

## SECTION H:

## ANAESTHESIA

Fee      Anae

1. Payment for anaesthesia is for professional services for the administration of any type of anaesthesia, general, regional, sedation or monitored anaesthesia care in accordance with the Canadian Society of Anaesthesiologist's Guidelines to the Practice of Anaesthesia. However, ring block, local infiltration and topical or spray anaesthetics will not be paid unless they meet the full definition of anaesthetic professional services as noted above. Payment for anaesthesia includes same day pre-anaesthetic as well as post-anaesthetic examinations and all supportive measures during anaesthesia but does not include the cost of drugs, materials or facilities.

2. An anaesthetic payment for a beneficiary:

(a) is based on the time from the start of continuous attendance by the anaesthetist until such time as the attendance by the anaesthetist to that patient is no longer required. The Anaesthetic Fee Codes implying continuous attendance may only be billed for one patient at a time.

(b) includes a procedure carried out during administration of the anaesthetic or in the resuscitative period except that invasive monitoring will be approved to the primary anaesthetist in addition to the anaesthetic as follows:

- (i) 687H, 134A, 135A, 136A, 316A, 140A, 141A or 142A at 100 percent of the appropriate listed amount;
- (ii) 160L at 75 percent of the appropriate listed amount.

3. When more than one procedure is performed during the same anaesthetic, the payment to the anaesthetist shall be based on the highest anaesthetic complexity as noted in the section headed "Anaesthesia Categories by Surgical Procedure".

4. Pre-anaesthetic consultation on same day of surgery is approved for high risk cases by report.

Payment for a pre-anaesthetic consultation is intended to apply where the consultation is provided in potentially high risk situations to assess the fitness of the patient for the anaesthetic/surgical procedure and to advise on pre-anaesthetic treatment. It is expected that these consultations will apply predominantly to risk levels IV and V and are not intended to apply to a pre-anaesthetic assessment situation.

5. When a physician admits a patient to a hospital for urgent surgery on an emergency basis and later on the same day provides anaesthesia services for the surgeon to whom the case has been referred, then both the visit and anaesthesia services will be paid.

6. In special cases where the safety of the patient or the facilitation of the operation requires the services of a second anaesthetist, payment to the assisting anaesthetist will be based on 100 percent of the listed rate of payment in the same anaesthetic category as the principle anaesthetist for the calculated anaesthetic time according to the appropriate time units of 15 minutes.

7. "Anaesthetic Standby" is defined as professional services provided for a patient at the request of another physician during a procedure which normally would not require the presence of an Anaesthetist. The need for Anaesthetic Standby should be justified by high risk or complexity of the procedure. Anaesthetic standby services should be billed under Code 918A according to criteria provided in Section A.

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"Standby" followed by administration of anaesthesia must be clarified, for example the commencement and termination time for each service, an explanation for the necessity for "standby" with an outline of the services provided and the name of the physician who requested the "standby".

8. If an anaesthetic is provided for both dental and other surgery, the most favourable single base code is paid with the remainder paid as time units.

**Visits**

**Consultation**

-- includes all visit necessary, history and examination, review of laboratory and/or other data and written submission of the consultant's opinion and recommendations to the referring doctor

9H      -- major      \$229.00 \*

11H     -- repeat      \$115.00 \*

A formal consultation for the same or related condition repeated within 90 days by the same physician. It should not be used for routine follow-up of the patient for which either service code '5' "partial assessment or subsequent review" or service code '7' "follow-up assessment" are appropriate.

Special call surcharges for additional patients seen (refer to Section A, Special Call Services and Surcharges).

Out-of-Hours Premiums - see explanation in Section A.

Anaesthetics -- any type (excluding local infiltration, ring block, topical or spray anaesthetics)

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Where the anaesthetic category is listed as:

|      |  |            |
|------|--|------------|
| 500H | Low Complexity: (Low) Startup          | \$55.70 *  |
| 501H | -- Per 15 minutes                      | \$86.90 *  |
| 502H | Intermediate Complexity: (Med) Startup | \$66.70 *  |
| 503H | -- Per 15 minutes                      | \$99.70 *  |
| 504H | High Complexity: (High) Startup        | \$79.90 *  |
| 505H | -- Per 15 minutes                      | \$116.00 * |
| 506H | Dental Procedures: Startup             | \$66.70 *  |
| 507H | Dental Procedures: -- Per 15 minutes   | \$99.70 *  |

**Note:** All dental anesthesia for patients under age 14 is insured.

**Complex Anaesthesia Premiums (billed in addition to regular codes (500H to 507H) the indicated conditions exist)**

Anesthesia premiums are payable to the anesthetist billing "H" section codes. These services should not be billed by the surgical assistant billing "J" section codes; surgical assistant should use the applicable time-of-day premiums.

580H    Operative premium for complexity and risk - per 15 minutes      \$29.10 \*  
           - for patients up to 2 years of age, a weight of greater than the

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97th percentile for age according to the WHO growth charts for Canada  
 - for patients greater than 2 and up to 16 years old, a Body Mass Index, (weight[kg]/height[m]2) greater than the 97th percentile for age according to the WHO growth charts for Canada  
 - for patients over the age of 16, a Body Mass Index, (weight[kg]/height[m]2) greater than 40  
 - patients with a massive blood loss requiring transfusion of 35 or more ml/kg of blood products

585H Operative premium for complexity and risk \$58.20 \*  
 -- per 15 minutes  
 -- Patients where there is recognition and agreement between the surgeon and anaesthetist that undue delay in surgical treatment would pose a significant risk to life or major body part

-- Patients with multiple trauma involving at least 2 of the following:  
 - Abdominal injury requiring laparotomy;  
 - Thoracic injury requiring chest tube or thoractomy;  
 - Head injury with GCS less than 9;  
 - Fracture of cervical spine, pelvis, femur, proximal tibia or humerus;  
 - Burns to more than 30 percent of the body surface.

Codes 580H and 585H cannot be billed together.  
 Codes 580H and 585H are not eligible for additional premiums.

**Premium for Anaesthesia beginning before 5:00 p.m. and ending after 5:00 p.m.**

540H Bill for the number of 15 minute time units provided after 5:00 p.m. and indicate on comment record the start of the anaesthetic time (this is not eligible for other premiums) \$58.20 \*

Example:  
 A procedure provided on a weekday by an anaesthetic, started at 2:00 p.m. and ended at 7:00 p.m. and involved the transfusion of 40 ml/kg of blood products the codes to be billed are:  
 - no regular time based premiums are billable. The location of service should be 2 or 3;  
 - 504H (normally medium but greater than 4 hours) = \$58.50  
 - 505H at 20 units X \$80.20 = \$1,604.00  
 - 540H at 8 units (15 minute units after 5:00 p.m.) X \$18.40 = \$147.20  
 - 580H at 20 units (all 15 minute units) X \$20.00 = \$400.00  
 Total billing = \$2,209.70

If this procedure started at 6:00 p.m. and ended at 11:00 p.m.:  
 - the location of service would be submitted as a "B" resulting in an amount in the total premium field for each applicable service line;  
 - the 540H would not be billed, and  
 - the 580H would be billed as shown above.

If the transfusion involved only 30 ml/kg of blood products the 580H would not be billed for the above example.

**Premiums for Anaesthesia beginning before midnight 11:59 p.m. and ending after 12:00 p.m.**

545H Bill for the number of 15 minute time units \$58.20 \*

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provided after 12:01 a.m. using the date of service when the service was initiated, and indicate on comment record the start of the anaesthetic time (545H is not eligible for other premiums.) Bill the number of units after midnight only.

Example:

A procedure provided on a weekday by an anaesthetist, started at 9:00 p.m. and ended at 2:00 a.m. the codes to be billed are:

- evening based premiums are billable using the location of service. (See Section A, Out-of-hours Premiums)
  - 504H (normally medium but greater than 4 hours) plus 25% evening premium = \$58.50 + \$14.63
  - 505H at 20 units X \$80.20 plus 25% evening premium = \$1,604.00 + \$401.00
  - 545H at 8 units (15 minute units after 12:00 a.m.) X \$18.40 = \$147.20
- Total billing = \$1,662.50 + premiums (including 545H) paid at \$562.83

### ANAESTHESIA CATEGORIES BY SURGICAL PROCEDURE

#### GENERAL CONSIDERATIONS

Anaesthesia is paid on the basis of the complexity of the surgical procedure and the total anaesthetic time. The following outlines the classification of anaesthetic complexity according to the surgical procedure(s).

#### **Low complexity:**

- All percutaneous diagnostic and therapeutic procedures not otherwise listed.
- Superficial surgery on the integumentary system, nerves, vessels, muscles, tendons and bones not otherwise listed.

#### **Medium complexity:**

- Anaesthesia in locations remote from the Operating Room including diagnostic or invasive radiology.
- Anaesthesia for cases listed as "Low complexity" done in the prone or sitting position (requires note on claim).
- Debridement and grafting of burns greater than 20 percent BSA.
- Low complexity cases lasting longer than 90 minutes but less than 4 hours

#### **High complexity:**

- All multiple trauma cases lasting longer than 4 hours.
- Anaesthesia for live organ donor retrieval.
- All cases lasting longer than 4 hours.
- All cardiac catheterizations.
- All laser procedures in the airway.

#### HEAD

##### **Low Complexity:**

- All procedures on the external, middle or inner ear.
- All procedures on the eye (including cataracts) or eyelids not otherwise listed.
- Anaesthesia for ECT.

##### **Medium Complexity:**

- All procedures on the skull, mandible, maxilla, orbits and facial bones.
- All procedures inside the nose or accessory sinuses.
- All intraoral procedures except those listed as "High complexity".
- The following eye procedures: repair of open eyes, scleral buckling, vitreoretinal procedures, strabismus correction, corneal transplants,

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glaucoma procedures, tumors and enucleation.

- All closed intracranial procedures done by needle techniques.

### ***High Complexity:***

- All open intracranial procedures on the brain, meninges or cerebral vessels.

### **NECK**

#### ***Medium Complexity:***

- All procedures on the thyroid gland, parathyroids, salivary glands, lymphatics and congenital branchial cleft defects.
- All endoscopic or open procedures on the larynx or trachea not otherwise listed.

#### ***High Complexity:***

- All procedures on the major vessels.
- Anaesthesia for cystic hygroma, laryngectomy, or radical neck dissection.
- Epiglottitis, foreign body in the airway, traumatic disruption of the larynx.

### **THORAX**

#### ***Low Complexity:***

- Anaesthesia for pacemakers, cardioversion, indwelling central lines.
- All breast surgery except those procedures listed separately.

#### ***Medium Complexity:***

- Anaesthesia for bronchoscopy, mediastinoscopy.
- All procedures on the ribs.
- Anaesthesia for reduction mammoplasty or (modified) radical mastectomy, axillary node dissection.

#### ***High Complexity:***

- All intrathoracic procedures on the heart, lungs, lymphatics or great vessels.
- All mediastinal procedures including esophagus and thymus.

### **SPINE AND CORD**

#### ***Medium Complexity:***

- All procedures for decompression or disc surgery.
- All procedures on the meninges or spinal cord and nerves not otherwise listed.
- All procedures on the vertebrae (except biopsy) not otherwise listed.

#### ***High Complexity:***

- All procedures for spine or spinal cord tumors.
- All procedures for multilevel spine instrumentation.

### **ABDOMEN**

#### ***Low Complexity:***

- All extraperitoneal procedures on the abdominal wall or urinary tract.
- All endoscopic procedures of the GI tract from esophagus to rectum.

#### ***Medium Complexity:***

- All intra-abdominal procedures except those listed below as "High complexity".

#### ***High Complexity:***

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- Resection of liver, pancreas, stomach, colon, kidney, adrenals or retroperitoneal tumors.
- All stomach procedures for weight reduction on morbidly obese patients.
- Radical cystectomy and ileal conduit surgery Radical prostatectomy, radical hysterectomy or Caesarean hysterectomy.
- All procedures on the aorta, its major intra-abdominal branches or vena cava.
- Repair of congenital gastroachisis or omphalocele.

### **PERINEUM**

#### ***Low Complexity:***

- All perianal or anorectal procedures (perineal approach).
- All endoscopic urology except those listed below as "Medium complexity".
- All procedures on the male external genitalia.
- All procedures on the female external genitalia except those listed below as "Medium complexity."

#### ***Medium Complexity:***

- Transurethral resection of prostate or bladder tumor.
- Percutaneous nephrolithotripsy.
  
- Hysteroscopic endometrial ablation, vaginal hysterectomy.
- Radical vulvectomy with or without node dissection.
- Amputation of the penis with or without node dissection.
- Vaginal fistulae repairs, vaginectomy.

### **EXTREMITY SURGERY**

#### ***Low Complexity:***

- All distal or minor proximal orthopaedic procedures, including arthroscopy, not otherwise listed.
- All surgery for vascular access.

#### ***Medium Complexity:***

- Arthroplasty of the hip, knee or shoulder.
- All open surgery on the pelvis, hip, femur or tibial plateau.
- Arterial vascular surgery outside the abdomen except AV fistulas.
- All limb amputation except fingers and toes.
- Myocutaneous flaps.
- Major tissue resections and/or regional node dissection for malignant disease.
- ACL reconstruction or shoulder repair.
- Major releases for clubfoot.

#### ***High Complexity:***

- Revision of arthroplasty for hip or knee.
- Free flaps or microvascular revascularization.

### **Epidural Anaesthesia for Labour and Delivery**

|      |  |            |
|------|--|------------|
| 600H | Initial set-up and subsequent maintenance of epidural anaesthesia by intermittent top-ups or continuous infusion, including continuous attendance at bedside during labour (Premiums are determined by the time of the initial set-up) | \$690.00 * |
| 601H | Restart of 600H of a previously functioning epidural. Not payable for anaesthesia shift changes. Please provide time of initial startup and restart. (Premiums are determined  | \$336.00 * |

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by the time of the restart set-up)

667H Attendance during delivery, (after the first hour covered under Code 600H) per 15 minutes or portion thereof  
Epidural paid at 75 percent where Delivery and Epidural (600H and 601H) are provided by the same physician by report. \$83.40 \*

**Intra-operative Transoesophageal Echocardiography**

687H Intra-operative Transoesophageal Echocardiography (billable with other echocardiogram or Swan-Ganz by report only) \$245.00 \*

**PAIN MANAGEMENT**

**Acute Pain Management**

190H Initiation of patient controlled analgesia \$33.70 \*

191H Injection of intrathecal opiate for post-operative pain management \$33.70 \*

192H Insertion or reinsertion of continuous epidural catheter for acute pain control including initial infusion of analgesic agent (for obstetrical cases see 600H) \$117.00 \*

193H Daily supervision of any acute pain control modality listed in this Acute Pain Management section starting the day after surgery (includes all patient visits and adjustments) \$59.20 \*

194H Insertion or reinsertion of continuous catheter technique local naesthetic blockage (excluding epidural) for acute pain control including initial infusion of analgesic agent \$117.00 \*

195H Injection of local anaesthetic to establish a major plexus block to assist in post-operative pain management (can not be claimed for topical, local infiltration or peripheral nerve block) \$116.00 \*

**Nerve Blocks**

The codes in this section are for use with conditions where pain is the presenting complaint or symptom, to diagnose (confirm nerve supply, etc.) and/or treat (sclerosis, etc.).

These items are not for use with regional anaesthesia prior to surgery, delivery, reduction of fractures, manipulations, etc. Regional anaesthesia provided by the same physician providing the surgical services is an inclusion in that service. Nerve blocks can be billed at 75 percent with pain clinic services, visit services and consultations for pain.

80H Intubation for the management of the airway or ventilation, not associated with Anesthetic \$202.00

**Facet Injection**

94H -- single \$181.00 \*    0

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| 95H  | -- each additional to a maximum of 5  | \$89.20 *  | 0    |
| <b>Trigger Point</b>   |   |            |      |
| 96H  | -- single   | \$89.20 *  | 0    |
| 97H  | -- one additional   | \$42.40 *  | 0    |
| Instances where more than two injections are required will be reviewed at the request of the physician, upon receipt of an explanation of the circumstances. |   |            |      |
| <b>Peripheral or Paravertebral Nerves</b>  |   |            |      |
| 98H  | -- single   | \$185.00 * | 0    |
| 99H  | -- each additional to a maximum of three additional units   | \$91.70 *  | 0    |
|  | -- with sclerosing agent  |            |      |
| 100H   | -- single nerve, add  | \$67.50 *  | 0    |
| 101H   | -- each additional nerve to a maximum of three units, add   | \$44.50 *  | 0    |
| 102H   | Sciatic or obturator nerve  | \$234.00 * | 0    |
| 103H   | -- with sclerosing agent  | \$306.00 * | 0    |
| 111H   | Trigeminal nerve, posterior root  | \$391.00 * | 0    |
| 112H   | -- with sclerosing agent  | \$612.00 * | 0    |
| 113H   | Intracranial nerve  | \$204.00 * | 0    |
| 114H   | -- with sclerosing agent  | \$353.00 * | 0    |
| 120H   | Somatic plexus, (e.g. Brachial)   | \$261.00 * | 0    |
| 121H   | -- with sclerosing agent  | \$308.00 * | 0    |
| 130H   | Stellate ganglion   | \$270.00 * | 0    |
| 131H   | Stellage ganglion -- with sclerosing agent  | \$308.00 * | 0    |
|  |   |            |      |
| 132H   | Lumbar sympathetic chain  | \$270.00 * | 0    |
| 133H   | -- with sclerosing agent  | \$313.00 * | 0    |
| 134H   | Other ganglion/plexus (e.g. Caelic)   | \$549.00 * | 0    |
| 135H   | -- with sclerosing agent  | \$612.00 * | 0    |
| <b>Epidural</b>  |   |            |      |
| 140H   | -- lumbar or caudal   | \$405.00 * | 0    |
| 141H   | -- with sclerosing agent  | \$459.00 * | 0    |
| 142H   | -- cervical or thoracic   | \$405.00 * | 0    |
| 143H   | -- with sclerosing agent  | \$459.00 * | 0    |
| 144H   | Epidural blood patch  | \$405.00 * | 0    |
| 145H   | Differential diagnostic subarachnoid block  | \$459.00 * | 0    |
| <b>Subarachnoid</b>  |   |            |      |
| 150H   | -- lumbar   | \$405.00 * | 0    |
| 151H   | -- with sclerosing agent  | \$612.00 * | 0    |
| 152H   | -- thoracic   | \$306.00 * | 0    |
| 153H   | -- with sclerosing agent  | \$612.00 * | 0    |
| 158H   | Injection of piriformis muscle  | \$173.00 * | 0    |
| 160H   | Diagnostic sympathetic thermal response monitoring (via thermo-couple -- paid in addition to 130H, 132H 133H) | \$51.00 *  | 0    |
| 161H   | X-ray control in connection with service, codes 94H to 153H, add  | \$121.00 * | 0    |
| <b>Note:</b> x-ray charges extra   |   |            |      |
| 220H   | Therapeutic intravenous regional -- anaesthesia   | \$306.00 * | 0    |



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### Anaesthesia

#### Pain Clinic

The following codes apply to services to patients with severe or chronic pain, which have been unresponsive to previous therapy; and who have been referred by a physician to a designated pain clinic centre recognized by Saskatchewan Health. The Initial Complete Assessment can be billed on an in-patient if the patient is admitted to the hospital as an alternative to the out-patient pain clinic in order to facilitate the work-up. 9H should be used for consultation on hospitalized patients with acute or chronic pain not specifically admitted for pain clinic work-up. Entitlement to these benefits is limited to a recognized specialist in anaesthesia or other physician with approved training. For other physicians involved in the pain control process the appropriate assessment within their own specialty section applies.

|      |  |            |
|------|--|------------|
| 201H | Initial Complete Assessment<br>-- includes pertinent family and patient history, pain history including review of previous therapies, functional enquiry, examination of all parts and systems necessary to diagnose and initiate treatment--complete record with written report to referring physician, and advice to patient | \$424.00 * |
| 203H | Subsequent assessment -- in-patient or out-patient<br>-- includes review of problems, reassessment of pain control, review of history and physical examination as necessary to maintain ongoing treatment, and advice to patient   | \$211.00 * |
| 205H | Minor routine follow-up assessment of patient hospitalized under pain clinic criteria<br>-- routine follow-up of pain treatment, with evaluation, and necessary changes to ongoing care  | \$158.00 * |

### Intensive Care

#### PREAMBLE

The intensive care payment section is intended to be used by physicians providing direct bedside care to critically ill and potentially unstable patients who are in need of intensive treatment. For less intensive situations, such as where patients are admitted to the CCU or ICU for monitoring it may be appropriate to use a visit fee (see below) along with codes 335H-339H.

This section will ordinarily be billed under the physician-in-charge of the patient for that day. Ventilatory support care is to be billed by the physician providing ventilator care, which could be the physician-in-charge or another physician. For patients who are readmitted to the unit greater than 72 hours after discharge, the first day rate will apply.

If another member of the team (physicians who share call for the ICU) sees the patient in an emergency situation with the physician-in-charge being unavailable, the use of a consultation fee may be permitted if accompanied by an informative comment or written explanation (by report).

Other physicians, such as surgeons, nephrologists and neurologists, concurrently involved in the patient's care can bill for consultations and/or visits. Physicians called in for a specific procedure (e.g. to insert a difficult arterial line) should be

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bill a procedure fee only. For patients transferred from one hospital to another, the original ICU team can bill for the transfer day, while the receiving team can bill for a day 1 onwards (e.g. ICU A will bill for April 1 to 4 (last day) and the receiving ICU B will bill for April 4 and onward).

Premiums and surcharges are not payable with codes in this section, with the exception of the 335H-339H series of codes (less intensive patient fees).

### Billing for Consultations/Procedures Concurrent with the Billing

Visits including consultations and some procedures are included in intensive care services when provided in the ICU/CCU units on the same day by the same physician, clinic or specialty.

### **INTENSIVE CARE PER DIEM LISTINGS**

1. The fees under physician-in-charge (normally the most responsible physician) apply per patient treated, i.e. while the physician-in-charge may change during the course of treatment, the daily fee formula as set out should be billed by the physicians involved as if there was only one physician-in-charge during the treatment program; in this sense, the daily fees can be construed as team fees.
2. When billing Intensive (Critical, Ventilatory or Comprehensive) Care fees, no other Intensive Care codes may be billed by the same physician(s) or same clinic or specialty. If a physician provides both critical and ventilatory care it should be billed as the comprehensive care codes. In either event the total fees cannot exceed the comprehensive fees.
3. Other physicians apart from those providing Critical Care or Comprehensive Care may claim the appropriate consultation, visit and procedure fees not listed in the fee schedule for Intensive Care with a meaningful explanation.
4. If Ventilatory Support only is provided, for example, by the anaesthetist(s), claims should then be made under Ventilatory Support. Comprehensive Care per diem fees do not apply.
5. If the patient has been discharged from the Unit for more than 72 hours and is re-admitted to the Unit, the first day rate applies again on the day of re-admission. The discharge and re-admission times must accompany the billing submission.
6. The appropriate visit and procedural codes apply after stopping Critical Care, Ventilatory Support or Comprehensive Care.
7. The Intensive Care per diem fees should not be claimed for stabilized patients and those patients who are in an intensive care unit for the purposes of monitoring. The appropriate consultation, assessment and procedural codes may apply (see preamble).
8. Intensive Care per diem fees do not include:
  - Echocardiography (321A, 521A, 531A, 323A, 523A, 533A, 324A, 534A, 557A, 150C);
  - E.C.G. provided by non-team (ICU) physicians (31D);
  - Closed Chest Drainage (95L);
  - Cardiac Pacemaker Insertion (121L);
  - Balloon Pump Insertion (132L);
  - Insertion of central venous catheter 134A-135A;
  - Intra-operative Transoesophageal Echocardiography (687H);

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- Swan-Ganz Catheterization (316A);
  - Cardiac Catheterization and Angiography (300A, 303A, 328A, 329A, 335A, 443A, 445A, 447A, 536A, 545A, 548A, 648A, 100C, 105C, 145C);
  - Cardioversion (42D);
  - Continuous Renal Replacement Therapy (CRRT) (135D, 136D);
  - Transcranial Doppler (360D);
  - Exercise Stress Test (62D);
  - Stress Echo (66D);
  - Peritoneal Dialysis (121D, 667L, 669L, 670L);
  - Haemodialysis (122D-124D, 660L, 661L);
  - Epidural Anaesthesia and Nerve Blocks (94H-161H, 192H-195H, 220H);
  - Percutaneous Endoscopic Gastrostomy (Peg) (443L, 444L, 447L)
  - Sigmoidoscopy (449L, 450L);
  - Colonoscopy (448L);
  - Oesophagogastroscopy (402L - 412L);
  - Bronchoscopy (520L);
  - ERCP (500L); or
  - Intubation for Laryngeal Obstruction (171T)
  - Tracheostomy (177T)
  - Certification of brain death and organ donor assessment (140Q, 150Q)
- Critical care codes (400H to 424H) can be billed at the same time as the procedures listed above with no reduction to the daily fees or units.

**INTENSIVE CARE**

**Critical care** - (Intensive Care Area) - includes provision of all aspects of care of a critically ill patient in an intensive Critical Care Area excluding ventilatory support and including initial consultation and assessment, emergency resuscitation, intravenous lines, endotracheal intubation, cutdowns, intraosseous infusion, pressure infusion sets and pharmacological agents, insertion of arterial, urinary catheters and nasogastric tubes, securing and

interpretation of laboratory tests, oximetry, transcutaneous blood gases, and intracranial pressure monitoring interpretation and assessment when

indicated (excluding insertion of I.C.P. measuring device). These fees are not billable for services rendered to patients admitted for E.C.G. monitoring or observation alone.

Physician-in-Charge is the physician(s) daily providing the above.

|      |                                       |            |
|------|---------------------------------------|------------|
| 400H | 1st day                               | \$677.00 * |
| 401H | 2nd day                               | \$371.00 * |
| 402H | 3rd to 7th days (inclusive) per diem  | \$341.00 * |
| 403H | 8th to 30th days (inclusive) per diem | \$171.00 * |
| 404H | thereafter, per diem                  | \$61.80 *  |

**Ventilatory Support** (Intensive Area) - includes provision of ventilatory care including initial consultation and assessment of the patient, intravenous lines, endotracheal intubation with positive pressure ventilation including insertion of arterial lines, tracheal toilet, use of artificial ventilator and all necessary measures for its supervision, obtaining and interpretation of blood gases, oximetry, transcutaneous blood gases and assessment.

Physician-in-Charge is the physician(s) daily providing the above.

|      |         |            |
|------|---------|------------|
| 410H | 1st day | \$591.00 * |
| 411H | 2nd day | \$296.00 * |

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| 412H | 3rd to 7th day (inclusive) per diem  | \$298.00 * |      |
| 413H | 8th to 30th day (inclusive) per diem | \$206.00 * |      |
| 414H | thereafter, per diem                 | \$76.20 *  |      |

### **COMPREHENSIVE CARE** (Intensive Care Area)

These fees apply to Intensive Care physicians who provide complete care (both Critical Care and Ventilatory Support as defined above) to Intensive Care Area patients.

These fees include:

- arterial and/or venous catheters
- artificial ventilation and necessary measures for respiratory support
- cardioversion and usual resuscitative measures
- cutdowns
- defibrillation
- emergency resuscitation
- endotracheal intubation
- initial consultation and assessment and subsequent examinations of the patient
- insertion of intravenous lines
- insertion of urinary catheters and nasogastric tubes
- intracranial pressure monitoring, interpretation and assessment when indicated (excluding insertion of I.C.P. measuring device).
- Intubation (80H) when performed by the same physician claiming ICU per diems (400H-424H)
- intraosseous infusion
- oximetry
- pressure infusion sets and pharmacological agents
- securing and interpretation of blood gases and laboratory tests
- tracheal toilet
- transcutaneous blood gases

If the patient has been reassigned from critical care to comprehensive care, the day of the transfer shall be deemed for payment purposes to be the second day of comprehensive care and may be billed with a meaningful explanation (e.g. A patient was in critical care from April 1 to 4 and then transferred to comprehensive care on April 4 to 6. The billing would be 400H, 401H, 402H, 421H, 422H and 422H).

**Physician-in-Charge is the physician(s) daily providing the above.**

|      |                                      |              |
|------|--------------------------------------|--------------|
| 420H | 1st day                              | \$1,121.00 * |
| 421H | 2nd day                              | \$506.00 *   |
| 422H | 3rd to 7th days (inclusive) per diem | \$506.00 *   |
| 423H | 8th to 30th day (inclusive) per diem | \$253.00 *   |
| 424H | thereafter per diem                  | \$130.00 *   |

### **Less Intensive Patients (such as Monitoring)**

Payment of these fees is for care of less intensive patients provided in either an Intensive Care or Coronary Care Unit. Code 918A (continuous personal attendance) may apply for services provided in other locations.

Payment is intended for the time that a physician spends with the patient. The times of each visit must be indicated on the claim by the physician providing the service.

Payment for concurrent care is only acceptable if submitted with an explanation satisfactory to Saskatchewan Health.

The procedures excluded from intensive care per diem listings on pages H.16 and H.17 are also excluded from this section (e.g. echocardiography, dialysis, etc.). However the number of time units must be reduced accordingly for 335H to 339H.

As well, codes in this section are eligible for after-hours premiums and first patient surcharges (see page A36).

**SECTION H:****ANAESTHESIA****Fee      Anae**

It may be appropriate to bill for a consultation/visit with these fee codes (see preamble page H.15). In some circumstances accurate times and meaningful explanations must be included with submission.

| Per 1/4 hour (please indicate the number of<br>1/4 hours as units) |                                    |            |
|--|------------------------------------|------------|
|  |                                    | \$58.00 *  |
| 335H   | 1st day - max per day              | \$348.00 * |
| 336H   | 2nd day - max per day              | \$290.00 * |
| 337H   | 3rd to 7th days - max per day      | \$174.00 * |
| 338H   | 8th to 30th day - max per day      | \$116.00 * |
| 339H   | thereafter, per diem - max per day | \$78.20 *  |

Where a patient is transferred from critical care to less intensive care the care is considered a continuation of the same hospitalization and care is based on the number of days since the initial hospitalization or the first day of intensive care (e.g. If a patient was in critical care from April 1 to 4 and moved to less intensive care on April 4 to 6, the codes billed would be 400H, 401H, 402H and 337H etc.).

ECG interpretations may be billed in addition to 335H to 339H.