Chronic Pain Management Services shall only be claimable by qualified specialists who have been approved by the Shared Health – Chief Medical Officer, or designate.

d) Chronic Pain Management Initial Assessment tariff **8570**

i) An initial assessment shall consist of an appropriate examination of the patient, a review of radiological and/or laboratory findings, and a written report. The anesthetist, through initial assessment, determines an initial diagnostic opinion and/or therapeutic management of chronic pain and/or related problems.

ii) Chronic Pain Management Initial Assessment tariff **8570** unit value is twenty-one (21) units per fifteen (15) minute period or portion thereof.

iii) Tariff **8515** (pre-anesthetic evaluation) is not claimable in addition to tariff **8570**.

iv) Diagnostic or therapeutic anesthetic procedures may be claimed in addition to tariff **8570**.

v) An anesthetist may not claim tariff **8570** during any period when diagnostic or therapeutic procedures are provided.

vi) Virtual Chronic Pain Management, Initial Assessment services may be claimed using tariff 8437.

vii) Virtual Chronic Pain Management, Initial Assessment tariff 8437 unit value is twenty-one (21) units per fifteen (15) minute period or portion thereof.

e) Chronic Pain Management Follow-up Assessment tariff **8571**

i) A follow-up assessment applies when a patient is seen for the same condition/problem by the same anesthetist within six (6) months, or when, in the judgement of the anesthetist, the visit does not warrant the services described in tariff **8570**.

ii) Chronic Pain Management Follow-up Assessment tariff **8571** unit value is twenty (20) units per fifteen (15) minute period or portion thereof.

iii) Tariff **8515** (pre-anesthetic evaluation) is not claimable in addition to tariff **8571**.

iv) Diagnostic or therapeutic anesthetic procedures may be claimed in addition to tariff **8571**.

v) An anesthetist may not claim tariff **8571** during any period when diagnostic or therapeutic procedures are provided.

vi) Virtual Chronic Pain Management, Follow-up Assessment services may be claimed using tariff 8438.

vii) Virtual Chronic Pain Management, Follow-up Assessment tariff 8438 unit value is twenty (20) units per fifteen (15) minute period or portion thereof.

f) Anesthetic Services provided in accordance with Rules of Application for Anesthesia Services 6 d) and 6 e) may not exceed the Funded Sessions per Rules of Application for Anesthesia Services 6 a).

7. Monitored Anesthetic Care

a) Monitored Anesthetic Care is the situation where a surgeon, gastroenterologist, radiologist or cardiologist and, in exceptional circumstances, other medical practitioner, requests an anesthetist's continuous attendance during a procedure. The anesthetist shall be in attendance and not engaged in any other duties. The anesthetist shall be remunerated in accordance with Anesthetic Procedural Services listed in Appendix A.

b) For any procedure not listed in Appendix A, the anesthetist shall be paid at the rate of twenty (20) units per fifteen (15) minute period or portion thereof.

8. Post Anesthetic Recovery

a) The immediate post anesthetic care is considered terminated when the anesthetist has transferred care of the patient.

b) Where the anesthetist is required to attend the patient in the recovery area, other than in the circumstances described in Rules of Application for Anesthesia Services 8 c), the anesthetist shall be paid per fifteen (15) minute period or portion thereof at the unit value of the original anesthetic procedural service.

c) Where an anesthetist is called to provide care to a critically ill patient, this may be claimed in accordance with the Physician's Manual, General Schedule, "Detention with a Critically Ill Patient" and/or "Resuscitation".

9. Visit Pages

a) An anesthetist who is enrolled on the Specialist Register of the College of Physicians and Surgeons of Manitoba and whose registration is so defined is entitled to submit claims for visit services in accordance with Section A (Anesthesiology visit page) of the Physician's Manual.

b) Non-specialist or general practitioner anesthetists as defined in Rules of Application for Anesthesia Services 1 a) are entitled to submit claims for visit services in accordance with Section A, (General Practice visit page) of the Physician's Manual.

c) Notwithstanding Rules of Application for Anesthesia Services 9, where an anesthetic consultation tariff **8550** or **8516** is provided in accordance with Rules of Application for Anesthesia Services 15, the anesthetist shall be remunerated per Rule of Application for Anesthesia Services 15 d).

10. Out–of–Hours Premiums

a) An out-of-hours premium may be claimed on anesthetic services as follows:

Tariff	Time Period	Premium
5556	1700 to 2359 hours (5:00 p.m. to 11:59) Seven days per week	50%
5557	2400 to 0700 hours (Midnight to 7:00 a.m.) Seven days per week	75%
5558	0701 to 1659 hours (7:01 a.m. to 4:59 p.m.) Saturday, Sunday and Holidays (listed on Appendix D)	50%

b) Out-of-hours premiums do not apply to the first case of a scheduled slate.

c) Rule of Application for Anesthesia Services 10 b) does not apply to the situation where the first case of a scheduled slate is not completed by 1700 hours (5:00 p.m.).

d) An out-of-hours premium shall only apply to a procedural fee modifier in those cases where the procedure is commenced within an out-of-hours period.

e) The out-of-hours premium shall apply to all anesthetic services performed during the out-of-hours period. Where part of an anesthetic service is provided within the out-of-hours period, the premium shall be payable. No premium shall apply to the portion of the anesthetic service provided outside of the out-of-hours premium period.

f) Appendix G provides examples of the calculation of remuneration for anesthetic services with out-of-hours premiums.

11. Calculation of Remuneration for Anesthetic Procedural Services

a) Remuneration for the provision of Anesthetic Procedural Services is calculated as follows:

Step 1—Determination of remuneration for the pre-anesthetic evaluation

i) Subject to Rules of Application for Anesthesia Services 3 d), 3 f), 5 d) and 15 c), the pre-anesthetic evaluation is calculated by multiplying the unit value of twelve (12) by the unit value rate of two dollars and twenty one and three tenths cents ($2.213).

Step 2—Determination of remuneration for anesthetic procedural services

i) Select the appropriate Anesthetic Procedural Service(s) from Appendix A and determine the unit value per fifteen (15) minute period or portion thereof.

ii) Calculate the time taken to perform the Anesthetic Procedural Service in fifteen (15) minute periods or portion thereof.

iii) Multiply the unit value times the number of fifteen (15) minute periods and portion thereof (as calculated at **Step 2** ii).

iv) Multiply the result of **Step 2** iii) by the unit value rate of two dollars and twenty one and three tenths cents ($2.213) to determine the remuneration for the Anesthetic Procedural Service.

Step 3—Determination of remuneration for anesthetic procedural modifiers, special invasive procedures and other non-time based services.

i) Where applicable, select the appropriate anesthetic procedural modifiers, special invasive procedures and other non-time based services and multiply the corresponding unit value by the unit value rate of two dollars and twenty one and three tenths cents ($2.213).

Step 4—Determination of Out-of-Hours Premiums

i) For anesthetic services performed during an out-of-hours period, and for those procedural modifiers applying to procedures commenced during an out-of-hours period, multiply the applicable number of units by the appropriate premium percentage times the unit value rate of two dollars and twenty one and three tenths cents ($2.213).

b) Remuneration for the provision of anesthetic procedural services is the sum of **Steps 1** to **4** inclusive.

c) Appendix F provides examples of the calculation of remuneration for Anesthetic Procedural Services.

12. Pre–Operative Anesthesia Clinics

a) Pre-operative anesthesia clinics shall only be held at locations approved and funded by Manitoba Health.

b) The anesthesia services provided in a pre-operative anesthesia clinic are time based. Anesthetic time shall be calculated in fifteen (15) minute periods or portion thereof.

c) The unit value of services provided in a pre-operative anesthesia clinic is thirty (30) units per fifteen (15) minute period or portion thereof, and claimed under tariff **8517**.

d) Sessions approved and funded by Manitoba Health for pre-operative anesthesia clinics are as follows:

Pre-Operative Anesthesia Clinics	Funded Sessions Per Year
Pre-Operative Anesthesia Clinics in the City of Winnipeg	1,092
Brandon Regional Health Centre Pre-Operative Anesthesia Clinic	70

e) A funded session means eight (8) hours.

f) The Anesthesia Medical Director of the Winnipeg Regional Health Authority or the Brandon Regional Health Authority, in consultation with anesthetists, shall determine the specific locations, days and times that pre-operative anesthetic clinics operate.

g) Where the Anesthesia Medical Director of the Winnipeg Regional Health Authority determines that the funded sessions need to be reallocated, the matter shall be referred to the Anesthesia Committee for review.

h) The Guidelines for Anesthesia Consultation are attached as Part V.

13. Special Invasive Procedures

a) Special invasive procedures for the purpose of monitoring complicated patients are not included in the anesthetic procedural service as referenced in Rules of Application for Anesthesia Services 2 a).

b) Special invasive procedures are not time based procedures. Payment is based on the unit value of the service regardless of the time required.

c) The unit values of the special invasive procedures are as follows:

i) Tariff **2300**—Arterial puncture for blood withdrawal for blood gas estimations..... 8 units

ii) Tariff **2301**—Continuous arterial catheter for blood gases ..... 15 units

iii) Tariff **9834**—Vein—insertion of venous pressure catheter and including venous pressure measurements—Percutaneous ..... 25 units

iv) Tariff **2303**—Cardiac catheterization, right heart (Swan Ganz) ..... 30 units

d) Where clinical circumstances warrant, an anesthetist may claim more than one (1) special invasive procedure.

14. Acute Pain Services

a) Acute pain services and unit values are as follows:

i) Tariff **8951**—Single epidural/intrathecal injection service, to include patient assessment and preparation ..... 40 units

ii) Tariff **8953**—Indwelling epidural analgesia service, to include patient assessment, testing of the epidural catheter, and first analgesic/anesthetic injection (when independent of an operative procedure) ..... 70 units

iii) Tariff **8955**—Indwelling epidural analgesia service, when used as an adjunct to general anesthesia, and subsequently for postoperative analgesia ..... 50 units

iv) Tariff **8956**—Supervision of indwelling epidural analgesia catheter service (per 24 hours or major portion thereof). The initial monitoring fee of 15 units shall be paid in all cases. However, in the second and subsequent 24 hour periods the 15 units shall only be payable after 12 hours ..... 15 units

v) Tariff **8958**—Subsequent epidural analgesic injections/assessment (to a maximum of 3 per 24 hours) per rendered attendance. (Time of injection should be reported on claim) ..... 15 units

vi) Tariff **8942**—Peripheral nerve sheath catheters inserted at the time of surgery for the purpose of postoperative pain relief. ..... 40 units

vii) Tariff **8943**—Supervision of peripheral nerve sheath catheter service (per 24 hours or major portion thereof). The initial monitoring fee of 15 units shall be paid in all cases. However, in the second and subsequent 24 hour periods, the 15 units shall only be payable after 12 hours ..... 15 units

viii) Tariff **8944**—Subsequent peripheral nerve sheath catheter analgesic/anesthetic injections and/or assessment (to a maximum of 3 per 24 hours) per rendered attendance (time of injection should be reported on claim) ..... 15 units

ix) Tariff **8940**—Insertion of peripheral nerve sheath catheter outside the OR setting ..... 50 units

b) The tariffs listed in Rule of Application for Anesthesia Services 14 a) are not included in the anesthetic procedural service as referenced in Rule of Application for Anesthesia Services 2 a).

c) Acute Pain Services are not time based. Payment is based on the unit value of the service regardless of the time required.

15. Consultation

a) A consultation (tariff **8550**) may be claimed by an anesthetist when a medical practitioner, registered nurse (extended practice), or dentist/oral surgeon has requested, in writing, the anesthetist's opinion as to a patient's fitness for surgery, a patient's fitness for anesthesia, as to further treatment required before anesthesia can be undertaken or advice or opinion regarding acute pain management.

b) Where an anesthetist provides an anesthetic service or an acute pain service following a consultation, the full unit value for that anesthetic or acute pain service shall be paid in addition to payment for the consultation.

c) Where an anesthesia consultation (tariff **8550** or **8516**) is claimed within 72 hours of an anesthetic service, tariff **8515** will not be paid unless the anesthetic service is provided by an anesthetist who did not provide the consultation as per Rule of Application for Anesthesia Services 15 a).

d) The unit value of a consultation (tariff **8550** or **8516**) is seventy-two (72) units. Payment is based on the unit value regardless of the time required.

e) The Guidelines for Anesthesia Consultation are attached as Part V.

f) A consultation may not be claimed where an anesthetist provides such services in a pre-operative anesthetic clinic.

g) A consultation may not be claimed where the patient is referred to the anesthetist for the sole purpose of providing post-operative Patient Controlled Analgesia.

h) Tariff 8406 may not be claimed on the same day as a consultation.

16. Requirement for Second Anesthetist

a) Where clinical circumstances necessitate the attendance of a second anesthetist, such anesthetist shall be remunerated at seventy percent (70%) of the total anesthetic remuneration payable to the first anesthetist.

b) Where one anesthetist commences an anesthetic service and is replaced by another anesthetist during the provision of the anesthetic services, the total remuneration shall not exceed the amount payable had the one anesthetist completed the anesthetic service.

Part III—In–Hospital On–Call Anesthesia Coverage

Where an anesthetist provides In-Hospital On-Call Anesthesia Coverage remuneration shall be in accordance with this Part.

17. Sites and Services

a) One anesthetist per site is required to provide twenty-four (24) hour per day In-Hospital On-Call Anesthetic Coverage at the following sites and services:

Tariff	Site	Service	Benefits [per fifteen (15) minute period or portion thereof]
8201	St. Boniface General Hospital	Obstetrics	37.47
8202	Brandon Regional Health Centre	Obstetrics and Emergency Surgery	33.87
8203	Health Sciences Centre	Obstetrics	37.47
8204	Health Sciences Centre	Emergency Surgery	28.86

b) Where an anesthetist is required to provide In-Hospital On-Call Anesthetic Coverage at the following site and service.

Tariff	Site	Service	Benefits [per fifteen (15) minute period or portion thereof]
8205	St. Boniface General Hospital	Emergency Surgery	28.86
8206	Grace Hospital	Emergency Surgery	28.86

18. Anesthetic Services

a) In-Hospital On-Call Anesthesia Coverage is time based and shall be calculated in fifteen (15) minute periods or portion thereof.

b) Where an anesthetist providing coverage under Part III at Brandon Regional Health Centre, Grace Hospital, Health Sciences Centre or St. Boniface General Hospital is required to provide anesthetic services other than obstetrical procedures listed in Rule of Application for Anesthesia 19 a), such anesthetist shall be remunerated in accordance with Rule of Application for Anesthesia Services 20.

19. In–Hospital On–Call Anesthesia Coverage for Obstetrics

a) An anesthetist who provides In-Hospital On-Call Anesthesia Coverage for obstetrics as per Rule of Application for Anesthesia Services 17 may, additionally, claim for any of the following anesthetic procedural services:

Tariff Number	Procedure
4800	Caesarean section, with or without sterilization (procedure only)
4803	Caesarean hysterectomy
4809	Incompetent cervix in pregnancy, suture
4832	Abnormal presentation or position (delivered vaginally), multiple pregnancy
4833	Transverse or occiput posterior position with forceps extraction and/or vacuum extraction (other than elective forceps)
4843	Manual removal of placenta
4847	Management of post partum haemorrhage requiring reassessment under anesthesia
4562	Post-partum sterilization by any method, unilateral or bilateral
4581	Ovarian cysts, excision, unilateral or bilateral
2128*	Tracheal aspiration for meconium staining under direct vision (independent procedure)
4711	Dilatation of cervix, in-hospital
4855	Abortion, spontaneous, requiring dilatation and curettage
4870	Dilatation and curettage for post-partum bleeding (on re-admission to hospital)

b) It is specifically agreed that payment for the In-Hospital On-Call Anesthesia Coverage for obstetrics is intended to compensate for all anesthesia obstetrical services other than those listed in Rule of Application for Anesthesia Services 19 a) and 19 d), provided during the scheduled On-Call period.

c) Where an anesthetist provides services listed in Rule of Application for Anesthesia Services 19 a) or 19 d), remuneration shall be in accordance with Part II—Rules of Application for Anesthesia Services

d) Where an anesthetist provides obstetrical epidural services, tariff **4877** may be claimed once per patient per delivery in addition to claims for In-Hospital On-Call Anesthesia Coverage.

20. Provision of Anesthetic Services During In–Hospital On–Call Anesthesia Coverage

a) Where an anesthetist is required to provide anesthetic services during a period of In-Hospital On-Call Anesthesia Coverage, such anesthetist shall be remunerated in accordance with Part II—Rules of Application for Anesthesia Services.

b) The In-Hospital On-Call Anesthesia Coverage remuneration shall apply during the period of time that the anesthetist provides anesthetic services in accordance with Part II—Rules of Application for Anesthesia Services to a maximum of the end of the scheduled On-Call period.

PART IV—OUT–OF–HOSPITAL ON–CALL ANESTHESIA COVERAGE

Where an anesthetist provides Out-of-Hospital On-Call Anesthesia Coverage, remuneration shall be in accordance with this Part.

21. COVERAGE

Out-of-Hospital On-Call Coverage is categorized as follows:

Out-of-Hospital On-Call Anesthesia Coverage		
Block A[5]	Evening Coverage	Monday to Friday inclusive, from 1600 to 2359 hours (4:00 P.M. to 11:59 P.M)
Block B	Night Coverage	Monday to Sunday inclusive, from 2400 to 0700 hours (Midnight to 7:00 A.M.)
Block C	Saturday, Sunday and Holidays Coverage (listed on Appendix D)	0701 to 2359 hours (7:01 A.M. to 11:59 P.M.)

22. OUT–OF–HOSPITAL ON–CALL ANESTHESIA COVERAGE

Out-of-Hospital On-Call Anesthesia Coverage is time-based and shall be calculated in sixty (60) minute periods or portion thereof.

23. COMMUNITY FACILITIES

a) Seven Oaks General Hospital

Grace General Hospital

Victoria General Hospital

Concordia General Hospital

Out-of-Hospital On-Call Coverage to be provided by one anesthetist at each hospital as follows:

Tariff **8210**—Block A—one anesthetist at $57.71 per hour;

Tariff **8211**—Block B—one anesthetist at $40.39 per hour; and

Tariff **8212**—Block C—one anesthetist at $57.71 per hour.

b) Misericordia Health Centre

Out-of-Hospital On-Call Coverage to be provided by one anesthetist at the Centre as follows:

Tariff **8210**—Block A—one anesthetist at $57.71 per hour;

Tariff **8211**—Block B—one anesthetist at $40.39 per hour; and

Tariff **8212**—Block C—one anesthetist at $57.71 per hour.

[5] For Rural Hospital Facilities, Block A coverage shall commence at 1600 hours (4:00 p.m.) or at the completion of the scheduled slate, whichever is earlier.

24. TERTIARY FACILITIES

a) St. Boniface General Hospital—**Four anesthetists to provide Out-of-Hospital On-Call Coverage as follows:**

General Anesthesia—one anesthetist

Cardiac—one anesthetist

Acute/Chronic Pain—one anesthetist

Back-up—one anesthetist

b) St. Boniface General Hospital/Health Sciences Centre

Cardiac Backup/Cardiac Trauma—one anesthetist

c) Health Sciences Centre—**Four anesthetists to provide Out-of-Hospital On-Call Coverage as follows:**

General Anesthesia—one anesthetist

Acute/Chronic Pain—one anesthetist

Paediatric—one anesthetist

Paediatric Acute/Chronic Pain—one anesthetist

d) Tariff **8213**—Block A at $57.71 per hour per anesthetist;

Tariff **8214**—Block B at $40.39 per hour per anesthetist; and

Tariff **8215**—Block C at $57.71 per hour per anesthetist

e) Tariff **8219**—Health Sciences Centre Paediatric Back-up

Block C rate at $58.29 per hour for twenty-four (24) hour coverage on Saturday, Sunday and Holidays.

25. RURAL FACILITIES

Selkirk & District Hospital

Portage General Hospital

Boundary Trails Health Centre

Bethesda Hospital Steinbach

Bethel Hospital Winkler

Dauphin General Hospital

Thompson General Hospital

Neepawa Health Centre (Memorial Hospital)

Out-of-Hospital On-Call Coverage is provided by one anesthetist at each hospital as follows:

Tariff **8216**—Block A—one anesthetist at $34.79 per hour;

Tariff **8217**—Block B—one anesthetist at $18.56 per hour; and

Tariff **8218**—Block C—one anesthetist at $34.79 per hour.

26. CALL BACK TO HOSPITAL

a) Where an anesthetist who is providing On-Call Out-of-Hospital Anesthesia Coverage is called back to provide anesthesia services in an emergency, the following shall apply:

b) For Tertiary and Community Facilities the On-Call Out-of-Hospital Anesthesia Coverage remuneration shall discontinue when the anesthetist commences an anesthetic service in accordance with Part II—Rules of Application for Anesthesia Services.

c) The anesthetist shall claim for anesthetic services in accordance with Part II—Rules of Application for Anesthesia Services.

d) For Tertiary and Community Facilities when the anesthetic services have been completed then the anesthetist shall resume providing On-Call Out-of-Hospital Anesthesia Coverage and shall be remunerated in accordance with this Part.

e) For Rural Facilities, the On-Call Out-of-Hospital Anesthesia Coverage remuneration continues throughout the block of coverage including when the anesthetist is providing services in accordance with Part II—Rules of Application for Anesthesia Services.

f) For information purposes a detailed summary of facilities and payments is provided as Appendix E.

27. Special Call

Where an anesthetist is not covered by Part IV Out-of-Hospital On-Call Anesthesia Coverage, or is providing Out-of-Hospital On-Call Coverage to a rural facility, as defined in Part IV Out-of Hospital On-Call Anesthesia Coverage, such anesthetist shall be eligible for a Special Call benefit in accordance with the Rule of Application 3 in the Physician's Manual.

Part V—Guidelines for Anesthesia Consultations

28. Guidelines

a) The Rules of Application regarding Anesthesia Consultation are set out in Rule of Application for Anesthesia Services 15. Part V is intended to assist in determining when an Anesthesia Consultation would be appropriate.

b) The requirement for an Anesthetic Consultation is dependant upon the severity of the condition, the magnitude of the proposed procedure and the extent of previous investigations. The attached list provides instances where a patient would benefit from a pre-operative consultation with an anesthetist. The objective of these consultations is to modify risk factors, provide advice on suitability for surgery and facilitate high quality, efficient and safe peri-operative care.

c) The list is not intended to be exhaustive.

Airway Conditions

Previous failed intubation

Known or suspected difficult intubation

Emergency airway management outside OR

Obstructive sleep apnea

Permanent tracheostomy

Syndromes associated with difficult airway anatomy (e.g. Pierre Robin, Treacher-Collins)

Anesthesia Related Conditions

Known or suspected history of Malignant Hyperthermia

Known or suspected family history of Malignant Hyperthermia

Plasma-cholinesterase deficiency or family history

Anesthetic complications with previous surgery

Quantification of anesthesia risk

Evaluation following **or** cancellation for medically unfit

Latex allergy

Cardiac Disease

- Suboptimal treatment of Congestive heart failure
- Ischemic heart disease:
  - Suboptimally treated I.H.D.
  - History of recent MI (within 6 months)
  - Low threshold angina (Class III & IV)
  - Recent change in previously stable angina
  - Chest pain not previously investigated
- Symptomatic Valvular Heart Disease
- Significant murmur not investigated
- Symptomatic arrythmia
- Symptomatic cardiomyopathy
- Pulmonary hypertension
- Complex congenital heart disease
- Hypertension poorly controlled (e.g. diastolic > 110)
- Hemodynamically unstable patient
- Pericardial tamponade
- Superior vena cava syndrome
- Previous heart transplant

Endocrine Disease

- Morbid obesity (Body Mass Index > 35)
- Carcinoid syndrome
- Pheochromocytoma
- Cushing’s Syndrome
- Uncontrolled hyperthyroidism
- Untreated hypothyroidism
- Pregnant patient for non-obstetrical surgery, excluding peripheral procedures
- Type I diabetic for major vascular, abdominal, thoracic, renal transplant, or major orthopaedic procedure
- Paediatric insulin dependent diabetic with complications

Gastro-Intestinal Disease

- Active hepatitis
- Advanced cirrhosis
- Metastatic liver disease with impaired function
- Previous liver transplantation with impaired function
- Obstructive jaundice
- Biliary atresia
- GT anomalies (e.g. omphalocoele, gastroschisis)

Hematologic Conditions

Severe symptomatic anemia

Sickle-cell disease with anemia or history of crisis

Bleeding diathesis excluding minor surgery

Patient refusal of blood products excluding minor surgery

Pre-operative management of chronic anticoagulant therapy

Leukemia on active treatment

Metabolic Conditions

Acute or chronic renal failure requiring medical therapy

Major electrolyte disturbance

Significant acidosis

Porphyria

Cachexia

Severe burn > 30 %

Septic shock

Extremes of age: (e.g. octogenarian for radical surgery)

newborn apgar < 8

Inborn errors of metabolism (e.g. Hunter-Hurler)

Neurologic Disease

History of TIA or Stroke in past 8 weeks

Critical carotid stenosis

Intracranial mass or raised intracranial pressure

Neuromuscular disease such as muscular dystrophy, myasthesia…etc.

Uncontrolled seizure disorder

Musculo-Skeletal Conditions

Major congenital deformity (e.g. dwarfism, phocomelia)

Quadriplegia/paraplegia

Severe rheumatoid arthritis

Severe kypho-scoliosis with pulmonary dysfunction

Pharmacologic

Recent chemotherapy (e.g. cardiotoxic drugs, alkylating agents)

Drug interactions—MAO inhibitors, amiodarone

Complicated drug allergy histories

Pulmonary Disease

Past history of post-op respiratory complication

Sleep apnea

Recurrent pneumonia or recent pneumonia

Severe respiratory disease:

Asthma requiring frequent hospitalization

COPD on home Oxygen or FEVl < 50% of predicted

Pulmonary fibrosis

Anterior mediastinal mass with airway or vascular compression

Chronic ventilatory patients

Significant perinatal apnea

History of SIDS or near SIDS

Pulmonary Disease of prematurity

Miscellaneous

Trauma patient with 2 or more systems involved

Rare condition not previously mentioned

Unusual situation not previously mentioned

PART VI—ANESTHESIA COMMITTEE

29. GUIDING PRINCIPLES

a) The parties recognize that this Agreement represents a major change in the remuneration of anesthetic services. The parties therefore agree to the establishment of an Anesthesia Committee to assist in the administration of this Agreement and make recommendations as may be appropriate from time to time.

b) The Committee shall be governed by the primary principle guiding the fee schedule reform process—"that physician services should be remunerated in a fair and equitable manner".

30. THE COMMITTEE

The Committee shall be made up of three members appointed by Manitoba Health and three members appointed by the Board of Directors of Doctors Manitoba.

31. TERMS OF REFERENCE

a) The Committee shall be responsible for monitoring the implementation of this Agreement and making recommendations to the parties.

b) The Committee shall be responsible to ensure that the principles of relative value are maintained when new anesthetic services are introduced and make such recommendations as may be appropriate to the parties.

c) Either party may request the Committee to review any issues regarding this Agreement.

32. DISPUTE RESOLUTION

Notwithstanding the provisions of Rules of Application for Anesthesia Services 29 to 31 inclusive, or any other provision of this Agreement, any dispute arising under this Agreement shall be subject to determination in accordance with the Dispute Resolution/Grievance Arbitration Process set out in the Physician's Manual.

APPENDICES

APPENDIX A—ANESTHETIC PROCEDURAL SERVICES

(In Accordance with Part II—Rule of Application 2 in Anesthesia Section)

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
0101	20.000	0127	20.000	0224	21.375	0290	20.000
0103	20.000	0128	20.000	0225	21.375	0291	20.000
0104	20.000	0129	20.000	0226	21.375	0292	21.375
0105	20.000	0130	20.000	0227	21.375	0293	21.375
0106	20.000	0140	21.375	0230	20.000	0294	21.375
0107	20.000	0141	21.375	0247	20.000	0295	21.375
0108	20.000	0142	21.375	0248	20.000	0296	21.375
0109	20.000	0143	21.375	0249	20.000	0297	21.375
0110	20.000	0145	21.375	0250	20.000	0298	21.375
0111	20.000	0146	21.375	0251	20.000	0299	21.375
0112	20.000	0147	21.375	0253	20.000	0300	21.375
0113	20.000	0148	21.375	0254	20.000	0301	21.375
0114	20.000	0149	21.375	0255	20.000	0302	21.375
0116	20.000	0170	20.000	0256	20.000	0303	21.375
0117	20.000	0171	20.000	0257	20.000	0304	22.750
0118	20.000	0172	20.000	0258	20.000	0305	22.750
0119	20.000	0216	20.000	0259	20.000	0306	26.875
0120	20.000	0217	20.000	0261	25.500	0307	20.000
0121	20.000	0218	20.000	0280	22.750	0308	20.000
0122	20.000	0219	20.000	0282	22.750	0309	21.375
0123	20.000	0220	20.000	0286	20.000	0310	21.375
0124	20.000	0221	20.000	0287	20.000	0311	20.000
0125	20.000	0222	21.375	0288	20.000	0312	20.000
0126	20.000	0223	21.375	0289	20.000	0313	21.375

0314	21.375	0359	25.500	0405	20.000	0446	21.375
0315	20.000	0360	25.500	0406	20.000	0447	20.000
0316	20.000	0361	25.500	0407	20.000	0448	20.000
0317	21.375	0362	25.500	0408	20.000	0449	20.000
0318	21.375	0363	25.500	0412	20.000	0450	21.375
0319	20.000	0364	25.500	0413	20.000	0451	21.375
0320	20.000	0365	25.500	0414	20.000	0452	21.375
0321	21.375	0366	25.500	0415	20.000	0453	21.375
0322	21.375	0367	25.500	0416	20.000	0454	21.375
0323	20.000	0368	25.500	0417	20.000	0455	21.375
0324	21.375	0369	25.500	0418	20.000	0456	21.375
0325	21.375	0370	25.500	0419	20.000	0457	21.375
0326	21.375	0371	25.500	0420	20.000	0458	21.375
0327	21.375	0372	25.500	0421	20.000	0459	21.375
0328	21.375	0373	25.500	0422	20.000	0460	21.375
0329	21.375	0374	25.500	0423	20.000	0461	20.000
0330	21.375	0375	25.500	0424	20.000	0462	20.000
0332	21.375	0376	25.500	0425	20.000	0463	20.000
0333	21.375	0377	25.500	0426	20.000	0464	20.000
0334	21.375	0378	25.500	0427	20.000	0465	22.750
0335	21.375	0379	25.500	0428	20.000	0466	22.750
0336	21.375	0384	22.750	0429	20.000	0467	22.750
0337	20.000	0389	22.750	0430	20.000	0468	22.750
0338	20.000	0390	22.750	0431	20.000	0469	22.750
0339	22.750	0391	22.750	0432	20.000	0470	21.375
0343	25.500	0392	22.750	0433	20.000	0471	21.375
0344	25.500	0393	20.000	0434	20.000	0472	21.375
0345	20.000	0394	20.000	0435	20.000	0473	20.000
0346	25.500	0395	20.000	0437	20.000	0474	22.750
0347	22.750	0396	20.000	0438	21.375	0475	22.750
0348	25.500	0397	20.000	0439	20.000	0476	22.750
0349	25.500	0398	20.000	0440	20.000	0477	20.000
0350	25.500	0399	20.000	0441	20.000	0489	21.375
0352	21.375	0400	20.000	0442	21.375	0501	20.000
0353	25.500	0401	20.000	0443	21.375	0503	20.000
0357	25.500	0403	20.000	0444	21.375	0504	20.000
0358	25.500	0404	20.000	0445	21.375	0506	20.000

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
0510	20.000	0564	20.000	0606	25.500	0642	26.875
0517	20.000	0565	20.000	0607	25.500	0645	25.500
0518	20.000	0566	20.000	0608	25.500	0646	22.750
0519	20.000	0567	20.000	0610	25.500	0647	25.500
0520	20.000	0568	20.000	0611	21.375	0648	22.750
0521	20.000	0570	20.000	0612	21.375	0649	21.375
0523	20.000	0572	20.000	0613	21.375	0650	21.375
0524	20.000	0575	25.500	0614	21.375	0651	21.375
0525	20.000	0576	21.375	0615	21.375	0652	21.375
0526	21.375	0577	20.000	0616	22.750	0654	21.375
0527	21.375	0580	22.750	0617	21.375	0655	21.375
0528	22.750	0581	22.750	0618	20.000	0656	21.375
0530	20.000	0582	22.750	0619	21.375	0659	21.375
0531	20.000	0583	25.500	0620	21.375	0661	21.375
0532	21.375	0584	25.500	0621	25.500	0686	21.375
0534	21.375	0585	25.500	0622	21.375	0687	21.375
0536	21.375	0586	25.500	0623	21.375	0688	21.375
0537	20.000	0587	25.500	0624	20.000	0691	20.000
0539	22.750	0588	25.500	0625	21.375	0693	21.375
0541	20.000	0589	25.500	0626	25.500	0694	20.000
0543	22.750	0590	25.500	0627	25.500	0696	20.000
0549	21.375	0591	20.000	0628	25.500	0699	21.375
0550	20.000	0592	25.500	0629	25.500	0701	21.375
0551	20.000	0593	20.000	0630	25.500	0703	20.000
0552	21.375	0594	25.500	0631	25.500	0704	21.375
0553	21.375	0595	20.000	0632	25.500	0705	21.375
0554	20.000	0596	25.500	0633	25.500	0706	21.375
0555	20.000	0597	25.500	0634	21.375	0720	21.375
0556	20.000	0598	25.500	0635	26.875	0723	22.750
0557	20.000	0599	25.500	0636	26.875	0733	21.375
0558	20.000	0600	25.500	0637	21.375	0734	21.375
0559	20.000	0602	25.500	0638	21.375	0739	21.375
0560	21.375	0603	25.500	0639	21.375	0740	21.375
0561	20.000	0604	25.500	0640	21.375	0742	21.375
0563	20.000	0605	25.500	0641	21.375	0754	21.375

0757	21.375	0874	22.750	1001	21.375	1080	21.375
0770	21.375	0877	20.000	1002	20.000	1085	21.375
0771	26.875	0879	22.750	1003	20.000	1093	21.375
0772	26.875	0881	20.000	1006	20.000	1095	21.375
0773	26.875	0882	22.750	1007	21.375	1101	21.375
0774	26.875	0883	22.750	1008	21.375	1102	21.375
0780	20.000	0884	22.750	1010	20.000	1103	21.375
0782	21.375	0885	20.000	1013	20.000	1104	21.375
0785	20.000	0887	21.375	1017	20.000	1105	25.500
0787	21.375	0897	21.375	1025	22.750	1107	25.500
0789	20.000	0901	20.000	1026	20.000	1109	26.875
0790	21.375	0904	22.750	1027	22.750	1111	26.875
0792	20.000	0907	20.000	1028	22.750	1113	26.875
0794	21.375	0910	22.750	1029	22.750	1114	25.500
0801	21.375	0911	20.000	1030	22.750	1115	25.500
0803	20.000	0912	22.750	1031	22.750	1116	26.875
0805	21.375	0914	20.000	1032	22.750	1118	26.875
0807	20.000	0916	21.375	1033	22.750	1119	26.875
0809	20.000	0926	20.000	1034	22.750	1121	26.875
0810	21.375	0928	22.750	1035	22.750	1124	25.500
0811	21.375	0930	22.750	1036	22.750	1126	25.500
0813	20.000	0935	21.375	1037	22.750	1128	25.500
0816	21.375	0936	20.000	1038	22.750	1129	25.500
0818	20.000	0937	21.375	1039	22.750	1130	25.500
0819	21.375	0938	20.000	1040	22.750	1131	25.500
0821	20.000	0941	21.375	1041	22.750	1132	25.500
0823	21.375	0942	21.375	1042	22.750	1133	22.750
0830	21.375	0944	20.000	1043	22.750	1134	22.750
0842	20.000	0946	21.375	1044	22.750	1136	26.875
0844	21.375	0961	20.000	1045	22.750	1139	26.875
0848	21.375	0963	21.375	1049	20.000	1140	26.875
0852	20.000	0964	20.000	1050	20.000	1143	20.000
0854	21.375	0967	20.000	1051	20.000	1144	20.000
0865	20.000	0970	20.000	1053	20.000	1145	20.000
0868	22.750	0980	20.000	1065	21.375	1146	26.875
0870	22.750	0982	20.000	1073	26.875	1149	22.750
0872	20.000	0989	21.375	1074	25.500	1152	21.375

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
1154	25.500	1196	21.375	1244	20.000	1336	21.375
1153	20.000	1197	21.375	1245	20.000	1337	25.500
1162	20.000	1198	21.375	1246	20.000	1338	25.500
1163	20.000	1200	22.750	1247	20.000	1339	25.500
1164	20.000	1201	21.375	1250	20.000	1344	20.000
1165	20.000	1202	20.000	1251	20.000	1346	21.375
1166	20.000	1203	22.750	1252	20.000	1352	20.000
1167	20.000	1204	22.750	1254	20.000	1355	20.000
1168	20.000	1205	22.750	1256	21.375	1357	20.000
1170	20.000	1206	22.750	1258	22.750	1361	20.000
1171	25.500	1207	22.750	1262	21.375	1363	20.000
1172	22.750	1208	22.750	1264	22.750	1371	20.000
1173	21.375	1211	21.375	1267	21.375	1373	20.000
1174	22.750	1212	21.375	1270	22.750	1378	20.000
1175	21.375	1213	21.375	1273	20.000	1387	20.000
1176	20.000	1214	21.375	1275	21.375	1390	22.750
1177	20.000	1215	21.375	1278	20.000	1401	20.000
1178	20.000	1216	20.000	1281	21.375	1402	22.750
1179	25.500	1217	20.000	1284	20.000	1403	22.750
1180	22.750	1218	20.000	1286	21.375	1404	21.375
1181	20.000	1221	20.000	1288	22.750	1405	21.375
1182	22.750	1222	20.000	1290	20.000	1406	20.000
1183	20.000	1223	20.000	1292	20.000	1407	25.500
1184	20.000	1224	20.000	1295	20.000	1408	25.500
1185	20.000	1226	20.000	1297	20.000	1409	25.500
1186	22.750	1227	20.000	1298	20.000	1410	20.000
1187	20.000	1228	20.000	1299	20.000	1411	25.500
1188	22.750	1232	20.000	1301	20.000	1412	25.500
1189	22.750	1236	21.375	1304	20.000	1414	25.500
1190	20.000	1237	21.375	1306	20.000	1415	22.750
1191	21.375	1238	21.375	1317	20.000	1416	26.875
1192	22.750	1239	21.375	1328	20.000	1417	22.750
1193	22.750	1240	21.375	1332	20.000	1418	22.750
1194	22.750	1241	20.000	1334	21.375	1419	25.500
1195	22.750	1242	20.000	1335	22.750	1420	26.875

1421	26.875	1521	20.000	1633	20.000	1771	21.375
1422	22.750	1522	20.000	1634	20.000	1772	20.000
1423	22.750	1525	20.000	1635	21.375	1774	21.375
1424	22.750	1531	20.000	1636	21.375	1778	21.375
1425	22.750	1534	20.000	1640	20.000	1782	21.375
1426	26.875	1535	20.000	1641	20.000	1785	21.375
1430	20.000	1536	20.000	1654	21.375	1788	21.375
1431	20.000	1539	20.000	1655	21.375	1802	21.375
1433	20.000	1540	20.000	1656	22.750	1803	21.375
1435	20.000	1541	20.000	1657	20.000	1804	21.375
1436	20.000	1542	20.000	1659	20.000	1811	20.000
1440	22.750	1543	20.000	1661	20.000	1815	20.000
1442	22.750	1550	20.000	1670	21.375	1817	20.000
1444	22.750	1552	20.000	1701	25.500	1819	21.375
1446	22.750	1553	20.000	1703	25.500	1820	21.375
1448	22.750	1562	21.375	1705	21.375	1840	21.375
1449	22.750	1570	20.000	1708	20.000	1841	21.375
1450	20.000	1573	20.000	1709	20.000	1842	21.375
1451	20.000	1574	20.000	1710	21.375	1843	22.750
1452	20.000	1580	20.000	1711	21.375	1844	21.375
1453	20.000	1582	20.000	1712	20.000	1845	21.375
1454	21.375	1583	20.000	1718	20.000	1846	21.375
1456	21.375	1584	20.000	1722	20.000	1848	21.375
1458	20.000	1585	20.000	1725	20.000	1849	22.750
1460	20.000	1586	20.000	1739	20.000	1851	20.000
1461	21.375	1589	20.000	1740	20.000	1854	20.000
1470	22.750	1593	20.000	1741	20.000	1856	20.000
1471	22.750	1595	20.000	1742	20.000	1860	20.000
1500	21.375	1596	20.000	1743	20.000	1862	20.000
1501	21.375	1601	22.750	1745	25.500	1867	20.000
1502	21.375	1604	22.750	1748	25.500	1870	20.000
1503	21.375	1607	22.750	1750	21.375	1878	20.000
1504	25.500	1609	22.750	1752	22.750	1882	20.000
1505	25.500	1612	20.000	1760	22.750	1885	20.000
1511	20.000	1613	20.000	1761	20.000	1886	20.000
1514	20.000	1616	20.000	1763	22.750	1889	20.000
1519	20.000	1632	20.000	1767	21.375	1890	20.000

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
1891	20.000	1978	22.750	2028	21.375	2120	22.750
1892	20.000	1979	22.750	2029	21.375	2121	22.750
1893	20.000	1981	21.375	2030	20.000	2122	22.750
1894	20.000	1985	21.375	2031	20.000	2123	22.750
1895	20.000	1988	21.375	2032	21.375	2124	22.750
1896	20.000	1991	21.375	2033	21.375	2126	22.750
1897	20.000	1992	21.375	2034	21.375	2127	22.750
1898	20.000	1994	22.750	2041	22.750	2129	22.750
1899	20.000	1995	21.375	2051	25.500	2130	22.750
1904	21.375	1996	22.750	2052	22.750	2131	22.750
1905	21.375	2001	21.375	2053	22.750	2132	25.500
1906	20.000	2002	21.375	2054	22.750	2133	26.875
1907	21.375	2003	26.875	2070	22.750	2134	26.875
1908	20.000	2004	26.875	2071	22.750	2135	26.875
1917	21.375	2005	26.875	2074	22.750	2136	25.500
1922	22.750	2006	21.375	2077	22.750	2137	25.500
1924	21.375	2007	21.375	2078	22.750	2139	26.875
1928	21.375	2009	21.375	2079	25.500	2151	26.875
1929	21.375	2010	21.375	2080	25.500	2152	26.875
1930	21.375	2011	21.375	2081	22.750	2153	26.875
1935	21.375	2012	21.375	2089	25.500	2154	22.750
1949	21.375	2013	22.750	2100	22.750	2155	26.875
1950	21.375	2014	21.375	2101	22.750	2156	21.375
1951	21.375	2015	21.375	2102	21.375	2157	21.375
1952	22.750	2017	21.375	2103	21.375	2158	22.750
1953	21.375	2018	21.375	2104	21.375	2159	26.875
1954	21.375	2019	21.375	2105	22.750	2160	26.875
1955	21.375	2020	21.375	2108	22.750	2170	26.875
1956	21.375	2021	21.375	2110	22.750	2171	26.875
1957	21.375	2022	21.375	2112	25.500	2172	26.875
1966	21.375	2023	21.375	2113	22.750	2173	26.875
1967	21.375	2024	21.375	2115	22.750	2174	26.875
1968	21.375	2025	21.375	2116	25.500	2177	26.875
1969	21.375	2026	21.375	2118	22.750	2180	20.000
1972	21.375	2027	21.375	2119	25.500	2183	20.000

2187	26.875	2305	21.375	2352	25.500	2404	26.875
2188	25.500	2306	21.375	2353	25.500	2405	26.875
2189	26.875	2307	21.375	2354	26.875	2406	26.875
2190	25.500	2308	21.375	2355	25.500	2407	26.875
2191	26.875	2309	21.375	2356	26.875	2408	26.875
2192	26.875	2310	25.500	2357	22.750	2409	26.875
2193	26.875	2311	21.375	2358	26.875	2410	26.875
2194	26.875	2312	22.750	2359	25.500	2411	26.875
2196	25.500	2314	20.000	2360	26.875	2412	26.875
2197	26.875	2316	26.875	2361	21.375	2413	26.875
2198	26.875	2317	20.000	2362	25.500	2415	26.875
2199	26.875	2318	26.875	2363	21.375	2417	26.875
2200	25.500	2319	22.750	2364	25.500	2418	26.875
2201	25.500	2320	26.875	2365	21.375	2420	26.875
2202	25.500	2321	22.750	2366	25.500	2422	26.875
2209	25.500	2322	26.875	2367	22.750	2423	26.875
2210	25.500	2323	25.500	2369	26.875	2424	26.875
2211	22.750	2324	26.875	2372	26.875	2425	26.875
2213	25.500	2325	21.375	2373	21.375	2426	26.875
2219	25.500	2326	22.750	2375	26.875	2427	26.875
2220	22.750	2327	21.375	2376	26.875	2428	26.875
2221	20.000	2328	21.375	2377	21.375	2429	25.500
2222	20.000	2329	21.375	2378	26.875	2430	26.875
2224	20.000	2330	21.375	2379	22.750	2431	25.500
2225	20.000	2332	25.500	2381	21.375	2432	26.875
2229	21.375	2334	21.375	2385	26.875	2433	22.750
2230	21.375	2336	26.875	2388	26.875	2434	26.875
2272	26.875	2338	26.875	2390	26.875	2435	26.875
2273	26.875	2339	21.375	2392	26.875	2436	26.875
2280	26.875	2340	26.875	2393	25.500	2437	26.875
2281	26.875	2342	26.875	2394	26.875	2438	26.875
2286	26.875	2344	26.875	2395	25.500	2440	26.875
2287	26.875	2345	21.375	2396	26.875	2441	26.875
2288	26.875	2348	21.375	2398	26.875	2442	26.875
2289	26.875	2349	25.500	2400	26.875	2443	26.875
2302	21.375	2350	25.500	2402	26.875	2444	26.875
2304	21.375	2351	22.750	2403	21.375	2447	22.750

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
2448	26.875	2485	22.750	2522	20.000	2575	22.750
2449	22.750	2486	26.875	2523	25.500	2576	22.750
2450	26.875	2487	25.500	2524	22.750	2577	22.750
2451	26.875	2488	26.875	2525	22.750	2578	25.500
2452	26.875	2489	25.500	2526	20.000	2579	26.875
2453	26.875	2490	25.500	2527	22.750	2580	25.500
2454	26.875	2491	25.500	2528	20.000	2581	25.500
2455	26.875	2492	26.875	2529	25.500	2582	25.500
2456	26.875	2493	25.500	2530	20.000	2583	25.500
2457	26.875	2495	25.500	2531	22.750	2584	25.500
2458	26.875	2496	25.500	2532	22.750	2585	25.500
2459	26.875	2497	25.500	2533	25.500	2586	22.750
2461	25.500	2498	25.500	2534	22.750	2587	25.500
2462	26.875	2499	25.500	2535	25.500	2588	25.500
2463	25.500	2500	25.500	2536	26.875	2589	25.500
2464	26.875	2501	25.500	2537	25.500	2590	25.500
2465	25.500	2502	25.500	2538	25.500	2591	25.500
2466	21.375	2503	25.500	2539	25.500	2592	25.500
2467	22.750	2505	26.875	2540	25.500	2593	22.750
2468	26.875	2506	25.500	2541	22.750	2594	22.750
2469	25.500	2507	26.875	2543	22.750	2595	22.750
2470	26.875	2508	22.750	2545	22.750	2598	20.000
2471	22.750	2509	26.875	2546	20.000	2599	25.500
2472	25.500	2510	25.500	2547	22.750	2601	22.750
2473	25.500	2511	26.875	2548	20.000	2602	20.000
2474	22.750	2512	25.500	2549	20.000	2604	25.500
2475	25.500	2513	26.875	2550	20.000	2608	21.375
2476	25.500	2514	26.875	2552	25.500	2609	25.500
2477	26.875	2515	26.875	2553	20.000	2619	21.375
2479	26.875	2516	25.500	2554	22.750	2620	21.375
2480	21.375	2517	26.875	2555	20.000	2621	21.375
2481	22.750	2518	25.500	2569	26.875	2622	21.375
2482	26.875	2519	25.500	2572	22.750	2623	21.375
2483	22.750	2520	25.500	2573	22.750	2624	21.375
2484	26.875	2521	25.500	2574	22.750	2625	21.375

2626	21.375
2627	21.375
2628	21.375
2629	21.375
2630	21.375
2631	20.000
2632	21.375
2633	21.375
2634	21.375
2641	20.000
2642	21.375
2643	20.000
2644	20.000
2645	21.375
2647	25.500
2648	25.500
2652	22.750
2658	21.375
2665	22.750
2666	22.750
2671	22.750
2672	20.000
2674	22.750
2675	22.750
2676	21.375
2678	21.375
2684	22.750
2685	22.750
2686	26.875
2687	22.750
2689	26.875
2691	25.500
2693	25.500
2696	25.500
2699	22.750
2700	26.875
2701	21.375
2702	26.875
2703	26.875
2704	26.875
2705	25.500
2706	26.875
2708	26.875
2709	26.875
2710	26.875
2711	26.875
2712	26.875
2713	26.875
2715	26.875
2716	26.875
2717	26.875
2718	26.875
2719	26.875
2720	26.875
2721	26.875
2722	26.875
2723	26.875
2724	26.875
2725	26.875
2729	26.875
2730	26.875
2731	26.875
2732	26.875
2733	26.875
2734	26.875
2739	26.875
2741	21.375
2742	21.375
2743	21.375
2746	21.375
2752	20.000
2754	21.375
2758	21.375
2759	21.375
2762	21.375
2765	21.375
2769	21.375
2775	21.375
2781	20.000
2783	21.375
2784	21.375
2785	22.750
2786	20.000
2787	22.750
2788	25.500
2789	22.750
2790	22.750
2799	25.500
2815	25.500
2819	20.000
2871	21.375
2881	20.000
2883	22.750
2885	21.375
2887	21.375
2889	22.750
2890	22.750
2891	21.375
2892	22.750
2894	22.750
2895	22.750
2897	22.750
2898	22.750
2899	22.750
2915	21.375
2916	21.375
2918	21.375
2919	21.375
2921	21.375
2925	21.375
2927	21.375
2930	21.375
2934	22.750
2937	22.750
2941	21.375
2949	22.750
2950	21.375
2951	21.375
2961	21.375
2971	25.500
2975	21.375
2978	25.500
2979	25.500
2980	21.375
2981	21.375
2982	21.375
2987	22.750
2989	20.000
2990	20.000
2992	21.375
2994	25. 500
2996	21.375
2998	21.375
3000	21.375
3002	21.375
3004	21.375
3006	25.500
3008	20.000
3010	21.375
3011	22.750
3020	22.750
3021	22.750
3022	22.750
3031	21.375
3033	22.750
3038	22.750
3040	26.875
3041	26.875

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
3043	25.500	3098	21.375	3172	22.750	3227	22.750
3044	25.500	3099	21.375	3174	22.750	3228	22.750
3046	25.500	3100	20.000	3175	22.750	3231	21.375
3047	22.750	3101	22.750	3177	21.375	3235	22.750
3048	22.750	3103	21.375	3179	22.750	3241	22.750
3049	22.750	3104	21.375	3180	25.500	3251	21.375
3053	21.375	3105	22.750	3181	25.500	3259	22.750
3055	21.375	3112	22.750	3182	25.500	3261	21.375
3057	21.375	3114	22.750	3183	25.500	3262	22.750
3063	21.375	3115	22.750	3184	22.750	3263	22.750
3065	21.375	3117	22.750	3185	21.375	3283	20.000
3066	21.375	3118	22.750	3186	21.375	3285	21.375
3067	25.500	3121	21.375	3187	21.375	3286	25.500
3068	25.500	3122	21.375	3188	21.375	3288	25.500
3069	25.500	3123	21.375	3189	21.375	3289	25.500
3070	25.500	3124	22.750	3190	21.375	3290	22.750
3072	25.500	3125	25.500	3191	22.750	3292	22.750
3075	21.375	3131	22.750	3193	22.750	3296	20.000
3076	25.500	3133	22.750	3194	22.750	3297	21.375
3077	22.750	3134	21.375	3195	22.750	3298	22.750
3078	25.500	3135	22.750	3199	22.750	3299	20.000
3079	25.500	3136	21.375	3201	22.750	3300	20.000
3080	21.375	3137	22.750	3203	21.375	3301	25.500
3081	25.500	3138	25.500	3204	22.750	3311	20.000
3082	22.750	3139	25.500	3205	22.750	3312	20.000
3083	25.500	3140	25.500	3207	22.750	3313	20.000
3084	22.750	3141	22.750	3208	22.750	3315	20.000
3085	22.750	3142	22.750	3209	22.750	3317	20.000
3086	25.500	3149	25.500	3215	22.750	3319	20.000
3089	26.875	3153	22.750	3216	22.750	3320	20.000
3092	21.375	3160	20.000	3221	22.750	3321	21.375
3093	21.375	3161	22.750	3223	22.750	3322	21.375
3094	21.375	3162	21.375	3224	22.750	3323	20.000
3095	21.375	3166	22.750	3225	21.375	3325	22.750
3096	21.375	3171	22.750	3226	22.750	3326	22.750

3328	22.750
3329	22.750
3331	21.375
3333	21.375
3335	21.375
3340	20.000
3341	21.375
3353	20.000
3354	20.000
3355	20.000
3356	20.000
3357	20.000
3364	20.000
3365	20.000
3371	20.000
3372	20.000
3377	20.000
3380	20.000
3392	20.000
3395	20.000
3396	20.000
3397	20.000
3398	25.500
3401	20.000
3420	21.375
3421	20.000
3422	21.375
3424	21.375
3425	21.375
3426	21.375
3427	21.375
3428	22.750
3429	20.000
3433	20.000
3434	20.000
3456	21.375
3458	21.375
3464	26.875
3471	22.750
3472	22.750
3481	25.500
3491	26.875
3492	26.875
3493	22.750
3494	26.875
3495	22.750
3496	25.500
3497	25.500
3499	25.500
3500	22.750
3503	22.750
3504	22.750
3505	21.375
3506	21.375
3515	22.750
3516	22.750
3518	22.750
3520	25.500
3522	22.750
3524	22.750
3526	22.750
3528	22.750
3541	22.750
3542	25.500
3544	22.750
3546	22.750
3547	22.750
3550	22.750
3551	26.875
3552	26.875
3565	22.750
3567	22.750
3568	22.750
3569	25.500
3571	22.750
3572	21.375
3573	22.750
3574	21.375
3575	22.750
3576	21.375
3577	22.750
3580	22.750
3582	22.750
3583	22.750
3584	22.750
3585	22.750
3586	22.750
3587	22.750
3591	21.375
3592	21.375
3593	21.375
3594	22.750
3596	21.375
3597	21.375
3600	26.875
3619	22.750
3631	20.000
3632	20.000
3633	21.375
3635	21.375
3636	20.000
3646	20.000
3651	21.375
3660	22.750
3661	21.375
3663	21.375
3664	21.375
3666	21.375
3668	22.750
3707	25.500
3708	26.875
3709	25.500
3710	22.750
3734	22.750
3790	21.375
3792	21.375
3793	21.375
3794	20.000
3800	21.375
3801	21.375
3802	22.750
3803	21.375
3804	21.375
3805	21.375
3806	21.375
3807	20.000
3808	22.750
3809	25.500
3810	25.500
3811	22.750
3812	22.750
3813	21.375
3814	25.500
3815	25.500
3816	25.500
3817	22.750
3819	22.750
3820	21.375
3821	22.750
3822	22.750
3823	25.500
3824	22.750
3825	22.750
3826	22.750
3827	22.750
3829	21.375
3830	21.375
3831	22.750

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
3833	22.750	3893	21.375	3943	21.375	3987	21.375
3835	22.750	3895	22.750	3944	20.000	3989	21.375
3839	22.750	3900	20.000	3945	21.375	3991	20.000
3841	22.750	3901	20.000	3946	20.000	3994	20.000
3845	22.750	3902	20.000	3947	21.375	3995	25.500
3846	22.750	3906	20.000	3950	20.000	4000	20.000
3851	22.750	3907	20.000	3951	20.000	4001	20.000
3857	22.750	3908	21.375	3952	22.750	4004	20.000
3858	22.750	3909	21.375	3953	22.750	4005	20.000
3861	21.375	3911	22.750	3954	20.000	4006	20.000
3865	21.375	3912	22.750	3955	22.750	4011	21.375
3866	21.375	3914	22.750	3956	21.375	4019	21.375
3867	21.375	3918	21.375	3957	21.375	4021	21.375
3871	22.750	3919	25.500	3958	21.375	4022	22.750
3872	21.375	3920	22.750	3959	21.375	4023	25.500
3873	21.375	3921	21.375	3960	22.750	4024	25.500
3874	22.750	3922	22.750	3961	22.750	4025	25.500
3875	21.375	3923	21.375	3965	21.375	4026	25.500
3876	22.750	3924	21.375	3966	21.375	4031	20.000
3877	22.750	3926	20.000	3967	21.375	4033	20.000
3878	21.375	3927	20.000	3968	21.375	4034	20.000
3879	21.375	3928	21.375	3969	21.375	4035	20.000
3880	22.750	3929	20.000	3970	22.750	4101	20.000
3881	22.750	3930	20.000	3971	20.000	4111	20.000
3882	21.375	3931	20.000	3972	22.750	4114	20.000
3883	21.375	3932	20.000	3973	20.000	4115	20.000
3884	22.750	3933	20.000	3974	22.750	4116	20.000
3885	22.750	3934	20.000	3976	20.000	4118	20.000
3886	22.750	3935	20.000	3977	20.000	4119	20.000
3887	21.375	3936	22.750	3978	20.000	4120	20.000
3888	21.375	3937	21.375	3979	20.000	4122	20.000
3889	22.750	3939	21.375	3980	21.375	4123	20.000
3890	21.375	3940	20.000	3981	20.000	4125	20.000
3891	21.375	3941	20.000	3982	20.000	4126	20.000
3892	21.375	3942	20.000	3983	20.000	4127	20.000

4128	20.000	4224	20.000	4425	21.375	4494	21.375
4129	20.000	4227	20.000	4426	21.375	4497	21.375
4130	20.000	4229	20.000	4427	20.000	4498	20.000
4133	20.000	4241	20.000	4428	20.000	4499	20.000
4135	20.000	4251	20.000	4429	21.375	4500	21.375
4138	22.750	4252	20.000	4430	20.000	4501	20.000
4139	21.375	4259	20.000	4431	20.000	4507	20.000
4141	20.000	4271	20.000	4432	20.000	4511	20.000
4142	20.000	4275	20.000	4433	20.000	4521	20.000
4143	20.000	4278	20.000	4434	20.000	4545	21.375
4144	20.000	4279	20.000	4441	20.000	4551	21.375
4145	20.000	4281	20.000	4443	20.000	4561	21.375
4146	21.375	4291	20.000	4444	21.375	4562	21.375
4148	20.000	4299	20.000	4445	21.375	4566	20.000
4152	20.000	4301	20.000	4455	20.000	4567	22.750
4153	20.000	4302	20.000	4461	20.000	4571	21.375
4154	20.000	4305	20.000	4463	20.000	4581	21.375
4155	20.000	4307	20.000	4471	20.000	4582	21.375
4156	20.000	4308	20.000	4472	20.000	4583	21.375
4157	20.000	4310	22.750	4473	21.375	4585	21.375
4159	20.000	4313	25.500	4474	20.000	4586	22.750
4161	20.000	4314	20.000	4475	20.000	4600	22.750
4163	20.000	4315	20.000	4476	20.000	4602	22.750
4165	20.000	4316	22.750	4477	20.000	4605	22.750
4174	20.000	4318	22.750	4478	20.000	4606	22.750
4176	20.000	4319	22.750	4479	21.375	4607	22.750
4181	20.000	4320	25.500	4480	21.375	4608	22.750
4182	20.000	4321	22.750	4481	20.000	4609	22.750
4189	20.000	4324	22.750	4482	20.000	4610	22.750
4191	20.000	4325	20.000	4483	22.750	4611	20.000
4200	20.000	4329	22.750	4484	20.000	4612	20.000
4201	20.000	4403	20.000	4485	21.375	4613	20.000
4202	20.000	4404	20.000	4486	22.750	4614	21.375
4209	20.000	4405	20.000	4487	21.375	4617	22.750
4211	20.000	4411	20.000	4488	20.000	4620	22.750
4215	20.000	4421	20.000	4489	20.000	4621	22.750
4221	20.000	4424	21.375	4493	20.000	4622	22.750

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
4627	22.750	4812	21.375	4912	21.375	5056	22.750
4631	22.750	4815	20.000	4914	21.375	5057	21.375
4632	21.375	4816	21.375	4940	21.375	5058	22.750
4633	20.000	4822	20.000	4941	21.375	5059	22.750
4634	21.375	4829	21.375	4949	22.750	5060	21.375
4635	20.000	4830	21.375	4971	21.375	5061	21.375
4636	20.000	4831	21.375	4972	25.500	5062	22.750
4639	22.750	4832	21.375	4979	25.500	5063	21.375
4641	20.000	4833	21.375	4988	25.500	5065	26.875
4645	20.000	4834	21.375	4989	25.500	5067	26.875
4646	20.000	4835	21.375	4990	25.500	5071	26.875
4647	20.000	4836	21.375	4991	25.500	5073	26.875
4648	20.000	4837	21.375	4993	22.750	5075	26.875
4671	20.000	4838	21.375	4994	26.875	5077	26.875
4672	20.000	4839	21.375	4999	22.750	5079	26.875
4677	20.000	4840	21.375	5001	25.500	5081	26.875
4678	20.000	4841	21.375	5003	25.500	5083	26.875
4679	20.000	4842	21.375	5005	25.500	5084	22.750
4681	21.375	4843	22.750	5007	25.500	5085	26.875
4694	21.375	4844	21.375	5009	25.500	5087	26.875
4695	21.375	4845	21.375	5011	25.500	5089	26.875
4696	21.375	4846	21.375	5013	25.500	5090	26.875
4699	22.750	4847	22.750	5015	25.500	5091	25.500
4701	22.750	4850	20.000	5017	22.750	5092	25.500
4705	20.000	4855	20.000	5019	22.750	5093	25.500
4706	20.000	4860	20.000	5021	25.500	5095	25.500
4711	20.000	4861	20.000	5023	26.875	5097	25.500
4735	20.000	4862	20.000	5025	26.875	5098	26.875
4745	20.000	4866	20.000	5027	26.875	5099	22.750
4800	22.750	4870	21.375	5029	26.875	5101	25.500
4802	20.000	4899	25.500	5031	26.875	5103	25.500
4803	26.875	4907	21.375	5033	26.875	5105	25.500
4806	20.000	4909	20.000	5035	26.875	5106	25.500
4809	21.375	4910	20.000	5037	26.875	5107	25.500
4811	22.750	4911	21.375	5049	22.750	5118	22.750

5200	25.500
5201	21.375
5202	21.375
5203	22.750
5204	25.500
5205	25.500
5207	25.500
5209	25.500
5211	25.500
5215	22.750
5217	25.500
5219	25.500
5221	22.750
5224	22.750
5225	21.375
5226	22.750
5227	21.375
5228	22.750
5229	25.500
5230	22.750
5231	22.750
5233	21.375
5235	20.000
5237	21.375
5239	21.375
5244	20.000
5284	20.000
5286	20.000
5287	20.000
5289	22.750
5291	22.750
5292	20.000
5293	21.375
5296	20.000
5351	21.375
5352	21.375
5353	21.375
5354	21.375
5355	21.375
5356	21.375
5371	22.750
5372	22.750
5375	25.500
5376	25.500
5381	21.375
5382	21.375
5385	22.750
5386	22.750
5390	22.750
5399	22.750
5401	21.375
5411	22.750
5413	22.750
5414	22.750
5431	21.375
5438	22.750
5439	22.750
5441	22.750
5445	22.750
5446	22.750
5451	22.750
5452	22.750
5453	20.000
5456	22.750
5457	22.750
5458	20.000
5471	22.750
5475	22.750
5481	22.750
5482	22.750
5483	22.750
5484	22.750
5485	22.750
5492	22.750
5493	22.750
5494	22.750
5495	21.375
5501	21.375
5507	21.375
5521	22.750
5532	21.375
5533	21.375
5534	21.375
5535	21.375
5536	21.375
5537	21.375
5538	21.375
5541	21.375
5542	21.375
5546	21.375
5547	21.375
5551	21.375
5552	21.375
5554	21.375
5561	21.375
5601	21.375
5604	21.375
5610	21.375
5611	21.375
5612	21.375
5613	21.375
5614	21.375
5615	21.375
5616	21.375
5622	21.375
5624	21.375
5630	21.375
5631	22.750
5632	22.750
5633	22.750
5634	21.375
5635	20.000
5636	21.375
5638	22.750
5639	22.750
5641	21.375
5642	21.375
5643	21.375
5644	21.375
5647	21.375
5651	22.750
5652	22.750
5653	22.750
5662	22.750
5664	22.750
5665	22.750
5670	22.750
5681	22.750
5691	21.375
5692	21.375
5697	21.375
5698	21.375
5702	21.375
5703	21.375
5712	21.375
5728	21.375
5730	21.375
5731	21.375
5732	21.375
5734	21.375
5741	20.000
5742	20.000
5743	20.000
5744	20.000
5751	20.000
5753	20.000
5775	22.750
5777	22.750

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]
5778	22.750	5969	22.750	6117	21.375	6162	20.000
5801	20.000	5970	21.375	6118	21.375	6163	21.375
5803	20.000	5971	21.375	6120	20.000	6165	25.500
5804	20.000	5972	21.375	6121	20.000	6166	21.375
5811	20.000	5973	22.750	6122	20.000	6167	25.500
5813	20.000	5974	22.750	6123	20.000	6168	26.875
5815	20.000	5975	21.375	6124	21.375	6169	25.500
5821	20.000	5976	22.750	6125	21.375	6170	25.500
5831	20.000	5977	21.375	6126	20.000	6171	21.375
5833	20.000	5981	20.000	6127	20.000	6172	21.375
5835	20.000	5983	21.375	6128	20.000	6173	22.750
5841	20.000	5991	21.375	6129	21.375	6174	22.750
5842	20.000	5992	21.375	6130	21.375	6178	26.875
5843	20.000	5993	21.375	6131	22.750	6179	26.875
5844	20.000	5995	22.750	6132	20.000	6180	26.875
5845	20.000	5997	21.375	6141	20.000	6181	26.875
5881	22.750	5998	21.375	6143	21.375	6182	26.875
5882	22.750	6001	21.375	6144	20.000	6183	26.875
5883	25.500	6011	21.375	6145	22.750	6184	26.875
5884	22.750	6031	21.375	6146	20.000	6185	26.875
5885	22.750	6033	21.375	6147	21.375	6186	26.875
5886	22.750	6100	21.375	6148	22.750	6187	26.875
5887	22.750	6101	21.375	6149	22.750	6188	25.500
5888	22.750	6102	21.375	6150	22.750	6189	22.750
5889	22.750	6104	21.375	6151	22.750	6190	22.750
5922	21.375	6106	21.375	6152	21.375	6191	20.000
5925	21.375	6107	21.375	6153	21.375	6193	21.375
5940	21.375	6108	21.375	6154	21.375	6195	21.375
5956	20.000	6109	21.375	6155	21.375	6197	20.000
5957	21.375	6110	20.000	6156	21.375	6198	20.000
5959	20.000	6111	22.750	6157	21.375	6200	20.000
5960	21.375	6112	22.750	6158	21.375	6201	20.000
5961	20.000	6113	25.500	6159	21.375	6202	20.000
5962	20.000	6114	20.000	6160	21.375	6203	20.000
5963	20.000	6115	20.000	6161	20.000	6204	20.000

6205	20.000
6206	20.000
6207	20.000
6208	20.000
6209	20.000
6210	20.000
6211	20.000
6212	20.000
6213	20.000
6214	20.000
6215	20.000
6216	20.000
6217	20.000
6218	20.000
6219	20.000
6220	20.000
6221	20.000
6222	20.000
6223	20.000
6224	20.000
6225	20.000
6226	20.000
6227	20.000
6228	22.750
6229	20.000
6230	20.000
6231	20.000
6232	20.000
6235	20.000
6236	20.000
6237	20.000
6238	20.000
6239	20.000
6240	20.000
6241	20.000
6242	20.000
6243	20.000
6244	20.000
6245	20.000
6246	20.000
6247	20.000
6250	20.000
6251	20.000
6252	20.000
6253	20.000
6255	20.000
6256	20.000
6260	21.375
6261	21.375
6262	21.375
6263	21.375
6264	21.375
6265	21.375
6266	21.375
6267	21.375
6268	21.375
6269	21.375
6270	21.375
6271	25.500
6272	25.500
6273	25.500
6274	25.500
6275	25.500
6276	25.500
6999	21.375
7202	20.000
7203	20.000
7204	20.000
7205	20.000
7216	20.000
9822	20.000
9823	20.000
9824	20.000
9825	20.000
9826	20.000
9827	20.000
9828	20.000
9833	20.000
9835	20.000
9850	20.000

TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]	TARIFF #	UNIT VALUE [per fifteen (15) minute period or portion thereof]

APPENDIX B—DIAGNOSTIC AND THERAPEUTIC ANESTHETIC PROCEDURES

Fluoroscopic Control

5396* Fluoroscopic control of percutaneous spinal pain management procedures, per full fifteen (15) minute period, add 24.91

5398* Injection of radio-opaque contrast agent, add-on to tariff 5396 ..... 27.93

Note: *1) Tariffs 5396 and 5398 are limited to anesthetists, specialists in physical medicine and other qualified physicians who have training in fluoroscopic control of percutaneous spinal pain management procedures;*

2) Tariff 5396 may only be claimed in conjunction with tariffs 5300, 5304, 5305, 5306, 5307, 5308, 5309, 5313, 5321 or 5329;

3) A maximum of sixty (60) minutes per patient per day can be claimed for tariff 5396.

4) Tariff 5398 may only be claimed once per patient per day.

TARIFF	PROCEDURE	UNITS
5312*	Intercostal, one or more	30
5318*	Phrenic	60
5317*	Sciatic	60
5320*	Sphenopalatine ganglion	60
5311*	Nerve plexus blocks	40
5319*	Peripheral nerve—single and multiple	30

Epidural Blocks

5304 Lumbar or Caudal 60

5329 Multiple Transforaminal site injections by a pain management specialist 105

Note: *The specific nerve root sites that were injected with an epidural block must be noted on the claim for tariff 5329.*

5305 Thoracic 80

5306 Cervical 80

Nerve Root or Facet Blocks

5300* Cervical single 60

5307 Cervical multiple 80

5308 Thoracic single 60

5309 Thoracic multiple 80

5313 Coccygeal, lumbar or sacral–single 47

5321 Lumbar multiple 60

5328 Nerve Root or Facet—Cryotherapy and/or Neurolysis, additional benefit 20

Subarachnoid (spinal) Blocks

5322 Subdural/Spinal 60

TARIFF	PROCEDURE	UNITS
5323	Differential spinal	72

Sympathetic Nerve Blocks

5302*	Stellate ganglion	60
5298*	Paravertebral (lumbar sympathetic)	60
5315*	Splanchnic/Coeliac plexus	80

Permanent Cryosection and/or Neurolysis

5324	Major plexus or nerve root	120
5325	Single peripheral nerve	30
5326	Multiple peripheral nerves	76
5327	Epidural or subarachnoid neurolysis	120
5316	Supra and infra diaphragmatic nerve neurolysis including splanchnic, coeliac and sympathetic nerves with x-ray contrast and x-ray control	120

Injection Tendon Sheath, Ligaments

1046	Single injections	10
1047	Multiple injections, regardless of number	15
1048	IV injections for diagnosis and/or therapeutic management of pain syndromes	20
2566	IV sympathetic blockade	60

Intra-Articular Injections

1055	Intra-Articular injections with fluoroscopic control	45

Note: *1) This procedural fee is intended to cover the procedural portion of the service including the placing of an instrument into the joint space and introducing local anesthetic and/or contrast media and/or steroids and/or other analgesic/diagnostic agents under fluoroscopic control.*

2) When two (2) or more intra-articular injections are performed on the same patient on the same day by the same physician, 100% of the unit value shall be paid for the first injection and 75% for each additional injection.

Percutaneous Insertion of long term epidural catheters

5110	Lumbar or Caudal	72
5111	Thoracic	84
5112	Cervical	92

Percutaneous Insertion of long term intrathecal catheters

5114	Lumbar or Caudal	84
5115	Thoracic	92
5116	Cervical	100
5117	Implantation of permanent epidural/intrathecal catheter, (e.g. DuPen catheter system)	106

TARIFF	PROCEDURE	UNITS
5224	Percutaneous implantation of neurostimulator electrodes-epidural	190
5228	Incision and placement of subcutaneous neurostimulator/receiver	182
5230	Revision or removal of permanent spinal neurostimulator receiver and/or electrodes	182

Therapeutic Procedures

8950	Epidural injection of autologous blood, any site	50
2128*	Tracheal aspiration for meconium staining under direct vision	50
2596	Anesthesia for emergency relief of acute upper airway (above the carnia) obstruction (excluding choanal atresia)	120
2597	Intubation not associated with an anesthetic service	50
2618	Controlled hypothermia and/or pump oxygenation in non-cardiac anesthesia	80
2560	Intravenous therapy, establishment	15
2567	Autonomic blockade by pharmacologic or major neuraxial technique to minimize blood loss or facilitate surgery. A sustained mean blood pressure below 60 mmHg is required to bill this tariff	60

Pregnancy and Maternity

4877	Continuous Conduction Anesthesia (Epidural) by In-Hospital On-Call Anesthetist providing coverage under Part III	85

Note: *1) Tariff 4877 may only be claimed when the anesthetist is claiming In-Hospital On-Call Anesthetic Coverage at St Boniface General Hospital (tariff 8201), Brandon Regional Health Centre (tariff 8202) or Health Science Centre (tariff 8203).*

2) Pre-anesthetic Evaluation, tariff 8515, is not payable in addition to tariff 4877.

Electro-Convulsive Therapy

8586	Anesthesia only	25

Patient Controlled Analgesia

8406	Initial assessment and recommendations by anesthetists or GP anesthetists when requested by an attending service	12
8407	Subsequent assessment and recommendations	8

Note: *Patient controlled analgesia means patient controlled intravenous or subcutaneous analgesia—usually via an indwelling catheter. Medication is infused and controlled by a monitoring device. The device (pump) can be set to deliver a predetermined dose of medication—there is a "lock out" capability which does not allow the patient to exceed a pre-set dosage.*

Intra-Operative/Peri-Operative Procedures

TARIFF	PROCEDURE	UNITS
2106	Intra-Operative/Peri Operative Comprehensive Transesophageal Echocardiography (TEE) Study including setup and patient preparation, cardiac monitoring and re-evaluation, 2-D study, color flow mapping, doppler study and M-mode, interpretation and reporting per case.	108
	Note: *1) This tariff shall only be claimed when provided by qualified anesthetists in relation to cardiac surgery, spine surgery, neurosurgery, vascular surgery or trauma surgery.*	
	2) Claims must include a relevant diagnostic code for the cardiac condition.	
	3) Only one (1) claim per patient per operation may be made.	
2107	Epiaortic/Epicardiac Ultrasound Study and on-heart monitoring	30
	Note: *This tariff may not be claimed in addition to tariff 2106.*	

Fast Track Recovery Intensive Care Cardiac Science Unit

a) The unit value of the Fast Track Recovery Intensive Care Cardiac Sciences service is 29.165 units per fifteen (15) minute period or portion thereof, and claimed under tariff 8277.

b) Out-of-hours premiums may not be claimed in addition to 8277.

c) Other services rendered concurrently cannot be claimed in addition to 8277.

d) The total amount of fifteen (15) minute time periods claimed for 8277, as a total across all physicians, may not exceed forty (40) time periods (i.e. ten (10) hours) per day.

e) 8277 may only be claimed by Attending Fast Track Cardiac Anesthesiologists who provide in-hospital coverage of the Intensive Care Cardiac Science Unit at St. Boniface General Hospital.

f) The start and stop times for providing the services, shall be submitted on the claim.

Anesthesia Miscellaneous

Local Anesthesia

40000	Local injections to anesthetize an area through absorption by area nerves This includes anesthetic injected directly into desired area or injected proximally for absorption into nerves supplying the area, (e.g. “ring anesthesia” in a finger proximal to the area; but does not include specific nerve blocks.) **This excludes topical anesthesia.**	3.97

		UNIT VALUE [PER FIFTEEN (15) MINUTE PERIOD OR PORTION THEREOF]
6999	Dental Anesthesia	21.375
2490	Multi-organ donor	25.500

Pulsed or Continuous Radiofrequency Lesioning

Lesioning of nerves arising from cervical or thoracic levels:

5800 One level, per side 448.90

5802 Multiple levels, per side 790.50

Lesioning of nerves arising from lumbar or sacral levels:

5805 One level, per side 342.57

5806 Multiple levels, per side 624.68

Lesioning of cranial nerves:

5807 Single or multiple levels, one side or bilateral..... 1,122.00

Note:

1) *Bilateral lesioning shall be claimed at 100% of the above fees when performed at the same sitting.*
2) *To be claimed only at approved sites.*
3) *To be claimed only by qualified physicians designated by the WRHA Medical Director, Anesthesia Program in consultation with the Medical Director for the Provincial Pain Management Service.*
4) *Where monitored Anesthesia Care is required during these procedures it shall be claimed only when provided by a separate anesthesiologist.*
5) *The above procedures include fluoroscopy.*
6) *Maximum of four (4) procedures per nerve per annum.*
7) *Additional procedures may be claimed by Special Report.*

APPENDIX C—PHYSICIANS ELIGIBLE TO CLAIM FOR CHRONIC PAIN MANAGEMENT SERVICES

In accordance with Rules of Application for Anesthesia Services 6 c), anesthetists who are eligible to claim for the provision of Chronic Pain Management Services are those with the appropriate training, as may be agreed upon from time to time by Doctors Manitoba and Manitoba Health.

APPENDIX D—HOLIDAYS

"Holiday" means:

- New Year's Day
- Louis Riel Day
- Good Friday
- Easter Monday
- Victoria Day
- Canada Day
- August Civic Holiday
- Labour Day
- National Day for Truth and Reconciliation
- Thanksgiving Day
- Remembrance Day
- Christmas Day
- Boxing Day

"Day" means calendar day.

Note: *If any of these days falls on a Saturday or Sunday, the day observed will apply as stated in the Physician's Newsletter.*

APPENDIX E—OUT–OF–HOSPITAL ON–CALL ANESTHESIA COVERAGE—REMUNERATION

Facility/Program	Evening	Night	Weekend/Holiday
	1600 to 2400 hours (4 p.m. to Midnight)	2400 to 0700 hours (Midnight to 7 a.m.)	0700 to 2400 hours (7 a.m. to Midnight)
Total Hours	**8**	**7**	**17**
I. Urban Community Facilities			
Seven Oaks/Grace/Victoria/Concordia	$452.64	$277.20	$961.86
Per person per hour	$56.58	$39.60	$56.58
Misericordia Health Centre	$452.64	$277.20	$961.86
Per person per hour	$56.58	$39.60	$56.58
II. Urban Tertiary Facilities			
St. Boniface General	$452.64	$277.20	$961.86
St. Boniface Cardiac	$452.64	$277.20	$961.86
St. Boniface Acute/Chronic Pain	$452.64	$277.20	$961.86
St. Boniface Backup	$452.64	$277.20	$961.86
HSC General	$452.64	$277.20	$961.86
HSC Cardiac	$452.64	$277.20	$961.86
HSC Paediatric	$452.64	$277.20	$961.86
HSC Acute/Chronic Pain	$452.64	$277.20	$961.86
HSC Paediatric Backup (24 hours)	$-	$-	$1,357.92
III. Rural Facilities			
Steinbach, Selkirk, Portage la Prairie	$257.20	$120.05	$546.55
Morden, Winkler, Dauphin, Thompson	$257.20	$120.05	$546.55
Per Anesthetist per hour	$32.15	$17.15	$32.15

NOTE 1) HSC Paediatric backup is for a twenty-four hour (24) period.

APPENDIX F—EXAMPLES: CALCULATION OF REMUNERATION FOR ANESTHETIC PROCEDURAL SERVICES

Example 1

Case History: A 60 year old woman undergoing a hepatic lobectomy. Arterial line, percutaneous venous pressure catheter and epidural inserted for the procedure.

Duration of case—5 hours, 20 minutes.

Service Category	Tariff	Service Description	Unit Value	# Time Periods	Total Units	Unit Value Rate	Payment
Pre-Anesthetic Evaluation	8515	Pre-Anesthetic Evaluation	12	n/a	12	$2.213	$26.56
Anesthetic Procedural Service	3494	Hepatic Lobectomy—Left	26.875	22	591.25	$2.213	$1,308.44
Special Invasive Procedure	9834	Venous Pressure Catheter	25	n/a	25	$2.213	$55.33
Special Invasive Procedure	2301	Continuous Arterial Catheter	15	n/a	15	$2.213	$33.20
Acute Pain Service	8955	Indwelling epidural analgesia	50	n/a	50	$2.213	$110.65
Total Remuneration							**$1,534.18**

Example 2

Case History: A 5 year old child undergoing a tonsillectomy.

Duration of case—40 minutes.

Service Category	Tariff	Service Description	Unit Value	# Time Periods	Total Units	Unit Value Rate	Payment
Pre-Anesthetic Evaluation	8515	Pre-Anesthetic Evaluation	12	n/a	12	$2.213	$26.56
Anesthetic Procedural Service	2992	Tonsillectomy	21.375	3	64.125	$2.213	$141.91
Total Remuneration							**$168.47**

Example 3

Case History: A 55 year old male undergoing repair of an inguinal hernia.

Duration of case—55 minutes.

Service Category	Tariff	Service Description	Unit Value	# Time Periods	Total Units	Unit Value Rate	Payment
Pre-Anesthetic Evaluation	8515	Pre-Anesthetic Evaluation	12	n/a	12	$2.213	$26.56
Anesthetic Procedural Service	3631	Inguinal hernia – Initial	20.000	4	80	$2.213	$177.04
Total Remuneration							**$203.60**

Example 4

Case History: A 75 year old male undergoing an aortic valve replacement. Arterial line and a percutaneous venous pressure catheter inserted for the procedure. Cardiopulmonary bypass operator—90 minutes. Duration of case—6 hours.

Service Category	Tariff	Service Description	Unit Value	# Time Periods	Total Units	Unit Value Rate	Payment
Pre-Anesthetic Evaluation	8515	Pre-Anesthetic Evaluation	12	n/a	12	$2.213	$26.56
Anesthetic Procedural Service	2378	Aortic valve replacement with prosthetic valve	26.875	24	645	$2.213	$1,427.39
Anesthetic Procedural Modifier	2616	Patient over 70 years of age	10	n/a	10	$2.213	$22.13
Special Invasive Procedure	9834	Venous Pressure Catheter	25	n/a	25	$2.213	$55.33
Special Invasive Procedure	2301	Continuous Arterial Catheter	15	n/a	15	$2.213	$33.20
Total Remuneration							**$1,564.61**

Note: *There is no charge for the cardiopulmonary bypass operator.*

APPENDIX G—EXAMPLES: CALCULATION OF REMUNERATION FOR ANESTHETIC PROCEDURAL SERVICES AND OUT–OF–HOURS PREMIUMS

Case History: A weekday emergency cholecystectomy for a 80 year old male. Arterial line inserted for the procedure. Duration of case—1 hour, 20 minutes.

Example 1. Case starts at 1000 hours (10:00 a.m.) and finishes at 1120 hours (11:20 a.m.)

Service Category	Tariff	Service Description	Unit Value	# Time Periods	Total Units	Unit Value Rate	Payment
Pre-Anesthetic Evaluation	8515	Pre-Anesthetic Evaluation	12	na	12	$2.213	$26.56
Anesthetic Procedural Service	3515	Cholecystectomy	22.750	6	136.5	$2.213	$302.07
Anesthetic Procedural Modifier	2616	Patient over 70 years of age	10	na	10	$2.213	$22.13
Special Invasive Procedure	2301	Continuous Arterial Catheter	15	na	15	$2.213	$33.20
Total Remuneration							**$383.96**

Note: *All services were provided outside the out-of-hours premium periods.*

Example 2. Case starts at 1630 hours (4:30 p.m.) and finishes at 1750 hours (5:50 p.m.)

Service Category	Tariff	Service Description	Unit Value	# Time Periods	Total Units	Unit Value Rate	Payment
Pre-Anesthetic Evaluation	8515	Pre-Anesthetic Evaluation	12	n/a	12	$2.213	$26.56
Anesthetic Procedural Service	3515	Cholecystectomy	22.750	6	136.5	$2.213	$302.07
Anesthetic Procedural Modifier	2616	Patient over 70 years of age	10	n/a	10	$2.213	$22.13
Special Invasive Procedure	2301	Continuous Arterial Catheter	15	n/a	15	$2.213	$33.20
Subtotal							**$383.96**
Out-of-Hours Premiums	**Tariff**	**Service Description**	**Unit Value**	**# Time Periods**	**Total Units**	**Unit Value Rate**	**Premium**	**Payment**
From 1700 to 2400 hours (5:00 p.m. to Midnight)	3515	Cholecystectomy	22.750	4	91	$2.213	50%	$100.69
Subtotal								**$100.69**
Total Remuneration Including Out-of-Hour Premium								**$484.65**

Note: *Tariffs 8515, 2616, 2301 and the first two (2) periods of tariff 3515 were provided before 1700 hours (5:00 p.m.) and are not eligible for the 50% out-of-hours premium.*

Example 3. Case starts at 1700 hours (5:00 p.m.) and finishes at 1820 hours (6:20 p.m.)

Service Category	Tariff	Service Description	Unit Value	# Time Periods	Total Units	Unit Value Rate	Payment
Pre-Anesthetic Evaluation	8515	Pre-Anesthetic Evaluation	12	n/a	12	$2.213	$26.56
Anesthetic Procedural Service	3515	Cholecystectomy	22.750	6	136.5	$2.213	$302.07
Anesthetic Procedural Modifier	2616	Patient over 70 years of age	10	n/a	10	$2.213	$22.13
Special Invasive Procedure	2301	Continuous Arterial Catheter	15	n/a	15	$2.213	$33.20
Subtotal							**$383.96**

Out-of-Hours Premiums	Tariff	Service Description	Unit Value	# Time Periods	Total Units	Unit Value Rate	Premium	Payment
From 1700 to 2400 hours (5:00 p.m. to Midnight)	8515	Pre-Anesthetic Evaluation	12	n/a	12	$2.213	50%	$13.28
	3515	Cholecystectomy	22.750	6	136.5	$2.213	50%	$151.04
	2616	Patient over 70 years of age	10	n/a	10	$2.213	50%	$11.07
	2301	Continuous Arterial Catheter	15	n/a	15	$2.213	50%	$16.60
Subtotal								**$191.99**
Total Remuneration Including Out-of-Hour Premium								**$575.95**

Note: *All services were provided between 1700 hours (5:00 p.m.) and 2400 hours (Midnight) and are eligible for the 50% out-of-hours premium.*

Example 4. Case starts at 2330 hours (11:30 p.m.) and finishes at 0050 hours (12:50 a.m.)

Service Category	Tariff	Service Description	Unit Value	# Time Periods	Total Units	Unit Value Rate	Payment
Pre-Anesthetic Evaluation	8515	Pre-Anesthetic Evaluation	12	n/a	12	$2.213	$26.56
Anesthetic Procedural Service	3515	Cholecystectomy	22.750	6	136.5	$2.213	$302.07
Anesthetic Procedural Modifier	2616	Patient over 70 years of age	10	n/a	10	$2.213	$22.13
Special Invasive Procedure	2301	Continuous Arterial Catheter	15	n/a	15	$2.213	$33.20
Subtotal							**$383.96**
Out-of-Hours Premiums	**Tariff**	**Service Description**	**Unit Value**	**# Time Periods**	**Total Units**	**Unit Value Rate**	**Premium**	**Payment**
From 1700 to 2400 hours (5:00 p.m. to Midnight)	8515	Pre-Anesthetic Evaluation	12	n/a	12	$2.213	50%	$13.28
	3515	Cholecystectomy	22.750	2	45.5	$2.213	50%	$50.34
	2616	Patient over 70 years of age	10	n/a	10	$2.213	50%	$11.07
	2301	Continuous Arterial Catheter	15	n/a	15	$2.213	50%	$16.60
Subtotal								**$91.29**
	Tariff	**Service Description**	**Unit Value**	**# Time Periods**	**Total Units**	**Unit Value Rate**	**Premium**	**Payment**
From 2400 to 0700 hours (Midnight to 7:00 a.m.)	3515	Cholecystectomy	22.750	4	91	$2.213	75%	$151.04
Subtotal								**$151.04**
Total Remuneration Including Out-of-Hour Premium								**$626.29**

Note: *Tariffs 8515, 2616, 2301 and the first two (2) periods of tariff 3515 were provided after 1700 hours (5:00 p.m.) and before 2400 hours (Midnight) and are eligible for the 50% premium. The last periods of tariff 3515 occur after 2400 hours (Midnight) and are eligible for the 75% out-of-hours premium.*

Example 5. Case starts at 2400 hours (Midnight) and finishes at 0120 hours (1:20 a.m.)

Service Category	Tariff	Service Description	Unit Value	# Time Periods	Total Units	Unit Value Rate	Payment
Pre-Anesthetic Evaluation	8515	Pre-Anesthetic Evaluation	12	n/a	12	$2.213	$26.56
Anesthetic Procedural Service	3515	Cholecystectomy	22.750	6	136.5	$2.213	$302.07
Anesthetic Procedural Modifier	2616	Patient over 70 years of age	10	n/a	10	$2.213	$22.13
Special Invasive Procedure	2301	Continuous Arterial Catheter	15	n/a	15	$2.213	$33.20
Subtotal							**$383.96**
Out-of-Hours Premiums	**Tariff**	**Service Description**	**Unit Value**	**# Time Periods**	**Total Units**	**Unit Value Rate**	**Premium**	**Payment**
From 0000 to 0700 hours (Midnight to 7:00 a.m.)	8515	Pre-Anesthetic Evaluation	12	n/a	12	$2.213	75%	$19.92
	3515	Cholecystectomy	22.750	6	136.5	$2.213	75%	$226.56
	2616	Patient over 70 years of age	10	n/a	10	$2.213	75%	$16.60
	2301	Continuous Arterial Catheter	15	n/a	15	$2.213	75%	$24.90
Subtotal								**$287.98**
Total Remuneration Including Out-of-Hour Premium								**$671.94**

NOTE All services were provided between 2400 hours (Midnight) and 0700 hours (7:00 a.m.) are eligible for the 75% out-of-hours premium.

INTEGUMENTARY SYSTEM

These benefits cannot be correctly interpreted without reference to the Rules of Application.

SURGICAL PROCEDURES

Note: *1) When a surgical procedure is indicated by an asterisk, the benefit is for the procedure and not for the management of the case. The benefit for the initial visit(s) and follow-up care shall be provided in addition to the procedural benefit.*

Rules of Application such as 23, 24, 25, 26, 27, 28, 29 and 31 are not to be applied to asterisked procedures unless the procedure is an integral part of another surgical procedure and, as such, is included in a block fee.

2) The minimum benefit for procedures performed with general anesthesia shall be $72.80 notwithstanding that a lesser benefit or no benefit at all, may be listed for the procedure performed without general anesthetic.

3) In multiple surgical services done on the same day, the benefit of the first is paid at 100% and, unless otherwise stated in the schedule, the others at 75%.

4) Fee for Service (F/S) means that the procedure is included in the visit fee or any other procedure which is involved with it,(e.g. the application of a cast).

CUTANEOUS PROCEDURES

INVESTIGATION

			UNIT VALUE
0171*	Biopsy of skin, subcutaneous tissue or mucous membrane, including simple closure or punch biopsy (independent procedure)	33.95	20.000
0172*	Dermatoscopy	28.56	20.000
	Note: *Limited to specialists in Dermatology.*		
0415*	Woods light examination	4.13	20.000

INCISION

0106*	Abscess or hematoma, puncture aspiration	28.59	20.000
0103*	Carbuncle drainage	68.19	20.000
0101*	Superficial localized infection such as steatoma, furuncle, boil, paronychia, felon, pilonidal abscess—incision and drainage	45.79	20.000
0170*	Acne Surgery—Marsupialization, opening or removal of multiple milia, comedones, cysts, pustules, etc.—each sitting	27.87	20.000
0130*	Foreign body subcutaneous tissue, removal, simple	24.72	20.000
0256	removal, complicated	***By Report***	20.000

			UNIT VALUE
0125	Laser treatment of port wine stains and hemangiomas each square inch (6.25 sq. cm.) or portion thereof	65.06	20.000

Note: *1) Patient must be under sixteen (16) years of age at time of treatment.*

2) Maximum payable $3000.00 per session unless prior written approval from Manitoba Health is obtained.

3) Maximum of one (1) session payable per patient, per day.

4) A physician may claim a maximum of eight (8) sessions per patient. Payment beyond eight (8) sessions requires prior written approval from Manitoba Health.

5) Physicians treating patients, sixteen (16) years of age or older, with significantly symptomatic (e.g., bleeding, chronically painful) port wine stains or hemangiomas may submit claims using tariffs 0128 and 0129*. Medical indications must be submitted on claim in notes or remarks area.*

6) Limited to specialists in Dermatology or Plastic Surgery.

0128*	Pulsed dye laser, first square inch (6.25 sq. cm.) or portion thereof	65.31	20.000
0129*	each additional square inch or portion thereof, same session	65.31	20.000
0394*	Laser vaporization—face—one (1) lesion	57.69	20.000
0395*	two (2) lesions	86.64	20.000
0396*	three (3) or more lesions	141.37	20.000
0397*	Elsewhere—one (1) lesion	57.64	20.000
0398*	two (2) lesions	57.64	20.000
0399*	three (3) or more lesions	86.33	20.000
0428*	Reconstructive laser depilation, per square inch (6.25 sq. cm) or portion thereof	64.67	20.000

Note: *1) 0428 is limited to specialists in Plastic Surgery.*

2) Limited to Face and Head.

3) To be utilized to bring the face or head to normal after surgery due to trauma, cancer or birth anomaly.

REVISION AND REPAIR

0251*	Wound repair (local anesthetic included) simple, any location	47.67	20.000
0250	multiple	***By Report***	20.000
0412*	Intralesional injections, up to and including seven (7) lesions	27.04	20.000
0413*	more than seven (7) lesions	26.78	20.000
0414*	Ultraviolet light therapy	13.98	20.000
0245*	Ultraviolet B therapy (UVB) per treatment	17.51	

Note: *A physician may claim subsequent visits for re-assessment at the rate of one (1) visit per eight (8) UVB treatments. More frequent visits may be claimed **By Report**.*

0240	Narrow Band UVB Phototherapy (NB–UVB)—Professional Component	19.00	

0241 Narrow Band UVB Phototherapy (NB–UVB)—Technical Component 12.46

Note: *1) Tariffs 0240 and 0241 are limited to specialists in Dermatology.*

2) A physician may claim subsequent visits for re-assessment at a rate of one (1) visit per five (5) NB-UVB treatments.

RESECTION

Skin or subcutaneous lesion (removal of sutures included in visit)

			UNIT VALUE
0253*	single	58.65	20.000
0254*	two (2), three (3), four (4), and five (5) lesions, each	34.99	20.000
0255	multiple	***By Report***	20.000
	Removal of sutures by other than the surgeon or his deputy or his assistant.	F/S	
0230*	Nail Removal, avulsion, partial or complete	57.33	20.000
0257	nail and matrix removed; partial or complete (i.e., from ingrown or deformed nail)	111.11	20.000
0402*	Warts and fibrocutaneous tags, simple	32.08	
	Plantar Warts—removal by any method with or without primary closure		
0420*	first plantar wart, each sitting	34.88	20.000
0421*	two (2) plantar warts, each sitting	49.67	20.000
0422*	three (3) or more, each sitting	70.18	20.000
	Note: *Tariffs 0420, 0421 or 0422 may be claimed for each sitting, regardless of whether the wart(s) are "recurrent" or "new".*		
0258	Pilonidal cyst or sinus, excision—packing or primary closure	304.84	20.000
0247	excision and plastic closure	327.25	20.000
0248	marsupialization	298.03	20.000
0400*	Cautery (electro, chemo, cryo) destruction or simple surgical excision of benign or pre-malignant lesions, face, one (1) lesion with or without curettage	39.93	20.000
0432*	second lesion	19.99	20.000
0433*	additional lesions, each	10.00	20.000
0401*	Elsewhere	20.25	20.000
0404*	second lesion	10.41	20.000
0405*	additional lesions, each	5.21	20.000
0406	complicated lesions	***By Report***	20.000
0407*	Cautery (electro, chemo, cryo) destruction of malignant lesions confirmed by biopsy, trunk	86.45	20.000
0434*	second lesion	43.04	20.000
0435*	additional lesions, each	21.62	20.000
0408*	other areas	85.99	20.000
0416*	second lesion	47.45	20.000
0417*	additional lesions, each	39.10	20.000

			UNIT VALUE
	Abrasion of skin, total face for removal of scars and acne scars		
0333	primary	147.80	21.375
0334	secondary	55.12	21.375
0335	Abrasion regional cheeks, chin, 1/4 face, forehead or elsewhere, primary	170.96	21.375
0336	secondary	55.63	21.375
0337	Dermajection	306.28	20.000
0340*	Dermajection intralesional	20.91	
0403*	Cryotherapy (CO^2 slush, liquid N^2)	20.40	20.000
0249	**Unlisted or Unusually Complicated**	***By Report***	20.000

BURNS

0351*	Burn—initial or subsequent treatment, first degree, when no more than local treatment is necessary	43.12	

DRESSINGS

	Dressings—second or third degree burns, single or multiple, initial or subsequent, without anesthesia		
0354*	small	27.04	
0355*	medium (whole face or whole extremity, etc.)	41.51	
0356*	large	49.32	
	Dressings—second or third degree burns, initial or subsequent, with general anesthesia		
0352*	small or medium	81.45	21.375
0353*	large, or with major debridement, per hour	274.81	25.500
0357	unlisted or unusually complicated	***By Report***	25.500
0359	Non Burn Dressings, major debridement and dressing, with anesthesia (excluding local anesthesia)	***By Report***	25.500

DEBRIDEMENT

0259*	Debridement of full thickness chronic skin ulcer, i.e., neuropathic or vascular, down to fascia, up to 30 sq. cm. in size, involving the foot or leg below the knee	87.67	20.000
0260*	Debridement of full thickness chronic skin ulcer, i.e., neuropathic or vascular, down to fascia, bone and/or muscle, up to 30 sq. cm. in size, involving the foot or leg below the knee	100.82	

		UNIT VALUE	
0261	Major debridement of necrotizing soft tissue infection per fifteen (15) minutes or major portion thereof	143.07	25.500

Note: *Tariff 0261 may only be claimed for major debridement of necrotizing soft tissue infection, including Fournier's Gangrene, completed under general anesthesia.*

RECONSTRUCTIVE AND PLASTIC SURGERY

Note: *1) In multiple surgical services done on the same day, the benefit of the first is paid at 100%, and unless otherwise stated in the schedule, the others at 75%.*

2) Elective Plastic Surgery:

The Manitoba Health Services Insurance Act has certain exclusions for elective plastic surgery for cosmetic purposes except where the Minister is satisfied prior to the operation that surgery is medically required.

a) Not all plastic surgery operations for cosmetic purposes are eligible for benefits.

b) All plastic surgery initiated prior to the age of 16 years for the correction of congenital defects is eligible for benefits.

c) All plastic surgery performed to correct or minimize the effects of trauma, burns, sepsis or surgical excision of lesions for treatment or diagnosis is also eligible for benefits.

d) Elective plastic surgery for beautifying purposes, such as:

- *Blepharoplasty*
- *Rhytidectomy*
- *Rhinoplasty*
- *Otoplasty*
- *Mammoplasty*

are generally not eligible for benefits unless the Minister is satisfied, prior to the operation, that such surgery is necessary for medical reasons.

The following tariffs are not to be used for ordinary and usual excisions of lesions or repairs of lacerations. (The tariffs for such remain namely, 0253, 0254, 0255 and 0251, 0250).

They are to be used only where special considerations apply, such as the site of the lesion, the extent of the lesion, possible interference with function, and, as well as treating the lesion to achieve the optimal cosmetic result.

EXCISION AND/OR REPAIR BY DIRECT CLOSURE OF A LACERATION RESULTING IN LINEAR CLOSURE

Note: *1) 2nd, 3rd, 4th, and 5th lacerations, each.....75%*

six (6) or more, each 50%

2) When

a) the nature of the injury and/or

*b) the medical circumstances of the patient, are such that the laceration(s) cannot be repaired under local anesthesia; then a claim for the augmented fee for treatment under general anesthesia can be made **By Report**.*

0100 Add on to surgical fee when performed under general anesthesia 78.70

TRUNK, ARMS, LEGS

			UNIT VALUE
0104*	Resulting in a repair less than 5 cm.	56.04	20.000
0105*	Resulting in a repair 5—10 cm.	74.54	20.000

FACE, SCALP, NECK, GENITALIA, HANDS, FEET

0107*	Resulting in a repair less than 5 cm.	87.31	20.000
0108*	Resulting in a repair 5—10 cm.	144.69	20.000

EYELIDS, EARS, LIPS, NOSE, MUCOUS MEMBRANE

0109*	Resulting in a repair less than 2 cm.	132.95	20.000
0110*	Resulting in a repair 2—4 cm.	119.15	20.000
0111	**Unlisted or Unusually Complicated**	***By Report***	20.000

EXCISION AND/OR REPAIR BY DIRECT CLOSURE OF A LESION RESULTING IN LINEAR CLOSURE

Note: *1) Second lesion 75%*

third lesion 75%

fourth lesion 75%

2) A maximum of four (4) lesions may be claimed.

TRUNK, ARMS, LEGS

0112	Resulting in a repair less than 5 cm.	61.30	20.000
0113	Resulting in a repair 5—10 cm.	103.43	20.000

FACE, SCALP, NECK, GENITALIA, HANDS, FEET

			UNIT VALUE
0116	Resulting in a repair less than 5 cm.	97.09	20.000
0117	Resulting in a repair 5—10 cm.	107.60	20.000

EYELIDS, EARS, LIPS, NOSE, MUCOUS MEMBRANE

0118	Resulting in a repair less than 2 cm.	110.42	20.000
0119	Resulting in a repair 2—4 cm.	162.08	20.000
0120	**Unlisted or Unusually Complicated**	***By Report***	20.000

EXCISION AND/OR REPAIR OF A LESION RESULTING IN COMPLEX MULTILAYERED CLOSURE REQUIRING UNDERMINING

Note: *1) Second lesion 75%*
third lesion 75%
fourth lesion 75%
2) A maximum of four (4) lesions may be claimed

TRUNK

(3 cm of undermining required on at least one side of the incision)

0216	Defect up to 6 sq. cm.	131.74	20.000
0217	Between 6 sq. cm. and 19 sq. cm.	212.58	20.000
0218	More than 19 sq. cm.	***By Report***	20.000

ARMS, LEGS, AND SCALP

(3 cm of undermining required on at least one side of the incision)

0219	Defect up to 6 sq. cm.	136.43	20.000
0220	Between 6 sq. cm. and 19 sq. cm.	217.17	20.000
0221	More than 19 sq. cm.	***By Report***	20.000

AXILLA, CHEEKS, CHIN, FEET, FOREHEAD, GENITALIA, HANDS, MOUTH AND NECK

(2 cm of undermining required on at least one side of the incision)

0222	Defect up to 6 sq. cm.	185.99	21.375
0223	Between 6 sq. cm. and 19 sq. cm.	267.78	21.375
0224	More than 19 sq. cm.	***By Report***	21.375

EARS, EYELIDS, LIPS AND NOSE

(1.5 cm of undermining required on at least one side of the incision)

0225	Defect up to 6 sq. cm.	232.67	21.375
0226	Between 6 sq. cm. and 19 sq. cm.	286.45	21.375

			UNIT VALUE
0227	More than 19 sq. cm.	***By Report***	21.375

ADJACENT TISSUE TRANSFER

Excision and/or repair by **adjacent** tissue transfer or re-arrangement (e.g., Z-plasty, W-plasty, rotation flap, double pedicle flap).

TRUNK

0286	Defect up to 6 sq. cm.	263.48	20.000
0287	Between 6 sq. cm. and 19 sq. cm.	425.17	20.000
0288	More than 19 sq. cm.	***By Report***	20.000

ARMS, LEGS AND SCALP

0289	Defect up to 6 sq. cm.	272.85	20.000
0290	Between 6 sq. cm. and 19 sq. cm.	434.34	20.000
0291	More than 19 sq. cm.	***By Report***	20.000

AXILLA, CHEEKS, CHIN, FEET, FOREHEAD, GENITALIA, HANDS, MOUTH AND NECK

0292	Defect up to 6 sq. cm.	371.95	21.375
0293	Between 6 sq. cm. and 19 sq. cm.	535.55	21.375
0294	More than 19 sq. cm.	***By Report***	21.375

EARS, EYELIDS, LIPS AND NOSE

0295	Defect up to 6 sq. cm.	390.45	21.375
0296	Between 6 sq. cm. and 19 sq. cm.	649.33	21.375
0297	More than 19 sq. cm.	***By Report***	21.375
0298	Eyelid, full-thickness, excision and repair, by advancement flaps up to 1/4 eyelid margin	501.20	21.375
0299	over 1/4 eyelid margin	515.46	21.375
0300	By transfer of flaps or tarso-conjunctiva from opposing eyelid, up to 2/3 of eyelid	637.34	21.375
0301	Repair of total eyelid, one (1) or more stages, lower lid	***By Report***	21.375
0302	upper lid	***By Report***	21.375

RHYTIDECTOMY

Note: *Rhytidectomy, when done as elective plastic surgery for cosmetic purposes is an exclusion under the Plan, except when the Minister is satisfied prior to the operation that such surgery is medically required. It is the responsibility of the physician to obtain this approval prior to the operation.*

			UNIT VALUE
0327	Rhytidectomy, cheeks and chin	563.52	21.375
0328	eyelid, lower	196.82	21.375
0329	eyelid, upper	219.96	21.375
0330	forehead	315.97	21.375
0332	neck	563.52	21.375

REPAIR WEB FINGERS

1811	Freeing of web fingers with flaps	406.73	20.000
1815	with graft	519.95	20.000
1817	complex	***By Report***	20.000
0338	Removal of tattoos	***By Report***	20.000

Note: *Claims for removal of tattoos must be accompanied by a full description as to size, area involved, procedures used, and time consumed. Benefits payable will be in accordance with existing tariffs in the fee manual depending upon the method of closure used.*

HYPERHIDROSIS, UNILATERAL

0418	excision with direct closure	57.69	20.000
0423	excision with extensive undermining	300.04	20.000
0424	excision with graft	385.31	20.000

HYDRADENITIS SUPPURATIVE, UNILATERAL

Excision of skin and subcutaneous tissue

0425	with direct closure	218.61	20.000
0426	with skin graft	389.16	20.000
0427	with regional flap	475.02	20.000

SKIN GRAFTS

Note: *1) In multiple surgical services done on the same day, the benefit of the first is paid at 100%, and unless otherwise stated in the schedule, the others at 75%.*

2) Benefit shall be determined according to the size and location of the recipient area and the type of graft.

3) Unless as otherwise noted below, benefits include simple debridement of granulations or recent avulsions, the creation and/or surgical preparation of the defect, obtaining and placing of graft, and the care of the donor site.

4) When repair of the donor site requires skin graft or local flap, only 75% of the benefit for this is payable—See Rule of Application 25 and 26.

5) When the skin graft involves the use of Living Skin Equivalents or Dermal (substitute) tissue of non-human origin eg. Oasis or acellular xenograft implant, sixty-five percent (65%) of the benefit shall be paid.

			UNIT VALUE
0345*	Graft, pinch, split or full thickness to cover small ulcer, tip of digit or other minimal open area (except on face), up to defect size (2 cm.) diameter	126.36	20.000

Tissue Expansion–(areas other than the breast)

0140	Insertion of tissue expander, face, neck and scalp	406.18	21.375
0141	insertion of an additional expander through a different incision	320.15	21.375
0142	Insertion of expander in other areas, extremeties, trunk excluding breast	406.18	21.375
0143	insertion of additional expander through a different incision	320.15	21.375
0144	Removal of injection port under local anesthesia	63.77	
0145	Removal of an injection port under general anesthesia	78.80	21.375
0146	Removal and replacement of ruptured or leaking expander, face, neck, scalp	406.18	21.375
0147	Removal and replacement of ruptured or leaking expander, extremities, trunk excluding breast	406.18	21.375
0148*	Inflation of tissue expander, one (1)	22.95	21.375
0149*	Inflation of each additional expander at same visit to a maximum of three (3)	11.42	21.375

SPLIT SKIN GRAFTS

0303	Split skin grafts, arms, legs, scalp and trunk up to 100.0 sq. cm.	276.38	21.375
0480	with allograft overlay, each additional 100.0 sq. cm. or part thereof add to 0303 or 0304	32.29	
0304	each additional 100.0 sq. cm. or part thereof	49.30	22.750
0305	Split skin grafts, ears, face, feet, genitalia, hands, multiple digits, neck, up to 100.0 sq. cm.	367.93	22.750
0481	with allograft overlay, each additional 100.0 sq. cm. or part thereof add to 0305 or 0306	118.46	
0306	each additional 100.0 sq. cm. or part thereof	180.44	26.875

Note: *1) A ratio of 2:1 mesh or greater is utilized, and*

2) The patient has either:

a. Burns on 30% or more of the patient's body area; or

b. Frostbite on 20% or more of the patient's body area; or

c. Necrotizing Fasciitis on 10% or more of the patient's body.

BURNS

Note: *For burn eschar and burn scars, when the recipient area for split skin grafting is created by surgical excision of essentially intact eschar or scar, including subcutaneous tissue, 50% should be claimed by means of the following tariffs in addition to the appropriate split thickness graft tariffs. This applies for both immediate and delayed grafting.*

0380 Creation of recipient area as above, claim with 0303.....138.19

0381 Creation of recipient area as above, claim with 0304.....24.99

0382 Creation of recipient area as above, claim with 0305.....186.72

0383 Creation of recipient area as above, claim with 0306.....91.65

FULL THICKNESS GRAFTS

			UNIT VALUE
	Full thickness, free, up to 19 sq. cm., including direct closure of donor site.		
0307	Trunk (19 sq. cm.)	373.86	20.000
0308	Arms, legs, scalp	344.04	20.000
0309	Axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth, neck	304.05	21.375
0310	Ears, eyelids, lips, nose	366.96	21.375

For each additional 19 sq. cm. in the above procedures, add 50% of area benefit.

For repair of donor site requiring skin graft or local flaps—See Rule of Application 26.

BURNS

Note: *For burn eschar and burn scars, when the recipient area for full thickness grafting is created by surgical excision of essentially intact eschar or scar, including subcutaneous tissue, 50% should be claimed by means of the following tariffs in addition to the appropriate full thickness graft tariffs. This applies to both immediate and delayed grafting.*

0385 Creation of recipient area as above, claim with 0307.....62.33

0386 Creation of recipient area as above, claim with 0308.....115.21

0387 Creation of recipient area as above, claim with 0309.....151.46

0388 Creation of recipient area as above, claim with 0310.....161.82

BENIGN AND MALIGNANT LESIONS

Note: *For benign and malignant lesions, when the recipient area for split skin grafting is created by surgical excision of the lesion(s), including subcutaneous tissue, the excision should be claimed by means of the following tariffs in addition to the appropriate split thickness graft tariffs (area less than 10 sq. cm.—graft benefit only, no benefit for excision).*

		UNIT VALUE	
0121	Area 10—50 square cm.	161.69	20.000
0122	Area 50—100 square cm.	214.90	20.000
0123	Area over 100 square cm.	***By Report***	20.000

Note: *For benign and malignant lesions, when the recipient area for full thickness grafting is created by surgical excision of the lesion(s), including subcutaneous tissue, the excision should be claimed by means of the following tariffs in addition to the appropriate full thickness graft tariffs (area less than 10 sq. cm.—graft benefit only, no benefit for excision).*

0124	Area 10—50 square cm.	161.69	20.000
0126	Area 50—100 square cm.	161.69	20.000
0127	Area over 100 square cm.	***By Report***	20.000

MOHS MICROGRAPHICALLY CONTROLLED EXCISION

Definition/Required Elements of Service

Mohs micrographic surgery is the specialized technique for the surgical removal of high-risk skin cancers (e.g., basal cell carcinoma, squamous cell carcinoma and melanoma) where the entire peripheral and deep sectors of the excised specimen is appropriately marked, orientated, mapped, mounted and processed for microscopic examination of 100% of the tumour margins by or under the supervision of the same physician who excised the specimen. This process is repeated, removing only tissue that contains residual cancerous tissue, until a margin completely free of cancerous tissue is reached while preserving as much healthy tissue as possible.

0133	Initial cut, including debulking to obtain 1st pathological evaluation	503.37
0134	One or more additional cuts, add	311.58

Note:
1) *These tariffs may only be claimed by a physician with subspecialty fellowship training in Mohs micrographic surgical technique.*
2) *These tariffs may only be claimed when a certified pathologist has confirmed the diagnosis from a prior biopsy.*
3) *Tariff 0134 may be claimed only once, whether or not excision of the lesion extends to multiple sessions.*
4) *The benefit for reconstruction of the defect is to be paid in addition to tariffs 0133 and 0134.*
5) *The preparation of slides must be rendered or supervised by the physician claiming the tariff. All tissue section slides must be microscopically reviewed and interpreted directly by the physician.*

EXCISION OF SKIN CANCER WITH EN FACE FROZEN SECTIONS

0280	Initial cut, including debulking	310.59	22.750
0282	One or more additional cuts, add	263.52	22.750

Note: *1) Refers to the technique in which:*

i) A tangential specimen of the tumour is obtained with a minimal margin of tissue;

ii) A pathologist is present during the procedure;

iii) The entire peripheral and deep margins (except eyelids) of the excised tissue are marked, mapped and mounted by the surgeon to enable the pathologist to view the specimen in the appropriate orientation; and

iv) There are a minimum of two margins on the frozen section pathology report.

2) Tariff 0282 may only be claimed when frozen section pathology report shows that additional excision(s) in the corresponding sector(s) of the tumor bed are required for complete removal of the tumor.

3) Tariff 0282 may only be claimed once per patient per day.

4) These tariffs may only be claimed when a certified pathologist has confirmed the diagnosis from a prior biopsy, or where diagnosis of malignancy is confirmed on the final frozen section pathology report.

5) Limited to specialists in Plastic Surgery, Otolaryngology and Ophthalmology with fellowship training in occulo-plastic surgery.

6) Limited to cancers of the head or neck.

7) The benefit for reconstruction of the defect is payable in accordance with the Surgical Rules of Application in addition to tariffs 0280 and 0282.

RECONSTRUCTION BY THE DISTANT TRANSFER OF TISSUE

Benefits for the following tariffs do not include extensive immobilization and plaster casts may be claimed in addition—See Plaster Casts.

			UNIT VALUE
0311	Preparation (raising) of pedicle flap, direct or tubed, including direct closure of donor site, trunk	414.34	20.000
0312	arms, legs and scalp	407.08	20.000
0313	axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth and neck	414.34	21.375
0314	ears, eyelids, lips and nose	350.84	21.375
0315	Delay, intermediate transfer or sectioning of pedicle or tubed or direct flap, trunk	333.40	20.000
0316	arms, legs and scalp	301.87	20.000
0317	axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth and neck	276.01	21.375
0318	ears, eyelids, lips and nose	276.01	21.375
0319	Excision of lesion and/or preparation of recipient site and attachment of direct or tubed pedicle flap, trunk	278.65	20.000
0320	arms, legs and scalp	348.16	20.000
0321	axilla, cheeks, chin, feet, forehead, genitalia, hands, mouth and neck	385.31	21.375
0322	ears, eyelids, lips and nose	498.98	21.375

GRAFTS TO SPECIAL SITES

0323	Composite grafts (full-thickness of external ear or nasal alae)	335.95	20.000
0324	Derma-fat-fascia-graft (except to breast)	351.50	21.375
0325	Facial nerve paralysis, free fascia grafts	464.62	21.375
0326	Re-animation of muscle transfers	691.32	21.375

REIMPLANTATION INVOLVING VASCULAR AND NEUROANASTOMOSIS

			UNIT VALUE
0344	Digit, with or without vein graft	2,456.47	25.500
0346	Major limb, including upper extremity proximal to wrist; lower extremity proximal to ankle; hand or foot	***By Report***	25.500
0347	Revision—minor	***By Report***	22.750
0348	Revision—major	***By Report***	25.500

Note: *Benefits for revision will be calculated on the basis of $234.25 per hour.*

FREE TISSUE TRANSFER

Note: *1) When the three (3) elements in the procedure are done **sequentially**, 100% of the most expensive element will be paid; plus 85% of the other two (2) elements plus an assistant's fee.*

*2) When the three (3) procedures are **synchronous**, 100% will be paid for two (2) elements plus 85% for the third element plus an assistant's fee for the third element.*

0349	Elevation of free island skin and subcutaneous flap and closure of defect	1,053.59	25.500
0343	Elevation of free island skin and subcutaneous flap and closure of defect using perforator free tissue transfer (includes DIEP, SIEA, ALT, SGAP, IGAP, TAP and perforator TUG)	2,084.37	25.500
0350	Preparation of microvascular recipient site for free island skin subcutaneous flap	1,107.99	25.500
0358	Transplantation of free island skin and subcutaneous flap with microvascular anastomosis(es)	971.94	25.500

INNERVATED FREE ISLAND SKIN AND TISSUE TRANSFER

0360	Elevation of innervated free island skin and subcutaneous flap and closure of defect	1,100.36	25.500
0361	Preparation of microvascular recipient site for innervated free island skin and subcutaneous flap	1,100.36	25.500
0362	Transplantation of innervated free island skin and subcutaneous flap with microvascular anastomosis(es) and nerve repair	1,149.45	25.500

FREE MUSCLE AND SKIN FLAP TRANSFER

0363	Elevation of free island skin and muscle flap and closure of defect	1,046.80	25.500
0364	Preparation of microvascular recipient site for free island skin and muscle flap	1,064.23	25.500

0365	Transplantation of free island skin and muscle flap with microvascular anastomosis(es)	1,457.78	25.500

FREE INNERVATED MYOCUTANEOUS FLAP INCLUDING TENDON AND NERVE

			UNIT VALUE
0366	Elevation of free island muscle flap with tendon and nerve and closure of defect	1,293.03	25.500
0367	Preparation of microvascular recipient site for muscle, tendon and nerve anastomosis(es)	1,264.20	25.500
0368	Transplantation of free island muscle flap with tendon nerve and microvascular anastomosis(es)	1,429.54	25.500

FREE OSSEOUS TISSUE TRANSFER

0369	Elevation of free island bone flap and closure of defect	1,080.37	25.500
0370	Preparation of microvascular recipient site for free island bone flap	1,005.12	25.500
0371	Transplantation of free island bone flap for micro-vascular anastomosis(es) and bone fixation	1,185.81	25.500

FREE OSSEOCUTANEOUS TISSUE TRANSFER

0372	Elevation of free island skin and bone flap and closure of defect	1,119.41	25.500
0373	Preparation of microvascular recipient site for free island skin and bone flap	1,196.99	25.500
0374	Transplantation of free island skin and bone flap with microvascular anastomosis(es) and bone fixation	1,360.74	25.500

FREE TOE OR FINGER TRANSFER

0375	Elevation of free toe or finger and closure of defect	1,348.74	25.500
0376	Preparation of microvascular recipient site for free toe or finger transplant	1,069.57	25.500
0377	Transplantation of free island toe or finger with microvascular anastomosis(es) and tendon nerve and bone repair	1,090.98	25.500
0378	Revision of free vascularized tissue transfer—minor	***By Report***	25.500
0379	Revision—major with microvascular reanastomosis or vein grafts	***By Report***	25.500

Note: *Benefits for revision will be calculated on the basis of $234.25 per hour.*

MYOCUTANEOUS FLAPS

0384	Sternomastoid, tensor fascia lata, gluteus maximus, gracilis sartorius, rectus femoris, gastrocnemius (medial and lateral) trapezius	1,070.07	22.750
0389	Pectoralis major, latissimus dorsi, unilateral rectus abdominus	1,011.86	22.750
0390	Lower rectus abdominus flap	975.40	22.750
0391	Repair of abdominal defect, same surgeon, add	356.19	22.750
0392	Repair of abdominal defect, different surgeon, add	385.20	22.750
0339	**Unlisted or Unusually Complicated**	***By Report***	22.750

BREAST

These benefits cannot be correctly interpreted without reference to the Rules of Application.

INVESTIGATION

			UNIT VALUE
0430*	Cyst aspirations	38.02	20.000
0440*	Needle (core) biopsies	44.50	20.000
0437	Wire Guided Breast Biopsy	310.66	20.000
0441*	Single biopsy—one (1) breast	194.91	20.000
0439*	Two (2) or more biopsies through separate incisions, one (1) breast	309.32	20.000
0447	Bilateral breast biopsies	347.38	20.000
0438	Sentinel lymph node biopsy in breast neoplasm	562.84	21.375

Note: *1) When one (1) or more of the procedures (0438, 0442, 0457, 0443, 0471, 2658) are performed by the same surgeon under the same anesthetic in addition to sentinel lymph node biopsy, the procedure with the highest fee shall be paid at 100% and the remaining procedures at 75%.*

2) When more than one (1) lymph node basin identified as having a sentinel node (separate surgical site) at the same anesthetic—claim 2nd sentinel at 75% in addition.

3) Completion of axillary node dissection following a positive sentinel node biopsy on final pathological diagnosis not at the same anesthesia—claim tariff 2658 at 100% regardless of time interval.

INCISION

0114*	Superficial abscess drainage	37.04	20.000
0431	Mastotomy with exploration and drainage of deep abscess	150.37	20.000

REVISION OR REPAIR

Note: *These procedures have certain restrictions under the Regulations when done as elective surgery. To be certain that the case is covered, written approval from the Minister should be obtained before the procedure is undertaken.*

No Previous Breast Surgery

0450	Reduction mammoplasty, unilateral	534.21	21.375
0451	Reduction mammoplasty, bilateral	952.63	21.375
0452	Balancing breast surgery, where there has been ablative surgery on the opposite side	534.21	21.375
0453	Augmentation mammoplasty, unilateral, with prosthesis	414.76	21.375
0454	Augmentation mammoplasty, bilateral, with prosthesis	738.50	21.375

Following Previous Breast Surgery

Note: *1) The following are insured services if the previous breast surgery was an insured service.*

2) The treatment of complications of previous cosmetic (uninsured) breast surgery will be approved only for symptomatic physical disorders. Additional cosmetic procedures including the procurement and replacement of secondary prosthesis are not insured.

			UNIT VALUE
0455	Reconstruction mammoplasty—definitive, unilateral with permanent prosthesis	534.93	21.375
0456	Replacement mammoplasty—two (2) stages, unilateral, first stage, insertion of tissue expander, subcutaneous	464.24	21.375
0458	submuscular	464.24	21.375
0459	Second stage—removal of tissue expander and insertion of prosthesis	307.98	21.375
0460*	Inflation of tissue expander per visit; each additional expander to a maximum of three (3) per visit, add 50%	22.49	21.375
0461*	Breast capsulotomy closed, no anesthetic—local	12.26	20.000
0462*	general anesthetic	79.58	20.000
0463	Breast open capsulotomy with or without replacement of breast prosthesis	293.61	20.000
0473	Capsulectomy	315.45	20.000
0464	Breast total capsulectomy and replacement mammoplasty	***By Report***	20.000
0465	Breast mound reconstruction latissimus dorsi, myocutaneous flap	1,195.44	22.750
0466	vertical rectus abdominis myocutaneous flap	713.93	22.750
0467	upper transverse rectus abdominis myocutaneous flap	1,004.24	22.750
0468	with lower transverse abdominis flap	1,288.60	22.750
0469	Breast mound creation by soft tissue (claimable in addition to tariff 0468 only)	129.40	22.750
0474	Repair of abdominal defect—same surgeon	243.03	22.750
0475	different surgeon	396.88	22.750
0476	Revision of breast mound	357.20	22.750

NIPPLE AND AREOLA RECONSTRUCTION

NIPPLE

0307	Full thickness graft	373.86	20.000
0323	Composite graft (full thickness of external ear or nasal alae)	335.95	20.000
0286	Local flap	263.48	20.000
0393	Other methods	***By Report***	20.000

			UNIT VALUE
AREOLA			
0303	Split thickness graft	276.38	21.375
0419	Tattooing areola	***By Report***	20.000
0429	Other methods	***By Report***	20.000
COMBINED SURGERY			
	Subcutaneous mastectomy for benign breast disease and immediate insertion of permanent mammary prosthesis		
0477	unilateral—one (1) surgeon	471.83	20.000
RESECTION			
0448	Removal of subareolar button, male	266.10	20.000
0449	Subcutaneous mastectomy, male or female	424.90	20.000
0445	Excision of cyst, fibro adenoma or other benign tumor, aberrant breast tissue, duct lesion, nipple lesion (including any other partial mastectomy) unilateral	194.91	21.375
0444	bilateral	347.38	21.375
0442	Partial mastectomy (lumpectomy) for malignancy	303.60	21.375
0443	Partial mastectomy (lumpectomy) & axillary node dissection	836.32	21.375
0457	Simple complete mastectomy	460.19	21.375
0471	Modified radical mastectomy	883.66	21.375
0470	Radical mastectomy	906.63	21.375
0446	Excision of breast tumor including chest wall	513.81	21.375
0472	Removal of pectoral muscles, subsequent for recurrence	200.69	21.375
2658	Axilla dissection alone	596.89	21.375
0489	**Unlisted or Unusually Complicated**	***By Report***	21.375

MUSCULOSKELETAL SYSTEM

These benefits cannot be correctly interpreted without reference to the Rules of Application.

BONES

Benefits include the application of first cast or traction device and subsequent casts required for three (3) weeks.

			UNIT VALUE
0549*	Biopsy, needle, vertebra (x-ray control)	212.56	21.375
0551*	excision, femur, humerus, pelvis, radius, skull, tibia, vertebra	293.15	20.000
0550*	other bones	204.50	20.000
	Note: *Biopsy preceding definitive surgery, 50% of listed benefit.*		
0501*	Bone marrow aspirations, single or multiple, any number of sites, at the same sitting	49.89	20.000
0503*	curette	49.89	20.000
0504*	Bone marrow biopsy by trephine, single or multiple sites, at the same sitting, with or without marrow aspirations, with or without local anesthesia, total	164.11	20.000
0506*	professional	79.43	20.000
0507*	Harvesting Hemipelves and Long Bones for Bone Bank from Cadavers, initial bone, all inclusive benefit, additional bones, each to be paid at 50% of tariff 0507	139.60	

GUSTILLO FRACTURE

0990	Gustillo I, less than 1 cm add,	30.60
0991	Gustillo II, equal to or greater than 1 cm add,	76.50
0992	Gustilo III, equal to or greater than 10 cm or regardless of the wound size at least one of the following conditions is met; high energy impact, extensive soft tissue injury and/or contamination, periosteal stripping, severe communition or segmental pattern, require soft tissue transfer, presence of a vascular injury, add.	408.00
0993	Irrigation, Drainage and/or Debridement for Postoperative Infection or open fracture payable per 15 minutes or major portion thereof	141.65

Notes:

1) *The assignment of the grade of an open fracture is dependent on several factors as is ultimately and most accurately done at the time of surgery.*
2) *The most severe factor decides what grade is assigned to the injury.*
3) *0990, 0991 or 0992 are payable at the time of initial reduction or fixation.*
4) *0993 may only be claimed when the procedure is done in the operating room.*
5) *0993 may only be claimed when any of 0990, 0991 or 0992 have previously been claimed.*
6) *0993 may be claimed once every second day.*

MUSCULOSKELETAL ONCOLOGY SURGICAL SERVICES

			UNIT VALUE
0575	Biopsy of suspected sarcoma, resection of a complex bone, and/or complex soft tumour tissue(s), per 15 minutes	137.19	25.500

Note: *1) Limited to Fellowship trained musculoskeletal surgical oncology specialists as approved by Shared Health CMO.*

2) Where appropriate, bone biopsies to be claimed under tariff 0550 or 0551.

BONE WIRING, ETC.

0595*	Tongs or Caliper, insertion (Independent Procedure)	222.83	20.000
0593*	Metal pin (Steinmann pin), insertion	83.49	20.000
0519*	Removal, pin or wire, closed	44.97	20.000

Note: *Payable at 100% whenever the hardware is removed.*

0520*	Open removal of plates, pins, wires, screws, etc., one (1) incision	153.97	20.000
0521*	two (2) incisions	153.97	20.000
0523*	three (3) incisions	219.71	20.000
0591*	Wire (Kirschner wire), insertion	104.98	20.000
0525*	**Unlisted or Unusually Complicated**	***By Report***	20.000

ALTERATION OF LIMB LENGTH

0654	Epiphyseal arrest—stapling or epiphysiodesis, femur	506.86	21.375
0655	tibia and fibula	533.95	21.375
0656	femur, tibia and fibula combined	726.09	21.375
0659	Hemi-epiphyseal arrest—for knock-knee or bow leg, femur or tibia	366.08	21.375
0661	femur and tibia	493.26	21.375
0611	Osteoplasty, shortening of bone, femur, humerus, tibia	723.05	21.375
0612	radius, ulna	363.30	21.375
0613	other bones	269.66	21.375
0614	lengthening of bone, femur, tibia and fibula	820.66	21.375
0517	Removal of staples, two (2)	105.51	20.000
0518	three (3) or more	153.20	20.000

BONE GRAFT

Osteoperiosteal graft, periosteal graft, includes obtaining and placing of graft

0624	carpal scaphoid	482.59	20.000
0619	chin	230.57	21.375
0625	clavicle	364.07	21.375

			UNIT VALUE
0617	femur	530.76	21.375
0617	humerus	530.76	21.375
0619	malar prominences	230.57	21.375
0617	mandible, major portion	530.76	21.375
0619	nose	230.57	21.375
0618	radius	364.07	20.000
0617	radius and ulna	530.76	21.375
0615	skull	506.03	21.375
0617	tibia	530.76	21.375
0623	tibia—medial malleolus	255.00	21.375
0618	ulna	364.07	20.000
0620	other bones	204.61	21.375
0622	Cartilage graft—to ear, face, nose or skull	412.34	21.375

EXCISION OF BONE

0558	carpus, proximal row	440.93	20.000
0557	single bone	281.14	20.000
0552	clavicle—partial	261.73	21.375
0553	total	510.31	21.375
0560	coccyx	380.35	21.375
0559	femur, head and neck	408.10	20.000
0556	fibula—partial or total	269.79	20.000
0559	humerus, head	400.10	20.000
0563	metatarsal—partial	233.94	20.000
0564	total	233.94	20.000
0561	patella—partial or total	343.26	20.000
0555	radius—head	372.21	20.000
0555	styloid process	372.21	20.000
0568	sesamoid, one (1) or more, unilateral	260.49	20.000
0554	talus	473.12	20.000
0570	tarsal scaphoid, accessory	242.00	20.000
0572	ulna, lower end	356.25	20.000

OSTEOMYELITIS

0510	acute drainage of bone	323.89	20.000
	Chronic sequestrectomy minor (no anesthetic)	F/S	

			UNIT VALUE
0576	major, craterization, guttering or saucerization of bone; diaphysectomy, including closed irrigation of femur, humerus, pelvis, tibia, fibula, radius, ulna	424.90	21.375
0577	other bones	387.30	20.000

Excision of bone cyst, chondroma or exostosis

0566	femur, humerus, pelvis, tibia	417.49	20.000
0565	fibula, radius, ulna	345.74	20.000
0567	other bones	297.99	20.000

OSTEOTOMY

Cutting, division or transection of bone with or without fixation

0524	calcaneum (Dwyer's operation)	496.71	20.000
0526	clavicle	432.79	21.375
0528	glenoid—anterior or posterior	790.50	22.750
0532	femur, subtrochanteric	766.72	21.375
0534	supracondylar	923.52	21.375
0527	humerus	718.22	21.375
0539	pelvis, for congenital dislocation of hip	926.93	22.750
0541	for ectopia vesicae	1,000.90	20.000
0530	radius (malunited Colles' fracture)	607.28	20.000
0543	spine, for ankylosing spondylitis	1,048.79	22.750
0536	tibia	644.91	21.375
0531	ulna	496.71	20.000
0537	lesser bones (fibula, metatarsals, etc.)	332.60	20.000
0580	Radical resection of bone for tumor with bone grafting, if required, maxilla, femur, humerus, pelvis, scapula and tibia	1,044.11	22.750
0581	other bones	482.81	22.750
0582	**Unlisted or Unusually Complicated**	***By Report***	22.750

CRANIOFACIAL SURGERY

Note: *Those benefits denoted by + include harvesting of bone and cartilage grafts.*

0583+	Lefort II maxillary osteotomy and advancement	1,602.27	25.500
0584	Onlay bone grafts to face when not part of standard osteotomy for reconstruction, maxilla—unilateral	431.60	25.500
0585	bilateral	463.08	25.500
0586	zygoma—unilateral	369.38	25.500
0587	bilateral	502.64	25.500
0588	frontal—unilateral	531.24	25.500

			UNIT VALUE
0589	bilateral	564.19	25.500
0590	Forward bilateral osteotomy of the zygoma including bone graft	260.64	25.500
0592+	Bilateral periorbital correction, Treacher-Collins Syndrome with or without bone grafts (extracranial)	1,576.21	25.500
0594+	Bilateral periorbital correction, Treacher-Collins Syndrome with skull and muscle transpositions (includes skull reconstruction—intracranial)	1,995.50	25.500
0596+	Lefort III total maxillary advancement	2,227.34	25.500
0597+	Lefort III and subcranial hypertelorism and correction	2,831.92	25.500
0598+	Lefort III and Lefort I maxillary advancement	2,590.85	25.500
0599+	Lefort II, subcranial hypertelorism correction, Lefort I maxillary advancement	2,652.00	25.500
0600+	Upper Lefort III advancement without occlusal change, unilateral	891.12	25.500
0602	Forehead advancement (bone grafts not included), unilateral	1,317.73	25.500
0603	bilateral	1,602.27	25.500
0616	Mandibular osteoplasty—for prognathism or micrognathism, one (1) or two (2) stages	950.74	22.750
5996	Intra-operative monitoring of cranial/facial nerves remote from the skull base, add	145.06	
	Note: *5996 may only be claimed in addition to the following tariffs, 0616, 2666, 2927, 2934, 4972, 5957, 5971, 5973, 5974, 5976, 5977, 5992, and 5995*		
0604+	Cranial vault reshaping—anterior or posterior half	1,692.57	25.500
0605+	Total cranial vault reshaping	1,994.00	25.500
0606	Medial transnasal canthopexy—unilateral	452.93	25.500
0607	when done in conjunction with another procedure	245.49	25.500
0608	Lateral canthoplasty—unilateral	280.11	25.500
0610	when done in conjunction with another procedure	400.70	25.500
0621+	Hypertelorism correction, intracranial approach	2,145.91	25.500
0626+	subcranial U osteotomies	1,989.15	25.500
0627+	medial orbital wall osteotomies	1,155.88	25.500
0628+	medial and lateral orbital wall osteotomies	1,789.15	25.500
0629+	Orbital dystopia—intracranial approach	1,802.85	25.500
0630+	extracranial approach	1,623.60	25.500
0631	Four (4) wall orbital decompression for malignant exophthalmos	1,839.06	25.500
0648	Two (2) wall orbital decompression	859.24	22.750
0632	Late correction traumatic enophthalmos (Tessier Technique, total periorbital stripping bone grafts)—intracranial	1,844.06	25.500
0633	extracranial	1,445.29	25.500
0634	Harvesting of bone graft when not included—iliac bone graft	201.09	21.375
0637	rib graft—one (1) rib, add	311.56	21.375
0638	each subsequent rib, add	117.80	21.375

0639	costochondral or chondral graft—one (1) rib, add	229.68	21.375
0640	each subsequent rib, add	145.79	21.375
0641	split cranial graft, add	192.68	21.375
0649	Dental Model Fabrication (obtaining a dental impression, pouring and shaping the model)	198.05	21.375
0650	Dental Model Surgery and Splint Fabrication (mounting dental model on articulator, fabricating, molding and polishing the splint)	198.05	21.375

Tooth Extraction (per tooth)

0651	Impacted, each, add to surgical fee	165.60	21.375
0652	Non-Impacted, each, add to surgical fee	110.42	21.375

Note: *1) Payable only as add-ons to maxillo-facial procedures, listed in Section F under the headings Craniofacial Surgery and Fractures – Facial Bones, and tariffs 2790, 2788, and 2885.*

2) Each tooth extracted is payable at 100%.

SPINE

ANTERIOR AND POSTERIOR PROCEDURES

Note: *When anterior and posterior spinal procedures are performed on the same day, same anesthetic, the higher fee is payable at 100% and the lesser fee is payable at 85%. Notwithstanding that the lesser fee is payable at 85%, all procedures that include the word "add" are to be paid at 100%.*

SPINE APPROACH

1230 Trans abdominal or retroperitoneal approach to spine 456.12

Note: *Benefit payable when spinal surgical service(s) is performed by a different surgeon.*

ANTERIOR INSTRUMENTATION

Cervical C2-C7

			UNIT VALUE
1105	two (2) vertebrae	1,177.16	25.500
1106	add on per additional vertebra	220.83	

Cervico-Thoracic C7-T4

1107	two (2) vertebrae	1,082.42	25.500
1108	add on per additional vertebra	270.61	

Dorsal

0645	Anterior Instrumentation of Spine and/or Osteotomy, via chest	1,037.51	25.500
0646	via abdomen	1,273.33	22.750
0647	via chest and abdomen	1,172.37	25.500

DECOMPRESSION

Cervical-Thoracic-Lumbar

5203	Intervertebral discs, excision anterior approach, cervical	1,272.76	22.750
5205	Laminectomy–laminae only for decompression of the spinal cord and nerve roots unilateral–first level	1,033.19	25.500
5200	bilateral, first level	1,138.95	25.500
5207	Laminectomy–for lesion, laminae only for decompression of spinal cord or meninges unilateral–first level	1,239.85	25.500
5204	bilateral, first level	1,317.84	25.500
5211	each additional vertebral level (unilateral or bilateral) add to 5205, 5200, 5207 or 5204	251.32	25.500
5209	Laminotomy, cervical	1,112.92	25.500

		UNIT VALUE	
1074	Excision of lumbar intervertebral disc, one (1), all methods, any approach e.g. minimally invasive, includes all associated bone and soft tissue procedures e.g. laminotomy, foraminotomy, laminectomy, facetectomy, fat graft, microscope, fluoroscopy	1,255.09	25.500
1073	more than one (1)	1,540.35	26.875
1109	Vertebrectomy including disc and adjacent end plates, add	1,910.61	26.875
1110	per additional vertebra, add	378.88	
1111	Total disc excision with end plates for fusion or disc replacement, add	957.68	26.875
1112	per additional vertebra, add	310.95	
1113	Partial vertebrectomy, add	650.73	26.875
1114	Posteriolateral decompressions of the vertebral body–must include lamina, and complete laminectomy and a portion of facets, pedicles, unilateral–first level, add	1,085.47	25.500
1115	bilateral, first level, add	1,350.74	25.500
1220	each additional vertebral level (unilateral or bilateral), add to 1114 or 1115	432.94	

FUSION-CERVICAL

POSTERIOR FUSION

1116	Occipito-cervical fusion (includes wires, screws and graft when necessary)	2,470.83	26.875
1117	add on per vertebra below C2	276.01	
1118	C1-C2 fusion—wires and graft	618.12	26.875
1119	C1-C2 fusion including transarticular screws and wires	1,311.90	26.875
1120	add on flat bone graft	270.61	

CERVICO-THORACIC-LUMBAR

0636	Spine, two (2) vertebrae, (e.g. lumbo-sacral)	902.30	26.875
0635	three (3) to five (5) vertebrae	1,241.60	26.875
0642	More than five (5) vertebrae	1,529.80	26.875
1121	Posterior or Posteriolateral fusion with instrumentation including pedicle screws, two (2) vertebrae	1,473.90	26.875
1122	add on per additional vertebra	276.01	
1123	add on per Sacral vertebra (maximum per patient $3,000.00)	331.19	

ALIF OR PLIF
Alif-(anteriorlumbar interbody fusion)

Plif-(posteriorlumbar interbody fusion)

			UNIT VALUE
1124	Vertebra Replacement–with autogenous or allograft bone, cement, tri-cortical bone and/or cage per vertebra, add	386.48	25.500
1219	Partial vertebral replacement–with autogenous or allograft bone, cement, tricortical bone and/or cage per vertebra, add	190.59	
1126	Intervertebral disc replacement any type for radical disc excision–tricortical strut graft, autograft, allograft, bone cement prosthetic with or without cage, per vertebra, add	568.67	25.500
1171	Artificial disc insertion	2,096.00	25.500
1179	each additional level replaced, add	825.39	25.500

Anterior Release—includes discectomy and section of longitudinal ligament including open or thoroscopic approach, through posterior or posteriolateral approach

1128	one (1) intervertebral disc space	721.14	25.500
1129	two (2)—three (3) intervertebral disc spaces	2,087.71	25.500
1130	four (4)—six (6) intervertebral disc spaces	3,494.23	25.500
1131	Greater than six (6) intervertebral disc spaces (per disc space) (maximum per patient including fusion $3,000.00), add	165.60	25.500
1132	Fusion with anterior release with morsellized non-structural bone graft per intervertebral disc space, add	262.60	25.500

BONE GRAFT
Procurement and application of graft from remote site

1100	Morsellized bone graft (allograft, not synthetic bone graft), to one or more sites, add	220.78	
1133	Onlay graft for posterior lateral fusion, add	276.01	22.750

MISCELLANEOUS

1134	Laminoplasty	824.16	22.750
1135	add on per additional vertebra	206.04	
1136	Odontoidectomy, transoral with microscope	1,545.30	26.875
1139	Open Vertebroplasty, posterior approach with augmentation of bone with autograft, bone cement or bone substitute	1,298.92	26.875
1140	Odontoid fracture–open reduction and interior fixation with screw	1,236.24	26.875

		UNIT VALUE	
1146	Multi–vertebral level saucerization of spinal wound with re-opening of the initial incision down to the spine for major infection, drainage of hematoma, including debridement, add	541.21	26.875
	Note: *1) Where required, re-instrumentation may be claimed in addition to tariff 1146.*		
	2) Payable in the post–operative period.		
1147	Intra-operative ultrasound, add	163.95	
1148	MEP/SSEP electro-physiological monitoring, primary spine surgeon, add	259.44	
1169	MEP/SSEP electro-physiological monitoring, non-operating physician per hour or major portion	184.01	
1209	Removal of hardware (plates, pins, wires, screws, etc.) from the spine, add	255.00	
	Note: *1) Not payable for scar excision or exploration of the fusion mass.*		
	2) Where required, re-instrumentation may be claimed in addition to 1209.		
1210	Complete Spinal Duraplasty requiring application of a graft for degenerative or traumatic tears (autologous, allogenic, synthetic), add	295.65	

FRACTURES

These benefits cannot be correctly interpreted without reference to Rules of Application 34 to 42.

Note: *In compound fractures requiring closed reduction $47.00 may be added to the fee for closed reduction.*

HEAD

Skull, non operative depressed with operation – See Nervous System

FACIAL BONES

0686	Nasal, simple, closed reduction with or without nasal packing or splinting	117.19	21.375
0687	compound, closed reduction	175.24	21.375
0688	simple or compound, open reduction	425.73	21.375
0691	Malar, simple, closed reduction	87.00	20.000
0693	simple or compound, depressed, open reduction	496.40	21.375
0694	multiple surgical procedures	627.19	20.000
0696	Maxilla, simple, closed reduction	330.34	20.000
0699	simple or compound, closed reduction with wiring of teeth	438.92	21.375
0701	simple or compound, open reduction with wiring of teeth or local fixation	588.55	21.375
0703	Mandible, simple, closed reduction	418.26	20.000
0704	simple or compound, closed reduction and wiring of teeth	371.33	21.375
0705	simple or compound, open reduction	615.75	21.375
0706	skeletal pinning with external fixation	494.24	21.375

SPINE AND TRUNK

			UNIT VALUE
0739	Clavicle, closed reduction—child	62.53	21.375
0740	adult	83.91	21.375
0742	open reduction	489.65	21.375
0733	Sacrum, reduction, closed or open	***By Report***	21.375
0734	Ribs, where operative procedure necessary	***By Report***	21.375
0754	Scapula, open reduction	568.96	21.375
0757	Sternum, reduction, closed or open	***By Report***	21.375
0720	Vertebra, process, one (1) or more, body, closed reduction	388.59	21.375
0723	open reduction, with or without plating or grafting	925.02	22.750

PELVIS
(Ilium, ischium, pubis including acetabulum)

0770	Pelvis, closed reduction, with traction	518.14	21.375
0771	open reduction	881.39	26.875
0772	Acetabular fracture, lips, open reduction	1,156.97	26.875
0773	one (1) pillar, open reduction	1,205.13	26.875
0774	two (2) pillars, open reduction	2,115.41	26.875

UPPER EXTREMITY

0780	Humerus, neck, closed reduction	162.20	20.000
0782	open reduction	581.79	21.375
0785	shaft, closed reduction	187.34	20.000
0787	open reduction	628.99	21.375
0789	supracondylar or dicondylar, closed reduction	269.76	20.000
0790	open reduction	690.83	21.375
0792	medial or lateral condyle, closed reduction	176.52	20.000
0794	open reduction	526.20	21.375
0809	Radius, head or neck, closed reduction	158.50	20.000
0801	open reduction or excision	464.25	21.375
0803	shaft, closed reduction	137.84	20.000
0805	open reduction	435.25	21.375
0807	distal end (e.g., Colles'), closed reduction	150.98	20.000
0811	skeletal pinning, with external fixation	349.29	21.375
0810	open reduction	475.60	21.375
0813	Ulna, olecranon or shaft, closed reduction	126.46	20.000
0816	open reduction or excision	384.50	21.375

			UNIT VALUE
0818	with dislocation of radial head (Monteggia fracture), closed reduction	245.86	20.000
0819	open reduction	502.95	21.375
0821	Radius and ulna, closed reduction	211.92	20.000
0823	open reduction	570.88	21.375
0830	Carpal bone, open reduction with or without fixation	570.42	21.375
0842	Metacarpal, closed reduction	120.38	20.000
0848	skeletal pinning with external fixation	221.39	21.375
0844	open reduction	356.76	21.375
0852	Phalanges, fingers or thumbs, closed reduction	119.86	20.000
0854	open reduction	356.86	21.375

LOWER EXTREMITY

0865	Femur, neck, closed reduction, cast or traction	521.85	20.000
0868	open reduction with internal fixation	759.55	22.750
0870	prosthetic replacement	679.73	22.750
0877	slipped upper femoral epiphysis, closed reduction, cast or traction	464.11	20.000
0884	open reduction with internal fixation by pin, pins or bone graft	768.48	22.750
0879	reconstruction	812.83	22.750
0872	intertrochanteric, closed reduction	453.03	20.000
0874	open reduction	722.73	22.750
0881	shaft or supracondylar, closed reduction	368.66	20.000
0882	skeletal pinning with external fixation	430.42	22.750
0883	open reduction	827.61	22.750
0885	condyle or condyles, closed reduction	265.79	20.000
0887	open reduction	863.36	21.375
0897	Patella, open reduction	375.67	21.375
0911	Tibia, condyle, plateau or spines, closed reduction	216.65	20.000
0912	open reduction	717.55	22.750
0901	shaft, closed reduction	233.35	20.000
0904	open reduction	563.30	22.750
0907	medial malleolus, closed reduction	162.00	20.000
0910	open reduction	304.89	22.750
0914	Fibula, shaft, or lateral malleolus, closed reduction	161.12	20.000
0916	open reduction	319.98	21.375
0926	Tibia and fibula, shaft, closed reduction	217.07	20.000
0930	skeletal pinning with external fixation	362.63	22.750

		UNIT VALUE
0928	open reduction 669.48	22.750
0933	bimalleolar, closed reduction 234.21	20.000
0935	open reduction 602.16	21.375
0938	trimalleolar, closed reduction 233.03	20.000
0941	open reduction 667.45	21.375
0942	Tibial plafond, open reduction 896.48	21.375
0936	Talus, closed reduction 168.70	20.000
0937	open reduction 570.58	21.375
0961	Calcaneum, closed reduction 159.63	20.000
0964	skeletal pinning with external fixation 420.68	20.000
0963	open reduction 731.85	21.375
0944	Tarsal bones, except talus and calcaneum, closed reduction 146.39	20.000
0946	open reduction 494.75	21.375
0967	Metatarsal, closed reduction 98.24	20.000
0970	open reduction 278.15	20.000
0980	Phalanges, closed reduction 126.92	20.000
0982	open reduction 365.52	20.000
0989	**Unlisted or Unusually Complicated** ..... ***By Report***	21.375

GUSTILLO FRACTURE

0990	Gustillo I, less than 1 cm add, ... 30.60	
0991	Gustillo II, equal to or greater than 1 cm add, ... 76.50	
0992	Gustilo III, equal to or greater than 10 cm or regardless of the wound size at least one of the following conditions is met; high energy impact, extensive soft tissue injury and/or contamination, periosteal stripping, severe communition or segmental pattern, require soft tissue transfer, presence of a vascular injury, add. 408.00	
0993	Irrigation, Drainage and/or Debridement for Postoperative Infection or open fracture payable per 15 minutes or major thereof 141.65	

Notes: *1) The assignment of the grade of an open fracture is dependent on several factors as is ultimately and most accurately done at the time of surgery.*

2) The most severe factor decides what grade is assigned to the injury

3) 0990, 0991 or 0992 are payable at the time of initial reduction or fixation.

4) 0993 may only be claimed when the procedure is done in the operating room.

5) 0993 may only be claimed when any of 0990, 0991 or 0993 have previously been claimed.

6) 0993 may be claimed once every second day.

			UNIT VALUE

JOINTS

1049*	Puncture for aspiration and/or injection of medication into joint, bursa, or tendon sheath	23.39	20.000
1050*	Arthroscopy (with or without biopsy), large joint	317.45	20.000
1051*	small joint (M.P. or I.P.)	263.53	20.000
1053*	small joint	263.53	20.000
1085	Meniscus of temporomandibular joint	296.70	21.375

ARTHROSCOPIC PROCEDURES

SHOULDER

1025	Diagnostic arthroscopy shoulder (independent procedure)	321.47	22.750
1027	Arthroscopy shoulder with therapeutic intervention including debridement, removal loose body, drilling	519.32	22.750
1028	Synovectomy shoulder–complete	527.11	22.750
1029	Subacromial decompression	333.43	22.750
1030	Distal clavicle excision	399.04	22.750
1031	Repair sternoclavicular, acromioclavicular dislocation (acute)	407.29	22.750
1032	Stabilization for recurrent sternoclavicular, acromioclavicular instability (independent procedure)	703.55	22.750
1033	Posterior glenohumeral stabilization (independent procedure)	703.55	22.750
1034	Anterior glenohumeral stabilization (independent procedure)	703.55	22.750
1035	Superior Labrum Anterior–Posterior (SLAP) repair (independent procedure)	595.32	22.750
1036	SLAP and anterior or posterior glenohumeral stabilization (independent procedure)	838.90	22.750
1037	Rotator cuff repair	540.75	22.750
1038	Rotator cuff repair, and/or SLAP repair, and/or anterior glenohumeral stabilization, and/or posterior glenohumeral stabilization	1,039.11	22.750
1039	Revision rotator cuff repair	1,055.39	22.750
1040	Shoulder stabilization with bone and/or tendon graft (allograft, autograft)	947.12	22.750
1041	Rotator cuff repair with muscle transfer any type (e.g. latissimus dorsi for massive cuff tear)	947.12	22.750
1042	Rotator cuff repair with tendon graft–allo/autograft or synthetic	1,055.39	22.750
1043	Circumferential glenohumeral stabilization (Glenoid labrum)	1,055.39	22.750
1044	Glenohumeral thermal stabilization	616.26	22.750
1045	Major release glenohumeral joint (for arthrofibrosis/adhesive capsulitis)	703.55	22.750

ELBOW (ARTHROSCOPIC)

1390	Arthroscopy, elbow with therapeutic intervention	355.94	22.750

		UNIT VALUE
1391	removal loose bodies, add	74.69
1392	synovectomy, add	74.69
1393	exostectomy coronoid, add	74.69
1394	exostectomy coronoid fossa, add	74.69
1395	exostectomy olecranon, add	74.69
1396	exostectomy olecranon fossa, add	74.69
1397	microfracture, add	74.69
1398	excision or repair OCD lesion, add	74.69

Note: *1) Each add-on is payable at 100%.*

2) A maximum of five (5) add-ons may be claimed per elbow for the same patient, same day.

WRIST

1820	Arthroscopic radiocarpal joint, includes midcarpal joint and/or distal radioulnar joint	396.80	21.375
1821	TFCC tear debridement, add	74.69	
1822	chondral shaving of distal radius, add	74.69	
1823	chondral shaving of carpus, add	74.69	
1824	partial synovectomy, add	74.69	
1825	complete synovectomy for rheumatoid arthritis, must include midcarpal and distal radioulnar joint(s), add	74.69	
1826	microfracture, add	74.69	
1827	distal ulna resection, add	74.69	
1828	TFCC and/or UT split repair, add	103.02	
1829	ganglionectomy, add	74.69	
1830	soft tissue capsular release, add	74.69	
1831	radial styloidectomy, add	74.69	

Note: *1) Each add-on is payable at 100%.*

2) A maximum of five (5) add-ons may be claimed for the same patient, same day.

Ligament Repairs of the Wrist

1840	Direct ligament repair of distal radio-ulnar joint (includes dorsal and palmar ligament)	526.89	21.375
1841	Reconstruction of distal radio-ulnar joint, includes tendon wrap or weave	540.86	21.375
1842	Open triangulo fibrocartilage complex repair	526.89	21.375
1843	Total wrist arthroplasty or total distal radio-ulnar arthroplasty including soft tissue interposition using synthetic prosthesis	699.45	22.750
1844	Acute wrist ligament direct repair (including scapholunate or lunotriquetral ligament and pinning)	526.89	21.375

			UNIT VALUE
1845	Acute wrist ligament reconstruction with capsulodesis (including scapholunate or lunotriquetral ligament)	526.89	21.375
1846	Chronic wrist ligament reconstruction (including scapholunate or lunotriquetral ligament) includes capsulotomy of wrist, ORIF carpal bones and reconstruction of wrist ligament using tendon graft (includes tendon harvest)	669.63	21.375
1847	Posterior interosseous neurectomy, add	161.49	

Scaphoid Deformity

1848	ORIF or percutaneous screw fixation of non-displaced/minimally displaced carpal fracture	602.67	21.375
1849	Open scaphoid or lunate debridement and internal fixation for scaphoid or lunate non-union with vascularized pedicled bone flap	875.67	22.750

HIP

1470	Diagnostic hip arthroscopy (independent procedure)	393.57	22.750
1471	Arthroscopy, hip with therapeutic intervention, includes labral debridement, chondroplasty of acetabulum and/or femoral head	683.40	22.750
1481	labrum repair major, (two (2) or more implants), add	357.00	
1482	femoral neck osteoplasty, add	309.06	
1483	acetabular osteoplasty major, add	206.04	
1469	microfracture, add	74.69	
1474	loose body removal, add	74.69	
1475	labral repair minor, (one (1) implant), add	74.69	
1478	trochanteric bursectomy, add	74.69	
1479	release, iliopsoas tendon or iliotibial band, add	90.56	
1484	repair of abductor, unilateral, add	382.15	

Note: *1) Each add-on is payable at 100%.*

2) A maximum of five (5) add-ons (1469, 1474, 1475, 1478, and 1479) may be claimed for the same patient, same day.

3) 1481, 1482, 1483 and 1484 claimable in addition at 100%.

KNEE

1080	Arthroscopy knee joint	252.45	21.375
1081	meniscectomy or meniscal repair, add	74.69	
1083	chondral shaving of patella, add	101.66	
1084	chondral shaving of the trochlea, add	101.66	
1086	trimming of synovium, add	78.64	
1087	osteophyte trimming, add	101.66	
1088	microfracture, add	85.00	
1089	additional meniscectomy or meniscal repair (one), add	81.75	

		UNIT VALUE
1090	debride femoral condyle, add 101.66	
1091	debride tibial plateau, add 101.66	
1092	patellar retinacular release, add 103.97	
1094	removal of loose body, add 74.69	

Notes: *1) Each add-on is payable at 100%.*

2) A maximum of five (5) add-ons may be claimed per knee for the same patient, same day.

ANKLE

1670	Peritalar arthroscopy, regardless of portals used 372.58	21.375
1671	Second peritalar joint arthroscopy, performed in conjunction to ankle arthroscopy without redraping, add 242.71	
	Add-ons:	
1672	exostectomy tibia, add 74.69	
1673	exostectomy talus, add 74.69	
1674	exostectomy calcaneus, add 74.69	
1675	chondroplasty tibia, add 74.69	
1676	chondroplasty talus, add 74.69	
1677	chondroplasty calcaneus, add 74.69	
1678	synovectomy minor, add 74.69	
1679	synovectomy major (see Note 4), add 153.00	
1680	arthrolysis, add 74.69	
1681	microfracture tibia, add 74.69	
1682	microfracture talus, add 74.69	
1683	microfracture calcaneus, add 74.69	
1684	removal os trigonum, add 74.69	
1685	tenolysis, add 74.69	
1686	tendon debridement, add 74.69	

Note: *1) A maximum of five (5) add-ons may be claimed per joint for the same patient, same day.*

2) Tariffs for peritalar arthrodesis are payable in accordance with Surgical Rules of Application in addition to 1670 and 1671.

3) Tariffs for scoping add-ons are not payable for the joint that was arthrodesed.

4) Tariff 1679 is not payable with tariff 1678, and is only payable for infection, hemophilic arthropathy, rheumatoid arthritis, synovial chondromatosis and PVNS (pigmented villonodular synovitis).

MANIPULATION, (INDEPENDENT PROCEDURES)

Of joint under general anesthesia, not including reduction of dislocation, including application of cast or traction

			UNIT VALUE
1221*	Shoulder	96.11	20.000
1222*	Elbow	86.79	20.000
1223*	Wrist	86.79	20.000
1224*	Digits, one (1) or more, under anesthesia, where no other surgical procedure is performed	32.34	20.000
1226*	Hip	92.31	20.000
1227*	Knee	86.79	20.000
1228*	Ankle	86.79	20.000
1244*	Club foot with application of cast, unilateral, initial	38.66	20.000
1245*	subsequent	38.66	20.000
1246*	bilateral, initial	60.69	20.000
1247*	subsequent	60.69	20.000
1232*	Spine	77.89	20.000

ARTHRODESIS

Fusion of joint, with or without bone graft

			UNIT VALUE
1166	Shoulder	1,211.36	20.000
1167	Elbow	411.05	20.000
1168	Wrist	742.26	20.000
1170	Finger or thumb—one (1) joint	410.33	20.000
1173	Sacroiliac	705.94	21.375
1175	Hip	703.63	21.375
1176	Knee	940.57	20.000
1177	Ankle	783.13	20.000
1250	Subtalar Fusion	611.95	20.000
1252	Midfoot joint arthrodesis	517.80	20.000
1253	Additional midfoot joint, add	102.00	
1254	MTP Fusion	390.92	20.000
	Note: *Tariffs 1250, 1252, 1253 and 1254 include excision, fixation and any associated tendon transfers.*		
1185	Foot, triple arthrodesis, unilateral	862.64	20.000
1187	with tendon transplantation	1,040.71	20.000
1178	Toe, one (1) (50% for each additional toe)	311.17	20.000

ARTHRECTOMY

Excision of joint – See Arthroplasty

1065	Temporomandibular joint, unilateral	368.63	21.375
1595	Toes, multiple arthrodesis for claw foot, one (1) foot	446.75	20.000
1596	both feet	520.35	20.000
1181	Hallux rigidus	404.27	20.000
1183	Tarsal joint, one (1) or more	339.51	20.000
1184	Other joints, lower extremity	447.93	20.000
1190	Stabilization of joints by bone block	294.07	20.000
1191	Acromionectomy	378.57	21.375

ARTHROPLASTY

Plastic or reconstructive operation on joint, any type

Shoulder Arthroplasty

Note: *Includes, except where noted below, all associated bone and soft tissue procedures including partial acromionectomy, partial excision of end clavicle, osteotomy, synovectomy, injection of medications and rotator cuff repair.*

			UNIT VALUE
1200	Shoulder, total arthroplasty with glenoid and humeral components	937.79	22.750
1203	Shoulder arthroplasty with humeral component	791.71	22.750
1204	Shoulder, revision of one or both components of shoulder arthroplasty	1,605.83	22.750
1205	Shoulder revision to temporary arthroplasty using prostalac	1,282.40	22.750
1206	Shoulder, removal of one or both components of shoulder arthroplasty without replacement	1,071.41	22.750
1207	Autogenous, structural bone graft from another site, add	262.75	22.750
1208	Allogenous, structural bone graft, add	150.56	22.750

Elbow Arthroplasty

Note: *Includes, except where noted, below, all associated bone and soft tissue procedures including ligament balancing, neurolysis and nerve transposition and synovectomy.*

1180	Radial head arthroplasty only with implant	576.76	22.750
1182	Primary total elbow arthroplasty (2 or 3 components) includes synovectomy, excision of radial head and transposition of ulnar nerve	1,237.68	22.750

Revision Elbow Arthroplasty

1186	Revision total elbow arthroplasty–humeral component only	1,550.50	22.750
1188	Revision total elbow arthroplasty–ulnar component only	1,389.69	22.750
1189	Revision total elbow arthroplasty–radial head only	1,367.02	22.750
1192	Revision total elbow arthroplasty–humeral and ulnar or all three components	1,627.46	22.750
1193	Revision total elbow arthroplasty–humeral or ulnar and radial head	1,644.82	22.750
1194	Autogenous, structural bone graft from another site, add	202.54	22.750
1195	Allograft, structural bone graft, add	150.56	22.750

Revision Elbow Arthroplasty without Replacement

1196	Removal of one component without replacement	1,442.54	21.375
1197	Removal of two (2) or more components without replacement	1,428.84	21.375
1198	Elbow, flexor–plasty—Soft tissue correction of elbow flexion contracture	513.50	21.375

Distraction/Interposition Arthroplasty

Note: *Includes application of distraction and/or external fixation device.*

			UNIT VALUE
1172	using autogenous material, bone or soft tissue from another site	1,104.73	22.750
1174	using allograft material	775.02	22.750

Note: *Removal and revison arthroplasty includes all associated bone and soft tissue procedures including osteotomy, use of bone substitute, osteoset, nerve transposition and synovectomy. Applies only to tariffs 1186, 1188, 1189, 1192, 1193, 1196 and 1197.*

Hand and Wrist Arthroplasty

1143	Wrist	557.19	20.000
1144	Finger, one (1) joint	367.27	20.000
1145	four (4) fingers for rheumatoid disease, including synovectomy and redirecting of extensor tendons	1,220.63	20.000

CMC Arthroplasty

1236	Thumb CMC includes trapeziectomy and suspensionplasty	816.00	21.375
1237	CMC arthroplasty with implant	510.00	21.375
1238	MCP/IP joint arthroplasty with pyrocarbon or silicone components including extensor tendon centralization with or without collateral ligament reconstruction	652.80	21.375
1239	MCP joint replacement all four digits with silicone components	1,531.53	21.375
1240	Cubital Tunnel Release	511.32	21.375

Note: *Fees for 1236-1240 includes all associated bone and soft tissue procedures.*

Hip Arthroplasty

Rules: *1) All arthroplasty fees include associated bone and soft tissue procedures, including but not limited to synovectomy, ligament and tendon release and lengthening and repair, and injection of medications.*

2) Revision fees include insertion of PROSTALAC type components.

Note: *1) Repair of periprosthetic femoral fracture when done at the same time and the same incision as hip arthroplasty – add on 50% of fracture tariffs 0874 or 0883.*

2) Repair of periprosthetic femoral fracture when done at the same time as hip arthroplasty but through separate incision – add on 75% of fracture tariff 0883.

3) Repair of periprosthetic acetabular fracture at the same time and same incision as revision hip arthroplasty – add on 50% of fracture tariffs, 0772, 0773, or 0774.

1415	Total hip arthroplasty	929.04	22.750
1149	femoral head replacement type	691.37	22.750

			UNIT VALUE
1154	where previous uncemented AustinMoore prosthesis, cup or plates require removal, add	131.61	25.500
1414	Revision of hemi-arthroplasty (cemented AustinMoore or any other implant) to total hip	1,395.51	25.500
1416	Total hip arthroplasty with take down of arthrodesis	1,222.07	26.875
1417	Revision total hip arthroplasty with exchange of acetabular liner only	967.88	22.750
1418	Revision total hip arthroplasty with removal and replacement of modular head component	1,319.89	22.750
1419	Revision total hip arthroplasty with exchange of acetabualar liner and removal and replacement of modular head component	1,328.45	25.500
1420	Revision total hip arthroplasty with removal and replacement of one component	1,465.15	26.875
1421	Revision total hip arthroplasty with removal and replacement of both components	1,653.06	26.875
1422	Removal of hip prosthesis without replacement	1,151.92	22.750
1423	Bipolar hip arthroplasty	691.37	22.750
1424	Unipolar hip arthroplasty	691.37	22.750
1425	Resection, femoral head (e.g. Girdlestone procedure)	634.71	22.750
1426	Peri-acetabular osteotomy	1,490.53	26.875
1440	Structural bone graft and bone graft substitutes, including fixation of graft e.g. Tantalum type, to one or more sites, add	386.48	22.750
1442	Morsellized bone graft, to one or more sites, add	236.64	22.750
1444	Impaction bone graft to femur (Exeter/Ling technique), add	386.48	22.750
1446	Extended trochanteric osteotomy, add	220.83	22.750
1448	Non-structural bone substitute, to one or more sites, add	57.39	22.750

Note: *Tariffs 1440, 1442, 1444, 1446 and 1448 are add-ons that apply to Hip Arthroplasty only.*

Knee Arthroplasty

Rules: *1) All arthroplasty fees include associated bone and soft tissue procedures, including but not limited to synovectomy, ligament and tendon release and lengthening and repair, and injection of medications.*

2) Revision fees include insertion of PROSTALAC type components.

1402	Total knee arthroplasty, with patellar resurfacing	909.92	22.750
1403	Total knee arthroplasty without patellar resurfacing	909.92	22.750
1404	Unicondylar knee arthroplasty, medial or lateral compartment	901.27	21.375
1405	Patellar resurfacing only	729.08	21.375
1407	Total knee arthroplasty with removal of previous partial prosthesis	1,639.72	25.500
1408	Revision knee arthroplasty with removal and replacement of modular tibial bearing surface (with or without patellar revision)	1,365.42	25.500
1409	Revision of knee arthroplasty with removal and replacement of one or both femoral or tibial components (with or without patellar component revision)	1,615.51	25.500

			UNIT VALUE
1411	Removal of knee prosthesis with or without spacer insertion	889.01	25.500
1412	Removal of knee prosthesis with knee arthrodesis, with or without bone graft	1,772.72	25.500
1440	Structural bone graft and bone graft substitutes, including fixation of graft e.g. Tantalum type, to one or more sites, add	386.48	22.750
1442	Morsellized bone graft, to one or more sites, add	236.64	22.750
1444	Impaction bone graft to femur (Exeter/Ling technique), add	386.48	22.750
1449	Tibial tubercle osteotomy, add	210.16	22.750
1448	Non-structural bone substitute, to one or more sites, add	57.39	22.750

Note: *Tariffs 1440, 1442, 1444, 1448 and 1449 are add-ons that apply to Knee Arthroplasty only.*

Foot and Ankle Arthroplasty

1152	Ankle, distraction includes application of frame	996.87	21.375
1500	Total ankle arthroplasty	1,201.05	21.375
1501	Revision total ankle arthroplasty with exchange of liner	986.11	21.375
1502	Removal of ankle prosthesis with or without spacer insertion	942.53	21.375
1503	Revision of one or both components of ankle arthroplasty	1,697.77	21.375
1504	Removal of ankle prosthesis with ankle arthrodesis, with or without bone graft	1,928.53	25.500
1505	Total ankle arthroplasty with take down of arthrodesis	1,253.75	25.500
1506	Morsellized bone graft, to one or more sites, add	236.64	
1507	Impaction bone graft or structural bone graft to one or more sites, add	390.34	

Notes: *1) All arthroplasty fees include associated bone and soft tissue procedures including but not limited to synovectomy, ligament lengthening and injection of medications.*

2) Other procedures, e.g., subtular fusion, deltoid and/or lateral ligament repair, tendon repair and/or release and calcaneous osteotomy performed away from the ankle, at the same sitting, are claimable in accordance with the Surgical Rules of Application.

3) 1506 and 1507 are not claimable together. 1506 and 1507 may only be claimed as add-ons to tariffs 1500, 1503 and 1505.

1153	Toe, one (1) joint (50% for each additional)	279.08	20.000
1162	First Metatarsophalangeal joint, all methods including hallux valgus correction with bunionectomy and medial placation	360.57	20.000
1233	Proximal phalanx osteotomy, add	312.33	
1234	Shaft metatarsal osteotomy, add	312.33	
1235	1st TMT fusion, add	309.06	
1163	Reconstruction, all metacarpophalangeal joints, one (1) hand	891.17	20.000
1164	all metatarsophalangeal joints, one (1) foot	622.09	20.000
1165	both feet	1,067.22	20.000

ARTHROTOMY OR CAPSULOTOMY

With exploration, drainage, or removal of loose body, (e.g. for osteochondritis, foreign body or synovial biopsy).

			UNIT VALUE
1001	Shoulder	402.66	21.375
1002	Elbow	377.73	20.000
1003	Wrist	388.74	20.000
1017	Finger, one (1)	290.21	20.000
1006	Other joints of upper extremity	350.47	20.000
1007	Hip	479.61	21.375
1008	Knee	376.80	21.375
1010	Ankle	365.72	20.000
1026	Toe, great toe	325.44	20.000
1013	Other joints lower extremity	325.44	20.000

DISLOCATION

1251*	Dislocation, temporomandibular joint, closed reduction	51.75	20.000
1256	Vertebrae, cervical, closed reduction	592.06	21.375
1258	open reduction	592.06	22.750
1262	dorsal, simple, closed reduction	592.06	21.375
1264	open reduction	1,025.88	22.750
1267	lumbar, simple, closed reduction	259.61	21.375
1270	open reduction	1,025.88	22.750
1273	Clavicle, sternoclavicular, closed reduction	83.31	20.000
1275	open reduction	405.71	21.375
1278	acromioclavicular, closed reduction	138.94	20.000
1281	open reduction	370.36	21.375
1284	Shoulder, humerus, closed reduction	143.40	20.000
1286	open reduction	527.51	21.375
1288	Tuberosity transfer, for locked dislocation	838.90	22.750
1290	Elbow, closed reduction	136.45	20.000
1292	open reduction	423.00	20.000
1295	Wrist carpal, one (1) bone, closed reduction	134.60	20.000
1297	open reduction	422.18	20.000
1298	more than one (1) bone, closed reduction	153.91	20.000
1301	open reduction	422.18	20.000
1299	Club hand, congenital, open reduction	815.46	20.000
1304	Metacarpal, one (1) bone, closed reduction	76.93	20.000

1306	open reduction	294.07	20.000
	Finger, one (1) or more joints, closed reduction	F/S	
1317	open reduction	280.32	20.000
Thumb, closed reduction		F/S	
1328	open reduction	289.33	20.000
			UNIT VALUE
1332	Hip, closed reduction	235.51	20.000
1334	open reduction	570.27	21.375
Congenital, closed reduction		F/S	
1336	open reduction	993.27	21.375
1335	Open reduction congenital hip dislocation, includes open adduction tenotomy, arthrotomy hip, Psoas tendon lengthening	1,261.12	22.750
1337	Open reduction congenital hip dislocation with pelvic osteotomy, includes open adduction tenotomy, arthrotomy hip, Psoas tendon lengthening and pelvic osteotomy	1,873.31	25.500
1338	Open reduction congenital hip dislocation, includes open adduction tenotomy, arthrotomy hip, Psoas tendon lengthening, with femoral osteotomy	1,579.97	25.500
1339	Open reduction congenital hip dislocation, includes open adduction tenotomy, arthrotomy hip, Psoas tendon lengthening, with femoral and pelvic osteotomy	2,171.87	25.500
1344	Knee, closed reduction	135.49	20.000
1346	open reduction	380.60	21.375
	Patella, closed reduction	F/S	
1352	open reduction	379.32	20.000
1355	Ankle, closed reduction	166.59	20.000
1357	open reduction	346.30	20.000
1361	Tarsal, closed reduction	173.85	20.000
1363	open reduction	314.06	20.000
1371	Talotarsal, closed reduction	134.30	20.000
1373	open reduction	322.58	20.000
	Metatarsal, one (1) bone, closed reduction	F/S	
1378	open reduction	221.19	20.000
	Toe, one (1), closed reduction	F/S	
1387	open reduction	214.64	20.000

SUTURE

Capsulorrhaphy—suture or repair of joint capsule for recurrent dislocation

			UNIT VALUE
1201	Shoulder (independent procedure)	623.94	21.375
1202	Patella (independent procedure)	664.07	20.000
1211	Knee, repair/reattachment of collateral ligament, each	624.55	21.375
1212	Collateral ligament reconstruction	649.74	21.375
1213	Posterior cruciate ligament reconstruction	978.89	21.375
1215	Anterior cruciate ligament reconstruction	707.65	21.375
1214	Posterolateral corner reconstruction	787.59	21.375
1218	Ankle, reconstruction, collateral ligament, one (1)	405.59	20.000
1216	both	536.73	20.000
1217	Reconstruction, metacarpophalangeal or interphalangeal ligaments, both, one (1) finger	369.48	20.000

SYNOVECTOMY

1095	Shoulder	525.30	21.375
1093	Elbow	478.69	21.375
1101	Hip, complete	559.50	21.375
1102	Knee	481.15	21.375
1103	Ankle	423.11	21.375
1104	Wrist	413.89	21.375

BURSA

1401*	Drainage of infected bursa	75.61	20.000
1049*	Puncture for aspiration and/or injection of medication into joint, bursa, or tendon sheath	23.39	20.000
1406	Calcareous deposits, subdeltoid, removal	155.35	20.000
1410	trochanteric, removal	187.09	20.000
1430	Excision of bursa, radical, forearm, wrist or palm, (e.g. for Rheumatoid or Tuberculous tenosynovitis).	369.12	20.000
1436	Excision of bursa, ischial	210.42	20.000
1431	olecranon	191.97	20.000
1433	prepatellar	209.54	20.000
1435	subacromial	260.79	20.000

EXCISION

			UNIT VALUE
1562	Baker's cyst, synovial cyst of popliteal space, excision	409.30	21.375
1430	Bursa, forearm, radical excision, (e.g. for tenosynovitis fungosa, tuberculosis and other granulomas).	369.12	20.000

MUSCLES

Electromyogram – See Central Nervous System

1460*	Biopsy of muscle	109.35	20.000
1461*	Biopsy of muscle for malignant hyperthermia, three (3) or more	152.52	21.375
1450	Foreign body in muscle, removal, general anesthesia	***By Report***	20.000
1451	Muscle or fascial compartment release, per limb segment	427.53	20.000
	Note: *A maximum of two services per limb may be claimed.*		
1452	Gastrocnemius, recession, at calf	213.10	20.000
1453	at knee	254.46	20.000
1456	Scalenus anticus, division, with resection of cervical rib	445.97	21.375
1454	without resection of cervical rib	248.17	21.375
1458	Sternomastoid, division, for torticollis, open operation	351.66	20.000

TENDONS, TENDON SHEATHS AND FASCIA

1049*	Puncture for aspiration and/or injection of medication into joint, bursa, or tendon sheath	23.39	20.000

INCISION

1511	Tendon sheath, drainage, for acute tenosynovitis, one (1) digit	276.45	20.000
1514	single, palm and/or wrist, ulnar or radical bursa infection, in hospital	227.16	20.000
1519	trigger finger release	237.05	20.000

Tenolysis flexor tendon and/or extensor tendon(s) within palms, wrists or digits irrespective of the number of digits or incisions involved:

1540	Single tendon	242.10	20.000
1542	Two (2) to four (4) tendons	432.68	20.000
1543	Five (5) or more tendons	808.71	20.000
1544	Tenolysis flexor tendon with pulley preservation - first digit, add	82.42	
1545	Tenolysis flexor tendon with pulley preservation - second and subsequent digit, each, add	61.81	
1546	Tenolysis flexor tendon with capsulotomy - first digit, add	82.42	
1547	Tenolysis flexor tendon with capsulotomy – second and subsequent digit, each, add	61.81	

Note: *1) Manitoba will pay an additional $80 for the first digit, and $60 each for subsequent digit, where a pulley preservation of flexor tendon(s) is performed with the tenolysis on that digit.*

2) *Manitoba will pay an additional $80 for the first digit, and $60 each for subsequent digit, where a capsulotomy is performed with the tenolysis on that digit.*

3) *Tariffs 1544, 1545, 1546 and 1547 may only be claimed in addition to 1540, 1542 or 1543.*

4) *Tariffs 1544, 1545 may be claimed with tariffs 1546 and 1547 where both pulley preservation and capsulotomy are performed with the tenolysis on that digit.*

5) *Tariff 1017 may not be claimed in addition to tariffs 1540 – 1547.*

			UNIT VALUE
1521	Club foot, soft tissue correction, including tendoachilles lengthening	669.12	20.000
1522	Steindler release or plantar fasciotomy (for club foot)	235.92	20.000
1525	Humerus, lateral epicondyle, stripping for "Tennis Elbow"	446.08	20.000
1531	Iliotibial band, division, open operation	225.72	20.000
1534	Ilium, stripping (Soutter operation)	283.56	20.000
1535	Tenotomy, corrective, single digit, subcutaneous	201.56	20.000
1536	multiple	275.52	20.000
1541	hip adductors, open	314.67	20.000
1539	subcutaneous	203.78	20.000
1550	Ulnar Nerve Release	257.55	20.000
	Note: *May be claimed with other procedures.*		
5235	Decompression, median nerve at carpal tunnel, simple	243.89	20.000

EXCISION

1552	Tendon, or fibrous sheath, excision of lesion, including ganglion, digits only	218.40	20.000
1553	other locations	304.37	20.000
1570	Fasciotomy, single, palm or sole, subcutaneous	291.70	20.000
Fasciectomy			
1573	for Dupuytren's contracture, partial	446.03	20.000
1574	including finger extensions and vertical bands, radical	483.99	20.000

REPAIR

1616	Abdominal fascial transplant, bilateral	427.53	20.000
1640	Biceps tendon, ruptured, from insertion to elbow	451.41	20.000
1641	Elbow, flexor-plasty	577.64	20.000
1580	Extensor tendon, repair or suture, single, distal to wrist or ankle	250.29	20.000
1582	forearm or leg	294.84	20.000
1583	Flexor tendon, repair or suture, single, unless otherwise listed	391.73	20.000

			UNIT VALUE
1584	Peroneal Tendon Stabilization (includes all methods)	515.10	20.000
1612	Fascial graft, free, for reconstruction of tendon pulley or repair bowstring tendon, single (independent procedure)	315.55	20.000
1613	for reconstruction of tendon pulley or repair bowstring tendon to form gliding surface for tendons	240.09	20.000
1657	Iliopsoas transfer	521.54	20.000
1659	Long head of biceps, repair or tenodesis, ruptured	322.03	20.000
	Note: *Tariff 1659 may be claimed for open or arthroscopic procedure.*		
1632	Patellar advancement	454.52	20.000
1661	Pectoralis to biceps transfer (Clark's operation)	625.64	20.000
1633	Acute quadriceps or patellar tendon repair, ruptured, insertion	472.99	20.000
1634	Chronic quadriceps or patellar tendon repair	537.96	20.000
1655	Scapulopexy	377.05	21.375
1654	Supraspinatus tendon or musculotendinous cuff shoulder, repair	602.41	21.375
1656	Scapular stabilization (any type)	798.41	22.750
1635	Tendo Achilles, ruptured, suture	382.98	21.375
1636	fascial graft	401.68	21.375
1589	Tendon, lengthening or shortening	289.84	20.000
1585	Transfer or transplant, or free graft, single distal to elbow, distal to knee	455.14	20.000
1586	elbow to shoulder, knee to hip	500.63	20.000
1593	multiple transfer, for peripheral nerve palsy	845.64	20.000
1595	for claw hand or foot, one (1) hand or foot	446.75	20.000
1596	both hands or both feet	520.35	20.000
	Note: *Retrieve or reroute, through separate incision, add 25% of benefit, applies to tariffs 1589, 1585, 1586, 1593, 1595 and 1596.*		

ELBOW AND HUMEROUS REPAIR CODES

1601	Repair collateral ligament, medial or lateral	508.67	22.750
1602	with ORIF radial head, add	372.63	
1603	with radial head arthroplasty, add	548.94	
1604	Repair collateral ligament, medial and lateral	690.85	22.750
1605	with ORIF radial head, add	275.79	
1606	with radial head arthroplasty, add	548.94	
1607	Reconstruction collateral ligament, medial or lateral	555.08	22.750
1608	autogenous tendon graft from another site, add	290.65	
1609	Reconstruction collateral ligament, medial and lateral	669.63	22.750
1610	autogenous tendon graft from another site, add	250.08	

AMPUTATION

	UPPER EXTREMITY	UNIT VALUE	
1701	Interthoracoscapular	697.68	25.500
1703	Shoulder, disarticulation	736.02	25.500
1705	Humerus	647.84	21.375
1710	guillotine	647.84	21.375
1709	secondary closure or minor scar revision	98.90	20.000
1711	reamputation	767.75	21.375
1708	Radius and ulna	624.87	20.000
1712	Cineplasty, complete procedure	697.45	20.000
1718	Wrist, disarticulation	615.70	20.000
1722	Hand through metacarpal bones	658.30	20.000
1725	Metacarpal, with finger or thumb, one (1), with split or Wolff Graft, or skin-plasty, and/or tenodesis with definite resection of palmar digital nerves	487.49	20.000
1740	Finger or thumb, any joint distal to metacarpal, or phalanx, one (1) with skin graft	287.73	20.000
1741	additional fingers, same hand, with skin graft, each	251.67	20.000
1742	Finger or thumb, any joint distal to metacarpal, or phalanx, one (1) without skin graft	277.12	20.000
1743	additional fingers, same hand, without skin graft, each	246.68	20.000
1739	all fingers, same hand	721.45	20.000
	Note: *Repair of stump of already amputated finger or toe, requiring only simple repair of wound.*		
0251*	Wound, simple repair (including local anesthetic)	47.67	20.000

LOWER EXTREMITY

1745	Interpelviabdominal	1,607.73	25.500
1748	Hip, disarticulation	902.25	25.500
1752	Femur, including supracondylar	615.60	22.750
1760	guillotine	615.60	22.750
1761	secondary closure or minor scar revision	174.00	20.000
1763	reamputation	449.17	22.750
1750	Knee, disarticulation	615.23	21.375
1767	Tibia and fibula	672.77	21.375
1771	guillotine	672.77	21.375
1772	secondary closure or minor scar revision	155.97	20.000

			UNIT VALUE
1774	reamputation	240.96	21.375
1778	Ankle (Syme, Pirogoff), with skin-plasty and resection of nerves	671.69	21.375
1782	Foot, transmetatarsal	551.21	21.375
1785	midtarsal	551.21	21.375
1788	Metatarsal with toe, split or Wolff Graft, or skin plasty and/or tenodesis, with definitive resection of digital nerves	320.85	21.375
1802	Toe, any joint or phalanx, one (1)	230.14	21.375
1804	each additional toe, same foot	149.48	21.375
1803	all toes, one (1) foot	413.51	21.375
1819	**Unlisted or Unusually Complicated**	***By Report***	21.375

PLASTER CASTS (INDEPENDENT PROCEDURES ONLY)

1862*	Shoulder plaster, shoulder spica	118.58	20.000
1860*	shoulder to hand	45.47	20.000
1854*	Elbow to fingers	39.32	20.000
1851*	Forearm	39.32	20.000
1856*	Hand and wrist	38.81	20.000
1867*	Knee (foot to thigh)	42.09	20.000
1893*	Cylinder cast (ankle to thigh)	69.21	20.000
1894*	Ankle (foot to mid leg) short leg	37.91	20.000
1895*	long leg	43.57	20.000
1890*	Patellar tendon bearing leg cast	60.06	20.000
1896*	Ambulatory leg cast—short leg	39.77	20.000
1897*	long leg	46.41	20.000
1878*	Spica, hip to foot, unilateral	240.96	20.000
1882*	bilateral	395.65	20.000
1885*	Body, shoulder to hips	176.10	20.000
1886*	including head	116.06	20.000
1241*	Risser jacket, localizer, body only	89.12	20.000
1242*	including head	151.44	20.000
1898*	Turnbuckle jacket, body only	209.96	20.000
1899*	including head	155.25	20.000
1891*	Unna boot	27.71	20.000
1892*	Wedging cast	37.91	20.000
1870*	Application of cast brace	112.70	20.000
1889	**Unlisted or Unusually Complicated**	***By Report***	20.000

RESPIRATORY SYSTEM

These benefits cannot be correctly interpreted without reference to the Rules of Application.

NOSE

EXTERNAL

Note: *Rhinoplasty, when done as elective plastic surgery for cosmetic purposes is an exclusion under the regulations, except where the Minister is satisfied prior to the operation that such surgery is medically required. It is the responsibility of the physician to obtain this approval prior to the operation.*

			UNIT VALUE
1924	Rhinophyma, excision or planing	313.18	21.375
1950	Rhinoplasty, complete, external parts including bony pyramid, lateral and alar cartilages and elevation of tip, if necessary	739.84	21.375
1949	with septoplasty	624.45	21.375
1956	tip only	339.09	21.375

For saddle deformity by autogenous bone or other implant – See Bone Graft, Musculoskeletal Section

INTERNAL

1904*	Drainage of nasal abscess	37.91	21.375
1905*	septal abscess	37.91	21.375
1906*	Proetz treatment	4.27	20.000
1908*	Biopsy, soft tissue nose including simple closure	47.96	20.000
1907*	Nose, foreign body removal	15.10	21.375
1915*	polyp single excision in office	74.21	
1965*	Turbinate cautery	51.31	
1966*	with general anesthetic	78.80	21.375

Note: *For tariffs 1965 and 1966, 50% of the listed benefit is payable when done in conjunction with other nasal procedures for which a bloc fee is listed.*

1967*	Epistaxis, control by anterior packing	45.08	21.375
1968*	posterior packing	132.39	21.375
1969	freezing—See Section C—Anesthesia	***By Report***	21.375
1970*	Epistaxis, control by cautery of the septum in a nose that is not actively bleeding	33.07	
1971*	actual control of a bleeding nose	33.07	
1972	Endoscopic Control of Epistaxis with sphenopalatine artery ligation, unilateral or bilateral	487.10	21.375
1951	Choanal atresia, correction intranasal	270.53	21.375
1952	transpalatine approach	509.44	22.750

Microsurgical Trans-nasal Repair of Choanal Atresia

			UNIT VALUE
1953	unilateral	374.99	21.375
1954	bilateral	446.51	21.375
1917	Nasal polyps, multiple, unilateral, excision in hospital	107.60	21.375
1922	Nasopharyngeal fibroma excision	***By Report***	22.750
1928	Septoplasty or classic submucous resection	330.64	21.375
1929	with repair of septal perforation—including graft	451.07	21.375
1955	Septoplasty and dorsal hump removal	464.77	21.375
1957	Dorsal hump removal	193.22	21.375

Note: *Notes 1 and 2 apply to tariffs 1955 and 1957.*

1) *The patient must have had previous trauma.*

2) *These procedures have certain restrictions under the Regulations when done as elective surgery. To be certain that the case is covered, written approval from the Minister should be obtained before the procedure is undertaken.*

1930	Endonasal microplasty	507.65	21.375
1935*	Turbinectomy, partial or complete	75.31	21.375
0686	Fractured nose, simple, closed reduction with or without nasal packing or splinting	117.19	21.375
0687	compound, closed reduction	175.24	21.375
0688	simple or compound, open reduction	425.73	21.375

SINUSES

1981*	Antrum puncture and washout	33.32	21.375

Note: *For tariff 1981, 50% of the listed benefit is payable when done in conjunction with other nasal procedures for which a bloc fee is listed.*

1978	Ligation of artery, anterio ethmoid	309.89	22.750
1979	internal maxillary via Caldwell-Luc	486.05	22.750
2006	Obliteration of sinuses, ethmoids, intranasal, unilateral	385.14	21.375
2007	frontal, osteoplastic approach	880.25	21.375
1994	Frontal, ethmoids and sphenoids, radical exenteration by external approach	682.15	22.750
1995	Maxillary	791.60	21.375
1996	Otolaryngological component of craniofacial resection for tumor of ethmoid or frontal sinus or orbit (in conjuction with neurosurgeon)	3,289.43	22.750

Note: *Tariff 1996 includes rhinotomy, ethmoidectomy, cribform plate, and orbital exenteration.*

2032	Oro-antral fistula, closure by Caldwell-Luc and Antrum window and mucosal or muco periosteal flaps	419.86	21.375
1988	Sinusotomy, Caldwell-Luc	362.73	21.375
1992	frontal, trephine	244.78	21.375
1991	sphenoid	216.91	21.375

			UNIT VALUE
1985	maxillary, antrostomy	126.26	21.375
2001	Endoscopic frontal sinusotomy, unilateral	259.72	21.375
2002	Endoscopic frontal sinus drill-out, primary frontal sinusotomy not claimable in addition, unilateral	471.24	21.375
2003	Endoscopic transnasal approach to pituitary fossa lesion, including septal mucosal flap and other procedures as required (otolaryngologist component)	1,916.58	26.875
2004	Revision, endoscopic transnasal approach to pituitary fossa lesion, including septal mucosal flap and other procedures as required (otolaryngologist component)	1,529.85	26.875
2005	Extended endoscopic transnasal approach to skull base lesion, for access to lesions in each anatomic area (anterior cranial fossa, clivus/posterior cranial fossa, C1-C2, occipital condyles), including dura repairs if needed (otolaryngologist component)	3,634.72	26.875

Note: *1) Tariff 0296 pedicled vascular flap may be claimed at 75% in addition to tariffs 2003, 2004 and 2005 where required for lesions extending beyond the sella turcica and/or repair of CSF leaks.*

2) Tariffs 2001 to 2005 may only be claimed by fellowship trained rhinologists or head and neck surgeons, as approved by the Head of the WRHA Otolaryngology program.

COMBINED INTRANASAL PROCEDURES

2013	External ethmoidectomy unilateral	423.06	22.750
	Ethmoidectomy		
2009	and antrostomy, unilateral	349.86	21.375
2010	bilateral	613.28	21.375
2011	and polypectomy, unilateral	337.45	21.375
2012	bilateral	579.85	21.375
2014	and polypectomy and antrostomy, unilateral	446.03	21.375
2015	bilateral	758.28	21.375
2017	Polypectomy and antrostomy, unilateral	229.58	21.375
2018	bilateral	393.59	21.375
	Septoplasty		
2019	and antrostomy, unilateral	415.43	21.375
2020	bilateral	632.59	21.375
2021	and ethmoidectomy, unilateral	667.42	21.375
2022	bilateral	886.95	21.375
2023	and polypectomy, unilateral	401.47	21.375
2024	bilateral	595.76	21.375
2025	and polypectomy and ethmoidectomy, unilateral	612.09	21.375
2026	bilateral	966.58	21.375
2027	and polypectomy and ethmoidectomy and antrostomy, unilateral	691.37	21.375

			UNIT VALUE
2028	bilateral	1,066.21	21.375
2033	and ethmoidectomy and antrostomy, unilateral	619.87	21.375
2034	and ethmoidectomy and antrostomy, bilateral	980.13	21.375
2029	**Unlisted or Unusually Complicated**	***By Report***	21.375

LARYNX

Cervical lymph node dissection—See Lymph Nodes

2071*	Laryngoscopy, direct, diagnostic	71.76	22.750
2074*	direct, with biopsy	142.63	22.750
2070*	direct for foreign body removal (in office)	204.23	22.750
2030*	Fiberoptic nasendoscopy nasopharyngoscopy flexible	51.36	20.000
2031*	Fiberoptic nasopharyngolaryngoscopy flexible	52.44	20.000

Note: *These items may be claimed by appropriately trained specialists only where visualization of the larynx or nasopharynx has failed with the laryngeal mirror.*

2078	Suspension micro-laryngoscopy without CO^2 laser	247.96	22.750
2079	Suspension laryngoscopy with removal of complicated lesion from larynx or trachea by CO^2 laser	314.11	25.500
6131	Laryngogram (procedural portion of Radiology)	21.03	22.750
2053	Arytenoidectomy, external approach	421.97	22.750
2051	Laryngectomy, partial, with preservation of voice	981.32	25.500
2052	total	1,112.31	22.750
2050	Vocal cord injection	210.31	

Note: *2031* (Fiberoptic nasopharyngolaryngoscopy flexible) may not be claimed in addition.*

2054	Thyroplasty with Silastic Implant	436.23	22.750
2041	Laryngo-fissure with removal of tumor or laryngocele	351.30	22.750
2081	Laryngoscopy, direct with complete removal of cord lesion	289.78	22.750
2077	with foreign body removal	215.31	22.750
2080	Laryngotracheoplasty–with bronchoscopy or laryngoscopy, with or without local flap or graft, with or without tracheostomy, with or without suprahyoid release, with or without resection of the cricoid and/or blunt retro sternal tracheo-bronchial mobilization	1,515.41	25.500

Note: *A surgical assistant benefit may be claimed in addition to tariff 2080. The total fee (tariff 2080 and the surgical assistant benefit) may be apportioned in accordance with the Rule of Application 30.*

2089	**Unlisted or Unusually Complicated**	***By Report***	25.500

TRACHEA AND BRONCHI

			UNIT VALUE
2127*	Trachea, aspiration under direct vision (independent procedure)	74.72	22.750
2128*	Tracheal aspiration for meconium staining under direct vision (independent procedure)	108.50	
6145	Tracheogram (procedural portion of radiology)	22.08	22.750
2129*	Dilatation tracheal stenosis	213.56	22.750
2131	with suspension laryngoscopy	266.36	22.750
2113*	Bronchoscopy, with biopsy if necessary	150.51	22.750
2121*	with bronchial aspiration	159.78	22.750
2126*	with catheterization of bronchi for broncho-spirometry (independent procedure)	71.76	22.750
2122*	with drainage of lung abscess or cavity	137.79	22.750
2123*	with lipiodol injection	137.79	22.750
2116	with stent placement	269.45	25.500
2119	with brachytherapy	229.65	25.500
2136	total lung washout lavage—(unilateral)	865.93	25.500
2137	with bronchopleural fistula—tisseel injection	162.33	25.500
2124*	subsequent (i.e. in same hospital admission)	112.60	22.750
2130*	Panendoscopy with or without biopsy, three (3) or more of nasopharyngoscopy, laryngoscopy, bronchoscopy, or esophagoscopy using separate instruments in search of malignant disease.	396.78	22.750
2112	Bronchoscopy, with control of severe hemorrhage	192.12	25.500
2120	with excision of tumor, with or without laser	387.98	22.750
2115*	with lung biopsy	220.77	22.750
2118	with removal of foreign body	325.99	22.750
2105	Tracheal fenestration	358.28	22.750
2132	Tracheoplasty, intrathoracic	964.27	25.500
2101*	Tracheotomy (not to be claimed with tariff 2052 laryngectomy, total)	366.03	22.750
2100	Cricothyroidotomy	303.55	22.750
2102	Tracheoesophageal puncture following laryngectomy (separate operation) including delayed insertion of voice prosthesis.	360.52	21.375
2103	Tracheoesophageal puncture at the time of laryngectomy, including delayed insertion of voice prosthesis.	167.30	21.375
2104*	Repeat insertion of voice prosthesis (independent procedure)	68.55	21.375
2134	Bronchoplasty, excise stenosis and anastomosis	957.06	26.875
2133	graft repair	1,409.17	26.875
2135	with lobectomy and anastomosis	1,488.07	26.875

		UNIT VALUE	
2108	Endo-bronchial ultrasound (EBUS), with or without Doppler	217.26	22.750
2109	Biopsies of each nodal area done by EBUS, maximum of three (3) payable add,	55.89	
	Note: *A bronchoscopy done at the same time as EBUS will be payable at 75% of the listed fee.*		
2110	Electromagnetic Navigational Bronchoscopy, including entering data from CT scan into navigation planning computer and determining the navigation plan	663.00	22.750
	Note: *1) Fiberoptic bronchoscopy (Tariff 2113*) done at the time of Navigational Bronchoscopy will be payable at 75%.*		
	2) Endobronchial ultrasound (Tariff 2108) and associated tariffs done at the time of Navigational Bronchoscopy will be payable at 75%.		
2139	**Unlisted or Unusually Complicated**	***By Report***	26.875

LUNGS AND PLEURA

2180*	Lung, needle biopsy	111.26	20.000
2225*	Pleura, needle biopsy (including thoracentesis)	71.60	20.000
2229*	Pleural Indwelling Catheter Insertion	204.00	21.375
2230*	Pleural Indwelling Catheter Removal	71.40	21.375
2220*	Thoracoscopy, with or without biopsy	265.00	22.750
2183*	Thoracentesis	71.76	20.000
2221*	Pneumothorax, diagnostic or therapeutic, initial	59.34	20.000
2222*	subsequent	72.58	20.000
2224*	Administration of chemotherapy, including aspiration thoracentesis and sample	72.94	20.000
2684*	Mediastinoscopy	314.78	22.750
2193	Lobectomy, total or subtotal	1,376.35	26.875
2189	Lobectomy following previous lung resection on the same side	1,377.54	26.875
2191	Pneumonectomy, total	1,529.13	26.875
2184	with diagnostic wedge resection, add to tariffs 2191 and 2193	47.24	
2185	with sleeve resection of pulmonary artery, add to tariff 2193	146.49	
2194	Wedge resection	1,027.11	26.875
2186	re-operaton more than 180 days subsequent to previous excision, to appropriate excision fee, add to tariffs 2193, 2194 and 3709	155.35	
2187	Wedge resection following previous lung resection on the same side	1,064.66	26.875
2140	Minimally Invasive surgery, e.g., VATS (video assisted thoracic surgery) or thoracoscopic surgery, add	25%	
	Note: *1) Tariff 2140 is eligible to be claimed in addition to the following tariffs: 2155, 2170, 2171, 2172, 2173, 2177, 2186, 2187, 2189, 2191, 2192, 2193, 2194, 2209, 2360, 2686, 2691, 2693, 2696, 5375, 5376 and 5386*		
2177	Pulmonary decortication	896.63	26.875

			UNIT VALUE
2171	Pleurectomy	715.53	26.875
2172	Wedge resection with partial pleurectomy	1,139.20	26.875
2173	Decortication with parietal pleurectomy and empyemectomy	1,358.21	26.875
2174	Late decortication for fibrothorax	1,656.12	26.875
2192	Lobectomy with concomitant decortication of remaining lung	1,860.44	26.875
2157*	Insertion of chest tube for closed drainage (independent procedure)	127.17	21.375
2156*	bilateral at same sitting (independent procedure)	203.29	21.375
2151	Thoracotomy, cardiac massage	609.10	26.875
2152	exploratory, including biopsy	479.50	26.875
2153	hemorrhage control, not postoperative	721.19	26.875
2155	Thoracotomy for postoperative bleeding following lung or esophageal surgery	401.83	26.875
2170	Pneumonotomy, open drainage of abscess or cyst of lung	429.73	26.875
2160	Removal of foreign body from lung	530.97	26.875
2154	Open drainage of empyema cavity by rib resection (independent procedure)	414.66	22.750
2190	Lung Harvesting—Unilateral	1,536.65	25.500
2196	Lung Harvesting—Bilateral	2,739.56	25.500
2197	Lung Transplantation—Unilateral	3,427.17	26.875
2198	Lung Transplantation—Bilateral	6,073.08	26.875

Note: *The fees for tariffs 2197 and 2198 include the recipient pneumonectomy.*

VIDEO ASSISTED PLEUROLYSIS

2188	Pleurolysis and scope—via scope	389.66	25.500
2199	**Unlisted or Unusually Complicated**	***By Report***	26.875

RIBS AND CHEST WALL

1456	Scalenus anticus, division, with resection of cervical rib	445.97	21.375
1454	without resection of cervical rib	248.17	21.375
2209	Intrathoracic tumors without lung involvement, excision	966.12	25.500
2210	Pectus excavatum or carinatum, correction	970.73	25.500
2211	Thoracoplasty, for pulmonary disease	589.05	22.750
2213	Chest wall repair – single rib	306.00	25.500
2214	each additional rib to a maximum of six, add	76.50	
2215	ORIF sternal fracture, add	306.00	
2216	Bone graft when obtained from remote site, add	204.00	
2217	Mesh repair intercostal defect, add	255.00	

UNIT VALUE

Notes: *1) Intercostal neurolysis for non-union can be billed By Report.*

2) Tariff 2152 Thoracotomy, exploratory, claimable in addition to 2213, subject to Surgical Rules.

3) 2213 is not claimable in addition to tariffs 2203 or 2204 for Chest wall reconstruction.

4) Use of local bones, acquired during open reduction and/or allograft, is not payable for 2216.

2200	Chest wall tumor resection—with one (1) rib	649.49	25.500
2201	Chest wall tumor resection—two (2) or more	865.93	25.500
2202	with prosthetic reconstruction	1,147.90	25.500
2203	Chest wall reconstruction add to lobectomy,	270.61	
2204	with merthacrolyate cement reconstruction—add to previous tariff	257.55	
2219	**Unlisted or Unusually Complicated**	***By Report***	25.500

LUNG FUNCTION TESTS

Note: *1) No visit benefit will be paid in addition to the following procedures if the patient's visit is for the procedure alone.*

2) All complex lung function tests involve a written record; analysis of it, calculation of the predicted value for the subject, and interpretation of the results plus a report.

The interpretation and report should include at least the specific tariffs listed under each test but the fee also covers all other measurements, interpretations and the report of them which can be derived from the test.

3) Where test is repeated after drug administration the cost of the drug is included in the benefit.

Simple spirometry, recording of FVC and FEV/1

9882*	Total	40.28
9878*	Professional component	14.01
9881*	Technical component	26.27

Forced expiration measuring FVC, FEV/1, FEV/1/FVC and MMEFR

8810*	Total	37.27
8811*	Professional component	16.55
8812*	Technical component	20.72

Repeat after drug administration, add

8850*	Total	17.90
8813*	Professional component	10.81
8814*	Technical component	7.09

The following complex lung function tests will be claimable only when done in a "designated" facility which is under the direction of an appropriately trained physician.

Flow volume loops measuring at least FVC, PEFR and Flow 50%

8815* Total 38.54

8816* Professional component 16.18

8817* Technical component 22.36

Repeat after drug administration, add

8851* Total 20.12

8818* Professional component 7.78

8819* Technical component 12.34

Measurement of lung volumes by any method and recording of RLC, FRC, and RV including airway resistance if plethysmography is used,

8820* Total 54.25

8821* Professional component 25.79

8822* Technical component 28.46

Repeat after drug administration, add

8852* Total 19.07

8823* Professional component 9.23

8824* Technical component 9.84

Simple breath Nitrogen washout curve analysis

8825* Total 36.08

8826* Professional component 18.82

8827* Technical component 17.26

Repeat after drug administration, add

8853* Total 18.54

8828* Professional component 12.93

8829* Technical component 5.61

Measurement of diffusing capacity by any method

8830* Total 60.22

8831* Professional component 31.68

8832* Technical component 28.54

Lung compliance with static pressure—volume curve

8833* Total 126.10

8834* Professional component 59.96

8835* Technical component 66.14

GAS EXCHANGE WITH OR WITHOUT EXERCISE STUDIES

Stage 1—progressive exercise testing—measurement of ventilation and cardiac response, EKG monitoring

8836* Total 132.37

8837* Professional component..... 83.70

8838* Technical component..... 48.67

With additional recording of oxygen saturation, add

8854* Total 32.19

8839* Professional component..... 16.38

8840* Technical component..... 15.81

Steady state gas exchange at rest—includes arterial blood gas collection, blood gas analysis measurement of expired gas volumes and concentrations

8841* Total 224.18

8842* Professional component..... 98.80

8843* Technical component..... 125.38

Steady state gas exchange at exercise—as above but done during steady state exercise at various levels

8844* Total 156.75

8845* Professional component..... 81.44

8846* Technical component..... 75.31

PULMONARY PROVOCATION STUDIES

Note: *1) The Notes 1, 2 and 3, under LUNG FUNCTION TESTS apply.*

2) The studies are claimable only when done in a "designated" facility which is under the direction of an appropriately trained physician.

3) The fee covers the physicians' supervision of the tests and the cost of drugs or antigens or both. It also includes any skin testing necessary for judging the starting dose of antigens administered.

4) The fee covers all possible methods and numbers of measurements and a whole session of provocation (including a pre test, test and post test measurement). Only one (1) study session of provocation per patient per day may be claimed, except that, two (2) claims may be made when there is exercise administration for asthma detection (tariff 8860) and also cold air administration for measurement of non specific reactivity for asthma (tariff 8863).

Exercise administration for asthma detection

8862* Total 79.95

8860* Professional component..... 40.18

8861* Technical component..... 39.77

Histamine, methacholine, cold air administration for measurement of non specific reactivity for asthma

8865* Total 155.56

8863* Professional component 102.71

8864* Technical component 52.85

Antigen administration for detection of specific reactivity for asthma

8868* Total 93.38

8866* Professional component 34.35

8867* Technical component 59.03

Antigen administration for detection of specific reactivity for allergic alveolitis

8871* Total 94.73

8869* Professional component 35.70

8870* Technical component 59.03

PEDIATRIC OXIMETRY STUDIES

~8877* Oximetry measured at least twice during rest or exercise with changing levels of oxygen supplementation 10.30

~8878* Overnight oximetry study 25.76

~8879* 24-Hour oximetry study 30.91

Note: *~8877, ~8878 and ~8879 are payable for the evaluation of pediatric patients and may only be claimed by pediatric respirologists approved by the CMO of Shared Health or designate.*

SIX MINUTE WALKING TEST

8847* Six Minute Walking Test (6MWT) for Oxygen Saturation 16.08

Note: *1) 8847 is limited to Specialists in Respirology and Paediatrics, as designated by the Head of the WRHA Medicine Program or Head of the WRHA Child Health Program.*

2) 8847 is payable only where the service is provided at a facility designated by Manitoba Health.

3) May not be claimed with tariff 8839.

SLEEP STUDY

8872 Diagnostic Polysomnography—Includes continuous overnight monitoring of sleep (EEG, EOG, EMG), oxygen saturation, ECG, airflow and respiratory effort, as well as the interpretation and preparation of sleep study report. 220.83

8873 Therapeutic Polysomnography—Includes continuous monitoring of sleep (EEG, EOG, EMG), oxygen saturation, ECG, airflow and respiratory effort during which specific therapy for sleep disordered breathing is administered (this may include CPAP/BiPAP or mandibular advancement device) and the effect monitored 145.25

8874 Multiple Sleep Latency Testing 222.63

Note: *1) The above are payable only for the services provided in a designated sleep laboratory (Health Science Centre; St. Boniface General Hospital; Children's Hospital, Brandon Regional Health Centre) by Specialists with training in sleep medicine or paediatric sleep studies.*

2) Special Call *Premiums and After Hour Premiums may not be claimed in addition.*

3) Split night diagnostic and therapeutic polysomnography provided as a one-night study claim tariff 8872 and tariff 8873 each at a 100%.

PORTABLE SLEEP STUDY AND AUTO CPAP TITRATION

Tariffs 8875 and 8876 may only be claimed by qualified physicians designated by the WRHA Sleep Program Director.

8875 Portable Sleep Study–Interpretation 145.25

Note: *Includes overnight sleep study with continuous monitoring of oxygen saturation, ECG and ventilation.*

8876 Auto CPAP Titration–Therapeutic 95.37

Note: *Payable for a maximum 4 times per patient, per 12 month period.*

CARDIOVASCULAR SYSTEM

These benefits cannot be correctly interpreted without reference to the Rules of Application.

CODE STEMI ECG INTERPRETATION

9727 Code STEMI ECG Interpretation.....21.62

Note: *1) This tariff may be claimed for the immediate interpretation of an ECG submitted electronically to the physician by a paramedic requesting direction as to appropriate care of a patient with a suspected ST elevated myocardial infarction (STEMI) (e.g., immediate thrombolytic drug treatment and/or percutaneous coronary intervention).*

2) No claim may be made until the Physician responds to the request.

3) The tariff includes all related communications with a paramedic and other health care providers, if required, regarding the care and treatment of the patient during the patient's transport to hospital.

4) Claims for additional services rendered to the patient, including subsequent ECG interpretation, may be made in addition to this tariff.

5) The claim must include the name of the paramedic who initiated the request to the physician for ECG interpretation and the time of day the communications were completed.

6) When applicable, after hours premium may be claimed.

7) Services shall be documented in the Patient Care Report (PCR) generated by the paramedic and such documentation is required, upon request by Manitoba Health, to support the claim submitted.

HEART AND PERICARDIUM

Note: *Numbers (1) through (4) are applicable to Manitoba Physicians only.*

1) ECGs that are performed for screening or are medically unnecessary are not insured services.

2) Neither tariff 9836 nor tariff 9838 will be paid unless:

- *The tracing is interpreted within a period of 30 days from the time the tracing was taken, and*
- *The interpretation is conducted by a physician deemed by the College of Physicians and Surgeons of Manitoba to be qualified to interpret ECGs.*

3) The benefit for interpretation includes the written interpretation/report.

4) The benefits in this section apply to ECGs generated on equipment with a minimum capacity of 12 leads.

9836* Electrocardiogram, with interpretation and report twelve (12) leads.....25.25

9837* without interpretation and report twelve (12) leads.....14.12

9838* interpretation and report by physician who did not take tracing twelve (12) leads.....11.07

9693* Interpretation of Intracardiac Electrograms from a Cardiac Device (e.g., ICD, Pacemaker) via Remote Monitoring.....27.14

9832* Ergometer exercise test with interpretation and report (cardiovascular assessment) 118.92

9831* professional component 79.00

9830* technical component 39.92

9794* Rogitine test for Pheochromocytoma 25.65

9840* Phonocardiogram 17.36

9841* Continuous ambulatory monitoring, professional fee for interpretation of the recording 44.17

Note: *Tariff 9841 may only be claimed when the recording device is installed in a hospital under the direction of an appropriately trained physician.*

9796* Patient activated event recorder, professional fee for interpretation and written report. 37.18

Note: *1) Tariff 9796 may only be claimed when the recording device is installed in a hospital under the direction of an appropriately trained physician.*

2) May be claimed once per patient, per two (2) week period.

ECHOCARDIOGRAPHY

9729 Transthoracic echocardiogram (TTE) 146.12

9730 Non Intraoperative Transesophageal echocardiogram (TEE) 192.88

9732 Stress echocardiogram 254.39

9736 Contrast echocardiogram 254.39

9739 Echo directed pericardiocentesis 366.24

9741 Pediatric echocardiogram 147.57

9743 Limited echocardiogram 75.79

Note: *Tariffs 9729, 9730, 9732, 9736, 9739, 9741, and 9743 are limited to Echocardiographers who have been approved by the WRHA Chief Medical Officer or Vice President Medical of the Brandon Regional Health Authority, as applicable.*

VASCULAR TESTING

7800* Impedence plethysmography 9.89

7802* Venous reflux 13.14

7804* Digital pressures 10.51

7806* Skin temperatures 15.76

7808* Pulse wave recording 10.51

7810* Special cardiovascular function tests 37.09

7812* Cold sensitivity testing 26.28

Note: *Tariffs 7800, 7802, 7804, 7806, 7808, 7810 and 7812 are payable only where the service is provided at Grace Hospital, Health Sciences Centre or St. Boniface General Hospital.*

			UNIT VALUE
2302*	Cardiac catheterization, left heart	234.58	21.375
2304*	left heart plus right heart	329.92	21.375
2306*	Cardiac catheterization, right heart, outside the O.R. setting	172.09	21.375
2307*	Selective coronary artery arteriography	283.88	21.375
2308*	and left heart catheterization	482.81	21.375
2325*	and right heart catheterization	404.56	21.375
2327*	and both left heart catheterization and right heart catheterization	546.16	21.375
2234	Intracoronary artery or intracoronary bypass graft, drug injection(s), add	87.57	
2235	Measurement of cardiac output by flick or thermodilution, add	101.99	
2236	Intra-cardiac oximetry, add	98.21	
	Note: *Tariffs 2234, 2235 and 2236 may only be claimed in addition to an interventional cardiology procedure.*		
2397*	Intracoronary Ultrasound or OCT, add	125.74	
2401*	Coronary pressure derived fractional flow reserve (Coronary FFR) per coronary vessel, add	124.50	
	Note: *1) Tariffs 2401 and 2397 may be claimed in addition to tariffs 2307, 2308, 2325 or 2327.*		
	2) Coronary angioplasty (tariffs 6267, 6268 or 6270) is payable at 100% when rendered on the same day as tariff 2401 or 2397.		
2399	Coronary thrombectomy, add	102.00	
2478	Atherectomy, any method e.g., orbital, rotoblation, add	204.00	
2305*	Coronary artery bypass graft angiogram including internal mammary artery implant per graft injection regardless of any number of distal anastomoses	99.67	21.375
	Note: *When the above bypass angiography is done along with any other procedure, claim 50% for the bypass angiogram benefit.*		
2393	Atrial fibrillation ablation (MAZE) of left or right atrium, in addition to cardiac surgery	1,981.16	25.500
2395	Atrial fibrillation ablation (MAZE) of both left and right atriums, in addition to cardiac surgery	1,728.73	25.500
	Note: *Tariff 2393 or 2395 are payable at 100% of the listed benefit.*		
2310*	Septostomy, balloon (additional to cardiac catheterization) (independent procedure)	342.43	25.500
2312*	Cardioversion, D.C. countershock, including immediate follow-up care	110.75	22.750
2381*	Implantation or Removal of Loop Recorder	263.11	21.375
2323*	Endomyocardial biopsies, transvascular, right or left heart	307.98	25.500
	Note: *When other procedures are carried out at the same sitting, fees for lesser procedures are to be claimed at 75% of the listed benefits whether or not they are asterisked.*		
2316	Aortico-pulmonary window, closed repair	1,479.69	26.875
2318	anastomosis, Edward's repair	957.06	26.875

			UNIT VALUE
2320	Pott's repair	1,014.24	26.875
2322	Atrial septal defect, closed creation (Blalock-Hanlon procedure)	969.42	26.875
2324	Cardiac arrest, surgical treatment by open cardiac massage (independent procedure)	569.87	26.875

PACEMAKER

2326	Cardiac pacemaker, implantation with thoracotomy	723.15	22.750
2332	repeat implantation with thoracotomy	893.01	25.500
2309*	Insertion of temporary transvenous endocardial electrode for cardiac pacemaking	165.71	21.375
2328	Insertion of permanent transvenous endocardial electrode and implantation of pack (includes insertion of temporary transvenous electrode at same surgical procedure)	400.10	21.375
2329	Insertion of atrio-ventricular sequential dual chamber pacemaker with permanent atrial and ventricular endocardial electrodes	585.41	21.375
2391	Percutaneous left ventricular pacemaker lead placement	334.51	
	Note: *Tariff 2391 is payable at 100% when claimed in addition to tariffs 2329, 2363 or 2379.*		
2330	Change of pacemaker battery (independent procedure)	220.62	21.375
2334	repeat transvenous	281.37	21.375
2345	Repositioning of endocardial electrode	289.78	21.375
2373	Removal of pacemaker pack with or without partial removal of electrodes	224.38	21.375

CARDIAC ELECTROPHYSIOLOGY

2311*	Electrophysiology Study using previously inserted electrode	325.17	21.375
2348*	Electrophysiology Study with insertion of one (1) or two (2) electrode(s)	564.60	21.375
2349*	Catheter Ablation (AV nodal as a sole procedure)	518.70	25.500
2355*	Catheter Ablation in addition to an Electrophysiology Study	258.17	25.500
2357*	Full Electrophysiology Study [insertion of three (3) or more electrodes]	1,254.53	22.750
2359*	Full Electrophysiology Study with Catheter Ablation	1,603.61	25.500
2650	Where Advanced 3-Dimensional Mapping System is performed in conjunction with tariff 2359, add	612.00	
2383*	Electrophysiology/Catheter Ablation—Assistant Fee per fifteen (15) minutes or portion thereof	39.08	
2361*	Repeat Catheter Ablation at a different site, same study	133.21	21.375
2363*	Implantation of Internal Cardioverter Defibrillator including induction of arrhythmia and cardioversion when necessary	1,075.22	21.375
2365*	Internal Cardioverter Defibrillator Replacement without new transvenous electrode	429.27	21.375
2367*	Internal Cardioverter Defibrillator, Defibrillation Testing	493.34	22.750
2377*	Atrial lead with Internal Cardiac Defibrillator (add-on)	169.78	21.375
2379*	Implantation of dual chamber Internal Cardioverter Defribillator including induction of arrhythmia and cardioversion when necessary	1,226.66	22.750

		UNIT VALUE	
2343*	Esophageal Electrophysiological Studies (EEP)	221.90	
	Note: *The fee for tariff 2343 includes conscious sedation, monitoring, placement of an esophageal electrode catheter, followed by various pacing protocols.*		
2339*	Tilt Table Testing	226.34	21.375

EXTRA CORPOREAL MEMBRANE OXYGENATION (ECMO)

2385	Establishment of ECMO including, arterial and venous cannulation and complete pump by-pass, and care of the patient for the first twenty-four (24) hours	1,055.39	26.875
2387	Subsequent care of ECMO patient after first twenty-four (24) hours, per day	340.99	
2389	Arterial and venous decannulation	428.15	

VENTRICULAR ASSIST DEVICE

2286	Insertion of a temporary extracorporeal ventricular assist device	1,082.17	26.875
2287	Removal of a temporary extracorporeal ventricular assist device	633.22	26.875
2288	Insertion of a permanent implantable ventricular assist device	3,971.42	26.875
2289	Removal of a permanent implantable ventricular assist device	1,986.48	26.875

Note:

1) *Rule of Application 29 does not apply to tariffs 2286, 2287, 2288 or 2289. Tariffs 2286, 2287, 2288 or 2289 shall be paid at 100% of the fee when rendered as a separate surgical service within the inclusive postoperative period.*
2) *Tariff 2286 or 2287 are payable at 75% of the listed fee when rendered at the same time as tariff 2288.*
3) *When tariff 2288 is rendered in conjunction with other cardiac surgical services, the highest value service shall be paid at 100%, and all other services shall be paid at 75% of the listed fee.*

CARDIAC SURGERY

2336	Cardiorrhaphy suture of heart wound or injury	752.57	26.875
2338	Cardiotomy for intracardiac foreign bodies	645.06	26.875
2340	Cardiotomy for intracardiac foreign bodies with cardiopulmonary bypass and hypothermia	862.92	26.875
2342	Mitral commissurotomy, closed	863.31	26.875
2344	Mitral commissurotomy, repeat closed	1,101.28	26.875
2350	Patent ductus arteriosus, closure—adult	856.19	25.500
2352	Patent ductus arteriosus, closure—child	736.49	25.500
2351	Transcutaneous catheter occlusion of the patent ductus arteriosis	605.50	22.750
2353	Pericardiocentesis	176.03	25.500
2360	Pericardium, biopsy (thoracotomy)	372.68	26.875
2354	Pericardial cysts or tumors, removal	879.89	26.875
2356	Pericardiectomy for constrictive pericarditis	1,853.38	26.875

			UNIT VALUE
2358	Pericardiotomy exploratory, with drainage, or removal of foreign bodies	705.53	26.875
2362	Pulmonary artery, banding	674.93	25.500
2364	subclavian anastomosis (Blalock)	857.18	25.500
2366	superiorcaval anastomosis (Glenn)	1,000.26	25.500
2486	Coarctation of the aorta—adult	1,145.81	26.875
2488	Coarctation of the aorta—child	995.17	26.875
2470	Aortic arch anomalies, vascular ring	796.34	26.875
2521	Pump assist, balloon, intra-aortic, including removal	730.63	25.500
2522	percutaneous, including removal	353.33	20.000
2523	Anesthetic basic value for removal	***By Report***	25.500
2369	**Unlisted or Unusually Complicated**	***By Report***	26.875

TRANSCATHETER AORTIC VALVE IMPLANTATION (TAVI)

2272	TAVI first operator	1,748.85	26.875
2273	TAVI second operator	1,748.85	26.875

Notes: *1) Except as noted TAVI includes all surgical and imaging services provided by all physicians. Specifically, pre-operative assessment, cardiac catheterization, vascular access and closure, imaging of the heart and general circulation, valvuloplasty and pressure measurements, insertion of pace maker wires and making changes to pacemaker function on the day of the procedure.*

2) A visit for the same patient may not be claimed on the same day as 2272 or 2273.

3) Echocardiography services may be claimed in addition when provided by a separate operator.

4) Conference tariffs for the same patient may not be claimed on the same day as 2272 or 2273.

5) A surgical assist benefit may not be claimed in addition to 2272 or 2273.

6) Where alternate access is required, an appropriate surgical service (e.g., tariff 2152 Thoracotomy) and the corresponding surgical assist benefit may be claimed in addition at 75%.

*7) Where the assistance of a third physician is required, this physician may claim tariff 8550 when the claim is accompanied by a **Special Report** which must describe the circumstances, complications, conditions, and treatment required.*

PERCUTANEOUS MITRAL VALVE REPAIR

~2280	Percutaneous mitral valve repair (e.g., Transcatheter Edge to Edge Repair), First operator	1,838.91	26.875
~2281	Percutaneous mitral valve repair (e.g., Transcatheter Edge to Edge Repair), Second operator	612.97	26.875

Notes: *1) A surgical assist benefit may not be claimed in addition to ~2280 or ~2281.*

2) Imaging studies (including all angiographic and ultrasound studies) performed during the procedure are included in ~2280 and ~2281

TRANSCATHERTER PROCEDURES

		UNIT VALUE
6154	Transcatheter therapy, infusion, any method, (e.g. Thrombolysis other than coronary).....521.56	21.375
6155	Transcatheter retrieval, percutaneous, of intravascular foreign body (e.g. fractured venous or arterial catheter).....329.35	21.375
6128	Transluminal angioplasty, any method, peripheral artery 414.46	20.000
6156	Transluminal angioplasty, any method, each additional peripheral artery, add 207.23	21.375
6157	Transluminal angioplasty, any method, renal or other visceral artery.....450.33	21.375
6158	Transluminal angioplasty, any method, each additional visceral artery, add.....225.17	21.375
6159	Transluminal angioplasty, venous (e.g. Subclavian stenosis) 414.46	21.375
6163	Dialysis graft Thrombolysis and/or Removal of Clot 567.03	21.375

Note: *This tariff includes the following:*

1) Interrogation of central veins (venogram)

2) Treatment of venous stenosis (angioplasty)

3) Removal of clot within graft (whether thrombolytic therapy or mechanical device or combination of both)

4) Removal of arterial plug

5) Hemostasis

6) Introduction of one, two or more sheaths to do procedure

7) Completion angiogram of graft post procedure

6165	Vascular stent placement.....98.24	25.500
6168	Endovascular stent grafting (e.g. Aorta) 1,014.70	26.875
6169	Carotid angioplasty 491.02	25.500
6170	Carotid stent placement.....95.89	25.500
6195	Image guided central line placement.....132.40	21.375
6156	Transluminal angioplasty, any method, each additional peripheral artery, add 207.23	21.375
6158	Transluminal angioplasty, any method, each additional visceral artery, add.....225.17	21.375

OPEN HEART SURGERY

Additional special services, per hour or fraction thereof.....86.44

For multiple open heart procedures, 75% of the listed procedural benefits will be added for each additional tariff, however, the complete pump bypass benefit will only be charged once.

2371 Complete pump bypass 573.92

Note: *1) To be added to applicable open heart surgical procedure, i.e. the benefit for any open heart surgical procedure will be the listed benefit plus the additional benefit for the pump bypass.*

2) Tariff 2371 may be added to other (non-open heart) procedures when applicable or may be done independent of any other surgical procedure for maintenance of circulation.

		UNIT VALUE	
2494	Coronary artery bypass graft without cardiopulmonary bypass, add to surgical fee	568.24	
	Note: *Tariff 2371 may not be claimed in addition to 2494.*		
2735	Addition of deep hypothermia circulatory arrest to cardiopulmonary bypass, add to surgical fee	432.94	
2736	Axillary cannulation for CPB with or without graft, add to surgical and bypass fee	451.07	
2737	Femoral cannulation for CPB with or without graft, add to surgical and bypass fee	451.07	
2375	Anesthetic basic value for complete bypass when employed independent of any other surgical procedure for maintenance of circulation.	***By Report***	26.875
	Note: *The above service is not claimable in addition to anesthetic basic value for surgery.*		
2370	Cardiopulmonary bypass operator	345.03	
	Note: *1) When tariff 2370 is claimed by an Anesthetist, that physician may not claim for anesthetic time for that period during which the pump is operating.*		
	2) When tariff 2370 is claimed in addition to anesthetic fees, the total anesthetic time and the pump run time should be reported on the claim form.		
2372	Anomalous pulmonary venous drainage, total correction	1,364.10	26.875
2376	Aortic sinus of valsalva, ruptured with fistula	1,353.89	26.875
2378	Aortic valve, replacement with prosthetic valve	1,946.00	26.875
2388	supravalvular stenosis, correction	1,120.96	26.875
2390	valvulotomy	891.69	26.875
2700	Aortic valve repair (e.g. Suture or patch repair of cusp or cusps, commissurotomy, decalcification of valve or excision of valve lesion)	1,534.32	26.875
2702	Aortic valve repair and replacement of ascending aorta with artificial graft	2,763.82	26.875
2703	Aortic valve replacement with stentless aortic valve—subcoronary technique without coronary reimplantation	2,733.12	26.875
2704	Aortic valve replacement with stentless aortic valve—full root technique with coronary reimplantation	3,061.08	26.875
2706	Aortic valve replacement with homograft with coronary reimplantation	3,115.78	26.875
2707	Aortic root enlargement with pericardial or synthetic patch, add to tariffs 2700, 2702, 2703, 2704 and 2378	649.49	
2708	Aortic valve sparing root replacement (David or Yacoub) with coronary reimplantation	3,463.82	26.875
2712	Aortic valve replacement with prosthetic valve and resection/replacement of ascending aortic aneurysm with artificial graft	3,382.40	26.875

			UNIT VALUE
2713	Ascending aortic aneurysm repair and replacement of lesser curvature of aortic arch (hemi-arch replacement)	2,116.32	26.875
2714	Plication of ascending aorta, add to surgical fee	655.98	
2392	Aorticopulmonary window, open	955.30	26.875
2394	Atrial septal defect, primum	1,473.54	26.875
2396	secundum suture	1,205.96	26.875
2398	patch	1,205.96	26.875
2400	plus pulmonary stenosis	912.76	26.875
2402	plus partial anomalous pulmonary drainage	1,380.01	26.875
2403	Percutaneous closure of atrial septal defect or patent foramen ovale	864.54	21.375
2738	Suture of Patent Foramen Ovale (PFO) at time of open heart operation, add to surgical fee	458.34	
2404	Atrioventricularis communis	1,103.86	26.875
2406	Coronary artery, arterioplasty, direct repair, with arterioplasty and/or endarterectomy	973.08	26.875
2407	Coronary bypass graft, single	1,421.22	26.875
2409	two (2)	1,721.87	26.875
2411	three (3)	1,989.72	26.875
2413	four (4)	2,274.01	26.875
2415	five (5)	2,518.38	26.875
2417	six (6) or more	2,803.07	26.875
2421	Arterial conduit, add on to coronary bypass graft (per arterial conduit)	267.85	
2709	Bentall procedure with bilateral coronary reimplantation	3,170.45	26.875
2710	Bentall procedure including one direct coronary reimplantation and one interposition graft	3,345.31	26.875
2711	Bentall procedure including bilateral interposition grafts (no direct coronary reimplanation)	3,561.15	26.875

Note: *For tariffs 2709, 2710, 2711, Bentall procedure is defined as follows:*

1) *Replacement of the aortic root and the aortic valve with a composite graft-valve device and reimplantation of the main coronary arteries into the sides of the conduit.*

2) *For distal coronary artery disease Coronary Artery Bypass Graft (CABG) procedure may be claimed in addition at 50%.*

2408	Intracardiac tumor, excision	1,545.71	26.875
2410	Mitral valve, annuloplasty	1,393.91	26.875
2412	replacement	1,749.23	26.875
2405	Mitral valve repair—leaflet and/or chordal repair with annuloplasty ring	2,241.14	26.875
2418	Pulmonary valve, infundibulectomy	1,274.03	26.875
2420	patch	1,299.99	26.875

			UNIT VALUE
2422	valvulotomy	1,338.18	26.875
2424	Tetralogy of Fallot, complete correction	991.93	26.875
2426	with atrial septal defect	912.76	26.875
2428	with outflow patch	912.76	26.875
2430	with patent ductus arteriosus	1,055.96	26.875
2432	with previous Blalock anastomosis	1,058.47	26.875
2434	with previous Edward's anastomosis	1,055.96	26.875
2436	with previous Pott's anastomosis	1,055.96	26.875
2438	Transposition of great vessels—complete correction	1,133.32	26.875
2440	Tricuspid valve, annuloplasty and/or commissurotomy	1,382.73	26.875
2441	Tricuspid valve replacement	1,655.53	26.875
2442	Ebstein's syndrome, correction by valve replacement	912.76	26.875
2444	replacement	912.76	26.875
2448	Ventricular septal defect, repair, suture of patch	1,386.60	26.875
2450	plus aortic regurgitation	887.00	26.875
2452	plus corrected transposition	912.76	26.875
2454	plus patent ductus arteriosus	999.50	26.875
2719	Repair of post infarction ventricular septal defect with or without patch	2,405.21	26.875
2720	Ventricular aneurysm—resection and repair	1,311.90	26.875
2721	Repair of sub-aortic left ventricular out flow tract obstruction	1,916.48	26.875
2729	Heart transplantation including recipient cardiectomy and donor heart implant	3,675.35	26.875
2730	Donor cardiectomy	1,300.94	26.875
2731	Recipient cardiectomy	1,109.63	26.875
2456	Repeat open heart procedure (s) more than fourteen days after previous open heart procedure, add to surgical fee	701.77	26.875
2159	Mediansternotomy or Thoracotomy for postoperative bleeding following cardiac or aortic surgery	401.83	26.875
2732	Delayed closure of sternotomy wound post cardiac surgery	689.93	26.875
2733	Repair sternal wound dehiscence/non–union minimum of one week post cardiac surgery	811.82	26.875
2734	Debridement of sternum and mediastinum and repair of wound dehiscence minimum of one week post cardiac surgery	1,082.42	26.875
	Note: *Rule of Application 29 does not apply to tariffs 2732, 2733 and 2734 i.e., A Special Report is not required.*		
2459	**Unlisted or Unusually Complicated**	***By Report***	26.875

ARTERIES

ANGIOGRAPHY—SEE ANGIOGRAPHY

			UNIT VALUE
2300*	Arterial puncture of blood withdrawal (independent procedure)	17.70	
2301	Continuous arterial catheter for blood gases	33.20	
2314*	Artery—cutdown for insertion of cannula or needle (independent procedure)	44.06	20.000
2317*	Biopsy—of temporal or other artery (independent procedure)	150.77	20.000
2319	Ligation of peripheral artery or arteries for hemorrhage control	***By Report***	22.750
2321	Ligation of major artery for hemorrhage control as a separate procedure	460.24	22.750

ANEURYSM, AORTA—REPAIR/RECONSTRUCTION

2458	Abdominal aorta, with grafting (tubular graft)	1,634.57	26.875
2455	aorto-femoral repair, bilateral	2,137.45	26.875
2457	aorto-iliac repair, bilateral	2,046.26	26.875
2638	Supra renal aortic clamping for aortic graft, add	108.27	
	Note: *The above tariff 2638 may be claimed in addition to any vascular surgical service.*		
2639	Inferior mesenteric artery re-implantation with aortic graft, add	216.50	
	Note: *The above tariff 2639 may be claimed in addition to any vascular surgical service.*		
2640	Internal iliac graft add-on to aortic graft, add	408.73	
	Note: *The above tariff 2640 may be claimed in addition to tariffs 2455, 2457.*		
2462	Thoracic aorta, ascending	1,530.57	26.875
2464	descending	1,475.92	26.875
2715	Aortic arch replacement—with complete island graft	3,084.94	26.875
2716	with two (2) separate arch vessel anastamoses	3,446.55	26.875
2717	with three (3) separate arch vessel anastamoses	4,381.33	26.875
2718	with four (4) separate arch vessel anastamoses	5,329.10	26.875
2722	Thoracoabdominal aortic aneurysm repair—proximal to celiac artery	3,553.71	26.875
2723	with one (1) viceral artery anastamosis (or island)	4,227.61	26.875
2724	with two (2) viceral artery anastamoses (or islands)	4,901.53	26.875
2725	with three (3) viceral artery anastomoses (or islands)	5,575.43	26.875
2739	Thoracoabdominal aortic aneurysm repair with four (4) visceral artery anastomoses (or islands)	5,744.61	26.875
2726	for each anastomosis to spinal artery (ies), add to the above tariffs 2722, 2723, 2724, 2725 or tariff 2464	243.47	
2727	Aortic dissection with or without external rupture, add to surgical fee	30% premium	
2728	Aortic aneurysm with rupture, add to surgical fee	30% premium	

ANEURYSM, PERIPHERAL VESSELS—REPAIR/RECONSTRUCTION

Unilateral

			UNIT VALUE
2463	axillary	997.56	25.500
2465	carotid	1,137.18	25.500
2467	common femoral	921.10	22.750
2469	innominate	1,276.56	25.500
2471	popliteal	1,172.03	22.750
2473	subclavian	1,037.51	25.500
2475	visceral	1,173.19	25.500

Note: *Ruptured on any of the above aneurysms, add 25%.*

ANEURYSM, TRAUMATIC—REPAIR/RECONSTRUCTION

2477	with ligation	660.21	26.875
2479	with reconstruction	1,360.48	26.875

ARTERIO-VENOUS FISTULA

For Hemodialysis—See Hemodialysis Section.

2481	Congenital	***By Report***	22.750
2483	Traumatic, with obliteration	609.40	22.750
2485	with reconstruction	1,097.78	22.750

ARTERIOTOMY, FOR REMOVAL OF EMBOLUS

2472	aorta	647.32	25.500
2487	axillary	535.76	25.500
2489	brachial	535.76	25.500
2491	carotid	585.56	25.500
2493	femoral	605.68	25.500
2495	iliac	791.18	25.500
2497	innominate	574.44	25.500
2499	popliteal	605.68	25.500
2501	renal	973.04	25.500
2503	superior mesenteric	883.34	25.500
2480	Carotid, artery, ligation	265.62	21.375
2482	Chemotherapy, by continuous arterial infusion	***By Report***	26.875
2484	by isolation perfusion	***By Report***	26.875

GRAFTING, BYPASS GRAFT

			UNIT VALUE
2492	abdominal aorto-tubular	960.15	26.875
2505	aorto-carotid	1,605.62	26.875
2507	aorto-femoral, unilateral	1,295.11	26.875
2509	bilateral or aorto-bifemoral	2,137.45	26.875
2511	aorto-femoral, with concomitant femoral (deep femoral) endarterectomy, unilateral	1,980.92	26.875
2513	bilateral	3,042.25	26.875
2646	extensive femoral endartectomy plus patch angioplasty at the time of another bypass procedure, paid at 100%	776.44	
2515	aorto-iliac, unilateral	1,702.96	26.875
2517	bifurcation	2,007.20	26.875
2519	aorto-axillary, unilateral	1,000.32	25.500
2647	aorta visceral (celiac, superior mesenteric or inferior mesenteric artery) bypass for mesenteric ischemia – single vessel	1,311.90	25.500
2648	aorta visceral (celiac, superior mesenteric or inferior mesenteric artery) bypass for mesenteric ischemia – two separate vessels	1,683.75	25.500
2525	axillary	999.09	22.750
2527	axillo-axillary, prosthetic	819.63	22.750
2531	vein	1,023.98	22.750
2533	axillo-femoral, unilateral	1,035.25	25.500
2535	bilateral	1,624.99	25.500
2537	carotid-subclavian, prosthetic	1,258.85	25.500
2599	vein	1,383.30	25.500
2572	cross-femoral—femoral prosthetic	941.14	22.750
2573	vein	1,119.21	22.750
2574	femoral-popliteal, prosthetic	971.85	22.750
2575	vein	1,364.21	22.750
2637	Composite graft – vein-to-vein or prosthetic-to-vein, per additional anastomosis, add	324.72	
	Note: *The above tariff 2637 may be claimed in addition any vascular surgical service.*		
2576	femoral-tibial, posterior or anterior prosthetic	1,264.93	22.750
2577	vein	1,643.12	22.750
2637	Composite graft – vein-to-vein or prosthetic-to-vein, per additional anastomosis, add	324.72	
	Note: *The above tariff 2637 may be claimed in addition to any vascular surgical service.*		
2496	iliac, unilateral	1,702.96	25.500
2578	ilio-femoral, unilateral	1,170.88	25.500
2498	innominate	1,018.57	25.500

			UNIT VALUE
2579	juxta-renal, aorto-femoral	1,950.22	26.875
2500	renal, unilateral	1,287.90	25.500
2580	bilateral	1,615.02	25.500
2502	subclavian, unilateral	1,291.67	25.500
2581	bilateral	1,528.82	25.500
2582	subclavian—subclavian, subcutaneous, prosthetic	908.92	25.500
2583	vein	1,005.84	25.500

THROMBOENDARTERECTOMY (INDEPENDENT PROCEDURES)

2506	aorta	1,323.58	25.500
2584	aorta-iliac, unilateral	1,060.08	25.500
2585	bilateral	1,805.28	25.500
2586	axillary, unilateral	933.96	22.750
2587	aorto-ilio-femoral, unilateral	1,708.40	25.500
2588	bilateral	2,155.50	25.500
2508	femoral, unilateral	1,035.25	22.750
2510	iliac, unilateral	1,030.48	25.500
2512	innominate	1,035.35	25.500
2514	internal carotid	1,416.32	26.875
2516	renal, unilateral	1,269.54	25.500
2589	bilateral	1,478.34	25.500
2518	subclavian	1,034.73	25.500
2520	superior mesenteric	1,115.08	25.500
2590	vertebral, with or without patch graft	1,017.84	25.500

PROFUNDOPLASTY

2524	Extended profundoplasty with endarterectomy common femoral to 3rd branch of profunda with or without patch	1,053.59	22.750

WOUND OR INJURY OF MAJOR ARTERY, REPAIR

2591	aorta	1,221.91	25.500
2592	trunk vessels	1,119.60	25.500
2593	peripheral vessels, suture	515.26	22.750
2594	prosthetic graft	992.13	22.750
2595	vein graft	1,184.12	22.750
2529	**Unlisted or Unusually Complicated**	***By Report***	25.500

ARTERIAL GRAFT RE-DO OPERATIONS

INFECTED ABDOMINAL AORTIC GRAFTS

			UNIT VALUE
2423	Removal of total graft without reconstruction payable at 100% of the current fee listed for the initial graft	100%	26.875
2425	Removal of total graft with in situ replacement payable at 50% of the current fee listed for the initial graft	50%	26.875
2427	Removal of total graft with extra anatomic reconstruction payable at 75% of the current fee listed for the initial graft	75%	26.875
2429	Removal of one (1) limb segment only payable at 50% of the current fee listed for the initial graft	50%	25.500

Note: *Above procedures apply to tariffs 2458, 2455, 2457, 2509.*

1) *Initial graft procedure tariff number should be submitted on claim in notes or remarks area.*

2) *Reconstruction at same operation is payable at 100% of the appropriate service tariff.*

2636	Donor femoral vein for bypass, add	487.10	

Note: *The above tariff 2636 may be claimed in addition to any vascular surgical service.*

INFECTED EXTREMITY PROSTHETIC GRAFTS

2431	Ilio-femoral, axillo-femoral or cross-femoral graft removal payable at 75% of the current fee listed for the initial graft	75%	25.500
2636	Donor femoral vein for bypass, add	487.10	

Note: *The above tariff 2636 may be claimed in addition to any vascular surgical service.*

2433	Removal of graft, femoral, popliteal, tibial payable at 50% of the current fee listed for the initial graft	50%	22.750

Note: *Above procedures apply to any vascular surgical service.*

1) *Initial graft procedure tariff number should be submitted on claim in the notes or remarks area.*

2) *Reconstruction at same operation is payable at 100% of the appropriate service tariff.*

INTESTINAL PROSTHETIC FISTULA

2435	Direct repair of aorta with or without omental coverage (no graft reconstruction)	1,160.06	26.875
2437	Intestinal repair—with or without resection (same as small bowel resection) when done by second surgeon	690.38	26.875
2439	intestinal repair when done by same surgeon, add.	462.72	

Note: *For graft removal and repair see infected grafts.*

ANASTOMOTIC ANEURYSM

			UNIT VALUE
	Graft Replacement of Anastomotic Aneurysm include thrombectomy and repair.		
2443	Aortic or iliac anastomotic aneurysm add 25% to appropriate service tariffs	Add 25%	26.875
	Note: *Above procedure applies to tariffs 2458, 2455, 2457, 2509.*		
	Lower Extremity—Femoral, Popliteal, Tibial		
2447	femoral anastomotic aneurysm repair—(pay at 50% when done with aorta-femoral repair)	1,261.58	22.750
2449	anastomotic aneurysm at other sites: pay same as repair of primary aneurysm at that site		22.750
2451	repair of ruptured aneurysm add 25% of the current fee assigned to site involved	Add 25%	26.875
	Graft Thrombosis—after Three (3) Weeks—Post op		
2453	aortic graft limb thrombectomy with revision of anastomosis or graft replacement	2,379.75	26.875
	Lower Extremity—Femoral, Popliteal, Tibial		
2461	graft thrombectomy with revision of anastomosis.	1,000.27	25.500
2466	graft thrombectomy only	551.46	21.375
	Reoperation—within Two (2) Weeks—Post op		
2468	abdominal graft—graft or anastomotic bleeding post-op	432.94	26.875
2474	extremity graft—graft or anastomotic bleeding post-op	218.66	22.750
	Graft Thrombosis—within Three (3) Weeks—Post-op		
2476	thrombectomy with or without revision payable at 25% of the current fee listed for the initial procedure	25%	25.500

HEMODIALYSIS ARTERIO—VENOUS FISTULA

Revisions [after three (3) weeks post-op]

PROSTHETIC GRAFT FISTULA (3801)

2608	Patch angioplasty prosthesis—artery or vein anastomosis with or without thrombectomy (75% of 3801)	393.51	21.375
2619	Patch angioplasty or revision prosthesis vein and artery anastomosis with or without thrombectomy (same as 3801)	524.68	21.375
2620	Prosthesis graft thrombectomy—only (50% of 3801)	262.34	21.375
2621	Prosthetic graft replacement with or without graft excision or graft thrombectomy (same as 3801)	524.68	21.375
2622	Prosthetic graft excision with closure of artery and vein anastomosis (e.g. infected graft or false aneurysm—75% of 3801)	393.51	21.375
2623	Banding for steal syndrome (50% of 3801)	262.34	21.375
2624	Interposition graft (100% of 3801)	524.68	21.375

AUTOGENOUS ARTERIO-VENOUS FISTULA (3800)

			UNIT VALUE
2625	Brachial basilic with transposition	769.66	21.375
2626	Banding for steal syndrome (3800 x 50%)	225.49	21.375
2627	Revision of, or new anastomosis artery or vein with or without thrombectomy (3800 x 75%)	338.23	21.375
2628	Revision of, or new anastomosis artery and vein with or without thrombectomy	621.75	21.375
2629	Closure of fistula with direct repair of artery	495.74	21.375
2630	Ligation of vein and/or artery for closure of fistula (3800 x 25%)	112.74	21.375
2632	Excision of venous aneurysm without repair (3800 x 50%)	225.49	21.375
2633	Excision of arterial aneurysm without repair (3800 at 50%)	225.49	21.375
2634	Interposition autogenous graft (3800 at 100%)	450.97	21.375

VEINS

INVESTIGATION—SEE VENOGRAMS

Add 50% to fee payable for procedural fees when patient is less than two (2) years of age. Premium applies to tariffs 9822, 9823, 9825, 9826, 9828 and 9833.

INCISION

8957*	Intravenous (injection)	11.80	
2560	Intravenous therapy, establishment	33.20	
	Note: *This fee may not normally be charged by a physician who has charged for a visit or anesthetic that day or a block fee for a surgical procedure. It is to be charged only in emergency situations, or when a physician with special experience (e.g., Anesthetist) has to perform the procedure because of exceptional difficulties.*		
2561*	Phlebotomy, therapeutic	10.71	
9833*	Cutdown for insertion of needle or cannula (independent procedure)	36.63	20.000
9834*	Vein—insertion of venous pressure catheter and including venous pressure measurements (independent procedure) percutaneous	55.33	
9835*	exposure and incision of vein	46.72	20.000

CATHETERIZATION FOR CHEMOTHERAPY, HYPERALIMENTATION OR HEMODIALYSIS

			UNIT VALUE
9822	Centrally positioned catheter inserted by stab techniques with three (3) weeks care of the catheter and wound, including replacement if required (independent procedure)	102.71	20.000
9823	Partially buried, centrally positioned catheter with Dacron cuff, (e.g. Broviac, Hickman, Cook) with three (3) weeks care of the catheter and wound including replacement, if required (independent procedure)	228.35	20.000
9824	Replacement in a new site within three (3) weeks of insertion	283.41	20.000
9825	Removal of a partially buried catheter which had been centrally placed after three (3) weeks of insertion, or of revision, or of replacement	68.40	20.000
9826	Insertion of a totally buried catheter with subcutaneous reservoir including replacement if necessary and three (3) weeks care of the wound (e.g., Portacath) with catheter located in a central vein or peritoneal cavity	261.57	20.000
9827	Revision of above after three (3) weeks of insertion	121.82	20.000
9828	Removal after three (3) weeks from insertion	68.40	20.000
	Note: *Physicians supervising TPN are to claim concomitant care in accordance with Rules of Application 14, 47, and 48.*		
2536	Pulmonary, embolectomy (with cardiac bypass)	1,321.75	26.875
2541	Thrombectomy for vena cava	605.25	22.750
2543	for iliac vein	481.67	22.750
2545	for common femoral	605.68	22.750
2547	on either one (1) of these veins with additional ligation of the vena cava	855.59	22.750

REVISION AND REPAIR

2528	Ligation, femoral vein	218.41	20.000
2530	iliac vein	442.06	20.000
2532	inferior vena cava	481.36	22.750
2534	Plication, inferior vena cava	543.86	22.750
2538	Shunt porto-caval	1,156.66	25.500
2540	spleno-renal	1,190.50	25.500
2539	meso-caval (with or without graft)	1,080.11	25.500
2552	Wound or injury of major vein, suture, trunk	603.75	25.500
2554	extremity	482.11	22.750
2526	Insertion of endovenous filter by transcutaneous catheterization—Greenfield umbrella or filter	314.40	20.000
2569	**Unlisted or Unusually Complicated**	***By Report***	26.875

VARICOSE VEINS—ITEMS INCLUDE THE LOCAL ANESTHETIC

Note: *Tariff 2549 may be claimed in addition to tariff 2550 or 2548.*

INCISION

		UNIT VALUE	
2313*	Varicose vein injection	25.40	
2544	maximum accumulative benefit, per leg	222.47	
2570*	Foam sclerotherapy of the greater or smaller saphenous vein (GSV, SSV, AAGSV and PAGSV), or Foam sclerotherapy via catheter of saphenous branches or perforating veins, per leg	285.60	
2571*	Abscess or hematoma resulting from 2570, puncture aspiration	28.31	

Note: *1) 2571 is payable in the post-operative period for post-procedure pain for 2570. 2571 is payable to a maximum of (5) five per leg for each sitting, subject to the rules of application:*

a. 1st 2571 paid at 100%
b. 2nd, 3rd, 4th and 5th paid at 75%.

2) 2570 and 2571 may only be claimed by physicians with fellowship designation with the Canadian Society of Phlebology (CSP) or equivalent e.g., Diploma of American Board of Venous and Lymphatic Medicine or appropriate surgical training.

3) A physician may claim a maximum of (5) five 2570 treatments per leg per 12 month period.

4) The benefit for 2570 is inclusive of all imaging required.

2549*	Incision and ligation or avulsion of varicose veins under local anesthetic at any one (1) sitting, initial vein–for general anesthetic see Rule of Application 57	114.40	20.000
2551*	each additional	26.68	
2598	maximum accumulative benefit, per leg	418.57	20.000

REVISION AND REPAIR

2546	Long saphenous vein at saphenofemoral junction, ligation and division with or without retrograde injection or distal interruptions	283.66	20.000

RESECTION

2550	Long or short saphenous vein, ligation and division and complete stripping	354.96	20.000
2548	Long and short saphenous vein, ligation and division and complete stripping	400.02	20.000
2553	Linton or Cockett's procedure	456.28	20.000
2555	with complete stripping	546.41	20.000

ANGIOGRAMS

Procedural Services

Note: *1) These procedural benefits are intended to cover compensation for the professional service of placing an instrument and introducing contrast media (except in excretion studies of the biliary and renal tracts, and oral or rectal administration for study of the alimentary canal).*

2) The same benefits may be charged for similar services associated with diagnostic physiological studies of non-radiological nature, for example, catheterization for physiological sampling or the transmission of pressure, sound or electrical waves or the therapeutic injection of drugs.

3) For Angiography procedures, introduction may be made by:

- *Percutaneous needle or cutdown on superficial peripheral vein.*
- *Percutaneous catheter or cutdown on peripheral vein.*
- *Exposure of major artery.*

4) In Column C ONLY; when two (2) or more examinations are done on the same patient on the same day, 50% of the benefits of the others are paid, and if bilateral, 75% of the others are paid.

"Selective" means instrument passed deliberately into branch, tributary or cardiac chamber.

COLUMN C: Represents the additional benefit for the professional procedural portion of the examinations and is separate and distinct from the professional supervisory and interpretative benefits of Column Pro.

ANGIOGRAPHY

AORTOGRAMS

		COLUMN C	UNIT VALUE
6200	Abdominal	154.97	20.000
6201	Arch	166.54	20.000
6202	Intravenous	74.03	20.000
6203	Thoracic	167.57	20.000
6204	Translumbar	92.67	20.000
6205	Other—specify	132.09	20.000

For two (2) examinations done on same patient, same day—See NOTE 4

SELECTIVE ANGIOGRAMS

6210	Adrenal arteriogram	170.92	20.000
6211	Angiographic examination dialysis shunt	152.00	20.000
6212	Axillary	177.35	20.000
6213	Brachial	166.45	20.000
6208	Cerebral (brachial retrograde)	154.28	20.000

		COLUMN C	UNIT VALUE
6214	Bronchial	124.81	20.000
6215	Carotid	178.79	20.000
6216	Celiac	150.58	20.000
6217	Common iliac	153.60	20.000
6229	Popliteal, with antegrade catheterization	112.81	20.000
6218	External carotid arteriogram	150.58	20.000
6219	Hepatic	150.58	20.000
6220	Inferior mesenteric	154.51	20.000
6221	Innominate	160.34	20.000
6222	Internal iliac	112.81	20.000
6223	Renal	154.51	20.000
6224	Superior mesenteric	129.19	20.000
6225	Subclavian	131.11	20.000
6226	Splenic	154.51	20.000
6227	Vertebral	166.09	20.000
6228	Transcatheter therapy, embolization, any method	453.27	22.750
6235	Bilateral selective angiogram or venogram	302.77	20.000
6206	Internal mammary	119.96	20.000
6207	Left gastric	150.58	20.000
6209	Gastroduodenal	150.58	20.000
6231	Internal carotid	155.63	20.000
6232	Super selective angiogram (e.g., Distal branch of any of the above selective)	132.51	20.000
	For two (2) examinations done on the same patient, same day—See NOTE 4.		

FEMORAL ARTERIOGRAMS

		COLUMN C	UNIT VALUE
6230	Unilateral	173.01	20.000
	bilateral—See NOTE 4		

VENOGRAMS

6236	Azygogram	108.65	20.000
6237	Femoral	117.77	20.000
6238	Iliac	71.64	20.000
6239	Inferior vena cavogram	107.73	20.000
6240	Intraosseous	77.74	20.000
6241	Jugular	82.32	20.000
6242	Lower limb	120.43	20.000
6243	Subclavian	120.43	20.000
6244	Superior vena cavogram	132.94	20.000
6245	Umbilical vein catheterization	101.67	20.000
6246	Upper limb	137.69	20.000
6247	Orbital venogram	77.05	20.000
	For two (2) examinations done on same patient, same day—See NOTE 4		

SELECTIVE VENOGRAMS

6250	Adrenal	169.44	20.000
6251	Hepatic	160.91	20.000
6252	Jugular	160.91	20.000
6253	Renal	160.91	20.000
6235	Bilateral selective angiogram or venogram	302.77	20.000
	For two (2) examinations done on same patient, same day—See NOTE 4		

ANGIOGRAPHY

6255	By exposure of major vein, abdominal or thoracic	161.80	20.000
6256	cerebral	184.58	20.000

ANGIOCARDIOGRAMS

6260	Atrial, left	338.30	21.375
6261	right	280.83	21.375
6262	Pulmonary angiogram	182.66	21.375
6263	Selective coronary angiogram	326.46	21.375
6264	with left and/or right heart catheterization	403.99	21.375

		COLUMN C	UNIT VALUE
6265	Ventricular, left	338.30	21.375
6266	right	280.83	21.375
6267	Percutaneous transluminal balloon coronary angioplasty including angiography with or without pressure measurements on one (1) or more sites on a single coronary artery	793.15	21.375
6268	on two (2) coronary arteries (i.e., right and circumflex, or right and anterior descending, or circumflex and anterior descending)	1,055.45	21.375
6270	on three (3) coronary arteries, right, circumflex, and anterior descending	1,317.74	21.375

Note: *1) Tariffs 6267, 6268 and 6270 include associated angiograms at the time of the procedure and pressure measurement, aortography, pacemaker adjustments including connecting to a guide wire, cardioversion, and continuing care during that hospital admission.*

2) Only one (1) of the three tariffs (6267, 6268 or 6270) can be claimed for one (1) sitting.

3) If a patient does not have a pacemaker and one has to be inserted at the time, such will be paid for at 50% notwithstanding the fact that the benefit is asterisked.

4) Notwithstanding Note 1, tariffs 2307, 2308, 2325 or 2327 may be claimed in addition at 50% when done at the same sitting provided the patient has not undergone the same service within the preceding fourteen (14) days.

2397*	Intracoronary Ultrasound or OCT, add	125.74	
2401*	Coronary pressure derived fractional flow reserve (Coronary FFR) per coronary vessel, add	124.50	

Note: *1) Tariffs 2401 and 2397 may be claimed in addition to tariffs 2307, 2308, 2325 or 2327.*

2) Coronary angioplasty (tariffs 6267, 6268 or 6270) is payable at 100% when rendered on the same day as tariff 2401 or 2397.

2399	Coronary thrombectomy, add	102.00	
2478	Atherectomy, any method e.g., orbital, rotoblation, add	204.00	
6278	Insertion of stent(s) in single (1) coronary artery	157.95	
6279	Insertion of stent(s) in two (2) coronary arteries	211.09	
6280	Insertion of stent(s) in three (3) coronary arteries	263.47	

Note: *The fees for tariffs 6278, 6279 and 6280 shall be equivalent to 20% of the fees for tariffs 6267, 6268, 6270 respectively.*

6271	Aortic balloon valvuloplasty	692.35	25.500
6272	Coarctation balloon valvuloplasty	458.96	25.500
6273	Pulmonary balloon valvuloplasty	728.30	25.500
6274	Mitral valve balloon valvuloplasty	1,030.72	25.500
6275	Pulmonary artery stenosis, first vessel	422.38	25.500
6276	each additional vessel	588.99	25.500

Note: *Each of the above tariffs 6271, 6272, 6273, 6274, 6275, and 6276, includes angiographs, pressure measurements, aortography, pacemaker adjustments, cardioversion and care during that admission.*

6269 **Unlisted or Unusually Complicated** ..... ***By Report*** 21.375

HEMIC AND LYMPHATIC SYSTEMS

These benefits cannot be correctly interpreted without reference to the Rules of Application.

Add 50% to fee payable for procedural fees when patient is less than two (2) years of age. Premium applies to tariffs 2691 and 2693.

LYMPH NODES

INVESTIGATION

			UNIT VALUE
2643*	Cervical lymph node biopsy (independent procedure)	211.69	20.000
2642*	Anterior scalene dissection (independent procedure)	231.83	21.375
2644*	Axilla lymph node biopsy (independent procedure)	167.82	20.000
2641*	Other nodes biopsy (independent procedure)	142.47	20.000
0438	Sentinel lymph node biopsy in breast neoplasm	562.84	21.375

Note: *1) When one (1) or more of the procedures (0438, 0442, 0457, 0443, 0471, 2658) are performed by the same surgeon under the same anesthetic in addition to sentinel lymph node biopsy, the procedure with the highest fee shall be paid at 100% and the remaining procedures at 75%.*

2) When more than one (1) lymph node basin identified as having a sentinel node (separate surgical site) at the same anesthetic—claim 2nd sentinel at 75% in addition.

3) Completion of axillary node dissection following a positive sentinel node biopsy on final pathological diagnosis not at the same anesthesia—claim tariff 2658 at 100% regardless of time interval.

2645	Sentinel lymph node biopsy in melanoma	486.15	21.375

Note: *1) With wide excision when one (1) or more procedures are performed by the same surgeon under the same anesthetic in addition to sentinel lymph node biopsy, the procedure with the highest fee shall be paid at 100% and the remaining procedures at 75%.*

2) When more than one (1) lymph node basin identified as having a sentinel node (separate surgical site) at the same anesthetic—claim 2nd sentinel at 75% in addition.

3) Completion of lymphadenectomy following a positive sentinel node biopsy on final pathological diagnosis not at the same anesthesia—claim tariff 2658 or tariff 2672 at 100% regardless of time interval.

3582	Staging laparotomy for lymphoma with retroperitoneal node dissection and dissection of porta hepatis	1,034.37	22.750
3583	two (2) or more liver biopsies, add	62.07	22.750
3584	splenectomy, add	819.53	22.750
3585	lateral ovary transposition, add	104.57	22.750
3586	medial ovary transposition, add	60.53	22.750
3587	open iliac crest biopsy, add	103.54	22.750

INCISION

			UNIT VALUE
2631*	Abscess of lymph node, simple drainage	71.66	20.000

REVISION AND REPAIR

2696	Thoracic duct repair	644.08	25.500

RESECTION

2665	Lymphadenectomy, cervical, radical, unilateral	1,221.07	22.750
2676	suprahyoid, unilateral	566.42	21.375
2678	bilateral	436.80	21.375
2658	axilla, radical	596.89	21.375
2672	inguinal, superficial	539.62	20.000
2652	iliac, deep	847.40	22.750
2674	retroperitoneal, including pelvic, aortic and renal dissection	1,493.79	22.750
2675	staging pelvic lymphadenectomy for prostate cancer	689.00	22.750
2671	Primary retroperitoneal lymphadenectomy, thoracoabdominal or transperitoneal, for testis cancer	1,584.35	22.750
2673	for post chemotherapy patients, add	546.63	
2666	Modifed Radical Neck Dissection including removal of all cervical lymph nodes (level 1-5 inclusive) with preservation of any or all of the sternocleidomastoid muscle, the internal jugular vein and the accessory nerve	1,338.38	22.750
5996	Intra-operative monitoring of cranial/facial nerves remote from the skull base, add	145.06	

Note: *5996 may only be claimed in addition to the following tariffs, 0616, 2666, 2927, 2934, 4972, 5957, 5971, 5973, 5974, 5975, 5976, 5977, 5992 and 5995.*

2699	**Unlisted or Unusually Complicated**	***By Report***	22.750

SPLEEN

INVESTIGATION

2602*	Needle biopsy	87.15	20.000
2603	Biopsy of spleen when exposed at other operations	30.65	

REPAIR

2604	Suture repair or partial splenectomy (excluding intraoperative trauma)	***By Report***	25.500

RESECTION

			UNIT VALUE
2601	Splenectomy	766.72	22.750
2609	**Unlisted or Unusually Complicated**	***By Report***	25.500

MEDIASTINUM

INVESTIGATION

2684*	Mediastinoscopy	314.78	22.750
2685*	Mediastinoscopy with bronchoscopy or esophagoscopy, or gastroscopy with or without biopsy	401.83	22.750
2687	Bronchoscopy, mediastinoscopy and left anterior mediastinotomy	568.93	22.750

RESECTION

2691	Mediastinal cyst excision	925.79	25.500
2693	Mediastinal tumor excision	932.90	25.500
2686	Thymectomy	830.60	26.875
2689	**Unlisted or Unusually Complicated**	***By Report***	26.875

DIGESTIVE SYSTEM

These benefits cannot be correctly interpreted without reference to the Rules of Application.

Add 50% to fee payable for procedural fees when patient is less than two (2) years of age. Premium applies to tariffs 3067, 3105, 3133, 3135, 3141, 3172, 3174, 3179, 3191, 3195, 3201, 3231, 3235 and 3226.

LIPS

INVESTIGATION

2753*	Biopsy of lip	44.97	

INCISION

			UNIT VALUE
2752*	Abscess of lips, drainage	46.36	20.000

REVISION AND REPAIR

2754	Cleft lip repair, primary, unilateral	777.18	21.375
2758	bilateral, one (1) stage	871.32	21.375
2759	two (2) stages—per stage	658.50	21.375
2762	secondary repair by creation of defect and re-closure, unilateral	593.75	21.375
2765	bilateral, per major stage	665.76	21.375

RESECTION

2741	V excision of lip, less than 1/3	150.98	21.375
2743	1/3 to 1/2	229.63	21.375
2742	Vermilionectomy—(lip peel)	299.58	21.375
2746	Resection of more than 1/2 the lip without plastic closure	378.88	21.375
2769	**Unlisted or Unusually Complicated**	***By Report***	21.375

MOUTH

INVESTIGATION

2819*	Biopsy of cheek or gum mucosa	41.41	20.000
4908*	Needle biopsy of neck masses	35.28	

INCISION

2815*	Abscess, alveola, gum or cheek intraoral drainage	58.36	25.500
2705*	Ludwig's angina, external drainage	73.64	25.500

RESECTION

			UNIT VALUE
2790	Malignant intraoral lesion with incontinuity neck dissection	1,896.29	22.750
2788	Malignant intraoral lesion with incontinuity neck dissection and resection of mandible	2,066.43	25.500
2799	**Unlisted or Unusually Complicated**	***By Report***	25.500

TONGUE

INVESTIGATION

2781*	Biopsy anterior 1/3	48.42	20.000
2783*	Posterior 2/3	48.42	21.375

INCISION

2701*	Lingual or sublingual abscess drainage	48.94	21.375
2775*	Thyroglossal duct abscess drainage	48.94	21.375

REVISION AND REPAIR

2786	Tongue tie, incision of frenulum under local anesthetic – for general anesthetic see Rule of Application 57	55.74	20.000

RESECTION

2784	Benign or small malignant tumor under 1.5 cm. local or general anesthetic	143.66	21.375
2785	Partial glossectomy for lesions over 1.5 cm.	361.29	22.750
2787	Total glossectomy	602.16	22.750
4941	Thyroglossal duct, cyst or sinus excision	456.23	21.375
2789	**Unlisted or Unusually Complicated**	***By Report***	22.750

PALATE

INVESTIGATION

2881*	Biopsy palate	41.41	20.000

INCISION

2871*	Palate abscess drainage	66.19	21.375

REVISION AND REPAIR—CLEFT PALATE

2891	Alveolar ridge anterior palate defect	425.52	21.375
2892	Complete, including alveolar ridge	830.86	22.750
2890	partial	603.29	22.750

			UNIT VALUE
2895	Major revision complete cleft	647.32	22.750
2894	Major revision partial cleft	647.32	22.750
2897	Secondary lengthening	616.16	22.750
2898	Pharyngoplasty—attachment of pharyngeal flap to palate	582.57	22.750

RESECTION

2885	Palate lesion resection	435.88	21.375
2887*	Uvulectomy	42.24	21.375
2888*	Complete assessment of cleft palate function including complete history and physical examination, video and audio recordings, local nasal and pharyngeal anesthesia and nasendoscopy	90.25	
2899	**Unlisted or Unusually Complicated**	***By Report***	22.750

PHARYNX

INVESTIGATION

2981*	Biopsy nasopharynx	44.09	21.375
2982*	oropharynx	36.16	21.375
2980*	hypopharynx	44.09	21.375

INCISION

2979*	Peritonsillar abscess drainage	160.25	25.500
2971*	Retropharyngeal or parapharyngeal abscess, intraoral or extra-oral drainage	189.25	25.500
2978*	Transcervical incision and drainage of deep neck space abscess, external incision under general anesthesia	309.78	25.500

REVISION AND REPAIR

2994	Hemorrhage post-tonsillectomy	305.46	25.500
3021	Pharynx wound repair	***By Report***	22.750
3077	Pyriformotomy (independent procedure)	99.93	22.750
3011	Pharyngoplasty—reconstructive operation on pharynx	***By Report***	22.750
2883	Uvulopalatopharyngoplasty (UPPP) with or without tonsillectomy or other pharyngeal surgery	490.01	22.750

Note: *UPPP is an insured service when sleep apnea has been confirmed by a provincial sleep laboratory study and there is evidence of an anatomical problem of the oral pharynx amenable to surgical correction.*

RESECTION

			UNIT VALUE
2975	Nasopharyngeal fibroma	***By Report***	21.375
2989	Branchial cleft cyst or sinus, subcutaneous	390.97	20.000
2990	deep	584.61	20.000
2987	Pharyngeal diverticulum resection and/or crico-pharyngeal myotomy	519.07	22.750
3049	Endoscopic pharyngeal myotomy	467.16	22.750
	Note: *Tariffs 3055, 3063, 3057, 3065, 3121, 3122, 3123 and other endoscopic procedures may not be claimed in addition on the same day.*		
2996	Adenoidectomy alone	157.82	21.375
2992	Tonsillectomy with or without adenoidectomy or uvulectomy	316.20	21.375
2997*	Tonsil tag, local anesthesia	14.07	
2998*	general anesthesia	100.70	21.375
2889	**Unlisted or Unusually Complicated**	***By Report***	22.750

SALIVARY GLAND AND DUCTS

5996	Intra-operative monitoring of cranial/facial nerves remote from the skull base, add	145.06	
	Note: *5996 may only be claimed in addition to the following tariffs, 0616, 2666, 2927, 2934, 4972, 5957, 5971, 5973, 5974, 5975, 5976, 5977, 5992 and 5995.*		

INVESTIGATION

2921*	Biopsy salivary gland	41.88	21.375

INCISION

2915*	Submaxillary or parotid duct calculus, uncomplicated, intraoral removal, office procedure	68.62	21.375
2919	difficult, intraoral removal in hospital	161.57	21.375
2916	Parotid calculus, extra-oral removal	198.52	21.375
2918*	Submaxillary or parotid abscess drainage	217.42	21.375

REVISION AND REPAIR

2961*	Salivary duct dilation	80.05	21.375
2941	plastic repair	293.32	21.375
2951	Salivary fistula closure	297.64	21.375
2950	Rerouting of submandibular ducts	410.54	21.375

RESECTION

2930	Submaxillary tumor and/or submandibular gland excision and/or sublingual gland excision	475.38	21.375

			UNIT VALUE
2925	Superficial parotid tumor, excision without nerve dissection	662.01	21.375
2927	Superficial parotid lobectomy with nerve dissection	892.10	21.375
2934	Total parotid excision with facial nerve dissection	1,288.11	22.750
2937	with facial nerve sacrifice	970.35	22.750
2949	**Unlisted or Unusually Complicated**	***By Report***	22.750

ABDOMEN

INVESTIGATION

3572*	Laparoscopy, diagnostic	193.52	21.375
3574*	Laparoscopy, diagnostic when followed at the same sitting by an open abdominal operation, add	188.63	21.375
3579	Converted surgery, from laparoscopic to open technique, add	188.63	
	Note: *Tariff 3540, 3572, and 3574 may not be claimed in addition.*		
3589*	Abdominal lavage for trauma	49.09	
3577	Laparotomy for trauma	674.94	22.750
	Note: *Laparotomy for trauma includes complete exploration of intraperitoneal and retroperitoneal structures including hematoma and evacuation of blood and control of bleeding from minor vessels. [When one or more abdominal surgical services are performed by the same surgeon in addition to laparotomy for trauma, the procedure with the highest fee (including tariff 3577) shall be paid at 100%, and the remaining surgical services (including tariff 3577) shall be paid at 75%.]*		
3571	Exploratory laparotomy	461.66	22.750
3594	Second look procedure after ischemic bowel resection	420.66	22.750

INCISION

3588*	Abdominal paracentesis, initial	67.53	
3590*	subsequent	67.53	
3573	Abscess, intra-abdominal drainage including subphrenic and pelvic abscess exclusive of appendicular	478.84	22.750
3285	Transrectal abscess drainage	221.29	21.375
3575	Subphrenic abscess drainage	584.80	22.750

REVISION AND REPAIR

3668	Omphalocele first stage or subsequent stage regardless of when performed	732.95	22.750
3663	Epigastric hernia, initial	336.98	21.375
3664	recurrent	385.14	21.375
3666	Umbilical hernia	388.49	21.375

			UNIT VALUE
3661	Ventral hernia, incisional repair with or without prosthesis includes enterolysis (independent procedure)	655.98	21.375
3660	Ventral hernia—massive incisional—with or without enterolysis, with or without prosthesis (independent procedure)	780.59	22.750
3646	Femoral hernia, initial	430.67	20.000
3651	recurrent	530.40	21.375
3631	Inguinal hernia, initial	430.67	20.000
3632	pediatric with negative contralateral exploration	485.68	20.000
3636	with excision of hydrocele and/or orchiectomy	499.90	20.000
3635	recurrent	556.57	21.375
3633	Incarcerated hernia without bowel resection	535.21	21.375
3734	Wound disruption (postop), secondary suture	441.60	22.750
3591	Peritoneo-venous shunt, placement	574.87	21.375
3592	removal for infection	245.24	21.375
3593	removal and replacement of valve for blockage	182.87	21.375
3707	Diaphragm (transabdominal or thoracic), rupture, early repair	1,005.22	25.500
3708	diaphragm hernias excluding anti-reflux surgery	1,015.45	26.875
3706	with prosthesis, add	273.31	

RESECTION

3596	Abdominal panniculectomy—large (vertical skin resection 15 cm. to 30 cm.)	680.55	21.375
3597	Abdominal panniculectomy—massive (vertical skin resection over 30 cm.)	1,059.98	21.375

Note: *1) Written prior approval from the Minister is required. The application must include evidence that abdominal panniculectomy is medically indicated, secondary to chronic or recurrent subpanus intertrigo, which has been unresponsive to reasonable period of medical treatment.*

2) Cosmetic (uninsured) procedures (e.g. liposuction, abdominoplasty and/or umbillicoplasty) performed in conjunction with tariff 3596 or tariff 3597, are not eligible for benefits.

3) Tariffs 3596 and 3597, when performed with another abdominal or pelvic procedure (e.g. hernia repair), are payable only when the requirements as set out above are fulfilled.

3580	Retroperitoneal or transperitoneal tumor or cyst; excision	962.93	22.750
3619	**Unlisted or Unusually Complicated**	***By Report***	22.750

PERITONECTOMY AND INSTALLATION OF HEATED INTRAPERITONEAL CHEMOTHERAPY (HIPEC)

			UNIT VALUE
3600	Peritonectomy and installation of heated intraperitoneal chemotherapy (HIPEC)	3,837.50	26.875

Note: *1) 3600 is payable as an all inclusive benefit. It includes resection of all organs and lymph nodes as required.*

2) 3600 is payable as an approved treatment for:

a) Peritoneal mesothelioma;

b) Pseudomyxoma peritonei; and

c) Abdominal carcinomatosis from gastrointestinal cancers.

3) 3600 is payable only when the service is provided at Health Sciences Centre.

4) 3600 may be claimed only by physicians designated as eligible by the Shared Health Chief Medical Officer (or designate).

ENDOSCOPY

Note: *Tariffs 3000, 3002, 3004, 3006, 3008 and 3010 may only be claimed in addition to gastrointestinal endosopic procedure tariffs.*

3000*	Balloon dilatation of colonic, pyloric, esophageal or small bowel strictures, add	104.57	21.375
3002*	Botox injection, add	52.48	21.375
3004*	Hemostasis G. I. Tract by any endoscopic method or technique (e.g., cautery, injection, banding), add	120.64	21.375
3006*	Hemodynamic instability, add	55.18	25.500

Note: *Claim, for tariff 3006, must indicate that the patient exhibits one (1) or more of the following: Pulse Rate >100/minute; Blood pressure <80 systolic; hemoglobin <80; On-going bleeding.*

3008*	Placement of jejunal or small bowel feeding tube beyond pyloris, add	84.78	20.000
3010	Insertion of small bowel or colonic stent (s) (includes dilatation if necessary), add	187.04	21.375

Note: *Tariff 3000 may not be claimed in addition to tariff 3010.*

3012	Multiple, ten (10) or more, endoscopic biopsies, add	63.55	

Note: *1) Tariff 3012 may only be claimed in addition to tariffs 3185, 3186, 3187 or 3189.*

2) A minimum of ten (10) biopsy specimens must be obtained.

3013 Multiple, ten (10) or more, endoscopic biopsies of the upper GI tract add on to procedural fee 38.64

Note: *1) Tariff 3013 may only be claimed in addition to tariffs 3055, 3121, 3122 or 3123.*

2) A minimum of ten (10) biopsy specimens must be obtained.

3014 Endoscopic Mucosal Resection, add 172.33

Note: *1) Tariffs 3014 may be claimed in addition to tariff 3055, 3121, or 3185.*

2) May be claimed for the following:

a) Barrett's Esophagus;

b) Subepithelial lesion;

c) Sessile polypoid lesion;

d) Large sessile polyp; or,

e) Flat dysplasia in the stomach, duodenum or colon/rectum.

3) Only indicated for non-pedunculated lesions greater than 20 mm or mucosal invasion confirmed by imaging.

4) Polypectomy may not be claimed in addition.

0005 Endoscopic Tray Fee 193.80

May only be claimed in addition to tariffs 1949, 3055, 3065, 3095, 3121, 3122, 3123, 3185, 3186, 3187, 3189, 3926, 3927, 3928, 3929, 3931, 3932, 3933, 3939, 4636 and 4647 when the service is rendered in the **physician's office.**

Note: *Tray Fee tariff 0005 is claimable only in instances where expenses are directly incurred by the physician for medical/surgical supplies. Tray Fee tariff 0005 is not claimable in relation to services performed at a hospital, personal care home or other publically funded facility or a facility on contract with a Regional Health Authority to perform such insured services.*

ESOPHAGUS

			UNIT VALUE
3055*	Esophagoscopy, diagnostic, with or without biopsy	110.42	21.375
3063*	subsequent, same hospital admission	101.94	21.375
3057	with foreign body removal	192.34	21.375
3065*	with injection of varices or band ligation	217.47	21.375
3084*	Radiofrequency Ablation for Barrett's Esophagus, includes biopsies, polypectomies, control of bleeding and endoscopy with or without image guidance	242.10	22.750
3082	Endoscopic Submucosal Dissection (ESD) and resection of a gastric or esophageal tumour	1,236.24	22.750

Note: *Limited to specialists in Thoracic Surgery, Gastroenterology or General Surgery, with advanced endoscopy as approved by the Shared Health Provincial Chief Medical Officer (CMO) or designate.*

STOMACH

3121*	Gastroscopy, diagnostic with or without biopsy	125.74	21.375

			UNIT VALUE
3122*	with polypectomy	212.22	21.375
3123*	Esophagogastroduodenoscopy (EGD) with or without biopsy	133.30	21.375
3124*	Esophagogastroduodenoscopy (EGD) with debridement and/or necrosectomy of extraluminal cyst, with or without revision of stent	488.99	22.750

Note: *1) Additional claims for 3124 for the same patient within 60 days shall be payable at 85%.*

2) Patients must have previously undergone an Endoscopic Ultrasound.

SMALL INTESTINE

3215*	Balloon assisted enteroscopy, oral route	334.82	22.750
3216*	Balloon assisted enteroscopy, rectal route	360.57	22.750

Note: *1) Patients will have previously undergone some or all of the following: a capsule endoscopy, CT scan, or present exceptional clinical circumstances as per by report, such as small bowel bleeding.*

2) Payable only for services performed at a facility to be designated by Manitoba Health (Health Sciences Centre) by a gastroenterologist who has been approved by the Gastroenterology Section Head at the Winnipeg Regional Health Authority.

3) Tariffs 3055, 3057, 3063, 3065, 3121, 3122, 3123, 3190, cannot be claimed concurrently with tariff 3215.

4) Tariffs 3185, 3186, 3187, 3188, 3189, 3196 cannot be claimed concurrently with tariff 3216.

3190*	Small bowel enteroscopy by mouth using designated enteroscope or colonoscope	236.95	21.375

Note: *Pathology report may be required.*

3192	Capsule Endoscopy–Includes the review of imaging of the small bowel and report to the referring physician	446.10	

Note: *1) A visit cannot be claimed at the same sitting as the initiation of capsule endoscopy.*

2) Minimum time for the service is one (1) hour including the assessment of referrals to determine indication for procedure.

3) Patients will have previously undergone some or all of the following: Esophagogastroduodenoscopy (EGD), colonoscopy, small bowel enteroscopy and/or small bowel series–radiography & fluoroscopy.

4) Payable only for services provided by a Gastroenterologist or by a qualified physician with training in capsule endoscopy, at a facility to be designated by Manitoba Health (Health Science Centre and Brandon Regional Health Centre).

COLON AND APPENDIX

Note: *1) Tariffs 3185 or 3186 are payable where the service is requested for:*

i.) a symptomatic patient;

ii.) an asymptomatic patient with a family history of colorectal cancer; or

iii.) an asymptomatic patient who is fifty (50) years of age or older.

2) Tariffs 3185 and 3186 are payable once every thirty-six (36) month period in respect to each asymptomatic patient.

Note: *"Symptomatic patient" includes but is not limited to a patient who has a personal history of colorectal cancer, adenomatous polyps, inflammatory bowel disease, or a positive result on a self-administered fecal occult blood test (FOBT).*

"Family history" means at least one first-degree relative (parent, sibling or child) or at least two second-degree relatives (grandparents, grandchildren, uncles, aunts, nieces, nephews or half-siblings) who have been diagnosed with colorectal cancer.

			UNIT VALUE
3185*	Colonoscopy	201.92	21.375
3186*	with biopsy	211.92	21.375
3187*	with polypectomy using snare	308.23	21.375
3189*	with polypectomy using electro-cautery device	308.23	21.375
3188*	more than one (1) polyp removed at the same sitting, add to 3187 or 3189 for each to a maximum of four (4) additional polyps, (using snare or electro-cautery device)	74.58	21.375
3196*	Ileal intubation, in conjunction with colonoscopy, with or without biopsies, add	21.84	

Note: *1) Tariff 3196 may only be claimed in addition to tariffs 3185, 3186, 3187 and 3189.*

2) Ileal intubation is not to be claimed for routine screening of asymptomatic patients. The patient must exhibit at least one (1) of the following symptoms: abdominal pain, chronic diarrhea or GI bleeding.

3199	Endoscopic Submucosal Dissection (ESD) and resection of gastro-intestinal tumour	714.00	22.750

Note: *1) 3199 is limited to specialists in Gastroenterology and General Surgery with additional training in advanced endoscopy as approved by the Shared Health Provincial Chief Medical Officer (CMO) or designate.*

2) For lesions distal to the gastric pylorus.

RECTUM

3311*	Proctosigmoidoscopy, rigid or flexible up to 25 cm. alone	56.30	20.000
3313*	with biopsy	64.92	20.000

			UNIT VALUE
3315*	Proctosigmoidoscopy, with removal of single lesion	90.56	20.000
3317*	multiple lesions	112.44	20.000
3319	complicated for hemorrhage control or removal of foreign body	***By Report***	20.000
3320*	flexible sigmoidoscopy between 25 cm. and 65 cm., with or without biopsy	85.58	20.000
3323*	without biopsy, with removal of a single polyp	113.22	20.000
3324*	more than one (1) polyp removed at the same time, add $44.55 for each to a maximum of four (4) additional polyps	44.55	
3312*	Proctosigmoidoscopy with deep muscle biopsies (separate specimens) under regional or general anesthesia, e.g., for Hirschsprung's Disease.	147.17	20.000

ENDOSCOPIC ULTRASOUND

Payable only for echo-endoscope or mini-probe services provided by gastroenterologist, general surgeon or thoracic surgeon at a facility designated by Manitoba Health, which are now at Health Science Center and St. Boniface General Hospital.

Echo-Endoscope

3020	Endoscopic ultrasound using linear or radial echo-endoscope excluding biliary or pancreatic examination	240.04	22.750
3022	Endoscopic ultrasound using linear or radial echo-endoscope including biliary and/or pancreatic examination	300.15	22.750

Note: *Tariff 3024 through tariff 3036 may be claimed in addition to tariff 3020 or tariff 3022.*

3024	Fine needle aspiration (FNA), each FNA to a maximum of five (5) per lesion, add	60.01
3026	Core needle biopsy, each biopsy to a maximum of two (2) biopsies per lesion, add	60.01
3028	Fine needle aspiration of pancreatic cyst with removal of cyst fluid, including fine needle aspiration of cyst wall, add	230.78
3030	Injection into one or more of the following–metastases, nodes, masses, or celiac plexus, add	171.53
3034	Cap-assisted endoscopic mucosal or sub-mucosal resection, per resection, add	117.14
3036	Endoscopic ultrasound assisted drainage of pancreatic pseudocyst including stent insertion, add	206.04

Note: *1) Tariff 3020 may not be claimed with tariff 3022 for the same sitting.*

2) EGD, Gastroscopy, Flexible Sigmoidoscopy or Colonoscopy (tariffs 3123, 3121, 3320, or 3185) may not be claimed in addition to tariff 3020 or tariff 3022 unless the endoscopy is required due to the limited visualization with the linear or radial echo-endoscope.

3) EGD, Gastroscopy, Flexible Sigmoidoscopy or Colonoscopy (tariffs 3123, 3121, 3320, or 3185) may be claimed on the same day as tariff 3030 or tariff 3022 if the endoscopic examination is clinically indicated and precedes the echo-endoscopic examination.

4) Patients will have previously undergone examinations of the upper/lower G.I. e.g. endoscopy or Radiological studies (MRI, CT Contrast).

5) Tariffs 3022, 3028, 3036 are not payable to thoracic surgeons.

		UNIT VALUE	

Mini Probe

Note: *The following may be claimed in addition to endoscopy tariffs 3123, 3121, 3320 or 3185.*

3038	Endoscopic ultrasound, radial or linear mini probe through endoscope to endoscopy fee, add	114.35	22.750

Note: *Tariffs 3020, 3024, 3026 or 3034 may be claimed in addition to tariff 3038.*

Miscellaneous Doppler Studies

3039	Where doppler is used as an additional diagnostic modality on any endoscopic ultrasound procedure, add	25.81	

Note: *The above tariff 3039 may be claimed in addition to tariffs, 3020, 3022, and 3038.*

ESOPHAGUS

INVESTIGATION

3064	Esophageal manometry	188.24	
3071*	Oesophageal PH monitoring	175.24	

Note: *Tariffs 3064 and 3071 are payable only where the service is provided at Health Sciences Centre, St. Boniface General Hospital or Brandon Regional Health Centre.*

INCISION

3075	Cervical esophagostomy (external fistulization of esophagus)	433.71	21.375
3031	Cervical esophagotomy with or without foreign body removal	426.35	21.375
3033	Transthoracic esophagotomy with or without foreign body removal	631.00	22.750

REVISION AND REPAIR

3098*	Stricture of esophagus, dilatation, indirect with wire or thread, initial	53.98	21.375
3099*	dilatation, indirect with wire or thread, subsequent	41.16	21.375
3094*	Wire-Guided esophageal dilatation requiring general anesthetic and fluoroscopy, including esophagoscopy	188.32	21.375
3095	Esophagoscopy with dilatation with pneumatic balloon for stricture or achalasia	220.77	21.375
3092*	simple dilatation with bougie or sound	88.92	21.375
3093	Esophageal dilatation with bougie under general anesthetic	151.18	21.375
3066	prosthesis, endoesophageal tube insertion for malignant stricture	552.02	21.375
3072	cardioplasty, esophagogastric for stricture	557.34	25.500
3096*	Achalasia, dilatation of cardia, initial (pneumatic)	145.31	21.375
3076	esophagomyotomy (Heller procedure)	888.19	25.500

			UNIT VALUE
3047	Endoscopic gastro-esophageal myotomy	799.37	22.750
	Note: *Tariffs 3055, 3063, 3057, 3065, 3121, 3122, 3123 and other endoscopic procedures may not be claimed in addition on the same day.*		
3710	Hiatus hernia (anti-reflux surgery), transabdominal	852.70	22.750
3709	transthoracic	852.70	25.500
3068	direct ligation	852.70	25.500
3050*	esophageal tamponade insertion (Sengstaken-Blakemore balloon)	38.61	
	Note: *Only one (1) claim for insertion will be paid per twenty-four (24) hour period.*		
3069	Repair of paraesophageal hernia, greater than 50% of stomach, intrathoracic, either abdominal or thoracic approach, confirmed by pre-operative imaging.	1,530.00	25.500
3078	Tracheoesophageal fistula with atresia repair	1,885.33	25.500
3079	Tracheoesophageal fistula repair with gastrostomy	1,324.01	25.500
3080	Cervical esophageal fistula closure	381.07	21.375
3086	Thoracic esophageal fistula closure	929.29	25.500
3085	Ruptured esophagus, cervical repair, drainage with or without suture (i.e., suture repair optional, primary treatment is opening neck with wide drainage)	577.15	22.750
3081	mediastinal drainage	674.88	25.500
3083	thoracic repair	672.31	25.500
3053	Radioactive substance—insertion via esophagoscopy	113.84	21.375

RESECTION

3070	Esophageal diverticulum—transthoracic resection with or without myotomy and anti-reflux surgery	677.82	25.500
3044	Esophagectomy, transthoracic, end to end lower 1/3	1,608.45	25.500
3043	upper 2/3	1,530.00	25.500
3046	Esophagogastrectomy, either thoracoabdominal or through separate abdominal and thoracic incisions	1,756.34	25.500
3067	Total esophagectomy with replacement by intestine or stomach	3,238.81	25.500
	Note: *Tariff 3067 includes esophageal anastomosis performed in chest or neck, and pyloromyotomy, pyloroplasty, feeding tube and thoracic duct ligation.*		
3040	Esophageal defunctioning, esophagectomy with or without gastrectomy, with cervical esophagostomy and gastrostomy with or without feeding jejunostomy, without immediate esophageal reconstruction	1,647.87	26.875
3041	Delayed esophageal reconstruction, with stomach, colon or intestine, with or without feeding jejunostomy	2,214.73	26.875
3089	**Unlisted or Unusually Complicated**	***By Report***	26.875

STOMACH

INVESTIGATION

			UNIT VALUE
3100*	Gastric biopsy via tube	38.10	20.000
3103*	superficial, when stomach is exposed at another procedure	32.74	21.375

INCISION OR DRAINAGE

3101	Gastrotomy with exploration or foreign body removal	527.36	22.750
3102*	Gastric lavage	34.40	
3104*	Gastrostomy, button insertion, removal, or replacement	55.18	21.375

REVISION AND REPAIR

3141	Closure or repair, gastrorrhaphy for perforated ulcer	711.76	22.750
3142	repair wound or laceration	711.76	22.750
3153	closure gastrostomy	645.63	22.750
3137	Gastrostomy creation (independent procedure)	506.58	22.750
3136*	Percutaneous Endoscopic Gastrostomy (P.E.G.)	263.06	21.375
3134*	Insertion or reinsertion of jejunostomy (“J”) tube through gastrostomy opening	153.09	21.375
3131	Drainage procedures, pyloroplasty	548.37	22.750
3133	gastroduodenostomy	616.11	22.750
3135	gastrojejunostomy	616.11	22.750
3120	revision of gastroenterostomy and gastrectomy, add	438.97	
3105	pyloromyotomy (Ramstedt)	522.67	22.750
3048	Endoscopic pyloromyotomy	470.40	22.750
	Note: *Tariffs 3055, 3063, 3057, 3065, 3121, 3122, 3123 and other endoscopic procedures may not be claimed in addition on the same day.*		
3118	Vagotomy, truncal transabdominal	517.14	22.750
2152	truncal transthoracic	479.50	26.875
3119	as an addition to other procedure, add	109.29	
2158	Highly selective (parietal cell) vagotomy when performed as the sole procedure without pyloroplasty or gastro enterostomy	604.00	22.750
3138	Gastric bypass for morbid obesity	758.23	25.500
3139	Gastroplasty (gastric partitioning)	645.94	25.500
3140	Intestinal bypass for morbid obesity	577.94	25.500
3125	Laparoscopic Roux-En-Y Gastric Bypass	1,939.81	25.500

RESECTION

			UNIT VALUE
3112	Gastric ulcer or tumor, local excision	662.49	22.750
3115	Gastrectomy, subtotal, less than 2/3	1,201.01	22.750
3117	high, subtotal, more than 2/3	1,407.06	22.750
3114	total	1,533.35	22.750
3149	**Unlisted or Unusually Complicated**	***By Report***	25.500

SMALL INTESTINE

INVESTIGATION

3160*	Jejunal biopsy, tube	98.33	20.000
3113	Focused Bowel Ultrasound	99.96	

Notes: *1) Subsequent Focused bowel ultrasound services provided to the same patient within a period of 30 days, are payable at 50%.*

2) Limited to Specialists in Gastroenterology.

INCISION

3161	Enterotomy with exploration or removal of foreign body	630.84	22.750
3177	Biopsy of small bowel when exposed at other procedures	33.07	21.375

REVISION AND REPAIR

3141	Closure, duodenorrhaphy for perforated ulcer	711.76	22.750
3221	repair of traumatic laceration, single	578.35	22.750
3223	repair multiple lacerations	***By Report***	22.750
3227	small bowel fistula, external or internal including resection	***By Report***	22.750
3201	Small bowel obstruction, nonresective operative management, (i.e. enterolysis, reduction, volvulus, intussusception, internal hernia, enteroanastomosis)	710.58	22.750
3228	Noble plication procedure	432.68	22.750
3194	Jejunostomy-creation (independent procedure)	546.78	22.750
3193	Ileostomy, alone	626.64	22.750
3203	revision skin level (independent procedure)	234.48	21.375
3204	revision full thickness	547.61	22.750
3205	revision from simple to continent ileostomy (Kock)	975.02	22.750
3206	continent ileostomy as part of a resective procedure, add	497.23	
3207	repair of continent ileostomy	268.63	22.750
3208	closure of loop ileostomy (simple), (independent procedure)	578.77	22.750
3209	closure of ileostomy by internal anastomosis	607.18	22.750
3140	Intestinal bypass for morbid obesity	577.94	25.500

			UNIT VALUE
3241	Mesentery suture	535.76	22.750
3191	Enteroanastomosis	683.38	22.750

RESECTION

3171	Excision of one (1) or more lesions through a single enterotomy	695.23	22.750
3172	multiple enterotomies	801.29	22.750
3174	Small bowel resection with or without anastomosis or proximal enterostomy	801.29	22.750
3175	Massive small bowel resection greater than fifty (50) % of small bowel	916.20	22.750
3231	Meckel's diverticulum resection	643.10	21.375
3235	Mesentery excision	667.26	22.750
3259	**Unlisted or Unusually Complicated**	***By Report***	22.750

COLON AND APPENDIX

INVESTIGATION

3177	Biopsy of colon when exposed at other operations, add	33.07	
3113	Focused Bowel Ultrasound	99.96	

Notes: *1) Subsequent Focused bowel ultrasound services provided to the same patient within a period of 30 days, are payable at 50%.*

2) Limited to Specialists in Gastroenterology.

INCISION

3251	Appendix abscess, transabdominal drainage	341.92	21.375
3162	Colotomy with exploration with or without foreign body removal	626.77	21.375

REVISION AND REPAIR

3221	Colon laceration, perforation, or rupture, single suture with or without ileostomy or colostomy	578.35	22.750
3223	multiple	***By Report***	22.750
3195	Colostomy or cecostomy (independent procedure)	529.73	22.750
3203	revision, simple	234.48	21.375
3204	revision, full-thickness	547.61	22.750
3225	closure of loop colostomy—no bowel resection (independent procedure)	578.92	21.375
3226	closure by internal anastomosis (laparotomy) (independent procedure)	598.20	22.750
3224	closure with internal anastomosis (subsequent to Hartman's procedure) (independent procedure)	1,104.83	22.750
3166	Exteriorization (Mikulicz)	650.11	22.750

RESECTION

			UNIT VALUE
3261	Appendectomy	477.75	21.375
3262	perforated appendix	477.75	22.750
3263	with drainage of abscess	498.67	22.750
	Excision of one (1) or more lesions by colotomy		
3171	single enterotomy	695.23	22.750
3172	multiple enterotomies	801.29	22.750
3179	Colectomy, partial, with or without anastomosis or colostomy	1,019.02	22.750
3180	total, with or without anastomosis or ileostomy	1,410.29	25.500
3181	total colectomy and proctectomy—one (1) surgeon	1,939.07	25.500
3182	two (2) surgeons (1st surgeon)	1,873.83	25.500
3183	two (2) surgeons (2nd surgeon)	1,447.79	25.500
3184	Mucosal proctectomy, ileal-anal anastomosis with formation of an ileal pelvic pouch and proximal ileostomy, with total colectomy or after a previous total colectomy	2,498.91	22.750
3259	**Unlisted or Unusually Complicated**	***By Report***	22.750

RECTUM

INVESTIGATION

3302*	Anorectal manometry	175.24	

Note: *Tariff 3302 is payable only where the service is provided at Health Sciences Centre or St. Boniface General Hospital.*

INCISION

3285	Pelvic abscess transrectal drainage—See Abdomen Section	221.29	21.375

REVISION AND REPAIR

3310*	Stricture, bougie dilatation of rectum	43.57	
3296	division of rectal stricture	154.17	20.000
3321	proctoplasty	506.76	21.375
3335	Fistula, rectovaginal closure	439.49	21.375
3333	rectourethral closure	605.71	21.375
3331	rectovesical closure	542.92	21.375
3341*	Procidentia, perineal approaches, reduction (independent procedure)	14.99	21.375
3322	perirectal injection of sclerosing solution	77.99	21.375
3426	Thiersch wire procedure	208.62	21.375
3297	Rhen-Delorme	609.42	21.375
3321	perineal proctoplasty for mucous membrane prolapse	506.76	21.375

			UNIT VALUE
3328	resection with anastomosis posterior approach (Kraske)	434.74	22.750
3325	Procidentia, abdominal approach, abdominal proctopexy	830.30	22.750
3326	resection and anastomosis	830.30	22.750
3329	combined approach	935.77	22.750
3398	Transanal Endoscopic Microsurgical (TEM) resection of rectal lesion using transanal operating proctoscope with full insufflation and pressure monitoring under general anesthesia	765.29	25.500

Note: *1) Resection of an additional lesion payable only if complete removal, repositioning and reinsertion of the proctoscope is required.*

2) Tariff 3398 may be billed only by fellowship trained colon and rectal surgeons and surgical oncologists.

RESECTION

Local Removal

3300	Extensive local excision of benign or malignant lesion	365.32	20.000
3299	Electrocoagulation of a large villous adenoma or a malignant lesion	359.74	20.000

Proctectomy

3290	Anterior resection, with anastomosis, below the peritoneal reflection, or with end colostomy (Hartmann)	1,261.54	22.750
3298	Posterior resection (Kraske) for malignant tumor of the rectum, primary or recurrent	877.93	22.750
3292	Rectal resection for congenital megacolon	1,394.29	22.750

Abdomino-perineal proctosigmoidectomy

3289	one (1) surgeon	1,767.85	25.500
3288	two (2) surgeons—abdominal surgeon	1,438.57	25.500
3286	two (2) surgeons—perineal surgeon	517.68	25.500
3301	**Unlisted or Unusually Complicated**	***By Report***	25.500

ANUS

Note: *Proctosigmoidoscopy will be paid in addition to the procedure at the same sitting if it has not been done by the same surgeon within three (3) weeks of the operation.*

INVESTIGATION

3340*	Biopsy, anus	29.57	20.000

INCISION

3392*	External hemorrhoid (enucleate thrombosis)	56.66	20.000
3283*	Perianal abscess, incision and drainage	125.01	20.000
3357	Ischiorectal abscess (independent procedure)	201.51	20.000

REVISION AND REPAIR

			UNIT VALUE
3427	Imperforate anus, perineal reconstruction	851.98	21.375
3428	combined reconstruction	1,226.66	22.750
3365*	Anal stenosis or stricture, dilatation anus	43.57	20.000
3421*	anoplasty, infant, minor thin septum	191.83	20.000
3364*	sphincterotomy (independent procedure)	258.28	20.000
3420	anoplasty	409.87	21.375
3422	Posterior saggital anorectoplasty	514.64	21.375
3425	Anal incontinence, sphincteroplasty	439.95	21.375
3424	muscle transplant	***By Report***	21.375

RESECTION

3433*	Condylomata, external, electrodesiccation, initial sitting	78.14	20.000
3434*	subsequent, per sitting	77.62	20.000
3372	extensive, removal under general anesthesia	155.09	20.000
3371	Fissure, fissurectomy with or without sphincterotomy	292.73	20.000
3353	Fistula, fistulotomy or fistulectomy, subcutaneous	279.57	20.000
3356	submuscular	337.95	20.000
3354	complex or multiple	***By Report***	20.000
3355	second stage	99.83	20.000
3318*	Seaton removal in the office	15.15	
3395*	Hemorrhoids, tag or polyp (independent procedure), single	67.07	20.000
3396*	multiple	60.63	20.000
3397*	Barron ligation of internal hemorrhoid, per sitting	58.10	20.000
3401*	Injection of sclerosing solution, per sitting	45.90	20.000
3377	Hemorrhoidectomy, external, complete	145.10	20.000
3380	internal and external with or without fissurectomy or fistulotomy	332.13	20.000
3429	**Unlisted or Unusually Complicated**	***By Report***	20.000

BILIARY TRACT

Note: *Where cholangiogram by instillation into the bile ducts at the time of the operation is done, no procedural benefit is paid to the surgeon.*

INVESTIGATION

3505*	E.R.C.P. (endoscopic retrograde cholangio-pancreatography)	273.21	21.375
3506*	E.R.C.P., subsequent, when provided within sixty (60) days of tariff 3505	259.30	21.375
3498*	Add-on to E.R.C.P. (any combination of spincterotomy, dilatation, stent, naso-biliary tubing)	126.41	

3531	Cholangioscopy/Pancreatoscopy in addition to tariffs 3505 or 3506, add	128.78
3532	Lithotripsy in addition to tariffs 3505 or 3506, (maximum 1 service per sitting) add	103.02
3533	All biopsies taken via cholangioscope/pancreatoscope, (maximum 1 service per sitting) add to 3531	51.51

INCISION

			UNIT VALUE
3504	Gallbladder, cholecystotomy with drainage of the gallbladder with or without removal of calculus	478.22	22.750
3495	Bile ducts, choledochostomy with drainage of the bile ducts with or without calculus removal	936.20	22.750
3518	transduodenal choledocholithotomy	745.66	22.750
3493	sphincterotomy or sphincteroplasty transduodenal	1,035.35	22.750
3503	atresia of bile ducts (congenital) exploration	535.91	22.750

REVISION AND REPAIR

3526	Gallbladder,—Roux-en-Y or anastomosis loop	747.57	22.750
3528	Roux-en-Y anastomosis to G.I. tract	1,110.50	22.750
3520	Bile ducts, end-to-end reconstruction	929.29	25.500
3522	direct anastomosis to G.I. tract	1,040.86	22.750
3524	Hepatico-jejunostomy Roux-en-Y or anastomosis loop	1,542.52	22.750

RESECTION

3515	Gallbladder, cholecystectomy	612.19	22.750
3516	with open exploration of common duct	956.42	22.750
3499	**Unlisted or Unusually Complicated**	***By Report***	25.500

LIVER

INVESTIGATION

3456*	Needle biopsy	111.52	21.375
3457*	Open biopsy of liver, needle, one or more, when exposed at other operation, add	111.26	
3459*	Open biopsy of liver, excisional, one or more, when exposed at other operation, add	125.68	
3458	Transjugular liver biopsy, including history, examination, advice, pressure readings, fluoroscopy, angiography, and any other imaging by the same physician	244.98	21.375
3461	Fibroscan (transient elastography) for the measurement of liver fibrosis, interpretation only	25.76	
3462	Fibroscan (transient elastography) for the measurement of liver fibrosis, without interpretation	25.76	

Note: *1) Tariff 3461 may only be claimed by an Internal Medicine specialist who has complete training in Fibroscan procedures and interpretation of the diagnostic results.*

2) Tariff 3462 is payable only for services provided in a Fibroscan site approved by Manitoba Health.

INCISION

			UNIT VALUE
3471	Liver abscess drainage	582.06	22.750
3472	Marsupialization or drainage of liver cyst	582.06	22.750

REVISION AND REPAIR

3481	Hepatorrhaphy, suture of wound or injury including omental pack	649.49	25.500

RESECTION

3464	Partial hepatectomy greater than sixty-four (64) cubic centimeters	1,020.72	26.875
3494	hepatic lobectomy left	2,034.89	26.875
3492	hepatic lobectomy right	2,034.89	26.875
3491	tri-segmentectomy	2,174.55	26.875
3496	Radiofrequency ablation of single liver tumor	1,020.72	25.500
3497	Ablation of a second or subsequent tumor add to tariff 3496 for each additional tumor	255.18	25.500
3499	**Unlisted or Unusually Complicated**	***By Report***	25.500

PANCREAS

INVESTIGATION

Biopsy pancreas, additional for when exposed at other operations.

3564*	needle biopsy	108.27
3566*	incision biopsy	124.03

INCISION

3565	Marsupialization of pseudocyst	693.07	22.750
3541	Drainage of pancreatic abscess	855.54	22.750
3542	Acute pancreatitis, abdominal drainage	855.54	25.500
3544	Pancreatic calculus removal	641.81	22.750

REVISION AND REPAIR

3567	Pancreatic pseudocyst, cystogastrostomy	973.34	22.750
3568	cystojejunostomy Roux-en-Y	973.34	22.750
3546	Pancreaticojejunostomy	917.86	22.750

			UNIT VALUE
3547	Longitudinal anastomosis of pancreatic duct to intestine (Peustow)	1,313.66	22.750

RESECTION

3550	Distal pancreatectomy with or without splenectomy	1,700.55	22.750
3551	Pancreaticoduodenectomy	3,290.66	26.875
3552	Total pancreatectomy with or without splenectomy	2,213.36	26.875
3569	**Unlisted or Unusually Complicated**	***By Report***	25.500

URINARY SYSTEM

These benefits cannot be correctly interpreted without reference to the Rules of Application.

URODYNAMIC STUDIES

9869* Uroflow studies, professional 31.63

9870* total 40.95

9873* Cystometry with rectal and vesical pressures, professional 58.93

9874* total 94.21

9877* Urethral pressure profile studies, professional 58.93

9888* total 61.81

9897* All above tests, combined, professional 128.06

9899* total 188.58

9889* Cystometry with flow studies, professional 51.82

9896* total 81.20

9844* Video fluoroscopic multichannel urodynamic assessment to include monitoring of intravesicular, intra-abdominal, and urethral pressures, with simultaneous fluoroscope imaging and recording of filling and voiding phases including interpretation 75.20

Note: *Fees listed for urodynamic services are payable in hospital (professional) and in private offices (total) except where otherwise specified.*

7875* Post void residual assessment 28.66

Note: *Tariff 7875 is payable only where the service is provided by approved physicians as determined by the Provincial CMO or designate.*

The Rules of Application apply in the urinary system for diagnostic and therapeutic procedures. Multiple procedures done at the same sitting and in the same area, have benefits of 100% of the schedule for the major procedure, (the one with the greatest benefit) and 75% for all others. When a surgical service is done by means of the cystoscope, any cystoscopic examinations at that sitting are included in the benefit for the surgical service.

Fee for Service (F/S) means that the procedure is included in the visit fee or any other procedure which is involved with it, (e.g. the application of a cast).

CYSTOSCOPY DIAGNOSTIC

			UNIT VALUE
3931*	Cystoscopy, diagnostic, office or hospital, male or female, initial	94.05	20.000
3932*	subsequent, (i.e. for the same condition in hospital or office)	81.03	20.000
3933*	with biopsy	125.89	20.000
3926*	with manometry (cystometrogram or bladder capacity evaluation)	79.73	20.000
3927*	with needle biopsy of prostate	137.07	20.000
3928*	with ureteral catheterization, with or without retrograde pyelogram, unilateral or bilateral	128.17	21.375
3939*	with ureteral meatotomy	193.58	21.375
3929*	with differential renal function studies	113.07	20.000

PANENDOSCOPY

3930*	cystoscopy and urethroscopy	94.05	20.000
3934*	cystoscopy, urethroscopy, urethral meatotomy and dilatation, male (under general anesthesia)	114.87	20.000
3935	**Unlisted or Unusually Complicated**	***By Report***	20.000

KIDNEY

	Artery, renal, surgery for hypertension—See Arteries		
	Catheter, change or reinsert in nephrostomy	F/S	
3818	Biopsy of kidney, additional for, when done at the time of other operations	31.99	
3820*	Biopsy, kidney needle	139.54	21.375
3829*	Kidney or renal pelvis, aspiration or injection of cyst	68.72	21.375
3830*	Perirenal insufflation, unilateral or bilateral	113.17	21.375
3813	Aberrant renal vessels, division or transection (independent procedure)	962.41	21.375
3819*	Biopsy, open renal (independent procedure)	399.36	22.750
3827	Cyst of kidney, excision	491.93	22.750
3845	Fistula, closure, pyelostomy or nephrostomy	691.04	22.750
3824	Heminephrectomy	1,524.19	22.750
3846	Horseshoe kidney, symphysiotomy	611.75	22.750
3821	Nephrectomy, including partial ureterectomy through same incision	1,161.09	22.750
3822	plus total ureterectomy with resection of uretero-vesical junction	1,455.47	22.750
3825	without resection of uretero-vesical junction	1,152.84	22.750
3823	Radical nephrectomy, (includes thoracic approach, excision of perinephric fat, regional lymph nodes and where required, adrenal gland)	1,564.82	25.500

			UNIT VALUE
3810	Radical nephrectomy (includes thoracic approach, excision of perinephric fat, regional lymph nodes and where required, adrenal gland) with infrahepatic caval thrombectomy	1,819.13	25.500
3814	Radical nephrectomy (includes thoracic approach, excision of perinephric fat, regional lymph nodes and where required, adrenal gland) with suprahepatic caval thrombectomy	2,550.00	25.500
3815	Partial nephrectomy, requiring complete vascular dissection and control, with or without renal cooling	1,525.88	25.500
3809	Laparoscopic radical nephrectomy (includes excision of perinephric fat, regional lymph nodes and where required, adrenal gland)	1,774.69	25.500
3816	Laparoscopic partial nephrectomy, requiring complete vascular dissection and control, with or without renal cooling	1,771.94	25.500
3811	Nephrolithotomy, including removal of staghorn calculus	950.47	22.750
3812	Renal fillet (splitting of kidney) for removal of staghorn calculus	1,050.35	22.750
3835	Nephropexy, fixation or suspension of kidney (independent procedure)	432.94	22.750
3841	Nephrorrhaphy, suture of kidney wound or injury	842.19	22.750
3808	Nephrostomy, nephrotomy with drainage	419.04	22.750
3802	Perirenal abscess, drainage (independent procedure)	457.15	22.750
3831	Pyeloplasty, plastic operation on renal pelvis with or without plastic operation or ureter	965.05	22.750
3833	Laparoscopic Pyeloplasty, with or without insertion of ureteral stent, cystoscopy or retrograde pyelogram	1,226.66	22.750
3817	Pyelotomy, with drainage or removal of calculus, pyelolithotomy	796.45	22.750
3839	**Unlisted or Unusually Complicated**	***By Report***	22.750

URETER

3851	Unilateral drainage, exploration by open surgery, with or without ureterotomy (independent procedure)	506.86	22.750
3895	Fistula, ureteral closure	***By Report***	22.750
3958*	Cystoscopy and diagnostic ureteroscopy above the intramural ureter using the rigid or flexible ureteroscope	316.94	21.375
3956*	plus post-procedure ureteric stenting	459.32	21.375
3959	Cystoscopy and ureteroscopy above the intramural ureter with calculus manipulation and removal using the rigid or flexible ureteroscope	544.82	21.375
3957	with electrohydraulic or ultrasonic calculus disintegration using the rigid or flexible ureteroscope	529.73	21.375
3928*	Cystoscopy with ureteral catheterization, with or without retrograde pyelogram, unilateral or bilateral	128.17	21.375
3939*	with ureteral meatotomy	193.58	21.375
3945	ureterocele, fulguration or resection	282.43	21.375

			UNIT VALUE
3937	ureteral calculus, manipulation, including ureteral meatotomy if necessary, and including repeat manipulation(s), if necessary	225.92	21.375
3865	Endoscopic insertion of ureteral stent including ureteral meatotomy if necessary, and including repeated attempts at insertions if necessary	234.16	21.375
3866	bilateral, insertion at one sitting	341.52	21.375
	Note: *Claim 50% for repeat insertion(s) if needed within three (3) weeks.*		
3867	Endoscopic removal of ureteral stent(s)	98.12	21.375
3861	Ureterectomy, with bladder cuff (independent procedure)	572.89	21.375
3936	Open excision of ureterocoele with concomitant ipsilateral ureteric reimplant	937.07	22.750
3876	Ureteroneocystostomy, anastomosis of ureter to bladder, unilateral	773.43	22.750
3877	bilateral	1,207.60	22.750
3870	ureteral tapering with neouretero cystostomy, add	223.04	
3880	Ureteroenterostomy, anastomosis of ureter to intestine, unilateral	613.74	22.750
3881	bilateral	694.26	22.750
3885	Ureterostomy, transplantation of ureter to skin, unilateral	446.03	22.750
3886	bilateral	668.03	22.750
3857	Ureterolithotomy, upper three-quarters of ureter	574.18	22.750
3858	lower one-quarter of ureter	600.71	22.750
3871	Ureteroplasty, plastic operation on ureter	826.48	22.750
3874	Ureteropyelostomy, anastomosis of ureter and renal pelvis	902.66	22.750
3884	Ureterorrhaphy, suture of ureter (independent procedure)	466.43	22.750
3889	**Unlisted or Unusually Complicated**	***By Report***	22.750

EXTRA CORPOREAL SHOCK WAVE LITHOTRIPSY

3893*	Extra corporeal shock wave lithotripsy of renal and ureteric calculi	430.27	21.375
	Note: *E.S.W.L. includes the associated services by the urologist, starting the I.V., administering sedatives and analgesics as required, accepting responsibility for the safety of the patient both during the procedure and during the recovery period. Bilateral treatment of calculi is to be claimed at 100% for the first side and 75% for the second, at the same sitting.*		

PERCUTANEOUS TRANSRENAL OPERATIVE PROCEDURES FOR STONE REMOVAL

3872	Percutaneous nephrostomy for stone removal with or without selective catheterization of calyx or calyces	296.90	21.375
3873	Single stone removal without electrohydraulic or ultrasound lithotripsy, with or without antegrade stent insertion including tract dilatation and nephroscopy	493.11	21.375
3875	plus nephrostomy, by the same physician, at the same sitting	893.44	21.375
3878	with electrohydraulic or ultrasound lithotripsy, with or without antegrade stent insertion including tract dilatation and nephroscopy	784.03	21.375
3879	plus nephrostomy, by the same physician, at the same sitting	802.98	21.375

		UNIT VALUE	
3882	Multiple stone removal without electrohydraulic or ultrasound lithotripsy, with or without antegrade stent insertion including tract dilatation and nephroscopy	839.87	21.375
3883	plus nephrostomy, by the same physician, at the same sitting	1,094.53	21.375
3887	with electrohydraulic or ultrasound lithotripsy, with or without antegrade stent insertion including tract dilatation and nephroscopy	899.82	21.375
3888	plus nephrostomy, by the same physician, at the same sitting	1,090.41	21.375
3890	Repeat stone removal through the original access after any of the above by the same surgeon	397.80	21.375
3891	by a different surgeon	***By Report***	21.375
3892	through new access after any of the above	***By Report***	21.375

BLADDER

3900*	Bladder, aspiration by needle	37.33	20.000
3902*	insertion of suprapubic catheter by trochar	119.50	20.000
3903*	function studies	28.79	
3904*	Initial catheterization for acute urinary retention when performed by a physician (independent procedure)	24.56	
	Change or reinsertion of catheter, suprapubic	F/S	
3960	Urachal cyst and umbilical hernia repair	398.79	22.750
3961	Bladder injury or rupture, cystorrhaphy	541.63	22.750
3918	Bladder neck, female, transurethral resection	361.65	21.375
3966	Cutaneous Vesicostomy	477.96	21.375
3967	Cystoplasty, plastic operation on bladder, anterior YV-plasty, etc.	687.45	21.375
3968	Vesico urethroplasty for incontinence (Tanagho Procedure)	701.40	21.375
	Fascial sling for incontinence—primary procedure		
3974	including fascial harvesting	557.54	22.750
	Fascial sling incontinence—following previous failed procedure(s)		
3970	with fascia	649.49	22.750
3972	with prosthesis	587.57	22.750
3969	Hydraulic urinary sphincter for incontinence, insertion of, male or female	964.94	21.375
3906	Cystotomy, with drainage	354.18	20.000
3901	with fulguration	440.28	20.000
3907	with removal of calculus	381.75	20.000
3920	Diverticulum, bladder, excision (independent procedure)	630.23	22.750
3914	Diverticulum of bladder—transurethral roller ball cautery	264.44	22.750

			UNIT VALUE
3965	Fistula, closure, vesicorectal	605.71	21.375
3921	vesicouterine	884.64	21.375
3923	vesicovaginal	903.18	21.375
3925	when a colostomy is part of the above, add	116.16	
3908	Perivesical or prevesical space abscess drainage	504.85	21.375
3946*	Manual clot evacuation from bladder	64.08	20.000
3922	Tumor bladder, excision	441.70	22.750
3909	Cystostomy, closure (independent procedure)	243.08	21.375
3955	Diversion, urinary, to isolated intestine where bladder is mobilized and anastomosed to intestinal segment	1,141.41	22.750
3953	Bladder augmentation with intestine or stomach	1,258.70	22.750
3905*	Chemotherapeutic instillations in bladder, per instillation, to include necessary catheterization (professional fee only)	62.07	
3950	Intravesicle Botulinum Toxin Injection	270.61	20.000

Note: *Includes cystoscopy.*

CYSTOSCOPY THERAPEUTIC

3940*	With fulguration or treatment of minor (less than 0.5 cm.) lesion, with or without biopsy	147.22	20.000
3941	Bladder tumors, small (0.5 cm. to 2.0 cm.) fulguration, initial	317.82	20.000
3942	subsequent, (i.e. during same hospital admission)	281.14	20.000
3924	large, transurethral resection	522.62	21.375
3943	Radioactive substance, insertion, with or without biopsy or fulguration	201.61	21.375
3944	Interstitial cystitis, dilatation, electro- and/or chemo-fulguration, under general anesthetic	108.32	20.000
3954	Collagen injection periurethral/ureteral under cystoscopy control	305.39	20.000
3947	Foreign body, including calculus, removal from bladder or urethra	217.83	21.375
3951	Calculus in bladder, litholapaxy	350.32	20.000
3952	Ileal loop creation, and transplanting ureters to it (without cystectomy)	1,478.86	22.750

CYSTECTOMY

3911	partial, without ureter transplants	543.44	22.750
3912	with one or both ureter transplants to bladder	906.12	22.750
3995	Radical cystectomy (includes resection of seminal vesicles, or uterus and ovaries)	1,983.90	25.500
3996	creation of ileal conduit and transplantation of ureters to ileal conduit, add	515.10	
3997	creation of continent urinary diversion (catheterizable pouch or neobladder) and transplantation of ureters to urinary diversion, add	618.12	

Note: *Only one of tariffs 3996 or 3997 may be claimed with 3995.*

3998	extended lymphadenectomy for bladder cancer (to the level of the bifurcation of the great vessels), add	618.12	

Note: *Tariff 3998 may only be claimed with 3995.*

			UNIT VALUE
3919	**Unlisted or Unusually Complicated**	***By Report***	25.500

URETHRA

3978	Abscess, periurethral, drainage	74.10	20.000
3981	Caruncle, urethral, excision or fulguration	121.34	20.000
4031*	Urethral stricture, dilatation, male, initial	51.05	20.000
4033*	subsequent	51.05	20.000
4034*	under general anesthesia	93.08	20.000
4035*	female, local–for general anesthesia see Rule of Application 57	36.28	20.000
3977*	Meatotomy, male (independent procedure)	99.93	20.000
3976*	female, including meatoplasty	74.89	20.000
4000*	Urethroscopy, diagnostic, initial or subsequent	64.90	20.000
4022	Anastomotic stricture repair	961.58	22.750
4023	One stage reconstruction of anterior urethra with tissue transfer	1,442.28	25.500
4024	Posterior reconstruction (urethral distraction defect after pelvis fracture)	1,442.28	25.500
4025	First stage urethral reconstruction (complex structures with fibrosis, fistulae, or significant loss of urethra)	1,201.87	25.500
4026	Second stage urethral reconstruction (may only be claimed after first stage reconstruction)	1,201.87	25.500

Note: *1) For 4022 to 4026, adjacent tissue transfer, skin grafts (including split skin grafts and full thickness grafts), chordee repair, external urethrotomy, cystoscopy and cystotomy, are included and not payable in addition.*

2) 4022 to 4026 may only be claimed by surgeons approved by the Provincial Medical Specialist Lead for Surgery.

4021	Wounds, urethral: urethrorrhaphy	***By Report***	21.375
4011	Urethroplasty, plastic operation on urethra	***By Report***	21.375

URETHROSCOPY THERAPEUTIC

4006	With fulguration of posterior urethra	154.12	20.000
4004	With internal urethrotomy, blind	163.29	20.000
4005	With visual internal urethrotomy using cold knife urethrotome	224.94	20.000
4001	With removal of calculus or foreign body	249.26	20.000
3971*	Urethrotomy, external, anterior	227.37	20.000
3973*	perineal	227.37	20.000
3994	Polyps, urethral, excision or fulguration with or without urethroscopy	128.41	20.000

3991	Diverticulum of urethra, excision (independent procedure)	393.03	20.000
3979	Urinary, extravasation, simple perineal drainage (independent procedure)	194.61	20.000
3980	complicated	227.42	21.375
4019	Extravasation, perineal urinary, drainage with diversion of urinary stream	366.18	21.375
3982	Fistula, urethral, closure (independent procedure)	***By Report***	20.000
3983	urethrovaginal closure	401.16	20.000
3987	Urethrectomy, perineal approach	374.27	21.375
3989	**Unlisted or Unusually Complicated**	***By Report***	21.375

HEMODIALYSIS

These benefits cannot be correctly interpreted without reference to the Rules of Application.

Performance of hemodialysis includes supervision and procedure, history, physical and appropriate adjustments of solutions and other problems arising during dialysis.

Where patients with ***Chronic Renal Failure*** are admitted for complications such as bacteremia, peritonitis, problems in fluid management, osteodystrophy, etc., charges for hospital stay should be the same as for any other medical admission, and may be in addition to those made for repeat dialysis—See also Peritoneal Dialysis.

ACUTE RENAL FAILURE

			UNIT VALUE
9798	Initial hemodialysis—See Rules 44 and 45	437.22	
9799	subsequent hemodialysis, each	214.15	
	Notes: *1) When chronic dialysis patients require acute dialysis services, tariff 9799 may be claimed for up to seven (7) days. Thereafter, subsequent chronic dialysis may be claimed. For patients in ICU, 9799 may be claimed everyday for up to fourteen days.*		
	2) Concomitant care may be claimed on days when no dialysis is administered.		
3803	Insertion of arteriovenous bypass for acute renal failure (AV shunt) each time new cannula is required	328.43	21.375
3800	Hemodialysis—arteriovenous fistula side-to-side anastomosis	450.97	21.375
3801	Hemodialysis—prosthetic AV fistula	524.68	21.375
3804	Hemodialysis—AV venous bypass graft	767.35	21.375
3790	Insertion of temporary AV catheter, one (1) or more sites, per sitting	218.01	21.375

CHRONIC RENAL FAILURE

9801	Initial hemodialysis—See Rules 44 and 45	247.87	
9802	subsequent hemodialysis, each	54.06	
3803	Insertion of arteriovenous bypass (each time new cannula required) (AV shunt)	328.43	21.375
3800	Hemodialysis—arteriovenous fistula side-to-side anastomosis	450.97	21.375
3801	Hemodialysis—prosthetic AV fistula	524.68	21.375
3804	Hemodialysis—AV venous bypass graft	767.35	21.375
3790	Insertion of temporary AV catheter, one (1) or more sites, per sitting	218.01	21.375
3792	Declotting of AV shunts	98.64	21.375
	Note: *The above fee is not claimable for patients with acute renal failure—See Rule 44*		
9814	Weekly retainer for a nephrologist providing support and supervision to a home dialysis patient	119.55	
	Note: *Tariff 9814 may not be claimed concurrently with tariffs 9802, 9799, 9798, or 9801.*		

9820 Weekly retainer for a nephrologist providing support and supervision to physicians caring for a patient at a Local Centre Dialysis Unit (LCDU) 159.27

Note: *1) LCDUs are currently in place at the following locations: Bethesda Regional Health Centre, Boundary Trails Health Centre, Berens River Renal Health Centre, Dauphin Regional Health Centre, Flin Flon General Hospital, Gimli Hospital, Hodgson Area Renal Health Centre, Island Lake Regional Renal Unit, Lakeshore General Hospital, Norway House Hospital, Pine Falls General Hospital, Portage District General Hospital, Swan Valley Health Centre, Selkirk & District General Hospital, The Pas Health Complex, Thompson General Hospital.*

2) Tariff 9820 may not be claimed concurrently with tariffs 9802, 9799, 9798 or 9801.

3) Includes telephone/facsimile/e-mail communications with the LCDU or LCDU physicians regarding the patient.

PERITONEAL DIALYSIS

See general remarks in Hemodialysis.

ACUTE RENAL FAILURE

9805 Initial peritoneal dialysis, complete medical management, up to two (2) weeks 774.97

9807 subsequent dialysis, after two (2) weeks 171.89

			UNIT VALUE
3793	Insertion of temporary (stylocath) catheter	147.53	21.375
3805	Insertion of permanent catheter	267.18	21.375
3807	Removal of permanent catheter	195.33	20.000

CHRONIC RENAL FAILURE

9806 Initial peritoneal dialysis, first twenty-four (24) hours 114.20

9819 Intermittent subsequent dialysis (maximum $180.00 per week) 64.92

3826	Laparoscopic peritoneal dialysis catheter insertion/repositioning, including omentopexy/colopexy	574.85	22.750
3805	Insertion of permanent catheter	267.18	21.375
3807	Removal of permanent catheter	195.33	20.000
3793	Insertion of temporary (stylocath) catheter	147.53	21.375

9610 Chronic ambulatory peritoneal dialysis, in hospital, per day 39.88

3794 Declotting of permanent catheter 99.67 20.000

Note: *The above is not claimable for patients with acute renal failure—See Rule 44*

9821 Weekly retainer for a nephrologist providing support and supervision to a home dialysis patient 119.55

Note: *Tariff 9821 may not be claimed concurrently with tariffs 9805, 9806, 9807 or 9819.*

3806 **Unlisted or Unusually Complicated** ..... ***By Report*** 21.375

MALE GENITAL SYSTEM

These benefits cannot be correctly interpreted without reference to the Rules of Application.

PENIS

			UNIT VALUE
4111*	Biopsy penis (independent procedure)	60.68	20.000
4120*	Penile skin lesion, including warts, local excision or fulguration, per sitting	88.44	20.000
3977*	Meatotomy penis	99.93	20.000
4101*	Prepuce, dorsal or lateral "split" (independent procedure)	89.34	20.000
4122*	Circumcision, newborn	248.28	20.000
4123	surgical excision other than clamp or dorsal slit, any age except newborn	257.55	20.000
4135	Epispadias, plastic operation for penile epispadias distal external sphincter	***By Report***	20.000
4138	Plastic operation on penis with exstrophy of bladder	***By Report***	22.750

TREATMENT OF ERECTILE DYSFUNCTION

	First visit—appropriate visit fee applies—See Rules of Application	F/S	
4102	Second visit—consecutive—See Note 1	39.87	
4103	Penile injection—See Note 2	39.20	

Note: *1) All other visits related to this service are not claimable.*

*2) A **total** of two injections are claimable when provided during the first and/or second visit. All other injections related to this service which may be provided during visits subsequent to the second visit are not claimable.*

HYPOSPADIAS

4125	One stage procedure, chordee release and construction of urethra	773.99	20.000
4126	release of chordee only	317.82	20.000
4127	Second stage procedure, penile	615.65	20.000
4128	scrotal hypospadias repair	522.41	20.000
4129	perineal hypospadias repair	581.03	20.000
4130	closure—urethro-cutaneous fistula	454.11	20.000
4133	Nesbitt procedure, correction of penile curvature	340.07	20.000
4114	Amputation of penis, partial	425.88	20.000
4115	complete	669.78	20.000
4116	radical	821.84	20.000
4119	Prosthesis, penis (Pearman, etc.)	463.73	20.000
4118	Hydraulically operated erectile prosthesis, insertion of	728.13	20.000
4139	**Unlisted or Unusually Complicated**	***By Report***	21.375

TESTIS

			UNIT VALUE
4141*	Biopsy, testis, needle (independent procedure)	65.16	20.000
4142	Biopsy, incisional (independent procedure) unilateral	115.84	20.000
4143	bilateral	125.43	20.000
4144	Orchiectomy, simple, unilateral	195.12	20.000
4145	bilateral	388.92	20.000
4146	radical, with retro-peritoneal gland dissection, unilateral or bilateral	770.54	21.375
4155	Testicular prosthesis	386.50	20.000
	Note: *No fee payable if done at time of orchiectomy.*		
4148	Inguinal approach for testicular mass, with or without orchiectomy	311.75	20.000
4156	Orchiopexy, any type, with or without hernia repair	540.60	20.000
4157	second stage, Thorek type	72.63	20.000
4152	Torsion of testis, surgical reduction	450.42	20.000
4153	with fixation of contralateral testis	494.06	20.000
4154	fixation of contralateral testis (independent procedure)	363.14	20.000
4159	**Unlisted or Unusually Complicated**	***By Report***	20.000

EPIDIDYMIS

4161*	Epididymis, drainage of abscess	115.33	20.000
4176	Epididymectomy, unilateral	319.36	20.000
4163	Epididymis, exploration, with or without biopsy	144.80	20.000
4181	Epididymovasostomy, anastomosis of epididymis to vas deferens, unilateral	423.77	20.000
4182	bilateral	734.79	20.000
4174	Spermatocele, excision, with or without epididymectomy	314.21	20.000
4165	Vasogram, unilateral	82.42	20.000
4189	**Unlisted or Unusually Complicated**	***By Report***	20.000

TUNICA VAGINALIS

4191*	Hydrocele, puncture aspiration, with or without injection	33.31	20.000
4200	repair	357.00	20.000
4201	excision, unilateral	266.52	20.000
4202	with hernia repair	626.06	20.000
4209	**Unlisted or Unusually Complicated**	***By Report***	20.000

SCROTUM

			UNIT VALUE
4211*	Scrotum, drainage of abscess	49.17	20.000
4215	Foreign body in scrotum, removal	***By Report***	20.000
4224	Resection of scrotum	***By Report***	20.000
4227	Scrotoplasty, plastic operation on scrotum	***By Report***	20.000
4221	Skin lesion, scrotum, local excision	42.14	20.000
4229	**Unlisted or Unusually Complicated**	***By Report***	20.000

VAS DEFERENS

4241	Vasectomy, partial or complete, unilateral or bilateral (independent procedure)— See Rule of Application 1 re: counselling	204.70	20.000
4251	Vasovasostomy (anastomosis) unilateral	281.09	20.000
4252	bilateral	745.81	20.000
4259	**Unlisted or Unusually Complicated**	***By Report***	20.000

SPERMATIC CORD

4271	Hydrocele of spermatic cord, excision, unilateral (independent procedure)	266.52	20.000
4275	Varicocele, excision, unilateral (independent procedure)	284.64	20.000
4278	with hernia repair and/or hydrocele and/or varicocele excision	298.45	20.000
4279	**Unlisted or Unusually Complicated**	***By Report***	20.000

SEMINAL VESICLES

4291	Vesiculectomy	***By Report***	20.000
4281	Vesiculotomy, unilateral	***By Report***	20.000
4299	**Unlisted or Unusually Complicated**	***By Report***	20.000

PROSTATE

4305*	Core needle biopsy transrectal, systematic, image-guided (up to 5 cores), or digitally directed prostate biopsy (unlimited cores)	109.14	20.000
4314*	Core needle biopsy, transrectal, systematic, image-guided (between 6 and 11 cores)	206.04	20.000
4315*	Core needle biopsy, transrectal, systematic, image-guided (12 or more cores)	303.91	20.000
4301	Abscess, prostatic, external drainage, prostatotomy	171.94	20.000
	Note: *Only one (1) service, total, of tariffs 4305*, 4314* or 4315* is payable per sitting; these tariffs are not payable in combination of each other.*		
4310	Prostate Cryosurgery	1,287.75	22.750

			UNIT VALUE
4313	Prostatectomy, radical, perineal	1,448.61	25.500
4318	retropubic	702.44	22.750
4319	retropubic, radical	1,462.37	22.750
4320	Combined radical prostatectomy and staging lymphadenectomy	1,848.80	25.500
	Note: *The above does not apply for simple prostatectomy (non-radical) combined with staging lymphadenectomy.*		
4316	suprapubic	702.44	22.750
4321	transurethral, including control of postoperative bleeding	585.93	22.750
4324	revision, delayed, within twelve (12) months	365.21	22.750
4325	Transurethral sphincterotomy—male	365.05	20.000

PROSTATE BRACHYTHERAPY

4300	Planning Ultrasound–Urological component	198.05	
	Note: *A surgical assistant benefit may not be claimed for tariff 4300.*		
4302	Seed Implantation–Urological component including diagnostic cystoscopy and/or urethroscopy	724.38	20.000
4329	**Unlisted or Unusually Complicated**	***By Report***	22.750

FEMALE GENITAL SYSTEM

These benefits cannot be correctly interpreted without reference to the Rules of Application.

VULVA

Local incision of lesion of vulva or urethra—See Integumentary System

			UNIT VALUE
4421*	Biopsy	38.47	20.000
4430*	Condylomata accuminata, excision or destruction by any method, of less than ten (10) warts over an area no more than 25% of the vulvar area	71.49	20.000
4432*	of ten (10) or more warts over an area of more than 25% of the vulvar area	129.96	20.000
4427	Extensive removal under general anesthesia. Extensive condylomata involving massive lesions of the vulva, the perineum, the vagina and anus	146.54	20.000
4434*	Carcinoma in situ or dysplasia, biopsy proven, excision or destruction by any method	100.24	20.000
4403*	Vulva, abscess, incision and drainage	56.81	20.000
4404	varicocele, excision, unilateral (independent procedure)	193.52	20.000
4405*	Bartholin's gland, abscess, incision and drainage	71.08	20.000
4428	Clitoridectomy	111.93	20.000
4433	Cyst, Bartholin, excision or marsupialization	120.79	20.000
4431	Hymen, excision	113.12	20.000
4411	incision	113.12	20.000
4455	Injury of vulva and/or perineum, recent, non-obstetrical repair	***By Report***	20.000
4745	Perineal fistula, closure	160.75	20.000
4735	laceration, old, third degree, repair	317.05	20.000
4443	Prolapse of urethral mucosa, plastic repair (independent procedure)	***By Report***	20.000
4441	Vulva and/or perineum, plastic repair	***By Report***	20.000
4424	Vulvectomy, complete or partial (more than 1/3)	380.87	21.375
4426	radical, without regional node dissection	465.80	21.375
4425	including regional lymph nodes	771.05	21.375

Note: *Tariff 4424 may not be claimed for multiple biopsies of the vulva. (See tariff 4421).*

4429	**Unlisted or Unusually Complicated**	***By Report***	21.375

Note: *If more than one (1) of the following procedures are done at the same sitting, payments will be 100% for the first, 75% for the second and 75% for the third, etc., 4430, 4432, 4434, 4472, 4475, 4482, 4633, 4635 and 4636.*

VAGINA

9783*	Huhner test	19.47	
			UNIT VALUE
4471*	Vagina, biopsy	35.08	20.000
4472*	Condylomata accuminata, excision or destruction by any method, of less than ten (10) warts, or of warts over an area no more than 25% of the vaginal area	53.78	20.000
4475*	Condylomata accuminata, excision or destruction by any method, of ten (10) or more warts, or of warts over an area more than 25% of the vaginal area	104.05	20.000
4482*	Carcinoma in situ or dysplasia, biopsy proven, excision or destruction by any method	84.63	20.000
4511*	dilatation under general anesthesia	31.16	20.000
4497	Artificial vagina, construction of, for congenital absence	***By Report***	21.375
4476	Benign lesion of vagina, excision	108.63	20.000
4477*	Colposcopy with or without biopsy cervix or vagina	59.98	20.000
4463*	Colpopuncture—aspiration of pouch of Douglas	96.23	20.000
4461	Colpotomy, diagnostic, or drainage of pelvic abscess	189.15	20.000
4521	Culdoscopy (independent procedure)	128.47	20.000
3335	Fistula, repair, recto-vaginal	439.49	21.375
4507	urethro-vaginal	413.81	20.000
3923	vesico-vaginal	885.47	21.375
4501	Injury of vagina, recent, non-obstetrical, suture	***By Report***	20.000
4802	Reverse Episiotomy	119.61	20.000
4478	Vaginal septum, excision	181.32	20.000
4473	Vaginectomy, complete or partial	562.39	21.375
4480	**Unlisted or Unusually Complicated**	***By Report***	21.375

Note: *If more than one (1) of the following procedures are done at the same sitting, payments will be 100% for the first, 75% for the second and 75% for the third, etc. , 4430, 4432, 4434, 4472, 4475, 4482, 4633, 4635 and 4636.*

VAGINAL PROCEDURES ON CERVIX OR UTERUS

CERVIX

	Chemocautery—silver nitrate, etc.—included in visit fee.	F/S	
9795*	Taking of cytological smears for cancer screening	24.18	
			UNIT VALUE
4611*	Cervix—local excision of lesion, cauterization or biopsy, one (1) or more sites	32.56	20.000
4634	Amputation of cervix (independent procedure)	270.22	21.375
4632	Cervical stump, removal	396.83	21.375
4633*	Carcinoma in situ or dysplasia, biopsy proven, destruction by any method, of an area no more than 25% of the circumference	100.24	20.000
4635*	more than 25% of the circumference (including immediately contiguous vaginal areas)	122.24	20.000
4636*	Conization by any method, with or without D & C	187.04	20.000

Note: *If more than one (1) of the following procedures are done at the same sitting, payments will be 100% for the first, 75% for the second and 75% for the third, etc. , 4430, 4432, 4434, 4472, 4475, 4482, 4633, 4635 and 4636.*

4641*	Cryosurgery of the cervix for other conditions	***By Report***	20.000
4646	Dilatation and curettage	120.33	20.000
4711	Dilatation of cervix, in hospital	105.06	20.000
4706	Incompetent cervix, non-pregnant, repair	207.32	20.000
4671	Radioactive substances, insertion into cervix and/or uterus, initial	198.05	20.000
4672	subsequent	136.09	20.000
4705	Trachelorrhaphy, suture of recent non-obstetrical injury or laceration of cervix	***By Report***	20.000
4616*	Pessary, initial fitting or refitting	57.01	

Note: *1) May be claimed once per patient per twelve (12) month period.*

2) Claims for additional services rendered to a patient (e.g., visits) may be made in addition to this tariff.

BIRTH CONTROL

4677*	Intrauterine device insertion	51.82	20.000
4678	Removal I.U.D.	31.06	20.000

Note: *Pudendal block tariff 5314 is claimable in addition.*

4679	hospital (under general anesthesia)	94.83	20.000
4680	Dilatation outside of hospital, add 4677 or 4678	51.00	
4675*	Insertion of subcutaneous contraceptive capsules, e.g. Norplant	54.11	
4676*	Removal of subcutaneous contraceptive capsules, e.g. Norplant	83.79	

UTERUS

			UNIT VALUE
4850	Abortion, spontaneous [under twenty (20) weeks] no surgery, fee-for-service, to maximum of	122.02	20.000
4855	requiring dilatation and curettage	149.38	20.000
4860	therapeutic, by dilatation and curettage and/or suction method	156.54	20.000
4861	by amnio infusion with or without D & C	213.82	20.000
4862	therapeutic dilatation and extraction D & E	276.01	20.000
	Note: *The above procedure is payable for services rendered after fifteen (15) weeks gestation.*		
4866*	Insertion of Laminaria Tent (s)	33.76	20.000
4612*	Endometrium, biopsy (independent procedure)	34.67	20.000
4613*	Curettage—aspiration technique—professional services only	43.68	20.000
4566*	Uterus and tubes, insufflation with CO^2 (Rubin's test)	37.76	20.000
4647*	Hysteroscopy with or without biopsy with or without D & C	182.14	20.000
4479	Myomectomy, vaginal	386.33	21.375
4487	Myomectomy, laparoscopic, single or multiple	530.40	21.375
4631	Hysterectomy, vaginal, with or without repair	749.99	22.750
4645	Metroplasty	415.74	20.000
4648	Hysteroscopically—guided endometrial ablation	351.54	20.000
0005	Endoscopic Tray Fee	193.80	
	May only be claimed in addition to tariffs 1949, 3055, 3065, 3095, 3121, 3122, 3123, 3185, 3186, 3187, 3189, 3926, 3927, 3928, 3929, 3931, 3932, 3933, 3939, 4636 and 4647 when the service is rendered in the **physician's office.**		
	Note: *Tray Fee tariff 0005 is claimable only in instances where expenses are directly incurred by the physician for medical/surgical supplies. Tray Fee tariff 0005 is not claimable in relation to services performed at a hospital, personal care home or other publically funded facility or a facility on contract with a Regional Health Authority to perform such insured services.*		
4639	**Unlisted or Unusually Complicated**	***By Report***	22.750

OPERATIONS FOR PROLAPSE OR INCONTINENCE

4483	Combined abdominovaginal two-team urethral sling following previous failed sling procedure(s) with or without cystocele repair with or without cystoscopy,		
	vaginal surgeon	321.42	22.750
4486	abdominal surgeon	321.42	22.750
	Note: *A Surgical Assist fee may not be claimed in addition by a surgeon who claims tariff 4483 or tariff 4486.*		
4488	Cystocele and rectocele	481.26	20.000
4489	with amputation of cervix	489.75	20.000
4481	Cystocele and/or urethrocele	271.46	20.000

			UNIT VALUE
4493	Enterocele repair—vaginal approach	354.44	20.000
4474	Le Fort operation	272.23	20.000
4484	Rectocele	271.46	20.000
4444	Urethral suspension, suprapubic (Marshall-Marchetti)	418.83	21.375
4445	Urethral suspension re-operation	523.04	21.375
4631	Hysterectomy, vaginal, with or without repair	749.99	22.750
4498	Abdominal vault suspension (e.g., Sacral colpopexy) with or without mesh	549.10	20.000
4499	Vaginal Route Vault Suspension with or without mesh	463.59	20.000

Note: *1) Tariffs 4481, 4484, 4488, 4493 and/or 4494 are payable at 75% when rendered in addition to tariff 4498 or 4499 through the same incision.*

2) Tariffs 4481, 4484, 4488, 4493 and/or 4494 are payable at 75% when rendered in addition to tariff 4498 or 4499 through a different incision.

4485	Urethral sling for incontinence (e.g. TFVT or TOT) with or without cystocele repair	564.29	21.375

Note: *1) Tariffs 4484, 4493, 4498 or 4499 are payable at 75% when rendered in addition to tariff 4485 through a different incision.*

2) This tariff may only be claimed once per patient. Subsequent repeat procedures must be claimed under tariff 3972.

4500	**Unlisted or Unusually Complicated**	***By Report***	21.375

LAPAROSCOPIC SURGERY

Note: *1) For multiple laparoscopic surgical services done at the same* sitting, benefits for the following will be paid at:

- *First procedure ..... 100% of the listed fee*
- *Second procedure ..... 75% of the listed fee*
- *Third procedure ..... 75% of the listed fee*
- *Fourth procedure ..... 25% of the listed fee*
- *More than four procedures 0%*

2) Procedures are eligible for surgical assistants where residents are unavailable.

3) Where the total value of all procedures is less than $155.66 the surgical assistant shall be paid $61.75.

4) Any laparoscopic operative procedure includes diagnostic laparoscopy.

4600	Ovarian drilling unilateral or bilateral	277.43	22.750
4602	Hydatid cyst of Morgagni greater than > 2.5 cm unilateral or bilateral	266.25	22.750
4605	Treatment of endometriosis, minor, first thirty (30) minutes of operating time (independent procedure)	218.79	22.750

Note: *Tariffs 3500 and 3501 may not be claimed in addition.*

			UNIT VALUE
4606	Treatment of endometriosis – major, each additional fifteen (15) minute period of operating time	109.40	22.750
	Note: *1) Tariffs 3500 and 3501 may not be claimed in addition.*		
	2) The following services may be claimed in addition to tariff 4605 and 4606: oophorectomy, salpingoophorectomy, hysterectomy.		
	3) Lysis of adhesions is included in tariffs 4605 or 4606.		
	4) 4605 and 4606 shall be paid at 100% when provided in conjunction with additional surgical services.		
4607	Laparoscopic assisted vaginal hysterectomy (LAVH) – with or without adnexa add to tariff 4631, or 4621	240.16	22.750
4608	Salpingolysis e.g. Fimbrioplasty, lysis of adhesions/debridement for infertility, unilateral or bilateral	352.53	22.750
	Note: *Tariffs 3500 and 3501 may not be claimed in addition.*		
4609	Laparoscopic radical hysterectomy and bilateral radical lymph node dissection	1,749.23	22.750
4691	Intraoperative morcellation of fibroids, requiring a minimum of 30 minutes operative time, add	232.56	
	Note: *Claimable in addition to tariffs for laparoscopic or vaginal hysterectomy or laparoscopic myomectomy.*		
4670	Injection of Botulinum Toxin for myofascial pelvic floor pain	270.61	
	Note: *May be billed in addition to pudendal block (5314).*		
4551	Tuboplasty (e.g. salpingostomy) for infertility, unilateral or bilateral	449.12	21.375
	Note: *Tariff 4551 is not to be claimed with tariffs 3500, 3501 or 4608.*		
4696	The procedure(s) described above under tariff 4551 when medically necessary to operate under the operating microscope	577.99	21.375
3572*	Laparoscopy, diagnostic	193.52	21.375
3574*	Laparoscopy, diagnostic when followed at the same sitting by an open abdominal operation, add	188.63	21.375
3579	Converted surgery, from laparoscopic to open technique, add	188.63	
Note:	*Tariff 3540, 3572*, and 3574* may not be claimed in addition.*		
3576*	Laparoscopy, diagnostic, performed at the time of possible I.V.F. or G.I.F.T. procedure	124.14	21.375
	Note: *This tariff is claimable only when done in a designated facility, by an appropriately trained physician who is a member of the I.V.F./G.I.F.T. team, and only when a previous diagnostic laparoscopy has not been performed within the previous nine (9) months by any member of the I.V.F./G.I.F.T. team.*		

ABDOMINAL OPERATIONS

4494	Enterocele repair—abdominal approach	354.44	21.375
4811	Extrauterine pregnancy, ectopic, removal by laparotomy	475.23	22.750
4561	Sterilization by any method, unilateral or bilateral	238.55	21.375

		UNIT VALUE
4562	Post partum sterilization by any method, unilateral or bilateral 238.55	21.375
4815	Hydatidiform mole, removal by dilatation and curettage 127.64	20.000
	Note: *Repeat D & C for hydatidiform mole will be paid at the same rate.*	
4829	Abdominal hysterotomy (mole or previable fetus) 317.05	21.375
4627	Hysterectomy, radical, with pelvic lymphadenectomy 1,032.62	22.750
4621	sub-total, with or without adnexal surgery 593.46	22.750
4617	total, with or without adnexal surgery 598.55	22.750
4610	Paraaortic Lymphadenectomy (Unilateral or Bilateral) 789.34	22.750
4620	Obesity and/or stage 3-4 endometriosis–add to hysterectomy 127.11	22.750
	Note: *1) Patient is obese when twice ideal body weight or 45 kilograms over ideal body weight or Body Mass Index > 35.*	
	2) Claims involving an obese patient must include the patient's Body Mass Index and weight.	
	3) For claims involving stage 3-4 endometriosis, documentation of the pathology report indicating stage 3-4 endometriosis shall be included in the patient's record in order to support the claim to Manitoba Health.	
4618	Selective pelvic lymph node dissection for gynaecologic cancer as an add on to tariff 4617 ..... 506.45	
4619	Total extensive omentectomy at time of surgery, for gynaecological cancer or suspected gynaecological cancer, add 216.96	
	Note: *Tariff 4619 may be claimed in addition to tariff 3571.*	
4622	Excision of gynaecological cancer from retroperitoneal/transperitoneal space 823.80	22.750
	Note: *1) Tariff 4622 may only be claimed by gynaecology-oncologists.*	
	2) Tariff 4617 is payable at 50% when claimed in addition to tariff 4622.	
4694	Hysterosalpingostomy and/or midtubal anastomosis, resection and anastomosis of tubes to uterus and/or resection and reanastomosis of the tube(s), unilateral or bilateral 663.60	21.375
4695	The procedure(s) described above under tariff 4694 when medically necessary to operate under the operating microscope 663.60	21.375
4614	Myomectomy 429.29	21.375
4583	Oophorectomy, unilateral or bilateral, complete or partial 391.17	21.375
4571	Ovarian abscess or cyst, abdominal drainage 391.17	21.375
4581	cysts, excision, unilateral or bilateral 459.01	21.375
4582	Torsion of Ovary, surgical reduction 450.42	21.375
4567	Presacral neurectomy ..... ***By Report***	22.750
4701	Ruptured uterus, non-obstetrical, suture 396.78	22.750
4545	Salpingectomy or Salpingo-oophorectomy total, unilateral or bilateral, when removed for morbidity, not for sterilization 444.52	21.375
4681	Uterine suspension 300.67	21.375

			UNIT VALUE
3571	Laparotomy, exploratory	461.66	22.750
4585	Laparotomy with biopsies to determine chemotherapy response for carcinoma of ovary	600.10	21.375
4586	with hysterectomy	956.20	22.750
4699	**Unlisted or Unusually Complicated**	***By Report***	22.750

OBSTETRICS

PREGNANCY AND MATERNITY

Please refer to General Schedule to determine the applicable after hours premium period for obstetrical deliveries and related services.

RULE OF APPLICATION 33

Obstetrics *(Amended April 1, 2019)*

a) ***Pre-natal care*** includes a comprehensive pre-natal assessment, follow-up pre-natal visits, which would generally occur at four (4) week intervals to twenty-eight (28) weeks, followed by visits every second week to thirty-six (36) weeks, then weekly until delivery. However, complicated pregnancies may require additional visits.

b) A ***comprehensive pre-natal assessment*** (8400) includes a full patient history, an inquiry into and examination of all relevant parts or systems, a comprehensive pelvic examination, completion of the pre-natal record and advice to the patient. All other pre-natal visits (8401), as well as post-natal visit (8402) include the necessary history, examination, appropriate record and advice to the patient. All pre-natal visits include pregnancy related counselling in the form of providing advice to the patient or the patient's representative(s).

c) The ***comprehensive pre-natal assessment*** (8400) generally should be about 20 minutes or longer in duration. The pre-natal visit (8401), as well as the post-natal visit (8402) generally should be about 10 minutes in duration, otherwise tariff 8509 (General Practice) or 8530 (Obstetrics & Gynaecology) should be claimed.

d) If during the course of the pregnancy the pre-natal care of the patient is transferred from a general practitioner to either a specialist in obstetrics and gynaecology or a general practitioner with additional training in obstetrics, the receiving physician may claim a comprehensive pre-natal assessment (8400) upon the initiation of their care.

e) Other than during the pre-natal or post-natal visit, the physician may charge for all visits for conditions unrelated to the pregnancy, under the appropriate fee items listed elsewhere.

f) A post-natal visit (8402) may only be billed once following delivery. The post-natal period is usually considered as 6 weeks (42 days) following delivery. However, complicated pregnancies may require additional visits which should be claimed under the appropriate office, home or hospital visit tariffs.

g) Necessary laboratory investigations, routine urinalysis and haemoglobin estimations, etc., are payable in addition to the benefits for obstetrical care.

h) Benefits listed under the headings ***Induction of Labour and Management of Complications of Labour*** will be paid in addition to other obstetrical care benefits as outlined in the manual. A physician may claim for more than one complication of the first and second stage of labour.

i) Benefits for complications of the third and fourth stage of labour may be claimed by either the physician who performed the delivery or another physician that is called in specifically for these complications. One or more of tariffs 4843, 4844, 4845, 4846, and 4847 may be claimed.

j) Serious complications that require hospitalization prior to delivery are not included in the benefits provided for obstetrical care. Such complications will be paid for at the scheduled benefits if substantiated by ***Special Report***.

k) If during the course of labour the attending physician calls a consultant to perform the delivery or caesarean section because complications have arisen, the attending physician may claim either tariff 4824, 4825 or 4826, in addition to the pre- and post-natal visits.

OBSTETRICAL BENEFITS

OBSTETRICAL CARE

			UNIT VALUE
4822	Routine vaginal delivery without manual removal of placenta, with or without repair of minor lacerations	570.53	20.000
4824	Attendance by physician during labor and delivery, or caesarean section when no surgical assistance or anesthesia services are provided by the physician, and the delivery/procedure is carried out by a consultant	549.10	
	Note: *The above benefit is not payable in addition to an assistant's fee.*		
4825	Attendance by physician during labor when the physician must transfer the patient to another facility because of fetal or maternal indications	447.51	
4826	Attendance by physician during labor and delivery, or caesarean section when the physician provides surgical assistance or anesthesia services and the delivery/procedure is carried out by a consultant	549.10	
	Note: *The physician may claim tariff 4826, and any applicable surgical assistant or anesthetic benefits.*		
4803	Caesarean hysterectomy	1,011.66	26.875
4800	Caesarean section with or without sterilization	699.86	22.750
4869	Physician attending a delivery for the care of the newborn at the request of another physician (due to high risk delivery or caesarean section)	144.53	
	Note: *This benefit will only be payable when accompanied by a* ***Special Report*** *when substantiated by the physician rendering the obstetrical service, and is chargeable in addition to the subsequent care of the newborn, or any other services provided by the physician. The attendance includes up to thirty (30) minutes care. In the event that procedures are performed during the first thirty (30) minutes these may be claimed if desired rather than tariff 4869. In cases where care is necessary longer than thirty (30) minutes after birth, then fees for detention time beyond thirty (30) minutes should apply, subject to tariff 8573 "Detention with a critically ill patient"—See* *General Schedule*		
4806*	Amniocentesis, initial or subsequent	101.06	20.000
4805*	Oxytocin challenge test with interpretation, technical component	28.05	
4804*	professional component	11.03	
4818*	Chorionic villus sampling, including ultrasound guidance for trophoblast biopsies for prenatal diagnosis	165.14	
4870	Dilatation and curettage for post partum bleeding (on re-admission to hospital)	102.66	21.375
4812	Fetal transfusion, intrauterine, initial and subsequent	361.03	21.375
4816	Diagnostic or therapeutic fetal umbilical vessel puncture and aspiration, including ultrasound guidance at the time of sampling only, or sampling and direct intravascular fetal transfusion	313.91	21.375
	Note: *The above benefit is for division between the two (2) physicians, the ultrasound guidance physician and the physician inserting the needle.*		
4817*	Physician transfusionist serving with the above service tariff 4816	91.01	

		UNIT VALUE	
4819*	Dynamic ultrasound fetal risk initial assessment, including the collection and interpretation of biometric and morphometric data	58.98	
	Note: *In addition to the above, the physician may claim the appropriate visit examination benefit.*		
4820	Subsequent ultrasound fetal risk assessment, including the collection and interpretation of biometric or morphometric data and the patient assessment. This benefit is all inclusive and no visit fee is claimable in addition	60.55	
	Note: *The above two (2) services, tariffs 4819 and 4820 are insured services only when provided in designated facilities and performed by appropriately trained physicians.*		
4851	Urgent obstetrical ultrasound for fetal age determination, professional	20.40	
4852	Urgent obstetrical ultrasound for fetal age determination, technical	30.60	
4809	Incompetent cervix in pregnancy, suture	198.98	21.375
4562	Post partum sterilization by any method, unilateral or bilateral	238.55	21.375
4875	Continuous conduction anesthesia (epidural)	289.03	
4876	for each subsequent injection	96.38	
	Note: *Tariffs 4875 and 4876 may not be claimed when the anesthetist is claiming In-Hospital On-Call Anesthetic Coverage at St. Boniface General Hospital (tariff 8201), Brandon Regional Health Centre (tariff 8202) or Health Sciences Centre (tariff 8203). (See Part III-Rules of Application for Anesthesia Services.)*		
4899	**Unlisted or Unusually Complicated**	***By Report***	25.500

INDUCTION OF LABOR

Note: *Only one (1) of the following may be claimed on any one (1) patient.*

4813*	Surgical	28.85	
4814*	Medical	82.67	

MANAGEMENT OF COMPLICATIONS OF FIRST AND SECOND STAGE OF LABOR

4828*	Initiation and supervision of internal electronic fetal monitoring	66.96	
	Note: *1) May only be claimed when a physician initiates and monitors the patient's progress.*		
	2) May be claimed in addition to delivery benefits regardless of who performs the delivery.		
	3) May only be claimed by one physician per delivery.		
	4) A claim for fetal monitor clip application under tariff 4836 may not be made in addition to this tariff.		
4830*	Abnormal presentation or position (delivered vaginally), breech	119.86	21.375
4831*	face and brow	109.20	21.375
4832*	multiple pregnancy	167.25	21.375

			UNIT VALUE
4833*	Transverse or occiput posterior position with forceps extraction and/or vacuum extraction (other than elective forceps)	97.97	21.375
4834*	Augmentation of labor (other than simple artificial ruptured membranes)	82.67	21.375
4835*	Prolonged rupture of membranes [twenty-four (24) hours or more]	78.95	21.375
4836*	Fetal monitor clip application and/or intrauterine catheter insertion (for measuring intrauterine pressures)	29.48	21.375
4837*	Scalp blood sampling for assessing fetal states in labor	51.51	21.375
4838*	Abruptio placenta	78.95	21.375
4839*	Double set-up (to rule out placenta praevia if patient does not proceed to cesarean section)	77.42	21.375
4840*	Hypertensive disorders requiring hypotensive regime and monitoring—P.E.T./Eclampsia	98.84	21.375
4841*	Vaginal delivery following previous caesarean section	138.51	21.375
4842*	Severe associated maternal condition or risk during pregnancy (e.g.—diabetes, chronic nephritis, renal transplant, Rh carditis)	77.01	21.375
4848*	Lower cavity assisted delivery with forceps and/or vacuum extraction (may not be claimed with tariff 4833), add	47.39	
4810	Shoulder dystocia, add	136.21	

MANAGEMENT OF COMPLICATIONS OF THIRD AND FOURTH STAGES OF LABOR

4843	Manual removal of placenta	100.29	22.750
4844	3rd or 4th degree laceration	91.18	21.375
4845	Extensive vault and/or cervical laceration	89.37	21.375
4846	Evacuation of vulval hematoma under anesthesia	88.49	21.375
4847	Management of post partum hemorrhage requiring reassessment under anesthesia	88.49	22.750

ENDOCRINE SYSTEM

These benefits cannot be correctly interpreted without reference to the Rules of Application.

THYROID

INVESTIGATION

			UNIT VALUE
4910*	Needle aspiration biopsy (cytology)	59.29	20.000
4909*	Needle core biopsy (histology)	71.54	20.000
4908*	Needle biopsy of Neck Masses	35.28	
4907	Open biopsy	236.54	21.375

INCISION

4940*	Aspiration of thyroid cyst	37.23	21.375
2775*	Thyroglossal duct cyst incision and drainage	48.94	21.375

RESECTION

4911	Thyroidectomy, adenoma or cyst excision	669.32	21.375
4912	Lobectomy, unilateral or subtotal thyroidectomy	757.61	21.375
4914	total thyroidectomy	1,112.51	21.375
4941	Thyroglossal duct cyst or sinus excision	456.23	21.375
4949	**Unlisted or Unusually Complicated**	***By Report***	22.750

PARATHYROID

RESECTION

4971	Exploration of the neck and/or removal of parathyroids or parathyroid tumor	1,089.28	21.375
4972	Mediastinal exploration by splitting of the sternum	701.35	25.500
5996	Intra-operative monitoring of cranial/facial nerves remote from the skull base, add	145.06	
	Note: *5996 may only be claimed in addition to the following tariffs, 0616, 2666, 2927, 2934, 4972, 5957, 5971, 5973, 5974, 5975, 5976, 5977, 5992 and 5995.*		
4979	**Unlisted or Unusually Complicated**	***By Report***	25.500

ADRENAL

RESECTION

			UNIT VALUE
4988	Adrenalectomy or biopsy, unilateral	986.88	25.500
4989	bilateral, one (1) stage	698.48	25.500
4990	bilateral, two (2) stages	1,512.49	25.500
4991	**Unlisted or Unusually Complicated**	***By Report***	25.500

CAROTID BODY

RESECTION

4994	Carotid body tumor, excision	598.60	26.875
4993	excision with sacrifice of the carotid artery	704.66	22.750
4999	**Unlisted or Unusually Complicated**	***By Report***	22.750

ENDOCRINE AND METABOLIC TESTING

7850*	Cortrosyn/ACTH stimulation test	26.28
7851*	Combined PRL/TRH	13.14
7852*	GnRH stimulation test	67.79
7853*	Insulin stimulation test	86.28
7854*	Tolbutamide tolerance test	148.25
7855*	TRH test for prolactin stimulation	13.01
7856*	Water deprivation test	86.33
7857*	Triple stimulation test	122.71
7858*	Pentagastrin stimulation test	37.09
7859*	TRh/GnRH stimulation test	77.88
7860*	Glucose growth hormone suppression test	148.25
7861*	Prolonged fast: short from variant	157.37
7862*	Glucagon stimulation test	157.37
7863*	Saline infusion test for aldosteronism	74.12
7864*	Thyroxine absorption test	148.25
7865	Growth Hormone stimulation testing per agent tested	51.51

Note: *7865 is payable at 100% for each agent tested.*

7866	Human Chorionic Gonadtropin (HCG) stimulation testing	51.51

Note: *The fees listed above are payable only where the service is provided at Health Sciences Centre or St. Boniface General Hospital.*

RENAL TRANSPLANTS

These benefits cannot be correctly interpreted without reference to the Rules of Application.

			UNIT VALUE
5883	Renal transplant	2,007.19	25.500
5884	Cadaver nephrectomy—single for local implant or export	1,037.36	22.750
5885	Cadaver nephrectomy—double for local implants or export	1,037.36	22.750
5900	Donor nephrectomy after cardiac death	2,575.50	

Note: *Tariff 5900 is for all procedures performed including but not limited to: unilateral or bilateral nephrectomy, aortic and venous cannulation, supra renal clamping and incisional or excisional biopsy of the spleen.*

5886	Live donor nephrectomy	1,333.54	22.750
5881	Laparoscopic live donor nephrectomy	1,751.34	22.750
5887	Rejection transplant nephrectomy	1,030.72	22.750
5888	Pre-transplant nephrectomy (recipient)—unilateral	504.80	22.750
5889	bilateral	908.62	22.750
5882	Marsupialization of post transplant lymphocele	553.06	22.750

Note: *The above fees represent the total fees of those surgeons in actual attendance and will be divided among the team in accordance with their involvement. They do not include Nephrologists fees which are listed below.*

NEPHROLOGISTS BENEFITS

Recipient related services; including nephrological management of transplantation including examination, supervision of allocation, tissue typing and interpretation of cross-match and immunological risk, determining induction and maintenance immunosuppression and complete patient care for the first three (3) day of post-operative care.

Note: *1) One of each service may be billed per patient.*

2) 5871, 5872 and 5873 are payable to the attending physician of record for the day.

5871	Day 1	623.58
5872	Day 2	312.31
5873	Day 3	312.31
5898	Donor related services; including the nephrological management of organ procurement, management of the neurologically "dead" donor on life support systems, the assessment of renal functions pre-nephrectomy, immunotherapy pre-nephrectomy, and assessment of potential recipients, etc.	459.62
5894	Subsequent postoperative routine care at daily care rates, per day	91.10
5895	Management of rejection crises, care ordinarily equivalent to that of the first three (3) postoperative days, per day	165.36
5896	Management of rejection crises requiring dialysis; as for acute renal failure (includes daily care by a Nephrologist); equivalent to repeat hemodialysis in acute renal failure, per dialysis—See existing schedule	200.02

5897 Dialysis without rejection crises, care equivalent to that for chronic renal failure on repeat hemodialysis, per dialysis—See existing schedule 86.23

Note: *The above fees represent the total fees for those Nephrologists directly involved with the transplant and will be divided amongst them according to the involvement of each.*

NERVOUS SYSTEM

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

These benefits cannot be correctly interpreted without reference to the Rules of Application.

		UNIT VALUE	
5290*	Alcohol injection subarachnoid	143.16	
5294*	2nd or 3rd branch of trigeminal nerve	252.55	
5295*	under x-ray control, excluding x-ray	216.14	
5296*	retrobulbar	209.92	20.000
5049*	Crutchfield tongs or other skeletal traction device, application	187.06	22.750
7900*	Nerve Conduction Studies Simple—Professional Testing performed on 2 or fewer motor and/or sensory nerves potentially involved by a disease process, with or without comparison testing. The physician performs or supervises the performance of the studies and interprets the results.	72.74	
7901*	Nerve Conduction Studies Simple—Technical	38.74	
7902*	Nerve Conduction Studies Intermediate—Professional Testing performed on 3 or 4 motor and/or sensory nerves potentially involved by a disease process, with or without a comparison test. The physician performs or supervises the performance of the studies and interprets the results.	106.26	
7903*	Nerve Conduction Studies Intermediate—Technical	58.47	
7904*	Nerve Conduction Studies Complex—Professional Testing performed on 5 or more sensory and/or motor nerves potentially involved by a disease process, with or without comparison testing of normal or opposite side nerves. The physician performs or supervises the performance of the studies and interprets the results	115.38	
7905*	Nerve Conduction Studies Complex—Technical	67.22	
7906*	Special Nerve Conduction Testing—Professional Special Nerve Conduction Studies may be claimed in addition to nerve conduction studies included in complex testing. The physician performs or supervises the performance of this test, and interprets the results	100.76	
7907*	H-Reflex—Claim in addition to tariffs 7900, 7902, and 7904 This test requires a comparison of left and right limbs	14.88	
7908*	EMG Complex—Professional Needle EMG testing performed on more than 4 muscles potentially manifesting consequences of a disease process, with or without comparison testing of normal or opposite side muscles	109.93	
7909*	EMG Complex—Technical	65.47	
7910*	EMG Limited—Professional Needle EMG performed on 4 or less muscles potentially manifesting consequences of a disease process, with or without comparison testing of normal or opposite side muscles	70.80	
7911*	EMG Limited—Technical	37.79	

7912* Repetitive Nerve Stimulation
Testing of 2 or more nerve/muscle combinations, with or without exercise. The test must be performed or supervised by the physician 62.99

7913* Brain Stem Evoked Audiometry Potentials—Technical
Should be conducted with bilateral stimulation unless patient context precludes 40.95

7914* Brain Stem Evoked Audiometry Potentials—Professional
Physician performance or supervision is required 26.63

7915* Brain Stem Evoked Audiometry Potentials—Interpretation 20.06

7916* Electroretinography—Technical 46.04

7917* Electroretinography—Interpretation 60.96

7939* Electroretinography—Professional Physician performance or supervision is required 24.57

7918* EEG Routine—Technical
16 or more channels recorded over a 20 minute period with referential and bipolar montages. Hyperventilation stimulation should be done in all cases possible where a contraindication exists 51.87

7919* EEG Routine—Professional 44.61

7920* Sleep Deprived Recordings
Sleep deprived recordings should be performed for at least 40 minutes. This tariff is not to be claimed in addition to studies testing sleep disorders, overnight recording, telemetry or other ambulatory EEG monitoring 84.26

7921* Screening Sleep Disorder Study—Interpretation
2 hour sleep study with continuous monitoring of oxygen saturation, ECG and ventilation by polysomngraphy with a technician in attendance during the study period 98.04

7922* Screening Sleep Disorder—Technical 82.52

7923* Prolonged (10 minutes) EEG—Professional
Supplemental recording of 16 or more channels mandated by the diagnostic issue being addressed, e.g., sleep deprived recording. Maximum of 30 minutes. Supplemental recording beyond 30 minutes must be submitted By-Report 14.52

7924* EMG—Single Fibre Electromyography (professional) 213.77

7925* EMG—Specialised Professional
Diaphragm, laryngeal, extraocular muscle or genital/rectal muscle needle EMG performed alone or in addition to other EMG. Needle EMG of other muscles requiring special techniques/expertise may be performed and submitted on a By-Report basis 98.38

7926* EMG Specialised—Technical 62.99

7927* Blink Reflex
Test must be performed or supervised by the physician, with testing of 2 or more nerve/muscle combinations, with or without exercise 38.56

7928* Autonomic Neurophysiology—Professional
Requires the performance of more than 2 tests of the autonomic nervous system function with electrophysiologic recording. Testing must be performed with physician supervision and interpretation. 36.68

7929* Evoked Potentials: Somatosensory—Technical
(Includes set-up per patient maintenance as necessary, as well as processing). 43.01

7930* Evoked Potentials: Somatosensory—Professional
Recording is required from any combination of 2 limbs. Physician performance or supervision is required 98.38

7931* Evoked Potentials: Additional 2 limbs—Professional
Physician performance or supervision is required 36.72

7932* Evoked Potentials: Additional 2 limbs—Interpretation 40.40

7933* Evoked Potentials: Additional 2 limbs—Technical 4.58

7934* Evoked Potentials: Somatosensory—Interpretation 40.96

7935* Visual Evoked Potentials—Technical
Monocular or binocular recording should be performed unless patient context precludes. Flash or pattern shift stimulation should be used. 38.16

7936* Visual Evoked Potentials—Professional
Physician performance or supervision is required 24.46

7937* Visual Evoked Potentials—Interpretation 20.49

7938* Tensilon Test 22.51

7940* Prolonged EEG—Technical 10.35

7941* EEG Telemetry—Professional 94.81

7942* EEG Telemetry—Technical 47.85

7943* Ambulatory (12-24 hrs.) EEG—Technical
Recording by telemetry or patient monitored recording device. Includes set-up per patient maintenance as necessary, as well as processing 42.54

7944* Ambulatory EEG—Professional 52.95

7946 Stereo/EEG intracranial telemetry (SEEG Telemetry) review and interpretation of recordings – per fifteen (15) minutes or major portion thereof. 80.30

***Note**: A maximum of three (3) hours may be claimed per day per patient.*

7945* Ischaemic forearm lactate exercise tests 45.85

7947* Video EEG Telemetry – review and interpretation per fifteen (15) minutes or major portion thereof 38.37

***Note:** Tariff 7947 may be claimed to a maximum of three (3) hours per patient per day.*

7948* Intraoperative monitoring of carotid endarterectomy 74.12

7949* Electro – oculogram 24.72

7950* Insertion of sphenoidal electrodes 37.09

7951* Neuromuscular transmission study 37.09

7952* Sodium amytal intracarotid injections test 103.84

Note: *Tariffs 7947, 7948, 7949, 7950, 7951, and 7952 are payable only where the service is provided at the Health Sciences Centre or St. Boniface General Hospital.*

NERVE LESIONING FOR SPASTICITY MANAGEMENT

Chemical Nerve Lesioning for Multi-focal Spasticity Management:

7955 Single peripheral nerve..... 102.00

7956 Additional peripheral nerves, per nerve, add..... 81.60

Note: *Maximum of 3 peripheral nerves can be claimed with 7956.*

BOTULINUM TOXIN

9757 Series of bilateral intramuscular injections of Botulinum Toxin for control of blepharospasms, including pre-injection assessment, any necessary EMG control, subsequent visits and any further injections within six (6) weeks..... 158.60

9758 Series of intramuscular injections of Botulinum Toxin for control of hemifacial spasms, including pre-injection assessment, any necessary EMG control, subsequent visits and any further injections within six (6) weeks..... 158.60

9766 Series of unilateral or bilateral intramuscular injections of Botulinum Toxin for control of spasmodic torticollis, focal spasticity, focal painful dystonia and strabismus, and spasmodic dysphonia including any EMG control, subsequent visits and any further injections within six (6) weeks..... 180.91

Note: *Notwithstanding the above, in exceptional circumstances and by* ***Special Report*** *a physician may claim any of the above three tariffs a second time within the six (6) weeks following the initial series of injections.*

BOTULINUM TOXIN FOR HYPERHIDROSIS

9731 A series of botulinum toxin injections for axillary hyperhidrosis (bilateral)..... 226.34

9733 A series of botulinum toxin injections for palmar hyperhidrosis (bilateral)..... 332.91

9735 A series of botulinum toxin injections for plantar hyperhidrosis (bilateral)..... 499.34

Note: *1) Botulinum toxin injections are indicated in those cases of hyperhidrosis where conservative measures (e.g. aluminum chloride, iontophoresis, or systemic medications) fail to resolve the problem or where the symptoms of hyperhidrosis are severe enough to give rise to emotional and social, as well as functional problems that impact the patient's quality of life.*

2) The treatment shall be administered by a specialist in Dermatology, Plastic Surgery or Neurology, or physicians with appropriate experience/training in the use of botulinum toxin for these indications, as determined by the Shared Health Chief Medical Officer (CMO).

3) The treatment includes pre-injection assessment, nerve blocs/local anesthetic, subsequent visits and any further injections within 12 (twelve) weeks.

PULSED OR CONTINUOUS RADIOFREQUENCY LESIONING

Lesioning of nerves arising from cervical or thoracic levels:

5800 One level, per side 448.90

5802 Multiple levels, per side 790.50

Lesioning of nerves arising from lumbar or sacral levels:

5805 One level, per side 342.57

5806 Multiple levels, per side 624.68

Lesioning of cranial nerves:

5807 Single or multiple levels, one side or bilateral 1,122.00

Note: *1) Bilateral lesioning shall be claimed at 100% of the above fees when performed at the same sitting.*

2) To be claimed only at approved sites.

3) To be claimed only by qualified physicians designated by the WRHA Medical Director, Anesthesia Program in consultation with the Medical Director for the Provincial Pain Management Service.

4) Where monitored Anesthesia Care is required during these procedures it shall be claimed only when provided by a separate anesthesiologist.

5) The above procedures include fluoroscopy.

6) Maximum of four (4) procedures per nerve per annum.

7) Additional procedures may be claimed by Special Report.

IMPLANTABLE INTRATHECAL DRUG PUMPS

8925* Assessment of intrathecal drug test doses 226.34

8926* Coordination, monitoring, and assistance in implantation of intrathecal drug pump 193.19

8927* Refill of implanted intrathecal drug pump 113.17

Note: *1) May be claimed by physicians designated as Physiatrists by The College of Physicians and Surgeons of Manitoba; or*

2) May be claimed by physicians designated as Anesthetists by The College of Physicians and Surgeons of Manitoba who provide services at the Health Science Centre Pain Clinic.

NERVE BLOCKS

Are paid as benefits only when injections are made to specific nerves as an isolated service for diagnostic or therapeutic purposes. They are not intended for cases where local anesthesia is used in lacerations and repairs, etc., and is obtained by general infiltration around the area of the nerve and they will not be paid in these cases except by ***Special Report***.

FLUOROSCOPIC CONTROL

5396* Fluoroscopic control of percutaneous spinal pain management procedures, per full fifteen (15) minute period, add 24.91

5398* Injection of radio-opaque contrast agent, add-on to tariff 5396 ..... 27.93

Note: *1) Tariffs 5396 and 5398 are limited to anesthetists, specialists in physical medicine and other qualified physicians who have training in fluoroscopic control of percutaneous spinal pain management procedures;*

2) Tariff 5396 may only be claimed in conjunction with tariffs 5300, 5304, 5305, 5306, 5307, 5308, 5309, 5313, 5321 or 5329;

3) A maximum of sixty (60) minutes per patient per day can be claimed for tariff 5396.

4) Tariff 5398 may only be claimed once per patient per day.

NERVE BLOCK FOR HAND SURGERY

Tariff 5319 may be claimed for major nerve blocks at or proximal to the wrist (e.g., radial, ulna or median nerve not ringblock) by the same physician that provides the surgical service, when:

1) No anaesthetist or other provider of anaesthetic services is present; and,

2) The nerve block is the sole method of providing operative anaesthetic; and,

3) The nerve block is provided in conjunction with one of the following tariffs: 0844, 0854, 1017, 1519, 1540, 1542, 1543, 1552, 1570, 1573, 1574, 1580, 1583, 1585, 1589, 1740, 1742, 5235, 5286, 5287, 2593 and 2595.

The benefit includes whatever number of injections are required for the specific nerve listed.

5311* Nerve plexus blocks 88.52

5300* cervical, single 132.78

5313* coccygeal, lumbar or sacral–single 104.01

5361* ilioinguinal and iliohypogastric 61.56

5312* intercostal, one (1) or more 66.39

5298* paravertebral, (lumbar sympathetic) 132.78

5318* phrenic 132.78

5314* pudendal 61.56

5317* sciatic 132.78

5320* sphenopalatine ganglion 132.78

5315* splanchnic/coeliac plexus 177.04

5316 supra and infra diaphragmatic nerve neurolysis including splanchnic, coeliac sympathetic nerves with x-ray contrast and x-ray control 265.56

5302* stellate ganglion 132.78

5319* peripheral nerve—single and multiple 66.39

Epidural Blocks

5304 Lumbar or Caudal 132.78

5329 Multiple Transforaminal site injections by a pain management specialist 232.37

Note: *The specific nerve root sites that were injected with an epidural block must be noted on the claim for tariff 5329.*

5305 Thoracic 177.04

5306 Cervical 177.04

Nerve Root or Facet Blocks

5307 Cervical multiple 177.04

5308 Thoracic single 132.78

5309 Thoracic multiple 177.04

5321 Lumbar multiple 132.78

5328 Nerve Root or Facet—Cryotherapy and/or Neurolysis, additional benefit. 44.26

Subarachnoid (spinal) Blocks

5322 Subdural/Spinal 132.78

5323 Differential spinal 159.34

Permanent Cryosection and/or Neurolysis

5324 Major plexus or nerve root 265.56

5325 Single peripheral nerve 66.39

5326 Multiple peripheral nerves 168.19

5327 Epidural or subarachnoid neurolysis 265.56

Percutaneous Insertion of long term epidural catheters

5110 Lumbar or Caudal 159.34

5111 Thoracic 185.89

5112 Cervical 203.60

Percutaneous Insertion of long term intrathecal catheters

5114 Lumbar or Caudal 185.89

5115 Thoracic 203.60

5116 Cervical 221.30

5117 Implantation of permanent epidural/intrathecal catheter, (e.g. DuPen catheter system) 234.58

Paraspinous Block

5301 Paraspinous block, per injection 90.76

Note: *1) Limited to a) Specialists in Physical Medicine, and b) Anesthesiology pain specialists designated by the WRHA Head of Physical Medicine.*

2) Maximum of two (2) injections per visit.

3) No visit benefit will be paid in addition to this tariff if the patient's visit is for the procedure alone.

4) Maximum of six (6) treatments (of up to two (2) injections each) in a six (6) month period.

			UNIT VALUE
5062*	Puncture, cisternal (independent procedure)	22.26	22.750
5063*	Intrathecal antineoplastic chemotherapy by cisternal route	88.08	21.375
5061*	by lumbar route	88.08	21.375
5060*	Puncture, spinal, lumbar simple (independent procedure)	94.57	21.375
5057*	diagnostic, initial, with study of hydrodynamics	104.25	21.375
5059	if patient is under four (4) years, add the following to above two (2) procedures	7.60	22.750
5056*	subdural, through fontanelle (infant)	35.19	22.750
5058*	ventricular, through previous burr holes or fontanelle	38.69	22.750
5099*	Ventricular, with introduction of dye and recovery by spinal puncture	146.29	22.750
9866*	Photomotogram, tracing and interpretation	6.44	

SKULL, MENINGES AND BRAIN

See Rules 25 to 29 re multiple procedures at same operation sitting.

CRANIOTOMY FOLLOWING TRAUMA

5001	Brain scar, excision	***By Report***	25.500
5003	Burr Holes, exploratory, for subdural puncture, not followed by surgery, unilateral	382.86	25.500
5005	multiple, bilateral	370.87	25.500
5007	Cranioplasty for skull defect, bone, metal or plastic	994.66	25.500
5009	Dura repair by graft, including repair for cerebro-spinal Rhinorrhea	838.90	25.500
5011	Foreign body, removal from brain	751.02	25.500
5013	Hematoma, subdural, extradural or intracerebral, evacuation by burr holes only	704.66	25.500
5015	requiring craniotomy	832.40	25.500
5017	Skull fracture, depressed, "Ping Pong Ball" elevation	107.66	22.750
5019	depressed, simple elevation	922.34	22.750
5021	with debridement of brain and repair of dura	755.14	25.500

CRANIOTOMY FOR NON-TRAUMATIC CAUSES

5023	Burr Holes, exploratory, ventricular puncture, or ventriculography, not followed by surgery	150.41	26.875
5025	followed by surgery	150.41	26.875

			UNIT VALUE
5027	Craniectomy for craniostenosis, single suture	818.86	26.875
5029	multiple sutures	1,029.89	26.875
5031	sub-occipital for brain tumor	1,216.67	26.875
5033	sub-occipital for tractotomy or section of 5th, 8th, 9th or cranial nerves	1,147.95	26.875
5035	subtemporal for decompression	832.40	26.875
5037	for osteomyelitis of skull	***By Report***	26.875
5065	Craniotomy, for brain abscess, drainage	644.91	26.875
5067	subsequent tapping aspiration, in operating room	72.89	26.875
5069	at bedside	40.28	
5071	for choroid plexus, excision	376.02	26.875
5073	for Gasserian ganglion, sensory root surgery	830.34	26.875
5075	for lobotomy, unilateral	298.76	26.875
5077	bilateral	450.20	26.875
5079	for orbital decompression, unilateral	799.44	26.875
5081	for pallidectomy, any method, including localizing techniques, single or multiple stages	799.44	26.875
5083	for topectomy	748.96	26.875
5084	Percutaneous thermocoagulation of trigeminal nerve, unilateral	612.35	22.750
5085	Craniotomy, osteoplastic, for arteriovenous malformation	***By Report***	26.875
5087	for excision of brain tumor, abscess or cyst, supratentorial	2,057.79	26.875
5089	for obliteration of aneurysm	1,280.54	26.875
5090	Carotid cavernous fistula closure with preservation of carotid artery	3,572.73	26.875
5098	Extracranial—intracranial arterial bypass	1,262.00	26.875
5091	Encephalocele, repair	***By Report***	25.500
5100	Intra-operative Electrocorticography (ECOG)	159.63	

Note: *This tariff may be claimed by physicians licensed by The College of Physicians and Surgeons of Manitoba to practice neurology and who have expertise in encephalography as determined by the Head, Section of Neurology, University of Manitoba.*

HYDROCEPHALUS

	Percutaneous irrigation of shunt	F/S	
5093	Obstructed valve, replacement	255.90	25.500
5092	Revision of shunt under general anesthesia	160.30	25.500
5095	Shunt, removal in toto without replacement	239.01	25.500
5097	Ventricular catheter, replacement	246.63	25.500
5101	Ventriculo-auricular shunt	751.02	25.500
5103	Ventriculo-auricular peritoneal pleural ureteral shunt	755.14	25.500

			UNIT VALUE
5105	Ventriculocisternostomy	755.14	25.500
	Note: *Re-opening of cranial operations within three (3) week period—50% of scheduled benefit, except for re-opening to remove infected bone flap when benefit will be:*		
5106	Removal of infected bone flap	163.80	25.500

STEREOTACTIC SURGERY FOR INTRACRANIAL LESIONS, CYSTS OR ABSCESSES

5107	Computed tomography guided stereotactic surgery for needle biopsy of intracranial lesions, and for drainage of intracranial cysts or abscesses, to include ventriculography	721.14	25.500
5108	with implantation and removal of radioactive sources in the brain, add	206.04	
5118	Gamma Knife Radiosurgery – Neurosurgery component	824.16	22.750
	Note: *1) Includes the review of submitted data, application of the stereotactic frame to the patient's head and revision and review of obtained images (either CT and/or MRI), the outline of the treatment plan and attendance with the patient for the duration of the radiosurgery.*		
	2) This surgery should be done in conjunction with the radiation oncologist.		
5119	Gamma Knife Radiosurgery – Radiation Oncology Component	933.72	
	Note: *1) Includes entering data from CT scan into the treatment planning computer, determining the treatment plan and prescription with the radiotherapy physicist, responsibility for the administration of the single fraction radiosurgery and presence throughout the entire procedure.*		
	2) This procedure is done in conjunction with the neurosurgeon.		

SPINE AND SPINAL CORD

Laminotomy—Lumbar—See Arthrectomy

5201	Cordotomy, cervico-dorsal	727.32	21.375
5202	Percutaneous cordotomy (thermocoagulation technique), unilateral	721.60	21.375
5203	Intervertebral discs, excision anterior approach, cervical	1,272.76	22.750
5205	Laminectomy–laminae only for decompression of the spinal cord and nerve roots unilateral–first level	1,033.19	25.500
5200	bilateral, first level	1,138.95	25.500
5207	Laminectomy–for lesion, laminae only for decompression of spinal cord or meninges unilateral–first level	1,239.85	25.500
5204	bilateral, first level	1,317.84	25.500
5211	each additional vertebral level (unilateral or bilateral) add to 5205, 5200, 5207 or 5204	251.32	25.500
5209	Laminotomy, cervical	1,112.12	25.500
5215	Lumbar subarachnoid-peritoneal-ureteral shunt	603.70	22.750
5217	Meningocele, repair	1,008.55	25.500

			UNIT VALUE
5219	Meningomyelocele	704.66	25.500
5221	Rhizotomy	1,053.84	22.750
5224	Percutaneous implantation of neurostimulator electrodes, epidural or intradural	420.47	22.750
5226	Laminectomy for implantation of neurostimulator, epidural electrodes	490.78	22.750
5228	Incision and placement of subcutaneous neurostimulator/receiver (pack)	402.77	22.750
5230	Revision or removal of permanent spinal neurostimulator/receiver (pack) and/or electrodes beyond three (3) weeks from placement	402.77	22.750
	Note: *Re-opening of spinal cord lesions within three (3) weeks—50% of schedule benefits.*		
5240	Initial programming and interrogation of implanted neuro stimulation device	206.04	
5242	Follow-up interrogation of implanted neuro stimulation device	154.53	

PERIPHERAL NERVES, OTHER EXTRACRANIAL NERVES AND GANGLIA

5225	Avulsion or transection of nerves, infraorbital	186.72	21.375
5227	occipital	295.80	21.375
5229	phrenic	156.23	25.500
5231	spinal	357.94	22.750
5233	Anastomosis, to establish other than normal anatomical continuity; spinal accessory-facial, spinal accessory-hypoglossal, hypoglossal-facial, etc.	584.79	21.375
5235	Decompression, median nerve at carpal tunnel, simple	243.89	20.000
5237	Neurectomy, obturator	281.24	21.375
5239	Stoefel's	307.20	21.375
5244*	Sural nerve biopsy	154.21	20.000

DEEP BRAIN STIMULATION

5240	Initial programming and interrogation of implanted neuro stimulation device	206.04	
5242	Follow-up interrogation of implanted neuro stimulation device	154.53	

SUTURE OF NERVES, PRIMARY

Note: *1) Additional nerves will be paid at 75%.*

2) Microsurgery "add on" will be 40% payable on the basic fee only.

3) For secondary or delayed anastomosis or reanastomosis including local advancement to overcome a gap, add 25% to fee for primary repair.

			UNIT VALUE
5286	Suture and/or excision neuroma and/or neurolysis—minor nerve digital or cutaneous	313.13	20.000
5287	Suture and/or excision neuroma, and/or neurolysis—major nerve	568.84	20.000
5289	lumbar plexus	***By Report***	22.750
5291	sciatic nerve	***By Report***	22.750
5292	graft to minor nerve (e.g. digital or cutaneous)	576.91	20.000
5293	graft to major nerve	708.10	21.375
5284	Ulnar nerve, transplantation, including neurolysis (independent procedure)	448.09	20.000

BRACHIAL PLEXUS

5351	Supraclavicular and/or infraclavicular approach to the brachial plexus includes preparation of the nerve roots for grafting/transfer with or without microscope, nerve grafting payable in addition	1,777.10	21.375
5352	Multiple cable nerve grafts (includes harvest), for reconstruction and/or repair of brachial plexus with or without microscope, for one major nerve, payable in addition to 5351, 5353, 5354, 5355 and 5356, add	1,390.77	21.375
5353	Intraplexal intrafasicular nerve transfers, includes neurolysis [triceps branch to axillary nerve, ulnar nerve fascicle to biceps nerve branch (musculocutaneous nerve), median nerve fascicle to brachialis nerve branch (musculocutaneous nerve)] with or without microscope	1,684.38	21.375
5354	Extraplexal intrafasicular nerve transfer includes neurolysis (spinal accessory nerve to suprascapular nerve) with or with microscope	1,667.70	21.375
5355	Extraplexal intrafasicular nerve transfers of two (2) or more intercostal nerves for brachial plexus reconstruction (includes neurolysis, harvest and transfer) with or without microscope	2,178.87	21.375

Distal Peripheral Nerve

5356	Extraplexal intrafasicular peripheral nerve transfers, includes neurolysis (AIN to ulnar motor nerve, tibial to peroneal nerve) with or without microscope	1,667.70	21.375

Note: *Functional muscle reconstruction payable at 100% only when billed using all three of the following tariffs 0363, 0364 and 0365, payable in addition to 5353, 5354, 5355 and 5356.*

VEGETATIVE NERVOUS SYSTEM

See Rules 25 to 29 re multiple procedures at same operation sitting.

Sympathectomy

			UNIT VALUE
5371	Cervical, unilateral	456.81	22.750
5372	bilateral	671.54	22.750
5375	Cervico-thoracic, Smithwicke type, supra and infra-diaphragmatic, unilateral	462.56	25.500
5376	bilateral, concomitant or delayed	821.02	25.500
5381	Lumbar, unilateral	412.08	21.375
5382	bilateral	569.24	21.375
5385	Splanchnicectomy, Peet type, unilateral	474.92	22.750
5386	bilateral	674.73	22.750
5390	Presacral neurectomy, hypogastric plexus	***By Report***	22.750

CENTRAL NERVOUS SYSTEM

5303*	Intracerebral injection of medication/biologic substance through intracranial port	38.41	

Vagal Nerve Stimulation

5240	Initial programming and interrogation of implanted neuro stimulation device	206.04	
5242	Follow-up interrogation of implanted neuro stimulation device	154.53	
5399	**Unlisted or Unusually Complicated**	***By Report***	22.750

OCULAR SYSTEM

These benefits cannot be correctly interpreted without reference to the Rules of Application.

SPECIAL DIAGNOSTIC OCULAR TESTS

			UNIT VALUE
9855*	Contact lens fitting, supervision for six (6) months, including three (3) visits	102.51	
9898	Initial fitting of contact lens following congenital cataract surgery [fee includes cost of lenses and services for six (6) months]	***By Report***	
9815*	Diurnal tension curve–bilateral	68.75	
9851*	Electroretinography	75.36	
9655	Mutifocal Electroretinogram, bilateral	55.40	
9656	Dark Adaptation Curve, bilateral	38.13	
	Note: Tariffs 9655 and 9656 are payable only when provided at Misericordia Health Centre or Children's Hospital.		
5635*	Examination under general anesthesia	195.38	20.000
	Note: *The above cannot be claimed together with a non-asterisked procedure at the same sitting.*		
9856*	Fluorescein fundus angiography, total	65.28	
9852*	professional	56.91	
9857*	Fluorescein fundus angioscopy	58.35	
9850*	Fundus photography, unilateral or bilateral	13.97	20.000
9848*	Glaucoma, provocative test	21.27	
9847*	Gonioscopy or three mirror examination, bilateral	19.65	
9858*	Indirect ophthalmoscopy with scleral depressions for complete examination of the fundus and periphery with detailed drawing in patients with retinal pathology or suspected retinal pathology	19.74	
	Note: *An indirect ophthalmoscopy examination without a detailed drawing of pathology is often part of a routine eye examination. Tariff 9858 is not to be claimed in such circumstances.*		
9854*	Low vision aid assessment	86.22	
9849*	Special muscle studies	18.14	
9859*	Subconjunctival injection (independent procedure)	28.07	
9845*	Tonography	21.22	
	Note: *The above is done by a machine which makes a graph. Tonometry—the measurement only, is part of refractions and when done separately is included in the office visit.*		
9652	Frequency Doubled Technology Perimetry	15.45	
	Note: *9652 cannot be claimed in conjunction with other visual field tests.*		

		UNIT VALUE
9853*	Visual fields, perimetry or tangent screen	22.15
9846*	perimetry and tangent screen	43.06
9789*	Computerized perimetry screening, professional component	14.37
9771*	technical component	18.03
9790*	total	32.40
9791*	Computerized perimetry threshold, professional component	18.03
9772*	technical component	36.11
9792*	total	54.14
9890*	Ultrasonography of eye to determine axial length (ophthalmic biometry A-mode)—payable only when done in preparation for cataract surgery, total	67.44
9891*	professional component	34.98
9892*	technical component	32.46
9893*	Ultrasonography of eye A-mode for other conditions (specify condition)	75.20
9894*	professional component	40.85
9895*	technical component	34.35

Note: *For bilateral ultrasonography procedures, add 50%. The above tariffs are to be claimed only when the services are performed outside of publicly funded institutions.*

ANESTHESIA FOR EYE SURGERY

The following procedure has a single benefit whether one (1) or more is used and is in addition to the surgical procedure.

5500*	O'Brian Akinesia—Retrobulbar Block—Van Lint Akinesia (not to be claimed with tariff 5612 unless in conjunction with a second major procedure)	79.48

EYE SURGERY

ORBIT

5662	Orbit, excision of benign lesion requiring bone flap	652.22	22.750
5681	plastic repair	***By Report***	22.750
5664	Orbital contents, exenteration or evisceration with or without graft	1,011.76	22.750
5651	Orbitotomy, with exploration	565.53	22.750
5652	with drainage of intraorbital abscess	667.47	22.750
5653	with removal of intraorbital foreign body	837.71	22.750
5665	Blowout fracture of orbit and repair surrounding tissues with or without implantation of silicone	590.60	22.750
5296*	Retrobulbar injection of alcohol	209.92	20.000

EYELIDS

		UNIT VALUE	
	Repair of lacerations of eyelids—See Integumentary System		
5691*	Blepharotomy with drainage of abscess	57.33	21.375
5692*	with drainage of Meibomian glands, Hordeolum (stye)	71.45	21.375
5728*	Ectropion or entropion, cautery puncture	113.22	21.375
5730	Entropion or trichiasis, simple plastic repair (e.g. Wheelers operation)	331.78	21.375
5731	Ectropion or Entropion—full thickness, excision and repair by advancement flaps (including tarsal plate) up to 1/4 eyelid margin	383.86	21.375
5732	over 1/4 eyelid margin	383.86	21.375
5698	Levator palpebrae muscle, resection or equivalent surgery for ptosis	536.32	21.375
5697	recession	541.68	21.375
5712*	Epilation, electrolytic or by cryotherapy	70.93	21.375
5702*	Meibomian gland (chalazion) incision and excision, single	90.91	21.375
5703*	multiple	122.49	21.375
5734	Tarsorrhaphy, suture of tarsal cartilage	220.56	21.375

RHYTIDECTOMY

Note: *Rhytidectomy, when done as elective plastic surgery for cosmetic purposes is an exclusion under the "Act", except where the Minister is satisfied prior to the operation that such surgery is medically required. It is the responsibility of the physician to obtain this approval prior to the operation.*

See Rhytidectomy under Integumentary Section.

0328	Rhytidectomy, eyelid lower	196.82	21.375
0329	eyelid upper	219.96	21.375

BOTULINUM TOXIN

9757	Series of bilateral intramuscular injections of Botulinum Toxin for control of blepharospasms, including pre-injection assessment, any necessary EMG control, subsequent visits and any further injections within six (6) weeks	158.60	
9758	Series of intramuscular injections of Botulinum Toxin for control of hemifacial spasms, including pre-injection assessment, any necessary EMG control, subsequent visits and any further injections within six (6) weeks	158.60	

Note: *Notwithstanding the above, in exceptional circumstances and by* ***Special Report*** *a physician may claim either of the above two tariffs a second time within the six (6) weeks following the initial series of injections.*

LACRIMAL DUCT, SAC AND WALL

5803*	Lacrimal sac, drainage	58.57	20.000
5843*	Naso-lacrimal duct, probing, initial	29.52	20.000
5844*	subsequent	28.95	20.000

			UNIT VALUE
5845*	under general Anesthesia	205.84	20.000
5835*	Punctum, closure by cautery	70.53	20.000
5841*	dilatation and irrigation of naso-lacrimal duct	27.76	20.000
5842*	Canaliculoplasty (3 snip procedure)	74.23	20.000

			UNIT VALUE
5831	Canaliculi, plastic repair	474.05	20.000
5811	Dacryoadenectomy, excision of lacrimal gland	381.75	20.000
5813	Dacryocystectomy, excision of lacrimal sac	382.70	20.000
5804	Dacryocystomy or dacryocystostomy, intranasal	314.11	20.000
5833	Dacryocystorhinostomy fistulization of lacrimal sac into nasal cavity with or without anterior ethmoidectomy, Toti	600.81	20.000
5801	Lacrimal gland, drainage of abscess	96.70	20.000
5815	tumor excision	431.70	20.000
5821	Lacrimal nasal duct, catheterization, initial, in hospital	180.81	20.000

OCULAR MUSCLES

5647	Muscle transplant	778.54	21.375
5641	Myotomy, tenotomy, recession, resection, advancement or shortening of ocular muscles for strabismus, one muscle	538.34	21.375
5642	each additional muscle at the same operation whether unilateral or bilateral	380.35	21.375
5643	subsequent operation, one muscle	579.57	21.375
5644	each additional muscle	313.92	21.375
5645	for adjustable suture(s), per eye, add	253.12	

CONJUNCTIVA

5751*	Biopsy	70.31	20.000
5753*	Cyst or other lesion, excision	96.53	20.000
5741*	Foreign body removal, from surface	33.84	20.000
5742*	embedded, single	37.50	20.000
5744*	multiple	***By Report***	20.000
5743*	Suture for laceration	146.70	20.000
9859*	Subconjunctival injection (independent procedure)	28.07	
5775	Conjunctival flap for corneal ulcer, perforating wound, etc	320.49	22.750
5777	Conjunctiva or mucous membrane graft	***By Report***	22.750
5778	Conjunctiva dacryocystorhinostomy with implant	600.81	22.750

		UNIT VALUE	
CORNEA			
5445*	Foreign body removal, single	37.66	22.750
	Note: *When tariff 5445 is performed twice on the same patient, same day, different provider, each claim shall be paid at 100%.*		
5446*	multiple	***By Report***	22.750
5465*	Ulcer, curettage and cauterization	24.62	
5451	Keratectomy, partial	350.32	22.750
5452	complete	347.85	22.750
5471	Keratoplasty, corneal transplant, lamellar or penetrating	1,036.43	22.750
5472	corneal tissue preparation, where surgery occurs, add to tariff 5471	113.21	
	Note: *5472 cannot be claimed when the corneal tissue processing is performed by Tissue Bank Manitoba.*		
5475	Deep anterior lamellar keratoplasty (DELK) with graft	1,406.58	22.750
	Note: *Where attempted DELK converts to penetrating keratoplasty, 5475 shall be paid.*		
5441	Keratotomy, any type	76.13	22.750
5481	Perforated cornea suture	617.76	22.750
5456	Epikeratophakia in cases with medical necessity such as aphakia in children, and aphakia in adults in whom intraocular lenses are unacceptable or secondary lenses inappropriate, severe astigmatism, certain corneal abnormalities, and injury. Epikeratophakia is not an insured service when done as a cosmetic procedure.	625.95	22.750
5457	Pterygium, excision	231.22	22.750
5458	and repair of defect by free conjunctival graft, including repair of donor site	366.96	20.000
5453	Excimer Laser Surgery, Professional	345.58	20.000
5454	Excimer Laser Surgery, Technical	648.31	
	Note: *1) Excimer laser surgery is an insured service if the surgery is medically required. It is the responsibility of the physician to obtain written approval from the Minister before the surgery is undertaken.*		
	2) These tariffs are not payable with respect to Excimer laser surgery performed for the sole purpose of eliminating the need for eyeglasses or contact lenses.		
SCLERA AND ANTERIOR CHAMBER			
5496*	Aspiration, diagnostic	76.08	
5497*	Injection	28.71	
5501	Anterior chamber, irrigation and reformation	399.31	21.375
5493	Intraocular foreign body, removal with magnet without operative incision	322.47	22.750
5492	removal from anterior and posterior chamber with magnet, with incision	478.58	22.750

			UNIT VALUE
5494	removal of non-magnetic intraocular foreign body from posterior chamber with incision	615.32	22.750
5495	Sclerotomy, posterior	232.67	21.375
5521	Suture of sclera for wound or injury	***By Report***	22.750

IRIS AND CILIARY BODY

5551	Ciliary body, diathermy or cryotherapy	352.23	21.375
5554	Cyclodialysis	343.01	21.375
5401	Goniotomy, primary	214.86	21.375
5552	Iridodialysis, repair	403.11	21.375
5533	Iridotomy with photocoagulator	156.45	21.375
5541	Lesion of iris, excision	1,883.46	21.375
5542	and ciliary body, excision	1,039.30	21.375
5546	Surgical iridectomy	369.38	21.375
5547	Surgical trabeculectomy or similar filtering procedure for the treatment of glaucoma	813.30	21.375
5508	Filtering procedure, placement of seton for posterior bleb formation, add to 5547	255.00	
5548	Trabeculectomy revision, add to 5547	255.00	
5561	Prolapsed iris, repair with suture of perforated sclera or cornea	***By Report***	21.375
5532	Laser iridotomy, professional	156.45	21.375
5534	total	241.38	21.375
5538	Laser trabeculoplasty, professional	234.24	21.375
5537	total	274.91	21.375
5507	Ab-interno canal surgery (stent, ablation or similar)	459.00	21.375

CRYSTALLINE LENS

5604	Aspiration of lens material for congenital cataract, one or more stages	751.27	21.375
5601	Discission, needling of lens, primary	164.99	21.375
5611	Extraction of lens, intracapsular or extracapsular, unilateral, with or without iridectomy	545.18	21.375
5610	Insertion of secondary intraocular lens	506.35	21.375
5612	Extraction of lens with insertion of intraocular implant—unilateral, with or without iridectomy	459.00	21.375
	Note: *When tariff 5612 is performed twice on the same patient, same day, each claim shall be paid at 100%.*		
5615	Repositioning of intraocular lens	313.23	21.375
5616	Repositioning of intraocular lens with suturing of haptic to iris or stroma	618.12	21.375
5614	Removal of intraocular implant, unilateral	474.92	21.375
5613	Capsulectomy	267.95	21.375

5535	Laser capsulotomy, vitreolysis of vitreous bands, iridoplasty, pupilloplasty, synechiotomy, professional	152.88	21.375
5536	total	178.22	21.375

			UNIT VALUE
VITREOUS			
5622	Planned anterior vitrectomy as a secondary procedure, add on	303.96	21.375
5624	Removal of vitreous body by posterior or anterior approach with or without extraction of lens	1,005.73	21.375
5640	With preretinal membrane peeling, add to 5624	173.40	
5625*	Intravitreal injection of medication	136.43	
	Note: *1) Tariff 5625 cannot be claimed with tariff 5624.*		
	2) Second eye at same sitting paid at 75%.		
RETINA			
5631	Reattachment of retina; coagulation, scleral resection, with insertion of implant, with or without encircling band	892.98	22.750
5638	subsequent operation	921.67	22.750
5639	removal of band	284.38	22.750
5634	Coagulation of retina for neovascular disease, initial	312.78	21.375
5636	subsequent [within sixty (60) days of last coagulation treatment]	263.21	21.375
5632	Coagulation of retinal break(s), one (1) or more stages	336.62	22.750
5630	Coagulation of retina for tumor(s), one (1) or more stages of the same lesion	432.68	21.375
5633	with draining of subretinal fluid	476.98	22.750
PHOTODYNAMIC THERAPY			
	Note: *Payable only for services rendered at a designated facility (Misericordia Health Centre) by a retinal specialist.*		
5693	Photodynamic therapy for wet macular degeneration—one eye	382.66	
5694	Photodynamic therapy for wet macular degeneration—second eye at same sitting, add	108.27	
5695	Photodynamic therapy for choroidal neovascularization other than wet macular degeneration—one eye	382.66	
5696	Photodynamic therapy for choroidal neovascularization other than wet macular degeneration—second eye at same sitting, add	152.37	
EYEBALL			
5411	Enucleation or evisceration	595.35	22.750
5413	with implant	849.24	22.750
5414	secondary implant	618.38	22.750
5438	Enucleation of eye for eye bank, unilateral or bilateral	133.88	22.750
5431	Suture of eyeball for wound or injury	***By Report***	21.375
5482	Anterior Open Globe including full thickness laceration of the cornea and/or anterior 2 mm of the sclera, Simple, linear laceration	408.00	22.750

			UNIT VALUE
5483	Complex, stellate laceration and/or tissue prolapse and/or loss	867.00	22.750
5484	Posterior Open Globe repair, full thickness laceration of the sclera with involvement posterior to the anterior 2 mm or the sclera. Includes globe exploration	1,428.00	22.750
5485	Exploration of the Globe to rule out the presence of a posterior open globe. No open globe found	714.00	22.750

Notes: *1) Posterior globe is defined as past the midpoint of the eye.*

2) Where performed, additional procedures including vitrectomy and/or retinal detachment repair are billable in addition to 5482 to 5485.

OPTIC NERVE

5670	Optic Nerve Sheath Fenestration	839.61	22.750

OCULAR

5439	**Unlisted or Unusually Complicated**	***By Report***	22.750

AUDIO-VESTIBULAR SYSTEM

These benefits cannot be correctly interpreted without reference to the Rules of Application.

DIAGNOSTIC PROCEDURES

	Automated impedance tympanometer with hand-held micro tympanometer (included in visit fee)	F/S
	Audiogram—screening	F/S
9745*	Audiogram—puretone—air & bone (bilateral), total	22.26
9740*	professional portion	14.27
9746*	air & bone with speech tests (bilateral), total	31.99
9742*	professional portion	19.42
9749*	air & bone with speech tests and suprathreshold tests (bilateral), total	31.99
9744*	professional portion	20.96
9770*	Automated impedance tympanometer with or without ipsilateral or contralateral reflexes, total	11.42
9786*	professional portion	7.78
9752	Vestibular Evoked Myogenic Potential Test, professional fee for interpretation	54.65

Note: *1) Tariff 9752 is payable only for tests provided in a facility designated by Manitoba Health.*

2) Tariff 9752 may only be claimed by physicians designated as specialists in Otolaryngology by the College of Physicians and Surgeons of Manitoba.

9900	Rotational Chair Testing, per frequency	61.20

Note: *1) Maximum four (4) frequencies per patient per day.*

2) Limited to specialists in Otolaryngology and Neurology.

ADVANCED TESTING

Note: *1) A maximum of three (3) advanced tests are payable at the same sitting.*

2) When performed at the same sitting as tariffs 9770 and 9786, a maximum of two (2) advanced tests are payable in addition.

3) When performing contralateral reflexes as a single test, claim tariff 9770 or 9786.

4) The benefit amounts listed are for unilateral or bilateral testing.

5) These tariffs are payable only to physicians with appropriate training in advanced testing as determined by The College of Physicians and Surgeons.

9788*	Four (4) frequency acoustic reflex thresholds to test the integrity across brain stem pathways, total	16.22
9797*	professional portion	7.01
9709*	to assist in diagnosis of recruitment, total	15.45

		UNIT VALUE	
9712*	professional portion	7.11	
9714*	Two (2) frequency acoustic reflex decay estimations to assist in diagnosis of cochlear nerve lesions, total	15.30	
9723*	professional portion	9.73	
9755*	Torsional rotation test	29.78	
9756*	Cortical evoked or brain stem evoked audiometry (electrocochleography) professional fee only	54.11	
	Note: *The above service is an insured service only when provided in a facility designated by the Minister.*		
9747*	Hearing aid evaluation	27.71	
9748*	Caloric tests	27.59	
9750*	Electronystagmography	68.80	

EAR CANAL

5979*	Removal of Cerumen, by syringing, irrigation, curetting or debridement, unilateral or bilateral	15.30	
5980*	Ear, foreign body removal	15.30	
5981*	Ear, foreign body removal in hospital under local anesthetic–for general anesthesia see Rule of Application 57	72.22	20.000
5982*	Polyp removal in office	35.60	
5959*	Microscopic debridement of ears	32.51	20.000
	Note: *The above benefit may be claimed when indicated in cases of chronic otitis media with cholesteatosis and/or pathology in the middle ear or mastoid cavities, external otitis, keratosis obturans, cholesteatosis of the external canal, and postop or post-radiotherapy debridement. This benefit is not to be claimed when debridement of ears under microscopy is done for removal of cerumen or examination only.*		
5961*	Myringotomy	64.95	20.000

EXTERNAL EAR

5922	Exostoses, excision, single, pedunculated	228.91	21.375
5925	multiple, sessile	425.39	21.375

OTOPLASTY

Note: *Otoplasty in patients over the age of sixteen (16) years is generally not eligible for benefits unless the Minister is satisfied prior to the operation that such surgery is necessary for medical reasons.*

5940	Otoplasty: plastic operation on ear—unilateral	361.68	21.375
	Reconstruction of ear with graft of skin plus cartilage, bone or other implant— See Integumentary System and Bone Graft.		

MIDDLE EAR

5996	Intra-operative monitoring of cranial/facial nerves remote from the skull base, add	145.06	

Note: *5996 may only be claimed in addition to the following tariffs, 0616, 2666, 2927, 2934, 4972, 5957, 5971, 5973, 5974, 5975, 5976, 5977, 5992 and 5995.*

			UNIT VALUE
6011	Labyrinthotomy or labyrinthectomy	637.54	21.375
5977	Mastoid obliteration	419.93	21.375
5970*	Cautery and patching of ear drum	39.20	21.375
5971	Mastoidectomy, cortical	824.38	21.375
5975	radical or modified radical	892.20	21.375
5976	Temporal Bone Resection for neoplasm, subtotal and lateral, to include mastoidectomy and excision of external auditory canal but not including muscle flap reconstruction.	2,199.89	22.750

Note: *Muscle flap reconstruction is payable in addition under tariff 0384.*

5972	Implantation of electromagnetic bone conductor hearing device	382.66	21.375
5993	Myringoplasty	366.95	21.375
5983	Polyp, middle ear, removal in hospital	78.19	21.375
6001	Post-aural fistula, closure	138.57	21.375
6031	Stapedectomy with prosthesis, fenestration of oval window	754.57	21.375
6033	Stapes mobilization	417.79	21.375
5992	Tympanoplasty with mastoidectomy	1,117.51	21.375
5991	without mastoidectomy	568.21	21.375
5962	Myringotomy, with insertion of tubes, unilateral or bilateral	138.01	20.000
5963	removal of tubes under general anesthetic	139.65	20.000
5956	Tympanotomy, exploratory for deafness or other reason	250.00	20.000
5973	Cochlear implant insertion, unilateral, with or without mastoidectomy, posterior tympanotomy, includes free tissue harvest for cochleostomy obliteration and musculoperiosteal temporalis muscle rotation flap	1,492.28	22.750
5974	Revision cochlear implant, for removal of old implant and insertion of new implant with or without mastoidectomy, posterior tympanotomy, includes free tissue harvest for chochleostomy obliteration and musculoperiosteal temporalis muscle rotation flap	1,856.40	22.750
5997	Major congenital ear anomalies operations unilateral (up to a maximum of $667.00)	***By Report***	21.375
5998	less than major procedures, unilateral	***By Report***	21.375
5995	Endolymphatic shunt, unilateral	760.44	22.750
5957	Posterior tympanotomy with full ear reconstruction, unilateral	738.19	21.375
5960	Closure of perilymph fistula	411.05	21.375
5958	Iontophoresis of middle ear, per treatment	69.80	

UNIT VALUE

AUDIO–VESTIBULAR SYSTEM

5969	**Unlisted or Unusually Complicated**	***By Report***	22.750

DIAGNOSTIC RADIOLOGICAL PROCEDURES

Column Tec.

The benefit for radiographic examinations, including the production of radiographs, supply of contrast media, equipment maintenance, capital cost of replacement equipment, fixed and variable overhead costs of the premises, technical services administration, production of one or more copies of the report by a certified radiologist and fee collection costs.

Column Pro.

The benefit for supervision of imaging services, advising the referring physician as to the most appropriate imaging modality, maintenance of quality control, imaging interpretation and fluoroscopic assessment.

CONSULTATIONS

8550	Radiology Consultation		86.05

Note: *A radiology consultation may be claimed following a written request from a physician for a radiologist's opinion regarding the advisability of performing a radiological procedure. It shall consist of such examination of the patient as necessary and appropriate and a discussion of the risks and limitations of the proposed procedure. A written or dictated report shall be provided to the referring physician.*

This tariff may be claimed regardless of whether the radiologist renders additional services and/or procedures to the patient during or following the initial visit.

		COLUMN TEC	COLUMN PRO
7600	Review of Submitted Imaging Study		71.05

Note: *1) This tariff may be claimed following a written request from a physician for a review and interpretation of a submitted imaging study performed elsewhere.*

2) This tariff may be claimed for each imaging study reviewed.

3) A written or dictated report shall be provided to the referring physician.

HEAD AND NECK

7004	Eye—orbits	24.61	12.16
7009	Facial bones	30.58	14.50
7022	Larynx or nasopharynx or neck for soft tissue	20.48	9.30
7006	Mandible	29.43	12.88
7008	Mastoids routine	37.43	17.93
7010	Nasal bones	23.46	9.85
7001	Panorex	13.19	12.93
7012	Paranasal sinuses	34.63	16.29
7020	Salivary gland	23.33	12.46

		COLUMN TEC	COLUMN PRO
7014	Skull	34.25	15.30
7015	Zygomatic Arch Views	26.43	12.97
7007	Temporomandibular joints	33.78	13.87
7400	Added views of any of the above (not films) additional	7.83	4.15

CHEST

7024	Chest, single P.A.	23.86	13.57
7025	P.A. and lateral	28.24	12.99
7027	Chest fluoroscopy	18.76	13.79
7032	fluoroscopy and radiography	37.19	22.30
7033	Pacemaker (fluoro and films)	17.45	10.44
7026	Portable chest	23.61	13.59
7331	Ribs, both sides	26.52	11.30
7031	one (1) side	26.16	11.41
7332	Thoracic Inlet [two (2) views]	28.68	13.29
7401	Added views of any of the above (not films) additional	12.84	5.45

SPINE AND PELVIS

7039	Pelvis, A.P. view	24.17	11.01
7339	with lateral hip joint	37.75	15.08
7041	Sacroiliac joints	30.37	15.08
7341	Skeletal survey [thorax, skull, thoracic and lumbar spine, pelvis, two (2) long bones]	89.25	39.78
7035	Spine, complete	97.86	40.36
7037	two (2) full areas	75.78	29.66
7277	Skeletal survey—suspect child abuse	65.75	33.03
7036	Cervical spine, routine views	40.00	15.88
7038	with special added views (obliques, and/or flexion and extension)	69.13	29.31
7193	Lumbo-sacral, routine views	52.31	21.42
7054	with special added views (obliques, and/or flexion and extension)	46.39	18.42
7194	Thoracic spine	37.62	15.21
7061	Single combining region (thoraco-lumbar)	37.05	14.64

		COLUMN TEC	COLUMN PRO
7034	Sacrum and/or coccyx	31.12	13.99
7057	Scoliosis series	69.06	30.94
7402	Special views [minimum two (2) views] e.g., obliques done as a special request (at a separate visit)	29.54	7.23

Note: *1) When examination includes routine views of two (2) areas e.g., lumbo-sacral and cervical, this should be claimed as—two (2) full areas—See tariff 7037*

2) When examination includes routine views of three (3) or more areas, this should be claimed as—spine, complete—See tariff 7035.

UPPER EXTREMITY

7065	Bone age studies	33.36	14.25
7046	Clavicle	24.79	11.14
7048	Elbow	24.60	9.40
7052	Fingers	17.62	8.55
7049	Forearm	23.67	9.63
7051	Hand	22.43	9.79
7047	Humerus	22.64	9.67
7093	Joints—acromio-clavicular with weights	29.22	13.04
7045	sterno clavicular	31.45	11.24
7046	Scapula	24.79	11.14
7044	Shoulder, A.P. and lateral routine	27.17	12.27
7069	Sternum	24.51	10.87
7050	Wrist	22.30	9.42
7403	Added views of any of the above (not films) additional	16.98	7.50

LOWER EXTREMITY

7059	Ankle	23.51	10.28
7066	Bone length study with precise measurement	42.22	18.11
7366	Calcaneus	21.56	9.39
7055	Femur	24.60	9.48
7060	Foot	20.41	8.94
7053	Hip	33.14	13.03
7056	Knee or patella	26.48	11.43
7058	Tibia and fibula	24.60	9.39
7062	Toes	17.51	8.31
7404	Added views of any of the above (not films) additional	8.47	4.25

		COLUMN TEC	COLUMN PRO
ABDOMEN			
7067	Abdomen, single view	21.24	9.78
7068	two (2) views	32.20	15.67
7072	Management of long intestinal tube manipulation fluoroscopy	26.19	62.16
GASTROINTESTINAL TRACT			
7073	Esophagus, fluoroscopy and radiography	46.41	24.46
7116	Swallowing function, pharynx and/or esophagus with fluoroscopy and/or video.	29.55	29.74
7117	Video palate study fluoroscopy and/or video	29.55	37.64
7074	Stomach and duodenum, fluoroscopy and radiography (including esophagus)	76.86	42.13
7075	with small bowel series	102.45	54.54
7376	Esophagus, stomach, duodenum (including survey films, if taken) double contrast with or without glucagon or other relaxant	102.46	56.63
7377	with small bowel series	127.68	69.17
7076	Small bowel series—radiography and fluoroscopy	51.86	26.06
7077	Colon—Single contrast barium enema	69.69	34.09
7078	Colon—Double contrast barium enema	94.99	48.61
7079	Cholecystogram, oral	38.68	15.48
7081	retrograde/tube cholangiogram	49.62	23.02
7082	in operating room	28.20	19.70
URINARY TRACT			
7192	Ileal Conduit Loopogram	49.87	12.11
7083	K.U.B.	25.02	11.24
7084	Pyelogram, intravenous, routine including preliminary film	49.75	27.86
7385	Retrograde pyelogram	27.35	12.83
7387	Retrograde urethrography	21.30	17.03
7405	Added views of any of the above (not films) additional	7.82	4.15
7118	Nephrostogram	27.35	22.07
OBSTETRICAL STUDIES			
7089	Abdomen and pelvis for fetus	19.90	9.89

COMPUTERIZED AXIAL TOMOGRAPHY

		COLUMN PRO
BRAIN		
7112	Infused examination of the brain	73.14
7113	Non-infused examination of the brain	50.89
7114	Infused and non-infused examination of the brain	83.77
NON-BRAIN		
7221	Skull base (internal auditory canals, sella turcica) examination	100.76
7222	Facial bone (orbits) examination	100.76
7223	Neck examination	100.97
7224	Thorax examination	100.76
7225	Abdomen and/or pelvis examination	107.62
7226	Musculoskeletal examination	100.76
7227	Spine—cervical examination	100.76
7228	thoracic examination	100.76
7229	lumbar examination	100.76
7201	Cardiac CT/CT Coronary Angiography	103.52

Note: *1) Limited to specialists in Diagnostic Radiology and/or Cardiology with training in Cardiac CT.*

2) Payable only where the service is provided in one of the following designated facilities: Health Sciences Centre, St. Boniface General Hospital, Brandon General Hospital, Boundary Trails Health Centre, Selkirk General Hospital and Grace General Hospital.

3) Claims for tariff 7224 CT Thorax and/or tariff 7231 CT 3-D Workstation Review for service performed on the same patient, same day shall each be paid at 100% of the listed benefit.

4) Not for routine screening of asymptomatic patients.

7230	Biopsy and/or drainage	115.50
7231	3-D Workstation Review (applies to CT schedule and tariffs listed in Note 4)	84.79

Note: *1) Additional CT scans of **different** anatomic regions on any one (1) patient on the same day may be claimed at 100% of the fee schedule.*

*2) A second CT scan of the **same** anatomic region on any one (1) patient on the same day may be claimed at 50% of the fee schedule but only in exceptional circumstances, and by **Special Report**.*

3) Computerized Axial Tomography is an insured service only when provided in a facility designated by the Minister.

4) 3-D Workstation Review can be claimed in addition to tariffs 7135, 7138, 7141, 7145, 7147, 7181 and 7182.

SPECIAL PROCEDURES—ANGIOGRAPHY

SUPERVISION & INTERPRETATION

For Column C (The Procedural Portion) Of Angiograms—See Angiograms Section.

		COLUMN TEC	COLUMN PRO
AORTOGRAMS			
7120	Abdominal	76.30	45.49
7121	Arch	76.30	45.49
7123	Thoracic	76.30	44.42
7124	Translumbar	76.30	32.62
7125	Other—specify	76.30	43.16
7126	For two (2) examinations done on same patient, on same day	102.35	43.15
SELECTIVE ANGIOGRAMS			
7130	Adrenal arteriogram	76.30	41.93
7131	Angiographic examination dialysis shunt	76.30	33.08
7132	Axillary	76.30	32.29
7133	Brachial	76.30	32.31
7134	Bronchial	76.30	41.75
7135	Carotid	63.80	44.42
7136	Celiac	76.30	43.12
7137	Common iliac	76.30	32.64
7129	Popliteal, with antegrade catheterization	76.30	32.31
7138	External carotid arteriogram	76.30	34.72
7139	Hepatic	72.95	41.75
7140	Inferior mesenteric	76.30	32.64
7141	Innominate	73.50	43.27
7142	Internal iliac	76.30	32.64
7143	Renal	76.30	43.12
7144	Superior mesenteric	76.30	43.12
7145	Subclavian	76.30	43.30

		COLUMN TEC	COLUMN PRO
7146	Splenic	71.30	41.75
7147	Vertebral	72.95	42.08
7148	For two (2) examinations done on same patient, on same day	102.35	51.96
7149	For three (3) examinations done on same patient, on same day	152.75	94.81
7152	Bilateral selective angiogram or venogram	101.70	58.76
7127	Internal mammary	76.30	41.93
7128	Left gastric	76.30	41.93
7180	Gastroduodenal	76.30	36.62

SUPERVISION & INTERPRETATION

7181	Internal carotid	76.30	39.63
7182	Super selective angiogram (e.g. distal branch of any of the above selectives)	76.30	43.30

FEMORAL ARTERIOGRAMS

7150	Unilateral	50.95	24.35
7151	Bilateral	76.30	35.85

VENOGRAMS

7153	Azygogram	72.95	35.25
7154	Femoral	73.50	30.09
7155	Iliac	76.30	32.64
7156	Inferior vena cavogram	76.30	33.05
7158	Jugular	76.30	33.97
7159	Lower limb	76.30	44.14
7160	Subclavian	76.30	32.62
7161	Superior vena cavogram	72.80	35.29
7163	Upper limb	72.95	30.06
7164	For two (2) examinations done on same patient, on same day	97.70	58.76

SELECTIVE VENOGRAMS

7165	Adrenal	76.30	31.82
7166	Hepatic	76.30	36.83
7167	Jugular	76.30	31.82
7168	Renal	76.30	35.39

		COLUMN PRO
7152	Bilateral selective angiogram or venogram 101.70	58.76
7169	For two (2) examinations done on same patient, on same day 102.35	70.80

ANGIOGRAPHY, BY EXPOSURE OF MAJOR VEIN

ANGIOCARDIOGRAMS

7173	right 72.95	51.73
7174	Pulmonary angiogram 72.95	41.75
7175	Selective coronary angiogram 76.30	54.11
7176	with left or right heart catheterization 76.30	46.91
7177	Ventricular, left 76.30	62.07
7178	right 76.30	51.73

Note: *For all above Angiography procedures, introduction may be made by:*

- *Percutaneous needle or cut down on superficial peripheral vein.*
- *Percutaneous catheter or cut down on superficial peripheral vein.*
- *Exposure of major artery.*

"Selective" means instrument passed deliberately into branch, tributary or cardiac chamber.

INTERVENTIONAL NEURORADIOLOGY

SUPERVISION & INTERPRETATION

For Column C (the procedural portion) of Neuroradiology, see Angiograms Section

7183	Intracranial AVM embolization	57.18
7184	Intracranial AVM coiling	132.09
7185	Intracranial intra arterial thrombolysis	57.18
7186	Intracranial intravenous thrombolysis	57.18
7187	Intracranial tumor embolization	57.18
7188	Embolization of epistaxis	57.18
7189	Carotid cavernous fistula occlusion	57.18
7195	Carotid artery balloon test occlusion	57.18
7196	Carotid artery permanent balloon occlusion	57.18
7197	Angioplasty of intracranial vasospasm	66.76
7198	Percutaneous vertebroplasty	153.98
7199	Percutaneous imaging guided nerve root injection	50.27
7200	Percutaneous imaging guided facet joint injection	50.27

TRANSCATHETER PROCEDURES—INTERVENTIONAL RADIOLOGY

SUPERVISION & INTERPRETATION

For Column C (the procedural portion) see Transcatheter Procedures.

7257	Venous sampling through catheter, (eg. for parathyroid hormone, renin)	57.18
7258	Transcatheter therapy, embolization, any method	173.43
7259	Transcatheter therapy, infusion, any method, (eg. Thrombolysis other than coronary)	39.90
7260	Percutaneous placement of IVC filter	39.90
7261	Transcatheter retrieval, percutaneous, of intravascular foreign body (eg. fractured venous or arterial catheter)	39.90
7262	Transluminal angioplasty, any method, peripheral artery	67.71
7263	Transluminal angioplasty, venous (eg. subclavian stenosis)	67.71
7264	T.I.P.S (Transjugular intrahepatic portosystemic shunt)	39.90
7265	Mammary ductogram or galactogram, single duct	22.68
7266	Mammary ductogram or galactogram, multiple ducts	41.65
7267	Dialysis Graft Thrombectomy	39.90
7268	Image guided central line placement	66.52
7269	Vascular stent placement	177.65
7270	Non vascular stent placement	39.90
7271	Gastrointestinal stent placement	39.90
7272	Tracheobronchial stent placement	39.49
7273	Endovascular stent grafting (eg. aorta)	39.90
7274	Carotid angioplasty	57.18
7275	Carotid stent placement	173.43
7276	Uterine embolization	39.90

SPECIAL OTHER RADIOLOGICAL PROCEDURES

		COLUMN TEC	COLUMN PRO
	Note: *The following are all independent procedures (for Column C, See Special Procedures).*		
7063	Arthrography	36.60	31.25
7109	Biliary tract stones—non-operative extraction	89.80	38.52
7030	Bronchography, unilateral	28.90	26.82
7330	bilateral	50.95	38.45

CENTRAL NERVOUS SYSTEM

7043	Discography	51.10	37.74
7042	Myelography	37.74	40.07

MISCELLANEOUS

7382	Cholangiography, percutaneous	35.65	39.45
7086	Cystogram	22.30	11.96
7088	Voiding Cysto-urethrogram	41.80	19.97
7389	Vaginogram	46.30	11.97
7386	Dacrocystography	26.83	11.37
7392	Fetal transfusion, intrauterine	38.20	22.00
7394	Fistula, injection with fluoroscopy	19.85	16.41
7071	Fluoroscopy (isolated)	4.85	20.49
7371	Fluoroscopic control of clinical procedures done by another physician, per ¼ hour	11.70	24.61
7092	Hysterosalpingography	47.01	19.43
7101	Tomography	49.20	25.16
7301	with contrast procedure, add	12.40	41.17
7323	Lung biopsy (needle)	13.00	10.88
7099	Mammography, unilateral	56.09	31.33
7098	bilateral	94.51	55.08
	Note: *Tariffs 7098 and 7099 are payable for all diagnostic mammographies, bilateral or unilateral as determined by a physician's requisition, except for requisitions for Screening Mammography services performed in compliance with the requirements of tariff 7104.*		
7324	Operating room arteriogram	76.30	42.54
7325	Percutaneous antegrade pyelogram	28.20	23.28
7096	in home, extra	76.00	
7021	Sialography	33.26	15.71
7094	Sinogram	19.85	16.27

		COLUMN TEC	COLUMN PRO
7384	Renal puncture; percutaneous	25.60	17.36
7326	Vasogram	21.95	7.35
7327	Specimen radiograph	9.05	5.65
7100	Bone Mineral Densitometry with DEXA (Dual—Energy X-ray Absorptiometry), one or more sites		59.81
7380	Trabecular Bone Scoring, add to 7100		7.65
7108	Vertebral Fracture Assessment (VFA) (Review of low radiation dose imaging acquired with Bone Mineral Densitometry), add		13.03

Note: *1) Claimable for patients with a T-score equal to or less than -1.5 and any one of the following:*

i) age 70 years or older;

ii) age 50 years or older and historical height loss > 5cm;

iii) age 50 years or older and measured height loss > 2.5cm;

iv) age 50 years or older and chronic corticosteroid therapy (7.5 mg or more of prednisone daily for at least three (3) months in the previous twelve (12) months);

v) a routine lumbar spine scan which indicates a possible undiagnosed fracture.

2) To be eligible to claim 7108, a physician must have received specialized training in VFA.

7375	Nephrostomy catheter exchange	28.20	32.55
7374	Abscessogram	19.85	50.03
7378	Percutaneous cecostomy	19.85	14.44
7379	Percutaneous gastrostomy	19.85	14.62

SCREENING RADIOLOGICAL PROCEDURES

		COLUMN PRO
7104	Screening Mammography, bilateral	34.50

Note: *Tariff 7104 is payable:*

a) where the service is requested for an asymptomatic woman aged 50 years and over;

b) where the service is provided:

i) in one of the following designated facilities:

- *Misericordia Health Centre*
- *Brandon Regional Health Centre*
- *Thompson General Hospital*
- *Boundary Trails Health Centre, or*

ii) in the Program's mobile van: and

*c) only once within **any** twenty-four month period in respect of each qualifying patient, unless authorized by a representative of the Manitoba Breast Screening Program.*

Note: *"Asymptomatic" woman means a woman who has not had breast cancer, or signs/symptoms such as breast masses, clear or bloody nipple discharge or dimpling;*

An asymptomatic woman with a first degree relative with breast cancer is eligible for either a Screening Mammography or a diagnostic mammography (tariffs 7098 and 7099) as determined by a physician's requisition or by a representative of the Manitoba Breast Screening Program.

"First degree relative" means the woman's mother or sister(s).

INTERVENTIONAL RADIOLOGY

Column C: These procedural fees are intended to cover the procedural portion of the examination and are separate and distinct from the professional supervisory and interpretative fees of Column Pro.

Represents the additional benefit for the professional procedural portion of the examinations and is separate and distinct from the professional supervisory and interpretative benefits of Column Pro.

Note: *1) These procedural fees are intended to cover compensation for the professional service of placing an instrument and introducing contrast media (except in excretion studies of the biliary and renal tracts, and oral or rectal administration for study of the alimentary canal).*

2) The same fees may be charged for similar services associated with diagnostic physiological studies of non-radiological nature, for example—catheterization for physiological sampling or the transmission of pressure, sound or electrical waves or the therapeutic injection of drugs.

3) In Column C ONLY; when two (2) or more examinations are done on the same patient on the same day, 50% of the benefits of the others are paid, and if bilateral, 75% of the others are paid.

"Selective" means instrument passed deliberately into branch, tributary or cardiac chamber.

		COLUMN C	UNIT VALUE
6110	Arthrography	57.10	20.000
6109	Biliary tract stones—non-operative extraction	214.19	21.375
6107	Percutaneous transhepatic catheter drainage of obstructed bile ducts, including daily supervision and including percutaneous Cholangiogram and catheterization to duodenum, if achieved	334.53	21.375
6108	Replacement of catheter in above	93.11	21.375
6111	Bronchography, unilateral	45.47	22.750
6112	bilateral	81.78	22.750
6113	Pericardiocentesis	132.00	25.500
6196	Galactogram, cannulation of direct injection of contrast and subsequent mammographic imaging	63.80	
6197	Intra mammary needling for localization of occult breast lesion(s)	74.53	20.000
6191	Percutaneous diagnostic biopsies/aspirations	98.93	20.000
6198	Therapeutic procedure of large needle and tube insertion for drainage of abnormal fluid collections, including subsequent catheter care, and adjustment as required	239.23	20.000
6193	Stereotactic breast biopsies (CORE)	122.74	21.375
6199	Core needle biopsy	119.64	
6195	Image guided central line placement	132.40	21.375
6106	Biliary stent placement	99.79	21.375
6120	Cystogram	52.96	20.000
6121	Stress Cystogram	8.29	20.000
6122	Voiding Cystourethrogram	59.64	20.000

		COLUMN C	UNIT VALUE
6126	Vaginogram	8.73	20.000
6123	Dacrocystography	48.97	20.000
6127	Hysterosalpingography	74.03	20.000
6129	Fallopian Tubal Recanalization, unilateral	269.08	21.375
6130	Fallopian Tubal Recanalization, bilateral	403.61	21.375

Note: *1) Hysterosalpingography (tariffs 6127 and 7092) is not payable in addition to 6129 and 6130.*

2) 6129 and 6130 includes all imaging performed during the procedure.

6131	Laryngogram	21.45	22.750
6124	Lung biopsy (needle)	119.29	21.375
6132	Lymphangiography, unilateral bilateral—See Rules of Application.	62.81	20.000
6125	Percutaneous antegrade, pyelogram	135.50	21.375
6141	Sialography	59.97	20.000
6143	Renal puncture, percutaneous	129.95	21.375
6144	Splenoportography	113.73	20.000
6145	Tracheogram, etc.	22.08	22.750
6146	Retrograde urethrography	33.53	20.000
6147	Hydrostatic reduction of intussusception by barium enema	123.17	21.375
6100	Percutaneous cecostomy	228.23	21.375
6101	Retrograde cholangiogram	64.07	21.375
6102	Abscessogram	26.72	21.375
6103	Nephrostogram	43.88	
6104	Percutaneous Gastrostomy	181.47	21.375
6105	Jejunal Biopsy	83.24	
6119	Cecostomy/Gastrostomy Tube Catheter Exchange	97.06	

INTERVENTIONAL NEURORADIOLOGY

6114	Discography	124.16	20.000
6115	Myelography	126.07	20.000
6117	Ventriculography	107.02	21.375
6118	Cholangiography, percutaneous	185.13	21.375
6178	Intracranial AVM embolization	916.32	26.875
6179	Intracranial AVM coiling	2,249.49	26.875
6180	Intracranial intra arterial thrombolysis	725.68	26.875
6181	Intracranial intravenous thrombolysis	812.51	26.875

		COLUMN C	UNIT VALUE
6182	Intracranial tumor embolization	412.60	26.875
6183	Embolization of epistaxis	722.05	26.875
6184	Carotid cavernous fistula occlusion	1,340.94	26.875
6185	Carotid artery balloon test occlusion	138.77	26.875
6186	Carotid artery permanent balloon test occlusion	412.60	26.875
6187	Angioplasty of intracranial vasospasm	802.87	26.875
6188	Percutaneous vertebroplasty	675.19	25.500
6189	Percutaneous imaging guided nerve root injection	295.44	22.750
6190	Percutaneous imaging guided facet joint injection	103.05	22.750

PERCUTANEOUS TRANSRENAL OPERATIVE PROCEDURES FOR STONE REMOVAL

6148	Insertion of temporary antegrade stent by the radiologist in any of the percutaneous transrenal procedures performed by the urologist	125.89	22.750
6149	Dilatation of the skin to kidney tract by the radiologist	90.25	22.750

Note: *The fees for tariffs 6148 and 6149 are to be deducted from the urologist's fee.*

PERCUTANEOUS TRANSRENAL OPERATIVE PROCEDURES FOR DRAINAGE IN NON-STONE CASES

6150	Percutaneous nephrostomy under ultrasound or fluoroscopy for drainage of obstructive uropathy, with or without the insertion of any temporary stent	268.38	22.750
6151	Insertion of a permanent indwelling antegrade stent and/or antegrade dilatation of a stricture	125.79	22.750
6152	Nephrostomy catheter exchange	73.62	21.375
6173	Percutaneous Guided Thermal Ablation of liver, kidney, lung or bone using image guidance, one (1) lesion	550.64	22.750
6174	each additional lesion, add	413.02	22.750

Note: *1) 6173 and 6174 limited to specialists in Radiology.*

2) 6174 is claimable for a maximum of three (3) additional lesions per patient per day.

3) CT, MRI or ultrasound guidance, is not payable in addition when performed at the same sitting.

TRANSCATHETER PROCEDURES

		COLUMN C	UNIT VALUE
6153	Venous sampling through catheter, (e.g. for parathyroid hormone, renin)	67.29	21.375
6228	Transcatheter therapy, embolization, any method	453.27	22.750
6154	Transcatheter therapy, infusion, any method, (e.g. Thrombolysis other than coronary)	521.56	21.375
6155	Transcatheter retrieval, percutaneous, of intravascular foreign body (e.g. fractured venous or arterial catheter)	329.35	21.375
6128	Transluminal angioplasty, any method, peripheral artery	414.46	20.000
6156	Transluminal angioplasty, any method, each additional peripheral artery, add	207.23	21.375
6157	Transluminal angioplasty, any method, renal or other visceral artery	450.33	21.375
6158	Transluminal angioplasty, any method, each additional visceral artery, add	225.17	21.375
6159	Transluminal angioplasty, venous (e.g. Subclavian stenosis)	414.46	21.375
6160	T.I.P.S (Transjugular intrahepatic portosystemic shunt)	715.07	21.375
6161	Mammary ductogram or galactogram, single duct	51.10	20.000
6162	Mammary ductogram or galactogram, multiple ducts	71.76	20.000
6163	Dialysis graft Thrombolysis and/or Removal of Clot	567.03	21.375
	Note: *This tariff includes the following:* *1) Interrogation of central veins (venogram)* *2) Treatment of venous stenosis (angioplasty)* *3) Removal of clot within graft (whether thrombolytic therapy or mechanical device or combination of both)* *4) Removal of arterial plug* *5) Hemostasis* *6) Introduction of one, two or more sheaths to do procedure* *7) Completion angiogram of graft post procedure*		
6195	Image guided central line placement	132.40	21.375
6165	Vascular stent placement	98.24	25.500
6166	Gastrointestinal stent placement	239.58	21.375
6167	Tracheobronchial stent placement	239.77	25.500
6168	Endovascular stent grafting (e.g. Aorta)	1,014.70	26.875
6169	Carotid angioplasty	491.02	25.500
6170	Carotid stent placement	95.89	25.500
6171	Uterine embolization	362.20	21.375
6172	Uterine embolization—additional uterine artery at 50%	181.10	21.375

ANGIOGRAMS

Procedural Services

Note: *1) These procedural benefits are intended to cover compensation for the professional service of placing an instrument and introducing contrast media (except in excretion studies of the biliary and renal tracts, and oral or rectal administration for study of the alimentary canal).*

2) The same benefits may be charged for similar services associated with diagnostic physiological studies of non-radiological nature, for example, catheterization for physiological sampling or the transmission of pressure, sound or electrical waves or the therapeutic injection of drugs.

3) For Angiography procedures, introduction may be made by:

- *Percutaneous needle or cutdown on superficial peripheral vein.*
- *Percutaneous catheter or cutdown on peripheral vein.*
- *Exposure of major artery.*

*4) In Column C **only**; when two (2) or more examinations are done on the same patient on the same day, 50% of the benefits of the others are paid, and if bilateral, 75% of the others are paid.*

"Selective" means instrument passed deliberately into branch, tributary or cardiac chamber.

Column C: Represents the additional benefit for the professional procedural portion of the examinations and is separate and distinct from the professional supervisory and interpretative benefits of Column Pro.

ANGIOGRAPHY

AORTOGRAMS

		COLUMN C	UNIT VALUE
6200	Abdominal	154.97	20.000
6201	Arch	166.54	20.000
6202	Intravenous	74.03	20.000
6203	Thoracic	167.57	20.000
6204	Translumbar	92.67	20.000
6205	Other—specify	132.09	20.000
	For two (2) examinations done on same patient, same day—See Note 4		

SELECTIVE ANGIOGRAMS

		COLUMN C	UNIT VALUE
6210	Adrenal arteriogram	170.92	20.000
6211	Angiographic examination dialysis shunt	152.00	20.000
6212	Axillary	177.35	20.000
6213	Brachial	166.45	20.000
6208	Cerebral (brachial retrograde)	154.28	20.000
6214	Bronchial	124.81	20.000
6215	Carotid	178.79	20.000
6216	Celiac	150.58	20.000
6217	Common iliac	153.60	20.000
6229	Popliteal, with antegrade catheterization	112.81	20.000
6218	External carotid arteriogram	150.58	20.000
6219	Hepatic	150.58	20.000
6220	Inferior mesenteric	154.51	20.000
6221	Innominate	160.34	20.000
6222	Internal iliac	112.81	20.000
6223	Renal	154.51	20.000
6224	Superior mesenteric	129.19	20.000
6225	Subclavian	131.11	20.000
6226	Splenic	154.51	20.000
6227	Vertebral	166.09	20.000
6235	Bilateral selective angiogram or venogram	302.77	20.000
6206	Internal mammary	119.96	20.000
6207	Left gastric	150.58	20.000
6209	Gastroduodenal	150.58	20.000
6231	Internal carotid	155.63	20.000
6232	Super Selective Angiogram (e.g. Distal branch of any of the above selective)	132.51	20.000

For two (2) examinations done on the same patient, same day—See Note 4

FEMORAL ARTERIOGRAMS

6230	Unilateral	173.01	20.000
	Bilateral—See Note 4		

VENOGRAMS

		COLUMN C	UNIT VALUE
6236	Azygogram	108.65	20.000
6237	Femoral	117.77	20.000
6238	Iliac	71.64	20.000
6239	Inferior vena cavogram	107.73	20.000
6240	Intraosseous	77.74	20.000
6241	Jugular	82.32	20.000
6242	Lower limb	120.43	20.000
6243	Subclavian	120.43	20.000
6244	Superior vena cavogram	132.94	20.000
6245	Umbilical vein catheterization	101.67	20.000
6246	Upper limb	137.69	20.000
6247	Orbital venogram	77.05	20.000
	For two (2) examinations done on same patient, same day—See Note 4		

SELECTIVE VENOGRAMS

6250	Adrenal	169.44	20.000
6251	Hepatic	160.91	20.000
6252	Jugular	160.91	20.000
6253	Renal	160.91	20.000
6235	Bilateral selective angiogram or venogram	302.77	20.000
	For two (2) examinations done on same patient, same day—See Note 4		

ANGIOGRAPHY

6255	By exposure of major vein, abdominal or thoracic	161.80	20.000
6256	cerebral	184.58	20.000

ANGIOCARDIOGRAMS

6260	Atrial, left	338.30	21.375
6261	right	280.83	21.375
6262	Pulmonary angiogram	182.66	21.375
6263	Selective coronary angiogram	326.46	21.375
6264	with left and/or right heart catheterization	403.99	21.375
6265	Ventricular, left	338.30	21.375
6266	right	280.83	21.375

		COLUMN C	UNIT VALUE
6267	Percutaneous transluminal balloon coronary angioplasty including angiography with or without pressure measurements on one (1) or more sites on a single coronary artery	793.15	21.375
6268	On two (2) coronary arteries (i.e., right and circumflex, or right and anterior descending, or circumflex and anterior descending)	1,055.45	21.375
6270	On three (3) coronary arteries, right, circumflex, and anterior descending	1,317.74	21.375

Note: *1) Tariffs 6267, 6268 and 6270 include associated angiograms at the time of the procedure and pressure measurement, aortography, pacemaker adjustments including connecting to a guide wire, cardioversion, and continuing care during that hospital admission.*

2) Only one (1) of the three tariffs (6267, 6268 or 6270) can be claimed for one (1) sitting.

3) If a patient does not have a pacemaker and one has to be inserted at the time, such will be paid for at 50% notwithstanding the fact that the benefit is asterisked.

4) Notwithstanding Note 1, tariffs 2307, 2308, 2325 or 2327 may be claimed in addition at 50% when done at the same sitting provided the patient has not undergone the same service within the preceding fourteen (14) days.

6269	**Unlisted or Unusually Complicated**	***By Report***

MAGNETIC RESONANCE IMAGING SERVICES

HEAD

		COLUMN PRO
7501	Multislice T2 (1 or 2 echoes)	75.91
7502	Multislice I.R. or T1	75.91
7503	Repeat (another plane, different pulse sequence to a maximum of 2 repeats)	38.01

NECK

7504	Multislice T2 (1 or 2 echoes)	79.04
7505	Multislice I.R. or T1	79.04
7506	Repeat (another plane, different pulse sequence to a maximum of 3 repeats)	39.55

THORAX

7507	Multislice T2 (1 or 2 echoes)	84.79
7508	Multislice I.R. or T1	79.04
7509	Repeat (another plane, different pulse sequence to a maximum of 3 repeats)	42.38

ABDOMEN

7510	Multislice T2 (1 or 2 echoes)	84.79
7511	Multislice I.R. or T1	81.10
7512	Repeat (another plane, different pulse sequence to a maximum of 3 repeats)	42.38

PELVIS

7513	Multislice T2 (1 or 2 echoes)	84.79
7514	Multislice I.R. or T1	79.04
7515	Repeat (another plane, different pulse sequence to a maximum of 3 repeats)	42.38

EXTREMITIES

7516	Multislice T2 (1 or 2 echoes)	73.14
7517	Multislice I.R. or T1	67.66
7518	Repeat (another plane, different pulse sequence to a maximum of 2 repeats)	37.14

LIMITED SPINE (ONE SEGMENT)

		COLUMN PRO
7519	Multislice T2 (1 or 2 echoes)	67.86
7520	Multislice I.R. or T1	65.20
7521	Repeat (another plane, different pulse sequence to a maximum of 2 repeats)	33.92

INTERMEDIATE SPINE (2 ADJOINING SEGMENTS)

7522	Multislice T2 (1 or 2 echoes)	82.70
7523	Multislice I.R. or T1	73.76
7524	Repeat (another plane, different pulse sequence to a maximum of 2 repeats)	40.27

COMPLEX SPINE (2 OR MORE NON-ADJOINING SEGMENTS)

7525	Multislice T2 (1 or 2 echoes)	117.68
7526	Multislice I.R. or T1	109.53
7527	Repeat (another plane, different pulse sequence to a maximum of 2 repeats)	59.35
7528	3D Workstation review (applies to MRI schedule)	107.07

DIAGNOSTIC ULTRASOUND SERVICES

HEAD AND NECK

7300	Cranial Sonography	38.06
7302	Sonography, soft tissues (e.g. Thyroid, parathyroid, salivary glands, orbits) real time study	39.24

CHEST

7304	Sonography, chest (e.g., pleural, chest wall, or mediastinal mass) real time study	38.06
7305	Sonography, breast unilateral real time study	34.81
7306	Sonography, breast bilateral real time study	57.51
7307	Sonography, breast unilateral real time study where performed by sonologist	84.03
7308	Sonography, breast bilateral real time study where performed by sonologist	163.51

ABDOMEN AND RETROPERITONEUM

		COLUMN PRO
7309	Sonography, abdominal complete real time	49.28
7310	Sonography, abdominal limited (e.g. single organ, quadrant, follow up time) real time	34.47
7311	Sonography, renal (bilateral), or aorta or retroperitoneum real time	41.70
7312	Sonography of organ transplant real time & doppler studies	38.92
7313	Complete doppler exam of portal venous system	38.06
7314	Complete doppler exam of mesenteric veins	42.43

SPINAL CANAL

7315	Sonography, spinal canal and contents	65.45

SKIN AND SUBCUTANEOUS TISSUES

7316	Sonography, skin and subcutaneous tissues real time	38.06

OBSTETRICS AND FEMALE PELVIS

7317	Sonography, pregnancy uterus complete fetal and maternal evaluation	43.86
7318	Sonography, complete fetal/maternal evaluation multiple gestation	68.89
7319	Sonography, pregnancy uterus limited (fetal size, heart beat, placental localization, position or emergency in delivery room)	33.28
7320	Fetal biophysical profile scoring	32.82
7321	Echocardiography, fetal, cardiovascular system, real time with or without M-mode and/or doppler studies	99.76
7328	Echocardiography, fetal follow up or repeat study of above	32.52
7329	Sonography—pregnancy uterus first trimester	47.46
7334	Sonography—pregnancy uterus late first trimester/early second trimester	49.49
7335	Sonography—transvaginal	43.17
7336	Sonography—pelvic (non obstetric)—complete	44.14
7337	Hysterosonography	37.19
7338	Sonography—translabial	24.88

GENITALIA

7342	Sonography, scrotum/transperineal	39.24
7343	Sonography, transrectal	37.24
7344	Sonography, penis	37.19
7397	Sonography, inguinal hernia, when performed with scrotum exam, add	18.36
7398	Sonography, penile injection, add	39.78

EXTREMITIES

		COLUMN PRO
7345	Sonography, extremity, non-vascular-real time (hips, shoulders, knee, etc.), per limb	38.06

MISCELLANEOUS—DOPPLER STUDIES

7346	Where doppler is used as the primary diagnostic modality on any of the above procedures, add	34.47
7347	Where doppler is used not as the primary diagnostic modality but has a reasonable likelihood of providing ancillary diagnostic information, add	23.44

VASCULAR STUDIES

7348	Duplex scan or extra cranial arteries—complete bilateral	95.42
7349	Duplex scan of extra cranial arteries—limited/follow up study	37.19
7350	Duplex scan of extremity arteries—complete unilateral	38.06
7351	Duplex scan of extremity arteries—complete bilateral	60.55
7352	Duplex scan of extremity arteries—limited/follow up study	36.83
7353	Duplex scan of extremity veins—complete unilateral	39.24
7354	Duplex scan of extremity veins—complete bilateral	62.38
7355	Duplex scan of extremity veins—limited/follow up study	34.72
7356	Duplex scan of arterial inflow and/or venous outflow of abdominal, pelvic and/or retroperitoneal organs	54.64
7357	Duplex scan of aorta, IVC, iliac vasculature or bypass grafts	38.06
7358	Duplex scan of vascular access graft	48.02
7359	Video review of vascular studies, add	34.47
7360	Intravenous contrast enhancement, add	10.81
7361	Ultrasound guided compression repair of arterial pseudo-aneurysm or A-V fistula per ¼ hour	25.91
7399	Ultrasound 3-D Workstation Review	49.19

SONOLOGIST PERFORMED PROCEDURES

Tariffs 7363 or 7365 are payable in addition to tariffs 6191, 6197, 6198, or 6199.

		COLUMN C
7362	Portable ultrasound examination performed by sonologist [or the first full thirty (30) minute period and for each additional thirty (30) minute period or portion thereof]	51.75
7363	Sonologist performs part of examination for a minimum of ten (10) minutes or less where the sonologists input revises the technologists initial or provisional finding or changes the management of the patient's care	26.16
7365	Sonologist performs all of examination	46.06
7367	Hysterosonography	48.50
7368	Sonography, intraoperative real time study performed by radiologist [for the first full thirty (30) minute period and for each additional thirty (30) minute period or portion thereof]	52.28

Note: *RE: Sonologist performs all examination where due to particular circumstances a sonologist performs all of an examination, examples would include but are not limited to:*

i) Rural Manitoba no technician available

ii) After hours no technician available

iii) New or complex procedure no qualified technician

SPECIAL OTHER RADIOLOGICAL PROCEDURES

Where a sonologist provides interventional and/or invasive procedures he/she shall be eligible to claim tariffs from the Diagnostic Radiological Procedures Fee Schedule regardless of the imaging modality.

NUCLEAR MEDICINE—IN VIVO

Column Tec.
This includes fees for the technical and physical aspects of the services rendered. The cost of the material is additional.

Column Pro.
This is the fee for the professional services only, performed by a physician.

DIAGNOSTIC ISOTOPE PROCEDURES

BLOOD (FERROKINETICS)

		COLUMN TEC	COLUMN PRO
9919	Plasma clearance	89.57	35.24
9920	Iron turnover	79.30	32.46
9923	Red blood cell utilization	79.30	32.14
9941	with serial organ counts, add	62.85	16.38
9910	Plasma volume	53.31	23.31
9903	Red blood cell volume	54.86	22.84
9904	survival	95.65	44.06
9942	with serial organ counts, add	201.67	68.51
9901	Schilling test	46.70	20.09
9902	with intrinsic factor, add	22.90	16.66
9905	Red blood cell labelling		9.86
9907	White blood cell labelling		16.91

BONE AND JOINT

9943	Bone Scan, regional	196.89	106.18
9944	whole body	212.77	105.97
9945	Joint Scan, regional	106.50	43.79
9946	whole body	214.74	100.31
9947	Bone marrow scan	227.09	122.37

BRAIN (CENTRAL NERVOUS SYSTEM)

9930	Brain scan	88.03	57.54
9949	with flow study, add	17.56	18.24
9951	C.S.F. circulation	306.34	122.22
9952	Myelogram	133.54	103.39

CARDIOVASCULAR

		COLUMN TEC	COLUMN PRO
9912	Cardiac output	47.70	19.37
9913	Circulation time	120.26	47.39
9953	Myocardial scan	174.03	101.89
9954	Myocardial perfusion scan, immediate	235.29	103.59
9955	immediate and delayed	334.93	121.51
9957	Myocardial wall motion, rest (does not include computerization)	153.23	73.07
9958	combined rest and stress (does not include computerization)	179.93	81.73
9959	Administered and supervised pharmacological or physical stress on any of the above, add	43.27	91.11
9960	Additional measurements [maximum of three (3)]	31.19	14.18
9961	Cardiomyography (first pass non-gated)	162.85	71.31
9962	Venogram	107.38	65.86
9963	Arteriography	73.25	43.01
9964	Thrombosis localization	98.08	80.91

EYE

9933	Tumor localization	56.25	53.32
9965	Lacrimal duct study	195.31	70.24

GASTROINTESTINAL

9980	Gastrointestinal mucosa scan	171.87	82.62
9966	Biliary tract scan	149.87	65.70
9925	Liver scan	110.03	50.86
9936	Spleen scan	114.92	53.01
9967	Liver and spleen (when both requested)	119.26	67.10
9968	Dynamic liver study	84.95	33.25
9969	Salivary gland scan	88.00	41.16
9914	Gastrointestinal absorption/malabsorption (this includes tests, such as G.I. protein loss, evaluation of enterohepatic circulation or assessment of gastrointestinal absorption of other agents such as iron or copper)	142.63	56.11
9970	Stool blood loss	101.50	51.93
9971	Liver/lung scan	258.60	103.03

LUNG

9932	Perfusion scan	182.41	78.25
9972	Ventilation scan	130.84	75.61

KIDNEY

		COLUMN TEC	COLUMN PRO
9928	Renogram	74.30	32.14
9927	Renal scan	86.48	45.62
9974	Reflux cystogram	115.68	68.29
9975	Sequential scan: one (1) isotope	163.06	82.05
9976	two (2) isotopes	121.75	99.25

THYROID

9906	Uptake	76.49	40.47
9977	Scan	94.24	51.38
9937	Uptake with scan	126.68	62.69
9908	Scan after stimulation	63.20	21.69
9978	Uptake with washout	36.00	14.94

MISCELLANEOUS

9979	Adrenal scan	419.63	129.59
9935	Placental scan	22.60	42.91
9981	Soft tissue scan: total body (Gallium and/or any other radionuclide)	278.16	138.77
9982	regional (Gallium and/or any other radionuclide)	275.41	174.19
9983	Lymph nodes and lymphangiogram	112.05	77.12
9984	Skin flow	79.30	32.14
9931	Parathyroid imaging		78.00
9939	Abdominal shunt patency		72.35
9940	Gastrointestinal motility, including esophageal, gastric, and bowel studies		66.07
9950	Gastrointestinal bleeding		80.03
9986	Blood flow to an organ, or an add on to another procedure when not otherwise listed	99.90	50.55
9987	Assessment of fatty liver	80.10	95.47
9926	Administered and supervised pharmacological intervention as part of other imaging		11.01
	Note: *Tariff 9926 shall be claimed for non-cardiac studies only.*		
9988	CO^2 exhalation studies	60.25	25.06
9996	Extra views or films of any specific organ	18.99	11.26
	Note: *Tariff 9996 shall be claimed when additional images are necessary to clarify abnormal findings or inconclusive studies.*		

DATA MANIPULATION (INCLUDES REFORMATTING, GATING, AND COMPUTERIZATION)

Note: *Nuclear medicine—in Vitro—See Radioassay under Laboratory—General*

		COLUMN TEC	COLUMN PRO
9989	Curve analysis, without blood samples	40.23	57.85
9990	with blood samples	56.75	53.32
9991	Ejection fraction and cine formatting (usually done in conjunction with wall motion studies) one (1) analysis (plus appropriate wall motion charge)	43.68	39.16
9992	each additional [maximum of three (3)]	54.49	45.21
9993	Image enhancement	31.14	27.44
9994	Gating (already included in myocardial wall motion)	50.70	17.82
9995	Quantitation of static studies	106.31	63.01
9929	S.P.E.C.T.—Single Photon Emission Computerized Tomography	53.64	37.56
9924	S.P.E.C.T. with transmission attenuation correction	48.66	51.44

Note: *1) The specific organ imaged will also be claimed under its own tariff number.*

2) Only one of 9929 or 9924 may be claimed for S.P.E.C.T. Imaging.

3) Where separate scan acquisitions are performed on the same patient on the same day at different times or on different organs, a maximum of two claims for tariffs 9929 and/or 9924 will be paid.

9922	SPECT/CT Workstation Review		81.60

Note: *1) CT scan not to be claimed in addition.*

2) SPECT/CT Workstation Review is an insured service only when provided at Health Sciences Centre, St. Boniface General Hospital, Grace General Hospital, Victoria General Hospital, Seven Oaks General Hospital and Brandon General Hospital.

3) May only be claimed in addition to tariffs 9924, 9929 and 9993.

Positron Emission Tomography (PET)

9915	Positron Emission Tomography (PET) scan – Regional Scan		231.80
9916	Positron Emission Tomography – Whole Body Scan		334.82

Note: *Physicians who are compensated pursuant to the Nuclear Medicine Alternate Funding Agreement are not eligible to claim 9915 and 9916.*

Therapeutic Isotope Procedures

8550	Consultation (by Isotope Therapist only) See Rules of Application 7, 8, 10	120.48	
7213	Radionuclide treatment	113.80	116.50
7214	re-treatment	97.15	41.67
7212	Radiation Synovectomy		139.03

		UNIT VALUE	
Therapeutic Radiology Radium Therapy			
7208	Intracavity, single	196.77	
7209	course	363.66	
7210	Interstitial	281.81	
7211	in combination with x-ray therapy	241.44	
7207	Superficial, plaque or mold	54.35	
Radio-Therapy			
7202	Superficial, benign, single lesion, treatment per visit	7.01	20.000
7203	multiple lesions, treatments per visit	10.05	20.000
7216	Plantar wart per treatment, visit	10.05	20.000
7204	Superficial, malignant, single lesion, total treatment for any number of visits	66.19	20.000
7205	multiple lesions, total treatment for any number of visits	113.32	20.000
Deep Therapy			
7206	Deep x-ray or cobalt beam per treatment	57.18	

LABORATORY PROCEDURES—GENERAL—DELETED (JANUARY 1, 2017)

LABORATORY PROCEDURES (SHORT LIST)

Claims for the following procedures will be accepted only from physicians who have been approved under the Manitoba Quality Assurance Program (MANQAP) administered by The College of Physicians and Surgeons of Manitoba, and who limit performance of laboratory work for the diagnosis of his/her own patients to those laboratory procedures which have been approved. The above approval is not required by physicians who practice outside of Manitoba. The schedule benefit includes the collection of specimens, where necessary.

BACTERIOLOGY

9715 Microscopic examination, trichomonads 11.64

9717 pinworms (Scotch Tape Method) 4.27

9716 Microscopic examination of smears and wet preparations, fungi 11.11

9738 Microscopic examination of synovial fluid under polarized light for uric acid crystals 12.42

BIOCHEMISTRY

9142 Glucose, reflectance meter/photoelectric estimation.....3.62

Note: *Tariff 9142 should only be ordered when clinically indicated. This test may be ordered for diabetics or patients with increased risk factors for diabetes, and for pregnant women.*

FECES

9374 Blood occult 5.10

Note: *Tariff 9374 should only be ordered when clinically indicated.*

HEMATOLOGY

For two (2) or more of the following hematology procedures done on automated equipment and on one sample of blood (W.B.C., R.B.C., HgB., Hematocrit and indices), the fee for each procedure shall be the same as the comparable manual test, to an accrued maximum of.....5.76

Note: *Claims are to be made under the tariff numbers of the individual tests ordered by the attending physician even though a profile was analyzed.*

9312 White cell count 4.34

Note: *Tariff 9312 should only be ordered when clinically indicated.*

9315 White cell differential count and cell morphology.....6.53

Note: *Tariff 9315 should only be ordered when clinically indicated. When the White Cell Count (tariff 9312) is outside the normal range of 4-11 x 10 to the power of 9 per litre, a laboratory may, without a further requisition from the ordering physician, perform a white cell morphology (tariff 9315).*

9147 Hematocrit.....3.78

Note: *Tariff 9147 should only be ordered when clinically indicated.*

9150 Hemoglobin (photoelectric) 4.12

9273 Sedimentation rate 3.50

Note: *Tariff 9273 is a non-specific indicator of disease processes, its measurement should only be ordered in limited clinical situations.*

9290 HCG (human chorionic gonadotrophins) (pregnancy test) qualitative-blood 9.04

SEROLOGY

9170 Heterophile antibodies, slide test (monotest) 9.63

9721 Throat Swab—Rapid Antigen Detection Test 12.90

URINE

9521 HCG (human chorionic gonadotrophins) (pregnancy test) qualitative-urine 9.04

9641 Urinalysis, complete, including microscopic examination of centrifuged specimen 5.82

Note: *Tariff 9641 should be reserved for those patients who have abnormalities detected by Urinalysis, stick, tape or tablet for sugar, protein, ketones, urobilinogen, bilirubin or blood, or any other qualitative assessment not listed elsewhere (tariff 9644) or who have clinical indications for complete urinalysis.*

9644 Urinalysis, stick, tape or tablet for sugar, protein, ketones urobilinogen, bilirubin or blood, or any other qualitative assessment not listed elsewhere 3.58

Note: *Tariff 9644 should only be ordered when clinically indicated.*

9711 Screening test for Bacteruria, spoon or agar slide technique 7.36

APPENDICES