NEW BRUNSWICK

REGULATION 84-20

under the

Medical Services Payment Act

(O.C. 84-64)

Filed February 13, 1984

Under section 12 of the Medical Services Payment Act, the Lieutenant-Governor in Council makes the following Regulation:

1  This Regulation may be cited as the General Regulation - Medical Services Payment Act.

2  In this Regulation

   "Act" means the Medical Services Payment Act; (loi)

   "agreement" means an agreement entered into by the provincial authority with the New Brunswick Medical Society under section 4.1 of the Act; (convention)

   "beneficiary" means (bénéficiaire)

   (a) a resident who has resided in the Province for not less than the period of time prescribed in subsection 3(1) other than

      (i) a dependent of a beneficiary, or

      (ii) a person mentioned in paragraphs 4(1)(a), (c) and (d),

   (b) a visitor, other than a dependent, who has obtained authorization to enter Canada for the purposes of engaging in employment and includes a clergyman, priest or member of a religious order who has obtained authorization to enter in connection with the carrying out of religious duties, and

   (c) a visitor, other than a dependent, who

      (i) is a full-time student enrolled at a designated learning institution,

      (ii) holds a valid study permit under the Immigration and Refugee Protection Act (Canada) entitling the person to be in Canada for a period of at least six consecutive months, and

      (iii) makes his or her home and is ordinarily present in the Province;

   "dental practitioner" means a person lawfully entitled to practise dentistry in the place in which such practice is carried on by that person; (dentiste)

   "dependent" means (personne à charge)

   (a) a resident who has been residing in the Province for not less than the period of time prescribed in section 2.1 and who is

      (i) the spouse of a person described in paragraph (a) or (b) of the definition "beneficiary" if not maintaining a separate household, or

      (ii) a child of a person described in paragraph (a) or (b) of the definition "beneficiary" if the child is under 19 years of age, unmarried and dependent on the person for support, including

         (A) an adopted child,

         (B) a child in relation to whom the beneficiary stands in the place of a parent if that beneficiary's spouse is a parent of the child, and

         (C) a child whose parents are not married to one another; or

   (b) a person who holds a valid permit under the Immigration and Refugee Protection Act (Canada) entitling the person to be in Canada for a period of at least six consecutive months, who makes his or her home and is ordinarily present in the Province and who is

      (i) the spouse of a person described in paragraph (c) of the definition "beneficiary" if not maintaining a separate household, or...
(ii) a child of a person described in paragraph (c) of the definition "beneficiary" if the child is under 19 years of age, unmarried and dependent on the person for support, including

(A) an adopted child,

(B) a child in relation to whom the beneficiary stands in the place of a parent if that beneficiary's spouse is a parent of the child, and

(C) a child whose parents are not married to one another;

"designated learning institution" means a post-secondary learning institution located in the Province that is designated, for the purposes of the Immigration and Refugee Protection Regulations (Canada), by the Minister of Post-Secondary Education of the Province of New Brunswick; (établissement d'enseignement désigné)

"Director" means the person designated by the Minister to perform the duties, functions, tasks and to assume the responsibilities allocated to the Director by this Regulation; (Directeur)

"entitled person" means a beneficiary or dependent who is eligible under this Regulation to receive entitled services; (personne admissible)

"general practitioner" means a medical practitioner who is not a specialist; (généraliste)

"hospital corporation" Repealed: 2002-33

"Medical Director" Repealed: 97-23

"Medicare Branch" means the Medicare Insured Services and Physician Remuneration Branch and the Medicare Eligibility and Claims Branch of the Department of Health; (Direction de l'assurance-maladie)

"Medicare" means the medical services plan established under this Regulation; (Assurance-maladie)

"members of the Royal Canadian Mounted Police force" Repealed: 2013-31

"non-participating medical practitioner" means a medical practitioner who is practising outside the provisions of the Act and the regulations; (médecin non participant)

"non-participating oral and maxillofacial surgeon" means an oral and maxillofacial surgeon who is practising outside the provisions of the Act and the regulations; (chirurgien bucco-dentaire et maxillo-facial non participant)

"optometrist" Repealed: 93-103

"oral surgeon" means a dental practitioner who is recognized as having special qualifications by the licensing body of the jurisdiction in which that person practises; (chirurgien dentiste)

"participating medical practitioner" means a medical practitioner who is practising within the provisions of the Act and the regulations; (médecin participant)

"participating oral and maxillofacial surgeon" means an oral and maxillofacial surgeon who is practising within the provisions of the Act and the regulations; (chirurgien bucco-dentaire et maxillo-facial participant)

"practitioner number" means an identification number issued by the Director that permits a medical practitioner or an oral and maxillofacial surgeon to receive payments, directly or indirectly, from Medicare in respect of entitled services rendered by the medical practitioner or the oral and maxillofacial surgeon; (numéro de médecin)

"regional health authority" means a regional health authority established under the Regional Health Authorities Act; (régie régionale de la santé)

"Schedule of Fees" Repealed: 96-111

"specialist" means a medical practitioner whose name is on the Medical Specialists Register of the College of Physicians and Surgeons of New Brunswick or a medical practitioner practising outside New Brunswick who is recognized as a specialist by the licensing body of the jurisdiction in which that person practises; (spécialiste)

"spouse" means (conjoint)

(a) a person to whom a beneficiary is married, or

(b) a person with whom a beneficiary has cohabited continuously in a conjugal relationship for at least one year.

86-150; 87-20; 93-103; 93-142; 94-13; 96-47; 96-111; 97-23; 2000, c.26, s.187; 2002-33; 2002-90; 2003-51; 2006, c.16, s.108; 2013-31; 2014-87; 2017-36; 2017, c.63, s.35

2.1 Subject to section 4, a person shall be eligible to become a dependent on the first day of the third month following the month of arrival in the Province.

2002-90; 2017-36

3(1) Subject to section 4, a person shall be eligible to become a beneficiary on the first day of the third month following the month of arrival in the Province.

3(2) Except as otherwise provided in the Act and this Regulation, a beneficiary is eligible to have payment made on his or her behalf or to receive an amount computed in accordance with this Regulation for entitled services received

(a) within the Province,

(b) outside the Province, or
(c) while temporarily absent from the Province by that person or any dependents.

3(3) Notwithstanding subsection (2), no beneficiary is eligible to receive reimbursement or have payment made on his or her behalf for the cost of any entitled service where that person has had payment made on his or her behalf for such entitled service under any contract of insurance.

3(4) For the purposes of this section, a person is "temporarily absent from the Province" where that person is absent from New Brunswick

(a) for the purpose of a business engagement but not when the period of absence exceeds 182 days in a 12 month period,

(a.1) for the purpose of a vacation or visit but not when the period of absence exceeds 212 days in a 12 month period, or

(b) for the express purpose of furthering an education in a province or country where that person is not eligible to receive reimbursement or have payment made on his or her behalf for or with respect to entitled services under the medical services plan, if any, of that province or country and who is not gainfully employed outside the Province except during vacation periods but not where the period of absence exceeds twelve consecutive months.

3(5) The Director may, with respect to a person meeting the requirements of paragraph (4)(a), (a.1) or (b) and any dependents, upon such terms, as it is considered to be in accordance with the intention of the Medicare Branch and this section, enlarge the time during which that person shall be deemed to be temporarily absent from the Province.

3(6) Notwithstanding the definition of "dependent" a newborn child is deemed, during the first three months following its birth, to have the status of its mother or, if the mother has no status, the status of its father under Medicare.

3(7) A beneficiary who leaves the Province ceases to be a beneficiary for purposes of coverage by the Medicare Branch,

(a) in the case of an individual who in the opinion of the Director has ceased to be a resident of the Province and has established a residence elsewhere in Canada upon the first day of the third month following the month of arrival at the new residence,

(b) in the case of any other beneficiary who in the opinion of the Director leaves the Province to establish residence elsewhere in Canada, subject to section 3, twelve months after the date of departure, and

(c) in the case of an individual who in the opinion of the Director has ceased to be a resident of the Province and has established residence elsewhere than in Canada upon the date that person left Canada.

3(8) For the purposes of this Regulation, the spouse of a beneficiary who ceases to be a resident and moves outside the Province is deemed to be a beneficiary during such time, if any, the spouse remains in the Province after the beneficiary ceases to be a resident and during this time the dependents of the beneficiary are deemed to be dependents of that person's spouse.

3.1 Despite sections 2.1 and 3, the spouse or dependent of a regular member of the Canadian Armed Forces who has entered the Province from another province or territory of Canada is exempt from any waiting period with regards to eligibility to receive entitled services if, in the opinion of the Director, he or she establishes residence in the Province.

2010-101

4(1) The following persons, whether residents or not, are not beneficiaries:

(a) the regular members of the Canadian Armed Forces;

(b) Repealed: 2013-31

(c) persons serving a term of imprisonment in a penitentiary maintained by the Government of Canada; or

(d) persons who have entered the Province from another province for the purpose of furthering their education and who are eligible to apply for and to receive reimbursement or have payment made on his or her behalf for or with respect to entitled services under the medical services plan, if any, of that province.

4(2) Where a person described in paragraph (1)(a) or (c) has dependents residing in the Province, the spouse of that person or other person standing in the place of a parent to the dependents, is deemed to be the beneficiary and is eligible to receive reimbursement or have payment made on his or her behalf for or with respect to entitled services received by the beneficiary or the dependents.

4(3) Where a person described in paragraph (1)(a) or (c) has no spouse, the Director may designate that person a beneficiary for purposes of receiving reimbursement or have payment made on his or her behalf for or with respect to entitled services received by any dependents.

4(4) A person mentioned in paragraph (1)(a) or (c) shall, upon ceasing to be a person as therein mentioned and upon discharge within the province, become a beneficiary.

4(5) Immigrants who, in the opinion of the Director, are or will become permanent residents under the Immigration Act (Canada) and Canadian citizens as defined in the Citizenship Act (Canada) who have entered the Province from another country shall be entitled to become beneficiaries on the first day of arrival in the Province if they will, in the opinion of the Director, establish residence in the Province.

4(6) Notwithstanding the definition of "dependent", the dependents of persons mentioned in subsection (5) shall be entitled to become beneficiaries in accordance with the provisions of subsection (5).

4(7) Any person who is a full-time student enrolled at a designated learning institution and who holds a valid study permit under the Immigration and Refugee Protection Act (Canada) entitling the person to be in Canada for a period of at least six consecutive months shall be entitled to become a beneficiary on the first day of classes or on the commencement date specified in the study permit, whichever is later, if the person will, in the opinion of the Director, establish residence in the Province.

4(8) A spouse or child of a person mentioned in subsection (7) shall be entitled to become a dependent and eligible to receive entitled services on the first day of classes or on the commencement date specified in the study permit, whichever is later, if the spouse or child will, in the opinion of
A beneficiary who wishes to become eligible to receive entitled services shall register, together with any dependents, with the Medicare Branch on a registration form provided by the Medicare Branch for the purpose, or be registered by a person acting on his behalf.

The Director may at any time re-issue a New Brunswick Medicare Card to a beneficiary and the New Brunswick Medicare Card held by the beneficiary immediately before receiving the re-issued card ceases to be a valid card upon receipt of the re-issued card.

A beneficiary or a dependent requesting entitled services shall produce and show to the medical practitioner or oral and maxillofacial surgeon from whom the request is made a valid unexpired card issued under this section identifying the beneficiary or dependent to whom it was issued and signed by the person or, if the person is unable to sign, by the person’s legal representative.

The services listed in Schedule 2 are deemed not to be entitled services under Medicare.

A medical practitioner or an oral and maxillofacial surgeon who wishes to practise within the provisions of the Act and the regulations shall apply to the Director for a practitioner number and, subject to this section, the Director shall issue a practitioner number to the medical practitioner or oral and maxillofacial surgeon.

A beneficiary who acquires a dependent after registration shall, as soon as possible, register the dependent with the Medicare Branch.

Every New Brunswick Medicare Card that is not made of plastic and that does not possess an electromagnetic strip on the back of the card ceases to be a valid card as of February 28, 1995.

A beneficiary who wishes to remain eligible to receive entitled services shall, before the expiry date on a card issued under subsection (2) or re-issued under subsection (2.01), as the case may be, re-register, together with any dependents, with the Medicare Branch on a form provided by the Medicare Branch, or be re-registered by a person acting on the beneficiary’s behalf.

A beneficiary or a dependent requesting entitled services shall produce and show to the medical practitioner or oral and maxillofacial surgeon from whom the request is made, a valid unexpired card issued under this section identifying the beneficiary or dependent to whom it was issued and signed by the person or, if the person is unable to sign, by the person’s legal representative.

The fee to be paid by a beneficiary to replace a New Brunswick Medicare Card as a result of loss, damage, destruction or theft of the card is ten dollars.

The Minister may waive a fee to be paid by a beneficiary under subsection (1) where, in the Minister’s opinion, the payment of the fee would constitute a hardship.

A beneficiary who acquires a dependent after registration shall, as soon as possible, register the dependent with the Medicare Branch.

A beneficiary shall notify the Medicare Branch when any dependents cease to be dependents, or where there is a change of address.

There is established in the Province a plan to be known as Medicare which shall provide, in accordance with the Act and this Regulation, payment to or on behalf of any beneficiary for or with respect to all entitled services received by that person or any dependents.

Medicare shall be administered and operated by the Medicare Branch composed of the Director and such other persons as are, in the opinion of the Minister, required.

Entitled services under Medicare shall not include services that a person is eligible for and entitled to under the terms of any of the statutes listed in Schedule 1 to this Regulation or which are provided in non-compliance with any Act or regulation of the Province.

The services listed in Schedule 2 are deemed not to be entitled services under Medicare.

A medical practitioner or an oral and maxillofacial surgeon who wishes to practise within the provisions of the Act and the regulations shall apply to the Director for a practitioner number and, subject to this section, the Director shall issue a practitioner number to the medical practitioner or oral and maxillofacial surgeon.

The Director shall not issue a practitioner number to a medical practitioner or an oral and maxillofacial surgeon unless the medical practitioner or oral and maxillofacial surgeon holds privileges granted by a regional health authority and signs an agreement with the Minister on the form prescribed in Schedule 3.

Notwithstanding subsection (1.1), the Director shall issue a practitioner number to a medical practitioner described in subsection 5.2(2) or (3) of the Act whether or not the medical practitioner holds privileges granted by a regional health authority.
11(1.3) A practitioner number issued by the Director before the commencement of this subsection to a medical practitioner described in subsection 5.2(2) or (3) of the Act shall be deemed to be a practitioner number issued under subsection (1.2).

11(1.4) A medical practitioner or an oral and maxillofacial surgeon may use a practitioner number only for so long as the medical practitioner or the oral and maxillofacial surgeon holds privileges granted by a regional health authority, unless the practitioner number is sooner revoked, suspended or cancelled by the Director.

11(1.5) Subject to subsection (1.6), a medical practitioner who is issued a practitioner number under this section and who does not hold privileges granted by a regional health authority may use the practitioner number until it is revoked, suspended or cancelled by the Director.

11(1.6) A medical practitioner referred to in subsection (1.5) who subsequently obtains privileges granted by a regional health authority is subject to the requirements of subsection (1.4).

11(1.7) notwithstanding subsection (1.4), a practitioner number may be used where the privileges granted by a regional health authority to the medical practitioner or the oral and maxillofacial surgeon are temporarily suspended, unless the practitioner number is revoked, suspended or cancelled by the Director.

11(1.8) The Director

(a) may revoke, suspend or cancel a practitioner number issued to a medical practitioner or an oral and maxillofacial surgeon for cause, and

(b) shall revoke or cancel a practitioner number issued to a medical practitioner or an oral and maxillofacial surgeon where the medical practitioner's or the oral and maxillofacial surgeon's privileges are revoked by a regional health authority, unless the medical practitioner or the oral and maxillofacial surgeon has been granted privileges by another regional health authority.

11(1.9) Where a medical practitioner or an oral and maxillofacial surgeon is being replaced on a locum tenens basis, the Director shall suspend the practitioner number issued to the medical practitioner or the oral and maxillofacial surgeon being replaced for the duration of the replacement.

11(2) Subject to section 13, where a participating medical practitioner or a participating oral and maxillofacial surgeon provides an entitled service to a beneficiary or dependent, he shall within three months after rendering that service submit an account for service to the Medicare Branch

(a) on a form provided by the Medicare Branch, or

(b) in an electronic format approved by the Medicare Branch.

11(2.1) Where a participating medical practitioner or a participating oral and maxillofacial surgeon submits an account for service under paragraph (2)(a), he shall provide the following information:

(a) whether the participating medical practitioner, the participating oral and maxillofacial surgeon or the beneficiary is to be paid;

(b) the patient's name;

(c) the patient's Medicare number;

(d) the patient's day, month and year of birth;

(e) the patient's sex;

(f) the beneficiary's address where the address is different than that on the New Brunswick Medicare Card;

(g) the name and practitioner number of the participating medical practitioner or the participating oral maxillofacial surgeon;

(h) the role the participating medical practitioner or the participating oral and maxillofacial surgeon played in providing the entitled service;

(i) the time spent by the participating medical practitioner or the participating oral and maxillofacial surgeon on the service if that is required to determine the amount of payment;

(j) the name of the transferring or referring

(i) medical practitioner,

(ii) oral and maxillofacial surgeon,

(iii) nurse practitioner,

(iii.1) midwife,

(iv) optometrist,

(v) dental practitioner,

(vi) registered nurse who works in a preoperative clinic or within the Colorectal Cancer Screening Program or who is a Sexual Assault Nurse Examiner, or

(vii) registered nurse, social worker, psychologist or occupational therapist who is a member of a mobile crisis response team with respect to mental health or of a multidisciplinary team in a mental health clinic;

(k) the diagnosis;

(l) the dates of hospital days charged;

(m) the number of hospital days charged;
(n) the date or dates of the entitled service;
(o) whether the entitled service was provided at the participating medical practitioner's office, patient's home, in-patient or out-patient department of a hospital facility, nursing home or elsewhere;
(p) the description of the entitled service, the service code for the entitled service and fee charges;
(q) the name of the hospital facility, nursing home or other place where the entitled service was provided;
(r) whether, to the knowledge of the participating medical practitioner or participating oral and maxillofacial surgeon, the entitled service was one for which a claim could be made
   (i) under any statute listed in Schedule 1 of this Regulation, or
   (ii) against a third party or an insurer by reason of a motor vehicle accident, occupational injury, industrial disease or otherwise;
(s) the treatment information or remarks;
(t) the signature of the participating medical practitioner, the participating oral and maxillofacial surgeon or designate and the date of the account;
(u) the specific anesthesia modifier to describe the service type;
(v) the service modifier to further define the service rendered;
(w) the vaccine lot number of the immunization being administered;
(x) the on-call code when a participating medical practitioner or participating oral and maxillofacial surgeon submits a fee for service claim provided under the mandated on-call program;
(y) the referral date being the date on which the patient was referred;
(z) the referral type where the participating medical practitioner or participating oral and maxillofacial surgeon indicates whether he or she was referred a patient or whether he or she referred a patient to another practitioner;
(aa) the rotation code where the participating medical practitioner or participating oral and maxillofacial surgeon indicates the on-call rotation code for the specific on-call rotation he or she is covering; and
(bb) the assigned number from the prior consultation process that determines coverage of a service where reasonable doubt exists as to its eligibility as an entitled service.

11(2.2) Where a participating medical practitioner or participating oral and maxillofacial surgeon submits an account for service under paragraph (2)(b), he shall provide the following information:

(a) the patient’s name;
(b) the patient’s Medicare number;
(c) the patient’s day, month and year of birth;
(d) the patient’s sex;
(e) the practitioner number of the participating medical practitioner or the participating oral and maxillofacial surgeon;
(f) the role the participating medical practitioner or participating oral and maxillofacial surgeon played in providing the service;
(g) the time spent by the participating medical practitioner or participating oral and maxillofacial surgeon on the entitled service if that is required to determine the amount of payment;
(h) the number of the transferring or referring
   (i) medical practitioner,
   (ii) oral and maxillofacial surgeon,
   (iii) nurse practitioner,
   (iii.1) midwife,
   (iv) optometrist,
   (v) dental practitioner,
   (vi) registered nurse who works in a preoperative clinic or within the Colorectal Cancer Screening Program or who is a Sexual Assault Nurse Examiner, or
   (vii) registered nurse, social worker, psychologist or occupational therapist who is a member of a mobile crisis response team with respect to mental health or of a multidisciplinary team in a mental health clinic;
(i) the diagnosis;
(j) the dates of hospital days charged;
(k) the number of hospital days charged;
A participating medical practitioner or a participating oral and maxillofacial surgeon who submits an account for service under

Notwithstanding subsection (2), the Director may require the medical practitioner or oral and maxillofacial surgeon to supply such additional

A participating medical practitioner or participating oral and maxillofacial surgeon may, at any time, elect to practise outside the provisions of

Where an entitled service is provided in accordance with subsection (1), the amount that is payable for the service by the Medicare Branch

The requirement to submit accounts within three months after the services are rendered does not apply in respect of entitled services

Before providing a service under paragraph (2)

shall be paid

The participant practitioner or oral maxillofacial surgeon shall inform the person that he or she may charge the person for the service directly and shall provide

beneficiary or dependent and wishes to charge the person for the service and not submit an account for service to Medicare, the medical

11(2.3) A participating medical practitioner or a participating oral and maxillofacial surgeon who submits an account for service under paragraph (2)(b) shall

(a) as a condition of submitting his account in that manner, agree to permit an audit of his books and records by the Medicare Branch,

(b) retain the documentation relating to the account for a period of seven years in a format and manner approved by the Medicare Branch, and

(c) when requested, submit to the Medicare Branch the documentation retained under paragraph (b).

11(3) Notwithstanding subsection (2), the Director may require the medical practitioner or oral and maxillofacial surgeon to supply such additional information concerning the services rendered and within such time as in the opinion of the Director is necessary to enable the Director to make an assessment.

11(4) If an account is not submitted for payment within the time limit prescribed under subsection (2), an account shall not be accepted for payment unless the time limit is waived by the Director in respect of that account.

11(5) The requirement to submit accounts within three months after the services are rendered does not apply in respect of entitled services rendered before April 1, 1997.

12 A participating medical practitioner or participating oral and maxillofacial surgeon may, at any time, elect to practise outside the provisions of the Act and the regulations by surrendering the practitioner number issued to the medical practitioner or oral maxillofacial surgeon and by notifying the Director of the medical practitioner’s or oral and maxillofacial surgeon’s intention to practise outside the provisions of the Act and the regulations.

12.1 No medical practitioner or oral and maxillofacial surgeon shall use the practitioner number of any other medical practitioner or oral and maxillofacial surgeon.

13(1) Where a participating medical practitioner or participating oral and maxillofacial surgeon provides an entitled service to a person who is a beneficiary or dependent and wishes to charge the person for the service and not submit an account for service to Medicare, the medical practitioner or oral and maxillofacial surgeon shall inform the person that he or she may charge the person for the service directly and shall provide the person with such information as is prescribed in subsections 11(2.1) and (3) on a form provided by the Medicare Branch so as to enable the person to make a claim for reimbursement.

13(1.1) Before providing a service under paragraph (n.1) of Schedule 2 to a person who is a beneficiary or a dependent, a participating medical practitioner or a participating oral and maxillofacial surgeon shall

(a) inform or cause to be informed the person in such manner as is required by the Director that he or she will be charging the person directly for the service and that the person is not entitled to be reimbursed by the Medicare Branch for the service, and

(b) complete a waiver on a form provided by the Medicare Branch and send it to the Medicare Branch before charging the person for the service.

13(2) Where an entitled service is provided in accordance with subsection (1), the amount that is payable for the service by the Medicare Branch shall be paid

(a) directly to the person where that person is a beneficiary,

(b) to the beneficiary where the person receiving the service was a dependent, or

(c) to the dependent when, in the opinion of the Director, special circumstances warrant payment in this manner.

13(3) Notwithstanding any other section of this Regulation, the Director may, make payments directly to persons acting on behalf of patients, and such payments to be made in accordance with this Regulation and are not to exceed the amounts provided hereunder.

13(4) Where a non-participating medical practitioner or non-participating oral and maxillofacial surgeon resident and practising outside the Province provides an entitled service to a beneficiary or dependent, the Director may, in his discretion, accept from the beneficiary a claim for reimbursement notwithstanding that all the information set out in subsection 11(2.1) has not been provided.

13(5) Notwithstanding the provisions of this section, where a non-participating medical practitioner or non-participating oral and maxillofacial surgeon resident and practising outside the Province provides an entitled service to a beneficiary or dependent, the Director may, in his discretion, accept from that medical practitioner or oral and maxillofacial surgeon an account for service rendered to the beneficiary or dependent and make payment in the amounts permitted by this Regulation directly to the medical practitioner or oral and maxillofacial surgeon notwithstanding that all the information set out in subsection 11(2.1) has not been provided.

13(6) Any payment made pursuant to subsection (5) shall be in lieu of making payment to the beneficiary.

Notwithstanding any other provision of this Regulation, the Minister, on the advice of the Insured Services Appeal Committee established under section 33.01, may authorize payments in excess of the prescribed rates for entitled services if such payments do not exceed the amounts actually incurred or paid by or on behalf of an entitled person.
14.01(1) Notwithstanding sections 13, 13.1 and 14, no payment shall be made for entitled services unless the account or claim for reimbursement is received by the Medicare Branch.

(a) in the case of a claim for reimbursement by a beneficiary for services rendered to a beneficiary or dependent inside the Province, within six months after the date upon which the entitled services were rendered, and

(b) in the case of entitled services rendered to a beneficiary or dependent outside the Province, within twelve months after the date upon which the entitled services were rendered.

14.01(2) Notwithstanding subsection (1), an account or claim for reimbursement that is received after the applicable period may be paid if the Director so directs.

91-172; 96-111; 97-23

14.1 In section 14.4 "ordinary entitled services" means entitled services rendered in the Province on a fee for service basis, but does not include travelling expenses.

(1) "services assurés ordinaires"

90-83; 2003-51; 2009-135

14.2 Repealed: 2009-135

90-83; 93-25; 93-142; 2003-51; 2009-135

14.21 Repealed: 2009-135

93-142; 2009-135

14.3 Repealed: 91-13

90-83; 91-13

14.4(1) For the twelve month period beginning on April 1 of any year, the Lieutenant-Governor in Council may determine the sum that is available to the Medicare Branch for payments for ordinary entitled services rendered by medical practitioners or oral and maxillofacial surgeons.

14.4(2) A determination under subsection (1) may be made at any time before or during the twelve month period to which it relates.

14.4(3) Notwithstanding any other provision of this Regulation, where a determination has been made under subsection (1) and the total of all amounts paid by the Medicare Branch for ordinary entitled services rendered by medical practitioners or oral and maxillofacial surgeons exceeds

(a) by June 30 of the period to which the determination relates, twenty-seven per cent of the sum determined,

(b) by September 30 of the period to which the determination relates, forty-eight per cent of the sum determined,

(c) by December 31 of the period to which the determination relates, seventy-four per cent of the sum determined, or

(d) by March 31 of the period to which the determination relates, one hundred per cent of the sum determined,

the amount payable for ordinary entitled services rendered by every medical practitioner or oral and maxillofacial surgeon shall be, if the Director so directs, for the three months immediately following a period in which an excess occurred, a percentage below the amount that would be payable apart from this section.

14.4(4) Where during part or all of any period referred to in subsection (2) the amounts payable for ordinary entitled services have been set under that subsection, and at the end of that period the total of all amounts paid by the Medicare Branch for ordinary entitled services rendered by medical practitioners and oral and maxillofacial surgeons has not reached the level set by subsection (2) for the end of that period, the amount payable during the three months that immediately follow for ordinary entitled services rendered by any medical practitioner or oral and maxillofacial surgeon shall be, if the Director so directs, a percentage above the amount that would be payable apart from this section.

14.4(5) In acting under subsections (2) and (3) and in determining percentages for the purpose of those subsections the Director shall have regard to the following principles:

(a) that the levels stated in subsection (2) should not be exceeded, and

(b) that subject to paragraph (a), the total of all amounts actually paid by the Medicare Branch for ordinary entitled services rendered by medical practitioners or oral and maxillofacial surgeons should be, at the end of each period referred to in subsection (2), as close as possible to the total of the amounts that would have been paid for those entitled services if the amounts payable had not been affected by subsection (2).

14.4(6) In acting under subsections (2) and (3) and in determining percentages for the purpose of those subsections in relation to payments to be made in the three months immediately following the end of the twelve month period to which a determination under subsection (1) relates, the Director may assume, unless a further determination has already been made under subsection (1), that for the twelve month period that is about to begin a determination will be made under subsection (1) in the same terms as the determination that was made for the twelve month period that is ending.

90-83; 2003-51

14.5 Repealed: 2003-48

96-47; 97-106; 99-29; 2001-101; 2003-48

15(1) In this section and section 5.4 of the Act, "assess", with respect to accounts submitted for payment under the medical services plan means

(a) to evaluate the accounts,

(b) to investigate the accounts to determine their correctness or validity, and
(c) to apply and interpret the agreement and the rules applicable to the assessment of accounts made under paragraph (3)(a) to the accounts submitted for payment,

and "assessment" has a corresponding meaning.

15(2) The provincial authority may, in the provincial authority’s sole discretion, require any person who has submitted an account for payment by the Medicare Branch to supply such additional information within such time as in the opinion of the provincial authority is necessary to enable an assessment to be made.

15(3) The provincial authority may

(a) develop, in consultation with the Professional Review Committee, rules applicable to the assessment of accounts, and

(b) in addition to those actions referred to in the Act, take such action with respect to the payment of accounts so assessed which, in the opinion of the provincial authority, will give effect to assessments made under the Act such as

(i) denying payment of an account,

(ii) providing that payment with respect to any entitled service for which payment is claimed in an account be made at a rate less than that provided in the agreement for the entitled service, or

(iii) any other action that the provincial authority considers necessary.

16 Repealed: 96-111

17(1) Repealed: 2010-106

17(2) Repealed: 2010-106

17(3) A person, being a beneficiary who has submitted an account for payment by the Medicare Branch and who has any complaint concerning eligibility to receive payment for entitled services or the assessment of accounts with respect to entitled services rendered or received, may make a request to the provincial authority that the matter complained of be reviewed by the Insured Services Appeal Committee as established under section 33.01.

18 Repealed: 2010-106

22(1) Subject to section 10, entitled services shall be deemed to include the health services listed in Schedule 4 when rendered by a qualified dental practitioner in a hospital facility if the condition of the patient is such that the services are medically required to be rendered in a hospital facility.

22(2) The dental practitioner rendering the entitled services mentioned in subsection (1) may make application for payment in the same manner as a medical practitioner and the provisions in this Regulation respecting payment for entitled services shall apply mutatis mutandis to a dental practitioner.

22(3.1) Except where otherwise provided in this Regulation, payment for entitled services rendered by a dental practitioner on or after April 1, 1998, shall be at the rate of ninety-eight cents per unit for the unit values listed for such services in Schedule 4 or the amount billed, whichever is the lesser.

22(3) Subsection 13(1) applies with the necessary modifications to a dental practitioner rendering an entitled service.

22(4) Subsection 13(1.1) applies with the necessary modifications to a dental practitioner rendering a service under paragraph (n.1) of Schedule 2.

23 Repealed: 96-111

24(1) The members appointed to the Professional Review Committee shall be appointed from persons nominated by the New Brunswick Medical Society and shall be medical practitioners duly registered and licensed in accordance with the terms of the Medical Act.

24(2) The members appointed under subsection (1) shall appoint one of their number as chairman at the first meeting of the committee.

25(1) Any member appointed to the Professional Review Committee shall be appointed for an initial term of one to three years at the discretion of the Minister.

25(2) A member may be reappointed any number of times for a term of three years.
25(3) If a member is unable or unwilling to perform the duties properly due to incapacity, incompetence, absence or for any other reason whatsoever, that person shall be removed as a member and another shall be appointed.

25(4) Notwithstanding the expiration of the term, a member shall continue to be a member until replaced.

25(5) The provisions of this Regulation shall apply to the appointment of any person who is appointed to replace another member, provided however, that where a new member is appointed to replace another member whose term has not expired the new member shall be appointed initially for the remainder of the unexpired term only.

26 The objects of the Professional Review Committee shall be to attempt to enhance the standards of medical service, to protect the interests of the public, government, the medical profession and the oral and maxillofacial surgery profession in the operation of the medical services plan and to provide experienced professional counsel to any medical practitioner or oral and maxillofacial surgeon whose pattern of practice under the medical services plan appears not to be in the best interest of the public, the medical profession or the oral and maxillofacial surgery profession.

27 Repealed: 96-48

27.1 Repealed: 96-48

28 The powers of the Professional Review Committee shall be

(a) to engage special consultants or otherwise knowledgeable people as required to aid in the review of a particular situation,

(b) to add to the committee, when appropriate, with the approval of the provincial authority, one or more representatives of the particular branch of medical practice under review in a particular situation, as co-opted members for a particular purpose,

(c) to invite members of the medical profession or others to attend before the committee to give information and explanations relevant to any matter under review,

(d) to appoint such sub-committees as it considers necessary for the attainment of its objects, with the approval of the provincial authority, to appoint to such sub-committees persons who are not members of the committee,

(e) to agree to pay to sub-committee members and other special consultants engaged by the committee who are not members of the committee such remuneration and allowances as shall be determined from time to time by the provincial authority,

(f) review and make recommendations to the provincial authority on the method of assessing accounts for payment for entitled services provided to beneficiaries by medical practitioners or oral and maxillofacial surgeons,

(g) review the assessment of accounts for payment for entitled services to beneficiaries by medical practitioners or oral and maxillofacial surgeons that are referred to it by the provincial authority and make recommendations concerning the assessment of such accounts to the provincial authority, and

(h) to make recommendations to the provincial authority on any matter referred to it concerning the planning of structured audits, the findings of audits in process and the conclusions of audit processes.

29 The members and co-opted members shall receive such remuneration and allowances as shall be determined from time to time by the provincial authority.

30 The Professional Review Committee may adopt such rules and procedures for the conducting of its business as it sees fit.

31 The provincial authority shall provide and pay for secretarial and other assistance as may reasonably be required for the conduct of the Professional Review Committee’s work.

32 The provincial authority may

(a) make available to the Professional Review Committee all information possessed by the provincial authority which is relevant and necessary for the attainment of the Committee’s objectives, and

(b) designate individuals within the department to provide and maintain continuing liaison between the Professional Review Committee and the provincial authority.

33 The Professional Review Committee shall

(a) upon the review of any matter forwarded to it by the provincial authority or designate make written recommendations concerning the matter, and

(b) maintain on a confidential basis adequate records of all recommendations and the reasons therefor.

33.001 Where a medical practitioner or an oral and maxillofacial surgeon and the provincial authority disagree on the assessment of accounts with respect to entitled services rendered or with respect to audit findings, the parties shall engage in discussions in order to resolve the dispute.
33.002 Where a medical practitioner or an oral and maxillofacial surgeon is not satisfied with the assessment of accounts with respect to entitled services rendered or with respect to audit findings, the medical practitioner or the oral and maxillofacial surgeon may make a request to the provincial authority to refer the matter to the Professional Review Committee for a recommendation concerning the assessment of such accounts.

33.003(1) Where a medical practitioner or an oral and maxillofacial surgeon is not satisfied with the assessment of accounts with respect to entitled services rendered or with respect to audit findings, the medical practitioner or oral and maxillofacial surgeon may appeal the assessment or the audit findings to an adjudicator.

33.003(2) An adjudicator shall be appointed by mutual agreement between the Department of Health and the New Brunswick Medical Society.

33.003(3) An adjudicator shall be appointed for a term of one year which may be renewed and his or her name shall be placed on a list maintained by the provincial authority.

33.004(1) A medical practitioner or an oral and maxillofacial surgeon who wishes to make an appeal under subsection 33.003(1) shall file with the provincial authority a notice of appeal within 60 days after receipt of the final notice of assessment issued by the provincial authority.

33.004(2) The notice of appeal shall include the reasons for the appeal and the official language chosen by the appellant.

33.004(3) If a medical practitioner or an oral and maxillofacial surgeon has made full payment of the amount specified in the final notice of assessment or has agreed to a repayment schedule, the provincial authority shall refer the notice of appeal to an adjudicator within 30 days after receipt of the notice of appeal.

33.004(4) Within 30 days after receiving the notice of appeal, the adjudicator shall set out the time and place for the hearing of the appeal, and shall advise the appellant and the provincial authority in writing of the time and place of the hearing.

33.004(5) With the consent of both parties, the adjudicator may determine the appeal based on the written representations of the parties without a hearing.

33.004(6) Only non-identifying medical information shall be contained in written or oral representations.

33.004(7) For the purposes of a hearing, an adjudicator has all the powers, privileges and immunities of a commissioner under the Inquiries Act.

33.004(8) Within 30 days after the hearing or the receipt of written representations, the adjudicator shall render a written decision in which he or she may affirm, vary or reverse the amount specified in the final notice of assessment.

33.004(9) The decision of the adjudicator is final and binding on both parties.

33.004(10) The decision of the adjudicator must be implemented within 30 days after the decision is rendered.

33.004(11) If the decision of the adjudicator affirms the amount specified in the final notice of assessment and the medical practitioner or the oral and maxillofacial surgeon has agreed to a repayment schedule with the provincial authority, the decision shall be deemed to have been implemented.

33.005 The expenses related to the appeal shall be equally shared between the Department of Health and the New Brunswick Medical Society.

33.01(1) There shall be established a committee which shall be known as the Insured Services Appeal Committee and which shall consist of the following:

(a) three voting members who shall be appointed by the Minister; and

(b) the Director or his or her designate who shall act as secretary.

33.01(1.1) The members appointed to the Insured Services Appeal Committee by the Minister shall include

(a) at least one medical practitioner duly registered and licensed under the Medical Act, and

(b) at least one person with knowledge of the health care system.

33.01(2) The function of the Insured Services Appeal Committee is to advise the Minister on appeals by persons on matters in dispute or disagreement with respect to

(a) an application to become or continue to be a beneficiary,

(b) refusal of a claim for payment for entitled services or reduction of the amount so claimed, or

(c) any other matter that may be requested by the Minister in the application or interpretation of the Act and the regulations made thereunder.

33.01(3) The term of appointment of members of the Insured Services Appeal Committee appointed under paragraph (1)(a) shall be for a term of three years and all members shall be eligible for reappointment for two additional terms.

33.01(4) The Minister may appoint in accordance with subsection (1) a person to fill a vacancy that occurs in the membership of the Insured Services Appeal Committee and such person so appointed shall hold office for the remainder of the term of office of the person in whose place that person is appointed.

33.01(5) The Minister shall appoint a chairperson from the members appointed in paragraph (1)(a).
33.01(6) A majority of voting members constitutes a quorum and is sufficient for the exercise of all functions of the Insured Services Appeal Committee.

33.01(7) The Minister shall supply secretarial and other assistance, as may be reasonably required by the Insured Services Appeal Committee.

33.01(8) The Insured Services Appeal Committee shall meet at the call of the chairperson as required.

33.01(9) Members of the Insured Services Appeal Committee shall serve without salary but may be reimbursed

(a) actual travelling and other necessary out-of-pocket expenses, and

(b) for attendance at meetings,
at such rate as may be approved by the Minister.

33.01(10) The Insured Services Appeal Committee may adopt such procedures for conducting its business as it sees fit.

33.02 Repealed: 2011-15

97-23; 2011-15; 2014-87

33.03 Repealed: 2011-15

97-23; 2011-15

33.04 Those persons who are members of the Insured Services Appeal Committee immediately before the commencement of this section constitute the members of the Insured Services Appeal Committee until the expiry of their term.

2011-15

33.05 Despite subsection 33.01(3) and section 33.04, of the persons who are members of the Insured Services Appeal Committee on the commencement of section 33.04, only the chairperson is eligible for reappointment for an additional term of one year.

2011-15

33.1(1) The following terms and conditions apply to the sharing of proceeds of any recovery under subsection 10(7) of the Act:

(a) the barrister and solicitor acting on behalf of the injured person shall pay the share of Her Majesty the Queen in right of the Province by a cheque made payable to the Minister of Finance within thirty days after the receipt of the proceeds; and

(b) the barrister and solicitor acting on behalf of the injured person shall provide, with the cheque required under paragraph (a), an affidavit of the barrister and solicitor acting on behalf of the injured person and an affidavit of the barrister and solicitor acting on behalf of the person who is paying the proceeds to the injured person and the affidavits shall include the following:

(i) the names of the persons involved;

(ii) the name of the barrister and solicitor acting for the other person;

(iii) whether the claim was settled or a judgment was obtained and when;

(iv) in the case of a settlement, the amount of general damages and the amount of special damages that the barrister and solicitor making the affidavit reasonably believes the injured person was entitled to recover;

(v) in the case of a judgment, the amount of general damages and the amount of special damages awarded to the injured person;

(vi) the amount recovered by the injured person for general damages and the amount recovered for special damages;

(vii) a statement affirming that the amount recovered by the injured person for special damages bears the same proportion to the special damages referred to in subparagraph (iv) or (v), as the case may be, as the amount recovered by the injured person for general damages bears to the general damages referred to in subparagraph (iv) or (v), as the case may be;

(viii) the cost of entitled services claimed by the injured person; and

(ix) the amount that is being paid to Her Majesty the Queen in right of the Province under subsection 10(7) of the Act.

33.1(2) Where an injured person or a person paying the proceeds to the injured person is not represented by a barrister and solicitor, the payment of the proceeds under paragraph (1)(a) and an affidavit required under paragraph (1)(b) shall be made by the person making the claim, whether acting on his own behalf or on behalf of another person.

87-20; 89-78

33.2 Where a barrister and solicitor recovers a sum in respect of the cost of entitled services in accordance with section 10 of the Act, a fee shall be paid as follows:

(a) fifteen per cent on the first five thousand dollars recovered;

(b) ten per cent on the next ten thousand dollars recovered; and

(c) five per cent on that amount recovered in excess of fifteen thousand dollars.

89-78

REQUEST FOR REVIEW
33.3(1) A medical practitioner who has been refused privileges by a regional health authority on any of the bases set out in subsection 4.01(2) of the [Hospital Services Act](https://www.canlii.org/en/nb/laws/regu/nb-reg-84-20/latest/nb-reg-84-20.html) may request the provincial authority to re-calculate the actual number of full time equivalents for the type of practice in which the medical practitioner proposes to become engaged in the area in which the medical practitioner proposes to practise, to ensure that the actual number of full time equivalents has been properly calculated and adjusted.

33.3(2) Subject to subsection (3), a request shall be made in writing within thirty days after privileges have been refused by a regional health authority.

33.3(3) A request under subsection (1) that relates to the period between July 1, 1993 and the commencement of this section shall be made within thirty days after the commencement of this section.

33.3(4) The provincial authority shall provide the medical practitioner making the request with relevant non-identifying information respecting the calculation and adjustment of the actual number of full time equivalents as it pertains to the medical practitioner making the request.

33.3(5) The provincial authority may, as a result of any representation made by the medical practitioner, adjust the actual number of full time equivalents previously calculated and adjusted if the calculation is shown to be erroneous.

33.3(6) The provincial authority shall inform the medical practitioner referred to in subsection (1) of any decision to adjust or not adjust the actual number of full time equivalents within ten days after the decision is made.

94-13; 2002-33

### Regulation 70-124 under the Medical Services Payment Act is repealed.

#### SCHEDULE 0.1

**DECLARATION OF RESIDENCY FORM**

Repealed: 2014-87

2014-87

#### SCHEDULE 1

1 Acts of the Parliament of Canada:

   (a) Aeronautics Act, chapter A-3, Revised Statutes of Canada, 1970.

   (b) Civilian War Pension and Allowances Act, chapter C-20, Revised Statutes of Canada, 1970.

   (c) Government Employees Compensation Act, chapter G-8, Revised Statutes of Canada, 1970.

   (d) Merchant Seamen Compensation Act, chapter M-11, Revised Statutes of Canada, 1970.


   (f) Pension Act, chapter P-7, Revised Statutes of Canada, 1970.

   (g) Royal Canadian Mounted Police Act, chapter R-9, Revised Statutes of Canada, 1970.

   (h) Royal Canadian Mounted Police Pension Continuation Act, chapter R-10, Revised Statutes of Canada, 1970.


   (j) Veterans Rehabilitation Act, chapter V-5, Revised Statutes of Canada, 1970.

2 Acts of the Legislature of New Brunswick:


   (b) Blind Workmen’s Compensation Act, chapter B-6, Revised Statutes of New Brunswick, 1973.

   (c) Hospital Services Act, chapter H-9, Revised Statutes of New Brunswick, 1973.

3 Acts of other jurisdictions:

   Any statute or law enacted by any provincial legislature or other competent jurisdiction other than Canada or New Brunswick under which a person who receives insured medical treatment is eligible for and entitled to such services or to reimbursement in whole or in part of the cost of such services.

#### SCHEDULE 2

The following are deemed not to be entitled services:

   (a) elective plastic surgery or other services for cosmetic purposes:

      (a.01) correction of inverted nipple;

      (a.02) breast augmentation;
(a.03) otoplasty for persons over the age of eighteen;

(a.04) removal of minor skin lesions, except where the lesions are or are suspected to be pre-cancerous;

(a.1) abortion, unless the abortion is performed in a hospital facility approved by the jurisdiction in which the hospital facility is located;

(a.2) surgical assistance for cataract surgery unless such assistance is required because of risk of procedural failure, other than the risk inherent in the removal of the cataract itself, due to the existence of an illness or other complication;

(b) medicines, drugs, materials, surgical supplies or prosthetic devices;

(c) Repealed: 2016-33

(d) advice or prescription renewal by telephone which is not specifically provided for in the Schedule of Fees;

(e) examinations of medical records or certificates at the request of a third party, or other services required by hospital regulations or medical by-laws;

(f) dental services provided by a medical practitioner or an oral and maxillofacial surgeon;

(f.1) services that are generally accepted within New Brunswick as experimental or that are provided as applied research;

(f.2) services that are provided in conjunction with or in relation to the services referred to in paragraph (f.1);

(g) Repealed: 96-111

(h) testimony in a court or before any other tribunal;

(i) immunization, examinations or certificates for purpose of travel, employment, emigration, insurance, or at the request of any third party;

(j) services provided by medical practitioners or oral and maxillofacial surgeons to members of their immediate family;

(k) psychoanalysis;

(l) electrocardiogram (E.C.G.) where not performed by a specialist in internal medicine or paediatrics;

(m) laboratory procedures not included as part of an examination or consultation fee;

(n) refractions;

(n.1) services provided within the Province by medical practitioners, oral and maxillofacial surgeons or dental practitioners for which the fee exceeds the amount payable under this Regulation;

(o) the fitting and supplying of eye glasses or contact lenses;

(p) Repealed: 2016-50

(p.1) radiology services provided in the Province by a private radiology clinic;

(q) acupuncture;

(r) complete medical examinations when performed for the purposes of a periodic check-up and not for medically necessary purposes;

(s) circumcision of the newborn;

(t) reversal of vasectomies;

(u) second and subsequent injections for impotence;

(v) reversal of tubal ligations;

(w) intrauterine insemination;

(x) bariatric surgery unless the person has a body mass index

(i) of 40 or greater, or

(ii) of 35 or greater but less than 40, as well as obesity-related comorbid conditions;

(y) venipuncture for the purposes of the taking of blood when performed as a stand-alone procedure in a facility that is not an approved hospital facility.

85-65; 85-156; 86-94; 86-150; 86-155; 87-22; 87-148; 89-47; 90-83; 93-25; 93-91; 93-114; 93-103; 94-118; 96-111; 2003-51; 2006-66; 2009-38; 2014-160; 2016-33; 2016-50

SCHEDULE 3

AGREEMENT

I, a duly registered medical practitioner/a duly registered oral and maxillofacial surgeon (strike out the inapplicable portion), apply to practise my profession in accordance with the Medical Services Payment Act and the regulations under that Act. In particular, I agree to accept payment by the Medicare Branch for any entitled service provided by me for which I submit an account to the Medicare Branch as payment in full for that service and I shall not make any further claim against any person with respect to that service.
(Where the participating medical practitioner or participating oral and maxillofacial surgeon is a corporation, this agreement must be signed by an authorized officer.)

86-150; 97-23; 2003-51

**SCHEDULE 4**

98-52

1(1) The following services when rendered by a qualified dental practitioner in a hospital, if the condition of the patient is such that the services are medically required to be rendered in a hospital, shall be paid at the rate prescribed in section 22 of this Regulation for the unit values listed in this subsection as follows:

<table>
<thead>
<tr>
<th>Surgical dental procedures</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abscess of dental origin, incision and drainage</td>
<td>38</td>
</tr>
<tr>
<td>Intraoral cysts</td>
<td></td>
</tr>
<tr>
<td>Diameter up to 1.5 cm</td>
<td>97</td>
</tr>
<tr>
<td>Diameter greater than 1.5 cm up to 2.5 cm</td>
<td>122</td>
</tr>
<tr>
<td>Diameter greater than 2.5 cm</td>
<td>246</td>
</tr>
<tr>
<td>Intraoral biopsy</td>
<td></td>
</tr>
<tr>
<td>Soft tissue</td>
<td>31</td>
</tr>
<tr>
<td>Bone</td>
<td>77</td>
</tr>
<tr>
<td>Benign intraoral tumours, excision</td>
<td></td>
</tr>
<tr>
<td>Diameter up to 1 cm</td>
<td>54</td>
</tr>
<tr>
<td>Diameter greater than 1 cm up to 2.5 cm</td>
<td>109</td>
</tr>
<tr>
<td>Diameter greater than 2.5 cm</td>
<td>214</td>
</tr>
<tr>
<td>Gingivoplasty</td>
<td></td>
</tr>
<tr>
<td>First quadrant</td>
<td>91</td>
</tr>
<tr>
<td>Each additional</td>
<td>91</td>
</tr>
<tr>
<td>Sulcus deepening and ridge reconstruction</td>
<td></td>
</tr>
<tr>
<td>First quadrant</td>
<td>149</td>
</tr>
<tr>
<td>Additional quadrants: 50% of listed fee</td>
<td>149</td>
</tr>
<tr>
<td>Antro-oral fistula, repair and closure</td>
<td>231</td>
</tr>
<tr>
<td>Avulsion of nerve</td>
<td>92</td>
</tr>
<tr>
<td>Incision</td>
<td></td>
</tr>
<tr>
<td>Sialolithotomy, under general anaesthesia</td>
<td></td>
</tr>
<tr>
<td>Simple</td>
<td>46</td>
</tr>
<tr>
<td>Complicated</td>
<td>139</td>
</tr>
<tr>
<td>Submandibular gland, excision</td>
<td>185</td>
</tr>
<tr>
<td>Lacerations, facial and intraoral - total care</td>
<td></td>
</tr>
<tr>
<td>First 5 cm in extent</td>
<td>46</td>
</tr>
<tr>
<td>More than 5 cm up to 10 cm</td>
<td>72</td>
</tr>
<tr>
<td>Complicated (add 5 units per cm)</td>
<td></td>
</tr>
<tr>
<td>Sinusotomy for removal of foreign body</td>
<td>92</td>
</tr>
<tr>
<td>Mandible - fractures</td>
<td></td>
</tr>
<tr>
<td>Interdental and intermaxillary wiring</td>
<td>154</td>
</tr>
<tr>
<td>Simple or compound, unilateral or bilateral, reduction and fixation</td>
<td>269</td>
</tr>
<tr>
<td>Operative reduction and intermaxillary wiring</td>
<td></td>
</tr>
<tr>
<td>Bilateral</td>
<td>357</td>
</tr>
<tr>
<td>Skeleton pinning, circumferential wiring of mandible, wiring of Gunning splints or dentures</td>
<td>500</td>
</tr>
<tr>
<td>Removal of fracture fixation devices</td>
<td></td>
</tr>
<tr>
<td>Facial suspension</td>
<td>100</td>
</tr>
<tr>
<td>Intermaxillary</td>
<td>38</td>
</tr>
<tr>
<td>Preauricular sinus simple</td>
<td>77</td>
</tr>
<tr>
<td>Repair of palate fistula</td>
<td>231</td>
</tr>
<tr>
<td>Arthroscopy (+/- biopsy)</td>
<td></td>
</tr>
<tr>
<td>Diagnostic arthroscopy</td>
<td>139</td>
</tr>
<tr>
<td>Plication of Meniscus</td>
<td>204</td>
</tr>
<tr>
<td>Mandible - resection</td>
<td></td>
</tr>
<tr>
<td>Prognathism and micrognathia - double resection</td>
<td></td>
</tr>
<tr>
<td>Mandible or maxilla - one or more stages</td>
<td>616</td>
</tr>
<tr>
<td>Tumours - enucleation, resection, partial resection of mandible</td>
<td></td>
</tr>
<tr>
<td>With bone graft</td>
<td>231</td>
</tr>
<tr>
<td>Hemimandibulectomy</td>
<td>308</td>
</tr>
<tr>
<td>Bone graft to jaw or face</td>
<td></td>
</tr>
<tr>
<td>Procedure Description</td>
<td>Price</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Autologous............</td>
<td>308</td>
</tr>
<tr>
<td>Non-autologous.........</td>
<td>231</td>
</tr>
<tr>
<td>Mandibular osteotomy (not payable in addition to prognathism or micrognathia).......</td>
<td>308</td>
</tr>
<tr>
<td>Osteomyelitis of mandible - sequestrectomy only...............</td>
<td>154</td>
</tr>
<tr>
<td>Exposure, excision of soft tissue, saucerization sequestrectomy, including muscle flap........</td>
<td>231</td>
</tr>
<tr>
<td>Plus bone graft........</td>
<td>308</td>
</tr>
<tr>
<td>Osteotomies - facial bones (not applicable to fractures) ....</td>
<td>582</td>
</tr>
<tr>
<td>Malar (maxillary).........</td>
<td>582</td>
</tr>
<tr>
<td>Low maxillary osteotomy and advancement (LeFort I), including bone grafts........</td>
<td>769</td>
</tr>
<tr>
<td>Two segments.................</td>
<td></td>
</tr>
<tr>
<td>Three or more segments........</td>
<td>910</td>
</tr>
<tr>
<td>Maxillary osteotomy and advancement (LeFort II), including bone grafts........</td>
<td>910</td>
</tr>
<tr>
<td>Total maxillary advancement (LeFort III), including bone grafts........</td>
<td>1219</td>
</tr>
<tr>
<td>Temporomandibular joint Dislocation - closed reduction..........</td>
<td>23</td>
</tr>
<tr>
<td>Meniscectomy.............</td>
<td>154</td>
</tr>
<tr>
<td>Condylectomy or arthroplasty.............</td>
<td>231</td>
</tr>
<tr>
<td>- add with fixation..........</td>
<td>46</td>
</tr>
<tr>
<td>- with prosthesis...........</td>
<td>448</td>
</tr>
<tr>
<td>Maxilla - fractures LeFort type I Reduction and dental wiring including circumferential wiring..........</td>
<td>154</td>
</tr>
<tr>
<td>External craniofacial fixation..........</td>
<td>385</td>
</tr>
<tr>
<td>LeFort types II and III facial suspension.................</td>
<td>385</td>
</tr>
<tr>
<td>LeFort type III complicated, i.e. antral packing, suspension, etc........</td>
<td>462</td>
</tr>
<tr>
<td>Malar fractures - simple elevation.............</td>
<td>115</td>
</tr>
<tr>
<td>Operative reduction with pinning, interosseous or Kirshner wires........</td>
<td>231</td>
</tr>
<tr>
<td>Maxillo-orbital fractures - operative reduction with antrostomy and packing........</td>
<td>269</td>
</tr>
</tbody>
</table>

1(2) The procedural fee includes all care within the postoperative period of forty-two days.

1(3) Prostheses used by a dental practitioner in the course of rendering an entitled service are to be billed to the hospital in which the service is provided.

99-29; 2003-51

Surgical assistance by a dentist on an entitled procedure performed by another dentist

2(1) Where the services of a dentist are necessary in addition to those of another dentist in connection with any of the procedures listed in subsection 1(1), such services will be treated as a surgical assistance.

2(2) The fee applicable to a surgical assistance by a dentist in connection with any of the major procedures listed in subsection 1(1) shall be thirty-three per cent of the fee for the procedure.

2(3) A dentist claiming a surgical assistance fee may not claim additional fees for services rendered to that patient during the specified postoperative period.

2003-51

Consultation

3 Where a consultation and report on a hospital in-patient is requested in writing by a medical practitioner, oral surgeon or an oral and maxillofacial surgeon, such consultation is payable, subject to the assessment rules of the agreement, at a fee of forty-five units.

96-111; 97-23; 98-52; 2003-51

SCHEDULE 5

Repealed: 93-103

84-78; 85-156; 86-155; 87-148; 88-31; 88-133; 89-8; 90-41; 93-103

N.B. This Regulation is consolidated to January 1, 2018.
By lexum for the law societies members of the Federation of Law Societies of Canada