In the Matter of an Arbitration

BETWEEN:

ONTARIO MEDICAL ASSOCIATION

(the "OMA")

- AND -

MINISTRY OF HEALTH

(the "MOH")

(together, "the PARTIES")

BOOK OF DOCUMENTS OF THE
ONTARIO MEDICAL ASSOCIATION
VOLUME 5 of 8

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News Release: Over 30,000 OPS Unified Members Win Largest Wage Increases since 2012!

January 23, 2024 - 10:30 am

Press Release

Bargaining News

Ontario Public Service, Ontario Public Service - Unified

Toronto, January 22, 2024 – This past weekend, the Ontario Public Service (OPS) Unified Bargaining Team met with the employer and Arbitrator Gerry Lee as part of ongoing Wage Reopener negotiations – a process that was triggered when the Ford government's Bill 124 was deemed unconstitutional.

As a result of successful mediation and arbitration, Arbitrator Gerry Lee issued an Award that includes the largest increases (9.5% across the board spread over three years) that OPS Unified has seen since 2012.

"This Award is a direct result of the unwavering solidarity of OPS Unified members who refused to back down," said OPSEU/SEFPO President JP Hornick. "Their perseverance is what moved the needle in our favour and what enabled to win the largest increases these workers have seen in nearly 12 years!"

The Award issued by Arbitrator Gerry Lee includes across the board wage increases* of:

- Year 1 – 2022 – 3%
- Year 2 – 2023 – 3.5%
- Year 3 – 2024 – 3%

(*Inclusive of the 1% already agreed upon in the signed 2022 Collective Agreement)

The arbitrator also identified several job classes with significant hiring and retention issues related to wage disparity and awarded immediate Special Wage Adjustments.

In addition to these awards, the agreement includes a new dispute resolution process to address wage disparities in other job classifications. Formalizing this new framework is significant as it creates a new mechanism for OPS Unified members in many job classes to push for the gains that they have long been fighting for.

"This government may think that their majority means they hold all the power. But this win is proof that when we build worker power and solidarity, workers have the power to fight for what they deserve. This is just the beginning. We will build on this win and take this energy to the next round of bargaining this year!" added Hornick.

These historic gains will help reverse the harmful impacts of the Ford government's unconstitutional wage restraint legislation that were felt by all OPS Unified members.

The OPS Unified Bargaining Team represents all 30,000 OPS Unified members.

TAB 109

MEMORANDUM OF AGREEMENT

("MOA")

BETWEEN:

The Crown in Right of Ontario
(as represented by Treasury Board Secretariat)
"Employer"

AND

Ontario Public Service Employees Union/Syndicat des employés de la fonction publique de l'Ontario
"OPSEU/SEFPO"
On behalf of the
OPS Unified Bargaining Unit

Herein after referred to as the "Parties"

WHEREAS during the recent round of collective bargaining, OPSEU/SEFPO Unified identified several classifications in the Unified bargaining unit that in their view warranted exceptional consideration in the form of special wage adjustments;

AND WHEREAS an award was issued by Arbitrator Gerry Lee on January 21, 2024 which, among other things, awarded special wage adjustments to certain classifications in certain ministries in the Unified bargaining unit (the "**Award**");

AND WHEREAS the Parties desire to establish a process to engage in further discussions on special wage adjustments for the outstanding classifications proposed by OPSEU/SEFPO that were not addressed in the Award;

AND WHEREAS the Parties have settled in a full and final way any and all issues and claims as it pertains to the OPS Unified Bargaining Unit arising from the OPSEU/SEFPO application in Court File No CV-20-00638156-0000 (the "**Application**");

NOW THEREFORE, the Parties agree to the following on a without prejudice and without precedent basis, including in respect of any matter relating to or arising from the Application:

1. The process to address the outstanding classifications for which OPSEU/SEFPO seeks special wage adjustments is set out below in three (3) phases:

    a) Phase 1 – The Parties will establish a joint committee, with equal representation from both the Employer and OPSEU/SEFPO, within sixty

(60) days from the date of signing of this MOA. This will be considered a duty assignment, including caucus time as necessary.

b) The Parties will meet and review the outstanding classifications proposed by OPSEU/SEFPO during the most recent round of collective bargaining or such additional classifications agreed to by the Parties.

OPSEU/SEFPO will make a written submission for review and consideration by the committee. The committee will review such submissions using the following criteria: (1) retention and recruitment issues related to compensation; (2) a comparison between the employees and other comparable employees in the public sector if there are no comparators within the public sector, other comparators can be used; and (3) the economic situation in Ontario.

The Employer will issue its response to OPSEU/SEFPO submissions in writing. Should OPSEU/SEFPO disagree with the Employer's response and/or the Parties reach an impasse at the committee level on any of the classifications, either OPSEU/SEFPO or the Employer may refer the matter to Phase 2.

c) Phase 2 – The Parties will agree to jointly appoint and share the cost of a third-party mediator to assist them in facilitating a final outcome. The mediator shall issue a report of non-binding recommendations to the Parties. If the Parties are unable to reach a final outcome at Phase 2, either OPSEU/SEFPO or the Employer may refer the matter to Phase 3.

d) Phase 3 – The Parties will agree to jointly appoint and share the cost of an arbitrator. The Parties agree to prepare and deliver concise written interest arbitration submissions within the criteria noted in paragraph 1 (a) and the arbitrator will issue a binding interest arbitration award. If the parties are not able to agree to an Arbitrator, then Arbitrator Gerry Lee will appoint an Arbitrator.

2. The Parties agree that Phases 1-3 will be completed by December 31, 2024 or an alternate date as agreed to by the Parties.

3. The Parties agree that this signed MOA constitutes the entire agreement between the Parties with respect to the subject matter herein and supersedes any and all prior oral or written agreements, arrangements or understandings between them.

4. The Parties agree that Arbitrator Gerry Lee shall remain seized with the interpretation and administration of this Memorandum of Agreement.

5. The Parties agree that this MOA will be executed electronically and in counterpart.

Dated at Toronto this 21st day of January 2024.

For OPSEU/SEFPO:

DocuSigned by:
Coleen Houlder
87C28930E1B34E4...

Coleen Houlder (Chair)

DocuSigned by:
Amanda Usher
351BCC8D0C2B4BD...

Amanda Usher (Vice-Chair)

DocuSigned by:
D28BD62B391B478...

Michele Morrison

DocuSigned by:
Grace Grieve
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Grace Grieve

DocuSigned by:
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Chris Eckert

For the Employer:

DocuSigned by:
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Steven MacKay

DocuSigned by:
Minerva Papasin
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Minerva Papasin

DocuSigned by:
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Shenouka Dissanyake

DocuSigned by:
Lisa Rawlings
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Lisa Rawlings

DocuSigned by:
Leslie Aiston
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Leslie Aiston

DocuSigned by:
chris draxl
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Chris Draxl

DocuSigned by:
Daryl O'Grady
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Daryl O'Grady

DocuSigned by:
Joe Labaki
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Joe Labaki

DocuSigned by:
Holly Sullivan
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Holly Sullivan

DocuSigned by:
Shawn Burr
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Shawn Burr

DocuSigned by:
Kevin Sprague
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Kevin Sprague

DocuSigned by:
Len Elliott
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Len Elliott

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Glenna Caldwell
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Glenna Caldwell

TAB 110

March 10th, 2023

OPG Memorandum of Settlement - Summary

This round of Collective Bargaining was marked with a number of significant issues. The impending closure of Pickering with the loss of a substantial number of jobs and the subsequent announcement in September regarding its possible refurbishment, Bill 124, which imposed limits to wage increases, the Superior Court Decision rendering the Bill null and void and the government's insistence to OPG that a 1% per year wage increase was a hard cap on wages. The Bargaining Committee persevered over the course of the past year. With the support of the membership who gave the Committee an overwhelming Strike Mandate in early February, we were able to convince OPG and the government that a 1% wage increase was unacceptable, a negotiated agreement was possible and that the issues at bargaining could be resolved.

The 1% wage increase from the one (1) year collective agreement rollover for 2021 remains subject of the government's appeal of the Bill 124 decision making the Bill "null and void". The Superior Court Decision has left the issue of remedy (including the imposed wage increase) open. If the government's appeal is unsuccessful, the Superior Court Justice will hear arguments from the parties and rule on any payments or wage increases associated with his previous decision, including the one (1) year rollover.

The Memorandum of Settlement (MOS) dated March 3, 2023, is unanimously endorsed by your Bargaining Committee and the Chief Stewards with two Chief Stewards abstaining.

The MOS contains **no concessions** and a number of improvements, including the following highlights:

- An 8.25% wage increase over 2 years.
- A payment of $5,000 to active Regular and Term employees.
- Employment security for Regular employees through the end of the Pickering transition, expected to be in 2029.
- A voluntary separation package for eligible members in both nuclear and non-nuclear memberships through the Pickering Transition Agreement.
- Renewal of the Nuclear Staffing Agreement and the Corporate Staffing Agreement with a minimum of one hundred and twenty (120) Terms being converted to Regular positions.
- A bonus payment for all nuclear members, including Appendix A members, who volunteer to work an XYZ Shift Schedule for outages.
- Increases in vacation and training allowances for Term employees.
- Re-opener language for the Nuclear Staffing Agreement and the Corporate Staffing Agreement should the Pickering Refurbishment be announced.

A Member Bulletin will be sent out early next week with details of the ratification process. A detailed summary can be found on the following pages.

Andrew Clunis
Vice President – Sector 1
Power Workers' Union

Mike Hambly
Vice President – Sector 2
Power Workers' Union

The MOS contains a number of improvements and no concessions. The agreement is for a duration of 2 years, from April 1, 2022 to March 31, 2024.

Effective April 1, 2022 a wage increase of 4.75% will be made, including full retroactive pay. Effective April 1, 2023 a second wage increase of 3.50% will be added, for a total of **8.25% over 2 years** of the Collective Agreement.

On the date of ratification all active Regular and Term employees will receive a payment of **$2,500**. A second payment of **$2,500** will be paid to all active Regular and Term employees on April 1, 2023.

A new roster of Deputy Arbitrators including John Murray, Pauline Pasieka and Eli Gedalof is appointed to assist the Chief Arbitrator, John Stout. The addition of a roster will allow for better scheduling of mediations and arbitrations.

Nuclear Training Technicians will receive 10% above their wage rate to align with Non-nuclear Training Technicians.

New employees with a relevant red seal or certificate of qualification will be placed at Step 5 of the appropriate band when hired.

Articles 11, 13 and 14 will remain suspended until the end of the Pickering Transition Agreement which is expected to be in 2029. Employment security for Regular Employees is extended until the end of the Pickering Transition Agreement which is expected to be in 2029, subject to Pickering Transition Agreement thresholds.

The extension of a 250 hour below threshold PSAs until the end of the Pickering Transition Agreement which is expected to be in 2029.

Clean-up of the Pregnancy/Parental Leave provisions to coincide with recent legislative changes.
Minor Health Benefit improvements to:

- Chiropractic – Increase from $775 to $900 each year (effective April 1, 2023)
- Vision Care – Increase from $600 to $650 each two year period
- Physiotherapy – Increase from $2000 to $2,500 each year (effective April 1, 2023)
- Add coverage for services of a Registered Social Worker
- Include viscosupplementation injections for the treatment of osteoarthritis
- Add additional coverage at the special group rate for out of country coverage those retirees over 74 and up to 85 years of age without changing OPG's funding obligation.
- Continue out of country travel insurance to regular PWU employees

Equity Principles have been added to the Terms of Reference for the Joint Employment Equity/Diversity Committee.

An increase in the boot allowance for Regular Employees required to wear CSA approved footwear from $300 to $350 each year.

An increase in the "shift differential" payments of $0.10 in each year of the collective agreement.
An increase in meal allowances for all sections of the collective agreement from $15 to $20 when the employee chooses to accept the meal allowance instead of the actual cost of a meal.

New Personnel Development Training requests by employees will require pre-approval prior to enrolment in the training.

During shift changes details of time balance changes are to be provided within seven (7) days of the commencement of the shift change period instead of prior to the shift change.

Under Part C Emergency Overtime, the minimum payment is increased from three (3) to four (4) hours at premium rates.

For Appendix A employees;

- New "stand off" language to allow for short durations when work is delayed will mean fewer layoffs.
- An increase in boot allowance from $150 to $200 for the life of the collective agreement.
- The addition of Eli Gedalof to the roster of Arbitrators.

The parties also agreed to extend the Alternative to Article 11 Mid-Term agreement to March 31, 2024, extend Out of Country coverage to March 31, 2024, renew existing mid-term agreements and to meet and discuss how to allow for two (2) days of religious observance leave changes that would not result in a cost increase to the company.

MID-TERM AGREEMENT GEN-PWU-1009 – CORPORATE STAFFING AGREEMENT

The Corporate Staffing Agreement has been extended to the completion of the Pickering Safe Storage Project with improvements for Term employees, protection from displacement of any non-nuclear employee as a result of the Pickering Transition agreement and language that converts some Term employees to Regular positions. Changes include:

- Ten (10) paid vacation days and ten (10) unpaid vacation days for Term employees who have completed 48 months of continuous service. Term employees with less than forty-eight (48) months continuous service will be eligible for twenty (20) days of unpaid vacation.
- Terms will have the right to apply to Regular nuclear supervisory positions and will be considered after PWU represented Regular members.
- Terms moving into a Regular position in the classification they previously occupied will be placed at the closest equivalent band and step they held in the previous position. Terms selected to Regular classifications different from their previous classification will be placed on the Band at Step 4. Term Operator Trainees will be assessed according to experience and qualifications and placed on the Apprentices/Trainees/Operator Trainee Band.
- Clean up of Term approval and referral process language.
- Training allowance of up to $10,000 for external training opportunities outside of work hours to Term employees who continue their employment at OPG until the safe shutdown and storage of PNGS.
- Language to facilitate the movement of surplus Nuclear members into Non-nuclear jobs in conjunction with the Pickering Transition Agreement with **no displacement of non-nuclear employees.**
- A Voluntary Separation Package (VSP) of up to one hundred and twenty (120) weeks for members in conjunction with the transition of Pickering.
- A minimum of one hundred (100) non-nuclear members will be eligible to receive the voluntary separation package.
- Non-nuclear employees will have priority to non-nuclear vacancies prior to surplus nuclear employees from the Pickering Transition Agreement.
- Language that confirms that in the event of an announcement extending the life of any unit beyond December 31, 2026, (including through refurbishment) the parties will meet to discuss any necessary changed to the CSA.
- Conversion to Regular status of:
    - Term employees who achieve their 10 year milestone.

MID-TERM AGREEMENT NUC-PWU-1009 - NUCLEAR STAFFING AGREEMENT

The Nuclear Staffing Agreement has been extended to the completion of the Pickering Safe Storage Project with improvements for Term employees and language that converts some Term employees to Regular positions. Changes include:

- Ten (10) paid vacation days and ten (10) unpaid vacation days for Term employees who have completed 48 months of continuous service. Term employees with less than forty-eight (48) months continuous service will be eligible for twenty (20) days of unpaid vacation.
- Terms will have the right to apply to Regular nuclear supervisory positions and will be considered after PWU represented Regular members.
- Terms moving into a Regular position in the classification they previously occupied will be placed at the closest equivalent band and step they held in the previous position. Terms selected to Regular classifications different from their previous classification will be placed on the Band at Step 4. Term Trainees will be assessed according to experience and qualifications and placed on the Apprentices/Trainees/Operator Trainee Band.
- Clean up of Term approval and referral process language.
- Training allowance of up to $10,000 for external training opportunities outside of work hours to Term employees who continue their employment at OPG until the safe shutdown and storage of PNGS.
- Conversion to Regular status of:
    - Term employees who achieve their 10 year milestone.
    - A minimum of forty (40) Term employees per year for a total of one hundred and twenty (120).
    - In the event of an announcement to proceed with the refurbishment of Pickering, a needs assessment will be done to determine the number of Terms required and hired as Regular employees within 90 days.
    - Where Term employees' release to a non-nuclear position is delayed, the employee will convert to Regular status and OPG will offer up to eighty (80) Term employees the choice to "convert in place" and remain in their current nuclear classification at Pickering or Darlington and fill the non-nuclear position externally.
- Language that confirms that in the event of an announcement extending the life of any unit beyond December 31, 2026, (including through refurbishment) the parties will meet to discuss any necessary changed to the NSA, including the immediate hire of the one hundred and twenty (120) Terms above.

LETTER OF UNDERSTANDING REGARDING PICKERING ANO RETENTION

Negotiated with the assistance of the ANO Committee, the Letter of Understanding (LOU) provides wage protection to Authorized Nuclear Operators (ANO) that may be affected by the closure of Pickering and ensures Pickering will remain open and operating.

ANO's who are no longer required to maintain their CNSC Certification will maintain their rate of pay, including their Retention of Certification bonus for three (3) years after which the Retention Certification bonus will be reduced by one third (1/3) each year until no bonus is paid.

LETTER OF UNDERSTANDING REGARDING THE XYZ OUTAGE SCHEDULE

When using the XYZ Outage Shift at nuclear sites, OPG will use volunteers and offer a $1,250 per week bonus to a maximum of $9,000 to Regular, Term and Appendix A employees who volunteer.

LETTER OF INTENT REGARDING PSA DISPUTES AT PICKERING

The parties agreed to a pilot dispute resolution process for disputes associated with Pickering PSAs. The pilot process will provide for more timely resolution to PSA issues. It will use Arbitrator/Mediator Jules Bloch following an expedited mediation/arbitration process, without legal counsel and utilizing simplified briefs.

LETTER OF UNDERSTANDING REGARDING SMALL MODULAR REACTORS

The LOU maintains the PWU jurisdiction over all work at the new Small Modular Reactor (SMR) being constructed at the Darlington site.

New classifications have been developed with selection language. Postings will be made following Article 10 of the Collective Agreement. Employees selected to the SMR position will not be eligible to take part in the Pickering Transition Agreement process and will not be subject to layoff or transfer resulting from the Pickering Transition Agreement. Members selected to the SMR position will not be able to post out of the position for three (3) years without management agreement.

There shall be no displacements, deployments or any other movement to SMRs under Article 11 or otherwise. One (1) year following the date the SMR enters commercial operation Article 11 will apply across nuclear.

A PSA for certain work has been agreed to with a Standing Committee created to review the use of contractors.

The LOU can be reopened after OPG has completed four SMRs at Darlington or if a decision is made not to construct and operate four SMRs at Darlington.

PICKERING TRANSITION AGREEMENT

The Pickering Transition Agreement sets out the principles and steps of the Modified Alternative to Article 11 process for employees who will be adversely affected as a result of the PNGS transition. The Pickering Transition Agreement provides a detailed process for the safe shutdown and storage of Pickering and includes:

- Reopener language should the life of any unit at Pickering beyond December 2026 be announced.
- Employment security for all Regular members to the end of the Pickering Transition Agreement which is expected to be 2029.
- Voluntary terminations with separation entitlements for eligible Regular members of up to one hundred and twenty (120) weeks pay.
- Redeployment of surplus Regular employees within Nuclear Job Classifications with wage maintenance.
- Redeployment of surplus Regular Nuclear Employees to Nuclear Job Classification Potential Openings with wage maintenance.
- A process for the transition of Term employees to Regular positions.
- Redeployment of surplus Nuclear Employees to Non-Nuclear Job Classification Potential Openings.
- A four (4) crew Safe Storage Outage Schedule with a bonus of $400 per week to a maximum of $6,400.
- Agreement to meet and discuss a four (4) crew balanced shift schedule to support continued station operations at Pickering with an expedited arbitration process should agreement not be reached.

A Member Bulletin will be sent out early next week with details of the ratification process.

TAB 111

https://www.thestar.com/politics/provincial/ontario-power-workers-get-retroactive-raises-in-2-year-contract-deal/article_cd1397d8-20f6-5388-b8b8-6a375fe90bd1.html

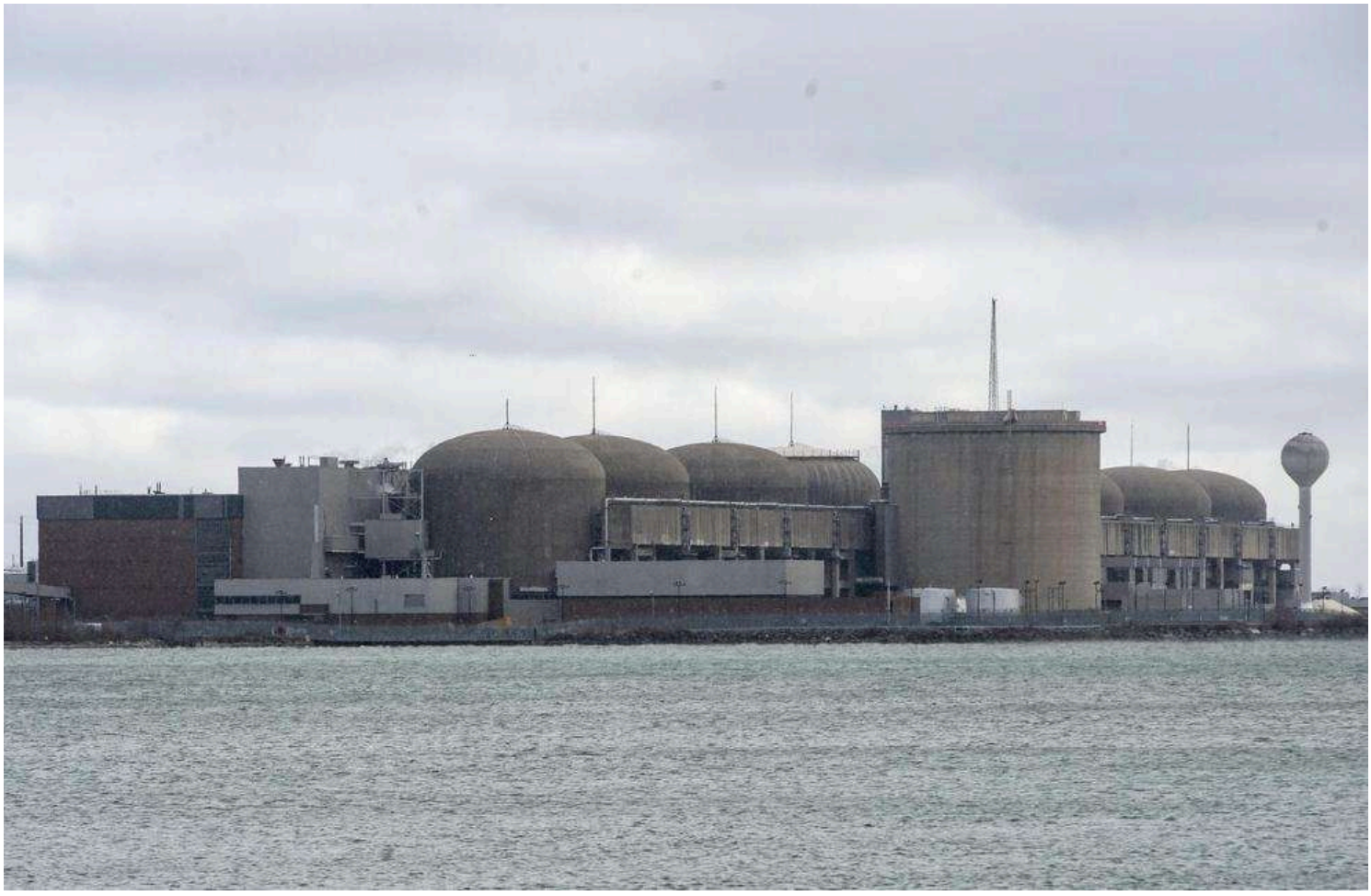
PROVINCIAL POLITICS

Ontario power workers get retroactive raises in 2-year contract deal

About 5,000 members of the Power Workers' Union, who run Ontario Power Generation facilities across the province, have ratified a two-year deal retroactive to April 1, 2022.

By **Robert Benzie Queen's Park Bureau Chief**

May 3, 2023



The Pickering nuclear generating station is seen on Jan. 12, 2020.
Frank Gunn / THE CANADIAN PRESS FILE PHOTO

Unionized workers who keep the lights on in Ontario have been given a jolt in pay.

About 5,000 members of the Power Workers' Union, who run Ontario Power Generation nuclear, hydro and thermal facilities across the province, have ratified a two-year deal retroactive to April 1, 2022.

Under the agreement, the workers — who had been without a contract for more than a year — will receive a 4.75 per cent increase for the first year and 3.5 per cent for the second, plus signing bonuses totalling $5,000.

That's a more lucrative payout than in other recent Ontario public service labour settlements, and far exceeds the one per cent wage cap that was in place under the controversial Bill 124.

The 2019 law, which limited wage increases for nurses and other public servants to one per cent annually for three years, was struck down as unconstitutional in an Ontario Superior Court of Justice ruling five months ago.

Premier Doug Ford's Progressive Conservatives are challenging that decision.

In a statement that did not address the amounts in the Power Workers' deal, Energy Minister Todd Smith said he was "pleased" by the accord.

"The women and men of the PWU play a key role in building Ontario's clean energy future," said Smith.

"I look forward to continued collaboration as we build the generation we need to power our growing population and economy, including Canada's first grid-scale small modular nuclear reactor," he said.

PWU spokesman John Ives would not comment on the terms of the accord, saying only that union members had ratified it.

Ontario Power Generation spokesman Neal Kelly said the collective agreement "brings value and certainty to employees and meets OPG's operational needs."

"The agreement is a fair and reasonable outcome for employees as we lead the clean energy transition through safe, reliable, affordable power generation," said Kelly.

The contract, which expires next March 31, includes provisions for employees of the Pickering nuclear generating station, which OPG has said will stop producing electricity in September 2026.

A transition agreement "would provide job security for regular employees through any Pickering end of commercial operations downsizing and redeployment," according to a joint statement sent to employees by Crown utility and the union.

The statement also referred to "changes to the nuclear staffing agreement which includes conversion of a certain number of terms and potentially more based on Pickering's positive refurbishment announcement," hinting that more news is coming soon.

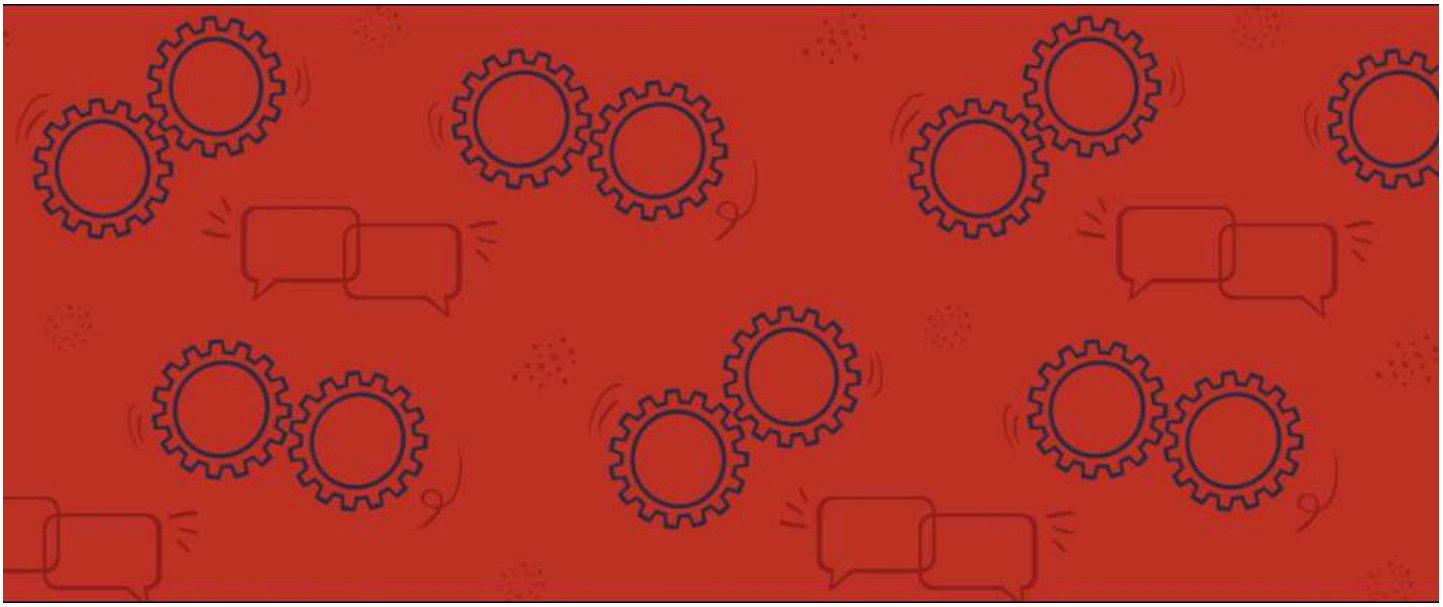
Ford's government is eager to refurbish the Pickering facility, which currently generates enough power for 1.5-million homes. Its "A" reactors are slated to close in 2024 while its "B" units would continue another two years.

While refurbishing Pickering, which dates back to 1971, would take years, OPG said it could lead to another three decades of "reliable, clean and zero-emissions electricity from the facility."

With Ontarians moving toward electric vehicles, Queen's Park is mindful that the strain on the electricity grid will only grow in the years ahead.

Robert Benzie *is the Star's Queen's Park bureau chief and a reporter covering Ontario politics. Follow him on Twitter:* **@robertbenzie**.

TAB 112



Breaking down the gains in PSAC's Treasury Board settlement

May 6, 2023

In the hours after reaching a deal with Treasury Board, we shared with PSAC members the highlights of the wage increases and remote work language that were negotiated.

As we prepare ratification kits that contain the full details of the new agreements to share with you in the coming days, we'd like to provide more details and clarification on the key improvements we secured in this round of bargaining.

Strike action improves final wage offer and other benefits

Beating the pre-strike three-year offer

It took getting a strong strike mandate and serving notice to strike for the Liberal government to finally offer a wage proposal that they had publicly supported for months, following the Public Interest Commission's recommendations, but refused to actually put on the table.

Then they refused to move from that – or move on anything else. Our national strike made all the difference. Each day of the strike built the pressure we needed to secure more gains at the table.

This was the employer's offer as the strike began compared to what we secured for those first three years they offered:

Year of the agreement	2021	2022	2023	Total compounded increase
Treasury Board offer	1.5%	4.5%	3%	9.3%
PSAC tentative agreement	1.5%	4.75%	3.5%	10.1%
Compounded gains for members	N/A	+0.3%	+0.8%	+0.8%

Securing increases for a fourth year in line with projected inflation

We moved the dial on the government's pre-strike offer, but we needed more to reach an agreement.

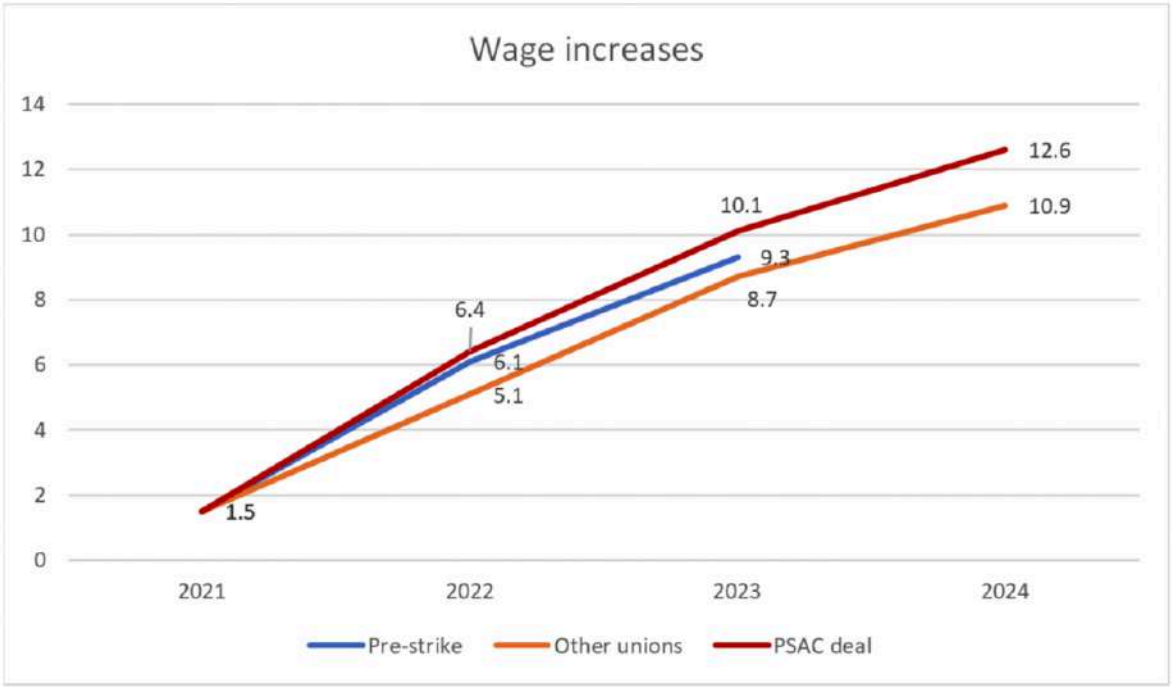
That's why we negotiated a fourth year into the agreement that meets projected inflation. The Bank of Canada projects inflation to average 2.3% in 2024, so we locked in an increase of 2.25% for that year of the agreement. This only became possible in the second week of the strike.

Year of the agreement	2021	2022	2023	2024	Total
Wage increase	1.5%	4.75%	3.5%	2.25%	**12%**
Total compounded wage increase	1.5%	6.4%	10.1%	12.6%	**12.6%**

Improving on other agreements

Member Login

We didn't just improve on the employer's overall offer through our strike, we also secured increases significantly above agreements already signed by other federal public service unions over that same period:



A $2,500 pensionable lump sum payment averaging 3.7% of salary

As part of their pre-strike offer, the government also tabled a non-pensionable lump sum payment of $500. After we began our strike action, we secured a $2500 lump sum – and made it fully pensionable.

For an average member making $67,305 a year, it represents 3.7% of salary, and a lot more for the thousands who make less than that.

This lump sum payment will be applicable to all members of the bargaining unit employed at the time of signing the agreement. For the 15% of PSAC members nearing retirement, the pensionable lump sum payment will contribute to their average salary for their best five years of service and increase their overall pension payments in retirement by $500 per year.

It could be worth over $10,000 in increased pension payments depending on how many years a worker collects their pension.

The dollars add up – $23,000 more on average in your pocket

For PSAC members in the TC, SV, EB, and PA groups, a 12.6% wage increase would add on average of $8,473 to your base salary by 2024.

If you add up the yearly salary increases, along with the $2,500 lump-sum payment, **the average PSAC member will receive an additional $23,000 over the life of the agreement based on an average Treasury Board member's salary of $67,305.**

	2020	**2021**	**2022**	**2022***	**2023**	**2023****	**2024**	**2024*****
Individual wage Increase	N/A	1.5%	3.5%	1.25%	3%	0.5%	2%	0.25%
Cumulative wage increase (compounded)	N/A	1.5%	5.1%	6.4%	9.6%	10.1%	12.3%	12.6%
Average increase ($)	N/A	$1,010	$3,401	$4,284	$6,432	$6,801	$8,283	$8,473
Average Salary	$67,305	$68,315	$70,706	$71,589	$73,737	$74,106	$75,588	$75,777

** The 4.75% increase in 2022 is made up of a 3.5% general economic increase as well as an additional 1.25% wage adjustment that compounds the economic increase.*
*** The 3.5% increase in 2023 is made up of a 3% general economic increase as well as an additional 0.50% wage adjustment that compounds the economic increase.*
**** The 2.25% increase in 2024 is made up of a 2% general economic increase as well as an additional 0.25% wage adjustment that compounds the economic increase.*

Additional wage increases and benefits for specific bargaining tables

Prior to taking strike action, the government adamantly refused to budge on any of the other improvements and benefits we had tabled. By the end of the strike, at each of the TC, EB, SV, and PA tables, PSAC won wage adjustments for specific jobs that have fallen significantly below their counterparts in other sectors. We also negotiated better leave provisions and increases to allowances.

None of these gains would have been possible without taking strike action and pressuring the government to deliver better.

You can read more about the table-specific gains here:

- PA group – Program and Administrative Services
- EB group – Education and Library Science
- TC group – Technical Services
- SV group – Operational Services

Strongest remote work protections in the federal public service

Prior to taking strike action, we had not made any gains on remote work as the government dug in on their position. But that all changed by the end of the strike. Our goal was to get the improvements we secured directly into the collective agreement. Instead, as part of the give and take of every round of bargaining, we agreed to have those improvements implemented as part of a letter of agreement that sets us up to win the full victory in our next contract.

PSAC members will now be protected from arbitrary decisions about remote work. We have negotiated language that requires managers to assess remote work requests individually, not by group, and provide written responses that will allow members and PSAC to hold the employer accountable to equitable and fair decision-making. Having all remote work requests reviewed on an individual basis will prevent future "one size fits all" type mandates like the government announced in December last year.

That means employee rights around remote work arrangements will be protected through a grievance process, and grievances that are not settled prior to the final step of the grievance process can be referred to a new joint union-management panel for review in each department to address issues related to the employer's application of the remote work directive in the workplace.

PSAC and Treasury Board have also agreed to create a joint committee to review and update the outdated telework policy.

Once the agreement is ratified, PSAC members can begin to challenge decisions on their remote work arrangements based on the new language negotiated, and the union can begin working with the employer to review the overall policy.

Big gains by using our collective bargaining power and strike action

PSAC secured the strongest collective agreement in the federal public service that raises the bar for our members and all workers in Canada.

Because over 100,000 PSAC members came together on the picket lines to demand better, you secured:

- A better first three-year wage offer
- A fourth year with full inflationary increases
- A $2500 pensionable lump sum payment
- Wage adjustments, along with better leave provisions and increased allowances
- The strongest remote work protections in the federal public service
- Protections against contracting out
- Safer and more inclusive workplaces
- Seniority protections

TAB 113

EC Group – Tentative Agreement

Article	Current collective agreement	What you would get under this new tentative agreement
Appendix A: Rates of pay and duration	Last increase in June 2021 (1.5%) The Employer began this round of bargaining by offering an average 1.65% per year over 4 years.	General offer: 12.5% over 4 years (13.14% compounded) Year 1 – Increase to rates of pay: 3.50% Year 1 – Wage adjustment: 1.25% Year 2 – Increase to rates of pay: 3.00% + 0.5% pay line adjustment Year 3 – Increase to rates of pay: 2.00% Year 3 – Wage adjustment: 0.25% Year 4 – Increase to rates of pay: 2% Pensionable one-time lump sum: $2,500
New: Letter of agreement (LoA) on telework		The LoA will provide for the creation of departmental panels, made up of department management and CAPE, who will review employee grievances on telework decisions. A joint consultation committee will be established and review the Directive on Telework as it applies across the federal public service. This committee will meet within 90 days of the signing of the collective agreement.
New: Letter of agreement regarding work-related communication outside of scheduled hours of work (Right to disconnect practices)		The Employer will consult the Association after changes to the *Canada Labour Code* come into force and will collaboratively develop a new policy instrument.

Article 17: No sexual harassment	Complainants and respondents must request official copy of the investigation report.	The Employer will provide the investigation report.
Article 19: Leave, general **And** **Article 24: Vacation leave**	19.07. Granted leave cannot be offered again if received in other Bargaining unit/collective agreement to which the Employer is a party or under other Employer's regulations. 24.02. Increment of vacation leave to 4 weeks vacation after 8 years of service. 24.02 Recognition of years of service outside the public service limited to LoP and OPBO. 24.16 Employee may receive a one-time entitlement (leave) of 37.5h.	19. 07 The Employer's regulations are opened to schedule I, IV and V of the *Financial Administration Act.* 24.02. CAPE received an earlier increment: 4 weeks after 7 years of service. 24.02. The recognition of years of service is extended to new CAPE members who have transferred in from Parliament and related Employers. CAPE also confirmed that Schedule I, IV, V of the *Financial Administration Act* is included in this provision. 24.16. Employee will be credited to the one-time entitlement only once during their career in the public service as specified in the new article 24.02.
Article 20: Designated paid holidays		National Day of Truth and Reconciliation will be recognized in this new deal. Consequently, part-time employees' payment will be increased from 4.25% to 4.6% in appendix B.
21.02: Bereavement leave with pay	21.02d. 1 day of bereavement leave related to the death of brother-in-law or sister-in-law, and grandparents of spouse.	Death of aunt or uncle added.
21.13: Leave with pay for family-related	21.13 The Employer may grant leave with pay under the circumstances enumerated in this article (e.g: take family member for medical appointment, to attend school function, etc.)	21.13 Visit to a family member, who is nearing the end of their life, would be added to the circumstance in which the employee can have a paid FRR. (Article 21.23.c.i)

responsibilities (FRR)	21.13.c. viii. 7.5h of leave of the 37.5h will be used to attend an appointment with a legal representative for non-employment-related matters.	21.13 Increase to 15h instead of 7.5h
Article 28: Hours of work **And** **Appendix C: Variable hours of work**	Employees had the opportunity to complete their weekly hours of employment in a period other than 5 full days, as long as they work 37.5h per week. Employees may receive a meal allowance ($12) for overtime more than 3h before or after their scheduled work hours.	In this new deal, upon request of employees, they may choose a more flexible/variable schedule as established in Appendix C, provided that it won't result in any additional payment by reason only of this variation. Employees who have obtained authorization to work at their residence won't receive the allowance.
Article 33: Shift and weekend premiums	Employees working on shifts receive a shift premium of $2 per hour.	The shift premium will increase to $2.25.
Article 35: Discipline	Under your collective agreement, when employees are required to attend a meeting, they will receive a written notice 1 day prior.	Notice period increases from 1 to 2 working days.
New article: Leave for traditional Indigenous practices	There is no recognition of Indigenous practices in the collective agreement.	In this new deal, employee who self-declare as Indigenous person will be granted 15h of leave with pay and 22.5h leave without pay per fiscal year.

Appendix D: Penological factor allowance	Employees working in Correctional Service Canada may receive an allowance of maximum of $2,000 and a minimum of $600.	The allowance has increased, and employees will receive a single amount of $2,140 (no max and min).
Appendix J: MOU with respect to implementation of the collective agreement	The implementation of the collective agreement will be completed in 180 days and for compensation that requires manual processing, the implementation will be completed within 560 days after signature. For late payment, employees may receive $50 after 181 days, and will be entitled to receive an additional $50 for every subsequent period of 90 days.	The implementation will be completed in 180 days and manual processing in 460 days. If late payment (more than 180 days), will receive a lump sum $200 if amount owed is greater than $500.
New Appendix: MOU on maternity and parental leave		In order to coordinate benefits with the new Québec legislation and to discuss other ways to make the extended leave more flexible, a joint consultation will commence. If agreement is made, the party may re-open the collective agreement.
New Appendix on Pay simplification solutions		Given the ongoing implementation of the pay system, a joint consultation will review pay administration to find targeted solutions. Parties may re-open the collective agreement should a revision be necessary.
New appendix on gender-inclusive language		A joint-consultation will be established to review the collective agreement and render the language more gender-inclusive.

- **Other facts about this tentative agreement:**
    - The Employer agrees to discuss the possibility of implementing a general definition of family with specificities under other leave provisions. We saw a discrepancy of family definition under different leave and would want to standardize the language.

- The Employer commits to not propose the elimination or the reduction of the existing bilingualism bonus set forth in the current National Joint Council (NJC) Bilingual Bonus Directive during the life of this collective agreement.
- Editorial changes:
  - Definition of the Employer in article 2, change to “his” Majesty.
- Appendix K is deleted as the new policy covering harassment and violence took its place.

TAB 114

IT Tentative Agreement Update

News

Stewards

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Upcoming Events

Executive

Bargaining Team

To all proud IT Group members,

A tentative agreement has been signed and will be presented to the members once the translation is available. In the coming weeks, we will be sending all members a ratification kit and will be scheduling information sessions. Following these, we will be opening the voting period online. We aim to have sent the ratification kits by early to mid November, and will aim to host information sessions throughout November and into early december. The voting period should be completed by mid to late December. More details with exact dates will be communicated to members as they are scheduled.

Ratification of this new collective agreement is in the hands of the IT Group members. If members vote for this tentative agreement, the collective agreement will be ratified. If members vote against this agreement, the Group will present a case in front of an arbitrator in the coming months, who will make a binding decision.

Over the past months of meetings with the Treasury Board (TB), your bargaining team has worked hard to get you the best deal possible. We have arrived at a deal that your IT Group Bargaining Team believes is the best path forward for IT Group members.

At the beginning of bargaining, I shared with you the bargaining priorities that your bargaining team extracted out of surveys, emails and numerous meetings with IT Group members. Your bargaining team has fought hard to address those priorities. This deal makes important progress on fair pay, improved training and career advancement, and supports and protects our collective agreement language against contracting out. It will put more money in the pockets of thousands of workers and will finally resolve our longstanding and unfair lack of pay parity.

will have received more than the 1.50% pay increase in 2021. This also means that IT Group members that were in the Group in 2021 will see a significant increase to their retroactive pay. A long time injustice is finally corrected for all our members, and this correction will be applied to the very first day of this collective agreement.

With almost $5 million a year of new money for a dedicated Training and Development Fund, IT Group workers will have better access to the professional training they deserve. This will support career advancement and help reduce contracting out in a time of rapid technological change.

For years PIPSC has been leading the way on the fight against contracting out – with our IT Group members leading the way. This deal preserves language in the collective agreement against contracting out, despite the government's efforts to remove these protections.

While the government is finally taking action to crack down on wasteful contracting out, make no mistake, we'll keep up the pressure until we get the job done.

Detailed information, which will include the full text of the tentative agreement, will be provided in the upcoming weeks once it has been fully translated. In the meantime, here is a brief summary of improvements according to your listed priorities.

Duration

This is a 4 year deal, starting December 22, 2021, and ending December 21, 2025.

Pay

Wage Rate Increases

Date	% Increase	Total % increase	Total % increase (Compound)
December 22, 2021 - increase to rates of pay	1.50	1.50	1.50
December 22, 2021 - additional Pay Line Adjustment (parity)	1.50	3.00	3.02
December 22, 2022 - increase to rates of pay	3.50	6.50	6.63

December 22, 2023 - increases to rates of pay	3.00	10.75	11.20
December 22, 2023 - pay line adjustment	0.50	11.25	11.76
December 22, 2024 - increase to rates of pay	2.00	13.25	13.99
December 22, 2024 - wage adjustment	0.25	13.50	14.28

December 22, 2021 – Additional Pay Line Adjustment (parity) for the IT-05 level of 1.0% for a total of 2.50%, to be applied to every step.

The agreement also includes a $2500 one-time pensionable lump sum allowance that will be paid to all employees in the bargaining unit on the date of signing of the collective agreement.

Allowances

Correctional Service Specific Duty Allowance (CSSDA)

Increase the allowance by 7%, from $2,000 to $2,140

Contracting Out

At the beginning of the round, it was clear that the employer had set removing our contracting out protections from our collective agreement as their highest priority. This was reiterated throughout the bargaining process, at every meeting. It was not something that your bargaining team would entertain.

In order to reach this tentative agreement, the IT Group will put the over 3000 contracting out grievances it has filed against TB in abeyance and has agreed to withdraw them if this tentative agreement is ratified by IT members. This is without prejudice and in no way prevents us from pursuing our Contracting Out Action Plan moving forward. We will continue to review federal government IT contracts and grieve those that contravene Article 30. If the IT Group members vote against this tentative agreement and it is therefore not ratified, PIPSC will go ahead with its adjudication hearing scheduled in April on the test cases we have identified.

The IT Group and the Contracting Out Action Team have led the way in the fight against wasteful and unfair contracting out. After years of pressure, the government has finally launched a crackdown on outsourcing. With our collective agreement protections still in place, we have means at our disposal to keep the government to account. We stopped the government from taking away this

Remote Work

Attempts have been made in the past number of rounds of bargaining to get remote work language in the collective agreement to no avail due to management's steadfast refusal to even entertain a discussion around remote work. This round has seen some movement.

While the language we have obtained is still technically not in the collective agreement, it is a significant step in providing some protection against the employer making changes based on a whim.

We have secured a letter of agreement with the employer which indicates that remote work is voluntary, can be requested by the employee, and that decisions will be made on a case-by-case basis. Should a remote work request be refused, the refusal must be provided in writing.

In addition, whereas previously the decision of the employer was final, with no recourse, the letter also establishes a separate grievance process that includes a joint employer/PIPSC panel which will review grievances that have reached the final step of this process.

Finally, management has agreed to establish a Joint consultation committee for the review of the Employer's Return to Office Directive, Co-Chaired with equal representation. This committee will meet within 90 days of signing and complete work within one year.

Training and Development Fund

The new IT community Training and Development Fund is a jointly managed fund that allocates an additional four million seven hundred and twenty five thousand dollars ($4,725,000) worth of training annually dedicated exclusively to IT Group members. With this newly introduced fund, members now have access to additional resources to continue their professional training and development.

Work-life Balance

Our goal in this area was to improve your work-life balance through improvement in areas such as flexible work hours and increased premiums for certain situations. Here are some of the improvements in this area:

- Part-Time employees
  - Article 37.05 - The premium part-time employees receive in pay for the designated holidays has been increased from 4.25% to 4.6%
    - New language to provide for an increase of 0.38% in the event an additional designated holiday is proclaimed by Parliament.

pm.

- Shift and weekend premiums
  - Shift premiums have been increased from $2.00/hour to $2.25/hour between 1600 and 0800
  - Weekend premiums have been increased from $2.00/hour to $2.25/hour

- Right to disconnect
  - The Employer will consult with the Institute after changes to the Canada Labour Code come into force and will collaboratively generate a new policy.

Leave

Time off is vitally important. It has an impact not only on our physical health but also on our mental and emotional health as well. Here are some examples of what we have achieved in this area:

- The time required to get 4 weeks of vacation leave has been reduced from 8 years to 7 years.
- The National Day of Truth and Reconciliation has been added to the list of designated holidays.
- NEW Article - Leave for Indigenous Cultural Practices - 5 days leave (2 paid, 3 unpaid) may be taken for participating in Indigenous Cultural Practices.
- Leave for Religious Observance amended to permit the use of personal leave days.

Mental Health

Since 2020, it has become exceedingly clear that mental health is vitally important in the day-to-day lives of our members. There are numerous ways that we are attempting to improve the ways in which the collective agreement will provide mental health support for our members.

- Bereavement Leave
  - Article 17.02 Expanded the language to add son-in-law and daughter-in-law to the definition of immediate family, increasing the amount of bereavement leave from 1 day to 7 calendar days;
  - Article 17.02 (b) Aunt and uncle added to those family members for which you are entitled to 1 day of bereavement leave;
  - Article 17.02 (c) Addition of 3 days of still-born bereavement leave.

- Care Leave

- Leave with pay for family-related responsibilities
  - NEW Article 17.12 (c) (vi.) - Language expanded to include visiting a family member who, due to an incurable terminal illness, is nearing the end of their life.
  - 17.12 (c) (vii.) - Increasing the number of hours which may be used under this clause for financial, legal or professional appointments to 15 hours from 7.5.

- Domestic Violence Leave
  - 17.19 (b) Expanded the language to include abuse or neglect experienced from a family member.
  - 17.19 (c) Employees are no longer required to provide written documentation under this article.

Other Improvements

In addition to the above, there are a number of other areas in which improvements have been made to the collective agreement, some of which are noted below:

- Grievances
  - Language has been added to clarify that all three steps are not mandatory

- Medical Appointments for Pregnant Employees
  - Language has been added to clarify that 3.75 hours can be used for each routine medical appointment.

- Gender Neutral Language
  - The IT Bargaining team worked with the Treasury Board to make the entire collective agreement gender neutral and is the first group within PIPSC to accomplish this.

Implementation

Appendix L – Implementation of the Collective Agreement

- Implementation is subject to ratification by the IT Group Membership and Treasury Board

- Prospective compensation increases and retroactive amounts that require manual processing will be implemented within four hundred and sixty (460) days after signature of the Collective Agreement.

In addition to the above, there are a number of other purely administrative changes which were agreed upon such as replacing all references to the Computer Systems and CS with Information Technology and IT, addition of a section heading, renewal of references to Government of Canada policies, and changing Her Majesty to His Majesty.

The IT Bargaining Team appreciates the strong support of our stewards and members. A full ratification package will be sent electronically to all Regular IT members prior to voting. Contract information sessions will be held for members.

To vote on this tentative agreement, members of our bargaining unit must be Regular members of the IT Group. If you have not signed up yet for membership, please complete the online form at member application.

In Solidarity,

Robert Scott
IT Group Bargaining Officer

Published on 27 October 2023

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Press Release — Largest federal public sector unions call for ongoing Phoenix damages on 8th anniversary

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Women in Science (WiS) Café Series

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TAB 115

CAAT-A Bargaining Bulletin: August 2023

August 16, 2023 - 5:24 pm

Notice

Bargaining, Bargaining News, Bill 124

College Faculty, Colleges

Important update from your CAAT-A Bargaining Team on wage reopener settlement with the College Employer Council

PDF version.

Dear Faculty Members,

We are pleased to share with you the outcome of our recent mediated settlement with the College Employer Council regarding our compensation for the period 2021-24.

Given the circumstances, we believe we've achieved a commendable outcome.

It is essential to understand the context in which these negotiations took place. Unlike an arbitration where outcomes are awarded in a decision by a third-party arbitrator, we had to come to a mutual agreement between both parties. This was purely a mediation with no binding mechanism, and in such an environment, leverage is often limited. Quite simply, both sides had to agree.

Considering these constraints, we are incredibly proud of what we have accomplished together. We achieved an outcome very similar to what we are seeing arbitrators award (**award** being the operative word) in other postsecondary contexts.

Our collective efforts have resulted in:

- A 3% salary increase for the first year,
- A 3% increase for the second year, and
- A 3.5% increase for the third year

(Including the 1% increases originally awarded in September 2022 by Arbitrator Kaplan under Bill 124.)

This is the first time since 2006 that we have secured a wage increase beyond 2%. These increases are long overdue. Consequently, the top-step salary for professors, counsellors, and librarians will be $126,689, effective October 1st, 2023, which is roughly $8,000 more than it would have been under Bill 124. As well, given that the adjustments cover the period since October 2021, members – including partial-load members – should see retroactive payment for increases within the next month.

We also achieved significant improvements to our paramedical benefits that could result in thousands of dollars in additional savings for members. Effective October 1st, 2023, SunLife will cover 90% (up from 85%) of paramedical expenses, up to $4,750/year (up from $2,000/year).

We must caution that these improvements were possible because Bill 124 was declared null and void by an Ontario Court. However, Doug Ford's government is currently appealing that decision. If the law were to come back into effect, the parties have agreed that our mediator, Eli Gedalof, will address and resolve issues of the law's impact on this settlement.

During the unprecedented challenges of the pandemic, each of us stepped up, doing what was necessary to navigate our students and our colleges through the crisis. We experienced significant unacknowledged and uncompensated increases in our workloads, adapting and innovating to ensure that our students received the education they deserve.

It is crucial to note that at the same time that we've been pushing our limits, the colleges have reported record profits. In this year alone, they collectively reported a staggering $656 million surplus, and since our strike in 2017 they've accumulated over $2.3 billion in profits. These profits are a direct result of the tireless efforts of our faculty members, including full-time professors, instructors, counsellors, librarians, and the precarious, contract faculty who make up over 40% of our bargaining unit.

These profits have been built on our backs, and it is high time we receive our fair share.

In our final demand set process, we prioritized an increase in wages and benefits that align with our established comparators and increases in inflation. This fight for fair wages is not just about numbers — it is about respect, recognition, and ensuring that our compensation reflects our worth.

We have been lagging behind our comparators. We should be at the midpoint between the lowest top step for university faculty and the highest salary for high school teachers in Ontario. This deal does not get us there, but it does bring us closer to that benchmark, even if we still have some distance to go.

As a bargaining team, we want to be clear: this agreement was made possible only because the 16,000 college faculty members stood together during a challenging round of bargaining that began in July, 2021.

Together, we authorized a strike mandate despite the pandemic. Together, we rejected a management offer that failed to address our demands. And now, together, we have finalized a collective agreement that achieves significant gains in compensation and equity, including addressing partial-load issues.

So, while we celebrate this necessary step forward for full-time and partial-load faculty today, let's look ahead to returning to the bargaining table next year, by which time the report of the Workload Task Force should be complete. We can all look forward to engaging in free and fair bargaining without punitive, unconstitutional legislative constraints.

We want to extend our gratitude for your solidarity and trust throughout this wage reopener process and look forward to your support in the fight ahead.

Your CAAT-A Bargaining Team

Ravi Ramkissoonsingh, Local 242 (Niagara) – Chair
Michelle Arbour, Local 125 (Lambton)
Shawn Pentecost, Local 415 (Algonquin)
Jonathan Singer, Local 560 (Seneca)
Rebecca Ward, Local 732 (Confederation)

TAB 116

LIGHT

Menu

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NO THANKS ALLOW

Local

ECONOMY

B.C. tops the list of the most expensive provinces in Canada: study

By Amy Judd • Global News
Posted November 6, 2023 6:55 pm
2 min read

Office towers, hotels and condos are seen in downtown Vancouver on Sunday, Oct. 25, 2020. **THE CANADIAN PRESS/Darryl Dyck**

A- A+

A year fr and what to d s.

We'd like to show you notifications for the latest news, features and updates.

Accordin ce company ving or renting a st, buying clothes and a night at a hotel.

The soaring cost of living dominated debate in the B.C. legislature on Monday.

"Families can't even afford the essentials anymore under this NDP government," Renee Merrifield, the BC United MLA for Kelowna-Mission said.

She said she received a letter from a constituent about how getting a raise at work doesn't even mean disposable income anymore.

"This is the farthest from reality," Merrifield said. "It doesn't even cover the increased cost of fuel, let alone the rising cost of everything else."

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Trendin

Ottawa po
says

Winnipeg lab records fight about avoiding 'embarrassment,' not security: docs

Toronto's breaking news sent to your email as it happens.

"What we can control, though, is income supports in people's pockets, which is why we have increased the minimum wage, which is why we've increased social assistance rates while we've invested in child care," she said.

The **study** considered 55 contributing factors, sorted into seven categories and each assigned a score of 10, including income, property prices, rent, bills, food, transport, health and personal care, and other lifestyle costs. Each score was weighted to produce the ranking, with the final score out of 100:

- British Columbia – 79
- Ontario – 71
- Alberta – 67
- Manitoba – 61
- Saskatchewan – 60
- Nova Scotia – 56

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We'd like to show you notifications for the latest news, features and updates.

"Data from Statistics Canada shows that British Columbia has the highest cost of living in Canada, and Newfoundland and Labrador has the lowest," a spokesperson said in a release.

"It's clear that the two most expensive provinces have exceptionally high house prices, but general living costs tend to be higher, too. British Columbia ranked among the top three most expensive provinces in every category, except accommodation, bills, and utilities expenses, where it placed fourth."

MORE ON MONEY

- Financial concern a key reason Canadians are having fewer kids: poll
- Ottawa's 'Shark Tank': Invitation-only program helped rapid test importers land billions
- 'No urgency' for Bank of Canada to cut rates as economy skirts recession

JOURNALISTIC STANDARDS REPORT AN ERROR COMMENT

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TAB 117

Compounded Growth

	British Columbia	Alberta	Saskatchewan	Manitoba	Quebec (FMOQ)	Quebec (FMSQ)	New Brunswick	Prince Edward Island	Newfoundland and Labrador	Nova Scotia	Ontario
2011 to 2023	17.5%	9.5%	30.4%	28.8%	24.8%	27.1%	15.5%	29.4%	22.2%	22.1%	-0.4%

Fee/Comp Rate Changes

Fiscal Year	British Columbia	Alberta	Saskatchewan	Manitoba	Quebec (FMOQ)	Quebec (FMSQ)	New Brunswick	Prince Edward Island	Newfoundland and Labrador	Nova Scotia	Ontario
2012	0.50%	0.00%	3.74%	0.00%	1.00%	1.80%	0.00%	3.10%		1.00%	-3.38%
2013	0.50%	0.00%	1.50%	6.40%	1.75%	1.75%	0.00%	3.10%	0.0%	2.00%	-2.55%
2014	0.00%	2.50%	1.50%	4.20%	0.00%	2.00%	2.00%	3.70%	0.0%	2.00%	0.00%
2015	0.95%	2.50%	1.95%	2.26%	2.60%	4.60%	2.00%	0.00%	1.8%	0.00%	-1.69%
2016	0.85%	1.10%	2.95%	2.00%	2.70%	3.00%	1.00%	0.00%	1.8%	0.00%	-1.39%
2017	0.90%	1.10%	0.00%	2.40%	3.90%	5.20%	1.00%	3.00%	2.79%	1.00%	0.75%
2018	0.50%	0.00%	0.00%	2.60%	4.70%	2.00%	1.00%	2.00%	2.79%	1.50%	1.25%
2019	1.70%	0.00%	1.00%	0.00%	1.40%	1.00%	1.00%	1.75%	2.79%	2.00%	1.00%
2020	0.80%	0.00%	2.00%	0.00%	2.10%	1.00%	2.00%	2.36%	2.79%	2.00%	1.00%
2021	2.40%	0.00%	2.00%	0.75%	2.30%	1.00%	1.50%	2.36%	2.79%	2.00%	1.00%
2022	3.60%	1.00%	5.50%	1.00%		1.00%	1.50%	2.36%	2.79%	2.00%	1.00%
2023	3.60%	1.00%	4.90%	4.20%			1.50%	2.36%		4.70%	2.80%

Compensation Index

Fiscal Year	British Columbia	Alberta	Saskatchewan	Manitoba	Quebec (FMOQ)	Quebec (FMSQ)	New Brunswick	Prince Edward Island	Newfoundland and Labrador	Nova Scotia	
2011	100	100	100	100	100	100	100	100	100	100	100
2012	100.5	100.0	103.7	100.0	101.0	101.8	100.0	103.1	100.0	101.0	96.6
2013	101.0	100.0	105.3	106.4	102.8	103.6	100.0	106.3	100.0	103.0	94.2
2014	101.0	102.5	106.9	110.9	102.8	105.7	102.0	110.2	100.0	105.1	94.2
2015	102.0	105.1	109.0	113.4	105.4	110.5	104.0	110.2	101.8	105.1	92.6
2016	102.8	106.2	112.2	115.6	108.3	113.8	105.1	110.2	103.6	105.1	91.3
2017	103.8	107.4	112.2	118.4	112.5	119.7	106.1	113.5	106.5	106.1	92.0
2018	104.3	107.4	112.2	121.5	117.8	122.1	107.2	115.8	109.5	107.7	93.1
2019	106.0	107.4	113.3	121.5	119.4	123.4	108.3	117.8	112.6	109.9	94.0
2020	106.9	107.4	115.6	121.5	122.0	124.6	110.4	120.6	115.7	112.1	95.0
2021	109.5	107.4	117.9	122.4	124.8	125.8	112.1	123.5	118.9	114.3	95.9
2022	113.4	108.5	124.4	123.6	124.8	127.1	113.8	126.4	122.2	116.6	96.9
2023	117.5	109.5	130.4	128.8	124.8	127.1	115.5	129.4	122.2	122.1	99.6

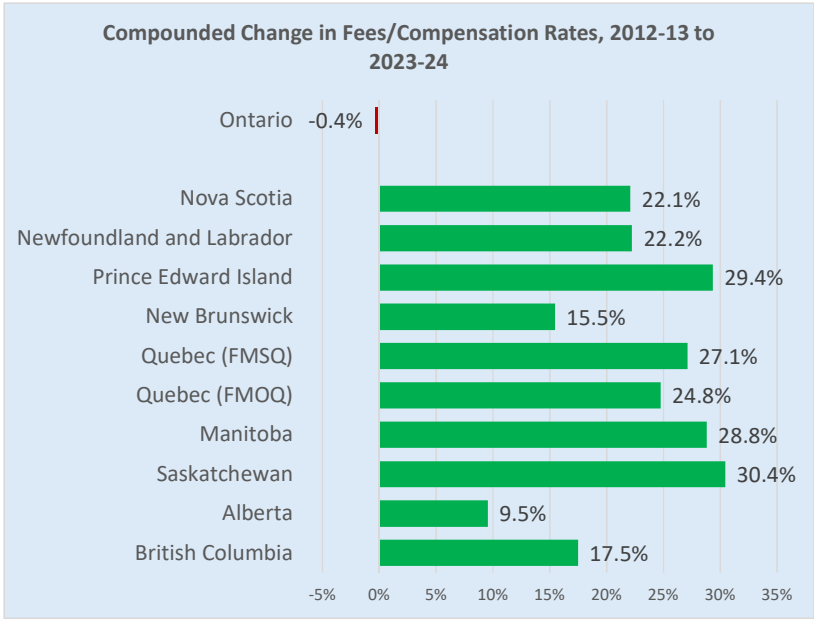
2017-2023	14.3%	3.1%	16.3%	11.4%	15.2%	11.7%	9.9%	17.4%	18.0%	16.2%		9.1%
2021-2023	9.9%	2.0%	12.9%	6.0%	2.3%	2.0%	4.6%	7.2%	5.7%	8.9%		4.9%

NOTES:
(1) See OMA Arbitration Brief, Re: Phase I - Overview, Redress and Normative Compensation Increases, s. 284. Highlighted in green are numbers used in that Brief.
(2) See folder on Team related to interprovincial comparison, b. Summary of PTMA Agreements_March222024. Highlighed in yellow are from Slide 4.
Highlighted in orange are numbers from slide 2 (fees only).

(3) Ontario numbers are inclusive of all items except ATB cuts in 2015 and their reversal in 2019.

(4) Red are Schedule of Fees changes from CMA Canadiant Health Policy and Negotiations Scan.

(5) Cells in blue are ones I could not find (QC and NFLD).



TAB 118

News Release

Health

Province and New Brunswick Medical Society ratify new four-year agreement

22 June 2017

FREDERICTON (GNB) – The provincial government and the New Brunswick Medical Society have signed a new four-year physician services master agreement which is intended to enhance access to primary health care in the province.

“Your government knows that the availability and delivery of health-care services have an impact on the quality of life of New Brunswickers,” said Health Minister Victor Boudreau. “Today, we are proud to announce a new four-year agreement with physicians which paves the way for transformative change in our province’s health-care landscape.”

The new physician services master agreement provides for fee-for service and salary increases of one per cent per year for four years, retroactive to April 1, 2016.

In addition to the economic increases, the agreement includes the establishment of a committee to review fee codes which have been significantly impacted by recent technological advances.

“For the first time in our history, all physicians practising in the province -- both fee-for-service physicians and salaried physicians -- were represented at the negotiating table under one formal bargaining process,” said New Brunswick Medical Society President Lynn Murphy-Kaulbeck. “This is a significant achievement for both the medical society and the province.”

The agreement also establishes Family Medicine New Brunswick, a new, collaborative model for family physicians that aims to:

- improve the recruitment of family doctors;
- provide New Brunswickers with better access to family doctors, including after hours; and
- help give family doctors more time for patient care.

Physicians working under the new Family Medicine New Brunswick model will operate under a blended payment model, with about 60 per cent of their payments based upon their patient roster, and the remaining 40 per cent based upon a reduced fee-for-service model.

“This new agreement is a true testament to the passion and vision for change shared by the provincial government and the New Brunswick Medical Society,” said Boudreau. “By enacting change today, we are getting things done to ensure that our province is ready to meet the challenges facing our health-care system in years to come.”

22-06-17

more >

Media Contact(s)

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TAB 119

HER MAJESTY THE QUEEN IN RIGHT
OF THE PROVINCE OF NEW BRUNSWICK,
as represented by the MINISTER OF HEALTH

- and -

THE NEW BRUNSWICK MEDICAL SOCIETY

PHYSICIAN SERVICES MASTER AGREEMENT

Effective April 1, 2020

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PHYSICIAN SERVICES MASTER AGREEMENT

THIS AGREEMENT is made effective the 1st day of April, 2020

BETWEEN:

HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF NEW BRUNSWICK, as represented by the **MINISTER OF HEALTH**, (the "**Minister**")

- and -

THE NEW BRUNSWICK MEDICAL SOCIETY, a body corporate existing pursuant to the *Medical Act*, SNB 1981, c. 87 as amended (the "**Society**")

WHEREAS:

A. the Minister is the provincial authority under the *Medical Services Payment Act*, RSNB 1973, c. M-7 (the "**Act**");

B. under subsection 4.1(1) of the Act, the Minister, with the approval of the Lieutenant-Governor in Council, is authorized to enter into an agreement with the Society respecting the payment for furnishing entitled services on a fee for service basis in accordance with a tariff or a system of payment that provides reasonable compensation to medical practitioners;

C. the Society is the professional association of medical practitioners in New Brunswick and is authorized to negotiate on their behalf and enter into an agreement with the Minister pursuant to subsection 4.1(1) of the Act respecting payment for furnishing entitled services on a fee for service basis;

D. the Parties have negotiated an agreement for payments to and for the benefit of Physicians furnishing entitled services on a fee for service basis for the period April 1, 2020 to March 31, 2025, including changes to the Tariff;

E. the Minister, pursuant to his authority under the Act and the *Financial Administration Act*, RSNB 2011, c. 160 (the "**FAA**"), and the Society, on behalf of Physicians remunerated pursuant to the Medical Pay Plan, (i) have agreed upon a process for negotiating certain elements of remuneration and other terms of service for those Physicians and for resolving related disputes, and (ii) pursuant to such process, have negotiated an agreement for payments to and for the benefit of those Physicians; and

F. the Lieutenant-Governor in Council has granted approval to the Minister to enter into this Agreement;

THIS AGREEMENT WITNESSES that the Parties have agreed as follows:

PART A - GENERAL PROVISIONS

1.0 INTERPRETATION

1.1 Definitions

In this Agreement, terms defined in the Act and not otherwise defined herein have the meanings assigned to them in the Act, and:

"**Academic Funding Plan**" means a contractual agreement between the Minister, Physicians, and organizations such as Regional Health Authorities and universities, under which the Physician is remunerated through a fixed funding formula in exchange for meeting agreed upon deliverables for patient care, clinical coverage, and research and academic work;

"**Act**" has the meaning assigned in the recitals to this Agreement;

"**Agreement**" means this agreement, including all Schedules referenced in **Section 1.4**, as it may be modified, amended, supplemented or restated by written agreement between the Parties;

"**Alternate Funding Plan**" means a contractual agreement between the Minister, Physicians, and Regional Health Authorities, under which Physicians are remunerated on a funding pool basis in exchange for meeting agreed-upon deliverables for patient care and clinical coverage;

"**Board of Management**" means the Board of Management or any successor as established under the FAA;

"**CME**" means continuing medical education as described in **Schedule A**;

"**CMPA**" means the Canadian Medical Protective Association;

"**Contract Year**" means a year during the Term commencing on April 1 of a calendar year and ending on March 31 of the next calendar year;

"**Dedicated Funding Pool**" means a funding pool for a specific program in respect of which any surpluses are maintained by the Society within that program and are not available for alternate use or reallocation;

"**Distribution**" means the allocation of the FFS GEI Amount for each Contract Year in accordance with the process described in **Section 4.0**;

"**Effective Date**" means April 1, 2020;

"**FAA**" has the meaning assigned in the recitals to this Agreement;

"**FFS Claims**" means accounts submitted by Physicians in accordance with the Tariff;

"**FFS Physician**" means a Physician who furnishes entitled services on a fee for service basis;

"**FFS**" means the basis of remuneration of Physicians, including all payments, reimbursements and benefits, in accordance with (i) the Tariff, (ii) Sessional Rates, (iii) Academic Funding Plans, (iv) Alternate Funding Plans, and (v) other funding programs, as provided in **Part B** and the corresponding Schedules to this Agreement;

"**FFS Retention Fund** means the fund established in accordance with **Schedule H**;

"**General Economic Increase**" or "**GEI**" means the annual percentage increase in funding to be applied in each Contract Year as set out in **Section 3.4** for funding for FFS Physicians and in **Section 10.3(a)** for funding for MPP Physicians;

"**MPP Physician**" means a Physician who is remunerated according to the Medical Pay Plan on a non-fee for service basis, including:

(a) new salaried Physicians;

(b) established salaried Physicians;

(c) established Physicians who have personal service contracts;

(d) established Physicians who have professional service contracts; and

(e) any other Physicians as may be agreed in writing between the Parties;

"**Medical Pay Plan**" or "**MPP**" means the New Brunswick Medical Pay Plan and the Addendum to the Medical Pay Plan that set out the remuneration arrangements for MPP Physicians, as set out in **Schedule W**;

"**NBMS Economics Committee**" means the FFS Economics Committee of the Society, which is established by and reports to the Society's board of directors;

"**Negotiation DRP**" means the dispute resolution process established and defined in the *Negotiation and Dispute Resolution Regulation - Medical Services Payment Act*, New Brunswick Regulation 2002-53;

"**New Service Item**" means a new fee item and associated service code for a procedure, technology or technique proposed by the Minister or the Society to be included in the Tariff;

"**Non-Resident Claim**" means a claim for payment of amounts in respect of the cost of entitled services furnished to a non-resident of the Province, as contemplated under the Act;

"**Parties**" means the parties to this Agreement, and "**Party**" means one of them;

"**Physician**" means a participating medical practitioner, as defined in Regulation 84-20 under the Act, including a FFS Physician and a MPP Physician;

"**Plans**" includes Academic Funding Plans, Alternate Funding Plans and any other plans agreed to by the Parties pursuant to **Section 8.0**;

"**Predecessor Agreement**" means the Fee for Service Master Agreement between the Parties made effective April 1, 2016;

"**Protected Funding Pool**" means a funding pool in respect of which Residuals are available for Redistribution in accordance with **Section 6.5(a)**;

"**Redistribution**" means the alternate use or reallocation of Residuals available to the Society from Protected Funding Pools, in accordance with **Section 6.5**;

"**Regional Health Authority" or "RHA**"" means a regional health authority established under the RHAA;

"**Residual**" means any surplus funds from a Protected Funding Pool available for alternate use or reallocation by the Society following the annual reconciliation by the Minister;

"**RHAA**" means the *Regional Health Authorities Act*, RSNB 2011, c. 217;

"**Sessional Rates**" means payment rates set on an hourly basis for Physicians rendering entitled services, as may be approved by the Minister;

"**Tariff**" has the meaning assigned in **Section 5.1**;

"**Term**" has the meaning assigned in **Section 2.2**; and

other capitalized terms have the meanings given to them in the body of this Agreement.

1.2 **Certain Rules of Interpretation**

In this Agreement, (i) words importing the singular include the plural and vice versa, and words importing a particular gender include all genders, (ii) the word "including" means "including without limitation", (iii) where a term is defined herein, a capitalized derivative of such term has a corresponding meaning unless the context otherwise requires, (v) headings are for convenience of reference only and shall not affect the construction or interpretation of this Agreement, and (vi) unless otherwise indicated, references to a Part, Section or Schedule followed by a number or letter refer to the specified Part, Section or Schedule of this Agreement.

1.3 **No Drafting Presumption**

The Parties acknowledge that their respective legal advisors have reviewed and participated in settling the terms of this Agreement and agree that any rule of construction to the effect that any ambiguity is to be resolved against the drafting party shall not apply to the interpretation of this Agreement.

1.4 **Schedules**

The following are the Schedules attached to and incorporated by reference in this Agreement, which are deemed to be part hereof:

Schedule A	-	Continuing Medical Education Guidelines
Schedule B	-	Canadian Medical Protective Association
Schedule C	-	Mandated On-Call / Second Call Program
Schedule D	-	Parental Leave Program
Schedule E	-	Supplementary Honoraria Program
Schedule F	-	Medicare Assessment Framework
Schedule G	-	Province Wide On-Call Program
Schedule H	-	FFS Retention Fund
Schedule I	-	Joint Oversight Committee
Schedule J	-	Specific Funding Items
Schedule K	-	Distribution Document
Schedule L	-	*(Intentionally Omitted)*
Schedule M	-	Principles of Consultation Billings
Schedule N	-	Closed Intensive Care Unit Alternate Funding Options
Schedule O	-	FFS and MPP Base Amounts
Schedule P	-	Saint John Regional Hospital Intermediate Medical Care Unit AFP
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Schedule U	-	AHEP Consolidation
Schedule V	-	Family Medicine New Brunswick Program
Schedule W	-	Medical Pay Plan and Addendum to Medical Pay Plan
Schedule X	-	Other Items
Schedule y	-	New Brunswick Primary Care Network
Schedule Z	-	Hospitalist Program

2.0 SCOPE OF AGREEMENT

2.1 Purpose of Agreement

This Agreement:

(a) with respect to FFS Physicians under **Part B**, is an agreement pursuant to subsection 4.1(1) of the Act respecting the payment in accordance with the Tariff and other systems of payment which the Parties agree will provide reasonable compensation to FFS Physicians for furnishing entitled services on a fee for service basis; and

(b) with respect to MPP Physicians under **Part C**, sets out the agreement of the Minister, pursuant to his authority under the Act and the FAA, and the Society, as authorized representative of and negotiating agent for Physicians remunerated pursuant to the Medical Pay Plan on other than a fee for service basis:

(i) as to a process for negotiating specified elements of reasonable compensation and other terms of service for MPP Physicians with a view to reaching an agreement on those elements of compensation and terms of service, and for resolving disputes which may arise during the course of such negotiations, as set out in **Part C**; and

(ii) in respect of those elements of compensation and other terms of service during the Term, as set out in **Part C**.

2.2 **Term of Agreement**

(a) This Agreement is effective as of the Effective Date and will remain in force until the date on which it is replaced by another agreement (the "**Term**").

(b) For the purposes of the Negotiation DRP only, the "termination date" of this Agreement is March 31, 2025.

PART B - FFS PHYSICIANS

3.0 BASIS OF COMPENSATION

3.1 **Additional Definitions**

In this **Section 3.0**:

"**Applicable Agreement**", where such term appears in **Section 3.2**, means (i) the Predecessor Agreement, when determining the FFS Base Amount in respect of the 2020-2021 Contract Year, and (ii) this Agreement, when determining the FFS Base Amount in respect of each of the remaining Contract Years;

"**Applicable Reference Year**" means, for a Contract Year, the period associated with that Contract Year in the following table:

Contract Year	Applicable Reference Year
2020-2021	April 1, 2019 – March 31, 2020
2021-2022	April 1, 2019 – March 31, 2020
2022-2023	April 1, 2021 – March 31, 2022
2023-2024	April 1, 2022 – March 31, 2023
2024-2025	April 1, 2023 – March 31, 2024

provided however that, if mutually agreed in writing by the Parties, where the Applicable Reference Year fiscal information is not available, the previous Applicable Reference Year will apply for the purposes of **Section 3.2**.

"**Cash Payments**" means actual payments made by the Minister in a fiscal year;

"**FFS Base Amount**" means the amount in respect of a Contract Year determined in accordance with **Section 3.2**;

"**FFS Funding Base**" means, for each Contract Year, the total amount of the funding the Minister will make available during that Contract Year for payments under this **Part B**, calculated in accordance with **Section 3.5(b)**;

"**FFS GEI**" means, with respect to a Contract Year, the GEI for that Contract Year set out in **Section 3.4**;

"**FFS GEI Amount**" means the amount for a Contract Year calculated in accordance with **Section 3.5(a)**; and

"FFS Payments" means Cash Payments to Physicians at Applicable Reference Year Tariff Rates excluding payments for Non-Resident Claims, and excluding payment of claims under **Sections 3.2(b)** and **3.2(r)** and payment of claims out of the funds listed in **Sections 3.2(h)**, **3.2(k)**, **3.2(o)**, **3.2(p)** and **3.2(q)**.

3.2 **FFS Base Amount**

The FFS Base Amount in respect of a Contract Year is the aggregate of the following Cash Payments made or funding allocated by the Minister during or in respect of the Applicable Reference Year for that Contract Year:

(a) FFS Payments;

(b) manual payments to Physicians including:

(i) payments at agreed Sessional Rates;

(ii) any other manual payments; and

(iii) payments to FFS Physicians related to the Access Initiative (Collaborative Practice) Program;

(c) fund for Alternate Funding Plans, including annualization of changes made during the Applicable Reference Year;

(d) fund for Academic Funding Plans, including annualization of changes made during the Applicable Reference Year;

(e) upward or downward adjustments to budgeted funds resulting from transfers of Physicians from one type of remuneration to another during the Applicable Reference Year (including annualization for the Applicable Reference Year);

(f) payments for CME expenses as described in **Schedule A** to the Applicable Agreement;

(g) fund for reimbursement of CMPA medical liability protection premiums for FFS practice as described in **Schedule B** to the Applicable Agreement;

(h) fund for the Mandated On-Call / Second Call Program as described in **Schedule C** to the Applicable Agreement;

(i) fund for the Parental Leave Program as described in **Schedule D** to the Applicable Agreement;

(j) fund for Supplementary Honoraria as described in **Schedule E** to the Applicable Agreement;

(k) fund for the Province-Wide On-Call Program as described in **Schedule G** to the Applicable Agreement;

(l) fund for the FFS Retention Fund as described in **Schedule H** to the Applicable Agreement;

(m) fund for the EMR program as described in **Section 6.1(b)**;

(n) fund for the Physicians Wellness Service as described in **Schedule S**;

(o) fund for Chronic Disease Management claims, where applicable;

(p) fund for Chart Initiation Fee claims, where applicable;

(q) fund for Seniors' Code enhancement claims, where applicable;

(r) payments for capitation under the Family Medicine New Brunswick Program; and

(s) any other funding as agreed to in writing by the Parties.

3.3 **FFS Base Amounts**

The Parties agree that the FFS Base Amount for the purposes of calculating the FFS Funding Base for the 2020-2021 Contract Year will be $540,251,254 based on amounts set out in Schedule O. For the 2021-2022 Contract Year and the 2022-2023 Contract Year the FFS Base Amount will be the compounded 2020-2021 FFS Base Amount and estimated funding allocated by the Minister under the categories in **Section 3.2** as summarized in **Schedule J.**

3.4 **FFS General Economic Increase**

The FFS GEI for each Contract Year is as follows:

Contract Year	GEI
2020-2021	2.0 %
2021-2022	1.5 %
2022-2023	1.5 %
2023-2024	1.5 %
2024-2025	1.5 %

3.5 **FFS GEI Amount and FFS Funding Base**

For each Contract Year:

(a) the FFS GEI Amount is the amount calculated by multiplying the FFS Base Amount in respect of that Contract Year by the FFS GEI for that Contract Year; and

(b) the FFS Funding Base is the FFS Base Amount in respect of that Contract Year plus the FFS GEI Amount for that Contract Year.

3.6 **Funding by the Minister**

The Minister will provide the FFS Funding Base for each Contract Year for payment of FFS Physician accounts for entitled services furnished on a fee for service basis, and for payment in respect of the other services and programs described in this **Part B** and the associated Schedules.

3.7 **Agreed Funding Items**

The Parties Acknowledge that **Schedule J** sets out specific funding items as agreed to by the Parties and the amount of the funding as agreed or estimated for those items.

Schedule J contains estimates that are based on information available and circumstances which exist at the time of execution of this Agreement and are subject to changes based on the information available, for the applicable fiscal years.

4.0 DISTRIBUTION OF FFS GEI AMOUNT

4.1 **Basis of Distribution**

The Distribution of the FFS GEI Amount for each Contract Year to the budgeted amounts for FFS payments pursuant to particular items of the Tariff and to other programs and expenses funded by the Minister under this **Part B** will be as mutually agreed in writing by the Parties or as otherwise determined pursuant to this **Section 4.0**.

4.2 **GEI Targeted Funding Initiatives**

For the 2021-2022 Contract Year, 0.5% of the 1.5% FFS GEI is allocated to support the following GEI targeted funding initiatives as mutually agreed in writing by the Parties:

(a) Primary care task force;

(b) Surgical improvements initiative;

(c) Specialty visits;

(d) Coronary care unit support; and

(e) Sessional rates for joint priorities.

4.3 **Distributions**

(a) *Distribution Proposals* - As soon as practicable after the Applicable Reference Year data pursuant to **Section 3.2** is available for a Contract Year (each an "**Applicable Contract Year**"):

(i) the Minister will notify the Society of the FFS Base Amount and the GEI Amount for the Applicable Contract Year; and

(ii) subject to **Section 4.2**, the Parties shall exchange written proposals setting out their respective priorities with respect to the Distribution of the FFS GEI Amount (each a "**Distribution Proposal**") for the Applicable Contract Year.

(b) *Negotiation of Distribution* - Following the exchange of Distribution Proposals pursuant to **Section 4.3(a)** and any amendments thereto, the Parties shall negotiate in good faith to reach agreement upon the Distribution for the Applicable Contract Year.

(c) *Dispute Resolution* - If the Parties fail to agree in writing on the Distribution for the Applicable Contract Year by no later than December 31 of the Applicable Contract Year, either Party may submit the outstanding issues for determination pursuant to the Negotiation DRP.

4.4 **Incorporation and Application of Distributions**

(a) *Incorporation of Distribution* - When the Distribution for a Contract Year is (i) mutually agreed in writing by the Parties, or (ii) finally determined pursuant to the Negotiation DRP, as the case may be, the Distribution for that Contract Year as so agreed or determined will thereupon be incorporated in and form part of this Agreement. The Parties will promptly cause the terms of the Distribution to be set forth in and appended as **Schedule K**, or an amended **Schedule K**, to this Agreement.

(b) *Application of Distribution* - The final Distribution for a Contract Year, as agreed or determined pursuant to **Section 4.3**, will be applied retroactively, if and as applicable, to all transactions affected by the Distribution that occurred on and after the first day of the Contract Year, and all resulting supplementary payments to FFS Physicians and other financial adjustments will be promptly made.

5.0 TARIFF

5.1 Adoption of Tariff

The New Brunswick Physicians' Manual in the form mutually agreed in writing by the Parties, or otherwise determined pursuant to this Agreement, to be in effect from time to time (the "**Tariff**"):

(a) is incorporated in and forms an integral part of this Agreement;

(b) will contain the schedule of fees, amended as outlined in **Schedule K**, including the terms and conditions applicable to the schedule of fees, to be used by Physicians to guide their submission of FFS Claims to the Minister; and

(c) is intended to provide reasonable compensation to Physicians for the entitled services furnished by them on a fee for service basis.

The Tariff will be revised and re-published periodically by the Minister whenever changes to FFS items resulting from a Distribution pursuant to **Section 4.0** or other negotiated amendments to the Tariff come into effect.

5.2 Payments under the Tariff

The Minister agrees to assess FFS Claims submitted by and to make payments to Physicians in accordance with the Tariff for services on a fee for service basis.

5.3 New Service Items Negotiation Process

The New Service Items negotiation process is as defined in **Schedule Q**.

5.4 Fee Code Review

(a) The Fee Code Review Committee (previously referred to as the "**Oversight Committee**") established under the 2014-2016 Physician Services Master Agreement and continued by the Predecessor Agreement to oversee the review of the Tariff and associated fees is continued under this Agreement. The Fee Code Review Committee shall establish priorities and working group schedules.

(b) Specialty based working groups shall be continued or established to review their specific sections to clarify the application of the service codes, the fees and attending narratives. Their recommendations shall be submitted to the Fee Code Review Committee.

(c) The Parties will endeavour to complete the review during the Term.

(d) Implementation of any resulting recommendations for change shall be cost neutral, unless otherwise mutually agreed upon in writing by the Parties.

(e) The Parties shall be responsible for their respective costs with respect to the operations of the Fee Code Review Committee and working groups.

6.0 NON-TARIFF ITEMS

6.1 Program Funding

(a) *General* - The following programs and other non-Tariff items under the Predecessor Agreement, as amended if applicable, are continued during the Term of this Agreement upon and subject to the terms and conditions contained in the respective Schedules:

(i) Continuing Medical Education (CME) Guidelines for Private Practice Physicians as set out in **Schedule A**;

(ii) CMPA Program of Compensation for Medical Liability Protection Premiums Fee for Service/Private Practice as set out in **Schedule B**;

(iii) Mandated On-Call Program as set out in **Schedule C**;

(iv) Parental Leave Program for FFS Physicians as set out in **Schedule D**;

(v) Supplementary Honoraria Program as set out in **Schedule E**;

(vi) FFS Retention Fund Program as set out in **Schedule H**;

(vii) Remuneration for Surgical Cancellations as set out in **Schedule R**;

(viii) Physician Wellness Service as set out in **Schedule S**; and

(ix) Family Medicine New Brunswick as set out in **Schedule V**.

(b) *Electronic Medical Records* – The Parties agree to continue the Electronic Medical Records (EMR) Dedicated Funding Pool of $1,500,000 established under the 2014-2016 Physician Services Master Agreement and continued under the Predecessor Agreement to provide support to FFS Physicians who operate a New Brunswick government conformant EMR. Qualifying FFS Physicians will be eligible for reimbursement of 50% of their monthly fee, up to a maximum of $200 per month. The Parties may agree in writing to revise the monthly reimbursement amount.

6.2 **New Programs – New Brunswick Primary Care Network and Hospitalist Program**

(a) The New Brunswick Primary Care Network program shall be implemented as set out in **Schedule Y**.

(b) The Hospitalist Program shall be implemented as set out in **Schedule Z**.

6.3 **Business Continuity Plan**

In the event a Physician is exposed or infected in the course of their work during a pandemic and therefore unable to work due to illness or quarantine, they will be eligible to apply for additional compensation of up to 100% of their average Medicare payments during the period of their illness or quarantine.

6.4 **Virtual Care**

(a) The Parties agree that remuneration arrangements for virtual care, established at the time of execution of this Agreement, will continue as a pilot project. During the pilot project period the Parties agree to compile and assess data with respect to the utilization of virtual care.

(b) The Parties agree to meet monthly, through the existing NBMS/DH Joint Oversight Committee continued under **Schedule I**, to review the usage rates for virtual billing. The Parties may mutually decide to adjust the use of particular virtual codes. Upon 90 days notice to the other Party either Party may suspend the use of a particular virtual code.

(c) The Parties respective negotiating committees will reconvene at the end of the pilot project, in or as soon as practicable after March 2022, to review the data and consider a virtual care framework for the future.

6.5 **Residual Program Funding**

(a) *Protected Funding Pools* - Protected Funding Pool balances shall be reconciled annually by the Minister and any surplus in a Protected Funding Pool shall be available to the Society as agreed by the Parties for alternate use or reallocation. Any over-expenditure of a Protected Funding Pool shall be funded with the existing surplus from other Protected Funding Pools, or shall be recovered from the following year's Distribution if no funding is available in the current year. As of the Effective Date, the Protected Funding Pools are as follows:

(i) Mandated On-Call
(ii) Second Call
(iii) Province Wide Call
(iv) Supplementary Honoraria
(v) Physicians Wellness Service

(b) *Dedicated Funding Pools* - As of the Effective Date, the Dedicated Funding Pools where surpluses are maintained by the Society within those individual programs and are not available for alternate use or reallocation are as follows:

(i) Parental Leave
(ii) CMPA
(iii) EMR Program

6.6 **Other Funding**

The Parties agree that funding will be provided by the Minister to be directed to the following items:

(a) Changes to Emergency Department funding models as follows:

(i) Sessional ER (Hourly) Rate

This increase will be accomplished over the duration of this Agreement as follows:

	Regional ER Rate	Non-regional ER Rate
April 1, 2019	$205.32	$197.88
April 1, 2020	$213.84	$199.93
April 1, 2021	$222.72	$208.23
April 1, 2022	$231.96	$216.87
April 1, 2023	$241.58	$225.86

(ii) Best Practice Models

The Parties agree that a modified version of the SJRH Emergency Department Academic Funding Arrangement will be available for all zones before the end of the 2024-2025 Contract Year and will include, at a minimum:

1. Centralized scheduling
2. Rotating regional shifts
3. Centralized financial (hours, rates, etc.) management

(b) Saint John Regional Hospital Intermediate Medical Care Unit Plan

The Parties agree to establish a Plan as set out in the attached **Schedule P**.

7.0 OTHER FFS PROVISIONS

7.1 **Costing of New Initiatives**

(a) *New Initiatives/Fees* - Any funding shortfall resulting from a variance between actual and estimated costs of a new initiative or fee negotiated during the term of this

Agreement shall be recovered through the following Contract Year's Distribution unless it is a new initiative or service introduced by the Minister, and any surplus will be available for alternate use or reallocation in the following Contract Year.

(b) *Distribution* - Any funding shortfall resulting from new service codes introduced through Distribution shall be recovered through the following Contract Years' Distribution, and any surplus will be available for alternate use or reallocation in the following Contract Year. This does not apply to increases in existing fee codes through the fee Distribution process.

(c) *Protected Funding Pools* - Any funding shortfall in the total amount available for Protected Funding Pools shall be recovered through the following Contract Year's Distribution, and any surplus will be available for alternate use or reallocation in the following Contract Year.

7.2 **Physicians Providing Locum Services after Payout from FFS Retention Fund**

The following guidelines apply to Physicians who wish to provide locum services after collecting their payout from the FFS Retention Fund:

(a) Physicians may bill Medicare for locum services for a maximum of five years after payout from the FFS Retention Fund;

(b) Physicians who have accepted their payout from the FFS Retention Fund will not be eligible for a minimum guarantee as per the relevant Medicare Locum Policy;

(c) Physicians must provide Medicare with an acceptable transition plan for patients or their practice; and

(d) Locums may earn a maximum of $75,000 annually. The only exception to the $75,000 annual income is if the locum is covering a parental leave, in which case no maximum annual earnings apply.

7.3 **Sole Payment**

The Parties agree to co-operate to ensure that their agreement with respect to the amounts to be paid to any FFS Physician (for services provided to beneficiaries on an opted-in basis), both under the Tariff pursuant to **Section 5.0** and for non-Tariff payments pursuant to **Section 6.0**, will be the sole payment by the Minister or any other provincial authority for or in respect to such Tariff and non-Tariff items.

7.4 **Reciprocal Agreement with Quebec**

The Parties acknowledge and recognize that (i) New Brunswick and Quebec share patients and medical services, yet there is no medical reciprocal agreement addressing how these services are remunerated, and (ii) the Department of Health has no ability to bind the Province of Quebec to any agreement, and that there are other jurisdictional and legal issues

requiring consideration relative to this item. The Minister agrees to cause the Department of Health to endeavor to explore the potential for negotiating a medical reciprocal agreement with the Province of Quebec.

7.5 **Other Items**

The Parties agree to the other items set forth in **Schedule X**.

8.0 ALTERNATE MODELS OF REMUNERATION

8.1 **New Plans**

The Parties agree to follow the process set out in **Schedule T** for negotiating and establishing Plans as alternate models of remuneration.

8.2 **No Arbitration**

All newly proposed Plans requested during the Term shall require consultation between the Parties. Where the Parties fail to reach agreement on a newly proposed Plan, it will be deferred to the following round of negotiations. Failure to reach agreement on a newly proposed Plan will not be subject to any form of arbitration outside FFS negotiations. This provision does not in any way limit the statutory powers of the Minister to restrict the right of arbitration contained in any existing Plan.

8.3 **Closed Intensive Care Unit Funding Options**

(a) The Closed Intensive Care Unit Funding Options described in **Schedule N** are continued under this Agreement subject to the terms and conditions contained therein.

(b) Compensation under the Closed Intensive Care Unit Funding Options referred to in **Section 8.3** shall be adjusted annually based on an escalator that will be determined through Distribution by the NBMS Economics Committee.

8.4 **New Funding**

Any additional requests for alternate models of remuneration may be funded through Distribution. New funding may also be approved through mutual agreement of the Parties.

PART C - MPP PHYSICIANS

9.0 NEGOTIATION PROCESS FOR MPP PHYSICIANS

9.1 **General**

The Minister and the Society will negotiate the matters that are subject to negotiation pursuant to **Section 9.2**, and if applicable will resolve any dispute arising from such negotiations, following a process substantially the same as the process for negotiating and

resolving disputes with respect to an agreement under subsection 4.1 of the Act, as set out in the Negotiation DRP. This **Section 9.0** will apply to the negotiation of, and if applicable the dispute resolution process for, the extension or renewal of, or successor agreement to, this **Part C**.

9.2 **Matters Subject to Negotiation**

Subject to **Section 9.3**, the matters subject to negotiation and dispute resolution under this **Part C** generally include the Medical Pay Plan, including general increases, certification increases, changes and Addendums thereon, and the provisions of the related New Brunswick Policy for Physicians on the Medical Pay Plan, including the following:

(a) Remuneration matters limited to the following:

  (i) salary;

  (ii) remuneration levels;

  (iii) compensation for:

    (A) On-call stipend

    (B) mandated On-call services;

    (C) mandated second call;

    (D) called in when not participating in On-call;

    (E) on-site coverage in psychiatric facilities of Centracare and Restigouche;

    (F) autopsy fees (type 1 and 2); and

    (G) Provincial-Wide On-call;

(b) Non-Clinical Funding

  (i) CMPA; and

  (ii) CME programs;

(c) Patient Rounds;

(d) Working on Statutory Holidays;

(e) Working excessive hours;

(f) FFS Program Threshold;

(g) FFS Program Guidelines;

(h) Accountability Benchmarks;

(i) Locums; and

(j) Office Overhead and Personnel.

9.3 **Matters not Subject to Negotiation**

The matters not subject to negotiation and dispute resolution under this **Part C** are as follows:

(a) Clinical Department Heads;

(b) Supervisory Allowance;

(c) Part Time Positions;

(d) Other Physician Responsibilities;

(e) Subject to **Section 9.4(e)**, vacation and other leaves (including sick leave);

(f) Insured Benefits (Health and Dental benefits);

(g) Long Term Disability Benefits;

(h) Shadow Billing;

(i) Research;

(j) Statutory Deductions;

(k) Ownership of Materials;

(l) Medicare Funded Positions;

(m) Return of Service on Incentives;

(n) Relocation Expenses;

(o) Monitoring and Compliance / Practitioner Audits; and

(p) The New Brunswick Shared-Risk Pension Plan.

9.4 **Agreed Upon Matters**

The Parties acknowledge and agree the following principles govern negotiations and the resulting agreement under this **Part C**:

(a) The current Medical Pay Plan in place for MPP Physicians will remain in effect until revised, renewed or amended in accordance with this Agreement, or by mutual written agreement between the Parties.

(b) The starting point for the negotiation of the remuneration and compensation for MPP Physicians will be the current Medical Pay Plan and the then-existing levels of remuneration and compensation.

(c) The MPP GEI will include any negotiated adjustments to existing programs and any funding for new initiatives negotiated by the Parties.

(d) The criteria for Physician reimbursement under the CME and CMPA programs will be standardized and consistent for both MPP Physicians and FFS Physicians.

(e) Vacation Leave credits for MPP Physicians are accumulated as outlined in the current Addendum to the Medical Pay Plan. There shall be no changes to the existing Vacation Leave benefits without the express written agreement of both Parties.

(f) MPP Physicians who are full-time (i.e., 1.0 full-time equivalent), are expected to work 37.5 hours per week. The hours of work shall normally be provided between 0800 and 1800 hours, Monday to Friday, unless otherwise agreed to between the MPP Physician and the applicable Regional Health Authority. There shall be no changes to existing Normal Hours of Work without the express written agreement of both Parties.

9.5 **Approvals and Ratification**

The Parties acknowledge and agree that any agreement reached under the process outlined in this **Section 9.0** will be subject to approval by the Board of Management, and ratification and approval by the Society's members and Board of Directors.

9.6 **Limit to Negotiations**

The Parties acknowledge and agree that the basis of remuneration for MPP Physicians on matters outlined in **Section 9.2** have been agreed upon and reflected in **Section 10.0** and will not be subject to re-negotiation under this **Section 9.0** during the Term.

10.0 BASIS OF REMUNERATION

10.1 **General**

The Parties acknowledge and agree that the basis of remuneration and other terms of service for MPP Physicians set out in this **Section 10.0** have been negotiated and agreed to by the Parties in accordance with the provisions of **Section 9.0**.

10.2 **Additional Definition**

In this **Section 10.0, "MPP GEI"** means, with respect to a Contract Year, the GEI for that Contract Year as set out in **Section 10.3(a)**.

10.3 **Basis of Remuneration - MPP Physicians**

(a) MPP General Economic Increase:

The MPP GEI for each Contract Year is as follows:

Contract Year	GEI
2020-2021	2.0%
2021-2022	1.5%
2022-2023	1.5%

Contract Year	GEI
2023-2024	1.5%
2024-2025	1.5%

(b) MPP Physician Remuneration:

MPP Physicians will be remunerated in accordance with the Medical Pay Plan as adjusted annually as of the first day of each Contract Year by the applicable Contract Year's MPP GEI, as set out in **Schedule W**.

10.4 **Funding by the Minister**

The Minister will provide funding to the Regional Health Authorities pursuant to the RHAA to pay the MPP Physicians in accordance with the Medical Pay Plan utilizing the adjusted rates for the applicable Contract Year.

PART D - OTHER PROVISIONS

11.0 DISPUTES

11.1 **Definition**

In this **Section 11.0**, "**Dispute**" means any difference, controversy or dispute between the Parties as to any matter arising out of or related to this Agreement, including without limitation, the validity, interpretation, application, administration, enforcement or termination of this Agreement, the rights or liabilities of the Parties hereunder, any failure to agree where agreement between the Parties is called for, or any claim whatsoever arising out of any alleged failure to perform or breach of obligations under this Agreement, but excluding any matter or dispute that is required by this Agreement to be resolved pursuant to the Negotiation DRP.

11.2 **Notice of Dispute**

If a Party considers that there is a Dispute, that Party may give notice of the Dispute to the other Party and such notice shall provide all relevant particulars of the Dispute. The Parties shall attempt in good faith to resolve the Dispute, but if it is not resolved by written agreement of the Parties within 30 days after delivery of the notice, the Dispute shall be resolved pursuant to **Section 11.3**.

11.3 **Arbitration**

If a Dispute is not resolved pursuant to **Section 11.2**, either Party may by notice to the other Party refer the Dispute to final and binding arbitration in accordance with the *Arbitration Act*, SNB 2014, c 100 (the "**Arbitration Act**"). Neither Party shall commence any proceedings relating to a Dispute in any jurisdiction, other than in accordance with the terms of this Agreement and this Agreement shall constitute a complete bar to any such proceedings. The

arbitration shall be conducted by a single arbitrator agreed upon by the Parties. If the single arbitrator cannot be agreed upon within 10 Business Days of referral of a Dispute, either Party may apply under the Arbitration Act for judicial appointment of the single arbitrator. In respect of any arbitration to be conducted pursuant to this **Section 11.3**, the following rules shall apply:

(a) the arbitration shall be conducted in English or French, as mutually agreed in writing by the Parties or as determined by the Arbitrator;

(b) the arbitration shall be conducted in the City of Fredericton, New Brunswick;

(c) no such arbitrator shall have previously been employed by either Party and shall not have a direct or indirect interest in either Party or the subject matter of the arbitration;

(d) the costs of the arbitration, excluding a Party's legal fees and disbursements shall, unless otherwise ordered by the arbitrator, be borne equally by the Parties;

(e) The arbitration hearing shall be completed within 120 days after the selection or appointment of the arbitrator. In order to facilitate the arbitration hearing in an expedited manner and in the absence of an agreement of the Parties to the contrary, the following procedures shall be followed by the arbitrator and the Parties:

(i) Within 10 Business Days after the selection or appointment of the arbitrator, the claimant shall send a written statement to the respondent and the arbitrator outlining the facts supporting the claimant's claim, the points at issue and the relief or remedy sought;

(ii) Within 10 Business Days after the respondent receives the claimant's statement, the respondent shall send a written statement to the claimant and the arbitrator outlining the respondent's defence, and a written statement of the respondent's counterclaim, if any, outlining the facts supporting the counterclaim, the points at issue, and the relief or remedy sought;

(iii) The claimant may respond to a counterclaim by sending a written statement to the respondent and the arbitrator outlining the claimant's defence to the counterclaim within 10 Business Days after the claimant receives the counterclaim; and

(iv) Each Party shall submit with the Party's statements a list of the documents upon which the Party intends to rely, which shall specify the document type, date, author, recipient and subject-matter;

(f) The arbitrator shall deliver his or her award within 30 days after completion of the hearing or within such other time as the Parties may agree; and

(g) Subject to subsection 45(1) of the Arbitration Act, the award of the arbitrator shall be final and binding upon the Parties with no right of appeal, whether as to fact, law, or mixed fact and law, and shall be enforceable by them in any court of competent jurisdiction.

Notwithstanding any provision contained herein to the contrary, the Parties agree that the arbitration procedure set forth in this **Section 11.3** shall not apply in circumstances where (i) the claimant is seeking a temporary restraining order or other immediate injunctive relief, (ii) a third party has brought a claim, except with the consent of such third party, or (iii) the Dispute relates to claims in respect of intellectual property rights, whether initiated by third parties or by a Party.

12.0 APPLICATION OF AGREEMENT

This Agreement applies to and is binding on the Minister and the Society and on any Physician receiving payment hereunder, regardless of whether or not they have made themselves aware of the terms of this Agreement.

13.0 NOTICES

(a) Any notice required or permitted to be given to the Minister by the Society shall be sufficiently given if personally delivered to the office of the Minister or if sent by the registered mail to the office of the Minister.

(b) Any notice required or permitted to be given to the Society by the Minister shall be sufficiently given if personally delivered to the office of the President of the Society or if sent by registered mail to the office of the President.

(c) Any notice given by registered mail shall be deemed to have been given 48 hours after the time it is posted.

14.0 MISCELLANEOUS

(a) *Amendment* - No modification of this Agreement is valid unless set out in writing and signed by an authorized representative of each of the Parties.

(b) *Invalidity* - In the event that any provision in this agreement shall be deemed void or invalid by a court of competent jurisdiction, the remaining provisions shall be and remain in full force and effect.

(c) *Waivers* - The waiver by either party of any breach or violation of any provision of this Agreement shall not operate or be construed as a waiver of any subsequent breach or violation of it.

(d) *Language* - The Parties have required that this Agreement and all documents relating thereto be drawn up in the English language. Les Parties ont demandés que cette convention et ci que tous les documents qui s'y rattachent soient rédigés en anglais.

(e) *Severability* - If any part of this Agreement is held to be unenforceable or invalid, it will be severed from the rest of this Agreement which shall continue in full force and effect.

(f) *Entire Agreement* - This Agreement constitutes the entire agreement between the Parties and supersedes all prior agreements and negotiations with respect to the subject matter hereof.

(g) *Further Assurances* - Each party shall do such acts and shall execute such further documents as are within its power as the other party may at any time reasonably request in order to give full effect to the provisions of this Agreement.

IN WITNESSES WHEREOF the Parties have executed this Agreement, to take effect as of the Effective Date.

SIGNED AND DELIVERED in the presence of:

Witness

Witness

HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF NEW BRUNSWICK, as represented by the **MINISTER OF HEALTH**

Hon. Dorothy Shephard
Minister of Health

Date Signed: March 15, 2022

THE NEW BRUNSWICK MEDICAL SOCIETY

Dr. Mark MacMillan
President

Date Signed: March 11, 2022

Schedule A

CONTINUING MEDICAL EDUCATION GUIDELINES

1.0 Assigning CME Credits

Effective April 1, 2017, in order to be eligible for CME credits, physicians (including locums) must meet the following criteria:

For FFS Physicians:

- Must be licensed in New Brunswick
- Medicare income must be equal to or greater than the Medicare income threshold established for the year reimbursement is being requested.

For Salaried Physicians:

- Must be licensed in New Brunswick
- Must have been employed under Part I or Part III of the *Public Service Labour Relations Act* and
- Must be remunerated under the Medical Pay Plan for more than six (6) months; and must be employed, as a minimum, in a half-time position (0.5 FTE).

1.1.1 Active FFS Physicians with annual Medicare income less than the income threshold will be eligible to receive annual CME Credits once in any two-year period subject to established program criteria, provided their cumulative Medicare Income over that two-year period is equal to or greater than the income threshold for the second year. The annual allocation will be assigned once the physician's cumulative Medicare income over the two-year period reaches the income threshold for the second year. This provision does not apply to locums or salaried physicians.

1.1.2 Both FFS and Salaried Physicians on maternity leave, will be eligible for full credits in that fiscal year.

Physicians who become disabled or ill will be eligible for full credits for that fiscal year. These applications will be assessed on an individual basis.

1.1.3 In a fiscal year, a physician can only be allocated credits in either the FFS (FFS/Sessional/AFP/APP) or the salaried program. Physicians who switch remuneration models during a fiscal year, who meet the eligibility criteria for both programs, will be assigned credits based on the Program they qualified for first (FFS or Salary).

2.0 Value of Credits

2.1 By March 31st of each year, the Society will provide the value of CME credits to the Department of Health.

2.2 Effective January 1, 2005, there will be two types of credits, urban and rural. Physicians who have practice locations beyond and not falling between Moncton, Dieppe and Riverview; or Saint John, Rothesay, Hampton, Quispamsis and Grand Bay/Westfield; or Fredericton, Oromocto and New Maryland, will be eligible to receive rural credits.

2.2.1 In the event of a dispute, the Parties will resolve the matter using the following as a benchmark: In order to be deemed "rural" for the purpose of this Program, at least 75% of the income must be generated in a community or communities that meet the definition of rural. If less than 75% of the income is generated in rural communities then the urban contribution rates would apply.

2.3 If within a fiscal year, a physician relocates their practice from an urban location to a rural location or from a rural location to an urban location, then for that year, and subject to all other qualifying requirements, the physician would be awarded the credits for which they first qualified, rural or urban.

3.0 Accumulation of Credits

3.1 Credits accumulated must be claimed within three years.

4.0 Course Eligibility

4.1 The physician must be in active practice in New Brunswick at the time of the CME event.

4.2 As a general guide, courses must be accredited. The final determination for course eligibility will be the responsibility of the Department of Health and the Society.

4.3 Home-centered CME programs approved by the College of Family Physicians of Canada, the American Academy of Family Physicians or an equivalent organization representing a specific specialty, may be eligible for funding. Any hardware expenses such as computers, TVs, etc. or other expenses such as books, journal subscriptions or other similar materials that may be required to undertake the home centered CME are ineligible expenditures. Any other home-centered CME programs will be considered on a case-by-case basis.

5.0 Application Procedure

5.1 Physicians must complete the Program Application Forms available through the Society's office. Completed applications must be submitted to the Society's office, accompanied by the following documentation:

- Certificate of attendance (receipt of registration does not constitute proof of attendance)

6.0 Claims Assessment

6.1 Tuition/Registration

Tuition/Registration fees will be reimbursed at 100% in addition to the per diems. Receipt is required for tuition or registration fee. Annual dues and Social fees will not be reimbursed.

6.2 Per Diem

The following table is used to assess per diem payments: (per diems include accommodations, meals, transportation i.e. mileage, automobile rental or airfare)

Type	Per Diem
NB	$300.00
PEI/NS/PQ/NL/ON/Maine	$500.00
Rest of Canada	$600.00
International excluding Maine	$700.00

6.2.1 Travel Days

The following formula/scale will be used to determine the total number of travel days eligible for reimbursement:

Travel Days	Claim Days
<100 kms	0 Days
Between 101 kms – 400 kms	½ day
Between 401 kms – 800 kms	1 day
> 800 kms	2 days

6.2.2 Program Days

The maximum number of Programs days will be determined by the number of actual days of attendance or the number of CME hours determined by the formula/scale below, whichever is less.

Total Number of CME Hours for the Program	Maximum Number of Days Eligible for Reimbursement
Up to 3.5	1
3.5+ to 7	2
7+ to 10.5	3
10.5+ to 14	4

14+ to 17.5	5
17.5+ to 21	6
21+ to 24.5	7
24.5+ to 28	8

6.2.3 Office Overhead / Income Replacement

FFS Physicians will be eligible for Office Overhead/Income Replacement as follows:

Maximum of $300/day

In general, the office overhead allowance will be paid at 100% for each Program day and travel days assigned according to the Travel Days formula under section 6.2.

6.3 Mobile/Home-centered CME

Claims for Mobile/Home-centered CME will be eligible for the following reimbursement:

- Registration Fee (Receipt Required)
- Office overhead/Income Replacement

Note:

-Eligible CME expenses will be reimbursed at the lessor of CME credits available or the total of eligible CME Expenses.

-In cases where a balance remains on the CME Claim, the balance of the claim will be automatically paid out once the physician is allocated more credits in the program.

7.0 Reimbursement Cheques

The Society will submit to the Department of Health, on a monthly basis, physician accounts that qualify for reimbursement. The Society is responsible for verifying the eligibility of physicians applying for CME and for processing of applications. The Department of Health will process invoices and make cheques payable to the Society. The Society is responsible for distribution of individual CME payments to physicians.

8.0 Maintenance of Documents

8.1 It will be the responsibility of the Society to maintain all documents required to support invoices submitted to the Department of Health for payment.

8.2 The Society will maintain a master listing of credits earned and used by each physician.

8.3 The Department of Health will provide to the Society, on request, information regarding a physician's income relevant to the CME earnings requirements, or in the case of Salaried Physicians, a list of Salaried Physicians.

8.4 For the purpose of administering the rural CME credits, the Department of Health shall provide to the Society on a semi-annual basis an electronic listing of eligible physicians. The list shall be produced using Medicare's Standard Geographical Location Code.

When the Society adds new physicians to its database an "urban" or "rural" notation will be assigned on the basis of the description in Paragraphs 2.2 and 2.3. The new assignments will be verified with the Department at the end of each month.

9.0 Program Funding

9.1 Effective April 1, 2014, the funding and the income threshold for eligible physicians will be adjusted annually through the negotiation and distribution processes.

9.2 NBMS will submit an invoice on or before April 10th of the fiscal year for the "Initial program funding" of $350,000. NBMS will be required to continue to submit monthly invoices with appropriate details. The initial program funding will be reconciled at the end of the fiscal year on the March invoice for CME.

9.3 Changes agreed upon, effective April 1, 2017, will be reevaluated annually.

10.0 CME Audits

In addition to any audit the Auditor General might want to conduct, the Department of Health reserves the right to audit all documents pertinent to CME accounts held by the Society.

11.0 Program Administration Fee

Effective April 1, 2020 until March 30, 2025, the Society will apply an administration fee of 1.5%. The amount will be added to each batch of claims submitted.

Schedule B

CANADIAN MEDICAL PROTECTIVE ASSOCIATION

PROGRAM OF COMPENSATION FOR
MEDICAL LIABILITY PROTECTION PREMIUMS

The Society has negotiated an annual fund with the Department of Health to reimburse Physicians for a portion of their medical liability protection premiums.

Historically, all eligible Physicians have obtained medical liability coverage through the Canadian Medical Protective Association (CMPA). Therefore, the risk categories referenced in this document refer to the CMPA Type of Work (TOW) Codes and the level of compensation is calculated using the CMPA fee structure as the frame of reference. However, eligible Physicians may be compensated for premiums paid to other companies, provided that appropriate supporting documentation is submitted to the Society.

1.0 Eligibility Criteria

A Physician is eligible for compensation if he/she satisfies all of the following conditions:

a) Is a member of the New Brunswick Medical Society (locum Physicians are eligible).

b) Is a New Brunswick physician engaged in FFS, sessional or Salaried Practice

FFS (includes sessional and Alternate Models of Remuneration): receives income from the Department of Health during the period for which they are being assessed for reimbursement or

Salaried Physicians: appears as an active salaried physician on Medicare's Salaried Physician List during the period for which they are being assessed for reimbursement.

c) Has not received compensation for CMPA premiums paid from any other organization or jurisdiction, for the same period of time for which the Physician is requesting compensation from New Brunswick. This is not intended to preclude reimbursement to Regional Health Authorities who have already paid the cost of coverage for the Physician.

d) Is a member of the CMPA Type of Work Code described in the formula or equivalent category with another provider.

e) CMPA Province of Work (POW) Code indicates the Physician worked in New Brunswick during the same period of time for which the Physician is requesting compensation from New Brunswick.

f) Has paid their CMPA premiums in full for the period for which they are seeking compensation.

2.0 Physician Reimbursement

2.1 The deductible can be modified during the term of the contract subject to the mutual agreement of the parties.

Physicians will receive 47% of their premium OR the difference between the appropriate TOW code and the deductible, whichever amount is greater.

Physicians will be reimbursed on a quarterly basis for their CMPA Premiums as follows:

- May for the preceding January to March period
- August for the preceding April to June period
- November for the preceding July to September period
- February for the preceding October to December period

2.2 Specialties (FFS and salaried) with CMPA premiums ≥ $15,000 would receive payment in 6 month installments; an initial payment in February covering the period January 1 – June 30 and a second payment in July, covering the period July 1 – December 31.

2.2.1 Income verification for all physicians, including those with Premiums ≥ $15,000 would continue to be done quarterly.

2.2.2 All other specialties will continue to be reimbursed quarterly, to include quarterly income verification.

2.2.3 Locums will now be eligible for reimbursement on a quarterly basis rather than once per year, at the end of the year.

2.3 Compensation requests must be received by the Society within one year of the Physician incurring the expense for medical liability protection.

2.4 If a Physician meets all of the eligibility criteria for only a portion of the year, the Physician is eligible for a pro-rata portion of the reimbursement.

2.4.1 The amount of reimbursement is calculated as follows: The total number of months the Physician was a member of the Society; practicing in New Brunswick based on CMPA's POW Code and in an eligible CMPA TOW code, including the month of registration (or departure), divided by 12; multiplied by the full reimbursement for that risk category. (The total is rounded up to the nearest dollar.)

2.4.2 If the Society's office has been informed of the exact date the Physician has left New Brunswick or began to practice in New Brunswick, the reimbursement will be prorated based on the date of departure/commencement. The amount of eligible months assumes that the Physician is in an eligible category for the months indicated.

3.0 Processing of Payments

3.1 CMPA Physician Payment Information

3.1.1 The Society will only accept the CMPA acknowledgement of fees paid, in electronic format from the CMPA. This file is posted to a secure website by CMPA for download by the New Brunswick Medical Society. CMPA has been advised that if any New Brunswick Physician requests the CMPA to fax Acknowledgements to the Society, they are to do so.

3.1.2 The data capture for the electronic file is based on the CMPA POW (Province of Work) code. CMPA provides the Society with the information on all Physicians who have indicated to the CMPA that they are or have been practising in New Brunswick during the year being assessed, and have not withdrawn permission for the release of information. This means locum Physicians will automatically be included in the electronic CMPA file.

3.1.3 The quarterly electronic file cannot be made available until after the CMPA has processed the payment of monthly fees, which is usually around the 20th of the month.

3.2 Assessment of Eligibility for Compensation

3.2.1 Payment, TOW, and POW information received from the CMPA is matched against the NB Medical Society's membership database as well as NB Medicare's billing data, to determine whether the physician meets the eligibility criteria of the funding program as outlined in paragraph 1.0. This will be done on a quarterly basis.

3.2.2 Queries are done on the data, to identify NB Medical Society members who were not included in the CMPA data file and may potentially be eligible for compensation.

3.2.3 Physicians during the course of the year may change their CMPA TOW or POW code. Each of the electronic transfers that CMPA sends the Society contains membership information for the entire membership year. Prior periods for the year will be checked against previously received information to ensure that members have received the correct amount of compensation and that no prior period adjustments are needed.

4.0 Notification of Physicians

4.1 Given that the Society has direct access to an electronic CMPA file that contains physician payment information, the majority of eligible physicians will not have to do anything in order to receive reimbursement.

4.2 Physicians are informed about the Program when they become members of the New Brunswick Medical Society.

4.3 "Reminder" notices may be included in the Society Newsletter as well as in the Society Economics Newsletter, or other publications.

5.0 **Timeline**

a) March of each fiscal year – submit manual payment requisition to the Department requesting funds for the year, as per paragraph 6.1.

b) Confirm electronic file access dates with CMPA

CMPA data should be available for download, the first day of work following the dates listed below.

March 20	(January-March period)
June 20	(April – June period)
September 20	(July – September period)
December 20	(October – December period)

c) May, August, November and February – distribute payments, follow-up letters to physicians.

d) No later than the end of April – Payment report to the Department, reporting the total payments made to Physicians with respect to the previous calendar year.

6.0 **Program Funding Formula**

The reimbursement formula described in Section 2 will be funded as follows:

6.1 The Department will fund the reimbursement program with annual funding of $7,802,972 ($5,869,151 FFS and $1,933,821 Salary). Total protected funding of $7,802,972 will be transferred to the NBMS as of April 1 of each year.

6.1.1 Any funding remaining in the protected funding pool at the end of the fiscal year will be maintained by the NBMS to offset future liability in the program.

6.1.2 If the total cost of the reimbursement program exceeds $7,802,972, the balance of the required funding will be taken from the reserve until such time as the reserve is depleted.

6.1.3 Any cost in addition to the protected funding pool, once the residual is depleted, will be funded through negotiation or fee distribution.

7. **Interest**

Interest earned on funds received from NB Medicare for the Compensation Program, shall be retained by the Society and shall be considered to be the administration fee for the operation of the Compensation Program.

Schedule C

MANDATED ON-CALL / SECOND CALL PROGRAM

1.0 Mandate

1.1 To provide compensation for mandated on-call/second call in New Brunswick hospitals, nursing homes, and NB Provincial Jails for specialists and general practitioners.

2.0 Objective

2.1 Primary objective of the Program is to meet the emergency/urgent needs of the public and to ensure that Physicians who provide mandated on-call/second call coverage as defined are compensated.

3.0 Definitions

3.1 Where used in this Schedule C, the following terms and expressions shall have the meaning indicated opposite such terms and expressions:

3.1.1 "non-regional hospital" means all hospitals, other than a "regional hospital";

3.1.2 "regional hospital" means the following New Brunswick hospitals: Dr. Everett Chalmers, Saint John Regional, The Moncton Hospital, Dr. Georges L. Dumont, Campbellton Regional, Chaleur Regional, Edmundston Regional, and Miramichi Regional;

3.1.3 "on-call" means, any period outside regular working hours (Monday through Friday and on weekends and statutory holidays", whereby a Physician will be available to respond to urgent or emergent requests from a facility (hospital, nursing home, or an NB Provincial Jail) for the purpose of examining, treating, providing diagnostic services or advice regarding a patient.

3.1.3.1 In the case of a hospital facility this includes discharged or unaffiliated patients who: present from the community via the emergency room, are referred by Physicians from other facilities or are in-patients admitted under the care of a Physician in another specialty.

3.1.3.2 In the case of nursing homes, this includes all existing or newly admitted residents.

3.1.4 "On-site" means attendance at a facility.

4.0 Staff By-laws, Privilege Rules and Regulations

This Schedule does not modify, nullify or void any medical staff by-laws, privilege rules and regulations between a Regional Health Authority and a Physician concerning work performed on an on-call basis;

5.0 Exclusions

5.1 The Program applies to Physicians working under all payment modalities. Physicians who receive on-call remuneration or other methods of compensation, agreed to separately by the Department and the Society to reimburse them for mandated on-call/second call, will be excluded.

5.2 The Department and the Society have agreed to the following exclusions:

- On call for surgeons and anesthetists in Sussex;
- Non-regional emergency rooms;
- Intensivists working in closed ICUs without on-site coverage;
- Psychiatry on-call at the Restigouche Hospital Center and Centracare;
- Obstetrics rural on-call at Campbellton Regional Hospital;
- Provincial Trauma Team Control Leader and Trauma Team Leaders in Saint John – SJRH and Moncton – TMH;
- Neonatal Intensive Care Units in Fredericton – DECH, Saint John – SJRH and Moncton – TMH;
- Alternate Funding Arrangements
- Any future payment arrangements agreed to by the Parties which include remuneration for on-call.
- Hospitalist project at Saint John Regional Hospital.

6.0 Principles

6.1 Remuneration is only available for mandated on-call as determined by the Medical Advisory Committee (MAC) for the Zone and the Regional Medical Advisory Committee (RMAC) within the Regional Health Authorities and/or by individual Nursing Homes and/or through a request from the Department of Public Safety on behalf of NB Provincial Jails.

6.2 There must be a response within 10 minutes or if required, attendance within 20 minutes unless alternative arrangements are stipulated by the RHA/Nursing Home/NB Provincial Jail.

6.3 This Program does not include routine consultations or work not defined as emergent/urgent. Physicians may continue to provide these services during the on-call period but must be available as described in article 6.2 above. This Program does not include routine on-call coverage for a Physician's own patients and those of their on-call group, however coverage applies to new admissions and orphan patients. As always, providing on-call coverage includes caring for hospitalized patients.

6.3.1 This compensation does not include on-call availability during normal working hours on week days.

6.3.2 After Hours Emergency Premium is not applicable to service code 8989 or any other service code for an on-call compensation.

6.4 Any request for a new Mandated On-call rotation must be submitted to MAC and RMAC and if approved, submitted in writing to the Department of Health. The Department will forward all requests for new call groups to the NBMS. The approval process will now be a two-step process:

1. Approve the Call – MAC/RMAC
2. Approve the Funding – NBMS Economics Committee/Dept. of Health

The NBMS FFS Economics Committee in conjunction with the Department of Health will have the authority to approve or deny an application for a new call group rotation. Each year the Economics Committee will report to the NBMS Board on the applications received throughout the year and the decisions regarding approval.

6.5 A regular review of all active On-call groups will be done by the NBMS FFS Economics Committee in conjunction with the Department of Health. The FFS Economics Committee will have the authority to request groups appear before the committee for review.

6.6 The Department requires prior notification, from the RHA, Nursing Home, or NB Provincial Jail, of any proposed additions or deletions to the number of rotations. Any changes will be made following proper consultation with the Society. Once a decision has been made regarding the number of rotations, the Department will notify the appropriate Parties of the decision.

6.7 Notwithstanding article 6.6, the number of rotations for NB Provincial Jails shall not exceed two (2) unless otherwise agreed to by the Parties.

6.8 Second call will be compensated effective April 1, 2006 for Anesthesia, Obs/Gyn and General Surgery for the 8 Regional Hospitals as mandated by the individual RHAs.

6.9 On-call rotations for General Practice, Specialists and Provincial Jails will be remunerated at the same rate. On-call rotations for Nursing Homes will be remunerated at $148.47 until March 31, 2020 at which time the rate will be reviewed.

6.10 Criteria for availability: If a Physician is participating as part of a service that is available 365 days (24x7) then they would qualify. If a Physician is not part of group that is able to cover 365 days then the following applies: a solo Physician must be available a minimum of 90 days of the year. A 2 Physician group must be available a minimum of 180 days, a 3 Physician group must be available a minimum of 270 days and 4 or more Physician group must be available 365 days. This criterion will be monitored quarterly by the parties.

6.11 Effective April 1, 2014, $2,000,000 will be transferred from the Salaried Physician Mandated On-call program to the FFS Mandated On-call budget to create a single Mandated On-call protected funding pool.

6.12 All claims for on call coverage, including FFS, salaried or Alternate Payment, Academic Payment or Alternate Funding Plans (where applicable), must be submitted FFS, unless otherwise agreed to in writing between the Parties.

6.13 A Physician will receive on-call compensation only once per night, regardless of how many services are covered or if it is for one or more regions/nursing homes/NB Provincial Jails of the province.

6.13.1 The only exception to article 6.13, above, is that, effective April 1, 2017, a physician or physician group is able to bill up to a maximum of 2 mandated on-call rotations when covering 2 or more zones, where the out of zone mandated on-call rotation is already funded, and

a. a vacant specialty position exists in that zone.; or
b. other exceptional circumstances are mutually agreed between the Parties.

6.14 Locums will be eligible for this remuneration, if they are replacing a Physician who meets the criteria.

6.15 When a Physician is called in to examine, diagnose and treat a patient he/she may bill the appropriate FFS fee and the After Hours Emergency Premium, as applicable.

6.16 RHAs will be required to submit information upon request providing monthly details (Physician's name, specialty and date of service). Regions must document all rotations covered by out-of-region Physicians.

6.17 Separate funding pools are created to assist in the management and sustainability of the program. The funding pools are listed below:

A. General Practice Funding Pool
Including non-regional, GP Addiction, GP Obs/Gyn, GP sexual Assault, Palliative Care, GP Geriatrics, Hospitalists, Methadone, Newborns and OR assists

B. Specialty Funding Pool

C. Nursing Home Funding Pool
D. Jails Funding Pool

7.0 Billing

7.1 The following services codes have been developed for FFS billing purposes. The date of service on the claim will reflect the date the on-call shift begins. One Physician will be compensated per date of service. Only one service/date can be billed on a claim.

Service Code 8989	General Practice (FFS and Salaried) rotations
Service Code 8990	Specialists (FFS and Salaried) rotations
Service Code 8991	Nursing Home rotations
Service Code 8992	Provincial Jail Rotations

7.2 Service code 8997 has been developed for FFS billing purposes for a second call.

7.3 Effective January 16, 2016, billing submissions for mandated on-call stipends outside the 3-month (92 days) window will not be considered.

8.0 Residual

8.1 The yearly expenses will not exceed allocated funding.

8.2 Three (3) percent of the allocated funding will be held back to fund additions to the roster list through the year. Any residual at year end will be allocated retroactively to adjust the rate to Physicians who have provided on-call coverage during the period.

8.3 The NBMS FFS Economics Committee in collaboration with the Department of Health will determine each year whether requests for call groups will be funded through contingency funding or a fee distribution or if a decision is made not to fund a request, the requesting group, either Specialist or General Practitioners, would need to determine whether a new call group will be funded out of the existing budget, which may result in a reduced daily call rate for that funding pool.

8.4 If provided, additional funding for second call coverage will be part of the original funding pool and therefore any residual will be available for retroactive adjustments including the 3% holdback.

8.5 Should the residual be depleted prior to the end of the fiscal year, the over-expenditure will be funded from any funds available from the second call and Inter-Regional Call pools prior to the residuals of these pools being paid out.

8.6 The percentage of hold back will be examined by the Parties at each year end.

9.0 Over-Expenditure

If the actual amount spent exceeds the available amount in any fiscal year, then the rate for the next fiscal period will be adjusted proportionately.

Schedule D

PARENTAL LEAVE PROGRAM
PRIVATE PRACTICE PHYSICIANS

1.0 Purpose

The purpose of this document is to set out the criteria which must be met by Fee For Service (FFS) Physicians in order to be eligible for Parental Leave which includes maternity, paternity, adoption, and surrogacy.

2.0 Description

Since January 1, 2006, the Department has offered a program to provide maternity, paternity, adoption, and surrogacy benefits to FFS Physicians who meet the eligibility criteria set out in this document.

3.0 Benefits

3.1 Physicians are reimbursed a maximum of 26 consecutive weeks at two thousand dollars ($2,000) per week. No "top-ups" can be made from any other source.

3.2

a) The Department provides an all-inclusive amount of $800,000 annually to fund the Parental Leave Program for Physicians under the FFS Agreement.

b) This amount provides a self-sufficient fund which will not sustain any cost overruns.

c) In the event the amount is not fully spent, the remaining funds will be retained by the Society for future years.

4.0 Eligibility Criteria

4.1 Physicians are eligible for benefits provided that their income meets or exceeds the income threshold either during the fiscal year or during the 12-month period prior to requesting benefits. To be eligible, the physician must be registered with the Department of Health as an active FFS physician at the time of application to the Program. The income threshold is the same as the CME income threshold and will be adjusted using the same formula as the CME threshold.

4.2 Physicians are eligible if they reside in New Brunswick, have an established practice in New Brunswick for 12-months and are full-dues paying members of the Society.

4.3 In the event a physician does not qualify under section 4.2, the physician will be eligible to access the FFS Parental Leave Program by signing a 12 month Return of Service Agreement attached at Appendix A.

4.4 This Program does not apply to locums.

4.5 In general, remuneration for parental leave starts the week of the date of birth or, if the baby is detained in hospital, the start of remuneration for parental leave may be deferred until the week the baby is released from hospital. In the case of an adoptive child five years of age or under, remuneration for parental leave will begin the week during which care of the adoptive child is commenced by the adopting parents.

4.6 The remuneration for parental leave may begin sooner than the week of the birth of the child only if the mother is required for health reasons to stop working. If the applicant is required to begin maternity leave sooner than the week of the birth, a medical certificate will be required indicating medical necessity.

Other Specific Circumstances

4.8 In the event of a two-physician family, each individual physician will be eligible to apply for up to 26 weeks of benefits. In these circumstances, the parents may choose to take their leave individually, concurrently, or consecutively. Leave for one physician cannot be transferred to the other.

4.9 Any individual, concurrent, or consecutive leave must be taken and completed within 52 weeks of the child's birth or adoption for both physician spouses. Leave for one physician spouse cannot be transferred to the other.

4.10 Effective April 1, 2009, Physicians who continue to bill FFS while on parental leave are ineligible for parental leave benefits during weeks where billings exceed $1,200 per week.

4.11

a) In the case where a locum has been hired to replace a Physician on parental leave, the Physician on parental leave will normally have their billing number suspended.

b) Effective April 1, 2009 in the event the Physician on parental leave is required to perform necessary duties their billings will be limited to $1,200 per week after which parental leave benefits will be lost and transferred to the FFS fund.

4.12 The Physician must normally give at least four weeks' notice in writing before the commencement of parental leave and inform the Society and the Physician Registrar at the Department in writing of the length of the parental leave intended to be taken. A medical certificate is required in the case of maternity leave. In the case of an adoption, a letter from the adopting agency indicating expected placement date is required.

5.0 Documentation Required (Post-birth/placement)

5.1 The following documents are required to receive benefits under this program:

a) **for Maternity/Paternity:**

(i) Birth Certificate or written verification from the attending Physician or adoption agency, including surrogacy birth, and

(ii) if the child is detained in hospital, notification of hospital release.

b) **for Adoption:**

(i) A letter from the adopting agency confirming date of placement.

5.2 All documentation must be retained by the Society and made available to the Department upon request.

6.0 Review

6.1 The Parties agree to review payments under this Parental Leave Program annually

6.2 Appeals/exceptions will be individually assessed by the DH and the Society.

7.0 Program Management

7.1 a) The Program is managed by the Society.

b) The Department provides the all-inclusive amount of $800,000 on Jan 1st annually.

c) The income will be included in the consolidated earnings.

d) Payment details will be submitted to the Department quarterly by the Society.

7.2 Notwithstanding Section 3.2 (c) of this Schedule, any interest earned by this fund after it is provided to the Society shall be retained by the Society.

8.0 Payment

8.1 Benefits will be paid on a monthly basis.

8.2 It is the understanding of the Parties that Parental, Adoption, and/or Surrogacy leave benefits are considered a taxable benefit.

9.0 Scope

This document applies to all Physicians:

a) whose primary method of payment is FFS, sessional or Alternate Payment/Funding Plan, or Academic Funding Plan; and

b) who meet the eligibility criteria described in article 4 of this Schedule.

10.0 Authority

The Parties agree that the authority for this Schedule is the Fee-for-Service Master Agreement.

11.0 Changes

This document can only be changed with the written consent of both parties.

12.0 Distribution

12.1 The Department will make its employees aware of this document and any changes.

12.2 The Society will make its members aware of this document and any changes, as well as disseminate all information to its members.

Schedule E

SUPPLEMENTARY HONORARIA PROGRAM

The Parties have agreed to renew the Supplementary Honoraria Program. The parameters of this Program are as follows:

1.0 Administration

1.1 Only FFS physicians will be eligible under this program.

1.2 The Program will be administered by the Society

1.3 Physicians who serve on approved departmental and joint NBMS/DH committees under the Master Agreement are entitled to receive an honoraria payment under this Program.

1.4 The Department will submit to the Society quarterly accounts detailing payments made by the Department.

1.5 Based on the quarterly accounts, the Society will prepare and submit an account, identifying the eligible Physicians, to the Department for the honoraria amount available under this Program.

1.6 The Minister agrees to make payment in the amount of 3% with respect to the Society's Program administration costs.

1.7 The records and accounts to support this Program will be maintained by the Society and will be available for audit purposes by the Minister.

2.0 Funding

2.1 Effective April 1, 2016, the Minister will fund this Program up to a maximum of $260,000 per year.

2.2 The Society will issue payment directly to the eligible Physicians.

2.3 a) Effective April 1, 2009, the total fee paid to FFS physicians who participate in joint NBMS/DH Committees is $500 per half day or $1000 per full day;

b) This Program will be responsible for payment of the difference between the amounts stipulated herein and the Department *Policies and Procedures Manual, Policy 213, Remuneration for Departmental Committees;*

c) Effective April 1, 2016, for joint NBMS and DH Committees, this program will cover the Supplementary Honoraria top-up portion only, excluding travel, meals and any accommodations costs.

2.4 Payment will be made by the Society to Physicians on a quarterly basis during the fiscal year.

2.5 Eligible Physicians must be residents of the Province at the time of payment by the Society.

2.6 The Program payment will be made by the Society will cover honoraria costs only; other expenses are excluded.

2.7 This is a Protected Funding Pool and any surplus remaining in the fund at the end of the fiscal year shall be available for alternate distribution, as mutually agreed to.

3.0 Review

3.1 The Schedule will be reviewed from time to time and changes may be adopted that are mutually agreeable to the Parties.

3.2 Increases in the funding of this Program will be dealt with through the FFS negotiation.

3.3 The Parties will review the funding during fee distribution or negotiations.

Schedule F

Medicare Assessment Framework

Pursuant to the *Medical Services Payment Act* and Regulations, the Department of Health may develop, in consultation with the Professional Review Committee (PRC), rules applicable to the assessment of accounts. In addition to those actions referred to in the Act, the Provincial Authority may also take actions to deny payment of an account, or to provide that payment be made at a rate less than that provided in the agreement for entitled services, or any other action that the provincial authority considers necessary.

The following process is intended to establish new assessment rules with respect to the assessment of accounts of physicians with patterns of billing which require review. This includes questions of:

- Whether the quality of service provided was below a minimum acceptable level;
- Whether the level of service provided was in excess of what could be considered to be medically required; and
- Whether there has been a misuse of the fee schedule under the medical services plan or under an agreement entered into under section 4.1 of the Act.

Process:

1. *Quarterly Review of Data by NB Medicare*

A. General Practitioners

Medicare will generate a report at the end of each quarter which will identify physicians whose total billings for all fee types (FFS, AFP, Sessional, On-Call) are three (3) or more standard deviations greater than their specialty remuneration average over the course of a quarter, using the quarterly Consolidated Earnings Report; and a minimum annual income threshold of $190,000.00

a. If a physician's billings are three (3) or more Standard Deviations above the average for their specialty at the end of any quarter a letter will be sent from the Department of Health (DH) to the physician:

   i. Explaining the process and potential actions if billings remain greater than three (3) standard deviations

   ii. Providing an opportunity for the physician to respond to the concerns addressed in the letter

b. The quarterly list of physicians identified will be provided to PRC along with any letters of response from those physicians

If a physician exceeds three (3) standard deviations above the average for a second quarter within the same 12- month period, a letter will be sent by the Provincial Authority to the physician:

a. Advising of specific concerns related to the physician's billing patterns. And notifying the physician that the following daily payment rate for the number of office visits will be implemented.

Patients per day	Rate
0 to 55(~2 SD)	100%
56 to 65	50%
66 and above	0%

b. Inviting the physician to make representations to the PRC respecting the matter under review.

Upon review of any representations made by the physician, the physician will be notified if:

i. No further action is to be taken and the limit on the number of patients per day be removed and that withheld funds be reimbursed; or

ii. A Medicare audit and/or assessment is to be completed; or

iii. An amount of overpayment to be recovered from the physician; or

iv. An external review is to be completed as set out below.

PRC will notify the physician in writing of the results of its review of any representations executed by the Provincial Authority as noted above.

B. Specialists

Medicare will generate a report at the end of each quarter which will identify physicians whose total billings for all fee types (FFS, AFP, Sessional, On-Call) are three (3) or more standard deviations greater than their specialty remuneration average over the course of a quarter, using the quarterly Consolidated Earnings Report; and a minimum annual income threshold of $250,000.00.

a. If a physician's billings are three (3) or more Standard Deviations above the average for their specialty at the end of any quarter a letter will be sent from the Department of Health (DH) to the physician:

   i. Explaining the process and potential actions if billings remain greater than three (3) standard deviations

   ii. Providing an opportunity for the physician to respond to the concerns addressed in the letter

b. The quarterly list of physicians identified will be provided to PRC along with any letters of response from those physicians

If a physician exceeds three (3) standard deviations above the average for a second quarter within the same 12-month period, a letter will be sent by the Provincial Authority to the physician:

i. Advising of specific concerns related to the physician's billing patterns and inviting the physician to make representations to the PRC respecting the matter under review.

ii. Advising that all future bi-weekly billings in excess of two (2) standard deviations above the average for that specialty section shall be withheld by NB Medicare pending review by the PRC.

Upon review of any representations made by the physician, the physician will be notified if::

i. No further action be taken and the amounts withheld in 1. B (g) (iv) be returned to the physician;

ii. A Medicare audit and/or assessment be completed;

iii. An amount of overpayment be recovered from the physician; and/or

iv. An external review be completed as set out below.

PRC will notify the physician in writing of the results of its review of any representations executed by the Provincial Authority as noted above.

2. *Order for External Review*

a. The physician may request (at their cost), a comprehensive physician-assisted external review from a Consultant or Firm with relevant expertise as recommended and approved by the Provincial Authority to provide further determination of whether

i. the quality of service provided was below a minimum acceptable level; and/or

ii. the level of service provided was in excess of what could be considered to be medically required; and/or

iii. there has been misuse of the fee schedule under the medical services plan or under an agreement entered into under the *Medical Services Payment Act.*

Once an external review is requested, it must be completed within 90 days.

The PRC shall consider the results of any external review and make recommendations, as needed to the Minister within 6 weeks of receipt of a report.

b. Upon implementation of above-noted capped payment rates, physicians may continue to see and bill for patients beyond the prescribed levels, and any payments reduced or withheld shall be held in trust with the Department of Health until the conclusion of any external review.

3. *PRC Recommendations*

a. If, following a Medicare audit or assessment there is a determination that an overpayment has been made; regular Medicare audit and recovery processes will be followed.

b. If, following an external review, the PRC determines that:

   i. the quality of service provided was acceptable; and/or

   ii. the level of service provided was considered to be medically required; and/or

   iii. there was no misuse of the fee schedule under the medical services plan;

   any physician payments reduced or withheld shall be released to the physician, and any costs for external review services incurred by the physician to perform the external review will be reimbursed to the physician upon provision of proof of payment. No further actions pursuant to this assessment rules framework will be taken against that physician for at least 2 fiscal years.

c. If, following the review, the PRC determines that:

   i. the quality of service provided was below a minimum acceptable level; and/or

   ii. the level of service provided was in excess of what could be considered to be medically required; and/or

   iii. there has been misuse of the fee schedule under the medical services plan or under an agreement entered into under the *Medical Services Payment Act:*

   Any physician payments reduced or withheld shall be released to the Department of Health, and the PRC may make additional recommendations to the Provincial Authority regarding recovery for any identified overpayments.

   Furthermore, the PRC may make any recommendations they may deem appropriate, up to and including, suspension as per section 5.5 (6) of the *Medical Payments Service Act*.

Schedule G

PROVINCE WIDE ON-CALL PROGRAM

1. Definitions

In this Schedule:

"Province wide on-call services" means any period outside regular working hours Monday through Friday and on weekends and statutory holidays, whereby a physician will be available to respond to urgent or emergent requests from a facility for the purpose of examining, treating, providing diagnostic services or advice regarding a patient.

"Mandated on-call" is defined in the Mandated On-call Guidelines, Schedule C of the Fee-for-Service Master Agreement signed October 20, 2009.

2. Mandate

2.1 To provide compensation for Province-wide on-call services in New Brunswick hospitals for the specialties of designated groups. This call will be formally arranged by the specialty group to cover the Province. All physicians in each specialty group must participate in the Province-wide on-call services unless otherwise specified.

3. Objective

3.1 The primary objective of the program is to remunerate on-call physicians providing Province wide on-call services including medical advice to physicians within and outside their home region/zone for emergent/urgent referrals.

This agreement does not modify, nullify or void any medical staff by-laws, privilege rules and regulations, between a Regional Health Authority and a physician concerning work performed on an on-call basis.

4. Responsibilities of the On-call Physician

4.1 The on-call physician will provide province wide on-call services in New Brunswick hospitals.

4.2 There must normally be a response within 20 minutes unless alternative arrangements are stipulated by the Department of Health

4.3 This Program does not include routine consultations or work not defined as emergent/urgent. Physicians may continue to provide these services during the on-call period but must be available as described in article 4.2 above. This Program does not include routine on-call coverage for a Physician's own patients and those of their on-call group; however coverage applies to new admissions and orphan patients. As always, providing on-call coverage includes caring for hospitalized patients.

4.4 The group must be available to provide on-call services for a minimum of 115 days (weekends and statutory holidays) per year

4.5 All claims for on-call coverage, including FFS, Salaried or Alternate Payment, Academic Payment or Alternate Funding Plans, must be submitted FFS.

4.6 A Physician will receive on-call compensation only once per night, regardless of how many services are covered.

4.7 Locums will be eligible for this remuneration if they are replacing a Physician who meets the criteria.

4.8 When a Physician is called in to examine, diagnose and treat a patient he/she may bill the appropriate FFS fee and the After-Hours Emergency Premium, as applicable.

5. Principles

5.1 RHAs will be required to submit information upon request providing monthly details (Physician's name, specialty and date of service).

5.1.1 Monthly rotation schedules are to be completed within the on-call group and forwarded to each RHA. Each RHA must then forward to each Medical Director who will notify each hospital of the on-call schedules.

5.2 Remuneration is only available for Province wide on-call as approved by the New Brunswick Medical society and the Department of Health.

5.3 No other Supplementary on-call payments made by an RHA.

6. Billing

6.1 Service code 8998 has been developed for FFS billing purposes. The date of service on the claim will reflect the date the on-call shift begins. One Physician will be compensated per date of service. Only one service/date can be on a claim.

6.2 Remuneration for each date of service will be set at $500.

6.3 A physician can only bill once in a 24-hour period.

7. Residual

7.1 A dedicated funding pool of $600,000 has been set aside for this initiative.

7.2 The yearly expenses will not exceed allocated funding.

7.3 Any residual at year end will be allocated retroactively to adjust the rate to physicians who have rendered mandated on-call coverage (under Schedule C of the FFS Master Agreement) during the period.

SCHEDULE H

FFS Retention Fund

Overview

1. The Government of the Province of New Brunswick (the "Province") and the New Brunswick Medical Society ("NBMS") have agreed to establish a program (the "Program") that will aim to maximize retention of participating fee for service medical practitioners within the Province. Salaried physicians and locum physicians are not eligible to participate in the Program.

2. Each practice that meets certain criteria with respect to the length and continuity of practice in the Province (an "Eligible Practice"), will be entitled to receive a payment from the Fund at the conclusion of practice in the Province as evidenced by the surrender of the billing number of the principal physician of the qualifying fee for service physician's practice ("Qualifying Practice").

3. For each fiscal year commencing on April 1, 2005, the Province will credit to a notional account (the "Fund") a dollar amount ("Contribution") with respect to each "Qualifying Practice".

   (a) The contribution will be made by the end of the first quarter based upon an estimate for the current Fiscal Years and an adjustment for variance with respect to the prior year estimate.

   (b) The annual incremental cost associated with adding new positions to the fund will be borne by the Department.

   (c) The cost of movement between ranges will be the responsibility of the Society.

   (d) Should the Program / Fund be terminated, for any reason, the Province and the NBMS will negotiate an alternative application for the Contribution and any residual in the Fund.

4. The annual dollar amount of the "Contribution" for each "Qualifying Practice" will be determined by multiplying the number of units awarded to the "Qualifying Practice" by the applicable unit value for that Fiscal Year.

   (a) The unit value cannot be altered during the fee-for-service (FFS) Distribution Phase.

   (b) The number of units awarded to a "Qualifying Practice" will be based upon the physician's number of years of service on a fee-for-service basis to NB Medicare as well as the location and based on the FFS Full-time Equivalent (FTE) of the "Qualifying Practice".

   See Attachment A - Tables 1, 2 & 3.

   (c) Years of service as a locum physician will not be included in the "years of service" count.

5. No Units will be awarded to a Qualifying Practice for the year in which it becomes an Eligible Practice.

6. Similar to other programs that have been established as a result of compensation negotiations between the NBMS and the Province, this Retention Program will be administered by the NBMS and payments will be issued by the NBMS using funds received from NB Medicare. The NBMS will submit periodic requests to NB Medicare for the amount of funds required to issue payments to eligible physicians.

7. The NBMS does and will not hold an actual pool of funding equal to the cumulative funds total for the Program. Neither will the Province, although the Province is disclosing a related liability on its financial statements. Payments from the Program are deducted from a "notional" fund balance.

8. Notional interest shall accrue each fiscal year on the balance of the Fund at the "Special Purpose Rate" as defined in NB Regulation 83-227 under the Financial Administration Act. The amount of the notional interest rate will be calculated on the last day of the previous quarter and credited to the balance of the Fund on the last day of the quarter.

9. Each Qualifying Practice must have one and only one principal physician. No physician may be the principal physician of more than one Qualifying Practice at any one time. A Qualifying Practice may be either an individual physician or a professional corporation. Where a group of fee for service physicians practice together in a partnership, the interest of each partner in that partnership shall be deemed a separate Qualifying Practice and the Units shall be held by the partner physician directly. For the purposes of the Program, only the services provided by the principal physician will be considered as services provided by the Qualifying Practice.

Transfer of Units

10. On the transfer of the principal physician from one Qualifying Practice to another, the first Qualifying Practice may transfer Units to the second Qualifying Practice. For example, where a physician practicing as the proprietor of a Qualifying Practice chooses to incorporate the practice, the Units held by the physician as proprietor of the first Qualifying Practice may be transferred to the professional corporation.

Categorization of Practices as "Rural" or "Urban"

11. The determination of the location of a practice will be done by application of the definition used with respect to the Program of Supplementary Funding for CME in effect on the first day of each fiscal year. For the year commencing April 1, 2005, a practice will be considered rural if the practice locations are beyond, and not falling between:
    - Moncton, Dieppe and Riverview
    - Saint John, Rothesay, Hampton, Quispamsis and Grand Bay/Westfield
    - Fredericton, Oromocto and New Maryland.

12. Where a practice has more than one location in a particular year (either by reason of a move or a practice carried out from multiple locations), the practice will be deemed to be "rural" for that particular year if not less than 75% of the billings of that practice were generated in a community or communities meeting the definition of "rural".

13. A determination of the location of practice as "rural" or "urban" for the fiscal years commencing prior to April 1, 2005 will be made for each practice. The Province will provide the NBMS with a list setting out the determination of location for each practice in the Province in the relevant period and will notify the principal physician of each practice of such determination. Each new practice

established following April 1, 2005 will be assigned an urban or rural location through agreement between the Province and NBMS.

Determination of Eligibility to Receive a Payment from the Fund

14. A practice will be an Eligible Practice and eligible to receive payment from the Fund as determined on the date of the relinquishment of the practitioner number of its principal physician if either:

    (a) The principal physician has provided service on a fee-for-service basis in the Province for not less than 15 continuous years. Temporary breaks in FFS service will not constitute a break in continuous service if:

        i. the break is of less than 12 months duration; or

        ii. the break of more than 12 months duration is for educational purposes with the prior approval of the Province and NBMS; or

    (b) The principal physician has provided service on a fee-for-service basis in the Province for not less than 20 years in total, provided that there has not been an interruption in FFS service in excess of 3 years in that period, other than a break for educational purposes (as set out in 14(a)(ii) above), with the prior approval of the Province and the NBMS.

    (c) A physician remunerated under the medical pay plan who has changed his principle mode of remuneration from FFS to Salary, will retain past shares prior to the transfer date (per 14 (a) and (b)) and would not accumulate any further shares during the year of transfer.

15. Where the principal physician of a practice ceases to practice in the Province by reason of death prior to relinquishment of the practitioner number the practice will be an Eligible Practice, as at the date of death of the physician regardless of the number of years of service of that physician. An amount will be payable to the estate based upon the number of units accumulated by the physician multiplied by the calculated unit value at the time of payment.

16. The practice of a permanently disabled principal physician will be an Eligible Practice at the date on which the Province or the NBMS is notified of the disability and the practitioner number is relinquished as a result of that disability, regardless of the number of years of service. A physician will be considered permanently disabled upon examination by an independent physician acceptable to both the Province and the NBMS who certifies that the physician is not capable of practicing medicine and will not become capable of practicing in his or her lifetime by reason of a recognized medical condition.

Forfeiture of Units in the Fund

17. A practice will forfeit all Units on the third anniversary of the day on which an interruption of service commenced, other than a break for educational purposes of the principal physician with the prior approval of the Province and NBMS.

18. For the purposes of determining the number of Units outstanding, an Eligible Practice will be deemed to have redeemed all Units on the first day of the fiscal year in which it became an Eligible Practice.

Determination of Payment to an Eligible Practice

19. Upon becoming an Eligible Practice, a practice will be entitled to receive a payment equal to the sum of:

    (a) the Eligible Practice's proportionate share in the Fund determined as at the last day of the last completed fiscal year (the "Determination Date"); and

    (b) the amount of the Contribution (prorated) made to the Fund with respect to that practice for the year in which it becomes an Eligible Practice.

20. Within 60 days of notification that a practice has become an Eligible Practice the NBMS will provide the principal physician of that Eligible Practice with a statement setting out the amount of the payment to which that Eligible Practice is entitled. In the event the NBMS is unable to provide a precise calculation of the amount of the payment within that time period, it shall provide an estimated amount.

21. Unless directed otherwise by the principal physician, the NBMS shall make a payment to the Eligible Practice as soon as reasonably practicable upon receipt of payment from the Province. However, the NBMS will have no obligation to pay any amount to the Eligible Practice unless and until it has received payment from the Province of the required amount.

Tax Liability Related to the Payment to an Eligible Practice

22. According to the advance rulings obtained from the Canada Revenue Agency (CRA):

    (a) The payment from the Program to an Eligible Practice must be declared as income in the year that the Medicare billing number is surrendered.

    (b) The Society will issue a Form T4A or T4A-NR Supplementary (Non-Resident of Canada) to the Eligible Practice, after the payment has been made.

    (c) Neither the Province nor the Society is required to withhold any amount from the payment to the eligible practice unless the payment is subject to the application of subsection 105 (1) of the Regulations (Income Tax Act) where such payment is made to a person who is not a resident in Canada for the purposes of the Income Tax Act at that time.

    Note: The CRA did not issue a ruling with respect to the GST/HST status of the payment to the eligible practice but provided an interpretation that to the extent that the payments are provided through the Medicare Plan they would appear to be consideration for an exempt supply pursuant to section 9 of Part II of Schedule V to the Excise Tax Act.

Payment Processing and Administration

23. Quarterly, or at such other interval as may be agreed by the Province and the NBMS, (the "Reporting Interval"), the NBMS shall deliver to the Province a request for payment from the Fund. The amount requested shall include:

    (a) All amounts payable in the next Reporting Interval with respect to Eligible Practices but only to the extent such amounts have not been previously requested and paid; and

(b) Amounts payable to NBMS to defray its costs of the administration of the Program. While the NBMS intends to recover its entire costs of administering the Program, including capital costs, the Society will not profit from the Program. The definition of Capital costs shall be consistent with the Society's audited Financial Statements.

(c) The notional balance of the Fund will be reduced by the amount of any payments made by the province to the Society whether according to paragraph (a) or (b).

(d) The Canada Revenue Agency has ruled that the payments from the Province to the Society with respect to administration costs are consideration for a taxable supply and are therefore subject to GST/HST. No deduction shall be made from the Fund with respect to such tax.

24. The Province shall have the right to review all requests for payment received from the NBMS and to facilitate that review, the NBMS shall provide the agents of the Province with reasonable access to all NBMS books and records related to the administration of the Fund.

Record Keeping

25. The NBMS will be responsible for the maintenance of a database, or databases as required, incorporating the information necessary to administer the Program and allowing the generation of the required reports.

26. Not more than 30 days following the end of each fiscal year, the Province will provide the following information to the NBMS with respect to each practice in the Province, as of March 31 of that fiscal year in a mutually acceptable electronic format:

(a) name of the principal physician;

(b) urban/rural designation; and

(c) FTE calculation for each physician as per the Medical Service Payment Act Section 2.2 (4).

26.1 On a quarterly basis, the Province will provide the following:

(d) on the last day of each quarter, the notional interest rate applied to the Fund (as per #8);

(e) the opening Fund balance;

(f) a listing of all physicians who have left the province or retired; and

(g) any other information deemed relevant to administer the Fund.

26.2 Prior to the start-up of the Program, the Province will provide, for each principal physician, the years of continuous and years of cumulative service in the Province as of April 1, 2005.

Reporting

27. Not more than 90 days following the end of each fiscal year the NBMS shall provide to the Province reports setting out the following information with respect to the Fund, for that fiscal year:

(a) the opening Fund balance;

(b) an estimate of contributions to the Fund for the current fiscal year and a reconciliation of the funds contributed for the previous fiscal year;

(c) amounts paid with respect to Eligible Practices, during the year;

(d) amounts paid to NBMS for administration during the year;

(e) the balance of the Fund at the end of the year;

(f) the cumulative number of Units awarded to practices and outstanding as at March 31 of the prior year; and

(g) the number of Units awarded and outstanding as at the end of the fiscal year.

28. Quarterly, or at such other interval as may be determined by the Province and the NBMS, the NBMS shall provide to the Province a report with respect to those practices which became Eligible Practices in that period setting out:

(a) name of the principal physician of each Eligible Practice;

(b) the proportionate interest in the Fund as at the last day of the last completed fiscal year;

(c) the amount of the Contribution with respect to that practice for the fiscal year in progress;

(d) the aggregate amount payable with respect to all practices which became Eligible Practices in that period.

29. NBMS will make available to each principal physician an individual report or record for each year outlining the information in the database with respect to that physician's practice. The NBMS will make available to all physicians the information set out in #27 above.

Dispute Resolution

30. In the event either the NBMS or the Province wish to question any amount, determination or other information provided under the Program, that party shall give the other notice in writing of its intention to do so not more than 60 days after receipt of the report or other notice of the amount at issue. The other party shall respond to such notice within 30 days with a written proposal to rectify the problem. If the notifying party is not satisfied with that proposal, the parties shall engage a mediator and the dispute shall then be adjudicated in accordance with the Negotiation and Dispute Resolution Regulation 2002-53 enacted under the *Medical Services Payment Act*.

Indemnification

31. The NBMS has agreed to indemnify and save harmless the Province from all actions, claims, suits, demands, loss and damage arising out of the Program.

32. Likewise, each physician who applies to receive a payment from the Program will be required to sign a document to indemnify and save harmless the NBMS from all actions, claims, suits, demands, loss and damage arising out of the Program.

Schedule I

Joint Oversight Committee – Terms of Reference

Name of Committee:	NBMS/Department of Health Joint Oversight Committee
Reports to:	NBMS- FFS & Salaried Economics Committees DOH- Assistant Deputy Minister of Policy, Planning, Medicare and Pharmaceutical Services
Functions:	The Committee will be responsible for identifying potential resolutions of ongoing and/or unresolved issues including proposed Fee Schedule changes, billing and assessment rules and other administrative or financial/economic matters related to contractual relationships between the Department of Health and the NB Medical Society for FFS and Salaried. The Committee could be used for related joint planning and establishing of priorities. The Committee will function and make recommendations by consensus. The Committee will meet a minimum of 8 times a year, ideally every 6 weeks or as required.
Membership:	The Committee will consist of six (6) members, 3 from the NBMS and 3 from the Department of Health. The Committee has the power to add members on an ad-hoc basis based on the issues before the Committee. The Committee will be co-chaired by the parties.

SCHEDULE J
SPECIFIC FUNDING ITEMS

	2% 2020-21	1.5% 2021-22	1.5% 2022-23	1.5% 2023-24	1.5% 2024-25
Fee for Service					
Base	$ 540,251,254	$ 552,172,876	$ 563,346,816	$ 585,549,225	$ 596,455,805
GEI	$ 10,805,025	$ 5,521,729	$ 8,450,202	$ 8,783,238	$ 8,946,837
GEI 0.5% Target Priorities		$ 2,760,864		(GEI $ estimated)	(GEI $ estimated)
Subtotal	$ 551,056,279	$ 560,455,469	$ 571,797,018	$ 594,332,464	$ 605,402,642
Other Targeted Priorities (2)					
Hospitalist Program			$ 11,779,000 (1)		
Closed ICUs		$ 1,255,565			
SJRH Medical Care Unit		$ 323,544			
FMNB Operational Costs		$ (122,000)	$ 49,000	$ 120,000	$ (16,000)
FMNB Capitaion Savings		$ (415,000)			
Emergency Dept. Rate Increase	$ 1,116,597	$ 1,849,238	$ 1,924,207	$ 2,003,341	
Subtotal	$ 1,116,597	$ 2,891,347	$ 13,752,207	$ 2,123,341	$ (16,000)
Total	$ 552,172,876	$ 563,346,816	$ 585,549,225	$ 596,455,805	$ 605,386,642

(1) Funding for the Hospalist Program, while assigned to the 2022-23 fiscal year, can be paid retroactively to April 1, 2021, provided the hospital seeking retroactivity has operated under a sessional hospitlaist model.

(2) Funding for Other Targeted Priorities are estimates and subject to change.

Schedule L

(Intentionally Omitted)

Schedule M

PRINCIPLES OF CONSULTATION BILLINGS

These principles were drafted to assist Physicians in the appropriate billing of Consultation codes as found in the various sections of the New Brunswick Physician's Manual. Instructions regarding referrals, physical examinations, documentation required, applicability of the after-hours emergency premium, and consultation billings when physicians are receiving sessional payment are provided.

Introduction

A billable consultation refers to the situation where a recognized provider (see Chapter 1, Section 1.7.1 (h) or Section 1.7.2 (j) of the Physician Manual) specifically requests the opinion of a physician who is competent to give advice in the requested field because of the complexity, obscurity or seriousness of the case. The request may result from the referring provider's own assessment of the patient or from his concurrence with a request by the patient or a person acting on behalf of the patient.

A consultation IS:

- Initiated by the referring physician, not the consultant.
- A written or verbally requested assessment of a patient that is correctly documented in the patients clinical file, including date and time of the request.
- Made by an approved allied healthcare professional.
- A request for reassessment of a patient after a change in the existing condition

A consultation IS NOT:

- A follow-up care visit/service provided to a patient where an existing diagnosed condition has been managed by the consultant/physician/specialty.
- A subsequent visit arranged by the consultant for follow-up (see visit code listed in the specialty section).
- To provide temporary/routine patient coverage for patients in the physicians absence.
- A transfer of care from same specialty for continuation of care.
- A referred patient for a procedure that has not received the proper assessment of a consultation.

Note: A patient referred for diagnostic procedure needs complete assessment consultation in order to bill a consultation.

Required documentation in order to Support the Referral

In order to meet the billing requirements of a consultation, a written referral or documentation of a referral by telephone must be included in the file. The documentation must include:

A. Patient's name, Medicare number, and date of birth
B. Consultant's name or the name of service being referred to
C. Specialty
D. Date of the referral
E. Name of the referring Physician

F. Reason for requesting an opinion
G. Date and time of verbal request by telephone when applicable.

Note: A form issued by the consultant to the referring physician, asking them to sign and return it to the consultant physician, does not constitute an acceptable consultation request.

Documentation Required in the Consultation Report

In order to fulfill a requested consultation, "The consultant is obliged to perform an assessment as per the definition of a consultation in Chapter 3, section 1.2.4 and ensure inclusion in the Consultation report.

The documentation must include:

A. Written communication back to the referring Physician including the patient's name, Medicare number and date of birth
B. Name of the referring Physician
C. Date of the consultation
D. Name of the consultant
E. Evidence of a history and appropriate comprehensive examination of the pertinent system(s) having been performed
F. Review of laboratory or other pertinent data (as required)
G. Opinion and further recommendations for management

Note: It is incumbent upon the physician to maintain adequate clinical records that support the service(s) being claimed when using electronic medical record software (eg Meditech) for billing a service. (Chapter 1, section 7.2)

After-Hours Emergency Premium

The definition of emergency services for the purpose of billing premiums, refers to those services which must be performed without delay because of the medical condition of the patient. The time of the service provision is not in itself the determining factor for premium charges. There must be documented evidence as to the emergent nature of the after-hours service. This premium is only payable when both criteria have been met; an emergency service (Chapter 3, section 1.2.2 d) provided after-hours (Chapter 4, section 2.12).

Fee-for-Service Consultation Billings and Sessional Remuneration

Unless otherwise specified, sessional fees are all inclusive rates and physicians are not to bill fee-for-service in addition to their sessional payment, regardless of where the service is provided.

Schedule N

CLOSED INTENSIVE CARE UNIT (ICU) ALTERNATE FUNDING OPTIONS

This proposal has been specifically designed as and is exclusively applicable to a Closed Intensive Care Unit Alternate Funding Plan.

1. Mandate

To provide reasonable compensation through an alternate funding plan (AFP) to Physicians who are providing Critical Care services in a Closed Intensive Care Unit.

2. Definitions

2.1 "Critical Care" (intensive care/internal medicine/cardiac care) is a multidisciplinary and multi-professional field concerned with patients who have sustained or are at risk of sustaining life-threatening single or multiple organ system failures due to disease or injury.

2.2 "Intensivists" are physicians who have demonstrated interest and have acquired experience and/or certification in Critical Care medicine. Intensivists participating in a Closed Intensive Care Unit must be certified to provide Critical Care services or have demonstrated the necessary expertise to provide Critical Care services as determined by the Regional Health Authorities.

2.3 "Closed concept" involves units where a team of appropriately recognized Intensivists are continuously available to provide management of critically ill patients. Only a member of the Intensivists team may admit and discharge patients.

3. Deliverables

3.1 Direct Patient Care

The team and each of its members, agree to:

3.1.1 Provide total and complete medical care of admitted Intensive Care Unit ("ICU") patients, including timely admissions and discharges; appropriate ordering of diagnostic services and prescribing of pharmaceuticals; applying all protocols that have been adopted by the team regarding the delivery of care to ICU patients; effective arrangements for follow-up care by other Physicians;

3.1.2 Provide coverage in accordance with the terms of each respective hospital's individual Alternate Funding Plan ("AFP") agreement;

3.1.4 Abide by RHA and Medical Staff bylaws and rules with respect to the medical administration of the ICU;

3.1.5 Provide FFS history only claims (shadow billing) electronically to the Department.

3.2 General

Each team member agrees to:

3.2.1 Participate in the, respective AFP;

3.2.2 Surrender any third party billing except medical-legal;

3.2.3 Not bill Fee For Service ("FFS") for any service provided by the Intensivist while covering on or off site for admitted ICU patients;

3.2.4 Be excluded from any participation/remuneration under the AFP if he/she suffers a loss or suspension of Medical Staff privileges;

3.2.5 Be excluded from any participation/remuneration under the AFP if he/she suffers a loss or suspension of his/her license to practice medicine in the Province of New Brunswick;

3.2.6 Maintain current qualifications in Advanced Cardiac Life Support;

3.2.7 Participate in teaching and team conferences; the development of standards, protocols and policies;

3.2.8 Evaluate new equipment and technology;

3.2.9 Participate in CME events (to respond to rapid system changes in the environment);

3.2.10 Participate in organ donor activities;

3.2.11 Participate in quality assurance processes;

3.2.12 Contribute to recruitment and retention initiatives.

4. Funding

4.1 The funding for each AFP shall be provided in accordance with the terms of each respective hospital's individual alternate funding plan agreement.

4.2 While providing on-site coverage or off-site coverage, the Intensivist may bill FFS for services rendered to patients not yet admitted to the Closed ICU.

4.3 Each team is free to determine the allocation of any negotiated funding.

Closed ICU Funding Options

4.4 Effective April 1, 2020, the following ICU AFP Rates will be payable to each of the respective closed ICUs providing **on-site, after-hours coverage**:

Hospital	Budget
DECH	$ 1,327,782
GLD	$ 1,327,782
SJRH	$ 1,991,674
TMH	$ 1,991,674

4.5 Effective April 1, 2022, closed units with **off-site, after-hours coverage** will be offered $850,000.00 per closed ICU:

4.6 Effective April 1, 2019, the ICU AFPs at each of Chaleur Regional Hospital and Edmunston Regional Hospital with **off-site after-hours coverage** will receive $661,730.00 per closed ICU, to be adjusted by Distribution.

4.7 Any increase in bed numbers in any of the respective closed ICUs during the term of this Agreement shall trigger a renegotiation of rates payable to that respective closed ICU.

4.8 Any request for enhanced ICU AFP Funding shall be considered and funded through the Distribution process.

4.9 Any funding surplus realized through the reduction in ICU Service Coverage shall be calculated and made available to the NBMS residual funding pool for general distribution.

4.10 Should any other situation arise where new closed units are created, with the approval of the Department, the related funding responsibility will rest with the Department.

4.11 This agreement does not include Coronary Care Units (CCU).

4.12 Any escalator will be determined through fee distribution by the Economics Committee.

4.13 All closed ICU AFPs shall comply with the AFP Framework agreement set out in Schedule T of the *Physician Services Master Agreement*.

Schedule O
2019-2020 Base

As per Articles 3.2 of this agreement;
FFS Base for 2019-2020

Payments for FFS claims (April 1, 2019 to March 31, 2020)	$	389,763,752
Capitation		3,505,036
Manual Payments (sessional, collaborative practice and other)		58,780,252
AFP & APP funding (including annualization of changes)		43,613,105
Changes in remuneration type (including annualization)		(323,806)
CME expenses		5,186,169
Fund for CMPA		5,869,151
Fund for Mandated On Call / Second Call		14,947,820
Fund for Parental Leave Program		800,000
Fund for Supplementary Honoraria		260,000
Fund for Province-Wide Call		600,000
Fund for Retention Fund		4,855,937
Fund for EMR		1,500,000
Fund for Physician in Crisis		50,000
Fund for Chronic Disease Management Claims		3,500,000
Fund for Chart Initiation Fee Claims		2,180,000
Fund for Senior Code enhancement Claims		2,042,897
CMPA - Salaried		1,933,821
CME - Salaried		1,187,120
Total	$	540,251,254

SCHEDULE P

SAINT JOHN REGIONAL HOSPITAL
INTERMEDIATE MEDICAL CARE UNIT AFP

The parties have agreed to negotiate the terms of an Alternate Funding Plan (AFP) that would guarantee provision of medical care to between 25-30 inpatients who are admitted to the Intermediate Medical Care Unit (IMCU) at the Saint John Regional Hospital (SJRH).

Deliverables

Deliverables for participating IMCU Physicians will include total service coverage for the IMCU. Deliverables under this AFP Proposal shall include, but are not limited to the following:

1. Provision of collaborative, longitudinal, Internal Medicine service to follow inpatients admitted to the IMCU, and to provide medical guidance on workup/management.
2. Provision of Step-Up Unit for:
    a. SJRH Family Medicine and Emergency Department inpatient service;
    b. Charlotte County and Sussex Family Medicine Inpatient Service.
3. Provision of Step-Down Unit for:
    a. SJRH Medical ICU.
4. Provision of services to all patients with advanced care requirements that are not commonly utilized among Hospitalist/FP service.
5. Provision of services to stroke patients who require admission to the Neuro-ICU.
6. Provincial point of admission for all patients requiring plasma exchange.
7. Provision of admission for chronic hemodialysis patients during acute medical admission.
8. Participating physicians will provide a practice plan to Medicare and Horizon to outline the expected coverage hours and rates of payment (expected to include two physicians providing coverage to the IMCU between 08:00 – 18:00 Monday – Friday, and one physician providing coverage to the IMCU between 08:00 – 18:00 Saturday - Sunday.
9. IMCU physicians will submit fee-for-service history only claims (shadow billing) under a designated shadow-billing account electronically to Medicare for all IMCU services provided to patients admitted to the unit.
10. Salaried physicians may only receive funding from this AFP for services rendered after-hours, on statutory holidays, or on weekends.
11. During IMCU service hours, IMCU physicians shall prioritize care to patients admitted to the IMCU program.

FFS Billing

1. Participating IMCU physicians may bill fee-for-service (FFS) at any time during IMCU hours for work done outside the IMCU (non-IMCU patients), provided such other work does not interfere with availability for the IMCU service.
2. Participating IMCU physicians may bill FFS at any time during IMCU hours for new consults for patients being newly admitted to this service.
3. Salaried physicians are not eligible for IMCU fee-for-service funding during their regular salaried working hours.

Funding

A separate funding pool will be established for this AFP:

a. Total annual funding in the amount of $965,328 will be transferred to Horizon Health. The frequency of the transfer of funds will occur as agreed by Horizon and the DH.
b. At the end of each fiscal year, namely March 31, any funds remaining in the pool will be carried forward and credited against new funding for the following fiscal year.
c. At the end of each fiscal year, namely March 31, the Parties consent and agree that any over-expenditure on the part of the Physicians will not be funded by the Minister or RHA B unless otherwise agreed between Parties.
d. During the term of the agreement, the total annual funding pool will be subject to and adjusted by the Fee Distribution, as negotiated by the NBMS and the Department of Health as part of the Physician Services Master Agreement.

Resolution of Disputes

Reference to the standard dispute resolution clause, i.e. conventional arbitration under *Arbitration Act*, SNB, 1992 Ch. A-10.1, will be included.

Termination

Reference to standard termination clauses i.e. 60 days written notice by either party, termination by mutual written agreement of all parties, etc, will need to be included.

Duration

The duration of this agreement will be from June 1, 2019 to March 31, 2024.

Notes

*Contract language to be drafted and agreed upon between the parties.

Current Funding Available

(Coverage of approx. 25-30 beds)

IMCU Inpatient WEEKDAY Coverage	Hours	Total Hrs Rate	Total Budget
(1 x IM 0800-1600) (5 days x 8 hrs x 52 wk)	2080	$142.80/hr	$297,024
(1 x IM 0800-1300) (5 days x 5 hrs x 52 wk)	1300	$142.80/hr	$185,640
IMCU Inpatient WEEKEND Coverage			
(1 x IM 0800-1200) (2days x 4 hrs x 52 wk)	416	$195/hr	$81,120
WEEKDAY Back-up MOC OVERFLOW			
(2 x IM 1201-1700) (5 days x 10 hrs x 52 wk)	2600	$30/hr	$78,000
TOTAL BUDGET			**$641,784**

Proposed New Funding for AFP

IMCU Inpatient	Hours	Total Hrs Rate	Total Budget	Difference
WEEKDAY Coverage				
(1 x IM 0800-1800) (5 days x 10 hrs x 52 wk)	2600	$142.80/hr	$371,280	(+74,256)
(1 x IM 0800-1800) (5 days x 10 hrs x 52 wk)	2600	$142.80/hr	$371,280	(+185,640)
IMCU Inpatient				
WEEKEND Coverage				
(1 x IM 0800-1800) (2days x 10 hrs x 52 wk)	1040	$142.80/hr	$148,512	(+67,392)
WEEKDAY Back-up MOC				
OVERFLOW				
(2 x IM 1201-1700) (5 days x 2 hrs x 52 wk)	520	$142.80/hr	$74,256	(-3,744)
TOTAL BUDGET			**$965,328**	(323,544)

NB Comparators

Chaleur – Closed Small ICU (5-7 Beds)
$657,000/year
1 IM available 10 hours/day + Call

DECH CMC – Consult Service to Hospitalist (3-5 beds)
$250,737/year
1 IM available 5 hrs/day (Weekdays) + 5 hours on Weekends

URVH CCU – Coverage of 5 bed unit
$483,623/year
1 IM available 8 hrs/day + Call After hours/Weekends

Schedule Q

New Service Items

Definition:

A new service is defined as new fee item(s) created for new procedure(s), new technique(s), new technology or new program(s). The New Service Items (NSI) process is not to be used for fee increases or for new fee items that have a higher fee for a service currently adequately described and paid under an existing fee code.

Effective April 1, 2020, all requests for New Service Items are to be submitted to the NBMS Fee-for-Service (FFS) Economics Committee and will be reviewed during the annual Fee Distribution process. All NSI requests will be submitted to the NBMS FFS Economics Committee using the NSI Request Form and must be signed by the Section Liaison Representative acknowledging they have read and support the request.

Where it is determined and agreed by the parties, that an NSI request is cost neutral, or will produce a cost savings, these requests can be resolved outside of the formal NSI process.

Where it is determined that an NSI request requires new funding be added to the Medicare budget, the process will be as follows:

a) Requests that are initiated or approved by either the Department of Health (DH) or a Regional Health Authority will be funded by the Department of Health through an increase to the annual Medicare budget.

b) Requests from the NBMS or physician members, will be funded through the annual FFS Fee Distribution process.

All NSI requests, initiated by the NBMS or physician members, requiring additional funding, will be forwarded to the Department of Health prior to consideration by the FFS Economics Committee, to ensure there is support for the request.

The Economics Committee will work with the requesting section and the Department of Health through the FFS Fee Distribution process to define, create and fund approved NSI requests.

Notice of approved new codes funded through the FFS Fee Distribution process, outlined above, will be communicated by NB Medicare, along with all other changes resulting from an annual Fee Distribution.

Schedule R

Remuneration for Surgical Cancellations

Goal:
To recognize the opportunity cost to the New Brunswick health care system of cancelled surgeries and to establish a remuneration plan for physicians for surgeries cancelled for non-medical or administrative reasons.

Fee:
100% of the fee payable to the surgeon, surgical assistant and anesthesiologist had the surgery not been cancelled due to the non-medical reason defined herein.

- Non-medical and administrative reasons:
  - Post op bed unavailable
  - Equipment unavailable or malfunction
  - OR staff unavailable
- This fee will only be payable if the surgery is cancelled within 24 hours of the scheduled day of surgery (or Friday for a surgery scheduled for Monday)
- This fee will be payable only when physicians are unable to perform other surgical procedures in place of their cancelled surgeries
- *Payable once per physician per patient for the same condition within 30 days of the initial cancellation.*
- *Applicable only to scheduled procedures as booked on the OR booking card.*
- Fees will apply to surgical procedures performed in the main OR.
- Fees will not apply to surgeries which do not require admission (including all day surgeries).
- Salaried physicians (including anesthesiologists and surgical assistants) or those in an alternate funding arrangement would not be eligible.
- After Hours Emergency Premium does not apply.
- If required, the RHA will confirm whether case was cancelled or not.
- The information required for audit purposes will be provided by the RHA.
- This fee does not apply to surgery cancelled for out-of-province patients.

Anesthesiologists must use the average time spent on the specific procedure being billed. Only modifiers identified during pre-anesthetic evaluation are applicable for billing.

Schedule S

PHYSICIAN WELLNESS SERVICE

1.0 Purpose

The purpose of this document is to identify the annual funding available to the New Brunswick Medical Society ("NBMS") for the purposes of providing Physician Health and Wellness Services to members of the NBMS.

2.0 Description

Effective April 1, 2020, the Department of Health will maintain a Protected Funding Pool to be used for providing individualized health and wellness support to physicians practicing within New Brunswick.

3.0 Benefits

The NBMS is authorized to utilize this Protected Funding Pool to provide physicians with access to benefits such as health promotion and wellness initiatives, specialized counseling services, and specialized in-patient treatment services.

4.0 Funding

4.1 Effective April 1, 2020, the Department will increase the all-inclusive amount of $50,000 annually to $250,000 annually to fund the Physician Wellness Service under the Physician Service Master Agreement.

4.2 This amount provides a self-sufficient fund which will not sustain any cost overruns.

4.3 The funding pool balances shall be reconciled annually by the Minister and any surplus shall be available to the Society upon mutual agreement for alternate use or reallocation. Any over-expenditure of funds shall be funded with the existing surplus from other Protected Funding Pools, or shall be recovered from the following year's Distribution if no funding is available in the current year.

5.0 Eligibility Criteria

5.1 The NBMS may establish eligibility criteria as necessary, in consultation with the Department of Health.

Original: April 1, 2016
Amended: April 1, 2020

6.0 Program Management

6.1 The Program is administered by the New Brunswick Medical Society.

6.2 A report detailing Program payments, will be submitted to the Department annually by the New Brunswick Medical Society by April 30th for previous year.

6.3 Any interest earned by this fund after it is provided to the Society shall be retained by the Society.

7.0 Authority

The Parties agree that the authority for this Schedule is the Physician Services Master Agreement.

8.0 Changes

This document may only be changed with the written consent of both parties.

9.0 Distribution

13.1 The Department will make its employees aware of this document and any changes.

13.2 The New Brunswick Medical Society will make its members aware of this document and any changes, as well as disseminate all information to its members.

Original: April 1, 2016
Amended: April 1, 2020

Schedule T

AFP Management Framework

I. Background:

In response to the evolving nature of medical practice and the needs of Department of Health and physicians to ensure access to health care for New Brunswick patients, the New Brunswick Medical Society (NBMS) has facilitated and carried out negotiations with the Department of Health to establish Alternate Models of Remuneration, where appropriate. These Alternate Models of Remuneration are negotiated on behalf of physicians or groups of physicians who perform necessary services that often do not fit the traditional models of compensation, such as Fee-For-Service (FFS) and Salary compensation.

II. Definitions:

Alternative Funding Plan (AFP) – AFPs are contractual arrangements between the Department of Health, the NBMS and the RHA. AFPs provide flexibility in practice, encouraging coordination and integration of medical services, providing stabilized compensation for highly specialized groups, specialists and sub-specialists. Each AFP includes at a minimum, all of the physicians working in the department or division, but may be expanded to include Specialty or sub-specialty within the Regional Health Authority (RHA) or Province. AFPs create a fixed pool of funding for clinical departments of physicians, wherein physicians have autonomy and control over allocated funds and establishing the means of meeting agreed-upon deliverables for patient care and coverage. Funds from the AFP are distributed to physicians through a practice plan that is developed and agreed to by the department/division physicians.

Academic Funding Plan – A less common model of alternate funding is an Academic Funding Plan. Academic Funding Plans are contractual arrangements between physicians, the Department of Health, the Regional Health Authority and may include other organizations such as hospitals, universities and private funders. Academic Funding Plans apply to individual academic departments or divisions and carry different deliverables and funding from various sources. Academic Funding Plans recognize and compensate physicians for their direct clinical services in addition to their academic, research and administrative deliverables.

III. Goals of Alternative Remuneration Models may include:

1. Improving patient care throughout New Brunswick
2. Ensuring equitable and predictable physician remuneration throughout New Brunswick
3. Ensuring effective recruitment and retention of physicians to New Brunswick
4. Ensuring practical and achievable deliverables are met
5. Ensuring access to health care and physician support in rural and remote communities, and to highly trained specialists throughout the Province

The NBMS and the Department of Health recognize that the use of Alternate Models of Remuneration is an evolving model of health care funding, and will be subject to review and revision, by mutual agreement, as necessary.

IV. Process:

a. ***Negotiation of NEW AFPs***

Step 1: Physician Practice-Assessment

Physicians interested in being considered for funding under an Alternate Model of Remuneration must first prepare their own Practice-Assessment to identify specific relevant information, and to ensure they are in a position to engage in discussions with the RHA, Department of Health and the NBMS. The Practice-Assessment should include the following information:

i. A description of the existing group of physicians, and the scope of their practice (clinical and geographic)

ii. A description of current activities for which the group of physicians currently engages (clinical, research, teaching)

iii. An accounting of the total resource base currently dedicated to the group of physicians (total Remuneration)

iv. For salaried physicians, an accounting of benchmarks and shadow-billing data available

v. A preliminary assessment of interest within the group of physicians (alternative funding in a particular community would only be pursued if all members of that particular discipline/specialty have agreed to participate)

Upon completion of the Practice-Assessment, the group of physicians will meet with representatives of the NBMS to confirm all relevant information is included and establish timeframes for engaging with government.

Step 2: Identifying Common Data and Deliverables

In consultation with the NBMS, the group of physicians should define a common data set that will serve as a basis for articulating deliverables. Physicians interested in pursuing alternative funding will require consideration of the data concerning the relevant parties (Physicians, Government, RHA, University, other), and the deliverables associated with the funding (Clinical, Administrative, Teaching/Education, Research).

A fundamental component of this part of the process will be identifying the method of measuring performance and objectives of the Alternate Models of Remuneration.

Upon identification of the common data, deliverables and performance measurement by the physicians, the NBMS will engage with the Department of Health, and any other parties to the proposed agreement to identify prospective issues or matters for further consideration.

Step 3: Negotiation, Drafting and Revision of Agreement

Engaging with Department of Health, and others, the NBMS will facilitate the negotiation, drafting and revision of the terms of the alternative funding agreement. The NBMS will work with a designated

representative(s) of the group of physicians, ensuring there is consensus and approval among all affected physicians regarding the drafting of the proposed agreement. Any forms and templates created, amended or deleted pursuant to this AFP framework are subject to agreement by the AFP Advisory Committee.

All AFP contracts are expected to include the following key terms:

- Provision of additional resources will be established through a contract re-opener clause.
- Full participation of all physicians within that particular discipline/specialty, subject to the agreement of the NBMS, RHA and DH.
- Any third-party income, with the exception of medical legal work, and external academic funding arrangements shall be returned to the payor unless otherwise specified in the AFP contract.
- Any right of physicians to bill for Mandated on-call compensation, FFS earnings, CME, CMPA, Parental Leave and the FFS Retention Fund Program must be addressed within each contract.
- Each AFP shall include a Practice Plan which must address:
    - Agreed expectations and deliverables regarding service volumes and hours/days worked by physicians; and
    - Obligations of the parties related to shadow-billing, monitoring and compliance, budget oversight, and administration.

This framework will apply to the determination of initial arrangements as well as renegotiating terms and conditions as contracts expire.

Step 4: Finalizing the Agreement

Upon completion of the negotiation of the relevant agreement, the NBMS will submit the following to the Department of Health and the Regional Health Authority:

- AFP Proposal Agreement Template;
- AFP Funding and Costing Template;
- Practice Plan; and
- Any other applicable templates and forms.

Upon review and approval by the Department of Health and the Regional Health Authority, a long-form contract shall be drafted giving effect to the purpose and intention of the AFP Proposal.

An AFP is conditional on NBMS and any physicians completing and submitting to the Department of Health all required forms, templates and practice plan.

b. *AFP Maintenance and Revisions*

An AFP Advisory Committee shall be established to consult and advise on issues of AFP negotiation and re-negotiation, as necessary. The AFP Advisory Committee shall be established pursuant to the Terms of Reference attached as **Appendix 1**.

c. *AFP Accountability*

Monitoring of AFP activities and evaluation of deliverables will be conducted on an annual basis (at a minimum). Failure to meet deliverables will lead to financial and/or administrative actions, up to and including termination of the AFP.

APPENDIX 1
AFP MANAGEMENT FRAMEWORK
AFP ADVISORY COMMITTEE TOR

AFP ADVISORY COMMITTEE
TERMS OF REFERENCE

PROJECT NAME:	AFP Advisory Committee
DATE:	March 2021

PURPOSE OF THE COMMITTEE

The AFP Advisory Committee (the "Committee") will consist of representatives from the Department of Health (DH), the Regional Health Authorities (RHAs) and the New Brunswick Medical Society (NBMS). The primary function of the committee is to collaboratively address new and ongoing negotiations issues related to the creation and maintenance of AFPs.

COMMITTEE RESPONSIBILITIES

- Review data provided by the DH, RHAs, and Physician;
- Provide advice and consultation on the negotiation of newly proposed AFPs;
- Provide advice and consultation on issues that may arise within existing AFPs;
- Identify opportunities for improvement to the AFP process; and
- Provide feedback and recommendations to the parties, as requested.

COMMITTEE MEETINGS

The Committee will hold recurring face to face and/or Video/Teleconference meetings. The Committee will meet as required. Meeting dates will be mutually agreed upon by the parties.

MEETING AGENDA & MINUTES

- A standardized agenda will be prepared prior to each meeting, issues/action items will be identified/assigned/reviewed, and formal minutes of the meeting will be recorded and distributed for review/approval at the following meeting.

- The meeting will be co-chaired by the Department of Health and the NBMS.

Membership

The Committee will consist of members of the designated parties and other ad-hoc members as required, including AFP members.

The Committee shall include two representatives of the Department of Health, two members from the NBMS Negotiations Committee, one representative of Vitalité Health Network, and one representative of Horizon Health Network.

This Committee will be in effect from (date) to (date) and will provide recommendations as requested.

Committee Costs

Each party will be responsible for costs associated with their respective members. Physician members will be eligible for top up funding from the Supplementary Honoraria Program.

Committee Membership

Name	Organization	Phone	E-Mail
Representative	NBMS		
Representative	NBMS Negotiations Committee Rep		
RHA Representative	RHA		
RHA Representative	RHA		
DH Representative	DH		
DH Representative	DH		

Schedule U

After-Hours Emergency Premium (AHEP) Consolidation

The Parties agree to amend and consolidate the various existing language regarding AHEP under Chapter 4, Section 2.12 of the New Brunswick Physicians Manual:

2.12 *After Hours Emergency Premium

After-hours is defined as 18:00 to 06:59 hours on weekdays and all day on Saturdays, Sundays and statutory holidays; and, for non-specialists only, anaesthesia at the sacrifice of regularly scheduled office hours. The premium is *60% of the normal rate of payment with a minimum for the total billing of 30 general units or 3 anaesthesia units. Between the hours of midnight and 06:59 hours, the premium increases to *100%. When multiple services are performed, the minimum 30 general units or 3 anaesthesia units is only applicable for the primary service.

Emergency services for this purpose are defined as services, which must be performed without delay because of the medical condition of the patient. This includes non-elective caesarean sections and effective April 1, 2017, would include **non-elective** surgery done in the after-hours period, due to lack of available daytime operating room time or resources.

The premium does not apply to services performed by physicians providing scheduled on-site coverage during after-hours periods. The premium applies to the following emergency services:

a. surgical procedures performed under general, spinal or epidural anaesthesia and surgical assistance and anaesthesia related thereto;
b. procedures performed under major nerve root blocks;
c. reduction of shoulder dislocations (Service Code 502);
d. daytime anaesthesia by non-specialist at the sacrifice of regularly scheduled office hours;
e. consultations;
f. emergency hospital admissions;
g. initial assessments in intensive care and concentrated care units;
h. initial management of trauma;
i. after-hours detention;
j. cadaver - organ, tissue or bone removal;
k. obstetrical deliveries, including medically indicated induction of labour, which proceeds to delivery after hours;
l. Procedural Sedation: Procedural sedation (moderate sedation/analgesia) is a deeper level of sedation/analgesia than anxiolysis (minimal sedation). It (moderate sedation) is defined as a drug-induced depression of consciousness during which patients respond purposefully (reflex withdrawal from a painful

stimulus is not considered a purposeful response) to verbal commands, either alone or accompanied by light tactile stimulation. The medically controlled state of depressed consciousness:

- Allows protective reflexes to be maintained;
- Retains the patient's ability to maintain a patient airway independently and continuously.

Medicare Note: Claims involving premium payments must show the time of day the service was rendered including weekends and statutory holidays. The total amount billed (fee plus premium) should be entered on the same claim line. Services performed under major nerve block must be identified on the claim.

Refer to Chapter 4, Section 2.12.1 for values and details for billing purposes

Emergency visit – A situation where the demands of the patient and/or the physician's interpretation of the condition require that he responds immediately at the sacrifice of regular office hours or routine medical practice. **The need for immediate response is the intended controlling feature.** Immediate attendance because of personal choice or availability of the physician is not considered an emergency visit. Urgent visits for acute or chronic conditions which do not interfere with routine medical practice, do not constitute emergency visits. **Emergency visits may include any visit codes for services rendered on an emergency basis at the office, home, nursing home, Extra Mural, or hospital, or emergency calls in which the patient is seen outside – e.g. on the street. All claims for emergency based visits must show the time of day the services were rendered.** [*chapter 3, section 1.2.2(d)*]

The definition of emergency services, for the purposes of billing premiums, refers to those services which must be performed without delay because of the medical condition of the patient. The time of the service is not by itself the determining factor for premium charges. There must be documented evidence as to the emergent nature of the after-hours service. This premium is only payable when both criteria have been met: an emergency service, provided after-hours. [*chapter 3, section "Guidelines for the billing of Consultations"*]

The premium does not apply to services performed by physicians providing scheduled on-site coverage during after-hours periods.

An after-hours emergency premium can be billed when:

- A physician requests a consultation at 21:40 hrs for a patient in kidney failure where organ function is compromised. A consultation is rendered at 22:00 hrs. The specialist bills a consultation with after-hours emergency premium. Both are payable as the "emergent" and "after-hours" criteria are met.

An after-hours emergency premium cannot be billed when:

- A physician requests a consultation on April 1 at 11:00 hrs regarding a patient's lack of appetite. A specialist renders the consultation on April 6 at 20:00 hours. The specialist bills a consultation with an after-hours emergency premium. The

consultation is billable; the premium is not (providing a service 5 days after the request does not support the emergent nature of the request. [*chapter 3, section "Guidelines for the billing of Consultations"*]

The Premium applies to the following emergency services:
(Include items (a) – (l) per Chapter 4, section 2.12).

SCHEDULE V

FAMILY MEDICINE NEW BRUNSWICK PROGRAM

1.0 BACKGROUND

1.1 The Minister and the Society entered into a Memorandum of Understanding dated January 29, 2016 (the "**MOU**"), to work cooperatively in pursuing and establishing a new model of family medicine delivery within the Province of New Brunswick.

1.2 Pursuant to the MOU, the Parties agreed to develop a mutually acceptable Framework Document which would provide details on the proposed organization, administration and resources required to operationalize a new model of family medicine delivery within the Province of New Brunswick.

1.3 The Parties have developed a mutually acceptable Framework Document (hereinafter referred to as the "**FMNB Operational Guide**") which shall guide the Parties as they seek to operationalize this new model of family medicine delivery within the Province of New Brunswick.

2.0 FAMILY MEDICINE NEW BRUNSWICK

2.1 The Parties agree to establish a new model for primary care delivery within the Province of New Brunswick, which shall be known as Family Medicine New Brunswick ("**FMNB**"). The principles underpinning this model include:

(a) a patient-centered, team-based, inter-professional approach from providers;
(b) a sustainable and financially responsible approach to family medicine in New Brunswick;
(c) timely, longitudinal patient access to health-care professionals;
(d) full use of the Provincial Electronic Medical Record;
(e) a focus on disease prevention, self-care, and chronic disease management; and
(f) productive and quality focused health-care professionals.

2.2 FMNB shall be funded by the Minister, and organized as a program pursuant to the Physician Services Master Agreement of which this Schedule V forms part (the "**PSMA**").

3.0 THE FMNB OPERATIONAL GUIDE

3.1 Further to the Objectives and Vision set out in the MOU, the Parties have developed the FMNB Operational Guide dated October 21, 2016, which is intended to guide the Parties in operationalizing the vision for FMNB. The FMNB Operational Guide is hereby incorporated in and forms part of this Schedule.

3.2 The Parties agree to establish the FMNB Program Management Committee, according to the FMNB Program Management Committee Terms of Reference, as set out in the FMNB Operational Guide.

3.3 The Parties agree that the Society has a mandate to operationalize FMNB as a Physician Services Program under the PSMA, in compliance with the FMNB Operational Guide.

3.4 The Parties agree that the FMNB Operational Guide is an iterative document. Any revisions to the FMNB Operational Guide may be mutually agreed upon by the FMNB Program Management Committee.

3.5 The Parties may agree to renegotiate the terms of this Schedule and the FMNB Operational Guide as necessary as mutually agreed by the Parties.

4.0 COMMUNICATIONS

4.1 The Parties agree to consult and coordinate with each other with respect to physician and public facing communications to be released by either Party concerning the FMNB program.

5.0 PROGRAM TERMINATION

This Family Medicine New Brunswick Program may only be terminated:

(a) one year after written notice of termination is given by either Party to the other; or
(b) on a date set by mutual written agreement of the Parties.

6.0 BUDGET

The 2021 – 2026 budget for Family Medicine New Brunswick Program is as follows:

	2021-22	2022-23	2023-24	2024-25	2025-26
(Variable Cost Estimates)	**Year 5**	**Year 6**	**Year 7**	**Year 8**	**Year 9**
Staff, administration and information technology (salary, office space, travel, telecom, supplies, comms, strategic events, legal, translation)	$504,000	$504,000	$600,000	$600,000	$600,000
Physician Stewardship Group & PMC (Operating Board)	$24,000	$28,000	$32,000	$36,000	$40,000
Clinic On-boarding & Ongoing Cost (initial cost, honoraria, ongoing cost)	$35,000	$35,000	$35,000	$35,000	$35,000
Annual Conference	-	$65,000	$65,000	$65,000	$65,000
Patient and Physician survey	$20,000	-	$20,000	-	$20,000
Total Organizational Costs	**$583,000**	**$632,000**	**$752,000**	**$736,000**	**$760,000**

2.0 - Electronic Medical Record (EMR) Costs:

	2021-22	2022-23	2023-24	2024-25	2025-26
(Variable Cost Estimates)	**Year 5**	**Year 6**	**Year 7**	**Year 8**	**Year 9**
Projected number of physicians anticipated to be engaged in the model	**60**	**80**	**100**	**120**	**140**
EMR one-time implementation ($2k)	$20,000	$40,000	$40,000	$40,000	$40,000
EMR operational fees ($454/mo.)	$327,000	$436,000	$545,000	$654,000	$763,000
IH or other vendors /FMNB support	$15,000	$15,000	$15,000	$15,000	$15,000
Information Technology (Merge/Splits/data migration from other EMRs)	$50,000	$50,000	$50,000	$50,000	$50,000
Total EMR Costs	**$412,000**	**$541,000**	**$650,000**	**$759,000**	**$868,000**

3.0 – Overhead Support

	2021-22	2022-23	2023-24	2024-25	2025-26
	Year 5	**Year 6**	**Year 7**	**Year 8**	**Year 9**
Projected number of physicians anticipated to be engaged in the model	**60**	**80**	**100**	**120**	**140**
OH Support ($5k/yr; office renos /IT/etc.)	$300,000	$400,000	$500,000	$600,000	$700,000
Total Overhead Support Costs	**$300,000**	**$400,000**	**$500,000**	**$600,000**	**$700,000**

4.0 - Total Forecasted Funding:

	2021-22	2022-23	2023-24	2024-25	2025-26
	Year 5	**Year 6**	**Year 7**	**Year 8**	**Year 9**
Organizational Costs	**$583,000**	**$632,000**	**$752,000**	**$736,000**	**$760,000**
EMR Costs	**$412,000**	**$541,000**	**$650,000**	**$759,000**	**$868,000**
Overhead Support Costs	**$300,000**	**$400,000**	**$500,000**	**$600,000**	**$700,000**
Total Operational Costs	**$1,295,000**	**$1,573,000**	**$1,902,000**	**$2,095,000**	**$2,328,000**

DH will reimburse the Society semi-annually based on costs incurred up to the maximum organizational costs per year, as indicated in the table below. At the end of each fiscal year, the Society will provide DH a listing of itemized costs incurred to support the amounts invoiced to DH.

The Society is permitted to carry forward unused funds from one fiscal year to the following fiscal year in an amount up to 10% of the total organizational costs for the fiscal year, as outlined in the table below. Any remaining accumulated or annual surplus at the end of Year 9 shall be returned to DH.

The Society will submit quarterly invoices for funding with appropriate detail which will be reconciled at the end of the fiscal year.

The Operational Plan shall be amended effective April 1, 2022 to include:

- Elimination of the MGR in favour of a 6-month Professional Services Contract for new physicians joining the program; and
- Implementation of New Brunswick Age/Gender Ratio Index with Capitation at the current base rate of $96.09.

Schedule W

Medical Pay Plan and

Addendum to Medical Pay Plan

Medical Officer - Clinical
Bi-weekly Rates: April 1, 2020
Medical Pay Plan

	LEVEL	BI-WEEKLY & ANNUAL RATES						
		1	2	A	B	C	D	E
6231 3 01	General Practitioner	6,684	6,980	7,177	7,504	7,834		
		173,784	181,480	186,602	195,104	203,684		
6233 3 01	Non-Certified Specialist			9,026	9,363	9,714		
				234,676	243,438	252,564		
6241 1 01	Medical Officer of Health I			9,026	9,363	9,714		
				234,676	243,438	252,564		
6234 3 01	Certified Specialist			9,928	10,299	10,972		
				258,128	267,774	285,272		
6242 1 01	Medical Officer of Health II			9,928	10,299	10,972		
				258,128	267,774	285,272		
6235 3 01	Clinical Program Department Head**			10,756	11,167	11,736		
				279,656	290,342	305,136		
6243 1 01	Chief Medical Officer of Health			10,756	11,167	11,736		
				279,656	290,342	305,136		
6236 1 01	Deputy Chief Medical Health Officer			9,566	9,924	10,296	10,709 *	11,134 *
				248,716	258,024	267,696	278,434	289,484

Market adjustment for Oncologists of 22.5% in addition to the general economic increases

Market adjustment for Psychiatry of 22.5% in addition to the general economic increases

Market adjustment for Pathologists of 22.5% in addition to the general economic increases

Steps 1 and 2 are rates of pay only applicable for those employees who are uncertified general practitioners.

*Steps D and E are rates of pay only applicable for those employees who are Certified Medical Specialists.

****NOTE:** Employees currently remunerated for the Department Head or Supervisory duties receiving 4%, under the Medical Pay Plan, will continue to be paid on a "Present Incumbent Only" basis.

Medical Officer - Clinical
Bi-weekly & Annual Rates: April 1, 2021
Medical Pay Plan

	LEVEL	BI-WEEKLY & ANNUAL RATES						
		1	2	A	B	C	D	E
6231 3 01	General Practitioner	6,784	7,085	7,285	7,617	7,952		
		176,384	184,210	189,410	198,042	206,752		
6233 3 01	Non-Certified Specialist			9,161	9,503	9,860		
				238,186	247,078	256,360		
6241 1 01	Medical Officer of Health I			9,161	9,503	9,860		
				238,186	247,078	256,360		
6234 3 01	Certified Specialist			10,077	10,453	11,137		
				262,002	271,778	289,562		
6242 1 01	Medical Officer of Health II			10,077	10,453	11,137		
				262,002	271,778	289,562		
6235 3 01	Clinical Program Department Head**			10,917	11,335	11,912		
				283,842	294,710	309,712		
6243 1 01	Chief Medical Officer of Health			10,917	11,335	11,912		
				283,842	294,710	309,712		
6236 1 01	Deputy Chief Medical Health Officer			9,709	10,073	10,450	10,870 *	11,301 *
				252,434	261,898	271,700	282,620	293,826

Market adjustment for Oncologists of 22.5% in addition to the general economic increases

Market adjustment for Psychiatry of 22.5% in addition to the general economic increases

Market adjustment for Pathologists of 22.5% in addition to the general economic increases

Steps 1 and 2 are rates of pay only applicable for those employees who are uncertified general practitioners.

*Steps D and E are rates of pay only applicable for those employees who are Certified Medical Specialists.

**NOTE: Employees currently remunerated for the Department Head or Supervisory duties receiving 4%, under the Medical Pay Plan, will continue to be paid on a "Present Incumbent Only" basis.

Medical Officer - Clinical
Bi-weekly & Annual Rates: April 1, 2022
Medical Pay Plan

	LEVEL	BI-WEEKLY & ANNUAL RATES						
		1	2	A	B	C	D	E
6231 3 01	General Practitioner	6,886	7,191	7,394	7,731	8,071		
		179,036	186,966	192,244	201,006	209,846		
6233 3 01	Non-Certified Specialist			9,298	9,646	10,008		
				241,748	250,796	260,208		
6241 1 01	Medical Officer of Health I			9,298	9,646	10,008		
				241,748	250,796	260,208		
6234 3 01	Certified Specialist			10,228	10,610	11,304		
				265,928	275,860	293,904		
6242 1 01	Medical Officer of Health II			10,228	10,610	11,304		
				265,928	275,860	293,904		
6235 3 01	Clinical Program Department Head**			11,081	11,505	12,091		
				288,106	299,130	314,366		
6243 1 01	Chief Medical Officer of Health			11,081	11,505	12,091		
				288,106	299,130	314,366		
6236 1 01	Deputy Chief Medical Health Officer			9,855	10,224	10,607	11,033 *	11,471 *
				256,230	265,824	275,782	286,858	298,246

Market adjustment for Oncologists of 26.5% in addition to the general economic increases

Market adjustment for Psychiatry of 22.5% in addition to the general economic increases

Market adjustment for Pathologists of 22.5% in addition to the general economic increases

Steps 1 and 2 are rates of pay only applicable for those employees who are uncertified general practitioners.

*Steps D and E are rates of pay only applicable for those employees who are Certified Medical Specialists.

**NOTE: Employees currently remunerated for the Department Head or Supervisory duties receiving 4%, under the Medical Pay Plan, will continue to be paid on a "Present Incumbent Only" basis.

Medical Officer - Clinical
Bi-weekly & Annual Rates: April 1, 2023
Medical Pay Plan

	LEVEL	BI-WEEKLY & ANNUAL RATES						
		1	2	A	B	C	D	E
6231 3 01	General Practitioner	6,989	7,299	7,505	7,847	8,192		
		181,714	189,774	195,130	204,022	212,992		
6233 3 01	Non-Certified Specialist			9,437	9,791	10,158		
				245,362	254,566	264,108		
6241 1 01	Medical Officer of Health I			9,437	9,791	10,158		
				245,362	254,566	264,108		
6234 3 01	Certified Specialist			10,381	10,769	11,474		
				269,906	279,994	298,324		
6242 1 01	Medical Officer of Health II			10,381	10,769	11,474		
				269,906	279,994	298,324		
6235 3 01	Clinical Program Department Head**			11,247	11,678	12,272		
				292,422	303,628	319,072		
6243 1 01	Chief Medical Officer of Health			11,247	11,678	12,272		
				292,422	303,628	319,072		
6236 1 01	Deputy Chief Medical Health Officer			10,003	10,377	10,766	11,198 *	11,643 *
				260,078	269,802	279,916	291,148	302,718

Market adjustment for Oncologists of 26.5% in addition to the general economic increases

Market adjustment for Psychiatry of 22.5% in addition to the general economic increases

Market adjustment for Pathologists of 22.5% in addition to the general economic increases

Steps 1 and 2 are rates of pay only applicable for those employees who are uncertified general practitioners.

***Steps D and E are rates of pay only applicable for those employees who are Certified Medical Specialists.**

****NOTE:** Employees currently remunerated for the Department Head or Supervisory duties receiving 4%, under the Medical Pay Plan, will continue to be paid on a "Present Incumbent Only" basis.

Medical Officer - Clinical
Bi-weekly & Annual Rates: April 1, 2024
Medical Pay Plan

	LEVEL	BI-WEEKLY & ANNUAL RATES						
		1	2	A	B	C	D	E
6231 3 01	General Practitioner	7,094	7,408	7,618	7,965	8,315		
		184,444	192,608	198,068	207,090	216,190		
6233 3 01	Non-Certified Specialist			9,579	9,938	10,310		
				249,054	258,388	268,060		
6241 1 01	Medical Officer of Health I			9,579	9,938	10,310		
				249,054	258,388	268,060		
6234 3 01	Certified Specialist			10,537	10,931	11,646		
				273,962	284,206	302,796		
6242 1 01	Medical Officer of Health II			10,537	10,931	11,646		
				273,962	284,206	302,796		
6235 3 01	Clinical Program Department Head**			11,416	11,853	12,456		
				296,816	308,178	323,856		
6243 1 01	Chief Medical Officer of Health			11,416	11,853	12,456		
				296,816	308,178	323,856		
6236 1 01	Deputy Chief Medical Health Officer			10,153	10,533	10,927	11,366 *	11,818 *
				263,978	273,858	284,102	295,516	307,268

Market adjustment for Oncologists of 26.5% in addition to the general economic increases

Market adjustment for Psychiatry of 22.5% in addition to the general economic increases

Market adjustment for Pathologists of 22.5% in addition to the general economic increases

Steps 1 and 2 are rates of pay only applicable for those employees who are uncertified general practitioners.

***Steps D and E are rates of pay only applicable for those employees who are Certified Medical Specialists.**

****NOTE:** Employees currently remunerated for the Department Head or Supervisory duties receiving 4%, under the Medical Pay Plan, will continue to be paid on a "Present Incumbent Only" basis.

Addenda du Régime de rémunération du personnel médical

HONORAIRES D'AUTOPSIE :

Type I : Mort subite et inattendue

Taux applicable aux autopsies	
	Type 1
2020-2021	790,33 $
2021-2022	802,19 $
2022-2023	814,22 $
2023-2024	826,43 $
2024-2025	838,83 $

Type II : Autopsie judiciaire

Taux applicables aux autopsies	
	Type 2
2020-2021	1 292,68 $
2021-2022	1 312,07 $
2022-2023	1 331,75 $
2023-2024	1 351,72 $
2024-2025	1 372,00 $

De plus, une prime de 35 % est accordée pour toutes les autopsies entreprises après 18 h les jours de la semaine, ainsi que pour les autopsies réalisées durant les fins de semaine et les jours fériés.

PLAFOND DES REVENUS EN HONORAIRES À L'ACTE

Les revenus en honoraires à l'acte permis aux termes du régime d'assurance-maladie pour le revenu tiré d'une pratique privée sont limités aux montants énumérés ci-dessous. Une fois le plafond annuel atteint, la rémunération s'établit à 50 % du barème des honoraires.

Plafond des revenus en honoraires à l'acte (PRHA)		
	AEG	**PRHA**
2020-2021	**2,00 %**	55 517,44 $
2021-2022	**1,50 %**	56 350,20 $
2022-2023	**1,50 %**	57 195,46 $
2023-2024	**1,50 %**	58 053,39 $
2024-2025	**1,50 %**	58 924,19 $

Addendum to the Medical Pay Plan

AUTOPSY FEES:

Type I: Sudden and unexpected death

Autopsy Rates	
	Type 1
2020-21	$790.33
2021-22	$802.19
2022-23	$814.22
2023-24	$826.43
2024-25	$838.83

Type II: Forensic

Autopsy Rates	
	Type 2
2020-21	$1,292.68
2021-22	$1,312.07
2022-23	$1,331.75
2023-24	$1,351.72
2024-25	$1,372.00

In addition, a 35 % premium is allocated for all autopsies, initiated after 6 p.m. on weekdays, as well as for autopsies performed on weekends and holidays.

FEE FOR SERVICE INCOME THRESHOLD:

The allowable fee-for-service earnings under Medicare for private practice income are limited to the amounts listed below. Once the annual income ceiling has been reached for that year, earnings are paid at 50% of the Fee Schedule.

Fee for Service Income Threshold (FIT)		
	GEI	**FIT**
2020-21	**2,00 %**	$55,517.44
2021-22	**1,50 %**	$56,350.20
2022-23	**1,50 %**	$57,195.46
2023-24	**1,50 %**	$58,053.39
2024-25	**1,50 %**	$58,924.19

SERVICE DE GARDE :

À compter du 1er octobre 2005, les médecins salariés qui prennent part à la rotation d'un service de garde peuvent facturer à l'acte quand on fait appel à leurs services urgents et émergents en dehors des heures normales de travail. Les honoraires pour les services de garde rémunérés à l'acte ne seront pas appliqués au plafond annuel des revenus de pratique provenant de toutes les sources de l'Assurance-maladie.

SERVICE SUR PLACE AUX ÉTABLISSEMENTS PSYCHIATRIQUES CENTRACARE ET DU RESTIGOUCHE :

Nuit	160 $
Fin de semaine et jour férié	240 $

Le tarif unique indiqué ci-dessus est global et s'applique à toute visite, quel qu'en soit le nombre ou à tout service sur place effectué en dehors des heures régulières de jour.

ASSURANCE RESPONSABILITÉ PROFESSIONNELLE DE L'ASSOCIATION CANADIENNE DE PROTECTION MÉDICALE (ACPM) POUR MÉDECINS SALARIÉS (à compter du 1er janvier 2005)

Veuillez consulter l'annexe B de l'Entente-cadre sur les services de médecin.

FORMATION MÉDICALE CONTINUE :

a) Les médecins salariés à temps plein ont droit à un nombre maximal de dix jours par exercice financier pour assister aux activités approuvées de formation médicale continue (FMC). Il est possible d'accumuler ces jours sur une période de deux ans.

b) Les médecins salariés à temps partiel ont droit à des jours de FMC calculés au prorata.

ON-CALL:

Effective October 1, 2005, salaried physicians who take part in an on-call rotation may bill fee-for-service when called in to render urgent and emergent services outside normal working hours. Fee-for-service earnings related to on-call will not be applied against the annual threshold for additional practice income from all Medicare sources.

ON SITE COVERAGE IN THE PSYCHIATRIC FACILITIES OF CENTRACARE AND RESTIGOUCHE:

Night	$160
Weekend and Holiday	$240

The above single fee is all inclusive and applies to any number of visits or to on-site coverage beyond the regular daytime hours.

PROFESSIONAL LIABILITY COVERAGE (CMPA) FOR SALARIED PHYSICIANS (effective January 1, 2005):

Refer to Schedule B of the Physician Services Master Agreement.

CONTINUING MEDICAL EDUCATION:

a) Full time salaried physicians are allowed up to ten days per fiscal year for the purpose of attending approved CME events. These days can be accumulated over a two-year period.

b) Part time salaried physicians are entitled to CME days on prorated basis.

CONGÉS :	**VACATION LEAVE:**
À compter du 1er avril 2009, le cumul des crédits de congé sera calculé au taux suivant :	The accumulation of vacation credits, effective April 1, 2009, shall be at a rate of:
a) 1 jour $^{2}/_{3}$ par mois, soit quatre (4) semaines par année à compter de la date d'embauche; b) 2 jours $^{1}/_{12}$ par mois, soit cinq (5) semaines par année à compter du 181e mois d'emploi continu.	a) 1 $^{2}/_{3}$ days per month, 4 weeks per annum from date of hiring; b) 2 $^{1}/_{12}$ days per month, 5 weeks per annum, commencing with the 181st month of continuous employment.
Remarque : Les médecins salariés ayant le statut d'employé sont protégés par les *Directives en matière de ressources humaines applicables au personnel de gestion et aux employés non syndiqués* (Partie I ou III des services publics), selon l'employeur (ministère de la Santé ou une régie régionale de la santé).	Note: The salaried physicians with employee status are covered by the Human Resources Policies for Management and Non-Union Employees, Parts I or III, depending on the employer (Department of Health or Regional Health Authorities).

SCHEDULE "X"

OTHER ITEMS

Time of Day

The Parties agreed to expand time of day requirement to include office-based consults and visit codes, including virtual care. No additional rule will be implemented in the Medicare system related to this change.

Nursing Home Formula

The parties agree to establish a joint working group to review and update the existing formula for determining sessional hours provided to nursing homes.

Fee Schedule Conversion

The parties agree that a working group will be struck to review the feasibility of converting the existing unit and unit value-based Physician's Manual to express the value of services in dollars. The working group will strive to convene within 60 days of the signing of the PSMA.

Service Location for Service Codes

The Parties agree to form a working group with members of the Department of Health and the New Brunswick Medical Society to review service location codes for specific areas of concern to the Department of Health. The exercise would be a continuation of previous specialty review project to be completed with the timeline of this current Physician Services Master Agreement.

Anaesthesia

The Parties agree to form a working group with members from the Department of Health, New Brunswick Medical Society and the Regional Health Authorities to explore remuneration options for anesthesiologists to address recruitment, retention and access challenges and provide recommendations within 6 months of the signing of the Physician Services Master Agreement. The Department of Health reserves the right to accept or reject the recommendations by the working group. In the event that the Department of Health accepts the recommendations, the agreed upon and approved funding shall be provided outside the Physician Services Master Agreement.

Technology Review Committee

The Parties agree that the recommendations from the Review of Services Impacted by Medical and Technological Advancements (established under Schedule L of the Predecessor Agreement) be reviewed by the NBMS Board within 3 months of the signing of this Agreement.

Chart Initiation Fee

The Parties agree that effective April 1, 2022, the Chart Initiation Fee (continued under Schedule F of the Predecessor Agreement, and henceforth referred to in the Physician's Manual) is no longer funded through a $2,180,000 Protected Funding Pool. The Chart Initiation Fee will only be billable as a Service Code.

MPP Physicians – Market Adjustment and Elimination of Code 73

The Parties agree to establish an increased market adjustment for Psychiatrists and Oncologists paid in accordance with the Medical Pay Plan, which shall be reflected in **Schedule W**. The Parties have also agreed to eliminate and de-insure service code 73 from the Physician's Manual – Radiation Oncology, Medical Oncology and Hematology Consultation.

MPP Physicians – Fee For Service Income Threshold (FIT)

The Parties agree that effective April 1, 2020, the FIT amount will be $55,517.44. The FIT shall increase by the FFS GEI for each year of this Agreement. There shall be no retroactivity applied to previously claimed FIT amounts.

FFS income for locum coverage is excluded from the FIT calculation provided prior approval has been granted by Medicare.

Exceptions to this policy will be considered on a case-by-case basis for priority services as agreed upon by the Parties.

The Medical Pay Plan Policy shall be amended to reflect the changes noted above.

MPP Physicians – Lifting of Moratorium for Salaried Physicians

The Minister agrees to lift the moratorium for hiring new salaried physicians. The RHAs will have the authority to offer this remuneration option for positions at their sole discretion.

MPP Physicians – FN 2016

The Minister reaffirms the provisions contained within FN 2016. The DH will create a quarterly review process to resolve any specific variations to this policy identified by the NBMS.

MPP Physicians – Weekend Rounding and the Excessive Hours Policy

The Parties agree that the Medical Pay Plan Policy shall be amended to permit physicians to record and submit hours spent rounding on weekends as eligible hours for the Excessive Hours Policy.

MPP Physicians – Coroners Autopsy Fees

The Parties agree that the Addendum to the Medical Pay Plan Policy attached as **Schedule W** shall be amended to increase Coroners Autopsy Fees by an amount equivalent to each year's FFS GEI since 2012. No retroactivity shall be applied to the autopsy fees claimed prior to April 1, 2020.

Pre and Post-Op Period

The Parties agree to revise the Physicians Manual to reduce the preoperative period from 30 days to 2 days, and that the postoperative period be reduced from 30 days to 14 days.

Surgical Prioritization Tool

The Parties agree to eliminate and de-insure the Surgical Prioritization Tool Service Code 1810 from the Physicians Manual.

Physician Billing Training

The Parties agree to add the following language to the Physicians Manual:

> **"Training for Medicare billing rules, service codes, policies, and procedures as per the *Physicians' Manual* is provided free of charge by the Medicare Practitioner Liaison Officers.** Completion of this training is mandatory and NB Medicare will strive to provide the in-person training within three months of a physician commencing practice.
>
> **Medicare also provides a web-based, pre-recorded training tool, with 24/7 access, to permit remote completion of elements common to all physicians (e.g., Chapters 1 to 4).** The web-based training is mandatory and must be completed withing three months of commencing practice.
>
> If a new physician fails to complete the web-based training within three months of commencing practice, NB Medicare will withhold billings until such time as the training has been completed. NB Medicare will release the withheld funds once the web-based training is completed.
>
> Follow up and refresher training sessions are also available to all physicians.
>
> Changes to be effective 3 months from date of signing of a new Physician Services Master Agreement.

Schedule Y

NEW BRUNSWICK PRIMARY CARE NETWORK

Purpose:

The NBMS and DH agree:

a) That every resident of New Brunswick has the right to have access to a primary care provider;
b) That the Patient Connect List will be eliminated, and every resident of New Brunswick unattached to a primary care provider will have access to the Primary Care Network; and
c) That the Department of Health, in consultation with the New Brunswick Medical Society (NBMS), will establish a provincial patient registry.

A. Patient Registry

Terms

The rostering of patients ("Patient Registry") would consist of documenting every primary care provider and affiliated patients in the Province.

Once the Patient Registry is activated, The Department of Health will provide all primary care providers with a system to formally register all patients with the Patient Registry within twenty-four (24) months.

The rostering process for every NB resident and primary care provider will be administered by the Department of Health and will be completed no later than twenty-four (24) months from the signing of this agreement.

Conditions

Upon request by DH, a primary care provider who does not provide a current and accurate patient list to the RHA and Department of Health as noted above shall not be entitled to any chart initiation fees as per Schedule F.

B. Elimination of Orphan Patients – Implementation of NB Primary Care Network

Mandate

The New Brunswick Primary Care Network (NBPCN) will become the health system's front door for any New Brunswicker that does not currently have a primary care provider.

NBPCN will provide timely access to primary care leveraging all health system partners and existing physical infrastructure across the province.

The mandate of NBPCN will include the following:

- the registration process to the network for unattached patients. Eligible individuals include recently orphaned patients and new citizens to New Brunswick;
- the coordination, scheduling and triage of requests for primary care services for all patients attached to the network;
- the establishment and management of a formal process for patients looking for a change in provider due to patient-provider issues or concerns;
- the management of the process to formally assign patients from the network to primary-care providers that agree to accept them, based on a medical triage approach;
- any other terms, conditions and requirements that DH and the NBMS consider appropriate.

The NBMS will cooperate, engage and support the mandate as set out above.

C. Physician Remuneration for Participation in NBPCN

1. Primary Care Base Physician Remuneration

    a. $45.00/visit
    b. These visits can be performed in person or through a virtual setting.

2. Additional Physician Remuneration

    a. Seniors Office Visit add-on (code 8101)
    b. Pap Tray Fee (code 1999)

3. Additional Benefits

    a. Every participating clinic or physician will have access to:

        i. a cloud-based Electronic Medical Record (EMR) and virtual care platform to ensure continuity of care for the patients of the network
        ii. Nurse Triage
        iii. GNB provided technology
        iv. Other overhead support as mutually agreed by the Department of Health and the NBMS.

4. Fee for Service Income Threshold (FIT)

    a. Salaried physicians who want to participate in the NBPCN outside their Medical Pay Plan arrangements will require an approved Written Declaration Form for Fee-for-Service Income prior to any services being rendered. These FFS earnings will be exempt from the FIT.

5. ER Physician Participation

    a. ER Physicians shall be permitted to participate in NBPCN outside their regular required ER hours.

6. Chart Initiation Fee

    a. The Chart Initiation Fee as per Schedule F will only be made available when a primary care provider assumes the ongoing care of a patient from the list provided by the Department of Health.

SCHEDULE "Z"

Hospitalist Program

Purpose:

To create a Closed Concept hospitalist model to replace traditional inpatient coverage by Family Physicians at the 8 eligible Regional Hospitals in New Brunswick.

"Closed Concept" involves units where a team of appropriately credentialed physicians are continuously available to provide management of primary care inpatients. Only a member of the hospitalist team may admit and discharge patients.

To recognize the right of the Regional Health Authorities (RHAs) and the eligible hospitals to manage all hospitalist inpatients and to promote greater access to family medicine physicians in their community practice.

To standardize hospitalists remuneration and patient care levels throughout eligible hospitals in the Province.

To provide additional remuneration for physician hospitalists based on performance.

To ensure that physician hospitalists care for all attached and unattached family medicine inpatients at an eligible hospital.

Eligible hospitals:

Dr. Everett Chalmers Hospital
Dr. Georges Dumont Hospital
Bathurst Regional Hospital
Saint John Regional Hospital
Edmundston Regional Hospital
Moncton City Hospital
Campbellton Regional Hospital
Miramichi Regional Hospital

Estimated Funding:

$10 - 12M over the term of the agreement.

Remuneration Model:

A. Variable Remuneration: physician hospitalist groups at an eligible hospital will be paid a variable sessional rate as follows.

Performance level	Rate
Level 1 (Base rate)	$152.00
Level 2 (Meets Expectations)	$160.00
Level 3 (Exceeds Expectations)	$168.00

The base rate will be paid at Level 1

- Based on performance as per calculation in Section B, physicians may be entitled to a retroactive bonus pay. The Level 2 bonus is $8/hr worked and the Level 3 bonus is $16/hr worked.

- Variable Remuneration is based on the following:

    a) 17 bed average responsibility per hospitalist per day, depending on acuity;

    b) 8 hours per day (normally 08:00 – 16:00).

B. Calculation of Variable Remuneration for physician hospitalist groups will be done at the hospital level and determined by the RHAs based on the following objective and subjective criteria, which shall be reviewed annually:

Objective Criteria:

- Length of Hospital Stays.
- Readmission rates
- Cost of hospital stays
- Timely patient admissions and discharges

The objective criteria will be reviewed, modified and determined annually by the RHAs, to ensure that the objective criteria are accurate indicators of performance and whether there are any modifications to the criteria that should be made. This review, modification, and determination shall occur subject to:

a) receiving non-binding recommendations by the Local Medical Advisory Committee "LMAC" and
b) consultation with the hospitalist physician group at an eligible hospital ("Hospitalist Group") and the NBMS.

Subjective Criteria:

In addition to the objective criteria above, the RHAs shall also consider the efficiency, performance, quality of care of the Hospitalist Group based on the specific and unique circumstances that exist within the Hospitalist Group and/or the hospital at which the hospitalist works.

The subjective criteria will be reviewed, modified and determined annually by the RHAs, to ensure that the subjective criteria are accurate indicators of performance and whether there are any modifications to the criteria that should be made. This review, modification and determination shall occur subject to:

a) receiving non-binding recommendations by the LMAC and
b) consultation with the Hospitalist Group and the NBMS.

Commencing January 1, 2022, the variable remuneration period of review shall be the calendar year of January 1 to December 31. Any payment of the variable remuneration bonus shall occur within sixty (60) days of the expiry of the RHA fiscal year.

Additional:

- The RHAs will establish a work plan specific to each participating Hospitalist Group in consultation with the physicians each fiscal year. A mid-year and end year review will be conducted based on the work plan and established KPIs between the RHA and the participating Hospitalist Group.

- The RHAs agree to resource staff responsible for reviewing and monitoring KPI data, with the obligation to report data to applicable hospitalist physicians quarterly.

- The RHAs shall make KPI data available to a hospitalist physician upon request.

- In the event a decision is not made by the RHA with respect to the review of a Hospitalist Group within sixty (60) days following the expiry of the RHA fiscal year, all physicians within the Hospitalist Group will be paid a Level 2 bonus.

- Once an eligible hospital implements this closed concept hospitalist model, only hospitalist physicians will have the right to be remunerated for hospitalist inpatients.

- The Hospitalist Group shall have the responsibility to ensure adequate after hours on call coverage.

- Other than the compensation set forth in this proposal, Hospitalists shall not receive any additional remuneration for work performed in excess of the 17-bed average per day/8 hours per day, unless otherwise agreed to by the DH.

TAB 120

THIS AGREEMENT DATED the 9th day of September, 2016

PHYSICIAN SERVICES MASTER AGREEMENT

BETWEEN:

HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF NOVA SCOTIA, as represented by the Minister of Health and Wellness ("**DHW**")

OF THE FIRST PART

-and-

DOCTORS NOVA SCOTIA, as represented by the President of Doctors Nova Scotia ("**DNS**")

OF THE SECOND PART

AGREEMENT PREAMBLE

WHEREAS DHW has the power, pursuant to the *Health Services and Insurance Act, 1989, R.S.N.S., c.197,* as amended, to negotiate in good faith compensation for Insured Medical Services with professional organizations representing providers and may establish fees or other systems of payment for Insured Medical Services and, with the approval of the Governor-in-Council, may authorize payment in respect thereof;

AND WHEREAS pursuant to the *Doctors Nova Scotia Act*, S.N.S. 1995-96, c.12; as amended 2012, c.26, Doctors Nova Scotia is recognized as the sole bargaining agent for any and all duly qualified medical practitioners in the Province of Nova Scotia;

AND WHEREAS the Parties acknowledge that DHW has an obligation to maintain and improve the health status of the population, to determine service organization, and to determine the allocation of provincial funding for health services consistent with this Agreement;

AND WHEREAS the Parties agree that the Health Authorities are responsible for regional service planning and operations and allocation of fiscal, human and capital resources to meet the health service needs of Insured Residents;

AND WHEREAS the parties, together with the Health Authorities, wish to continue to work together in a relationship built upon transparency, constructive collaboration and mutual respect;

THEREFORE in consideration of the terms of this Physician Services Master Agreement (the "**Agreement**"), the Parties agree as follows:

1. DEFINITIONS

In this Agreement:

(a) "**2008 Master Agreement**" means the Physician Services Master Agreement executed by the Parties in October 2008, as amended;

(b) "**Act**" means the *Health Services and Insurance Act, 1989, R.S.N.S., c.197,* as amended;

(c) "**Agreement**" means this document including all Schedules as amended from time to time in accordance with this Agreement;

(d) "**Clinical Services Reporting**" means reporting by Physicians of Insured Medical Service encounter information to MSI in the format prescribed by DHW;

(e) "**Fee Committee**" means the Fee Committee as outlined in Article 4.1(d) of this Agreement;

(f) "**General Practitioner**" means a Physician registered with the College of Physicians and Surgeons whose name does not appear on the Medical Specialist Register, but includes those who have either a CCFP or CCFP-EM certification;

(g) "**Health Authorities**", means the Nova Scotia Health Authority as defined in the *Health Authorities Act, S.N.S. 2014, c. 32*, and the IWK Health Centre;

(h) "**Insured Medical Services**" means insured medical services that Insured Residents are entitled to receive under the provisions of the Act and the regulations made pursuant thereto;

(i) "**Insured Residents**" are Residents of Nova Scotia as defined by the Act and the regulations made pursuant thereto;

(j) "**MAMG**" means the Master Agreement Management Group as outlined in Article 5 of this Agreement;

(k) "**MASG**" means the Master Agreement Steering Group pursuant to the 2008 Master Agreement;

(l) "**MSI**" means the Medical Services Insurance program, administered on behalf of the Province, for the payment to Physicians for providing Insured Medical Services pursuant to the Act;

(m) "**MSI Physician's Manual**" means the document that contains the Preamble and Insured Medical Services, including their descriptions and codes, any special conditions and their value in units;

(n) "**Physician**" means a medical practitioner under the *Medical Act, S.N.S. 1995-96, c. 10 as amended*, of Nova Scotia who is licensed by the College of Physicians and Surgeons of Nova Scotia to practice medicine in the Province, in good standing and not subject to any suspension of license;

(o) "**Preamble**" means the Preamble to the MSI Physician's Manual that provides the billing rules and is the authority for the proper interpretation of the Insured Medical Services;

(p) "**Resident Physician**" is a Physician registered with the College of Physicians and Surgeons in an educational category of the Medical Register and registered at a recognized university in Canada in a postgraduate course of study in medicine;

(q) **"Sessional Rate"** means the fee paid for eligible medical services of a Physician engaged on a time basis;

(r) **"Specialist"** means a Physician registered with the College of Physicians and Surgeons whose name appears on the Medical Specialist Register of Nova Scotia, excluding those who have either a CCFP or CCFP-EM certification;

(s) "**Tariff**" means the system of payment for Insured Medical Services as outlined in the MSI Physician's Manual and defined in the Act;

(t) "**Unit Value System**" means the representation of the actual fees for Insured Medical Services by separate unit categories: the Medical Service Unit (MSU) and the Anaesthesia Unit (AU);

(u) **"Year"** means the fiscal year of the Province of Nova Scotia, from April 1 to March 31.

2. TERM OF AGREEMENT

(a) This Agreement shall take effect on April 1, 2015 and continues to remain in force and effect for a period of four (4) years, terminating on March 31, 2019.

(b) Only the rate increases referred to in Article 4.1(b) of this Agreement will take effect on April 1, 2015; all other elements of this Agreement will take effect upon execution by both Parties.

(c) This Agreement and the attached Schedules constitute the whole Agreement between the parties unless duly modified in writing and signed by both parties. No representation or statement not expressly contained herein will be binding upon any party.

(d) Upon termination of this Agreement, the Tariff then in effect on March 31, 2019 and the provisions of Articles 4.1 (e) and 4.1 (k) shall remain in effect until such time as the Parties agree upon a new Agreement, or a new Agreement is established. Further, for the purposes of this Agreement all other provisions shall continue after termination until such time as the Parties agree upon a new Agreement, or a new Agreement is established.

3. RESPONSIBILITIES OF THE PARTIES

(a) DNS recognizes that DHW oversees and directs funding for the health care system across the Province, within the limits of a budget that is a portion of provincial program spending allocated to DHW by the Nova Scotia Legislature and Department of Finance.

(b) DNS agrees to co-operate with the Health Authorities in facilitating the delivery of Insured Medical Services and will take all appropriate measures to encourage Physicians to comply with applicable agreements.

(c) Pursuant to section 7 of the *Doctors Nova Scotia Act*, S.N.S. 1995-96, c.12; as amended 2012, c.26, and other applicable authority, DHW recognizes DNS as the sole bargaining agent for any and all duly qualified medical practitioners in the Province of Nova Scotia who provide Insured Medical Services that are funded through DHW and/or a Health Authority.

(d) DHW and DNS agree to negotiate in good faith and make every reasonable effort to conclude a subsequent agreement prior to the expiry of this Agreement.

4. PHYSICIAN COMPENSATION

4.1 General and Fees

(a) **Unit Value System**

(i) All costing, payments and statistical analysis will be based on "date of service" and more specifically, the Tariff in place on the date the Insured Medical Service is provided.

(ii) The portion of the Tariff, which includes the Preamble and the Insured Medical Services agreed to pursuant to the Act, will continue to be published with the actual fee represented in units and will be formalized in

regulations made pursuant to the Act, as necessary. The Tariff in effect as of April 1, 2015 shall remain in effect except to the extent altered by the terms of this Agreement.

(iii) The units will continue to be categorized as follows:

(A) Medical Service Units (the "MSU") for all Insured Medical Services except anaesthesia services; and

(B) Anaesthesia Units (the "AU") for all anaesthesia services.

(iv) The MSU value is currently 2.42 and the AU value is currently 20.55.

(b) **Rate Increases**

(i) The following annual increases will apply to the MSU, the AU, the Sessional hourly rates, the Intensive Care Unit ("ICU") minimum income daily guarantees, the Emergency Department ("ED") hourly rates, the Psychiatry hourly rates, the CAPP rates (including the mentor and ED assessment rates), the Collaborative Emergency Centre ("CEC") rates and Alternative Payment Plan annual rates effective April 1 of each year of this Agreement:

Fiscal Year	Rate Increases
April 1, 2015 – March 31, 2016	0%
April 1, 2016 – March 31, 2017	0%
April 1, 2017 – March 31, 2018	1.0%
April 1, 2018 – March 31, 2019	1.5%

(ii) The rates for ICU and ED will be reviewed and may be adjusted by DHW, with the agreement of DNS.

(iii)The rates in effect as of April 1, 2015 are as outlined in Schedule "A" to this Agreement.

(c) **APP Increases**

(i) The rate for each Anaesthesia APP and Collaborative GP APP will increase by an annual amount of $10,000 effective upon signing of this Agreement, payable biweekly, and by a further $5,000 effective April 1, 2017. These amounts are for 1.0 FTEs, and will be proportionally reduced for APPs of less than 1.0 FTE.

(ii) The rate for each solo GP APP will increase by an annual amount of $8,000, effective upon signing of this Agreement, payable biweekly. This amount is for 1.0 FTEs, and will be proportionally reduced for APPs of less than 1.0 FTE.

(iii)The Parties agree that all other terms associated with the APP accountability model, continue in effect and may be revised as agreed by the MAMG.

(d) **Fee Schedule Adjustments and New Fees**

(i) The Fee Committee (FC) will review requests for new fees, to amend current fees, and for additions, revisions or clarifications of the Preamble to the MSI Physician's Manual, including any changes to the wording of the MSI Physician's Manual that may be needed as a result.

(ii) The Fee Committee will be governed by the existing terms of reference for the Fee Schedule Advisory Committee established pursuant to the 2008 Master Agreement unless amended by FC.

(iii)Notwithstanding (ii) above, Fee Committee shall have decision-making authority to approve adjustments to the fee schedule for all items where the Committee reaches consensus and for which the Committee has sufficient budget. Items which exceed the Committee's budget or about which the Committee is not able to reach agreement will proceed to the MAMG for decision.

(iv)Notwithstanding (ii) above, either Party may choose to add one additional member to the Committee.

(v) The Parties agree that the Fee Schedule may be adjusted from time to time as approved by the Fee Committee or by the MAMG if referred from Fee Committee.

(vi)The Parties agree that the following funds shall be provided by DHW to the Fee Committee exclusively for new fees, fee adjustments or preamble changes in response to applications:

Fiscal Year	**Incremental New Funding**
April 1, 2015 – March 31, 2016	$0
April 1, 2016 – March 31, 2017	$815,000
April 1, 2017 – March 31, 2018	$1,000,000
April 1, 2018 – March 31, 2019	$4,500,000

(vii) The Parties agree that the DHW will provide additional funding in the amounts outlined in the following table in order for Fee Committee to establish and/or enhance fees in the following areas.

Fiscal Year	Transition of Programs	Complex Care	Surgical Emergency Premium	Non Face to Face	Methadone
April 1, 2016 – March 31, 2017	$4,270,000	$0	$0	$0	$300,000
April 1, 2017 – March 31, 2018	$10,070,000	$1,000,000	$500,000	$1,500,000	$700,000
April 1, 2018 – March 31, 2019	$0	$0	$0	$1,500,000	$0

(viii) The Parties agree that base funding will not be reduced as a result of unspent fee schedule funding in a year. The Fee Committee shall, by October of each year and periodically thereafter as requested by MAMG, notify the MAMG of any projected funds that may be unused each fiscal year.

(ix) The Parties agree that Fee Committee will review the billing rules for the surgical emergency premium to consider and ensure that the rules governing the premium appropriately support the intent of the premium in circumstances where procedures or consults are done in, or moved to off-hours due to factors beyond the control of the physician.

(x) The Parties agree that, upon application, the Fee Committee will review enhancement of the fees for multiple and bilateral surgical procedures, with any incremental cost to be covered by the funds allocated to Fee Committee as assigned in (vi) of this section.

(xi) The Parties agree that non face to face for physicians will be introduced on a pilot basis. Full parameters and guidelines will be developed by Fee Committee with priority areas that include seniors' care, mental health and chronic care. The program will be reviewed for effectiveness after the end of the second year of the pilot. The Fee Committee will develop, implement, manage, and evaluate interim fees related to the provision of non-face-to-face care, consistent with the following terms:

A. Specialists:

(i) The interim fees will remunerate both physician-to-physician and physician-to-patient telephone interactions that are charted in the patient's record.

(ii) Physician to physician telephone interactions must be accompanied by a written request from a General Practitioner and must be charted by the Specialist.

(iii) The rate for physician to physician interactions will be 25 MSU and for Specialist to patient interactions will be 11.5 MSU.

(iv) Detailed billing rules to be developed by the Fee Committee, which could include for example a restriction that telephone fees are not billable for delivery of normal test results or a restriction that the physician must have seen the patient within a certain amount of time preceding a telephone visit being billed.

B. General Practitioners:

(i) The interim fees will remunerate both physician-to-physician and physician-to-patient telephone interactions that are charted in the patient's record.

(ii) Telephone interactions with patients will be billable only where the patient is 65 years of age or older and/or is suffering from mental illness or chronic disease.

(iii) Physician to physician telephone interactions must be accompanied by a written request from a General Practitioner and must be charted by the General Practitioner.

(iv) The rate will be 11.5 MSU.

(v) Detailed billing rules to be developed by the Fee Committee, which could include for example a restriction that telephone fees are not billable for delivery of normal test results or a restriction that the physician must have seen the patient within a certain amount of time preceding a telephone visit being billed.

C. The interim fees will take effect on April 1, 2017.

D. The Fee Committee will develop an evaluation framework to be shared with the MAMG prior to the new fees taking effect.

E. The Fee Committee will conduct an evaluation of the interim fees 18 months after implementation.

F. The Parties agree that if the MAMG concludes based on the evaluation that the interim fees will be discontinued, then the Parties shall jointly reallocate the actual 2018/19 expenditure on these fees to other non face-to-face patient care initiatives.

(e) **Canadian Medical Protective Association ("CMPA") Assistance**

(i) DHW agrees to continue to provide funding for CMPA reimbursement in accordance with the following criteria:

a) All Resident Physicians who are funded by the Province will continue to receive full reimbursement of their CMPA premium fees unless in future they receive funding or coverage for this purpose from another source; and

b) All other Physicians will be eligible to receive a reimbursement of 90% of their CMPA premium fees in excess of $1,750.

(ii) Reimbursement will be paid directly by DHW to eligible physicians based on electronic submission of information received from CMPA. DHW will communicate a payment schedule to Physicians and payments will be made on a timely basis and consistent with that schedule.

(f) **Continuing Medical Education**

DHW will maintain current funding and criteria for the Professional Development Support Programs as outlined in the 2008 Master Agreement for both General Practitioners and Specialists. DHW may randomly withhold annual payments to select physicians pending submission of supporting documentation that CME activities were undertaken in order to substantiate payment.

(g) **Electronic Medical Record (EMR)**

DHW will provide a one-time Physician-specific EMR Investment Grant of $10,000 (Envelope "A" as outlined in Schedule "I" of the 2008 Master Agreement), for both General Practitioners and Specialists. The eligibility criteria for this Grant in effect at the time of execution of this Agreement shall continue unless changed by MAMG.

(h) **Physician Manual Modernization Project (PMMP)**

DNS will provide the balance of funds available in the year-end transfer account monitored by the MASG to support the PMMP, with DHW providing all remaining funds to complete the Project (Phase 5). Working with DNS, DHW will develop an implementation plan that includes projected costing.

(i) **Continuity of Fees and Programs under the Expired Master Agreement**

The Parties agree that certain programs from the expired Master Agreement will be transitioned to fee codes, others will be terminated, and others will continue in their current state, all as outlined in Schedule "B" to this Agreement.

(j) **Targeted Project Funding**

DHW agrees to provide targeted project funding in accordance with Schedule "C".

(k) **Benefits**

(i) DHW will fund 65% of all premiums paid to provide health and dental coverage in accordance with the plan in effect upon execution of this Agreement, and 100% of parental leave and professional support program (EAP type) expenses. Any benefits changes which result in increased premiums require approval of DHW to be eligible for continued financial support.

(ii) DHW will reimburse DNS based on monthly invoicing.

(iii) The balance currently held as excess in the DNS Recruitment and Retention Fund under the 2008 Master Agreement will be drawn down to an appropriate reserve as jointly agreed by the Parties after consultation between the Parties' auditors. Any surplus above the agreed reserve will be used to fund the DHW portion of the costs of benefits until the agreed reserve is reached.

(iv) DHW will pay an administration fee of $300,000 per year, which represents 4% of the benefits program value of $7,500,000, payable to DNS monthly, in advance.

(l) **Remit Payments to DNS**

DNS may, at its sole discretion, direct DHW to remit any payments owing to an individual Physician under this Agreement to DNS in the event that the Physician has failed to pay their required DNS dues in a timely manner. Such payments could include any of the payments pursuant to this Article 4. DNS agrees that DHW is in no way liable for the remittance, nor for any challenges, legal or otherwise associated with them. In the event that DHW has engaged a third party to administer payments, DHW agrees to make every reasonable effort to effect any remittance requests through that third party. Any costs associated with these requests shall be the sole responsibility of DNS. DNS may choose to recover those costs from the Physician in question, as determined by DNS.

5. GOVERNANCE

5.1 A Master Agreement Management Group (MAMG) will be established to oversee the implementation and operation of this Agreement.

5.2 The terms of reference and decision making will be as outlined in Schedule "D".

6. ACCESS TO INFORMATION

(a) The Parties agree to share relevant information that is requested by a Party. Relevant historical and predicative data prepared by any Party will be fully shared. In cases where the information is not readily accessible or is not provided on request, the matter may be referred to the MAMG.

(b) DNS will be provided with electronic access to information on a monthly basis regarding Fee-For-Service billings and other payments made by DHW for Insured Medical Services, including the DHW's spreadsheets for Health Service Code, Physicians Payments and Physician Payments by Service Location and, upon request by DNS, electronic access will be provided to other routinely provided DHW information which is in relation to Fee-For-Service billings and other payments made by the DHW including utilization and cost information. The Parties agree that this information will not be in patient identifiable form. DHW agrees to consider all reasonable requests from DNS for changes to the format of this data.

7. CLINICAL ACADEMIC FUNDING PLANS AND ALTERNATIVE PAYMENT PLANS

Payments to Physicians pursuant to Clinical Academic Funding Plans or Alternative Payment Plans are payments for Insured Medical Services that are not included in the Tariff or in the amendments to the Tariff provided for in this Agreement. In the event that a Clinical Academic Funding Plan or Alternative Payment Plan contract is terminated or upon the expiration of any such contract, not renewed or re-negotiated, payment to Physicians for the provision of Insured Medical Services will be made pursuant to the Tariff. Privileges for the same geographic location cannot be withdrawn from or denied to Physicians by DHW or the Health Authorities in these circumstances.

8. AUDITS

DNS agrees that the DHW has the right to conduct audits of Physicians with respect to claims for Insured Medical Services including claims submitted by Physicians pursuant to Clinical Academic Funding Plan and Alternative Payment Plan contracts, within the terms outlined in Schedule "E" to this Agreement. All other contractual performance and compliance issues affecting Clinical Academic Funding Plan and Alternative Payment Plan Physicians shall be resolved pursuant to the terms of those contracts.

9. NOTICE

(a) All notices, requests, demands or other communications (collectively, "Notices") required or permitted to be given by one Party to the other Party pursuant to this Agreement shall be given in writing by personal delivery or by registered mail, postage prepaid, or by facsimile transmission to such other Party as follows:

If to DHW:	Minister of Health and Wellness
With a copy to:	Deputy Minister of Health and Wellness
If to DNS:	President of DNS
With a copy to:	Chief Executive Officer

(b) All Notices shall be deemed to have been received when delivered or transmitted, or, if mailed, Forty Eight (48) hours after 12:01 a.m. on the day following the day of the mailing thereof. If any Notice has been mailed and if regular mail service is interrupted by strikes or other irregularities, such Notice shall be deemed to have been received Forty Eight (48) hours after 12:01 a.m. on the day following the resumption of normal mail service, provided that during the period that regular mail service is interrupted all Notices shall be given by personal delivery or by facsimile transmission.

10. AMENDMENTS

(a) This Agreement may be amended upon Notice at any time by the mutual written consent of the Parties.

(b) No amendment or modification of this Agreement will become effective unless reduced to writing and duly executed by the Parties hereto.

11. CONSEQUENTIAL AMENDMENTS

The Parties agree that the Preamble, the Fee Schedule and any fee codes will be amended where necessary, to implement this Agreement.

12. GOVERNING LAW

This Agreement will be governed by, and construed in accordance with, the laws of the Province of Nova Scotia.

13. HEADINGS

The headings of the Articles of this Agreement have been inserted for reference only and do not define, limit, alter or enlarge the meaning of any provision of this Agreement.

14. ENTIRE AGREEMENT

(a) This Agreement and the attached Schedules constitute the whole of the Agreement between the Parties unless duly amended as provided in Article 10.

(b) No representation or statement not expressly contained in this Agreement will be binding upon any Party.

15. BENEFIT AND BINDING

This Agreement shall enure to the benefit of and be binding upon the Parties hereto and their respective successors and assigns.

Dated at Halifax, in the Halifax Regional Municipality, Province of Nova Scotia, on this ___ day of September, 2016.

SIGNED, SEALED AND DELIVERED in the presence of

Witness

Witness

Witness

HER MAJESTY THE QUEEN in right of the Province of Nova Scotia as represented in this behalf by the Department of Health and Wellness

Minister of Health and Wellness

September 8, 2016
Date

DOCTORS NOVA SCOTIA

Per:
President

Sept. 9/2016
Date

Per:
Chair, Board of Directors

Sept 9/16.
Date

SCHEDULE "A"

RATES EFFECTIVE APRIL 1, 2015

A. Sessional hourly rates: $145.20 for General Practitioners and $169.40 for Specialists.

B. ICU minimum daily income guarantees: as outlined in the Regional Hospital Intensive Care Unit and Comprehensive Care Alternate Payment Plan Options and Operating Guidelines, signed by the Parties on December 16, 2008.

C. Psychiatry hourly rates: $149.90 for certified and $110.55 for non-certified.

D. Emergency hourly rates: $192.00 for regional sites, $167.04 for other hybrid funding sites, $147.62 for Level 3 sites and $73.81 for Level 4 sites.

E. GP Alternative Payment Plan annual rate: $235,667.

F. Palliative Care/Geriatrics Alternative Payment Plan annual rates: $235,667 for General Practitioners with no additional training, $242,093 for General Practitioners with post-graduate certification, and $261,541 for certified Specialists.

G. Neonatology Alternative Payment Plan annual rate: $283,780.

H. Obstetrics/Gynecology Alternative Payment Plan annual rate: $331,416.

I. Pediatrics Alternative Payment Plan annual rate: $286,082.

J. Anesthesia Alternative Payment Plan annual rates: $265,299 for Category 1 and $250,041 for Category 2.

K. CAPP rates: shall be the rates as approved and in effect as of April 1, 2015.

L. CEC rates: shall be the direct funding provided by DHW for each CEC as of April 1, 2015.

SCHEDULE "B"

TRANSITION, TERMINATION AND CONTINUATION OF

2008 MASTER AGREEMENT PROGRAMS

I. PROGRAMS TRANSITIONING TO FEE-BASED INITIATIVES

(a) The funding for the following programs will transition to fee-based initiatives as outlined in Article 4:

(i) Comprehensive Care Incentive Program (CCIP)

(ii) Collaborative Practice Incentive Program

(iii) Electronic Medical Records Envelopes B and C

(iv) Unattached and Orphan Patients Program (collectively, the "Transitioning Programs")

(b) The Fee Committee will be provided with a budget as outlined in Article 4.1(d)(vi) and the Committee will decide on appropriate fee codes and fee values to support physicians in providing care. First priority areas will be participating in comprehensive care, collaborative practice, utilizing electronic medical records and addressing the issue of unattached and orphan patients.

(c) For purposes of the CCIP, the Fee Committee will set fees that ensure the $6 million CCIP budget is reallocated in support of primary care. The Parties have completed an initial assessment for home visits, nursing home visits, inpatient care, maternity and newborn care, and visits with children under the age of two. Additional fees to support comprehensive care will be determined by the Fee Committee, with the following areas as priority: tray fees for certain in-office procedures, care plan oversight for care of patients in nursing homes, travel fees for home and nursing home visits, visits with children at five years old, and geriatrics visits.

(d) The Transitioning Programs shall end when new fees are approved by the Fee Committee or MAMG (on referral from Fee Committee) and put in effect by DHW.

II. PROGRAMS BEING TERMINATED

(e) DHW will terminate the Community Remote Practice On-Call program on a staged basis. Effective upon execution of this Agreement, the pro-rated annual amount for General Practitioners currently eligible for this program will be reduced to $20,000. Effective April 1, 2017, the annual amount will be reduced to $10,000 and effective April 1, 2018 the bi-weekly payments will be terminated.

(f) DHW and the Health Authorities will develop a new Community On-Call Program, subject to DNS approval of the rates. Funding for any such Program will be secured by DHW outside the parameters of this Agreement.

III. PROGRAMS CONTINUING IN MODIFIED FORM

Rural Specialist Retention

(g) The Rural Specialist Incentive Program will continue in its current form. The MAMG will review the Program to better incent recruitment in addition to retention. Program modifications are effective no earlier than April 1, 2017.

Complex Care Visit and Chronic Disease Management Fees

(h) The Chronic Disease Management and Complex Care Visit Fees will continue in their current form until revised by the Fee Committee. The Fee Committee will review and revise the fees to ensure they are more reflective of the level of service required to manage chronic/complex illness and available for the care provided to a greater portion of the chronically ill patient population, and will utilize the additional $1 million investment pursuant to article 4.1(d)(vii) to enhance or add new fees to support complex and chronic care.

Facility On-Call

(i) The Facility On-Call program rates will continue in its current form. All approved on-call rotas will be reviewed by the Health Authority to ensure they align with patient care and service coverage requirements. All required rotas continue to be funded (unless determined to no longer be required) and other eligible rotas are able to be funded through the program.

IV. PROGRAMS CONTINUING IN CURRENT FORM

(j) All other fee-based and program funding in effect on the date of execution of this Agreement shall continue with the same terms and conditions as those in effect on the date of execution, unless the Parties agree otherwise. This includes but is not limited to:

- GP Surgical Assist Program
- Nova Scotia Provincial Locum Program
- Emergency Department Services and Compensation
- Regional Hospital Intensive Care Unit Payment Plan
- Evening and Weekend GP Office Visit Incentive
- Continuing Care

SCHEDULE "C"

TARGETED PROJECT FUNDING

- **Goal: Targeted funding must be accountable to Nova Scotians and support quality patient care and system priorities**

Parameters for all Project Funding

- Project work (including deliverables) supporting the three areas identified below and approved by MAMG
- Project work will align with DNS fiscal year (Sept-Aug)
- Quarterly reports to MAMG summarizing work done and time spent.
- Maximum amount allocated for each fiscal year, to be paid to DNS on a quarterly basis.
- Maximum amounts identified below are fixed overall but may be adjusted between priority areas as agreed by MAMG.
- DNS agrees to conduct a reconciliation at each year-end to ensure time spent equates to time paid. Reconciliation to be based on time spent and agreed upon hourly amount
    - Agreed upon hourly amount for physicians is based on $150.00 per hour
    - Agreed upon hourly amount for staff is $70 per hour (time to be reported based on half-days)

Project Funding:

1. Fee Schedule

Purpose: Support to FSC and fee schedule related items

Amount: Maximum annual amount ($330,000)

Project work to include:

- Research required to support FSC applications (Typically a medical professional)
- General Support to FSC
    - Track all applications to FSC
    - Responsible for timely communication to applicants (at the direction of FSC)
- Support for the Application Process, including but not limited to:
    - Make applications available to physicians
    - Ensure communication to physicians on a regular basis on the application process
    - Liaison between FSC and physician to ensure applications are complete
- Work between DHW/MSI medical consultants on billing issues
    - Mediating potential disputes between physicians and MSI/DHW
    - Working with DHW/MSI to address fee related issues
- Other work as agreed

2. Clinical Practice Support

Purpose: Projects that support physicians attempting to transition their practices in alignment with health system change and priorities.

Amount: Maximum annual amount ($500,000)

Project work to include but not be limited to:

- Support for physicians transitioning to an EMR. Includes expectation that staff will need to visit physicians' offices to support the transition.
- Support for physicians to ensure maximum use of EMR.
- Support for physicians to eliminate office Fax machines
- Other areas as agreed to

Some of this project work will need to take place in physician's offices. Others will require a liaison function as between DHW, the Health Authorities, DNS and physicians to support physicians in transitioning their practices in ways that align with health system priorities.

3. Physician Initiatives

Purpose: Joint initiatives between DNS and DHW that support physicians and residents

Amount: Maximum annual amount $625,000

Initiatives to include:

- CME (effective April 1, 2017 transition this funding to Labour and Advanced Education)
- Bursary program
- Retirement and succession planning
- Support through MSI for billing education sessions
- Medical student engagement
- Physician leadership
- Other initiatives as directed by the MAMG

SCHEDULE "D"

GOVERNANCE

Principles:

- Governance structure designed to foster and support an ongoing collaborative relationship between DNS, DHW and the NSHA/IWK
- Agile and flexible structure with ability to adjust as the system evolves
- Ensure accountability and transparency in contract management

Committee:

Master Agreement Management Group (MAMG)

- Mandate:
    - To oversee the implementation and operation of the Master Agreement
    - To discuss any operational issues arising from the Master Agreement
    - To establish working groups and engage contractors and/or consultants as required to investigate issues of importance to the ongoing implementation and oversight of the Master Agreement
        - Determine specific projects to be funded in a year when DHW identifies funds available from under-utilization trends in fee schedule
    - To receive reports on Master Agreement initiatives, including:
        - DHW to provide quarterly financials on the Agreement
        - Quarterly reports from DNS on work done and invoiced from Project Funding initiatives
        - DHW/NSHA to provide reports on the performance of programs (uptake; outcomes; etc.)
    - To oversee an evaluation of the non face-to-face patient care program and make decisions arising out of the results of that evaluation
    - To make decisions on matters arising during the life of the Agreement. Examples we can anticipate:
        - Approval of the community on-call rate once the program is designed
        - Decisions on how to allocate funds that may become available during the life of the agreement from CMPA in the event of a reduction in CMPA fees, and the non face-to-face budget in the event that the program evaluation does not support its continuation
        - Issues that Fee Committee may refer to MAMG

- Decisions of the MAMG shall be:

    (i) In the first instance by consensus.
    (ii) If consensus is not reached on an issue, then by majority.
    (iii) In the event that a majority decision cannot be reached, then a ninth member will, at the request of either Party, be appointed by the co-chairs for resolution of the issue.
    (iv) The ninth member will chair those portions of the MAMG meeting(s) which involve consideration of the unresolved issue, will decide how best to conduct the meeting(s) and to resolve the issue, and will have all powers granted pursuant to the *Commercial Arbitration Act*. This is not

intended to be a formal arbitration. There shall be no legal counsel and no calling of evidence. The rules of natural justice do not necessarily apply, except in the discretion of the ninth member.

(v) The decision of the MAMG reached through this process shall be final and binding on all Parties.

In the event that the Parties have a dispute with respect to the interpretation or application of an MAMG decision, or that either Party has a dispute with respect to the conduct of the other Party regarding the interpretation, application or administration of this Agreement, the dispute shall be resolved pursuant to this MAMG decision-making process.

- Standing Committees:
  - MAMG may agree to establish standing committees as necessary.
  - APP Working Group to continue. Recognizing this is a priority area the mandate of this group will be determined by MAMG.

- Composition and frequency of MAMG meetings:
  - To be composed of 4 DNS representatives and 4 DHW representatives.
  - To meet at least quarterly.
  - DHW to continue to prepare agendas and meeting materials in consultation with DNS.

SCHEDULE "E"

Claims Monitoring and Resolution Mechanism

Preamble

In May 2013, the DHW and DNS jointly commissioned Mr. John Carter, FCA to review the claims monitoring and resolution mechanisms that were in place in Nova Scotia at that time. The resulting report, *The Physician Audit and Appeal in Nova Scotia*, recommended a number of improvements based on best practices across the country to ensure appropriate accountability, while at the same time reducing claims payment wait time in some areas.

An implementation team was struck to execute the report's recommendations, and was comprised of representatives from DNS, the DHW and Medavie Blue Cross (the claims administrator for Medical Services Insurance or MSI), as well as Mr. Carter. This collaborative process has resulted in a new appeal process (Schedule E) that will guide future audit and pre-payment assessment appeals.

All parties agree that it is the physician's responsibility to ensure claims are appropriate and consistent with the MSI Physician's Manual and clarifications articulated in the Physicians' Bulletins and that they meet required minimum standards for billing purposes. To assist the physicians and in the spirit of ongoing collaboration DNS and DHW acknowledge that education of physicians about appropriate billing is a joint responsibility and that together, all parties will continue to work on mechanisms to educate physicians.

1. For the purposes of this Schedule "E":

    a) **Audit Period** is limited to the twenty-four (24) months prior to the commencement of the audit, unless otherwise extended pursuant to Article 20;

    b) **Claims** means both fee for service and shadow service claims;

    c) **Days** means business days;

    d) **Implementation Date** means thirty (30) calendar days after Schedule "E" is fully executed by both DNS and DHW;

    e) **MSI** means Medical Services Insurance as administered by Medavie Blue Cross and any successor organization operating on behalf of the Province of Nova Scotia in respect of the payment to physicians for insured medical services;

    f) **Monitoring** includes both pre-payment assessment of Claims and post payment audit of Claims;

    g) **Party** means DHW or the physician;

    h) **Post payment audit of Claims** includes any automated and/or manual systems and process in place to review Claims submitted by physicians after a Claim has been paid; and

i) **Pre-payment assessment of Claims** includes any automated (rules in the billing system) and/or manual systems and processes in place to review Claims submitted by physicians prior to payment.

2. DHW, through MSI, shall conduct Monitoring of Claims intended to determine whether:

   a) the service was an insured service in Nova Scotia;

   b) the service was performed;

   c) the service was medically necessary;

   d) the service was correctly represented in the Claim for payment; and

   e) the service meets the requirements set out in:

      i. the Preamble of the MSI Physician's Manual, and

      ii. any relevant clarification provided to physicians in the MSI Physicians Bulletin

3. DHW, through MSI, shall ensure that the Claims monitoring and resolution process as outlined herein is followed.

Pre-Payment Assessment

4. If a physician's Claims are adjusted or rejected as the result of a Pre-Payment Assessment, the physician will be notified electronically by MSI through the adjudication response (the "MSI Result").

5. The physician is deemed to receive the MSI Result five (5) days after the day the MSI Result is sent.

6. If Pre-Payment Assessment results in adjustment or rejection of a Claim due to rules that are in the billing system, it cannot be disputed by an individual physician. In this circumstance, DNS has the authority, as the sole bargaining agent for physicians in Nova Scotia, to raise the issue with the Master Agreement Management Group, if DNS in its sole discretion determines that the subject matter requires further consideration.

7. If Pre-Payment Assessment results in adjustment or rejection of a Claim for any other reason (including but not limited to Claims assessed as part of the pre-payment assessment of multiple Claims [same patient, same day, same provider] or Claims assessed as part of a random pre-payment assessment process), the physician can dispute the adjustment and/or rejection as provided herein.

8. In order to dispute a MSI Result, the physician must, within ten (10) days after receipt of the MSI Result, contact MSI in writing to initiate the Request for Pre-payment Assessment Review. If the physician fails to contact MSI within that time, he/she is deemed to agree with the MSI Result and forfeits further rights to Facilitated Resolution or Arbitration.

9. Once a Pre-Payment Assessment Review is initiated this will be considered by both the DHW Medical Consultant and the DNS Medical Consultant within fifteen (15) days of receipt of the Request for Pre-Payment Assessment Review.

10. If both the DHW and DNS Medical Consultants determine that the dispute involves a policy decision the MSI Result cannot be disputed by an individual physician and that physician will be notified by DHW, with a copy to DNS. A policy decision includes but is not limited to items specifically negotiated by DNS and DHW. In this circumstance, DNS has the authority, as the sole bargaining agent for physicians in Nova Scotia, to raise the issue with the Master Agreement Management Group, if DNS in its sole discretion determines that the subject matter requires further consideration. The physician will have no further access to the Schedule "E" process for the Pre-Payment Assessment, and no further right of appeal.

11. If one or both of the DHW and DNS Medical Consultants determines that the dispute does not involve a policy decision then the pre-payment assessment will move directly to Facilitated Resolution, commencing at Clause 31.

12. If both the DHW and DNS Medical Consultants agree that the Claims being submitted by a physician indicate a pattern of deliberate non-compliance with the MSI Physician's Manual and/or MSI Bulletins, that physician will have no further access to the Schedule "E" process for the Pre-Payment Assessment, and no further right of appeal on that matter.

Post-Payment Audit

13. A physician may be identified for post-payment audit (the "Audit") in a variety of ways, including but not limited to:

    - Service Verification Letters;
    - Case Mix Grouping - Peer Profiling;
    - Referral;
    - Periodic Random Selection;
    - Use of New Fee Codes;
    - Specific Fee Codes identified for audit.

14. An Audit may occur by way of periodic review of MSI data (periodic review) and/or an on-site visit.

Periodic Review

15. A physician will not be notified in advance of an audit conducted by way of periodic review of MSI data.

16. The results of the Audit will be provided to the physician in writing (the "Audit Result") where, in the auditor's opinion, the periodic review showed the physician's billing to be inappropriate.

On-Site Audits

17. Any physician identified for an on-site Audit will be notified in writing that an Audit will occur and which fee codes will be included in the Audit. The Audit will be scheduled at a mutually agreeable time. The auditor may require inspection of any books, accounts, documents, reports, invoices and patient records in any form, including electronic that are maintained by or on behalf of the physician (the "Records") to clarify or verify services for which Claims have been submitted.

18. The results of the Audit will be provided to the physician in writing (the "Audit Result").

Audit Scope

19. The auditor may, acting objectively and with reasonable notice, extend an audit of a physician's practice to cover fee codes that were not originally selected if the audit results suggest potential for additional incorrect billings. The reasons for extending the fee codes audited must be provided to the physician with the notice of the extension and cannot be challenged as a part of the Audit and Appeal process.

20. The Audit Period may be extended in exceptional circumstances.

Notification of Audit Results

21. For the purposes of Clauses 16 and 18, notice of the Audit results will include:

    a) a detailed summary of each Claim deemed to be inappropriate with explanatory comments as to the nature of the deficiency;

    b) the financial implications of the Audit; and

    c) details on what steps may be taken to resolve the matter, which will include a link to an electronic copy of this Schedule E.

22. The physician is deemed to receive the Audit Result five (5) days after the day it is sent by regular post.

23. A cover letter that identifies the physician, and states that a notice of the Audit Result has been issued, will be copied to DNS; the notice itself, as well as any additional details, will be sent to the physician alone.

Audit Review

24. Where the physician disagrees with the Audit Result, the physician will, within twenty (20) days of receipt of the findings, contact MSI in writing to initiate the Audit Review (Notice of Audit Review). The Notice will include the basis for the disagreement and provide documentation, including all relevant clinical documentation, to support that position. If

the physician fails to provide the Notice to MSI within that time, s/he is deemed to agree with the Audit Result and forfeits further rights to Audit Review, Facilitated Resolution, or Arbitration. If deemed to agree with the Audit Result then any associated recovery shall be made from future payments to the physician. The purpose of the Audit Review is to ensure that MSI has all information/documentation relevant to the Audit.

25. MSI will review all information and documentation provided as part of the Notice of Audit Review. After the Review, the MSI Medical Consultant may do one of the following:

    a) In order to ensure an efficient and effective Audit Review process, if, in the sole discretion of the MSI Medical Consultant, the Notice provided by the physician does not provide any new information that may change the Audit Result, the MSI Medical Consultant will issue a Notice of Determination and the matter may be referred directly to Facilitated Resolution (without an Audit Review meeting between the MSI Medical Consultant and the physician).

    b) Request a meeting with the physician, either by telephone or in person, to facilitate the documentation review process; such meeting to be scheduled within fifteen (15) days of receipt of the Notice of Audit Review.

26. Upon review of all additional information/documentation provided to MSI by the physician, MSI will issue a Notice of Determination.

27. The Notice of Determination shall include:

    - a statement of the findings of the Audit, including any adjustments made as a result of the Audit Review;
    - detail of all outstanding issues that have not been resolved; and
    - a form that may be used by the physician to object to the Notice of Determination.

28. A cover letter that identifies the physician, and states that a Notice of Determination has been issued, will be copied to DNS; the Notice itself, as well as any additional details, will be sent to the physician alone.

29. If the physician disagrees with the Notice of Determination, the physician may, by notice in writing, within twenty (20) days from the date he/she receives the Notice of Determination, submit an objection in writing to MSI (the "Notice of Dispute"). In the Notice of Dispute, the physician may only make representations related to matters referred to in the Notice of Determination, or which are related directly thereto. If the physician fails to contact MSI within that time, he/she is deemed to agree with the Audit Result and forfeits further rights to Facilitated Resolution or Arbitration. Any associated recovery shall be made from future payments to the physician.

30. The physician is deemed to receive the Notice of Determination five (5) days after the day it is sent by regular post.

Facilitated Resolution

31. When MSI receives a Notice of Dispute, or where either the DHW Medical Consultant or the DNS Medical Consultant determines that a pre-payment assessment dispute does not

involve a policy decision per Clause 11, the Facilitated Resolution stage will begin. MSI will notify both the DHW and DNS Medical Consultants.

32. DHW and DNS will agree upon a list of Facilitators in a separate document. The Facilitator will be chosen from that list by starting at the top and moving down until a non-conflicted Facilitator is located that is available to begin the Facilitated Resolution within sixty (60) days. In the event none of the Facilitators are available within sixty (60) days' time, the next available non-conflicted Facilitator will be chosen. For each subsequent Facilitated Resolution, the search for available Facilitators will commence at the point on the list that is immediately after the Facilitator most recently chosen to participate.

33. The Facilitated Resolution will proceed on a "without prejudice" basis and will commence on a date agreed upon by DNS and DHW that is no later than sixty (60) days after appointment of a Facilitator; if agreement on a Facilitated Resolution date is not reached, the Facilitated Resolution will commence on the first business day following expiry of the sixty (60) days.

34. The Facilitated Resolution will proceed in accordance with Schedule C of the *Commercial Arbitration Act*, S.N.S. 1999, c.5, (CAA) with the exception of CAA Clauses 2, 15 and 16, and with the Facilitator having the same duties and powers as a CAA mediator.

35. The Facilitated Resolution will involve only the DHW Medical Consultant, the DNS Medical Consultant, MSI audit personnel, the physician, and the Facilitator. For the sake of certainty:

    - legal representatives will not attend the Facilitated Resolution;
    - agreement may only be reached with consensus between the DHW Medical Consultant and the physician;
    - if agreement is reached, the Facilitator will document the terms of the agreement (the Agreement) and the DHW Medical Consultant and the physician will sign the Agreement, at which time the Agreement will become binding on both Parties;
    - if agreement is not reached, the physician has thirty (30) days to provide notice of intent to proceed to Arbitration as outlined herein. If no notice is provided, the physician is deemed to agree with the Audit Results and forfeits further rights to Arbitration.

36. Each Party is responsible for its own legal costs. The Parties will each bear half of all other expenses related to the Facilitated Resolution, unless DHW and DNS agree on an alternative arrangement.

37. If either DHW or the physician do not participate in the Facilitated Resolution, the non-participating party is deemed to have forfeited its claim against the other and the matter is concluded, excepting however where both the DHW and the physician, acting reasonably, agree to reschedule the Facilitated Resolution, it may be rescheduled to a date that is no later than thirty (30) days after the originally scheduled date.

38. Upon receipt of notice to proceed to Arbitration, the dispute will be finally determined by Arbitration presided over by a Resolution Panel (the "Panel"). The Arbitration will proceed in accordance with the *Commercial Arbitration Act*, S.N.S. 1999, c.5, (CAA) except as specifically altered herein. The parties agree that only matters contained in the Notice of Determination which are contested in the Notice of Dispute will be subject to Arbitration.

39. The Panel will be comprised of three individuals, one from each of the Lawyer, Non-Physician, and Physician Categories, as set out in a document agreed upon by both DNS and DHW, and once constituted, shall be an arbitrator under the CAA. All three individuals will be chosen to form the Panel by starting at the top of each Category's list and moving down until a non-conflicted Member from each Category is located that is available to participate in the Arbitration within sixty (60) days' time. In the event none of the Members in a particular Category are available within sixty (60) days' time, the next available non-conflicted Member in that Category will be chosen. For each subsequent Panel, the search for available Members will commence at the point on each Category list that is immediately after the Member most recently chosen to participate on a Panel. The Panel Member chosen from the Lawyer Category will serve as Chair of the Panel.

40. For the Lawyer Category, there will be a roster of no less than three lawyers jointly appointed by DNS and DHW. Each lawyer will serve on the roster for a period of three (3) years, and will be eligible for a second three (3) year term if approved by both DNS and DHW.

41. For the Non-Physician Category, there will be a roster of no less than three non-physicians jointly appointed by DNS and DHW. Each non-physician will serve on the roster for a period of three (3) years, and will be eligible for a second three (3) year term if approved by both DNS and DHW.

42. For the Physician Category, there will be a roster of no less than ten physicians jointly appointed by DNS and DHW. The physicians will serve on the roster for a period of three (3) years, and will be eligible for a second three (3) year term if approved by both DNS and DHW.

43. The physician is entitled to have legal counsel present at the Arbitration. If the physician elects to do so, DHW may also have legal counsel present.

44. The Panel will determine the dispute based on the Physician's Manual, including the Preamble thereto and MSI Bulletins. Relevant written correspondence/documents between MSI and the physician may be considered. Only that version of the Manual and those Bulletins that were in effect at the time the services in dispute were provided will be considered.

45. The Panel will determine the dispute by majority vote.

46. The decision of the Resolution Panel shall be final and binding on the physician and DHW. The Chair will provide a written decision, signed by all members of the Panel, within ten (10) days of the conclusion of the Arbitration.

47. Each Party is responsible for its own legal costs. The Parties will each bear half of all other expenses related to the Arbitration, unless DHW and DNS agree on an alternative arrangement. Notwithstanding the above, the Panel may apportion non-legal expenses as it sees fit.

48. Any amounts owing to either the physician or DHW as a result of the decision of the Panel will be due and payable on the date of the Decision, and will bear interest from that day at the prime rate as calculated by the Minister of Finance from time to time, based upon the variable reference rates of interest declared by the five largest Canadian financial institutions or their successors as their rates for Canadian dollar consumer loans, plus an additional 2%. The prime rate is calculated by ignoring both the highest and the lowest of those five rates and taking the average of the remaining three rates.

49. DHW and DNS agree to review the process one (1) year after its implementation, and agree that, unless the Parties agree otherwise, Schedule "E" will terminate upon termination of the Physician Services Master Agreement.

50. Without limiting the generality of the foregoing, if after one (1) year the Facilitated Resolution phase does not successfully resolve 65% of the files it receives, specifically excluding the files which reach Facilitation by way of the Transition Process, the Facilitated Resolution phase will be removed from Schedule "E", unless both DHW and DNS agree otherwise.

51. Any clause in this Schedule may be altered or waived with the agreement of the DHW Medical Consultant and the DNS Medical Consultant.

Transition Provisions

52. With the exception of any Arbitrations that are already scheduled as of the Implementation Date of the revised Schedule E, any portion of the claims monitoring process as defined herein that remains outstanding at the Implementation Date shall be governed by the revised Schedule E.

53. With the exception of any Arbitrations that are already scheduled as of the Implementation Date, each physician for whom any portion of the claims monitoring process is ongoing will be notified fifteen (15) days in advance of the Implementation Date.

54. Within twenty (20) days of the Implementation Date, each physician must communicate a request to proceed to the next step in the claims monitoring process, otherwise any outstanding Audit or Pre-payment assessment will be confirmed.

    a) For greater certainty:

        i. a physician who has received and disagrees with an Audit Result shall submit to MSI a Notice of Audit Review to initiate Audit Review as outlined herein;

        ii. a physician who has received and disagrees with a Notice of Determination shall submit a Notice of Dispute in writing to MSI, and Facilitated Resolution shall proceed as outlined herein;

iii. a physician who has submitted a Notice of Dispute but has not yet had Arbitration scheduled shall proceed with Facilitated Resolution as outlined herein.

55. Any dispute that ceases to follow the processes set out in this Schedule E, or the initiation of any insolvency steps by the Physician, will result in the commencement of collection procedures as outlined herein.

56. DNS and DHW agree that, pursuant to s. 7 of the Doctors Nova Scotia Act, this Schedule E is an agreement which DNS may enter into that binds its members.

57. Physicians are only permitted to challenge pre-payment assessment of claims and/or post-payment audit of claims through the processes outlined in this Schedule.

58. The results of any arbitration, facilitated resolution or decision pursuant to clauses 6, 10, 12, 19, 20, and 25(a) are final and conclusive, and are not open to question or review by a court or other body on any grounds, including by way of judicial review.

TAB 121

Investing in Family Doctors

Government is investing $39.6 million to improve access to primary care

Fee Increase – $11.3 million (fee for service doctors)

Support ongoing efforts to retain current family doctors and recruit new ones

- Government is investing $11.3 million to raise the basic office visit rates
  - Basic office visit rate for patients under 65 will move from $31.72 to $36.00
  - Basic office visit rate for patients 65 and over will move from $40.26 to $44.54
- The rate increase is available to family doctors with an established family practice, or who are establishing a family practice

Alternative Payment Plan (APP) Increase – $2.6 million (contract doctors)

Help retain family doctors on APPs

- Government is investing $2.6 million to increase compensation for family doctors under APP contracts
- Compensation will increase corresponding to the overall increase to the fee for service expenditures family doctors are receiving
- This applies to family doctors under APP contracts regardless of whether they are full or part-time, providing they meet a billing threshold

Enrolment Incentive Trust – $6.6 million

Encourage doctors to develop an up-to-date patient list, on a voluntary basis

- A one-time enrolment incentive of $7.50 per current patient
- Money will be placed in trust and managed by an independent trustee

Patient Attachment Incentive Trust – $6.4 million

Better connect Nova Scotians with a family practice

- Offer a one-time incentive of $150 per patient to doctors for accepting a patient from the 811 *Need a Family Practice* registry
- Also available to family doctors who take on new patients referred from an emergency department, or from a practice where a doctor is retiring or relocating
- Money will be placed in trust and managed by an independent trustee

Technology Incentive – $4.2 million

A pilot project to deliver telephone and e-health services that will improve access to primary health care, convenience for patients and efficiency for doctors

- Participating family doctors can receive up to $12,000 a year for using technology to communicate with their patients
- Simplify the billing code requirement for the current non-face-to-face fees (ie: prescription renewal by phone)
- Doctors agree to take part in the pilot evaluation process
- Compensation will be pro-rated for doctors working part-time

Electronic Medical Record (EMR) Incentive Trust and EMR Support – $8.5 million

Financially support family doctors using electronic medical records, improving overall quality care in a practice

- One-time payment for those family doctors changing electronic medical record providers
- One-time incentive to expedite the EMR transition from Nightingale on Demand (software being phased out)
- $5.2 million, for the one time payments, will be placed in trust and managed by an independent trustee
- Financial support for EMR users

NOVA SCOTIA

TAB 122

Nova Scotia's doctors ratify new four-year contracts

November 27, 2019, 10:33 am

**** Doctors NS Media Release

On Nov. 25, the province's doctors signalled they're ready for change by approving two new four-year agreements with the provincial government.

"These contracts begin to recognize the value of Nova Scotia's doctors and will help to begin stabilizing some of the most vital services in our health-care system

so that patients have better access to the care they need, when they need it," said Dr. Gary Ernest, President of Doctors Nova Scotia.

The new agreements will help address several issues that affect the province's ability to retain and recruit doctors, including more competitive compensation, physician engagement, physicians' work environment and physicians' right to representation.

Doctors Nova Scotia has been advocating for critical improvements in these areas so that Nova Scotia can become a place where doctors want to practise medicine.

The association has been able to make progress on all of the key recommendations it made with Maritime Resident Doctors and Dalhousie Medical Student Society in the 2018 report, *Road Map to a Stable Physician Workforce*.

Under these contracts, all Nova Scotia doctors will receive a 2% increase in each of the four years of the contracts. In addition, there are targeted investments in five key areas: comprehensive primary care, emergency care, psychiatry, obstetrics and gynecology, and anesthesia.

"While the contracts don't solve every problem in the system and they don't make every speciality nationally competitive, we believe the contracts are a step in the right direction and an important investment in the future of our health-care system," said Dr. Ernest.

The targeted investments support specialities that experience tremendous difficulty recruiting much needed physicians because other provinces offer more competitive rates.

Family doctors who provide comprehensive care, such as through office visits, emergency medicine, inpatient care and obstetrics/maternal care, will see a significant increase in pay, bringing their compensation to the top in Atlantic Canada. Community-based hospital inpatient care will be shored up through a new model for family physicians in rural Nova Scotia. As well, there is an investment to pilot a new blended capitation payment model for family doctors.

Specialists who practise emergency medicine, obstetrics and gynecology, psychiatry and anaesthesiology will see an increase under these contracts to improve the province's ability to recruit and retain to these essential services.

The Master Agreement also includes important improvements to physicians' work environment. Government has made a commitment to support succession planning, allowing retiring and new-to-practise physicians the opportunity to overlap and work together so that there is a seamless handoff for patients and uninterrupted care delivery.

In recognition of the importance of training medical learners in communities around the province, physicians who mentor these learners, who previously were not paid – or were underpaid – for this work, will now receive more appropriate stipends for teaching medical students and residents.

Under this new contract, physician audits in Nova Scotia will become far less punitive and more focused on educating physicians about proper billing technique and documentation.

Through the contract, government has committed to reducing the administrative burden physicians have struggled with. Unnecessarily repetitive or cumbersome paperwork requirements, such as completing paperwork requested by government departments when arranging a locum to fill in for them during maternity leave or sick time, will be streamlined so that physicians can spend more time with their patients.

“We believe the contracts signal a new level of support for physicians from the government and the health authorities. We look forward to working more closely with government to continue making improvements in the system for all Nova Scotians,” said Dr. Ernest.

The new four-year contracts come into effect upon signing, which is expected to take place on Nov. 29, 2019, and will replace the 2015 Master Agreement and Clinical/Academic Funding Plan (C/AFP) agreements, which expired on March 31, 2019. The agreements impact 2,944 physicians.

TAB 123

NOVA SCOTIA

News release

Province, Doctors Nova Scotia Reach New Four-Year Agreements

20 July 2023 | 1:25 PM

Health and Wellness

Doctors Nova Scotia and the Province have successfully negotiated new, four-year physician and clinical academic funding agreements.

The contracts cover doctors' compensation and benefits as well as funding for clinical and academic responsibilities. Ratification by Doctors Nova Scotia's members was announced today, July 20.

"Physicians play an invaluable role in all aspects of our healthcare system. I'd like to thank Doctors Nova Scotia for their collaborative approach during negotiations that resulted in a fair and balanced contract for all parties," said Michelle Thompson, Minister of Health and Wellness. "This is a good deal for our doctors and will be great for patients. One key aspect of the new agreements was including investments in improving access and attachment to primary care, which serves as the foundation for the healthcare system."

The new agreements provide a new payment model option for family physicians that will increase their compensation based on the hours worked, the services they provide and the number of patients in their practices.

Family physicians compensated through fee for service will be eligible for a grant and will receive an annual payment based on their number of patients.

There is also funding in the agreement for family physicians to hire allied healthcare providers, such as physiotherapists and dietitians, in their offices.

Other investments through the agreements will help:

- improve access to regional specialty services and reduce the surgical wait list
- support training the next generation of physicians
- support physician recruitment and retention.

The new agreements will be posted in the coming days at: https://doctorsns.com/sites/default/files/2023-2027_PhysicianAgreement.pdf

Quotes:

> "A sincere thank you to Minister Thompson and the Province for open and collaborative talks at the negotiations table. The agreements offer meaningful improvements that will lead to better access to primary and specialty care for Nova Scotians and more satisfying professional and personal lives for some of Nova Scotia's doctors. This is essential to our ability to recruit and retain much-needed physicians in Nova Scotia."

– Dr. Colin Audain, President, Doctors Nova Scotia

Quick Facts:

- all parties had agreed to an interest-based bargaining approach, a first for physician negotiations in Nova Scotia
- the new agreements replace the 2019 Master Agreement and Clinical Academic Funding Plan (C/AFP) Agreement that began on April 1, 2019, and expired on March 31, 2023
- in the 2022-2023 departmental budget, physician services cost about $1.04 billion
- the new agreements will add about $177 million to the budget by the fourth year (2026-27)

Additional Resources:

Action for Health, the government's plan to improve healthcare in Nova Scotia: https://novascotia.ca/actionforhealth/

Mandate letter of the Minister of Health and Wellness: https://novascotia.ca/exec_council/letters-2021/ministerial-mandate-letter-2021-DHW.pdf

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TAB 124

Doctors accept new four-year contracts

July 20th, 2023

Nova Scotia's doctors have accepted two new four-year agreements with the provincial government.

"A sincere thank you to Minister Thompson and the province for open and collaborative talks at the negotiations table. The agreements offer meaningful improvements that will lead to better access to primary and specialty care for Nova Scotians and more satisfying professional and personal lives for some of Nova Scotia's doctors," said Dr. Colin Audain, President of Doctors Nova Scotia (DNS). "This is essential to our ability to recruit and retain much-needed physicians in Nova Scotia."

"Physicians play an invaluable role in all aspects of our health-care system," said Minister Michelle Thompson, Department of Health and Wellness. "One key aspect of the new agreements was including investments in improving access and attachment to primary care, which serves as the foundation for the health-care system."

Throughout negotiations, the goal has been to stabilize family medicine. Without good access to primary care, the effects are being felt across the system – most acutely by family physicians themselves, who struggle to see so many in their communities without a family doctor, and by physicians in emergency departments and specialty services, as they work to support patients who don't have a family physician to quarterback their care.

“Our focus has been building a Physician Agreement that helps to retain our current family physicians and makes longitudinal family medicine practice more attractive to medical learners and physicians,” said Dr. Audain. “The agreement makes significant investments in initiatives that will help stabilize family medicine in Nova Scotia and work to make office-based practice more sustainable for all physicians.”

A new payment model, called the Longitudinal Family Medicine payment model, will support family doctors in providing exemplary patient care across the lifespan and at all levels of complexity.

Family physicians will also receive overhead support, new fee codes that recognize some of the unpaid work family physicians do, and support for family doctors to hire allied health-care providers to enhance team-based care.

Stabilizing specialty services to support patient care in rural communities around the province was also a priority. Rural specialists will receive overhead support, enhanced on-call rates, a commitment to a more stable complement of physician FTE in core services, and an enhanced process for requesting additional physician resources.

All physicians in the province will see a 10% increase in salary spread over the life of the contract (3% in years 1 and 2, 2% in years 3 and 4), retroactive to April 1, 2023. They will also benefit from investments in physician wellness and a more robust locum program, which will provide better opportunities for physicians to have coverage when they are sick or on leave. Many physicians will receive enhanced funding for teaching and training future generations of physicians, and will now be able to plan better for retirement by pairing up with a physician transitioning into practice as they transition out of practice. This ensures patients won’t be left without a doctor to manage their care.

Previous commitments such as funding for electronic medical records and reducing unnecessary physician administrative burden will continue.

“We believe these contracts are good for physicians, good for our patients and good for the health system,” said Dr. Audain.

With more than 148,000 Nova Scotians without access to a family physician, 25% of practising physicians over the age of 60 and long wait times for specialist services, this strong investment in the health system is needed.

The 2019 Master Agreement (now known as the Physician Agreement) and Clinical/Academic Funding Plan C/AFP Agreement began on April 1, 2019, and expired on March 31, 2023. The new agreements are retroactive to April 1, 2023, and end March 31, 2027. They will affect more than 3,300 physicians.

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TAB 125

MASTER AGREEMENT

Between

The Medical Society of Prince Edward Island

And

The Government of Prince Edward Island

And

Health PEI

April 1, 2015 - March 31, 2019

MASTER AGREEMENT

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SECTION A - GENERAL

ARTICLE A1 - PURPOSE OF AGREEMENT

A1.1 The parties to this Agreement share a desire to maintain and improve the high quality of service provided, so that the people of Prince Edward Island shall be well and effectively served. Accordingly, they are determined to maintain and foster an effective working relationship.

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

ARTICLE A2 - APPLICATION, DURATION AND AMENDMENTS

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

A2.2 This Agreement shall be in force and effect for the period from April 1, 2015 to March 31, 2019, and shall remain in force and effect during the period of negotiation, mediation or interest arbitration carried out to achieve a new agreement.

A2.3 This Agreement constitutes the entire agreement between the parties, and no prior representations, undertakings or promises whatsoever, whether express or implied, shall form part of this Agreement**.**

A2.4 This Agreement may only be amended by mutual agreement, in writing, and no verbal agreements shall be required, permitted or recognized. Unless otherwise previously stipulated, alternate payment agreements shall coincide with the duration of this Agreement.

ARTICLE A3 - INTERPRETATION AND DEFINITIONS

A3.1 "Alternate Payment" means compensation provided for physician services on a basis other than fee for service. Alternate payments may include, but are not limited to, salary, contract for service, sessional payments (hourly, daily, weekly or monthly rates), and on-call remuneration.

A3.2 "Basic Health Services" means all services rendered by physicians that in the opinion of the Minister are medically required but do not include those listed in section (1) (c) (i) of the *Health Services Payment Act Regulations.*

A3.3 "Blended Payment" means a method of additional compensation based upon the total value of an eligible physician's submitted and approved shadow billing claims.

A3.4 "Board" means the Board of Directors of Health PEI.

A3.5 "Complement" means the complement of participating physicians for a region and/or the province approved by the Minister.

A3.6 "Consultation" means a request by one physician for an opinion from another physician competent to furnish advice where the patient's condition demands a further opinion.

A3.7 "Department" means the Department of Health and Wellness, which is authorized to act on behalf of the Minister.

A3.8 "Executive Director of Medical Affairs" means the position in Health PEI responsible for the administration and delivery of medical programs in the Province.

A3.9 "Employing Authority" or "Employer" means Health PEI established pursuant to the *Health Services Act*.

A3.10 "Full Time Salaried Physician" means a physician who works a regular schedule of hours as outlined in Article B4.1(a).

A3.11 "Family Physician" means a legally qualified medical practitioner who is not a specialist. The terms "Family Physician" and "General Practitioner" are interchangeable.

A3.12 "Government" means the Government of the Province of Prince Edward Island.

A3.13 "Health Services Payment Advisory Committee" means the provincial committee established under the provisions of the *Health Services Payment Act Regulations*.

A3.14 "Medical Director" means the individual assigned the administrative responsibilities for the medical affairs of the respective hospitals or programs within the province.

A3.15 "Medical Society" means the Medical Society of Prince Edward Island, Canadian Medical Association, Prince Edward Island Division.

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

A3.17 "On-Call" means a physician is required to be available to render service to or on behalf of a patient for a diagnosis or treatment at such locations as may be required in accordance with this Agreement, such as the home of the patient, at the doctor's office, at a hospital or at other health care institutions.

A3.18 "Part-Time Salaried Physician" means a physician who works less than full time hours, as outlined in section B4.1(a).

A3.19 "Physician" means a legally qualified medical practitioner who is entitled to practice medicine in Prince Edward Island pursuant to the *Medical Act*.

A3.20 "Probationary Employee" means a physician to whom Section B applies who has not completed his/her probationary period as defined in Section B16.4.

A3.21 "Sessional Fee" means a payment method other than fee for service that is based upon a time calculation.

A3.22 "Shadow Billing" means the process where physicians receiving alternate payment submit specially designated claims for the medical services provided to patients that result in no payment, subject to the blended payment where applicable.

A3.23 "Specialist" means a legally qualified medical practitioner who is recognized as a specialist by the College of Physicians and Surgeons of Prince Edward Island.

A3.24 "Tariff" means the Preamble and the rate of fee for service payment as set out in the Tariff of Fees established pursuant to the *Health Services Payment Act* and this Agreement. The Tariff of Fees is attached hereto as Schedule "A".

A3.25 The term "he" shall be considered gender neutral throughout the document.

ARTICLE A4 - RECOGNITION

A4.1 The Government and Health PEI recognizes the Medical Society as the sole and exclusive bargaining agent for all of its members who are engaged in the practice of medicine in respect of all matters arising from this Agreement, including but not limited to fee for service and alternate payment.

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

A.4.3 The parties hereto or their designates and physicians, are prohibited from making written or verbal agreements which are in conflict with the terms of this Agreement. Any contractual arrangements between a Physician and Government or Health PEI related to the practice of medicine as defined in the *Medical Act* shall be provided to the Medical Society within thirty (30) days of signing.

A.4.5 (a) If the Government or Health PEI or their designates and a physician or physicians make a written or verbal agreement which is in conflict with the terms of this Agreement, such action shall automatically trigger a reopening of this Agreement at the Medical Society's sole option, for the purpose of negotiating the Article(s)

which have been violated, and Articles A10 - Mediation and A11 - Interest Arbitration shall apply;

(b) For the purpose of this sub-article, notice to negotiate under sub-article A8.4(a) shall not apply; and

(c) The Article(s) found to be in conflict with the written or verbal agreement shall be separable from the remainder of this Agreement and all other Articles herein shall continue in full force and effect.

ARTICLE A5 - ADMINISTRATIVE AUTHORITY

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

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

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

ARTICLE A6 - INFORMATION

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

A6.2 On a quarterly basis, commencing July 1, 2017, and from time to time upon request, Health PEI shall provide identifiable physician payment data to the Medical Society for the sole purpose of enabling the Medical Society to represent physicians' interests. Between quarterly reports, Health PEI shall respond to reasonable data requests within fifteen (15) business days of the request, or at such other time as may be agreed upon by the parties. Such data shall be transferred in electronic form.

A6.3 The Medical Society shall indemnify and save harmless the Government and Health PEI from any privacy complaints made by physicians or related liability that may arise from Health PEI's good faith provision of identifiable physician payment data to the Medical Society.

ARTICLE A7 - CORRESPONDENCE

A7.1 Correspondence from the Government and Health PEI to the Medical Society shall be addressed to a specified designate of the Medical Society and addressed to:

The Medical Society of Prince Edward Island
2 Myrtle Street
Stratford, PE
C1B 2W2

A7.2 Correspondence from the Medical Society to the Government and Health PEI shall be addressed to a specified designate of the Department or Health PEI and addressed to:

Department of Health and Wellness
PO Box 2000
Charlottetown, PE
C1A 7N8

Health PEI
16 Garfield St, PO Box 2000
Charlottetown, PE
C1A 7N8

A7.3 Each party shall provide to the other a list of specified designates within thirty (30) days of the signing date of this Agreement.

A7.4 In the event that a dispute or matter involves a physician who is an employee of, or who provides a contract for service to the Department or Health PEI, the correspondence shall be addressed to the Department or Health PEI and copied to the Medical Society.

A7.5 In all cases, the parties may correspond by facsimile or email.

ARTICLE A8 - NEGOTIATIONS

A8.1 The parties to the negotiation of an agreement respecting physician compensation shall be the Medical Society and a Health Negotiation Committee appointed pursuant to the *Health Services Act*.

A8.2 The parties shall:

(a) not later than five months before the expiry date of any agreement in force, meet to determine the data and information that each should make available to the other;

(b) not later than four months before the expiry date of any agreement in force, meet to present and analyse the data and information that each has collected in accordance with clause (a); and

(c) prior to the commencement of formal negotiations, attempt to resolve as many issues as possible through mutual consultation.

A8.3 Neither party to an agreement shall change any term or condition therein unless the other party consents to the change or until a new agreement has been concluded by consultation, negotiation, mediation, or arbitration.

A8.4 (a) Not earlier than three (3) months preceding the expiry date of an agreement in force at the time either party may by notice in writing require the other party to commence negotiations with a view to the renewal or revision of an existing agreement or entering into a new agreement.

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

A8.5 When one party has given notice under subsection A8.4(a) the parties shall, without delay, but in any case within fourteen (14) calendar days after the notice was given, meet or cause representatives on their behalf to meet and commence to negotiate with a view to the renewal or revision of an existing agreement or entering into a new agreement.

A8.6 Where the negotiations have been entered into under section A8.5, a party so negotiating shall not discontinue or withdraw from the negotiations on the ground that no notice, or improper or insufficient notice, has been given under section A8.4.

A8.7 An agreement remains in force until a new agreement is entered into to replace it.

ARTICLE A9 - GENERAL GRIEVANCE PROCEDURE

A9.1 The parties hereto recognize the benefit of dealing with disputes as quickly as possible, and shall make an earnest effort to settle such disputes promptly and fairly.

A9.2 Where a dispute arises between a physician and Health PEI concerning the Tariff of Fees, attached hereto as Schedule "A" to this Agreement, as it applies to such physician, which cannot be satisfactorily resolved through discussion with the Executive Director of Medical Affairs or his designate, such dispute or matter shall be referred to the Health Services Payment Advisory Committee (HSPAC) for a decision and recommendation. If HSPAC reaches a decision on the matter or dispute, such decision shall be provided to the Minister as a recommendation. If HSPAC is not able to reach a decision, HSPAC shall advise the Minister that a recommendation cannot be made and the matter will be referred to the Minister for a decision. The decision of the Minister shall be final and only challenged by way of judicial review.

A9.3 Where a dispute arises between a salaried physician and Health PEI on any matter other than matters subject to Article A9.2 including, but not limited to, disputes regarding the application, interpretation, or alleged violation of this Agreement, the matter shall be dealt with as outlined in Article B3.

A9.4 Where a dispute arises between a fee-for-service physician, contract-for-service physician, or sessional physician, and Health PEI, on any matter other than matters

subject to Article A9.2 including, but not limited to, disputes regarding the application, interpretation or alleged violation of this Agreement or of the particular contract between the physician and Health PEI, the matter may be referred by either party to the Joint Consultation Committee to discuss and resolve. If the dispute is not resolved through the Joint Consultation Committee, either party may refer the matter to mediation and/or arbitration in accordance with Articles A10 and A12.

A9.5 Where a dispute arises between the Medical Society (acting on behalf of any of its members) and Health PEI on any matter regarding the application, interpretation, or alleged violation of this Agreement, other than matters subject to Article A9.2 or A9.3, such dispute may be referred to the Joint Consultation Committee to discuss and resolve. If the dispute is not resolved through the Joint Consultation Committee, either party may refer the dispute in writing to mediation and arbitration in accordance with Articles A10 and A12.

A9.6 Communication between the parties shall be in writing at all stages.

ARTICLE A10 - MEDIATION

A10.1 Where notice to negotiate has been given under sub-article A8.4(a) and the parties have commenced negotiations and have reached an impasse, either party may request the assistance of a mediator. The parties shall attempt to select a mutually agreeable mediator between them. If the parties are unable to agree upon a mutually agreeable mediator within fifteen (15) calendar days, then either party may request the Minister responsible for the *Labour Act* in writing, to appoint a mediator to confer with the parties thereto to assist them in concluding an agreement, or a renewal or revision thereof and such request shall be accompanied by a statement of difficulties that have been encountered before the commencement or in the course of negotiations.

A10.2 The mediator appointed under sub-article A10.1 shall inquire into the matters in dispute and endeavour to bring about agreement between the parties.

A10.3 The mediator shall be paid such remuneration as the Minister responsible for the *Labour Act* determines and the mediator's fees and expenses shall be cost shared on a basis of 75% by Health PEI and 25% by the Medical Society, respectively.

A10.4 In the event a mediator is unable to resolve one or more of the matters within thirty (30) calendar days of the appointment of the said mediator, either party may thereafter, by serving written notice upon the other party, refer such a matter in dispute for resolution by interest arbitration or rights arbitration, as the case may be.

A10.5 In the event of a grievance dispute between the Medical Society and Health PEI, or a grievance dispute between a salaried physician, a contract for service physician or a physician receiving any other form of alternate payment, and Health PEI, as the case may be, the mediation process in this Article shall also be used.

ARTICLE A11 - INTEREST ARBITRATION

A11.1 The party giving notice shall, at the time of giving notice, name its appointee to the Board of Arbitration. The other party shall, within ten (10) calendar days of the receipt of such notice, name its appointee to the Board of Arbitration. The two appointees shall, within a further fifteen (15) calendar days, agree upon a chairperson for the Board of Arbitration.

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

A11.3 No person who has a pecuniary interest in a matter before the Board of Arbitration, or is acting, or has acted within a period of two (2) years prior to the date notice has been served in accordance with sub-article A11.1 hereof, as solicitor, counsel, employee, agent, independent contractor or consultant to, or for, or on behalf of, either of the parties to this Agreement, or who is currently an employee of Health PEI, shall be eligible for appointment as a member of the Board of Arbitration. A person who is otherwise eligible shall not be disqualified solely as a result of having been the appointee of either party to a previous Board of Arbitration.

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

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

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

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

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

(a) the fiscal policies of the Province;

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

(c) fair and reasonable compensation for physicians; and

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

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

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

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

ARTICLE A12 - RIGHTS ARBITRATION

A12.1 If any difference arises out of the interpretation, application, operation or any contravention or alleged contravention of an agreement between the parties referenced in the preamble of this Agreement, or as to whether any such difference can be the subject of arbitration, the parties shall meet and attempt to resolve the difference. If the matter is not resolved either party may refer the dispute to mediation and then arbitration as provided for in this Agreement.

A12.2 When hearing a dispute arising out of any issue of interpretation, application, operation or any contravention or alleged contravention of an agreement, the Board of Arbitration shall have full remedial authority and shall order such remedy as may be just, but the Board of Arbitration shall have no jurisdiction to amend the provisions of such agreement.

ARTICLE A13 - RESPONSIBILITY FOR THE CONTINUANCE OF OPERATIONS

A13.1 Provided the parties have recourse to the dispute resolution mechanism provided for herein, the Medical Society shall not organize, incite, support or sanction a withdrawal of services, suspension or slowdown of work, or any other interference with the business of the Province or Health PEI, and the Medical Society shall make all reasonable efforts to urge its members to refrain from such activities.

ARTICLE A14 - COMMITTEE STRUCTURES AND PURPOSES

A14.1 The Health Services Payment Advisory Committee

A committee created pursuant to the *Health Services Payment Act* and Regulations.

A14.2 The Physician Resource Planning Committee

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

A14.3 The Joint Consultation Committee

(a) A joint committee of the parties that meets at least on a quarterly basis and is co-chaired by a member from the Medical Society and a member of Health PEI. The Committee shall consist of eight (8) members, four (4) from each party. A quorum shall be five (5) with a minimum of two (2) representatives from each party. The function of the Committee shall be to perform functions specifically referred to it by this Agreement including, but not limited to, those functions as listed in Article A9

(b) It is agreed that this Committee shall not have jurisdiction over the Tariff of Fees, or any alternate payment matters. The Committee shall not supersede the activities of any other committee of the Medical Society or Health PEI. The Committee shall not have the power to bind either the Medical Society or Health PEI to any decisions reached in their discussions. The Committee shall have the power to make recommendations to the Medical Society and Health PEI with respect to its discussions and conclusions.

(c) In addition to (a) above this Committee has jurisdiction to deal with Master Agreement matters of mutual concern not otherwise assigned to HSPAC or FCAC, to include possible amendments to the Master Agreement.

A14.4 The Fee Code Advisory Committee

(a) The Medical Society and Health PEI shall establish a Fee Code Advisory Committee which shall be comprised of three (3) representatives of the Medical Society, two (2) representatives of Health PEI, and one (1) representative of the Government.

(b) The function of the Fee Code Advisory Committee shall be to review proposed changes to the Tariff of Fees, and to perform such functions specifically referred to it by this Agreement.

(c) It is agreed that, during the term of this agreement, the Fee Code Advisory Committee shall:

(i) have authority to amend the Tariff of Fees; and

(ii) adhere to the yearly funding allocation as follows:

2017-2018	$ 50,000
2018-2019	$ 175,000

(iii) follow the terms of reference as developed in accordance with the MOU -- "Development of Terms of Reference - Fee Code Advisory Committee".

(d) A positive funding balance in Article A14.4(c)(ii) at the end of any fiscal year shall be carried forward and added to the funding allotment for the following fiscal year.

(e) During the term of this Agreement, either or both the Medical Society and Health PEI may make recommendations on proposed changes to the Tariff of Fees to the Fee Code Advisory Committee, including recommendations to add new fee codes, amend existing fee codes, or delist existing fee codes. The Fee Code Advisory Committee shall consider all proposed amendments and determine whether to accept or reject the proposed amendments.

(f) All decisions are decided based on the majority. To constitute a quorum, there must be at least one Medical Society, Health PEI and Government representative present. For all matters that go to vote, Health PEI has 2 votes, Government 1 vote and Medical Society 3 votes, regardless of the number of attendees.

(g) In the event that a majority decision cannot be reached then an additional member will, at the request of either party, be appointed by the parties for the resolution of the issue. The additional member will chair those portions of FCAC meetings which involve consideration of the unresolved issue and will decide how best to conduct the meetings and to resolve the issue. This is not intended to be a formal arbitration. There shall be no legal counsel and no calling of evidence. The rules of natural justice cannot necessarily apply, except in the discretion of the additional member. The decision of FCAC reached through this process shall be final.

(h) The committee will use a fair and transparent process in considering proposed amendments, including but not limited to providing groups with a vested interest

in the proposed amendment with the opportunity to make submissions for the Committee's consideration.

(i) Any amendments made by the Fee Code Advisory Committee shall form part of this Agreement and shall be binding on the parties.

ARTICLE A15 - SAVINGS CLAUSE

A15.1 If any article in this Agreement shall be found to be in conflict with any statute, such article shall be deemed null and void. However, such article shall be separable from the remainder of this Agreement, and all other articles herein shall continue in full force and effect. The parties to this Agreement shall negotiate a replacement for the article rendered null and void.

A15.2 In the event that the parties cannot reach mutual agreement, the matter in dispute under sub-article A15.1 shall be subject to mediation and interest arbitration proceedings.

ARTICLE A16 - DISCRIMINATION

A16.1 There shall be no discrimination practised by either party with respect to any physician on the basis of race, creed, colour, gender, sexual orientation, marital status, ethnic or national origin, age, disability or membership activity or lack of activity in the Medical Society.

ARTICLE A17 - ELECTION OF PAYMENT MODALITY

A17.1 Fee-for-service physicians shall be permitted to change to an alternate payment modality with the prior approval of Health PEI.

A17.2 (a) Physicians who receive alternate payment shall have the right to convert to fee-for-service practice provided that eight (8) weeks of written notice is given to Health PEI, and provided that the Physician continues the same range of medical services within the same delivery model and geographic area where the alternate payment services were performed.

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

(c) If the alternate payment physician is not retained during the full notice period for reasons of just cause or non-performance of the work, as the case may be, the payment referred to in A17.2(b) shall not apply.

A17.3 A physician who converts from alternate payment modality to fee for service practice shall not be permitted by Health PEI to commence practice as a fee for service physician until such time as both the physician and Health PEI have signed a fee for service letter of confirmation. Such letter shall stipulate the geographic area and the range of medical services for the physician. The geographic area and the range of services will be consistent with the physician's work within the immediately preceding 12 month period.

A17.4 Physicians who convert to fee for service pursuant to this Article are subject to Article C11.

ARTICLE A18 - SHADOW BILLING

A18.1 All physicians receiving alternate payment shall shadow bill. Any physician receiving alternate payment who fails to shadow bill may be required to convert to fee-for-service at the discretion of Health PEI in those circumstances.

A18.2 Salaried physicians or physicians who are on a contract for service shall be provided with administrative support by Health PEI to effect the shadow billing.

A18.3 Any physician who shadow bills for any service shall only shadow bill for services performed by the physician personally.

ARTICLE A19 - PROTECTION FOR PHYSICIANS UNDERTAKING MILITARY SERVICE

A19.1 Health PEI shall grant leave of absence of no more than fifty-two (52) weeks without pay to a physician who requests leave for the purpose of taking Reserve Military training or activation for operational reasons with the Canadian Forces. The physician's position in the complement shall be protected and available upon return from active duty.

ARTICLE A20 - PRACTICE TRANSITION AND SUCCESSION PLANNING

A20.1 When a physician expresses an interest to retire or leave practice ("departing physician") and desires overlap with a replacement in their practice ("incoming physician"), the departing physician shall provide at least six months advance notice to their designated Medical Director prior to ceasing practice.

A20.2 The departing physician shall sign a Transition Agreement with Health PEI wherein the departing physician agrees to cease practice on a specified date ("cessation date"), which agreement will be irrevocable.

A20.3 The departing physician will not be permitted to practice medicine in any pay modality after the cessation date.

A20.4 Notwithstanding Article A20.3, a departing physician who retires from practice and remains resident in the province, may be permitted to provide periodic medical services after the cessation date provided they obtain the express written consent to do so from Health PEI.

A20.5 Upon receipt of the signed agreement from the departing physician, Health PEI will commence a search for a replacement physician.

A20.6 An incoming physician who is replacing:

(a) a family physician shall have a maximum of 4 weeks of overlap immediately prior to the family physician ceasing practice; or

(b) a specialist shall have a maximum of 8 weeks of overlap immediately prior to the specialist ceasing practice;

(c) a surgeon shall have a maximum of 12 weeks of overlap immediately prior to the surgeon ceasing practice;

A20.7 During the period of overlap, the departing physician and the incoming physician:

(a) shall both be entitled to bill or shadow bill, as applicable, in accordance with the Tariff of Fees; and

(b) must share all Health PEI facility resources, including but not limited to, OR time and ambulatory care clinic time, assigned or allocated to the departing physician.

A20.8 Transition arrangements other than what is specified in this Article will be at the sole discretion of Health PEI.

ARTICLE A21 - PHYSICIAN CONTRACTS

A21.1 After the signing of this Agreement, all salaried and contract for service physicians shall sign new contracts in the form attached as Appendix A and B as applicable. This includes both incumbent and new salaried and contract for service physicians.

A21.2 After the signing of this Agreement all new fee for service physicians must sign a letter of offer or a letter of confirmation stipulating the range of medical services, the delivery model and the geographic where the fee for service work will be performed.

SECTION B - SALARIED PHYSICIANS

ARTICLE B1 - APPLICATION OF SECTIONS A, C and D TO SALARIED PHYSICIANS

B.1 Sections A, C and D of this Agreement shall apply to salaried physicians, except where there is a conflict, the provisions of Section B shall prevail.

ARTICLE B2 - JOB DESCRIPTIONS

B2.1 Each salaried physician shall have a written job description.

B2.2 A job description shall contain:

(a) the job title;

(b) the title of the Medical Director to whom the physician will report for clinical and administrative purposes

(c) a summary of the position's responsibilities;

(d) a description of the position's specific duties, including
   (i) location of the physician's specific place(s) of work;
   (ii) expected workload (to be determined on an individualized basis);
   (iii) expected type and range of medical services to be provided;
   (iv) expected on-call coverage requirements as per the Master Agreement; and
   (v) any other related duties.

B2.3 A physician who accepts a salaried position shall not be permitted by Health PEI to commence employment unless both the physician and Health PEI have signed the contract of employment, which shall include the job description. The contract of employment to be used is attached as Appendix "A".

B2.4 Health PEI may make revisions to the physician's job description with thirty (30) days written notice, and discussion with the physician involved. The Medical Society will be advised before any revised job description is presented to any salaried physician, and will be provided with any revised job description when completed. Any revisions must be reasonable and shall be based on operational requirements. In the event the physician does not agree with the revisions, they may grieve the decision pursuant to Article B3.

ARTICLE B3 - GRIEVANCE PROCEDURE (Salaried Physicians)

B3.1 A grievance means a dispute between a salaried physician and the Employing Authority regarding the application, interpretation, or alleged violation of this Agreement. Disputes that do not involve matters covered in Section B of this Agreement shall proceed directly from Step One to Step Three of the grievance procedure.

B3.2 STEP ONE

Within ten (10) calendar days of an event giving rise to a grievance, a physician with the written approval of the Medical Society, shall submit the grievance in writing to his or her immediate supervisor. The written grievance shall state the facts giving rise to the alleged grievance, identify the provisions of the Agreement alleged to be in violation by specific reference, and state the contention of the physician with respect to these provisions, and shall also indicate the specific relief requested. The Employing Authority's designate shall reply in writing within ten (10) calendar days of receipt of the written grievance. Failure to respond within the time limit will be interpreted as a rejection of the grievance.

B3.3 STEP TWO

If the grievance is not resolved at Step One, the Medical Society acting on behalf of the physician may, within ten (10) calendar days of receiving the written reply as required at Step One, refer the grievance in writing to the Director of Human Resources. The Director of Human Resources shall reply in writing within ten (10) calendar days of receipt of the written grievance. Failure to respond within the time limit will be interpreted as a rejection of the grievance.

B3.4 STEP THREE

If the grievance is not resolved at Step Two, the Medical Society acting on behalf of the physician may, within ten (10) calendar days of receiving the written reply as required at Step Two, refer the grievance in writing to the Joint Consultation Committee for resolution. The Joint Consultation Committee shall meet within 30 days of receiving the referral and hear from both parties in an effort to resolve the grievance. The Joint Consultation Committee shall render a decision within ten (10) calendar days of the meeting. Failure to respond within the time limit will be interpreted as a rejection of the grievance.

B3.5 STEP FOUR

Failing satisfactory resolution of the grievance at Step Three, either the Medical Society or the Employing Authority may refer the grievance to mediation and/or arbitration in accordance with Articles A10 and A12.

B3.6 TIME LIMITS

The mandatory time limits specified in Step One, Step Two and Step Three may be extended by mutual agreement of the parties and shall be confirmed in writing.

B3.7 Unless dismissed or suspended by the Employing Authority, or otherwise as agreed to between the parties, a physician shall continue to work in accordance with this Agreement until such time as the grievance is resolved.

B3.8 Replies to the grievance shall be in writing at all stages.

ARTICLE B4 - HOURS OF WORK

B4.1 (a) The normal hours of work shall be 37.5 hours per week, Monday to Friday, unless otherwise agreed to between the physician and the Employing Authority.

(b) In consultation with each physician, the Employing Authority shall establish the work schedule/content for the normal hours of work in keeping with the service requirements of the Employing Authority. Revisions to such work schedule/content shall not be made unless there has been consultation between the physician and the Employing Authority.

(c) Salaried physicians shall not be permitted to bill fee-for-service during their normal hours of work as defined in sub articles 4.1(a) and 4.1(b).

(d) Salaried physicians may be paid on a fee-for-service basis for services provided outside their normal hours of work, but only in accordance with Article C10 of this Agreement.

B4.2 (a) For physicians not on-call, pre-approved hours worked in excess of 37.5 during this salaried period (the "overtime hours") shall be taken as equivalent time off in lieu, subject to operational needs and prior approval by the Employing Authority. In the event it is not possible to take time off in lieu, the overtime hours may be paid to the physician at the physician's then current hourly rate.

(b) Subject to an emergency situation, all overtime shall be pre-approved.

(c) Any claim for unapproved overtime must be submitted to the Employing Authority and must contain a full description of the emergency situation which required overtime.

B4.3 (a) Physicians who share a call rota shall declare in writing to their respective Medical Director the same daily eight-hour period, between 8 am and 8 pm, Monday to Friday, during which no fee-for-service on-call billing shall be permitted.

(b) Fee-for-service billing for on-call services shall be permitted outside of the declared period in sub-article B5.3(a) and paid at the physician's applicable specialty rate.

B4.4 When a physician is not on-call and is requested to see a special case outside of the normal salaried work day as defined in the job description, request for payment shall be processed as time in lieu or fee-for-service at the physician's option. A request for time in lieu shall include documentation of the time spent.

B4.5 Part-time physicians shall be paid pro rata salary, pension, vacation, statutory holidays and sick leave and receive pro rata continuing medical education (CME) benefits (as per Article B15). Part-time physicians shall receive fully paid benefits for life insurance, health care, dental, and long-term disability as such benefits apply to their base part-time salary.

ARTICLE B5 - WORKERS' COMPENSATION

B5.1 Workers' compensation coverage is provided to salaried physicians in accordance with the *Workers' Compensation Act and Regulations*.

B5.2 In cases of injury on duty, transportation to and from the nearest physician and/or hospital for appropriate medical care shall be provided by the Employing Authority.

ARTICLE B6 - SICK LEAVE

B6.1 Sick leave shall be provided in accordance with this article to enable salaried physicians to be absent during periods of illness from their regularly scheduled hours of work without loss of salary.

B6.2 Physicians shall accumulate sick leave benefits at the rate of 11.25 hours per month for each calendar month of continuous employment to a maximum accumulation 1612.5 hours.

B6.3 A physician appointed before the 16th of the month shall be eligible to accumulate full sick leave credits for that month.

B6.4 When an illness is caused due to the use of alcohol or other drugs and where the physician elects or is directed to undertake an approved treatment and rehabilitation program, the physician shall be granted sick leave with pay to the maximum of his/her available sick leave credits and long term disability benefits.

ARTICLE B7 - SPECIAL LEAVE

General Leave

B7.1 A physician shall be required to submit a written request for any leave of absence specifying the reason for such leave. Each request shall be considered on an individual basis and shall be at the discretion of the Employing Authority, in accordance with the terms of this Agreement or applicable legislation. Except in emergencies, such requests should be made at least four weeks in advance.

B7.2 Physicians granted leave of absence with pay shall be deemed to be continuously employed and shall retain their benefits and years of service and continue to accrue same during such leave of absence.

B7.3 Physicians granted leave of absence without pay shall be deemed to be continuously employed and shall retain their years of service accumulated to date for all purposes and shall be entitled to continue to access group insurance plans during a leave of absence subject to the terms and conditions of the contract(s) of insurance, but further years of service and benefits shall not accrue during such leave of absence.

Disability Leave

B7.4 Upon the expiry of sick leave, a physician who is eligible for LTD benefits shall be provided disability leave without pay for the period requested, up to a maximum of twelve (12) months. During the period of unpaid disability leave, the Employing Authority shall continue to pay group insurance premiums and the employer's share of pension contributions, provided the physician matches the contributions.

B7.5 Following the expiration of the twelve (12) month disability leave the physician shall be terminated from employment. If the physician is eligible and approved for Long Term Disability coverage pursuant to sub-article B17.3, the Employing Authority shall continue to pay the group insurance premiums and employer's share of pension contributions so long as the physician continues to be in receipt of LTD benefits.

Deferred Salary Plan

B7.6 A physician may apply for special leave of one year under the deferred salary plan administered by the Employing Authority. Under usual circumstances, this leave shall only be granted if a locum tenens physician is hired to replace the physician on such special leave. Leave of absence under a deferred salary plan must comply with the *Income Tax Act.*

Family Illness Leave

B7.7 Where no one other than the physician can provide for the medical needs of a member of his/her immediate family during illness, the physician shall be granted up to one (1)

day paid leave. Where leave in excess of one (1) day is required, a medical certificate signed by a treating physician is required. Family Illness leave shall be limited to 37.5 hours per illness to a maximum of 75 hours per fiscal year.

B7.8 For the purpose of Article B7.7, "immediate family" means:

(a) the physician's spouse and dependent children;
(b) the physician's parents;
(c) any other relative residing in the same household.

B7.9 In the case of serious illness of a parent, spouse, brother, sister, or child, compassionate leave with pay of up to three (3) days shall not be unreasonably withheld. For greater clarity, serious illness in this Article shall mean life-threatening illness.

Bereavement Leave

B7.10 In the event of the death of a physician's spouse, child, step-child, grandchild or ward of the physician (including the child of a common-law spouse), or in the event of the death of the physician's parent (including a natural parent, guardian, foster parent, or any other person standing in loco parentis):

(a) upon request, a full-time physician shall be granted leave with pay for five (5) days, provided the leave is taken within seven (7) days of the death. Up to two (2) additional days may be authorized for travelling time;

(b) upon request, a part-time physician shall be granted leave with pay for four (4) days, provided the leave is taken within seven (7) days of the death and only if the physician is regularly scheduled to work during that period.

B7.11 In the event of the death of a physician's brother, sister, grandparent, great grandparent, brother-in-law, sister-in-law, mother-in-law, father-in-law, son-in-law, daughter-in-law, or any relative permanently residing with the physician:

(a) upon request, a full-time physician shall be granted leave with pay for three (3) days, provided the leave is taken within seven (7) days of the death. Up to two (2) additional days may be authorized for travelling time;

(b) upon request, a part-time physician shall be granted leave with pay for up to two (2) days, provided the leave is taken within seven (7) days of the death and only if the physician is regularly scheduled to work during that period.

ARTICLE B8 - VACATIONS

B8.1 A vacation year is the period beginning on the 1st day of April and ending on the 31st day of March of the following year.

B8.2 The following annual vacation entitlement shall be earned by a full-time physician:

(a) Four weeks' (20 working days) vacation with pay annually, during the first five years of medical practice in Canada or outside Canada but while under licensure by a Canadian jurisdictional authority. Vacation entitlement shall be earned at the rate of 1 ⅔ days per month.

(b) Five weeks' (25 working days) vacation with pay in the vacation year in which a physician completes his sixth year of medical practice in Canada or outside Canada but while under licensure by a Canadian jurisdictional authority, and yearly thereafter until the completion of 15 years of medical practice. Vacation entitlement shall be earned at the rate of $2\ ^{1}/_{12}$ days per month.

(c) Six weeks' (30 working days) vacation with pay in the vacation year in which a physician completes his sixteenth year of medical practice in Canada or outside Canada but while under licensure by a Canadian jurisdictional authority, and yearly thereafter. Vacation entitlement shall be earned at the rate of 2 ½ days per month.

B8.3 (a) Vacation leave shall generally be taken in the vacation year in which it is earned. By mutual agreement with the Employing Authority, vacation may be taken in advance to a maximum of the vacation year's entitlement.

(b) Subject to this entire article, up to one year's entitlement of vacation may be carried over from one year to the next. Employees who make reasonable attempts to take their vacation during the year, but do not receive their requested vacation, shall be permitted to carry over or request a payout of their excess vacation. Employees' requests for vacation shall be in writing on the approved vacation leave form. The Employer shall respond to all requests on the same form. Employees shall retain copies of documents showing denied vacation requests.

(c) For employees who have at least one year of vacation entitlement in their vacation leave bank, the employees shall select their vacation prior to December 15th of each year. If the employee fails to select his/her vacation by December 15th, then the employer shall advise the employee of the dates of their vacation as selected by the employer, which will be taken before March 31st. If, for reasons beyond the control of the employee, the vacation as scheduled by the employer cannot be taken, then it shall be carried over in the employee's vacation bank or paid out to the employee at the employee's discretion.

(d) Employees who carried over more than the maximum entitlement at the end of the March 31, 2011 fiscal year shall have until March 31, 2018 to utilize their excess.

B8.4 For scheduling purposes, all requests for vacation leave must be made in advance and shall be submitted to the Employing Authority for approval prior to taking the vacation leave requested.

B8.5 Vacation leave scheduling shall be determined on the basis of years employed in continuous full-time or part-time medical practice.

B8.6 If the physician is subsequently unable to take vacation at the approved scheduled time because of a specific request in writing from the Employing Authority, then every effort shall be made by the employee and the Employing Authority to reschedule the vacation prior to the end of the vacation year.

B8.7 In the event that inadequate staffing precludes the physician from taking vacation leave at the requested time, every effort shall be made by the Employing Authority to find suitable locum tenens coverage for the requested vacation period.

B8.8 A physician shall not be precluded from taking approved vacation leave by reason that the Employing Authority is unable to fund a locum physician.

B8.9 Where a physician dies or leaves the position, the physician or his estate shall receive pay at the physician's then current rate of pay for any accumulated unused vacation leave.

ARTICLE B9 - STATUTORY HOLIDAYS

B9.1 A physician who is required to be on-call on a holiday shall receive a day off in lieu of the holiday, to be taken at a time mutually agreeable to the physician and the Employing Authority. Days off in lieu shall not be accumulated and must be used during the current fiscal year. All accrued holiday time will be paid out at the end of the fiscal year.

B9.2 Holidays are defined as New Year's Day, Islander Day, Good Friday, Easter Monday, Victoria Day, Canada Day, Labour Day, Thanksgiving Day, Remembrance Day, Christmas Day, Boxing Day and a floating holiday.

B9.3 A salaried physician on call on a statutory holiday shall be permitted to bill fee-for-service for services rendered outside the physician's regular hours of work. No fee for service billing shall otherwise be permitted.

ARTICLE B10 - MATERNITY / PATERNITY / PARENTAL LEAVE

B10.1 Maternity Leave

A physician who

(a) has been in the employment of the Employing Authority for a continuous period of twenty weeks or more;

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

(c) provides the Employing Authority with a certificate of a qualified medical practitioner certifying that the physician is pregnant and specifying the estimated date of birth,

shall be granted up to seventeen continuous weeks of maternity leave without pay, commencing not more than eleven weeks immediately preceding the estimated date of birth. Sick leave shall be granted for allied conditions requiring hospitalization and confinement, where such confinement is supported by a certificate signed by a qualified medical practitioner. The Employing Authority reserves the right to have a physician examine the employee.

B10.2 Parental Leave

A physician who

(a) has been in the employment of the Employing Authority for a continuous period of twenty weeks or more;

(b) and who,
(i) becomes the natural mother or father of a child,
(ii) assumes actual care and custody of a child, for the purposes of adoption, or
(iii) adopts or obtains legal guardianship of a child under the law of a province,

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

is entitled to and shall be granted, parental leave without pay for a continuous period of up to 35 weeks.

B10.3 Both Parents are Physicians

In the case where both parents are salaried physicians, the aggregate amount of maternity and parental leave in respect of the same event, shall not exceed 52 weeks.

B10.4 A full time physician mentioned in B10.1 or B10.2 who is subject to a waiting period of 10 days before receiving EI benefits shall receive leave with pay for the 10 day waiting period. This provision shall be prorated for part-time physicians based on paid hours in the previous twelve months.

B10.5 In the event that both parents are salaried physicians the total amount of time taken by either one or both parents under Article B 10.4 shall not exceed ten (10) days.

B10.6 When a physician decides to return to work after maternity or parental leave, she/he shall provide the Employing Authority with at least two (2) weeks notice.

B10.7 Birth or Adoption

A male physician upon request shall be granted one (1) day's leave with pay on the occasion of the birth of his child.

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

ARTICLE B11 - TRAVEL

B11.1 Travel allowances in accordance with the provincial rates, as determined from time to time by the Department of Finance and Municipal Affairs for provincial employees generally, shall be paid for physicians' travel on clinical or administrative business for the Employing Authority.

ARTICLE B12 - LOSS OF PERSONAL EFFECTS

B12.1 Where a physician, during the course of the physician's employment, because of the action of an inmate, patient, visitor or member of the public, suffers damage to or loss of eye glasses, false teeth, a watch, or other personal effects and/or professional instruments usually carried with or worn by the physician in the performance of the physician's duties, including clothing, the Employing Authority shall pay to the physician in compensation for repairs or replacement an amount not exceeding $250 for any one item. All such incidents of loss of or damage to personal effects shall be reported in writing by the physician to the Employing Authority within two normal working days of the incident or discovery thereof.

ARTICLE B13 - RETIREMENT

B13.1 For the purpose of this Article:

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

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

B13.2 A physician must provide written notice to Health PEI of their election to retire, in order to qualify for a retirement allowance under this Article.

B13.3 Any physician who has 10 or more years of continuous service as a salaried physician for Health PEI and has attained the age of 55 years shall, upon retirement, receive a retirement allowance equal to five days' pay for each full year of continuous salaried service in the province, to a maximum of 130 working days. Periods of part-time service during the years of continuous service shall be paid out on a pro-rata basis.

B13.4 Physicians shall give a minimum of eight weeks' notice of resignation and retirement of employment. If the Employing Authority chooses not to retain the physician in employment for the eight-week period after notice is received, the physician shall receive a payment equal to the amount of wages or salary that the physician would have earned had the physician worked during the course of the eight-week period.

B13.5 Physicians shall be expected on resignation and retirement to give a minimum of eight weeks' notice. Under exceptional circumstances, acceptance of less than eight weeks' notice shall be considered, and, if accepted, severance shall be equal to the notice period if the Employing Authority chooses not to retain the physician to the end of the notice period.

ARTICLE B14 - LIABILITY

B14.1 The physician agrees to maintain active individual membership with the Canadian Medical Protective Association (CMPA). Alternatively, the physician agrees to maintain individual professional malpractice liability insurance with limits of not less than $5,000,000 for any one occurrence. This insurance shall be with an insurer and in a form acceptable to the Employing Authority, who shall have the right, but not the obligation to review this insurance to determine its acceptability. Acceptance by the Employing Authority of such insurance coverage shall not be construed as a waiver of any conditions of this Agreement. The physician shall provide the Employing Authority with a certificate of insurance evidencing such insurance.

B14.2 The physician shall pay CMPA dues or in the alternative, individual malpractice liability insurance as aforementioned. The Medical Society, upon receipt of evidence of payment shall provide reimbursement in accordance with Article D2 - CMPA Assistance.

B14.3 If an action or proceeding is brought against any physician for an alleged tort committed by him in the performance of his duties, the physician shall advise the Employing Authority immediately.

ARTICLE B15 - CONTINUING MEDICAL EDUCATION (CME)

B15.1 (a) Physicians working full-time or part-time physicians working 0.6 FTE or more shall be provided with up to seventy-five (75) hours paid leave of absence per fiscal year for the purpose of attending approved CME. Physicians employed less than 0.6 FTE are entitled to thirty-seven and one half (37.5) hours paid leave of absence. There shall be no carryover of entitlement from year to year, except where a short-staffing situation has prevented the physician from taking his/her CME leave, or where the physician has received approval to undertake an unusually lengthy CME program.

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

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

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

B15.2 CME must be of potential professional benefit to the physician and the majority of the CME must relate to the physician's area of expertise and practice with the Employing Authority. All applications for CME funding shall be made in writing to the Physician's Medical Director no later than 30 days prior to departure for the CME program, unless otherwise mutually agreed. The application shall state the following:

(a) Nature of the CME;

(b) Purpose of the CME;

(c) How the CME will advance the practice of the Physician, as well as its advantage to patients and the health system;

(d) Location of the CME;

(e) Costs associated with the CME;

(f) Total number of CME hours, travel hours, and vacation days to be utilized before and after the CME program;

(g) Arrangements for coverage of the Physician's service obligations (patient care, on-call, etc.) during attendance at the CME program.

Upon considering the foregoing, the Medical Director shall decide whether to approve the application. Such approval shall not be unreasonably withheld.

B15.3 Where the Employing Authority requests a physician to upgrade his clinical skills for the purpose of undertaking new clinical responsibilities in practice, (e.g., expanded neonatology services), and the physician so agrees, the physician shall continue to receive his salary and benefits while upgrading his clinical skills and the Employing Authority shall reimburse the physician for all out-of-pocket costs in accordance with the Government's travel regulations and policies as approved from time to time by Treasury Board.

B15.4 Approval for this leave shall be subject to adequate staffing levels being in place during the period of absence. In the event that inadequate staffing would prevent the physician from attending a particular education leave, reasonable effort shall be made by the Employing Authority, in consultation with the physician, to obtain a locum tenens for the period of leave.

B15.5 A physician shall be reimbursed for CME expenses based on approval of receipts on the following basis:

(a) for a full-time or part-time general practitioner working 0.6 FTE or greater - up to $5,000 per annum;

(b) for a full-time or part-time specialist working 0.6 FTE or greater - up to $7,000 per annum;

(c) physicians working less than 0.6 FTE are eligible for one-half of the allowances in paragraphs (a) or (b) above;

(d) for the purpose of this article, "time worked" includes overtime hours worked;

(e) physicians beginning employment during a fiscal year shall have a pro-rated entitlement.

B15.6 The following CME expenses are eligible for reimbursement:

(a) registration fees;

(b) up to full-fare economy flight or other travel costs up to the equivalent full-fare economy rate;

(c) miscellaneous expenses associated with travel (e.g., taxis, tolls, etc.);

(d) meals as per approved Government travel policy;

(e) accommodations (unless otherwise approved, no greater than the hotel conference rate at CME site for duration of CME only); and

(f) books, journals, educational software and other CME materials may be purchased for CME purposes whether undertaken in PEI or at other approved sites.

B15.7 Electronic equipment is not eligible for reimbursement. If such equipment is required for the performance of work duties, associated costs should be discussed with the physician's respective Medical Director or designate.

ARTICLE B16 - SALARIES

B16.1 For the duration of this Agreement, the annual rates of pay for classifications shall be in accordance with the following salary scales, which shall include allowance for professional dues:

(a) Family Physicians

	Apr-01-15	Apr-01-16	Apr-01-17	Apr-01-18
Class I	147,320	147,320	148,499	150,266
Class II	151,990	151,990	153,206	155,030
Class III	158,980	158,980	160,252	162,160
Class IV	169,690	169,690	171,048	173,084

(i) Class IV is limited to a Family Physician who has a certificate of competency from a recognized educational program acceptable to Health PEI in Palliative Care, Geriatric Medicine, Oncology, Dermatology, Addictions or Pain Management, or who has the required equivalent experience as determined by the Employer and who is required by the Employer to have this level of competency or experience for the position.

(b) Specialists

	Apr-01-15	Apr-01-16	Apr-01-17	Apr-01-18
Class I	204,280	204,280	205,914	208,366
Class II	210,670	210,670	212,355	214,883
Class III	236,200	236,200	238,090	240,924
Class IV	320,000	320,000	330,720	346,800
Class V	340,000	340,000	342,720	346,800

(i) Class IV is limited to a specialist in Laboratory Medicine as certified by the Royal College of Physicians and Surgeons of Canada, or is otherwise recognized as a specialist in this field as determined by the College of Physicians and Surgeons of Prince Edward Island, and who is required by the Employer to have this level of competency for the position.

(ii) Class V is limited to a specialist in Radiation Oncology or Medical Oncology as certified by the Royal College of Physicians and Surgeons of Canada, or is otherwise recognized as a specialist in one of these fields as determined by the College of Physicians and Surgeons of Prince Edward Island, and who is required by the Employer to have this level of competency for the position.

B16.2 A physician's annual rate of pay shall be adjusted to a specific step on the applicable scale as follows:

(a) A physician who is a probationary employee and has not yet completed his/her probationary period shall be paid at Class I.

(b) Upon completion of the probationary period, a physician shall be paid at Class II.

(c) Advancement to Class III shall occur following nineteen hundred and fifty [1950] hours service at Class II, subject to the physician's satisfactory performance.

(d) Notwithstanding sub-article B16.2(c), a physician who is not CCFP or FRCP credentialed shall remain in Class II for a period of thirty nine hundred (3900) hours before being eligible to move to Class III.

B16.3 Notwithstanding the provisions of Article B16.2, Health PEI may place the new physician in a class greater than that provided for in Article B16.2 to reflect professional experience.

B16.4 (a) A physician hired on or after the signing of this Agreement shall be hired as a probationary employee, and shall be subject to a "probationary period" of the lesser of nine hundred seventy five (975) working hours or one year.

(b) The Employer shall review a probationary employee's performance at least one time prior to the completion of his/her probationary period. The probationary employee shall be given the opportunity to read the appraisal and attach his/her comments prior to completion of the probationary period. The performance review shall be conducted by the Medical Director, Department Head, and/or another physician who is the physician's supervisor, as determined by the Employer.

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

B16.5 The Employer shall, prior to each anniversary date of a physician, review the performance of the employee. The physician concerned shall be given the opportunity to read the appraisal and attach his comments. The performance review shall be conducted by the Medical Director, Department Head and /or another physician who is the physician's supervisor as determined by the Employer.

B16.6 The Employer shall notify the physician in writing when an increment is not granted. Such notice shall contain the reason for not granting the increment increase and shall be provided to the employee no later than the date on which the increment increase would otherwise have been due.

B16.7 The anniversary date of part-time physicians shall be on completion of one thousand nine hundred and fifty (1950) hours of work or paid leave. The computation of hours shall include overtime.

B16.8 All physicians listed in the Complement (which list shall be updated by the parties from time to time) who convert to salary from fee for service status shall be paid at Class III.

B16.9 Excluding Specialists in Laboratory Medicine and Radiation Oncology, an employee shall be paid a blended payment consisting of his/her applicable base salary and a percentage of the value of submitted and approved shadow billing claims, in accordance with Article C5.

ARTICLE B17 - PENSION AND BENEFIT COVERAGE

B17.1 Physicians who elected to remain in the Civil Service Superannuation Fund shall have their pension contributions matched by the Employer as authorized by the *Civil Service Superannuation Act*, subject to the maximum allowed by law.

B17.2 All other physicians shall designate their own RRSP account to which the Physician and Employer shall make contributions. The Physician shall contribute the equivalent of 9% of his/her base salary via payroll deduction, which shall not exceed 50% of the maximum permissible contribution provided for in the *Income Tax Act*. The Employer shall match that contribution.

B17.3 Physicians shall be enrolled in those group insurance benefit programs provided under the Public Sector Group Insurance Plan including basic group life insurance, basic health care, basic dental benefits, and basic long-term disability. Premiums for such coverage shall be fully paid by the Employing Authority.

ARTICLE B18 - COMPENSATION FOR UNINSURED SERVICES/THIRD PARTY BILLINGS PERFORMED BY SALARIED PHYSICIANS

B18.1 Salaried physicians are compensated by the Employer for work they perform during the agreed hours of work. However, from time to time certain patients are examined/treated during such hours and the salaried physician is entitled to bill an uninsured patient or third party for such services, and shall not be required to work additional offset time for examining/treating uninsured patients. In such cases, the salaried physician may declare in writing, once in each fiscal year, that either of the following options shall apply:

(a) The salaried physician waives his entitlement to bill an uninsured patient or third party, and the Employing Authority submits the bill for such services and retains the fees; or

(b) The salaried physician retains the fees for such services, and must complete any associated documentation outside of his agreed hours of work

It is the intention of the parties that work on uninsured services shall be limited to those incidentally arising in the course of a physician's regular practice. Salaried physicians shall report to the Employer all payments received pursuant to this provision.

B18.2 Notwithstanding sub-article B18.1, in accordance with past practice, salaried pathologists who perform coroner's autopsies shall continue to receive and retain payment for such uninsured services performed during salaried hours, and shall not be required to work additional offset time.

ARTICLE B19 - ON-CALL DUTY (SALARIED SPECIALISTS ONLY)

B19.1 Subject to sub-article B19.5, or unless otherwise agreed, salaried specialists shall provide continuous comprehensive on-call coverage.

B19.2 (a) Salaried specialists who share a call rota shall declare in writing to their respective Medical Director the same daily eight hour period, between 8 am and 8 pm, Monday to Friday, during which no fee-for-service on-call billing shall be permitted.

(b) Fee-for-service billing for on-call services shall be permitted outside of the declared period in sub-article B19.2(a) and paid at the salaried specialist's applicable specialty rate.

B19.3 When a salaried specialist is not on-call and is requested to see a special case outside of the normal salaried work day as defined in the job description, request for payment shall be processed as time in lieu or fee-for-service at the physician's option. A request for time in lieu shall include documentation of the time spent.

B19.4 Subject to sub-article B19.2, salaried specialists compensated by fee-for-service payments for on-call duties shall be entitled to bill Health PEI on a fee-for-service basis, for services provided outside the declared salaried hours as determined by Article B19.2. Such billing shall be according to the fee-for-services tariff schedule. Physicians are responsible for submitting their own billings.

B19.5 A full-time salaried specialist shall not be required to be on-call more than an average of one day in three, except where coverage of vacation absences and continuing medical education (CME) leave is required. If the physician voluntarily agrees to more frequent on-call service, it shall be indicated in the job description. On-call service shall be no greater than one day in four for part-time salaried physicians who work at 0.6 FTE or less.

ARTICLE B20 - DISCIPLINE

B20.1 No salaried physician who has successfully completed the probationary period shall be disciplined by the Employing Authority except for just cause.

SECTION C - OTHER PHYSICIAN SERVICES

ARTICLE C1 - TARIFF OF FEES

C1.1 Health PEI shall pay physicians in accordance with the Tariff of Fees, attached hereto as Schedule "A", for health services provided to entitled persons under the Health Services Payment Plan.

C1.2 Subject to Article A14.4, during the term of this Master Agreement, the Fee Code Advisory Committee shall have authority to amend the Tariff of Fees, attached hereto as Schedule "A", including the Preamble to the Tariff of Fees. Any amendments made by the Fee Code Advisory Committee shall form part of this Agreement and shall be binding on the parties. Amendments shall be effective as of the date determined by the Fee Code Advisory Committee, and shall not be retroactive.

ARTICLE C2 - EMERGENCY DEPARTMENT (ED) SERVICES

C2.1 **ED Services - On-site Coverage**

Sessional fees and fee-for-service payments shall be payable for work performed at the Queen Elizabeth Hospital ("QEH"), Prince County Hospital ("PCH"), Kings County Memorial Hospital ("KCMH"), and Western Hospital ("WH") Emergency Departments. The number of funded hours of on-site coverage for each of these facilities, as of the signing of this Agreement, is listed in Appendix "H".

Funded hours for on-site coverage shall be paid by an hourly sessional fee which shall be billed using the site-specific fee code listed in the Tariff of Fees. A premium of 8% (10% effective April 1, 2018) shall apply for on-site coverage provided on weekends and statutory holidays.

C2.2 In addition to sessional fees, Emergency Department Physicians ("EDPs") and ED locum physicians shall be paid the following percentage of the value of all submitted and approved shadow billing claims that have a service date on or after the following dates:

Apr-01-2015	Apr-01-2016	Apr-01-2017	Apr-01-2018
28%	28%	29%	31%

C2.3 The number of funded on-site coverage hours at each hospital is determined by taking into account patient volume and acuity of illness. The precise daily requirements for EDP coverage may vary from time to time according to patient volume and acuity of illness, and shall be determined by the Head of each Emergency Department (PCH and QEH) or applicable Medical Director (KCMH and WH). All coverage hours actually

provided in accordance with daily requirements shall be paid so long as the annual cost does not exceed the annual funding derived from the daily hours of on-site coverage as approved by the Minister. For monitoring purposes, Health PEI shall provide quarterly reports to the Head of each Emergency Department or applicable Medical Director with respect to actual costs to date. In the event that the quarterly report indicates that there is an unused accumulation or an excess utilization of one hundred (100) funded hours or more, the Head of the Emergency Department or applicable Medical Director shall meet with the Joint Consultation Committee to discuss and determine any action required.

C2.4 If the workload in the Emergency Department warrants a change in the total number of funded on-site coverage hours at a hospital, then requests for a change in funded coverage hours and/or additions to the EDP complement shall be addressed in the usual manner through the Physician Resource Planning Committee.

C2.5 **Rural Hospital Incentive and On-Call Retainer**

(a) For the term of this Agreement, "rural hospital" shall mean Souris Hospital, Kings County Memorial Hospital (Montague), Community Hospital (O'Leary), or Western Hospital (Alberton).

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

(c) The annual Rural Hospital Incentive shall be:

(i) $5,000 for physicians practicing at a rural hospital with an emergency department where the physician is remunerated with the ED On-site sessional fee (or equivalent) defined in Article C2.1; or

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

(d) Such incentive payments shall be pro-rated for permanent part-time physicians, and shall not apply to locum physicians. A physician may be eligible to receive only one of the above incentive payments.

(e) The Rural Hospital On-Call Retainer shall be paid to one (1) physician per rural hospital per twenty-four (24) hour period using fee code 0185 for the provision of in-patient on-call services at a rural hospital without a 24-hour emergency department.

(f) In addition to the Rural Hospital On-Call Retainer, physicians shall be paid fee-for-service for all approved claims for services rendered while on-call, which in

the case of alternate pay physicians must be outside the physicians' regularly scheduled hours of work.

C2.6 In the event that Health PEI decides to fund certain on-site Emergency Department coverage at a hospital listed in sub-article C2.5, and the affected physicians through the Medical Society have been consulted and have agreed to provide such on-site coverage, then remuneration shall be in accordance with the sessional fees and fee-for-service payments set out in sub-articles C2.1 and C2.2.

C2.7 Each group of EDPs shall enter into a group Emergency Service Coverage Agreement with Health PEI in the form attached hereto as Appendix "D1" for the PCH and QEH, and Appendix "D2" for the KCMH and WH.

C2.8 (a) New physicians, engaged to practice Emergency Medicine in the province after the signing of this Master Agreement, may provide services on a fee-for-service basis outside of their scheduled Emergency Department hours, provided the Physician obtains prior written authorization from Health PEI. Such authorization shall not be unreasonably withheld.

(b) Failure to obtain prior written authorization from Health PEI, when required, for such fee-for-service work performed outside their scheduled Emergency Department hours shall result in the Physician being paid at 50% of the Tariff rate for all such fee-for-service work.

(c) For the purpose of this Article, an EDP does not require prior written authorization from Health PEI for services performed on a fee-for-service basis outside an Emergency Department but within any other location of the hospital.

C2.9 **Other Provisions Respecting Emergency Departments**

All of the following paragraphs apply at all times to services provided in the Emergency Departments at QEH and PCH**;** at KCMH between the hours of 8:00 a.m. and 10:00 p.m., and at WH between the hours of 8:00 a.m. and 8:00 p.m. (generally known as "Site 4 visits").

(a) Subject to Article C2.8, all services (irrespective of type) provided outside an Emergency Department, i.e., non-site 4 visits, shall continue to be paid by Health PEI on a fee-for-service basis. For the purpose of this paragraph, "outside the Emergency Department" means any other location within the hospital or outside the hospital, including but not limited to a private medical clinic. For greater certainty, any emergency physician who bills fee-for-service outside an Emergency Department shall be paid at the full rate in the Tariff of Fees for all fee-for-service work that is rendered, shall not be regarded as a locum, and Article C11 herein shall not apply. It is expected that such services shall primarily occur outside the EDP's scheduled shift duty.

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

(c) EDPs shall submit shadow billing claims, as required in Article A18 for all services provided to patients during their ER shifts. Except for those physicians who are salaried, the shadow billing claims shall be submitted at physicians' own expense, using individual billing numbers.

(d) Subject to Article C2.8, an EDP who occasionally provides primary care to patients in the Emergency Department outside of that physician's regular ER shift duty shall be paid by Health PEI on a fee-for-service basis, subject to the following:

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

(ii) For the purpose of this Article, "same day" is defined as the 24-hour period commencing at 0001 hours during which the shift is worked. For shifts extending over 0001 hours, the day during which the FFS billing restriction applies, is the day in which the longest portion of the shift is worked.

(e) Scheduling of physicians for Emergency Department coverage shall be the responsibility of the Head of Emergency or Medical Director, as applicable, at each hospital.

(f) If the workload in the Emergency Department warrants a change in the total hours of physician coverage, then requests for a change shall be addressed in the usual manner through the Physician Resource Planning Committee.

ARTICLE C3 - ON-CALL SERVICES

C3.1 (a) **On-Call Retainer (plus fee-for-service)** - Specialist or Other Physician As Applicable

One (1) specialist, or other physician as applicable, from each of the following clinical groups shall be entitled to a daily on-call retainer plus fee-for-service for providing twenty-four (24) hour coverage to each of the listed hospitals or provincial service, as the case may be:

Queen Elizabeth Hospital:
Internal Medicine, Pediatrics, General Surgery, Ob/Gyn, Anaesthesia, Surgical Assistant

Prince County Hospital:
Internal Medicine, Pediatrics, General Surgery, Ob/Gyn, Anaesthesia, Surgical Assistant

Provincial coverage:
Psychiatry, Radiology, ENT, Orthopedics, Ophthalmology, Plastic Surgery, Urology, Nephrology, Medical Oncology, Radiation Oncology, Palliative Care, Laboratory Medicine

(b) **On-Call Retainer (plus fee-for-service)** - Family Physicians

A daily on-call retainer plus fee-for-service shall be paid to Family Physicians providing on-call coverage at each of the following facilities:

(i) Queen Elizabeth Hospital and Prince County Hospital

- for in-patient coverage by one (1) physician per group per day. The on-call retainer fee will vary according to group size as listed in the Tariff of Fees. Claims for group coverage require a comment listing the names of the physicians in the group.

- for after-hours Hospitalist in-patient coverage by one (1) physician per hospitalist group per day. At the signing of this Agreement, there are five (5) hospitalist groups at the QEH and two (2) hospitalist groups at the PCH.

- for QEH Unit 9 (psychiatry) unaffiliated inpatient coverage by one (1) physician per day.

- for QEH Unit 7 (rehab) in-patient coverage by one (1) physician per day.

(ii) Souris Hospital and Western Hospital and Community Hospital and Kings County Memorial Hospital
- for in-patient coverage by one (1) physician per hospital per day.

(iii) Hillsborough Hospital and Mt. Herbert Addiction Services
- for in-patient coverage by one (1) physician per facility per day.

(iv) Provincial Correctional Services
- for inmate coverage by one (1) physician per day.

(c) The daily retainer for each clinical group shall be paid according to a group-specific fee code as listed in the Tariff of Fees, and shall qualify for weekend and holiday premiums as listed in the Preamble to the Tariff of Fees.

(d) Payment of the retainer is contingent upon the following conditions being met:

(i) provision of twenty-four (24) hours per day, seven (7) days per week continuous coverage for each listed clinical group;

(ii) the clinical group commits to provide coverage for not less than a period of one (1) calendar month, except that in the event there are fewer than three (3) physicians practising in a particular clinical group, each physician must provide no less than one (1) day in three (3) coverage (i.e., a minimum of ten (10) days per month;

(iii) the physician is responsible to an emergency department, a hospital or a hospital unit, or other facility, as the case may be, and is available to respond to a request by hospital or facility staff to attend to a patient;

(iv) the physician's name appears on an established facility call schedule;

(v) the physician shall be entitled to bill fee-for-service in addition to the on-call retainer for all services rendered when on-call;

(vi) the physician is not otherwise compensated through another contractual arrangement for on-call coverage; and

(vii) in the event an on-call locum physician leaves the province early, the on-call retainer may be divided with another physician, provided a comment is added to the claim.

(viii) Any physician entitled to receive an on-call retainer or on-call per diem, who is unavailable or does not respond when called or paged, shall not be entitled to receive the on-call payment under this Article.

C3.2 **<u>On-Call Per Diem (no fee-for-service)</u>** - Salaried Physicians

(a) Salaried specialists who provide coverage in support of 24-hour emergency department service may elect, on an annual basis, to be compensated for on-call duties either by the on-call retainer plus fee-for-service set out in sub-article C3.1, or by an on-call alternate payment per diem of $500.00.

(b) A salaried Palliative Care specialist who provides coverage in support of 24-hour palliative service shall be compensated for on-call duties by an on-call alternate payment per diem of $400.00.

C3.3 Salaried Medical Oncology specialists

(a) Where a salaried medical oncology specialist provides "first on-call" coverage as set out in sub-articles B19.2(a) or (b), the provisions of Article B19 shall apply;

(b) Where a salaried medical oncology specialist backs up a GP Oncology Associate by providing "second on-call" coverage, the specialist shall be entitled to a retainer fee (fee code 0174) plus fee-for-service in accordance with sub-article B19.4.

C3.4 Neurology On-Call Coverage

Where a neurologist backs up an Internal Medicine specialist by providing "second on-call" coverage for neurology, the neurologist shall be entitled to a retainer fee (fee code 0503) plus fee-for-service.

C3.5 On-Call Coverage for Multiple Clinical Groups

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

C3.6 Weekend and Holiday Premiums for On-Call Coverage

When on-call coverage is required to be provided on weekends (from Saturday 08:00 hrs to Monday 08:00 hrs) and on holidays as designated in the Preamble to the Tariff of Fees, all on-call retainers and per diems, as well as Hospitalist daily sessional fees, shall be paid at the applicable rate plus an add-on premium of twenty-five per cent (25%).

C3.7 Payment for Additional On-Call Coverage during Physician Shortages

In the event of a physician shortage for more than thirty (30) days in clinical groups of five (5) or less providing on-call coverage as outlined in sub-article C3.1(a), and the shortage is due to a vacancy in the approved complement or extended sick leave, Health PEI shall make every reasonable effort to fill the vacancy with either permanent or temporary locum physicians. If a physician is required to provide additional on-call coverage as a result of such physician shortage (i.e., is required to be on-call on those days that otherwise would have been covered by a locum), the physician shall be paid, in addition to the applicable on-call retainer or per diem, the same locum support payment ($150 per day at the signing of this Agreement) that otherwise would have been paid to a locum to provide the on-call coverage. Such additional payment shall not apply where the physician shortage is due to Continuing Medical Education or vacation leave.

C3.8 Hospital On-Call Response Fee

(a) A hospital On-Call Response Fee is intended to compensate on-call physicians for the disruption and inconvenience of having to respond emergently to the request of another physician or a charge nurse to provide service to a patient, which is not part of the on-call physician's normal routine, by returning to hospital after-hours (weekdays 18:00-08:00 and weekends/holidays 08:00-08:00).

(b) The hospital On-Call Response Fee for each clinical group shall be paid according to the fee code as listed in the Tariff of Fees, and shall qualify for weekend and holiday premiums as listed in the Preamble to the Tariff of Fees.

(c) This fee may be claimed only once per day on-call, and is payable in addition to the physician's usual On-Call Retainer Fee plus fee-for-service or On-Call Per Diem.

(d) For the purpose of this article, "hospital" is defined as: Queen Elizabeth Hospital, Prince County Hospital, Western Hospital, Community Hospital O'Leary, Kings County Memorial Hospital, Souris Hospital and Hillsborough Hospital.

(e) Payment of this fee requires clear documentation on the patient's chart outlining the time the physician was called in, the nature of the patient's emergent problem and the medical necessity for the physician to be called back to personally attend to the patient. A comment is required on the claim identifying the patient seen, the person who requested the physician's return to hospital and the nature of the emergency.

(f) This fee is not payable if the physician has not been requested to return to hospital by another physician or a charge nurse, and is not payable if there is no medical necessity for the physician to attend to the request in person.

(g) For physicians such as obstetricians who remain on-site after-hours while on-call, this fee may be claimed only if called to personally attend to a patient's emergent problem.

C3.9 Other Hospital Care Retention Payments

(a) Each full-time fee-for-service Family Physician who maintains active medical staff privileges at either the Prince County Hospital or the Queen Elizabeth Hospital, and who participates in the provision of in-patient care shall receive an annual retention payment of $7,500.00, payable in equal biweekly installments. This retention payment shall be pro-rated for part-time physicians.

(b) Each full-time specialist in Internal Medicine who maintains active medical staff privileges at either the Prince County Hospital or the Queen Elizabeth Hospital, and who participates equitably in on-call coverage for a Critical Care Unit shall receive an annual retention payment of $36,400.00, payable in equal biweekly

installments. This retention payment shall be pro-rated according to the proportion of Critical Care on-call coverage provided at each hospital.

An internist who provides more than his/her equal share of on-call coverage to a Critical Care Unit shall receive an additional retention payment in proportion to the additional days of on-call coverage that is provided by such physician in the event of a physician vacancy or vacancies which are not covered by a locum physician.

ARTICLE C4 - CONTRACT FOR SERVICES

C4.1 A physician who enters into a contract for services (ref. Appendix "B") with Health PEI (hereinafter a "contract-for-services physician") shall be paid an hourly rate based upon the following calculation:

(a) Take the applicable annual salary for a similarly qualified General Practitioner or Specialist as set out in Article B16, add an amount in lieu of benefits, and divide the sum by 1,725 hours.

In lieu of benefits amounts are as listed below:

Apr-01-2015	Apr-01-2016	Apr-01-2017	Apr-01-2018
$15,000	$15,000	$15,800	$17,000

Example: Specialist at Class III at April 1, 2017;

$238,090 + $15,800 = $253,890 divided by 1,725 = $147.18 per hour.

C4.2 In the event that a contract-for-services physician's pre-existing contract for services provides for another hourly rate or other compensation that is greater than the hourly rate calculated by this article, such other hourly rate or other compensation shall continue to be payable by Health PEI until such time as the hourly rate calculated by this article is greater than the pre-existing hourly rate or other compensation.

C4.3 Excluding Specialists in Radiation Oncology and Laboratory Medicine, a contract-for-services physician shall be paid a blended payment consisting of his applicable contract rate and a percentage of the value of submitted and approved shadow billing claims, in accordance with Article C5.

C4.4 (a) Every contract for services entered into between a contract-for-services physician and Health PEI shall set out maximum number of hours of work that are to be performed and remunerated under the contract for services.

(b) The physician shall submit a written invoice for actual hours worked on a monthly, quarterly or other period as may be specified in the contract for services, whereupon Health PEI shall pay the physician within thirty (30) days.

(c) An invoice for services in excess of the maximum agreed upon hours shall be paid, subject to the following:

(i) the invoice must be accompanied by a full description of the hours worked and an explanation for why such excess hours were incurred;

(ii) within 2 weeks of submitting the invoice, the Physician shall meet with his/her Medical Director to discuss whether an increase in the contracted hours is necessary; and

(iii) no further payments shall be made for excess hours subsequently invoiced until the above meeting has been held.

C4.5 Contract-for-Services physicians may be paid on a fee-for-service basis for services provided outside their normal hours of work, but only in accordance with Article C10 of this Agreement.

ARTICLE C5 - BLENDED PAYMENT (Salary and Contract-for-Service Physicians)

C5.1 Excluding specialists in Laboratory Medicine and Radiation Oncology, salaried and contract physicians who are part of the approved complement shall receive a blended payment consisting of their applicable salary or contract rate and the following percentage of the value of their submitted and approved shadow billing claims that have a service date on or after the following dates:

Apr-01-2015	Apr-01-2016	Apr-01-2017	Apr-01-2018
28%	28%	30.5%	31%

C5.2 Effective April 1, 2015 through to and including September 30,2017, payment of the shadow billing portion of the blended payment is contingent upon the physician's meeting certain minimum expectations of a productive and efficient practice within their regular work hours. A productive and efficient practice shall be defined as follows (pro-rated for part-time physicians):

(a) Family Physicians in salary Class I, II, III, and those in Class IV who practice Addictions and Oncology

(i) $125,000 approved shadow billing amount per annum ($31,250 per quarter); and,
(ii) 3000 approved shadow billing claims per annum (750 per quarter)

(b) Family Physicians in salary Class IV as defined in Article B18.1 who practice Dermatology, Geriatrics, Pain Management or Palliative Care medicine

(i) $125,000 approved shadow billing amount per annum ($31,250 per quarter); and,
(ii) 200 initial consultation claims per annum (50 per quarter), including eligible telephone consultations

(c) Specialists - Category I
(Internal Medicine, Obstetrics, Pediatrics, Psychiatry, Physical Medicine)

(i) $160,000 approved shadow billing amount per annum ($40,000 per quarter); and,
(ii) 200 initial consultation claims per annum (50 per quarter), including eligible telephone consultations

(d) Specialists - Category II
(Dermatology, ENT, General Surgery, Plastic Surgery, Ophthalmology, Neurology)

(i) $160,000 approved shadow billing amount per annum ($40,000 per quarter); and,
(ii) 600 initial consultation claims per annum (150 per quarter)

C5.3 Beginning October 1, 2017, payment of the shadow billing portion of the blended payment shall be contingent upon the physician's approved shadow billings reaching a threshold percentage of their salary or contract rate, as follows:

(a) Family Physicians:
(i) Effective October 1, 2017 - shadow billing threshold of 80% salary/contract rate
(ii) Effective October 1, 2018 - shadow billing threshold of 85% salary/contract rate

(b) Specialists:
(i) Effective October 1, 2017 - shadow billing threshold of 73% salary/contract rate
(ii) Effective October 1, 2018 - shadow billing threshold of 77% salary/contract rate

C5.4 (a) Prior to July 1, 2017, Health PEI may advise any salary or contract physician that they will need to convert to fee-for-service payment modality as of October 1, 2017 if they do not achieve the blended payment threshold set out in Article C5.2 by September 30, 2017.

(b) On or after October 1, 2017, Health PEI may advise any salary or contract physician that they will need to convert to fee-for-service payment modality if they do not achieve the applicable blended payment threshold within ninety (90) days of the notice. This 90-day notice period does not apply to physicians who have to convert to Fee-for-Service as a result of the notice provided under Article C5.4(a).

C5.5 The thresholds set out above in Article C5.2 shall be pro-rated for physicians working part-time and those working greater than full-time hours (ie, overtime). Pro-ration shall

exclude salaried/contract hours worked in a hospital where a top-up fee is paid instead of the usual Emergency Department or Hospitalist sessional fees. Appendix F ceases to be in effect when Article C5.2 ceases to be in effect.

C5.6 Physicians who meet the requisite threshold for a quarter shall be paid the blended payment for that quarter. If a physician fails to meet the requisite threshold for a quarter, he/she shall not be paid the shadow billing portion of the blended payment for that quarter. However, if the physician meets the annual thresholds, he/she shall be entitled to a reconsideration and reconciliation on the calendar year as a whole.

C5.7 Physicians working in Anesthesiology shall be entitled to the blended payment without a requisite shadow-billing threshold.

C5.8 Physicians who have submitted all their shadow-billing claims for a quarter within 45 days following the end of that quarter shall be paid the amount owing within 90 days following the end of that quarter.

C5.9 The blended payment shall not apply to locum physicians who are temporarily replacing a salaried or contract physician, but shall apply to long-term (6 months or more) locums.

ARTICLE C6 - LONG TERM CARE

C6.1 Each long term care (LTC) facility in the province shall have a House Physician or a physician who collaborates with a Nurse Practitioner.

C6.2 Where a Long Term Care facility has a House Physician, the House Physician shall:

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

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

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

C6.3 House Physicians shall be paid in the following manner:

(a) a standard administrative and on call fee per bed per annum (for providing twenty-four (24) hour/seven (7) day per week coverage for each resident) of $300.00, based on the approved bed capacity of the Long Term Care Facility, to be paid in monthly installments (this amount includes provision for CME); and

(b) payment for medical services, either by

(i) fee-for-service, or

(ii) a standard medical services fee per bed per annum of $270.00, based on the approved bed capacity of the Long Term Care Facility, to be paid in monthly installments. If the House Physician elects this option, fee-for-service billing is not permitted, except for hospital inpatient services.

C6.4 (a) The long term care facilities and applicable bed counts are listed in Appendix "I".

(b) The complexity and acuity level of patients (residents) in the Prince Edward Home (chronic under age 60 unit) and in the respite beds at the Sherwood Home are greater as compared with the standard long term care facility. The bed count is therefore adjusted to recognize a weighting of 1.5 for each bed in the Prince Edward Home chronic under age 60 unit and the respite beds at Sherwood Home.

C6.5 It is the responsibility of the house physician, in consultation with the facility administration to ensure continuous call coverage.

C6.6 The contract for all Long Term Care Facility house physicians shall include the following (Ref. Appendix "C"):

- date/term of contract;
- identification of Health PEI as the contracting authority (or party responsible for supervising the clinical aspects at government facilities, or the Director of Nursing at private nursing homes);
- job description appended as a schedule to the contract;
- direct supervisor relative to LTC contracted responsibilities;
- if applicable, working hours , on-call rotation expectations, off-site response times;
- compensation in accordance with this Agreement;
- accountability and reporting requirements, i.e. shadow billing (not eligible for clinical work incentive), other reporting requirements as determined by management;
- ensuring continuous care coverage; and
- notice/termination requirements.

C6.7 Each house physician appointment is subject to an annual review conducted by the administration of the applicable Long Term Care Facility. The recruitment of a house physician or renewal of such physician's contract shall be the responsibility of the applicable Long Term Care Facility management. All such contracts shall be consistent with the provisions of this Agreement.

C6.8 Where a Long Term Care facility has a physician who collaborates with a Nurse Practitioner to provide care to the residents of that facility, the collaborating physician shall be paid in the following manner:

(a) fee code 2510 for time spent collaborating with the Nurse Practitioner; and

(b) fee-for-service payment for any medical services the physician personally provides to residents.

For greater certainty, a physician who collaborates with a Nurse Practitioner shall not receive payment per Article C6.3 for House Physician services at the same LTC facility.

ARTICLE C7 - VISITING SPECIALISTS

C7.1 Eligible out of province Visiting Specialists shall be compensated as follows:

(a) Professional Fees

Options for payment modalities include the following:

(i) Fee-for-service, or
(ii) Sessional fee (fee code 9901), which is an hourly rate for clinical work.

The physician shall have the option to switch payment modalities once yearly

(b) Expense allowances for non-clinical time

(i) Reimbursement for air travel up to the full-fare economy rate (seven day advance booking is required); actual taxi costs and airport parking (receipts required); or

(ii) For use of a private vehicle per round trip from Halifax, Moncton or Saint John, reimbursement shall be in accordance with provincial travel allowance rates as determined from time to time by the Department of Finance and Municipal Affairs for provincial employees generally, plus reimbursement for the actual cost of road and bridge tolls;

(iii) For a visiting specialist who is required to provide a clinic in Summerside, reimbursement shall be in accordance with provincial travel allowance rates as determined from time to time by the Department of Finance and Municipal Affairs for provincial employees generally or reimbursement for a vehicle rental. Vehicle insurance is the visiting specialist's responsibility;

(iv) Reimbursement of $50.00 per hour shall be paid for actual travel time incurred between the visiting specialist's office and the Prince Edward Island work site.

(v) Reimbursement of required PEI licensure fees;

(vi) Reimbursement for accommodations shall be provided if pre-approved by Health PEI;

(vii) Reimbursement for meals as per Treasury Board out-of-province meal allowance; and

(viii) If allied health professionals accompany the Visiting Specialist, prior approval for travel and accommodation expenses must be obtained from the Executive Director of Medical Affairs or designate. Salaries of such allied health professionals shall not be covered by Health PEI.

ARTICLE C8 - CHIEF AND DEPUTY CHIEF HEALTH OFFICERS

C8.1 It is acknowledged that this Agreement applies to and covers physicians who provide services to the Government as the Chief Health Officer and/or the Deputy Chief Health Officer (the "Health Officer").

C8.2 Where the Health Officer is an employee, the annual salary (pro-rated for a part-time employee) shall be:

Apr-01-2015	Apr-01-2016	Apr-01-2017	Apr-01-2018
$219,100	$219,100	$227,830	$240,924

C8.3 Except for Article B16, Section B of this Agreement shall apply to a Health Officer who is an employee of the Department, subject to any pre-existing benefits that are greater than or in addition to the benefits provided under this Agreement.

C8.4 Subject to any pre-existing compensation (or reimbursement of expenses) that is greater than or in addition to the compensation provided under this Agreement, where the Health Officer is an independent contractor, compensation shall be in accordance with sub-article C4.1, summarized as follows:

April 1, 2015	($219,100 + $15,000)	divided by 1,725 hours	= $135.71
April 1, 2016	($219,100 + $15,000)	divided by 1,725 hours	= $135.71
April 1, 2017	($227,830 + $15,800)	divided by 1,725 hours	= $141.23
April 1, 2018	($240,924 + $17,000)	divided by 1,725 hours	= $149.52

C8.5 On-call compensation for a Health Officer shall be an on-call per diem of $325 (no fee-for-service).

ARTICLE C9 - HONORARIA

C9.1 An Honoraria program in accordance with Health PEI's honoraria policy, attached hereto as Appendix "K", shall continue, except that:

(a) Subject to Article C9.1(c), Health PEI shall provide reimbursement directly to eligible physicians at the rate of two hundred ($200) dollars per hour, or part thereof in excess of fifteen (15) minutes, to a maximum of one thousand two hundred dollars ($1,200) per day;

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

(c) Any claim for an honoraria incurred prior to April 1, 2017 will be determined in accordance with the prior Master Agreement which expired on March 31, 2015.

C9.2 Health PEI in issuing a payment to a physician shall indicate, with the payment, that it is made pursuant to the Master Agreement between the Department of Health and The Medical Society of Prince Edward Island.

C9.3 Health PEI shall provide a report to the Medical Society by March 31st of each year for the prior period ending December 31st detailing expenditure for honoraria including each physician's name, meetings attended and amount paid.

ARTICLE C10 - FEE-FOR-SERVICE OUTSIDE ALTERNATE PAYMENT HOURS

C10.1 This Article applies only to Salaried and Contract-for-Service physicians.

C10.2 Physicians shall be paid full fees for all fee-for-service work performed outside the alternate payment hours for which they have been engaged by Health PEI, subject to all of the following conditions:

(a) the physician has performed such fee-for-service work, outside the alternate payment hours for which he/she has been engaged by Health PEI, within the 12-month period immediately preceding the signing of this Master Agreement; and

(b) the physician works productively during his/her alternate payment hours by meeting the thresholds for CWI/blended payments within 6 months following the signing of this Master Agreement and continues to maintain such productivity; and

(c) the physician continues to fulfill and satisfy the responsibilities for which he/she has been engaged by Health PEI.

C10.3 Physicians who do not meet all the conditions listed in Article C10.2 must obtain prior written authorization from Health PEI before performing fee-for-service work outside the alternate payment hours for which they have been engaged by Health PEI. Such authorization shall not be unreasonably withheld.

C10.4 Failure to obtain prior written authorization from Health PEI, when required, for fee-for-service work performed outside the alternate payment hours for which a physician has been engaged by Health PEI shall result in the physician being paid at 50% of the tariff rate for all such fee-for-service work.

C10.5 For greater clarity, any Salaried or Contract-for-Service physician newly engaged by Health PEI after the signing of this Master Agreement would require prior written authorization from Health PEI before performing any fee-for-service work outside the alternate payment hours for which he/she has been engaged, as the first condition listed in Article C10.2 above would not have been met.

C10.6 Salaried and Contract-for-Service physicians do not require prior authorization from Health PEI for the following fee-for-service work performed outside their alternate payment hours:

(a) on-call services
(b) hospital inpatient services
(c) services provided to patients in their home, nursing home or community care facility.

ARTICLE C11 - PARTIAL PAYMENT FOR PHYSICIANS OUTSIDE THE COMPLEMENT

C11.1 The Physician Resource Planning Committee makes recommendations to the Minister on the complement of each region, and the Medical Society acknowledges the Minister's authority to determine the complement of each region.

C11.2 Physicians in receipt of a billing number, on or after April 1, 1993, who are not part of the approved complement of a given region, shall be paid at 50% of the rates set out in the Tariff of Fees for any work done in that region without approval from Health PEI.

C11.3 As of the signing date of this Agreement any new fee for service physician who acts in a manner inconsistent with his/her letter of offer or confirmation letter shall be paid at 50% of their rates set out in Tariff of Fees for any work done without approval from Health PEI.

ARTICLE C12 - INTERNATIONAL CLASSIFICATION OF DISEASES CODING (ICD)

C12.1 Fee-for-service physicians utilize ICD-9 coding when submitting their claims to Health PEI. In the event that Health PEI requires physicians to utilize ICD-10 coding, Health PEI shall be responsible for the costs associated with having software vendors upgrade physicians' electronic billing software to conform to ICD-10 coding.

ARTICLE C13 - COLLABORATIVE FAMILY PRACTICE INCENTIVE PROGRAM

C13.1 Health PEI shall provide funding to the following maximum amounts for a Collaborative Family Practice Incentive Program for Family Physicians who collaborate with other licensed health care professionals:

Year	Funding
April 1, 2017 - March 31, 2018	$350,000
April 1, 2018 - March 31, 2019	$350,000

C13.2 The goal of this program is to improve patient access to primary health care providers in the patient's Primary Health Care Network. Under this program:

(a) Family Physicians, regardless of usual payment modality, who have an approved plan to collaborate with other Family Physicians to ensure their patients have timely access to a physician and that medical services are provided to their patients when they are admitted to hospital will receive an incentive payment of $5,000 per year, paid in equal biweekly installments; and

(b) Family Physicians, regardless of usual payment modality, who have an approved plan to collaborate with other licensed health care professionals working in their Primary Health Care Network will receive an incentive payment of $5,000 per year, paid in equal biweekly installments.

(c) A locum physician is not eligible for incentive payments under this program.

(d) Applications for participation in this program shall be submitted to the Executive Director of Community Hospitals and Primary Care for approval, which shall include:

(i) the name of each physician who will participate in the collaborative group;
(ii) the locations of the included practices;
(iii) an operational plan for providing patients with timely access to their primary health care provider; and
(iv) if applicable, a plan to improve the health of the group's patients through collaboration with other licensed health care providers in the Primary Health Care Network.

C13.3 Health PEI shall provide a copy of each Collaborative Family Practice Incentive Agreement to the Medical Society.

ARTICLE C14 - HOSPITALIST SERVICES

C14.1 For the purposes of this Article, an "unaffiliated" patient shall be defined as a hospitalized patient who does not have a regular family physician, or whose regular family physician does not have admitting privileges in the hospital where the patient has been admitted. This does not include patients whose regular family physician, with admitting privileges in the hospital where the patient is to be admitted, is temporarily unavailable (for less than four weeks) due to vacation, illness, bereavement or CME.

C14.2 Health PEI shall ensure that, upon admission to hospital, all unaffiliated patients shall be under the care of an attending physician. Subject to Article C14.11, at the Prince County Hospital (PCH) and the Queen Elizabeth Hospital (QEH), an unaffiliated patient shall be assigned to the care of a Hospitalist physician. The Hospitalist shall provide comprehensive inpatient care for unaffiliated patients, including admission history and physical examination, daily medical management, participation in multi-disciplinary rounds and family conferences as needed, and discharge planning.

C14.3 Notwithstanding Article C14.2, the Hospitalist shall be responsible only for those unaffiliated patients for whom he/she is the attending physician. Unaffiliated newborn, pediatric, and psychiatric patients may or may not fall under the care of the Hospitalist, depending upon the particular arrangements at each hospital.

C14.4 In recognition of the different types of Hospitalist practice profile, two different types of Hospitalist shall be defined as follows:

(a) "Type 1 Hospitalist" shall be defined by the provision of care to patients with a mixed variety of age groups (newborn, pediatric, adult, etc.), illnesses (medical, surgical, psychiatric, etc.) and acuity levels.

(b) "Type 2 Hospitalist" shall be defined by the provision of care to adult medical patients only.

C14.5 The number of beds for which each type of Hospitalist is engaged to manage shall be as follows:

(a) Type 1 Hospitalist: 21 beds ("full line"), no more than 19 of which are acute, or 11 beds ("half line")

(b) Type 2 Hospitalist: 17 beds ("full line"), no more than 15 of which are acute, or 9 beds ("half line")

C14.6 The type of Hospitalist which is utilized by a particular hospital shall be as designated by the Executive Director of Medical Affairs.

C14.7 Each group of Hospitalists at the PCH and QEH shall enter into a Hospitalist Service Coverage Agreement with Health PEI, in the form attached hereto as Appendix "E".

C14.8 Each Hospitalist shall be paid a daily sessional fee for inpatient care of unaffiliated patients. The daily sessional fee shall be billed as a fee code which is specific to the type of Hospitalist and to the maximum number of beds for which the Hospitalist is engaged to manage. Salaried physicians providing Hospitalist care shall be remunerated at the same sessional rate by billing a top-up fee equal to the difference between their daily salary (including benefits) and the Hospitalist sessional daily rate. Any inpatient care provided by a Hospitalist to unaffiliated patients in excess of his/her maximum patient load shall be remunerated on a fee-for-service basis.

C14.9 Overnight on-call coverage for Hospitalist inpatients between the hours of 18:00 and 08:00 hrs the following morning shall be remunerated by an on-call retainer plus fee-for-service for each Hospitalist line, as outlined in Section 11.D.2 of the Tariff of Fees. A Hospitalist providing overnight on-call coverage for more than one Hospitalist line shall be entitled to receive an on-call retainer for each Hospitalist line covered. It is acknowledged that, even though on-call coverage may commence any time after 18:00 hrs, the normal daily duties of the Hospitalist may extend beyond this time, and each Hospitalist is expected to complete his/her daily duties prior to signing out to the Hospitalist on-call.

C14.10 Maximum bed capacity for a Hospitalist Service at a given hospital shall be defined as the bed capacity for an individual Hospitalist line multiplied by the number of Hospitalist lines in the service, taking into consideration both the total occupied beds and the maximum number of acute care beds. Based on the number of hospitalist lines specified in Article C14.14, the maximum bed capacity for each facility is as follows:

(a) PCH maximum is 42 occupied beds unless there are 38 acute beds occupied, in which case the maximum bed capacity is 38;

(b) QEH maximum is 85 occupied beds unless there are 75 acute beds occupied, in which case the maximum bed capacity is 75

Once the Maximum bed capacity has been reached in a facility, it triggers an overflow situation. "Overflow" unaffiliated patients are unaffiliated acute care patients admitted after the maximum acute bed hospitalist capacity has been reached plus unaffiliated Alternate Level of Care (ALC) patients who are not part of the total bed hospitalist capacity.

C14.11 "Overflow" unaffiliated patients, admitted after the maximum Hospitalist Service bed capacity has been reached, shall be dealt with in one of two ways, depending upon the particular arrangements at each hospital:

(a) Hospitalists may add overflow unaffiliated patients to their hospitalist lines; or

(b) Overflow unaffiliated patients may be assigned to another physician who has agreed to be on standby to accept these patients.

A physician on standby to accept overflow unaffiliated patients shall be paid a standby fee of $100 for each day he/she is on standby. This fee cannot be billed in addition to any other hospitalist on-call fee. Once the standby physician begins to assume care of overflow inpatients, he/she shall be paid an on-call retainer instead of the standby fee. (fee code 0034 for up to a half-line of overflow patients, and fee code 0108 for more than a half line)

A physician who agrees to accept responsibility for an overflow patient shall continue to provide inpatient care to that patient until such time as that physician chooses to transfer care of the patient to another physician or discharge the patient. A physician on standby for overflow patients shall transfer care of his/her overflow patients to the Hospitalist Service as capacity becomes available, with initial priority given to acute care patients followed by ALC patients.

C14.12 The Hospitalist Group is responsible for organizing standby physician coverage pursuant to C14.11.

C14.13 Remuneration for the care of "overflow" unaffiliated patients shall be either by fee-for-service, or by a sessional daily rate, billed as Fee Code 0106, for each overflow unaffiliated patient. If a physician chooses the latter option for any given unaffiliated patient, no fee-for-service claims may be billed by that physician for the care of that patient during the first five (5) weeks of the patient's hospital stay, following which billing will revert to regular fee-for-service rates (fee codes 0134 and 0135). Care of unaffiliated newborns may not be billed under Fee Code 0106.

C14.14 Health PEI shall fund the provision of the Hospitalist Service based on coverage of 2 lines/day at the PCH and 5 lines/day at the QEH.

C14.15 Hospitalist service data shall be compiled on a monthly basis and shared with the Medical Director and Hospitalist Program leader at each hospital. Such data shall include, but not be limited to, monthly admissions and discharges, acuity measures, and daily census of unaffiliated patients.

C14.16 The Hospitalist Service shall be reviewed quarterly. If the service experiences a sustained increase in workload that warrants a change in the funded on-site coverage, Health PEI shall engage in a consultative process to determine how the number of Hospitalist lines can be increased. Similarly, if the Hospitalist Service has experienced a sustained decrease in utilization, Health PEI may engage in a consultative process to determine how the number of Hospitalist lines can be decreased.

C14.17 Management and remuneration for the care of unaffiliated patients in the rural hospitals shall be either by fee-for-service or by a sessional daily rate as described in Article C14.13.

C14.18 (a) Any Hospitalist Physician, engaged to practice Hospitalist Medicine before the signing of this Master Agreement, may provide services on a fee-for-service basis outside of their inpatient care responsibilities, provided they continue to fulfill the responsibilities for which they have been engaged by Health PEI.

(b) New physicians, engaged to practice Hospitalist Medicine after the signing of this Master Agreement, may provide services on a fee-for-service basis outside of their inpatient care responsibilities, provided the Physician obtains prior written authorization from Health PEI. Such authorization shall not be unreasonably withheld.

(c) Failure to obtain prior written authorization from Health PEI, when required, for such fee-for-service work performed outside their inpatient care responsibilities shall result in the Physician being paid at 50% of the Tariff rate for all such fee-for-service work.

(d) For the purpose of this Article, a Hospitalist Physician does not require prior written authorization from Health PEI for services performed on a fee-for-service basis for any inpatient care or services provided in the hospital while on-call.

SECTION D - NON-CLINICAL PROGRAM FUNDING

ARTICLE D1 - PHYSICIAN RETENTION PROGRAM

D1.1 A Physician Retention Program is established, effective October 1, 2012, in an effort to enhance the stability of physician services throughout the provincial health care system.

D1.2 On October 15th of each fiscal year, Health PEI shall remit to the Medical Society the sum of $500,000.

D1.3 On or before December 31st of each year after the establishment of this program, the Medical Society shall use this funding to pay an annual retention incentive of $2,000 to each eligible physician.

D1.4 An eligible physician is a physician who, as of December 31st of the previous calendar year has been an ordinary member of the Medical Society for the previous five years and received remuneration under the provisions of this Agreement, and who

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

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

D1.5 In consultation with the Joint Consultation Committee, the Medical Society shall be required to expend all the remaining funding for this program by increasing the otherwise approved retention incentive to eligible physicians.

D1.6 Within six (6) months following the Medical Society's fiscal year end, the Medical Society shall provide the following information to Health PEI:

(a) an audited report of actual expenditures for this program; and

(b) an annual report indicating the names of the physicians, by specialty, who received a payment under this program.

D1.7 All program funds and investment interest earned thereon, if any, shall be held in trust by the Medical Society and used for the purpose set out in this Article. Notwithstanding the foregoing, the Medical Society shall have the right to deduct from rebate program funds and retain an administration fee calculated as three percent (3%) of the specific funding provided in sub-article D1.2.

ARTICLE D2 - CMPA ASSISTANCE

D2.1 A rebate program in respect of Canadian Medical Protective Association ("CMPA") premiums or other professional malpractice liability insurance premiums shall be administered by the Medical Society in accordance with this Article for the duration of this Agreement.

D2.2 Funding provided by Health PEI to the Medical Society for the purpose of the rebate program shall be used by the Medical Society to help offset the cost of CMPA premiums or other professional malpractice liability insurance premiums paid by physicians.

D2.3 Where a physician is not a CMPA member, the physician shall at all times hold a valid certificate of professional malpractice liability insurance with coverage of not less than $5,000,000 per claim.

D2.4 (a) In each calendar year, Health PEI shall provide annual funding ("Annual Amount") to the Medical Society, pursuant to Article D2.2, in two (2) equal installments, on April 15th and October 15th.

(b) For the calendar year 2017 ("Base Year"), the Annual Amount of funding shall be $675,000 ("Base Year Amount"). The "Base Year Per-Physician Amount" shall be the Base Year Amount divided by the number of physicians (279) who paid CMPA premiums in 2015. It is agreed that the "Base Year Per-Physician Amount is calculated to be $675,000 ÷ 279 physicians = $2,419.35.

(c) In each subsequent calendar year, the Parties shall determine the Annual Amount for that calendar year by multiplying $2,419.35 by the number of physicians who paid CMPA premiums in that calendar year.

(d) If the Annual Amount paid by Health PEI pursuant to Article D2.4(b) or D2.4(c) combined with the total Deductible Amount paid by physicians, pursuant to Article D2.5(a), in a calendar year is less than the total cost of premiums paid by physicians to CMPA in that calendar year, the Parties shall each contribute to the shortfall as follows:

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

(e) For the purpose of this Article, the methodology for any payment under Article D2.4(d)(ii) by the physicians shall be determined exclusively by MSPEI.

D2.5 (a) Every member of the Medical Society, including locums, covered by this Master Agreement shall be entitled to participate in the rebate program. A physician shall be responsible for the first $1,500 of annual CMPA premiums or other professional malpractice liability insurance premiums. The difference between

annual CMPA premiums or other professional malpractice liability insurance premiums and $1,500 shall be rebated by the Medical Society, subject to proration based upon the actual number of months in practice on PEI. In the case of a locum physician, the first $1,500 of CMPA premiums or other professional malpractice liability insurance premiums shall also be subject to such proration.

(b) Notwithstanding Article D2.5(a), the amount to be reimbursed by the Medical Society for professional malpractice liability insurance provided by another carrier (non-CMPA) shall not exceed the amount the physician would have been eligible for had the physician been enrolled in CMPA.

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

D2.6 The Medical Society shall provide Health PEI with a written statement detailing the distribution of the rebate program funds, including accumulated interest, administration fees and accumulated surplus, if any, by April 30th of each year for the immediately preceding calendar year.

D2.7 All program funds and investment interest earned thereon, if any, shall be held in trust by the Medical Society and used for the purpose set out in this article. Notwithstanding the foregoing the Medical Society shall have the right to deduct from rebate program funds and retain an administration fee calculated as three per cent (3%) of the specific funding provided in sub-article D2.4.

D2.8 In the event the rebate program experiences an accumulated surplus as at April 30th of any year, such surplus shall become the initial funding available to the Medical Society for the purpose of the rebate program in the following year.

D2.9 In the event the "Trust Fund" does not have sufficient resources to meet the expenditures for CMPA premiums or other professional malpractice liability insurance premiums, Health PEI shall, on receipt of a detailed statement on August 31st and February 28th of each year from the Medical Society, provide additional funding to cover the shortfall pursuant to Article D2.4(d).

D2.10 CMPA funding for the period April 1, 2015 to March 31, 2017 will be determined based on the contents of the prior Master Agreement that ended March 31, 2015.

ARTICLE D3 - CME (Non-Salaried Physicians)

D3.1 A Continuing Medical Education (CME) program shall be available for physicians who are not otherwise entitled to CME under Article B15, shall be continued for the duration of this Agreement, and shall be administered by the Medical Society.

D3.2 Subject to Article D3.7, Health PEI shall provide annual dedicated funding to the Medical Society in the amount of $280,000. Health PEI shall pay this funding to the Medical Society installments of $140,000, on April 15th and October 15th of each year.

D3.3 In the event that the funds provided are not expended, to a maximum of $10,000 in any one year, the unspent funds shall be carried forward by the Medical Society and applied to the program in the following year and shall be in addition to the specific funding provided in sub-article D3.2.

D3.4 Subject to the maximum of amount that may be carried forward and in consultation with the Joint Consultation Committee, the Medical Society shall be required to expend all other funding for this program by increasing the otherwise approved annual reimbursement to eligible physicians for CME expenses.

D3.5 The amount for program administration in any annual CME budget shall not exceed $40,000 per year.

D3.6 The Medical Society shall provide the following information to Health PEI:

(a) no later than November 15th of each year, an itemized annual budget indicating projected CME program expenditures;

(b) within six (6) months following the Medical Society's fiscal year end, an audited report of actual CME program receipts and expenditures; and

(c) within six (6) months following the Medical Society's fiscal year end, an annual report indicating the number of physicians by specialty who participated in individual educational events funded under this program, including the types of education (topics) by physician group (e.g. GP's and each major specialist group).

D3.7 CME funding provided by Health PEI for periods prior to April 1, 2017 will be determined in accordance with the prior Master Agreement which expired on March 31, 2015.

ARTICLE D4 - PHYSICIAN HEALTH AND WELLNESS

D4.1 Subject to Article D4.4, Health PEI shall provide to MSPEI the sum of $200,000 on an annual basis for the purpose of developing and operating a program to provide assistance for physicians who are developing or experiencing difficulty in the personal

or professional lives. Health PEI shall have representation on any committee established for the purpose of developing and operating this program.

D4.2 The annual payment referred to in Article D5.1 shall be paid to the Medical Society on May 1st of each year.

D4.3 In the event that funds provided are not expended in the year provided, the unspent funds shall be carried forward by the Medical Society and applied to this program in the following year in addition to the annual payment. The unspent funds shall not be used for any other purpose.

D4.4 Physician Health and Wellness funding for the period April 1, 2015 to March 31, 2017 will be determined based on the contents of MD Support Program provisions in the prior Master Agreement that ended March 31, 2015.

ARTICLE D5 - MATERNITY/PARENTAL BENEFITS PROGRAM

D5.1 A Maternity/Parental Benefits Program shall be continued for the duration of this Agreement to provide partial income replacement for a physician parent who takes a temporary leave from practice in Prince Edward Island in relation to the birth/adoption of their child.

D5.2 Fee-for-service and alternate funded physicians shall be eligible for the program, which shall be designed and administered by the Medical Society generally in accordance with the program described in Appendix "G" but subject to the specific criteria to be determined by the Medical Society,

D5.3 Subject to Article D5.7, on May 1st of each fiscal year Health PEI shall fund the program by paying to the Medical Society $122,400 each year.

D5.4 In the event that the funds provided are not expended in any one year the unspent funds shall be carried forward by the Medical Society and applied to the program in the following year and shall be in addition to the specific funding provided in sub-article D5.3. If the unspent funds from year to year accumulate, the Medical Society may transfer any amount in excess of $122,400 to another support or benefit program under this Agreement, and shall advise the Joint Consultation Committee of such transfer.

D5.5 All program funds and investment interest earned thereon, if any, shall be held in trust by the Medical Society and used for the purposes set out in this article. Notwithstanding the foregoing the Medical Society shall have the right to deduct from such program funds and retain an administration fee calculated as two per cent (2%) of the specific funding provided in sub-article D5.3.

D5.6 The Medical Society shall provide a report to Health PEI by December 31st of each year for the year in which the program occurred which includes a summary of expenditures for each eligible physician.

D5.7 Any funding provided by Health PEI for periods prior to April 1, 2017 will be determined in accordance with the prior Master Agreement which expired on March 31, 2015.

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

DATED at Charlottetown, Prince Edward Island, this 12 day of May, 2017.

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

Witness

Minister of Health and Wellness

On behalf of Health PEI

Witness

Chief Executive Officer

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

Witness

President

MEMORANDUM OF AGREEMENT

CHIEF CORONER AND DEPUTY CHIEF CORONER

Memorandum of Agreement

Between

The Office of the Attorney General

and

The Medical Society of PEI

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

Effective May, 2017, the Chief Coroner shall be paid an annual stipend of $72,000.

The Coroner's Office shall provide on-call services to both the Eastern and Western regions of the province 24 hours per day 7 days per week. Remuneration for on-call coverage shall be billed as fee code 0020 of the Tariff of Fees per day for each region.

MEMORANDUM OF UNDERSTANDING

DEVELOPMENT OF TERMS OF REFERENCE
FEE CODE ADVISORY COMMITTEE

The parties agree to establish a joint Task Force to develop terms of reference for the Fee Code Advisory Committee (FCAC) which will include, but not be limited to, determining the methodology and system that will be used to review and recommend changes to the Tariff. These changes will include the addition of new fee codes, amendment of existing fee codes and delisting existing fee codes.

Within 30 days of signing the Master Agreement, each party shall appoint three persons to serve on the Task Force. At the first meeting of the Task Force, two co-chairs (one from each party) shall be appointed.

The Task Force shall establish terms of reference for FCAC which will include:

- Purpose and objectives
- Reporting
- Support resources
- Evaluation and decision-making methodology
- Meeting schedule
- Other items the task force determines necessary for a quality outcome

It is expected the Task Force will use a best practices scan to develop the decision-making framework that will be used to evaluate additions, amendments and deletions to the Tariff. This framework shall include, but not be limited to, a scientific measure to determine complexity and patient benefit; financial implications; impact on other specialties; and what is being done in other jurisdictions.

It is agreed that a project manager may be retained to assist the committee in providing objective, evidence-informed research and expertise. The project manager will be hired by Health PEI, MSPEI will participate in hiring, and the project manager will report to the co-chairs of the Committee.

The mandate of the project manager will be to assist the Task Force in developing its terms of reference and its decision-making framework. The terms of reference developed for FCAC by the Task Force shall form an appendix to the Master Agreement.

Funding for this Task Force, including the cost of the project manager, will be to a maximum of $100,000 to be equally split between the parties, of which MSPEI's portion of the funding will come from the 1st year annual allotment to FCAC. Any unspent funds will be added to the next year's annual FCAC allotment.

The Task Force will report to both parties within four months of signing of the Master Agreement, with the expectation that the Fee Code Advisory Committee will hold its first meeting no later than six months after signing.

MEMORANDUM OF UNDERSTANDING

PHYSICIAN ENGAGEMENT

WHEREAS the parties acknowledge and agree that the future success of healthcare on Prince Edward Island ("PEI") depends in part on meaningful collaboration and an ongoing respectful, transparent and honest relationship between physicians and Health PEI;

AND WHEREAS the parties recognize that physicians are in a position to provide advice, guidance and leadership as part of a collaborative approach with respect to the planning of physician services and future delivery of healthcare on PEI;

AND WHEREAS in a mutual desire to ensure that PEI has the finest healthcare system in Canada, taking into account its size and resources, both human and financial, the parties wish to ensure that there is collaboration wherever the role and responsibilities of physicians is the subject matter of the discussion;

AND WHEREAS the parties recognize the need for input from physicians on decisions that significantly impact physicians and their patients, whether on the system wide basis or on a location based basis;

AND WHEREAS the opportunity for input by physicians must be real and substantive;

AND WHEREAS Health PEI recognizes that MSPEI is the authorized representative of physicians on PEI;

AND WHEREAS in order to achieve success in the collaborative effort, physicians appointed or selected to represent the views of MSPEI must be appointed by MSPEI;

AND WHEREAS the parties also recognize that the ultimate decision to spend resources of the government of Prince Edward Island remains with Health PEI;

NOW THEREFORE the parties agree as follows:

1. When a committee is appointed by Health PEI to consider the creation of a new policy or to amend a current policy which may impact on how MSPEI Members deliver healthcare in PEI, the committee shall have representation from MSPEI.

2. When a committee is appointed by Health PEI to consider any fundamental or transformational changes to the operations of healthcare in PEI which may significantly impact physicians, the committee shall have representation from MSPEI.

3. Health PEI agrees to commit to meaningful consultation on any fundamental or transformational changes to the operations of healthcare in PEI which may significantly

impact physicians. For the purpose of this MOU, "meaningful consultation" means Health PEI will ensure concerns and input of physicians are represented by MSPEI and considered. For greater certainty, issues requiring meaningful consultation include, but are not limited to:

(a) Any fundamental or transformational change decision affecting physicians and delivery of physician services;

(b) Any changes to Medical Staff By-Laws and rules which affect delivery of healthcare by physicians;

(c) Substantial quality and cost improvement opportunities; and

(d) Substantial quality improvement projects including quality assurance projects identified by any facility or Health PEI.

4. Any physician(s) appointed to a committee pursuant to paragraphs 1 or 2, must:

(a) be appointed by MSPEI, which appointment must be made within a reasonable time; and

(b) participate on the committee to explain the views of physicians with respect to the proposed policy change.

5. In the event MSPEI does not appoint a physician to a committee within a reasonable time frame, MSPEI will be deemed to have waived the right to appoint representation and the committee shall proceed with its mandate.

6. Should MSPEI have any concerns with respect to Health PEI's compliance with this MOU, such concerns may be addressed pursuant to the grievance procedure set out in Article A9. It is agreed that an arbitrator appointed pursuant to Article A9 shall have authority to void a policy or decision, as it applies to physicians, should the arbitrator determine that the policy or decision was made by Health PEI in contravention of this MOU.

7. It is jointly acknowledged that, in keeping with this MOU, the following issues are those which Health PEI intends to consult with MSPEI:

(a) Practitioner Claims Monitoring, Compliance and Recovery Policy

(b) Medical leadership remuneration framework

(c) Locum Tenens Policy

LETTER OF UNDERSTANDING

PHYSICIAN LEADERSHIP DEVELOPMENT FUND

1. The parties recognize and agree that there is an ongoing need for the engagement of physicians in the future healthcare developments within Prince Edward Island.

2. MSPEI agrees on its own behalf and on behalf of its Membership, to enhance the collaboration and leadership skills of its Members both for Provincial and local roles.

3. Health PEI agrees to provide to MSPEI the sum of $300,000.00 annually to facilitate training of MSPEI Members in leadership skills to enable meaningful consultation with respect to the management and delivery of change within facilities or across the province within Health PEI.

4. MSPEI shall be entitled to utilize the fund to engage external trainers, to arrange and pay for external training, and/or to employ staff within MSPEI to provide physician leadership training.

5. Upon the signing of this Master Agreement, representatives of the parties shall commence work to develop an evaluation framework to be used to evaluate the leadership training program implemented pursuant to this Letter of Understanding. Development of such framework shall be completed within 6 months of the signing of this Master Agreement.

6. The parties shall meet 6 months prior to expiry of this Master Agreement to conduct an evaluation in accordance with the evaluation framework established pursuant to paragraph 5.

MEMORANDUM OF UNDERSTANDING
PILOT PROJECT
WALK-IN CLINIC FEE CODE

WHEREAS the parties acknowledge and agree that changes are required with respect to the utilization of walk in clinics by family physicians to provide care to patients who are part of their practice panel.

AND WHEREAS the parties recognize the potential benefit of a walk-in clinic fee code which will be at a lower rate than the limited office visit fee code (0113).

AND WHEREAS it is the mutual desire of the parties to ensure that the family physician continue to see her/his patients at their office rather than at a walk-in clinic.

AND WHEREAS the parties agree to enter into a pilot project to determine the value in eliminating the basic office visit fee code (0123) and creating a walk-in clinic fee code.

IT IS HEREBY AGREED as follows:

1. The parties will initiate a pilot project covering the period October 1, 2017 to March 31, 2019 (Pilot Project Term).

2. For the Pilot Project Term the parties agree and acknowledge that this MOU will take precedence over the preamble/tariff in any areas where there is conflict between the two documents.

3. For the Pilot Project Term the basic office visit fee code (0123) will be inactivated and would not be used for any type of visit at either a walk-in clinic or regular office practice.

4. For the Pilot Project Term the limited office visit fee code (0113) would no longer have any time limit assigned to it. For the Pilot Project Term fee code 0113 can be used for an office visit of any duration.

5. For the Pilot Project Term a walk-in clinic fee code will be created that would have a lower value than the current value assigned to the current basic office visit fee code (0123). There will be no time duration on the walk-in fee code. The walk-in clinic fee code can only be claimed for services provided at a walk-in clinic visit. Only one walk-in clinic fee can be claimed per patient per physician per day.

6. Upon the signing of this Master Agreement representatives of the parties shall commence work to develop an evaluation framework to be used to evaluate this pilot project. Development of such a framework shall be completed prior to October 1, 2017 which is the implementation date of this Pilot Project.

7. The parties shall meet three months prior to the expiry of the Master Agreement to conduct an evaluation in accordance with the evaluation framework established pursuant to the above paragraph.

8. All aspects of the Pilot Project will be continued following the termination of the Master Agreement until a decision by the parties, following evaluation pursuant to paragraph 7, about whether to continue or cease the project.

LETTER OF UNDERSTANDING

EMPLOYER-EMPLOYEE RELATIONS

1. Within three months of signing of this Agreement, both parties agree to participate in the development and sponsorship of information sessions related to Articles B1 to B20 of the Master Agreement for all Salaried Physicians and all pertinent administrative staff who assist Physicians in their daily tasks as relates to the aforementioned Articles; and to sponsor such sessions on at least an annual basis.

   Such sessions will also include information on relevant Health PEI policies, benefit programs, and the obligations of both parties in a healthy employer-employee relationship.

   Of note, information will be provided on the availability of benefits such as health insurance for retired Salaried Physicians.

2. In addition, as relates to the aforementioned, both parties agree to meet twice a year to resolve issues of misunderstanding and gaps in communication and where necessary, to identify the provision of new information and development of new processes which will enable a healthy employee-employer relationship.

3. The Director of HR shall be the lead representative on behalf of Health PEI with respect to all matters concerning this Letter of Understanding.

APPENDIX A

CONTRACT OF EMPLOYMENT
(Salaried Physician)

THIS CONTRACT MADE

BETWEEN: **Dr._____**

(the "Physician")

- and -

Health PEI

(the "Employer")

IN CONSIDERATION OF the covenants and conditions herein contained, the parties hereto agree that the Physician shall be employed by the Employer on the following terms and conditions:

INTERPRETATION

1. In this Contract, "Master Agreement" means the Agreement entered into from time to time between Health PEI and the Medical Society of Prince Edward Island (the "Medical Society").

TERM

2. The term of this employment shall be for continuous years, commencing on _____ , and shall be subject to: i) Paragraph 17 of this Contract; ii) the Physician's successful completion of a probationary period as defined in Article B16 of the Master Agreement; iii) on-going satisfactory performance by the Physician; and iv) adherence to the terms of this Contract and the Master Agreement.

SERVICES AND RESPONSIBILITES

3. The Physician shall assume all those responsibilities and diligently execute all those duties set out in the Job Description attached hereto. It is understood and agreed that the attached Job Description is subject to review and update in accordance with the Master Agreement. The Physician shall report to the Medical Director and shall follow all reasonable direction as provided to the Physician by the Employer.

4. The Physician shall apply for and maintain admitting privileges at the hospital(s) in which he/she may be required to perform services, and the Employer may require the Physician to provide in-patient care for his/her patients.

5. The Physician shall be subject to the same personnel policies and guidelines that apply to all Health PEI employees, and also to Health PEI Medical Staff Bylaws and hospital rules/regulations, and to all policies adopted by Health PEI in accordance with the Master Agreement. Health PEI shall provide the Physician with access to all such policies, guidelines, bylaws, rules and regulations. Health PEI shall make available, and the Physician agrees to participate in, training opportunities in relation to such policies, guidelines, bylaws, rules and regulations, at no cost to the Physician. For greater clarity, Family Physicians agree to comply with Health PEI's policy on minimum panel size.

6. The Physician shall participate equitably, including weekends and holidays, in an on-call schedule for family physician/specialist services, with individual commitment to be not more frequently than averaging a 1-in-3 call schedule (122 days/year). The Physician shall cooperate in the development of an on-call/vacation schedule to be developed by the Physician and the Employer, and paid according to the provisions of the Master Agreement. The on-call obligation is detailed in the Job Description attached hereto.

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

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

9. The Physician is subject to an annual performance review pursuant to the provisions of the Master Agreement.

PAYMENTS AND BENEFITS

10. The Physician shall be paid in accordance with Article B16 of the Master Agreement, starting at salary Class _____, on the basis of a 37.5 hour work week schedule, which has been developed in consultation with the Physician and approved by the Employer. Salaries shall be pro-rated for part-time work.

11. The Employer shall make deductions from salary payable to the Physician as outlined in the Master Agreement and as required by any provincial or federal statute.

12. The Physician is entitled to the benefits listed below, in accordance with the Master Agreement, including but not limited to:

- Vacation Leave
- Special Leave
- Sick Leave
- Statutory Holidays
- RRSP/Pension Plan contribution
- Long-Term Disability
- Health and Dental Plan
- Life Insurance
- Deferred Salary Plan
- Continuing Medical Education

13. The Physician's aggregate compensation shall be determined by the applicable salary, blended payment, on-call service coverage and other services the Physician may agree to provide from time to time.

14. If the Physician has satisfied all the conditions set out in this Contract and the Master Agreement, the Physician may be paid on a fee-for-service basis for services performed outside their regular work schedule, but only in accordance with Article C10 of the Master Agreement.

LIABILITY

15. The Physician certifies and agrees to provide written verification prior to execution of this Contract that he/she is registered and licensed with the College of Physicians and Surgeons of PEI and is a member of the Medical Society.

16. The Physician shall maintain active membership with the Canadian Medical Protective Association (CMPA) in accordance with the Master Agreement. Acceptance by the Employer of such membership shall not be construed as a waiver of any conditions of this Contract. The Physician shall provide the Employer with written evidence of CMPA membership, and shall notify the Employer of any changes in CMPA membership.

TERMINATION

17. (a) In the event the Physician wishes to terminate this Contract, he/she shall provide as much advance notice as is possible. In no case shall the notice be less than eight (8) weeks.

(b) If the Employer wishes to terminate this Contract, without cause, the Employer shall provide the following advance notice, or pay in lieu thereof, to the Physician:

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

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

(c) The Employer shall be entitled to terminate this Contract with just cause without notice.

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

GENERAL

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

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

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

21. As an employee of the Employer, the Physician agrees to support and participate in planning that is aligned with the Health System Strategic Plans. This general obligation shall not limit the Physician's freedom of expression as an advocate for optimal patient care and for what the Physician believes to be in the best interest of the public health care system. It is further acknowledged that where the Physician is acting in the capacity of representative of his/her peers, such as but not limited to President of the Medical Staff, Chief of Staff, etc., the Physician shall have the right to express the views and concerns of physicians with respect to Health System Strategic Planning.

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

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

SIGNED AND DELIVERED
in the presence of:

_____	_____	_____
WITNESS	**Physician**	DATE
_____	_____	_____
WITNESS	**Employer**	DATE

APPENDIX B

CONTRACT FOR SERVICES
(General)

THIS CONTRACT MADE

BETWEEN: **Dr._____**

(the "Physician")

- and -

Health PEI

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

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

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

INTERPRETATION

1. In this Contract,

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

TERM

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

SERVICES

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

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

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

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

7. The Physician shall participate equitably, including weekends and holidays, in an on-call schedule for family physician/specialty services with individual commitment to be not more frequently than averaging a 1 in 3 call schedule (122 days/year). The Physician shall cooperate in the development of an on-call/vacation schedule to be developed by the Physician and Health PEI. Compensation for on-call services shall be in accordance with the Master Agreement.

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

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

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

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

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

ACCOUNTS AND PAYMENTS

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

    (a) An hourly rate of $_____ as determined by Article C4 of the Master Agreement, for _____ hours of work each week;

    (b) Invoices for services rendered under this Contract shall be submitted to the Physician's respective Medical Director, or designate, for the hours worked during each bi-weekly period;

    (c) Payment shall be made bi-weekly upon the receipt of invoices which have been authorized for payment by the Medical Director; and

    (d) An invoice for services in excess of the agreed upon hours shall be subject to Article C4.4 of the Master Agreement.

    (e) The Physician's aggregate compensation shall be determined by the applicable hourly rate and hours worked, blended payment, on-call service coverage and other services the Physician may agree to provide from time to time.

14. If the Physician has satisfied all the conditions set out in this Contract and the Master Agreement, the Physician may be paid on a fee-for-service basis for services performed outside their regular work schedule, but only in accordance with Article C10 of the Master Agreement.

INDEPENDENT CONTRACTOR

15. The Physician is an independent contractor and he/she is entitled to no other benefits or payment whatsoever other than those specified in this Contract and the Master Agreement.

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

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

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

LIABILITY AND INDEMNIFICATION

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

20. The Physician shall:

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

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

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

TERMINATION

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

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

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

GENERAL

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

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

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

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

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

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

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

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

SIGNED AND DELIVERED
in the presence of:

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

APPENDIX C

CONTRACT FOR SERVICES: LONG TERM CARE

THIS CONTRACT MADE

BETWEEN: **Dr._____**

(the " House Physician")

- and -

Health PEI

WHEREAS Health PEI requires the services of the House Physician to provide medical services to residents and advice to staff of the _____Long Term Care Facility;

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

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

INTERPRETATION

1. In this contract,

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

TERM

2. The term of this Contract shall commence on _____ and shall remain in effect until _____ unless earlier terminated in accordance with articles 17, 18 or 19, or extended by mutual agreement between the parties in writing.

SERVICES

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

4. The House Physician shall provide continuous coverage to the residents of the Long Term Care Facility who do not have a personal physician, and also to residents who have a personal physician who cannot be reached or is otherwise unavailable.

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

6. If at any time during the term of this contract the House Physician cannot perform any of the services described in Schedule "A", he/she shall notify Health PEI immediately and arrange for a replacement House Physician to perform the services. Where a House Physician has selected the option of a standard medical services fee (in lieu of the fee-for-service payment option) as set out in the Master Agreement, he/she shall continue to receive this payment during periods of his/her absence, and shall be solely responsible for paying the replacement House Physician for all services rendered. Where a House Physician has selected the fee-for-service payment option, the replacement House Physician shall also be paid on a fee-for-service basis.

7. Where a House Physician selects the option of a standard medical services fee (in lieu of fee-for-service) as set out in the Master Agreement, the physician shall participate in a shadow billing process determined by Health PEI for the purpose of recording and monitoring patient care service activity at the physician's expense.

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

ACCOUNTS AND PAYMENTS

9. The House Physician shall be paid by the Department in accordance with Article C1 of the Master Agreement, in the following manner:

    (a) a standard administrative and on call fee per bed per annum (for providing twenty four (24) hour/seven (7) day per week coverage for each resident) of $300.00, based on the approved bed capacity of the Long Term Care Facility, to be paid in monthly installments, (this amount includes provision for CME); and

    (b) payment for medical services, either by
        (i) fee-for-service, or
        (ii) a standard medical services fee per bed per annum of $270.00, based on the approved bed capacity of the Long Term Care Facility, to be paid in

monthly installments. If the House Physician elects this option, fee-for-service billing is not permitted, except for hospital inpatient services.

10. In the case of private nursing homes located outside of the municipality of the House Physician, he/she may seek remuneration for travel costs and travel time from the private Long Term Care Facility based on the Medical Society's guidelines for uninsured services.

INDEPENDENT CONTRACTOR

11. The House Physician is an independent contractor and he/she is entitled to no other benefits or payment whatsoever other than those specified in this contract and the Master Agreement.

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

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

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

LIABILITY AND INDEMNIFICATION

15. The House Physician certifies and shall provide written verification prior to execution of this contract that he/she is registered and licensed with the College of Physicians and Surgeons of PEI and is a member of the Medical Society.

16. The House Physician shall:

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

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

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

TERMINATION

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

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

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

    (a) Health PEI reasonably believes that the Physician's conduct may threaten the safety of patients or staff;
    (b) the Physician becomes incapable of providing the services for any reason;
    (c) the Physician is convicted of an indictable offence;
    (d) the Physician fails to hold a valid licence from the College of Physicians and Surgeons of PEI to practice medicine, or is found guilty of professional misconduct by the College; or
    (e) the Physician fails to maintain liability/malpractice coverage with the Canadian Medical Protective Association or equivalent coverage with an insurance carrier satisfactory to Health PEI.

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

GENERAL

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

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

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

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

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

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

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

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

SIGNED AND DELIVERED
in the presence of

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

SCHEDULE "A"

The House Physician's responsibilities shall be to:

a) provide twenty-four hour, seven days a week, "on call" coverage to the _____ _____ (name of facility);

b) provide a minimum average of one visit per week per facility;

c) maintain medical records on all residents/patients under his/her care in keeping with established standards;

d) notify the Chief Health Officer or his delegate of discovery of any communicable disease of which notice must be given under the Public Health Act and regulations;

e) perform a complete physical examination and medical history documentation on admission; thereafter, an annual physical examination would be required unless it is otherwise identified as not warranted; appropriate medical forms must be completed;

f) provide medical services when urgently required for residents with other attending physicians who are not available and have provided no alternate coverage;

g) provide consultation services when required by other attending physicians and collaborate with health care/community agencies (Acute Care, Mental Health, Home Care, Social Services, Pastoral Care, Addiction Services and Island Hospice Association, etc) in coordinating resident/patient care;

h) be involved in a multi-disciplinary team approach to the development of and regular evaluation of resident/patient care plans;

i) perform weekly rounds, assess resident care issues, and provide medical services as required/requested;

j) provide advice regarding such things as stocked medications, narcotics, communicable diseases, and general public health issues such as flu shots, behavioral problem management, visitors;

k) evaluate and assess resident/patient drug profiles at least every three months;

l) comply with established standards of practice for geriatric care and long-term medical care, including those outlined by Accreditation Canada; and

m) ensure that a replacement physician acceptable to the facility is available.

NOTE: Any compensation for exceptional travel time or mileage shall remain the responsibility of the facility requiring the service.

APPENDIX D1

EMERGENCY SERVICE COVERAGE AGREEMENT

(Prince County Hospital or Queen Elizabeth Hospital)

THIS AGREEMENT dated the _____day of _____, 20__

BETWEEN:

Health PEI

-and-

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

THE PARTIES hereto agree as follows:

ARTICLE 1 - DURATION OF AGREEMENT

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

ARTICLE 2 - SERVICES AND COMPENSATION

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

2.2 Health PEI shall fund the provision of this coverage in accordance with Article C2 of the Master Agreement, based on coverage of 38 hours/day at the PCH and 56 hours/day at the QEH. Coverage hours may be increased from time to time if needed and mutually agreed by Health PEI and the Group.

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

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

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

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

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

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

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

ARTICLE 3 - INDEPENDENT CONTRACTORS

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

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

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

3.4 Each Emergency Department Physician shall maintain adequate medical liability coverage through the Canadian Medical Protective Association or equivalent medical liability insurer (ref. sub-article D2.3 of the Master Agreement between Health PEI and the PEI Medical Society).

ARTICLE 4 - GENERAL

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

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

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

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

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

APPENDIX D2

EMERGENCY SERVICE COVERAGE AGREEMENT

(KCMH or Western Hospital)

THIS AGREEMENT dated the _____day of _____, 20__

BETWEEN:

Health PEI

-and-

_____

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

THE PARTIES hereto agree as follows:

ARTICLE 1 - DURATION OF AGREEMENT

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

ARTICLE 2 - SERVICES AND COMPENSATION

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

2.2 Health PEI shall fund the provision of this coverage in accordance with Article C2 of the Master Agreement, based on coverage of 14 hours/day at the KCMH and 12 hours/day at the WH. Coverage hours may be increased from time to time if needed and mutually agreed by Health PEI and the Group.

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

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

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

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

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

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

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

ARTICLE 3 - INDEPENDENT CONTRACTORS

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

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

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

3.4 Each Emergency Department Physician shall maintain adequate medical liability coverage through the Canadian Medical Protective Association or equivalent medical liability insurer (ref. sub-article D2.3 of the Master Agreement between Health PEI and the PEI Medical Society).

ARTICLE 4 - GENERAL

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

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

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

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

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

APPENDIX E

HOSPITALIST SERVICE COVERAGE AGREEMENT

(Prince County Hospital and Queen Elizabeth Hospital)

THIS AGREEMENT dated the _____day of _____, 20__

BETWEEN:

Health PEI

-and-

_____

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

THE PARTIES hereto agree as follows:

ARTICLE 1 - DURATION OF AGREEMENT

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

ARTICLE 2 - SERVICES AND COMPENSATION

2.1 In accordance with Article C14 of the Master Agreement, the Group shall provide continuous hospital inpatient medical coverage for unaffiliated patients at the _____ Hospital in _____.

2.2 Health PEI shall fund the provision of this Hospitalist Service in accordance with Article C14 of the Master Agreement, based on coverage of 2 lines/day at the PCH and 5 lines/day at the QEH.

2.3 The Group and Health PEI shall be jointly responsible for maintaining and, when necessary, recruiting physicians to adequately staff the Hospitalist Service to the funded

lines. The Group shall also be responsible for recruiting physicians for the standby role pursuant to Article C14.11.

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

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

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

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

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

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

ARTICLE 3 - INDEPENDENT CONTRACTORS

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

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

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

3.4 Each Hospitalist Physician shall maintain adequate medical liability coverage through the Canadian Medical Protective Association or equivalent medical liability insurer (ref. sub-article D2.3 of the Master Agreement between Health PEI and the PEI Medical Society).

ARTICLE 4 - GENERAL

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

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

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

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

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

APPENDIX F

BLENDED PAYMENT THRESHOLD ALGORITHM

1. From Medicare billing data, determine the total shadow billing for each physician over the previous 3-month quarter using the following criteria:

   (a) Period equals previous 3-month quarter
   (b) Paid Amount equals $0.00
   (c) Approved Amount is greater than $0.00
   (d) Exclude the following specialty codes:
   Code 17 - Radiation Oncology
   Code 19 - Laboratory Medicine
   Code 23 - Medical Oncology
   Code 27 and 44 - ED On-site Sessional Shadow Billing
   Code 40 - Long Term Care
   Code 94 - Nursing
   Code 95 - Nurse Practitioner
   (e) Report to include columns for Physician Number, Physician Name, Specialty Code, Approved Amount, Paid Amount, Total Records, Total Initial Consultations.

2. From the Employer's Payroll System and the Claims Payment System, determine the actual hours paid to each salaried and contract physician, respectively, in the pay periods ending in the previous 3-month quarter. Exclude salaried/contract hours worked in a hospital where a top-up fee is paid instead of the usual Emergency Department or Hospitalist sessional fees.

3. The proration of quarterly thresholds will be calculated as follows:

   Adjusted (prorated) quarterly threshold =

   $$\text{Basic Quarterly Threshold} \times \frac{\text{Total hours paid for pay periods ending in quarter}}{\text{Total pay periods ending in quarter} \times 75 \text{ hrs/pay period}}$$

4. The Basic Quarterly Threshold applies to both the approved shadow-billing dollar value threshold and the shadow-billing workload threshold (number of claims/consults), as provided in Article C5.

5. Physicians who are at or above the adjusted (prorated) thresholds for both dollar value and workload will be entitled to the Blended Payment, which shall be the applicable percentage of the value of approved shadow-billing claims for that quarter.

6. For the purposes of the shadow billing consultation threshold, “initial consultations” are:

   (i) all fee codes which are identified as initial consultations in accordance with the Master Agreement Preamble 9.A. (codes xx60), plus

   (ii) fee code 0148 which is identified as an initial consultation in accordance with the Master Agreement Preamble 11.B.1, plus

   (iii) fee code 0250 which is identified as an initial consultation for chronic pain in accordance with Master Agreement Preamble 21.M, plus

   (iv) fee codes which are identified as telephone consultations for Specialists and Palliative Care, in accordance with Master Agreement Preamble 11.C.1, plus

   (v) for Psychiatry, for in-patient hospital services only, fee code 1263 (complete re-examination by a medical specialist), plus

   (vi) for Pediatric physicians only, fee code 1136 (attendance at maternal delivery +/- intubation), plus

   (vii) for Internal Medicine and Pediatric physicians, the following fee codes where attendance at the first day of admission to an ICU or NICU also includes a consultation: 0595, 1145, 1148, 1150, 1154, plus

   (viii) for Obstetrics/Gynecology physicians, fee code 0700 (initial prenatal visit), plus

   (ix) for Obstetrics/Gynecology physicians, fee code 0795 (outpatient assessment for complication of pregnancy/labor).

APPENDIX G

"For Information Only"

MATERNITY/PARENTAL BENEFITS PROGRAM

INFORMATION FOR PHYSICIANS

The Medical Society administers a Maternity/Parental Benefits Program for eligible physicians on Prince Edward Island. The Program provides partial income replacement for a physician parent who wants to take a temporary leave from PEI practice for the birth/adoption of a child. This Program is intended to financially assist physicians who suffer a loss of income because they provide little or no physician services during the period of leave. The program covers PEI physicians regardless their income modality (fee-for-service or alternate payment).

Am I eligible to claim?

If you have practiced medicine on PEI immediately prior to taking a leave of absence to care for a newborn or adopted child aged 5 or under, you are eligible to file a claim for benefits. These benefits are available to physicians who earned income directly or indirectly from Health PEI immediately prior to their leave for providing medical services and/or administrative duties. Applicants must have held a "Full" or "Full Time" license with the College of Physicians and Surgeons of PEI prior to the leave, and are required to continue to pay dues to the Medical Society. For greater clarity, these benefit programs are not available to physicians who, prior to the start of the parental leave, held a short-term or temporary license or served as a locum.

What benefits are available?

In general, you are eligible for up to 17 consecutive weeks of benefits as long as you have earned qualifying income for at least 17 weeks in the 12 months prior to your leave. If you have earned qualifying income for less than 17 weeks in the year prior to your leave, your maximum benefit period will be equal to the number of weeks you actually worked. You must take a minimum two weeks leave. In the event of a still birth, or death soon after birth, in cases of 19 or more weeks gestation, a compassionate benefit of up to one month is available to qualifying physicians.

Your parental leave claim period can begin as early as four weeks prior to the expected birth/adoption, but no later than six weeks after the baby's discharge from hospital or date of placement of your adopted child. Claimants must file an application for benefits within six months of the birth or adoption of a child. Thereafter, claims will not be accepted.

The amount of your weekly benefit is based on your qualifying income over the past year. It will be calculated as 60% of your average gross weekly earnings over the best six months of the 12 months (or portion thereof) immediately prior to your leave. However, the maximum gross benefit is $1,200 per week, regardless of your qualifying income. If you have worked less than six months in the past year, your qualifying income will be calculated on all weeks worked prior to the leave. Benefits will not be adjusted in the case of retroactive pay increases.

Can I earn other income while on leave?

While benefits are being paid, you may also receive up to $2,000 gross income per bi-weekly claim period from all other sources. Your weekly benefit will be reduced, dollar for dollar, if you receive more than $2,000 income from other sources during that bi-weekly claim period. Other sources of income include salary top-ups, vacation pay, fee-for-service remittance income, disability insurance benefits, etc. (Employment Insurance benefits are deducted from your weekly benefits under this Program.). However, any income you receive while on leave for services you provided *prior* to the start of your parental leave should **not** be reported. It does not affect your benefit under this program. Only income earned and received while on leave should be reported.

Can I share the leave with my spouse?

If both parents are physicians, they can *sequentially* share the 17 consecutive week benefit period if both take a leave of absence from their practice. The amount of benefit paid in any week will be based on the qualifying income of whichever parent is on leave at that time.

What else should I know?

Benefits are only payable to physicians who are resident on PEI during the benefit period. Relocation from the province will automatically terminate benefits.

Maternity/Parental benefits are taxable and the Medical Society is required to submit income taxes on your behalf. We automatically will submit taxes at the maximum rate. A T4A slip will be issued to you for income tax purposes.

How do I apply?

Contact the Medical Society by calling 368-7303. You will be sent an Application for Benefits form. You must complete and return the Application form to establish your eligibility for benefit (the maximum weekly benefit you are eligible for and the maximum number of consecutive weeks that you may claim).

Thereafter, you will be sent a series of simple biweekly Claim forms. To be eligible to receive a benefit for each biweekly period, you must submit a Claim form to detail income you have earned and received from *all other sources* during the claim period. The Medical Society will calculate your benefit and send you a cheque two weeks following the end of each claim period.

What information does the Medical Society require?

You must begin your claim within 6 weeks of the adoption/discharge. To initiate your claim the Medical Society needs the following information, which you will be asked to provide on the Application for Benefits form:

- Identifying information about yourself
- Key dates affecting your maternity/parental leave
- Information on your qualifying income for each month during the 12 months prior to your leave
- Applications must be received within six months of the birth or adoption of a child (however, the actual leave must have begun no later than 6 weeks after the date of the birth or adoption).

In addition, for audit and verification purposes, you must agree to provide copies of relevant financial reports (e.g. income tax returns, Health PEI remittances, other employer remittances, etc.) upon our request.

Finally, you must submit proof of the birth/adoption, such as a physician's or hospital's report of the birth, or birth certificate/adoption certificate.

SAMPLE CALCULATIONS

1. Determination of Qualifying Income & Benefit Amount

Your benefit level is affected by your past gross income. You must report your monthly gross income on the application form so we can calculate your qualifying income. It will be calculated as 60% of your average gross weekly earnings over the best 6 of the 12 months (or portion thereof) immediately prior to your leave. However, the maximum benefit available to all claimants is $1,200 per week regardless of prior income.

Example

- Salaried physician who earned $12,000 gross income per month for all 12 months prior to the start of actual leave period.
- Gross income on best 6 months is 6 x $12,000 = $72,000.
- Qualifying income per week is $72,000 ÷ 26 weeks = $2,769
- 60% of qualifying income is .6 x $2,769 = 1,661.
- Benefit is maximized at $1,200 per week.

Example

- A fee-for-service physician worked only 8 months prior to start of actual leave. We use the gross income from the best 6 months: $10,000, $11,000, $12,200, $10,900, $9,200, $10,500.
- Total gross over best 6 months = $63,800.
- Qualifying income per week = $63,800 ÷ 26 weeks = $2,454
- 60% of qualifying income is .6 x $2,454 = $1,472
- Benefit is maximized at $1,200 per week.

2. Factors Which Can Change Your Benefit Amount

You are allowed to earn and receive a maximum of $2,000 of income per bi-weekly claim period from all other sources in addition to your maternity leave benefit. If you earn and receive more than that, the extra earnings are deducted dollar for dollar from your benefit.

Example

- Salaried physician is entitled to $1,200 per week from the Maternity/Parental Benefit Program.
- Physician also receives $417 a week for E.I. benefits.
- There is a reduction to the leave benefit equal to E.I. received.

Example

- Physician is entitled to $1,200 per week from the Maternity/Parental Benefits Program.
- Physician receives a substantial payout for delayed claims while on leave.
- There is no reduction to the leave benefit because the payout was for services provided before the parental leave period began. There is no need to report income for such services.

Example

- Physician is entitled to $1,200 per week from the Maternity/Parental Benefits Program.
- Physician decides to provide services during leave and subsequently earns and receives a $2,500 remittance for those services while still on leave. Physician will receive only a $1,900 benefit for the biweekly leave period because she/he exceeded the $2,000 bi-weekly maximum income from other sources by $500 ($2,500-$2,000 = $500).

Further Questions?

If you have any other questions or concerns about this Program please contact the Medical Society office.

APPENDIX H

"For Information Only"

EMERGENCY DEPARTMENT ON-SITE COVERAGE FUNDED HOURS

The following is the funded hours of Emergency Department on-site coverage per day for each of the listed facilities:

Queen Elizabeth Hospital	56 hours
Prince County Hospital	38 hours
Kings County Memorial Hospital	14 hours
Western Hospital	12 hours

APPENDIX I

"For Information Only"

LONG TERM CARE FACILITIES and BED COUNT

The following list constitutes the Long Term Care facilities and applicable LTC bed count in the province, as of February 22, 2017:

(a) Standard Long Term Care facilities:

Government Facilities:	**LTC Beds** (incl. Respite)
Maplewood Manor	48
Margaret Stewart Ellis	25
Stewart Memorial Manor (21 + 2 respite)	23
Wedgewood Manor	76
Summerset Manor	82
Riverview Manor	49
Colville Manor	52
Sherwood Home (14 + 2 respite @ 1.5 each)	17
Beach Grove Home	131
The Mount	30 (when fully operational)

Private Nursing Homes:	**LTC Beds**
Garden Home	131
Atlantic Baptist Nursing Home	101
MacMillan Lodge	20
Clinton View Lodge	34
Whisperwood Villa	61 + 2 temporary
Gillis Lodge	49 + 19 temporary
Southshore Villa	31
Park West Lodge	15 + 1 temporary
Andrews of Summerside	10

(b) Non-Standard Long Term Care facility (Prince Edward Home):

Long Term Care	80
Respite	2
Palliative	8
Restorative	11
Chronic (under age 60)	27 (equivalent 41)

These bed numbers are subject to change by Health PEI during the term of this contract.

APPENDIX J

"For Information Only"

LOCUM TENENS POLICY

DEFINITION:

A locum tenens physician is a licensed physician who is substituting and providing services for another fully licensed physician (the resident physician) or providing temporary service in a vacant practice.

PURPOSE:

The purpose of a Locum Tenens arrangement is:

a) to allow existing resident physicians time off for vacation leave, CME and sick leave;
b) to provide temporary service in a vacant practice until a permanent replacement is approved.

PROCEDURE:

1. The locum physician shall have a temporary billing number or a permanent billing number if he/she is part of the existing physician complement. Both physicians must complete the Locum Tenens Information Form attached hereto as Schedule A. Only one of the two physicians is permitted to bill during the period of the locum (resident physician's number is deactivated).

2. The locum physician may be compensated either by fee-for-service or by alternate funding. Where alternate funding is the modality, the locum physician shall be paid at the rate for which he/she is qualified in accordance with Article B18 or C4, as the case may be. In addition, the locum shall be eligible for the same compensation for on-call services as is payable to the resident physician, including, but not limited to, on-call per diems and retainers, as the case may be.

3. Where a locum tenens is filling a vacancy or providing community-based on call the locum physician must work a minimum of one day to be eligible for travel and accommodation allowance.

4. Both physicians must include time of day as indicated on the application form (commence and/or cease, particularly for part days). Failure to do so could result in claims being rejected.

5. Recovery for overhead expenses, as applicable, is to be negotiated between the resident physician/clinic and the locum tenens physician.

SCHEDULE A

LOCUM TENENS
INFORMATION FORM

Surname	First Name	Initials	Billing #

Name of Physician Being Temporarily Replaced _____ Billing # _____

Date & Time Practice Commences: _____

Date & Time Practice Ceases: _____

Address of Temporary Practice: _____

_____

_____

Address Payment to be Forwarded to: _____

_____

_____

_____

Signature of Physician Being Replaced

DEPARTMENT OF HEALTH & WELLNESS
RECRUITMENT AND RETENTION SECRETARIAT POLICY

POLICY NAME: **LOCUM TENENS SUPPORT PROGRAM**

EFFECTIVE DATE: August 3, 2010

APPROVED BY: _____
Department of Health and Wellness

DEFINITION:

A locum tenens physician is a licensed physician who is substituting and providing temporary services for another fully licensed physician (the permanent physician) or providing temporary service in a vacant practice.

POLICY STATEMENT

In support of the Locum Tenens Policy outlined in the Master Agreement between the Medical Society of PEI and the Government of PEI, the Health Recruitment and Retention Secretariat and Medical Affairs have developed the following policy for the Locum Support Program:

1. Decisions regarding locum coverage requirements reside with the network/site Medical Director. The respective Medical Director will review a locum request to determine if it is appropriate and meets the policy outlined below. If the request is appropriate, he or she will approve it and forward it to the Recruitment & Retention Secretariat for final confirmation, support, and payment.

2. Permanent physicians may request locum coverage in the following instances only:

    2.1 There is at least a 1.0 full-time equivalent vacancy in the physician complement in the service area and the permanent physician will be absent from his/her practice for a 3-week period or greater;

    OR

    2.2 Permanent physicians are expected to coordinate vacations within their physician group, but in the event that two or more physicians must be away at the same time and there is a requirement of the permanent physician to provide coverage to the area emergency department, a locum may be requested and approved at the discretion of the respective network/site Medical Director.

    OR

2.3 There is no current vacancy in the physician complement in the service area; however, the permanent physician will be absent from his/her practice for more than a 4-week period for the following reasons: sick leave, special leave, paternity leave and maternity leave;

OR

2.4 The permanent physician is part of a specialty area consisting of three or fewer physicians for the service area. In these instances, the period of absence can be less than 3 weeks.

3. Locum physicians replacing a fee-for-service physician have the option of working under a fee-for-service or a contract-for-service arrangement.

3.1 If the locum physician works on a contract-for-service basis, the permanent physician is eligible for subsidization for overhead costs at a regular rate set by the Division of Medical Affairs on April 1 of each year. This rate can be paid on a daily/weekly/or monthly basis.

3.2 If the locum physician works on a fee-for-service basis, the permanent physician is responsible to negotiate a rate with the locum physician to cover the cost of office overhead, which is paid by the locum physician to the permanent physician.

4. In specialty areas with a complement of three (3) or fewer physicians in which a vacancy exists, a guaranteed minimum of $1,500 per weekend day will be offered to facilitate locum coverage. Recruitment and Retention Secretariat will provide $1,125 (if locum physician chooses on-call retainer plus fee for service) or $875 (if physician chooses on-call per diem only) toward the guaranteed minimum for each approved locum. Payment will be issued upon the submission of an invoice by the service area.

5. Requests for locum coverage by network/site Medical Directors should be made as far in advance as possible to allow for licensure. If the locum request meets the Locum Support Program criteria, Recruitment and Retention shall provide the site with a list of available locum physicians. The network/site must secure the locum service and the permanent physician must make contact with the locum physician. Recruitment and Retention Secretariat will provide C.V.'s, advice, support, and assistance to the network/site throughout the process of arranging the locum service.

6. Checklists have been developed for the permanent physician, locum physician, and administrative coordinators to ensure the process to finalize orientation, payment, licensing, work site arrangements and other details involved in preparing the locum physician to begin working is completed.

7. The Locum Support Program covers the following:

7.1 Return economy airfare up to a maximum of $2,000. In an extenuating circumstance, approval for an amount greater than $2,000 must be approved by the Manager of Recruitment and Retention. Travel by car will be reimbursed according to the current government mileage rates up to no more than the cost of one economy return air ticket. Bridge and road toll fees will be covered. Receipts are required.

7.2 Medical Society fees

7.3 College of Physicians and Surgeons of PEI licensure fees.

8. Daily Locum Support Stipend:

8.1 From October 1 to May 31 of each year, the locum physician is entitled to a stipend of $150 for each day worked to help offset accommodation and car rental costs. The total yearly maximum is $7,500 calculated on a fiscal year basis from April 1 to March 31 of each year. In an area of significant need, the maximum of $7500 may be exceeded. To be exceeded, the network/site Medical Director must seek approval from the Manager of Recruitment and Retention and the Director of Medical Affairs.

8.2 During peak tourism season, June 1 to September 30, the locum physician is entitled to a stipend of $200 for each day worked to offset accommodation and car rental costs. The total yearly maximum is $7,500 calculated on a fiscal year basis, from April 1 to March 31 of each year. In an area of significant need, the maximum of $7,500 may be exceeded. To be exceeded, the network/site Medical Director must seek approval from the Manager of Recruitment and Retention and the Director of Medical Affairs.

8.3 To obtain the stipend, the physician must complete the Locum Support Stipend Form, have the dates verified and signed by an individual designated by network/site, and send to the Recruitment and Retention Secretariat at the end of each month of the locum.

9. The Locum Support Program does NOT cover costs associated with the following:
- CMPA dues
- letters of good standing
- medical examinations
- work permits
- cell phones
- internet or satellite service
- meals
- cleaning fees
- travel time to and from the locum
- travel to and from work for the duration of the locum

10. Permanent Prince Edward Island Physicians who perform locum services are eligible for reimbursement from the Locum Support Program for in-province travel (as per Treasury Board policy) and accommodation costs, with receipts, to a total maximum of $150/day. Reimbursement for travel and accommodations cannot exceed $150 a day, except during the peak tourism season as described above in article 8.2. Island physicians providing locum services shall not be eligible for reimbursement for "travel time" to and from the locum.

11. In the event of a physician shortage for more than 30 days in clinical groups of 5 or fewer providing on-call coverage, the network/site physician shall be eligible for reimbursement according to clause C 3.7 of the Master Agreement.

PERMANENT PHYSICIAN SEEKING LOCUM
Locum Program Checklist

1. Ensure need for the locum is requested and approved through the network/site Medical Director who will forward request to the Recruitment and Retention Secretariat.

2. Complete the Locum Tenens Request Form and fax to the Montague Medicare Office at (902) 838-0940 once the locum is confirmed.

3. Work with network/site administrative coordinator to ensure a package of forms related to licensure and credentialing is forwarded to the locum.

4. Contact locum tenens physician and ensure dates are confirmed.

5. Ensure your administrative staff assist with billings for the locum physician.

6. If locum physician is billing fee-for-service for all services, make arrangement with locum physician for the coverage of overhead expenses.

7. If locum physician is on a contract-for-service, ensure the physician submits hours worked by fax to the Montague Medicare Office (902) 838-0940.

RECRUITMENT AND RETENTION SECRETARIAT
LOCUM SUPPORT STIPEND REQUEST FORM

The completion of this form is necessary for the processing of locum payments to all locum physicians. The payment will be received by separate cheque. For any assistance in completing this form, please call the Recruitment and Retention Secretariat at (902) 368-6302/620-3874

INVOICE FOR THE LOCUM STIPEND FOR THE MONTH OF _____

Invoice to: Locum Support Program, Recruitment and Retention Secretariat
Department of Health and Wellness, 16 Garfield Street
Charlottetown, PE C1A 7N8 **OR** Fax (902) 620-3072

Name of physician _____

Address _____

Please indicate dates (including hours) worked in the above month (or attach copy of sheet with dates and hours worked with approved signature):

	hrs.		hrs.		hrs.		hrs.
Day 1	_____	Day 9	_____	Day 17	_____	Day 25	_____
Day 2	_____	Day 10	_____	Day 18	_____	Day 26	_____
Day 3	_____	Day 11	_____	Day 19	_____	Day 27	_____
Day 4	_____	Day 12	_____	Day 20	_____	Day 28	_____
Day 5	_____	Day 13	_____	Day 21	_____	Day 29	_____
Day 6	_____	Day 14	_____	Day 22	_____	Day 30	_____
Day 7	_____	Day 15	_____	Day 23	_____	Day 31	_____
Day 8	_____	Day 16	_____	Day 24	_____		

Daily Stipend Claim of $150 X _____ days worked: (a) _____
From October 1 - May30

Daily Stipend Claim of $200 X _____ days worked: (b) _____
From June 1 - September 30

Travel Costs (attach receipts): _____

TOTAL AMOUNT PAYABLE **$ _____**

Note 1: Stipend allowance is subject to a maximum of $7,500 over a 12 month period (April 1 - March 31) to assist with travel and accommodation costs.

Signature of Locum Physician _____ Date_____

FOR OFFICE USE ONLY: (Must be legible or please print) Name

Date(s) worked verified by Network representative _____

APPENDIX K

"For Information Only"

HEALTH PEI
POLICIES AND PROCEDURES MANUAL

POLICY NAME: **PHYSICIAN HONORARIA POLICY**

EFFECTIVE DATE: April 1, 2001

APPROVED BY: _____
Health PEI

INTRODUCTION:

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

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

1.0 INTERPRETATION/DEFINITIONS:

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

(a) "Chairperson" means the person appointed by the Health PEI to hold that position or to act as chairperson in the absence of the appointed chairperson

(b) "Committee" means all Provincial committees established by the Health PEI. This excludes those committees where physicians are required to participate as part of their usual medical staff functions or as a condition to having admitting privileges in that facility.

(c) "Honoraria" means rate of compensation paid to a person for attending a committee meeting or any other meeting the person is requested to attend, based on their capacity as chairperson or member of a committee.

2.0 APPROVAL PROCESS:

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

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

3.0 ELIGIBILITY FOR HONORARIA:

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

4.0 HONORARIA RATES:

As per Article C9 in the Master Agreement.

NOTE: Meeting time does not include travel time.

5.0 TRAVEL EXPENSES:

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

6.0 ADMINISTRATION:

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

PHYSICIAN HONORARIUM PAYMENT FORM

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

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

Honorarium amount: Health PEI shall provide reimbursement directly to eligible physicians at the rate $200/hour, or part thereof in excess of 15 minutes, to a maximum of $1,200/day.

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

Physician Name: _____ Employee ID: _____

Address: _____

Committee Name	Meeting Date	Start Time	End Time	Honorarium Amount	Travel Distance
			TOTAL:	$	km

Prepared By: _____ Date Prepared: _____

Approved By: _____ Date Approved: _____

FOR OFFICE USE ONLY:

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

APPENDIX L

"For Information Only"

NEW FEE CODES AND RE-DEFINED FEE CODES

The following is a list of all new fee codes and fee codes which have been redefined or reworded, which are now incorporated into the Tariff of Fees, attached hereto as Schedule "A".

New fee codes are flagged with an asterisk (*), and redefined fee codes are shown with the wording changes in the service descriptions in *italics*.

All new and substantively redefined fees listed here shall be effective as of June 1, 2017. Increases to all other fees listed in the Tariff of Fees shall be effective on April 1, 2017.

Description		Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
On-Call Services						
On-Call Retainer - Medical Oncology (Provincial)	*	**2390**			300.00	300.00
On-Call Retainer - Radiation Oncology (Provincial)	*	**4840**			300.00	300.00
On-Call Retainer - Overflow Unaffiliated Inpatients (QEH)	*	**0066**			100.00	100.00
On-Call Per Diem (in lieu of Retainer Fee plus FFS) - Salaried Specialists only						
On-call Per Diem (in lieu of FFS) - Internal Medicine - **See Article C3.2**	*	**0504**			500.00	500.00
On-call Per Diem (in lieu of FFS) - Pediatrics - **See Article C3.2**	*	**1152**			500.00	500.00
On-call Per Diem (in lieu of FFS) - ENT - **See Article C3.2**	*	**1065**			500.00	500.00
On-call Per Diem (in lieu of FFS) - Ophthalmology - **See Article C3.2**	*	**0855**			500.00	500.00
On-call Per Diem (in lieu of FFS) - Laboratory Medicine - **See Article C3.2**	*	**1955**			500.00	500.00
On-call Per Diem (in lieu of FFS) - Medical Oncology - **See Article C3.2**	*	**2380**			500.00	500.00
On-call Per Diem (in lieu of FFS) - Radiation Oncology - **See Article C3.2**	*	**4855**			500.00	500.00
On-call Per Diem (in lieu of FFS) - Palliative Care - **See Article C3.2**	*	**0073**			400.00	400.00
Office Visits						
Basic Office Visit - See Preamble 9.F (*suspended Oct.01, 2017*)		**0123**	28.00	28.00	28.00	-------
Walk-In Clinic Visit - **See Preamble 9.F.1** (*effective Oct..01, 2017*)	*	**0094**			25.00	25.00
New Patient Fee (*eliminate Apr.01, 2017*)		**0010**	150.00	150.00	-------	-------
Hospital Emergency Department Visits						
ED sessional overnight premium (00:00-08:00)-weekday - **See Preamble 12.A.5**	*	**0076**			43.75	43.75
ED sessional overnight premium (00:00-08:00)-Sat,Sun,Holiday - **Preamble 12.A.5**	*	**0077**			29.75	26.25
Telephone Consultation (specialists)						
Telephone Consultation (Geriatrics) - **See Preamble 11.C.1**	*	**2850**			46.08	46.80
Telephone Consultation (Dermatology) - **See Preamble 11.C.1**		**0350**			46.08	46.80
Telephone Consultation (General Surgery) - **See Preamble 11.C.1**	*	**0450**			46.08	46.80
Telephone Consultation (Plastic Surgery) - **See Preamble 11.C.1**	*	**9750**			46.08	46.80
Telephone Consultation (Vascular Surgery) - **See Preamble 11.C.1**	*	**0420**			46.08	46.80
Telephone Consultation (Obstetrics/Gynecology) - **See Preamble 11.C.1**		**0750**			46.08	46.80
Telephone Consultation (Ophthalmology) - **See Preamble 11.C.1**	*	**0850**			46.08	46.80
Telephone Consultation (Orthopedics) - **See Preamble 11.C.1**		**0950**			46.08	46.80
Telephone Consultation (Otolaryngology) - **See Preamble 11.C.1**	*	**1050**			46.08	46.80

Description		Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Telephone Consultation (Psychiatry) - **See Preamble 11.C.1**	*	**1250**			46.08	46.80
Telephone Consultation (Urology) - **See Preamble 11.C.1**	*	**1350**			46.08	46.80
Telephone Consultation (Physical Medicine) - **See Preamble 11.C.1**	*	**1650**			46.08	46.80
Telephone Consultation (Medical Oncology) - **See Preamble 11.C.1**	*	**2350**			46.08	46.80
Telephone Consultation (Radiation Oncology) - **See Preamble 11.C.1**	*	**4850**			46.08	46.80
Telephone Consultation (Medical Microbiology) - **See Preamble 11.C.1**	*	**4350**			46.08	46.80
Telephone Consultation (Neurology) - **See Preamble 11.C.1**	*	**2225**			46.08	46.80
Diagnostic & Therapeutic Procedures						
Chronic Dialysis - subsequent treatment - See Preamble 21.L		**2137**	74.00	74.00	75.78	76.96
ED *& Critical Care* Ultrasound - See Preamble 21.H		**2900**	30.00	30.00	30.72	31.20
Morbid Obesity Premium (Surgery) - See Preamble 14.E.10	*	**0074**			100.00	100.00
Morbid Obesity Premium (Anesthesia) - See Preamble 18.L	*	**0075**			100.00	100.00
Immunization – Influenza (Reporting Only) - See Preamble 21.G.4	*	**0081**			0.00	0.00
Immunization - Pneumococcal (Reporting Only) - See Preamble 21.G.4	*	**0082**			0.00	0.00
Immunization - Tetanus/pertussis (Tdap) (Reporting Only) - See Preamble 21.G.4	*	**0083**			0.00	0.00
Immunization - Hepatitis A/B (Reporting Only) - See Preamble 21.G.4	*	**0084**			0.00	0.00
Immunization - Varicella zoster (Reporting Only) - See Preamble 21.G.4	*	**0085**			0.00	0.00
Miscellaneous Surgical Procedures						
Insertion of Loop recorder *(surgeon or internist)*		**4778**	107.00	107.00	109.57	111.28
Caesarian Section *(procedure only)*		**6004**	599.20	599.20	613.58	623.17

SCHEDULE A

Schedule of Payments for Medical Services

April 1, 2015 - to - March 31, 2019

Health PEI
Medicare Office
PO Box 3000
Montague, PE C0A 1R0
(902) 838-0900

TARIFF OF FEES

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PREAMBLE TO THE TARIFF OF FEES

1. INTRODUCTION

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

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

2. GENERAL CONSIDERATIONS

As a general overall policy, the Tariff of Fees should be applied in accordance with commonly established practices in the billing of patients prior to the introduction of the *Hospitals Act* and *Health Services Payment Act.*

In general, it is expected that documentation will be on a patient's chart that support claims for services. If such documentation is absent, the claim may not be paid. In particular, documentation must support that the services provided meet the criteria and/or requirements which are specified in this Preamble and Tariff and so the claim is eligible for payment. Further, any fee code which is affected by time of day must be supported by a start time documented on the patient's chart. Any time-related fee code which is affected by the time spent providing the service must be supported by documentation of time spent on the patient's chart. Any fee code which is affected by both time of day and time spent requires documentation of both start time and time spent on the patient's chart. Time-related fee codes are those codes for which physician bills for services based on 'blocks of time' or where there is a minimum time requirement specified in the Preamble or Tariff.

The term "he" shall be considered gender neutral throughout the tariff.

Electronic Submission of Claims - All claims must be submitted in an electronic form within three (3) months from the date of the service.

3. ACCEPTANCE OF TARIFF

For the purpose of payment for services under the Plan, physicians shall claim 100% of the Tariff of Fees and the accepted claims shall be paid at the tariff established by the Department of Health in accordance with Section 4 (b) of the *Act*.

A participating physician may not charge an amount above the Tariff of Fees.

4. PARTICIPATION OF PHYSICIANS

All physicians practicing in Prince Edward Island are considered to be participating physicians under the Act, unless they opt out in accordance with Section 10.1(1)(2) of the Act. Consequently, accounts for basic health services provided to entitled persons are to be submitted to, and shall be paid by, Health PEI.

4.A. Election to Opt Out

A physician may opt out of the Plan by notice in writing to Health PEI as provided for under Section 10(1)(2) of the *Health Services Payment Act.*

4.B. Patient Claim Information

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

4.C. Election to Participate

A physician may opt back into the Plan by application in writing to Health PEI as provided for under section 10(1)(2) of the Health Services Payment Act.

4.D. Selective Service(s) Opting Out

4.D.1 Procedure to Become Non-Participating Physician

Opted-in physicians may elect to opt out for any given patient for the total management of the condition under care, including any complications which may develop; for a series of services for which a composite fee applies, or for which the fees are inter-related, the physician would have to either opt in or opt out for the entire series of services.

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

If the opted-in physician wishes to opt out for a particular patient or a particular service, he may, as at present, submit his claim to Health PEI on behalf of the patient. The patient shall then receive payment from Health PEI as per the Tariff of Fees and shall be responsible for additional fees from the opted out physician.

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

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

(i) The physician must inform the patient prior to the rendering of the service that he or she shall be billed directly for the service(s) being rendered;

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

5. MEDICAL NECESSITY

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

5.A. Services Rendered Without Medical Supervision

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

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

5.B. Delegated Functions

The following fee codes may be billed as the percentage of the Tariff of Fees as specified in this Preamble when these services are delegated by a fee-for-service physician who is approved by Health PEI to bill for delegated services:

Fee codes 0113, 0123, 0115, 2228, 2229, 2230, 2231, 2501, 2505.

The delegated functions percentage rate to be applied to the designated fee codes shall be as follows:

Apr-01-2015	Apr-01-2016	Apr-01-2017	Apr-01-2018
66⅔%	66⅔%	72.3%	75%

Approval of such arrangements shall be at the sole discretion of Health PEI, after consultation with MSPEI, and shall be limited to physicians who work 75% or greater on a fee-for-service basis. The visit is required to be documented on the patient's chart.

The physician shall submit the bill at the listed percentage of the standard rate with a notation in the comment section indicating that the service was delegated to another health professional employed by the physician. Role Code #28 must be used for all delegated services for which a fee-for-service physician is submitting a claim.

6. INDEPENDENT CONSIDERATION (fee code 9999)

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

(i) Where a fee is listed as Independent Consideration in the Tariff of Fees.
(ii) When requested by a physician (An explanatory note must accompany the claim).
(iii) When a service is claimed which is not listed in the Tariff of Fees.

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

7. EMERGENCY VISIT DEFINITION

An emergency visit refers to a situation where the demands of the patient and/or the physician's interpretation of the condition is such that he responds immediately at the sacrifice of regular office hours or routine medical practice. The need for immediate response is the intended controlling feature. Immediate attendance because of a personal choice or availability of physician is not considered an emergency visit. Urgent visits for acute or chronic conditions, which do not interfere with routine medical practice do not constitute an emergency visit. The premium fee (xx94) for emergency visits shall be added to the regular fee. Time of day must be indicated on the claim.

8. HEALTH PROMOTION COUNSELING (fee code 2505)

Counseling patients and/or relatives in providing advice, encouragement, and direction for health care topics is an insured service. Such topics may include, but are not limited to, lipid or dietary counseling, smoking cessation, healthy heart advice, allergy counseling, etc. This service is payable in blocks of five (5) minutes with a minimum of fifteen (15) minutes to a maximum of 45 minutes per session and one (1) hour per patient per month. Such time shall be recorded on the patient's chart. Physicians can not submit a claim for this service on a day when visit fees are claimed.

9. OFFICE VISIT CODES

Office visit codes refer to services provided by a physician to a patient for diagnosis and/or treatment in the office, and shall generally be limited to one per physician per patient per day. In situations where two or more members of the same family attend a physician's office on the same day, each patient shall be treated as a separate individual for the purpose of claims submitted**.**

9.A. Consultation (fee codes xx60)

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

The referral must be initiated by a Physician, or a Resident licensed by the College of Physicians and Surgeons of PEI, or a Nurse Practitioner, or other licensed health professional related to a specialist's field of practice, such as optometrist for ophthalmology, physiotherapist for orthopedic surgery, psychiatric nurse for psychiatry, and other similar referrals as approved by Health PEI. Consultation requests by patients, their representatives, or a third party acting on their behalf, do not qualify as consultations payable under the Plan. Family Physicians can take referrals from allied health professionals for unaffiliated patients.

No consultation fee shall be claimed unless the consultation has been specifically requested by the referring practitioner and unless a written report is rendered. The referring practitioner must forward a written request for a consultation, which should include a description of the presenting complaint, the treatment undertaken (if any) and any relevant diagnostic test findings and patient information. The consulting physician must show the name of the referring practitioner in the appropriate section on his claim and must retain a copy of the written request for consultation, signed by the referring practitioner in the patient's chart. He must also submit his findings along with recommendations for further care, in writing, to the referring practitioner or family physician. Consultation claims for referrals from non-physicians must show "999" in the "referred by" field and a comment indicating the referring practitioner.

Discussion of a case by telephone or by letter between two physicians does not qualify as a consultation and is therefore not payable under the Plan, except if billed as a telephone consultation by an In-Province or Out-of-Province specialist or by a Palliative Care Physician, as per 11.C.1.

9.B. Consultation by a Family Physician (fee code 0160)

A consultation by a family physician requires that the consultant obtain a relevant history and perform a relevant physical examination, review pertinent x-ray films, laboratory or other data and submit his opinion and recommendation in writing to the referring physician or Nurse Practitioner. The patient should return to the referring physician or Nurse Practitioner for continuing care. The condition of the patient as justified by the diagnosis is the control mechanism for paying for such consults between family physicians. Trivial or minor problems

shall result in the consult being reduced to an office visit or rejected on grounds of "not medically necessary." Information on the claim must substantiate necessity of consult between family physicians. A referral by a Nurse Practitioner to her collaborating physician shall not be considered a consultation.

9.C. Repeat Consultation (fee codes xx62)

A repeat consultation shall be a re-assessment for the same or related illness, or complication thereof, within 30 days of the initial consultation. A repeat consultation shall contain all the required elements of a consultation and implies that some interval care has been delivered by the referring practitioner prior to the request for a repeat consultation. Situations where a consulting physician requests a patient to return at a later date for an assessment does not qualify as a repeat consultation as there has been no written and signed referral by the attending practitioner.

9.D. Comprehensive Office Visit (fee codes xx10)

A comprehensive office visit is an in-depth evaluation of a patient necessitated by the seriousness, complexity, or obscurity of the patient's complaint(s) or medical condition. A comprehensive office visit shall comprise of a full history, which includes a history of the presenting complaint as well as past medical history, a full functional inquiry, a detailed examination of relevant body systems, a recommendation for treatment and all the relevant advice related to the presenting complaint. A detailed record of the findings and advice to the patient shall be considered part of the examination.

A comprehensive office visit may not be claimed within 30 days of a previous visit for the same complaint or medical condition. Visits provided within a 30-day period for the same condition or complication should be claimed as a limited office visit.

With regard to specialists,

(i) fee codes xx10 shall be billed where the patient has been initially referred for consultation and a subsequent visit relates to the same diagnosis, and

(ii) these visits can be billed to a maximum of four times within a twelve-month period. If additional such visits are required, a comment on the claim shall be required.

9.E. Limited Office Visit (fee codes xx13)

A limited office visit is a service rendered to a patient who presents with one or more complaints that require the physician to take a history of the presenting complaint(s), examine the affected part, region, or system, and provide a corresponding diagnosis and recommendation for treatment and/or care. The limited office visit is less involved than the comprehensive visit in terms of the functional inquiry, physical examination and documentation of the prior history, but shall require a minimum of 10 minutes of physician time, subject to Section 9.F.1.

A limited office visit may be claimed when the physician performs a limited assessment for a new condition or when monitoring or providing treatment of an established condition. Generally, payment shall be limited to no more than one office visit per patient per physician per day, except in cases where it is medically necessary in the physician's opinion to render a repeat office visit on the same day, and such medical necessity is documented both on the patient's chart, and as a comment on the electronic claims submission.

Office visit codes may not be claimed by a physician who has performed a major surgical procedure in the previous 30 days where the visit is related to the surgery performed. In the case of fractures and/or dislocations, the stated fee shall cover treatment including that related to the care of the fracture for a period of 45 days following the procedure**.**

9.F. Basic Office Visit (fee code 0123) - Family Physicians

A basic office visit is a service rendered by a family physician to a patient who presents with a relatively minor condition which requires only a brief problem-focused assessment, little or no physical examination, and less than 10 minutes of physician time, subject to Section 9.F.1.

9.F.1 Walk-In Clinic Visit (fee code 0094)

In accordance with the "Memorandum of Understanding – Pilot Project: Walk-In Clinic Fee Code", on a trial basis, effective October 1, 2017, a Walk-in Clinic fee code will be created that can only be claimed for services provided at a walk-in clinic visit. Only one walk-in clinic fee can be claimed per patient per physician per day. There will be no time duration on the walk-in fee code. Fee code 0113 can no longer be used for services provided at walk-in clinics when the Walk-in Clinic Visit fee code becomes effective.

During the pilot project, the Basic Office Visit (fee code 0123) will be deactivated and cannot be used for any type of visit at either a walk-in clinic or regular office practice. Services provided during a Family Physician's scheduled office hours previously billed under fee code 0123 should be billed under fee code 0113.

Further, during the pilot project, the minimum time requirement for the limited office visit fee code (0113), as specified in Preamble 9.E., will not apply and so it can be used for an office visit of any duration.

9.G. Complete Re-examination by a Medical Specialist (fee codes xx63)

When a referred patient is seen in consultation for the first time and, when the nature and complexity of the referring problem requires a follow-up examination with complete re-examination, this shall be paid regardless of the interval between initial consultation and subsequent visit(s).

9.H. Annual Health Examination

An annual health examination for the detection of disease conditions at an early stage before symptoms appear is regarded as a basic health service and may be claimed only once in a calendar year. A diagnosis must not be indicated on a claim for an annual health exam. If a diagnosis is indicated, the physician should claim for a complete examination.

9.H.1 Procedures in Addition to Annual Health Examination

In addition to the fee for an annual health exam, physicians may bill for procedures related to health maintenance and disease prevention, such as venipuncture (2238 or 2239), urinalysis (2002 or 2003), injections (2009) such as flu shots and vitamin B12 shots, and pelvic exam or Pap test (2001 or 2008), all of which are payable in addition to an annual health exam, subject to the provisions of Section 5.A of this preamble. The insertion of an intra-uterine contraceptive device (Fee Code 6939) shall be paid at one-half the regular fee if inserted at the same time as an annual health exam.

9.I. Emergency Services in a Physician's Office

A physician who makes an unscheduled, non-elective, emergency visit to his office after regular office hours shall be entitled to claim the emergency office visit fee, providing a special trip to the office is necessary. The diagnosis/treatment/comment indicated on the claim must justify the service on an emergency basis. Time of visit must be specified on the claim. Additional patients seen during this special trip may be claimed at the normal office visit rate.

9.J. Continuing Care at a Specialist's Office

A specialist may charge his Specialty rates, as established in the tariff, when the patient is referred by a physician for continuing care. The service being rendered must be within the field in which the specialist is certified by the College of Physicians and Surgeons of Prince Edward Island, otherwise the Family Practice rate shall apply.

10. HOSPITAL VISIT CODES

Hospital visit codes are limited to medical services rendered to an entitled person formally admitted to hospital (including the inpatient Palliative Care Unit at the Prince Edward Home) for diagnostic tests and/or treatment. All initial visits, consultations and procedures must be supported by documentation. Routine daily visits by the attending physician need documentation only if the patient condition warrants.

10.A. Hospital Consultation

A hospital consultation refers to an assessment, rendered at the written request of another physician, by a physician competent to provide advice when the patient's condition, due to its complexity, obscurity, or seriousness, necessitates an expert opinion.

The referral must be initiated by a Physician, or a Resident licensed by the College of Physicians and Surgeons of PEI. Consultation requests by patients, their representatives, or a third party acting on their behalf, do not qualify as consultations payable under the Plan.

No consultation fee shall be claimed unless the consultation has been specifically requested by the referring physician and unless a written report is rendered. A written request for a consultation, signed by the referring physician, must appear on the patient's chart, on the emergency department record, or on the hospital order sheet. The consulting physician must show the name of the referring physician in the appropriate section on his claim, and must also document his findings, along with recommendations for further care, on the patient's chart.

Where a family physician maintains day-to-day responsibility for care, and requests only a consultation, the family physician shall charge on a per visit basis, and the consultant shall charge a consultant's fee.

Discussion of a case by telephone or by letter between two physicians does not qualify as a consultation and is therefore not payable under the Plan, except if billed as a telephone consultation by an In-Province or Out-of-Province specialist or by a Palliative Care Physician, as per 11.C.1.

10.A.1 Consultations Required by Hospitals

Consultations required by statute or hospital regulations are allowable benefits and are billable to the Plan.

10.A.2 Consultation by Specialist Prior to Intensive Care

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

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

(iii) **Transfer of Care**: Where the attending physician transfers a patient to the care of a consultant, but does not request a consultation, only the fee for visits shall be allowed. Where the transfer of care from a specialist to a physician in the same specialty occurs, only the fee for visits shall be allowed, unless the receiving physician has special skills required for the treatment of the patient.

10.B. Complete Examination in Hospital / Initial Hospital Visit (fee codes xx30)

A complete hospital examination cannot be billed by the attending physician until the physician has personally seen the patient and documented the History and Physical on the chart. Any daily

hospital care, including acceptance of responsibility of care from the admitting physician prior to the complete examination, may be claimed as a subsequent hospital visit.

10.B.1 Initial Visit - Unaffiliated patient (fee code 0132)

An unaffiliated patient is a patient who does not have a regular family physician, or whose regular family physician does not have admitting privileges in the hospital where the patient has been admitted. This tariff cannot be claimed for newborns. This tariff also does not apply to patients whose regular family physician, with admitting privileges in the hospital where the patient is to be admitted, is temporarily unavailable due to vacation, illness, bereavement or CME, for less than four (4) weeks. This fee is payable in addition to the initial hospital visit fee. This fee code is applicable to family physicians only.

10.C. Other Hospital Visits

10.C.1 Concurrent Care

This refers to a situation where medical indication requires the services of more than one physician for adequate care of the patient on the same day. The physicians concerned shall have supplementary skills in different fields of practice, and each submits his separate account for the services rendered to the patient. Medical necessity for the requirement of multiple physicians must be established and noted on the claim and the patient chart.

Team procedures are not considered to be Concurrent Care when a team fee is listed in the Schedule of Fees.

10.C.2 Continuing Care and Supportive Care

(i) In medical cases of unusual severity, the responsibility for the day-to-day continuing care of the patient may be transferred from the attending physician to the consultant for a period of time. The consultant should charge, in addition to his consultation fee, his day-to-day continuing care on a per visit basis at the specialty rate listed for his specialty.

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

10.C.3 Directive Care

Directive care by a consultant may be claimed only in cases where the condition of the patient requires this special service and where the attending physician specifically requests the consultant to provide this service, and documents this request on the patient's chart. In such cases, both physicians may claim on a per visit basis.

10.C.4 Extended Care Hospital Beds

During the period when patients are admitted or transferred to a community hospital (KCMH and Western) or an extended care hospital (Souris and Community Hospital O'Leary) for extended care, the attending physician may bill under fee codes 0145, 0144, 0055, and 0056 as outlined in the Tariff of Fees. Extended care patients are those who have been designated as convalescent, restorative, or alternate level of care (ALC) awaiting placement for a long term care or community care bed. Hospital visit fees cannot be claimed for individuals who are admitted for respite services.

Designated palliative care physicians who provide palliative care services to patients under the Provincial Palliative Care Program in community or extended care hospitals may bill for inpatient services using fee codes 0163 and 0164.

10.C.5 Intensive Care / Critical Care

Critical care fees (fee codes xx95, xx96, xx97, xx98, xx02) apply to the daily care of critically ill and potentially unstable patients who require intensive monitoring and treatment in a designated, approved intensive care area. Critical care fees include initial consultation and assessment and daily management of the patient, including the following procedures, as required: insertion of intravenous lines, arterial and central venous catheters, urinary catheters, pressure infusion sets and pharmacological agents, securing and interpretation of blood gases, oximetry, nasogastric tubes, endotracheal intubation, tracheal toilet, artificial ventilation and all necessary measures for respiratory support.

The following critical care services may be claimed in addition to the daily critical care fee codes: Swan-Ganz catheter insertion, transvenous pacemaker insertion, chest tube insertion, cardioversion, renal dialysis, and detention.

Critical care fees are payable to the physician in charge of the daily management of the patient. Other physicians who become involved in the patient's care may charge the appropriate consultation, visit or procedure fees, including Concurrent Care as defined in 10.C.1.

Critical care fees do not apply when stable, non-critically ill patients are admitted to an intensive care area for convenience, cardiac rhythm monitoring or observation alone, or when patients who were critically ill no longer require intensive care, but remain in the intensive care area after a transfer order is written because of lack of beds elsewhere in the hospital. Critical care fees can be claimed one per 24-hour period up to and including the day the patient is medically suitable for transfer from the intensive care area. Intermediate/Progressive Care (fee code 0501) applies to the care of stabilized non-critically ill patients in an intensive care area, which may be an Intensive Care Unit, Coronary Care Unit, Progressive Care Unit, or Intermediate Care Unit.

Documentation including physical assessments, changes to patient symptoms, interpretation of necessary tests, and management plan on a daily basis is required to support billing these codes.

First day critical care codes require time of day when requesting after-hours premiums. Detention may be billed in relation to first day critical care when the time spent with the patient exceeds the specific time maximums noted in the tariff for the first day critical care by the specialist. Clear supporting documentation on the additional time requirements must be present on the patient chart.

10.C.6 Visits Prior to Surgery

(a) Visit By a Surgeon Prior to Surgery

A visit by a surgeon other than a consultation within a day of the operation by the same surgeon for the same illness may not be claimed, as this is considered to be included in the surgical fee. However, consideration may be given in special cases where sufficient documentation is provided.

(b) Visit By Attending Physician Prior to Surgery

An attending physician may carry out hospital investigations prior to referring a patient to a Surgeon, and shall be entitled to submit claims for his services up to the time of referral. He shall only be entitled to submit claims beyond this time if he continues to be responsible for a condition not related to the surgery.

10.C.7 Visit Prior to Surgical Assist

A physician who submits a claim for a visit to an entitled person at home, in the office, or in the emergency department, and later on the same day assists at an operation, shall be allowed the fee for the visit in addition to the assistant's fee. The visit shall not be payable, however, if the physician concerned is also the surgeon performing the operation on the patient.

10.C.8 Multiple Physicians

A physician must indicate on his claim each day he has actually seen the patient in hospital. Generally, only one physician shall be paid for one hospital visit per patient per day. Any claim involving more than one hospital visit per day or the attendance of two physicians on the same day should be accompanied by an explanatory note.

In cases where a physician is temporarily replacing the attending physician, the attending physician shall not claim for the visits that are rendered by the replacement physician.

10.C.9 Discharge Fee

A hospital Discharge Fee may be claimed by the physician (either a family physician or a specialist when a patient is admitted for non-surgical hospitalization) who performs the activities in discharging a hospital in-patient. These activities include, as necessary, the completion of the patient’s chart, discharge summary, writing prescriptions for the patient, providing discharge instructions to the patient and arranging for follow-up care of the patient.

The fee is not payable where surgery or fracture care is provided in a hospital setting unless a patient is transferred to a family physician for follow-up care after surgery/fracture care. In this case, the family physician may claim the discharge fee if the family physician performs the discharge duties. This fee cannot be claimed by the operating surgeon in association with any surgical code being billed, or for immediate post-partum care.

A hospital visit fee may be claimed in addition to the discharge fee where a hospital visit is provided on the same day.

10.D. Detention

10.D.1 Definition of Detention

"Detention Time" is defined as the time in excess of half an hour spent by the physician in actually examining or treating a patient; the time so spent constitutes detention time only when the time is spent by the physician exclusively, continuously, and when physically present with the patient in respect of whom detention time is charged. Detention is not restricted to services provided only in hospital. Detention does not apply when the time is spent doing procedures.

Detention does not commence until after the first half hour of service. In cases where consultations are billed for the same patient, detention does not begin until after the first 45 minutes for the specialty groups of internal medicine, pediatrics, psychiatry, palliative care, and physiatry. For all other specialty groups, detention starts 30 minutes after the beginning of the consultation. Claims submitted must include sufficient documentation and time spent justifying the charge for Detention. This service is payable in blocks of fifteen (15) minutes or major portion thereof.

10.D.2 Detention for Ambulance Transport of Patients

When a physician has accepted the responsibility of transporting a patient from one location to another, the physician shall be paid detention during time of travel from this location back to original site. Claims should have a comment record, indicating the length of time of the detention and any other information that would assist in adjudicating the claim.

10.D.3 **Special Call Requiring Detention** (fee codes xx76)

(Hospitalized inpatients only)

Where a consultation or a visit fee is charged and the physician is called back on the same day to provide further medical care, detention shall begin immediately.

Where a physician on duty in the Emergency Department is called to the floor to see/treat an inpatient, payment shall be made on a detention basis with actual time spent indicated on claim, and shall be payable in addition to the ER sessional rate. Time of day must also be indicated on the chart.

10.D.4 **Special Detention - Radiology** (fee code 8871)

Between 18:00 and 08:00 hours and on Saturdays, Sundays and holidays, detention for radiologists shall begin when the radiologist arrives at the hospital. If more than one patient is seen, detention may be claimed for the first patient only.

10.E. Hospital Emergency Department Visits

Physicians attending patients in the Emergency Department (ED) of a hospital shall claim under the appropriate ED code in the applicable section of the Tariff of Fees.

Emergency Department visits are categorized by both the time of day and the level of complexity of the encounter.

10.E.1 Time of Day

"Day" applies to visits between the hours of 08:00 and 18:00.
"Night" applies to visits between the hours of 18:00 and 08:00 the following day
"Weekend" applies to visits between the hours of 18:00 Friday and 08:00 Monday.

10.E.2 Level of Complexity

(a) Level I - Limited visit

A Level I Emergency Department visit (limited visit) is a service rendered to a patient who presents to the Emergency Department with a single condition requiring only a brief history of the presenting complaint, examination of the affected part, region or system, review of any required laboratory and/or imaging studies, and treatments.

(b) Level II - Comprehensive Visit

A Level II Emergency Department visit (comprehensive visit) is an in-depth evaluation of a patient necessitated by the seriousness, complexity, or obscurity of the patient's complaint(s) or medical condition. A comprehensive visit shall comprise of a full history, a full functional inquiry, and a detailed examination of relevant body systems. It shall also include a review of any required laboratory and/or imaging studies, and the initiation of appropriate treatment.

A comprehensive visit may also be claimed for those patients whose illness or injury requires prolonged observation, continuous therapy and/or multiple reassessment(s).

A comprehensive visit may be claimed, when appropriate, when a patient is seen in the Emergency Department for the first time that day by that physician. Return visits for the same condition on the same or following day by the same physician should be claimed as a limited visit.

Reassessment by physician on duty in the Emergency Department is the service provided when, at least two hours after the original assessment or re-assessment is completed (including appropriate investigation and treatment), a subsequent assessment indicates that further provision of care and/or investigation is required and performed. A maximum of three (3) reassessments may be claimed per patient per day with a maximum of two reassessments per physician per patient per day. A reassessment by the same physician shall be paid at the same rate as a limited visit. A reassessment by a different physician may be paid as a comprehensive visit if indicated, subject to appropriate documentation.

(c) Level III - Resuscitation/critical care visit

A Level III Emergency Department visit (resuscitation/critical care visit) pertains to the management of a life-threatening illness or injury which requires immediate evaluation and emergent intervention/treatment by the emergency physician. Emergency conditions necessitating Level III care would include resuscitation of cardiac arrest, multiple trauma, cardio-respiratory failure, shock, coma, cardiac arrhythmias with hemodynamic compromise, hypothermia, and other immediately life-threatening situations.

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

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

Since emergency situations can occur anywhere in the hospital, resuscitation care is not restricted to emergency departments or emergency physicians, although it is expected that the physician in charge of the resuscitation shall normally be the physician on duty in the Emergency Department.

Because resuscitation situations often require the services of more than one physician at the same time, Level III care may be billed by up to three physicians per life-threatening emergency situation, when required. The attending physician shall document the need for more than one (1) physician.

10.E.3 Return Visits

When the patient has been discharged from the emergency department and returns the same day unexpectedly, another visit by a different physician may be claimed.

10.E.4 Multiple Physicians

The transfer of care between emergency physicians at the change of shift may generate a new visit fee, subject to appropriate documentation of an assessment.

10.E.5 Medical conditions treated in addition to minor surgical procedures

Patients may present, for example, with a laceration requiring suture repair and also require treatment of an unassociated, unrelated illness or injury. Both a visit fee (Level I, II, or III) and the procedural fee may be billed, and shall be paid in full.

Patients may also present with an emergency medical condition associated with a laceration (e.g. syncope with a scalp laceration or seizure disorder with a facial laceration). Again, both the appropriate visit fee (Level I, II, III) and a procedural fee may be billed, and shall be paid in full.

10.F Hospital In-patient Care of Unaffiliated ("orphan") Patients

Hospital in-patient care of unaffiliated patients shall be in accordance with Article C14 of the Master Agreement.

In accordance with Article C14.8, hospitalists shall be paid a daily sessional fee for inpatient care of unaffiliated patients. The daily sessional fee shall be billed as a fee code which is specific to the type of Hospitalist and to the maximum number of beds for which the Hospitalist is engaged to manage:

Hospitalist Type 1 (Mixed Patient)

Fee Code 0107	maximum 21 beds (full line)	no more than 19 acute
Fee Code 0102	maximum 11 beds (half line)	

Hospitalist Type 2 (Adult Medical)

Fee Code 0101	maximum 17 beds (full line)	no more than 15 acute
Fee Code 0037	maximum 09 beds (half line)	

Salaried physicians providing Hospitalist care shall be remunerated at the same sessional rate by billing a top-up fee equal to the difference between their daily salary (including benefits) and the Hospitalist sessional daily rate. Any inpatient care provided by a Hospitalist to unaffiliated patients in excess of his/her maximum patient load shall be remunerated by fee-for-service.

In accordance with Article C14.9, overnight on-call coverage for Hospitalist inpatients between the hours of 18:00 and 08:00 hrs the following morning shall be remunerated by an on-call retainer (Fee Code 0108) plus fee-for-service for each Hospitalist line, as outlined in Section 11.D.2. A Hospitalist providing overnight on-call coverage for more than one Hospitalist line shall be entitled to receive an on-call retainer for each Hospitalist line covered. It is acknowledged that, even though on-call coverage may commence any time after 18:00 hrs, the normal daily duties of the Hospitalist may extend beyond this time, and each Hospitalist is expected to complete his/her daily duties prior to signing out to the Hospitalist on-call.

The management of "overflow" unaffiliated patients, admitted after the maximum Hospitalist Service bed capacity has been reached, shall be in accordance with Articles C14.11, C14.12, and C14.13 of the Master Agreement. Remuneration for the care of these overflow patients shall be either by fee-for-service, or by a sessional daily rate, billed as Fee Code 0106, for each overflow unaffiliated patient. If a physician chooses the latter option for any given unaffiliated patient, no fee-for-service claims may be billed by that physician for the care of that patient during the first five (5) weeks of the patient's hospital stay, following which billing will revert to regular fee-for-service rates (fee codes 0134 and 0135). Care of unaffiliated newborns may not be billed under Fee Code 0106.

Management and remuneration for the care of unaffiliated patients in the rural hospitals shall be the same as for the "overflow" unaffiliated patients at the Prince County and Queen Elizabeth Hospitals, as outlined above.

11. OTHER VISIT CODES

This category includes visit codes relating to visits in the Home, Long Term Care Institutions, Nursing Homes, etc.

11.A. Home Visit

Refers to services rendered other than at the physician's office and may include calls in which a patient is seen at the site of onset of illness or injury. Frequency of visits shall usually not exceed one per patient per day by the same physician except in unusual circumstances, in which case the physician should provide a suitable explanation on his claim.

11.A.1 Additional Patients Seen

Refers to an additional member of the same family, or person living in the same household or institution, examined and treated during a home visit.

11.A.2 Additional Fee for Emergency House Call (Fee codes xx25)

This fee applies between the hours of 08:00 and 18:00 only, in addition to the corresponding home visit or procedure.

11.B. Palliative Care

11.B.1 Palliative Care Consultation

A palliative care consultation must fulfill the normal requirements of a consultation, and include a psychosocial assessment, comprehensive review of pharmacotherapy, appropriate counseling and, where indicated, consideration of appropriate community services. A minimum of 45 minutes must be spent with the patient by a designated physician with recognized training and expertise in palliative care.

11.B.2 Repeat Palliative Care Consultation

A repeat Palliative Care Consultation shall be a reassessment for the same or related illness or complication thereof, within 30 days of the initial Palliative Care Consultation. A repeat consultation shall contain all the required elements of a Palliative Care Consultation and implies that some interval care has been delivered by the referring physician prior to the request for a repeat consultation. Situations where a consulting physician requests a patient to return at a later date for an assessment do not qualify as a repeat consultation as there has been no written and signed referral by the attending physician.

11.B.3 Palliative Care Telephone Call

Physicians may bill for telephone calls initiated by allied health professionals, in which the physician provides advice and direction regarding a palliative home care patient. The patient must be in a formal palliative home care program, and the claim must be supported by documentation on the patient's chart. Limit of three claims per patient per week.

11.B.4 Palliative Home Care Admission

This fee is applicable only to patients admitted to a formal palliative home care program. It is applicable anywhere in the Province and is not limited to designated palliative care physicians.

11.C Telephone Consultation

11.C.1 Telephone Consultation (Specialists)

This service is restricted to in-province and out-of-province (OOP) specialists, and palliative care physicians, who provide telephone advice to physicians. It also applies to obstetricians who provide telephone advice to physicians and nurse practitioners in relation to prenatal care, and to internists who provide telephone advice to remote patient monitoring (RPM) registered nurses. This service includes history review, history of presenting complaint, review of pertinent diagnostic data including relevant PACS imaging studies, discussion of patient condition/management, and advice to the referring physician, but without the consulting physician seeing the patient. Documentation must include a written submission of the consultant's opinion and recommendations to the referring physician. This service cannot be billed if the specialist sees the patient and bills a consultation within 3 days of the telephone consultation. Health PEI shall not be required to provide PACS outside the hospital.

11.C.2 Telephone Prescription Renewal

This service is billable when a physician is requested by a patient to communicate a prescription renewal by telephone, fax or email without seeing the patient. Documentation on the patient's chart must include the name of the pharmacy, as well as the drug, dose and amount prescribed. This service may not be billed if the physician sees the patient and bills for a visit within three

(3) days of this service. A physician may bill for this service no more often than once per patient per month.

11.D On-Call Retainer Fees

11.D.1 Specialists and Surgical Assistants

One (1) specialist, or other physician as applicable, from each of the following clinical groups shall be entitled to a daily on-call retainer plus fee-for-service for providing twenty-four (24) hour coverage to each of the listed hospitals or provincial service, as the case may be:

Queen Elizabeth Hospital
Internal Medicine, General Surgery, Anesthesia, Pediatrics, Ob/Gyn, Surgical Assistant

Prince County Hospital
Internal Medicine, General Surgery, Anesthesia, Pediatrics, Ob/Gyn, Surgical Assistant

Provincial
ENT, Orthopedics, Ophthalmology, Urology, Plastic Surgery, Psychiatry, Radiology, Nephrology, Medical Oncology, Radiation Oncology, Laboratory Medicine, Palliative Care

11.D.2 Family Physicians

A daily on-call retainer plus fee-for-service shall be paid to Family Physicians providing on-call coverage at each of the following facilities:

Queen Elizabeth Hospital and Prince County Hospital

- fee codes 0015-0019 for in-patient coverage by one physician per group per day. The on-call retainer fee will vary according to group size as listed in the Tariff of Fees. Claims for group coverage require a comment listing the names of the physicians in the group.

- fee code 0108 for afterhours Hospitalist in-patient coverage by one physician per hospitalist line per day.

- fee code 0199 for QEH Unit 9 (psychiatry) unaffiliated inpatient coverage by one physician per day.

- fee code 0147 for QEH Unit 7 (rehab) in-patient coverage by one physician per day.

Souris Hospital, Community Hospital O'Leary, Kings County Memorial Hospital and Western Hospital

- fee code 0185 for in-patient coverage by one physician per hospital per day.

Hillsborough Hospital and Mt. Herbert Addiction Services

- fee codes 0197 and 0198 for in-patient coverage by one physician per facility per day.

Provincial Correctional Services

- fee code 0030 for inmate coverage by one physician per day.

11.D.3 Payment of Retainer

The daily retainer for each clinical group shall be paid according to a group-specific fee code as listed in the Tariff of Fees, and shall qualify for weekend and holiday premiums (see 12.B).

Payment of the on-call retainer is contingent upon the following conditions being met:

(i) provision of twenty-four (24) hours per day, seven (7) days per week continuous coverage for each listed clinical group;

(ii) the clinical group commits to provide coverage for not less than a period of one (1) calendar month, except that in the event there are fewer than three (3) physicians practising in a particular clinical group, each physician must provide no less than one (1) day in three (3) coverage (i.e., a minimum of ten (10) days per month);

(iii) the physician is responsible to an emergency department, a hospital or a hospital unit, or other facility, as the case may be, and is available to respond to a request by hospital or facility staff to attend to a patient emergency;

(iv) the physician's name appears on an established facility call schedule;

(v) the physician shall be entitled to bill fee-for-service in addition to the on-call retainer for all services rendered when on-call;

(vi) the physician is not otherwise compensated through another contractual arrangement for on-call coverage; and

(vii) in the event an on-call locum physician leaves the province early, the on-call retainer may be divided with another physician, provided a comment is added to the claim.

(viii) Any physician scheduled to receive an on-call retainer or on-call per diem, who is unavailable or does not respond when called or paged, shall not be entitled to receive the on-call retainer payment.

11.D.4 Salaried Medical Oncology specialists

Where a salaried medical oncology specialist backs up a GP Oncology Associate by providing "second on-call" coverage, the specialist shall be entitled to a retainer fee (Fee Code 0174) plus fee-for-service.

11.D.5 Neurology On-Call Coverage

Where a neurologist backs up an Internal Medicine specialist by providing "second on-call" coverage for neurology, the neurologist shall be entitled to a retainer fee (Fee Code 0503) plus fee-for-service.

11.D.6 On-Call Coverage for Multiple Clinical Groups

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

11.D.7 Payment for Additional On-Call Coverage during Physician Shortages

In the event of a physician shortage for more than thirty (30) days, in clinical groups of five (5) or less as outlined in Section 11.D.1, and the shortage is due to a vacancy in the approved complement or extended sick leave, Health PEI shall make every reasonable effort to fill the vacancy with either permanent or temporary locum physicians. If a physician is required to provide additional on-call coverage as a result of such physician shortage (i.e., is required to be on-call on those days that otherwise would have been covered by a locum), the physician shall be paid, in addition to the applicable on-call retainer or per diem, the same locum support payment ($150 per day at the signing of this Agreement) that otherwise would have been paid to a locum to provide the on-call coverage. Such additional payment shall not apply where the physician shortage is due to Continuing Medical Education or vacation leave.

11.E Hospital On-Call Response Fee (fee code 0060)

A hospital On-Call Response Fee is intended to compensate on-call physicians for the disruption and inconvenience of having to respond emergently to the request of another physician or a charge nurse to provide service to a patient, which is not part of the on-call physician's normal routine, by returning to hospital after-hours (weekdays 18:00-08:00 and weekends/holidays 08:00-08:00

The hospital On-Call Response Fee for each clinical group shall be paid according to the fee code as listed in the Tariff of Fees, and shall qualify for weekend and holiday premiums as listed in the Preamble to the Tariff of Fees.

This fee may be claimed only once per day on-call, and is payable in addition to the physician's usual On-Call Retainer Fee plus fee-for-service or On-Call Perdiem.

For the purpose of this article, "hospital" is defined as: Queen Elizabeth Hospital, Prince County Hospital, Western Hospital, Community Hospital O'Leary, Kings County Memorial Hospital, Souris Hospital and Hillsborough Hospital.

Payment of this fee requires clear documentation on the patient's chart outlining the time the physician was called in, the nature of the patient's emergent problem and the medical necessity for the physician to be called back to personally attend to the patient. A comment is required on the claim identifying the patient seen, the person who requested the physician's return to hospital and the nature of the emergency.

This fee is not payable if the physician has not been requested to return to hospital by another physician or a charge nurse, and is not payable if there is no medical necessity for the physician to attend to the request in person.

For physicians such as obstetricians who remain on-site after-hours while on-call, this fee may be claimed only if called to personally attend to a patient's emergent problem.

11.F On-Line Medical Control

11.F.1 Retainer Fee

On-Line Medical Control allows registered nurses and paramedics to speak directly with a physician when advice is needed regarding patients presenting at a Collaborative Emergency Center (CEC) or patients being attended in the field by Island EMS.

On-Line Medical Control will be provided by a designated group of physicians who have knowledge and understanding of the full scope of practice of paramedics and nurses who care for patients at a CEC or function as Island EMS patient care providers. One physician from the group shall be entitled to a daily on-call retainer for providing coverage to respond to calls from CEC or Island EMS in a twenty-four (24) hour period.

11.F.2 Telephone Advice (CEC and EMS)

This service is restricted to physicians who provide telephone advice to CEC nurses and paramedics working at a CEC and paramedics in the field with patients. It involves a discussion of the patient's condition and management, and documentation of the physician's opinion and recommendations to the nurse or paramedic.

Documentation must include a summary of the phsycian's opinion and recommendations to the nurse or paramedic. Any telephone advice provided to CEC or Island EMS staff during a patient encounter will be paid a fee per patient encounter, subject to afterhours and weekend/holiday premiums. If the physician is working at an emergency department while on-call, then the telephone fee is to be shadow-billed.

11.G Nurse Practitioner Collaboration

Family Physicians, regardless of the communication mode (one-to-one, telephone, text, Blackberry messaging (BBM), fax), who have signed an agreement to collaborate with a Nurse

Practitioner (NP) may bill for blocks of 10 minutes, or major portion thereof, for time spent collaborating with the NP on treatment, management, or intervention plans for patients.

12. PREMIUM FEES

12.A After-Hours Premium

The following paragraphs show the charges applicable to physician services when provided on an emergency basis within defined hours. The rules regarding the application of After-Hours Premium for Emergency Services are as follows:

12A.1 Application of Premium

Where at least two thirds of a service rendered falls within a premium period, the premium rate applicable to that period shall apply for the entire service. In all other cases, the service must be billed at the lower rate.

12.A.2 Surgical Start Time

For billing purposes, the start time of surgical procedures is determined by the recorded anesthetic start time.

12.A.3 After-Hours Premium for Emergency Situations Only.

After hours premiums refer to emergency situations and are not to be billed when the time the service is rendered is for the convenience of the physician. For radiology services, the reading of the image must occur at the time of the emergency in order for the premium to apply.

Physicians are required to include on the comment record the date and time of the emergency situation. An E Indicator is required.

12.A.4 After-Hours Premium for Emergency Service (18:00-24:00)

Consultations, surgical procedures, assists for surgical procedures, deliveries, anaesthesia services, radiology services, resuscitation, home visits, community care facility visits, diagnostic and therapeutic procedures, detention, on-line medical control, assessment of labour, and other services rendered on an emergency basis during the hours of 18:00 to midnight shall be paid at normal fees plus 25%. Time and E indicator must be shown on claim.

12.A.5 After-Hours Premium for Emergency Service (24:00-08:00)

Consultations, surgical procedures, assists for surgical procedures, deliveries, anaesthesia services, radiology services, resuscitation, home visits, community care facility visits, diagnostic and therapeutic procedures, detention, on-line medical control, assessment of labour, and other

services rendered on an emergency basis during the hours of midnight to 08:00 shall be paid at normal fee plus 100%.

Effective June 1, 2017, Emergency Department sessional fees shall qualify for an afterhours premium of 25% during the hours of midnight to 08:00 to a maximum of 8 hours per night for each of the QEH and PCH Emergency Departments. This "overnight" premium shall be billed as fee code 0076 on weekday(Mon-Fri) nights and fee code 0077 on Saturday, Sunday and Holiday nights. Only one emergency department physician from each of the Emergency Departments may claim this premium for any one of the eight hours during 24:00 to 08:00.

Time and E indicator must be shown on claim.

12.A.6 After-Hours Premium for Emergency Service (08:00-18:00) (Saturdays, Sundays, Holidays)

Consultations, surgical procedures, assists for surgical procedures, deliveries, anesthesia services, radiology services, resuscitation, home visits, community care facility visits, diagnostic and therapeutic procedures, detention, on-line medical control, assessment of labour, and other services rendered on an emergency basis during the hours 08:00 to 18:00 on Saturdays, Sundays and holidays shall be paid normal fees plus 25%. E indicator must be shown on claim.

12.B Weekend and Holiday Premium for On-Call Coverage

When on-call coverage is required to be provided on weekends (from Saturday 08:00 hrs to Monday 08:00 hrs) and on holidays as designated in the Preamble to the Tariff of Fees, all on-call retainers and perdiems shall be paid at the applicable rate plus an add-on premium of twenty-five per cent (25%). Emergency Department sessional fees shall qualify for a weekend and holiday premium of 8% (10% effective April 1, 2018.

12.C. Weekend and Holiday Premium for Hospital Inpatient Visits

A premium of 25% shall apply to all hospital inpatient visits and Hospitalist daily sessional fees, provided on weekends and statutory holidays.

Applies to fee codes xx30, xx33, xx34, xx35, 0132, 0136, 0140, xx41, xx42, 0143, 0146, 0163, 0164, 0003, 0701, 0104, 0704, 0795, xx71, 0501, all critical care fee codes, hospitalist sessional fee codes

12.D. Geriatric Premium

A geriatric premium of 25% shall apply to all consultations, repeat consultations, office visits, home visits, ED visits and resuscitation provided to patients 75 years of age and over. This applies to Family Physicians and all other specialties.

Applies to fee codes xx60, xx62, xx10, xx11, xx13, xx21, xx24, xx80, xx81, xx90, xx91, xx86, xx87, xx68, xx69, 2231, 0512, 0563, 0123, 0812, 0182, 0183, 0184.

13. PSYCHIATRIC SERVICES

13.A. Psychotherapy

Psychotherapy is defined as a procedure carried out by a physician to treat mental, emotional and psychosomatic illness through a therapeutic relationship with the patient in an individual, group or family setting. Psychotherapy always entails continuing medical diagnostic evaluation and responsibility and may be carried out in conjunction with drugs and other treatment(s) (e.g. ECT). Psychotherapy assumes that the psychological and physical components of an illness are intertwined and that at any point in the disease process, psychological symptoms and signs may give rise to, substitute for, or run concurrently with physical symptoms and signs and vice versa.

This service is payable in blocks of fifteen (15) minutes or a major portion thereof, with a minimum of fifteen (15) minutes of service. Such time shall be recorded on the patient's chart. Physicians can not submit a claim for this service on a day when visit fees are claimed.

13.B. Certification for Admission to a Psychiatric Facility

Medical examinations required in connection with the certification of an entitled person to a mental institution or alcohol/drug treatment facility are acceptable as a benefit under the Plan (fee code 2800). A visit is not payable in addition to the certification examination. This fee code shall be subject to afterhours premiums, if indicated.

13.C. Limitation

Where a claim is submitted for psychotherapy provided to an entitled person, no claim shall be accepted for a subsequent visit by the same physician on the same day unless it is medically necessary or for an unrelated cause.

13.D. Psychotherapy Services in Hospital by Family Physician

A family physician may claim for psychotherapy in hospital. This service is payable in blocks of fifteen (15) minutes or a major portion thereof, with a minimum of fifteen (15) minutes of service. Such time shall be recorded on the patient's chart. Physicians can not submit a claim for this service on a day when visit fees are claimed.

13.E. Group Psychotherapy & Diagnostic/Therapeutic Interview

Billings must include PHN & DOB for each patient involved. This service is payable in blocks of fifteen (15) minutes or a major portion thereof, with a minimum of fifteen (15) minutes of service. Such time shall be recorded on the patient's chart. Physicians can not submit a claim for this service on a day when visit fees are claimed.

13.F. Hospital In-Patients under Attending Care of Psychiatrist

Fee code 0146 is payable to the family physician if a complete medical assessment is requested by the psychiatrist.

In addition, Supportive Care may be billed to a maximum of seven (7) visits during a hospital stay. The diagnosis may be the same or related for supportive care.

If the family physician is requested by the psychiatrist to see the patient for a physical condition, then Concurrent Care would apply (fee code 0142).

13.G. Case Management Conference

A Case Management Conference is a scheduled, multi-disciplinary meeting with other professionals for the purpose of discussing a treatment, management or intervention plan for the patient(s). The patient(s) and/or family members may or may not be present at the conference. This service is payable in blocks of fifteen (15) minutes or major portion thereof, with a minimum of 15 minutes of service.

13.H. Diagnostic and Therapeutic Interview

A diagnostic and therapeutic interview is a scheduled interview with a patient and/or a patient's family or other persons who may have relevant information about the patient's circumstances for the purpose of obtaining a collateral history and discussing a treatment, management or intervention plan for the patient. The patient may or may not be present during the interview. This service is payable in blocks of fifteen (15) minutes or a major portion thereof, with a minimum of fifteen (15) minutes of service. Such time shall be recorded on the patient's chart. Physicians can not submit a claim for this service on a day when visit fees are claimed. This fee may be billed by psychiatry, pediatrics, internal medicine and family practice. This fee may also be billed by surgical specialties if the diagnosis is related to cancer.

13.I. Mental Health Crisis Care

Mental health crisis care is an unscheduled and unanticipated visit to a family physician by a patient who exhibits mental distress that requires immediate attention.

This service is payable in blocks of fifteen (15) minutes or a major portion thereof, with a minimum of fifteen (15) minutes of service. Such time shall be recorded on the patient's chart. Physicians can not submit a claim for this service on a day when visit fees are claimed.

13.J. **Prenatal Psychosocial Assessment** (fee code 2590)

A claim may be submitted once per patient per pregnancy. This service is payable in blocks of fifteen (15) minutes or a major portion thereof, with a minimum of fifteen (15) minutes of service and to a maximum of 45 minutes. Such time shall be recorded on the patient's chart. Physicians can not submit a claim for this service on a day when visit fees are claimed.

14. SURGICAL SERVICES

The fee for surgical procedures shall include the customary pre and post-operative care as deemed necessary by the operating surgeon for a period of up to 30 days post-operatively or two office visits if necessary for the follow-up examination subsequent to discharge from hospital.

In cases where a surgeon is the primary physician responsible for critically-ill patients in an ICU, the surgeon shall be allowed to bill applicable Critical Care codes (0595-0598). However, these fees would not be applicable if another physician e.g. an internist is also charging Critical Care (0595-0598) rates. (Ref. Section 10.C.5.)

Laparoscopic procedures converted to open will not be paid in addition to surgical procedures as either Fee Code 5450 (Laparotomy) or Fee Code 5460 (Laparoscopy).

14.A. Pre-Operative Consultation and Investigation

A consultation by a surgeon which subsequently leads to surgery shall be paid in addition to the procedural fee, as long as the documentation requirements for consultations in Sections 9.A. or 10.A. are met.

In unusually complicated cases requiring prolonged preoperative care, visit fees may be claimed by the surgeon and must be accompanied by an adequate explanation.

14.B. Post-Operative Period

The normal post-operative period is deemed to be 30 days for all surgical procedures except fractures and dislocations where the normal post-operative period is 45 days.

14.C. Procedures During Visits

Surgical procedures performed in the course of a home visit may be charged in addition to the fee for the visit but if performed in connection with an office call, only procedure fees shall be charged if it was the primary reason for the visit. A procedural fee may be charged in addition to the office visit fee when the condition requiring the procedure was not the primary reason for the visit. Explanation must be provided clearly indicating there is no relationship between these two services.

14.D. Cosmetic Surgery (See PRIOR APPROVAL Section 30 & Preamble Appendix D)

14.E. SURGICAL PROCEDURES

14E.1 Role Codes

Role Codes #24, #25, #26 and #27 apply when the attending surgeon identifies the need for a qualified actively practicing second surgeon to assist in a procedure because of the second surgeon's expertise in a specific area. Prior approval is required for non-emergency cases, explaining the requirement for a second surgeon.

#10 Surgeon billing 100% of tariff

#11 Surgeon billing 65% of tariff - applies to surgeries performed by the same surgeon through different incisions under the same anaesthetic.

#12 Surgeon billing 50% of tariff - applies to surgeries performed by the same surgeon through the same incision under the same anaesthetic.

#21 Assistant billing 33% of surgeon's claim where **surgeon has billed 100%** of tariff (surgeon role #10).

#22 Assistant billing 33% of surgeon's claim where **surgeon has billed 65%** of tariff (surgeon role #11).

#23 Assistant billing 33% of surgeon's claim where **surgeon has billed 50%** of tariff (surgeon role #12).

#24 Assistant billing 75% of surgeon's claim where **surgeon has billed 100%** of tariff (surgeon role #10).

#25 Assistant billing 75% of surgeon's claim where **surgeon has billed 65**% of tariff (surgeon role #11).

#26 Assistant billing 75% of surgeon's claim where **surgeon has billed 50%** of tariff (surgeon role #12).

#27 Assistant billing 75% of surgeon's claim where an **intra-operative consultation** has occurred. (Ref 14.E.5.(c))

14.E.2 Similar Procedures Done Concurrently

When two similar procedures, e.g. sutures, are done at one time, the charge for the second procedure should be 50% of the listed fee, or as indicated in the schedule. When done at an interval under a separate anaesthetic, the full fee shall apply.

14.E.3 Multiple Procedures Through Same Incision

When more than one operative procedure is performed by the same surgeon through the same incision and under the same anaesthetic, the full fee shall be charged for the major procedure, and 50% the listed fee for the second procedure, except where such combined operations are specified in the schedule. This does not apply where an appendix or ovarian cyst is removed incidentally during an operation, for which no additional payment shall be made. Salpingectomy, with or without oophorectomy, (fee code 6700) performed at the time of hysterectomy is billable at 25% per side.

14.E.4 Multiple Procedures Through Separate Incisions

When procedures are done by one surgeon through separate incisions under one anaesthetic, the charge for the lesser procedure should be 65% of the listed fee.

14.E.5 Separate Surgeons

(a) Different Procedures

When different operative procedures are done by two different surgeons under the same anaesthetic for different conditions, the fee shall be 100% of the listed fee for each condition.

(b) Same Procedure

Where the attending surgeon identifies the need for a qualified actively practicing second surgeon to assist in a procedure because of the second surgeon's expertise in a specific area, the second surgeon shall be paid at 75% of the attending surgeon's fee. Prior approval is required for non-emergency cases, explaining the requirement for a second surgeon.

(c) Intra-operative Consultations

When the attending physician identifies the need for a consultation from a qualified actively practicing second surgeon, during an operation in progress, the second surgeon shall be paid a separate consultation fee.

If the second surgeon assumes responsibility for the surgery, he shall be paid the surgical fee but not the consultation. The original surgeon shall be paid an assistant fee at 75% (Role Code #27). The original assistant (now the second assistant) shall continue to be paid at 33% (Role Code #21).

If the second surgeon becomes an assistant, the second surgeon shall be paid a separate consultation fee and an assistant's fee paid at 75% (Role code # 24). The original surgeon shall be paid for the operation at 100% (Role Code #10). The original assistant (now the second assistant) shall continue to be paid at 33% (Role Code #21).

If a second surgeon of a different specialty comes in and does his surgery, a consult will be paid.

14.E.6 Subsequent Operation

When a subsequent operation becomes necessary during the same hospitalization because of complications, or for a new or different condition developing during the same hospitalization, full fee shall be paid for procedures listed in the surgical schedule, which are performed because of complications.

14.E.7 Procedure Done in Stages

Where operative procedures are normally performed in stages, the full fee may be claimed for each procedure.

14.E.8 Pre-operative Diagnostic Procedures

Diagnostic procedures carried out prior to surgery shall be eligible for payment according to the Schedule.

14.E.9 Surgical Procedures Performed in Ambulatory Settings

Surgical procedures that can be safely and appropriately performed in an approved ambulatory setting (i.e., a hospital setting or a non-hospital setting approved by Health PEI) shall be paid at the same rate as if the procedure had been performed in a hospital operating room.

14.E.10 Surgical Procedures for Morbidly Obese Patients

Effective June 1, 2017, a Surgical Obesity Premium may be claimed for designated major surgical procedures performed on the neck, peritoneal cavity, pelvis, retroperitoneum, hip, or knee of patients with a Body Mass Index (BMI) of 40 or higher. This premium may be claimed by the surgeon only once per surgical session, in addition to the regular surgical fee, for major surgical procedures performed in a hospital operating room using an open technique for the neck, hip, and knee, or an open or laparoscopic technique for the peritoneal cavity, pelvis, and retroperitoneum. This premium is billed as fee code 0074, and must be supported by documentation of the BMI on the patient's medical record, as well as on the billing claim.

The Surgical Obesity Premium may not be claimed for bariatric surgical procedures, nor for procedures limited to the skin or subcutaneous tissues, nor for procedures performed under local anesthesia or conscious sedation, nor for procedures consisting of aspiration, needle biopsy, dilation, endoscopy, cautery, ablation, or catheterization.

15. SURGICAL ASSISTANTS

15.A. Minor Surgical Procedure

The necessity of a surgical assistant for a minor surgical procedure shall be left to the discretion of the surgeon. On occasion, explanations may be required.

15.B Schedule of Rates

A surgical assistant shall render a separate claim for his services in accordance with the following:

(i) 33% of the fee listed for the procedure

(ii) When a second assistant is required by the surgeon, he may claim a fee as if he were the first assistant. Necessity of the second assistant must be indicated on the surgeon's claim and Health PEI has been assured that the requirement for a second assistant shall be a low frequency item

(iii) Surgical assists must be identified with Role Code No. 21, 22, 23, 24, 25, 26 or 27 as applicable on the claim

15.C. Concurrent Care Limitations

When an Assistant's fee is claimed, the physician may not claim for Concurrent or Supportive Care unless he is caring for a disease or condition not related to the surgical procedure at which he assisted.

16. VASCULAR SURGICAL PROCEDURES

16.A. Veins and Arteries

(i) Excision or repair procedures for arteries and veins include endarterectomy, thrombectomy and/or bypass graft.

(ii) Excision or repair procedures for arteries and veins include harvest of graft tissue, except where the harvest of graft tissue is beyond the normal parameters, which will be paid for as indicated.

(iii) Common femoral artery repair includes repair to the profunda femoris artery as far as the first major branch. If the repair extends beyond the first major branch of the profunda femoris artery, Fee Code 4652 may be claimed in addition. If added to another vascular procedure in the same incision/limb the fee will be paid at 50%.

(iv) Exposure of leg vessels for evaluation and re-vascularization - Fee Code 4643 may be claimed plus fee for sympathectomy or amputation, if required.

(v) Two distinct vascular procedures at same sitting, with same exposure, the second procedure will be paid at 50%.

(vi) Two distinct vascular or endovascular procedures via different exposures, the second procedure will be paid at 65%.

16.B. Harvesting

A surgeon may claim an add on fee when harvesting an arm vein, a superficial femoral vein or an opposite leg vein from the non-operative site.

16.C. Venous Wounds

During vascular procedures on venous wounds a laparotomy or thoracotomy will be paid at 50%, if required.

16.D. Arteriovenous Procedures

If an arteriovenous fistula is required as part of a vascular procedure, it shall be paid at 50% of the operation procedure.

16.E. Portal Hypertension

The fee for portal hypertension procedures shall include a splenectomy, as required.

16.F. Percutaneous Arterial Procedures

(i) Angiography for the renal mesenteric arch shall be paid per minor vessel, in addition to Fee Code 4635 – Arteriography Selective.

(ii) Multiple angioplasties are paid as one fee for each named vessel. If an angioplasty is required on a contiguous vessel it will be paid at 50%.

(iii) Operative arteriography will only be paid once per vessel per 24-hour period.

16.G. Aorto-iliac Procedures

(i) For aorto-iliac procedures, if a thoracotomy or laparotomy procedure is required, it shall be paid in addition to the operative procedure.

(ii) If re-vascularization is required for the removal of infected aortic graph stem and limbs, it will be paid in addition to the operative procedure at 50%.

16.H. Lower Limb Arterial Procedures

In cases of extended profundoplasty – first or second muscular branch – Fee Codes 4642 and 4652 may be claimed if it is the sole procedure. If done as a secondary procedure, it may be claimed at 50%.

17. FRACTURE CARE

17.A. Definitions

Open reduction shall mean the reduction of a fracture by an operative procedure and is intended to include exposure of the fracture site with fixation as indicated.

Closed reduction shall mean the reduction of a fracture by non-operative methods with the aid of local or general anesthesia.

No reduction shall mean treatment of a fracture by any method other than that designated above.

17. B. Composite Fee

The fees listed for fractures are intended to cover the treatment of the fracture including any necessary after care, e.g. physiotherapy supervision, exercises, cast changes, etc., for a period of forty five (45) days. Where aftercare cannot be provided by the initial surgeon, the subsequent treating physician is entitled to claim for a cast change when required.

17.C. Immobilization

Immobilization in a plaster cast or splint is not a prerequisite for claiming a fee for fractures.

17.D. Compound Fractures

The fee for compound fractures and/or compound dislocations shall be the fee for the appropriate fracture or dislocation plus 50%.

If an open reduction is performed, the fee for the open reduction shall apply.

17.E. Separate Surgeons

If different surgeons treat different fractures on the same patient at the same time, each surgeon shall be entitled to full fees for the initial fracture and 50% fees for subsequent fractures treated.

17.F. Repeated Closed Reductions

When repeated closed reductions are carried out by one surgeon for the same fracture, then the listed fee for that fracture shall apply to the first reduction and 50% for each subsequent reduction. In cases where two closed reductions are done for one fracture, the tariff should be half the usual fee for the first reduction when done by the same surgeon. When the subsequent reduction is done by a different surgeon, the full fee should apply in each case.

17.G. Closed Reduction followed by Open Reduction

Where one surgeon performs a closed reduction of a fracture and later has to perform an open reduction, then the fee shall be 50% for the closed reduction and 100% for the open reduction.

17.H. Multiple Fractures

In multiple fractures, the fee for the major fracture requiring open reduction, plus 50% of the fee for the minor fractures requiring cast or closed reduction, shall apply.

17.I. Second Surgeon

When it becomes necessary for a second surgeon to perform a reduction, the full fee shall apply for this procedure. The first physician in this case shall be entitled to 100% of the fee for the closed reduction.

18. ANESTHESIA SERVICES

18.A. Anesthesia Fees

Anesthesia fees are payable only when the anesthetic is personally administered by a physician other than the surgeon, assistant surgeon or obstetrician and who remains in constant attendance during the procedure for the sole purpose of rendering an anesthetic service.

An anesthesia fee is for professional services only and includes:

18.B. Pre-Anesthesia Evaluation

Pre-anesthesia evaluation of the patient as an anesthetic risk, ordering of pre-medication as indicated, administration of all types of anesthesia, fluids or blood incidental to anesthesia or surgical procedure and immediate post-anesthetic supervision.

18.C. Supportive and Resuscitation Measures

Immediate supportive and resuscitation measures in the operating room and/or the recovery ward as indicated by the patient's condition.

18.D. Complication

Treatment of any complication arising from anesthesia within 48 hours.

18.E. Anesthesia Detention Fee

Anesthesia detention fees apply when an anesthetist is called and is personally present as a stand by to render anesthetic services**.**

18.F. Anesthesia for a Normal Delivery

Anesthesia for a normal delivery is an allowable service providing it was medically necessary in the opinion of the attending physician.

Fee code 2525 (Continuous Conduction Anesthesia (Epidural) for Obstetrics) is a composite fee that includes consultation, catheter insertion, first dose, and maintenance.

18.G. Anesthesia Outside Hospital

Claims for anesthetic services by a physician outside hospital shall be considered for payment only in an emergency or disaster situation.

18.H. Cancelled Surgery

This fee code (0266) is claimed when an anesthetist makes a pre-operative visit to a patient whose surgery is subsequently cancelled. If the anesthetist administers anesthesia within 7 days from the visit, this fee code is not payable; if anesthesia is administered by a different anesthetist, then the fee is payable.

18.I. Definition Beginning and End of Anesthesia

Anesthesia time begins, with the exception of ECT cases, ten (10) minutes prior to the patient's arrival in the operation room to allow for informed consent and preparation of equipment and ends when the anesthetist is no longer in personal attendance (when the patient may be safely placed under the customary post-operative supervision). Anesthesia time may extend for up to 30 minutes after the patient leaves the operating room.

18.J Acute Pain Service Initiation

Fee code 0280 is payable when a qualified physician initiates an acute pain service involving patient-controlled analgesia (PCA) and other acute pain modalities such as indwelling nerve catheters, to a patient admitted to hospital. The service must include all the components of a major consultation with the appropriate chart documentation. This does not require a consultation request from another physician.

This fee code involves an assessment of the patient in order to determine the acute pain control modality most appropriate for that patient, and includes the initial management of the acute pain service. Daily maintenance of PCA is payable as fee code 2534, which may not be billed on the same day as fee code 0280. Any procedures performed for acute pain management are payable in addition to these service fees.

Fee code 0280 is not payable to the same physician in addition to a consultation (fee code 0260) or other composite fees, which include consultation (i.e. fee codes 2521, 2525, 0296) where the reason for the consultation is for the purpose of initiation of acute pain management service.

However, where a pre-operative consultation has been provided prior to the administration of an anesthetic, the anesthetist may bill fee codes 0280 and 2534 for post-operative acute pain management.

Any major interventions or complications, which require another physician to attend the patient, may be billed as a 0260 consultation or detention, as appropriate.

18.K Follow-up Visit

This fee code (0213) can be billed in situations where, subsequent to an initial consultation by the anesthetist, a patient has returned for a re-assessment of the patient's readiness for the anesthetic services required to perform the planned surgical procedure(s). The follow up visit shall require a minimum of 10 minutes of physician time.

A follow up visit may also be claimed when an anesthetist provides treatment of a complication arising from anesthesia more than 48 hours after surgery.

18.L Surgical Procedures for Morbidly Obese Patients

Effective June 1, 2017, an Anesthesia Obesity Premium may be claimed for major surgical procedures performed on patients with a Body Mass Index (BMI) of 40 or higher. This premium may be claimed by anesthesiologist only once per surgical session, in addition to the regular anesthesia fee, for major surgical procedures performed in a hospital operating room where the surgery is done under general, spinal, or epidural anesthesia. This premium is billed as fee code 0075, and must be supported by documentation of the BMI on the patient's medical record, as well as on the billing claim.

The Anesthesia Obesity Premium may not be claimed for procedures performed under local anesthesia or conscious sedation.

19. OBSTETRICAL SERVICES

Obstetrical care includes initial visit, prenatal visits and necessary laboratory tests, delivery, post- partum care in hospital and postnatal visit. All composite obstetrical fees have been eliminated in favor of individual fees for services rendered.

19.A. Prenatal Visits

These are visits to a physician's office prior to delivery of the infant. These are usually monthly visits but may be more frequent in the last three months. Claims should be submitted on a regular basis and not held until delivery takes place. A specialist may claim an initial prenatal visit as fee code 0700, or 0760 if the patient was referred, but not both.

19.B. Delivery

This usually refers to the time in hospital while labor proceeds to the delivery of the infant.

Where a failed operative (forceps) delivery leads to C-section by the same physician, the C-section fee code 6004 is payable at 100% and failed operation (forceps) delivery 6007 is payable at 50%.

Fee code 0004 is to be claimed if the general practitioner has attended a complicated labor where the patient is referred to cesarean section or operative delivery. The fee code includes assistance with the referred procedure. This fee code may also be claimed and paid in full by a physician called on an emergency basis to attend a precipitous delivery prior to the arrival of the attending physician/obstetrician. In either case, the attending physician/obstetrician shall also be paid in full for attending at the delivery, unless the entire delivery has already been completed prior to the arrival of the attending physician/obstetrician.

19.C. In-Hospital Post-partum Care

This refers to the immediate care following delivery of the baby while the mother is still in hospital, and may be billed regardless of the method of delivery.

19.D. Postnatal Visit

This usually occurs about 6 weeks following the delivery and shall include a pelvic examination. Therefore, the postnatal period is defined as approximately 6 weeks.

19.E. Multiple Pregnancy

Second and additional deliveries shall be claimed at 100% of delivery fee.

19.F. Outpatient Assessment for Complications of Pregnancy/Labor

This tariff can be billed where a patient presents to hospital with a complication of pregnancy or labor after 20 weeks gestation by dates. An obstetrician may bill this tariff without a consultation request, provided the physician has not seen the patient within the prior 30 days. The service must include all the components of a major consultation with the appropriate chart documentation.

19.G. Obstetric Ultrasound in Hospital

Obstetric Ultrasound may be billed by an obstetrician when performed in hospital to assess fetal viability once in the first trimester. It may be repeated after 12 weeks gestation to determine viability if examination by fetoscope or doppler fails to detect a fetal heart beat. It may be billed after 24 weeks gestation to assess fetal pelvic presentation and to locate the placenta. It may not be billed if an ultrasound is performed in Diagnostic Imaging for the same diagnosis on the same day.

19.H. Oxytocin Challenge Test

Oxytocin Challenge Test may be performed in the Labor and Delivery Unit by an Obstetrician to ascertain fetal well-being in a fetus who has reached the age of viability and shows signs of possible intrauterine compromise.

19. I. Scalp pH Monitoring

Scalp pH Monitoring may be performed in the Labor and Delivery Unit by an Obstetrician to help to assess the well-being of a fetus with a non-reassuring fetal heart tracing or other signs of possible intrauterine compromise in labor. Payment will be limited to 3 times per labor.

19. J. Biophysical Profile

Biophysical Profile Assessment may be performed by an Obstetrician to assess the well-being of a fetus. The examination may include ultrasonographic assessment of fetal breathing, fetal tone, fetal movement and amniotic fluid volume.

19.K Induction of Labor

Payment will not be made for ARM as the sole means of induction.

20. PEDIATRIC SERVICES

20.A. Newborn Care

Newborn care refers to routine care of a well baby during the first ten (10) days including complete examination and necessary parental advice.

Premature infant means an infant weighing 5 ½ lbs. (2500 grams) or less at birth.

Fee code 1136 applies to attendance at maternal delivery and shall include the consult. Fee code 1160, a pediatric consult, may not be billed on the same day as 1136 unless a comment is provided. Fee code 1136 may be billed in addition to fee codes 1145, 1148 or 1150 (Pediatric Intensive Care).

20.A.1 Pediatric Detention for Newborn Resuscitation

The Pediatric detention fee (1170) may be billed when a pediatrician is requested by an obstetrician to be physically present on stand-by in anticipation of rendering newborn resuscitation services when a delivery occurs. This stand-by detention shall commence at the time the obstetrician specifies physical attendance is required and shall end once the delivery occurs and newborn resuscitation (1136) begins.

20.B. Well Baby Care

Well baby care refers to periodic office visits to a maximum of nine visits of a healthy baby for routine supervision and development and any parental instructions required. Well baby care may be claimed only until the patient reaches his/her first birthday. Claims billed under well baby care after the first birthday shall be paid as office visits and a diagnosis shall be necessary.

20.C. Child Care

Pediatrics shall include the care of children up to their 16th birthday.

20.D. Patients 16 and over

Consultations for those patients 16 years of age and over shall be considered if accompanied by an explanation.

20.E. Pediatric Critical Care

Fee Code 1154 can be billed for pediatric patients who are ill enough to require critical care, which includes constant nursing care, continuous cardio-respiratory monitoring and intravenous therapy. This code can be billed regardless of whether the patient is in ICU or in a designated room on the pediatric floor with specialized nursing care. Appropriate documentation must be on the chart.

20.F. Neonatal Intensive Care

Neonatal intensive care fees are applicable to Pediatricians with special training in Neonatal Intensive Care.

If infant has been transferred from one level to another, in either direction, up or down, second day fees apply. Regular visit and procedure fees will apply the day following termination of Neonatal Intensive Care. If patient has been discharged from Unit more than 48 hours and is readmitted to Unit 1st day rate applies again on day of re-admission.

The appropriate consultation, procedure and visit fees shall apply after stopping artificial respiration or special care.

21. DIAGNOSTIC AND THERAPEUTIC PROCEDURES

When a Diagnostic and Therapeutic Procedure is claimed at the same time as a visit or consultation fee, both fees are payable in full, except when such procedure is the sole reason for the patient's attendance.

21.A. Provision of Surgical Dressing in Physician's Office

Change of Surgical Dressing in a physician's office may be claimed under Tariff of Fees fee code 2010 in Diagnostic and Therapeutic Procedures whether rendered by the physician or his staff.

21.B. Multiple Venepunctures

When a diagnostic test requires multiple venepunctures, up to five (5) venepunctures (fee code 2238) in one day may be billed if an appropriate comment is included.

21.C. Pelvic Examination

Pap smear with or without pelvic examination (fee code 2008) or pelvic examination only (fee code 2001) may be billed in conjunction with any visit other than an obstetrical or gynecological consultation.

21.D. Vaginal Pessary Fitting

This fee code may be billed by a Gynecologist, in addition to a consultation or visit fee, for a patient with pelvic relaxation problems. Subsequent follow-up visits after the initial fitting shall be paid as an office visit.

21.E. Urodynamic Studies

No more than four (4) urodynamic study fee codes may be billed per patient per visit.

21.F. Skin Lesions

Generally, removal of skin lesions for cosmetic purposes is not an insured service. However, the following conditions are insured services:

(i) The removal of malignant lesions or lesions recognized as presenting a significant risk of producing malignant lesions. Examples are neurofibromatosis (Von Recklinghausen's disease), keratoses in chronic dialysis patients.

(ii) The removal of non-malignant skin lesions, which because of their location or size, result in recurring bleeding or recurring infections not amenable to non-surgical management.

(iii) Fee Code 3046 (single or multiple) is limited to a maximum of three sittings per year for each individual patient per physician.

(iv) Excision Biopsy (fee code 3030) of skin lesions for the purpose of determination of pathology.

21.G. Injections

21.G.1. Injections of Vitamin B12 for Pernicious Anemia

Injections of B12 shall not be paid more frequently than once every four (4) weeks after the first two weeks of such treatment.

21.G.2. Subsequent Injections on the Same Visit

An additional amount shall not be allowed for subsequent injections on the same visit unless the patient develops a reaction at the time of the visit requiring further treatment. This is in accordance with the wording of the Tariff of Fees, fee code 2009.

21.G.3. Injection of Joints

Where two or more joints are injected on the same visit, 65% (as per surgical rules) of the usual fee shall be allowed for the second and subsequent procedures.

21.G.4 Immunization Reporting

Physicians are able to bill for patient immunization injections using fee code 2009. In accordance with Preamble 21.G.2, fee code 2009 can only be billed once per patient visit.

Pursuant to the Immunization Regulations of the PEI Public Health Act, physicians must submit to the Chief Public Health Officer (CPHO) quarterly reports of all immunizations provided to individuals on PEI.

To provide physicians with the option of electronically reporting immunizations to the CPHO, with all associated data elements, the following zero dollar immunization fee codes have been established, with the associated ICD9 diagnostic codes to be used:

0081	Immunization - Influenza	(ICD9 diagnostic code V04.8)
0082	Immunization - Pneumococcal	(ICD9 diagnostic code V06.6)
0083	Immunization - Tetanus/pertussis (Tdap)	(ICD9 diagnostic code V06.3)
0084	Immunization - Hepatitis A/B	(ICD9 diagnostic code V05.3)
0085	Immunization - Varicella zoster	(ICD9 diagnostic code V04.89)

For those physicians who wish to file their immunization reports electronically via the claims payment system, in addition to submitting a claim for fee code 2009, the physician must also submit a $0 claim for each of the immunizations administered using applicable fee code listed above.

If Physicians choose to report their immunization manually (i.e. paper filing), the physician is responsible for ensuring they utilize the forms prepared by the CPHO and providing all required data elements specified on the forms.

21.H Emergency Department and Critical Care Ultrasound

ED and Critical Care Ultrasound may be billed once per patient per physician per day by a physician appropriately trained in ED and Critical Care Ultrasound procedures.

21.I. Emergency Procedural Sedation

Procedural sedation is payable in addition to the procedure for which sedation is required, and applies to emergency procedures only.

21.J. Modified Sleep Apnea Study

Modified sleep apnea study will be limited to one per month per patient.

21.K Electromyography (EMG) and Nerve Conduction Studies

When referring to muscles of more than one region, or examination of a specific region, "region" is intended to mean one of the four following anatomic areas: head and neck, both upper limbs, both lower limbs, trunk (anterior and posterior).

When referring to nerve conduction studies, "per nerve studied" is intended to mean both the motor and sensory nerve conduction examination of a single nerve (mixed, motor, or sensory). Multiples may be claimed when another nerve (mixed, motor, or sensory) is examined and when separate nerve conduction studies of a major nerve branch are required, to a maximum of six (6) nerves.

Electrophysiological evaluation for nerve entrapment is a composite fee including conduction studies of one or more nerves suspected of being entrapped, together with EMG studies of the appropriate muscles as necessary.

21.L Dialysis Management

Remuneration for the management of patients receiving hemodialysis may be through direct patient contact in dialysis units in Charlottetown and Summerside, as well as through indirect distance supervision of patients in satellite dialysis units in Alberton and Souris.

Patients in Charlottetown and Summerside will receive directed care through regular physician contact in their respective dialysis units. Patients in Alberton and Souris will follow a satellite model unless directed care is mandated by specific patient issues. Satellite care includes phone and fax communication with nursing staff, prescription requests, monitoring of lab data, monthly teleconferences, liaison with other physicians, quarterly patient assessments, and other dialysis needs that may arise. It is assumed that patients receive dialysis three times weekly, and physicians are available 24 hours daily.

Direct physician management is care provided by the physician to the patient at the dialysis site on the day of treatment. Direct physician management of dialysis for acutely ill patients shall be

payable using fee code 2055 for the initial acute treatment and fee code 2056 for up to two subsequent acute treatments. Direct physician management of dialysis for patients with chronic renal failure shall be payable using fee code 2135 for the initial treatment and fee code 2137 for all subsequent treatments, up to a maximum of three (3) treatments per patient per week, unless medical necessity requires additional treatments, in which case a comment must appear on the claim. Satellite dialysis care (indirect distance supervision) shall be payable as a weekly management fee per patient using fee code 2058.

21.M Pain Management

Chronic Pain Consultation and Follow-up

Chronic pain management consultations and follow-up visits (fee codes 0250 and 0252) may be billed only by physicians designated by Health PEI as having additional recognized training and expertise in pain management.

Peripheral Nerve Blocks

Nerve blocks are eligible for payment only when rendered as an isolated service for diagnostic or therapeutic purposes. Nerve blocks administered as regional anesthesia prior to, during, immediately following a diagnostic, therapeutic or surgical procedure which the physician performs on the same patient are not eligible for payment. Local infiltration used as an anesthetic for any procedure is not eligible for payment. When a major plexus or peripheral nerve block is rendered, additional blocks of one or more nerves within the same nerve distribution are not eligible for payment.

Unless otherwise specified, all nerve block fee codes are for unilateral procedures only; if a bilateral block is performed, the second side is payable at 65% of the first.

Notwithstanding maximums applicable to individual nerve block services, there is an overall maximum of eight (8) per patient per day for any combination of nerve blocks. Nerve blocks beyond this overall maximum are not eligible for payment. Nerve blocks which are defined as a bilateral procedure are counted as two (2) services for the purpose of the overall daily maximum.

Peripheral nerve blocks with sclerosing solutions such as alcohol or phenol are payable as a 50% add-on premium to the peripheral nerve block fee, and require an explanatory comment on the claim.

Interventional Pain Injections

Interventional pain injections include injections into facet and sacroiliac joints, nerve roots, epidural and subarachnoid spaces, sympathetic nerve trunks and other deep nerve plexus/ganglia blocks rendered for the purpose of diagnosing the source of pain or developing a therapeutic treatment plan. Most of these injections are payable only when rendered with imaging guidance; in such cases, the imaging fees are included in the overall injection fee and are not payable

separately. Interventional pain injections include the injection of contrast, medication and/or other solutions.

Interventional pain injections are only eligible for payment if documentation clearly describes:

- the procedure performed or, where image guidance is used, images of needle placement that clearly identify the site of injection and/or spread of contrast; and,
- the purpose of any diagnostic pain-related injection and the subsequent response to the procedure indicating a positive or negative result.

22. LABORATORY SERVICES

22.A. Autopsies

A complete autopsy consists of dissection of the chest, abdomen, and head. A limited autopsy consists of dissection of a particular region with exclusion of other areas (e.g., dissection of the chest and abdomen, with exclusion of the head).

22.B. Cytology

Cytology fees are applicable to those cases requiring diagnosis after screening by a cytotechnologist or those cases requiring screening by a pathologist as part of an accepted and recognized quality control program.

23. DIAGNOSTIC IMAGING SERVICES

23.A. MRI - Limitations

(i)	Cranial repeat sequence	- Fee Code 8976	- maximum of three repeats
	Thorax repeat sequence	- Fee Code 8981	- maximum of three repeats
	Abdomen repeat sequence	- Fee Code 8983	- maximum of three repeats
	Spine repeat sequence	- Fee Code 8989	- maximum of three repeats
(ii)	ENT repeat sequence	- Fee Code 8978	- maximum of three repeats plus GAD
(iii)	Pelvis repeat sequence	- Fee Code 8985	- maximum of four repeats plus GAD
(iv)	Extremities repeat sequence	- Fee Code 8987	- maximum of three repeats

24. PATIENT ACCESS TO PHYSICIAN PROGRAM

The Patient Access to Physician Program terminates effective March 31, 2017. Claims for accepting new patients into a physician's practice during the period April 1, 2015 to March 31, 2017 will be determined based on the Preamble to the Tariff contents in the prior Master Agreement that expired on March 31, 2015.

25. MISCELLANEOUS

25.A. Time Limit - Submission of Claims

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

25.B. Time Limit - Surgical/Obstetrical Claims

The time period allowed before a surgical procedure becomes outdated for billing purposes shall begin on the date on which the major procedure was performed.

25.C. Time Limit - Claims on Extended Care Patients

Claims for services rendered to extended care patients and obstetrical patients should be submitted at appropriate intervals to ensure that no period greater than the allowable time elapses between the provision of a service and the date the corresponding claim is received at Health PEI.

25.D. Time Limit - Submission of Appeals

Physicians appealing a reduction or rejection of a claim also are required to submit their appeal prior to the expiry of the allowable time period from the date the claim appeared on a payment statement. Failure to do so shall result in the appeal being declared "stale dated" and not reviewed.

25.E. Maximum Visit

When there are more than 10 non-hospital visits in 90 days to the same physician, a comment record is required to substantiate payment of the claim.

26. UNINSURED SERVICES / Examinations Requested by a Third Party

Section 1(d)(I) (D) of the *Health Services Payment Act Regulations* states that "examinations required in connection with employment, insurance, admission to an educational institution or camp, procurement of a passport or visa or legal proceedings, or any similar examination at the request of a third party are excluded as Basic Health Services."

Included in the above would be services and examinations rendered at the request of the following groups:

a. Insurance companies
b. Educational institutions

c. Employers
d. Youth groups, e.g. Scouts Canada, Cadet Services of Canada
e. Various summer camps
f. Office of the Attorney General - PEI (e.g., court requests, jury duty exemption)
g. Workers' Compensation Board of any province or territory
h. Veterans Affairs Canada (incl. RCMP)
i. Citizenship and Immigration - Canada - e.g., Visa Purposes
j. Federal, Provincial or Municipal Governments
k. Physical Examination For Adoption Purposes
l. Advice and Injection for Out of Country Travel
m. National Defense Canada
n. Group examination immunizations or inoculations unless such group, prior to administration of such examinations, immunizations or inoculations, received approval thereof by the Minister – Section 1(d)(i)(E) – *Health Services Payment Act*.

Claims for discussion of a patient's condition with another member of the family, other than for psychotherapy or diagnostic/therapeutic interview, shall not be accepted as an insured service.

27. HOLIDAYS

For the purpose of the Tariff of Fees, the following days are designated holidays:

a. New Year's Day
b. Islander Day
c. Good Friday
d. Easter Monday
e. Victoria Day
f. Canada Day
g. Labor Day
h. Thanksgiving
i. Remembrance Day
j. Christmas Day
k. Boxing Day
l. Christmas Eve Afternoon (12 noon)
m. Floating holiday
   - Friday of Summerside Lobster Festival week (or in the absence of the Festival, the 2nd Friday in July) for Prince County
   - Gold Cup and Saucer Day for Queens & Kings Counties

When a statutory holiday falls on a Saturday or Sunday and when such statutory holiday is celebrated on a subsequent weekday, holiday rates shall apply for services rendered on an emergency basis on that designated weekday.

Holidays are considered to begin at 08:00 hrs on the day of the holiday (or designated holiday), and end at 08:00 hrs the following morning.

28. INTERPROVINCIAL RECIPROCAL BILLING OF MEDICAL CLAIMS

On April 1, 1988 a reciprocal billing arrangement for physician's medical claims came into effect between Prince Edward Island and all provinces and territories except Quebec.

The arrangement allows Prince Edward Island physicians to bill Health PEI directly for services rendered to eligible Canadian residents other than residents covered by the Quebec Plan.

29. WORKERS' COMPENSATION BOARD CLAIMS

Where a patient receives services for a WCB-related complaint and at the same visit, receives a service for an unrelated diagnosis, both services may be billed to the respective paying agencies.

30. PRIOR APPROVAL

All physician referrals made for non-emergency out-of-province/out-of-country physician or hospital services must receive prior approval from Health PEI. Prior approval is not necessary in the case of emergency transfers but an emergency out-of-province referral request must still be reported on a claim to Health PEI using the appropriate out-of-province referral fee code. Failure to obtain prior or emergency approval shall result in the patient/parent being held responsible for the total costs of the services. Schedule D outlines the policy/procedures for the out-of-province referral program. Such prior approval is valid for a period of one (1) year.

31. AUDIT PROCESS

An audit process is defined in the *Health Services Payment Act and Regulations* which charges Health PEI with the responsibility to ensure accountability for expenditures on basic health services.

32. ADMINISTRATIVE MEETINGS

A physician is eligible to claim an Administrative Meeting fee (fee code 0050) when the meeting meets the following criteria:

(a) The meeting is initiated or authorized by an individual to whom the physician is accountable, for example, a Medical Director or Health Care Network Manager;
(b) The meeting is planned in advance; and
(c) The discussions of the meeting are documented.

Up to two meetings per month are eligible for payment for workplace/unit staff meetings, for example, hospital department staff meetings and primary health care clinic staff meetings.

In addition, presentations for education sessions are eligible to be claimed as administrative meetings, provided the education sessions are part of the physician's duties and the sessions are being done at the direction of a supervisor. Preparation time to a maximum of four (4) hours may also be eligible.

Attendance at CME (professional development) and meetings with medical supply or pharmaceutical representatives are **not** eligible for this fee.

Any physician who receives an honorarium or an administrative stipend for such meetings is **not** eligible to claim the Administrative Meeting fee for these meetings.

Billing should be claimed as fee code 0050 per 15 minutes, using Provincial Health Number "01741230" and Diagnostic Code "V689". Time of day, time spent and comments are required on the claim, which should be billed as fee-for-service or shadow-billing, depending on the physician's payment modality at the time of the meeting.

33. TRANSITIONAL PROVISION

Claims for services or procedures during the period April 1, 2015 to March 31, 2017 will be determined based on the Preamble to the Tariff contents in the prior Master Agreement that expired on March 31, 2015.

Preamble APPENDIX A

TREATMENT LOCATIONS

Code	Facility
001	Queen Elizabeth Hospital
002	Hillsborough Hospital
003	Prince County Hospital
004	Western Hospital
005	King's County Memorial Hospital
006	Community Hospital
007	Souris Hospital
009	Dr. Eric Found Centre
011	Addiction Services (Queen's County)
012	Addiction Services (Souris)
013	Addiction Services (Summerside)
014	Beach Grove Home
015	Prince Edward Home
016	Wedgewood Manor
017	Summerset Manor
018	Maplewood Manor
019	Colville Manor
020	Riverview Manor
021	Garden Home
022	Whisperwood Villa (Long Term Care)
023	Lennox Nursing Home
024	Parkwest Lodge
025	Atlantic Baptist Home
026	MacMillan Lodge
027	Sunset Lodge
028	Clinton View Lodge (Long Term Care)
029	Dr. John Gillis Lodge (Long Term Care)
030	South Shore Villa (Long Term Care)
031	Sherwood Home
032	Provincial Correctional Centre
033	Prince County Jail
034	PEI Youth Centre
035	Community Care Facilities
036	Margaret Stewart Ellis LTC (Community Hospital)
037	Long Term Care (Stewart Memorial Manor)
038	Acute Care No Longer Required (Western Hospital)
039	Visiting Specialist (Prince County Hospital)
040	Visiting Specialist (Queen Elizabeth Hospital)
041	Patient's Home
042	Lady Slipper Villa
043	Acute Care No Longer Required (King's County)
044	Acute Care No Longer Required (Souris Hospital)
045	Whisperwood Villa (Community Care)
046	Clinton View Lodge (Community Care)
047	Dr. John Gillis Lodge (Community Care)
048	South Shore Villa (Community Care)
049	Salaried Physician Office (Souris)
150	Davis Lodge (Community Care)
151	Rev. Phillips Residence (Community Care)
152	Le Chez Nova (Community Care)
153	MacDonald Rest Home (Community Care)
154	MacEwen Mews (Community Care)
155	Miscouche Villa (Community Care)
156	Andrews Lodge - Charlottetown (Community Care)
157	The Valley Lodge (Community Care)
158	Corrigan Home (Community Care)
159	Corrigan Lodge (Community Care)
160	Langille House (Community Care)
161	MacQuaid Lodge (Community Care)
162	Old Rose Lodge (Community Care)
163	Riverview Rest Home (Community Care)
164	Rosewood Residence (Community Care)
165	MacKinnon Pines (Community Care)
166	Shady Rest (Community Care)
167	Bayview Lodge (Community Care)
168	Addiction Services (Montague)
169	Addiction Services (Alberton)
170	Andrews Lodge II (Summerside)
171	Richmond Centre
172	McGill Centre
173	Four Neighbourhoods Community Health Centre
174	Lacey House
175	Mental Health Clinic (Summerside)
176	Beechwood Family Health Centre (O'Leary)
177	Central Queens Health Centre (Hunter River)
178	Gulf Shore Family Health Centre
179	Polyclinic Night Clinic
180	Harbourside Family Health Centre (Summerside)
181	Smith Lodge
182	Boardwalk Professional Clinic
183	Salaried Physician Office (Montague)
184	Polyclinic
185	Parkdale Medical Centre
186	Addiction Services (Mt. Herbert)
187	Garfield Street
188	Sherwood Medical Centre
189	Andrews Lodge (Stratford)
190	Crapaud Wholeness Family Clinic
191	O'Leary Health Centre
192	Tyne Valley Health Centre
193	Eastern Kings Health Centre
194	Guardian Drug O'Leary Clinic
195	Murphy's Stratford Walk-in Clinic
196	Physician's Home
946	Dr. Alfredo Campos Office
947	Dr. Paul Phelan Office (Summerside)
948	Morell Walk-In Clinic
951	King's County Medical Centre
952	Western Hospital Clinic
953	Charlottetown Area Health Centre
954	Summerside Medical Centre
955	Belvedere Eye Clinic
956	Cornwall Medical Centre
957	Kensington Family Medical Centre
958	Stratford Medical Clinic
959	Wholeness Family Clinic (Crapaud)
960	Dr. Hani Farag Office
961	Dr. Abdulrahem Laftah Office
962	Dr. Issam Habbi Office
963	Dr. Baldev Sethi Office
964	Dr. Phil Hansen Office
965	Dr. Chris Stewart Office
966	Dr. Gregory Mitton Office
967	Drs. Guy & Andrew Boswall Office
968	Dr. Lloyd Molyneaux Office
969	Dr. Harold Molyneaux Office
970	Dr. Sterling Keizer/Dr.Heather Keizer Office
971	Dr. Trina Stewart Office

Code	Facility
972	Hove Family Physician Clinic - Alberton
973	Tignish Medical Center
974	Linden Avenue Medical Center
975	Drs. Singh/Dhillon Office
976	Dr. David I. Stewart (South Shore Pharmacy)
977	East Prince Health Centre (Summerside)
978	Murphy's Community Centre
979	Parkhill Place (Summerside)
980	Park Lane Medical Clinic
981	Geneva Villa (Charlottetown)
982	Perrin's Marina Villa (Montague)
983	Lennox Island Health Centre
984	Abegweit First Nation Mikmaq Wellness Centre (Scothfort)
985	Flu Clinic (various locations)
986	Charlottetown Civic Centre
987	Kensington Community Care Centre
988	West Prince Family Health Clinic
989	Stamper Residence
990	Charlotte Residence
991	Tignish Seniors Home Care Co-op
992	Dr. Jonathan Sharp Office
993	Seaside Medical Centre (Souris)
994	Murray River Health Centre
995	Spring Park National Walk-In Clinic
996	Dr. Jaggi Rao Office (Alberta)
997	Ground Ambulance Service
998	The Mount (Long Term Care)
1000	Sea Isle Medical Centre (Summerside)
1001	Queen St. Medical Centre
1002	Superstore Summerside Walk-In Clinic
1003	Holland College Charlottetown Centre
1004	Provincial Palliative Care Centre
1018	UPEI
1020	Chances Family Centre
1028	Dr. Naqvi Office
1029	Adolescent Day Treatment Centre
1030	Dr. Ben Spears Office
1031	Women's Wellness Program
2744	Maritime Sleep Clinic

SERVICE SITES

CODE	SERVICE SITE (Facility Type)
01	OFFICE
02	HOME
03	HOSPITAL IN-PATIENT
04	HOSPTIAL OUT-PATIENT
05	OTHER OFFICE
06	DAY SURGERY
07	SPECIALTY CLINIC IN HOSPITAL
08	COMMUNITY CARE / NURSING HOME
09	OTHER SITE
10	A - UPEI CLINIC
11	D - DETOX CENTRE
12	F - FIRST PATIENT
13	I - IN-PATIENT RADIOLOGY
14	N - NIGHT CLINIC
15	O - OUT-PATIENT RADIOLOGY
16	P - PCH VISITING SPECIALIST
17	Q - QEH VISITING SPECIALIST
18	S - SATURDAY/SUNDAY OFFICE
19	X - RADIOLOGY
20	PROVIDER ANY FACILITY TYPE
21	E - EMERGENCY RADIOLOGY
27	WALK-IN CLINIC
101	PUBLIC DENTAL FACILITY
102	PRIVATE DENTAL FACILITY
103	PUBLIC HEALTH HYGEINIST

SPECIALTY CODES

Code	Specialty	Code	Specialty
01	General Practice	29	Pediatric Psychiatry
02	Anesthesia	30	Nephrology
03	Dermatology	31	Specialist (Shadow Billing)
04	General Surgery	32	Locum - Psychiatry (Shadow Billing)
05	Internal Medicine	33	Locum - Souris (Salaried Billing)
06	Neurosurgery	34	Locum - Montague (Salaried Billing)
07	Obstetrics & Gynecology	35	Locum - Queens Region (Salaried Billing)
08	Ophthalmology	36	Locum - P.C.H. (Salaried Billing)
09	Orthopedic Surgery	37	Locum - Alberton (Salaried Billing)
10	Otolaryngology	38	Locum - O'Leary (Salaried Billing)
11	Pediatrics	39	Locum - Tyne Valley (Salaried Billing)
12	Psychiatry	40	Long Term Care (Shadow Billing)
13	Urology	42	Pediatric Rheumatology
14	Dentistry	43	Medical Microbiology
15	Radiology	44	Emergency Medicine
16	Physical Medicine	45	Medical Oncology Clinical Associate
17	Radiation Oncology	46	Pain Management
18	Respirology	47	Palliative Care
19	Anatomic Pathology	48	Radiation Oncology Clinical Associate
20	Optometry	49	Hospitalist
21	Addictions	50	Pediatric Gastroenterology
22	Neurology	94	Nursing
23	Medical Oncology	95	Nurse Practitioner
24	Pediatric Cardiology	96	Dental Preventative
25	Neonatology	97	Plastic Surgery
26	Genetics/Metabolic diseases	98	All but Dental
27	ED On-Site Sessional Shadow Billing	99	G.P. and Eye Exams
28	Geriatric Medicine	100	Pharmacy

Preamble APPENDIX B

CLAIM MESSAGES

ID	DESCRIPTION	ID	DESCRIPTION
1	MORE THAN 3 MESSAGES	155	TIME SPENT MISSING
2	PROVIDER HAS NO ADMITTING PRIVILEGES	156	FEE CODE MISSING
3	LOCUM COVERING ON TIME/DATE OF SERVICE	157	FEE CLAIMED MISSING
80	INCORRECT NUMBER OF SURFACES	158	LETTER ON FILE @ MEDICAL ADVISOR
81	SERVICE SAME DAY	159	PERINATAL DEATH-NO P.H.N. ASSIGNED
82	MORE THAN 4 X-RAYS DURING YEAR	160	REFERRING PROVIDER NAME MISSING
83	X-RAY LIMIT REACHED FOR YEAR	162	CANCEL-NO REPLY TO CORRESPONDENCE
84	INVALID TREATMENT STATUS	163	FEE CODE CHANGED TO CORRESPOND WITH DIAGNOSIS
85	NO MORE THAN ONE EXAM PER YEAR	164	CLAIM VOID (PROVIDERS REQUEST)
86	PRIVATE DENTIST CLAIMING SEALANT FEE CODE	165	EXPLANATION ON CLAIM,LOOK IT UP
87	85% REDUCTION RATE	166	SEE WRITTEN CORRESPONDENCE
88	INCORRECT AGE FOR TOOTH AND FEE CODE	167	RES# SUPPLIED,IGNORE SERVICE DATE
89	INCORRECT AGE FOR FEE CODE	168	CLAIM CREATED,SEE ORIGINAL
90	PRIVATE DENTIST SHOULD NOT BE PAID	169	PATIENT NOT REGISTERED
91	MORE THAN ONE SERVICE PER YEAR ON SAME TOOTH	170	CLAIM MODIFIED BY PROV AUDITOR
92	EMERGENCY ON SAME DAY AS OTHER SERVICE	171	BILLED TO WRONG RESIDENT
93	FILLING PERFORMED ON SAME DAY & TOOTH	172	MEDICAL NECESSITY ESTABLISHED
94	INVALID SURFACES FOR FEE CODE	173	ADVISED BY PROVIDER (PHONE OR COMMENT)
95	REGISTRATION FEE COLLECTED	174	M.A.C. DECISION
96	FEE CODE DOESN'T MATCH TOOTH	176	COMMENT EXISTS/CLAIM APPROVED
97	TOOTH PREVIOUSLY EXTRACTED	177	ADDED ONLINE BY ADD NEW CLAIM SCREEN
98	CLAIM TOO OLD	178	RETROACTIVITY PAID MANUALLY
99	INVALID QUADRANT/TOOTH	179	SERVICE DATE > RECEIVED DATE
100	IN SUSPENSE - DATA CAPTURE	180	CLAIM NUMBER.NOT IN ASSIGNED RANGE
101	NEWBORN - WAITING FOR P.H.N.	181	NO CLAIM # RECORD FOR PRACTITIONER
102	RESIDENT NOT ELIGIBLE ON DATE OF SERVICE	182	MOVED FROM 51,52,53 TO 64 ZERO PAY
103	NO HOUSEHOLD FOR RESIDENT	183	RESIDENT HAD INVAL OR TEMP S.I.N.
104	PROVIDER NOT ACTIVE ON DATE OF SERVICE	184	CLAIM TYPE 8,MAY BE NEWBORN
105	PROVIDER SPECIALTY NOT ELIGIBLE ON DATE	185	IN-PATIENT CLAIM SHOWS DIFFERENT DATES
106	PROVIDER SPECIALTY NOT ON FEES RECORD	186	SALARIED PHYSICIAN-PAY @ ZERO
107	FACILITY TYPE NOT ON FEES RECORD	187	CIHI QEH/PCH MISSING DATA
109	VALIDATION ATTEMPTS > 8	188	DISCHARGE-ADMIT NOT= DAYS STAY
110	CLAIM IS ON HOLD - CLAIMS AUDITOR	189	CLAIM HAS BEEN SENT FOR M.A.D.
111	NO LOT NUMBER FOR HOUSEHOLD	191	AMOUNT APPROVED REMOVED PAID IN ERROR
112	SERVICE DATE NOT SATURDAY OR SUNDAY	197	OUT OF PROVINCE LOCATION 213 CHOICE PROGRAM
113	ELIGIBILITY SUSPENDED HEALTH ACT	198	OUT OF PROVINCE LOCATION 417 HOMEWOOD HEALTH
114	PHYSICIAN NOT ELIGIBLE FOR PROGRAM	199	ORIGIN/BATCH# CHGD FROM PREVIOUS#
115	PATIENT NOT ON REGISTRY	201	RESIDENT NUMBER NOT ON FILE
151	DIAGNOSIS MISSING/NOT LEGIBLE	202	MISMATCH ON RESIDENT DATE OF BIRTH
152	PROVIDER NUMBER MISSING	203	MISMATCH ON RESIDENT SEX
153	DATE OF SERVICE MISSING	204	PROVIDER NOT ON FILE
154	TIME OF DAY MISSING ON CHART	205	PROVIDER SPECIALTY DOES NOT AGREE

206	REFERRED TO NOT ON FILE
207	REFERRED BY NOT ON FILE
208	BILLING PROVIDER SAME AS REFERRED TO/BY
209	PAYEE NOT ON FILE
210	FEE CLAIMED NOT ON FILE
211	DIAGNOSTIC CODE NOT ON FILE
212	TREATMENT LOCATION NOT ON FILE
214	PROVIDER ROLE CORRECTED
215	INVALID DATE OF SERVICE
216	VERIFY DATE OF SERVICE (OVER 7 MONTHS)
217	CANCELLED SHOULD BE SHADOW BILLED
218	CLAIM ADDED BY ONLINE TRANSACTION
219	RESPONSIBILITY FOR PAYMENT NOT INDICATED
220	ADJUSTMENT MADE MANUALLY
221	ERROR MADE BY BILLING PROVINCE
222	BATCH NUMBER NOT VALID
223	COMMENT INDICATOR REQUIRED
224	EMERGENCY INDICATOR REQUIRED
225	PROVINCE CODE NOT VALID
226	DOS CHANGED TO PROCESS ADJUSTMENT
227	CLAIM ALREADY SENT FOR M.A.D
228	P.H.N.REQURIED FOR PAYMENT
230	NOT ADMITTING PROVIDER
231	CLAIM APPROVED RE O.R. CORRESPONDENCE
232	CLAIM NOT APPROVED RE O.R. CORRESPONDENCE
233	NOT APPROVED RE W.C.B LIST
234	PROVIDER NOT ON CALL
235	WORKING VISA EXPIRED
236	O.K. TO PAY REGISTRATION PROBLEM
237	SERVICE COUNT NE INDIVIDUAL CLAIMS
238	BILL UNDER ASSIGNED P.H.N.
500	SERVICES TOO FREQUENT SAME PROVIDER
501	SERVICES TOO FREQUENT DIFFERENT PROVIDER
502	AGE DOES NOT MATCH FEE CODE
503	PATIENT NOT FEMALE
504	PATIENT NOT MALE
505	SERVICE AFTER HOURS
506	TWO VISITS/CONSULTS + EXPLANATION
507	OTHER SERVICE SAME DAY EXAM
508	TWO EXAMINATIONS WITHIN SPAN
510	MORE THAN ONE INITIAL VISIT IN 30 DAYS
511	MORE THAN 10 VISITS
512	VISIT DURING HOSPITALIZATION
514	SERVICE PRIOR TO INITIAL HOSPITAL VISIT
515	INITAL HOSPITAL VISIT ON RE-ADMISSION
516	SERVICE SAME DAY AS HOME VISIT
517	SERVICE SAME DAY AS OUT PATIENT
518	OUTSIDE REGULAR HOURS
519	DOUBLE BILLING
520	ADDITIONAL SERVICE FOR NEWBORN
521	OVER TIME LIMIT
522	HOSPITAL VISIT BEING PAID
523	PREVIOUSLY PAID WITHIN 24 HRS
524	SERVICE SAME DAY AS ANAESTHESIA
525	NO SURGICAL SERVICE ON HISTORY
527	MAJOR CONSULTATION PREVIOUSLY PAID
528	REPEAT CONSULTATION PREVIOUSLY PAID
529	LIST 1 PROCEDURES BEING PAID
530	TWO EYE EXAMS
531	TWO LIST 2 PROCEDRES SAME DAY
532	AGE LIMIT-CHILD OVER 4 YEARS
533	CONSULTATION AND SURGERY < 200
534	TWO SURGICAL PROCEDURES
535	VISIT AFTER SURGERY
536	VISIT PRIOR TO SURGERY
537	DUAL ROLE IN SURGERY
538	NO CLAIM FROM SURGEON
539	FRACTURE PREVIOUSLY PAID
540	CLOSED FOLLOWED BY OPEN
541	SKULL CALIPER THEN SPINAL SURGY
542	PACEMAKER AND VISITS
543	INITAL VISIT AND CONSULTATION
545	CONSULT NOT PAYABLE INCLUDED IN COMPLETE
547	VISIT AFTER SURGERY-NOT PAYABLE
548	VISIT SAME DAY SURGICAL PROCEDURE
549	THERAPUTIC LIST 2 WITH SURGERY
550	ONLY TWO SESSIONS PER WEEK
551	VERIFY FEE CODE CLAIMED
552	ADJUST FEE CODE TO APPROVE
553	REFERRAL PENDING APPROVAL
554	APPROVED REFERRAL ON FILE
555	REJECTED REFERRAL ON FILE
556	NO REFERRAL ON FILE FOR SERVICE
559	CHART NUMBER CONTAINS NON-NUMERIC DATA
577	CLAIM PAID TWICE-CHECK HISTORY
578	CLAIM PUT TO HISTORY ONLY(ONLINE)
597	REQUIRES INDEPENDANT CONSIDERATION
598	ASSESSMENT ATTEMPTS > 8
599	CLAIM TO BE MANUALLY ASSESSED
601	INVALID FORMAT IN DATE OF BIRTH
602	SEX INDICATOR MUST BE M OR F
603	SPECIALTY CODE MUST BE 46388 OR 99
604	CORRUPT DATA IN RESIDENT NAME
605	ROLE CONTAINS CORRUPT DATA

606 INVALID FORMAT IN SERVICE DATE
607 HOUR OF DAY/SPENT MUST BE 44927
608 TIME OF DAY SPENT/MIN RANGE 21551
609 SERVICE COUNT CONTAINS INVALID DATA
610 SERVICE SITE CONTAINS INVALID DATA
611 REF TO/BY CONTAINS INVALID DATA
612 PAYMENT RESP CONTAINS INVALID DATA
613 EMERGENCY INDICATOR CONTAINS INVALID DATA
614 BATCH NUM CONTAINS CORRUPT DATA
615 I.C. INDICATOR CONTAINS INVALID DATA
616 FEE CODE CONTAINS INVALID DATA
617 DIAGNOSTIC CODE CONTAINS INVALID DATA
618 TREATMENT LOCATION CONTAINS INVALID DATA
619 O.P. REG# CONTAINS INVALID DATA
620 PROVINCE CODE FOR HOST INVALID DATA
621 UNABLE TO LOCATE/CONTACT PATIENT
622 NO STEP DOWN AVAILABLE
700 CLAIM PAID AT CHILDS RATE
701 CLAIM PAID AT NEWBORN RATE
702 FEE CODE ADJUSTED
703 AGE PROHIBITS THIS SERVICE
704 FEE CODE AND AMOUNT ADJUSTED
705 AFTER HOURS PREMIUM ADDED
706 TWO VISITS SAME DAY NOT PAYABLE
707 PAYMENT INCLUDED WITH SURGICAL FEE
708 PAID AT G.P.RATES NOT SPECIALTY
709 MAXIMUM 1 HEALTH EXAM PER YEAR
710 HEALTH EXAM NOT PAID-AGE FACTOR
711 ASSISTANTS FEE INCLUDES THIS SERVICE
712 WELL BABY CARE VISITS EXCEEDED
713 MAX TIME/SESSIONS EXCEEDED
714 PSYCHOTHERAPY PREVIOUSLY PAID
715 INTENSIVE CARE VISIT PREVIOUSLY PAID
717 VISIT/CONSULT PREVIOUSLY PAID
718 TOTAL NUMBER OF SERVICES EXCEEDED
719 CONVALESCENT CARE,ONLY IN COMMUNITY CARE FACILITY
720 INITIAL VISIT RULED REPEAT
721 PATIENT IN HOSPITAL ON SERVICE DATE
722 MEDICAL ADVISORS DECISION
723 PROCEDURE CONSIDERED SOLE PURPOSE FOR VISIT
724 SEX DOES NOT MATCH FEE CODE
725 NOT PAYABLE OUTSIDE OFFICE HOURS
726 BILATERAL PROCEDURES PAID AT 0.5
727 APPARENT DUPLICATE CLAIM
728 ANOTHER PROVIDER PAID SAME SERVCE
729 FEE CLAIMED EXCEEDS TARIFF AMOUNT
730 PAID CORRESPONDING TO SURGEONS CLAIM
731 FEE ADJUSTED TO SERVICES RENDERED
732 NUMBER OF VISITS EXCEEDED FIRST 35 DAYS
733 LIST 1 NOT PAYABLE IN ADDITION TO THIS SERVICE
734 REDUCED TO REPEAT CONSULTATION
735 CONSULT NOT PAYABLE WITH ANESTHESA
736 POST-OP VISITS
737 TEN VISITS EXCEEDED IN 90 DAYS EXPLANATION REQUIRED
738 CLAIM INELIGIBLE AFTER 6 MONTHS
740 RE-ADMITTED WITHIN TEN DAYS
741 PRIOR TO PATIENTS ELIGIBILITY DATE
742 PATIENT NOT REGISTERED
743 REFERRAL DENIED-SERVICE PROVIDED LOCALLY
744 PATIENT NO LONGER ELIGIBLE
745 WRITTEN CORRESPONDENCE ON FILE
746 D.V.A./ R.C.M.P./D.N.D RESPONSIBILITY
747 W.C.B. RESPONSIBILITY
748 REDUCED TO OFFICE VISIT RATE
749 NOT PAID WITHOUT EXPLANATION
750 NUMBER OF VISITS EXCEEDED 6th-13th WEEK
751 MAXIMUM FEE AFTER 13th WEEK
752 MAXIMUM SUPPORTIVE CARE(7 VISITS)
754 MAXIMUM DIRECTIVE CARE VISITS EXCEEDED
755 REPEAT OPERATION PAID AT LOWER RATE
756 PROVIDER SPECIALITY NOT ON FEES RECORD
757 CLOSED FOLLOWED BY OPEN REDUCTION @ 0.5
758 SEPARATE INCISION PAID AT 0.65
759 NOT INPATIENT ON DATE OF SERVICE
760 CONSULT/VISIT NOT PAID WITH PROCEDURE
761 PREVIOUS PAYMENT MADE ON THIS DATE
762 HEALTH EXAM-3rd PARTY UNINSURED
763 PROVIDER SPECIALITY DOES NOT AGREE
764 PROCESSING ERROR(CLAIM ADJUSTED)
765 HOST REGISTRATION NUMBER NOT VALID
766 PROVIDER NOT ELIGIBLE ON DATE OF SERVICE
767 AFTER HOURS PREMIUM NOT APPLICABLE
768 FACILITY TYPE NOT ON FEES RECORD
769 NO REPLY TO CORRESPONDENCE WITH PROVIDER
770 I.C.U. NOT PAYABLE AFTER 1st DAY
771 PAID AS CONVALESCENT CARE
772 NOT PAID WITH HEALTH/COMPLETE EXAM
773 CORRECTED RESIDENT INFORMATION
774 MISMATCH ON RESIDENT SURNAME
775 UNINSURED SERVICE
776 NOT PAYABLE WITHOUT PSYCH VISIT
777 FOR APPROVAL,RE-$AMOUNT APPROVED
778 HOSPITAL CODE 10 REQUIRED
779 EMERGENCY NOT INDICATED

780	CONSIDERED TRANSFERED,NOT CONSULT'
781	CONSIDERED INCIDENTAL SURGERY
782	MULTIPLE PROCEDURES-SAME INCISION, 0.5
783	ADMITTING PROVIDER BILLS TOTAL HOSPITAL CARE
784	MEDICAL NECESSITY NOT ESTABLISHED
785	SUPP CARE MAY APPLY-RESUBMIT
786	ROLE IN ERROR DUE TO SERVICE CATEGORY
787	CORRECTED CLAIM INFORMATION
788	DOES NOT AGREE WITH SURGEONS CLAIM
789	PLEASE VERIFY RESIDENT INFORMATION
790	FEE CODE CLAIMED CORRECTED
792	MULTIPLE PROCEDURES-REDUCED FEE
793	REFERRAL APPROVED
794	NOT COVERED BY W.C.B.
795	TIME OF DAY/SPENT NOT ON CLAIM
796	REFERRING PROVIDER NOT INDICATED
797	RETROACTIVE PAYMENT APPLIED
798	CLAIM IMPROPERLY COMPLETED
799	DIAGNOSTIC CODE NOT ON FILE
800	HOST REGISTRATION NUMBER NOT VALID
801	APPROVED REFERRAL ON FILE
802	SERVICE DEEMED EMERGENCY
803	NOT APPROVED-REFERRAL ON FILE
804	HOSPITAL LOCATION CODE INAPPROPRIATE
805	SERVICE DATE/COUNTS NOT =
806	DIAGNOSTIC CODE INAPPROPRIATE
807	PAID AT MAXIMUM WEEKLY RATE
808	QUE RESIDENT-BILL PROVINCE DIRECT
809	VISIT MUST BE BILLED PRIOR TO DETENTION
810	TIME AND/OR DAY INCORRECT
811	FACILITY TYPE DOESN`T MATCH ADMISSION/DISCHARGE
812	SERVICE DATE DOESN'T MATCH ADMISSION/DISCHARGE
813	FACILITY TYPE AND FACILITY MISMATCH
820	NO REFERRAL BUT WOULD BE APPROVED
821	NO REFERRAL QUESTIONABLE APPROVAL
822	NO REFERRAL WOULD NOT BE APPROVED
823	NOT ASSESSED.D.O.S.PRIOR TO 970701
825	REQUEST CANCELLED UNABLE TO ASSESS
826	NON-INSURED SERVICE
827	CONTRACT ADJUSTMENT FROM N.B.
828	IGNORE CLAIM-DUPLICATE SUBMISSION
829	PATIENT HAS VALID P.H.N FOR P.E.I.
830	CORRECTED PROVIDER SPECIALTY
831	$ APPROVED ADJUSTED TO ZERO
832	UNABLE TO LOCATE PATIENT
833	STUDENT OFF ISLAND
834	RESIDENT LEFT P.E.I.
835	RESIDENT COVERED BY ANOTHER PROVINCE
836	ADJUSTMENT MADE BY OTHER PROVINCE
837	FAMILY MEMBER A STUDENT
838	WAITING PERIOD - NEW PROVINCE
839	RESIDENT IN ELIGIBILITY STATUS 40
840	PATIENT UNDER CARE OF SPECIALIST
841	LACK OF INFORMATION PLEASE CLARIFY
842	SERVICE SITE/FEE CODE INCORRECT
843	DATE OF SERVICE INCONSISTENT
844	INSUFFICENT DOCUMENTATION
845	NO DOCUMENTATION AVAILABLE
846	PATIENT UNDER CARE OF GEN.PRACT.
847	SERVICE NOT AN EMERGENCY SITUATION
848	PATIENT WENT FROM OPD DIRECTLY ICU
849	PATIENT NOT SEEN BY PROVIDER ON THIS DATE
850	PATIENT OUT ON PASS
851	PATIENT IS DECEASED-AUDIT
852	TIME SPENT NOT INDICATED ON FILE
853	MONEY RETRIEVED MANUALLY
854	PAYMENT NOT REVERSED NO $ FOR PROVIDER
855	DOLLAR AMOUNT REDUCED BY CLAIMS AUDITOR
856	CLAIM ASSESSED BY CLAIMS AUDITOR
857	ADJUSTED TO APPROPRIATE FEE CODE
858	REFERRAL LETTER NOT AT SITE BILLED
859	TWO OR MORE PATIENTS SAME TIME NOT PAYABLE
860	APPEAL APPROVED BY MEDICAL ADVISOR
861	COMMENT HAS INSUFFICENT INFORMATION
862	SECOND DIAGNOSIS REQUIRED (M.A.)
863	CONFILCT WITH O.R. REPORT (M.A.)
864	PAYMENT IS INCLUDED IN PREVIOUS FEE CODE
865	PROVIDER NOT SESSIONAL AT TIME OF SERVICE
866	LONG TERM CARE PATIENT
867	PILOT PROGRAM CRITERIA NOT MET FOR PAYMENT
875	RESPONSIBILITY OF BILLING PROVINCE
876	CLAIM INELIGIBLE AFTER 3 MONTHS
877	PATHOLOGY REPORT REQUIRED
878	VERIFY AFTER HOURS PREMIUM
879	FACILITY INCORRECT
897	RETRO CLAIM COULD NOT BE MATCHED TO ORIGINAL CLAIM
900	*EMPTY*
901	CONSULT
902	CONSULT/INVESTIGATION
903	CONSULT/INVESTIGATION/TREATMENT
904	VERIFY HOST NUMBER
999	CLAIM CONVERTED FROM OLD SYSTEM
1000	CORRESPONDENCE NOT SENT BACK TO REFERRING PROVIDER
1001	MEDICAL ADVISORS DECISION WITH CLAIMS AUDITOR'S INPUT

1002	RESIDENT DECEASED
1003	PROVIDER OVER CAP
1004	O.R. REPORT NOT ON FILE
1005	PROVIDER BILLED PATIENT FOR SERVICE-PATIENT REIMBURSED
1006	CHECK ELIGIBILITY FOR P.E.I.
1007	RESIDENT ISSUED NEW P.H.N
1008	INFORMATION UPDATE NO PAYMENT ADJUSTED
1009	NO LETTER ON FILE
1010	CLAIM ON HOLD-ASSESSMENT
1011	PROCEDURE CODE NOT ON FILE
1012	PHN/FEE CODE/FACILITY MISMATCH
1013	SHOULD BE CLAIM TYPE 6
1014	NO FACILITY REQUIRED
1015	PATIENT U.S. RESIDENT
1016	PRIOR APPROVAL REQUIRED
1017	CLAIM ASSESSED RE: PREAMBLE TO THE TARIFF OF FEES
1018	VERIFY PROVIDER ROLE
1019	OOP PROVIDER SPECIALITY CODE NOT ON FILE
1020	SCALING AND/OR FLOURIDE NOT COVERED
1021	PAYMENT ADJUSTMENT ON PREVIOUSLY PAID CLAIM
1022	FEE CLAIMED DOES NOT EQUAL SERVICE COUNT
1023	FEE CLAIMED DOES NOT MATCH COMMENT
1025	MAXIMUM SUPPORTIVE CARE (7 VISITS)
1026	PATIENT NOT ON PROVINCIAL REGISTRY
1027	PHYSICIAN NOT ELIGIBLE FOR PILOT PROGRAM
1028	PATIENT NOT INDICATED ON PILOT PROGRAM
1029	NO PILOT PROGRAM APPLICATION AT REGISTRY OFFICE
1030	FEE FOR SERVICE NOT PAYABLE DURING CONTRACT/SALARY HOURS
1031	SERVICE NOT PROVIDED IN OFFICE

Preamble Appendix B - ***continued***

CLAIM STATUS

Code	Claim Status Description
11	To Process - Original Claim
12	To Process - Re-Edit Claim
21	In Suspense - Data Capture
22	In Suspense - Newborn
23	In Suspense - Hold Claim
24	In Suspense - Eligibility
25	In Suspense - Correction
31	In Error - Validation
35	In Error - Return To Provider
41	Pending Action - To Assess
42	Pending Action - To Review
43	Pending Action - To Review
44	Pending Action - To Adjust
45	Independent Consideration - MAC
46	Out of Province referral
47	Out of Province claim
51	To Pay
52	To Reverse
53	To Cancel
61	Settled - Paid
62	Settled - Reversed
63	Settled - Cancelled
64	Settled - History only
65	Cancelled History only

CLAIM TYPE

Code	Claim Type Description
1	In-Province - Pay Provider
2	In-Province - Pay Resident
3	In-Province - Hospital - In-Province Resident
4	In-Province - Hospital - OOP Resident
5	In-Province - Provider - OOP Resident
6	Out-Of-Province - Referral
7	Out-Of-Province - In-Patient
8	Out-Of-Province - Medical
9	Out-Of-Province - Out-Patient

Preamble APPENDIX C

NON-PATIENT SPECIFIC FEE CODE BILLING PARAMETERS

Service Description	Fee Code	Provincial Health No.	Diagnostic Code	Facility Type
On-Call Retainer (Queen Elizabeth Hospital) - See Preamble 11.D.1 and 11.D.2				
Anesthesia	0240	01696921	V85.1	3
Surgery	0440	01696947	V85.1	3
Internal Medicine	0540	01696962	V85.1	3
Ob/Gyn	0740	01696988	V85.1	3
Pediatrics	1140	01697036	V85.1	3
Surgical Assistant	0159	01853217	V85.1	3
Urban Family Physician - group of 1	0015	02155950	V85.1	3
Urban Family Physician - group of 2	0016	02155950	V85.1	3
Urban Family Physician - group of 3	0017	02155950	V85.1	3
Urban Family Physician - group of 4	0018	02155950	V85.1	3
Urban Family Physician - group of 5-7	0019	02155950	V85.1	3
Hospitalist (full-line)	0108	01942804	V85.1	3
Hospitalist (half-line)	0034	01942804	V85.1	3
On-Call Retainer (Prince County Hospital) - See Preamble 11.D.1 and 11.D.2				
Anesthesia	0240	01696939	V85.1	3
Surgery	0440	01696954	V85.1	3
Internal Medicine	0540	01696970	V85.1	3
Ob/Gyn	0740	01696996	V85.1	3
Pediatrics	1140	02052959	V85.1	3
Surgical Assistant	0159	02175453	V85.1	3
Urban Family Physician - group of 1	0015	02175313	V85.1	3
Urban Family Physician - group of 2	0016	02175313	V85.1	3
Urban Family Physician - group of 3	0017	02175313	V85.1	3
Urban Family Physician - group of 4	0018	02175313	V85.1	3
Urban Family Physician - group of 5-7	0019	02175313	V85.1	3
Hospitalist (full-line)	0108	02056851	V85.1	3
Hospitalist (half-line)	0034	02056851	V85.1	3
On-Call Retainer (Provincial) - See Preamble 11.D.1 and 11.D.2				
Nephrology	0549	02498186	V85.1	3
Ophthalmology	0840	01697002	V85.1	3
Orthopedics	0940	01697010	V85.1	3
ENT	1040	01697028	V85.1	3
Plastic Surgery	9740	01697069	V85.1	3
Psychiatry	1240	02155935	V85.1	3
Urology	1340	01697044	V85.1	3
Radiology	1540	01697051	V85.1	3

Service Description	Fee Code	Provincial Health No.	Diagnostic Code	Facility Type
Laboratory Medicine	1940	02155836	V85.1	3
Medical Oncology	2390	02155901	V85.1	3
Radiation Oncology	4840	02898989	V85.1	3
GP Oncology	0177	02155869	V85.1	3
GP Palliative Care	0179	02155877	V85.1	3
On-Call Retainer (Other)				
Unaffiliated Psychiatric inpatient - QEH	0199	02082220	V85.1	3
Overflow Unaffiliated inpatients - QEH	0066	01942796	V85.1	3
Medical Officer Rehab Unit - QEH	0147	01663608	V85.1	3
Medical Officer Hillsborough Hospital	0197	02155885	V85.1	3
Medical Officer Addictions - Mt. Herbert	0198	02155893	V85.1	3
Ambulatory Detox Service - PCH & Western	0158	02175461	V85.1	3
Corrections	0030	02280519	V85.1	3
Coroner - East	0020	02455822	V85.1	3
Coroner - West	0020	02455830	V85.1	3
Oncology backup - See Preamble 11.D.4..	0174	02155901	V85.1	3
Neurology backup - See Preamble 11.D.5	0503	02155927	V85.1	3
Rural Family Physician - Alberton	0040	02201085	V85.1	3
Rural Family Physician - O'Leary	0185	01530997	V85.1	3
Rural Family Physician - Tyne Valley	0185	01531003	V85.1	3
Rural Family Physician - Souris	0185	01530971	V85.1	3
Rural Family Physician - Montague	0185	02155943	V85.1	3
On-Call Per Diem (in lieu of Retainer plus FFS) - Salaried Specialists Only - See Article C3.2				
(Queen Elizabeth Hospital)				
Internal Medicine	0504	01696962	V85.1	3
Pediatrics	1152	01697036	V85.1	3
(Prince County Hospital)				
Internal Medicine	0504	01696970	V85.1	3
Pediatrics	1152	02052959	V85.1	3
(Provincial)				
ENT	1065	01697028	V85.1	3
Ophthalmology	0855	01697002	V85.1	3
Laboratory Medicine	1955	02155836	V85.1	3
Medical Oncology	2380	02155901	V85.1	3
Radiation Oncology	4855	02898989	V85.1	3
Palliative Care	0073	02155877	V85.1	3
Hospitalist Sessional Fee (daily)				
Hospitalist Type 1 - max. 21 beds	0107	02056844	V85.1	3
Hospitalist Type 1 - max. 11 beds	0102	02056844	V85.1	3
Hospitalist Type 2 - max. 17 beds	0101	01942796	V85.1	3
Hospitalist Type 2 - max. 09 beds	0037	01942796	V85.1	3

Service Description	Fee Code	Provincial Health No.	Diagnostic Code	Facility Type
Hospitalist Type 1 top-up Class I - 21 beds	0038	02056844	V85.1	3
Hospitalist Type 1 top-up Class II - 21 beds	0039	02056844	V85.1	3
Hospitalist Type 1 top-up Class III - 21 beds	0041	02056844	V85.1	3
Hospitalist Type 1 top-up Class I - 11 beds	0042	02056844	V85.1	3
Hospitalist Type 1 top-up Class II - 11 beds	0043	02056844	V85.1	3
Hospitalist Type 1 top-up Class III - 11 beds	0044	02056844	V85.1	3
Hospitalist Type 2 top-up Class I - 17 beds	0025	01942796	V85.1	3
Hospitalist Type 2 top-up Class II - 17 beds	0026	01942796	V85.1	3
Hospitalist Type 2 top-up Class III - 17 beds	0027	01942796	V85.1	3
Hospitalist Type 2 top-up Class I - 09 beds	0045	01942796	V85.1	3
Hospitalist Type 2 top-up Class II - 09 beds	0046	01942796	V85.1	3
Hospitalist Type 2 top-up Class III - 09 beds	0047	01942796	V85.1	3
ED Sessional Fee (hourly)				
ED Sessional Fee - Q.E.H.	0155	01533652	V85.0	4
ED Sessional Fee - P.C.H.	0156	01533660	V85.0	4
ED Sessional Fee - Kings County	0150	01530963	V85.0	4
ED Sessional Fee - Western	0152	01530989	V85.0	4
ED Sessional Night Premium QEH (weekday)	0076	01533652	V85.1	4
ED Sessional Night Premium QEH (w/e+holiday)	0077	01533652	V85.1	4
ED Sessional Night Premium PCH (weekday)	0076	01533660	V85.1	4
ED Sessional Night Premium PCH (w/e+holiday)	0077	01533660	V85.1	4
Administrative Meeting	0050	01741230	V68.9	
On-Line Medical Control				
On-Call Retainer	0090	02611861	V85.1	4
Telephone Advice (CEC) - non-Canadian	0071	02612406	V71.8	4
Telephone Advice (EMS) - non-PEI	0072	02612414	V71.8	4

Preamble APPENDIX D

PRIOR APPROVAL

Prior approval is required from Health PEI before some surgical procedures are undertaken. Care should be exercised in ensuring such approval has been granted, before the surgery is undertaken.

The following is a general outline of services that may be covered under prior approval.

FACE AND NECK

1. Scar revision in exposed areas of the head and neck related to trauma, disease or surgery, unless the initial surgery was for cosmetic reasons only, hence uninsured.

2. Blepharoplasty of upper eyelids if there is encroachment of the visual axis.

3. Outstanding, protruding or congenitally deformed ears, under 18 years of age.

4. Rhinoplasty may be approved if the malformation significantly obstructs the nasal airway.

5. Conditions amenable to pulse dye laser treatment of the head and neck for which prior approval is necessary include:

    1) Pyogenic Granuloma
    2) Glomus tumors
    3) Lymphangiomas
    4) Port Wine Stains

OTHER BODY AREAS

1. Scar revision is insured if scars cause a functional disability, or if revision is part of a pre-planned staged reconstructive procedure. Scar revision is also approved if there is a history of post-operative complications.

2. With prior approval, augmentation mammoplasty is insured for congenital or post surgical amastia. If unilateral augmentation mammoplasty is approved for the above reasons then a balancing operation such as reduction or mastopexy may be approved for the opposite breast.

3. Reduction mammoplasty requires prior approval, and is payable only once in a patient's lifetime. A BMI of 27 or less is mandatory as is an estimate in excess of 500 grams to be removed from each breast reduction application.

4. After successful treatment of morbid obesity by gastroplasty, intestinal by-pass surgery or strict dietary control, a lipectomy/panniculectomy, may be approved, and is payable only once in a patient's lifetime.

   Candidates who qualify for morbid obesity procedures must have:

   a) Body mass index greater than 40
   b) Evidence that weight loss has been attempted through several other accepted forms of reduction therapy
   c) Existing medical conditions which are being aggravated as a result of excess body weight.

5. Circumcision less than one year of age.

Fee codes requiring prior approval:

DESCRIPTION	FEE CODE
Augmentation by prosthesis - Unilateral	3072
Male mastectomy (Benign)	3077
Removal of breast prosthesis	3079
Surgical Planing, face for acne, whole face	3080
Surgical Planing, single area, e.g. trauma scar	3081
Reduction - Mammoplasty - Unilateral	3082
Augmentation by prosthesis - Bilateral	3083
Rhinoplasty, with or without graft, and closure of septal perforation	4016
Gastric partition for morbid obesity	5233
Gastric partition plus all other procedures for morbid obesity	5234
Lipectomy, removal of panniculus	5456
Ptosis	7410
Ptosis - secondary repair	7411
Blepharoplasty	7430 and 7431
Repair - reconstruction of the ear with graft of skin or cartilage	7710
Penile prosthesis for impotence	8417
Insertion of Testicular prosthesis (for age 18 and over)	8507
TRAM Flap	3097

UNINSURED SERVICES

1. Otoplasty over the age of 18 years.

2. Reversal of vasectomy or tubal ligation.

3. Removal of tattoos.

4. Cosmetic surgery.

5. In vitro fertilization.

6. Simple lipoma, as well as warts, papillomata, keratosis, nevi, and moles - removal by any means. (Fee Codes 3039, 3041, 3042, 3043, 3044, 3045). For exceptions, please refer to Section 21.F of the Preamble to the Tariff of Fees.

7. Visits and injections related to upcoming out-of-country travel.

8. Sex reassignment surgery, excluding the following procedures: Double Mastectomy, Hysterectomy, Oophorectomy, Ochiectomy, and Penectomy.

Preamble APPENDIX E

POLICY NAME: CRITERIA FOR OUT-OF-PROVINCE REFERRALS

EFFECTIVE DATE: April 1, 1995 POLICY #: REF 001

INTRODUCTION:

All referrals made to out-of-Province medical services and facilities must receive prior approval from the Department of Health. Failure to obtain this approval shall result in the patient being held fully responsible for the total costs of the services provided.

POLICY GUIDELINES:

1. *OUT-OF-PROVINCE (WITHIN CANADA)*

   i. Payment may be provided under the Plan for an eligible resident of Prince Edward Island to obtain in-patient and/or out-patient medical services outside the Province in the instances of extreme emergency or sudden illness (*) occurring while outside the Province.

   ii. All cases excluding extreme emergency or sudden illness require written approval from the Department of Health.

   iii. Prior written approval may be granted if after consult with a local specialist and in the opinion of a local general practitioner and/or specialist, adequate medical services are not available in Prince Edward Island.

   iv. Prior written approval may be granted if only one (1) consultant/specialist is available in Prince Edward Island in the specific medical specialty service required.

   v. Prior written approval may be granted if the required medical services are provided in Prince Edward Island but other extenuating circumstances exist. Such cases shall be reviewed by the Medical Director of the Department.

   vi. Eligible residents of Prince Edward Island requesting an out-of-Province referral for medical services by preference only shall not be approved.

   vii. Prior written approval must be obtained for out-of-Province treatment. This referral is effective for a 12 month period only providing the referral is for the same diagnosis and the same physician.

   viii. Payment shall not exceed the daily standard per diem rate as authorized by the Province where the hospital services are rendered.

2. *OUT OF COUNTRY*

i. Insured services may be provided under the Plan for an eligible resident of Prince Edward Island to obtain in-patient and/or out-patient medical services outside Canada if written prior approval is obtained from the Department.

ii. Prior written approval may be granted if after consult with a local specialist and in the opinion of a local general practitioner and/or specialist, adequate medical services are not available in Canada.

iii. Payment may be provided under the Plan for an eligible resident of Prince Edward Island to obtain in-patient and/or out-patient medical services outside Canada in the instances of extreme emergency or sudden illness occurring while outside the country.

In cases where the Medical Director's interpretation of policy is disputed, the case shall be referred to the Medical Advisory Committee of the Department of Health for adjudication.

(*)*Extreme emergency or sudden illness* *- a medical situation or occurrence of a serious nature, developing suddenly and unexpectedly, and demanding immediate medical attention.*

APPROVED: _____

REVIEW DATES: _____; _____; _____

POLICY NAME: CRITERIA FOR PAYMENT OF OUT-OF-PROVINCE REFERRALS

EFFECTIVE DATE: April 1, 1995 POLICY #: REF 004

INTRODUCTION:

The referral policy applies to those residents who request non-emergency or elective services. In these cases, the local physician advises and recommends a referral on behalf of the patient. The Department of Health determines whether or not it is a service that is pre-approved for payment.

POLICY GUIDELINES:

The criteria used to determine if the Department shall pay the out-of-Province cost is categorized into four groups. The decision to approve payment is based on:

i. If the service is not available locally (e.g., neurosurgery, cardiac surgery)
ii. If the resident has only one choice (e.g. dermatology)
iii. If there is inadequate service locally (e.g., neonatology)
iv. If there are justifiable extenuating circumstances.

1. Non-emergency services out-of-country are only approved for payment if two or more specialists document that the services is not available in Canada.

2. Residents who are approved for payment are notified by letter as well as those who were not approved for payment.

3. Residents who go out-of-Province knowing that the Department has not agreed to pay and who have been notified that they are responsible for costs are invoiced for the amount of the services provided. If a resident leaves the Province without a pre-approved referral for a service that is available locally, they shall be notified and billed for the services provided.

APPROVED: _____

REVIEW DATES: _____; _____; _____

_____; _____; _____

TARIFF OF FEES

GENERAL PRACTICE

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

1. REFERRED CASES

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Consultation - **See Preamble 9.A, 9.B, 10.A**	0160	80.00	80.00	81.92	83.20
Repeat Consultation within 30 days - **See Preamble 9.C**	0162	40.00	40.00	40.96	41.60
G.P. Dermatology Consultation (designated physicians only)	0137	80.00	80.00	81.92	83.20

2. OFFICE VISITS

Comprehensive office visit - **See Preamble 9.D**	0110	60.00	60.00	61.44	62.40
Limited office visit - **See Preamble 9.E**	0113	35.00	35.00	35.84	36.40
Basic office visit - **See Preamble 9.F** *(suspended Oct.01, 2017)*	0123	28.00	28.00	28.00	0.00
Walk-In Clinic visit - **See Preamble 9.F.1** *(effective Oct.01, 2017)*	0094	0.00	0.00	25.00	25.00
Well baby care - **See Preamble 20.B**	0115	35.00	35.00	35.84	36.40
Annual Health Exam: - **See Preamble 9.H**					
Age 1-2	2228	35.00	35.00	35.84	36.40
Age 3-16	2229	35.00	35.00	35.84	36.40
Age 17-64	2230	45.00	45.00	46.08	46.80
Age 65+	2231	60.00	60.00	61.44	62.40
Emergency office visit at physician's home					
outside regular office hours including weekends and holidays					
- Day (08:00 - 18:00)	0112	35.00	35.00	35.84	36.40
- Night(18:00 - 08:00)	0114	35.00	35.00	35.84	36.40
Emergency office visit at physician's office					
outside regular office hours - **See Preamble 9.I**					
- Day (08:00 - 18:00) - Monday to Saturday	0118	35.00	35.00	35.84	36.40
- Sundays & Holidays	0120	35.00	35.00	35.84	36.40
- Night(18:00 - 08:00) - Monday to Thursday	0119	35.00	35.00	35.84	36.40
- Friday to Sunday, & Holidays	0116	35.00	35.00	35.84	36.40
Extra patients seen during emergency office visit	0113	35.00	35.00	35.84	36.40

3. HOSPITAL VISITS - In-Patient Services

Initial hospital visit - **See Preamble 10.B**	0130	100.00	100.00	109.00	115.00
Unaffiliated patient (add) - **See Preamble 10.B.1**	0132	75.00	75.00	81.75	86.25
Subsequent hospital visits					
First 5 weeks, per visit	0133	50.00	50.00	54.50	57.50
From 6th to 13th week inclusive, per visit	0134	30.00	30.00	32.70	34.50
After 13th week, per week	0135	30.00	30.00	32.70	34.50
Discharge fee - **See Preamble 10.C.9**	0136	40.00	40.00	43.60	46.00
Supportive care, per visit - **See Preamble 10.C.2**	0140	25.00	25.00	27.25	28.75
Concurrent care, per visit - **See Preamble 10.C.1**	0142	50.00	50.00	54.50	57.50
Continuing care, per visit - **See Preamble 10.C.2**	0143	50.00	50.00	54.50	57.50

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Extended Care Hospital Beds - **See Preamble 10.C.4**					
- initial visit	0145	75.00	75.00	81.75	86.25
- subsequent visits					
First 5 weeks, per visit	0144	50.00	50.00	54.50	57.50
From 6th to 13th week inclusive, per visit	0055	30.00	30.00	32.70	34.50
After 13th week, per week	0056	30.00	30.00	32.70	34.50
History & Physical Examination for Dental care	0141	100.00	100.00	109.00	115.00
Complete assessment by a family physician of a patient under the attending care of a psychiatrist	0146	100.00	100.00	109.00	115.00

4. OBSTETRICAL CARE

Delivery only	0002	599.20	599.20	613.58	623.17
Assessment of Labor	0003	50.00	50.00	51.20	52.00
Attendance at complicated labor or precipitous delivery - **See Preamble 19.B**	0004	599.20	599.20	613.58	623.17
Initial prenatal visit	0100	60.00	60.00	61.44	62.40
Subsequent prenatal visit	0103	35.00	35.00	35.84	36.40
Postnatal visit	0105	35.00	35.00	35.84	36.40
Postpartum care visit (in-hospital)	0104	50.00	50.00	51.20	52.00
Neonatal Resuscitation (attendance at delivery for neonatal resuscitation)	0036	120.00	120.00	122.88	124.80

5. HOSPITAL EMERGENCY DEPARTMENT VISITS

Limited ED Visit (Level I visit) - **See Preamble 10.E.2(a)**					
- Day(08:00-18:00) - Monday to Friday	0180	31.50	31.50	32.26	32.76
- Saturday,Sunday,Holiday	0190	36.50	36.50	37.38	37.96
- Night(18:00-08:00) - Monday to Thursday	0181	41.00	41.00	41.98	42.64
- Friday,Saturday,Sunday,Holiday	0191	61.00	61.00	62.46	63.44
Comprehensive ED Visit (Level II visit) - **See Preamble 10.E.2(b)**					
- Day(08:00-18:00) - Monday to Friday	0186	57.50	57.50	58.88	59.80
- Saturday,Sunday,Holiday	0168	66.50	66.50	68.10	69.16
- Night(18:00-08:00) - Monday to Thursday	0187	77.50	77.50	79.36	80.60
- Friday,Saturday,Sunday,Holiday	0169	110.00	110.00	112.64	114.40
Resuscitation ED Visit (Level III visit) - **See Preamble 10.E.2(c)**					
- first 15 minutes	0182	100.00	100.00	102.40	104.00
- second 15 minutes	0183	50.00	50.00	51.20	52.00
- subsequent 15-minutes periods	0184	50.00	50.00	51.20	52.00
Additional fee allowed for strict emergency visit - **See Preamble 7**	0194	25.00	25.00	25.60	26.00
Complete examination in ED - patients age 55 yrs or over	0195	85.00	85.00	87.04	88.40
Care in the Emergency Department by a second physician (for a patient that has been in observation for over 8 hours) Claim requires a comment, time of day, and can only be billed once.	0196	50.00	50.00	51.20	52.00
Emergency Department coverage (hourly sessional rates)					
Kings County Hospital	0150	175.00	175.00	175.00	175.00
Western Hospital	0152	175.00	175.00	175.00	175.00
Queen Elizabeth Hospital	0155	175.00	175.00	175.00	175.00
Prince County Hospital	0156	175.00	175.00	175.00	175.00
ED sessional night premium (00:00-08:00)-weekday -**Preamble 12.A.5** *(Jun.1,2017)*	0076	0.00	0.00	43.75	43.75
ED sessional night premium (00:00-08:00)-W/E+holiday -**Preamble 12.A.5** *(Jun.1,2017)*	0077	0.00	0.00	29.75	26.25

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
ED sessional top-up fee (Salary Class I)	0005	80.90	80.90	79.75	78.03
ED sessional top-up fee (Salary Class II)	0006	78.19	78.19	77.03	75.27
ED sessional top-up fee (Salary Class III)	0007	74.14	74.14	72.94	71.14
6. ON-CALL RETAINERS - See Preamble 11.D					
Urban Family Physician (QEH & PCH) - per group of 1	0015	45.00	45.00	54.00	60.00
- per group of 2	0016	90.00	90.00	108.00	120.00
- per group of 3	0017	135.00	135.00	162.00	180.00
- per group of 4	0018	180.00	180.00	216.00	240.00
- per group of 5 - 7	0019	225.00	225.00	270.00	300.00
Rural Family Physician (per hospital) - Souris, Alberton, O'Leary, Montague	0185	225.00	225.00	270.00	300.00
Hospitalist (full-line)	0108	225.00	225.00	225.00	225.00
Hospitalist (half-line)	0034	112.50	112.50	112.50	112.50
Overflow Unaffiliated Inpatients (QEH) - **See Preamble 10.F**	0066	0.00	0.00	100.00	100.00
Unaffiliated Psychiatry inpatient coverage (QEH)	0199	225.00	225.00	270.00	300.00
Medical Officer Rehab Unit (QEH)	0147	225.00	225.00	270.00	300.00
Medical Officer Hillsborough Hospital	0197	225.00	225.00	270.00	300.00
Medical Officer Addictions Unit (Mt.Herbert)	0198	225.00	225.00	270.00	300.00
Ambulatory Detox Service (PCH & Western Hospital)	0158	100.00	100.00	102.40	104.00
GP Oncology (Provincial)	0177	300.00	300.00	300.00	300.00
GP Palliative Care (Provincial)	0179	300.00	300.00	300.00	300.00
Surgical Assistant (QEH & PCH)	0159	300.00	300.00	300.00	300.00
Corrections	0030	225.00	225.00	270.00	300.00
Coroner (East or West)	0020	150.00	150.00	153.60	156.00
On-Line Medical Control	0090	225.00	225.00	270.00	300.00
7. HOSPITAL ON-CALL RESPONSE FEE - see Preamble 11.E	0060	150.00	150.00	153.60	156.00
8. DETENTION FEES - See Preamble 10.D.1					
Detention after first half hour (per 15 min.)	0170	45.00	45.00	46.08	46.80
Special call requiring detention(per 15 min.)- **See Preamble 10.D.3**	0176	45.00	45.00	46.08	46.80
NOTE: Ambulance transport to be billed as detention - **See Preamble 10.D.2**					
9. PSYCHIATRIC/COUNSELING SERVICES - See Preamble 13.					
Psychotherapy - **See Preamble 13.A**	2501	42.50	42.50	43.52	44.20
Group psychotherapy - **See Preamble 13.E**	2502	42.50	42.50	43.52	44.20
Member of Group Psychotherapy	2580	0.00	0.00	0.00	0.00
Psychotherapy by a General Practitioner in Hospital - See **Preamble 13.D**	2503	42.50	42.50	43.52	44.20
Mental Health Crisis Care - **See Preamble 13.I**	2508	42.50	42.50	43.52	44.20
Diagnostic and Therapeutic interview - **See Preamble 13.H**	2588	42.50	42.50	43.52	44.20
Case Management Conference - **See Preamble 13.G**	2507	42.50	42.50	43.52	44.20
Health Promotion counseling (max. 45 minutes) - **See Preamble 8**	2505	42.50	42.50	14.51	14.73
Prenatal Psychosocial Assessment (once/pregnancy - max.45 minutes) -**Preamble 13.J**	2590	42.50	42.50	43.52	44.20
10. TELEPHONE PRESCRIPTION RENEWAL - See Preamble 11.C.3 (max. 1 per patient per month)	2019	5.00	5.00	6.50	7.50

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
11. HOME VISITS					
Home visit	0121	62.00	62.00	63.49	64.48
Each additional patient seen during home visit	0124	31.00	31.00	31.74	32.24
Additional fee allowed for emergency visit - **See Preamble 11.A.2**	0125	25.00	25.00	25.60	26.00
12. HOSPITALIST SERVICES - See Preamble 10.F					
Hospitalist Type 1 daily sessional fee - max. 21 beds	0107	1,280.00	1,280.00	1,310.72	1,331.20
Hospitalist Type 1 daily sessional fee - max. 11 beds	0102	670.00	670.00	686.08	696.80
Hospitalist Type 2 daily sessional fee - max. 17 beds	0101	1,360.00	1,360.00	1,392.64	1,414.40
Hospitalist Type 2 daily sessional fee - max. 09 beds	0037	720.00	720.00	737.28	748.80
Hospitalist Type 1 sessional top-up fee (Salary Class I) - max. 21 beds	0038	574.26	574.26	596.38	603.95
Hospitalist Type 1 sessional top-up fee (Salary Class II) - max. 21 beds	0039	553.96	553.96	575.91	583.24
Hospitalist Type 1 sessional top-up fee (Salary Class III) - max. 21 beds	0041	523.57	523.57	545.28	552.25
Hospitalist Type 1 sessional top-up fee (Salary Class I) - max. 11 beds	0042	300.80	300.80	311.90	315.86
Hospitalist Type 1 sessional top-up fee (Salary Class II) - max. 11 beds	0043	290.17	290.17	301.18	305.01
Hospitalist Type 1 sessional top-up fee (Salary Class III) - max. 11 beds	0044	274.25	274.25	285.13	288.78
Hospitalist Type 2 sessional top-up fee (Salary Class I) - max. 17 beds	0025	654.26	654.26	678.30	687.15
Hospitalist Type 2 sessional top-up fee (Salary Class II) - max. 17 beds	0026	633.96	633.96	657.83	666.44
Hospitalist Type 2 sessional top-up fee (Salary Class III) - max. 17 beds	0027	603.57	603.57	627.20	635.45
Hospitalist Type 2 sessional top-up fee (Salary Class I) - max. 09 beds	0045	346.37	346.37	359.10	363.79
Hospitalist Type 2 sessional top-up fee (Salary Class II) - max. 09 beds	0046	335.62	335.62	348.26	352.82
Hospitalist Type 2 sessional top-up fee (Salary Class III) - max. 09 beds	0047	319.53	319.53	332.05	336.41
Hospitalist on-call retainer (18:00-08:00 hrs daily)	0108	225.00	225.00	225.00	225.00
Hospitalist shadow billing code	0111	0.00	0.00	0.00	0.00
Hospitalist patient daily care	0106	80.00	80.00	81.92	83.20
This is a daily fee for Unaffiliated patient care when not covered by a hospitalist, in lieu of other daily fees.					
13. COMMUNITY CARE FACILITIES (includes nursing homes, manors, other LTC facilities)					
Visit	0127	55.00	55.00	56.32	57.20
Each additional patient	0129	27.50	27.50	28.16	28.60
14. PALLIATIVE CARE - See Preamble 11.B.					
These fees may be billed only by designated physicians with additional training in this specialty area.					
Palliative Care Consultation - G.P.	0148	160.00	160.00	163.84	166.40
- Specialist	2048	160.00	160.00	163.84	166.40
Repeat Palliative Care Consultation - G.P.	0167	80.00	80.00	81.92	83.20
- Specialist	2067	80.00	80.00	81.92	83.20
Palliative Care Unit Inpatient - initial visit	0163	100.00	100.00	109.00	115.00
Palliative Care Unit Inpatient - daily care visit	0164	50.00	50.00	54.50	57.50
Palliative Home Care Admission	0149	120.00	120.00	122.88	124.80
Palliative Home Care Visit	0173	75.00	75.00	76.80	78.00
Palliative Care telephone call (max. 3 claims/patient/week)	0139	15.00	15.00	15.36	15.60
Palliative Care telephone consultation - **See Preamble 11.C.1**	0165	45.00	45.00	46.08	46.80

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
15. GERIATRIC CARE					
These fees may be billed only by designated physicians with additional training in this specialty area.					
Consultation	2860	160.00	160.00	163.84	166.40
Repeat Consultation (within 30 days)	2862	80.00	80.00	81.92	83.20
Follow-up Visit	2863	35.00	35.00	35.84	36.40
Home Care Visit	2821	75.00	75.00	90.00	100.00
Competency Assessment	2880	75.00	75.00	76.80	78.00
Diagnostic and Therapeutic Interview - **See Preamble 13.H**	2886	45.00	45.00	46.08	46.80
Case Management Conference - **See Preamble 13.G**	2807	45.00	45.00	46.08	46.80
Detention - **See Preamble 10.D.1**	2870	45.00	45.00	46.08	46.80
Geriatric Care telephone consultation - **See Preamble 11.C.1**	2850	0.00	0.00	46.08	46.80
16. NEW PATIENT FEE - See Preamble 24 *(eliminate Apr.01, 2017)*	0010	150.00	150.00	0.00	0.00
17. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	40.00	40.00	50.00	50.00
18. ON-LINE MEDICAL CONTROL - See Preamble 11.F					
CEC - Telephone Consultation	0071	41.60	41.60	42.60	43.26
EMS - Telephone Consultation	0072	41.60	41.60	42.60	43.26
19. NURSE PRACTITIONER COLLABORATION - Preamble 11.G (per 10 min)	2510	28.33	28.33	29.01	29.46
20. ON-CALL PER DIEM in lieu of Retainer+FFS (Salaried Palliative Care)**Article C3.2**	0073	0.00	0.00	400.00	400.00

ANESTHESIA

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

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
1. CONSULTATION - See Preamble 9.A and 10.A	0260	103.00	103.00	105.47	107.12
2. SURGICAL ANESTHESIA - Sessional Fee					
First 30 minute block	0265	97.50	97.50	99.84	101.40
2nd, 3rd, 4th blocks of 30 minutes (per block)	0265	62.95	62.95	64.46	65.47
Each subsequent 15 minute block beyond 2 hours	0265	62.95	62.95	64.46	65.47
Charge for Cancelled Surgery - **See Preamble 18.H**	0266	100.00	100.00	102.40	104.00
3. FOLLOW-UP VISIT	0213	35.00	35.00	35.84	36.40
4. ANESTHESIA CRITICAL CARE - See Preamble 10.C.5					
Physician-in-Charge:					
Anesthesia Critical Care - 1st day, includes consult (90 minutes)	0296	290.00	290.00	296.96	301.60
Anesthesia Critical Care - Days 2-30 inclusive, per day	0297	168.00	168.00	172.03	174.72
Anesthesia Critical Care - Day 31 onward, per day	0298	84.00	84.00	86.02	87.36
Intensive Care Visit - per day	0271	100.00	100.00	102.40	104.00
5. DETENTION FEES - See Preamble 10.D.1 and 18.E					
Detention after first half hour (per 15 min.)	0270	45.00	45.00	46.08	46.80
Special call requiring detention(per 15 min.) - **See Preamble 10.D.3**	0276	45.00	45.00	46.08	46.80
6. ACUTE PAIN MANAGEMENT					
Epidural spinal block - Lumbar and Caudal	2520	75.00	75.00	76.80	78.00
Epidural spinal block (continuous)					
- consultation and institution	2521	220.00	220.00	225.28	228.80
- maintenance (per day)	2523	82.50	82.50	84.48	85.80
Acute Pain Service - initiation	0280	103.00	103.00	105.47	107.12
Patient-controlled analgesia (PCA) - maintenance	2534	27.50	27.50	28.16	28.60
Continuous Conduction Anesthesia (Epidural) for Obstetrics - **See Preamble 18.F**	2525	407.00	407.00	416.77	423.28
Other Local/Regional Anesthesia - **See Diag./Therapeutic Procedures**					
7. CHRONIC PAIN MANAGEMENT - See Preamble 21.M					
Chronic Pain consultation	0250	103.00	103.00	105.47	107.12
Chronic Pain follow-up visit	0252	35.00	35.00	35.84	36.40
8. ON-CALL RETAINER - Anesthesia (QEH & PCH)	0240	300.00	300.00	300.00	300.00
9. HOSPITAL ON-CALL RESPONSE FEE - see Preamble 11.E	0060	150.00	150.00	153.60	156.00
10. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	40.00	40.00	50.00	50.00

DERMATOLOGY

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

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
1. REFERRED CASES					
Consultation (office, hospital, home) - **See Preamble 9.A and 10.A**	0360	103.00	103.00	105.47	107.12
Repeat Consultation within 30 days (same illness or complication) - **See Preamble 9.C**	0362	51.50	51.50	52.74	53.56
2. OFFICE VISITS - See Preamble 9.D and 9.E					
Comprehensive Office Visit	0310	60.00	60.00	61.44	62.40
Initial Office Visit with regional exam	0311	35.00	35.00	35.84	36.40
Limited Office Visit	0313	35.00	35.00	35.84	36.40
3. HOSPITAL VISITS - In-Patient Services					
Initial hospital visit	0330	100.00	100.00	109.00	115.00
Subsequent hospital visits					
First five weeks, per visit	0333	50.00	50.00	54.50	57.50
From 6th week to 13th week, per visit	0334	30.00	30.00	32.70	34.50
After 13th week, per week	0335	30.00	30.00	32.70	34.50
Continuing care	0341	50.00	50.00	54.50	57.50
Directive care	0342	50.00	50.00	54.50	57.50
4. INTENSIVE CARE VISIT - per day	0371	100.00	100.00	102.40	104.00
5. HOSPITAL EMERGENCY DEPARTMENT VISITS					
Limited ED Visit (Level I visit) - **See Preamble 10.E.2(a)**					
- Day(08:00-18:00) - Monday to Friday	0380	31.50	31.50	32.26	32.76
- Saturday,Sunday,Holiday	0390	36.50	36.50	37.38	37.96
- Night(18:00-08:00) - Monday to Thursday	0381	41.00	41.00	41.98	42.64
- Friday,Saturday,Sunday,Holiday	0391	61.00	61.00	62.46	63.44
Comprehensive ED Visit (Level II visit) - **See Preamble 10.E.2(b)**					
- Day(08:00-18:00) - Monday to Friday	0386	57.50	57.50	58.88	59.80
- Saturday,Sunday,Holiday	0368	66.50	66.50	68.10	69.16
- Night(18:00-08:00) - Monday to Thursday	0387	77.50	77.50	79.36	80.60
- Friday,Saturday,Sunday,Holiday	0369	110.00	110.00	112.64	114.40
Additional fee allowed for strict emergency visit - **See Preamble 7**	0394	25.00	25.00	25.60	26.00
6. DETENTION FEES - See Preamble 10.D.1					
Detention after first half hour (per 15 min.)	0370	45.00	45.00	46.08	46.80
Special call requiring detention(per 15 min.) - **See Preamble 10.D.3**	0376	45.00	45.00	46.08	46.80

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
7. TELEPHONE SERVICES					
Telephone Consultation (Dermatology) - **See Preamble 11.C.1**	0350	45.00	45.00	46.08	46.80
Telephone Prescription Renewal (max. 1/patient/month) - **See Preamble 11.C.3**	2019	5.00	5.00	6.50	7.50
8. HOME VISITS (includes nursing homes, manors, etc.)					
Home visit	0321	62.00	62.00	63.49	64.48
Each additional patient	0324	31.00	31.00	31.74	32.24
Additional fee allowed for emergency visit - **See Preamble 11.A.2**	0325	25.00	25.00	25.60	26.00
9. SPECIAL PROCEDURES					
Ultraviolet Light Therapy - general or local application	0395	21.40	21.40	21.91	22.26
10. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	40.00	40.00	50.00	50.00

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
GENERAL SURGERY					
These fees cannot be correctly interpreted without reference to the Preamble.					
1. REFERRED CASES					
Consultation (office, hospital, home) - **See Preamble 9.A and 10.A**	0460	103.00	103.00	105.47	107.12
Repeat Consultation within 30 days (same illness or complication) - **See Preamble 9.C**	0462	51.50	51.50	52.74	53.56
2. OFFICE VISITS - See Preamble 9.D and 9.E					
Comprehensive Office Visit	0410	60.00	60.00	61.44	62.40
Initial Office Visit with regional exam	0411	35.00	35.00	35.84	36.40
Limited Office Visit	0413	35.00	35.00	35.84	36.40
3. HOSPITAL VISITS - In-Patient Services					
Initial hospital visit	0430	100.00	100.00	109.00	115.00
Subsequent hospital visits					
First five weeks, per visit	0433	50.00	50.00	54.50	57.50
From 6th week to 13th week, per visit	0434	30.00	30.00	32.70	34.50
After 13th week, per week	0435	30.00	30.00	32.70	34.50
Continuing care	0441	50.00	50.00	54.50	57.50
Directive care	0442	50.00	50.00	54.50	57.50
4. INTENSIVE CARE VISIT - per day	0471	100.00	100.00	102.40	104.00
5. HOSPITAL EMERGENCY DEPARTMENT VISITS					
Limited ED Visit (Level I visit) - **See Preamble 10.E.2(a)**					
- Day(08:00-18:00) - Monday to Friday	0480	31.50	31.50	32.26	32.76
- Saturday,Sunday,Holiday	0490	36.50	36.50	37.38	37.96
- Night(18:00-08:00) - Monday to Thursday	0481	41.00	41.00	41.98	42.64
- Friday,Saturday,Sunday,Holiday	0491	61.00	61.00	62.46	63.44
Comprehensive ED Visit (Level II visit) - **See Preamble 10.E.2(b)**					
- Day(08:00-18:00) - Monday to Friday	0486	57.50	57.50	58.88	59.80
- Saturday,Sunday,Holiday	0468	66.50	66.50	68.10	69.16
- Night(18:00-08:00) - Monday to Thursday	0487	77.50	77.50	79.36	80.60
- Friday,Saturday,Sunday,Holiday	0469	110.00	110.00	112.64	114.40
Resuscitation ED Visit (Level III visit) - **See Preamble 10.E.2(c)**					
- first 15 minutes	0182	100.00	100.00	102.40	104.00
- second 15 minutes	0183	50.00	50.00	51.20	52.00
- subsequent 15-minutes periods	0184	50.00	50.00	51.20	52.00
Additional fee allowed for strict emergency visit - **See Preamble 7**	0494	25.00	25.00	25.60	26.00
6. ON-CALL RETAINERS - General Surgery (QEH & PCH)	0440	300.00	300.00	300.00	300.00
- Plastic Surgery (Provincial)	9740	300.00	300.00	300.00	300.00
7. HOSPITAL ON-CALL RESPONSE FEE - see Preamble 11.E	0060	150.00	150.00	153.60	156.00

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
8. DETENTION FEES - See Preamble 10.D.1					
Detention after first half hour (per 15 min.)	0470	45.00	45.00	46.08	46.80
Special call requiring detention(per 15 min.)**- See Preamble 10.D.3**	0476	45.00	45.00	46.08	46.80
9. TELEPHONE SERVICES					
Telephone Consultation (General Surgery) - **see Preamble 11.C.1**	0450	0.00	0.00	46.08	46.80
Telephone Consultation (Vascular Surgery) - **see Preamble 11.C.1**	0420	0.00	0.00	46.08	46.80
Telephone Consultation (Plastic Surgery) - **see Preamble 11.C.1**	9750	0.00	0.00	46.08	46.80
Telephone Prescription Renewal (max. 1/patient/month) **- See Preamble 11.C.3**	2019	5.00	5.00	6.50	7.50
10. HOME VISITS (includes nursing homes, manors, etc.)					
Home visit	0421	62.00	62.00	63.49	64.48
Each additional patient	0424	31.00	31.00	31.74	32.24
Additional fee allowed for emergency visit **-See Preamble 11.A.2**	0425	25.00	25.00	25.60	26.00
11. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	40.00	40.00	50.00	50.00

INTERNAL MEDICINE

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

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
1. REFERRED CASES					
Consultation (office, hospital, home) - **See Preamble 9.A and 10.A**	0560	190.00	190.00	194.56	197.60
Repeat Consultation within 30 days (same illness or complication) - **See Preamble 9.C**	0562	95.00	95.00	97.28	98.80
Complete re-examination by a medical specialist **-See Preamble 9.G**	0563	70.00	70.00	71.68	72.80
2. OFFICE VISITS - See Preamble 9.D and 19.E					
Comprehensive Office Visit	0510	70.00	70.00	71.68	72.80
Subsequent Office Visit with complete re-examination	0512	70.00	70.00	71.68	72.80
Limited Office Visit	0513	35.00	35.00	35.84	36.40
3. HOSPITAL VISITS - In-Patient Services					
Initial hospital visit	0530	100.00	100.00	109.00	115.00
Subsequent hospital visits					
First five weeks, per visit	0533	50.00	50.00	54.50	57.50
From 6th week to 13th week, per visit	0534	30.00	30.00	32.70	34.50
After 13th week, per week	0535	30.00	30.00	32.70	34.50
Continuing care	0541	50.00	50.00	54.50	57.50
Directive care	0542	50.00	50.00	54.50	57.50
4. CRITICAL CARE - See Preamble 10.C.5					
Physician-in-Charge:					
Critical Care - 1st day, includes consultation (90 minutes)	0595	290.00	290.00	296.96	301.60
Critical Care - 1st day, consult within previous 10 days (45 min.)	0596	168.00	168.00	172.03	174.72
Critical Care - Days 2-30 inclusive, per day	0597	168.00	168.00	172.03	174.72
Critical Care - Day 31 onward, per day	0598	84.00	84.00	86.02	87.36
Intermediate/Progressive Care - per day	0501	132.00	132.00	135.17	137.28
Concurrent Critical Care - per day	0502	168.00	168.00	172.03	174.72
5. HOSPITAL EMERGENCY DEPARTMENT VISITS					
Limited ED Visit (Level I visit) - **See Preamble 10.E.2(a)**					
- Day(08:00-18:00) - Monday to Friday	0580	31.50	31.50	32.26	32.76
- Saturday,Sunday,Holiday	0590	36.50	36.50	37.38	37.96
- Night(18:00-08:00) - Monday to Thursday	0581	41.00	41.00	41.98	42.64
- Friday,Saturday,Sunday,Holiday	0591	61.00	61.00	62.46	63.44
Comprehensive ED Visit (Level II visit) - **See Preamble 10.E.2(b)**					
- Day(08:00-18:00) - Monday to Friday	0586	57.50	57.50	58.88	59.80
- Saturday,Sunday,Holiday	0568	66.50	66.50	68.10	69.16
- Night(18:00-08:00) - Monday to Thursday	0587	77.50	77.50	79.36	80.60
- Friday,Saturday,Sunday,Holiday	0569	110.00	110.00	112.64	114.40

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Resuscitation ED Visit (Level III visit) - **See Preamble 10.E.2(c)**					
- first 15 minutes	0182	100.00	100.00	102.40	104.00
- second 15 minutes	0183	50.00	50.00	51.20	52.00
- subsequent 15-minutes periods	0184	50.00	50.00	51.20	52.00
Additional fee allowed for strict emergency visit - **See Preamble 7**	0594	25.00	25.00	25.60	26.00
6. ON-CALL RETAINERS - Internal Medicine (QEH & PCH)	0540	300.00	300.00	300.00	300.00
- Nephrology (Provincial)	0549	300.00	300.00	300.00	300.00
- Neurology (backup service)	0503	100.00	100.00	100.00	100.00
- Oncology (backup service)	0174	100.00	100.00	100.00	100.00
- Laboratory Medicine (Provincial)	1940	300.00	300.00	300.00	300.00
- Medical Oncology (Provincial)	2390	0.00	0.00	300.00	300.00
7. HOSPITAL ON-CALL RESPONSE FEE - see Preamble 11.E	0060	150.00	150.00	153.60	156.00
8. DETENTION FEES - See Preamble 10.D.1					
Detention after first half hour (per 15 min.)	0570	45.00	45.00	46.08	46.80
Special call requiring detention(per 15 min.) - **See Preamble 10.D.3**	0576	45.00	45.00	46.08	46.80
9. COUNSELING SERVICES - See Preamble 8 and 13					
Diagnostic and therapeutic interview - **See Preamble 13.H**	2586	55.00	55.00	56.32	57.20
Case Management Conference - **See Preamble 13.G**	2507	42.50	42.50	43.52	44.20
Health Promotion counseling (max. 45 minutes) - **See Preamble 8**	2505	42.50	42.50	14.51	14.73
10. TELEPHONE SERVICES					
Telephone Consultation (Internal Medicine) - **see Preamble 11.C.1**	0550	45.00	45.00	46.08	46.80
Telephone Consultation (Medical Oncology) - **see Preamble 11.C.1**	2350	0.00	0.00	46.08	46.80
Telephone Consultation (Neurology) - **see Preamble 11.C.1**	2225	0.00	0.00	46.08	46.80
Telephone Consultation (Medical Microbiology) - **see Preamble 11.C.1**	4350	0.00	0.00	46.08	46.80
Telephone Prescription Renewal (max. 1/patient/month) - **See Preamble 11.C.3**	2019	5.00	5.00	6.50	7.50
11. HOME VISITS (includes nursing homes, manors, etc.)					
Home visit	0521	62.00	62.00	63.49	64.48
Each additional patient	0524	31.00	31.00	31.74	32.24
Additional fee allowed for emergency visit -**See Preamble 11.A.2**	0525	25.00	25.00	25.60	26.00
12. SPECIAL PROCEDURES					
Pacemakers - see Fee Codes 4760-4776					
Stress tests and other procedures - see Diagnostic/Therapeutic Procedures					
13. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	40.00	40.00	50.00	50.00

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
14. ON-CALL PER DIEM in lieu of Retainer+FFS (Salaried Physicians only)**Article C3.2**					
- Internal Medicine (QEH & PCH)	0504	0.00	0.00	500.00	500.00
- Medical Oncology (Provincial)	2380	0.00	0.00	500.00	500.00
- Laboratory Medicine (Provincial)	1955	0.00	0.00	500.00	500.00

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
OBSTETRICS AND GYNECOLOGY					
These fees cannot be correctly interpreted without reference to the Preamble.					
1. REFERRED CASES					
Consultation (office, hospital, home) - **See Preamble 9.A and 10.A**	0760	103.00	103.00	105.47	107.12
Repeat Consultation within 30 days (same illness or complication) - **See Preamble 9.C**	0762	51.50	51.50	52.74	53.56
Consultation - Reproductive Endocrinology	0764	103.00	103.00	105.47	107.12
Repeat Consultation - Reproductive Endocrinology	0765	51.50	51.50	52.74	53.56
2. OFFICE VISITS - See Preamble 9.D and 9.E					
Comprehensive Office Visit	0710	60.00	60.00	61.44	62.40
Initial Office Visit with regional exam	0711	35.00	35.00	35.84	36.40
Limited Office Visit	0713	35.00	35.00	35.84	36.40
Initial prenatal visit	0700	60.00	60.00	61.44	62.40
Subsequent prenatal visit	0703	35.00	35.00	35.84	36.40
Postnatal visit	0705	35.00	35.00	35.84	36.40
3. HOSPITAL VISITS - In-Patient Services					
Initial hospital visit	0730	100.00	100.00	109.00	115.00
Subsequent hospital visits					
First five weeks, per visit	0733	50.00	50.00	54.50	57.50
From 6th week to 13th week, per visit	0734	30.00	30.00	32.70	34.50
After 13th week, per week	0735	30.00	30.00	32.70	34.50
Continuing care	0741	50.00	50.00	54.50	57.50
Directive care	0742	50.00	50.00	54.50	57.50
Assessment of labour	0701	50.00	50.00	51.20	52.00
Postpartum visit	0704	50.00	50.00	51.20	52.00
4. INTENSIVE CARE VISIT - per day	0771	100.00	100.00	102.40	104.00
5. HOSPITAL EMERGENCY DEPARTMENT VISITS					
Limited ED Visit (Level I visit) - **See Preamble 10.E.2(a)**					
- Day(08:00-18:00) - Monday to Friday	0780	31.50	31.50	32.26	32.76
- Saturday,Sunday,Holiday	0790	36.50	36.50	37.38	37.96
- Night(18:00-08:00) - Monday to Thursday	0781	41.00	41.00	41.98	42.64
- Friday,Saturday,Sunday,Holiday	0791	61.00	61.00	62.46	63.44
Comprehensive ED Visit (Level II visit) - **See Preamble 10.E.2(b)**					
- Day(08:00-18:00) - Monday to Friday	0786	57.50	57.50	58.88	59.80
- Saturday,Sunday,Holiday	0768	66.50	66.50	68.10	69.16
- Night(18:00-08:00) - Monday to Thursday	0787	77.50	77.50	79.36	80.60
- Friday,Saturday,Sunday,Holiday	0769	110.00	110.00	112.64	114.40
Additional fee allowed for strict emergency visit - **See Preamble 7**	0794	25.00	25.00	25.60	26.00
Outpatient assessment for complications of pregnancy/labor	0795	103.00	103.00	105.47	107.12

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
6. ON-CALL RETAINER - Obstetrics/Gynecology (QEH & PCH)	0740	300.00	300.00	300.00	300.00
7. HOSPITAL ON-CALL RESPONSE FEE - see Preamble 11.E	0060	150.00	150.00	153.60	156.00
8. DETENTION FEES - See Preamble 10.D.1					
Detention after first half hour (per 15 min.)	0770	45.00	45.00	46.08	46.80
Special call requiring detention(per 15 min.)- **See Preamble 10.D.3**	0776	45.00	45.00	46.08	46.80
9. TELEPHONE SERVICES					
Telephone Consultation (Obstetrics/Gynecology) - **see Preamble 11.C.1**	0750	45.00	45.00	46.08	46.80
Telephone Prescription Renewal (max. 1/patient/month) - **See Preamble 11.C.3**	2019	5.00	5.00	6.50	7.50
10. HOME VISITS (includes nursing homes, manors, etc.)					
Home visit	0721	62.00	62.00	63.49	64.48
Each additional patient	0724	31.00	31.00	31.74	32.24
Additional fee allowed for emergency visit -**See Preamble 11.A.2**	0725	25.00	25.00	25.60	26.00
11. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	40.00	40.00	50.00	50.00

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
OPHTHALMOLOGY					
These fees cannot be correctly interpreted without reference to the Preamble.					
1. REFERRED CASES					
Consultation (office, hospital, home) - **See Preamble 9.A and 10.A**	0860	103.00	103.00	105.47	107.12
Repeat Consultation within 30 days (same illness or complication) - **See Preamble 9.C**	0862	51.50	51.50	52.74	53.56
2. OFFICE VISITS - See Preamble 9.D and 9.E					
Comprehensive Office Visit	0810	60.00	60.00	61.44	62.40
Initial Office Visit with regional exam	0811	35.00	35.00	35.84	36.40
Limited Office Visit	0813	35.00	35.00	35.84	36.40
Subsequent Office Visit with special tests	0812	60.00	60.00	61.44	62.40
3. HOSPITAL VISITS - In-Patient Services					
Initial hospital visit	0830	100.00	100.00	109.00	115.00
Subsequent hospital visits					
First five weeks, per visit	0833	50.00	50.00	54.50	57.50
From 6th week to 13th week, per visit	0834	30.00	30.00	32.70	34.50
After 13th week, per week	0835	30.00	30.00	32.70	34.50
Continuing care	0841	50.00	50.00	54.50	57.50
Directive care	0842	50.00	50.00	54.50	57.50
4. INTENSIVE CARE VISIT - per day	0871	100.00	100.00	102.40	104.00
5. HOSPITAL EMERGENCY DEPARTMENT VISITS					
Limited ED Visit (Level I visit) - **See Preamble 10.E.2(a)**					
- Day(08:00-18:00) - Monday to Friday	0880	31.50	31.50	32.26	32.76
- Saturday,Sunday,Holiday	0890	36.50	36.50	37.38	37.96
- Night(18:00-08:00) - Monday to Thursday	0881	41.00	41.00	41.98	42.64
- Friday,Saturday,Sunday,Holiday	0891	61.00	61.00	62.46	63.44
Comprehensive ED Visit (Level II visit) - **See Preamble 10.E.2(b)**					
- Day(08:00-18:00) - Monday to Friday	0886	57.50	57.50	58.88	59.80
- Saturday,Sunday,Holiday	0868	66.50	66.50	68.10	69.16
- Night(18:00-08:00) - Monday to Thursday	0887	77.50	77.50	79.36	80.60
- Friday,Saturday,Sunday,Holiday	0869	110.00	110.00	112.64	114.40
Additional fee allowed for strict emergency visit - **See Preamble 7**	0894	25.00	25.00	25.60	26.00
6. ON-CALL RETAINER - Ophthalmology (Provincial)	0840	300.00	300.00	300.00	300.00
7. HOSPITAL ON-CALL RESPONSE FEE - see Preamble 11.E	0060	150.00	150.00	153.60	156.00
8. DETENTION FEES - See Preamble Section 10.D.1					
Detention after first half hour (per 15 min.)	0870	45.00	45.00	46.08	46.80

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Special call requiring detention(per 15 min.) **- See Preamble 10.D.3**	0876	45.00	45.00	46.08	46.80
9. TELEPHONE SERVICES					
Telephone Consultation (Ophthalmology) **- see Preamble 11.C.1**	0850	0.00	0.00	46.08	46.80
Telephone Prescription Renewal (max. 1/patient/month) **- See Preamble 11.C.3**	2019	5.00	5.00	6.50	7.50
10. HOME VISITS (includes nursing homes, manors, etc.)					
Home visit	0821	62.00	62.00	63.49	64.48
Each additional patient	0824	31.00	31.00	31.74	32.24
Additional fee allowed for emergency visit **- See Preamble 11.A.2**	0825	25.00	25.00	25.60	26.00
11. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	40.00	40.00	50.00	50.00
12. ON-CALL PER DIEM in lieu of Retainer+FFS(Salaried Ophthalmology)**Article C3.2**	0855	0.00	0.00	500.00	500.00

ORTHOPEDIC SURGERY

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

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
1. REFERRED CASES					
Consultation (office, hospital, home) - **See Preamble 9.A and 10.A**	0960	103.00	103.00	105.47	107.12
Repeat Consultation within 30 days (same illness or complication) - **See Preamble 9.C**	0962	51.50	51.50	52.74	53.56
2. OFFICE VISITS - See Preamble 9.D and 9.E					
Comprehensive Office Visit	0910	60.00	60.00	61.44	62.40
Initial Office Visit with regional exam	0911	35.00	35.00	35.84	36.40
Limited Office Visit	0913	35.00	35.00	35.84	36.40
3. HOSPITAL VISITS - In-Patient Services					
Initial hospital visit	0930	100.00	100.00	109.00	115.00
Subsequent hospital visits					
First five weeks, per visit	0933	50.00	50.00	54.50	57.50
From 6th week to 13th week, per visit	0934	30.00	30.00	32.70	34.50
After 13th week, per week	0935	30.00	30.00	32.70	34.50
Continuing care	0941	50.00	50.00	54.50	57.50
Directive care	0942	50.00	50.00	54.50	57.50
4. INTENSIVE CARE VISIT - per day	0971	100.00	100.00	102.40	104.00
5. HOSPITAL EMERGENCY DEPARTMENT VISITS					
Limited ED Visit (Level I visit)- **See Preamble 10.E.2(a)**					
- Day(08:00-18:00) - Monday to Friday	0980	31.50	31.50	32.26	32.76
- Saturday,Sunday,Holiday	0990	36.50	36.50	37.38	37.96
- Night(18:00-08:00) - Monday to Thursday	0981	41.00	41.00	41.98	42.64
- Friday,Saturday,Sunday,Holiday	0991	61.00	61.00	62.46	63.44
Comprehensive ED Visit (Level II visit)- **See Preamble 10.E.2(b)**					
- Day(08:00-18:00) - Monday to Friday	0986	57.50	57.50	58.88	59.80
- Saturday,Sunday,Holiday	0968	66.50	66.50	68.10	69.16
- Night(18:00-08:00) - Monday to Thursday	0987	77.50	77.50	79.36	80.60
- Friday,Saturday,Sunday,Holiday	0969	110.00	110.00	112.64	114.40
Additional fee allowed for strict emergency visit - **See Preamble 7**	0994	25.00	25.00	25.60	26.00
6. ON-CALL RETAINER - Orthopedics (Provincial)	0940	300.00	300.00	300.00	300.00
7. HOSPITAL ON-CALL RESPONSE FEE - see Preamble 11.E	0060	150.00	150.00	153.60	156.00
8. DETENTION FEES - See Preamble 10.D.1					
Detention after first half hour (per 15 min.)	0970	45.00	45.00	46.08	46.80
Special call requiring detention(per 15 min.) - **See Preamble 10.D.3**	0976	45.00	45.00	46.08	46.80

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
9. TELEPHONE SERVICES					
Telephone Consultation (Orthopedics) - **see Preamble 11.C.2**	0950	45.00	45.00	46.08	46.80
Telephone Prescription Renewal (max. 1/patient/month) - **See Preamble 11.C.3**	2019	5.00	5.00	6.50	7.50
10. HOME VISITS (includes nursing homes, manors, etc.)					
Home visit	0921	62.00	62.00	63.49	64.48
Each additional patient	0924	31.00	31.00	31.74	32.24
Additional fee allowed for emergency visit -**See Preamble 11.A.2**	0925	25.00	25.00	25.60	26.00
11. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	40.00	40.00	50.00	50.00

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
OTOLARYNGOLOGY					
These fees cannot be correctly interpreted without reference to the Preamble.					
1. REFERRED CASES					
Consultation (office, hospital, home) - **See Preamble 9.A and 10.A**	1060	103.00	103.00	105.47	107.12
Repeat Consultation within 30 days (same illness or complication) - **See Preamble 9.C**	1062	51.50	51.50	52.74	53.56
2. OFFICE VISITS - See Preamble 9.D and 9.E					
Comprehensive Office Visit	1010	60.00	60.00	61.44	62.40
Initial Office Visit with regional exam	1011	35.00	35.00	35.84	36.40
Limited Office Visit	1013	35.00	35.00	35.84	36.40
3. HOSPITAL VISITS - In-Patient Services					
Initial hospital visit	1030	100.00	100.00	109.00	115.00
Subsequent hospital visits					
First five weeks, per visit	1033	50.00	50.00	54.50	57.50
From 6th week to 13th week, per visit	1034	30.00	30.00	32.70	34.50
After 13th week, per week	1035	30.00	30.00	32.70	34.50
Continuing care	1041	50.00	50.00	54.50	57.50
Directive care	1042	50.00	50.00	54.50	57.50
4. INTENSIVE CARE VISIT - per day	1071	100.00	100.00	102.40	104.00
5. HOSPITAL EMERGENCY DEPARTMENT VISITS					
Limited ED Visit (Level I visit) - **See Preamble 10.E.2(a)**					
- Day(08:00-18:00) - Monday to Friday	1080	31.50	31.50	32.26	32.76
- Saturday,Sunday,Holiday	1090	36.50	36.50	37.38	37.96
- Night(18:00-08:00) - Monday to Thursday	1081	41.00	41.00	41.98	42.64
- Friday,Saturday,Sunday,Holiday	1091	61.00	61.00	62.46	63.44
Comprehensive ED Visit (Level II visit) - **See Preamble 10.E.2(b)**					
- Day(08:00-18:00) - Monday to Friday	1086	57.50	57.50	58.88	59.80
- Saturday,Sunday,Holiday	1068	66.50	66.50	68.10	69.16
- Night(18:00-08:00) - Monday to Thursday	1087	77.50	77.50	79.36	80.60
- Friday,Saturday,Sunday,Holiday	1069	110.00	110.00	112.64	114.40
Additional fee allowed for strict emergency visit - **See Preamble 7**	1094	25.00	25.00	25.60	26.00
6. ON-CALL RETAINER - ENT(Provincial)	1040	300.00	300.00	300.00	300.00
7. HOSPITAL ON-CALL RESPONSE FEE - see Preamble 11.E	0060	150.00	150.00	153.60	156.00
8. DETENTION FEES - See Preamble 10.D.1					
Detention after first half hour (per 15 min.)	1070	45.00	45.00	46.08	46.80
Special call requiring detention(per 15 min.) - **See Preamble 10.D.3**	1076	45.00	45.00	46.08	46.80

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
9. TELEPHONE SERVICES					
Telephone Consultation (ENT) - **see Preamble 11.C.2**	1050	0.00	0.00	46.08	46.80
Telephone Prescription Renewal (max. 1/patient/month) - **See Preamble 11.C.3**	2019	5.00	5.00	6.50	7.50
10. HOME VISITS (includes nursing homes, manors, etc.)					
Home visit	1021	62.00	62.00	63.49	64.48
Each additional patient	1024	31.00	31.00	31.74	32.24
Additional fee allowed for emergency visit - **See Preamble 11.A.2**	1025	25.00	25.00	25.60	26.00
11. SPECIAL PROCEDURES					
See Diagnostic & Therapeutic Procedures					
12. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	40.00	40.00	50.00	50.00
13. ON-CALL PER DIEM in lieu of Retainer+FFS (Salaried E.N.T.) - **Article C3.2**	1065	0.00	0.00	500.00	500.00

PEDIATRICS

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

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
1. REFERRED CASES					
Consultation (office, hospital, home) - **See Preamble 9.A and 10.A**	1160	190.00	190.00	194.56	197.60
Repeat Consultation within 30 days (same illness or complication) - **See Preamble 9.C**	1162	95.00	95.00	97.28	98.80
Complete re-examination by a medical specialist -**See Preamble 9.G**	1163	70.00	70.00	71.68	72.80
2. OFFICE VISITS - See Preamble 9.D and 9.E					
Comprehensive Office Visit	1110	70.00	70.00	71.68	72.80
Initial Office Visit with regional examination	1111	35.00	35.00	35.84	36.40
Subsequent Office Visit with complete re-examination	1112	70.00	70.00	71.68	72.80
Limited Office Visit	1113	35.00	35.00	35.84	36.40
Well baby care - **See Preamble 20.B**	1115	35.00	35.00	35.84	36.40
3. HOSPITAL VISITS - In-Patient Services					
Initial hospital visit	1130	100.00	100.00	109.00	115.00
Subsequent hospital visits					
First five weeks, per visit	1133	50.00	50.00	54.50	57.50
From 6th week to 13th week, per visit	1134	30.00	30.00	32.70	34.50
After 13th week, per week	1135	30.00	30.00	32.70	34.50
Continuing care	1141	50.00	50.00	54.50	57.50
Directive care	1142	50.00	50.00	54.50	57.50
Attendance at maternal delivery +/- intubation - **See Preamble 20.A**	1136	120.00	120.00	122.88	124.80
Healthy Newborn					
Hospital Visit fees apply					
Ill Newborn					
Initial hospital visit	1182	54.00	54.00	55.30	56.16
Subsequent hospital visits					
First five weeks, per visit	1183	11.55	11.55	11.83	12.01
From 6th week to 13th week, per visit (max.5 visits/week)	1184	10.50	10.50	10.75	10.92
After 13th week, per week	1185	14.50	14.50	14.85	15.08
Premature Newborn					
Initial hospital visit	1137	75.75	75.75	77.57	78.78
Thereafter up to 3 weeks, per week	1138	64.45	64.45	66.00	67.03
After 3 weeks, per week	1139	32.45	32.45	33.23	33.75
4. PEDIATRIC CRITICAL CARE - See Preamble 10.C.5 and 20.E					
Physician-in-Charge:					
Pediatric Critical Care - 1st day, includes consult (90 minutes)	1154	290.00	290.00	296.96	301.60
Pediatric Critical Care - 1st day, consult in previous 10 days(45 min.)	1155	168.00	168.00	172.03	174.72
Pediatric Critical Care - Days 2-30 inclusive, per day	1156	168.00	168.00	172.03	174.72
Pediatric Critical Care - Day 31 onward, per day	1157	84.00	84.00	86.02	87.36
Intensive Care Visit - per day	1179	100.00	100.00	102.40	104.00

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
5. NEONATAL INTENSIVE CARE - See Preamble 10.C.5 and 20.F					
Level A: Full life support including invasive monitoring, ventilatory support, and parenteral alimentation					
Neonatal ICU Care - 1st day, includes consult (120 minutes)	1145	350.00	350.00	358.40	364.00
Neonatal ICU Care - Days 2-30 inclusive, per day	1146	175.00	175.00	179.20	182.00
Neonatal ICU Care - Day 31 onward, per day	1147	116.00	116.00	118.78	120.64
Level B: Intensive Care including full monitoring both invasive and non-invasive, oxygen administration and intravenous therapy, but without ventilatory support.					
Neonatal ICU Care - 1st day, includes consult (90 minutes)	1148	240.00	240.00	245.76	249.60
Neonatal ICU Care - 2nd day onward, per day	1149	85.00	85.00	87.04	88.40
Level C: Intermediate care including oxygen administration, non-invasive monitoring and gavage feeding.					
Neonatal ICU Care - 1st day, includes consult (60 minutes)	1150	200.00	200.00	204.80	208.00
Neonatal ICU Care - 2nd day onward, per day	1151	70.00	70.00	71.68	72.80
6. HOSPITAL EMERGENCY DEPARTMENT VISITS					
Limited ED Visit (Level I visit)- **See Preamble 10.E.2(a)**					
- Day(08:00-18:00) - Monday to Friday	1180	31.50	31.50	32.26	32.76
- Saturday,Sunday,Holiday	1190	36.50	36.50	37.38	37.96
- Night(18:00-08:00) - Monday to Thursday	1181	41.00	41.00	41.98	42.64
- Friday,Saturday,Sunday,Holiday	1191	61.00	61.00	62.46	63.44
Comprehensive ED Visit (Level II visit) - **See Preamble 10.E.2(b)**					
- Day(08:00-18:00) - Monday to Friday	1186	57.50	57.50	58.88	59.80
- Saturday,Sunday,Holiday	1168	66.50	66.50	68.10	69.16
- Night(18:00-08:00) - Monday to Thursday	1187	77.50	77.50	79.36	80.60
- Friday,Saturday,Sunday,Holiday	1169	110.00	110.00	112.64	114.40
Resuscitation ED Visit (Level III visit) - **See Preamble 10.E.2(c)**					
- first 15 minutes	0182	100.00	100.00	102.40	104.00
- second 15 minutes	0183	50.00	50.00	51.20	52.00
- subsequent 15-minutes periods	0184	50.00	50.00	51.20	52.00
Additional fee allowed for strict emergency visit - **See Preamble 7**	1194	25.00	25.00	25.60	26.00
7. ON-CALL RETAINER - Pediatrics (QEH & PCH)	1140	300.00	300.00	300.00	300.00
8. HOSPITAL ON-CALL RESPONSE FEE - see Preamble 11.E	0060	150.00	150.00	153.60	156.00
9. DETENTION FEES - See Preamble 10.D.1					
Detention after first half hour (per 15 min.)	1170	45.00	45.00	46.08	46.80
Special call requiring detention(per 15 min.) - **See Preamble 10.D.3**	1176	45.00	45.00	46.08	46.80

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
10. COUNSELING SERVICES - See Preamble 8 and 13					
Health Promotion counseling (max. 45 minutes) **- See Preamble 8**	2505	42.50	42.50	14.51	14.73
Case Management Conference - **See Preamble 13.G**	2507	42.50	42.50	43.52	44.20
Diagnostic and therapeutic interview - **See Preamble 13.H** (includes genetic, drug, psychiatric, family counseling)	2586	55.00	55.00	56.32	57.20
11. TELEPHONE SERVICES					
Telephone Consultation (Pediatrics) - **see Preamble 11.C.1**	1120	45.00	45.00	46.08	46.80
Telephone Prescription Renewal (max. 1/patient/month) **- See Preamble 11.C.3**	2019	5.00	5.00	6.50	7.50
12. HOME VISITS (includes nursing homes, manors, etc.)					
Home visit	1121	62.00	62.00	63.49	64.48
Each additional patient	1124	31.00	31.00	31.74	32.24
Additional fee allowed for emergency visit **- See Preamble 11.A.2**	1125	25.00	25.00	25.60	26.00
13. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	40.00	40.00	50.00	50.00
14. ON-CALL PER DIEM in lieu of Retainer+FFS (Salaried Pediatrics)**- Article C3.2**	1152	0.00	0.00	500.00	500.00

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
PSYCHIATRY					
These fees cannot be correctly interpreted without reference to the Preamble.					
1. REFERRED CASES					
Consultation (office, hospital, home) - **See Preamble 9.A and 10.A**	1260	205.00	205.00	209.92	213.20
Repeat Consultation within 30 days (same illness or complication) - **See Preamble 9.C**	1262	102.50	102.50	104.96	106.60
Complete re-examination by a medical specialist -**See Preamble 9.G**	1263	70.00	70.00	71.68	72.80
2. OFFICE VISITS - See Preamble 9.D and 9.E					
Comprehensive Office Visit	1210	70.00	70.00	71.68	72.80
Limited Office Visit	1213	35.00	35.00	35.84	36.40
Sessional fee - Member of Group	2582	0.00	0.00	0.00	0.00
3. HOSPITAL VISITS - In-Patient Services					
Initial hospital visit	1230	100.00	100.00	109.00	115.00
Subsequent hospital visits					
First five weeks, per visit	1233	50.00	50.00	54.50	57.50
From 6th week to 13th week, per visit	1234	30.00	30.00	32.70	34.50
After 13th week, per week	1235	30.00	30.00	32.70	34.50
Continuing care	1241	50.00	50.00	54.50	57.50
Directive care	1242	50.00	50.00	54.50	57.50
4. PSYCHIATRIC SERVICES - See Preamble 13					
Psychotherapy	2504	55.00	55.00	56.32	57.20
Group psychotherapy	2587	55.00	55.00	56.32	57.20
Member of Group Psychotherapy	2581	0.00	0.00	0.00	0.00
Diagnostic and/or Therapeutic interview	2586	55.00	55.00	56.32	57.20
Case Management Conference	2507	42.50	42.50	43.52	44.20
NOTE: In exceptionally long cases, psychiatrists should claim detention fees after 45 minutes					
5. HOSPITAL EMERGENCY DEPARTMENT VISITS					
Limited ED Visit (Level I visit)- **See Preamble 10.E.2(a)**					
- Day(08:00-18:00) - Monday to Friday	1280	31.50	31.50	32.26	32.76
- Saturday,Sunday,Holiday	1290	36.50	36.50	37.38	37.96
- Night(18:00-08:00) - Monday to Thursday	1281	41.00	41.00	41.98	42.64
- Friday,Saturday,Sunday,Holiday	1291	61.00	61.00	62.46	63.44
Comprehensive ED Visit (Level II visit)- **See Preamble 10.E.2(b)**					
- Day(08:00-18:00) - Monday to Friday	1286	57.50	57.50	58.88	59.80
- Saturday,Sunday,Holiday	1268	66.50	66.50	68.10	69.16
- Night(18:00-08:00) - Monday to Thursday	1287	77.50	77.50	79.36	80.60
- Friday,Saturday,Sunday,Holiday	1269	110.00	110.00	112.64	114.40
Additional fee allowed for strict emergency visit - **See Preamble 7**	1294	25.00	25.00	25.60	26.00

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
6. ON-CALL RETAINER - Psychiatry (Provincial)	1240	300.00	300.00	300.00	300.00
7. HOSPITAL ON-CALL RESPONSE FEE - see Preamble 11.E	0060	150.00	150.00	153.60	156.00
8. DETENTION FEES - See Preamble 10.D.1					
Detention after first half hour (per 15 min.)	1270	45.00	45.00	46.08	46.80
Special call requiring detention(per 15 min.) **- See Preamble 10.D.3**	1276	45.00	45.00	46.08	46.80
9. TELEPHONE SERVICES					
Telephone Consultation (Psychiatry) **- see Preamble 11.C.2**	1250	0.00	0.00	46.08	46.80
Telephone Prescription Renewal (max. 1/patient/month) **- See Preamble 11.C.3**	2019	5.00	5.00	6.50	7.50
10. HOME VISITS (includes nursing homes, manors, etc.)					
Home visit	1221	62.00	62.00	63.49	64.48
Each additional patient	1224	31.00	31.00	31.74	32.24
Additional fee allowed for emergency visit **- See Preamble 11.A.2**	1225	25.00	25.00	25.60	26.00
11. SPECIAL PROCEDURES					
Phototherapy	2589	6.10	6.10	6.25	6.34
Electroconvulsive therapy - see Diagnostic/Therapeutic Procedures					
12. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	40.00	40.00	50.00	50.00

UROLOGY

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

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
1. REFERRED CASES					
Consultation (office, hospital, home) - **See Preamble 9.A and 10.A**	1360	103.00	103.00	105.47	107.12
Repeat Consultation within 30 days (same illness or complication) - **See Preamble 9.C**	1362	51.50	51.50	52.74	53.56
2. OFFICE VISITS - See Preamble 9.D and 9.E					
Comprehensive Office Visit	1310	60.00	60.00	61.44	62.40
Initial Office Visit with regional exam	1311	35.00	35.00	35.84	36.40
Limited Office Visit	1313	35.00	35.00	35.84	36.40
3. HOSPITAL VISITS - In-Patient Services					
Initial hospital visit	1330	100.00	100.00	109.00	115.00
Subsequent hospital visits					
First five weeks, per visit	1333	50.00	50.00	54.50	57.50
From 6th week to 13th week, per visit	1334	30.00	30.00	32.70	34.50
After 13th week, per week	1335	30.00	30.00	32.70	34.50
Continuing care	1341	50.00	50.00	54.50	57.50
Directive care	1342	50.00	50.00	54.50	57.50
4. INTENSIVE CARE VISIT - per day	1371	100.00	100.00	102.40	104.00
5. HOSPITAL EMERGENCY DEPARTMENT VISITS					
Limited ED Visit (Level I visit)- **See Preamble 10.E.2(a)**					
- Day(08:00-18:00) - Monday to Friday	1380	31.50	31.50	32.26	32.76
- Saturday,Sunday,Holiday	1390	36.50	36.50	37.38	37.96
- Night(18:00-08:00) - Monday to Thursday	1381	41.00	41.00	41.98	42.64
- Friday,Saturday,Sunday,Holiday	1391	61.00	61.00	62.46	63.44
Comprehensive ED Visit (Level II visit)- **See Preamble 10.E.2(b)**					
- Day(08:00-18:00) - Monday to Friday	1386	57.50	57.50	58.88	59.80
- Saturday,Sunday,Holiday	1368	66.50	66.50	68.10	69.16
- Night(18:00-08:00) - Monday to Thursday	1387	77.50	77.50	79.36	80.60
- Friday,Saturday,Sunday,Holiday	1369	110.00	110.00	112.64	114.40
Additional fee allowed for strict emergency visit - **See Preamble 7**	1394	25.00	25.00	25.60	26.00
6. ON CALL RETAINER - Urology (Provincial)	1340	300.00	300.00	300.00	300.00
7. HOSPITAL ON-CALL RESPONSE FEE - see Preamble 11.E	0060	150.00	150.00	153.60	156.00
8. DETENTION FEES - See Preamble 10.D.1					
Detention after first half hour (per 15 min.)	1370	45.00	45.00	46.08	46.80
Special call requiring detention(per 15 min.) - **See Preamble 10.D.3**	1376	45.00	45.00	46.08	46.80

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
9. TELEPHONE SERVICES					
Telephone Consultation (Urology) - **see Preamble 11.C.2**	1350	0.00	0.00	46.08	46.80
Telephone Prescription Renewal (max. 1/patient/month) - **See Preamble 11.C.3**	2019	5.00	5.00	6.50	7.50
10. HOME VISITS (includes nursing homes, manors, etc.)					
Home visit	1321	62.00	62.00	63.49	64.48
Each additional patient	1324	31.00	31.00	31.74	32.24
Additional fee allowed for emergency visit - **See Preamble 11.A.2**	1325	25.00	25.00	25.60	26.00
11. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	40.00	40.00	50.00	50.00

PHYSICAL MEDICINE

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

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
1. REFERRED CASES					
Consultation (office, hospital, home) - **See Preamble 9.A and 10.A**	1660	190.00	190.00	194.56	197.60
Repeat Consultation within 30 days (same illness or complication) - **See Preamble 9.C**	1662	95.00	95.00	97.28	98.80
Complete re-examination by a medical specialist **-See Preamble 9.G**	1663	70.00	70.00	71.68	72.80
2. OFFICE VISITS - See Preamble 9.D and 9.E					
Comprehensive Office Visit	1610	70.00	70.00	71.68	72.80
Initial Office Visit with regional exam	1611	35.00	35.00	35.84	36.40
Limited Office Visit	1613	35.00	35.00	35.84	36.40
3. HOSPITAL VISITS - In-Patient Services					
Initial hospital visit	1630	100.00	100.00	109.00	115.00
Subsequent hospital visits					
First five weeks, per visit	1633	50.00	50.00	54.50	57.50
From 6th week to 13th week, per visit	1634	30.00	30.00	32.70	34.50
After 13th week, per week	1635	30.00	30.00	32.70	34.50
Continuing care	1641	50.00	50.00	54.50	57.50
Directive care	1642	50.00	50.00	54.50	57.50
4. INTENSIVE CARE VISIT - per day	1671	100.00	100.00	102.40	104.00
5. HOSPITAL EMERGENCY DEPARTMENT VISITS					
Limited ED Visit (Level I visit)- **See Preamble 10.E.2(a)**					
- Day(08:00-18:00) - Monday to Friday	1680	31.50	31.50	32.26	32.76
- Saturday,Sunday,Holiday	1690	36.50	36.50	37.38	37.96
- Night(18:00-08:00) - Monday to Thursday	1681	41.00	41.00	41.98	42.64
- Friday,Saturday,Sunday,Holiday	1691	61.00	61.00	62.46	63.44
Comprehensive ED Visit (Level II visit)- **See Preamble 10.E.2(b)**					
- Day(08:00-18:00) - Monday to Friday	1686	57.50	57.50	58.88	59.80
- Saturday,Sunday,Holiday	1668	66.50	66.50	68.10	69.16
- Night(18:00-08:00) - Monday to Thursday	1687	77.50	77.50	79.36	80.60
- Friday,Saturday,Sunday,Holiday	1669	110.00	110.00	112.64	114.40
Additional fee allowed for strict emergency visit - **See Preamble 7**	1694	25.00	25.00	25.60	26.00
6. DETENTION FEES - See Preamble 10.D.1					
Detention after first half hour (per 15 min.)	1670	45.00	45.00	46.08	46.80
Special call requiring detention(per 15 min.) - **See Preamble 10.D.3**	1676	45.00	45.00	46.08	46.80

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
9. TELEPHONE SERVICES					
Telephone Consultation (Physical Medicine) - **see Preamble 11.C.2**	1650	0.00	0.00	46.08	46.80
Telephone Prescription Renewal (max. 1/patient/month) - **See Preamble 11.C.3**	2019	5.00	5.00	6.50	7.50
8. HOME VISITS (includes nursing homes, manors, etc.)					
Home visit	1621	62.00	62.00	63.49	64.48
Each additional patient	1624	31.00	31.00	31.74	32.24
Additional fee allowed for emergency visit - **See Preamble 11.A.2**	1625	25.00	25.00	25.60	26.00
9. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	40.00	40.00	50.00	50.00

RADIATION ONCOLOGY

The listed fees are for the professional services of a certified therapeutic radiologist, the services of a specialist for the intra-cavitary or interstitial application of radium or sealed sources and the services of a specialist using non-sealed sources of radioisotopes in a laboratory authorized by the Atomic Energy Control Board of Canada.
Other medical services to the patient are not included in these figures.
The cost of material is additional.

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
1. CONSULTATIONS					
Consultation (office, hospital, home) - **See Preamble 9.A and 10.A**	1760	190.00	190.00	194.56	197.60
Repeat Consultation within 30 days (same illness or complication) - **See Preamble 9.C**	1762	95.00	95.00	97.28	98.80
Follow-up visit at request of patient	1713	35.00	35.00	35.84	36.40
2. EXTERNAL THERAPY					
Treatment planning, dosage calculation and preparation of any special treatment device. (This is to apply only to malignant conditions treated radically.)	1715	36.50	36.50	37.38	37.96
Superficial therapy - x-ray under 100 K.V.P. per treatment visit	1716	6.85	6.85	7.01	7.12
Deep therapy - e.g. super voltage, Cobalt 60 or x-rays over 150 K.V.P. per visit	1717	9.40	9.40	9.63	9.78
Preparation and application of Radium mould	1718	16.50	16.50	16.90	17.16
Application of Strontium 90 ophthalmic device	1719	8.40	8.40	8.60	8.74
Treatment planning for non malignant conditions	1720	22.75	22.75	23.30	23.66
3. INTERSTITIAL THERAPY					
Consultation and treatment planning fees as above. Interstitial insertion of Radium needles, Gold 98 grains or other sealed Radioisotopes.					
Biopsy as separate procedure	1725	182.60	182.60	186.98	189.90
4. INTRACAVITARY THERAPY					
Consultation and treatment planning fees as above.					
Radium insertion - per insertion	1730	157.70	157.70	161.48	164.01
Provision of radium in suitable containers and attendance in the operating room with advice and dosage calculation	1731	91.35	91.35	93.54	95.00
5. RADIOISOTOPE THERAPY					
Consultation and treatment planning fees as above (Treatment planning fee to apply to malignant conditions only)					
Radioisotope therapy - carcinoma of thyroid (per course of Tx)	1735	74.65	74.65	76.44	77.64
Treatment for hyperthyroidism and/or cardiac disease (per course of Tx)	1736	54.90	54.90	56.22	57.10
Treatment for Polycythemia Vera with Page 33 (per course of Tx)	1737	44.75	44.75	45.82	46.54

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
6. RADIATION THERAPY (Shadow Billing)	2600	0.00	0.00	0.00	0.00
7. TELEPHONE SERVICES					
Telephone Consultation (Radiation Oncology) **- see Preamble 11.C.2**	4850	0.00	0.00	46.08	46.80
Telephone Prescription Renewal (max. 1/patient/month) **- See Preamble 11.C.3**	2019	5.00	5.00	6.50	7.50
8. ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	40.00	40.00	50.00	50.00
9. ON-CALL RETAINER - Radiation Oncology (Provincial)	4840	0.00	0.00	300.00	300.00
10. HOSPITAL ON-CALL RESPONSE FEE - see Preamble 11.E	0060	150.00	150.00	153.60	156.00
11. ON-CALL PER DIEM in lieu of Retainer+FFS (Salaried Rad.Onc.) **-Article C3.2**	4855	0.00	0.00	500.00	500.00

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

These fees cannot be correctly interpreted without reference to Preamble.

See Preamble 21 and Preamble 5.A
Cost of medication used in any of these procedures is additional.

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
OFFICE LABORATORY PROCEDURES					
Urinalysis - complete (routine and microscopic)	2002	4.50	4.50	4.61	4.68
Urinalysis - partial	2003	2.25	2.25	2.30	2.34
Hemoglobin estimation	2004	4.00	4.00	4.10	4.16
Occult blood in stool	2005	2.25	2.25	2.30	2.34
Nasal smear for eosinophil	2006	4.00	4.00	4.10	4.16
ALLERGY SKIN TESTS					
Technical Component, per test (maximum 48 tests)	2349	0.70	0.70	0.72	0.73
Professional Component, per test (maximum 48 tests)	2359	0.20	0.20	0.20	0.21
Allergy counseling (billed as counseling fee 2505)					
ANTICOAGULATION THERAPY SUPERVISION (by telephone - per month)	2106	15.00	15.00	15.36	15.60
ARTHOGRAM - See Diagnostic Imaging					
ASPIRATIONS					
Lymph Node in neck	2050	24.34	24.34	24.92	25.31
Bladder	2107	40.00	40.00	40.96	41.60
Breast cyst	2108	30.00	30.00	30.72	31.20
Bursa	2109	26.75	26.75	27.39	27.82
Cisterna magna	2110	24.13	24.13	24.71	25.10
Duodenum	2111	40.13	40.13	41.09	41.74
Esophagus or stomach	2112	21.40	21.40	21.91	22.26
Hydrocele	2113	21.40	21.40	21.91	22.26
Joint	2114	35.00	35.00	35.84	36.40
Lumbar puncture	2115	100.00	100.00	102.40	104.00
Therapeutic Pericardiocentesis	2116	160.00	160.00	163.84	166.40
Subdural (tap)	2117	31.73	31.73	32.49	33.00
Subdural puncture(each additional tap)	2118	10.49	10.49	10.74	10.91
Thyroid cyst	2119	30.00	30.00	30.72	31.20
AUDIOMETRIC TESTS - See Otolaryngology					
AUTOPSY - non-coroner's autopsy on evenings and weekends	1900	1,250.00	1,250.00	1,280.00	1,300.00
BIOPSIES - see Needle Biopsies					
Breast Excisional Biopsy	3073	146.59	146.59	156.23	162.66
BLOOD TRANSFUSION					
Indirect Transfusions	2123	21.19	21.19	21.70	22.04

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
CARDIAC PROCEDURES					
Cardioversion only (one procedure to be billed per session)	2124	112.35	112.35	115.05	116.84
Selective percutaneous aortography - see Diagnostic Imaging					
Catheterization					
Catheterization of heart-right	2126	158.63	158.63	162.44	164.98
Hepatic wedge pressure	2127	105.72	105.72	108.26	109.95
Catheterization of heart-left	2128	211.54	211.54	216.62	220.00
Left ventricular puncture	2129	105.72	105.72	108.26	109.95
Phonocardiogram - Supervision and interpretation	2217	31.73	31.73	32.49	33.00
CERTIFICATION of patient to mental health or addictions facility	2800	42.80	42.80	43.83	44.51
CHEMOTHERAPY					
Administration of chemotherapy (includes Diagnostic/Therapeutic aspiration)	2215	60.00	60.00	61.44	62.40
IV administration of chemotherapy agent - per injection	2174	21.40	21.40	21.91	22.26
Additional injections of chemotherapy at time of init. injection	2264	10.54	10.54	10.79	10.96
Administration of chemotherapy into an Omaya Reservoir	2550	38.95	38.95	39.88	40.51
Intrathecal chemotherapy including diagnostic lumbar puncture	2551	130.00	130.00	133.12	135.20
Administration of sclerosing material via chest tube	2552	53.50	53.50	54.78	55.64
DIALYSIS for Renal Failure - See Preamble 21.L					
Acute Dialysis - first treatment	2055	585.00	585.00	599.04	608.40
Acute Dialysis - subsequent treatment (up to 2)	2056	268.80	268.80	275.25	279.55
Chronic Dialysis - first treatment	2135	182.81	182.81	187.20	190.12
Chronic Dialysis - subsequent treatment - **See Preamble 21.L**	2137	74.00	74.00	75.78	76.96
Satellite Dialysis Management (per patient per week)	2058	40.00	40.00	40.96	41.60
Insertion of permanent peritoneal dialysis catheter	2132	155.36	155.36	159.09	161.57
Dialysis catheter - tunneling and insertion	2038	150.00	150.00	153.60	156.00
Dialysis catheter - removal and/or replacement	2039	200.00	200.00	204.80	208.00
DIAGNOSTIC IMAGING PROCEDURES					
Cystogram	2700	34.72	34.72	35.55	36.11
Arthogram	2701	34.72	34.72	35.55	36.11
Bronchogram	2702	46.22	46.22	47.33	48.07
Sialogram	2705	46.22	46.22	47.33	48.07
Hysterosalpingogram	2706	69.44	69.44	71.11	72.22
Percutaneous transhepatic cholangiogram	2708	81.05	81.05	83.00	84.29
Lymphogram	2709	115.72	115.72	118.50	120.35
Myelogram - Lumbar	2172	73.88	73.88	75.65	76.84
DRESSING CHANGE	2010	10.70	10.70	16.28	20.00
ED AND CRITICAL CARE ULTRASOUND - See Preamble 21.H	2900	30.00	30.00	30.72	31.20
ELECTROCARDIOGRAM (ECG) & OTHER CARDIOLOGY STUDIES					
Note: Payment for interpretation of electrocardiograms made only to those physicians so qualified.					
ECG - Technical Component only	2257	10.70	10.70	10.96	11.13
ECG - procedure with interpretation in office	2142	21.40	21.40	21.91	22.26
ECG - procedure with interpretation in home	2143	26.80	26.80	27.44	27.87

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
ECG - Interpretation only	2145	10.70	10.70	10.96	11.13
Holter Monitoring	2144	51.36	51.36	52.59	53.41
Loop Event Recorder interpretation	4780	21.40	21.40	21.91	22.26
Stress Test	0599	85.60	85.60	87.65	89.02
Myocardial Perfusion (MIBI) Stress Test - exercise or pharmacologic (includes all injections, IV's, interpretation)	4754	107.00	107.00	109.57	111.28
Exercise tests:					
(The following fees refer to the professional component only)					
1. Simple progressive exercise tests at several workloads, with measurements of heart rate by ECG and of ventilation	2249	25.36	25.36	25.97	26.37
2. Exercise in a steady state at two or more work loads with measurements of heart rate by ECG, ventilation, VO, VCO, end tidal and mixed venous PCO2	2250	52.80	52.80	54.07	54.91
3. As above with calculation of cardiac output by respiratory gas technique	2251	84.53	84.53	86.56	87.91
ELECTROCONVULSIVE THERAPY (ECT)	2151	75.00	75.00	76.80	78.00
ELECTROENCEPHALOGRAM (EEG)					
EEG Interpretation only	2146	30.76	30.76	31.50	31.99
Insertion of sub-temporal needles (add)	2147	21.19	21.19	21.70	22.04
With activating Drugs, e.g. Metrazule (add)	2148	21.19	21.19	21.70	22.04
EMG & OTHER NEUROMUSCULAR STUDIES - see Preamble 21.K					
Electromyography (major) - examination of muscles of more than one region	2149	90.00	90.00	92.16	93.60
Electromyography (minor) - examination of muscles of a specific limb or region	2150	60.00	60.00	61.44	62.40
Nerve Conduction Studies, per nerve studied (maximum 6 nerves)	2140	30.52	30.52	31.25	31.74
Nerve entrapment evaluation (composite fee)	2166	85.60	85.60	87.65	89.02
Tensilon test	2269	22.74	22.74	23.29	23.65
ENDOCRINOLOGY AND METABOLISM					
ACTH Stimulation Test	2248	43.66	43.66	44.71	45.41
Insulin Hypoglycemia for Pituitary Function	2152	60.94	60.94	62.40	63.38
TRH Test	2153	30.44	30.44	31.17	31.66
GNRH (LHRH) Tests	2154	30.44	30.44	31.17	31.66
Combined calcium and pentagastrin	2155	73.13	73.13	74.89	76.06
Calcium or pentagastrin alone	2156	48.74	48.74	49.91	50.69
GASTROENTEROLOGY PROCEDURES					
Ambulatory 24 hour Esophageal pH Monitoring	2309	32.96	32.96	33.75	34.28
Esophageal HCL drip test	2157	31.73	31.73	32.49	33.00
Esophageal Motility studies	2158	73.88	73.88	75.65	76.84
Esophageal variceal banding(includes esophagoscopy)	5166	278.20	278.20	284.88	289.33
Achalasia Botox injection	2167	64.20	64.20	65.74	66.77
Gastro-esophageal tamponade	2159	60.00	60.00	61.44	62.40
Gastric lavage - diagnostic and emergency	2162	26.75	26.75	27.39	27.82
Gastroscopy - Diagnostic, biopsy, removal of foreign body	5218	192.81	192.81	197.44	200.52
- subsequent - within 45 days of initial procedure (IC for full fee may be given under exceptional circumstances)	5219	76.18	76.18	78.01	79.23
Peritoneal lavage	2255	80.25	80.25	82.18	83.46

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Balloon stricture dilatation(incl. gastro/sigmoido/colonoscopy)	2237	264.29	264.29	270.63	274.86
Repeat balloon stricture dilatation within 30 days					
- with gastroscopy	2370	208.31	208.31	213.31	216.64
- with sigmoidoscopy	2371	158.90	158.90	162.71	165.26
- with colonoscopy of descending colon	2372	158.90	158.90	162.71	165.26
- with colonoscopy of descending & transverse colon	2373	185.65	185.65	190.11	193.08
- with colonoscopy of complete colon	2374	212.40	212.40	217.50	220.90
Fractional test - meal (samples and analysis)	2163	31.73	31.73	32.49	33.00
Proctoscopic exam	2007	20.00	20.00	20.48	20.80
Sigmoidoscopy - Rigid (with or without biopsy)	2235	50.00	50.00	51.20	52.00
Sigmoidoscopy - Flexible (with or without biopsy)	2242	85.00	85.00	87.04	88.40
Colonoscopy - descending colon	2310	100.00	100.00	102.40	104.00
Colonoscopy - descending & transverse colon	2320	160.00	160.00	163.84	166.40
Colonoscopy - complete colon	2260	225.00	225.00	230.40	234.00
Removal of polyp under colonoscopic examination - first polyp	2360	85.71	85.71	87.77	89.14
Plus 25% of the fee for each additional polyp (maximum of 5 polyps)					
Ileoscopy	2315	100.00	100.00	102.40	104.00
Removal of rectal foreign body	2021	85.00	85.00	87.04	88.40
Argon Coagulation of stomach or rectum - single or multiple (add-on fee)	2022	80.25	80.25	82.18	83.46
GYNECOLOGIC TESTS & PROCEDURES					
Pelvic Examination Only	2001	8.00	8.00	8.19	8.32
Pap Smear with/without Pelvic examination	2008	14.00	14.00	14.34	14.56
Pap Screening Clinic	2018	0.00	0.00	0.00	0.00
Cryotherapy of cervix	2131	44.41	44.41	45.48	46.19
Fitting of diaphragm	6936	35.47	35.47	36.32	36.89
Vaginal Pessary - initial fitting	2605	16.05	16.05	16.44	16.69
Insertion of Pessary (paid as Visit Fee only)					
Vaginal Insufflation (paid as Visit Fee only)					
IMMUNIZATION REPORTING - See Preamble 21.G.4					
Immunization - Influenza (reporting only)	0081	0.00	0.00	0.00	0.00
Immunization - Pneumococcal (reporting only)	0082	0.00	0.00	0.00	0.00
Immunization - Tetanus/Pertussis (reporting only)	0083	0.00	0.00	0.00	0.00
Immunization - Hepatitis A/B (reporting only)	0084	0.00	0.00	0.00	0.00
Immunization - Varicella zoster (reporting only)	0085	0.00	0.00	0.00	0.00
INJECTIONS					
Injection - IM, SC, immunization (one or more)	2009	10.00	10.00	10.24	10.40
Hyposensitization/Allergy shot	2102	10.00	10.00	10.24	10.40
B.C.G. Vaccination, including necessary Tuberculin tests	2122	10.49	10.49	10.74	10.91
Vaccination with certificate	2243	17.12	17.12	17.53	17.80
Injection - IV	2165	15.00	15.00	15.36	15.60
Injection of medication - e.g. bursa, joint	2168	26.75	26.75	28.70	30.00
Injection of hemorrhoids, initial	2169	21.40	21.40	21.91	22.26
Injection of hemorrhoids, subsequent	2170	16.10	16.10	16.49	16.74
Injection for pruritus ani	2171	21.40	21.40	21.91	22.26
Injection - Ages 0 to 4 only - by cut down	2252	53.50	53.50	54.78	55.64
Injection - Ages 0 to 4 only - by scalp vein	2253	26.75	26.75	27.39	27.82
IV Iron infusion - total care	2410	53.50	53.50	54.78	55.64

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Cryoprecipitate - includes preparation and administration	2015	21.67	21.67	22.19	22.54
Intrathecal Epi-morph Injection	2307	61.53	61.53	63.01	63.99
Intravenous Pyelogram - after hours in Emergency Dept	2265	37.45	37.45	38.35	38.95
Injection of medication into chest/abdominal cavities -see Paracentesis					
MORBID OBESITY PREMIUMS					
Morbid Obesity Premium (Surgery) - **See Preamble 14.E.10**	0074	0.00	0.00	100.00	100.00
Morbid Obesity Premium (Anesthesia) - **See Preamble 18.L**	0075	0.00	0.00	100.00	100.00
NEEDLE BIOPSY PROCEDURES					
Bone Marrow	2175	100.00	100.00	102.40	104.00
Kidney	2176	73.88	73.88	75.65	76.84
Liver	2177	80.25	80.25	82.18	83.46
Lung	2263	74.90	74.90	76.70	77.90
Lung - transbronchial	2268	124.33	124.33	127.31	129.30
Pleura	2178	42.43	42.43	43.45	44.13
Pericardium	2181	158.63	158.63	162.44	164.98
Prostate	2182	84.53	84.53	86.56	87.91
Synovial Tissue	2180	52.80	52.80	54.07	54.91
Thyroid	2259	50.00	50.00	51.20	52.00
NERVE BLOCKS and OTHER PAIN INJECTIONS - see Preamble 21.M					
Somatic or peripheral nerve not specifically listed - single	2183	40.00	40.00	40.96	41.60
- each additional (to max. of 4)	2184	20.00	20.00	20.48	20.80
Cervical plexus	2186	74.90	74.90	76.70	77.90
Brachial plexus	2189	64.20	64.20	65.74	66.77
Supraorbital branch of Ophthalmic Nerve (Trigeminal)	2450	64.20	64.20	65.74	66.77
Infraorbital branch of Maxillary Nerve (Trigeminal)	2188	64.20	64.20	65.74	66.77
Mental branch of Mandibular Nerve (Trigeminal)	2187	64.20	64.20	65.74	66.77
Maxillary or Mandibular division of Trigeminal Nerve	2206	74.90	74.90	76.70	77.90
Therapeutic Seventh Cranial nerve block - unilateral	2304	44.94	44.94	46.02	46.74
Therapeutic Seventh Cranial nerve block - bilateral	2305	67.46	67.46	69.08	70.16
Other Cranial Nerve	2451	64.20	64.20	65.74	66.77
Occipital Nerve	2100	40.00	40.00	40.96	41.60
Transverse Scapular Nerve	2452	64.20	64.20	65.74	66.77
Intercostal Nerve - single	2453	40.00	40.00	40.96	41.60
Intercostal Nerve - each additional (to max. of 4)	2454	20.00	20.00	20.48	20.80
Paravertebral Nerve - single	2210	74.90	74.90	76.70	77.90
Paravertebral Nerve - single - injection for chronic pain	2470	40.00	40.00	40.96	41.60
Paravertebral Nerve - each additional (to max. of 4)	2211	37.45	37.45	38.35	38.95
Paravertebral Nerve - each additional (to max. of 4) - injection for chronic pain	2471	20.00	20.00	20.48	20.80
Ilioinguinal and/or Iliohypogastric Nerves	2455	64.20	64.20	65.74	66.77
Sciatic Nerve	2192	64.20	64.20	65.74	66.77
Sciatic Nerve - injection for chronic pain	2472	40.00	40.00	40.96	41.60
Femoral Nerve	2456	64.20	64.20	65.74	66.77
Obturator Nerve	2193	64.20	64.20	65.74	66.77
Pudendal Nerve	2194	64.20	64.20	65.74	66.77
Lateral Femoral Cutaneous Nerve	2204	70.00	70.00	71.68	72.80
Combined 3-in-1 block (femoral, obturator, lateral femoral cutaneous)	2457	85.60	85.60	87.65	89.02
Fascia Iliaca Compartment block	2458	64.20	64.20	65.74	66.77

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Transversus Abdominis Plane (TAP) block - unilateral	2459	32.10	32.10	32.87	33.38
Transversus Abdominis Plane (TAP) block - bilateral	2460	52.97	52.97	54.24	55.09
Nerve block with fluoroscopic guidance (add on)	2461	45.00	45.00	46.08	46.80
Nerve block with ultrasound guidance (add on)	2462	30.00	30.00	30.72	31.20
Nerve block with alcohol or other sclerosing agent - add 50% (with comment)					
Vertebral Facet Joint injections					
- with fluoroscopic guidance - single	2533	98.50	98.50	100.86	102.44
- each additional, up to 6	2463	64.03	64.03	65.57	66.59
- with ultrasound guidance - single	2464	83.50	83.50	85.50	86.84
- each additional, up to 6	2465	54.28	54.28	55.58	56.45
Sacroiliac Joint injection with fluorscopic guidance - unilateral	2466	98.50	98.50	100.86	102.44
- bilateral	2467	162.53	162.53	166.43	169.03
Diagnostic nerve root block with fluoroscopic guidance (any number of sites)	2468	171.20	171.20	175.31	178.05
Epidural injections					
Cervical epidural injection with fluoroscopic guidance	2531	171.20	171.20	175.31	178.05
Thoracic epidural injection with fluoroscopic guidance	2532	171.20	171.20	175.31	178.05
Lumbar epidural injection with fluoroscopic guidance	2524	171.20	171.20	175.31	178.05
Caudal epidural injection	2191	69.55	69.55	71.22	72.33
Epidural - single injection	2196	85.60	85.60	87.65	89.02
Subarachnoid (diagnostic spinal)	2195	74.90	74.90	76.70	77.90
Sympathetic Nerve injections					
Cervical sympathetic or Stellate ganglion block	2199	107.00	107.00	109.57	111.28
- with U/S or fluoroscopic guidance	2208	160.50	160.50	164.35	166.92
Thoracic, Lumbar, Sacral sympathetic block with fluoroscopic guidance	2205	160.50	160.50	164.35	166.92
Lumbar sympathetic nerve block	2185	90.95	90.95	93.13	94.59
Ganglion/Plexus injections					
Presacral (superior hypogastric plexus) block	2190	64.20	64.20	65.74	66.77
Celiac, splanchnic, hypogastric ganglion/plexus block w/ fluoro guidance	2197	160.50	160.50	164.35	166.92
Trigeminal (Gasserian) ganglion block	2198	107.00	107.00	109.57	111.28
- with fluoroscopic guidance	2202	160.50	160.50	164.35	166.92
Spheno-palatine ganglion block with fluoroscopic guidance	2207	160.50	160.50	164.35	166.92
Superior Laryngeal Nerve with fluoroscopic guidance	2209	160.50	160.50	164.35	166.92
IV Guanethidine/Bier Block	2530	107.00	107.00	109.57	111.28
Trigger point injection (myoneural pain block) with local anesthetic (one or more)	2101	21.40	21.40	21.91	22.26
OBSTETRIC TESTS & PROCEDURES					
Ultrasound procedures by Obstetrician	2606	60.99	60.99	62.45	63.43
Insertion of Intrauterine Pressure Catheter (IUPC)	2601	50.83	50.83	52.05	52.86
Oxytocin Challenge Test	2602	32.10	32.10	32.87	33.38
Scalp pH Sampling (maximum of 2)	2603	66.34	66.34	67.93	68.99
Biophysical Profile	2604	60.99	60.99	62.45	63.43

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
OPHTHALMIC TESTS					
Annual Diabetic Retinopathy Photographic Screening	2308	11.24	11.24	11.51	11.69
Anterior stromal puncture corneal erosion	2303	57.08	57.08	58.45	59.36
Intravitreol Injection of Eye	2306	214.00	214.00	214.00	214.00
Visual Fields with a Goldman perimeter	2258	40.82	40.82	41.80	42.45
Visual Field interpretation	2408	16.05	16.05	16.44	16.69
Ultrasound - procedure only	8887	40.55	40.55	41.52	42.17
Ultrasound - interpretation	8889	22.15	22.15	22.68	23.04
Fluorescein / Digital Angiography	7510	61.04	61.04	62.50	63.48
Optical Coherence Tomography (OCT) - composite fee (max. 4/year)	2414	61.04	61.04	62.50	63.48
Optical Coherence Tomography (OCT) - technical fee (max. 4/year)	2417	44.99	44.99	46.07	46.79
Optical Coherence Tomography (OCT) - professional fee (max. 4/year)	2415	16.05	16.05	16.44	16.69
Heidelberg Retina Tomography (HRT) - nonscreening (max.4/year)	2413	30.00	30.00	30.72	31.20
Pachymetry - one or both eyes (only once per patient lifetime)	2412	12.00	12.00	12.29	12.48
IOL Master / Ocular Biometry - procedure only	2420	40.55	40.55	41.52	42.17
IOL Master / Ocular Biometry - interpretation	2421	22.15	22.15	22.68	23.04
OTOLARYNGOLOGY TESTS & PROCEDURES					
Impedance audiometry	1095	22.71	22.71	23.26	23.62
Complete hearing test (incl.audiometry, tuning fork, speech test)	2540	39.98	39.98	40.94	41.58
Cerumen removal (unilateral or bilateral)	2000	12.00	12.00	12.29	12.48
Microdebridement in office	1099	27.39	27.39	28.05	28.49
Vestibular function tests	2541	23.06	23.06	23.61	23.98
Modified Sleep study	2549	42.80	42.80	43.83	44.51
Emergency Cricothyrotomy	2901	214.00	214.00	219.14	222.56
Change of Tracheostomy Tube (paid as Visit Fee only)					
PARACENTESIS (Thoracic or Abdominal)					
Diagnostic aspiration	2213	50.00	50.00	51.20	52.00
Therapeutic aspiration (including diagnostic sample)	2214	65.00	65.00	66.56	67.60
PROCEDURAL SEDATION (Emergency)	2011	30.00	30.00	30.72	31.20
PULMONARY FUNCTION STUDIES					
1. Evaluation and interpretation of results of complete pulmonary function study (i.e. ventilation, lung volumes, and pulmonary diffusing capacity) with or without other studies	2218	53.50	53.50	54.78	55.64
2. Evaluation and Interpretation of:					
(a) Maximum breathing capacity or peak flow study	2219	11.50	11.50	11.78	11.96
(b) Pulmonary diffusion capacity	2220	21.19	21.19	21.70	22.04
(c) Pulmonary pressure tracings only	2222	11.50	11.50	11.78	11.96
(d) Lung volume determination	2223	22.52	22.52	23.06	23.42
(e) Vital capacity and timed unit capacity	2247	11.50	11.50	11.78	11.96
Methacholine challenge	2245	72.23	72.23	73.96	75.12
RHEUMATOLOGY AND PHYSICAL MEDICINE					
Uric acid crystals	2233	6.37	6.37	6.52	6.62
Mucin clot	2234	2.14	2.14	2.19	2.23

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
STERILITY INVESTIGATION					
Male, sperm cell count and morphology	2236	10.49	10.49	10.74	10.91
Female - see Gynecology					
SWEAT TEST	2261	34.03	34.03	34.85	35.39
VENIPUNCTURE					
Venipuncture - infant or child under 6 years	2239	21.40	21.40	21.91	22.26
Venipuncture - adult or child 6 years or older	2238	10.00	10.00	10.60	11.00
Venipuncture - femoral vein puncture	2240	21.40	21.40	21.91	22.26
Venipuncture - jugular vein puncture	2241	21.40	21.40	21.91	22.26
IV Start on Pediatric patient(under 6 years)	2232	42.80	42.80	43.83	44.51
Central I.V. Line Insertion	2254	120.00	120.00	122.88	124.80
Central Venous Pressure - placement of catheter	2244	53.50	53.50	54.78	55.64
Swan-Ganz Catheter	2262	171.20	171.20	175.31	178.05
Therapeutic phlebotomy	2266	21.19	21.19	21.70	22.04
Umbilical vessel catheterization	2256	77.09	77.09	78.94	80.17
Arterial puncture for blood gases	2400	21.40	21.40	21.91	22.26
Arterial cannulation (Arterial Line insertion)	4599	60.00	60.00	61.44	62.40
UROLOGICAL TESTS & PROCEDURES					
Cystometrogram	2246	32.10	32.10	32.87	33.38
Urodynamic Studies:					
Urine Flow rate determination	2267	12.84	12.84	13.15	13.35
Urethral pressure profile or leak pressure test	2276	21.40	21.40	21.91	22.26
Electromyography	2278	21.40	21.40	21.91	22.26
Pressure flow study	2284	21.40	21.40	21.91	22.26
Videourodynamic assessment	2290	21.40	21.40	21.91	22.26
Periurethral collagen injection	2292	160.50	160.50	164.35	166.92
Intravenous Pyelogram - after hours in Emergency Dept	2265	37.45	37.45	38.35	38.95
Prostatic massage (paid as Visit Fee only)					
Insertion of urinary catheter (transurethral)	2902	35.00	35.00	35.84	36.40
Aspiration of corpus cavernosum for priapism	2903	64.20	64.20	65.74	66.77
Reduction of paraphimosis, including dorsal slit	2904	53.50	53.50	54.78	55.64

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
VASCULAR LAB DIAGNOSTIC PROCEDURES					
Extracranial cerebrovascular assessment:					
Bilateral carotid and/or subclavian and/or vertebral arteries					
Doppler scan or B scan – *technical component*	2270	43.50	43.50	44.54	45.24
– *professional component*	2271	24.45	24.45	25.04	25.43
Frequency analysis – *technical component*	2272	43.50	43.50	44.54	45.24
– *professional component*	2273	24.45	24.45	25.04	25.43
Frequency analysis plus scan – *technical component*	2274	65.32	65.32	66.89	67.93
– *professional component*	2275	36.75	36.75	37.63	38.22
Peripheral arterial evaluation:					
(not to be billed routinely w/ above cerebrovascular assessment)					
Doppler scan or B scan	2277	16.42	16.42	16.81	17.08
Frequency analysis	2279	13.59	13.59	13.92	14.13
Frequency analysis plus scan – *technical component*	2280	31.30	31.30	32.05	32.55
– *professional component*	2281	25.79	25.79	26.41	26.82
Venous assessment:					
Bilateral femoral, popliteal, post/ant tibial veins – *technical component*	2282	6.85	6.85	7.01	7.12
– *professional component*	2283	10.91	10.91	11.17	11.35
(not chargeable during surgery or during post-op stay in hospital)					
Ankle pressure determination – *professional component*	2285	8.93	8.93	9.14	9.29
(not chargeable during surgery or during post-op stay in hospital)					
Ankle pressure measurements w/ segmental pressure +/- Doppler recordings -- *tech*	2286	20.54	20.54	21.03	21.36
-- *prof*	2287	24.45	24.45	25.04	25.43
Ankle pressure measurements with exercise or tourniquet hyperemia					
induced velocity changes, added to the above – *technical component*	2288	7.54	7.54	7.72	7.84
– *professional component*	2289	11.61	11.61	11.89	12.07
Penile pressure recordings - two or more pressures – *professional component*	2291	8.13	8.13	8.33	8.46
Strain gauge plethysmography (venous capacitance and venous outflow) – *prof*	2293	6.10	6.10	6.25	6.34
Periorbital studies for reversed flow in carotid system					
by Doppler or by photo plethysmography – *technical component*	2294	13.59	13.59	13.92	14.13
– *professional component*	2295	14.93	14.93	15.29	15.53
Venous Refilling Time – *technical component*	2296	12.36	12.36	12.66	12.85
– *professional component*	2297	6.10	6.10	6.25	6.34

*Professional and technical components are only payable when qualified physicians provide both components.

OFFICE VASCULAR DIAGNOSTIC PROCEDURES

Ultrasound assessment of cerebral circulation					
with segmental pressures and analysis of wave forms – *composite fee.*	2300	47.56	47.56	48.70	49.46
(technical and professional components)					
Ultrasound assessment of cerebral circulation					
plus periorbital flow studies – *composite fee.*	2301	47.56	47.56	48.70	49.46
(technical and professional components)					

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018

OPERATIONS ON THE INTEGUMENTARY SYSTEM

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

SKIN AND SUBCUTANEOUS TISSUE

Incision

Abscess					
Subcutaneous boil, infected cyst, superficial lymphadenitis, paronychia, felon, etc.					
- Local anesthetic	3000	37.45	37.45	38.35	38.95
- General anesthetic	3001	46.22	46.22	47.33	48.07
Carbuncle - neck, complete care	3002	92.50	92.50	94.72	96.20
Perianal or pilonidal - local anesthetic	3003	42.80	42.80	53.12	60.00
- general anesthetic, complete care	3004	69.44	69.44	71.11	72.22
Ischio-rectal - simple incision - local anesthetic	3005	42.80	42.80	53.12	60.00
- Unroofing - complete care	3006	138.83	138.83	142.16	144.38
Palmar and plantar space infections, tenosynovitis					
- general or regional - complete care	3007	138.83	138.83	142.16	144.38
Hematoma - local anesthetic	3008	37.45	37.45	38.35	38.95
- general anesthetic -depending on size, complicating factors	3009	46.22	46.22	47.33	48.07
Tongue-tie release - infant (paid as Visit Fee only)					
- child - local anesthetic	3010	14.18	14.18	14.52	14.75
- general anesthetic	3011	46.22	46.22	47.33	48.07
Removal of foreign body or fibroma - local anesthetic	3012	42.80	42.80	47.12	50.00
- general anesthetic	3013	I.C.	I.C.	I.C.	I.C.

Note: Pre and Post-operative care for the above at visit fees unless otherwise specified.

Excision

*Excision Biopsy	3030	44.94	44.94	47.98	50.00
Carcinoma of skin, excision, - simple	3031	81.05	81.05	83.00	84.29
- complicated, depending on site, etc.	3032	I.C.	I.C.	I.C.	I.C.
*Pilonidal Cyst - simple excision or marsupialisation	3033	220.21	220.21	225.50	229.02
*Sebaceous Cyst - face or neck	3034	44.94	44.94	77.98	100.00
- other areas	3035	40.66	40.66	61.26	75.00
Fingernail or Toenail Removal - Simple	3036	48.15	48.15	64.26	75.00
Resection of portion of nail, nail bed and matrix	3037	51.36	51.36	65.54	75.00
Radical removal of nail	3038	115.72	115.72	136.29	150.00
(includes destruction of nail bed, shortening of phalanx if necessary)					

*Note: Pre and Post-operative care for the above at visit fees unless otherwise specified.

Lipoma - simple removal, local anesthetic	3039	46.22	46.22	63.49	75.00
- complicated, large or involving deeper structures	3040	I.C.	I.C.	I.C.	I.C.
Neuroma - simple, subcutaneous, local anesthetic	3041	46.22	46.22	47.33	48.07

Warts, incl. papillomatosis, keratosis, nevi, moles, pyogenic granuloma
- removal by use of medical methods (paid as Visit Fee only)

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Benign skin lesion - cryotherapy, initial visit (1 or more)	3042	26.48	26.48	27.12	27.54
- cryotherapy, subsequent visit (1 or more)	3043	11.66	11.66	11.94	12.13
Warts, including papillomata, keratosis, nevi, moles, pyogenic granuloma					
- curettage or electrocautery (1 or more)	3044	30.00	30.00	30.72	31.20
- simple excision (1 or more)	3045	33.01	33.01	33.80	34.33
Plantar warts - cryotherapy, curettage, or electrocautery (1 or more)	3046	30.00	30.00	30.72	31.20
(maximum of 3 sittings per year per patient per physician)					
- surgical excision	3047	59.12	59.12	60.54	61.48
Introduction					
Implantation of hormone pellets **(Prior approval required)**	3049	34.72	34.72	35.55	36.11
Suture					
Simple wounds or lacerations	3050	60.00	60.00	69.00	75.00
Complicated, extensive lacerations	3051	I.C.	I.C.	I.C.	I.C.
Repair					
Thermal burns - simple small burns, office dressing (paid as Visit Fee only)					
Extensive burns - requiring debridement, grafts, etc.	3052	I.C.	I.C.	I.C.	I.C.
Skin Graft					
The fee would depend on the size and location of the area grafted and type of graft. Additional procedures other than skin grafting are extra - tendon grafts, inlay grafts,etc Local tissue shift advancement: rotation, transposition, Z-plasty,etc. will depend on the site and size.					
Small skin graft, with or without skin graft for secondary defect	3053	214.00	214.00	219.14	222.56
Eyebrow, eyelid, lip, ear, nose	3054	275.20	275.20	281.80	286.21
Large flap, i.e. for decubitus ulcer	3055	404.83	404.83	414.55	421.02
Flaps from a distance, direct, small,(eg.cross finger flap) to incl.staging	3056	275.20	275.20	281.80	286.21
Flaps from a distance - direct, large,(eg.cross leg flap) initial stage	3057	495.46	495.46	507.35	515.28
- further staging, per stage - 50% of					
- indirect, - major stage per operation	3058	347.11	347.11	355.44	360.99
- minor stage per operation	3059	173.61	173.61	177.78	180.55
Longer stage with skin graft	3060	347.11	347.11	355.44	360.99
Delay of tube or pedicle	3061	81.05	81.05	83.00	84.29
Full thickness grafts					
Eyelid, nose, lips	3062	275.20	275.20	281.80	286.21
Finger tip	3063	115.72	115.72	118.50	120.35
Volar/palm	3064	173.61	173.61	177.78	180.55
Island graft	3065	462.83	462.83	473.94	481.34
Split thickness grafts					
- very small, very minor, e.g. trauma	3066	107.00	107.00	109.57	111.28
- minor to medium sized areas, e.g. varicose ulcer, breast	3067	173.61	173.61	177.78	180.55
- intermediate large area trunk, legs	3068	275.20	275.20	281.80	286.21
- major large areas extensive but thickness grafting	3069	404.83	404.83	414.55	421.02
Destruction					
Surgical planing - face for acne, whole face **(Prior approval)**	3080	231.23	231.23	236.78	240.48
- single area, eg.trauma scar **(Prior approval)**	3081	81.05	81.05	83.00	84.29
Sweat gland excision - axillary, inguinal, perineal (unilateral)	4915	230.05	230.05	235.57	239.25
- with skin graft(s) and/or rotation flap(s)	4916	337.05	337.05	345.14	350.53

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
MALIGNANT SKIN LESIONS (incl. biopsy of each lesion - 1 or more)					
Deep Cryotherapy					
Face or Neck					
- Single lesion	3087	77.90	77.90	79.77	81.02
- Two lesions	3088	128.03	128.03	131.10	133.15
- Three or more lesions	3089	243.53	243.53	249.37	253.27
Other Areas					
- Single lesion	3090	62.11	62.11	63.60	64.59
- Two lesions	3091	102.45	102.45	104.91	106.55
- Three or more lesions	3092	204.64	204.64	209.55	212.83

OPERATIONS ON THE BREAST

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

Incision					
Drainage of intramammary abscess, single or multiple					
(includes pre and post-operative care)	3070	92.50	92.50	98.58	102.64
- Repeat incision	3071	92.50	92.50	98.58	102.64
Aspiration of breast cyst	2108	30.00	30.00	30.72	31.20
Excision					
Mastectomy - simple	3074	319.23	319.23	340.23	354.23
- Lumpectomy	3086	264.29	264.29	281.67	293.26
- segmental with Axillary Dissection	3084	662.12	662.12	705.67	734.71
- radical or modified radical	3075	662.12	662.12	705.67	734.71
- radical with skin graft	3076	605.73	605.73	645.57	672.14
- male simple **(Prior approval required)**	3077	138.83	138.83	147.96	154.05
- partial or resection of duct papilloma for bleeding	3078	138.83	138.83	147.96	154.05
(incl. removal of fistula abscess/underlying aerolar tissue)					
Insertion of breast tissue expander	3093	219.35	219.35	224.61	228.12
Percutaneous inflation of tissue expanders (per visit)	3096	24.18	24.18	24.76	25.15
Removal of breast tissue expander - general anesthetic	3094	78.97	78.97	80.87	82.13
- local anesthetic	3095	39.48	39.48	40.43	41.06
Removal of breast tissue expander at time of subsequent surgery					
Mammoplasty - augmentation, by prosthesis-unilateral**(Prior approval)**	3072	280.50	280.50	287.23	291.72
- augmentation ,by prosthesis-bilateral**(Prior approval)**	3083	462.83	462.83	473.94	481.34
- reduction - unilateral**(Prior approval required)**	3082	449.40	449.40	460.19	467.38
Removal of breast prosthesis **(Prior approval required)**	3079	81.05	81.05	83.00	84.29
- with capsulotomy	3098	107.00	107.00	109.57	111.28
- with capsulectomy	3099	187.25	187.25	191.74	194.74
Needle Biopsy - Breast	3085	89.88	89.88	95.79	99.73
Sentinel node biopsy	4805	236.47	236.47	279.03	307.41
Tram Flap - first surgeon **(Prior approval required)**	3097	I.C.	I.C.	I.C.	I.C.
- second surgeon	9999	I.C.	I.C.	I.C.	I.C.

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018

OPERATIONS ON THE MUSCULOSKELETAL SYSTEM

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

APPLICATION OF CASTS - Not requiring an anesthetic and not associated with initial fractures or initial dislocations.

Finger	3100	31.94	31.94	32.71	33.22
Arm or leg	3101	50.00	50.00	51.20	52.00
Shoulder spica	3102	57.78	57.78	59.17	60.09
Head and torso	3103	115.72	115.72	118.50	120.35
Body cast (torso)	3104	92.50	92.50	94.72	96.20
Hip spica, single	3105	81.05	81.05	83.00	84.29
Removal of plaster (not continuity of treatment)	3106	38.20	38.20	39.12	39.73
Unna boot	3107	23.06	23.06	23.61	23.98

APPLICATION OF CORRECTIVE SPLINTS - Arthritic & spastic deformities not associated with fractures or dislocations.

Upper limb - hand and wrist	3108	34.72	34.72	35.55	36.11
- elbow	3109	34.72	34.72	35.55	36.11
- shoulder	3110	46.22	46.22	47.33	48.07
Lower limb - whole leg	3111	46.22	46.22	47.33	48.07
- below knee	3112	34.72	34.72	35.55	36.11
Neck	3113	34.72	34.72	35.55	36.11

INTRODUCTION

Injection of medication into bursa, ganglion or joints - see 2168
(including preliminary aspiration - medications not included)

BONES

INCISION

Incision for osteomyelitis

Hand and foot - osteomyelitis					
Phalanx	3150	57.78	57.78	59.17	60.09
Metacarpal or metatarsal	3151	115.72	115.72	118.50	120.35
Carpus or tarsus	3152	115.72	115.72	118.50	120.35
Humerus - acute osteomyelitis					
Incision and drainage	3153	173.61	173.61	177.78	180.55
Saucerization	3154	289.17	289.17	296.11	300.74
Secondary closure	3155	173.61	173.61	177.78	180.55
Humerus - chronic osteomyelitis					
Sequestrectomy, simple	3156	173.61	173.61	177.78	180.55
Saucerization and bone chips where necessary	3157	347.11	347.11	355.44	360.99
Secondary closure	3158	173.61	173.61	177.78	180.55
Radius or ulna - acute osteomyelitis					
Incision and drainage	3159	173.61	173.61	177.78	180.55
Saucerization	3160	289.17	289.17	296.11	300.74
Secondary closure	3161	173.61	173.61	177.78	180.55

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Radius or ulna - chronic osteomyelitis					
Sequestrectomy, simple	3162	173.61	173.61	177.78	180.55
Saucerization and bone chips where necessary	3163	347.11	347.11	355.44	360.99
Secondary closure	3164	173.61	173.61	177.78	180.55
Tibia - acute osteomyelitis					
Incision and drainage	3165	173.61	173.61	177.78	180.55
Tibia - chronic osteomyelitis					
Sequestrectomy, simple	3167	231.23	231.23	236.78	240.48
Saucerization and bone chips where necessary	3168	347.11	347.11	355.44	360.99
Secondary closure	3169	173.61	173.61	177.78	180.55
Femur - acute osteomyelitis					
Incision and drainage	3170	231.23	231.23	236.78	240.48
Saucerization	3171	404.83	404.83	414.55	421.02
Femur - chronic osteomyelitis					
Sequestrectomy, simple	3172	231.23	231.23	236.78	240.48
Saucerization and bone chips where necessary	3173	404.83	404.83	414.55	421.02
Secondary closure	3174	173.61	173.61	177.78	180.55
Pelvis - osteomyelitis					
Sequestrectomy, simple	3175	289.17	289.17	296.11	300.74
Other, depending on extent of operation	3176	I.C.	I.C.	I.C.	I.C.
Vertebra - acute osteomyelitis					
Incision and drainage	3177	231.23	231.23	236.78	240.48
Saucerization and bone chips where necessary	3178	462.83	462.83	473.94	481.34
Secondary closure	3179	173.61	173.61	177.78	180.55
Vertebra - chronic osteomyelitis					
Sequestrectomy, simple	3180	231.23	231.23	236.78	240.48
Saucerization and/or bone graft	3181	404.83	404.83	414.55	421.02
Skull - osteomyelitis	3182	I.C.	I.C.	I.C.	I.C.
Transection of Bone (Osteotomy)					
Phalanx, metacarpal, metatarsal	3183	173.61	173.61	177.78	180.55
Radius, ulna, fibula	3184	289.17	289.17	296.11	300.74
Humerus, tibia	3185	378.25	378.25	387.33	393.38
Femur, neck or shaft	3186	578.50	578.50	592.38	601.64
Spine	3187	I.C.	I.C.	I.C.	I.C.
Incision for removal of bone plates, screws, and other appliances used for fixation because of complications					
- local anesthesia	3188	118.72	118.72	121.57	123.47
- general anesthesia	3189	189.55	189.55	194.10	197.13
EXCISION					
Bone Tumor, depending on site and extent	3190	I.C.	I.C.	I.C.	I.C.
Bone Biopsy					
Vertebra - x-ray control	3191	231.23	231.23	236.78	240.48
- open	3192	330.31	330.31	338.24	343.52
Other - punch, simple	3193	115.72	115.72	118.50	120.35
- punch, x-ray control	3194	173.61	173.61	177.78	180.55
- open	3195	173.61	173.61	177.78	180.55

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Skull					
Maxilla, with or without exenteration of orbit and skin graft	3196	660.67	660.67	676.53	687.10
Mandible	3197	440.41	440.41	450.98	458.03
Upper Extremity					
Carpal bone (1 or more)	3199	275.15	275.15	281.75	286.16
Radius - styloid	3200	231.23	231.23	236.78	240.48
- head	3201	231.23	231.23	236.78	240.48
- head with replacement	3202	347.11	347.11	355.44	360.99
Ulna - lower end	3203	220.21	220.21	225.50	229.02
- olecranon and fascial repair	3205	347.11	347.11	355.44	360.99
Humerus - head	3206	440.41	440.41	450.98	458.03
- head with replacement	3207	550.62	550.62	563.83	572.64
- exostosis	3208	220.21	220.21	225.50	229.02
- tumor - simple excision	3209	289.17	289.17	296.11	300.74
- excision and bone graft	3210	462.83	462.83	473.94	481.34
- excision resection and reconstruction	3211	I.C.	I.C.	I.C.	I.C.
Acromion and/or outer end of clavicle	3212	231.23	231.23	236.78	240.48
Lower extremity					
Foot bones - proximal phalanx	3213	173.61	173.61	177.78	180.55
- tumor of phalanx, excision and replacement	3214	275.20	275.20	281.80	286.21
- sesamoid	3215	220.21	220.21	225.50	229.02
- bunion - exostectomy only - unilateral	3216	201.75	201.75	206.59	209.82
- bilateral	3217	208.17	208.17	213.17	216.50
- Keller	3218	275.20	275.20	281.80	286.21
- scaphoid, accessory	3219	220.21	220.21	225.50	229.02
- tarsal bar	3220	275.20	275.20	281.80	286.21
- calcaneal spur, exostosis	3221	173.61	173.61	177.78	180.55
- os calcis or talus	3222	330.31	330.31	338.24	343.52
- metatarsal head	3223	173.61	173.61	177.78	180.55
- each additional	3224	57.78	57.78	59.17	60.09
Tibia - exostosis	3225	231.23	231.23	236.78	240.48
- tumor (see humerus)					
Patella - excision with reconstruction	3226	330.31	330.31	338.24	343.52
- excision with prosthesis	3227	462.83	462.83	473.94	481.34
Femur - exostosis	3228	231.23	231.23	236.78	240.48
- head and neck	3229	462.83	462.83	473.94	481.34
- tumor (see humerus)					
Trunk					
Cervical rib - complete removal	3230	550.62	550.62	563.83	572.64
REPAIR, MANIPULATION AND RECONSTRUCTION					
Grafts of Bone - see fractures					
Lengthening of Bone					
- Tibia	3232	550.62	550.62	563.83	572.64
- Femur	3233	660.67	660.67	676.53	687.10
Shortening of Bone					
- Femur, Tibia, Humerus	3234	550.62	550.62	563.83	572.64
- metatarsal - one	3235	275.20	275.20	281.80	286.21
- more than one	3236	385.41	385.41	394.66	400.83

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Reconstruction of Chest					
- Pectus excavatum - infant	3242	289.17	289.17	296.11	300.74
- other than infant	3243	578.50	578.50	592.38	601.64
Scapulopexy - congenital evaluation	3244	462.83	462.83	473.94	481.34
- winged scapula	3245	462.83	462.83	473.94	481.34
Reconstruction of foot (Joplin, McBride, Lapitus, etc.)					
eg. osteotomy and/or tendon transfers, etc.					
- Unilateral	3246	381.88	381.88	391.05	397.16
- Bilateral	3247	578.50	578.50	592.38	601.64
Exostectomy and arthrodesis, metacarpophalangeal joint					
- Unilateral	3248	330.31	330.31	338.24	343.52
- Bilateral	3249	520.56	520.56	533.05	541.38
Bone graft (paid at 100% in addition to other procedure)	3258	134.87	134.87	138.11	140.26

FRACTURES

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

Upper Extremity

Phalanx (finger/thumb)					
- No reduction	3300	48.90	48.90	50.07	50.86
- Closed reduction	3301	94.43	94.43	96.70	98.21
- Open reduction	3302	173.61	173.61	177.78	180.55
Metacarpal					
- No reduction (1 or more)	3303	48.90	48.90	50.07	50.86
- Reduction with or without extension	3304	113.90	113.90	116.63	118.46
- Open reduction	3305	220.21	220.21	225.50	229.02
Bennett's Fracture/Dislocation					
- No reduction	3306	57.78	57.78	59.17	60.09
- Reduction with external pin fixation	3544	150.44	150.44	154.05	156.46
- Reduction with or without extension	3307	127.28	127.28	130.33	132.37
- Open reduction	3308	231.23	231.23	236.78	240.48
Carpus (excluding Scaphoid)					
- Closed reduction	3309	127.28	127.28	130.33	132.37
- Open reduction (1 or more)	3310	220.21	220.21	225.50	229.02
Scaphoid					
- Closed reduction	3311	127.76	127.76	130.83	132.87
- Excision	3312	220.21	220.21	225.50	229.02
- Bone graft or replacement	3313	440.41	440.41	450.98	458.03
Radial Head					
- Closed reduction of head	3314	144.88	144.88	148.36	150.68
- Excision or open reduction of head	3315	220.21	220.21	225.50	229.02
Radius and Ulna - Colles					
- No reduction, cast	3316	88.01	88.01	90.12	91.53
- Closed reduction	3317	153.97	153.97	157.67	160.13
- Open reduction	3318	330.31	330.31	338.24	343.52
Radius and Ulna - Shafts					
- No reduction	3319	88.01	88.01	90.12	91.53
- Closed reduction	3320	203.41	203.41	208.29	211.55
- Open reduction	3321	404.83	404.83	414.55	421.02

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Radius and Ulna - Monteggia					
- Closed reduction	3323	242.25	242.25	248.06	251.94
- Open reduction	3324	385.41	385.41	394.66	400.83
Radius or Ulna					
- No reduction, cast	3326	88.01	88.01	90.12	91.53
- Closed reduction	3327	173.61	173.61	177.78	180.55
- Open reduction	3328	275.20	275.20	281.80	286.21
Olecranon					
- No reduction, cast	3330	92.50	92.50	94.72	96.20
- Closed reduction	3331	173.61	173.61	177.78	180.55
- Open reduction	3332	275.20	275.20	281.80	286.21
Humerus - Epicondyle(medial or lateral)					
- Closed reduction	3333	204.48	204.48	209.39	212.66
- Open reduction	3334	275.20	275.20	281.80	286.21
Humerus - Supra or transcondylar					
- No reduction	3335	108.07	108.07	110.66	112.39
- Closed reduction	3336	254.34	254.34	260.44	264.51
- Open reduction	3337	347.11	347.11	355.44	360.99
Humerus - Shaft					
- No reduction	3338	127.28	127.28	130.33	132.37
- Closed reduction	3339	242.25	242.25	248.06	251.94
- Open reduction	3340	385.41	385.41	394.66	400.83
Humerus - Neck or Tuberosity					
- No reduction	3342	127.28	127.28	130.33	132.37
- Closed reduction	3343	242.25	242.25	248.06	251.94
- Open reduction	3344	404.83	404.83	414.55	421.02
Lower Extremity					
Phalanx (toe)					
- No reduction	3345	46.22	46.22	47.33	48.07
- Closed reduction	3346	81.05	81.05	83.00	84.29
- Open reduction	3347	173.61	173.61	177.78	180.55
Metatarsal (1 or more)					
- No reduction	3348	57.78	57.78	59.17	60.09
- Closed reduction	3349	92.50	92.50	94.72	96.20
- Open reduction	3350	220.21	220.21	225.50	229.02
Tarsus (excluding Os Calcis) (1 or more)					
- No reduction	3351	118.50	118.50	121.34	123.24
- Closed reduction	3352	190.94	190.94	195.52	198.58
- Open reduction	3353	330.31	330.31	338.24	343.52
Os Calcis					
- No reduction - no cast	3354	106.95	106.95	109.52	111.23
- cast	3355	115.72	115.72	118.50	120.35
- Closed reduction (manipulation)	3356	264.29	264.29	270.63	274.86
- Open reduction	3357	330.31	330.31	338.24	343.52
- Open reduction, primary arthrodesis	3358	440.41	440.41	450.98	458.03
Ankle Fracture or Fracture/Dislocation					
- No reduction	3359	92.50	92.50	94.72	96.20
- Closed reduction	3360	242.25	242.25	248.06	251.94

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
- Open reduction - medial malleolus	3361	275.20	275.20	281.80	286.21
- bi or trimalleolar	3362	385.41	385.41	394.66	400.83
Tibia with or without Fibula					
- No reduction	3363	165.48	165.48	169.45	172.10
- Closed reduction	3364	261.72	261.72	268.00	272.19
- Open reduction	3365	404.83	404.83	414.55	421.02
Fibula Only					
- No reduction	3367	81.05	81.05	83.00	84.29
- Closed reduction	3368	115.72	115.72	118.50	120.35
- Open reduction	3369	231.23	231.23	236.78	240.48
Patella					
- No reduction	3370	92.50	92.50	94.72	96.20
- Closed reduction	3371	115.72	115.72	118.50	120.35
- Open reduction - by suture	3372	330.31	330.31	338.24	343.52
- excision	3373	330.31	330.31	338.24	343.52
Femur - Shaft or Transcondylar					
- No reduction, cast	3374	195.06	195.06	199.74	202.86
- Closed reduction - child	3375	289.17	289.17	296.11	300.74
- adult	3376	404.83	404.83	414.55	421.02
- Open reduction	3377	514.46	514.46	526.81	535.04
Femur - Neck or Intertrochanteric					
- No reduction	3379	231.23	231.23	236.78	240.48
- Closed reduction	3380	347.11	347.11	355.44	360.99
- Open reduction, pin and/or plate	3381	632.48	632.48	647.66	657.78
- Prosthesis	3382	672.76	672.76	688.91	699.67
Spine					
Spinous or transverse process, facet, etc.	3383	115.72	115.72	118.50	120.35
Vertebral body fracture/dislocation, without cord injury					
- Supervision, bed rest only (paid as Visit Fee only)					
- Skull calipers, visit fee plus	3385	115.72	115.72	118.50	120.35
- Closed reduction, +/- anesthetic, cast, frame, brace, etc	3384	275.20	275.20	281.80	286.21
- Open reduction +/- internal fixation	3386	660.67	660.67	676.53	687.10
- Open reduction/fusion	3387	693.90	693.90	710.55	721.66
- Open reduction/fusion, with Neurosurgeon (each surgeon)	3388	520.56	520.56	533.05	541.38
Vertebral body fracture/dislocation, with cord injury					
- No operation (paid as Visit Fee only)					
- Skull calipers, visit fee plus	3389	115.72	115.72	118.50	120.35
- Closed reduction under Anesthesia	3390	550.62	550.62	563.83	572.64
- Open reduction +/- internal fixation	3391	809.78	809.78	829.21	842.17
- Open reduction/fusion	3392	809.78	809.78	829.21	842.17
- Open reduction/fusion, with Neurosurgeon (each surgeon)	3393	550.62	550.62	563.83	572.64
- Open reduction with decompression of cord or nerve roots	3394	770.72	770.72	789.22	801.55
Sacrum					
- Complete care	3395	57.78	57.78	59.17	60.09
Coccyx					
- No reduction, complete care	3396	57.78	57.78	59.17	60.09
- Excision	3397	220.21	220.21	225.50	229.02

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Trunk					
Clavicle					
- No reduction - child (age 15 years or less)	3398	63.88	63.88	65.41	66.44
- adult	3399	69.44	69.44	71.11	72.22
- Closed reduction - child (age 15 years or less)	3400	118.50	118.50	121.34	123.24
- adult	3401	118.50	118.50	121.34	123.24
- Open reduction	3402	231.23	231.23	236.78	240.48
Scapula - body, neck or glenoid					
- No reduction	3404	63.88	63.88	65.41	66.44
- Closed reduction	3405	115.72	115.72	118.50	120.35
Sternum					
- No reduction	3406	57.78	57.78	59.17	60.09
- Closed reduction	3407	115.72	115.72	118.50	120.35
- Open reduction	3408	231.23	231.23	236.78	240.48
Ribs					
- Uncomplicated - 3 ribs or less	3409	34.72	34.72	35.55	36.11
- each additional	3410	11.61	11.61	11.89	12.07
- Complicated, requiring special treatment	3411	I.C.	I.C.	I.C.	I.C.
Pelvis					
- No reduction - bed rest and supervision	3412	20.70	20.70	21.20	21.53
- manipulation and control	3413	347.11	347.11	355.44	360.99
- Open reduction	3414	I.C.	I.C.	I.C.	I.C.
Head					
Nasal Bones					
- No reduction	3415	34.72	34.72	35.55	36.11
- Closed reduction - local anaesthetic	3416	85.97	85.97	88.03	89.41
- general anaesthetic	3417	115.72	115.72	118.50	120.35
- Open reduction, rhinoplastic method	3418	231.23	231.23	236.78	240.48
Mandible					
- No reduction, no wiring of teeth	3419	57.78	57.78	59.17	60.09
- Closed reduction, including wiring of teeth	3420	231.23	231.23	236.78	240.48
- Open reduction, unilateral or bilateral skeletal fixation	3421	347.11	347.11	355.44	360.99
Maxilla - Malar bone					
- Reduction by direction of forceps	3423	115.72	115.72	118.50	120.35
- Open reduction	3424	231.23	231.23	236.78	240.48
Complicated mid-face	3425	I.C.	I.C.	I.C.	I.C.
Skull - No reduction, complete care, simple or compound (paid as Visit Fee only)					
JOINTS					
INCISION (Arthrotomy)					
Wrist, elbow, shoulder, ankle	3500	231.23	231.23	236.78	240.48
Knee - exploratory and/or removal loose body	3501	275.20	275.20	281.80	286.21
- Meniscus/debridement, compartment	3502	424.58	424.58	434.77	441.56
Hip - exploratory and/or removal loose body	3503	440.41	440.41	450.98	458.03

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
EXCISION					
Capsulectomy - Synovectomy - Debridement					
Elbow, wrist	3504	347.11	347.11	355.44	360.99
Shoulder	3505	462.83	462.83	473.94	481.34
Hip	3506	550.62	550.62	563.83	572.64
Knee	3507	462.83	462.83	473.94	481.34
Fingers, toes - one or more joints	3508	173.61	173.61	177.78	180.55
Neurectomy					
Elbow, knee	3509	330.31	330.31	338.24	343.52
Hip	3510	404.83	404.83	414.55	421.02
Chondrectomy					
Knee - menisectomy	3512	330.31	330.31	338.24	343.52
- Baker's cyst	3513	173.61	173.61	177.78	180.55
Intervertebral Discs					
Excision of intervertebral disc - lumbar					
- single	3514	550.62	550.62	563.83	572.64
- bilateral, recurrent or multiple	3515	693.90	693.90	710.55	721.66
Excision of intervertebral disc with fusion					
- one surgeon	3519	809.78	809.78	829.21	842.17
- two surgeons, each	3520	520.56	520.56	533.05	541.38
RECONSTRUCTION					
Arthroplasty - all types					
Interphalangeal, Metacarpophalangeal	3521	231.23	231.23	236.78	240.48
Hand, reconstruction of rheumatoid joints, multiple	3522	550.62	550.62	563.83	572.64
Wrist, ankle	3523	440.41	440.41	450.98	458.03
Elbow, knee	3524	813.15	813.15	832.67	845.68
Acromio, or sternoclavicular	3525	289.17	289.17	296.11	300.74
Shoulder	3550	1,001.04	1,001.04	1,025.06	1,041.08
Foot - Hallux rigidus	3526	231.23	231.23	236.78	240.48
- Keller operation	3528	275.20	275.20	281.80	286.21
Hip - Cup arthroplasty	3529	693.90	693.90	710.55	721.66
- Total arthroplasty	3530	862.47	862.47	883.17	896.97
Hip arthroplasty - resurfacing	3250	1,001.04	1,001.04	1,025.06	1,041.08
Conversion of Moores prosthesis to total hip	3255	1,080.86	1,080.86	1,106.80	1,124.09
Revision of total hip	3256	1,352.37	1,352.37	1,384.83	1,406.46
Total knee	3251	813.15	813.15	832.67	845.68
Revision of total knee	3257	1,244.30	1,244.30	1,274.16	1,294.07
Removal of total knee, without replacement, w/insertion of spacer	3259	I.C.	I.C.	I.C.	I.C.
Total ankle	3252	710.64	710.64	727.70	739.07
Arthroplasty	3253	173.61	173.61	177.78	180.55
Arthrodesis					
Finger, thumb	3531	231.23	231.23	236.78	240.48
Wrist, elbow, ankle	3532	440.41	440.41	450.98	458.03
Shoulder, knee, sacroiliac	3533	550.62	550.62	563.83	572.64
Hip	3534	693.90	693.90	710.55	721.66
Foot - toe, one joint	3535	390.18	390.18	399.54	405.79
- toe, multiple joints	3536	34.72	34.72	35.55	36.11
- mid-tarsal, sub-talar, triple, etc	3537	440.41	440.41	450.98	458.03

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
- pan-talar, one stage	3538	578.50	578.50	592.38	601.64
- congenital club foot, fusions and tendon transfers	3539	550.62	550.62	563.83	572.64
Spinal Column fusion - one or two spaces	3540	660.67	660.67	676.53	687.10
- more than two spaces	3541	809.78	809.78	829.21	842.17
Chemonucleolysis - incl. placement of needle, injection (per disc)	3545	259.21	259.21	265.43	269.58
ARTHROSCOPY					
Diagnostic Arthroscopy - all joints (including instrumentation, lavage and biopsy)	3254	188.86	188.86	193.39	196.41
Surgical Procedures with or without Arthroscopy (all joints)					
Lateral/medial retinacular release	3848	194.47	194.47	199.14	202.25
Synovectomy - 1 compartment	3542	330.31	330.31	338.24	343.52
- 2 or more compartments	3507	462.83	462.83	473.94	481.34
Menisectomy/debridement - 1 compartment	3502	424.58	424.58	434.77	441.56
- 2 or more compartments	3547	529.33	529.33	542.03	550.50
Reduction & pinning of intra-articular fragments	3548	330.31	330.31	338.24	343.52
Meniscal repair (medial or lateral)	3549	330.31	330.31	338.24	343.52

All above arthroscopy fees are mutually exclusive for the same joint (eg. cannot do both debridement and synovectomy on the same joint)
Diagnostic fee will not be paid in addition to procedure for the same leg.
When 2 or more joints being done, the 2nd procedure will be paid at 65%.
Tissue from arthroscopic synovectomy requires pathology.

DISLOCATIONS

Upper Extremity

Finger and Thumb					
- Closed reduction, one	3600	57.78	57.78	59.17	60.09
- Open reduction	3601	173.61	173.61	177.78	180.55
Metacarpophalangeal					
- Closed reduction, one	3602	65.06	65.06	66.62	67.66
- Open reduction	3603	173.61	173.61	177.78	180.55
Wrist and Carpal Bones					
- Closed reduction	3604	173.61	173.61	177.78	180.55
- Open reduction	3605	330.31	330.31	338.24	343.52
Elbow					
- Closed reduction	3606	183.56	183.56	187.97	190.90
- Open reduction	3607	330.31	330.31	338.24	343.52
- Dislocation of head of radius	3546	49.70	49.70	50.89	51.69
Shoulder					
- Closed reduction	3608	121.23	121.23	124.14	126.08
- Open reduction	3609	404.83	404.83	414.55	421.02
- Recurrent dislocations, repair, all types	3610	484.44	484.44	496.07	503.82
Acromioclavicular					
- Closed reduction	3611	69.44	69.44	71.11	72.22
- Open reduction	3612	289.17	289.17	296.11	300.74
Sternoclavicular					
- Closed reduction	3613	63.56	63.56	65.09	66.10
- Open reduction	3614	231.23	231.23	236.78	240.48

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Lower Extremity					
Toe, Interphalangeal					
- Closed reduction	3615	34.72	34.72	35.55	36.11
- Open reduction	3616	173.61	173.61	177.78	180.55
Metatarsophalangeal					
- Closed reduction	3617	65.06	65.06	66.62	67.66
- Open reduction	3618	173.61	173.61	177.78	180.55
Tarsus					
- Closed reduction	3619	144.88	144.88	148.36	150.68
- Open reduction	3620	289.17	289.17	296.11	300.74
Ankle, Subluxation					
- Closed reduction with or without general anesthetic	3621	177.41	177.41	181.67	184.51
- Open reduction	3622	330.31	330.31	338.24	343.52
- Repair or recurrent subluxation	3623	440.41	440.41	450.98	458.03
Knee					
- Closed reduction	3624	204.48	204.48	209.39	212.66
- Simple reduction	3625	404.83	404.83	414.55	421.02
- Open reduction/reconstruction of ligaments, medial collateral, lateral collateral and/or cruciates +/- menisectomy	3647	520.56	520.56	533.05	541.38
Patella					
- Closed reduction, with or without anesthetic	3626	81.05	81.05	83.00	84.29
- Open reduction for recurrent dislocation	3627	347.11	347.11	355.44	360.99
- Open reduction/reconstruction of ligaments, medial collateral, lateral collateral and/or cruciates +/- menisectomy	3648	520.56	520.56	533.05	541.38
Hip					
Anterior or Posterior Dislocation					
- Closed reduction with or without anesthetic	3628	204.48	204.48	209.39	212.66
- Open reduction	3629	404.83	404.83	414.55	421.02
Central Dislocation					
- Closed reduction with or without anesthetic	3630	231.23	231.23	236.78	240.48
- Open reduction	3631	462.83	462.83	473.94	481.34
Congenital Dislocation					
Closed reduction with or without anesthetic					
- unilateral	3632	173.61	173.61	177.78	180.55
- repeat manipulation and plaster	3633	81.05	81.05	83.00	84.29
Simple or rotation osteotomy	3634	462.83	462.83	473.94	481.34
Acetabuloplasty	3635	578.50	578.50	592.38	601.64
Spine					
Intervertebral					
- Closed reduction, correction spica	3636	231.23	231.23	236.78	240.48
- Open reduction	3637	440.41	440.41	450.98	458.03
- Open reduction/fusion, cervical spine, +/- cord injury	3638	715.72	715.72	732.90	744.35
- Open reduction/fusion, thoracic/lumbar, +/- cord injury	3639	693.90	693.90	710.55	721.66
Sacrococcygeal					
- Non-operative (paid as Visit Fee only)					
- Open reduction - removal of coccyx	3640	231.23	231.23	236.78	240.48
Temporomandibular					
- Closed reduction	3641	50.66	50.66	51.88	52.69
- Open reduction	3642	231.23	231.23	236.78	240.48

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
MANIPULATION					
Manipulation of Joints under General Anesthesia					
- Wrist, elbow, ankle	3643	34.72	34.72	35.55	36.11
- Shoulder, knee, hip	3644	57.78	57.78	59.17	60.09
Congenital foot deformity, club-foot, +/- anesthetic					
Dennis Brown's splints	3645	23.06	23.06	23.61	23.98
Manipulation and cast, single	3646	34.72	34.72	35.55	36.11
BURSAE					
Incision					
Removal of calcium	3701	231.23	231.23	236.78	240.48
Excision					
Olecranon, prepatellar bursae	3702	173.61	173.61	177.78	180.55
Humero-radial	3703	173.61	173.61	177.78	180.55
Sub-acromial	3704	231.23	231.23	236.78	240.48
Sub-trochanteric	3705	275.20	275.20	281.80	286.21
Biopsy					
Superficial bursa	3706	34.72	34.72	35.55	36.11
MUSCLES					
Incision					
Removal of foreign body, general anesthetic					
- Simple	3750	57.78	57.78	59.17	60.09
- Complicated e.g. gunshot wound	3751	I.C.	I.C.	I.C.	I.C.
Release or cutting of muscle (myotomy) - Tennis Elbow	3754	173.61	173.61	177.78	180.55
Excision					
Biopsy, independent procedure	3755	57.78	57.78	59.17	60.09
Resection of muscle	3756	I.C.	I.C.	I.C.	I.C.
Local excision of lesion of muscle	3757	81.05	81.05	83.00	84.29
Repair					
Manipulation and injection, tennis elbow	3758	34.72	34.72	35.55	36.11
Quadricepsplasty	3760	404.83	404.83	414.55	421.02
TENDONS, TENDON SHEATHS, FASCIA					
Incision					
Exploration of tendon or tendon sheath	3800	138.83	138.83	142.16	144.38
Tenosynovitis, finger	3801	138.83	138.83	142.16	144.38
Trigger finger, release	3802	138.83	138.83	142.16	144.38
Exploration of fascia	3803	164.57	164.57	168.52	171.15
Drainage of tendon sheath	3804	138.83	138.83	142.16	144.38
Tenotomy (closed)					
Toe - single	3805	34.72	34.72	35.55	36.11
- multiple	3806	57.78	57.78	59.17	60.09
Plantar fascia	3807	57.78	57.78	59.17	60.09
Hip adductors	3808	57.78	57.78	59.17	60.09
Tendo-Achilles	3809	57.78	57.78	59.17	60.09

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Excision					
Ganglion, tendon sheath or joint	3810	138.78	138.78	142.11	144.33
DeQuervian's (Wrist)	3811	277.56	277.56	284.22	288.66
Tendon sheath for tuberculosis	3812	347.11	347.11	355.44	360.99
Fascia for Dupuytren's - partial	3813	231.23	231.23	236.78	240.48
- complete	3814	404.83	404.83	414.55	421.02
Xanthoma	3815	115.72	115.72	118.50	120.35
Repair					
Tenoplasty, shortening, lengthening, etc.					
- one tendon, one location	3816	231.23	231.23	236.78	240.48
- two or more	3817	289.17	289.17	296.11	300.74
Tendon graft					
- Hand, Wrist - single	3818	440.41	440.41	450.98	458.03
- two or more	3819	550.62	550.62	563.83	572.64
- other location	3820	437.95	437.95	448.46	455.47
Fasciotomy					
- Lengthening of ileo-tibial band - unilateral	3821	220.21	220.21	225.50	229.02
- Decompression of carpal tunnel	5968	231.23	231.23	236.78	240.48
Transplant of tendon, transposition					
- Hand, Forearm - single	3823	231.23	231.23	236.78	240.48
- multiple	3824	404.83	404.83	414.55	421.02
- Shoulder - pectoralis minor	3825	231.23	231.23	236.78	240.48
- trapezius	3826	385.41	385.41	394.66	400.83
- Foot, Ankle - single	3827	231.23	231.23	236.78	240.48
- multiple	3828	404.83	404.83	414.55	421.02
- Knee - transposition of tendons	3829	347.11	347.11	355.44	360.99
- Foot - tenodesis	3830	231.23	231.23	236.78	240.48
Repair of mallet finger - closed	3831	59.12	59.12	60.54	61.48
- operative	3832	173.61	173.61	177.78	180.55
Tenoplasty - Achilles, biceps, or quadriceps tendon	3847	275.20	275.20	281.80	286.21
Suture					
Tenorrhaphy, tendon suture					
Finger, hand, wrist, foot, ankle					
Extensor tendon - partially severed	3849	160.50	160.50	164.35	166.92
- single	3833	173.61	173.61	177.78	180.55
- each subsequent	3834	80.25	80.25	82.18	83.46
Flexor tendon - single	3835	267.50	267.50	273.92	278.20
- each subsequent	3836	133.75	133.75	136.96	139.10
Achilles, biceps, quadriceps	3837	289.17	289.17	296.11	300.74
Reconstruction (fascia and ligaments)					
Shoulder - rotator cuff tear	3838	385.41	385.41	394.66	400.83
- late repair	3839	462.83	462.83	473.94	481.34
- acromioplasty only	3840	347.11	347.11	355.44	360.99
Acromioclavicular, sternoclavicular - early repair(see Dislocations)					
- late repair	3841	385.41	385.41	394.66	400.83
Elbow, wrist, ankle - early repair	3842	231.23	231.23	236.78	240.48
- late repair	3843	404.83	404.83	414.55	421.02
Knee - early repair	3844	347.11	347.11	355.44	360.99
- late repair	3845	509.11	509.11	521.33	529.47
Metacarpophalangeal - early or late	3846	173.61	173.61	177.78	180.55

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
AMPUTATION					
Upper Extremity					
Through phalanx	3900	80.25	80.25	82.18	83.46
Through metacarpal or M.P. joint	3901	115.72	115.72	118.50	120.35
Of hand - through all metacarpals	3902	289.17	289.17	296.11	300.74
Through radius and ulna	3903	347.11	347.11	355.44	360.99
Through humerus	3904	347.11	347.11	355.44	360.99
At shoulder	3905	404.83	404.83	414.55	421.02
Fore quarter	3906	550.62	550.62	563.83	572.64
Lower Extremity					
Through phalanx	3907	81.05	81.05	83.00	84.29
Through metatarsal or M.P. joint	3908	115.72	115.72	118.50	120.35
Transmetatarsal	3909	275.20	275.20	281.80	286.21
Symes	3910	330.31	330.31	338.24	343.52
Through tibia and fibula	3911	347.11	347.11	355.44	360.99
At knee - Gritti - Stokes or Callander	3912	347.11	347.11	355.44	360.99
Through femur	3913	347.11	347.11	355.44	360.99
At hip	3914	660.67	660.67	676.53	687.10
Hind quarter	3915	809.78	809.78	829.21	842.17
Hemipelvectomy	3916	809.78	809.78	829.21	842.17

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
OPERATIONS ON THE RESPIRATORY SYSTEM					
These fees cannot be correctly interpreted without reference to the Preamble.					
NOSE					
Incision					
Drainage of nasal abscess, complete care	4000	59.12	59.12	60.54	61.48
Drainage of septal abscess, complete care	4001	92.50	92.50	94.72	96.20
Excision					
Biopsy of soft tissue	4002	53.50	53.50	54.78	55.64
Nasal Polypi					
- Unilateral - local anesthetic	4003	34.72	34.72	35.55	36.11
- general anesthetic	4004	57.78	57.78	59.17	60.09
- Bilateral - local anesthetic	4005	57.78	57.78	59.17	60.09
- general anesthetic	4006	115.72	115.72	118.50	120.35
Excision of choanal polyp	4007	81.05	81.05	83.00	84.29
Excision of skin of nose for rhinophyma - uncomplicated	4009	81.05	81.05	83.00	84.29
Septectomy, submucous resection	4010	231.23	231.23	236.78	240.48
Septectomy, submucous resection - including septoplasty	4011	289.17	289.17	296.11	300.74
Turbinectomy - complete or partial	4012	46.22	46.22	47.33	48.07
- Submucosal turbinectomy	4013	I.C.	I.C.	I.C.	I.C.
Endoscopy					
Rhinoscopy with removal of foreign body in nose	4014	37.45	37.45	38.35	38.95
- under general Anesthesia	4015	46.22	46.22	47.33	48.07
Repair					
Rhinoplasty, and closure of septal perforation					
Complete with or without grafts **(Prior approval required)**	4016	680.36	680.36	696.69	707.57
Nasal septal button insertion	7907	97.62	97.62	99.96	101.52
Lysis of nasal adhesions	7908	118.24	118.24	121.08	122.97
Destruction					
Infraction of turbinate, unilateral or bilateral	4019	23.06	23.06	23.61	23.98
Cauterization of turbinates - unilateral	4020	34.72	34.72	35.55	36.11
- bilateral	4021	57.78	57.78	59.17	60.09
Manipulation					
Control of primary nasal hemorrhage (Epistaxis)					
- With cauterization of nasal septum	4022	23.06	23.06	23.61	23.98
- With anterior nasal packing	4023	53.50	53.50	54.78	55.64
- With posterior nasal packing	4024	90.95	90.95	93.13	94.59
Control of secondary hemorrhage same as above	4025	81.05	81.05	83.00	84.29
Epistaxis control by ligation of ethmoidal arteries	7905	115.72	115.72	118.50	120.35
Epistaxis control by ligation of maxillary arteries	7906	449.75	449.75	460.54	467.74
Catheterization of Eustachian Tube for infiltration of middle ear	4026	11.61	11.61	11.89	12.07
SINUSES					
Incision					
Sinusotomy, sinusectomy, as indicated					

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Maxillary sinusotomy - intranasal (unilateral)	4027	138.83	138.83	142.16	144.38
- radical, Caldwell-Luc (unilateral)	4028	330.31	330.31	338.24	343.52
Frontal Trephine and sinusectomy	4029	173.61	173.61	177.78	180.55
- Radical	4030	550.62	550.62	563.83	572.64
External fronto-ethmoidal with sphenoid if necessary	4031	173.61	173.61	177.78	180.55
Ethmoidal - intranasal (unilateral)	4032	173.61	173.61	177.78	180.55
Intranasal ethmoidectomy - anterior only	7909	171.90	171.90	176.03	178.78
- anterior and posterior	7910	280.34	280.34	287.07	291.55
Sphenoidal - intranasal	4033	231.23	231.23	236.78	240.48
Introduction					
Lavage - maxillary	4034	23.06	23.06	23.61	23.98
- frontal	4035	46.22	46.22	47.33	48.07
- sphenoidal	4036	46.22	46.22	47.33	48.07
Suture					
Closure of antro-oral fistula	4037	347.11	347.11	355.44	360.99
Examination under general Anesthesia of the post-nasal space	4040	45.26	45.26	46.35	47.07
Submucous Diathermy of the turbinates (Bilateral)	4041	60.94	60.94	62.40	63.38
LARYNX					
Excision					
Laryngectomy - partial (laryngo-fissure)	4100	462.83	462.83	473.94	481.34
- total	4101	693.90	693.90	710.55	721.66
Introduction					
Intubation of larynx (Independent procedure)	4104	60.00	60.00	61.44	62.40
Endoscopy					
Laryngoscopy, direct - without biopsy (only 1 procedure paid per session)	4105	85.00	85.00	87.04	88.40
- with biopsy	4106	105.00	105.00	107.52	109.20
Laryngoscopy with removal of foreign body	4107	200.00	200.00	204.80	208.00
Laryngoscopy with removal of benign growth	4108	250.00	250.00	256.00	260.00
Laryngoscopy, indirect - with biopsy	4109	85.00	85.00	87.04	88.40
Repair					
Laryngoplasty, plastic operation on larynx	4110	I.C.	I.C.	I.C.	I.C.
Arytenoidopexy (King or Kelly)	4111	440.41	440.41	450.98	458.03
TRACHEA AND BRONCHI					
Incision					
Tracheostomy	4200	220.21	220.21	225.50	229.02
Endoscopy					
Bronchoscopy, diagnostic. (1 procedure paid per session)	4201	152.31	152.31	195.92	225.00
- With biopsy	4202	152.31	152.31	195.92	225.00
- With insertion of radioactive substance	4203	152.31	152.31	195.92	225.00
- With removal of foreign body	4204	220.21	220.21	225.50	229.02
- With excision of tumor	4205	220.21	220.21	225.50	229.02
Broncho-esophagoscopy +/- biopsy (1 procedure paid/session)	4206	208.17	208.17	213.17	216.50
Quadroscopy	4209	201.05	201.05	215.42	225.00
Includes direct laryngoscopy, esophagoscopy, examination of the post nasal space and bronchoscopy.					
Bronchoscopy with Transbronchial lung biopsy - single lobe	4210	209.72	209.72	214.75	218.11
- each additional lobe	4212	53.50	53.50	54.78	55.64
Bronchoscopy with Transbronchial Needle Aspiration (TBNA) of lymph nodes	4213	209.72	209.72	214.75	218.11

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Endobronchial Ultrasound (EBUS)	4214	285.88	285.88	292.74	297.32
Endoscopy through tracheostomy	4211	53.50	53.50	54.78	55.64
Suture					
Tracheorrhapy - suture of external wound in trachea	4207	173.61	173.61	177.78	180.55
Closure of tracheostomy or tracheal fistula	4208	173.61	173.61	177.78	180.55
LUNGS AND PLEURA					
Incision					
Thoracocentesis					
- Closed drainage - operation and after care (chest tube)	4400	189.18	189.18	193.72	196.75
- Open drainage - Rib resection and drainage	4401	283.76	283.76	290.57	295.11
Drainage of lung abscess	4402	416.39	416.39	426.38	433.05
Exploratory thoracotomy or removal of foreign body	4403	416.39	416.39	426.38	433.05
Biopsy of pleura or lung	4404	472.94	472.94	484.29	491.86
Needle biopsy of pleura	2178	42.43	42.43	43.45	44.13
Excision					
Pneumonectomy	4406	945.88	945.88	968.58	983.72
Lobectomy	4407	910.41	910.41	932.26	946.83
Lobectomy and segmental resection	4408	809.78	809.78	829.21	842.17
Segmental resection	4409	809.78	809.78	829.21	842.17
Wedge resection	4410	567.53	567.53	581.15	590.23
Pleurectomy - pleural decortication	4411	662.12	662.12	678.01	688.60
- with bullous emphysema	4412	660.67	660.67	676.53	687.10
Thoracoscopy	4413	236.47	236.47	242.15	245.93
CHEST WALL AND MEDIASTINUM					
Incision					
Mediastinotomy with drainage	4300	462.83	462.83	473.94	481.34
Reconstruction					
Pectus excavatum - infant	3242	289.17	289.17	296.11	300.74
- other than infant	3243	578.50	578.50	592.38	601.64
Excision					
Chest wall tumor involving ribs/cartilage, and reconstruction of chest wall	4302	733.06	733.06	750.65	762.38
Mediastinal tumor	4303	578.50	578.50	592.38	601.64
Transaxillary resection 1st rib	4313	543.88	543.88	556.93	565.64
Surgical Collapse					
Thoracoplasty - one stage	4305	440.41	440.41	450.98	458.03
- multi-stage, each	4306	277.56	277.56	284.22	288.66
Pneumolysis - intrapleural	4308	208.17	208.17	213.17	216.50
- extrapleural	4309	347.11	347.11	355.44	360.99
Apicolysis - extrafascial (Sembs)	4310	347.11	347.11	355.44	360.99
- extrapleural	4311	347.11	347.11	355.44	360.99
Mediastinoscopy	4304	283.76	283.76	290.57	295.11

OPERATIONS ON THE CARDIOVASCULAR SYSTEM

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

VEINS

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Varicose Veins and Ulcers					
Injection of varicose veins - single	4511	11.61	11.61	11.89	12.07
- multiple at same sitting	4512	49.70	49.70	50.89	51.69
Sclerotherapy, comprehensive, on referred patients (one leg)	4529	124.33	124.33	127.31	129.30
Ligation - multiple, one leg	4513	138.83	138.83	142.16	144.38
Ligation - saphenofemoral or saphenopopliteal junction (one leg)	4514	138.83	138.83	142.16	144.38
Ligation and stripping of stab avulsions (one leg)					
- Long saphenous vein	4515	231.23	231.23	236.78	240.48
- with multiple low ligation & excision-ligation of perforators	4516	289.17	289.17	296.11	300.74
- Short saphenous vein	4517	115.72	115.72	118.50	120.35
Excision of venous stasis ulcer, and skin graft	4521	231.23	231.23	236.78	240.48
- with ligation and stripping of stab avulsions (one leg)	4519	347.11	347.11	355.44	360.99
Subfascial control of perforators, open or by SEPS	4522	347.11	347.11	355.44	360.99
- with stripping of stab avulsions	4523	462.83	462.83	473.94	481.34
Recurrent or complicated varicose veins	4518	408.42	408.42	418.22	424.76
Venous Thrombectomy					
Iliac or femoral vein thrombectomy	4524	550.62	550.62	563.83	572.64
Interruption of vena cava - transvenous IVC filter	4655	278.20	278.20	284.88	289.33
Vein Harvesting					
Harvest arm vein (add)	4656	106.23	106.23	108.78	110.48
Harvest superficial femoral vein (add)	4657	106.23	106.23	108.78	110.48
Harvest opposite leg vein (add)	4658	88.40	88.40	90.52	91.94
Venous Wounds					
Suture repair wound of major vein	4528	298.21	298.21	305.37	310.14
Repair lacerated major vein (eg. femoral, popliteal, subclavian, brachial),					
or microscopic repair of digital vein	4530	272.14	272.14	278.67	283.03
- by patch	4531	425.65	425.65	435.87	442.68
- by vein graft	4532	566.07	566.07	579.66	588.71
Arteriovenous Procedures					
Repair of AV anomaly	4533	416.39	416.39	426.38	433.05
Creation of AV fistula	4505	416.39	416.39	426.38	433.05
Closure/obliteration of AV fistula	4527	66.23	66.23	67.82	68.88
Portal Hypertension					
Portocaval shunt	4501	809.78	809.78	829.21	842.17
Distal splenorenal shunt	4525	992.75	992.75	1,016.58	1,032.46
Mesocaval shunt	4503	770.72	770.72	789.22	801.55
Esopho-gastric devasularization and esophageal transection,	4534	768.82	768.82	787.27	799.57
(including reanastomosis and splenectomy)					
Other Venous Procedures					
Venogram	4500	57.83	57.83	59.22	60.14
Ligation - Jugular vein, internal	4506	173.61	173.61	177.78	180.55
Ligation - Inferior vena cava, ligation or placation	4508	462.83	462.83	473.94	481.34

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Ligation - Saphenous	4510	57.78	57.78	59.17	60.09
Superior vena cava bypass graft	4526	596.47	596.47	610.79	620.33
Venous anastomosis - Splenorenal	4502	809.78	809.78	829.21	842.17
ARTERIES					
Percutaneous Vascular Procedures					
Arterial cannulation	4599	60.00	60.00	61.44	62.40
Angiography					
- Carotid	4630	115.72	115.72	118.50	120.35
- Femoral - unilateral	4631	57.78	57.78	59.17	60.09
- bilateral	4632	92.50	92.50	94.72	96.20
- Aortography	4633	115.72	115.72	118.50	120.35
- Arteriography, selective	4635	115.72	115.72	118.50	120.35
- Renal Mesenteric arch - per major vessel (add)	4538	21.40	21.40	21.91	22.26
Operative arteriography - one or more (add)	4536	57.78	57.78	59.17	60.09
Exposure of major artery for aortography	4634	173.61	173.61	177.78	180.55
Arterial cannulation for aortography	4636	57.78	57.78	59.17	60.09
Dilatations and Stents					
Dilatation/Stent of Iliac artery - unilateral	4537	267.99	267.99	274.42	278.71
Vascular stent (add)	4535	68.27	68.27	69.91	71.00
Arterial Wounds					
Suture of lacerated major artery of limb	4671	271.22	271.22	277.73	282.07
Repair of lacerated major artery of limb, or microscopic repair of digital artery (including patch angioplasty)	4670	426.84	426.84	437.08	443.91
Brachiocephalic Procedures					
Carotid body tumor	4627	693.90	693.90	710.55	721.66
- with graft	4628	751.94	751.94	769.99	782.02
- with vessel bypass	4629	809.78	809.78	829.21	842.17
Carotid endarterectomy	5652	693.90	693.90	710.55	721.66
- with patch graft	5653	809.78	809.78	829.21	842.17
- with graft and by-pass shunt	5654	925.50	925.50	947.71	962.52
Aneurysm repair					
- Carotid	4660	702.52	702.52	719.38	730.62
- Subclavian	4661	742.45	742.45	760.27	772.15
- Axillary or Brachial - synthetic graft	4663	578.50	578.50	592.38	601.64
- vein graft	4664	693.90	693.90	710.55	721.66
Brachiocephalic arterial bypass with autogenous vein graft	4662	562.01	562.01	575.50	584.49
- includes Carotid-subclavian, Carotid-axillary, Axillo-axillary, Axillo-brachial, Brachio-distal					
Aorto-Iliac Procedures					
Thoracic aortic aneurysm repair - without bypass with hypothermia	4606	809.78	809.78	829.21	842.17
- with by-pass	4607	1,041.16	1,041.16	1,066.15	1,082.81
Thoraco-abdominal aneurysm repair	4665	1,655.29	1,655.29	1,695.02	1,721.50
- with rupture	4666	1,809.00	1,809.00	1,852.42	1,881.36
Abdominal aortic aneurysm repair	4608	925.50	925.50	947.71	962.52
- with rupture	4609	1,041.16	1,041.16	1,066.15	1,082.81
- Aortic Bifurcation graft	4617	1,139.34	1,139.34	1,166.68	1,184.91
- Reimplantation of inferior mesenteric artery (add)	4654	139.15	139.15	142.49	144.72

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Thromboendarterectomy	4618	693.90	693.90	710.55	721.66
Endarterectomy of aorta and/or aortic bifurcation	4619	809.78	809.78	829.21	842.17
Pelvic aneurysm repair - ligation exclusion	4667	387.88	387.88	397.19	403.40
- with graft	4668	603.00	603.00	617.47	627.12
Ilio-femoral bypass	4669	627.02	627.02	642.07	652.10
Total removal of infected aortic graft (stem and limbs)	4672	786.11	786.11	804.98	817.55
Partial removal of infected aortic graft (one limb only)	4673	294.46	294.46	301.53	306.24
Closure of duodenal fistula (add)	4674	108.75	108.75	111.36	113.10
Visceral Artery Repairs					
Superior mesenteric, celiac, renal, hepatic:					
- Aneurysm repair or bypass for obstruction	4675	485.78	485.78	497.44	505.21
- Endarterectomy or graft	4676	577.80	577.80	591.67	600.91
- By-pass to additional artery	4677	I.C.	I.C.	I.C.	I.C.
Embolectomy - Mesenteric	4624	481.50	481.50	493.06	500.76
- Renal	4625	578.50	578.50	592.38	601.64
Lower Limb Arterial Procedures					
Femoro-popliteal or femoro-femoral or axillo-femoral bypass					
- synthetic graft	4620	578.50	578.50	592.38	601.64
- vein graft	4621	693.90	693.90	710.55	721.66
Femoro-distal bypass(eg.anterior or posterial tibial)	4644	751.94	751.94	769.99	782.02
In situ peripheral vein procedure (add)	4653	264.99	264.99	271.35	275.59
Femoral or popliteal endarterectomy	4659	650.22	650.22	665.83	676.23
Peripheral aneurysm repair - lower limb (eg.femoral,popliteal)	4651	648.15	648.15	663.71	674.08
Peripheral false aneurysm repair	4650	701.12	701.12	717.95	729.16
Arterioplasty of lower limb artery or vein graft					
- Femoral	4637	347.11	347.11	355.44	360.99
- Iliac	4638	347.11	347.11	355.44	360.99
Embolectomy/thrombectomy - Iliac or femoral artery	4623	462.83	462.83	473.94	481.34
- Transfemoral (bilateral)	4622	693.90	693.90	710.55	721.66
Limb fasciotomy for ischemia - single	4678	143.88	143.88	147.33	149.64
- multiple	4679	274.09	274.09	280.67	285.05
Secondary closure of fasciotomy	4680	83.33	83.33	85.33	86.66
Composite graft, combining 2 or more conduits (add)	4681	114.19	114.19	116.93	118.76
Extended profundoplasty					
- to first major branch	4642	462.83	462.83	473.94	481.34
- to second major branch	4652	612.90	612.90	627.61	637.42
Exposure of leg vessels for inspection/evaluation, per exposure	4643	115.72	115.72	118.50	120.35
Sympathectomy					
Transcervical	5980	462.83	462.83	473.94	481.34
Transaxillary	5981	481.13	481.13	492.68	500.38
Translumbar	5983	365.73	365.73	374.51	380.36
Other Vascular Procedures					
Transcervical or transaxillary resection of 1st rib	4313	543.88	543.88	556.93	565.64
Temporal artery biopsy	4682	81.05	81.05	83.00	84.29
Closure of lymphatic fistula groin	4683	177.45	177.45	181.71	184.55
Re-operation after 1 month for failed vascular graft (add)	4684	298.49	298.49	305.65	310.43
Arteriotomy	4600	81.05	81.05	83.00	84.29
Transection of artery - peripheral	4603	173.61	173.61	177.78	180.55
- intra-abdominal or intra-thoracic	4604	231.23	231.23	236.78	240.48

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Ligation carotid, neck - simple	4639	173.61	173.61	177.78	180.55
Ligation anterior ethmoid artery for epistaxis	4641	115.72	115.72	118.50	120.35
HEART AND PERICARDIUM					
Incision					
Atrial or ventricular puncture	4700	46.22	46.22	47.33	48.07
Biopsy of pericardium - by needle	2181	158.63	158.63	162.44	164.98
- by thoracotomy	4702	347.11	347.11	355.44	360.99
Cardiotomy with exploration	4703	578.50	578.50	592.38	601.64
- with removal of foreign body or tumor	4704	578.50	578.50	592.38	601.64
- By closed technique	4705	693.90	693.90	710.55	721.66
- By open technique without bypass	4706	809.78	809.78	829.21	842.17
- By open technique with bypass	4707	925.50	925.50	947.71	962.52
Excision					
Pericardiectomy - partial	4708	462.83	462.83	473.94	481.34
- sub-total	4709	693.90	693.90	710.55	721.66
Introduction					
Catheterization of heart - right	2126	158.63	158.63	162.44	164.98
- Hepatic wedge pressure	2127	105.72	105.72	108.26	109.95
Catheterization of heart - left	2128	211.54	211.54	216.62	220.00
- insertion of catheter pacemaker	4716	231.23	231.23	236.78	240.48
Insertion of Portacath	4714	250.38	250.38	256.39	260.40
Removal of Portacath	4715	219.08	219.08	224.34	227.84
Insertion of Hickman catheter	4717	152.31	152.31	155.97	158.40
Removal of Hickman catheter	4713	78.18	78.18	80.06	81.31
Insertion of Loop recorder (surgeon or internist)	4778	107.00	107.00	109.57	111.28
Removal of Loop recorder	4779	53.50	53.50	54.78	55.64
Repair					
Patent ductus arteriosus	4718	578.50	578.50	592.38	601.64
Pulmonary Stenosis - Open heart - without bypass	4738	809.78	809.78	829.21	842.17
Pericardial insufflation with powder	4747	347.11	347.11	355.44	360.99
Suture of wound (heart)	4752	578.50	578.50	592.38	601.64
Open Cardiac Massage	4753	231.23	231.23	236.78	240.48
Includes fee for thoracotomy and cardiac massage in addition to fee for operation during which arrest occurred					
PACEMAKER PROCEDURES					
Temporary catheter pacemaker					
Insertion (incl.repositioning w/in 24 hrs) - medical fee	4770	186.13	186.13	190.60	193.58
- surgical fee	4760	248.35	248.35	254.31	258.28
- composite fee	4766	329.13	329.13	337.03	342.30
Repositioning after 24 hrs - medical fee	4771	75.11	75.11	76.91	78.11
- surgical fee	4761	94.00	94.00	96.26	97.76
- composite fee	4767	131.61	131.61	134.77	136.87
Replace - medical fee	4772	124.39	124.39	127.38	129.37
- surgical fee	4762	188.05	188.05	192.56	195.57
- composite fee	4768	263.33	263.33	269.65	273.86

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Permanent pacemaker					
Insertion (epicardial) - medical fee	4773	182.49	182.49	186.87	189.79
- surgical fee	4769	503.70	503.70	515.79	523.85
Insertion (transvenous) - medical fee	4777	267.50	267.50	273.92	278.20
- surgical fee	4763	360.54	360.54	369.19	374.96
Insertion (dual chamber or ICD) - medical fee	4781	267.50	267.50	273.92	278.20
- surgical fee	4782	432.12	432.12	442.49	449.40
Reposition/replace wire - medical fee	4774	124.39	124.39	127.38	129.37
- surgical fee	4764	188.05	188.05	192.56	195.57
Reposition/replace power source - medical fee	4775	124.39	124.39	127.38	129.37
- surgical fee	4765	248.35	248.35	254.31	258.28
Reprogram or interrogate pacemaker (including ICD) - medical fee	4776	85.60	85.60	87.65	89.02

OPERATIONS ON THE HEMATIC AND LYMPHATIC SYSTEMS

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	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
SPLEEN and BONE MARROW					
Excision					
Splenectomy	4802	591.18	591.18	605.37	614.83
Biopsy of Marrow, as Independent Procedure					
- Aspiration, needle or punch	2175	100.00	100.00	102.40	104.00
- Bone button	4804	69.44	69.44	71.11	72.22
LYMPH CHANNELS					
Excision					
Cystic hygroma	4900	416.39	416.39	426.38	433.05
Lymphedema					
- Kondolean	4901	416.39	416.39	426.38	433.05
- Radical Sleeve Excision	4902	693.90	693.90	710.55	721.66
- Lymphangiogram	4903	208.17	208.17	213.17	216.50
Excision of Lymph Glands					
Tumor, suprahyoid - unilateral	4904	354.71	354.71	363.22	368.90
- bilateral	4905	520.56	520.56	533.05	541.38
Radical neck dissection	4906	693.90	693.90	710.55	721.66
Dissection of inguinal glands	4907	347.11	347.11	355.44	360.99
Radical dissection of axillary glands	4908	438.17	438.17	448.69	455.70
Radical dissection of inguinal glands, including iliac glands	4909	462.83	462.83	473.94	481.34
Radical dissection of inguinal glands and iliac glands, bilateral	4910	525.74	525.74	538.36	546.77
Fine Needle Biopsy - cervical, axillary, inguinal	4809	54.52	54.52	55.83	56.70
Lymph gland Biopsy - cervical, axillary, inguinal	4911	82.60	82.60	93.04	100.00
- Scalene	4912	146.59	146.59	150.11	152.45
- Complicated biopsy	4913	I.C.	I.C.	I.C.	I.C.
- Sentinel Node biopsy	4805	236.47	236.47	279.03	307.41
Laparotomy for lymphoma staging	4914	578.50	578.50	592.38	601.64
Sweat gland excision - axillary, inguinal, perineal (unilateral)	4915	230.05	230.05	235.57	239.25
- with skin graft(s) and/or rotation flap(s)	4916	337.05	337.05	345.14	350.53

OPERATIONS ON THE DIGESTIVE SYSTEM

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

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
MOUTH					
Incision					
Drainage of Ludwig's Angina, complete care	5000	115.72	115.72	118.50	120.35
Excision					
Biopsy	5001	53.50	53.50	54.78	55.64
Excision of - simple lesion	5002	46.22	46.22	47.33	48.07
- leukoplakia, limited	5003	69.44	69.44	71.11	72.22
Excision of ranula of dermoid cyst	5005	138.83	138.83	142.16	144.38
Local excision CA floor of mouth, mandible, alveolar margin, or buccal mucosa	5006	208.17	208.17	213.17	216.50
- With hemimandibulectomy	5007	462.83	462.83	473.94	481.34
- Either of above combined with unilateral neck dissection	5008	809.78	809.78	829.21	842.17
Suture					
Closure of antero-oral fistula with flap	5010	347.11	347.11	355.44	360.99
Closure of antero-oral fistula with radical antrotomy	5011	404.83	404.83	414.55	421.02
LIPS					
Excision					
Biopsy	5020	53.50	53.50	54.78	55.64
Lip Shave	5021	138.83	138.83	142.16	144.38
Excision of simple lesion	5022	69.44	69.44	87.78	100.00
V-excision for carcinoma	5023	212.82	212.82	217.93	221.33
- plus radical neck dissection	5024	751.94	751.94	769.99	782.02
Excision one half lip - plus reconstruction	5025	347.11	347.11	355.44	360.99
- plus radical neck dissection	5026	809.78	809.78	829.21	842.17
Total excision of lip	5027	462.83	462.83	473.94	481.34
- plus radical neck dissection	5028	809.78	809.78	829.21	842.17
Repair					
Harelip - unilateral	5029	347.11	347.11	355.44	360.99
TONGUE					
Excision					
Biopsy	5040	53.50	53.50	54.78	55.64
Local excision of simple tumor	5041	115.72	115.72	121.29	125.00
Hemiglossectomy	5042	347.11	347.11	355.44	360.99
- plus radical neck dissection	5043	809.78	809.78	829.21	842.17
Total glossectomy	5044	416.39	416.39	426.38	433.05
- plus radical neck dissection	5045	809.78	809.78	829.21	842.17
Repair					
Minor lacerations	5047	53.50	53.50	54.78	55.64
TEETH AND GUMS					
Incision					
Drainage of alveolar abscess - general anesthetic	5060	46.22	46.22	47.33	48.07

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Excision					
Biopsy of gum	5061	53.50	53.50	54.78	55.64
Mucous cyst	5063	46.22	46.22	47.33	48.07
Suture					
Suture of gum, secondary	5064	53.50	53.50	54.78	55.64
PALATE AND UVULA					
Incision					
Palate abscess	5080	80.25	80.25	82.18	83.46
Excision					
Uvulectomy - independent procedure	5081	46.22	46.22	47.33	48.07
Biopsy	5082	46.22	46.22	47.33	48.07
Excision of simple lesion	5083	69.44	69.44	71.11	72.22
Excision of malignant lesion (with reconstruction)	5084	323.94	323.94	331.71	336.90
Suture					
Suture of palate wound	5086	34.72	34.72	35.55	36.11
Uvulopalatopharyngoplasty	5087	266.06	266.06	272.45	276.70
(includes tonsillectomy, partial palatectomy and pharyngoplasty)					
SALIVARY GLANDS AND DUCTS					
Incision					
Sialolithotomy - local anesthetic	5100	34.72	34.72	35.55	36.11
- general anesthetic - simple	5102	69.44	69.44	71.11	72.22
- complicated	5103	208.17	208.17	213.17	216.50
Excision					
Submandibular gland	5104	277.56	277.56	284.22	288.66
Parotid gland - Superficial parotidectomy	5105	605.94	605.94	620.48	630.18
- Total parotidectomy	5106	768.53	768.53	786.97	799.27
- plus unilateral radical neck dissection	5107	809.78	809.78	829.21	842.17
Repair					
Plastic repair of salivary duct	5108	289.17	289.17	296.11	300.74
Dilation of salivary duct (independent procedure)	5109	46.22	46.22	47.33	48.07
Probing					
Catheterization for Sialogram	5111	46.22	46.22	47.33	48.07
RADICAL NECK DISSECTION					
A composite resection of the head and neck for malignancy, neck dissection with reconstruction utilizing local or distant flaps	5112	2,056.65	2,056.65	2,106.01	2,138.92
A composite fee which includes elevation of free island skin and bone flap and closure of defect; preparation of microvascular recipient site for free island skin and bone flap immediately following ablative surgery and when recipient vessels are in the site of ablation; and transplanation of free island skin and bone flap with microvascular anastomosis(es) and bone fixation	5113	2,076.66	2,076.66	2,126.50	2,159.73

* NOTE in most cases this procedure will require 8 hours or more.
Where a procedure requires less than 8 hours, independent consideration will be considered.

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
PHARYNX, ADENOIDS AND TONSILS					
Incision					
Biopsy of Pharynx	5120	82.76	82.76	84.75	86.07
Drainage of retropharyngeal abscess					
- internal approach	5121	57.78	57.78	59.17	60.09
- external approach	5122	173.61	173.61	177.78	180.55
Drainage of peritonsillar abscess, operation only	5123	80.25	80.25	82.18	83.46
Excision					
Branchial cyst	5124	354.71	354.71	363.22	368.90
Sinus	5125	462.83	462.83	473.94	481.34
Pharyngo-esophageal diverticulum	5126	578.50	578.50	592.38	601.64
Thyroglossal duct cyst	5127	289.17	289.17	296.11	300.74
Cyst and sinus	5128	416.39	416.39	426.38	433.05
Tonsillectomy with or without adenoidectomy					
- Under age 16	5129	173.34	173.34	195.34	210.00
- Adult	5130	173.34	173.34	195.34	210.00
Excision of Tonsil tag - unilateral	5131	92.50	92.50	94.72	96.20
Excision of Lingual tonsil (independent procedure)	5132	92.50	92.50	94.72	96.20
Adenoidectomy without tonsillectomy	5138	57.78	57.78	59.17	60.09
Post-tonsillectomy/adenoidectomy hemorrage control (same surgeon)	7911	70.94	70.94	72.64	73.78
Post-tonsillectomy/adenoidectomy hemorrage control (different surgeon)	7912	130.06	130.06	133.18	135.26
Repair					
Choanal atresia	5133	578.50	578.50	592.38	601.64
Pouch-Back Flap (Pharyngeal)	5134	520.56	520.56	533.05	541.38
Suture of exterior wound or injury of pharynx	5136	I.C.	I.C.	I.C.	I.C.
Removal of Foreign Body - pharynx	5137	80.25	80.25	82.18	83.46
ESOPHAGUS					
Incision					
Cervical esophagotomy	5140	347.11	347.11	355.44	360.99
Thoracic esophagotomy	5141	462.83	462.83	473.94	481.34
Esophagomyotomy	5142	578.50	578.50	592.38	601.64
Excision					
Intrathoracic diverticulum	5143	555.28	555.28	568.61	577.49
Extrathoracic diverticulum - one stage	5144	462.83	462.83	473.94	481.34
Resection of esophagus - primary anastomosis	5145	809.78	809.78	829.21	842.17
- With replacement by jejunum, colon, or stomach					
- 1st surgeon	5146	925.50	925.50	947.71	962.52
- 2nd surgeon	5147	231.23	231.23	236.78	240.48
Esophago-gastrectomy	5148	925.50	925.50	947.71	962.52
Esophageal bypass with colon or jejunum	5149	809.78	809.78	829.21	842.17
Endoscopy					
Esophagoscopy - with or without biopsy (only 1 procedure paid per session)	5150	160.00	160.00	163.84	166.40
- with removal of foreign body	5151	230.00	230.00	235.52	239.20
Esophago-bronchoscopy (only 1 procedure paid per session)	5152	208.17	208.17	213.17	216.50
Esophago-gastroscopy w/Elder-Palmer or similar(only 1 procedure per session)	5153	173.61	173.61	177.78	180.55

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Repair					
Esophagoplasty (repair of stricture)	5155	693.90	693.90	710.55	721.66
Esophageal Hiatus Hernia					
- Abdominal approach	5156	578.50	578.50	592.38	601.64
- Abdominal approach plus cholecystectomy, if indicated	5157	693.90	693.90	710.55	721.66
- Transthoracic approach	5158	578.50	578.50	592.38	601.64
Repair of hiatal hernia plus esophagoplasty	5175	809.78	809.78	829.21	842.17
Fundoplication with or without hiatal hernia repair	5176	578.50	578.50	592.38	601.64
Ruptured esophagus	5159	555.28	555.28	568.61	577.49
- Cervical drainage	5160	404.83	404.83	414.55	421.02
Esophago-gastrostomy	5161	809.78	809.78	829.21	842.17
Esophago-duodenostomy or jejunostomy	5162	809.78	809.78	829.21	842.17
Closure of esophageal-tracheal fistula	5163	809.78	809.78	829.21	842.17
Esophagotomy with ligation of varices	5164	555.28	555.28	568.61	577.49
Injection of Esophageal varices or bleeding ulcer w/ Esophagoscopy					
- initial	5165	277.56	277.56	284.22	288.66
- repeat, within 30 days	5177	208.38	208.38	213.38	216.72
Banding of Esophageal varices (with Esophagoscopy)					
- initial	5166	278.20	278.20	284.88	289.33
- repeat, within 30 days	5178	208.38	208.38	213.38	216.72
Gastro-esophageal tamponade	2159	60.00	60.00	61.44	62.40
Introduction of Mousseau-Barbin tube	5167	347.11	347.11	355.44	360.99
Dilation					
Indirect					
- Active - with or without guiding string	5168	57.78	57.78	59.17	60.09
- Passive - using mercury filled tubes	5169	23.06	23.06	23.61	23.98
With Esophagoscopy					
- Initial	5172	264.29	264.29	270.63	274.86
- Repeat	5173	69.44	69.44	71.11	72.22
Dilation of esophagus with fluoroscopic control	5174	81.05	81.05	83.00	84.29
STOMACH					
Incision					
Gastrotomy with removal of tumor or foreign body	5200	347.11	347.11	355.44	360.99
Pyloromyotomy (Ramstedt's)	5201	496.59	496.59	508.51	516.45
Simple tube gastrostomy	5202	347.11	347.11	355.44	360.99
Percutaneous Endoscopic Gastrostomy (PEG)	5240	213.30	213.30	218.42	221.83
Excision					
Biopsy - by gastroscopy	5204	208.17	208.17	213.17	216.50
- by gastrotomy	5205	347.11	347.11	355.44	360.99
Gastrectomy					
- Wedge resection for ulcer	5207	437.47	437.47	447.97	454.97
- Partial, or subtotal	5208	719.84	719.84	737.12	748.63
- Plus repair of hiatus hernia	5209	809.78	809.78	829.21	842.17
- After previous gastro-enterostomy or partial gastrectomy	5210	809.78	809.78	829.21	842.17
- Antrectomy or subtotal - plus vagotomy	5211	809.78	809.78	829.21	842.17
- Total Gastrectomy	5212	925.50	925.50	947.71	962.52
Excision of gastroduodenal lesion (recurrent ulcer)	5213	809.78	809.78	829.21	842.17
- plus vagotomy	5214	925.50	925.50	947.71	962.52

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Excision of gastrojejunal lesion (recurrent ulcer)	5215	809.78	809.78	829.21	842.17
Any of the above, plus cholecystectomy (add)	5217	115.72	115.72	118.50	120.35
Endoscopy					
Gastroscopy - Diagnostic, biopsy, removal of foreign body	5218	192.81	192.81	197.44	200.52
- subsequent - within 45 days of initial procedure	5219	76.18	76.18	78.01	79.23
(IC for full fee may be given under exceptional circumstances)					
Repair					
Pyloroplasty	5220	425.65	425.65	435.87	442.68
- Pyloroplasty plus vagotomy	5221	550.62	550.62	563.83	572.64
Gastroduodenostomy, gastrojejunostomy, or gastrogastrostomy	5222	425.65	425.65	435.87	442.68
- Either of the above plus vagotomy	5223	578.50	578.50	592.38	601.64
Pyloroplasty or gastroenterostomy with vagotomy and hiatal hernia	5224	693.90	693.90	710.55	721.66
Vagotomy alone	5225	416.39	416.39	426.38	433.05
Any of the above plus cholecystectomy (add)	5226	115.72	115.72	118.50	120.35
Suture					
Closure of gastrostomy or other external fistula of stomach	5227	277.56	277.56	284.22	288.66
Closure of perforated ulcer or wound of stomach	5228	425.65	425.65	435.87	442.68
Closure of gastro-colic or gastro-jejunocolic fistula,					
- one stage	5229	809.78	809.78	829.21	842.17
- two stages, including colostomy	5230	809.78	809.78	829.21	842.17
Gastric cooling	5231	138.83	138.83	142.16	144.38
Highly Selective Vagotomy	5232	680.89	680.89	697.23	708.13
Gastric partition for morbid obesity **(Prior approval required)**	5233	I.C.	I.C.	I.C.	I.C.
Gastric partition + all other procedures for morbid obesity**(Prior approval)**	5234	I.C.	I.C.	I.C.	I.C.
E.R.C.P.(Endoscopic Retrograde Cholangio-Pancreatography)					
Standard E.R.C.P.	5235	245.08	245.08	250.96	254.88
E.R.C.P. Biopsy (Additional)	5236	12.47	12.47	12.77	12.97
E.R.C.P. on a bilroth II	5237	206.30	206.30	211.25	214.55
E.R.C.P. with biliary tract dilatation	5241	317.79	317.79	325.42	330.50
E.R.C.P. with sphincterotomy	5238	369.69	369.69	378.56	384.48
E.R.C.P. Stent placement (Additional)	5239	67.46	67.46	69.08	70.16
INTESTINES (EXCEPT RECTUM)					
Incision					
Ileostomy for ulcerative colitis	5250	416.39	416.39	443.78	462.04
Ileostomy or jejunostomy (with tube)	5251	289.17	289.17	308.19	320.87
1st stage Mikulicz	5252	416.39	416.39	443.78	462.04
Colostomy	5253	444.42	444.42	473.65	493.14
- Revision of colostomy for stenosis	5278	138.83	138.83	147.96	154.05
Cecostomy, as single procedure	5255	289.17	289.17	308.19	320.87
Enterotomy or colostomy	5256	425.65	425.65	453.65	472.32
- with operative sigmoidoscopy	5257	462.83	462.83	493.27	513.57
- multiple with operative sigmoidoscopy	5258	578.50	578.50	616.55	641.92
Excision					
Biopsy by intubation	5259	69.44	69.44	74.01	77.05
Local excision of lesion of small intestine incl. duodenal diverticulum	5260	472.94	472.94	504.05	524.79
Enterectomy with Anastomosis					

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Small Intestine					
- Duodenectomy	5261	567.53	567.53	604.86	629.75
- Other	5262	567.53	567.53	604.86	629.75
Small and Large Intestine					
- Terminal ileum, caecum	5263	709.41	709.41	756.07	787.18
- Terminal ileum, caecum, ascending colon	5264	709.41	709.41	756.07	787.18
Large Intestine					
- Segmental colectomy	5265	723.59	723.59	771.19	802.92
- Hemicolectomy, right or left	5266	723.59	723.59	771.19	802.92
- Total colectomy without perineal resection	5267	1,064.12	1,064.12	1,134.12	1,180.78
- Total colectomy with ileostomy and abdomino-perineal resection					
- single team	5268	1,032.82	1,032.82	1,100.76	1,146.05
- two team - 1st surgeon	5269	955.78	955.78	1,018.65	1,060.56
- 1st assistant	5270	277.56	277.56	295.82	307.99
- 2nd assistant	5271	208.17	208.17	221.86	230.99
Intestinal Obstruction					
- without resection	5272	591.18	591.18	630.07	655.99
- with resection	5273	709.41	709.41	756.07	787.18
- Entero-enterostomy	5275	425.65	425.65	453.65	472.32
- Duodenal atresia, duodeno-jejunostomy	5276	462.83	462.83	493.27	513.57
Multiple stage procedures, preliminary colostomy, bowel resection, closure of colostomy, etc., to be paid at fee listed for each procedure.					
Repair					
Fecal fistula, radical with resection	5277	636.33	636.33	678.19	706.09
Revision of ileostomy or colostomy	5278	138.83	138.83	147.96	154.05
Closure of perforation	5279	370.54	370.54	394.91	411.16
Closure of perforation with colostomy	5280	462.83	462.83	493.27	513.57
Cecopexy or sigmoidopexy, independent operation	5281	347.11	347.11	369.94	385.16
Suture					
Closure of enterostomy plus resection	5282	472.94	472.94	504.05	524.79
Closure of colostomy	5283	472.94	472.94	504.05	524.79
Plication of small intestine for adhesions	5284	520.56	520.56	554.80	577.63
Manipulation					
Dilation of enterostomy, colostomy, etc.					
- with anesthetic	5285	46.22	46.22	49.26	51.29
- without anesthetic (paid as Visit Fee only)					
E.E.A. Stapler	5286	56.23	56.23	59.93	62.39
MECKEL'S DIVERTICULUM AND THE MESENTERY					
Excision					
Meckel's diverticulum	5287	347.11	347.11	369.94	385.16
Local excision of lesion or mesentery	5288	347.11	347.11	369.94	385.16
Resection of mesentery	5289	347.11	347.11	369.94	385.16
Mesenteric cyst	5290	347.11	347.11	369.94	385.16

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
APPENDIX					
Incision					
Drainage of abscess, complete care	5300	289.17	289.17	308.19	320.87
Excision					
Appendectomy	5301	413.82	413.82	441.04	459.19
- With gross perforation and peritonitis	5302	555.70	555.70	592.25	616.62
- With removal of Meckel's Diverticulum	5303	358.45	358.45	382.03	397.75
RECTUM					
Incision					
Proctotomy - with drainage (perirectal abscess)	5322	138.83	138.83	147.96	154.05
Pelvic abscess - drainage	5323	173.61	173.61	185.03	192.64
Excision					
Proctectomy					
- Anterior resection of rectum	5324	1,064.12	1,064.12	1,134.12	1,180.78
- Perineal resection of rectum	5325	555.28	555.28	591.81	616.16
- Abdomino-perineal resection plus colostomy					
- Single team	5326	1,064.12	1,064.12	1,134.12	1,180.78
- Two team - 1st surgeon	5327	1,001.52	1,001.52	1,067.40	1,111.32
- 1st assistant	5328	472.94	472.94	504.05	524.79
- 2nd assistant	5329	319.23	319.23	340.23	354.23
Hartmann's procedure	5330	723.59	723.59	771.19	802.92
Reanastomosis following Hartmann's procedure	5331	594.92	594.92	634.05	660.14
Rectal polyp - low, excision or cauterization	5336	69.44	69.44	74.01	77.05
- upper rectum and sigmoid through sigmoidoscope	5337	141.88	141.88	151.21	157.43
Biopsy of recto-sigmoid for Hirschprung's disease	5338	92.50	92.50	98.58	102.64
Electro-coagulation of rectal carcinoma					
- initial	5358	231.23	231.23	246.44	256.58
- repeat	5359	115.72	115.72	123.33	128.41
Repair					
Proctostomy	5339	347.11	347.11	369.94	385.16
Proctopexy - abdominal route	5340	416.39	416.39	443.78	462.04
Rectal prolapse					
- Excision of mucous membrane	5341	231.23	231.23	246.44	256.58
- Perineal repair, major	5342	416.39	416.39	443.78	462.04
- Abdominal approach	5343	555.28	555.28	591.81	616.16
- Thiersch wire procedure	5344	138.83	138.83	147.96	154.05
Suture of Rectum					
- External approach	5345	277.56	277.56	295.82	307.99
- Intraperitoneal approach	5346	462.83	462.83	493.27	513.57
Closure of Fistula					
- Recto-vaginal	5347	462.83	462.83	493.27	513.57
- Recto-vesical	5348	462.83	462.83	493.27	513.57
ANUS					
Clamping of internal hemorrhoid - per haemorrhoid	5349	70.94	70.94	72.64	73.78
Incision					
Thrombosed haemorrhoid					
- Local anesthetic	5350	42.80	42.80	43.83	44.51
- General anesthetic	5351	57.78	57.78	59.17	60.09

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Excision					
Local excision of anal lesion (fissure, malignancy)	5352	138.83	138.83	142.16	144.38
Hemorrhoidectomy, with or without sigmoidoscopy	5353	212.82	212.82	217.93	221.33
Anal polyp, hemorrhoidal tags	5354	70.94	70.94	72.64	73.78
Fistula-in-ano - low level	5355	212.82	212.82	217.93	221.33
- high level with division of internal sphincter	5356	425.65	425.65	435.87	442.68
Biopsy, independent operation, general anesthetic	5357	46.22	46.22	47.33	48.07
Introduction					
Hemorrhoid injection - initial	2169	21.40	21.40	21.91	22.26
- subsequent	2170	16.10	16.10	16.49	16.74
Injection for pruritus ani or anal fissure	2171	21.40	21.40	21.91	22.26
Repair					
Excision of scar, for stenosis	5361	138.83	138.83	142.16	144.38
Anaplasty for stenosis	5362	277.56	277.56	284.22	288.66
Repair of anal sphincter	5363	347.11	347.11	355.44	360.99
- Repair of anal sphincter and anorectal ring	5364	347.11	347.11	355.44	360.99
Repair of Imperforate Anus/Membranous obstruction of anus	5365	138.83	138.83	142.16	144.38
Destruction					
Cauterization of fissure	5371	26.75	26.75	27.39	27.82
Electro-dessication of condylomata	5372	80.25	80.25	82.18	83.46
Manipulation					
Dilation of anal sphincter under general anesthetic (independent procedure)	5373	23.06	23.06	23.61	23.98
Anoscopy	5374	15.00	15.00	15.36	15.60
Partial Lateral internal sphincterotomy	5375	204.37	204.37	209.27	212.54
LIVER					
Incision					
Hepatotomy					
- Drainage of abscess or cyst	5381	416.39	416.39	426.38	433.05
- Removal of foreign body	5382	416.39	416.39	426.38	433.05
- Incision and packing of wound	5383	416.39	416.39	426.38	433.05
Excision					
Hepatectomy					
- Local excision of lesion	5384	416.39	416.39	426.38	433.05
- Partial Resection of liver (partial hepatectomy or lobectomy)	5385	925.50	925.50	947.71	962.52
Biopsy - needle	2177	80.25	80.25	82.18	83.46
Repair					
Suture of liver wound/rupture	5388	I.C.	I.C.	I.C.	I.C.
BILIARY TRACT					
Incision					
Cholecystostomy	5390	347.11	347.11	355.44	360.99
Cholecysto-enterostomy	5391	416.39	416.39	426.38	433.05
Cholecysto-enterostomy plus enteroenterostomy	5392	462.83	462.83	473.94	481.34
Cholecystogastrostomy	5393	416.39	416.39	426.38	433.05
Choledochoduodenostomy	5394	578.50	578.50	592.38	601.64
Common duct exploration	5395	555.28	555.28	568.61	577.49
Common duct exploration with duodenotomy, sphincterotomy	5396	693.90	693.90	710.55	721.66

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Excision					
Choledochectomy	5398	693.90	693.90	710.55	721.66
Excision of Ampulla of Vater	5399	636.33	636.33	651.60	661.78
Cholecystectomy	5400	575.00	575.00	588.80	598.00
- with operative cholangiogram	5401	614.82	614.82	629.58	639.41
Cholecystectomy and exploration of bile duct	5402	650.29	650.29	665.90	676.30
- with operative cholangiogram	5403	709.41	709.41	726.44	737.79
Cholecystectomy and exploration of bile ducts plus duodenotomy	5404	693.90	693.90	710.55	721.66
Repair					
Surgical reconstruction of common bile duct	5405	925.50	925.50	947.71	962.52
Suture					
Closure of fistula	5406	636.33	636.33	651.60	661.78
PANCREAS					
Incision					
Pancreatotomy	5410	462.83	462.83	473.94	481.34
Pancreatic abscess or cyst	5411	462.83	462.83	473.94	481.34
Excision					
Pancreatectomy					
- Local Excision of lesion	5414	555.28	555.28	568.61	577.49
- Partial - resection of tail	5415	555.28	555.28	568.61	577.49
Pancreatico-duodenal resection (Whipple type operation)	5416	925.50	925.50	947.71	962.52
Excision pancreatic cyst	5417	555.28	555.28	568.61	577.49
Repair					
Pancreatico - gastrostomy	5418	555.28	555.28	568.61	577.49
- duodenostomy	5419	555.28	555.28	568.61	577.49
- jejunostomy	5420	555.28	555.28	568.61	577.49
Marsupialization of cyst	5421	462.83	462.83	473.94	481.34
ABDOMEN, PERITONEUM AND OMENTUM					
Incision					
Laparotomy, with or without biopsy	5450	413.82	413.82	423.75	430.37
Peritoneal abscess					
- Drainage of subphrenic abscess	5451	416.39	416.39	426.38	433.05
- Intra-abdominal abscess, other	5452	425.65	425.65	435.87	442.68
Drainage of abdominal wall abscess					
- general anesthetic, complete care	5480	69.44	69.44	71.11	72.22
Removal of foreign body, abdominal wall - gun shot	5453	I.C.	I.C.	I.C.	I.C.
Excision					
Desmoid tumor, depending on extent	5454	I.C.	I.C.	I.C.	I.C.
Lipectomy, removal of panniculus **(Prior approval required)**	5456	347.11	347.11	355.44	360.99
Retroperitoneal tumor	5457	555.28	555.28	568.61	577.49
Mesenteric cyst	5458	347.11	347.11	355.44	360.99
Endoscopy					
Peritoneoscopy (laparoscopy)	5460	208.12	208.12	213.11	216.44
Repair					
Herniotomy and Herniorrhaphy					
- Inguinal or femoral, single	5461	331.06	331.06	339.01	344.30
- Inguinal - single with hydrocele	5462	378.35	378.35	387.43	393.48

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
- Inguinal and femoral - same side	5463	347.11	347.11	355.44	360.99
- Sliding hernia	5464	347.11	347.11	355.44	360.99
- Inguinal or femoral repair by prosthesis or graft	5465	378.35	378.35	387.43	393.48
Recurrent hernia	5466	472.94	472.94	484.29	491.86
- Recurrent hernia repair by prosthesis or graft	5467	496.59	496.59	508.51	516.45
Umbilical hernia - adult	5468	354.71	354.71	363.22	368.90
- child	5469	220.21	220.21	225.50	229.02
Enterocele, infant	5470	347.11	347.11	355.44	360.99
Omphalocoele	5471	462.83	462.83	473.94	481.34
Diaphragmatic hernia	5472	578.50	578.50	592.38	601.64
- with prosthesis	5473	636.33	636.33	651.60	661.78
Incisional or ventral hernia - repair by suture	5474	472.94	472.94	484.29	491.86
- repair by prosthesis	5475	500.76	500.76	512.78	520.79
Epigastric hernia	5476	331.06	331.06	339.01	344.30
Strangulated or Incarcerated Hernia					
- without resection	5477	347.11	347.11	355.44	360.99
- with resection	5478	625.95	625.95	640.97	650.99
Suture					
Secondary closure for evisceration	5479	271.94	271.94	278.47	282.82

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
OPERATIONS ON THE ENDOCRINE SYSTEM					
These fees cannot be correctly interpreted without reference to the Preamble.					
THYROID GLAND					
Incision					
Abscess, complete care	5500	138.83	138.83	142.16	144.38
Excision					
Biopsy - needle (core)	5501	46.22	46.22	47.33	48.07
- surgical	5502	277.56	277.56	284.22	288.66
Thyroidectomy					
- Bilateral total thyroidectomy	5503	636.33	636.33	651.60	661.78
- Total lobectomy	5504	532.06	532.06	544.83	553.34
- Total lobectomy plus subtotal lobectomy	5505	520.56	520.56	533.05	541.38
- Sub-total bilateral thyroidectomy	5506	462.83	462.83	473.94	481.34
- Partial lobectomy	5507	416.39	416.39	426.38	433.05
Excision of solitary nodule	5508	277.56	277.56	284.22	288.66
If one of the following procedures carried out with either of the above add:					
- Unilateral limited node dissection	5509	138.83	138.83	142.16	144.38
- Bilateral limited node dissection	5510	277.56	277.56	284.22	288.66
- Radical neck dissection unilateral	5511	347.11	347.11	355.44	360.99
PARATHYROID, THYMUS AND ADRENAL GLANDS					
Excision					
Parathyroidectomy - for hyperplasia	5550	636.33	636.33	651.60	661.78
- parathyroid tumor	5551	555.28	555.28	568.61	577.49
- if sternal splitting required	5552	693.90	693.90	710.55	721.66
Thymectomy	5553	693.90	693.90	710.55	721.66
Adrenal exploration - unilateral	5554	347.11	347.11	355.44	360.99
Adrenalectomy - unilateral	5555	578.50	578.50	592.38	601.64

OPERATIONS ON THE NERVOUS SYSTEM

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

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Diagnostic Procedures					
Lumbar puncture	2115	100.00	100.00	102.40	104.00
Subdural puncture - first	2117	31.73	31.73	32.49	33.00
- each additional	2118	10.49	10.49	10.74	10.91
Myelogram - Lumbar	2172	73.88	73.88	75.65	76.84
Arteriography					
- carotid or vertebral (percutaneous)	4630	115.72	115.72	118.50	120.35
- carotid or vertebral (cutdown,brachial)	4634	173.61	173.61	177.78	180.55
- aortic arch study (percutaneous)	4633	115.72	115.72	118.50	120.35
- aortic arch study (cutdown,brachial)	4634	173.61	173.61	177.78	180.55
Vascular Procedures					
Carotid endarterectomy	5652	693.90	693.90	710.55	721.66
- with patch graft	5653	809.78	809.78	829.21	842.17
- with graft and by-pass shunt	5654	925.50	925.50	947.71	962.52
Trauma					
Scalp laceration					
- simple uncomplicated	3050	60.00	60.00	69.00	75.00
- extensive, multiple or complicated	3051	I.C.	I.C.	I.C.	I.C.
Head Injury (closed) - initial examination & recommendations	5702	64.20	64.20	65.74	66.77
Skull fracture					
- Non-operative - same as in Head Injury, closed					
- Decompressive Craniotomy					
- Temporal	5710	462.83	462.83	473.94	481.34
- Subtemporal	5711	693.90	693.90	710.55	721.66
Extradural hematoma - surgical management	5716	636.33	636.33	651.60	661.78
Subdural hematoma - with burr holes	5717	636.33	636.33	651.60	661.78
Vertebral body fracture/dislocation, without cord injury					
Supervision, bed rest only (paid as Visit Fee only)					
Skull calipers, - visit fee plus	3385	115.72	115.72	118.50	120.35
Closed reduction, +/- anesthetic, cast, frame, brace, etc.	3384	275.20	275.20	281.80	286.21
Open reduction with or without internal fixation	3386	660.67	660.67	676.53	687.10
Open reduction and fusion	3387	693.90	693.90	710.55	721.66
Open reduction/fusion with Orthopedic surgeon -each surgeon	3388	520.56	520.56	533.05	541.38
Vertebral body fracture/dislocation, with cord injury					
No operation (paid as Visit Fee only)					
Skull Calipers, - visit fee plus	3389	115.72	115.72	118.50	120.35
Closed reduction under Anesthesia	3390	550.62	550.62	563.83	572.64
Open reduction with or without internal fixation	3391	809.78	809.78	829.21	842.17
Open reduction and fusion	3392	809.78	809.78	829.21	842.17
Open reduction/fusion with Orthopaedic surgeon -each surgeon	3393	550.62	550.62	563.83	572.64
Open reduction and decompression of cord or nerve roots	3394	770.72	770.72	789.22	801.55

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Brain					
Craniotomy					
- Burr hole and aspiration	5859	578.50	578.50	592.38	601.64
Spinal Cord					
Laminectomy					
- For excision of neoplasm, hematoma, vascular anomaly, constrictive pachy-meningitis of spinal cord or nerve roots	5900	809.78	809.78	829.21	842.17
- For decompression of spinal cord or cauda equine	5902	693.90	693.90	710.55	721.66
- For treatment of extradural abscess	5903	693.90	693.90	710.55	721.66
Discs					
Lumbar					
- Unilateral	3514	550.62	550.62	563.83	572.64
- Bilateral, multiple or recurrent	3515	693.90	693.90	710.55	721.66
Excision of disc with fusion - one surgeon	3519	809.78	809.78	829.21	842.17
- two surgeons, each	3520	520.56	520.56	533.05	541.38
Peripheral Nerves					
Exploration of major nerve (median,ulnar,radial,sciatic,etc) +/- neurolysis	5963	231.23	231.23	236.78	240.48
Removal tumor major peripheral nerve	5964	347.11	347.11	355.44	360.99
Suture major peripheral nerve	5965	347.11	347.11	355.44	360.99
Suture small peripheral nerve (digital)	5967	173.61	173.61	177.78	180.55
Decompression median nerve at wrist (carpal tunnel syndrome)	5968	231.23	231.23	236.78	240.48
Decompression ulnar nerve at elbow (cubital tunnel syndrome)	5969	231.23	231.23	236.78	240.48
Transposition of ulnar nerve at elbow	5970	289.17	289.17	296.11	300.74
Morton’s Neuroma, excision	5973	231.23	231.23	236.78	240.48
Sympathectomy					
- Cervical	5980	462.83	462.83	473.94	481.34
- Cervicodorsal	5981	481.13	481.13	492.68	500.38
- Lumbar	5983	365.73	365.73	374.51	380.36

OPERATIONS ON THE FEMALE REPRODUCTIVE SYSTEM

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

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
OBSTETRICAL CARE					
Initial prenatal visit	0700	60.00	60.00	61.44	62.40
Assessment of labour	0701	50.00	50.00	51.20	52.00
This fee can only be billed once for the period of the assessment. Not applicable if the same physician delivers within 24 hours. Time of day is required.					
Prenatal visit in office	0703	35.00	35.00	35.84	36.40
Postnatal visit in office	0705	35.00	35.00	35.84	36.40
Post-partum visit in hospital	0704	50.00	50.00	51.20	52.00
OBSTETRICAL OPERATIONS					
Vaginal Delivery - non-operative	6001	599.20	599.20	613.58	623.17
Caesarean Section - procedure only	6004	599.20	599.20	613.58	623.17
- Sterilization at time of C-Section, hysterotomy, laparotomy,etc	6005	75.70	75.70	77.52	78.73
- Caesarean Hysterectomy, subtotal or total	6006	794.10	794.10	813.16	825.86
Operative delivery other than Caesarean section	6007	599.20	599.20	613.58	623.17
Surgical or medical induction of labour, consultation/procedure	6008	73.35	73.35	75.11	76.28
Abortion - complete, under 20 weeks (paid as Visit Fee only)					
- incomplete, including D & C	6009	148.52	148.52	152.08	154.46
- therapeutic	6010	161.78	161.78	165.66	168.25
Missed abortion, with or without intra-uterine hypertonic solution	6012	161.78	161.78	165.66	168.25
Repair of third degree laceration, consultation/procedure	6013	118.24	118.24	121.08	122.97
(includes evacuation of vaginal hematoma and repair)					
**Retained placenta removal, consultation/procedure	6014	118.24	118.24	121.08	122.97
Ectopic pregnancy	6015	360.00	360.00	368.64	374.40
Suture of incompetent cervix during pregnancy	6016	204.32	204.32	209.22	212.49
Sterilization - postpartum (in addition to obstetrical fee)	6017	275.20	275.20	281.80	286.21
Amniocentesis	6019	54.46	54.46	55.77	56.64
Abortion incomplete without Anesthesia or D&C (in hospital)	6021	81.05	81.05	83.00	84.29
Post coital testing	6025	36.54	36.54	37.42	38.00
Post-partum vaginal hematoma - evacuation/suture (gen.anesth.)	6947	112.35	112.35	115.05	116.84
Perineal/Vaginal/Cervical laceration - repair(general anesthesia)	6948	101.65	101.65	104.09	105.72
Post-partum hemorrhage - surgical management	6953	413.82	413.82	423.75	430.37
(eg. vessel ligation, compression sutures)					
**Chargeable by an obstetrician on his own patient when the services of an anesthetist is required.					
Fetal Monitoring					
Consultation/interpretation of fetal monitoring records	6022	46.22	46.22	47.33	48.07
External cephalic version with or without tocolysis	6024	129.95	129.95	133.07	135.15
Ultrasound procedures by Obstetrician	2606	60.99	60.99	62.45	63.43
Insertion of Intrauterine Pressure Catheter (IUPC)	2601	50.83	50.83	52.05	52.86
Oxytocin Challenge Test	2602	32.10	32.10	32.87	33.38

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Scalp pH Sampling (maximum of 2)	2603	66.34	66.34	67.93	68.99
Biophysical Profile	2604	60.99	60.99	62.45	63.43
VULVA					
Incision					
Hymenectomy	6500	57.78	57.78	59.17	60.09
Abscess of vulva, Bartholin or Skene's gland					
- complete care	6501	59.12	59.12	60.54	61.48
- Marsupialization or cautery	6502	70.03	70.03	71.71	72.83
Excision					
Vulvectomy - simple	6503	277.56	277.56	284.22	288.66
Cyst of Bartholin's gland	6506	141.88	141.88	145.29	147.56
Condylomata	6508	118.24	118.24	121.08	122.97
VAGINA					
Incision					
Colpotomy, posterior, drainage or needling	6600	92.50	92.50	94.72	96.20
Excision					
Local excision of cyst	6601	165.53	165.53	169.50	172.15
Repair					
Cystocele or Rectocele	6602	230.85	230.85	236.39	240.08
Cystocele and Rectocele	6603	398.04	398.04	407.59	413.96
Cystocele, Rectocele and prolapse (Fothergill)	6604	462.83	462.83	473.94	481.34
Cystocele, Rectocele and excision of cervical stump	6605	462.83	462.83	473.94	481.34
Paravaginal repair of cystocele	6803	219.35	219.35	224.61	228.12
Vaginal vault prolapse (post-hysterectomy,vaginal or abdominal)	6606	467.32	467.32	478.54	486.01
Rectocele and repair of anal sphincter	6607	396.33	396.33	405.84	412.18
Perineorrhaphy (without rectocele repair)	6608	138.83	138.83	142.16	144.38
Repair of double vagina	6611	208.17	208.17	213.17	216.50
Closure of fistula - vesico-vaginal	6612	462.83	462.83	473.94	481.34
- recto-vaginal	6613	462.83	462.83	473.94	481.34
- uretero-vaginal	6614	555.28	555.28	568.61	577.49
Urethral caruncle or prolapse of mucosa	6615	92.50	92.50	94.72	96.20
Enterocele	6616	423.24	423.24	433.40	440.17
Retropubic operation for incontinence (Marchetti)	6617	396.33	396.33	405.84	412.18
Operations for stress incontinence - vaginal	6618	354.71	354.71	363.22	368.90
- abdominal	6619	472.94	472.94	484.29	491.86
- combined	6620	709.41	709.41	726.44	737.79
Transvaginal Tape (TVT) procedure (including cystoscopy)	6639	502.90	502.90	514.97	523.02
Colposacropexy	6951	597.06	597.06	611.39	620.94
Sacrospinous vault fixation (add on fee)	6952	101.65	101.65	104.09	105.72
Manipulation					
Examination +/- dilation - general anesthesia(independent operation)	6622	81.05	81.05	83.00	84.29
UTERUS AND CERVIX					
Excision					
Diagnostic curettage	6901	110.21	110.21	112.86	114.62
Myomectomy	6902	396.60	396.60	406.12	412.46

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Hysterectomy - total, abdominal or vaginal	6903	446.24	446.24	456.95	464.09
- with cystocele or rectocele repair	6900	599.20	599.20	613.58	623.17
- with cystocele and rectocele repair	6933	706.20	706.20	723.15	734.45
Hysterectomy - partial or subtotal, with or without adnexae	6905	330.31	330.31	338.24	343.52
- with rectocele and/or cystocele repair	6906	440.41	440.41	450.98	458.03
Laparoscopic Hysterectomy - total, abdominal or vaginal	6958	557.80	557.80	571.19	580.11
Laparoscopic Hysterectomy - partial or subtotal, with or without adnexa	6959	412.89	412.89	422.80	429.41
Septate uterus	6908	440.41	440.41	450.98	458.03
Cervical polyp, without D&C	6909	33.33	33.33	34.13	34.66
Amputation of cervix	6910	198.22	198.22	202.98	206.15
Cervical stump - vaginal	6911	264.29	264.29	270.63	274.86
- abdominal	6912	330.31	330.31	338.24	343.52
Biopsy of cervix - independent operation with general anesthesia	6913	55.59	55.59	56.92	57.81
Introduction					
Insufflation, Rubin's test and D&C	6916	115.72	115.72	118.50	120.35
Insufflation and endometrial biopsy	6917	69.44	69.44	87.78	100.00
Hysterosalpingogram	6918	83.57	83.57	85.58	86.91
I.U.C.D. insertion	6919	75.65	75.65	90.26	100.00
I.U.C.D. insertion at annual health exam	6939	27.50	27.50	28.16	28.60
Repair					
Hysteropexy (uterine suspension)	6920	275.20	275.20	281.80	286.21
- with rectocele and cystocele repair	6922	440.41	440.41	450.98	458.03
Cervix with or without biopsy	6923	198.22	198.22	202.98	206.15
Incompetent cervix - any suture repair	6924	165.15	165.15	169.11	171.76
Repair of inversion of uterus - operative	6925	396.33	396.33	405.84	412.18
- manual	6926	165.15	165.15	169.11	171.76
Electro-cautery of cervix - office procedure	6928	34.72	34.72	35.55	36.11
Biopsy of cervix - office procedure (without colposcopy)	6929	33.01	33.01	33.80	34.33
Conization of cervix - with D&C	6930	173.61	173.61	177.78	180.55
- without D&C (LEEP)	6632	64.20	64.20	65.74	66.77
Endometrial biopsy	6931	44.94	44.94	46.02	46.74
Injection of fissure in ano	6932	23.06	23.06	23.61	23.98
Colposcopy - without biopsy	6934	84.58	84.58	86.61	87.96
- with biopsy (includes Pap)	6989	117.59	117.59	120.41	122.29
Artificial insemination	6935	46.22	46.22	47.33	48.07
Vaporization of endometriosis & treatment of pelvic pain, (including all associated procedures)	6937	342.77	342.77	351.00	356.48
Surgical procedure for infertility involving tubal blockage at cornua	6938	685.55	685.55	702.00	712.97
Hysteroscopy - diagnostic	6945	144.45	144.45	147.92	150.23
- therapeutic, with D&C, +/-polyp removal	6946	201.16	201.16	205.99	209.21
Endometrial ablation (+/- D&C; +/- hysteroscopy)	6942	406.76	406.76	416.52	423.03
Hysteroscopic resection of endometrial tumor	6949	449.40	449.40	460.19	467.38
Omentectomy, infra-colic and infra-gastric	6630	194.53	194.53	199.20	202.31
Omental biopsy - single or multiple (add-on fee)	6631	53.50	53.50	54.78	55.64
Staging laparotomy for gynecological CA including total hysterectomy/bilateral salpingoophorectomy, bilateral selective pelvic lymphadenectomies, omental biopsies, selective periaortic lymphadenectomy, pelvic washings.	6950	859.69	859.69	880.32	894.08

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
FALLOPIAN TUBES					
Peritoneoscopy (Laparoscopy)	5460	208.12	208.12	213.11	216.44
Excision					
Salpingectomy and Salpingo-oophorectomy	6700	346.31	346.31	354.62	360.16
Repair					
Tubal plastic operation	6701	385.41	385.41	394.66	400.83
Sterilization	6702	275.20	275.20	281.80	286.21
Lysis of adhesion	6704	333.41	333.41	341.41	346.75
Infertility investigation with tubal insufflation	6705	225.24	225.24	230.65	234.25
Follicular tracking by ultrasound	6710	82.60	82.60	84.58	85.90
OVARY					
Excision					
Ovarian cyst	6800	330.31	330.31	338.24	343.52
Paraovarian cyst	6801	330.31	330.31	338.24	343.52
Oophorocystectomy	6802	330.31	330.31	338.24	343.52

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
OPERATIONS ON THE EYE					
These fees cannot be correctly interpreted without reference to the Preamble.					
Examination under general Anesthesia with or without intubation	7000	57.78	57.78	59.17	60.09
EYEBALL					
Incision					
Goniotomy	7002	347.11	347.11	355.44	360.99
Excision					
Enucleation	7003	289.17	289.17	296.11	300.74
- with prosthesis implant	7004	347.11	347.11	355.44	360.99
Repair					
Evisceration	7005	289.17	289.17	296.11	300.74
- with implant	7006	347.11	347.11	355.44	360.99
Removal intraocular foreign body	7007	385.41	385.41	394.66	400.83
CORNEA					
Incision					
Paracentesis	7050	54.94	54.94	56.26	57.14
Removal embedded foreign body					
- Local anesthetic	7051	37.45	37.45	38.35	38.95
- General anesthetic	7052	54.94	54.94	56.26	57.14
Excision					
Keratectomy	7053	347.11	347.11	355.44	360.99
Excision of dermoid	7054	173.61	173.61	177.78	180.55
Repair					
Corneal transplant					
- penetrating	7058	715.72	715.72	732.90	744.35
- Lamellar	7059	550.62	550.62	563.83	572.64
Suture penetrating wound					
- with excision of iris	7060	347.11	347.11	355.44	360.99
- without excision of iris	7061	231.23	231.23	236.78	240.48
Removal of corneal sutures in O.R	7062	53.29	53.29	54.57	55.42
Corneal retrieval	7063	140.54	140.54	143.91	146.16
Bandage Contact Lens	7511	89.29	89.29	91.43	92.86
SCLERA					
Excision					
Sclerectomy	7102	385.41	385.41	394.66	400.83
Suture					
All penetrating wounds	7103	347.11	347.11	355.44	360.99
IRIS AND CILIARY BODY					
Incision					
*Iridectomy	7150	275.20	275.20	281.80	286.21
Iridencleisis	7151	347.11	347.11	355.44	360.99
Division of anterior synechia following penetrating keratoplasty	7152	173.61	173.61	177.78	180.55

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Destruction					
Diathermy of Ciliary body	7153	231.23	231.23	236.78	240.48
Anterior chamber open evacuation of clot	7156	347.11	347.11	355.44	360.99
Iridencysis	7160	340.63	340.63	348.81	354.26
Trabeculoplasty	7161	360.27	360.27	368.92	374.68
Anterior Vitrectomy	7162	321.59	321.59	329.31	334.45
***Note - Fee applies to laser as well as surgical iridectomy. Repeat procedure not payable within 30 days.					
LENS					
Incision					
Capsulotomy	7202	220.21	220.21	225.50	229.02
Excision					
Cataract					
- Senile	7203	490.43	490.43	502.20	510.05
- Congenital	7204	518.31	518.31	530.75	539.04
- Traumatic	7205	518.31	518.31	530.75	539.04
Extraction of dislocated lens	7206	518.31	518.31	530.75	539.04
Severance of Vitreous Strands (Yag Laser)	7208	167.29	167.29	171.30	173.98
Cataract Extraction with Intra-ocular Lens Insertion	7210	555.55	555.55	555.55	555.55
Secondary Lens Insertion	7211	356.36	356.36	364.91	370.61
Reposition of Intra-ocular Lens	7212	170.18	170.18	174.26	176.99
Removal of Intra-ocular Lens	7213	299.49	299.49	306.68	311.47
RETINA					
Re-attachment of retina and choroid					
- Simple coagulation (diathermy)	7250	462.83	462.83	473.94	481.34
- Photocoagulation	7251	440.41	440.41	450.98	458.03
- Cryopexy	7252	440.41	440.41	450.98	458.03
- Non-circling tube or buckle procedures, including operations in which silicone is implanted to produce a non-permanent small choroidal elevation	7253	693.90	693.90	710.55	721.66
- For circling tube, as a first operation	7254	693.90	693.90	710.55	721.66
- Previously untreated retinal detachments, including scleral resection	7255	693.90	693.90	710.55	721.66
- Secondary operations after an unsuccessful operation or for a fresh detachment after a previously successful operation, including an encircling tube	7256	925.50	925.50	947.71	962.52
Pneumatic Retinopexy	7259	660.18	660.18	676.02	686.59
- repeat same eye within 30 days	7260	330.09	330.09	338.01	343.29
Independent Procedures					
- Photocoagulation	7257	275.20	275.20	281.80	286.21
- Cryopexy	7258	275.20	275.20	281.80	286.21
Fluorescein / Digital Angiography	7510	61.04	61.04	62.50	63.48
EXTRAOCULAR MUSCLES					
Repair					
Strabismus Procedures					
- one or more than one muscle, one or both eyes	7300	330.31	330.31	417.12	475.00
- subsequent operation by same surgeon within 6 months	7301	173.61	173.61	234.44	275.00

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
- Adjustable Suture Technique	7302	340.63	340.63	348.81	354.26
ORBIT					
Incision					
Drainage of abscess	7350	231.23	231.23	236.78	240.48
Lateral orbiotomy, Kronlein procedure	7351	578.50	578.50	592.38	601.64
Excision					
Tumor - orbital	7352	404.83	404.83	414.55	421.02
- lacrimal gland	7353	404.83	404.83	414.55	421.02
Exenterations, with or without major plastic repair	7354	462.83	462.83	473.94	481.34
Biopsy	7355	115.72	115.72	118.50	120.35
Repair					
Orbital fracture, open reduction rim wall fracture (zygomatic fract/disloc)	7356	347.11	347.11	355.44	360.99
Blowout fracture of floor	7357	404.83	404.83	414.55	421.02
Secondary repair of blowout fracture by combined or orbital approach	7358	636.33	636.33	651.60	661.78
EYELIDS					
Incision					
Drainage of abscess - local anesthetic	7400	37.45	37.45	38.35	38.95
Excision					
Chalazion - single or multiple - complete care					
- local anesthetic	7402	46.44	46.44	47.55	48.30
- general anesthetic	7403	57.78	57.78	59.17	60.09
Epilation by Hyfurcator, electrolysis	7404	23.06	23.06	23.61	23.98
Lid Tumors					
- very minor	7405	34.72	34.72	35.55	36.11
- minor	7406	165.15	165.15	169.11	171.76
- intermediate	7407	289.17	289.17	296.11	300.74
- major	7408	404.83	404.83	414.55	421.02
- extensive major	7409	578.50	578.50	592.38	601.64
Repair					
Ptosis **(Prior approval required)**	7410	347.11	347.11	355.44	360.99
- secondary repair **(Prior approval required)**	7411	578.50	578.50	592.38	601.64
Blepharoplasty **(Prior approval required)**					
- excision of skin, with or without muscle, per lid	7430	142.58	142.58	146.00	148.28
- with removal of orbital fat, +/-lid fold reconstruction/graft	7431	186.18	186.18	190.65	193.63
Districhiasis - unilateral	7412	347.11	347.11	355.44	360.99
Trichiasis, surgical repair by transplantation	7413	I.C.	I.C.	I.C.	I.C.
Entropion, other than Zeigler puncture	7414	347.75	347.75	356.10	361.66
Ectropion, other than Zeigler puncture	7415	347.11	347.11	355.44	360.99
Laceration, full thickness, including margin					
- less than 2cm	7421	173.61	173.61	177.78	180.55
- greater than 2cm	7417	347.11	347.11	355.44	360.99
Suture					
Tarsorrhaphy	7418	115.72	115.72	118.50	120.35
Double adhesion	7419	173.61	173.61	177.78	180.55
Treatment of Trichiasis by electrolysis in the O.R. or by laser oblation of hair follicles	7420	53.29	53.29	54.57	55.42

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
CONJUNCTIVA					
Removal of foreign body - office call fee					
Excision					
Pterygium - unilateral with conjunctival autograph	7450	224.70	224.70	230.09	233.69
Peritomy - unilateral	7451	81.05	81.05	83.00	84.29
Biopsy	7452	34.72	34.72	35.55	36.11
Repair					
Plastic repair - depending on extent	7453	I.C.	I.C.	I.C.	I.C.
LACRIMAL TRACT					
Incision					
Daryocystotomy - general anesthetic	7500	57.78	57.78	59.17	60.09
Excision					
Dacryocystectomy	7502	289.17	289.17	296.11	300.74
Introduction					
Catheterization or irrigation of duct (paid as Visit Fee only)					
Repair					
Lacerated canaliculus	7503	231.23	231.23	236.78	240.48
Dacrocystorrhinostomy	7504	462.83	462.83	473.94	481.34
Manipulation					
Dilation of punctum (paid as Visit Fee only)					
Probing and dilation of duct - Office procedure (paid as Visit Fee only)					
- General anesthetic - initial or repeat, unilateral or bilateral	7505	75.00	75.00	76.80	78.00
Three snip procedure for ectropion of the lower lacrimal punctums (bilateral)	7512	66.29	66.29	67.88	68.94

OPERATIONS ON THE EAR

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

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
EXTERNAL EAR					
Incision					
Drainage of abscess or hematoma of auricle or external ear canal					
- local anesthetic	7700	80.25	80.25	82.18	83.46
- general anesthetic	7701	57.78	57.78	59.17	60.09
Excision					
Biopsy of ear	7702	80.25	80.25	92.10	100.00
Local excision of lesion on ear	7703	57.78	57.78	59.17	60.09
Partial excision of ear	7704	173.61	173.61	177.78	180.55
Complete excision or amputation of ear	7705	231.23	231.23	236.78	240.48
Radical excision of malignant lesion of external ear canal	7706	462.83	462.83	473.94	481.34
Excision of pre-auricular sinus, simple - local anesthetic	7720	81.57	81.57	83.53	84.83
- general anesthetic	7721	163.13	163.13	167.05	169.66
Excision of ear canal Exostosis - single	7913	302.18	302.18	309.43	314.27
- multiple	7914	532.06	532.06	544.83	553.34
Endoscopy					
Removal of foreign body from external ear canal					
- simple	7707	37.45	37.45	38.35	38.95
- under general anesthetic	7708	57.78	57.78	59.17	60.09
Repair					
Reconstruction of ear with graft of skin/cartilage **(Prior approval required)**	7710	I.C.	I.C.	I.C.	I.C.
Construction of ear canal for congenital atresia	7711	809.78	809.78	829.21	842.17
Removal of plastic drainage tubes	7712	20.70	20.70	21.20	21.53
Removal of plastic drainage tubes under general anesthetic	7713	51.47	51.47	52.71	53.53
Fiberoptic endoscopy	7714	19.47	19.47	25.79	30.00
MIDDLE EAR					
Incision					
Myringotomy (without after care) - local anesthetic	7800	34.72	34.72	35.55	36.11
- general anesthetic	7801	69.44	69.44	71.11	72.22
Myringotomy (operative Microscope) and insertion of prosthesis	7802	110.21	110.21	112.86	114.62
Aspiration of serous otitis	7803	23.06	23.06	23.61	23.98
Excision					
Mastoidectomy - simple, unilateral	7804	347.11	347.11	355.44	360.99
- Radical or modified radical, unilateral	7805	578.50	578.50	592.38	601.64
Removal of middle ear polyp by snare (not including post-op care)	7806	46.22	46.22	47.33	48.07
Repair					
Revision of radical mastoid cavity	7807	578.50	578.50	592.38	601.64
Stapes mobilization	7808	578.50	578.50	592.38	601.64
Stapedectomy	7809	809.78	809.78	829.21	842.17
Myringoplasty	7811	347.11	347.11	355.44	360.99
Tympanoplasty	7812	660.67	660.67	676.53	687.10
Facial nerve decompression	7813	578.50	578.50	592.38	601.64
Facial nerve graft	7814	693.90	693.90	710.55	721.66

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Middle ear exploration	7815	347.11	347.11	355.44	360.99
Cleaning of mastoid cavity	7915	68.92	68.92	70.57	71.68
INTERNAL EAR					
Excision					
Labyrinthectomy	7901	693.90	693.90	710.55	721.66
Meatoplasty (may be claimed in addition to a mastoidectomy)	7902	118.18	118.18	121.02	122.91

OPERATIONS ON THE URINARY SYSTEM

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

KIDNEY AND PERINEPHRIUM

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Incision					
Drainage of Kidney abscess, including excision of carbuncle	8000	347.11	347.11	355.44	360.99
Drainage of perinephric abscess	8001	231.23	231.23	236.78	240.48
Adrenal exploration, unilateral	8002	347.11	347.11	355.44	360.99
Renal exploration	8003	347.11	347.11	355.44	360.99
Nephrostomy	8004	404.83	404.83	414.55	421.02
Transection of aberrant renal vessel	8006	404.83	404.83	414.55	421.02
- Secondary operation - additional	8007	115.72	115.72	118.50	120.35
Pyelolithotomy	8009	404.83	404.83	414.55	421.02
- Removal of Staghorn calculus	8030	649.38	649.38	664.97	675.36
Excision					
Adrenalectomy, unilateral	8011	578.50	578.50	592.38	601.64
Functional tumors (pheochromocytoma)	8012	578.50	578.50	592.38	601.64
Renal cyst	8013	404.83	404.83	414.55	421.02
Heminephrectomy	8014	555.28	555.28	568.61	577.49
- Secondary operation - additional	8015	115.72	115.72	118.50	120.35
Nephrectomy					
- Ectopic	8016	462.83	462.83	473.94	481.34
- Lumbar	8017	485.83	485.83	497.49	505.26
- Transperitoneal	8018	462.83	462.83	473.94	481.34
- Thoraco-abdominal	8019	693.90	693.90	710.55	721.66
- Radical nephrectomy - lumbar or thoraco-abdominal	8020	660.67	660.67	676.53	687.10
- Nephro-ureterectomy	8021	578.50	578.50	592.38	601.64
- Nephro-ureterectomy with resection of uretero-vesical junction	8022	693.90	693.90	710.55	721.66
- Secondary operation - additional	8023	115.72	115.72	118.50	120.35
Donor nephrectomy - unilateral or bilateral	8031	463.79	463.79	474.92	482.34
Open renal biopsy	8024	347.11	347.11	355.44	360.99
Needle Biopsy	2176	73.88	73.88	75.65	76.84
Partial removal and reconstruction of kidney for Renal CA	8010	660.67	660.67	676.53	687.10
Repair					
Pyeloureteroplasty	8025	520.56	520.56	533.05	541.38
Nephropexy	8026	347.11	347.11	355.44	360.99
Symphysiotomy for horseshoe kidney +/- nephropexy & assoc.procedures	8028	555.28	555.28	568.61	577.49
Renal auto-transplantation	8032	894.57	894.57	916.04	930.35
Suture					
Ruptured or lacerated kidney - repair or removal	8029	462.83	462.83	473.94	481.34

URETER

Incision					
Peri-ureteral abscess	8100	231.23	231.23	236.78	240.48

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Ureterotomy					
- Upper two-thirds	8102	416.39	416.39	426.38	433.05
- Lower one-third	8103	485.83	485.83	497.49	505.26
Ureterotomy where ureter has been previously opened					
- Upper two-thirds	8125	441.38	441.38	451.97	459.04
- Lower one-third	8126	506.27	506.27	518.42	526.52
Excision					
Ureterectomy	8104	404.83	404.83	414.55	421.02
- including ureterovesical junction	8105	462.83	462.83	473.94	481.34
Repair					
Ureterovesical anastomosis, reimplantation	8106	555.28	555.28	568.61	577.49
Uretero-ileal conduit	8107	693.90	693.90	710.55	721.66
Uretero-ileal conduit with total cystectomy	8108	1,041.16	1,041.16	1,066.15	1,082.81
Uretero-colic anastomosis or transplant	8109	520.56	520.56	533.05	541.38
- with cystectomy, one stage	8110	832.83	832.83	852.82	866.14
- with cystectomy, and colostomy	8111	971.61	971.61	994.93	1,010.47
Ileo-ureteral substitution	8112	693.90	693.90	710.55	721.66
Uretero-ureterostomy	8113	578.50	578.50	592.38	601.64
Ureterostomy,cutaneous-unilateral	8114	347.11	347.11	355.44	360.99
Uretero-vaginal fistula	8115	555.28	555.28	568.61	577.49
Ureterolysis for peri-ureteral fibrosis, unilateral	8116	462.83	462.83	473.94	481.34
Spontaneous or traumataic rupture or transection					
- Immediate - upper two thirds	8118	404.83	404.83	414.55	421.02
- lower one-third	8119	462.83	462.83	473.94	481.34
- Late repair - upper two-thirds	8120	462.83	462.83	473.94	481.34
- lower one-third	8121	520.56	520.56	533.05	541.38
Bladder flap (BOARI) to include re-implantation of ureter	8127	497.02	497.02	508.95	516.90
Revision of ureteral-ileal anastomosis	8128	434.96	434.96	445.40	452.36
Partial resection and revision of ileal conduit	8129	397.72	397.72	407.27	413.63
Endoscopic procedures					
Calibration and/or dilation (one or both sides)	8122	101.65	101.65	104.09	105.72
Endoscopic removal of calculus +/- ureteral meatotomy (Basket extraction)	8123	294.25	294.25	301.31	306.02
Manipulation only, stone not removed	8124	171.20	171.20	175.31	178.05
Insertion of ureteral stent	8199	278.20	278.20	284.88	289.33
BLADDER					
Endoscopy - Cystoscopy					
Diagnostic - with or without catheterization of ureters, collection of ureteral specimens of urine, intravenous function test, but not including subsequent hospital care	8200	101.65	101.65	104.09	105.72
- With biopsy (transurethral)	8202	171.20	171.20	175.31	178.05
- With electrocoagulation of tumor - single	8203	171.20	171.20	175.31	178.05
- multiple	8204	214.00	214.00	219.14	222.56
- With urethral dilation	8205	110.00	110.00	112.64	114.40
- With bladder dilation	8206	171.20	171.20	175.31	178.05
- With electrocoagulation of Hunner's ulcers	8207	171.20	171.20	175.31	178.05
- With electro-excision of tumor(s) including base & adjacent muscle					
- single	8208	308.37	308.37	315.77	320.70
- multiple	8209	449.40	449.40	460.19	467.38
- With electrosurgical ureteral meatotomy	8211	192.60	192.60	197.22	200.30

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
- With removal of foreign body or calculus	8212	214.00	214.00	219.14	222.56
- With litholapaxy, visual or tactile and removal of fragments	8214	264.29	264.29	270.63	274.86
- With urethral meatotomy and plastic repair	8215	171.20	171.20	175.31	178.05
- With insertion of ureteral stent	8199	278.20	278.20	284.88	289.33
- With brush biopsy of the ureter and renal pelvis	8198	214.00	214.00	219.14	222.56
- With retrograde pyelogram	8242	92.50	92.50	118.00	135.00
- Wtih intravesical Botox injections (1 or more)	8250	214.00	214.00	219.14	222.56
Incision					
Cystotomy or cystostomy	8216	173.61	173.61	177.78	180.55
Cystotomy or cystostomy and electro-coagulation of tumor	8217	347.11	347.11	355.44	360.99
Cystotomy with trochar and cannula and insertion of tube	8218	115.72	115.72	118.50	120.35
Cystolithotomy	8219	231.23	231.23	236.78	240.48
Excision					
Cystectomy, partial - for atony	8223	462.83	462.83	473.94	481.34
- for tumor or diverticulum	8224	520.56	520.56	533.05	541.38
- with reimplantation of ureter	8225	578.50	578.50	592.38	601.64
Cystectomy, complete without transplant	8226	578.50	578.50	592.38	601.64
Cystectomy, complete with colocystoplasty	8227	925.50	925.50	947.71	962.52
- Second surgeon	8228	231.23	231.23	236.78	240.48
Excision of urachus and repair of bladder	8229	289.17	289.17	296.11	300.74
Therapeutic pelvic & retroperitoneal lymphadenectomy for bladder cancer	8243	652.43	652.43	668.09	678.53
Repair					
Extrophy					
- primary closure	8230	347.11	347.11	355.44	360.99
- urinary diversion for bladder extrophy and excision of ectopic bladder and repair of abdominal wall	8231	925.50	925.50	947.71	962.52
- excision of bladder and repair of abdominal wall	8232	347.11	347.11	355.44	360.99
Repair of ruptured bladder	8233	416.39	416.39	426.38	433.05
Ileocystoplasty or colocystoplasty	8234	693.90	693.90	710.55	721.66
Closure of fistula					
- external,suprapubic	8239	277.56	277.56	284.22	288.66
- Vesicovaginal-transvesical approach	8240	555.28	555.28	568.61	577.49
- Vesicorectal or vesicosigmoid	8241	462.83	462.83	473.94	481.34
URETHRA					
Endoscopy					
Biopsy including endoscopy	8300	92.50	92.50	94.72	96.20
Internal urethrotomy	8301	138.83	138.83	142.16	144.38
Removal of foreign body or calculus	8302	173.61	173.61	177.78	180.55
Meatal extraction of foreign body	8303	37.45	37.45	38.35	38.95
Incision					
Urethrotomy - external	8304	277.56	277.56	284.22	288.66
Cold Knife (visual) internal urethrotomy	8197	228.98	228.98	234.48	238.14
Meatotomy and plastic repair	8305	81.05	81.05	83.00	84.29
Periurethral abscess	8308	57.78	57.78	59.17	60.09
External sphincterotomy (transurethral)	8335	324.69	324.69	332.48	337.68
Excision					
Caruncle	8309	81.05	81.05	83.00	84.29
- with cystoscopy	8310	138.83	138.83	142.16	144.38
Urethral papilloma, single or multiple	8311	138.83	138.83	142.16	144.38

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Prolapse	8312	92.50	92.50	94.72	96.20
- with cystoscopy	8313	138.83	138.83	142.16	144.38
Stricture - one stage with diversion	8314	416.39	416.39	426.38	433.05
- two stage - first stage	8315	208.17	208.17	213.17	216.50
- second stage	8316	416.39	416.39	426.38	433.05
Diverticulectomy - male or female	8317	289.17	289.17	296.11	300.74
Posterior urethral valve - by endoscopy	8318	115.72	115.72	118.50	120.35
- open operation	8319	289.17	289.17	296.11	300.74
Biopsy	8320	34.72	34.72	35.55	36.11
Urethrectomy	8334	428.00	428.00	438.27	445.12
Repair					
Urethral sling	8321	347.11	347.11	355.44	360.99
Urethrovesical suspension for stress incontinence	8322	416.39	416.39	426.38	433.05
Urethrovesical suspension with partial cystectomy or vesicopexy	8323	555.28	555.28	568.61	577.49
Transvaginal Tape (TVT) procedure (including cystoscopy)	6639	502.90	502.90	514.97	523.02
Urethrolysis (includes cystoscopy)	8339	374.50	374.50	383.49	389.48
Suture					
Rupture - anterior urethra (diversion of urine extra)	8324	277.56	277.56	284.22	288.66
- posterior urethra - immediate repair	8325	485.83	485.83	497.49	505.26
- late repair	8326	636.33	636.33	651.60	661.78
Recto-urethral fistula	8328	462.83	462.83	473.94	481.34
- with colostomy	8329	578.50	578.50	592.38	601.64
Urethro-cutaneous fistula	8333	277.56	277.56	284.22	288.66
Manipulation					
Dilation of stricture - local anesthetic	8330	23.06	23.06	23.61	23.98
- general anesthetic	8331	57.78	57.78	59.17	60.09
- filiforms and followers	8332	41.89	41.89	42.90	43.57
Insertion of artificial urinary sphincter	8336	642.00	642.00	657.41	667.68
PERCUTANEOUS PROCEDURES					
Percutaneous Renal & Upper Ureteric procedures					
Renal/Upper ureteral stone removal - single stone					
- without electrohydraulic or ultrasonic lithotripsy	8592	500.23	500.23	512.24	520.24
- with electrohydraulic and/or ultrasonic lithotripsy	8593	600.22	600.22	614.63	624.23
Renal/Upper ureteral stone removal - multiple stones or staghorn					
- without electrohydraulic or ultrasonic lithrotripsy	8594	600.22	600.22	614.63	624.23
- with electrohydraulic and/or ultrasonic lithotripsy	8595	800.20	800.20	819.40	832.21
Repeat through original access within one week for any of the above	8596	400.23	400.23	409.84	416.24
Percutaneous nephrostomy	8597	160.13	160.13	163.97	166.54
Percutaneous endopyeloplasty for UPJ obstruction/stenosis	8033	277.56	277.56	284.22	288.66
Percutaneous Lower Ureteric procedures					
Ureteroscopy only	8588	100.95	100.95	202.38	270.00
Ureteroscopy with electrohydraulic and/or ultrasonic lithotripsy	8598	600.22	600.22	614.63	624.23
Ureteroscopy plus basket	8599	500.23	500.23	512.24	520.24
Extracorporeal Shockwave Lithotripsy (ESWL)					
ESWL - one side, one stone	8040	385.20	385.20	394.44	400.61
ESWL - one side, multiple stones	8041	577.80	577.80	591.67	600.91
ESWL - bilateral stones, one stone per side	8042	642.00	642.00	657.41	667.68
ESWL - bilateral stones, multiple stones per side	8043	936.25	936.25	958.72	973.70

OPERATIONS ON THE MALE REPRODUCTIVE SYSTEM

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

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
PENIS					
Incision					
Split of prepuce - newborn	8400	11.61	11.61	11.89	12.07
- child or infant	8401	12.84	12.84	13.15	13.35
- adult	8402	25.68	25.68	26.30	26.71
Excision					
Circumcision - infant over 10 days or child under 12 years	8404	138.55	138.55	160.42	175.00
- adult	8405	138.10	138.10	160.24	175.00
Condylomata	8406	57.78	57.78	59.17	60.09
Biopsy	8407	46.22	46.22	47.33	48.07
Amputation					
- Partial	8408	208.17	208.17	213.17	216.50
- Partial with inguinal glands dissection - 1 or 2 stages	8409	555.28	555.28	568.61	577.49
- Total with inguinal and femoral glands dissection - 1 or 2 stages	8410	693.90	693.90	710.55	721.66
Repair					
Epispadias	8411	347.11	347.11	355.44	360.99
Hypospadias - including urinary diversion					
- Chordee repair	8412	231.23	231.23	236.78	240.48
Plastic reconstruction urethra, penile - one stage	8413	347.11	347.11	355.44	360.99
- two stage	8414	462.83	462.83	473.94	481.34
Plastic reconstruction penoscrotal or perineal - one stage	8415	462.83	462.83	473.94	481.34
- two stage	8416	578.50	578.50	592.38	601.64
Penile prosthesis for impotence **(Prior approval required)**	8417	328.01	328.01	335.88	341.13
Insertion of hydraulic penile prosthesis	8420	401.73	401.73	411.37	417.80
Removal of infected penile prosthesis	8422	267.50	267.50	273.92	278.20
Excision of Peyronie's plaque	8418	208.76	208.76	213.77	217.11
Nesbitt procedure for Peyronie's disease	8337	577.80	577.80	591.67	600.91
Intracorporeal injections of vasoactive substances for impotence (Dx & Tx)	8419	15.52	15.52	15.89	16.14
TESTES					
Incision					
Abscess	8500	57.78	57.78	59.17	60.09
Excision					
Orchidectomy, unilateral	8501	208.17	208.17	213.17	216.50
Biopsy - single	8502	57.78	57.78	59.17	60.09
- with vasography	8503	115.72	115.72	118.50	120.35
Radical orchidectomy for malignancy - unilateral	8508	321.00	321.00	328.70	333.84
Repair					
Orchidopexy or exploration, unilateral	8504	396.33	396.33	405.84	412.18
Reduction of torsion of testis or appendix testis and repair	8505	208.17	208.17	213.17	216.50
Ruptured testicle	8506	208.17	208.17	213.17	216.50
Insertion of testicular prosthesis **(Prior approval required for age 18 yrs & over)**	8507	172.27	172.27	176.40	179.16
Retroperitoneal lymphadenectomy for testicular cancer	8421	I.C.	I.C.	I.C.	I.C.

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
EPIDIDYMIS					
Incision					
Abscess	8510	57.78	57.78	59.17	60.09
Excision					
Spermatocele	8511	208.17	208.17	213.17	216.50
Epididymectomy, unilateral	8512	208.17	208.17	213.17	216.50
Anastomosis, epididymovasostomy, unilateral	8513	208.17	208.17	213.17	216.50
TUNICA VAGINALIS					
Excision					
Hydrocele - unilateral	8520	198.22	198.22	202.98	206.15
Hydrocele - aspiration	8521	23.06	23.06	23.61	23.98
SCROTUM					
Incision					
Abscess or hematocele	8530	57.78	57.78	59.17	60.09
Exploration, unilateral	8531	138.83	138.83	142.16	144.38
Excision					
Minor lesions, e.g. sebaceous cysts, fibromata, etc	3035	40.66	40.66	61.26	75.00
Resection of scrotum	8533	231.23	231.23	236.78	240.48
Suture					
Trauma - laceration, depending on extent and complications	8534	I.C.	I.C.	I.C.	I.C.
VAS DEFERENS					
Vasography, single procedure	8540	57.78	57.78	59.17	60.09
Suture					
Ligation, bilateral (vasectomy)	8543	141.24	141.24	152.50	160.00
SPERMATIC CORD					
Excision					
Varicocele, unilateral	8550	208.17	208.17	213.17	216.50
Hydrocele, unilateral	8551	208.17	208.17	213.17	216.50
SEMINAL VESICLES					
Incision					
Abscess	8560	115.72	115.72	118.50	120.35
Excision					
Vesiculectomy	8561	578.50	578.50	592.38	601.64
PROSTATE					
Incision					
Biopsy - perineal open operation	8572	231.23	231.23	236.78	240.48
- needle, perineal	2182	84.53	84.53	86.56	87.91
- needle, perineal with cystoscopy	8574	138.83	138.83	142.16	144.38
- ultrasound guided transrectal (1 billing per procedure)	8582	130.00	130.00	133.12	135.20
Excision					
Prostatectomy					
Radical prostatovesiculectomy	8577	832.83	832.83	852.82	866.14

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Suprapubic - one stage or two stages	8578	555.28	555.28	568.61	577.49
- with diverticulectomy	8579	693.90	693.90	710.55	721.66
- with partial cystectomy for atony of bladder	8580	693.90	693.90	710.55	721.66
Retropubic - simple	8581	550.62	550.62	563.83	572.64
Staging pelvic lymphadenectomy for Carcinoma of prostate	8591	328.01	328.01	335.88	341.13
Endoscopy					
Transurethral electro-resection (TURP)	8584	550.62	550.62	563.83	572.64
Resection of bladder neck - adult	8587	347.11	347.11	355.44	360.99
Change of suprapubic tube	8590	23.06	23.06	23.61	23.98

DIAGNOSTIC IMAGING

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

These are the fees for consultation between the Certified Diagnostic Radiologist and the referring physician, supervision of x-ray service, fluoroscopy, interpretation of radiographs and fluoroscopic findings. This does not include special procedural fees listed separately in the schedule.

NOTE: Fees for Clinical procedures related to x-ray examination are listed under 'Special Procedural Fee' or under the appropriate Specialty section.

NOTE: Where cine or videotape is used, fee is to be increased by 25%.

NOTE: Non-certified Radiologists are paid at 75% of following fees.

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
ON-CALL RETAINER - Radiology (Provincial)	1540	300.00	300.00	300.00	300.00
HOSPITAL ON-CALL RESPONSE FEE - see Preamble 11.E	0060	150.00	150.00	153.60	156.00
ADMINISTRATIVE MEETING - See Preamble 32 (per 15 minutes)	0050	40.00	40.00	50.00	50.00
ADDITIONAL FEE FOR EMERGENCY STUDIES	8859	24.77	24.77	25.36	25.76
FLUOROSCOPY - per 15 minute block	8860	45.00	45.00	46.08	46.80
SPECIAL DETENTION - per 15 minute block	8871	45.00	45.00	46.08	46.80

PLAIN FILMS

HEAD AND NECK

Eye for foreign body	8600	7.81	7.81	8.00	8.12
Eye for localization additional	8601	20.92	20.92	21.42	21.76
Optic Foramina	8602	7.81	7.81	8.00	8.12
Facial bones	8603	11.61	11.61	11.89	12.07
Mandible	8604	7.81	7.81	8.00	8.12
Mastoids necessary added views	8605	11.45	11.45	11.72	11.91
Neck for soft tissues	8606	8.61	8.61	8.82	8.95
Nasal bones	8607	10.59	10.59	10.84	11.01
Salivary gland region	8608	7.81	7.81	8.00	8.12
Sella turcica	8609	6.37	6.37	6.52	6.62
Sinuses paranasal	8610	10.11	10.11	10.35	10.51
Skull - routine views	8611	11.77	11.77	12.05	12.24
Skull - special additional views	8612	6.37	6.37	6.52	6.62
Teeth - up to half set	8613	6.37	6.37	6.52	6.62
Teeth - full set	8614	10.54	10.54	10.79	10.96
Temperomandibular joint	8615	8.35	8.35	8.55	8.68
Internal auditory meati	8616	10.54	10.54	10.79	10.96

SPINE AND PELVIS

Cervical spine - routine views	8620	11.50	11.50	11.78	11.96
Cervical spine - with special added views	8621	13.59	13.59	13.92	14.13
Thoracic spine	8622	9.42	9.42	9.65	9.80

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Lumbar spine - routine views	8623	11.50	11.50	11.78	11.96
Lumbar spine - with special added views	8624	12.57	12.57	12.87	13.07
Sacrum and/or coccyx	8625	7.81	7.81	8.00	8.12
Pelvis	8626	8.61	8.61	8.82	8.95
S.I. Joints	8627	8.61	8.61	8.82	8.95
Complete spine scoliosis series	8628	19.85	19.85	20.33	20.64
Ribs each side	8629	7.86	7.86	8.05	8.17
Sternum	8630	7.81	7.81	8.00	8.12
EXTREMITIES					
Clavicle	8635	8.72	8.72	8.93	9.07
Sternoclavicular joints	8636	7.81	7.81	8.00	8.12
Shoulder	8637	8.72	8.72	8.93	9.07
Scapula	8638	7.81	7.81	8.00	8.12
Humerus	8639	8.72	8.72	8.93	9.07
Elbow	8640	8.72	8.72	8.93	9.07
Forearm	8641	8.72	8.72	8.93	9.07
Wrist	8642	8.56	8.56	8.77	8.90
Hand	8643	8.56	8.56	8.77	8.90
Finger	8644	4.12	4.12	4.22	4.28
Acromioclavicular joints with weights	8645	10.54	10.54	10.79	10.96
Hip	8646	8.61	8.61	8.82	8.95
Hip pinning - interpretation	8647	8.77	8.77	8.98	9.12
Hip pinning - supervision and interpretation	8648	31.24	31.24	31.99	32.49
Femur	8649	8.61	8.61	8.82	8.95
Orthoroentgenogram	8650	9.31	9.31	9.53	9.68
Knee	8651	8.83	8.83	9.04	9.18
Tibia & Fibula	8652	8.72	8.72	8.93	9.07
Ankle	8653	8.56	8.56	8.77	8.90
Calcaneus	8654	8.56	8.56	8.77	8.90
Foot	8655	8.56	8.56	8.77	8.90
Toe	8656	4.12	4.12	4.22	4.28
Bone age determination	8657	10.54	10.54	10.79	10.96
Metastatic series: chest, skull, spine, pelvis & thorax	8658	20.92	20.92	21.42	21.76
Metabolic bone survey: skull,mandible,hands,knees,abdomen,thorax,pelvis	8659	20.92	20.92	21.42	21.76
All long bones (additional to metastatic series)	8660	4.98	4.98	5.10	5.18
Special additional views of extremity	8661	3.64	3.64	3.73	3.79
Feet - weight bearing	8662	6.63	6.63	6.79	6.90
CHEST					
Single view	8665	6.47	6.47	6.63	6.73
Multiple views	8666	11.56	11.56	11.84	12.02
Fluoroscopy only	8667	12.57	12.57	12.87	13.07
ABDOMEN					
Survey film	8670	7.86	7.86	8.05	8.17
Multiple films	8671	11.50	11.50	11.78	11.96
G.I.TRACT					
Barium swallow - pharynx & esophagus	8675	24.88	24.88	25.48	25.88

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Upper G.I. series - esophagus, stomach & duodenum	8676	38.41	38.41	39.33	39.95
Upper G.I. series & small bowel study	8677	53.66	53.66	54.95	55.81
Colon - barium only	8678	28.36	28.36	29.04	29.49
Colon - double contrast	8679	40.13	40.13	41.09	41.74
Cholecystogram	8680	9.31	9.31	9.53	9.68
T-tube cholangiogram (fluoroscopy additional)	8681	15.68	15.68	16.06	16.31
Operative cholangiogram	8682	10.54	10.54	10.79	10.96
Percutaneous transhepatic cholangiogram (interpretation only)	8684	20.92	20.92	21.42	21.76
- Fluoroscopy additional	8685	10.54	10.54	10.79	10.96
Hypotonic duodenogram	8686	24.88	24.88	25.48	25.88
Insertion of a catheter in duodenum for small bowel enema					
- procedure	8688	53.82	53.82	55.11	55.97
- interpretation	8689	9.10	9.10	9.32	9.46
G.U. TRACT					
Survey film	8690	4.98	4.98	5.10	5.18
Retrograde pyelogram	8691	9.31	9.31	9.53	9.68
Intravenous pyelogram (excluding injection fee)	8692	31.83	31.83	32.59	33.10
Pyelogram special technique - hypertensive	8695	26.11	26.11	26.74	27.15
Stress or voiding cystogram	8696	20.92	20.92	21.42	21.76
Stress or voiding cystogram with urethrogram	8697	24.88	24.88	25.48	25.88
Urethrogram and/or cystogram (interpretation)	8698	9.31	9.31	9.53	9.68
T-tube pyelogram (fluoroscopy additional)	8700	9.31	9.31	9.53	9.68
Renal cystography	8701	12.41	12.41	12.71	12.91
Retrograde pyelogram - procedure	8702	30.71	30.71	31.45	31.94
Nephrostogram - procedure	8703	30.71	30.71	31.45	31.94
- interpretation	8704	9.10	9.10	9.32	9.46
Catheter Cystourethrogram (CUG)	8711	24.45	24.45	25.04	25.43
OBSTETRICS AND GYNECOLOGY					
Survey films	8705	5.03	5.03	5.15	5.23
Hysterosalpingogram	8708	18.83	18.83	19.28	19.58
VASCULAR					
Peripheral Arteriography & Venography					
- Unilateral	8715	16.69	16.69	17.09	17.36
- Bilateral	8716	23.17	23.17	23.73	24.10
Aortography	8717	41.62	41.62	42.62	43.28
- Each selective examination in addition to aortography	8718	24.88	24.88	25.48	25.88
Translumbar aortogram	8721	19.74	19.74	20.21	20.53
Arch aortogram	8727	31.24	31.24	31.99	32.49
Splenoportogram	8728	24.88	24.88	25.48	25.88
Lymphangiogram	8729	24.88	24.88	25.48	25.88
Selective angiography	8730	31.24	31.24	31.99	32.49
Carotid arteriogram - unilateral	8731	31.24	31.24	31.99	32.49
- bilateral	8734	41.62	41.62	42.62	43.28
SPECIAL EXAMINATIONS					
Loopogram	8744	39.86	39.86	40.82	41.45
Arthrogram	8745	24.88	24.88	25.48	25.88

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Fistula or sinus with contrast medium (excluding fluoroscopy)	8749	12.57	12.57	12.87	13.07
Laminography, Planography, Tomography (excluding plane film studies)					
- One plane	8750	19.21	19.21	19.67	19.98
- Two planes	8751	26.11	26.11	26.74	27.15
Mammography Screening (bilateral)	8739	28.60	28.60	29.29	29.74
Mammography - unilateral	8740	16.10	16.10	16.49	16.74
- bilateral	8741	38.52	38.52	39.44	40.06
- additional views	8742	3.85	3.85	3.94	4.00
- tumor localization	8790	150.66	150.66	154.28	156.69
Stereotactic Breast Biopsy	8743	147.66	147.66	151.20	153.57
Myelogram - Lumbar	8754	24.88	24.88	25.48	25.88
- Dorsal	8755	19.74	19.74	20.21	20.53
- Cervical	8756	19.74	19.74	20.21	20.53
- Complete	8757	41.30	41.30	42.29	42.95
Sialogram	8759	12.57	12.57	12.87	13.07
Fluoroscopy only	8762	12.57	12.57	12.87	13.07
Interpretation of submitted films	8763	12.57	12.57	12.87	13.07
ULTRA SOUND PROCEDURES					
B Mode Scan (interpretation) - pelvic	8766	44.20	44.20	45.26	45.97
B Mode Scan (interpretation) - abdominal	8791	54.90	54.90	56.22	57.10
B Mode Scan (obstetrics)	8767	51.58	51.58	52.82	53.64
M Mode Scan interpretation	8768	58.85	58.85	60.26	61.20
Doppler Interpretation	8769	53.50	53.50	54.78	55.64
Ultrasonography (procedures done by radiologist)	8770	82.60	82.60	84.58	85.90
Sonohysterogram - composite fee	8793	90.95	90.95	93.13	94.59
CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC IMAGING EXAMINATIONS					
1. These procedural fees are intended to cover compensation for the professional service or placing an instrument and introducing contrast media (except oral or rectal administration for study of the alimentary tract).					
2. The same fee may be charged for similar services associated with diagnostic physiological studies of non-radiological nature e.g. catheterization for physiological sampling or the transmission of pressure, sound or electrical waves. In such cases, separate fees are listed for the performance of the physiological studies and their interpretation.					
Peripheral angiogram	4630	115.72	115.72	118.50	120.35
Thoracic or abdominal angiogram - see Vascular fee schedule					
Myelogram - Lumbar	2172	73.88	73.88	75.65	76.84
Cystogram	2700	34.72	34.72	35.55	36.11
Arthrogram	2701	34.72	34.72	35.55	36.11
Bronchogram	2702	46.22	46.22	47.33	48.07
Sialogram	2705	46.22	46.22	47.33	48.07
Hysterosalpingogram	2706	69.44	69.44	71.11	72.22
Percutaneous transhepatic cholangiogram	2708	81.05	81.05	83.00	84.29
Lymphogram	2709	115.72	115.72	118.50	120.35

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Percutaneous Procedures					
Percutaneous aspiration of renal cyst under imaging guidance	8771	95.55	95.55	97.84	99.37
Percutaneous aspiration of renal cyst with sclerosing injection	8772	119.41	119.41	122.28	124.19
Percutaneous biopsy of solid masses using ultrasound or fluoroscopy	8773	119.41	119.41	122.28	124.19
Percutaneous nephrostomy tube insertion under ultrasound or fluoroscopy	8774	191.21	191.21	195.80	198.86
Percutaneous diagnostic tap of fluid collection	8775	95.55	95.55	97.84	99.37
Percutaneous insertion drainage tube into fluid collection (excl.nephrostomy)	8776	143.43	143.43	146.87	149.17
Aspiration of renal cyst	8777	119.41	119.41	122.28	124.19
Percutaneous biliary drainage	8778	278.20	278.20	284.88	289.33
Change of biliary drainage catheter	8779	96.30	96.30	98.61	100.15
Biliary stricture dilatation/stent	8780	139.10	139.10	142.44	144.66
Angiography					
Arch aortogram	8900	113.53	113.53	116.25	118.07
- One selective off arch	8901	56.66	56.66	58.02	58.93
- Two selective off arch	8902	113.53	113.53	116.25	118.07
Abdominal aortogram	8903	113.53	113.53	116.25	118.07
- One selective off aorta	8904	56.66	56.66	58.02	58.93
- Two selective off aorta	8905	113.53	113.53	116.25	118.07
Femoral arteriogram - unilateral	8906	56.66	56.66	58.02	58.93
- bilateral	8907	90.63	90.63	92.81	94.26
Arteriogram - Selective	8908	113.53	113.53	116.25	118.07
Percutaneous needle aspiration biopsy	8909	118.13	118.13	120.97	122.86
Percutaneous transhepatic cholangiogram	8910	72.55	72.55	74.29	75.45
Arterial embolization (includes arteriogram)	8911	166.87	166.87	170.87	173.54
Renins I.V.C.	8912	59.06	59.06	60.48	61.42
Splenoportogram	8913	70.89	70.89	72.59	73.73
Biopsy or renal cyst puncture	8914	94.48	94.48	96.75	98.26
Lymphangiogram - unilateral	8915	204.21	204.21	209.11	212.38
- bilateral	8916	306.13	306.13	313.48	318.38
Angioplasty	8917	236.36	236.36	242.03	245.81
Inferior venacavagram	8918	59.06	59.06	60.48	61.42
Femoral arteriogram papaverine injection with pressure measurement	8919	73.40	73.40	75.16	76.34
Myocardial Perfusion Imaging - rest and stress incl.all assoc. IVs,injections,image manipulations & interpretation)	8794	95.23	95.23	97.52	99.04
NUCLEAR MEDICINE SCANS					
THYROID					
Uptake studies, single or multiple within 2 weeks	8800	29.75	29.75	30.46	30.94
Uptake plus scan	8801	49.54	49.54	50.73	51.52
Perchlorate flush	8802	24.77	24.77	25.36	25.76
Radioactive MIBG scan	8813	58.48	58.48	59.88	60.82
BLOOD VOLUME					
Plasma volume	8803	16.59	16.59	16.99	17.25
Red cell volume	8804	16.59	16.59	16.99	17.25
Repeated plasma volume studies, each	8805	8.35	8.35	8.55	8.68
Plasma iron clearance and turnover	8806	24.77	24.77	25.36	25.76
Iron red cell utilization	8807	24.77	24.77	25.36	25.76

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
Red cell survival	8808	33.01	33.01	33.80	34.33
Sequestration studies	8809	33.01	33.01	33.80	34.33
Electrolyte spaces	8810	33.01	33.01	33.80	34.33
Other complex tests	8811	I.C.	I.C.	I.C.	I.C.
RENAL FUNCTION					
Pertechnetate Scan	8812	24.88	24.88	25.48	25.88
Hippuran renogram	8815	29.75	29.75	30.46	30.94
Renal scan	8816	24.77	24.77	25.36	25.76
Combination of scan with renogram	8817	49.54	49.54	50.73	51.52
Other radioactive materials - uptake and clearance	8818	16.59	16.59	16.99	17.25
Vascular studies using radionuclides	8819	29.75	29.75	30.46	30.94
Other complex tests	8820	I.C.	I.C.	I.C.	I.C.
GASTROINTESTINAL TRACT					
Schilling test	8825	19.90	19.90	20.38	20.70
Schilling test - repeat after intrinsic factor	8826	10.00	10.00	10.24	10.40
Liver scan	8828	39.59	39.59	40.54	41.17
Abdominal scan for ectopic gastric mucosa	8830	39.59	39.59	40.54	41.17
HIDA scan	8834	59.39	59.39	60.82	61.77
Gastric emptying study	8814	48.79	48.79	49.96	50.74
CIRCULATORY SYSTEM					
Spleen scan	8835	39.59	39.59	40.54	41.17
Cardiac scan	8836	33.01	33.01	33.80	34.33
Cardiac output	8837	41.93	41.93	42.94	43.61
Circulation time	8838	16.59	16.59	16.99	17.25
RESPIRATORY SYSTEM					
Lung scan - ventilation or perfusion	8840	49.49	49.49	50.68	51.47
- ventilation and perfusion on same day	8841	79.29	79.29	81.19	82.46
Pulmonary aspiration test	8842	40.66	40.66	41.64	42.29
SKELETAL SYSTEM					
Bone tumor scans	8850	71.37	71.37	73.08	74.22
Metabolic studies	8851	33.01	33.01	33.80	34.33
Bone Densitometry	8852	26.96	26.96	27.61	28.04
OTHER SYSTEMS					
Gallium 67 for abscess localization	8856	49.54	49.54	50.73	51.52
Parathyroid scan	8857	49.49	49.49	50.68	51.47

For multiple isotopes as in liver and pancreas, or lung and liver -
→ Use fee for one study + 50%.

Where electronic memory or data storage and playback is used
and the material studied later for additional information -
→ 50% is added to the fee

SPECT (nuclear scan tomography) - add-on fee	8799	25.00	25.00	25.60	26.00

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
COMPUTED TOMOGRAPHY (CT)					
HEAD - without IV contrast	8925	81.21	81.21	83.16	84.46
- with IV contrast	8926	91.38	91.38	93.57	95.04
- with and without IV contrast	8927	114.76	114.76	117.51	119.35
COMPLEX HEAD* - without IV contrast	8928	80.68	80.68	82.62	83.91
- with IV contrast	8929	94.21	94.21	96.47	97.98
- with and without IV contrast	8930	107.64	107.64	110.22	111.95
*Complex Head CT Scans are meant to be multiplaner (multidirectional) head CT Scans - To include one or more of the following areas: Pituitary Fossa, Posterior Fossa, Internal Auditory Meati, Orbits and related structures, the Temporal bone and its contents and the Tempero Mandibular joints. 8925, 8926 & 8927 not to be billed in addition to those fees for complex head studies.					
NECK - without IV contrast	8931	53.71	53.71	55.00	55.86
- with IV contrast	8932	80.68	80.68	82.62	83.91
- with and without IV contrast	8933	94.21	94.21	96.47	97.98
THORAX - without IV contrast	8934	101.65	101.65	104.09	105.72
- with IV contrast	8935	104.33	104.33	106.83	108.50
- with and without IV contrast	8936	117.38	117.38	120.20	122.08
ABDOMEN - without IV contrast	8937	107.64	107.64	110.22	111.95
- with IV contrast	8938	110.16	110.16	112.80	114.57
- with and without IV contrast	8939	122.19	122.19	125.12	127.08
PELVIS - without IV contrast	8940	107.64	107.64	110.22	111.95
- with IV contrast	8941	110.16	110.16	112.80	114.57
- with and without IV contrast	8942	122.19	122.19	125.12	127.08
EXTREMITIES (one or more) - without IV contrast	8943	53.71	53.71	55.00	55.86
- with IV contrast	8944	80.68	80.68	82.62	83.91
- with and without IV contrast	8945	94.21	94.21	96.47	97.98
SPINE - without IV contrast	8946	107.64	107.64	110.22	111.95
- with IV contrast	8947	110.16	110.16	112.80	114.57
- with and without IV contrast	8948	122.19	122.19	125.12	127.08
CT Guidance of Biopsy	8949	38.73	38.73	39.66	40.28
CT Scan Aborted	8950	13.64	13.64	13.97	14.19

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
MAGNETIC RESONANCE IMAGING (MRI)					
HEAD					
Cranial Multisection SE	8975	78.22	78.22	80.10	81.35
Cranial Repeat, sequence (maximum of 3 repeats)	8976	38.52	38.52	39.44	40.06
E.N.T.					
ENT Multisection SE	8977	78.22	78.22	80.10	81.35
ENT Repeat, sequence (maximum of 3 repeats + GAD)	8978	38.52	38.52	39.44	40.06
THORAX					
Thorax Multisection SE	8979	90.20	90.20	92.36	93.81
MRI Gating*	8980	27.07	27.07	27.72	28.15
Thorax Repeat, sequence (maximum of 3 repeats)	8981	45.15	45.15	46.23	46.96
ABDOMEN					
Abdomen Multisection SE	8982	90.20	90.20	92.36	93.81
Abdomen Repeat, sequence (maximum of 3 repeats)	8983	45.15	45.15	46.23	46.96
PELVIS					
Pelvis Multisection SE	8984	90.20	90.20	92.36	93.81
Pelvis Repeat, sequence (maximum of 4 repeats + GAD)	8985	45.15	45.15	46.23	46.96
EXTREMITIES					
Extremities Multisection SE	8986	78.22	78.22	80.10	81.35
Extremities Repeat, sequence (maximum of 3 repeats)	8987	38.52	38.52	39.44	40.06
SPINE					
Spine(one segment) Multisection SE	8988	72.23	72.23	73.96	75.12
Spine(one segment) Repeat, sequence (maximum of 3 repeats)	8989	36.06	36.06	36.93	37.50
MRI Enhancement*(gadolinium) - includes injection/infusion	8990	42.80	42.80	43.83	44.51
Spectroscopy* - includes injection/infusion	8991	42.80	42.80	43.83	44.51
Three Dimensional MRI acquisition sequence*, including post-processing (minimum of 60 slices; maximum 1 per patient per day)	8992	67.14	67.14	68.75	69.83

(* indicates another fee code will be billed with these fee codes)

	Fee Code	Apr-01 2015	Apr-01 2016	Apr-01 2017	Apr-01 2018
OUT-OF-PROVINCE REFERRAL FEE CODES					
The Out-of-Province Referral Fee Codes are matched to the Department's criteria for approval. The approval criteria were developed in consultation with the P.E.I. Medical Society. Physicians should utilize one of the following fee codes for each out-of-province referral, depending on the reason for the referral:					
1) "The insured (in Prince Edward Island)medical and/or hospital service is not available within the province".					
Service Not Available - Consultation	9401	0.00	0.00	0.00	0.00
Service Not Available - Consultation/Investigation	9402	0.00	0.00	0.00	0.00
Service Not Available - Consultation/Investigation/Treatment	9403	0.00	0.00	0.00	0.00
2) There exists within Prince Edward Island only 1 medical practitioner in the required specialty".					
Only One Specialist - Consultation	9404	0.00	0.00	0.00	0.00
Only One Specialist - Consultation/Investigation	9405	0.00	0.00	0.00	0.00
Only One Specialist - Consultation/Investigation/Treatment	9406	0.00	0.00	0.00	0.00
3) In the opinion of a Prince Edward Island physician and the Medical Director of the Department of Health and Social Services, adequate service is not available within the province".					
Adequate Service Not Available* - Consultation	9407	0.00	0.00	0.00	0.00
Adequate Service Not Available* - Consultation/Investigation	9408	0.00	0.00	0.00	0.00
Adequate Service Not Available* - Consultation/Investigation/Treatment	9409	0.00	0.00	0.00	0.00
4) In the opinion of the Medical Director of the Department of Health and Social Services extenuating circumstances exist and are documented that permit services to be provided in another province or territory".					
Extenuating Circumstances* - Consultation	9410	0.00	0.00	0.00	0.00
Extenuating Circumstances* - Consultation/Investigation	9411	0.00	0.00	0.00	0.00
Extenuating Circumstances* - Consultation/Investigation/Treatment	9412	0.00	0.00	0.00	0.00
***SUPPORTING DOCUMENTATION/COMMENT MUST BE PROVIDED**					
VISITING SPECIALIST SESSIONAL RATE (per hour)	9901	175.00	175.00	179.20	182.00
INDEPENDENT CONSIDERATION	9999	I.C.	I.C.	I.C.	I.C.
Time of day, time spent and comment required.					

TARIFF OF FEES

FEE CODE INDEX

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
0002	OBS - DELIVERY ONLY	599.20	599.20	613.58	623.17
0003	ASSESSMENT OF LABOUR (G.P.)	50.00	50.00	51.20	52.00
0004	ATTEND. COMPLICATED LABOR/DELIVERY & ASSIST AT C/S	599.20	599.20	613.58	623.17
0005	ED SESSIONAL TOP-UP FEE FOR GP SALARY LEVEL 1	80.90	80.90	79.75	78.03
0006	ED SESSIONAL TOP-UP FEE FOR GP SALARY LEVEL 2	78.19	78.19	77.03	75.27
0007	ED SESSIONAL TOP-UP FEE FOR GP SALARY LEVEL 3	74.14	74.14	72.94	71.14
0010	NEW PATIENT FEE (G.P.)	150.00	150.00	0.00	0.00
0015	ONCALL RETAINER - URBAN GP GROUP OF 1	45.00	45.00	54.00	60.00
0016	ONCALL RETAINER - URBAN GP GROUP OF 2	90.00	90.00	108.00	120.00
0017	ONCALL RETAINER - URBAN GP GROUP OF 3	135.00	135.00	162.00	180.00
0018	ONCALL RETAINER - URBAN GP GROUP OF 4	180.00	180.00	216.00	240.00
0019	ONCALL RETAINER - URBAN GP GROUP OF 5 - 7	225.00	225.00	270.00	300.00
0020	ON-CALL RETAINER - CORONER (EAST OR WEST)	150.00	150.00	153.60	156.00
0025	HOSPITALIST TYPE 2 TOP-UP (SALARY LEVEL 1) - 17 BEDS	654.26	654.26	678.30	687.15
0026	HOSPITALIST TYPE 2 TOP-UP (SALARY LEVEL 2) - 17 BEDS	633.96	633.96	657.83	666.44
0027	HOSPITALIST TYPE 2 TOP-UP (SALARY LEVEL 3) - 17 BEDS	603.57	603.57	627.20	635.45
0030	ON-CALL RETAINER - CORRECTIONS	225.00	225.00	270.00	300.00
0034	HOSPITALIST ONCALL RETAINER (HALF-LINE)	112.50	112.50	112.50	112.50
0036	ATTENDING DELIVERY FOR NEONATAL RESUSC	120.00	120.00	122.88	124.80
0037	HOSPITALIST TYPE 2 DAILY SESSIONAL FEE - 09 BEDS	720.00	720.00	737.28	748.80
0038	HOSPITALIST TYPE 1 TOP-UP (SALARY LEVEL 1) - 21 BEDS	574.26	574.26	596.38	603.95
0039	HOSPITALIST TYPE 1 TOP-UP (SALARY LEVEL 2) - 21 BEDS	553.96	553.96	575.91	583.24
0041	HOSPITALIST TYPE 1 TOP-UP (SALARY LEVEL 3) - 21 BEDS	523.57	523.57	545.28	552.25
0042	HOSPITALIST TYPE 1 TOP-UP (SALARY LEVEL 1) - 11 BEDS	300.80	300.80	311.90	315.86
0043	HOSPITALIST TYPE 1 TOP-UP (SALARY LEVEL 2) - 11 BEDS	290.17	290.17	301.18	305.01
0044	HOSPITALIST TYPE 1 TOP-UP (SALARY LEVEL 3) - 11 BEDS	274.25	274.25	285.13	288.78
0045	HOSPITALIST TYPE 2 TOP-UP (SALARY LEVEL 1) - 09 BEDS	346.37	346.37	359.10	363.79
0046	HOSPITALIST TYPE 2 TOP-UP (SALARY LEVEL 2) - 09 BEDS	335.62	335.62	348.26	352.82
0047	HOSPITALIST TYPE 2 TOP-UP (SALARY LEVEL 3) - 09 BEDS	319.53	319.53	332.05	336.41
0050	ADMINISTRATIVE MEETING	40.00	40.00	50.00	50.00
0055	SUBSEQUENT EXTENDED CARE (6th to 13th week inclusive),PER VISIT	30.00	30.00	32.70	34.50
0056	SUBSEQUENT EXTENDED CARE (after 13th week),PER WEEK	30.00	30.00	32.70	34.50
0060	HOSPITAL ON-CALL RESPONSE FEE	150.00	150.00	153.60	156.00
0066	ONCALL RETAINER - OVERFLOW UNAFFILIATED PATIENTS (QEH)	0.00	0.00	100.00	100.00
0071	TELEPHONE CONSULTATION - CEC	41.60	41.60	42.60	43.26
0072	TELEPHONE CONSULTATION - EMS	41.60	41.60	42.60	43.26
0073	ONCALL PER DIEM (IN LIEU OF FFS) - PALLIATIVE CARE (Salaried only)	0.00	0.00	400.00	400.00
0074	MORBID OBESITY PREMIUM - SURGERY	0.00	0.00	100.00	100.00
0075	MORBID OBESITY PREMIUM - ANESTHESIA	0.00	0.00	100.00	100.00
0076	ED SESSIONAL NIGHT PREMIUM - WEEKDAY	0.00	0.00	43.75	43.75
0077	ED SESSIONAL NIGHT PREMIUM - WEEKEND OR HOLIDAY	0.00	0.00	29.75	26.25
0080	HOSPITAL ON-CALL RESPONSE FEE (DENTAL)	150.00			
0081	IMMUNIZATION REPORTING - INFLUENZA	0.00	0.00	0.00	0.00
0082	IMMUNIZATION REPORTING - PNEUMOCOCCAL VACCINE	0.00	0.00	0.00	0.00
0083	IMMUNIZATION REPORTING - TETANUS/PERTUSSIS	0.00	0.00	0.00	0.00
0084	IMMUNIZATION REPORTING - HEPATITIS A/B	0.00	0.00	0.00	0.00
0085	IMMUNIZATION REPORTING - VARICELLA ZOSTER	0.00	0.00	0.00	0.00
0090	ONCALL RETAINER - ON-LINE MEDICAL CONTROL	225.00	225.00	270.00	300.00
0094	WALK-IN CLINIC VISIT	0.00	0.00	25.00	25.00
0100	OBS-INITIAL VISIT	60.00	60.00	61.44	62.40
0101	HOSPITALIST TYPE 2 DAILY SESSIONAL FEE - 17 BEDS	1,360.00	1,360.00	1,392.64	1,414.40

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
0102	HOSPITALIST TYPE 1 DAILY SESSIONAL FEE - 11 BEDS	670.00	670.00	686.08	696.80
0103	OBS-PRENATAL VISIT	35.00	35.00	35.84	36.40
0104	OBS-IN HOSPITAL DAILY CARE	50.00	50.00	51.20	52.00
0105	OBS-POST NATAL VISIT	35.00	35.00	35.84	36.40
0106	HOSPITALIST ALL HOSPITALS	80.00	80.00	81.92	83.20
0107	HOSPITALIST TYPE 1 DAILY SESSIONAL FEE - 21 BEDS	1,280.00	1,280.00	1,310.72	1,331.20
0108	HOSPITALIST ON-CALL RETAINER (FULL-LINE)	225.00	225.00	225.00	225.00
0110	COMPREHENSIVE OFFICE VISIT	60.00	60.00	61.44	62.40
0111	HOSPITALIST SHADOW	0.00	0.00	0.00	0.00
0112	EMERGENCY VISIT - PROVIDERS HOME - DAY	35.00	35.00	35.84	36.40
0113	LIMITED OFFICE VISIT	35.00	35.00	35.84	36.40
0114	EMERGENCY VISIT - PROVIDERS HOME - NIGHT	35.00	35.00	35.84	36.40
0115	WELL BABY CARE	35.00	35.00	35.84	36.40
0116	EMERGENCY.CALL 6PM-8AM SUNDAY OR HOLIDAYS	35.00	35.00	35.84	36.40
0118	EMERGENCY OFFICE CALL - DAY	35.00	35.00	35.84	36.40
0119	EMERGENCY OFFICE CALL - NIGHT	35.00	35.00	35.84	36.40
0120	EMERGENCY OFFICE VISIT - SUNDAY,HOLIDAYS	35.00	35.00	35.84	36.40
0121	HOME DAY VISIT	62.00	62.00	63.49	64.48
0123	BASIC OFFICE VISIT (G.P.)	28.00	28.00	28.00	0.00
0124	HOME VISIT - ADDITIONAL FAMILY MEMBER	31.00	31.00	31.74	32.24
0125	ADDITIONAL FEE FOR STRICT EMERGENCY	25.00	25.00	25.60	26.00
0127	DAY VISIT-8AM-9PM-NURSING HOME,ETC	55.00	55.00	56.32	57.20
0129	EACH ADDITIONAL PATIENT NURSING HOME "ETC"	27.50	27.50	28.16	28.60
0130	INITIAL HOSPITAL VISIT (DAY)	100.00	100.00	109.00	115.00
0132	INITIAL HOSPITAL VISIT- ORPHAN PATIENT	75.00	75.00	81.75	86.25
0133	SUBSEQUENT HOSPITAL VISIT (1st-5th WEEKS)	50.00	50.00	54.50	57.50
0134	SUBSEQUENT HOSPITAL VISIT (6-13th WEEKS)	30.00	30.00	32.70	34.50
0135	SUBSEQUENT HOSPITAL VISIT (AFTER 13th WEEK)	30.00	30.00	32.70	34.50
0136	HOSPITAL DISCHARGE FEE	40.00	40.00	43.60	46.00
0137	G.P. DERMATOLOGY CONSULTATION	80.00	80.00	81.92	83.20
0139	PALLIATIVE CARE - TELEPHONE CALL	15.00	15.00	15.36	15.60
0140	SUPPORTIVE CARE	25.00	25.00	27.25	28.75
0141	HISTORY/PHYSICAL FOR DENTAL	100.00	100.00	109.00	115.00
0142	CONCURRENT CARE	50.00	50.00	54.50	57.50
0143	CONTINUING CARE	50.00	50.00	54.50	57.50
0144	CONVALESC CARE SUBSEQUENT VISIT	50.00	50.00	54.50	57.50
0145	CONVALESCENT CARE INITIAL VISIT	75.00	75.00	81.75	86.25
0146	EXAM BY GP REQUEST BY PSYCHIATRIST	100.00	100.00	109.00	115.00
0147	MEDICAL OFFICER Q.E.H. REHAB	225.00	225.00	270.00	300.00
0148	COMPREHENSIVE PALLIATIVE CARE CONSULT - GP	160.00	160.00	163.84	166.40
0149	PALLIATIVE HOME CARE ADMISSION	120.00	120.00	122.88	124.80
0150	ED SESSIONAL FEE - KINGS COUNTY HOSPITAL	175.00	175.00	175.00	175.00
0152	ED SESSIONAL FEE - WESTERN HOSPITAL	175.00	175.00	175.00	175.00
0155	ED SESSIONAL FEE - QUEEN ELIZABETH HOSPITAL	175.00	175.00	175.00	175.00
0156	ED SESSIONAL FEE - PRINCE COUNTY HOSPITAL	175.00	175.00	175.00	175.00
0158	AMBULATORY DETOX SERVICE	100.00	100.00	102.40	104.00
0159	ON-CALL RETAINER FOR SURGICAL ASSISTANT	300.00	300.00	300.00	300.00
0160	G.P. CONSULTATION	80.00	80.00	81.92	83.20
0162	G.P. REPEAT CONSULTATION	40.00	40.00	40.96	41.60
0163	PALLIATIVE CARE INPATIENT - INITIAL VISIT	100.00	100.00	109.00	115.00
0164	PALLIATIVE CARE INPATIENT - SUBSEQUENT VISIT	50.00	50.00	54.50	57.50
0165	TELEPHONE CONSULTATION - PALLIATIVE CARE	45.00	45.00	46.08	46.80
0167	REPEAT PALLIATIVE CARE CONSULTATION - GP	80.00	80.00	81.92	83.20
0168	COMPREHENSIVE ED VISIT - SAT,SUN,HOLIDAY (DAY)	66.50	66.50	68.10	69.16
0169	COMPREHENSIVE ED VISIT - FRI,SAT,SUN,HOLI (NIGHT)	110.00	110.00	112.64	114.40
0170	DETENTION	45.00	45.00	46.08	46.80
0173	PALLIATIVE HOME CARE VISIT	75.00	75.00	76.80	78.00

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
0174	ONCALL RETAINER - ONCOLOGY BACKUP	100.00	100.00	100.00	100.00
0176	DETENTION-SPECIAL CALL	45.00	45.00	46.08	46.80
0177	ONCALL RETAINER - GP ONCOLOGY	300.00	300.00	300.00	300.00
0179	ONCALL RETAINER - GP PALLIATIVE	300.00	300.00	300.00	300.00
0180	LIMITED ED VISIT - MON-FRI (DAY)	31.50	31.50	32.26	32.76
0181	LIMITED ED VISIT - MON-THURS (NIGHT)	41.00	41.00	41.98	42.64
0182	RESUSCITATION/15 MIN	100.00	100.00	102.40	104.00
0183	RESUSCITATION-SECOND 15 MIN	50.00	50.00	51.20	52.00
0184	RESUS.SUBSEQUENT 15 MIN PERIOD	50.00	50.00	51.20	52.00
0185	ON-CALL RETAINER - SOURIS, STEWART, O'LEARY, KCMH	225.00	225.00	270.00	300.00
0186	COMPREHENSIVE ED VISIT - MON-FRI (DAY)	57.50	57.50	58.88	59.80
0187	COMPREHENSIVE ED VISIT - MON-THURS (NIGHT)	77.50	77.50	79.36	80.60
0190	LIMITED ED VISIT - SAT,SUN,HOLIDAY (DAY)	36.50	36.50	37.38	37.96
0191	LIMITED ED VISIT - FRI,SAT,SUN,HOLIDAY (NIGHT)	61.00	61.00	62.46	63.44
0194	OUT-PATIENT - ADDITIONAL FEE	25.00	25.00	25.60	26.00
0195	COMPLETE EXAM-OUT-PATIENT-55 YRS AND OVER	85.00	85.00	87.04	88.40
0196	OBSERVATION (OUT-PATIENT- OVER 8 HOURS)	50.00	50.00	51.20	52.00
0197	ONCALL RETAINER - HILLSBOROUGH	225.00	225.00	270.00	300.00
0198	ONCALL RETAINER - MT.HERBERT	225.00	225.00	270.00	300.00
0199	ONCALL RETAINER - GP PSYCHIATRY	225.00	225.00	270.00	300.00
0213	ANESTHESIA-FOLLOW-UP VISIT	35.00	35.00	35.84	36.40
0240	RETAINER ANESTHESIA Q.E.H. AND P.C.H.	300.00	300.00	300.00	300.00
0250	CHRONIC PAIN CONSULTATION	103.00	103.00	105.47	107.12
0252	CHRONIC PAIN FOLLOW-UP VISIT	35.00	35.00	35.84	36.40
0260	ANESTHESIA-CONSULTATION	103.00	103.00	105.47	107.12
0265	ANESTHESIA SESSIONAL FEE - FIRST 30 MIN. BLOCK	97.50	97.50	99.84	101.40
0266	CANCELLED SURGERY	100.00	100.00	102.40	104.00
0270	ANESTHESIA (DETENTION)	45.00	45.00	46.08	46.80
0271	ANESTHESIA-INTENSIVE CARE	100.00	100.00	102.40	104.00
0276	ANESTHESIA (DETENTION-SPECIAL)	45.00	45.00	46.08	46.80
0280	ACUTE PAIN SERVICE - INITIATION	103.00	103.00	105.47	107.12
0296	FIRST DAY/INTENSIVE RESPIRATORY CARE	290.00	290.00	296.96	301.60
0297	ANESTHESIA CRIT. CARE - DAY 2-30 INCL, PER DAY	168.00	168.00	172.03	174.72
0298	ANESTHESIA CRIT. CARE - DAY 31 ONWARD, PER DAY	84.00	84.00	86.02	87.36
0310	COMPREHENSIVE OFFICE VISIT	60.00	60.00	61.44	62.40
0311	INITIAL OFFICE VISIT WITH REGIONAL EXAM	35.00	35.00	35.84	36.40
0313	LIMITED OFFICE VISIT	35.00	35.00	35.84	36.40
0321	DAY HOME VISIT-MONDAY TO SATURDAY	62.00	62.00	63.49	64.48
0324	HOME VISIT-ADDITIONAL FAMILY MEMBER	31.00	31.00	31.74	32.24
0325	ADDITIONAL FEE FOR STRICT EMERGENCY	25.00	25.00	25.60	26.00
0330	INITIAL HOSPITAL VISIT	100.00	100.00	109.00	115.00
0333	SUBSEQUENT HOSPITAL VISITS (1ST 5 WEEKS)	50.00	50.00	54.50	57.50
0334	SUBSEQUENT HOSPITAL VISITS (6-13 WEEK)	30.00	30.00	32.70	34.50
0335	SUBSEQUENT HOSPITAL VISITS (AFTER 13th WEEK)	30.00	30.00	32.70	34.50
0341	CONTINUING CARE	50.00	50.00	54.50	57.50
0342	DIRECTIVE CARE	50.00	50.00	54.50	57.50
0350	TELEPHONE CONSULTATION - DERMATOLOGY	45.00	45.00	46.08	46.80
0360	CONSULTATION-INITIAL	103.00	103.00	105.47	107.12
0362	CONSULTATION-SUBSEQUENT	51.50	51.50	52.74	53.56
0368	COMPREHENSIVE ED VISIT - SAT,SUN,HOLIDAY (DAY)	66.50	66.50	68.10	69.16
0369	COMPREHENSIVE ED VISIT - FRI,SAT,SUN,HOLI (NIGHT)	110.00	110.00	112.64	114.40
0370	DETENTION	45.00	45.00	46.08	46.80
0371	INTENSIVE CARE	100.00	100.00	102.40	104.00
0376	DETENTION-SPECIAL CARE	45.00	45.00	46.08	46.80
0380	LIMITED ED VISIT - MON-FRI (DAY)	31.50	31.50	32.26	32.76
0381	LIMITED ED VISIT - MON-THURS (NIGHT)	41.00	41.00	41.98	42.64
0386	COMPREHENSIVE ED VISIT - MON-FRI (DAY)	57.50	57.50	58.88	59.80

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
0387	COMPREHENSIVE ED VISIT - MON-THURS (NIGHT)	77.50	77.50	79.36	80.60
0390	LIMITED ED VISIT - SAT,SUN,HOLIDAY (DAY)	36.50	36.50	37.38	37.96
0391	LIMITED ED VISIT - FRI,SAT,SUN,HOLIDAY (NIGHT)	61.00	61.00	62.46	63.44
0394	OUT-PT-ADDITIONAL FEE FOR STRICT EMERGENCY	25.00	25.00	25.60	26.00
0395	ULTRAVIOLET LIGHT THERAPY	21.40	21.40	21.91	22.26
0410	COMPREHENSIVE OFFICE VISIT	60.00	60.00	61.44	62.40
0411	INITIAL OFFICE VISIT WITH REGIONAL EXAM	35.00	35.00	35.84	36.40
0413	LIMITED OFFICE VISIT	35.00	35.00	35.84	36.40
0420	TELEPHONE CONSULTATION - VASCULAR SURGERY	0.00	0.00	46.08	46.80
0421	DAY HOME VISIT - MONDAY TO SUNDAY	62.00	62.00	63.49	64.48
0424	HOME VISIT - ADDITIONAL FAMILY MEMBER	31.00	31.00	31.74	32.24
0425	ADDITIONAL FEE FOR STRICT EMERGENCY	25.00	25.00	25.60	26.00
0430	INITIAL HOSPITAL VISIT	100.00	100.00	109.00	115.00
0433	SUBSEQUENT HOSPITAL VISITS (1st 5 WEEKS)	50.00	50.00	54.50	57.50
0434	SUBSEQUENT HOSPITAL VISITS (6-13th WEEK)	30.00	30.00	32.70	34.50
0435	SUBSEQUENT HOSPIRAL VISITS (AFTER 13th WEEK)	30.00	30.00	32.70	34.50
0440	RETAINER SURGERY Q.E.H. AND P.C.H.	300.00	300.00	300.00	300.00
0441	CONTINUING CARE	50.00	50.00	54.50	57.50
0442	DIRECTIVE CARE	50.00	50.00	54.50	57.50
0450	TELEPHONE CONSULTATION - GENERAL SURGERY	0.00	0.00	46.08	46.80
0460	CONSULTATION-INITIAL	103.00	103.00	105.47	107.12
0462	CONSULTATION-SUBSEQUENT	51.50	51.50	52.74	53.56
0468	COMPREHENSIVE ED VISIT - SAT,SUN,HOLIDAY (DAY)	66.50	66.50	68.10	69.16
0469	COMPREHENSIVE ED VISIT - FRI,SAT,SUN,HOLI (NIGHT)	110.00	110.00	112.64	114.40
0470	DETENTION	45.00	45.00	46.08	46.80
0471	INTENSIVE CARE	100.00	100.00	102.40	104.00
0476	DETENTION-SPECIAL CALL	45.00	45.00	46.08	46.80
0480	LIMITED ED VISIT - MON-FRI (DAY)	31.50	31.50	32.26	32.76
0481	LIMITED ED VISIT - MON-THURS (NIGHT)	41.00	41.00	41.98	42.64
0486	COMPREHENSIVE ED VISIT - MON-FRI (DAY)	57.50	57.50	58.88	59.80
0487	COMPREHENSIVE ED VISIT - MON-THURS (NIGHT)	77.50	77.50	79.36	80.60
0490	LIMITED ED VISIT - SAT,SUN,HOLIDAY (DAY)	36.50	36.50	37.38	37.96
0491	LIMITED ED VISIT - FRI,SAT,SUN,HOLIDAY (NIGHT)	61.00	61.00	62.46	63.44
0494	OUT-PT-ADDITIONAL FEE FOR STRICT EMERGENCY	25.00	25.00	25.60	26.00
0501	INTERMEDIATE/PROGRESSIVE CARE	132.00	132.00	135.17	137.28
0502	CONCURRENT CARE/DAY	168.00	168.00	172.03	174.72
0503	ONCALL RETAINER - NEUROLOGY	100.00	100.00	100.00	100.00
0504	ONCALL PERDIEM (IN LIEU OF FFS)-INTERNAL MEDICINE (Salaried only)	0.00	0.00	500.00	500.00
0510	INITIAL OFFICE VISIT WITH COMPLETE EXAM	70.00	70.00	71.68	72.80
0512	REPEAT OFFICE VISIT WITH COMPLETE EXAM	70.00	70.00	71.68	72.80
0513	LIMITED OFFICE VISIT	35.00	35.00	35.84	36.40
0521	DAY HOME VISIT - MONDAY TO SUNDAY	62.00	62.00	63.49	64.48
0524	HOME VISIT-ADDITIONAL FAMILY MEMBER	31.00	31.00	31.74	32.24
0525	ADDITIONAL FEE FOR STRICT EMERGENCY	25.00	25.00	25.60	26.00
0530	INITIAL HOSPITAL VISIT	100.00	100.00	109.00	115.00
0533	SUBSEQUENT HOSPITAL VISITS - 1st 5 WEEKS	50.00	50.00	54.50	57.50
0534	SUBSEQUENT HOSPITAL VISITS - 6-13th WEEK	30.00	30.00	32.70	34.50
0535	SUBSEQUENT HOSPITAL VISITS - AFTER 13th WEEK	30.00	30.00	32.70	34.50
0540	RETAINER INTERNAL MEDICINE Q.E.H. AND P.C.H	300.00	300.00	300.00	300.00
0541	CONTINUING CARE	50.00	50.00	54.50	57.50
0542	DIRECTIVE CARE	50.00	50.00	54.50	57.50
0549	ONCALL RETAINER - NEPHROLOGY	300.00	300.00	300.00	300.00
0550	TELEPHONE CONSULT - INTERNIST	45.00	45.00	46.08	46.80
0560	CONSULTATION-INITIAL	190.00	190.00	194.56	197.60
0562	CONSULTATION-SUBSEQUENT	95.00	95.00	97.28	98.80
0563	CONSULTATION-COMPLETE RE EXAM	70.00	70.00	71.68	72.80
0568	COMPREHENSIVE ED VISIT - SAT,SUN,HOLIDAY (DAY)	66.50	66.50	68.10	69.16

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
0569	COMPREHENSIVE ED VISIT - FRI,SAT,SUN,HOLI (NIGHT)	110.00	110.00	112.64	114.40
0570	DETENTION	45.00	45.00	46.08	46.80
0576	DETENTION-SPECIAL CALL	45.00	45.00	46.08	46.80
0580	LIMITED ED VISIT - MON-FRI (DAY)	31.50	31.50	32.26	32.76
0581	LIMITED ED VISIT - MON-THURS (NIGHT)	41.00	41.00	41.98	42.64
0586	COMPREHENSIVE ED VISIT - MON-FRI (DAY)	57.50	57.50	58.88	59.80
0587	COMPREHENSIVE ED VISIT - MON-THURS (NIGHT)	77.50	77.50	79.36	80.60
0590	LIMITED ED VISIT - SAT,SUN,HOLIDAY (DAY)	36.50	36.50	37.38	37.96
0591	LIMITED ED VISIT - FRI,SAT,SUN,HOLIDAY (NIGHT)	61.00	61.00	62.46	63.44
0594	ADDITIONAL FEE FOR STRICT EMERGENCY	25.00	25.00	25.60	26.00
0595	PHYSICIAN IN CHARGE/CRITICAL CARE	290.00	290.00	296.96	301.60
0596	INTENSIVE RESPIRATORY CARE(1st DAY)	168.00	168.00	172.03	174.72
0597	CRITICAL CARE - DAY 2-30 INCLUSIVE, PER DAY	168.00	168.00	172.03	174.72
0598	CRITICAL CARE - DAY 31 ONWARD, PER DAY	84.00	84.00	86.02	87.36
0599	STRESS TEST	85.60	85.60	87.65	89.02
0700	OBS INITIAL VISIT	60.00	60.00	61.44	62.40
0701	ASSESSMENT OF LABOUR (OB/GYN)	50.00	50.00	51.20	52.00
0703	OBS PRENATAL VISIT	35.00	35.00	35.84	36.40
0704	IN HOSPITAL DAILY CARE	50.00	50.00	51.20	52.00
0705	OBS-POST NATAL VISIT	35.00	35.00	35.84	36.40
0710	COMPREHENSIVE OFFICE VISIT	60.00	60.00	61.44	62.40
0711	INITIAL OFFICE VISIT WITH REGIONAL	35.00	35.00	35.84	36.40
0713	LIMITED OFFICE VISIT	35.00	35.00	35.84	36.40
0721	DAY HOME VISIT - MONDAY TO SUNDAY	62.00	62.00	63.49	64.48
0724	HOME VISIT-ADDITIONAL FAMILY MEMBER	31.00	31.00	31.74	32.24
0725	ADDITIONAL FEE FOR STRICT EMERGENCY	25.00	25.00	25.60	26.00
0730	INITIAL HOSPITAL VISIT	100.00	100.00	109.00	115.00
0733	SUBSEQUENT HOSPITAL VISITS - 1st 6 WEEKS	50.00	50.00	54.50	57.50
0734	SUBSEQUENT HOSPITAL VISITS 6th-13th WEEK'S	30.00	30.00	32.70	34.50
0735	SUBSEQUENT HOSPITAL VISITS/AFTER 13th WEEK	30.00	30.00	32.70	34.50
0740	RETAINER OBS/GYN Q.E.H. AND P.C.H.	300.00	300.00	300.00	300.00
0741	CONTINUING CARE	50.00	50.00	54.50	57.50
0742	DIRECTIVE CARE	50.00	50.00	54.50	57.50
0750	TELEPHONE CONSULTATION - OBSTETRICS/GYNECOLOGY SPECIALIST	45.00	45.00	46.08	46.80
0760	CONSULTATION-INITIAL	103.00	103.00	105.47	107.12
0762	CONSULTATION-SUBSEQUENT	51.50	51.50	52.74	53.56
0764	CONSULTATION-REPRODUCTIVE ENDOCRINOLOGY	103.00	103.00	105.47	107.12
0765	REPEAT CONSULT REPRODUCTIVE ENDOCRINOLOGY	51.50	51.50	52.74	53.56
0768	COMPREHENSIVE ED VISIT - SAT,SUN,HOLIDAY (DAY)	66.50	66.50	68.10	69.16
0769	COMPREHENSIVE ED VISIT - FRI,SAT,SUN,HOLI (NIGHT)	110.00	110.00	112.64	114.40
0770	DETENTION	45.00	45.00	46.08	46.80
0771	INTENSIVE CARE	100.00	100.00	102.40	104.00
0776	DETENTION-SPECIAL CALL	45.00	45.00	46.08	46.80
0780	LIMITED ED VISIT - MON-FRI (DAY)	31.50	31.50	32.26	32.76
0781	LIMITED ED VISIT - MON-THURS (NIGHT)	41.00	41.00	41.98	42.64
0786	COMPREHENSIVE ED VISIT - MON-FRI (DAY)	57.50	57.50	58.88	59.80
0787	COMPREHENSIVE ED VISIT - MON-THURS (NIGHT)	77.50	77.50	79.36	80.60
0790	LIMITED ED VISIT - SAT,SUN,HOLIDAY (DAY)	36.50	36.50	37.38	37.96
0791	LIMITED ED VISIT - FRI,SAT,SUN,HOLIDAY (NIGHT)	61.00	61.00	62.46	63.44
0794	OUT-PT-ADDITIONAL FEE FOR STRICT EMERGENCY	25.00	25.00	25.60	26.00
0795	OUT-PT ASSESSMENT FOR COMPLIC PREG/LABOR	103.00	103.00	105.47	107.12
0810	COMPREHENSIVE OFFICE VISIT	60.00	60.00	61.44	62.40
0811	INITIAL OFFICE VISIT WITH REGIONAL EXAM	35.00	35.00	35.84	36.40
0812	SUBSEQUENT VISIT FOR SPECIAL TESTS	60.00	60.00	61.44	62.40
0813	LIMITED OFFICE VISIT	35.00	35.00	35.84	36.40
0821	DAY HOME VISIT - MONDAY TO SUNDAY	62.00	62.00	63.49	64.48
0824	HOME VISIT-ADDITIONAL FAMILY MEMBER	31.00	31.00	31.74	32.24

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
0825	ADDITIONAL FEE FOR STRICT EMERGENCY	25.00	25.00	25.60	26.00
0830	INITIAL HOSPITAL VISIT	100.00	100.00	109.00	115.00
0833	SUBSEQUENT HOSPITAL VISITS - 1st 5 WEEKS	50.00	50.00	54.50	57.50
0834	SUBSEQUENT HOSPITAL VISITS 6-13th WEEK	30.00	30.00	32.70	34.50
0835	SUBSEQUENT HOSPITAL VISITS AFTER 13th WEEK	30.00	30.00	32.70	34.50
0840	RETAINER OPHTHALMOLOGY Q.E.H.	300.00	300.00	300.00	300.00
0841	CONTINUING CARE	50.00	50.00	54.50	57.50
0842	DIRECTIVE CARE	50.00	50.00	54.50	57.50
0850	TELEPHONE CONSULTATION - OPHTHALMOLOGY	0.00	0.00	46.08	46.80
0855	ONCALL PER DIEM (IN LIEU OF FFS) - OPHTHALMOLOGY (Salaried only)	0.00	0.00	500.00	500.00
0860	CONSULTATION-INITIAL	103.00	103.00	105.47	107.12
0862	CONSULTATION-SUBSEQUENT	51.50	51.50	52.74	53.56
0868	COMPREHENSIVE ED VISIT - SAT,SUN,HOLIDAY (DAY)	66.50	66.50	68.10	69.16
0869	COMPREHENSIVE ED VISIT - FRI,SAT,SUN,HOLI (NIGHT)	110.00	110.00	112.64	114.40
0870	DETENTION	45.00	45.00	46.08	46.80
0871	INTENSIVE CARE	100.00	100.00	102.40	104.00
0876	DETENTION-SPECIAL CALL	45.00	45.00	46.08	46.80
0880	LIMITED ED VISIT - MON-FRI (DAY)	31.50	31.50	32.26	32.76
0881	LIMITED ED VISIT - MON-THURS (NIGHT)	41.00	41.00	41.98	42.64
0886	COMPREHENSIVE ED VISIT - MON-FRI (DAY)	57.50	57.50	58.88	59.80
0887	COMPREHENSIVE ED VISIT - MON-THURS (NIGHT)	77.50	77.50	79.36	80.60
0890	LIMITED ED VISIT - SAT,SUN,HOLIDAY (DAY)	36.50	36.50	37.38	37.96
0891	LIMITED ED VISIT - FRI,SAT,SUN,HOLIDAY (NIGHT)	61.00	61.00	62.46	63.44
0894	OUT-PT-ADDITIONAL FEE FOR STRICT EMERGENCY	25.00	25.00	25.60	26.00
0910	COMPREHENSIVE OFFICE VISIT	60.00	60.00	61.44	62.40
0911	INITIAL OFFICE VISIT WITH REGIONAL EXAM	35.00	35.00	35.84	36.40
0913	LIMITED OFFICE VISIT	35.00	35.00	35.84	36.40
0921	DAY HOME VISIT - MONDAY TO SUNDAY	62.00	62.00	63.49	64.48
0924	HOME VISIT-ADDITIONAL FAMILY MEMBER	31.00	31.00	31.74	32.24
0925	ADDITIONAL FEE FOR STRICT EMERGENCY	25.00	25.00	25.60	26.00
0930	INITIAL HOSPITAL VISIT	100.00	100.00	109.00	115.00
0933	SUBSEQUENT HOSPITAL VISITS 1st 5 WEEKS	50.00	50.00	54.50	57.50
0934	SUBSEQUENT HOSPITAL VISITS 6-13th WEEK	30.00	30.00	32.70	34.50
0935	SUBSEQUENT HOSPITAL VISITS AFTER 13th WEEK	30.00	30.00	32.70	34.50
0940	RETAINER ORTHOPEDICS Q.E.H.	300.00	300.00	300.00	300.00
0941	CONTINUING CARE	50.00	50.00	54.50	57.50
0942	DIRECTIVE CARE	50.00	50.00	54.50	57.50
0950	TELEPHONE CONSULTATION - ORTHOPEDICS	45.00	45.00	46.08	46.80
0960	CONSULTATION-INITIAL	103.00	103.00	105.47	107.12
0962	CONSULTATION-SUBSEQUENT	51.50	51.50	52.74	53.56
0968	COMPREHENSIVE ED VISIT - SAT,SUN,HOLIDAY (DAY)	66.50	66.50	68.10	69.16
0969	COMPREHENSIVE ED VISIT - FRI,SAT,SUN,HOLI (NIGHT)	110.00	110.00	112.64	114.40
0970	DETENTION	45.00	45.00	46.08	46.80
0971	INTENSIVE CARE	100.00	100.00	102.40	104.00
0976	DETENTION-SPECIAL CALL	45.00	45.00	46.08	46.80
0980	LIMITED ED VISIT - MON-FRI (DAY)	31.50	31.50	32.26	32.76
0981	LIMITED ED VISIT - MON-THURS (NIGHT)	41.00	41.00	41.98	42.64
0986	COMPREHENSIVE ED VISIT - MON-FRI (DAY)	57.50	57.50	58.88	59.80
0987	COMPREHENSIVE ED VISIT - MON-THURS (NIGHT)	77.50	77.50	79.36	80.60
0990	LIMITED ED VISIT - SAT,SUN,HOLIDAY (DAY)	36.50	36.50	37.38	37.96
0991	LIMITED ED VISIT - FRI,SAT,SUN,HOLIDAY (NIGHT)	61.00	61.00	62.46	63.44
0994	OUT-PATIENT-ADDITIONAL FEE STRICT EMERGENCY	25.00	25.00	25.60	26.00
1010	COMPREHENSIVE OFFICE VISIT	60.00	60.00	61.44	62.40
1011	INITIAL OFFICE VISIT WITH REGIONAL EXAM	35.00	35.00	35.84	36.40
1013	LIMITED OFFICE VISIT	35.00	35.00	35.84	36.40
1021	DAY HOME VISIT	62.00	62.00	63.49	64.48
1024	HOME VISIT-ADDITIONAL FAMILY MEMBER	31.00	31.00	31.74	32.24

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
1025	ADDITIONAL FEE FOR STRICT EMERGENCY	25.00	25.00	25.60	26.00
1030	INITIAL HOSPITAL VISIT	100.00	100.00	109.00	115.00
1033	SUBSEQUENT HOSPITAL VISITS 1st 5 WEEKS	50.00	50.00	54.50	57.50
1034	SUBSEQUENT HOSPITAL VISITS 6-13th WEEK	30.00	30.00	32.70	34.50
1035	SUBSEQUENT HOSPITAL VISITS AFTER 13th WEEK	30.00	30.00	32.70	34.50
1040	RETAINER ENT PROVINCIAL	300.00	300.00	300.00	300.00
1041	CONTINUING CARE	50.00	50.00	54.50	57.50
1042	DIRECTIVE CARE	50.00	50.00	54.50	57.50
1050	TELEPHONE CONSULTATION - OTOLARYNGOLOGY	0.00	0.00	46.08	46.80
1060	CONSULTATION-INITIAL	103.00	103.00	105.47	107.12
1062	CONSULTATION-SUBSEQUENT	51.50	51.50	52.74	53.56
1065	ONCALL PER DIEM (IN LIEU OF FFS) - ENT (Salaried only)	0.00	0.00	500.00	500.00
1068	COMPREHENSIVE ED VISIT - SAT,SUN,HOLIDAY (DAY)	66.50	66.50	68.10	69.16
1069	COMPREHENSIVE ED VISIT - FRI,SAT,SUN,HOLI (NIGHT)	110.00	110.00	112.64	114.40
1070	DETENTION	45.00	45.00	46.08	46.80
1071	INTENSIVE CARE	100.00	100.00	102.40	104.00
1076	DETENTION-SPECIAL CALL	45.00	45.00	46.08	46.80
1080	LIMITED ED VISIT - MON-FRI (DAY)	31.50	31.50	32.26	32.76
1081	LIMITED ED VISIT - MON-THURS (NIGHT)	41.00	41.00	41.98	42.64
1086	COMPREHENSIVE ED VISIT - MON-FRI (DAY)	57.50	57.50	58.88	59.80
1087	COMPREHENSIVE ED VISIT - MON-THURS (NIGHT)	77.50	77.50	79.36	80.60
1090	LIMITED ED VISIT - SAT,SUN,HOLIDAY (DAY)	36.50	36.50	37.38	37.96
1091	LIMITED ED VISIT - FRI,SAT,SUN,HOLIDAY (NIGHT)	61.00	61.00	62.46	63.44
1094	OUT-PT-ADDITIONAL FEE FOR STRICT EMERGENCY	25.00	25.00	25.60	26.00
1095	IMPEDENCE AUDIOMETRY	22.71	22.71	23.26	23.62
1099	MICRODEBRIDEMENT	27.39	27.39	28.05	28.49
1110	INITIAL OFFICE VISIT WITH COMPLETE EXAM	70.00	70.00	71.68	72.80
1111	INITIAL OFFICE VISIT WITH REGIONAL EXAM	35.00	35.00	35.84	36.40
1112	SUBSEQUENT OFFICE VISIT WITH COMPLETE	70.00	70.00	71.68	72.80
1113	LIMITED OFFICE VISIT	35.00	35.00	35.84	36.40
1115	WELL BABY CARE	35.00	35.00	35.84	36.40
1120	TELEPHONE CONSULTATION - PEDIATRIC	45.00	45.00	46.08	46.80
1121	DAY HOME VISIT	62.00	62.00	63.49	64.48
1124	HOME VISIT-ADDITIONAL FAMILY MEMBER	31.00	31.00	31.74	32.24
1125	ADDITIONAL FEE FOR STRICT EMERGENCY	25.00	25.00	25.60	26.00
1130	INITIAL HOSPITAL VISIT DAY	100.00	100.00	109.00	115.00
1133	SUBSEQUENT HOSPITAL VISITS 1st 5 WEEKS	50.00	50.00	54.50	57.50
1134	SUBSEQUENT HOSPITAL VISITS 6-13th WEEK	30.00	30.00	32.70	34.50
1135	SUBSEQUENT HOSPITAL VISITS AFTER 13th WEEK	30.00	30.00	32.70	34.50
1136	ATTENDANCE AT MATERNAL DELIVERY	120.00	120.00	122.88	124.80
1137	PREMATURE CARE - INITIAL VISIT	75.75	75.75	77.57	78.78
1138	PREMATURE CARE-SUB UP TO 3 WEEKS	64.45	64.45	66.00	67.03
1139	PREMATURE CARE-SUB AFTER 3 WEEKS	32.45	32.45	33.23	33.75
1140	RETAINER PEDIATRICS Q.E.H.	300.00	300.00	300.00	300.00
1141	CONTINUING CARE	50.00	50.00	54.50	57.50
1142	DIRECTIVE CARE	50.00	50.00	54.50	57.50
1145	NEONATAL I.C.U.(1st DAY) LEVEL A	350.00	350.00	358.40	364.00
1146	NEONATAL I.C.U.(DAY 2-30 INCL) LEVEL A	175.00	175.00	179.20	182.00
1147	NEONATAL I.C.U. (DAY 31 ONWARD) LEVEL A	116.00	116.00	118.78	120.64
1148	NEONATAL I.C.U.(1st DAY) LEVEL B	240.00	240.00	245.76	249.60
1149	NEONATAL I.C.U.(2nd DAY ONWARD) LEVEL B	85.00	85.00	87.04	88.40
1150	NEONATAL I.C.U.(1st DAY) LEVEL C	200.00	200.00	204.80	208.00
1151	NEONATAL I.C.U.(2nd DAY ONWARD) LEVEL C	70.00	70.00	71.68	72.80
1152	ONCALL PER DIEM (IN LIEU OF FFS) - PEDIATRICS (Salaried only)	0.00	0.00	500.00	500.00
1154	PEDIATRIC CONSULT ICU 1st DAY	290.00	290.00	296.96	301.60
1155	PEDIATRIC INTENSIVE CARE 1st DAY	168.00	168.00	172.03	174.72
1156	PEDIATRIC CRIT. CARE (DAY 2-30 INCL), PER DAY	168.00	168.00	172.03	174.72

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
1157	PEDIATRIC CRIT. CARE (DAY 31 ONWARD) PER DAY	84.00	84.00	86.02	87.36
1160	CONSULTATION-INITIAL	190.00	190.00	194.56	197.60
1162	CONSULTATION-SUBSEQUENT	95.00	95.00	97.28	98.80
1163	CONSULTATION-COMPLETE RE-EXAM	70.00	70.00	71.68	72.80
1168	COMPREHENSIVE ED VISIT - SAT,SUN,HOLIDAY (DAY)	66.50	66.50	68.10	69.16
1169	COMPREHENSIVE ED VISIT - FRI,SAT,SUN,HOLI (NIGHT)	110.00	110.00	112.64	114.40
1170	DETENTION	45.00	45.00	46.08	46.80
1176	DETENTION-SPECIAL CALL	45.00	45.00	46.08	46.80
1179	INTENSIVE CARE	100.00	100.00	102.40	104.00
1180	LIMITED ED VISIT - MON-FRI (DAY)	31.50	31.50	32.26	32.76
1181	LIMITED ED VISIT - MON-THURS (NIGHT)	41.00	41.00	41.98	42.64
1182	ILL NEWBORN-INITIAL HOSPITAL VISIT	54.00	54.00	55.30	56.16
1183	ILL NEWBORN-SUBSEQUENT VISITS 1st 5 WEEKS	11.55	11.55	11.83	12.01
1184	ILL NEWBORN-SUBSEQUENT VISITS 6-13 WEEK	10.50	10.50	10.75	10.92
1185	ILL NEWBORN AFTER 13th WEEK	14.50	14.50	14.85	15.08
1186	COMPREHENSIVE ED VISIT - MON-FRI (DAY)	57.50	57.50	58.88	59.80
1187	COMPREHENSIVE ED VISIT - MON-THURS (NIGHT)	77.50	77.50	79.36	80.60
1190	LIMITED ED VISIT - SAT,SUN,HOLIDAY (DAY)	36.50	36.50	37.38	37.96
1191	LIMITED ED VISIT - FRI,SAT,SUN,HOLIDAY (NIGHT)	61.00	61.00	62.46	63.44
1194	ADDITIONAL FEE FOR STRICT EMERGENCY	25.00	25.00	25.60	26.00
1210	INITIAL OFFICE VISIT WITH COMPLETE EXAM	70.00	70.00	71.68	72.80
1213	LIMITED OFFICE VISIT	35.00	35.00	35.84	36.40
1221	DAY HOME VISIT - MONDAY TO FRIDAY	62.00	62.00	63.49	64.48
1224	HOME VISIT-ADDITIONAL FAMILY MEMBER	31.00	31.00	31.74	32.24
1225	ADDITIONAL FEE FOR STRICT EMERGENCY	25.00	25.00	25.60	26.00
1230	INITIAL HOSPITAL VISIT	100.00	100.00	109.00	115.00
1233	SUBSEQUENT HOSPITAL VISITS 1st 5 WEEKS	50.00	50.00	54.50	57.50
1234	SUBSEQUENT VISIT - 6-13th WEEK	30.00	30.00	32.70	34.50
1235	SUBSEQUENT VISITS AFTER 13th WEEK	30.00	30.00	32.70	34.50
1240	ONCALL RETAINER - PSYCHIATRY	300.00	300.00	300.00	300.00
1241	CONTINUING CARE	50.00	50.00	54.50	57.50
1242	DIRECTIVE CARE	50.00	50.00	54.50	57.50
1250	TELEPHONE CONSULTATION - PSYCHIATRY	0.00	0.00	46.08	46.80
1260	CONSULTATION-INITIAL	205.00	205.00	209.92	213.20
1262	CONSULTATION-SUBSEQUENT	102.50	102.50	104.96	106.60
1263	CONSULTATION-COMPLETE RE-EXAM	70.00	70.00	71.68	72.80
1268	COMPREHENSIVE ED VISIT - SAT,SUN,HOLIDAY (DAY)	66.50	66.50	68.10	69.16
1269	COMPREHENSIVE ED VISIT - FRI,SAT,SUN,HOLI (NIGHT)	110.00	110.00	112.64	114.40
1270	DETENTION	45.00	45.00	46.08	46.80
1276	DETENTION-SPECIAL CALL	45.00	45.00	46.08	46.80
1280	LIMITED ED VISIT - MON-FRI (DAY)	31.50	31.50	32.26	32.76
1281	LIMITED ED VISIT - MON-THURS (NIGHT)	41.00	41.00	41.98	42.64
1286	COMPREHENSIVE ED VISIT - MON-FRI (DAY)	57.50	57.50	58.88	59.80
1287	COMPREHENSIVE ED VISIT - MON-THURS (NIGHT)	77.50	77.50	79.36	80.60
1290	LIMITED ED VISIT - SAT,SUN,HOLIDAY (DAY)	36.50	36.50	37.38	37.96
1291	LIMITED ED VISIT - FRI,SAT,SUN,HOLIDAY (NIGHT)	61.00	61.00	62.46	63.44
1294	ADDITIONAL FEE FOR STRICT EMERGENCY	25.00	25.00	25.60	26.00
1310	COMPREHENSIVE OFFICE VISIT	60.00	60.00	61.44	62.40
1311	INITIAL OFFICE VISIT WITH REGIONAL EXAM	35.00	35.00	35.84	36.40
1313	LIMITED OFFICE VISIT	35.00	35.00	35.84	36.40
1321	DAY HOME VISIT - MONDAY TO SUNDAY	62.00	62.00	63.49	64.48
1324	HOME VISIT-ADDITIONAL FAMILY MEMBER	31.00	31.00	31.74	32.24
1325	ADDITIONAL FEE FOR STRICT EMERGENCY	25.00	25.00	25.60	26.00
1330	INITIAL HOSPITAL VISIT	100.00	100.00	109.00	115.00
1333	SUBSEQUENT HOSPITAL VISITS 1st 5 WEEKS	50.00	50.00	54.50	57.50
1334	SUBSEQUENT HOSPITAL VISITS 6-13 WEEKS	30.00	30.00	32.70	34.50
1335	SUBSEQUENT HOSPITAL VISITS AFTER 13th WEEK	30.00	30.00	32.70	34.50

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
1340	RETAINER UROLOGY Q.E.H.	300.00	300.00	300.00	300.00
1341	CONTINUING CARE	50.00	50.00	54.50	57.50
1342	DIRECTIVE CARE	50.00	50.00	54.50	57.50
1350	TELEPHONE CONSULTATION - UROLOGY	0.00	0.00	46.08	46.80
1360	CONSULTATION-INITIAL	103.00	103.00	105.47	107.12
1362	CONSULTATION-SUBSEQUENT	51.50	51.50	52.74	53.56
1368	COMPREHENSIVE ED VISIT - SAT,SUN,HOLIDAY (DAY)	66.50	66.50	68.10	69.16
1369	COMPREHENSIVE ED VISIT - FRI,SAT,SUN,HOLI (NIGHT)	110.00	110.00	112.64	114.40
1370	DETENTION	45.00	45.00	46.08	46.80
1371	INTENSIVE CARE	100.00	100.00	102.40	104.00
1376	DETENTION-SPECIAL CALL	45.00	45.00	46.08	46.80
1380	LIMITED ED VISIT - MON-FRI (DAY)	31.50	31.50	32.26	32.76
1381	LIMITED ED VISIT - MON-THURS (NIGHT)	41.00	41.00	41.98	42.64
1386	COMPREHENSIVE ED VISIT - MON-FRI (DAY)	57.50	57.50	58.88	59.80
1387	COMPREHENSIVE ED VISIT - MON-THURS (NIGHT)	77.50	77.50	79.36	80.60
1390	LIMITED ED VISIT - SAT,SUN,HOLIDAY (DAY)	36.50	36.50	37.38	37.96
1391	LIMITED ED VISIT - FRI,SAT,SUN,HOLIDAY (NIGHT)	61.00	61.00	62.46	63.44
1394	OUT-PT ADDITIONAL FEE FOR STRICT EMERGENCY	25.00	25.00	25.60	26.00
1540	RETAINER RADIOLOGY QEH	300.00	300.00	300.00	300.00
1610	INITIAL OFFICE VISIT WITH COMPLETE EXAM	70.00	70.00	71.68	72.80
1611	INITIAL OFFICE VISIT WITH REGIONAL EXAM	35.00	35.00	35.84	36.40
1613	LIMITED OFFICE VISIT	35.00	35.00	35.84	36.40
1621	DAY HOME VISIT	62.00	62.00	63.49	64.48
1624	HOME VISIT-ADDITIONAL FAMILY MEMBERS	31.00	31.00	31.74	32.24
1625	ADDITIONAL FEE FOR STRICT EMERGENCY	25.00	25.00	25.60	26.00
1630	INITIAL HOSPITAL VISIT	100.00	100.00	109.00	115.00
1633	SUBSEQUENT HOSPITAL VISIT-1st 5 WEEKS	50.00	50.00	54.50	57.50
1634	SUBSEQUENT HOSPITAL VISIT 6-13th WEEK	30.00	30.00	32.70	34.50
1635	SUBSEQUENT HOSPITAL VISIT - AFTER 13th WEEK	30.00	30.00	32.70	34.50
1641	CONTINUING CARE	50.00	50.00	54.50	57.50
1642	DIRECTIVE CARE	50.00	50.00	54.50	57.50
1650	TELEPHONE CONSULTATION - PHYSICAL MEDICINE	0.00	0.00	46.08	46.80
1660	CONSULTATION-INITIAL	190.00	190.00	194.56	197.60
1662	CONSULTATION-SUBSEQUENT	95.00	95.00	97.28	98.80
1663	CONSULTATION-COMPLETE RE-EXAM	70.00	70.00	71.68	72.80
1668	COMPREHENSIVE ED VISIT - SAT,SUN,HOLIDAY (DAY)	66.50	66.50	68.10	69.16
1669	COMPREHENSIVE ED VISIT - FRI,SAT,SUN,HOLI (NIGHT)	110.00	110.00	112.64	114.40
1670	DETENTION	45.00	45.00	46.08	46.80
1671	INTENSIVE CARE	100.00	100.00	102.40	104.00
1676	DETENTION-SPECIAL CALL	45.00	45.00	46.08	46.80
1680	LIMITED ED VISIT - MON-FRI (DAY)	31.50	31.50	32.26	32.76
1681	LIMITED ED VISIT - MON-THURS (NIGHT)	41.00	41.00	41.98	42.64
1686	COMPREHENSIVE ED VISIT - MON-FRI (DAY)	57.50	57.50	58.88	59.80
1687	COMPREHENSIVE ED VISIT - MON-THURS (NIGHT)	77.50	77.50	79.36	80.60
1690	LIMITED ED VISIT - SAT,SUN,HOLIDAY (DAY)	36.50	36.50	37.38	37.96
1691	LIMITED ED VISIT - FRI,SAT,SUN,HOLIDAY (NIGHT)	61.00	61.00	62.46	63.44
1694	OUT-PT ADDITIONAL FEE FOR STRICT EMERGENCY	25.00	25.00	25.60	26.00
1713	RADIATION ONCOLOGY FOLLOW-UP VISIT	35.00	35.00	35.84	36.40
1715	ONCOLOGY-TREATMENT PLANNING	36.50	36.50	37.38	37.96
1716	ONCOLOGY-SUPERFICIAL THERAPY	6.85	6.85	7.01	7.12
1717	ONCOLOGY-DEEP THERAPY	9.40	9.40	9.63	9.78
1718	RADIUM MOULD	16.50	16.50	16.90	17.16
1719	ONCOLOGY-OPTHALMIC DEVICE	8.40	8.40	8.60	8.74
1720	TREATMENT PLANNING FOR NON MALIG CONDITION	22.75	22.75	23.30	23.66
1725	ONCOLOGY BIOPSY (INTERSTITAL THERAPY)	182.60	182.60	186.98	189.90
1730	RADIUM INSERTION	157.70	157.70	161.48	164.01
1731	RADIUM PROVISION-OPERATING ROOM	91.35	91.35	93.54	95.00

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
1735	RADIOISOTOPE THERAPY-CARCINOMA OF THYROID	74.65	74.65	76.44	77.64
1736	TREATMENT OF HYPERTHYROIDISM	54.90	54.90	56.22	57.10
1737	TREATMENT OF POLYCYTHEMIA VERA	44.75	44.75	45.82	46.54
1760	RADIATION ONCOLOGY CONSULTATION	190.00	190.00	194.56	197.60
1762	REPEAT CONSULTATION	95.00	95.00	97.28	98.80
1900	AUTOPSY - NON-CORONERS (EVENINGS & WEEKENDS)	1,250.00	1,250.00	1,280.00	1,300.00
1940	ONCALL RETAINER - LABORATORY	300.00	300.00	300.00	300.00
1955	ONCALL PERDIEM (IN LIEU OF FFS) - LAB. MEDICINE (Salaried only)	0.00	0.00	500.00	500.00
2000	CERUMEN REMOVAL	12.00	12.00	12.29	12.48
2001	PELVIC EXAM	8.00	8.00	8.19	8.32
2002	URINALYSIS	4.50	4.50	4.61	4.68
2003	PARTIAL EXAMINATION	2.25	2.25	2.30	2.34
2004	HAEMAGLOBIN	4.00	4.00	4.10	4.16
2005	OCCULT BLOOD IN STOOL	2.25	2.25	2.30	2.34
2006	NASAL SMEAR FOR EOSINOPHILS	4.00	4.00	4.10	4.16
2007	PROCTOSCOPIC EXAM	20.00	20.00	20.48	20.80
2008	PAP SMEAR WITH OR WITHOUT PELVIC EXAM	14.00	14.00	14.34	14.56
2009	INJECTION OTHER THAN ALLERGY	10.00	10.00	10.24	10.40
2010	CHANGE OF DRESSING	10.70	10.70	16.28	20.00
2011	EMERGENCY PROCEDURAL SEDATION	30.00	30.00	30.72	31.20
2015	CRYOPRECIPITATE	21.67	21.67	22.19	22.54
2018	PAP SCREENING CLINIC	0.00	0.00	0.00	0.00
2019	TELEPHONE PRESCRIPTION RENEWAL	5.00	5.00	6.50	7.50
2021	REMOVAL OF RECTAL FOREIGN BODY	85.00	85.00	87.04	88.40
2022	ARGON COAG. STOMACH OR RECTUM (ADD-ON FEE)	80.25	80.25	82.18	83.46
2038	DIALYSIS CATHETER - TUNNELING AND INSERTION	150.00	150.00	153.60	156.00
2039	DIALYSIS CATHETER - REMOVAL AND/OR REPLACEMENT	200.00	200.00	204.80	208.00
2048	COMPREHENS PALLIATIVE CARE CONSULT-SPECIALIST	160.00	160.00	163.84	166.40
2050	ASPIRATION OF LYMPH NODE IN NECK	24.34	24.34	24.92	25.31
2055	ACUTE DIALYSIS - FIRST TREATMENT	585.00	585.00	599.04	608.40
2056	ACUTE DIALYSIS - SUBSEQUENT TREATMENT (UP TO 2)	268.80	268.80	275.25	279.55
2058	SATELLITE DIALYSIS MANAGEMENT (PER PATIENT / WEEK)	40.00	40.00	40.96	41.60
2067	REPEAT PALLIATIVE CARE CONSULT-SPECIALIST	80.00	80.00	81.92	83.20
2100	OCCIPITAL NERVE BLOCK	40.00	40.00	40.96	41.60
2101	TRIGGER POINT INJECTION (ONE OR MORE)	21.40	21.40	21.91	22.26
2102	HYPOSENSITIZATION-SUBSEQUENT VISITS	10.00	10.00	10.24	10.40
2106	SUPERVISION OF ANTI-COAGULENT THERAPY	15.00	15.00	15.36	15.60
2107	ASPIRATION-BLADDER	40.00	40.00	40.96	41.60
2108	ASPIRATION-BREAST CYST	30.00	30.00	30.72	31.20
2109	ASPIRATION-BURSA	26.75	26.75	27.39	27.82
2110	ASPIRATION-CISTERNA MAGNA	24.13	24.13	24.71	25.10
2111	ASPIRATION-DUODENUM	40.13	40.13	41.09	41.74
2112	ASPIRATION-ESOPHAGUS/STOMACH	21.40	21.40	21.91	22.26
2113	ASPIRATION-HYDROCELE	21.40	21.40	21.91	22.26
2114	ASPIRATION-JOINT	35.00	35.00	35.84	36.40
2115	LUMBAR PUNCTURE	100.00	100.00	102.40	104.00
2116	PERICARDIOCENTESIS	160.00	160.00	163.84	166.40
2117	SUBDURAL TAP	31.73	31.73	32.49	33.00
2118	SUBDURAL PUNCTURE-EACH ADDITIONAL	10.49	10.49	10.74	10.91
2119	ASPIRATION-THYROID CYST	30.00	30.00	30.72	31.20
2122	B.C.G. VACCINATION	10.49	10.49	10.74	10.91
2123	BLOOD TRANSFUSION	21.19	21.19	21.70	22.04
2124	CARDIOVERSION	112.35	112.35	115.05	116.84
2126	SELECTIVE CORONARY ANGIOGRPHY OF HEART-RIGHT	158.63	158.63	162.44	164.98
2127	HEPATIC-WEDGE PRESSURE	105.72	105.72	108.26	109.95
2128	HEPATIC-WEDGE PRESSURE OF HEART LEFT	211.54	211.54	216.62	220.00
2129	LEFT VENTRICULAR PUNCTURE	105.72	105.72	108.26	109.95

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
2131	CRYOTHERAPY OF CERVIX	44.41	44.41	45.48	46.19
2132	INSERTION-PERM PERITONEAL DIALYSIS CATHETER	155.36	155.36	159.09	161.57
2135	CHRONIC DIALYSIS - FIRST TREATMENT	182.81	182.81	187.20	190.12
2137	CHRONIC DIALYSIS - SUBSEQUENT TREATMENT	74.00	74.00	75.78	76.96
2140	NERVE CONDUCTION STUDIES, PER NERVE, (MAX. 6)	30.52	30.52	31.25	31.74
2142	ECG INTERPRETATION IN OFFICE	21.40	21.40	21.91	22.26
2143	ECG (HOME)	26.80	26.80	27.44	27.87
2144	HOLTER MONITORING	51.36	51.36	52.59	53.41
2145	ECG-INTERPRETATION ONLY	10.70	10.70	10.96	11.13
2146	EEG INTERPRETATION ONLY	30.76	30.76	31.50	31.99
2147	EEG - INSERTION SUBTEMPORAL NEEDLES	21.19	21.19	21.70	22.04
2148	EEG ACTIVATING DRUGS	21.19	21.19	21.70	22.04
2149	EMG (MAJOR) - MUSCLES OF MORE THAN ONE REGION	90.00	90.00	92.16	93.60
2150	EMG (MINOR) - MUSCLES OF A SPECIFIC LIMB OR REGION	60.00	60.00	61.44	62.40
2151	ELECTROCONVULSIVE THERAPY	75.00	75.00	76.80	78.00
2152	INSULIN HYPOGLYCEMIA/PITUITARY FUNCTION	60.94	60.94	62.40	63.38
2153	TRH TEST	30.44	30.44	31.17	31.66
2154	GNRH(LHRH) TEST	30.44	30.44	31.17	31.66
2155	CALCIUM AND PENTAGASTRIN	73.13	73.13	74.89	76.06
2156	CALCIUM OR PENTAGASTRIN ALONE	48.74	48.74	49.91	50.69
2157	HCL DRIP TEST (ESOPHAGUS)	31.73	31.73	32.49	33.00
2158	MOTILITY STUDIES (ESOPHAGUS)	73.88	73.88	75.65	76.84
2159	GASTRO-ESOPHAGEAL TAMPONADE	60.00	60.00	61.44	62.40
2162	GASTRIC LAVAGE	26.75	26.75	27.39	27.82
2163	GASTRO-ENTEROLOGY FRACTIONAL TEST-MEAL	31.73	31.73	32.49	33.00
2165	INJECTION-INTRAVENOUS	15.00	15.00	15.36	15.60
2166	NERVE ENTRAPMENT EVALUATION (COMPOSITE FEE)	85.60	85.60	87.65	89.02
2167	ACHALASIA BOTOX INJECTION	64.20	64.20	65.74	66.77
2168	INJECTION MEDICATION-BURSA JOINT,ETC.	26.75	26.75	28.70	30.00
2169	INJECTION HEMORRHOIDS-INITIAL	21.40	21.40	21.91	22.26
2170	INJECTION HEMORRHOIDS SUBSEQUENT	16.10	16.10	16.49	16.74
2171	INJECTION OF PRURITIS ANI	21.40	21.40	21.91	22.26
2172	MYELOGRAM-LUMBAR	73.88	73.88	75.65	76.84
2174	IV ADMIN OF CHEMOTHERAPY AGENT-PER INJECTION	21.40	21.40	21.91	22.26
2175	BONE MARROW (NEEDLE BIOPSY)	100.00	100.00	102.40	104.00
2176	KIDNEY-NEEDLE BIOPSY	73.88	73.88	75.65	76.84
2177	LIVER-NEEDLE BIOPSY	80.25	80.25	82.18	83.46
2178	PLEURA-NEEDLE BIOPSY	42.43	42.43	43.45	44.13
2180	SYNOVIAL TISSUE-NEEDLE BIOPSY	52.80	52.80	54.07	54.91
2181	PERICARDIUM-NEEDLE BIOPSY	158.63	158.63	162.44	164.98
2182	PROSTATE-NEEDLE BIOPSY	84.53	84.53	86.56	87.91
2183	SOMATIC OR PERIPHERAL NERVE BLOCK - SINGLE	40.00	40.00	40.96	41.60
2184	SOMATIC/ PERIPH. NERVE BLOCK - ADDITIONAL (MAX. 4)	20.00	20.00	20.48	20.80
2185	LUMBAR SYMPATHETIC NERVE BLOCK	90.95	90.95	93.13	94.59
2186	CERVICAL PLEXUS BLOCK	74.90	74.90	76.70	77.90
2187	MENTAL BRANCH MANDIBULAR NERVE	64.20	64.20	65.74	66.77
2188	INFRAORBITAL BRANCH MAXILLARY NERVE	64.20	64.20	65.74	66.77
2189	BRACHIAL PLEXUS BLOCK	64.20	64.20	65.74	66.77
2190	PRESACRAL (SUPERIOR HYPOGASTRIC PLEXUS) BLOCK	64.20	64.20	65.74	66.77
2191	CAUDAL EPIDURAL INJECTION	69.55	69.55	71.22	72.33
2192	SCIATIC NERVE BLOCK	64.20	64.20	65.74	66.77
2193	OBTURATOR NERVE BLOCK	64.20	64.20	65.74	66.77
2194	PUDENDAL NERVE BLOCK	64.20	64.20	65.74	66.77
2195	SUBARACHNOID (DIAGNOSTIC SPINAL) BLOCK	74.90	74.90	76.70	77.90
2196	EPIDURAL - SINGLE INJECTION	85.60	85.60	87.65	89.02
2197	CELIAC/HYPOGASTRIC PLEXUS BLOCK - FLUORO GUIDED	160.50	160.50	164.35	166.92
2198	TRIGEMINAL (GASSERIAN) GANGLION BLOCK	107.00	107.00	109.57	111.28

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
2199	CERVICAL SYMPATHETIC OR STELLATE GANGLION BLOCK	107.00	107.00	109.57	111.28
2202	GASSERIAN GANGLION BLOCK - FLUORO GUIDED	160.50	160.50	164.35	166.92
2204	LATERAL FEMORAL CUTANEOUS NERVE BLOCK	70.00	70.00	71.68	72.80
2205	THORAC/LUMBAR/SACRAL SYMPATH BLOCK -FLUOR GUIDED	160.50	160.50	164.35	166.92
2206	MAXILLARY / MANDIBULAR DIVISION TRIGEMINAL NERVE	74.90	74.90	76.70	77.90
2207	SPHENO-PALATINE GANGLION BLOCK - FLUORO GUIDED	160.50	160.50	164.35	166.92
2208	STELLATE GANGLION BLOCK - U/S OR FLUORO GUIDED	160.50	160.50	164.35	166.92
2209	SUPERIOR LARYNGEAL NERVE BLOCK - FLUORO GUIDED	160.50	160.50	164.35	166.92
2210	PARAVERTEBRAL NERVE BLOCK - SINGLE	74.90	74.90	76.70	77.90
2211	PARAVERTEBRAL NERVE BLOCK - ADDITIONAL (MAX. 4)	37.45	37.45	38.35	38.95
2213	PARACENTESIS-THORACIC OR ABDO ASPIRATION	50.00	50.00	51.20	52.00
2214	THERAPEUTIC ASPIRATION	65.00	65.00	66.56	67.60
2215	ADMINISTRATION OF CHEMOTHERAPY	60.00	60.00	61.44	62.40
2217	PHONOCARDIOGRAM	31.73	31.73	32.49	33.00
2218	ROUTINE SURVEY-PULMONARY FUNCTION	53.50	53.50	54.78	55.64
2219	INDIVIDUAL TESTS-MAXIMUM BREATHING CAPACITY	11.50	11.50	11.78	11.96
2220	PULMONARY DIFFUSING CAPACITY	21.19	21.19	21.70	22.04
2222	INTERPRETATION PRESSURE TRACINGS	11.50	11.50	11.78	11.96
2223	LUNG CAPACITY DETERMINATIONS	22.52	22.52	23.06	23.42
2225	TELEPHONE CONSULTATION - NEUROLOGY	0.00	0.00	46.08	46.80
2228	ANNUAL HEALTH EXAM 1-2 YEARS	35.00	35.00	35.84	36.40
2229	ANNUAL HEALTH EXAM 3-16 YEARS	35.00	35.00	35.84	36.40
2230	ANNUAL HEALTH EXAM 17-64 YEARS	45.00	45.00	46.08	46.80
2231	ANNUAL HEALTH EXAM 65 YEARS PLUS	60.00	60.00	61.44	62.40
2232	IV START ON PEDIATRIC PATIENT	42.80	42.80	43.83	44.51
2233	URIC ACID CRYSTALS	6.37	6.37	6.52	6.62
2234	MUCIN CLOT	2.14	2.14	2.19	2.23
2235	SIGMOIDOSOCOPIC	50.00	50.00	51.20	52.00
2236	STERILITY INVESTIGATION-MALE	10.49	10.49	10.74	10.91
2237	BALLOON STRCT.DILAT-INC GSCPY,SSCPY OR CSCPY	264.29	264.29	270.63	274.86
2238	VENIPUNCTURE	10.00	10.00	10.60	11.00
2239	VENIPUNCTURE INFANT OR CHILD UNDER SIX	21.40	21.40	21.91	22.26
2240	FEMORAL VEIN PUNCTURE	21.40	21.40	21.91	22.26
2241	JUGULAR VEIN PUNCTURE	21.40	21.40	21.91	22.26
2242	SIGMOIDOSCOPY-FLEXIBLE (W/ OR W/OUT BIOPSY)	85.00	85.00	87.04	88.40
2243	VACCINATION	17.12	17.12	17.53	17.80
2244	CENTRAL VENOUS PRESSURE	53.50	53.50	54.78	55.64
2245	METACHOLINE CHALLENGE	72.23	72.23	73.96	75.12
2246	CYSTOMETROGRAM	32.10	32.10	32.87	33.38
2247	VITAL CAPACITY AND TIMED UNIT CAPACITY	11.50	11.50	11.78	11.96
2248	ACTH STIMULATION TEST	43.66	43.66	44.71	45.41
2249	SIMPLE PROGRESSIVE EXERCISE TESTS	25.36	25.36	25.97	26.37
2250	EXERCISE IN A STEADY STATE	52.80	52.80	54.07	54.91
2251	EXERCISE IN A STEADY STATE	84.53	84.53	86.56	87.91
2252	INJECTIONS BY CUTDOWN-AGES 0-4 YRS	53.50	53.50	54.78	55.64
2253	INJECTIONS BY SCALP VEIN	26.75	26.75	27.39	27.82
2254	CENTRAL IV LINE INSERTION	120.00	120.00	122.88	124.80
2255	PERITONEAL LAVAGE	80.25	80.25	82.18	83.46
2256	UMBILICAL VESSEL CATHETERIZATION	77.09	77.09	78.94	80.17
2257	ECG-TECHNICAL COMPONENT	10.70	10.70	10.96	11.13
2258	VISUAL FIELDS-GOLDMAN PERIMETER	40.82	40.82	41.80	42.45
2259	ASPIRATION BIOPSY/THYROID	50.00	50.00	51.20	52.00
2260	COLONSCOPY OF COMPLETE COLON	225.00	225.00	230.40	234.00
2261	SWEAT TEST	34.03	34.03	34.85	35.39
2262	SWAN'S GANZ CATHETER	171.20	171.20	175.31	178.05
2263	NEEDLE BIOPSY-LUNG	74.90	74.90	76.70	77.90
2264	ADDITIONAL INJECTION OF CHEMOTHERAPY	10.54	10.54	10.79	10.96

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
2265	I.V.PYLEOGRAM IN O.P.D.	37.45	37.45	38.35	38.95
2266	THERAPEUTIC PHLEBOTOMY	21.19	21.19	21.70	22.04
2267	URINE FLOW RATE DETERMINATION	12.84	12.84	13.15	13.35
2268	NEEDLE BIOPSY LUNG	124.33	124.33	127.31	129.30
2269	TENSILON TEST	22.74	22.74	23.29	23.65
2270	DOPPLER SCAN OR B SCAN TECHNICAL COMPONENT	43.50	43.50	44.54	45.24
2271	DOPPLER SCAN OR B SCAN PROFESSIONAL COMPNENT	24.45	24.45	25.04	25.43
2272	FREQUENCY ANALYSIS TECHNICAL COMPONENT	43.50	43.50	44.54	45.24
2273	FREQUENCY ANALYSIS PROFESSIONAL COMPONENT	24.45	24.45	25.04	25.43
2274	FREQUENCY ANALYSIS PLUS SCAN TECH COMPONENT	65.32	65.32	66.89	67.93
2275	FREQUENCY ANALYSIS PLUS SCAN PROF COMPONENT	36.75	36.75	37.63	38.22
2276	URETHRAL PRESSURE PROFILE OR LEAK PRESS TEST	21.40	21.40	21.91	22.26
2277	DOPPLER SCAN OR B SCAN	16.42	16.42	16.81	17.08
2278	ELECTROMYOGRAPHY	21.40	21.40	21.91	22.26
2279	FREQUENCY ANALYSIS	13.59	13.59	13.92	14.13
2280	FREQUENCY ANALYSIS PLUS SCAN TECHN COMPNENT	31.30	31.30	32.05	32.55
2281	FREQUENCY ANALYSIS PLUS SCAN PROF COMPONENT	25.79	25.79	26.41	26.82
2282	VENOUS ASSESSMENT TECHNICAL COMPONENT	6.85	6.85	7.01	7.12
2283	VENOUS ASSESSMENT PROFESSIONAL COMPONENT	10.91	10.91	11.17	11.35
2284	PRESSURE/FLOW STUDY	21.40	21.40	21.91	22.26
2285	ANKLE PRESSURE DETERMINATION	8.93	8.93	9.14	9.29
2286	ANKLE PRESS MEAS/DOPPLER RECRD TECH COMPNENT	20.54	20.54	21.03	21.36
2287	ANKLE PRESS MEAS/DOPPLER RECRD PROF COMPNENT	24.45	24.45	25.04	25.43
2288	ANKLE PRESS/EXERCISE-HYPEREMIA TECH COMPNENT	7.54	7.54	7.72	7.84
2289	ANKLE PRESS/EXERCISE-HYPEREMIA PROF COMPNENT	11.61	11.61	11.89	12.07
2290	VIDEOURODYNAMIC ASSESSMENT	21.40	21.40	21.91	22.26
2291	PENILE PRESSURE RECORD-TWO OR MORE	8.13	8.13	8.33	8.46
2292	PERI-URETHRAL COLLAGEN INJECTN INCL CYSTSCPY	160.50	160.50	164.35	166.92
2293	STRAIN GAUGE PLETHYSMOGRAPHY	6.10	6.10	6.25	6.34
2294	PERIORBITAL STUDIES BY DOPPLER TECH COMPONENT	13.59	13.59	13.92	14.13
2295	PERIORBITAL STUDIES BY DOPPLER PROF COMPONENT	14.93	14.93	15.29	15.53
2296	VENOUS REFILLING TIME TECHNICAL COMPONENT	12.36	12.36	12.66	12.85
2297	VENOUS REFILLING TIME PROFESSIONAL COMPONENT	6.10	6.10	6.25	6.34
2300	ULTRASOUND ASSESS OF CEREBRAL CIRCULATION	47.56	47.56	48.70	49.46
2301	ULTRASOUND ASSESSMENT-PLUS PERIORBITAL FLOW	47.56	47.56	48.70	49.46
2303	STROMAL PUNCTURE CORNEAL EROSION-ANTERIOR	57.08	57.08	58.45	59.36
2304	SEVENTH CRANIAL NERVE BLOCK - UNILATERAL	44.94	44.94	46.02	46.74
2305	SEVENTH CRANIAL NERVE BLOCK - BILATERAL	67.46	67.46	69.08	70.16
2306	INTRAVITREOL INJECTION OF EYE	214.00	214.00	214.00	214.00
2307	INTRATHECAL EPI-MORPH INJECTION	61.53	61.53	63.01	63.99
2308	ANNUAL DIABETIC RETINOPATHY	11.24	11.24	11.51	11.69
2309	AMBULATORY 24 HOUR ESOPHEGAL PH MONITORING	32.96	32.96	33.75	34.28
2310	COLONOSCOPY DESCENDING COLON	100.00	100.00	102.40	104.00
2315	ILEOSCOPY	100.00	100.00	102.40	104.00
2320	COLONOSCOPY DESCENDING & TRANSVERSE COLON	160.00	160.00	163.84	166.40
2349	ALLERGY TEST TECHNICAL COMPONENT	0.70	0.70	0.72	0.73
2350	TELEPHONE CONSULTATION - MEDICAL ONCOLOGY	0.00	0.00	46.08	46.80
2359	ALLERGY TEST PROFESSIONAL COMPONENT	0.20	0.20	0.20	0.21
2360	REMOVAL POLYP/COLONOSCOPIC EXAM	85.71	85.71	87.77	89.14
2370	REPT BALLOON STRIC.DILAT.W/IN 30 DYS-INCL GSCPY	208.31	208.31	213.31	216.64
2371	INCLUDES SIGMOIDOSCOPY	158.90	158.90	162.71	165.26
2372	INCLUDES COLONOSCOPY DESCENDING COLON	158.90	158.90	162.71	165.26
2373	INCLUDES COLONSCPY DECSND&TRANSVERSE COLON	185.65	185.65	190.11	193.08
2374	INCLUDES COLONOSCOPY COMPLETE COLON	212.40	212.40	217.50	220.90
2380	ONCALL PERDIEM (IN LIEU OF FFS)-MEDICAL ONCOLOGY(Salaried only)	0.00	0.00	500.00	500.00
2390	ONCALL RETAINER - MEDICAL ONCOLOGY	0.00	0.00	300.00	300.00
2400	ARTERIAL PUNCTURE FOR BLOOD GASES	21.40	21.40	21.91	22.26

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
2408	VISUAL FIELD INTERPRETATION	16.05	16.05	16.44	16.69
2410	IV IRON INFUSION-TOTAL CARE	53.50	53.50	54.78	55.64
2412	PACHYMETRY	12.00	12.00	12.29	12.48
2413	HEIDELBERG RETINA TOMOGRAPHY	30.00	30.00	30.72	31.20
2414	OPTICAL COHERENCE TOMOGRAPHY - COMPOSITE FEE	61.04	61.04	62.50	63.48
2415	OPTICAL COHERENCE TOMOGRAPHY - PROFESSIONAL FEE	16.05	16.05	16.44	16.69
2417	OPTICAL COHERENCE TOMOGRAPHY - TECHNICAL FEE	44.99	44.99	46.07	46.79
2420	IOL MASTER / OCULAR BIOMETRY - PROCEDURE ONLY	40.55	40.55	41.52	42.17
2421	IOL MASTER / OCULAR BIOMETRY - INTERPRETATION	22.15	22.15	22.68	23.04
2450	SUPRAORBITAL BRANCH OPHTHALMIC NERVE BLOCK	64.20	64.20	65.74	66.77
2451	OTHER CRANIAL NERVE BLOCK	64.20	64.20	65.74	66.77
2452	TRANSVERSE SCAPULAR NERVE BLOCK	64.20	64.20	65.74	66.77
2453	INTERCOSTAL NERVE BLOCK - SINGLE	40.00	40.00	40.96	41.60
2454	INTERCOSTAL NERVE BLOCK - ADDITIONAL (MAX. 4)	20.00	20.00	20.48	20.80
2455	ILIOINGUINAL AND/OR ILIOHYPOGASTRIC NERVE BLOCK	64.20	64.20	65.74	66.77
2456	FEMORAL NERVE BLOCK	64.20	64.20	65.74	66.77
2457	3-IN-1 BLOCK (FEM, OBTURATOR, LAT FEM CUTANEOUS)	85.60	85.60	87.65	89.02
2458	FASCIA ILIACA COMPARTMENT BLOCK	64.20	64.20	65.74	66.77
2459	TRANSVERSUS ABDOMINIS PLANE BLOCK - UNILAT	32.10	32.10	32.87	33.38
2460	TRANSVERSUS ABDOMINIS PLANE BLOCK - BILAT	52.97	52.97	54.24	55.09
2461	NERVE BLOCK W/ FLUOROSCOPIC GUIDANCE (ADD ON)	45.00	45.00	46.08	46.80
2462	NERVE BLOCK W/ ULTRASOUND GUIDANCE (ADD ON)	30.00	30.00	30.72	31.20
2463	FACET JOINT INJECTION - FLUORO GUIDED -ADD'L, MAX. 6	64.03	64.03	65.57	66.59
2464	FACET JOINT INJECTION - U/S GUIDED (SINGLE)	83.50	83.50	85.50	86.84
2465	FACET JOINT INJECTION - U/S GUIDED -ADD'L, MAX. 6	54.28	54.28	55.58	56.45
2466	SACROILIAC JOINT INJECTION - FLUORO GUIDED -UNILAT	98.50	98.50	100.86	102.44
2467	SACROILIAC JOINT INJECTION - FLUORO GUIDED -BILAT	162.53	162.53	166.43	169.03
2468	DIAGNOSTIC NERVE ROOT BLOCK - FLUORO GUIDED -ANY #	171.20	171.20	175.31	178.05
2470	INJECTION CHRONIC PAIN MANAGEMENT-PARAVERT.NERVE(SINGLE)	40.00	40.00	40.96	41.60
2471	INJECT'N CHRONIC PAIN MGMT-PARAVERT.NERVE(EACH ADDITIONAL	20.00	20.00	20.48	20.80
2472	INJECTION FOR CHRONIC PAIN MANAGEMENT - SCIATIC NERVE	40.00	40.00	40.96	41.60
2501	PSYCHOTHERAPY-GENERAL PRACTITIONER	42.50	42.50	43.52	44.20
2502	GROUP PSYCHOTHERAPY-GENERAL PRACTITIONER	42.50	42.50	43.52	44.20
2503	PSYCHOTHERAPY BY A GP -IN HOSPITAL	42.50	42.50	43.52	44.20
2504	PSYCHOTHERAPY-PSYCHIATRIST	55.00	55.00	56.32	57.20
2505	HEALTH PROMOTION COUNSELLING	42.50	42.50	14.51	14.73
2507	CASE MANAGEMENT PER 15 MINUTES	42.50	42.50	43.52	44.20
2508	MENTAL HEALTH CRISIS CARE-GP-PER 15 MINUTES	42.50	42.50	43.52	44.20
2510	NURSE PRACTITIONER COLLABORATION	28.33	28.33	29.01	29.46
2520	EPIDURAL SPINAL BLOCK	75.00	75.00	76.80	78.00
2521	EPIDURAL SPINAL BLOCK (CONTINUOUS)	220.00	220.00	225.28	228.80
2523	EPIDURAL SPINAL BLOCK MAXIMUM ONE PER DAY	82.50	82.50	84.48	85.80
2524	LUMBAR EPIDURAL INJECTION - FLUORO GUIDED	171.20	171.20	175.31	178.05
2525	CATHETER FOR ANALYGESIA/FIRST DOSE	407.00	407.00	416.77	423.28
2530	IV GUANETHIDINE OR BIER BLOCK	107.00	107.00	109.57	111.28
2531	CERVICAL EPIDURAL INJECTION - FLUORO GUIDED	171.20	171.20	175.31	178.05
2532	THORACIC EPIDURAL INJECTION - FLUORO GUIDED	171.20	171.20	175.31	178.05
2533	FACET JOINT INJECTION - FLUORO GUIDED (SINGLE)	98.50	98.50	100.86	102.44
2534	PATIENT CONTROLLED ANALGESIA-MAINTENANCE	27.50	27.50	28.16	28.60
2540	AUDIOMETRY-TUNING FORK AND SPEECH TEST	39.98	39.98	40.94	41.58
2541	VESTIBULAR FUNCTION TESTS	23.06	23.06	23.61	23.98
2549	MODIFIED SLEEP STUDY	42.80	42.80	43.83	44.51
2550	ADMIN OF CHEMOTHERAPY IN OMAYA RESERVOIR	38.95	38.95	39.88	40.51
2551	INTRATHECAL CHEMOTHRPY INCL LUMBAR PNCTURE	130.00	130.00	133.12	135.20
2552	ADMIN OF SELEROSING MATERIAL VIA CHEST TUBE	53.50	53.50	54.78	55.64
2580	MEMBER OF GROUP PSYCHOTHERAPY (G P)	0.00	0.00	0.00	0.00
2581	MEMBER OF GROUP PSYCHOTHERAPY (SP)	0.00	0.00	0.00	0.00

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
2582	MEMBER OF SESSIONAL SERVICE	0.00	0.00	0.00	0.00
2586	DIAGNOSTIC/THERAPEUTIC INTERVIEW-RELATIVES	55.00	55.00	56.32	57.20
2587	GROUP PSYCHOTHERAPY	55.00	55.00	56.32	57.20
2588	DIAGNOSTIC/THERAPEUTIC INTERVIEW	42.50	42.50	43.52	44.20
2589	PHOTOTHERAPY	6.10	6.10	6.25	6.34
2590	PRENATAL PSYCHOSOCIAL ASSESSMENT	42.50	42.50	43.52	44.20
2600	RADIATION THERAPY	0.00	0.00	0.00	0.00
2601	INSERTION OF IUPC	50.83	50.83	52.05	52.86
2602	OXYTOCIN CHALLENGE TEST	32.10	32.10	32.87	33.38
2603	SCALP PH SAMPLING	66.34	66.34	67.93	68.99
2604	BIOPHYSICAL PROFILE	60.99	60.99	62.45	63.43
2605	VAGINAL PESSARY FITTING(INITIAL)	16.05	16.05	16.44	16.69
2606	ULTRASOUND PROCEDURES - OBSTETRICIAN	60.99	60.99	62.45	63.43
2700	CYSTOGRAM	34.72	34.72	35.55	36.11
2701	ARTHROGRAM	34.72	34.72	35.55	36.11
2702	BRONCHOGRAM	46.22	46.22	47.33	48.07
2705	SIALOGRAM	46.22	46.22	47.33	48.07
2706	HYSTEROSALPINGOGRAM	69.44	69.44	71.11	72.22
2708	PERCUTANEOUS TRANSHEP CHOLANGIOGRAM	81.05	81.05	83.00	84.29
2709	LYMPHOGRAM	115.72	115.72	118.50	120.35
2800	ADMISSION EXAM TO ALCOHOL OR MENTAL FACILITY	42.80	42.80	43.83	44.51
2807	CASE MANAGEMENT-GERIATRIC MEDICINE	45.00	45.00	46.08	46.80
2821	HOME VISIT-GERIATRIC MEDICINE	75.00	75.00	90.00	100.00
2850	TELEPHONE CONSULTATION - GERIATRICS	0.00	0.00	46.08	46.80
2860	CONSULTATION-GERIATRIC MEDICINE	160.00	160.00	163.84	166.40
2862	REPEAT CONSULT W/IN 30 DAYS-GERIATRIC MEDICINE	80.00	80.00	81.92	83.20
2863	FOLLOW UP VISIT-GERIATRIC MEDICINE	35.00	35.00	35.84	36.40
2870	DETENTION-GERIATRIC MEDICINE	45.00	45.00	46.08	46.80
2880	COMPENTENCY ASSESSMENT-GERIATRIC MEDICINE	75.00	75.00	76.80	78.00
2886	DIAG.&THERA. INTERVIEW-GERIATRIC MEDICINE	45.00	45.00	46.08	46.80
2900	ED & CRITICAL CARE ULTRASOUND	30.00	30.00	30.72	31.20
2901	EMERGENCY CRICOTHYROTOMY	214.00	214.00	219.14	222.56
2902	URINARY CATHETER - TRANSURETHRAL	35.00	35.00	35.84	36.40
2903	ASPIRATION FOR PRIAPISM	64.20	64.20	65.74	66.77
2904	PARAPHIMOSIS REDUCTION	53.50	53.50	54.78	55.64
3000	ABSCESS-LOCAL ANAESTHETIC	37.45	37.45	38.35	38.95
3001	ABSCESS-GENERAL ANAESTHETIC	46.22	46.22	47.33	48.07
3002	CARBUNCLE-COMPLETE CARE	92.50	92.50	94.72	96.20
3003	PERIANAL OR PILONIDAL-LOCAL	42.80	42.80	53.12	60.00
3004	PERIANAL OR PILONIDAL-GEN ANAES	69.44	69.44	71.11	72.22
3005	ISCHIORECTAL-SIMPLE INCISION W/ LOCL ANESTHETIC	42.80	42.80	53.12	60.00
3006	UNROOFING-COMPLETE CARE	138.83	138.83	142.16	144.38
3007	PALMAR AND PLANTAR SPACE INFECTIONS	138.83	138.83	142.16	144.38
3008	HAEMATOMA-LOCAL	37.45	37.45	38.35	38.95
3009	HAEMATOMA-GENERAL ANAESTHETIC	46.22	46.22	47.33	48.07
3010	TONGUE TIE-LOCAL	14.18	14.18	14.52	14.75
3011	TONGUE TIE-GENERAL	46.22	46.22	47.33	48.07
3012	REMOVAL OF FOREIGN BODY OR FIBROMA	42.80	42.80	47.12	50.00
3013	REMOVAL OF FOREIGN BODY-GENERAL ANAESTHETIC	I.C.	I.C.	I.C.	I.C.
3030	BIOPSY	44.94	44.94	47.98	50.00
3031	CARCINOMA OF SKIN	81.05	81.05	83.00	84.29
3032	CARCINOMA-COMPLICATED	I.C.	I.C.	I.C.	I.C.
3033	CYST-PILONIDAL	220.21	220.21	225.50	229.02
3034	CYST-SEBACEOUS (FACE OR NECK)	44.94	44.94	77.98	100.00
3035	CYST-SEBACEOUS (OTHER AREAS)	40.66	40.66	61.26	75.00
3036	REMOVAL OF FINGER OR TOE NAIL	48.15	48.15	64.26	75.00
3037	RESECTION OF NAIL-BED AND MATRIX	51.36	51.36	65.54	75.00

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
3038	RADICAL REMOVAL OF NAIL	115.72	115.72	136.29	150.00
3039	LIPOMA-SIMPLE (LOCAL)	46.22	46.22	63.49	75.00
3040	LIPOMA-COMPLICATED	I.C.	I.C.	I.C.	I.C.
3041	NEUROMA-SIMPLE	46.22	46.22	47.33	48.07
3042	BENIGN SKIN LESION-INITAL CRYOTHERAPY	26.48	26.48	27.12	27.54
3043	BENIGN SKIN LESION-SUBSEQUENT CRYOTHERAPY	11.66	11.66	11.94	12.13
3044	WARTS-CURETTAGE OR ELECTROCAUTERY	30.00	30.00	30.72	31.20
3045	WARTS-SIMPLE EXCISION	33.01	33.01	33.80	34.33
3046	PLANTAR WART-CURETTAGE	30.00	30.00	30.72	31.20
3047	PLANTAR WART-SURGICAL EXCISION	59.12	59.12	60.54	61.48
3049	IMPLANTATION OF HORMONE PELLETS	34.72	34.72	35.55	36.11
3050	SUTURE-SIMPLE WOUNDS OR LACERATIONS	60.00	60.00	69.00	75.00
3051	SUTURE-COMPLICATED LACERATIONS	I.C.	I.C.	I.C.	I.C.
3052	EXTENSIVE BURNS (REPAIR)	I.C.	I.C.	I.C.	I.C.
3053	SKIN GRAFT-SMALL	214.00	214.00	219.14	222.56
3054	SKIN GRAFT-EYE BROW,LID,EAR,NOSE	275.20	275.20	281.80	286.21
3055	SKIN GRAFT-LARGE	404.83	404.83	414.55	421.02
3056	CROSS FINGER FLAP	275.20	275.20	281.80	286.21
3057	CROSS LEG FLAP	495.46	495.46	507.35	515.28
3058	INDIRECT SKIN GRAFT-MAJOR	347.11	347.11	355.44	360.99
3059	INDIRECT SKIN GRAFT-MINOR	173.61	173.61	177.78	180.55
3060	LONGER STAGE WITH SKIN GRAFT	347.11	347.11	355.44	360.99
3061	DELAY OF TUBE OR PEDICLE	81.05	81.05	83.00	84.29
3062	FULL GRAFTS-EYELID, NOSE,LIPS	275.20	275.20	281.80	286.21
3063	FULL GRAFTS-FINGER TIP	115.72	115.72	118.50	120.35
3064	FULL GRAFTS-VOLAR PALM	173.61	173.61	177.78	180.55
3065	FULL GRAFTS-ISLAND GRAFT	462.83	462.83	473.94	481.34
3066	SPLIT THICKNESS GRAFT-MINOR	107.00	107.00	109.57	111.28
3067	SPLIT THICKNESS GRAFTS-MINOR TO MEDIUM	173.61	173.61	177.78	180.55
3068	SPLIT SKIN GRAFTS-INTERMEDIATE AREA	275.20	275.20	281.80	286.21
3069	SPLIT THICKNESS GRAFTS-MAJOR GRAFT	404.83	404.83	414.55	421.02
3070	DRAINAGE OF INTRAMAMMARY ABSCESS	92.50	92.50	98.58	102.64
3071	REPEAT INCISION	92.50	92.50	98.58	102.64
3072	AUGUMENT PROSTHESIS UNILATERAL	280.50	280.50	287.23	291.72
3073	EXCISIONAL BIOPSY	146.59	146.59	156.23	162.66
3074	MASTECTOMY-SIMPLE	319.23	319.23	340.23	354.23
3075	MASTECTOMY-RADICAL	662.12	662.12	705.67	734.71
3076	MASTECTOMY-RADICAL WITH SKIN GRAFT	605.73	605.73	645.57	672.14
3077	MASTECTOMY-MALE,SIMPLE	138.83	138.83	147.96	154.05
3078	MASTECTOMY-PARTIAL OR RESECTION	138.83	138.83	147.96	154.05
3079	REMOVAL OF BREAST PROSTHESIS	81.05	81.05	83.00	84.29
3080	SURGICAL PLANING-FACE	231.23	231.23	236.78	240.48
3081	SINGLE AREA-SURGICAL PLANING	81.05	81.05	83.00	84.29
3082	MAMMOPLASTY-UNILATERAL	449.40	449.40	460.19	467.38
3083	AUGMENTATION PROSTHESIS-BILATERAL	462.83	462.83	473.94	481.34
3084	SEGMENTAL MASTECTOMY	662.12	662.12	705.67	734.71
3085	BIOPSY-NEEDLE BREAST	89.88	89.88	95.79	99.73
3086	LUMPECTOMY	264.29	264.29	281.67	293.26
3087	CRYOTHERAPY-FACE/NECK SINGLE LESION	77.90	77.90	79.77	81.02
3088	CRYOTHERAPY-FACE/NECK 2 LESIONS	128.03	128.03	131.10	133.15
3089	CRYOTHERAPY-FACE/NECK 3 OR MORE LESIONS	243.53	243.53	249.37	253.27
3090	CRYOTHERAPY-OTHER AREAS 1 LESION	62.11	62.11	63.60	64.59
3091	CRYOTHERAPY-OTHER AREAS 2 LESIONS	102.45	102.45	104.91	106.55
3092	CRYOTHERAPY-OTHER AREAS 3 OR MORE LEISONS	204.64	204.64	209.55	212.83
3093	INSERTION OF BREAST TISSUE EXPANDER	219.35	219.35	224.61	228.12
3094	REMOVAL BREAST TISSUE EXPANDER - GEN ANESTH	78.97	78.97	80.87	82.13
3095	REMOVAL BREAST TISSUE EXPANDER - LOCL ANESTH	39.48	39.48	40.43	41.06

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
3096	PERCUTAN INFLATION TISSUE EXPANDER - PER VISIT	24.18	24.18	24.76	25.15
3097	TRAM FLAP - FIRST SURGEON	I.C.	I.C.	I.C.	I.C.
3098	REMOVAL BREAST PROSTHESIS WITH CAPSULOTOMY	107.00	107.00	109.57	111.28
3099	REMOVAL BREAST PROSTHESIS WITH CAPSULECTOMY	187.25	187.25	191.74	194.74
3100	CORRECTIVE SPLINTS FINGER	31.94	31.94	32.71	33.22
3101	ARM OR LEG	50.00	50.00	51.20	52.00
3102	SHOULDER SPICA	57.78	57.78	59.17	60.09
3103	HEAD AND TORSO	115.72	115.72	118.50	120.35
3104	BODY CAST (TORSO)	92.50	92.50	94.72	96.20
3105	HIP SPICA, SINGLE	81.05	81.05	83.00	84.29
3106	REMOVAL OF PLASTER	38.20	38.20	39.12	39.73
3107	UNNA BOOT	23.06	23.06	23.61	23.98
3108	CORRECTIVE SPLINTS-HAND AND WRIST	34.72	34.72	35.55	36.11
3109	CORRECTIVE SPLINTS-ELBOW	34.72	34.72	35.55	36.11
3110	SHOULDER	46.22	46.22	47.33	48.07
3111	CORRECTIVE SPLINTS-WHOLE LEG	46.22	46.22	47.33	48.07
3112	CORRECTIVE SPLINTS-BELOW KNEE	34.72	34.72	35.55	36.11
3113	CORRECTIVE SPLINTS-NECK	34.72	34.72	35.55	36.11
3150	PHALANX	57.78	57.78	59.17	60.09
3151	METACARPAL OR METATRSAL	115.72	115.72	118.50	120.35
3152	CARPUS OR TARSUS	115.72	115.72	118.50	120.35
3153	HUMERUS-INCISION AND DRAINAGE	173.61	173.61	177.78	180.55
3154	HUMERUS-SAUCERIZATION	289.17	289.17	296.11	300.74
3155	HUMERUS-SECONDARY CLOSURE	173.61	173.61	177.78	180.55
3156	HUMERUS-SEQUESTRECTOMY,SIMPLE	173.61	173.61	177.78	180.55
3157	HUMERUS-SAUCERIZATION AND BONE CHIPS	347.11	347.11	355.44	360.99
3158	HUMERUS (CHRONIC)-SECONDARY CLOSURE	173.61	173.61	177.78	180.55
3159	RADIUS OR ULNA (ACUTE-INCISION AND DRAINAGE)	173.61	173.61	177.78	180.55
3160	RADIUS OR ULNA(ACUTE)-SAUCERIZATION	289.17	289.17	296.11	300.74
3161	RADIUS/ULNA (ACUTE-SECONDARY CLOSURE)	173.61	173.61	177.78	180.55
3162	RADIUS/ULNA(CHRONIC)-SEQUESTRECTOMY,SIMPLE	173.61	173.61	177.78	180.55
3163	RADIUS/ULNA(CHRONIC)-SAUCERIZATN & BONE CHPS	347.11	347.11	355.44	360.99
3164	RADIUS/ULNA(CHRONIC)-SECONDARY CLOSURE	173.61	173.61	177.78	180.55
3165	TIBIA(ACUTE)-INCISION AND DRAINAGE	173.61	173.61	177.78	180.55
3167	TIBIA(CHRONIC)-SEQUESTRECTOMY,SIMPLE	231.23	231.23	236.78	240.48
3168	TIBIA(CHRONIC)-SAUCERIZATN & BONE CHIPS	347.11	347.11	355.44	360.99
3169	TIBIA(CHRONIC)-SECONDARY CLOSURE	173.61	173.61	177.78	180.55
3170	FEMUR(ACUTE)-INCISION AND DRAINAGE	231.23	231.23	236.78	240.48
3171	FEMUS (ACUTE)-SAUCERIZATION	404.83	404.83	414.55	421.02
3172	FEMUR(CHRONIC)-SEQUESTRECTOMY-SIMPLE	231.23	231.23	236.78	240.48
3173	FEMUR(CHRONIC)-SAUCERIZATION AND BONE CHIPS	404.83	404.83	414.55	421.02
3174	FEMUR(CHRONIC)-SECONDARY CLOSURE	173.61	173.61	177.78	180.55
3175	PELVIS-SEQUESTRECTOMY,SIMPLE	289.17	289.17	296.11	300.74
3176	PELVIS-OTHER	I.C.	I.C.	I.C.	I.C.
3177	VERTEBRA(ACUTE)-INCISION AND DRAINAGE	231.23	231.23	236.78	240.48
3178	VERTEBRA(ACUTE)-SAUCERIZATION AND BONE CHIPS	462.83	462.83	473.94	481.34
3179	VERTEBRA (ACUTE)-SECONDARY CLOSURE	173.61	173.61	177.78	180.55
3180	VERTEBRA(CHRONIC)-SEQUESTRECTOMY- SIMPLE	231.23	231.23	236.78	240.48
3181	VERTEBRA(CHRONIC)SAUCERIZATN +/OR BONE GRAFT	404.83	404.83	414.55	421.02
3182	SKULL, OSTEOMYELITIS	I.C.	I.C.	I.C.	I.C.
3183	PHALANX, METACARPAL, METATARSAL	173.61	173.61	177.78	180.55
3184	RADIUS, ULNA, FIBULA	289.17	289.17	296.11	300.74
3185	HUMERUS, TIBIA	378.25	378.25	387.33	393.38
3186	FEMUR, NECK OR SHAFT	578.50	578.50	592.38	601.64
3187	SPINE	I.C.	I.C.	I.C.	I.C.
3188	INCIS-REMOVAL BONE PLATES-LOCAL	118.72	118.72	121.57	123.47
3189	INCIS-REMOVE BONE PLATES-GENERAL	189.55	189.55	194.10	197.13

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
3190	BONE TUMOR	I.C.	I.C.	I.C.	I.C.
3191	BONE BIOPSY-VERTEBRA,X-RAY CONTROL	231.23	231.23	236.78	240.48
3192	BONE BIOPSY-VERTEBRA,OPEN	330.31	330.31	338.24	343.52
3193	BONE BIOPSY-OPEN, PUNCH, SIMPLE	115.72	115.72	118.50	120.35
3194	BONE BIOP-OTHER,PUNCH,X-RAY CONTROL	173.61	173.61	177.78	180.55
3195	BONE BIOPSY-OTHER,OPEN	173.61	173.61	177.78	180.55
3196	MAXILLA	660.67	660.67	676.53	687.10
3197	MANDIBLE	440.41	440.41	450.98	458.03
3199	UPPER EXTREMITY-CARPAL BONE(S)	275.15	275.15	281.75	286.16
3200	UPPER EXTREMITY-RADIUS-STYLOID	231.23	231.23	236.78	240.48
3201	UPPER EXTREMITY-RADIUS HEAD	231.23	231.23	236.78	240.48
3202	RADIUS-HEAD WITH REPLACEMENT	347.11	347.11	355.44	360.99
3203	UPPER EXTREMITY,ULNA-LOWER END	220.21	220.21	225.50	229.02
3205	ULNA,OLECRANON AND FACIAL REPAIR	347.11	347.11	355.44	360.99
3206	HUMERUS-HEAD	440.41	440.41	450.98	458.03
3207	HUMERUS-HEAD WITH REPLACEMENT	550.62	550.62	563.83	572.64
3208	HUMERUS-EXOSTOSIS	220.21	220.21	225.50	229.02
3209	HUMERUS-TUMOR SIMPLE EXCISION	289.17	289.17	296.11	300.74
3210	HUMERUS-TUMOR,EXCISION AND BONE GRAFT	462.83	462.83	473.94	481.34
3211	HUMERUS-TUMOR,RECONSTRUCTION	I.C.	I.C.	I.C.	I.C.
3212	ACROMION OR OUTER END OF CLAVICLE	231.23	231.23	236.78	240.48
3213	EXCISION-FOOTBONES,PROXIMAL PHALANX	173.61	173.61	177.78	180.55
3214	EXCISION AND REPLACEMENT OF TUMOR OF PHALANX	275.20	275.20	281.80	286.21
3215	FOOT BONES,SESAMOIDS	220.21	220.21	225.50	229.02
3216	BUNION-EXOSTECTOMY UNILATERAL	201.75	201.75	206.59	209.82
3217	BUNION-EXOSTECTOMY BILATERAL	208.17	208.17	213.17	216.50
3218	FOOTBONES-KELLER	275.20	275.20	281.80	286.21
3219	FOOTBONES-SCAPHOID	220.21	220.21	225.50	229.02
3220	FOOTBONES-TARSAL BAR	275.20	275.20	281.80	286.21
3221	FOOTBONES-CALCANEAL SPUR,EXOSTOSIS	173.61	173.61	177.78	180.55
3222	FOOT BONES-OS CALCIS OR TALUS	330.31	330.31	338.24	343.52
3223	FOOTBONES-METATARSAL HEAD	173.61	173.61	177.78	180.55
3224	FOOTBONES-EACH ADDITIONAL	57.78	57.78	59.17	60.09
3225	TIBIA-EXOSTOSIS	231.23	231.23	236.78	240.48
3226	PATELLA,EXCISION-RECONSTRUCTION	330.31	330.31	338.24	343.52
3227	PATELLA,EXCISION-PROSTHESIS	462.83	462.83	473.94	481.34
3228	FEMUR,EXOSTOSIS	231.23	231.23	236.78	240.48
3229	FEMUR,HEAD AND NECK	462.83	462.83	473.94	481.34
3230	TRUNK-CERVICAL RIB,COMPLETE REMOVAL	550.62	550.62	563.83	572.64
3232	LENGHTHENING OF BONE-TIBIA	550.62	550.62	563.83	572.64
3233	LENGTHENING OF BONE-FEMUR	660.67	660.67	676.53	687.10
3234	SHORTENING BONE-TIBIA,FEMUR,HUMERUS	550.62	550.62	563.83	572.64
3235	SHORTENING OF BONE-METATARSAL(ONE)	275.20	275.20	281.80	286.21
3236	SHORTNING BONE-METATRSL,MORE THAN 1	385.41	385.41	394.66	400.83
3242	RECONSTRUCT CHEST-PECTUS EXCAVATUM (INFANT)	289.17	289.17	296.11	300.74
3243	RECONSTRCT CHEST-PECT EXCAVATUM (NON-INFNT)	578.50	578.50	592.38	601.64
3244	SCAPULOPEXY-CONGENITAL ELEVATION	462.83	462.83	473.94	481.34
3245	SCAPULOPEXY-WINGED SCAPULA	462.83	462.83	473.94	481.34
3246	RECONSTRUCTION OF FOOT-UNILATERAL	381.88	381.88	391.05	397.16
3247	RECONSTRUCTION OF FOOT-BILATERAL	578.50	578.50	592.38	601.64
3248	METACARPOPHALANGEAL JOINT-UNILATRAL	330.31	330.31	338.24	343.52
3249	METACARPOPHALANGEAL JOINT-BILATERAL	520.56	520.56	533.05	541.38
3250	HIP ARTHROPLASTY-RESURFACING	1,001.04	1,001.04	1,025.06	1,041.08
3251	TOTAL KNEE	813.15	813.15	832.67	845.68
3252	TOTAL ANKLE	710.64	710.64	727.70	739.07
3253	ARTHROPLASTY	173.61	173.61	177.78	180.55
3254	DIAGNOSTIC ARTHROSCPY ALL JOINTS	188.86	188.86	193.39	196.41

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
3255	CONVERSION OF MOORES PROSTHESIS TO TOTAL HIP	1,080.86	1,080.86	1,106.80	1,124.09
3256	REVISION OF TOTAL HIP	1,352.37	1,352.37	1,384.83	1,406.46
3257	REVISION OF TOTAL KNEE	1,244.30	1,244.30	1,274.16	1,294.07
3258	BONE GRAFT (NOT ASS WITH ACUTE FRACTURE	134.87	134.87	138.11	140.26
3259	REMOV TOTL KNEE, W/O REPLCMNT, W/ INSRT SPACER	I.C.	I.C.	I.C.	I.C.
3300	PHALANX-NO REDUCTION	48.90	48.90	50.07	50.86
3301	PHALANX-CLOSED REDUCTION	94.43	94.43	96.70	98.21
3302	PHALANX-OPEN REDUCTION	173.61	173.61	177.78	180.55
3303	METACARPAL-NO REDUCTION (ONE/MORE)	48.90	48.90	50.07	50.86
3304	METACARPAL-REDUCTION	113.90	113.90	116.63	118.46
3305	METACARPAL-OPEN REDUCTION	220.21	220.21	225.50	229.02
3306	BENNETT'S FRACTURE(DISLOCATION)-NO REDUCTION	57.78	57.78	59.17	60.09
3307	BENNETT'S FRACTURE(DISLOCATION)-REDUCTION	127.28	127.28	130.33	132.37
3308	BENNETT'S FRACTURE-OPEN REDUCTION	231.23	231.23	236.78	240.48
3309	CARPUS-CLOSED REDUCTION,ONE OR MORE	127.28	127.28	130.33	132.37
3310	CARPUS-OPEN REDUCTION,ONE OR MORE	220.21	220.21	225.50	229.02
3311	SCAPHOID-CLOSED REDUCTION	127.76	127.76	130.83	132.87
3312	SCAPHOID-EXCISION	220.21	220.21	225.50	229.02
3313	SCAPHOID-BONE GRAFT OR REPLACEMENT	440.41	440.41	450.98	458.03
3314	RADIUS-CLOSED REDUCTION OF HEAD	144.88	144.88	148.36	150.68
3315	RADIUS-EXCISION OR OPEN REDUCTION OF HEAD	220.21	220.21	225.50	229.02
3316	RADIUS AND ULNA-COLLES-NO REDUCTION-CAST	88.01	88.01	90.12	91.53
3317	RADIUS AND ULNA,COLLES-CLOSED REDUCTION	153.97	153.97	157.67	160.13
3318	RADIUS AND ULNA-COLLES,OPEN REDUCTION	330.31	330.31	338.24	343.52
3319	RADIUS AND ULNA,SHAFTS-NO REDUCTION	88.01	88.01	90.12	91.53
3320	RADIUS AND ULNA,SHAFTS-CLOSED REDUCTION	203.41	203.41	208.29	211.55
3321	RADIUS AND ULNA,SHAFTS-OPEN REDUCTION	404.83	404.83	414.55	421.02
3323	MONTEGGIA-CLOSED REDUCTION	242.25	242.25	248.06	251.94
3324	MONTEGGIA OPEN REDUCTION	385.41	385.41	394.66	400.83
3326	RADIUS OR ULNA-NO REDUCTION,CAST	88.01	88.01	90.12	91.53
3327	RADIUS OR ULNA-CLOSED REDUCTION	173.61	173.61	177.78	180.55
3328	RADIUS OR ULNA-OPEN REDUCTION	275.20	275.20	281.80	286.21
3330	OLECRANON-NO REDUCTION,CAST	92.50	92.50	94.72	96.20
3331	OLECRANON-CLOSED REDUCTION	173.61	173.61	177.78	180.55
3332	OLECRANON-OPEN REDUCTION	275.20	275.20	281.80	286.21
3333	HUMERUS-EPICONDYLE,CLOSED REDUCTION	204.48	204.48	209.39	212.66
3334	HUMERUS-EPICONDYLE,OPEN REDUCTION	275.20	275.20	281.80	286.21
3335	SUPRA OR TRANSCONDYLAR-NO REDUCTION	108.07	108.07	110.66	112.39
3336	SUPRA OR TRANSCONDYLAR-CLOSE REDUCTION	254.34	254.34	260.44	264.51
3337	SUPRA OR TRANSCONDYLAR-OPEN REDUCTION	347.11	347.11	355.44	360.99
3338	SHAFT-NO REDUCTION	127.28	127.28	130.33	132.37
3339	SHAFT-CLOSED REDUCTION	242.25	242.25	248.06	251.94
3340	SHAFT-OPEN REDUCTION	385.41	385.41	394.66	400.83
3342	NECK OR TUBEROSITY-NO REDUCTION	127.28	127.28	130.33	132.37
3343	NECK OR TUBEROSITY-CLOSED REDUCTION	242.25	242.25	248.06	251.94
3344	NECK OR TUBEROSITY-OPEN REDUCTION	404.83	404.83	414.55	421.02
3345	PHALANX-NO REDUCTION	46.22	46.22	47.33	48.07
3346	PHALANX-CLOSED REDUCTION	81.05	81.05	83.00	84.29
3347	PHALANX-OPEN REDUCTION	173.61	173.61	177.78	180.55
3348	METATARSAL-NO REDUCTION,ONE OR MORE	57.78	57.78	59.17	60.09
3349	METATARSAL-CLOSED REDUCTION	92.50	92.50	94.72	96.20
3350	METATARSAL-OPEN REDUCTION	220.21	220.21	225.50	229.02
3351	TARSUS-NO REDUCTION-ONE OR MORE	118.50	118.50	121.34	123.24
3352	TARSUS-CLOSED REDUCTION	190.94	190.94	195.52	198.58
3353	TARSUS-OPEN REDUCTION	330.31	330.31	338.24	343.52
3354	OS CALCIS-NO REDUCTION, NO CAST	106.95	106.95	109.52	111.23
3355	OS CALCIS-NO REDUCTION,CAST	115.72	115.72	118.50	120.35

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
3356	OS CALCIS-CLOSED REDUCTION	264.29	264.29	270.63	274.86
3357	OS CALCIS-OPEN REDUCTION	330.31	330.31	338.24	343.52
3358	OS CALCIS-OPEN REDUCTION PRIMARY ARTHRODESIS	440.41	440.41	450.98	458.03
3359	ANKLE FRACTURE-NO REDUCTION	92.50	92.50	94.72	96.20
3360	ANKLE FRACTURE-CLOSED REDUCTION	242.25	242.25	248.06	251.94
3361	ANKLE-OPEN REDUCTION-MEDIAL MALLEOLUS	275.20	275.20	281.80	286.21
3362	ANKLE-OPEN REDUCTION BI OR TRIMALLEAOLAR	385.41	385.41	394.66	400.83
3363	TIBIA-NO REDUCTION	165.48	165.48	169.45	172.10
3364	TIBIA-CLOSED REDUCTION	261.72	261.72	268.00	272.19
3365	TIBIA-OPEN REDUCTION	404.83	404.83	414.55	421.02
3367	FIBULA-NO REDUCTION	81.05	81.05	83.00	84.29
3368	FIBULA-CLOSED REDUCTION	115.72	115.72	118.50	120.35
3369	FIBULA-OPEN REDUCTION	231.23	231.23	236.78	240.48
3370	PATELLA-NO REDUCTION	92.50	92.50	94.72	96.20
3371	PATELLA-CLOSED REDUCTION	115.72	115.72	118.50	120.35
3372	PATELLA-OPEN REDUCTION BY SUTURE	330.31	330.31	338.24	343.52
3373	PATELLA-OPEN REDUCTION BY EXCISION	330.31	330.31	338.24	343.52
3374	FEMUR,SHAFT OR TRANS-NO REDUCTION,CAST	195.06	195.06	199.74	202.86
3375	FEMUR,CLOSED REDUCTION-CHILD	289.17	289.17	296.11	300.74
3376	FEMUR,CLOSED REDUCTION-ADULT	404.83	404.83	414.55	421.02
3377	FEMUR-OPEN REDUCTION	514.46	514.46	526.81	535.04
3379	NECK-NO REDUCTION	231.23	231.23	236.78	240.48
3380	NECK-CLOSED REDUCTION	347.11	347.11	355.44	360.99
3381	NECK OPEN REDUCTION,PIN AND/OR PLATE	632.48	632.48	647.66	657.78
3382	NECK-PROSTHESIS	672.76	672.76	688.91	699.67
3383	SPINE-FRACTURE-SPINOUS/TRANSVERSE	115.72	115.72	118.50	120.35
3384	SPINE-CLOSED REDUCTION	275.20	275.20	281.80	286.21
3385	SPINE-SKULL CALIPERS	115.72	115.72	118.50	120.35
3386	SPINE-OPEN REDUCTION	660.67	660.67	676.53	687.10
3387	SPINE-OPEN REDUCTION WITH FUSION	693.90	693.90	710.55	721.66
3388	SPINE-OPEN AND FUSION WITH CORD INJURY	520.56	520.56	533.05	541.38
3389	SKULL CALIPERS	115.72	115.72	118.50	120.35
3390	SPINE-CLOSED REDUCTION UNDER ANAES	550.62	550.62	563.83	572.64
3391	SPINE-OPEN REDUCTION	809.78	809.78	829.21	842.17
3392	SPINE-OPEN REDUCTION WITH FUSION	809.78	809.78	829.21	842.17
3393	SPINE-OPEN REDUCTION AND FUSION-EACH SURGERY	550.62	550.62	563.83	572.64
3394	SPINE-OPEN,DECOMPRESSION OF CORD	770.72	770.72	789.22	801.55
3395	SACRUM-COMPLETE CARE	57.78	57.78	59.17	60.09
3396	COCCYX-NO REDUCTION-COMPLETE CARE	57.78	57.78	59.17	60.09
3397	COCCYX-EXCISION	220.21	220.21	225.50	229.02
3398	CLAVICLE-NO REDUCTION -CHILD	63.88	63.88	65.41	66.44
3399	CLAVICLE-NO REDUCTION-ADULT	69.44	69.44	71.11	72.22
3400	CLAVICLE-CLOSED REDUCTION-CHILD	118.50	118.50	121.34	123.24
3401	CLAVICLE-CLOSED REDUCTION-ADULT	118.50	118.50	121.34	123.24
3402	CLAVICLE-OPEN REDUCTION	231.23	231.23	236.78	240.48
3404	SCAPULA-NO REDUCTION	63.88	63.88	65.41	66.44
3405	SCAPULA-CLOSED REDUCTION	115.72	115.72	118.50	120.35
3406	STERNUM-NO REDUCTION	57.78	57.78	59.17	60.09
3407	STERNUM-CLOSED REDUCTION	115.72	115.72	118.50	120.35
3408	STERNUM-OPEN REDUCTION	231.23	231.23	236.78	240.48
3409	RIBS-UNCOMPLICATED(THREE OR LESS)	34.72	34.72	35.55	36.11
3410	RIBS-EACH ADDITIONAL (OVER 3)	11.61	11.61	11.89	12.07
3411	RIBS-COMPLICATED	I.C.	I.C.	I.C.	I.C.
3412	PELVIS-NO REDUCTION	20.70	20.70	21.20	21.53
3413	PELVIS-NO REDUCTION	347.11	347.11	355.44	360.99
3414	PELVIS-OPEN REDUCTION	I.C.	I.C.	I.C.	I.C.
3415	NASAL BONES-NO REDUCTION	34.72	34.72	35.55	36.11

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
3416	NASAL BONES-CLOSED,LOCAL	85.97	85.97	88.03	89.41
3417	NASAL BONES-CLOSED,GENERAL	115.72	115.72	118.50	120.35
3418	NASAL BONES-OPEN	231.23	231.23	236.78	240.48
3419	MANDIBLE-NO REDUCTION	57.78	57.78	59.17	60.09
3420	MANDIBLE-CLOSED REDUCTION	231.23	231.23	236.78	240.48
3421	MANDIBLE-OPEN	347.11	347.11	355.44	360.99
3423	MAXILLA-REDUCTION BY DIRECTION-FORCEPS	115.72	115.72	118.50	120.35
3424	MAXILLA-OPEN REDUCTION	231.23	231.23	236.78	240.48
3425	MAXILLA-COMPLICATED	I.C.	I.C.	I.C.	I.C.
3500	ARTHROTOMY-WRIST,ELBOW,SHOULDER,ANKLE	231.23	231.23	236.78	240.48
3501	ARTHROTOMY-KNEE EXPLORATORY	275.20	275.20	281.80	286.21
3502	MENIS/DEB ICOMPARTMENT	424.58	424.58	434.77	441.56
3503	ARTHROTOMY-HIP EXPLORATORY	440.41	440.41	450.98	458.03
3504	CAPSULECTOMY-ELBOW,WRIST	347.11	347.11	355.44	360.99
3505	CAPSULECTOMY-SHOULDER	462.83	462.83	473.94	481.34
3506	CAPSULECTOMY-HIP	550.62	550.62	563.83	572.64
3507	SYNOVECTOMY 2 OR MORE COMPARTMENTS	462.83	462.83	473.94	481.34
3508	CAPSULECTOMY-FINGERS,TOES	173.61	173.61	177.78	180.55
3509	NEURECTOMY-ELBOW,KNEE	330.31	330.31	338.24	343.52
3510	NEURECTOMY-HIP	404.83	404.83	414.55	421.02
3512	CHONDRECTOMY-KNEE MENISECTOMY	330.31	330.31	338.24	343.52
3513	CHRONDRECTOMY-BAKER'S CYST (KNEE)	173.61	173.61	177.78	180.55
3514	EXCISION OF INTERVERTEBRAL DISC	550.62	550.62	563.83	572.64
3515	EXCIS-INTERVERT DISC,BILATERAL MULTPLE	693.90	693.90	710.55	721.66
3519	FUSION-ONE SURGEON	809.78	809.78	829.21	842.17
3520	FUSION-TWO SURGEONS	520.56	520.56	533.05	541.38
3521	INTERPHALANGEAL,METACARPOPHALANGEAL	231.23	231.23	236.78	240.48
3522	HAND,RECONSTRUCT-RHEUMATOID JOINTS	550.62	550.62	563.83	572.64
3523	ARTHOPLASTY-WRIST,ANKLE	440.41	440.41	450.98	458.03
3524	ARTHOPLASTY-SHOULDER,ELBOW,KNEE	813.15	813.15	832.67	845.68
3525	ACROMIO OR STERNOCLAVICULAR	289.17	289.17	296.11	300.74
3526	FOOT-HALLUX RIGIDUS	231.23	231.23	236.78	240.48
3528	FOOT-KELLER OPERATION	275.20	275.20	281.80	286.21
3529	HIP-CUP ARTHROPLASTY	693.90	693.90	710.55	721.66
3530	HIP-TOTAL ARTHROPLASTY	862.47	862.47	883.17	896.97
3531	ARTHRODESIS-FINGER,THUMB	231.23	231.23	236.78	240.48
3532	ARTHRODESIS-WRIST,ELBOW,ANKLE	440.41	440.41	450.98	458.03
3533	ARTHRODESIS-SHOULDER,KNEE,SACROILIC	550.62	550.62	563.83	572.64
3534	ARTHRODESIS-HIP	693.90	693.90	710.55	721.66
3535	ARTHRODESIS-FOOT,TOE, ONE JOINT	390.18	390.18	399.54	405.79
3536	ARTHRODESIS-FOOT,TOE,MULTIPLE JOINT	34.72	34.72	35.55	36.11
3537	ARTHRODESIS-FOOT MID-TARSAL	440.41	440.41	450.98	458.03
3538	ARTHRODESIS-FOOT PAN TALER	578.50	578.50	592.38	601.64
3539	ARTHRODESIS-CONGENITAL CLUB FOOT	550.62	550.62	563.83	572.64
3540	SPINAL COLUMN FUSION-ONE OR TWO SPACES	660.67	660.67	676.53	687.10
3541	SPINAL COLUMN.FUSION MORE THAN 2 SPACE	809.78	809.78	829.21	842.17
3542	SYNOVECTOMY 1 COMPARTMENT	330.31	330.31	338.24	343.52
3544	REDUCTION WITH EXTERNAL PIN FIX	150.44	150.44	154.05	156.46
3545	CHEMONUCLEOLYSIS INCL NEEDL & INJECTN PER DISC	259.21	259.21	265.43	269.58
3546	DISLOCATION OF HEAD OF RADIUS	49.70	49.70	50.89	51.69
3547	MENISECTOMY/DEBRIDMNT 2 OR MORE COMPRTMNTS	529.33	529.33	542.03	550.50
3548	REDUCTN+PINNING INTRA-ARTICULAR FRAGMENTS	330.31	330.31	338.24	343.52
3549	MENISCAL REPAIR (MEDIAL OR LATERAL)	330.31	330.31	338.24	343.52
3550	SHOULDER ARTHROPLASTY	1,001.04	1,001.04	1,025.06	1,041.08
3600	FINGER AND THUMB-CLOSED REDUCTION,ONE	57.78	57.78	59.17	60.09
3601	FINGER AND THUMB-OPEN REDUCTION	173.61	173.61	177.78	180.55
3602	METACARPOPHALANGEAL-CLOSE REDUCTION	65.06	65.06	66.62	67.66

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
3603	METCARPOPHALANGEAL-OPEN REDUCTION	173.61	173.61	177.78	180.55
3604	WRIST AND CARPAL BONES-CLOSED REDUCTION	173.61	173.61	177.78	180.55
3605	WRIST AND CARPAL BONES-OPEN REDUCTION	330.31	330.31	338.24	343.52
3606	ELBOW-CLOSED REDUCTION	183.56	183.56	187.97	190.90
3607	ELBOW-OPEN REDUCTION	330.31	330.31	338.24	343.52
3608	SHOULDER-CLOSED REDUCTION	121.23	121.23	124.14	126.08
3609	SHOULDER-OPEN REDUCTION	404.83	404.83	414.55	421.02
3610	SHOULDER-RECURRENT DISLOCATIONS	484.44	484.44	496.07	503.82
3611	ACROMIOCLAVICULAR-CLOSED REDUCTION	69.44	69.44	71.11	72.22
3612	ACROMIOCLAVICULAR-OPEN REDUCTION	289.17	289.17	296.11	300.74
3613	STERNOCLAVICULAR-CLOSED REDUCTION	63.56	63.56	65.09	66.10
3614	STERNOCLAVICULAR-OPEN REDUCTION	231.23	231.23	236.78	240.48
3615	TOE,INTERPHALANGEAL-CLOSED REDUCTION	34.72	34.72	35.55	36.11
3616	TOE,INTERPHALANGEAL-OPEN REDUCTION	173.61	173.61	177.78	180.55
3617	METATARSOPHALANGEAL-CLOSE REDUCTION	65.06	65.06	66.62	67.66
3618	METATARSOPHALANGEAL-OPEN REDUCTION	173.61	173.61	177.78	180.55
3619	TARSAL-CLOSED REDUCTION	144.88	144.88	148.36	150.68
3620	TARSAL-OPEN REDUCTION	289.17	289.17	296.11	300.74
3621	ANKLE-CLOSED REDUCTION	177.41	177.41	181.67	184.51
3622	ANKLE-OPEN REDUCTION	330.31	330.31	338.24	343.52
3623	ANKLE REPAIR-RECURRENT SUBLUXATION	440.41	440.41	450.98	458.03
3624	KNEE-CLOSED REDUCTION	204.48	204.48	209.39	212.66
3625	KNEE-SIMPLE REDUCTION	404.83	404.83	414.55	421.02
3626	PATELLA-CLOSED REDUCTION	81.05	81.05	83.00	84.29
3627	PATELLA-OPEN REDUCTN FOR RECURR DISLOCATION	347.11	347.11	355.44	360.99
3628	HIP-CLOSED REDUCTION	204.48	204.48	209.39	212.66
3629	HIP-OPEN REDUCTION	404.83	404.83	414.55	421.02
3630	HIP-CENTRAL DISLOCATION-CLOSED REDUCTION	231.23	231.23	236.78	240.48
3631	HIP-CENTRAL DISLOCATION-OPEN REDUCTION	462.83	462.83	473.94	481.34
3632	HIP-CONGENITAL DISLOCATION-CLOSED UNILATERAL	173.61	173.61	177.78	180.55
3633	HIP-CONGEN DISLOCN-REPEAT MANIPUL+PLASTER	81.05	81.05	83.00	84.29
3634	HIP-CONGENITAL DISLOCATION-OSTEOTOMY	462.83	462.83	473.94	481.34
3635	HIP-CONGENITAL DISLOCATION-ACETABULOPLASTY	578.50	578.50	592.38	601.64
3636	SPINE-INTERVERTEBRAL-CLOSED REDUCTION	231.23	231.23	236.78	240.48
3637	SPINE-INTERVERTEBRAL-OPEN REDUCTION	440.41	440.41	450.98	458.03
3638	OPEN REDUCTION-FUSION CERVICAL SPINE	715.72	715.72	732.90	744.35
3639	OPEN REDUCTION-FUSION,THORACIC AND LUMBAR	693.90	693.90	710.55	721.66
3640	SACROCOCCYGEAL-OPEN REDUCTION	231.23	231.23	236.78	240.48
3641	TEMPOROMANDIBULAR-CLOSED REDUCTION	50.66	50.66	51.88	52.69
3642	TEMPOROMANDIBULAR-OPEN REDUCTION	231.23	231.23	236.78	240.48
3643	MANIPULATION OF WRIST,ELBOW,ANKLE	34.72	34.72	35.55	36.11
3644	MANIPULATION OF SHOULDER,KNEE,HIP	57.78	57.78	59.17	60.09
3645	CONGENITAL FOOT DENNIS BROWN SPLINTS	23.06	23.06	23.61	23.98
3646	CONGENITAL FOOT MANIPULATION AND CAST	34.72	34.72	35.55	36.11
3647	KNEE-OPEN REDUCTION-RECONSTRUCT LIGAMENTS	520.56	520.56	533.05	541.38
3648	PATELLA-OPEN REDUCTN-RECONSTRUCT LIGAMENTS	520.56	520.56	533.05	541.38
3701	BURSA-INCISION,REMOVAL OF CALCIUM	231.23	231.23	236.78	240.48
3702	BURSA,EXCISION OLECRANON	173.61	173.61	177.78	180.55
3703	BURSA-EXCISION HUMERO-RADIAL	173.61	173.61	177.78	180.55
3704	BURSA-EXCISION-SUB-ACROMIAL	231.23	231.23	236.78	240.48
3705	BURSA-EXCISION-SUB TROCHANTERIC	275.20	275.20	281.80	286.21
3706	BIOPSY-SUPERFICIAL BURSA	34.72	34.72	35.55	36.11
3750	MUSCLES-REMOVAL OF FOREIGN BODY	57.78	57.78	59.17	60.09
3751	MUSCLE-COMPLICATED REMOVAL FOREIGN BODY	I.C.	I.C.	I.C.	I.C.
3754	TENNIS ELBOW	173.61	173.61	177.78	180.55
3755	MUSCLE BIOPSY	57.78	57.78	59.17	60.09
3756	RESECTION OF MUSCLE	I.C.	I.C.	I.C.	I.C.

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
3757	LOCAL EXCISION OF LESION OF MUSCLE	81.05	81.05	83.00	84.29
3758	MANIPULATION AND INJECTION-TENNIS ELBOW	34.72	34.72	35.55	36.11
3760	QUADRICEPSPLASTY	404.83	404.83	414.55	421.02
3800	EXPLORATION OF TENDON/TENDON SHEATH	138.83	138.83	142.16	144.38
3801	TENOSYNOVITIS,FINGER	138.83	138.83	142.16	144.38
3802	TRIGGER FINGER-RELEASE	138.83	138.83	142.16	144.38
3803	EXPLORATION OF FASCIA	164.57	164.57	168.52	171.15
3804	DRAINAGE OF TENDON SHEATH	138.83	138.83	142.16	144.38
3805	TENOTOMY-TOE,SINGULAR	34.72	34.72	35.55	36.11
3806	TENOTOMY-TOE,MULTIPLE	57.78	57.78	59.17	60.09
3807	TENOTOMY-PLANTAR FASCIA	57.78	57.78	59.17	60.09
3808	TENOTOMY-HIP ADDUCTORS	57.78	57.78	59.17	60.09
3809	TENOTOMY-TENDO ACHILLES	57.78	57.78	59.17	60.09
3810	GANGLION-TENDON SHEATH OR JOINT	138.78	138.78	142.11	144.33
3811	BAKER'S CYST-DEQUERVAINS	277.56	277.56	284.22	288.66
3812	TENDON SHEATH FOR TUBERCULOSIS	347.11	347.11	355.44	360.99
3813	FASCIA FOR DUPUYTREN'S-PARTIAL	231.23	231.23	236.78	240.48
3814	FASCIA FOR DUPUYTREN'S-COMPLETE	404.83	404.83	414.55	421.02
3815	XANTHOMA	115.72	115.72	118.50	120.35
3816	TENOPLASTY-ONE TENDON	231.23	231.23	236.78	240.48
3817	TENOPLASTY-TWO OR MORE TENDONS	289.17	289.17	296.11	300.74
3818	TENDON GRAFT-WRIST OR HAND-SINGLE	440.41	440.41	450.98	458.03
3819	TENDON GRAFT-WRIST/HAND-TWO AND GREATER	550.62	550.62	563.83	572.64
3820	TENDON GRAFT-OTHER LOCATION	437.95	437.95	448.46	455.47
3821	FASCIOTOMY	220.21	220.21	225.50	229.02
3823	TENDON TRANSPLANT-HAND,FOREARM-SINGLE	231.23	231.23	236.78	240.48
3824	TENDON TRANSPLANT-HAND,FOREARM-MULTIPLE	404.83	404.83	414.55	421.02
3825	SHOULDER-PECTORALIS MINOR	231.23	231.23	236.78	240.48
3826	TENDON TRANS SHOULDER TRAPEZIUS	385.41	385.41	394.66	400.83
3827	TENDON TRANSPLANT-FOOT,ANKLE,SINGLE	231.23	231.23	236.78	240.48
3828	TENDON TRANSPLANT-FOOT,ANKLE-MULTIPLE	404.83	404.83	414.55	421.02
3829	KNEE-TRANSPOSITION OF TENDONS	347.11	347.11	355.44	360.99
3830	FOOT-TENDODESIS	231.23	231.23	236.78	240.48
3831	REPAIR OF MALLET FINGER-CLOSED	59.12	59.12	60.54	61.48
3832	REPAIR OF MALLET FINGER-OPERATIVE	173.61	173.61	177.78	180.55
3833	SUTURE-EXTENSOR TENDON-SINGLE	173.61	173.61	177.78	180.55
3834	SUTURE-EXTENSOR TENDON EACH SUBSEQUENT	80.25	80.25	82.18	83.46
3835	SUTURE-FLEXOR TENDON-SINGLE	267.50	267.50	273.92	278.20
3836	SUTURE-FLEXOR TENDON EACH SUBSEQUENT	133.75	133.75	136.96	139.10
3837	SUTURE-ACHILLES,BICEPS,QUADRICEPS	289.17	289.17	296.11	300.74
3838	FASCIA AND LIGAMENTS-SHOULDER CUFF TEAR	385.41	385.41	394.66	400.83
3839	FASCIA AND LIGAMENTS-SHOULDER-LATE REPAIR	462.83	462.83	473.94	481.34
3840	RECONSTRUCTION OF SHOULDER ACROMIOPLASTY	347.11	347.11	355.44	360.99
3841	ACROMIOCLAVICULAR/STERNOCLAVICULAR	385.41	385.41	394.66	400.83
3842	ELBOW,WRIST,ANKLE-EARLY REPAIR	231.23	231.23	236.78	240.48
3843	ELBOW,WRIST,ANKLE-LATE REPAIR	404.83	404.83	414.55	421.02
3844	KNEE-EARLY REPAIR	347.11	347.11	355.44	360.99
3845	KNEE-LATE REPAIR	509.11	509.11	521.33	529.47
3846	METACARPOPHALANGEAL-EARLY OR LATER	173.61	173.61	177.78	180.55
3847	TENOPLASTY-ACHILLES BICEPS/QUADRICEPS TENDON	275.20	275.20	281.80	286.21
3848	LATERAL/MEDIAL RETNACULAR RELEASE	194.47	194.47	199.14	202.25
3849	EXTENSOR TENDOR-PARTIALLY SEVERED	160.50	160.50	164.35	166.92
3900	AMPUTATION-UP EXTREMITY THROUGH PHALANX	80.25	80.25	82.18	83.46
3901	AMPUTATION THROUGH METACARPAL OR MP JOINT	115.72	115.72	118.50	120.35
3902	AMPUTATION HAND-THROUGH ALL METACARPALS	289.17	289.17	296.11	300.74
3903	AMPUTN UP EXTREMITY THROUGH RADIUS AND ULNA	347.11	347.11	355.44	360.99
3904	AMPUTATION UP EXTREMITY THROUGH HUMERUS	347.11	347.11	355.44	360.99

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
3905	AMPUTATION UPPER EXTREMITY AT SHOULDER	404.83	404.83	414.55	421.02
3906	AMPUTATION UPPER EXTREMITY,FORE QUARTER	550.62	550.62	563.83	572.64
3907	AMPUTN-LOWER EXTREMITY THROUGH PHALANX	81.05	81.05	83.00	84.29
3908	AMPUTATION THROUGH METATARSAL OR MP JOINT	115.72	115.72	118.50	120.35
3909	AMPUTATION-LOWER-TRANSMETATARSAL	275.20	275.20	281.80	286.21
3910	AMPUTATION-LOWER-SYMES	330.31	330.31	338.24	343.52
3911	AMPUTATION-LOWER-THROUGH TIBIA AND FIBULA	347.11	347.11	355.44	360.99
3912	AMPUTATION-LOWER-AT KNEE	347.11	347.11	355.44	360.99
3913	AMPUTATION-LOWER-THROUGH FEMUR	347.11	347.11	355.44	360.99
3914	AMPUTATION-LOWER-AT HIP	660.67	660.67	676.53	687.10
3915	AMPUTATION-LOWER-HIND QUARTER	809.78	809.78	829.21	842.17
3916	AMPUTATION-LOWER-HEMIPELVECTOMY	809.78	809.78	829.21	842.17
4000	NOSE-NASAL ABSCESS	59.12	59.12	60.54	61.48
4001	NOSE-SEPTAL ABSCESS	92.50	92.50	94.72	96.20
4002	BIOPSY OF SOFT TISSUE	53.50	53.50	54.78	55.64
4003	NASAL POLYPI-UNILATERAL LOCAL	34.72	34.72	35.55	36.11
4004	NASAL POLYPI-UNILATERAL GENERAL	57.78	57.78	59.17	60.09
4005	NASAL POLYPI-BILATERAL LOCAL	57.78	57.78	59.17	60.09
4006	NASAL POLYPI-BILATERAL GENERAL	115.72	115.72	118.50	120.35
4007	EXCISION OF CHOANAL POLYP	81.05	81.05	83.00	84.29
4009	EXCISION-NOSE SKIN-RHINOPHYMA,UNCOMPLICATED	81.05	81.05	83.00	84.29
4010	SEPTECTOMY	231.23	231.23	236.78	240.48
4011	SEPTECTOMY INCLUDING SEPTOPLASTY	289.17	289.17	296.11	300.74
4012	TURBINECTOMY	46.22	46.22	47.33	48.07
4013	SUBMUCOSAL TURBINECTOMY	I.C.	I.C.	I.C.	I.C.
4014	RHINOSCOPY-REMOVAL FOREIGN BODY-NOSE	37.45	37.45	38.35	38.95
4015	RHINOSCOPY-GENERAL ANESTHETIC	46.22	46.22	47.33	48.07
4016	RHINOPLASTY/CLOSURE SEPTAL PERFORATION	680.36	680.36	696.69	707.57
4019	INFRACTION OF TURBINATE	23.06	23.06	23.61	23.98
4020	CAUTERIZATION TURBINATES-UNILATERAL	34.72	34.72	35.55	36.11
4021	CAUTERIZATION TURBINATES-BILATERAL	57.78	57.78	59.17	60.09
4022	NASAL HEMORRHAGE-CAUTERIZ NASAL SEPTUM	23.06	23.06	23.61	23.98
4023	NASAL HEMORRHAGE-ANTERIOR NASAL PACKING	53.50	53.50	54.78	55.64
4024	NASAL HEMORRHAGE-POSTERIOR NASAL PACKING	90.95	90.95	93.13	94.59
4025	CONTROL OF SECONDARY HEMORRHAGE	81.05	81.05	83.00	84.29
4026	CATHETERIZATION OF EUSTACHIAN TUBE	11.61	11.61	11.89	12.07
4027	SINUSOTOMY-MAXILLARY,INTRANASAL-UNILATERAL	138.83	138.83	142.16	144.38
4028	SINUSOTOMY-RADICAL-UNILATERAL	330.31	330.31	338.24	343.52
4029	FRONTAL TREPHINE AND SINUSECTOMY	173.61	173.61	177.78	180.55
4030	FRONTAL-RADICAL	550.62	550.62	563.83	572.64
4031	FRONTAL-EXTERNAL FRONTO-ETHMOIDAL	173.61	173.61	177.78	180.55
4032	ETHMOIDAL-INTRANASAL,UNILATERAL	173.61	173.61	177.78	180.55
4033	SPHENOIDAL-INTRANASAL	231.23	231.23	236.78	240.48
4034	LAVAGE-MAXILLARY	23.06	23.06	23.61	23.98
4035	LAVAGE-FRONTAL	46.22	46.22	47.33	48.07
4036	LAVAGE-SPHENOIDAL	46.22	46.22	47.33	48.07
4037	SUTURE-CLOSURE ANTRO-ORAL FISTULA	347.11	347.11	355.44	360.99
4040	EXAM POST-NASAL SPACE UNDER GEN ANAESTHESIA	45.26	45.26	46.35	47.07
4041	SUBMUCUS DIATHERMY/TURBINATES	60.94	60.94	62.40	63.38
4100	LARYNGECTOMY-PARTIAL	462.83	462.83	473.94	481.34
4101	LARYNGECTOMY-TOTAL	693.90	693.90	710.55	721.66
4104	INTUBATION OF LARYNX	60.00	60.00	61.44	62.40
4105	LARYNGOSCOPY-DIRECT	85.00	85.00	87.04	88.40
4106	LARYNGOSCOPY-DIRECT WITH BIOPSY	105.00	105.00	107.52	109.20
4107	LARYNGOSCOPY-REMOVAL FOREIGN BODY	200.00	200.00	204.80	208.00
4108	LARYNGOSCOPY-REMOVAL BENIGN GROWTH	250.00	250.00	256.00	260.00
4109	LARYNGOSCOPY-INDIRECT WITH BIOPSY	85.00	85.00	87.04	88.40

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
4110	LARYNGOPLASTY	I.C.	I.C.	I.C.	I.C.
4111	ARYTENOIDOPEXY	440.41	440.41	450.98	458.03
4200	TRACHEOSTOMY	220.21	220.21	225.50	229.02
4201	BRONCHOSCOPY-DIAGNOSTIC	152.31	152.31	195.92	225.00
4202	BRONCHOSCOPY WITH BIOPSY	152.31	152.31	195.92	225.00
4203	BRONCHOSCPY-INSERT RADIOACTIVE SUBSTANCE	152.31	152.31	195.92	225.00
4204	BRONCHOSCOPY-REMOVAL FOREIGN BODY	220.21	220.21	225.50	229.02
4205	BRONCHOSCOPY WITH EXCISION TUMOR	220.21	220.21	225.50	229.02
4206	BRONCHO-ESOPHAGOSCOPY	208.17	208.17	213.17	216.50
4207	TRACHEORRHAPY	173.61	173.61	177.78	180.55
4208	CLOSE TRACHEOSTOMY/TRACHEAL FISTULA	173.61	173.61	177.78	180.55
4209	QUADROSCOPY	201.05	201.05	215.42	225.00
4210	BRONCHOSCOPY W/ TRANSBRONCH LUNG BX -SINGLE LOBE	209.72	209.72	214.75	218.11
4211	ENDOSCOPY THROUGH TRACHEOSTOMY	53.50	53.50	54.78	55.64
4212	BRONCHOSCOPY +TRANSBRONCH LUNG BX -ADD'L LOBE	53.50	53.50	54.78	55.64
4213	BRONCHOSC'PY +TRANSBRONCH NEEDLE ASPIRAT'N NODES	209.72	209.72	214.75	218.11
4214	ENDOBRONCHIAL ULTRASOUND (EBUS)	285.88	285.88	292.74	297.32
4300	MEDIASTINOTOMY	462.83	462.83	473.94	481.34
4302	CHEST WALL TUMOR	733.06	733.06	750.65	762.38
4303	MEDIASTINAL TUMOR	578.50	578.50	592.38	601.64
4304	MEDIASTINOSCOPY	283.76	283.76	290.57	295.11
4305	THORACOPLASTY-ONE STAGE	440.41	440.41	450.98	458.03
4306	THORACOPLASTY-MULTI-STAGE	277.56	277.56	284.22	288.66
4308	PNEUMOLYSIS-INTRAPLEURAL	208.17	208.17	213.17	216.50
4309	PNEUMOLYSIS-EXTRAPLEURAL	347.11	347.11	355.44	360.99
4310	APICOLYSIS-EXTRAFASCIAL	347.11	347.11	355.44	360.99
4311	APICOLYSIS-EXTRAPLEURAL	347.11	347.11	355.44	360.99
4313	TRANSAXILLARY-RESECTION 1ST RIB	543.88	543.88	556.93	565.64
4350	TELEPHONE CONSULTATION - MEDICAL MICROBIOLOGY	0.00	0.00	46.08	46.80
4400	THORACOTOMY-CLOSED DRAINAGE	189.18	189.18	193.72	196.75
4401	THORACOTOMY-RIB RESECTION	283.76	283.76	290.57	295.11
4402	THORACOTOMY-DRAINAGE LUNG ABCESS	416.39	416.39	426.38	433.05
4403	EXPLORATORY THORACOTOMY	416.39	416.39	426.38	433.05
4404	BIOPSY OF PLEURA OR LUNG	472.94	472.94	484.29	491.86
4406	PNEUMONECTOMY	945.88	945.88	968.58	983.72
4407	LOBECTOMY	910.41	910.41	932.26	946.83
4408	LOBECTOMY WITH SEGMENTAL RESECTION	809.78	809.78	829.21	842.17
4409	SEGMENTAL RESECTION	809.78	809.78	829.21	842.17
4410	WEDGE RESECTION	567.53	567.53	581.15	590.23
4411	PLEURECTOMY-PLEURAL DECORTICATION	662.12	662.12	678.01	688.60
4412	PLEURECTOMY-WITH BULLOUS EMPHYSEMA	660.67	660.67	676.53	687.10
4413	THORACOSCOPY	236.47	236.47	242.15	245.93
4500	VENOGRAM	57.83	57.83	59.22	60.14
4501	VENOUS ANASTOMOSIS-PORTO CAVAL SHUNT	809.78	809.78	829.21	842.17
4502	VENOUS ANASTOMOSIS-SPLENO RENAL SHUNT	809.78	809.78	829.21	842.17
4503	VENOUS ANASTOMOSIS-MESO CAVAL SHUNT	770.72	770.72	789.22	801.55
4505	CREATION OF A-V FISTULA	416.39	416.39	426.38	433.05
4506	JUGULAR VEIN,INTERNAL	173.61	173.61	177.78	180.55
4508	INFERIOR VENA CAVA-LIGATION OR PLICATION	462.83	462.83	473.94	481.34
4510	SAPHENOUS	57.78	57.78	59.17	60.09
4511	INJECTION-SINGLE	11.61	11.61	11.89	12.07
4512	INJECTION-MULTIPLE AT SAME SITTING	49.70	49.70	50.89	51.69
4513	LIGATION,MULTIPLE-ONE LEG	138.83	138.83	142.16	144.38
4514	LIGAT SAPHENO-FEM OR SAPHEN-POP JUNCT (ONE LEG)	138.83	138.83	142.16	144.38
4515	LONG SAPHEN LIGAT/STRIPPING STAB AVULS (ONE LEG)	231.23	231.23	236.78	240.48
4516	MULT LOW LIGATION &EXCISN LIGATN-PERFORAORS	289.17	289.17	296.11	300.74
4517	SHORT SAPHENOUS LIGATION/ STRIPPING (ONE LEG)	115.72	115.72	118.50	120.35

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
4518	RECURRENT OR COMPLICATED VARICOSE VEINS	408.42	408.42	418.22	424.76
4519	EXCISION ULCER,LIGAT/STRIPPING/SKIN GRAFT(ONE LEG)	347.11	347.11	355.44	360.99
4521	EXCISION STASIS ULCER AND SKIN GRAFT	231.23	231.23	236.78	240.48
4522	SUB-FASCIAL LIGATION	347.11	347.11	355.44	360.99
4523	SUB FASCIAL LIGATION-STRIPPING VEIN	462.83	462.83	473.94	481.34
4524	TROMBECTOMY,ILIAC OR FEMORAL	550.62	550.62	563.83	572.64
4525	DISTAL SPLENORENAL SHUNT	992.75	992.75	1,016.58	1,032.46
4526	SUPERIOR VENA CAVA BYPASS GRAFT	596.47	596.47	610.79	620.33
4527	OBLITERATION OF AV FISTULA	66.23	66.23	67.82	68.88
4528	SUTURE-A MAJOR VEIN REPAIR	298.21	298.21	305.37	310.14
4529	SCLEROTHERAPY COMPREHENSIVE (ONE LEG)	124.33	124.33	127.31	129.30
4530	REPAIR MAJOR VEIN OR MICROREPAIR DIGITAL VEIN	272.14	272.14	278.67	283.03
4531	REPAIR MAJOR VEIN BY PATCH	425.65	425.65	435.87	442.68
4532	REPAIR MAJOR VEIN BY VEIN GRAFT	566.07	566.07	579.66	588.71
4533	REPAIR A-V ANOMALY	416.39	416.39	426.38	433.05
4534	ESOPH DEVASC/TRANSECTION/REANASTOMOSIS W/SPLENECTOM	768.82	768.82	787.27	799.57
4535	VASCULAR STENT (ADD)	68.27	68.27	69.91	71.00
4536	OPERATIVE ARTERIOGRAM-ONE OR MORE (ADD)	57.78	57.78	59.17	60.09
4537	DILATION/STENT ILIAC ARTERY - UNILATERAL	267.99	267.99	274.42	278.71
4538	ANGIOGRAPHY-RENAL/MESENTERIC-PER VESSEL (ADD)	21.40	21.40	21.91	22.26
4599	ARTERIAL CANNULATION	60.00	60.00	61.44	62.40
4600	ARTERIOTOMY	81.05	81.05	83.00	84.29
4603	TRANSECTION OF ARTERY	173.61	173.61	177.78	180.55
4604	INTRA-ABDOMINAL OR INTRA-THORACIC	231.23	231.23	236.78	240.48
4606	THORACIC AORTA WITHOUT BYPASS	809.78	809.78	829.21	842.17
4607	THORACIC AORTA-WITH BYPASS	1,041.16	1,041.16	1,066.15	1,082.81
4608	ABDOMINAL AORTA	925.50	925.50	947.71	962.52
4609	ABDOMINAL AORTA WITH RUPTURE	1,041.16	1,041.16	1,066.15	1,082.81
4617	AORTA-BIFURCATION GRAFT	1,139.34	1,139.34	1,166.68	1,184.91
4618	THROMBOENDARTERECTOMY	693.90	693.90	710.55	721.66
4619	THROMBOENDARTERECTOMY OF AORTA/BIFURCATION	809.78	809.78	829.21	842.17
4620	FEM/POP, FEM/FEM, AXILLO/FEM - SYNTHETIC GRAFT	578.50	578.50	592.38	601.64
4621	FEM/POP, FEM/FEM, AXILLO/FEM - AUTOGEN.VEIN GRAFT	693.90	693.90	710.55	721.66
4622	EMBOLECTOMY-AORTIC/TRANSFEMORAL - BILAT.	693.90	693.90	710.55	721.66
4623	EMBOLECTOMY-ILIAC OR FEMORAL	462.83	462.83	473.94	481.34
4624	MESENTERIC EMBOLECTOMY	481.50	481.50	493.06	500.76
4625	EMBOLECTOMY-RENAL	578.50	578.50	592.38	601.64
4627	CAROTID BODY TUMOR	693.90	693.90	710.55	721.66
4628	CAROTID BODY TUMOR WITH GRAFT	751.94	751.94	769.99	782.02
4629	CAROTID BODY TUMOR-VESSEL BYPASS	809.78	809.78	829.21	842.17
4630	ARTERIOGRAPHY CAROTID	115.72	115.72	118.50	120.35
4631	ARTERIOGRAPHY-FEMORAL UNILATERAL	57.78	57.78	59.17	60.09
4632	ARTERIOGRAPHY-FEMORAL BILATERAL	92.50	92.50	94.72	96.20
4633	AORTOGRAPHY-PERCUTANEOUS	115.72	115.72	118.50	120.35
4634	AORTOGRAPHY-EXPOSURE MAJOR ARTERY	173.61	173.61	177.78	180.55
4635	ARTERIOGRAPHY-SELECTIVE	115.72	115.72	118.50	120.35
4636	AORTOGRAPHY-ARTERIAL CANNULATION	57.78	57.78	59.17	60.09
4637	ARTERIOPLASTY-FEMORAL	347.11	347.11	355.44	360.99
4638	ARTERIOPLASTY-ILIAC	347.11	347.11	355.44	360.99
4639	SUTURE-LIGATION CAROTID,NECK-SIMPLE	173.61	173.61	177.78	180.55
4641	LIGATION ANTERIOR ETHMOID ARTERY	115.72	115.72	118.50	120.35
4642	PROFUNDOPLASTY- TO FIRST MAJOR BRANCH	462.83	462.83	473.94	481.34
4643	EXPOSURE OF LEG VESSELS	115.72	115.72	118.50	120.35
4644	FEMORAL ANTERIOR OR POSTERIOR TIBIAL BYPASS	751.94	751.94	769.99	782.02
4650	REPAIR OF FALSE ANEURYSM	701.12	701.12	717.95	729.16
4651	REPAIR OF POPLITEAL OR FEMORAL ANEURYSM	648.15	648.15	663.71	674.08
4652	EXTENDED PROFUNDOPLASTY- TO 2ND MAJOR BRANCH	612.90	612.90	627.61	637.42

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
4653	IN-SITU PERIPHERAL VEIN GRAFT PROCEDURE (ADD)	264.99	264.99	271.35	275.59
4654	REIMPLANT INFERIOR MESENTERIC ARTERY (ADD)	139.15	139.15	142.49	144.72
4655	INTERRUPT VENA CAVA - TRANSVENOUS IVC FILTER	278.20	278.20	284.88	289.33
4656	HARVEST ARM VEIN (ADD)	106.23	106.23	108.78	110.48
4657	HARVEST SUP.FEM. VEIN (ADD)	106.23	106.23	108.78	110.48
4658	HARVEST OPPOSITE LEG VEIN (ADD)	88.40	88.40	90.52	91.94
4659	ENDARTERECTOMY - FEMORAL OR POPLITEAL	650.22	650.22	665.83	676.23
4660	CAROTID ANEURYSM REPAIR	702.52	702.52	719.38	730.62
4661	SUBCLAVIAN ANEURYSM REPAIR	742.45	742.45	760.27	772.15
4662	BRACHIOCEPHALIC ARTERIAL BYPASS	562.01	562.01	575.50	584.49
4663	AXILLARY/BRACHIAL ANEURYSM REPAIR - SYNTHETIC	578.50	578.50	592.38	601.64
4664	AXILLARY/BRACHIAL ANEURYSM REPAIR - VEIN	693.90	693.90	710.55	721.66
4665	THORACO-ABDOMINAL ANEURYSM REPAIR	1,655.29	1,655.29	1,695.02	1,721.50
4666	THORACO-ABDOMINAL ANEURYSM REPAIR (RUPTURED)	1,809.00	1,809.00	1,852.42	1,881.36
4667	PELVIC ANEURYSM REPAIR - LIGATION	387.88	387.88	397.19	403.40
4668	PELVIC ANEURYSM REPAIR - GRAFT	603.00	603.00	617.47	627.12
4669	ILIO-FEMORAL BYPASS	627.02	627.02	642.07	652.10
4670	REPAIR LACERATION MAJOR ARTERY OR MICRO DIGITAL	426.84	426.84	437.08	443.91
4671	SUTURE LACERATION MAJOR ARTERY LIMB	271.22	271.22	277.73	282.07
4672	TOTAL REMOVAL INFECTED AORTIC GRAFT	786.11	786.11	804.98	817.55
4673	PARTIAL REMOVAL INFECTED AORTIC GRAFT	294.46	294.46	301.53	306.24
4674	CLOSURE DUODENAL FISTULA (ADD)	108.75	108.75	111.36	113.10
4675	VISCERAL ARTERY ANEURYSM REPAIR OR BYPASS	485.78	485.78	497.44	505.21
4676	VISCERAL ARTERY ENDARTERECTOMY OR GRAFT	577.80	577.80	591.67	600.91
4677	VISCERAL ARTERY BYPASS TO ADDITIONAL ARTERY	I.C.	I.C.	I.C.	I.C.
4678	LIMB FASCIOTOMY FOR ISCHEMIA (SINGLE)	143.88	143.88	147.33	149.64
4679	LIMB FASCIOTOMY FOR ISCHEMIA (MULTIPLE)	274.09	274.09	280.67	285.05
4680	LIMB FASCIOTOMY SECONDARY CLOSURE	83.33	83.33	85.33	86.66
4681	COMPOSITE GRAFT (ADD)	114.19	114.19	116.93	118.76
4682	TEMPORAL ARTERY BIOPSY	81.05	81.05	83.00	84.29
4683	CLOSURE LYMPHATIC FISTULA OF GROIN	177.45	177.45	181.71	184.55
4684	REPEAT PROCED. AFTER FOR FAILED GRAFT (ADD)	298.49	298.49	305.65	310.43
4700	ATRIAL OR VENTRICULAR PUNCTURE	46.22	46.22	47.33	48.07
4702	BIOPSY OF PERICARDIUM	347.11	347.11	355.44	360.99
4703	CARDIOTOMY WITH EXPLORATION	578.50	578.50	592.38	601.64
4704	CARDIOTOMY-REMOVAL FOREIGN BODY OR TUMOR	578.50	578.50	592.38	601.64
4705	CARDIOTOMY BY CLOSED TECHNIQUE	693.90	693.90	710.55	721.66
4706	CARDIOTOMY BY OPEN TECHNIQUE	809.78	809.78	829.21	842.17
4707	CARDIOTOMY BY OPEN TECHNIQUE-BYPASS	925.50	925.50	947.71	962.52
4708	PERICARDIECTOMY-PARTIAL	462.83	462.83	473.94	481.34
4709	PERICARDIECTOMY-SUBTOTAL	693.90	693.90	710.55	721.66
4713	REMOVAL HICKMAN CATHETER	78.18	78.18	80.06	81.31
4714	INSERTION OF PORTACATH	250.38	250.38	256.39	260.40
4715	REMOVAL OF PORTACATH	219.08	219.08	224.34	227.84
4716	CATHERIZATION OF CATHETER PACEMAKER	231.23	231.23	236.78	240.48
4717	HICKMAN CATHETER	152.31	152.31	155.97	158.40
4718	PATENT DUCTUS ARTERIOSUS	578.50	578.50	592.38	601.64
4738	PULMONARY STENOSIS-OPEN HEART	809.78	809.78	829.21	842.17
4747	PERICARDIAL INSUFFLATION-POWDER	347.11	347.11	355.44	360.99
4752	SUTURE OF WOUND	578.50	578.50	592.38	601.64
4753	CARDIAC MASSAGE	231.23	231.23	236.78	240.48
4754	NUCLEAR (MIBI) STRESS TESTING	107.00	107.00	109.57	111.28
4760	INSERTION TEMPORARY CATHETER PACEMAKER	248.35	248.35	254.31	258.28
4761	REPOSITION TEMPORARY CATHETER PACEMAKER	94.00	94.00	96.26	97.76
4762	REPLACE TEMPORARY CATHETER PACEMAKER	188.05	188.05	192.56	195.57
4763	INSERTION OF PERMANENT PACEMAKER	360.54	360.54	369.19	374.96
4764	REPOSITION PERMANENT PACEMAKER WIRE	188.05	188.05	192.56	195.57

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
4765	REPOSITIONING POWER SOURCE	248.35	248.35	254.31	258.28
4766	INSERTION TEMPORARY CATHETER PACEMAKER	329.13	329.13	337.03	342.30
4767	REPOSITION TEMPORARY CATHETER PACEMAKER	131.61	131.61	134.77	136.87
4768	REPLACE TEMPORARY CATHETER PACEMAKER	263.33	263.33	269.65	273.86
4769	INSERTION PERMANENT PACEMAKER/EPICARDIAL	503.70	503.70	515.79	523.85
4770	INSERTION TEMPORARY CATHETER PACEMAKER	186.13	186.13	190.60	193.58
4771	REPOSITION TEMPORARY CATHETER PACEMAKER	75.11	75.11	76.91	78.11
4772	REPLACE TEMPORARY CATHETER PACEMAKER	124.39	124.39	127.38	129.37
4773	INSERTION PERMANENT PACEMAKER	182.49	182.49	186.87	189.79
4774	REPOSITION PERMANENT PACEMAKER WIRE	124.39	124.39	127.38	129.37
4775	REPOSITIONING POWER SOURCE	124.39	124.39	127.38	129.37
4776	REPROGRAM OR INTERROGATE PACEMAKER (INCL. ICD)	85.60	85.60	87.65	89.02
4777	INSERTION PERM PACEMAKER/INTRAVENOU	267.50	267.50	273.92	278.20
4778	INSERTION OF LOOP RECORDER	107.00	107.00	109.57	111.28
4779	REMOVAL OF LOOP RECORDER	53.50	53.50	54.78	55.64
4780	LOOP RECORDER INTERPRETATION	21.40	21.40	21.91	22.26
4781	INSERTION - DUAL CHAMBER PACEMAKER / ICD -MEDICAL	267.50	267.50	273.92	278.20
4782	INSERTION - DUAL CHAMBER PACEMAKER / ICD -SURGICAL	432.12	432.12	442.49	449.40
4802	SPLENECTOMY	591.18	591.18	605.37	614.83
4804	BONE BUTTON	69.44	69.44	71.11	72.22
4805	SENTINEL NODE BIPOSY	236.47	236.47	279.03	307.41
4809	FINE NEEDLE BPSY CERV, AXILL OR INGUINAL NODES	54.52	54.52	55.83	56.70
4840	ONCALL RETAINER - RADIATION ONCOLOGY	0.00	0.00	300.00	300.00
4850	TELEPHONE CONSULTATION - RADIATION ONCOLOGY	0.00	0.00	46.08	46.80
4855	ONCALL PERDIEM (IN LIEU OF FFS)-RADIATION ONCOLGY(Salariedonly)	0.00	0.00	500.00	500.00
4900	CYSTIC HYGROMA	416.39	416.39	426.38	433.05
4901	KONDOLEON	416.39	416.39	426.38	433.05
4902	RADICAL SLEEVE EXCISION	693.90	693.90	710.55	721.66
4903	LYMPHANIGIOGRAM	208.17	208.17	213.17	216.50
4904	SUPRAHYOID-UNILATERAL	354.71	354.71	363.22	368.90
4905	SUPRAHYOID-BILATERAL	520.56	520.56	533.05	541.38
4906	RADICAL NECK DISSECTION	693.90	693.90	710.55	721.66
4907	DISSECTION OF INGUINAL GLANDS	347.11	347.11	355.44	360.99
4908	RADICAL DISSECTION-AXILLARY GLANDS	438.17	438.17	448.69	455.70
4909	RADICAL DISSECTION-INGUINAL AND ILIAC GLANDS	462.83	462.83	473.94	481.34
4910	RADICAL DISSECTN-INGUINAL &ILIAC GLANDS-BILAT	525.74	525.74	538.36	546.77
4911	BIOPSY-CERVICAL,AXILLARY,INGUINAL	82.60	82.60	93.04	100.00
4912	SCALENE	146.59	146.59	150.11	152.45
4913	COMPLICATED BIOPSY	I.C.	I.C.	I.C.	I.C.
4914	LAPAROTOMY	578.50	578.50	592.38	601.64
4915	EXCISN-INGUIN,PERINL,OR AXILL SWEAT GLNDS-UNIL	230.05	230.05	235.57	239.25
4916	WITH SKIN GRAFT(S) AND/OR ROTATION FLAP(S)	337.05	337.05	345.14	350.53
5000	DRAINAGE OF LUDWIG'S ANGINA	115.72	115.72	118.50	120.35
5001	MOUTH BIOPSY	53.50	53.50	54.78	55.64
5002	MOUTH-EXCISION OF SIMPLE LESION	46.22	46.22	47.33	48.07
5003	MOUTH-LEUKOPLAKIA, LIMITED	69.44	69.44	71.11	72.22
5005	EXCISION OF RANULA OF DERMOID CYST	138.83	138.83	142.16	144.38
5006	LOCL EXCISN-CA MOUTH, MANDB ALVEOL MARGIN	208.17	208.17	213.17	216.50
5007	LOCAL EXCISN-CA MOUTH, W/ HEMIMANDIBLCTOMY	462.83	462.83	473.94	481.34
5008	LOCAL EXCISN-CA -UNILATERAL NECK DISSECTION	809.78	809.78	829.21	842.17
5010	CLOSURE OF ANTRO-ORAL FISTULA WITH FLAP	347.11	347.11	355.44	360.99
5011	CLOSE ANTRO-ORAL FISTULA W/ RADICL ANTROTOMY	404.83	404.83	414.55	421.02
5020	LIP BIOPSY	53.50	53.50	54.78	55.64
5021	LIP SHAVE	138.83	138.83	142.16	144.38
5022	LIP-EXCISION OF SIMPLE LESION	69.44	69.44	87.78	100.00
5023	V-EXCISION FOR CARCINOMA	212.82	212.82	217.93	221.33
5024	V-EXCISION CA AND RADICLE NECK DISSECTION	751.94	751.94	769.99	782.02

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
5025	ONE HALF LIP PLUS RECONSTRUCTION	347.11	347.11	355.44	360.99
5026	ONE HALF LIP PLUS RADICLE NECK DISSECTION	809.78	809.78	829.21	842.17
5027	TOTAL EXCISION OF LIP	462.83	462.83	473.94	481.34
5028	TOTAL LIP EXCISION PLUS RADICLE NECK DISSECTION	809.78	809.78	829.21	842.17
5029	HARE LIP-UNILATERAL	347.11	347.11	355.44	360.99
5040	TONGUE BIOPSY	53.50	53.50	54.78	55.64
5041	TONGUE-LOCAL EXCISION SIMPLE TUMOR	115.72	115.72	121.29	125.00
5042	HEMIGLOSSECTOMY	347.11	347.11	355.44	360.99
5043	HEMIGLOSSECTOMY AND RADICAL NECK DISSECTION	809.78	809.78	829.21	842.17
5044	TOTAL GLOSSECTOMY	416.39	416.39	426.38	433.05
5045	TOTAL GLOSSECTOMY + RADICAL NECK DISSECTION	809.78	809.78	829.21	842.17
5047	SUTURE MINOR TONGUE LACERATIONS	53.50	53.50	54.78	55.64
5060	DRAINAGE OF ALVEOLAR ABSCESS	46.22	46.22	47.33	48.07
5061	BIOPSY OF GUM	53.50	53.50	54.78	55.64
5063	MUCOUS CYST	46.22	46.22	47.33	48.07
5064	SUTURE OF GUM	53.50	53.50	54.78	55.64
5080	PALATE ABSCESS	80.25	80.25	82.18	83.46
5081	UVULECTOMY	46.22	46.22	47.33	48.07
5082	PALATE AND UVULA-BIOPSY	46.22	46.22	47.33	48.07
5083	PALATE AND UVULA-EXCISION SIMPLE LESION	69.44	69.44	71.11	72.22
5084	PLATE AND UVULA-EXCISION OF MALIGNANT LESION	323.94	323.94	331.71	336.90
5086	SUTURE OF PALATE WOUND	34.72	34.72	35.55	36.11
5087	UVULOPALATOPHARYNGOPLASTY	266.06	266.06	272.45	276.70
5100	SIALOLITHOTOMY -LOCAL	34.72	34.72	35.55	36.11
5102	SIALOLITHOTOMY-GENERAL ANAESTHETIC	69.44	69.44	71.11	72.22
5103	SIALOLITHOTOMY-COMPLICATED	208.17	208.17	213.17	216.50
5104	SUBMANDIBULAR GLAND-EXCISION	277.56	277.56	284.22	288.66
5105	PAROTID GLAND-SUPERFICIAL PAROTIDECTMY	605.94	605.94	620.48	630.18
5106	TOTAL PAROTIDECTOMY	768.53	768.53	786.97	799.27
5107	TOTAL PAROTIDECTOMY + UNILAT NECK DISSECTION	809.78	809.78	829.21	842.17
5108	PLASTIC REPAIR OF DUCT	289.17	289.17	296.11	300.74
5109	DILATION OF DUCT	46.22	46.22	47.33	48.07
5111	CATHETERIZATION-SIALOGRAM	46.22	46.22	47.33	48.07
5112	RADICAL NECK DISECTION	2,056.65	2,056.65	2,106.01	2,138.92
5113	COMPOSITE FEE RADICAL NECK DISSECTION	2,076.66	2,076.66	2,126.50	2,159.73
5120	BIOPSY OF PHARNYX	82.76	82.76	84.75	86.07
5121	DRAIN RETROPHARYNGEAL ABSCESS-INTERNAL	57.78	57.78	59.17	60.09
5122	DRAIN RETROPHARYNGEAL ABSCESS-EXTERNAL	173.61	173.61	177.78	180.55
5123	DRAINAGE OF PERITONSILLAR ABSCESS	80.25	80.25	82.18	83.46
5124	BRANCHIAL CYST	354.71	354.71	363.22	368.90
5125	EXCISION-SINUS	462.83	462.83	473.94	481.34
5126	PHARYNGO-OESOPHAGEAL DIVERTICULUM	578.50	578.50	592.38	601.64
5127	THYROGLOSSAL DUCT CYST	289.17	289.17	296.11	300.74
5128	CYST AND SINUS	416.39	416.39	426.38	433.05
5129	TONSILLECTOMY	173.34	173.34	195.34	210.00
5130	TONSILLECTOMY-ADULT	173.34	173.34	195.34	210.00
5131	EXCISION OF TONSIL TAG-UNILATERAL	92.50	92.50	94.72	96.20
5132	EXCISION OF LINGUAL TONSIL	92.50	92.50	94.72	96.20
5133	CHOANAL ATRESIA	578.50	578.50	592.38	601.64
5134	PUCH-BACK FLAP	520.56	520.56	533.05	541.38
5136	SUTURE OF EXTERNAL WOUND OF PHARNYX	I.C.	I.C.	I.C.	I.C.
5137	REMOVAL OF FOREIGN BODY-PHARNYX	80.25	80.25	82.18	83.46
5138	ADENOIDECTOMY	57.78	57.78	59.17	60.09
5140	CERVICAL OESOPHAGOTOMY	347.11	347.11	355.44	360.99
5141	THORACIC OESOPHAGOTOMY	462.83	462.83	473.94	481.34
5142	OESOPHAGOMYOTOMY	578.50	578.50	592.38	601.64
5143	INTRATHORACIC DIVERTICULUM	555.28	555.28	568.61	577.49

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
5144	EXTRATHORACIC DIVERTICULUM	462.83	462.83	473.94	481.34
5145	RESECTION OF OESOPHAGUS	809.78	809.78	829.21	842.17
5146	RESECTION ESOPHAGUS-REPLACEMENT-1ST SURGEON	925.50	925.50	947.71	962.52
5147	RESECTION ESOPHAGUS-REPLACEMENT-2ND SURGEON	231.23	231.23	236.78	240.48
5148	ESOPHAGO-GASTRECTOMY	925.50	925.50	947.71	962.52
5149	ESOPHAGEAL BYPASS	809.78	809.78	829.21	842.17
5150	ESOPHAGOSCOPY	160.00	160.00	163.84	166.40
5151	ESOPHAGOSCOPY-REMOVE FOREIGN BODY	230.00	230.00	235.52	239.20
5152	ESOPHAGO-BRONCHOSCOPY	208.17	208.17	213.17	216.50
5153	ESOPHAGO-GASTROSCOPY-ELDER-PALMER	173.61	173.61	177.78	180.55
5155	ESOPHAGOPLASTY	693.90	693.90	710.55	721.66
5156	ESOPHAGEAL HIATUS HERNIA-ABDO APPROACH	578.50	578.50	592.38	601.64
5157	ESOPHAGEAL HIATUS HERNIA-ABDO+CHOECCYSTOMY	693.90	693.90	710.55	721.66
5158	ESOPHAGEAL ILIATUS HERNIA-TRANSTHORAC APPRCH	578.50	578.50	592.38	601.64
5159	RUPTURED OESOPHAGUS	555.28	555.28	568.61	577.49
5160	RUPTURED OESOPHAGUS-CERVICAL DRAIN	404.83	404.83	414.55	421.02
5161	ESOPHAGO-GASTROSTOMY	809.78	809.78	829.21	842.17
5162	ESOPHAGO-DUODENOSTOMY	809.78	809.78	829.21	842.17
5163	CLOSURE OF OESOPHAGEAL	809.78	809.78	829.21	842.17
5164	ESOPHAGOTOMY WITH LIGATION VARICES	555.28	555.28	568.61	577.49
5165	ESOPHAGEAL VARICES-INITIAL	277.56	277.56	284.22	288.66
5166	ESOPHAGEAL VARICEAL BANDING (ESOPHAGOSCOPY)	278.20	278.20	284.88	289.33
5167	INTRODUCTION OF MOUSSEAU-BARBIN TUBE	347.11	347.11	355.44	360.99
5168	DILATION-ACTIVE	57.78	57.78	59.17	60.09
5169	DILATION-PASSIVE-MERCURY FILLED TUBES	23.06	23.06	23.61	23.98
5172	DILATION WITH OSOPHAGOSCOPY-INITIAL	264.29	264.29	270.63	274.86
5173	DILATION OF OEXOPHAGOSCOPY-REPEAT	69.44	69.44	71.11	72.22
5174	DILATION OF OESOPHAGUS	81.05	81.05	83.00	84.29
5175	REPAIR OF HIATAL HERNIA	809.78	809.78	829.21	842.17
5176	FUNDOPLICATION +/- HIATAL HERNIA REPAIR	578.50	578.50	592.38	601.64
5177	INJECTN-ESOPH VARIC-REP W/IN 30 DY-INCL ESPHSCPY	208.38	208.38	213.38	216.72
5178	ESOPH VARIC BANDG-REP W/IN 30 DYS-INCL ESPHSCPY	208.38	208.38	213.38	216.72
5200	GASTROTOMY	347.11	347.11	355.44	360.99
5201	PYLOROMYOTOMY	496.59	496.59	508.51	516.45
5202	SIMPLE TUBE GASTROSTOMY	347.11	347.11	355.44	360.99
5204	BIOPSY BY GASTROSCOPY	208.17	208.17	213.17	216.50
5205	BIOPSY BY GASTROTOMY	347.11	347.11	355.44	360.99
5207	WEDGE RESECTION FOR ULCER	437.47	437.47	447.97	454.97
5208	GASTRECTOMY-PARTIAL	719.84	719.84	737.12	748.63
5209	GASTRECTOMY AND REPAIR HIATUS HERNIA	809.78	809.78	829.21	842.17
5210	AFTER GASTRECTOMY	809.78	809.78	829.21	842.17
5211	ANTRECTOMY	809.78	809.78	829.21	842.17
5212	TOTAL GASTRECTOMY	925.50	925.50	947.71	962.52
5213	EXCISION OF GASTRODUODENAL LESION	809.78	809.78	829.21	842.17
5214	EXCISE GASTRODUODENAL LESION AND VAGOTOMY	925.50	925.50	947.71	962.52
5215	EXCISION OF GASTROJEJUNAL LESION	809.78	809.78	829.21	842.17
5217	GASTRECTMY-EXCISION LESION & CHOLECTYSTOMY	115.72	115.72	118.50	120.35
5218	GASTROSCPY-DIAGNOS BIOPSY-REMOVAL FB	192.81	192.81	197.44	200.52
5219	GASTROSCOPY-SUBSEQUENT	76.18	76.18	78.01	79.23
5220	PYLOROPLASTY	425.65	425.65	435.87	442.68
5221	PYLOROPLASTY AND VAGOTOMY	550.62	550.62	563.83	572.64
5222	GASTRODUODENOSTOMY OR OTHER	425.65	425.65	435.87	442.68
5223	VAGOTOMY PLUS	578.50	578.50	592.38	601.64
5224	PYLORPLSTY GASTROENTSTMY W/VAGTMY & H.HERN	693.90	693.90	710.55	721.66
5225	VAGOTOMY ALONE	416.39	416.39	426.38	433.05
5226	CHOLECTYSTECTOMY PLUS OTHERS	115.72	115.72	118.50	120.35
5227	CLOSURE OF GASTROSTOMY	277.56	277.56	284.22	288.66

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
5228	CLOSURE OF PERFORATED ULCER	425.65	425.65	435.87	442.68
5229	CLOSURE OF GASTRO-COLIC FISTULA	809.78	809.78	829.21	842.17
5230	CLOSURE OF GASTRO-COLIC-TWO STAGES	809.78	809.78	829.21	842.17
5231	GASTRIC COOLING	138.83	138.83	142.16	144.38
5232	HIGHLY SELECTIVE VAGOTOMY	680.89	680.89	697.23	708.13
5233	GASTRIC PARTITION/MORBID OBESITY	I.C.	I.C.	I.C.	I.C.
5234	GASTRIC PARTIT+OTH PRCEDURES FOR MORB OBESITY	I.C.	I.C.	I.C.	I.C.
5235	STANDARD E.R.C.P.	245.08	245.08	250.96	254.88
5236	BIOPSY AT TIME OF PROCEDURE	12.47	12.47	12.77	12.97
5237	E.R.C.P. ON A BILROTH II	206.30	206.30	211.25	214.55
5238	E.R.C.P. WITH SPINCTEROTOMY	369.69	369.69	378.56	384.48
5239	PLACEMENT OF STENT AT E.R.C.P.	67.46	67.46	69.08	70.16
5240	PERCUTANEOUS ENDOSCOPIC GASTROSTOMY (PEG)	213.30	213.30	218.42	221.83
5241	ERCP WITH BILIARY DILATATION	317.79	317.79	325.42	330.50
5250	ILEOSTOMY FOR ULCERATIVE COLITIS	416.39	416.39	443.78	462.04
5251	ILEOSTOMY FOR JEJUNOSCOMY	289.17	289.17	308.19	320.87
5252	1st STAGE MICHULIEZ	416.39	416.39	443.78	462.04
5253	COLOSTOMY	444.42	444.42	473.65	493.14
5255	CECOSTOMY	289.17	289.17	308.19	320.87
5256	ENTEROTOMY OR COLOTOMY	425.65	425.65	453.65	472.32
5257	ENTEROTOMY/COLOTOMY AND SIGMOIDOSCOPY	462.83	462.83	493.27	513.57
5258	MULTIPLE ENTEROTOMY AND SIGMOIDOSCOPY	578.50	578.50	616.55	641.92
5259	INTESTINES-BIOPSY	69.44	69.44	74.01	77.05
5260	LOCAL EXCISION OF LESION	472.94	472.94	504.05	524.79
5261	DUODENECTOMY	567.53	567.53	604.86	629.75
5262	ENTERECTOMY-OTHER	567.53	567.53	604.86	629.75
5263	TERMINAL ILEUM AND CAECUM	709.41	709.41	756.07	787.18
5264	TERMINAL ILEUM, CAECUM AND ASCENDING COLON	709.41	709.41	756.07	787.18
5265	SEGMENTAL	723.59	723.59	771.19	802.92
5266	HEMICOLECTOMY	723.59	723.59	771.19	802.92
5267	TOTAL COLECTOMY	1,064.12	1,064.12	1,134.12	1,180.78
5268	TOT COLCTMY W/ILEOSTMY/ABD PERI RSXN SNGL TM	1,032.82	1,032.82	1,100.76	1,146.05
5269	TOT COLCTMY W/ILEOSTMY/ABD PERI RSXN 1ST SRGN	955.78	955.78	1,018.65	1,060.56
5270	TOT COLCTMY W/ILEOSTMY/ABD PERI RSXN 1ST ASST	277.56	277.56	295.82	307.99
5271	TOT COLCTMY W/ILEOSTMY/ABD PERI RSXN 2ND ASST	208.17	208.17	221.86	230.99
5272	INTESTINAL OBSTRUCTION NO RESECTION	591.18	591.18	630.07	655.99
5273	INTESTINAL OBSTRUCTION AND RESECTION	709.41	709.41	756.07	787.18
5275	ENTERO-ENTEROSTOMY	425.65	425.65	453.65	472.32
5276	DUODENAL ATRESIA,DUDENO-JEJUNOSTOMY	462.83	462.83	493.27	513.57
5277	FECAL FISTULA-RADICAL RESECTION	636.33	636.33	678.19	706.09
5278	REVISION OF ILEOSTOMY OR COLOSTOMY	138.83	138.83	147.96	154.05
5279	CLOSURE OF PERFORATION	370.54	370.54	394.91	411.16
5280	CLOSURE PERFORATION WITH COLOSTOMY	462.83	462.83	493.27	513.57
5281	CECOPEXY OR SIGMOIDOPEXY	347.11	347.11	369.94	385.16
5282	CLOSURE OF ENTEROSTOMY	472.94	472.94	504.05	524.79
5283	CLOSURE OF COLOSTOMY	472.94	472.94	504.05	524.79
5284	PLICATION SMALL INTESTINE FOR ADHESION	520.56	520.56	554.80	577.63
5285	DILATION ENTEROSTOMY,ETC.ANAESTHET	46.22	46.22	49.26	51.29
5286	E.E.A.STAPLER	56.23	56.23	59.93	62.39
5287	MECKEL'S DIVERTICULUM	347.11	347.11	369.94	385.16
5288	LOCAL EXCISION OF LESION,MESENTERY	347.11	347.11	369.94	385.16
5289	RESECTION OF MESENTERY	347.11	347.11	369.94	385.16
5290	MESENTERIC CYST	347.11	347.11	369.94	385.16
5300	DRAINAGE OF APPENDIX ABCESS	289.17	289.17	308.19	320.87
5301	APPENDECTOMY	413.82	413.82	441.04	459.19
5302	APPENDECTOMY W/ GROSS PERFOR AND PERITONITIS	555.70	555.70	592.25	616.62
5303	APPNDCTMY,REMOVE MECKEL'S DIVERTCLM	358.45	358.45	382.03	397.75

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
5322	PROCTOTOMY WITH DRAINAGE	138.83	138.83	147.96	154.05
5323	PELVIC ABSCESS	173.61	173.61	185.03	192.64
5324	PROCTECTOMY-ANTERIOR RESECTION RECTUM	1,064.12	1,064.12	1,134.12	1,180.78
5325	PROCTECTOMY-PERINEAL RESECTION RECTUM	555.28	555.28	591.81	616.16
5326	ABDO-PERINEAL RSXN+COLOSTOMY-SINGLE TEAM	1,064.12	1,064.12	1,134.12	1,180.78
5327	ABDO-PERINAL RSXN+COLOSTOMY-2 TEAM 1ST SURG	1,001.52	1,001.52	1,067.40	1,111.32
5328	ABDO-PERI RSXN+COLOSTOMY-2 TEAM 1ST SURG ASST	472.94	472.94	504.05	524.79
5329	ABDO-PERI RSXN+COLOSTOMY-2 TEAM 2ND SURGEON	319.23	319.23	340.23	354.23
5330	HARTMAN PROCEDURE	723.59	723.59	771.19	802.92
5331	REANASTOMOSIS FOLLOWING HARTMAN PROCEDURE	594.92	594.92	634.05	660.14
5336	RECTAL POLYP	69.44	69.44	74.01	77.05
5337	RECTAL POLYP-THROUGH SIGMOIDOSCOPE	141.88	141.88	151.21	157.43
5338	BIOPSY,RECTO-SIGMOID-HIRSCHPRUNG'S	92.50	92.50	98.58	102.64
5339	PROCTOSTOMY	347.11	347.11	369.94	385.16
5340	PROCTOPEXY-ABDOMINAL ROUTE	416.39	416.39	443.78	462.04
5341	RECTAL PROLAPSE-EXCISE MUCOUS MEMBRANE	231.23	231.23	246.44	256.58
5342	RECTAL PROLAPSE-PERINEAL REPAIR MAJOR	416.39	416.39	443.78	462.04
5343	RECTAL PROLAPSE-ABDOMINAL APPROACH	555.28	555.28	591.81	616.16
5344	RECTAL PROLAPSE-THIERSCH WIRE PROCEDURE	138.83	138.83	147.96	154.05
5345	SUTURE-EXTERNAL APPROACH	277.56	277.56	295.82	307.99
5346	SUTURE INTRAPERITONEAL APPROACH	462.83	462.83	493.27	513.57
5347	CLOSURE OF FISTULA-RECTO-VAGINAL	462.83	462.83	493.27	513.57
5348	CLOSURE OF FISTULA-RECTO-VESICAL	462.83	462.83	493.27	513.57
5349	CLAMPING OF INTERNAL HEMORRHOID-PER HEMORH	70.94	70.94	72.64	73.78
5350	THROMBOSED HEMORRHOID	42.80	42.80	43.83	44.51
5351	THROMBOSED HEMORRHOID-GENERAL	57.78	57.78	59.17	60.09
5352	LOCAL EXCISION OF LESION	138.83	138.83	142.16	144.38
5353	HAEMORRHOIDECTOMY	212.82	212.82	217.93	221.33
5354	ANAL POLYP-HEMORRHOIDIAL TAGS	70.94	70.94	72.64	73.78
5355	FISTULA-IN-ANO,LOW LEVEL	212.82	212.82	217.93	221.33
5356	FISTULA-IN-ANO,HIGH LEVEL	425.65	425.65	435.87	442.68
5357	ANUS BIOPSY-GENERAL	46.22	46.22	47.33	48.07
5358	ELECTROCOAG RECTAL CARCINOMA-INITAL	231.23	231.23	246.44	256.58
5359	ELECTRO COAGULATION RECTAL CA-REPEAT	115.72	115.72	123.33	128.41
5361	EXCISION OF SCAR, FOR STENOSIS	138.83	138.83	142.16	144.38
5362	ANOPLASTY FOR STENOSIS	277.56	277.56	284.22	288.66
5363	REPAIR OF ANAL SPHINCTER	347.11	347.11	355.44	360.99
5364	REPAIR OF SPHINCTER AND ANORECTAL RING	347.11	347.11	355.44	360.99
5365	MEMBRANOUS OBSTRUCTION OF ANUS	138.83	138.83	142.16	144.38
5371	CAUTERIZATION OF FISSURE	26.75	26.75	27.39	27.82
5372	ELECTRO DESSICATION OF CONDYLOMATA	80.25	80.25	82.18	83.46
5373	DILATION OF ANAL SPHINCTER	23.06	23.06	23.61	23.98
5374	ANOSCOPY	15.00	15.00	15.36	15.60
5375	PARTIAL LATERAL SPHINCTEROTOMY	204.37	204.37	209.27	212.54
5381	DRAINAGE OF ABSCESS -LIVER	416.39	416.39	426.38	433.05
5382	REMOVAL OF FOREIGN BODY -LIVER	416.39	416.39	426.38	433.05
5383	INCISION AND PACKING OF LIVER WOUND	416.39	416.39	426.38	433.05
5384	HEPATECTOMY-LOCAL EXCISION,LESION	416.39	416.39	426.38	433.05
5385	RESECTION OF LIVER	925.50	925.50	947.71	962.52
5388	SUTURE OF RUPTURE OR WOUND -LIVER	I.C.	I.C.	I.C.	I.C.
5390	CHOLECYSTOSTOMY	347.11	347.11	355.44	360.99
5391	CHOLECYSTENTEROSTOMY	416.39	416.39	426.38	433.05
5392	CHOLECYSTENTEROSTMY AND ENTRORSTMY	462.83	462.83	473.94	481.34
5393	CHOLECYSTOGASTROSTOMY	416.39	416.39	426.38	433.05
5394	CHOLEDOCHODUODENOSTOMY	578.50	578.50	592.38	601.64
5395	COMMON DUCT EXPLORATION	555.28	555.28	568.61	577.49
5396	COMMON DUCT EXPLOR W/ DUODOTMY SPHNCTRTMY	693.90	693.90	710.55	721.66

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
5398	CHOLEDOCHECTOMY	693.90	693.90	710.55	721.66
5399	EXCISION OF AMPULLA OF VATER	636.33	636.33	651.60	661.78
5400	CHOLECYSTOMY	575.00	575.00	588.80	598.00
5401	CHOLECYSTOMY-OPERATIVE CHOLANGIOGRM	614.82	614.82	629.58	639.41
5402	CHOLECYSTECTOMY AND EXPLORATION BILE DUCT	650.29	650.29	665.90	676.30
5403	CHOLECYSTMY-EXPLOR BILE DUCT+CHLANGIOGRAM	709.41	709.41	726.44	737.79
5404	CHOLECYSTECTOMY WITH DUODENOTOMY	693.90	693.90	710.55	721.66
5405	SURGICAL RECONSTRCTION COMMON BILE DUCT	925.50	925.50	947.71	962.52
5406	SUTURE-CLOSURE OF FISTULA	636.33	636.33	651.60	661.78
5410	PANCREATOTOMY	462.83	462.83	473.94	481.34
5411	PANCREATIC ABSCESS	462.83	462.83	473.94	481.34
5414	LOCAL EXCISION OF LESION	555.28	555.28	568.61	577.49
5415	PARTIAL PANCREATECTOMY	555.28	555.28	568.61	577.49
5416	PANCREATICO-DUODENAL RESECTION	925.50	925.50	947.71	962.52
5417	EXCISION PANCREATIC CYST	555.28	555.28	568.61	577.49
5418	PANCREATICO-GASTROSTOMY	555.28	555.28	568.61	577.49
5419	PANCREATICO-DUODENOSTOMY	555.28	555.28	568.61	577.49
5420	PANCREATICO-JEJUNOSTOMY	555.28	555.28	568.61	577.49
5421	MARSUPIALIZATION OF CYST	462.83	462.83	473.94	481.34
5450	LAPAROTOMY	413.82	413.82	423.75	430.37
5451	DRAINAGE OF SUBPHRENIC ABCESS	416.39	416.39	426.38	433.05
5452	INTRA-ABDOMINAL ABCESS	425.65	425.65	435.87	442.68
5453	REMOVAL OF FOREIGN BODY-GUN SHOT	I.C.	I.C.	I.C.	I.C.
5454	DESMOID TUMOR	I.C.	I.C.	I.C.	I.C.
5456	LIPECTOMY	347.11	347.11	355.44	360.99
5457	RETROPERITONEAL TUMOR	555.28	555.28	568.61	577.49
5458	MESENTERIC CYST	347.11	347.11	355.44	360.99
5460	PERITONEOSCOPY	208.12	208.12	213.11	216.44
5461	HERNIOTOMY+HERNIORRHAPY-INGUINAL/FEMORAL	331.06	331.06	339.01	344.30
5462	HERNIOTOMY AND HERNIORRHAPHY-INGUINAL	378.35	378.35	387.43	393.48
5463	HERNIOTMY+HERNIORRPHY-INGUINL/FEM-SAME SIDE	347.11	347.11	355.44	360.99
5464	SLIDING HERNIA	347.11	347.11	355.44	360.99
5465	INGUINAL/FEMORAL REPAIR-PROSTHESIS	378.35	378.35	387.43	393.48
5466	RECURRENT HERNIA	472.94	472.94	484.29	491.86
5467	RECUR HERNIA REPAIR-PROSTHES/GRAFT	496.59	496.59	508.51	516.45
5468	UMBILICAL HERNIA	354.71	354.71	363.22	368.90
5469	UMBILICAL HERNIA-CHILD	220.21	220.21	225.50	229.02
5470	ENTEROCELE-INFANT	347.11	347.11	355.44	360.99
5471	OMPHALOCELE-INFANT	462.83	462.83	473.94	481.34
5472	DIAPHRAGMATIC HERNIA	578.50	578.50	592.38	601.64
5473	DIAPHRAGMATIC HERNIA WITH PROSTHES	636.33	636.33	651.60	661.78
5474	INCISION/VENTRAL REPAIR BY SUTURE	472.94	472.94	484.29	491.86
5475	INCISION/VENTRAL REPAIR BY PROSTHESIS	500.76	500.76	512.78	520.79
5476	EPIGASTRIC HERNIA	331.06	331.06	339.01	344.30
5477	STRANGULATED SUTURE	347.11	347.11	355.44	360.99
5478	STRANGULATED SUTURE WITH RESECTION	625.95	625.95	640.97	650.99
5479	SECONDARY CLOSURE FOR EVISCERATION	271.94	271.94	278.47	282.82
5480	DRAINAGE OF ABDOMINAL WALL ABCESS	69.44	69.44	71.11	72.22
5500	THYROID GLAND-ABSCESS	138.83	138.83	142.16	144.38
5501	THYROID GLAND-BIOPSY	46.22	46.22	47.33	48.07
5502	THYROID GLAND BIOPSY-SURGICAL	277.56	277.56	284.22	288.66
5503	BILATERAL TOTAL THYROIDECTOMY	636.33	636.33	651.60	661.78
5504	TOTAL LOBECTOMY	532.06	532.06	544.83	553.34
5505	TOTAL LOBECTOMY AND SUBTOTAL LOBECTMY	520.56	520.56	533.05	541.38
5506	SUB-TOTAL BILATERAL THYROIDECTOMY	462.83	462.83	473.94	481.34
5507	PARTIAL LOBECTOMY	416.39	416.39	426.38	433.05
5508	EXCISION OF SOLITARY NODULE	277.56	277.56	284.22	288.66

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
5509	UNILATERAL LIMITED NODE DISSECTION	138.83	138.83	142.16	144.38
5510	BILATERAL LIMITED NODE DISSECTION	277.56	277.56	284.22	288.66
5511	RADICAL NECK DISSECTION UNILATERAL	347.11	347.11	355.44	360.99
5550	PARATHYROIDECTOMY FOR HYPERPLASIA	636.33	636.33	651.60	661.78
5551	PARATHYROID TUMOR	555.28	555.28	568.61	577.49
5552	PARATHYROID TUMOR-STERNAL SPLITTING REQUIRED	693.90	693.90	710.55	721.66
5553	THYMECTOMY	693.90	693.90	710.55	721.66
5554	ADRENAL EXPLORATION-UNILATEAL	347.11	347.11	355.44	360.99
5555	ADRENALECTOMY-UNILATERAL	578.50	578.50	592.38	601.64
5652	CAROTID ENDARTERECTOMY	693.90	693.90	710.55	721.66
5653	CAROTID ENDARTERECTOMY-PATCH GRAFT	809.78	809.78	829.21	842.17
5654	CAROTID ENDARTERECTOMY-GRAFT+BY PASS SHUNT	925.50	925.50	947.71	962.52
5702	HEAD INJURY	64.20	64.20	65.74	66.77
5710	DECOMPRESSIVE CRANIECTOMY-SUBTEMPORAL	462.83	462.83	473.94	481.34
5711	DECOMPRESSIVE CRANIECTOMY-SUBTEMPORAL	693.90	693.90	710.55	721.66
5716	MENINGES-EXTRADURAL	636.33	636.33	651.60	661.78
5717	MENINGES-SUBDURAL WITH BURR HOLES	636.33	636.33	651.60	661.78
5859	BURR HOLE AND ASPIRATION	578.50	578.50	592.38	601.64
5900	LAMINECTOMY FOR EXCISION	809.78	809.78	829.21	842.17
5902	LAMINECTOMY-DECOMPRESS SPINAL CORD	693.90	693.90	710.55	721.66
5903	LAMINECTOMY-EXTRADURAL ABSCESS	693.90	693.90	710.55	721.66
5963	EXPLORATION OF MAJOR NERVE	231.23	231.23	236.78	240.48
5964	REMOVAL TUMOR MAJOR PERIPHERAL NERVE	347.11	347.11	355.44	360.99
5965	SUTURE MAJOR PERIPHERAL NERVE	347.11	347.11	355.44	360.99
5967	SUTURE SMALL PERIPHERAL NERVE	173.61	173.61	177.78	180.55
5968	DECOMPRESSION MEDIAN NERVE AT WRIST	231.23	231.23	236.78	240.48
5969	DECOMPRESSION ULNAR NERVE AT ELBOW	231.23	231.23	236.78	240.48
5970	TRANSPOSITION OF ULNAR NERVE	289.17	289.17	296.11	300.74
5973	MORTON'S NEUROMA	231.23	231.23	236.78	240.48
5980	SYMPATHECTOMY-CERVICAL	462.83	462.83	473.94	481.34
5981	SYMPATHECTOMY-CERVICODORSAL	481.13	481.13	492.68	500.38
5983	SYMPATHECTOMY-LUMBAR	365.73	365.73	374.51	380.36
6001	DELIVERY	599.20	599.20	613.58	623.17
6004	CAESARIAN SECTION-PROCEDURE ONLY	599.20	599.20	613.58	623.17
6005	STERILIZ AT TIME OF C/SXN,HYST,LAPAROTMY ETC.	75.70	75.70	77.52	78.73
6006	CAESARIAN HYSTERECTOMY-SUBTOTAL OR TOTAL	794.10	794.10	813.16	825.86
6007	OPERATIVE DELIVRY NOT CAESARIAN,C&P	599.20	599.20	613.58	623.17
6008	SURGICAL/MEDICAL INDUCTION-LABOUR	73.35	73.35	75.11	76.28
6009	ABORTION-INCOMPLETE INCLUDING D&C	148.52	148.52	152.08	154.46
6010	ABORTION-THERAPEUTIC	161.78	161.78	165.66	168.25
6012	MISSED ABORT+/-I.U.HYPERTONIC SOLUTION	161.78	161.78	165.66	168.25
6013	REPAIR THIRD DEGREE LACN CONSULT+PROCEDURE	118.24	118.24	121.08	122.97
6014	RETAINED PLACENTA REMOVAL-CONSULT+PROCED	118.24	118.24	121.08	122.97
6015	ECTOPIC PREGNANCY	360.00	360.00	368.64	374.40
6016	SUTURE INCOMPETENT CERVIX IN PREGNANCY	204.32	204.32	209.22	212.49
6017	STERILZATION-POST PARTUM	275.20	275.20	281.80	286.21
6019	AMNIOCENTESIS	54.46	54.46	55.77	56.64
6021	ABORTION-INCOMPLETE	81.05	81.05	83.00	84.29
6022	CONSULT+INTERPRET FETAL MONITORING RECORDS	46.22	46.22	47.33	48.07
6024	FETAL MONITORING,UNDER TOCOLYSIS	129.95	129.95	133.07	135.15
6025	POST COITAL TESTING	36.54	36.54	37.42	38.00
6500	HYMENECTOMY	57.78	57.78	59.17	60.09
6501	ABSCESS OF VULVA	59.12	59.12	60.54	61.48
6502	MARSUPIALIZATION OR CAUTERY	70.03	70.03	71.71	72.83
6503	VULVECTOMY-SIMPLE	277.56	277.56	284.22	288.66
6506	CYST OF BARTHOLIN'S GLAND	141.88	141.88	145.29	147.56
6508	CONDYLOMATA	118.24	118.24	121.08	122.97

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
6600	COLPOTOMY	92.50	92.50	94.72	96.20
6601	LOCAL EXCISION OF VAGINAL CYST	165.53	165.53	169.50	172.15
6602	CYSTOCELE OR RECTOCELE	230.85	230.85	236.39	240.08
6603	CYSTOCELE AND RECTOCELE	398.04	398.04	407.59	413.96
6604	CYSTOCELE,RECTOCELE AND PROLAPSE	462.83	462.83	473.94	481.34
6605	CYSTOCELE, RECTOCELE + EXCISION CERVICAL STUMP	462.83	462.83	473.94	481.34
6606	VAGINAL VAULT-PROLAPSE	467.32	467.32	478.54	486.01
6607	RECTOCELE AND REPAIR ANAL SPHINCTER	396.33	396.33	405.84	412.18
6608	PERINEORRHAPHY (WITHOUT RECTOCELE REPAIR)	138.83	138.83	142.16	144.38
6611	REPAIR OF DOUBLE VAGINA	208.17	208.17	213.17	216.50
6612	CLOSURE OF FISTULA-VESICO VAGINAL	462.83	462.83	473.94	481.34
6613	CLOSURE OF FISTULA-RECTOVAGINAL	462.83	462.83	473.94	481.34
6614	CLOSURE OF FISTULA-URETERO VAGINAL	555.28	555.28	568.61	577.49
6615	URETHRAL CARUNCLE-PROLAPSE-MUCOSA	92.50	92.50	94.72	96.20
6616	ENTEROCELE	423.24	423.24	433.40	440.17
6617	RETROPUBIC OPERATION-INCONTINENCE	396.33	396.33	405.84	412.18
6618	OPERATIONS FOR STRESS INCONTINENCE-VAGINAL	354.71	354.71	363.22	368.90
6619	OPERATIONS FOR STRESS INCONTINENCE-ABDOMINAL	472.94	472.94	484.29	491.86
6620	OPERATIONS FOR STRESS INCONTINENCE-COMBINED	709.41	709.41	726.44	737.79
6622	ENDOSCOPY-EXAM AND/OR DILATION	81.05	81.05	83.00	84.29
6630	INFRACOLIC / INFRAGASTRIC OMENTECTOMY	194.53	194.53	199.20	202.31
6631	OMENTAL BIOPSY - SINGLE OR MULTIPLE (ADD-ON)	53.50	53.50	54.78	55.64
6632	CONIZATION OF CERVIX WITHOUT D&C (LEEP)	64.20	64.20	65.74	66.77
6639	TRANSVAGINAL TAPE (TVT) PROCED INCL CYSTOSCPY	502.90	502.90	514.97	523.02
6700	SALPINGECTMY AND SALPINGO OOPHORECTMY	346.31	346.31	354.62	360.16
6701	TUBAL PLASTIC-OPERATION	385.41	385.41	394.66	400.83
6702	STERILZATION	275.20	275.20	281.80	286.21
6704	LYSIS OF ADHESION	333.41	333.41	341.41	346.75
6705	INFERTILITY INVESTIGATION	225.24	225.24	230.65	234.25
6710	FOLLICULAR TRACKING BY ULTRASOUND	82.60	82.60	84.58	85.90
6800	EXCISION OF OVARIAN CYST	330.31	330.31	338.24	343.52
6801	EXCISION OF PARAOVARIAN CYST	330.31	330.31	338.24	343.52
6802	OOPHOROCYSTECTOMY	330.31	330.31	338.24	343.52
6803	PARAVAGINAL REPAIR OF CYSTOCELE	219.35	219.35	224.61	228.12
6900	HYSTERECTOMY W/ CYSTOCELE OR RECTOCELE REPAIR	599.20	599.20	613.58	623.17
6901	D&C	110.21	110.21	112.86	114.62
6902	MYOMECTOMY	396.60	396.60	406.12	412.46
6903	HYSTERECTOMY	446.24	446.24	456.95	464.09
6905	HYSTERECTOMY-PARTIAL	330.31	330.31	338.24	343.52
6906	HYSTERECTOMY-PARTIAL WITH RECT/CYS	440.41	440.41	450.98	458.03
6908	SEPTATE UTERUS	440.41	440.41	450.98	458.03
6909	CERVICAL POLYP	33.33	33.33	34.13	34.66
6910	AMPUTATION OF CERVIX	198.22	198.22	202.98	206.15
6911	CERVICAL STUMP-VAGINAL	264.29	264.29	270.63	274.86
6912	CERVICAL STUMP-ABDOMINAL	330.31	330.31	338.24	343.52
6913	BIOPSY OF CERVIX	55.59	55.59	56.92	57.81
6916	INSUFFLATION-RUBIN'S TEST AND D&C	115.72	115.72	118.50	120.35
6917	INSUFFLATION AND ENDOMETRIAL BIOPSY	69.44	69.44	87.78	100.00
6918	HYSTEROSALPINGOGRAM	83.57	83.57	85.58	86.91
6919	IUCD	75.65	75.65	90.26	100.00
6920	HYSTEROPEXY	275.20	275.20	281.80	286.21
6922	HYSTEROPEXY-RECTOCELE AND CYSTOCELE	440.41	440.41	450.98	458.03
6923	CERVIX WITH/WITHOUT BIOPSY	198.22	198.22	202.98	206.15
6924	INCOMPETENT CERVIX	165.15	165.15	169.11	171.76
6925	REPAIR INVERSTION OF UTERUS-OPERATIVE	396.33	396.33	405.84	412.18
6926	REPAIR INVERSION OF UTERUS-MANUAL	165.15	165.15	169.11	171.76
6928	ELECTRO-CAUTERY OF CERVIX	34.72	34.72	35.55	36.11

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
6929	BIOPSY OF CERVIX - OFFICE PROCED W/OUT COLPOSCOPY	33.01	33.01	33.80	34.33
6930	D&C AND CONIZATION OF CERVIX	173.61	173.61	177.78	180.55
6931	ENDOMETRIAL BIOPSY	44.94	44.94	46.02	46.74
6932	INJECTION OF FISSURE IN ANO	23.06	23.06	23.61	23.98
6933	HYSTERECTOMY W/ CYSTOCELE AND RECTOCELE REPAIR	706.20	706.20	723.15	734.45
6934	COLPOSCOPY WITHOUT BIOPSY	84.58	84.58	86.61	87.96
6935	ARTIFICIAL INSEMINATION	46.22	46.22	47.33	48.07
6936	FITTING OF DIAPHRAGM	35.47	35.47	36.32	36.89
6937	VAPORIZATION ENDOMETRIOSIS	342.77	342.77	351.00	356.48
6938	INFERTILITY/TUBAL BLOCKAGE/CORNUA	685.55	685.55	702.00	712.97
6939	IUCD INSERTED DURING ANNUAL EXAM	27.50	27.50	28.16	28.60
6942	ENDOMETRIAL ABLATION+/- D&C, +/- HYSTEROSCOPY	406.76	406.76	416.52	423.03
6945	DIAGNOSTIC HYSTEROSCOPY	144.45	144.45	147.92	150.23
6946	THERAPEUTIC HYSTEROSCOPY	201.16	201.16	205.99	209.21
6947	VAGINAL HEMATOMA (GENERAL ANESTHESIA)	112.35	112.35	115.05	116.84
6948	VAGINAL/CERVICAL LACERATION (GEN.ANESTH)	101.65	101.65	104.09	105.72
6949	HYSTEROSCOPY RSXN ENDOMETRIAL TUMOR	449.40	449.40	460.19	467.38
6950	STAGING LAPAROTMY GYNEC CA INCL HYSTX/SALPX	859.69	859.69	880.32	894.08
6951	COLPOSACROPEXY	597.06	597.06	611.39	620.94
6952	SACROSPINOUS VAULT FIXATION (ADD ON)	101.65	101.65	104.09	105.72
6953	POSTPARTUM HEMORRAGE (SURGICAL MGMT)	413.82	413.82	423.75	430.37
6958	LAPAROSCOPIC HYSTERECTOMY - TOTAL, ABDO OR VAG	557.80	557.80	571.19	580.11
6959	LAPAROSCOPIC HYSTERECTOMY - SUBTOTAL, +/-ADNEXA	412.89	412.89	422.80	429.41
6989	COLPOSCOPY WITH BIOPSY (INCLUDES PAP)	117.59	117.59	120.41	122.29
7000	EYE EXAM UNDER GENERAL ANAESTHESIA	57.78	57.78	59.17	60.09
7002	GONIOTOMY	347.11	347.11	355.44	360.99
7003	ENUCLEATION	289.17	289.17	296.11	300.74
7004	ENUCLEATION WITH PROSTHESIS IMPLANT	347.11	347.11	355.44	360.99
7005	EVISCERATION	289.17	289.17	296.11	300.74
7006	EVISCERATION WITH IMPLANT	347.11	347.11	355.44	360.99
7007	REMOVAL INTRAOCULAR FOREIGN BODY	385.41	385.41	394.66	400.83
7050	PARACENTESIS	54.94	54.94	56.26	57.14
7051	REMOVAL FOREIGN BODY LOCAL - EYE	37.45	37.45	38.35	38.95
7052	REMOVAL FOREIGN BODY-GENERAL - EYE	54.94	54.94	56.26	57.14
7053	KERATECTOMY	347.11	347.11	355.44	360.99
7054	EXCISION OF DERMOID	173.61	173.61	177.78	180.55
7058	CORNEAL TRANSPLANT-PENETRATING	715.72	715.72	732.90	744.35
7059	CORNEAL TRANSPLANT-LAMELLAR	550.62	550.62	563.83	572.64
7060	SUTURE WITH EXCISION OF IRIS	347.11	347.11	355.44	360.99
7061	SUTURE WITHOUT EXCISION OF IRIS	231.23	231.23	236.78	240.48
7062	REMOVAL OF CORNEAL SUTURES	53.29	53.29	54.57	55.42
7063	CORNEAL RETRIEVAL	140.54	140.54	143.91	146.16
7102	SCLERECTOMY	385.41	385.41	394.66	400.83
7103	SUTURE-ALL PENETRATING WOUNDS	347.11	347.11	355.44	360.99
7150	IRIDECTOMY	275.20	275.20	281.80	286.21
7151	IRIDENCLEISIS	347.11	347.11	355.44	360.99
7152	DIVISION OF ANTERIOR SYNECHIA	173.61	173.61	177.78	180.55
7153	CRYOTHERAPY OF CILIARY BODY	231.23	231.23	236.78	240.48
7156	ANTERIOR CHAMBER OPEN EVACUATION OF CLOT	347.11	347.11	355.44	360.99
7160	IRIDENCLESIS	340.63	340.63	348.81	354.26
7161	TRABECULOPLASTY	360.27	360.27	368.92	374.68
7162	ANTERIOR VITRECTOMY	321.59	321.59	329.31	334.45
7202	CAPSULOTOMY	220.21	220.21	225.50	229.02
7203	CATARACT-SENILE	490.43	490.43	502.20	510.05
7204	CATARACT-CONGENITAL	518.31	518.31	530.75	539.04
7205	CATARACT-TRAUMATIC	518.31	518.31	530.75	539.04
7206	CATARACT-EXTRACT-DISLOCATED LENS	518.31	518.31	530.75	539.04

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
7208	SEVERANCE OF VITREOUS STRANDS	167.29	167.29	171.30	173.98
7210	CATARACT EXTRACT-INTRA-OCULAR LENS	555.55	555.55	555.55	555.55
7211	SECONDARY LENS INSERTION	356.36	356.36	364.91	370.61
7212	REPOSITION INTRA-OCULAR LENS	170.18	170.18	174.26	176.99
7213	REMOVAL-INTRA-OCULAR LENS	299.49	299.49	306.68	311.47
7250	RE-ATTACH OF RETINA AND CHOROID -SIMPLE	462.83	462.83	473.94	481.34
7251	RE-ATTACH OF RETINA & CHOROID -PHOTOCOAGULATION	440.41	440.41	450.98	458.03
7252	CRYOPEXY	440.41	440.41	450.98	458.03
7253	NON-CIRCLING TUBE OR BUCKLE PROCED	693.90	693.90	710.55	721.66
7254	CIRCLING TUBE-1ST OPERATION	693.90	693.90	710.55	721.66
7255	UNTREATED RETINAL DETACHMENTS	693.90	693.90	710.55	721.66
7256	SECONDARY OPERATION FOR DETACHMENT	925.50	925.50	947.71	962.52
7257	PHOTOCOAGULATION-INDEPENDENT PROCED	275.20	275.20	281.80	286.21
7258	CRYOPEXY-INDEPENDENT PROCEDURE	275.20	275.20	281.80	286.21
7259	PNEUMATIC RETINOPEXY	660.18	660.18	676.02	686.59
7260	PNEUMATIC RETINOPEXY -REPEAT SAME EYE W/IN 30 DAYS	330.09	330.09	338.01	343.29
7300	STRABISMUS PROCEDURES	330.31	330.31	417.12	475.00
7301	STRABISMUS PROCED-SUB OPERATIONS	173.61	173.61	234.44	275.00
7302	STRABISMUS SURGERY	340.63	340.63	348.81	354.26
7350	DRAINAGE OF ABSCESS-ORBIT	231.23	231.23	236.78	240.48
7351	LATERAL ORBIOTOMY-KRONLEIN PROCED	578.50	578.50	592.38	601.64
7352	TUMOR-ORBITAL	404.83	404.83	414.55	421.02
7353	TUMOR-LACRIMAL GLAND	404.83	404.83	414.55	421.02
7354	EXENTERATIONS	462.83	462.83	473.94	481.34
7355	ORBIT BIOPSY	115.72	115.72	118.50	120.35
7356	ORBITAL FRACTURE	347.11	347.11	355.44	360.99
7357	BLOWOUT FRACTURE OF FLOOR	404.83	404.83	414.55	421.02
7358	SECONDARY REPAIR OF BLOWOUT FRACTURE	636.33	636.33	651.60	661.78
7400	DRAINAGE OF EYELID ABSCESS-LOCAL	37.45	37.45	38.35	38.95
7402	CHALAZION-LOCAL	46.44	46.44	47.55	48.30
7403	CHALAZION-GENERAL	57.78	57.78	59.17	60.09
7404	EPILATION BY HYFRECOTOR	23.06	23.06	23.61	23.98
7405	LID TUMORS-VERY MINOR	34.72	34.72	35.55	36.11
7406	LID TUMORS-MINOR	165.15	165.15	169.11	171.76
7407	LID TUMORS-INTERMEDIATE	289.17	289.17	296.11	300.74
7408	LID TUMORS-MAJOR	404.83	404.83	414.55	421.02
7409	LID TUMORS-EXTENSIVE	578.50	578.50	592.38	601.64
7410	PTOSIS	347.11	347.11	355.44	360.99
7411	PTOSIS-SECONDARY REPAIR	578.50	578.50	592.38	601.64
7412	DISTRICHIASIS-UNILATERAL	347.11	347.11	355.44	360.99
7413	TRICHIASIS	I.C.	I.C.	I.C.	I.C.
7414	ENTROPION	347.75	347.75	356.10	361.66
7415	ECTROPION	347.11	347.11	355.44	360.99
7417	LACERATION	347.11	347.11	355.44	360.99
7418	SUTURE-TARSORRHAPHY	115.72	115.72	118.50	120.35
7419	DOUBLE ADHESION	173.61	173.61	177.78	180.55
7420	TREATMENT OF TRICHIASIS	53.29	53.29	54.57	55.42
7421	EYELID REPAIR LACERATION (LESS THAN 2CM)	173.61	173.61	177.78	180.55
7430	BLEPHAROPLSTY-EXCISN SKIN+/-MUSCLE-PER LID	142.58	142.58	146.00	148.28
7431	PLUS REMOV ORB FAT+/-LID FOLD RECONSTR OR GRFT	186.18	186.18	190.65	193.63
7450	PTERYGIUM-UNILATERAL	224.70	224.70	230.09	233.69
7451	PERITOMY	81.05	81.05	83.00	84.29
7452	CONJUNCTIVA BIOPSY	34.72	34.72	35.55	36.11
7453	CONJUNCTIVA-PLASTIC REPAIR	I.C.	I.C.	I.C.	I.C.
7500	DACRYOCYSTOTOMY	57.78	57.78	59.17	60.09
7502	DACRYOCYSTECTOMY	289.17	289.17	296.11	300.74
7503	LACERATED CANALICULUS	231.23	231.23	236.78	240.48

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
7504	DACROCYSTORHINOSTOMY	462.83	462.83	473.94	481.34
7505	PROBING AND DILATION OF DUCT-GENERAL	75.00	75.00	76.80	78.00
7510	FLUORESCEIN / DIGITAL ANGIOGRAM	61.04	61.04	62.50	63.48
7511	BANDAGE CONTACT LENS	89.29	89.29	91.43	92.86
7512	THREE-SNIP PROCEDURE	66.29	66.29	67.88	68.94
7700	DRAIN ABSCESS OR HEMATOMA-LOCAL	80.25	80.25	82.18	83.46
7701	DRAIN ABSCESS OR HEMATOMA-GENERAL	57.78	57.78	59.17	60.09
7702	BIOPSY OF EAR	80.25	80.25	92.10	100.00
7703	LOCAL EXCISION-LESION ON EAR	57.78	57.78	59.17	60.09
7704	PARTIAL EXCISION OF EAR	173.61	173.61	177.78	180.55
7705	COMPLETE EXCISION OF EAR	231.23	231.23	236.78	240.48
7706	RADICAL EXCISION-MALIGNANT LESION	462.83	462.83	473.94	481.34
7707	REMOVAL OF FOREIGN BODY-SIMPLE	37.45	37.45	38.35	38.95
7708	REMOVAL OF FOREIGN BODY-GENERAL	57.78	57.78	59.17	60.09
7710	RECONSTRUCTION OF EAR/SKIN GRAFT	I.C.	I.C.	I.C.	I.C.
7711	CONSTRUCTION OF EAR CANAL	809.78	809.78	829.21	842.17
7712	REMOVAL OF PLASTIC DRAINAGE TUBES	20.70	20.70	21.20	21.53
7713	REMOVAL OF DRAINAGE TUBE-GENERAL	51.47	51.47	52.71	53.53
7714	FIBREOPTIC ENDOSCOPY	19.47	19.47	25.79	30.00
7720	EXCISN PRE-AURICULAR SINUS-SIMPLE-LOC ANES	81.57	81.57	83.53	84.83
7721	EXCISN PRE-AURICULAR SINUS-GEN ANESTHETIC	163.13	163.13	167.05	169.66
7800	MYRINGOTOMY-LOCAL	34.72	34.72	35.55	36.11
7801	MYRINGOTOMY-GENERAL	69.44	69.44	71.11	72.22
7802	MYRINGOTOMY AND INSERTION OF PROSTHES	110.21	110.21	112.86	114.62
7803	ASPIRATION FOR SEROUS OTITIS	23.06	23.06	23.61	23.98
7804	MASTOIDECTOMY-SIMPLE-UNILATERAL	347.11	347.11	355.44	360.99
7805	RADICAL MASTOIDECTOMY-UNILATERAL	578.50	578.50	592.38	601.64
7806	REMOVAL MIDDLE EAR POLYP BY SNARE	46.22	46.22	47.33	48.07
7807	REVISION OF RADICAL MASTOID CAVITY	578.50	578.50	592.38	601.64
7808	STAPES MOBILIZATION	578.50	578.50	592.38	601.64
7809	STAPEDECTOMY	809.78	809.78	829.21	842.17
7811	MYRINGOPLASTY	347.11	347.11	355.44	360.99
7812	TYMPANOPLASTY	660.67	660.67	676.53	687.10
7813	FACIAL NERVE DECOMPRESSION	578.50	578.50	592.38	601.64
7814	FACIAL NERVE GRAFT	693.90	693.90	710.55	721.66
7815	MIDDLE EAR EXPLORATION	347.11	347.11	355.44	360.99
7901	LABYRINTHECTOMY-EXCISION	693.90	693.90	710.55	721.66
7902	MEATOPLASTY	118.18	118.18	121.02	122.91
7905	ETHMOIDAL ARTERY LIGATION FOR EPISTAXIS	115.72	115.72	118.50	120.35
7906	MAXILLARY ARTERY LIGATION FOR EPISTAXIS	449.75	449.75	460.54	467.74
7907	NASAL SEPTAL BUTTON INSERTION	97.62	97.62	99.96	101.52
7908	LYSIS OF NASAL ADHESIONS	118.24	118.24	121.08	122.97
7909	INTRANASAL ETHMOIDECTOMY(ANTERIOR)	171.90	171.90	176.03	178.78
7910	INTRANASAL ETHMOIDECTOMY(ANT.+POST.)	280.34	280.34	287.07	291.55
7911	POST-TONSIL/ADENOIDECTOMY BLEED(SAME SURGEON)	70.94	70.94	72.64	73.78
7912	POST-TONSIL/ADENOIDECTOMY BLEED(DIFF SURGEON)	130.06	130.06	133.18	135.26
7913	EXCISION EAR CANAL EXOSTOSIS (SINGLE)	302.18	302.18	309.43	314.27
7914	EXCISION EAR CANAL EXOSTOSIS (MULTIPLE)	532.06	532.06	544.83	553.34
7915	MASTOID CAVITY CLEANING	68.92	68.92	70.57	71.68
8000	DRAINAGE OF KIDNEY ABSCESS	347.11	347.11	355.44	360.99
8001	DRAINAGE OF PERINEPHRIC ABSCESS	231.23	231.23	236.78	240.48
8002	ADRENAL EXPLORATION-UNILATERAL	347.11	347.11	355.44	360.99
8003	RENAL EXPLORATION	347.11	347.11	355.44	360.99
8004	NEPHROSTOMY	404.83	404.83	414.55	421.02
8006	TRANSECTION ABERRANT RENAL VESSEL	404.83	404.83	414.55	421.02
8007	SECONDARY OPERATION-ADDITIONAL	115.72	115.72	118.50	120.35
8009	PYELOITHOTOMY	404.83	404.83	414.55	421.02

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
8010	PARTIAL NEPHRECTOMY/RECONSTRUCTION FOR CA	660.67	660.67	676.53	687.10
8011	ADRENALECTOMY-UNILATERAL	578.50	578.50	592.38	601.64
8012	FUNCTIONAL TUMORS	578.50	578.50	592.38	601.64
8013	RENAL CYST	404.83	404.83	414.55	421.02
8014	HEMINEPHRECTOMY	555.28	555.28	568.61	577.49
8015	SECONDARY OPERATION-ADDITIONAL	115.72	115.72	118.50	120.35
8016	NEPHRECTOMY-ECTOPIC	462.83	462.83	473.94	481.34
8017	LUMBAR	485.83	485.83	497.49	505.26
8018	TRANSPERITONEAL	462.83	462.83	473.94	481.34
8019	TRANSPERITONEAL-THORACO-ABDOMINAL	693.90	693.90	710.55	721.66
8020	RADICAL NEPHRECTOMY	660.67	660.67	676.53	687.10
8021	NEPHRO-URETERECTOMY	578.50	578.50	592.38	601.64
8022	NEPHRO-URETERECTOMY WITH RESECTION	693.90	693.90	710.55	721.66
8023	NEPHRO-URETERECTOMY-SECONDARY OPER	115.72	115.72	118.50	120.35
8024	OPEN RENAL BIOPSY	347.11	347.11	355.44	360.99
8025	PYELOURETOPLASTY	520.56	520.56	533.05	541.38
8026	NEPHROPEXY	347.11	347.11	355.44	360.99
8028	SYMPHYSIOTOMY	555.28	555.28	568.61	577.49
8029	SUTURE RUPTURED KIDNEY	462.83	462.83	473.94	481.34
8030	REMOVAL OF STAGHORN CALCULUS	649.38	649.38	664.97	675.36
8031	DONOR NEPHRECTOMY-UNILATERAL OR BILATERAL	463.79	463.79	474.92	482.34
8032	RENAL AUTO TRANSPLANTATION	894.57	894.57	916.04	930.35
8033	PERCUT ENDOPYELOPLSTY FOR UPJ OBSTRUCTION	277.56	277.56	284.22	288.66
8040	ESWL - ONE SIDE, ONE STONE	385.20	385.20	394.44	400.61
8041	ESWL - ONE SIDE, MULTIPLE STONES	577.80	577.80	591.67	600.91
8042	ESWL - BILATERAL, ONE STONE PER SIDE	642.00	642.00	657.41	667.68
8043	ESWL - BILATERAL, MULTIPLE STONES PER SIDE	936.25	936.25	958.72	973.70
8100	PERI-URETERAL ABSCESS	231.23	231.23	236.78	240.48
8102	URETEROTOMY-UPPER TWO THIRDS	416.39	416.39	426.38	433.05
8103	URETEROTOMY-LOWER ONE THIRD	485.83	485.83	497.49	505.26
8104	URETERECTOMY	404.83	404.83	414.55	421.02
8105	URETERECTOMY-URETEROVESICAL JUNCTION	462.83	462.83	473.94	481.34
8106	URETEROVESICAL ANASTOMOSIS	555.28	555.28	568.61	577.49
8107	URETERO-ILEAL CONDUIT	693.90	693.90	710.55	721.66
8108	URETERO-ILEAL COND-TOTAL CYSTECT	1,041.16	1,041.16	1,066.15	1,082.81
8109	URETERO-COLIC ANASTOMOSIS	520.56	520.56	533.05	541.38
8110	URETERO-COLIC ANASTOMOSIS-CYSTECT	832.83	832.83	852.82	866.14
8111	URET-COLIC ANASTOMOSIS-CYSTECTMY+COLOSTMY	971.61	971.61	994.93	1,010.47
8112	ILEO-URETERAL SUBSTITUTION	693.90	693.90	710.55	721.66
8113	URETERO-URETEROSTOMY	578.50	578.50	592.38	601.64
8114	URETEROSTOMY-CUTANEOUS UNILATERAL	347.11	347.11	355.44	360.99
8115	URETERO-VAGINAL FISTURE	555.28	555.28	568.61	577.49
8116	URETEROLYSIS PERI-URETERAL FIBROSIS-UNILAT	462.83	462.83	473.94	481.34
8118	SPONTANEOUS RUPTURE IMMEDIATE-UPPER	404.83	404.83	414.55	421.02
8119	SPONTANEOUS RUPTURE-IMMEDIATE LOWER	462.83	462.83	473.94	481.34
8120	SPONTANEOUS RUPTURE-LATE REPAIR-UP	462.83	462.83	473.94	481.34
8121	SPONTANEOUS RUPTURE-LATE REPAIR-LOW	520.56	520.56	533.05	541.38
8122	ENDOSCOPIC PROCEDURES-CALIBRATION/DILATION	101.65	101.65	104.09	105.72
8123	ENDOSCOPIC REMOVAL OF CALCULUS	294.25	294.25	301.31	306.02
8124	ENDOSCOPIC PROCEDURES-MANIPULATION ONLY	171.20	171.20	175.31	178.05
8125	URETEROTOMY-UPPER TWO THIRDS	441.38	441.38	451.97	459.04
8126	URETEROTOMY-LOWER ONE THIRD	506.27	506.27	518.42	526.52
8127	BLADDER FLAP (BOARI) INCL REIMPLANT	497.02	497.02	508.95	516.90
8128	REVISION OF URETERAL-ILEAL ANASTOMOSIS	434.96	434.96	445.40	452.36
8129	PARTIAL RESECTION+REVISION OF ILEAL CONDUIT	397.72	397.72	407.27	413.63
8197	COLD KNIFE (VISUAL) INTERNAL URETHROTOMY	228.98	228.98	234.48	238.14
8198	BRUSH BIOPSY OF URETER/RENAL PELVIS	214.00	214.00	219.14	222.56

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
8199	ENDOSCOPY WITH INSERT URETERAL STNT	278.20	278.20	284.88	289.33
8200	ENDOSCOPY-CYSTOSCOPY-DIAGNOSTIC	101.65	101.65	104.09	105.72
8202	ENDOSCOPY-CYSTOSCOPY WITH BIOPSY	171.20	171.20	175.31	178.05
8203	ENDOSCOPY-CYSTOSCOPY-ELECTROCOAG TUMOR	171.20	171.20	175.31	178.05
8204	ENDOSCPY-CYSTOSCPY-ELECTROCOAG TUMOR MULT	214.00	214.00	219.14	222.56
8205	ENDOSCOPY-CYSTOSCOPY-URETHRAL DILATION	110.00	110.00	112.64	114.40
8206	ENDOSCOPY-CYSTOSCOPY-BLADDER DILATION	171.20	171.20	175.31	178.05
8207	ENDOSCPY-CYSTOSCPY-COAGULATN HUNNER ULCER	171.20	171.20	175.31	178.05
8208	ENDOSCPY-CYSTOSCPY-ELCTROCOAG-EXCISN TUMOR	308.37	308.37	315.77	320.70
8209	ENDSCPY-CYSTO-ELCTROCOAG/EXCSN TUMOR MULT	449.40	449.40	460.19	467.38
8211	ELECTROSURGICAL URETERAL METOTOMY	192.60	192.60	197.22	200.30
8212	ENDOSCOPY-CYSTOSCOPY-REMOVAL FOREIGN BODY	214.00	214.00	219.14	222.56
8214	ENDOSCOPY/CYSTOSCOPY-LITHOPLAPAXY	264.29	264.29	270.63	274.86
8215	URETHRAL MEATOTOMY AND PLASTIC REPAIR	171.20	171.20	175.31	178.05
8216	CYSTOTOMY OR CYSTOSTOMY	173.61	173.61	177.78	180.55
8217	CYSTOT/CYSTOS AND ELCTRCGLTN TUMOR	347.11	347.11	355.44	360.99
8218	CYSTOTOMY WITH TROCHAR AND CANNULA	115.72	115.72	118.50	120.35
8219	CYSTOLITHOTOMY	231.23	231.23	236.78	240.48
8223	CYSTECTOMY-PARTIAL	462.83	462.83	473.94	481.34
8224	CYSTECTOMY FOR TUMOR DIVERTICULUM	520.56	520.56	533.05	541.38
8225	CYSTECTOMY-REIMPLANTATION OF URETER	578.50	578.50	592.38	601.64
8226	COMPLETE CYSTECTOMY	578.50	578.50	592.38	601.64
8227	CYSTECTOMY WITH COLOCYSTOPLASTY	925.50	925.50	947.71	962.52
8228	CYSTECTOMY-COLOCYSTOPLASTY-2ND SURGERY	231.23	231.23	236.78	240.48
8229	EXCISION URACHUS AND REPAIR BLADDER	289.17	289.17	296.11	300.74
8230	EXTROPHY	347.11	347.11	355.44	360.99
8231	EXTROPHY-URINARY DIVERSION & EXCIS	925.50	925.50	947.71	962.52
8232	EXTROPHY-EXCSN BLADDER+REPAIR BLADDER WALL	347.11	347.11	355.44	360.99
8233	REPAIR OF RUPTURED BLADDER	416.39	416.39	426.38	433.05
8234	ILEOCYSTOPLASTY	693.90	693.90	710.55	721.66
8239	CLOSURE FISTULA,EXTERNAL-SUPRAPUBIC	277.56	277.56	284.22	288.66
8240	VESICOVAGINAL-TRANSVESICAL APPROACH	555.28	555.28	568.61	577.49
8241	VESICORECTAL OR VESICOSIGMOID	462.83	462.83	473.94	481.34
8242	CYSTOSCOPY-RETROGRAPHY PYELOGRAM	92.50	92.50	118.00	135.00
8243	PEVIC AND RETROPERITONEAL LYMPH CANCER	652.43	652.43	668.09	678.53
8250	INTRAVESICAL BOTOX INJECTIONS (1 OR MORE)	214.00	214.00	219.14	222.56
8300	BIOPSY INCLUDING ENDOSCOPY	92.50	92.50	94.72	96.20
8301	INTERNAL URETHROTOMY	138.83	138.83	142.16	144.38
8302	REMOVAL OF FOREIGN BODY	173.61	173.61	177.78	180.55
8303	MEATAL EXTRACTION OF FOREIGN BODY	37.45	37.45	38.35	38.95
8304	URETHROTOMY-EXTERNAL	277.56	277.56	284.22	288.66
8305	MEATOTOMY AND PLASTIC REPAIR	81.05	81.05	83.00	84.29
8308	PERIURETHRAL ABSCESS	57.78	57.78	59.17	60.09
8309	CARUNCLE	81.05	81.05	83.00	84.29
8310	CARUNCLE INCLUDING CYSTOSCOPY	138.83	138.83	142.16	144.38
8311	URETHRAL PAPILLOMA	138.83	138.83	142.16	144.38
8312	PROLAPSE	92.50	92.50	94.72	96.20
8313	PROLAPSE WITH CYSTOSCOPY	138.83	138.83	142.16	144.38
8314	STRICTURE-ONE STAGE	416.39	416.39	426.38	433.05
8315	STRICTURE-TWO STAGE (1ST STAGE)	208.17	208.17	213.17	216.50
8316	STRICTURE-SECOND STAGE	416.39	416.39	426.38	433.05
8317	DIVERTICULECTOMY	289.17	289.17	296.11	300.74
8318	POSTERIOR URETHRAL VALVE-ENDOSCOPY	115.72	115.72	118.50	120.35
8319	POST URETHRAL VALVE-OPEN OPERATION	289.17	289.17	296.11	300.74
8320	BIOPSY-EXCISION	34.72	34.72	35.55	36.11
8321	URETHRAL SLING	347.11	347.11	355.44	360.99
8322	URETHROVESICAL SUSPENSION-STRESS INCONINENCY	416.39	416.39	426.38	433.05

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
8323	URETHRVESIC SUSPNSN+PARTL CYSTECTMY/VESCPXY	555.28	555.28	568.61	577.49
8324	SUTURE-RUPTURE OF ANTERIOR URETHRA	277.56	277.56	284.22	288.66
8325	SUTURE-POST URETHRA-IMMEDIATE REPAIR	485.83	485.83	497.49	505.26
8326	SUTURE-POST URETHRA-LATE REPAIR	636.33	636.33	651.60	661.78
8328	RECTO-URETHRAL FISTULA	462.83	462.83	473.94	481.34
8329	RECTO-URETHRAL FISTULA-COLOSTOMY	578.50	578.50	592.38	601.64
8330	DILATION OF STRICTURE LOCAL	23.06	23.06	23.61	23.98
8331	DILATION OF STRICTURE-GENERAL	57.78	57.78	59.17	60.09
8332	DILATION STRICTURE-FILLFORMS AND FOLLOWERS	41.89	41.89	42.90	43.57
8333	SUTURE URETHROCUTANEOUS FISTULA	277.56	277.56	284.22	288.66
8334	URETHRECTOMY	428.00	428.00	438.27	445.12
8335	EXTERNAL SPINCTEROTOMY (TRANSURETHL)	324.69	324.69	332.48	337.68
8336	INSERTION OF ARTIFICIAL URINARY SPHINCTER	642.00	642.00	657.41	667.68
8337	NESBITT PROCEDURE FOR PEYRONIE'S DISEASE	577.80	577.80	591.67	600.91
8339	URETHROLYSIS (INCLUDES CYSTOSCOPY)	374.50	374.50	383.49	389.48
8400	SPLIT OF PREPUCE-NEWBORN	11.61	11.61	11.89	12.07
8401	SPLIT OF PREPUCE-CHILD	12.84	12.84	13.15	13.35
8402	SPLIT OF PREPUCE-ADULT	25.68	25.68	26.30	26.71
8404	CIRCUMCISION-CHILD UNDER 12	138.55	138.55	160.42	175.00
8405	CIRCUMCISION-ADULT	138.10	138.10	160.24	175.00
8406	CONDYLOMATA	57.78	57.78	59.17	60.09
8407	BIOPSY-PENIS	46.22	46.22	47.33	48.07
8408	PARTIAL AMPUTATION OF PENIS	208.17	208.17	213.17	216.50
8409	PARTIAL AMPUTATION-PENIS AND INGUINAL GLANDS	555.28	555.28	568.61	577.49
8410	TOTAL AMPUTATION PENIS AND INGUINAL GLANDS	693.90	693.90	710.55	721.66
8411	EPISPADIUS	347.11	347.11	355.44	360.99
8412	HYPOSPADIUS-CHRORDEE REPAIR	231.23	231.23	236.78	240.48
8413	PLASTIC RECONTRUCTION URETHRE-ONE STAGE	347.11	347.11	355.44	360.99
8414	PLASTIC RECONTRUCTION URETHRA-TWO STAGE	462.83	462.83	473.94	481.34
8415	PLASTIC RECONTRUCTION PENOSCROTAL-1ST STAGE	462.83	462.83	473.94	481.34
8416	PLASTIC RECONTRUCTION PENOSCROTAL 2ND STAGE	578.50	578.50	592.38	601.64
8417	PENILE PROSTHESIS FOR IMPOTENCE	328.01	328.01	335.88	341.13
8418	EXCISION OF PEYRONIE'S PLAQUE	208.76	208.76	213.77	217.11
8419	INJECTION SUBSTANCE IMPOTENCE THERAPY	15.52	15.52	15.89	16.14
8420	INSERTION OF HYDRAULIC PENILE PROSTHESIS	401.73	401.73	411.37	417.80
8421	RETROPERITONEL LYMPHADENECTOMY TESTIC CA	I.C.	I.C.	I.C.	I.C.
8422	REMOVAL OF INFECTED PENILE PROSTHESIS	267.50	267.50	273.92	278.20
8500	TESTES ABSCESS	57.78	57.78	59.17	60.09
8501	ORCHIDECTOMY-UNILATERAL	208.17	208.17	213.17	216.50
8502	TESTES BIOPSY-SINGLE	57.78	57.78	59.17	60.09
8503	TESTES BIOPSY WITH VASOGRAPHY	115.72	115.72	118.50	120.35
8504	ORCHIDOPEXY	396.33	396.33	405.84	412.18
8505	REDUCT TORSION OR APPENDIX TESTIS	208.17	208.17	213.17	216.50
8506	RUPTURED TESTICLE	208.17	208.17	213.17	216.50
8507	INSERTION OF TESTICULAR PROSTHESIS	172.27	172.27	176.40	179.16
8508	RADICAL ORCHIECTOMY FOR CA-UNILATERAL	321.00	321.00	328.70	333.84
8510	EPIDIDYMIS-ABSCESS	57.78	57.78	59.17	60.09
8511	SPERMATOCELE	208.17	208.17	213.17	216.50
8512	EPIDIDYMECTOMY-UNILATERAL	208.17	208.17	213.17	216.50
8513	ANASTOMOSIS-EPIDIDYMOVASOSTOMY UNILATERAL	208.17	208.17	213.17	216.50
8520	HYDROCELE-UNILATERAL	198.22	198.22	202.98	206.15
8521	HYDROCELE-ASPIRATION	23.06	23.06	23.61	23.98
8530	SCROTOM ABSCESS	57.78	57.78	59.17	60.09
8531	SCROTUM EXPLORATION-UNILATERAL	138.83	138.83	142.16	144.38
8533	RESECTION OF SCROTUM	231.23	231.23	236.78	240.48
8534	SUTURE-INTEGUMENTARY SYSTEM	I.C.	I.C.	I.C.	I.C.
8540	VASOGRAPHY	57.78	57.78	59.17	60.09

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
8543	SUTURE-LIGATION-BILATERAL	141.24	141.24	152.50	160.00
8550	VARICOCELE-SINGLE	208.17	208.17	213.17	216.50
8551	HYDROCELE-SPERMATIC CORD	208.17	208.17	213.17	216.50
8560	SEMINAL VESICLES-ABSCESS	115.72	115.72	118.50	120.35
8561	VESICULECTOMY	578.50	578.50	592.38	601.64
8572	PROSTATE BIOPSY PERINEAL	231.23	231.23	236.78	240.48
8574	PROSTATE BIOPSY-NEEDLE	138.83	138.83	142.16	144.38
8577	RADICAL PROSTATOVESICULECTOMY	832.83	832.83	852.82	866.14
8578	PROSTATECTOMY-SUBRAPUBIC	555.28	555.28	568.61	577.49
8579	SUPRAPUBIC WITH DIVETICULECTOMY	693.90	693.90	710.55	721.66
8580	SUPRAPUBIC WITH PARTIAL CYSTECTOMY	693.90	693.90	710.55	721.66
8581	PROSTATECTOMY-RETROPUBIC-SIMPLE	550.62	550.62	563.83	572.64
8582	PROSTATE BIOPSY - U/S GUIDED TRANSRECT	130.00	130.00	133.12	135.20
8584	TRANSURETHRAL ELECTRORESECTION	550.62	550.62	563.83	572.64
8587	RESECTION OF BLADDER NECK-ADULT	347.11	347.11	355.44	360.99
8588	URETEROSCOPY ONLY	100.95	100.95	202.38	270.00
8590	CHANGE OF SUPRAPUBIC TUBE	23.06	23.06	23.61	23.98
8591	LYMPHADENECTOMY FOR CANCER OF PROSTATE	328.01	328.01	335.88	341.13
8592	URETERAL/RENAL STONE REMOVAL SINGLE	500.23	500.23	512.24	520.24
8593	URET STONE REMOV ELECHYDROLIC U/S LITHTRPSY	600.22	600.22	614.63	624.23
8594	RENAL/UPPER URETERAL STONE REMOVAL	600.22	600.22	614.63	624.23
8595	RENAL/UP URET WITH ELECRO/ULTRA	800.20	800.20	819.40	832.21
8596	REPEAT ORIG ABSCESS WITH ONE WEEK	400.23	400.23	409.84	416.24
8597	PERCUTANEOUS NEPHROSTOMY	160.13	160.13	163.97	166.54
8598	URETEROSCOPY WITH ULTRA/ELECT LITH	600.22	600.22	614.63	624.23
8599	URETEROSCOPY PLUS BASKET	500.23	500.23	512.24	520.24
8600	EYE FOR FOREIGN BODY	7.81	7.81	8.00	8.12
8601	EYE FOR LOCALIZATION ADDITIONAL	20.92	20.92	21.42	21.76
8602	OPTIC FORAMINA	7.81	7.81	8.00	8.12
8603	FACIAL BONES	11.61	11.61	11.89	12.07
8604	MANDIBLE	7.81	7.81	8.00	8.12
8605	MASTOIDS	11.45	11.45	11.72	11.91
8606	NECK-FOR SOFT TISSUES	8.61	8.61	8.82	8.95
8607	NASAL BONES	10.59	10.59	10.84	11.01
8608	SALIVARY GLAND REGION	7.81	7.81	8.00	8.12
8609	SELLA TURCICA	6.37	6.37	6.52	6.62
8610	SINUSES-PARANASAL	10.11	10.11	10.35	10.51
8611	SKULL-ROUTINE VIEWS	11.77	11.77	12.05	12.24
8612	SKULL-SPECIAL ADDITIONAL VIEWS	6.37	6.37	6.52	6.62
8613	TEETH UP TO HALF SET	6.37	6.37	6.52	6.62
8614	TEETH-FULL SET	10.54	10.54	10.79	10.96
8615	TEMPEROMANDIBULAR JOINT	8.35	8.35	8.55	8.68
8616	INTERNAL AUDITORY MEATI	10.54	10.54	10.79	10.96
8620	CERVICAL SPINE-ROUTINE	11.50	11.50	11.78	11.96
8621	CERVICAL SPINE WITH SPECIAL VIEWS	13.59	13.59	13.92	14.13
8622	THORACIC SPINE	9.42	9.42	9.65	9.80
8623	LUMBAR SPINE-ROUTINE	11.50	11.50	11.78	11.96
8624	LUMBAR SPINE-SPECIAL VIEWS	12.57	12.57	12.87	13.07
8625	SACRUM AND/OR COCCYX	7.81	7.81	8.00	8.12
8626	PELVIS	8.61	8.61	8.82	8.95
8627	S.I. JOINTS	8.61	8.61	8.82	8.95
8628	COMPLETE SPINE SCOLIOSIS SERIES	19.85	19.85	20.33	20.64
8629	RIBS-EACH SIDE	7.86	7.86	8.05	8.17
8630	STERNUM	7.81	7.81	8.00	8.12
8635	CLAVICLE	8.72	8.72	8.93	9.07
8636	STEROCLAVICULAR JOINTS	7.81	7.81	8.00	8.12
8637	SHOULDER	8.72	8.72	8.93	9.07

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
8638	SCAPULA	7.81	7.81	8.00	8.12
8639	HUMERUS	8.72	8.72	8.93	9.07
8640	ELBOW	8.72	8.72	8.93	9.07
8641	FOREARM	8.72	8.72	8.93	9.07
8642	WRIST	8.56	8.56	8.77	8.90
8643	HAND	8.56	8.56	8.77	8.90
8644	FINGER	4.12	4.12	4.22	4.28
8645	ACROMIOCLAVICULAR JOINTS WITH WGHTS	10.54	10.54	10.79	10.96
8646	HIP	8.61	8.61	8.82	8.95
8647	HIP PINNING-INTERPRETATION	8.77	8.77	8.98	9.12
8648	HIP PINNING-SUPERVISION AND INTERPRETATION	31.24	31.24	31.99	32.49
8649	FEMUR	8.61	8.61	8.82	8.95
8650	ORTHOROENTGENOGRAM	9.31	9.31	9.53	9.68
8651	KNEE	8.83	8.83	9.04	9.18
8652	TIBIA AND FIBULA	8.72	8.72	8.93	9.07
8653	ANKLE	8.56	8.56	8.77	8.90
8654	CALCANEUS	8.56	8.56	8.77	8.90
8655	FOOT	8.56	8.56	8.77	8.90
8656	TOE	4.12	4.12	4.22	4.28
8657	BONE AGE DETERMINATION	10.54	10.54	10.79	10.96
8658	METASTATIC SERIES	20.92	20.92	21.42	21.76
8659	METABOLIC BONE SURVEY	20.92	20.92	21.42	21.76
8660	ALL LONG BONES	4.98	4.98	5.10	5.18
8661	SPECIAL ADDITIONAL VIEWS OF EXTREMITY	3.64	3.64	3.73	3.79
8662	FEET-WEIGHT BEARING	6.63	6.63	6.79	6.90
8665	CHEST-SINGLE VIEW	6.47	6.47	6.63	6.73
8666	CHEST-MULTIPLE VIEWS	11.56	11.56	11.84	12.02
8667	CHEST FLUOROSCOPY ONLY	12.57	12.57	12.87	13.07
8670	ABDOMEN-SURVEY FILM	7.86	7.86	8.05	8.17
8671	ABDOMEN-MULTIPLE FILMS	11.50	11.50	11.78	11.96
8675	BARIUM SWALLOW	24.88	24.88	25.48	25.88
8676	STOMACH AND DUODENUM	38.41	38.41	39.33	39.95
8677	UPPER G.I SERIES AND SMALL BOWEL STUDY	53.66	53.66	54.95	55.81
8678	COLON-BARIUM ONLY	28.36	28.36	29.04	29.49
8679	COLON-DOUBLE CONTRAST	40.13	40.13	41.09	41.74
8680	CHOLECYSTOGRAM	9.31	9.31	9.53	9.68
8681	T-TUBE CHOLANGIOGRAM	15.68	15.68	16.06	16.31
8682	OPERATIVE CHOLANGIOGRAM	10.54	10.54	10.79	10.96
8684	P.T. CHOLANGIOGRAM-INTERPRETATION	20.92	20.92	21.42	21.76
8685	P.T. CHOLANGIOGRAM-FLUROSCOPY ADDITIONAL	10.54	10.54	10.79	10.96
8686	HYPOTONIC DUODENOGRAM	24.88	24.88	25.48	25.88
8688	INSERT CATH DUODENUM/SM BOWEL ENEMA/PROCED	53.82	53.82	55.11	55.97
8689	INSERT CATH DUODEN/SM BOWEL ENEMA/INTERPRET	9.10	9.10	9.32	9.46
8690	G.U. TRACT-SURVEY FILM	4.98	4.98	5.10	5.18
8691	RETROGRADE PYELOGRAM	9.31	9.31	9.53	9.68
8692	INTRAVENOUS PYELOGRAM	31.83	31.83	32.59	33.10
8695	PYELOGRAM-HYPERTENSIVE	26.11	26.11	26.74	27.15
8696	STRESS OR VOIDING CYSTOGRAM	20.92	20.92	21.42	21.76
8697	STRESS/VOIDING CYSTOGRAM-URETHROGRM	24.88	24.88	25.48	25.88
8698	URETHROGRAM+/-CYSTOGRAM-INTERPRETATION	9.31	9.31	9.53	9.68
8700	T-TUBE PYELOGRAM	9.31	9.31	9.53	9.68
8701	RENAL CYSTOGRAPHY	12.41	12.41	12.71	12.91
8702	RETROGRADE PYELOGRAM-PROCEDURE	30.71	30.71	31.45	31.94
8703	NEPHROSTOGRAM- PROCEDURE	30.71	30.71	31.45	31.94
8704	NEPHROSTOGRAM- INTERPRETATION	9.10	9.10	9.32	9.46
8705	OBSTETRICS AND GYNAECOLOGY-SURVEY FILMS	5.03	5.03	5.15	5.23
8708	HYSTEROSALPINOGRAM	18.83	18.83	19.28	19.58

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
8711	CATHETER CUG	24.45	24.45	25.04	25.43
8715	PERI ARTERIOGRAPHY AND VENOGRPHY-UNILATERAL	16.69	16.69	17.09	17.36
8716	PERI ARTERIOGRAPHY AND VENOGRPHY-BILATERAL	23.17	23.17	23.73	24.10
8717	AORTOGRAPHY	41.62	41.62	42.62	43.28
8718	EACH SELECT EXAM IN AD TO AORTOGRPY	24.88	24.88	25.48	25.88
8721	TRANSLUMBAR AORTOGRAM	19.74	19.74	20.21	20.53
8727	ARCH AORTOGRAM	31.24	31.24	31.99	32.49
8728	SPLENOPORTOGRAM	24.88	24.88	25.48	25.88
8729	LYMPHANGIOGRAM	24.88	24.88	25.48	25.88
8730	SELECTIVE ANGIOGRAPHY	31.24	31.24	31.99	32.49
8731	CAROTID ARTERIOGRAM-UNILATERAL	31.24	31.24	31.99	32.49
8734	CAROTID ARTERIOGRAM-BILATERAL	41.62	41.62	42.62	43.28
8739	MAMMOGRAPHY SCREENING BILATERAL EX	28.60	28.60	29.29	29.74
8740	MAMMOGRAPHY-UNILATERAL	16.10	16.10	16.49	16.74
8741	MAMMOGRAPHY-BILATERAL	38.52	38.52	39.44	40.06
8742	MAMMOGRAPHY-ADDITIONAL VIEWS	3.85	3.85	3.94	4.00
8743	STEREOTACTIC BREAST BIOPSY	147.66	147.66	151.20	153.57
8744	LOOPOGRAM	39.86	39.86	40.82	41.45
8745	ARTHROGRAM	24.88	24.88	25.48	25.88
8749	FISTULA OR SINUS WITH CONTRAST MED	12.57	12.57	12.87	13.07
8750	LAMINOGRPHY,PLANOGRPHY,TOMOGRPHY-1 PLANE	19.21	19.21	19.67	19.98
8751	LAMINOGRPHY,PLANOGRPHY,TOMOGRPHY-2 PLANES	26.11	26.11	26.74	27.15
8754	MYELOGRAM-LUMBAR	24.88	24.88	25.48	25.88
8755	MYELOGRAM-DORSAL	19.74	19.74	20.21	20.53
8756	MYELOGRAM-CERVICAL	19.74	19.74	20.21	20.53
8757	MYELOGRAM-COMPLETE	41.30	41.30	42.29	42.95
8759	SIALOGRAM	12.57	12.57	12.87	13.07
8762	FLUOROSCOPY ONLY	12.57	12.57	12.87	13.07
8763	INTERPRETATION OF SUBMITTED FILMS	12.57	12.57	12.87	13.07
8766	ULTRASOUND B MODE - PELVIC	44.20	44.20	45.26	45.97
8767	ULTRASOUND B MODE - OBSTETRICAL	51.58	51.58	52.82	53.64
8768	M MODE INTERPRETATION-ULTRA SOUND	58.85	58.85	60.26	61.20
8769	DOPPLER INTERPRETATION	53.50	53.50	54.78	55.64
8770	ULTRASONOGRAPHY	82.60	82.60	84.58	85.90
8771	PERCUTANEOUS ASP RENAL CYST/IMAGING	95.55	95.55	97.84	99.37
8772	PERCUTANEOUS ASP RENAL CYST/SCLEROS	119.41	119.41	122.28	124.19
8773	PERCUTANEOUS BIOPSY US/FLUOROSCOPY	119.41	119.41	122.28	124.19
8774	PERCUTANEOUS NEPHROSTOMY TURE INSE	191.21	191.21	195.80	198.86
8775	PERCUTANEOUS DIAGNOSTIC TAP	95.55	95.55	97.84	99.37
8776	PERCUTANEOUS INSERT DRAINAGE TUBE	143.43	143.43	146.87	149.17
8777	ASPIRATION RENAL CYST	119.41	119.41	122.28	124.19
8778	PERCUTANEOUS BILIARY DRAINAGE	278.20	278.20	284.88	289.33
8779	CHANGE OF BILIARY DRAINAGE CATHETER	96.30	96.30	98.61	100.15
8780	BILIARY STRICTURE DILATION/STENTING	139.10	139.10	142.44	144.66
8790	TUMOR LOCALIZATION	150.66	150.66	154.28	156.69
8791	ULTRASOUND B MODE - ABDOMINAL	54.90	54.90	56.22	57.10
8793	SONOHYSTEROGRAM - COMPOSITE FEE	90.95	90.95	93.13	94.59
8794	MYOCARDIAL PERFUSION IMAGING - REST AND STRESS	95.23	95.23	97.52	99.04
8799	SPECT (NUCLEAR SCAN TOMOGRAPHY) - ADD-ON FEE	25.00	25.00	25.60	26.00
8800	THYROID UPTAKE STUDIES	29.75	29.75	30.46	30.94
8801	THYROID UPTAKE PLUS SCAN	49.54	49.54	50.73	51.52
8802	THYROID PERCHLORATE FLUSH	24.77	24.77	25.36	25.76
8803	PLASMA VOLUME	16.59	16.59	16.99	17.25
8804	RED CELL VOLUME	16.59	16.59	16.99	17.25
8805	REPEAT PLASMA VOL STUDIES,EACH	8.35	8.35	8.55	8.68
8806	PLASMA IRON CLEARANCE AND TURNOVER	24.77	24.77	25.36	25.76
8807	IRON RED CELL UTILIZATION	24.77	24.77	25.36	25.76

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
8808	RED CELL SURVIVAL	33.01	33.01	33.80	34.33
8809	SEQUESTRATION STUDIES	33.01	33.01	33.80	34.33
8810	ELECTROLYTE SPACES	33.01	33.01	33.80	34.33
8811	OTHER COMPLEX TESTS (BLOOD VOL)	I.C.	I.C.	I.C.	I.C.
8812	PERTECHNETATE SCAN	24.88	24.88	25.48	25.88
8813	RADIOACTIVE MIBG SCAN	58.48	58.48	59.88	60.82
8814	GASTRIC EMPTYING STUDY	48.79	48.79	49.96	50.74
8815	HIPPURAN RENOGRAM	29.75	29.75	30.46	30.94
8816	RENAL SCAN	24.77	24.77	25.36	25.76
8817	COMBO-SCAN WITH RENOGRAM	49.54	49.54	50.73	51.52
8818	OTHER RADIOACTIVE MATER-UPTAKE / CLEARANCE	16.59	16.59	16.99	17.25
8819	VASCULAR STUDIES USING RADIONUCLIDS	29.75	29.75	30.46	30.94
8820	OTHER COMPLEX TESTS (RENAL FUNCTION)	I.C.	I.C.	I.C.	I.C.
8825	SCHILLING TEST	19.90	19.90	20.38	20.70
8826	SCHILLING TEST-REPEAT	10.00	10.00	10.24	10.40
8828	LIVER SCAN	39.59	39.59	40.54	41.17
8830	ABDOMINAL SCAN FOR ECTOPIC GASTRIC MUCOSA	39.59	39.59	40.54	41.17
8834	HIDA SCAN	59.39	59.39	60.82	61.77
8835	SPLEEN SCAN	39.59	39.59	40.54	41.17
8836	CARDIAC SCAN	33.01	33.01	33.80	34.33
8837	CARDIAC OUTPUT	41.93	41.93	42.94	43.61
8838	CIRCULATION TIME	16.59	16.59	16.99	17.25
8840	LUNG SCAN-VENT OR PERFUSION	49.49	49.49	50.68	51.47
8841	LUNG SCAN-VENT & PERF ON SAME DAY	79.29	79.29	81.19	82.46
8842	PULMONARY ASPIRATION TEST	40.66	40.66	41.64	42.29
8850	BONE TUMOR SCANS	71.37	71.37	73.08	74.22
8851	METABOLIC STUDIES	33.01	33.01	33.80	34.33
8852	BONE DENSITOMETRY	26.96	26.96	27.61	28.04
8856	GALLIUM 67-ABCESS LOCALIZATION X	49.54	49.54	50.73	51.52
8857	PARATHYROID SCAN	49.49	49.49	50.68	51.47
8859	ADDITIONAL FOR EMERGENCY STUDIES X	24.77	24.77	25.36	25.76
8860	FLUOROSCOPY-PER 15 MIN	45.00	45.00	46.08	46.80
8871	DETENTION FEE PER 15 MIN BEGINNING	45.00	45.00	46.08	46.80
8887	B MODE PROCEDURE-INTERPRETATION	40.55	40.55	41.52	42.17
8889	A MODE PROCEDURE/INTERPRETATION	22.15	22.15	22.68	23.04
8900	ARCH AORTOGRAM	113.53	113.53	116.25	118.07
8901	ANGIOGRAPHY ONE SELECTIVE OFF ARCH	56.66	56.66	58.02	58.93
8902	ANGIOGRAPHY TWO SELECTIVE OFF ARCH	113.53	113.53	116.25	118.07
8903	ABDOMINAL AORTOGRAM	113.53	113.53	116.25	118.07
8904	ANGIOGRAPHY ONE SELECTIVE OFF AORTA	56.66	56.66	58.02	58.93
8905	ANGIOGRAPHY TWO SELECTIVE OFF AORTA	113.53	113.53	116.25	118.07
8906	FEMORAL ARTERIOGRAM	56.66	56.66	58.02	58.93
8907	BILATERAL FEMORAL ARTERIOGRAM	90.63	90.63	92.81	94.26
8908	ARTERIOGRAM SELECTIVE	113.53	113.53	116.25	118.07
8909	PERCUTANEOUS NEEDLE ASPIRATION BIO	118.13	118.13	120.97	122.86
8910	PERCUTANEOUS TRANSHEPATIC CHOLANGI	72.55	72.55	74.29	75.45
8911	ARTERIAL EMBOLIZATION	166.87	166.87	170.87	173.54
8912	RENNINS I V C	59.06	59.06	60.48	61.42
8913	SPLENOPORTOGRAM	70.89	70.89	72.59	73.73
8914	BIOPSY/RENAL CYST PUNCTURE	94.48	94.48	96.75	98.26
8915	LYMPHANGIOGRAM UNILATERAL	204.21	204.21	209.11	212.38
8916	LYMPHANGIOGRAM BILATERAL	306.13	306.13	313.48	318.38
8917	LYMPHANGIOGRAM ANGIOPLASTY	236.36	236.36	242.03	245.81
8918	LYMPHANGIOGRAM INF VENA CAVA	59.06	59.06	60.48	61.42
8919	FEMORAL ARTERIOGRAM PAPAVERINE INJECTION	73.40	73.40	75.16	76.34
8925	HEAD-WITHOUT IV CONTRAST	81.21	81.21	83.16	84.46
8926	HEAD-WITH IV CONTRAST	91.38	91.38	93.57	95.04

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
8927	HEAD-WITH AND WITHOUT IV CONTRAST	114.76	114.76	117.51	119.35
8928	COMPLEX HEAD-WITHOUT IV CONTRAST	80.68	80.68	82.62	83.91
8929	COMPLEX HEAD-WITH IV CONTRAST	94.21	94.21	96.47	97.98
8930	COMPLEX HEAD-WITH/WITHOUT IV CONTRAST	107.64	107.64	110.22	111.95
8931	NECK-WITHOUT IV CONTRAST	53.71	53.71	55.00	55.86
8932	NECK-WITH IV CONTRAST	80.68	80.68	82.62	83.91
8933	NECK-WITH/WITHOUT IV CONTRAST	94.21	94.21	96.47	97.98
8934	THORAX-WITHOUT IV CONTRAST	101.65	101.65	104.09	105.72
8935	THORAX-WITH IV CONTRAST	104.33	104.33	106.83	108.50
8936	THORAX-WITH/WITHOUT IV CONTRAST	117.38	117.38	120.20	122.08
8937	ABDOMEN-WITHOUT IV CONTRAST	107.64	107.64	110.22	111.95
8938	ABDOMEN-WITH IV CONTRAST	110.16	110.16	112.80	114.57
8939	ABDOMEN-WITH/WITHOUT IV CONTRAST	122.19	122.19	125.12	127.08
8940	PELVIS-WITHOUT IV CONTRAST	107.64	107.64	110.22	111.95
8941	PELVIS-WITH IV CONTRAST	110.16	110.16	112.80	114.57
8942	PELVIS-WITH/WITHOUT IV CONTRAST	122.19	122.19	125.12	127.08
8943	EXTREMITIES/ONE/MORE/WITHOUT IV CONTRAST	53.71	53.71	55.00	55.86
8944	EXTREMITIES/ONE/MORE/WITH IV CONTRAST	80.68	80.68	82.62	83.91
8945	EXTREMITIES/ONE/MORE/WITH/OUT IV CONTRAST	94.21	94.21	96.47	97.98
8946	SPINE-WITHOUT IV CONTRAST	107.64	107.64	110.22	111.95
8947	SPINE-WITH IV CONTRAST	110.16	110.16	112.80	114.57
8948	SPINE-WITH/WITHOUT IV CONTRAST	122.19	122.19	125.12	127.08
8949	CT GUIDANCE OF BIOPSY	38.73	38.73	39.66	40.28
8950	SCAN ABORTED	13.64	13.64	13.97	14.19
8975	CRANIAL - MULTI-SLICE SCOUT SEQUENCE	78.22	78.22	80.10	81.35
8976	CRANIAL - ADDITIONAL SEQUENCE	38.52	38.52	39.44	40.06
8977	ENT - MULTI-SLICE SCOUT SEQUENCE	78.22	78.22	80.10	81.35
8978	ENT - ADDITIONAL SEQUENCE	38.52	38.52	39.44	40.06
8979	THORAX - MULTI-SLICE SCOUT SEQUENCE	90.20	90.20	92.36	93.81
8980	MRI GATING	27.07	27.07	27.72	28.15
8981	THORAX - ADDITIONAL SEQUENCE	45.15	45.15	46.23	46.96
8982	ABDOMEN - MULTI-SLICE SCOUT SEQUENCE	90.20	90.20	92.36	93.81
8983	ABDOMEN - ADDITIONAL SEQUENCE	45.15	45.15	46.23	46.96
8984	PELVIS - MULTI-SLICE SCOUT SEQUENCE	90.20	90.20	92.36	93.81
8985	PELVIS - ADDITIONAL SEQUENCE	45.15	45.15	46.23	46.96
8986	EXTREMITY - MULTI-SLICE SCOUT SEQUENCE	78.22	78.22	80.10	81.35
8987	EXTREMITY - ADDITIONAL SEQUENCE	38.52	38.52	39.44	40.06
8988	SPINE - MULTI-SLICE SCOUT SEQUENCE	72.23	72.23	73.96	75.12
8989	SPINE - ADDITIONAL SEQUENCE	36.06	36.06	36.93	37.50
8990	MRI ENHANCEMENT (GADOLINIUM)	42.80	42.80	43.83	44.51
8991	SPECTROSCOPY	42.80	42.80	43.83	44.51
8992	3D	67.14	67.14	68.75	69.83
9000	ERUPTED TOOTH	0.00			
9001	RESIDUAL ROOTS	0.00			
9002	RESIDUAL ROOTS-COMPLICATED	0.00			
9003	IMPACTED TEETH	0.00			
9004	IMPACTED TEETH-DIFFICULT	0.00			
9010	ALVEOPLASTY	154.68			
9011	GINGIVOPLASTY	140.88			
9020	SUCULUS DEEPENING AND RIDGE CONSTRUCTION	269.33			
9021	SUCULUS DEEP RIDGE CONSTRUCTION-GRAFT	551.26			
9025	EXPOSURE TOOTH-ORTHO TREATMENT	184.25			
9026	EXPOSURE TOOTH WITH ORTHO ATTACHMNT	229.29			
9030	CLOSURE INTRA-ORAL LACERATION-LOCAL	76.12			
9031	CLOSURE INTRA ORAL LACERATION-GENERAL	76.12			
9032	CLOSURE LACERATIONS-DEBRIDEMENT	114.79			
9040	ANTERIOR TOOTH-ROOT RESECTION	132.54			

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
9041	ROOT RESECTION-POSTERIOR TOOTH	188.66			
9045	ABSCESS-INTRAORAL	76.12			
9046	ABSCESS-EXTRAORAL	178.79			
9047	SEQUESTRECTOMY	204.27			
9048	SEQUESTRECTOMY WITH SAUCERIZATION	408.39			
9060	SIMPLE INTERDENTAL WIRING MANDIBLE	362.29			
9061	MAND FRACTURE-COMPOUND FIX BY PINNING	541.08			
9062	MAXILLARY FRACTURE RADICAL ANSTROSTOMY	448.89			
9063	MAXILLARY FRACTURE-COMPOUND	598.70			
9065	MALAR FRACTURE-OPEN REDUCTION PINNING	358.50			
9066	MALAR FRACT-OPEN REDUCTN, ANTROS AND PACKING	448.89			
9067	MAJOR FRACTURE IN MIDDLE THIRD FACE	902.46			
9068	ALVEOLAR FRACTURE	235.66			
9069	INCISION OF BONE PLATES, REMOVAL MANDIBULAR WIRES	227.84			
9080	INTRA-ORAL CYSTS-LESS THAN 2.0 CM.	154.53			
9081	INTRA-ORAL CYSTS GREATER THAN 2 CM.	229.29			
9082	INTRA-ORAL CYSTS-COMPLICATED	453.73			
9090	INTRA-ORAL BIOPSY SOFT TISSUE	76.12			
9091	INTRA-ORAL BIOPSY-BONE	127.68			
9095	INTRA-ORAL TUMORS LESS THAN 2 CM.	122.23			
9096	INTRA ORAL TUMORS GREATER THAN 2CM.	377.61			
9100	REMOVAL ROOT/FOREIGN BODY-MAX ANTRUM	179.55			
9110	CLOSURE OF ANTRA-ORAL FISTULA	536.54			
9120	TEMPORO-MANDIBLE DISLOCATION-CLOSED	53.39			
9121	TEMPORO-MANDIBLE DISLOCATION,OPEN	357.43			
9130	SIALOLITHOTOMY-SIMPLE	89.63			
9131	SIALOLITHOTOMY-COMPLICATED	269.33			
9140	EXCISION OF RANULA	214.28			
9150	PROGNATHISM	1,516.93			
9152	PROGNATHISM-TWO SURGEONS				
9155	MICROGNATHISM	1,516.93			
9156	MICROGNATHISM (TWO SURGEONS)				
9158	MICROGNATHISM-BONE GRAFT	1,819.31			
9160	CONDYLECTOMY-WITHOUT FIXATION	523.93			
9162	CONDYLECTOMY-FIXATION	536.54			
9170	ALCOHOL NERVE BLOCK	74.76			
9175	AVULSION OF NERVE	252.80			
9176	REPAIR/CLOSURE ORAL/NASAL FISTULA W/BONE GRFT	1,006.94			
9177	REPAIR/CLOSURE ORAL/NASL FISTULA W/O BONE GRFT	672.56			
9178	SEGMENTAL OSTEOTOMY	1,040.15			
9179	ALVEOLAR RIDGE RECONSTRUCTION	500.74			
9180	ALVEOLAR RIDGE RECONSTRUCTION	890.63			
9181	ARTHROPLASTY-EMINOPLASTY	445.24			
9182	ARTHROPLASTY-CONDYLECTOMY	979.49			
9183	ARTHROPLASTY-MENISECTOMY	667.87			
9184	ARTHROPLASTY-PLICATION OF MENISCUS	890.63			
9185	ORTHOGNATHIC SURGERY TREATMENT PLAN	1,500.00			
9200	CONSULTATION- ORAL SURGEON	95.07			
9202	ONCALL RETAINER FEE DENTAL	300.00			
9401	SERVICE NOT AVAILABLE LOCALLY CONSULT	0.00	0.00	0.00	0.00
9402	SERVICE NOT AVAIL LOC CONSULT/INVESIGATION	0.00	0.00	0.00	0.00
9403	SERVICE NOT AVAIL LOC CONSULT/INVESTIG/TRTMNT	0.00	0.00	0.00	0.00
9404	ONE SPECIALIST CONSULT	0.00	0.00	0.00	0.00
9405	ONE SPECIALIST CONSULT/INVESTIGATION	0.00	0.00	0.00	0.00
9406	ONE SPECIALIST CONSULT/INVESTIG/TREATMENT	0.00	0.00	0.00	0.00
9407	ADEQUATE SERVICE NOT AVAILABLE CONSULT	0.00	0.00	0.00	0.00
9408	ADEQUATE SERVICE NOT AVAIL CONSULT/INVESTIG	0.00	0.00	0.00	0.00

Code	Description	Apr-1-15	Apr-1-16	Apr-1-17	Apr-1-18
9409	ADEQUATE SERV NOT AVAIL CONSLT/INVSTG/TRTMNT	0.00	0.00	0.00	0.00
9410	EXTENUATING CIRCUMSTANCES CONSULT	0.00	0.00	0.00	0.00
9411	EXTENUATING CIRCUMSTANCES CONSULT INVESTIG	0.00	0.00	0.00	0.00
9412	EXTENUATG CIRCMSTNC CONSULT/INVESTIG/TRTMNT	0.00	0.00	0.00	0.00
9740	RETAINER PLASTIC SURGERY Q.E.H.	300.00	300.00	300.00	300.00
9750	TELEPHONE CONSULTATION - PLASTIC SURGERY	0.00	0.00	46.08	46.80
9801	SPECIALIST CLINIC PATIENT	0.00	0.00	0.00	0.00
9901	VISITING SPECIALIST (PER HOUR)	175.00	175.00	179.20	182.00
9903	ALTERNATE PROVIDER	0.00	0.00	0.00	0.00
9904	PHYSICIAN AND ALTERNATE	0.00	0.00	0.00	0.00
9977	IN PROVINCE IN PATIENT	0.00	0.00	0.00	0.00
9988	OUT OF PROVINCE FEE CODE	0.00	0.00	0.00	0.00
9999	INDEPENDANT CONSIDERATION	I.C.	I.C.	I.C.	I.C.

TAB 126

President's Letter

November 8, 2017

Lynn Dwyer, MD
President

2013-2017 MOA Update

Dear Colleagues:

I am pleased to inform you that representatives of the NLMA and the provincial government plan to sign the 2013-2017 Memorandum of Agreement on November 17.

An Agreement in Principle was reached in 2015, and ratified by a vote of the membership in October of that year, but finalizing the legal text took longer than expected. Further delays occurred as we sought to finalize the terms of reference for binding arbitration (which will now be the subject of further discussions after the MOA is signed), and as the government sought additional amendments to the MOA in June 2017 (which the government set aside after opposition from the NLMA).

We have been advised by government that systems are ready to make retroactive payments to salaried, fee-for-service and APP physicians within weeks of the signing. We have informed the government that it is essential the payments are made within 2017. It will take some additional time to implement the specific fee code increases and, in the interim, FFS physicians will receive across-the-board adjustments in their biweekly pay. In addition, salaried physicians will see quarterly payments included in their biweekly pay.

Other improvements negotiated in the MOA include:

- new fee code initiatives developed for the Family Practice Renewal Program;
- fee code review process;
- new data-sharing agreement;
- review of the Rural FFS Retention Bonus program for family physicians;
- maintain CMPA reimbursement;
- and, development of criteria and methodology for transitioning hospital-based services to private offices.

The full text of the MOA will be posted to the NLMA website and shared with members once it is signed.

Best Regards,

Lynn Dwyer, MD
President

Newfoundland & Labrador Medical Association
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St. John's, NL
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president@nlma.nl.ca

TAB 127

MEMORANDUM OF AGREEMENT

BETWEEN

NEWFOUNDLAND & LABRADOR MEDICAL ASSOCIATION

AND

GOVERNMENT OF NEWFOUNDLAND AND LABRADOR

Date Signed: December 6, 2017 Expires: September 30, 2017

THIS AGREEMENT made this 6th of December Anno Domini 2017.

BETWEEN:

HER MAJESTY THE QUEEN IN RIGHT OF NEWFOUNDLAND AND LABRADOR, represented herein by the President of the Treasury Board and the Minister of Health and Community Services (hereinafter referred to as the "Government")

of the one part

AND:

THE NEWFOUNDLAND AND LABRADOR MEDICAL ASSOCIATION, a body organized and existing under the laws of the Province of Newfoundland and Labrador and having its Registered Office in the City of St. John's (hereinafter referred to as the "NLMA")

of the other part

Together, the "Parties"

THIS AGREEMENT WITNESSETH that for and in consideration of the premises, covenants, conditions, stipulations, and provisos herein contained, the parties hereto agree as follows:

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SECTION A – GENERAL CONSIDERATIONS

Article 1 Purpose of Agreement

1.01 **WHEREAS**

a) Government and physicians share responsibility for the provision of medical services to the public;

b) Both parties agree that the delivery of medical services must take into full consideration:

(i) reasonable and fair compensation and working conditions for physicians providing insured medical services;

(ii) the need for sufficient physician resources to provide adequate medical care in Newfoundland and Labrador; and

(iii) the financial circumstances of Government; and

c) Government and the NLMA, on behalf of physicians, wish to establish a working relationship based on cooperation and good faith;

The parties have negotiated this Memorandum of Agreement with respect to levels of compensation, employment related benefits and service coverage.

Article 2 Interpretation

Under this Agreement the following definitions will apply.

"Agreement" means this Memorandum of Agreement.

"Alternate Payment Plan (APP)" means an agreement between Government, a Regional Integrated Health Authority (RHA), and the NLMA, that provides remuneration in a format other than salary or fee-for-service (FFS) to a group of physicians in a specialty, including family medicine, in return for the provision of medical services.

"Consensus" means general agreement, characterized by the absence of sustained opposition to substantial issues by any of the voting members of a committee established under this Agreement, and by a process that involves seeking to take into account the views of all voting members and to reconcile any conflicting arguments. Consensus does not require unanimity.

"Geographic Full-Time (GFT) physician" means a physician with clinical

responsibilities who also has an academic teaching appointment at Memorial University. The compensation for the academic component is separate from the compensation for clinical work.

"Maritime Weighted Parity" means the weighted average formula agreed upon by the parties the outcomes of which are used in this agreement.

"Fee-For-Service (FFS)" means the submission of accounts by and payment of fees to physicians for insured medical services in accordance with the MCP Payment Schedule under the Medical Care Plan, pursuant to the *Medical Care Insurance Act, 1999*, SNL 1999, C. M-5.1 (*"Medical Care Insurance Act, 1999"*).

"Health and Community Services (HCS)" means the department or branch of the Government of Newfoundland and Labrador which provides leadership in health and community services programs and policy development for the Province.

"MCP Payment Schedule" means the schedule of fees payable, and the rules and conditions for payment of insured services provided by licensed physicians to beneficiaries under the *Medical Care Insurance Act, 1999* and the *Regulations* made thereunder.

"Newfoundland and Labrador Medical Association (NLMA)" means the medical association representing, advocating for, and negotiating on behalf of Newfoundland and Labrador physicians pursuant to the *Medical Act, 2011*, SNL 2011, c. M.-4.02.

"Physician" means a person who is lawfully entitled to engage in the practice of medicine in the Province pursuant to the *Medical Act, 2011*, SNL 2011 c. M.-4.02, and includes a person who, under the regulations, is entitled to provide insured services.

"Province" means the Province of Newfoundland and Labrador.

"Regional Health Authority (RHA)" means a regional health authority for each health region of the Province established under the *Regional Health Authorities Act*, SNL 2006, c. R-7.1 to provide for the delivery and administration of health and community services in the health region.

"Salaried Physician" means a physician who is an employee of an RHA and who provides medical services as required by the RHA.

"Specialist" means a physician who is recognized as a specialist by the *College of Physicians and Surgeons of Newfoundland and Labrador* or a physician practising outside the Province who is recognized as a specialist by the appropriate regulatory body in the jurisdiction where the physician practises.

Article 3 **Term of Agreement and Interest Arbitration**

3.01 Notwithstanding the date of execution hereof and except as otherwise provided herein, this Agreement shall be effective from October 1, 2013 and shall remain in full force and effect until September 30, 2017.

3.02 Throughout this Agreement, the following meaning shall apply:
Year 1: October 1, 2013 - September 30, 2014;
Year 2: October 1, 2014 - September 30, 2015;
Year 3: October 1, 2015 – September 30, 2016;
Year 4: October 1, 2016 – September 30, 2017.

3.03 Either party to this Agreement may at any time within the one hundred and eighty (180) calendar day period immediately preceding the September 30, 2017 expiration date of this Agreement, give written notice to the other party to commence negotiations for a new agreement.

3.04 Within thirty (30) days following the receipt of the notice referred to in Article 3.03 or a further time that the parties may agree upon, the parties hereto shall enter into good faith negotiations and use reasonable efforts to negotiate a new Agreement.

3.05 If at the expiration date of this Agreement a new agreement has not been negotiated replacing this Agreement, this Agreement shall continue and remain in full force and effect until a new agreement has either been negotiated replacing this Agreement or the terms and conditions of a new agreement have been determined by a combination of negotiation and arbitration as provided for in this Agreement.

3.06 The parties agree to the terms of interest arbitration as articulated at Schedule "N", Interest Arbitration.

Article 4 **Parties to the Agreement**

4.01 The parties to this Agreement are Government and the NLMA.

4.02 The parties recognize that, where applicable, the interests of Government may be represented by the President of Treasury Board and/or the Minister of Health and Community Services or any Minister as may be designated by Government from time to time.

Article 5 **Physicians' Negotiator**

5.01 The NLMA is recognized as the sole and exclusive negotiator on behalf of

physicians licensed by the College of Physicians and Surgeons of Newfoundland and Labrador to practice in this Province for matters which fall within the scope of this Agreement save and except physicians employed in the following positions:

i. Vice President, Medical Services - Eastern RHA
ii. Vice President, Medical Services - Central RHA
iii. Vice President, Medical Services - Western RHA
iv. Vice President, Medical Services - Labrador-Grenfell RHA
v. Medical Director - Eastern RHA
vi. Medical Consultant – HCS
vii. Director of Physician Services – HCS
viii. Assistant Director of Physicians Services – HCS
ix. Chief Medical Examiner – Department of Justice and Public Safety
x. Chief Medical Officer of Health - HCS

Article 6 Government Negotiator

6.01 The President of Treasury Board and/or any Minister as may be designated by Government from time to time is recognized as the sole and exclusive negotiator on behalf of Government for matters that fall within the scope of this Agreement.

Article 7 Subsidiary Agreements

7.01 All subsidiary agreements currently in effect between physicians, RHAs, the NLMA and Government shall be null and void effective the date of signing by all parties of the new Agreement and shall be replaced with the following:

(i) Waterford Physicians "On-duty, on-site" Payment Policy – Schedule "A"
(ii) Institutional Workload Disruption Payment Policy – Schedule "B"
(iii) Salaried Physician Retention Bonuses – Schedule "C"
(iv) Specialty Corrections Fund – Schedule "D"
(v) Alternate Payment Plans – Schedule "E"
(vi) FFS Increases, By FFS Specialty Group – Schedule "F"
(vii) Approved Category 'A' Facilities (24-Hour On-Site Emergency Department Coverage) – Schedule "G"
(viii) Approved Category 'B' Facilities (24-Hour Emergency Department Coverage) – Schedule "H"
(ix) Obstetrical Bonus Policy for Fee-for-service Family Physicians – Schedule "I"
(x) Family Practice Renewal Program – Schedule "J"
(xi) Physician Services Liaison Committee (PSLC) Terms of Reference

– Schedule "K"

(xii) MCP Payment Schedule Review Committee (PSRC) Terms of Reference – Schedule "L"

(xiii) On-Call Rates – Schedule "M"

(xiv) Interest Arbitration – Schedule "N"

Article 8 Government Rights

8.01 All functions, rights, powers, and authorities, which are not specifically abridged, delegated or modified by this Agreement, are recognized by the NLMA as being retained by Government or its delegated authorities.

Article 9 Effect of Legislation

9.01 The parties acknowledge that legislation takes precedence over any provision of this Agreement. It is also acknowledged that should any legislation render null and void any provision of this Agreement, the remaining provisions shall remain in effect during the term of this Agreement.

Article 10 Agreement to Amend

10.01 It is agreed by the parties to this Agreement that any provision of this Agreement may be amended by mutual written consent of Government and the NLMA during the term of this Agreement.

Article 11 Service Coverage

11.01 Physicians commit to provide, in accordance with the negotiated MCP payment schedule and/or negotiated salary, insured services which have traditionally been funded through MCP and which the public might reasonably expect to be available, subject to resources and skill limitations.

11.02 The NLMA will make best efforts to encourage all practicing physicians providing clinical services in the Province to be credentialed and privileged with a RHA.

Article 12 **Physician Services Liaison Committee (PSLC)**

The parties agree to maintain the PSLC, through which medical issues of mutual concern may be addressed collaboratively and to act as an oversight body for the administration of this Agreement. The operation and mandate of the PSLC is described in Schedule "K".

Article 13 **Dispute Resolution**

In the event that a disagreement arises regarding the interpretation of this Agreement:

(i) Either party may refer the matter to the Physician Services Liaison Committee (PSLC) for resolution;

(ii) Should the PSLC be unable to resolve the matter, the parties may, by mutual agreement, engage the services of a mediator to assist the parties in reaching a resolution, recognizing that any proposals or recommendations at this stage are not binding on the parties. The cost of mediation shall be equally borne by the parties; and

(iii) The parties may, by mutual agreement, engage the services of an arbitrator(s) in accordance with the *Arbitration Act, RSNL 1990 cA-14,* the cost of which arbitration shall be equally borne by the parties.

SECTION B - COMPENSATION ISSUES

Article 14 **Total Funding**

14.01 The parties agree to the following funding, for matters which fall within the scope of this Agreement, to be allocated in accordance with the Agreement on behalf of physicians licensed by the College of Physicians and Surgeons of Newfoundland and Labrador to practice in this Province. All amounts include related Specialty Corrections.

	Oct 01, 2015 Sep 30, 2016	Oct 01, 2016 Sep 30, 2017	Total MOA Amount
Primary Care Renewal	$1,049,979	$3,450,021	$4,500,000
FFS Parity (Family Medicine)	$1,087,525	$1,103,741	$2,191,266

FFS Parity (Specialist)	$333,003	$499,504	$832,506
ED Cat. A Parity	$404,400	$606,600	$1,011,000
FFS Increase (Family Physician)	$978,774	$993,368	$1,972,141
FFS Increase (Specialist)	$1,348,434	$2,022,651	$3,371,086
Salaried Increase	$1,306,440	$1,959,659	$3,266,099
Other FFS/APP (Family Physician)	$252,968	$256,740	$509,709
Other FFS/APP (Specialist)	$509,403	$764,105	$1,273,509
Rural FFS Ret. Bonus & Rural Premium Program	$0	$1,000,000	$1,000,000
TOTAL	**$7,270,926**	**$12,656,389**	**$19,927,315**

Article 15 **Fee- for- Service Compensation**

15.01 Fee-for-Service Increases

Fee-For-Service (FFS) physician groups shall receive increased remuneration as follows:

(i) FFS physician groups identified as being under Maritime Weighted Parity as of October 1, 2014, using 2013-14 units and October, 2014 rates, will attain at least 100% of Maritime Weighted Parity, requiring overall funding of $3,023,772 (organized by Family Physicians ($2,191,266) and Specialists ($832,506) as per the table above), as of the beginning of the fourth year of this Agreement (October 1, 2016).

(ii) In addition to 15.01(i), each FFS physician group will receive funding derived from the Full Time Equivalent methodology agreed upon by the Parties. The total amount provided to all groups under this allocation, as of the beginning of the fourth year of this Agreement (October 1, 2016), is $5,343,227 (organized by Family Physicians ($1,972,141) and Specialists ($3,371,086) as per the table above.

(iii)FFS Family Physicians as a group will receive, under (i) and (ii), above, a combined total allocation per FTE of $10,431, based on an agreed FTE count of 399.14.

(iv) Family Physicians as a group will, in addition, be provided access to funding under the Primary Care Renewal Program, as noted in the table above, and as detailed in Schedule "J", attached.

(v) All FFS Specialist groups will receive, under (i) and (ii), above, a combined total allocation per FTE of $12,940 based on an agreed FTE count of 318.66.

(vi) A further amount will be allocated to each physician group based on other payments not considered under the Maritime Weighted Parity methodology. These include APP payments, sessional payments, FFS Intensive Care Unit (ICU) payments, surgical assisting payments, premiums for surgery fee codes, Category B payments, and Specialty Corrections in the total amount of $1,783,218 (Family Physicians ($509,709) and Specialists ($1,273,509).

(vii) The funding identified in paragraphs 15.01(i) through (vi), above, will have 40% distributed effective October 1, 2015 and the remaining funding distributed effective October 1, 2016.

(viii) Notwithstanding Article 15.01(vii), the funding distributed to FFS Family Physicians on October 1, 2015 from Article 15.01 (iii) will be 49.6%.

(ix) Clinical Stabilization Fund (CSF) funding remaining from the 2009-2013 Agreement allocation will be utilized as a contingency pending the final result of the Maritime Weighted Parity analysis.

(x) The Maritime Weighted Parity formula will be reviewed by the parties prior to the next negotiation and any future use will be based on an agreed methodology.

15.02 Schedule of Payments

Until such time as the MCP Payment Schedule fee code allocation process is completed:

(i) FFS physicians will continue to claim for services using MCP Payment Schedule rates in effect.

(ii) The applicable dollar increase for each group will be paid out as an adjustment in each pay period until such time as the Fee Code Allocation Process outlined below in Articles 15.03 and 15.04 is completed.

15.03 FFS Fee Code Allocation

Government and the NLMA will collaborate in the allocation of new funds to specific fee codes and rates for each specialty (the "FFS Fee Code Allocation Process").

The FFS Fee Code Allocation Process will be based on the following principles:

1. no fee code shall exceed the Ontario Health Insurance Plan rate for a comparable service unless mutually agreed;
2. there shall be no fee code allocation to offset overhead costs; and
3. there shall be no fee code allocation for currently non-insured services.

15.04 FFS Fee Code Allocation Process

The parties will table proposals for allocation of funding to fee codes, and will review proposals and determine fee code allocation jointly and collaboratively by consensus. Any fee code allocation which has not been established through this collaborative process will be determined as outlined in steps (i) and (ii) below:

(i) The NLMA will first allocate 50% of the remaining portion of the FFS increase, based on cost estimates provided by HCS, and will immediately provide this information to HCS.

(ii) Within thirty (30) days of receipt of the information from the NLMA as referred to in 15.04 (i) HCS shall allocate the remaining 50% of the FFS increase.

15.05 MCP Payment Schedule Review Process

The parties agree to review the MCP Payment Schedule in accordance with the terms of reference of the MCP Payment Schedule Review Committee as set out in Schedule "L".

15.06 Category 'A' Designated Facilities – Emergency Department

With the exception of arrangements made under the Alternate Payment Plan for Adult Emergency Department (Health Science Centre/St. Clare's Mercy Hospital) as set out in Schedule "E", all FFS Physicians providing on-site coverage at Category 'A' designated emergency facilities, which are identified in Schedule "G", Approved Category 'A' Facilities (24-Hour On-Site Emergency Department Coverage), shall be compensated at an hourly rate as follows:

	October 1, 2013	October 1, 2014	October 1, 2015	October 1, 2016
Payment Rates	**$184.44**	**$184.44**	**$188.51**	**$194.62**

15.07 Category 'B' Designated Facilities – Emergency Department

FFS Physicians providing emergency department (ED) services coverage at Category 'B' designated facilities, as more particularly set out in Schedule "H", shall be compensated as follows:

1. Payment for daytime ED coverage, 8 a.m. to 6 p.m., Monday – Friday:

   a) FFS Category 'B' physicians:
      - $41.18 per hour (plus fee-for-service claims) as per the MCP Payment Schedule.

2. Payments for after-hours ED coverage, 6 p.m. to 8 a.m. Monday to Friday, all-day Saturday, all-day Sunday, and statutory holidays:

   a) Fee-for-service Category 'B' Emergency physicians may bill, at their discretion, either:
      - $73.00 per hour (no fee-for-service claims); or
      - $41.18 per hour (plus fee-for-service claims).
      - The method of payment chosen by the physician must apply to the entire shift or period of coverage provided.

3. There are no additional payments available under the on-call program described in Article 15.12.

15.08 Retention Bonuses – Rural FFS Physicians (excluding physicians on APPs)

Until such time as this program may be amended pursuant to Article 15.09, FFS Family Physicians and FFS Specialists, who practice outside St. John's/Mount Pearl, will be eligible to receive an annual retention bonus based on accumulated service time, as follows:

	After 12 Eligible Months	After 24 Eligible Months	After 36 Eligible Months
FFS FPs	$6,000	$8,000	$10,000

FFS Specialists	$5,000	$10,000	$15,000

Rules on eligibility will be determined by the parties and may be amended from time to time where appropriate

15.09 FFS Retention Bonus Program Review

The parties will undertake a review of the FFS Retention Bonus Program as it applies to FFS Family Physicians under Article 15.08, including the option of merging it with the funds that are currently provided for the Rural Hospital GP Premium (not funded under this Agreement), to create a better targeted and more effective retention bonus program for FFS Family Physicians. This review will be completed during Year 3 of the Agreement, and a new program agreed upon in sufficient time for implementation in Year 4 of the Agreement. The new program will be funded at current levels plus an additional $1.0 million per annum. If for any reason the review is not completed in sufficient time for implementation in Year 4 of the Agreement, the $1.0 million will be allocated annually under either the existing FFS Retention Bonus Program, or the Rural Hospital GP Premium, or both, by mutual agreement of the parties, until such time as a new program is adopted.

15.10 Canadian Medical Protective Association (CMPA) reimbursement for FFS Physicians

The parties agree that, for the calendar year 2013 (rebate paid out in 2014) and until the end of the term of this Agreement, the HCS's calculation of the eligible Canadian Medical Protective Association reimbursement will be the difference between what the physician paid and 60% of the General Practitioner basic rate. All other aspects of the payment policy in effect on the date of signing of this Agreement will remain unchanged.

15.11 Obstetrical Bonus

FFS Family Physicians are eligible for the Obstetrical bonus policy as outlined in Schedule "I", Obstetrical Bonus Policy for Salaried and Fee-for-Service Family Physicians.

15.12 Recognition of On-Call

(i) A total budget of $14,874,821 per annum will be utilized for On-call and Internal Locum payments, payable to eligible FFS and salaried physicians. Any surplus funds will be allocated through agreement of both parties.

(ii) The rates for on-call billing for each physician group are set out

in Schedule "M", On-Call Rates.

(iii) General Obligations

a. On-call physicians will be available to respond to urgent or emergent requests to attend a facility for the purpose of examining, treating or providing diagnostic services to discharged or unattached patients:

- who present from the community via the emergency department;
- who are referred by physicians from other facilities; or
- who are in-patients admitted to physicians in another specialty.

b. Approved on-call rotations must follow a defined call schedule which provides coverage 24 hours per day, 365 days a year. This can involve locum coverage or cross coverage with another group.

c. The on-call services will operate from designated facilities.

d. Being on-call for one's own patients or being on-call for patients admitted to other physicians in the same specialty on-call rotation is not sufficient to qualify for an on-call payment under this program. However, physicians may continue to see their own and their specialty group's patients and make FFS claims related to them during the period they are also on-call for unattached patients.

e. Only on-call rotations recommended by a RHA Vice President of Medical Services and approved by HCS are eligible to receive on-call payments.

f. Physicians on APPs who have on-call payments factored into their APP budget are not eligible to claim the on-call payment.

15.13 Surgical Assist - Dedicated time method Surgical Assistance

Until such time as the FFS Fee Code Allocation Process is completed:

- FFS physicians should continue to claim for services using the rates in the MCP Payment Schedule in effect as of October 1, 2015. These payments will be increased based on the percentage increase being

applied to all FFS physicians;

- Retroactive payment (using a date of service of October 1, 2015) will be paid as expeditiously as possible after signing of this Agreement based on the percentage increase applicable;

- Following the retroactive payment, the applicable increase will be paid bi-weekly as required until such time as the FFS Fee Code Allocation Process is completed and new fees are implemented.

Article 16 Salaried Physician Compensation

16.01 Quarterly Payments

Quarterly payments received by salaried physicians under the previous Memorandum of Agreement will become part of regular salary and be blended into bi-weekly payments as of October 1, 2015.

16.02 Salary Scales

The salary scales for Family Physicians in Category "B" Facilities, all other Family Physicians, Specialists, and Oncologists/Pathologists are as follows:

October 1, 2015 Salary Scale:

Salary Scale	Step 1	Step 2	Step 3	Step 4	Step 5
Family Physicians (Category 'B')	$128,144	$134,404	$140,665	$146,925	$153,185
Family Physicians	$154,524	$162,104	$169,685	$177,265	$184,845
Specialists	$215,749	$226,391	$237,031	$247,676	$258,316
Oncologists/Pathologists	$228,302	$235,816	$243,328	$250,841	$258,322

October 1, 2016 Salary Scale:

Salary Scale	Step 1	Step 2	Step 3	Step 4	Step 5
Family Physicians (Category 'B')	$132,542	$138,802	$145,063	$151,323	$157,583
Family Physicians	$158,922	$166,502	$174,083	$181,663	$189,243
Specialists	$220,147	$230,789	$241,429	$252,074	$262,714
Oncologists/Pathologists	$232,700	$240,214	$247,726	$255,239	$262,720

16.03 Per Diem Locum Rates

Locum rates paid under this Agreement shall be as follows:

	October 1, 2013	October 1, 2014	October 1, 2015	October 1, 2016
Family Physicians (Category B)	$689	$689	$704	$726
Family Physicians	$838	$838	$853	$875
Specialists	$1,188	$1,188	$1,203	$1,225
Oncologist/Pathologists	$1,188	$1,188	$1,203	$1,225

16.04 Category 'B' Designated Facilities – Emergency Department

Salaried physicians providing emergency department (ED) services coverage at Category 'B' designated facilities, as more particularly set out in Schedule "H", shall be compensated as follows:

1) Payment for daytime ED coverage, 8 a.m. to 6 p.m., Monday – Friday:

   a) Salaried Category 'B' Physicians:
      - Included in the bi-weekly salary

b) Salaried Locum Category 'B' Physicians:
- Included in the daily locum rate

2) Payments for after-hours ED coverage, 6 p.m. to 8 a.m. Monday to Friday, all-day Saturday, all-day Sunday, and statutory holidays:

a) Salaried Category 'B' physicians:
- $73.00 per hour (no FFS claims permitted)

b) Salaried Locum Category 'B' physicians;
- $73.00 per hour (no FFS claims permitted)

c) Salaried Family Physicians at Category 'B' facilities:
- Remain eligible for their annual Retention bonus;
- Are not eligible for the annual after-hours coverage payment; and
- Are not eligible for participation in the provincial on-call program.

16.05 Geographic Retention Bonuses

The geographic locations encompassed by the categories outlined below are set out in Schedule "C", Salaried Physician Retention Bonus Categories, and are to be paid on the salaried physician's anniversary date.

a) Retention bonuses - Salaried Family Physicians

Retention bonuses will be paid to salaried Family Physicians including those at Category 'B' Facilities as follows:

	Level 1 After12 Eligible Months	**Level 2 After 24 Eligible Months**	**Level 3 After 36 Eligible Months**
Category 0	$15,000	$30,000	$45,000
Category 1	$10,000	$20,000	$30,000
Category 2	$7,500	$15,000	$22,500
Category 3	$2,500	$5,000	$7,500

b) Retention bonuses - Salaried Specialists

Retention bonuses will be paid to Salaried Specialists, including Oncologists/Pathologists, as follows:

	Level 1 After 12 Eligible Months	Level 2 After 24 Eligible Months	Level 3 After 36 Eligible Months
Category 0	$18,000	$36,000	$54,000
Category 1	$12,000	$24,000	$36,000
Category 2	$8,000	$16,000	$24,000
Category 3	$4,000	$8,000	$12,000

16.06 Obstetrical Bonus

Salaried Family Physicians are eligible for the Obstetrical Bonus Policy as outlined in Schedule "I", Obstetrical Bonus Policy for Salaried and Fee-For-Service Family Physicians.

16.07 Oncology and Pathology Bonus

The Oncology and Pathology Bonus is paid out on the physician's anniversary dates as follows:

Step	1	2	3	4	5
Amount	$50,000	$56,250	$60,000	$60,000	$60,000

16.08 Recognition of On-Call

(i) A budget of $14,874,821 per annum will be utilized for On-call and Internal Locum payment that is payable to eligible FFS and salaried physicians. Any surplus funds will be allocated through agreement of both parties.

(ii) The rate for on-call billing for each physician group is included in Schedule "M", On-Call Rates.

(iii) General Obligations:

(a) On-call physicians will be available to respond to urgent or emergent requests to attend a facility for the purpose of examining, or treating, or providing diagnostic services to discharged or unattached patients:

- who present from the community via the emergency

department;
- who are referred by physicians from other facilities; or
- who are in-patients admitted to physicians in another specialty.

(b) Approved on-call rotations must follow a defined on-call schedule which provides coverage 24 hours per day, 365 days a year. This can involve locum coverage or cross coverage with another group.

(c) The on-call services will be based from designated facilities.

(d) Being on-call for one's own patients or being on-call for patients admitted to other physicians in the same specialty on-call rotation is not sufficient to qualify for an on-call payment under this program. However, physicians may continue to see their own and their specialty group's patients during the period they are on-call for unattached patients.

(e) Only on-call rotations recommended by a RHA Vice President of Medical Services and approved by HCS are eligible to receive on-call payments.

(f) Physicians on APPs who have on-call payments factored into their APP budget are not eligible to claim the on-call payment.

16.09 Critical Escort Duty

The hourly rate for critical escort duty will be $107.00.

16.10 University Physicians (Geographic Full-Time - "GFT")

The compensation for GFT physicians working at 0.8 clinical FTE will be at 90% of the applicable salary scale. Compensation for GFT physicians working at less than 0.8 clinical FTE will be proportionate to their clinical FTE status. For example, a GFT physician working at 0.5 clinical FTE will be remunerated as follows: 0.5/0.8 x 90% of applicable salary scale.

16.11 Registered Retirement Savings Plan (RRSP)

(i) Government commits to maintaining an employer-sponsored salaried physician RRSP.

(ii) As a condition of employment all salaried physicians, except those participating in the Public Service Pension Plan pursuant to an election made prior to November 30, 2000, are required to participate in the employer-sponsored RRSP.

Article 17 Other Compensation Issues

17.01 Clinical Stabilization Fund

(i) The parties agree to extend the Clinical Stabilization Fund (the "CSF") until such time as all remaining annual funds have been allocated for ongoing purposes by a joint committee of the parties to this Agreement. The parties acknowledge that as of October 1, 2015 the unallocated annual funds are $929,582.

(ii) Where the parties are unable to agree on the the manner of disbursement of the CSF, the NLMA will allocate 50% of any unallocated CSF, based on cost estimates provided by the HCS, and will immediately provide this information to HCS.

(iii) The Department of Health and Community Services will then allocate the remaining 50% of the unallocated CSF within thirty (30) days of receiving the information from the NLMA as referred to in (ii) above.

17.02 Transitioning of Hospital Services

(i) The parties agree to establish a committee (consisting of two members appointed by the NLMA and two members appointed by HCS) to consider the options available for the potential to have FFS physicians perform in private medical offices, surgical, diagnostic or therapeutic procedures that at present are non-insured services unless they are provided in facilities listed in the *Hospital Insurance Regulations* Schedule under the *Hospital Insurance Agreement Act*. The following issues will be reviewed:

a) Timeliness of care and follow-up;
b) Appropriateness of the service;
c) Cost-effectiveness of the service;
d) Identification of a quality assurance program for the service; and
e) Monitoring of the service.

(ii) The Committee's sole responsibility will be to make recommendations to the Minister of HCS related to the issues stated above, once per annum. Decisions regarding recommendations made to the Minister will be made by consensus. Such recommendations will not impact the Minister's discretion in determining which, if any, hospital-based services may be insured when provided within private offices by FFS physicians.

SECTION C - SALARIED PHYSICIANS - TERMS AND CONDITIONS OF EMPLOYMENT

The terms and conditions of employment for salaried physicians under this Agreement supersede all other conflicting terms and conditions within employer human resource policies.

Article 18 Definitions

18.01 (a) Probationary Period
All newly hired salaried physicians shall be required to serve a twelve (12) month probationary period during which time the performance of the salaried physician shall be reviewed by RHA designate and, if unsatisfactory, the employment of the salaried physician shall be terminated. If successful, the salaried physician shall be given a letter by the RHA confirming the completion of the probationary period.

(b) Month of Service
Means a calendar month in which the salaried physician is in receipt of full salary for that month and includes any month in which the salaried physician is on approved leave of absence without pay, which leave shall not be in excess of twenty (20) days.

(c) Scale Definitions
The scale definitions contained in the Terms and Conditions of Employment for Salaried Physicians shall continue to apply until such time as amended by the mutual consent of the parties to this Agreement.

Article 19 Termination

19.01 A salaried physician is required to give the Employer three (3) months written notice of resignation and the Employer is required to give a salaried physician three (3) months written notice of termination of employment, except for just cause where no notice is required.

Article 20 Advertising of Vacancies

20.01 Physicians may apply for vacant publicly-funded salaried physician positions within Newfoundland and Labrador, as advertised by the Employers.

Article 21 Part-Time Salaried Physicians

21.01 Salaried physicians working less than a full schedule are considered part-time and are covered by this Agreement for the purpose of benefits outlined in this Agreement, which they shall receive on a prorated basis based on the work week and the specific arrangements they have with their Employer. The method of prorating will be defined in the letter of appointment from the Employer.

Article 22 Statutory Holidays

22.01 There shall be a total of nine (9) paid statutory holidays for salaried physicians. The Employer shall define the days on which those nine (9) paid statutory holidays will be observed. Whether or not a salaried physician is required to work on a paid statutory holiday shall be determined in consultation with the Vice President of Medical Services or designate where the salaried physician works.

22.02 If a salaried physician is required to work and works on a paid statutory holiday, he/she shall be scheduled to take another day off with pay in lieu of that holiday within ninety (90) days of the holiday. If the day off is not scheduled by the Employer within ninety (90) days, the day off with pay in lieu of the holiday will be taken at a time before the end of the fiscal year, as mutually agreed upon between the salaried physician and authorized in writing by the Vice President of Medical Services or designate. The day off with pay in lieu of the holiday will not be carried forward more than one fiscal year. It is the responsibility of the Employer to schedule this leave. If leave is carried over to the next fiscal year and is not taken in that fiscal year, it will be paid out in April of the following fiscal year.

22.03 A salaried physician required to provide on-call for a portion of the paid statutory holiday shall be deemed to have worked during the holiday. A paid statutory holiday shall be the twenty-four (24) hour period commencing at 00:01 on the day designated by the Employer as the paid statutory holiday.

Article 23 Annual Leave

23.01 Salaried physicians shall be entitled to annual leave as follows:

(a) Twenty (20) days per year for salaried physicians with one (1) year to ten (10) years of service as a salaried physician.

(b) Twenty-five (25) days per year for salaried physicians with more

than ten (10) years of service but less than twenty-five (25) years of service as a salaried physician.

(c) Thirty (30) days per year for salaried physicians with twenty-five (25) years of service or more as a salaried physician.

(d) A year of service is equivalent to twelve (12) months of service as a salaried physician.

(e) Annual leave is an accumulative benefit and any unused annual leave is payable on termination of employment.

(f) A physician may carry forward to another year any portion of annual leave not taken by him/her in previous years until, by doing so he/she has accumulated a maximum of:

i) twenty (20) days annual leave, if he/she is eligible to receive twenty (20) days in any year;

ii) twenty-five (25) days annual leave, if he/she is eligible to receive twenty-five days in any year; and

iii) thirty (30) days annual leave, if he/she is eligible to receive thirty (30) days in any year.

Each of the above accumulations is in addition to his/her current annual leave entitlement. Physicians with additional accumulated time as of May 15, 2003 will have that time "grand-parented". However these physicians will be subject to this policy for any future year's accumulated annual leave.

Article 24 Approval for Leaves of Absence

24.01 All leaves of absence, paid or unpaid, require the prior approval of the Vice President of Medical Services or designate. Salaried physicians shall submit requests for leave in writing and give as much notice as possible.

Article 25 Bereavement or Compassionate Leave

25.01 A salaried physician shall be entitled up to three (3) days paid compassionate leave upon the death of the salaried physician's mother, father, brother, sister, child, spouse, common-law spouse, grandmother, grandfather, grandchild, father-in-law, mother-in-law. If the salaried physician is required to travel outside the Province, one (1) additional day with pay shall be granted. In extraordinary circumstances, the Employer may grant additional unpaid

leave. This leave is not cumulative and is not payable on termination or resignation.

Article 26 Compensatory Leave

26.01 All salaried physicians (excluding Casualty Officers) employed by the Employer will be entitled to one (1) week (five (5) working days) of compensatory leave once the salaried physician completes one (1) year of service with that Employer. Salaried physicians maintain eligibility for compensatory leave if their area of employment changes, (i.e. RHA). Such leave is cumulative and payable on termination of employment.

Article 27 Deferred Salary Plan

27.01 With the approval of the Employer, salaried physicians shall be eligible to access the deferred salary plan with those Employers who have made the arrangements with Canada Revenue Agency.

Article 28 Family Leave

28.01 A salaried physician who is required to attend to the temporary care of a family member living in the same household, or to attend to needs relating to the birth of the salaried physician's child, or to attend to matters relating to a home or family emergency, shall be allowed up to three (3) days paid family leave in any calendar year provided that no other person was available to attend to these needs and provided that the salaried physician gave the Employer as much notice as possible. This leave is non-cumulative and is not payable on termination of employment.

Article 29 Maternity Leave, Adoption Leave and Parental Leave

29.01 A salaried physician is entitled to a maximum of fifty-two (52) weeks unpaid maternity, adoption or parental leave.

29.02 A salaried physician may request maternity leave without pay which may commence prior to the expected date of delivery.

29.03 Adoption leave shall be granted to a salaried physician who legally adopts a child and upon presentation of proof of adoption.

29.04 A salaried physician may return to duty after two (2) weeks' notice of his/her intent to do so.

29.05 A salaried physician shall resume his/her former salary upon return from leave, with no loss of accrued benefits.

29.06 Periods of leave of up to fifty-two (52) weeks without pay for maternity, adoption, or parental leave(s) shall be counted for accumulation of annual or paid leave entitlement, sick leave, severance pay, and step progression.

29.07 Salaried physicians on maternity, adoption or parental leave will continue to pay their portion of group insurance premiums to a maximum of fifty-two (52) weeks, unless they provide proof of alternative coverage and sign a waiver declining continued coverage. When a salaried physician opts to continue to pay their portion of group insurance premiums, the Employer shall also pay its share of the group insurance premiums.

29.08 Neither the salaried physician nor the Employer will be required to contribute to the Employer group RRSP plan during the period of maternity, adoption or parental leave.

29.09 A salaried physician may be awarded sick leave for illness that is a result of or may be associated with pregnancy.

29.10 The Employer may grant a leave of absence without pay when a salaried physician is unable to return to duty after the expiration of this leave.

Article 30 Miscellaneous Leave

30.01 After applying in writing, and upon receiving approval from the Employer, each salaried physician is entitled to take up to five (5) days paid leave per calendar year to attend educational sessions such as conventions or refresher courses. The five (5) days, which are non-cumulative, are in addition to and would not be considered to interfere with Study Leave benefits. The leave is not payable on termination of employment. The Salaried physician should apply for this special leave as far in advance as possible.

Article 31 Paid Leave Program

31.01 Physicians who have been participating in the paid leave program since September 1, 2002 will remain eligible for the program under the same conditions as all other entrants; however, no further entrant will be permitted. A list of the current physicians participating under this program has been provided to the NLMA.

31.02 Salaried physicians who are under the paid leave program will continue to receive the benefit of the paid leave program as long as the program stays

in place with that Employer, or until the salaried physician leaves that Employer. Salaried physicians who are on a paid leave program will not be entitled to annual leave or sick leave under this Agreement.

Article 32 Sick Leave

32.01 (a) The total amount of sick leave which may be awarded to a salaried physician is calculated by multiplying the number of months of service by two (2) to a maximum of four hundred and eighty (480) days in total. Any sick leave taken by a salaried physician will be deducted from the sick leave accumulation.

(b) Notwithstanding Article 32.01(a), the total amount of sick leave which may be awarded to a salaried physician hired after October 1, 2005 is calculated by multiplying the number of months of service by one (1) to a maximum of two hundred and forty (240) days in total. Any sick leave taken by a salaried physician will be deducted from the sick leave accumulation.

32.02 At any occasion if the Employer feels the salaried physician is either excessively using sick leave or misusing sick leave, the Employer may request a medical certificate.

32.03 Sick leave is an accumulative benefit, but it is not payable on termination of employment.

Article 33 Unpaid Leaves of Absence

33.01 With the approval of the Employer, a salaried physician may be granted leaves of absence without pay provided that the salaried physician has no annual or paid leave available to him/her.

Article 34 Study Leave

34.01 Salaried physicians are entitled to the following study leave provisions:

(a) A salaried physician taking study leave is entitled to ten (10) days paid study leave per year.

(b) A salaried physician who does not take study leave in years one (1) and two (2), but who wishes to take accumulative study leave in year three (3), would be entitled to take up to sixty (60) days paid study leave.

(c) A salaried physician who does not take study leave in years one (1) to three (3), but who wishes to take accumulative study leave in year four (4), would be entitled to take up to eighty (80) days paid study leave.

(d) A salaried physician who does not take study leave in years one (1) to four (4), but who wishes to take accumulative study leave in year five (5), would be entitled to take up to one hundred twenty (120) days paid study leave.

(e) Accumulative study leave may be taken in respect to any three (3) year, four (4) year, or five (5) year period in accordance with the above.

(f) Study leave is available to prepare for and write the licensing and certification exams.

(g) Study leave must be requested in writing at least three (3) months prior to such leave and approved by the Employer and taken in respect of courses and programs recognized by the Employer.

(h) Salaried physicians will be paid full salary during study leave, assuming that the salaried physician received no additional remuneration.

(i) A salaried physician taking study leave must agree that following the conclusion of the study leave he or she will provide salaried service with the same Employer for a period that is twice the length of the study leave.

(j) Study leave is not payable on termination of employment.

Article 35 Additional Billings

35.01 Billing for Non-Insured Services

Salaried physicians may direct bill for any services not insured under provincial legislation. Salaried physicians are entitled to bill Workplace NL for services provided to persons covered by the Workplace NL plan, insurance companies for routine medical examinations of insured people, and other provincial medical care plans in respect of services provided to non-residents covered by such plans. Salaried physicians may submit bills to individual residents of the Province who are not covered by the Province's Medical Care Plan, including those covered by legislation of the Government of Canada, such as, war veterans with disabilities, and members of the Canadian Armed Forces.

35.02 Billing for Insured Services

Salaried physicians can bill fee-for-service when they are on an approved leave of absence from the Employer. This arrangement requires the approval, in writing, of the Physician Services Division of the Department of Health and Community Services.

Article 36 Professional Liability Insurance

36.01 Before commencing practice, every salaried physician must obtain professional liability insurance. Salaried physicians are responsible for paying their own professional liability insurance.

36.02 Notwithstanding Article 36.01, the parties agree that, for the calendar year 2013 (rebate paid out in 2014) and until the end of the term of this Agreement, the RHAs' calculation of the eligible Canadian Medical Protective Association reimbursement will be the difference between what the physician paid and 60% of the General Practitioner basic rate.

Article 37 Severance Pay

37.01 A salaried physician who has nine (9) years or more of continuous employment with any employer covered under these Terms and Conditions of Employment is entitled to be paid on resignation, non-disciplinary termination, death, or retirement, severance pay equal to the amount obtained by multiplying the number of completed years of continuous employment with the Employer(s) by the salaried physician's weekly salary to a maximum of twenty (20) weeks.

37.02 Continuous service shall not be deemed to have been broken where a salaried physician is on approved unpaid leave. However, the time spent on such approved unpaid leave shall not be counted as part of the time worked in the computation of the entitlement to severance pay, except as specifically provided for in this Agreement (maternity, adoption, or parental leave).

37.03 If a salaried physician qualifies and receives severance pay under Article 37.01 above, and is subsequently re-employed as a salaried physician by an Employer covered by this Agreement within the time frame for which he/she was paid severance pay, the salaried physician shall repay to the Employer the balance of the severance pay, i.e., if the salaried physician received twenty (20) weeks' severance pay and was re-employed by an Employer as a salaried physician under the terms of this Agreement, fifteen (15) weeks after being terminated, the salaried physician would

repay five (5) weeks' severance pay.

Article 38 Meal Rates and Kilometre Rates for Use of Own Vehicle

38.01 Salaried physicians who are authorized by the Employer to travel on employer business shall be reimbursed the appropriate meal and mileage rates in accordance with Government's Treasury Board approved Meal Rates and Transportation policies, which policies may be amended from time to time.

Article 39 Relocation Expenses

39.01 A salaried physician who is required by the Employer to relocate from one geographical location to another shall be compensated by the Employer for expenses that are legitimately and directly associated with this move. Such compensation shall be in accordance with Government's Treasury Board approved relocation expense policy, which may be amended from time to time.

Article 40 Contact Allowance – Waterford Hospital

40.01 Contact allowance shall be maintained for those salaried physicians at the Waterford Hospital who were in receipt of the allowance prior to April 1, 1998 and are currently receiving the contact allowance. The rate of the allowance shall be $3,000.00 per annum. Salaried physicians hired after April 1, 1998 shall not receive any contact allowance.

Article 41 Damage or Loss of Personal Property

41.01 Where a salaried physician in the performance of his/her duties suffers a loss of any personal property, and it can be determined that the salaried physician would reasonably be expected to have such property in his/her possession during the performance of his/her duties, such loss shall be reported in writing by the salaried physician to the Employer within two (2) days of the loss, and if such loss was not due to the salaried physician's negligence, the Employer may compensate for such loss up to a maximum of three hundred dollars ($300.00) per incident.

Article 42 Workers' Compensation

42.01 The *Workplace Health, Safety and Compensation Act* applies to all salaried physicians.

Article 43 Health Benefits

43.01 Salaried physicians are eligible for the group insurance benefits as outlined in Government of Newfoundland Group Insurance Plan, which may be amended from time to time. A summary of the Plan in effect at the date of signing will be attached as an Appendix to the Terms and Conditions of Employment for Salaried Physicians.

Schedule "A"

Waterford Physicians "On-duty, on-site" Payment Policy

Salaried Family Physicians employed at the Waterford Hospital (Eastern RHA) are required to remain on-site when designated to provide On-duty services, including emergent In-patient services and Emergency Department Coverage. In general, the GP designated as being "On-duty" provides 24 hours of coverage.

The GP designated as being "On-duty, on-site" will be eligible to receive this payment in addition to the provincial On-call per diem fee in effect at the time. The on-duty, on-site per diem rates are:

Weekdays – Monday to Friday (includes statutory holidays)

Effective October 1, 2013	$626
Effective October 1, 2014	$626
Effective October 1, 2015	$626
Effective October 1, 2016	$626

Weekends – Saturday and Sunday

Effective October 1, 2013	$938
Effective October 1, 2014	$938
Effective October 1, 2015	$938
Effective October 1, 2016	$938

In addition to the payment rates noted above, after a physician provides three (3) weekday shifts and one (1) weekend or statutory holiday shift in a month, the per diem rates will be $1,330 and $2,000 for weekdays and weekends respectively.

Schedule "B"

Institutional Workload Disruption Payment Policy

Policy:

In the event that a hospital is forced to:

a) adopt an "emergencies only" status, due to a major work disruption or stoppage resulting from a non-physician labour dispute; or

b) in the event that a hospital is forced to unexpectedly close all or a portion of their facility (i.e. "facility closure"),

The following arrangement can be invoked which will provide an optional salaried arrangement for groups of institutionally-based, FFS physicians.

Principles:

1. Any "group" of physicians can invoke this salaried payment in lieu of fee-for-service. A "group" is defined as any specialty (or subspecialty) group per facility that maintains a separate on-call rota. Specialties that provide city-wide on-call can be divided into groups by facility, provided the normal on-call rotation is maintained. To invoke this arrangement it is necessary that all members of the "group" who remain during the "emergencies only" or "facility closure" time accept this arrangement with the exception noted in #2 below.

2. A physician who is part of a group noted under Section b) above may apply to remain on a FFS method of remuneration in situations where the closure is partial and some routine services are maintained or when start up is partial. When choosing to do so, it is for the full period of the partial or complete facility closure (see rules related to this outlined below).

3. It is understood that physician groups who accept this arrangement will be physically present during normal working hours. A physician who receives this method of payment will not be eligible for educational leave or vacation time.

4. Normal on-call coverage must continue to be provided during the "emergency only" period of the facility closure period.

Application:

1. Physician groups who invoke this arrangement will receive payments directly from MCP.

2. Payment will be at a rate equivalent to the top of the appropriate salaried physician scale in effect at the time, with no adjustment for benefits.

3. Payments will be bi-weekly, based on current MCP fee-for-service payment dates, prorated for the applicable time period.

4. For those physicians who accept the agreement (except for those who are approved under principle #2) above, no FFS or sessional claims will be accepted for services rendered while this arrangement is in effect. Following termination of this arrangement, billings will be monitored to ensure that stock-piling of claims has not occurred.

Implementation:

1. To initiate this policy, it is required that written notice be sent by each hospital's administration to the Medical Director of MCP, stating the date the "emergencies only" or "facility closure" status was activated.

2. Written acceptance of the payment arrangement for the duration of the "emergencies only" or "facility closure" period must be received from every member of any eligible physician group.

3. For a physician or physicians who apply to remain FFS but is/are part of a group that has chosen to accept the salaried arrangement, such approval will only be granted when there is conclusive evidence that the work/on-call schedules have been maintained as would have occurred prior to the work disruption. The RHA's Vice President of Medicine will request such information and provide it to the Medical Director (HCS). The Medical Director (HCS) will review the information and decide whether approval will be granted.

4. This arrangement will stay in effect for physicians who accept this mode of payment until written notice of the earlier of:

   - discontinuation of the "emergencies only" or "facility closure" status by the hospital administration to the Assistant Director of Physician Services - HCS; or

   - written agreement by all "group" physicians to discontinue the arrangement.

Schedule "C"

Salaried Physician Retention Bonus Categories

The categories for retention bonuses shall be as listed below, or as modified according to the mutual agreement of the parties. If additional communities are identified, they shall be assigned to Category 2 unless otherwise agreed to by all the parties.

Salaried Family Physicians Retention Bonus Table:

Category 0
Labrador

Category 1

Baie Verte	Buchans	Burgeo	Cow Head
Flowers Cove	Fogo	Hampden	Harbour Breton
Hermitage	Jackson's Arm	La Scie	Mose Ambrose
Norris Point	Port Saunders	Ramea	Roddickton
St. Alban's	Trepassey	Woody Point	

Category 2

Bay L'Argent	Bell Island	Bonavista	Botwood
Brookfield	Burin	Cape St. George	Carmanville
Centreville	Codroy Valley	Ferryland	Gambo
Glovertown	Grand Bank	Hare Bay	Lewisporte
Lourdes	Marystown	Musgrave Harbour	Musgravetown
Old Perlican	Placentia	Port aux Basques	Springdale
St. Anthony	St. George's	Stephenville Crossing	St. Lawrence
Terrenceville	Trinity	Twillingate	Virgin Arm
Western Bay	Whitbourne	Jefferies	

Category 3

Carbonear	Clarenville	Corner Brook	Gander
Grand Falls-Windsor	St. John's	Stephenville	

Salaried Specialist Retention Bonus Table:

Category 0
Labrador

Category 1

Burin	St. Anthony

Category 2

Carbonear	Clarenville	Corner Brook	Gander
Grand Falls-Windsor	Stephenville		

Category 3 St. John's

Schedule "D"

Specialty Corrections Fund

The Parties agree to the disbursement of the $3,200,000 Specialty Corrections Fund as follows:

Specialty Group	Dollar Allocation
Orthopedics	$2,529,608
Plastic Surgery	$260,525
Neurology	$265,997
Psychiatry	$143,870

1. Unless agreed to by both parties, the dollars associated with this fund will not be combined with any other specialty specific budgets for fee code allocation on new fee codes or rates published in the MCP Payment Schedule.

2. Unless agreed to by both parties, the specialty specific payment adjustments resulting from this Schedule will continue.

Schedule "E"

Alternate Payment Plans (APPs)

The following is a list of APPs in effect as of October 1, 2015:

Eastern Health

a) Adult Critical Care
b) Adult Emergency Department (Health Sciences Centre/St. Clare's Mercy Hospital)
c) Adult Haematology/Oncology
d) Anaesthesia (Carbonear General Hospital)
e) Anaesthesia Neurocoiling
f) Cardiac Surgery Anesthesia
g) Cardiac Surgery
h) Medical Oncology Services
i) Neonatology Services
j) Obstetrical Anaesthesia Services
k) Obstetrical/Gynaecology (Non-elective) Services
l) Otolaryngology Services (Dr. H. Bliss Murphy Cancer Centre)
m) Paediatric Anaesthesia Services
n) Paediatric Ophthalmology
o) Paediatric Ophthalmology (Premature Infant) Services
p) Paediatric Orthopaedic Services
q) Paediatric Surgical Services
r) Paediatric Urology Services
s) Thoracic Surgery Services
t) Vascular Surgery

Central Health

a) Anaesthesia Services – (James Paton Memorial Regional Health Centre)
b) Anaesthesia Services (Central Newfoundland Regional Health Centre)
c) General Surgery – (Central Newfoundland Regional Health Centre)
d) Orthopedic Surgery Services (James Paton Memorial Regional Health Centre)

Western Health

a) Anesthesia (Western Memorial Regional Health Centre)

During the term of this Agreement, both parties agree to continue a review of the general principles and current issues being experienced with APPs, based on the experiences in this Province and other provinces. Of particular note, productivity, accountability,

reporting, termination dates, funding, and the impact on recruitment are some of the issues to be reviewed. As part of the review, a document will be produced detailing the new principles and practices.

All existing APPs will be reviewed, and for those where agreement by all parties exists to continue, the APPs must be rewritten to conform to the new principles and policies. For those where agreement to continue is not received, appropriate notification to the signatories of the APP will occur and the proper processes, as outlined in the APP agreement(s), will be followed for the termination of same.

Quarterly payments received by APP physicians under the 2009-2013 Memorandum of Agreement will be blended into bi-weekly payments as of October 1, 2015.

Schedule "F"

FFS Increases by FFS Specialty Group

The table below shows the nominal increase by Year 4 of this Agreement per FTE physician for each physician group, and the funding that is available for allocation to each physician group. These increases will be applied on a biweekly basis proportionate to amounts billed by each FFS physician, in their respective specialty Group, until the fee code allocation process is completed.

Specialty	Group Nominal Amount per FTE	Group Increase on FFS payments	Group Increase on other payments*	Total
General Practice	$10,431	$4,163,407	$509,709	$4,673,116
Anaesthesia	$12,940	$398,373	$434,042	$832,415
Radiology	$12,940	$657,390	$117	$657,706
Nuclear Medicine	$12,940	$25,881	$0	$25,881
Medical Specialties:				
Dermatology	$12,940	$132,446	$2	$132,448
Internal Medicine	$12,940	$860,788	$169,741	$1,030,530
Neurology	$12,940	$68,300	$27	$68,327
Paediatrics	$12,940	$320,930	$151,510	$472,460
Psychiatry	$12,940	$216,313	$0	$216,313
Surgical Specialties:				
Obstetrics & Gynaecology	$12,940	$305,848	$65,615	$371,458
Ophthalmology	$12,940	$241,262	$13,794	$255,052
Otolaryngology	$12,940	$155,454	$14,840	$170,291
General Surgery	$12,940	$308,320	$274,436	$582,756
Orthopedics Surgery	$12,940	$197,550	$87,259	$284,808
Neurosurgery	$12,940	$50,261	$25,257	$75,518
Plastic Surgery	$12,940	$60,626	$1,829	$62,456
Urology	$12,940	$123,646	$10,307	$133,953
TOTAL		**$8,287,016**	**$1,758,483**	**$10,045,499**
***Including APP, sessional, ICU, Surgical Assist, Surgical Premiums, and Category B**				

Schedule "G"

Approved Category "A" Facilities
24-Hour On-Site Emergency Department Coverage

This schedule is provided for information only.

Hospital Number	Hospital Name
0302	Burin Peninsula Health Care Centre, Burin
0230	Carbonear General Hospital, Carbonear
0213	Central Nfld. Regional Health Centre, Grand Falls-Windsor
0248	Dr. G.B. Cross Memorial Hospital, Clarenville
0205	James Paton Memorial Hospital, Gander
0175	Western Memorial Regional Hospital, Corner Brook
0256	General Hospital, Health Sciences Centre, St. John's
0281	Janeway Children's Health & Rehabilitation Centre, St. John's
0264	St. Clare's Mercy Hospital, St. John's
0159	Labrador West Health Centre, Labrador City
0183	Sir Thomas Roddick Hospital, Stephenville
0167	Labrador Health Centre, Happy Valley-Goose Bay
0141	Dr. Charles S. Curtis Memorial Hospital, St. Anthony

Schedule "H"

Approved Category "B" Facilities
24-Hour Emergency Department Coverage

This schedule is provided for information only.

Facility Number	Facility Name
0051	Baie Verte Peninsula Health Centre, Baie Verte
0353	Dr. Walter Templeman Community Health Centre, Bell Island
0345	Bonavista Community Health Centre, Bonavista
0442	Bonne Bay Health Centre, Bonne Bay
0451	Dr. Hugh Twomey Health Care Centre, Botwood
0299	Brookfield/Bonnews Health Care Centre, Brookfield
0434	A.M. Guy Memorial Health Centre, Buchans
0388	Calder Health Care Centre, Burgeo
0329	Fogo Island Hospital, Fogo
0016	Grand Bank Community Centre, Grand Bank
0311	Connaigre Peninsula Health Care Centre, Harbour Breton
0200	North Haven Emergency Centre, Lewisporte
0337	Dr. A.A. Wilkinson Memorial Health Centre, Old Perlican
0418	Placentia Health Centre, Placentia
0191	Dr. C.L. LeGrow Health Centre, Port aux Basques
0396	Rufus Guinchard Health Care Centre, Port Saunders
0426	Green Bay Community Health Centre, Springdale
0022	U.S. Memorial Health Centre, St. Lawrence
0221	Notre Dame Bay Memorial Health Centre, Twillingate
0400	Dr. William Newhook Community Health Centre, Whitbourne

Schedule "I"

Obstetrical Bonus Policy for Salaried and Fee-for-service Family Physicians

Under this policy, there is dedicated funding for a bonus payable to salaried family physicians and FFS family physicians (FP) that provide labour and delivery obstetrical services.

Eligibility

Fee-for-Service

FFS FPs who provide obstetrical services billable as either fee code 80004 *(Delivery)* or 80014 *(Attendance at labor)* are eligible to receive a bonus payment after the end of each fiscal year. The bonus is paid in addition to the MCP Payment Schedule obstetrical fees 80004 and 80014.

Salaried

Salaried FPs who provide obstetrical services where they either: (i) perform the delivery; or (ii) attend the patient during labor but transfer the patient to a specialist because of complications during labor and/or delivery, are eligible to receive a bonus payment after the end of each fiscal year.

Calculation of the Bonus

Fee-for-Service

The bonus amount for an individual FFS FP will be calculated after the end of the fiscal year by multiplying the total number of delivery and attendance at labor events (codes 80004 and 80014) times $100, and adding the result to the applicable figure from the following table:

Total Units 80004 + 80014	Bonus Contribution
5-15	$5,000
16-30	$7,500
31 or more	$10,000

Salaried

The bonus amount for an individual salaried FP will be calculated after the end of the fiscal year by adding the total number of eligible services and multiplying it by $100 and adding the result to the applicable figure from the following table:

Total Units	Bonus Contribution
5-15	$5,000
16-30	$7,500
31 or more	$10,000

Example:

A FP provided 24 eligible labor and delivery services in the one year period. The bonus payment will be 24 x $100 plus $7500 = $9900.

Applying for the Bonus

Fee-for-Service

FFS FPs must submit an application for the bonus within ninety (90) days of the end of each fiscal year (March 31st). The application form can be printed from the MCP website.

Salaried

Salaried FPs who wish to apply for the bonus for the first time must complete the *Application for Salaried General Practitioner Obstetrics Bonus* form. The Department of Health and Community Services will open an Obstetrics Bonus file for each salaried FP who completes and returns the form. If an application was submitted in a previous year, a secondary application is not required.

On an ongoing basis, each salaried FP who has a file opened must submit copies of their patient records for the eligible services. Copies of actual patient labor and delivery record should be submitted as soon as possible after the eligible service has been provided.

Schedule "J"

Family Practice Renewal Program

This Schedule to the Agreement outlines the principles, structure, physician and broad program areas for a Family Practice Renewal Program. This Schedule addresses matters of unique interest and applicability to Family Physicians.

GUIDING PRINCIPLES FOR PRIMARY CARE RENEWAL

The parties agree that improved population health and health system sustainability in Newfoundland and Labrador will require a renewed focus on primary health care reform. The parties acknowledge that Family Physicians have an important role to play in the improvement and full integration of primary care and primary health care services and supports.

In alignment with the Province's new Primary Health Care Framework/Action Plan, the Family Practice Renewal Program shall incorporate the following principles, which the Family Practice Renewal Committee will convert into priorities and targets as specific programs and initiatives are designed and implemented.

Patient-Centered Services and Supports

Primary health care services should be provided in the manner that works best for patients and their families. Family Physicians and other primary health care providers should partner with patients, their families, and the local community to meet a range of health care needs and preferences.

Collaborative Multi-Disciplinary Teams

Processes must be developed to enable inter-professional communication and decision making that brings together the separate and shared knowledge of various providers to achieve the best possible patient outcomes.

Multi-Disciplinary Teams should include each patient's family physician or family practice group and a variety of other primary health care professionals all working together and at their full scope of practice to improve patient outcomes. This should include providers collaborating to increase continuity of care and improve the integration of community-based services and supports with secondary, tertiary, home, and long term care services.

Increased collaboration among physicians, and between physicians, regional health authorities, and other health professionals to solve health system and population health issues, to improve health outcomes, and to increase patient and provider satisfaction must be encouraged.

Coordination of Care

Highly coordinated services and supports at the primary health care level are essential to effective treatment plans that maximize the health and wellness of individual patients. Coordination of care requires awareness of available supports and clear communication between patients, providers, community stakeholders, and across the spectrum of primary, secondary, long-term, and tertiary health care.

Comprehensiveness of Care

Comprehensive care encompasses the provision and organization of a full range of services and supports across the spectrum of the patient's health and wellness needs. It is a patient-centered approach to care that acknowledges an individual's physical and mental health needs throughout their entire life and does not focus on the episodic treatment of specific diseases or illnesses. Comprehensive care includes the provision of a range of primary care services within the family physician's scope of practice or the organization of services provided by other physicians and primary health care providers.

Access to Appropriate Services and Supports

Appropriate access centers on the patient's ability to receive the right care, from the right provider, at the right time, and in the right place. It includes an approach to service delivery that aligns with the patient's needs for health care services and supports available in her or his local area or within a reasonable distance. It includes improved access to primary care physicians and increased availability of physicians outside of traditional business hours and on weekends.

Attachment and Longitudinal Relationships

Primary health care providers should be supported to build long-term patient-provider relationships that foster the development of trust and respect between the patient, the family physician or practice, and other health care professionals providing services and supports to the patient. Physicians should be encouraged to act as the most responsible provider for their patients and ensure that care is coordinated, consistent, and the patient's long-term needs are considered.

Communities of Practice

Communities of practice should include Family Physicians coming together in a physical or virtual way to share information and experiences and learn from each other and the other health care professionals they work with. Communities of practice support the identification of local primary health care solutions, recognize the need for each provider to participate in ongoing personal and professional development, and encourage innovative means to improving patient care. They enable faster response to emerging health issues at both the community and regional levels.

Continuous Evaluation and Evidence-Based Decision Making

Ongoing monitoring and evaluation of primary care services is essential to the process of continuous quality improvement. Greater use of evidence-based and cost-effective approaches to management of the common conditions encountered in primary care must be encouraged. Improving the effectiveness of primary health care services and supports, the satisfaction of providers, and the health outcomes of the population requires ongoing evaluation and continuous improvement of service delivery models. Public investments in primary health care must help to achieve better care, better health, and better value.

Community Engagement and a Local Focus

Local communities have an important role to play in working with Family Physicians, other primary health care providers, and regional health authorities to improve the health of their residents. No one community is the same, and improving population health and wellness may require solutions tailored to individual communities and regions.

ARTICLE 1 - DEFINITIONS AND INTERPRETATION

1.1 Words used in this Schedule that are defined in the 2013-2017 Agreement have the same meaning as in the 2013-2017 Agreement unless otherwise defined in this Schedule.

1.2 **"Schedule"** means this document, as amended from time to time as provided within the Agreement.

1.3 **"Attachment"** means ensuring citizens of Newfoundland and Labrador have access to a family physician with whom they develop a long-term relationship.

1.4 **"Family Practice Renewal Program (FPRP)"** is the renewal program including governance, funding, and evaluation structures described within this Schedule.

1.5 **"Family Practice Renewal Committee (FPRC)"** means the governance committee for the Primary Care Renewal Program.

1.6 **"Practice Improvement Program"** means a jointly sponsored program of the Department of Health and Community Services (HCS) and the NLMA through the FPRC. The program offers continuing professional development for physicians and their staff, as appropriate, to help them improve practice efficiency, support change management, and to enable enhanced delivery of patient care.

1.7 **"Family Practice Networks (FPN)"** means the initiative created and supported by the FPRC to organize physicians at the sub-regional or regional level in order to address common health care goals in their communities. Each FPN will participate in a Collaborative Services Committee (CSC) with the relevant RHA. Each FPN will be

a not-for-profit corporation constituted by the physicians within their sub-region or region.

1.8 **"Collaborative Services Committee (CSC)"** means the joint committee of the FPN and the RHA, with membership shared equally between FPN representatives and RHA representatives with decision-making authority. The CSC may also choose to invite patients and local community representatives to participate as ex-officio members. The mandate of the CSC is to identify and respond to primary health care needs of the community. The partners work to co-design programs to improve local primary health care. Decisions of the CSC are made by consensus and both FPN and RHA participation is mandated.

1.9 **Comprehensive care"** is the delivery of a full range of primary health care services including the following:

(a) Health and health risk assessments
(b) Coordination of patient care across the spectrum of primary, secondary, and tertiary care, including making referrals, and acting upon consultative advice
(c) Longitudinal care of patients across the spectrum of their medical needs
(d) Diagnosis and management of acute ailments
(e) Guidelines-based chronic disease management
(f) Primary reproductive care including the organization of appropriate screening
(g) The provision of or the arrangement with another provider for the provision of prenatal, obstetrical, postnatal, and newborn care
(h) Mental health care and counselling
(i) End of life planning / advanced care directives
(j) Palliative and end of life care
(k) Care and support of the frail elderly
(l) Support for hospital, home, rehabilitation, and long-term care facilities
(m) Patient education and preventative care, including support and education for ongoing patient self-management
(n) The maintenance of a longitudinal patient record

ARTICLE 2 – Family Practice Renewal Committee

2.1 The FPRC is hereby established under this Agreement as a mechanism for representatives of HCS, the NLMA, and RHAs to work together on matters affecting the provision of insured primary care services by Family Physicians in Newfoundland and Labrador.

2.2 The mandate of the FPRC is to:

(a) Within available funding, design program initiatives that seek to improve primary care in the Province consistent with the principles outlined in the preamble of this Schedule and the goals identified in Article 3 of this Schedule.
(b) Build a culture of collaboration and innovation between HCS, the NLMA,

RHAs, and other stakeholders as appropriate.

(c) Identify gaps in care and address population health needs.
(d) Work with stakeholders to identify changes in primary health care delivery, including physician services, which could result in improvements in patient care and health outcomes.
(e) Work to identify and implement initiatives that will result in more effective utilization of physician and other health care resources, and a more fiscally sustainable health care system.
(f) Establish clear metrics for the evaluation of primary care and primary health care services as per Article 5 of this Schedule.

2.3 The FPRC shall be composed of three (3) members appointed by HCS and three (3) members appointed by the NLMA.

(a) Committee members are to be appointed on staggered terms of two (2) and three (3) years to ensure continuity.
(b) Representatives of the RHAs may be HCS appointees and/or participate in the FPRC as ex-officio members.
(c) A patient or citizen representative will be jointly selected by the appointed members to participate as non-voting ex-officio member.
(d) From time-to-time appointed committee members may agree to invite relevant stakeholders, including physicians, allied health care professionals, government representatives, citizens, and R H A employees to participate in FPRC meetings and discussions.
(e) Quorum for all FPRC meetings will require at least two (2) appointed members from HCS and two (2) appointed members from the NLMA.
(f) Within its mandate, the FPRC has authority to establish rules and procedures for the orderly conduct of business.

2.4 The FPRC shall be co-chaired by a member chosen by the HCS members and a member chosen by the NLMA members.

2.5 The FPRC will develop annual work plans and ensure that evaluations to measure outputs and outcomes are an integral part of the plan.

2.6 The FPRC will establish communication protocols to allow the co-chairs to communicate information about the business and/or decisions of the FPRC to physicians, Government, and other stakeholders including the public.

2.7 The cost of evaluation and administrative and clerical support required for the work of the FPRC will be paid from the funds to be allocated to the PCRP pursuant to this Schedule.

(a) Spending on auditing or evaluation activities is not to exceed 5% of total FPRP funding allocated during the fiscal year in which the evaluation activities occur.
(b) Spending on administrative and clerical support is not to exceed 15% of total FPRP funding allocated during the fiscal year in which it is spent.
(c) Program development, implementation, and operating costs will not be

included in the spending limits described in Articles 2.7 (a) and (b) of this Schedule.

(d) Physician participation in the FPRC will be compensated at a rate to be determined by the FPRC.

2.8 Decisions of the FPRC shall be by consensus.

ARTICLE 3 – GOALS OF FAMILY PRACTICE RENEWAL PROGRAM

3.1 Improved health outcomes, particularly among high-needs populations and those living with chronic disease(s).

3.2 Improved coordination of patient care across the continuum of care, and between providers and community-based services and supports.

3.3 Increased collaboration between local Family Physicians, and between Family Physicians and other primary health care providers.

3.4 The establishment of collaborative, community-based multidisciplinary teams.

3.5 Greater collaboration between Family Physicians and RHAs leading to improved alignment on priority issues.

3.6 Improved recruitment and retention of Family Physicians, particularly in rural and underserviced communities.

3.7 Enhanced access to primary care services, such as through the provision of more flexible and conveniently scheduled after-hours clinics and improved access to same-day or next-day urgent appointments.

3.8 Improved patient-physician longitudinal attachment, particularly for those living with chronic disease(s).

3.9 Improved patient and provider satisfaction including greater work-life balance for Family Physicians.

3.10 Measureable improvements in system sustainability including reduced demand on secondary and tertiary emergency departments and other acute care services.

ARTICLE 4 – FAMILY PRACTICE RENEWAL PROGRAM FUNDING

4.1 The FPRC will allocate funding for FPRP initiatives under this Agreement within the following annual budgets:

Agreement Year 3	$1,049,979
Agreement Year 4	$3,450,021
Total Funding	$4,500,000

In the event this Agreement expires and no replacement agreement is in place, the FPRP will continue to be funded at an annual rate of $4.5M until such a time as a new agreement is in place.

4.2 The FPRC will use the FPRP funds available pursuant to section 4.1 for the following purposes:

(a) To design and fund new condition-based fee code initiatives for the support of comprehensive care delivery, including:
   i. Increased coordination and collaboration with other primary health care providers.
   ii. Improved patient access.
   iii. Improved identification and management of a full range of Comprehensive Care services.

(b) To fund the development and implementation of FPNs as a means to organize Family Physicians at the sub-regional or regional level in order to address common health care goals in their communities.

   i. FPNs will participate in a Collaborative Services Committee (CSC) with the relevant RHA, as well as other committees or projects that result from the work of the CSC.
   ii. FPNs will organize and promote the participation of physicians in their region in activities that improve the delivery of Primary Health Care services.
   iii. FPNs will be supported and funded within a program framework and funding formula, to be developed by the FPRC, with funds to be used for management, honoraria, administrative expenses and other expenses relevant to the mandate of the program. The program framework will also specify accountability requirements of the FPNs.
   iv. FPNs will not engage in labor relations or advocacy activities regarding compensation and benefits of salaried physicians.
   v. The establishment of a CSC does not preclude or limit an RHA's right to consult or work collaboratively with physicians outside of the formal CSC structure.

(c) To fund the development and operation of a Practice Improvement Program designed to support evidence-based change management aligned with initiatives described in Articles 4.2(a) and (b) of this Schedule and the following target areas:
   i. Primary care best practices and guidelines-based care
   ii. Clinical and practice efficiency
   iii. Adoption of new technology (exclusive of electronic medical records program)
   iv. Practice reorganization
   v. Multi/interdisciplinary collaboration and coordination

vi. Health prevention and promotion
vii. Mental health and addictions
viii. Other target areas as agreed by the FPRC.

4.3 Any funds identified in Article 4.1 of this Schedule that remain unexpended at the end of any fiscal year will be available to the FPRC for use as one-time allocations to improve the quality of primary health care. One-time allocations will require FPRC consensus.

ARTICLE 5 – Accountability and Evaluation

5.1 The FPRC will regularly monitor, review, and evaluate all initiatives implemented and/or funded under the FPRP.

5.2 The FPRP goals identified in Article 3 of this Schedule will serve as the basis for developing all PCRP evaluation metrics. Specific indicators and output and outcome targets will be defined by the FPRC for each individual initiative.

5.3 Funding for newly approved FPRP initiatives, including one time allocations, will not be released prior to the FPRC approving an evaluation plan that will include the following elements:

(a) defined evaluation objectives;
(b) defined and measurable output and outcome indicators;
(c) ongoing and continuous collection of relevant data;
(d) dissemination of relevant data or monitoring results to stakeholders involved in the initiative;
(e) regular progress reports to the FPRC;
(f) explicit reporting deadlines with a minimum of one formal written status report per fiscal year;
(g) an evaluation budget and work plan describing evaluation activities, deliverables, timeframes, and responsible parties; and
(h) a clear communications plan that describes how evaluation findings will be reported to physicians, government, and relevant stakeholders, including the public.

5.4 The FPRC may employ evaluation staff or enter into agreements with third parties, including academics, research organizations, and evaluation professionals to ensure proper and timely evaluation of all initiatives.

5.5 The results of all formal written status reports will be public records, accessible under the *Access to Information and Protection of Privacy Act*, SNL2015 c. A-1.2, and will be communicated publicly. This will include the public release of annual evaluation summaries and, when appropriate, publication of evaluation findings in academic journals.

5.6 The FPRC will review evaluation results on an annual basis. In cases where the

FPRC deems a PCRP initiative has underperformed or was unsuccessful, the FPRC will be responsible for amending or ending the initiative.

5.7 All FPRP initiatives that do not demonstrate progress in reaching the goals identified in Article 3 of this Schedule within 3 (three) years will be discontinued unless otherwise agreed by FPRC consensus.

(a) Funding previously allocated to unsuccessful or canceled initiatives will be returned to the FPRP budget and re-administered by the FPRC.

(b) Article 5.7(a) of this Schedule applies to all FPRP initiatives, including all physician payments and remuneration initiatives within the FPRP.

Schedule "K"

Physician Services Liaison Committee (PSLC) Terms of Reference

Purpose of PSLC

To maintain an ongoing mechanism through which medical issues of mutual concern may be addressed collaboratively between the NLMA and HCS, and to act as an oversight body for the administration of the Agreement.

Membership of PSLC

The membership shall consist of four (4) members selected by the NLMA and four (4) members selected by HCS. The Chair shall be appointed for a one-year term and shall alternate between the NLMA and the HCS representatives. The Deputy Minister of the HCS and the NLMA Executive Director shall agree on the Chair.

Frequency of Meetings

Meetings shall be held at least quarterly, or at the call of the Chair for urgent issues that may arise between regular meetings.

Quorum

Two members from the NLMA and two members from the HCS shall constitute a quorum. Decisions will be made by consensus.

Record of Discussions and Action Items

A record of discussions and action items shall be kept for all meetings. All discussions at the meetings shall be confidential. These records shall be available to the Minister, Deputy Minister, and the Executive of HCS, and the Executive and Board of Directors for the NLMA. These records shall also be made available to the CEOs of the RHAs where appropriate.

Location

The time and location of the meetings shall be at the call of the Chair.

Mandate

1) To provide information and advice to the HCS on medical issues from a policy, systemic, and strategic perspective.

2) To oversee the administration of the Agreement.

3) To generally explore options that would contribute to a sustainable health

care system that maintains and/or enhances quality of service that is reasonably accessible to all.

4) To create sub-committees and establish, where necessary, terms of reference for these committees, to address issues such as:

   a) Improving efficiency;
   b) Developing clinical practice guidelines;
   c) Exploring standards related to such issues as wait times and hospital lengths of stay;
   d) Physician recruitment and retention;
   e) Interdisciplinary primary care delivery models;
   f) Primary health care;
   g) Clinical stabilization;
   h) MCP Payment schedule review;
   i) Others, at the discretion of the PSLC.

5) To liaise with other professional groups, RHAs, or other organizations when both parties consider it necessary or useful;

6) Upon the request of the Minister of HCS, to review and provide timely advice on issues that may be directed to the Committee by the Minister of HCS.

Costs

The costs of participation in the PSLC will be borne by the parties separately.

Schedule "L"

MCP Payment Schedule Review Committee Terms of Reference

The MCP Payment Schedule Review Committee (PSRC) will be responsible for the ongoing review, editing, and drafting associated with maintaining the integrity of the MCP Payment Schedule.

Scope:

The PSRC will consider and make recommendations to the Minister of HCS regarding:

I. MCP Payment Schedule Review Process
II. MCP Payment Schedule Fee Code Allocation Process
III. MCP Payment Schedule Fee Code Addition Process

Composition of the Committee:

The PSRC will consist of four members:

- Two (2) HCS representatives, and,
- Two (2) NLMA representatives.

Alternate and/or additional members may attend PSRC meetings.

Frequency of Meetings:

The PSRC will meet a minimum of four times a year, otherwise on an as needed basis. Meetings shall be held at least quarterly or by mutual agreement for urgent issues that may arise between regular meetings.

Work of the Committee:

I. MCP Payment Schedule Review Process

The PSRC is responsible for reviewing the MCP Payment Schedule in order to identify areas for change to ensure that public expenditure on insured medical services yields high quality patient care and high value for money. In this regard the PSRC will:

1. Develop a methodology to analyze physicians' FFS billings in order to identify fee codes or groups of fee codes, and billing rules for review.
2. Establish a process to review and adjust fee codes and billing rules to reflect changes in time, technology, direct cost, market comparison, and other such factors as may be determined by the parties from time to time, for the purpose of adjusting such fees and rules appropriately.
3. Identify fees that are no longer necessary, for elimination.

4. Fee codes may have funding increased or decreased, via valuation change or via rule modification, but in any event, no new fee codes will be introduced via the review.
5. In cases where fee codes are reduced, ensure that no discipline will have its overall funding adjusted to less than parity with Maritime Weighted Average (MWA), notwithstanding instances where money has been added to a code that is not in the MWA comparison.
6. Fee codes and billing rules will be adjusted on an overall cost-neutral basis only. No new funding will be allocated to support the MCP Payment Schedule Review process.
7. Consult with affected discipline(s) on any recommended adjustments to fees.
8. Provide ninety (90) days' notice of any adjustments to affected discipline(s).
9. Re-allocate any savings as a result of adjustments to fee codes firstly within the discipline and secondly in another discipline to respond to unmet needs.
10. After the process is complete, HCS representatives shall seek the approval of the Minister of HCS for the proposed revisions to the MCP Payment Schedule.
11. Promote the initiatives of *Choosing Wisely Canada* to optimize value and minimize waste in medical care.
12. Decisions of the PSRC shall be made by consensus and shall be subject to the approval of the Minister of HCS.

II. MCP Payment Schedule Fee Code Allocation Process

Increases awarded by agreement between HCS and the NLMA shall be allocated to individual fee codes in the MCP Payment Schedule by the PSRC in accordance with the following FFS fee code allocation process:

1. The parties will table proposals for allocation of funding to fee codes, and will review proposals and determine funding allocation jointly and collaboratively by consensus.

2. Fee code funding not allocated by consensus via this collaborative process will be determined as outlined in i) and ii) below:

    i) The NLMA will first allocate 50% of the remaining portion of the FFS increase, based on cost estimates provided by HCS, and will immediately provide this information to HCS.

    ii) HCS will then allocate the remaining 50% during the next thirty (30) day period.

3. Following allocation in accordance with (1) and/or (2), above, HCS representatives will seek the approval of the Minister of HCS for the proposed revisions to the MCP Payment Schedule.

III. MCP Payment Schedule Fee Code Addition Process

The PSRC is responsible for receiving applications for new fee codes in order to ensure that the MCP Payment Schedule includes appropriate fee codes for new physician services that become available in the Province, and for the overall maintenance of the integrity of the MCP Payment Schedule, in accordance with the following:

1. The PSRC will receive applications for new fee codes from physicians or from HCS and will review them jointly and collaboratively and work toward a consensus-based response.
2. The PSRC will develop and use a MCP Payment Schedule Request form that must be completed by HCS or the physician (or discipline) making the proposal. From time to time the PSRC may review and revise the form to ensure suitability.
3. The PSRC will consider such things as insurability, the site of the proposed service and the rate and terms and conditions of payment with reference to Maritime parity.
4. Where reference to Maritime parity is not possible, by consensus, the PSRC may make reference to the rates and/or terms and conditions established by another province/territory outside of the Maritime Provinces.
5. After the process is complete HCS representatives shall seek the approval of the Minister of HCS for the proposed revisions to the MCP Payment Schedule.
6. In the absence of consensus, HCS representatives will make a recommendation to the Minister of HCS and the NLMA may also advise the Minister of HCS regarding their separate recommendation.
7. Revisions to the MCP Payment Schedule that have been approved by the Minister of HCS will take effect ninety (90) days following the date of approval by the Minister of HCS.

Schedule "M"

On-Call Rates

On-call service shall be remunerated according to the following four-tiers and the rules as published from time to time in the MCP On-Call Payment Information Manual:

Level I	$300.24
Level II	$266.88
Level III	$233.52
Level IV	$200.16

Schedule "N"

Interest Arbitration

1. Should the parties fail to enter into a new agreement to replace this Agreement within twelve (12) months following the date of the receipt by any party of the written notice referred to in Article 3.03 of this Agreement, any party may give written notice to the other party of its intention to invoke the arbitration provisions set forth in this Schedule.

2. Where a party has given notice under section 1 of this Schedule of its intention to invoke the arbitration provisions, the parties agree to submit all matters in dispute to a three (3) member Arbitration Board, which shall be constituted and shall proceed as follows:

   (a) Within ten (10) days following the receipt by any party of the notice referred to in section 1, each of the parties shall nominate an arbitrator to be its nominee on the Arbitration Board and shall give written notice to the other party of the name and address of the person so nominated.

   (b) Within seven (7) days following the nomination of the persons to the Arbitration Board referred to in section 2(a), the two persons so nominated shall together select a third person who shall be the Chairperson of the Arbitration Board, and the three persons so nominated and selected shall together constitute the Arbitration Board for the purpose herein set forth.

   (c) Within thirty (30) days following the selection of the Chairperson of the Arbitration Board as provided in section 2(b), or within such other period as may be mutually agreed by the parties, the Arbitration Board shall convene a hearing to arbitrate the matters in dispute.

   (d) Not later than ten (10) days prior to the day set for the commencement of the hearing referred to in section 2(c), each party shall submit to the Arbitration Board, in writing, a statement of its respective positions on the matters in dispute together with all relevant documentation in support thereof, and shall serve a copy on the other party. Subject to section 2(e), no matter may be submitted to the Arbitration Board as a matter in dispute unless:

      (i) within one hundred and eighty (180) days following the date of the receipt by any party of the written notice referred to in Article 3.03 that matter has been the subject of a written proposal by one party towards settlement of the matter and which written proposal has been delivered to the other party within that 180 day period; or

(ii) both parties consent in writing to that matter being submitted to the Arbitration Board as a matter in dispute.

(e) Unless both parties explicitly consent in writing, no matter may be submitted to the Arbitration Board that involves a decision or decisions by Government as to: (i) the allocation of human resources, including without limitation, the number and allocation of salaried positions and the location of services; (ii) the allocation of fee codes (i.e.fee code allocations); (iii) new services to be compensated; (iv) new programs, new benefits, new bonuses and new incentives; and (v) determination of what are insured services. Other than the foregoing, the Arbitration Board shall be able to determine any matter in dispute concerning compensation and benefits, including the rules and terms that define the entitlement of physicians to such compensation and benefits, that are contained in the Agreement under which the referral to arbitration has been made, including, subject to section 2(f), the duration of the agreement.

(f) The arbitration referred to section 2(c) shall be governed by the provisions of the *Arbitration Act*, RSNL 1990, c. A-14. In conducting the arbitration and making its decision or award, the Arbitration Board shall give due consideration to the purposes of the Agreement set out in Article 1.01(b). The Arbitration Board shall not have jurisdiction to make a decision or award for a period covering more than three (3) years unless the parties agree otherwise. The Arbitration Board shall give full opportunity to the parties to present evidence and make submissions.

(g) The Arbitration Board shall use conventional arbitration principles and, in making its decision, shall consider and take into account any matter(s) or factor(s) which it judges to be relevant, including the following factors:

i. Evidence relating to comparable groups in Atlantic Canada;
ii. Reasonable and fair compensation and working conditions for physicians in rendering professional services;
iii. The ability of Government to pay in light of its current and projected fiscal position, including levels of taxation, expenditures and debt levels; and
iv. Recent general economic increases provided to the provincial public sector unions in Newfoundland and Labrador.

(h) The Arbitration Board may, should it determine that either party has failed to bargain in good faith to conclude a new agreement, refer the parties back to bargaining for a period of thirty (30) days with a view to resolving, clarifying, or otherwise addressing one or more matters in dispute.

(i) The Arbitration Board shall deliver its decision or award by

majority decision in writing within forty-five (45) days from the conclusion of the hearing referred to in section 2(c), and the decision or award of the majority shall be the decision of the Arbitration Board and shall be final and binding on the parties with respect to the matters in dispute and shall not be subject to any appeal. Should there be no majority decision or award, the decision or award of the Chairperson of the Arbitration Board shall be the decision or award of the Arbitration Board. The decision or award of the Arbitration Board shall be implemented in the manner provided in the decision or award. The Arbitration Board shall have jurisdiction to provide clarification to the parties concerning the decision or award, provided, however, that the Arbitration Board shall not change its decision or award in any substantive way.

(j) Each party shall bear its own costs and expenses of the arbitration, including the costs and expenses of its nominee to the Arbitration Board, and shall share equally the costs and expenses of the arbitration including those of the Chairperson of the Arbitration Board.

(k) The Arbitration Board shall not have jurisdiction to amend or vary the terms of any part of Article 1.01(b), Article 3.03 or this Schedule of the Agreement.

(l) Judgment upon the decision or award of the Arbitration Board may with leave of the Court be entered in the Supreme Court of Newfoundland and Labrador and, if so registered, be enforced subject to those restrictions, if any, and ordered by the Court.

(m) Nothing in this Agreement prohibits, limits or restricts the right of either party to seek judicial review of the award or decision of the Arbitration Board or of a component thereof on a matter of law or jurisdiction.

3. Neither the NLMA nor any of its members shall declare, organize, authorize, encourage, support, participate in, or sanction any stoppage of work or strike or withdrawal or curtailment of services or slowdown of work.

4. This Schedule shall be of no force and effect unless and until:

(i) the College of Physicians and Surgeons of Newfoundland and Labrador (the "College") enacts a by-law that, in substance, defines engagement by a physician, alone or in concert with other physicians, in a cessation or refusal to work or to continue to work, including, without limitation, a resignation, slow-down of work or other such concerted activity, or threat thereof, in respect of the provision of an existing insured service, for the purpose of exerting economic influence on either Government or the NLMA to achieve

personal economic gain or to achieve a benefit in excess of those determined pursuant to the terms of this Agreement, as being conduct deserving of sanction; and

(ii) the parties explicitly confirm in writing that the by-law of the College described in section 4(i) satisfies the requirements of this Schedule, such confirmation not to be unreasonably withheld.

5. This Schedule shall cease to be of any force or effect on the earlier of either:

1. the parties' written agreement,
2. an amendment to the by-law referenced in section 4(i) that:

   a) has the effect of removing or altering the behaviors or actions which are grounds for sanction by the College, or
   b) limits the College's ability to sanction a physician;

   or

3. the by-law referenced in section 4(i) being invalidated through litigation before the courts with the effect of removing or altering the behaviors or actions which are grounds for sanction by the College or limiting the College's ability to sanction a physician.

The following Schedules are not subject to interest arbitration:

1. Schedule "B" Institutional Workload Disruption Payment Policy
2. Schedule "C" Salaried Physician Retention Bonus Categories
3. Schedule "E" Alternate Payment Plans
4. Schedule "G" Approved Category "A" Facilities: 24 Hour on site Emergency Department coverage
5. Schedule "H" Approved Category "B" Facilities: 24 Hour Emergency Department coverage
6. Schedule "K" Physician Services Liaison Committee Terms of Reference
7. Schedule "L" MCP Payment Schedule Review Committee Terms of Reference
8. Schedule "N" Interest Arbitration

The following Schedules are subject to interest arbitration:

1. Schedule "D" Specialty Corrections Fund
2. Schedule "F" FFS Increases, By FFS Specialty Group

The following Schedules are subject to interest arbitration in part, as indicated:

1. Schedule "A" Waterford Physicians On-Duty, on-site Payment Policy: rates only
2. Schedule "I" Obstetrical Bonus Policy for Salaried and FFS Family Physicians: rates only
3. Schedule "J" Primary Care Renewal Program: clause 4.1 ("Funding") only
4. Schedule "M" On-call Rates: Overall funding only; rates not subject to arbitration.

END OF SCHEDULES TO THE AGREEMENT

NEWFOUNDLAND AND LABRADOR
MEDICAL ASSOCIATION

Overview of Tentative Agreement

between the Newfoundland & Labrador Medical Association and the Government of Newfoundland & Labrador

2013-2017

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Financial Overview

- Overall monetary offer from the government of Newfoundland and Labrador in the amount of $19.918 million.
- This represents a 4.6% overall increase to the compensation components of the Physician Services Budget.

FFS Increase	$7,515,604 (distributed equally per FTE)
Other FFS/APP increases	$2,633,963
Salaried Base Increase	$2,702,088 (distributed equally per FTE)
Other Salaried Related Increases	$564,011
ED Cat. A Parity Adjustment	$1,010,000
Rural FFS Retention Bonus & Rural Premium Programs	$1,000,000
Primary Care Renewal	$4,500,000
Total	**$19,925,666**

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Allocation Method:

- Equal dollar amount per Full-Time Equivalent (FTE) Physician distributed in two funding blocks:
  1. FFS Physicians: FTE amount approximately $10,500 (The amount available to each specialty group for micro-allocation to fee codes is determined by the number of FTEs in the specialty multiplied by the FTE $ amount. The number of FTEs has been estimated by using MCP billing data and a formula developed by the Canadian Institute for Health Information.

  2. Salaried Physicians: FTE amount approximately $7,700 (The number of FTEs is based on RHA reports to the Department of Health and Community Services. The total amount of funding (#FTEs multiplied by the FTE $ amount) will be allocated to salary scales.)

- Each funding block represents an increase of 3% on average, but increases to sub-groups and individual specialties will vary between 1.7% and 7.3%.
- Funding blocks will be allocated 40% in 2015-16 and 60% in 2016-17.
- There is no retroactive funding for 2013-14 and 2014-15.
- Increases for Alternate Payment Plan groups will be the same percentage increase as their broader FFS specialty group.
- Every specialty group was assessed to determine whether the FTE increase would be sufficient to reach parity with the Maritime Provinces. Only one group needed a parity adjustment (Category A Emergency) to ensure this benchmark was reached.
- Note: Salaried Category B physicians receive their increase through the Family Medicine salary increase. FFS Category B physicians receive their increase through the Family Medicine FFS increase.
- For a detailed explanation of calculating FTE for each specialty, download the ***Calculating Full-time Equivalent*** (pdf) document.

Total Number of Physicians (per specialty) by Full-time Equivalent (FTE) and Head Count

Category		FTE Count	Head Count
Fee-for-service Specialties	Family Medicine	399.1	412
	Dermatology	10.2	10
	General Surgery	23.8	24
	Internal Medicine	66.5	68
	Nuclear Medicine	2.0	2
	Neurosurgery	3.9	4
	Neurology	5.3	5
	Obstetrics/Gynecology	23.6	24
	Ophthalmology	18.6	18
	Orthopedics	15.3	15
	Otolaryngology	12.0	12
	Paediatrics	24.8	23
	Plastic Surgery	4.7	5
	Psychiatry	16.7	17
	Urology	9.6	10
	Radiology	50.8	55
	Anaesthesia	30.8	32
FFS Specialties		**717.8**	**736**
Salaried	General Practice Specialists	351	391
Salaried		**351**	**391**
Overall TOTAL*		**1068.8**	**1127**

*Overall Total does not include APP

** *Allocation method does not apply to Category A Emergency (refer to FFS Section)*

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Fee-For-Service Physicians:

Payment Schedule Review Process

- A new Payment Schedule Review Committee (PSRC) comprised of representatives of the NLMA and the Department of Health and Community Services, will be responsible for the ongoing review, editing, and drafting of the MCP Medical Payment Schedule.

- **PSRC Review Process:** A process will be established to review and adjust fee codes and billing rules to reflect changes in time, technology, direct cost, market comparison, and other such factors as may be determined by the parties. The PSRC will develop a methodology for analyzing FFS billings. The process may identify fee codes that require an increase or decrease in funding, or it may identify fees that are no longer necessary. There will be 90 days' notice and consultation with affected disciplines on any recommended adjustments to fees. Fee codes and billing rules will generally be adjusted on an overall cost-neutral basis only. Any savings as a result of adjustments to fee codes will remain invested in the Physician Services Budget. These savings will first be considered for re-allocation within the affected discipline and secondly, allocation in another discipline to respond to unmet needs. In cases where fee codes are reduced, no discipline will have its funding adjusted to less than Maritime parity. Decisions of the PSRC shall be made by consensus and shall be subject to the approval of the Minister. This process will ensure physicians are protected from unilateral changes to fee codes without first initiating the PSRC review process.

- **Fee Code Addition Process:** The PSRC is also responsible for receiving applications for new fee codes in order to ensure that the Fee Schedule includes appropriate fee codes for new physician services that become available in the province. The PSRC will receive applications for new fee codes from physicians or from the DHCS and will review them jointly and collaboratively with the NLMA to work toward a consensus-based decision.

Category A Emergency

- The FTE allocation methodology does not apply to Category A Emergency Physicians.
- Category A Emergency Physicians will receive a parity adjustment increase of 5.5% to the Category A Emergency rate.

FFS/GP Rural Retention Bonuses

- NLMA proposed a review of the Rural Retention Bonus for FFS GPs, particularly to address administrative inefficiencies in the program.
- Government proposed a broader review of the Rural Retention Bonus, as well as the 20% Rural Hospital GP Premium. This may result in a merged program.
- Government also agreed to add an additional $1 million to the program.

Obstetrical Bonus

- The parties agree to new eligibility criteria for the Obstetrical Bonus.
- The bonus will be paid to GP/FPs who participate in 5 or more deliveries per annum. GPs/FPs must perform a minimum of five (5) deliveries within the consecutive 12-month time period of April 1- March 31 in order to qualify. This is a change from the previous criteria where a physician who participated in fewer than five deliveries in a year would have qualified.
- The program will have the following contribution rates: $5,000 for 5-15 units, $7,500 for 16-30 units, and $10,000 for 31 or more units.
- There are no other changes to the existing policy other than the changes noted above.

Transition of Hospital Services to Private

- The parties agree to establish a committee that will review services that could be transferred from hospitals to private physician offices.
- The committee will review: timeliness of care and follow-up; appropriateness of the service; cost-effectiveness of the service; identification of a quality assurance program for the service; and, monitoring of the service.
- The committee will make recommendations by consensus once annually to the Minister of Health and Community Services.
- NLMA will consult with members to develop a candidate list.

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Salaried Physicians:

Salaried Quarterly Payments

- Quarterly payments received by salaried physicians under the previous MOA will be blended into bi-weekly payments when the agreement comes into effect.

Salaried Group RRSP program

- The Salaried Physician Group RRSP will now be referenced in the MOA for the first time, adding a degree of contractual protection for this program that did not exist before, as per below:
  "The employer commits to maintain an employer-sponsored salaried physician group RRSP and as a condition of employment, all salaried physicians, except those participating in the Public Service Pension Plan pursuant to an election made prior to November 30, 2000, are required to participate in the employer sponsored group RRSP."

New/Clarified Guidelines for Statutory Holidays

- As previous, there shall be a total of nine (9) paid holidays for salaried physicians.
- If the Vice President of Medical Services or designate requires the salaried physician to work on a holiday, he/she will be scheduled off with pay on another day in lieu of the holiday within 90 days of the holiday occurring. If the employer fails to schedule the salaried physician off within the 90 days, the day in lieu will be taken at a time mutually agreed upon between the salaried physician and the Vice President of Medical Services or designate.
- Days in lieu that are not taken within the fiscal year will be forfeited except when the employer has not been able to grant the salaried physician's request for a day to be taken in lieu of working the statutory holiday. The day can then be rolled over and the employer must approve the day in lieu in the next fiscal year.
- Other guidelines as stated in previous MOA.

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All Physicians:

CMPA Fees

- The parties reached an agreement to maintain the status quo for CMPA fee reimbursement.
- Calculation of the eligible CMPA reimbursement will be the difference between what the physician pays and 60% of the General Practitioner basic rate.

MOA Co-Governance Package

- **Physician Services Liaison Committee (PSLC) Modified Terms of Reference**
  The PSLC is mandated to provide information and/or advice to the DHCS on medical issues from a policy, systemic and/or strategic perspective. The PSLC terms of reference are now modified to establish the PSLC as the oversight body for the administration and implementation of the MOA. Criteria have been established for meeting quorums, frequency of meetings and consensus-based decision making.

- **Data Sharing Agreement**
  The DHCS agrees to share comprehensive data on all aspects of the MOA, including routine data-sharing of MCP physician services payments at the fee code, site and community level. DHCS also agrees to share comparable data on salaries, alternate payment plans and all bonuses at the physician payment and location level. Identification of the names of specific physicians or any patient identifying information will be omitted. The DHCS has also committed to share the Physician Supply Report, the Average FFS Payment Report and the APP Expenditure Report.

- **Dispute Settlement**
  The parties agree to a dispute settlement process regarding disagreements on interpretation of the MOA. In the event that a disagreement arises regarding the interpretation of the MOA, either party may now refer the matter to the PSLC for resolution. Should the PSLC be unable to resolve the matter, the parties may, by mutual agreement, engage the services of a mediator to assist the parties in reaching a resolution, recognizing that any proposals or recommendations at this stage are not binding on the parties; and, the parties may, by mutual agreement, engage the services of an Arbitrator.

Policies Outside MOA

- Certain sections of the MOA, and certain types of physician compensation, have supplementary rules contained within DHCS policies (see list below) that exist outside the MOA, most of which have been published in a document called the *Salaried Quick Reference Guidelines*. These supplementary rules, of course, must be consistent with the MOA, but it has been a concern of the NLMA that the Department could potentially amend these rules without any obligation to consult NLMA or seek its consent. Therefore, under the new agreement, the Department of Health and Community Services has now agreed to consult with the NLMA prior to making any changes to the policies listed below. Please note that related sections of the MOA are unaffected by this new obligation to consult. There has been no dilution of the strength of the MOA by adding this consultation requirement for matters that exist outside the MOA.

- **Policies**
  - Rural FFS General Practitioner Hospital Premium
  - Rural FFS Psychiatry Premium
  - On Call and After Hours Bonus
  - Additional Workload
  - Salaried Physician Group RRSP
  - Salaried Physician Retention Bonus
  - Locum Policy
  - Critical Escort
  - Category A Emergency Department Coverage by Salaried GPs
  - Oncology Annual Stipend
  - On-Call Policy
  - Appeal of the Salaried Physician Step Assignment

- Under this arrangement, "to consult" means that the DHCS will: express its intention regarding any proposed changes to the NLMA; provide the NLMA with an opportunity to seek clarification and to respond to the proposed changes; and, take the NLMA's response into account before making changes to a policy.

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Primary Health Renewal:

- The parties agree to a new Primary Care Renewal Program to accelerate reform in the province. The program is based on the British Columbia model of improving payments for comprehensive family practice and access combined with establishing new Divisions of Family Practice.
- Principles of the program will be incorporated into priorities, targets and initiatives. Principles include patient-centered services and supports; collaborative inter-disciplinary teams; coordination of care; comprehensiveness of care; access to appropriate services and supports; patient attachment and longitudinal relationships; communities of practice (physical or virtual); community engagement; and, continuous evaluation and evidence-based decision making.
- Click here for a detailed list of the **Goals of the Primary Care Renewal Program** (pdf).

Funding

- Funding for PCRP initiatives will be allocated within the following budgets:

MOA Year 3 (2015-16)	$1 Million
MOA Year 4 (2016-17)	$4.5 Million (annual budget that continues into future agreements)
Total Annualized Funding	**$4.5 Million**

Family Practice Renewal Committee

- A Family Practice Renewal Committee (FPRC) will be established to design the programs and fee code initiatives within the program budget, and to provide ongoing governance for the program.
- The FPRC shall be composed of 3 (three) members appointed by DHCS, and 3 (three) members appointed by the NLMA. The FPRC shall be co-chaired by a member chosen by the DHCS members and a member chosen by the NLMA members.
- Decisions of the FPRC shall be made by consensus.

Fee Code Initiatives

- Funds will be allocated to design and fund new condition-based fee code initiatives for the support of comprehensive care delivery, which may include such ideas as:
  - increased coordination and collaboration with other primary health care providers;
  - improved patient access; and
  - improved identification and management of a full range of comprehensive care services.

Practice Improvement Program

- This program, jointly sponsored by the NLMA and DHCS and administered by the FPRC, offers continuing professional development for physicians and their staff to help improve practice efficiency, support evidence-based change management, and to enable enhanced delivery of patient care.
- The program targets the following areas:
  - primary care best practices and guidelines-based care;
  - clinical and practice efficiency;
  - adoption of new technology (exclusive of an electronic medical record program);
  - practice reorganization;
  - inter-disciplinary collaboration and coordination;

- health prevention and promotion;
- mental health and addictions; and,
- other target areas as agreed by the FPRC.

Family Practice Networks

- Family Practice Networks (FPN) will be created at the sub regional or regional level.
- Each FPN will be a not-for-profit corporation constituted by the physicians within their sub-region or region.
- FPNs will organize and promote the participation of physicians in their region in activities that improve the delivery of primary health care services.
- FPNs will be supported and funded within a program framework and funding formula, to be developed by the FPRC, with funds to be used for management, honoraria, administrative expenses and other expenses relevant to the mandate of the program.
- Each FPN will participate on its own Collaborative Services Committee (CSC) with the relevant regional health authority (RHA). Membership in the CSC will be shared equally between FPN representatives and RHA representatives with decision-making authority.
- Each CSC will be a place for dialogue between family doctors and the RHA focused on addressing issues and problems in primary health care access and delivery in that region or sub-region. The partners will work to co-design solutions and initiatives to improve local primary health care. Decisions of the CSC will be made by consensus and both FPN and RHA participation is mandated.
- The CSC may also choose to invite patients and local community representatives to participate as ex-officio members.

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Arbitration Terms of Reference:

- NLMA and DHCS have negotiated the final wording for the terms of reference for binding arbitration, an item outstanding from the last MOA 2009-2013.
- The terms of reference will come into effect when the College of Physicians and Surgeons of Newfoundland and Labrador passes a bylaw preventing physician job actions or strikes, where individual physicians or groups of physicians exert economic pressure on government or the NLMA to achieve benefits not included in the MOA.

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Parental Leave Benefits:

- NLMA and government have agreed to fund a parental leave benefits program through the permanent allocation of funds from the jointly administered Clinical Stabilization Fund (CSF).
- While not all details have been finalized, NLMA expects that the program will be available for 17 weeks for both FFS and salaried physicians at a total rate of about $1200 per week.
- There will be no loss of accrued benefits, step progression or severance pay for salaried physicians.
- FFS Physicians working part-time during parental leave may potentially bill up to $1,500 per week in additional income to help defray overhead costs.
- The same parental leave benefits will be available for physicians who adopt a child.

**All details are subject to change following development of the final policy by the CSF Management Committee.*

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This week's releases (15)

This month's releases (59)

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Public information, contact Manitoba Government Inquiry: 1-866-626-4862 or 204-945-3744.

Media requests for general information, contact Communications and Engagement: newsroom@gov.mb.ca.

Media requests for ministerial comment, contact Cabinet Communications: cabcom@manitoba.ca.

Twitter Feed

News Release - Manitoba

October 7, 2011

DOCTORS RATIFY NEW FOUR-YEAR AGREEMENT WITH MANITOBA GOVERNMENT

– – –

New Contract Will Help Recruit More Doctors, Give Families Quality Care: Selinger

Doctors have ratified a new four-year agreement with the Manitoba government that will help recruit and retain more physicians in communities across the province and support the government's plan to ensure all Manitobans have access to a family doctor by 2015, Premier Greg Selinger announced today.

Backgrounder
Contract by the Numbers

"Health care remains the top priority of our government because we know that it is still the top priority for Manitoba families," said Selinger. "We are pleased doctors have ratified this new agreement which will help to recruit and retain more doctors in our province while supporting our plan to ensure all Manitobans have a family doctor by 2015."

The new contract is retroactive to April 1, 2011, and increases the province's funding for medical services by approximately $125 million over four years, he said, noting key components include:

- a 66 per cent increase to the Physician Retention Fund designed to retain doctors currently practising in Manitoba;
- new fee tariffs including those for chronic disease management, which will enable doctors to spend more time with patients who need it most;
- a requirement for newly recruited physicians to participate in the Family Doctor Connection Program, as part of the province's commitment to help Manitobans find a family doctor;
- a commitment to work together on provincial priorities such as implementing primary-care homes and networks, a key component of ensuring all Manitobans have a family doctor by 2015;
- competitive general rate increases of 10.6 per cent for physicians over the term of the contract, with a long-term commitment to ensure remuneration for Manitoba doctors remains competitive; and
- remuneration incentives to recruit and retain physicians in critical areas of practice including intensive-care specialists, pathologists, diagnostic specialists, physicians working in remote locations, physicians working with the provincial Lifeflight air ambulance program and other specialties.

The new master agreement was approved by the Doctors Manitoba board of directors and ratified by the members who voted in a mail ballot.

"The key to recruiting and retaining physicians in Manitoba is to ensure that the compensation is competitive with the average paid in Ontario, Saskatchewan and Alberta," said Dr. Jason Scott, president of Doctors Manitoba. "This new agreement will help ensure this occurs in this agreement and into the future."

"The new agreement with Doctors Manitoba gives doctors the support they need to offer improved care for families across our province including spending more time with

conditions," said Health Minister Theresa Oswald. "The contract also includes important provisions that will help to recruit and retain more doctors in Manitoba, which will further improve patient access to the health services they need."

Last year, Manitoba saw a net increase of 87 more doctors practising in Manitoba, a record increase. Since 1999, the province has seen a net gain of nearly 500 more doctors practising across the province, Oswald said.

The minister noted the terms of this new agreement will ensure compensation paid to physicians is competitive with neighbouring jurisdictions in a fiscally responsible manner consistent with Manitoba's five-year plan for economic recovery.

The new agreement was developed in partnership with Manitoba Health, Doctors Manitoba, regional health authorities and other stakeholders.

The previous agreement between the Province of Manitoba and Doctors Manitoba was a three-year contract worth approximately $100 million, signed in September 2008.

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BACKGROUND INFORMATION ATTACHED

For more information:

- Public information, contact Manitoba Government Inquiry: 1-866-626-4862 or 204-945-3744.
- Media requests for general information, contact Communications and Engagement: newsroom@gov.mb.ca.
- Media requests for ministerial comment, contact Cabinet Communications: cabcom@manitoba.ca.

Tweets from @MBGovNews

Manitoba... · Oct 21, 2023

Statement from Families Minister Nahanni Fontaine, Minister Responsible for Gender Equity, on the `No Space For Hate' Counter-Protest Party bit.ly/3MckT91

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Manitoba... · Oct 24, 2023

Statement from Premier Wab Kinew and Health, Seniors and Long-Term Care Minister Uzoma

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Manitoba Public Insurance
Manitoba Hydro
Manitoba Liquor and Lotteries
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TAB 129

AGREEMENT

between

HER MAJESTY IN RIGHT OF THE PROVINCE OF MANITOBA
REPRESENTED BY THE MINISTER OF HEALTH

and

DOCTORS MANITOBA

April 1st, 2011 to March 31, 2015

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THIS AGREEMENT made and entered into this 2nd day of September, 2011

BETWEEN:

HER MAJESTY IN RIGHT OF THE PROVINCE OF MANITOBA
REPRESENTED BY THE MINISTER OF HEALTH

(Hereinafter referred to as "the Government")

OF THE FIRST PART

- and -

DOCTORS MANITOBA

OF THE SECOND PART.

WHEREAS Doctors Manitoba is the certified bargaining agent of certain specified physicians of the Government, more specifically having been certified under the Labour Relations Act of the Province of Manitoba by the Manitoba Labour Board on the 25th day of June, A.D. l974, under Certificate No. MLB-2710 as certified bargaining agent for a unit described as follows:

"All physicians employed by the Province of Manitoba, except those excluded by the Act."

AND WHEREAS Doctors Manitoba and the Government have agreed to enter into a collective agreement containing terms and conditions of employment of the said physicians employed by the Government, including provisions with reference to rates of pay and hours of work;

NOW THIS AGREEMENT WITNESSETH THAT in consideration of the premises of the covenants and agreements of the parties hereto, hereinafter contained, and by them to be respectfully observed, kept and performed, the parties hereto covenant and agree as follows:

ARTICLE 1 - GOVERNMENT TO PROVIDE COPY OF AGREEMENT

1:01 A copy of this Agreement shall be provided by the Government to each of the present physicians employed by it, and to all future physicians bound by this Agreement. The Government and Doctors Manitoba shall share equally all costs in connection with the printing and distribution of the agreement for use by present and future physicians covered by this Agreement.

ARTICLE 2 - INTERPRETATION

2:01 "**Employing Authority**" means:

(a) in respect of the Department in which a physician is employed:

(i) The Minister presiding over the Department;

(ii) The Deputy Minister; or

(iii) Any person designated by the Minister to act as employing authority in respect of the Department on behalf of the Minister and of whom Doctors Manitoba has been given written notice.

2:02 Wherever the singular and the masculine are used in this Agreement, the same shall be construed as meaning the plural, or the feminine or the neuter where the context so admits or requires and the converse shall hold as applicable.

2:03 In this Agreement, unless the context otherwise requires, and except as other-wise provided in this agreement the expression:

(a) "**accumulated service**" means the equivalent length of service acquired by the physician in accordance with the following:

(i) accumulated service is calculated based on all hours for which a physician has received regular pay. This includes regular hours worked and approved leaves of absence from the Government of Manitoba where regular pay is maintained;

(ii) accumulated service does not include any leaves of absence without pay including but not limited to suspensions without pay, Workers' Compensation, and other leave situations;

(iii) accumulated service must be continuous service;

(iv) one (1) year of accumulated service equals 1885 hours; and

(v) a physician can only receive a maximum of one (1) year of accumulated service in any twelve (12) month period.

(b) "**continuous service**" means consecutive and contiguous days, weeks, months and/or years of employment with the Government of Manitoba where there has been no break in service involving the termination of the physician.

(c) "**calendar service**" means the length of continuous service from the physician's most recent date of hire to the present. Periods of lay-off while not affecting the continuity of service, are not included in the calculation of calendar service.

(d) "**vacation credit**" means one (1) day (7.25 hours) of paid vacation.

ARTICLE 3 - DISCRIMINATION

3:01 There shall be no discrimination by either party against any member of the bargaining unit because of that member's participation or non-participation in lawful activities of Doctors Manitoba or because of that member's participation or non-participation either on the Joint Committee or Negotiations Committee established pursuant to this Agreement, or both.

ARTICLE 4 - RECOGNITION OF DOCTORS MANITOBA

4:01 The Government recognizes Doctors Manitoba as the sole and exclusive bargaining agent for those physicians of the Government referred to in the Certificate No. MLB-2710 of the Manitoba Labour Board, and, as well, such further and other class or classes of employees as may be agreed upon by the parties during the currency of this Agreement or any extension thereof.

ARTICLE 5 - MANAGEMENT RIGHTS

5:01 Except as in this Agreement otherwise expressly provided, it is acknowledged that the Government has the right, responsibility and authority to manage, operate and generally regulate its affairs and functions. The Government agrees that their functions shall be exercised in a manner not inconsistent with the terms of this Agreement, and that any type of disciplinary action taken against any member of the bargaining unit herein must only be taken for just and proper cause.

5:02 In administering this Agreement, the government shall act reasonably, fairly, in good faith and in a manner consistent with the Agreement as a whole.

ARTICLE 6 - SICK LEAVE

6:01 A physician shall be allowed sick leave with pay to the extent of that physician's accumulated sick leave credits.

6:02 The sick leave to which a physician is entitled shall accumulate:

(a) during the first four (4) years of calendar service at the rate of 3.625 hours for each 72.5 hours of accumulated service**;**

(b) after the first four (4) years of calendar service at the rate of 7.25 hours for each 72.5 hours of accumulated service.

6:03 Subject to sub-article 6:04 sick leave shall not accumulate beyond two hundred and eight (208) working days (1,508 hours).

6:04 The Civil Service Commission, at the request of the Employing Authority, may grant, in addition to the sick leave accumulated under this Agreement:

(a) to a physician who has been employed for not less than ten (10) years but less than fifteen (15) years, and who has been granted not more than two hundred and eight (208) working days (1,508 hours) of sick leave with pay during the physician's years of service, an additional period of sick leave with pay, which additional sick leave shall increase the total sick leave for all the physician's years of service to not more than two hundred and twenty-eight (228) working days (1,643 hours);

(b) to a physician who has been employed for not less than fifteen (15) years but less than twenty (20) years, and who has been granted not more than two hundred and twenty-eight (228) working days (1,653 hours) of sick leave during the physician's years of service, an additional period of sick leave with pay which additional sick leave shall increase the total sick leave for all the physician's years of service to not more than two hundred and fifty-six (256) working days (1,856 hours); and

(c) to a physician who has been employed for not less than twenty (20) years and who has been granted not more than two hundred and fifty-six (256) working days (1,856 hours) of sick leave during the physician's years of service, an additional period of sick leave with pay which additional leave shall increase the total sick leave for all the physician's years of service to not more than two hundred and ninety-six (296) working days (2,146 hours).

6:05 A physician who has been absent because of sickness shall furnish, if requested by the Deputy Minister or his designate, within fifteen (15) working days of the sickness, a medical certificate from a duly qualified medical practitioner designated by or acceptable to the Employing Authority, certifying that the physician is or was unable to be present at work because of the sickness. Where a physician fails to produce the requested medical certificate as aforesaid, the physician shall not be entitled to be paid for the period of absence.

6:06 The Government may, in its discretion, grant additional sick leave with pay over and above a physician's accumulated sick leave.

6:07 A physician shall accumulate sick leave credits from the date of commencement of employment.

6:08 Physicians who are on sick leave on statutory holidays or annual vacation shall be credited as having used this holiday or vacation on the day or days on which it or they fall and shall not be charged with having used a day or days of sick leave on that day or days. This sub-article does not apply to physicians who are in receipt of benefits under The Workers Compensation Act.

6:09 Physicians may obtain information concerning their accumulated sick leave credits upon request in writing to their personnel office and shall be provided with the information within thirty (30) days of the receipt of the request.

6:10 Where a physician becomes ill during the period of his scheduled annual vacation, the Employing Authority may grant sick leave and credit the physician with alternate days vacation equivalent to the number of days approved sick leave providing the illness is over three (3) days and requires hospitalization. The physician shall be responsible to provide proof of hospitalization satisfactory to the Employing Authority.

6:11 When an employee is unable to work and is in receipt of an income replacement indemnity (IRI) from Manitoba Public Insurance (MPI) as a result of an injury incurred in a vehicle accident, the employee may elect to be paid an additional amount, which when combined with the IRI benefit, shall ensure the maintenance of net salary consistent as if they were in receipt of regular sick leave. Such additional amount shall be chargeable to the employee's sick leave credits accrued at the time the employee commenced receipt of the IRI and such additional payment shall be payable until the employee's accrued sick leave credits have been exhausted.

6:12 Sick leave shall not accumulate during periods when a physician is absent on sick leave and/or absent on Workers' Compensation for a period of more than ten (10) consecutive working days.

ARTICLE 7 - MATERNITY LEAVE

7:01 A physician who qualifies for Maternity Leave may apply for such leave in accordance with either Plan A or Plan B but not both.

PLAN A

7:02 In order to qualify for Plan A, a pregnant physician must:

(a) have completed seven (7) continuous months of employment for or with the Government;

(b) submit to the Employing Authority an application in writing for leave under Plan A at least four (4) weeks before the day specified by her in the application as the day on which she intends to commence such leave; and

(c) provide the Employing Authority with a certificate of a duly qualified medical practitioner certifying that she is pregnant and specifying the estimated date of her delivery.

7:03 A physician who qualifies is entitled to and shall be granted maternity leave without pay consisting of:

(a) a period not exceeding seventeen (17) weeks if delivery occurs on or before the date of delivery specified in the certificate mentioned in sub-article 7:02(c); or

(b) a period of seventeen (17) weeks plus an additional period equal to the period between the date of delivery specified in the certificate mentioned in sub-article 7:02(c) and the actual date of delivery, if delivery occurs after the date mentioned in that certificate;

(c) the Civil Service Commission may vary the length of maternity leave upon proper certification by the attending physician, and recommendation by the Employing Authority.

7:04 A physician who has been granted maternity leave shall be permitted to apply up to a maximum of ten (10) days of her accumulated sick leave against the Employment Insurance waiting period. Should the physician not return to work following her maternity leave for a period of employment sufficient to allow for re-accumulation of the number of sick days granted, the physician shall compensate the Government for the balance of the outstanding days at the time of termination. Approved sick leave with pay granted during the period of return shall be counted as days worked.

PLAN B

7:05 In order to qualify for Plan B a pregnant physician must:

(a) have completed seven (7) continuous months of employment for or with the Government;

(b) submit to the Employing Authority an application in writing, for leave under Plan B at least four (4) weeks before the day specified by her in the application as the day on which she intends to commence such leave;

(c) provide the Employing Authority with a certificate of a duly qualified medical practitioner certifying that she is pregnant and specifying the estimated date of her delivery;

(d) provide the Employing Authority with proof that she has applied for Employment Insurance benefits and that Human Resources Development Canada (HRDC) has agreed that the physician has qualified for and is entitled to such Employment Insurance benefits pursuant to Section 22, Employment Insurance Act.

7:06 An applicant for maternity leave under Plan B must sign an agreement with the Employing Authority providing that:

(a) she shall return to work and remain in the employ of the Government on a full time basis for at least six (6) months following her return to work;

(b) if she does not take parental leave as provided in Article 8 - Parental Leave, she shall return to work on the date of the expiry of her maternity leave;

(c) if she does take parental leave as provided in Article 8 - Parental Leave, she shall return to work on the date of the expiry of her parental leave; and

(d) should she fail to return to work as provided above, she is indebted to the Government for the full amount of pay received from the Government as a maternity allowance during her entire period of maternity leave.

7:07 At the physician's request and with the recommendation of the Employing Authority, the Civil Service Commission may authorize a physician who has received maternity leave under Plan B to return to work on a part-time basis for a period of twelve (12) months.

7:08 A physician who qualifies is entitled to a maternity leave consisting of:

(a) a period not exceeding seventeen (17) weeks if delivery occurs on or before the date of delivery specified in the certificate mentioned in sub-article 7:05(c); or

(b) a period of seventeen (17) weeks plus an additional period equal to the period between the date of delivery specified in the certificate mentioned in sub-article 7:05(c) and the actual date of delivery, if delivery occurs after the date mentioned in that certificate;

(c) the Civil Service Commission may vary the length of maternity leave upon proper certification by the attending physician, and recommendation by the Employing Authority.

7:09 During the period of maternity leave, a physician who qualifies is entitled to a maternity leave allowance in accordance with the Supplementary Unemployment Benefit (SUB) plan as follows:

(a) for the first two (2) weeks a physician shall receive ninety-three percent (93%) of her weekly rate of pay;

(b) for up to a maximum of fifteen (15) additional weeks, payments equivalent to the difference between the Employment Insurance benefits the physician is eligible to receive and ninety-three percent (93%) of her weekly rate of pay;

(c) all other time as may be provided under sub-article 7:08 shall be on a leave without pay basis.

7:10 Plaา B does not apply to term physicians or physicians who normally are subject to seasonal lay-off.

7:11 During the period of maternity leave, benefits shall not accrue. However, the period of maternity leave shall count as service towards eligibility for long service vacation and long service sick leave entitlement.

7:12 Where a physician's anniversary date falls during the period of maternity leave under Plan A or B, the physician shall be eligible to receive a merit increase effective the date upon which she returns to her position of employment.

7:13 The parties agree that for and in consideration of the Maternity Leave provisions negotiated into the 1996-97 Collective Agreement, Doctors Manitoba hereby agrees not to process to arbitration any grievances respecting the utilization of accumulated sick leave credits to cover part or all of a physician's Maternity Leave.

ARTICLE 8 - PARENTAL LEAVE

8:01 A physician who adopts or becomes a parent of a child is entitled to a maximum of thirty-seven (37) continuous weeks of unpaid parental leave if:

(a) the physician has completed seven (7) continuous months of employment with the Government;

(b) the physician gives written notice to the Government at least four (4) weeks before the day specified in the notice as the day on which the physician intends to commence the leave; and

(c) in the case of adoption, the adoption occurs or is recognized under Manitoba law.

8:02 A physician who gives less notice than is required under sub-article 8:01(b) is entitled to the thirty-seven (37) weeks of parental leave less the number of days by which the notice given is less than four (4) weeks.

8:03 Subject to sub-article 8:04, parental leave must commence no later than the first (1^{st}) anniversary date of the birth or adoption of the child or the date on which the child comes into the actual care and custody of the physician.

8:04 Where a physician takes parental leave in addition to maternity leave, the physician must commence the parental leave immediately on expiry of the maternity leave without a return to work unless otherwise approved by the Employing Authority.

8:05 A physician's parental leave ends:

(a) thirty-seven (37) weeks after it began; or

(b) if sub-article 8:02 applies, thirty-seven (37) weeks after it began less the number of days provided for in that sub-article.

8:06 A physician may end his or her parental leave earlier than the day set out in sub-article 8:05 by giving the Government written notice at least two (2) weeks or one (1) pay period, whichever is longer, before the day the physician wishes to end the leave.

ARTICLE 9 - PATERNITY LEAVE

9:01 When a physician's spouse or common-law partner gives birth to a child, the physician shall be granted one (1) day leave of absence with pay to attend to matters arising out of the birth of the child. Such leave may be granted on the day of or the day following the birth of the child, or the day of the physician's spouse's or common-law partner's admission to or discharge from hospital.

ARTICLE 10 - CIVIL LIABILITY

10:01 If an action or proceeding is brought against any physician employed by the Government, for an alleged tort committed by him in the performance of his duties, then:

(a) the physician, upon being served with any legal process, or upon receipt of any action or proceeding as hereinbefore referred to, being commenced against him shall advise the Government through the Deputy Minister of Health, Family Services, Justice or Labour of any such notification or legal process;

(b) the Government shall pay any damages or costs awarded against any such physician in any such action or proceedings and all legal fees;

(c) the Government shall pay any sum required to be paid by such physician in connection with the settlement of any claim made against such physician if such settlement is approved by the Government, through the Deputy Minister of Health, Family Services, Justice or Labour before the same is finalized; provided the conduct of the physician which gave rise to the action did not constitute gross negligence of his duty as a physician; and/or

(d) upon the physician notifying the Government in accordance with sub-article 10:01(a), the Government and the physician shall forthwith meet and appoint counsel that is mutually agreeable to both parties. Should the parties be unable to agree on counsel that is satisfactory to both, then the Government shall unilaterally appoint counsel. The Government accepts full responsibility for the conduct of the action and the physician agrees to cooperate fully with appointed counsel.

ARTICLE 11 - GENERAL HOLIDAYS

11:01 In this Agreement, the following days shall be recognized as paid holidays:

New Year's Day	August Civic Holiday
Louis Riel Day	Labour Day
Good Friday	Thanksgiving Day
Easter Monday	Remembrance Day
Victoria Day	Christmas Day
Canada Day	Boxing Day

plus any other Statutory Holidays as declared by the Federal, Provincial or Local Government authority.

11:02 Where the exigencies of the service permit, a physician shall be entitled to close his or her office at one o'clock in the afternoon (1:00 p.m.) on December 24th when that day is a normal working day and that day shall be considered as a full working day for purposes of calculation.

11:03 Where any of the holidays fall on a Saturday or Sunday, the holiday shall be observed on the following Monday. Where holidays fall on both Saturday and Sunday, the holidays shall be observed on the following Monday and Tuesday.

11:04 If any physician is required to work on New Year's Day, Good Friday, Canada Day, Christmas Day, or Boxing Day, the physician shall receive pay at the rate of one and one-half (1.5) times the physician's regular salary rate for each hour worked to a maximum of seven and one-quarter (7.25 hours) on said holiday.

11:05 A physician who is required to work on a holiday as specified in sub-article 11:01 shall accumulate compensating time off at the rate of one (1) hour for each hour so worked, and such accumulated time may, at the physician's choice, be taken at such time as it runs consecutively with the physician's annual vacation period or at any other time convenient to the physician and approved by the physician's Director.

11:06 Physicians who are on days off or annual leave at the time that any of the above-mentioned holidays occur, shall receive a compensatory day off at a time mutually agreed between the physician and the physician's Director.

11:07 For any non-used accumulated compensatory time off existing at the time of a physician's termination of employment or retirement, as the case may be, the physician shall receive payment in lieu thereof at the physician's then current rate of pay as specified in sub-articles 32:01, 32:03, 32:04, 32:05 and 32:06.

ARTICLE 12 - WORKERS COMPENSATION

12:01 When a physician is in receipt of Workers Compensation allowance, the physician, if the physician so elects, shall be paid an additional amount which when combined with the compensation allowance shall insure the maintenance of the physician's gross salary. Such additional amount shall be chargeable to the physician's sick leave credits accrued at the time the physician commenced receipt of Workers Compensation allowances, and such additional payments shall be payable until the physician's accrued sick leave credits have been exhausted.

12:02 When a physician is absent due to sickness, injury or disability for which compensation is paid under The Workers Compensation Act, vacation leave shall accumulate as if the physician were not absent, but the extent of such accumulation shall not continue beyond twelve (12) consecutive calendar months from the date the sickness, injury or disability occurred.

ARTICLE 13 - TERM OF AGREEMENT

13:01 This Agreement shall become effective from and including April 1, 2011 and shall continue in effect up to and including March 31, 2015 and shall remain in force and effect from year to Year thereafter unless written notice to negotiate a renewal, or revision and renewal is given by either party at least forty-five (45) days prior to but not more than one-hundred and eighty (180) days prior to the expiry date hereof. During the period required to negotiate a renewal, or revision and renewal of this Agreement, this Agreement shall remain in full force and effect without change.

13:02 Where notice for revision of this Agreement is given under sub-article 13:01, the party giving notice agrees to give to the other their written proposals for the revision of the Agreement at least thirty (30) days prior to the expiry date of the Agreement. The parties shall, within twenty (20) working days following receipt of the specific proposals for revision to the Agreement, commence collective bargaining. These limits may be changed by mutual agreement between the parties hereto.

13:03 All additions, deletions, amendments and/or revisions from the previous Agreement shall be effective from April 1, 2011 unless otherwise specified.

ARTICLE 14 – DOCTORS MANITOBA SECURITY

14:01 The Government agrees to deduct the amount of annual dues and levies, as determined by Doctors Manitoba, on a bi-weekly basis, from salaries or wages of each and every physician covered by this Agreement whether a member of Doctors Manitoba or not.

14:02 The Government agrees that the aforesaid deductions shall continue during the life of this Agreement and after the expiry date thereof, during the entire period that any negotiations are proceeding with a view to concluding a new collective agreement.

14:03 Doctors Manitoba agrees to advise the Government of the amount of Doctors Manitoba annual dues or levies and all amounts deducted under sub-article 14:01 shall be forwarded by the Government to the Treasurer of Doctors Manitoba on on a bi-weekly basis. Such dues shall be forwarded to Doctors Manitoba together with a list of the names of the physicians for whom deductions have been made.

14:04 In consideration of the premises, and of the Government making the compulsory deduction of Doctors Manitoba dues or levies as herein provided, Doctors Manitoba agrees to, and does hereby indemnify and save the Government harmless from all

claims, demands and proceedings of any action and from all costs which might arise or be taken against the Government by reason of the Government making the compulsory check-off of Doctors Manitoba dues and levies provided for in this sub-article.

14:05 Doctors Manitoba shall notify the Government in writing of any changes in the amount of dues and levies at least two (2) months in advance of the end of the pay period in which the deductions are to be made.

14:06 Doctors Manitoba shall provide the Government with a list of officers and representatives of Doctors Manitoba and shall provide the Government with a revised list from time to time as occasion may require.

14:07 The amount of the dues or levies shall be certified to the Government over the signature of a responsible officer of Doctors Manitoba.

ARTICLE 15 – DOCTORS MANITOBA BUSINESS

15:01 Any grievor and his Doctors Manitoba representative who are on duty or who are due to come on duty during the course of any of the meetings hereinafter referred to, shall be allowed time off with pay to attend meetings with Government or its authorized designees, relating to processing of a grievance or grievances, in which the grievor or representative is involved, including arbitration hearings to which they are a party. Any physician subpoenaed as a witness to an arbitration shall be allowed time off with pay to attend such arbitration hearing.

15:02 The Government shall grant to a maximum of four (4) employee representatives serving on the Negotiation Committee of Doctors Manitoba time off with pay while meeting with representatives of the Government to negotiate a revised or new collective agreement. Such representatives shall not incur any loss of any benefits accrued to them under the terms of this collective agreement for such meetings.

15:03 A physician requiring time off to attend arbitration hearings or negotiation meetings on the physician's normal work day shall give notice to the Director in advance of the time the physician is required to be off for such purpose or purposes.

ARTICLE 16 - RELIEF DUTIES

16:01 A physician who is appointed to a senior position for a period of more than ten (10) consecutive working days shall be paid a salary equivalent to the bottom of the scale for the position for which he is relieving or the next increment level above the physician's own prevailing salary. This increased rate shall be paid retroactive to the first (1st) day of the assumption of the senior position.

16:02 Should a physician's increment date be reached during the course of the temporary employment referred to in sub-article 16:01, such physician shall be credited with said increment on the physician's increment date and the Government shall

thereafter pay not less than the higher increment level referred to in sub-article 16:01 as long as the temporary employment continues.

ARTICLE 17 - PART-TIME PHYSICIANS

17:01 **DEFINITION:** A part-time physician is one who is not employed full-time but who works on a regular schedule week by week, irrespective of the number of hours worked in each week.

17:02 Any part-time physician who works more than one day per week (7.25 hours) but less than full-time shall be paid pro rata salary and pro rata benefits as set out under the terms of this Agreement.

17:03 Any part-time physician who works one (1) day or less per week shall be paid sessional fees at a minimum of thirty dollars ($30.00) per hour for less than a half day session; eighty-five dollars ($85.00) per half day of work and one hundred and fifty dollars ($150.00) per full day of work, and shall not be entitled to any other benefits under this Agreement.

17:04 Any part-time physician who presently works under contract with the government or any part-time physician who in the future enters (in accordance with Article 31 – "Employment of Physicians") into a contract with the Government shall be governed by the terms of the said contract and shall not be entitled to any of the benefits of this Agreement except as may be specified in the said contract.

17:05 It is understood and agreed between Doctors Manitoba and the Government that any issue that may be raised as to the status of part-time physicians under contract shall be submitted to the Manitoba Labour Board for determination pursuant to Section 142(5) of The Labour Relations Act.

ARTICLE 18 - COMPASSIONATE OR BEREAVEMENT LEAVE

18:01 Compassionate or Bereavement Leave with pay in the amount of three (3) working days shall be granted to a physician in the event of the death of a parent, spouse, child, sibling, or a person permanently residing in the physician's household or with whom the physician permanently resides.

18:02 Compassionate or Bereavement Leave with pay of one (1) day shall be granted in the event of the death of an immediate relative not included in sub-article 18:01, including, without limiting the generality of the foregoing, parent-in-law, grandparent, grandchild, uncle or aunt, and such Compassionate or Bereavement Leave, at the discretion of the Employing Authority, may be extended up to three (3) working days with pay.

18:03 Compassionate or Bereavement Leave may be granted to a physician in respect of the death of any person not mentioned in sub-article 18:01 or 18:02 at the discretion of the Employing Authority.

18:04 The extension of the Compassionate or Bereavement Leave provided for under sub-articles 18:01 and 18:02 above up to a maximum of five (5) working days with pay may be granted by the Employing Authority where distant travel is required by the physician involved and such extension shall not be unreasonably withheld.

18:05 For other purposes, such as dangerous illness in the immediate family, a physician shall be entitled to leave with pay up to a maximum of five (5) days to be granted on the recommendation of the Employing Authority and charged against the employee's sick leave credits.

18:06 For purposes of the administration of sub-article 18:05 and Article 6 - Sick Leave, the parties hereto agree as follows:

(a) any leave which may be granted to a physician under sub-article 18:05 shall be deducted from the physician's sick leave credits in the following sequence:

(i) sick leave credits accumulated in previous years;

(ii) subject to sub-article 18:06(b), sick leave credits accumulated in the current year.

(b) a physician's sick leave accumulation shall not be reduced to less than twelve (12) days per year as a result of the application of sub-article 18:05.

ARTICLE 19 - VACATION

19:01 For the purposes of this Agreement, a vacation year is the period beginning on the first (1st) day of April and ending on the thirty-first (31st) day of March the following year.

19:02 A physician who has completed less than one (1) year's continuous employment as of April lst, in any year, shall be granted a vacation with pay pro-rated for the complete months worked. Such physician may, on request, also receive sufficient leave of absence without pay to complete any partial week of vacation.

19:03 Physicians shall earn vacation leave credits during each vacation year on the following basis:

(a) physicians who have completed less than two (2) calendar years of service shall earn vacation credits at the rate of a maximum of fifteen (15) credits for 1885 hours of accumulated service to be taken in the vacation year following the vacation year in which the vacation is earned;

(b) commencing from the beginning of the vacation year in which two (2) calendar years of service shall be completed physicians shall earn vacation credits at the rate of a maximum of twenty (20) credits for 1885 hours of accumulated

service to be taken in the vacation year in which three (3) calendar years of service are completed and yearly thereafter;

(c) commencing from the beginning of the vacation year in which nine (9) calendar years of service shall be completed physicians shall earn vacation credits at the rate of a maximum of twenty-five (25) credits for 1,885 hours of accumulated service to be taken in the vacation year in which ten (10) calendar years of service are completed and yearly thereafter;

(d) commencing from the beginning of the vacation year in which nineteen (19) calendar years of service shall be completed physicians shall earn vacation credits at the rate of a maximum of thirty (30) credits for 1,885 hours of accumulated service to be taken in the vacation year in which twenty (20) calendar years of service are completed and yearly thereafter; and

(e) under no circumstance can a physician earn more than the maximum vacation credits in any vacation year (i.e. 15, 20, 25 or 30 vacation credits per vacation year).

19:04 (a) All requests for earned vacation leave shall be submitted for scheduling and approval by the Employing Authority. If the physician is subsequently unable to take his earned vacation at the approved scheduled time because of a specific request in writing from the Medical Director or Chief Medical Officer, Public Health, then every effort shall be made by the physician and the Medical Director or Chief Medical Officer, Public Health, to reschedule the vacation prior to the end of the vacation year. If the physician and the Director are unable to reschedule the vacation prior to the end of the vacation year, then the physician may elect to carry over his or her earned vacation entitlement to the next vacation year or, at the physician's option, receive payment in lieu of such vacation entitlement. Under no circumstances may a physician elect to carry more than one (1) year's earned vacation entitlement into the next vacation year.

(b) Subject to the requirements of the service, vacation leave scheduling for physicians covered by this Agreement shall be rotated regardless of seniority of service.

19:05 (a) A physician shall accumulate vacation credits from the date of commencement of employment.

(b) Subject to sub-articles 19:04(a) and 19:05(b) vacation leave shall be taken in the year in which it is earned. However, with the approval of the Employing Authority vacation that has been earned in a vacation year may be taken in that vacation year.

(c) Under no circumstance shall vacation leave be taken in advance of when it was earned.

19:06 Where a physician dies or leaves the service, he or his estate shall receive pay at the physician's then current rate of pay for the accumulated, unused vacation leave. The current rate of pay shall include the amounts specified in sub-articles 32:01, 32:03, 32:04, 32:05 and 32:06.

ARTICLE 20 - LEAVE OF ABSENCE

20:01 A physician shall be required to submit a written request for any leave of absence referred to in this Agreement unless otherwise herein stipulated. These requests shall specify the reason for the leave and shall be considered on an individual basis, and may be allowed at the discretion of the Employing Authority. Unless otherwise indicated in the Agreement, except in emergencies, such requests must be made at least four (4) weeks in advance.

20:02 Physicians granted leave of absence with pay shall retain their seniority and benefits and shall continue to accrue the same during the said leave of absence.

20:03 Physicians granted leave of absence without pay shall retain their seniority and benefits but further seniority and benefits shall not accrue during the said leave of absence.

ARTICLE 21 - NEW CLASSIFICATIONS

21:01 The Government and Doctors Manitoba agree that if a dispute should arise between them as to whether or not any physician is a member of the bargaining unit by reason of the definition of the word “employee” as it is used in The Labour Relations Act, then either of the parties hereto may submit the dispute to the Manitoba Labour Board for its ruling on such issue pursuant to Section 142(5) of the said Act.

21:02 If the Manitoba Labour Board rules that any such physician is an “employee” within the meaning of the said Act, then the Government agrees with Doctors Manitoba that it shall meet forthwith with representatives of Doctors Manitoba to negotiate the classification and the salary schedule of such classification for inclusion in this Agreement, and if the Government and Doctors Manitoba are unable to reach agreement on such classification and salary schedule, or either of them, then only the following issues regarding the matter may be submitted by either party to arbitration for final settlement, namely:

(a) the determination of an appropriate classification based on an assessment of the duties and responsibilities of the new or revised position established by the Government based on a comparison with the duties and responsibilities of existing position classifications; and

(b) the determination of the salary range of the new position which shall relate equitably to the salary ranges paid for existing position classifications based

on a comparison of the relative value of the duties and responsibilities of the new or revised position.

21:03 (a) Where the Government wishes to establish a new classification not contained within the Agreement, the Government shall submit to Doctors Manitoba written notice of the proposed new classification together with a description of the duties of such classification and the proposed wage rate. The Government and Doctors Manitoba shall meet for the purpose of discussing the duties and negotiating the rate of pay for such classification.

(b) Any concerns on duties may, within fifteen (15) days of notice being given in sub-article 21:03(a), be submitted in writing by a physician to the Joint Committee established under Article 29 of this Agreement. If the Joint Committee fails to resolve the concerns within forty-five (45) days of notice being given under sub-article 21:03(a), the determination of duties by the Government shall prevail.

(c) If the parties are unable to reach agreement on a salary schedule for such classification within forty-five (45) days of the Government submitting the new proposed classification to Doctors Manitoba, then such dispute on the salary schedule may be submitted by either party to an Arbitration Board established under Article 24 of this Agreement. The decision of the Arbitration Board shall be final and binding on all parties. Until such time as the parties agree or an Arbitration Board decides the issue, no physician shall work in the new classification proposed by the Government.

ARTICLE 22 - MEDICAL FITNESS

22:01 A physical examination by a duly qualified medical practitioner designated by or acceptable to the Employing Authority may be required prior to initial appointment to any position covered by this Agreement.

22:02 The Employing Authority may require a physician to have a physical examination or a psychiatric examination or both. The physical examination must be performed by a duly qualified medical practitioner and the psychiatric examination must be performed by a duly qualified specialist in psychiatry. Such examining physicians shall be designated by or acceptable to the Employing Authority.

22:03 A physician who has been examined pursuant to sub-article 22:01 or 22:02 shall, if the physician requests same in writing, receive within twenty (20) days following the date of the examination a copy of the written opinion that was submitted to the Employing Authority.

22:04 If a physician questions the accuracy and/or disagrees with the written opinion, the physician may request that a second (2^{nd}) medical opinion be obtained and such request shall be granted by the Government. The second (2^{nd}) examination shall be conducted by a duly qualified medical practitioner or psychiatric specialist, as the case may be, as selected by the College of Physicians and Surgeons of Manitoba.

The physician being examined shall receive a copy of the second (2nd) opinion within twenty (20) days following the date of the examination.

22:05 Unless the physician otherwise agrees, the medical opinion shall be submitted only to the party requesting the opinion and such opinion shall remain confidential.

22:06 A duly qualified medical practitioner giving a physical examination or a duly qualified specialist in psychiatry giving a psychiatric examination shall complete the forms required by the regulations.

22:07 The cost of the physical or psychiatric examination or examinations or reports given or made pursuant to sub-article 22:01 or 22:02 shall be borne in their entirety by the Government and those given or made pursuant to sub-article 22:04 shall be borne by the physician.

ARTICLE 23 - PERSONAL EFFECTS

23:01 Where a physician who is covered by this Agreement and who, during the course of the physician's employment, because of the action of an inmate, patient, visitor or member of the public, suffers damage to, or loss of, eye-glasses, false teeth, a watch or other personal effects and/or professional instruments usually carried with or worn by the physician in the performance of the physician's duties, including clothing, the department in which the physician is employed shall reimburse the physician at full replacement cost provided that the item that is lost or damaged beyond repair has been purchased within three (3) months of the incident and proof of purchase is submitted. In other cases, reimbursement shall be at seventy-five percent (75%) of the replacement cost.

23:02 All incidents of loss of, or damage to, personal effects as mentioned in sub-article 23:01 shall be reported in writing by the physician whose personal effects are lost or damaged, or by someone else on the physician's behalf, to the administrator within two (2) normal working days of the incident or the discovery thereof.

23:03 Each incident respecting loss of, or damage to, personal effects as mentioned in sub-article 23:01 shall be assessed separately and the administrator shall recommend the amount of compensation that should, in his opinion, be paid in respect of each incident.

ARTICLE 24 - GRIEVANCE PROCEDURE

24:01 **PURPOSE:** The purpose of this Article is to establish procedures for discussing, processing, and settling of grievances as defined in this Article.

24:02 **DEFINITION:** The word “grievance” used throughout this Article shall mean a complaint involving wages, hours of work, terms or conditions of employment, or any other working conditions of a physician, and shall include, without restricting the

generality of the foregoing any difference between the parties with regard to meaning, application or alleged violation of this Agreement, or any part thereof. It is understood and agreed by both parties hereto that any alleged violation of the express terms of the Agreement or any dispute as to the meaning or application of the express terms of the Agreement may be arbitrable and the Arbitration Board shall have the power to decide whether any such issue is arbitrable or not but the Arbitration Board shall not have the power to alter, amend or modify the express terms of this Agreement.

24:03 **PROCEDURE:** Any physician who believes he or she has a grievance or that he or she has been unjustly treated and alleges a violation or misinterpretation or misapplication of an Article under The Civil Service Act or this Agreement or a violation or misapplication of an approved policy respecting conditions of employment, shall submit the grievance in writing and the grievance shall be dealt with as follows:

(a) **Step 1**

Within fifteen (15) working days from the time of the alleged grievance the physician, Doctors Manitoba representative, or both, shall discuss the matter with the physician's immediate supervisor with a view to resolving the issue. The supervisor shall issue a decision at this level in writing and shall forward such decision to the physician and Doctors Manitoba within five (5) working days.

(b) **Step 2**

If no settlement is reached within the time limit specified in Step 1, the physician, Doctors Manitoba representative, or both, shall, within five (5) working days of receipt of the decision in Step 1, or if no decision is received within the time limit specified, arrange a meeting with the appropriate Medical Director, Chief Medical Consultant or the Assistant Deputy Minister. Such meeting shall be within five (5) working days. The decision at this level shall be made in writing and forwarded to the physician and Doctors Manitoba within ten (10) working days of the meeting.

(c) **Step 3**

If no settlement is reached within the time limit specified in Step 2, the grievance may be submitted in writing to the Deputy Minister or his designate within ten (10) working days of receipt of the decision in Step 2 or, if no decision is received, upon the termination of the specified time limit. The Deputy Minister or his designate shall issue his decision in writing to the physician and Doctors Manitoba within fifteen (15) working days following receipt of the grievance.

24:04 **ARBITRATION:** Failing satisfactory settlement of a grievance pursuant to the procedure outlined above, then the controversy may at any time within ten (10) working days thereafter be referred by either party to a Board of Arbitration to be

composed of one (1) nominee appointed by the Government and one (1) by Doctors Manitoba, such appointments to be made within ten (10) calendar days of such referral. The two (2) nominees so appointed shall, within fourteen (14) calendar days of the nomination of the last of them select a third (3rd) member who shall be the Chairman. If one of the parties fails or neglects to appoint a nominee within the time limits above set forth, then the other party may apply to the Chief Justice of the Province of Manitoba, or in his absence the Chief Justice of the Court of Queen's Bench, to appoint such nominee. A decision of the majority of the Board of Arbitration shall be final and binding on both parties hereto.

(a) Should the two (2) appointed arbitrators fail to agree upon a Chairman within the time limit herein provided, then the two (2) arbitrators shall forthwith apply to the Chief Justice of the Province of Manitoba, or in his absence the Chief Justice of the Court of Queen's Bench, to select a Chairman.

(b) Each party shall be responsible for the costs and expenses of its appointee, and the costs and expenses of the Chairman of the Arbitration Board shall be shared equally between the Government and Doctors Manitoba.

(c) In the case of a grievance involving an alleged unjust lay-off, suspension or discharge, the Arbitration Board may reinstate the physician with full compensation for time lost on the basis of the regular hours of work or may make such other award as may be deemed just and equitable.

(d) If the decision of the Arbitration Board is to reinstate any physician, the Arbitration Board shall deduct any wages earned through other employment since the lay-off, suspension or discharge in question, from the award, if any.

24:05 **POLICY GRIEVANCES:** In addition to the foregoing, Doctors Manitoba may process a grievance of a general nature (called a “policy grievance”) with respect to any matter of dispute which affects any physician employed by the Government and represented by Doctors Manitoba, and any such policy grievance may be instituted at Step 2 of the grievance procedure hereinbefore set forth.

24:06 **TIME LIMITS:** The time limits as stated herein may be extended by mutual agreement in writing of the Employing Authority and Doctors Manitoba.

ARTICLE 25 - RESIGNATION

25:01 Any physician who is voluntarily terminating employment with the Government shall give a written Notice of Termination to the Government at least four (4) weeks before the date on which the physician's termination is to be effective and the Civil Service Commission may authorize the Employing Authority, in lieu of retaining the physician in employment for the four (4) week period after Notice of Termination, to pay the physician an amount equal to the amount of wages or salary that the physician would have earned had the physician worked during the course of the four (4) week period.

ARTICLE 26 - HOURS OF WORK

26:01 It is understood and agreed that except as hereinafter expressly provided, the work week shall be thirty-six and one-quarter (36.25) hours.

26:02 It is understood and agreed that the work day or normal shift of work shall consist of seven and one-quarter (7.25) hours.

ARTICLE 27 - OVERTIME

27:01 Overtime shall be authorized in such manner and by persons in such positions as the Government may designate, and Doctors Manitoba shall be notified in writing by the Government from time to time of the positions designated by the Government as having authority to authorize overtime and time off in lieu of payment therefore. The notification to Doctors Manitoba shall be in writing and shall be within thirty (30) days of the ratification of this Agreement. Doctors Manitoba shall be notified in writing of any subsequent changes within thirty (30) days of such change.

27:02 Overtime shall be deemed to mean time required of the physician to be spent on any “special assignment” as designated by the authorized person as hereinbefore set forth, and it is understood and agreed that “special assignment” does not include regular recurring work other than work due to special circumstances required to be done outside of the normal hours of the physician's work.

27:03 In lieu of payment for authorized overtime a physician shall receive time off work equivalent to the time spent in providing overtime services as hereinbefore set forth.

27:04 When overtime has been authorized in accordance with sub-articles 27:01 and 27:02 a physician shall be credited with a minimum of one (1) hour's overtime when the physician is called out or scheduled to work overtime provided that the period of overtime worked by the physician is not contiguous to his scheduled working hours.

ARTICLE 28 - CONTINUING MEDICAL EDUCATION

28:01 The Government and Doctors Manitoba mutually recognize the desirability of having all physicians covered by this agreement able to maintain a high level of knowledge of developments and advances in their particular field of medicine and as a consequence thereof the Government agrees to budget such amount in each year as may be practicable. The Minister shall consider the guidelines recommended by the particular Medical Director involved and is prepared to receive recommendations from Doctors Manitoba or from any physician in this regard to enable continuing medical education of the physicians employed whether by leave of absence, attendance at training programs and seminars or medical conventions.

28:02 The physician shall be entitled to up to eight (8) working days leave of absence with pay per fiscal year for the purpose of attending seminars or courses.

28:03 The physician shall be entitled to attend seminars or courses provided no more than twenty percent (20%) of the normal staffing requirement of the institution in question is absent during the relevant period.

28:04 For physicians not employed within an institution, the department shall grant the leave requested provided operational requirements permit.

28:05 Doctors Manitoba shall be responsible to resolve any disputes as to which physician(s) can take leave when the requests for leave would involve more than twenty percent (20%) of the normal staffing requirement of the institution in question being absent for any reason during the relevant period.

28:06 The seminars or courses must fall within the field of practice of the physician.

28:07 A physician shall not be entitled to bank any of the eight (8) working days leave of absence not used in a particular fiscal year.

28:08 Reimbursement of the whole or part of the cost for any such courses or seminars is to be in the sole discretion of the Government.

28:09 A physician should endeavour to give as much notice as possible of his desire and intention to attend a particular course or seminar. A minimum of one (1) week's notice shall be required. Where a physician wishes to request that the Government consider payment of the whole or part of the cost for any such courses or seminars, a minimum of four (4) week's notice shall be required.

ARTICLE 29 - JOINT COMMITTEE

29:01 The Government and Doctors Manitoba shall forthwith establish a Joint Committee which shall consist of six (6) members, with three (3) being selected by each party. The Joint Committee shall discuss matters of concern to either party, and without limiting the generality of the foregoing, deal specifically with proposals to be made by Doctors Manitoba in reference to pension plans, superannuation and plans of insurance covering physicians within the bargaining unit dealt with by this Agreement, and with other methods of determining classifications of physicians and pay scales to be applied in respect thereto and any other matter which may be raised by either party to this Agreement. A physician serving on the Joint Committee shall suffer no reduction of pay.

29:02 The Joint Committee shall meet not less often than once every four (4) months, unless otherwise mutually agreed upon, to consider matters of concern to either party as specified under sub-article 29:01.

ARTICLE 30 - STAND-BY OR ON-CALL DUTY

30:01 In addition to the compensation payable under this Agreement, a physician who is required to provide stand-by or on-call coverage for a twenty-four (24) hour period

shall be paid by the Employer in accordance with the specialist on-call rate denoted in the Master Agreement dated September 2, 2011 between the Government and Doctors Manitoba.

30:02 Any physician required to be on stand-by or on-call as set forth above for a lesser period of time than set out in sub-article 30:01 shall be paid on a pro rata basis.

ARTICLE 31 - RECRUITMENT AND APPOINTMENT

31:01 Subject to Section 14 of the Civil Service Act, vacant or new positions in the bargaining unit shall be filled in accordance with the following:

(a) whenever possible and in the public interest, by promotion within the civil service; and

(b) when in the public interest, by recruiting from without the civil service.

31:02 Notwithstanding sub-article 31:01, first consideration for filling vacancies or new positions shall be given to physicians on the re-employment list.

31:03 Where a vacant or new position is to be filled through competition, a bulletin shall be posted for a minimum of ten (10) calendar days.

31:04 The bulletin shall state the closing date for applications, the location of the position, the classification, the duties and responsibilities of the position, the qualifications required and the salary range. Doctors Manitoba shall be provided with a copy of all bulletins as they are issued.

31:05 The selection of physicians for vacant or new positions shall be on the basis of qualifications, ability, prior work performance and seniority. Where the above factors are relatively equal, seniority shall be the determining factor.

31:06 Where a physician is moved from one (1) department to another, or within a department, the Civil Service Commission shall inform the departments or the department concerned of the move. The department from which the physician is moved, or within which the physician is moved, shall release the physician from the position within thirty (30) days of being so informed, or within one (1) week of obtaining a replacement for the physician, whichever is the earlier.

31:07 A physician who is notified that he or she is an unsuccessful applicant for a vacant position shall be supplied with the reasons for non-acceptance within ten (10) days of making a written request to the Civil Service Commission. Such a request shall be made within ten (10) days of receipt of the notification that the physician was an unsuccessful applicant.

31:08 A regular physician may apply for and be appointed to a term position as a regular physician provided that the department has developed an employment plan which

shall return the physician to the physician's regular position or an acceptable alternate position.

ARTICLE 32 - SALARIES

32:01 Salaries payable to the subject physician shall be as shown in Schedule "A" which is attached hereto and which forms part of this Agreement.

32:02 (a) Physicians are eligible for annual merit increments within the pay range for physician's classification. An increment may be granted in recognition of satisfactory service on the physician's anniversary date which is the first (1st) of the following dates that falls on or after the date the physician is employed:

(i) the first (1st) day of January bi-weekly pay period;

(ii) the first (1st) day of April bi-weekly pay period;

(iii) the first (1st) day of July bi-weekly pay period; or

(iv) the first (1st) day of October bi-weekly pay period.

(b) Should a physician not be granted an increment as mentioned in sub-article 32:02(a), the Employing Authority shall advise the physician in writing why the increment was not granted.

(c) Should the physician not be granted an increment in recognition of satisfactory service as mentioned in sub-article 32:02(a), the physician shall have the right to resort to the grievance procedure.

(d) When an increment is not granted to a physician as mentioned in sub-article 32:02(a), the increment may be granted to the physician on the first (1st) day of the next or any subsequent quarter of the year following the date when the reason for not granting the increment ceases to exist.

(e) Where a physician is not granted an increment in sub-article 32:02(a), the physician may be eligible for an increment on any subsequent anniversary date notwithstanding that the physician was granted an increment under sub-article 32:02(d).

32:03 Any physician falling within the classification of Medical Officer 3 who has a certification or fellowship recognized by the Royal College of Physicians and Surgeons of Canada and/or is recognized as a specialist by the College of Physicians and Surgeons of Manitoba shall be paid an additional salary as set out in Schedule "B" hereto which salary shall be in addition to the salary as set out in Schedule "A" hereto.

32:04 It is understood and agreed that any physician who has earned specialist qualifications to diploma level and who possesses such a diploma in Psychiatry,

Public Health, Laboratory Medicine or Radiology qualifying the physician to work in that specialty in the area in which he is employed shall be paid an additional salary as set out in Schedule “B” hereto which salary shall be in addition to the salary as set out in Schedule “A” hereto.

32:05 It is understood and agreed that any physician who has earned specialist qualifications to Masters or Doctorate level and possesses a Master of Science or Doctor of Philosophy in Community Health Sciences, Master of Public Health or equivalent as recognized by Manitoba Health qualifying the physician to work in the area in which he is employed shall be paid an additional salary as set out in Schedule “B” hereto which salary shall be in addition to the salary as set out in Schedule “A” hereto.

32:06 It is understood and agreed, that any physician who provides evidence from the Royal College of Physicians and Surgeons of Canada that the physician possesses the qualifications, training and experience which make the physician eligible to sit the certification examinations of the Royal College of Physicians and Surgeons of Canada, shall at a minimum be classified as Medical Officer 3 in the area of Psychiatry, Public Health, Laboratory Medicine, or Radiology dependent upon the speciality in which the physician is employed shall be paid an additional salary as set out in Schedule “B” hereto which salary shall be in addition to the salary as set out in Schedule “A” hereto.

32:07 All payments for diploma, Masters, Doctorate eligibility and certification are non-cumulative.

32:08 When a physician is promoted to another position, the physician shall be paid at a rate of pay set out for that position in Schedule “A” that is one (1) increment more than the rate of pay the physician was being paid in the physician's former position.

32:09 The official rate of pay, for information purposes only is the bi-weekly rate of pay as provided in the Salary Schedule.

ARTICLE 33 - SEVERANCE PAY

33:01 Physicians with nine (9) or more years of accumulated service whose services are terminated as a result of retirement in accordance with the provisions of The Civil Service Superannuation Act, or death, shall be entitled to be paid severance pay in the amount of one (1) week’s pay for each complete year of accumulated service or portion thereof, but the total amount of severance pay shall not exceed fifteen (15) weeks’ pay. Example: 10 years, 8 months of accumulated service equals 10.67 years of accumulated service for purposes of calculation. The rate of pay referred to in this Article shall be the last rate of pay in effect for the physician at the time of retirement or death and shall include those amounts specified in sub-articles 32:01, 32:03, 32:04, 32:05 and 32.06.

33:02 Where a physician in his ninth (9^{th}) year of accumulated service fails to complete nine (9) years’ accumulated service as a result of retirement in accordance with the

provisions of The Civil Service Superannuation Act, or death, the physician shall be paid or his estate shall be paid in the event of his death severance pay on the basis of nine (9) weeks' pay multiplied by the portion of one (1) year of accumulated service which the employee has acquired in the employee's ninth (9^{th}) year of accumulated service.

33:03 Physicians with three (3) or more years of accumulated service whose services are terminated as a result of permanent lay-off shall be paid severance pay in the amount of one (1) week's pay for each complete year of accumulated service or portion thereof, but the total amount of severance pay shall not exceed twenty-two (22) weeks' pay.

33:04 Where a physician in his third (3^{rd}) year of accumulated service fails to complete three (3) years accumulated service as a result of permanent lay-off, the physician shall be paid severance pay on the basis of three (3) weeks' pay multiplied by the portion of one (1) year of accumulated service which the physician has acquired in the physician's third (3^{rd}) year of accumulated service.

33:05 The payment under sub-article 33:01 shall not be subject to superannuation deductions.

33:06 A physician who accepts a position with a District Health Board established pursuant to The District Health and Social Services Act with no loss in existing benefits shall not be eligible for severance pay.

ARTICLE 34 - REMOTENESS ALLOWANCE

34:01 The Government shall provide remoteness allowances to physicians in accordance with the current agreement between the M.G.E.U. and the Government and any revisions subsequently negotiated between the M.G.E.U. and the Government.

ARTICLE 35 - TRANSPORTATION AND ALLOWANCES

35:01 The Government shall provide travelling and related expenses to physicians in accordance with the current agreement between the M.G.E.U. and the Government and any revisions subsequently negotiated between the M.G.E.U. and the Government.

ARTICLE 36 - PHYSICIAN PERFORMANCE REVIEW AND PHYSICIAN FILES

36:01 When a formal assessment of a physician's performance is made, the physician concerned shall be given an opportunity to sign the assessment form in question upon its completion for the sole purpose of indicating that its contents have been read. The physician shall have the right to place his own comments in a space provided on the form or as an attachment to which reference is made on the form prior to his signing. Immediately upon the physician signing the assessment form,

the physician shall be provided with a true copy if requested for the physician's own record.

36:02 The Government agrees not to introduce as evidence in a hearing any document from the file of a physician, the content of which the physician was not aware at the time of filing or within a reasonable period thereafter.

36:03 When an unsatisfactory report is to be placed on a physician's file, the physician concerned shall be given an opportunity to sign the report in question for the sole purpose of indicating that its contents have been read. The physician shall have the right to place the physician's own comments in a space provided in the form as an attachment to which reference is made on the form prior to the physician's signing. Immediately upon signing the report, the physician shall be provided with a true copy for the physician's own record, if requested.

36:04 Any notice of disciplinary action which may have been placed on the personal file of a physician shall be removed from the file and destroyed after eighteen (18) months has elapsed since the disciplinary action was taken provided that no further disciplinary action has been recorded during this period.

36:05 Upon written request to the Deputy Minister concerned or his designate, a physician shall have the right to examine, along with a representative of the physician's choice, the file referred to in sub-article 36:06 and upon request shall receive a true copy of any document in the said file.

36:06 The Government agrees that there shall be a complete file kept or used by the Government for each physician.

ARTICLE 37 - GENERAL

37:01 Where operational requirements permit, a physician shall be given forty-five (45) days notice of a major revision to existing duties within the physician's existing classification.

ARTICLE 38 - CHANGE OF WORK HEADQUARTERS

38:01 Where, as a result of a reorganization of a Department or part of a Department a physician's work headquarters is moved from one city or town to another city or town requiring a change of residence by the physician, the physician shall be given notice of the move ninety (90) days in advance of the date upon which the move of the physician is to be effected. Such notice shall be provided in writing to the physician by the Employing Authority.

38:02 Where a physician has accepted relocation involving a change in residence by the physician, the physician shall be reimbursed for expenses incurred due to the

relocation in accordance with existing policy respecting “Expenses of Removal on Transfer”.

38:03 Where such notice has been given to a physician and the physician is unable to relocate, every reasonable effort shall be made to place the physician in another suitable position within the Civil Service.

38:04 Where a physician with more than six (6) years of continuous service is unable to relocate, he shall be subject to lay-off. If the physician has not been offered another suitable position within one (1) year from the date of lay-off he shall be permanently laid-off and shall be eligible for severance pay in accordance with Article 33 - Severance Pay.

38:05 For purposes of interpretation of this Article, where the term “suitable position” is used it means a position which the physician is reasonably qualified for and able to perform and which position is in a location that would not require a change of residence by the physician.

ARTICLE 39 - DENTAL PLAN

39:01 The parties agree to the continuation of the Dental Plan. The contents of the plan shall be consistent with the provisions of the plan which has been negotiated by the Manitoba Government and General Employees’ Union and the Government of Manitoba.

ARTICLE 40 - LONG TERM DISABILITY PLAN (L.T.D.)

40:01 The current Long Term Disability Plan as is applicable to the Manitoba Government Employees' Union - Government Employees' Master Agreement shall be maintained for government employed physicians subject to a maximum cost of one percent (1%) of payroll funded by the Government.

ARTICLE 41 - VISION CARE PLAN

41:01 The parties agree to the continuation of the Vision Care Plan. The contents of the plan shall be consistent with the provisions of the plan which has been negotiated by the Manitoba Government and General Employees’ Union and the Government of Manitoba.

ARTICLE 42 - PRESCRIPTION DRUG PLAN

42:01 The parties agree to the continuation of the Prescription Drug Plan. The contents of the plan shall be consistent with the provisions of the plan which has been negotiated by the Manitoba Government and General Employees’ Union and the Government of Manitoba.

ARTICLE 43 - AMBULANCE AND HOSPITAL SEMI-PRIVATE PLAN

43:01 The parties agree to the continuation of the Ambulance and Hospital Semi-Private Plan. The contents of the plan shall be consistent with the provisions of the plan which has been negotiated by the Manitoba Government and General Employees' Union and the Government of Manitoba.

ARTICLE 44 - CANADIAN MEDICAL PROTECTIVE ASSOCIATION (CMPA) COVERAGE

44:01 Physicians shall be eligible for Canadian Medical Protective Association (CMPA) reimbursement in accordance with the Master Agreement dated September 2, 2011 between Doctors Manitoba and the Province of Manitoba.

ARTICLE 45 - LAY-OFF

45:01 Subject to consideration of respective merits, abilities, and records of performance of the physicians concerned, in determining the order of laying off physicians, consideration shall be given to classification and service seniority of the physicians in the classification from which physicians are being laid off.

45:02 An Employing Authority laying off a regular physician shall give the physician four (4) weeks' written notice, or in the absence of such notice to the physician, payment in place of notice, but where a physician is being laid off at the end of a specific term of employment or after the completion of a specific job for which he or she was employed, no notice of lay-off is required.

45:03 A term physician who is laid off before the end of a term of employment or completion of a job for which he or she was employed shall be given the following notice:

(a) where the physician has completed less than one (1) year of continuous service, the physician shall be given two (2) weeks' written notice before the lay-off date or payment in place of notice;

(b) where the physician has completed one (1) or more years of continuous service, the physician shall be given four (4) weeks' written notice before the lay-off date or payment in place of notice.

45:04 A term physician who has been employed in the same position for one (1) or more years of continuous service and whose term expires or who is laid off before the end of a term of employment or completion of a job may be placed on an employment availability list by the department for one (1) year, during which the physician is to be considered for re-employment to the position if it is to be refilled.

45:05 Where a physician alleges that his or her lay-off has not been in accordance with this Agreement, the grievance procedure set out in this agreement shall apply except that the grievance shall be initiated in the second (2^{nd}) step of the procedure.

45:06 Physicians who are laid off shall be placed on a re-employment or other list which shall be maintained by the Government for a period of twenty-four (24) months from the effective date of the lay-off and shall be called back in the reverse order of lay-off for the classification from which the physician was laid off.

ARTICLE 46 - TERM PHYSICIANS

46:01 **"Term physician"** means a physician hired for a specific term of employment. The term of employment may be based on a specific period of time or the completion of a specific job or until the occurrence of a specified event.

46:02 Where the employment of a term physician terminates at the end of a specific term of employment, then:

(a) the Employing Authority shall not be required to give any notice or payment in lieu thereof; and

(b) the physician shall not be required to give any notice of resignation.

46:03 Where a term physician is laid off, then the following shall apply:

(a) if the lay-off is at the end of a specific term of employment, no notice of lay-off is required; and

(b) if the lay-off is prior to the end of a specific term of employment, a physician shall receive written notice prior to the lay-off or granted payment in lieu thereof based on the following:

(i) four (4) weeks' notice to a physician with one (1) or more years of seniority; or

(ii) two (2) weeks' notice to a physician with less than one (1) year of full-time seniority.

46:04 Where a term physician is employed in the same position performing the same function for a period of more than twenty-four (24) continuous months and where the need for the position is expected to continue, the department shall convert the physician to regular civil service status.

46:05 A physician appointed to a term position shall be informed in writing as to the duration of the term. Where the term relates to the reasons set out in sub-article 46:07, the physician shall be so informed. Failure to comply with the foregoing shall not in itself negate the physician's status as a term physician.

46:06 Where the physician is not to be converted in accordance with sub-article 46:04, the physician shall be notified in writing of the reasons prior to the completion of twenty-four (24) continuous months of service. Inadvertent failure to provide such notice

shall not result in a right to conversion if the other conditions in sub-article 46:04 are not met. A meeting may be held with the physician to discuss the matter. The physician has the option to have a Doctors Manitoba representative present.

46:07 Sub-article 46:06 does not apply:

(a) where a term physician is replacing a physician who is absent for any reason; or

(b) to a term physician whose salary is cost shared under a Federal-Provincial cost sharing agreement which requires, as a condition of cost sharing, that physicians are not regular (permanent) physicians.

ARTICLE 47 – INTEREST AND RETROACTIVITY

47:01 Unless otherwise agreed to in writing by the parties:

(a) Where the parties have agreed upon any increase or revision of the wage rates within the Agreement, and which gives rise to retroactive pay, the Government shall pay to physicians interest on retroactive pay calculated from the effective date of such change to the date of actual payment**;** or

(b) Where any such change as referred to in sub-article 47:01(a) occurs as the result of an award or decision of a board of arbitration, the Government shall pay to physicians interest on the retroactive pay calculated from the date the interest arbitration agreement is entered into until the date of actual payment.

47:02 The rate of interest payable is:

(a) For the period January 1 to June 30 in each year, the prime lending rate of the Bank of Canada minus two percent (-2%) as that rate stood on January 1 of that year**;** and

(b) For the period July 1 to December 31 in each year, the prime lending rate of the Bank of Canada minus two percent (-2%) as that rate stood on July 1 of that year.

Compounded annually.

ARTICLE 48 – RATIFICATION

48:01 This Agreement shall be final and binding upon communication by Doctors Manitoba of acceptance to Manitoba.

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

HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF MANITOBA,

Per. *Original signed by The Honourable Stan Struthers*
Minister Responsible for
the Civil Service Act

Per. *Original signed by Rick Stevenson*
Richard Stevenson
Assistant Deputy Minister of
Labour Relations,
Treasury Board Secretariat

DOCTORS MANITOBA

Per. *Original signed by Robert Cram*
Robert D. Cram
Acting Chief Executive Officer

MEMORANDUM OF AGREEMENT

SUBJECT: PRESCRIPTION DRUG PLAN

1. The Government agrees to maintain a Prescription Drug Care Plan as follows:

   (a) eligibility requirements for physicians and dependents shall be the same as the Dental Services Plan;

   (b) co-insurance be based on eighty percent (80%) reimbursement; and

   (c) the maximum payment per contract (family) is five hundred dollars ($500) per year.

2. Other terms and conditions of the Prescription Drug Care Plan shall be similar to those currently in effect for the drug coverage provisions of the existing physician-paid Extended Health Benefit (EHB) Plan.

Original signed by Robert Cram	*Original signed by Rick Stevenson*
On behalf of the Government Employed Doctors	On behalf of the Government of Manitoba
Original signed by Allison Crolly	*Original signed by Jennifer Scott*
Witness	Witness

September 2, 2011
Date

SCHEDULE "A"

Salary Schedule

Effective From April 1, 2011 through March 31, 2012

Winnipeg		Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
Medical Officer 1	Annual	$157,830.00	$161,348.00	$164,884.00	$168,402.00	$171,939.00	$175,457.00
MF 1	Biweekly	$6,050.13	$6,184.98	$6,320.55	$6,455.40	$6,590.98	$6,725.83
	Hourly	$83.45	$85.31	$87.18	$89.04	$90.91	$92.77
Medical Officer 2	Annual	$175,457.00	$178,993.00	$182,511.00	$186,048.00	$189,566.00	$193,102.00
MF 2	Biweekly	$6,725.83	$6,861.40	$6,996.25	$7,131.83	$7,266.68	$7,402.25
	Hourly	$92.77	$94.64	$96.50	$98.37	$100.23	$102.10
Medical Officer 3	Annual	$204,885.00	$208,403.00	$211,921.00	$215,458.00	$218,976.00	$222,512.00
MF 3	Biweekly	$7,853.93	$7,988.78	$8,123.63	$8,259.20	$8,394.05	$8,529.63
	Hourly	$108.33	$110.19	$112.05	$113.92	$115.78	$117.65

Rural & Brandon Region (includes Rural Manitoba or City of Brandon fee differential of 5%)

		Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
Medical Officer 1	Annual	$165,716.00	$169,423.00	$173,130.00	$176,818.00	$180,544.00	$184,232.00
MD 1	Biweekly	$6,352.45	$6,494.55	$6,636.65	$6,778.03	$6,920.85	$7,062.23
	Hourly	$87.62	$89.58	$91.54	$93.49	$95.46	$97.41
Medical Officer 2	Annual	$184,232.00	$187,939.00	$191,646.00	$195,353.00	$199,041.00	$202,767.00
MD 2	Biweekly	$7,062.23	$7,204.33	$7,346.43	$7,488.53	$7,629.90	$7,772.73
	Hourly	$97.41	$99.37	$101.33	$103.29	$105.24	$107.21
Medical Officer 3	Annual	$215,136.00	$218,824.00	$222,512.00	$226,238.00	$229,926.00	$233,633.00
MD 3	Biweekly	$8,246.88	$8,388.25	$8,529.63	$8,672.45	$8,813.83	$8,955.93
	Hourly	$113.75	$115.70	$117.65	$119.62	$121.57	$123.53

Northern Region (Includes Northern Manitoba fee differential of 25%)

		Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
Medical Officer 1	Annual	$197,282.00	$201,689.00	$206,115.00	$210,503.00	$214,928.00	$219,316.00
MN 1	Biweekly	$7,562.48	$7,731.40	$7,901.05	$8,069.25	$8,238.90	$8,407.10
	Hourly	$104.31	$106.64	$108.98	$111.30	$113.64	$115.96
Medical Officer 2	Annual	$219,316.00	$223,742.00	$228,149.00	$232,555.00	$236,962.00	$241,388.00
MN 2	Biweekly	$8,407.10	$8,576.75	$8,745.68	$8,914.60	$9,083.53	$9,253.18
	Hourly	$115.96	$118.30	$120.63	$122.96	$125.29	$127.63
Medical Officer 3	Annual	$256,102.00	$260,509.00	$264,897.00	$269,322.00	$273,729.00	$278,136.00
MN 3	Biweekly	$9,817.23	$9,986.15	$10,154.35	$10,324.00	$10,492.93	$10,661.85
	Hourly	$135.41	$137.74	$140.06	$142.40	$144.73	$147.06

SCHEDULE "A"

Salary Schedule

Effective From April 1, 2012 through March 31, 2013

Winnipeg		Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
Medical Officer 1	Annual	$157,830.00	$161,348.00	$164,884.00	$168,402.00	$171,939.00	$175,457.00
MF 1	Biweekly	$6,050.13	$6,184.98	$6,320.55	$6,455.40	$6,590.98	$6,725.83
	Hourly	$83.45	$85.31	$87.18	$89.04	$90.91	$92.77
Medical Officer 2	Annual	$175,457.00	$178,993.00	$182,511.00	$186,048.00	$189,566.00	$193,102.00
MF 2	Biweekly	$6,725.83	$6,861.40	$6,996.25	$7,131.83	$7,266.68	$7,402.25
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MF 3	Biweekly	$7,853.93	$7,988.78	$8,123.63	$8,259.20	$8,394.05	$8,529.63
	Hourly	$108.33	$110.19	$112.05	$113.92	$115.78	$117.65

Rural & Brandon Region (includes Rural Manitoba or City of Brandon fee differential of 5%)

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Medical Officer 1	Annual	$165,716.00	$169,423.00	$173,130.00	$176,818.00	$180,544.00	$184,232.00
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	Hourly	$97.41	$99.37	$101.33	$103.29	$105.24	$107.21
Medical Officer 3	Annual	$215,136.00	$218,824.00	$222,512.00	$226,238.00	$229,926.00	$233,633.00
MD 3	Biweekly	$8,246.88	$8,388.25	$8,529.63	$8,672.45	$8,813.83	$8,955.93
	Hourly	$113.75	$115.70	$117.65	$119.62	$121.57	$123.53

Northern Region (includes Northern Manitoba fee differential of 25%)

		Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
Medical Officer 1	Annual	$197,282.00	$201,689.00	$206,115.00	$210,503.00	$214,928.00	$219,316.00
MN 1	Biweekly	$7,562.48	$7,731.40	$7,901.05	$8,069.25	$8,238.90	$8,407.10
	Hourly	$104.31	$106.64	$108.98	$111.30	$113.64	$115.96
Medical Officer 2	Annual	$219,316.00	$223,742.00	$228,149.00	$232,555.00	$236,962.00	$241,388.00
MN 2	Biweekly	$8,407.10	$8,576.75	$8,745.68	$8,914.60	$9,083.53	$9,253.18
	Hourly	$115.96	$118.30	$120.63	$122.96	$125.29	$127.63
Medical Officer 3	Annual	$256,102.00	$260,509.00	$264,897.00	$269,322.00	$273,729.00	$278,136.00
MN 3	Biweekly	$9,817.23	$9,986.15	$10,154.35	$10,324.00	$10,492.93	$10,661.85
	Hourly	$135.41	$137.74	$140.06	$142.40	$144.73	$147.06

SCHEDULE "A"

Salary Schedule

Effective From April 1, 2013 through March 31, 2014

Winnipeg		Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
Medical Officer 1	Annual	$167,929.00	$171,674.00	$175,438.00	$179,182.00	$182,946.00	$186,691.00
MF 1	Biweekly	$6,437.28	$6,580.83	$6,725.10	$6,868.65	$7,012.93	$7,156.48
	Hourly	$88.79	$90.77	$92.76	$94.74	$96.73	$98.71
Medical Officer 2	Annual	$186,691.00	$190,455.00	$194,199.00	$197,963.00	$201,689.00	$205,453.00
MF 2	Biweekly	$7,156.48	$7,300.75	$7,444.30	$7,588.58	$7,731.40	$7,875.68
	Hourly	$98.71	$100.70	$102.68	$104.67	$106.64	$108.63
Medical Officer 3	Annual	$217,992.00	$221,737.00	$225,482.00	$229,246.00	$232,990.00	$236,754.00
MF 3	Biweekly	$8,356.35	$8,499.90	$8,643.45	$8,787.73	$8,931.28	$9,075.55
	Hourly	$115.26	$117.24	$119.22	$121.21	$123.19	$125.18

Rural & Brandon Region (includes Rural Manitoba or City of Brandon fee differential of 5%)

		Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
Medical Officer 1	Annual	$176,327.00	$180,261.00	$184,213.00	$188,147.00	$192,100.00	$196,034.00
MD 1	Biweekly	$6,759.18	$6,909.98	$7,061.50	$7,212.30	$7,363.83	$7,514.63
	Hourly	$93.23	$95.31	$97.40	$99.48	$101.57	$103.65
Medical Officer 2	Annual	$196,034.00	$199,987.00	$203,902.00	$207,855.00	$211,770.00	$215,723.00
MD 2	Biweekly	$7,514.63	$7,666.15	$7,816.23	$7,967.75	$8,117.83	$8,269.35
	Hourly	$103.65	$105.74	$107.81	$109.90	$111.97	$114.06
Medical Officer 3	Annual	$228,886.00	$232,820.00	$236,754.00	$240,707.00	$244,641.00	$248,593.00
MD 3	Biweekly	$8,773.95	$8,924.75	$9,075.55	$9,227.08	$9,377.88	$9,529.40
	Hourly	$121.02	$123.10	$125.18	$127.27	$129.35	$131.44

Northern Region (Includes Northern Manitoba fee differential of 25%)

		Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
Medical Officer 1	Annual	$209,916.00	$214,588.00	$219,297.00	$223,988.00	$228,678.00	$233,369.00
MN 1	Biweekly	$8,046.78	$8,225.85	$8,406.38	$8,586.18	$8,765.98	$8,945.78
	Hourly	$110.99	$113.46	$115.95	$118.43	$120.91	$123.39
Medical Officer 2	Annual	$233,369.00	$238,078.00	$242,749.00	$247,459.00	$252,111.00	$256,821.00
MN 2	Biweekly	$8,945.78	$9,126.30	$9,305.38	$9,485.90	$9,664.25	$9,844.78
	Hourly	$123.39	$125.88	$128.35	$130.84	$133.30	$135.79
Medical Officer 3	Annual	$272,500.00	$277,171.00	$281,862.00	$286,552.00	$291,243.00	$295,952.00
MN 3	Biweekly	$10,445.80	$10,624.88	$10,804.68	$10,984.48	$11,164.28	$11,344.80
	Hourly	$144.08	$146.55	$149.03	$151.51	$153.99	$156.48

SCHEDULE "A"

Salary Schedule

Effective From April 1, 2014 through March 31, 2015

Winnipeg		Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
Medical Officer 1	Annual	$174,568.00	$178,445.00	$182,360.00	$186,256.00	$190,171.00	$194,048.00
MF 1	Biweekly	$6,691.75	$6,840.38	$6,990.45	$7,139.80	$7,289.88	$7,438.50
	Hourly	$92.30	$94.35	$96.42	$98.48	$100.55	$102.60
Medical Officer 2	Annual	$194,048.00	$197,963.00	$201,859.00	$205,774.00	$209,652.00	$213,566.00
MF 2	Biweekly	$7,438.50	$7,588.58	$7,737.93	$7,888.00	$8,036.63	$8,186.70
	Hourly	$102.60	$104.67	$106.73	$108.80	$110.85	$112.92
Medical Officer 3	Annual	$226,598.00	$230,494.00	$234,390.00	$238,305.00	$242,182.00	$246,097.00
MF 3	Biweekly	$8,686.23	$8,835.58	$8,984.93	$9,135.00	$9,283.63	$9,433.70
	Hourly	$119.81	$121.87	$123.93	$126.00	$128.05	$130.12

Rural & Brandon Region (includes Rural Manitoba or City of Brandon fee differential of 5%)

		Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
Medical Officer 1	Annual	$183,306.00	$187,372.00	$191,476.00	$195,561.00	$199,684.00	$203,751.00
MD 1	Biweekly	$7,026.70	$7,182.58	$7,339.90	$7,496.50	$7,654.55	$7,810.43
	Hourly	$96.92	$99.07	$101.24	$103.40	$105.58	$107.73
Medical Officer 2	Annual	$203,751.00	$207,855.00	$211,959.00	$216,063.00	$220,129.00	$224,252.00
MD 2	Biweekly	$7,810.43	$7,967.75	$8,125.08	$8,282.40	$8,438.28	$8,596.33
	Hourly	$107.73	$109.90	$112.07	$114.24	$116.39	$118.57
Medical Officer 3	Annual	$237,925	$242,012.00	$246,116.00	$250,220.00	$254,286.00	$258,409.00
MD 3	Biweekly	$9,120.50	$9,277.10	$9,434.43	$9,591.75	$9,747.63	$9,905.68
	Hourly	$125.80	$127.96	$130.13	$132.30	$134.45	$136.63

Northern Region (includes Northern Manitoba fee differential of 25%)

		Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
Medical Officer 1	Annual	$218,219.00	$223,061.00	$227,959.00	$232,820.00	$237,719.00	$242,560.00
MN 1	Biweekly	$8,365.05	$8,550.65	$8,738.43	$8,924.75	$9,112.53	$9,298.13
	Hourly	$115.38	$117.94	$120.53	$123.10	$125.69	$128.25
Medical Officer 2	Annual	$242,560.00	$247,459.00	$252,319.00	$257,218.00	$262,060.00	$266,958.00
MN 2	Biweekly	$9,298.13	$9,485.90	$9,672.23	$9,860.00	$10,045.60	$10,233.38
	Hourly	$128.25	$130.84	$133.41	$136.00	$138.56	$141.15
Medical Officer 3	Annual	$283,242.00	$288,122.00	$292,983.00	$297,881.00	$302,723.00	$307,621.00
MN 3	Biweekly	$10,857.60	$11,044.65	$11,230.98	$11,418.75	$11,604.35	$11,792.13
	Hourly	$149.76	$152.34	$154.91	$157.50	$160.06	$162.65

SCHEDULE "B"

Winnipeg

Additional Salary

		Effective 1-Apr-11	Effective 1-Apr-12	Effective 1-Apr-13	Effective 1-Apr-14
Certification or Fellowship recognized by the Royal College of Physicians and Surgeons of Canada or Recognized as a Specialist by the College of Physicians and Surgeons of Manitoba	Additional Annual Salary	$37,599.00	$37,599.00	$40,005.00	$41,584.00
	Bi-weekly	$1,441.30	$1,441.30	$1,533.54	$1,594.08
Master of Science or Doctor of Philosophy in Community Health Sciences, Master of Public Health or equivalent as recognized by Manitoba Health	**Additional Annual Salary**	$2,512.00	$2,512.00	$2,673.00	$2,778.00
	Bi-weekly	$96.24	$96.24	$102.40	$106.44
Diploma in Psychiatry, Public Health, Laboratory Medicine or Radiology	Additional Annual Salary	$1,256.00	$1,256.00	$1,336.00	$1,389.00
	Bi-weekly	$48.12	$48.12	$51.20	$53.22
Eligible to sit the certification examinations of the Royal College of Physicians and Surgeons of Canada	Additional Annual Salary	$2,761.00	$2,761.00	$2,938.00	$3,054.00
	Bi-weekly	$105.86	$105.86	$112.64	$117.08

SCHEDULE "B"

Rural and Brandon Region (includes Rural Manitoba or City of Brandon fee differential of 5%)

Additional Salary

		Effective 1-Apr-11	Effective 1-Apr-12	Effective 1-Apr-13	Effective 1-Apr-14
Certification or Fellowship recognized by the Royal College of Physicians and Surgeons of Canada or Recognized as a Specialist by the College of Physicians and Surgeons of Manitoba	Additional Annual Salary	$39,479.00	$39,479.00	$42,005.00	$43,663.00
	Bi-weekly	$1,513.37	$1,513.37	$1,610.22	$1,673.78
Master of Science or Doctor of Philosophy in Community Health Sciences, Master of Public Health or equivalent as recognized by Manitoba Health	**Additional Annual Salary**	$2,638.00	$2,638.00	$2,807.00	$2,917.00
	Bi-weekly	$101.05	$101.05	$107.52	$111.76
Diploma in Psychiatry, Public Health, Laboratory Medicine or Radiology	Additional Annual Salary	$1,319.00	$1,319.00	$1,403.00	$1,458.00
	Bi-weekly	$50.53	$50.53	$53.76	$55.88
Eligible to sit the certification examinations of the Royal College of Physicians and Surgeons of Canada	Additional Annual Salary	$2,899.00	$2,899.00	$3,085.00	$3,207.00
	Bi-weekly	$111.15	$111.15	$118.27	$122.93

SCHEDULE "B"

Northern Region (Includes Northern Manitoba fee differential of 25%)

Additional Salary

		Effective 1-Apr-11	Effective 1-Apr-12	Effective 1-Apr-13	Effective 1-Apr-14
Certification or Fellowship recognized by the Royal College of Physicians and Surgeons of Canada or Recognized as a Specialist by the College of Physicians and Surgeons of Manitoba	Additional Annual Salary	$46,999.00	$46,999.00	$50,006.00	$51,980.00
	Bi-weekly	$1,801.63	$1,801.63	$1,916.93	$1,992.60
Master of Science or Doctor of Philosophy in Community Health Sciences, Master of Public Health or equivalent as recognized by Manitoba Health	**Additional Annual Salary**	$3,140.00	$3,140.00	$3,341.00	$3,473.00
	Bi-weekly	$120.30	$120.30	$128.00	$133.05
Diploma in Psychiatry, Public Health, Laboratory Medicine or Radiology	Additional Annual Salary	$1,570.00	$1,570.00	$1,670.00	$1,736.00
	Bi-weekly	$60.15	$60.15	$64.00	$66.53
Eligible to sit the certification examinations of the Royal College of Physicians and Surgeons of Canada	Additional Annual Salary	$3,451.00	$3,451.00	$3,673.00	$3,818.00
	Bi-weekly	$132.33	$132.33	$140.80	$146.35

TAB 130

Just what the doctors ordered

Deal aims to keep province competitive

By: Larry Kusch
Posted: **1:00 AM CDT Friday, Oct. 14, 2011**

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Hey there, time traveller!
This article was published **13/10/2011** (4581 days ago), so information in it may no longer be current.

In what's being described as a win for Manitoba doctors, the Selinger government has committed to paying physicians fees comparable to those received by MDs in richer neighbouring provinces.

The province's 2,400 doctors, in a four-year agreement ratified Oct. 4, are assured their fees or salaries will be in line in the future with those paid, on average, in Alberta, Saskatchewan and Ontario.

Sampling of the fee increases in the latest contract between the province and Doctors Manitoba:

The fee for delivering a baby, now $465.50, will rise to $500 on April 1, 2014

The fee for a prenatal visit, currently at $30.05, rises to $32.50 in April 2013 and $34.40 in April 2014

A surgeon who repairs a stomach wound or laceration will be able to charge $586.35 in April 2014, compared with $5(now

The new deal increases general fees to physicians by 10.6 per cent over the next four years and offers millions in incentives to retain certain specialists and doctors in remote areas. It also commits the province to contributing millions more dollars to a generous doctor-managed fund that rewards all MDs who remain in the province for a prescribed time.

Dr. Brian Postl

But the commitment to the so-called OPA (Ontario-Prairie average for remuneration) was the deal-maker.

Dr. Brian Postl, dean of medicine at the University of Manitoba, called it a “pretty big win” for doctors — and a positive step in the province’s bid to retain and recruit doctors.

But he said it could put some “fiscal pressure” on Manitoba down the road if doctor settlements in neighbouring provinces go way up.

“From a public-purse perspective, it’s a little more difficult because the provinces around us, at least from

A GP who works on an hourly basis will receive $640.45 by 2014 for a seven-hour day compared with $579.05. The rate is higher for specialists and MDs working in rural and remote areas

A surgeon who performs a coronary bypass (triple) will receive $1,820 by 2014, compared with $1,785 now

The fee for a complete history and physical exam, now $110.15, will rise to $126 in 2014

time to time, tend to have more money," Postl said Thursday.

The organization that represents the province's physicians, Doctors Manitoba, has refused repeated requests for comment on its new master agreement with the government. The province, until Thursday, also offered no more comment than what was contained in a two-page press release last Friday. However, the *Free Press* obtained a copy of the deal and several related documents and fee schedules from an anonymous source on Thursday.

Asked Thursday if the province could afford to tie future fee increases to levels paid to doctors in wealthier provinces, Health Minister Theresa Oswald said Manitoba could ill afford not to.

Theresa Oswald

"My broad question would be, 'Can we afford not to compensate doctors in a robust way in such a competitive environment?' " she said in a telephone interview. "We know that

the whole nation has been living with a shortage of doctors."

In line with settlements with other public-sector workers, physicians will not generally receive a fee hike during the first two years of the contract, which is retroactive to this past April 1. However, fees will rise 6.4 per cent in third year of the deal and 4.2 per cent in the final year, a source said.

The government also agreed to greatly enhance payments to a Doctors Manitoba-controlled fund that rewards all physicians for staying in the province long-term. By the end of next year, the province's annual payments to the fund will rise to $10 million from the current $6 million.

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Doctors receive the bonus money every five years. The amount they get

depends on years of service and whether they work part time or full time. The last time there was a payment, physicians with 25 years' service received cheques in the neighbourhood of $15,000 to $20,000, a doctor said Thursday. Terry Goertzen, an assistant deputy minister of health, said the fund helps keep Manitoba competitive with other provinces as an attractive place for doctors.

"We've had record-breaking growth in our physician complement over the last number of years, and this is an important piece of trying to compete and to keep them here as well as to attract them into the future," he said.

Remuneration to Manitoba doctors will top $1 billion this year. The new deal will cost the province an extra $125 million over the length of the contract.

CP The Canadian Press archives The province will pay doctors in excess of $1 billion this year. The new agreement will cost an

The total includes $80 million in fee increases, increased incentives to keep physicians here and new payments to

extra $125 million over its four-year duration.

MDs for chronic-disease management, pain management and diagnostic procedures.

larry.kusch@freepress.mb.ca

Larry Kusch

Legislature reporter

Larry Kusch didn't know what he wanted to do with his life until he attended a high school newspaper editor's workshop in Regina in the summer of 1969 and listened to a university student speak glowingly about the journalism program at Carleton University in Ottawa.

Read full biography

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LOCAL

TAB 131

THIS MASTER AGREEMENT made this 12th day of February, 2015

BETWEEN:

HER MAJESTY IN RIGHT OF THE PROVINCE OF MANITOBA, REPRESENTED BY THE MINISTER OF HEALTH

(hereinafter called "Manitoba")

- and -

DOCTORS MANITOBA

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SCHEDULE "1" – Schedule of Benefits (Fee-For-Service) and Alternate Funded Agreements/Payment Arrangements

SCHEDULE "2" – Ontario-Prairie Average

SCHEDULE "3" – Allocation and Tariff Rate Tables

SCHEDULE "4" – Amendments to the Physician's Manual

THIS MASTER AGREEMENT made this 12th day of February, 2015

BETWEEN:

HER MAJESTY IN RIGHT OF THE PROVINCE OF MANITOBA, REPRESENTED BY THE MINISTER OF HEALTH

(hereinafter called "Manitoba")

- and -

DOCTORS MANITOBA

In consideration of the mutual covenants and agreements set out herein, the parties hereto agree as follows:

ARTICLE 1 - DEFINITIONS

1:01 "Schedule of Benefits" means the schedule of fees payable by Manitoba in respect of insured medical services, and the Rules of Application and Claims Submissions and Payment Procedures in regard thereto, commonly referred to as the "Manitoba Physician's Manual". The Schedule of Benefits is an integral part of this Agreement.

1:02 "2013 - 2014 Base Payout" means the total fee-for-service payments paid by Manitoba during the fiscal year 2013 - 2014 in respect of insured medical services rendered in Manitoba by medical practitioners to insured persons (excluding private laboratory services), which is acknowledged by the parties to be $637,428,962 for the twelve (12) month period ending March 31, 2014.

1:03 Schedule "1" means the Schedule of Benefits referred to in sub-article 1:01 and all of the alternate funded agreements/payment arrangements between the parties, all of which are attached hereto and form part of this Master Agreement, and are subject to interest arbitration in accordance with Article 15.

ARTICLE 2 – DURATION

2:01 This Agreement shall take effect April 1, 2015, and shall continue in full force and effect until March 31, 2019 subject to other expiration dates as specified herein.

ARTICLE 3 – COMPENSATION INCREASES

General

3:01 The parties acknowledge and agree as follows:

a) the ability of the Province of Manitoba, Manitoba Health, Healthy Living and Seniors, the respective Regional Health Authorities and other health system stakeholders to recruit and retain physicians is enhanced when compensation paid to physicians is competitive;

b) the average of the rates paid to physicians in Ontario, Alberta and Saskatchewan for particular comparable services is known as the Ontario-Prairie Average ("OPA");

c) the OPA provides objective data for comparable services from relevant labour markets;

d) Doctors Manitoba's position is that the most appropriate comparator for fee for service rates has been and continues to be the fee for service rates received by physicians in Ontario, Alberta and Saskatchewan for comparable services and work;

e) Doctors Manitoba has raised the issue of each tariff being paid in accordance with the OPA in each round of bargaining between the parties from 1998/1999 to present and has based its fee for service bargaining proposals during these rounds on the tariff-by-tariff OPA comparisons;

f) following the agreement between the parties or the delivery of the arbitrated award for any overall fee-for-service increases and at the request of Doctors Manitoba, funds from each round of bargaining/arbitration from 1998/1999 to present have been allocated on the basis of, and utilizing the OPA. Manitoba has agreed to the allocations proposed by Doctors Manitoba but did not accept OPA as the basis for the amounts agreed upon;

g) Manitoba is aware of Doctors Manitoba's reliance on OPA for its bargaining positions in past fee-for-service negotiations. Manitoba has not accepted the OPA as the sole criterion to be considered at negotiations or arbitration;

h) the tariff-by-tariff OPA methodology and calculations (as defined and generally described in Schedule "2" attached hereto and forming part of this Agreement) have been reviewed by Manitoba and agreed upon by the parties except where explicitly agreed otherwise in writing;

i) the parties have agreed upon the terms of the Physician's Manual tariff micro-allocation (as per Schedule "3" attached hereto and forming part of this Agreement) based on the tariff-by-tariff OPA methodology other than as explicitly agreed otherwise in writing; and

j) the terms of this Agreement, including the structure and timing of increases, are a result of unique and special circumstances at the time of the execution of the Agreement.

Fee For Service

3:02 The parties have agreed that overall percentage increases shall be applied to the Schedule of Benefits as follows:

April 1, 2015	1%
April 1, 2016	1% (non-compounded)
April 1, 2017	1% (non-compounded)
April 1, 2018	1% (non-compounded)

These percentage increases shall be applied to the 2013-2014 Base Payout and shall be implemented in accordance with Schedule "3".

3:03 In addition to the overall percentage increases referenced in sub-article 3:02, additional fixed amount increases shall be applied to the Schedule of Benefits in part as targeted investments to meet the health care needs of Manitobans, as follows:

April 1, 2015	$8,006,232
April 1, 2016	$6,374,290
April 1, 2017	$8,924,005
April 1, 2018	$10,198,863

3:04 Additionally, the parties agree to amend the Physician's Manual in accordance with Schedule "4" attached hereto and forming part of this Agreement.

3:05 It is acknowledged that the increases referenced in sub-articles 3:02 and 3:03 result in a total amount of $59,000,549 to be allocated in accordance with Schedules "3" and "4".

3:06 The parties have considered that Manitoba is introducing its new fee-for-service claims processing system (CPS), which, as of the date of execution of this Agreement is scheduled to be operational imminently. It is agreed by the parties that all of the tariff rate adjustments in Schedule "3" that are to be effective April 1, 2015 will be reconciled by the new CPS and paid out to fee-for-service physicians as soon as possible after implementation of the system. More particularly, it is understood and acknowledged that Manitoba, through the new CPS, will conduct a re-adjudication and reconciliation process no later than July 2015. Through this re-adjudication and reconciliation process, Manitoba will pay the Schedule "3" April 1, 2015 tariff rate adjustments to the physicians through a tariff by tariff rate comparison of March 31, 2015 and April 1, 2015 applicable rates for each claim submitted for Schedule "3" services rendered by each physician during the period between April 1, 2015 and the re-adjudication date. Payment shall be made no later than August 15, 2015.

3:07 The parties acknowledge and agree that as of April 1, 2015 every tariff in the Physician's Manual will be equal to or greater than the OPA as at April 1, 2014. Additional increases are provided to attempt to maintain competitiveness for the remainder of the term of this Agreement. It is further agreed that neither party may dispute that as at April 1, 2015 each tariff has reached or exceeded the OPA as denoted in Schedule "2" as at April 1, 2014 at any future interest arbitration or dispute resolution process for the purposes of determining physician remuneration between the parties.

Alternate Funding

3:08 The parties have agreed that overall increases shall be applied to the rates set out in the alternate funded agreements/payment arrangements, referenced in Schedule "1", unless otherwise denoted in such alternate funded agreements/payment arrangements, as follows:

April 1, 2015	1%
April 1, 2016	1% (non-compounded)
April 1, 2017	1% (non-compounded)
April 1, 2018	1% (non-compounded)

3:09 In addition to the overall percentage increases referenced in sub-article 3:07, additional fixed amount increases shall be applied to the alternately funded agreements/payment arrangements referenced in Schedule "1" in part as targeted investments to meet the health care needs of Manitobans, as follows:

April 1, 2015	$3,412,191
April 1, 2016	$2,720,651
April 1, 2017	$3,808,911
April 1, 2018	$4,353,042

3:10 Manitoba shall direct the respective Regional Health Authorities and other applicable health system stakeholders to implement as denoted each of the rate increases in each of the alternate funded agreements/payment arrangements. Retroactive payments, including interest where applicable, shall be made in accordance with sub-article 4:02 of this Agreement.

Other

3:11 If, during the term of this Agreement, establishment of a new fee tariff is considered or a request to amend an existing tariff is made, the parties will consider the OPA with respect to the possible establishment of such new tariff or amendment of an existing tariff in the Physician's Manual.

3:12 If during the term of this Agreement, one of the parties is of the view that a material change has been made to the fee schedule(s) of Ontario, Saskatchewan or Alberta:

i. such change shall be brought to the attention of the other party within a reasonable period of time; and

ii. the parties agree to consider the material change and to try to reach consensus as to the impact of the material change, if any, to the tariff-by-tariff OPA methodology, and the established matches, linkages and micro-allocation, and to determine how, if at all, such material change should be considered within the context of renewal of this Agreement.

It is acknowledged and agreed that a change solely to a tariff rate/fee is not a material change with respect to the agreed upon tariff matches or tariff linkages.

ARTICLE 4 – RETROACTIVE PAYMENTS

4:01 For the purpose of this article, "eligible physician" means any physician who has provided services pursuant to an Agreement in Schedule 1 hereto that has an increase effective April 1, 2015, at any time during the period April 1, 2015 to July 1, 2015.

4:02 Upon ratification of this Agreement in accordance with Article 19, Manitoba shall direct the respective Regional Health Authorities to adjust the rates payable pursuant to the Schedule 1 Agreement by no later than July 1, 2015, and thereafter provide to Manitoba calculations of any retroactive amount payable to each eligible physician for the period April 1, 2015 to July 1, 2015. Upon receipt of this information, Manitoba shall, in turn, provide this information to Doctors Manitoba. The parties agree that they shall make all reasonable efforts to jointly verify the retroactive amount payable to each eligible physician. Manitoba shall make all reasonable efforts to pay all retroactive payments by August 15, 2015.

ARTICLE 5 – PROFESSIONAL LIABILITY INSURANCE FUND

5:01 The Professional Liability Insurance Fund ("PLIF") is hereby continued and Doctors Manitoba shall continue to administer PLIF in accordance with its past practice.

5:02 The Minister shall provide funding to Doctors Manitoba in trust for the purpose of PLIF in the amount of $5,557,525 every 6 months (up to and including January 15, 2019), payable by no later than January 15 and July 15 of each year, commencing on July 15, 2015. Effective April 1, 2015, and thereafter, the remaining funding obligation of Manitoba stipulated in and pursuant to sub-article 5:02 of the 2011 Master Agreement between the parties is extinguished and shall no longer be due and payable.

5:03 The purpose of PLIF is to reimburse on the basis set out below all Manitoba physicians (General Practitioners and Specialists), regardless of their payment modality, excluding interns and residents, for annual dues/fees or premiums payable (collectively "dues") for the physician's Canadian Medical Protective Association (or equivalent medical liability insurer) coverage. Physicians shall be eligible for reimbursement from PLIF in relation to such dues, on the following basis:

(a) The physician shall pay a base dues amount of $1,300;
(b) In addition, the physician shall pay 26% of the balance of the dues owing after payment of the $1,300 base amount;

(c) The physician shall be eligible for reimbursement from PLIF of 74% of the balance of the dues owing after payment of the $1,300 base amount.

5:04 In the event the amount of funding received by Doctors Manitoba is greater than Doctors Manitoba needs in a particular calendar year for the purpose of PLIF, the surplus (including interest), or any portion thereof, shall be used by Doctors Manitoba for the purpose of the CME Fund referenced in Article 6 hereof. In such case, the accumulated surplus plus interest, if any, plus the amount referenced in sub-article 6:02, shall become the initial amount of funding available for the purpose of the CME Fund in 2019.

5:05 In the event that the amount available in PLIF is insufficient to fulfill the purpose described in sub-article 5:03 hereof, the Minister shall provide additional funding to Doctors Manitoba to ensure the purpose is fulfilled.

5:06 Doctors Manitoba shall, within thirty (30) days of a written request from the Minister, provide an interim written report of the status of PLIF, including interest and payments into and disbursements from PLIF to date.

5:07 Doctors Manitoba shall, no later than July 31 of each year, provide to the Minister a complete written accounting of amounts paid into PLIF (including interest) and of disbursements from PLIF, which shall include an audited financial statement in a form satisfactory to the Provincial Auditor, as well as an accounting of expenses incurred in respect to the administration of PLIF, as referenced in sub-article 5:11 hereof.

5:08 It is acknowledged that all payments made from PLIF to eligible physicians constitute taxable income when received by such physicians.

5:09 Doctors Manitoba shall have the power to deduct, and retain for its own use, an amount equal to the current Doctors Manitoba dues as determined by Doctors Manitoba, from any disbursement to be made from PLIF to any non-member of Doctors Manitoba, but Doctors Manitoba shall not have such power where a non-member has already paid an amount equal to the current Doctors Manitoba dues.

5:10 All interest earned by PLIF shall be deposited in PLIF, and shall be held in trust and used for the purpose of PLIF.

5:11 Notwithstanding the foregoing, Doctors Manitoba shall have the power to use up to $100,000 per year from PLIF to offset reasonable expenses incurred by Doctors Manitoba in the administration of PLIF during that year, which expenses shall be approved by the Minister.

ARTICLE 6 – CONTINUING MEDICAL EDUCATION FUND

6:01 The Continuing Medical Education Fund (the "CME Fund") is hereby continued and Doctors Manitoba shall continue to administer the CME Fund in accordance with its past practice.

6:02 Manitoba shall provide funding to Doctors Manitoba in trust for the purpose of the CME Fund in the amount of $3,150,000 per annum, (up to and including January 15, 2019), payable by no later than January 15 of each year, commencing on January 15, 2016.

6:03 The purpose of the CME Fund is to partially reimburse fee-for-service physicians for their expenses incurred in Continuing Medical Education activities. Doctors Manitoba alone shall determine the eligibility criteria for disbursements from the CME Fund, and shall inform Manitoba of those criteria. It is acknowledged that such criteria may permit reimbursement for a physician's out-of-province transportation expenses associated with those Continuing Medical Education Activities to a maximum of fifty percent (50%) of the annual rebate to which the physician is entitled.

6:04 In the event the amount of funding received by Doctors Manitoba is greater than Doctors Manitoba needs in a particular calendar year for the purpose of the CME Fund, the surplus shall be carried forward to be used in subsequent calendar years for the purpose of the CME Fund, and the accumulated surplus plus interest, if any, shall become the initial amount of funding available for the purpose of the CME Fund in 2020.

6:05 Doctors Manitoba shall, within thirty (30) days of a written request from the Minister, provide an interim written report on the status of the CME Fund, including payments and interest into the CME Fund and disbursements from the CME Fund to date.

6:06 Doctors Manitoba shall, no later than March 31 of each year, provide to the Minister a complete written accounting of payments and interest into the CME Fund and disbursements from the CME Fund, which shall include an audited financial statement in a form satisfactory to the Provincial Auditor.

6:07 It is acknowledged that all payments made from the CME Fund to eligible physicians constitute taxable income when received by such physicians.

6:08 Doctors Manitoba shall have the power to deduct, and retain for its own use, an amount equal to the current Doctors Manitoba dues as determined by Doctors Manitoba, from any disbursement to be made from the CME Fund to any non-member of Doctors Manitoba, but Doctors Manitoba shall

not have such power where a non-member has already paid an amount equal to the current Doctors Manitoba dues.

6:09 All interest earned by the CME Fund shall be deposited in the CME Fund, and shall be held in trust and used for the purpose of the CME Fund.

6:10 Notwithstanding the foregoing, Doctors Manitoba shall have the power to use up to $100,000 per year from the CME Fund to offset reasonable expenses incurred by Doctors Manitoba in the administration of the CME Fund during that year, which expenses shall be approved by the Minister.

6:11 The parties acknowledge and agree that in addition to the funding provided by Manitoba pursuant to this Article to support continuing medical education, Manitoba, with the concurrence of Doctors Manitoba, will also contribute $400,000 per annum payable to the WRHA for procurement of the province-wide license for UpToDate, an evidence-based clinical decision support resource. In the event the WRHA does not procure UpToDate by January 1, 2016, funding to the CME Fund pursuant to Article 6:01 shall be increased by the $400,000 per annum.

ARTICLE 7 – MATERNITY/PARENTAL BENEFITS FUND

7:01 The Maternity/Parental Benefits Fund (the "Mat/Par Fund") is hereby continued and Doctors Manitoba shall continue to administer such Mat/Par Fund in accordance with its past practice. The purpose of the Mat/Par Fund is to provide certain maternity/parental benefits to Manitoba physicians and residents and interns. It is acknowledged that Manitoba has provided funding to Doctors Manitoba in the amount of $1 million in trust for the purpose of the Mat/Par Fund in the 2015 calendar year.

7:02 Doctors Manitoba alone shall determine the eligibility criteria for disbursements from the Mat/Par Fund, and shall inform the Minister of those criteria. Doctors Manitoba shall consult with the Minister prior to determining the criteria.

7:03 The Minister shall provide funding to Doctors Manitoba in trust for the purpose of the Mat/Par Fund in the amount of $1.25 million per annum (up to and including January 15, 2019), payable by no later than January 15 of each year, commencing on January 15, 2016.

7:04 In the event the amount of funding received by Doctors Manitoba is greater than Doctors Manitoba needs in a particular calendar year for the purpose of the Mat/Par Fund:

(i) the surplus (including interest), or any portion thereof, may be carried forward to be used in subsequent calendar years for the

purpose of the Mat/Par Fund, and the accumulated surplus plus interest, if any, shall become the initial amount of funding available for the purpose of the Mat/Par Fund in 2020; and/or

(ii) the surplus (including interest) or any portion thereof may, notwithstanding sub-article 7:09, from time to time and in the absolute discretion of Doctors Manitoba, be used for the purpose of the CME Fund referenced in Article 6 hereof. In such case, the accumulated surplus plus interest, if any, plus the amount referenced in sub-article 6:02, shall become the initial amount of funding available for the purpose of the CME Fund in 2020.

7:05 Doctors Manitoba shall, within thirty (30) days of a written request from the Minister, provide an interim written report on the status of the Mat/Par Fund, including payments and interest into the Mat/Par Fund and disbursements from the Mat/Par Fund to date.

7:06 Doctors Manitoba shall, no later than March 31 of each year, provide to the Minister a complete written accounting of payments and interest into the Mat/Par Fund and disbursements from the Mat/Par Fund, which shall include an audited financial statement in a form satisfactory to the Provincial Auditor.

7:07 It is acknowledged that all payments made from the Mat/Par Fund to eligible physicians constitute taxable income when received by such physicians.

7:08 Doctors Manitoba shall have the power to deduct, and retain for its own use, an amount equal to the current Doctors Manitoba dues as determined by Doctors Manitoba, from any disbursement to be made from the Mat/Par Fund to any non-member of Doctors Manitoba, but Doctors Manitoba shall not have such power where a non-member has already paid an amount equal to the current Doctors Manitoba dues.

7:09 All interest earned by the Mat/Par Fund shall be deposited in the Mat/Par Fund, and shall, subject to sub-article 7:04 (ii), be held in trust and used for the purpose of the Mat/Par Fund.

7:10 Notwithstanding the foregoing, Doctors Manitoba shall have the power to use up to $50,000 per year from the Mat/Par Fund to offset reasonable expenses incurred by Doctors Manitoba in the administration of the Mat/Par Fund during that year, which expenses shall be approved by the Minister.

ARTICLE 8 – PHYSICIAN RETENTION FUND

8:01 The Physician Retention Fund (the "Retention Fund") is hereby continued for the purpose of providing certain retention incentives to Manitoba physicians. Doctors Manitoba shall administer the Retention Fund. Effective April 1, 2015, Manitoba shall provide funding to Doctors Manitoba in the amount of $10 million per annum in trust for the purpose of the Retention Fund, payable by no later than April 15 of each year.

8:02 The Retention Fund shall support the retention of both family medicine and specialist physicians practicing in Manitoba. The Retention Fund recognizes the geographic diversity of Manitoba and issues of retention relevant to diversity. Doctors Manitoba shall continue to administer the Retention Fund in accordance with Doctors Manitoba's established criteria.

8:03 Such annual payment shall continue to be made after the expiration of the term of this Agreement, and throughout the duration of any subsequent master agreement or interest arbitration process as provided for in this Agreement.

8:04 Doctors Manitoba shall, within thirty (30) days of a written request from the Minister, provide an interim written report on the status of the Retention Fund, including payments and interest into the Retention Fund and disbursements from the Retention Fund to date.

8:05 Doctors Manitoba shall, no later than July 31 of each year, provide to the Minister a complete written accounting of payments and interest into the Retention Fund and disbursements from the Retention Fund, which shall include an audited financial statement in a form satisfactory to the Provincial Auditor.

8:06 It is acknowledged that all payments made from the Retention Fund to eligible physicians constitute taxable income when received by such physicians.

8:07 Doctors Manitoba shall have the power to deduct, and retain for its own use, an amount equal to the current Doctors Manitoba dues as determined by Doctors Manitoba, from any disbursement to be made from the Retention Fund to any non-member of Doctors Manitoba, but Doctors Manitoba shall not have such power where a non-member has already paid an amount equal to the current Doctors Manitoba dues.

8:08 All interest earned by the Retention Fund shall be deposited in the Retention Fund, and shall be held in trust and used for the purpose of the Retention Fund.

8:09 Notwithstanding the foregoing, Doctors Manitoba shall have the power to use up to $100,000 per year from the Retention Fund to offset reasonable expenses incurred by Doctors Manitoba in the administration of the Retention Fund during that year, which expenses shall be approved by the Minister.

ARTICLE 9 – CONTINUATION OF FUNDS

9:01 The parties agree that the Funds outlined in Articles 5, 6 and 7 of this Agreement, said Funds being the Professional Liability Insurance Fund, CME Fund and the Mat/Par Fund, shall continue after the expiration of the term of this Agreement until such time as the terms of a subsequent Master Agreement are agreed upon by the parties or they are finalized pursuant to the interest arbitration process provided for in this Agreement.

ARTICLE 10 – PHYSICIAN'S MANUAL

10:01 The Minister shall not amend the Physician's Manual without first obtaining Doctors Manitoba's written agreement or pursuant to a decision of the Board of Arbitration.

10:02 The parties acknowledge and agree that the Physician's Manual shall be amended in accordance with the amendments contained in Schedule "4" attached hereto and forming part of this Agreement.

10:03 The Minister shall continue to make available on the Government of Manitoba website an electronic version of the Physician's Manual for viewing access and downloading and shall continue to update the electronic version of the Physician's Manual on a quarterly basis and in accordance with sub-article 10:01.

10:04 It is acknowledged that, during the term of this Agreement, the parties may agree to make further amendments to the existing Rules of Application, Claims Submission and Payment Procedures and/or fee tariffs contained in the Physician's Manual, or to introduce new fee tariffs into the Physician's Manual. These amendments shall be incorporated into the electronic version of the Physician's Manual in accordance with sub-article 10:03.

10:05 It is acknowledged that on June 26, 2001, the parties entered into an agreement dealing with the introduction into the Physician's Manual of one (1) category of new fee tariffs, namely "provisional tariffs" (the "Provisional Tariffs Agreement"). This Agreement, attached hereto as Appendix "C",

forms part of this Agreement and shall continue in full force and effect until its provisions are changed by mutual written agreement of the parties.

ARTICLE 11 – PATIENT ACCESS REGISTRY TOOL (PART)

11:01 The parties acknowledge and agree that it is their desire to work together in an effort to improve the health care delivery system and provide quality health care services to Manitobans. They further acknowledge and agree that initiatives like the Patient Access Registry Tool ("PART"), an electronic wait list registry designed to provide quick and easy access to information on a variety of wait time issues to parties responsible for the delivery of services, including the number of patients who are waiting for access to surgical services, specialized clinical services and medical/surgical consultations in Manitoba, and aggregate statistics on wait times, are intended to improve the health care delivery system for the benefit of all Manitobans.

11:02 In order to work towards improving the health care delivery system within the Province of Manitoba, Doctors Manitoba shall take all reasonable steps to ensure that the physicians who it represents and to whom this Agreement applies who provide surgical services, specialized clinical services and/or medical or surgical consultations, provide to Manitoba, to the extent permitted by law, and without limitation, *The Personal Health Information Act* and *The Freedom of Information and Protection of Privacy Act*, any and all information required to establish, implement and maintain PART. For greater certainty, this information includes, but is not limited to, submission of completed PART forms, in the form provided to physicians by Manitoba from time to time, for each patient seen by the physicians.

ARTICLE 12 – TRIPARTITE AGREEMENT AND HEALTH SYSTEM SUSTAINABILITY

12:01 Attached hereto as Appendix "D" and forming part of this Agreement is the Tripartite Agreement which sets out a formal process by which Manitoba, Doctors, Manitoba and the Regional Health Authorities, University of Manitoba, CancerCare Manitoba and Diagnostic Services of Manitoba Inc. ("Stakeholders") will work in partnership to develop strategies to address certain health care matters outlined therein. The parties acknowledge and agree that it is in the interest of Manitobans and the public health care system generally that Manitoba, Doctors Manitoba and the Stakeholders work collaboratively to ensure that quality and comprehensive health care services are delivered to Manitobans through a system which is accessible, sustainable, cost effective and accountable.

12:02 The parties further acknowledge and agree that Manitoba has raised concerns about the overall sustainability of the health care system. The parties are committed to working together with health system stakeholders during the term of the Master Agreement to discuss, explore and facilitate system improvement, to enhance the sustainability of the health care system, in an effort to realize medical and health care system efficiencies of $50 million over the term of the Master Agreement. Further details regarding the parties' commitment in this regard are as denoted in the Tripartite Agreement.

12:03 The Tripartite Agreement shall be signed by the parties thereto following the execution of this Agreement in the same form and content as is contained in Appendix "D".

ARTICLE 13 – PHYSICIAN ENGAGEMENT

13:01 The parties agree that, effective April 1, 2016 in order to maintain a fee-for-service billing number, physicians will work together with regional health authorities (RHAs) and other health system stakeholders such as Diagnostics Services of Manitoba and CancerCare Manitoba, as applicable, in an effort to provide medical services that meet the population and health system needs in the RHA(s) (or other health system stakeholders as applicable) in which they provide services. The parties agree that the applicable process is as follows:

a) Requests for issuance of a fee-for-service billing number will be submitted by the physician to the Practitioner Registry of Manitoba Health, Healthy Living and Seniors at:

Practitioner Registry
Manitoba Health, Healthy Living and Seniors
3rd Floor, 300 Carlton Street
Winnipeg, Manitoba R3B 3M9
Phone: 204-788-2567
Fax: 204-942-2356
Email: practitionerregistry@gov.mb.ca

b) Upon issuance of a billing number to a physician by the Registry, the Registry will provide the physician's contact information to the RHA(s) (and any other applicable health system stakeholder(s)) to or in which the physician will provide medical services.

c) The RHA(s) (or other health system stakeholder(s)) will contact the physician and the medical leadership will meet with the physician to discuss the population and health system needs of the region/health system stakeholder so that the physician may be fully

informed and may structure his/her practice in alignment with these needs.

d) Physicians agree to keep their contact information current with the Practitioner Registry of Manitoba Health, Healthy Living and Seniors and will immediately advise the Practitioner Registry of any changes to their practice location(s).

e) On-going communication between physicians and the RHA(s) (or other health system stakeholders) with regard to population and health systems needs, and the integration, coordination, cooperation and/or interaction of physicians' practices with the RHA(s)/health system stakeholder(s) will be encouraged and supported through the term of this Agreement. To this end the Physician will, if requested, meet with the RHA(s)/health system stakeholders medical leadership on a semi-annual basis. Reasonable efforts shall be made to accommodate physicians' practices and schedules when requesting such meetings.

13:02 The parties acknowledge that the Family Doctor Finder is a service that exists to assist Manitoba residents with finding a family physician and to help Manitobans to access continuous quality health care.

Family Doctor Finder is supported by primary care connectors who are located in each health region, and who act as a central point of contact to help connect physicians, and other primary care providers, to regional and provincial resources. The primary care connectors also provide a bridge between new patients and available health care resources.

13:03 Given the important role that primary care connectors play with respect to the Family Doctor Finder service, the parties agree that effective April 1, 2015:

a) at the time that a new fee for service billing number is issued to a general practitioner physician, the general practitioner will, upon request, meet with the primary care connector in their region within 60 days of issuance of the physician's billing number;

b) Upon that meeting described in sub-article 13:03(a), the physician shall discuss the acceptance of new patients from the Family Doctor Finder service, and will work collaboratively with the primary care connector to determine the number of patients to be accepted; and

c) all general practitioners will, if requested, meet with the RHA's connector when meeting with the RHA(s)/health system stakeholders medical leadership as noted in 13:01(e), to apprise the primary care connector of his/her particular practice area of

focus and his/her capacity to accept new patients. Reasonable efforts shall be made to accommodate physicians' practices and schedules when requesting such meetings.

ARTICLE 14 – GENERAL

14:01 Except for the provisions of Article 7, this Agreement does not apply to the Collective Agreement for the Professional Association of Residents and Interns of Manitoba.

14:02 The parties acknowledge and agree that the sharing of relevant information in a timely way is crucial to the achievement of the objectives established in this Agreement. To the extent permitted by law, and without limitation, *The Personal Health Information Act* and *The Freedom of Information and Protection of Privacy Act*, each party will provide, upon written request, all existing relevant information, which is reasonably required by the other party to properly perform its responsibilities or obligations under this Agreement. For greater certainty, relevant information which may be reasonably required by the other party includes, but is not limited to:

(a) Lists, records and statistical information respecting physicians and insured services (e.g., the physician remuneration database and descending remittance database);

(b) Names of physicians practicing in particular Regions;

(c) Details respecting deliverables provided by physicians;

(d) Details regarding the benefits and compensation paid to and received by physicians pursuant to any remuneration contract between Doctors Manitoba and Manitoba, or service contract between the physician and a Regional Health Authority (or other employer of record or payor);

(e) Copies of contracts, letters of offer, memorandums of understanding and pay records relating to physicians as identified in (d) above;

(f) Information regarding patients who are waiting for facility-based services and the procedures completed in facility operating rooms;

(g) Information regarding the patients seen by physicians in clinic as well as patient wait time/wait list information or reports generated by these physicians; and

(h) Information required to establish, implement and maintain PART, including the information, which pursuant to Article 11 of this Agreement, should be provided to Manitoba by physicians.

The information to be provided by the parties pursuant to this provision includes information which is in the possession of the Regional Health Authorities and the agencies and other entities funded by the Regional Health Authorities to provide medical service, and on whose behalf Manitoba is acting in this Agreement, as well as the physicians who are represented by Doctors Manitoba and to whom this Agreement applies.

In cases where requested information is not provided or is not provided in the requested manner or form, the matter may be referred to the Master Committee established pursuant to the Tripartite Agreement for resolution. If directed by the Master Committee, the party will provide the information to the other party in the manner and form directed by the Committee.

It is understood and agreed that certain information exchanged between the parties pursuant to this provision will be confidential in nature. Both parties shall maintain strict confidentiality of all information supplied pursuant to this provision and may, unless otherwise directed by the Master Committee or the information is already in the public domain, require the other party to enter into a confidentiality agreement respecting the information provided to it.

14:03 The following provision applies to the fee-for-service component of this Agreement and the applicable alternate funding contracts/payment arrangements referenced in Schedule "1", and shall continue in full force and effect unless terminated by mutual agreement of the parties:

(a) Where the parties have agreed upon any increase, revision, or inclusion, of or to any tariff or rule of application which is, or shall be, included within Fee-for-Service Agreement, and which gives rise to retroactive pay, the Minister shall pay to medical practitioners interest on retroactive pay calculated from the effective date of such change to the date of actual payment; or

(b) Where any such change as referred to in (a) above occurs as the result of an award or decision of a board of arbitration, the Minister shall pay to medical practitioners interest on the retroactive pay calculated from the date the interest arbitration agreement is entered into until the date of actual payment.

The rate of interest payable is:

(i) for the period January 1 to June 30 in each year, the prime lending rate of the Bank of Canada minus 2% as that rate stood on January 1 of that year; and
(ii) for the period July 1 to December 31 in each year, the prime lending rate of the Bank of Canada minus 2% as that rate stood on July 1 of that year

compounded annually.

14:04 The parties acknowledge and agree that one (1) year after the date of the execution of this Master Agreement they will meet to discuss and evaluate the effectiveness and efficiency of the Dispute Resolution process contained in the Physician's Manual with a view to amending such process as necessary in order to ensure its effectiveness as a dispute resolution mechanism. They further acknowledge and agree that at the end of the term of the Master Agreement, they will review the composition of the 5-member arbitration board with a view to amending the composition of the Board as necessary. Unless and until the provisions are amended as mutually agreed to by the parties in writing, Part VII of the Physician's Manual as amended herein shall continue to be effective.

ARTICLE 15 – INTEREST ARBITRATION

15:01 This Agreement shall remain in full force and effect until March 31, 2019, and if notice is given by either party by January 1, 2019, the parties shall be bound to commence a new interest arbitration process. Any issue in dispute arising from negotiations between the parties with respect to duration of the next master agreement, compensation and relevant non-pecuniary issues arising from Schedule "1", including, but not limited to, compensation for clinical, administrative, teaching, on-call coverage or other physicians services, and the Retention Fund denoted in Article 8 shall be referred to a Board of Interest Arbitration (the "Board") for final determination. Either party may by written notice to the other party require that the arbitration process commence by requesting that the Board schedule hearing dates.

15:02 The arbitration process does not cover the Collective Agreement for the Professional Association of Residents and Interns of Manitoba, nor Private Laboratories.

15:03 The Chairperson of the Board shall be selected by the parties. In the event the parties are unable to agree upon a Chairperson, a Chairperson shall be appointed, as follows:

The parties shall each propose the name of a potential Chairperson from among those names the parties have already discussed, and shall jointly submit the two (2) names to the Dean of the Faculty of Law of the University of Manitoba (or in the Dean's absence, the Acting Dean) who shall serve as a "tie-breaker". The tie-breaker shall be requested to select, within three (3) business days, one (1) of the named persons to act as Chairperson. The tie-breaker shall not be apprised of which party proposed which name.

15:04 The Board shall decide upon the overall increases to compensation to be applied to each of the agreements/payment arrangements referenced in Schedule "1", and the Retention Fund denoted in Article 8 and decide upon four (4) distinct awards as provided for herein.

15:05 In making its determination the Board shall be bound to consider the following:

i) competitiveness with rates paid in Ontario, Saskatchewan and Alberta, more specifically the OPA;
ii) physician resources and recruitment and retention of physicians;
iii) the general economic circumstances;
iv) the bargaining history of the parties; and
v) the *Canada Health Act* (and any other applicable legislation).

Further, in assessing the above-noted factors, the Board shall consider the principles of fairness and reasonableness.

15:06 The Board shall issue one (1) overall award for fee-for-service physician services, excluding private laboratories services. To explain and support its position before the Board with respect to the amount of the overall award for fee-for-service physician services, each party shall be entitled to make as many submissions as it deems necessary on a group by group and issue by issue basis before an overall award is made.

15:07 Once the Board has determined the overall award for fee-for-service physician services, the parties shall make every reasonable effort to reach an agreement as to how the award shall be allocated among the various blocs of practice. If the parties are unable to agree on the allocation within thirty (30) calendar days of the decision of the Board, either party may ask the Board to determine the appropriate allocation. Once the allocation of the award among the various blocs of practice has been determined, either by agreement between the parties or by the Board, the parties shall make every reasonable effort to reach an agreement as to how the award shall be allocated within each bloc of practice. If the parties are unable to agree on the allocation within each bloc of practice within sixty (60) calendar days of the determination of the allocation among the various

blocs of practice, either party may ask the Board to determine the appropriate allocation within each bloc of practice.

15:08 For the purpose of determining the overall award for fee-for-service physician services effective April 1, 2019 and for the purpose of allocating such award, the parties agree to use the Manitoba Health A4MC300RPT3 report for the twelve months ending March 31, 2019.

15:09 Following the determination of the overall award for fee-for-service physician services, the Minister shall forthwith increase the compensation payable to all physicians covered by alternate funding agreements/payment arrangements referenced in Schedule "1", by an amount equal to one half (1/2) of the overall annualized percentage increase consistent with the overall award for fee-for-service physician services.

15:10 Each party shall select two (2) of the alternate funded agreements/payment arrangements referenced in Schedule "1", or one (1) of the alternate funded agreements/payment arrangements referenced in Schedule "1" and the Retention Fund denoted in Article 8 to then be the subject of four (4) distinct awards by the Board. The parties shall, within two (2) weeks of the award issued under sub-article 15:06, notify each other of the distinct matters so selected. The Board shall determine the order in which the four (4) distinct matters are arbitrated. Following the determination of each distinctive award the Minister shall forthwith implement such award, less the amount already paid under sub-article 15:09.

15:11 Once the Board determines the awards under sub-article 15:10, the Board shall proceed to determine one (1) overall award for the remaining alternate funded agreements/payment arrangements as well as the Retention Fund denoted in Article 8 if it has not already been the subject of a distinct award issued by the Board pursuant to sub-article 15:10. In so doing, the Board shall not take into account the four (4) distinct awards under sub-article 15:10, but shall honour, make no variation to and take into account any of the Board's other awards.

15:12 To explain and support its position before the Board with respect to the amount of the overall award for alternate funded agreements/payment arrangements and/or the Retention Fund denoted in Article 8, each party shall be entitled to make as many submissions as it deems necessary on a group by group and issue by issue basis before an overall increase is awarded.

15:13 Once the Board has determined the overall increase for the remaining alternate funded agreements/payment arrangements and/or the Retention Fund denoted in Article 8, the Minister shall forthwith implement the award, less the amount already paid under sub-article 15:09.

15:14 At all times prior to the commencement of arbitration hearings provided for under this Agreement, Doctors Manitoba shall be entitled to raise new issues not covered by this Agreement with respect to physicians for whom Doctors Manitoba acts or may act in the future. In the event Manitoba takes the position that any such issue is not arbitrable, the provisions of Article 16 hereof shall not apply in respect of that issue.

15:15 For the duration of this Agreement, the period covered by the next master agreement, or the period covered by an arbitration award, there shall be no fee-for-service global cap or funding envelope or expenditure limit, income caps or thresholds, caps by bloc of practice or other such expenditure limits.

15:16 The Board shall be established in accordance with the provisions of Appendix "A" attached hereto and forming part of this Agreement.

15:17 The parties shall make every reasonable effort to expedite the arbitration process and shall request that the Board schedule sufficient hearing dates.

ARTICLE 16 – CONTINUITY OF SERVICES

16:01 For the duration of this Agreement, the period covered by the next master agreement, or the period covered by an arbitration award:

(a) Doctors Manitoba shall not declare, organize, authorize, encourage or incite any stoppage of work or strike or withdrawal or curtailment of services or slowdown by medical practitioners;
(b) Doctors Manitoba shall take all reasonable steps to ensure medical practitioners continue to provide all services without interruption;
(c) medical practitioners shall not participate in a stoppage of work or strike or withdrawal or curtailment of services or slowdown and shall continue to provide all services without interruption;
(d) paragraphs (a) to (c) above shall apply only to those physician services with respect to which the parties have entered into an agreement or which are capable of being referred to a Board of Interest Arbitration for final determination.

ARTICLE 17 – RIGHTS ARBITRATION

17:01 If a difference arises out of the interpretation, application, operation or any contravention or alleged contravention of any agreement entered into between Doctors Manitoba and Manitoba or Regional Health Authority, or as to whether any such difference can be the subject of arbitration, the parties shall meet and attempt to resolve the difference. If the matter is not resolved promptly either party may refer the dispute to a sole Rights Arbitrator for determination in accordance with Appendix "B" attached hereto and forming part of this Agreement.

ARTICLE 18 – ENTIRE AGREEMENT

18:01 This Agreement constitutes the entire Agreement between the parties hereto in respect of the subject matters contained herein, and no other intentions, or undertakings, whether express or implied, form part of this Agreement.

ARTICLE 19 – RATIFICATION

19:01 Doctors Manitoba shall recommend acceptance of this Agreement to its members. This Agreement shall become final and binding upon written communication by Doctors Manitoba of such acceptance to Manitoba.

IN WITNESS WHEREOF the parties hereto have executed these presents the day and year above written.

HER MAJESTY IN RIGHT OF THE PROVINCE OF MANITOBA, REPRESENTED BY THE MINISTER OF HEALTH

"ORIGINAL SIGNED"

Per: _____

Honourable Sharon Blady
Minister of Health

DOCTORS MANITOBA

"ORIGINAL SIGNED"

Per: _____

Robert D. Cram
Chief Executive Officer

APPENDIX "A"

Board of Interest Arbitration

1. The Board of Interest Arbitration shall be composed of three (3) persons, one (1) appointed by Doctors Manitoba, one (1) appointed by the Minister and the Chairperson to be selected by the parties. No medical practitioner or person who has a pecuniary interest in a matter before such Board of Interest Arbitration, 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 either of the parties hereto, or is currently an employee of the Government of Manitoba, shall be eligible for appointment as a member of such Board of Interest Arbitration. An individual who is otherwise eligible to be a member of the Board of Interest Arbitration shall not be disqualified solely as a result of having been the appointee of either party to a previous Board of Interest Arbitration.

2. The Board of Interest Arbitration constituted hereunder shall have the power to determine its own procedures and shall have the power to receive and accept such evidence and information, affidavit or otherwise as in its discretion the Board sees fit, whether admissible in a Court of Law or not; and the Board of Interest Arbitration shall give full opportunity to the parties to present evidence, make submissions, and to be heard.

3. There are three (3) separate arbitration processes that are referenced in this Agreement, namely the arbitration regarding the overall award for fee-for-service physician services referenced in sub-article 15:06, the arbitration regarding the four (4) distinct matters referenced in sub-article 15:10 and, the arbitration regarding the overall award for alternate funded agreements/payment arrangements and/or the Retention Fund denoted in Article 8 referenced in sub-article 15:11. Five (5) weeks prior to the commencement of each of the above arbitration processes, Doctors Manitoba shall provide to the Minister and file with the Board its written submission regarding all matters to be addressed before the Board in that arbitration. Two (2) weeks after receipt of Doctors Manitoba's submission, the Minister shall provide to Doctors Manitoba and file with the Board the Minister's written submission regarding all matters to be addressed before the Board in that arbitration. The written submissions shall contain the substance of each party's position and argument on all matters to be addressed before the Board in that arbitration, but neither party shall be precluded from making further submissions, so long as such submissions do not materially depart from their original submission, or from submitting supporting evidence during the course of that arbitration.

4. Eight (8) weeks prior to the commencement of the arbitration regarding the overall award for alternate funded agreements/payment arrangements and/or the Retention Fund denoted in Article 8 referenced in sub-article 15:11, Doctors Manitoba shall provide to the Minister and file with the Board a list of those alternate funded agreements/payment arrangements or the Retention Fund denoted in Article 8 which it intends to address specifically in its written submission in the arbitration process to follow. One (1) week after receipt of Doctors Manitoba's list, the Minister shall provide to Doctors Manitoba and file with the Board the Minister's list of those alternate funded agreements/payment arrangements or the Retention Fund denoted in Article 8 which the Minister intends to address specifically in the Minister's written submission in the arbitration process to follow.

5. In making its decision, the Board of Interest Arbitration shall consider any matter or factor, which it judges to be relevant based on the evidence submitted and on the merits.

6. The decision of a majority of the members of the Board of Interest Arbitration shall be the decision of the Board of Interest Arbitration.

7. The Board of Interest Arbitration shall make its decision in regard to the specific matter(s) referred to it within thirty (30) days from the completion of the hearing respecting the matter(s), or within such longer period of time as the parties may mutually agree upon.

8. The decision of the Board of Interest Arbitration shall be final and binding on both parties and on physicians, and shall not be appealed to or reviewed by any Court.

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

10. Each party to the Board of Interest Arbitration shall be responsible for the approved costs and expenses of its appointee to such Board of Interest Arbitration, and the approved costs and expenses of the Chairperson shall be shared equally between the parties.

APPENDIX "B"

Rights Arbitration

1. A sole Arbitrator shall be selected by the parties. No medical practitioner or person who has a pecuniary interest in a matter before such Arbitrator 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 either of the parties hereto, or is currently an employee of the Government of Manitoba, shall be eligible for appointment as Arbitrator. An individual who is otherwise eligible to be an Arbitrator shall not be disqualified solely as a result of having been the Chairperson to a previous Board of Arbitration between the parties.

2. If the parties have been unable to agree upon an Arbitrator, the parties shall each propose the name of a potential Arbitrator and shall jointly submit the two (2) names to a "tie-breaker", to be jointly appointed by the parties, who shall, within three (3) business days, select one (1) of the named persons to act as Arbitrator. The parties agree that the tie-breaker shall not be apprised of which party proposed which name.

3. The Arbitrator appointed hereunder shall have the power to determine his/her own procedures and shall have the power to receive and accept such evidence and information, affidavit or otherwise as in his/her discretion he/she sees fit, whether admissible in a Court of Law or not; and the Arbitrator shall give full opportunity to the parties to present evidence, make submissions, and to be heard. The Arbitrator shall have full remedial authority and shall order such remedy as may be just, but the Arbitrator shall have no jurisdiction to amend the provisions of any agreement between the parties.

4. In making his/her decision, the Arbitrator shall consider any matter or factor, which he/she judges to be relevant based on the evidence submitted and on the merits.

5. The Arbitrator shall make his/her decision in regard to the specific matter(s) referred to him/her within thirty (30) days from the completion of the hearing respecting the matter(s), or within such longer period of time as the parties may mutually agree upon.

6. The decision of the Arbitrator shall be final and binding on both parties and on physicians and shall not be appealed to or reviewed by any Court.

7. Immediately upon receipt of the decision of the Arbitrator the parties shall forthwith give effect to and implement the decision. In the event a question arises with respect to interpreting the decision, the Arbitrator shall remain seized of the matter and shall provide clarification to the parties as may be appropriate, but the Arbitrator shall not change his/her decision in any way.

8. The parties shall share equally in the approved costs and expenses of the Arbitrator.

APPENDIX "C"

THIS AGREEMENT made this 26th day of June, 2001

BETWEEN:

HER MAJESTY IN RIGHT OF THE PROVINCE OF MANITOBA, REPRESENTED BY THE MINISTER OF HEALTH
(hereinafter "Manitoba")

- and -

MANITOBA MEDICAL ASSOCIATION
(hereinafter the "MMA")

WHEREAS the parties wish to establish a mechanism to incorporate into the Manitoba Physician's Manual "provisional" fee tariffs,

NOW THEREFORE the parties hereto agree as follows:

1. This Agreement shall be in effect from July 1, 2001, and shall continue in full force and effect until such provisions are changed by mutual written agreement of the parties.

2. By agreement between the parties, a fee tariff may be included in the Manitoba Physician's Manual as a "provisional tariff".

3. The Physician's Manual shall be amended to include a Rule of Application for provisional tariffs. Appendix "A" attached hereto sets out the precise wording of this amendment.

4. Each claim for a provisional tariff shall include the information set out in Appendix "A" of this agreement.

5. A provisional tariff shall remain provisional for a period not to exceed eighteen (18) months (the "evaluation period") following the effective date of the tariff. During the evaluation period, Manitoba shall review claim submissions and operative reports to determine the level of complexity and amount of time that is involved in providing the service. Manitoba shall, upon request, provide to the MMA copies of these claim submissions and operative reports.

6. Upon the expiration of the evaluation period, each party shall notify the other in writing as to whether they agree to have the provisional tariff incorporated into the Manitoba Physician's Manual as a permanent tariff.

7. If the parties agree that the provisional tariff shall be incorporated into the Manitoba Physician's Manual as a permanent tariff, Manitoba shall amend the Manual accordingly.

8. If the parties do not agree that the provisional tariff shall be incorporated into the Manitoba Physician's Manual as a permanent tariff, the parties shall have two (2) weeks to negotiate amendments to the rate and/or description of the tariff.

9. If, by the end of the two (2) week period, the parties agree upon the rate/description of the tariff, Manitoba shall amend the Manitoba Physician's Manual to include the tariff as a permanent tariff.

10. If, by the end of the two (2) week period, the parties do not agree upon the rate/description of the tariff, the issue shall be referred to a single arbitrator.

    The parties shall maintain a list of potential arbitrators who shall be selected on a rotating basis to hear disputes pursuant to this Agreement.

    The arbitrator shall have the power to determine his/her own procedures and shall have the power to receive and accept such evidence and information as he/she sees fit, whether admissible in a Court of Law or not. The arbitrator shall give full opportunity to the parties to present evidence, make submissions, and to be heard.

    The arbitrator shall render his/her decision regarding the rate/description of the tariff in writing within thirty days of completion of the hearing respecting the matter or within such longer time as the parties may mutually agree upon.

    The approved and agreed upon costs and expenses of the arbitrator shall be shared equally between the parties.

    The decision of the arbitrator shall be final and binding on both parties.

    Following receipt of the decision of the arbitrator, Manitoba shall advise physicians of the permanent fee tariff in the Physician's Newsletter and subsequently amend the Manitoba Physician's Manual to include the tariff as a permanent fee tariff.

11. During the dispute resolution process, the tariff shall continue to be listed in the Manitoba Physician's Manual as a provisional tariff and shall continue to be paid accordingly.

12. If, following the evaluation period, a provisional tariff is deleted from the Physician's Manual, and is:
    a) not replaced by a permanent tariff, or
    b) replaced by a permanent tariff at a rate different than the rate of the provisional tariff

    no retroactive adjustment to claims for services provided during the term of the provisional tariff shall arise therefrom.

13. This Agreement constitutes the entire Agreement between the parties hereto, and no other intention or undertaking, whether express or implied, forms part of this Agreement.

14. The MMA shall recommend acceptance of this Agreement to its Board of Directors. This Agreement shall become final and binding upon written communication by the MMA of such acceptance to Manitoba.

HER MAJESTY IN RIGHT OF THE PROVINCE OF MANITOBA, REPRESENTED BY THE MINISTER OF HEALTH, ACTING FOR THE WRHA

Per: (ORIGINAL SIGNED BY)
Rick Dedi
Asst. Deputy Minister,
Insured Benefits, Pharmacare
and Labour Market Services

MANITOBA MEDICAL ASSOCIATION

Per: (ORIGINAL SIGNED BY)
John Laplume
Executive Director

APPENDIX "D"

TRIPARTITE AGREEMENT dated February 12, 2015

BETWEEN:

HER MAJESTY IN RIGHT OF THE PROVINCE OF MANITOBA, REPRESENTED BY THE MINISTER OF HEALTH,

(hereinafter "Manitoba")

- and -

DOCTORS MANITOBA

(hereinafter "Doctors Manitoba")

- and -

THE HEALTH SYSTEM STAKEHOLDERS IDENTIFIED IN THE ATTACHED SCHEDULE "A"

(hereinafter the "Stakeholders")

WHEREAS Manitoba and the Stakeholders have a shared obligation and the paramount responsibility to ensure that quality health care services are delivered to Manitobans through a system which is, to the fullest extent possible, sustainable, accessible, cost-effective, accountable, integrated, adaptable, innovative, efficient and effective;

AND WHEREAS Doctors Manitoba represents a majority of the physicians in Manitoba and those physicians have a significant and valued role in the provision of health care services in the Province of Manitoba and have a shared obligation and responsibility in the continued provision of appropriate, quality health care to Manitobans;

AND WHEREAS numerous health care matters previously discussed and negotiated between Manitoba and Doctors Manitoba affect the health care system of which the Stakeholders are a part such that it would be beneficial for them to be involved in these discussions and negotiations both now and in the future;

AND WHEREAS Manitoba, Doctors Manitoba and the Stakeholders (hereinafter collectively referred to as the "parties") wish to continue a relationship based on trust, respect, confidence, communication, collaboration

and cooperation so that they can work together to develop strategies to address certain of these matters which are key to the improvement of the health care system in Manitoba;

AND WHEREAS the parties have decided to enter into this Agreement to continue to foster such a relationship and address these matters;

NOW THEREFORE the parties acknowledge and agree as follows:

Article 1 – Systemic Improvements and Service Delivery

1:01 The parties will, pursuant to the Committee structure established pursuant to Article 2 of this Agreement, work together in an effort to improve health care delivery within the Province of Manitoba by developing proposals and strategies to respond to and address the following matters and/or initiatives:

(A) Systemic Improvements

i) Health System Sustainability

Doctors Manitoba acknowledges that health care system sustainability is a key priority for Manitoba. The parties commit to work together with health system stakeholders during the term of the Master Agreement to discuss, explore and facilitate system improvement to enhance the sustainability of the health care system, in an effort to realize medical and health care system efficiencies of $50 million over the term of the Master Agreement, while still ensuring the delivery of high quality, appropriate and comprehensive care to improve health for Manitobans.

The parties agree that a broad provincial approach to the review of the current health care system must be taken in order to achieve any transformative and sustained health care system change. In addition, the parties agree that, in discussing potential system improvements, a broad health care sector perspective needs to be engaged with respect to current health care service utilization. It is recognized that health care system utilization efficiencies can only be achieved through partnership and engagement with, and the support of the health care providers involved, given the extent to which effective implementation of such efficiencies are within the purview of health care service providers. To this end, potential service reduction cost efficiency strategies will be considered, including but not limited to:

1) The use of most appropriate health care providers and settings.
2) The implementation of best practice and appropriate care guidelines.
3) The appropriate use of diagnostic services.
4) The use of quality care indicators and workload measures.
5) The modernization of the Physician's Manual.
6) The introduction and expansion of technological change as a mechanism to improve system delivery.
7) The use of public health, preventative medicine and public education.
8) The management and coordination of care based on Manitoba's provincial population.
9) The utilization of and transparency in data collection, including feedback.

Specific areas of exploration are as more particularly described in Schedule "B" attached hereto.

ii) Collaborative and Quality Care

The parties are of the view that overall quality care improvement within the health care system requires linking individual health care professionals' service provision with improved systemic delivery of patient-centred, inter-professionally delivered collaborative care and reflect emerging evidence on effective and safe transitions of care.

Physicians, as clinical leaders within the health care system, play a fundamental role in this. The parties will work together to encourage physicians to continue to work collaboratively with other health care team members, within the primary care setting and otherwise, to further facilitate the implementation of inter-professional and/or team-based patient centred care models within the health care system and improve the quality of care for Manitobans.

Manitoba supports the Patient's Medical Home direction described by the College of Family Physicians of Canada and the associated standards of care. The parties will work together to support the provision of quality care to patients in a demonstrable and transparent manner across Manitoba.

To that end the parties will discuss various quality measures and processes.

(B) Models of Care

i) Independent Contractors

The alternately funded remuneration agreements which form part of the Master Agreement will be reviewed by the parties with a view to amending them to more clearly reflect certain of the physicians' status as independent contractors and the structure of their independent contractor relationships with the stakeholders. The parties agree that, where possible, independent contractor physicians shall assume responsibility for all of the overhead expenses associated with the services they provide. To this end, the parties are committed to working to eliminate the Independent Contractor Fee No. 2 physician category ("IC2"), as contained in the alternately funded remuneration agreements during the term of the Agreement. The parties will also work together to make any necessary amendments to the applicable agreements to reflect such elimination.

ii) Access to Care:Telemedicine

Manitoba continues to be committed to improving access to patient care across the province. The parties agree to work together, in consultation with MB Telehealth – WRHA, to improve access to care by considering increasing access to telemedicine services in Manitoba where appropriate. Consideration will also be given to amending the wording of the tariff descriptions and Rules of Application for telemedicine in the Physician's Manual in order to further this goal.

iii) Pathology

Workload measures have been agreed to for pathologists and are contained in the pathology agreements which form part of the Master Agreement. The parties agree to work together over the term of this Agreement to consider the appropriateness of the workload measures contained within the agreements with a view to adopting alternate workload measures as necessary and where appropriate as agreed in writing by the parties.

iv) Rural and Northern Emergency Room Services

The parties acknowledge and agree that certain concerns have arisen regarding the provision of emergency room

services in various communities in rural and northern Manitoba. They further acknowledge that the model of service delivery for these communities is being reviewed.

As denoted in the Basic A and B Hospitals Memorandum of Understanding dated February 12, 2015, it is anticipated that during the term of the 2015 Master Agreement, different models of service may be piloted in relation to the delivery of emergency room services in communities served by Basic A and B hospitals in various parts of the Province. The parties agree to work together with respect to development and implementation of such models of service on a trial basis over the term of the Master Agreement.

Article 2 – Master and Working Committees

2:01 The parties hereby constitute the following Committees to oversee and provide general guidance to the tripartite relationship, manage the processes outlined within this Agreement and ensure that proposals and strategies for responding to the specific matters of concern or initiatives outlined in Article 1 of this Agreement are developed and implemented by consensus:

(A) Tripartite Process Management Master Committee

i. The Tripartite Process Management Master Committee ("Master Committee") shall consist of the Deputy Minister of Health, Healthy Living and Seniors, the Chief Executive Officer of Doctors Manitoba and a health system stakeholder representative to be appointed by the Deputy Minister.

ii. The Master Committee shall:

a. oversee and provide guidance to the tripartite relationship generally;
b. work to resolve any issue(s) forwarded to it by the Tripartite Process Working Committee(s);
c. develop and manage the processes and procedures for, as well as the specific list of matters to be considered and tasks to be performed by, the Tripartite Process Working Committee(s);
d. refer any medical remuneration matters arising out of consideration of any New Model of Care or policy matter that cannot be agreed upon, back to the Tripartite Process Working Committee(s) with directions as to further analysis.

iii. Decisions or recommendations of the Master Committee shall be by consensus. Once consensus is achieved and Doctors Manitoba has, where required, confirmed ratification by physicians, the Systemic Improvement or Model of Care matter shall, if appropriate be integrated into the Master Agreement and all relevant terms and provisions thereof, including Continuity of Services (Article 16) and Binding Arbitration (Articles 15 and 17), shall be applicable.

(B) Tripartite Process Working Committee(s)

i. The Tripartite Process Working Committee(s) ("Working Committee(s)") shall consist of up to 6 members, up to 2 of whom shall be appointed by each one of the parties. Each party shall have equal representation on the Committee(s).

ii. The Working Committee(s) shall work to address and resolve the specific matters of concern as delegated to them by the Master Committee in accordance with the processes and procedures developed by the Master Committee.

iii. Decisions of the Working Committee shall be by consensus. Any matter that cannot be agreed upon shall be referred to the Master Committee for resolution.

Article 3 – Roles and Responsibilities of the Parties

3:01 The parties agree to cooperate fully toward the realization of the objectives set out in this Agreement. The parties shall actively participate in and work with the Master Committee and Working Committee(s) as required in order to facilitate consideration and resolution of the matters addressed by the Committees.

3:02 The parties acknowledge and agree that additional resources may, in some cases, be required to fund medical remuneration costs associated with Systemic Improvement or Model of Care matters. If such additional resources are required in order to ensure that the parties can work effectively to structure the new medical service delivery models and appropriately compensate for same if consensus is reached as to new Systemic Improvement or Model of Care matters, the amount of required funding for the identified Systemic Improvement or Model of Care issue(s) and the allocation of same will be determined by Manitoba after it has considered any recommendations that have been made by the Master Committee and/or Working Committees. Once Manitoba has determined the amount of required funding and the allocation of same, all medical

remuneration proposals will be subject to a Doctors Manitoba ratification process by the affected physicians.

3:03 The parties acknowledge and agree that the terms of this Agreement do not commit or require any party to provide funding of any kind in relation to the activities of the Committees.

Article 4 – Duration

4:01 This Agreement shall be effective upon execution by the parties hereto, and shall remain in full force and effect until March 31, 2019. The terms hereof may be extended beyond March 31, 2019 by mutual written agreement of the parties.

Article 5 – Amendment

5:01 Amendments to this Agreement, including identification of the matters to be considered and addressed by the Committees, may be made at any time with the written consent of the parties.

Article 6 – Entire Agreement

6:01 This Agreement constitutes the entire Agreement between the parties hereto with respect to the matters contained herein, and no other intentions or undertakings, whether express or implied, form part of this Agreement.

Article 7 – Execution of Agreement

7:01 This Agreement may be executed in any number of counterparts each of which, when so executed, shall be deemed to be an original and all such counterparts shall constitute one and the same instrument and, notwithstanding the date of actual execution, shall be deemed to have been executed on the day and year written above.

IN WITNESS WHEREOF the parties hereto have executed these presents the day and year written above.

HER MAJESTY IN RIGHT OF THE PROVINCE OF MANITOBA, REPRESENTED BY THE MINISTER OF HEALTH

Per: _____

DOCTORS MANITOBA

Per: _____

INTERLAKE EASTERN REGIONAL HEALTH AUTHORITY

Per: _____

NORTHERN REGIONAL HEALTH AUTHORITY

Per: _____

SOUTHERN HEALTH– SANTE SUD

Per: _____

PRAIRIE MOUNTAIN HEALTH

Per: _____

DIAGNOSTIC SERVICES OF MANITOBA INC.

Per: _____

UNIVERSITY OF MANITOBA

Per: _____

WINNIPEG REGIONAL HEALTH AUTHORITY (including the Churchill Health Centre Division)

Per: _____

CANCERCARE MANITOBA

Per: _____

Schedule "A"

STAKEHOLDER SIGNATORIES

- Interlake Eastern Regional Health Authority;
- Northern Regional Health Authority;
- Southern Health – Santé Sud;
- Prairie Mountain Health;
- Diagnostic Services of Manitoba Inc.;
- University of Manitoba (including the J.A. Hildes Northern Medical Unit);
- Winnipeg Regional Health Authority (including the Churchill Health Centre Division);
- CancerCare Manitoba.

Schedule "B"

Health System Sustainability

Tripartite Agreement Working Committees to analyze and develop for implementation potential service (and volume) reduction-cost efficiency strategies, for *province-wide application*, related to:

1. **The use of most appropriate health care providers and settings.**
2. **The implementation of best practice and appropriate care guidelines.**
3. **The appropriate use of diagnostic services.**
4. **The use of quality care indicators and workload measures.**
5. **The modernization of the Physician's Manual.**
6. **The introduction and expansion of technological change as a mechanism to improve system delivery.**
7. **The use of public health, preventative medicine and public education.**
8. **The management and coordination of care based on Manitoba's provincial population.**
9. **The utilization of and transparency in data collection, including feedback.**

More particularly, areas of exploration could include, but are not limited to, the following:

1. **The use of most appropriate health care providers and settings.**

   By engagement in an assessment and re-evaluation of where and by whom aspects of health care are delivered, there are opportunities to reduce the need for medical service intervention (reducing the number of patient visits, examinations, consultations, specialist referrals, and in some cases procedures performed). This review may include for example:

   a. The use of medical homes and health care teams ("My HTs") in an effort to support continuous patient care through the use of most appropriate and qualified health care providers.
   b. Identifying lower-cost providers, settings and services for care (could include discussion of insuring or de-insuring various services).

c. the use of non-FFS settings to deliver primary care to specific appropriate patient populations (e.g. chronic conditions, complex care needs).
d. Exploring the introduction of new models of care, and the consolidation of services at fewer sites with fewer health care providers, where appropriate and feasible, (e.g. "Hub and Spoke" ER care model; number of Basic A and B ER facilities in operation in rural/northern Manitoba).
e. Analysis of follow-up care and its delivery with a view to services being provided in a lower cost setting where appropriate and possible.
f. Improving access to palliative care services in patients' homes.
g. The use of collaborative care in FFS settings.

2. The implementation of best practice and appropriate care guidelines.

Based, in part, on principles developed and advocated through the *Choosing Wisely* initiative (supported by the Canadian Medical Association), it may be possible to reduce the number of patient visits, examinations, consultations, specialist referrals, and in some cases procedures performed. This review may include, for example:

a. Improving access to palliative care services for a patient with a serious illness, who is pursuing disease-directed treatment.
b. Use of colonoscopies for patients deemed low risk for colon cancer.
c. Avoiding unnecessary procedures (e.g. minimally symptomatic inguinal hernia repairs, needle lavage treatment for knee arthritis.

3. The appropriate use of diagnostic services.

Based, in part, on principles developed and advocated through the *Choosing Wisely* initiative, it may be possible to reduce the number of patient visits, examinations, consultations, specialist referrals, and in some cases procedures performed. This review may include for example:

a. The use of routine, preoperative laboratory or other testing (e.g. chest X-rays, ECGs, cardiac stress tests) for low risk surgeries without any clinical indication.
b. Imaging of lower-back pain and minor head trauma as a standard procedure if red flags are not present.
c. The use of whole body scans for diagnosing peripheral and axial arthritis in adults.
d. The use of Pap smear screening for patients who are under 21 and over 69 years of age.
e. Annual screening blood tests for low risk patients.
f. Routine examinations and testing such as Vitamin D tests or mammograms in low risk patients.
g. Public education on the necessity, benefits and risks of testing.

4. **The use of quality care indicators and workload measures.**

   This review may include for example:

   a. The continued implementation and use of processes and practices to help ensure efficiencies within the OR (including with respect to management of OR slates).
   b. Better linkage of physician remuneration to the effective management of a patient's primary care, and to the coordination of the patient's overall care with appropriate providers (through the continued use of patient enrollment and development of primary care quality indicators).
   c. The development of appropriate care plans that target the specific needs of the various health populations within the province through the use of quality indicators.

5. **The modernization of the Physician's Manual.**

   This review may include for example:

   a. Consideration of the introduction of a more comprehensive Manual, incorporating service delivery by nurse practitioners (NPs), physician assistants (PAs), clinical assistants (Cl.As) and, where applicable, nurses.
   b. Exploration of the introduction and delineation of the relative-value (percentage) of each service, by provider, billable on a per-clinic/network/team basis.
   c. Review of the visits, examinations and consultations in each bloc of practice in the Physician's Manual to ensure efficiency in service delivery. For example, that:
      - All patient issues are encompassed in the visit, examination;
      - Services are bundled where appropriate and not remunerated separately;
      - Current minimum and maximum *insured* levels of service are reviewed and evaluated;
      - Need for introduction of new maximum *insured* levels is considered (by service type, per day/annum, per patient, etc.);
      - Where determined appropriate, need for GP referral to specialist is eliminated.
   d. Review of the procedures in each section in the Physician's Manual to remove out-dated and cost-ineffective services in order to ensure that the most cost-effective, best value procedures are insured, remunerated and incented.
   e. Claims processes and assessment review.

6. **The introduction and expansion of technological change as a mechanism to improve system delivery.**

   This review may include for example:

   a. Access to Telemedicine.
   b. The implementation and use of electronic medical records (EMRs), in the context of My Health Teams and otherwise to integrate the regional systems, with each other and providers offices to help create clinical efficiencies.
   c. Exploring the use of a standardized physician scheduling system across the Regions, in an effort to streamline the complexities associated with scheduling physicians.

7. **The use of public health, preventative medicine and public education.**

   This review may include for example:

   a. Reviewing access to, resources for and drivers for the use of such resources for public health issues such as: smoking cessation, addictions care, obesity and prenatal care.
   b. Exploration of the development of a mental-health strategy for children including identifying and treating mental health issues early in children and considers the use of collaborate care and a range of health care providers for the provision of care.
   c. The development of an elder care strategy.

8. **The management and coordination of care based on Manitoba's provincial population.**

   This review may include for example:

   a. The inclusion of culturally appropriate supports in the provision of health care (e.g. the inclusion of Aboriginal Spiritual/Cultural Care Providers into a patient's health care team).
   b. Development of strategies to encourage medical residents, nursing and other students to fill system vacancies by working in rural and northern communities.
   c. Identification of and engagement with the system's highest-risk patients (using *Patient Utilization Review Committee*, hospital admission information, etc.) to develop specific efficiency strategies associated with treating those patients.
   d. The use of medical residents and physicians assistants to assist pre-op and post-op orthopaedic patients, in terms of the coordination of their pain management plans, the communication of their protocols.

9. **The utilization of and transparency in data provision, including feedback.**

This review may include for example:

a. Consideration of funding to Regions being contingent on the provision of data to MHHLS with respect to quality indicators or workload measures as stipulated by the Committee, so that such data could be used to steer improvements and efficiencies in the system.

TAB 132

Doctors Manitoba

Board of Directors

Annual Reports

2014-2015

Governance and Nominating Committee Report

The purpose of the Governance and Nominating Committee is to provide a focus on board governance that will enhance Doctors Manitoba's performance by assessing and making recommendations regarding board effectiveness, the recruitment of board members, and the selection of the President of the Board of Directors, Board Officers and the Board Chair.

Key activities of the Governance and Nominating Committee:

- Board Composition – Succession Planning
- Board Recruitment and Needs Assessment
- Board Representation on Operational Committees
- Nominations/Appointments for Doctors Manitoba Executive
- Nominations/Appointments for CMA Committees
- Board Self-Evaluation Process

Members of the Governance and Nominating Committee:

- Dr. Darcy Johnson (Chair)
- Dr. David Cram
- Dr. Barbara Kelleher
- Dr. Albert Chudley
- Dr. Brian Rumbolt
- Mr. Scott Baldwin (QSM Consulting)
- Dr. Robert Kippen (ex-officio)
- Mr. Robert Cram (ex-officio)

Doctors Manitoba

Finance and Audit Committee Report

The purpose of the Finance and Audit Committee is to coordinate the Board of Directors financial oversight responsibilities by recommending policy to the Board and monitoring its implementation. The Committee also provides board oversight of Doctors Manitoba's annual financial audit.

Key activities of the Finance and Audit Committee:

- Review Annual Audit Plan
- Receive and review audit presentation from Auditor
- Review Quarterly Financial Statements
- Review Annual Budgets
- Reviewed financial reporting protocols and timelines
- Review and recommend investment for Doctors Manitoba reserve funds

Audited Financial Statements

We are pleased to report that Doctors Manitoba continued its strong financial position in 2014, recording a surplus of **$376,090** *(2013 - $284,269)* and net assets of **$7,519,617**, an increase of 5.3% (2013 - *$7,143,527)*.

At August 31, 2014, Doctors Manitoba net assets consisted of **$2,958,252** in Capital Assets (building), **$4,561,365** in Unrestricted Net Assets (in the form of cash and investments).

Overall revenue in 2014 *($3,941,156)* increased by 3.2% from 2013 *($3,820,672)*, mainly due to a $61,218 increase in Memberships Dues *(2014 - $2,970,433 vs. 2013- $2,909,215) and* a $34,768 *(2014 - $432,814 vs. 2013 - $398,046)* increase in interest earned on reserves held by Insurers and insurance administration allowances.

Note that approximately 75% of the Association's revenue is derived from Membership Dues *(2014 - $2,970,433)* and that another 10% is derived from Benefit Program Administration Fees *(2014 - $350,000)*. These steady and predictable revenues provide the Association with a consistent cash flow year to year.

Doctors Manitoba

Overall expenses in 2014 increased by $297,550 (*2014 - $3,701,524 vs. 2013 - $3,403,974*). Two initiatives in 2014, per our Strategic Plan, contributed to the increased expenses – sponsorship of the Fit Kids Healthy Kids program with Sport Manitoba ($150,000) and the development Phase 2 of the Doctors Care TV series ($167,000).

As a result of the continued financial strength of Doctors Manitoba, membership dues will remain unchanged for 2015-16. Doctors Manitoba membership fees have not been raised since 2007. A full-time member will continue to pay **$1,145.**

Members of the Finance and Audit Committee:

- Dr. Barbara Kelleher (Chair)
- Dr. David Cram
- Dr. Aaron Chiu
- Mr. Harold Dueck (CA)
- Dr. Robert Kippen (ex-officio)
- Mr. Robert Cram (ex-officio)

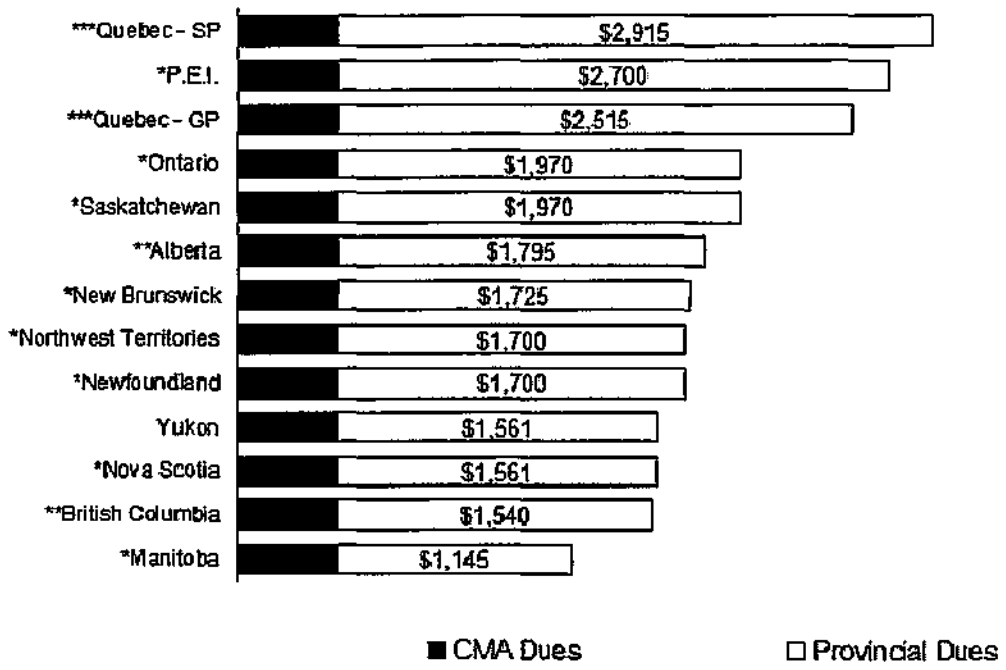
Membership Report

The trend of increased membership in Doctors Manitoba continued last year. At December 31, 2014 there were 4,172 physicians registered in Manitoba, which is a net gain of 2.4% over the previous year *(2013 – 4,075)*.

	DEC31-2014		DEC31-2013	
	Member	**Affiliate**	**Member**	**Affiliate**
Full-Time	2,146	161	2,121	122
Resident	548	23	541	19
Retired	183	12	182	7
Part-Time	82	15	89	10
Non-Resident	-	264	-	244
Student	431	-	433	-
Honorary	46	-	48	-
Salaried	190	41	187	41
Other	17	13	4	27
TOTAL	**3,643**	**529**	**3,605**	**470**

Doctors Manitoba

Provincial/Territorial Medical Association Membership Dues Comparison (JAN-2015)



Note: All provincial dues are represented in the Canadian Medical Association Fee Schedule. CMA dues are $495 for a Full-Time Member for 2015.

* *Payment of provincial dues is compulsory by law*

** *Physicians must either be members or pay an administrative fee to receive benefits.*

*** *Quebec physicians pay dues on a compulsory basis to either the General Practitioners Federation or the Specialists Federation at the rates shown. The Federations represent Quebec physicians in fee negotiations with the province, not the QMA. The rates shown also include non-compulsory dues of $315 to the QMA.*

Doctors Manitoba Dues were last increased effective September 1, 2007 from $945 to $1145.

Doctors Manitoba

Health and Wellness Committee Report

Doctors Manitoba established a Physician Health and Wellness Committee in December 2012. The Committee's main goal is to provide assistance and guidance to all Manitoba physicians for wellness activities.

Physician health has traditionally been centered on stress and burnout, but the emphasis is now shifting towards wellness promotion and encouraging doctors to look after their long-term health. As such, the Committee has been working on developing a master plan that provides a broad range of assistance and training to its members for wellness activities.

The Board of Directors first set out the terms of reference for the Committee that included the following:

- Develop Education/ Workshops for Manitoba physicians
- Develop an EAP program for Manitoba physicians
- Develop a Wellness program for Manitoba physicians
- Develop a physician connection line for Manitoba physicians to access a Family Physician
- Complete a Survey of Manitoba Doctors

The Physician Health and Wellness Committee identified some strategic initiatives in 2014 for action. These initiatives included:

- Facilitate the hosting of the Canadian Conference on Physician Health in Winnipeg in 2015.
- Organize and offer as many health and wellness related workshops as possible
- Work with an insurance company to introduce a Physician Assistance Plan to all Manitoba physicians, residents and medical students.
- Create a Doctors Manitoba Physician Health and Wellness website to raise awareness of the importance of physician health and promote wellness initiatives

During 2014 (and early 2015), the Health and Wellness committee presented a number of health and wellness workshops including:

Doctors Manitoba

1. Disruptive Behaviour offered through the CMA's Physician Management Institute
2. Introduction to Mindfulness instructed by Dr. Melanie St. Hilaire
3. Sustainable High Performance workshop instructed by Dr. Cal Botterill, Mr. Aman Hussain and Dr. Jason Brooks

Members of the Health & Wellness Committee:

- Dr. Flordeliz Osler (Chair)
- Dr. Terry Babick
- Dr. Mark Prober
- Dr. Rebecca Renkas
- Dr. Philippe Erhard
- Dr. Derek Fewer
- Dr. Jarrett Lobley
- Dr. Ann Loewen
- Mr. Shan Pirzada
- Dr. Cornelia Van Ineveld
- Dr. David Cram
- Dr. Robert Kippen (ex-officio)

Doctors Manitoba

Negotiated Benefits Program Update

Continuing Medical Education Program (CME)

Paid CME claims for year ended December 31, 2014 were 1,537, totaling $3,996,707. Total claims for the year increased by 2.3% over the previous year (1,537 vs. 1,502 in 2013). The maximum benefit of $3,500 was claimed by 42% of physicians. The year-end cash position of the fund at December 31, 2014 was $4,696,207.

Professional Liability Insurance Fund (PLIF)

PLIF Program rebates for year ended May 31, 2014 totaled $4,613,236. The 2014 year-end surplus amount is $296,561.

Maternity/Paternity Benefit Program

Paid maternity/paternity claims for the year ended December 31, 2014 totaled $957,843. Claims included 72 new claims plus 15 claims that began in 2013 and carried over into 2014. The year-end cash position of the fund is $28,909.

Physician Retention Program

Physician Retention payments for the year ended March 31, 2014 totaled $2,460,990. This amount was paid to the physicians who reached their five-year milestone during the year plus death and disability benefits during that year. The audited fund balance at March 31, 2014 was $13,256,750.

Doctors Manitoba

Insurance Program Update

The insurance plans administered by Doctors Manitoba continue to provide members with well-priced coverage while providing continued financial stability. Programs are currently operating with fully funded reserves.

Disability Income Plan

For the year ended May 31, 2014 the Disability Income Plan had a deficit of $428,799. The Disability Trust Account balance at December 31, 2014 was $2,267,012 of which $428,799 was transferred to the Insurer (Manulife Financial) to fully fund reserves. The balance in the Disability Trust Account at May 31, 2015 will be approximately $1,838,200. This reserve will be used to ensure stable rates in future plan years with a negative experience.

Office Overhead Expense Plan

For the year ended May 31, 2014 the Office Overhead Expense Insurance Plan generated a surplus of $46,471, allowing for a 70% refund of the 2013/2014 experience-rated premium ($61,855) to members (138) participating in the plan for 2015/2016. The balance in the Office Overhead Expense Account at May 31, 2015 will be approximately $253,400. This reserve will be used to provide future rebates and to ensure stable rates in future plan years with a negative experience.

Term Life Plan

For the year ended December 31, 2013 the Term Life Insurance Plan generated a surplus of $1,048,086. The Term Life Trust Account balance at December 31, 2014 was $2,503,115 of which $694,095 (50% of the 2013 experience rated premium) was refunded to members (1,700) participating in the plan in 2015.

Doctors Manitoba

Extended Health Care Plan

For the year ended June 30, 2014 the Extended Health Care Plan generated a surplus of $207,076. A portion of the surplus was directed to the Rate Stabilization Reserve while the balance remains on deposit with Blue Cross to subsidize future rate increases or to fund benefit enhancements. Premiums in 2015 were reduced by 10% for plan participants (448).

NEGOTIATIONS UPDATE

The Master Agreement

This past year has marked the negotiation and ratification of a new Master Agreement between Doctors Manitoba and Manitoba Health, Healthy Living and Seniors.

The new four year Master Agreement became effective on April1, 2015 and will expire in March 31, 2019. It includes all fee-for-service payments to physicians and services which are paid pursuant to 71 Doctors Manitoba negotiated alternate funded agreements. These agreements cover a wide variety of services from on-call to ICU coverage to employed physicians.

The new Master Agreement provides for increases of 1% in each year plus additional targeted money to both fee-for-service and alternately funded priority areas. Fee-for- service allocations were done by applying increases based on comparing fees to the Ontario-Prairie Average (the "OPA").

Other highlights include the introduction of Compressive Care Management tariffs which will come into effect in 2017, BMI premiums for various surgeries, and increases to the per diem rate for 24 hour off-site specialist on-call coverage from $442.85 to $500 through the term of the Agreement

Doctors Manitoba's benefits plans which are funded through the Master Agreement were also secured and strengthened for the duration of the Agreement. Increased funding to the

Doctors Manitoba

Paternity/Parental Benefits Fund and Continuing Medical Education Fund and continued funding to the Physicians Retention Fund was secured. Additionally the PLIF fund, which provides rebates for physicians CMPA dues, was renegotiated. Under a new negotiated model whereby the government and physicians each pay a set share of the CMPA dues, the government will more than double its previous funding commitment to this program.

There will be no fee-for-service cap, expenditure limit, income caps or thresholds for the duration of this Master Agreement.

In addition to the monetary gains, the Master Agreement will continue to contain language which acknowledges the OPA as a key factor in future deals.

The Master agreement was signed on February 12, 2015 and was unanimously endorsed by Doctors Manitoba's Board of Directors and overwhelmingly ratified by a vote of the membership.

The Master Agreement is not the only issue which kept negotiations staff busy over the past year. Doctors Manitoba continued to negotiate new funding for a wide range of Physician's Manual amendments, new fee tariffs, address billing disputes and provide negotiations services and advice to individuals and groups of physicians with regard to their remuneration with various RHAs and agencies.

Doctors Manitoba also continues to represent more than 500 residents and interns in their negotiations with the Winnipeg Regional Health Authority. Doctors Manitoba, on behalf of the Professional Association of Residents and Interns of Manitoba (PARIM) continues to work toward a negotiated settlement of this matter however in the event that negotiations are unsuccessful, arbitration is scheduled to commence on May 19, 2015.

Doctors Manitoba

AUDITS

Doctors Manitoba continues to represent both specialists and family physicians that are undergoing audits by Manitoba Health. Manitoba Health reviewed a wide variety of practices and tariffs including visits tariffs, psychiatric care, phone call tariffs and monthly monitoring tariffs. Where it was determined that a physician had been in violation of the Physician's Manual, settlements were negotiated by Doctors Manitoba. In other cases where, after investigation there appeared to be no wrongdoing on the part of the physician, Doctors Manitoba vigorously defended them against any claim for repayment made by Manitoba Health.

NEGOTIATIONS STAFF

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TAB 133

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This week's releases (15)

This month's releases (59)

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July 2023 GO

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Media requests for ministerial comment, contact Cabinet Communications: cabcom@manitoba.ca.

Twitter Feed

News Release - Manitoba

July 20, 2023

MANITOBA GOVERNMENT AND DOCTORS MANITOBA REACH LANDMARK TENTATIVE AGREEMENT

Historic Investments to Retain and Recruit More Physicians: Stefanson

The Manitoba government has reached a comprehensive tentative agreement with Doctors Manitoba for a new Physician Services Agreement, which features record overall funding increases of $268 million for physician services over four years, Premier Heather Stefanson announced today.

Backgrounder
Backgrounder 1
Backgrounder 2

“Our government is making historic additional investments to retain and recruit more doctors in the middle of a global physician shortage,” said Stefanson. “By working together on a common vision with Doctors Manitoba, these unprecedented investments recognize the critical importance of our physicians and will maintain Manitoba’s competitiveness with other jurisdictions while improving access to the vital medical services physicians provide for all Manitobans.”

In addition to competitive general increases for physician services, the government and Doctors Manitoba targeted new funding to shared priority areas for improving patient care. These include:

- increased funding for specialty and hospital services to help attract more physician coverage for inpatient and emergency department care, and more resources to address surgical and diagnostic backlogs.
- an innovative new funding model for longitudinal family medicine that blends existing volume-based payments with funding for patient panels and time-based stipends. This blended model will offer more predictable funding to stabilize family medicine clinic operations, which will connect more Manitobans with a family doctor. For patients, it will mean more time with their doctor for complicated medical concerns.
- new rural and northern retention and recruitment incentives and additional funding to help stabilize physician coverage in rural hospitals and remote First Nations communities.
- creating a new visit type for family physicians and pediatricians for patients with more than one medical concern.
- permanent funding model for virtual visits, ensuring Manitobans will continue to be able to receive appropriate care by phone or video, if they wish.

“The Doctors Manitoba board of directors is pleased with this tentative agreement and we have recommended it to physicians for their approval,” said Dr. Michael Boroditsky, president, Doctors Manitoba. “The significant funding increases offered by the government is an essential part of retaining and recruiting more doctors to our province, which will help to turn around the physician shortage. For Manitobans, this should mean improved access to physician care, whether it’s seeing a family doctor or visiting an ER, accessing surgical or diagnostic procedures, and accessing care in Winnipeg or in rural and northern communities.”

Tweets from @MBGovNews

Manitoba... · Oct 21, 2023

Statement from Families Minister Nahanni Fontaine, Minister Responsible for Gender Equity, on the `No Space For Hate' Counter-Protest Party bit.ly/3MckT91

ALT

46 196

Manitoba... · Oct 24, 2023

Statement from Premier Wab Kinew and Health, Seniors and Long-Term Care Minister Uzoma

The agreement helps to advance reconciliation with a new-shared recognition of the Treaty and traditional Indigenous lands on which physicians deliver care and a joint commitment to adopt, and work towards the Calls to Action from the Truth and Reconciliation Commission. Additional increased funding will improve physician coverage in remote First Nations communities.

Health Minister Audrey Gordon recognized important developments that complement the historic funding increases, to support improved physician engagement and well-being.

"The new Physician Services Agreement focuses on improving access to health services across the province by recognizing the devotion and professionalism of Manitoba physicians, while ensuring they are trusted and respected partners in health system improvements," said Gordon. "Whether it's continuing our work on reducing administrative burdens, ensuring physicians are consulted during health system change, or continuing our investment into physician health and wellness, this agreement reflects our government's commitment to listening to doctors and supporting them through the essential care they provide to all Manitobans."

Boroditsky noted that while the board has reviewed and recommended this tentative agreement, it is subject to ratification by physicians in Manitoba. The ratification process is now underway and is anticipated to conclude by Aug. 14, he added.

The Physician Services Agreement covers physician remuneration and funding to operate medical practices, including costs for staff, equipment, supplies, clinic space, and other expenses. The tentative agreement also includes increased funding with market adjustments and a special retention payment in the first year, followed by compounding two per cent annual general increases in the three remaining years of this agreement, which will expire on March 31, 2027. The current agreement expired on March 31.

- 30 -

BACKGROUND INFORMATION ATTACHED

For more information:

- Public information, contact Manitoba Government Inquiry: 1-866-626-4862 or 204-945-3744.
- Media requests for general information, contact Communications and Engagement: newsroom@gov.mb.ca.
- Media requests for ministerial comment, contact Cabinet Communications: cabcom@manitoba.ca.

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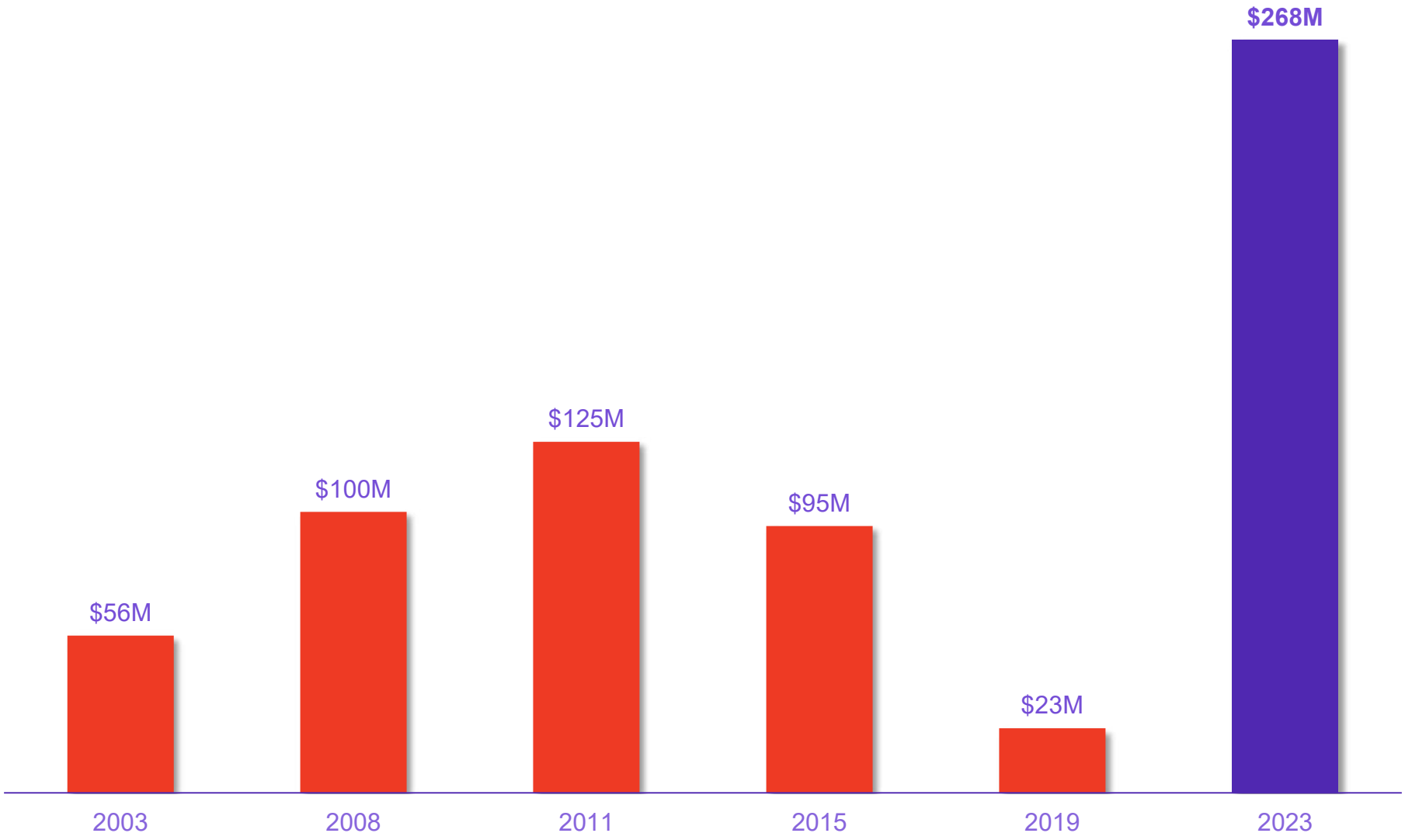
Manitoba Backgrounder

PHYSICIAN SERVICES AGREEMENT FUNDING OVER TWENTY YEARS

Past physician services agreements have increased funding for physician services at different levels, with the most recent tentative agreement featuring a historic level of increases, including:

- 2003: $56 million;
- 2008: $100 million;
- 2011: $125 million;
- 2015: $95 million;
- 2019: $23 million; and
- 2023: $268 million


$56M
$100M
$125M
$95M
$23M
$268M
2003
2008
2011
2015
2019
2023

TAB 134

Summary of a tentative agreement between the Saskatchewan Medical Association and Ministry of Health, 2013-14 to 2016-17

The Saskatchewan Medical Association (SMA) has reached a new four-year tentative agreement with the Government of Saskatchewan to cover the period April 1, 2013 to March 31, 2017. This agreement applies to both fee-for-service and non-fee-for-service physicians.

A. Fees

Lump Sum Retroactive Payments and Payment Schedule Rate Increases	
Fiscal Year	**Increases to Funding**
2013-14	1.5% lump sum retroactive payment (based on 2013-14 gross billings)
2014-15	1.5% lump sum retroactive payment (based on 2014-15 gross billings)
2015-16	1.95% Payment Schedule rate increase (effective Oct 1, 2015)
2016-17	2.95% Payment Schedule rate increase (effective Apr 1, 2016)

Please note the existing Payment Schedule remains in effect until September 30, 2015. Further, it is understood that agreements with physicians for clinical services with third-party agencies such as Regional Health Authorities, Saskatchewan Cancer Agency, Community Clinics and the College of Medicine, will be treated similarly.

B. Programs

The increased funding achieved in this contract and outlined below ensures the continuation of the current entitlements under existing programs and makes provision to accommodate increased numbers of physicians.

1. Increases to Funding for Existing Programs			
Program	**Current Funding**	**Increases to Funding**	**Effective Date**
Specialist Emergency Coverage Program (SECP)	$30.4M	$500K annualized	2015-16
		$1.5M annualized	2016-17
Family Physician Comprehensive Care Program (FPCCP)	$13.3M	$1M annualized	2016-17
Parental Leave	$700K	$300K one-time	2016-17
		$300K annualized	2016-17
Electronic Medical Record (EMR)/ SMA Share	$2.8M	$1.0M one-time	2016-17
		$800K annualized	2016-17
Continuing Medical Education (CME)	$4.4M	$250K annualized	2016-17
Long Term Retention Fund (LTRF)	$7.2M	$2.4M one-time	2016-17
		$800K annualized	2016-17

2. New Funding for Innovative Programs		
Program	**Fiscal Year (April 1 to March 31)**	**New Funding**
Whites of the Eyes	2016-17	$3.5M one-time
Appropriateness	2016-17	$1.1M one-time
New Items Fund	2016-17	$500K one-time

The SMA and the Ministry has agreed to form joint working groups to establish the parameters and criteria regarding these Innovative Programs.

Whites of the Eyes: The intent of this funding is to initiate pilot projects to subsequently inform and develop future practices. Improved patient access and health outcomes through collaborative care and use of technology are desirable by everyone working in the health system. *White of the Eyes* refers to providing patient care via a variety of approaches beyond in-person care. Physician compensation for other, innovative methods to deliver patient care (e.g., telephone, secure emailing, secure messaging) is becoming increasingly commonplace in other health systems and is key to enable better, timely access to care, and acknowledge the unpaid care physicians are currently delivering.

Appropriateness: Appropriateness refers to the right service for the right patient at the right time. The goal is to ensure care is provided in an appropriate and effective manner, minimizing unnecessary waste and improving quality in the health system. Enabling and compensating physicians to dedicate their time and curiosity to collaboratively define and achieve appropriate care is key to success.

3. Continued Funding for Existing Programs	
Program	**Current Funding**
Quality and Access Fund	$3.0M annualized
Committee on Rural and Regional Planning (CORRP)	$3.14M annualize
Specialist Recruitment and Retention (SR&R)	$2.0M annualized
GP-Specialist	$1.4M annualized
Metro On-call	$2.6M annualized
Chronic Disease Management Quality Improvement Program (CDM-QIP)	$3.0M annualized

4. Changes to Existing Programs		
Program	**Calendar Year**	**Funding Details**
Canadian Medical Protective Association (CMPA)	2015	Unchanged – Physicians reimbursed 100% of CMPA dues
	2016	Physicians will pay the first $1000 with the Program covering the balance of CMPA dues

C. Modernization of the Payment Schedule

There is mutual agreement between the SMA and Ministry of Health to proceed with modernization of the Payment Schedule, within the principles of patient-centred care, appropriateness and fairness. This work is to be revenue-neutral.

TAB 135

Feb. 5, 2024

Ministry of Health news release: Saskatchewan Doctors Ratify New Four-Year Contract

Released on February 5, 2024

Today, Health Minister Everett Hindley and Saskatchewan Medical Association (SMA) President Dr. Annette Epp were pleased to announce that Saskatchewan physicians have ratified a new four-year contract with the Government of Saskatchewan. Ninety-three per cent of physicians who cast ballots voted in favour of the agreement.

"Thank you to the SMA for collaborating with the provincial government on the unprecedented investment in this new agreement which will help to retain and recruit physicians in Saskatchewan," Hindley said. "The agreement provides a strong foundation for competitive remuneration and benefits, and addresses concerns raised by physicians while we continue to work toward a full blended capitation model. This is a step forward toward greater access for patients to primary health care providers, and that ongoing work will continue."

The new agreement includes a record setting increase in on-going funding for physician services and initiatives of approximately $245 million, which includes general rate increases and investments in recruitment and retention programs that allow Saskatchewan to remain competitive in the midst of a challenging national and international labor landscape. The agreement also includes significant investments in primary care that will increase team-based care and provide more stable funding to family physicians, resulting in improved access to health care services.

"Our goal was to reach an agreement that recognizes the critical role physicians play in the health care system and provide the support they need to deliver high-quality, accessible patient care," Dr. Epp said. "I firmly believe this new agreement acknowledges and values Saskatchewan physicians."

Highlights of the new contract include:

Compensation, Benefits, Recruitment and Retention

- An overall average general rate increase of 2.5% per year over four years (April 1, 2022 to March 31, 2026).
- A competitive market rate adjustment applied to the first year of the agreement.
- Increased funding to support long term retention, parental leave and continuing medical education.

New Targeted Investments

- Introduction of a new primary care payment model for family physicians that unifies existing volume-based pay with a new capitation payment (based on patient contacts and panel size), allowing more time to deal with complex patient issues and an increased focus on preventive care. This investment of more than $50 million in annual funding is expected to stabilize and begin a transformation of primary care in Saskatchewan.
- An innovation fund of up to $10 million annually over the duration of the agreement, that will increase the amount of team-based care in primary health care settings, resulting in health care providers working to the top of their scope and improving access to primary care in the province.
- Funding to address gender pay inequity in physician fee codes, as well as new funding to support physician training and awareness related to equity, diversity, racism, and truth and reconciliation.
- A new Rural and Northern Practice Recognition Premium that recognizes the unique nature and critical importance of rural medicine.
- Introduction of permanent virtual care codes to increase efficient access to health services for patients and reduce unnecessary travel for appropriate services.

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Sask. Women Physicians Day shines spotlight on issues faced by women physicians (https://www.sma.sk.ca/sask-women-physicians-day-shines-spotlight-on-issues-faced-by-women-physicians/)
March 13, 2024

Ministry of Health news release: Saskatchewan Doctors Ratify New Four-Year Contract

February 5, 2024

(https://www.sma.sk.ca/ministry-of-health-news-release-saskatchewan-doctors-ratify-new-four-year-contract/)

Practice Enhancement Program (PEP) provides physicians with an opportunity for improvement

January 30, 2024

(https://www.sma.sk.ca/practice-enhancement-program-pep-provides-physicians-with-an-opportunity-for-improvement/)

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Members guide (https://www.sma.sk.ca/?page_id=2881)

As the common voice of our members, we serve, represent and unite Saskatchewan physicians. We advance the honour and integrity of the medical profession; advance the professional, personal, educational, and economic welfare of Saskatchewan physicians; and promote a high-

quality, patient-centred health care system.

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