Version 2, Last updated October 11, 2023

Schedule "R"

Blended Capitation Model for Primary Care

This Schedule to the Agreement outlines the principles, structure, rates, rules and other related matters for a blended capitation remuneration model for primary care. The Parties agree that this Schedule shall be effective on April 1, 2023.

1.0 Program Objective

The objective of the Blended Capitation Program (Program) is to contribute to a health care system in which all citizens have timely access to excellent team-based primary care that provides comprehensive, continuous primary care to Attached patients. The Program will enable, promote, and support team-based primary care, comprehensive family medicine, greater attachment, access to and quality of care for patients, and improved recruitment, retention and professional satisfaction for physicians. The parties are committed to working cooperatively in pursuit of this objective.

1.01 Public Accountability

The parties acknowledge that, in the Blended Capitation Model (Model) of primary care, the majority of compensation is based upon patient attachment, where the physician commits to provide ongoing care and treatment to a patient throughout an entire year, and not on the episodic provision of care or treatment. The parties therefore agree that there must be appropriate accountability for the public funds so expended and that the management and administration of the Model by the Family Practice Renewal Committee (FPRC) must include, through the use of appropriate performance metrics, the continuing assessment and evaluation of the operation of the Model.

Definitions

Attached means that there is a formalized, continuous relationship between a patient and Blended Capitation family practice. Attachment is formalized through discussion and documentation in accordance with section 3.4.

Basket of Services means the set of core insured services provided by participating physicians for attached patients and reflects the typical activities of a family physician (non-specialized) in an office-based setting. The Basket of Services is set out in Appendix B. The Basket of Services may be provided in-person or virtually, as determined appropriate by the provider.

Blended Capitation Model (Model) means the payment model for physicians licensed to practice family medicine in Newfoundland and Labrador that provides a capitation payment for providing a Basket of Services to each Attached patient, and a partial fee-for-service payment for each service provided within the MCP Medical Payment Schedule to an Attached patient, in accordance with this Schedule.

Blended Capitation Group (Group) means a group of three or more physicians who enroll in the Model and are working together to provide their patients comprehensive access to quality primary health care services.

Capitation Payment means the payment made annually to a physician for the care of an Attached patient. The capitation payment for an individual Attached patient is the base Capitation Rate set out in section 3.8 adjusted in accordance with the Complexity Modifier set out in the table in Appendix A.

Complexity Modifier means a methodology to adjust Capitation Payments to physicians based on the complexity of care required by patients as set out in the table in Appendix A.

Income Floor means a guaranteed minimum level of compensation provided to physicians participating in the Model for an initial period of up to two years, calculated pursuant to section 3.12.

Program means the rules, funding and processes that, collectively, within the Schedule, describe physician eligibility for Blended Capitation payments, and other obligations of the parties and program participants.

Provider Roster means the patients who are Attached to a physician.

2.0 Governance and Administration

2.1 Payments under this Program will be made by Government consistent with, and within the scope of, this Schedule.

2.2 The FPRC will carry out implementation of the Program consistent with, and within the scope of, this Schedule, and will consult widely with stakeholder groups. The FPRC will develop additional program objectives, rules, and processes as necessary, consistent with, and within the scope of, this Schedule.

a) The Family Practice Renewal Program (FPRP) will be responsible for Model administration, project management, physician engagement, enrolling physician practices, entering into agreements with physician practices, and practice improvement initiatives to support successful practices.

b) The FPRC will establish staffing and administrative requirements within the funding amounts set out in this Schedule.

c) The FPRC will establish an evaluation subcommittee including two patient representatives to develop an evaluation framework and complete a formal evaluation of the Program, inclusive of access, quality, and other relevant objectives, to be completed within five years of the Effective Date. The FPRC will also ensure that a formal evaluation to measure outcomes of the Program is conducted.

d) The Program will be comprehensively tested to identify risks, including those around cost escalation, and will explore solutions to mitigate those risks. The FPRC will continuously review the Program to update its rules and processes and to determine if modifications to the parameters of the Model are required. The FPRC may make recommendations to the Parties for changes to this Schedule as and when they are deemed necessary.

2.3 The administration budget for the Model will be funded through a combination of FPRP's existing budget, including the accumulated surplus available as of the Effective Date, and through additional funding from Government in accordance with the table below. These contributions may at any time be re-evaluated at the request of the Minister of Health and Community Services or the NLMA and may be modified by written agreement of the Parties. Any surplus remaining as of March 31, 2028, taking into account the opening accumulated surplus and the continuing annual funding, may be utilized for further operational funding of the Program or otherwise shall be returned to Government.

Additional funding from HCS	
Date of signing to March 31, 2024	$600,000
Fiscal 2024/2025	$500,000
Fiscal 2025/2026	$300,000
Fiscal 2026/2027	$300,000
Fiscal 2027-2028	$300,000
TOTAL	**$2,000,000**

3.0 Blended Capitation Model

3.1 **Timelines.**

April 1, 2023	The Program will be open for applications.
October 30, 2023	The Program will start to issue notifications of acceptance. Subsequent notifications will be made within 3 months of receipt of application. The date of acceptance into the Program will be the start date of the income guarantee period and the date that payment of all transition/incentive grants and stipends will be authorized.
April 1, 2024	The billing system for capitation claims and partial fee-for-service claims will be ready no later than this date. A test group of a maximum of 75 physicians will start billing on the new billing system no later than this date.

	If the billing system is ready for launch prior to April 1, 2024 the test group may start at that time.
July 1, 2024	Once the reliability and accuracy of the billing system are confirmed by Government, on or before July 1, 2024, the billing system will be open to all other applicants who have been accepted into the Program.

3.2 **Group Size.** The minimum Blended Capitation Group size will be three physicians. The FPRC will establish rules and procedures to allow Blended Capitation Groups that drop below the mandatory group size the opportunity to reach the minimum size of three.

3.3 **Eligibility.** Participation by physicians in the Blended Capitation Model will be voluntary. Physicians paid through either Fee-For-Services (FFS) or an alternate method may convert to the Model if they meet the eligibility criteria as defined below. Physicians may transition back to FFS at their discretion, in accordance with terms and conditions that will be developed under section 2.2.

All family physicians will be eligible for payment through the Model, provided they commit to the following items in a Blended Capitation Group agreement with the Program:

a) Commit to provide comprehensive continuous primary healthcare services across the life span of their patients, based on patient needs and responsive to documented needs of the geographic community they serve;

b) Meet parameters set out in this Schedule;

c) Meet performance indicators as established in section 3.6;

d) Are part of a Group of family physicians in one practice or across multiple practices, who practice in an office-based setting in Newfoundland and Labrador and partner together in providing after-hours care for their Attached patients;

e) Are a member of a Family Practice Network, where one exists in their geographic region;

f) Maintain registration with the College of Physicians and Surgeons of Newfoundland and Labrador (CPSNL) as follows:

- Full registration, or;
- Provisional Licence and are part of a Group that provides adequate opportunity for practice supervision as per CPSNL policies and guidelines;

g) Use the provincial Electronic Medical Record (EMR);

h) In regard to physicians who have a private primary care practice located in a Health Authority facility, they shall bill office codes for services provided in their private primary care practice, and facility-based codes for services provided as part of RHA/PHA services;

i) Submit data on access, quality and other matters as may be agreed by the Parties, as specified in this schedule, or as approved by the FPRC;

j) Participate in quality initiatives and activities as outlined in section 3.14; and

k) Agree to participate in Program evaluation.

3.4 **Rostering.**

a) A patient is deemed to be Attached when they are rostered within the information system designed for that purpose.

b) On a regular basis, as required by the payment system, physicians will confirm the Attachment of their current patients, new patients, and de-rostered patients.

c) Patients who enter Long-Term Care facilities will be automatically de-rostered from their physician.

d) MCP will generate reports on out-of-practice visits for the Attached patients of each family physician. These reports will be designed to assist physicians with identifying opportunities to improve patient access.

3.5 **Service Expectations.** Physicians participating in the Program will meet the following service expectations:

a) Physicians commit to using best practices in scheduling to provide timely access to appointments, including the ability for patients, where appropriate, to access their own physician or another physician in the Group or other team members on the same day.

b) Each physician will coordinate with the other physicians in the Group as required to ensure that non-emergency primary care services will be accessible during reasonable, regular hours each week of the year and meet the health needs of the patient population served by the Group.

c) **After-hours**: A Blended Capitation Group will provide after-hours clinics for Attached patients outside the hours of 9am to 5pm, Monday to Friday. The number of hours of after-hours clinics that each Group must provide per quarter (i.e., 13 week period) shall be 2.2 hours per 100 patients on the total practice roster (including the rosters of non-physician providers), provided that in any event, and regardless of roster size, there are a minimum of 3 after-hours clinic hours per week per Group.

Examples:			
Number Attached Patients	Hours per Quarter (13 weeks) Formula: Roster Size/100x2.2	Average Hours per week	Minimum Hours per week
3600	79	6.1	3
4000	88	6.8	3
6000	132	10.1	3
7200	158	12.2	3

All physicians will participate in after-hours service expectations, with distribution being adjusted by taking into consideration the regular, ongoing provision of services such as hospital emergency room coverage, anesthesia services, obstetric services, and long-term care services, or other relevant factors. FPRC will develop policies and rules regarding the foregoing after-hours service expectations.

c.1) **Redistribution/Exemption – After Hours Expectations (Effective September 1, 2023 up to August 31, 2025)**

- The Group that provides regular, ongoing provision of services such as hospitalist services, primary care services for unattached patients, hospital emergency room coverage, anesthesia services, obstetric services, and long-term care services may distribute their after-hours BCM service to the Group's Nurse Practitioner (NP), where the Group has hired a NP;
- The Group that provides regular, ongoing provision of services such as hospitalist services, primary care services for unattached patients, hospital emergency room coverage, anesthesia services, obstetric services, and long-term care services, where the Group has not hired a NP, may be exempted from the BCM after-hours requirement in subsection 3.5 (c), on application to the FPRP and on decision of the FPRP in accordance with the FPRP's policies and rules;
- This subsection 3.5 (c.1) shall only be in effect for the transition period September 1, 2023 and August 31, 2025 and only so long as the physician

provides at least two hours of the types of services described in the above two bullets to NLHS for every one hour of after-hours BCM service redistributed/exempted; and,

- Where a physician member of a Group does not provide the type or duration of services to the NLHS as described in the above three bullets, that member of the Group is not eligible for redistribution/exemption of after-hours service expectations as set out in subsection 3.5 (c). The physician will provide after-hours service pursuant to the s. 3.5 (c) formula but prorated to the number of patients who are attached to them.

d) Where reasonably possible, services will be provided by the physicians in a Group rather than by locums or subcontractors.

e) Excellent availability of and access to team-based primary care is considered to include, unless circumstances dictate otherwise, each practice providing an average service level of not fewer than 88 Attached patient care encounters per 100 Attached patients each 3-month quarter (13 weeks).

13 week recommended access level per practice (Examples):		
Number Attached patients	Care Encounters per quarter	Average number of care encounters per week
3750	3300	254
5400	4752	365
7200	6336	487

f) The maximum roster for each physician shall be 2,400 Attached patients.

g) **Other Providers:** Where a nurse practitioner is employed by or contracted to work as part of a Blended Capitation Group, 900 patients may be rostered by the physicians in the Group in addition to the amount specified in section 3.5 (f). Where a registered nurse is employed by or contracted to work as part of a Blended Capitation Group, 600 patients may be rostered by the physicians in the Group in addition to the amount specified in section 3.5 (f). The actual roster of any provider within a Group will be as agreed between the Group and the provider, and the division of the additional rostered patients as specified in this section between the physicians for billing purposes will be as agreed by the physicians in the Group. There shall be no cap on the number of other providers that may be added to a Group but the total roster addition under this section shall be capped at 3000, unless otherwise approved by the FPRC.

3.6 **Performance Indicators.** Physicians will be accountable to the Program for reporting on performance indicators. The FPRC will be responsible for implementing the performance indicators of the Model.

a) The following indicators will be measured:

- Percentage of same day or next day appointments available to Attached patients.
- After-hours access provided to Attached patients. This indicator will be based on after-hours service expectations in section 3.5 (c).
- Relational continuity, meaning the ongoing therapeutic relationship between a family physician, including their team, and an Attached patient. This indicator will measure the proportion of visits by Attached patients to their family physician, and to their family physician's Blended Capitation Group.

b) A phased-in implementation approach to measuring performance indicators will be used. This will involve creating a baseline of data, ensuring that the metrics are

reliable, and informing Blended Capitation Groups how to access and interpret the indicators.

c) Indicators will be measured at the Group level and at the individual physician level.

d) The objective of the performance indicators process is to encourage continuous improvement and/or maintenance of accessibility and high-quality care. If a Group, (or an individual physician within a Group), is not maintaining accessibility or quality of care, consistent with the above objective, based on the performance indicators, the FPRC will engage the Group or the physician in a process of information exchange and performance improvement. If, following these activities, improvement has not been achieved, the FPRC will have discretion to terminate the Group (or an individual physician within a Group) from the Program.

e) The FPRC will further develop definitions and guidelines for the Performance Indicator program. For the purposes of section 3.6 (d) above, indicators will be limited to activities and outputs over which the practice has control and will not be linked to patient behaviour or outcomes.

f) The FPRC will monitor and adjust these indicators as required and may develop additional indicators.

g) Indicators will be based on Provincial Electronic Medical Record (EMR) data or data from hospital information systems. New data gathering requirements that create additional work for physician practices will not be introduced unless approved by FPRC.

h) Physicians will permit access to EMR data by NLCHI for purposes of indicator requirements under this Schedule.

i) Should the FPRC be unable to reach a decision regarding termination, as described in section 3.6 (d), the FPRC will refer the matter to the Minister of Health and Community Services for a determination after consultation with Government and NLMA members of the FPRC. Within 10 days of the Minister's decision, the NLMA may refer any dispute, controversy or claim arising out of or relating to the Minister's determination, including any question regarding the Minister's interpretation and application of this Schedule, to arbitration for final resolution in accordance with the *Arbitration Act, RSNL 1990 cA-14.* The cost of arbitration shall be equally borne by the Parties.

3.7 **Payment Blend.**

a) MCP will provide remuneration to the physicians in a Blended Capitation Group for care of Attached patients in the form of a Capitation Payment, and FFS payments at a rate of 25% of the rates in the MCP Medical Payment Schedule, for in-basket

services, and 100% of the rates in the MCP Medical Payment Schedule for other insured services.

b) For clarity, the Blended Capitation payments do not include payments received by physicians for services to patients outside the normal in-basket practice setting. Such excluded payments include: emergency department payments, the rural retention bonus, CMPA reimbursement, obstetrical bonus, on-call payments, surgical assist payments, academic payments, and other sessional payments and/or employment income from health authorities or third parties. The FPRC may add other categories of excluded payments to this list.

c) Continuation of the practice of billing for insured services provided by medical learners, to support clinical teaching activities, will be at 100% FFS.

3.8 **Capitation Rate.** The base Capitation Rate will be $186.29 per patient per fiscal year and will change in the future according to negotiated changes for Family Medicine fee codes in the Memorandum of Agreement. The Capitation Rate will be adjusted for each Attached patient according to the table appended to this Schedule (Appendix A). The table may be adjusted from time to time on the written agreement of the parties.

3.9 **FFS Billing for Non-Rostered Patients.** After the Income Floor period, the FFS limit per physician for in-basket services provided to non-Attached patients is $56,000. There is no limit for FFS billings for the provision of "out of basket" services for rostered and non-rostered patients.

3.10 **Locum Arrangements.** The Capitation Rate accounts for the cost of a physician hiring a locum for two weeks of practice coverage annually.

Blended Capitation Groups will hire and pay locums as needed. Payment agreements may vary based on terms decided upon by the host physician and locum and funding of such arrangements is not the responsibility of the Government.

Locum physicians will submit all billings for services rendered through the locum physician's billing number, with the payment assigned to the blended capitation physician or Group. This will generate the FFS payment for in-basket services delivered to Attached patients, as well as the FFS payment for out-of-basket services delivered to all patients and in-basket services delivered to non-Attached patients.

3.11 **Complexity Modifier.** The Parties agree that the Blended Capitation Model must incorporate measures of patient complexity to compensate physicians fairly for the care of complex patients and to improve access for complex patients. The Parties commit to work together to ensure that the Age/Gender Complexity Modifiers matrix in Appendix A is as relevant as possible to the Newfoundland and Labrador context. The Parties agree to review

Appendix A, along with other measures of patient complexity, during the term of this Schedule.

3.12 **Income Floor**. Physicians will receive a two-year guaranteed minimum income (Income Floor) starting on the date of their acceptance into the Model.

a) The Income Floor for physicians accepted into the Model, who have been in practice greater than two years, will be calculated by averaging the physician's billings from two recent, representative years of active practice in Newfoundland and Labrador prior to application to the Program, excluding periods of time when the physician was away from their practice, such as time on parental leave, plus an additional 10.9% payable in year one of the Income Floor period. The FPRC will develop a policy to apply to individual cases to account for periods of parental, sick or other appropriate types of leave.

b) The Income Floor for physicians without a two-year billing history and physicians who do not have an established patient panel, will be set at Step 1 from the Memorandum of Agreement, or for a physician transitioning from a salaried position their current Step, of the Salary Scale for Family Physicians, adjusted to the proportion of FTE of comprehensive primary care the physician commits to provide in accordance with the table below, plus an additional 30% in recognition of overhead expenses, and an additional 10.9% payable in year one of the Income Floor period. The amount of FTE of comprehensive primary care that will be required to qualify for payment under this section will be determined according to the number of three-hour community medicine blocks provided per four-week period.

FTE Adjustment Factor	Minimum number of three-hour community-based primary care blocks per week, on average over a four-week period
1.0	9
0.9	8
0.8	7
0.7	6
0.6	5
0.5	4

c) If the Model and billing system are not operational when a physician enters year two of the Income Floor period, the physician will continue to receive the 10.9% premium on a month to month basis until the billing system is ready, up to the end of their two-year Income Floor period.

d) During the Income Floor period, after the billing system becomes operational, physicians will bill under the Blended Capitation Model, as established in this Schedule.

e) Physicians will be eligible for a top-up payment if their Income Floor would have paid more than the Blended Capitation Model, inclusive of FFS billings for out-of-basket services and for non-rostered patients. This calculation will be completed, and top-up payments made, on a semi-annual basis.

3.13 **Transition Incentive.** A payment of $11,250 will be made by HCS to each physician upon acceptance into the Model.

3.14 **Redeployment of FPRP Funding.**

a) The FPRC will develop rules and processes as necessary, consistent with, and within the scope of, this Schedule to implement redeployment of FPRP Fee Code funding to the Program.

b) When a FFS physician starts under the Model, the two-year average FPRP fee code earnings of that physician will be removed from the FPRP Fee Code budget.

c) **Quality of Care Stipend.** Each physician, upon being accepted into the Program, will be entitled to receive an annual quality of care stipend of $7,500 in recognition of the physician's participation in FPRP or practice-initiated quality programs, practice improvement and related professional development. This stipend will be subject to FPRP guidelines. The FPRP will draw this funding from the redeployed FPRP Fee Code budget.

d) **One-Time Start-Up Grant.** Each physician, upon being accepted into the Program, and who part of a Blended Capitation Group at the time of the Group's establishment, will receive a one-time grant of $10,000 in recognition of start-up costs under the Model related to areas such as renovations, technology, training, and legal services. For clarity, a physician joining an established Blended Capitation Group will not be eligible for this grant. The FPRP will draw this funding from the accumulated FPRP surplus.

e) **EMR Transition Grant.** Practices will be required to commit to using the provincial EMR as a condition of acceptance into the Model. Each practice who is using a different EMR at the time of their acceptance into the Model will be entitled to receive an EMR transition grant of $30,000. The FPRP will draw this funding from the accumulated FPRP surplus. Blended Capitation Model billing will commence on confirmation of successful transition to the provincial EMR. Physicians shall complete the transition to the provincial EMR within six months from the date of their acceptance into the Model. Billing under the Blended Capitation Model cannot start until the provincial EMR is in place. If the transition is not completed within six months, access to the 10.9% premium (section 3.12) will be held in abeyance until such time as the provincial EMR transition within the practice is complete.

f) **Procedures Bonus.** Each physician will be entitled to receive an annual procedures bonus as follows:

- A physician will be entitled to the bonus who bills $1,200 of in-basket Procedures fee codes (as set out in Appendix B) in a calendar year, with the $1200 measured according to 100% of MCP Medical Payment Schedule;
- Bonus payment of $2,500;
- Procedures bonus is payable when the above billing threshold is achieved during the year.

For the first five years of this agreement, the source of funds for the procedures bonus will be the FPRP surplus. Thereafter, the bonus will continue from an alternate source of funding.

Appendix A – Age/Gender Complexity Modifiers

Age/Gender Complexity Modifiers[1]

Age Group	Female	Male	Non-Binary[2]
0 – 4	0.62	0.64	0.64
5 – 9	0.45	0.44	0.45
10 – 14	0.46	0.43	0.46
15 – 19	0.64	0.46	0.64
20 – 24	0.82	0.53	0.82
25 – 29	0.92	0.64	0.92
30 – 34	1.01	0.69	1.01
35 – 39	1.01	0.70	1.01
40 – 44	1.01	0.73	1.01
45 – 49	1.05	0.77	1.05
50 – 54	1.08	0.85	1.08
55 – 59	1.08	0.92	1.08
60 – 64	1.11	1.00	1.11
65 – 69	1.32	1.22	1.32
70 – 74	1.48	1.41	1.48
75 – 79	1.67	1.65	1.67
80 – 84	1.73	1.80	1.80
85 – 89	1.73	1.80	1.80
90+	1.73	1.80	1.80

Notes:

(1) Age/gender complexity modifiers to be multiplied by $186.29 when calculating payment for enrolled patients.

(2) Non-binary modifiers represent the higher value of female or male modifiers for each age group.

Appendix B – Basket of Services

Fee code	Description
Office	
111010	Office - Pre-Dental General Assessment
112010	Office - General Assessment
114010	Office - General Reassessment
118010	Office - Routine Post-Operative Care
121010	Office - Partial Assessment
122010	Office - Visit For Well-Baby Care
123010	Office - Partial Assessment Of A Patient Aged 65 To 74 Years Of Age
124010	Office - Partial Assessment Of A Patient Aged 75 Years Or Older
126010	Office - Partial Assessment Of A Patient Who Received A Whscc Service during the same Office Visit.
127010	Office - Chronic Disease Management of a Patient under 75 Years of Age
129010	Office - Family Medicine Counselling (Add-On to 121,123,124).....Add on
131010	Office - Psychotherapy - Individual, Per 1/2 Hr Or Major Part Thereof (I.E. In Excess Of 15 Minutes)
132010	Office - Psychotherapy - Group (4 To 8 People) Per Member, Per Hour - Or Major Part Thereof
136010	Office - Psychotherapy - Family Therapy (2 Or More Family Members) Per 1/2 Hour, Per Family
139010	Fee For Patients Seen In Scheduled After Hours Clinic…..Add on
181010	Office - Detention Per 1/4 Hr
543800	Office E.C.G. - Technical Component
543820	Office E.C.G. - Professional Component
147	Driver medical examination of a patient who is 75 years of age or older, as required by Motor Registration for age
Family Practice Renewal Program	
520010	Shared Care - Family Practice Renewal Program
521010	Patient Care Telephone Code
522010	Family Practice Renewal Program - COPD
Procedures	
546140	Speculum exam (no charge if done as part of the following: consultation, repeat consultation, general or specific assessment, routine post-natal visit, or surgical procedure requiring the use of a speculum)
540000	When A Procedure(S) Is The Sole Reason For A Visit; I.E., When No Consultation Or Visit Fees Is Being Charged, Add $4.60 Basic Fee Per Visit Regardless Of The Number Of Procedures Carried Out.
542260	Anticoagulant Supervision - Long Term - Per Month
545980	Ear Syringing - Uni Or Bilateral Note: May Be Billed For Service Rendered In Office, Home Or Hospital Settings.
546440	Bursa, Joint Or Tendon Sheath Injection - Including Pre- Liminary Aspiration

546460	Bursa, Joint Or Tendon Sheath Injection - Each Additional Site Or Area - (Maximum 8 Injections Per Visit)
546560	Intradermal, Intramuscular Or Subcutaneous Injection - Each Additional Injection
546580	Intradermal, Intramuscular Or Subcutaneous Injection - First Injection
901000	Abscess Or Haematoma - Local Anaesthetic - Subcutaneous - One (I.O.P.)
901020	Abscess Or Haematoma - Local Anaesthetic - Two (I.O.P.)
901040	Abscess Or Haematoma - Local Anaesthetic - Three Or More (I.O.P.)
901100	Abscess Or Haematoma - Local Anaesthetic - Palmar Or Plantar Spaces (I.O.P.)
901220	Comedones, Acne Pustules, Milia - Ten Or Less (I.O.P.)
901240	Comedones, Acne Pustules, Milia - Eleven Or More (I.O.P.)
901260	Foreign Body Removal - Local Anaesthetic (I.O.P.)
901560	Removal Of Verruca, Etc. By Electrocoagulation And/Or Curetting And/Or Cryosurgery And/Or Laser Surgery - Single Lesions (I.O.P.)
901580	Removal Of Verruca, Etc. By Electrocoagulation And/Or Curetting - And/Or Cryosurgery And/Or Laser Surgery - Two Lesions - (I.O.P.)
901600	Removal Of Verruca, Etc. By Electrocoagulation And/Or Curetting - And/Or Cryosurgery And/Or Laser Surgery - Three Or More Lesions (I.O.P.)
901760	Removal Of Palmar Or Plantar Verruca By Electrocoagulation And/Or Curetting, And/Or Cryosurgery And/Or Laser Surgery - Single Lesion - (I.O.P.)
901780	Removal Of Palmar Or Plantar Verruca By Electrocoagulation And/Or Curetting, And/Or Cryosurgery And/Or Laser Surgery - Two Lesions (I.O.P.)
901800	Removal Of Palmar Or Plantar Verruca By Electrocoagulation And/Or Curetting, And/Or Cryosurgery And/Or Laser Surgery - Three Or More Lesions (I.O.P.)
902240	Excision Of Pressure Sore Or Decubitus Ulcer - Minor, Less Than 1 Cm. Average Diameter (I.O.P.)
902520	Excision Of Malignant And Premalignant Lesions (Other Areas)- Single Lesion
902530	Excision Of Malignant And Premalignant Lesions (Other Areas) - Two Lesions
902540	Excision Of Malignant And Premalignant Lesions (Other Areas) - Three Or More
902580	Curettage, Electrodessication Or Cryosurgery (Face Or Neck) - Single Lesion
902600	Curettage, Electrodessication Or Cryosurgery (Face Or Neck) - Two Lesions
902620	Curettage, Electrodessication Or Cryosurgery (Face Or Neck) - Three Or More Lesions
902640	Curettage, Electrodessication Or Cryosurgery (Other Areas) - Single Lesion

902660	Curettage, Electrodessication Or Cryosurgery (Other Areas) - Two Lesions
902680	Curettage, Electrodessication Or Cryosurgery (Other Areas) - Three Or More Lesions
903040	Debridement And Dressing - Major (I.O.P.)
905600	Chemical And/Or Cryotherapy Treatment Of Minor Skin Lesions - One Or More Lesions, Per Treatment (I.O.P.)
906820	Aspiration Of Breast Cyst - One Or More (I.O.P)
933500	Knee - Incision And Drainage - Soft Tissue (I.O.P.)
971200	Bladder Catheterization, Acute Retention Or Change Of Re- Tention Catheter - Office (I.O.P.)
971220	Bladder Catheterization, Acute Retention Or Change Of Re- Tention Catheter - Home (I.O.P.)
Other	
371010	Hospital (In-Patient) - Supportive Care - Not Exceeding 1 Visit Every 2 Days In 1st. 7 Days - Per Visit
372010	Hospital (In-Patient) - Supportive Care - Not Exceeding 1 Visit Every 4 Days Thereafter - Per Visit
500000	Pandemic Virtual Care Assessment (Telephone or Video)
502010	Telemedicine - Partial Assessment