CONTACT INFORMATION

PRACTITIONER REGISTRY/USER SITE MAINTENANCE

204-788-2567 or 204-786-7225

Email: practitionerregistry@gov.mb.ca

Practitioner Registry staff at Manitoba Health, Healthy Living and Seniors (“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
• 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 SecurID token (FOB) for access to EPiCS and iREG
• Notification of address change
• Registration of laboratory and x-ray facilities

CLAIMS UNIT—CLAIMS ENQUIRY

204-786-7355

Claims Unit staff provides assistance and information to providers 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

For additional information, please see our Claims Processing System webpage at http://www.gov.mb.ca/health/claims/index.html
**REGISTRATION/CLIENT SERVICES**

**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 your practice.
  - Physicians who would like to have more information about eChart should contact Manitoba e-Health at [www.echartmanitoba.ca](http://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.

Additional information regarding PHIN can be found on the Claims processing System webpage at [http://www.gov.mb.ca/health/claims/index.html](http://www.gov.mb.ca/health/claims/index.html)

**HELP DESK (INFORMATION SYSTEMS BRANCH)**

**204-786-7200**

Help 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 Master Agreement between the Minister of Health “the Minister” 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.

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.

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 Manitoba Health Help Desk at 204-786-7200.

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:

Manager, Claims Unit
Fee-for Service/Insured Benefits
Manitoba Health
3rd Floor, 300 Carlton Street
Winnipeg, MB R3B 3M9

RECIPIROCAL 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).

You should submit your 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 you provide insured services to a Quebec resident, your 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](http://www.ramq.gouv.qc.ca/en/courrier/index.shtml)). You will also be paid the applicable Quebec rates for the services rendered. You 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. The public 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
A Remittance Advice statement is the electronic information that Manitoba Health provides each pay period (at mid-month and month end) to assist you with reconciling your claims in your practice management systems.

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 you or your 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 Manitoba Health Help Desk at 204-786-7200.

The Remittance Advice statement has two (2) parts, a listing of “processed claims” and a listing of “pending claims.” The decision regarding the information you wish to extract from the remittance file is made by you and your 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 you would like to see on your reports, please contact your 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
Claims Submission and Payment Procedures

- 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 claims listed as pending. Pending claims will be listed as a “processed claim” on a future Remittance Advice once they have been adjudicated.

**Questions regarding your 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.

   “rural Manitoba” means that part of Manitoba south of the 53rd parallel of latitude except the city of Winnipeg and the city of Brandon.

**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>
<thead>
<tr>
<th>Column I</th>
<th>Column II</th>
</tr>
</thead>
<tbody>
<tr>
<td>25%</td>
<td>Northern Manitoba</td>
</tr>
<tr>
<td>5%</td>
<td>Rural Manitoba</td>
</tr>
<tr>
<td>5%</td>
<td>City of Brandon</td>
</tr>
<tr>
<td>0%</td>
<td>City of Winnipeg</td>
</tr>
<tr>
<td>0%</td>
<td>Outside Manitoba</td>
</tr>
</tbody>
</table>

**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 July 1 to December 31 in each year, the prime lending rate of the Bank of Canada as that rate stood on July 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.

In the event that a claim assessment cannot be satisfactorily resolved, we suggest the physician submit a written request for a decision to the Director, Fee-for-Service/Insured Benefits, Manitoba Health.

Referral to the Arbitration Board

Where a dispute arises between a physician and the Minister 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) may refer the dispute to an Arbitration Board ("Board") for a decision by providing written notice to Manitoba Health.

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

Such Board shall be composed of five (5) members: The Chairperson, two nominees appointed by the physician or Doctors Manitoba and two nominees appointed by the Minister. At least one of the two nominees for each of the Minister and Doctors Manitoba shall be a physician. The Chairperson shall be selected on a rotating basis from a list of lawyers agreed to by the Minister and Doctors Manitoba. The list of agreed upon Chairpersons may, from time to time, be modified by the agreement of the parties.

Within thirty (30) calendar days after receipt of written notice of intention to refer the dispute to a Board, the parties shall notify the Chairperson and each party shall notify the other of its appointee to the Board.
If either party fails to name any or all of its appointees to the Board with thirty (30) calendar days of the notice of referral to Arbitration being provided to Manitoba Health, that 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).

Notwithstanding the above, the parties may by mutual agreement, choose to proceed using a single arbitrator determined in accordance with the procedure for determining the Chairperson of the Board.

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 the Minister or Doctors Manitoba, is eligible for appointment to the Board.

The 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 the Board 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 Board shall have full remedial authority and shall order such remedy as may be just, but the Board shall have no authority to amend this Regulation or the provisions of the Master Agreement respecting fee-for-service physicians between the Minister and Doctors Manitoba, or as amended from time to time.

The Board shall makes its award in regard to the specific matter(s) referred to it 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, a decision of the Board 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 the 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 Board 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**

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.
7—Consultation (Amended July 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 dentist/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.
Visits/Examinations—Internal Medicine (01)

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

Office, Home Visits

8540 Complete History and Physical Examination—new patient or new illness or complete examination of old patient ................................................................. 94.20

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ................................................................................................................. 65.00

8403 Regional History and Examination or Subsequent Visit .................................. 53.50

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 ....................... 200.10

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 .................. 166.75

8416 Midwifery Assessment & Report—See General Schedule

Special Call—See General Schedule

Hospital Care

8540 Complete History and Physical Examination—new patient or new illness ...................... 94.20

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ................................................................................................................. 65.00

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 .......................................................... 200.10

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 ........................................... 166.75

8664  Extended Consultation—Unassigned Patient–Child minimum of forty-five (45) minutes of patient/physician contact time ................................................................................. 248.95

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 ........................................................................................................ 207.45

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.

8510  Regional History Examination ............................................................................................................. 67.10

8520  Hospital Care—per day .................................................................................................................. 38.85

8526  Clinical Teaching Unit (CTU) patient care supplement—per day .......................................................... 20.00

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 .................................................................................................................. 38.85

CHRONIC CARE—SEE GENERAL SCHEDULE
These benefits cannot be correctly interpreted without reference to the Rules of Application.

**OFFICE, HOME VISITS**

8540  Complete History and Physical Examination—new patient or new illness, or complete examination of old patient ................................................................. 90.65

8502  Complete or extensive re-examination for same illness  
By Report—See Rule 6 ................................................................. 65.55

8403  Regional History and Examination or Subsequent Visit ............................................. 52.85

8492  Comprehensive Cognitive Assessment ................................................................. 210.00

*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 ............................................. 105.00

- 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 ...................... 210.90

*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 ................................................................. 175.75

**SPECIAL CALL—SEE GENERAL SCHEDULE**

**HOSPITAL CARE**

8540  Complete History and Physical Examination—new patient or new illness ................................. 90.65

8502  Complete or extensive re-examination for same illness  
By Report—See Rule 6 ................................................................. 65.55
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................. 210.90

**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........................................................................................................................................... 175.75

8664 Extended Consultation—Unassigned Patient—Child minimum of forty-five (45) minutes of patient/physician contact time ................................................................................. 261.10

**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................................................................................................. 217.60

**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.......................... 300.00

**Note:**
1) Includes determination of the hyperacute stroke period and recommendation with regard to the administration of tPA.
2) Includes 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 or 8480.
5) Tariff 8510 may be claimed on the same day, same patient where the physician is required to return to provide additional assessments.

8510 Regional History and Examination.............................................................................................. 61.00

8520 Hospital Care—per day ............................................................................................................... 38.95
These benefits cannot be correctly interpreted without reference to the Rules of Application.

**OFFICE, HOME VISITS**

8540  Complete History and Physical Examination—new patient or new illness, or
      complete examination of old patient........................................................................................................... 102.25

8502  Complete or extensive re-examination for same illness
      By Report—See Rule 6 ........................................................................................................................................... 75.00

8403  Regional History and Examination or Subsequent Visit ................................................................. 65.00

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 .................................................................................................................................................. 243.00

**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 ..................................................................................................................................... 202.50

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 ................................................................................................................................................. 100.00

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 ................................................................................................. 35.45

**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.

**SPECIAL CALL—SEE GENERAL SCHEDULE**

**HOSPITAL CARE**

8540  Complete History and Physical Examination—new patient or new illness........................................... 102.25

8502  Complete or extensive re-examination for same illness .................................................................................. 75.00
      By Report—See Rule 6
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 .............................................................. 243.00

**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.

Consultation (including requests by Geriatric Program Assessment Team GPAT)—See Rules 7 to 10 .............................................................................................................. 202.50

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 ......................................................................................................................... 100.00

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 ...............................................................................

**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.

Regional History and Examination ........................................................................................................... 70.00

Hospital Care—per day .......................................................................................................................... 50.00

**Concomitant Care**

Concomitant Care—per day .................................................................................................................... 50.00

**Chronic Care—See General Schedule**
These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540  Complete History and Physical Examination—new patient or new illness, or complete examination of old patient.......................................................... 81.00

8502  Complete or extensive re-examination for same illness
By Report—See Rule 6 ............................................................................................................... 66.00

8403  Regional History and Examination or Subsequent Visit ........................................................................ 48.25

8626  Extended Consultation—See Rules 7 to 10—Child minimum of forty-five (45) minutes of patient/physician contact time ................................................................................. 210.00

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 ............................................................................................... 175.00

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540  Complete History and Physical Examination—new patient or new illness, or complete examination of old patient.......................................................... 81.00

8502  Complete or extensive re-examination for same illness
By Report—See Rule 6 ............................................................................................................... 66.00

8626  Extended Consultation—See Rules 7 to 10—Child minimum of forty-five (45) minutes of patient/physician contact time ................................................................................. 210.00

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 ............................................................................................... 175.00
8664  Extended Consultation—Unassigned Patient—Child minimum of forty-five (45) minutes of patient/physician contact time .................................................................................................................. 261.25

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.

8595  Consultation—Unassigned Patient.................................................................................................................. 217.70

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.

8510  Regional History and Examination ............................................................................................................. 56.00

8520  Hospital Care—per day ................................................................................................................................. 38.50

CONCOMITANT CARE

8524  Concomitant Care—per day .......................................................................................................................... 38.50

CHRONIC CARE—SEE GENERAL SCHEDULE
Cardiology (01-4)

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

Office, Home Visits

8540 Complete History and Physical Examination—new patient or new illness, or complete examination of old patient ................................................................. 83.50

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ........................................................................................................ 70.60

8403 Regional History and Examination or Subsequent Visit .......................................................... 54.00

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 ...................... 193.20

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 .............................. 161.00

Special Call—See General Schedule

Hospital Care

8540 Complete History and Physical Examination—new patient or new illness ......................... 83.50

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6 ........................................................................................................ 70.60

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 ...................... 193.20

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 .............................. 161.00
8664  Extended Consultation—Unassigned Patient—Child minimum of forty-five (45) minutes of patient/physician contact time ........................................................................................................ 236.60

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 ........................................................................................................... 197.15

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.

8510  Regional History and Examination ....................................................................................................... 65.25

8520  Hospital Care—per day .......................................................................................................................... 41.75

8526  Clinical Teaching Unit (CTU) patient care supplement—per day .......................................................... 20.00

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 ..................................................................................................................... 41.75

CHRONIC CARE—SEE GENERAL SCHEDULE
GASTROENTEROLOGY (01-5)

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

OFFICE, HOME VISITS

8540 Complete History and Physical Examination—new patient or new illness, or complete examination of old patient........................................................................................................... 78.50

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6............................................................................................................... 60.45

8403 Regional History and Examination or Subsequent Visit ..................................................... 53.00

8626 Extended Consultation—See Rules 7 to 10—Child minimum of forty-five (45) minutes of patient/physician contact time ................................................................. 196.50

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.

8550 Consultation—See Rules 7 to 10 .......................................................................................... 163.75

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540 Complete History and Physical Examination—new patient or new illness................................. 78.50

8502 Complete or extensive re-examination for same illness
By Report—See Rule 6............................................................................................................... 60.45

8626 Extended Consultation—See Rules 7 to 10—Child minimum of forty-five (45) minutes of patient/physician contact time .................................................................................... 196.50

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.

8550 Consultation—See Rules 7 to 10 .......................................................................................... 163.75
Extended Consultation—Unassigned Patient—Child minimum of forty-five (45) minutes of patient/physician contact time .................................................................................. 242.50

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.

Consultation—Unassigned Patient ............................................................................................. 202.10

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.

Regional History and Examination .............................................................................................. 60.45

Hospital Care—per day .................................................................................................................. 38.60

CONCOMITANT CARE

Concomitant Care—per day ......................................................................................................... 38.60

CHRONIC CARE—SEE GENERAL SCHEDULE
These benefits cannot be correctly interpreted without reference to the Rules of Application.

### OFFICE, HOME VISITS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>8540</td>
<td>Complete History and Physical Examination—new patient or new illness, or complete examination of old patient</td>
<td>105.00</td>
</tr>
<tr>
<td>8502</td>
<td>Complete or extensive re-examination for same illness By Report—See Rule 6</td>
<td>65.45</td>
</tr>
<tr>
<td>8403</td>
<td>Regional History and Examination or Subsequent Visit</td>
<td>69.70</td>
</tr>
<tr>
<td>8626</td>
<td>Extended Consultation—See Rules 7 to 10—Child minimum of forty-five (45) minutes of patient/physician contact time</td>
<td>210.30</td>
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**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.

### SPECIAL CALL—SEE GENERAL SCHEDULE

### HOSPITAL CARE

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**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.

### Consultation—See Rules 7 to 10

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<tbody>
<tr>
<td>8550</td>
<td>Consultation—See Rules 7 to 10</td>
<td>175.25</td>
</tr>
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</table>

Rules of Application.
8664  Extended Consultation—Unassigned Patient–Child minimum of forty-five (45) minutes of patient/physician contact time .................................................................................................................. 262.15

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............................................................................................................................. 218.45

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.

8510  Regional History and Examination ........................................................................................................................... 69.70
8520  Hospital Care—per day .................................................................................................................................................. 42.00

**CONCOMITANT CARE**

8524  Concomitant Care—per day........................................................................................................................................ 42.00

**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

8540 Complete History and Physical Examination—new patient or new illness, or complete examination of old patient.................................................................................................................. 94.20
8502 Complete or extensive re-examination for same illness
   By Report—See Rule 6 ........................................................................................................ 64.75
8403 Regional History and Examination or Subsequent Visit .......................................................... 53.25
8626 Extended Consultation—See Rules 7 to 10–Child minimum of forty-five (45) minutes of patient/physician contact time .................................................................................. 200.10
   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 .......................................................................................... 166.75

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540 Complete History and Physical Examination—new patient or new illness................................. 94.20
8502 Complete or extensive re-examination for same illness
   By Report—See Rule 6 ........................................................................................................ 64.75
8626 Extended Consultation—See Rules 7 to 10–Child minimum of forty-five (45) minutes of patient/physician contact time .................................................................................. 200.10
   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 .......................................................................................... 166.75
8510 Regional History and Examination .......................................................................................... 67.00
8520 Hospital Care—per day ........................................................................................................... 38.90
These benefits cannot be correctly interpreted without reference to the Rules of Application.

OFFICE, HOME VISITS

8540 Complete History and Physical Examination—new patient or new illness, or complete examination of old patient................................................................. 92.50

8502 Complete or extensive re-examination for same illness

By Report—See Rule 6 ........................................................................................................... 86.75

8403 Regional History and Examination or Subsequent Visit ................................................. 63.25

8408 Review and interpretation of genetic information for patients seen exclusively by a genetic counsellor.................................................................................................................. 38.40

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 ................................................................................. 237.50

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.

8550 Consultation—See Rules 7 to 10........................................................................................................... 197.90

8416 Midwifery Assessment & Report—See General Schedule

SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

8540 Complete History and Physical Examination—new patient or new illness................................. 92.50

8502 Complete or extensive re-examination for same illness

By Report—See Rule 6 ........................................................................................................... 86.75
8626  Extended Consultation—See Rules 7 to 10—Child minimum of forty-five (45) minutes of patient/physician contact time ........................................................................................................237.50

  **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.**

8550  Consultation—See Rules 7 to 10........................................................................................................197.90

8664  Extended Consultation—Unassigned Patient—Child minimum of forty-five (45) minutes of patient/physician contact time ........................................................................................................287.10

  **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........................................................................................................239.25

  **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.

8510  Regional History and Examination ........................................................................................................73.80

8520  Hospital Care—per day ..................................................................................................................................36.50

**Concomitant Care**

8524  Concomitant Care—per day ..................................................................................................................................36.50

**Chronic Care—See General Schedule**
These benefits cannot be correctly interpreted without reference to the Rules of Application.

**OFFICE, HOME VISITS**

8540 Complete History and Physical Examination ................................................................. 91.40

8498 Complete History and Physical Examination with Gynaecological Examination,  
**including** the taking of cytological smear for cancer screening—cervix  
See Rule 17(a) for full tariff description ........................................................................... 109.65

8499 Complete History and Physical Examination with Gynaecological Examination,  
**excluding** the taking of cytological smears for cancer screening  
See Rule 17(b) for full tariff description ............................................................................... 96.40

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 ..................... 200.70

**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  
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services or communication with others, either in writing or by  
television. 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 ..................... 167.25

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] ........................................................................................................... 60.00

**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.

8470 Regional Intermediate Visit—regional or subsequent visit with Gynaecological  
examination, **including** the taking of cytological smears for cancer screening—  
cervix—See Rule 17(c) for full tariff description ............................................................... 70.90

8471 Regional Intermediate Visit—regional or subsequent visit with Gynaecological  
examination, **excluding** the taking of cytological smears for cancer screening  
See Rule 17(d) for full tariff description ............................................................................... 57.50

8509 Regional Basic Visit—Regional or Subsequent Visit .................................................. 45.75

**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.
• 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]................................................................. 60.00

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. .................. 54.45

8597 Feeding Case Management per fifteen (15) minute period or major portion thereof............... 43.30

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

8540 Complete History and Physical Examination................................................................. 91.40

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 ..................... 200.70

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.

8550 Consultation (including by Dentist/oral Surgeon)—See Rules 7 to 10 ......................... 167.25

8498 Complete History and Physical Examination with Gynaecological Examination, including the taking of cytological smear for cancer screening—cervix
See Rule 17(a) for full tariff description................................................................. 109.65

8499 Complete History and Physical Examination with Gynaecological Examination, excluding the taking of cytological smears for cancer screening
See Rule 17(b) for full tariff description. ................................................................. 96.40
8470 Regional Intermediate Visit—regional or subsequent visit with Gynaecological examination, including the taking of cytological smears for cancer screening—cervix—See Rule 17(c) for full tariff description .......................................................... 70.90

8471 Regional Intermediate Visit—regional or subsequent visit with Gynaecological examination, excluding the taking of cytological smears for cancer screening See Rule 17(d) for full tariff description .......................................................... 57.50

8510 Regional History and Examination .................................................................................. 58.50

8520 Hospital Care—per day ........................................................................................................ 37.95

8526 Clinical Teaching Unit (CTU) patient care supplement—per day .................................... 20.00

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 ................................................................. 28.75

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 ............................................................................ 28.75

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 ........................................................................................................ 37.95

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

**PSYCHIATRY (03)**

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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
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<tbody>
<tr>
<td>8503</td>
<td>Complete History and Psychiatric Examination—adult</td>
<td>129.25</td>
</tr>
<tr>
<td>8504</td>
<td>Complete History and Psychiatric Examination—child</td>
<td>176.25</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Patient must be under eighteen (18) years of age.</td>
<td></td>
</tr>
<tr>
<td>8530</td>
<td>Subsequent Visit</td>
<td>42.25</td>
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</tbody>
</table>
8624 Extended Consultation—See Rules 7 to 10—Geriatric (age 70 and older) minimum of forty-five (45) minutes of patient/physician contact time .......................................................... 303.10

**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 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.

8625 Extended Consultation—See Rules 7 to 10—Adult minimum of forty-five (45) minutes of patient/physician contact time .................................................................................. 235.70

**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 .................................................................................... 196.40

8626 Extended Consultation—See Rules 7 to 10—Child minimum of forty-five (45) minutes of patient/physician contact time .................................................................................. 303.10

**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 .................................................................................... 252.60

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

8622 Consultation—geriatric patient—See Rules 7 to 10 ........................................................................... 252.60

**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.
Psychiatry Intake Registry Consultation to Primary Care Provider–Adult—See Rules 7 to 10............................................................. 260.00

Psychiatry Intake Registry Consultation to Primary Care Provider–Child—See Rules 7 to 10 (Patient under the age of 18) ............................................................. 320.00

Psychiatry Intake Registry Consultation to Primary Care Provider–Geriatric—See Rules 7 to 10 (Patient at least 70 years of age) ............................................................. 320.00

**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.

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 ............................................................. 384.00

**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.

Extended Psychiatry Intake Registry Originated Consultation to Primary Care Provider–Adult minimum of forty-five (45) minutes of patient/physician contact time .......... 312.00

**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 ..........384.00

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 .................................................................47.50

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 ...........................................................45.25

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 ................................................................. 48.45

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.

3) Interview must be on a one-to-one basis between the psychiatrist and the person being interviewed, and must take place in person. 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.

Psychiatrist to General Practitioner telephone consultation:

8007 Consulting psychiatrist, direct physician to physician telephone response within two (2) hours of referring General Practitioner’s request ................................................................. 60.00

8008 Consulting psychiatrist, direct physician to physician telephone response with forty-eight (48) hours of referring General Practitioner’s request ................................................................. 47.50

**Note:**

1) Payable to a psychiatrist for two-way telephone communication, initiated at the request of a General Practitioner 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 with 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 first contact with the psychiatrist and must be physician to physician. Not payable for written communication.

7) 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**

- **8503** Complete History and Psychiatric Examination—adult.........................................................129.25
- **8504** Complete History and Psychiatric Examination—child............................................................176.25
  
  **Note:** Patient must be under eighteen (18) years of age.

- **8624** Extended Consultation—See Rules 7 to 10—Geriatric (age 70 and older) minimum of forty-five (45) minutes of patient/physician contact time ..........................................................303.10
  
  **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 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.

- **8625** Extended Consultation—See Rules 7 to 10—Adult minimum of forty-five (45) minutes of patient/physician contact time ..................................................................................235.70
  
  **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..................................................................................196.40
8626  Extended Consultation—See Rules 7 to 10—Child minimum of forty-five (45) minutes of patient/physician contact time ................................................................. 303.10

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 ................................................................................. 252.60

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 ..................................................... 355.45

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.

8663  Extended Consultation—Unassigned Patient—Adult minimum of forty-five (45) minutes of patient/physician contact time ................................................................. 287.95

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 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 ................................................................................. 239.95

8664  Extended Consultation—Unassigned Patient—Child minimum of forty-five (45) minutes of patient/physician contact time ................................................................. 355.45

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.
Consultation—Unassigned Patient—child...................................................................................... 296.20

**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.

Consultation—Unassigned Patient—Geriatric—See Rules 7 to 10 ............................................. 296.20

**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.

Psychiatry Intake Registry Consultation to Primary Care Provider—Adult—See Rules 7 to 10 ........................................................................................................................................ 260.00

Psychiatry Intake Registry Consultation to Primary Care Provider—Child—See Rules 7 to 10 (Patient under the age of 18) ................................................................................ 320.00

Psychiatry Intake Registry Consultation to Primary Care Provider—Geriatric—See Rules 7 to 10 (Patient at least 70 years of age)....................................................... 320.00

**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.
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 ................................................................. 384.00

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.

Extended Psychiatry Intake Registry Originated Consultation to Primary Care Provider–Adult minimum of forty-five (45) minutes of patient/physician contact time .......... 312.00

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.

Extended Psychiatry Intake Registry Originated Consultation to Primary Care Provider–Child minimum of forty-five (45) minutes of patient/physician contact time ........... 384.00

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.

Hospital Care—per day ........................................................................................................................................... 35.00

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.

CONCOMITANT CARE

Concomitant Care—per day ............................................................................................................................. 31.25

PSYCHOTHERAPY (WITH OR WITHOUT INTRAVENOUS DRUGS)

Individual ................................................................................................................................................................. 47.50

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 ......................................................... 52.55
8446 Group of five (5) or more patients ......................................................... 58.50

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) ................................................................. 83.30

**Psychiatric Care**

Psychiatric care means the provision of individual psychotherapy services that may or may not be prearranged.

8584 Individual ........................................................................................................ 60.00

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.

Psychiatrist to General Practitioner telephone consultation:

8007 Consulting psychiatrist, direct physician to physician telephone response within two (2) hours of referring General Practitioner’s request ................................................................. 60.00
8008 Consulting psychiatrist, direct physician to physician telephone response with forty-eight (48) hours of referring General Practitioner’s request ................................................................. 47.50

Note:
1) Payable to a psychiatrist for two-way telephone communication, initiated at the request of a General Practitioner 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 first contact with the psychiatrist and must be physician to physician. Not payable for written communication.

7) 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.
These benefits cannot be correctly interpreted without reference to the Rules of Application.

**OFFICE, HOME VISITS**

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<thead>
<tr>
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<th>Description</th>
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<tbody>
<tr>
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<td>Complete History and Physical Examination</td>
<td>53.65</td>
</tr>
<tr>
<td>8403</td>
<td>Regional History and Examination or Subsequent Visit</td>
<td>30.00</td>
</tr>
<tr>
<td>8626</td>
<td>Extended Consultation—See Rules 7 to 10—Child minimum of forty-five (45) minutes of patient/physician contact time</td>
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**Note:**
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<td>Consultation—See Rules 7 to 10</td>
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**SPECIAL CALL—SEE GENERAL SCHEDULE**

**HOSPITAL CARE**

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8664  Extended Consultation—Unassigned Patient–Child minimum of forty-five (45) minutes of patient/physician contact time .......................................................... 199.50

Note:  1)  Patient must be under eighteen (18) years of age.
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8595  Consultation—Unassigned Patient ............................................................................................................. 166.25

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 ............................................................................................................ 30.10
8520  Hospital Care—per day ................................................................................................................................. 30.95

CONCOMITANT CARE

8524  Concomitant Care—per day .......................................................................................................................... 30.95

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 ................................................................. 52.60
8403 Regional History and Examination or Subsequent Visit .................................................. 30.00
8626 Extended Consultation—See Rules 7 to 10—Child minimum of forty-five (45) minutes of patient/physician contact time .................................................................................. 168.60

Note: 1) Patient must be under eighteen (18) years of age.
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8550 Consultation—See Rules 7 to 10 .................................................................................. 140.50

Special Call—See General Schedule

Hospital Care

8540 Complete History and Physical Examination ................................................................. 52.60
8626 Extended Consultation—See Rules 7 to 10—Child minimum of forty-five (45) minutes of patient/physician contact time .................................................................................. 168.60

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8550 Consultation—See Rules 7 to 10 .................................................................................. 140.50
Extended Consultation—Unassigned Patient—Child minimum of forty-five (45) minutes of patient/physician contact time ................................................................. 222.65

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Consultation—Unassigned Patient ........................................................................................................ 185.55

**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.

Regional History and Examination .................................................................................................... 29.50

Hospital Care—per day ......................................................................................................................... 30.00

**CONCOMITANT CARE**

Concomitant Care—per day .................................................................................................................. 30.00

**CHRONIC CARE—SEE GENERAL SCHEDULE**
These benefits cannot be correctly interpreted without reference to the [Rules of Application](#).

### Office, Home Visits

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<tr>
<td>8540</td>
<td>Complete History and Physical Examination</td>
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<tr>
<td>8530</td>
<td>Subsequent Visit</td>
<td>41.10</td>
</tr>
<tr>
<td>8626</td>
<td>Extended Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10— Child minimum of forty-five (45) minutes of patient/physician contact time</td>
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<tbody>
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<td>Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10</td>
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### Special Call—See General Schedule

### Hospital Care

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<td>Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10</td>
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<tr>
<td>8520</td>
<td>Hospital Care—per day</td>
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### Concomitant Care

<table>
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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>8524</td>
<td>Concomitant Care—per day</td>
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### Chronic Care—See General Schedule
These benefits cannot be correctly interpreted without reference to the Rules of Application.

**OFFICE, HOME VISITS**

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<tbody>
<tr>
<td>8540</td>
<td>Complete History and Physical Examination</td>
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<tr>
<td>8403</td>
<td>Regional History and Examination or Subsequent Visit</td>
<td>37.50</td>
</tr>
<tr>
<td>8626</td>
<td>Extended Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10—Child minimum of forty-five (45) minutes of patient/physician contact time</td>
<td>100.80</td>
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<tbody>
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<td>8550</td>
<td>Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10</td>
<td>84.00</td>
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**SPECIAL CALL—SEE GENERAL SCHEDULE**

**HOSPITAL CARE**

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<td>84.00</td>
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<tr>
<td>8510</td>
<td>Regional History and Examination</td>
<td>43.55</td>
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<tr>
<td>8520</td>
<td>Hospital Care—per day</td>
<td>28.75</td>
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**CONCOMITANT CARE**

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<th>Rate</th>
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<tbody>
<tr>
<td>8524</td>
<td>Concomitant Care—per day</td>
<td>28.75</td>
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ORTHOPAEDIC SURGERY (04-5)

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

OFFICE, HOME VISITS

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<tbody>
<tr>
<td>8540</td>
<td>Complete History and Physical Examination</td>
<td>45.65</td>
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<tr>
<td>8403</td>
<td>Regional History and Examination or Subsequent Visit</td>
<td>30.00</td>
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<td>8626</td>
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<td>8550</td>
<td>Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10</td>
<td>90.30</td>
</tr>
<tr>
<td>8440</td>
<td>Orthopaedic Spinal Consultation</td>
<td>220.20</td>
</tr>
</tbody>
</table>

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.
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 ............................. 108.35

Note: 1) Patient must be under eighteen (18) years of age.
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8550  Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10 ...................................... 90.30

8664  Extended Consultation—Unassigned Patient—Child minimum of forty-five (45) minutes of patient/physician contact time ................................................................. 152.95

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8595  Consultation—Unassigned Patient ................................................................. 127.45

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 ................................................................. 30.50

8520  Hospital Care—per day .................................................................................... 27.25

**CONCOMITANT CARE**

8524  Concomitant Care—per day ............................................................................ 27.25

**CHRONIC CARE—SEE GENERAL SCHEDULE**
These benefits cannot be correctly interpreted without reference to the Rules of Application.

**Office, Home Visits**

8540 Complete History and Physical Examination ................................................................. 61.20

8403 Regional History and Examination or Subsequent Visit .................................................... 30.60

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 ............................. 138.65

**Note:**

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8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10 ............................. 115.55

8440 Orthopaedic Spinal Consultation ..................................................................................... 220.20

**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.

**SPECIAL CALL—SEE GENERAL SCHEDULE**

**HOSPITAL CARE**

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<td>8510</td>
<td>Regional History and Examination</td>
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<td>8520</td>
<td>Hospital Care—per day</td>
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<tbody>
<tr>
<td>8524</td>
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**CHRONIC CARE—SEE GENERAL SCHEDULE**
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) ......................................................... 78.95

8505 Regional History and Examination of the Eye ............................................................... 49.50

8530 Subsequent Visit ........................................................................................................ 40.45

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 ...................................................... 121.00

**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 ........................................................................................................ 100.85

8449 Extended Ophthalmology Consultation for the Assessment and/or Treatment of Uveitis—See Rules 7 to 10 ........................................................................................................ 143.30

**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.
SPECIAL CALL—SEE GENERAL SCHEDULE

HOSPITAL CARE

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)........................................................................................................................................  78.95

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..................................................................................................................... 121.00

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 ........................................................................................................................................... 100.85

8510  Regional History and Examination of the Eye ........................................................................................................ 39.20

8520  Hospital Care—per day ........................................................................................................................................... 30.00

CONCOMITANT CARE

8524  Concomitant Care—per day ........................................................................................................................................... 30.00

CHRONIC CARE—SEE GENERAL SCHEDULE
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.......................................................................................................................................................................................................................................................................................................................................................58.00

8403  Regional History and Examination or Subsequent Visit ..................................................................................................................................................................................................................................................................................................................................37.20

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 ..................................................................................................................................................................................................................................................................................................................................103.20

*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..................................................................................................................................................................................................................................................................................................................................86.00

**SPECIAL CALL—SEE GENERAL SCHEDULE**

**HOSPITAL CARE**

8544  Complete History and ENT Examination, including screening audiogram when necessary ..................................................................................................................................................................................................................................................................................................................................58.00

8512  Regional History and Examination ..................................................................................................................................................................................................................................................................................................................................36.00

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 ..................................................................................................................................................................................................................................................................................................................................103.20

*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..................................................................................................................................................................................................................................................................................................................................86.00
8509  Regional Basic Visit—Regional or Subsequent Visit .................................................................. 25.05

**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.

8425  Regional or Subsequent Visit—patients aged 65–69 years .......................................................... 37.60
8513  Regional or Subsequent Visit—patients aged 70 years and over ................................................. 41.55
8529  Regional Intermediate Visit—Regional or Subsequent Visit or Well Baby Care ......................... 35.05

**Note:** 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.

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

8400  Comprehensive pre-natal assessment ........................................................................................... 80.35
8401  Pre-natal visit ................................................................................................................................... 35.05
8402  Post-natal visit ................................................................................................................................... 35.05
8550  Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10 ............................................. 88.65
8617  Geriatric Consultation (by physician with certificate in Care of the Elderly)—See Rules 7 to 10 .................................................................................................................................. 146.52
8516  Anesthetic consultation ...................................................................................................................... 146.52

**Note:** For other anesthetic services—See Section C

8416  Midwifery Assessment & Report—See General Schedule

General Practitioner to psychiatrist telephone consultation:

8006  Referring General Practitioner ...................................................................................................... 15.35

**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

8540 Complete History and Physical Examination ................................................................. 80.35
Note: 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.

8424 patients aged 65–69 years ................................................................................................. 86.65
8500 patients aged 70 years and over ..................................................................................... 95.90
8498 Complete History and Physical Examination with Gynaecological Examination, including the taking of cytological smear for cancer screening—cervix
See Rule 17(a) for full tariff description ................................................................................. 95.35
8420 patients aged 65–69 years—See Rule 17(a) for full tariff description ............................. 102.90
8450 patients aged 70 years and over—See Rule 17(a) for full tariff description ...................... 113.80
8499 Complete History and Physical Examination with Gynaecological Examination, excluding the taking of cytological smears for cancer screening
See Rule 17(b) for full tariff description ................................................................................. 95.35
8421 patients aged 65–69 years—See Rule 17(b) for full tariff description ............................. 102.90
8460 patients aged 70 years and over—See Rule 17(b) for full tariff description ...................... 113.80
8470 General Practice (11) 
Regional Intermediate Visit—regional or subsequent visit with Gynaecological examination, **including** the taking of cytological smears for cancer screening—cervix—See Rule 17(c) for full tariff description ........................................................................47.25 

8422 patients aged 65–69 years—See Rule 17(c) for full tariff description ........................................50.80 
8451 patients aged 70 years and over—See Rule 17(c) for full tariff description ..............................56.20 
8471 Regional Intermediate Visit—regional or subsequent visit with Gynaecological examination, **excluding** the taking of cytological smears for cancer screening See Rule 17(d) for full tariff description ........................................................................47.25 
8423 patients aged 65–69 years—See Rule 17(d) for full tariff description ........................................50.80 
8461 patients aged 70 years and over—See Rule 17(d) for full tariff description ..............................56.20 

8451 Regional Intermediate Visit—regional or subsequent visit with Gynaecological examination, **excluding** the taking of cytological smears for cancer screening See Rule 17(d) for full tariff description ........................................................................47.25 
8423 patients aged 65–69 years—See Rule 17(d) for full tariff description ........................................50.80 
8461 patients aged 70 years and over—See Rule 17(d) for full tariff description ..............................56.20 

8510 Regional History and Examination ..............................................................................................35.05 
8430 patients aged 65–69 years .............................................................................................................37.60 
8514 patients aged 70 years and over ..................................................................................................41.55 
8550 Consultation (including by Dentist/Oral Surgeon)—See Rules 7 to 10 .........................................88.65 
8617 Geriatric Consultation (by physician with certificate in Care of the Elderly)—See Rules 7 to 10 ..........................................................................................................................146.52 
8594 Complete History and Physical Examination—Unassigned patient ..........................................122.15 

**Note:** 
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, 8498, 8499, 8450, 8460, 8500, 8424, 8420, or 8421 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, 8498, 8499, 8450, 8460, 8500, 8424, 8420, or 8421.** 
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, 8498, 8499, 8450, 8460, 8500, 8424, 8420, or 8421 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 ......................................................................................................15.35 

**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 with 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 ............................................................................................................... 35.05

CONCOMITANT CARE

8524 Concomitant Care—per day ........................................................................................................ 35.05

CHRONIC CARE—SEE GENERAL SCHEDULE

CHRONIC DISEASE MANAGEMENT

8431 Annual management of Diabetes, including development of patient care plan ....................... 45.00

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

### Office, Home Visits

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
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<tbody>
<tr>
<td>8540</td>
<td>Complete History and Physical Examination</td>
<td>87.65</td>
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<tr>
<td>8520</td>
<td>Complete or extensive re-examination for same illness</td>
<td>85.25</td>
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<tr>
<td></td>
<td><strong>By Report</strong>—See Rule 6</td>
<td></td>
</tr>
<tr>
<td>8403</td>
<td>Regional History and Examination or Subsequent Visit</td>
<td>68.00</td>
</tr>
<tr>
<td>8626</td>
<td>Extended Consultation—See Rules 7 to 10—Child minimum of forty-five (45)</td>
<td>223.10</td>
</tr>
<tr>
<td></td>
<td>minutes of patient/physician contact time</td>
<td></td>
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<tr>
<td><strong>Note:</strong></td>
<td>1) Patient must be under eighteen (18) years of age.</td>
<td></td>
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<tr>
<td></td>
<td>2) Patient/physician contact time must be documented with start and stop</td>
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<td>times on the patient’s record. Patient/physician contact time is defined</td>
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<td>as time the physician spends directly in the presence of the patient for</td>
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<td>services or communication with others, either in writing or by telephone.</td>
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<td>Time spent performing procedures for which another tariff</td>
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<td>is claimable may not be counted towards contact time for the purposes of</td>
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<td>an extended visit.</td>
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<tr>
<td>8550</td>
<td>Consultation—See Rules 7 to 10</td>
<td>185.90</td>
</tr>
<tr>
<td>8483</td>
<td>Physiatry Family Conference</td>
<td>46.00</td>
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</table>

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.

<table>
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<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
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<tbody>
<tr>
<td>8484</td>
<td>Physiatry Community Conference</td>
<td>44.00</td>
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</tbody>
</table>

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.

Special Call—See General Schedule

Hospital Care

8540 Complete History and Physical Examination.................................................................87.65

8502 Complete or extensive re-examination for same illness.................................................... 85.25

By Report—See Rule 6

8626 Extended Consultation—See Rules 7 to 10—Child minimum of forty-five (45) minutes of patient/physician contact time .............................................................................. 223.10

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...................................................................................185.90

8664 Extended Consultation—Unassigned Patient—Child minimum of forty-five (45) minutes of patient/physician contact time ................................................................. 268.70

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.................................................................................... 223.90

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
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 ........................................................... 61.20
8403 Regional History and Examination or Subsequent Visit ........................................... 30.60
8626 Extended Consultation—See Rules 7 to 10—Child minimum of forty-five (45) minutes of patient/physician contact time .................................................................................. 151.10

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 ................................................................................. 125.90

Special Call—See General Schedule

Hospital Care

8540 Complete History and Physical Examination ........................................................... 61.20
8626 Extended Consultation—See Rules 7 to 10—Child minimum of forty-five (45) minutes of patient/physician contact time .................................................................................. 151.10

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 ................................................................................. 125.90
8664  Extended Consultation—Unassigned Patient—Child minimum of forty-five (45) minutes of patient/physician contact time ................................................................. 204.00

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 .......................................................................................... 170.00

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 ......................................................................................... 30.70

8520  Hospital Care—per day ......................................................................................................... 30.60

**CONCOMITANT CARE**

8524  Concomitant Care—per day ............................................................................................... 30.60

**CHRONIC CARE—SEE GENERAL SCHEDULE**
These benefits cannot be correctly interpreted without reference to the Rules of Application.

**OFFICE, HOME VISITS**

- **8540** Complete History and Physical Examination ................................................................. 68.85
- **8403** Regional History and Examination or Subsequent Visit ................................................... 36.70
- **8626** Extended Consultation—See Rules 7 to 10—Child minimum of forty-five (45) minutes of patient/physician contact time ................................................................. 160.80

**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 .................................................................................. 134.00

**SPECIAL CALL—SEE GENERAL SCHEDULE**

**HOSPITAL CARE**

- **8540** Complete History and Physical Examination ................................................................. 68.85
- **8626** Extended Consultation—See Rules 7 to 10—Child minimum of forty-five (45) minutes of patient/physician contact time ................................................................. 160.80

**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 .................................................................................. 134.00
8664 Extended Consultation—Unassigned Patient–Child minimum of forty-five (45) minutes of patient/physician contact time ................................................................................................................. 202.80

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.

Note:

8595 Consultation—Unassigned Patient ............................................................................................................. 169.00

“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............................................................................................................. 36.70
8520 Hospital Care—per day .................................................................................................................. 30.60

CONCOMITANT CARE

8524 Concomitant Care—per day ............................................................................................................. 30.60

CHRONIC CARE—SEE GENERAL SCHEDULE
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.....................................................  80.90

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) ............................................................................................................  40.45

8574 Special consideration in exceptional circumstances and prolonged detention .......................By Report

8575 Detention and care at the bedside of a critically ill patient, for the second half hour, when no procedural benefit applies. Per additional fifteen (15) minute period (or major portion thereof) .....................................................  20.00

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.

8565 Trip (without patient), preceding or following ambulance transfer of a critically ill patient, per fifteen (15) minute period (or major portion thereof).....................................................  20.00

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) .....................................................................................  47.50

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) .....................................................  48.50

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.
**SHARED CARE CONFERENCE**

8650  Shared Care Conference ...............................................................................................................48.45

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.

**Note:**
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.

**PATIENT CARE FAMILY CONFERENCE**

8473  Patient Care Family Conference ..................................................................................................37.70

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 .......................................................... 37.70

**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 ............... 50.00

**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.
**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, 3579, 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, 3122, 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, 3915, 3916, 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

Tariff 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, 3810, 3814, 3910, 3913, 3917, 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.
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—Three anesthetists to provide Out-of-Hospital On-Call Coverage as follows:
   - General Anesthesia—one anesthetist
   - Acute/Chronic Pain—one anesthetist
   - Paediatric—one anesthetist
d) Tariff 8213—Block A at $53.06 per hour per anesthetist;
   - Tariff 8214—Block B at $37.14 per hour per anesthetist; and
   - Tariff 8215—Block C at $53.06 per hour per anesthetist
e) Tariff 8219—Health Sciences Centre Paediatric Back-up
   - Block C rate at $53.06 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
Out-of-Hospital On-Call Coverage is provided by one anesthetist at each hospital as follows:
   - Tariff 8216—Block A—one anesthetist at $28.95 per hour;
   - Tariff 8217—Block B—one anesthetist at $15.45 per hour; and
   - Tariff 8218—Block C—one anesthetist at $28.95 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
Pulsed or Continuous Radiofrequency Lesioning

Lesioning of nerves arising from cervical or thoracic levels:

- **5800** One level, per side................................................................. 440.10
- **5802** Multiple levels, per side .......................................................... 775.00

Lesioning of nerves arising from lumbar or sacral levels:

- **5805** One level, per side................................................................. 332.52
- **5806** Multiple levels, per side .......................................................... 600.00

Lesioning of cranial nerves:

- **5807** Single or multiple levels, one side or bilateral ......................... 1,100.00

**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.

**Anesthesia Miscellaneous**

**Local Anesthesia**

- **40000** Local injections to anesthetize an area through absorption by area nerves. ....................... 3.65

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.**
Dressings—second or third degree burns, initial or subsequent, with general anesthesia

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>0352*</td>
<td>small or medium</td>
<td>75.25 21.375</td>
</tr>
<tr>
<td>0353*</td>
<td>large, or with major debridement, per hour</td>
<td>251.30 25.500</td>
</tr>
<tr>
<td>0357</td>
<td>unlisted or unusually complicated</td>
<td>By Report 25.500</td>
</tr>
<tr>
<td>0359</td>
<td>Non Burn Dressings, major debridement and dressing, with anesthesia (excluding local anesthesia)</td>
<td>By Report 25.500</td>
</tr>
</tbody>
</table>

DEBRIDMENT

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>0259*</td>
<td>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</td>
<td>81.00 20.000</td>
</tr>
<tr>
<td>0260*</td>
<td>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.</td>
<td>81.00</td>
</tr>
<tr>
<td>0261</td>
<td>Major debridement of necrotizing soft tissue infection per fifteen (15) minutes or major portion thereof</td>
<td>100.00 25.500</td>
</tr>
</tbody>
</table>

Note: Tariff 0261 may only be claimed for major debridement of necrotizing soft tissue infection completed under general anesthesia.
~1682 microfracture talus, add .................................................................72.50
~1683 microfracture calcaneus, add ...............................................................72.50
~1684 removal os trigonum, add .................................................................72.50
~1685 tenolysis, add .......................................................................................72.50
~1686 tendon debridement, add.................................................................72.50

**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.

### MANIPULATION, (INDEPENDENT PROCEDURES)
Of joint under general anesthesia, not including reduction of dislocation, including application of cast or traction

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure</th>
<th>Unit Value</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>1221*</td>
<td>Shoulder</td>
<td>87.90</td>
<td>20.000</td>
</tr>
<tr>
<td>1222*</td>
<td>Elbow</td>
<td>79.40</td>
<td>20.000</td>
</tr>
<tr>
<td>1223*</td>
<td>Wrist</td>
<td>79.40</td>
<td>20.000</td>
</tr>
<tr>
<td>1224*</td>
<td>Digits, one (1) or more, under anesthesia, where no other surgical procedure is performed</td>
<td>29.60</td>
<td>20.000</td>
</tr>
<tr>
<td>1226*</td>
<td>Hip</td>
<td>84.45</td>
<td>20.000</td>
</tr>
<tr>
<td>1227*</td>
<td>Knee</td>
<td>79.40</td>
<td>20.000</td>
</tr>
<tr>
<td>1228*</td>
<td>Ankle</td>
<td>79.40</td>
<td>20.000</td>
</tr>
<tr>
<td>1244*</td>
<td>Club foot with application of cast, unilateral, initial</td>
<td>35.70</td>
<td>20.000</td>
</tr>
<tr>
<td>1245*</td>
<td>subsequent</td>
<td>35.70</td>
<td>20.000</td>
</tr>
<tr>
<td>1246*</td>
<td>bilateral, initial</td>
<td>56.10</td>
<td>20.000</td>
</tr>
<tr>
<td>1247*</td>
<td>subsequent</td>
<td>56.10</td>
<td>20.000</td>
</tr>
<tr>
<td>1232*</td>
<td>Spine</td>
<td>71.25</td>
<td>20.000</td>
</tr>
</tbody>
</table>

### ARTHRODESIS
Fusion of joint, with or without bone graft

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure</th>
<th>Unit Value</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>1166</td>
<td>Shoulder</td>
<td>1,108.05</td>
<td>20.000</td>
</tr>
<tr>
<td>1167</td>
<td>Elbow</td>
<td>399.00</td>
<td>20.000</td>
</tr>
<tr>
<td>1168</td>
<td>Wrist</td>
<td>678.90</td>
<td>20.000</td>
</tr>
<tr>
<td>1170</td>
<td>Finger or thumb—one (1) joint</td>
<td>375.35</td>
<td>20.000</td>
</tr>
<tr>
<td>1173</td>
<td>Sacroiliac</td>
<td>645.75</td>
<td>21.375</td>
</tr>
<tr>
<td>1175</td>
<td>Hip</td>
<td>683.00</td>
<td>21.375</td>
</tr>
<tr>
<td>1176</td>
<td>Knee</td>
<td>860.35</td>
<td>20.000</td>
</tr>
<tr>
<td>1177</td>
<td>Ankle</td>
<td>708.20</td>
<td>20.000</td>
</tr>
<tr>
<td>1252</td>
<td>Midfoot joint arthrodesis</td>
<td>400.00</td>
<td>20.000</td>
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</tbody>
</table>
### ARTHRECTOMY

**Excision of joint – See Arthroplasty**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Value</th>
<th>Unit Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>1065</td>
<td>Temporomandibular joint, unilateral</td>
<td>247.00</td>
<td>21.375</td>
</tr>
<tr>
<td>1595</td>
<td>Toes, multiple arthrodesis for claw foot, one (1) foot</td>
<td>408.65</td>
<td>20.000</td>
</tr>
<tr>
<td>1596</td>
<td>both feet</td>
<td>476.00</td>
<td>20.000</td>
</tr>
<tr>
<td>1181</td>
<td>Hallux rigidus</td>
<td>350.95</td>
<td>20.000</td>
</tr>
<tr>
<td>1183</td>
<td>Tarsal joint, one (1) or more</td>
<td>304.25</td>
<td>20.000</td>
</tr>
<tr>
<td>1184</td>
<td>Other joints, lower extremity</td>
<td>409.70</td>
<td>20.000</td>
</tr>
<tr>
<td>1190</td>
<td>Stabilization of joints by bone block</td>
<td>268.95</td>
<td>20.000</td>
</tr>
<tr>
<td>1191</td>
<td>Acromionectomy</td>
<td>349.70</td>
<td>21.375</td>
</tr>
</tbody>
</table>

### 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.*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Value</th>
<th>Unit Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>1200</td>
<td>Shoulder, total arthroplasty with glenoid and humeral components</td>
<td>857.80</td>
<td>22.750</td>
</tr>
<tr>
<td>1203</td>
<td>Shoulder arthroplasty with humeral component</td>
<td>724.20</td>
<td>22.750</td>
</tr>
<tr>
<td>1204</td>
<td>Shoulder, revision of one or both components of shoulder arthroplasty</td>
<td>1,468.85</td>
<td>22.750</td>
</tr>
<tr>
<td>1205</td>
<td>Shoulder revision to temporary arthroplasty using prostalac</td>
<td>1,173.00</td>
<td>22.750</td>
</tr>
<tr>
<td>1206</td>
<td>Shoulder, removal of one or both components of shoulder arthroplasty without replacement</td>
<td>980.00</td>
<td>22.750</td>
</tr>
<tr>
<td>1207</td>
<td>Autogenous, structural bone graft from another site, add.</td>
<td>242.75</td>
<td>22.750</td>
</tr>
<tr>
<td>1208</td>
<td>Allogenous, structural bone graft, add.</td>
<td>137.75</td>
<td>22.750</td>
</tr>
</tbody>
</table>

#### Elbow Arthroplasty

*Note: Includes, except where noted, below, all associated bone and soft tissue procedures including ligament balancing, neurolysis and nerve transposition and synovectomy.*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Value</th>
<th>Unit Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>1180</td>
<td>Radial head arthroplasty only with implant</td>
<td>532.85</td>
<td>22.750</td>
</tr>
</tbody>
</table>
1337 Open reduction congenital hip dislocation with pelvic osteotomy, includes open adduction tenotomy, arthrotomy hip, Psoas tendon lengthening and pelvic osteotomy ........................................... 1,713.55 25.500
1338 Open reduction congenital hip dislocation, includes open adduction tenotomy, arthrotomy hip, Psoas tendon lengthening, with femoral osteotomy ........................................ 1,445.20 25.500
1339 Open reduction congenital hip dislocation, includes open adduction tenotomy, arthrotomy hip, Psoas tendon lengthening, with femoral and pelvic osteotomy .................................. 1,986.55 25.500
1344 Knee, closed reduction ............................................................................................................... 122.05 20.000
1346 Open reduction ........................................................................................................................ 348.15 21.375
1339 Open reduction congenital hip dislocation, includes open adduction tenotomy, arthrotomy hip, Psoas tendon lengthening, with femoral and pelvic osteotomy ..................... 1,986.55 25.500
1344 Knee, closed reduction ............................................................................................................... 122.05 20.000
1346 Open reduction ........................................................................................................................ 348.15 21.375
1352 Patella, closed reduction ............................................................................................................ F/S
1352 Open reduction ........................................................................................................................ 346.95 20.000
1355 Ankle, closed reduction ............................................................................................................ 316.75 20.000
1357 Open reduction ........................................................................................................................ 346.95 20.000
1361 Tarsal, closed reduction ............................................................................................................ 159.00 20.000
1363 Open reduction ........................................................................................................................ 287.25 20.000
1371 Talotarsal, closed reduction ........................................................................................................ 110.90 20.000
1373 Open reduction ........................................................................................................................ 298.00 20.000
1378 Open reduction ........................................................................................................................ 202.30 20.000
1387 Open reduction ........................................................................................................................ 196.30 20.000

**SUTURE**

Capsulorrhaphy—suture or repair of joint capsule for recurrent dislocation

1201 Shoulder (independent procedure) ........................................................................................... 570.70 21.375
1202 Patella (independent procedure) ............................................................................................... 613.55 21.000
1211 Knee, repair/reattachment of collateral ligament, each .............................................................. 577.00 21.375
1212 Collateral ligament reconstruction ............................................................................................ 637.00 21.375
1213 Posterior cruciate ligament reconstruction .................................................................................. 747.20 21.375
1215 Anterior cruciate ligament reconstruction ................................................................................... 637.00 21.375
1214 Posterolateral corner reconstruction ........................................................................................... 677.30 21.375
1218 Ankle, reconstruction, collateral ligament, one (1) .................................................................... 371.05 20.000
1218 Ankle, reconstruction, collateral ligament, both ......................................................................... 491.00 20.000
1217 Reconstruction, metacarpophalangeal or interphalangeal ligaments, both, one (1) finger ................................................................................................................................. 337.95 20.000

**SYNOVECTOMY**

1095 Shoulder ................................................................................................................................... 480.50 21.375
1093 Elbow ......................................................................................................................................... 437.85 21.375
RESPIRATORY SYSTEM

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

Surgical Assistant’s benefits will be 30% of the surgical fee if the assistant is a Thoracic Surgeon; otherwise, the assistant fees listed under the General Schedule (Section B) will apply.

**Note:** The 30% surgical assistant’s benefit will only apply in addition to the following tariffs, 2193, 2194, 3067, 2177, 3046, 2174, 2191, 2196, 2173, 5376, 2693, 2202, 2172, 2686, 2696, 2136, 2691, 2209, 3041, 3040, 2135, 2585, 2190, 2171, 2200, 2201, 3041 and 5386.

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.

<table>
<thead>
<tr>
<th>Unit Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>286.45</td>
<td>1924 Rhinophyma, excision or planing</td>
</tr>
<tr>
<td>676.70</td>
<td>1950 Rhinoplasty, complete, external parts including bony pyramid, lateral and alar cartilages and elevation of tip, if necessary</td>
</tr>
<tr>
<td>571.20</td>
<td>1949 with septoplasty</td>
</tr>
<tr>
<td>310.15</td>
<td>1956 tip only</td>
</tr>
</tbody>
</table>

For saddle deformity by autogenous bone or other implant – See Bone Graft, Musculoskeletal Section

INTERNAL

<table>
<thead>
<tr>
<th>Unit Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>34.70</td>
<td>1904* Drainage of nasal abscess</td>
</tr>
<tr>
<td>34.70</td>
<td>1905* septal abscess</td>
</tr>
<tr>
<td>3.85</td>
<td>1906* Proetz treatment</td>
</tr>
<tr>
<td>43.85</td>
<td>1908* Biopsy, soft tissue nose including simple closure</td>
</tr>
<tr>
<td>13.75</td>
<td>1907* Nose, foreign body removal</td>
</tr>
<tr>
<td>68.55</td>
<td>1915* polyp single excision in office</td>
</tr>
<tr>
<td>46.90</td>
<td>1965* Turbinate cautery</td>
</tr>
<tr>
<td>72.80</td>
<td>1966* with general anesthetic</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Unit Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>41.65</td>
<td>1967* Epistaxis, control by anterior packing</td>
</tr>
<tr>
<td>120.30</td>
<td>1968* posterior packing</td>
</tr>
<tr>
<td>21.375</td>
<td>1969 freezing—See Section C—Anesthesia</td>
</tr>
</tbody>
</table>

**By Report**

<table>
<thead>
<tr>
<th>Unit Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>25.20</td>
<td>1970* Epistaxis, control by cautery of the septum in a nose that is not actively bleeding</td>
</tr>
<tr>
<td>25.20</td>
<td>1971* actual control of a bleeding nose</td>
</tr>
<tr>
<td>Year</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2032</td>
<td>Oro-antral fistula, closure by Caldwell-Luc and Antrum window and mucosal or</td>
</tr>
<tr>
<td></td>
<td>muco periosteal flaps</td>
</tr>
<tr>
<td>1988</td>
<td>Sinusotomy, Caldwell-Luc</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>1992</td>
<td>Frontal, trephine</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>1991</td>
<td>Sphenoid</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>1985</td>
<td>Maxillary, antrostomy</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>Endoscopic frontal sinusotomy, unilateral</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>Endoscopic frontal sinus drill-out, primary frontal sinusotomy not claimable</td>
</tr>
<tr>
<td></td>
<td>in addition, unilateral</td>
</tr>
<tr>
<td>2003</td>
<td>Endoscopic transnasal approach to pituitary fossa lesion, including septal</td>
</tr>
<tr>
<td></td>
<td>mucosal flap and other procedures as required (otolaryngologist component)</td>
</tr>
<tr>
<td>2004</td>
<td>Revision, endoscopic transnasal approach to pituitary fossa lesion, including</td>
</tr>
<tr>
<td></td>
<td>septal mucosal flap and other procedures as required (otolaryngologist component)</td>
</tr>
<tr>
<td>2005</td>
<td>Extended endoscopic transnasal approach to skull based lesion, for access to</td>
</tr>
<tr>
<td></td>
<td>lesions in each anatomic areas (anterior cranial fossa, clivus/posterior cranial fossa, C1-C2, occipital condyles), including dura repairs if needed (otolaryngologist component)</td>
</tr>
</tbody>
</table>

**Note:**
1) Tariff 0296 pedical 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

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>External ethmoidectomy unilateral</td>
<td>386.95</td>
</tr>
<tr>
<td></td>
<td></td>
<td>22.750</td>
</tr>
</tbody>
</table>

**Ethmoidectomy**

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>and antrostomy, unilateral</td>
<td>320.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>21.375</td>
</tr>
<tr>
<td>2010</td>
<td>Bilateral</td>
<td>561.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>21.375</td>
</tr>
<tr>
<td>2011</td>
<td>and polypectomy, unilateral</td>
<td>308.70</td>
</tr>
<tr>
<td></td>
<td></td>
<td>21.375</td>
</tr>
<tr>
<td>2012</td>
<td>Bilateral</td>
<td>530.40</td>
</tr>
<tr>
<td></td>
<td></td>
<td>21.375</td>
</tr>
<tr>
<td>2014</td>
<td>and polypectomy and antrostomy, unilateral</td>
<td>408.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>21.375</td>
</tr>
<tr>
<td>2015</td>
<td>Bilateral</td>
<td>693.60</td>
</tr>
<tr>
<td></td>
<td></td>
<td>21.375</td>
</tr>
<tr>
<td>2017</td>
<td>Polypectomy and antrostomy, unilateral</td>
<td>210.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>21.375</td>
</tr>
<tr>
<td>2018</td>
<td>Bilateral</td>
<td>360.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>21.375</td>
</tr>
</tbody>
</table>

**Septoplasty**

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>and antrostomy, unilateral</td>
<td>380.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>21.375</td>
</tr>
<tr>
<td>2020</td>
<td>Bilateral</td>
<td>578.65</td>
</tr>
<tr>
<td></td>
<td></td>
<td>21.375</td>
</tr>
<tr>
<td>2021</td>
<td>and ethmoidectomy, unilateral</td>
<td>610.50</td>
</tr>
<tr>
<td></td>
<td></td>
<td>21.375</td>
</tr>
<tr>
<td>2022</td>
<td>Bilateral</td>
<td>811.25</td>
</tr>
<tr>
<td></td>
<td></td>
<td>21.375</td>
</tr>
<tr>
<td>2023</td>
<td>and polypectomy, unilateral</td>
<td>367.20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>21.375</td>
</tr>
</tbody>
</table>
## TRACHEA AND BRONCHI

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2127*</td>
<td>Trachea, aspiration under direct vision (independent procedure)</td>
<td>69.00</td>
</tr>
<tr>
<td>2128*</td>
<td>Tracheal aspiration for meconium staining under direct vision (independent procedure)</td>
<td>101.75</td>
</tr>
<tr>
<td>6145</td>
<td>Tracheogram (procedural portion of radiology)</td>
<td>20.50</td>
</tr>
<tr>
<td>2129*</td>
<td>Dilatation tracheal stenosis</td>
<td>195.35</td>
</tr>
<tr>
<td>2131</td>
<td>with suspension laryngoscopy</td>
<td>243.70</td>
</tr>
<tr>
<td>2113*</td>
<td>Bronchoscopy, with biopsy if necessary</td>
<td>137.70</td>
</tr>
<tr>
<td>2121*</td>
<td>with bronchial aspiration</td>
<td>146.15</td>
</tr>
<tr>
<td>2126*</td>
<td>with catheterization of bronchi for broncho-spirometry (independent procedure)</td>
<td>66.25</td>
</tr>
<tr>
<td>2122*</td>
<td>with drainage of lung abscess or cavity</td>
<td>126.10</td>
</tr>
<tr>
<td>2123*</td>
<td>with lipiodol injection</td>
<td>126.10</td>
</tr>
<tr>
<td>2116</td>
<td>with stent placement</td>
<td>246.40</td>
</tr>
<tr>
<td>2119</td>
<td>with brachytherapy</td>
<td>212.15</td>
</tr>
<tr>
<td>2136</td>
<td>total lung washout lavage—(unilateral)</td>
<td>800.00</td>
</tr>
<tr>
<td>2137</td>
<td>with bronchopleural fistula—tisseel injection</td>
<td>150.00</td>
</tr>
<tr>
<td>2124*</td>
<td>subsequent (i.e. in same hospital admission)</td>
<td>103.00</td>
</tr>
<tr>
<td>2130*</td>
<td>Panendoscopy with or without biopsy, three (3) or more of nasopharyngoscopy, laryngoscopy, bronchoscopy, or esophagoscopy using separate instruments in search of malignant disease</td>
<td>362.95</td>
</tr>
<tr>
<td>2112</td>
<td>Bronchoscopy, with control of severe hemorrhage</td>
<td>177.50</td>
</tr>
<tr>
<td>2120</td>
<td>with excision of tumor, with or without laser</td>
<td>354.85</td>
</tr>
<tr>
<td>2115*</td>
<td>with lung biopsy</td>
<td>201.95</td>
</tr>
<tr>
<td>2117</td>
<td>with removal of foreign body—adult</td>
<td>301.20</td>
</tr>
<tr>
<td>2118</td>
<td>with removal of foreign body—child</td>
<td>252.00</td>
</tr>
<tr>
<td>2105</td>
<td>Tracheal fenestration</td>
<td>331.00</td>
</tr>
<tr>
<td>2132</td>
<td>Tracheoplasty, intrathoracic</td>
<td>882.00</td>
</tr>
<tr>
<td>2101*</td>
<td>Tracheotomy (not to be claimed with tariff 2052 laryngectomy, total)</td>
<td>334.80</td>
</tr>
<tr>
<td>2100</td>
<td>Cricothyroidotomoy</td>
<td>277.65</td>
</tr>
<tr>
<td>2102</td>
<td>Tracheoesophageal puncture following laryngectomy (separate operation) including delayed insertion of voice prosthesis</td>
<td>329.75</td>
</tr>
<tr>
<td>2103</td>
<td>Tracheoesophageal puncture at the time of laryngectomy, including delayed insertion of voice prosthesis</td>
<td>153.05</td>
</tr>
<tr>
<td>2104*</td>
<td>Repeat insertion of voice prosthesis (independent procedure)</td>
<td>58.20</td>
</tr>
</tbody>
</table>
### Respiratory System

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2134</td>
<td>Bronchoplasty, excise stenosis and anastomosis</td>
<td>929.00</td>
</tr>
<tr>
<td>2133</td>
<td>Graft repair</td>
<td>973.00</td>
</tr>
<tr>
<td>2135</td>
<td>with lobectomy and anastomosis</td>
<td>1,361.20</td>
</tr>
<tr>
<td>2108</td>
<td>Endo-bronchial ultrasound (EBUS), with or without Doppler</td>
<td>200.00</td>
</tr>
<tr>
<td>2109</td>
<td>Biopsies of each nodal area done by EBUS, maximum of three (3)</td>
<td>54.25</td>
</tr>
</tbody>
</table>

**Note**: A bronchoscopy done at the same time as EBUS will be payable at 75% of the listed fee.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2193</td>
<td>Lobectomy, total or subtotal</td>
<td>1,215.60</td>
</tr>
<tr>
<td>2189</td>
<td>Lobectomy following previous lung resection on the same side</td>
<td>1,337.16</td>
</tr>
<tr>
<td>2191</td>
<td>Pneumonecctomy, total</td>
<td>1,412.70</td>
</tr>
<tr>
<td>2194</td>
<td>Wedge resection</td>
<td>939.50</td>
</tr>
<tr>
<td>2187</td>
<td>Wedge resection following previous lung resection on the same</td>
<td>1,033.45</td>
</tr>
<tr>
<td></td>
<td>side</td>
<td>26.875</td>
</tr>
<tr>
<td>2177</td>
<td>Pulmonary decorticating</td>
<td>820.15</td>
</tr>
<tr>
<td>2171</td>
<td>Pleurectomy</td>
<td>654.50</td>
</tr>
<tr>
<td>2172</td>
<td>Wedge resection with partial pleurectomy</td>
<td>1,042.00</td>
</tr>
<tr>
<td>2173</td>
<td>Decorticating with parietal pleurectomy and empyemectomy</td>
<td>1,242.35</td>
</tr>
<tr>
<td>2174</td>
<td>Late decorticating for fibrothorax</td>
<td>1,530.00</td>
</tr>
<tr>
<td>2192</td>
<td>Lobectomy with concomitant decorticating of remaining lung</td>
<td>1,701.75</td>
</tr>
<tr>
<td>2157*</td>
<td>Insertion of chest tube for closed drainage (independent procedure)</td>
<td>116.35</td>
</tr>
<tr>
<td>2156*</td>
<td>Bilateral at same sitting (independent procedure)</td>
<td>187.80</td>
</tr>
<tr>
<td>2151</td>
<td>Thoracotomy, cardiac massage</td>
<td>557.15</td>
</tr>
<tr>
<td>2152</td>
<td>exploratory, including biopsy</td>
<td>438.60</td>
</tr>
</tbody>
</table>

**LUNGS AND PLEURA**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2180*</td>
<td>Lung, needle biopsy</td>
<td>101.75</td>
</tr>
<tr>
<td>2225*</td>
<td>Pleura, needle biopsy (including thoracentesis)</td>
<td>65.50</td>
</tr>
<tr>
<td>2220*</td>
<td>Thoracoscopy, with or without biopsy</td>
<td>204.00</td>
</tr>
<tr>
<td>2183*</td>
<td>Thoracentesis</td>
<td>65.65</td>
</tr>
<tr>
<td>2221*</td>
<td>Pneumothorax, diagnostic or therapeutic, initial</td>
<td>54.25</td>
</tr>
<tr>
<td>2222*</td>
<td>subsequent</td>
<td>13.75</td>
</tr>
<tr>
<td>2224*</td>
<td>Administration of chemotherapy, including aspiration thoracentesis and sample</td>
<td>66.70</td>
</tr>
<tr>
<td>2684*</td>
<td>Mediastinoscopy</td>
<td>287.95</td>
</tr>
<tr>
<td>2193</td>
<td>Lobectomy, total or subtotal</td>
<td>1,215.60</td>
</tr>
<tr>
<td>2189</td>
<td>Lobectomy following previous lung resection on the same side</td>
<td>1,337.16</td>
</tr>
<tr>
<td>2191</td>
<td>Pneumonecctomy, total</td>
<td>1,412.70</td>
</tr>
<tr>
<td>2184</td>
<td>with diagnostic wedge resection, add to tariffs 2191 and 2193</td>
<td>45.85</td>
</tr>
<tr>
<td>2185</td>
<td>with sleeve resection of pulmonary artery, add to tariff 2193</td>
<td>142.20</td>
</tr>
<tr>
<td>2194</td>
<td>Wedge resection</td>
<td>939.50</td>
</tr>
<tr>
<td>2186</td>
<td>re-operaton more than 180 days subsequent to previous excision,</td>
<td>150.00</td>
</tr>
<tr>
<td></td>
<td>to appropriate excision fee, add to tariffs 2193, 2194 and 3709</td>
<td></td>
</tr>
<tr>
<td>2187</td>
<td>Wedge resection following previous lung resection on the same</td>
<td>1,033.45</td>
</tr>
<tr>
<td></td>
<td>side</td>
<td>26.875</td>
</tr>
<tr>
<td>2177</td>
<td>Pulmonary decorticating</td>
<td>820.15</td>
</tr>
<tr>
<td>2171</td>
<td>Pleurectomy</td>
<td>654.50</td>
</tr>
<tr>
<td>2172</td>
<td>Wedge resection with partial pleurectomy</td>
<td>1,042.00</td>
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</tr>
<tr>
<td>2157*</td>
<td>Insertion of chest tube for closed drainage (independent procedure)</td>
<td>116.35</td>
</tr>
<tr>
<td>2156*</td>
<td>Bilateral at same sitting (independent procedure)</td>
<td>187.80</td>
</tr>
<tr>
<td>2151</td>
<td>Thoracotomy, cardiac massage</td>
<td>557.15</td>
</tr>
<tr>
<td>2152</td>
<td>exploratory, including biopsy</td>
<td>438.60</td>
</tr>
</tbody>
</table>
Respiratory System

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Value</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>2153</td>
<td>hemorrhage control, not postoperative</td>
<td>666.25</td>
<td>26.875</td>
</tr>
<tr>
<td>2155</td>
<td>Thoracotomy for postoperative bleeding following lung or esophageal surgery</td>
<td>367.55</td>
<td>26.875</td>
</tr>
<tr>
<td>2170</td>
<td>Pneumonotomy, open drainage of abscess or cyst of lung</td>
<td>397.00</td>
<td>26.875</td>
</tr>
<tr>
<td>2160</td>
<td>Removal of foreign body from lung</td>
<td>470.00</td>
<td>26.875</td>
</tr>
<tr>
<td>2154</td>
<td>Open drainage of empyema cavity by rib resection (independent procedure)</td>
<td>379.25</td>
<td>22.750</td>
</tr>
<tr>
<td>2190</td>
<td>Lung Harvesting—Unilateral</td>
<td>1,405.60</td>
<td>25.500</td>
</tr>
<tr>
<td>2196</td>
<td>Lung Harvesting—Bilateral</td>
<td>2,505.90</td>
<td>25.500</td>
</tr>
<tr>
<td>2197</td>
<td>Lung Transplantation—Unilateral</td>
<td>3,134.80</td>
<td>26.875</td>
</tr>
<tr>
<td>2198</td>
<td>Lung Transplantation—Bilateral</td>
<td>5,555.05</td>
<td>26.875</td>
</tr>
</tbody>
</table>

**Note:**
- a) The fees for tariffs 2197 and 2198 include the recipient pneumonectomy.
- b) First assistant—30% of fee payable to principle surgeon.
- c) Second assistant—30% of fee payable to principle surgeon.

**VIDEO ASSISTED PLEUROLYSIS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Value</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>2188</td>
<td>Pleurolysis and scope—via scope</td>
<td>300.00</td>
<td>25.500</td>
</tr>
<tr>
<td>2199</td>
<td>Unlisted or Unusually Complicated</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**RIBS AND CHEST WALL**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Value</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1456</td>
<td>Scalenus anticus, division, with resection of cervical rib</td>
<td>407.95</td>
<td>21.375</td>
</tr>
<tr>
<td>1454</td>
<td>without resection of cervical rib</td>
<td>191.50</td>
<td>21.375</td>
</tr>
<tr>
<td>2209</td>
<td>Intrathoracic tumors without lung involvement, excision</td>
<td>883.70</td>
<td>25.500</td>
</tr>
<tr>
<td>2210</td>
<td>Pectus excavatum or carinatum, correction</td>
<td>896.80</td>
<td>25.500</td>
</tr>
<tr>
<td>2211</td>
<td>Thoracoplasty, for pulmonary disease</td>
<td>577.50</td>
<td>22.750</td>
</tr>
<tr>
<td>2200</td>
<td>Chest wall tumor resection—with one (1) rib</td>
<td>600.00</td>
<td>25.500</td>
</tr>
<tr>
<td>2201</td>
<td>Chest wall tumor resection—two (2) or more</td>
<td>800.00</td>
<td>25.500</td>
</tr>
<tr>
<td>2202</td>
<td>with prosthetic reconstruction</td>
<td>1,050.00</td>
<td>25.500</td>
</tr>
<tr>
<td>2203</td>
<td>Chest wall reconstruction add to lobectomy or pneumonectomy</td>
<td>250.00</td>
<td></td>
</tr>
<tr>
<td>2204</td>
<td>with merthacrolyte cement reconstruction—add to previous tariff</td>
<td>250.00</td>
<td></td>
</tr>
<tr>
<td>2219</td>
<td>Unlisted or Unusually Complicated</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2302*</td>
<td>Cardiac catheterization, left heart</td>
<td>214.55</td>
</tr>
<tr>
<td>2304*</td>
<td>left heart plus right heart</td>
<td>301.75</td>
</tr>
<tr>
<td>2306*</td>
<td>Cardiac catheterization, right heart, outside the O.R. setting</td>
<td>157.40</td>
</tr>
<tr>
<td>2307*</td>
<td>Selective coronary artery arteriography</td>
<td>259.65</td>
</tr>
<tr>
<td>2308*</td>
<td>and left heart catheterization</td>
<td>441.60</td>
</tr>
<tr>
<td>2325*</td>
<td>and right heart catheterization</td>
<td>370.05</td>
</tr>
<tr>
<td>2327*</td>
<td>and both left heart catheterization and right heart catheterization</td>
<td>499.55</td>
</tr>
<tr>
<td>2234</td>
<td>Intracoronary artery or intracoronary bypass graft, drug injection(s), add</td>
<td>85.00</td>
</tr>
<tr>
<td>2235</td>
<td>Measurement of cardiac output by flick or thermodilution, add</td>
<td>99.00</td>
</tr>
<tr>
<td>2236</td>
<td>Intra-cardiac oximetry, add</td>
<td>70.00</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Tariffs 2234, 2235 and 2236 may only be claimed in addition to an</td>
<td></td>
</tr>
<tr>
<td></td>
<td>interventional cardiology procedure.</td>
<td></td>
</tr>
<tr>
<td>2397*</td>
<td>Intracoronary Ultrasound, add</td>
<td>115.00</td>
</tr>
<tr>
<td>2401*</td>
<td>Coronary pressure derived fractional flow reserve (Coronary FFR) per coronary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>vessel, add</td>
<td>113.90</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> 1) Tariffs 2401 and 2397 may be claimed in addition to tariffs 2307</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2308, 2325 or 2327.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2) Coronary angioplasty (tariffs 6267, 6268 or 6270) is payable at 100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>when rendered on the same day as tariff 2401 or 2397.</td>
<td></td>
</tr>
<tr>
<td>2305*</td>
<td>Coronary artery bypass graft angiogram including internal mammary artery</td>
<td>91.20</td>
</tr>
<tr>
<td></td>
<td>implant per graft injection regardless of any number of distal anastomoses</td>
<td>21.375</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> When the above bypass angiography is done along with any other</td>
<td></td>
</tr>
<tr>
<td></td>
<td>procedure, claim 50% for the bypass angiogram benefit.</td>
<td></td>
</tr>
<tr>
<td>2393</td>
<td>Atrial fibrillation ablation (MAZE) of left or right atrium, in addition to</td>
<td>746.15</td>
</tr>
<tr>
<td></td>
<td>cardiac surgery</td>
<td>25.500</td>
</tr>
<tr>
<td>2395</td>
<td>Atrial fibrillation ablation (MAZE) of both left and right atriums, in</td>
<td>1,581.25</td>
</tr>
<tr>
<td></td>
<td>addition to cardiac surgery</td>
<td>25.500</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Tariff 2393 or 2395 are payable at 100% of the listed benefit.</td>
<td></td>
</tr>
<tr>
<td>2310*</td>
<td>Septostomy, balloon (additional to cardiac catheterization) (independent</td>
<td>313.25</td>
</tr>
<tr>
<td></td>
<td>procedure)</td>
<td>25.500</td>
</tr>
<tr>
<td>2312*</td>
<td>Cardioversion, D.C. countershock, including immediate follow-up care</td>
<td>101.30</td>
</tr>
<tr>
<td></td>
<td>...............................................................................................................</td>
<td>22.750</td>
</tr>
<tr>
<td>2381*</td>
<td>Implantation or Removal of Loop Recorder</td>
<td>240.70</td>
</tr>
<tr>
<td>2323*</td>
<td>Endomyocardial biopsies, transvascular, right or left heart</td>
<td>281.70</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> When other procedures are carried out at the same sitting, fees for</td>
<td></td>
</tr>
<tr>
<td></td>
<td>lesser procedures are to be claimed at 75% of the listed benefits whether or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>not they are asterisked.</td>
<td></td>
</tr>
<tr>
<td>2316</td>
<td>Aortico-pulmonary window, closed repair</td>
<td>1,255.85</td>
</tr>
<tr>
<td>2318</td>
<td>anastomosis, Edward’s repair</td>
<td>929.00</td>
</tr>
<tr>
<td>2320</td>
<td>Pott’s repair</td>
<td>937.00</td>
</tr>
<tr>
<td>2322</td>
<td>Atrial septal defect, closed creation (Blalock-Hanlon procedure)</td>
<td>941.00</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong></td>
<td>26.875</td>
</tr>
</tbody>
</table>
### Revision and Repair

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>3526</td>
<td>Gallbladder,—Roux-en-Y or anastomosis loop</td>
<td>683.75</td>
</tr>
<tr>
<td>3528</td>
<td>Roux-en-Y anastomosis to G.I. tract</td>
<td>1,015.80</td>
</tr>
<tr>
<td>3520</td>
<td>Bile ducts , end-to-end reconstruction</td>
<td>850.00</td>
</tr>
<tr>
<td>3522</td>
<td>direct anastomosis to G.I. tract</td>
<td>952.10</td>
</tr>
<tr>
<td>3524</td>
<td>Hepatico-jejunostomy Roux-en-Y or anastomosis loop</td>
<td>1,410.95</td>
</tr>
</tbody>
</table>

### Resection

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>3515</td>
<td>Gallbladder, cholecystectomy</td>
<td>560.00</td>
</tr>
<tr>
<td>3516</td>
<td>with open exploration of common duct</td>
<td>867.00</td>
</tr>
<tr>
<td>3499</td>
<td>Unlisted or Unusually Complicated</td>
<td>By Report</td>
</tr>
</tbody>
</table>

### Liver

#### Investigation

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>3456*</td>
<td>Needle biopsy</td>
<td>102.00</td>
</tr>
<tr>
<td>3457*</td>
<td>Open biopsy of liver, needle, one or more, when exposed at other operation, add</td>
<td>101.75</td>
</tr>
<tr>
<td>3459*</td>
<td>Open biopsy of liver, excisional, one or more, when exposed at other operation, add</td>
<td>114.95</td>
</tr>
<tr>
<td>3458</td>
<td>Transjugular liver biopsy, including history, examination, advice, pressure readings, fluoroscopy, angiography, and any other imaging by the same physician</td>
<td>227.75</td>
</tr>
<tr>
<td>~3461</td>
<td>Fibroscan (transient elastography) for the measurement of liver fibrosis, interpretation only</td>
<td>25.00</td>
</tr>
<tr>
<td>~3462</td>
<td>Fibroscan (transient elastography) for the measurement of liver fibrosis, without interpretation</td>
<td>25.00</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>3471</td>
<td>Liver abscess drainage</td>
<td>532.40</td>
</tr>
<tr>
<td>3472</td>
<td>Marsupialization or drainage of liver cyst</td>
<td>532.40</td>
</tr>
</tbody>
</table>

#### Revision and Repair

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>3481</td>
<td>Hepatorrhaphy, suture of wound or injury including omental pack</td>
<td>600.00</td>
</tr>
</tbody>
</table>
These benefits cannot be correctly interpreted without reference to the Rules of Application.

**URODYNAMIC STUDIES**

9869* Uroflow studies, professional ........................................................................................................... 28.90
9870* total ................................................................................................................................................. 37.45
9873* Cystometry with rectal and vesical pressures, professional ......................................................... 53.90
9874* total ................................................................................................................................................. 86.20
9877* Urethral pressure profile studies, professional ............................................................................... 53.90
9888* total ................................................................................................................................................. 56.50
9897* All above tests, combined, professional ....................................................................................... 109.85
9899* total ............................................................................................................................................... 172.50
9896* Cystometry with flow studies, professional .................................................................................. 47.40
9896* total ............................................................................................................................................... 66.75
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 ........................................................................................................................................ 68.75

*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 ........................................................................................................ 26.45

*Note: Tariff 7875 is payable only where the service is provided at Health Sciences Centre or St. Boniface General Hospital.

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).
### Scrotum

<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>4211* Scrotum, drainage of abscess</td>
<td>37.00</td>
</tr>
<tr>
<td>4215 Foreign body in scrotum, removal</td>
<td>By Report</td>
</tr>
<tr>
<td>4224 Resection of scrotum</td>
<td>By Report</td>
</tr>
<tr>
<td>4227 Scrotoplasty, plastic operation on scrotum</td>
<td>By Report</td>
</tr>
<tr>
<td>4221 Skin lesion, scrotum, local excision</td>
<td>38.55</td>
</tr>
<tr>
<td>4229 Unlisted or Unusually Complicated</td>
<td>By Report</td>
</tr>
</tbody>
</table>

### Vas Deferens

<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>4241 Vasectomy, partial or complete, unilateral or bilateral (independent procedure)</td>
<td>187.25</td>
</tr>
<tr>
<td>4251 Vasovasostomy (anastomosis) unilateral</td>
<td>272.85</td>
</tr>
<tr>
<td>4252 Vasovasostomy (anastomosis) bilateral</td>
<td>682.20</td>
</tr>
<tr>
<td>4259 Unlisted or Unusually Complicated</td>
<td>By Report</td>
</tr>
</tbody>
</table>

### Spermatic Cord

<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>4271 Hydrocele of spermatic cord, excision, unilateral (independent procedure)</td>
<td>243.80</td>
</tr>
<tr>
<td>4275 Varicocele, excision, unilateral (independent procedure)</td>
<td>260.40</td>
</tr>
<tr>
<td>4278 Varicocele, excision, unilateral (independent procedure) with hernia repair and/or hydrocele and/or varicocele excision</td>
<td>273.00</td>
</tr>
<tr>
<td>4279 Unlisted or Unusually Complicated</td>
<td>By Report</td>
</tr>
</tbody>
</table>

### Seminal Vesicles

<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>4291 Vesiculectomy</td>
<td>By Report</td>
</tr>
<tr>
<td>4281 Vesiculotomy, unilateral</td>
<td>By Report</td>
</tr>
<tr>
<td>4299 Unlisted or Unusually Complicated</td>
<td>By Report</td>
</tr>
</tbody>
</table>

### Prostate

<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>4305* Biopsy prostate, needle without cystoscopy</td>
<td>102.00</td>
</tr>
<tr>
<td>4301 Abscess, prostatic, external drainage, prostatotomy</td>
<td>160.45</td>
</tr>
<tr>
<td>4307 Biopsy, incisional, perineal approach (independent procedure)</td>
<td>319.50</td>
</tr>
<tr>
<td>4308 Biopsy, transrectal</td>
<td>289.45</td>
</tr>
<tr>
<td>4310 Prostate Cryosurgery</td>
<td>1,250.00</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>4421*</td>
<td>Biopsy</td>
<td>35.20</td>
</tr>
<tr>
<td>4430*</td>
<td>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</td>
<td>65.40</td>
</tr>
<tr>
<td>4432*</td>
<td>of ten (10) or more warts over an area of more than 25% of the vulvar area</td>
<td>118.85</td>
</tr>
<tr>
<td>4427</td>
<td>Extensive removal under general anesthesia. Extensive condylomata involving massive lesions of the vulva, the perineum, the vagina and anus</td>
<td>134.00</td>
</tr>
<tr>
<td>4434*</td>
<td>Carcinoma in situ or dysplasia, biopsy proven, excision or destruction by any method</td>
<td>91.70</td>
</tr>
<tr>
<td>4403*</td>
<td>Vulva, abscess, incision and drainage</td>
<td>51.95</td>
</tr>
<tr>
<td>4404</td>
<td>varicocele, excision, unilateral (independent procedure)</td>
<td>177.00</td>
</tr>
<tr>
<td>4405*</td>
<td>Bartholin’s gland, abscess, incision and drainage</td>
<td>65.00</td>
</tr>
<tr>
<td>4428</td>
<td>Clitoridectomy</td>
<td>102.35</td>
</tr>
<tr>
<td>4433</td>
<td>Cyst, Bartholin, excision or marsupialization</td>
<td>110.50</td>
</tr>
<tr>
<td>4431</td>
<td>Hymen, excision</td>
<td>103.50</td>
</tr>
<tr>
<td>4411</td>
<td>incision</td>
<td>103.50</td>
</tr>
<tr>
<td>4455</td>
<td>Injury of vulva and/or perineum, recent, non-obstetrical repair</td>
<td>By Report</td>
</tr>
<tr>
<td>4745</td>
<td>Perineal fistula, closure</td>
<td>148.50</td>
</tr>
<tr>
<td>4735</td>
<td>laceration, old, third degree, repair</td>
<td>290.00</td>
</tr>
<tr>
<td>4443</td>
<td>Prolapse of urethral mucosa, plastic repair (independent procedure)</td>
<td>By Report</td>
</tr>
<tr>
<td>4441</td>
<td>Vulva and/or perineum, plastic repair</td>
<td>By Report</td>
</tr>
<tr>
<td>4424</td>
<td>Vulvectomy, complete or partial (more than 1/3)</td>
<td>351.85</td>
</tr>
<tr>
<td>4426</td>
<td>radical, without regional node dissection</td>
<td>426.10</td>
</tr>
<tr>
<td>4425</td>
<td>including regional lymph nodes</td>
<td>705.25</td>
</tr>
</tbody>
</table>

Note: Tariff 4424 may not be claimed for multiple biopsies of the vulva. (See tariff 4421).

Unlisted or Unusually Complicated

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.
Female Genital System

4607 Laparoscopic assisted vaginal hysterectomy (LAVH) – with or without adnexa add to tariff 4631, or 4621 ............................................................... 221.85 22.750

4608 Salpingolysis e.g. Fimbrioplasty, lysis of adhesions/debridement for infertility, unilateral or bilateral ................................................................. 322.45 22.750

Note: Tariff 4608 is not to be claimed with tariffs 4551 or 4603.

4609 Laparoscopic radical hysterectomy and bilateral radical lymph node dissection .......... 1,600.00 22.750

4551 Tuboplasty (e.g. salpingostomy) for infertility, unilateral or bilateral ........................................... 410.80 21.375

Note: Tariff 4551 is not to be claimed with tariffs 4603 or 4608.

4696 The procedure(s) described above under tariff 4551 when medically necessary to operate under the operating microscope .................................................................................... 528.70 21.375

3572* Laparoscopy, diagnostic ........................................................................................................ 177.00 21.375

3574* Laparoscopy, diagnostic when followed at the same sitting by an open abdominal operation, add ................................................................................................. 172.55 21.375

3576* Laparoscopy, diagnostic, performed at the time of possible I.V.F. or G.I.F.T. procedure .................................................................................................................... 120.50 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 .................................................................................. 324.20 21.375

4811 Extrauterine pregnancy, ectopic, removal by laparotomy ...................................................... 434.70 22.750

4561 Sterilization by any method, unilateral or bilateral ...................................................................... 218.20 21.375

4562 Post partum sterilization by any method, unilateral or bilateral ................................................ 218.20 21.375

4815 Hydatidiform mole, removal by dilatation and curettage .......................................................... 116.70 20.000

Note: Repeat D & C for hydatidiform mole will be paid at the same rate.

4829 Abdominal hysterotomy (mole or previable fetus) .................................................................... 290.00 21.375

4627 Hysterectomy, radical, with pelvic lymphadenectomy .............................................................. 944.55 22.750

4621 sub-total, with or without adnexal surgery ............................................................................... 528.35 22.750

4617 total, with or without adnexal surgery ...................................................................................... 528.35 22.750

4610 Paraaortic Lymphadenectomy (Unilateral or Bilateral) .............................................................. 722.00 22.750

4620 Obesity and/or stage 3-4 endometriosis—add to hysterectomy .................................................. 108.30 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>4617</td>
<td>Tariff 4617, Selective pelvic lymph node dissection for gynaecologic cancer as an add on to</td>
<td>463.25</td>
</tr>
<tr>
<td>4618</td>
<td>Tariff 4618, Total extensive omentectomy at time of surgery, for gynaecological cancer or suspected gynaecological cancer, add</td>
<td>198.45</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Tariff 4619 may be claimed in addition to Tariff 3571.</td>
<td></td>
</tr>
<tr>
<td>4622</td>
<td>Tariff 4622, Excision of gynaecological cancer from retroperitoneal/transperitoneal space</td>
<td>753.55</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> 1) Tariff 4622 may only be claimed by gynaecology-oncologists.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2) Tariff 4617 is payable at 50% when claimed in addition to Tariff 4622.</td>
<td></td>
</tr>
<tr>
<td>4694</td>
<td>Tariff 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.</td>
<td>606.95</td>
</tr>
<tr>
<td>4695</td>
<td>Tariff 4695, The procedure(s) described above under Tariff 4694 when medically necessary to operate under the operating microscope.</td>
<td>606.95</td>
</tr>
<tr>
<td>4699</td>
<td>Tariff 4699, Unlisted or Unusually Complicated.</td>
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### Adrenal

#### Resection

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Value</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>4988</td>
<td>Adrenalectomy or biopsy, unilateral</td>
<td>902.70</td>
<td>25.500</td>
</tr>
<tr>
<td>4989</td>
<td>bilateral, one (1) stage</td>
<td>678.00</td>
<td>25.500</td>
</tr>
<tr>
<td>4990</td>
<td>bilateral, two (2) stages</td>
<td>1,380.50</td>
<td>25.500</td>
</tr>
<tr>
<td>4991</td>
<td>Unlisted or Unusually Complicated</td>
<td></td>
<td>25.500</td>
</tr>
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</table>

#### Carotid Body

#### Resection

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Value</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>4994</td>
<td>Carotid body tumor, excision</td>
<td>547.55</td>
<td>26.875</td>
</tr>
<tr>
<td>4993</td>
<td>excision with sacrifice of the carotid artery</td>
<td>684.00</td>
<td>22.750</td>
</tr>
<tr>
<td>4999</td>
<td>Unlisted or Unusually Complicated</td>
<td></td>
<td>22.750</td>
</tr>
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</table>

### Endocrine and Metabolic Testing

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>7850*</td>
<td>Cortrosyn/ACTH stimulation test</td>
<td>24.00</td>
</tr>
<tr>
<td>7851*</td>
<td>Combined PRL/TRH</td>
<td>12.00</td>
</tr>
<tr>
<td>7852*</td>
<td>GnRH stimulation test</td>
<td>62.00</td>
</tr>
<tr>
<td>7853*</td>
<td>Insulin stimulation test</td>
<td>78.90</td>
</tr>
<tr>
<td>7854*</td>
<td>Tolbutamide tolerance test</td>
<td>143.90</td>
</tr>
<tr>
<td>7855*</td>
<td>TRH test for prolactin stimulation</td>
<td>12.00</td>
</tr>
<tr>
<td>7856*</td>
<td>Water deprivation test</td>
<td>78.95</td>
</tr>
<tr>
<td>7857*</td>
<td>Triple stimulation test</td>
<td>71.95</td>
</tr>
<tr>
<td>7858*</td>
<td>Pentagastrin stimulation test</td>
<td>36.00</td>
</tr>
<tr>
<td>7859*</td>
<td>TRH/GnRH stimulation test</td>
<td>71.95</td>
</tr>
<tr>
<td>7860*</td>
<td>Glucose growth hormone suppression test</td>
<td>143.90</td>
</tr>
<tr>
<td>7861*</td>
<td>Prolonged fast: short from variant</td>
<td>143.90</td>
</tr>
<tr>
<td>7862*</td>
<td>Glucagon stimulation test</td>
<td>143.90</td>
</tr>
<tr>
<td>7863*</td>
<td>Saline infusion test for aldosteronism</td>
<td>71.95</td>
</tr>
<tr>
<td>7864*</td>
<td>Thyroxine absorption test</td>
<td>143.90</td>
</tr>
</tbody>
</table>

*Note:* The fees listed above are payable only where the service is provided at Health Sciences Centre or St. Boniface General Hospital.

~7865 Growth Hormone stimulation testing per agent tested ................................................ 50.00

*Note:* ~7865 is payable at 100% for each agent tested.

~7866 Human Chorionic Gonadotropin (HCG) stimulation testing ........................................ 50.00
PULSED OR CONTINUOUS RADIOFREQUENCY LESIONING

Lesioning of nerves arising from cervical or thoracic levels:

5800  One level, per side ........................................................................................................... 440.10

5802  Multiple levels, per side ................................................................................................... 775.00

Lesioning of nerves arising from lumbar or sacral levels:

5805  One level, per side ........................................................................................................... 332.52

5806  Multiple levels, per side ................................................................................................... 600.00

Lesioning of cranial nerves:

5807  Single or multiple levels, one side or bilateral ................................................................ 1,100.00

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 ...................................................................... 207.05

8926* Coordination, monitoring, and assistance in implantation of intrathecal drug pump ............... 178.50

8927* Refill of implanted intrathecal drug pump ........................................................................... 103.55

Note:  
1) May be claimed by physicians designated as Psychiatrists 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.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>5636</td>
<td>subsequent [within sixty (60) days of last coagulation treatment]</td>
<td>248.05</td>
</tr>
<tr>
<td>5632</td>
<td>Coagulation of retinal break(s), one (1) or more stages</td>
<td>314.05</td>
</tr>
<tr>
<td>5630</td>
<td>Coagulation of retina for tumor(s), one (1) or more stages of the same lesion</td>
<td>403.70</td>
</tr>
<tr>
<td>5633</td>
<td>with draining of subretinal fluid</td>
<td>445.00</td>
</tr>
<tr>
<td>5693</td>
<td>Photodynamic therapy for wet macular degeneration—one eye</td>
<td>357.00</td>
</tr>
<tr>
<td>5694</td>
<td>Photodynamic therapy for wet macular degeneration—second eye at same sitting, add</td>
<td>102.00</td>
</tr>
<tr>
<td>5695</td>
<td>Photodynamic therapy for choroidal neovascularization other than wet macular degeneration—one eye</td>
<td>357.00</td>
</tr>
<tr>
<td>5696</td>
<td>Photodynamic therapy for choroidal neovascularization other than wet macular degeneration—second eye at same sitting, add</td>
<td>142.15</td>
</tr>
<tr>
<td>5411</td>
<td>Enucleation or evisceration</td>
<td>555.45</td>
</tr>
<tr>
<td>5413</td>
<td>with implant</td>
<td>792.35</td>
</tr>
<tr>
<td>5414</td>
<td>secondary implant</td>
<td>576.95</td>
</tr>
<tr>
<td>5438</td>
<td>Enucleation of eye for eye bank, unilateral or bilateral</td>
<td>103.00</td>
</tr>
<tr>
<td>5431</td>
<td>Suture of eyeball for wound or injury</td>
<td>By Report</td>
</tr>
</tbody>
</table>

**Photodynamic Therapy**

*Note: Payable only for services rendered at a designated facility (Misericordia Health Centre) by a retinal specialist.*

<table>
<thead>
<tr>
<th>Code</th>
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<tr>
<td>5693</td>
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<td>Photodynamic therapy for wet macular degeneration—second eye at same sitting, add</td>
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<tr>
<td>5695</td>
<td>Photodynamic therapy for choroidal neovascularization other than wet macular degeneration—one eye</td>
<td>357.00</td>
</tr>
<tr>
<td>5696</td>
<td>Photodynamic therapy for choroidal neovascularization other than wet macular degeneration—second eye at same sitting, add</td>
<td>142.15</td>
</tr>
</tbody>
</table>

**Eyeball**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</tr>
</thead>
<tbody>
<tr>
<td>5411</td>
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<td>792.35</td>
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<tr>
<td>5414</td>
<td>secondary implant</td>
<td>576.95</td>
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<tr>
<td>5438</td>
<td>Enucleation of eye for eye bank, unilateral or bilateral</td>
<td>103.00</td>
</tr>
<tr>
<td>5431</td>
<td>Suture of eyeball for wound or injury</td>
<td>By Report</td>
</tr>
</tbody>
</table>

**Optic Nerve**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>5670</td>
<td>Optic Nerve Sheath Fenestration</td>
<td>815.00</td>
</tr>
</tbody>
</table>

**Ocular**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>5439</td>
<td>Unlisted or Unusually Complicated</td>
<td>By Report</td>
</tr>
</tbody>
</table>

April 1, 2015                    This page revised July 1, 2015
**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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>9715</td>
<td>Microscopic examination, trichomonads</td>
<td>10.70</td>
</tr>
<tr>
<td>9717</td>
<td>pinworms (Scotch Tape Method)</td>
<td>3.85</td>
</tr>
<tr>
<td>9716</td>
<td>Microscopic examination of smears and wet preparations, fungi</td>
<td>6.45</td>
</tr>
<tr>
<td>9738</td>
<td>Microscopic examination of synovial fluid under polarized light for uric acid crystals</td>
<td>5.85</td>
</tr>
</tbody>
</table>

### BIOCHEMISTRY

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>9142</td>
<td>Glucose, reflectance meter/photoelectric estimation</td>
<td>3.05</td>
</tr>
</tbody>
</table>

*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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>9374</td>
<td>Blood occult</td>
<td>4.65</td>
</tr>
</tbody>
</table>

*Note:* Tariff 9374 should only be ordered when clinically indicated.

### HEMATOLOGY

For automated procedures—See [Hematology](#)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>9312</td>
<td>White cell count</td>
<td>3.95</td>
</tr>
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</table>

*Note:* Tariff 9312 should only be ordered when clinically indicated.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>9315</td>
<td>White cell differential count and cell morphology</td>
<td>6.05</td>
</tr>
</tbody>
</table>

*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).

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
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<tbody>
<tr>
<td>9147</td>
<td>Hematocrit</td>
<td>3.35</td>
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</table>

*Note:* Tariff 9147 should only be ordered when clinically indicated.

<table>
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<th>Code</th>
<th>Description</th>
<th>Rate</th>
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<tbody>
<tr>
<td>9150</td>
<td>Hemoglobin (photoelectric)</td>
<td>3.60</td>
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<tr>
<td>9273</td>
<td>Sedimentation rate</td>
<td>3.25</td>
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</table>

*Note:* Tariff 9273 is a non-specific indicator of disease processes, its measurement should only be ordered in limited clinical situations.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
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</thead>
<tbody>
<tr>
<td>9290</td>
<td>HCG (human chorionic gonadotrophins) (pregnancy test) quantative-blood</td>
<td>7.90</td>
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### SEROLOGY

<table>
<thead>
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<th>Code</th>
<th>Description</th>
<th>Price</th>
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<tbody>
<tr>
<td>9170</td>
<td>Heterophile antibodies, slide test (monotest)</td>
<td>8.75</td>
</tr>
<tr>
<td>9721</td>
<td>Throat Swab—Rapid Antigen Detection Test</td>
<td>11.90</td>
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</tbody>
</table>

### URINE

<table>
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<th>Code</th>
<th>Description</th>
<th>Price</th>
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</thead>
<tbody>
<tr>
<td>9521</td>
<td>HCG (human chorionic gonadotropins) (pregnancy test) quantitative-urine</td>
<td>7.95</td>
</tr>
<tr>
<td>9641</td>
<td>Urinalysis, complete, including microscopic examination of centrifuged specimen</td>
<td>5.20</td>
</tr>
<tr>
<td><strong>Note:</strong></td>
<td>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.roll</td>
<td></td>
</tr>
<tr>
<td>9644</td>
<td>Urinalysis, stick, tape or tablet for sugar, protein, ketones urobilinogen, bilirubin or blood, or any other qualitative assessment not listed elsewhere</td>
<td>3.05</td>
</tr>
<tr>
<td><strong>Note:</strong></td>
<td>Tariff 9644 should only be ordered when clinically indicated.</td>
<td></td>
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<tr>
<td>9711</td>
<td>Screening test for Bacteruria, spoon or agar slide technique</td>
<td>6.70</td>
</tr>
</tbody>
</table>