FINAL

Interprovincial/territorial Reciprocal Billing – Out-Patient Rates For Billing Services Provided in NL, PE, NS, NB, ON, NT and YK * Effective for Visits on or After April 1, 2025

Rates Exclude All Physician Compensation except Those Paid Directly by the Hospital

Service Code	Description	Rate ($)
01	Standard Out-patient Visit, including select discrete high cost diagnostic imaging procedures. Excludes specific services identified within other service codes. See note #8.	$397
02	Day care surgery single rate code retired. See codes 18 to 20.	
03	Hemodialysis	$643
04	Computerized Tomography	$875
05	Outpatient Laboratory and all other Diagnostic Imaging procedures not specifically listed elsewhere in this schedule of service codes. Includes general radiography, mammography, outpatient laboratory, and referred-in laboratory specimens except for those identified as High Cost Outpatient Laboratory Service Code 15. See note #9.	$188
06	Chemotherapy drugs totaling less than $1,000: Bill a visit fee of $397 PLUS the actual acquisition cost of the drugs. No invoice is required. Use code 16 for drug costs totaling $1,000 or more. See note #10.	
07	Cyclosporine/Tacrolimus/AZT/Activase/Erythropoietin/Growth Hormone therapy visit: **$327 plus the actual drug costs**.	
08	Extracorporeal Shock Wave Lithotripsy (ESWL) - Lithotripsy for stones within the gallbladder are excluded.	$1,596
11	Magnetic Resonance Imaging.	$851
12	Radiotherapy Services.	$498
13	Cardiac pacemakers and/or defibrillators (any type)/cochlear implants/PCI with stents/endovascular coils: the invoiced price of the device (invoice required) in addition to the rate applicable to either the Standard Out-patient Visit or Day Care Surgery. In order to bill code 13, the device(s) must total $1,000 or more. See note #11.	

Service Code	Description	Rate ($)
15	High Cost Laboratory for laboratory services not specifically listed elsewhere in this schedule of service codes, and **above $188** the rate provided in the host province's schedule of benefits for laboratory medicine applies; or in the absence of a scheduled rate, an amount that is negotiated between the provincial plans (Genetic screening is excluded).	
16	Chemotherapy drugs totaling $1,000 or greater: Bill a visit fee of $397 PLUS the actual acquisition cost of the drugs. Invoice is required. Prior approval must be obtained for drugs over $5,000. See notes 10 and 12.	
17	PET-CT scan. See note #13.	$1,405
18	Day Care Surgery – Low. See note #14.	$1,154
19	Day Care Surgery – Medium. See note #14	$4,650
20	Day Care Surgery – High. See note #14.	$14,498
21	X-ray with Cardiac Catheterization	$2,587

* Jurisdictions must submit a request and rationale to the RRWG for review, if there is a need to change the set of rates (fees-included or fees-excluded) that they will be using province wide. The request must be received no later than May 30th of the year prior to the date of the change.

Rules of Application for Billing Out-Patient Services

1. Where applicable rates have been established based on an accumulation of costs reflective of the billing rule of one bill per patient per hospital per day.
2. Rates do not include physician compensation except those paid directly by the hospital. Physician services not paid directly by the hospital should be billed through Medical Reciprocal Billing or other separate arrangement with Quebec.
3. When two or more out-patient activities (service codes 01 to 12, 15 to 20) are provided to the same patient on the same day at the same hospital, regardless of whether the patient was discharged and/or readmitted to the same hospital on the same day, only one out-patient activity can be billed by the hospital (i.e., the one incurring the highest cost).
4. An out-patient charge can be billed on the same day of in-patient admission or discharge from the same hospital, as long as the patient is not a registered in-patient at the hospital at the time of service.
5. If a patient receives out-patient services while admitted as an in-patient the hospital cannot bill for the out-patient services. In these instances, the cost of the out-patient services are included in the in-patient per diem rates.
6. If a patient is registered at a hospital as an out-patient and leaves before being seen by a physician or receiving treatment, code 01 may be billed.
7. If a patient is seen as an out-patient at two different facilities on the same day, both facilities can bill the applicable out-patient rate.
8. An out-patient is an individual who has been officially accepted by a hospital and receives one or more health services without being admitted as an inpatient; and whose personal identifiable data is recorded in the registration or information system of the organization and to whom a unique

identifier is assigned to record and track services.

Select discrete high cost diagnostic imaging procedures include the following:

- Nuclear medicine - diagnostic images and treatment procedures using radiopharmaceuticals. Includes single photon emission computed tomography (SPECT). Excludes nuclear medicine scans superimposed on images from modalities such as CT or MRI (e.g. SPECT/CT) which have their own service codes.
- Fluoroscopy – an imaging technique to obtain real-time moving images of a patient through a fluoroscope, developed from the capture of external ionizing radiation on a fluorescent screen.
- Ultrasound - the production of a visual record of body tissues by means of high frequency sound waves.
- Interventional/Angiography Studies - the use of radiant energy from x-ray equipment during interventional and angiography studies. These radiographic techniques use minimally invasive methods and imaging guidance to perform studies that replace conventional surgery such as diagnostic arteriography, renal and peripheral vascular interventions, biliary, venous access procedures and embolization.

9. For the referred-in laboratory specimen this is a composite fee for all specimens in relation to one patient referred to an institution for laboratory tests but where the patient is not present.

   General radiography refers to the use of radiant energy from x-ray equipment for general diagnostic purposes. Mammography involves taking an x-ray of breast tissue for screening and/or diagnostic purposes

10. Chemotherapy drugs are all drugs used to treat cancer including monoclonal antibodies, tyrosine kinase inhibitors, angiogenesis inhibitors etc.
11. Cardiac pacemakers and/or defibrillators (any type)/cochlear implants/stents/endovascular coils:

    <u>Cardiac pacemakers and/or defibrillators (any type)</u>

    Refers to cardiac devices. Does not include temporary pacemakers or artificial heart.

    CCI codes:

    Percutaneous transluminal [transvenous] approach or approach NOS:

    - 1.HZ.53.GR-NM single chamber rate responsive pacemaker
    - 1.HZ.53.GR-NK dual chamber rate responsive pacemaker
    - 1.HZ.53.GR-NL fixed rate pacemaker
    - 1.HZ.53.GR-FS cardioverter/defibrillator
    - 1.HZ.53.GR-FR cardiac resynchronization therapy pacemaker
    - 1.HZ.53.GR-FU cardiac resynchronization therapy defibrillator

    Percutaneous approach (to tunnel subcutaneously):

    - 1.HZ.53.HN-FS Implantation of internal device, heart NEC cardioverter/defibrillator [AICD]

    Open (thoracotomy) approach:

    - 1.HZ.53.LA-NM single chamber rate responsive pacemaker
    - 1.HZ.53.LA-NK dual chamber rate responsive pacemaker
    - 1.HZ.53.LA-NL fixed rate pacemaker
    - 1.HZ.53.LA-FS cardioverter/defibrillator

- 1.HZ.53.LA-FR cardiac resynchronization therapy pacemaker

- 1.HZ.53.LA-FU cardiac resynchronization therapy defibrillator

Open Subxiphoid approach:

- 1.HZ.53.QA-NM single chamber rate responsive pacemaker

- 1.HZ.53.QA-NK dual chamber rate responsive pacemaker

- 1.HZ.53.QA-NL fixed rate pacemaker

Combined open (thoracotomy) approach and percutaneous transluminal (transvenous) approach:

- 1.HZ.53.SY-FS cardioverter/defibrillator

- 1.HZ.53.SY-FR cardiac resynchronization therapy pacemaker

- 1.HZ.53.SY-FU cardiac resynchronization therapy defibrillator

Cochlear Implants:

CCI codes:

- 1.DM.53.LA-LK Implantation of internal device, cochlea, of single channel cochlear implant

- 1.DM.53.LA-LL Implantation of internal device, cochlea, of multi-channel cochlear implant

Category does not include reposition of an existing, previously placed implant (1.DM.54.^^)

PCI (Percutaneous Coronary Intervention) with Stents (including drug eluting stents):

CCI codes:

- 1.IJ.50.GQ-NR Dilation, coronary arteries percutaneous transluminal approach [e.g. with angioplasty alone] using (endovascular) stent only

- 1.IJ.50.GQ-OA Dilation, coronary arteries percutaneous transluminal approach [e.g. with angioplasty alone] using balloon or cutting balloon dilator with (endovascular) stent-

- 1.IJ.50.GQ-OE Dilation, coronary arteries percutaneous transluminal approach [e.g. with angioplasty alone] using ultrasound (and balloon) dilator with (endovascular) stent

- 1.IJ.50.GU-OA Dilation, coronary arteries percutaneous transluminal approach with thrombectomy using balloon or cutting balloon dilator with (endovascular) stent

1.IJ.50.GQ-OB Dilation, coronary arteries percutaneous transluminal approach [e.g. with angioplasty alone] using laser (and balloon) dilator with (endovascular) stent

- 1.IJ.50.GU-OE Dilation, coronary arteries percutaneous transluminal approach with thrombectomy using ultrasound (and balloon) dilator with (endovascular) stent

- 1.IJ.50.GT-OA Dilation, coronary arteries percutaneous transluminal approach with atherectomy [e.g. rotational, directional, extraction catheter, laser] using balloon or cutting balloon dilator with (endovascular) stent

- 1.IJ.50.GT-OB Dilation, coronary arteries percutaneous transluminal approach with atherectomy [e.g. rotational, directional, extraction catheter, laser] using laser (and balloon) dilator with (endovascular) stent

- 1.IJ.50.GT-OE Dilation, coronary arteries percutaneous transluminal approach with atherectomy [e.g. rotational, directional, extraction catheter, laser] using ultrasound (and

balloon) dilator with (endovascular) stent

Stent Grafts:

Stent graft procedure is a procedure that uses percutaneous transluminal approach and (endovascular) stent with synthetic graft. EVAR related CCI codes are excluded from this procedure group.

CCI codes:

-1.IM.80.GQ-NR-N - Repair, pulmonary artery, using percutaneous transluminal approach and (endovascular) stent with synthetic tissue [e.g. stent graft].

-1.JK.80.GQ-NR-N - Repair, subclavian artery, using percutaneous transluminal approach and (endovascular) stent with synthetic tissue (e.g. stent graft).

-1.KE.80.GQ-NR-N - Repair, abdominal arteries NEC, using percutaneous transluminal (arterial) approach and (endovascular) stent graft [e.g. snorkel stent graft].

-1.KG.56.GQ-NR-N - Removal of foreign body, arteries of leg NEC using percutaneous transluminal approach and (endovascular) stent with synthetic graft [e.g. stent graft].

1.KG.80.GQ-NR-N - Repair, arteries of leg NEC using percutaneous transluminal approach and (endovascular) stent with synthetic graft [e.g. stent graft].

1.KT.80.GQ-NR-N - Repair, vessels of the pelvis, perineum and gluteal region using percutaneous transluminal (arterial) approach and (endovascular) stent graft.

Endovascular Coiling:

Endovascular coiling or endovascular embolization, is a surgical treatment for cerebral aneurysms. This is intended to prevent rupture in unruptured aneurysms, and rebleeding in ruptured aneurysms. The treatment uses detachable coils made of platinum that are inserted into the aneurysm using the microcatheter.

CCI codes

-1.JW.51.GQ-GE - Occlusion, intracranial vessels, percutaneous transluminal (arterial) approach using [detachable] coils.

12. Claims submitted with Code 16 must be accompanied by a hospital invoice that must identify the patient (name, health number, date of administration) and the cost of the drugs used in the visit. Prior approval **must be obtained** for chemotherapy drugs with a cost greater than $5,000. Hospitals should be informed that treatment should not take place until prior approval has been obtained. Hospitals should follow usual prior approval processes to request prior approval from the home Ministry.

    Only one prior approval request is needed for patients that require multiple visits. Hospitals should indicate on the prior-approval request that repeat visits are required.

    In emergency situations, where prior approval cannot be obtained in a timely manner, chemotherapy drugs can be reciprocally billed without prior approval. The host province must notify the home province in writing and provide a rationale as to why prior approval could not be requested, an adjustment can be requested if no rationale is provided.

13. A PET-CT scan can be billed under the following clinical indications only:

CANCER TYPE	CLINICAL INDICATION	ICD-10-CA Codes for Cancer Type	CCI Codes
ESOPHAGEAL CANCER	Staging prior to surgery; for baseline staging assessment of those patients diagnosed with esophageal cancer being considered for curative therapy and/or repeat PET-CT scan on completion of pre-operative/ neoadjuvant therapy, prior to surgery	C15.– Malignant neoplasm of oesophagus	3.**.70.CJ
COLORECTAL CANCER	Staging for potentially resectable recurrences (including rising CEA); where recurrent disease is suspected on the basis of an elevated and/or rising carcinoembryronic antigen (CEA) level(s) during follow-up after surgical resection but standard imaging tests are negative or equivocal PET-CT for apparent limited metastatic disease, such as organ-restricted liver or lung metastases, or limited nodal metastases (at presentation or follow-up) who are being considered for radical intent therapy, such as ablation, radiotherapy, or surgery. PET-CT should be considered prior to chemotherapy where the identification of occult metastases prior to resection or chemotherapy may render resection inappropriate or may alter a patient's management; or 6 weeks post chemotherapy	**C18.–** *Malignant neoplasm of colon* **C19** *Malignant neoplasm of rectosigmoid junction* **C20** *Malignant neoplasm of rectum* **C78.–** *Secondary malignant neoplasm of respiratory and digestive organs* **R76.8** *Other specified abnormal immunological findings in serum*	3.**.70.CJ

CANCER TYPE	CLINICAL INDICATION	ICD-10-CA Codes for Cancer Type	CCI Codes
GYNECOLOGICAL CANCER	Staging locally advanced cervical cancer; PET-CT for patients with locally advanced cancer of the cervix (+/- endometrial cancer) with positive or equivocal pelvic lymph nodes as assessed by PET-CT Re-staging prior to consideration of pelvic exenteration; PET-CT for patients with recurrent gynecologic malignancies under consideration for radical salvage surgery	**C51.–** *Malignant neoplasm of vulva* **C52** *Malignant neoplasm of vagina* **C53.–** *Malignant neoplasm of cervix uteri* **C54.–** *Malignant neoplasm of corpus uteri* **C55** *Malignant neoplasm of uterus, part unspecified* **C56.–** *Malignant neoplasm of ovary* **C57.–** *Malignant neoplasm of other and unspecified female genital organs* **C58** *Malignant neoplasm of placenta* **C77.–** *Secondary and unspecified malignant neoplasm of lymph nodes*	3.**.70.CJ

HEAD AND NECK	Diagnosis of the primary site; for the evaluation of metastatic squamous cell carcinoma in neck nodes when the primary disease site is unknown after standard radiologic and clinical investigation For the staging on nasopharyngeal cancer PET-CT to assess patients with N1, N2, or N3 metastatic squamous cell carcinoma of the head and neck, after chemoradiation, who have residual neck nodes of 1.5cm or greater on re-staging PET-CT performed 10-12 weeks post therapy Staging of patients with of locally advanced (N1, N2, or N3) malignancies of the head and neck	**C00.–** *Malignant neoplasm of lip* **C01** *Malignant neoplasm of base of tongue* **C02.–** *Malignant neoplasm of other and unspecified parts of tongue* **C03.–** *Malignant neoplasm of gum* **C04.–** *Malignant neoplasm of floor of mouth* **C05.–** *Malignant neoplasm of palate* **C06.–** *Malignant neoplasm of other and unspecified parts of mouth* **C07** *Malignant neoplasm of parotid gland* **C08.–** *Malignant neoplasm of other and unspecified major salivary glands* **C09.–** *Malignant neoplasm of tonsil* **C10.–** *Malignant neoplasm of oropharynx* **C11.–** *Malignant neoplasm of nasopharynx* **C12** *Malignant neoplasm of pyriform sinus* **C13.–** *Malignant neoplasm of hypopharynx* **C14.–** *Malignant neoplasm of other and ill-defined sites in the lip, oral cavity and pharynx* **C30.0–** *Malignant neoplasm of nasal cavity* **C31.–** *Malignant neoplasm of accessory sinuses* **C32.–** *Malignant neoplasm of larynx* **C41.–** *Malignant neoplasm of bone and articular cartilage of other and unspecified sites* **C49.0** *Malignant neoplasm of connective and soft tissue of head, face and neck* **C69.5** *Malignant neoplasm lacrimal gland & duct* **C76.0** *Malignant neoplasm of head, face and neck* **C77.0** *Secondary malignant neoplasm lymph nodes of head, face and neck*	3.**.70.CJ

CANCER TYPE	CLINICAL INDICATION	ICD-10-CA Codes for Cancer Type	CCI Codes
MELANOMA	Staging in node positive disease for whom radical surgery is planned; for the staging of melanoma patients with localized “high risk” tumours with potentially resectable disease; or for the evaluation of patients with melanoma and isolated metastasis at the time of recurrence when metastectomy is being contemplated	C43.– Malignant melanoma of skin C77.– Secondary and unspecified malignant neoplasm of lymph nodes C78.– Secondary malignant neoplasm of respiratory and digestive organs C79.– Secondary malignant neoplasm of other and unspecified sites	3.**.70.CJ

CANCER TYPE	CLINICAL INDICATION	ICD-10-CA Codes for Cancer Type	CCI Codes
LUNG	Solitary Pulmonary Nodule (SPN) (solid or semi-solid, excluding GGN), undiagnosed in patients at high risk from TTNB; SPN: a lung nodule for which a diagnosis could not be established by a needle biopsy due to unsuccessful attempted needle biopsy; the SPN is inaccessible to needle biopsy; or the existence of a contra-indication to the use of needle biopsy For initial staging of patients being considered for potentially curative therapy based on negative standard imaging tests; OR for staging of patients with locoregional recurrence, after primary treatment, being considered for definitive salvage therapy Initial staging, restaging, recurrent disease or multiple primaries being considered for potentially curative therapy For staging of patients with locoregional recurrence, after primary treatment, being considered for definitive salvage therapy Staging if limited stage disease is suspected and may be indicated for limited use in radiation treatment planning in patients with small cell lung cancer; Small cell lung cancer: limited disease small cell lung cancer where combined modality therapy with chemotherapy and radiotherapy is being considered	**C34.–** *Malignant neoplasm of bronchus and lung* **C77.–** *Secondary and unspecified malignant neoplasm of lymph nodes* **C78.–** *Secondary malignant neoplasm of respiratory and digestive organs* **C79.–** *Secondary malignant neoplasm of other and unspecified sites* **J98.4** *Other disorders of lung*	3.**.70.CJ

CANCER TYPE	CLINICAL INDICATION	ICD-10-CA Codes for Cancer Type	CCI Codes
LYMPHOMA	Baseline staging of patients with aggressive lymphomas being considered for curative intent treatment; for the baseline staging of patients with indolent lymphomas being considered for aggressive/curative therapy Evaluation of residual mass(es) following chemotherapy in a patient with Hodgkin's or non-Hodgkin's lymphoma when further potentially curative therapy (such as radiation or stem cell transplantation) is being considered; Assessment of response in Hodgkin's lymphoma after two (2) or three (3) cycles of chemotherapy, when chemotherapy is being considered as the definitive single modality therapy	**C81.–** *Hodgkin lymphoma* **C82.–** *Follicular lymphoma* **C83.–** *Non-follicular lymphoma* **C84.–** *Mature T/NK-cell lymphomas* **C85.–** *Other and unspecified types of non-Hodgkin lymphoma* **C86.–** *Other specified types of T/NK-cell lymphoma* **C88.4–** *Extranodal marginal zone B-cell lymphoma of mucosa-associated lymphoid tissue [MALT-lymphoma]*	3.**.70.CJ
TESTICULAR CANCER	Evaluation of residual mass; Germ cell tumours: where persistent disease is suspected on the basis of the presence of a residual mass after primary treatment for seminoma when curative surgical resection is being considered Germ cell tumours: where recurrent disease is suspected on the basis of elevated tumour marker(s) - (beta human chorionic gonadotrophin (HCG) and/or alpha fetoprotein) and standard imaging tests are negative	**C62.–** *Malignant neoplasm of testis*	3.**.70.CJ

CANCER TYPE	CLINICAL INDICATION	ICD-10-CA Codes for Cancer Type	CCI Codes
THYROID CARCINOMA	Detection of suspected recurrence based on rising TG with negative Iodine-131 scan; where recurrent or persistent disease is suspected on the basis of an elevated and/or rising thyroglobulin level(s) but standard imaging studies, including I-131 scan and/or neck ultrasound, are negative or equivocal	C73 Malignant neoplasm of thyroid gland	3.**.70.CJ

14. A day care surgery patient is one who has been pre-booked and registered to receive services from a functional centre that is equipped and staffed to provide day surgery (e.g. an operating room, an endoscopy suite, a cardiac catheterization lab).

    Code 18, 19 and 20 claims must include a corresponding CCI code. Code 18, 19 and 20 claims that are missing or provide an invalid CCI code are subject to IHIACC's adjustment process. I.e., the home jurisdiction pays the claim as billed and, after submitting an adjustment to the host jurisdiction, the host jurisdiction must pay back the claim amount to the home jurisdiction if a proper CCI code cannot be identified.

    CIHI produces a rate lookup table which provides the corresponding day care surgery rate after a CCI code is entered. If the CCI code provided does not have a corresponding day care surgery rate, the service cannot be billed as a day care surgery.

How to bill for chemotherapy drugs (codes 06 and 16)

Scenario 1

Examples	Drug	Costs ($)
Chemo drugs provided to the patient: August 14,2025	Fluorouracil	$15.00
Chemo drugs provided to the patient: August 14,2025	Trastuzumab	$5,000.00

STEP 1 - Determining service code, invoice and prior approval requirements

Examples	Response
Total drug costs used to determine: what code to bill, if an invoice is required and if prior approval is required	$5,015.00
Billing code used (code 06 under $1,000 or code 16 if $1,000 or over)	16
Invoice required (total is $1,000 or more)	YES
Prior approval required (total is over $5,000)	NO

STEP 2 - Determining the amount to claim

Examples	Costs ($)
Visit Amount (out-patient code 01)	$397.00
Total Cost Claimed (total drugs + visit amount)	$5,412.00

Prior-approval requests and invoices should never include the number of units (vials, tablets, dosage, etc.).

Scenario 2

Examples	Drug	Costs ($)
Chemo drugs provided to the patient: August 14,2025	Fluorouracil	$15.00
Chemo drugs provided to the patient: August 14,2025	Trastuzumab	$5,000.00
Chemo drugs provided to the patient: August 14,2025	Epirubicin	$95.00

STEP 1 - Determining service code, invoice and prior approval requirements

Examples	Response
Total drug costs used to determine: what code to bill, if an invoice is required and if prior approval is required	$5,110.00
Billing code used (code 06 under $1,000 or code 16 if $1,000 or over)	16
Invoice required (total is $1,000 or more)	YES
Prior approval required (total is over $5,000)	YES

STEP 2 - Determining the amount to claim

Examples	Costs ($)
Visit Amount (out-patient code 01)	$397.00
Total Cost Claimed (total drugs + visit amount)	$5,507.00

Prior-approval requests and invoices should never include the number of units (vials, tablets, dosage, etc.).

Scenario 3

Examples	Drug	Costs ($)
Chemo drugs provided to the patient: August 14,2025	Fluorouracil	$15.00
Chemo drugs provided to the patient: August 14,2025	Cyclophosphamide	$40.00
Chemo drugs provided to the patient: August 14,2025	Epirubicin	$95.00

STEP 1 - Determining service code, invoice and prior approval requirements

Examples	Response
Total drug costs used to determine: what code to bill, if an invoice is required and if prior approval is required	$150.00
Billing code used (code 06 under $1,000 or code 16 if $1,000 or over)	06
Invoice required (total is $1,000 or more)	NO
Prior approval required (total is over $3,000)	NO

STEP 2 - Determining the amount to claim

Examples	Costs ($)
Visit Amount (out-patient code 01)	$397.00
Total Cost Claimed (total drugs + visit amount)	$547.00

Prior-approval requests and invoices should never include the number of units (vials, tablets, dosage, etc.).

How to bill for laboratory services

Scenarios	Cost = or < $188	Cost > $188
Referred in specimen	Code 05	Code 15
Patient presents at lab with referral from outside the hospital	Code 05	Code 15
Patient seen at emergency/outpatient department and presents at lab on the same day	Code 01	Bill code 01 if the laboratory service cost $397 or less. Bill code 15 if the laboratory service cost more than $397. Only one service code can be billed (see rule 3).
Patient seen at emergency/outpatient department and presents at lab on a different day	Code 01 for emergency department visit and code 05 for lab	Code 01 for emergency department visit and code 15 for lab