8490 Initial Assessment of patient with hyperacute stroke symptoms and/or signs 318.35

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) 318.35

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.

MORBIDLY OBESE PATIENTS: BMI SUPPLEMENTS

One (1) BMI Supplement is payable to physicians in addition to the amount eligible for payment for the surgical procedures, or in the case of anesthesia, one (1) Anesthesia BMI Supplement is payable in addition to the amount eligible for anesthesia services.

0021 BMI Supplement (Group A), add.....65.00

0025 Anesthesia BMI Supplement (Group A), add 65.00

Tariffs 0021 and 0025 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, 4603, 4605, 4608, 4619, 4816 and 4832.

0022 BMI Supplement (Group B), add.....115.00

0026 Anesthesia BMI Supplement (Group B), add.....115.00

Tariffs 0022 and 0026 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, 3211, 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, 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, 4601, 4604, 4606, 4614, 4618, 4694, 4695, 4696, 4701, 4800, 4811, 4812, 4911, 4912 and 4994.

0023 BMI Supplement (Group C), add.....185.00

0027 Anesthesia BMI Supplement (Group C), add.....185.00

Tariffs 0023 and 0027 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.....330.00

0028 Anesthesia BMI Supplement (Group D), add 330.00

Tariffs 0024 and 0028 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, 3181, 3182, 3184, 3491, 3492, 3494, 3550, 3551, 3552, 3600, 3810, 3814, 3995, 4320 and 5883.

Note: *1) A BMI Supplement or an Anesthesia 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, and one Anesthesia BMI Supplement may be claimed per patient per day by the primary anesthesiologist.*

LAPAROSCOPIC SURGERY

3540 Laparoscopic surgery, add 17.5%

***Note**: 1.) Tariff 3540 is eligible to be claimed in addition to the following tariffs: 2601, 3068, 3112, 3114, 3115, 3117, 3133, 3135, 3140, 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, 3464, 3491, 3492, 3494, 3550.*

***Note:** 2.) Tariff 3572 or tariff 3574 may not be claimed in addition to 3540.*

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 $177.75

Medical Genetics $211.76

Paediatrics $180.50

Obstetrics $98.35

Anesthesia $153.58

General Practice $94.05

			UNIT VALUE
1032	Stabilization for recurrent sternoclavicular, acromioclavicular instability (independent procedure)	689.75	22.750
1033	Posterior glenohumeral stabilization (independent procedure)	689.75	22.750
1034	Anterior glenohumeral stabilization (independent procedure)	689.75	22.750
1035	Superior Labrum Anterior–Posterior (SLAP) repair (independent procedure)	583.65	22.750
1036	SLAP and anterior or posterior glenohumeral stabilization (independent procedure)	822.45	22.750
1037	Rotator cuff repair	524.90	22.750
1038	Rotator cuff repair, and/or SLAP repair, and/or anterior glenohumeral stabilization, and/or posterior glenohumeral stabilization	1,008.65	22.750
1039	Revision rotator cuff repair	1,034.70	22.750
1040	Shoulder stabilization with bone and/or tendon graft (allograft, autograft)	928.55	22.750
1041	Rotator cuff repair with muscle transfer any type (e.g. latissimus dorsi for massive cuff tear)	928.55	22.750
1042	Rotator cuff repair with tendon graft–allo/autograft or synthetic	1,034.70	22.750
1043	Circumferential glenohumeral stabilization (Glenoid labrum)	1,034.70	22.750
1044	Glenohumeral thermal stabilization	598.20	22.750
1045	Major release glenohumeral joint (for arthrofibrosis/adhesive capsulitis)	689.75	22.750

ELBOW (ARTHROSCOPIC)

1390	Arthroscopy, elbow with therapeutic intervention	345.50	22.750
1391	removal loose bodies, add	72.50	
1392	synovectomy, add	72.50	
1393	exostectomy coronoid, add	72.50	
1394	exostectomy coronoid fossa, add	72.50	
1395	exostectomy olecranon, add	72.50	
1396	exostectomy olecranon fossa, add	72.50	
1397	microfracture, add	72.50	
1398	excision or repair OCD lesion, add	72.50	

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	247.50	21.375
1821	TFCC tear debridement, add	72.50	
1822	chondral shaving of distal radius, add	72.50	
1823	chondral shaving of carpus, add	72.50	
1824	partial synovectomy, add	72.50	

1825	complete synovectomy for rheumatoid arthritis, must include midcarpal and distal radioulnar joint(s), add	72.50
1826	microfracture, add	72.50
1827	distal ulna resection, add	72.50
1828	TFCC and/or UT split repair, add	100.00
1829	ganglionectomy, add	72.50
1830	soft tissue capsular release, add	72.50
1831	radial styloidectomy, add	72.50

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

			UNIT VALUE
1840	Direct ligament repair of distal radio-ulnar joint (includes dorsal and palmar ligament)	511.45	21.375
1841	Reconstruction of distal radio-ulnar joint, includes tendon wrap or weave	525.00	21.375
1842	Open triangulo fibrocartilage complex repair	511.45	21.375
1843	Total wrist arthroplasty or total distal radio-ulnar arthroplasty including soft tissue interposition using synthetic prosthesis	678.95	22.750
1844	Acute wrist ligament direct repair (including scapholunate or lunotriquetral ligament and pinning)	511.45	21.375
1845	Acute wrist ligament reconstruction with capsulodesis (including scapholunate or lunotriquetral ligament)	511.45	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)	650.00	21.375
1847	Posterior interosseous neurectomy, add	156.75	

Scaphoid Deformity

1848	ORIF or percutaneous screw fixation of non-displaced/minimally displaced carpal fracture	585.00	21.375
1849	Open scaphoid or lunate debridement and internal fixation for scaphoid or lunate non-union with vascularized pedicled bone flap	850.00	22.750

HIP

1470	Diagnostic hip arthroscopy (independent procedure)	385.85	22.750
1471	Arthroscopy, hip with therapeutic intervention, includes labral debridement, chondroplasty of acetabulum and/or femoral head	670.00	22.750
1481	labrum repair major, (two (2) or more implants), add	350.00	
1482	femoral neck osteoplasty, add	300.00	
1483	acetabular osteoplasty major, add	200.00	
1469	microfracture, add	72.50	

1474	loose body removal, add	72.50
1475	labral repair minor, (one (1) implant), add	72.50
1478	trochanteric bursectomy, add	72.50
1479	release, iliopsoas tendon or iliotibial band, add	72.50
1484	repair of abductor, unilateral, add	370.95

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

			UNIT VALUE
1080	Arthroscopy knee joint	247.50	21.375
1081	meniscectomy or meniscal repair, add	72.50	
1083	chondral shaving of patella, add	72.50	
1084	chondral shaving of the trochlea, add	72.50	
1086	trimming of synovium, add	72.50	
1087	osteophyte trimming, add	72.50	
1088	microfracture, add	72.50	
1089	additional meniscectomy or meniscal repair (one), add	72.50	
1090	debride femoral condyle, add	72.50	
1091	debride tibial plateau, add	72.50	
1092	patellar retinacular release, add	72.50	
1094	removal of loose body, add	72.50	

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	300.00	21.375
1671	Second peritalar joint arthroscopy, performed in conjunction to ankle arthroscopy without redraping, add	125.00	

Add-ons:

1672	exostectomy tibia, add	72.50
1673	exostectomy talus, add	72.50
1674	exostectomy calcaneus, add	72.50
1675	chondroplasty tibia, add	72.50
1676	chondroplasty talus, add	72.50
1677	chondroplasty calcaneus, add	72.50

		UNIT VAULE
2023	and polypectomy, unilateral 389.70	21.375
2024	bilateral 578.30	21.375
2025	and polypectomy and ethmoidectomy, unilateral 594.15	21.375
2026	bilateral 938.25	21.375
2027	and polypectomy and ethmoidectomy and antrostomy, unilateral 671.10	21.375
2028	bilateral 1,034.95	21.375
2033	and ethmoidectomy and antrostomy, unilateral 601.70	21.375
2034	and ethmoidectomy and antrostomy, bilateral 951.40	21.375
2029	**Unlisted or Unusually Complicated** ..... ***By Report***	21.375

LARYNX

Cervical lymph node dissection—See Lymph Nodes

2071*	Laryngoscopy, direct, diagnostic 70.35	22.750
2074*	direct, with biopsy 138.45	22.750
2070*	direct for foreign body removal (in office) 198.25	22.750
2030*	Fiberoptic nasendoscopy nasopharyngoscopy flexible 50.35	20.000
2031*	Fiberoptic nasopharyngolaryngoscopy flexible 50.90	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 235.95	22.750
2079	Suspension laryngoscopy with removal of complicated lesion from larynx or trachea by CO^2 laser 304.90	25.500
6131	Laryngogram (procedural portion of Radiology) 19.90	22.750
2053	Arytenoidectomy, external approach 409.60	22.750
2051	Laryngectomy, partial, with preservation of voice 952.55	25.500
2052	total 1,079.70	22.750
2050	Vocal cord injection 204.15	

Note: *2031* (Fiberoptic nasopharyngolaryngoscopy flexible) may not be claimed in addition.*

2054	Thyroplasty with Silastic Implant 423.45	22.750
2041	Laryngo-fissure with removal of tumor or laryngocele 341.00	22.750
2081	Laryngoscopy, direct with complete removal of cord lesion 284.10	22.750
2077	with foreign body removal 203.60	22.750

			UNIT VALUE
2102	Tracheoesophageal puncture following laryngectomy (separate operation) including delayed insertion of voice prosthesis.	349.95	21.375
2103	Tracheoesophageal puncture at the time of laryngectomy, including delayed insertion of voice prosthesis.	162.40	21.375
2104*	Repeat insertion of voice prosthesis (independent procedure)	61.75	21.375
2134	Bronchoplasty, excise stenosis and anastomosis	929.00	26.875
2133	graft repair	973.00	26.875
2135	with lobectomy and anastomosis	1,444.45	26.875
2108	Endo-bronchial ultrasound (EBUS), with or without Doppler	200.00	22.750
2109	Biopsies of each nodal area done by EBUS, maximum of three (3) payable add,	54.25	
	Note: *A bronchoscopy done at the same time as EBUS will be payable at 75% of the listed fee.*		
2139	**Unlisted or Unusually Complicated**	***By Report***	26.875

LUNGS AND PLEURA

2180*	Lung, needle biopsy	108.00	20.000
2225*	Pleura, needle biopsy (including thoracentesis)	69.50	20.000
2220*	Thoracoscopy, with or without biopsy	216.50	22.750
2183*	Thoracentesis	69.65	20.000
2221*	Pneumothorax, diagnostic or therapeutic, initial	57.60	20.000
2222*	subsequent	13.75	20.000
2224*	Administration of chemotherapy, including aspiration thoracentesis and sample	70.80	20.000
2684*	Mediastinoscopy	305.55	22.750
2193	Lobectomy, total or subtotal	1,290.00	26.875
2189	Lobectomy following previous lung resection on the same side	1,337.16	26.875
2191	Pneumonectomy, total	1,499.15	26.875
2184	with diagnostic wedge resection, add to tariffs 2191 and 2193	45.85	
2185	with sleeve resection of pulmonary artery, add to tariff 2193	142.20	
2194	Wedge resection	997.00	26.875
2186	re-operaton more than 180 days subsequent to previous excision, to appropriate excision fee, add to tariffs 2193, 2194 and 3709	150.00	
2187	Wedge resection following previous lung resection on the same side	1,033.45	26.875
2140	Minimally Invasive surgery, e.g., VATS (video assisted thoracic surgery) or thoracoscopic surgery, add	17.5%	
	Note: *1) Tariff 2140 is eligible to be claimed in addition to the following tariffs: 2172, 2186, 2187 and 2194.*		
2177	Pulmonary decortication	870.35	26.875
2171	Pleurectomy	694.55	26.875

PERITONECTOMY AND INSTALLATION OF HEATED INTRAPERITONEAL CHEMOTHERAPY (HIPEC)

			UNIT VALUE
3600	Peritonectomy and installation of heated intraperitoneal chemotherapy (HIPEC)	3,725.00	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	101.50	21.375
3002*	Botox injection, add	51.45	21.375
3004*	Hemostasis G. I. Tract by any endoscopic method or technique (e.g., cautery, injection, banding), add	117.10	21.375
3006*	Hemodynamic instability, add	54.10	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	82.30	20.000
3010	Insertion of small bowel or colonic stent (s) (includes dilatation if necessary), add	181.55	21.375

Note: *Tariff 3000 may not be claimed in addition to tariff 3010.*

3012	Multiple, ten (10) or more, endoscopic biopsies, add	50.00	

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.

SCROTUM

			UNIT VALUE
4211*	Scrotum, drainage of abscess	39.25	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	40.90	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	198.70	20.000
4251	Vasovasostomy (anastomosis) unilateral	272.85	20.000
4252	bilateral	723.95	20.000
4259	**Unlisted or Unusually Complicated**	***By Report***	20.000

SPERMATIC CORD

4271	Hydrocele of spermatic cord, excision, unilateral (independent procedure)	258.70	20.000
4275	Varicocele, excision, unilateral (independent procedure)	276.30	20.000
4278	with hernia repair and/or hydrocele and/or varicocele excision	289.70	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)	107.00	20.000
4314*	Core needle biopsy, transrectal, systematic, image-guided (between 6 and 11 cores)	200.00	20.000
4315*	Core needle biopsy, transrectal, systematic, image-guided (12 or more cores)	295.00	20.000
4301	Abscess, prostatic, external drainage, prostatotomy	166.90	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	1,250.00	22.750

RENAL TRANSPLANTS

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

			UNIT VALUE
5883	Renal transplant	1,948.35	25.500
5884	Cadaver nephrectomy—single for local implant or export	1,006.95	22.750
5885	Cadaver nephrectomy—double for local implants or export	1,006.95	22.750
5900	Donor nephrectomy after cardiac death	2,500.00	

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	1,294.45	22.750
5881	Laparoscopic live donor nephrectomy	1,566.05	22.750
5887	Rejection transplant nephrectomy	1,000.50	22.750
5888	Pre-transplant nephrectomy (recipient)—unilateral	490.00	22.750
5889	bilateral	859.00	22.750
5882	Marsupialization of post transplant lymphocele	536.85	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	605.30
5872	Day 2	302.65
5873	Day 3	302.65
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.	446.15
5894	Subsequent postoperative routine care at daily care rates, per day	78.85
5895	Management of rejection crises, care ordinarily equivalent to that of the first three (3) postoperative days, per day	138.05
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	190.70