Ontario

Schedule of Benefits

Physician Services Under the Health Insurance Act

(March 9, 2026 (effective April 1, 2026))

Ministry of Health

[Commentary:
"The *Schedule* of Benefits: Physician Services is a *schedule* under Regulation 552 of the *Health Insurance Act* with the exception of the Table of Contents, Appendices A, B, C, F, G, H, Q, and the Numeric Index."]

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GENERAL PREAMBLE

INTRODUCTION

[Commentary:
The *Health Insurance Act* and, to a lesser extent, the *Integrated Community Health Services Centres Act, 2023* and the *Commitment to the Future of Medicare Act, 2004*, provide the legal foundation and framework for the *Schedule* of Benefits for Physician Services ("the *Schedule*").

The *Schedule* lists services insured by *OHIP* and includes the General Preamble (which impacts all physicians), Consultations and Visits section (which applies to all specialties) and specific system and/or specialty sections (including specialty preambles).

The General Preamble provides details about billing requirements for all physicians as follows:

The initial **Definitions Section (GP2)** begins with general definitions of key terms and phrases used in the *Schedule*. Those terms and phrases are italicized throughout the General Preamble as an indication that further information is available in the Definitions Section. The second group of defined terms refers specifically to maximums, minimums, and time or unit-based services.

The information provided in the **General Information Section (GP8)** is the foundation for the remainder of the General Preamble. A variety of subjects are reviewed as detailed in the table of contents. This is followed by the **Constituent and Common Elements of Insured Services (GP13)**. Next is the section which lists the **Specific Elements of Assessments (GP15)**. The next section provides information on **Consultations and Assessments (GP16)** followed by the section regarding services provided only in **Hospitals and Other Institutions (GP40)**.

The next section focuses on psychotherapy, counselling, and related services, followed by a similar review of services that involve interviews. The remaining sections include special visits, surgical assistants' services, anaesthesiologists' services, and others as listed in the table of contents.]

GENERAL PREAMBLE

DEFINITIONS

GENERAL DEFINITIONS

The words, phrases, and abbreviations defined below are italicized throughout the General Preamble for cross-reference. Unless otherwise specified, the following terms and expressions have the following meanings:

A. Age Definitions

adolescent	a person 16 or 17 years of age
adult	a person 18 years of age and older
child	a person 2 years to and including 15 years of age
infant	a person from 29 days up to, and less than, 2 years of age
newborn	a person from birth up to, and including, 28 days of age

B. Time Definitions

12 month period	any period of 12 consecutive months
calendar year	the period from January 1 to December 31
day	a calendar day
fiscal year	from April 1 of one year to March 31 of the following year
month	a calendar month
week	any period of 7 consecutive days

C. Other Definitions

Act	Health Insurance Act
Bariatric Centre of Excellence (BCoE)	a facility that is approved and funded by the Ministry of Health for assessment and surgical and non-surgical treatment of morbid obesity for persons who have been referred to the facility for that purpose.
Bariatric Regional Assessment and Treatment Centre (RATC)	a facility that is approved and funded by the Ministry of Health for the non-surgical assessment and treatment of morbid obesity for persons who have been referred to the facility for that purpose.
Body Mass Index (BMI)	the ratio of the patient's mass (measured in kilograms) to the square of the patient's height (measured in metres)
common elements	the components that are included in all insured physician services
constituent elements	the common elements and, where applicable, the specific elements of an insured service
CPSO	College of Physicians and Surgeons of Ontario

GENERAL PREAMBLE

DEFINITIONS

Dental Surgeon a health care practitioner who meets the definition of "dental surgeon" as set out in Regulation 552 under the *Act*, and who has been issued an OHIP registration number.

emergency department equivalent an office or other place, including Urgent Care Centres, Walk-in Clinics, Extended Hours Clinics, or other settings (other than a hospital emergency department) in which the only insured services provided are to patients who do not have pre-arranged appointments

general anaesthesia all forms of anaesthesia except topical anaesthesia or local infiltration

"H" fee a fee set out in the *Schedule* for the technical component of a diagnostic service provided either in a hospital or in an offsite premise operated by the hospital corporation that has received approval under section 4 of the *Public Hospitals Act*

holiday (for other than "H" prefix emergency department listings and Emergency Department Equivalent - A888) means all of the following:

1. Family Day, Good Friday, Victoria Day, Canada Day, Civic *Holiday*, Labour Day, Thanksgiving, New Year's Day, and if the *holiday* falls on a Saturday or Sunday either the Friday before or the Monday following the *holiday*, as determined at the choice of the physician.
2. Boxing Day and if Boxing Day falls on a Saturday, the Monday following Boxing Day.
3. Christmas Day and
   a. if Christmas Day falls on a Sunday, the Friday before Christmas Day; or
   b. if Christmas Day falls on a Saturday, the Friday before and the Monday following Christmas Day.

holiday (for "H" prefix emergency department listings and Emergency Department Equivalent - A888) means all of the following:

Family Day, Good Friday, Victoria Day, Canada Day, Civic Holiday, Labour Day, Thanksgiving, New Year's Day, December 25 through December 31 (inclusive) and,

   a. if Christmas Day falls on a Saturday or Sunday, the Friday before Christmas Day; and
   b. if New Year's Day falls on a Saturday or Sunday, the Monday following New Year's Day; and
   c. if Canada Day falls on a Saturday or Sunday either the Friday before or the Monday following Canada Day, as determined at the choice of the physician.

[Commentary:

1. Only services rendered on a *holiday* as defined above and listed as a *holiday* premium or service, e.g. certain special visit premiums, after-hours premiums and H-code emergency department services, are eligible for payment as *holiday* claims.
2. Special visit premiums are *not eligible for payment* with A888.]

DEFINITIONS

home	patient's place of residence including a multiple resident dwelling or single location that shares a common external building entrance or lobby, such as an apartment block, rest or retirement home, commercial hotel, motel or boarding house, university or boarding school residence, hostel, correctional facility, or group home and other than a hospital or Long-Term Care institution
ICHSC	Integrated Community Health Services Centre under the *Integrated Community Health Services Centres Act, 2023.*
independent operative procedure (IOP)	a procedural code with a "Z" prefix (which is payable in addition to the amount payable for an assessment)
major preoperative visit	the consultation or assessment where the decision to operate is made, regardless of the time interval between the major preoperative visit and the surgery
may include	when "may" or "may include" are used in the description of a listed service, all of the other services, or elements of, or components of insured services that are referred to following the terms "may", "may include", and that are performed in conjunction with the listed service are optional, but when rendered are included in the amount payable for the listed service
Medical Assistance in Dying (MAID)	Medical Assistance in Dying (MAID) is the service where a physician or nurse practitioner, at an individual's request: (a) administers a substance that causes an individual's death; or (b) prescribes or provides a substance for an individual to self-administer to cause their own death.
medical consultant	a designated MOH physician
MOH	Ministry of Health
most responsible physician	the attending physician who is primarily responsible for the day-to-day care of a hospital in-patient
not eligible for payment	when a service or a claim submitted for a service is described as "not eligible for payment", the service remains an insured service for which the amount payable is zero

[Commentary:
Patients cannot be charged for services described as "*not eligible for payment*" as they remain insured services.]

nurse practitioner	has the same meaning as "registered nurse in the extended class" as set out in Regulation 552 under the *Act*.
OHIP	Ontario Health Insurance Plan
OMA	Ontario Medical Association
only eligible for payment	when a service is described as "only eligible for payment" when certain conditions are met and those conditions are not met, the service becomes not eligible for payment.

GENERAL PREAMBLE

DEFINITIONS

[Commentary:
Patients cannot be charged for services described as "*only eligible for payment*" as they remain insured services.]

palliative care — care provided to a terminally ill patient in the final year of life where the decision has been made that there will be no aggressive treatment of the underlying disease and care is to be directed to maintaining the comfort of the patient until death occurs

patient's representative — the legal representative of a patient

"P" fee — the fee for the professional component of a diagnostic service

professional component — a class of service listed in the *Schedule* headed by a column listed "P" or with "professional component" listed opposite the service

[Commentary:
Additional information including the requirements for performing the *professional component* is found in the individual preambles to the applicable sections of the *Schedule*.]

referral — written request by a physician, *nurse practitioner*, or *dental surgeon* in connection with an insured dental procedure rendered in a hospital for the provision of expert services by another physician to the patient of the referring physician, nurse practitioner, or *dental surgeon*.

rendered personally by the physician — means that the service must be personally performed by the physician and may not be delegated to any other person. Services that are required to be "rendered personally by the physician" are uninsured if this requirement is not met

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specialist — a physician who holds one of the following:

1. a certification issued by the Royal College of Physicians and Surgeons of Canada (RCPSC);
2. a certificate of registration issued by the *CPSO* to a physician who has successfully completed the Assessment program for International Medical Graduates (APIMG) in a recognized medical or surgical specialty;
3. a certificate of registration as a *specialist* issued by the *CPSO* to a physician employed;
   - in a full-time teaching or full-time research appointment in a recognized medical or surgical specialty other than family or general practice; and
   - by the faculty of medicine of an Ontario university at the rank of assistant professor or higher;
4. a certificate of registration issued on the order of the Registration Committee of the *CPSO* to a physician who practices in a recognized medical or surgical specialty other than family or general practice, where the requirements of registration are otherwise not met, and to which certificate terms, conditions, or limitations may be attached; or
5. an equivalent certificate as described in 2, 3 or 4 above, issued by another Canadian jurisdiction to a physician who is exempted from subsections 9 (1) and (3) of the *Medicine Act, 1991* by a regulation made under that Act.

DEFINITIONS

specific elements specific components, in addition to the common elements, that are included in particular insured physician services found in the General Preamble or the specialty section of the *Schedule*

"T" fee the fee for the technical component of a service listed in the Pulmonary Function Studies section of the *Schedule*

technical component a class of service listed in the *Schedule* headed by a column listed "H" or "T" or with "technical component" listed opposite the service

[Commentary:
Additional information including the requirements for performing the *technical component* is found in the individual preambles to the applicable sections of the *Schedule*.]

transferal permanent or temporary complete transfer of the responsibility for the care of the patient from one physician to another

[Commentary:
A *transferal* occurs, for example, where the first physician is leaving temporarily on *holiday*s and is unable to continue to treat the patient.]

uninsured service a service that is not prescribed as "insured" under the Act

with or without when "with or without" are used in the description of a listed service, all of the other services, or elements of, or components of insured services that are referred to following the terms "with or without", and that are performed in conjunction with the listed service are optional, but when rendered are insured and are included in the amount payable for the listed service

GENERAL PREAMBLE

DEFINITIONS

MAXIMUMS, MINIMUMS AND TIME OR UNIT-BASED SERVICES

In this *Schedule* when the amount payable for a service is described:

a. In terms of a maximum number of services without reference to a specific time period to which the maximum applies, this means that the maximum refers to a maximum number of services per patient per day. Those services rendered to the same patient on the same day in excess of the maximum for that patient on that day are *not eligible for payment*.

b. In terms of a maximum number of services with reference to a specific time period to which the maximum applies, the services are calculated per patient and the number of services is based upon services rendered chronologically. Those services rendered to the same patient during that specific time period in excess of the maximum for that patient are *not eligible for payment*.

c. In terms of a maximum with reference to a specific part of the anatomy, this means a maximum number of services per patient per day. Those services rendered in excess of the maximum for that specific part of the anatomy per patient on that day are *not eligible for payment*.

d. In terms of a minimum number of services without reference to a specific time period to which the minimum applies, this means that the minimum refers to a minimum number of services per patient per day. With the exception of those services listed in the “Diagnostic Radiology” section of the *Schedule* or unless specifically stated otherwise, where less than the number of services required to satisfy the minimum are rendered, the services are *not eligible for payment*.

e. In terms of “repeat” or “repeats”, except with respect to repeat consultations or unless otherwise stated, this means the same service(s) is rendered to the same patient by the same physician on the same day.

f. In terms of a minimum required duration of time, the physician must record on the patient’s permanent medical record or chart the time when the insured service started and ended. If the patient’s permanent medical record or chart does not include this required information, the service is *not eligible for payment*.

g. Based upon the number of “units” of service rendered, the physician must record on the patient’s permanent medical record or chart the time when the insured service started and ended. If the patient’s permanent medical record or chart does not include this required information, the service is *not eligible for payment*.

GENERAL PREAMBLE

GENERAL INFORMATION

[Commentary: Services Insured by OHIP
The *Schedule* is established under section 37.1 of regulation 552 under the Act. The fees listed are the amounts payable by *OHIP* for insured services. Insured services under the Act are limited to those which are listed in this *Schedule*, medically necessary, are not otherwise excluded by legislation or regulation, and are rendered personally by physicians or by others delegated to perform them where such delegation is authorized in accordance with the *Schedule* requirements for delegated services.

Some services are specifically listed as uninsured in regulation 552, section 24 of the Act (see Appendix A), such as a service that is solely for the purpose of altering or restoring appearance. Other services may be uninsured depending on the circumstances. An example of a service which is uninsured in limited circumstances is psychotherapy, which is uninsured where it is a requirement for the patient to obtain a diploma or degree or to fulfill a course of study. Other examples of commonly *uninsured service*s include missed appointments or procedures, circumcision except if medically necessary, and certain services rendered and documents and forms completed in connection with non-medically necessary requests (e.g. life insurance application).]

[Commentary: Modifications to the Schedule
Under agreement between the *MOH* and the *OMA*, additions, deletions, fee changes, or other modifications to the *Schedule*, are made by the *MOH* following consultation and/or negotiation with the *OMA*. Physicians who wish to have modifications to the *Schedule* considered should submit any proposals to the Physician Payment Committee (PPC) through the appropriate clinical section of the *OMA*.

In the situation where a new therapy or procedure is being introduced into Ontario, and the physicians performing the new therapy or procedure wish to have a new fee item inserted into the *Schedule*, the following process is recommended.

An application for a new fee related to the new therapy or procedure should be submitted by the appropriate section(s) of the *OMA* to the PPC for consideration, with documentation supporting the introduction of this item into the *Schedule*. The PPC will advise *OHIP* whether or not this new therapy is experimental. If the PPC and the *MOH* agree that the item is experimental, the service is deemed uninsured (in accordance with section 24 of regulation 552 under the Act), and will not be introduced into the *Schedule*. If the *MOH*, on the advice of the PPC, determines that the new therapy or procedure is not experimental, the fee application will be handled in the usual manner as detailed above.]

[Commentary: Medical Research
Examinations or procedures for the purpose of a research or survey program are not insured services, nor are services provided by a laboratory or a hospital that support an examination or procedure that is for the purpose of research or a survey. The exception to this is that an assessment conducted to determine if an insured person is suitable for such a program is not necessarily an *uninsured service* (see section 24 of regulation 552 under the Act - this is provided as Appendix A of the *Schedule*).]

[Commentary: Medical Records
All insured services must be documented in appropriate records. The Act requires that the record establish that:

1. an insured service was provided;

2. the service for which the account is submitted is the service that was rendered; and

3. the service was medically necessary.

The medical record requirements as found in the Act are listed in Appendix G of the *Schedule*.]

GENERAL PREAMBLE

GENERAL INFORMATION

GENERAL PAYMENT RULES

[Commentary:
Claims for payment must be submitted to *OHIP* in the form and by the medium (e.g. electronic data transmission; machine readable input) as set out in sections 38.3 to 38.5 of regulation 552 under the Act and must contain the information required by the regulation and the General Manager of *OHIP*. Regulation 552 under the Act can be found at:

https://www.ontario.ca/laws/regulation/900552.

Claims must be submitted within three *month*s of the date the service was rendered, except in extenuating circumstances. A claim cannot be accepted for payment unless it meets all of the technical and formal requirements set out in the Act and regulations.]

1. The fee is payable only to the physician who rendered the service personally, or by the physician whose delegate rendered the service where delegation is authorized in accordance with the *Schedule*.

2. Where more than one physician renders different components of a listed service, only one fee is payable for that service, and the fee is payable only where the *Schedule* provides that different physicians may perform different components of the service.

[Commentary:
Where an insured service contains several components (e.g. surgical procedures that include post-operative care or fracture care), the components of the service are not divisible among physicians for claims purposes and the physicians are responsible for apportioning payment amongst themselves.]

3. Where the *Schedule* provides that different physicians may substitute for one another in performing the total service, only one fee is payable for the service.

[Commentary:
When physicians routinely or frequently substitute for each other in providing hospital visits to registered bed patients in active treatment hospitals, e.g. *week*end coverage or daily rounds by various members of a group, the *most responsible physician* may claim for all the visits.]

Specialist services

When a service rendered by a *specialist* comprises part of an insured consultation or assessment that falls within the scope of his or her *specialist* practice, the service is *not eligible for payment* unless the claim for the service is submitted either:

a. unless otherwise noted, in respect of a service described in the portions of the Consultations and Visits section of this *Schedule* that reflects the physician's Royal College of Physicians and Surgeons of Canada specialty, as documented in the records maintained by the *MOH* for claims payment purposes; or

b. in respect of a service described in this *Schedule* under the following sub-headings which can be claimed by any specialty: psychotherapy, counselling, HIV primary care, *palliative care* support, hypnotherapy, certification of mental illness, interviews, genetic assessments, midwife or aboriginal midwife-requested emergency and special emergency assessments, *home* care application, or *home* care supervision.

GENERAL PREAMBLE

GENERAL INFORMATION

When a service rendered by a *specialist* does not fall within the scope of the *specialist*'s practice and/or the *specialist* is providing primary care in a family or general practice setting, the service is *only eligible for payment* when the claim is submitted using the appropriate code from the "Family Practice & Practice in General" listings.

When more than one assessment is rendered to a patient during the same visit by the same physician who is qualified in one or more specialties, only one assessment is payable.

[Commentary:
Any additional assessment is *not eligible for payment*.]

Use of Codes, Prefixes and Suffixes

[Commentary:
Services are generally, but not necessarily, listed by anatomical system or specialty for convenience.]

The alpha-numeric fee code opposite the service listing in this *Schedule* must be set out in the claim submitted, together with the required suffix.

Surgical Codes: In the surgical part of the *Schedule*, the required suffixes are:

suffix A if the physician performs the procedure;

suffix B if the physician assisted at the surgery; and

suffix C if the physician administered the anaesthetic.

GENERAL PREAMBLE

GENERAL INFORMATION

GENERAL PAYMENT RULES

Diagnostic Services Rendered at a Hospital

The *technical component* of those diagnostic services that are listed with "*technical component*" or in a column headed "H" or "T" is *not eligible for payment* if the service is rendered to a patient who:

1. is an in-patient of a hospital; or
2. attends a hospital where he or she receives an insured diagnostic service; and
3. within 24 hours of receiving that diagnostic service, is admitted to the same hospital as an in-patient in connection with the same condition, illness, injury or disease in relation to which the diagnostic service was rendered.

[Commentary:

1. For those diagnostic services which have both technical and *professional component*s listed under one fee schedule code, the technical and *professional component*s are claimed separately. The claim for the *technical component* is submitted using the fee schedule code with the suffix B and the claim for the *professional component* is submitted using the fee schedule code with a suffix C.
2. The *technical component* may be listed as either "*technical component*" or in a column headed "H" or "T". The *professional component* may be listed as either "*professional component*" or in a column headed "P".]

The *technical component* of a diagnostic service listed in the column headed with an "H" and rendered outside of a hospital is *not eligible for payment* under the *Health Insurance Act*.

Payment for Diagnostic and Therapeutic Services Rendered at a Hospital

The *technical component* of a diagnostic and therapeutic service listed below and rendered in a hospital is payable at 86.10% of the listed fee in the column headed “T”.

G104A, G111A, G121A, G127A, G140A, G143A, G146A, G149A, G152A, G153A, G167A, G174A,G181A, G209A, G284A, G308A, G310A, G311A, G315A, G414A, G440A, G441A, G442A, G443A,G448A, G451A, G455A, G466A, G471A, G519A, G540A, G541A, G542A, G544A, G554A, G570A,G574A, G582A, G585A, G647A, G648A, G651A, G652A, G654A, G655A, G682A, G683A, G684A,G685A, G686A, G687A, G688A, G689A, G694A, G695A, G815A, G850A, G851A, G852A, G853A,G854A, G855A, G856A, G857A, G858A, J301B, J304B, J324B, J327B

Technical Component Requirements

The *technical component* of a diagnostic procedure as described in the relevant section of the *Schedule* is *only eligible for payment* where:

1. the physician has the necessary training and experience to personally render the *technical component* of the service; and
2. the physician maintains documentation that describes the process by which the physician monitors quality assurance in accordance with professional standards.

[Commentary:

1. The physician submitting a claim for the *technical component* is responsible for the complete quality assurance process for all elements of the *technical component* of the service, including data acquisition, reporting, and record keeping. The physician must be able to demonstrate the above upon request by the *MOH*.

GENERAL INFORMATION

2. For delegated services rendered in the physician's office, see the Delegated Procedures section in the General Preamble of this *Schedule*.]

Consultation and Assessment Codes

There are four different prefixes used for consultations and assessments listed in the "Consultations and Visits" section of the *Schedule*. The codes with the "A" prefix are described as the "General Listings". These must be used when submitting a claim for consultations and assessments except in the following situations when the code listed below must be used:

1. acute care hospital – non-emergency in-patient services – "C" prefix codes;
2. long term care institution – non-emergency in-patient services – "W" prefix codes;
3. emergency department – services rendered by a physician on duty – "H" prefix (H1- codes); or
4. rehabilitation unit – services rendered by a ***specialist*** in Physical Medicine – "H" prefix codes (H3XX codes)

[Commentary:
Submit claim using an "A" prefix assessment when an assessment is rendered in conjunction with a special visit premium. Information regarding when special visit premiums are payable is found on pages GP65 to GP78 of the General Preamble.]

Independent Consideration (IC)

Services listed in the *Schedule* without specified fees are identified as "IC" and are given independent consideration by the *medical consultant*. Claims for such services must be submitted with a supporting letter explaining the amount of the fee claimed, and must include an appropriate operative or consultation report, and a comparison of the scope and difficulty of the procedure in relation to non-IC procedures in the *Schedule*. For treatment of tumours not listed in the *Schedule*, surgeons must use the IC code, R993, and for surgical procedures not listed, but similar to a listed service, the code, R990.

USUAL VISIT CODE (UVC)

Services listed in the *Schedule* identified as "UVC" are services for which there is not a specific fee code. If provided, the service is included in the visit fee appropriate to the service rendered. The Usual Visit Code (UVC) for the visit shall be payable to the physician according to his or her own General or Specialty listings.

GENERAL PREAMBLE

CONSTITUENT AND COMMON ELEMENTS OF INSURED SERVICES

[Commentary:
This *Schedule* identifies the *constituent elements* that comprise insured services. *Common elements* apply to all insured services and *specific elements* apply to specific groups of services where identified either in the General Preamble or in the preamble to a specific system and/or specialty sections of the *Schedule*. There may be additional specific requirements ("required elements of service", "payment rules", "claims submission instructions" or "notes") for some individual services, and these are noted with the description of any such service within the *Schedule*. In order to determine the correct claim to use for a service rendered, the necessary information is found by reviewing the *common elements*, *specific elements*, and service specific information.

No charges may be made (except to *OHIP*) for an insured service rendered to an insured person or for any of the *constituent elements* of such insured services. This is prohibited by the Act and/or the *Commitment to the Future of Medicare Act, 2004*.

Most services include as a constituent element of the service the provision of the premises, equipment, supplies, and personnel used in the performance of the common and *specific elements* of the service. This is not, however, the case for services denoted by codes marked with the prefix "#", and for services that are divided into *professional and technical component*s where only the *professional component* is an insured service under the Act.

For those codes denoted with the prefix "#" and performed in a hospital, the premises, equipment, supplies, and personnel used to perform all elements of the service are funded by the hospital global budget.

For those services denoted with the prefix "#" and provided in an Integrated Community Health Services Centre (*ICHSC*), the premises, equipment, supplies, and personnel are funded under the facility costs set out in the *Integrated Community Health Services Centres Act, 2023.*

Patients cannot be charged for the premises, equipment, supplies and personnel for services denoted with the prefix "#" rendered outside of a hospital or *ICHSC* if the premises, equipment, supplies and personnel support, assist or provide a necessary adjunct to an insured service denoted with the prefix "#" as charging a patient would be contrary to the *Integrated Community Health Services Centres Act, 2023*.]

COMMON ELEMENTS OF INSURED SERVICES

All insured services include the skill, time, and responsibility involved in performing, including when delegated to a non-physician in accordance with the Delegated Procedures Section (GP62) of the General Preamble, supervising the performance of the *constituent elements* of the service.

Unless otherwise specifically listed in the *Schedule*, the following elements are common to all insured services.

A. Being available to provide follow-up insured services to the patient and arranging for coverage when not available.

B. Making arrangements for appointment(s) for the insured service.

C. Travelling to and from the place(s) where any element(s) of the service is (are) performed.

[Commentary:
Travelling to visit an insured person outside of the usual geographical area of practice of the person making the visit is an *uninsured service* – see Regulation 552 section 24(1) paragraph 1 under the Act.]

CONSTITUENT AND COMMON ELEMENTS OF INSURED SERVICES

D. Obtaining and reviewing information (including history taking) from any appropriate source(s) so as to arrive at any decision(s) made in order to perform the elements of the service.

Appropriate sources include but are not limited to:

1. patient and *patient's representative*

2. patient charts and records

3. investigational data

4. physicians, pharmacists, and other health professionals

5. suppliers and manufacturers of drugs and devices

6. relevant literature and research data.

E. Obtaining consents or delivering written consents, unless otherwise specifically listed in the Schedule.

F. Keeping and maintaining appropriate medical records.

G. Providing any medical prescriptions except where the request for this service is initiated by the patient or *patient's representative* and no related insured service is provided.

H. Preparing or submitting documents or records, or providing information for use in programs administered by the *MOH*.

I. Conferring with or providing advice, direction, information, or records to physicians and other professionals associated with the health and development of the patient.

J. Such planning, preparation, and administration for the performance of the elements of the service directly attributable either to a specific patient or to a physician maintaining his/her practice, unless otherwise specifically listed in the *Schedule*.

K. Except for services denoted by codes marked with the prefix "#", or for services that are divided into *professional and technical component*s where only the *professional component* is an insured service under the Act, providing premises, equipment, supplies, and personnel for the *common elements* of the service.

L. Waiting times associated with the provision of the service(s).

While no occasion may arise for performing elements A, B, C, D, F, G, H or K when performed in connection with the *specific elements* of a service, these are included in the service.

GENERAL PREAMBLE

SPECIFIC ELEMENTS OF ASSESSMENTS

In addition to the *common elements*, all services which are described as assessments, or as including assessments (e.g. consultations), include the following *specific elements*:

A. A direct physical encounter with the patient including taking a patient history and performing a physical examination.

B. Other inquiry (including taking a patient history), carried out to arrive at an opinion as to the nature of the patient's condition, (whether such inquiry takes place before, during or after the encounter during which the physical examination takes place) and/or follow-up care.

C. Performing any procedure(s) during the same encounter as the physical examination, unless the procedure(s) is(are) separately listed in the *Schedule* and an amount is payable for the procedure in conjunction with an assessment.

"Procedure" in this context includes obtaining specimens, preparation of the patient, interpretation of results and, unless otherwise specified, all diagnostic (including laboratory) and therapeutic (including surgical) services;

D. Making arrangements for any related assessments, procedures or therapy, and/or interpreting results.

E. Making arrangements for follow-up care.

F. Discussion with, and providing advice and information, including prescribing therapy to the patient or the *patient's representative*, whether by telephone or otherwise, on matters related to:

1. the service; and

2. in circumstances in which it would be professionally appropriate that results can be reported upon prior to any further patient visit, the results of related procedure(s) and/or assessment(s).

G. When medically indicated, monitoring the condition of the patient and intervening, until the next insured service is provided.

H. Providing premises, equipment, supplies, and personnel for the *specific elements* of the service except for any aspect(s) that is (are) performed in a hospital or nursing *home*.

While no occasion may arise for performing elements C, D, E, G, or H, when performed in connection with the other *specific elements*, they are included in the assessment.

GENERAL PREAMBLE

CONSULTATIONS

CONSULTATION

Definition/Required elements of service:

A consultation is an assessment rendered following a written request from a referring:

1. physician
2. *nurse practitioner* or
3. *dental surgeon* in connection with an insured dental procedure rendered in a hospital,

who, in light of his/her professional knowledge of the patient, requests the opinion of a physician (the "consultant physician") competent to give advice in this field because of the complexity, seriousness, or obscurity of the case, or because another opinion is requested by the patient or *patient's representative*.

[Commentary:

1. The referring physician, *nurse practitioner* or *dental surgeon* must determine if multiple requests by a patient or the *patient's representative* to different physicians in the same specialty for the same condition are medically necessary. Services that are not medically necessary are uninsured.
2. If the physician rendering the service requests a referring physician, *nurse practitioner* or *dental surgeon* to submit a consultation request for that service after the service has been provided, a consultation is not payable. The visit fee appropriate to the service rendered may be claimed.
3. Where a physician who has been paid for a consultation for the patient for the same diagnosis makes a request for a referral for ongoing management of the patient, the service rendered following the referral is not payable as a consultation, except as outlined in the Virtual Care Services section under definitions, part 3, commentary 3]

A consultation includes the services necessary to enable the consultant to prepare a written report (including findings, opinions, and recommendations) to the referring physician, *nurse practitioner* or *dental surgeon.* Where the *referral* is made by a *nurse practitioner,* the consultant shall provide the report to the *nurse practitioner* and the patient's primary care provider, if applicable. Except where otherwise specified, the consultant is required to perform a general, specific or medical specific assessment, including a review of all relevant data.

The following are additional requirements for a consultation:

- **a.** A copy of the written request for the consultation, signed by the referring physician, *nurse practitioner* or *dental surgeon* must be kept in the consulting physician's medical record, except in the case of a consultation which occurs in a hospital, long-term care institution or multi-specialty clinic where common medical records are maintained. In such cases, the written request may be contained on the common medical record.
- **b.** The request identifies the consultant by name and/or the specialty being consulted, the referring physician, *nurse practitioner* or *dental surgeon* by name and billing number, and identifies the patient by name and health number.
- **c.** The written request sets out the information relevant to the *referral* and specifies the service(s) required.

In the event these requirements are not met, the amount payable for a consultation will be reduced to a lesser assessment fee.

CONSULTATIONS

[Commentary:
The request would ordinarily also include appropriate clinical information, such as the reason for the *referral* for consultation, present and past history, physical findings and relevant test results and reports.]

Payment rules:

1. Consultations rendered to the same patient by the same physician for the same diagnosis are limited to one service per two consecutive *12 month periods* except:
   - **a.** When the additional consultation service(s) is a repeat consultation;
   - **b.** When a consultant has rendered a consultation service to a patient in any location and the same consultant is referred to the same patient a second time with the same diagnosis, then the number of consultations eligible for payment is a total of two services per two consecutive *12 month periods* only when:
     - **i.** the second consultation is rendered for a hospital inpatient or a patient in an Emergency Department; and
     - **ii.** the consultation is rendered more than 12 *months* but less than 24 *months* following the first consultation.

   See the Table below.

Limits on Consultation Services Rendered for the Same Problem Within Two Consecutive 12 Month Periods

Patient location where consultation rendered		**Total consultation services eligible for payment in two consecutive 12 month periods**	
First consultation	**Second consultation**	**Services rendered within first 12 months**	**Services rendered between 12 and 24 months**
All locations	Hospital Inpatient or Emergency Department	One service	One service
All locations	All locations except hospital inpatient or Emergency Department	One service	

2. Consultations rendered to the same patient by the same consultant with a clearly defined unrelated diagnosis are limited to one service every 12 *months.*
3. The amount payable for consultations will be adjusted to the amount payable for a general or specific assessment, depending upon the specialty of the consultant where:

CONSULTATIONS

a. consultations are in excess of the above limits;

b. the payment requirements of a repeat consultation are not met; or

c. the consultation is requested by a Medical Trainee.

Note:

1. The above limits are applicable to all consultations, including time-based and age-specific consultation services (e.g. special, extended and comprehensive consultations) but not repeat consultations.

2. In the preoperative preparation of a patient undergoing the following low risk elective surgical procedures under local anaesthesia and/or I.V. sedation, a preoperative consultation by any physician is *only eligible for payment* where the medical record demonstrates the consultation is medically necessary.

a. cataract surgery;

b. colonoscopy;

c. cystoscopy;

d. carpal tunnel surgery; or

e. arthroscopic surgery.

[Commentary:
Such medically necessary consultations would be very uncommon.]

GENERAL PREAMBLE

CONSULTATIONS

REPEAT CONSULTATION

Definition/Required elements of service:

A repeat consultation is an additional consultation rendered by the same consultant, in respect of the same presenting problem, following care rendered to the patient by another physician in the interval following the initial consultation but preceding the repeat consultation.

A repeat consultation has the same requirements as a consultation including the requirement for a new written request by the referring physician, *nurse practitioner* or *dental surgeon.*

LIMITED CONSULTATION

Definition/Required elements of service:

A limited consultation is a consultation which is less demanding and, in terms of time, normally requires substantially less of the physician's time than the full consultation. Otherwise, a limited consultation has the same requirements as a full consultation.

Under the heading of "Family Practice & Practice in General", a limited consultation is the service rendered by any physician who is not a *specialist*, where the service meets all the requirements for a consultation but, because of the nature of the *referral*, only those services which constitute a specific assessment are rendered.

EMERGENCY DEPARTMENT (ED) PHYSICIAN CONSULTATION

Payment rules:

1. The amount payable for a consultation by an ED Physician will be adjusted to a lesser assessment fee under either of the following circumstances:
   - **a.** the patient is referred by another ED physician in the same hospital; or
   - **b.** the service is rendered in any location other than the emergency department or other critical care area in a hospital, or to a critically ill patient in a hospital.
2. ED reports constitute adequate documentation of the written report of the consultation as long as the rendering of all *constituent elements* is clearly documented on all copies of the report. If the consulting physician fails to ensure that a copy of the ED report is sent to the physician or *nurse practitioner* who referred the patient, the amount payable for the service will be adjusted to the amount payable for an assessment.

Claims submission instruction:

Claims for ED Physician consultations are to be submitted using H055 for a *specialist* in emergency medicine (FRCP) and H065 for all other physicians.

SPECIAL SURGICAL CONSULTATION

Definition/Required elements of service:

A special surgical consultation is rendered when a surgeon provides all the appropriate elements of a regular consultation and spends a minimum of 50 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

GENERAL PREAMBLE

CONSULTATIONS

[Commentary:
Unless otherwise specified in the *Schedule*, the calculation of time excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultation and (2) non-patient-facing time such as time spent reviewing charts, imaging, or documentation, etc.]

Claims submission instruction:

Claims for special surgical consultations are to be submitted using either A935 or C935, as applicable.

GENERAL PREAMBLE

ASSESSMENTS

Specific requirements for assessments listed in the "Consultations and Visits" section of the *Schedule* are set out below:

GENERAL ASSESSMENT

Definition/Required elements of service:

A general assessment is a service, rendered at a place other than in a patient's *home* that requires a full history (the elements of which must include a history of the presenting complaint, family medical history, past medical history, social history, and a functional inquiry into all body parts and systems), and, except for breast, genital or rectal examination where not medically indicated or refused, an examination of all body parts and systems, and *may include* a detailed examination of one or more parts or systems.

Payment rules:

General assessments are limited to one per patient per physician per *12 month period* unless either of the following circumstances is met in which case the limit is increased to two per *12 month period*:

1. the patient presents a second time with a complaint for which the diagnosis is clearly different and unrelated to the diagnosis made at the time of the first general assessment; or
2. at least 90 days have elapsed since the date of the last general assessment and the second assessment is a hospital admission assessment.

The amount payable for general assessments in excess of these limits will be adjusted to a lesser assessment fee.

PERIODIC HEALTH VISIT

Definition: A periodic health visit (including a primary or secondary school examination) is performed on a patient, after their second birthday, who presents and reveals no apparent acute physical or mental illness. The service must include an intermediate assessment, a level 2 paediatric assessment or a partial assessment focusing on age and gender appropriate history, physical examination, health screening and relevant counselling.

Payment rules:

Periodic health visit is limited to one per patient per *12 month period* per physician.

> **[Commentary:**
> Periodic health visits in excess of the limit are not insured.]

Claims submission instruction:

Submit claims for periodic health visits using the fee codes listed below.

No diagnostic code is required unless otherwise specifically listed.

ASSESSMENTS

Family Practice & Practice in General

Code	Description
K017	*child*
K130	*adolescent*
K131	*adult* age 18 to 64 inclusive
K132	*adult* 65 years of age and older
K133	*adult* with Intellectual and Developmental Disability (IDD)

Paediatrics

Code	Description
K269	12 to 17 years
K267	2 to 11 years

GENERAL RE-ASSESSMENT

Definition/Required elements of service:

A general re-assessment includes all the services listed for a general assessment, with the exception of the patient's history, which need not include all the details already obtained in the original assessment.

Payment rules:

With the exception of general re-assessments rendered for hospital admissions, general re-assessments are limited to two per *12 month period*, per patient per physician. The amount payable for general re-assessments in excess of this limit will be adjusted to a lesser assessment fee.

ASSESSMENTS

SPECIFIC ASSESSMENT AND MEDICAL SPECIFIC ASSESSMENT

Definition/Required elements of service:

Specific assessment and medical specific assessment are services rendered by *specialist*s, in a place other than a patient's *home*, and require a full history of the presenting complaint and detailed examination of the affected part(s), region(s), or system(s) needed to make a diagnosis, and/or exclude disease, and/or assess function.

Payment rules:

Specific assessments or medical specific assessments are limited to one per patient per physician per *12 month period* unless either of the following circumstances are met in which case the limit is increased to two per patient per physician per *12 month period*:

1. the patient presents a second time with a complaint for which a clearly different diagnosis is made, unrelated to the diagnosis made at the time of the first specific assessment in that *12 month period*; or
2. in the case of a medical specific assessment, at least 90 days have elapsed since the date of the last specific assessment and the second assessment is a hospital admission assessment.

The amount payable for specific or medical specific assessments in excess of this limit will be adjusted to a lesser assessment fee.

In addition, any combination of medical specific assessments and complex medical specific re-assessments (see below) are limited to 4 per patient per physician per *12 month period*. The amount payable for these services in excess of this limit will be adjusted to a lesser assessment fee.

SPECIFIC RE-ASSESSMENT AND MEDICAL SPECIFIC RE-ASSESSMENT

Definition/Required elements of service:

Specific re-assessment and medical specific re-assessment are services rendered by *specialist*s and require a full, relevant history and physical examination of one or more systems.

[Commentary:
As outlined on page GP40, admission assessments are deemed to be a specific re-assessment or medical specific re-assessment under either of the following circumstances:

1. for those procedures prefixed with a "Z" or noted as an *IOP*, by a surgical *specialist* who has assessed the patient prior to admission in respect of the same illness; or

2. for those patients who have been assessed by a physician and subsequently admitted to the hospital for the same illness by the same physician.]

Payment rules:

Specific re-assessments or medical specific re-assessments are limited to two per patient per physician per consecutive *12 month period* except for specific re-assessments rendered for hospital admissions. The amount payable for specific or medical specific re-assessments in excess of this limit will be adjusted to a lesser assessment fee.

ASSESSMENTS

COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT

Definition/ Required elements of service:

A complex medical specific re-assessment is a re-assessment of a patient because of the complexity, obscurity, or seriousness of the patient's condition and includes all the requirements of a medical specific re-assessment. The physician must report his/her findings, opinions, or recommendations in writing to the patient's primary care physician or the amount payable for the service will be adjusted to a lesser assessment fee.

Payment rules:

Complex medical specific re-assessments are limited to 4 per patient per physician per *12 month period*. The amount payable for complex medical specific re-assessments in excess of this limit will be adjusted to a lesser assessment fee.

In addition, any combination of medical specific assessments and complex medical specific re-assessments are limited to 4 per patient per physician per *12 month period*. The amount payable for these services in excess of this limit will be adjusted to a lesser assessment fee.

ASSESSMENTS

PARTIAL ASSESSMENT

Definition/ Required elements of service:

A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and appropriate record.

Chronic Disease Assessment Premium

Definition/ Required elements of service:

Chronic disease assessment premium is payable in addition to the amount payable for an assessment when all of the following criteria are met:

a. The assessment is a

- **i.** medical specific assessment;
- **ii.** medical specific re-assessment;
- **iii.** complex medical specific re-assessment;
- **iv.** partial assessment; or
- **v.** level 2 paediatric assessment

b. The service is rendered by a physician registered with *OHIP* as having one of the following specialty designations:

07(Geriatrics), 15(Endocrinology & Metabolism), 18(Neurology), 26(Paediatrics), 28(Pathology), 31(Physical Medicine), 34(Therapeutic Radiology), 44(Medical Oncology), 46(Infectious Disease), 47(Respiratory Disease), 48(Rheumatology), 61(Haematology), 62(Clinical Immunology).

c. The assessment is rendered in an office setting or an out-patient clinic located in a hospital, other than an emergency department.

[Commentary:
The chronic disease assessment premium is not payable for assessments rendered to in-patients of any hospital, patients seen in a long-term care facility or patients seen in an emergency department.]

d. The patient has an established diagnosis of a chronic disease, documented in the patient's medical record.

ASSESSMENTS

Payment rules:

The following is a list of the diagnostic codes as specified by *OHIP* that must accompany the claim for payment purposes:

Diagnostic Code	Description
042	AIDS
043	AIDS-related complex
044	Other human immunodeficiency virus infection
250	Diabetes mellitus, including complications
286	Coagulation defects (e.g. haemophilia, other factor deficiencies)
282	Hereditary hemolytic anemia (e.g., thalassemia, sickle-cell anemia)
287	Purpura, thrombocytopenia, other haemorrhagic conditions
290	Senile dementia, presenile dementia
299	*Child* psychoses or autism
313	Behavioural disorders of *child*hood and adolescence
315	Specified delays in development (e.g. dyslexia, dyslalia, motor retardation)
332	Parkinson's Disease
340	Multiple Sclerosis
343	Cerebral Palsy
345	Epilepsy
402	Hypertensive Heart Disease
428	Congestive Heart Failure
491	Chronic Bronchitis
492	Emphysema
493	Asthma, Allergic Bronchitis
515	Pulmonary Fibrosis
555	Regional Enteritis, Crohn's Disease
556	Ulcerative Colitis
571	Cirrhosis of the Liver
585	Chronic Renal Failure, Uremia
710	Disseminated Lupus Erythaematosus, Generalized Scleroderma, Dermatomyositis
714	Rheumatoid Arthritis, Still's Disease
720	Ankylosing Spondylitis
721	Other seronegative spondyloarthropathies
758	Chromosomal Anomalies
765	Prematurity, low-birthweight *infant*
902	Educational problems

[Commentary:
The chronic disease assessment premium is not payable in situations where the diagnosis has not been established.]

ASSESSMENTS

LEVEL 1 PAEDIATRIC ASSESSMENT

Definition/Required elements of service:

A Level 1 paediatric assessment includes one or both of the following:

a. a brief history and examination of the affected part or region or related to a mental or emotional disorder; or

b. brief advice or information regarding health maintenance, diagnosis, treatment and/or prognosis.

LEVEL 2 PAEDIATRIC ASSESSMENT

Definition/Required elements of service:

A Level 2 paediatric assessment is a paediatric service that requires a more extensive examination than a level 1 paediatric assessment. It requires a history of the presenting complaint(s), inquiry concerning, and examination of the affected part(s), region(s), system(s), or mental or emotional disorder as needed to make a diagnosis, exclude disease, and/or assess function.

A Level 2 paediatric assessment also includes well baby care, which is a periodic assessment of a well *newborn*/*infant* during the first two years of life including complete examination with weight and measurements, and instructions to the parent(s) or *patient's representative* regarding health care.

INTERMEDIATE ASSESSMENT

Definition/Required elements of service:

An intermediate assessment is a primary care general practice service that requires a more extensive examination than a minor assessment. It requires a history of the presenting complaint(s), inquiry concerning, and examination of the affected part(s), region(s), system(s), or mental or emotional disorder as needed to make a diagnosis, exclude disease, and/or assess function.

INTERMEDIATE ASSESSMENT – PRONOUNCEMENT OF DEATH

Definition/Required elements of service:

Intermediate assessment – pronouncement of death is the service of pronouncing a patient dead in a location other than in the patient's *home*. This service *may include* any counselling of relatives that is rendered during the same visit, and completion of the death certificate.

[Commentary:

1. For pronouncement of death in the *home*, see house call assessments (page A6 of the *Schedule*).

2. Submit the claim for this service using the diagnostic code for the underlying cause of death, as recorded on the death certificate, rather than the immediate cause of death.]

MINOR ASSESSMENT

Definition/Required elements of service:

A minor assessment includes one or both of the following:

a. a brief history and examination of the affected part or region or related to a mental or emotional disorder; or

b. brief advice or information regarding health maintenance, diagnosis, treatment and/or prognosis.

ASSESSMENTS

PERIODIC OCULO-VISUAL ASSESSMENT

Definition/Required elements of service:

A periodic oculo-visual assessment is an examination of the eye and vision system rendered primarily to determine if a patient has a simple refractive error (defined as myopia, hypermetropia, presbyopia, anisometropia or astigmatism) for patients aged 19 or less or aged 65 or more. This service includes all components required to perform the assessment (ordinarily a history of the presenting complaint, past medical history, visual acuity examination, ocular mobility examination, slit lamp examination of the anterior segment, ophthalmoscopy, tonometry) advice and/or instruction to the patient and provision of a written refractive prescription if required.

Payment rules:

1. This service is limited to one per patient per *12 month period* regardless of whether a periodic oculo-visual assessment is rendered by the same physician, a different physician, or when the service is rendered by an optometrist described as a “major oculo-visual examination” in the *Schedule* of Benefits for Optometry Services. Services in excess of this limit or to patients aged 20 to 64 are not insured services.
2. Any other insured service rendered by the same physician (other than an ophthalmologist) to the same patient the same day as a periodic oculo-visual assessment is *not eligible for payment*.

[Commentary:

1. Other consultation and visit codes are not to be used as a substitute for this service when the limit is reached.
2. Re-assessment following a periodic oculo-visual assessment is to be claimed using a lesser assessment fee code and diagnostic code 367.]

FIRST VISIT BY PRIMARY CARE PHYSICIAN AFTER HOSPITAL DISCHARGE

E080 First visit after hospital discharge premium, to other service listed in payment rule 5 below ..... add 25.90

Payment rules:

1. Subject to payment rules 2 through 5, E080 is *only eligible for payment* for a visit with the patient's primary care physician in the physician’s office or the patient’s *home* within two *week*s of discharge following in-patient admission to an acute care hospital.

[Commentary:

This premium is not payable for visits rendered to patients in locations other than the physician's office or patient's *home*. As such, the premium is not payable for services rendered in places such as Nursing *Home*s, *Home*s for the Aged, chronic care hospitals, etc.]

2. E080 is *not eligible for payment* if the admission to hospital was for the purpose of obstetrical delivery unless the mother required admission to an ICU during the hospital stay.
3. E080 is *not eligible for payment* if the admission to hospital was for the purpose of *newborn* care unless the *infant* required admission to a NICU during the hospital stay.
4. E080 is *not eligible for payment* if the admission to hospital was for the purpose of performing day surgery.
5. E080 is *only eligible for payment* when rendered with the following services:
   A001, A003, A004, A007, A008, A261, A262, A263, A264, A888, A900, K004–K008, K013, K014, K022, K023, K028-K030, K032, K033, K037, K623, P003, P004, P008.

ASSESSMENTS

DETENTION

Definition/Required elements of service:

Detention is payable following another insured service when a physician is required to spend considerable extra time in active treatment and/or monitoring of the patient to the exclusion of all other work and in this section is based on 15-minute, or major part thereof, time units. The *specific elements* are those for assessments.

K001 Detention – per 15 minutes or major part thereof..... 21.10

Payment rules:

1. Detention is payable under the following circumstances:

GENERAL PREAMBLE

ASSESSMENTS

Service	Minimum time required in delivery of service before detention is payable
minor, partial, multiple systems assessment, level 1 and level 2 paediatric assessment, intermediate assessment, focused practice assessment or subsequent hospital visit	30 minutes
specific or general re-assessment	40 minutes
consultation, repeat consultation, specific or general assessment, complex dermatology assessment, complex endocrine neoplastic disease assessment, complex infectious disease assessment, complex neurological assessment, complex physiatry assessment, complex respiratory assessment, enhanced 18 *month* well baby visit, midwife or aboriginal midwife-requested anaesthesia assessment, midwife or aboriginal midwife-requested assessment, midwife or aboriginal midwife-requested genetic assessment, optometrist-requested assessment, optometrist-requested assessment for uveitis and ocular inflammatory diseases, optometrist-requested assessment for neuro-ophthalmic disorders, retinopathy of prematurity (ROP) assessment, special ophthalmologic assessment, complex rheumatology assessment, focused practice consultation, or focused practice repeat consultation	60 minutes
initial assessment-substance abuse, special community medicine consultation, special family and general practice consultation, special optometrist-requested assessment, special *palliative care* consultation, special surgical consultation, midwife or aboriginal midwife-requested special assessment, advanced dermatology consultation, neuro-ophthalmology consultation, uveitis and ocular inflammatory disease consultation, focused practice special consultation, special anaesthetic consultation, special interventional radiological consultation, or special Medical Assistance in Dying consultation	90 minutes

ASSESSMENTS

Service	Minimum time required in delivery of service before detention is payable
comprehensive cardiology consultation, comprehensive community medicine consultation, comprehensive endocrinology consultation, comprehensive family and general practice consultation, comprehensive geriatric consultation, comprehensive infectious disease consultation, comprehensive internal medicine consultation, comprehensive laboratory medicine consultation, comprehensive midwife or aboriginal midwife-requested genetic assessment, comprehensive nephrology consultation, comprehensive laboratory medicine consultation, comprehensive respiratory disease consultation, comprehensive physical medicine and rehabilitation consultation, comprehensive rheumatology consultation, special paediatric consultation, special genetic consultation, special neurology consultation, focused practice comprehensive consultation, comprehensive critical care medicine consultation, or comprehensive nuclear medicine consultation	120 minutes
extended comprehensive geriatric consultation, extended midwife or aboriginal midwife-requested genetic assessment, extended special genetic consultation, extended special paediatric consultation, paediatric neurodevelopmental consultation, or extended special neurology consultation	180 minutes

2. Detention is *not eligible for payment* in conjunction with diagnostic procedures, obstetrics, and those therapeutic procedures where the fee includes an assessment (e.g. non-*IOP* surgery).
3. Detention is *not eligible for payment* for time spent waiting.
4. For the purposes of calculation of time units payable for detention, the start time commences after the minimum time required for the assessment or consultation listed in the table has passed.
5. K001 is *not eligible for payment* for same patient same day as A190, A191, A192 A195, A197, A198, A695, A795 or A895.

Claims submission instructions:
Claims for detention are assessed by a *medical consultant* on an IC basis and require the submission of a written explanation.

ASSESSMENTS

DETENTION-IN-AMBULANCE

Definition/Required elements of service:

Detention-in-Ambulance is payable for constant attendance with a patient in an ambulance, to provide all aspects of care to the patient. Time is calculated only for that period during which the physician is in constant attendance with the patient in the ambulance. The service includes an initial examination and ongoing monitoring of the patient's condition and all interventions, except in those circumstances in which the *Schedule* provides for separate or additional payment for the intervention.

K101	Ground ambulance transfer with patient per 15 minutes or major part thereof	60.00
K111	Air ambulance transfer with patient per 15 minutes or major part thereof	60.00
K112	Trip to collect patient or return trip without patient to place of origin following air or ground ambulance transfer, per 15 minutes or major part thereof	21.10

Claims submission instruction:

Claims for Detention-in-Ambulance are assessed by a *medical consultant* on an IC basis and require the submission of a written explanation.

[Commentary:
K101 is not applicable to attendance in a vehicle other than an ambulance, in which case K001 may apply.]

DETENTION FOR THE TRANSPORT OF DONOR ORGANS

Definition/Required elements of service:

Detention for the Transport of Donor Organs is payable for time travelling to and from a donor centre (excluding time spent in the donor centre) for the purpose of collecting and transporting to the recipient hospital (a) donor organ(s), including fresh bone being harvested.

K102	per 15 minutes or major part thereof (*not eligible for payment* with K001)	20.20

Claims submission instruction:

Claims for Detention for the Transport of Donor Organs are assessed by a *medical consultant* on an IC basis and require the submission of a written explanation.

[Commentary:
Claims will be adjudicated on the basis of the most time-efficient means of travel to and from a donor centre.]

NEWBORN CARE

Definition/Required elements of service:

Newborn care is the routine care of a well *newborn* for up to the first ten days of life in hospital or *home* and includes an initial general assessment and subsequent assessments, as may be indicated, and instructions to the caregiver(s) regarding the *newborn*'s health care.

ASSESSMENTS

Payment rules:

1. *Newborn* care is limited to a maximum of one per patient except when a well baby is transferred to another hospital in which case the fee for *newborn* care may be payable to a physician at both hospitals.

   [Commentary:
   An example where this is possible is if the transfer occurred because of the state of health of the mother.]

2. Despite the requirement that to be eligible for a special visit premium the call be non-elective (see GP65), a special visit premium is payable in addition to this service if a physician is required to make an additional visit to the hospital outside of his or her normally scheduled hospital rounds to facilitate discharge of the *newborn* the same day as the visit.

ASSESSMENTS

WELL BABY CARE

Definition/Required elements of service:

Well baby care is a periodic assessment of a well *newborn*/*infant* during the first two years of life including complete examination with weight and measurements, and instructions to the parent(s) or *patient's representative* regarding health care.

ENHANCED 18 MONTH WELL BABY VISIT

Definition/Required elements of service:

Enhanced 18 *month* well baby visit is the service rendered when a physician performs all of the following in respect of a *child* from 17-24 *month*s of age:

a. Those services defined as "well baby care";

b. An 18 *month* age-appropriate developmental screen; and

c. Review with the patient's parent/guardian, legal representative or other caregiver of a brief standardized tool (completed by the patient's parent/guardian, legal representative or other caregiver) that aids the identification of *child*ren at risk of a developmental disorder.

Medical record requirements:
This service is eligible for payment only when, in addition to the medical record requirements for well baby care, an 18 *month* age-appropriate developmental screen and concerns identified from the review of the brief standardized tool with the parent/guardian, legal representative or other caregiver are recorded in the patient's permanent medical record.

[Commentary:
An example of an 18 *month* age-appropriate developmental screen would be that outlined in the Rourke Baby Record and an example of a brief standardized tool completed by the parent/guardian, legal representative or other caregiver that aids the identification of *child*ren at risk of a developmental disorder would be the Nipissing District Developmental Screen or similar parental questionnaire.]

PSYCHIATRIC ASSESSMENT UNDER THE MENTAL HEALTH ACT

Definition/Required elements of service:

A psychiatric assessment under the *Mental Health Act* (K620, K623, K624, and K629) includes such psychiatric history, inquiry, and examination of the patient, as is appropriate, to enable the physician to complete, and includes completing, the relevant forms and to notify the patient, family, *patient representative* and relevant authorities under the *Mental Health Act*, where appropriate.

GENERAL PREAMBLE

ASSESSMENTS

E-Assessments

Definition/Required elements of service:

An e-assessment is a service performed by a *specialist* when a primary care physician or *nurse practitioner* requests an opinion and/or recommendations from the *specialist* for management of a specific patient by providing information electronically through a secure server (e.g. secure messaging, EMR). The *specialist* is required to review all relevant data provided by the primary care physician or *nurse practitioner,* including the review of any additional information that may be submitted subsequent to the initial request. For the purpose of this service, "relevant data" *may include* family/patient history, history of the presenting complaint, laboratory and diagnostic tests, and visual images where indicated.

In addition to the *Common Elements*, E-assessments include the *specific elements* of assessments, as listed in the General Preamble, except for paragraphs A and B.

Payment rules:

1. E-assessments are *only eligible for payment* if the *specialist* has provided an opinion and/or recommendations for patient management to the primary care physician or *nurse practitioner* within 30 days from the date of the request. Where a service is requested by a *nurse practitioner* the consultant shall provide the report to the *nurse practitioner* and the patient's primary care provider, if applicable.

2. E-assessments are *not eligible for payment* to the *specialist* in the following circumstances

- **a.** when the purpose of the electronic communication is to arrange for transfer of the patient's care to any physician; or
- **b.** when rendered in whole or in part to arrange for a consultation, a different assessment, visit, or K-prefix time-based services, procedure(s), or diagnostic investigation(s); or
- **c.** when the *specialist* renders a K-prefix time-based service for the same patient within 30 days following the request for the *specialist* e-assessment; or
- **d.** in circumstances where the primary care physician or *specialist* receives compensation, other than by fee-for service under this *Schedule*, for participation in the e-assessment.

3. A consultation, a different assessment or visit rendered by the *specialist* for the same patient for the same diagnosis within 60 days following the request for the *specialist* e-assessment is only payable as a specific or partial assessment, as appropriate to the service rendered.

4. K738 is eligible for payment to the primary care physician when this physician is required to collect additional data (for example dermatology or ophthalmology images not present in the primary care physician's records) to support the *specialist*'s e-assessment. K738 is *not eligible for payment* where existing data is already available in the primary care physician's records for submission to the *specialist*.

[Commentary:

1. Following the primary care physician's request, the *specialist* decides whether an e-assessment is the most appropriate service in the circumstances. In some cases, direct patient contact or a consultation by videoconference may be more appropriate.

2. Payment, other than by fee-for-service, includes compensation where the physician receives remuneration under a salary, primary care, stipend, APP or AFP model.

3. Physicians who receive compensation other than by fee-for-service under this *Schedule* should consult their contract for guidance on shadow-billing.]

ASSESSMENTS

Medical record requirements:
An e-assessment is *only eligible for payment* if all of the following elements are included in the patient's permanent medical record of the *specialist*:

1. patient's name and health number;
2. name of the primary care physician or *nurse practitioner;*
3. date of, and reason for, the request; and
4. opinion, diagnosis, advice and/or recommendations of the *specialist*.

Claims submission instructions:
An e-assessment is *only eligible for payment* if the *specialist* includes the primary care physician's or *nurse practitioner's* provider number with the claim.

ASSESSMENTS

Initial E-ASSESSMENT

Definition/Required elements of service:

Initial e-assessment is the first e-assessment performed by a particular *specialist* that is requested by the primary care physician or *nurse practitioner* for a specific patient and diagnosis where the *specialist* must review all relevant data provided by the primary care physician and provide a written opinion that includes a diagnosis and/or management advice to the primary care physician or *nurse practitioner*.

[Commentary:
The time and intensity of this service is the same as a regular consultation. The *specialist* may choose to return their opinion by phone, however, a written opinion must be provided electronically or by mail.]

Payment rules:
Initial e-assessments are limited to a maximum of one per patient per *specialist* per *12 month period* unless the primary care physician or *nurse practitioner* makes a second request in relation to a complaint for which a clearly different diagnosis is made, unrelated to the diagnosis made at the time of the first e-assessment in that same *12 month period*, in which case the limit is increased to a maximum of two per patient per *specialist* per *12 month period*.

[Commentary:
If a subsequent e-assessment is related to the diagnosis made at the time of the initial e-assessment, then this service is payable as a repeat e-assessment, follow-up e-assessment or minor e-assessment as appropriate to the service rendered.]

REPEAT E-ASSESSMENT

Definition/ Required elements of service:

Repeat e-assessment is the first e-assessment performed by a particular *specialist* following an initial e-assessment or consultation by that *specialist* that is requested by the primary care physician or *nurse practitioner* for the same diagnosis where the *specialist* must review all relevant data provided by the primary care physician or *nurse practitioner* and provide an opinion that includes management advice to the primary care physician or *nurse practitioner*.

[Commentary:
The time and intensity of this service is the same as a specific assessment. The *specialist* may choose to return their opinion by phone.]

Payment rules:
Repeat e-assessments are limited to a maximum of one per patient per physician per *12 month period* unless the primary care physician or *nurse practitioner* makes a second request in relation to a complaint for which a clearly different diagnosis is made, unrelated to the diagnosis made at the time of the first e- assessment in that same *12 month period*, in which case the limit is increased to a maximum of two per patient per physician per *12 month period*.

ASSESSMENTS

Follow-up E-ASSESSMENT

Definition/ Required elements of service:

A follow-up e-assessment is the limited e-assessment rendered for follow-up by the *specialist* who has previously rendered any insured service to the patient for the same diagnosis. The *specialist* must review all relevant information submitted and provide an opinion and/or management advice to the primary care physician or *nurse practitioner*.

[Commentary:
The time and intensity of the service is the same as a partial assessment. The *specialist* may choose to return their opinion by phone.]

Payment rules:
Follow-up e-assessment is limited to a maximum of:

1. one (1) service per patient per day, same physician;

2. four (4) services per patient same physician per *12 month period*; and

3. one thousand (1000) services per physician per *12 month period*.

ASSESSMENTS

MINOR E-ASSESSMENT

Definition/ Required elements of service:

A minor e-assessment is a brief e-assessment rendered by the *specialist*. The *specialist* must review all relevant information submitted and provide an answer to the primary care physician's or *nurse practitioner's* specific clinical question.

Payment rules:

Minor e-assessment is limited to a maximum of:

1. one (1) service per patient per day, same physician;

2. twelve (12) services per patient same physician per *12 month period*; and

3. two thousand (2000) services per physician per *12 month period*.

[Commentary:

A minor e-assessment is where the primary care physician or *nurse practitioner* may ask a specific question related to the patient where the information provided is limited and the question asked is very specific. An example is where the primary care physician has initiated a treatment recommended by the *specialist*, and the primary care physician requests a brief email response related to proper dosing adjustments. One service *may include* multiple emails. The *specialist* may choose to return their opinion by phone.]

GENERAL PREAMBLE

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

ACUTE CARE HOSPITAL – NON-EMERGENCY IN-PATIENT SERVICES ("C" PREFIX SERVICES)

A. Admission Assessment – General Requirements

Definition:

a. An admission assessment is the initial assessment of the patient rendered for the purpose of admitting a patient to hospital.

b. The admitting physician is the physician who renders the admission assessment.

Payment rules:

1. Except as outlined below in paragraph 3, when the admitting physician has not previously assessed the patient for the same presenting illness within 90 days of the admission assessment, the admission assessment constitutes a consultation, general or medical specific or specific assessment depending on the specialty of the physician, the nature of the service rendered and any applicable payment rules.

2. Except as outlined below in paragraph 3, if the admitting physician has previously assessed the patient for the same presenting illness within 90 days of the admission assessment, the admission assessment constitutes a general re-assessment or specific re-assessment depending on the specialty of the physician, the nature of the service rendered and any applicable payment rules.

3. When a hospital in-patient is transferred from one physician to another physician, only one consultation, general or specific assessment or reassessment is eligible for payment per patient admission. The amount eligible for payment for services in excess of this limit will be adjusted to a lesser assessment fee. An additional admission assessment is *not eligible for payment* when a hospital inpatient is transferred from one physician to another physician within the same hospital.

Admission Assessments by Specialists:

When a patient has been assessed by a *specialist* in the emergency department (ED) or out-patient department (OPD) and that physician renders a service described as a consultation, specific assessment, or medical specific assessment and subsequently admits the patient to hospital, the initial consultation, specific, or medical specific assessment constitutes the admission assessment.

When a patient has been assessed by a *specialist* in the ED or OPD, and that physician renders any other assessment other than those listed in the paragraph immediately above, and that physician subsequently admits the patient to hospital, an admission assessment is eligible for payment in addition to the initial assessment, if each service is rendered separately.

[Commentary:
In accordance with the surgical preamble, a hospital admission assessment by the surgeon is *not eligible for payment*, unless it is the *major preoperative visit*]

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

Admission Assessments by General and Family Practitioners:

When a patient has been assessed by a general or family practitioner in the emergency department (ED) or out-patient department (OPD) and that physician renders a service described as a consultation, general assessment, or general re-assessment and subsequently admits the patient to hospital, the initial consultation, general assessment, general re-assessment constitutes the admission assessment.

When a patient has been assessed by a general or family practitioner in the ED or OPD and that physician renders any other assessment other than those listed in the paragraph immediately above, and subsequently admits the patient to hospital, an admission assessment is eligible for payment in addition to the initial assessment, if each assessment is rendered separately.

Payment rules:

A933/C933/C003/C004 are *not eligible for payment* for an admission assessment for an elective surgery patient when a pre-operative assessment has been rendered to the same patient within 30 days of admission by the same physician.

Admission Assessments by General and Family Practitioners in an Emergency Department Funded under an Emergency Department Alternative Funding Agreement:

When a patient has been assessed by the patient's general or family practitioner in an emergency department and that physician subsequently admits the patient to hospital, the General/Family Physician Emergency Department Assessment constitutes the admission assessment if the physician remains the *most responsible physician* for the patient.

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

Admission Assessments by Emergency Physicians:

When a patient has been assessed by an emergency physician in the ER or OPD and that physician renders a service described as a consultation, general assessment, or general re-assessment and subsequently admits the patient to hospital as the *most responsible physician* or that physician is asked to perform the admission assessment (even though the patient is admitted under a different *most responsible physician*), the initial consultation, general assessment, or general re-assessment constitutes the admission assessment.

When a patient has been assessed by an emergency physician in the ER or OPD and that physician renders any other assessment other than those listed in the paragraph immediately above, and subsequently renders the admission assessment, (even if the patient is admitted under a different *most responsible physician*), the admission assessment is payable as C004, in addition to the initial assessment, if both services are rendered separately.

Admission Assessment by the Most Responsible Physician (MRP) Premium

E082 Admission assessment by the MRP, to admission assessment ..... add 30%

Payment rules:

1. E082 is *only eligible for payment* once per patient per hospital admission.

2. E082 is *only eligible for payment*:

a. if the physician establishes that he or she does not receive any direct or indirect remuneration from a hospital or hospital foundation for rendering in-patient clinical services; or

b. where the physician receives any direct or indirect remuneration from a hospital or hospital foundation for rendering in-patient clinical services, if the physician establishes that such remuneration has been reduced by an amount equal to the amount that would be eligible for payment to the physician had he or she not received any such direct or indirect remuneration.

3. E082 is *not eligible for payment* for transfers within the same hospital.

4. E082 is not applicable to any other service or premium.

[Commentary:

1. E082 is *only eligible for payment* when the admitting physician is the *MRP*. If the *MRP* does not render the admission assessment, E082 is *not eligible for payment* for any service rendered by any physician during that hospital admission.

2. E082 is *not eligible for payment* for a patient admitted for obstetrical delivery or for a well *newborn*.

3. E082 is not applicable for any consultation or assessment related to day surgery.]

B. Subsequent Visit

Definition:

A subsequent visit is any routine assessment in hospital following the hospital admission assessment.

Attendance at Surgery: If, in the interest of the patient, the referring physician is asked to be present by the patient or the *patient's representative*, but does not assist at the procedure, the attendance at surgery by the referring physician constitutes a hospital subsequent visit.

Multidisciplinary care: Except where a single service for a team of physicians is listed in this *Schedule* (e.g. the *week*ly team fee for dialysis), when the complexity of the medical condition requires the services of several physicians in different disciplines, each physician visit constitutes a subsequent visit.

Payment rules:

1. Except in the circumstances outlined in paragraphs 2 and 3, or when a patient is referred from one physician to another (see Claims submission instruction below), subsequent visits are limited to one per patient, per day for the first 5 *week*s after admission, 3 visits per *week* from 6 to 13 *week*s after admission, and 6 visits per *month* after 13 *week*s. Services in excess of the limit are *not eligible for payment*.
2. After 5 *week*s of hospitalization, any assessment in hospital required as a result of an acute intercurrent illness in excess of the *week*ly or *month*ly limits set out above constitutes C121 – "additional visit due to intercurrent illness". The *week*ly or *month*ly limits set out above do not apply to additional visits due to intercurrent illness.
3. Pediatric subsequent visits (C262) are limited to one per patient, per day for the duration of the admission.
4. When a physician is already in the hospital and assesses one of his/her own patients or patients transferred to his/her care, the service constitutes a subsequent visit. If a physician assesses another physician's patient on an emergency basis, the General Listings ("A" prefix) apply.

Claims submission instruction:

When a hospital in-patient is referred from one physician to another physician, the date the second physician assessed the patient for the first time is considered the "admission date" for the purposes of determining the appropriate subsequent visit fee code.

[Commentary:
When a hospital in-patient is transferred from one physician to another physician, subsequent visits by the second physician are calculated based on the actual admission date of the patient.]

C. Subsequent visit by the Most Responsible Physician (MRP)

Subsequent visit by the MRP – day following the hospital admission assessment (C122)

Definition:

Subsequent visit by the *MRP* - day following the hospital admission assessment is payable to the physician identified as the patient's *MRP* for rendering a subsequent visit on this day.

Subsequent visit by the MRP – second day following the hospital admission assessment (C123)

Definition:

Subsequent visit by the *MRP* - second day following the hospital admission assessment is payable to the physician identified as the patient's *MRP* for rendering a subsequent visit on this day.

Payment rules:

1. C122, C123 are limited to a maximum of one each per hospital admission.

   [Commentary:
   C122, C123 are only payable for visits rendered by the *MRP*. Services rendered by physicians who are not the *MRP* may be payable at a lesser visit fee.]

2. C122, C123 are *not eligible for payment*:
   a. when rendered to the same patient the same day as C124 or C126 (Subsequent visit by the *MRP* - day of discharge); or
   b. for a patient admitted for obstetrical delivery or *newborn* care;
3. When a patient is transferred to another physician within the same hospital during either of these days, C122 or C123 are only payable to the physician who was the *MRP* for the majority of the day.
4. When a patient is transferred to another physician at a different hospital, the day of transfer shall be deemed for payment purposes to be the day of admission.
5. Only one of C122 or C142 is eligible for payment for the same patient during the same hospital admission. Only one of C123 or C143 is eligible for payment for the same patient during the same hospital admission.

   [Commentary:
   For first and second subsequent visits by the *MRP* following transfer from an Intensive Care Area (C142, C143), see General Preamble page GP46.]

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

Subsequent visit by the MRP - day of discharge (C124)

Definition/Required elements of service:

Subsequent visit by the *MRP* – day of discharge is payable to the physician identified as the *MRP* for rendering a subsequent visit on the day of discharge, and, in addition, requires completion of the discharge summary by the physician within 48 hours of discharge, arranging for follow-up of the patient (as appropriate) and prescription of discharge medications if any.

The discharge summary must include as a minimum the following information:

- **a.** reason for admission;
- **b.** procedures performed during the hospitalization;
- **c.** discharge diagnosis; and
- **d.** medications on discharge.

Payment rules:

1. C124 is only payable to the *MRP* and limited to one service per hospital admission.

2. C124 is *not eligible for payment* under any of the following circumstances:

- **a.** The patient was discharged within 48 hours of admission to hospital (calculated from the actual date of admission to hospital);
- **b.** The admission was for obstetrical delivery unless the mother required admission to an ICU, with subsequent transfer and discharge from another unit within the hospital during the hospital stay;
- **c.** The admission was for *newborn* care unless the *infant* was admitted to a NICU, with subsequent transfer and discharge from another unit within the hospital during the hospital stay;
- **d.** For transfers within the same hospital; or
- **e.** For discharges directly from a NICU or ICU where NICU or ICU critical care per diem services were rendered the same day.

[Commentary:

In the case of conflicting claims for this service, the physician to whom the patient has rostered (virtual or actual) may receive the payment for the service.]

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

D. First subsequent visit by the MRP following transfer from an Intensive Care Area

First subsequent visit by the MRP following transfer from an Intensive Care Area (C142)

Definition:

First subsequent visit by the *MRP* following patient's transfer from an Intensive Care Area (including Neonatal Intensive Care) where the patient was receiving Critical Care, Ventilatory Support, Comprehensive Care or Neonatal Intensive Care services immediately prior to the time of the transfer to an acute care hospital bed in the same hospital.

Second subsequent visit by the MRP following transfer from an Intensive Care Area (C143)

Definition:

Second subsequent visit by the *MRP* following patient's transfer from an Intensive Care Area (including Neonatal Intensive Care) where the patient was receiving Critical Care, Ventilatory Support, Comprehensive Care or Neonatal Intensive Care services immediately prior to the time of the transfer to an acute care hospital bed in the same hospital.

Payment rules:

1. C142, C143 are limited to a maximum of one each per hospital admission.

   [Commentary:
   1. C142, C143 are only payable for visits rendered by the *MRP*. Services rendered by physicians who are not the *MRP* may be eligible for payment at a lesser visit fee.
   2. C142 or C143 are *not eligible for payment* for visits rendered to patients who were in an Intensive Care Area only for monitoring purposes.]
2. C142, C143 are *not eligible for payment* to the same physician who rendered Critical Care, Ventilatory Support, Comprehensive Care or Neonatal Intensive Care services prior to the patient's transfer.
3. Only one of C122 or C142 is eligible for payment for the same patient during the same hospital admission. Only one of C123 or C143 is eligible for payment for the same patient during the same hospital admission.

   [Commentary:
   For Subsequent visit by the *MRP* – first and second day following the hospital admission assessment (C122, C123), see General Preamble page GP44.]
4. C142, C143 are *not eligible for payment* when rendered to the same patient the same day as C124 or C126 (Subsequent visit by the *MRP* – day of discharge)
5. When a patient is transferred to another physician within the same hospital, C142 or C143 are only payable to the physician who was the *MRP* for the majority of the day of the transfer.

E. Subsequent visit and palliative care visit by the MRP premium

E083 Subsequent visit by the MRP, to subsequent visits and C121, C122, C123, C124, C126, C142, C143, C882 or C982 add 30%

E084 Saturday, Sunday or *Holiday* subsequent visit by the MRP, to subsequent visits and C121, C122, C123, C124, C126, C142, C143, C882 or C982.....Add 45%

Payment rules:

1. E084 is *only eligible for payment* for subsequent visits provided on Saturdays, Sundays and *holidays*.

2. Only one of E083 or E084 is *eligible for payment* per patient per day.

3. E084 is *only eligible for payment* when the MRP is from one of the following specialties: 00 (Family Practice and Practice in General), 02 (Dermatology), 07 (Geriatrics), 11 (Critical Care Medicine), 12 (Emergency Medicine), 13 (Internal Medicine),15 (Endocrinology & Metabolism), 16 (Nephrology), 18 (Neurology), 72 (Occupational Medicine), 19 (Psychiatry), 22 (Genetics), 26 (Paediatrics), 28 (Pathology), 31 (Physical Medicine), 34 (Radiation Oncology), 41 (Gastroenterology), 44 (Medical Oncology), 46 (Infectious Disease), 47 (Respiratory Disease), 48 (Rheumatology), 60 (Cardiology), 61 (Haematology), 62 (Clinical Immunology).

4. E083 or E084 are *only eligible for payment*:

a. if the physician establishes that he or she does not receive any direct or indirect remuneration from a hospital or hospital foundation for rendering in-patient clinical services; or

b. where the physician receives any direct or indirect remuneration from a hospital or hospital foundation for rendering in-patient clinical services, if the physician establishes that such remuneration has been reduced by an amount equal to the amount that would be eligible for payment to the physician had he or she not received any such direct or indirect remuneration.

5. E083 or E084 are *not eligible for payment* for *palliative care* visits to patients in designated *palliative care* beds in Long-Term Care Institutions.

6. E083 or E084 are not applicable to any other service or premium.

[Commentary:

1. E083 or E084 are *only eligible for payment* with subsequent visits and *palliative care* visits rendered by the *MRP*.

2. Examples of subsequent visits eligible for payment with E083 are C002, C007, C009, C132, C137, C139, C032, C037 or C039. Examples of subsequent visits eligible for payment with E084 are C002, C007, C009, C132, C137, C139, C152, C157 or C159.

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

F. Concurrent Care

Definition/Required elements of service:

Concurrent care is any routine assessment rendered in hospital by the consultant following the consultant's first major assessment of the patient when the family physician remains the *most responsible physician* but the latter requests continued directive care by the consultant.

Payment rules:

Claims for concurrent care are limited to 4 per *week* during the first *week* of concurrent care, and 2 claims per *week* thereafter. Services in excess of this limit are *not eligible for payment*.

G. Supportive Care

Definition:

Supportive care is any routine visit rendered in hospital by the family physician who is not actively treating the case where:

- **a.** the patient is under the care of another physician;
- **b.** the supportive care is rendered at the request of the patient or family; and
- **c.** the care is provided for purposes of liaison or reassurance.

Payment rules:

Claims for supportive care are limited to 4 per *week* during the first *week* of supportive care, determined from the date of the first supportive visit, and 2 claims per *week* thereafter. Services in excess of this limit are *not eligible for payment*.

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

LONG-TERM CARE INSTITUTION: NON-EMERGENCY IN-PATIENT SERVICES ("W" PREFIX SERVICES)

These services apply to patients in chronic care hospitals, convalescent hospitals, nursing *home*s, *home*s for the aged and designated chronic or convalescent care beds in hospitals other than patients in designated *palliative care* beds - “W” prefix services.

A. Admission Assessment

Type 1 Admission Assessment

Definition/Required elements of service:

A Type 1 admission assessment is a general assessment rendered to a patient on admission.

Payment rules:

If the physician has rendered a consultation, general assessment, or general re-assessment of the patient prior to admission, the amount payable for the service will be adjusted to a lesser fee.

Type 2 Admission Assessment

Definition/Required elements of service:

A Type 2 admission assessment occurs when the admitting physician makes an initial visit to assess the condition of the patient following admission and has previously rendered a consultation, general assessment or general re-assessment of the patient prior to admission.

Type 3 Admission Assessment

Definition/Required elements of service:

A Type 3 admission assessment is a general re-assessment of a patient who is re-admitted to the long-term care institution after a minimum 3 day stay in another institution.

B. Subsequent Visit

Definition:

A subsequent visit is any routine assessment following the patient’s admission to a long-term care institution.

Payment rules:

Claims for these subsequent visits are subject to the limits described with each individual service as found under the applicable specialty in the Consultations and Visits section.

Claims submission instructions:

1. Submit claims for acute intercurrent illnesses requiring visits other than special visits using W121. When acute intercurrent illness requires a special visit, submit claims using the appropriate fees under General Listings (“A” prefix) and premiums.

   [Commentary:
   Claims for W121 are payable for visits for acute intercurrent illness whenever rendered. Such claims are not dependent on whether the *month*ly limit on the number of subsequent visits has been reached.]

2. When a physician is already in the institution and is asked to assess one of his/her own in-patients, the subsequent visit listings (“W” prefix) apply. However, if he/she is already in the institution and asked to assess another physician’s patient on an emergency basis, submit claims using the General Listings (“A” prefix).

GENERAL PREAMBLE

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

EMERGENCY DEPARTMENT - "H" PREFIX EMERGENCY DEPARTMENT SERVICES

For the purpose of emergency department – "H" prefix emergency department services:

"Hospital Urgent Care Clinic" means a clinic operated by a hospital corporation that provides services similar to some or all of those provided by an emergency department but that is open to the public for less than 24 hours in any given 24 hour period.

"Emergency Department Physician" means a physician:

a. working in a hospital emergency department specifically for the purpose of rendering services to unscheduled patients who attend the emergency department to receive physician services; or

b. working in a Hospital Urgent Care Clinic specifically for the purpose of rendering services to unscheduled patients who attend the Hospital Urgent Care Clinic to receive physician services.

There are specific "H" prefix listings (H1 – codes) for consultations, multiple systems assessments, minor assessments, comprehensive assessment and care and re-assessments rendered by the Emergency Department Physician. With the exception of the consultation fee (where a specific fee code exists for a *specialist* in emergency medicine), any physician on duty (regardless of specialty) in the emergency department must submit using these listings.

The "H" prefix listings under the heading, "Emergency Department Physician" on pages A15, A16 in the Consultations and Visits section of the *Schedule*, apply in the following circumstances:

a. when a full- or part-time Emergency Department Physician is working for a pre-arranged designated period of time or shift; or

b. for services rendered by an on-call physician where the service does not qualify for claiming a special visit premium.

PALLIATIVE CARE ASSESSMENT

Definition: A palliative care assessment is any routine assessment rendered by the most responsible physician for the purpose of providing palliative care to a patient other than one in a designated palliative care bed at the time the assessment was rendered.

Claims submission instruction:

Submit claims for *palliative care* visits, other than those in designated *palliative care* beds, using the appropriate "C" or "W" prefix *palliative care* fee schedule codes.

[Commentary:

1. *Palliative care* visits to patients in designated *palliative care* beds, regardless of facility type, are to be claimed using C882 or C982, as applicable.

2. Services rendered to patients whose unexpected death occurs after prolonged hospitalization for another diagnosis unrelated to the cause of death do not constitute *palliative care* assessments.]

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

MONTHLY MANAGEMENT OF A NURSING HOME OR HOME FOR THE AGED PATIENT

Definition/Required Elements of Service:

*Month*ly Management of a Nursing *Home* or *Home* for the Aged Patient is the provision by the *most responsible physician* (*MRP*) of routine medical care, management and supervision of a patient in a nursing *home* or *home* for the aged for one calendar *month*. The service requires a minimum of two assessments of the patient each *month*, where these assessments constitute services described as "W" prefix assessments.

The requirements above are subject to the exceptions as described in payment rule #8.

> **[Commentary:**
> As with all services described as assessments, direct physical encounter with the patient is required.]

In addition to the *common elements*, this service includes the provision of the following services by any physician to the same patient during the *month*.

A. Services described by subsequent visits (e.g. W003, W008).

B. Services described by additional visits due to “intercurrent illness” (W121) except if the conditions described in Payment rule #7 are satisfied.

C. Services described by *palliative care* subsequent visits (e.g. W872).

D. Services described by admission assessments (e.g. W102, W104, W107).

E. Services described by periodic health visit or general re-assessments (e.g. W109, W004).

F. Services described by visit for pronouncement of death (W777) or certification of death (W771) except if the services are performed in conjunction with a special visit.

G. Service described by anticoagulation supervision (G271).

H. Completion of home care referral form and *home* care supervision (K070, K071, K072).

I. Services described by the following diagnostic and therapeutic procedures – venipuncture (G489), injection (G372, G373), immunization (G538, G590), collection of cervical cancer screening specimen(s) (G365, G394, E430, E431), intravenous (G379), and laboratory test codes (G001, G002, G481, G004, G005, G009, G010, G011, G012, G014).

J. All medication reviews.

K. All discussions with the staff of the institution related to the patient’s care.

L. All telephone calls from the staff of the institution, patient, patient’s relative(s) or *patient’s representative* in respect of the patient between the hours of 0700 hours and 1700 hours Monday to Friday (excluding *holiday*s).

M. Ontario Drug Benefit Limited Use prescriptions/forms or Section 8 *Ontario Drug Benefits Act* requests.

GENERAL PREAMBLE

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

MONTHLY MANAGEMENT OF A NURSING HOME OR HOME FOR THE AGED PATIENT

Payment rules:

1. Except as outlined in payment rule #8, this service is *only eligible for payment* once per patient per calendar *month*.
2. This service is *only eligible for payment* to the *MRP*.
3. When W010 is rendered, none of the services listed as a component of W010 and rendered to the patient by any physician during the *month* are eligible for payment.
4. In the temporary absence of the patient's *MRP* (e.g. while that physician is on vacation), W010 remains payable to the patient's *MRP* if the service is performed by another physician.
5. In the event the *MRP* renders one "W" prefix assessment in a calendar *month* and the same physician has rendered W010 to that patient within the previous 11-*month* period, only that "W" prefix assessment in that *month* is eligible for payment.
6. In the event the *MRP* renders two, three or four "W" prefix assessments in a calendar *month* and the same physician has rendered W010 to that patient within the previous 11-*month* period, only W010 is eligible for payment.
7. In the event the *MRP* renders more than four "W" prefix assessments to the same patient in a *month* and the same physician has rendered W010 to that patient within the previous 11-*month* period, any subsequent visits for intercurrent illness rendered by the *MRP* to the same patient in excess of four in a *month* are payable as W121 in addition to payment of W010.
8. Despite the definition set out above, the requirements of W010 are met when less than two "W" prefix assessments were rendered during the *month* and/or when the patient was not in the institution for a full calendar *month* if:
   - **a.** a patient was newly admitted to the institution and an admission assessment was rendered; or
   - **b.** in the event of the death of a patient while in the institution or within 48 hours of transfer to hospital.
9. Age related premiums otherwise applicable to any component service of W010 are *not eligible for payment* in addition to W010.

Claims submission instructions:

1. Claims for W010 may be submitted when the minimum required elements of the service have been rendered for the *month*.

   [Commentary:
   - **a.** Payment for W010 is for management of the patient for the entire *month* for all the services listed as components of the W010 service, regardless of when the claim for W010 is submitted.
   - **b.** When claiming W010, do not also submit claims for "W" prefix services listed as components of the W010 for the same *month*.]

2. The admission date of the patient must be provided on the claim for W010 or the service is *not eligible for payment*.
   - **a.** Submit claims for W121 which meet the requirements outlined in payment rule #7 using the manual review indicator.

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

[Commentary:

Examples of services not included in the *Month*ly Management fee include:

a. visits which qualify for a special visit premium.

b. services described under interviews, psychotherapy or counselling with the patient, patient's relative(s) or *patient's representative* lasting 20 or more minutes and where all other criteria for these services are met.

c. services described as physician to physician telephone consultations.

d. services rendered by a *specialist* who is not the *MRP* or who is not replacing an absent *MRP*.]

PSYCHOTHERAPY, PSYCHIATRIC AND COUNSELLING SERVICES

SPECIFIC ELEMENTS

In addition to the *common elements*, all Psychotherapy, Hypnotherapy, Counselling, Primary Mental Health, and Psychiatric Care include the following *specific elements*.

A. Performing the appropriate therapy or interaction (described below) with the patient(s) or, in the case of K014, K015, and H313, the patient's relative(s) or *patient's representative*, which *may include* the appropriate inquires (including obtaining a patient history, and a brief physical examination) carried out in order to arrive at an opinion as to the nature of the patient's condition (whether such inquiry takes place before, during or after the encounter during which the therapy or other interaction takes place); any appropriate procedure(s), related service(s), and/or follow-up care.

B. Performing any procedure(s) during the same encounter as the therapy or other interaction unless the procedure(s) is(are) separately listed in the *Schedule* and an amount is payable for the procedure in conjunction with the therapy or interaction.

C. Making arrangements for any related assessments, procedures, or therapy.

D. Making arrangements for follow-up care.

E. Discussion with, and providing advice and information, including prescribing therapy to the patient or the *patient's representative*, whether by telephone or otherwise, on matters related to:

- **a.** the service; and
- **b.** in circumstances in which it would be professionally appropriate that results can be reported upon prior to any further patient visit, the results of related procedure(s) and/or assessment(s).

F. When medically indicated, monitoring the condition of the patient and intervening, until the next insured service is rendered.

G. Providing premises, equipment, supplies, and personnel for the *specific elements* of the service.

While no occasion may arise for performing elements B, C, D and F, when performed in connection with the other *specific elements* they are included in the service.

Payment rules:

1. These services are calculated and payable in time units of 30 minute increments. In calculating the time unit(s), the minimum time required in direct contact with the patient (or patient's relative or *patient's representative* as the case may be) and the physician in person, exclusive of time spent rendering any other separately billable intervention to the patient, is as follows:

PSYCHOTHERAPY, PSYCHIATRIC AND COUNSELLING SERVICES

# Units	Minimum Time with Patient
1 unit	20 minutes
2 units	46 minutes
3 units	76 minutes [1h 16m]
4 units	106 minutes [1h 46m]
5 units	136 minutes [2h 16m]
6 units	166 minutes [2h 46m]
7 units	196 minutes [3h 16m]
8 units	226 minutes [3h 46m]

2. Except for in-patient individual psychotherapy by a psychiatrist or in-patient individual psychiatric care for which the time can be consecutive or non-consecutive, for all other services in this section the time units must be calculated based upon consecutive time spent rendering the service.

3. Psychotherapy performed outside a hospital, psychiatric care, primary mental health care, or hypnotherapy rendered the same day as a consultation or other assessment by the same physician to the same patient is *not eligible for payment* unless there are clearly defined different diagnoses for the two services.

[Commentary:

1. Except as noted in payment rule #2 (where non-consecutive services can be cumulated), services less than 20 minutes do not constitute any of the services defined in this section and constitute the type of assessment rendered in the circumstances.

2. Unless otherwise specified in the *Schedule*, the calculation of time excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the service and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

GENERAL PREAMBLE

PSYCHOTHERAPY, PSYCHIATRIC AND COUNSELLING SERVICES

PSYCHOTHERAPY/FAMILY PSYCHOTHERAPY

Definition:

Psychotherapy is any form of treatment for mental illness, behavioural maladaptations, and/or other problems that are assumed to be of an emotional nature, where a physician deliberately establishes a professional relationship with a patient with the purpose of removing, modifying or retarding existing symptoms, or attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development.

Family psychotherapy is psychotherapy rendered to the patient in the presence of one or more members of the patient's household.

Payment rules:

1. Psychotherapy is *not eligible for payment* when rendered on the same day to the same patient by the same physician as obstetrical delivery.
2. Subsequent visits rendered by the same psychiatrist to the same patient on the same day as in-patient individual psychotherapy are *not eligible for payment*.

PSYCHIATRIC CARE/FAMILY PSYCHIATRIC CARE/PRIMARY MENTAL HEALTH CARE

Definition:

Psychiatric care/family psychiatric care/primary mental health care are services encompassing any combination or form of assessment and treatment by a physician for mental illness, behavioural maladaptations, and/or other problems that are assumed to be of an emotional nature, where there is consideration of the patient's biological and psychosocial functioning.

Family psychiatric care is psychiatric care of the patient carried out by the physician in the presence of one or more family members or in the presence of professional caregivers not on staff at the facility where the patient is receiving the care.

Payment rules:

Subsequent visits rendered by the same psychiatrist to the same patient on the same day as individual in-patient psychiatric care are *not eligible for payment*.

FOCUSED PRACTICE PSYCHOTHERAPY PREMIUM

The focused practice psychotherapy premium is payable automatically to an eligible physician subject to the definitions and rules described below.

Definitions:

"Qualifying services" means K004A, K006A, K007A, K010A, K012A, K019A, K020A, K024A K025A, K122A and K123A.

"*Fiscal year*" means April 1 - March 31st.

"Qualifying year" means the *fiscal year* preceding the date of determination of eligibility.

"Date of determination of eligibility" means the date upon which the General Manager determines that the conditions for payment in (1) or (2) below, have been met.

"All payments" means all payments made to the physician for insured services listed in this *Schedule* other than payments made for insured services listed in this *Schedule* for which a technical fee is payable.

PSYCHOTHERAPY, PSYCHIATRIC AND COUNSELLING SERVICES

Payment rules:

For the *12 month period* following the date of determination of eligibility for the premium, the amount payable to a physician shall be automatically increased by 17% for each of the following services rendered by the physician: K004, K006, K007, K010, K012, K019, K020, K024, and K025, in the following circumstances:

1. when the sum of all payments made to the physician for the qualifying services rendered in the qualifying year exceeds 50% of the sum of all payments made to the physician in the qualifying year; or
2. when the sum of all payments made to the physician for the qualifying services rendered in the qualifying year is at least 40% but not more than 49% of the sum of all payments made to the physician in the qualifying year and the requirements set out in (1.) were met by the physician in respect of the *fiscal year* preceding the qualifying year.

[Commentary:
While K122 and K123 are qualifying services for the purpose of determining eligibility for the focused practice psychotherapy premium, the premium is not payable for K122 and K123.]

PSYCHOTHERAPY, PSYCHIATRIC AND COUNSELLING SERVICES

HYPNOTHERAPY

Definition:

Hypnotherapy is a form of treatment that has the same goals as psychotherapy but is rendered with the patient under hypnosis.

Payment rules:

Hypnotherapy is *not eligible for payment* when rendered on the same day to the same patient by the same physician as obstetrical delivery.

COUNSELLING

Definition/Required elements of service:

Counselling is a patient visit dedicated solely to an educational dialogue with a physician. This service is rendered for the purpose of developing awareness of the patient's problems or situation and of modalities for prevention and/or treatment, and to provide advice and information in respect of diagnosis, treatment, health maintenance and prevention.

[Commentary:

1. Advice given to a patient that would ordinarily constitute part of a consultation, assessment, or other treatment, is included as a common or constituent element of the other service, and does not constitute counselling.
2. Detention time may be payable following a consultation or assessment when a physician is required to spend considerable extra time in treatment or monitoring of the patient. See GP29 for further information.]

Payment rules:

1. With the exception of the codes listed in the below, no other services are eligible for payment when rendered by the same physician the same day as any type of counselling service: E080, G010, G039, G040, G041, G042, G043, G202, G205, G365, G372, G384, G385, G394, G462, G480, G489, G482, G538, G590, G593, G840, G841, G842, G843, G844, G845, G846, G847, G848, H313, K002, K003, K008, K014, K015, K031, K035, K036, K038, K682, K683, K684, K730
2. Individual and group counselling services are limited to 3 units per patient per physician per year at the higher fee (K013 or K040 respectively); the amount payable for services rendered in excess of this limit will be adjusted to a lesser fee (K033 or K041 respectively).
3. If the patient does not have a pre-booked appointment, the amount payable for this service will be adjusted to a lesser assessment fee.

A. Individual Counselling

Definition:

Individual counselling is counselling rendered to a single patient.

B. Group Counselling

Definition:

Group Counselling is counselling rendered to two or more patients with a similar medical condition or situation.

Payment rules:

1. Group counselling is *only eligible for payment* when all of the following conditions are fulfilled:

a. The group counselling is pre-booked; and

b. When there is an ongoing physician-patient relationship.

2. In addition to meeting the usual medical record requirements for the service, the physician must also maintain a separate record (independent of the patient's medical record) of the names and health numbers of all persons in attendance at each group counselling session or the service is *not eligible for payment*.

Claims submission instruction:

The claim must be submitted under the health number of the group member for whom, when the service was rendered, the largest number of counselling units had previously been claimed by the physician during the year in which the service is rendered.

[Commentary:
Group counselling does not apply to lectures.]

C. Transplant Counselling

Definition/Required elements of service:

Transplant counselling is payable in circumstances where transplant or donation is imminent, for the purpose of providing the recipient, donor or family member with adequate information and clinical data to enable that person to make an informed decision regarding organ transplantation.

Claims submission instruction:

The claim must be submitted under the health number of the recipient or donor.

D. Counselling of Relatives on Behalf of a Catastrophically or Terminally Ill Patient

Definition:

Counselling of relatives on behalf of a catastrophically or terminally ill patient is counselling rendered to a relative or relatives or representative of a catastrophically or terminally ill patient, for the purpose of developing an awareness of modalities for treatment of the patient and/or his or her prognosis.

Claims submission instruction:

The claim must be submitted under the health number of the patient who is catastrophically or terminally ill.

E. Rehabilitation Counselling

Definition:

Rehabilitation counselling is counselling rendered for the purpose of developing an awareness of the modalities for treatment of the patient and/or his or her prognosis.

INTERVIEWS

SPECIFIC ELEMENTS

In addition to the *common elements*, all services described as interviews include the following *specific elements*.

A. Obtaining information from, engaging in discussion with, and providing advice and information to interviewee(s) on matters related to the patient's condition and care.

B. Providing premises, equipment, supplies and personnel for the *specific elements* of the service.

Payment rules:

1. These services are calculated and payable in time units of 30 minute increments. In calculating the time unit(s), the minimum time required in direct contact with the patient (or patient's relative or *patient's representative* as the case may be) and the physician in person is as follows:

# Units	Minimum time
1 unit:	20 minutes
2 units:	46 minutes
3 units:	76 minutes [1h 16m]
4 units:	106 minutes [1h 46m]
5 units:	136 minutes [2h 16m]
6 units:	166 minutes [2h 46m]
7 units:	196 minutes [3h 16m]
8 units:	226 minutes [3h 46m]

[Commentary:

1. Services less than 20 minutes in duration do not constitute any of the services defined in this section and constitute the type of assessment rendered in the circumstances.

2. Inquiry, discussion or provision of advice or information to a patient, patient's relative or representative that would ordinarily constitute part of a consultation, assessment (including those services which are defined in terms of an assessment) is included as a common or constituent element of the other service, and does not constitute an interview.]

2. If an appointment for the interview is not separately booked, the amount payable for this service will be adjusted to a lesser fee.

3. All services described as interviews must be rendered personally by the attending physician or they become *uninsured service*s.

GENERAL PREAMBLE

DELEGATED PROCEDURE

Definition:

The term “procedure” as it is used in this section does not include services such as assessments, consultations, psychotherapy, counselling etc.

Payment rules:

1. Where a procedure is performed by a physician’s employee(s) in the physician’s office, the service remains insured using the existing fee codes if all the following requirements are met:
   - **a.** the procedure is one which is generally and historically accepted as a procedure which may be carried out by the nurse or other medical assistant in the employ of the physician; and
   - **b.** subject to the exceptions set out below, at all times during the procedure, the physician (although he or she may be otherwise occupied), is:
     - **i.** physically present in the office or clinic at which the service is rendered in order to ensure that procedures are being performed competently; and
     - **ii.** available immediately to approve, modify or otherwise intervene in a procedure, as required, in the best interests of the patient.
2. Exceptions to the requirement for physician presence during the delegated procedure.

   Where all of the following conditions are met, the simple office procedures listed in the table below remain insured despite the physician not being physically present:
   - **a.** the non-physician performing the procedure is properly trained to perform the procedure, he/she reports to the physician, and the procedure is rendered in accordance with accepted professional standards and practice;
   - **b.** the procedure is performed only on the physician’s own patient, as evidenced by either an ongoing physician/patient relationship or a consultation/assessment rendered by the physician to the patient on the same day as the procedure is performed; and
   - **c.** the same medical record requirements must be met as if the physician personally had rendered the service. The record must be dated, identify the non-physician performing the service, and contain a brief note on the procedure performed by the non-physician.

Claims submission instruction:

A locum tenens replacing an absent physician in the absent physician’s office may submit claims for delegated procedures under either his/her own billing number or the billing number of the physician he/she is replacing.

DELEGATED PROCEDURE

COMMON PROCEDURAL DESCRIPTION	APPLICABLE FEE CODES	CURRENT PAGE #
Venipuncture	G480, G482, G489	J7
Injections and immunizations	G372, G373, G538, G590, G593, G840, G841, G842, G843, G844, G845, G846, G847, G848	J54
Ultraviolet light therapy	G470	J36
Administration of oral polio vaccine	G462	J54
Simple office laboratory procedures	G001, G002, G004, G005, G009, G010, G011, G012, G014, G481	J67
Ear syringing, curetting or debridement	G420	J97
B.C.G. inoculation	G369	J53
Simple Spirometry and Flow Volume Loop	J301, J324, J304, J327	H4
Casts	Z198-Z209, Z211, Z213, Z216, Z873	N7

[Commentary:
Claims for services delegated to an individual employed by the physician submitting the claim are payable by *OHIP*. Claims are not payable for delegated services provided by an individual who is employed by a facility or organization such as a public hospital, public health unit, industrial clinics, long-term care facilities or Family Health Teams.]

AGE-BASED FEE PREMIUMS

1. Despite any other provision in this *Schedule*, the amount payable for the following services to an insured person who falls into the age group described in the Age Group column of the following Age Premium Table is increased by the percentage specified in Percentage Increase column opposite the Age Group:

a. A consultation, limited consultation or repeat consultation rendered by a *specialist*, as those services are defined in this *Schedule*.

b. A surgical procedure listed in Parts K to Z inclusive of this *Schedule*.

c. Basic and time unit surgical assistant services listed in Parts K to Z inclusive of this *Schedule*.

d. Clinical Procedures associated with Diagnostic Radiological Examinations.

e. A specific assessment or a partial assessment rendered by a specialist in ophthalmology (23) (A233 or A234).

f. A Midwife or Aboriginal Midwife-Requested Special Assessment (A815, C815 or A817) or a Midwife or Aboriginal Midwife-Requested Assessment (A813, C813 or A814) rendered by a *specialist*.

age premium table

Item	Age Group	Percentage Increase
1	Less than 30 days of age	30%
2	At least 30 days but less than one year of age	25%
3	At least one year but less than two years of age	20%
4	At least two years but less than five years of age	15%
5	At least five years but less than 16 years of age	10%

2. Despite any other provision in this *Schedule*, the amount payable for the following services to an insured person who is at least 65 years of age, as those services are defined in this *Schedule*, is increased by 15 per cent:

a. A general assessment (A003, C003, W102, or W109);

b. A general re-assessment (A004, C004, W004);

c. An intermediate assessment (A007);

d. A focused practice assessment (A917, A927, A937, A947, A957 or A967);

e. A periodic health visit (K132).

f. Comprehensive assessment and care (H102, H122, H132, H152)

g. A multiple systems assessment (H103, H123, H133, H153)

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUMS

Special visit means a visit initiated by a patient or an individual on behalf of the patient for the purpose of rendering a non-elective service or, if rendered in the patient's *home*, a non-elective or elective service.

A special visit premium is payable in respect of a special visit rendered to an insured person, subject to the conditions and limitations set out below. All special visit premiums are subject to the maximums, limitations and conditions set out in the "Special Visit Premium Table" applicable in the circumstances.

Payment rules:

1. Special visit premiums are *only eligible for payment* when rendered with certain services listed under "Consultations and Visits" and "Diagnostic and Therapeutic Procedures" sections of this *Schedule*.

2. Regardless of the time of day at which the service is rendered, special visit premiums are *not eligible for payment* in the following circumstances:

- **a.** for patients seen during rounds at a hospital or long-term care institution (including a nursing *home* or *home* for the aged);
- **b.** in conjunction with admission assessments of patients who have been admitted to hospital on an elective basis;
- **c.** for non-referred or transferred obstetrical patients except, in the case of transferred obstetrical patients for a special visit for obstetrical delivery with sacrifice of office hours for the first patient seen (C989);
- **d.** for services rendered in a place, other than a hospital or long-term care facility, that is scheduled to be open for the purpose of diagnosing or treating patients;
- **e.** for a visit for which critical care team fees are payable under this *Schedule*;
- **f.** in conjunction with any sleep study service listed in the sleep studies section of this *Schedule*; or
- **g.** for services rendered to patients who present to an office without an appointment while the physician is there, or for patients seen immediately before, during or immediately after routine or ordinary office hours even if held at night or on *week*ends or *holiday*s.

3. Special visit premiums are *not eligible for payment* with services described by emergency department "H" prefix fee codes.

[Commentary:
For elective *home* visits rendered during daytime, evenings, nights or *week*ends, submit claim(s) using fee codes found under the column titled "Elective *Home* Visit" of Special Visit Premium Table VI listed on page GP75.]

Sacrifice of office hours means an insured service rendered when the demands of the patient and/or the patient's condition are such that the physician makes a previously unscheduled non-elective visit to the patient at a time when the physician had an office visit booked with one or more patients but, because of the previously unscheduled non-elective visit, any such office visit was delayed or cancelled.

SPECIAL VISIT PREMIUMS

PREMIUMS

[Commentary:
Special visit premiums are in respect of either or both: a "travel premium" and a "patient seen" premium (i.e. "first person seen premium" or "an additional person seen premium").]

A. Travel Premium

Definition/required elements of service:

A travel premium is *only eligible for payment* for travel from one location to another location ("the destination") subject to the payment rules below.

A travel premium is *not eligible for payment* when a physician is required to travel from one location to another within the same long-term care facility, hospital complex or within buildings situated on the same hospital campus.

[Commentary:
1. A first person seen premium may be eligible for payment in this circumstance.
2. Only one travel premium is eligible for payment for each separate trip to a destination regardless of the number of patients seen in association with each trip.]

B. First person seen premium

A first person seen premium is eligible for payment for the first person seen at the destination under one of the following circumstances ("the eligible times"):

1. if the insured service is commenced evenings (17:00 hr-24:00 hr) Monday to Friday; daytime or evenings on Saturdays, Sundays, and *Holiday*s; or nights (24:00 hr-07:00 hr);
2. if rendered requiring sacrifice of office hours; or
3. if rendered during daytime hours (07:00 - 17:00 hrs Monday through Friday) in circumstances in which a travel premium is eligible for payment.

C. Additional person premium

An additional person premium is *only eligible for payment* for services rendered at the destination to additional patients seen in emergency departments, outpatient departments, long-term care institutions or to hospital inpatients, provided that each additional patient service is commenced during the eligible times.

[Commentary:
Special visit premiums are *not eligible for payment* for elective services rendered at a long-term care institution, including a nursing *home* or *home* for the aged, even when the long-term care institution is the "*home*" of the patient.

Submit claims for routine elective visits in these locations as subsequent visits. For example, if the physician is called to a nursing *home* to see a patient for a non-elective problem at 8AM, and subsequently sees his/her routine patients on rounds, those additional patients do not qualify for the additional person premium.]

SPECIAL VISIT PREMIUMS

LIMITS FOR SPECIAL VISIT PREMIUMS

Special visit premiums in excess of the maximums listed in the Special Visit Premium Tables are *not eligible for payment*.

The maximums apply to the number of patients where special visit premiums may be eligible for payment on that service date or in the time period specified.

LIMITS FOR GERIATRIC HOME VISIT SPECIAL VISIT PREMIUMS

For the purpose of special visit premiums under the heading "Geriatric *Home* Visit Special Visit Premiums", the special visit premiums listed under Table X are *only eligible for payment* to:

a. a *specialist* in Geriatrics (07); or

b. a physician with an exemption to access bonus impact in Care of the Elderly from the *MOH*.

LIMITS FOR EMERGENCY DEPARTMENT PHYSICIAN

For the purpose of special visit premiums under the heading "Emergency Department Physician", "Emergency Department Physician" means a physician:

a. who on a day when the physician is scheduled to work in a hospital emergency department specifically for the purpose of rendering services to patients who attend the emergency department for physician services,

  i. is requested by the emergency department to attend at a time when the physician is not otherwise scheduled to work in the emergency department; and

  ii. who is not at the hospital at the time the emergency department request for attendance is made; or

b. is on-call on a scheduled basis specifically to be available to a hospital emergency department to render services to patients who attend the emergency department for physician services and who is not at the hospital at the time the emergency department request for attendance is made.

[Commentary:
Emergency department physicians may be primarily funded either through an Emergency Department Alternate Funding Arrangement (ED-AFA) or fee-for-service.]

In addition to the general restrictions regarding special visits as outlined above, there are specific restrictions which apply to special visit premiums for services rendered in the emergency department by Emergency Department Physicians (as defined above). These limits are listed in the Special Visit Premiums table under the heading “Emergency Department by Emergency Department Physician” (Table V). Special Visit Premiums listed in the Special Visit Premiums table under the heading "Emergency Department" (Table I) are *not eligible for payment* to Emergency Department Physicians (as defined above).

[Commentary:
1. First patient seen and additional person seen premiums for Emergency Department Physicians are eligible for payment only when the physician is required to travel, as defined under “Travel Premium” page GP66, to make a special visit to the hospital emergency department.

SPECIAL VISIT PREMIUMS

2. If the Emergency Department Physician is at the hospital at the time the emergency department request for attendance is made, the appropriate H prefix code may be eligible for payment.

3. If the Emergency Department Physician is called to a hospital ward on a non-elective basis, the General Listings ("A" prefix) apply and "C" prefix first person seen/additional person seen special visit premium may be eligible for payment.]

Note:
When special visits are rendered by physicians when they are not on duty to the emergency department, the limits for special visit premiums under the heading "Emergency Department" (Table I) apply (GP70). For patients assessed during this visit to the emergency department beyond the defined limits, submit claims for all subsequent patients using the "H" prefix listings.

SPECIAL VISIT PREMIUMS

Medical record requirements:

Special Visit Premiums are *only eligible for payment* if the following requirements are met:

1. For fee codes listed in Tables I, II, III, IV, VI, VII, VIII, IX and X the time at which the special visit takes place must be documented on the medical record.
2. For fee codes listed in Table V;
   a. the time of the request to attend in the emergency department must be documented on the medical record; and
   b. The specific situation requiring the physician's attendance must be documented on the medical record.

[Commentary:
When a special visit service occurs in a hospital, emergency department or long-term care institution where common medical records are maintained, the time when the visit takes place may be documented anywhere in the common medical record.]

Claims submission instructions:

Submit claims using the appropriate A-prefix assessment fee from the “General Listings” for an assessment rendered in conjunction with a special visit premium.

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE I

Emergency Department

Not eligible for payment to Emergency Department Physicians (see definition GP67)

Premium	Weekdays Daytime (07:00- 17:00)	Weekdays Daytime (07:00 - 17:00) with Sacrifice of Office Hours	Evenings (17:00- 24:00) Monday through Friday	Sat., Sun. and Holidays (07:00- 24:00)	Nights (00:00- 07:00)
Travel Premium	$37.40 K960 (max. 2 per time period)	$37.40 K961 (max. 2 per time period)	$37.40 K962 (max. 2 per time period)	$37.40 K963 (max. 6 per time period)	$37.40 K964 (no max. per time period)
First Person Seen	$20.55 K990 (max. 10 (total of first and additional person seen) per time period)	$41.10 K992 (max. 10 (total of first and additional person seen) per time period)	$61.70 K994 (max. 10 (total of first and additional person seen) per time period)	$77.10 K998 (max. 20 (total of first and additional person seen) per time period)	$102.80 K996 (no max. per time period)
Additional Person(s) seen	$20.55 K991 (max. 10 (total of first and additional person seen) per time period)	$41.10 K993 (max. 10 (total of first and additional person seen) per time period)	$61.70 K995 (max. 10 (total of first and additional person seen) per time period)	$77.10 K999 (max. 20 (total of first and additional person seen) per time period)	$102.80 K997 (no max. per time period)

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE II

Hospital Out-Patient Department

Premium	Weekdays Daytime (07:00-17:00)	Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours	Evenings (17:00-24:00) Monday through Friday	Sat., Sun. and Holidays (07:00-24:00)	Nights (00:00- 07:00)
Travel Premium	$37.40 U960 (max. 2 per time period)	$37.40 U961 (max. 2 per time period)	$37.40 U962 (max. 2 per time period)	$37.40 U963 (max. 6 per time period)	$37.40 U964 (no max. per time period)
First person seen	$20.55 U990 (max. 10 (total of first and additional person seen) per time period)	$41.10 U992 (max. 10 (total of first and additional person seen) per time period)	$61.70 U994 (max. 10 (total of first and additional person seen) per time period)	$77.10 U998 (max. 20 (total of first and additional person seen) per time period)	$102.80 U996 (no max. per time period)
Additional person(s) seen	$20.55 U991 (max. 10 (total of first and additional person seen) per time period)	$41.10 U993 (max. 10 (total of first and additional person seen) per time period)	$61.70 U995 (max. 10 (total of first and additional person seen) per time period)	$77.10 U999 (max. 20 (total of first and additional person seen) per time period)	$102.80 U997 (no max. per time period)

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE III

Hospital In-Patient

Premium	Weekdays Daytime (07:00-17:00)	Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours	Evenings (17:00-24:00) Monday through Friday	Sat., Sun. and Holidays (07:00-24:00)	Nights (00:00-07:00)
Travel Premium	$37.40 C960 (max. 2 per time period)	$37.40 C961 (max. 2 per time period)	$37.40 C962 (max. 2 per time period)	$37.40 C963 (max. 6 per time period)	$37.40 C964 (no max. per time period)
First person seen	$20.55 C990 (max. 10 (total of first and additional person seen) per time period)	$41.10 C992 (max. 10 (total of first and additional person seen) per time period)	$61.70 C994 (max. 10 (total of first and additional person seen) per time period)	$77.10 C986 (max. 20 (total of first and additional person seen) per time period)	$102.80 C996 (no max. per time period)
Additional person(s) seen	$20.55 C991 (max. 10 (total of first and additional person seen) per time period)	$41.10 C993 (max. 10 (total of first and additional person seen) per time period)	$61.70 C995 (max. 10 (total of first and additional person seen) per time period)	$77.10 C987 (max. 20 (total of first and additional person seen) per time period)	$102.80 C997 (no max. per time period)

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE IV

Long-Term Care Institution

Premium	Weekdays Daytime (07:00-17:00)	Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours	Evenings (17:00-24:00) Monday through Friday	Sat., Sun. and Holidays (07:00-24:00)	Nights (00:00-07:00)
Travel Premium	$37.40 W960 (max. 2 per time period)	$37.40 W961 (max. 2 per time period)	$37.40 W962 (max. 2 per time period)	$37.40 W963 (max. 6 per time period)	$37.40 W964 (no max. per time period)
First person seen	$20.55 W990 (max. 10 (total of first and additional person seen) per time period)	$41.10 W992 (max. 10 (total of first and additional person seen) per time period)	$61.70 W994 (max. 10 (total of first and additional person seen) per time period)	$77.10 W998 (max. 20 (total of first and additional person seen) per time period)	$102.80 W996 (no max. per time period)
Additional person(s) seen	$20.55 W991 (max. 10 (total of first and additional person seen) per time period)	$41.10 W993 (max. 10 (total of first and additional person seen) per time period)	$61.70 W995 (max. 10 (total of first and additional person seen) per time period)	$77.10 W999 (max. 20 (total of first and additional person seen) per time period)	$102.80 W997 (no max. per time period)

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE V

Emergency Department by Emergency Department Physician (as defined on GP67)

Premium	Weekdays Daytime (07:00-17:00)	Evenings (17:00-24:00) Monday through Friday	Sat., Sun. and Holidays (07:00-24:00)	Nights (00:00-07:00)
Travel Premium	$37.40 H960 (max. 2 per time period)	$37.40 H962 (max. 2 per time period)	$37.40 H963 (max. 4 per time period)	$37.40 H964 (no max. per time period)
First person seen	$20.55 H980 (max. 5 (total of first and additional person seen) per time period)	$61.70 H984 (max. 5 (total of first and additional person seen) per time period)	$77.10 H988 (max. 10 (total of first and additional person seen) per time period)	$102.80 H986 (no max. per time period)
Additional person(s) seen	$20.55 H981 (max. 5 (total of first and additional person seen) per time period)	$61.70 H985 (max. 5 (total of first and additional person seen) per time period)	$77.10 H989 (max. 10 (total of first and additional person seen) per time period)	$102.80 H987 (no max. per time period)

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE VI

Special Visits to Patient's Home (other than Long-Term Care Institution)

Premium	Weekdays Daytime (07:00-17:00) Non-elective	Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours Non-elective	Evenings (17:00-24:00) Monday through Friday Non-elective	Sat., Sun. and Holidays (07:00-24:00) Non-elective	Nights (00:00-07:00) Non-elective	Elective home visit
Travel Premium	$37.40 B960 (max. 2 per time period)	$37.40 B961 (max. 2 per time period)	$37.40 B962 (max. 2 per time period)	$37.40 B963 (max. 6 per time period)	$37.40 B964 (no max. per time period)	$37.40 B960 (max. 2 per time period)
First person seen	$28.25 B990 (max. 10 (total of first and additional person seen) per time period)	$45.25 B992 (max. 10 (total of first and additional person seen) per time period)	$67.85 B994 (max. 10 (total of first and additional person seen) per time period)	$84.80 B993 (max. 20 (total of first and additional person seen) per time period)	$113.10 B996 (no max. per time period)	$28.25 B990 (max. 10 (total of first and additional person seen) per time period)

Note:

1. The maximum number of services per physician per day for B960 is 2, for any combination of non-elective and elective visits.

2. The maximum number of services per physician per day for B990 is 10, for any combination of non-elective and elective visits.

3. Special visit to patient's *home* premiums are *only eligible for payment* for first patient seen, regardless of number of patients seen during one visit to a *home* or to one or more living units in a multiple resident dwelling. A multiple resident dwelling is a single location that shares a common external building entrance or lobby e.g. apartment block, rest or retirement *home*, commercial hotel, motel or boarding house, university or boarding school residence, hostel, correctional facility or group *home*.

[Commentary:

1. Special visit premiums listed in Table VI above are *not eligible for payment* with A007 or A001 when rendered in a patient's *home*. See page A4.

2. For A007 or A001 rendered in a patient's *home*, travelling to and from the *home* is included as a common element of the insured service. See page GP13 of this *Schedule*.]

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE VII

Palliative Care Home Visit

Premium	Weekdays Daytime (07:00-17:00)	Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours	Evenings (17:00-24:00) Monday through Friday	Sat., Sun. and Holidays (07:00-24:00)	Nights (00:00-07:00)
Travel Premium	$37.40 B966 (no max. per time period)	$37.40 B966 (no max. per time period)	$37.40 B966 (no max. per time period)	$37.40 B966 (no max. per time period)	$37.40 B966 (no max. per time period)
First person seen	$91.80 B998 (no max. per time period)	$91.80 B998 (no max. per time period)	$91.80 B998 (no max. per time period)	$91.80 B998 (no max. per time period)	$113.10 B997 (no max. per time period)

SPECIAL VISIT PREMIUM TABLE VIII

Physician Office

Premium	Weekdays Daytime (07:00-17:00)	Evenings (17:00-24:00) Monday through Friday	Sat., Sun. and Holidays (07:00-24:00)	Nights (00:00- 07:00)
Travel Premium	$37.40 A960 (max. 1 per time period)	$37.40 A962 (max. 1 per time period)	$37.40 A963 (max. 1 per time period)	$37.40 A964 (no max. per time period)
First person seen	$20.55 A990 (max. 1 per time period)	$61.70 A994 (max. 1 per time period)	$77.10 A998 (max. 1 per time period)	$102.80 A996 (no max. per time period)

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE IX

Other (non-professional setting not listed)

Premium	Weekdays Daytime (07:00-17:00)	Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours	Evenings (17:00-24:00) Monday through Friday	Sat., Sun. and Holidays (07:00-24:00)	Nights (00:00-07:00)
Travel Premium	$37.40 Q960 (max. 1 per time period)	$37.40 Q961 (max. 1 per time period)	$37.40 Q962 (max. 1 per time period)	$37.40 Q963 (max. 1 per time period)	$37.40 Q964 (no max. per time period)
First person seen	$20.55 Q990 (max. 1 per time period)	$41.10 Q992 (max. 1 per time period)	$61.70 Q994 (max. 1 per time period)	$77.10 Q998 (max. 1 per time period)	$102.80 Q996 (no max. per time period)

SPECIAL VISIT PREMIUM TABLE X

Geriatric Home Visit

Premium	Weekdays Daytime (07:00-17:00)	Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours	Evenings (17:00-24:00) Monday through Friday	Sat., Sun. and Holidays (07:00-24:00)	Nights (00:00-07:00)
Travel Premium	$37.40 B986 (no max. per time period)	$37.40 B986 (no max. per time period)	$37.40 B986 (no max. per time period)	$37.40 B986 (no max. per time period)	$37.40 B986 (no max. per time period)
First person seen	$91.80 B988 (no max. per time period)	$91.80 B988 (no max. per time period)	$91.80 B988 (no max. per time period)	$91.80 B988 (no max. per time period)	$113.10 B987 (no max. per time period)

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE - OBSTETRICAL DELIVERY WITH SACRIFICE OF OFFICE HOURS

Obstetrical Delivery with Sacrifice of Office Hours

Weekdays Daytime (07:00-17:00)	Sacrifice of Office Hours	Evenings (17:00- 24:00) Monday through Friday	Sat., Sun. and Holidays (07:00-24:00)	Nights (00:00-07:00)
$0.00	$78.55 C989 (max. 1 per time period)	$0.00	$0.00	$0.00

GENERAL PREAMBLE

SUPERVISION OF POSTGRADUATE MEDICAL TRAINEES

[Commentary:

1. A physician who supervises a medical trainee who renders an insured service is eligible to be paid for the insured service as if the supervising physician performed the service personally, subject to any terms, conditions and limitations found in this section.

2. The sole purpose of the terms and conditions described in this section is to define when a service is payable by *OHIP*. These terms and conditions do not alter the College of Physicians and Surgeons of Ontario Professional Responsibilities in Postgraduate Medical Education requirements or any requirements of the institutions responsible for postgraduate medical education.]

Note:
Unless otherwise specified in this section, all other payment requirements in the *Schedule* related to any service that is performed by a Medical Trainee are applicable.

DEFINITIONS:

For the purposes of this section of the *Schedule* only, the following Definitions apply:

Supervision: Supervision is performed by the Supervising Physician and includes the responsibility to guide, observe and assess the educational activities of the Medical Trainee and assures the quality of an insured service while being rendered by the Medical Trainee.

Supervision is only performed:

a. in person, by telephone, or videoconference, the method being consistent with the acuity of the service being rendered by the Medical Trainee as well as the Medical Trainee's level of competence;

b. when the service is provided within a setting approved by the educational institution where the Medical Trainee is registered; and

c. when the service is within the scope and oversight of the postgraduate medical training program in which the Medical Trainee is registered.

[Commentary:
The Supervising Physician and the Medical Trainee must be physically present in Ontario.]

Supervising Physician The Supervising Physician is a physician who performs Supervision of a Medical Trainee who renders an insured service to an insured person. The Supervising Physician must hold an academic appointment with the educational institution where the Medical Trainee is registered. The Supervising Physician of a Medical Trainee involved in the care of a patient may or may not be the most responsible physician for that patient.

Medical Trainee A Medical Trainee is a physician who is registered in a postgraduate training program as a Resident or Clinical Fellow at the time he/she performs an insured service.

Resident A Resident is registered in an accredited postgraduate training program that leads to certification for practice in Canada as a specialist or subspecialist by the Royal College of Physicians and Surgeons of Canada or to certification by the College of Family Physicians of Canada for practice in Canada as a family physician.

GENERAL PREAMBLE

SUPERVISION OF POSTGRADUATE MEDICAL TRAINEES

Clinical Fellow A Clinical Fellow is registered with a postgraduate training program that is approved by a university postgraduate medical education office in Ontario. The Clinical Fellow must have a Certificate of Registration with the College of Physicians and Surgeons of Ontario.

[Commentary:
An undergraduate is not a physician and does not meet the definition of a Medical Trainee]

Procedure A Procedure is an insured service that has anaesthesia base units listed in the column headed with “Anae” and includes anaesthesia services provided by Anaesthesiologists.

Non-Procedure A Non-Procedure Service is an insured service, other than Procedures and Time-Based Services.

Time-Based Services A Time-Based Service is an insured service described as Psychotherapy, Psychiatric and Counselling, Interviews, Hypnotherapy, Psychiatric Care and Primary Mental Health Care.

SUPERVISION OF POSTGRADUATE MEDICAL TRAINEES

Payment Rules

A. GENERAL

1. A service rendered by a Medical Trainee is *only eligible for payment* to the Supervising Physician where Supervision is provided as defined above and subject to the specific requirements below.
2. Where a Resident with an *OHIP* billing number is providing insured services independently and outside their training program, the insured service is *not eligible for payment* to a Supervising Physician as there is no Supervision provided.

   [Commentary:
   In the scenario described above the Resident is not performing the service as a Medical Trainee. In this scenario, the Resident would bill *OHIP* for the service provided.]
3. Where a Clinical Fellow with an *OHIP* billing number is providing insured services independently and outside their training program, the insured service is *not eligible for payment* to a Supervising Physician as there is no Supervision provided.

   [Commentary:
   In the scenario described above the Clinical Fellow is not performing the services as a Medical Trainee. In this scenario, the Clinical Fellow would bill *OHIP* for the services provided. For example, an orthopedic surgeon may be enrolled in a sarcoma surgery clinical fellowship but has privileges as a general orthopedic surgeon and may perform, and be eligible for payment, for rendering a service such as an open reduction of a fracture that is not being supervised by a Supervising Physician.]
4. Special Visit premiums are *not eligible for payment* to the Supervising Physician unless the Supervising Physician personally satisfies the payment requirements for a special visit premium.
5. The following services are *not eligible for payment* to the Supervising Physician when rendered by a Medical Trainee:
   - **a.** Case Conferences;
   - **b.** Multidisciplinary Cancer Conferences;
   - **c.** Provider-to-provider services, including:
     - **i.** Telephone Consultations;
     - **ii.** E-Consultations; and
     - **iii.** E-Assessments.
   - **d.** Virtual Care Services when provided to hospital inpatients or patients in an emergency department.

B. PROCEDURE SERVICES

1. A Procedure rendered by a Resident is *only eligible for payment* to the Supervising Physician when the Supervising Physician:
   - **a.** is aware the Resident will render the service; and
   - **b.** is physically present in the clinical facility at the time the service is rendered; and
   - **c.** is immediately available to personally attend the patient when requested by the Resident or other health care professional.

2. A Procedure rendered by a Clinical Fellow is *only eligible for payment* to the Supervising Physician when the Supervising Physician:

   a. is aware the Clinical Fellow will render the service; and

   b. is available to personally attend the patient when requested by the Clinical Fellow or other health care professional in a timely manner consistent with the acuity of the clinical scenario.

   Note:
   Payment rule 2(b) above is not applicable in circumstances where a Supervising Physician supervises Procedures rendered by a Clinical Fellow for the purpose of procurement of organs or tissues to be used in transplantation.

3. Where a Procedure is rendered by a Clinical Fellow with an *OHIP* billing number under the supervision of a Supervising Physician, the Procedure is eligible for payment to the Clinical Fellow as a surgical assistant if the Procedure has basic units listed in the column headed with "Asst".

   [Commentary:
   1. The Supervising Physician should submit a claim as the operating surgeon in this situation ("A" suffix).

   2. The Clinical Fellow should submit a claim as the assistant ("B" suffix).]

C. TIME-BASED SERVICES

1. A Time-Based Service rendered by a Medical Trainee is *only eligible for payment* to the Supervising Physician when the Supervising Physician is aware the Medical Trainee will render the service.

2. The number of time units payable is the time spent by the Medical Trainee providing the service to the patient subject to limits set out below:

   Note:
   1. Any time taken in discussion with the Medical Trainee about the case is *not eligible for payment*.

   2. The maximum number of time units payable for a Time-Based service rendered by the Medical Trainee(s) to an individual patient is two units.

   3. The maximum number of time units payable for a Time-Based service rendered by the Medical Trainee(s) to a group of two or more patients is four units.

   [Commentary:
   1. Where there is more than one Medical Trainee participating in the rendering of a time-based service concurrently, only the time units rendered by one Medical Trainee are eligible for payment to the same Supervising Physician.]

D. NUMBER OF MEDICAL TRAINEES

The following table describes the maximum number of services that are payable for services rendered concurrently by Medical Trainee(s) and the Supervising Physician.

GENERAL PREAMBLE

SUPERVISION OF POSTGRADUATE MEDICAL TRAINEES

Type of Insured Service	Location Where Insured Services are Rendered	Maximum number of insured services eligible for payment when rendered concurrently by the Medical Trainee(s) and the Supervising Physician
Procedures Only	Any	2
Procedures with any combination of Non-Procedures or Time-Based Services	Any	2
Any Combination of Non-Procedures or Time-Based Services	Any	3
Any Combination of Non-Procedures or Time-Based Services	Specialized Clinic in a Quaternary Hospital	4
Any Combination of Non-Procedures or Time-Based Services	Emergency Department	No Limit
Any Combination of Non-Procedures or Time-Based Services	Hospital Inpatient	No Limit

Note:

1. Maximum number of services rendered concurrently include all services rendered by both the Medical Trainee(s) and the Supervising Physician.

2. With respect to the maximum number of services eligible for payment in Specialized Clinics located at a Quaternary hospital, the following is applicable:

a. The maximums are applicable only for clinics that have been approved by the *MOH*.

b. In the absence of *MOH* approval, the other maximums pertaining to the type and location of insured services rendered by the Supervising Physician and Medical Trainee(s) are applicable.

3. The above maximums refer to Time-Based Services rendered to individual patients. In circumstances where Time-Based Services are rendered to groups of two or more patients, the group session is considered to be a service provided to one patient.

[Commentary:

1. If the Supervising Physician is personally performing a Procedure at the same time and is Supervising one Medical Trainee who is performing a Procedure, this situation describes two insured services that are payable.

2. If the Supervising Physician is personally performing a Procedure and at the same time is Supervising two Medical Trainees who are both performing Procedures, this situation describes three services but only two of the three insured services are payable.

3. If the Supervising Physician is personally rendering a service other than a Procedure (i.e. a Non-Procedure or a Time-Based Service) and is supervising two Medical Trainees who are performing Procedures concurrently, this situation describes three services but only two insured services that are payable.

4. If the Supervising Physician is personally rendering a Non-Procedure and is Supervising two Medical Trainees who are both performing Non-Procedures or Time-Based services at the same time, this situation describes three insured services that are payable.]

E. Forms

1. An insured service listed in the *Schedule* that includes the completion of a form is *not eligible for payment* to a Supervising Physician if rendered by a Medical Trainee unless the form has been reviewed and signed by the Supervising Physician.

F. Medical Record Requirements

1. A service is *only eligible for payment* to the Supervising Physician when the medical record of the patient(s) identifies the following information at the time of the provision of the service:

a. The Supervising Physician;

b. The Medical Trainee and level of training;

c. The description of the insured service performed by the Medical Trainee;

d. Patient consent to the Supervision of services of a Medical Trainee; and

e. Where the service rendered is a Time-Based service, the Supervising Physician has at a minimum, reviewed the nature and outcome of the service and the patient record(s), with the Medical Trainee.

2. In addition to the requirements in 1 above, the Supervising Physician must have:

a. signed off on the service rendered by the Medical Trainee in the patient's medical record; or

b. where the Supervising Physician was not immediately available to sign off on the service rendered by the Medical Trainee, the Medical Trainee has written the date and time a discussion occurred with the Supervising Physician regarding the provision of the service in the patient's medical record.

[Commentary:
Each entry into the patient's medical record does not need to contain all of the above medical record keeping requirements. However, it must be evident upon review of the entire medical record that all requirements were met at the time of the provision of the Supervised service.

Supervision of the Medical Trainee by the Supervising Physician must be evident in the medical record. This *may include* a physical visit to the patient and/or a chart review and detailed discussion between the Supervising Physician, the Medical Trainee, and other member(s) of the health team.

The service date to be used for claims is the date the Medical Trainee rendered the insured service to the patient.]

GENERAL PREAMBLE

SURGICAL ASSISTANTS' SERVICES

SPECIFIC ELEMENTS

In addition to the *common elements*, assistance at surgery includes the following *specific elements*.

A. Preparing or supervising the preparation of the patient for the procedure.

B. Performing the procedure by any method, or assisting another physician in the performance of the procedure(s), assisting with the carrying out of all recovery room procedures and the transfer of the patient to the recovery room, and any ongoing monitoring and detention rendered during the immediate post-operative and recovery period, when indicated.

C. Making arrangements for any related assessments, procedures, or therapy, (including obtaining any specimens from the patient) and/or interpreting results.

D. When medically indicated, monitoring the condition of the patient for post-procedure follow-up until the first post-operative visit.

E. Discussion with, and providing any advice and information, including prescribing therapy to the patient or the *patient's representative*, whether by telephone or otherwise, on matters related to the service.

F. Providing premises, equipment, supplies, and personnel for services identified with prefix # for any aspect(s) of A, C, D, and E that is (are) performed in a place other than the place in which the surgical procedure is performed.

While no occasion may arise for performing elements A, C, D or E, when performed in connection with the *specific elements* of a service, these are included in the service.

CALCULATION OF FEE PAYABLE: BASIC UNITS AND TIME UNITS

Except where "nil" is listed opposite the service in the column headed with "Asst", the amount payable for the surgical assistant service is calculated by adding together the number of basic and time units and multiplying that total by the unit fee.

Assistant Unit Fee $12.91

Basic Units: The number of basic units is the number of units listed opposite the service in the column headed with "Asst", except

a. where multiple or bilateral surgical procedures are performed during the same anaesthetic, the number of basic units is that listed in the column headed with "Asst" opposite the service that describes the major procedure; or

b. where no basic unit is listed opposite the service in the column headed with "Asst" and where "nil" is not listed opposite the service in the column headed with "Asst", the number of basic units is that listed opposite the service under the column headed with "Anae". This type of service is *only eligible for payment* upon authorization by a *medical consultant* following submission of a letter from the surgeon outlining the reason the assistant was required. Submit claims for this type of service using fee code M400B.

Where "nil" is listed opposite the service in the column headed with "Asst", the assistant's service is *not eligible for payment*.

SURGICAL ASSISTANTS' SERVICES

Time Units: For the purpose of calculating time units, time is determined per operation as the total of the following, excluding any time spent waiting between surgical procedures:

a. time spent by the physician in direct contact with the patient in the operating room prior to scrub time to assist with patient preparation; and

b. time spent by the physician assisting at the patient's surgery starting with scrub time and ending when the physician is no longer required to be in attendance with that patient.

Time units are calculated for each 15 minutes or part thereof. The unit value of each 15 minute period or part thereof is:

During the first hour or less.....	1 unit
After the first hour up to and including the first 1.75 hours	2 units
After 1.75 hours	3 units

Claims submission instruction:

Submit claims for assisting at surgery using the suffix "B", with the procedural code.

[Commentary:
See Appendix H for a table stating the duration of surgical assisting and corresponding time units.]

SURGICAL ASSISTANTS' SERVICES

AFTER HOURS PREMIUMS

These premiums are payable when a case commences:

E400B	Evenings (17:00h – 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays or Holidays - increase the total assistant's fee by	50%
E401B	Nights (00:00h – 07:00h) - increase the total assistant's fee by	75%

REPLACEMENT SURGICAL ASSISTANT

When one surgical assistant ("the first assistant") starts a procedure and is replaced by another surgical assistant ("the replacement assistant") during a surgical procedure:

a. The amount payable to the first assistant is calculated by adding the listed procedural basic units plus time units for the time the first assistant is in attendance.

b. The service provided by the replacement assistant constitutes E005B based on the number of time units for the time the replacement assistant is in attendance.

Payment rules:

1. Base units are *not eligible for payment* to the replacement assistant.

2. Time units for the replacement assistant are calculated based on the total time the replacement assistant participates in the case. Time unit values are calculated in the same manner as would have applied to the original assistant had he/she not been replaced.

[Commentary:
As an example, if the original assistant is eligible for double time units when the replacement assistant takes over, the replacement assistant is also eligible for double time units.]

3. E400B or E401B is eligible for payment with E005B only if the beginning of the case commences after hours.

Medical record requirements:
E005B is *only eligible for payment* when the start and stop times are documented in the patient's permanent medical record.

SURGICAL ASSISTANTS' SERVICES

SPECIAL VISIT PREMIUMS

All special visit premiums are subject to the maximums, limitations and conditions set out in the "Special Visit Premium Table" applicable in the circumstances.

Sacrifice of Office Hours

[Commentary:
For the definition of Sacrifice of Office Hours, see GP65.]

C988B	Special visit premium to assist at non-elective surgery with sacrifice of office hours - first patient seen	76.40

Evenings, Weekend/Holiday and Nights

C998B	Evenings (17:00h - 24:00h) Monday to Friday, first patient seen.....	96.80
C983B	Saturdays, Sundays or Holidays, daytime and evenings (07:00h -24:00h), first patient seen	112.40
C999B	Nights (00:00h - 07:00h), first patient seen	138.60

Payment rules:

1. C988B, C998B, C983B and C999B are *only eligible for payment* for the first patient seen on each special visit.
2. C988B, C998B, C983B, C999B are *only eligible for payment* when the physician is required to travel from one location to another location, as defined under "Travel Premium", page GP66.

[Commentary:
1. The specific requirements for special visits are found on pages GP65 to GP77.
2. These premiums are eligible for payment in addition to the E400 and E401 premiums.]

SURGICAL ASSISTANTS' SERVICES

SPECIAL VISIT PREMIUM TABLE - SURGICAL ASSISTANT SERVICES

Surgical Assistant Services

Weekdays Daytime (07:00-17:00)	Sacrifice of Office Hours	Evenings (17:00-24:00) Monday through Friday	Sat., Sun. and Holidays (07:00-24:00)	Nights (00:00-07:00)
$0.00	$76.40 C988B (max. 1 per time period)	$96.80 C998B (max. 2 per time period)	$112.40 C983B (max. 6 per time period)	$138.60 C999B (no max. per time period)

SURGICAL ASSISTANTS' SERVICES

CANCELLED SURGERY – ASSISTANT SERVICES

Payment rules:

1. If the procedure is cancelled prior to induction of anaesthesia, the service constitutes a subsequent hospital visit.
2. When an anaesthetic has begun but the operation is cancelled due to a complication prior to commencement of surgery and the assistant has scrubbed but is not required to do anything further, the service is payable as E006B with the actual number of time units added to 6 basic units for this service.

[Commentary:
If the operation is cancelled after surgery has commenced, the amount payable is calculated by adding the listed procedural basic units plus time units and multiplying the total by the unit fee listed at the start of this section.]

SECOND ASSISTANT

Payment rules:

When more than one assistant was required for a surgical procedure, unless the service is listed below, the second assistant's service is *only eligible for payment* following authorization by a *medical consultant* and requires submission of a letter from the surgeon outlining the reason the second assistant was required. The amount payable for the second assistant is calculated in the same manner as the amount payable for the first assistant.

Services where a second assistant's services are payable and authorization is not required:
D043, D046, D047, D052, D060, E645, F135, M112, M117, M134, M142, N539, N540, P042, P051, P052, P056, P059, R008, R009, R013, R014, R015, R016, R055, R056, R064, R065, R067, R069, R134, R135, R136, R140, R182, R240, R241, R244, R326, R327, R334, R393, R438, R440, R441, R483, R487, R545, R553, R568, R593, R594, R617, R645, R701, R702, R704, R712, R713, R714, R715, R718, R726, R727, R728, R729, R732, R733, R734, R735, R737, R742, R743, R746, R747, R749, R764, R770, R771, R772, R773, R774, R786, R799, R800, R801, R802, R803, R804, R811, R815, R817, R818, R830, R832, R858, R863, R870, R872, R874, R876, R927, R929, R920, R930, S005, S007, S079, S090, S091, S092, S096, S098, S099, S120, S125, S189, S210, S211, S213, S214, S267, S270, S271, S274, S275, S294, S295, S298, S300, S321, S416, S429, S440, S441, S453, S454, S462, S484, S750, S757, S758, S759, S816

[Commentary:
E003B is *not eligible for payment* for second assistant services.]

SURGICAL ASSISTANT STANDBY

Definition/Required elements of service:

E101B is a time-based service limited to one surgical case per physician per day payable for standby as a surgical assistant following a minimum of 30 minutes of unforeseen delay beyond the scheduled start time for surgery. The physician must be physically present in the operating room suite for the period between the scheduled and actual surgical start time.

SURGICAL ASSISTANTS' SERVICES

E101B time units are calculated for each 15 minutes or part thereof. The unit value of each 15 minute period or part thereof is:

During the first hour or less	1 unit
After the first hour up to and including the first 1.75 hours	2 units
After 1.75 hours	3 units

Payment rules:

1. For calculation of time units, the start time for this service commences 30 minutes after the scheduled surgical start time and ends when the surgery actually commences as recorded in the hospital's operating suite records. There are no basic units.
2. E101B is *not eligible for payment* if during the standby time for which E101B would otherwise be eligible for payment, other insured services are rendered for which payment is made by *OHIP*.

Claims submission instruction::

1. Claims for surgical assistant standby are to be submitted using E101B.
2. Following standby, when the scheduled surgery commences, claims for assisting at surgery are to be submitted using the suffix "B", with the procedural code. The unit value of each 15 minute period or part thereof recommences as follows:

During the first hour or less	1 unit
After the first hour up to and including the first 1.75 hours	2 units
After 1.75 hours	3 units

[Commentary:

1. E101B is payable with after hours premiums.

2. Following standby, when the scheduled surgery commences, submit a separate claim for assisting, this should not be claimed using E101B. Time calculations are separate from surgical assistant standby and not a continuation of E101B. Submit both claims using the manual review indicator and include documentation to support the start and stop times claimed as the period of standby, such as a copy of the medical record or an explanatory letter.]

ANAESTHESIOLOGISTS' SERVICES

SPECIFIC ELEMENTS

In addition to the *common elements*, the *general anaesthesia* service includes the following *specific elements*.

A. Supervising the preparation of the patient for anaesthesia.

B. Performing the anaesthetic procedure, and procedures associated with the anaesthetic procedure which are not separately payable including providing all supportive measures to the patient during and immediately after the period of anaesthesia; transfer of or assisting with the transfer of the patient to the recovery room; all indicated recovery room procedures, and ongoing monitoring and detention during the immediate post-operative and recovery period.

C. Making arrangements for any assessments, procedures, or therapy, including obtaining any specimens (except for arterial puncture Z459), and/or interpreting the results, on matters related to the service.

D. Making, or supervising the making of, arrangements for follow-up care and when medically indicated, post-procedure monitoring of the patient's condition until the next insured service is provided.

E. Discussion with, and providing any advice and information, including prescribing therapy to the patient or the *patient's representative*, whether by telephone or otherwise, on matters related to the service.

F. Providing premises, equipment, supplies, and personnel for any aspect(s) of *specific elements* A, C, D, and E that is (are) performed in a place other than the place in which the general anaesthetic service is performed.

While no occasion may arise for performing elements C, D or E, when performed in connection with the other *specific elements*, they are included in the general anaesthetic service.

The *general anaesthesia* service includes:

a. a pre-anaesthetic evaluation, with *specific elements* as for assessments (see GP15);

b. the anaesthetic procedure; and

c. post-anaesthetic follow-up.

Note:

1. With the exception of the listings in the "Consultations and Visits" section, all references to an anaesthesiologist in this *Schedule* are references to any physician providing anaesthetic services.

2. As defined in the General Preamble (see GP3), *general anaesthesia*, for the purposes of this *Schedule*, includes all forms of anaesthesia except topical anaesthesia or local infiltration, unless otherwise specifically listed.

CALCULATION OF FEE PAYABLE – BASIC AND TIME UNITS

The amount payable for the anaesthesia service is calculated by adding the number of basic and time units and multiplying the total by the anaesthesiologist unit fee.

Anaesthesiologist Unit fee $15.96

Basic Units: The number of basic units is the number of basic units listed opposite the service in the column headed with "Anae" except,

ANAESTHESIOLOGISTS' SERVICES

a. where multiple or bilateral surgical procedures are performed during the same anaesthetic, the number of basic units listed in the column headed with "Anae" opposite the service that describes the major procedure; or

b. where the basic units are listed as IC, or where no basic units are listed, the amount payable is calculated by adding the appropriate time units to the basic units listed for a comparable procedure (taking into account the region, modifying conditions, or techniques).

Time Units: Time units are calculated on the basis of time spent by the anaesthesiologist and commence when the anaesthesiologist is first in attendance with the patient in the OR for the purpose of initiating anaesthesia and end when the anaesthesiologist is no longer in attendance (when the patient may safely be placed under customary post-operative supervision). Time units are calculated for each 15 minutes or part thereof. The unit value of each 15 minute period or part thereof is:

During the first hour	1 unit
After the first hour up to and including the first 1.5 hours	2 units
After 1.5 hours	3 units

Claims submission instruction:

Submit claims for anaesthesia services rendered with a surgical procedure using the suffix "C", with the procedural code.

[Commentary:
see Appendix H for a table stating the duration of the anaesthesia service and corresponding time units.]

ANAESTHESIOLOGISTS' SERVICES

AFTER HOURS PREMIUMS

These premiums are payable when a case commences:

E400C Evenings (17:00h – 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays or Holidays - increase the total anaesthetic fee by 50%

E401C Nights (00:00h – 07:00h) - increase the total anaesthetic fee by 75%

SPECIAL VISIT PREMIUMS

All special visit premiums are subject to the maximums, limitations and conditions set out in the "Special Visit Premium Table" applicable in the circumstances.

Anaesthesia special visit premiums are *only eligible for payment* when an anaesthesiologist is required to travel, as defined under "Travel Premium" page GP66, to make a special visit to the hospital to administer an anaesthetic for a case that commences:

Evenings, Weekend/Holiday, Nights and Sacrifice of Office Hours

C998C Evenings (17:00h - 24:00h) Monday to Friday; or for non-elective surgery with sacrifice of office hours - Weekdays 60.00

C985C Saturdays, Sundays or Holidays daytime and evenings (07:00h - 24:00h) 75.00

C999C Nights (00:00h - 07:00h)..... 100.00

Payment rules:

C998C, C985C and C999C are eligible for payment only for the first patient seen on each special visit.

[Commentary:

1. The specific requirements for special visits are found in pages GP65 to GP77.

2. These premiums are payable in addition to the E400 and E401 premiums.]

SPECIAL VISIT PREMIUM TABLE - ANAESTHESIA SERVICES

Anaesthesia Services

Weekdays Daytime (07:00-17:00)	Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours	Evenings (17:00-24:00) Monday through Friday	Sat., Sun. and Holidays (07:00-24:00)	Nights (00:00-07:00)
$0.00	$60.00 C998C (max. 2 per time period)	$60.00 C998C (max. 2 per time period)	$75.00 C985C (max. 6 per time period)	$100.00 C999C (no max. per time period)

ANAESTHESIOLOGISTS' SERVICES

CANCELLED SURGERY - ANAESTHESIA SERVICES

Payment rules:

1. If an anaesthesiologist examines a patient prior to surgery and the surgery is cancelled prior to the induction of anaesthesia, the service rendered constitutes a hospital subsequent visit.
2. When an anaesthetic has begun but the operation is cancelled prior to commencement of surgery, the service constitutes E006C with the actual number of time units added to 6 basic units for this service.

[Commentary:
If the operation is cancelled after surgery has commenced, the amount payable is calculated by adding the listed procedural basic units plus time units and multiplying the total by the unit fee.]

SECOND ANAESTHESIOLOGIST

Unless otherwise specified in the *Schedule*, when the anaesthetic services of more than one anaesthesiologist are necessary in the interest of the patient, the service provided by the second anaesthesiologist constitutes E001C with the actual number of time units (based on the actual time assisting the first anaesthesiologist) added to 6 basic units.

REPLACEMENT ANAESTHESIOLOGIST

When one anaesthesiologist starts a procedure and is replaced by another anaesthesiologist ("the replacement anaesthesiologist") during a surgical procedure or delivery:

a. the amount payable to the first anaesthesiologist is calculated by adding the listed procedural basic units plus time units for the time the first anaesthesiologist is in attendance;

b. except in the case of continuous conduction anaesthesia, the service provided by the replacement anaesthesiologist constitutes E005C based on the actual number of time units and 6 basic units.

Note:
E005C qualifies for the premiums E400C or E401C only if the case commences after hours (see GP94).

[Commentary:
1. Each anaesthesiologist must indicate, as part of the medical record, his/her starting and finishing times.

2. For continuous conduction anaesthesia, the replacement anaesthesiologist submits claims using the applicable continuous conduction anaesthesia fee code.]

OBSTETRICS – CONTINUOUS CONDUCTION ANAESTHESIA

P014C, introduction of a catheter for labour analgesia, including the first dose of medication with or without any combined spinal-epidural injection(s), has a value of 7 basic units.

P016C time units for maintenance of obstetrical epidural anaesthesia are calculated on the basis of 1 unit for each ½ hour of time to a maximum of 12 units per patient, per physician, per day.

E100C time units for attendance at delivery are calculated on the basis of 4 base units and 1 unit for each ¼ hour

ANAESTHESIOLOGISTS' SERVICES

[Commentary:

1. As these services fall under the definition of *general anaesthesia*, the *specific elements* for *general anaesthesia* apply to P014C, P016C and E100C.

2. For additional information on obstetrical anaesthesia services, see page K9 of the *Schedule*.]

ANAESTHESIOLOGISTS' SERVICES

EXTRA UNITS

Extra Units: An amount is payable for extra units in addition to basic units when an anaesthesiologist administers an anaesthetic to:

Fee code	Criteria	Number of extra units
E021C	premature *newborn* less than 37 *week*s gestational age	9 units
E014C	*newborn* to 28 days	5 units
E009C	*infant* from 29 days to 1 year of age	4 units
E019C	*infant* or *child* from 1 year to 8 years of age inclusive	2 units
E007C	*adult* aged from 70 to 79 years, inclusive	1 unit
E018C	*adult* aged 80 years and older	3 units
E010C	patient with *body mass index (BMI)* > 40	2 units
E011C	patient in prone position during surgery	4 units
E024C	patient in sitting position during surgery, greater than 60 degrees upright	4 units
E025C	unanticipated massive transfusion – transfusion of at least one blood volume of red blood cells	10 units
E012C	patient who is known to have malignant hyperthermia or there is a strong suspicion of susceptibility, and the anaesthetic requires full malignant hyperthermia set up and management	5 units
E022C	ASA III - patient with severe systemic disease limiting activity but not incapacitating	2 units
E017C	ASA IV – patient with incapacitating systemic disease that is a constant threat to life	10 units
E016C	ASA V – moribund patient not expected to live 24 hours *with or without* operation	20 units
E020C	ASA E - patient undergoing anaesthesia for emergency surgery which commences within 24 hours of operating room booking, to E022C, E017C or E016C	4 units

ANAESTHESIOLOGISTS' SERVICES

Note:
E025C is *only eligible for payment* for an unanticipated transfusion of blood during a surgical procedure where:

1. greater than 70 ml/kg of red blood cells are transfused for a patient with a weight up to 50 kg; or

2. 10 or more units of red blood cells are transfused for a patient with a weight exceeding 50 kg.

[Commentary:
1. For E010, BMI is calculated by dividing the patient's weight (in kilograms) by the square of the patient's height (in metres).

2. E025C is defined by the amount of blood transfused rather than the amount of blood loss. The volume of blood transfused does not include blood collected from a cell saver, hemodilution techniques or non-red blood cell components.]

Payment rules:

1. In the description of E022C, E016C, E017C and E020C, reference to ASA level for Physical Status Classification means the level determined by the anaesthesiologist at the time of the pre-operative anaesthesia assessment.

[Commentary:
The level determined above does not vary, for example, when complications arise during surgery.]

2. E016C, E017C and E020C are *not eligible for payment* when anaesthesia is rendered to a brain dead patient for organ donations.

ANAESTHESIOLOGISTS' SERVICES

REPLACEMENT OF LISTED BASIC UNITS

Circumstances under which the listed basic units for a procedure are replaced with the following basic units:

Fee code	Description	Replace Number of Basic units with
E002C	when hypothermia is used by the anaesthesiologist in procedures not specifically identified as requiring hypothermia	25 basic units
E013C	when anaesthetic management is required for the emergency relief of acute upper airway (above the carina) obstruction (excluding choanal atresia)	10 basic units

Claims submission instructions:

When claims are submitted using E002C and E013C, no claims should be submitted using procedural C suffix codes for the same procedure.

ANAESTHESIA FOR NERVE BLOCK PROCEDURES

When a physician renders an anaesthesia service in support of services performed by another physician listed in Nerve Blocks for Acute Pain Management, Interventional Pain Injections or the Peripheral/Other Nerve Block sections of the *Schedule* the anaesthesia service is *only eligible for payment* as one of the following:

E030C Procedural sedation..... 4 basic units

Note:
Extra units listed on GP97 are not payable with E030C.

E031C General anaesthesia or deep sedation..... 4 basic units

Note:
Extra units listed on GP97 are not payable with E031C.

[Commentary:
Z432C is *not eligible for payment* for an anaesthesia service in support of a nerve block.]

GENERAL PREAMBLE

ANAESTHESIOLOGISTS' SERVICES

ANAESTHESIA FOR ocular SURGERY, EXAMINATION UNDER ANAESTHESIA, colonoscopy, sigmoidoscopy and cystoscopy

For the purposes of E023C and E032C, anaesthesia means an anaesthesia service other than local infiltration, topical anaesthesia or procedural sedation rendered in support of the listed procedures. E023C and E032C replaces the listed basic units and time units for anaesthesia for these procedures.

Ocular Surgery, Cystoscopy, and Examination Under Anaesthesia

E023C Anaesthesia service for E138, E139, E140, E141, E144, E145, E146, E186, E187, E149, Z432, Z606, or Z607 ..... 6 basic units, plus time units.

Colonoscopy and Sigmoidoscopy

E032C Anaesthesia service for Z491, Z492, Z493, Z494, Z495, Z496, Z497, Z498, Z499, Z555 or Z580 ..... 4 basic units, plus time units

[Commentary:

1. Deep sedation, *general anaesthesia* or regional anaesthesia, performed by an anaesthesiologist, are examples of anaesthesia that may be rendered for E023C and E032C.

2. Anaesthesia extra units listed on GP97 are eligible for payment with E023C and E032C.

3. Local infiltration or topical anaesthesia used as an anaesthetic for any procedure is *not eligible for payment*.]

Note:

For the purposes of anaesthesia services the following definitions apply:

1. Procedural Sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

2. Deep Sedation is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

3. *General Anaesthesia* is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

ANAESTHESIA ADMINISTERED BY SAME PHYSICIAN PERFORMING A PROCEDURE

1. Except as described in paragraph 2, when a physician administers an anaesthetic, nerve block and/or other medication prior to, during, immediately after or otherwise in conjunction with a diagnostic, therapeutic or surgical procedure which the physician performs on the same patient, the administration of the anaesthetic, nerve block and/or other medication is *not eligible for payment*.

ANAESTHESIOLOGISTS' SERVICES

2. A major or minor peripheral nerve block, major plexus block, neuraxial injection (*with or without* catheter) or intrapleural block (*with or without* catheter) for post-operative pain control (with a duration of action more than 4 hours) is eligible for payment as G224 when rendered in conjunction with a procedure which the physician performs on the same patient. With the exception of a bilateral pudendal block (where only one service is eligible for payment), G224 is eligible for payment once per region per side where bilateral procedures are performed.

[Commentary:
For additional information, refer to the Nerve Blocks for Acute Pain Management, Interventional Pain Injections and the Peripheral/Other Nerve Block sections of the *Schedule*.]

GENERAL PREAMBLE

SUPPORTIVE CARE/MONITORING BY SURGICAL ASSISTANT OR ANAESTHESIOLOGIST

SPECIFIC ELEMENTS

In addition to the *common elements*, supportive care or monitoring by the surgical assistant or anaesthesiologist includes the following *specific elements*.

A. Being in constant attendance at a surgical procedure for the sole purpose of monitoring the condition of the patient (including appropriate physical examination and inquiry) and being immediately available to provide, and including the provision of, special supportive care to the patient.

B. Discussion with, and providing advice and information, including prescribing therapy to the patient or the *patient's representative*, whether by telephone or otherwise, on matters related to:

1. the service; and

2. in circumstances in which it would be professionally appropriate that results can be reported upon prior to any further patient visit, the results of related procedure(s) and/or assessment(s).

C. Providing premises, equipment, supplies, and personnel for any aspect(s) of the *specific elements* of the service that is(are) performed at a place other than the place in which the attendance occurs.

While no occasion may arise for performing element B, when performed in connection with the other elements it is included in the service.

CALCULATION OF FEE PAYABLE

The fee for this service is calculated in the same manner as for assistant and anaesthesia services.

	Asst	Anae
E003 Supportive care/Monitoring	6	4

Payment rules:

1. For E003B, the assistants' premiums apply as for assistants' services.

2. Anaesthesia extra units listed on GP97 are *not eligible for payment* with E003C.

3. E003B is *not eligible for payment* for second assistant services.

OTHER PREMIUMS

INTENSIVE OR CORONARY CARE UNIT PREMIUM

C101 For each patient seen on a visit to ICU or CCU (subject to the exceptions set out below).....add 9.10

Payment rules:
C101 is *not eligible for payment* with Supportive Care or with Critical Care, Ventilatory Care, Comprehensive Care, Acquired Brain Injury Management or Neonatal Intensive Care where team fees are claimed.

[Commentary:
C101 is also payable alone when no other separate fee is payable for the service provided in the ICU or CCU.]

Hospitalist Premium

The Hospitalist premium is payable automatically to an eligible physician subject to the definitions and rules described below.

Definitions:

"Qualifying services" means E082, C122, C123, C124, C126, C002, C007, C009, C132, C137, C139, C142, C143, A/C933, and C882/C982.

"*Fiscal year*" means April 1 - March 31st.

"Qualifying year" means the *fiscal year* preceding the date of determination of eligibility, except in cases where the physician has taken a pregnancy or parental leave during this period as confirmed by an application to the Pregnancy and Parental Leave Benefits Program. In such cases, "Qualifying year" means the most recent fiscal year not impacted by the leave.

"Date of determination of eligibility" means the date upon which the General Manager determines that the conditions for payment in (1), (2), and (3) below, have been met.

Payment rules:
For the *12 month period* following the date of determination of eligibility for the premium, the amount payable to a physician shall be automatically increased by 17% for all qualifying services except for E082 in the following circumstances:

1. The physician has provided at least 1500 qualifying services in the qualifying year; and
2. The physician has provided at least one qualifying service per day on at least 110 days in the qualifying year; and
3. The physician is a General and Family Practice (00) or an Internal Medicine (13) *specialist*.

AFTER HOURS PROCEDURE PREMIUMS

These premiums are payable only when the following criteria are met:

a. the service provided is one of the following:

OTHER PREMIUMS

Non-elective Surgical Procedures (including fractures or dislocations), Obstetrical Deliveries, Clinical Procedures Associated with Diagnostic Radiological Examinations, Ground Ambulance Transfer (K101), Air Ambulance Transfer (K111), Transport of Donor Organs (K102), Return Trip (K112), or one of the following Major Invasive Procedures:
G060, G061, G062, G065, G066, G067, G068, G082, G083, G085, G090, G099, G117, G118, G119, G125, G176, G177, G178, G179, G211, G224, G246, G248, G249, G260, G261, G262, G263, G268, G269, G275, G277, G279, G280, G282, G287, G288, G290, G297, G298, G303, G309, G322, G323, G324, G330, G331, G336, G347, G348, G349, G356, G376, G379, G380, G509, J001 to J068, and X112 when required for intussusception

and;

b. the procedure is either (a) non-elective; or (b) an elective procedure which, because of an intervening surgical emergency procedure(s) was delayed and commenced between:

Emergency Department Physician

E412	Evenings (17:00h – 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays, Holidays - increase the procedural fee(s) by	20%
E413	Nights (00:00h – 07:00h) - increase the procedural fee(s) by .	40%

Physician – other than an Emergency Department Physician

E409	Evenings (17:00h – 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays, Holidays - increase the procedural fee(s) by	50%
E410	Nights (00:00h – 07:00h) - increase the procedural fee(s) by .	75%

Payment rules:

1. E409/E410 is not payable for a procedure rendered by an Emergency Department Physician
2. E412/E413 is only payable for a procedure rendered by an Emergency Department Physician who at the time the service was rendered is required to submit claims using “H” prefix emergency services.

[Commentary:
See General Preamble GP50 for definitions and conditions for Emergency Department Physician.]

OTHER PREMIUMS

AFTER HOURS SPECIAL VISIT PREMIUMS FOR DIAGNOSTIC SERVICES

All special visit premiums are subject to the maximums, limitations and conditions set out in the "Special Visit Premium Table" applicable in the circumstances.

Subject to the provision set out below, these special visit premiums are eligible for payment for non-elective services rendered by *specialist*s in Diagnostic Radiology, Radiation Oncology or Nuclear Medicine for an acute care hospital in-patient, out-patient or emergency department patient for services listed in the following sections of the *Schedule*:

Nuclear Medicine, Radiation Oncology, Diagnostic Radiology, Clinical Procedures Associated with Diagnostic Radiology Examinations, Magnetic Resonance Imaging and Diagnostic Ultrasound.

When a physician providing one or more of the foregoing non-elective services renders a special visit (as defined under “Special Visit” page GP65) in the hospital during the time periods set out below for the purpose of interpreting the results of a diagnostic service, performing a procedure, rendering a diagnostic radiology or nuclear medicine consultation or to conclude that a procedure is not medically indicated, a special visit premium is eligible for payment payable in addition to the appropriate diagnostic radiology or nuclear medicine consultation, interpretation, or procedural fee, or by itself if the decision is made not to perform the procedure.

Payment rules:

1. These special visit premiums are *not eligible for payment* for services rendered outside of a hospital, for example via PACS.
2. Only one special visit person seen premium is eligible for payment per patient regardless of the number of eligible services rendered during the same special visit for that patient.
3. These special visit premiums are *not eligible for payment* in addition to any other special visit premium for the same special visit.
4. For the purpose of interpreting the results of a diagnostic service or performing a diagnostic service, these special visit premiums are *only eligible for payment* if the request for the interpretation relates to a patient’s condition requiring urgent interpretation that affects the patient’s management.

[Commentary:
The specific requirements for special visits are found on pages GP65 to GP78.]

SPECIAL VISIT PREMIUM TABLE - NON ELECTIVE DIAGNOSTIC SERVICES

Non-elective Diagnostic Services

Premium	Evenings (17:00-24:00) Monday through Friday	Sat., Sun. and Holidays (07:00- 24:00)	Nights (00:00- 07:00)
Travel Premium	$37.40 C102 (max. 2 per time period)	$37.40 C103 (max. 6 per time period)	$37.40 C104 (no max. per time period)
First person seen	$61.70 C109 (max. 2 per time period)	$77.10 C108 (max. 6 per time period)	$102.80 C110 (no max. per time period)
Additional person(s) seen	$61.70 C105 (max. 2 per time period)	$77.10 C106 (max. 6 per time period)	$102.80 C107 (no max. per time period)

OTHER PREMIUMS

[Commentary:
For the purposes of non-elective diagnostic services special visit premiums, first person seen and additional person(s) seen mean the eligible diagnostic service(s) rendered for each individual patient.]

OTHER PREMIUMS

AFTER HOURS SPECIAL VISIT PREMIUMS

The following premiums are payable for providing management and supervision of continuous catheter infusions for analgesia for a hospital in-patient (G247) rendered during the time periods set out below:

E402 Evenings (17:00h – 24:00h) Monday to Friday or daytime and evenings on Saturday, Sunday or Holidays ..... add 40%

E403 Nights (00:00h – 07:00h) ..... add 50%

[Commentary:
For additional information, refer to the Nerve Blocks for Acute Pain Management section of the *Schedule*.]

AFTER HOURS PREMIUMS FOR URGENT CT/MRI INTERPRETATION

Subject to the provisions set out below, these premiums are payable in addition to the CT or MRI services listed in the Diagnostic Radiology and Magnetic Resonance Imaging sections of the *Schedule* for interpreting a CT and/or MRI study on an urgent basis via a picture archiving and communication system (PACS), using diagnostic workstations and monitors consistent with Digital Imaging and Communications in Medicine (DICOM) standards. The physician must be physically present in Ontario at a location other than the hospital where the patient receives the CT or MRI study and provide the interpretation via PACS, including review of any relevant prior images available through the PACS.

Evenings, Weekend/Holiday and Nights

E406	Evenings (17:00h - 24:00h) Monday to Friday.....	60.00
E407	Saturdays, Sundays or Holidays daytime and evenings (07:00h - 24:00h).....	75.00
E408	Nights (00:00h - 07:00h).....	100.00

Payment rules:

1. These premiums are *only eligible for payment* for an urgent CT or MRI interpretation for an acute care hospital in-patient, emergency department or Hospital Urgent Care Clinic patient and only if the following requirements are satisfied:

a. the *referral* for the interpretation relates to a patient's condition that requires urgent interpretation of a CT or MRI study for the urgent management of the patient;

b. the *referral* is from a physician or oral and maxillofacial surgeon who has privileges at the hospital where the service is rendered;

c. the interpreting physician has radiology privileges at the hospital where the request for the service originates; and

d. the interpretation is transmitted to the referring provider within three hours of the completion of the CT/MRI study.

Note:
If the request for interpretation occurs prior to an eligible after hours period, but the interpretation cannot be provided prior to that eligible after hours period due to factors beyond the control of the interpreting physician, these premiums remain eligible for payment if the payment rules are otherwise satisfied.

2. E406, E407 and E408 are limited to a maximum of one per patient, per physician, per day, regardless of the number of CT and/or MRI images interpreted for that patient.

OTHER PREMIUMS

3. After hours premiums in excess of the maximums listed in the After Hours Premium Table are *not eligible for payment*.

Medical record requirements:
These premiums are *only eligible for payment* if the patient's permanent medical record contains the following information:

1. The time of the request and the time of the transmission of the interpretation; and

2. A description of any factors referred to in the note above.

OTHER PREMIUMS

AFTER HOURS PREMIUM TABLE – Urgent CT/MRI Services

Urgent CT/MRI Services

Evenings (17:00- 24:00) Monday through Friday	Sat., Sun. and Holidays (07:00- 24:00)	Nights (00:00- 07:00)
$60.00 E406 (max. 2 per time period)	$75.00 E407 (max. 6 per time period)	$100.00 E408 (no max. per time period)

TRAUMA PREMIUM

Definition/Required elements of service:

The trauma premium is payable for each of the services and units described below when:

a. rendered either on the day of the trauma or within 24 hours of the trauma; and

b. for trauma patients age 16 or more who have an Injury Severity Score (ISS) of greater than 15, or for patients less than age 16 who have an Injury Severity Score of greater than 12.

E420 Trauma premium ..... add 50%

Payment rules:

1. The premium is applicable to the following services and units;

a. services listed in the Consultation and Visits Section (Section A of the *Schedule*);

b. services listed in the Obstetrics Section (Section K of the *Schedule*);

c. services listed in the Surgical Procedures section (Section M through Z of the *Schedule*);

d. the following resuscitative services: G395, G391, G521, G522 and G523.

e. basic and time units provided by surgical assistants; or

f. basic and time units provided by anaesthesiologists.

2. The premium is payable only for the services for which the medical record lists the ISS score.

Claims submission instruction:

For claims payment purposes, the trauma premium and associated services must be submitted on the same claim record.

[Commentary:
Other special visit and after hours premiums are payable with services eligible for the trauma premium in accordance with the *Schedule*. However, the trauma premium is not applicable to these services.]

EMERGENCY DEPARTMENT ALTERNATIVE FUNDING AGREEMENTS

When one or more physicians have contracted with the *MOH* to provide insured physician services under an emergency department alternative funding agreement (ED AFA) in lieu of fee-for-service payments under the *Schedule*, then no insured service encompassed by the contract relating to the emergency department alternative funding agreement is payable, whether or not the physician who renders the service is a party to the contract unless the physician is/are:

a. a second on-call physician who either does or does not participate in the ED AFA and who can submit fee-for-service claims under the hospital's ED AFA second on-call group number;

b. general practitioner experts ('GP Experts') who, in accordance with the ED AFA, are entitled to submit fee-for-service claims under the hospital's ED AFA GP Expert group number; or

c. the patient's general/family physician only for services payable as A100 - General/Family Physician Emergency Department Assessment.

DIAGNOSTIC PROCEDURES ORDERED BY PERSONS OTHER THAN PHYSICIANS

Midwives and Aboriginal Midwives

Diagnostic ultrasound for normal, complicated or high-risk pregnancy and pelvic diagnostic ultrasound during the postpartum period rendered in an *ICHSC* or hospital is insured when referred by a midwife or aboriginal midwife.

Nurse Practitioners

Diagnostic procedures listed in the Diagnostic Radiology, Magnetic Resonance Imaging (MRI), Diagnostic Ultrasound, Pulmonary Function Studies, and Diagnostic and Therapeutic Procedures sections of the *Schedule* and rendered in an *ICHSC*, or a hospital, are insured when referred by a *nurse practitioner* if the *nurse practitioner* is either authorized to order the test under the *Nursing Act* or permitted to order the test in accordance with the regulations under the *Regulated Health Professions Act*.

Diagnostic procedures listed in the Electrocardiography section of the *Schedule* rendered in any clinical setting are insured when referred by a *nurse practitioner* if the *nurse practitioner* is either authorized to order the test under the *Nursing Act* or permitted to order the test in accordance with the regulations under the *Regulated Health Professions Act*.

Oral and Maxillofacial Surgeons

Diagnostic procedures listed in the Nuclear Medicine, Diagnostic Radiology, Magnetic Resonance Imagine (MRI), Diagnostic Ultrasound, and Pulmonary Function Studies sections of the *Schedule* and rendered in a hospital are insured when referred by an *oral and maxillofacial surgeon* if the *oral and maxillofacial surgeon* is either authorized to order the test under the *Dentistry Act* or permitted to order the test in accordance with the regulations under the *Regulated Health Professions Act*, and the test is rendered:

a. in connection with a dental surgical procedure provided by an *oral and maxillofacial surgeon* in a hospital and it is medically necessary for the patient to receive the dental surgical procedure in a hospital; or

b. on the order of an *oral and maxillofacial surgeon* who has reasonable grounds to believe that a dental surgical procedure, performed by an *oral and maxillofacial surgeon*, will be required in connection with the test and that it will be medically necessary for the patient to receive the dental surgical procedure in a hospital.

NOT ALLOCATED

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OHIP LISTED SPECIALTIES

NOT ALLOCATED

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

GENERAL LISTINGS

A005 Consultation..... 95.60

Special family and general practice consultation

This service is a consultation rendered by a GP/FP physician who provides all the elements of a consultation and spends a minimum of 50 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A911 Special family and general practice consultation..... 164.95

Comprehensive family and general practice consultation

This service is a consultation rendered by a GP/FP physician who provides all the elements of a consultation and spends a minimum of 75 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A912 Comprehensive family and general practice consultation 247.40

Payment rules:

1. For A911 and A912, the start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.

2. No other consultation, assessment, visit or counselling service is eligible for payment when rendered the same day as one of A911 or A912 to the same patient by the same physician.

[Commentary:

1. A911 and A912 must satisfy all the elements of a consultation (see page GP16).

2. Unless otherwise specified in the *Schedule*, the calculation of the 50 minute and 75 minute minimum for special and comprehensive consultations respectively excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultation and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

Special palliative care consultation

A special *palliative care* consultation is a consultation requested because of the need for specialized management for *palliative care* where the physician spends a minimum of 50 minutes in direct contact with the patient and/or patient's representative/family in consultation (majority of time must be spent in consultation with the patient) exclusive of time spent rendering any other separately billable intervention to the patient. In addition to the general requirements for a consultation, the service includes a psychosocial assessment, comprehensive review of pharmacotherapy, appropriate counselling and consideration of appropriate community services, where indicated.

A945 Special palliative care consultation..... 174.25

Payment rules:

1. Start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.

2. When the duration of a *palliative care* consultation (A945 or C945) exceeds 50 minutes, one or more units of K023 are payable in addition to A945 or C945, provided that the minimum time requirements for K023 are met. The time periods for A945 or C945 and K023 are mutually exclusive (i.e. the start time for determination of minimum time requirements for K023 occurs 50 minutes after start time for A945 or C945).

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

[Commentary:
Unless otherwise specified in the *Schedule*, the calculation of time excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultation and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

Palliative care support

Palliative care support is a time-based service payable for providing pain and symptom management, emotional support and counselling to patients receiving *palliative* care.

K023	Palliative care support	per unit	85.25

Payment rules:

1. With the exception of A945/C945, any other services listed under the "Family Practice & Practice in General" in the "Consultations and Visits" section of the *Schedule* are *not eligible for payment* when rendered with this service.
2. Start and stop times must be recorded in the patient's permanent medical record or the service will be adjusted to a lesser paying fee.
3. When the duration of A945 or C945 exceeds 50 minutes, one or more units of K023 are payable in addition to A945 or C945, provided that the minimum time requirements for K023 units occurs 50 minutes after the start time for A945 or C945.
4. This service is claimed in units. Unit means ½ hour or major part thereof - see General Preamble GP7, GP55 for definitions and time-keeping requirements.

Special Medical Assistance in Dying consultation

A special Medical Assistance in Dying (MAID) consultation is a consultation conducted for the purpose of assessing the eligibility for MAID in a patient who has submitted a written request for MAID. This service is a consultation rendered by a physician who provides all the elements of a consultation and spends a minimum of fifty (50) minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient. A350 includes the preparation and transmission of all necessary documentation.

A320	Special Medical Assistance in Dying (MAID) consultation.....		174.25

Payment rules:

1. Start and stop times must be recorded in the patient’s permanent medical record.
2. When the duration of a special MAID consultation (A320 or C320) exceeds 50 minutes, one or more units of K321 are payable in addition to A320 or C320, provided that the minimum time requirements for K321 are met. The time periods for A320 or C320 and K321 are mutually exclusive (i.e. the start time for determination of minimum time requirements for K321 occurs 50 minutes after start time for A320 or C320).

Medical Assistance in Dying support

Medical Assistance in Dying (MAID) support is a time-based service payable for providing MAID assessment, support and counselling to patients requesting MAID, and provision of MAID by a physician. MAID support is o*nly eligible for payment* when *rendered personally by the physician.*

K321	Medical Assistance in Dying (MAID) support.....	per unit	85.25

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Payment rules:

1. This service is claimed in units. Unit means ½ hour or major part thereof - see General Preamble GP7, GP55 for definitions and time-keeping requirements. Start and stop times must be recorded in the patient's permanent medical record. Minimum time requirements can be consecutive or non-consecutive time on the same day.
2. When the duration of A320 or C320 exceeds 50 minutes, one or more units of K321 are payable in addition to A320 or C320, provided that the minimum time requirements for K321 units occurs 50 minutes after the start time for A320 or C320.
3. K321 is payable to a maximum of two physicians, same patient same day.
4. With the exception of A320/C320, no other insured services or premiums are eligible for payment during the same period of time when MAID support is claimed.
5. K321 is payable in circumstances where the patient is found to be ineligible for MAID on the day of planned MAID intervention or where the patient does not provide consent for MAID intervention.

Claims submission instructions:

Claims in excess of 12 units by the same physician for the same patient should be submitted using the manual review indicator and accompanied by supporting documentation.

[Commentary:

1. The CPSO has established guidance, which lay out a number of safeguards for the provision of MAID in Ontario. For further information related to the provision of MAID in Ontario, physicians should refer to the CPSO's website (http://www.cpso.on.ca/).]

A905	Limited consultation	80.15
A006	Repeat consultation	47.10

A003 General assessment 95.60

Note:
A003 is *not eligible for payment* for an assessment provided in the patient's *home*.

A004 General re-assessment 39.35

Note:
The collection of cervical cancer screening specimen(s) is included in the consultation, repeat consultation, general or specific assessment (or re-assessment), or routine postnatal visit when pelvic examination is normal part of the foregoing services. However, the add-on codes E430 or E431 can be billed in addition to these services when collection of cervical cancer screening specimen(s) is performed outside of a hospital or *ICHSC*.

A001 Minor assessment 26.80

A007 Intermediate assessment or well baby care 44.55

E432 - when pelvic exam including speculum is performed outside of hospital or *ICHSC*, to A001 and A007 ..... add 5.00

A002 Enhanced 18 month well baby visit (see General Preamble GP34) 73.95

Payment rules:

1. Special visit premiums listed in Table VI on page GP75 of this *Schedule* are *not eligible for payment* with A007 or A001 when rendered in a patient's home.
2. For A007 or A001 rendered in a patient's home, travelling to and from the home is included as a common element of the insured service. See page GP13 of this *Schedule*.
3. See the Definitions section of this *Schedule* for the definition of home.
4. E432 is limited to one service per patient per day.
5. E432 is *only eligible for payment* when the procedure is personally rendered by the physician.
6. E432 is *not eligible for payment* with E430, E431, or E542.

Mini assessment

A mini assessment is rendered when an assessment of a patient for an unrelated non-WSIB problem is performed during the same visit as an assessment of a WSIB related problem for which only a minor assessment was rendered.

A008 Mini assessment 13.40

[Commentary:
A008 is only payable when the WSIB component of the visit is the service described as A001. In circumstances where a different service or a higher level of assessment is claimed, A008 is not payable in addition.]

Periodic health visit

K017 child 49.55

K130 adolescent 87.10

K131 adult age 18 to 64 inclusive 64.25

K132 adult 65 years of age and older 91.35

E089 - when rendered to a cisgender female or a transgender, nonbinary, gender fluid or agender patient, to K131 and K132 ..... add 20%

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Payment rules:

1. For definitions and payment rules - see General Preamble GP21.

2. E089 is *only eligible for payment* when the patient's gender identity is documented in the patient's medical record.

Emergency department equivalent - partial assessment

An *emergency department equivalent* - partial assessment is an assessment rendered in an *emergency department equivalent* on a Saturday, Sunday or *Holiday* for the purpose of dealing with an emergency.

A888 Emergency department equivalent - partial assessment..... 44.55

[Commentary:

For services described by *emergency department equivalent* - partial assessment, the only fee code payable is A888.]

Payment rules:

1. Hypnotherapy or counselling rendered to the same patient by the same physician on the same day as A888 are *not eligible for payment*.

2. No premiums are payable for a service rendered in an *emergency department equivalent*.

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Complex house call assessment

A complex house call assessment is a primary care service rendered in a patient's *home* to a patient that is considered either a frail elderly patient or a housebound patient. The service provided must satisfy, at a minimum, all of the requirements of an intermediate assessment.

A900 Complex house call assessment..... 64.80

Payment rules:

1. A complex house call assessment is *only eligible for payment* for the first person seen during a single visit to the same location.

2. A900 is *not eligible for payment* unless the patient is a frail elderly patient or a housebound patient.

Note:

1. For the purposes of A900, a frail elderly patient is a patient who is 65 years of age or over who has one or more of the following:

- **a.** Complex medical management needs, that may include polypharmacy;
- **b.** Cognitive impairment (e.g. dementia or delirium);
- **c.** Age-related reduced mobility or falls; or
- **d.** Unexplained functional decline not otherwise specified.

2. For the purposes of A900, a housebound patient is a patient who meets all the following criteria:

- **a.** The person has difficulty in accessing office-based primary health care services because of medical, physical, cognitive, or psychosocial needs/conditions;
- **b.** Transportation and other strategies to remedy the access difficulties have been considered but are not available or not appropriate in the person's circumstances; and
- **c.** The person's care and support requirements can be effectively and appropriately delivered at home.

[Commentary:

1. A900 is payable when rendered in the patient's home or an assisted living or retirement residence.

2. A900 is not payable when rendered in a long-term care home.]

Medical record requirements:

Complex house call assessment is not payable if the medical record does not:

1. Demonstrate that an intermediate assessment was rendered; and

2. Demonstrate that the patient was a frail elderly or housebound patient.

House call assessment - Pronouncement of death in the home

A house call assessment - Pronouncement of death in the *home* is the service rendered when a physician pronounces a patient dead in a *home*. This service includes completion of the death certificate and counselling of any relatives which may be rendered during the same visit.

A902 House call assessment - Pronouncement of death in the home 64.80

Claims submission instructions:

Submit the claim using the diagnostic code for the underlying cause of death as recorded on the death certificate.

Note:

For special visit premiums, please see pages GP65 to GP78 of the General Preamble.

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

On-call admission assessment

On-call admission assessment is the first hospital in-patient admission general assessment per patient per 30-day period if:

a. the physician is a general practitioner or family physician participating in the hospital's on-call roster whether or not the physician is on-call the day the service is rendered;

b. the admission is non-elective; and

c. the physician is the *most responsible physician* with respect to subsequent in-patient care.

The amount payable for any additional on-call admission assessment rendered by the same physician to the same patient in the same 30-day period is reduced to the amount payable for a general re-assessment.

A933 On-call admission assessment 82.00

General/Family physician emergency department assessment

General/Family physician emergency department assessment is an assessment of a patient that satisfies as a minimum the requirements of an intermediate assessment and is rendered by the patient's general/family physician in an emergency department funded under an Emergency Department Alternative Funding Agreement (ED-AFA). For that visit, the service includes any re-assessment of the patient by the general/family physician in the emergency department and any appropriate collaboration with the emergency department physician.

The service is *only eligible for payment* when the general/family physician's attendance is required because of the complexity, obscurity or seriousness of the patient's condition.

A100 General/Family physician emergency department assessment 78.95

Payment rules:

No other service (including special visit or other premiums) rendered by the same physician to the same patient during the same visit to the emergency department is eligible for payment with this service.

Claims submission instructions:

For claims payment purposes, the hospital master number associated with the emergency department must be submitted on the claim.

[Commentary:

1. Services described as A100 rendered in an emergency department not funded under an ED-AFA may be payable under other existing fee schedule codes.

2. In the event the patient is subsequently admitted to hospital, and the general/family physician remains the *MRP* for the patient, the General/Family Physician emergency department assessment constitutes the admission assessment. see General Preamble GP41 for additional information.]

Certification of death

Certification of death is payable to the physician who personally completes the death certificate on a patient who has been pronounced dead by another physician, medical resident or other authorized health professional. Claims submitted for this service must include the diagnostic code for the underlying cause of death as recorded on the death certificate. The service *may include* any counselling of relatives that is rendered at the same visit. Certification of death rendered in conjunction with A902 or A777/C777 is an insured service payable at nil.

A771 Certification of death 24.20

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

A777 Intermediate assessment - Pronouncement of death (see General Preamble GP27)..... 44.55

Certification of stillbirth

Certification of stillbirth is payable to the physician who personally completes the Medical Certificate of Stillbirth. The service may include any counselling of family members that is rendered at the same visit.

A772 Certification of stillbirth..... 24.20

Claims submission instructions:
For claims payment purposes, the Health Card Number of the patient experiencing the stillbirth must be submitted on the claim.

Periodic health visit for adults with Intellectual and Developmental Disabilities (IDD)

Definition/Required elements of service:

A periodic health visit for adults with IDD is a service performed on an adult with IDD that consists of an intermediate assessment, appropriate history, physical examination, health screening and relevant counselling, and a coordinated care and management plan consistent with the current Canadian consensus guidelines on the primary care of adults with IDD.

The service must include:

- **a.** Evaluation for and identification of any need for special accommodations in clinical settings as well as other health care access issues,
- **b.** Proactive review of the patient's genetic and psychosocial risks,
- **c.** Review of any chronic diseases,
- **d.** Review of systems,
- **e.** An in-person physical examination that includes, at a minimum:
  - **i.** Measurement of vital signs including weight or waist circumference,
  - **ii.** Screening for abnormalities in hearing, vision, and dentition,
  - **iii.** Screening examination of musculoskeletal and neurological systems,
  - **iv.** Survey examination of skin,
  - **v.** Detailed examination of any part(s), region(s) or system(s) needed to make a diagnosis, and/or rule out disease as a contributing factor
- **f.** Documentation of a coordinated care and management plan,
- **g.** Written communication of the care and management plan to the patient and their guardian, legal representative or other caregiver

K133 Periodic health visit for adults with Intellectual and Developmental Disabilities (IDD)..... 164.25

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Payment rules:

1. K133 is limited to one per patient per 12 month period.
2. Only one of K133, K131, or K132 is eligible for payment per patient per physician per 12 month period.
3. This service can be provided over multiple distinct time periods, however, a minimum of 50 minutes total time spent in direct contact with the patient is required, exclusive of time spent rendering any other separately billable intervention to the patient. Start and stop times must be recorded for each time period related to the service. For payment purposes, the service date on the claim must be the date on which all requirements for the service have been completed. No other services are eligible for payment for time periods used to meet the time requirements of this service.
4. While some aspects of K133 may be provided virtually, a minimum of 26 minutes must be provided through direct physical encounter(s).
5. K133 is only payable when the patient has one of the following conditions (listed with ministry diagnostic codes):
   a. Autism spectrum disorder (299)
   b. Intellectual disability or Fetal Alcohol Syndrome (319)
   c. Cerebral palsy (343)
   d. Spina bifida, with or without hydrocephalus, meningocele, meningomyelocele (741)
   e. Chromosomal anomalies such as Down's syndrome, Fragile X syndrome, other autosomal anomalies (758)

Claims submission instructions:

A diagnostic code listed above that corresponds to the patient's condition must accompany the claim for payment purposes.

[Commentary:

1. Guidelines relating to coordinated care and management plans can be found at: https://www.cfp.ca/content/cfp/64/4/254.full.pdf]
2. Unless otherwise specified in the *Schedule*, the calculation of time excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the periodic health visit and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

Focused practice assessment (FPA)

FPA is an assessment rendered by a GP/FP physician, unless otherwise specified, with additional training and/or experience in sport medicine, allergy, pain management, sleep medicine, addiction medicine (including methadone) or care of the elderly (age 65 or older). The assessment must satisfy, at a minimum, all of the requirements of an intermediate assessment.

A917	Sport medicine FPA	44.55
A927	Allergy FPA	44.55
A937	Pain management FPA	44.55
A947	Sleep medicine FPA	44.55
A957	Addiction medicine FPA	44.55
A967	Care of the elderly FPA	44.55

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Payment rules:

1. No other consultation, assessment, visit or counselling service is eligible for payment when rendered the same day as one of A917, A927, A937, A947, A957 or A967 to the same patient by the same physician.

2. E079 is *not eligible for payment* with any FPA.

3. A957 may also be billed by a *specialist* with additional training and/or experience in addiction medicine (including methadone).

[Commentary:
Physicians should be prepared to provide to the ministry documentation demonstrating training and/or experience on request.]

Periodic oculo-visual assessment

see General Preamble GP28 for definitions and conditions

A110	aged 19 years and below	48.90
A112	aged 65 years and above	48.90

Identification of patient for a major eye examination

Identification of patient for a major eye examination, is the service of determining that a patient aged 20 to 64 inclusive has a medical condition (other than diabetes mellitus, glaucoma, cataract, retinal disease, amblyopia, visual field defects, corneal disease, strabismus, recurrent uveitis or optic pathway disease) requiring a major eye examination and providing such a patient with a completed requisition.

E077	- identification of patient for a major eye examination.. add	10.25

Note:

1. This service is limited to a maximum of one every four fiscal years by the same physician for the same patient unless the patient seeks a major eye examination from a physician other than the one to whom the original requisition was provided.

2. This service is limited to a maximum of one per fiscal year by any physician to the same patient.

Major eye examination

A major eye examination is a complete evaluation of the eye and vision system for patients aged 20 to 64 inclusive. The examination must include the following elements:

a. relevant history (ocular medical history, relevant past medical history, relevant family history)

b. a comprehensive examination (visual acuity, gross visual field testing by confrontation, ocular mobility, slit lamp examination, ophthalmoscopy and, where indicated, ophthalmoscopy through dilated pupils and tonometry)

c. visual field testing by the same physician where indicated

d. refraction, and if needed, provision of a refractive prescription

e. advice and instruction to the patient

f. submission of the findings of the assessment in writing to the patient's primary care physician or *nurse practitioner*

g. any other medically necessary components of the examination (including eye-related procedures) not specifically listed above.

A115	Major eye examination.....	53.60

Note:

1. This service is only insured if the patient is described in (a) or (b) below:

a. A patient has one of the following medical conditions:

i. diabetes mellitus, type 1 or type 2
ii. glaucoma
iii. cataract
iv. retinal disease
v. amblyopia
vi. visual field defects
vii. corneal disease
viii. strabismus
ix. recurrent uveitis
x. optic pathway disease; or

b. The patient must have a valid "request for eye examination requisition" completed by another physician or by a *nurse practitioner*

2. This service is limited to one per patient per consecutive *12 month period* regardless of whether a major eye examination is rendered by the same physician, a different physician, or when the service is rendered by an optometrist described as a “major oculo-visual examination” in the *Schedule* of Benefits for Optometry Services. Where the services described as comprising a major eye examination are rendered to the same patient more than once per 12 month period, the services remain insured and payable at a lesser assessment fee.

3. Any service rendered by the same physician to the same patient on the same day that the physician renders a major eye examination is *not eligible for payment*.

4. If all the elements of a major eye examination are not performed when a patient described in note 1 above attends for the service, the service remains insured but payable at a lesser assessment fee.

5. The requisition is not valid following the end of the fiscal year (March 31) of the 5th year following the year upon which the requisition was completed.

[Commentary:
Assessments rendered solely for the purpose of refraction for patients aged 20 to 64 are not insured services.]

Midwife or Aboriginal Midwife-Requested Assessment (MAMRA)

Midwife or Aboriginal Midwife-Requested Assessment (MAMRA) is an assessment of a mother or newborn provided by a physician upon the written request of a midwife or aboriginal midwife because of the complex, obscure or serious nature of the patient’s problem and is payable to a family physician or obstetrician for such an assessment in any setting.

Urgent or emergency requests may be initiated verbally but must subsequently be requested in writing. The written request must be retained on the patient’s permanent medical record. The MAMRA must include the common and specific elements of a general or specific assessment and the physician must submit his/her findings, opinions and recommendations verbally to the midwife or aboriginal midwife and in writing to both the midwife or aboriginal midwife and the patient’s primary care physician or *nurse practitioner*, if applicable. Maximum one per patient per physician per pregnancy.

A813 Midwife or Aboriginal Midwife-Requested Assessment (MAMRA)..... 111.70

Midwife or Aboriginal Midwife-Requested Special Assessment (MAMRSA)

Midwife or Aboriginal Midwife-Requested Special Assessment must include constituent elements of A813 and is payable in any setting:

a. to a paediatrician for an urgent or emergency assessment of a newborn; or

b. to a family physician or obstetrician for assessment of a mother or newborn when, because of the very complex, obscure or serious nature of the problem, the physician must spend a minimum of 50 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient. The start and stop times of the assessment must be recorded on the patient's permanent medical record. In the absence of such information, the service is payable as A813. Maximum one per patient per physician per pregnancy.

A815 Midwife or Aboriginal Midwife-Requested Special Assessment (MAMRSA) 186.95

[Commentary:
Unless otherwise specified in the *Schedule*, the calculation of time excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the assessment and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C005 Consultation 95.60
C911 Special family and general practice consultation - subject to the same conditions as A911 ..... 164.95
C912 Comprehensive family and general practice consultation - subject to the same conditions as A912 ..... 247.40
C945 Special palliative care consultation - subject to the same conditions as A945 ..... 174.25
C320 Special Medical Assistance in Dying (MAID) consultation - subject to the same conditions as A320 ..... 174.25
C905 Limited consultation 81.25
C006 Repeat consultation 47.10
C003 General assessment 89.65
C004 General re-assessment 38.35
C813 Midwife or Aboriginal Midwife-Requested Assessment - subject to the same conditions as A813 ..... 111.70
C815 Midwife or Aboriginal Midwife-Requested Special Assessment - subject to the same conditions as A815 ..... 186.95
C933 On-call admission assessment - subject to the same conditions as A933 ..... 82.00
C777 Intermediate assessment - Pronouncement of death - subject to the same conditions as A777 ..... 44.55
C771 Certification of death - subject to the same conditions as A771 24.20

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

C772 Certification of stillbirth - subject to the same conditions as A772 ..... 24.20

Subsequent visits

C002 - first five weeks ..... per visit 40.05
C007 - sixth to thirteenth week inclusive (maximum 3 per patient per week) ..... per visit 40.05
C009 - after thirteenth week (maximum 6 per patient per month) ..... per visit 40.05

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122 - day following the hospital admission assessment 71.80
C123 - second day following the hospital assessment 71.80
C124 - day of discharge 71.80
C126 - day of discharge, medically complex patient 95.10

Payment rules:

1. In addition to satisfying all of the elements and payment rules of subsequent visit by the MRP – day of discharge (see page GP45), C126 is *only eligible for payment* under the following conditions:

a. the patient has been admitted to hospital for a minimum of 7 consecutive days,
b. the patient has a minimum of three diagnoses that contributed to the length of stay, and

2. The minimum amount of time dedicated to the provision of C126 must be 45 minutes, exclusive of time spent rendering any other separately billable intervention and personally rendered by the physician, or the service will be adjusted to a lesser paying fee.

3. Only one of C124 or C126 is *eligible for payment* per hospital admission.

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142 - first subsequent visit by the MRP following transfer from an Intensive Care Area 71.80
C143 - second subsequent visit by the MRP following transfer from an Intensive Care Area 71.80

C121 Additional visits due to intercurrent illness (see General Preamble GP43) ..... per visit 40.05

C008 Concurrent care ..... per visit 40.05
C010 Supportive care ..... per visit 40.05

C882 Palliative care (see General Preamble GP50) ..... per visit 40.05

Attendance at maternal delivery for care of high risk baby(ies)

Attendance at maternal delivery for high risk baby(ies) requires constant attendance at the delivery of a baby expected to be at risk by a physician who is not a paediatrician, and includes an assessment of the *newborn*.

H007 Attendance at maternal delivery for care of high risk baby(ies) 61.65

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Payment rules:
This service is *not eligible for payment* if any other service is rendered by the same physician at the time of the delivery.

H001 Newborn care in hospital and/or home 71.15

[Commentary:
For definition of newborn care, see GP34.]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

EMERGENCY DEPARTMENT PHYSICIAN

Note:
See General Preamble GP50 for definitions and conditions for Emergency Department Physician.

In-patient interim admission orders

In-patient interim admission orders is payable to an Emergency Department Physician who is on-call or on duty in the emergency department or Hospital Urgent Care Clinic for writing in-patient interim admission orders pending admission of a “non-elective” patient by a different *most responsible physician* (see General Preamble GP4).

Comprehensive assessment and care

Comprehensive assessment and care is a service rendered in an emergency department or Hospital Urgent Care Clinic that requires a full history (including systems review, past history, medication review and social/domestic evaluation), a full physical examination, concomitant treatment, and intermittent attendance on the patient over many hours as warranted by the patient’s condition and ongoing evaluation of response to treatment.

It also includes the following as indicated:

a. interpretation of any laboratory and/or radiological investigation; and

b. any necessary liaison with the following: the family physician, family, other institution (e.g. nursing *home*), and other agencies (e.g. *Home* Care, VON, CAS, police, or detoxification centre).

[Commentary:
Re-assessments, where required, are payable in addition to this service if the criteria described in the *Schedule* are met.]

Multiple systems assessment

A multiple systems assessment is an assessment rendered in an emergency department or Hospital Urgent Care Clinic that includes a detailed history and examination of more than one system, part or region.

Re-assessment

A re-assessment is an assessment rendered in an emergency department or Hospital Urgent Care Clinic at least two hours after the original assessment or re-assessment (including appropriate investigation and treatment), which indicates that further care and/or investigation is required and performed.

Payment rules:

1. This service is *not eligible for payment* under any of the following circumstances:

a. for discharge assessments;

b. when the patient is admitted by the Emergency Department Physician; or

c. when the reassessment leads directly to a *referral* for consultation.

2. This service is limited to three per patient per day and two per physician per patient per day. Services in excess of these limits are *not eligible for payment*.

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

H065	Consultation in Emergency Medicine	95.60
H105	In-patient interim admission orders	29.05

Note:

1. H105 is payable in addition to the initial consultation or assessment rendered in the emergency department or Hospital Urgent Care Clinic provided that each service is rendered separately by the Emergency Department Physician.

2. H105 is an insured service payable at nil if the hospital admission assessment is payable to the Emergency Department Physician.

Monday to Friday - Daytime (08:00h to 17:00h)

H102	Comprehensive assessment and care	56.70
H103	Multiple systems assessment	46.65
H101	Minor assessment	22.65
H104	Re-assessment	22.75

Monday to Thursday - Evenings (17:00h to 24:00h)

H132	Comprehensive assessment and care	75.40
H133	Multiple systems assessment	61.50
H131	Minor assessment	30.05
H134	Re-assessment	30.05

Friday Evenings (17:00h to 24:00h) and Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h)

H152	Comprehensive assessment and care	85.70
H153	Multiple systems assessment	69.60
H151	Minor assessment	34.15
H154	Re-assessment	34.15

Nights (00:00h to 08:00h)

H122	Comprehensive assessment and care	99.60
H123	Multiple systems assessment	80.95
H121	Minor assessment	39.85
H124	Re-assessment	39.80

3. With the exception of ultrasound guidance, (J149) or emergency department investigative ultrasound (H100), ultrasound services listed in this *Schedule* rendered by an Emergency Department Physician are *not eligible for payment*.

4. When any other service is rendered by the Emergency Department Physician in premium hours (and assessments may not be claimed), apply one of the following premiums per patient visit.

H112	- nights (00:00h to 08:00h)	50.95
H113	- daytime and evenings (08:00h to 24:00h) on Saturdays, Sundays or Holidays and Friday Evenings (17:00h to 24:00h)	32.20
H114	- evenings (17:00h to 24:00h) on Mondays to Thursdays	23.65

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Emergency department investigative ultrasound

An Emergency Department investigative ultrasound is *only eligible for payment* when:

1. the procedure is personally rendered by an Emergency Department Physician who meets standards for training and experience to render the service;
2. a *specialist* in Diagnostic Radiology is not available to render an urgent interpretation; and
3. the procedure is rendered for a patient that is clinically suspected of having at least one of the following life-threatening conditions:
   - **a.** pericardial tamponade
   - **b.** cardiac standstill
   - **c.** intraperitoneal hemorrhage associated with trauma
   - **d.** ruptured abdominal aortic aneurysm
   - **e.** ruptured ectopic pregnancy

H100 Emergency department investigative ultrasound..... 19.65

Payment rules:

1. H100 is limited to two (2) services per patient per day where the second service is rendered as a follow-up to the first service for the same condition(s).
2. Services listed in the Diagnostic Ultrasound section of the *Schedule*, both technical and *professional component*s are *not eligible for payment* to any physician when ultrasound images described by H100 are eligible for payment.

Note:

H100 is *only eligible for payment* when it is rendered using equipment that meets the following minimum technical requirements:

1. Images must be of a quality acceptable to allow a different physician who meets standards for training and experience to render the service to arrive at the same interpretation;
2. Scanning capabilities must include B- and M-mode; and
3. The trans-abdominal probe must be at least 3.5MHz or greater.

Medical record requirements:

The service is *only eligible for payment* when the Emergency Department investigative ultrasound includes both a permanent record of the image(s) and an interpretative report.

Claims submission instructions:

Claims in excess of two (2) services of H100 per day by the same physician for the same patient should be submitted using the manual review indicator and accompanied by supporting documentation.

[Commentary:

1. See page GP50 for the definition of an “Emergency Department Physician”.
2. Current standards and minimum requirements for training and experience for Emergency Department investigative ultrasound may be found at the Canadian Emergency Ultrasound Society website at the following link: http://www.cpocus.ca.]

Emergency department pelvic exam with speculum

H264 Emergency department pelvic exam with speculum..... 12.00

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Payment rules:

1. H264 is limited to one service per patient per day.
2. H264 is *only eligible for payment* when the procedure is personally rendered by an Emergency Department Physician.
3. H264 is eligible for payment in addition to the amount eligible for payment for an assessment.

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W105	Consultation	95.60
W911	Special family and general practice consultation - subject to the same conditions as A911	164.95
W912	Comprehensive family and general practice consultation - subject to the same conditions as A912	247.40
W106	Repeat consultation	45.90

Admission assessment

W102	- Type 1	71.20
W104	- Type 2	20.60
W107	- Type 3	30.70
W109	Periodic health visit	72.35
W777	Intermediate assessment - Pronouncement of death - subject to the same conditions as A777	44.55
W771	Certification of death - subject to same conditions as A771	24.20
W004	General re-assessment of patient in nursing home (per the Nursing Homes Act).	38.35

Note:
W004 may be claimed 6 *month*s after Periodic health visit (per the *Nursing Homes Act*).

Subsequent visits (see General Preamble GP49)

Chronic care or convalescent hospital

W002	- first 4 subsequent visits per patient per month ....per visit	40.05
W001	- additional subsequent visits (maximum 4 per patient per month)....per visit	40.05
W882	- palliative care (see General Preamble GP50) ....per visit	40.05

Nursing *home* or *home* for the aged

W003	- first 2 subsequent visits per patient per month ....per visit	40.05
W008	- additional subsequent visits (maximum 2 per patient per month)....per visit	40.05
W872	- palliative care (see General Preamble GP50) ....per visit	40.05
W121	Additional visits due to intercurrent illness (see General Preamble GP49) ....per visit	40.05
W124	Subsequent visit – day of discharge ....per visit	71.80

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Payment rules:

1. In addition to satisfying all of the elements and payment rules of subsequent visit by the MRP – day of discharge (see page GP45), W124 is *only eligible for payment* under the following conditions:

a. the discharge summary must include follow up required,

b. the patient has been admitted to chronic care or convalescent hospital or nursing home or home for the aged for a minimum of 30 consecutive days, and

c. the patient is discharged to another facility or to home where the ongoing care is expected to be assumed by a different provider.

2. W124 is *not eligible for payment* for a patient admitted for respite care.

*Month*ly Management of a Nursing *Home* or *Home* for the Aged Patient

W010 Monthly management fee (per patient per month) (see General Preamble GP51 to GP52) 135.30

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Primary mental health care

Primary mental health care is not to be billed in conjunction with other consultations and visits rendered by a physician during the same patient visit unless there are clearly different diagnoses for the two services. Unit means ½ hour or major part thereof - see General Preamble GP7, GP54 to GP61 for definitions and time-keeping requirements.

K005 Individual care..... per unit 80.00

Counselling

Unit means ½ hour or major part thereof - see General Preamble GP7, GP54 to GP61 for definitions and time-keeping requirements.

Individual care

K013 - first three units of K013 and K040 combined per patient per provider per 12 month period ..... per unit 80.00

K033 - additional units per patient per provider per 12 month period ..... per unit 56.30

Group counselling - 2 or more persons

K040 - where no group members have received more than 3 units of any counselling paid under codes K013 and K040 combined per provider per 12 month period ..... per unit 80.00

K041 - additional units where any group member has received 3 or more units of any counselling paid under codes K013 and K040 combined per provider per 12 month period . per unit 57.30

K014 Counselling for transplant recipients, donors or families of recipients and donors - 1 or more persons ..... per unit 80.00

K015 Counselling of relatives - on behalf of catastrophically or terminally ill patient - 1 or more persons ..... per unit 80.00

Chronic disease shared appointment

Definition /Required elements of service:

Chronic disease shared appointment is a pre-scheduled primary care service rendered for chronic disease management, to two or more patients with the same diagnosis of one of the diseases listed below, that consists of assessment and the provision of advice and information in respect of diagnosis, treatment, health maintenance and prevention.

Each patient must have an established diagnosis of one of the following chronic diseases:

a. Diabetes

b. Congestive Heart Failure

c. Asthma

d. Chronic obstructive pulmonary disease (COPD)

e. Hypercholesterolemia

f. Fibromyalgia

The physician must be in constant personal attendance for the duration of the appointment session, although another appropriately qualified health professional may lead parts of the educational component of the session (for example, a diabetic educator or nurse). In addition, a clinically appropriate assessment must be rendered to each patient by the same physician as a component of the chronic disease shared appointment.

This service has the same *specific elements* as an assessment.

[Commentary:
A clinically appropriate assessment *may include* a brief history or examination of the affected part or region or related mental or emotional disorder.

Chronic disease shared appointment - per patient - maximum 8 units per patient per day

K140	- 2 patients	per unit	40.05
K141	- 3 patients	per unit	26.65
K142	- 4 patients	per unit	20.15
K143	- 5 patients	per unit	16.60
K144	- 6 to 12 patients	per unit	14.10

[Commentary:
A claim must be submitted for each patient receiving a service. For example, if three patients are seen in a shared appointment, K141 is submitted for each patient. If four patients are seen, K142 is submitted for each patient.]

Payment rules:

1. Unit means ½ hour or major part thereof - see General Preamble GP7, GP54 to GP61 for definitions and time-keeping requirements.

2. The service is *only eligible for payment* when:

a. the appointment is pre-scheduled; and

b. each patient regularly visits the physician or another physician in the same physician group for management of their chronic disease.

3. Chronic disease shared appointment rendered the same day as an additional assessment by the same physician to the same patient is *not eligible for payment* unless there are clearly defined different diagnoses for the two services.

4. Chronic disease shared appointments are *only eligible for payment* for up to a maximum of twelve (12) patients per shared appointment.

Medical record requirements:
The service is *only eligible for payment* where the clinically appropriate assessment rendered on the same day is recorded in each patient's permanent medical record.

Claims submission instructions:
A locum tenens replacing an absent physician in the absent physician's office must submit claims under their own billing number.

[Commentary:
Chronic disease shared appointment does not apply to lectures.]

Psychotherapy

Includes narcoanalysis or psychoanalysis or treatment of sexual dysfunction - see General Preamble GP54.

Note:
Psychotherapy outside hospital and hypnotherapy may not be claimed as such when provided in conjunction with a consultation or other assessments rendered by a physician during the same patient visit unless there are clearly defined different diagnoses for the two services. Unit means ½ hour or major part thereof - see General Preamble GP7, GP54 to GP61 for definitions and time-keeping requirements.

K007	Individual care	per unit	80.00
	Group - per member - first 12 units per day		
K019	- 2 people.....	per unit	40.05
K020	- 3 people.....	per unit	26.65
K012	- 4 people.....	per unit	20.15
K024	- 5 people.....	per unit	16.60
K025	- 6 to 12 people.....	per unit	14.10
K010	- additional units per member (maximum 6 units per patient per day)	per unit	12.80
	Family		
K004	- 2 or more family members in attendance at the same time	per unit	86.85

Hypnotherapy

Unit means ½ hour or major part thereof - see General Preamble GP7, GP54 to GP61 for definitions and time-keeping requirements.

K006	Individual care*	per unit	80.00

Note:
* May not be claimed in conjunction with delivery as the service is included in the obstetrical fees.

Certification of mental illness

See General Preamble GP34 for definitions and conditions.

Form 1

Application for psychiatric assessment in accordance with the *Mental Health Act* includes necessary history, examination, notification of the patient, family and relevant authorities and completion of form.

K623	Application for psychiatric assessment	133.60

Form 3

Certification of involuntary admission in accordance with the *Mental Health Act* includes necessary history, examination, notification of the patient, family and relevant authorities and completion of form.

K624	Certification of involuntary admission	164.50
K629	All other re-certification(s) of involuntary admission including completion of appropriate forms.	48.75

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Note:

1. A completed Form 1 Application by a Physician For Psychiatric Assessment retained on the patient's medical record is sufficient documentation to indicate that a consultation for involuntary psychiatric treatment has been requested by the referring physician.
2. Consultations or assessments claimed in addition to certification or re-certification same day are payable at nil.
3. Certification of incompetence (financial) including assessment to determine incompetence is not an insured service (see Appendix A).

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Community treatment order (CTO)

CTO Services - are time-based all-inclusive services payable per patient to one or more physicians for the purpose of personally initiating, supervising and renewing a CTO. Eligible physicians include both the *most responsible physician* and any physician identified in the Community Treatment Plan (CTP). Each physician will individually submit claims for only those insured CTO services personally rendered by that physician. Services rendered by persons other than the physician who submits the claim are payable at nil.

In addition to the *common elements* of insured services and the *specific elements* of any service listed under “Family Practice & Practice In General” in the “Consultations and Visits” section, CTO services include:

- **a.** all consultations and visits with the patient, family or substitute decision-maker for the purpose of mandatory assessment of the patient in support of initiation, renewal, or termination of the CTO;
- **b.** interviews with the patient, family or substitute decision-maker to give notice of entitlement to legal and rights advice or to obtain informed consent under the *Health Care Consent Act*;
- **c.** all consultations, assessments and other visits including psychotherapy, psychiatric care, interviews, counselling or hypnotherapy with the patient, family or substitute decision-maker pertaining to on-going clinical management of the patient under a CTO;
- **d.** preparation of a CTP, including any necessary chart review and clinical correspondence;
- **e.** participation in scheduled or unscheduled case conferences or other meetings with one or more health care providers, community service providers, other persons identified in the CTP, legal counsel and rights advisors relating to initiation, supervision or renewal of a CTO;
- **f.** providing advice, direction or information by telephone, electronic or other means in response to an inquiry from the patient, family, substitute decision-maker, health care providers, community service providers, other persons identified in the CTP, legal counsel and rights advisors relating to initiation, renewal or on-going supervision of a CTO; and
- **g.** completion of CTO related forms, including but not limited to Form 45 CTO Initiation or Renewal, Form 47 Order for Examination and related forms or notices regarding notice of rights advice and notice of 2nd renewal to Consent and Capacity Board.

The following insured services and any associated premiums are not considered CTO services and may be claimed separately:

- **a.** assessments and special visits for emergent call to the emergency department or to a hospital in-patient;
- **b.** services related to application for psychiatric assessment or certification of involuntary admission;
- **c.** services relating to assessment and treatment of a medical condition or diagnosis unrelated to the CTO; and
- **d.** in-patient services, except those directly related to mandatory assessment for the purpose of initiating a CTO.

CONSULTATIONS AND VISITS

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Unit means ½ hour or major part thereof - see General Preamble GP7, GP54 to GP61 for Definitions and time-keeping requirements. A single all-inclusive claim for CTO Initiation or CTO Renewal is submitted once per patient per physician per initiation or renewal in any six *month* period on an Independent Consideration basis. A single all-inclusive claim for CTO Supervision is submitted once per patient per *month* on an Independent Consideration basis. The form provided by the *MOH* for elapsed times must be completed and submitted with each claim and a copy retained on the patient's permanent medical record. The total number of allowable units rendered per claim shall be determined by adding the actual elapsed time of each insured activity rounded to the nearest minute, dividing by 30 and rounding to the nearest whole unit. In the absence of a claim in accordance with these requirements, the amount payable for CTO services is nil.

K887 CTO initiation including completion of the CTO form and all preceding CTO services directly related to CTO initiation.. ..... per unit 107.90

K888 CTO supervision including all associated CTO services except those related to initiation or renewal..... per unit 107.90

K889 CTO renewal including completion of the CTO form and all preceding CTO services directly related to CTO renewal . ..... per unit 107.90

Note:

1. Travel to visit an insured person within the usual geographic area of the physician's practice is a common element of insured services. Time units for any CTO services based in whole or in part on travel time are therefore insured but payable at nil.
2. Travel time and expenses related to appearances before the Consent and Capacity Board are not insured.

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Interviews

Interviews are *not eligible for payment* when the information being obtained is part of the history normally included in the consultation or assessment of the patient. The interview must be a booked, separate appointment lasting at least 20 minutes. Unit means ½ hour or major part thereof - see General Preamble GP7, GP54 to GP61 for definitions and time-keeping requirements.

K002 Interviews with relatives or a person who is authorized to make a treatment decision on behalf of the patient in accordance with the Health Care Consent Act ..... per unit 80.00

Payment rules:
K002 is *only eligible for payment* if the physician can demonstrate that the purpose of the interview is not for the sole purpose of obtaining consent.

K003 Interviews with Children's Aid Society (CAS) or legal guardian on be half of the patient in accordance with the Health Care Consent Act conducted for a purpose other than to obtain consent..... per unit 80.00

Note:
K002, K003 are claimed using the patient's health number and diagnosis. These listings apply to situations where medically necessary information cannot be obtained from or given to the patient or guardian, e.g. because of illness, incompetence, etc.

K008 Diagnostic interview and/or counselling with child and/or parent for psychological problem or learning disabilities ..... per unit 80.00

Note:
K008 is claimed using the *child*'s health number. Psychological testing is not an insured service.

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Multidisciplinary cancer conference

A multidisciplinary cancer conference (MCC) is a service conducted for the purpose of discussing and directing the management of one or more cancer patients where the physician is in attendance either in person, by telephone or videoconference as a participant or chairperson in accordance with the defined roles and minimum standards established by Ontario Health.

K708	MCC Participant, per patient.....	37.05
K709	MCC Chairperson, per patient.....	47.75
K710	MCC Radiologist Participant, per patient.....	37.05
K711	MCC Nuclear Medicine Participant for patients requiring PET scan, per patient.....	37.05

Payment rules:

1. K708, K709, K710, and K711 are *only eligible for payment* in circumstances where:

a. the MCC meets the minimum standards, including attendance requirements, established by Ontario Health; and

b. the MCC is pre-scheduled.

2. K708, K709, K710, and K711 are eligible for payment for each patient discussed where the total time of discussion for all patients meets the minimum time requirements described in the table below, otherwise the number of patients for K708, K709, K710, and K711 are payable will be adjusted to correspond to the overall time of discussion.

3. K708, K710, and K711 are *only eligible for payment* if the physician is actively participating in the case conference, and their participation is documented in the record.

4. K708, K710, and K711 are each limited to a maximum of 5 services per patient per day, any physician.

5. K708, K710, and K711 are each limited to a maximum of 8 services, per physician, per day.

6. Only K708 or K709 or K710 or K711 is eligible for payment to the same physician, same day.

7. K709 is limited to a maximum of 8 services per physician, per day.

8. Any other insured service rendered during a MCC is *not eligible for payment*.

9. K708, K709, K710, and K711 are *not eligible for payment* where a physician receives payment, other than by fee-for-service under this *Schedule*, for the preparation and/or participation in a MCC.

10. K708 and K709 are *not eligible for payment* to physicians from the following specialties: Radiation Oncology (34), Diagnostic Radiology (33) and Laboratory Medicine (28).

11. K710 is *only eligible for payment* to physicians from Diagnostic Radiology (33).

12. K711 is *only eligible for payment* to physicians from Nuclear Medicine (63).

Medical record requirements:

1. identification of the patient and physician participants;

2. total time of discussion for all patients discussed; and

3. the outcome or decision of the case conference related to each of the patients discussed.

[Commentary:

1. The 2006 Multidisciplinary Cancer Conference standards can be found at the Ontario Health website at the following link: https://www.cancercareontario.ca/en/guidelines-advice/types-of-cancer/286

2. "Payment, other than by fee-for-service" includes compensation where the physician receives remuneration under a salary, primary care, stipend, APP or AFP model.

3. One common medical record in the patient's chart for the MCC that indicates the physician participants (including listing the time the service commenced and terminated and individual attendance times for each participant if different) would satisfy the medical record requirements for billing purposes.]

[Commentary:

1. The time spent per patient does not have to be 10 minutes. For example, if the physician participates in discussion about three patients and patient A is discussed for 5 minutes, patient B is discussed for 15 minutes and patient C for 10 minutes, the total time of discussion is 30 minutes and a claim may be submitted for each of the three patients. The time spent at the MCC should be recorded as 30 minutes.

2. If the physician participates in a discussion about four patients and the total time of discussion is 20 minutes the physician should only submit a claim for two patients.

3. A physician can only be either a chairperson, participant or radiologist participant on any given day.]

Number of Patients Discussed	Minimum Total Time of Discussion
1 patient	10 minutes
2 patients	20 minutes
3 patients	30 minutes
4 patients	40 minutes
5 patients	50 minutes
6 patients	60 minutes
7 patients	70 minutes
8 patients	80 minutes

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

CASE CONFERENCES

PREAMBLE

Definition/Required elements of service:

Where the conditions set out in this *Schedule* are met, a case conference is an insured service despite paragraph 6 of s. 24(1) of Regulation 552. A case conference is a pre-scheduled meeting, conducted for the purpose of discussing and directing the management of an individual patient. The required elements are applicable for all case conferences, except in circumstances where these requirements are modified for specific case conferences, as indicated. A case conference:

a. must be conducted by personal attendance, videoconference or by telephone (or any combination thereof);

b. must involve at least 2 other participants who meet the eligible participant requirements as indicated in the specific listed case conference services; and

c. at least one of the physician participants is the physician most responsible for the care of the patient.

[Commentary:
Case conferences for educational purposes such as rounds, journal club, group learning sessions, or continuing professional development, or any meeting where the conference is not for the purpose of discussing and directing the management of an individual patient is not a case conference.]

For case conferences where the time unit is defined in 10 minute increments, the following payment rules and medical record requirements are applicable, except in circumstances where these requirements are modified for specific listed case conference services, as indicated.

Note:
"Regulated social worker" refers to a social worker regulated under the *Social Work and Social Service Work Act* and who holds a current certificate of registration from the Ontario College of Social Workers and Social Service Workers.

Case conferences are time based services calculated in time units of 10 minute increments. In calculating time unit(s), the minimum time required is based upon consecutive time spent participating in the case conference as follows:

# Units	Minimum time
1 unit	10 minutes
2 units	16 minutes
3 units	26 minutes
4 units	36 minutes
5 units	46 minutes
6 units	56 minutes
7 units	66 minutes [1h 6m]
8 units	76 minutes [1h 16m]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Payment rules:

1. A case conference is *only eligible for payment* if the physician is actively participating in the case conference, and the physician's participation is evident in the record.

2. A case conference is *only eligible for payment* in circumstances where there is a minimum of 10 minutes of patient related discussion.

3. A case conference is *only eligible for payment* if the case conference is pre-scheduled.

4. Any other insured service rendered during a case conference is *not eligible for payment*.

5. A case conference is *not eligible for payment* in circumstances where the required participants necessary to meet the minimum requirements of the case conference service receive remuneration, in whole or in part, from the physician claiming the service.

6. The case conference is *not eligible for payment* to a physician who receives payment, other than by fee-for-service under this *Schedule*, for the preparation and/or participation in the case conference.

7. Where payment for a case conference is an included element of another service, services defined as case conferences are *not eligible for payment*.

[Commentary:

1. Chronic dialysis team fees are all-inclusive benefits for professional aspects of managing chronic dialysis and includes all related case conferences (see page J39).

2. "Payment, other than by fee-for-service" includes compensation where the physician receives remuneration under a salary, primary care, stipend, APP or AFP model.]

Medical record requirements:

A case conference is *only eligible for payment* where the case conference record includes all of the following elements:

1. identification of the patient;

2. start and stop time of the discussion regarding the patient;

3. identification of the eligible participants, and

4. the outcome or decision of the case conference.

[Commentary:

1. In circumstances where more than one patient is discussed at a case conference, claims for case conference may be submitted for each patient provided that the case conference requirements for each patient have been fulfilled.

2. One common medical record in the patient's chart for the case conference signed or initialled by all physician participants (including listing the time the service commenced and terminated and individual attendance times for each participant if different) would satisfy the medical record requirements for billing purposes.]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Hospital in-patient case conference

In addition to the definitions, required elements, payment rules, medical record requirements in the Preamble - Case conferences, a hospital in-patient case conference is participation by the physician most responsible for the care of the patient and at least 2 other participants that include physicians, regulated social workers and/or regulated health professionals regarding a hospital in-patient.

K121 Hospital in-patient case conference..... per unit 37.05

Payment rules:

1. K121 is eligible for payment for a case conference regarding a hospital in-patient at an acute care hospital, chronic care hospital, or rehabilitation hospital. K121 is *not eligible for payment* for a resident in a long term care institution.

2. K121 is limited to a maximum of 4 services per patient, per physician, per *12 month period*.

3. A maximum of 8 units of K121 are payable per physician, per patient, per day.

4. K121 is *not eligible for payment* for radiation treatment planning services listed in the Radiation Oncology section of this *Schedule*.

5. Services described in the supervision of postgraduate medical trainees section of this *Schedule* are *not eligible for payment* as K121.

[Commentary:

1. For case conferences regarding out-patients, see K700, K701, K702, K703, K704 and K707 for applicable services.

2. For case conferences regarding an in-patient in a long term care institution, see K124.]

Palliative care out-patient case conference

In addition to the definitions, required elements, payment rules, medical record requirements in the Preamble - Case conferences, a *palliative care* out-patient case conference is participation by the physician most responsible for the care of the patient and at least 2 other participants that include physicians, regulated social workers and/or regulated health professionals regarding a *palliative care* out-patient.

K700 Palliative care out-patient case conference..... per unit 37.05

Payment rules:

1. K700 is *only eligible for payment* for case conference services regarding a *palliative care* out-patient.

2. No other case conference or telephone consultation service is eligible for payment with K700 for the same patient on the same day.

3. K700 is limited to a maximum of 4 services per patient, per physician, per *12 month period*.

4. A maximum of 8 units of K700 are payable per physician, per patient, per day.

5. K700 is *not eligible for payment* for radiation treatment planning services listed in the Radiation Oncology section of this *Schedule*.

[Commentary:

1. For definitions related to *palliative care*, see General Definitions in the General Preamble of the *Schedule*.

2. For case conferences regarding an in-patient in an acute care hospital, chronic care hospital, or rehabilitation hospital, see K121.

3. For case conferences regarding an in-patient in a long term care institution, see K705 or K124.]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Paediatric out-patient case conference

In addition to the definitions, required elements, payment rules, medical record requirements in the Preamble - Case conferences, a paediatric out-patient case conference is participation by the physician most responsible for the care of the patient with at least 2 other participants that include physicians, regulated social workers regulated health professionals, education professionals, and/or personnel employed by an accredited centre of *Child*ren's Mental Health Ontario, regarding an out-patient less than 18 years of age.

K704 Paediatric out-patient case conference ..... per unit 37.05

Payment rules:

1. No other case conference or telephone consultation service is eligible for payment with K704 for the same patient on the same day.

2. K704 is limited to a maximum of 4 services per patient, per physician, per *12 month period*.

3. A maximum of 8 units of K704 are payable per physician, per patient, per day.

4. K704 is *only eligible for payment* when the physician most responsible has a specialty designation in Paediatrics (26) or Psychiatry (19).

[Commentary:

1. For case conferences regarding an in-patient in an acute care hospital, chronic care hospital, or rehabilitation hospital, see K121.

2. For case conferences regarding an in-patient in a long term care institution, see K705 or K124.

3. K704 is eligible for payment to physicians other than those who are *specialist*s in Paediatrics (26) or Psychiatry (19) as long as the physician most responsible is a paediatrician or psychiatrist.

4. For a list of mental health centres accredited by *Child*ren's Mental Health Ontario, see the following link: https://cmho.org/our-members/.]

Mental health out-patient case conference

In addition to the definitions, required elements, payment rules, medical record requirements in the Preamble - Case conferences, a mental health out-patient case conference is participation by the physician most responsible for the care of the patient with at least 2 other participants that include physicians, regulated social workers, regulated health professionals, and/or personnel employed by a mental health community agency funded by the Ontario Ministry of Health, regarding an *adult* out-patient.

K701 Mental health out-patient case conference..... per unit 37.05

Payment rules:

1. No other case conference or telephone consultation service is eligible for payment with K701 for the same patient on the same day.

2. K701 is limited to a maximum of 4 services per patient, per physician, per *12 month period*.

3. A maximum of 8 units of K701 are payable per physician, per patient, per day.

4. K701 is *only eligible for payment* when the physician most responsible has a specialty designation in Psychiatry (19).

[Commentary:

1. For case conferences regarding an out-patient aged less than 18 years of age, see K704.

2. For case conferences regarding an in-patient in an acute care hospital, chronic care hospital, or rehabilitation hospital, see K121.

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

3. K701 is eligible for payment to physicians other than those who are *specialist*s in Psychiatry (19) as long as the physician most responsible is a psychiatrist.

4. For case conferences regarding an in-patient in a long term care institution, other than a patient meeting the definition of a K705 service, see K124.]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Bariatric out-patient case conference

In addition to the definitions, required elements, payment rules, medical record requirements in the Preamble - Case conferences, bariatric out-patient case conference is participation by the physician most responsible for the care of the patient with at least 2 other participants that are working at a *Bariatric Centres of Excellence (BCoE)* or a *Bariatric Regional Assessment and Treatment Centre (RATC)* and include physicians, regulated social workers and/or regulated health professionals regarding an out-patient registered with a BCoE or a Bariatric RATC for the purpose of pre-operative evaluation and/or post-operative follow-up medical care.

K702 Bariatric out-patient case conference ..... per unit 37.05

Payment rules:

1. K702 is *only eligible for payment* when rendered for a patient registered in a BCoE or a Bariatric RATC.

2. K702 is *only eligible for payment* for physicians identified to the ministry as working in a BCoE or a Bariatric RATC.

3. No other case conference or telephone consultation service is eligible for payment with K702 for the same patient on the same day.

4. K702 is limited to a maximum of 4 services per patient, per physician per *12 month period*.

5. A maximum of 8 units of K702 are payable per physician, per patient, per day.

[Commentary:

1. For the definitions of a BCoE and/or a Bariatric RATC, see Definitions in the General Preamble.

2. For case conferences regarding an in-patient in an acute care hospital, chronic care hospital, or rehabilitation hospital, see K121.

3. For case conferences regarding an in-patient in a long term care institution, see K124.]

Geriatric out-patient case conference

In addition to the definitions, required elements, payment rules, medical record requirements in the Preamble - Case conferences, geriatric out-patient case conference is participation by the physician most responsible for the care of the patient with at least 2 other participants that include physicians, regulated social workers and/or regulated health professionals regarding an out-patient who is at least 65 years of age or, a patient less than 65 years of age who has dementia.

K703 Geriatric out-patient case conference..... per unit 37.05

Payment rules:

1. K703 is *not eligible for payment* with any other case conference or telephone consultation service for the same patient on the same day.

2. K703 is limited to a maximum of 4 services per patient, per physician, per *12 month period*.

3. A maximum of 8 units of K703 are payable per physician, per patient, per day.

4. K703 is *only eligible for payment* to:

- **a.** a *specialist* in Geriatrics (07); or
- **b.** a physician with an exemption to access bonus impact in Care of the Elderly from the *MOH*.

[Commentary:

1. For case conferences regarding an in-patient in an acute care hospital, chronic care hospital or rehabilitation hospital, see K121.

2. For case conferences regarding an in-patient in a long term care institution, see K124.]

Chronic pain out-patient case conference

In addition to the definitions, required elements, payment rules, medical record requirements in the Preamble - Case conferences, chronic pain out-patient case conference is participation by the physician most responsible for the treatment of the patient`s chronic pain with at least 2 other participants that include physicians, regulated social workers and/or regulated health professionals regarding an out-patient.

K707 Chronic pain out-patient case conference ..... per unit 37.05

Payment rules:

1. K707 is *not eligible for payment* with any other case conference or telephone consultation service for the same patient on the same day.

2. K707 is limited to a maximum of 4 services per patient, per physician, per *12 month period*.

3. A maximum of 8 units of K707 are payable per physician, per patient, per day.

[Commentary:

1. For case conferences regarding an in-patient in an acute care hospital, chronic care hospital or rehabilitation hospital, see K121.

2. For case conferences regarding an in-patient in a long term care institution, see K124.

3. Chronic pain is defined as a pain condition with duration of symptomatology of at least 6 *month*s.]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Long-term care/Ontario Health atHome case conference

In addition to the definitions, required elements, payment rules, medical record requirements in the Preamble - Case conferences, a long-term care/Ontario Health atHome case conference is participation by the physician most responsible for the care of the patient and at least 2 other participants that include physicians, regulated social workers, employees of a Ontario Health atHome and/or regulated health professionals regarding a long-term care institution inpatient.

K124 Long-term care/Ontario Health atHome case conference . per unit 37.05

Payment rules:

1. K124 is limited to a maximum of 4 services per patient, per physician, per *12 month period*.

2. A maximum of 8 units of K124 are payable per physician, per patient, per day.

3. K124 is *not eligible for payment* for radiation treatment planning services listed in the Radiation Oncology section of this *Schedule*.

4. Services described in the supervision of postgraduate medical trainees section of this *Schedule* are *not eligible for payment* as K124.

[Commentary:

1. For case conferences regarding out-patients, see K700, K701, K702, K703, K704, and K707 for applicable services.

2. For case conferences regarding an in-patient in an acute care hospital, chronic care hospital or rehabilitation hospital, see K121.]

Long-term care – High risk patient case conference

In addition to the definitions, required elements, payment rules, medical record requirements in the Preamble - Case conferences, a Long-term care – High risk patient case conference is participation by a physician and at least 2 other participants that include physicians, employees of Ontario Health atHome, regulated social workers and/or regulated health professionals regarding a long-term care institution high risk inpatient.

K705 Long-term care – high risk patient conference ..... per unit 37.05

Payment rules:

1. K705 is limited to a maximum of 4 services per patient, per physician, per *12 month period*.

2. A maximum of 8 units of K705 are payable per physician, per patient, per day.

3. K705 is *not eligible for payment* for radiation treatment planning services listed in the Radiation Oncology section of this *Schedule*.

4. Services described in the supervision of postgraduate medical trainees section of this *Schedule* are *not eligible for payment* as K705.

Note:

1. In circumstances where the physician other than the physician most responsible for the care of the patient participates in the case conference, K705 is *only eligible for payment* when the physician's participation is for directing the care of the individual patient.

2. For the purposes of K705, a high risk patient is a patient identified by staff in the long term institution with clinical instability based on a change in the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) for Nursing Homes.

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

[Commentary:

1. For case conferences regarding out-patients, see K700, K701, K702, K703, K704, and K707 for applicable services.
2. For case conferences regarding an in-patient in an acute care hospital, chronic care hospital, or rehabilitation hospital, see K121.
3. For case conferences regarding an in-patient in a long term care institution, other than a patient meeting the definition of a K705 service, see K124.
4. The Resident Assessment Instrument – Minimum Data Set (RAI-MDS) for Nursing *Home*s can be found at the following link: https://www.cms.gov/NursingHomeQualityInits/20_NHQIMDS20.asp.]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Convalescent care program case conference

In addition to the definitions, required elements, payment rules, medical record requirements in the Preamble - Case conferences, a convalescent care case conference is participation by the physician most responsible for the care of the patient and at least 2 other participants that include physicians, regulated social workers, employees of the Convalescent Care Program and/or regulated health professionals regarding a patient enrolled in a Convalescent Care Program funded by the *MOH*.

K706 Convalescent care program case conference 37.05

Payment rules:

1. K706 is limited to a maximum of 8 services per patient, per physician, per *12 month period*.

2. A maximum of 4 units of K706 are payable per physician, per patient, per day.

3. Services described in the supervision of postgraduate medical trainees section of this *Schedule* are *not eligible for payment* as K706.

[Commentary:

1. For case conferences regarding out-patients, see K700, K701, K702, K703, K704 and K707 for applicable services.

2. For case conferences regarding an in-patient in an acute care hospital, chronic care hospital, or rehabilitation hospital, see K121.

3. For case conferences regarding an in-patient in a long term care institution, see K705 or K124.]

Multidisciplinary Respiratory Case Conference

In addition to the definitions, required elements, payment rules, medical record requirements in the Preamble - Case conferences, a multidisciplinary respiratory case conference is participation by the physician most responsible for the care of the patient and at least 2 other participants that include physicians, regulated social workers and/or regulated health professionals regarding a patient with interstitial lung disease.

K715 Multidisciplinary respiratory case conference 37.05

Payment rules:

1. K715 is limited to a maximum of 4 services per patient, per physician, per *12 month period.*

2. A maximum of 8 units of K715 are payable per physician, per patient, per day.

3. Services described in the supervision of postgraduate medical trainees section of this *Schedule* are *not eligible for payment* as K715.

[Commentary:

1. For case conferences regarding out-patients, see K700, K701, K702, K703, K704 and K707 for applicable services.

2. For case conferences regarding an in-patient in an acute care hospital, chronic care hospital, or rehabilitation hospital, see K121.

3. For case conferences regarding an in-patient in a long term care institution, see K705 or K124.]

Multidisciplinary Epilepsy Surgery Case Conference

In addition to the definitions, required elements, payment rules, medical record requirements in the Preamble - Case conferences, a multidisciplinary epilepsy surgery case conference is participation by the physician most responsible for the care of the patient and at least 2 other participants that include physicians, regulated social workers and/or regulated health professionals regarding a patient who may be a candidate for epilepsy surgery.

K714 Multidisciplinary epilepsy surgery case conference..... 37.05

Payment rules:

1. K714 is limited to a maximum of 4 services per patient, per physician, per *12 month period.*

2. A maximum of 8 units of K714 are payable per physician, per patient, per day.

3. Services described in the supervision of postgraduate medical trainees section of this *Schedule* are *not eligible for payment* as K714.

[Commentary:

1. For case conferences regarding out-patients, see K700, K701, K702, K703, K704 and K707 for applicable services.

2. For case conferences regarding an in-patient in an acute care hospital, chronic care hospital, or rehabilitation hospital, see K121.

3. For case conferences regarding an in-patient in a long-term care institution, see K705 or K124.]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

PHYSICIAN/NURSE PRACTITIONER TO PHYSICIAN TELEPHONE CONSULTATION

Physician to physician telephone consultation is a service where the referring physician or nurse practitioner, in light of his/her professional knowledge of the patient, requests the opinion of a physician (the "consultant physician") by telephone who is competent to give advice in the particular field because of the complexity, seriousness, or obscurity of the case.

This service is *only eligible for payment* if the consultant physician has provided an opinion and/or recommendations for patient treatment and/or management.

For the purpose of this service, "relevant data" include family/patient history, history of the presenting complaint, laboratory and diagnostic tests, where indicated and feasible in the circumstances.

Note:
The Definition/Required elements of service and payment rules for consultations in the General Preamble are not applicable to physician to physician telephone consultations.

Definition/Required elements of service – Referring physician/Nurse Practitioner

The referring physician or nurse practitioner initiates the telephone consultation with the intention of continuing the care, treatment and management of the patient.

In addition to the Constituent and *Common Elements* of Insured Services described in the General Preamble of this *Schedule*, this service includes the transmission of relevant data to the consultant physician and all other services rendered by the referring physician or nurse practitioner to obtain the advice of the consultant physician.

Note:
This service is eligible for payment in addition to visits or other services provided to the same patient on the same day by the same referring physician.

Definition/Required elements of service – Consultant physician

This service includes all services rendered by the consultant physician to provide opinion/advice/recommendations on patient care, treatment and management to the referring physician. The consultant physician is required to review all relevant data provided by the referring physician or nurse practitioner.

K730	Physician to physician telephone consultation - Referring physician	37.05
K731	Physician to physician telephone consultation - Consultant physician	47.75

Physician on duty in an emergency department or a hospital urgent care clinic

K734	Physician to physician telephone consultation - Referring physician	37.05
K735	Physician to physician telephone consultation - Consultant physician	47.75

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

[Commentary:
Referring and consultant physicians participating in physician to physician telephone consultations while on duty in an emergency department or a hospital urgent care clinic should submit claims using K734 and K735. K730 and K731 should not be claimed in these circumstances.]

Payment rules:

1. A maximum of one K730 or K734 service is eligible for payment per patient per day.

2. A maximum of one K731 or K735 service is eligible for payment per patient per day.

3. This service is *only eligible for payment* for a physician to physician telephone consultation service:

- **a.** that includes a minimum of 10 minutes of patient-related discussion for any given patient
- **b.** where the referring physician/nurse practitioner and consultant physician are physically present in Ontario at the time of the service

4. This service is *not eligible for payment* to the referring or consultant physicians in the following circumstances:

- **a.** when the purpose of the telephone discussion is to arrange for transfer of the patient's care to any physician;
- **b.** when rendered in whole or in part to arrange for a consultation, assessment, visit, or K-prefix time-based services, procedure(s), or diagnostic investigation(s);
- **c.** when rendered primarily to discuss results of diagnostic investigation(s); or
- **d.** when a consultant physician renders a consultation, assessment, visit, or K-prefix time-based service, on the same day or next day following the physician to physician telephone consultation for the same patient.

5. In circumstances where a physician receives compensation, other than by fee-for-service under this *Schedule*, for participation in the telephone consultation, this service is *not eligible for payment* to that physician.

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Medical record requirements:

Physician to physician telephone consultation is *only eligible for payment* where the following elements are included in the medical record for a physician who submits a claim for the service:

1. patient's name and health number;

2. start and stop times of the discussion;

3. name of the referring physician or nurse practitioner and consultant physician;

4. reason for the consultation; and

5. the opinion and recommendations of the consultant physician.

Claims submission instructions:

K731 and K735 are *only eligible for payment* if the consultant physician includes the referring physician's or nurse practitioner's provider number with the claim.

[Commentary:

1. In calculating the minimum time requirement, time does not need to be continuous. In circumstances where a physician to physician telephone consultation service with the consultant physician on the same day is not continuous, the total time represents the cumulative time of all telephone consultations with the same physicians on that day pertaining to the same patient.

2. Payment, other than by fee-for-service includes compensation where the physician receives remuneration under a salary, primary care, stipend, APP or AFP model.

3. Physicians who receive compensation other than by fee-for-service under this *Schedule* should consult their contract for guidance on shadow-billing.]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

CRITICALL TELEPHONE CONSULTATION

CritiCall telephone consultation is a service where the referring physician, or nurse practitioner in light of his/her professional knowledge of a patient, requests the opinion of a physician (the "consultant physician") by telephone and where the telephone consultation has been arranged by CritiCall Ontario.

Note:
The Definition/Required elements of service and Payment rules for consultations in the General Preamble are not applicable to CritiCall telephone consultations.

Definition/Required elements of service – Referring physician/Nurse practitioner

The referring physician/nurse practitioner initiates the telephone consultation through CritiCall for the purpose of discussing the management of the patient and/or transfer of the patient to the consultant physician.

In addition to the Constituent and *Common Elements* of Insured Services described in the General Preamble of this *Schedule*, this service includes the transmission of relevant data to the consultant physician and all other services rendered by the referring physician/nurse practitioner to obtain the advice of the consultant physician.

Note:
This service is eligible for payment in addition to visits or other services provided to the same patient on the same day by the same referring physician.

Definition/Required elements of service – Consultant physician(s)

This service includes all services rendered by the consultant physician(s) necessary to provide advice on patient management. The consultant physician(s) is required to review all relevant data provided by the referring physician/nurse practitioner.

K732	CritiCall telephone consultation - Referring physician	37.05
K733	CritiCall telephone consultation - Consultant physician.....	47.75
E150	CritiCall review of complex neuroimaging, to K733	44.00

Physician on duty in an emergency department or a hospital urgent care clinic

K736	CritiCall telephone consultation - Referring physician	37.05
K737	CritiCall telephone consultation - Consultant physician.....	47.75

[Commentary:
Referring and consultant physicians participating in Criticall telephone consultations while on duty in an emergency department or a hospital urgent care clinic should submit claims using K736 and K737. K732 and K733 should not be claimed in these circumstances.]

Payment rules:

1. A maximum of 2 K732 or K736 services (any combination) are eligible for payment per patient, per day.

2. A maximum of 1 K733 or K737 service is eligible for payment per physician, per patient, per day.

3. A maximum of 1 E150 service is eligible for payment per physician, per patient, per day.

4. A maximum of 3 K733 or K737 services (any combination) are eligible for payment per patient, per day.

5. These services are *only eligible for payment* for a CritiCall telephone consultation service that fulfills all of the following criteria:

a. the telephone consultation service is arranged by, and subject to the requirements of CritiCall Ontario; and

b. the referring physician/nurse practitioner and patient are physically present in Ontario at the time of the telephone consultation.

6. E150 is *only eligible for payment*

a. to specialists in Neurosurgery (04) or Neurology(18);

b. for review of all complex neuroimaging provided by the referring physician/nurse practitioner which is defined as at least one brain and/or spinal CT, MRI or angiography; and,

c. when the analysis of the complex neuroimaging provided by the physician claiming E150 is documented in the patient permanent medical record.

7. E150 is *not eligible for payment* when the consultant physician renders a consultation, assessment, visit, or K-prefix time-based service, on the same day or next day for the same patient.

8. In circumstances where a physician receives compensation, other than by fee-for-service under this *Schedule*, for participation in the telephone consultation, these services are *not eligible for payment* to that physician.

Medical record requirements:

CritiCall telephone consultation is *only eligible for payment* where the following elements are included in the medical record for a physician who submits a claim for the service:

1. the telephone consultation was arranged by CritiCall Ontario;

2. identification of the patient by name and health number;

3. identification of the referring physician or *nurse practitioner* and consultant physician;

4. the reason for the consultation; and

5. the opinion and recommendations of the consultant physician(s).

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Claims submission instructions:

K733 and K737 are *only eligible for payment* if the consultant physician includes the referring physician or *nurse practitioner*'s provider number with the claim.

[Commentary:

1. "Payment, other than by fee-for-service" includes compensation where the physician receives remuneration under a salary, primary care, stipend, APP or AFP model.

2. In certain circumstances, more than one consultant physician may be required to participate in the same CritiCall telephone consultation. Each consultant physician may submit a claim for the teleconference subject to the established limits.

3. Physicians who receive compensation other than by fee-for-service under this *Schedule* should consult their contract for guidance on shadow-billing.]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

PHYSICIAN/NURSE PRACTITIONER TO PHYSICIAN E-CONSULTATION

Physician/nurse practitioner to physician e-consultation is a service where the referring physician or nurse practitioner, in light of his/her professional knowledge of the patient, requests the opinion of a physician (the "consultant physician") who is competent to give advice in the particular field because of the complexity, seriousness, or obscurity of the case and where both the request and opinion are sent by electronic means through a secure server.

This service is *only eligible for payment* if the consultant physician has provided an opinion and/or recommendations for patient treatment and/or management within thirty (30) days from the date of the e-consultation request.

For the purpose of this service, "relevant data" includes family/patient history, history of the presenting complaint, laboratory and diagnostic tests, where indicated.

Note:
The Definition/Required elements of service and payment rules for consultations in the General Preamble are not applicable to physician/nurse practitioner to physician e-consultations.

Definition/Required elements of service – Referring physician

The referring physician or nurse practitioner initiates the e-consultation with the intention of continuing the care, treatment and management of the patient.

In addition to the Constituent and *Common Elements* of Insured Services described in the General Preamble of this *Schedule*, this service includes the transmission of relevant data to the consultant physician and all other services rendered by the referring physician or nurse practitioner to obtain the advice of the consultant physician.

Note:
This service is eligible for payment in addition to visits or other services provided to the same patient on the same day by the same referring physician.

Definition/Required elements of service – Consultant physician

This service includes all services rendered by the consultant physician to provide opinion/ advice/recommendations on patient care, treatment and management to the referring physician or nurse practitioner. The consultant physician is required to review all relevant data provided by the referring physician or nurse practitioner. Where a service is requested by a nurse practitioner, the consultant physician shall provide the report to the nurse practitioner and the patient's primary care provider, if applicable.

K738	Physician to physician e-consultation – Referring physician ..	16.45
K739	Physician to physician e-consultation – Consultant physician	20.50

Payment rules:

1. K738 and K739 are each limited to a maximum of one (1) service per patient per day.

2. K738 and K739 are each limited to a maximum of six (6) services per patient, any physician, per *12 month period*.

3. K738 and K739 are each limited to a maximum of four hundred (400) services per physician, per *12 month period*.

4. This service is *not eligible for payment* to the referring or consultant physicians in the following circumstances:

a. when the purpose of the electronic communication is to arrange for transfer of the patient's care to any physician;

b. when rendered in whole or in part to arrange for a consultation, assessment, visit, or K-prefix time-based services, procedure(s), or diagnostic investigation(s);

c. when rendered primarily to discuss results of diagnostic investigation(s); or

d. when a consultant physician renders a consultation, assessment, visit, or K-prefix time-based service, on the same day or next day following the physician/nurse practitioner to physician e-consultation for the same patient.

5. In circumstances where a physician receives compensation, other than by fee-for service under this *Schedule*, for participation in the e-consultation, this service is *not eligible for payment* to that physician.

6. K739 is *not eligible for payment* to *specialist*s in Dermatology(02) or Ophthalmology(23).

7. K738 is eligible for payment to the primary care physician when this physician is required to collect additional data (for example dermatology or ophthalmology images not present in the primary care physician's records) to support a *specialist*'s initial, repeat, follow-up or minor e-assessment (see page GP37). K738 is *not eligible for payment* where existing data is already available in the primary care physician's records for submission to the *specialist*.

Medical record requirements:

Physician/nurse practitioner to physician e-consultation is *only eligible for payment* if all of the following elements are included in the medical record of the patient for a physician who submits a claim for the service:

1. patient's name and health number;

2. name of the referring physician or nurse practitioner and consultant physicians;

3. reason for the consultation; and

4. the opinion and recommendations of the consultant physician.

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Claims submission instructions:
K739 is *only eligible for payment* if the consultant physician includes the referring physician's or nurse practitioner's provider number with the claim.

[Commentary:
1. Payment, other than by fee-for-service includes compensation where the physician receives remuneration under a salary, primary care, stipend, APP or AFP model.
2. Physicians who receive compensation other than by fee-for-service under this *Schedule* should consult their contract for guidance on shadow-billing.]

HIV primary care

Primary care of patients infected with the Human Immunodeficiency Virus which includes any combination of common and *specific elements* of any insured service listed under "Family Practice & Practice In General" in the "Consultations and Visits" section and, in all cases, includes the same minimum time period requirements described for counselling in the General Preamble GP58. When a physician submits a claim for rendering any other consultation or visit to the same patient on the same day for which the physician submits a claim for HIV Primary Care, the HIV Primary Care service is included (in addition to the *common elements*) as a specific element of the other insured service. Unit means ½ hour or major part thereof - see General Preamble GP7, GP55 for definitions and time-keeping requirements.

K022 HIV primary care..... per unit 80.00

Intellectual and Developmental Disability Primary Care

Primary care of patients with intellectual and developmental disabilities which includes any combination of common elements and *specific elements* of any insured service listed under "Family Practice & Practice In General" in the "Consultations and Visits" section and, in all cases, includes the same minimum time period requirements described for counselling in the General Preamble GP58. When a physician submits a claim for rendering any other consultation or visit to the same patient on the same day for which the physician submits a claim for Intellectual and Developmental Disability Primary Care, the Intellectual and Developmental Disability Primary Care service is included (in addition to the *common elements*) as a specific element of the other insured service. Unit means ½ hour or major part thereof - see General Preamble GP7, GP55 for definitions and time-keeping requirements.

K125 Intellectual and Developmental Disability Primary Care
..... per unit 80.00

Payment rules:
K125 is *only eligible for payment* when the patient has Intellectual and Developmental Disability associated with one of the following conditions (listed with ministry diagnostic codes):

a. Autism spectrum disorder (299)
b. Intellectual disability or Fetal Alcohol Syndrome (319)
c. Cerebral palsy (343)
d. Spina bifida, with or without hydrocephalus, meningocele, meningomyelocele (741)
e. Chromosomal anomalies such as Down's syndrome, Fragile X syndrome, other autosomal anomalies (758)

Claims submission instructions:
A diagnostic code listed above that corresponds to the patient's condition must accompany the claim for payment purposes.

Fibromyalgia/myalgic encephalomyelitis care

Fibromyalgia/myalgic encephalomyelitis care is the provision of care to patients with fibromyalgia or myalgic encephalomyelitis. The service includes the common and *specific elements* of all insured services listed under “Family Practice & Practice In General” in the “Consultations and Visits” section of the *Schedule*.

K037 Fibromyalgia/myalgic encephalomyelitis care ..... per unit 80.00

Payment rules:

1. K037 is a time based service with time calculated based on units. Unit means ½ hour or major part thereof – see General Preamble GP7, GP55 for definitions and time-keeping requirements.

2. No other consultation, assessment, visit or time based service is eligible for payment when rendered the same day as K037 to the same patient by the same physician.

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Sexually transmitted infection (STI) or potential blood-borne pathogen management

Sexually transmitted infection (STI) or potential blood-borne pathogen management is a time based all-inclusive service for the purpose of providing assessment and counselling to a patient suspected of having a STI or to a patient with a potential blood-borne pathogen (e.g. following a "needle-stick" injury). This service is claimed in units - unit means ½ hour or major part thereof - see the General Preamble GP7, GP55 for definitions and time keeping requirements.

K028 STI management ..... per unit 80.00

Payment rules:

1. K028 is *not eligible for payment* when rendered with any consultation, assessment or visit by the same physician on the same day.

2. K028 is limited to a maximum of two units per patient per physician per day and four units per patient, per physician, per year.

Insulin therapy support (ITS)

ITS is a time-based all-inclusive visit fee per patient per day for the purpose of providing assessment, support and counselling to patients on intensive insulin therapy requiring at least 3 injections per day or using an infusion pump. The service includes any combination of common and *specific elements* of any insured service listed under “Family Practice & Practice In General” in the “Consultations and Visits” section and, in all cases, includes the same minimum time period requirements described for counselling in the General Preamble GP58. ITS rendered same patient same day as any other consultation or visit by the same physician is an insured service payable at nil. Unit means ½ hour or major part thereof - see General Preamble GP7, GP55 for definitions and time-keeping requirements. Maximum 6 units per patient, per physician, per year.

K029 Insulin therapy support (ITS) ..... per unit 80.00

[Commentary:

K029 may be payable for services that include training for patients on insulin who use devices such as glucose meters, insulin pumps and insulin pens and when *rendered personally by the physician* claiming K029.]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Diabetic management assessment (DMA)

DMA is an all-inclusive service payable to the *most responsible physician* for providing continuing management and support of a diabetic patient. The service must include an intermediate assessment, a level 2 paediatric assessment or a partial assessment focusing on diabetic target organ systems, relevant counselling and maintenance of a diabetic flow sheet retained on the patient's permanent medical record. The flow sheet must track lipids, cholesterol, Hgb A1C, urinalysis, blood pressure, fundal examination, peripheral vascular examination, weight and *body mass index (BMI)* and medication dosage. When DMA is rendered to the same patient same day as any other consultation or visit by the same physician or the above record is not maintained, the DMA is an insured service payable at nil. Maximum 4 per patient per *12 month period*.

K030 Diabetic Management Assessment 45.75

Diabetes management incentive (DMI)

DMI is a service rendered by the General/Family Physician most responsible for providing ongoing management of a diabetic patient. The service consists of ongoing management using a planned care approach consistent with the required elements of the Canadian Diabetes Association (CDA) Clinical Practice Guidelines, documenting that all of the CDA required elements have been provided for the previous *12 month period* and must include documentation that tracks, at a minimum, the following:

a. Lipids, cholesterol, HbA1C, blood pressure, weight and *body mass index (BMI)*, and medication dosage;

b. Discussion and offer of preventive measures including vascular protection, influenza and pneumococcal vaccination;

c. Health promotion counselling and patient self-management support;

d. Albumin to creatinine ratio (ACR);

e. Discussion and offer of *referral* for dilated eye examination; and

f. Foot examination and neurologic examination.

Q040 Diabetes management incentive 65.70

Payment rules:

1. Q040 is limited to a maximum of one service per patient per *12 month period*.

2. Q040 is *only eligible for payment* if the physician has rendered a minimum of three K030 services for the same patient in the same *12 month period* to which the Q040 service applies.

Medical record requirements:

A flow sheet or other documentation that records all of the required elements of the most current CDA guidelines must be included in the patient's permanent medical record, or the service is *not eligible for payment*.

Claims submission instructions:

Claims for Q040 must be submitted only when the required elements of the service have been completed for the previous *12 month period*.

[Commentary:

A copy of a flow sheet meeting the medical record requirements and CDA Clinical Practice guidelines may be found at the following link https://guidelines.diabetes.ca/GuideLines/media/Docs/cpg/Appendix-3.pdf.]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

MANAGEMENT OF A BARIATRIC SURGERY PATIENT IN A BARIATRIC CENTRE OF EXCELLENCE (BCOE) OR A BARIATRIC REGIONAL ASSESSMENT AND TREATMENT CENTRE (RATC)

Pre-operative medical management of a bariatric surgery patient in a BCoE or Bariatric RATC

Definition/Required elements of service:

Pre-operative medical management of a bariatric surgery patient is the supervision and pre-operative management of a bariatric surgery patient who is registered with, and, who is undergoing pre-operative medical evaluation and preparation related to bariatric surgery in a BCoE or Bariatric RATC. The applicable service is payable only to the physician at the BCoE or Bariatric RATC who is most responsible for the supervision and medical management of the patient in the pre-operative period.

In addition to the *Common Elements* in this *Schedule*, this service includes the provision of the following services to the same patient, during the pre-operative period:

a. All medication reviews.

b. All telephone calls involving the staff, patient, patient's relative(s) or *patient's representative* and the physician in connection with the patient.

K090 Pre-operative medical management of a bariatric surgery patient in a BCoE or Bariatric RATC..... 100.00

Payment rules:

1. K090 is *only eligible for payment* if the pre-operative period is a minimum of four *week*s.

2. K090 is *not eligible for payment* if a patient is determined not to be a candidate for bariatric surgery at the time of the initial consultation/assessment in the BCoE or Bariatric RATC.

3. K090 is *only eligible for payment* to a physician previously registered with the ministry as providing services in a BCoE or Bariatric RATC.

Note:

1. The pre-operative period for this service is defined as the period between the date the patient is determined to be a surgical candidate and the date that bariatric surgery is performed.

2. Consultations, assessments and procedures rendered by the physician who is most responsible for the supervision and management during the pre-operative period may be eligible for payment in addition to K090.

[Commentary:

1. For the definition of a BCoE or Bariatric RATC, see Definitions in the General Preamble.

2. The physician most responsible for care is anticipated to be a non-surgeon for the purposes of claiming this code.]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Post-operative monthly management of a bariatric surgery patient in a BCoE or Bariatric RATC

Definition/Required elements of service:

Post-operative *month*ly management of a bariatric surgery patient is the supervision and medical management of a post-operative bariatric surgery patient registered with, and who is receiving post-operative care, in a BCoE or Bariatric RATC. The service is payable to the physician at the BCoE or Bariatric RATC who is most responsible for the post-operative supervision and medical management of the patient.

In addition to the *Common Elements* in this *Schedule*, this service includes the provision of the following services to the same patient, during the post-operative period:

a. All medication reviews.

b. All telephone calls involving the staff, patient, patient's relative(s) or *patient's representative* and the physician in connection with the patient.

K091 Post-operative monthly management of a bariatric surgery patient in a BCoE or Bariatric RATC 25.00

Payment rules:

1. A maximum of one K091 service is eligible for payment per patient, per *month*.

2. A maximum of 6 K091 services are eligible for payment per patient, during the twenty-four consecutive *month* period beginning six *week*s following the date of surgery.

3. K091 is *only eligible for payment* if the physician personally has contact with the patient whether in person or by telephone during the *month* for which K091 is claimed.

4. K091 is *only eligible for payment* to a physician previously registered with the ministry as providing services in a BCoE or Bariatric RATC.

Note:

Consultations, assessments and procedures rendered by the physician who is most responsible for the supervision and medical management of the post-operative bariatric surgery patient may be eligible for payment in addition to K091.

[Commentary:

1. For the definition of a BCoE or Bariatric RATC, see Definitions in the General Preamble.

2. Payment of K091 will be made to only one physician, per patient, per *month*. In circumstances where the physician most responsible for the post-operative supervision and medical management of the patient is temporarily absent and/or the patient is transferred to another physician in any *month*, the physicians should determine who is the physician most responsible for the purposes of claim submission and payment. In the event that more than one claim is submitted for the same patient for the same *month*, the first claim submitted will be paid.]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Initial discussion with patient re: smoking cessation

Initial discussion with patient re: smoking cessation is the service rendered to a patient who currently smokes tobacco by the primary care physician most responsible for their patient's ongoing care, in accordance with the guidelines and subject to the conditions below.

E079 Initial discussion with patient, to eligible services ..... add 15.95

Payment rules:

1. E079 is *only eligible for payment* when rendered in conjunction with one of the following services: A001, A003, A004, A005, A006, A007, A008, A905, K005, K007, K013, K017, K130, K131, K132, K133, P003, P004, P005, P008, W001, W002, W003, W004, W008, W010, W102, W104, W107, W109 or W121.

2. E079 is limited to a maximum of one service per patient per *12 month period*.

Medical record requirements:

The medical record for this service must document that an initial smoking cessation discussion has taken place, by either completion of a flow sheet or other documentation consistent with the most current guidelines of the "Clinical Tobacco Intervention" (CTI) program, or the service is *not eligible for payment*.

[Commentary:

1. Physicians may complete a flow sheet or alternatively document that an initial discussion consistent with the 5A's model of the CTI program has taken place.]

2. E079 is *not eligible for payment* for discussions related to cannabis smoking or discussions related to vaping, including vaping tobacco.

Smoking cessation follow-up visit

Smoking cessation follow-up visit is the service rendered by a primary care physician in the 12 *month*s following E079 that is dedicated to a discussion of tobacco smoking cessation, in accordance with the guidelines and subject to the conditions below.

K039 Smoking cessation follow-up visit 39.25

Payment rules:

1. K039 is *only eligible for payment* when E079 is payable to the same physician in the preceding *12 month period*.

2. K039 is limited to a maximum of two services in the 12 *month*s following E079.

Medical record requirements:

The medical record for this service must document that a follow-up visit regarding smoking cessation has taken place, by either completion of a flow sheet or other documentation consistent with the most current guidelines of the "Clinical Tobacco Intervention" (CTI) program, or the service is *not eligible for payment*.

[Commentary:

1. APhysicians may complete a flow sheet or alternatively document that an initial discussion consistent with the 5A's model of the CTI program has taken place.]

2. K039 is *not eligible for payment* for discussions related to cannabis smoking or discussions related to vaping, including vaping tobacco.

Sexual assault examination

For investigation of alleged sexual assault and documentation using the evidence kit provided by Ministries of the Attorney General and the Solicitor General.

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

K018	- female	358.45
K021	- male	282.75

Ontario Hepatitis C Assistance Program (OHCAP)

Certification of Medical Eligibility for OHCAP - includes any combination of common and *specific elements* of any insured service listed under “Family Practice & Practice In General” in the “Consultations and Visits” section and completion of the Application for OHCAP - Physician’s Form. When a physician submits a claim for rendering any other consultation or visit on the same day for which the physician submits a claim for Certification of Medical Eligibility for OHCAP, the Certification service is included (in addition to the *common elements*) as a specific element of the other service.

K026	Certification of Medical Eligibility for OHCAP	54.70
K027	Certification of Medical Eligibility for OHCAP - includes only completion of Application for OHCAP - Physician’s Form without an associated consultation or visit on the same day.	21.85

Mandatory blood testing act - Physician report

K031	Completion of Form 1 - Physician report in accordance with the Mandatory Blood Testing Act	105.20

Specific neurocognitive assessment

A specific neurocognitive assessment is an assessment of neurocognitive function *rendered personally by the physician* where all of the following requirements are met:

a. test of memory, attention, language, visuospatial function and executive function.

b. a minimum of 20 minutes (consecutive or non-consecutive) and must be dedicated exclusively to this service (including administration of the tests and scoring) and must be completed on the same day; and

c. the start and stop time(s) must be recorded in the patient's medical record.

K032 Specific neurocognitive assessment..... 82.25

[Commentary:
Examples of neurocognitive assessment batteries which would be acceptable are the short form of the Behavioral Neurology Assessment (BNA) or the Dementia Rating Scale (DRS). The Mini-Mental State Examination ("Folstein") test is not considered acceptable for this purpose.]

Extended specific neurocognitive assessment

An extended specific neurocognitive assessment is an assessment of neurocognitive function r*endered personally by the physician* where all of the following requirements are met:

a. test of memory, attention, language, visuospatial function and executive function;

b. a minimum of 46 minutes (consecutive or non-consecutive) must be dedicated exclusively to this service (including administration of the tests and scoring) and must be completed on the same day; and

c. the start and stop time(s) must be recorded in the patient's medical record.

K042 Extended specific neurocognitive assessment..... 140.20

Payment rules:

1. K042 is *only eligible for payment* to specialists in one of the following: Geriatrics (07), Neurology (18), and Psychiatry (19).

2. Only one of K032 or K042 is eligible for payment to the same physician, same day.

[Commentary:
Examples of extended neurocognitive assessment batteries which would be acceptable, where the minimum time requirement has been met, are the Toronto Cognitive Assessment (TorCA) or the Behavioral Neurology Assessment-short form in addition to the Montreal Cognitive Assessment (BNA-SF + MOCA) or the Behavioral Neurology Assessment-short form in addition to the Frontal Assessment battery (BNA-SF + FAB). Note that for K042, MOCA or BNA-SF or FAB alone is not a sufficient neurocognitive assessment battery for payment purposes.

Home care referral form

The service rendered by the *most responsible physician* for completion and submission of a home care referral form to Ontario Health atHome on behalf of a patient for whom the physician provides on-going medical care. The amount payable for this service is as shown and is in addition to the assessment fee payable, where applicable. The amount payable for completion of the home care referral form if completed in whole or in part by a person other than the physician or the physician’s employee is nil.

K070 Completion of home care referral form..... 34.75

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Note:

1. K070 is limited to one per Ontario Health atHome *home* care program admission per patient.

2. K070 is *not eligible for payment* if the patient is currently receiving Ontario Health atHome *home* care.

Home care supervision

The service rendered by a physician for personally providing medical advice, direction or information to health care staff of a Ontario Health atHome or an Ontario Health atHome contractor on behalf of a patient for whom the physician provides on-going medical care. The date, medical advice, direction or information provided must be recorded in the patient's medical record. If the information is provided verbally to staff, the name of the staff person must be recorded. The amount payable for *home* care supervision without the required record of service in the patient's medical record is nil. The amount payable for *home* care supervision rendered on the same day as a consultation or visit by the same physician with the same patient is nil.

K071	Acute home care supervision (first 8 weeks following admission to Ontario Health atHome home care program)	21.95
K072	Chronic home care supervision (after the 8th week following admission to Ontario Health atHome home care program)	21.95

Payment rules:

1. K071 is limited to a maximum of one service per patient per physician per *week* for 8 *week*s following admission to Ontario Health atHome *home* care program.

2. K071 is limited to a maximum of two services per patient per *week* for 8 *week*s.

3. K072 is limited to a maximum of 2 services per *month* per patient per physician after the 8th *week* following admission to Ontario Health atHome *home* care program.

4. K072 is limited to a maximum of four services per patient per *month*.

Mandatory reporting of medical condition to the Ontario Ministry of Transportation (MTO)

Mandatory reporting of medical condition to the Ontario Ministry of Transportation (MTO) requires providing to MTO information that satisfies the requirements of the *Highway Traffic Act* or any applicable regulations, and includes providing any additional information to MTO regarding a previous report related to the same medical condition.

K035	Mandatory reporting of medical condition to the Ontario Ministry of Transportation	36.25

Claims submission instructions:

Claims in excess of one per *12 month period* by the same physician for the same patient should be submitted using the manual review indicator and accompanied by supporting documentation.

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Northern health travel grant application form

K036 Completion of northern health travel grant application form ... 10.25

[Commentary:
K036 is payable to both the referring physician and *specialist* physician.]

Long-Term Care Health Assessment Form

The service rendered for completion and submission of a health assessment form to Ontario Health atHome on behalf of a patient who is applying for admission to a Long-Term Care facility.

K038 Completion of Long-Term Care health assessment form 46.35

Immediate telephone reporting - specified reportable disease to the Medical Officer of Health

Telephone reporting of a specified reportable disease to a Medical Officer of Health (MOH) is the service of immediately providing all available information to a MOH in order to comply with the requirements of the *Health Protection and Promotion Act* and/or any applicable regulations, and includes providing, by any method, any subsequent information to a MOH regarding a previous report related to the same reported disease within the *12 month period*.

K034 Telephone reporting - specified reportable disease to a MOH 36.00

Payment rules:

1. K034 is limited to a maximum of one service per physician, per patient, per specified reportable disease, per *12 month period*.

2. K034 is *only eligible for payment* when the telephone report is personally rendered by the physician.

3. K034 is *only eligible for payment* for the following specified reportable diseases: anthrax, botulism, brucellosis, cholera, novel coronavirus (including SARS and MERS), cryptosporidiosis, cyclosporiasis, diphtheria, primary viral encephalitis, food poisoning (all causes), symptomatic giardiasis, invasive Haemophilus influenzae type b disease, Hantavirus pulmonary syndrome, hemorrhagic fevers (e.g. Ebola, Lassa, Marburg and other viral causes), hepatitis A, legionellosis, listeriosis, measles, acute bacterial meningitis, invasive meningococcal disease, paratyphoid fever, plague, acute poliomyelitis, Q fever, rabies, rubella, shigellosis, smallpox, invasive group A streptococcal infections, tularemia, typhoid fever, verotoxin-producing E. coli infection indicator conditions (e.g. haemolytic-uremic syndrome), and West Nile virus illness

Medical record requirements:
K034 is *only eligible for payment* if the patient record demonstrates that the required information of the report related to one of the specified reportable disease has been communicated immediately by telephone to the MOH.

[Commentary:

1. For payment purposes, an immediate telephone report to a MOH includes a report provided to a delegate of a MOH.

2. For payment purposes, the specified list of diseases has been identified as requiring an immediate telephone report.]

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

CLINICAL INTERPRETATION BY AN IMMUNOLOGIST

Clinical Interpretation by an immunologist requires review of clinical data and interpretation of diagnostic tests and the results of related assessments in order to arrive at an opinion as to the nature of the patient's condition. The physician must submit his/her findings, opinions, and recommendations in writing to the patient's physician.

K399 Clinical interpretation by an immunologist 29.05

Payment rules:

This service is *not eligible for payment* when rendered in association with a consultation on the same patient by the same physician.

FAMILY PRACTICE & PRACTICE IN GENERAL (00)

Addiction medicine – initial assessment – substance abuse

Initial assessment - substance abuse is an assessment where the physician spends a minimum of 50 minutes in direct contact with the patient assessing a patient related to substance abuse *with or without* the patient's relative(s) or *patient's representative*, exclusive of time spent rendering any other service that is separately eligible for payment to the patient. This service is *only eligible for payment* to the physician intending to subsequently render treatment of the patient's substance abuse.

The elements of the service must include:

- **i.** A complete history of illicit drug use, abuse and dependence, ensuring that a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis is recorded for each problematic drug;
- **ii.** A complete addiction medicine history;
- **iii.** Past medical history;
- **iv.** Family history;
- **v.** Psychosocial history, including education;
- **vi.** Review of systems;
- **vii.** A focused physical examination, when indicated;
- **viii.** Assessment/diagnosis including a DSM diagnosis for each problematic drug;
- **ix.** Review of treatment options;
- **x.** Formulation of a treatment plan;
- **xi.** Communication with the patient and/or family to obtain information for the assessment as well as for support staff working in the treatment environment;
- **xii.** Communication with previous care providers, including family doctors, as necessary.

A680 Initial assessment – substance abuse 164.95

Payment rules:

1. A680 is limited to one per patient per physician or practice group except in circumstances where a *12 month period* has elapsed since the most recent insured service rendered to the patient by the same physician.
2. A680 is *not eligible for payment* for the assessment of substance abuse related to smoking cessation.

[Commentary:

1. For assessment services related to smoking cessation, see general listings, A957, K039 and E079 services, as applicable.]
2. For the purpose of A680, practice group is defined as those physicians who are part of the same billing group or are co-located and have shared access to the patient's medical record.
3. Unless otherwise specified in the *Schedule*, the calculation of time excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the assessment and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

Medical record requirements:

1. Start and stop times of the service must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser assessment fee.
2. A DSM diagnosis must be recorded in relation to each problematic substance in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser assessment fee.
3. Relevant information obtained in the provision of all elements of the service must be recorded in the medical record or the amount payable for the service will be adjusted to a lesser assessment fee.

C680 Initial assessment – substance abuse – subject to the same conditions as A680 ..... 164.95

Substance abuse - extended assessment

A substance abuse - extended assessment is the service for providing care to patients receiving therapy for substance abuse. The service has the same *specific elements* as an assessment.

K680 Substance abuse - extended assessment..... per unit 80.00

Payment rules:

1. K680 is a time based service with time calculated based on units. Unit means ½ hour or major part thereof – see General Preamble GP7, GP55 for definitions and time-keeping requirements.

2. No other consultation, assessment, visit or time based service is eligible for payment when rendered the same day as K680 to the same patient by the same physician.

3. K680 is *not eligible for payment* for management of smoking cessation.

Medical record requirements:

Start and stop times must be recorded in the patient's permanent medical record or payment will be adjusted to reflect the service documented in the medical record.

[Commentary:

See K039 – smoking cessation.]

Monthly management of a patient in an Opioid Agonist Maintenance Program (OAMP)

Definition/Required elements of service:

*Month*ly management of a patient in an Opioid Agonist Maintenance Program (OAMP) is the one *month* management and supervision of a patient receiving opioid agonist treatment by the physician most responsible for the management and supervision of that patient when rendered in accordance with the definitions and payment rules described below.

This service includes the following *specific elements*:

a. All medication reviews, adjusting the dose of the opioid agonist therapy, and where appropriate, prescribing additional therapy, and discussions with pharmacists;

b. With the exception of all physician to physician telephone consultation services, discussion with, and providing advice and information to the patient, patient's relative(s), patient's representative or other caregiver(s), in person, by telephone or otherwise, on matters related to the service, regardless of identity of person initiating discussion; and

c. All discussions in respect of the patient’s opioid dependency, except where the discussion is payable as a separate service.

K682 Opioid Agonist Maintenance Program monthly management fee - intensive, per month..... 45.00

K683 Opioid Agonist Maintenance Program monthly management fee - maintenance, per month 38.00

K684 - Opioid Agonist Maintenance Program - team premium, per month, to K682 or K683..... add 6.00

Definitions:

a. Required services are:

i. a consultation, assessment or visit from the Consultation and Visits section of this *Schedule*; or

ii. a K-prefix time-based service excluding group services and case conferences.

b. OAMP - intensive, is the service for management of an OAMP patient receiving an opioid agonist where the physician renders at least two (2) required services in the *month*.

c. OAMP - maintenance, is the service for management of an OAMP patient receiving an opioid agonist where the physician renders one required service in the *month*.

d. OAMP - team premium, is the service for management of an OAMP patient receiving an opioid agonist where:

i. the physician most responsible for the OAMP management of the patient provides one of K682 or K683 in the *month* and supervises members of the OAMP management team;

ii. the OAMP management team consists of the physician most responsible for the OAMP treatment and at least two other non-physician members who have successfully completed a training program in addiction medicine that includes opioid agonist management;

iii. the OAMP management team members provides at least one in-person therapeutic encounter with the patient in the *month* for which the service is payable; and

iv. the therapeutic encounter is not primarily for the purpose of urine testing or the provision of a prescription.

e. A service primarily for the purpose of providing a prescription does not constitute a required service and does not count towards the minimum requirements of K682 or K683.

Payment rules:

1. K682, K683 and K684 are *only eligible for payment* to the physician most responsible for the patient's OAMP for the applicable *month*.

2. K684 is *only eligible for payment* when all required patient encounters are documented in the medical record.

3. K682 is limited to a maximum of six services per patient per *12 month period*.

4. A maximum of one of K682 or K683 is eligible for payment per patient per *month* any physician.

[Commentary:
OAMP *month*ly management fees may be claimed for a patient enrolled in a treatment program using methadone or buprenorphine.]

Claims submission instructions:
Claims for K683, K682 and K684 are payable only after the minimum requirements have been rendered for the *month*.

[Commentary:

1. In circumstances where the physician most responsible for the patient's OAMP is temporarily absent and/or the patient is transferred to another physician in any *month*, the physicians should determine who is the physician most responsible for the purposes of claim submission and payment. In the event that more than one claim is submitted for the same patient for the same *month*, only the first claim submitted is eligible for payment.

VIRTUAL CARE SERVICES

DEFINITIONS:

For the purposes of this section of the *Schedule* only, the following Definitions apply:

Comprehensive Virtual Care Service means a Virtual Care Service rendered where an Existing/Ongoing Patient-Physician Relationship exists, and in the physicians' professional opinion in accordance with accepted professional standards and practice, the person's care and support requirements can be effectively and appropriately delivered by Video or Telephone.

Existing/Ongoing Patient-Physician Relationship means:

1. Where a physician is providing a Virtual Care Service to a patient where there has been at least one insured service with a direct physical encounter between the patient and that physician (Family and General Practice Physician or *specialist*) in the preceding 24-months; or
2. Where a physician is providing a Virtual Care Service to a patient who has signed the *MOH*'s Patient Enrollment and Consent to Release Personal Health Information form and is enrolled to that physician or another physician within the same group (who is signatory/locum to a *MOH* alternate funding plan agreement); or
3. Where a *specialist* or GP Focused Practice Physician is providing a consultation by Video set out in Appendix J – Section 1, or has provided any such consultation in the preceding 24-months to that patient; or

[Commentary:
Where the visit leading to the referral for consultation has occurred virtually, it would be expected that the referring physician has an established relationship with the patient and that the clinical issue leading to the referral has been assessed in-person within the previous 12-months.]

[Commentary:
Where a physician who has been paid for a consultation for the patient for the same diagnosis makes a request for a *referral* for ongoing management of the patient, the service rendered following the *referral* is not payable as a consultation, unless the request for *referral*, if the *referral* is made, allows for an ongoing patient physician relationship in the context of a consultation by Video.]

4. Where a physician provides any of the following services, or has provided any of the following services in the preceding 24-months:
    - A920 – Medical management of early pregnancy - initial service by Video or Telephone,
    - A945/C945 – Special palliative care consultation by Video,
    - A320/C320 - Special Medical Assistance in Dying (MAID) consultation by Video,
    - A680/C680 – Initial assessment - substance abuse by Video,
    - A814, A817, A818 – Midwife or Aboriginal Midwife-Requested Assessments (MRAs) by Video,
    - A802 – Extended midwife or Aboriginal Midwife-requested genetic assessment by Video,

VIRTUAL CARE SERVICES

- A801 – Comprehensive midwife or Aboriginal Midwife-requested genetic assessment by Video,
- A800 – Midwife or Aboriginal Midwife-requested genetic assessment by Video,
- A253 – Optometrist-Requested Assessment (ORA) by Video,
- A256 – Special optometrist-requested assessment by Video,
- A957 – Addiction medicine FPA by Video,
- K680 – Substance abuse – extended assessment by Video.

[Commentary:

1. Follow-up Virtual Care Services provided in the 24-months subsequent to the services listed in 3 or 4 may be claimed as Comprehensive Virtual Care Services.]

GP Focused Practice Physician means, for the purpose of eligibility to provide a focused practice consultation by Video (A010, A011, A906, A913, A914), a physician who has been designated by the bi-lateral *MOH-OMA* GP Focused Practice Review Committee or a physician who is eligible for the focused practice psychotherapy premium.

Limited Virtual Care Service means a Virtual Care Service rendered where an Existing/ Ongoing Patient-Physician Relationship does not exist, and in the physicians' professional opinion in accordance with accepted professional standards and practice, the person's care and support requirements can be effectively and appropriately delivered by Video or Telephone.

Verified-Virtual Visit Solution means virtual service delivery platforms listed on Ontario Health's public list of verified solutions.

Virtual Care Service means a service provided using information technologies to render eligible services to patients remotely.

Eligible Virtual Care Service modalities are:

Telephone means synchronous audio-only communication (no visualization); and

Video means 2-way synchronous video-conference (audio and Video visualization) using a Verified-Virtual Visit Solution;

Terms and Conditions for Virtual Care Services

1. Other than a direct physical encounter, all other requirements and conditions for the appropriate service as described in the *Schedule* must be met.

2. Virtual Care Services are *not eligible for payment* where it is not medically appropriate to provide the specific service without a direct physical encounter.

a. If during the course of a Virtual Care Service it becomes apparent that the service cannot be appropriately completed without a direct physical encounter, the Virtual Care Service is *not eligible for payment* (only the service with a direct physical encounter is eligible for payment).

VIRTUAL CARE SERVICES

b. Where a patient requests a virtual visit (is not willing to present in-person, despite the physician's advice and availability), physicians may submit a claim for the appropriate fee code for the service that was rendered virtually.

3. Video services are *only eligible for payment* when performed using a Verified Virtual Visit Solution.

[Commentary:
Ontario Health's public list of verified solutions is available at: https://www.ontariohealth.ca/our-work/digital-standards/virtual-visits-verification-standard/vendor-list.]

4. All other insured services that are rendered by Video or Telephone to insured persons and that are not Comprehensive Virtual Care Services, Limited Virtual Care Services, or specifically listed as insured services or are a component of an insured service are n*ot eligible for payment*.

5. Virtual Care Services are *not eligible for payment* unless the delivery modality is documented on the patient's medical record.

6. Virtual Care Services are *not eligible for payment* unless initiated by the patient or the *patient's representative*, or the service represents a medically necessary follow-up visit to a preceding visit initiated by the patient or the *patient's representative*.

[Commentary:
As per GP15, following an insured service, discussion with, and providing advice and information, including prescribing therapy to the patient or the *patient's representative*, whether by Telephone or otherwise, on matters related to the service is a specific element of the preceding service and should not be separately claimed. This includes reporting results of related procedures and/or assessments (when professionally appropriate to report without additional patient assessment) and monitoring the patient's condition remotely until the next medically necessary assessment.

For clarity, administrative staff may co-ordinate appointments and organize care in a manner analogous to in-person encounters without violating this condition. Similarly, medically necessary follow-up services may be organized by the provider (or by their staff) without violating the condition. However, a physician-initiated call to "check-in" on a patient would not be eligible for payment, nor would any telephone calls or Video encounters conducted for administrative purposes (such as to inform patients of clinic closures or the availability of remote services).

Furthermore, services are *not eligible for payment* when initiated by the physician (or the physician's staff) without a clear and medically necessary reason for doing so. For example, the communication of normal lab work, unless medically necessary (in so far as the clinical management of the patient is altered) should not be billed.

Physician-initiated communication to provide advice or guidance regarding a previously rendered service is also not separately eligible/ billable. A common example of this would occur when a patient is provided with a prescription along with instruction to fill it only upon receipt of a positive test result. The call to inform the patient of the test result is *not eligible for payment* as it would be considered a Specific Element of the initial (refer to: item F, GP15, Schedule of Benefits).

As a general rule, the provider should consider whether the remote encounter would have occurred in their "in-person" practice. In circumstances where an in-person encounter would not have taken place, it is unlikely that a claim for a virtual service could be supported.

Consultations, which arise from requests from other providers, would not violate the condition in so far as the patient would have assented to the referral as part of their discussion with the referring provider.]

7. Virtual Care Services are *not eligible for payment* unless personally performed by the physician or rendered in accordance with the payment rules regarding supervision of a Medical Trainee.

8. Virtual Care Services are *not eligible for payment* for services provided to hospital inpatients or patients in a Long-Term Care institution unless all of the following requirements have been met:

- The physician providing the service is not the patient's MRP.
- The hospital/Long-Term Care institution does not have a physician on staff and present in the community with the expertise to render the necessary service, as documented by the referring physician in the patient's medical record.
- An assessment with a direct physical encounter by the referring physician must have been completed within 30 days preceding a virtual in-patient *specialist* consultation to confirm the need for a consultation.

9. Services involving a direct physical encounter must be made available by the physician providing Comprehensive Virtual Care Services, or by the physician's group, within a clinically appropriate time-frame, if it becomes apparent during a Virtual Care Service that a service involving a direct physical encounter is medically necessary, or if at the time of scheduling the service the patient expresses preference for a service involving a direct physical encounter.

[Commentary:
For the purpose of this provision, with respect to *specialist* and GP Focused Practice Physicians, a group is defined as: those physicians in the same hospital specialty call rotation, or who are co-located in shared clinical physical space, and have shared access to the patient's medical record. For family and general practice physicians, a group is defined as: Patient Enrollment Model physicians who are signatory or contracted to the same specific group contract (i.e., as identified by the same group billing number), or those physicians who are co-located in a shared clinical physical space and have shared access to the patient's medical record].

10. If during the course of a Virtual Care Service the modality changes (for example, a Telephone service transitions into a Video service), only the service performed by the modality that represents the greater part (more than 50%) of the time spent providing the Virtual Care Service is payable. For *time-based services*, the combined time of both modalities will be used to calculate the number of time units eligible for payment.

11. For *time-based services*, only time spent in direct communication with the patient or the *patient's representative* in the provision of the insured service will be used to calculate the number of time units eligible for payment.

[Commentary:
Both the patient and physician must be located in Ontario for the services to be insured and payable under OHIP (see section 37.1 of Regulation 552 under the HIA).]

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Claims submission instructions:

Comprehensive Virtual Care Services rendered within an Existing/Ongoing Patient-Physician Relationship must be claimed using the fee codes listed in Appendix J – Section 1.

Claims submitted for Comprehensive Virtual Care Services must include the modality indicator that identifies the technology used to deliver the service:

K300A – identifies Video technology used during the service

K301A – identifies Telephone technology (audio only) used during the service

Submit claims for Comprehensive Virtual Care Services using the in-person fee value regardless of whether the service is rendered by Video or Telephone. Payments for Telephone services will be automatically reduced as set out below.

Limited Virtual Care Services rendered outside of an Existing/Ongoing Patient-Physician Relationship must be claimed using the fee codes listed in Appendix J – Section 2.

Payment rules:

Comprehensive Virtual Care Services rendered by Video are payable at fees that are equivalent to the corresponding in-person fees for those services; or for Limited Virtual Care Services, the fees listed in Appendix J – Section 2 that correspond to those services.

The amount payable for Comprehensive Virtual Care Services rendered by Telephone is 85% of the corresponding in-person fee except for K007, K005, K197 and K198 which will be payable at 95% of the corresponding in-person fee.

Comprehensive Virtual Care Services – Virtual Only Fee Codes

Midwife or Aboriginal Midwife-Requested Assessment (MAMRA) by Video

Midwife or Aboriginal Midwife-Requested Assessment (MAMRA) by Video is an assessment of a mother or *newborn* provided by a physician upon the written request of a midwife or Aboriginal Midwife because of the complex, obscure or serious nature of the patient's problem and is payable to a family physician or obstetrician for such an assessment in any setting.

Urgent or emergency requests may be initiated verbally but must subsequently be requested in writing. The written request must be retained on the patient's permanent medical record. The MRA must include the common and *specific elements* of a specific assessment by Video and the physician must submit his/her findings, opinions and recommendations verbally to the midwife or Aboriginal Midwife, and in writing to both the midwife or Aboriginal Midwife and the patient's primary care physician or nurse practitioner, if applicable. Maximum one MAMRA (A814 or A813) per patient per physician per pregnancy.

A814 Midwife or Aboriginal Midwife-Requested Assessment (MAMRA) by Video..... 111.70

VIRTUAL CARE SERVICES

Midwife or Aboriginal Midwife-Requested Special Assessment (MAMRSA) by Video

Midwife or Aboriginal Midwife-Requested Special Assessment (MAMRSA) by Video must include constituent elements of A814 and is payable in any setting:

a. to a paediatrician for an urgent or emergency assessment of a *newborn*; or

b. to a family physician or obstetrician for assessment of a mother or *newborn* when, because of the very complex, obscure or serious nature of the problem, the physician must spend at least 50 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient. The start and stop times of the assessment must be recorded on the patient's permanent medical record. In the absence of such information, the service is payable as A814. Maximum one MAMRSA (A817 or A815) per patient per physician per pregnancy.

A817 Midwife or Aboriginal Midwife-Requested Special Assessment (MAMRSA) by Video 186.95

[Commentary:
Unless otherwise specified in the *Schedule*, the calculation of time excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the assessment and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

Midwife or Aboriginal Midwife-Requested Anaesthesia Assessment (MAMRAA) by Video

Midwife or Aboriginal Midwife-Requested Anaesthesia Assessment (MAMRAA) by Video is an assessment of a mother or *newborn* provided by an anaesthesiologist upon the written request of a midwife or Aboriginal Midwife because of the complex, obscure or serious nature of the patient's problem and is payable to an anaesthesiologist for such an assessment in any setting.

Urgent or emergency requests may be initiated verbally but must subsequently be requested in writing. The written request must be retained on the patient's permanent medical record. The MRAA must include the common and *specific elements* of a specific assessment by Video and the physician must submit his/her findings, opinions and recommendations verbally to the midwife or Aboriginal Midwife and in writing to both the midwife or Aboriginal Midwife and the patient's primary care physician or nurse practitioner, if applicable. Maximum one MAMRAA (A818 or A816) per patient per anaesthesiologist per pregnancy.

A818 Midwife or Aboriginal Midwife-Requested Anaesthesia Assessment (MAMRAA) by Video..... 106.80

VIRTUAL CARE SERVICES

GENERAL LISTINGS

Focused practice consultation by Video

Focused practice consultation by Video is a consultation rendered by a GP Focused Practice Physician who completes a full, relevant history of the presenting complaint and detailed examination of the affected part(s), region(s), or system(s) needed to make a diagnosis, and/or exclude disease, and/or assess function.

A010 GP focused practice consultation by Video 95.60

Focused practice repeat consultation by Video

Focused practice repeat consultation by Video is a repeat consultation rendered by a GP Focused Practice Physician who completes a full, relevant history of the presenting complaint and detailed examination of the affected part(s), region(s), or system(s) needed to make a diagnosis, and/or exclude disease, and/or assess function.

A011 GP focused practice repeat consultation by Video 47.10

Focused practice limited consultation by Video

Focused practice limited consultation by Video is a limited consultation rendered by a GP Focused Practice Physician who completes a full, relevant history of the presenting complaint and detailed examination of the affected part(s), region(s), or system(s) needed to make a diagnosis, and/or exclude disease, and/or assess function.

A906 GP focused practice limited consultation by Video..... 80.15

Focused practice special consultation by Video

Focused practice special consultation by Video is a consultation rendered by a GP Focused Practice Physician who completes a full, relevant history of the presenting complaint and detailed examination of the affected part(s), region(s), or system(s) needed to make a diagnosis, and/or exclude disease, and/or assess function and who spends a minimum of 50 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A913 GP focused practice special consultation by Video 164.95

Focused practice comprehensive consultation by Video

Focused practice comprehensive consultation by Video is a consultation rendered by a GP Focused Practice Physician who completes a full, relevant history of the presenting complaint and detailed examination of the affected part(s), region(s), or system(s) needed to make a diagnosis, and/or exclude disease, and/or assess function and who spends a minimum of 75 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A914 GP focused practice comprehensive consultation by Video... 247.40

[Commentary:

1. Required elements of consultations are set out under the heading Consultations in the General Preamble.

2. Unless otherwise specified in the *Schedule*, the calculation of time for A913 and A914 excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultation and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

VIRTUAL CARE SERVICES

Limited Virtual Care Services

Definitions/Required Elements of Service

A Limited Virtual Care Service is an assessment which includes at a minimum, history-taking and medically appropriate exam to arrive at a diagnosis and provide an appropriate management plan and/or management, and when provided, the other specific elements of assessments.

A101	Limited Virtual Care by Video	20.00
A102	Limited Virtual Care by Telephone	15.00

VIRTUAL CARE SERVICES

Virtual Care Services – Premiums and Management Fees

Premiums

The applicable premium(s) listed in the Premiums Table below are payable to physicians when providing eligible Comprehensive Virtual Care Services:

Applicable Premium	Descriptor	Premium Payable
E060	Post renal transplant assessment premium	25% of fee for virtual service
E078	Chronic Disease Assessment Premium	50% of fee for virtual service
E080 (video only)	First visit by primary care physician after hospital discharge	$25.25
E088	Congestive heart failure premium	50% of fee for virtual service
E098	Gastroenterology chronic disease assessment premium	28% of fee for virtual service
K187	Acute post-discharge community psychiatric care	15% of fee for virtual service
K188	High-risk community psychiatric care	15% of fee for virtual service
K189 (video only)	Urgent community psychiatric follow-up	$216.30
E079	Smoking cessation: Initial discussion with patient, to eligible services	$13.20 for phone and $15.55 for video
Age-Based Fee Premiums	-	10-30% of fee for virtual service
Focused Practice Psychotherapy Premium	-	17% of fee for virtual service
Internal Medicine Office Assessment Premium	-	12% of fee for virtual service
FHG In-Basket Premium	-	10% of fee for virtual service

VIRTUAL CARE SERVICES

Management Fees

Comprehensive Virtual Care Services are included as a consultation or assessment for the purposes of meeting the requirements for payment of the applicable management fee(s) listed in the Management Fees for Services by Telephone or Video Table below.

[Commentary:
All requirements and conditions for the appropriate management fee as described in the *Schedule* must be met.]

Fee Code	Descriptor
K045	Endocrinology & Metab/Internal Med-Diabetes management by a *specialist*-annual
K046	Endocrinology & Metab/Internal Med-Diabetes team management-annual
Q040	GP/FP-Diabetes management incentive-annual
K119	Paediatrics-Paediatric developmental assessment incentive-annual
K481	Rheumatology-Rheumatoid arthritis management by a specialist-annual
K682	Opioid Agonist Maintenance Program monthly management fee-intensive, per month
K683	Opioid Agonist Maintenance Program monthly management fee-maintenance, per month
K684	Opioid Agonist Maintenance Program-team premium, per month, to K682 or K683 add
K030*	Diabetic management assessment

Payment rules:
* A virtual K030 is only eligible for payment if a K030 involving a direct physical encounter has been performed in the preceding 12 months.

ANAESTHESIA (01)

GENERAL LISTINGS

Consultation

A015 Consultation 109.70
A016 Repeat consultation 52.15

SPECIAL ANAESTHETIC CONSULTATION

Definition/Required elements of service:

A special anaesthetic consultation is rendered when an anaesthesia (01) *specialist* provides all the appropriate elements of a regular consultation and is required to devote at least fifty (50) minutes of direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A210 Special anaesthetic consultation 163.20

[Commentary:
Unless otherwise specified in the *Schedule*, the calculation of time excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultation and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

Limited consultation for acute pain management

A limited consultation for acute pain management is a consultation which takes place when a physician is requested by another physician to see a hospital in-patient because of the complexity or severity of the acute pain condition.

A215 Limited consultation for acute pain management in association with special visit to hospital in-patient 69.75

Payment rules:

1. The routine pre-anaesthetic evaluation of the patient required by Reg 965 of the *Public Hospitals Act* does not constitute a consultation, regardless of where and when this evaluation is performed.

2. For A210 the start and stop time of the service must be recorded in the patient's permanent medical record

3. A215 is *not eligible for payment*:

- **a.** with P014C - introduction of catheter for labour analgesia, including the first dose of medication with or without any combined spinal-epidural injection(s);
- **b.** for management of routine post-operative pain; or
- **c.** for *referral*s from another anaesthesiologist.

[Commentary:

1. The general anaesthesia service includes a pre-anaesthetic evaluation, with specific elements as for assessments (see GP15) which does not constitute a consultation

2. P014C - is an anaesthesia service, therefore the pre-anaesthetic evaluation is included in the service and is not payable as a limited consultation for acute pain management or as any other consultation or assessment.]

Midwife or Aboriginal Midwife-Requested Anaesthesia Assessment (MAMRAA)

Midwife or Aboriginal Midwife-Requested Anaesthesia Assessment (MAMRAA) is an assessment of a mother or newborn provided by an anaesthesiologist upon the written request of a midwife or aboriginal midwife because of the complex, obscure or serious nature of the patient's problem and is payable to an anaesthesiologist for such an assessment in any setting.

Urgent or emergency requests may be initiated verbally but must subsequently be requested in writing. The written request must be retained on the patient's permanent medical record. The MAMRAA must include the common and specific elements of a general or specific assessment and the physician must submit his/her findings, opinions and recommendations verbally to the midwife or aboriginal midwife and in writing to both the midwife or aboriginal midwife and the patient's primary care physician or nurse practitioner, if applicable. Maximum one MAMRAA per patient per anaesthesiologist per pregnancy.

A816	Midwife or Aboriginal Midwife-Requested Anaesthesia Assessment (MAMRAA)	106.80

Claims submission instructions:
When providing this service to a hospital in-patient in association with a special visit premium, submit claim using A215 and the appropriate special visit premium beginning with a "C" prefix.

A013	Specific assessment	64.65
A014	Partial assessment	31.45

Emergency or Out-Patient Department (OPD)

Physician in hospital but not on duty in the emergency department when seeing patients in the emergency or OPD - use General Listings.

Non-Emergency Hospital In-Patient Services

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C015	Consultation - subject to the same conditions as A015	109.70
C016	Repeat consultation	52.15
C210	Special anaesthetic consultation – subject to same conditions as A210	163.20
C215	Limited consultation for acute pain management - subject to the same conditions as A215	69.75
C013	Specific assessment	64.65
C014	Specific re-assessment	28.00
C816	Midwife or Aboriginal Midwife-Requested Anaesthesiologist Assessment (MAMRAA) - subject to the same conditions as A816	106.80

ANAESTHESIA (01)

Subsequent visits

C012	- first five weeks	per visit	31.70
C017	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	31.70
C019	- after thirteenth week (maximum 6 per patient per month)	per visit	31.70

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions	95.10

Subsequent visits by the MRP following transfer from an intensive care area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an intensive care area		71.80
C143	- second subsequent visit by the MRP following transfer from an intensive care area		71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43)	per visit	40.05
C018	Concurrent care	per visit	31.70
C982	Palliative care (see General Preamble GP50)	per visit	40.05

CARDIOLOGY (60)

For services not listed, refer to Internal Medicine section

GENERAL LISTINGS

A605 Consultation 188.45

Comprehensive cardiology consultation

This service is a consultation rendered by a *specialist* in cardiology who provides all the appropriate elements of a consultation and spends a minimum of 75 minutes in direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

A600 Comprehensive cardiology consultation 342.25

Medical record requirements:
The start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.

[Commentary:
1. A600 must satisfy all the elements of a consultation (see page GP16).

2. Unless otherwise specified in the *Schedule*, the calculation time excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultation and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc..]

A675 Limited consultation 105.25
A606 Repeat consultation 105.25
A603 Medical specific assessment 96.70
A604 Medical specific re-assessment 72.65
A601 Complex medical specific re-assessment 84.10
A608 Partial assessment 49.80

CONGESTIVE HEART FAILURE PREMIUM

Definition/ Required elements of service:

Congestive heart failure premium is payable in addition to the amount payable for an assessment by a cardiology specialist (60) when all of the following criteria are met:

a. The assessment is a:

- **i.** medical specific assessment;
- **ii.** medical specific re-assessment;
- **iii.** complex medical specific re-assessment; or
- **iv.** partial assessment.

b. The assessment is rendered in an office setting or an out-patient clinic located in a hospital, other than an emergency department.

c. The patient has an established diagnosis of congestive heart failure, documented in the patient's medical record.

E088 Congestive heart failure premium ..... add 50%

[Commentary:
The congestive heart failure premium is not payable for assessments rendered to inpatients of any hospital, patients seen in a long-term care facility or patients seen in an emergency department.]

CARDIOLOGY (60)

Claims submission instructions:
Submit claims with diagnostic code 428.

Emergency or Out-Patient Department (OPD)

Physician in hospital but not on duty in the emergency department when seeing patients in the emergency or OPD - use General Listings.

Non-Emergency Hospital In-Patient Services

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C605	Consultation	188.45
C600	Comprehensive cardiology consultation - subject to the same conditions as A600	342.25
C675	Limited consultation	105.25
C606	Repeat consultation	105.25
C603	Medical specific assessment	96.70
C604	Medical specific re-assessment	72.65
C601	Complex medical specific re-assessment	84.10
	Subsequent visits	
C602	- first five weeks ... per visit	40.05
C607	- sixth to thirteenth week inclusive (maximum 3 per patient per week) ... per visit	40.05
C609	- after thirteenth week (maximum 6 per patient per month) ... per visit	40.05

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions	95.10

Subsequent visits by the MRP following transfer from an intensive care area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an intensive care area	71.80
C143	- second subsequent visit by the MRP following transfer from an intensive care area	71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43) ... per visit	40.05
C608	Concurrent care ... per visit	40.05
C982	Palliative care (see General Preamble GP50) ... per visit	40.05

CARDIAC SURGERY (09)

GENERAL LISTINGS

A095	Consultation	113.15
A935	Special surgical consultation (see General Preamble GP19).	194.65
A096	Repeat consultation	75.20
A093	Specific assessment	55.70
A094	Partial assessment	30.35

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the emergency department when seeing patients in the emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C095	Consultation	113.15
C935	Special surgical consultation (see General Preamble GP19).	194.65
C096	Repeat consultation	75.20
C093	Specific assessment	55.70
C094	Specific re-assessment	32.70

Subsequent visits

C092	- first five weeks ... per visit	31.00
C097	- sixth to thirteenth week inclusive (maximum 3 per patient per week) ... per visit	31.00
C099	- after thirteenth week (maximum 6 per patient per month) ... per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions	95.10

Subsequent visits by the MRP following transfer from an intensive care area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an intensive care area	71.80
C143	- second subsequent visit by the MRP following transfer from an intensive care area	71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43) ... per visit	40.05
C098	Concurrent care ... per visit	31.00
C982	Palliative care (see General Preamble GP50) ... per visit	40.05

CARDIAC SURGERY (09)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W095	Consultation	113.15
W096	Repeat consultation	75.20

CLINICAL IMMUNOLOGY (62)

For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

A625	Consultation	160.30
A525	Limited consultation	105.25
A626	Repeat consultation	105.25
A623	Medical specific assessment	95.95
A624	Medical specific re-assessment	72.00
A621	Complex medical specific re-assessment	83.40
A628	Partial assessment	44.75
E078	- chronic disease assessment premium (see General Preamble GP25) ... add 50%	

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C625	Consultation	160.30
C525	Limited consultation	105.25
C626	Repeat consultation	105.25
C623	Medical specific assessment	95.95
C624	Medical specific re-assessment	72.00
C621	Complex medical specific re-assessment	83.40

Subsequent visits

C622	- first five weeks ... per visit	40.05
C627	- sixth to thirteenth week inclusive (maximum 3 per patient per week) ... per visit	40.05
C629	- after thirteenth week (maximum 6 per patient per month) ... per visit	40.05

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions	95.10

CLINICAL IMMUNOLOGY (62)

Subsequent visits by the MRP following transfer from an intensive care area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area		71.80
C143	- second subsequent visit by the MRP following transfer from an intensive care area		71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43)	per visit	40.05
C628	Concurrent care	per visit	40.05
C982	Palliative care (see General Preamble GP50)	per visit	40.05

COMMUNITY MEDICINE (05)

General Listings

A055 Consultation 152.80

Special community medicine consultation

This service is a consultation rendered by a *specialist* in community medicine who provides all the appropriate elements of a consultation and spends a minimum of 50 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A050 Special community medicine consultation 176.10

Comprehensive community medicine consultation

This service is a consultation rendered by a *specialist* in community medicine who provides all the appropriate elements of a consultation and spends a minimum of 75 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A400 Comprehensive community medicine consultation..... 270.60

Medical record requirements:
For A050 and A400, the start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.

[Commentary:

1. A050 and A400 must satisfy all the elements of a consultation (see General Preamble GP16).

2. Unless otherwise specified in the Schedule, the calculation of the 50 and 75 minute minimum time for special and comprehensive community medicine consultations respectively excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultation and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc..]

A405 Limited consultation 94.75
A056 Repeat consultation 94.75
A053 Medical specific assessment 83.85
A054 Medical specific re-assessment..... 64.30
A051 Complex medical specific re-assessment..... 74.45
A058 Partial assessment 39.95

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the emergency department when seeing patients in the emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C055 Consultation 152.80
C050 Special community medicine consultation – subject to the same conditions as A050 ..... 176.10
C400 Comprehensive community medicine consultation – subject to the same conditions as A400 ..... 270.60

COMMUNITY MEDICINE (05)

C405	Limited consultation	94.75
C056	Repeat consultation	94.75
C053	Medical specific assessment	83.85
C054	Medical specific re-assessment	64.30
C051	Complex medical specific re-assessment	74.45

Subsequent visits

C052	- first five weeks ... per visit	40.05
C057	- sixth to thirteenth week (maximum 3 per patient per week) ... per visit	40.05
C059	- after thirteenth week (maximum 6 per patient per month) ... per visit	40.05

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions	95.10

Subsequent visits by the MRP following transfer from an intensive care area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C143	- second subsequent visit by the MRP following transfer from an intensive care area	71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43) ... per visit	40.05
C058	Concurrent care ... per visit	40.05
C982	Palliative care (see General Preamble GP50) ... per visit	40.05

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W055	Consultation	152.80
W050	Special community medicine consultation – subject to the same conditions as A050	176.10
W400	Comprehensive community medicine consultation – subject to the same conditions as A400	270.60
W405	Limited consultation	94.75
W056	Repeat consultation	94.75

COMMUNITY MEDICINE (05)

Admission assessment

W402	- Type 1	69.35
W404	- Type 2	20.60
W407	- Type 3	30.70
W409	Periodic health visit	65.05
W054	General re-assessment of patient in nursing home (as per the Nursing Homes Act)*	20.60

Note:
*May only be claimed 6 *month*s after Periodic health visit (as per the *Nursing Homes Act*).

Subsequent visits (see General Preamble GP49)

Chronic care or convalescent hospital

W052	- first 4 subsequent visits per patient per month	per visit	40.05
W051	- additional subsequent visits (maximum 6 per patient per month)	per visit	40.05
W982	- palliative care (see General Preamble GP50)	per visit	40.05

Nursing *home* or *home* for the aged

W053	- first 2 subsequent visits per patient per month	per visit	40.05
W058	- additional subsequent visits (maximum 3 per patient per month)	per visit	40.05
W972	- palliative care (see General Preamble GP50)	per visit	40.05
W121	Additional visits due to intercurrent illness (see General Preamble GP49)	per visit	40.05
W124	Subsequent visit – day of discharge (see A20 for terms and conditions)	per visit	71.80

CRITICAL CARE MEDICINE (11)

General Listings

A715 Consultation 196.55

Comprehensive critical care medicine consultation

This service is a consultation rendered by a *specialist* in critical care medicine who provides all the appropriate elements of a consultation and spends a minimum of 75 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A710 Comprehensive critical care medicine consultation 342.25

Medical record requirements:
The start and stop times must be recorded in the patient's permanent medical record.

[Commentary:
Unless otherwise specified in the *Schedule*, the calculation of time excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultation and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

A915 Limited consultation 122.00
A116 Repeat consultation 122.00
A713 Medical specific assessment 95.95
A114 Medical specific re-assessment 72.00
A111 Complex medical specific re-assessment 83.40
A118 Partial assessment 44.75

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C715 Consultation 196.55
C710 Comprehensive critical care medicine consultation - subject to the same conditions as A710 ..... 342.25
C915 Limited consultation 122.00
C116 Repeat consultation 122.00
C713 Medical specific assessment 95.95
C114 Medical specific re-assessment 72.00
C111 Complex medical specific re-assessment 83.40

Subsequent visits

C112 - first five weeks ..... per visit 40.05
C117 - sixth to thirteenth week inclusive (maximum 3 per patient per week) ..... per visit 40.05
C119 - after thirteenth week (maximum 6 per patient per month) ..... per visit 40.05

CRITICAL CARE MEDICINE (11)

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43) per visit	40.05
C118	Concurrent care per visit	34.10
C982	Palliative care (see General Preamble GP50) per visit	40.05

DERMATOLOGY (02)

GENERAL LISTINGS

A025	Consultation	77.50
A027	Consultation in association with special visit to a hospital in-patient, long-term care in-patient or emergency department patient	158.15

Claims submission instructions:
Submit claim using A027 and the appropriate special visit premium beginning with "C" prefix for a hospital in-patient, “W” prefix for a long-term care in-patient or “K” prefix for an emergency department patient.

A026	Repeat consultation	47.75
A023	Specific assessment	46.15
A024	Partial assessment	23.50
U025	Initial e-assessment	47.75
U023	Repeat e-assessment	31.15
U026	Follow-up e-assessment	23.50
U021	Minor e-assessment	11.80

Advanced Dermatology Consultation

This service is a consultation for the investigation, diagnosis, and management of any of the following diseases of the integumentary system where the complexity of the condition requires the medical expertise of a specialist in Dermatology (02).

a. Complex systemic disease with skin manifestations for at least one of the following:

- **i.** sarcoidosis;
- **ii.** systemic lupus erythematosus;
- **iii.** dermatomyositis;
- **iv.** scleroderma;
- **v.** relapsing polychondritis;
- **vi.** inflammatory bowel disease with pyoderma gangrenosum, or Sweet's syndrome, or erythema nodosum);
- **vii.** porphyria;
- **viii.** autoimmune blistering diseases (e.g. pemphigus, pemphigoid, linear IgA);
- **ix.** paraneoplastic syndromes involving the skin;
- **x.** vasculitis (including Behcet's disease); or
- **xi.** cutaneous lymphomas (including lymphomatoid papulosis). or

b. Prurigo nodularis,
or

c. Complex systemic drug reactions for at least one of the following:

- **i.** drug hypersensitivity syndrome;
- **ii.** erythema multiforme major; or
- **iii.** toxic epidermal necrolysis.

DERMATOLOGY (02)

or

d. "Complex psoriasis" or "complex dermatitis" as defined by at least one of the following criteria:

i. involvement of body surface area of greater than 30%;

ii. treatment with systemic therapy (e.g. methotrexate, acitretin, cyclosporine, biologics); or

iii. a visit that requires at least 30 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient

A021 Advanced Dermatology Consultation 164.90

[Commentary:
Unless otherwise specified in the *Schedule*, the calculation of time excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultation and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

DERMATOLOGY (02)

Complex dermatology assessment

This service is an assessment for the ongoing management of any of the following diseases where the complexity of the condition requires the continuing management by a dermatology *specialist*.

a. Complex systemic disease with skin manifestations for at least one of the following:

- **i.** sarcoidosis;
- **ii.** systemic lupus erythematosus;
- **iii.** dermatomyositis;
- **iv.** scleroderma;
- **v.** relapsing polychondritis;
- **vi.** inflammatory bowel disease with pyoderma gangrenosum, or Sweet's syndrome, or erythema nodosum;
- **vii.** porphyria;
- **viii.** autoimmune blistering diseases (e.g. pemphigus, pemphigoid, linear IgA);
- **ix.** paraneoplastic syndromes involving the skin;
- **x.** vasculitis (including Behcet's disease); or
- **xi.** cutaneous lymphomas (including lymphomatoid papulosis).

or

b. Prurigo nodularis.

or

c. Complex systemic drug reactions for at least one of the following:

- **i.** drug hypersensitivity syndrome;
- **ii.** erythema multifome major; or
- **iii.** toxic epidermal necrolysis.

or

d. "Complex psoriasis" or "complex dermatitis" as defined by at least one of the following criteria:

- **i.** involvement of body surface area of greater than 30%;
- **ii.** treatment with systemic therapy (e.g. methotrexate, acitretin, cyclosporine, biologics); or
- **iii.** a visit that requires at least 15 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

or

e. Complex skin cancer or high risk for developing skin cancer, as defined by at least one of the following criteria:

- **i.** High-risk melanoma stages T1b and higher;

DERMATOLOGY (02)

ii. High-risk Basal cell carcinoma, defined as having morpheic pathologic subtype;

iii. Squamous cell carcinoma stage 2 and above;

iv. Patients with field cancerization, defined as having at least 10 actinic keratoses; or

v. Patients with multiple dysplastic nevi as defined by at least one of the following criteria:

- two or more clinically atypical nevi;
- more than 100 nevi in patients between 20 and 50 years of age;
- more than 50 nevi in patients under 20 years of age or more than 50 years of age;
- more than one nevus in buttocks or instep;
- nevi on the anterior scalp; or
- one or more pigmented lesions in the iris.

vi. Patients with other skin neoplasms of uncertain behaviour requiring a pathology diagnosis documented in the medical record.

A020 Complex dermatology assessment..... 60.00

Payment rules:

1. A complex dermatology assessment must include all the elements of a specific assessment or the amount payable will be adjusted to lesser assessment fee.

2. Complex dermatology assessments are limited to 6 per patient, per physician, per *12 month period*. Services in excess of this limit will be adjusted to a lesser assessment fee.

[Commentary:
Unless otherwise specified in the *Schedule*, the calculation of time excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the assessment and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

DERMATOLOGY (02)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C025	Consultation		158.15
C026	Repeat consultation		47.75
C023	Specific assessment		46.15
C024	Specific re-assessment		27.25
C020	Complex dermatology assessment - subject to same conditions as A020		60.00

Subsequent visits

C022	- first five weeks	per visit	40.05
C027	- sixth to thirteenth week (maximum 3 per patient per week)	per visit	40.05
C029	- after thirteenth week (maximum 6 per patient per month)	per visit	40.05

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment		71.80
C123	- second day following the hospital assessment		71.80
C124	- day of discharge		71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)		95.10

Subsequent visits by the MRP following transfer from an intensive care area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area		71.80
C143	- second subsequent visit by the MRP following transfer from an intensive care area		71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43)	per visit	40.05
C028	Concurrent care	per visit	40.05
C982	Palliative care (see General Preamble GP50)	per visit	40.05

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

DERMATOLOGY (02)

W025	Consultation		158.15
W026	Repeat consultation		47.75

Subsequent visits (see General Preamble GP49)

Chronic care or convalescent hospital

W022	- first 4 subsequent visits per patient per month	per visit	40.05
W021	- additional subsequent visits (maximum 6 per patient per month)	per visit	40.05
W982	- palliative care (see General Preamble GP50)	per visit	40.05

Nursing *home* or *home* for the aged

W023	- first 2 subsequent visits per patient per month	per visit	40.05
W028	- additional subsequent visits (maximum 3 per patient per month)	per visit	40.05
W972	- palliative care (see General Preamble GP50)	per visit	40.05
W121	Additional visits due to intercurrent illness (see General Preamble GP49)	per visit	40.05
W124	Subsequent visit – day of discharge (see A20 for terms and conditions	per visit	71.80

EMERGENCY MEDICINE (12)

EMERGENCY DEPARTMENT - PHYSICIAN ON DUTY

H055 Consultation (see General Preamble GP19) 125.65

Note:

1. See General Preamble GP50 for definitions and conditions for physicians on duty.

2. All other consultations and visits - use the listings for Family Practice & Practice In General.

ENDOCRINOLOGY & METABOLISM (15)

GENERAL LISTINGS

A155 Consultation 172.95

Comprehensive endocrinology consultation

This service is a consultation rendered by a *specialist* in endocrinology who provides all the appropriate elements of a consultation and spends a minimum of seventy-five (75) minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A150 Comprehensive endocrinology consultation 342.25

Medical record requirements:
The start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.

[Commentary:

1. A150 must satisfy all the elements of a consultation (see page GP16).

2. Unless otherwise specified in the *Schedule*, the calculation of the 75 minute minimum time for comprehensive endocrinology consultations excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultation and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

A255 Limited consultation 110.15
A156 Repeat consultation 110.15
A153 Medical specific assessment 95.95
A154 Medical specific re-assessment 72.00
A151 Complex medical specific re-assessment 83.40
A158 Partial assessment 44.75

E078 - chronic disease assessment premium (see General Preamble GP25) ..... add 50%

Complex endocrine neoplastic disease assessment

This service is an assessment in relation to one or more of the following diseases where the complexity of the condition requires the ongoing management by an endocrinologist:

a. thyroid neoplasm;
b. parathyroid neoplasm;
c. pituitary neoplasm; or
d. adrenal neoplasm.

A760 Complex endocrine neoplastic disease assessment 102.95

Payment rules:

1. A760 must include the elements of a medical specific re-assessment, or the amount payable will be adjusted to a lesser assessment fee.

2. A760 is limited to 6 per patient, per physician, per *12 month period* and up to 12 per patient per physician for 24 consecutive *month*s. Services in excess of this limit will be adjusted to a lesser assessment fee.

3. E078 is *not eligible for payment* with A760.

[Commentary:
A760 is not payable for the evaluation and/or management of uncomplicated endocrine disorders.]

ENDOCRINOLOGY & METABOLISM (15)

DIABETES MANAGEMENT BY A SPECIALIST

Definition/Required elements of service:

Diabetes Management by a *specialist* is a service rendered by a *specialist* in Endocrinology, Internal Medicine or Paediatrics who is most responsible for providing ongoing management of a diabetic patient. This service includes all services related to the coordination, provision and documentation of ongoing management using a planned care approach consistent with the required elements of the current Canadian Diabetes Association (CDA) Clinical Practice Guidelines. The medical record must document that all of the CDA required elements have been provided for the previous *12 month period* and include, at a minimum, the following:

a. Lipids, cholesterol, HbA1C, blood pressure, weight and *body mass index (BMI)*, and medication dosage;

b. Discussion and offer of preventive measures including vascular protection, influenza and pneumococcal vaccination;

c. Health promotion counselling and patient self-management support;

d. Albumin to creatinine ratio (ACR);

e. Discussion and offer of *referral* for dilated eye examination; and

f. Foot examination and neurologic examination.

K045 Diabetes management by a specialist 80.25

Payment rules:

1. K045 is limited to a maximum of one service per patient per *12 month period*.

2. K045 is *only eligible for payment* if the physician has rendered a minimum of 4 of any of the following: consultations/assessments, K013, K033, K029, K002, K003 to the same patient in the *12 month period* for which K045 is claimed.

3. K045 is *only eligible for payment* when the physician has greater than 100 patients per year with diabetes.

4. K045 is eligible for payment to a physician from one of the following specialties: Internal Medicine (13), Endocrinology (15) or Paediatrics (26).

Medical record requirements:

K045 is *only eligible for payment* if the flow sheet and/or a diabetic registry record has been completed for the previous *12 month period* including the above listed requirements and is maintained in the patient's permanent medical record.

Claims submission instructions:

Claims for K045 may only be submitted when the required elements of the service have been completed for the previous *12 month period*.

[Commentary:

A copy of a flow sheet meeting the medical record requirements and CDA Clinical Practice Guidelines may be found at https://guidelines.diabetes.ca/GuideLines/media/Docs/cpg/Appendix-3.pdf

ENDOCRINOLOGY & METABOLISM (15)

DIABETES TEAM MANAGEMENT (DTM)

Definition/Required elements of service:

This is an annual fee payable to a *specialist* in internal medicine or endocrinology for the comprehensive team-based care of a patient with diabetes.

The diabetes management team must include the *specialist* most responsible for the diabetes management of the patient and at least one or more Certified Diabetes Educators (CDE). DTM includes all services related to the coordination, provision and documentation of all required elements of ongoing care, as necessary, by the physician and/or the CDE.

K046 Diabetes team management..... 127.20

Payment rules:

1. A maximum of one K046 is eligible for payment per patient per *12 month period*.

2. K046 is *only eligible for payment* if all of the following requirements are fulfilled:

- **a.** the physician has rendered a minimum of 4 of any combination of consultations/ assessments or K013, K033, K029, K002, K003 to the same patient in the *12 month period* for which K046 is claimed;
- **b.** the CDE is an employee of the physician;
- **c.** when the physician has treated more than 100 patients with diabetes during the period for which K046 is claimed; and
- **d.** the physician is from one of the following specialities: Internal Medicine (13) or Endocrinology (15).

3. K046 is *not eligible for payment* unless the physician documents the services rendered by the CDE. The physician must provide such documentation to the ministry, if requested.

4. The CDE must have current certification by the Canadian Diabetes Educator Certification Board at the time the CDE renders services to the patient.

Medical record requirements:

1. K046 is *only eligible for payment* when the record includes a flow sheet and/or a diabetic registry record meeting the published Standards of Care as defined in the Canadian Diabetes Association Clinical Practice Guidelines. The minimum required elements of the diabetes flow sheet include:

- **a.** Laboratory parameters including:
  - **i.** Lipid profile (cholesterol, triglycerides);
  - **ii.** glycosylated haemoglobin (HgbA1C);
  - **iii.** albumin to creatinine ratio (ACR; and
  - **iv.** estimated glomerular filtration rate (eGFR) or Creatinine Clearance (CrCl)
- **b.** Blood pressure;
- **c.** Height, weight and *body mass index (BMI)*;
- **d.** Medications (including dosage);
- **e.** Services related to prevention of diabetic complications;
- **f.** Health promotion counselling and patient self-management support;
- **g.** Evaluation and *referral*, as necessary, for dilated eye examination;
- **h.** Foot examination; and
- **i.** Neurological examination

2. K046 is *not eligible for payment* unless the record identifies any CDE performing the elements of the flow sheet.

[Commentary:

1. In circumstances where the CDE is employed by facilities, organizations or persons other than the physician, such as public hospitals, public health units, *ICHSC*s, industrial clinics or long-term care facilities, K046 is *not eligible for payment*.

2. For payment purposes, services rendered by the Certified Diabetic Educator (CDE) do not require the physical presence of a physician for direct supervision. It is required that the CDE performing services has the appropriate authorization from the applicable regulatory college, the CDE reports to the physician, and the services are rendered in accordance with accepted professional standards and practice.

3. K046 is payable in addition to K045.]

Claims submission instructions:

Claims for K046 may only be submitted when the required elements of the service have been completed for the previous *12 month period*.

ENDOCRINOLOGY & METABOLISM (15)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the emergency department when seeing patients in the emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C155	Consultation	172.95
C150	Comprehensive endocrinology consultation - subject to the same conditions as A150	342.25
C255	Limited consultation	110.15
C156	Repeat consultation	110.15
C153	Medical specific assessment	95.95
C154	Medical specific re-assessment	72.00
C151	Complex medical specific re-assessment	83.40
C760	Complex endocrine neoplastic disease assessment - subject to the same conditions as A760	102.95

Subsequent visits

C152	- first five weeks ... per visit	40.05
C157	- sixth to thirteenth week inclusive (maximum 3 per patient per week ... per visit	40.05
C159	- after thirteenth week (maximum 6 per patient per month) ... per visit	40.05

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

Subsequent visits by the MRP following transfer from an intensive care area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an intensive care area	71.80
C143	- second subsequent visit by the MRP following transfer from an intensive care area	71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43) ... per visit	40.05
C158	Concurrent care ... per visit	40.05
C982	Palliative care (see General Preamble GP50) ... per visit	40.05

ENDOCRINOLOGY & METABOLISM (15)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W155	Consultation	172.95
W150	Comprehensive endocrinology consultation - subject to the same conditions as A150	342.25
W255	Limited consultation	110.15
W156	Repeat consultation	110.15
W760	Complex endocrine neoplastic disease assessment - subject to the same conditions as A760	102.95

Admission assessment

W252	- Type 1	69.35
W254	- Type 2	20.60
W257	- Type 3	30.70
W259	Periodic health visit	65.05
W154	General re-assessment of patient in nursing home (as per the Nursing Homes Act)*	20.60

Note:
*May only be claimed 6 *month*s after Periodic health visit (as per the *Nursing Homes Act*).

Subsequent visits (see General Preamble GP49)

Chronic care or convalescent hospital

W152	- first 4 subsequent visits per patient per month	per visit	40.05
W151	- additional subsequent visits (maximum of 6 per patient per month)	per visit	40.05
W982	- palliative care (see General Preamble GP50)	per visit	40.05

Nursing *home* or *home* for the aged

W153	- first 2 subsequent visits per patient per month	per visit	40.05
W158	- subsequent visits per month (maximum of 3 per patient per month)	per visit	40.05
W972	- palliative care (see General Preamble GP50)	per visit	40.05
W121	Additional visits due to intercurrent illness (see General Preamble GP49)	per visit	40.05
W124	Subsequent visit – day of discharge (see A20 for terms and conditions)	per visit	71.80

GASTROENTEROLOGY (41)

For Services not listed, refer to Internal Medicine section.

GENERAL LISTINGS

A415	Consultation	159.45
A545	Limited consultation	106.90
A416	Repeat consultation	106.90
A413	Medical specific assessment	95.95
A414	Medical specific re-assessment	72.00
A411	Complex medical specific re-assessment	83.40
A418	Partial assessment	44.75
A120	Colonoscopy assessment, same day as colonoscopy	18.85

Note:

1. A120 is the only assessment service eligible for payment on the same day as a colonoscopy if a major pre-operative visit has been rendered by any physician in the *12 month period* prior to the date of the colonoscopy service.

2. A120 is *not eligible for payment* if a major pre-operative visit is eligible for payment on the same day as colonoscopy.

3. A120 is *only eligible for payment* to physicians in the following specialties: Internal Medicine (13) and Gastroenterology (41).

[Commentary:
For the definition of major pre-operative visit, see the definition page GP4.]

GASTROENTEROLOGY CHRONIC DISEASE ASSESSMENT PREMIUM

Definition/ Required elements of service:

Gastroenterology chronic disease assessment premium is payable in addition to the amount payable for an assessment by a gastroenterology specialist (41) when all of the following criteria are met:

a. The assessment is a

- **i.** medical specific assessment;
- **ii.** medical specific re-assessment;
- **iii.** complex medical specific re-assessment; or
- **iv.** partial assessment.

b. The assessment is rendered in an office setting or an out-patient clinic located in a hospital, other than an emergency department.

c. The patient has an established diagnosis of Crohn's disease, Ulcerative Colitis, malnutrition, Celiac disease, or chronic liver cirrhosis, documented in the patient's medical record.

E098 Gastroenterology chronic disease assessment premium ..... add 28%

[Commentary:
The gastroenterology chronic disease assessment premium is not payable for assessments rendered to inpatients of any hospital, patients seen in a long-term care facility or patients seen in an emergency department.]

GASTROENTEROLOGY (41)

Claims submission instructions:
Submit claims with one of the following diagnostic codes: 263, 555, 556, 571, or 579.

Emergency or Out-Patient Department (OPD)

Physician in hospital but not on duty in the emergency department when seeing patients in the emergency or OPD - use General Listings.

Non-Emergency Hospital In-Patient Services

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C415	Consultation	159.45
C545	Limited consultation	106.90
C416	Repeat consultation	106.90
C413	Medical specific assessment	95.95
C414	Medical specific re-assessment	72.00
C411	Complex medical specific re-assessment	83.40

GASTROENTEROLOGY (41)

Subsequent visits

C412	- first five weeks	per visit	40.05
C417	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	40.05
C419	- after thirteenth week (maximum 6 per patient per month)	per visit	40.05

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

Subsequent visits by the MRP following transfer from an intensive care area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an intensive care area		71.80
C143	- second subsequent visit by the MRP following transfer from an intensive care area		71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43)	per visit	40.05
C418	Concurrent care	per visit	40.05
C982	Palliative care (see General Preamble GP50)	per visit	40.05

GENERAL SURGERY (03)

GENERAL LISTINGS

A035	Consultation	114.75
A935	Special surgical consultation (see General Preamble GP19).	194.65
A036	Repeat consultation	76.45
A033	Specific assessment	56.40
A034	Partial assessment	34.10

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C035	Consultation	114.75
C935	Special surgical consultation (see General Preamble GP19).	194.65
C036	Repeat consultation	76.45
C033	Specific assessment	56.40
C034	Specific re-assessment	36.75

Subsequent visits

C032	- first five weeks	per visit	34.10
C037	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	34.10
C039	- after thirteenth week (maximum 6 per patient per month)	per visit	34.10

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43) per visit	40.05
C038	Concurrent care per visit	34.10
C982	Palliative care (see General Preamble GP50) per visit	40.05

GENERAL SURGERY (03)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W035	Consultation	114.75
W036	Repeat consultation	76.45

Subsequent visits (see General Preamble GP49)

Chronic care or convalescent hospital

W032	- first 4 subsequent visits per patient per month .....per visit	40.05
W031	- additional subsequent visits (maximum of 6 per patient per month).....per visit	40.05
W982	- palliative care (see General Preamble GP50) .....per visit	40.05

Nursing *home* or *home* for the aged

W033	- first 2 subsequent visits per patient per month .....per visit	40.05
W038	- subsequent visits per month (maximum of 3 per patient per month).....per visit	40.05
W972	- palliative care (see General Preamble GP50) .....per visit	40.05
W121	Additional visits due to intercurrent illness (see General Preamble GP49) .....per visit	40.05
W124	Subsequent visit – day of discharge (see A20 for terms and conditions).....per visit	71.80

GENERAL THORACIC SURGERY (64)

GENERAL LISTINGS

A645	Consultation	100.15
A935	Special surgical consultation (see General Preamble GP19).	194.65
A646	Repeat consultation	60.95
A643	Specific assessment	45.10
A644	Partial assessment	24.50

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C645	Consultation	100.15
C935	Special surgical consultation (see General Preamble GP19).	194.65
C646	Repeat consultation	60.95
C643	Specific assessment	45.10
C644	Specific re-assessment	26.40

Subsequent visits

C642	- first five weeks ... per visit	31.00
C647	- sixth to thirteenth week inclusive (maximum 3 per patient per week) ... per visit	31.00
C649	- after thirteenth week (maximum 6 per patient per month) ... per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43) ... per visit	40.05
C648	Concurrent care ... per visit	31.00
C982	Palliative care (see General Preamble GP50) ... per visit	40.05

GENERAL THORACIC SURGERY (64)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W645	Consultation	100.15
W646	Repeat consultation	60.95

GENETICS (22)

These listings may also be used by specialists with FCCMG designation (Fellow of the Canadian College of Medical Geneticists).

GENERAL LISTINGS

A225 Consultation* 190.50

Special genetic consultation

Special genetic consultation is a consultation in which the physician provides all the elements of a consultation (A225) and spends a minimum of 75 minutes in direct contact with the patient *with or without* family, exclusive of time spent rendering any other separately billable intervention to the patient.

A220 Special genetic consultation* 342.25

Medical record requirements:
The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

Extended special genetic consultation

Extended special genetic consultation is a consultation in which the physician provides all the elements of a consultation (A225) and spends a minimum of 90 minutes in direct contact with the patient *with or without* family, exclusive of time spent rendering any other separately billable intervention to the patient.

A223 Extended special genetic consultation* 442.40

Medical record requirements:
The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

[Commentary:
Unless otherwise specified in the *Schedule*, the calculation of time for A220 and A223 excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultation and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

A325 Limited consultation 119.40
A226 Repeat consultation 119.40
A221 Genetic minor assessment 38.05

GENETICS (22)

Midwife or Aboriginal Midwife-requested genetic assessment

This service is the assessment of a patient provided by a geneticist upon the written request of a midwife or aboriginal midwife because of the complex, obscure or serious nature of the patient's problem. The midwife or aboriginal midwife-requested genetic assessment includes the common and specific elements of an assessment.

A800 Midwife or Aboriginal Midwife-requested genetic assessment 167.35

Payment rules:

1. This service is limited to one per patient, per physician, per 24 month period.

2. The geneticist must submit his/her findings, opinions and recommendations in writing to both the midwife or aboriginal midwife and the patient's primary care physician or nurse practitioner, if applicable, or the amount payable for the service will be reduced to a lesser fee.

Medical record requirements:

The written request from the midwife or aboriginal midwife must be retained on the patient's permanent medical record, or the amount payable for the service will be reduced to a lesser fee.

Comprehensive midwife or aboriginal midwife-requested genetic assessment

This service is an assessment provided by a geneticist upon the written request of a midwife or aboriginal midwife because of the complex, obscure or serious nature of the patient's problem. This service includes the specific elements of an assessment and the physician must spend a minimum of 75 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A801 Comprehensive midwife or aboriginal midwife-requested genetic assessment..... 342.25

Payment rules:

1. This service is limited to one per patient, per physician, per 24 month period.

2. The geneticist must submit his/her findings, opinions and recommendations in writing to both the midwife or aboriginal midwife and the patient's primary care physician or nurse practitioner, if applicable, or the amount payable for the service will be reduced to a lesser fee.

Medical record requirements:

1. The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

2. The written request from the midwife or aboriginal midwife must be retained on the patient's permanent medical record, or the amount payable for the service will be reduced to a lesser fee.

Extended midwife or aboriginal midwife-requested genetic assessment

This service is the assessment provided by a geneticist upon the written request of a midwife or aboriginal midwife because of the complex, obscure or serious nature of the patient's problem. This service includes the specific elements of an assessment and the physician must spend a minimum of 90 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A802 Extended midwife or aboriginal midwife-requested genetic assessment 442.40

GENETICS (22)

Payment rules:

1. This service is limited to one per patient, per physician, per 24 month period.
2. The geneticist must submit his/her findings, opinions and recommendations in writing to both the midwife or aboriginal midwife and the patient's primary care physician or nurse practitioner, if applicable, or the amount payable for the service will be reduced to a lesser fee.

Medical record requirements:

1. The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.
2. The written request from the midwife or aboriginal midwife must be retained on the patient's permanent medical record, or the amount payable for the service will be reduced to a lesser fee.

[Commentary:

Unless otherwise specified in the *Schedule*, the calculation of time for A801 and A802 excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the assessment and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

GENETICS (22)

Genetic care

Genetic care is a time based service payable for rendering a genetic assessment. Time units are calculated based on the duration of direct contact between the physician and the patient or family. Unit means ½ hour or major part thereof - see General Preamble GP7, GP55 for definitions and time-keeping requirements.

K222 Genetic care, patient or family ..... per unit 90.55

Payment rules:
This service is limited to 4 units per patient, per day.

Clinical interpretation by a geneticist

Clinical interpretation by a Geneticist requires interpretation of pertinent pedigrees (which must contain a comprehensive ancestral history), and/or cytogenetic, biochemical, or molecular genetic reports. The service must be requested in writing by a physician who is participating in the patient's care and the geneticist must submit his/her findings, opinions, and recommendations in writing to the referring physician.

K223 Clinical interpretation 42.10

Payment rules:
This service is *not eligible for payment* when rendered in association with a consultation on the same patient.

Clinical interpretation by a geneticist requested by a midwife or aboriginal midwife

This service is the interpretation of pertinent pedigrees (which must contain a comprehensive ancestral history), and/or cytogenetic, biochemical, or molecular genetic reports. The service must be requested in writing by a midwife or aboriginal midwife who is participating in the patient's care and the geneticist must submit his/her findings, opinions, and recommendations in writing to both the midwife or aboriginal midwife and the patient's primary care physician or nurse practitioner, if applicable, or the amount payable for the service will be reduced to a lesser fee.

K224 Clinical interpretation requested by a midwife or aboriginal midwife 38.20

Complex Genetic Test Interpretation

Complex genetic test interpretation is a time-based service *only eligible for payment* for interpretation of complex genetic tests done in association with a consultation or genetic care service.

K229 Complex genetic test interpretation ..... per unit 65.85

Payment rules:

1. Complex genetic test interpretation includes interpretation done for any genetic testing where the laboratory report does not clearly explain the patient's phenotype or requires additional review to understand the implications of the result.
2. Unit means ½ hour or major part thereof - see General Preamble GP7, GP54 and GP55 for definitions and time-keeping requirements.
3. Time units are calculated based on the duration of time spent exclusively interpreting the complex genetic tests.
4. Maximum of 2 units per patient, per physician, per *12 month period*.

GENETICS (22)

Genetic family counselling

Genetic family counselling is counselling dedicated to an educational dialogue between the physician and one or more family members, guardians of a genetic patient or patient's representative for the purpose of providing information regarding treatment options and prognosis. The claim is submitted under the genetic patient’s health number.

K044 Genetic family counselling ..... per unit 62.75

Note:

Unit means ½ hour or major part thereof - see General Preamble GP7, GP55 for definitions and time keeping requirements.

GENETICS (22)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C225	Consultation*	190.50
C220	Special genetic consultation* - subject to the same conditions as A220	342.25
C223	Extended special genetic consultation* - subject to the same conditions as A223	442.40
C325	Limited consultation	119.40
C226	Repeat consultation	119.40
C800	Midwife or Aboriginal Midwife-requested genetic assessment – subject to the same conditions as A800	167.35
C801	Comprehensive midwife or aboriginal midwife-requested genetic assessment – subject to the same conditions as A801	342.25
C802	Extended midwife or aboriginal midwife-requested genetic assessment – subject to the same conditions as A802	442.40

Subsequent visits

C222	- first five weeks ... per visit	40.05
C227	- sixth to thirteenth week inclusive (maximum 3 per patient per week) ... per visit	40.05
C229	- after thirteenth week (maximum 6 per patient per month) ... per visit	40.05

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W225	Consultation*	190.50
W220	Special genetic consultation* - subject to the same conditions as A220	342.25
W223	Extended special genetic consultation* - subject to the same conditions as A223	442.40
W325	Limited consultation	119.40
W226	Repeat consultation	119.40

Note:

*A consultation is payable at nil if genetic care (K222) has previously been claimed by the same physician.

GENETICS (22)

Subsequent visits (see General Preamble GP49)

Chronic care or convalescent hospital

W222	- first 4 subsequent visits per patient per month	per visit	40.05
W221	- additional subsequent visits (maximum of 6 per patient per month)	per visit	40.05
W982	- palliative care (see General Preamble GP50)	per visit	40.05

Nursing *home* or *home* for the aged

W224	- first 2 subsequent visits per patient per month	per visit	40.05
W228	- subsequent visits per month (maximum of 3 per patient per month	per visit	40.05
W972	- palliative care (see General Preamble GP50)	per visit	40.05
W121	Additional visits due to intercurrent illness (see General Preamble GP49)	per visit	40.05
W124	Subsequent visit – day of discharge (see A20 for terms and conditions)	per visit	71.80

GERIATRICS (07)

GENERAL LISTINGS

A075 Consultation..... 223.30

A070 Consultation in association with special visit to a hospital in-patient, long-term care in-patient or emergency department patient 255.85

Claims submission instructions:
Submit claim using A070 and the appropriate special visit premium beginning with "C" prefix for a hospital in-patient, “W” prefix for a long-term care in-patient or “K” prefix for an emergency department patient.

Comprehensive geriatric consultation

A comprehensive geriatric consultation is a consultation performed by a physician with a certificate of special competence in Geriatrics on a patient:

a. at least 65 years of age; or

b. when the consultation is for the assessment of dementia; and

where the physician spends a minimum of 75 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A775 Comprehensive geriatric consultation..... 342.25

[Commentary:
A775 is eligible for payment when the consultation is for the assessment of dementia regardless of the patient's age.]

Medical record requirements:
The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

Payment rules:
A comprehensive geriatric consultation is *only eligible for payment* if this service has not been rendered on the same patient by the same consultant within the previous 2 years.

Extended comprehensive geriatric consultation

An extended comprehensive geriatric consultation is a consultation performed by a physician with a certificate of special competence in geriatrics on a patient:

a. at least 65 years of age; or

b. when the consultation is for the assessment of dementia; and

where the physician spends a minimum of 90 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A770 Extended comprehensive geriatric consultation 442.40

[Commentary:
A770 is eligible for payment when the consultation is for the assessment of dementia regardless of the patient's age.]

Medical record requirements:
The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

Payment rules:
An extended comprehensive geriatric consultation is *only eligible for payment* if this service has not been rendered on the same patient by the same consultant within the previous 2 years.

GERIATRICS (07)

[Commentary:
Unless otherwise specified in the *Schedule*, the calculation of time for A775 and A770 excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultation and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

GERIATRICS (07)

A375	Limited consultation	113.35
A076	Repeat consultation	113.35
A073	Medical specific assessment	99.05
A074	Medical specific re-assessment	79.85
A071	Complex medical specific re-assessment	103.80
A078	Partial assessment	49.65

Payment rules:
A073, A074, A071 and A078 are *only eligible for payment* for a patient at least 65 years of age or when the assessment is for the assessment of dementia.

[Commentary:
A073, A074, A071 and A078 are eligible for payment when the consultation is for the assessment of dementia regardless of the patient's age.]

E078 - chronic disease assessment premium (see General Preamble GP25) ..... add 50%

Geriatric telephone support

This is the service initiated by a caregiver where a physician provides telephone support to a caregiver(s) for a patient with an established diagnosis of dementia.

K077 Geriatric telephone support ..... per unit 43.10

Payment rules:

1. A maximum of two (2) units of K077 are eligible for payment per patient per day.

2. A maximum of twelve(12) K077 units are eligible for payment per patient per *12 month period*.

3. K077 is *only eligible for payment* where:

- **a.** there is a minimum of 10 minutes of patient-related discussion; and
- **b.** the physician:
  - **i.** is a *specialist* in Geriatrics (07); or
  - **ii.** has a certificate of special competence in Geriatrics; or
  - **iii.** has an exemption to access bonus impact in Care of the Elderly from the *MOH*.

4. In circumstances where a physician receives compensation, other than by fee-for-service under this *Schedule*, for the provision of telephone support for caregivers, this service is *not eligible for payment* to that physician.

[Commentary:

1. Payment, other than by fee-for-service includes compensation where the physician receives remuneration under a salary, primary care, stipend, APP or AFP model.

2. Physicians who receive compensation other than by fee-for-service under this *Schedule* should consult their contract for guidance on shadow-billing.]

Medical record requirements:
K077 is *only eligible for payment* where the following elements are included in the medical record:

1. patient's name and health number;

2. start and stop times of the discussion;

3. reason for the telephone support; and

4. the opinion, advice and/or recommendations of the physician.

GERIATRICS (07)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C075	Consultation	255.85
C775	Comprehensive geriatric consultation - subject to the same conditions as A775	342.25
C770	Extended comprehensive geriatric consultation - subject to the same conditions as A770	442.40
C375	Limited consultation	113.35
C076	Repeat consultation	113.35
C073	Medical specific assessment - subject to the same conditions as A073	99.05
C074	Medical specific re-assessment- subject to the same conditions as A074	79.85
C071	Complex medical specific re-assessment- subject to the same conditions as A071	103.80

Subsequent visits

C072	- first five weeks ... per visit	40.05
C077	- sixth to thirteenth week inclusive (maximum 3 per patient per week) ... per visit	40.05
C079	- after thirteenth week (maximum 6 per patient per month) ... per visit	40.05

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43) ... per visit	40.05
C078	Concurrent care ... per visit	40.05
C982	Palliative care (see General Preamble GP50) ... per visit	40.05

GERIATRICS (07)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W075	Consultation	249.90
W775	Comprehensive geriatric consultation - subject to the same conditions as A775	342.25
W770	Extended comprehensive geriatric consultation - subject to the same conditions as A770	442.40
W375	Limited consultation	113.35
W076	Repeat consultation	113.35

Admission assessment

W272	- Type 1	74.65
W274	- Type 2	20.60
W277	- Type 3	30.70
W279	Periodic health visit	65.05
W074	General reassessment of patient in nursing home (as per the Nursing Homes Act)*	20.60

Note:
*May only be claimed 6 *month*s after Periodic health visit (as per the *Nursing Homes Act*)

Subsequent visits (see General Preamble GP49)

Chronic care or convalescent hospital

W072	- first 4 subsequent visits per patient per month..... per visit	40.05
W071	- additional subsequent visits (maximum of 6 per patient per month)..... per visit	40.05
W982	- palliative care (see General Preamble GP50)..... per visit	40.05

Nursing *home* or *home* for the aged

W073	- first 2 subsequent visits per patient per month..... per visit	40.05
W078	- subsequent visits per month (maximum of 3 per patient per month)..... per visit	40.05
W972	- palliative care (see General Preamble GP50)..... per visit	40.05
W121	Additional visits due to intercurrent illness (see General Preamble GP49) ..... per visit	40.05
W124	Subsequent visit – day of discharge (see A20 for terms and conditions)..... per visit	71.80

*Month*ly Management of a Nursing *Home* or *Home* for the Aged Patient

W010	Monthly management fee (per patient per month) (see General Preamble GP51 to GP52)	135.30

HAEMATOLOGY (61)

For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

A615	Consultation	192.90
A655	Limited consultation	118.05
A616	Repeat consultation	118.05
A613	Medical specific assessment	95.95
A614	Medical specific re-assessment	72.00
A611	Complex medical specific re-assessment	83.40
A618	Partial assessment	44.75

E078 - chronic disease assessment premium (see General Preamble GP25) ..... add 50%

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C615	Consultation	192.90
C655	Limited consultation	118.05
C616	Repeat consultation	118.05
C613	Medical specific assessment	95.95
C614	Medical specific re-assessment	72.00
C611	Complex medical specific re-assessment	83.40

Subsequent visits

C612	- first five weeks ..... per visit	40.05
C617	- sixth to thirteenth week inclusive (maximum 3 per patient per week) ..... per visit	40.05
C619	- after thirteenth week (maximum 6 per patient per month) ..... per visit	40.05

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	71.80

HAEMATOLOGY (61)

C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area		71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43)	per visit	40.05
C618	Concurrent care	per visit	40.05
C982	Palliative care (see General Preamble GP50)	per visit	40.05

INFECTIOUS DISEASE (46)

GENERAL LISTINGS

A465 Consultation 205.90

Comprehensive infectious disease consultation

This service is a consultation rendered by a *specialist* in infectious disease who provides all the appropriate elements of a consultation and spends a minimum of 75 minutes in direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

A460 Comprehensive infectious disease consultation 342.25

Medical record requirements:
The start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.

[Commentary:
1. A460 must satisfy all the elements of a consultation (see page GP16).

2. Unless otherwise specified in the *Schedule*, the calculation of the 75 minute minimum time for comprehensive infectious disease consultations excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultation and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

A275 Limited consultation 119.30
A466 Repeat consultation 124.00
A463 Medical specific assessment 107.00
A464 Medical specific re-assessment 82.10
A461 Complex medical specific re-assessment 95.05
A468 Partial assessment 62.15

E078 - chronic disease assessment premium (see General Preamble GP25) ..... add 50%

Complex Infectious Disease Assessment

This service is an assessment for the ongoing management of any of the following infectious diseases where the complexity of the condition requires the continuing management by an infectious disease specialist and where the visit requires a minimum of 20 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient:

a. active pulmonary or extrapulmonary disease due to mycobacterial tuberculosis complex (latent tuberculosis infection is excluded); or

b. active pulmonary or extrapulmonary non-tuberculous mycobacterial disease (airway or tissue colonization without disease is excluded)

c. Deep seeded fungal infection (aspergilloma is excluded) - e.g.: dimorphic fungi, candida auris infections

d. Patient with an infection with a multi drug resistant organism (e.g. MDR pseudomonas, ESBL, AmpC, CPE, MRSA, VRE) who are currently requiring IV antibiotic (or PO linezolid), outside of hospital, supervised by the physician.

A270 Complex infectious disease assessment 95.05

INFECTIOUS DISEASE (46)

Payment rules:

1. A complex infectious disease assessment must include all the elements of a specific assessment or the amount payable will be adjusted to lesser assessment fee.
2. Complex infectious disease assessments are limited to 6 per patient, per physician, per 12 month period. Services in excess of this limit will be adjusted to a lesser assessment fee.

Medical record requirements:

The start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C465	Consultation	205.90
C460	Comprehensive infectious disease consultation - subject to the same conditions as A460	342.25
C275	Limited consultation	119.30
C466	Repeat consultation	124.00
C463	Medical specific assessment	107.00
C270	Complex infectious disease assessment - subject to the same conditions as A270	95.05
C464	Medical specific re-assessment	82.10
C461	Complex medical specific re-assessment	95.05

INFECTIOUS DISEASE (46)

Subsequent visits

C462	- first five weeks	per visit	40.05
C467	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	40.05
C469	- after thirteenth week (maximum 6 per patient per month)	per visit	40.05

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	71.80

C121	Additional visits due to intercurrent illness (see General Preamble GP43)	per visit	40.05
C468	Concurrent care	per visit	40.05
C982	Palliative care (see General Preamble GP50)	per visit	40.05

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W465	Consultation	205.90
W460	Comprehensive infectious disease consultation - subject to the same conditions as A460	342.25
W275	Limited consultation	119.30
W466	Repeat consultation	124.00

Admission assessment

W292	- Type 1	69.35
W294	- Type 2	20.60
W297	- Type 3	30.70
W299	Periodic health visit	65.05
W464	General re-assessment of patient in nursing home (as per the Nursing Homes Act)*	20.60

INFECTIOUS DISEASE (46)

Note:
*May only be claimed 6 *month*s after Periodic health visit (as per the *Nursing Homes Act*).

Subsequent visits (see General Preamble GP49)

Chronic care or convalescent hospital

W462	- first 4 subsequent visits per patient per month	per visit	40.05
W461	- additional subsequent visits (maximum of 6 per patient per month)	per visit	40.05
W982	- palliative care (see General Preamble GP50)	per visit	40.05

Nursing *home* or *home* for the aged

W463	- first 2 subsequent visits per patient per month	per visit	40.05
W468	- subsequent visits per month (maximum of 3 per patient per month)	per visit	40.05
W972	- palliative care (see General Preamble GP50)	per visit	40.05
W121	Additional visits due to intercurrent illness (see General Preamble GP49)	per visit	40.05
W124	Subsequent visit – day of discharge (see A20 for terms and conditions)	per visit	71.80

INTERNAL MEDICINE (13)

GENERAL LISTINGS

A135 Consultation 192.85

Comprehensive internal medicine consultation

This service is a consultation rendered by a *specialist* in internal medicine who provides all the appropriate elements of a consultation and spends a minimum of seventy-five (75) minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

A130 Comprehensive internal medicine consultation 342.25

Medical record requirements:
The start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.

[Commentary:
1. A130 must satisfy all the elements of a consultation (see page GP16).

2. Unless otherwise specified in the *Schedule*, the calculation time for comprehensive internal medicine consultations excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultation and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

A435 Limited consultation 123.10
A136 Repeat consultation 123.10
A133 Medical specific assessment 95.95
A134 Medical specific re-assessment 72.00
A131 Complex medical specific re-assessment 83.40
A138 Partial assessment 44.75

A120 Colonoscopy assessment, same day as colonoscopy 18.85

Note:
1. A120 is the only assessment service eligible for payment on the same day as a colonoscopy if a major pre-operative visit has been rendered by any physician in the *12 month period* prior to the date of the colonoscopy service.

2. A120 is *not eligible for payment* if a major pre-operative visit is eligible for payment on the same day as colonoscopy.

3. A120 is *only eligible for payment* to physicians in the following specialties: Internal Medicine (13) and Gastroenterology (41).

[Commentary:
For the definition of major pre-operative visit, see the definition page GP4.]

K045 Diabetes management by a specialist 80.25
K046 Diabetes team management 127.20

[Commentary:
For K045 and K046 definition/required elements, payment rules and record keeping requirements see Endocrinology and Metabolism section.]

INTERNAL MEDICINE (13)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C135	Consultation	192.85
C130	Comprehensive internal medicine consultation - subject to the same conditions as A130	342.25
C435	Limited consultation	123.10
C136	Repeat consultation	123.10
C133	Medical specific assessment	95.95
C134	Medical specific re-assessment	72.00
C131	Complex medical specific re-assessment	83.40

Subsequent visits

C132	- first five weeks ... per visit	40.05
C137	- sixth to thirteenth week inclusive (maximum 3 per patient per week) ... per visit	40.05
C139	- after thirteenth week (maximum 6 per patient per month) ... per visit	40.05

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43) ... per visit	40.05
C138	Concurrent care ... per visit	40.05
C982	Palliative care (see General Preamble GP50) ... per visit	40.05

INTERNAL MEDICINE (13)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W235	Consultation	192.85
W130	Comprehensive internal medicine consultation - subject to the same conditions as A130	342.25
W435	Limited consultation	123.10
W236	Repeat consultation	123.10

Admission assessment

W232	- Type 1	69.35
W234	- Type 2	20.60
W237	- Type 3	30.70
W239	Periodic health visit	65.05
W134	General re-assessment of patient in nursing home (as per the Nursing Homes Act)*	20.60

Note:
*May only be claimed 6 *month*s after Periodic health visit (as per the *Nursing Homes Act*).

Subsequent visits (see General Preamble GP49)

Chronic care or convalescent hospital

W132	- first 4 subsequent visits per patient per month	per visit	40.05
W131	- additional subsequent visits (maximum of 6 per patient per month)	per visit	40.05
W982	- palliative care (see General Preamble GP50)	per visit	40.05

Nursing *home* or *home* for the aged

W133	- first 2 subsequent visits per patient per month	per visit	40.05
W138	- subsequent visits per month (maximum of 3 per patient per month)	per visit	40.05
W972	- palliative care (see General Preamble GP50)	per visit	40.05
W121	Additional visits due to intercurrent illness (see General Preamble GP49)	per visit	40.05
W124	Subsequent visit – day of discharge (see A20 for terms and conditions)	per visit	71.80

LABORATORY MEDICINE (28)

The following fees are applicable to specialists in Haematopathology, Neuropathology, Medical Biochemistry, Medical Microbiology, Anatomic and General Pathology.

GENERAL LISTINGS

A285	Consultation	163.00
A286	Limited consultation	108.95
A586	Repeat consultation	110.00
A283	Medical specific assessment	82.50
A284	Partial assessment	38.85

E078 - chronic disease assessment premium (see General Preamble GP25) ..... add 50%

Comprehensive laboratory medicine consultation

This service is a consultation rendered by a specialist in laboratory medicine who provides all the appropriate elements of a consultation and spends a minimum of 75 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A580	Comprehensive internal medicine consultation	342.25

Medical record requirements:
The start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.

[Commentary:

1. A580 must satisfy all the elements of a consultation (see page GP16).
2. Unless otherwise specified in the *Schedule*, the calculation of time for comprehensive laboratory medicine consultations excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultation and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

Diagnostic consultation

A diagnostic laboratory medicine consultation is the service rendered when tissue, slides, specimens and/or laboratory results prepared in one licensed laboratory are referred to a laboratory medicine physician not in the same licensed laboratory for a written opinion. The *specific elements* are the same as for the L800 series of codes (see page J60 to J62).

A585	Diagnostic consultation	106.50

Payment rules:

1. A diagnostic laboratory medicine consultation is *not eligible for payment* when tissues, slides, specimens and/or laboratory results from a different licensed laboratory are used for comparison purposes with tissues, slides, specimens and/or laboratory results done in the consultant's licensed laboratory.
2. With the exception of those services set out in the section, "Special Procedures and Interpretation – Histology or Cytology", any other services rendered by the physician in association with a diagnostic laboratory medicine consultation are *not eligible for payment*.

LABORATORY MEDICINE (28)

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C285	Consultation		163.00
C286	Limited consultation		108.95
C586	Repeat consultation		110.00
C283	Medical specific assessment		82.50
C580	Comprehensive laboratory medicine consultation – subject to the same conditions as A580		342.25
C585	Diagnostic consultation - subject to the same conditions as A585		106.50
C288	Concurrent care	per visit	30.10

MEDICAL ONCOLOGY (44)

GENERAL LISTINGS

A445	Consultation	183.40
A845	Limited consultation	115.95
A446	Repeat consultation	115.95
A443	Medical specific assessment	95.95
A444	Medical specific re-assessment	72.00
A441	Complex medical specific re-assessment	83.40
A448	Partial assessment	44.75

E078 - chronic disease assessment premium (see General Preamble GP25) ..... add 50%

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C445	Consultation	183.40
C845	Limited consultation	115.95
C446	Repeat consultation	115.95
C443	Medical specific assessment	95.95
C444	Medical specific re-assessment	72.00
C441	Complex medical specific re-assessment	83.40

Subsequent visits

C442	- first five weeks ..... per visit	40.05
C447	- sixth to thirteenth week inclusive (maximum 3 per patient per week)..... per visit	40.05
C449	- after thirteenth week (maximum 6 per patient per month) ..... per visit	40.05

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

MEDICAL ONCOLOGY (44)

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43) ... per visit	40.05
C448	Concurrent care ... per visit	40.05
C982	Palliative care (see General Preamble GP50) ... per visit	40.05

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W445	Consultation	183.40
W845	Limited consultation	115.95
W446	Repeat consultation	115.95

Admission assessment

W842	- Type 1	69.35
W844	- Type 2	20.60
W847	- Type 3	30.70
W849	Periodic health visit	65.05
W444	General re-assessment of patient in nursing home (as per the Nursing Homes Act)*	20.60

Note:

*May only be claimed 6 *month*s after Periodic health visit (as per the *Nursing Homes Act*).

Subsequent visits (see General Preamble GP49)

Chronic care or convalescent hospital

W442	- first 4 subsequent visits per patient per month ... per visit	40.05
W441	- additional subsequent visits (maximum of 6 per patient per month) ... per visit	40.05
W982	- palliative care (see General Preamble GP50) ... per visit	40.05

Nursing *home* or *home* for the aged

W443	- first 2 subsequent visits per patient per month ... per visit	40.05
W448	- subsequent visits per month (maximum of 3 per patient per month) ... per visit	40.05
W972	- palliative care (see General Preamble GP50) ... per visit	40.05
W121	Additional visits due to intercurrent illness (see General Preamble GP49) ... per visit	40.05
W124	Subsequent visit – day of discharge (see A20 for terms and conditions) ... per visit	71.80

NEPHROLOGY (16)

GENERAL LISTINGS

A165 Consultation 180.75

Comprehensive nephrology consultation

This service is a consultation rendered by a *specialist* in nephrology who provides all the appropriate elements of a consultation and spends a minimum of seventy-five (75) minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

A160 Comprehensive nephrology consultation 342.25

Medical record requirements:

For A160, the start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.

[Commentary:

1. A160 must satisfy all the elements of a consultation (see page GP16).

2. Unless otherwise specified in the *Schedule*, the calculation of the 75 minute minimum time for comprehensive nephrology consultations excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultation and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

A865 Limited consultation 116.75
A166 Repeat consultation 116.75
A163 Medical specific assessment 95.95
A164 Medical specific re-assessment 72.00
A161 Complex medical specific re-assessment 83.40
A168 Partial assessment 44.75

Post Renal Transplant Assessment Premium

Post renal transplant assessment premium is payable in addition to the amount payable for an assessment.

E060 Post Renal Transplant Assessment Premium ..... Add 50%

Payment rules:

All of the following criteria apply:

1. The assessment is a:
- **a.** medical specific assessment (A163);
- **b.** medical specific re-assessment (A164);
- **c.** complex medical specific re-assessment (A161); or
- **d.** partial assessment (A168);

2. The service is rendered by a physician with a specialty designation in (16) Nephrology;

3. The assessment is *not eligible for payment* when rendered in an emergency department or *emergency department equivalent* or to a hospital inpatient;

4. The purpose of the assessment is post-transplant care; and

5. The patient is within the first three years of having received their renal transplant.

NEPHROLOGY (16)

[Commentary:
The post renal transplant assessment premium is not payable for assessments rendered to in-patients of any hospital, patients seen in a long-term care facility or patients seen in an emergency department or *emergency department equivalent*.]

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C165	Consultation	180.75
C160	Comprehensive nephrology consultation - subject to the same conditions as A160	342.25
C865	Limited consultation	116.75
C166	Repeat consultation	116.75
C163	Medical specific assessment	95.95
C164	Medical specific re-assessment	72.00
C161	Complex medical specific re-assessment	83.40

NEPHROLOGY (16)

Subsequent visits

C162	- first five weeks ..... per visit	40.05
C167	- sixth to thirteenth week inclusive (maximum 3 per patient per week) ..... per visit	40.05
C169	- after thirteenth week (maximum 6 per patient per month) ..... per visit	40.05

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment.....	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge.....	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions).....	95.10

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area.....	71.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area.....	71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43) ..... per visit	40.05
C168	Concurrent care ..... per visit	40.05
C982	Palliative care (see General Preamble GP50) ..... per visit	40.05

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W165	Consultation	180.75
W160	Comprehensive nephrology consultation - subject to the same conditions as A160.....	342.25
W865	Limited consultation.....	116.75
W166	Repeat consultation.....	116.75

Admission assessment

W862	- Type 1	69.35
W864	- Type 2	20.60
W867	- Type 3	30.70
W869	Periodic health visit	65.05
W164	General re-assessment of patient in nursing home (as per the Nursing Homes Act)*.....	20.60

NEPHROLOGY (16)

Note:
*May only be claimed 6 *month*s after Periodic health visit (as per the *Nursing Homes Act*).

Subsequent visits (see General Preamble GP49)

Chronic care or convalescent hospital

W162	- first 4 subsequent visits per patient per month..... per visit	40.05
W161	- additional subsequent visits (maximum of 6 per patient per month)..... per visit	40.05
W982	- palliative care (see General Preamble GP50)..... per visit	40.05

Nursing *home* or *home* for the aged

W163	- first 2 subsequent visits per patient per month..... per visit	40.05
W168	- subsequent visits per month (maximum of 3 per patient per month)..... per visit	40.05
W972	- palliative care (see General Preamble GP50)..... per visit	40.05
W121	Additional visits due to intercurrent illness (see General Preamble GP49) ..... per visit	40.05
W124	Subsequent visit – day of discharge (see A20 for terms and conditions)..... per visit	71.80

NEUROLOGY (18)

GENERAL LISTINGS

A185 Consultation 225.55

Special neurology consultation

Special neurology consultation is a consultation in which the physician provides all the elements of a consultation (A185) and spends a minimum of 75 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A180 Special neurology consultation 342.25

Medical record requirements:
The service is *only eligible for payment* if start and stop times of the service are recorded in the patient's permanent medical record.

Extended special neurology consultation

Extended special neurology consultation is a consultation in which the physician provides all the elements of a consultation (A185) and spends a minimum of 90 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A682 Extended special neurology consultation 442.40

Medical record requirements:
The service is *only eligible for payment* if start and stop times of the service are recorded in the patient's permanent medical record.

[Commentary:
Unless otherwise specified in the *Schedule*, the calculation of time for A180 and A682 excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultation and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

A385 Limited consultation 125.50
A186 Repeat consultation 125.50
A183 Medical specific assessment 82.40
A184 Medical specific re-assessment 64.95
A181 Complex medical specific re-assessment 75.20
A188 Partial assessment 39.40

E078 - chronic disease assessment premium (see General Preamble GP25) ..... add 50%

Dose titration and programming of external infusion pump for the treatment of advanced Parkinson's disease

Dose titration and programming of external infusion pump for the treatment of advanced Parkinson's disease is a time based all-inclusive service for the purpose of providing assessment and dose optimization for a patient with advanced Parkinson's disease receiving continuous subcutaneous or enteral infusion. This service is claimed in units - unit means ½ hour or major part thereof - see the General Preamble GP7, GP55 for definitions and time keeping requirements.

K180 Dose titration and programming of external infusion pump for the treatment of advanced Parkinson's disease..... per unit 125.00

NEUROLOGY (18)

Payment rules:

1. K180 includes the necessary consultation or assessments and interventions required to perform the service. Any other assessment service rendered by the same physician to the same patient on the same day as K180 is *not eligible for payment*.
2. K180 is *only eligible for payment* for patients with advanced parkinson's disease experiencing severe motor fluctuations (on/off periods, gait freezing, dyskinesia) that aren't well-controlled by optimized oral medications.
3. K180 is limited to a maximum of 4 units per patient per day and 20 units per patient per year.
4. K180 is *only eligible for payment* to a neurologist with experience or training in management of Parkinson's disease or related disorders.
5. K180 must be personally rendered by the physician.
6. The time unit is measured as the physician time spent fully devoted to the care of the patient and excludes time spent on separately billable interventions. Time unit total may include time which is consecutive or non-consecutive.

Medical record requirements:

The start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.

[Commentary:

Unless otherwise specified in the *Schedule*, the calculation of time for K180 excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the K180 and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

Complex neurological assessment

A complex neurological assessment is an assessment for the ongoing management of the following complex chronic neurological conditions where the complexity of the condition requires the continuing management by a neurologist and where the visit requires a minimum of 20 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient:

1. the following diseases of the neuromuscular system
   - **a.** generalized peripheral neuropathies;
   - **b.** myopathies;
   - **c.** diseases of the neuromuscular junction; or
   - **d.** diseases of the motor neurone.
2. the following chronic central nervous system disorders:
   - **a.** Malignant neoplasms (brain)
   - **b.** Psychosomatic disturbances (functional neurological disorder)
   - **c.** Chronic migraine or trigeminal autonomic cephalalgias
   - **d.** Huntington's chorea
   - **e.** Trigeminal neuralgia
   - **f.** Intracranial hemorrhage
   - **g.** Stroke

NEUROLOGY (18)

3. the following neuro-oncology conditions:

a. primary tumor of the central nervous system;

b. central nervous system metastasis;

c. neurological complications of cancer therapy;

d. paraneoplastic neurological syndromes.

A113 Complex neurological assessment 120.00

Payment rules:

1. A complex neurological assessment must include the elements of a medical specific re-assessment, or the amount payable will be adjusted to lesser assessment fee.

2. This service is *not eligible for payment* to a physician for the initial evaluation of the patient by that physician.

3. Complex neurological assessments are limited to 6 per patient, per physician, per *12 month period*. Services in excess of this limit will be adjusted to a lesser assessment fee.

4. This service is *not eligible for payment* unless the patient has an established diagnosis of a chronic complex neurological disease, documented in the patient's medical record.

5. E078 is *not eligible for payment* with A113.

Medical record requirements:

The start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.

[Commentary:

1. A complex neurological assessment is for the ongoing management of complex neurological disorders, where the complexity of the condition requires the continuing management by a neurologist. It is not intended for the evaluation and/or management of uncomplicated neurological disorders (e.g. carpal tunnel syndrome, Bell's palsy, asymptomatic diabetic neuropathy).

2. A consultation or assessment service, as appropriate, may be claimed for the initial evaluation of a patient. A complex neurological assessment is for the ongoing management of a patient with a complex neurological disorder.]

Consultation and Management for Acute Cerebral Vascular Syndrome (ACVS)

A Consultation and Management for ACVS is a service in which the physician provides all the elements of a consultation (A185) to a patient referred for suspected ACVS and, if necessary, treatment with intravenous thrombolysis therapy and post-administration monitoring.

A384 ..... 275.95

K181 - after first 30 minutes, must include intravenous thrombolysis therapy and monitoring, per 30 minute unit (or major part thereof) 90.00

Medical record requirements:

Consultation and Management for ACVS is *only eligible for payment* if start and stop times of the services and the time of onset of symptoms are recorded in the patient's permanent medical record.

NEUROLOGY (18)

Payment rules:

1. A384 and K181 are *only eligible for payment* for patients seen within the timeframe for eligibility for intravenous thrombolysis therapy as defined by the Canadian Stroke Best Practices.
2. A384 and K181 must be rendered in a hospital with CT or MRI facilities onsite.
3. A384 and K181 are *only eligible for payment* to a *specialist* in Neurology (18).
4. A384 and K181 are *only eligible for payment* if the physician remains in constant attendance with the patient.
5. G521, G522, G523, or G391 are *not eligible for payment* with A384 or K181.
6. K181 is *only eligible for payment* for patients treated with intravenous thrombolysis therapy as defined by the Canadian Stroke Best Practices.
7. K181 is limited to a maximum of 6 units per patient per *day*.

[Commentary:
The Canadian Stroke Best Practices can be found at the following link: https://www.strokebestpractices.ca/recommendations/acute-stroke-management/acute-ischemic-stroke-treatment

NEUROLOGY (18)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C185	Consultation	225.55
C180	Special neurology consultation - subject to the same conditions as A180	342.25
C682	Extended special neurology consultation - subject to the same conditions as A682	442.40
C384	Consultation and Management for ACVS - subject to the same conditions as A384	275.95
C385	Limited consultation	125.50
C186	Repeat consultation	125.50
C183	Medical specific assessment	82.40
C184	Medical specific re-assessment	64.95
C181	Complex medical specific re-assessment	75.20
C113	Complex neurological assessment - subject to the same conditions as A113	120.00

Subsequent visits

C182	- first five weeks ... per visit	40.05
C187	- sixth to thirteenth week inclusive (maximum 3 per patient per week) ... per visit	40.05
C189	- after thirteenth week (maximum 6 per patient per month) ... per visit	40.05

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43) ... per visit	40.05
C188	Concurrent care ... per visit	40.05
C982	Palliative care (see General Preamble GP50) ... per visit	40.05

NEUROLOGY (18)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W185	Consultation	225.55
W180	Special neurology consultation - subject to the same conditions as A180	342.25
W682	Extended special neurology consultation - subject to the same conditions as A682	442.40
W385	Limited consultation	125.50
W186	Repeat consultation	125.50
W113	Complex neurological assessment - subject to the same conditions as A113	120.00
W184	General re-assessment of patient in nursing home (as per the Nursing Homes Act)*	20.60

Note:
*May only be claimed 6 *month*s after Periodic health visit (as per the *Nursing Homes Act*).

Subsequent visits (see General Preamble GP49)

Chronic care or convalescent hospital

W182	- first 4 subsequent visits per patient per month	per visit	40.05
W181	- additional subsequent visits (maximum of 6 per patient per month)	per visit	40.05
W982	- palliative care (see General Preamble GP50)	per visit	40.05

Nursing *home* or *home* for the aged

W183	- first 2 subsequent visits per patient per month	per visit	40.05
W188	- subsequent visits per month (maximum of 3 per patient per month)	per visit	40.05
W972	- palliative care (see General Preamble GP50)	per visit	40.05

W121	Additional visits due to intercurrent illness (see General Preamble GP49)	per visit	40.05
W124	Subsequent visit – day of discharge (see A20 for terms and conditions)	per visit	71.80

NEUROSURGERY (04)

GENERAL LISTINGS

A045	Consultation	145.60
A935	Special surgical consultation (see General Preamble GP19).	194.65
A046	Repeat consultation	64.85
A043	Specific assessment	64.90
A044	Partial assessment	33.40

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C045	Consultation	145.60
C935	Special surgical consultation (see General Preamble GP19).	194.65
C046	Repeat consultation	64.85
C043	Specific assessment	64.90
C044	Specific re-assessment	33.40

Subsequent visits

C042	- first five weeks	per visit	31.00
C047	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	31.00
C049	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	71.80

C121	Additional visits due to intercurrent illness (see General Preamble GP43)	per visit	40.05
C048	Concurrent care	per visit	31.00
C982	Palliative care (see General Preamble GP50)	per visit	40.05

NEUROSURGERY (04)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W045	Consultation	145.60
W046	Repeat consultation	64.85

NUCLEAR MEDICINE (63)

GENERAL LISTINGS

A635 Consultation 188.40

Comprehensive nuclear medicine consultation

A comprehensive nuclear medicine consultation is a consultation rendered by a *specialist* in nuclear medicine who provides all the appropriate elements of a consultation and spends a minimum of 75 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A835 Comprehensive nuclear medicine consultation 342.25

Medical record requirements:
The start and stop times must be recorded in the patient's permanent medical record

[Commentary:
1. A835 must satisfy all the elements of a consultation (see page GP16).

2. Unless otherwise specified in the *Schedule*, the calculation of the 75 minute minimum time for comprehensive nuclear medicine consultation excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultation and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

Diagnostic consultation

A diagnostic nuclear medicine consultation is the service rendered:

a. when nuclear medicine studies rendered at one institution or facility are referred to a nuclear medicine *specialist* in a different institution or facility for a written opinion. In this case, the *specific elements* are the same as the nuclear medicine *professional component* (see page B1); or

b. when a nuclear medicine *specialist* is required to make a special visit at evening or night (17:00h to 07:00h) or on a Saturday, Sunday, or *holiday* to consult on the advisability of performing a nuclear medicine procedure, which eventually is not done. In this case, the *specific elements* are the same as for consultations (see page GP16).

A735 Diagnostic consultation 80.90

Payment rules:
A diagnostic nuclear medicine consultation is *not eligible for payment* when studies rendered in a different institution or facility are used for comparison purposes with nuclear medicine studies rendered in the consultant's institution or facility.

A636 Repeat consultation 84.00
A633 Specific assessment 72.00
A638 Partial assessment 48.00

Minor assessment

A minor assessment is the service rendered when a nuclear medicine *specialist* evaluates a patient on a non-emergent basis resulting in the cancellation or deferral of a planned diagnostic nuclear medicine procedure due to procedural difficulties, including lack of patient cooperation, if no other diagnostic nuclear medicine procedure is rendered.

A631 Minor assessment 26.80

NUCLEAR MEDICINE (63)

Minor assessment

A minor assessment is the service rendered when a nuclear medicine *specialist* evaluates a patient on a non-emergent basis on the advisability of performing a diagnostic nuclear medicine procedure which eventually is not done.

A632 Minor assessment 26.80

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C635 Consultation 188.40

C835 Comprehensive nuclear medicine consultation - subject to the same conditions of A835 ..... 342.25

C735 Diagnostic consultation - subject to the same conditions as A735 ..... 80.90

C636 Repeat consultation 84.00

OBSTETRICS AND GYNAECOLOGY (20)

GENERAL LISTINGS

A205	Consultation*	134.25
A935	Special surgical consultation (see General Preamble GP19).	194.65
A206	Repeat consultation*	71.45
A203	Specific assessment*	62.65
A204	Partial assessment	40.50
E432	- when pelvic exam including speculum is performed outside of hospital or *ICHSC*, to A203, A204, A205 and A206 add	5.00

Payment rules:

1. The collection of cervical cancer screening specimen(s) is included in the consultation, repeat consultation, general or specific assessment (or re-assessment), or routine post-natal visit when pelvic examination is normal part of the foregoing services. However, the add-on codes E430 or E431 can be billed in addition to these services when collection of cervical cancer screening specimen(s) is performed outside of a hospital or *ICHSC*.
2. E432 is limited to one service per patient per day.
3. E432 is *only eligible for payment* when the procedure is personally rendered by the physician.
4. E432 is not eligible for payment with E430, E431, or E542.

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C205	Consultation*	134.25
C935	Special surgical consultation (see General Preamble GP19).	194.65
C206	Repeat consultation*	71.45
C203	Specific assessment*	62.65
C204	Specific re-assessment*	44.30

Subsequent visits

C202	- first five weeks per visit	31.00
C207	- sixth to thirteenth week inclusive (maximum 3 per patient per week) per visit	31.00
C209	- after thirteenth week (maximum 6 per patient per month) per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

OBSTETRICS AND GYNAECOLOGY (20)

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area		71.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area		71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43)	per visit	40.05
C208	Concurrent care	per visit	31.00
C982	Palliative care (see General Preamble GP50)	per visit	40.05

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W305	Consultation*	134.25
W306	Repeat consultation*	71.45

Note:

*Includes (where indicated) b*iop*sy of cervix, collection of cervical cancer screening specimen(s), examination of trichomonas suspension.

OCCUPATIONAL MEDICINE (72)

GENERAL LISTINGS

A725	Consultation	192.85

Comprehensive occupational medicine consultation

This service is a consultation rendered by a specialist in occupational medicine who provides all the appropriate elements of a consultation and spends a minimum of 75 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A720	Comprehensive occupational medicine consultation	342.25

Medical record requirements:
The start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.

[Commentary:

1. A720 must satisfy all the elements of a consultation (see page GP16).

2. Unless otherwise specified in the *Schedule*, the calculation of time for comprehensive occupational medicine consultations excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultation and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

A925	Limited consultation	123.10
A726	Repeat consultation	123.10
A723	Medical specific assessment	95.95
A724	Medical specific re-assessment	72.00
A721	Complex medical specific re-assessment	83.40
A728	Partial assessment	44.75

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C725	Consultation	192.85
C720	Comprehensive occupational medicine consultation - subject to the same conditions as A720	342.25
C925	Limited consultation	123.10
C726	Repeat consultation	123.10
C723	Medical specific assessment	95.95
C724	Medical specific re-assessment	72.00
C721	Complex medical specific re-assessment	83.40

Subsequent visits

C722	- first five weeks	per visit	40.05
C727	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	40.05
C729	- after thirteenth week (maximum 6 per patient per month)	per visit	40.05

OCCUPATIONAL MEDICINE (72)

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	-	day following the hospital admission assessment	71.80
C123	-	second day following the hospital assessment	71.80
C124	-	day of discharge	71.80
C126	-	day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	-	first subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C143	-	second subsequent visit by the MRP following transfer from an Intensive Care Area	71.80

C121	Additional visits due to intercurrent illness (see General Preamble GP43)	per visit	40.05
C728	Concurrent care	per visit	40.05
C982	Palliative care (see General Preamble GP50)	per visit	40.05

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing Homes, Homes for the Aged, designated chronic or convalescent care beds in hospitals and nursing homes or homes for the aged, other than patients in designated palliative care beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W725	Consultation	192.85
W720	Comprehensive occupational medicine Comprehensive internal medicine consultation - subject to the same conditions as A720	342.25
W925	Limited consultation	123.10
W726	Repeat consultation	123.10

OPHTHALMOLOGY (23)

Note:
Ophthalmology consultations and visits *may include* retinal photography as a specific element of the insured service, where medically necessary.

GENERAL LISTINGS

A235	Consultation	86.25
A935	Special surgical consultation (see General Preamble GP19)	194.65
A236	Repeat consultation	48.00
A231	Neuro-ophthalmology consultation	155.45

Payment rules:

1. A231 is *only eligible for payment* when at least four of the following are documented as a part of the examination:

- **a.** Detailed pupillary examination (includes pharmacological testing as applicable)
- **b.** Detailed extraocular motility examination
- **c.** Ocular alignment testing
- **d.** Partial or complete neurological examination
- **e.** Detailed examination of the fundus
- **f.** Analysis of formal visual field test(s)
- **g.** Analysis of pertinent diagnostic imaging studies

2. A231 is *only eligible for payment* to an ophthalmologist with fellowship training in Neuro-ophthalmology.

3. A231 is *only eligible for payment* for the consultation of a patient with a neuro-ophthalmological disorder.

[Commentary:
In circumstances where a neuro-ophthalmologist renders a consultation service to a patient who is not referred for a neuro-ophthalmology consultation or, where the patient does not have a neuro-ophthalmological disorder, see general listings.]

A930	Uveitis and ocular inflammatory diseases consultation	157.00

Payment rules:

1. A930 is *only eligible for payment* to an ophthalmologist with fellowship training in uveitis and ocular inflammatory diseases

2. A930 is *only eligible for payment* for the consultation of a patient with a uveitis, ocular inflammatory or orbital inflammatory disorder

3. A930 is *only eligible for payment* when the following are documented as part of the examination:

- **a.** Dilated examination of the fundus; and
- **b.** Analysis of laboratory testing, radiological and ocular imaging studies performed for investigation of the patient's ocular inflammatory disease.

[Commentary:
In circumstances where an ophthalmologist with fellowship training in uveitis and ocular inflammatory diseases renders a consultation service to a patient who is not referred for a consultation for a uveitis, ocular or orbital inflammatory disorder or, where the patient does not have a uveitis, ocular or orbital inflammatory disorder, see general listings.]

A233	Specific assessment	60.50

OPHTHALMOLOGY (23)

A234 Partial assessment 31.95

Manual cycloplegic refraction is the service rendered personally by an ophthalmologist for evaluation of patients up to and including 15 years of age for the evaluation of strabismus and/or amblyopia requiring glasses or contact lenses.

E423 - manual cycloplegic refraction, to A233 or A234 ..... add 25.00

Payment rules:
E423 is limited to a maximum of two services per *12 month period* per patient per physician.

Assessment of paediatric patient with amblyopia

Assessment of paediatric patient with amblyopia (reduced vision in one eye) is the service rendered personally by an ophthalmologist for evaluation of patients 10 years old or less undergoing active treatment through occlusion therapy, penalization, dichoptic therapy, refractive therapy or similar, to maximize vision in the amblyopic eye(s).

E424 - assessment of paediatric patient with amblyopia, to A233 or A234..... add 50.00

Claims submission instructions:
Submit claims with diagnostic code 368.

U235 Initial e-assessment..... 48.05
U233 Repeat e-assessment..... 45.40
U236 Follow-up e-assessment..... 30.35
U231 Minor e-assessment 15.75

OPHTHALMOLOGY (23)

Periodic oculo-visual assessment

A237 - aged 19 years and below 59.35
A239 - aged 65 years and above 59.35

Note:
See General Preamble GP28 for definitions and conditions.

Major eye examination

A115 Major eye examination (see page A10) 53.60

Orthoptic assessment

Orthoptic assessment must include quantitative measurement of all cardinal positions of gaze (straight ahead, left, right, up, down, tilt right and tilt left), sensory testing for binocular vision suppression, cyclodeviation and retinal correspondence. An orthoptic assessment is eligible for payment in addition to an ophthalmology consultation or visit.

A230 Orthoptic assessment 26.20

Note:
A230 is *only eligible for payment* when all tests described under orthoptic assessment are rendered personally and interpreted personally by the physician and results and measurements are documented in the patient's permanent medical record.

[Commentary:
If a certified orthoptist is rendering the examination, G814 may be eligible for payment (page J94).]

Retinopathy of prematurity (ROP) assessment

Retinopathy of Prematurity (ROP) assessment is the service rendered by an ophthalmologist for initial assessment or follow-up assessment(s) of a patient with ROP who is either:

a. 9 *month*s of age or younger; or

b. aged 10 *month*s to 16 years with minimum stage 3 ROP disease.

A250 Retinopathy of prematurity assessment 125.80

Payment rules:
No other assessment or consultation is eligible for payment when rendered by the same physician to the same patient the same day as A250.

OPHTHALMOLOGY (23)

Vision Rehabilitation – Initial assessment and follow-up assessment

Definitions

The following phrases have the following meanings for the purpose of fee schedule codes A252 and A254.

Low visual acuity - best corrected visual acuity of 20/50 (6/15) or less in the better eye and not amenable to further medical and/or surgical treatment.

Significant oculomotor dysfunction - nerve palsy or nystagmus resulting in low visual acuity or visual field defects as defined and not amenable to further medical and/or surgical treatment.

Visual field defect - splitting of fixation, scotomata, quadranopic or hemianopic field defects not amenable to further medical and/or surgical treatment.

Initial vision rehabilitation assessment

Initial vision rehabilitation assessment by an ophthalmologist of a patient with either low visual acuity, visual field defect, or significant oculomotor dysfunction subject to the conditions below.

This service is only payable when a minimum of four (4) of the following eight (8) listed components are rendered during the same visit:

1. Cognitive assessment to determine capacity to cooperate with assessment and treatment.

2. Assessment of residual visual function to include at least two of the following tests: visual acuity tested with ETDRS charts, macular perimetry, contrast sensitivity tested at 5 spatial frequencies and fixation instability.

3. Assessment of eccentric preferred retinal loci.

4. Assessment of near functional visual acuity with ETDRS charts.

5. Assessment of reading skills.

[Commentary:
For example, using MNRead or Colenbrander charts.]

6. Prescribing of low vision devices aimed to improve residual visual function.

7. Preparation of a vision rehabilitation plan and/or discussion of the plan with the patient.

8. Supervised training of the patient, in accordance with recognized programs, for use of low vision devices and/or training for rehabilitation of skills dependent on vision.

A252 Initial vision rehabilitation assessment..... 251.65

Follow-up vision rehabilitation assessment

This service is only payable when a minimum of three (3) of the eight (8) components listed above are rendered in the same visit.

A254 Follow-up vision rehabilitation assessment 125.80

Payment rules:
For A252 and A254:

1. No other assessment or consultation is eligible for payment when rendered by the same physician to the same patient the same day as A252 or A254.

2. A252 is limited to two (2) per patient per five (5) year period per physician.

3. A254 is only payable when the patient has received an A252.

OPHTHALMOLOGY (23)

4. A254 is limited to ten (10) per patient per five (5) year period from the date of the most recent A252.

5. If the minimum required number of components for A252 or A254 are not rendered, the amount payable for the service will be reduced to a lesser fee.

[Commentary:
Diagnostic services (e.g. visual field testing), when rendered, are eligible for payment with these services.]

OPHTHALMOLOGY (23)

Optometrist-requested assessment (ORA)

Optometrist-requested assessment (ORA) is an assessment of a patient provided by an ophthalmologist upon the written request of an optometrist because of the complex, obscure or serious nature of the patient's problem. Urgent or emergency requests may be initiated verbally but must also be documented in writing. The ORA includes the common and *specific elements* of a specific assessment.

A253 Optometrist-Requested Assessment (ORA)..... 86.25

Payment rules:

1. This service is limited to one per patient, per physician, per *24 month period*.

2. The ophthalmologist must submit his/her findings, opinions and recommendations in writing to both the optometrist and the patient's primary care physician or nurse practitioner, if applicable, or the amount payable for the service will be reduced to a lesser fee.

Medical record requirements:

The written request from the optometrist must be retained on the patient's permanent medical record, or the amount payable for the service will be reduced to a lesser fee.

Special optometrist-requested assessment

A Special Optometrist-Requested Assessment is an assessment in which the ophthalmologist provides all the elements of an Optometrist-Requested Assessment (A253) and spends a minimum of 50 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A256 Special optometrist-requested assessment..... 194.65

Payment rules:

This service is limited to one per patient, per physician, per *24 month period*.

Medical record requirements:

The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

Optometrist-requested assessment for Uveitis and Ocular Inflammatory Diseases

Optometrist-requested assessment for uveitis and ocular inflammatory diseases is an assessment in which the ophthalmologist provides all the elements of an Optometrist-Requested Assessment (A253) for a patient with a uveitis, ocular inflammatory or orbital inflammatory disorder.

A931 Optometrist-requested assessment for uveitis and ocular inflammatory diseases..... 157.00

Payment rules:

1. A931 is *only eligible for payment* to an ophthalmologist with fellowship training in uveitis and ocular inflammatory diseases

2. A931 is *only eligible for payment* for the assessment of a patient with a uveitis, ocular inflammatory or orbital inflammatory disorder

3. A931 is *only eligible for payment* when the following are documented as part of the examination:

a. Dilated examination of the fundus; and

OPHTHALMOLOGY (23)

b. Analysis of laboratory testing, radiological and ocular imaging studies performed for investigation of the patient's ocular inflammatory disease.

4. This service is limited to one per patient, per physician, per 24 month period.

[Commentary:
In circumstances where an ophthalmologist with fellowship training in uveitis and ocular inflammatory diseases renders an assessment service to a patient who is not referred for an assessment for a uveitis, ocular or orbital inflammatory disorder or, where the patient does not have a uveitis, ocular or orbital inflammatory disorder, see general listings.]

Optometrist-requested assessment for Neuro-ophthalmic Disorders

Optometrist-requested assessment for neuro-ophthalmic disorders is an assessment in which the ophthalmologist provides all the elements of an Optometrist-Requested Assessment (A253) for a patient with a neuro-ophthalmic disorder.

A241 Optometrist-requested assessment for neuro-ophthalmic disorders..... 155.45

Payment rules:

1. A241 is *only eligible for payment* when at least four of the following are documented as a part of the examination:

a. Detailed pupillary examination (includes pharmacological testing as applicable)
b. Detailed extraocular motility examination
c. Ocular alignment testing
d. Partial or complete neurological examination
e. Detailed examination of the fundus
f. Analysis of formal visual field test(s)
g. Analysis of pertinent diagnostic imaging studies

2. A241 is *only eligible for payment* to an ophthalmologist with fellowship training in Neuro-ophthalmology.

3. A241 is *only eligible for payment* for the assessment of a patient with a neuro-ophthalmological disorder.

4. This service is limited to one per patient, per physician, per 24 month period.

[Commentary:
In circumstances where a neuro-ophthalmologist renders an assessment service to a patient who is not referred for a neuro-ophthalmology assessment or, where the patient does not have a neuro-ophthalmological disorder, see general listings.]

Special ophthalmologic assessment

Special ophthalmologic assessment is a complete ophthalmologic assessment, rendered by an ophthalmologist, to a person with a psychological problem, developmental delay, learning disability, or significant physical disability which so limits the person's participation in the assessment that the physician is required to spend a minimum of 20 minutes in direct contact with the patient, family, and/or legal representative, exclusive of time spent rendering any other separately billable intervention to the patient.

In addition to the assessment, this service requires all of the following:

a. the development of a continuing comprehensive vision care plan;

OPHTHALMOLOGY (23)

b. provision of appropriate information to the patient's health care team regarding the patient's vision to allow them to better prepare both general and academic plans; and

c. reporting the findings, opinions or recommendations in writing to other health care team members regarding this evaluation and future planning.

A251 Special ophthalmologic assessment..... 125.80

Payment rules:

1. No other assessment or consultation is eligible for payment when rendered by the same physician to the same patient the same day as A251.

2. This service is limited to a maximum of 2 services per patient per physician per *12 month period*.

Medical record requirements:

1. The start/stop time of the service must be documented in the patient's medical record or the amount payable for the service will be reduced to a lesser fee.

2. A statement of the medical condition and how it limits the patient's ability to participate in the assessment with the physician must be documented in the patient's medical record or the amount payable for the service will be reduced to a lesser fee.

3. A copy of the letter to other health care team members must be maintained in the patient's medical record or the service will be reduced to a lesser fee.

[Commentary:

1. Examples of medical conditions that may qualify for A251 include certain chromosomal abnormalities, autism, cerebral palsy etc. or evaluation of *child*ren/*infant*s with low vision associated with or resulting in developmental delay.

2. Unless otherwise specified in the *Schedule*, the calculation of time for A256 and A251 excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the assessment and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

OPHTHALMOLOGY (23)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C235	Consultation	85.95
C935	Special surgical consultation (see General Preamble GP19).	194.65
C236	Repeat consultation	48.00
C231	Neuro-Ophthalmology Consultation – subject to the same conditions as A231	155.45
C930	Uveitis and ocular inflammatory diseases consultation, subject to the same conditions as A930	157.00
C233	Specific assessment	60.50
C234	Specific re-assessment	30.75
C250	Retinopathy of prematurity assessment - subject to the same conditions as A250	125.80

Subsequent visits

C232	- first five weeks	per visit	31.00
C237	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	31.00
C239	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43) per visit	40.05
C238	Concurrent care per visit	31.00
C982	Palliative care (see General Preamble GP50) per visit	40.05

OPHTHALMOLOGY (23)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W535	Consultation	85.90
W536	Repeat consultation	48.00
W231	Neuro-Ophthalmology Consultation – subject to the same conditions as A231	155.45
W930	Uveitis and ocular inflammatory diseases consultation subject to the same conditions as A930	157.00

ORTHOPAEDIC SURGERY (06)

GENERAL LISTINGS

A065	Consultation	89.80
A935	Special surgical consultation (see General Preamble GP19).	194.65
A066	Repeat consultation	55.35
A063	Specific assessment	45.55
A064	Partial assessment	25.95

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C065	Consultation	89.80
C935	Special surgical consultation (see General Preamble GP19).	194.65
C066	Repeat consultation	55.35
C063	Specific assessment	45.55
C064	Specific re-assessment	27.30

Subsequent visits

C062	- first five weeks	per visit	31.00
C067	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	31.00
C069	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	71.80

C121	Additional visits due to intercurrent illness (see General Preamble GP43)	per visit	40.05
C068	Concurrent care	per visit	31.00
C982	Palliative care (see General Preamble GP50)	per visit	40.05

ORTHOPAEDIC SURGERY (06)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W065	Consultation		89.80
W066	Repeat consultation		55.35

Subsequent visits (see General Preamble GP49)

Chronic care or convalescent hospital

W062	- first 4 subsequent visits per patient per month	per visit	40.05
W061	- additional subsequent visits (maximum of 6 per patient per month)	per visit	40.05
W982	- palliative care (see General Preamble GP50)	per visit	40.05

Nursing *home* or *home* for the aged

W063	- first 2 subsequent visits per patient per month	per visit	40.05
W068	- subsequent visits per month (maximum of 3 per patient per month)	per visit	40.05
W972	- palliative care (see General Preamble GP50)	per visit	40.05
W121	Additional visits due to intercurrent illness (see General Preamble GP49)	per visit	40.05
W124	Subsequent visit – day of discharge (see A20 for terms and conditions)‘	per visit	71.80

OTOLARYNGOLOGY (24)

GENERAL LISTINGS

A245	Consultation	92.70
A935	Special surgical consultation (see General Preamble GP19).	194.65
A246	Repeat consultation	53.65
A243	Specific assessment	44.75
A244	Partial assessment	30.45

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C245	Consultation	92.70
C935	Special surgical consultation (see General Preamble GP19).	194.65
C246	Repeat consultation	53.65
C243	Specific assessment	44.75
C244	Specific re-assessment	31.00

Subsequent visits

C242	- first five weeks	per visit	31.00
C247	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	31.00
C249	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	71.80

C121	Additional visits due to intercurrent illness (see General Preamble GP43)	per visit	40.05
C248	Concurrent care	per visit	31.00
C982	Palliative care (see General Preamble GP50)	per visit	40.05

OTOLARYNGOLOGY (24)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W345	Consultation	92.70
W346	Repeat consultation	53.65

PAEDIATRICS (26)

GENERAL LISTINGS

Services rendered by a physician with a specialty designation in Paediatrics (26) (i.e. “paediatrician”) are eligible for payment for an *adult* patient where:

1. the paediatrician has rendered at least one consultation, assessment or visit from the general listings for Paediatrics in the Consultation and Visits section of this *Schedule* for the same patient in the *12 month period* prior to the patient's eighteenth birthday; and ongoing management of the patient with a chronic condition by the paediatrician is necessary; and the patient is less than 22 years of age; or
2. the paediatrician has obtained written prior approval from the *MOH* by demonstrating that the continuation of treatment is generally accepted and necessary for the patient under the circumstances.

A265 Consultation 190.35

Special paediatric consultation

Special paediatric consultation is a consultation in which the physician provides all the elements of a consultation (A265) and spends a minimum of 75 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A260 Special paediatric consultation 342.25

Medical record requirements:
The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

Extended special paediatric consultation

Extended special paediatric consultation is a consultation in which the physician provides all the elements of a consultation (A265) and spends a minimum of 90 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A662 Extended special paediatric consultation 442.40

Medical record requirements:
The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

Neurodevelopmental consultation

Neurodevelopmental consultation is a consultation in which the physician provides all the elements of a consultation (A265) for an *infant*, *child* or *adolescent* with complex neurodevelopmental conditions (e.g. autism, global development disorders etc.) and spends a minimum of 90 minutes in direct contact with the patient and caregiver, exclusive of time spent rendering any other separately billable intervention to the patient.

A667 Neurodevelopmental consultation 456.80

Payment rules:
This service is limited to a maximum of one per patient, per physician, per *12 month period*.

Medical record requirements:
The start and stop time must be recorded in the patient’s permanent medical record or the payment for this service will be reduced to a lesser fee.

PAEDIATRICS (26)

[Commentary:

1. Neurodevelopmental consultations for less complex conditions, e.g. attention deficit disorder, are payable at a lesser fee

2. Unless otherwise specified in the *Schedule*, the calculation of time for A260, A262 and A667 excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultation and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

PAEDIATRICS (26)

Prenatal consultation

A prenatal consultation is the service rendered by a paediatrician upon request of a physician or nurse practitioner who considers a fetus of greater than 20 *week*s gestation to be at risk or in jeopardy by reason of continuation of pregnancy in the presence of maternal and/or fetal distress.

[Commentary:
A prenatal consultation by a paediatrician does not preclude the paediatrician from claiming a post-natal consultation on the *infant*.]

A665	Prenatal consultation	105.50
A565	Limited consultation	104.70
A266	Repeat consultation	104.70
A263	Medical specific assessment	95.75
A264	Medical specific re-assessment	70.75
A661	Complex medical specific re-assessment	86.35
A268	Enhanced 18 month well baby visit (see General Preamble GP34)	74.25
A261	Level 1 - Paediatric assessment	24.85
A262	Level 2 - Paediatric assessment	50.20
E078	- chronic disease assessment premium (see General Preamble GP25)	add 50%
K045	Diabetes management by a specialist	80.25

[Commentary:
For K045 definition/required elements, payment rules, and record keeping requirements, see Endocrinology and Metabolism section.]

Periodic health visit

K267	- 2 - 11 years of age	48.05
K269	- 12 - 17 years of age	89.15

Note:

1. For definitions and payment rules - see General Preamble GP21.

2. Diagnostic interview and/or counselling with *child* and/or parent - see listings in Family Practice & Practice in General.

Paediatric Developmental Assessment Incentive (PDAI)

PDAI is the service rendered by a paediatrician most responsible for providing ongoing management of a paediatric patient at developmental risk. The service is for ongoing management using a developmental surveillance approach and documenting the indicators of the *child*'s development three times in a *12 month period*.

K119	Paediatric developmental assessment incentive	142.50

Payment rules:

1. K119 is limited to a maximum of one service per patient per *12 month period*.

2. K119 is limited to a maximum of six services per patient per lifetime.

3. K119 is *only eligible for payment* for a service rendered to a person under six years of age.

PAEDIATRICS (26)

4. K119 is *only eligible for payment* if the physician has rendered a minimum of three consultations or assessments or visits to the patient in the immediately preceding *12 month period*.

5. K119 is *only eligible for payment* to a *specialist* in Paediatrics (26).

Medical record requirements:

K119 is *only eligible for payment* if a standardized developmental screening tool has been completed three times for the previous *12 month period* and is maintained in the patient's permanent medical record.

Claims submission instructions:

Claims for K119 should only be submitted when the required elements of the service have been completed for the previous *12 month period*.

PAEDIATRICS (26)

Developmental and/or behavioural care

Developmental and/or behavioural care are services encompassing any combination or form of assessment and treatment by a paediatrician for mental illness, behavioural maladaptations, developmental disorders, and/or other problems that are assumed to be of a developmental or emotional nature where there is consideration of the patient's biological and psychosocial functioning. Unit means ½ hour or major part thereof - see General Preamble GP7, GP54 to GP61 for definitions and time-keeping requirements.

K122	- individual developmental and/or behavioural care . per unit	102.35
K123	- family developmental and/or behavioural care ..... per unit	116.15

Payment rules:

These services are only payable to paediatricians who satisfy one of the following criteria:

a. 35% or more of the dollar value of the annual fee-for-service claims in any *12 month period* consist of K122 and/or K123;

b. 35% or more of the dollar value of the annual fee-for-service claims in any *12 month period* consist of any combination of K005, K007, K019, K020, K012, K024, K025, K010, K004, K006, or K008; or

c. additional residency or fellowship training in paediatrics or psychiatry. Residency or fellowship training includes either completion of training in paediatric or *adolescent* developmental and/or behavioural medicine within a recognized paediatric residency training programme of at least one-year duration following completion of the first three years of residency, or a post residency fellowship or other equivalent programme in paediatrics, *adolescent* medicine or psychiatry. Documentation of additional residency or fellowship training must be provided if requested by the ministry.

[Commentary:

Paediatricians who do not meet the criteria listed above but believe they have appropriate training and/or experience to permit them to provide paediatric or *adolescent* developmental and/or behavioural care may contact the ministry to determine whether their training and/or experience constitute an equivalent residency, training or programme.

Services rendered by physicians who do not meet these requirements are still insured but eligible for payment under another fee *schedule* code e.g. primary mental health care (K005), counselling (K013/K033) or group counselling (K040/K041).]

PAEDIATRICS (26)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C265	Consultation	190.35
C260	Special paediatric consultation - subject to the same conditions as A260	342.25
C662	Extended special paediatric consultation - subject to the same conditions as A662	442.40
C667	Neurodevelopmental consultation - subject to same conditions as A667	456.80
C665	Prenatal consultation - subject to the same conditions as A665	105.50
C565	Limited consultation	104.70
C266	Repeat consultation	104.70
C263	Medical specific assessment	95.75
C264	Medical specific re-assessment	70.75
C661	Complex medical specific re-assessment	86.35

Subsequent visits

C262	- per visit	40.05

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43) per visit	40.05
C268	Concurrent care per visit	40.05
C982	Palliative care (see General Preamble GP50) per visit	40.05

PAEDIATRICS (26)

Attendance at maternal delivery

Attendance at maternal delivery requires constant attendance at the delivery of a baby expected to be at risk by a paediatrician, and includes an assessment of the *newborn*.

H267 Attendance at maternal delivery..... 63.45

Payment rules:
This service is *not eligible for payment* if any other service is rendered by the same physician at the time of the delivery unless the *newborn* is sick in which case a medical specific assessment (C263) is payable in addition to attendance at maternal delivery if rendered.

H261 Newborn care in hospital or home 82.90

[Commentary:
For definition of newborn care, see GP32.]

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W265 Consultation 190.35
W260 Special paediatric consultation - subject to the same conditions as A260..... 342.25
W662 Extended special paediatric consultation - subject to the same conditions as A662..... 442.40
W667 Neurodevelopmental consultation - subject to same conditions as A667..... 456.80
W565 Limited consultation 104.70
W266 Repeat consultation 104.70

Admission assessment

W562 - Type 1 ..... 69.35
W564 - Type 2 ..... 20.60
W567 - Type 3 ..... 30.70

W269 Periodic health visit 30.70

Subsequent visits (see General Preamble GP49)

Chronic care or convalescent hospital

W262 - first 4 subsequent visits per patient per month .....per visit 40.05
W261 - additional subsequent visits per month (maximum 6 per patient per month).....per visit 40.05
W982 - palliative care (see General Preamble GP50) .....per visit 40.05

Note:
In surgical cases requiring medical direction, standard in-hospital medical fees are to be claimed in addition to the surgical fee. This includes all operations on babies under one year of age, and all other older *child*ren who require medical supervision.

PHYSICAL MEDICINE & REHABILITATION (31)

GENERAL LISTINGS

A315 Consultation 220.80

Comprehensive physical medicine and rehabilitation consultation

A comprehensive physical medicine and rehabilitation consultation is a consultation in which the physician provides all the elements of a consultation and spends a minimum of 75 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A425 Comprehensive physical medicine and rehabilitation consultation 342.25

Payment rules:
A comprehensive physical medicine and rehabilitation consultation is limited to one every 2 years by the same physician.

Medical record requirements:
The start and stop time must be recorded in the patient's permanent medical record or the payment for the service will be reduced to a lesser fee.

[Commentary:
Unless otherwise specified in the *Schedule*, the calculation of time excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultation and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

A515 Limited consultation 106.60
A316 Repeat consultation 106.60
A313 Medical specific assessment 86.40
A310 Medical specific re-assessment 75.90
A311 Complex medical specific re-assessment 82.75
A318 Partial assessment 44.45

E078 - chronic disease assessment premium (see General Preamble GP25) ..... add 50%

PHYSICAL MEDICINE & REHABILITATION (31)

Complex neuromuscular assessment

A complex neuromuscular assessment is an assessment for the ongoing management of the following diseases of the neuromuscular system where the complexity of the condition requires the continuing management by a physical medicine and rehabilitation *specialist*:

a. generalized peripheral neuropathies;

b. myopathies;

c. diseases of the neuromuscular junction; or

d. diseases of the motor neurone

A510 Complex neuromuscular assessment..... 104.85

Payment rules:

1. A complex neuromuscular assessment must include the elements of a medical specific re-assessment, or the amount payable will be adjusted to lesser assessment fee.

2. This service is *not eligible for payment* to a physician for the initial evaluation of the patient by that physician.

3. Complex neuromuscular assessments are limited to 6 per patient, per physician, per *12 month period*.
Services in excess of this limit will be adjusted to a lesser assessment fee.

4. E078 is *not eligible for payment* with A510.

[Commentary:

1. A complex neuromuscular assessment is for the ongoing management of complex neuromuscular disorders, where the complexity of the condition requires the continuing management by a physical medicine and rehabilitation *specialist*. It is not intended for the evaluation and/or management of uncomplicated neuromuscular disorders (e.g. carpal tunnel syndrome, Bell's palsy, asymptomatic diabetic neuropathy).

2. A consultation or assessment service, as appropriate, may be claimed for the initial evaluation of a patient. A complex neuromuscular assessment is for the ongoing management of a patient with a complex neuromuscular disorder.]

Complex physiatry assessment

This service is an assessment in relation to the following diseases where the complexity of the condition requires the ongoing management by a physical medicine and rehabilitation *specialist*:

a. traumatic brain injury;

b. stroke (hemorrhagic and ischemic); or

c. spinal cord injury.

A511 Complex physiatry assessment..... 114.80

Payment rules:

1. A complex physiatry assessment must include the elements of a medical specific re-assessment, or the amount payable will be adjusted to a lesser assessment fee.

2. Complex physiatry assessments are limited to 6 per patient, per physician, per *12 month period*.
Services in excess of this limit will be adjusted to a lesser assessment fee.

3. E078 is *not eligible for payment* with A511.

PHYSICAL MEDICINE & REHABILITATION (31)

[Commentary:
A complex physiatry assessment is not intended for the evaluation and/or management of uncomplicated physiatric disorders (e.g. transient ischemic attacks, uncomplicated concussion, uncomplicated spinal cord injury e.g. American Spinal Injury Association level E-normal motor and sensory function.]

PHYSICAL MEDICINE & REHABILITATION (31)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C315	Consultation	233.65
C425	Comprehensive physical medicine and rehabilitation consultation – subject to the same conditions as A425	342.25
C515	Limited consultation	106.60
C316	Repeat consultation	106.60
C313	Medical specific assessment	86.40
C314	Medical specific re-assessment	75.90
C311	Complex medical specific re-assessment	82.75
C510	Complex neuromuscular assessment - subject to the same conditions as A510	104.85
C511	Complex physiatry assessment - subject to the same conditions as A511	114.80

Subsequent visits

C312	- first five weeks ... per visit	40.05
C317	- sixth to thirteenth week inclusive (maximum 3 per patient per week) ... per visit	40.05
C319	- after thirteenth week (maximum 6 per patient per month) ... per visit	40.05

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43) ... per visit	40.05
C318	Concurrent care ... per visit	40.05
C982	Palliative care (see General Preamble GP50) ... per visit	40.05

PHYSICAL MEDICINE & REHABILITATION (31)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W515	Consultation	233.65
W425	Comprehensive physical medicine and rehabilitation consultation - subject to the same conditions as A425	342.25
W310	Limited consultation	106.60
W516	Repeat consultation	106.60
W510	Complex neuromuscular assessment - subject to the same conditions as A510	104.85
W511	Complex physiatry assessment - subject to the same conditions as A511	114.80

Admission assessment

W512	- Type 1	69.35
W514	- Type 2	20.60
W517	- Type 3	30.70
W419	Periodic health visit	65.05
W314	General re-assessment of patient in nursing home*	20.60

Note:
*May only be claimed 6 *month*s after Periodic health visit (as per the *Nursing Homes Act*).

Subsequent visits (see General Preamble GP49)

Chronic care or convalescent hospital

W312	- first 4 subsequent visits per patient per month	per visit	40.05
W311	- additional subsequent visits (maximum of 6 per patient per month)	per visit	40.05
W982	palliative care (see General Preamble GP50)	per visit	40.05

Nursing *home* or *home* for the aged

W313	- first 2 subsequent visits per patient per month	per visit	40.05
W318	- subsequent visits per month (maximum of 3 per patient per month)	per visit	40.05
W972	- palliative care (see General Preamble GP50)	per visit	40.05
W121	Additional visits due to intercurrent illness (see General Preamble GP49)	per visit	40.05
W124	Subsequent visit – day of discharge (see A20 for terms and conditions)	per visit	71.80

PHYSICAL MEDICINE & REHABILITATION (31)

Team management in a Rehabilitation Unit

Team management in a Rehabilitation Unit active in-patient rehabilitation management from the initiation of rehabilitation care as it applies to fee codes H312, H317 and H319 means when this service is rendered by one physiatrist even if part of the service is rendered in an active treatment hospital and part is rendered in a rehabilitation unit, the *week*ly and *month*ly limitations under the following fee codes apply to the total rehabilitation care rendered. In other words, it is not possible to claim the maximum fees allowed under C312, C317 and C319 and then start claiming de novo under H312, H317 and H319 under the above circumstances.

H312	- first twelve weeks	per visit	50.15
H317	- from thirteenth to twenty-sixth week (maximum 3 per patient per week).....	per visit	50.15
H319	- twenty-seventh week onwards (maximum 6 per patient per month)	per visit	50.15

Rehabilitation counselling

Rehabilitation counselling one or more persons. Unit means ½ hour or major part thereof - see General Preamble GP7, GP55 for definitions and time-keeping requirements.

H313	Rehabilitation counselling	per unit	84.20

Physiatric management

Physiatric management is the service rendered by physiatrists for regulation, management and supervision of the active, regular, and ongoing treatment of a patient in a rehabilitation department by physical or other (e.g. occupational, speech) therapists. The service also includes making arrangements for any related assessments, procedures or therapy and making arrangements for follow-up care as required.

K313	Physiatric management		8.10

Payment rules:

1. Physiatric management is *not eligible for payment* if any other service is rendered by the same physician on the same day to the same patient.
2. This service is *only eligible for payment* on days when rehabilitation services are provided to patients seen previously by the physiatrist for consultation or assessment.

[Commentary:

1. The fee is not meant as an administrative fee for supervising a department of rehabilitation.
2. This fee applies only to those patients who require and receive frequent attention by the physician during the course of rehabilitation with regard to rehabilitative services or physical therapy, occupational therapy, speech therapy and discharge planning.]

PLASTIC SURGERY (08)

GENERAL LISTINGS

A085	Consultation	106.25
A935	Special surgical consultation (see General Preamble GP19).	194.65
A086	Repeat consultation	62.80
A083	Specific assessment	54.40
A084	Partial assessment	34.75

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C085	Consultation	106.25
C935	Special surgical consultation (see General Preamble GP19).	194.65
C086	Repeat consultation	62.80
C083	Specific assessment	54.40
C084	Specific re-assessment	34.90

Subsequent visits

C082	- first five weeks ... per visit	31.00
C087	- sixth to thirteenth week inclusive (maximum 3 per patient per week) ... per visit	31.00
C089	- after thirteenth week (maximum 6 per patient per month) ... per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43) ... per visit	40.05
C088	Concurrent care ... per visit	31.00
C982	Palliative care (see General Preamble GP50) ... per visit	40.05

PLASTIC SURGERY (08)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W085	Consultation	106.25
W086	Repeat consultation	62.80

PSYCHIATRY (19)

GENERAL LISTINGS

A195 Consultation 254.30

A895 Consultation in association with special visit to a hospital in-patient, long-term care in-patient or emergency department patient 297.00

Claims submission instructions:
Submit claim using A895 and the appropriate special visit premium beginning with "C" prefix for a hospital in-patient, “W” prefix for a long-term care in-patient or “K” prefix for an emergency department patient.

Special psychiatric consultation

Special psychiatric consultation is a consultation in which the physician provides all the elements of a consultation (A195) and spends a minimum of 75 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A190 Special psychiatric consultation 342.25

Medical record requirements:
The service is eligible for payment only if start and stop times of the service are recorded in the patient’s permanent medical record.

Geriatric psychiatric consultation

Geriatric psychiatric consultation is payable to a psychiatrist for a patient aged 75 years or older and must include all the elements of A195 and a minimum of 75 minutes in direct contact with the patient, exclusive of time spent in discussion with caregivers or time spent rendering any other separately billable intervention to the patient. The consultation must be scheduled a minimum of 24 hours prior to the visit. The start and stop time must be recorded in the patient’s permanent medical record. Maximum one per patient per physician every 5 years. Geriatric psychiatric consultations that do not conform with the above or are delegated in a clinic teaching unit to an intern, resident or fellow are payable as a lesser consultation or visit.

A795 Geriatric psychiatric consultation 342.25

Neurodevelopmental consultation

Neurodevelopmental consultation is payable when the physician provides all the elements of A195 for an *adult* with complex neurodevelopmental conditions e.g. autism, global developmental disorders etc., and must include a minimum of 90 minutes in direct contact with the patient and caregiver, exclusive of time spent rendering any other separately billable intervention to the patient. The start and stop times must be recorded in the patient’s permanent medical record. Maximum one per patient per physician every 5 years.

A695 Neurodevelopmental consultation 456.80

Note:
Neurodevelopmental consultations for *child*ren or *adolescent*s or for less complex conditions e.g. attention deficit disorder are payable at a lesser fee.

[Commentary:
Unless otherwise specified in the *Schedule*, the calculation of time for A190, A795 and A695 excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultation and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

PSYCHIATRY (19)

A395	Limited consultation	120.30
A196	Repeat consultation	120.30
A193	Specific assessment	98.70
A194	Partial assessment	47.05

Consultative interview on behalf of disturbed patient (including report)

A197	- consultative interview with parent(s) or patient representative(s) of patient less than age 22	271.35
A198	- consultative interview with patient less than age 22	271.35
A191	- consultative interview with caregiver(s) of a patient at least 65 years of age, or a patient less than 65 years of age with a diagnosis of dementia	271.35
A192	- consultative interview with patient at least 65 years of age, or a patient less than 65 years of age with a diagnosis of dementia	271.35

Note:

1. A191, A192, A197 and A198 are consultations.

2. A191, A192, A197, A198 are *not eligible for payment* for the same patient, same *day* as family psychiatric care or family psychotherapy (K191, K193, K195, K196).

3. For the purpose of A191, A192, A197 and A198, disturbed patient means someone experiencing a clinically significant disturbance in their cognition, emotional regulation, or behavior which limits their ability to provide a reliable and complete history.

[Commentary:
For psychiatric consultation extension with parents or caregivers, see K630.]

Initiation of Repetitive Transcranial Magnetic Stimulation (rTMS) for treatment resistant depression

Initiation of repetitive transcranial magnetic stimulation (rTMS) for treatment resistant depression is an assessment rendered by a specialist in Psychiatry where the physician spends a minimum of 30 minutes (consecutive or non-consecutive) in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient. The physician must be available to intervene in a timely fashion for the duration of the initial therapy session to manage adverse reactions or the service is *not eligible for payment*.

A199	Initiation of rTMS for treatment resistant depression	159.80

Payment rules:

1. A199 includes educational counselling by the physician, determination of the initial treatment modalities of rTMS including motor threshold and coil placement, electromyography (EMG) – if performed, and initial treatment monitoring personally provided by or in the presence of the physician – if performed.

2. A199 is *only eligible for payment* for a patient with an established diagnosis of treatment resistant depression, documented in the patient's medical record.

3. A199 is limited to a maximum of one service per patient per acute treatment protocol and a maximum of 2 services per patient 12 month period.

4. Indirect time, when the patient is not present, may not be included towards the minimum time requirement. Concurrent time, with more than one patient, may not be included towards the minimum time requirement.

PSYCHIATRY (19)

Psychiatric consultation extension

This service is eligible for payment for an extension to the consultations listed in the table below when the physician is required to spend an additional period of consecutive or non-consecutive time on the same day in direct contact with the patient and/or patient's relative(s), *patient's representative* or other caregivers.

Note:

The time unit measured excludes time spent on any other separately billable interventions.

K630 Psychiatric consultation extension..... per unit 134.00

Payment rules:

1. K630 is a time based service. Time is calculated based on units - Unit means ½ hour or major part thereof - see General Preamble GP7 for definitions and time-keeping requirements.

2. K630 is limited to a maximum of six units per patient per physician per day.

3. K630 is payable in accordance with the following rules:

Consultation	Minimum time with the patient before the start time for the first unit of K630	Minimum time required for consultation service + 1 unit of K630 to be payable	[Commentary: Minimum time required for consultation service + 2 units of K630 to be payable
A190, C190, W190	90 minutes	106 minutes	136 minutes
A195	60 min	76 min	106 min
A197 – sole service	60 min	76 min	106 min
A198 – sole service	60 min	76 min	106 min
A197 + A198 same patient same day	120 min	136 min	166 min
A695, C695, W695	120 min	136 min	166 min
A795, C795, W795	90 min	106 min	136 min
A895, C895, W895	60 min	76 min	106 min
A191	60 min	76 min	106 min
A192	60 min	76 min	106 min
A191+ A192 same patient same day	120 min	136 min	166 min]

[Commentary:

Unless otherwise specified in the *Schedule*, the calculation of time excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultation and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

PSYCHIATRY (19)

EMERGENCY OR OUT-PATIENT DEPARTMENT (ODP)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to n-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C895	Consultation	297.00
C190	Special psychiatric consultation - subject to the same conditions as A190	342.25
C395	Limited consultation	120.30
C196	Repeat consultation	120.30
C795	Geriatric psychiatric consultation - subject to same conditions as A795	342.25
C695	Neurodevelopmental consultation - subject to same conditions as A695	456.80
C193	Specific assessment	98.70
C194	Specific re-assessment	75.70

Subsequent visits

C192	- first five weeks ... per visit	40.05
C197	- sixth to thirteenth week inclusive (maximum 3 per patient per week) ... per visit	40.05
C199	- after thirteenth week (maximum 6 per patient per month) ... per visit	40.05

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43) ... per visit	40.05
C198	Concurrent care ... per visit	40.05
C982	Palliative care (see General Preamble GP50) ... per visit	40.05

PSYCHIATRY (19)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W895	Consultation	297.00
W190	Special psychiatric consultation - subject to the same conditions as A190	342.25
W795	Geriatric psychiatric consultation - subject to same conditions as A795	342.25
W695	Neurodevelopmental consultation - subject to same conditions as A695	456.80
W395	Limited consultation	120.30
W196	Repeat consultation	120.30

PSYCHIATRY (19)

PSYCHIATRIC CLINICAL PRACTICE MODIFIERS/PREMIUMS

Acute post-discharge community psychiatric care

Acute post-discharge community psychiatric care is a premium for a service that occurs during the (4) *week* period immediately following discharge where the patient was a hospital in-patient for treatment of a psychiatric condition. The premium is only applicable to K195, K196, K197 or K198.

K187 Acute post-discharge community psychiatric care, to K195, K196, K197 or K198 ..... add 15%

High risk community psychiatric care

High risk community psychiatric care is a premium for a service that occurs during the six (6) *month* period following a suicide attempt. For the purposes of this premium, suicide attempts include self-harm attempts with intent to commit suicide or high lethality self-harm attempts, but do not include self harm attempts of low lethality with no intent to commit suicide. The premium is applicable to A190, A191, A192, A195, A197, A198, A695, A795, K195, K196, K197 and K198.

K188 High risk community psychiatric care, to A190, A191, A192, A195, A197, A198, A695, A795, K195, K196, K197 or K198 ..... add 15%

Payment rules:

1. K187 or K188 are both payable with K195, K196, K197 or K198 when rendered during the first four (4) *week* period following discharge where the patient was a hospital in-patient for treatment of a psychiatric condition and the requirements for both K187 and K188 are met.

2. K188 is *not eligible for payment* in addition to K189 on the same patient same day.

K189 Urgent community psychiatric follow-up, to A190, A195, A192, A198, A695 or A795 ..... add 216.30

Payment rules:

1. K189 is *only eligible for payment* when the psychiatrist providing the urgent community psychiatric follow-up:

a. renders a service described by A190, A195, A192, A198, A695 or A795 to an out-patient on an urgent basis during the four (4) *week* period immediately following discharge where the patient was a hospital in-patient for treatment of a psychiatric condition;

b. did not provide services to the same patient during the same psychiatric hospital admission; and

c. will continue appropriate care of the out-patient for a minimum of six (6) *month*s as required.

2. K189 is limited to a maximum of one per physician per patient per *12 month period*.

PSYCHIATRY (19)

Assessments under the Mental Health Act

See General Preamble GP34 for definitions and conditions.

Consultation for involuntary psychiatric treatment

Consultation for involuntary psychiatric treatment in accordance with the *Mental Health Act*. Unit means ½ hour or major part thereof - see General Preamble GP7, GP55 for definitions and time-keeping requirements.

K620 Consultation for involuntary psychiatric treatment..... per unit 108.35

Form 1

Application for psychiatric assessment, in accordance with the *Mental Health Act* includes necessary history, examination, notification of the patient, family and relevant authorities and completion of form.

K623 Application for psychiatric assessment..... 133.60

Form 3

Certification of involuntary admission in accordance with the *Mental Health Act* includes necessary history, examination, notification of the patient, family and relevant authorities and completion of form.

K624 Certification of involuntary admission 164.50

K629 All other re-certification(s) of involuntary admission including completion of appropriate forms..... 48.75

Note:

1. A completed Form 1 Application by a Physician For Psychiatric Assessment retained on the patient's medical record is sufficient documentation to indicate that a consultation for involuntary psychiatric treatment has been requested by the referring physician.
2. Consultations or assessments claimed in addition to certification or re-certification same *day* are payable at nil.
3. Interviews with relatives on behalf of a patient, *Child*ren's Aid Society (CAS) staff or legal guardian, etc. - see listings in Family Practice & Practice In General.
4. Certification of incompetence (financial) including assessment to determine incompetence is not an insured benefit.

PSYCHIATRY (19)

PSYCHOTHERAPY, FAMILY PSYCHOTHERAPY, HYPNOTHERAPY AND PSYCHIATRIC CARE

Note:

1. For conditions and definitions - see General Preamble GP54 to GP61.
2. For electroconvulsive therapy fees, see Diagnostic and Therapeutic Procedures.
3. When claiming group therapy only services rendered to one group are payable at the same time
4. Unit means ½ hour or major part thereof - see General Preamble GP7, GP55 for definitions and time-keeping requirements.

Psychiatric care

K198	- out-patient	per unit	102.35
K199	- in-patient	per unit	118.00

Family psychiatric care

K196	- out-patient	per unit	116.15
K191	- in-patient	per unit	134.00

Note:
Family psychotherapy is claimed against the patient's health number and diagnosis.

Psychotherapy

K197	Individual out-patient psychotherapy	per unit	102.35
K190	Individual in-patient psychotherapy	per unit	107.25
K195	Family psychotherapy - out-patients (two or more members)	per unit	116.15
K193	Family psychotherapy - in-patients (two or more members)	per unit	121.65

Group psychotherapy, out-patients - per member - first 12 units per day

K208	- 2 people	per unit	51.20
K209	- 3 people	per unit	34.10
K203	- 4 people	per unit	25.60
K204	- 5 people	per unit	20.45
K205	- 6 to 12 people	per unit	18.45
K206	- additional units - per member (maximum 6 per patient per day)	per unit	16.40

Group psychotherapy, in-patients - per member - first 12 units per day

K210	- 2 people	per unit	53.70
K211	- 3 people	per unit	35.80
K200	- 4 people	per unit	26.75
K201	- 5 people	per unit	21.40
K202	- 6 to 12 people	per unit	19.35
K207	- additional units - per member (maximum 6 per patient per day)	per unit	16.40

PSYCHIATRY (19)

Hypnotherapy

K192	Individual	per unit	102.35
K194	Group - for induction and training for hypnosis - per member (maximum eight people)	per unit	18.60

DIAGNOSTIC RADIOLOGY (33)

GENERAL LISTINGS

Consultation

A diagnostic radiology consultation is the service rendered when:

a. radiographs or ultrasounds made at one institution or facility are referred to a radiologist at a different institution or facility for his/her written opinion. In this case, the *specific elements* are as for diagnostic radiology *professional component* (see page D1);

b. a radiologist is required to make a special visit at evening or night (17:00h to 07:00h) or on a Saturday, Sunday or *holiday* to consult on the advisability of performing a diagnostic radiological procedure which eventually is not done. In this case, the *specific elements* are the same as for consultations; or

c. when a radiologist is required to render an opinion prior to an interventional procedure and all of the following requirements are met. In this case, the *specific elements* are the same as for consultations:

i. the consultation is performed in an area remote from the radiologist's normal procedural suite;

ii. the requirements for a consultation are met;

iii. the consultation is not solely for the purpose of clarifying or obtaining consent; and

iv. the associated procedure is one of the following: J021, J025, J040, J041, J046, J048, J049, J050, J055, J056, J057, J058, J059, J063, J065, J066, N107, N118, N122, N125, S233, Z446, Z456, Z562, Z594.

A335 Consultation..... 57.90

Payment rules:

1. A diagnostic radiology consultation is *not eligible for payment* when radiographs made in a different institution or facility are used for comparison purposes with radiographs or ultrasounds made in the consultant's institution or facility.

2. A335 is *not eligible for payment* for CT and MRI services.

[Commentary:
For a second opinion by a radiologist of CT and MRI studies, see A330 and A332 respectively.]

Special interventional radiological consultation

A special interventional radiological consultation is the service described under part (c) of a regular consultation (A335) in circumstances in which because of the very complex, obscure or serious nature of the problem, the physician is required to spend a minimum of 50 minutes in direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient..

[Commentary:
Unless otherwise specified in the *Schedule*, the calculation of time excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultation and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

A365 Special interventional radiological consultation 258.35

DIAGNOSTIC RADIOLOGY (33)

A881 Dosimetry planning for transarterial radioembolization, per course of treatment 200.00

Radiology second opinion of CT or MRI Study

A radiology second opinion of CT or MRI study is the service rendered when CT or MRI images made and interpreted by a radiologist at one institution or facility are referred to a radiologist ("consultant radiologist") at a different institution or facility for his/her written interpretation. For the purposes of these services, "study" means all images related to one anatomical region, as these regions are listed in the payment rules below.

A330 Radiology second opinion of CT study, per study..... 103.60
A332 Radiology second opinion of MRI study, per study..... 231.15

Payment rules:

1. A330 and A332 are *not eligible for payment* when CT or MRI images made in a different institution or facility are used for comparison purposes with CT or MRI images made in the consultant radiologist's institution or facility.
2. A330 and A332 are limited to a maximum of one each per study per patient per 30 day period.
3. For CT studies, the anatomical regions are head, neck, thorax, abdomen, pelvis, extremities (one or more) and spine (one or more segments).
4. For MRI studies, the anatomical regions are head, neck, thorax, abdomen, breast(s), pelvis, extremities (one or more) and spine (one or more segments).
5. E406, E407 or E408 after hours premiums for diagnostic CT/MRI services are *not eligible for payment* with A330 or A332.

Medical record requirements:

A330 and A332 are *only eligible for payment* if both the written request from the referring physician and the consultant radiologist's second opinion report are included in the patient's permanent medical record.

Minor assessment

A minor assessment (A331) is the service rendered when a radiologist evaluates a patient on a non-emergent basis resulting in the cancellation or deferral of a planned diagnostic radiology procedure due to procedural difficulties, including lack of patient cooperation, if no other diagnostic radiology procedure is rendered.

A331 Minor assessment..... 26.80

Minor assessment

A minor assessment (A338) is the service rendered when a radiologist evaluates a patient on a non-emergent basis on the advisability of performing a diagnostic radiological procedure which eventually is not done.

A338 Minor assessment..... 26.80

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C335 Consultation - subject to the same conditions as A335 ..... 57.90

DIAGNOSTIC RADIOLOGY (33)

C365	Special interventional radiological consultation - subject to the same conditions as A365	258.35
C330	Radiology second opinion of CT study, per study - subject to the same conditions as A330	103.60
C332	Radiology second opinion of MRI study, per study - subject to the same conditions as A332	231.15

RADIATION ONCOLOGY (34)

GENERAL LISTINGS

A345	Consultation	178.75
A745	Limited consultation	114.90
A346	Repeat consultation	114.90
A343	Medical specific assessment	95.95
A340	Medical specific re-assessment	72.00
A341	Complex medical specific re-assessment	83.40
A348	Partial assessment	44.75

E078 - chronic disease assessment premium (see General Preamble GP25) ..... add 50%

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C345	Consultation	178.75
C745	Limited consultation	114.90
C346	Repeat consultation	114.90
C343	Medical specific assessment	95.95
C344	Medical specific re-assessment	72.00
C341	Complex medical specific re-assessment	83.40

Subsequent visits

C342	- first five weeks ..... per visit	40.05
C347	- sixth to thirteenth week inclusive (maximum 3 per patient per week) ..... per visit	40.05
C349	- after thirteenth week (maximum 6 per patient per month) ..... per visit	40.05

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	71.80

RADIATION ONCOLOGY (34)

C121	Additional visits due to intercurrent illness (see General Preamble GP43)	per visit	40.05
C348	Concurrent care	per visit	40.05
C982	Palliative care (see General Preamble GP50)	per visit	40.05

RESPIRATORY DISEASE (47)

For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

A475 Consultation 192.30

Comprehensive respiratory disease consultation

This service is a consultation rendered by a *specialist* in respiratory disease who provides all the appropriate elements of a consultation and spends a minimum of 75 minutes in direct contact with the patient, exclusive of time spent rendering any other separately billable intervention to the patient.

A470 Comprehensive respiratory disease consultation 342.25

Medical record requirements:
The start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.

[Commentary:

1. A470 must satisfy all the elements of a consultation (see page GP16).

2. Unless otherwise specified in the *Schedule*, the calculation of time for comprehensive respiratory diseases consultations excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultationand (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

A575 Limited consultation 119.35
A476 Repeat consultation 119.35
A473 Medical specific assessment 102.60
A474 Medical specific re-assessment 75.30
A471 Complex medical specific re-assessment 89.40
A478 Partial assessment 45.25

E078 - chronic disease assessment premium (see General Preamble GP25) ..... add 50%

Complex respiratory assessment

This service is an assessment for the ongoing management of the following conditions of the respiratory system where the complexity of the condition requires the continuing management by a respirology *specialist* (47):

a. chronic respiratory failure (i.e. a symptomatic patient with a PaO2 <60mmHg and/or or a PaCO2 >50mmHg);

b. bronchiectasis with frequent infections;

c. cystic fibrosis;

d. active pulmonary or extrapulmonary disease due to mycobacterial tuberculosis complex (latent tuberculosis infection is excluded); or

e. active pulmonary or extrapulmonary non-tuberculous mycobacterial disease (airway or tissue colonization without disease is excluded).

A570 Complex respiratory assessment 108.95

Payment rules:

1. A570 must include the elements of a medical specific re-assessment, or the amount payable will be adjusted to a lesser assessment fee.

RESPIRATORY DISEASE (47)

2. A570 is limited to 6 per patient, per physician, per *12 month period*. Services in excess of this limit will be adjusted to a lesser assessment fee.

3. E078 is *not eligible for payment* same patient same day as A570.

[Commentary:
A570 is not intended for the evaluation and/or management of uncomplicated respiratory disorders. For example, the applicable assessment service from the general listings should be claimed for assessment of patients for routine follow-up of uncomplicated chronic obstructive pulmonary disease (e.g. emphysema, chronic bronchitis).]

RESPIRATORY DISEASE (47)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C475	Consultation	185.80
C470	Comprehensive respiratory disease consultation - subject to the same conditions as A470	342.25
C575	Limited consultation	115.30
C476	Repeat consultation	115.30
C473	Medical specific assessment	99.15
C474	Medical specific re-assessment	72.80
C471	Complex medical specific re-assessment	86.40
C570	Complex respiratory assessment – subject to the same conditions as A570	105.25

Subsequent visits

C472	- first five weeks ... per visit	40.05
C477	- sixth to thirteenth week inclusive (maximum 3 per patient per week) ... per visit	40.05
C479	- after thirteenth week (maximum 6 per patient per month) ... per visit	40.05

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43) ... per visit	40.05
C478	Concurrent care ... per visit	40.05
C982	Palliative care (see General Preamble GP50) ... per visit	40.05

RHEUMATOLOGY (48)

For Services not listed, refer to Internal Medicine Section.

GENERAL LISTINGS

A485 Consultation 202.40

Comprehensive rheumatology consultation

This service is a consultation rendered by a *specialist* in rheumatology who provides all the appropriate elements of a consultation and spends a minimum of seventy-five (75) minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.

A590 Comprehensive rheumatology consultation 342.25

Medical record requirements:

For A590, the start and stop times must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser paying fee.

[Commentary:

1. A590 must satisfy all the elements of a consultation (see page GP16).

2. Unless otherwise specified in the *Schedule*, the calculation of the time for comprehensive rheumatology consultations excludes (1) time devoted to any other service or procedure for which an amount is payable in addition to the consultation and (2) non-patient-facing time such as such as time spent reviewing charts, imaging, or documentation, etc.]

A595 Limited consultation 124.50
A486 Repeat consultation 125.10
A483 Medical specific assessment 95.95
A484 Medical specific re-assessment 72.00
A481 Complex medical specific re-assessment 83.40
A488 Partial assessment 44.75

E078 - chronic disease assessment premium (see General Preamble GP25) ..... add 50%

Complex rheumatology assessment

A complex rheumatology assessment is an assessment for the ongoing management of the following diseases of the musculoskeletal system where the complexity of the condition requires the continuing management by a rheumatologist:

a. Systemic vasculitides;
b. Inflammatory myopathies;
c. Polymyalgia rheumatica; or
d. Paediatric vasculitides.

A480 Complex rheumatology assessment 113.85

Payment rules:

1. A complex rheumatology assessment must include the elements of a medical specific re-assessment, or the amount payable will be adjusted to lesser assessment fee.

2. This service is *not eligible for payment* to a physician for the initial evaluation of the patient by that physician.

3. Complex rheumatology assessments are limited to 6 per patient, per physician, per *12 month period*. Services in excess of this limit will be adjusted to a lesser assessment fee.

4. E078 is *not eligible for payment* with A480.

RHEUMATOLOGY (48)

[Commentary:

1. A complex rheumatology assessment is for the ongoing management of complex disorders of the musculoskeletal system, where the complexity of the condition requires the continuing management by a rheumatologist. It is not intended for the evaluation and/or management of uncomplicated rheumatologic disorders (e.g. osteoarthritis, bursitis/tendonitis, neck and back pain).
2. Examples of systemic vasculitides include Churg-Strauss angiitis, polyarteritis nodosa, Wegener's granulomatosis, Takayasu's vasculitis, microscopic polyangiitis, and temporal arteritis.
3. A consultation or assessment service, as appropriate, may be claimed for the initial evaluation of a patient. A complex rheumatology assessment is for the ongoing management of a patient with a complex rheumatology disorder.]

RHEUMATOLOGY (48)

Rheumatoid arthritis management by a specialist

Definition/Required elements of service

This is the service rendered by a *specialist* in Rheumatology who is most responsible for providing ongoing management of a patient with rheumatoid arthritis. This service includes all services related to the coordination, provision and documentation of ongoing management, including documentation of all medical record requirements, using a planned care approach.

K481 Rheumatoid arthritis management by a specialist 85.35

Payment rules:

1. K481 is limited to a maximum of one service per patient per *12 month period*.

2. K481 is *only eligible for payment* if the physician has rendered a minimum of three consultations/assessments to the patient in the *12 month period* for which K481 is claimed.

3. K481 is *only eligible for payment* when the physician has treated greater than 100 patients with rheumatoid arthritis for the *12 month period* for which K481 is claimed.

4. K481 is *only eligible for payment* to a physician in the following specialties: Rheumatology (48)

Medical record requirements:

K481 is *only eligible for payment* when the following information is recorded in the patient's permanent medical record for the previous *12 month period*:

1. Measurement of tender joint count;

2. Measurement of swollen joint count;

3. Physician and patient global assessment of disease activity;

4. Patient pain score;

5. Patient assessment of function (e.g. HAQ [Health Assessment Questionnaire] or SF36 [Short Form 36]);

6. Measurement of acute phase reactant (ESR or CRP); and

7. Calculation and recording of a pooled measure of RA disease activity (DAS-28 [Disease Activity Score 28], SDAI [Simplified Disease Activity Index], or CDAI [Clinical Disease Activity Index].

Claims submission instructions:

Claims for K481 should only be submitted when the required elements of the service have been completed for the *12 month period* for which K481 is claimed.

RHEUMATOLOGY (48)

Physician to allied professional telephone consultation

This is the service where the rheumatologist participates in a telephone consultation with one or more of the following allied professionals who is funded by and affiliated with the Arthritis Society, Ontario Division:

a. a physiotherapist who is a member of the College of Physiotherapists of Ontario;

b. an occupational therapist who is a member of the College of Occupational Therapists of Ontario; or

c. a social worker who is a member of the Ontario College of Social Workers and Social Service Workers.

K480 Physician to allied professional telephone consultation..... 31.35

Payment rules:

1. A maximum of one K480 service is eligible for payment per patient per day.

2. A maximum of two K480 services are eligible for payment per patient per *12 month period*.

3. K480 is *only eligible for payment* for a physician to allied professional telephone consultation that:

- **a.** includes a minimum of 10 minutes of patient-related discussion; and
- **b.** where there is an established physician-patient relationship.

4. K480 is *not eligible for payment* to the physician in the following circumstances:

- **a.** when the purpose of the telephone discussion is to arrange for an evaluation of the patient by the physician; or
- **b.** in circumstances where a physician receives compensation, other than by fee-for-service under this *Schedule*, for participation in the telephone consultation, this service is *not eligible for payment* to that physician.

[Commentary:

1. In calculating the minimum time requirement, time does not need to be continuous. In circumstances where a physician to allied health professional telephone consultation service with the consultant physician on the same day is not continuous, the total time represents the cumulative time of all telephone consultations with the same allied health professional on that day pertaining to the same patient.

2. Payment, other than by fee-for-service includes compensation where the physician receives remuneration under a salary, primary care, stipend, APP or AFP model.

3. Physicians who receive compensation other than by fee-for-service under this *Schedule* should consult their contract for guidance on shadow-billing.]

Medical record requirements:

K480 is *only eligible for payment* where the following elements are included in the medical record for a physician who submits a claim for the service:

1. patient's name and health number;

2. start and stop times of the discussion;

3. name(s) of the allied professional participating in the telephone consultation;

4. reason for the consultation; and

5. the opinion and recommendations of the physician.

RHEUMATOLOGY (48)

Note:

1. The definition/required elements of service and payment rules for consultations in the General Preamble are not applicable to physician to allied professional telephone consultations.
2. This service is eligible for payment in addition to visits or other services provided to the same patient on the same day by the same physician.

RHEUMATOLOGY (48)

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C485	Consultation	201.95
C590	Comprehensive rheumatology consultation - subject to the same conditions as A590	342.25
C595	Limited consultation	124.50
C486	Repeat consultation	124.50
C483	Medical specific assessment	95.95
C484	Medical specific re-assessment	72.00
C481	Complex medical specific re-assessment	83.40
C480	Complex rheumatology assessment - subject to the same conditions as A480	112.00

Subsequent visits

C482	- first five weeks ... per visit	40.05
C487	- sixth to thirteenth week inclusive (maximum 3 per patient per week) ... per visit	40.05
C489	- after thirteenth week (maximum 6 per patient per month) ... per visit	40.05

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43) ... per visit	40.05
C488	Concurrent care ... per visit	40.05
C982	Palliative care (see General Preamble GP50) ... per visit	40.05

UROLOGY (35)

GENERAL LISTINGS

A355	Consultation*	93.15
A935	Special surgical consultation (see General Preamble GP19).	194.65
A356	Repeat consultation*	64.90
A353	Specific assessment*	51.45
A354	Partial assessment	30.60

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patient(s) in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C355	Consultation*	93.15
C935	Special surgical consultation (see General Preamble GP19).	194.65
C356	Repeat consultation*	64.90
C353	Specific assessment*	51.45
C354	Specific re-assessment	29.35

Subsequent visits

C352	- first five weeks	per visit	31.60
C357	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	31.60
C359	- after thirteenth week (maximum 6 per patient per month)	per visit	31.60

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	71.80

C121	Additional visits due to intercurrent illness (see General Preamble GP43)	per visit	40.05
C358	Concurrent care	per visit	31.60
C982	Palliative care (see General Preamble GP50)	per visit	40.05

UROLOGY (35)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W355	Consultation*	93.15
W356	Repeat consultation*.....	64.90

Note:

**May include* physical examination pertaining to the genito-urinary tract and when necessary such procedures as urethral calibration, catheterization and prostatic fluid examination, but not to include endoscopic examination.

VASCULAR SURGERY (17)

GENERAL LISTINGS

A175	Consultation	125.15
A935	Special surgical consultation (see General Preamble GP19).	194.65
A176	Repeat consultation	66.60
A173	Specific assessment	49.30
A174	Partial assessment	26.75

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

C175	Consultation	125.15
C935	Special surgical consultation (see General Preamble GP19).	194.65
C176	Repeat consultation	66.60
C173	Specific assessment	49.30
C174	Specific re-assessment	28.80

Subsequent visits

C172	- first five weeks	per visit	31.00
C177	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	31.00
C179	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	71.80
C123	- second day following the hospital assessment	71.80
C124	- day of discharge	71.80
C126	- day of discharge, medically complex patient (see A13 for terms and conditions)	95.10

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	71.80
C121	Additional visits due to intercurrent illness (see General Preamble GP43) per visit	40.05
C178	Concurrent care per visit	31.00
C982	Palliative care (see General Preamble GP50) per visit	40.05

VASCULAR SURGERY (17)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP78.

W175	Consultation		125.15
W176	Repeat consultation		66.60

Subsequent visits (see General Preamble GP49)

Chronic care or convalescent hospital

W172	- first 4 subsequent visits per patient per month	per visit	40.05
W171	- additional subsequent visits (maximum of 6 per patient per month)	per visit	40.05
W982	- palliative care (see General Preamble GP50)	per visit	40.05

Nursing *home* or *home* for the aged

W173	- first 2 subsequent visits per patient per month	per visit	40.05
W178	- subsequent visits per month (maximum of 3 per patient per month)	per visit	40.05
W972	- palliative care (see General Preamble GP50)	per visit	40.05

W121	Additional visits due to intercurrent illness (see General Preamble GP49)	per visit	40.05
W124	Subsequent visit – day of discharge (see A20 for terms and conditions)	per visit	71.80

NOT ALLOCATED

CONSULTATIONS AND VISITS

NUCLEAR MEDICINE - IN VIVO

PREAMBLE

SPECIFIC ELEMENTS

Nuclear Medicine procedures are divided into a *professional component* listed in the columns headed with a "P", and a *technical component* listed in the column headed with an "H". The *technical component* of the procedure subject to the conditions stated under "Diagnostic Services Rendered at a Hospital" on page GP11, is *eligible for payment* only if the service is:

a. rendered at a hospital; or

b. rendered at an off-site premise operated by a hospital corporation that has received approval under section 4 of the *Public Hospitals Act*.

In addition to the *common elements*, the components of Nuclear Medicine procedures include the following *specific elements*.

For Professional Component

A. Providing clinical supervision, including approving, modifying and/or intervening in the performance of the procedure where appropriate.

B. Performance of any clinical procedure associated with the diagnostic procedure which is not separately billable.

C. Where appropriate, post-procedure monitoring, including intervening except where this constitutes a separately billable service.

D. Interpreting the results of the diagnostic procedure.

E. Providing premises for any aspect(s) of A and D that is(are) performed at a place other than the place in which the procedure is performed.

Note:

1. Element D must be personally performed by the physician who claims for the service.

2. If the physician claiming the fee for the service is personally unable to perform elements A, B and C, these may be delegated to another physician.

3. Where the only component provided is interpreting the results of the diagnostic procedure, the *specific elements* A and C listed for the *professional component* are included in the *specific elements* of the technical component.

For Technical Component H

A. Preparing the patient for the procedure.

B. Performing the diagnostic procedure(s).

C. Making arrangements for any appropriate follow-up care.

D. Providing records of the results of the procedure to the interpreting physician.

E. Discussion with, and providing information and advice to, the patient or *patient's representative*, whether by telephone or otherwise, on matters related to the service.

F. Preparing and transmitting a written, signed and dated interpretive report of the procedure to the referring provider.

G. Providing premises, equipment, supplies and personnel for all *specific elements* of the technical and *professional component*s except for the premises for any aspect(s) of A and D of the *professional component* that is(are) not performed at the place in which the procedure is performed.

NUCLEAR MEDICINE - IN VIVO

PREAMBLE

OTHER TERMS AND DEFINITIONS

1. *Professional and technical component*s are claimed separately. Claims for the *technical component* H are submitted using listed fee code with suffix B. Claims for *professional component* are submitted using listed fee code with suffix C. (e.g. J802C)
2. For services rendered outside a hospital setting the only fees billable under the *Health Insurance Act* are listed under P (use suffix C). Costs for the *technical component* of these services are only billable under the *Integrated Community Health Services Centres Act, 2023*.
3. With the exception of J818, J835, J834, J880 or when SPECT is claimed, if quantification or data manipulation is carried out in addition to visual inspection of imaging studies, add 30% to the appropriate professional benefit. For claim purposes, use prefix “Y”. Such activity must add significant diagnostic information not available by inspection alone and does not include simple image enhancement techniques such as smoothing, background subtraction, etc. Recording of images on videotape for replay and production of images on the video display of a computer do not in themselves justify the additional benefit. The claims for cardiac wall motion studies and calculation of ventricular ejection fraction (J811 and J813) already include an allowance for data manipulation as a general rule and no additional benefit may be claimed. The additional computer benefit may be claimed only when additional cardiac quantifications are performed i.e. stroke volume ratio and volume response curves and/or phase analysis.
4. If examination of Brain, Lung, Liver or Spleen is limited to one view, the benefit (H and P) is to be reduced by 50%.
5. Repeat studies on the same day may be claimed only after exercise or drug intervention.
6. When tomographic examination (SPECT) is billed, the 30% add-on referred to in paragraph 3 may not be claimed.
7. Interpretation of a computed tomography (CT) scan performed as a component of a Nuclear Medicine examination (e.g. SPECT/CT) is *not eligible for payment*.
8. Costs for the *technical component* of services rendered in an *ICHSC* are listed in the *Schedule* of Facility Costs.
9. The technical and professional fee components for myocardial perfusion imaging, echocardiography, and exercise stress testing are *not eligible for payment* in the routine preoperative preparation or screening of a patient for surgery where the patient will undergo a low-risk procedure or has a low risk of perioperative cardiac complications, unless there is a clinical indication for such investigations other than solely for preoperative preparation of the patient.

[Commentary:

1. Studies have indicated that for non-cardiac surgery, there may be no clinical benefit and there may be harm in performing functional cardiac testing in patients with low operative risk and little or limited benefit in moderate risk patients. Ordering of functional cardiac testing should done in accordance with accepted clinical guidelines such as those produced by the American College of Cardiology and American Heart Association.

NUCLEAR MEDICINE - IN VIVO

CARDIOVASCULAR SYSTEM

		H	P
	Venography		
J802	- peripheral and superior vena cava	96.35	45.85
	First Transit		
J804	- without blood pool images	16.10	18.85
J867	- with blood pool images	57.30	26.45
	Cardioangiography		
J806	- first pass for shunt detection, cardiac output and transit studies	95.10	47.45
	Myocardial Perfusion Scintigraphy		
J807	- resting, immediate post stress	217.55	38.10
J900	- application of PET for myocardial perfusion (maximum 1 per examination), to J807 ... add	43.50	23.65
J808	- delayed	80.10	20.90
J809	- application of SPECT to J807 or J808 ... add	43.50	23.65
J901	- application of Rubidium PET for cardiac perfusion (maximum 1 per examination), to J808 ... add	43.50	23.65

Payment rules:

1. J809 is limited to a maximum of 1 service with J807 per examination and a maximum of 2 services with J808 per examination.
2. J900 and J901 are *only eligible for payment* when performed for an indication listed as an approved "Routine PET Scan" on the PET Scans Ontario website on the date that the service was rendered. Please refer to the PET section of the *Schedule* of Benefits for more details
3. J900 and J901 are *not eligible for payment* when performed for an indication listed as evidence-building on the PET Scans Ontario website including PET Registry and/or PET Access Program indications.

	Myocardial scintigraphy		
J810	- acute infarction, injury, inflammation, infiltration	88.25	43.15
	Myocardial wall motion		
J811	- studies	95.10	43.25
J812	- repeat same day (to a maximum of three repeats)	48.15	20.90
J813	- studies with ejection fraction	135.15	62.50
J814	- repeat same day (to a maximum of three repeats)	48.15	33.00

Note:
J811 and/or J812 rendered in conjunction with J813 and/or J814 are insured services payable at nil.

J815	Detection of venous thrombosis using radioiodinated fibrinogen up to ten days	131.70	45.85

		H	P
	Oncological scintigraphy		
J869	Theranostic scintigraphy	555.35	56.55
J872	Metastatic survey with I-131	240.60	56.55
	Thyroid scintigraphy		
J818	- with Tc^{99m} or I^{131}	64.15	45.85
J871	- with I-123	103.10	45.85

[Commentary:

1. Indications for thyroid scanning include:

a. Hyperthyroidism (including nodules associated with hyperthyroidism); or

b. Congenital hypothyroidism; or

c. Masses in the neck or mediastinum suspected to be thyroid in origin.

d. Assessment of multinodular glands to guide tissue sampling ; or

e. Assessment of nodules with equivocal Fine Needle Aspiration findings.

2. Nuclear thyroid assessment is not generally indicated for the investigation of *adult* hypothyroidism.

3. Thyroid nodules of less than 1 cm in size may not be accurately assessed by thyroid scintigraphy.]

	Thyroid		
J817	- uptake	28.65	20.75
J870	- repeat	14.65	12.25
	Parathyroid scintigraphy		
J820	Parathyroid scintigraphy	234.70	62.95

Payment rules:

1. J820 is *only eligible for payment* for workup of hyperparathyroidism with biochemical evidence (e.g., elevated serum PTH) or inappropriately normal serum PTH elevated normalized serum calcium or ionized calcium.

2. J820 is *not eligible for payment* for evaluation of an incidental nodule found on anatomic imaging (e.g. ultrasound, CT, MRI) in the absence of a biochemical abnormality.

NUCLEAR MEDICINE - IN VIVO

GASTROINTESTINAL SYSTEM

		H	P
	Malabsorption test		
J824	- with C^{14} substrate	57.30	11.80
J873	- with whole body counting	137.70	16.25
	Gastrointestinal		
J825	- protein loss	82.45	11.10
J874	- blood loss using - Cr^{51}	61.90	11.05
J829	- transit	103.10	45.85
	Calcium absorption		
J826	- Ca^{45}	61.90	11.30
J875	- Ca^{47} absorption/excretion	253.10	35.25
J827	- Oesophageal motility studies - one or more	118.90	45.85
	Gastro-esophageal		
J876	- reflux	56.70	45.85
J877	- aspiration	40.15	45.85
	Abdominal scintigraphy		
J830	- Tc^{99m} sulphur colloid or pertechnetate Tc^{04}	87.00	45.85
J879	- LeVeen shunt patency	66.30	44.05
	Miscellaneous		
J831	Biliary scintigraphy	114.50	45.85
J832	Liver/spleen scintigraphy	80.10	45.85
J833	Salivary gland scintigraphy	96.25	45.85

GENITOURINARY SYSTEM

		H	P
J834	Dynamic renal imaging	96.25	37.10
	Computer assessed renal function		
J835	- includes first transit	131.70	65.80
J880	- repeat after pharmacological intervention	44.85	20.25
J836	Static renal scintigraphy	33.25	45.85
J837	ERPF by blood sample method	40.15	11.80
J838	GFR by blood sample method	40.15	11.80
J839	Cystography for vesicoureteric reflux	120.55	45.85
	Testicular and scrotal scintigraphy		
J840	- includes first transit	82.45	45.95

NUCLEAR MEDICINE - IN VIVO

HAEMATOPOIETIC SYSTEM

		H	P
J841	Plasma volume	43.50	13.50
J843	Red cell volume	48.15	13.50
J847	Ferrokinetics - clearance, turnover, and utilization	400.95	30.15
J848	Red cell, white cell or platelet survival	102.60	24.20
J849	Red cell survival with serial surface counts	148.25	30.85
	Bone marrow scintigraphy		
J881	- whole body	113.70	56.55
J882	- single site	84.85	45.85
	WBC scintigraphy		
J883	- whole body	364.30	56.55
J884	- single site	320.80	45.85

MUSCULOSKELETAL SYSTEM

		H	P
	Bone scintigraphy		
J850	- general survey	103.70	56.55
J851	- single site	84.85	45.85
	Gallium scintigraphy		
J852	- general survey	177.55	56.55
J853	- single site	123.70	45.85
	Application of tomography (SPECT)		
J819	- where each SPECT image represents a different organ or body area, to J852, maximum 3 images per examination ..... add	43.50	28.05

Note:
J850 and J851 are not to be billed together. J804 may be claimed in addition to J850 or J851 for blood pool study.

NUCLEAR MEDICINE - IN VIVO

NERVOUS SYSTEM AND RESPIRATORY SYSTEM

		H	P
	NERVOUS SYSTEM		
	CSF circulation		
J857	- with Tc^{99m}	120.25	52.05
J885	- with In^{111}	308.20	52.05
J886	- via shunt puncture	88.55	50.60
J858	Brain scintigraphy - except cerebral perfusion	90.40	51.00
J902	Brain scintigraphy - cerebral perfusion	90.40	49.80
	Payment rules: Only one of J858 or J902 are eligible for payment per patient, per study.		
	RESPIRATORY SYSTEM		
J859	Perfusion lung scintigraphy	85.90	41.05
J887	Ventilation lung scintigraphy	107.70	41.05
J860	Ventilation and perfusion (V/Q) scintigraphy - same day	171.85	86.40

NUCLEAR MEDICINE - IN VIVO

MISCELLANEOUS

		H	P
J861	Radionuclide lymphangiogram	112.20	62.40
J862	Ocular tumour localization	75.60	62.50
J864	Tear duct scintigraphy	97.35	48.90
J865	Total body counting including dosimetry	187.95	56.55
J878	RBC scintigraphy	143.20	45.85
	Application of Tomography (SPECT), other than to J807, J808, or J852		
J866	- maximum one per Nuclear Medicine examination ..... add	43.50	26.90
	Application of Hybrid Tomography (SPECT/CT)		
J903	Application of hybrid tomography (SPECT/CT), to J819 or J866 ..... add		15.00

Payment rules:
J903 is limited to a maximum of 1 service with J866 per examination and a maximum of 3 services with J819 per examination.

SCINTIMAMMOGRAPHY

H	P

Scintimammography is *not eligible for payment* unless at least one of the following conditions is met:

a. the patient has a dense breast(s) and one or both of the following risk factors:

i. a first degree relative with breast cancer diagnosed prior to age 50; or

ii. a first degree relative with breast cancer diagnosed over age 50 and patient is within 5 years of the age when the relative was diagnosed with breast cancer.

b. architectural distortion of the breasts due to prior breast surgery, radiotherapy, chemotherapy or the presence of breast prosthesis rendering mammography interpretation difficult;

c. malignant breast lesion when mammography is unable to exclude multifocal disease; or

d. solitary lesion identified on mammography of greater than 1 cm.

Scintimammography

J863	- unilateral or bilateral	99.95	45.85

Note:
For the purpose of this provision, "dense breast(s)" means (a) breast(s) occupied by over 75% fibroglandular tissue as noted on mammography.

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC NUCLEAR MEDICINE

Such procedural benefits are intended for the physician's service of placing an instrument or introducing diagnostic radiopharmaceuticals. They are not intended to be used for simple subcutaneous, intramuscular or intravenous injection nor for oral administration. Rather than double listing the procedures and benefits in this part of the fee *schedule*, physicians are directed to the following reference points in the *Schedule*

a. Intra-articular injections - G370 on page J53.

b. Injection into CSF spaces or shunt apparatus - Z801 or Z821 on page X8.

c. Arterial puncture - Z459 on pages H6 and J7.

d. Paracentesis in conjunction with shunt patency study - Z590 on page S34.

POSITRON EMISSION TOMOGRAPHY (PET)

PREAMBLE

SPECIFIC ELEMENTS

In addition to the *common elements*, the *professional component* of PET procedures includes the following *specific elements*.

For Professional Component P

A. Providing clinical supervision, including approving, modifying and/or intervening in the performance of the procedure where appropriate, and quality control of all elements of the *technical component* of the procedure.

B. Performance of any clinical procedure associated with the diagnostic procedure which is not separately billable (e.g. injections which are an integral part of the study).

C. Where appropriate, post-procedure monitoring, including intervening except where this constitutes a separately billable service.

D. Interpreting the results of the diagnostic procedure.

E. Providing premises for any aspect(s) of A and D that is(are) performed at a place other than the place in which the procedure is performed.

If the physician claiming the fee for the service is personally unable to perform elements A, B and C, these may be delegated to another physician, who must personally perform the service.

Element D must be personally performed by the physician who claims for the service.

POSITRON EMISSION TOMOGRAPHY (PET)

P

Note:

1. PET scanning is an insured service only when performed for an indication listed as an approved "Routine PET Scan" on the PET Scans Ontario website on the date that the service was rendered.
2. PET scanning is not an insured service when performed for an indication listed as evidence-building on the PET Scans Ontario website (including PET Registry and/or PET Access Program indications) on the date that the service was rendered.
3. PET scanning for all oncologic or suspected oncologic indications must be performed using a combined PET-computed tomography scanner (PET/CT) or combined PET-magnetic resonance imaging scanner (PET/MR) to provide attenuation correction and anatomic localization.
4. Interpretation of CT or MR imaging performed as part of a PET /CT or PET/MR study for attenuation correction and anatomic localization is *not eligible for payment*.

[Commentary:

1. Current PET imaging recommendations/guidelines and lists of approved routine and evidence-building indications can be found at the following link: https://ontariohealth.ca/clinical/pet-scans
2. APET scans may be available for uninsured indications through PET Scans Ontario Program, where evidence is being built in the province (Evidence-Building PET services). PET Scans Ontario is coordinated by Ontario Health. Additional information regarding Evidence-Building PET services may be found at the link provided above.

J715	PET – Cardiology, excluding myocardial perfusion	237.50
J714	PET – Oncology.....	290.50
J716	PET – Neurology	290.50
J717	PET – Infection and/or inflammation, excluding cardiac.....	290.50

Payment rules:

1. Only one of J714, J715, J716 or J717 is eligible for payment per patient per day.
2. J715 is *not eligible for payment* for assessment of myocardial perfusion using PET. See J900/J901 for further information.
3. J717 is *not eligible for payment* for cardiac-related infection and/or inflammation indications.

[Commentary:

Where the primary purpose of the PET scan is to investigate cardiac-related infection or inflammation, J715 should be claimed.]

RADIATION ONCOLOGY

PREAMBLE

SPECIFIC ELEMENTS

In addition to the *common elements*, all Radiation Oncology codes include the following *specific elements* with the exception of Treatment Planning (X310, X311, X312, X313, X322) to which elements A and B do not apply.

A. Supervising the preparation of the patient and preparing the patient for the procedure(s).

B. Supervising and/or performing the procedure(s), including application (superficial, interstitial or intracavitary) of the radiation source where appropriate, and including ongoing monitoring and detention during the immediate post-procedure and recovery period.

C. Making arrangements for any related assessments, procedures or therapy, including obtaining any specimens from the patient and interpretation of any results where appropriate.

D. Where indicated, making or supervising the making of arrangements for follow-up care and post-procedure monitoring of the patient's condition, including intervening, until the next insured service is provided.

E. Discussion with and providing advice and information, including prescribing therapy to the patient or the *patient's representative*, whether by telephone or otherwise, on matters related to the service.

F. Providing premises, equipment, supplies and personnel for the *specific elements*

- **a.** for services not identified with prefix #, for all elements.
- **b.** for services identified with prefix #, for any aspect(s) of A, C, D and E that is(are) performed in a place other than the place in which the procedure(s) is performed.

Specific elements for treatment planning

In addition to *Specific Elements* above, the following *specific elements* apply to Treatment Planning (X310, X311, X312, X313, X322).

A. Must include personal preparation of the medical component of the treatment plan and supervision of the radiation treatment planning, including dosage calculation and preparation of any special treatment device.

B. All subsequent adjustment(s) by any physician to that treatment plan during that complete course of treatment.

OTHER TERMS AND CONDITIONS

1. Treatment Planning (X310, X311, X312, X313) for radiotherapy that is rendered in a place other than an Ontario public hospital funded by Ontario Health to provide radiotherapy is an insured service payable at nil.
2. X305, X306, X322, X323, X324, X325 and X334 rendered in a place other than an Ontario public hospital are insured services payable at nil.
3. Any radiation oncology planning or treatment service that is rendered to a patient during a course of treatment for which Treatment Planning (X310, X311, X312, X313) *is eligible for payment,* is *not eligible for payment*.
4. X302, X304 may not be claimed by the staff of an Ontario public hospital funded by Ontario Health to provide radiotherapy.

RADIATION TREATMENT PLANNING

Treatment levels are defined by National Hospital Productivity Improvement Project (NHPIP) Codes as published in Activity-Based Funding for Radiation Services in Ontario, “Refining the Task Force on Human Resources for Radiation Services’ Interim Funding Formula, April 2001” Joint Policy and Planning Committee (JPPC) Report by the sub-committee Radiation Funding Working Group (RFWG).

Level 1 - Simple Treatment Planning

X310 - includes planning that does not meet criteria for X311, X312 and X313 per patient, per course of treatment..... 215.35

Level 2 - Intermediate Treatment Planning

- must include one or more of the following treatments and corresponding NHPIP codes

Treatment	NHPIP Code
Any 2, 3 or 4 field cases with contour	103, 104, 110, 111, 170, 215, 381, 382
Any case with contrast media/insertion	150, 151, 152, 160, 161, 191
Any 2, 3 or 4 field cases with 2D computerized dose distribution	310, 311, 312
Any extended SSD cases	120
All cases with standard shielding	220, 230
All cases with simple wax/Pb cut-out	240, 259

X311 Level 2 - per patient, per course of treatment..... 374.60

Level 3 - Complex Treatment Planning

- must include one or more of the following treatments and corresponding NHPIP codes

Treatment	NHPIP Code
All 5 and 6 field cases	105, 106, 314
All whole CNS cases	130, 314
4-field conformal distribution	317
5-field non-conformal distribution	318
6-field non-conformal distribution	319
6-field conformal initial calculation	328
6-field non-conformal initial calculation	329
5-field non-conformal initial calculation	335
5-field conformal initial calculation	336
8-field distribution	339
All total/hemi-body planning	350, 360
All cases with CT/MRI scan for treatment planning	370, 371, 372, 373, 382
All cases with custom shielding (e.g. Cerrobend)	224, 225, 231, 232, 234, 242, 313
All cases using manual or automatic compensators	241, 250, 251, 252, 253, 254
All cases with custom immobilization or device	200, 201, 204, 205, 206, 207, 260, 261, 262, 263

X312 Level 3 - per patient, per course of treatment..... 680.45

Fee

Level 4 - Full 3D Treatment Preparation

- radiation therapy must be oriented in two or more axes and must include one or more of the following treatments and corresponding NHPIP codes

Treatment	NHPIP Code
Full 3D target definition (volumetric imaging), 3D dose computation, 3D plan evaluation	333
Paediatric radiotherapy Stereotactic radiotherapy Total skin electron treatment Total body irradiation Intensity Modulated Radiotherapy (IMRT)	342

X313 Level 4 - per patient, per course of treatment 811.15

X302 Teleradiotherapy - x-ray, 150 KVP or higher, radium, cobalt, cesium betatron linear accelerator - amount payable per treatment visit 15.90

X304 Minor teleradiotherapy - x-ray, 150 KVP or less - amount payable per treatment visit 11.95

Intracavitary treatment planning for contact x-ray therapy including sigmoidoscopy or proctoscopy

X305 - first application 170.85

X306 - repeat application 85.50

X337 Placement of fiducial markers into the prostate 122.30

X338 Placement of rectal spacer 223.65

X339 Placement of fiducial markers into the vagina 76.45

Payment rules:
X337, X338 and X339 include any imaging or other guidance required – if performed. Obtaining and interpreting any images in conjunction with X337, X338 and X339 are *not eligible for payment* to any physician.

RADIATION ONCOLOGY

RADIUM AND RADIOISOTOPES (SEALED SOURCES)

		Fee
X322	Treatment planning, dosage calculation and preparation of any special treatment device	113.65
	Intracavitary application of radium or sealed sources including dilatation and curettage carried out at the same time as application	
X323	- first application	356.45
X334	- repeat application	178.35
X324	Interstitial application of radium or sealed radioisotope	356.45
# X325	Application of radium or radioisotope plaque or mould	111.25

Note:
X325 may be claimed as an in-patient or out-patient service. Claims for in-patient services must be in accordance with Other Terms and Definitions - #2 on page C1. If claimed as an out-patient service, allow to all listed physicians. Payment for out-patient services must be made to the registered Department of Radiology, in the case of a hospital, even though there is no *technical component* listed.

RADIATION ONCOLOGY

RADIOISOTOPES (NON-SEALED SOURCES)

		Fee
	The following benefits include treatment planning, dosage calculation and preparation of materials. Appropriate visit and procedural benefits (e.g. paracentesis) may be claimed in addition. Thyroid benefits (X326, X327, X335) include administration(s) within any three *month* period.	
# X326	Thyroid malignancy	100.00
# X327	Hyperthyroidism	80.00
# X335	Induction of hypothyroidism	80.00
# X336	Prostate malignancy	100.00
# X328	Polycythemia	100.00
# X329	Metastatic disease of bone	100.00
# X330	Ascites and/or pleural effusion(s) due to malignancy	100.00
# X332	Arthritis - single or multiple site	80.00

DIAGNOSTIC RADIOLOGY

PREAMBLE

SPECIFIC ELEMENTS

Diagnostic Radiology procedures are divided into a *professional component* listed in the column headed with a "P", and a *technical component* listed in the column headed with an "H". The *technical component* of the procedures subject to the conditions stated under "Diagnostic Services Rendered at a Hospital" on page GP11, is *eligible for payment* only if the service is:

a. rendered at a hospital; or

b. rendered at an off-site premise operated by a hospital corporation that has received approval under section 4 of the *Public Hospital Act*.

[Commentary:
As described in Regulation 552 of the *Health Insurance Act*, for a service to be insured, the interpreting physician must physically be present in Ontario when the interpretation service is rendered.]

In addition to the *common elements*, the components of Diagnostic Radiology procedures include the following *specific elements*.

For Professional Component P

A. Providing clinical supervision, including approving, modifying and/or intervening in the performance of the procedure where appropriate, and quality control of all elements of the *technical component* of the procedure.

B. Performance of any clinical procedure associated with the diagnostic procedure which is not separately billable (e.g. injections which are an integral part of the study) and of any fluoroscopy.

C. Where appropriate, post-procedure monitoring, including intervening except where this constitutes a separately billable service.

D. Interpreting the results of the diagnostic procedure.

E. Providing premises for any aspect(s) of A and D that is (are) performed at a place other than the place in which the procedure is performed.

If the physician claiming the fee for the service is personally unable to perform elements A, B and C, these may be delegated to another physician who must personally perform the service. Element D must be personally performed by the physician who claims for the service.

For Technical Component H

A. Preparing the patient for the procedure.

B. Performing the diagnostic procedure or assisting in the performance of fluoroscopy.

C. Making arrangements for any appropriate follow-up care.

D. Providing records of the results of the procedure to the interpreting physician.

E. Discussion with, and providing information and advice to, the patient or patient's representative, whether by telephone or otherwise, on matters related to the service.

F. Preparing and transmitting a written, signed and dated interpretive report of the procedure to the referring provider.

G. Providing premises, equipment, supplies and personnel for all *specific elements* of the technical and *professional component*s except for the premises for any aspect(s) of A and D of the *professional component* that is (are) not performed at the place in which the procedure is performed.

DIAGNOSTIC RADIOLOGY

PREAMBLE

OTHER TERMS AND DEFINITIONS

1. *Professional and technical component*s are claimed separately. Claims for *technical component* H are submitted using the listed fee code with suffix B. Claims for *professional component* P are submitted using the listed fee code with suffix C.
2. For services rendered outside a hospital setting the only fees billable under the *Health Insurance Act* are listed under the column P (use suffix C). Costs for the *technical component* of these services are only claimed under the *Integrated Community Health Services Centres Act, 2023*. Costs for the *technical component* of services rendered in an *ICHSC* are listed in the *Schedule* of Facility Costs.
3. Benefits for clinical procedures related to x-ray examinations are listed in the following section, or under Diagnostic and Therapeutic or Surgical Procedures. 'Clinical Procedures', in this context, are those by which contrast media are introduced, except oral or rectal administration for study of the alimentary tract, and intravenous injections, which are an integral part of the study, performed by the physician collecting the benefit for the procedure.
4. If less than the minimum number of views are performed, reduce listed fees by 25%.
5. If insured diagnostic radiology procedures yield abnormal findings or if they would yield information which in the opinion of the radiologist would be insufficient governed by the needs of the patient and the requirements of the referring provider or practitioner, the radiologist may add further views and claim for them (if listed).
6. All benefits listed apply to unilateral examinations unless otherwise specified. When a radiologist is asked to x-ray one extremity only, no additional claim should be made for comparison x-rays initiated by the radiologist.
7. A stereo pair is to be counted as two views.
8. No additional claim is warranted for the use of the image intensifier in diagnostic radiology.
9. Complex head CT scans are meant to be multiplanar (multidirectional) head CT scans - to include one or more of the following areas: pituitary fossa, posterior fossa, internal auditory meati, orbits and related structures, the temporal bone and its contents and the temporomandibular joints. X400, X401 and X188 are not to be billed in addition to those fees for complex head studies.
10. Nasal bones should not be routinely claimed in skull examination requests.
11. Mandible X006 and Temporomandibular joints X007 are not both to be routinely claimed on the same patient but only when specifically ordered.
12. Conventional films of the spine should not be routinely done and claimed for before myelography. The necessity of having plain film studies of the spine prior to interpreting the myelographic studies is obvious. It is not essential, however, that these be done at the institution where the myelogram was done. If they have been done at an outside office, then it is a matter for the radiologist and the referring provider to have the films available. If they cannot be made available to the radiologist, it is an acceptable practice for him to do the required procedure of these areas and to claim for them so that they may be available for interpretation along with the myelographic study.
13. Lumbar or lumbosacral spine X028 does not include the entire sacrum. An x-ray of the sacrum may be carried out and claimed for only when specifically indicated.

PREAMBLE

14. Three or more views of the chest should not be done routinely and claimed when a chest examination is requested.

15. Chest studies should not be routinely done and claimed in mammography cases.

16. Fluoroscopy claims should not be submitted for any examination performed by the radiologist where fluoroscopy is generally regarded as an integral part of the examinations e.g. examinations of the GI tract, urinary tract, and special procedures.

17. 'Colon - air contrast' may be claimed when performed according to generally accepted criteria. The colon should be scrupulously prepared. Five to eight full size views of the abdomen should be obtained after fluoroscopically controlled introduction of air and barium.

18. 'Oesophagus, stomach and duodenum - double contrast' presupposes the introduction of gas, the use of antifoam agent and a suitable barium mixture.

19. 'Pharynx and oesophagus - cine or videotape' (X106) should not be claimed routinely with X108 and X109 but only when specifically indicated.

20. Abdomen and chest studies should not be routinely done and claimed in gastrointestinal examinations.

21. Abdomen and/or pelvis should not be routinely claimed in lumbar spine examination requests.

22. A survey film of the abdomen is a single view. The ordering of additional films should be left to the discretion of the radiologist who should have the power to determine what examination is adequate for a specific patient. Obviously, if progress of a long tube is being followed, a survey film is sufficient. If, however, an intestinal obstruction is being followed, a single film is usually inadequate.

23. No extra fee should be claimed for rapid sequence intravenous pyelogram (IVP).

24. Nephrotomography is covered by the listings for IVP and planigram.

25. Preoperative and Routine Chest X-rays

a. The technical and professional fee components for chest x-ray, X090, X091 and X092 are *not eligible for payment* in the routine preoperative preparation or screening of a patient for non-cardiac, non-thoracic surgery, unless there is a clinical indication requiring a chest x-ray other than solely for preoperative preparation or screening of the patient.

[Commentary:
Examples of indications could include but are not limited to:

1. suspected active airway or airspace disease

2. workup of shortness of breath

3. metastatic workup]

b. The technical and professional fee components for chest x-ray, X090, X091 and X092 are *only eligible for payment* when rendered for a patient who has symptoms, signs or an indication supported by current clinical practice guidelines relevant to the individual patient's circumstances.

[Commentary:
Routine chest x-rays for screening or for admission to hospital without clinical indication are not payable.]

26. X-ray or CT studies of the lumbar spine should not be routinely ordered or rendered for low back pain without suspected or known pathology.

PREAMBLE

[Commentary:
Examples of suspected or known pathology include infection, tumour, osteoporosis, ankylosing spondylitis, fracture, inflammatory process, radicular syndrome, and cauda equina syndrome.]

DIAGNOSTIC RADIOLOGY

HEAD AND NECK

		H	P
	Skull		
X001	- four views	29.90	14.45
X009	- five or more views	37.25	17.90
X003	Sella turcica (when skull not examined)	14.90	7.00
	Facial bones		
X004	- three views	21.70	11.25
	Nose		
X005	- two views	14.90	7.00
	Mandible		
X006	- three views (unilateral or bilateral)	21.70	11.30
X012	- four or more views	29.90	14.45
X007	Temporomandibular joints - four views including open and closed mouth views	21.70	11.30
	Mastoids		
	- bilateral		
X010	- six views	28.65	15.55
X011	- Internal auditory meati (when skull not examined)	21.70	11.30
	Note: Dental x-rays of the teeth are not an insured benefit.		
X016	Eye, for foreign body	14.85	9.90
X017	Eye, for localization, additional	15.30	22.25
X018	Optic foramina	16.85	9.90
X019	Salivary gland region	13.75	8.70
	Neck for soft tissues		
X020	- two views	13.75	8.70

SPINE AND PELVIS

		H	P
	Cervical spine		
X025	- two or three views	25.90	8.70
X202	- four or five views	33.40	11.75
X203	- six or more views	40.35	14.45
	Thoracic spine		
X027	- two views	23.65	8.70
X204	- three or more	29.90	11.60
	Lumbar or lumbosacral spine		
X028	- two or three views	25.90	8.70
X205	- four or five views	33.40	11.75
X206	- six or more views	40.35	14.55
	Entire spine (scoliosis series)		
X032	- four views	53.55	22.65
	Orthoroentgenogram (3 foot film)		
X033	- single view	21.70	11.10
X031	- two or more views	29.70	14.55
	Sacrum and/or coccyx		
X034	- two views	23.95	7.00
X207	- three or more views	31.05	11.60
	Sacro-iliac joints		
X035	- two or three views	21.70	11.30
X208	- four or more views	28.95	14.25
	Pelvis and/or hip(s)		
X036	- one view	14.90	7.00
X037	- two views (e.g. AP and frog view, both hips, or AP both hips plus lateral one hip)	27.75	10.05
X038	- three or more views (e.g. pelvis and sacro-iliac joints, or AP both hips plus lateral each hip)	31.90	11.30

DIAGNOSTIC RADIOLOGY

UPPER EXTREMITIES

		H	P
	Clavicle		
X045	- two views	14.90	7.00
X209	- three or more views	22.90	9.70
	Acromioclavicular joints (bilateral) with or without weighted distraction		
X046	- two views	21.70	11.30
X210	- three or more views	29.60	14.25
	Sternoclavicular joints (bilateral)		
X047	- two or three views	17.95	8.70
X211	- four or more views	25.60	11.90
	Shoulder		
X048	- two views	17.95	8.70
X212	- three or more views	25.60	11.60
	Scapula		
X049	- two views	17.95	8.70
X213	- three or more views	25.80	11.60
	Humerus including one joint		
X050	- two views	14.90	7.00
X214	- three or more views	22.75	10.15
	Elbow		
X051	- two views	14.90	7.00
X215	- three or four views	22.90	9.90
X216	- five or more views	30.85	12.70
	Forearm including one joint		
X052	- two views	14.90	7.00
X217	- three or more views	22.90	9.90
	Wrist		
X053	- two or three views	14.90	7.00
X218	- four or more views	22.90	9.90
	Hand		
X054	- two or three views	14.90	7.00
X219	- four or more views	22.90	9.90
	Wrist and hand		
X055	- two or three views	21.70	14.25
X220	- four or more views	27.65	17.15
	Finger or thumb		
X056	- two views	11.50	5.15
X221	- three or more views	14.90	7.00

LOWER EXTREMITIES

		H	P
	Hip (unilateral)		
X060	- two or more views	23.75	8.35
	Femur including one joint		
X063	- two views	14.90	7.00
X223	- three or more views	22.20	9.90
	Knee including patella		
X065	- two views	14.90	7.00
X224	- three or four views	22.90	9.90
X225	- five or more views	30.85	12.70
	Tibia and fibula including one joint		
X066	- two views	14.90	7.00
X226	- three or more views	22.90	9.90
	Ankle		
X067	- two or three views	14.90	7.00
X227	- four or more views	22.90	9.90
	Calcaneus		
X068	- two views	14.90	7.00
X228	- three or more views	22.90	9.90
	Foot		
X069	- two or three views	14.90	7.00
X229	- four or more views	22.90	9.90
	Toe		
X072	- two views	11.50	5.15
X230	- three or more views	14.90	9.90
X064	Leg length studies (orthoroentgenogram)	21.70	11.30

SKELETAL SURVEYS

		H	P
	Skeletal survey for bone age		
X057	- single film	14.90	13.05
X058	- two or more films or views	21.70	15.70

Payment rules:
The professional components of X057 and X058 are *only eligible for payment* when the radiologist personally reviews the patient film(s) and compares against a standard reference atlas.

	Other survey studies - e.g. rheumatoid, metabolic or metastatic		
X080	- single view	7.45	3.60
X081	- each additional film or view	7.45	3.60

DIAGNOSTIC RADIOLOGY

CHEST AND ABDOMEN

		H	P
	Chest		
X090	- single view	14.90	6.95
X091	- two views	21.90	11.70
X092	- three or more views	28.15	13.55

Note:
Miniature chest film for survey purposes only is not an insured benefit.

	Ribs		
X039	- two or more views	17.95	8.55
	Sternum		
X040	- two or more views	17.95	8.55
	Thoracic inlet		
X096	- two or more views	14.90	7.00
	Abdomen		
X100	- single view	14.90	7.00
X101	- two or more views	22.80	10.05

DIAGNOSTIC RADIOLOGY

GASTROINTESTINAL TRACT

		H	P
	Palatopharyngeal analysis		
X105	- cine or videotape	29.50	40.25
	Pharynx and oesophagus		
X106	- cine or videotape	29.50	40.25
X107	Oesophagus when X103, X104, X108 or X109 not claimed	26.70	32.80
	Oesophagus, stomach and duodenum		
X108	- including survey film, if taken	46.30	41.65
X104	- double contrast, including survey film, if taken	48.50	50.65
X103	- double contrast, including survey film, if taken, and small bowel	60.95	63.75
X110	Hypotonic duodenogram	39.35	35.95
X109	Oesophagus, stomach and small bowel	59.10	54.35
	Small bowel only		
X111	- when only examination performed during patient's visit	26.40	23.80
	Colon		
X112	- barium enema including survey film, if taken	48.40	32.10
X113	- air contrast, primary or secondary, including survey films, if taken	61.30	54.35
	Gallbladder		
X114	- one or multiple day examinations	29.95	12.65
X120	- one or multiple day examinations with preliminary plain film	39.80	12.65
X116	T-tube cholangiogram	21.70	10.80
X117	Operative cholangiogram	21.70	12.10
X123	Operative pancreatogram or ERCP	21.70	9.80

GENITOURINARY TRACT

		H	P
X129	Retrograde pyelogram, unilateral or bilateral	21.70	9.80
X130	Intravenous pyelogram including preliminary film	49.65	24.85
X137	Cystogram (catheter)	23.85	9.15
X135	Cystourethrogram, stress or voiding (catheter)	27.50	13.80
X131	Cystourethrogram (non-catheter)	5.75	5.20
X191	Intestinal conduit examination or nephrostogram	21.70	9.80
X138	Percutaneous antegrade pyelogram	21.70	9.80
X139	Percutaneous nephrostogram	21.70	17.00
X134	Retrograde urethrogram	17.95	6.80
X136	Vasogram	17.95	6.80
X141	Cavernosography	20.65	8.30

OBSTETRICS AND GYNAECOLOGY

		H	P
X147	Hysterosalpingogram	29.80	12.40

DIAGNOSTIC RADIOLOGY

FLUOROSCOPY - BY PHYSICIAN WITH OR WITHOUT SPOT FILMS

		H	P
X195	Chest	9.25	21.75
X196	Skeleton	9.25	21.75
X197	Abdomen	9.25	21.75
X189	Fluoroscopic control of clinical procedures done by another physician per ¼ hour	7.30	36.40

DIAGNOSTIC RADIOLOGY

SPECIAL EXAMINATIONS

		H	P
	Abdominal, thoracic, cervical or cranial angiogram by catheterization		
	Using single films		
X179	- non-selective	29.60	15.85
X180	- selective (per vessel, to a maximum of 4)	38.95	31.35
	Using film changer, cine or multiformat camera		
X181	- non-selective	59.65	47.35
X182	- selective (per vessel, to a maximum of 4)	79.30	57.40
X140	- selective (5 or more vessels)	317.35	185.60
	Carotid angiogram by direct puncture		
X160	- unilateral	48.90	34.00
X161	- bilateral	78.60	69.65
	Peripheral angiogram		
X174	- unilateral	29.80	23.75
X175	- bilateral	39.35	47.35
X198	Splenoportogram	59.10	24.65
X199	Translumbar aortogram	59.10	24.65
	Vertebral angiogram - direct puncture or retrograde brachial injection		
X132	- unilateral	48.90	34.00
X133	- bilateral	79.90	51.05
X156	Arthrogram, tenogram or bursogram	26.25	30.00
X200	- with fluoroscopy and complete positioning throughout by physician	36.70	69.80
	Bronchogram		
X158	- unilateral	28.95	25.10
X159	- bilateral	38.40	34.60
X162	Cerebral stereotaxis	59.20	25.20
X122	Cholangiogram, percutaneous trans-hepatic	29.50	25.25
X121	Stereotactic core breast biopsy	-	90.75

BONE MINERAL DENSITY (BMD) MEASUREMENT

H	P

Dual-energy X-ray Absorptiometry (DXA) - by axial technique only

Definition:

For the purpose of subsequent testing, patient risk is defined using the fracture risk assessment tool (FRAX) or equivalent major osteoporotic fracture assessment tool. Levels of patient risk are defined as:

"high risk patient" means a patient with an estimated risk > 15%

"medium risk patient" means a patient with an estimated risk between 10% and 15%.

"low risk patient" means a patient with an estimated risk < 10%

Definition/Required elements of service:

Bone Mineral Density (BMD) measurement by DXA is an insured service only when all the following conditions have been met:

1. the service is rendered for the prevention and management of osteoporosis or osteopenia;
2. when more than one site is measured, the sites include both hip and spine and where measurement of both hip and spine is not technically feasible the site measured consists of either hip or spine.

[Commentary:
Measurement of hip and spine would be considered not technically feasible due to prosthesis or deformity.]

Baseline test (once per lifetime)

X145	- one site	42.85	40.15
X146	- two or more sites	55.20	48.00

Subsequent test - low or medium risk patient (once every 60 months)

X142	- one site	42.85	40.15
X148	- two or more sites	55.20	48.00

Subsequent test - high risk patient or therapy monitoring or risk factor for secondary osteoporosis (once every 36 months)

X149	- one site	42.85	40.15
X155	- two or more sites	55.20	48.00

Additional test – other risk factors (once every 12 months)

X237	- one site	42.85	40.15
X236	- two or more sites	55.20	48.00

Payment rules:

1. Patients are limited to one baseline test (X145 or X146) in their lifetime.
2. Subsequent test - low or medium risk patient (X142/X148) is limited to a maximum of one test rendered every 60 months following the baseline test (X145/X146). or any subsequent test (X142/X148/X149/X155) or any additional test (X236/X237).

BONE MINERAL DENSITY (BMD) MEASUREMENT

H P

3. (X149/X155) for a high-risk patient is limited to a maximum of one test every 36 *month*s following the baseline test (X145/X146) or any subsequent test (X142/X148/X149/X155) or any additional test (X236/X237)
4. X149/X155 for therapy monitoring is limited to a maximum of
   - **i.** one test rendered not earlier than 36 months after initiating pharmacotherapy; and/or
   - **ii.** one test rendered not earlier than 36 months after stopping bisphosphonate therapy.
5. X149/X155 for therapy monitoring is *not eligible for payment* when rendered earlier than 36 months following X145/X146 or X142/X148 or X149/X155 or X236/X237.
6. X149/X155 for risk factor for secondary osteoporosis are *only eligible for payment* when the medical record supports
   - **i.** a risk factor for secondary osteoporosis consistent with Canadian clinical practice guidelines in place at the time of the service;
   - **ii.** new fragility fracture; or
   - **iii.** other risk factor for rapid bone loss.
7. X149/X155 for risk factor for secondary osteoporosis is *not eligible for payment* when rendered earlier than 36 months following X145/X146 or X142/X148 or X149/X155 or X236/X237.
8. X236/X237y for other risk factors are *only eligible for payment* for patients with Hypercortisolism/Cushing's syndrome or receiving high-dose glucocorticoid therapy of > 20 mg Prednisone equivalent per day.
9. X236/X237 are limited to a maximum of one test every 12 months following any other BMD services (X145/X146 or X142/X148 or X149/X155 or X236/X237).

[Commentary:

1. The 2023 Clinical Practice Guideline for Management of Osteoporosis and Fracture Prevention in Canada can be found at https://www.cmaj.ca/content/195/39/E1333 and https://www.cmaj.ca/content/cmaj/suppl/2023/10/03/195.39.E1333.DC1/221647-guide-1-at.pdf
2. Individuals identified as low risk patients may only require repeat BMD testing at 10-year intervals
3. Canadian clinical practice guidelines and the use of BMD testing is primarily restricted to men and women over age 50, BMD testing in patients below that age is not routine practice unless specific comorbidities such as those listed in the Canadian clinical practice guidelines are present, or unless fragility fractures have occurred.]

COMPUTED TOMOGRAPHY (CT)

		H	P
	Head		
X400	- without IV contrast	-	43.25
X401	- with IV contrast	-	64.95
X188	- with and without IV contrast	-	75.85
E874	- with CT perfusion study, to X188, X400, X401, X402, X405, or X408	add	64.00

Note:

1. E874 is *only eligible for payment* when the study is rendered as part of the investigation of acute stroke and the interpretation is rendered within the limited period of time following acute stroke during which the treating physician must render therapeutic decisions.

2. E874 includes the administration of contrast necessary to complete the CT perfusion study.

3. E874 includes creation and interpretation of post-imaging colour mapping of cerebral perfusion maps for regional cerebral blood flow, cerebral blood volume, and mean blood transit time.

[Commentary:
For example, when a CT perfusion study is only performed in conjunction with a non-contrast CT head scan, the appropriate claim is E874 and the non-contrast CT head service (e.g. X400, X402). In this example, a claim for E874 with a contrast enhanced CT head service (e.g. X401, X405) would not be appropriate.]

	Complex head		
X402	- without IV contrast	-	64.95
X405	- with IV contrast	-	75.85
X408	- with and without IV contrast	-	86.60

Note:
Complex head (see Diagnostic Radiology Preamble, paragraph 9).

	Neck		
X403	- without IV contrast	-	86.60
X404	- with IV contrast	-	97.50
X124	- with and without IV contrast	-	108.30
	Thorax		
X406	- without IV contrast	-	64.95
X407	- with IV contrast	-	75.85
X125	- with and without IV contrast	-	86.60

COMPUTED TOMOGRAPHY (CT)

H	P

Cardio-thoracic

Cardio-thoracic CT is an imaging service of the cardio-thoracic structures including cardiac gating and 3D imaging post-processing, cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts) and requires imaging with contrast material(s) and which may be preceded by imaging without contrast material(s).

X235 Cardio-thoracic ..... - 147.50

Payment rules:

1. X235 includes performance or supervision of the following activities when clinicallyindicated:

- **i.** Administration of chronotropic medications (intravenous (IV) or oral beta blockers, calcium channel blockers, ivabradine, etc.)
- **ii.** Venipuncture, IV insertion, and medication injection

2. X235 is *only eligible for payment* when the service is performed using a minimum of a 64-slice CT scanner.

3. X235 is *only eligible for payment* when one or more of the following indications or clinical presentations are present:

- **i.** arterial and venous aneurysms;
- **ii.** traumatic injuries of arteries and veins;
- **iii.** arterial dissection and intramural hematoma;
- **iv.** arterial thromboembolism;
- **v.** vascular congenital anomalies and variants;
- **vi.** percutaneous and surgical, vascular interventions;
- **vii.** vascular infection, vasculitis, and collagen vascular disease;
- **viii.** sequelae of ischemic coronary disease (i.e. myocardial scarring, ventricular aneurysms, thrombi);
- **ix.** cardiac tumours and thrombi;
- **x.** pericardial diseases;
- **xi.** cardiac function evaluation, especially when Magnetic Resonance Imaging (MRI) or echocardiography are unsuitable
- **xii.** a clinically stable symptomatic patient with low to intermediate probability of obstructive coronary disease;
- **xiii.** a clinically stable symptomatic patient who has planned surgery for valvular or structural heart disease;
- **xiv.** a patient has low to intermediate probability of stent stenosis where the stent has a diameter > 3mm; or
- **xv.** a patient with suspected congenital coronary artery anomalies that are clinically relevant.

4. X417, X406, X407, and X125 are *not eligible for payment* with X235.

5. X235 includes all elements required to perform the study, including additional CT acquisition sequencing and/or post-processing, two or three dimensional reconstruction(s), and administration of contrast.

6. X235 is *not eligible for payment* solely for coronary artery calcium scoring.

COMPUTED TOMOGRAPHY (CT)

H P

7. X235 is *not eligible for payment* for routine screening or risk stratification in asymptomatic patients.

Medical record requirements:
X235 is *only eligible for payment* when the patient's permanent medical record includes all of the following:

1. An interpretation must be provided by a physician who meets the minimum training standards of the American College of Radiology or American College of Cardiology for cardiac CT imaging.
2. A detailed relevant patient history and demographics must be documented to support the scan protocol selection
3. A diagnosis of the entire field of view must be provided (lymph nodes, pleura, lungs, mediastinum, airways, bony thorax, spine, heart, arteries, veins, and related anatomy.
4. When appropriate, a quantitative evaluation of coronary artery calcium scoring for risk stratification must be documented.

COMPUTED TOMOGRAPHY (CT)

H	P

[Commentary:

1. For services where the heart vasculature and structures are not being visualized for the indications above, CT thorax (X406, X407 and/or X125) may be payable instead of X235.

2. The maintenance of radiation dose should be consistent with the As Low As Responsibly Achievable principle and current standards under the direction of the radiologist Radiation Protection Officer.

3. Ontario Clinical Guidance on Patient Selection and Prioritization for Coronary Computed Tomography Angiography can be found at https://www.corhealthontario.ca/Provincial-Clinical-Guidance-on-CCTA_Final.pdf]

Abdomen

X409	- without IV contrast	-	86.60
X410	- with IV contrast	-	97.50
X126	- with and without IV contrast	-	108.30

Pelvis

X231	- without IV contrast	-	86.60
X232	- with IV contrast	-	97.50
X233	- with and without IV contrast	-	108.30
X234	CT colonography	-	235.30

Note:

1. X234 includes all elements required to perform the study, including additional CT acquisition sequencing and/or post processing, two or three dimensional reconstruction(s), administration of contrast, and faecal tagging, if rendered.

2. X417, X409, X410, X126, X231, X232, X233 are *not eligible for payment* with X234.

Payment rules:

1. CT colonography is an insured service only in the following circumstances:

a. individuals who are at moderate risk for colorectal cancer based on family history and the patient refuses colonoscopy or where the patient has been advised of the relative risks and benefits of CT colonography and colonoscopy and the patient refuses colonoscopy;

b. for surveillance examination in patients with a history of previous colonic neoplasm, where clinically appropriate;

c. for diagnostic examination in symptomatic patients;

[Commentary:

Examples of relevant symptomatology include unexplained abdominal pain, diarrhea, constipation, gastrointestinal bleeding, anemia, intestinal obstruction, or weight loss.]

d. when rendered for a patient for whom colonoscopy is technically infeasible, has been difficult in the past, or contraindicated;

e. for patients who are at increased risk for complications during endoscopy such as, advanced age, sedation or anti-coagulation therapy, prior incomplete or difficult colonoscopy;

f. when double contrast barium enema services are unavailable or regarded as inadequate for clinical or diagnostic reasons.

COMPUTED TOMOGRAPHY (CT)

H P

2. CT colonography is *only eligible for payment* if:

- **a.** the study is interpreted using standard 2D and 3D rendering consistent with current practice guidelines;
- **b.** the study is performed on a minimum 16-detector CT scanner; and
- **c.** the interpretation is provided by a physician who must meet minimum training standards.

Medical record requirements:

X234 is *only eligible for payment* when the reporting radiologist:

1. documents a detailed relevant patient history and demographics to determine the scan protocol; and

2. provides a diagnosis of the entire detailed field of view including colonic and extra-colonic structures.

[Commentary:

1. CT colonography also refers to and includes “virtual colonoscopy”.

2. The maintenance of radiation dose should be consistent with the As Low As Responsibly Achievable principle and current standards under the direction of the radiologist Radiation Protection Officer.]

COMPUTED TOMOGRAPHY (CT)

		H	P
	Extremities (one or more)		
X412	- without IV contrast	-	43.25
X413	- with IV contrast	-	64.95
X127	- with and without IV contrast	-	75.85
	Spine(s)		
X415	- without IV contrast	-	86.60
X416	- with IV contrast	-	97.50
X128	- with and without IV contrast	-	108.30
X168	CT guidance of biopsy	-	42.50
X417	Three dimensional CT acquisition sequencing, including post-processing (minimum of 60 slices; maximum 1 scan per patient per day)	-	32.70

MISCELLANEOUS EXAMINATIONS

		H	P
X151	Cordotomy, percutaneous	48.40	34.85
X163	Dacrocystogram	29.60	11.60
	Discogram(s)		
X164	- one or more levels	28.95	25.10
X167	Fistula or sinus	21.50	17.55
X169	Laminogram, planigram, tomogram	39.90	12.40
X170	Laryngogram	28.95	23.00
X171	Lymphangiogram	49.00	25.15
X192	Mammary ductography	25.05	11.60
	Mammogram		
	No signs or symptoms		
X172	- unilateral	28.05	21.15
X178	- bilateral	37.15	33.85
	Signs or symptoms		
X184	- unilateral	28.05	21.15
X185	- bilateral	37.15	33.85
E448	- with 3D tomosynthesis, to X172C, X178C, X184C, or X185C	add 50%	

[Commentary:
"Signs or symptoms" pertains to individuals with identified signs or symptoms or follow-up of established disease.
"No Signs or Symptoms" refers to individuals where the sole reason for the request for a mammogram is for an identified risk factor in accordance with clinical practice guidelines]

Payment rules:
X169 and X417 are *not eligible for payment* with X172, X178, X184, or X185.

Claims submission instructions:
Where a patient requires an additional mammogram on the same day using a different mammogram modality, consistent with practice guidelines, submit claims for payment for the additional mammogram using the manual review indicator.

X194	Additional coned views with or without magnification (limit of two per breast) per film	5.95	5.65
X201	Breast biopsy specimen x-ray, per specimen	5.95	5.65
X150	Mechanical evaluation of knee	25.45	17.30
X193	Microradioscopy of the hands	14.50	12.65
X173	Myelogram - spine and/or posterior fossa	34.95	29.80
X190	Pantomography	17.75	7.55
X154	Penis	15.95	5.15
X165	Photographic subtraction	-	11.35
X176	Sialogram	29.80	12.40
X177	Skin thickness measurement	15.60	10.05
X183	Ventriculogram	48.40	37.85

MISCELLANEOUS EXAMINATIONS

		H	P
X166	Examination using portable machine “in home” add to first examination only	-	-

Note:
X166 does not apply to the use of a portable machine in a hospital. Can only be claimed once per day regardless of the number of people x-rayed in the same “*home*” including “nursing *home*”. The facility cost for X166 is listed in the *Schedule* of Facility Costs for *ICHSCs*.

NOT ALLOCATED

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

PREAMBLE

SPECIFIC ELEMENTS

In addition to the *common elements*, Clinical Procedures Associated with Diagnostic Radiological Examinations include the following *specific elements*.

A. Supervising the preparation of and/or preparing the patient for the procedure(s).

B. Performing the procedure(s) including the introduction of any contrast media and carrying out all appropriate recovery room procedures including transfer of the patient to the recovery room, ongoing monitoring and detention during the immediate post-procedure and recovery period.

C. Making arrangements for any related assessments or procedures, including obtaining any specimens from the patient and interpretation of any results where appropriate.

D. Where indicated, making or supervising the making of arrangements for follow-up care, and post-procedure monitoring of the patient's condition, including intervening, until the next insured service.

E. Discussion with, providing any advice and information and prescribing therapy to the patient or the *patient's representative*, whether by telephone or otherwise, on matters related to the service.

F. Providing premises, equipment, supplies and personnel for the specific element

- **a.** For services not identified with prefix # for all elements.
- **b.** For services identified with prefix # for any aspect(s) of A, C, D and E that is(are) performed in a place other than the place in which the procedure is performed.

Radiological services may be claimed in addition. See Diagnostic Radiology for the appropriate fees.

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

ANGIOGRAPHY

		Spec	Anae
	Note: For cardiac catheterization procedures, see the Diagnostic and Therapeutic Procedures section of the *Schedule*.		
	By catheterization - abdominal, thoracic, cervical or cranial		
# J021	- insertion of catheter (including cut down, if necessary) and injection, if given	186.05	6
# J022	- selective catheterization - add to catheter insertion fee (per vessel, to maximum of 4) ....each	92.15	
	Payment rules: J021 and J022 are *not eligible for payment* in addition to cardiac catheterization procedures (Z439 to G288).		
# J014	- selective catheterization for spinal and parathyroid angiography ("Selective" means manipulation of the catheter from the vessel of introduction into a branch tributary, or cardiac chamber with angiogram(s)) - add to catheter insertion fee	58.30	
# J056	- transcatheter fibrinolytic therapy	1027.95	7
	[Commentary: **1.** For Extracranial approach to include balloon catheter techniques see N107 in Neurological Surgical Procedures. **2.** For Carotid-cavernous fistula; extracranial approach to include balloon catheter techniques see N118 in Neurological Surgical Procedures.]		
# J058	Vascular stenting	101.55	6
	Note: J058 claimed same patient same *day* as G298 is payable at nil.		
# J066	Renal angioplasty	773.25	6
	Carotid angiogram		
# J031	- direct puncture	137.75	6
# J025	Transluminal angioplasty including angiography (if anatomy is known), with or without pressure measurements - one or more site(s) or vessel(s)	610.10	6
	Note: **1.** If anatomy unknown at time of procedure, claim J021 and/or J022 at 50%. For simultaneous bilateral punctures and ang*iop*lasties, the amount payable for the second ang*iop*lasty is reduced by 50%. **2.** J021 & J022 may not be claimed with J025 if anatomy is known.		
# J067	Spinal angiography for AV malformation, per vessel, maximum of 12 vessels per side	67.45	6
# J048	Percutaneous trans-hepatic catheter portal venography	476.65	6

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

ANGIOGRAPHY

		Spec	Anae
	Peripheral arteriogram		
# J027	- direct puncture	76.55	6
	Peripheral venogram		
# J026	- direct puncture	108.55	6
# J033	Splenoportogram	196.75	6
# J034	Trans-lumbar aortogram	137.75	6
	Vertebral angiogram		
# J032	- direct puncture or by retrograde brachial injection	170.85	6
	Embolization (e.g. for treatment of haemangioma or renal carcinoma)		
# J040	- first vessel, claim appropriate angiographic procedural and radiological fees plus	185.90	
# J047	- each additional vessel catheterized and occluded per vessel	87.05	
# J023	Intra-arterial infusion of drugs e.g. for control of gastrointestinal haemorrhage - claim appropriate angiographic procedural and radiological fees plus a per diem supervision fee of	52.10	
# J035	Pressure measurements during angiography	52.10	

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

MISCELLANEOUS PROCEDURES

		Spec	Anae
# J001	Arthrogram, tenogram or bursogram	52.10	7

Note:
Biliary duct calculus manipulation etc. (see Z562 listed in Digestive System - Biliary Tract.)

Bronchial brushing

# J024	- unilateral	89.90	6
# J044	- bilateral	135.00	6

Bronchogram

# J002	- unilateral	27.00	6
# J043	- bilateral	40.65	6

Bronchogram with intra-tracheal catheter

# J003	- unilateral	68.00	6
# J042	- bilateral	82.20	6

Carotid or vertebral artery occlusion by detachable balloon

# J050	- percutaneous	297.30	
# J053	Cavernosography	45.35	
# J005	Dacrocystogram	45.40	6

Discogram

# J006	- one disc	105.30	7
# J030	- each additional disc ... add	54.05	

Embolization of spinal arteriovenous malformation

# J049	- percutaneous	670.10	6
# J036	Fistula or sinus injection	29.40	
# J068	Hydrostatic/pneumatic reduction of intussusception	48.30	7
# J008	Hysterosalpingogram	56.70	6
# J004	Intramammary needling for localization under mammographic control	76.75	
# J009	Laryngogram	33.50	

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

MISCELLANEOUS PROCEDURES

		Spec	Anae
	Lymphangiogram		
# J010	- per side	114.90	
# J037	Mammary ductography	76.75	
# J011	Myelogram	101.90	6
# J038	- with supine views requiring removal and re-introduction of spinal needle ... add	23.75	
# J020	- with posterior fossa views ... add	26.05	
# J012	Nephrotomogram	-	6
# J060	Nephrostogram	52.10	
# J045	Percutaneous antegrade pyelogram	215.45	6
# J055	Percutaneous gastrostomy	394.90	
# J061	Percutaneous cecostomy	394.90	
# J062	Percutaneous cholecystostomy	394.90	
# J063	Percutaneous jejunostomy	458.05	
# J046	Percutaneous nephrostomy	394.90	6
# J064	Exchange or replacement of drainage tube	99.90	

Payment rules:

1. J064 is *only eligible for payment* when performed in an interventional radiology suite under fluoroscopic or other imaging guidance.

2. J064 includes any image guidance, when rendered, by any physician. Obtaining and interpreting any images in conjunction with J064 are *not eligible for payment* to any physician.

[Commentary:

J064 includes exchange or replacement of nephrostomy tubes, cholecystectomy tubes, pleural drainage catheters, abscess drainage catheters, and biliary drainage catheters.]

# J041	Percutaneous removal of intravascular and intraureteric foreign bodies	521.05	IC
# J065	Dilation of non-vascular structures	36.15	6
# J059	Non-vascular stenting	179.20	
# J069	Percutaneous focal thermal ablation of solid tumours using CT or ultrasound guidance	790.25	

Payment rules:

1. J069 is *only eligible for payment* for focal thermal ablation of solid tumours in patients meeting clinical criteria consistent with current clinical practice guidelines

2. J069 includes any image guidance, when rendered, by any physician. Obtaining and interpreting any images in conjunction with J069 are *not eligible for payment* to any physician.

CLINICAL PROCEDURES ASSOCIATED WITH DIAGNOSTIC RADIOLOGICAL EXAMINATIONS

MISCELLANEOUS PROCEDURES

			Spec	Anae
	[Commentary: Physicians should consult Ontario Health/Cancer Care Ontario's Focal Tumour Ablation in Ontario: Recommendations Report 2015 or subsequent guidelines to verify clinical indications for J069 https://www.cancercareontario.ca/en/guidelines-advice/types-of-cancer/48981]			
#	J051	Percutaneous spinal cord puncture for syringogram	166.95	6
#	J013	Percutaneous trans-hepatic cholangiogram	185.90	6
#	J057	Transjugular intrahepatic portosystemic shunt (TIPS)	1389.60	7
#	J052	Positive contrast cisternogram	99.90	6
	Z597	Intracavitary/intratumoural injections	159.05	7
#	J039	Renal cyst puncture	215.25	6
#	J018	Sialogram	80.10	6
#	J007	Tomogram	-	7
#	J028	Urethrogram and/or urethrocystogram and/or or intestinal conduit examination, cystogram	52.10	
#	J029	Vasogram	105.80	6

Note:
Intubation of small intestine (see Z540 listed in Digestive System - Intestines (except rectum)).

Embolization Procedures

#	S350	Image-guided transcatheter embolization for active gastrointestinal bleeding	1500.00	6
#	S351	Uterine artery, prostate artery or thoracic duct embolization	700.00	6

Payment rules:

1. S350 and S351 are *only eligible for payment* when performed within an interventional radiology suite.
2. S350 and S351 include all components of the service including, but not limited to:
   - **a.** vascular access
   - **b.** selective catheterization of one or more vessels
   - **c.** embolic agent delivery and embolization
   - **d.** fluoroscopy and all other intraprocedural imaging
3. S350 and S351 are *not eligible for payment* in additional to any other angiography services
4. Obtaining and interpreting any images in conjunction with S350 and S351 are *not eligible for payment* to any physician]

MAGNETIC RESONANCE IMAGING (MRI)

PREAMBLE

SPECIFIC ELEMENTS

In addition to the *common elements*, the *professional component* of MRI procedures includes the following *specific elements*.

For Professional Component P

A. Providing clinical supervision, including approving, modifying and/or intervening in the performance of the procedure where appropriate, and quality control of all elements of the *technical component* of the procedure.

B. Performance of any clinical procedure associated with the diagnostic procedure which is not separately billable (e.g. injections which are an integral part of the study).

C. Where appropriate, post-procedure monitoring, including intervening except where this constitutes a separately billable service.

D. Interpreting the results of the diagnostic procedure.

E. Providing premises for any aspect(s) of A and D that is(are) performed at a place other than the place in which the procedure is performed.

If the physician claiming the fee for the service is personally unable to perform elements A, B and C, these may be delegated to another physician, who must personally perform the service.

Element D must be personally performed by the physician who claims for the service.

OTHER TERMS AND DEFINITIONS

MRI studies of the lumbar spine should not be routinely ordered or rendered for low back pain without suspected or known pathology.

> **[Commentary:**
> Examples of suspected or known pathology include infection, tumour, osteoporosis, ankylosing spondylitis, fracture, inflammatory process, radicular syndrome, and cauda equina syndrome.]

		P
	Head	
X421	- multislice sequence	73.35
E875	- with magnetic resonance spectroscopy and/or fiber tracking, to X421 ... add	19.40
X425	- repeat (another plane, different pulse sequence - to a maximum of 2 repeats)	36.70
E876	- with magnetic resonance spectroscopy and/or fiber tracking, to X425 ... add	9.70

Payment rules:
E875 and E876 are limited to a maximum of one each per patient per day.

	Neck	
X431	- multislice sequence	73.35
X435	- repeat (another plane, different pulse sequence - to a maximum of 3 repeats)	36.70
	Thorax	
X441	- multislice sequence	73.35
X445	- repeat (another plane, different pulse sequence - to a maximum of 3 repeats)	36.70
	Abdomen	
X451	- multislice sequence	73.35
X455	- repeat (another plane, different pulse sequence - to a maximum of 3 repeats)	36.70
X458	- Magnetic resonance elastography (MRE) for quantification of fat and/or iron deposition in the liver	36.70

Payment rules:
X451/X455 are *not eligible for payment* when used as guidance for organ biopsy.

X480	MRI guidance of biopsy or lesion ablation, breast, unilateral	285.00
X481	MRI guidance of biopsy or lesion ablation, internal organ	285.00

Note:
X480 and X481 are *only eligible for payment* when a lesion can only be visualized by MRI or the use of another image guidance modality is not technically feasible.

[Commentary:
1. X487 and/or X499 may be eligible for payment in addition to X480 or X481.
2. Biopsy fee codes specific to the breast or internal organ may be eligible for payment in addition to X480 or X481.]

	Breast - unilateral or bilateral	
X446	- multislice sequence	73.35
X447	- repeat (another plane, different pulse sequence - to a maximum of 3 repeats)	36.70

Payment rules:
1. X446/X447 are *not eligible for payment* when used as guidance for breast biopsy.

2. X441/X445 thorax MRI is *not eligible for payment* same day, same physician as X446/X447.

Note:
Breast MRI is not an insured service for routine screening of an average risk individual.

		P
	Pelvis	
X461	- multislice sequence	73.35
X465	- repeat (another plane, different pulse sequence - to a maximum of 3 repeats)	36.70
	Extremity or joint(s)	
X471	- multislice sequence, one extremity and/or one joint	62.80
X475	- repeat (another plane, different pulse sequence - to a maximum of 3 repeats)	31.45
X488	- multislice sequence, two or more extremities, and/or two or more joints same extremity	108.80
X489	- repeat (another plane, different pulse sequence - to a maximum of 3 repeats)	54.35

Note:

1. X488 and X489 require imaging of two extremities or two or more joints in the same extremity during the same examination at one sitting.
2. X488 and X489 requires separate surface coil, separate imaging sequence, separate filming and separate post-processing for each joint examined.
3. For the purposes of X471, X475, X488 and X489, the following are considered eligible joints: shoulder, elbow, wrist, hip, knee and ankle.

[Commentary:
When weight-bearing x-rays demonstrate osteoarthritis and symptoms are suggestive of osteoarthritis, knee MRI scans are not recommended by the Canadian Orthopaedic Association, the Canadian Arthroplasty Society and the Arthroscopy Association of Canada as this investigation rarely adds useful information to guide diagnosis or treatment.https://choosingwiselycanada.org/orthopaedics/]

	Limited spine (one segment)	
X490	- multislice sequence	59.50
X492	- repeat (another plane, different pulse sequence - maximum of 3 repeats)	29.85
	Intermediate spine (2 adjoining segments)	
X493	- multislice sequence	68.45
X495	- repeat (another plane, different pulse sequence - maximum of 3 repeats)	34.15
	Complex spine (2 or more non-adjoining segments)	
X496	- multislice sequence	101.65
X498	- repeat (another plane, different pulse sequence - maximum of 3 repeats)	50.65
X486	- when cardiac gating is performed (must include application of chest electrodes and ECG interpretation)	add 30%
X487	- when gadolinium is used	add 36.65

		P
X499	Three Dimensional MRI acquisition sequence, including post-processing (minimum of 60 slices; maximum 1 per patient per day)	32.70

MAGNETIC RESONANCE IMAGING (MRI)

NOT ALLOCATED

DIAGNOSTIC ULTRASOUND

PREAMBLE

SPECIFIC ELEMENTS

Diagnostic Ultrasound procedures are divided into a *professional component* listed in the columns headed with a “P”, and a *technical component* listed in the column headed with an "H". The *technical component* of the procedures subject to the conditions stated under "Diagnostic Services Rendered at a Hospital" on page GP11, is *eligible for payment* only if the service is:

a. rendered at a hospital; or

b. rendered at an off-site premise operated by a hospital corporation that has received approval under section 4 of the *Public Hospitals Act*.

In addition to the *common elements*, the components of Diagnostic Ultrasound procedures include the following *specific elements*.

For Professional Component

A. Providing clinical supervision, including approving, modifying and/or intervening in the performance of the procedure where appropriate.

B. Performance of any clinical procedure associated with the diagnostic procedure which is not separately billable.

C. Where appropriate, post-procedure monitoring, including intervening except where this constitutes a separately billable service.

D. Interpreting the results of the diagnostic procedure.

E. Providing premises for any aspect of D that is performed at a place other than the place in which the procedure is performed.

Note:

1. Element D must be personally performed by the physician who claims for the service.

2. If the physician claiming the fee for the service is personally unable to perform elements A, B and C, these may be delegated to another physician.

3. Where the only component provided is interpreting the results of the diagnostic procedure, the *specific elements* A and C listed for the *professional component* are included in the *specific elements* of the technical component.

For Technical Component H

A. Preparing the patient for the procedure.

B. Performing the diagnostic procedure(s).

C. Making arrangements for any appropriate follow-up care.

D. Providing records of the results of the procedure to the interpreting physician.

E. Discussion with, and providing information and advice to, the patient or *patient’s representative*, whether by telephone or otherwise, on matters related to the service.

F. Preparing and transmitting a written, signed and dated interpretative report of the procedure to the referring provider.

G. Providing premises, equipment, supplies and personnel for all *specific elements* of the technical and *professional component*s except for the premises for any aspect of D of the *professional component* that is(are) not performed at the place in which the procedure is performed.

DIAGNOSTIC ULTRASOUND

PREAMBLE

OTHER TERMS AND DEFINITIONS

1. *Professional and technical component*s are claimed separately. Claims for the *technical component* H are submitted using listed fee code with suffix B. Claims for *professional component* are submitted using listed fee code with suffix C. (e.g. J102C)
2. For services rendered outside a hospital setting the only fees billable under the *Health Insurance Act* are listed under the column P (use suffix C). Costs for the *technical component* of these services are only billable under the *Integrated Community Health Services Centres Act, 2023* and are listed in the *Schedule* of Facility Costs.
3. A-Mode - implies a one-dimensional ultrasonic measurement procedure.
4. M-Mode - implies a one-dimensional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo-producing structures.
5. Scan B-Mode - implies a two-dimensional ultrasonic scanning procedure with a two-dimensional display. All ultrasound examinations include a permanent record and interpretative report.
6. If insured diagnostic ultrasound procedures yield abnormal findings or if they would yield information which in the opinion of the interpreting physician would be insufficient governed by the needs of the patient and the requirements of the referring provider or practitioner, the interpreting physician may add further views and claim for them (if listed).
7. All benefits listed apply to unilateral examinations unless otherwise specified. When imaging of only one anatomical area is requested, comparison ultrasound(s) initiated by the interpreting physician or facility are *not eligible for payment*.

[Commentary:
Ultrasound services are not insured when rendered to support in-vitro fertilization services or artificial insemination services. See Regulation 552 section 24(1) paragraph 23 and 29 under the *Act*.]

DIAGNOSTIC ULTRASOUND

HEAD AND NECK

		H	P
	Brain		
J122	- complete, B-mode	47.20	25.85
	Echography - ophthalmic (excluding vascular study)		
J102	- quantitative, A-mode	22.40	28.50
J103	- B-scan immersion	43.95	38.05
J107	- B-scan contact	21.75	18.85
J108	- biometry (Axial length - A-mode)	22.80	19.70
	Face and/or neck		
J105	- excluding vascular study	47.30	23.70

Note:
J105 is *not eligible for payment* when rendered for ultrasound imaging of the sinus(es).

DIAGNOSTIC ULTRASOUND

THORAX, ABDOMEN AND RETROPERITONEUM

		H	P
	Thorax		
J125	Chest masses, pleural effusion - A & B-mode	48.75	37.60
	Note:		
	Heart - Echocardiography - see listings in Diagnostic and Therapeutic Procedures.		
	Abdomen and Retroperitoneum		
	Abdominal scan		
J135	- complete.....	48.75	28.85
J128	- limited study (e.g. gallbladder only, aorta only or follow-up study).....	32.10	17.55

DIAGNOSTIC ULTRASOUND

PREGNANCY

		H	P
	Complete		
J159	- on or after 16 *week*s gestation (maximum one per normal pregnancy)	48.75	33.80
J160	- for high risk pregnancy or complications of pregnancy	48.75	32.25
J166	- multiple gestation, for each additional fetus, to J160 add	41.45	22.10
	Gestational age for Maternal Serum Screening Program		
J157	- before 16 *week*s gestation (maximum one per normal pregnancy)	32.10	17.55
	Limited		
J158	- for high risk pregnancy or complications of pregnancy	32.10	17.55
J167	- fetal Doppler evaluation of middle cerebral artery and/or ductus venosus, to J160 or J158 add	32.10	30.00

Payment rules:
J167 is *only eligible for payment* when rendered by a physician for assessment of:

a. fetal anemia, or

b. intrauterine growth retardation

i. with estimated fetal weight OR abdominal circumference measuring below the 10th percentile, or

ii. >=30 percentile decrease in estimated fetal weight since previous imaging, or

c. in high-risk pregnancies.

J168	- nuchal translucency for Prenatal Genetic Screening (maximum one per pregnancy)	39.00	20.85
J169	- multiple gestation, for each additional fetus, to J168. add	33.15	16.35

Payment rules:
Ultrasound services listed under the headings "Abdomen and Retroperitoneum" or "Pelvis" or "Pregnancy" rendered on the same day to the same patient by any physician as J168 are *not eligible for payment*.

DIAGNOSTIC ULTRASOUND

PELVIS

		H	P
	Pelvis		
J162	- complete*	48.75	26.55
J138	Intracavitary ultrasound* (e.g. transrectal, transvaginal)	48.75	26.50

Note:
*For ovulation induction purposes, the limit is one per cycle. Additional ultrasounds may be claimed as J164.

J165	Transvaginal sonohysterography - may include saline or other intracavitary contrast media except Echovist for demonstration of tubal patency	99.95	33.15
J476	Transvaginal sonohysterography - including Echovist contrast media for demonstration of tubal patency	232.90	30.65

Note:
J138 and J161 rendered in conjunction with J165 are insured services payable at nil.

[Commentary:
See Diagnostic and Therapeutic Procedures section page J46 for Transvaginal sonohysterography, introduction of catheter *with or without* injection or contrast media (G399).]

J163	- limited study - for other than pregnancy	32.10	17.55
	Intracavitary ultrasound		
J161	- limited - for other than pregnancy	32.10	16.25

Note:
1. For residual urine measurement by ultrasound (G900), see Diagnostic and Therapeutic Procedures, section J, Urology.

2. Residual urine measurement by ultrasound (G900) is *not eligible for payment* when rendered with an ultrasound of the pelvis or intracavitary ultrasound.

J164	Follicle monitoring studies	24.40	12.30

[Commentary:
Ultrasound services are not insured when rendered to support in-vitro fertilization services or artificial insemination services. See Regulation 552 section 24(1) paragraph 23 and 29 under the *Act*.]

		H	P
	Transcranial doppler assessment of intracranial circulation		
J189	Transcranial doppler assessment of intracranial circulation ...	-	23.65
J186	- assessment with power mode doppler		32.50
J187	- prolonged study requiring at least 50 minutes.....		32.50
J188	- follow-up study within 4 *week*s of J186 or J187 requiring at least 50 minutes		25.00

Payment rules:

1. J189 is *not eligible for payment* with J186, J187 or J188 same patient same day.

2. Only one of J186, J187 or J188 are payable same patient, same physician, same day.

Extra-cranial vessel assessment - above the aortic arch

Bilateral carotid and/or subclavian and/or vertebral arteries only

J190	- doppler scan or B scan, includes frequency/spectral analysis, if rendered	42.65	17.10
J201	- duplex scan i.e. simultaneous real time, B-mode imaging and frequency/spectral analysis	55.05	24.65

Note:

Only one of J190 or J201 is eligible for payment per patient per day.

Peripheral vessel assessment

(distal to inguinal ligament or axilla), artery and/or vein evaluation per extremity.
Not to be billed routinely with J190.

J193	- doppler scan or B scan, includes frequency/spectral analysis, if rendered, unilateral.....	22.05	14.30
J202	- duplex scan i.e. simultaneous real time, B-mode imaging and frequency/spectral analysis, unilateral	28.50	16.60

Note:

Only one of J193 or J202 is eligible for payment per extremity per patient per day.

Venous assessment

J198	- bilateral - includes assessment of femoral, popliteal and posterior or tibial veins with appropriate functional manoeuvres and permanent record	7.40	9.90

Note:

Not to be claimed during surgery or during patient's post-operative stay in hospital.

Doppler evaluation of organ transplantation

J205	- arterial and/or venous.....	22.05	15.50

VASCULAR SYSTEM

		H	P
	Duplex evaluation of portal hypertension		
J206	- must include doppler interrogation and documentation of superior mesenteric vein, splenic vein, portal veins, hepatic veins and hepatic arteries	22.05	15.50
	Note: Not to be billed unless study specifically requested by referring provider.		
	Duplex assessment of patency obstruction, and flow direction of vascular shunts		
J207	- must include doppler interrogation and documentation of vascular shunts	22.05	14.20
	Note: Not to be billed unless study specifically requested by referring provider.		

VASCULAR LABORATORY FEES

		H	P
	Ankle pressure measurements		
J200	- requires a minimum of 4 segmental pressure recordings and/or pulse volume recordings and/or Doppler recordings - unilateral or bilateral	20.40	21.40
J196	- with exercise and/or quantitative measurements, to J200 ..... add	8.00	10.10

Note:

1. G517 is *not eligible for payment* in addition to J200.

2. This service is *only eligible for payment* when the device used produces a hard copy output.

[Commentary:
For ankle pressure determination and ankle-arm index, see G517 under Cardiovascular Diagnostic & Therapeutic Procedures.]

	Penile pressure recordings		
J197	- two or more pressures	6.85	7.80
	Penile Doppler Evaluation		
J199	- doppler scan	6.85	7.80

Note:
Penile Doppler is only insured for the following indications:

1. priapism;

2. trauma;

3. revascularization;

4. primary erectile dysfunction; or

5. failure of both oral and injectable therapy for erectile dysfunction.

[Commentary:
Penile Doppler performed for other indications is not an insured service.]

	Transcutaneous tissue		
J203	- oxygen tension measurements	24.10	5.50
J204	- when done in addition to Doppler studies	13.20	5.50

DIAGNOSTIC ULTRASOUND

MISCELLANEOUS

		H	P
	Echography for placement of radiation therapy fields		
J180	- scan B-mode	35.15	18.90
	Extremities		
J182	- per limb (excluding vascular study)	25.50	14.95
E447	- two or more large joints imaged on the same limb ..... to J182 add 25%		

Payment rules:
For E447, a “large joint” is defined as any of the following: shoulder, elbow, hip, knee, or ankle.

	Breast		
J127	- scan B-mode (per breast)	23.70	14.30
	Scrotal		
J183	- scan	47.30	25.95

Portable ultrasound

E475	- only eligible for payment when personally rendered by a specialist in diagnostic radiology (33) in an area of a hospital outside of the diagnostic imaging department ..... per unit	-	27.30

Note:
E475 is payable on a per unit basis. Unit means ¼ hour or major part thereof - see General Preamble GP7, GP55 for definitions and time-keeping requirements.

J290	- Spinal sonography	-	30.60

ULTRASONIC GUIDANCE

SPECIFIC ELEMENTS

In addition to the *common elements*, the components of Ultrasonic Guidance include the following *specific elements*.

For Professional Component P

A. Providing clinical supervision and quality control of all elements of the *technical component* of the procedure.

B. Providing ultrasonic guidance for the physician performing the associated procedure.

C. Where appropriate, post-procedure monitoring, including intervening except where this constitutes a separately billable service.

D. Discussion with, and providing information and advice to the patient or *patient's representative*, whether by telephone of otherwise, on matters related to the service.

E. Providing premises for any aspect(s) of A and D that is(are) performed at a place other than the place in which the procedure is performed.

For Technical Component H

A. Preparing the patient for the procedure.

B. Assisting at the performance of the procedure.

C. Making arrangements for follow-up care.

D. Discussion with, and providing information and advice to the patient or *patient's representative*, whether by telephone or otherwise, on matters related to the service.

E. Providing premises, equipment, supplies and personnel for all *specific elements* of the technical and *professional component*s except for the premises for any aspect(s) of A and D of the *professional component* that is(are) not performed at the place in which the procedure is performed.

		H	P
J149	Ultrasonic guidance of biopsy, aspiration, amniocentesis or drainage procedures (one physician only)	47.30	56.45

Note:
J138 and J161 performed during the same visit as J149 is an insured service payable at nil.

J151	Ultrasound compression of groin pseudoaneurysm, per ¼ hour	-	21.45

DIAGNOSTIC ULTRASOUND

NOT ALLOCATED

PULMONARY FUNCTION STUDIES

PREAMBLE

SPECIFIC ELEMENTS

Pulmonary Function diagnostic procedures are divided into a *professional component* listed in the columns headed with a "P", and a *technical component* listed in the columns headed with an "H" or a "T". The *technical component* "H" of the procedures subject to the conditions stated under "Diagnostic Services Rendered at a Hospital" on page GP11, is *eligible for payment* only if the service is:

a. rendered at a hospital; or

b. rendered at an off-site premise operated by a hospital corporation that has received approval under section 4 of the *Public Hospitals Act*.

The *technical component* "T" of the procedure is *eligible for payment* for services rendered in a physician's office or a hospital with the latter subject to the conditions stated under "Diagnostic Services Rendered at a Hospital" and “Payment for Diagnostic and Therapeutic Services Rendered at a Hospital” on page GP11.

In addition to the *common elements*, the components of Pulmonary Function diagnostic procedures include the following *specific elements*.

For Professional Component P

A. Providing clinical supervision, including approving, modifying and/or intervening in the performance of the procedure where appropriate, and quality control of all elements of the *technical component* of the procedure.

B. Performance of any clinical procedure associated with the diagnostic procedure which is not separately billable.

C. Where appropriate, post-procedure monitoring, including intervening except where this constitutes a separately billable service.

D. Interpreting the results of the diagnostic procedure.

E. Providing premises for any aspect(s) of A and D that is(are) performed at a place other than the place in which the procedure is performed.

If the physician claiming the fee for the service is personally unable to perform elements A, B and C, these may be delegated to another physician, who must personally perform the service.

Element D must be personally performed by the physician who claims for the service.

For Technical Component H and T

A. Preparing the patient for the procedure.

B. Performing the diagnostic procedure

C. Making arrangements for any appropriate follow-up care.

D. Providing records of the results of the procedure to the interpreting physician.

E. Discussion with, and providing information and advice to, the patient or *patient’s representative*, whether by telephone or otherwise, on matters related to the service.

F. Preparing and transmitting a written, signed and dated interpretive report of the procedure to the referring provider.

PULMONARY FUNCTION STUDIES

PREAMBLE

G. Providing premises, equipment, supplies and personnel for all *specific elements* of the technical and *professional component*s except for the premises for any aspect(s) of A and D of the *professional component* that is(are) not performed at the place in which the procedure is performed.

PULMONARY FUNCTION STUDIES

PREAMBLE

OTHER TERMS AND DEFINITIONS

1. *Professional and technical component*s are claimed separately. Claims for *technical component* H are submitted using listed fee code with suffix B. Claims for *professional component* P are submitted using listed fee code with suffix C.
2. For services rendered outside a hospital setting (except for J301, J304, J324, and J327) the only fees billable under the *Health Insurance Act* are listed under the column P (use suffix C). Costs for the *technical component* of services rendered in an *ICHSC* are listed in the *Schedule* of Facility Costs.
3. Each of the following tests designated by an individual code number is considered to be specific and requires individual ordering.
4. Exercise assessment (J315, E450, E451, J316) requires a physician to be in attendance at all times.
5. The technical and professional fee components for pulmonary function studies are *not eligible for payment* in the routine preoperative preparation or screening of a patient for non-thoracic surgery unless required for respiratory diagnosis, anaesthetic decision making or optimization of a patient's respiratory disease prior to surgery.

PULMONARY FUNCTION STUDIES

		T	P
	Simple spirometry		
J301	Volume versus Time Study - must include Vital capacity, FEV_1, FEV_1 /FVC, and may include calculation of MMEFR(FEF25-75)	10.85	7.85
J324	- repeat after bronchodilator	3.25	4.20
	Flow volume loop		
J304	Volume versus Flow Study - from which an expiratory limb, and inspiratory limb if indicated, are generated. A flow volume loop may include derivation of FEV_1, VC, V_{50}, V_{25}	21.55	12.85
J327	- repeat after bronchodilator	3.25	7.65

Payment rules:

1. J301 or J324 are *not eligible for payment* same patient same day as J304 or J327.

2. J301, J324, J304 and J327 must represent the best of three recorded test results or the study is *not eligible for payment*.

3. J301 and J324 must be performed with a permanent record including a written interpretation by the physician or the study is *not eligible for payment*.

4. J304 and J327 are *only eligible for payment* for a study that meets all of the following requirements:

- **a.** There is a permanent record that includes a written interpretation by the physician;
- **b.** The permanent record includes constituent graph(s), tracing(s) and measurements with a scale on the tracing or graph of:
  - **i.** at least 5 mm per litre per second for flow; and
  - **ii.** 10 mm per litre for volume.
- **c.** The physician claiming the *professional component* must be able to demonstrate appropriate training in pulmonary function testing interpretation.

[Commentary:

1. J304 and J327 are *not eligible for payment* in the absence of documented physician interpretation. Computer-generated or automated interpretation does not satisfy payment eligibility.

2. Physicians should be prepared to provide to the ministry documentation demonstrating their training on request.]

PULMONARY FUNCTION STUDIES

		H	P
	Functional residual capacity		
J311	- by gas dilution method	16.30	21.00
J307	- by body plethysmography	17.50	21.35
	Note: J311 not to be claimed same patient same day as J307.		
J305	Lung compliance (pressure volume curve of the lung from TLC to FRC)	51.95	48.15
J306	Airways resistance by plethysmography or estimated using oesophageal catheter	16.20	19.20
J303	Extra pulmonary airways resistance by plethysmography	16.20	16.05
J340	Maximum inspiratory and expiratory pressures	2.81	3.81
J310	Carbon monoxide diffusing capacity by single breath method	21.40	21.55
J308	Carbon dioxide ventilatory response	19.90	14.60
	Stage I		
J315	Graded exercise to maximum tolerance (exercise must include continuous heart rate, oximetry and ventilation at rest and at each workload)	62.45	56.45
E450	- J315 plus J301 or J304 before and/or after exercise. add	13.30	8.95
E451	- J315 plus 12 lead E.C.G. done at rest, used for monitoring during the exercise and followed for at least 5 minutes post exercise. add	18.10	27.85
	Stage II		
J316	Repeated steady state graded exercise (must include heart rate, oximetry, ventilation, VO_2, VCO_2, BP, ECG, end tidal and mixed Venous CO_2 at rest, 3 levels of exercise and recovery)	90.00	72.70
J330	Assessment of exercise induced asthma (workload sufficient to achieve heart rate 85% of predicted maximum; performance of J301 or J304 before exercise and 5-10 minutes post exercise)	33.35	27.25
J319	Blood gas analysis - pH, PO_2, PCO_2, bicarbonate and base excess	11.25	-
J318	Arterialized venous blood sample collection (e.g. ear lobe)	3.79	-
J320	A-a oxygen gradient requiring measurement of RQ by sampling mixed expired gas and using alveolar air equation	27.55	12.85
J331	Estimate of shunt (Qs/Qt) breathing pure oxygen	27.55	16.05
J313	Mixed venous PCO_2, by the rebreathing method	11.25	4.70

PULMONARY FUNCTION STUDIES

		H	P
	Oxygen saturation		
J323	- by oximetry at rest, with or without O_2	4.20	-
J332	- by oximetry at rest and exercise, or during sleep with or without O_2	17.60	11.35
J334	- J332 with at least two levels of supplemental O_2	30.55	16.85
J336	- with single blind assessment of exercise on room air and with supplemental oxygen	30.55	16.85

Note:

1. J323 is *not eligible for payment* when rendered with J332, J315, J316, G315, G319, G111, G112, G570, G571, G582, G583, G574, G575 or any overnight sleep study.

2. J332 is *not eligible for payment* when rendered with J315, J316, G315, G319, G111, G112, G570, G571, G582, G583, G574, G575 or any overnight sleep study.

3. J336 is *only eligible for payment* for evaluation of a patient to determine eligibility for funding under the Ontario *Home* Oxygen Program.

4. J336 is not payable in addition to J332 or J334.

5. J301, J304, J324, or J327 are *not eligible for payment* when rendered to a patient who does not have symptoms, signs or an indication supported by current clinical practice guidelines relevant to the individual patient's circumstances.

Medical record requirements:

J323, J332, J334 or J336 are *not eligible for payment* unless a permanent record of the study is maintained.

J322	Standard O_2 consumption and CO_2 production	5.30	6.45
J333	Non-specific bronchial provocative test (histamine, methacholine, thermal challenge)	48.25	41.55
J335	Antigen challenge test	51.85	30.95
			Fee
Z459	Arterial puncture for blood gas analysis		10.20

Note:

For *home*/self-care ventilation listing - see Diagnostic and Therapeutic Procedures page J50.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

PREAMBLE

SPECIFIC ELEMENTS

The *specific elements* of some of the services listed in this section are identified at the relevant listing. These services include some that are defined in terms of either an assessment or series of assessments.

The *technical component* "T" of the service if rendered in a hospital is subject to the conditions stated under “Payment for Diagnostic and Therapeutic Services Rendered at a Hospital” on page GP11.

A. Where the services are not identified with prefix #, the *specific elements* are those listed in the General Preamble GP15.

B. Where the services are identified with prefix #, the *specific elements* are those listed in the General Preamble GP15 except for specific element H. In place of H includes providing premises, equipment, supplies and personnel for any aspect(s) of the *specific elements* that is (are) performed in a place other than the place in which the included procedures are performed.

R prefix and Z prefix codes in this section are subject to the provisions found in the Surgical Preamble.

The remaining services in this section of the *Schedule* are either non-invasive diagnostic procedures, invasive diagnostic procedures or therapeutic procedures, the *specific elements* for which are listed below.

Non-Invasive Diagnostic Procedures (other than Laboratory Medicine)

Some non-invasive diagnostic procedures are divided into a *technical component* and a *professional component*. In addition to the *common elements*, the components of non-invasive diagnostic procedures include the following *specific elements*.

For Professional Component

A. Providing clinical supervision, including approving, modifying and/or intervening in the performance of the procedure where appropriate.

B. Performance of any clinical procedure associated with the diagnostic procedure which is not separately billable.

C. Where appropriate, post-procedure monitoring, including intervening except where this constitutes a separately billable service.

D. Interpreting the results of the diagnostic procedure.

E. Providing premises for any aspect(s) of A and D that is(are) performed at a place other than the place in which the procedure is performed.

Note:

1. Element D must be personally performed by the physician who claims for the service.

2. If the physician claiming the fee for the service is personally unable to perform elements A, B and C, these may be delegated to another physician.

3. Where the only component provided is interpreting the results of the diagnostic procedure, the *specific elements* A and C listed for the *professional component* are included in the *specific elements* of the *technical component*.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

PREAMBLE

For Technical Component

A. Preparing the patient for the procedure.

B. Performing the diagnostic procedure(s).

C. Making arrangements for any appropriate follow-up care.

D. Preparing and providing records of the results of the procedure to the interpreting physician.

E. Discussion with, and providing information and advice to, the patient or patient's representative, whether by telephone or otherwise, on matters related to the service.

F. Preparing and transmitting a written, signed and dated interpretative report of the procedure to the referring provider.

G. Providing premises, equipment, supplies and personnel for all *specific elements* of the *technical* and *professional component*s except for the premises for any aspect(s) of A and D of the *professional component* that is(are) not performed at the place in which the procedure is performed.

Where non-invasive diagnostic procedures are not divided into *technical* and *professional component*s, the *specific elements* of services are:

1. for services not identified with prefix #, the combination of the *specific elements* listed for the *professional component* and for the *technical component*.
2. for services identified with prefix #, the combination of the *specific elements* listed for the *professional component* and *specific elements* A through E of the *technical component*.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

PREAMBLE

THERAPEUTIC AND INVASIVE DIAGNOSTIC PROCEDURES

In addition to the *common elements*, the components of these procedures include the following *specific elements*.

A. Supervising the preparation of the patient and preparing the patient for the procedure(s).

B. Performing the procedure(s), by any method, including ongoing monitoring and detention during the immediate post-procedure period.

C. Where appropriate, interpreting the results of the procedure and providing written interpretative report to the referring provider.

D. Making arrangements for any related assessments, procedures or therapy, including obtaining any specimens from the patient and interpretation of any results where appropriate.

E. Where indicated, making or supervising the making of arrangements for follow-up care and post-procedure monitoring of the patient's condition, including intervening, until the next insured service is provided.

F. Discussion with, and providing advice and information, including prescribing therapy to the patient or patient's representative, whether by telephone or otherwise, on matters related to the service.

G. Providing premises, equipment, supplies and personnel for the *specific elements*

1. for services not identified with prefix #, for all elements.

2. for services identified with prefix #, for any aspect(s) of A, B, D, E and F that is (are) performed in a place other than the place in which the procedure is performed.

OTHER TERMS AND DEFINITIONS

Services listed in the Diagnostic and Therapeutic Procedures Section are eligible for payment in addition to a consultation or assessment except where they are specifically listed as included in consultation or assessment services. When a procedure(s) is the sole reason for a visit, add G700, the basic fee-per-visit premium for those procedures marked (+) regardless of the number of procedures carried out during that visit. However, G700 is *not eligible for payment* to a physician in situations where:

1. a consultation or assessment is payable to the same physician for the same patient on the same day; and

2. that physician has a financial interest in the facility where the service is rendered.

Note:

1. G700 is *not eligible for payment* for a service provided in a hospital.

2. G700 is *not eligible for payment* when the service marked with (+) is *not eligible for payment*.

3. G700 is payable at 15% of the listed fee when the service is rendered to a patient who has signed the Ministry's Patient Enrolment and Consent to Release Personal Health Information form and who is enrolled to a physician or group of physicians who are signatories to a Ministry alternate funding plan agreement paying physicians primarily by capitation rather than fee for service, applicable regardless of which physician of the group renders the service to the enrolled patient.

		Fee
G700	Basic fee-per-visit premium for procedures marked(+)	8.80

ALLERGY

		Fee
	Note: If a patient presents for an allergy injection and has an acute infectious condition, albeit of the respiratory system, or some other unrelated condition which would have otherwise required a separate office visit, the physician is entitled to claim the appropriate assessment fee as well as the injection fee. If a patient requires a brief assessment of his allergic condition as well as the allergy injection, the physician should claim the injection and the basic fee, in which case the *specific elements* of the service include those of an assessment (see General Preamble GP15).	
# G185	Drug(s) desensitisation - in a hospital where full cardioresuscitative equipment is readily available because a significant risk of life-threatening anaphylaxis exists. The service must be performed under direct and ongoing physician attendance	184.95
+ G200	Acute desensitisation, e.g. ATS, penicillin	8.65
+ G201	Direct nasal tests, to a maximum of 3 per year ... per test	1.60
	Hyposensitisation	
G202	- each injection	7.15
G212	- when sole reason for visit (including first injection)	12.85
	Payment rules: G202 is limited to a maximum of 2 when an assessment is eligible for payment for the same visit and a maximum of 1 in addition to the injection included in G212 when sole reason for visit.	
G205	Insect venom desensitisation (immunotherapy) - per injection (maximum of 5 per day). In addition to G205, after the initial major assessment only, a minor or partial assessment may be claimed once per day if rendered	13.15
	Ophthalmic tests	
+ G203	- direct, to maximum of 3 per year ... per test	1.60
+ G204	- quantitative	12.40
	Patch test	
G206	- maximum of 90 per patient, per year ... per test	2.39
G198	- for industrial or occupational dermatoses, to a maximum of 125 per patient, per year ... per test	2.39
+ G207	Bronchial provocative testing - per session, to a maximum of 6 per year	14.15
	Provocation testing	
	For foods, food additives and medications, by blinded or open technique, maximum 5 testing sessions per *12 month period*.	
G208	Provocation testing ... per unit	21.90
	Payment rules: **1.** G208 is a time base service. Unit means one hour or major part thereof. **2.** In the event the allergic response is respiratory, only one pulmonary function test is eligible for payment the same day as G208.	

ALLERGY

		Fee
	[Commentary: See General Preamble GP7 for definitions and time keeping requirements.]	
G190	Serial oral or parenteral provocation testing to a food, drug or other substance when the service is rendered in a hospital, when an anaphylactic reaction is considered likely based on a documented history and the service is performed under direct and ongoing physician attendance	184.95
	[Commentary: See G208 for similar services rendered in office.]	

		T	P
	Skin testing		
G209	- technical component, to a maximum of 50 per year ..... per test	0.80	
G197	- professional component, to a maximum of 50 per year ..... per test		0.39

		Fee
	Venom allergy testing	
	Investigations including skin prick test(s), intracutaneous test(s) and any other procedures necessary to establish the role of venom allergy in contributing to a patient's illness(es).	
G199	Venom allergy testing, maximum of 2 per patient per physician per 12 month period	40.00
G195	Local anaesthetic hypersensitivity skin test, maximum of 2 per patient per physician per 12 month period	17.00
G196	Hypersensitivity skin test for validated drugs or agents excluding foods and inhalants, maximum of 3 per patient per physician per 12 month period	17.00
E582	- when testing with penicillin minor determinant mixture outside a hospital setting, to G196..... add	32.20

Physical urticaria challenges - to include at least 3 of the following:

- **a.** assessment of dermographic challenge with 100, 250 or 500 gm needle, measuring immediate and delayed responses,
- **b.** assessment of pressure challenge with 15 lbs. weight recording onset, peak, duration of response - immediate and delayed,
- **c.** assessment of ice cube cold challenges,
- **d.** assessment of cholinergic exercise challenge with use of treadmill or bicycle to target pulse rate greater or equal to 120 per minute and profuse sweating,
- **e.** vibration effect of light and water,
- **f.** histamine or methacholine

G213	Physical urticaria challenges	13.80

ANAESTHESIA

	Fee	Anae

SPECIFIC ELEMENTS

Examination under anaesthesia (EUA) (when sole procedure performed)

A. While this may be performed for diagnostic purposes, the *specific elements* are those for a therapeutic procedure.

B. EUA is payable only if sole procedure performed by examining physician. EUA claimed in conjunction with any other procedure is payable at nil.

C. Claims for EUA submitted without the applicable diagnostic code are payable at nil.

Note:
Despite paragraph b. listed under Basic Units on GP94, no anaesthesia service other than E023C is eligible for payment when rendered in support of Z432.

[Commentary:
Refer to E023C on GP100 for anaesthesia services rendered in support of Z432.]

Z432	EUA with or without intubation, and may include removal of vaginal foreign body	54.10	
Z430	Provision of anaesthetic services for patients undergoing magnetic resonance imaging	-	6

CARDIOVASCULAR

		Fee	Anae
	Vascular cannulation		
Z459	Arterial puncture	10.20	
# G268	Cannulation of artery for pressure measurements including cut down as necessary	31.25	

Note:
G268 is *not eligible for payment* with G249, G259, G261, G176, G177, G178, G288, Z443 or Z440.

# G269	Cannulation of central vein for pressure measurements or for feeding line - not to be billed with right heart catheterization (Z439) or with Swan-Ganz catheter insertion	31.25	
# G270	Intraosseous infusion	23.90	
# G309	Umbilical artery catheterization (including obtaining of blood sample)	45.55	
	Venipuncture		
+ G480	- infant	9.90	
+ G482	- child	7.35	
+ G489	- adolescent or adult	3.54	

Note:
G489 is not insured when rendered for the monitoring of adverse effects resulting from a calorie restricted weight loss program.

+ G483	Therapeutic venisection	9.70	
G282	Umbilical vein catheterization (including obtaining of blood sample)	43.60	
# Z438	Insertion of Swan-Ganz catheter (not included in respiratory or critical care benefits)	162.50	6

Note:
1. Swan-Ganz catheter insertion is included in the anaesthesia basic units of any surgical services where anaesthesia basic units are listed

2. Z438 includes dye dilution densitometry and/or thermal dilution studies, when rendered (except in the setting of a cardiac catheterization laboratory).

[Commentary:
See G285 for dye dilution densitometry and G286 for thermal dilution studies performed using a Swan-Ganz catheter in a cardiac catheterization laboratory.]

# Z456	Insertion of implantable central venous catheter	296.50	6
# Z457	Surgical removal or repair of tunneled central venous catheter	60.00	6
# Z446	Insertion of subcutaneous venous access reservoir	168.00	6
# Z447	- revision same site	130.70	6
# E684	- when performed in infant or child, to Z456 or Z446 ....add	233.65	

CARDIOVASCULAR

	Fee	Anae

FOR ANTICOAGULANT SUPERVISION - LONG-TERM, TELEPHONE ADVICE

In addition to the *common elements*, the components of this service include the following *specific elements*.

A. Monitoring the condition of a patient with respect to anticoagulant therapy, including ordering blood tests, interpreting the results and inquiry into possible complications.

B. Adjusting the dosage of the anticoagulant therapy and, where appropriate, prescribing other therapy.

C. Discussion with, and providing advice and information to the patient or patient's representative, by telephone, on matters related to the service even when initiated by the patient or patient's representative.

D. Making arrangements for any related assessments, procedures or therapy and interpreting results as appropriate.

E. Providing premises, equipment, supplies and personnel for the *specific elements*.

G271	Anticoagulant supervision - long-term, telephone advice ..... per month	13.10	

CARDIOVASCULAR

		Fee	Anae
	BLOOD TRANSFUSIONS		
# G275	Exchange transfusion	205.45	
	Note: Assistant at exchange transfusion (see General Preamble GP85).		
# G280	Intra-uterine fetal transfusion - initial or subsequent	186.90	
G276	Donor cell pheresis (platelets or leukocytes)	15.35	
	Therapeutic plasma exchange		
# G277	- initial and repeat, to a maximum of 5 per year ....each	82.00	
# G278	- more than 5 per year ....each	41.80	
# G272	Manual plasmapheresis (see General Preamble GP12)	I.C	
	LDL apheresis		
# G287	- initial and repeat, to a maximum of 5 per year ....each	82.00	
# G290	- more than 5 per year ....each	41.80	
	Note: LDL apheresis is an insured service only for the treatment of homozygous familial hypercholesterolemia.		
	CARDIOVERSION		
# Z437	Cardioversion (electrical and/or chemical) - maximum of three sessions per patient, per day	92.45	6
	CARDIAC CATHETERIZATION		
	Note: **1.** Cardiac catheterization procedures (Z439 to G288) include insertion of catheter (including cutdown and repair of vessels if rendered), catheter placement, contrast injection, imaging and interpretation. **2.** When more than one procedure is carried out at one sitting, the additional procedures are payable at 50% of the listed benefits. (Z439 to G288, excluding G262 and G263).		
	HAEMODYNAMIC/FLOW/METABOLIC STUDIES		
	Right heart		
# Z439	- pressures only	166.90	6
	Left heart		
# Z440	- retrograde aortic	208.50	7
# Z441	- transeptal	297.15	7
# G296	Dye dilution densitometry and/or thermal dilution studies - benefit covers all studies on same day in cath lab	110.95	
# G285	Dye dilution densitometry when rendered in a cardiac catheter lab using a Swan-Ganz catheter, to Z438 ..... add	32.90	
# G286	Thermal dilution studies when rendered in a cardiac catheter lab using a Swan-Ganz catheter, to Z438 ..... add	32.90	

CARDIOVASCULAR

	Fee	Anae

Note:

1. G296 is *not eligible for payment* on the same patient, same day as Z438.

2. G296, G299 and/or G289 are *not eligible for payment* with anaesthesia services rendered for a surgical procedure.

3. G285 or G286 are *not eligible for payment* on the same patient, same day as G296.

4. G285 is limited to a maximum of three services per Swann-Ganz insertion.

#	G299	Oximetry studies by catheterization	110.95
#	G289	Fick determination	110.95
#	G300	Metabolic studies, e.g. coronary sinus lactate and pyruvate determinations	110.95
#	G293	Exercise studies during cardiac catheterization	200.00
#	G306	Isotope studies during cardiac catheterization	110.95
#	G305	Intracardiac phonocardiography	122.40

CARDIOVASCULAR

		Fee	Anae
	ANGIOGRAPHY		
# G297	Angiograms (only two angiograms may be billed - one per right heart catheterization and one per left heart catheterization) irrespective of the number of chambers injected.....	117.55	
	Bypass graft angiogram		
# G509	- maximum one per bypass graft.....	80.40	
	Note: Includes internal mammary artery implant.		
	Selective coronary catheterization		
# Z442	- both arteries	286.75	6
# G263	- with other drug interventional studies ..... add	96.45	
	Note: Includes injection of intracoronary nitroglycerin.		
	Transluminal coronary angioplasty		
# Z434	- one or more sites on a single major vessel.....	467.05	6
G262	- each additional major vessel..... add	210.40	
	Note: If anatomy unknown at time of procedure, claim G297 at 50%.		
# G298	Coronary angioplasty stent, per stent.....	78.95	
	Note: J058 claimed same patient same day as G298 is payable at nil.		
	Percutaneous angioplasty		
# Z448	- aortic valve, pulmonic valve, pulmonary branch stenosis ..	487.90	20
# Z449	- for coarctation of aorta	415.15	20
# Z460	- closure of patent ductus arteriosis with umbrella	377.55	20
# Z461	- mitral valvuloplasty for rheumatic stenosis.....	566.20	
	Note: Z448 to Z461 includes angiography *with or without* pressure measurements.		

CARDIOVASCULAR

		Fee	Anae

ELECTROPHYSIOLOGY/ARRHYTHMIAS

# G249	Electrophysiologic measurements (includes one or all of sinus node recovery times, HIS bundle measurements, conduction times and/or refractory periods), includes percutaneous access and insertion of electrodes	231.65	

Arrhythmia induction

To include programmed electrical stimulation, drug provocation and termination of arrhythmia, if necessary - once per patient per 24 hours.

# G261	- atrial.....	331.05	
# G259	- ventricular.....	383.30	

Note:
G261and/or G259 are *not eligible for payment* with G521, G522, G523, G395 and G391.

Electrophysiologic Pacing, Mapping and Ablation

Includes percutaneous access, insertion of catheters and electrodes, electrocardiograms, intracardiac echocardiograms and image guidance when rendered.

# G176	- atrial pacing and mapping	334.25	
# G177	- ventricular pacing and mapping	416.80	
# Z423	- with the use of an advanced nonfluoroscopic computerized mapping and navigation system ("advanced mapping system") and/or procedure duration >4 hours	690.25	10

Note:
Z423 is *only eligible for payment* when rendered with G176 or G177.

[Commentary:
1. As of October 2009, the advanced mapping system is typically used in hospital for the mapping of the following arrhythmias:

Arrhythmias	Description
Atrial arrhythmia	Atrial fibrillation Atypical atrial flutter Post-surgical atrial flutter Atrial tachycardia Redo typical atrial flutter Redo reentrant tachycardia (accessory pathways, AV nodal reentry)
Ventricular arrhythmia	Ischemic ventricular tachycardia/premature ventricular ectopics Non-ischemic ventricular tachycardia/premature ventricular ectopics Idiopathic ventricular tachycardia/premature ventricular ectopics (e.g. fascicular, ARVD, bundle branch reentry, aortic cusp, outflow tract, etc.)
Other	Congenital heart disease arrhythmia

2. Examples of procedures lasting more than 4 hours and not utilizing the advanced mapping system are mapping and ablation of multiple accessory pathways and/or thick band accessory pathway(s).]

		Fee	Anae
	Electrophysiologic pacing, mapping and ablation		
# G178	- catheter ablation therapy	352.05	
# G179	- repeat pacing, mapping and catheter ablation for additional distinct arrhythmia(s) without the use of an advanced mapping system	111.20	

Note:
G179 is *not eligible for payment* with Z423.

# Z424	- transseptal left heart catheterization, with or without pressure measurements, with or without dye injection	297.15	6

Note:
1. Z424 is *only eligible for payment* when rendered with G176, G177 and/or G178.

2. Z424 is eligible for payment for each transseptal catheter placement to a maximum of 2.

# Z422	- retrograde aortic left heart catheterization with or without pressure measurement(s)	210.55	6

Note:
1. Z422 is *only eligible for payment* when rendered with G176, G177 and/or G178.

2. Z422 is limited to a maximum of one per electrophysiological pacing, mapping and/or ablation sitting.

G115	External cardiac pacing (temporary transthoracic) once per 24-hour period	46.30	

Note:
G115 is *not eligible for payment* with G521, G522, G523, G395 and G391.

# G366	Testing of arrhythmia inducibility by acute administration of anti-arrhythmic or adrenergic drugs to a maximum of 2 per 24 hours	148.50	

Note:
G366 is *not eligible for payment* for the use of isoproterenol for arrhythmia induction when rendered with G261 and/or G259.

# Z443	Insertion of temporary endocardial electrode	154.10	6
# Z431	Repositioning of temporary endocardial electrode	64.25	6
	Endomyocardial Biopsy		
# G288	- transvascular, right or left	200.00	
	Tilt table testing of vasomotor syncope		
# G314	- to include arterial cannulation, provocative and blocking drugs, physician must be continually present	112.00	

ELECTROCARDIOGRAPHY (ECG)

Fee

PREAMBLE

1. The *technical* and *professional* fee components for electrocardiogram, G310 and G313, are *not eligible for payment* in the routine preoperative preparation or screening of a patient for non-cardiac surgery unless the patient has at least one risk factor for cardiac disease or has known or suspected cardiorespiratory disease including dysrhythmias, unless there is a clinical indication requiring an ECG other than solely for preoperative preparation of the patient.

[Commentary:

1. Risk factors *may include* but are not limited to:
hypertension, diabetes, vascular disease, renal disease, hyperlipidemia, smoking history, older age.

2. ECG testing is not indicated prior to low risk surgery under local anaesthetic *with or without* procedural sedation such as cataract surgery unless there is an independent clinical indication unrelated to the surgery.]

G175	Insertion of oesophageal electrode in monitoring position.....		21.85
		T	**P**
	Electrocardiogram - twelve lead		
G310	- technical component	7.70	
G313	- professional component - must include written interpretation		4.55

Note:
G310 and G313 are *not eligible for payment* when rendered to a patient who does not have symptoms, signs or an indication supported by current clinical practice guidelines relevant to the individual patient's circumstances.

ELECTROCARDIOGRAPHY (ECG)

		T	P

STRESS TESTING

Maximal stress ECG

Maximal stress ECG (exhaustion, symptoms or ECG changes) or submaximal stress ECG (to target heart rate for patient) by a standard technique - with treadmill or ergometer and oscilloscopic continuous monitoring including ECGs taken during the procedure and resting ECGs before and after the procedure - physician must be in attendance at all times. The *professional component* includes the necessary clinical assessment immediately prior to testing.

G315	- technical component	50.55	
G319	- professional component		62.05

Dobutamine stress test

G174	- technical component, when rendered outside of hospital ..... add	54.25	

Dipyramidole Thallium stress test

G111	- technical component	58.95	
G112	- professional component		74.25

Note:

1. The *technical* and *professional* fee components for maximal stress ECG are *not eligible for payment* in the routine preoperative preparation or screening of a patient for surgery where the patient will undergo a low risk procedure or has a low risk of perioperative cardiac complications, unless there is a clinical indication requiring a exercise stress test study other than solely for preoperative preparation of the patient.

2. G315, G319, G174, G111 and G112 are *uninsured service*s for routine annual stress tests in asymptomatic patients where the patient's 10 year risk of coronary heart disease is less than 10% calculated by generally accepted methodology.

[Commentary:

An example of a generally accepted methodology for determining 10 year risk of coronary heart disease is the Framingham Risk Score.

1. Studies have indicated that for non cardiac surgery, there may be no clinical benefit and there may be harm in performing functional cardiac testing in patients with low operative risk and little or limited benefit in moderate risk patients. BMJ 2010, Jan 28; 340.

2. One example of a generally accepted guideline is the American College of Cardiology (ACC)/ American Heart Association (AHA) Guidelines that states:

- **a.** Non invasive testing could be considered in patients with 1 to 2 risk factors and poor functional capacity (less than 4 mets) who require intermediate risk surgery if it will change management (class IIb)
- **b.** Non invasive testing has not been show to be useful in patients with no clinical risk factors undergoing intermediate risk non cardiac surgery (class III).
- **c.** Non invasive testing has not been shown to useful in patients undergoing low risk non cardiac surgery (class III).]

ELECTROCARDIOGRAPHY (ECG)

CONTINUOUS ECG MONITORING (E.G. HOLTER)

Level 1

Requires a device capable of recording three or more simultaneous channels and the acquisition of a continuous ambulatory electrocardiographic recording of all beats, using three or more skin electrodes. The device must also have the ability to analyze and manually review all parts of the recording, and to produce graphical and quantitative reports of relevant parameters and diagnostic quality tracings for visual review, including post-hoc review of any portion of the recording to enable diagnostic rhythm analysis. Must include a patient diary and event marker capability to enable symptom-rhythm correlation. Minimum 12 hours of monitoring.

		T	P
G651	- technical component - 12 to 35 hours recording	27.75	
G652	- technical component - 12 to 35 hours scanning	38.00	
G650	- professional component - 12 to 35 hours recording		47.90
G682	- technical component - 36 to 59 hours recording	55.55	
G683	- technical component - 36 to 59 hours scanning	75.95	
G658	- professional component - 36 to 59 hours recording		75.45
G684	- technical component - 60 hours to 13 days recording	83.25	
G685	- technical component - 60 hours to 13 days scanning	113.90	
G659	- professional component - 60 hours to 13 days recording		95.85
G647	- technical component - 14 or more days recording	130.85	
G648	- technical component - 14 or more days scanning	190.45	
G649	- professional component - 14 or more days recording		122.25

Level 2

All other monitoring devices with fewer than three skin electrodes, or that record only portions of the monitoring period or do not provide trend analysis. Minimum 12 hours monitoring.

		T	P
G654	- technical component - 12 to 35 hours recording	26.45	
G655	- technical component - 12 to 35 hours scanning	18.10	
G653	- professional component - 12 to 35 hours recording		34.10
G686	- technical component - 36 to 59 hours recording	52.95	
G687	- technical component - 36 to 59 hours scanning	36.25	
G656	- professional component - 36 to 59 hours recording		51.15
G688	- technical component - 60 hours to 13 days recording	79.40	
G689	- technical component - 60 hours to 13 days scanning	54.40	
G657	- professional component - 60 hours to 13 days recording		68.20
G694	- technical component – 14 or more days recording	124.30	
G695	- technical component – 14 or more days scanning	91.45	
G696	- professional component – 14 or more days recording		86.80

Note:

1. Maximum one *professional component*, one technical recording component and one technical scanning component per patient, per recording.

ELECTROCARDIOGRAPHY (ECG)

T	P

2. Where the duration of the service is more than 36 hours, claims for such services must be submitted using the appropriate listed code for that time duration and cannot be submitted using multiples of lesser time duration codes.
3. G647, G648, G649, G694, G695 and G696 are *only eligible for payment* once per 30 day period per patient.
4. Services related to external cardiac loop recording devices that rely solely on patient activation to record electrocardiographic data and do not have the capability of real-time rhythm analysis are not insured.

Medical record requirements:

In order to demonstrate that payment requirements have been met, all test reports that form part of the patient record under this section must include the following information: the number of channels recorded, whether the recording was continuous, whether it was analyzed in real time, post-hoc or both and other information, such as, the name of the manufacturer and the model of the device(s) used in the performance of the test.

ELECTROCARDIOGRAPHY (ECG)

		T	P
	Interpretation of telephone transmitted ECG rhythm strip		
G311	- technical component	2.25	
G320	- professional component		4.30
	Single chamber reprogramming including electrocardiography		
G284	- technical component	10.25	
G283	- professional component		11.30
	Dual chamber reprogramming including electrocardiography		
G181	- technical component	13.40	
G180	- professional component		16.95
	Pacemaker pulse wave analysis including electrocardiography		
G308	- technical component	10.25	
G307	- professional component		9.55
	Automatic implantable defibrillator		
	Non-programmable including electrocardiography, interrogation and analysis		
G317	- professional component		27.80
	Programmable including electrocardiography, interrogation and reprogramming		
G321	- professional component		47.65

NON-INVASIVE CARDIOGRAPHY

		Fee
	BLOOD FLOW STUDY (DOPPLER OR OTHER) - UNILATERAL OR BILATERAL	
G517	Ankle pressure determination, includes calculation of the ankle-arm index systolic pressure ratio	10.05

Note:

1. G517 is *not eligible for payment* when rendered during surgery or during the patient's post-operative stay in hospital.

2. G517 is *not eligible for payment* in conjunction with J200.

		T	P
	Phlebography and/or carotid pulse tracing (with systolic time intervals)		
G519	- technical component	12.00	
G518	- professional component		11.20
	Impedance plethysmography		
G121	- technical component	14.55	
G120	- professional component		7.00
	Digital photoplethysmography		
G127	- technical component, per extremity	14.55	
G126	- professional component, per extremity		7.00

ECHOCARDIOGRAPHY

[Commentary:
Paragraphs 1-3 of this preamble do not apply to echocardiography services rendered to patients 17 years of age or younger, fetal echocardiography services, or to perioperative transoesophageal echocardiography (TEE) rendered to patients immediately before, during, or immediately after surgery, including the intensive care (ICU) setting.]

PREAMBLE

1. Echocardiography services are *only eligible for payment* when the service is rendered at a facility that has been issued a certificate of accreditation or received a letter of provisional recognition by an organization approved by the *MOH* to grant echocardiography accreditation.

   [Commentary:

   1. Accreditation Canada Diagnostics has been approved by the *MOH* to grant echocardiography accreditation.
   2. A list of accredited facilities can be found at https://diagnostics.accreditation.ca/Assessment-Programs/EQI-Program]

2. Echocardiography services are *only eligible for payment* if the physician performing the service establishes he/she:

   a. has Level III (advanced) echocardiography training; or

   b. has Level II (basic prerequisites for independent competence in echocardiography); or

   c. documented performance in an established laboratory, with interpretation of at least 400 Echo/Doppler studies per year for the preceding 3 years and at least 24 hours of accredited CME activities relevant to echocardiography over a period of two years for the preceding 3 years.

3. Echocardiography services are *only eligible for payment* if the service is rendered for an indication described in the document titled Standards for Provision of Echocardiography in Ontario found at https://www.corhealthontario.ca/resources-for-healthcare-planners-&-providers/eqi/standards and that was in place on the date the service was rendered.

   Note:
   Documentation of requirements 2a-c must be made available to the *MOH* on request.

4. Echocardiography services include cardiac monitoring and/or oximetry when rendered.

5. The technical and professional fee components for echocardiography are *not eligible for payment* in the routine preoperative preparation or screening of a patient for surgery, unless there is a clinical indication requiring an echocardiogram other than solely for preoperative preparation of the patient.

   [Commentary:
   Patients should only be considered for preoperative testing if the results of the test will change their management.]

ECHOCARDIOGRAPHY

T	P

Complete Study - 1 and 2 dimensions

Definition/Required elements of service:

A Complete Study – 1 and 2 dimensions is an echocardiogram that must include as a minimum all of the following components: acquisition, recording and storage of ultrasound images relevant to the assessment of all components of cardiac structure and function including chambers, valves, septae, pericardium and proximal great vessels. Also included when rendered is a Cardiac Doppler Study (*with or without* colour Doppler).

Note:
Where one or more components of cardiac structure and function cannot be imaged due to circumstances beyond the physician's control the echocardiogram is payable as a complete echocardiogram.

[Commentary:
If a single component of cardiac structure and function is imaged see G574/G575.]

G570	- technical component	130.80	
G571	- professional component		96.20

Medical record requirements:
G570 and G571 are *only eligible for payment* for an echocardiogram when:

1. The required components and findings of a complete study are documented;
2. There is a permanent recording on appropriate dynamic medium, either videotape or digitally, of the constituent images and measurements; and
3. If applicable, a description of the circumstance beyond the physician's control leading to one or more components of the echocardiogram not being rendered.

Stress Study

Definition/Required elements of service:

A stress echocardiography study includes the following required elements:

1. Initial baseline study of all components of cardiac structure and function including chambers, valves and septae and *may include* a Cardiac Doppler Study (*with or without* colour Doppler);
2. Stress images which *may include* various stages of stress and must include relevant peak or immediate post stress images relevant to the patient's clinical and diagnostic findings; and
3. A simultaneous comparison of all left ventricular wall segments and global function obtained from pre-stress and stress images.

[Commentary:
Stress images may be obtained when the stress is induced by exercise, pharmacologic agents or pacing.]

G582	- technical component	148.50	
G583	- professional component		110.15

Payment rules:
G570, G571, G574 or G575 are *not eligible for payment* with G582 or G583.

ECHOCARDIOGRAPHY

T | P

Medical record requirements:
G582 and G583 are *only eligible for payment* for an echocardiogram when:

1. The required components of the study and any findings from the simultaneous comparison of pre-stress and stress images are documented in the echocardiogram report; and
2. There is a permanent recording acquired with a high frame rate and includes the time from cessation of exercise on appropriate dynamic medium, either videotape or digitally, of the constituent images and measurements.

ECHOCARDIOGRAPHY

T P

Focused Study - not to be claimed in conjunction with pregnancy study

Definition/Required elements of service:

An examination limited to a single component of the cardiac assessment.

[Commentary:
Examples where a focused study may apply are:
1. Emergency assessment to guide immediate patient management.
2. Follow up within 2 *week*s of a complete study to re-evaluate a specific finding or question.]

G574 - technical component 18.65
G575 - professional component 13.95

Medical record requirements:
G574 and G575 are *only eligible for payment* for a focused echocardiography study when:

1. The component of the cardiac assessment and findings are documented; and
2. There is a permanent recording on appropriate dynamic medium, either videotape or digitally, of the constituent images and measurements.

Echocardiography contrast

G585 - technical component, with use of contrast agent, to G570 or G582..... add 147.25

Payment rules:
1. G585 is *only eligible for payment* with a complete study or stress study in difficult-to-image patients where:
- **a.** two or more contiguous segments are not seen on a recent non-contrast echocardiogram images;
- **b.** the contrast agent is bubble-based with a diameter 5 microns or less, with resonance frequencies in the diagnostic ultrasound range and the contrast agent is able to cross the pulmonary circulation; and
- **c.** *professional component* G571 or G583 is eligible for payment for the same echocardiography study.

2. G585 is *only eligible for payment* if the physician performing the service establishes he/she:
- **a.** has Level III (advanced) echocardiography training, with experience in administering and interpretation of contrast echocardiography; or
- **b.** has Level II (basic prerequisites for independent competence in echocardiography) training, plus additional training in contrast echocardiography to learn the appropriate techniques for administering contrast agents and interpreting contrast-enhanced echocardiograms.
- **c.** Started practice prior to January 1, 1990 and:
  - **i.** was trained to applicable echocardiography standards at the time of starting practice;
  - **ii.** has rendered and been paid for echocardiography services regularly since January 1, 1990;
  - **iii.** has rendered and been paid for at least 1800 echocardiograms in total in the 36 *month*s prior to September 1, 2011; and

ECHOCARDIOGRAPHY

T	P

iv. has additional training in contrast echocardiography to learn the appropriate techniques for administering contrast agents and interpreting contrast-enhanced echocardiograms.

Note:
Documentation of requirements 2a-c must be made available to the ministry on request.

[Commentary:
Additional training in contrast echocardiography can be obtained through courses, tutorials and preceptorships as examples.]

Medical record requirements:
G585 is *not eligible for payment* unless a permanent record of study images and loops is maintained on an appropriate dynamic medium, either videotape or digitally.

Transoesophageal echocardiography

G581	- professional component	25.00

ECHOCARDIOGRAPHY

		Fee
G579	Saline study (including venipuncture, to G571, G574 or G581 ..... add	11.35
G580	Insertion of oesophageal transducer	45.00

Note:
Peripheral Arterial and Venous Systems - see listings under Diagnostic Ultrasound.

[Commentary:
The Provision of Echocardiography in Canada guidelines of the Canadian Cardiovascular Society and the Canadian Society of Echocardiography can be found at the following link:
https://ccs.ca/wp-content/uploads/2020/12/Echo_STDP_2004.pdf

CRITICAL CARE

Fee

LIFE THREATENING CRITICAL CARE

The service rendered when a physician provides critical care to a critically ill or critically injured patient. For the purpose of this service, a critical illness or critical injury is one that acutely impairs one or more vital organ system(s) causing vital organ system failure as a result of which imminent life threatening deterioration in the patient's condition is highly probable.

[Commentary:
Examples of vital organ system failure include but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic and or respiratory failure.]

Amount payable per physician per patient for the first three physicians:

G521	- first ¼ hour (or part thereof)	125.10
G523	- second ¼ hour (or part thereof).....	64.50
G522	- after first ½ hour, per ¼ hour (or part thereof)	42.50
G391	Amount payable per physician per patient for the fourth and subsequent physicians (per ¼ hour or part thereof).....	34.35

The following services are *not eligible for payment* when rendered to the same patient by the same physician on the same day as any code described as "life threatening critical care":

1. Assessment and ongoing monitoring of the patient's condition.

2. Intravenous lines.

3. Cutdowns.

4. Arterial and/or venous catheters.

5. Central venous pressure (CVP) lines.

6. Endotracheal intubation.

7. Tracheal toilet.

8. Blood gases.

9. Nasogastric intubation with/without anaesthesia with/without lavage.

10. Urinary catheters.

11. Pressure infusion sets and pharmacological agents.

12. Defibrillation.

13. Cardioversion.

Payment rules:

1. The time unit is measured as the physician time spent fully devoted to the care of the patient and excludes time spent on separately billable interventions on the patient receiving the "life threatening critical care". The service is *only eligible for payment* for services rendered by the physician at the bedside or in the emergency department or on the hospital floor where the patient is located. Time unit total *may include* time which is consecutive or non-consecutive.

2. During the time reported for which any of these codes is claimed, the physician cannot provide services to other patients.

3. "Life threatening critical care" is *not eligible for payment* for the services of a physician rendered to the same patient on the same day for which the physician is paid a per diem fee for Critical Care (intensive care area), Ventilatory Support, Comprehensive Care or Neonatal Intensive Care.

4. Consultation or assessments rendered before or after provision of "life threatening critical care" may be eligible for payment on a fee-for-service basis but not when claiming Critical Care (intensive care area), Ventilatory Support, Comprehensive Care or Neonatal Intensive Care per diem fees.

5. G521, G522, G523, or G391 are *not eligible for payment* with A384 or K181.

Medical record requirements:
The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

[Commentary:
Time unit total *may include* time which is consecutive or non-consecutive.]

CRITICAL CARE

Fee

OTHER CRITICAL CARE

The service rendered when a physician provides resuscitation assessment and procedures in an emergency in circumstances other than those described as "life threatening critical care", where there is a potential threat to life or limb of such a type that without resuscitation efforts by the physician, there is a high probability the patient will suffer loss of limb or require "life threatening critical care".

Amount payable per physician per patient for the first three physicians:

G395	- first ¼ hour (or part thereof)	64.70
G391	- after first ¼ hour per ¼ hour (or part thereof).....	34.35

The following services are *not eligible for payment* when rendered to the same patient by the same physician on the same day as any code described as "other critical care":

1. Assessment and ongoing monitoring of the patient's condition.
2. Intravenous lines.
3. Cutdowns.
4. Arterial and/or venous catheters.
5. Central venous pressure (CVP) lines.
6. Endotracheal intubation.
7. Tracheal toilet.
8. Blood gases.
9. Nasogastric intubation with/without anaesthesia with/without lavage.
10. Urinary catheters.
11. Pressure infusion sets and pharmacological agents.

Payment rules:

1. G395 is *not eligible for payment* with G521, G522 or G523 for services rendered to the same patient by the same physician on the same day.
2. The time unit is measured as the physician time spent fully devoted to the care of the patient and excludes time spent on separately billable interventions on the patient receiving "other critical care". The service is *only eligible for payment* for services rendered by the physician at the bedside or in the emergency department or on the hospital floor where the patient is located. Time units *may include* time which is consecutive or non-consecutive.
3. During the time reported for which any of these codes is claimed, the physician cannot provide services to other patients.
4. "Other critical care" is *not eligible for payment* for the services of a physician rendered to the same patient on the same day for which the physician is paid a per diem fee for Critical Care (intensive care area), Ventilatory Support, Comprehensive Care or Neonatal Intensive Care.
5. Consultation or assessments rendered before or after provision of "other critical care" may be eligible for payment on a fee-for-service basis but not when claiming Critical Care (intensive care area), Ventilatory Support, Comprehensive Care or Neonatal Intensive Care per diem fees.

CRITICAL CARE

Fee

Medical record requirements:
The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

[Commentary:
Time unit total *may include* time which is consecutive or non-consecutive.]

[Commentary:
Life threatening critical care and other critical care
The duration of "life threatening critical care" and "other critical care" services that physicians should document is the time they actually spend evaluating, managing, and providing care to the critically ill or injured patient to the exclusion of all other work.

For example, time spent reviewing laboratory test results or discussing the critically ill patient's care with other medical staff in the unit or at the nursing station on the floor would be included in the definition of critical care, even when it does not occur at the bedside, if this time represents their full attention to the management of the critically ill/injured patient.

Time spent involved in activities in any location other than the bedside, emergency department or hospital floor where the patient is located cannot be claimed as the physician is not immediately available to the patient.

Submit claims manually when the total time spent in providing "life threatening critical care" or "other critical care" is greater than two (2) hours.]

G303	Transthoracic pacemaker - insertion	51.25
G211	Endotracheal intubation for resuscitation (not to be claimed when followed by a surgical procedure at which time it is included in the anaesthetic procedure)	38.35

CRITICAL CARE

CRITICAL CARE PER DIEM LISTINGS

A. The fees under physician-in-charge (the physician(s) daily providing the critical care services) apply per patient treated, i.e. while the physician-in-charge may change during the course of treatment, the daily fee formula as set out should be claimed by the physicians involved as if there was only one physician-in-charge during the treatment program; in this sense, the daily fees are team fees.

B. When claiming Critical, Ventilatory, Neonatal Intensive Care or Comprehensive Care fees no other Critical Care codes may be paid to the same physician(s).

C. Other physicians other than those providing Critical Care or Comprehensive Care may claim the appropriate consultation, visit and procedure fees not listed in the fee schedule for Critical Care. These claims will be adjudicated by the *Medical Consultant* in an Independent Consideration basis.

D. If Ventilatory Support only is provided, for example, by the anaesthesiologist(s), claims should then be made under Ventilatory Support. Comprehensive Care and Neonatal Intensive Care fees do not apply.

E. Other physicians should then claim Critical Care fees or the appropriate consultation, visit or procedures.

F. If the patient has been discharged from the Unit more than 48 hours and is re-admitted to the Unit, the 1st day rate applies again on the day of re-admission.

G. The appropriate consultation, assessment and procedural benefits apply after stopping Critical Care, Ventilatory Support, Comprehensive Care or Neonatal Intensive Care.

H. Unless otherwise stated, the Critical Care per diem fees should not be claimed for stabilized patients and those patients who are in an intensive care unit for the purposes of monitoring. The appropriate consultation, assessment and procedural benefits apply.

CRITICAL CARE

		Fee

CRITICAL CARE (INTENSIVE CARE AREA)

Critical Care is the service rendered by a physician for providing, in an Intensive Care Area, all aspects of care of a critically ill patient excluding ventilatory support and includes initial consultation and assessment, emergency resuscitation, intravenous lines, cutdowns, intraosseous infusion, pressure infusion sets and pharmacological agents, insertion of arterial, C.V.P. or urinary catheters and nasogastric intubation *with or without* anaesthesia, securing and interpretation of laboratory tests, oximetry, transcutaneous blood gases, and intracranial pressure monitoring interpretation and assessment when indicated (excluding insertion of I.C.P. measuring device). Except when a patient is on a ventilator, these fees are not payable for services rendered to stabilized patients in I.C.U.s, or patients admitted for ECG monitoring or observation alone. If the patient has been transferred from comprehensive care to critical care, the day of the transfer shall be deemed for payment purposes to be the second day of critical care.

Physician-in-charge

# G400	- 1st day		223.10
# G401	- 2nd to 30th day, inclusive	per diem	146.45
# G402	- 31st day onwards	per diem	58.60

VENTILATORY SUPPORT (INTENSIVE CARE AREA)

Ventilatory Support includes provision of ventilatory care including initial consultation and assessment of the patient, intravenous lines, endotracheal intubation with positive pressure ventilation including insertion of arterial C.V.P lines, tracheal toilet, use of artificial ventilator and all necessary measures for its supervision, obtaining and interpretation of blood gases, oximetry, transcutaneous blood gases and assessment. If the patient has been transferred from comprehensive care to ventilatory care, the day of the transfer shall be deemed for payment purposes to be the second day of ventilatory care.

Physician-in-charge

# G405	- 1st day		183.80
# G406	- 2nd to 30th day, inclusive	per diem	96.45
# G407	- 31st day onwards	per diem	64.20

COMPREHENSIVE CARE (INTENSIVE CARE AREA)

Comprehensive Care is the service rendered by an Intensive Care physician who provides complete care (both Critical Care and Ventilatory Support as defined above) to Intensive Care Area patients. This service includes the initial consultation and assessment and subsequent examinations of the patient, endotracheal intubation, tracheal toilet, artificial ventilation and all necessary measures for respiratory support, emergency resuscitation, insertion of intravenous lines, cutdowns, intraosseous infusion, arterial and/or venous catheters pressure infusion sets and pharmacological agents, insertion of C.V.P. lines, defibrillation, cardioversion and usual resuscitative measures, insertion of urinary catheters and nasogastric intubation *with or without* anaesthesia, securing and interpretation of blood gases and laboratory tests, oximetry, transcutaneous blood gases, intracranial pressure monitoring interpretation and assessment when indicated (excluding insertion of I.C.P. measuring device). Except when a patient is on a ventilator, these fees are not payable for services rendered to stabilized patients in I.C.U.s or patients admitted for E.C.G. monitoring or observation alone. If the patient has been transferred from critical care to comprehensive care, the day of the transfer shall be deemed for payment purposes to be the second day of comprehensive care.

CRITICAL CARE

			Fee
	Physician-in-charge		
# G557	- 1st day		429.30
# G558	- 2nd to 30th day, inclusive	per diem	256.25
# G559	- 31st day onwards	per diem	122.80

CRITICAL CARE

Fee

NEONATAL INTENSIVE CARE

Neonatal Intensive Care is the service rendered by a physician for being in constant or periodic attendance during a one-day period, to provide all aspects of care to Intensive Care Area patients. This consists of an initial consultation or assessment and such subsequent assessments as may be indicated, including ongoing monitoring of the patient's condition and the following procedures as required: insertion of arterial, venous, C.V.P. or urinary catheters, intravenous lines, interpreting of blood gases, nasogastric intubation *with or without* anaesthesia, pressure infusion sets and pharmaceutical agents, endotracheal intubation, tracheal toilet, artificial ventilation and all necessary measures for respiratory support. Separately billable interventions may be claimed in addition to these fees. There are three levels of neonatal intensive care depending on the procedures performed.

Level A

Full life support including monitoring (either invasive or non-invasive), ventilatory support and parenteral alimentation (all modalities)

# G600	- 1st day	376.05
# G601	- 2nd day onwards ..... per diem	187.95
# G603	Neonatal low volume intensive care - payable in lieu of G600 or G604 if sole newborn to maximum of 25 services per physician per fiscal year	564.00
# G604	Neonatal low birth weight intensive care - payable in lieu of G600 or G603 for newborn less than 750 grams in weight or 26 weeks gestational age	536.95

Level B

Intensive care including monitoring (invasive or non-invasive), oxygen administration and intravenous therapy, but without ventilatory support

# G610	- 1st day	258.05
# G611	- 2nd day onwards, ... per diem	129.00

Level C

Intermediate care including one or more of oxygen administration, non-invasive monitoring or gavage feeding

# G620	- 1st day	162.95
# G621	- 2nd day onwards, ... per diem	81.50

Note:

1. Physician-in-charge is the physician(s) daily providing the Neonatal Intensive Care.

2. These are team fees which apply to neonatologists /paediatricians/anaesthesiologists providing complete care. If *infant* has been transferred from one level to another in either direction, up or down, second day benefits apply.

CRITICAL CARE

		Fee

HYPERBARIC OXYGEN THERAPY (HBOT)

Hyperbaric Oxygen Therapy (HBOT) is the service rendered when a physician administers and supervises HBOT in a Health Canada approved multi-patient chamber or a single patient mono-chamber. Time is calculated based on the period of physician supervision while each patient receives HBOT inside the chamber. The *specific elements* of HBOT are those of an assessment, including ongoing monitoring of the patient's condition and intervening as appropriate.

Physician in constant attendance

Physician in chamber with patient(s), per session per patient

# G800	- first ¼ hour	83.80
# G801	- after first ¼ hour (per ¼ hour or major part thereof).....	41.90
# G802	- after 2 hours in chamber (per ¼ hour or major part thereof)	83.80

Physician in hyperbaric unit but not in chamber(s) with patient(s), per session per patient

# G804	- first ¼ hour	71.85
# G805	- after first ¼ hour (per ¼ hour or major part thereof).....	35.90

Payment rules:

1. A consultation or assessment is eligible for payment with HBOT when rendered.

2. If the physician is in the chamber, time calculated for HBOT *may include* time the physician devotes to separately billable interventions rendered to a patient provided that such interventions take place in the chamber during a period of continuous, uninterrupted HBOT.

[Commentary:

1. If the physician is outside the chamber, the time eligible for payment of HBOT does not include time spent rendering any separately billable intervention(s) during which the HBOT is interrupted or discontinued.

2. For multi-patient sessions, the time eligible for payment of HBOT is measured as the period of physician supervision (either inside or outside of the chamber) for each patient, subject to payment rule #2.]

Medical record requirements:

The service is eligible for payment only if the start and stop times of the service are recorded in each patient's permanent medical record.

Note:

1. HBOT is insured only for the treatment of those internationally recognized indications approved by the ministry.

2. HBOT is *only eligible for payment* for idiopathic sudden sensorineural hearing loss (ISSHL) when the following conditions are met:

- **a.** The patient is treated concurrently with corticosteroid unless corticosteroids are contraindicated;
- **b.** The treatment is initiated within 30 days of a diagnosis of ISSHL; and
- **c.** The diagnosis of ISSHL is made or confirmed by an Otolaryngologist prior to the initiation of treatment.

3. HBOT is *only eligible for payment* for avascular necrosis (AVN) of bone following diagnostic imaging confirmation of symptomatic early to mid-stage AVN, e.g. Ficat stage I, II, or III or equivalent.

CRITICAL CARE

Fee

Physician not in constant attendance

The service rendered when a physician supervises HBOT but is not physically present in the hyperbaric unit with the patient, but present in the facility and available to intervene in a timely fashion.

G807 - not in the hyperbaric unit, supervision 35.75

Payment rules:

1. G807 is limited to a maximum of one per patient per day.

2. G807 is limited to a maximum of 3 per physician per day.

3. G807 is *not eligible for payment* for the same patient, same day as G800, G801, or G802.

4. G805 is limited to a maximum of three units when claimed with G807 same patient same day.

Medical record requirements:

The medical record must demonstrate that there has been contact and/or direction provided to the hyperbaric unit in circumstances where G807 is claimed, otherwise the service is *not eligible for payment*.

[Commentary:

As of April 1, 2026, the following indications were approved by the MOH.

- air or gas embolism
- carbon monoxide poisoning and/or cyanide poisoning
- clostridial myositis and myonecrosis (gas gangrene)
- crush injury, compartment syndrome, and other acute traumatic ischemias
- decompression sickness
- enhancement of healing in selected problem wounds
- exceptional blood loss
- intracranial abscess
- necrotizing soft tissue infections (subcutaneous tissue, muscle, fascia)
- osteomyelitis (refractory)
- delayed radiation injury (soft tissue and bony necrosis)
- skin grafts and flaps (compromised)
- thermal burns
- id*iop*athic sudden sensorineural hearing loss (ISSHL)]
- avascular necrosis (AVN) of bone]

Hypothermia induction

G210 Hypothermia (therapeutic) induction and management 190.75

ICU/NICU admission assessment fee

G556 - ICU/NICU admission assessment is an initial visit rendered during night time (00:00-07:00), to G400, G405, G557, G600, G603, G604, G610 or G620 ..... add 136.40

Payment rules:

G556 is payable once per patient per hospital admission.

DERMATOLOGY

Fee

ULTRAVIOLET LIGHT THERAPY

Ultraviolet light therapy (general or local application) and/or Psoralen plus Ultraviolet A (PUVA) is an insured service only for treatment of dermatological conditions (maximum 1 per patient per day). G470 is an insured service payable at nil if rendered in a hospital in-patient or out-patient department.

+ G470 Ultraviolet light therapy 7.85

[Commentary:
See General Preamble GP62 for conditions and limitations regarding delegation and supervision of G470.]

DIALYSIS

		Asst	Fee	Anae
	Note: Team benefits to include listed items. This does not include preliminary investigation of the case.			
	Haemodialysis			
G325	Planning and delivery of the initial acute treatment		369.60	
# G323	Acute, repeat - for the first 3 services		184.80	
	Note: Haemodialysis to include haemofiltration, haemoperfusion.			
	Continuous venovenous haemodialysis			
# G083	- initial and acute (for the first 3 services)		397.30	
	Continuous venovenous haemofiltration			
# G085	- initial and acute (for the first 3 services)		385.75	
	Continuous haemodiafiltration			
# G082	Continuous venovenous haemodiafiltration - initial and acute (for the first 3 services)		397.30	
# G094	Chronic, continuous haemodiafiltration		69.90	
	Slow continuous ultrafiltration			
# G090	Venovenous slow continuous ultrafiltration - initial and acute (for the first 3 services)		331.05	
# G096	Chronic, slow continuous ultrafiltration		69.90	
# R843	Removal of cannula or A.V. shunt		101.00	7
# R827	Creation of A.V. fistula	6	490.15	7
	Note: R827 - see also listing under Cardiovascular System, Veins - Repair.			
	Bypass graft for haemodialysis			
# R851	- synthetic		482.70	7
# R840	- autogenous vein		496.60	7
	Subclavian or jugular catheter for haemodialysis			
# G324	- insertion		102.95	
# G336	- revision		17.65	
# R848	Dialysis cannula insertion under vision into central line (excluding percutaneous)		219.15	6
# G099	Percutaneous insertion of permanent jugular/femoral dialysis catheter (including subcutaneous positioning)		168.40	
# G327	Insertion of femoral catheter for dialysis		77.30	
# G312	Thrombolytic instillation into temporary and permanent percutaneous catheters		15.40	

DIALYSIS

		Asst	Fee	Anae
	Peritoneal dialysis			
# G330	Acute (up to 48 hours) includes stylette cannula insertion (temporary)		247.70	
# G331	Repeat acute (up to 48 hours) - for the first 3 services		223.00	
# R852	Insertion of peritoneal cannula by laparotomy or laparoscopy	6	352.50	6
# R885	Removal of peritoneal cannula by laparotomy or laparoscopy	6	256.10	6

Note:

1. E860 is *not eligible for payment* with R852 or R885, except in circumstances described in paragraph 23 of Surgical Preamble.

2. Z552, Z553 and S312 are *not eligible for payment* in association with R852 or R885.

	Tenckhoff type peritoneal catheter			
# R853	- insertion, chronic by trocar		154.40	7
# R854	- removal		63.10	

	Revision or repair of arterio-venous (AV) fistula or graft for haemodialysis			
# Z464	Declotting by cannula, any method	nil	150.00	nil
# R941	Thrombectomy, by open technique	7	350.00	10
# R942	Ligation, removal or obliteration of AV fistula or graft for haemodialysis	6	250.00	6
# R943	Revision and/or repair of AV fistula or graft by plication, imbrication, and/or resection, with or without thrombectomy	6	400.00	6
# R944	Revision and/or repair of AV fistula or graft by angioplasty, patch or graft, and/or segment replacement, with or without thrombectomy	6	650.00	6
# R945	Resection or repair of an AV fistula aneurysm(s), includes any necessary repair, with or without thrombectomy	6	975.50	6
# R946	Brachio-basilic vein AV fistula transposition for haemodialysis	10	975.50	17

Note:

1. Z464 includes placement of the cannula, administration of contrast and/or therapeutic agent(s), and any image guidance, when rendered. Obtaining and interpreting any images in conjunction with Z464 are *not eligible for payment* to any physician.

2. R943 and R944 include revision and/or repair of both the venous and arterial components of the AV fistula or graft, when rendered.

3. Only one of R941, R942, R943, R944, R945 or R946 is eligible for payment per patient per day, any physician.

4. R946 includes placement, venography and any image guidance. Obtaining and interpreting any images in conjunction with R946 are *not eligible for payment* to any physician.

5. R946 includes any revision and/or re-anastomosis, when rendered.

6. R942 is *not eligible for payment* for the same patient on the same day as R841 and R833.

DIALYSIS

Fee

CHRONIC DIALYSIS TEAM FEE

Chronic Dialysis Team Fee is the all-inclusive benefit per patient per *week* for professional aspects of managing chronic dialysis and end-stage renal failure in dialysis patients. It is a modality independent fee and is equal in monetary value whether the dialysis is delivered in hospital, community or *home* and whether it is haemodialysis or peritoneal dialysis. The team fee includes the services of all physicians routinely or periodically participating in the patient's dialysis treatment at:

a. the patient's principal treatment centre; or

b. at a place other than the patient's principal treatment centre (auxiliary treatment centre) where 3 or more dialysis treatments are rendered to the patient during the 7-day period referred to below.

The amount payable is in respect of a 7-day period of care, commencing at midnight Sunday and is payable to the *most responsible physician*.

Except as set out below, the amount payable to another physician in respect of these services rendered to a patient in respect of whom a claim is submitted and paid for this code is nil.

When a full 7-day period of team care is not rendered at the patient's principal treatment centre due to absence of the patient with treatment at an auxiliary treatment centre, the amount claimed for treatment at the principal treatment centre is reduced on a pro rata basis to equal 1/7 of the *week*ly fee for each day that the patient is the responsibility of the principal treatment centre.

In addition to the *common elements* of insured services and the *specific elements* of Diagnostic and Therapeutic Procedures, the team fee includes the following elements:

A. All consultations and visits for management and supervision of chronic dialysis treatments regardless of frequency, type or location of service and includes chronic dialysis of hospital in-patients.

B. All consultations and visits within the scope of practice of nephrology and general internal medicine for assessment and treatment of complications of chronic dialysis and management of end-stage renal disease and its complications in chronic dialysis patients.

C. All related counselling, interviews, psychotherapy of patients and family members.

D. All related case conferences.

The team fee does not include:

A. Assessments and special visit premiums for emergent calls to the emergency department.

B. Admission assessments and subsequent visits to acute care hospital in-patients for treatment of complications of dialysis, chronic renal disease or intercurrent illness.

C. Any other diagnostic and therapeutic procedures, including acute dialysis treatments.

D. Consultations and assessments by *specialist*s in other than internal medicine or internal medicine sub-specialists other than nephrologists.

E. Primary care by the patient's family physician.

F. Assessment by a renal transplantation specialist for entry into a transplantation program.

G. Intermittent chronic haemodialysis treatment at an auxiliary treatment centre if fewer than three dialysis treatments are rendered to the patient in the 7-day period referred to above.

DIALYSIS

		Fee
	Chronic dialysis weekly team fee	
# G860	Hospital haemodialysis or haemodiafiltration	135.80
# G861	Hospital peritoneal dialysis	135.80
# G862	Hospital self-care haemodialysis or satellite haemodialysis	135.80
# G863	*ICHSC* haemodialysis	135.80
# G864	Home peritoneal dialysis	135.80
# G865	Home haemodialysis	135.80
# G866	Intermittent haemodialysis - at an auxiliary treatment centre (per treatment, maximum 2 per patient per 7-day period referred to above)	73.45

Note:

1. Claim the code representing the predominant location and modality.

2. Where 3 or more treatments are rendered per 7-day period at an auxiliary treatment centre, the service comprises the chronic dialysis *week*ly team fee paid at the full amount, regardless of the number of treatments rendered.

ENDOCRINOLOGY AND METABOLISM

		Fee
+ G493	ACTH test - single or multiple, per injection	6.25
+ G337	Antidiuretic hormone response test including the 8 hour water deprivation test	16.95
+ G338	Clonidine suppression test (for the investigation of pheochromocytoma) - with physician present - includes venipunctures	24.90
	Glucagon test	
+ G494	- (Type A) for carbohydrate response	10.20
+ G495	- (Type B) for hypertension, pheochromocytoma and insulinoma provocative test (including cold pressor test)	42.30
G358	Growth hormone exercise stimulation test with physician present (includes venipunctures)	24.90
+ G340	Histamine test to include a control cold pressor test	45.45
+ G341	Hypertonic saline infusion test	16.95
+ G497	Insulin hypoglycemia pituitary function test with or without TRH and LHRH alone or in combination	49.80
+ G318	Insertion of non-biodegradable long-acting subcutaneous medication implant	42.00

Payment rules:

1. G318 is *not eligible for payment* when provided by injection.

2. G318 is *only eligible for payment* when the service is personally rendered by the physician

[Commentary:

1. Nexplanon is an example of non-biodegradable long-acting subcutaneous medication implant.

2. Zoladex is an example of a biodegradable medication implant for which G318 is *not eligible for payment*.

3. See Z114 and Z115 for removal of long-acting subcutaneous medication implant.

4. For injections that do not meet the above criteria for G318, see Injections listings on page J54 of the *Schedule*.]

Diabetes monthly management

The provision to a patient, patient's relative(s), patient's representative or other caregiver(s) of medical advice, direction or information by telephone or otherwise, in which a change in the frequency or dose of insulin therapy is initiated regarding a patient treated with insulin injections (2 or more daily) or insulin by pump (a "contact").

In addition to the *common elements*, the components of this service include the following *specific elements*.

A. Monitoring the condition of a patient with respect to insulin therapy, including ordering blood tests, reviewing patient's glucose self-monitoring, interpreting the results and inquiry into possible complications.

B. Adjusting the type, frequency and dose of insulin therapy, and where appropriate, prescribing alternate or additional therapy.

Fee

C. Discussion with, and providing advice and information to the patient, patient's relative(s), patient's representative or other caregiver(s), by telephone or otherwise, on matters related to the service, regardless of identity of person initiating discussion.

D. Making arrangements for any related assessments, procedures and/or therapy and interpreting results as appropriate.

E. Providing premises, equipment, supplies and personnel for the *specific elements*.

G500	- month in which insulin injections (2 or more daily) or insulin by pump is initiated; or month in which initial assessment by a specialist of a diabetic patient treated with insulin injections (2 or more daily) or insulin by pump occurs, 1 or more contacts	31.80
G514	- each additional month, 1 to 3 contacts	10.60
G520	- each additional month, 4 or more contacts	21.20

Payment rules:

1. G500 is limited to a maximum of two per patient per lifetime.

2. G500, G514 and G520 are *only eligible for payment* when rendered by the physician most responsible for the patient's diabetes care or by a physician substituting for that physician ("the substitute physician").

3. The clinical decision(s) pertaining to the medical advice, direction or information provided must be formulated personally by the physician or substitute physician.

4. A contact rendered on the same day as a consultation or assessment by the same physician to the same patient does not constitute a contact for the purpose of G500, G514 or G520.

5. G500, G514 and G520 are *not eligible for payment* for reviewing laboratory reports, patient created reports, or for communicating results to a patient when no change in the frequency or dose of insulin therapy is required.

6. Only one of G500, G514 and G520 is eligible for payment per patient per physician per *month*.

Medical record requirements:

G500/G514/G520 is *only eligible for payment* when a dated summary of each contact is recorded in the patient's permanent medical record.

Fee

[Commentary:

1. The clinical decision(s) formulated by the physician or substitute physician may be communicated to the patient, patient's relative, patient's representative or other caregiver by a staff member other than the physician.

2. *Month* refers to a calendar *month*.

3. If G514 and G520 are claimed in the same *month* by the same physician for the same patient, the total fee eligible for payment will be adjusted to the value of G520.]

+	G498	Intravenous glucose tolerance test	10.20
+	G499	Intravenous tolbutamide test	49.80
+	G513	Pentagastrin stimulation for calcitonin	42.30
+	G344	Phentolamine test	42.30
+	G501	TRH or LHRH test, per injection	6.25
+	G490	Saralasin test	42.30

Open circuit indirect calorimetry

Isothermal environment employing a ventilated hood system, to include height and weight of the subject, measurement of subjects body fat using four skin folds. Determination of resting energy expenditure in a patient 12-14 hours post prandial to include measurement of O2 consumption and CO2 saturation.

	G515	Open circuit indirect calorimetry	46.30

Measurement of thermic effect of feeding

To follow 1 hour measurement of resting energy expenditure, subject is given a balanced test meal and then calorimetry measurements are taken for two hours, to include timed urine samples (2-3 hours) and urine nitrogen excretion measurements in a steady state condition, interpretation of results in context of patient's clinical status and written report.

G516	Measurement of thermic effect of feeding	36.90

Oesophageal Studies

G350	- esophageal motility study(ies) with manometry and/or impedance planimetry.	97.85
G353	- esophageal provocation testing.....	35.00
G351	- esophageal reflux monitoring study for 24 hours or longer	51.50
G354	Anorectal manometry study.....	61.80

Payment rules:

G353 (esophageal provocation testing) is *only eligible for payment* when one or more of the following tests are performed: 1) acid perfusion testing; 2) provocative drug testing; 3) multiple rapid swallows; 4) rapid drink challenge; 5) solid bolus swallows.

GASTROENTEROLOGY

		Fee
G254	Management of post liver, lung or pancreas transplant immunosuppression - in lieu of non-emergency hospital visits in-patient visits ..... per visit	39.50

Note:

1. G254 is *not eligible for payment* in addition to a subsequent hospital visit or assessment.
2. G254 is *not eligible for payment* when rendered to an out-patient.
3. G254 is limited to a maximum of one service per patient per day.
4. G254 is *only eligible for payment* for a maximum of 2 *week*s post liver, lung or pancreas transplant surgery.

G349	Oesophageal tamponade (Blakemore bag) - insertion		45.30
	Gastric lavage		
+ G355	- diagnostic		9.60
G356	- therapeutic - with or without ice water lavage		33.80
# Z520	Change of gastrostomy tube.....		10.65
+ G357	Gastric secretion studies (Augmented Histamine or Histalog, or Pentagastrin) - procedure and supervision		19.55
G352	Biliary tract provocative test with cholecystokinin		9.60
# G322	Nasogastric intubation under general anaesthesia.....		9.60

		T	P
	Hydrogen breath test		
G167	- technical component	7.70	
G166	- professional component		10.45

		P
# G332	Capsule endoscopy	185.00

GYNAECOLOGY

		Fee
G363	Cervical mucous penetration test	22.00
G378	Insertion of intrauterine contraceptive device	47.50
G552	Removal of intrauterine contraceptive device	23.80
E542	- when performed outside hospital ... add	12.65

Payment rules:
G552 is *not eligible for payment* on the same day as G378.

+	G362	Insertion of laminaria tent	6.25
	E870	- when laminaria tent supplied by the physician ... add	8.35
	G334	Telephone supervisory fee for ovulation induction with human menopausal gonadotropins or gonadotropin-releasing hormone (*not eligible for payment* same day as visit), to a maximum of 10 per cycle ... per call	4.05
	G399	Transvaginal sonohysterography, introduction of catheter, with or without injection of contrast media	44.15

Note:
G399 is *only eligible for payment* when transvaginal sonohysterography professional and technical services (J165 or J476) are rendered (either by the same or another physician).

[Commentary:
1. See Diagnostic Ultrasound section page G6.

2. G334 is not insured when rendered to support in-vitro fertilization services or artificial insemination services. See Regulation 552 section 24(1) paragraph 23 and 29 under the *Act.*]

Cervical cancer screening

+	G365	Collection of cervical cancer screening specimen(s)	12.00
	E430	- when cervical cancer screening specimen(s) are collected outside of hospital or *ICHSC*, to G365 ... add	11.95

GYNAECOLOGY

		Fee
+ G394	Collection of additional cervical cancer screening specimen(s) for any of the following purposes: - Follow-up test once after low grade cytology results, where the follow-up specimen(s) are collected between March 3, 2025 and September 30, 2026; or - Once every 3 years for patients who are immunocompromised; or - Follow-up test once, a minimum of 24 *months* after testing human papillomavirus (HPV)-positive for other high risk subtype as defined by Ontario cervical cancer screening guidelines with normal/low grade cytology results; or - Follow-up test once, a minimum of 24 *months* after discharge from colposcopy when increased screening is recommended by Ontario cervical cancer screening guidelines; or - Repeat after an invalid HPV test or an unsatisfactory cytology test; or - Post-hysterectomy vaginal vault testing for patients with histologic evidence of dysplasia in the cervix at the time of hysterectomy; or - Where the physician is of the opinion that the patient is a member of a vulnerable group that may have difficulty accessing the services within the specified time period...	12.00
E431	- when cervical cancer screening specimen(s) are collected outside of hospital or *ICHSC*, to G394..... add	11.95

[Commentary:
E430 is payable when the requirements for G365 are met. E431 is payable when the requirements for G394 are met.]

Payment rules:

1. For G365 services provided between March 3, 2025 and March 31, 2028, G365 is limited to once per patient per 33 *month* period. For G365 services provided on or after April 1, 2028, G365 is limited to one per patient per 54 *month* period.

2. G365 is uninsured for patients less than 25 years of age.

3. G394 is limited to once per patient per lifetime for vaginal vault testing post-hysterectomy for patients with histologic evidence of dysplasia in the cervix at the time of hysterectomy.

4. G365 and G394 are *not eligible for payment* when performed in conjunction with a consultation, repeat consultation, general or specific assessment or reassessment or routine post-natal visit when a pelvic examination is a normal part of the foregoing services. One of the add-on codes E430 or E431 is eligible for payment in addition to these services when an insured collection of cervical cancer screening specimen(s) is performed outside of hospital or *ICHSC*.

5. G365 and G394 are *not eligible for payment* when performed in conjunction with an insured colposcopy service. One of the add-on codes E430 or E431 is eligible for payment in addition to these services when an insured collection of cervical cancer screening specimen(s) is performed outside of hospital or *ICHSC*.

Fee

Medical record requirements:
Physicians claiming G394 must document the clinical indication for the service in the patient's medical record. G394 is *not eligible for payment* if this documentation is not present.

[Commentary:
1. Collection of cervical cancer screening specimen(s) in excess of the specified limits are not insured.
2. Cervical cancer screening is generally not recommended for patients over 70 years of age.
3. Ontario cervical cancer screening Guidelines can be found at https://www.cancercareontario.ca
4. The Ontario cervical cancer screening guidelines define the immunocompromised screening population as people who:
   - **a.** Have a cervix; and
   - **b.** Are, or have ever been, sexually active; and
   - **c.** Are asymptomatic; and
   - **d.** Are part of any of the following populations at higher risk of pre-cancer and cervical cancer:
     - People who are living with human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), regardless of viral load
     - People with congenital (primary) immunodeficiency
     - Transplant recipients (solid organ or allogeneic stem cell transplants)
     - People requiring treatment (either continuously or at frequent intervals) with medications that cause immune suppression for three years or more
     - People who are living with systemic lupus erythematosus (SLE), regardless of whether they are receiving immunosuppressant treatment
     - People who are living with renal failure and require dialysis.]

Medical management of prolapse - Pessary

G398	Pessary fitting – initial or re-fitting.....	65.35
G550	Pessary care – pessary removal, care and reinsertion.....	10.00

Payment rules:
1. G398 is *eligible for payment* once per patient per 12-month period
2. G550 is *eligible for payment* up to 6 times per 12-month period
3. G550 is *not eligible for payment* for the same patient on the same day as G398
4. G398 or G550 are *not eligible for payment* when pessary removal is performed with no pessary care or reinsertion

[Commentary:
If applicable, a visit fee may be claimed in addition to pessary fitting or pessary care provided to the same patient during the same visit.]

Fee

HAEMOGLOBINOPATHIES AND CONGENITAL HAEMOLYTIC ANEMIAS

Transfusion support

The service rendered for transfusion support, iron overload management and Sickle Cell crisis management and prevention related to Sickle Cell Disease, Thalassemia or transfusion dependent Congenital Hemolytic Anemia. The service includes routine outpatient visits (including, for example, supervised blood transfusions, iron chelation therapy, monitoring of complications of iron overload, pain management of acute or chronic Sickle Cell Disease) and any counselling/psychotherapy/genetic counselling of the patient, the patient's relatives or their representatives.

The *specific elements* of this service are all services performed by the specialist in charge of the patient during a one-*week* period in providing non-emergency care to the patient, including providing any advice whether by telephone or otherwise and even when initiated by the patient, patient's relative(s), or their representative(s) and including providing all premises, equipment, supplies and personnel used by the specialist in charge of the patient to perform these services.

G098 Transfusion support, per patient ..... per week 32.35

Note:
When physicians are required to make emergency visits, the appropriate visits and premiums are eligible for payment. When the patient requires hospitalization, the appropriate fees for in-patient services are eligible for payment instead of G098.

Fee

HOME/SELF-CARE HAEMOPHILIA

Services rendered by the specialist in charge of the patient.

Haemophilia infusion

Haemophilia infusion includes routine clinic visits (system/drug/infusions technique/blood work review and physical examination), counselling/psychotherapy/genetic counselling of patients and relatives and supervised haemophilia infusion when required. The *specific elements* of this service are all services performed by the specialist in charge of the patient during a one-*week* period in providing non-emergency care to the patient who is self administering haemophilia therapy, including providing any advice and supervision in regard to self administration, whether by telephone or otherwise and even when initiated by the patient, patient's relative(s), or their representative and including providing all premises, equipment, supplies and personnel used by the specialist in charge of the patient to perform these services.

G100 Haemophilia infusion, per patient ..... per week 32.35

Note:
When physicians are required to make emergency visits to see patients on any form of *home*/ self care haemophilia infusion, the appropriate visits and premiums may be claimed. When the patient requires hospitalization, the appropriate fees for daily care and in-hospital infusions may be claimed instead of G100.

HOME/SELF-CARE VENTILATION

Home/self-care ventilation - to include positive and negative respirators and negative pressure respirators, diaphragmatic pacing devices and oscillating beds.

a. services rendered by *most responsible physician*;

b. includes routine clinic visits, *home* visits, telephone advice, communication with family and other medical personnel, care of supervised tracheostomy, counselling/psychotherapy of patients and relatives and supervised ventilation when required.

The *specific elements* of this service are all services performed by the *most responsible physician* during a one-*week* period in providing non-emergency care to the patient who is self administering ventilation therapy, including providing any advice and supervision in regard to self administration, whether by telephone or otherwise and even when initiated by the patient, or their representative and including providing all premises, equipment, supplies and personnel used by the *most responsible physician* to perform these services.

G101 Home/self-care ventilation, per patient ..... per week 33.55

Note:
When physicians are required to make emergency visits to see patients on *home*/self-care ventilation, the appropriate visit and premium fees may be claimed. When the patient requires hospitalization, the appropriate fees for daily care and in-hospital ventilation may be claimed instead of G101.

		Fee
	BOTULINUM TOXIN SERVICES	
G869	Botulinum toxin injection(s) of bladder detrusor muscle	150.00

Payment rules:

1. G869 is *only eligible for payment* for management of symptomatic refractory overactive bladder that has not been responsive to a minimum of three months of active treatment with behavioral modification or anticholinergics.

2. Only one G869 service is eligible for payment per patient per day and includes all injections necessary to deliver the total dosage (one treatment) that is recommended in current practice guidelines

3. G869 is *only eligible for payment* for one treatment per patient every 12 weeks. If, in the opinion of the treating physician, more frequent treatments are necessary, submit claim for manual review with supporting documentation. Authorization will be dependent on the physician demonstrating that the increased frequency of the service is generally accepted as necessary for the patient under the circumstances.

Medical record requirements:

Subsequent G869 services are *only eligible for payment* if the patient's response(s) to previous G869 services are documented in the permanent medical record.

[Commentary:

Z606 is eligible for payment with G869, if performed]

G870	Botulinum toxin injection(s) of extraocular muscle(s), (unilateral)	120.00
G871	Botulinum toxin injection(s) for blepharospasm, (unilateral or bilateral).....	120.00
G872	Botulinum toxin injection(s) for hemifacial spasm, (unilateral or bilateral).....	120.00
G873	Botulinum toxin injection(s) for spasmodic dysphonia	120.00
G874	Botulinum toxin injection(s) for sialorrhea or epiphora, (unilateral or bilateral).....	120.00
	Botulinum toxin injection for the following conditions: Oromandibular dystonia, limb dystonia, cervical dystonia or spasticity	
G875	First injection.....	40.00
G876	- each additional injection to a maximum of 11, to G875 ..... add	10.00
	EMG and/or ultrasound guidance for Botulinum toxin injections	
G877	- when EMG and/or ultrasound guidance required to determine injection site (for one injection), to G870, G873, G874, or G875..... add	18.85
G878	- when EMG and/or ultrasound guidance required to determine injection site (for two or more injections), to G870, G873, G874 or G876 ..... add	28.10
E543	- use of disposable EMG hypodermic electrode outside hospital (maximum of one per patient per day), to G877 or G878 ..... add	30.60

Payment rules:

1. When used to determine the injection site, EMG or ultrasound services other than G877 or G878 are *not eligible for payment* with Botulinum toxin services.

2. With the exception of G869, all Botulinum toxin services are limited to one treatment per condition, per patient every 10 *week*s. If, in the opinion of the treating physician, more frequent treatments are necessary, submit claim for manual review with supporting documentation. Authorization will be dependent on the physician demonstrating that the increased frequency of the service is generally accepted as necessary for the patient under the circumstances.

[Commentary:
Botulinum toxin injection(s) for indications other than those listed above are not insured services.]

INJECTIONS OR INFUSIONS

			Fee	Anae
+	G369	B.C.G. inoculation, following tuberculin tests	5.30	
+	G370	Injection of bursa, or injection and/or aspiration of joint, ganglion or tendon sheath	20.25	
	G371	- each additional bursa, joint, ganglion or tendon sheath, to a maximum of 5	19.90	
	E542	- when performed outside hospital, to G370 ..... add	12.65	
	G328	Aspiration of bursa or complex joint, with or without injection	39.80	
	G329	- each additional bursa or complex joint, to a maximum of 2	20.25	
	E542	- when performed outside hospital, to G328 ..... add	12.65	
	E446	- peripheral joint injection using image guidance following a failed blind attempt, to G370 or G371 ..... add	30.00	

Note:

1. For the purpose of G328 and G329, a joint is defined as complex only if it is:

a. a joint other than the knee; or

b. a knee joint in which the anatomy is distorted by disseminated lupus erythaematosus, dermatomyositis, rheumatoid arthritis, Still's disease, ankylosing spondylitis or other seronegative spondyloarthropathies.

2. E446 is *only eligible for payment* when injection of the joint must be repeated using any method of image guidance following a failed blind attempt(s) by the same or different physician. Professional and/or technical fees for obtaining and interpreting the images required for the purpose of guidance of the injection are *not eligible for payment* to any physician.

Payment rules:

1. G370, G371, G328 or G329 are *not eligible for payment* when rendered in conjunction with a surgical procedure involving the same site or area.

2. Only one of G370, G371, G328 and G329 is eligible for payment for the same bursa, joint or complex joint.

3. Aspiration and/or injection of the olecranon bursa is *only eligible for payment* as G370/G371.

4. G328/G329 are *not eligible for payment* solely for injection of complex joint.

5. G370, G371, G328, G329 are *uninsured service*s for injection of intra-articular viscosupplementation agents.

[Commentary:

1. Use of intra-articular viscosupplementation agent for treatment of osteoarthritis is not supported by evidence. An example of a viscosupplementation agent is hyaluronic acid. See https://www.hqontario.ca/Portals/0/Documents/evidence/reports/rev_hylan_061705.pdf

2. For percutaneous provocation vertebral discography, refer to J006 Discogram page E4.]

	G396	Injections of extensive keloids	24.90	
#	Z455	- under general anaesthesia	44.70	6

INJECTIONS OR INFUSIONS

		Fee	Anae
	INTRAMUSCULAR, SUBCUTANEOUS OR INTRADERMAL		
G372	- with visit (each injection)	4.55	
G373	- sole reason (first injection)	7.90	
G372	- each additional injection	4.55	

Note:

1. G372, G373 includes interpretation.

2. G372, G373 are not insured for vitamin injections when rendered for the purpose of facilitating weight loss.

IMMUNIZATION

[Commentary:
The immunization service may not be insured under some conditions. See Appendix A for link to relevant regulation.]

Note:

1. Where the sole reason for the visit is to provide the immunization service add G700.

2. G700 service is only payable once per patient per day.

+	G840	Diphtheria, Tetanus, and acellular Pertussis vaccine/ Inactivated Poliovirus vaccine (DTaP-IPV) - paediatric	8.80	
+	G841	Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio Virus, Haemophilus influenza type b (DTaP-IPV-Hib) - paediatric	8.80	
+	G842	Hepatitis B (HB)	8.80	
+	G843	Human Papillomavirus (HPV)	8.80	
+	G844	Meningococcal C Conjugate (Men-C)	8.80	
+	G845	Measles, Mumps, Rubella (MMR)	8.80	
+	G846	Pneumococcal Conjugate	8.80	
+	G847	Diphtheria, Tetanus, acellular Pertussis (Tdap) - adult	8.80	
+	G848	Varicella (VAR)	8.80	
+	G849	Respiratory Syncytial Virus (RSV)	8.80	
+	G538	Other immunizing agents not listed above	8.80	
+	G590	Influenza agent	8.80	
+	G593	COVID-19 vaccine	13.00	
		INTRALESIONAL INFILTRATION		
+	G375	- one or two lesions	10.50	
+	G377	- 3 or more lesions	15.80	
	G383	- extensive (see General Preamble GP12)	I.C	

Note:
Intralesional injection of acne lesions with corticosteroids is not an insured service.

+	G462	Administration of oral polio or rotavirus vaccine	8.80	
+	G592	Administration of intranasal influenza vaccine	1.65	
	G384	Infiltration of tissues for trigger point	8.85	
	G385	- for each additional site (to a maximum of 2) ..... add	4.55	

INJECTIONS OR INFUSIONS

		Fee
	INTRAVENOUS	
+ G376	Newborn or infant	10.20
+ G379	Child, adolescent or adult	6.15

Note:

1. G376 or G379 apply to cryoprecipitate infusion.

2. G376 or G379 may not be claimed with x-rays as they are included in the service.

3. Except for G381, injections into established I.V. apparatus may not be claimed.

G389	Preparation and infusion of gamma globulin, per patient, per day	13.90
+ G380	Cutdown including cannulation as necessary	27.05
G387	Intravenous local anaesthetic infusion for central neuropathic pain	125.00

Payment rules:

1. G387 is only insured for patients with central neuropathic pain who have first undertaken but not responded to generally accepted medical therapy.

2. The physician submitting the claim for this service must remain in constant attendance during the infusion and no part of the procedure may be delegated or G387 is not payable.

3. G387 is limited to a maximum of 6 per patient per *12 month period*.

Medical record requirements:

The medical record for the service must document the prior medical therapy that the patient did not respond to or G387 is *not eligible for payment*.

[Commentary:

1. Central neuropathic pain is pain caused by a primary lesion or dysfunction that affects the central nervous system.

2. At the time of this amendment to the *Schedule* of Benefits, generally accepted medical therapy that would be required prior to G387 is treatment with both a tricyclic antidepressant and at least one anticonvulsant.

SCLEROTHERAPY

Sclerotherapy is only insured for veins greater than 5 mm in diameter and associated with physical symptomatology and when *rendered personally by the physician*.

G536	Sclerotherapy including one post injection visit, unilateral	77.85
G537	Repeat sclerotherapy, unilateral	26.05

Note:

1. G536 and G537 include multiple injections and application of any necessary compression bandages.

2. Professional and/or technical fees for obtaining and/or interpreting images for the purpose of guidance are *not eligible for payment* in addition to G536 and G537.

3. Assistant units nil for G536, G537.

INJECTIONS OR INFUSIONS

PARENTERAL ALIMENTATION

		Fee
G510	Management of parenteral alimentation - physician in charge per visit	21.00
K401	Home parenteral nutrition (HPN) team management (per patient per week)	33.00

Payment rules:

1. In addition to the common elements, G510 includes the specific elements of assessments (see General Preamble GP15). Not to be claimed in addition to hospital visits
2. K401 is *only eligible for payment* when rendered to a patient on established home parenteral nutrition where the physician is acting as the most responsible provider for the HPN team
3. A maximum of one K401 service is eligible for payment per patient per week by any physician

Fee

CHEMOTHERAPY

Chemotherapy (pharmacologic therapy of malignancy or autoimmune disease) - with administration supervised by a physician for intravenous infusion for treatment of malignant or autoimmune disease. The physician must be available to intervene in a timely fashion at the initiation and for the duration of the prescribed therapy to manage immediate and delayed toxicities.

Chemotherapy and patient assessment provided by a physician includes all patient assessments by any physician for a 24 hour period following treatment administration.

Note:

1. G381, G345 and G359 are *only eligible for payment* with respect to the following classes of biologic agents:

a. monoclonal antibodies; and

b. cytokines.

2. G381, G345, G359, G075 and G390 include venipuncture, establishment of any vascular access line and administration of agent(s).

[Commentary:
Examples that are not considered biologic agents for payment purposes are blood products, insulin, and immunizing agents.]

\+ G381 Standard chemotherapy - agents with minor toxicity that require physician monitoring, including any additional standard chemotherapy other than the initial agent 54.50

[Commentary:
Examples of standard chemotherapy agents include cyclophosphamide, methotrexate, fluorouracil, leucovorin, and zoledronic acid.]

G345 Complex single agent or multi-agent therapy – chemotherapy and/or biologic agent(s) that can cause vesicant damage, infusion reactions, cardiac, neurologic, marrow or renal toxicities that may require immediate intervention by the physician 75.00

[Commentary:
Examples of complex single agents include rituxamib, bevacizumab, trastuzumab, anthracyclines, bortezomib, taxanes, cisplatin, and etoposide fludarabine.]

G359 Special single agent or multi-agent therapy – chemotherapy and/or biologic agent(s) with major toxicity that require frequent monitoring and prolonged administration periods and may require immediate intervention by the physician . 105.15

[Commentary:
Examples of special agent therapy include high-dose methotrexate with folinic acid rescue, methotrexate given in a dose of greater than 1 g/m2, high dose cisplatin greater than 75 mg/m2 given concurrently with hydration and osmotic diuresis, high dose cystosine, arabinoside (greater than 2 g/m2), high dose cyclophosphamide (greater than 1 g/m2), ifosfamide with MESNA protection, combination of biologic agents with complex chemotherapy, bispecific antibody.]

INJECTIONS OR INFUSIONS

		Fee
G075	Test dose (bleomycin and l-asparatiginase) once per patient per drug	30.50
G390	Supervision of chemotherapy for induction phase of acute leukemia or myeloablative therapy prior to bone marrow transplantation (maximum of 1 per induction phase or myeloablative therapy); and/or supervision of biologic agent(s) such as Chimeric Antigen Receptor T-Cell Therapy (CAR-T) infusion (maximum of 1 per infusion); and/or supervision of bispecific antibody infusion, during initial dosing phase, where there is a high risk of cytokine release syndrome (maximum of 3 per initial dosing phase).....	262.40

Monthly telephone supervision

G382	Supervision of chemotherapy (pharmacologic therapy of malignancy or autoimmune disease) by telephone, monthly	13.95

INJECTIONS OR INFUSIONS

Fee

Management of special oral chemotherapy

This is the service for the supervision of oral chemotherapy treatment for malignant disease where the agent(s) has a significant risk of toxicity in the period immediately following initiation. The physician must be available to intervene in a timely fashion for a 24 hour period following the initiation of the treatment.

In addition to the *Common Elements* in this *Schedule*, this service includes the provision of the following services to the same patient:

a. evaluation of any relevant laboratory, diagnostic and/or imaging investigations; and

b. all discussion or advice, whether by telephone or otherwise, involving the patient, staff, patient's relative(s) or *patient's representative* related to the oral chemotharapy for a period of twenty-one (21) days following initiation of the agent(s).

G388 Management of special oral chemotherapy, for malignant disease 28.00

Payment rules:

1. G388 is *not eligible for payment* for the same patient in the same *month* where G382 is payable.

2. G388 is *only eligible for payment* once per patient per month

[Commentary:
Examples of special oral chemotherapy include fludarabine, imatinib, dasatanib, nilotinib, erlotinib, capecitabine, sunitinib, sorafenib, thalidomide, temazolamide and lenalidomide.]

LABORATORY MEDICINE

SPECIFIC ELEMENTS

In addition to the *common elements*, all services listed under Laboratory Medicine include the following *specific elements*:

A. Interpretation of the results of the laboratory procedure.

B. Providing a written interpretative report of the procedure to the referring provider, if other than the interpreting physician.

C. Providing premises, equipment, supplies and personnel for any aspect(s) of the *constituent elements* that is (are) performed at a place other than the place in which the laboratory procedure is performed.

DEFINITIONS

L861 SURGICAL PATHOLOGY, LEVEL 1.

Gross examination without microscopic examination. This service includes any specimen for which, in the judgment of the examining physician, a diagnosis can be established by gross examination alone.

L862 SURGICAL PATHOLOGY, LEVEL 2.

Gross and microscopic examination for the purpose of confirming the identity of tissue and the absence of disease of the following specimens:

Appendix (incidental appendectomy); fallopian tube (sterilization); digit (traumatic amputation); hernia sac; hydrocele sac; nerve; skin (neonatal foreskin; plastic repair); sympathetic ganglion; testis (castration); vaginal mucosa (incidental); vas deferens (sterilization).

L863 SURGICAL PATHOLOGY, LEVEL 3.

Gross and microscopic examination of the following specimens:

Abscess; aneurysm; anal tag; appendix (other than incidental); artery or vein (atheromatous plaque; varicosity); Bartholin gland cyst; bone (other than pathologic fracture); bursa or synovial cyst; carpal tunnel tissue; cartilage (shavings); cholesteatoma; colostomy stoma; conjunctiva (pterygium); cornea; diverticulum (digestive tract); Dupuytren contracture tissue; femoral head (other than fracture); fissure or fistula; gallbladder; ganglion cyst; haematoma; haemorrhoid; hydatid of Morgagni; intervertebral disc; joint loose body; meniscus; mucocele (salivary); neuroma (traumatic; Morton); nasal or sinusoidal polyp (inflammatory); skin (acrochordon/tag; cyst; foreskin, other than neonate; debridement; pilonidal cyst or sinus); soft tissue (lip*oma*, debridement); spermatocele; tendon or tendon sheath; testicular appendage; thrombus or embolus; uterine contents (induced abortion); varicocele; vas deferens (other than sterilization).

LABORATORY MEDICINE

L864 SURGICAL PATHOLOGY, LEVEL 4.

Gross and microscopic examination of the following specimens:

Artery (biopsy); bone marrow (biopsy); bone exostosis; brain or meninges (other than neoplasm resection); branchial cleft cyst; breast (biopsy, not requiring microscopic evaluation of surgical margin; reduction mammoplasty); bronchus (biopsy); cell block; cervix (biopsy); digestive tract (biopsy); endocervix (biopsy or curettings); endometrium (biopsy or curettings); extremity (traumatic amputation); fallopian tube (biopsy; ectopic pregnancy); femoral head (fracture); digit (non-traumatic amputation); heart valve; joint (resection); kidney (biopsy); larynx (biopsy); lip (biopsy; wedge resection); lung (transbronchial biopsy); lymph node (biopsy); muscle (biopsy); nasal mucosa, nasopharynx or oropharynx (biopsy); nerve (biopsy); odontogenic or dental cyst; omentum (biopsy); oral or gingival mucosa (biopsy); ovary *with or without* fallopian tube (non-neoplastic); ovary (biopsy, wedge resection); paranasal sinus (biopsy); parathyroid gland; pericardium (biopsy); peritoneum (biopsy); pituitary gland (neoplasm); placenta (other than third trimester); pleura (biopsy); polyp (cervical; endometrial; digestive tract); prostate (needle biopsy; transurethral resection); salivary gland (biopsy); skin (other than cyst / tag / debridement / plastic repair); synovium; spleen; testis (other than biopsy, castration or neoplasm); thyroglossal duct cyst; tongue (biopsy); tonsil or adenoid (biopsy); trachea (biopsy); ureter (biopsy); urethra (biopsy); urinary bladder (biopsy); uterine contents (spontaneous or missed abortion); uterine leiomyoma (myomectomy); uterus *with or without* tubes and ovaries (for prolapse); vagina (biopsy); vulva (biopsy).

L865 SURGICAL PATHOLOGY, LEVEL 5.

Gross and microscopic examination of the following specimens:

Adrenal gland (resection); bone (biopsy or curettings, pathologic fracture); brain (biopsy); brain or meninges (neoplasm resection); breast (partial or simple mastectomy; excision requiring microscopic evaluation of surgical margin); cervix (conization); colon (segmental resection, other than neoplasm); extremity (non-traumatic amputation); eye (enucleation); kidney (partial or total nephrectomy); larynx (partial or total resection); liver (biopsy or wedge or partial resection); lung (wedge biopsy); lymph nodes (regional resection; sentinel); mediastinum (biopsy); myocardium (biopsy); odontogenic neoplasm; ovary *with or without* fallopian tube (neoplasm); pancreas (biopsy); placenta (third trimester); prostate (other than transurethral resection or radical resection); salivary gland; small intestine (resection, other than neoplasm); soft tissue mass (other than lipoma; biopsy or simple excision); stomach (partial or total resection, other than neoplasm); testis (biopsy); thymus (neoplasm); thyroid (partial or total thyroidectomy); ureter (resection); urinary bladder (transurethral resection); uterus *with or without* fallopian tubes and ovaries.

Note:

1. For uterine leiomyoma or prolapse, see L864.

2. For uterine neoplasm, see L866.

LABORATORY MEDICINE

L866 SURGICAL PATHOLOGY, LEVEL 6.

Gross and microscopic examination of the following specimens:

Bone (resection); breast (mastectomy with regional lymph nodes); colon (segmental resection for neoplasm); colon (total resection); extremity (disarticulation); fetus (with dissection); larynx (partial or total resection with regional lymph nodes); lung (partial or total resection); oesophagus (partial or total resection); pancreas (partial or total resection); prostate (radical resection); small intestine (resection for neoplasm); soft tissue neoplasm (extensive resection); stomach (partial or total resection for neoplasm); testis (neoplasm); tongue (resection for neoplasm); tonsil (resection for neoplasm); urinary bladder (partial or total resection); uterus *with or without* fallopian tubes and ovaries (neoplasm other than leiomyoma); vulva (partial or total resection).

L867 SURGICAL PATHOLOGY

Gross and microscopic examination of specimens not listed in Levels 2 through 6.

Payment rules:

1. The unit of a service in Surgical Pathology and Cytopathology is a specimen. A specimen is tissue that is identified and submitted for individual and separate examination and diagnosis.

[Commentary:
Surgical Pathology codes L861 through L866 denote increasing levels of physician work associated with examination of the specimens listed in the respective service code definitions.]

2. When the examination of a specimen requires any of the services listed under Special Procedures and Interpretation - Histology or Cytology, such services are eligible for payment in addition to any of the following services (when rendered):

- **a.** services listed under Anatomic Pathology - Surgical Pathology,
- **b.** services listed under Anatomic Pathology – Cytopathology; or
- **c.** a Diagnostic Laboratory Medicine Consultation (A585/C585) as listed in the "Consultation and Visits" section of the *Schedule*.

3. Cytology smears fees are payable in each case for which the physician is responsible whether or not all slides are personally examined by the physician.

[Commentary:

1. For the *technical component*s of Laboratory Medicine (L001 to L799 and L900 codes), please refer to the separate *Schedule* of Benefits for Laboratory Services.

2. See section 37.1 of regulation 552 under the *Health Insurance Act* for additional information regarding payment and insurability of Laboratory services.]

Claims submission instructions:

If multiple specimens are submitted from a single patient on the same occasion, assign each specimen the appropriate fee *schedule* code(s).

		Fee
	INTERPRETATION OF ANATOMICAL PATHOLOGY, HISTOLOGY AND CYTOLOGY	
	Anatomic Pathology - Surgical Pathology	
L861	Surgical Pathology, Level 1	5.35
L862	Surgical Pathology, Level 2	8.70
L863	Surgical Pathology, Level 3	14.70
L864	Surgical Pathology, Level 4	50.00
L865	Surgical Pathology, Level 5	106.00
L866	Surgical Pathology, Level 6	186.60
L867	Surgical Pathology, Unlisted specimens	47.95
L822	Operative consultation, with or without frozen section or direct smear	79.30
L823	- each subsequent frozen section or direct smear ..... add	39.30
	Anatomic Pathology - Cytopathology	
L812	Cervical vaginal specimens including all types of cellular abnormality, assessment of flora, and/or cytohormonal evaluation	4.75
L805	Aspiration biopsy e.g. lung, breast, thyroid, prostate	93.35
L806	Bronchial, oesophageal, gastric, endometrial or other brushings and washings	37.35
L808	Imprint, touch preparation and/or direct smear	37.35
L815	Sputum per specimen for general and/or specific assessment e.g. cellular abnormalities, asbestos bodies, lipids, haemosiderin.	37.35
L804	Smear, specific assessment e.g. eosinophils, asbestos bodies, amniotic fluid cells for estimation of fetal maturation	14.70
L810	Fluids e.g. pleural, ascitic cyst, pericardial, C.S.F., urine and joint	36.65
L824	Synovial fluid analysis, including description, viscosity, mucin clot, cell count, and compensated polarized light microscopy for crystals	25.40
L819	Basic seminal fluid analysis for infertility, including count, motility and morphology	13.95
	[Commentary: L819 must include all elements of a basic semen examination as described in the World Health Organization (WHO) Laboratory Manual for the Examination and Processing of Human Semen that is in effect on the date of service]	
L848	Seminal fluid analysis - quantitative kinetic studies	30.45
L820	Smear for spermatozoa	8.75

LABORATORY MEDICINE

		Fee
	Special Procedures and Interpretation - Histology or Cytology	
L841	Enzyme histochemistry and interpretation - per enzyme	16.05
L837	Immunohistochemistry, direct immunofluorescence, in situ hybridization, immunobead or other method and interpretation - per marker	16.00
L868	Special histochemistry for identification of microorganisms	36.00
L869	Special histochemistry for identification of elements other than microorganisms	16.00
L817	Anti-tissue antibodies and interpretation - per case	6.20
L842	- anti-tissue antibodies, screening dilution, titration and interpretation ..... add	8.70
L844	Special microscopy including polarization, phase-contrast, differential interference contrast, dark field, autofluorescence, or other microscopy and interpretation	25.75
L845	Specimen radiography or microradiography and interpretation	10.70
L816	Electron microscopy by TEM, STEM or SEM technique	100.65
L836	Morphometry per parameter	25.40
L846	Flow cell cytometry and interpretation - per marker	15.65
	Haematopathology	
L800	Blood film interpretation (Romanowsky stain)	29.40
L826	Blood film interpretation (special stain)	16.05
L802	Bone marrow interpretation (Romanowsky stain)	64.45
Z403	Bone marrow aspiration and/or core biopsy	133.55
L829	Haemoglobinopathy interpretation (payable for abnormal results only)	25.70

Fee

LABORATORY MEDICINE IN PHYSICIAN'S OFFICE

Definition:

A laboratory service ("test") set out in this section is an insured service eligible for payment only when rendered by a physician ("the original physician"), or by a physician substituting for the original physician, who performs the test in the original physician's own office for the physician's own patient.

Note:
Tests listed under "Miscellaneous Tests" may be claimed by any physician. Tests listed under "Reproductive medicine" and "Point of care drug testing" are only payable to those physicians where point of care testing is necessary for their practice.

[Commentary:

1. Fee codes listed in the separate *Schedule* of Benefits for Laboratory Services apply only to services provided by private laboratories licensed under the *Laboratory and Specimen Collection Centre Licensing Act*.]

2. Any service listed in this section is not insured when rendered to support in-vitro fertilization services or artificial insemination services. See Regulation 552 section 24(1) paragraph 23 and 29 under the *Act*.]

Medical record requirements:
Laboratory services are *only eligible for payment* if the result of the test(s), the physician's interpretation of the results of the test(s) and the treatment decision based on the test results are documented in the patient's permanent medical record.

A. Reproductive medicine

G015	FSH (pituitary gonadotrophins)	11.35
G016	TSH (thyroid stimulating hormone)	9.80
G017	Prolactin	14.50
G018	Estradiol	28.45
G019	LH (luteinizing hormone)	9.30
G020	Progesterone	14.50
G021	HCG (human chorionic gonadotrophins) quantitative	15.50

Note:
G021 is *not eligible for payment* for pregnancy tests. See G005.

G022	Testosterone	14.50
G023	Testosterone, free	25.85
G024	Androstenedione	38.80
G025	Dehydroepiandrosterone sulphate (DHEAS)	20.70
G026	17-OH progesterone	31.00
G027	Seminal fluid examination (complete)	11.35
G028	Cervicovaginal mucous specimen for cellular analysis for postcoital testing	10.35

Note:
G028 is *not eligible for payment* for obtaining or preparing cervical cancer screening specimen(s) or interpreting a cervical cancer screening test.

G029	Antithrombin III assay	28.45

LABORATORY MEDICINE

		Fee
G030	Circulating anticoagulant (e.g., lupus anticoagulant)	5.15
G032	Anti-DNA	23.25
G033	Anti-RNA	23.25
G034	Serial tube 4 or more antigens	15.50
G035	Titre - serial tube single antigen	7.75
G036	Sperm antibodies – screen	10.35
G037	Sperm antibodies – titre	20.70

		Fee
B. Point of care drug testing		
G041	Target drug testing, urine, qualitative or quantitative .. per test	3.70
G042	Target drug testing, urine, qualitative or quantitative .. per test	2.50

[Commentary:
G041 and G042 are tests for a specific drug of abuse.]

G040	Drugs of abuse screen, urine, must include testing for at least four drugs of abuse ..... per test	15.00
G043	Drugs of abuse screen, urine, must include testing for at least four drugs of abuse ..... per test	7.50

[Commentary:
Drugs of abuse *may include* any of the following: alcohol, methadone, methadone metabolite, morphine, a synthetic or semi-synthetic opiate, cocaine, benzodiazepines, amphetamines, methamphetamines, cannabinoids, barbiturates or any other drug of abuse.]

G039	Creatinine	1.03

Payment rules:

1. G040 and G041 are limited to a maximum of five (5) services per patient (any combination) per *month* to any physician when K682 or K683 is payable.

2. G042 and G043 are limited to a maximum of four (4) services per patient (any combination) per *month* to any physician when K682 or K683 is payable.

3. Any combination of G040, G041, G042 and G043 is limited to a maximum of three (3) services per patient per *month* for management of a patient with chronic pain, an addiction, or receiving opioid agonist treatment program where K682 or K683 is not payable in the *month* for the same patient to any physician.

4. G040, G041, G042 and G043 are *not eligible for payment* unless K623 or K624 or a consultation, assessment or time–based service involving a direct physical encounter with the patient is payable in the same *month* to the same physician rendering the G040, G041, G042 or G043 service.

5. G039 is limited to a maximum of two (2) tests per patient per *week*, any physician.

6. G039 is *only eligible for payment* when rendered to rule out urine tampering.

7. Only one of G040, G041, G042 or G043 is eligible for payment per urine sample.

C. Miscellaneous Tests

G031	Prothrombin time	6.40
G001	Cholesterol, total	5.70
G002	Glucose, quantitative or semi-quantitative	2.26
G481	Haemoglobin screen and/or haematocrit (any method or instrument)	1.37
G004	Occult blood	1.58
G005	Pregnancy test	3.88

Payment rules:

1. G005 is only insured when an immediate determination of pregnancy is required to prevent imminent physical harm to the patient.

LABORATORY MEDICINE

		Fee
G009	Urinalysis, routine (includes microscopic examination of centrifuged specimen plus any of SG, pH, protein, sugar, haemoglobin, ketones, urobilinogen, bilirubin)	4.90
G010	One or more parts of above without microscopy	2.64
G011	Fungus culture including KOH preparation and smear	13.05
G012	Wet preparation (for fungus, trichomonas, parasites)	1.93
G014	Rapid streptococcal test	6.80

Payment rules:
G009 and G010 are not insured when rendered for the monitoring of adverse effects resulting from a calorie restricted weight loss program.

NEPHROLOGY

Fee

SPECIFIC ELEMENTS

Nephrological management of donor procurement

In addition to the *common elements*, this service includes the following *specific elements*.

A. Monitoring the life support systems of a neurologically dead donor to ensure adequate perfusion and oxygenation of the kidneys.

B. Assessment of renal functions pre-nephrectomy, including the obtaining of specimens and interpretation of results and assessment as to potential recipients to be called in.

C. Prescribing and providing appropriate pre-nephrectomy immunotherapy.

D. Making arrangements for any related assessments, procedures or therapy, related to the harvesting of the organ(s).

E. Discussion with and providing advice and information to the patient's family or representative, whether by telephone or otherwise, on matters related to the service including advice unless separately billable, as to the results of such procedure(s) and/or related assessments as may have been performed.

F. Providing premises, equipment, supplies and personnel for the *specific elements*.

While no occasion may arise for performing elements C, D and E, when performed in connection with the other *specific elements*, they are included in the service.

	G411	Nephrological management of donor procurement	213.00
#	G347	Renal perfusion with hypothermia for organ transplantation ..	96.35
#	G348	Renal preservation with continuous machine perfusion	96.35

Nephrological component of renal transplantation

This applies to the service of being in constant or periodic attendance following transplantation, to provide all aspects of care to the renal transplant patient. This consists of an initial consultation or assessment and such subsequent assessments as may be indicated, including ongoing monitoring of the patient's condition and intervening as appropriate.

#	G412	1st day following transplantation.....		354.30
#	G408	2nd to 10th day, inclusive	per diem	177.10
#	G409	11th to 21st day, inclusive.....	per diem	88.55

Payment rules:

1. G412, G408, G409 are *not eligible for payment* following transplantation of an organ other than the kidney.

Note:

G412, G408, G409 includes complete patient care.

NERVE BLOCKS FOR ACUTE PAIN MANAGEMENT

PREAMBLE

1. Nerve blocks listed in this section are eligible for payment only when rendered for acute pain management, including peri-operative or post-operative pain management as described below and where the nerve block has a duration of action of more than 4 hours. Acute pain is defined as pain that occurs with sudden onset and that is expected to resolve within 6 *week*s.
2. Nerve blocks rendered for acute pain with a duration of action of less than 4 hours, topical anaesthesia or local infiltration used as an anaesthetic for any procedure, are *not eligible for payment*.
3. Except as described in paragraph 4, when a physician administers an anaesthetic, nerve block and/or other medication prior to, during, immediately after or otherwise in conjunction with a diagnostic, therapeutic or surgical procedure which the physician performs on the same patient, the administration of the anaesthetic, nerve block and/or other medication is *not eligible for payment*.
4. A major or minor peripheral nerve block, major plexus block, neuraxial injection (*with or without* catheter) or intrapleural block (*with or without* catheter) for post-operative pain control (with a duration of action more than 4 hours) is eligible for payment as G224 when rendered in conjunction with a procedure which the physician performs on the same patient.
5. When a physician renders an anaesthesia service in support of a procedure performed by another physician, a peripheral nerve block, plexus block, neuraxial injection or intrapleural injection using short-acting medication (with a duration of action less than 4 hours) is *not eligible for payment* in addition to the C-suffix anaesthesia service.
6. When a physician renders an anaesthesia service in support of a procedure performed by another physician, a peripheral nerve block, plexus block, neuraxial injection or intrapleural injection, listed in this section and performed for post-operative analgesia (with a duration of action more than 4 hours) is eligible for payment in addition to the C-suffix anaesthesia service.

   [Commentary:
   1. For the purposes of paragraph 6, only peripheral nerve blocks, plexus blocks, neuraxial injections or intrapleural injections listed in this section are eligible for payment. Nerve blocks listed elsewhere in the *Schedule* are not payable for acute pain management.
   2. For obstetrical continuous conduction anaesthesia, see P014C and P016C, listed in the Obstetrics section.]
7. With the exception of a bilateral pudendal block (where only one service is eligible for payment) a nerve block is payable once per region per side where bilateral procedures are performed.
8. Notwithstanding maximums applicable to individual nerve block services, there is an overall maximum of 8 per patient per day for any combination of nerve blocks. The ninth and subsequent nerve blocks per patient per day are *not eligible for payment*. Nerve blocks which are defined as a bilateral procedure are counted as two services for the purpose of the overall daily maximum.
9. Professional and/or technical fees for obtaining and/or interpreting images for the purpose of guidance (e.g. nerve stimulation, ultrasound, fluoroscopy) are *not eligible for payment* in addition to the injection services listed in this section.
10. For anaesthesia services in support of a nerve block or interventional pain injection procedure performed by another physician, see General Preamble.
11. Injection services listed elsewhere in the *Schedule* are *not eligible for payment* in addition to injections listed in this section for the same injection procedure.

NERVE BLOCKS FOR ACUTE PAIN MANAGEMENT

			Fee
		Neuraxial	
#	G248	Caudal, single injection	55.00
#	G125	Caudal/lumbar epidural with catheter	100.00
#	G118	Thoracic epidural with catheter	130.00
#	G062	Cervical epidural with catheter	160.00
	G260	Major plexus block	80.00

Payment rules:

1. The G260 service is a block of one of the following: brachial plexus, lumbar plexus, sacral plexus, deep cervical plexus, or a combined 3-in-1 block which must include the femoral, obturator and lateral femoral cutaneous nerves.

2. When a major plexus block is rendered, additional blocks of one or more nerves within the same nerve distribution are *not eligible for payment*.

[Commentary:
If a peripheral nerve block is performed that is not within the same nerve distribution of a major plexus block, then both blocks are eligible for payment. For example, a sciatic nerve block performed in addition to a combined 3-in-1 block.]

3. When 2 or more nerve blocks of major and/or minor peripheral nerves that are within the distribution of a major plexus are rendered individually, only G260 is eligible for payment.

[Commentary:
For example, if radial, median and ulnar nerve blocks are performed individually, only the brachial plexus block (i.e. major plexus block) is eligible for payment. If femoral, obturator and lateral femoral cutaneous blocks are performed individually, only the combined 3-in-1 (i.e. major plexus) block is eligible for payment.]

	G060	Peripheral nerve block, major	55.00

Payment rules:

1. The G060 service must consist of one of the following:

a. a block of one of: radial, median, ulnar, musculocutaneous, femoral, sciatic, common peroneal and/or tibial, obturator, suprascapular, pudendal (uni or bilateral), trigeminal or facial nerve;

b. a paravertebral block – first injection only;

c. an ankle block (must include 2 or more of the following: deep peroneal, superficial peroneal, posterior tibial, saphenous or sural nerve); or

d. a fascia iliaca block.

2. G060 is limited to a maximum of 4 services per patient per physician per day.

3. When a major peripheral nerve block is rendered, additional blocks of one or more nerves within the same nerve distribution are *not eligible for payment*.

NERVE BLOCKS FOR ACUTE PAIN MANAGEMENT

		Fee
G061	Peripheral nerve block, minor	30.00

Payment rules:

1. The G061 service must consist of one of the following:

a. a block of one of: ilioinguinal and/or iliohypogastric, genitofemoral, lateral femoral cutaneous, saphenous, occipital, supraorbital, infraorbital or glossopharyngeal nerve;

b. an intercostal block;

c. a superficial cervical plexus block;

d. a transversus abdominis plane (TAP) block; or

e. a paravertebral block – additional injection.

2. G061 is limited to a maximum of 4 services per patient per physician per day.

3. When a minor peripheral nerve block is rendered, additional blocks of one or more nerves within the same nerve distribution are *not eligible for payment*.

Percutaneous nerve block catheter insertion for continuous infusion analgesia

#	G279	Percutaneous nerve block catheter insertion	80.00

Payment rules:

1. G279 is eligible for payment in addition to the applicable peripheral nerve or plexus block.

2. G260 is *not eligible for payment* in addition to G279 when rendered for a continuous combined 3-in-1 block; G060 is eligible for payment in addition to G279 in this circumstance.

3. No guidance (e.g. nerve stimulation, ultrasound) used for percutaneous nerve block catheter insertion is eligible for payment.

	G066	Intrapleural block	55.00
	G067	Intrapleural block with continuous catheter	80.00
#	G068	Epidural blood patch	125.00
#	G065	Epidural blood patch injected through existing epidural catheter	62.50
	G224	Nerve block by same physician performing the procedure	15.55

[Commentary:
Refer to the Preamble of this section for additional information regarding G224.]

	G247	Hospital visits, to a maximum of 3 per patient per day	30.10

Payment rules:

G247 is *only eligible for payment* to the physician most responsible, or to a physician substituting for the physician most responsible, for providing management and supervision of a:

1. continuous catheter infusion for analgesia for a hospital in-patient; or

2. lumbar sub-arachnoid drainage catheter placed in association with a surgical procedure where there is increased risk of spinal cord ischemia.

[Commentary:
G247 is not for visits to patients solely receiving intravenous pain management, such as patient controlled analgesia alone; a continuous nerve/plexus block or epidural/spinal catheter must be present for G247 to be payable.]

Fee

Initiation of outpatient continuous nerve block infusion

The initiation of outpatient continuous nerve block infusion is the service rendered to prepare outpatients for discharge from hospital after the patient has had an insertion of a percutaneous nerve block catheter for continuous infusion analgesia or for outpatient palliative epidural infusion. The service includes an assessment of the patient and all procedures required to prepare the infusion, the infusion of medications and education or counselling of the patient, patient's relative(s), *patient representative* or other caregiver(s).

G063 Initiation of outpatient continuous nerve block infusion 29.20

Note:
When rendered to a hospital in-patient, the service described by G063 is included in G247.

Management and supervision of outpatient continuous nerve block infusion or outpatient palliative epidural infusion

In addition to the *common elements*, the components of this service include the following *specific elements*:

A. Monitoring the condition of a patient with respect to the continuous nerve block infusion.

B. Adjusting the dosage of the infusion therapy and, where appropriate, prescribing other therapy.

C. Discussion with, and providing advice and information to the patient, patient's relative(s), *patient representative* or other caregiver(s), by telephone or otherwise, on matters related to the service, regardless of the identity of the person initiating the discussion.

D. Making arrangements for any related assessments, procedures or therapy and interpreting results as appropriate.

E. Providing premises, equipment, supplies and personnel for the *specific elements*.

G064 Management and supervision of outpatient continuous nerve block infusion..... per day 20.00

Payment rules:

1. G064 is *only eligible for payment* when:

a. rendered by the physician most responsible for the patient's care or by a physician substituting for that physician (the "substitute physician"); and

b. the clinical decision(s) pertaining to the medical advice, direction or information provided is formulated personally by the physician or substitute physician.

2. G064 is *only eligible for payment* for a day when one or more components of element C are rendered in that day.

3. G064 rendered on the same day as a consultation or visit by the same physician is *not eligible for payment*.

4. G064 is limited to a maximum of 7 services per patient per G279 service.

Medical record requirements:
A dated summary of each contact must be recorded in the patient's permanent medical record or the service is *not eligible for payment*.

NERVE BLOCKS - INTERVENTIONAL PAIN INJECTIONS

PREAMBLE

1. Injections listed in this section rendered for the diagnosis of pain-related conditions are *only eligible for payment* when rendered solely for the purpose of diagnosing the source of pain or developing a therapeutic treatment plan.

   [Commentary:
   A repeat diagnostic pain-related injection on the same region is ideally rendered after 1 *week* of a previous diagnostic pain-related injection unless factors such as distance the patient has travelled for an assessment makes the ideal period impractical.]

2. Professional and/or technical fees for obtaining and/or interpreting images for the purpose of guidance are *not eligible for payment* in addition to the injection services listed in this section.

3. For anaesthesia services in support of interventional pain injection procedures, see General Preamble Anaesthesiologist Services.

4. Injections listed in this section include the injection of contrast, medication and/or other solution, unless separately listed.

5. Injection services listed elsewhere in the *Schedule* are *not eligible for payment* in addition to injections listed in this section for the same injection procedure.

   [Commentary:
   For example, joint injection fee codes G370 and G371 are *not eligible for payment* in addition to facet joint or sacroiliac joint injections listed in this section for the same injection procedure.]

6. If more than one procedure listed in this section is performed for the same patient on the same day, each procedure is *only eligible for payment* if rendered to diagnose or treat a separate condition.

7. For the purposes of this section, the term “site” refers to the anatomic area described by the fee code descriptor.

   Medical record requirements:
   Injections listed in this section are *only eligible for payment* if documentation clearly describes:

   1. the procedure performed, or where image guidance is used, images of final needle placement that clearly identify the site of injection and/or spread of contrast, when indicated; and

   2. the purpose of any diagnostic pain-related injection and the subsequent response to the procedure, indicating a positive or negative result.

NERVE BLOCKS - INTERVENTIONAL PAIN INJECTIONS

		Fee
	Vertebral facet injections	
	Percutaneous diagnostic injections with fluoroscopic guidance - facet medial branch block, facet joint injection or sacral lateral branch block.	
G910	Cervical, first site	80.00
G911	Thoracic, first site	80.00
G912	Lumbar/Sacral, first site	80.00
G913	- each additional site, to G910, G911 or G912 ..... add	20.00
	Percutaneous diagnostic lumbar facet medial branch block with ultrasound guidance	
G914	First site	56.00
G915	- each additional site, to G914 ..... add	14.00

[Commentary:
Ultrasound images must be of sufficient quality to clearly identify the injection site and needle placement at the junction of the transverse process and superior articular process.]

Payment rules:

1. G914 is *only eligible for payment* when a fluoroscopically guided facet injection has been rendered for the same site(s) within the previous *12 month period* by the same physician.

2. G913 and G915 are each limited to a maximum of 7 services per patient per day.

3. G910, G911, G912 or G914 are each limited to 6 services per patient per *12 month period*. If, in the opinion of the treating physician, more frequent services are necessary, the physician may obtain written prior authorization from the *MOH*. Authorization will be dependent on the physician demonstrating that the increased frequency of the service is generally accepted as necessary for the patient under the circumstances.

	Sacroiliac joint injections	
G916	Percutaneous diagnostic and/or corticosteroid sacroiliac joint injection with fluoroscopic guidance, unilateral	75.00
	Nerve root injections	
G917	Percutaneous diagnostic selective nerve root block with fluoroscopic guidance, with or without contrast – any number of sites	160.00

Payment rules:
G917 is limited to a maximum of 1 service per patient per *week* and a maximum of 12 services per patient per *12 month period*.

			Fee
	Epidural and spinal injections		
	Percutaneous epidural injections		
# G246	Lumbar		150.00
# G117	Thoracic		170.00
# G119	Cervical		190.00
# G918	Caudal		74.20
E440	- with injection of contrast using fluoroscopy, to G246, G117, G119 or G918	add	30.00
E441	- when performed at same level of previous spinal surgery, to G246, G117, G119 or G918	add	16.60
E442	- when performed using a transforaminal technique, to G246, G117, G119 or G918	add	20.00
E443	- with catheter for continuous infusion, to G246, G117, G119 or G918	add	80.00
# E833	- with insertion of subcutaneous port, G117, G119, G246 or G918	add	116.10

Payment rules:

1. Percutaneous epidural injections are limited to 12 services per patient per *12 month period* for any combination of G119, G117, G246 and G918. If, in the opinion of the treating physician, more frequent treatments are necessary, the physician may obtain written prior authorization from the *MOH*. Authorization will be dependent on the physician demonstrating that the increased frequency of the service is generally accepted as necessary for the patient under the circumstances.

2. G246, G117, G119 or G918 are *only eligible for payment* same patient same day with G236, G234 and G920 if rendered to diagnose or treat a separate condition.

[Commentary:
The sympathetic block that may result from an epidural injection is not payable as G920, G234 or G236.]

3. G246, G117, G119 or G918 are *not eligible for payment* with any concurrent surgical procedure or any anaesthetic fee, except for E030C or E031C when indicated as described in the General Preamble Anaesthesiologist Services.

[Commentary:

1. For initiation and management services for outpatient palliative epidural infusion, refer to G063 and G064 page J73.

2. For epidural blood patch, refer to G068 and G065 page J72.]

G245	Lumbar epidural or intrathecal injection of sclerosing solution		180.00
G239	Differential intrathecal spinal block		127.60
# G919	Percutaneous epidural adhesiolysis by infusion with fluoroscopic guidance		400.00

Note:

G919 is *only eligible for payment* if the following conditions are met:

1. it is used for the treatment of epidural fibrosis with symptoms of persistent back or radicular/ neuropathic leg pain following spinal surgery;

2. the patient has had inadequate symptom control following fluoroscopically-guided epidural steroid injections to the suspected site of pain generation and there is no alternate primary diagnosis, such as facet-mediated or sacroiliac joint-mediated pain; and

3. it is rendered with fluoroscopic guidance using:

a. a directional epidural catheter, with its final position confirmed using contrast;

b. hypertonic saline and hyaluronidase, which are infused for at least one hour; and

c. epidural corticosteroid, which is injected prior to catheter removal.

[Commentary:
If any of these conditions are not met, epidural adhesiolysis is *only eligible for payment* using another appropriate epidural injection service listed above. For example, if performing an interlaminar lumbar adhesiolysis at a previous surgical site using a bolus-through-needle technique rather than an infusion, and hypertonic saline, hyaluronidase, local anaesthetic and corticosteroid are injected following contrast injection to confirm needle placement, G246, E440 and E441 are eligible for payment.]

4. G919 is limited to a maximum of 4 services per patient per *12 month period*.

5. G246, G117, G119, G918, G245, E440, E441, E442, E443 or E833 are *not eligible for payment* with G919 for the same procedure for which G919 is payable.

		Fee
	Sympathetic nerve injections	
	Percutaneous cervical sympathetic nerve block or Stellate ganglion block	
G920	- with ultrasound or fluoroscopic guidance, unilateral.....	80.00
G234	- without ultrasound or fluoroscopic guidance, unilateral.....	55.10
	Percutaneous lumbar, thoracic or sacral sympathetic nerve block with fluoroscopic guidance	
G236	- unilateral or bilateral	150.00

Payment rules:

1. G920 and G234 are each limited to a maximum of one unilateral or one bilateral procedure per patient per day to a limit of 24 services for any combination of unilateral and bilateral procedures per patient per *12 month period*. G236 is limited to a maximum of one per patient per day to a limit of 12 per patient per *12 month period*. If, in the opinion of the treating physician, more frequent treatments are necessary, the physician may obtain written prior authorization from the *MOH*. Authorization will be dependent on the physician demonstrating that the increased frequency of the service is generally accepted as necessary for the patient under the circumstances.

2. G920, G234 and G236 are *only eligible for payment* same patient same day with other nerve block and/or injection services if rendered to diagnose or treat a separate condition.

3. G234 is *not eligible for payment* with G920 same patient same day.

4. The sympathetic block that may result from epidural, spinal, plexus and peripheral nerve blocks is not payable as G920, G234 or G236.

	Miscellaneous	
# G374	I.V. regional guanethidine	54.30
	Ganglion/Plexus injections	
G233	Percutaneous celiac, splanchnic or hypogastric ganglion/ plexus block with fluoroscopic guidance	200.00
E444	- with radiofrequency ablation, to G233 ..... add 50%	
G217	Percutaneous trigeminal ganglion block with fluoroscopic guidance.....	200.00
G232	Percutaneous spheno-palatine ganglion block with fluoroscopic guidance.....	150.00
E445	- when alcohol or other sclerosing solutions are used, to G920, G234, G236, G233, G217 or G232..... add 50%	
G921	Spheno-palatine ganglion block, transnasal topical, uni or bilateral.....	12.50

Payment rules:

G921 is not eligble for payment same patient same day with G232.

[Commentary:

For percutaneous provocation vertebral discography, refer to J006 Discogram page E4.]

NERVE BLOCKS - PERIPHERAL/OTHER INJECTIONS

PREAMBLE

1. With the exception of G224 as described in the Nerve Blocks for Acute Pain Management section, when a physician administers an anaesthetic, nerve block and/or other medication prior to, during, immediately after or otherwise in conjunction with a diagnostic, therapeutic or surgical procedure which the physician performs on the same patient, the administration of the anaesthetic, nerve block and/or other medication is *not eligible for payment*.
2. Notwithstanding maximums applicable to individual nerve block services, there is an overall maximum of 8 per patient per day for any combination of nerve blocks. The ninth and subsequent nerve blocks per patient per day are *not eligible for payment*. Nerve blocks which are defined as a bilateral procedure are counted as two services for the purpose of the overall daily maximum.
3. For anaesthesia services in support of a nerve block performed by another physician, see General Preamble.
4. Professional and/or technical fees for obtaining and/or interpreting images for the purpose of guidance (e.g. nerve stimulation, ultrasound, fluoroscopy) are *not eligible for payment* in addition to the injection services listed in this section.
5. Injection services listed elsewhere in the *Schedule* are *not eligible for payment* in addition to injections listed in this section for the same injection procedure.
6. Topical anaesthesia or local infiltration used as an anaesthetic for any procedure is *not eligible for payment*.

NERVE BLOCKS - PERIPHERAL/OTHER INJECTIONS

		Fee
G214	Brachial plexus	54.65
	Femoral nerve	
G243	- unilateral	54.65
G244	- bilateral	81.95
	Occipital nerve	
G264	- first block per day (maximum 1 per day to a maximum of 16 first blocks per calendar year)	34.10
G265	- each additional unilateral block following G264 per spinal level per day when G264 is payable in full (maximum 3 per day to a maximum of 48 additional blocks per calendar year)	17.10
G291	- first block per day in excess of 16 per calendar year may be payable on an independent consideration (IC) basis upon submission to the ministry of a written recommendation of an independent expert as described below. (maximum 1 per day to a maximum of 16 blocks for a single IC request). A new written recommendation is required on an IC basis each time the number of first blocks exceeds 16	19.85
G292	- each additional unilateral block following G291 per spinal level per day when G291 is payable in full (maximum 3 per day)	10.00

Note:

1. G265 and G292 are insured services payable at nil unless an amount is payable for G264 or G291 rendered to the same patient the same day.

2. When an amount is payable for G264, the amount payable for G291 rendered to the same patient on the same day is nil.

3. When an amount is payable for G265, the amount payable for G292 rendered to the same patient on the same day is nil.

4. For the purpose of G291, independent expert in respect of a patient is a physician who:

- **a.** has special knowledge and expertise in multidisciplinary management of chronic non-malignant pain;
- **b.** did not refer the patient for treatment;
- **c.** is not actively involved in management of the patient; and
- **d.** receives no direct or indirect financial benefit for the nerve block services being rendered to the patient.

[Commentary:
See Appendix B regarding conflict of interest.]

		Fee
	Percutaneous nerve block catheter insertion for continuous infusion analgesia	
G279	Percutaneous nerve block catheter insertion	80.00

Payment rules:

1. G279 is eligible for payment in addition to the applicable peripheral nerve or plexus block.

2. No guidance (e.g. nerve stimulation, ultrasound) used for percutaneous nerve block catheter insertion is eligible for payment.

[Commentary:
Maintenance of the catheter may constitute a subsequent visit subject to the limits as outlined on General Preamble GP43.]

G218	Ilioinguinal and iliohypogastric nerves	54.65
G219	Infraorbital	34.20
G220	Intercostal nerve	34.20
G221	- for each additional one add	16.95
G258	Intrapleural block (single injection)	44.25
G257	Intrapleural block (with the introduction of a catheter for the purpose of continuous analgesia)	77.25
G225	Mental branch of mandibular nerve	34.20
G250	Maxillary or mandibular division of trigeminal nerve	75.10
	Obturator nerve	
G241	- unilateral	54.65
G242	- bilateral	82.45
G227	Other cranial nerve block	54.65
G228	Paravertebral nerve block of cervical, thoracic or lumbar or sacral or coccygeal nerves	34.10
G123	- for each additional one (to a maximum of 4) add	17.10
	Pudendal	
G229	- unilateral	54.65
G240	- bilateral	82.45

Note:
For obstetrical continuous conduction anaesthesia, see P014 and P016, listed in the Obstetrics section of the *Schedule*.

G422	Retrobulbar injection (not to be claimed when used as a local anaesthesia)	34.20
	Sciatic nerve	
G230	- unilateral	54.65
G226	- bilateral	82.45
	Somatic or peripheral nerves not specifically listed	
G231	- one nerve or site	34.10
G223	- additional nerve(s) or site(s) add	17.10

NERVE BLOCK S - PERIPHERAL/OTHER INJECTIONS

		Fee
G256	Superior laryngeal nerve.....	34.10
G235	Supraorbital	34.10
G238	Transverse scapular nerve	34.10
E958	- when alcohol or other sclerosing solutions are used, the appropriate nerve block fees as listed above..... add 50%	

NEUROLOGY

		Fee
Z804	Lumbar puncture	150.00

Payment rules:

1. Z804 is *not eligible for payment* with C-suffix anaesthesia services rendered for surgical procedures, obstetrical anaesthesia procedures or with epidural services described in the nerve block sections of the *Schedule*.

2. Z804 includes injection of any medication or other therapeutic agent introduced at time of lumbar puncture.

3. Z804 includes image guidance if performed.

# G410	Amytal test (Wada)-bilateral - supervision and co-ordination of tests	68.40
# G413	Electrocorticogram - supervision and interpretation	170.85

Note:
G413 payable at nil when claimed with G267 same patient, same day.

# G551	Katzman test (subarachnoid infusion test) including lumbar puncture	170.85
# G267	Intra-operative evaluation of movement disorder patient during functional neurosurgery	270.05

Note:
G267 is not payable with assistant units.

# G547	Clinical Programming of Deep Brain Stimulator (DBS) - includes one or more visits for DBS checking, minor and major DBS adjustments, and intensive programming. First implantation site (maximum 1 per patient)	185.70
# G549	- additional implantation site(s) (maximum 1 per patient)	157.85

Electrophysiological assessment

# G266	- of movement disorders - includes multi-channel recording of EEG and EMG, rectification, averaging, back averaging, frequency analysis and cross correlation. Minimum of 3 hours. Physician must be physically present throughout assessment	278.85
# G548	- of Deep Brain Stimulators - includes measuring electrode impedance, recording EEG and EMG, rectification, averaging, frequency analysis and cross correlation. Minimum of 3 hours. Physician must be physically present throughout assessment	278.85
G417	- inserting subtemporal needle electrodes ... add	15.90

NEUROLOGY

	T	P

ELECTROENCEPHALOGRAPHY

Routine EEG

A routine EEG consists of at least a twenty minute recording with referential and bipolar montages and at least eight channels (except in neonates). Hyperventilation and photic stimulation should be done in all cases where clinically possible.

G414	Routine EEG - technical component	28.30	
G415	Routine EEG - professional component		23.15
G418	Routine EEG - professional component (16 - 21 channel EEG)		62.50

Sleep-deprived/induced EEG

A sleep-deprived/induced EEG is an EEG recording (*with or without* video monitoring) performed after an overnight period of sleep deprivation of greater than 4 hours; or the administration of a sedative/hypnotic agent prior to the EEG recording for the purposes of sleep induction, and must include all of the following:

a. at least 60 minutes of EEG recording time;

b. a minimum of 16 channels of EEG; and

c. recordings of at least two physiological parameters.

G541	- technical component	45.30	
G543	- professional component		120.00

EEG with time-locked video recording

An EEG with time-locked video recording must include all of the following:

a. at least 30 minutes of EEG recording time;

b. a minimum of 16 channels of EEG;

c. recordings of at least two physiological parameters; and

d. a time-locked video recording

G541	- technical component	45.30	
G496	- professional component		120.00

Note:

1. The amount payable for a sleep-deprived/induced EEG, or an EEG with time-locked video recording that does not meet the above requirements will be reduced to that for a routine EEG fees (i.e. G414 and G415/G418).

2. G414 is *not eligible for payment* with G541.

3. Only one of G415, G418, G543 or G496 are *eligible for payment* per day.

4. EEG services (i.e. G414, G415, G418, G496, G541, G543, G540, G545, G542, G546, G554, G555, or G544) are *not eligible for payment* with any overnight or daytime sleep study (i.e. J898, J899, J990, J896, J897, J895, J890, J889, J893 or J894).

NEUROLOGY

		T	P

Prolonged EEG monitoring

Videotape recording of clinical signs in association with spontaneous EEG. Unit means ¼ hour or major part thereof. See General Preamble GP7 for definitions and time-keeping requirements. Payable at nil if claimed with any baseline EEG.

G540	- technical component	per unit	10.50	
G545	- professional component	per unit		14.70

Payment rules:

1. G540 is limited to a maximum of 12 units.
2. G545 is limited to a maximum of 18 units per patient per service date, and to a maximum of 14 services per hospital admission.
3. G545 is *not eligible for payment* for EEG monitoring performed for routine physiologic surveillance, including depth of sedation or anaesthesia.
4. G545 is *not eligible for payment* on any service date where any other professional EEG service is eligible for payment.

Radiotelemetry or portable recordings to monitor spontaneous EEG from a freely moving patient, add to routine fees.

G542	- technical component		26.85	
G546	- professional component			30.45

Ambulatory EEG monitoring

This is to include 12 to 24 hours of EEG monitoring. The fee includes EEG electrodes and other physiological parameters felt necessary to arrive at an appropriate electrographic diagnosis.

G554	- technical component		53.75	
G555	- professional component			120.00

Polygraphic recording of parameters in addition to EEG (such as respiration, eye movement, EKG, muscle movements, etc.)

G544	- technical component, per item	add	9.60	

Note:
G544 limited to a maximum of 3.

[Commentary:
Examples of physiological parameters include ECG, respirations, EMG, extra-ocular movements, oxygen saturation, and temperature.]

NEUROLOGY

		T	P
	EVOKED POTENTIALS		
	Upper or lower limbs		
G140	- technical component	46.60	
G138	- professional component		71.65

Note:
When only one limb is tested, claim the applicable fee - G140 or G138 at 50%.

NEUROSURGERY

Fee

ACQUIRED ACUTE BRAIN INJURY MANAGEMENT

Definition/Required elements of service:

This is the service rendered by the neurosurgery specialist most responsible for management of a critically ill hospital in-patient with an acquired acute brain injury, where the neurosurgeon provides management:

a. post-operatively for a patient who has received an endovascular intracranial surgical procedure during the same hospital admission but only if that procedure was not performed by any neurosurgeon; or

b. for a patient who has not received an intracranial surgical procedure during the same hospital admission with the exception of Z820, Z812, N115, N139, N174, Z824, Z802, Z825, Z803.

[Commentary:

1. Examples of acquired acute brain injury include acutely raised intracranial pressure, subarachnoid, intracerebral or intraventricular haemorrhage, cerebritis, cerebral abscess, malignant cerebral edema, acute hydrocephalus, ventriculitis and trauma.

2. If a neurosurgeon renders an intracranial surgical procedure not on the exception list above, Acquired Acute Brain Injury Management is not payable for a post-operative patient to any physician.]

This service has the same *specific elements* as consultations and assessments.
In addition the service *may include* the following elements:

a. An initial consultation or assessment and such subsequent assessments as may be indicated, including ongoing monitoring of the patient's condition and intervening as appropriate;

b. management of coma and monitoring the life support systems to ensure optimum neurological perfusion and oxygenation;

c. management of intracranial pressure (excluding insertion of I.C.P. or brain oxygen/pH measuring device) including monitoring, interpretation and drainage of cerebrospinal fluid when indicated;

d. monitoring and management of cerebral vasospasm;

e. prophylaxis and management of seizures;

f. making arrangements for any related assessments, procedures or therapy, related to the patient’s acute neurological deterioration, including decompressive craniectomy, cerebral angioplasty or evacuation of intracranial space occupying lesions;

g. clinical and radiological assessment of the cervical spine and spinal cord for the determination of spinal stability;

h. performance and/or arranging tests for the establishment of a diagnosis of brain death

i. making *referral*s, when appropriate, to organ procurement professionals

j. all related discussion, counselling and interviews with the patient’s relative(s), patient's representative or other caregiver(s);

k. All related case conferences.

NEUROSURGERY

			Fee
	Acquired acute brain injury management		
G790	1st day	per diem	223.10
G791	2nd day to 30th day, inclusive	per diem	146.45
G792	31st day onwards	per diem	58.60

Payment rules:

1. Critical Care ICU per diem fees are not payable with G790, G791or G792 for the same patient, same day, same physician.

2. Consultations, assessments or any time based service such as counselling or interviews or case conferences are *not eligible for payment* same patient, same day with G790, G791 or G792.

3. G790 is only payable once per patient, per same hospital admission.

4. G791 and G792 are each only payable once per patient, per day.

5. G790, G791 or G792 are *not eligible for payment* for stabilized patients, whether or not the patient is in an ICU.

		Fee	Anae
	Contact lens fitting		
G424	- includes follow-up for 3 months except for patients under 4 years of age at the time of the initial fitting	201.00	
G431	- under general anaesthesia ... add	41.60	6

[Commentary:
Follow up services are payable in addition to contact lens fitting (G424) for *child*ren under 4 years of age.]

G423	One eye only, when the other eye has been previously fitted by the same physician, with follow-up for 3 months	90.30	

Note:
Contact lens fitting (G424 and G423) is only insured for the following indications:

- **i.** aphakia,
- **ii.** myopia greater than 9 diopters,
- **iii.** irregular astigmatism resulting from post corneal grafting or corneal scarring from disease, or
- **iv.** keratoconus.

[Commentary:
Contact lens fitting performed for other indications is an uninsured service]

G463	Hydrophilic Bandage lens fitting	90.30	
G453	Electro-oculogram - interpretation fee	41.60	
G426	Glaucoma provocative tests, including water drinking tests	9.70	
G427	Ophthalmodynamometry	9.60	
	Radioactive phosphorus examination		
G429	- anterior approach	42.45	
G430	- posterior approach	86.05	
G421	Subconjunctival or sub-Tenons capsule injection	27.70	

Note:
G429, G430, G421 - for bilateral procedures, add 50% of the listed benefit.

+ G435	Tonometry	5.10	

Note:
G435 may not be claimed in conjunction with an ophthalmological consultation or specific assessment as this is included in these services.

		T	P

Colour vision detailed assessment

Colour vision detailed assessment (not to be claimed for screening tests such as Ishihara, HRR and University, etc.) only where underlying pathology is present or suspected. Requires that the following services are rendered: one of the screening tests and at least two (2) of the following detailed tests: 100 Hue, D-15, Lathony New Colour Test or anomaloscope test. To be performed where underlying pathology is present or suspect. Not to be performed as a routine screening test.

G850	- technical component	23.65	
G438	- professional component		22.15

Dark adaptation curve (Goldmann adaptometer or equivalent)

G851	- technical component	35.50	
G437	- professional component		22.90

Electro-retinography with report

G852	Full field or multi-focal electro-retinography - technical component	38.50	
G439	Full field electro-retinography - professional component		75.00
G524	Multi-focal electro-retinography - professional component		75.00

Payment rules:

1. G852 is limited to 4 services per patient per *12 month period*.

2. G439 is limited to 2 services per patient per *12 month period*.

3. G524 is limited to 2 services per patient per *12 month period*.

4. G524 is *only eligible for payment* for the evaluation of disorders of the retina involving high resolution vision function (i.e. cone function).

5. Electro-retinography includes any pupil dilation and refraction necessary to complete the study.

Fluorescein angiography

G853	- technical component	25.50	
G425	- professional component		44.40

Fluorescein angioscopy

G854	- technical component	7.50	
G444	- professional component		7.00

Note:

G425, G853, G444, G854 - for bilateral procedures, add 50% of the listed benefit.

Hess screen examination

G855	- technical component	7.30	
G428	- professional component		6.85

Tonography (to include tonometry) with or without water

G856	- technical component	10.50	
G433	- professional component		9.90

OPHTHALMOLOGY

		T	P
	Visual fields - kinetic (with permanent record)		
G857	- technical component	5.10	
G436	- professional component		14.50
	Visual fields - static		
	Visual fields static perimetry, is *only eligible for payment* where underlying pathology is present or suspected and the following services are rendered: permanent record with measurement of a minimum of 50 points per eye, quantification of deficient points and monitoring of fixation/ reliability.		
G858	- technical component	15.45	
G432	- professional component		26.95

OPHTHALMOLOGY

Fee

Corneal pachymetry

Corneal pachymetry – measurement of corneal thickness by any method for the purpose of identifying patients at risk for glaucoma on the basis of suspicious optic nerve and/or visual field testing and/or elevated intraocular pressure, and/or family history.

G813 Corneal pachymetry, professional component..... 5.10

Payment rules:
This service is limited to one per patient per lifetime. Services in excess of this limit, or rendered for any purpose other than identifying patients at risk for glaucoma, are not insured services.

Keratometry

Keratometry - measurement of the central 4mm of the cornea for the purpose of assessing patients:

a. with irregular astigmatism resulting from scarring due to trauma, herpes simplex keratitis, dystrophies (such as Salzman's and map-dot-fingerprint dystrophy) or other inflammatory disorders; or

b. with keratoconus, pellucid marginal degeneration, keratoglobus, following penetrating keratoplasties or following pterygium excision, or

c. with corneal thinning or ectasia where corneal cross linking is being contemplated or has been performed.

G811 Keratometry, professional component 4.80

Corneal topography

Corneal topography - topographical mapping of the cornea for the purpose of assessing patients with same indications as those set out above for keratometry.

G810 Corneal topography, professional component 4.80

Payment rules:
G811 (keratometry) or G810 (corneal topography) rendered for other indications are not insured services.

Specular photomicroscopy

Specular photomicroscopy – Examination of the cornea prior to intraocular surgery when affected by Fuch's corneal dystrophy, pseudophacic keratopathy, or other conditions that may compromise the corneal endothelium.

G812 Specular photomicroscopy, professional component 4.80

Payment rules:
Specular photomicroscopy rendered for other indications is not an insured service.

OPHTHALMOLOGY

		Fee
	Optical coherence tomography (OCT) - retinal disease	
G818	OCT unilateral or bilateral - retinal disease, when the physician interprets the results and either performs the procedure or supervises the performance of the procedure.....	35.00
	Optical coherence tomography (OCT) - glaucoma	
G820	OCT unilateral or bilateral - glaucoma, when the physician interprets the results and either performs the procedure or supervises the performance of the procedure.....	35.00
G821	OCT unilateral or bilateral - active management of retinal disease with laser or intravitreal injections when the physician interprets the results and either performs the procedure or supervises the performance of the procedure	35.00
G822	OCT unilateral or bilateral - active management with laser or intravitreal injections for neovascularization associated with: **i.** retinal disease, e.g. wet acute macular degeneration; **ii.** diabetic macular edema; or **iii.** retinal vein occlusion when the physician interprets the results and either performs the procedure or supervises the performance of the procedure	25.00

Payment rules:

1. G822 is limited to a maximum of 8 services per patient per *12 month period* and a maximum of 16 services per patient for 24 consecutive *months*.

2. G822 is *only eligible for payment* when the limit of any combination of G818, G820 or G821 is reached.

G823	OCT unilateral or bilateral - evaluation of an infant/child/adolescent with retinal disease and/or glaucoma (including genetic retinal anomalies and cancer), or low vision associated with or resulting in developmental delay when the physician interprets the results and either performs the procedure or supervises the performance of the procedure on a patient younger than 18 years of age.....	35.00

Payment rules:

1. G823 is limited to a maximum of 12 services per *12 month period*.

2. G818, G820, G821 and G822 are *not eligible for payment* when rendered on a patient younger than 18 years of age.

Payment rules:

1. Except as described in payment rule #2, OCT is an insured service only:
- **a.** for the diagnosis and management of retinal disease and/or glaucoma; and
- **b.** when the ophthalmologist performing the service is the physician most responsible for the care of the patient's retinal disease and/or glaucoma.

2. Any OCT service rendered in whole or in part for preparation related to cataract surgery is *not eligible for payment*.

Fee

3. G818 is eligible for payment only for one or more of the following:
- **a.** hemorrhage or exudate in the macula on clinical examination;
- **b.** retinal folds/wrinkling on clinical examination;
- **c.** macular hole/pseudohole on clinical examination;
- **d.** vision loss not explained by dilated clinical examination findings; or
- **e.** presence or reasonable suspicion of choroidal neovascular membrane, subretinal fluid or cystoid macular edema on clinical examination.

4. G820 is eligible for payment only for one or more of the following:
- **a.** suspicion of glaucoma based on optic nerve appearance on dilated clinical examination;
- **b.** suspicion of glaucoma based on visual field testing;
- **c.** elevated intraocular pressure; or
- **d.** history of glaucoma in an immediate family member.

5. G818, G820, G821, G822 or G823 is *only eligible for payment* when a consultation or assessment has been rendered by the same physician for the same patient in relation to the same condition for which OCT is being performed.

[Commentary:
For every claim for G818, G820, G822 or G823 there must be a separate consultation or assessment claimed by the same physician, but the services do not necessarily have to be rendered on the same day.]

6. G820 is limited to a maximum of two services per patient per *12 month period*.

7. Any combination of G818, G820 or G821 is limited to a maximum of four services per patient per *12 month period*.

8. Only one of G818, G820, G821, G822 or G823 is eligible for payment per patient same day.

Orthoptic examination

Orthoptic examination must include quantitative measurement of all cardinal positions of gaze (straight ahead, left, right, up, down, tilt right and tilt left), sensory testing for binocular vision suppression, cyclodeviation, retinal correspondence and interpretation. Orthoptic examination is eligible for payment in addition to an ophthalmology consultation or visit. The examination must be rendered by an orthoptist who is certified by the Canadian Orthoptic Council and employed by the ophthalmologist or a public hospital. The interpretation component of the examination must be personally rendered by the ophthalmologist.

G814 Orthoptic examination..... 25.00

Note:
G814 is *only eligible for payment* when all tests described under orthoptic examination are rendered and the results and measurements are documented in the patient's permanent medical record.

[Commentary:
If the interpreting ophthalmologist is also rendering the examination, the service should be claimed as A230.]

OPHTHALMOLOGY

		T	P
	Visual evoked response - simple		
G149	- technical component	20.40	
G147	- professional component		12.30
	Visual evoked response - threshold		
G152	- technical component	34.95	
G150	- professional component		19.20

OPHTHALMOLOGY

Fee

OCULAR PHOTODYNAMIC THERAPY (PDT)

Ocular photodynamic therapy (PDT) is, subject to the limitations set out below, an insured service when rendered by an ophthalmologist. PDT must include completion and submission of patient registration and drug requisition forms, establishment of intravenous access, supervision of drug infusion and personal application of non-thermal diode laser for activation of verteporfin.

PDT is insured only if the patient's clinical condition meets all of the following:

a. the patient has predominantly classic subfoveal choroidal neovascularization (CNV) secondary to either age-related macular degeneration (AMD), Presumed Ocular Histoplasmosis Syndrome or pathologic myopia. Predominantly means that the area of classic subfoveal CNV is equal to or greater than 50% of the total CNV lesion, as determined by fluorescein angiography and documented by retinal photographs retained on the patient's permanent medical record;

b. treatment is commenced within 30 *month*s after initial diagnosis of predominantly classic subfoveal CNV secondary to AMD, Presumed Ocular Histoplasmosis Syndrome or pathologic myopia;

c. the patient's visual acuity is equal to or worse than 20/40; and

d. for each repeat therapy, recurrent or persistent CNV leakage is detected by fluorescein angiography and documented by retinal photographs retained on the patient's permanent medical record.

If the patient's clinical condition meets all the above criteria but retinal photographs are not made prior to the procedure and retained on the patient's permanent medical record or the procedure is not performed by an ophthalmologist, then PDT is *not eligible for payment*. Maximum one PDT (unilateral or bilateral) per patient per day.

G460	Unilateral PDT per patient	per day	330.00
G461	Bilateral PDT per patient.....	per day	500.00

Note:

1. G379 rendered to same patient in conjunction with G460 or G461 is an insured service payable at nil.

2. G460 rendered to same patient same day as G461 is an insured service payable at nil.

3. Assessments and angiography are payable in addition to PDT. Retinal photography is insured as a specific element of the assessment and is not payable separately.

[Commentary:

1. PDT will normally not be administered to each affected eye more frequently than once every 3 *month*s.

2. PDT performed for treatment of clinical conditions other than described above is uninsured.]

OTOLARYNGOLOGY

		Fee
# G103	Debridement of maxillectomy cavity	6.05
+ G420	Ear syringing and/or extensive curetting or debridement unilateral or bilateral	13.15

Note:

1. G420 is *not eligible for payment* when rendered in addition to Z906, Z907, Z908 or Z913.

2. G420 is only insured when:

a. there is impacted ear wax resulting in hearing loss that is unresponsive to topical application of cerumenolytics; or

b. immediate removal of ear wax is medically necessary to visualize the tympanic membrane or the external ear canal for diagnostic and/or therapeutic purposes.

+ G403	Particle repositioning maneuvre for benign paroxysmal positional vertigo	21.70

OTOLARYNGOLOGY

PREAMBLE

DIAGNOSTIC HEARING TEST

A. Diagnostic hearing tests (DHTs) are identified for payment purposes as either basic or advanced DHTs.

B. Basic DHTs are insured services payable at nil unless:

1. the *professional component* is rendered personally by a physician qualified by appropriate education or training and experience to perform basic DHTs (qualified physician); and

2. the *technical component* is either rendered by a qualified physician or delegated by a qualified physician to a person who is either an appropriately qualified employee of the physician or is an audiologist who is a member of the College of Audiologists and Speech-Language Pathologists of Ontario and employed by a public hospital.

C. Advanced DHTs are insured services payable at nil unless:

1. the *professional component* is personally rendered by an otolaryngologist or, for evoked audiometry, a neurologist or by a non-certified physician with equivalent post-graduate academic training (appropriate specialist or equivalent); and

2. the *technical component* is personally rendered by an appropriate specialist or equivalent, or delegated by an appropriate specialist or equivalent to an audiologist who is a member of the College of Audiologists and Speech-Language Pathologists of Ontario and is employed by the appropriate specialist or equivalent or a public hospital.

D. Physicians submitting claims for DHTs shall maintain written records of appropriate qualifications as indicated above for themselves and those employees to whom they may delegate the *technical component*. Such records must be made available to the ministry on request. In the absence of such records, the DHT is an insured service payable at nil.

[Commentary:

1. Delegated DHT services - To qualify for payment, delegated DHT services must comply with the requirements for delegation of insured services described in the General Preamble GP62.

2. Interpretation of DHT services - To qualify for payment, the physician who claims the *professional component* must personally interpret the DHT and cannot delegate the interpretation to another person.

3. Controlled Acts - Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis, or prescribing a hearing aid for a hearing impaired person are controlled acts. If a physician interprets a diagnostic hearing test without communicating the diagnosis to the patient or his or her personal representative, a controlled *act* has not occurred.

4. Fixed level screening audiometry is not an insured service.

5. DHTs at the request of or arranged by third party, e.g. school boards, employers or WSIB etc. are not insured services. See Appendix A regarding third party service.]

OTOLARYNGOLOGY

		T	P
	BASIC DIAGNOSTIC HEARING TESTS		
	Pure tone threshold audiometry with or without bone conduction		
G440	- technical component	11.95	
G525	- professional component		5.85
	Pure tone threshold audiometry (with or without bone conduction) and speech reception threshold and/or speech discrimination scores.		
G441	- technical component	20.80	
G526	- professional component		16.45
	ADVANCED DIAGNOSTIC HEARING TESTS		
	Impedance audiometry by manual or automated methods		
G442	- technical component	3.80	
G529	- professional component		1.86

Note:
G442, G529 *may include* stapedial reflex and/or compliance testing.

	Sound field audiometry (*infant*s and *child*ren)		
G448	- technical component	25.20	
G450	- professional component		5.70

Note:
The amount payable is reduced to nil if any claim is submitted for G525, G441 or G526 rendered to the patient on the same day.

	Miscellaneous advanced testing e.g. recruitment, tests of malingering, central auditory and stapedial reflex decay tests - per test		
G443	- technical component, to a maximum of 1 per test	9.05	
G530	- professional component, to a maximum of 1 per test		5.95
	Cortical evoked audiometry		
G143	- technical component	41.80	
G141	- professional component		19.15

Note:
For cortical evoked audiometry, multiple frequency, as required by WSIB - see Appendix F.

	Brain stem evoked audiometry		
G146	- technical component	41.80	
G144	- professional component		19.15

OTOLARYNGOLOGY

		T	P
	Electrocochleography (per ear):		
G815	- technical component	41.80	
G816	- professional component		19.15
	DIAGNOSTIC BALANCE TESTS		
	Positional testing with electronystagmography (ENG)		
G104	- technical component	21.55	
G105	- professional component		20.90
	Caloric testing with ENG		
G451	- technical component	21.55	
G533	- professional component		18.30

		Fee
G454	Stroboscopy	16.80
G191	Optokinetic tests	12.40
G108	Computerized rotation tests	20.20

PALLIATIVE CARE

Fee

TELEPHONE MANAGEMENT OF PALLIATIVE CARE

The provision by telephone of medical advice, direction or information at the request of the patient, patient's relative(s), *patient's representative* or other caregiver(s), regarding a patient receiving *palliative care* at *home*. The service must be *rendered personally by the physician* and is eligible for payment only when a dated summary of the telephone call is recorded in the patient's medical record.

G511 Telephone management regarding a patient receiving palliative care at home .....per call 18.20

Payment rules:

1. This service is limited to a maximum of two services per *week*.

2. This service is *not eligible for payment* if rendered the same day as a consultation, assessment, time-based service or other visit by the same physician.

3. This service is *not eligible for payment* if a claim is submitted for K071 or K072 for the same telephone call.

4. This service is *only eligible for payment* when rendered by the physician most responsible for the patient's care or by a physician substituting for this physician.

[Commentary:

This service is *only eligible for payment* when the patient is receiving *palliative care* in either the patient's *home* or the *home* of a family member or other individual with whom the patient is residing. See definitions of "*home*" and "*palliative care*" in the Definitions section of the General Preamble.]

PALLIATIVE CARE

Fee

PALLIATIVE CARE CASE MANAGEMENT FEE

The service rendered for providing supervision of *palliative care* to a patient for a period of one *week*, commencing at midnight Sunday, and includes the following *specific elements*.

A. Monitoring the condition of a patient including ordering tests and interpreting test results.

B. Discussion with and providing telephone advice to the patient, patient's family or *patient's representative* even if initiated by the patient, patient's family or *patient's representative*.

C. Arranging for assessments, procedures or therapy and coordinating community and hospital care including but not limited to urgent rescue palliative radiation therapy or chemotherapy, blood transfusions, paracentesis/thoracentesis, intravenous or subcutaneous therapy.

D. Providing premises, equipment, supplies and personnel for all elements of the service

G512 Palliative care case management fee..... 67.75

Payment rules:

1. The service is *only eligible for payment* when rendered by the physician most responsible for the patient's care, or by a physician substituting for this physician.

2. G511, K071 or K072 are *not eligible for payment* to any physician when rendered during a *week* that G512 is rendered.

3. G512 is limited to a maximum of one per *week* (Monday to Sunday inclusive) per patient and, in the instance a patient is transferred from one *most responsible physician* to another, is *only eligible for payment* to the physician who rendered the service the majority of the *week*.

4. In the event of the death of the patient or where care commences on any day of the *week*, G512 is eligible for payment even if the service was not provided for the entire *week*.

[Commentary:

1. Services not excluded in payment rule #2 such as assessments, subsequent visit fees, W010, K023, special visit premiums etc. remain eligible for payment when rendered with G512.

2. See the Definitions section of the General Preamble for the definition of *palliative care*

3. This service is eligible for payment for services rendered to patients receiving *palliative care* in any location including their *home*, hospital, nursing *home* etc.]

PHYSICAL MEDICINE

T	P

NEEDLE ELECTROMYOGRAPHY AND NERVE CONDUCTION STUDIES

PREAMBLE

1. When patients are referred directly to an electromyography (EMG) and/or nerve conduction studies (NCS) facility for diagnostic testing, then consultation or assessment by the diagnostic physician is *not eligible for payment* except where a medically necessary consultation or assessment is requested by the referring provider in addition to the EMG.
2. If a physician owns the EMG/NCS equipment and either employs and provides clinical supervision for a technician to perform the procedure or performs the procedure personally, then both the technical and the *professional component* are payable to the physician.
3. *Schedule* A, *Schedule* B, *Schedule* C and Single Fibre Electromyography refer to procedures performed using intramuscular placement of a recording needle electrode. Claims for surface EMG or other EMG techniques are *not eligible for payment*.
4. A nerve conduction study is a procedure using direct electrical stimulation of relevant peripheral nerve(s) with corresponding measurement(s) of evoked latency, conduction velocity, and amplitude using surface or percutaneous recording electrodes. Additional recordings, such as late responses or reflexes, are included in the service, if rendered. A permanent record of the procedure must be maintained in the patient chart.

Schedule A

Complete procedure i.e. conduction studies on two or more nerves presumed to be involved in the disease process together with EMG studies of appropriate muscles, as necessary and/or detailed studies of neuromuscular transmission. It also includes as necessary study of normal nerve and/or opposite side for comparison.

G455	- technical component	31.80	
G456	- professional component		120.00

Schedule B

Limited procedure i.e. conduction studies on a single nerve (motor and/or sensory conduction) and/or limited EMG studies of the involved muscle(s) and or limited neuromuscular transmission study.

G466	- technical component	21.40	
G457	- professional component		74.40

PHYSICAL MEDICINE

T	P

Schedule C

Complex neuromuscular electrodiagnostic testing requiring a minimum of 60 minutes of direct physician involvement.

The testing must include ten (10) or more electrodiagnostic studies, performed through any combination of the following:

a. Nerve conduction studies

b. Late motor response studies

c. Needle electromyography of distinct muscles

d. Repetitive stimulation of muscle-nerve pairs

e. Autonomic function studies

Note:
For the purposes of G471/G473, the cranial, cervical, thoracic and lumbosacral regions represent separate segments.

G471	- technical component	31.80	
G473	- professional component, when physician performs EMG and/or performs or supervises nerve conduction studies and interprets the results		275.00

Payment rules:

1. G473 is *only eligible for payment* when a minimum of 60 minutes of direct physician involvement has been rendered in relation to the service and to the exclusion of all other work.

2. G473 is *not eligible for payment* with G456 or G457 same patient same day.

3. G471 is *not eligible for payment* with G455 or G466 same patient same day.

4. G458 is eligible for payment in addition to G473 only when the time necessary to perform the G458 service is not included in the minimum time requirement for G473.

Medical record requirements:
The start and stop time must be recorded in the patient's medical record or the service is *not eligible for payment*. See General Preamble GP7 and GP55 for definitions and time-keeping requirements.

[Commentary:
Complex neuromuscular disorders where *Schedule* C nerve conduction studies/ electromyography may be appropriate include demyelinating neuropathies, mononeuritis multiplex, motor neuron disease, brachial/lumbosacral plexopathies and neuromuscular transmission disorders.]

PHYSICAL MEDICINE

		Fee
	Single fibre electromyography	
G458	Single fibre electromyography	275.00
	CHEMODENERVATION INJECTION	
	Chemodenervation injection of individual peripheral motor nerve using phenol, ethyl alcohol or similar non-anaesthetic chemical agents for reduction of focal spasticity, and *may include* electromyography (EMG) guidance of injection(s).	
G485	- first major nerve and/or branches.....	45.45
G486	- each additional major nerve and/or its branches same day ..... add	28.50
	Repeat or additional procedure within 30 days of previous chemodenervation injection	
G487	- first major nerve and/or its branches	28.50
G488	- each additional major nerve and/or its branches same day ..... add	18.80

Note:

1. Use nerve block listings under Nerve Blocks sub-section if anaesthetic agents are used instead of phenol or alcohol or similar non-anaesthetic chemical agents.

2. Chemodenervation injection into same muscle same day as botulinum toxin is an insured service payable at nil.

		Fee	Anae
	PSYCHIATRY		
	Electroconvulsive therapy (ECT) cerebral - single or multiple		
# G478	- in-patient.....	102.35	6
# G479	- out-patient	118.00	6

Note:
Electrosleep therapy or Sedac therapy are not insured benefits.

	RESPIRATORY DISEASE		
G404	Chronic ventilatory care outside an Intensive Care Unit.....	61.00	

Note:
Maximum 2 per *week*. Any other amount payable for consultations or assessments same patient, same physician, same day will be reduced to nil.

SLEEP STUDIES

For the purpose of sleep studies (including overnight sleep studies in non-specialized facilities, overnight sleep studies rendered in specialized facilities and daytime sleep studies),

"*CPSO* Standards" means the publication of the College of Physicians and Surgeons of Ontario entitled "Independent Health Facilities, Clinical Practice Parameters and Facility Standards, Sleep Medicine" in effect 6 *month*s prior to the date upon which the sleep study was rendered.

"off-site premises" means off-site premises operated by a hospital corporation that has received approval under section 4 of the *Public Hospitals Act*.

"prior approval" means approved for payment as an insured service, before the service is rendered, by the Ministry of Health following assessment on a case-by-case basis in accordance with all medically relevant criteria.

[Commentary:
A "physician practicing sleep medicine" refers to a physician who meets the Medical Staff requirements as defined in Chapter 2 of the "Independent Health Facilities, Clinical Practice Parameters and Facility Standards, Sleep Medicine, September 2010 from the *CPSO*.]

SPECIFIC ELEMENTS

Sleep Studies are divided into a *professional component* listed in the columns headed with a "P", and a *technical component* listed in the column headed with an "H" (the *technical component*).

The *specific elements* for the *technical component* H include the *specific elements* for the *technical component* of non-invasive diagnostic procedures listed in the Preamble to Diagnostic and Therapeutic Procedures.

If the physician is physically present during the study, the physician's physical presence is a specific element of the technical and *professional component*s.

OTHER TERMS AND CONDITIONS

For services rendered outside a hospital or off-site premises, the only fees payable under the *Health Insurance Act* are for the *professional component* listed under the "P" column (use suffix C). Costs for the *technical component* of these services are only payable under the *Integrated Community Health Services Centres Act, 2023* and are listed in the *Schedule* of Facility Costs.

Sleep studies are subject to limits or maximums set out below. Unless otherwise specifically provided, service(s) in excess of limits are not insured services except when prior approval to exceed the limit is obtained from the *MOH*. Despite the foregoing, where prior approval to exceed a limit is not requested from the *MOH* but the service would otherwise satisfy one or more of the conditions for which prior approval to exceed the limit is routinely granted (had prior approval been requested) any service in excess of the limit is *not eligible for payment*.

[Commentary:
For definitions of maximum and limits see GP7.]

Claims submission instructions:
Submit claims for *professional and technical component*s separately. Submit claims for the *technical component* H using listed fee code with suffix B. Submit claims for *professional component* using listed fee code with suffix C. (e.g. J890C)

SLEEP STUDIES

Technical Component

Payment rules:
The *technical component* of the procedure is eligible for payment only if it meets all of the following requirements:

1. It satisfies the conditions set out under “Diagnostic Services Rendered at a Hospital".
2. It is rendered at a hospital or off-site premises.
3. A technician is in constant attendance with the patient(s) during the period of the sleep study.
4. The qualifications of technical staff participating in the sleep study comply with the criteria set out in the *CPSO* Standards.
5. All equipment and test components comply with the criteria set out in the *CPSO* Standards.

Professional Component

Payment rules:
The *professional component* of any sleep study service is eligible for payment only if it meets all of the following requirements:

a. The qualifications of the physician interpreting the sleep study comply with the criteria for physicians practicing sleep medicine set out in the *CPSO* Standards. The service, if delegated in whole or in part, is delegated to a physician whose qualifications comply with the criteria for physicians practicing sleep medicine set out in the *CPSO* Standards; and
b. A physician meeting the qualifications above is accessible at all times during the sleep study;
  i. to make applicable decisions about the patient in connection with the performance of the procedure; and
  ii. to insure that all elements of the *technical component* of the procedure including set-up and monitoring are carried out in accordance with generally accepted standards of practice as set out in the *CPSO* Standards.

[Commentary:
1. Special visit premiums are *not eligible for payment* in conjunction with sleep studies.
2. Physical presence by the physician is not required. However, if the physician is physically present, the physician’s physical presence is a specific element of the *technical* and *professional component*s.]

Medical record requirements:
1. Records of the *technical component* must conform to the standards for facilities and facility operators (including records required prior to data analysis) as set out in the *CPSO* Standards, or the *technical component* is *not eligible for payment*.
2. Records of the *professional component* must conform to the *CPSO* record standards (including records required at data analysis, and reports) as set out in the *CPSO* Standards, or the *professional component* is *not eligible for payment*.

SLEEP STUDIES

H	P

A. Incomplete overnight sleep studies

If the recording does not contain information sufficient for a diagnostic interpretation as determined in accordance with generally accepted standards as set out in the CPSO Standards, the professional fee is *not eligible for payment* and the service constitutes one of the following, as determined by time in bed (total study time):

J898	Sleep study less than 1 hour	92.65
J899	Sleep study between 1 and 4 hours	185.40
J990	Sleep study more than 4 hours.....	370.75

Payment rules:

1. A maximum of one of any of J898, J899 and J990 is eligible for payment, per patient ,per facility, per *12 month period*.

2. J898, J899 and J990 are not included in the limits for overnight studies set out below.

B. Overnight sleep studies in non-specialized facilities

Level 1

Is an overnight sleep study with continuous monitoring of oxygen saturation, ECG and Ventilation (airflow and respiratory effort) and additional monitoring to stage sleep (including all of the following: EEG, EOG and sub-mental EMG).

Initial diagnostic study

"Initial diagnostic study" means the first overnight sleep study rendered to an insured person as an insured service in Ontario for the purpose of establishing the diagnosis of a sleep disorder (and includes a split night study). Every overnight diagnostic sleep study rendered before July 1, 2010 for which a claim was submitted and paid as an insured service under the *Health Insurance Act* constitutes an "initial diagnostic study" and is deemed to have been rendered on July 1, 2010.

Initial diagnostic study - Level 1

J896	- diagnostic study.....	370.75	97.50

Note:

1. A maximum of one initial diagnostic study is eligible for payment per patient per lifetime.

2. All subsequent overnight sleep studies constitute "repeat diagnostic" or "therapeutic" studies.

SLEEP STUDIES

H P

Repeat diagnostic study

"Repeat diagnostic study" means an overnight diagnostic sleep study rendered:

a. for the purpose of obtaining a second opinion at a different facility than the facility where the preceding study was rendered, provided that the following conditions are met:

i. prior to the repeat diagnostic study, the patient has been assessed by a physician who practices sleep medicine at the different facility,

[Commentary:
The different facility requirement above applies to a repeat diagnostic study rendered at a hospital, a hospital off-site premise or an *ICHSC*.]

ii. where the previous study was rendered at an *ICHSC* and the repeat diagnostic study is rendered at a different *ICHSC* (the "different facility") than the *ICHSC* where the preceding study was rendered (the "first facility"), neither the owner nor the operator of the different facility is, at the time the repeat study is rendered, an associate of the owner or operator of the first facility, where "associate" has the same meaning as in the *Integrated Community Health Services Centres Act, 2023*; or

b. for one or more of the following purposes, after pre-study assessment by a physician practicing sleep medicine:

i. re-evaluation of a previous negative or inconclusive diagnostic sleep study as indicated by persistent or progressive symptoms;

ii. re-evaluation, other than primarily for Positive Airway Pressure therapy (PAP) adjustment, of patients previously diagnosed with a primary sleep disorder in which there has been symptom development suggesting another co-morbid sleep disorder; or

iii. re-evaluation of patients with an established diagnosis of a sleep disorder other than a sleep related breathing disorder who have significant symptom progression or non-response to therapy.

[Commentary:
1. In the case of patients with previously diagnosed sleep related breathing disorders, although PAP treatment may be adjusted during a repeat study, a repeat study is *not eligible for payment* if rendered primarily for PAP treatment adjustment.

2. Examples of sleep disorders other than a sleep related breathing disorder are Narcolepsy, Idiopathic hypersomnia and Periodic Limb Movement Disorder.]

Repeat diagnostic study - Level 1

J897	- diagnostic study.....	370.75	97.50

Payment rules:

1. Repeat diagnostic studies are limited to one per patient, per facility, per *12-month period* except where prior approval has been given.

2. Repeat diagnostic studies performed in the same facility that performed the initial diagnostic study are *not eligible for payment* in the *12 month period* following an initial diagnostic study except where prior approval has been given.

Therapeutic study

Except as described in note #3 on page J112, "Therapeutic Study" means a sleep study rendered after pre-study assessment by a physician practicing sleep medicine, for any of the following purposes:

a. To establish optimal settings for nasal positive airway pressure therapy (CPAP/BiPAP/ASV etc.) and/or oxygen therapy for sleep related breathing disorders;

[Commentary:
Examples of sleep related breathing disorders are obstructive sleep apnea syndrome (OSAS), central sleep apnea syndrome (CSAS), Cheyne-Stokes breathing, complex sleep apnea syndrome, or hypoventilation syndromes.]

b. To evaluate the response to surgical procedures for the treatment of OSAS;

c. To determine the efficacy of oral appliance therapy for OSAS;

d. To evaluate the efficacy of positional therapy for the treatment of OSAS;

e. To evaluate the efficacy of substantial weight loss for the treatment of OSAS; or

f. To titrate ventilatory settings for patients with respiratory control disorders, neuromuscular or neurodegenerative diseases.

SLEEP STUDIES

		H	P
	Therapeutic study for sleep related breathing disorders - Level 1		
J895	- therapeutic study	370.75	97.50

Payment rules:

1. There is a limit of one therapeutic study per patient during any two consecutive *12 month period*s except where prior approval has been given.

2. J895 rendered to the same patient during the same 12 - hour period as J896 or J897 is *not eligible for payment*.

[Commentary:
Subject to the prior approval requirements, an additional therapeutic study in excess of the above limits may be payable when necessary to evaluate a change in the treatment modality for a sleep related breathing disorder.]

Note:

1. For payment purposes, repeat diagnostic studies or therapeutic studies for indications or in circumstances other than listed above, or in excess of the limits set out above require prior approval.

2. A repeat diagnostic study rendered without the required pre-study assessment by a physician practicing sleep medicine, is *not eligible for payment*.

3. A therapeutic study rendered without a pre-study assessment by a physician practicing sleep medicine is *not eligible for payment* except:

- **a.** For the therapeutic study that immediately follows an initial diagnostic or repeat diagnostic study where:
  - **i.** the time interval is such that it is unlikely the clinical circumstances of the patient has changed; and
  - **ii.** the physician practicing sleep medicine has previously assessed the patient and documented the applicable decisions with respect to the performance of the therapeutic study; or
- **b.** In exceptional circumstances where the physician can demonstrate to the ministry upon request that the *CPSO* standards are satisfied with the use of a clinical protocol or approved medical directive.

[Commentary:

1. An example of an exceptional circumstance may be where a patient is required to travel a long distance to a sleep facility and requires an initial diagnostic or repeat diagnostic study followed by a therapeutic study on a subsequent night. For payment purposes, a pre-study assessment by a physician practicing sleep medicine is not required provided the therapeutic study is rendered in accordance with a clinical protocol or medical directive that has been approved by an authority other than a physician affiliated with the sleep facility (e.g. a Medical Advisory Committee for a sleep clinic affiliated with a hospital). The physician should be prepared to provide any necessary supporting documentation to the ministry upon request.

2. Prior approval, where required, will typically be dependent on the physician demonstrating that the study is generally accepted as necessary for the patient under the circumstances.

3. Sleep studies that require prior approval also require a pre-study assessment by a physician practicing sleep medicine. It is this assessment upon which the request for prior approval is considered.

SLEEP STUDIES

H P

4. Prior approval requires a written request accompanied by supporting documentation including the pre-study assessment and the relevant previous sleep study reports.

5. Split-night sleep studies are claimed as J896 or J897 only, as appropriate to the study rendered.]

SLEEP STUDIES

H	P

C. Overnight sleep studies rendered in specialized facilities

A specialized facility is:

a. a facility where patients are on ventilatory support and that specializes in the treatment of *adult*s with conditions such as amyotropic lateral sclerosis or polio; or

b. a paediatric hospital where there is a Paediatric ICU and that treats *child*ren with respiratory control disorders.

Level 1

Overnight sleep study with continuous monitoring of oxygen saturation, ECG and Ventilation (airflow and respiratory effort) and additional monitoring to stage sleep (including all of the following: EEG, EOG and sub-mental EMG).

Specialized facility diagnostic study

J890	- diagnostic study	370.75	97.50

Specialized facility therapeutic study

J889	- therapeutic study	370.75	97.50

Payment rules:

1. J889 rendered to the same patient during the same 12 - hour period as J890 is *not eligible for payment*.

2. Except where prior approval is given, overnight sleep studies rendered in specialized facilities are limited to two per patient, per *12 month period* for any combination of such studies.

3. For services rendered on or after July 1, 2010, the *12 month period* is determined from July 1, 2009 onwards.

D. Daytime sleep studies

J893	Multiple sleep latency test	68.95	49.90
J894	Maintenance of wakefulness test	68.95	49.90

Payment rules:

1. J894 rendered to same patient same day as J893 is *not eligible for payment*.

2. A maximum of one J893 and a maximum of one J894 are payable per *12 month period* per facility per patient.

3. If the recording does not contain information sufficient for a diagnostic interpretation as determined in accordance with *CPSO* Standards, the service is *not eligible for payment*.

4. EEG services (i.e. G414, G415, G418, G541, G543, G540, G545, G542, G546, G554, G555, or G544) are *not eligible for payment* with any overnight or daytime sleep study (i.e. J898, J899, J990, J896, J897, J895, J890, J889, J893 or J894).

UROLOGY

		Fee	P
# G900	Residual urine measurement by ultrasound	12.70	

Note:
Residual urine measurement by ultrasound (G900) is *not eligible for payment* in addition to an ultrasound of the pelvis, intracavity ultrasound, G192 - G194, or G475 when cystometrogram and/or voiding pressure studies are rendered.

[Commentary:
G475 is payable with G900 when uroflow studies are performed (flow rate *with or without* postural studies) with residual urine measurement by ultrasound.]

+ G475	Cystometrogram and/or voiding pressure studies and/or flow rate with or without postural studies and/or urethral pressure profile including interpretation	23.75	
G192	Video fluoroscopic multichannel urodynamic assessment to include monitoring of intravesicular, intra-abdominal, and urethral pressures, with simultaneous fluoroscope imaging and recording of filling and voiding phases including interpretation	73.65	
# G193	Complete multichannel urodynamic assessment - to include monitoring of intravesicular, intra-abdominal, and urethral pressures, with or without pressure-flow studies.....	43.85	
# G194	- with EMG ..... add	8.35	
G477	Interpretation of comprehensive urodynamic studies (when the procedure is done by paramedical personnel)		5.40
+ G476	Prostatic massage	5.40	

NOT ALLOCATED

OBSTETRICS

PREAMBLE

SPECIFIC ELEMENTS

In addition to the *common elements*, most obstetrical services have the same *specific elements* as other services listed elsewhere in the *Schedule*.

Obstetrical Care includes the following kinds of services:

a. Prenatal visits (major or minor or high risk) and postnatal care in the office are assessments (see General Preamble GP21).

b. Labour-Delivery services have the *specific elements* of *IOP* Surgical Procedures identified with prefix # (see Surgical Preamble SP1).

c. Anaesthetic services have the same *specific elements* as other services provided by an anaesthesiologist (see General Preamble GP92).

d. Postnatal care in hospital/*home* (P007) is the initial assessment of a well patient postpartum with subsequent assessments of the well patient in the hospital or *home* until the patient's first visit to the physician's office. The *specific elements* for each visit are those for assessments (see General Preamble GP21).

e. Attendance at labour is a service of being in constant or periodic attendance on a patient, during stages one and two of labour but without completion of the delivery, to provide all aspects of care. This includes the initial assessment, and such subsequent assessments as may be indicated, including ongoing monitoring of the patient's conditions, intervening except where intervention is a separately billable service. The *specific elements* are those of assessments (see General Preamble GP21) except element H, but include providing premises, equipment, supplies and personnel for any aspects of the *specific elements* of the service that are performed outside the place in which the encounter(s) with the patient occurs.

f. Attendance at delivery, *specific elements* as for Surgical Assistants' Services (see General Preamble GP85).

For all other procedures listed in this section the *specific elements* are those of *IOP* surgical procedures identified with prefix # (see Surgical Preamble SP1) except for removal of Shirodkar suture for which the *specific elements* are those for surgical *IOP* procedures not identified with prefix #.

Fee *schedule* codes listed below which do not include providing all premises, equipment and personnel used to perform the *specific elements* of the service are identified with prefix #.

OBSTETRICS

PREAMBLE

OTHER TERMS AND DEFINITIONS

1. A prenatal major assessment includes a full history, and an examination of all parts or systems (and *may include* a detailed examination of one or more parts or systems), an appropriate record and advice to the patient. All other prenatal visits include the necessary history, examination, appropriate record and advice to the patient. All prenatal visits (major and minor and high risk) include pregnancy-related counselling as a form of providing advice to the patient or the *patient's representative*.

A prenatal general assessment is payable after another general assessment only if the reason for the first assessment does not pertain to the establishment of the antenatal care.

Normal (uncomplicated) prenatal care includes a prenatal general assessment visit, then *month*ly visits to 28 *week*s, followed by visits every 2nd *week* to 36 weeks, then weekly visits until delivery. However, complicated pregnancies may require additional visits. Labour, delivery and postpartum care are listed separately.

2. If an uncomplicated obstetrical patient is transferred from one physician to another physician for obstetrical care, the appropriate assessment benefit may be claimed by the second physician, followed by prenatal visits. This statement does not apply to physicians substituting for each other or when the second physician sees the patient for the first time in labour. If the obstetrical patient is referred to a consultant for obstetrical care because of the complexity, obscurity or seriousness of the case, the consultant may claim a consultation in addition to the prenatal visits.

3. Illnesses resulting from or associated with pregnancy or false labour requiring added *home* or hospital visits, shall be claimed on a per visit basis.

4. When a pregnant patient visits her physician for a condition unrelated to her pregnancy and apart from her routine scheduled prenatal visits, the physician may claim the appropriate assessment.

5. Fee schedule codes in this section are subject to the provisions of the Surgical Preamble where applicable.

6. An assessment is payable for illness resulting from, or associated with, pregnancy or false labour even if the patient progresses to delivery within the next two days. This does not apply to patients who are assessed in the first stage of labour and admitted, or are transferred, to the delivery room from the antenatal floor in labour.

7. The listings under the heading Referred Services may be claimed by the consultant physician in addition to the appropriate consultation or visit fee. They may not be claimed by physicians providing obstetrical care to their own patients.

8. If a consultant is requested by another physician to perform a surgical induction of labour, or emergency removal of a Shirodkar suture (except at delivery) assuming someone else has inserted the suture, the consultant should claim a consultation fee for this(these) service(s).

9. Medical induction or stimulation of labour may be claimed once per pregnancy by any one physician and only when carried out for a recognized obstetrical complication(s). The fee listed is applicable regardless of the time spent by the physician, therefore, detention may not be claimed.

PREAMBLE

10. The listings for “Attendance at labour and delivery” and for “Attendance of obstetric consultant(s) at delivery” may not be claimed by any physician when a patient is transferred to a second physician for normal obstetrical care.

11. Ordinary immediate care of the *newborn* is included in the labour-delivery fee and when the service is rendered by the anaesthesiologist, it is included in the anaesthetic benefit. A life threatening emergency situation requiring active resuscitation of the *newborn* provided by any physician may be claimed under codes G521, G522, G523. When indicated, endotracheal intubation and tracheo-bronchial toilet should be billed under G211 and not as G521, G522, G523.

12. When an obstetrician routinely transfers all *newborn*s to another physician, the latter may not claim a consultation for these *transferal*s. If the baby is well, the physician should claim *newborn* care in hospital plus attendance at maternal delivery (H007/H267) if this service is provided. If the baby is sick, the physician may claim a general assessment and attendance at maternal delivery (H007/H267) if this service is provided plus daily visits for as long as his/her services are required.

13. If an obstetrician who normally cares for *newborn*s him/herself or transfers the care of newborns to a family physician, refers a *newborn* to a paediatrician because of the complexity, obscurity or seriousness of the case, the latter may claim for this service according to the following guidelines:

- **a.** If attendance at maternal delivery is provided, C263 may be claimed in addition to H267 if a general assessment of the baby is carried out. A postnatal consultation of the baby, (C265) may not be claimed in addition to attendance at maternal delivery (H267).
- **b.** If attendance at maternal delivery (H267) is not provided, a postnatal consultation (C265) may be claimed, if rendered, whether or not a prenatal consultation has already been claimed.

14. Physicians may claim for assisted breech delivery under fee code P020 when the service includes spontaneous delivery to the umbilicus, with extraction of the shoulders, arms and head.

15. See General Preamble GP103 for After Hours Premiums.

16. If claims are being submitted in coded form, the obstetrician should add the suffix “A” to the listed procedural code, the assistant should add the suffix “B” to the listed procedural code, and the anaesthesiologist should add the suffix “C” to the listed procedural code.

PRENATAL CARE

	Asst	Surg	Anae
P003 General assessment (major prenatal visit)			93.85

Antenatal preventative health assessment

The service rendered by the *most responsible physician* for conducting the initial review of antenatal risk. The review must examine all current psychosocial, genetic and medical issues affecting antenatal risk and must be documented in writing in the patient's permanent medical record. Maximum once per pregnancy. P005 rendered same patient same day same physician as any other consultation or visit except P003 and P004 is an insured service payable at nil.

P005 Antenatal preventative health assessment			55.70
P004 Minor prenatal assessment			44.55

High risk prenatal assessment

A high risk prenatal assessment is an assessment by a maternal-fetal medicine *specialist* requiring a minimum of 20 minutes in direct contact with the patient for the management of a documented significant maternal and/or fetal risk factor(s) where the mother and/or fetus are at significant risk for serious complications during the pregnancy.

P002 High risk prenatal assessment			87.25

Medical record requirements:
The service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

Medical management of early pregnancy - initial service

Medical management of early pregnancy - initial service when a physician renders an initial assessment and administration of cytotoxic medication(s) for the termination of early pregnancy or missed abortion. The cost of the drug(s) is not included in the fee for the service.

A920 Medical management of early pregnancy - initial service			193.70

Payment rules:
Services described as consultations, assessments or counselling (and those procedures that are generally accepted components of this service) are *not eligible for payment* when rendered the same day to the same patient by the same physician as A920.

Medical management of ectopic pregnancy – initial service

Medical Management of ectopic pregnancy – initial service when a physician renders an initial assessment and administration of cytotoxic medication(s) for the termination of an ectopic pregnancy. The cost of the drug(s) is not included in the fee for the service.

A922 Medical management of ectopic pregnancy - initial service			249.75

Payment rules:
Services described as consultations, assessments or counselling (and those procedures that are generally accepted components of this service) are *not eligible for payment* when rendered the same day to the same patient by the same physician as A922.

[Commentary:
As with all insured services, A920 and A922 must be provided in accordance with professional standards - such as those published by the Society of Obstetricians and Gynaecologists of Canada.]

PRENATAL CARE

Asst	Surg	Anae

Medical management of early or ectopic pregnancy - follow-up visit

Medical management of early or ectopic pregnancy - follow-up visit is for a visit that is a follow-up of A920 or A922, whether rendered by the same physician who rendered the A920 or A922 service or by another physician.

A921 Medical management of early or ectopic pregnancy - follow-up visit 44.55

Payment rules:

1. Services described as consultations, assessments or counselling (and those procedures that are generally accepted components of this service) are *not eligible for payment* when rendered the same day to the same patient by the same physician as A921.

2. A921 is limited to two per patient per pregnancy. Services in excess of this limit will be adjusted to another assessment fee.

P001 Medical management of non-viable fetus or intra-uterine fetal demise between 14 and 20 weeks gestation 479.55

Payment rules:

1. P001 is *only eligible for payment* if the length of gestation is confirmed by ultrasound.

2. Services described as consultations, assessments or counselling (and those procedures that are generally accepted components of this service, including cervical ripening and oxytocin infusion if rendered) are *not eligible for payment* when rendered the same day to the same patient by the same physician as P001.

3. Z774 is eligible for payment in addition to P001 if uterine curettage is required for postpartum hemorrhage due to retained products.

[Commentary:

P001 is only payable for the active medical management of the patient. It is not payable when the fetus delivers spontaneously prior to initiating intervention.]

LABOUR - DELIVERY

		Asst	Surg	Anae
# P006	Vaginal		512.65	
# P020	Operative delivery, defined as any of: i) forceps or vacuum-assisted delivery, ii) breech delivery, or iii) shoulder dystocia using advanced maneuvers		535.60	6
# E502	- vaginal birth after caesarean section (VBAC) whether successful or unsuccessful ....add		51.00	

[Commentary:
P006 and P020 include the repair of a tear or episiotomy extension, first or second degree, when rendered.]

# P018	Caesarean section	6	579.80	7
# P041	Caesarean section including tubal interruption	6	609.20	7
# P042	Caesarean section including hysterectomy	8	1004.60	8
# E500	- for the third and each subsequent delivery, subject to the payment rules set out below, for each additional delivery, to P006, P018, P020, P041 or P042....add		148.60	
# E499	- for the second caesarian delivery, subject to the payment rules set out below, to P018, P041 or P042 ....add		397.75	

Payment rules:

1. For vaginal deliveries of two or more *infant*s, P006 or P020 as appropriate is eligible for payment for the first delivery, in addition to 85% of P006 or P020 as appropriate for the second delivery, and E500 for the third and each subsequent delivery.
2. For vaginal delivery of the first *infant* followed by caesarean section, one of P018, P041 or P042 as appropriate is eligible for payment, in addition to 85% of P006 or P020 as appropriate, and E500 for the third and each subsequent delivery.
3. For multiple deliveries by caesarean section only (*with or without* trial of labour), one of P018, P041 or P042 as appropriate is eligible for payment, in addition to E499 for the second delivery and E500 for the third and each subsequent delivery.
4. Despite payment rules above, for spontaneous vaginal deliveries between 20 and 23 weeks gestational age, only P006 is eligible for payment, regardless of the number of fetuses delivered.
5. Despite payment rules above, for multiple deliveries by caesarean section only between 20 and 23 weeks gestational age, only one of P018, P041 or P042 as appropriate is eligible for payment, in addition to E499 for the second delivery. E500 is *not eligible for payment* for the third or subsequent deliveries.
6. For delivery of one or more fetuses known to be stillborn in addition to delivery of one or more live fetuses, only the delivery of live fetuses is eligible for payment in accordance with the payment rules above. If all fetuses are known to be stillborn, only one of P006, P018, P020, P041 or P042 as appropriate, is eligible for payment.

Attendance at labour

P038	- when patient transferred to another centre for delivery	211.20

Attendance at labour and delivery

Payable to a physician other than an obstetric consultant for attending labour and delivery when the physician either assists at vaginal delivery or surgery, gives anaesthetic at a caesarean section or operative delivery, or resuscitates the *newborn.*

LABOUR - DELIVERY

	Asst	Surg	Anae
P009 Attendance at labour and delivery		512.65	

Note:
Anaesthesia or Assistant units are *not eligible for payment* when the same physician claims P009 on the same patient.

[Commentary:
See Obstetrics Preamble p. K1, paragraph "e" for the services included in attendance at labour. P009 or P038 is not payable if any of these component services of attendance at labour are not rendered.]

P010 Attendance of obstetric consultant(s) at delivery 211.20

Note:
Amount payable for attendance of a physician other than an obstetric consultant at only delivery is nil.

Special visit for first obstetrical delivery with sacrifice of office hours

Payable in addition to first obstetric delivery in calendar day. Maximum of one per physician per calendar day. See General Preamble GP65 for definition of special visit.

C989 - special visit for first obstetrical delivery with sacrifice of office hours .....add 78.55

Sole delivery premium

Payable in addition to labour and delivery fees P006A, P009A, E414, P018A, P020A, P038A or P041A if sole delivery in calendar day, to maximum of 25 sole delivery premiums per physician per *fiscal year*.

E411 - sole delivery premium ..... add 100%

LABOUR - DELIVERY

		Asst	Surg	Anae

High risk obstetrical premium

Payable in addition to labour and delivery procedures when at least one of the following conditions are present: fetal prematurity (<32 weeks gestational age), severe pregnancy induced hypertension, intrauterine growth retardation (IUGR) less than 10th percentile, or significant placental insufficiency as demonstrated by absent umbilical vessel flow or reverse systolic/diastolic (S/D) ratio.

#	E414	High risk obstetrical premium .....add	62.05	
#	P045	Repair of third degree tear or episiotomy extension, must include repair of perianal sphincter and perineum	82.15	6
#	P046	Repair of fourth degree tear or episiotomy extension, must include repair of rectal mucosa, perianal sphincter and perineum	200.00	6

Note:

1. Repair of a tear or episiotomy extension that does not extend into the perianal sphincter (third degree) is included in the labour and delivery fee (P006 and P020) and does not constitute P045 or P046.

2. Repair of the superficial transverse perineal muscle constitutes a repair of a second degree tear or episiotomy extension and does not constitute P045 or P046.

Claims submission instructions:

Claims for P046 submitted by a provider with a specialty other than Obstetrics and Gynecology (20) must be submitted for manual review.

#	Z774	Postpartum haemorrhage - exploration of vagina and cervix, uterine curettage	113.65	6
	P007	Postnatal care in hospital and/or home	65.55	
	P008	Postnatal care in office	43.80	

REFERRED SERVICES - WHEN ONLY SERVICES(S) RENDERED

Repair of laceration

#	P036	- vaginal	54.40	6
#	P039	- cervical.....	54.40	6
#	P029	Manual removal of retained placenta	54.40	6

OBSTETRICS

OBSTETRICAL ANAESTHESIA

		Asst	Surg	Anae
# P013	Obstetrical anaesthesia		-	6

Continuous conduction anaesthesia - see General Preamble GP95

# P014C	- introduction of catheter for labour analgesia, including the first dose of medication with or without any combined spinal-epidural injection(s)		-	7
# P016C	- maintenance of obstetrical epidural anaesthesia (one unit for each ½ hour to a maximum of 12)		-	
# E100C	attendance at delivery		-	4

Payment rules:

1. Anaesthesia extra units listed on GP97 are *not eligible for payment* with P014C except for E010C, E022C and E017C.

2. Z804 is *not eligible for payment* with P014C or P016C.

3. Anaesthesia extra units listed on GP97 are *not eligible for payment* with P016C or E100C.

4. E100C time units are payable for time spent in constant attendance at delivery, exclusive of time spent engaged in any separately payable services except for P016C. Start and stop times must be recorded in the patient's permanent medical record.

5. E100C time units for attendance at delivery are calculated as 4 basic units and 1 unit for each ¼ hour.

6. In instances where more than one anaesthesiologist is required to provide maintenance of obstetrical epidural anaesthesia sequentially, P016C is limited to a maximum of 12 units per patient, per physician, per day.

[Commentary:
Anaesthesia extra units listed on GP97 are eligible for payment with other C-suffix anaesthesia service rendered the same day as P014C/P016C/E100C, unless otherwise listed.]

Medical record requirements:
Where P016C is claimed by more than one anaesthesiologist per patient, per day, the medical records must document that care was provided by each anaesthesiologist sequentially.

HIGH RISK PREGNANCIES

			Asst	Surg	Anae
#	Z776	Fetal blood sampling		40.80	
#	Z773	Fetoscopy (may include fetal blood sample, cell harvest or amniocentesis or cordocentesis)		165.40	
#	Z734	Double set up examination to rule out placenta previa, or trial of forceps - failed leading to caesarean section (same physician)		58.00	
#	P030	Cervical ripening using topical, oral or mechanical agents, maximum once per pregnancy. Payable in conjunction with P023		58.60	

Note:
Cervical ripening rendered to same patient same day by same physician as a consultation or visit is an insured service payable at nil.

#	P023	Oxytocin infusion for induction or augmentation of labour		67.75	

Note:
See Obstetrics preamble #9.

Non stress test

Payable only for high risk pregnancies - must include interpretation of trace, discussion with patient and providing a written report to be retained in the patient's permanent medical record and *may include* application of the fetal monitor and data acquisition. Maximum one per patient per day.

#	P025	Non stress test		9.65	
#	Z721	Pharmacological suppression of premature labour by I.V. therapy to be claimed once per physician after 3 hours of supervision in same institution		67.75	
#	Z775	Pharmacological management of P.I.H. and toxemia by I.V therapy to be billed once per patient, per pregnancy		67.75	
#	Z778	Amniocentesis - diagnostic or genetic		102.00	
#	Z779	Chorionic villus sampling		153.00	
#	P031	Prophylactic cervical cerclage - any technique	6	145.10	6
#	P032	Emergency cervical cerclage when the external os is open to 2 cm or more and the membranes visible or prolapsed, any technique	6	250.00	6

[Commentary:
If the criteria for cervical cerclage listed under the definition of P032 are not met, submit claims using P031.]

	UVC	Elective removal of Shirodkar suture		visit.fee	
#	P034	Uterine inversion, manual replacements		125.75	6
#	Z777	Breech presentation - external cephalic version *with or without* tocolysis - to be claimed in hospital after 35 weeks, once per pregnancy		60.35	

Note:
Listings for ectopic pregnancy, hysterotomy, abortion and postpartum tubal interruption are listed under the Female Genital System - Corpus Uteri.

OBSTETRICS

MATERNAL - FETAL PROCEDURES

		Asst	Surg	Anae
# P050	Therapeutic amnio-reduction	6	248.85	6
# P051	Percutaneous fetal blood transfusion - into fetal hepatic vein	8	348.40	8
# P052	Percutaneous fetal blood sample - from umbilical cord or fetal hepatic vein	6	199.10	6
# P060	Percutaneous amnioinfusion	6	248.85	6
	Fetal management			
# P053	- selective fetal reduction of one or more fetuses by bipolar or unipolar cautery of umbilical cord	6	248.85	6
# P054	- selective fetal reduction of one or more fetuses by intracardiac potassium chloride injection	6	248.85	6
	Insertion of fetal shunt			
# P055	- bladder to amniotic cavity	8	398.10	8
# P056	- chest to amniotic cavity	8	398.10	8
# P057	Fine needle fetal body cavity aspiration from fetal abdomen, chest, heart, bladder and/or renal tract	6	199.10	6
# P058	In-utero ligation of umbilical cord vessels	8	464.45	8
# P059	In-utero placental vessel ablation by YAG laser	8	464.45	8

Note:
Procedures listed under Maternal - Fetal Procedures are payable in addition to J149 Ultrasonic Guidance and/or Z552 Diagnostic Laparoscopy, where applicable.

OBSTETRICS

NOT ALLOCATED

SURGICAL PREAMBLE

PREAMBLE

SPECIFIC ELEMENTS

In addition to the *common elements*, all surgical services include the following *specific elements*.

A. Supervising the preparation of and/or preparing the patient for the procedure(s).

B. Performing the procedure(s), by any method, or assisting another physician in the performance of the procedure and carrying out appropriate recovery room procedures, being responsible for the transfer of the patient to the recovery room, ongoing monitoring and detention during the immediate post-operative and recovery period.

C. Making arrangements for any related assessments or procedures, including obtaining any specimens from the patient and interpreting the results where appropriate.

D. Where indicated, making or supervising the making of arrangements for follow-up care, and post-procedure monitoring of the patient's condition, including intervening, until the first post-operative visit.

E. Discussion with, providing any advice and information, including prescribing therapy, to the patient or *patient's representative*, whether by telephone or otherwise, on matters related to the service.

F. Providing premises, equipment, supplies and personnel for the *specific elements*:

- **a.** for services not identified with prefix #, for all elements; or
- **b.** for services identified with prefix #, for any aspect(s) of A, C, D and E that is(are) performed in a place other than the place in which the surgical procedure(s) is performed.

SURGICAL PREAMBLE

PREAMBLE

OTHER TERMS AND DEFINITIONS

FOR DEFINITION OF THE ROLE OF THE SURGICAL ASSISTANT - SEE GENERAL PREAMBLE GP85.

FOR DEFINITION OF THE ROLES OF THE ANAESTHESIOLOGIST - SEE GENERAL PREAMBLE GP92.

With the exception of the listings in the "Consultations and Visits" section, all references to surgeon in this *Schedule* are references to any physician performing the surgical procedure.

1. If the surgeon is required to perform a service(s) not usually associated with the original surgical procedure, he/she may claim for these on a fee-for-service basis.

The surgical benefit as noted above does not include the *major pre-operative visit* regardless of the time interval between the major pre-operative visit and surgery.

The hospital or day care admission assessment (consultation, repeat consultation, general or specific assessment or re-assessment, partial assessment) may not be claimed by the surgeon unless it happens to be the major pre-operative visit as defined above.

Because the number of hospital visits is limited to three per *week* after the fifth *week* of hospitalization and six per *month* after the thirteenth *week* of hospitalization, the starting point for calculating the number of hospital visits is based on the date of admission if the operating surgeon has admitted the patient or the date of *referral* if the patient has been referred to the operating surgeon while in hospital.

The listed benefit for a procedure normally includes repair of any iatrogenic complications occurring during the course of the surgery performed by the same surgeon. Other major interventions should be handled on an individual basis. The surgical benefit includes the generally accepted surgical components of the procedure.

2. When a physician makes a special visit to perform a non-elective surgical procedure, he/she may claim the following benefits for procedures commencing:

a. 07:00h -17:00h - Monday to Friday
A consultation (if the case is referred) or the appropriate assessment, the appropriate special visit premium plus the procedural benefit.

b. 17:00h - 07:00h - Any night or on Saturdays/Sundays or *Holiday*s
A consultation or assessment, the appropriate special visit premium, the procedural benefit plus the surgical premium E409 or E410.

(see General Preamble GP65 to GP78 and GP103).

3. When more than one procedure is carried out by a surgeon under the same anaesthesia or within 14 days during the same hospitalization for the same condition, the full benefit applies to the major procedure and 85% of the listed benefit(s) applies to the other procedure(s) performed unless otherwise stated in the Preamble(s) or *Schedule*. The above statement applies to staged or bilateral procedures but does not apply when a normal appendix or simple ovarian or para-ovarian cyst is removed incidentally during an operation, for which no claim should be made.

4. When a subsequent operation becomes necessary for the same condition because of a complication or for a new condition, the full benefit should apply for each procedure.

PREAMBLE

5. When a subsequent non-elective procedure is done for a new condition by the same surgeon, the full benefit will apply to each procedure. When a subsequent elective procedure is done for a different condition within 14 days during the same hospitalization by the same surgeon, the benefit for the lesser procedure shall be reduced by 15%.

6. When different operative procedures are done by two different surgeons under the same anaesthesia for different conditions, the benefit will be 100% of the listed benefit for each condition. Under these circumstances, the basic assistant's benefit should not be claimed by either operating surgeon; however time units may be claimed.

7. As a general rule, when elective bilateral procedures are performed by two surgeons at the same time, one surgeon should claim for the surgical procedures and the other surgeon should claim the assistant's benefit.

8. Where two surgeons are working together in surgery in which neither a team fee nor other method of billing is set out in the benefit schedule, the surgeon should identify him/herself as the operating surgeon and claim accordingly; the surgeon who is assisting the operating surgeon should identify him/herself as such and claim the assistant's benefit.

   Where the second or assistant surgeon is brought into the case on a consultation basis, he/she may, when indicated, claim a consultation as well but should be prepared to justify it on an IC basis.

   Except where otherwise provided in this *Schedule*, if the nature or complexity of a procedure requires more than one operating surgeon, each providing a separate service in his/her own specialized field, e.g. one surgeon carries out the ablative part and another surgeon the reconstructive part of the procedure, then each surgeon should claim the listed benefit for his/her services. This statement applies when the additional procedure(s) are not the usual components of the main procedure. If one surgeon, in addition to performing a specialized portion of a procedure, acts as an assistant to the other surgeon during another portion of the procedure, he/she is eligible to be paid surgical assistan time units (but not basic time units) for the portion of the procedure spent assisting.

   When surgical procedures are rendered to trauma patients who have an Injury Severity Score (ISS) of greater than 15 for individuals age 16 or more, or an Injury Severity Score (ISS) of greater than 12 for individuals less than age 16, and it is required that two surgeons perform components of the same procedure, the full surgical fee for that procedure is payable to each surgeon.

   [Commentary:
   The full surgical fee is payable to each surgeon for surgical procedures rendered either on the day of the trauma or within 24 hours of the trauma.]

SURGICAL PREAMBLE

PREAMBLE

9. Unless otherwise stated, the listed benefits are for unilateral procedures only.

10. When a procedure is performed, a procedural benefit, if listed, should be claimed. Substitution of consultation and/or visit benefits for procedural benefits (except as in paragraph 11), is not in keeping with the intent of the benefit schedule.

11. When a surgical benefit (non-*IOP*, Complete Care, Fracture or Dislocation) is less than the surgical consultation benefit, and the case is referred, a physician may claim a surgical consultation benefit instead of the surgical benefit. However, to avoid the consultation being counted as such under the Ministry of Health limitation rules on the number of consultations allowed per year, the physician should claim the consultation fee under the surgical procedure nomenclature or code. Since the consultation is replacing a procedural benefit which includes the pre- and post-operative and surgical care, no additional claims beyond the consultation should be made.

12. If a physician performs a minor surgical procedure and during the same visit assesses and treats the patient for another completely unrelated and significant problem involving another body system, the physician should claim for the procedure as well as the appropriate assessment.

13. Where a procedure is listed with a "Z" code, the procedure is an "*Independent Operative Procedure* (*IOP*)". If the major pre-operative visit is rendered in the previous *12-month period* prior to the *IOP* service by the same physician, only the following assessment services are eligible for payment on the same day prior to the *IOP* service:

a. a minor assessment if rendered by a General and Family Physician; or

b. a partial assessment if rendered by a *specialist*.

When the major preoperative assessment is rendered on the same day as the *IOP*, no other consultation or assessment is eligible for payment if rendered prior to the *IOP* service by the same physician on the same day.

When multiple or bilateral *IOP* are performed at the same time by the same physician, the listed procedural benefits should be claimed in full but the pre- and post-operative benefits should be claimed as if only one procedure had been performed.

When an *IOP* service is rendered on the same day as a non-*IOP* service by the same physician, the hospital or day care admission assessment (consultation, repeat consultation, general or specific assessment or re -assessment, partial assessment) may not be claimed by the surgeon unless it happens to be the major preoperative visit as defined on GP4.

14. When procedures are specifically listed under Surgical Procedures, surgeons should use these listings rather than applying one of the plastic surgery listed fees under Skin and Subcutaneous Tissue in the Integumentary System Surgical Procedures section of this *Schedule*.

15. For excision of tumours not specifically listed in this *Schedule*, claims should be made on an IC basis (code R993). Independent Consideration also will be given (under code R990) to claims for other unusual but generally accepted surgical procedures which are not listed specifically in the *Schedule* (excluding non-major variations of listed procedures). In submitting claims, physicians should relate the service rendered to comparable listed procedures in terms of scope and difficulty (see General Preamble GP12).

PREAMBLE

16. **Cosmetic or esthetic surgery:** means a service to enhance appearance without being medically necessary. These services are not insured benefits (see Appendix D.)

17. **Reconstructive surgery:** is surgery to improve appearance and/or function to any area altered by disease, trauma or congenital deformity. Although surgery solely to restore appearance may be included in this definition under certain limited conditions, emotional, psychological or psychiatric grounds normally are not considered sufficient additional reason for coverage of such surgery. Appendix D of this *Schedule* describes the conditions under which surgery for alteration of appearance only may be a benefit. Physicians should submit requests to their regional *OHIP* Office for authorization of any proposed surgery which may fall outside of Ministry of Health coverage. (See Appendix D.)

18. Additional claims for biopsies performed when a surgeon is operating in the abdominal or thoracic cavity will be given Independent Consideration.

19. When a listed procedure is performed and no anaesthetic is required, the procedure should be claimed under the “local anaesthetic” listing.

20. Except as described in the paragraph below, when a physician administers an anaesthetic, nerve block and/or other medication prior to, during, immediately after or otherwise in conjunction with a diagnostic, therapeutic or surgical procedure which the physician performs on the same patient, the administration of the anaesthetic, nerve block and/or other medication is *not eligible for payment*.

    A major or minor peripheral nerve block, major plexus block, neuraxial injection (*with or without* catheter) or intrapleural block (*with or without* catheter) for post-operative pain control (with a duration of action more than 4 hours) is eligible for payment as G224 when rendered in conjunction with a procedure which the physician performs on the same patient.

    [Commentary:
    For additional information, refer to the Nerve Blocks - Acute Pain Management, Nerve Blocks - Interventional Pain Injections or Nerve Blocks - Peripheral/Other sections of the *Schedule*.]

21. If claims are being submitted in coded form, the surgeon should add the suffix A to the listed procedural code, the surgical assistant should add the suffix B to the listed procedural code and the anaesthesiologist should add the suffix C to the listed procedural code.

22. When Z222/Z223 is claimed for a patient for whom the physician submits a claim for rendering another insured service on the same day, the amount payable for Z222/Z223 is reduced to nil.

23. When a surgical procedure is attempted laparoscopically in the digestive system or the female genital system, but requires conversion to a laparotomy, unless otherwise specified, the diagnostic laparoscopic fee E860 is payable in addition to the procedural fee.

SURGICAL PREAMBLE

PREAMBLE

24. Morbidly obese patients

E676 is eligible for payment once per patient per physician in addition to the amount eligible for payment for the major surgical procedure(s) where a morbidly obese patient undergoes major surgery to the neck, thorax, peritoneal cavity, retroperitoneum, pelvis, or hip and:

a. the patient has a *Body Mass Index (BMI)* greater than 40

b. the surgery is rendered under *general anaesthesia* using either an open technique for the neck, thorax, or hip, or an open or laparoscopic technique for the peritoneal cavity, pelvis, retroperitoneum; and

c. the principal surgical technique is neither aspiration, core or fine needle biopsy, dilation, endoscopy, mediastinoscopy, thoracoscopy, cautery, ablation nor catheterization.

E676A	Morbidly obese patient, surgeon, to procedural fee(s)..... add	25%
E676B	Morbidly obese patient, surgical assistant, to major procedure add	6 units

Note:

E676A/B is only payable with the following procedures: D043, D046, D047, D052, E090, E499, E500, E505, E546, E589, E593, E626, E627, E655, E664, E673, E686, E697, E704, E706, E707, E708, E709, E711, E712, E713, E714, E718, E721, E722, E725, E728, E729, E731, E733, E734, E735, E736, E737, E738, E739, E743, E745, E748, E752, E754, E762, E764, E765, E766, E767, E768, E769, E771, E794, E796, E852, E853, E854, E855, E857, E860, E880, E882, E883, E884, E885, F100, F101, F135, M081, M082, M084, M090, M099, M100, M142, M143, M144, P018, P041, P042, P050, P055, P056, P057, P058, P059, P060, R108, R109, R216, R241, R269, R330, R423, R439, R440, R443, R470, R481, R488, R491, R553, R569, R590, R627, R628, R639, R686, R786, R800, R802, R803, R805, R806, R807, R811, R814, R815, R817, R823, R825, R826, R834, R839, R852, R855, R856, R858, R860, R861, R910, R885, R905, R913, R914, R915, R932, R933, R934, R935, R936, R937, S089, S090, S114, S115, S116, S117, S118, S120, S121, S122, S123, S124, S125, S128, S129, S131, S132, S133, S134, S137, S138, S139, S140, S149, S150, S154, S157, S158, S159, S160, S162, S164, S165, S166, S167, S168, S169, S170, S171, S172, S173, S175, S176, S177, S180, S182, S183, S184, S185, S187, S188, S189, S191, S192, S193, S194, S195, S196, S197, S199, S204, S207, S213, S214, S215, S217, S218, S222, S227, S265, S266, S267, S269, S270, S271, S274, S275, S276, S278, S280, S281, S282, S285, S287, S291, S292, S294, S295, S297, S298, S299, S300, S301, S302, S303, S304, S305, S306, S307, S308, S309, S310, S311, S312, S313, S314, S315, S318, S319, S321, S323, S325, S329, S332, S340, S342, S343, S344, S345, S405, S411, S416, S420, S422, S424, S427, S431, S432, S433, S434, S435, S436, S438, S440, S441, S445, S446, S447, S448, S449, S450, S451, S452, S453, S454, S455, S457, S460, S461, S462, S465, S466, S467, S468, S471, S482, S483, S488, S490, S491, S512, S513, S546, S549, S561, S590, S650, S651, S652, S710, S714, S727, S728, S729, S731, S733, S735, S736, S738, S739, S740, S741, S743, S745, S747, S748, S750, S751, S757, S758, S759, S760, S761, S763, S764, S766, S775, S776, S778, S780, S781, S782, S784, S788, S789, S790, S792, S793, S795, S798, S799, S800, S813, Z427, Z526, Z552, Z553, Z564, Z569, Z577, Z594, Z737, Z738

SURGICAL PREAMBLE

PREAMBLE

Medical record requirements:
E676 is *only eligible for payment* when the BMI is recorded in the patient's permanent medical record.

[Commentary:
E676 is *not eligible for payment* if the surgery is rendered under local anaesthesia.]

25. Lysis of extensive intra-abdominal adhesions and/or scarring e.g. post radiation

E673 is payable to the surgeon in addition to the fee for the major intra-abdominal procedure when at least 60 minutes of operative time is spent performing adhesiolysis. Adhesiolysis of less than 60 minutes is included in the fee for the major intra-abdominal procedure.

E673 Lysis of extensive intra-abdominal adhesions ..... add 124.10

26. Payment for all surgical procedures includes payment for any intraoperative monitoring of the patient, if rendered.

27. Cancelled surgery – surgical services

a. If the procedure is cancelled prior to induction of anaesthesia, the service constitutes a subsequent hospital visit.

b. When an anaesthetic has begun but the operation is cancelled due to a complication prior to commencement of surgery and the surgeon has scrubbed but is not required to do anything further, the service constitutes E006A and the amount payable is calculated by adding the time units to 6 basic units and multiplying by the surgical assistant's unit fee.

c. If the operation is cancelled after surgery has commenced but prior to its completion, the service is *eligible for payment* under independent consideration (R990).

[Commentary:
Submit claim for R990 by adding the time units to the listed procedural basic units and multiplying by the surgical assistant's unit fee and attach a copy of the operative report for review by a *medical consultant*.]

Note:
For the purpose of cancelled surgery, time units for the surgeon are calculated in the same way as time units for the surgical assistant (see General Preamble GP85).

28. Bariatric surgery

S120 (gastric bypass or partition), S189 (intestinal bypass) and S114 (sleeve gastrectomy) are insured services only when all of the following criteria are satisfied:

1. The surgery has been proposed for an indication supported by clinical practice guidelines adopted by the Canadian Association of Bariatric Physicians and Surgeons at the time of the surgery
2. The patient has attempted weight loss in the past without successful long-term weight reduction; and
3. The patient has been recommended for the surgery by a multidisciplinary team at a *Bariatric Regional Assessment and Treatment Centre* in Ontario.

PREAMBLE

29. Transplant surgery

Claims submission instructions:

Transplant recipient: Submit claims using the transplant recipient's Ontario health insurance number only.

If the recipient is from out-of-province, submit claims using the recipient's provincial health insurance number.

Transplant donor: Submit claims using the transplant donor's Ontario health insurance number.

For a donor with a health insurance number from another province or for a donor from another country, submit claims using the Ontario recipient's health insurance number.

In circumstances where the donor is an Ontario resident but the health insurance number cannot be obtained despite reasonable efforts to do so, use the recipient's Ontario health insurance number.

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

		Asst	Surg	Anae
	INCISION			
	Abscess or haematoma - Local anaesthetic			
Z101	- subcutaneous - one	nil	28.20	
Z173	- subcutaneous - two		33.25	
Z174	- subcutaneous - three or more		44.70	
Z104	- perianal		33.25	
Z106	- ischiorectal or pilonida		48.60	
Z103	- palmar or plantar spaces		48.60	
E542	- when performed outside hospital	add	12.65	
	Abscess or haematoma - General anaesthetic			
# Z102	- subcutaneous - one		48.60	6
# Z172	- subcutaneous - two or more		72.95	7
# Z105	- perianal		72.30	6
# Z107	- ischiorectal or pilonidal		118.30	6
# Z108	- palmar or plantar spaces		78.90	6
# E515	Incision of abscess or hematoma when performed as sole procedure under general anaesthetic in an operating room but not in an emergency department or *emergency department equivalent*. To Z102, Z172, Z105, Z107, Z541, Z574, Z758	add	110%	
	Foreign body removal			
Z114	- local anaesthetic		27.65	
E542	- when performed outside hospital	add	12.65	
# Z115	- general anaesthetic	6	97.30	6
# Z100	- complicated (see General Preamble GP12)	6	I.C	7
# Z227	Intramuscular abscess or haematoma		111.35	6
Z118	Aspiration of superficial lump for cytology		30.95	

[Commentary:
Z114 and Z115 are eligible for payment for removal of non-biodegradable long-acting subcutaneous medication implants]

Biopsy(ies)

Z116	- any method, when sutures are used		32.45	
E542	- when performed outside hospital	add	12.65	
Z113	- any method, when sutures are not used		32.45	

Note:
Z116 may be allowed more than once on an IC basis if medically necessary (in order to make a diagnosis or to plan treatment) to biopsy more than one lesion or to obtain a second biopsy from an extensive lesion. If claimed, may be allowed with chemical treatment of lesion (code Z117).

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

		Asst	Surg	Anae
# Z155	Biopsy(ies) - extensive, complicated or requiring general anaesthetic when sole procedure (see General Preamble GP12)		I.C	I.C
# Z245	Biopsy for malignant hyperthermia, three or more		167.45	10

SKIN AND SUBCUTANEOUS TISSUE

		Asst	Surg	Anae

EXCISION (WITH OR WITHOUT BIOPSY)

LESIONS - SINGLE OR MULTIPLE SITES

Note:

1. Tattoo removal - (see Appendix D Surface Pathology Section 3).

2. Removal of any lesions (e.g. keratosis, nevi) for cosmetic purposes and not for any clinical suspicion of disease or malignancy is not an insured service.

Group 1 - e.g. keratosis, pyogenic granuloma

(see Appendix D Surface Pathology)

Removal by excision and suture

Z156	- single lesion		21.90	6
Z157	- two lesions		29.05	6
Z158	- three or more lesions		48.50	6
E542	- when performed outside hospital	add	12.65	

Removal by electrocoagulation and/or curetting

Z159	- single lesion		11.55	6
Z160	- two lesions		17.35	6
Z161	- three or more lesions		28.70	6

Note:

1. Paring of a lesion by any method, including curetting, and/or electrocoagulation, without complete removal of the lesion does not constitute Z159, Z160 or Z161 and is *not eligible for payment*.

2. Excision or removal by electrocoagulation and/or curetting of plantar verrucae is not an insured service.

Group 2 - nevus

(see Appendix D Surface Pathology, Section 4)

Removal by excision and suture

Z162	- single lesion		21.90	6
Z163	- two lesions		29.05	6
Z164	- three or more lesions		48.50	6
E542	- when performed outside hospital	add	12.65	
#Z165	Congenital (extensive) (see General Preamble GP12)		I.C	I.C

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

			Asst	Surg	Anae
		Group 3 - cyst, haemangioma, lipoma			
		Face or neck - Local anaesthetic			
	Z122	- single lesion	nil	42.20	
	Z123	- two lesions		74.30	
	Z124	- three or more lesions		85.45	
	E542	- when performed outside hospital	add	12.65	
		Face or neck - General anaesthetic			
#	Z145	- single lesion	6	71.60	6
#	Z146	- two lesions	6	107.95	6
#	Z147	- three or more lesions	6	178.10	6
#	Z148	- extensive or massive (see General Preamble GP12)	6	I.C	7
		Other areas - Local anaesthetic			
	Z125	- single lesion	nil	35.05	
	Z126	- two lesions		49.30	
	Z127	- three or more lesions		65.75	
	E542	- when performed outside hospital	add	12.65	
		Other areas - General anaesthetic			
#	Z149	- single lesion	6	54.80	6
#	Z150	- two lesions	6	71.80	6
#	Z151	- three or more lesions	6	107.95	6
#	Z152	- extensive or massive (see General Preamble GP12)	6	I.C	6
		Group 4 - other lesions			
	Z096	Lipoma - 5 to 10 cm	6	87.65	6
	E542	- when performed outside hospital	add	12.65	
#	Z097	Lipoma - over 10 cm	6	175.30	6
#	R034	Congenital dermoid cyst adult	6	136.30	6
#	R043	- infant or child	6	220.30	6
#	R042	- midline, e.g. nasal	6	298.85	6
#	R037	Giant cell tumour	6	219.10	6
		Pilonidal cyst			
#	R035	- simple excision or marsupialization		219.10	6
#	R054	- simple excision or marsupialization, if patient's BMI greater than 40	6	273.90	6
#	R036	- excision and skin shift	6	306.75	6
		Inguinal, perineal or axillary skin and sweat glands for hyperhydrosis and/or hydradenitis			
#	R059	- unilateral	6	272.55	6
#	R060	- with skin graft(s) or rotation flap(s)	6	414.00	7

		Asst	Surg	Anae

EXCISION OF PRE-MALIGNANT LESIONS INCLUDING BIOPSY OF EACH LESION – SINGLE OR MULTIPLE SITES

The amount payable for excision of a pre-malignant lesion will be adjusted to a lesser fee if the pathologist's report is not retained in the patient's record.

Face or Neck

Simple excision

R160	- single lesion	6	58.30	6
R161	- two lesions	6	95.75	6
R162	- three or more lesions	6	191.45	6
E542	- when performed outside hospital	add	12.65	

Other Areas

Simple excision

R163	- single lesion	6	47.75	6
R164	- two lesions	6	78.65	6
R165	- three or more lesions	6	157.35	6
E542	- when performed outside hospital	add	12.65	

Note:
Excision of a pre-malignant lesion is only payable for the following lesions:

1. Dysplastic Nevus (nevus with dysplastic features, atypical melanocytic hyperplasia, atypical melanocytic proliferation, atypical lentiginous melanocytic proliferation or premalignant melanosis)
2. *Act*inic/Solar Keratosis
3. Chemical and other pre-malignant keratoses
4. Large Cell Acanthoma
5. Erythroplasia of Queryrat
6. Leukoplakia

[Commentary:
In-situ lesions such as Lentigo Maligna (melanoma-in-situ) and Bowen's Disease (squamous cell carcinoma-in-situ) are considered malignant lesions.]

Z119	Cryotherapy treatment of at least 5 pre-malignant actinic keratosis lesions on the same day, not to include freeze-thaw cycles		31.80	

Note:
Z119 is *only eligible for payment* when liquid nitrogen is used.

[Commentary:
For fewer than five lesions see Z117.]

Claims submission instructions:
Submit claims with diagnostic code 232.

		Asst	Surg	Anae

MALIGNANT LESIONS INCLUDING BIOPSY OF EACH LESION - SINGLE OR MULTIPLE SITES

The amount payable for treatment of a malignant lesion will be adjusted to a lesser fee if the pathologist's report is not retained in the patient's record.

Note:
A pre-malignant lesion is not a malignant lesion for the purposes of payment.

Face or neck

Simple excision

R048	- single lesion	6	100.95	6
R049	- two lesions	6	152.50	7
R050	- three or more lesions	6	255.25	7
E542	- when performed outside hospital ... add		12.65	

Other areas

Simple excision

R094	- single lesion	6	63.70	7
R040	- two lesions	6	104.85	6
R041	- three or more lesions	6	209.70	7
E542	- when performed outside hospital ... add		12.65	

Malignant melanoma

R010	- wide excision in any area and must include > 1 cm margins and layered closure	6	135.95	7
# E540	- if excision is performed in hospital for tumour free margin with frozen section, to excision or repair fees .... add 25%			

[Commentary:
For sentinel node b*iop*sy refer to Z427 p R2.]

Note:

1. When excision of benign, pre-malignant or malignant skin lesions are corrected by

a. Advancement flap including undermining of more than 2.5 cm per side, or

b. Rotation, transposition, Z-plasty, or

c. Other flap or graft

claim the appropriate benefit listed under Skin Flaps and Grafts Section instead of foregoing excision benefits.

2. Excision by S-plasty technique is considered a form of simple excision rather than a reconstructive flap.

Face or neck

Curettage, electrodesiccation or cryosurgery

R018	- single lesion	6	75.10	6
R019	- two lesions	6	123.70	7
R020	- three or more lesions	6	247.30	6

		Asst	Surg	Anae
	Other areas			
	Curettage, electrodesiccation or cryosurgery			
R031	- single lesion	6	60.35	6
R032	- two lesions	6	99.45	7
R033	- three or more lesions	6	199.05	6
# R051	Laser surgery on Group 1 - 4, pre-malignant and malignant lesions (see General Preamble GP12)		I.C	I.C
	Chemical and/or cryotherapy treatment of skin lesions			
Z117	- Chemical and/or cryotherapy treatment, one or more lesions		12.75	

Note:

1. Z117 includes paring and/or debulking of a lesion prior to or subsequent to chemical and/or cryotherapy treatment, when rendered.

2. Z117 is limited to a maximum of one service per patient per physician per day.

[Commentary:
See Appendix D (8) of this *Schedule* for the conditions under which treatment of warts is an insured service.]

	Asst	Surg	Anae

MOHS MICROGRAPHIC SURGERY

Definition/Required elements of service

Mohs micrographic surgery is eligible for payment when rendered for a lesion that is a histologically confirmed cutaneous malignancy (including basal cell carcinoma, squamous cell carcinoma, malignant melanoma, lentigo maligna, dermatofibrosarcoma protuberans, sebaceous carcinoma, microcystic adnexal carcinoma, atypical fibroxanthoma, Merkel cell carcinoma, eccrine carcinoma, extramammary Paget's disease, leiomyosarcoma and primary cutaneous adenocarcinoma); and that meets one or more of the following conditions:

a. a lesion with clinical margins greater than 1.5 cm;

b. a lesion located in an anatomically sensitive area, in particular but not limited to the periocular, perinasal, perilabial, and periauricular surfaces, or the nose;

c. a recurrent malignancy that has not responded to prior therapy;

d. a malignant lesion in a patient with immunodeficiency or genodermatoses predisposing to widespread skin cancers, such as basal cell nevus syndrome;

e. a histologically aggressive lesion (such as a basal cell carcinoma that is sclerosing, infiltrative, baso-squamous, or micronodular, or a squamous cell carcinoma that is poorly differentiated, or demonstrates peri-neural/lymphatic/vascular involvement) at any anatomic site.

# R081	- Initial cut, including debulking.....	6	315.45	7
# E524	- one or more additional cuts, to R081	add	273.45	

Note:

1. R081 and E524 are eligible for payment only to physicians with generally accepted specialized training in Mohs surgery.

[Commentary:
An example of generally accepted specialized training is the successful completion of a fellowship accredited by the American College of Mohs Surgery.]

1. R081 is eligible for payment only when the preparation of slides is rendered or supervised by the physician claiming R081 and all microscopic tissue sections are personally reviewed and interpreted by the physician claiming R081. If a pathologist interprets or submits a claim for analyzing histological slides prepared by the physician claiming R081, R081 and E524 are *not eligible for payment*.

[Commentary:
In these circumstances, the physician should instead claim the appropriate fee code for excising a malignant skin lesion.]

2. Closure of the resulting defect by undermining and advancement flaps is included in the above fees. If more complicated closure is necessary, the service may be eligible for payment using fee codes under skin flaps and grafts.

Payment rules:

1. R081 is eligible for payment once per lesion including when excision of the lesion is completed over two or more days up to two *week*s.

SKIN AND SUBCUTANEOUS TISSUE

Asst	Surg	Anae

2. E524 is eligible for payment once per lesion. An additional E524 may be eligible for payment on an Independent Consideration (IC) basis when claimed on a subsequent day up to two *week*s after the R081 service.

3. R081 *with or without* E524 is eligible for payment at 85% for a second lesion excised by Mohs surgery on the same patient on the same day. Submit a claim for three or more lesions for Independent Consideration with an operative report describing the indications for the surgery and the necessity for multiple procedures.

4. R081 *with or without* E524 may be eligible for payment on an Independent Consideration (IC) basis for a lesion that is histologically aggressive but not specified in the definition.

SKIN AND SUBCUTANEOUS TISSUE

		Asst	Surg	Anae

Wound and ulcer debridement

Debridement of wound(s) and/or ulcer(s) extending into subcutaneous tissue

Z080	- one			21.90
Z081	- two			32.90
Z082	- three			49.30
Z083	- four or more			65.75

Debridement of wound(s) and/or ulcer(s) extending into any of the following structures: tendon, ligament, bursa and/or bone

Z084	- one			65.75
Z085	- two or more			98.65
E542	- when performed outside hospital, to Z080, Z081, Z082, Z083, Z084 or Z085		add	12.65

Payment rules:

1. Wound and ulcer debridement services are *only eligible for payment* where:

a. the physician performs a minimum of 10 minutes of debridement; and

b. the service is *rendered personally by the physician*.

2. Suture of laceration (Z154, Z175, Z176, Z177, Z179, Z190, Z191, Z192), and complex laceration repair (Z187, Z188, Z189) services are *not eligible for payment* with wound and ulcer debridement services.

3. All wound and ulcer debridement services include the application of any necessary dressing if rendered.

[Commentary:
Debridement of wound(s) or ulcer(s) must be performed personally by the physician. Wound dressings may be performed by the physician or by others delegated to perform wound dressings where such delegation is authorized in accordance with the *Schedule* requirements for delegated services. See page GP62 of the General Preamble of this *Schedule*.]

Note:
Wound dressing and wound and debridement services are not payable in addition to any surgical procedure unless complications require such care in excess of the usual post-operative care.

Medical record requirements:
Wound or ulcer debridement services are *only eligible for payment* where:

1. the minimum time requirements involved in the debridement of the wound(s) or ulcer(s) are documented in the patient's permanent medical record; and

2. Documentation supporting the debridement of each separate lesion for which a claim is made is found in the medical record.

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

Asst	Surg	Anae

Burns

Note:
For burn care the following definitions apply:

Total Body Surface Area (TBSA) as calculated using the "rule of nines" or the Lund-Browder chart.

Young - a person 9 years of age and younger.

Adult - a person from 10 years up to, and including, 50 years of age.

Old - a person 51 years of age and older.

Minor Burn

a. less than 10% TBSA burn in *adult*

b. less than 5% TBSA burn in young or old

c. less than 2% TBSA full thickness burn - any age

Moderate Burn

a. 10 to 20 % TBSA burn in *adult*

b. 5 to 10 % TBSA burn in young or old

c. 2 to 5 % TBSA full thickness burn - any age

d. the following regardless of TBSA or age of patient:

i. high-voltage injury

ii. suspected inhalation injury

iii. circumferential burn

iv. concomitant medical problem predisposing to infection (e.g. diabetes, sickle cell disease)

Major Burn

a. more than 20% TBSA burn in *adult*

b. more than 10% TBSA burn in young or old

c. more than 5% TBSA full-thickness burn - any age

d. the following regardless of TBSA or age of patient:

i. high voltage burn

ii. known inhalation injury

iii. any deep partial and/or full thickness burn to face, eyes, ears, genitalia, hands, feet or joints

iv. significant associated injuries (e.g. fracture or major trauma)

Note:
For burn care requiring anaesthesiologists' and assistants' services, the following fee codes apply.

# R030	Minor burns	6	-	6
# R038	Moderate burns.....	6		10

SKIN AND SUBCUTANEOUS TISSUE

		Asst	Surg	Anae
# R039	Major burns	8	-	15

Resuscitation - Major Burn, Initial Care

These fees apply to the service of being in constant or periodic attendance following a major burn, to provide all aspects of resuscitation to the patient. This follows the initial assessment, and includes such subsequent assessments as may be indicated. The *specific elements* are those of an assessment, including ongoing monitoring of the patient's condition, and intervening as appropriate (see General Preamble GP15). Instead of element H, the assessment includes, providing premises, equipment, supplies and personnel for any aspects of the *specific elements* that is(are) performed in a place other than the place in which the assessment is performed. Separately billable interventions may be claimed in addition to these fees.

# Z180	- first day	106.25
# Z181	- continuing care, 2nd to 4th day inclusive, per day	53.10

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

			Asst	Surg	Anae
Debridement, excision, fasciotomy, escharotomy, and/or grafting - in Operating Room					
# R691	Minor burn	per unit		75.00	
# R692	Moderate burn	per unit		87.50	
# R693	Major burn	per unit		100.00	

Payment rules:

1. R691, R692 and R693 are eligible for payment only when rendered in an Operating Room.

2. Unit means ¼ hour or major part thereof.

3. Time units are calculated based on the time spent by the physician in direct contact with the patient and commence when the physician is first in attendance with the patient in the operating room and end when the physician is no longer in attendance with that patient in the operating room.

4. Only one of R691, R692 or R693 is eligible for payment for the same patient during the same encounter.

5. R083, R084, R085, R086, R087, R088, R091, R092, R093, R495 are *not eligible for payment* in addition to R691, R692 or R693.

[Commentary:
See General Preamble GP7 for definitions and time-keeping requirements. As noted on GP7, start and stop times must be recorded in the patient's permanent medical record or the service is *not eligible for payment*.]

Burn debridement and excision - outside Operating Room					
#R660	- hand - each digit			31.65	
#R661	- dorsum, palm - each			52.55	
#R662	- nose, cheek, lip, ear, forehead, scalp, neck, eyelid - each			31.65	
#R637	Debridement and excision, per % of total body treated other than hand, head or neck			32.50	
Skin allograft procurement					
R690	- for banking purposes, per % of total body harvested, other than hand, head or neck		7	17.25	7

NECROTIZING FASCIITIS

Debridement, excision, fasciotomy and flap and/or graft closure - in Operating Room					
# R698	Debridement, excision, fasciotomy and flap and/or graft closure for necrotizing fasciitis	per unit	6	100.00	10

Payment rules:

1. R698 is *only eligible for payment* when the service is rendered in an Operating Room and the patient requires Intensive Care Unit management on the day the surgery takes place.

2. R698 is *not eligible for payment* for reconstructive services.

3. Unit means ¼ hour or major part thereof.

4. Time units are calculated based on the time spent by the physician in direct contact with the patient in the operating room.

5. R495 is *not eligible for payment* in addition to R698

SKIN AND SUBCUTANEOUS TISSUE

Asst	Surg	Anae

[Commentary:

1. For reconstruction services, the appropriate fee codes apply.

2. See General Preamble GP7 for definitions and time-keeping requirements. As noted on GP7, start and stop times must be recorded in the patient's permanent medical record or the service is *not eligible for payment*.]

		Asst	Surg	Anae

Repair of lacerations

Note:
Wound closure via tissue adhesives (such as cyanoacrylate) is payable at 50% of the appropriate fee.

Z176	- up to 5 cm		21.90	6
Z154	- up to 5 cm if on face and/or requires tying of bleeders and/ or closure in layers		39.35	6
Z175	- 5.1 to 10 cm		39.35	6
Z177	- 5.1 to 10 cm if on face and/or requires tying of bleeders and/ or closure in layers		78.15	6
Z179	- 10.1 to 15 cm		55.20	6
Z190	- 10.1 to 15 cm if on face and/or requires tying of bleeders and/or closure in layers		111.20	6
Z191	- more than 15.1 cm - other than face		84.70	6
Z192	- more than 15.1 cm - on face		169.75	7
E530	- if inhalation general anaesthesia (other than 50% N2O/O2 mixture) is used, when suture of laceration is sole procedure	add	55.20	
E531	- if extensive debridement is required (see General Preamble GP12)	add	I.C	
E542	- when performed outside hospital	add	12.65	
R024	- Acute laceration earlobe, unilateral		110.25	
UVC	- Removal of sutures only		visit.fee	

Complex laceration repair

Face

A complex laceration repair of the face is a repair that requires a minimum of 20 minutes of time to perform the repair procedure and at least one of the following:

a. anatomical alignment of the vermilion border, eyebrow, eyelid or pinna;

b. closure of three or more layers (muscle sheath, subcutaneous tissue, skin etc.); or

c. ligation of multiple bleeding vessels.

Z187	Complex laceration repair, face		101.15

Anatomical area other than face (except zone 1 repair of digit)

A complex laceration repair of an anatomical area other than face is a repair that requires a minimum of 20 minutes of time to perform the repair procedure and at least one of the following:

a. closure of three or more layers (muscle sheath, subcutaneous tissue, skin etc.); or

b. ligation of multiple bleeding vessels.

Z188	Complex laceration repair, anatomical area other than face, (except digit, zone 1 repair)		101.15

	Asst	Surg	Anae

Zone 1 repair of digit

A complex repair of zone 1 of the digit is repair of an injury without soft tissue loss that requires a minimum of 20 minutes of time to perform the repair procedure.

Z189 Complex repair, digit, zone 1 repair, without soft tissue loss, per digit..... 101.15

Note:

1. Other repair fee codes are *not eligible for payment* in addition to Z189 for the same zone 1 injury.

2. For digit tip amputations or a zone 1 injury with soft tissue loss that would requirement advancement, graft or other surgical method of closure, see specific listings for surgical repair in the Integumentary System or Musckuloskeletal System Surgical Procedures sections of this *Schedule*.

Payment rules:

1. Wound and ulcer debridement services, Z128, Z129, and Z114 are *not eligible for payment* in addition to Z187, Z188 or Z189 for the same repair.

2. Z187, Z188, and Z189 include removal of any foreign bodies in the wound, irrigation and debridement when rendered.

3. Plastic Surgery Procedure services (i.e. R150, R151, R152, R153 and R154) are *not eligible for payment* for any laceration repair.

Medical record requirements:

Z187, Z188, and Z189 are *only eligible for payment* where the minimum time requirements involved in the repair service are documented in the patient's permanent medical record. The time requirement includes time to perform the repair exclusive of time spent rendering any other separately billable service.

[Commentary:

For laceration repairs that do not meet the above criteria for a complex laceration repair, see Repair of Lacerations listings on page M15.]

Muscle repair

# R525	- Simple muscle repair(s) to include repair of involved skin .	6	97.05	7
# R528	- Complex (see General Preamble GP12).....	6	I.C	6

	Asst	Surg	Anae

PREAMBLE TO SKIN FLAPS AND GRAFTS

The amount payable will depend on the size and location of the area grafted and the type of graft. Additional procedures other than the skin grafting are payable in addition to the skin flap or grafts, e.g. tendon grafts, inlay grafts, etc.

E540 - payable once per lesion for excision in hospital for tumour free margin with frozen section, to first flap or graft procedure..... add 25%

[Commentary:
For sentinel node b*iop*sy refer to Z427 p R2.]

Note:
When excision of benign, pre-malignant or malignant skin lesions are corrected by advancement flap including undermining of more than 2.5 cm per side, or by rotation, transposition, Z-plasty, flap or graft, claim appropriate benefit listed under Repair Section instead of foregoing excision benefits. Excision by S-plasty technique is considered a form of simple excision rather than a reconstructive flap.

SKIN FLAPS

A. Advancement flaps

Note:
To include undermining of more than 2.5 cm per side. Is intended to include excision of a lesion if this is technique of closure.

	Defect 2.1 to 5 cm			
# R011	- face, neck or scalp	6	89.85	6
# R002	- other areas	6	67.40	6
	Defect 5.1 to 10 cm			
# R012	- face, neck or scalp	6	247.15	6
# R003	- other areas	6	161.75	6
# R004	- Defect more than 10 cm such as thoracic abdominal flap..	6	242.70	7

B. Rotations, transpositions, Z-plasties

Note:
Includes undermining but will depend on the site and size.

	Defect less than 2 cm average diameter			
# R045	- face, neck or scalp	6	203.70	6
# R072	- other areas	6	133.40	7
	Defect 2.1 to 5 cm average diameter			
# R046	- face, neck or scalp	6	335.15	6
# R075	- other areas	6	223.35	6
	Defect 5.1 to 10 cm average diameter			
#R047	- face, neck or scalp	6	477.45	7
#R073	- other areas	6	318.45	7

		Asst	Surg	Anae
	Defect more than 10 cm average diameter			
#R076	- face, neck or scalp	6	709.90	7
#R074	- other areas	6	477.85	7
	C. Pedicle flaps			
# R070	Small/Intermediate, e.g. cross finger, cervical finger	6	293.75	7
# R071	- each subsequent stage	6	223.35	6
# R080	Large, e.g. cross leg, deltopectoral, forehead	6	416.30	6
# R078	- each subsequent stage	6	311.45	7
# E069	- preparation of a contracted recipient site, to R070 or R080 ..... add		134.75	
# R101	Delay, Small/Intermediate flap	6	132.45	7
# R100	Delay, major flap	6	291.90	6

		Asst	Surg	Anae
	D. Myocutaneous, myogenous or fascia-cutaneous flaps			
	Note: To include closure of donor site defect by any means.			
# R005	Sterno-mastoid, tensor fascia lata, gluteus maximus, gracilis, sartorius, rectus femoris, gastrocnemius (medial and lateral), trapezius	6	545.00	6
# R006	Pectoralis major	6	734.95	6
# R155	Latissimus dorsi or unilateral rectus abdominus	6	734.95	6
	Note: R006 is *not eligible for payment* for post-mastectomy breast reconstruction.			
# R008	Lower transverse rectus abdominus flap	6	984.55	8
	Repair of abdominal defect			
# Z196	- different surgeon		377.65	
# E523	- same surgeon, to other procedure	add	321.00	
# R009	Myocutaneous - osseous flaps e.g. pectoralis major myocutaneous flap with rib graft, trapezius flap with scapula spine	6	783.40	8
# R007	Other - (see General Preamble GP12)	I.C	I.C	I.C
	SKIN GRAFTS			
	A. Split thickness grafts (for burn grafts see pages M10 & M11)			
# R084	Very minor, very small areas, e.g. trauma		92.30	7
# R085	Minor, medium sized areas, e.g. small or skin ulcer, breast, etc	6	140.25	6
# R086	Intermediate, large areas, e.g. trunk, arms, legs	6	259.10	7
# R087	Major, complex areas, e.g. face, neck, hands	6	388.00	7
# R088	Extensive major, very large area(s)	6	567.95	6
	Note: The medical record must demonstrate the appropriateness of code claimed relative to size.			
	B. Full thickness grafts			
# R092	Minor - less than 1 cm average diameter		116.65	7
# R093	Intermediate - 1 cm to 5 cm average diameter	6	178.90	7
# R083	Major - over 5 cm	6	280.15	7
# R091	Complex - eyelid, nose, lip, face	6	263.95	7
	Note: **1.** R092, R093, R083, R091 - The medical record must demonstrate the appropriateness of codes claimed relative to size of graft. **2.** Skin grafts are *not eligible for payment* in addition to R117.			
# R057	Appendage or tissue re-vascularization involving microanastomosis with or without micro neuroanastomosis (see General Preamble GP12)	I.C	I.C	I.C
# R058	Revision of above (see General Preamble GP12)	I.C	I.C	I.C

SKIN AND SUBCUTANEOUS TISSUE

		Asst	Surg	Anae
	Stasis ulcer			
# R847	- with skin graft - per leg	6	195.85	7
# R845	- multiple ligation and skin graft - per leg	6	341.55	6
	Neurovascular island transfer			
# R061	Minor, e.g. finger tip	6	140.25	6
# R062	Intermediate, e.g. finger to thumb transfer	6	259.20	6
# R063	Major, e.g. foot to heel	6	430.85	6

		Asst	Surg	Anae

FREE ISLAND FLAPS

Note:
When excision of the lesion and preparation of the recipient site are carried out by different surgeons, the preparation fees should be reduced by 15%.

# R013	Free jejunum artery and vein for transplantation	10	338.85	10
# R014	Preparation of microvascular recipient site for free jejunum artery and vein	10	925.85	10
# R016	Preparation of microvascular recipient site for jejunum artery and vein immediately following ablative surgery, and when recipient vessels are in site of the ablation	10	544.95	10
# R015	Transplantation of free jejunum artery and vein with microvascular anastomosis	10	925.85	10
# R064	Elevation of free island skin and subcutaneous flap and closure of defect	10	874.60	10
# R065	Preparation of microvascular recipient site for free island skin subcutaneous flap	10	925.85	10
# R055	Preparation of microvascular recipient site for free island flap and subcutaneous flap immediately following ablative surgery and when recipient vessels are in site of the ablation	10	544.95	10
# R066	Transplantation of free island skin and subcutaneous flap with microvascular anastomosis(es)	10	925.85	10
# R067	Elevation of innervated free island skin and subcutaneous flap and closure of defect	10	1028.20	10
# R068	Preparation of microvascular recipient site for innervated free island skin and subcutaneous flap	10	1028.20	10
# R056	Preparation of microvascular recipient site for innervated free island skin and subcutaneous flap immediately following ablative surgery and when recipient vessels are in the site of ablation	10	605.15	10
# R069	Transplantation of innervated free island skin and subcutaneous flap with microvascular anastomosis(es) and nerve repair	10	961.60	10
# R125	Elevation of free island skin and muscle flap and closure of defect	10	874.60	10
# R126	Preparation of microvascular recipient site for free island skin and muscle flap	10	925.85	10
# R122	Preparation of microvascular recipient site for free island skin and muscle flap immediately following ablative surgery and when recipient vessels are in the site of the ablation	10	544.95	10
# R127	Transplantation of free island skin and muscle flap with microvascular anastomosis(es)	10	874.60	10

SKIN AND SUBCUTANEOUS TISSUE

FREE ISLAND FLAPS

		Asst	Surg	Anae
# R128	Elevation of free island muscle flap with tendon and nerve, and closure of defect	10	1183.50	10
# R129	Preparation of microvascular recipient site for muscle, tendon and nerve anastomosis(es)	10	1183.20	10
# R123	Preparation of microvascular recipient site for muscle, tendon and nerve anastomosis(es) immediately following ablative surgery and when recipient vessels are in site of the ablation	10	696.40	10
# R130	Transplantation of free island muscle flap with tendon, nerve and microvascular anastomosis(es)	10	1183.50	10
# R131	Elevation of free island bone flap and closure of defect	10	874.60	10
# R132	Preparation of microvascular recipient site for free island bone flap	10	925.85	10
# R124	Preparation of microvascular recipient site for free island bone flap immediately following ablative surgery and when recipient vessels are in the site of the ablation	10	544.95	10
# R133	Transplantation of free island bone flap with microvascular anastomosis(es) and bone fixation	10	1028.20	10
# R134	Elevation of free island skin and bone flap and closure of defect	10	1048.60	10
# R135	Preparation of microvascular recipient site for free island skin and bone flap	10	1048.60	10
# R140	Preparation of microvascular recipient site for free island skin and bone flap immediately following ablative surgery and when recipient vessels are in the site of the ablation	10	617.10	10
# R136	Transplantation of free island skin and bone flap with microvascular anastomosis(es) and bone fixation	10	1048.60	10
# R137	Elevation of free toe or finger and closure of defect	10	1048.60	10
# R138	Preparation of microvascular recipient site for free toe or finger transplant	10	1048.60	10
# R141	Preparation of microvascular recipient site for free toe or finger transplant immediately following ablative surgery and when recipient vessels are in the site of the ablation	10	617.10	10
# R139	Transplantation of free island toe or finger with microvascular anastomosis(es) and tendon nerve and bone repair	10	1233.75	10
# R025	Revision of free island flaps (see General Preamble GP12)	10	I.C	10
# R106	Skin flaps and grafts - other than listed above (see General Preamble GP12)	I.C	I.C	I.C

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

SKIN AND SUBCUTANEOUS TISSUE

		Asst	Surg	Anae
	FINGER OR TOE-NAIL			
Z110	Extensive debridement of onychogryphotic nail involving removal of multiple laminae		19.15	

Note:

1. Trimming or clipping of nails does not constitute Z110.

2. Z110 is *not eligible for payment* if not *rendered personally by the physician* claiming the service.

[Commentary:
Trimming or clipping of nails is not an insured service.]

	Simple, partial or complete, nail plate excision requiring anaesthesia			
Z128	- one		36.30	6
Z129	- multiple		39.20	6
E542	- when performed outside hospital	add	12.65	
	Radical, including destruction of nail bed			
# Z130	- one	nil	68.75	6
# Z131	- multiple		90.70	6
E542	- when performed outside hospital	add	12.65	
	Webbed fingers and toes			
# R089	Webbed fingers - one web space	6	400.00	6
# R090	Webbed toes - one web space	6	250.00	7
	SCAR REVISION - ANY METHOD OF CLOSURE			
	Up to 2.5 cm			
R021	- face or neck	6	115.60	6
R026	- other areas	6	77.35	6
	2.6 cm to 5 cm			
R022	- face or neck	6	194.85	6
R027	- other areas	6	130.10	6
	5.1 cm to 10 cm			
R023	- face or neck	6	277.90	7
R028	- other areas	6	185.60	6
	Greater than 10 cm			
R017	face or neck	6	417.05	7
R029	other areas	6	288.20	7

Note:

1. Authorization is required for all scar revisions in areas other than the face or neck (see Appendix D).

2. Revision of post-infection scarring of face must be claimed on an “I.C” basis - maximum payable will be as equated to R023.

SKIN AND SUBCUTANEOUS TISSUE

		Asst	Surg	Anae

PLASTIC SURGERY PROCEDURES

[Commentary:
The setting of benefits covering the various procedures of plastic surgery is a very difficult problem. Since many procedures are divided into stages which have to be considered in assessing a fee, it is felt that all such plastic surgical procedures should be classed by the responsible *specialist* as very minor, intermediate, major or extensive major. Benefits should be claimed according to procedures set forth in the tariff, except in cases which are difficult to define, in which case "I.C" should be the basis of the claim.]

The minimum benefit for each would be as follows:

# R150	Very minor		92.30	6
# R151	Minor	6	140.25	6
# R152	Intermediate	6	259.20	7
# R153	Major	6	388.00	7
# R154	Extensive major	6	568.95	6

Note:

1. Descriptive details of procedure (e.g. operative report) should be submitted with claims for codes R150 - R154 for professional assessment.

2. Taking of skin by a surgeon for grafting by an Oral Surgeon - claim as R150.

3. R150, R151, R152, R153, and R154 are *not eligible for payment* for the repair of any laceration(s). See repair of laceration services in the Integumentary System Surgical Procedures section of this *Schedule*.

4. R150, R151, R152, R153, and R154 are *not eligible for payment* to physicians in the following specialties: General and Family Practice (00) and Emergency Medicine (12).

# Z132	Insertion of tissue expander	6	304.10	7
# E527	- additional expander, same incision ..... add		58.95	
# E528	- additional expander, different incision ..... add		258.50	

Note:

1. Z132 is *not eligible for payment* for post-mastectomy reconstruction of the breast.

2. Authorization may be required from the Ministry of Health (e.g. for scars of legs, etc.).

Removal tissue expander injection port when sole procedure

# Z094	- general anaesthetic	6	75.45	6
# Z095	- local anaesthetic		37.70	
Z137	Percutaneous inflation of first tissue expander		23.05	
E541	- each additional expander (to a maximum of 3)		11.55	
# Z138	Replacement of tissue expander by permanent prosthesis		195.85	7

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

OPERATIONS OF THE BREAST

		Asst	Surg	Anae
	INCISION			
	Needle biopsy			
Z141	- one or more	nil	37.20	
E542	- when performed outside hospital ... add		12.65	
Z143	- large core breast biopsy - (14 gauge or larger bore needle)		144.85	
	Aspiration of cyst			
Z139	- one or more	nil	37.20	
	Drainage of intramammary abscess or haematoma			
# Z140	Single or multiloculated - local anaesthetic		33.00	
# Z740	Single or multiloculated - general anaesthetic		133.80	6
	EXCISION			
# R107	Tumour or tissue for diagnostic biopsy and/or treatment, e.g. carcinoma, fibroadenoma or fibrocystic disease (single or multiple - same breast)	6	169.95	6
# E525	- after localization with mammographic wire or radioactive seeds, to R107 ... add		48.05	
# R111	Partial mastectomy or wedge resection for treatment of breast disease, with or without biopsy, e.g. carcinoma or extensive fibrocystic disease	6	306.75	7
# E525	- after localization with mammographic wire or radioactive seeds to R111 ... add		48.05	
# E546	- with axillary node dissection up to the level of the axillary vein, to R111 ... add		388.75	
# E505	- with limited axillary node sampling, to R111 ... add		178.05	

Payment rules:

1. E505 is *not eligible for payment* in addition to Z427.

2. Z427 is *only eligible for payment* in addition to E546 when a frozen section report demonstrates micrometastases.

[Commentary:
For sentinel node b*iop*sy refer to Z427 p R2.]

	Mastectomy - female (with or without biopsy)			
# R108	- simple	6	330.00	7
E517	- with immediate postmastectomy superficial chest wall reconstruction, to R108 ... add 30%			
# R117	- skin sparing mastectomy performed with immediate breast reconstruction for malignancy or prophylaxis in high-risk female patients	6	495.00	7
E486	- with nipple sparing, to R117 ... add 30%			
# E505	- with limited axillary node sampling, to R108 or R117 add		178.05	

Payment rules:

1. E517 is *only eligible for payment* when the surgeon has performed and documented:

		Asst	Surg	Anae

a. extensive undermining for local advancement flaps >10cm to obliterate inferior or lateral excess flap deformities associated with simple mastectomies, or

b. modified M-plasty or fishtail closure

Note:
Skin grafts are *not eligible for payment* in addition to R117.

[Commentary:
For patients who have been approved by *OHIP* for mastectomy related to sex-reassignment surgery, the following fee codes may apply for mastectomy depending on the technique:

1. R108 - Mastectomy simple + R120 for nipple preservation and grafting.]

# R109	Mastectomy, radical or modified radical (with or without biopsy)	6	780.00	7

[Commentary:
Skin grafts are *eligible for payment* in addition to R109.]

Mastectomy - male (benign)

Unilateral - for treatment of *adolescent* gynecomastia, gynecomastia secondary to endocrine or genetic disorders (e.g. Klinefelter's Syndrome) or chemotherapy. Prior approval is not required. Removal of male breast fat tissue by liposuction is not an insured service.

# R146	- simple	6	177.50	7
# R147	- subcutaneous with nipple preservation	6	273.95	7

Mastectomy - male

Unilateral - for treatment of pathological male breast disease (*with or without* b*iop*sy), e.g. carcinoma

# R148	- simple	6	311.95	7
# R149	- subcutaneous with nipple preservation	6	273.95	7
# E505	- with limited axillary node sampling, to R148 or R149 add		178.05	

Oncoplastic Breast Surgery

# R102	Level 1 oncoplastic breast conserving lumpectomy or partial mastectomy for malignancy	6	350.00	7
# R158	Level 2 oncoplastic breast conserving lumpectomy or partial mastectomy for malignancy	6	547.45	7
# E505	- with limited axillary node sampling, to R102, R158 or R159 add		178.05	
# E525	- after localization with mammographic wire or radioactive seeds, to R102, R158 or R159 add		48.05	
# E546	- with axillary node dissection up to the level of the axillary vein, to R102, R158 or R159		388.75	
# R159	Level 3 oncoplastic breast conserving lumpectomy or partial mastectomy for malignancy	6	701.15	7

Payment rules:

1. R102 is *only eligible for payment* when

a. resected breast volume is <= 15% of ipsilateral breast parenchyma, and

b. the operative report documents dual plane undermining and lumpectomy defect closure

2. R102 includes nipple undermining, nipple-areolar complex elevation or centralization, skin resection and glandular advancement if performed.

OPERATIONS OF THE BREAST

Asst | Surg | Anae

3. R158 is *only eligible for payment* when

a. resected breast volume exceeds 15% of ipsilateral breast parenchyma, or

b. when the tumour is resected from the upper inner quadrant or the lower pole of the breast.

4. R158 is *only eligible for payment* when the operative report documents purposeful skin excision, glandular rotations, pre-emptive nipple recentralization, and de-epithelialization techniques that preserve the blood supply to the nipple-areolar complex and parenchyma.

5. R159 is *only eligible for payment* when

a. resected breast volume exceeds 25% of ipsilateral breast parenchyma, and

b. the operative report documents the use of reduction mammoplasty techniques sufficient to achieve cosmesis.

6. R159 include glandular pedicles coupled with large mobilizations, transpositions, and rotations of residual breast tissue if performed.

7. R102, R158 or R159 are *not eligible for payment* when

a. additional ipsilateral breast reconstructive procedure(s) are performed on the same day by a second surgeon, or

b. the procedure is part of a pre-planned staged breast reconstruction.

8. R143 is *not eligible for payment* on the same day as R102

[Commentary:
It is anticipated that contralateral balancing procedures will not be required when R102 is performed.]

OPERATIONS OF THE BREAST

		Asst	Surg	Anae

REPAIR

Post-mastectomy breast reconstruction

# R119	Breast mound creation by prosthesis as sole procedure.....	6	350.00	7
# R118	Breast skin reconstruction by local flaps or grafts, includes Wise pattern skin flaps and de-epithelialized skin flaps	6	405.60	6
# E529	- with breast mound creation by prosthesis, to R118 ... add		102.45	
# R156	Breast mound creation by insertion of tissue expander, includes creation of submuscular pocket	6	425.00	6
# E513	- breast mound creation by soft tissue, includes flap insetting and shaping for autogenous reconstruction, to R118, R125, R064, R008 or R155 ..... add		297.50	
# E514	- immediate breast reconstruction following mastectomy, to R125, R064, R156, R008, R118, or R155 ..... add		200.00	

Note:

1. Z132 is *not eligible for payment* with R156.

2. E513 is *not eligible for payment* with E529.

3. E514 is *only eligible for payment* if post-mastectomy breast reconstruction is performed immediately following mastectomy during the same anaesthesia.

# R114	Revision of breast mound	6	230.30	7
# R120	Nipple-areola reconstruction by grafts and/or flaps	6	300.00	7
# R142	Nipple-areola tattooing - unilateral.....	nil	175.00	nil
# R143	Contralateral balancing mastopexy or reduction, to include nipple transplantation or grafting, if rendered.....	6	472.15	6
# R144	Contralateral balancing augmentation mammoplasty.....	6	350.00	6

Note:

1. R143 and R144 are *only eligible for payment* when performed for post-mastectomy breast reconstruction. Prior authorization of payment from the Ministry of Health is not required.

2. R110 and R112 are *not eligible for payment* with R143 or R144.

[Commentary:

1. For reduction or augmentation mammoplasty performed for reasons other than a balancing procedure related to post-mastectomy breast reconstruction, see R110 and R112 respectively. Prior authorization of payment from the ministry is required.

2. See the applicable service for post-mastectomy breast reconstruction by myocutaneous flaps or free flaps.]

Reduction mammoplasty and augmentation mammoplasty (other than post-mastectomy breast reconstruction)

# R110	Reduction mammoplasty (female, to include nipple transplantation or grafting, if rendered) - unilateral	6	472.15	7
# R112	Augmentation mammoplasty - unilateral	6	350.00	7

OPERATIONS OF THE BREAST

		Asst	Surg	Anae

Note:
Prior authorization of payment from the Ministry of Health is required for R110 and R112 (see Surgical Preamble SP4; also, Appendix D).

# Z142	Removal of breast prosthesis	6	150.00	7
# Z135	Open capsulotomy with or without replacement of breast prosthesis	6	195.95	7
# Z182	Breast capsulectomy	6	255.05	7

Note:
Correction of inverted nipple(s) is not an insured service.

INTEGUMENTARY SYSTEM SURGICAL PROCEDURES

NOT ALLOCATED

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

PREAMBLE

A. The removal of a wire or pin or other device when used for traction or external fixation (except for rigid external fixators) in the treatment of a fracture or other orthopaedic procedure is to be included in the procedural fee (unless otherwise stated in the *Schedule*) unless a general anaesthetic is required, in which case a fee may be claimed. Removal of devices used for internal fixation more than 30 days after insertion may be claimed for in addition to the procedural benefit.

B. The benefit for total joint replacement also includes denervation of the joint, all tenotomies and division and repair of muscle.

C. The benefit for obtaining a bone graft is not to be claimed in cases of pseudoarthrosis repair, arthrodesis or for listings in which bone grafting is included.

D. For the supervision of limb fitting and 6 *month*s post-operative care following amputation, claim visit fees. Amputation with immediate fitting to include supervision of final limb fitting, add 40% (E586).

Note:
Reconstruction or Arthroplasty Procedures: If other procedures are claimed, same joint, same time, e.g. debridement, synovectomy, tendon release etc., the *Medical Consultant* will assess the surgeon's claim.

E554 - synovectomy requiring a minimum of 30 minutes to resect, to R236, R240, R241, R244, R281, R288, R437, R438, R439, R440, R441, R442, R443, R453, R454, R456, R479, R481, R482, R483, R485, R486, R487, R488, R491, R493, R496, R497, R498, R499, R500, R509, R510 ..... add 175.00

Payment rules:
Synovectomy codes other than E554 are *not eligible for payment* when rendered in addition to the codes listed above.

FRACTURES AND DISLOCATIONS

1. For fractures or dislocations requiring open or closed reduction or no reduction, the major pre-operative visit, i.e. consultation or appropriate assessment, may be claimed in addition to the listed benefits.
2. **OPEN REDUCTION** shall mean the treatment of a fracture and/or dislocation by either closed intramedullary fixation or by an operative procedure to expose the fracture. The benefits include fixation by internal or external devices.
3. **CLOSED REDUCTION** shall mean the reduction of a fracture or dislocation by non-operative methods (including traction).
4. **NO REDUCTION** shall mean the definitive treatment of a fracture or dislocation by any other method and includes the use of the initial external support other than a simple splint. No reduction, rigid immobilization, means that the device used to achieve a rigid immobilization is custom-molded and is applied by the physician. In cases involving no reduction, application of a simple splint, such as a metal splint, is not billable as rigid immobilization (visit fees only apply).
5. In multiple fractures or dislocations, the benefit for the major fracture or dislocation shall be 100% and the benefit for the other fractures or dislocations is 85%. When no procedural benefit is applicable, but that fracture or dislocation necessitates hospitalization or concurrent care over that demanded by the major injury, a visit benefit may be claimed in addition to other procedural benefits.

PREAMBLE

6. For repeat reductions (closed or open) for the same fracture or dislocation, the full benefit should be claimed for the final reduction and after care; previous reductions by the same surgeon should be claimed at 85%.

7. Emergency splinting of fractures in the emergency department should be on the basis of appropriate visit benefit, plus application of cast if appropriate.

8. Transferred cases:

   a. When patients are transferred to another physician for after care of fractures and dislocations treated by closed or no reduction, the physician rendering the initial care should claim 75% of the listed fee and the surgeon rendering subsequent care should claim visit fees except where otherwise specified. In cases involving open reduction, the percentage should be 80% for the surgeon providing the initial care.

   b. In cases where the original physician's attempts to reduce a fracture or dislocation under *general anaesthesia* is unsuccessful, and the patient is referred to another physician for definitive care, the original physician should claim 75% of the listed fee.

9. Pseudoarthrosis repair/reconstruction is only payable when a fracture requires additional reconstruction because of inadequate healing at least 4 *months* following the original injury. Pseudoarthrosis repair/reconstruction includes bone graft, debridement, osteotomy and internal or external fixation other than the use of an intramedullary nail with distal and proximal locking screws, or circular external fixation if performed.

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

GENERAL FEES

		Asst	Surg	Anae
	BONE/FASCIAL/DERMIS GRAFTS			
	Autogenous			
# E551	- separate incision ..... add		86.30	
# E552	- same incision ..... add		58.45	
# Z279	- different surgeon		193.00	
	Homogenous			
# E553	- banked bone or bone substitutes..... add		25.15	
	Allograft			
# R200	- cadaver - per long bone, each.....		144.80	
	Note: Other donor allografts are payable at 85% of the listed excision fee.			
	FIXATION			
# E547	- methyl methacrylate (not arthroplasty)..... add		59.40	
# E555	- rigid external fixation (excluding casts) for closed reduction, to closed reduction fee ..... add 50%			
# E544	- cast bracing with closed reduction, to closed reduction fee ..... add 40%			
# E569	- percutaneous pinning, to closed reduction fee .. add 50%			
# E826	- percutaneous pinning, to F005, F006, F009, or F016 ..... add 75%			
	Payment rules: **1.** E544 is *not eligible for payment* when a prefabricated cast, brace or splint is used. **2.** E555 is *not eligible for payment* with F095, F104, F134 or any fee code that includes traction. **3.** E569 is *not eligible for payment* for percutaneous fixation of sacral fractures or dislocations. **4.** E569 is *not eligible for payment* with E826.			
# E590	- rigid external fixation - pseudoarthrosis ..... add		76.10	
	Removal of internal fixation device more than 30 days after insertion			
# R267	- general anaesthetic.....	6	201.00	6
# R268	- local anaesthetic.....	6	54.85	6
# R598	Removal of extensive external fixation device under general anaesthetic.....		48.25	6
	Adjustment of circumferential external fixation			
# Z280	- without general anaesthetic.....		72.35	
# Z281	- with general anaesthetic.....		145.70	6
# Z210	- Insertion traction pin - excludes fractures and dislocations		33.35	
	WOUND CARE			
E550	- insertion of closed irrigation system during a surgical procedure for post-operative management..... add		63.15	

GENERAL FEES

		Asst	Surg	Anae
# E556	- extensive debridement of compound fractures or dislocations, to reduction fee ..... add 50%			

[Commentary:
E550 is *not eligible for payment* for the application of negative pressure wound therapy/ vacuum dressings or bladder irrigation systems.]

# Z783	Secondary closure		97.35	7

Note:
Z783 is *only eligible for payment* for the delayed surgical closure of a wound. Debridement of a wound with healing by secondary intention is not payable as Z783.

# R517	Excision of foreign body.....		107.70	6
# Z250	Chronic Electrical Stimulation (not to include T.E.N.S.) external or internal		193.00	7
# Z273	Muscle core biopsy using a 6mm or larger Bergstrom muscle biopsy needle or equivalent kit - includes one or more biopsies		63.35	

Note:
Z219 is *not eligible for payment* when rendered in addition to Z273.

GENERAL FEES

		Asst	Surg	Anae
ORTHOPAEDIC/GENERAL SURGERY COMPLEX BONE OR SOFT TISSUE TUMOUR SURGERY				
R226	Biopsy of suspected sarcoma, or resection of a complex bone or complex soft tissue tumour(s), per 15 minutes	10	150.00	15

Payment rules:

1. R226 is eligible for payment only to:

- **a.** an oncological orthopaedic surgeon with fellowship training in orthopaedic oncology; or
- **b.** an oncological sarcoma general surgeon with either completed Society of Surgical Oncology training prior to 2013 or Royal College of Physicians and Surgeons of Canada certification in general surgical oncology

Documentation of completed fellowship training and/or certification must be provided to the ministry prior to submitting a claim for R226.

[Commentary:
Surgeons eligible to claim R226 will typically be working within a multidisciplinary sarcoma subspecialty group.]

2. R226 is a time based service. Except when rendering the services of a surgical assistant, time calculation for the purpose of R226A includes all resection and reconstruction components of the procedure rendered by the physician claiming R226A.

[Commentary:
For any period of time that a surgeon claiming R226A renders the services of an assistant, the time spent assisting constitutes surgical assist time and is not eligible for payment as time for the purpose of R226A.]

3. Biopsy of suspected sarcoma, or resection of a complex bone or complex soft tissue tumour(s) is not eligible for payment as R226 when rendered in conjunction with another procedure(s) by the same surgeon when the biopsy or tumour resection is not the major procedure.

[Commentary:
In these circumstances (payment rule 3), use the appropriate fee code listing in the Schedule under biopsy or excision of bone or soft tissue.]

4. R226 is eligible for payment for complex tumour resection by amputation only when the tumour resected is malignant.

[Commentary:
For other tumour resection by amputation, use the appropriate fee code listing in the Schedule under amputation.]

5. If the nature, complexity and/or length of the procedure require(s) two oncological orthopaedic or general surgeons to render components of the same procedure simultaneously or sequentially, R226A is eligible for payment to each surgeon for the period that each provided primary surgical services.

Claims submission instructions:
Submit R226A claims for a second surgeon using the manual review indicator and accompanied by the operative report and a letter of explanation regarding the need for two oncological surgeons.

GENERAL FEES

Asst	Surg	Anae

[Commentary:
In accordance with the Surgical Preamble, if a surgeon who is not an oncological orthopaedic surgeon or an oncologic sarcoma general renders a specialized component of the procedure (eg reconstructive flaps or grafts), the surgeon should claim the appropriate fee code(s) from the Schedule for the service(s) rendered.]

6. Time calculation commences when the surgeon begins the procedure and ends when the surgeon leaves the operating room.

7. Time unit calculation is based on full 15 minute time units.

Medical record requirements:
This service is eligible for payment only if start and stop times of the service are recorded in the patient's permanent medical record.

[Commentary:
Any surgeon rendering R226A should also record in the patient's permanent medical record the start and stop times of surgical assistant services when rendered.]

			Asst	Surg	Anae
	CASTS				
	Corrective splints must be corrective to qualify for a benefit as such. The corrective splint listings are not applicable to simple immobilization such as with a Jones bandage or metal finger splint following soft tissue injury.				
	Application of plaster casts or corrective splints are not to be claimed if applied at the time of surgery (except for the application of a cast brace) or applied during the first 2 *week*s for a fracture or dislocation when a procedural fee is applicable. The subsequent application of plaster casts may be claimed according to the following *Schedule*.				
	Direct supervision requires the physical presence of the physician in the office in which the cast is applied at the time the cast is applied unless all conditions listed on page GP62 to GP63 of the General Preamble (Delegated Procedures) are met.				
E584	- application of plaster cast outside hospital or *ICHSC* add			11.15	
Z201	Finger			10.25	
Z202	Hand			14.90	6
Z203	Arm, forearm or wrist			24.10	6
Z199	Foot			14.90	6
# Z213	Below knee, knee splints (Stove pipe, etc.)			24.10	6
# Z211	Whole leg (mid thigh to toes)			28.80	6
Z198	Toes			10.25	6
# Z205	Head and torso		6	97.35	6
# Z208	Shoulder spica		6	97.35	7
# Z206	Body cast		6	57.50	6
	Hip spica				
# Z207	- unilateral		6	97.35	6
# Z209	- bilateral		6	121.60	7
Z216	Wedging of casts other than fracture treatment			10.25	
Z200	Application of Unna's paste			14.90	
Z873	Application of cast brace (must include hinge)			67.75	
Z291	Application Pavlik Harness or DDH Splint			24.10	
Z204	Removal of plaster (not associated with fractures or dislocations within 2 weeks of initial treatment)			10.25	

Payment rules:
Z201, Z198, and Z873 are *not eligible for payment* for application of a prefabricated cast, brace or splint.

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

HAND AND WRIST

		Asst	Surg	Anae
	AMPUTATION			
# R608	Phalanx, metacarpal or metacarpophalangeal joint		269.30	7
# E583	- each additional, to R608 add		94.60	
# R612	Wrist	6	289.50	6
# R629	Revision of amputated finger tip	6	241.55	6
	ARTHRODESIS			
# R465	Finger-thumb	6	394.70	7
# R777	Wrist - total or partial arthrodesis	6	833.45	6

Payment rules:

1. R465 and R777 include wrist denervation if performed.
2. R285, R286, R316, R317, R418 are *not eligible for payment* with R465 or R777
3. R777 is *only eligible for payment* for total wrist arthrodesis or for partial wrist arthrodesis involving 2 or more carpal bones

	ARTHROPLASTY			
# E564	- revision of arthroplasty add 35%			
	Wrist			
# R437	- interposition	6	374.00	7
# R485	- total radio-carpal	6	1130.15	6
# R479	- removal only	6	193.00	6
# R489	Single joint - total (arthrodesis and/or arthroplasties) maximum of 4	6	358.60	7
# R209	First carpometacarpal joint ligament reconstruction and tendon interposition arthroplasty (LRTI)	6	775.00	7
# R500	Removal - prosthesis without replacement	6	144.80	6
# R236	Carpal replacement	6	322.05	7

Payment rules:

1. R485 includes any and all of: carpal bone excision(s), proximal row carpectomy, radio-ulnar meniscectomy, intercarpal fusion(s), all tenotomies, division and repair of muscle, and wrist denervation, if performed.
2. R485 is *not eligible for payment* for carpometacarpal arthroplasty.
3. R285 and R316 are *not eligible for payment* with arthrodesis or arthroplasty fee codes for the same anatomic location.
4. R209 includes excision of the trapezium, suspensionplasty of the first metacarpal, ligament reconstruction with local tendon graft or allograft or nonbiologic material and interposition of soft tissue in the trapezial void and excision of the scaphotrapezoid joint, if performed.
5. R209 is *not eligible for payment* for suspensionplasty and/or hematoma-distraction arthroplasty alone.
6. E551, E552, E553, R597, R548 and R601 are *not eligible for payment* with R209.

[Commentary:
Suspensionplasty performed at the time of trapeziectomy without tendon interposition arthroplasty is payable as R285 and R597.]

HAND AND WRIST

		Asst	Surg	Anae
	ARTHROSCOPY			
# R682	Wrist arthroscopy setup, includes when rendered debridement, synovectomy, synovial biopsy, removal of loose body(ies) and/or screw, drilling of defect or microfracture, and/or wrist ganglion debridement.	6	400.00	7

Note:

1. A wrist procedure listed in the Hand and Wrist section of the *Schedule* performed arthroscopically is eligible for payment in addition to R682 if that procedure is not described as a component of R682 or described by an E-add-on code to R682.

2. Arthroscopic E-add-on codes listed below are *not eligible for payment* in addition to R682 when the service described by the E-code is a generally accepted component of a procedure described in Note #1.

# E479	Arthroscopy of midcarpal and/or distal radio-ulnar joint, through separate portals, to R682.....	add	192.00
# E478	Pinning of osteochondral fragment, to R682	add	251.55

Note:

F-prefix fracture procedures are *not eligible for payment* with E478 for the same fracture.

# E480	Triangular fibrocartilage complex repair, to R682	add	350.65
# E482	Soft tissue capsular release, for contractures, without bone procedure, to R682.....	add	251.55
# E483	Synovectomy for inflammatory arthritis requiring a minimum of 90 minutes to resect, to R682	add	326.55

Payment rules:

1. Synovectomy less then 90 minutes in duration is included in R682.

2. Only one of E482 or E483 is eligible for payment same patient same day.

HAND AND WRIST

		Asst	Surg	Anae
	ARTHROTOMY			
# R409	Finger		168.00	6
# R410	Wrist	6	250.00	6
	ASPIRATION/INJECTION			
	See Diagnostic and Therapeutic Procedures - Injections and Infusions.			
	BIOPSY			
	Bone			
# Z230	- punch, x-ray control		89.70	6
# Z214	- open biopsy or taking of bone graft by other than operating surgeon	6	144.80	6
	Joint			
Z221	- needle		49.20	
# R409	- open finger		168.00	6
# R410	- open wrist	6	250.00	6
	Soft tissue			
# Z228	- open		97.35	6
Z219	Muscle needle biopsy, soft tissue, per site		34.05	
	DECOMPRESSION - DENERVATION			
# N290	Decompression median nerve at wrist (carpal tunnel syndrome)	6	197.15	6
# N285	Exploration and/or decompression and/or transposition and/or neurolysis of major nerve (excluding carpal tunnel nerve)	7	283.50	7
	INCISION AND DRAINAGE			
# R409	Finger joint		168.00	6
# R410	Wrist joint	6	250.00	6
	Phalanx/metacarpal/carpus			
# R219	- incision and drainage	6	182.90	6
# R218	- sequestrectomy	6	144.80	6
# R217	- saucerization and bone graft	6	242.25	7
# R534	Tendon sheath	6	313.60	6
	EXAMINATION/MANIPULATION			
Z222	Manipulation - under general anaesthetic - sole procedure (see Surgical Preamble SP5).		134.10	6

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

HAND AND WRIST

		Asst	Surg	Anae
	EXCISION			
	Bone			
# R316	Proximal row carpectomy	6	451.90	7
# R285	Carpal - bone (one)	6	214.45	7
# R317	Dorsal exostosis (triquetrum)	6	189.75	6
# R286	Radial styloid	6	234.75	7
# R283	Phalanx/metacarpal	6	193.00	7
# R272	Bone tumour (see General Preamble GP12)	I.C	I.C	I.C
	Joint			
	Synovectomy/capsulectomy/debridement			
# R425	- finger joint	6	261.55	6
# R414	- two or more joints	6	339.65	7
# R407	Synovectomy of extensor or flexor tendons		224.45	6
# R418	Synovectomy/debridement - wrist	6	342.55	7
# R492	Radio-ulnar meniscectomy	6	231.10	7
	Soft tissue			
# R549	Ganglion - Simple or complex	6	221.80	6
# R551	Excision of fascia for Dupuytrens (palmar fibromatosis), single ray, with or without flaps.	6	322.15	7
# E832	- excision of fascia for Dupuytrens, additional rays, to R551 add		273.85	
# E831	- use of skin grafts, or revision surgery (with or without skin grafts), to R549 or R551		add 30%	

Payment rules:

1. Excision of fascia for Dupuytren's (R551, E832) is only insured for patients who demonstrate at least one of the following physical signs:

- **a.** Metacarpophalangeal (MCP) joint flexion contractures of 30 degrees or more.
- **b.** Interphalangeal (IP) joint flexion contracture of any degree.
- **c.** Adduction contractures of the interdigital web spaces with significant functional impairment.
- **d.** Recurrence of Dupuytren's disease, defined as any recurrent flexion contracture of the MCP or IP joints following prior interventional treatment (e.g., fasciotomy/fasciectomy).
- **e.** Significant functional impairment with any degree of contracture at the MCP or IP joints.

2. R551 is not payable for treatment of Dupuytren's by aponeurotomy.

3. A maximum of one R551 is eligible for payment per limb, per day.

4. A maximum of two E832 are eligible for payment per limb, per day.

5. Services listed under "Skin Flaps and Grafts" are *not eligible for payment* with R549 or R551.

6. R551, E832 and E831 include the palmar and digital components of the Dupuytrens procedure, when rendered.

[Commentary:
When excision of fascia for Dupuytren's is performed for one ray, claim R551; when two rays on the same hand are treated, claim R551 and E831; when three or more rays on the same hand are treated, claim R551 and E831 (2).]

HAND AND WRIST

		Asst	Surg	Anae
	Muscle			
# R522	- simple	6	193.00	6
# R523	- complex	6	484.35	7

RECONSTRUCTION

Bone - Pseudoarthrosis/non-union/avascular necrosis

# R321	Phalanx, metacarpal	6	392.90	7
# R322	Scaphoid	6	768.15	6
# R345	Carpal bone, other than scaphoid	6	260.75	6
# E497	- pedicled vascularized bone graft, to R322 or R345 ... add		526.40	

Note:

1. R322 and R345 must include fixation and a non-vascularized bone graft.

2. E497 is payable in addition to R322 and R345 if a pedicled vascularized bone graft is used in addition to, or in place of a non-vascularized bone graft.

3. F019 and Z279 rendered in conjunction with R322 and R345 are *not eligible for payment*.

Bone - Deformity

	Osteotomy - phalanx			
# R257	- terminal		162.65	6
# R258	- middle proximal or metacarpal	6	289.80	7
# E591	- each additional ... add		158.65	

Ligaments

# R597	Simple/single repair - wrist	6	325.45	7
# R548	Extensive/multiple repair - wrist	6	511.45	7
# R601	Metacarpal phalangeal repair	6	371.05	7

Note:

Reconstruction - Nerve - see page X13.

HAND AND WRIST

		Asst	Surg	Anae
	RECONSTRUCTION			
	Tendon			
	Tenoplasty			
# R557	- one	6	223.65	7
# E050	- each additional ... add		77.05	
	Tendon graft			
# R559	- one	6	382.30	7
# E052	- each additional ... add		324.35	
# R586	Reconstruction of flexor tendon pulley, per finger		97.35	7
	Silicone rod insertion			
# R554	- one	6	294.20	7
# E051	- each additional ... add		245.90	
	Transplant/transfer			
# R563	- single	6	376.05	7
# E054	- each additional ... add		311.60	
	Tendon repair - extensor			
# R578	- suture extensor tendon and/or open repair acute or chronic boutonniere deformity, single	6	276.10	7
# E580	- each additional* ... add		119.40	
	Flexor			
# R585	- single	6	433.10	7
# E581	- each additional* ... add		181.55	
	Mallet finger or Boutonniere deformity			
UVC	- closed		visit.fee	

Note:
*If additional tendon repair(s) requires a separate incision, bill according to Surgical Preamble SP2.

[Commentary:
Open repair of acute or chronic mallet or Boutonniere deformity may be claimed as R578.]

	Extremities			
# R602	Pollicization	6	596.35	6
# R603	Digital reimplantation involving microvascular and neuro anastomosis	8	1850.00	8
# R604	Revision of R602, R603 (see General Preamble GP12)	I.C	I.C	I.C
# R605	Reconstruction and plastic repair of traumatically amputated extremities (see General Preamble GP12)	I.C	I.C	I.C

HAND AND WRIST

		Asst	Surg	Anae
	RELEASE			
	Tendon			
	Tenolysis - flexor and/or extensor tendon of			
# R575	- one digit	6	194.05	6
# E537	- each additional digit	add	165.20	
# R541	Flexor tenolysis with pulley preservation	6	309.00	6
	Tenotomy or fasciotomy (closed)			
	Finger			
# Z247	- one		49.20	6
# Z248	- two		72.35	7
# Z249	- three or more		99.15	6
# Z231	- palmar or plantar		121.55	7
	Tendon release (open)			
# R536	- finger/palm		186.35	6
# E592	- more than one, to R536	add	158.40	
# R537	- wrist	6	208.40	6
# E571	- more than one, to R537	add	177.10	
	REDUCTION			
	Fractures			
	Phalanx			
F004	- no reduction, rigid immobilization		49.20	
F005	- closed reduction		99.25	6
E558	- each additional	add	22.25	
# F007	- open reduction	6	346.50	7
	Metacarpal			
F008	- no reduction, one or more, rigid immobilization		49.20	
F009	- closed reduction		99.25	6
E504	- each additional	add	22.20	
# F011	- open reduction	6	320.80	7
E559	- each additional (open)	add	174.55	
	Intra-articular			
F006	- closed reduction		119.75	
E503	- each additional	add	26.85	
# F010	- open reduction	6	419.00	7

HAND AND WRIST

			Asst	Surg	Anae
		REDUCTION			
		Fractures			
		Carpus			
	F102	- no reduction, rigid immobilization		49.20	
#	F016	- closed reduction, one or more		115.10	6
#	F017	- open reduction, one or more	6	443.00	7
		Scaphoid			
	F018	- no reduction, rigid immobilization		49.20	
#	F019	- open reduction	6	637.30	7
#	F020	- excision	6	193.00	7
		Dislocations			
		Finger			
	D001	- closed reduction		57.50	6
	E576	- each additional add		10.25	
#	D003	- open reduction	6	288.35	6
		Metacarpal/phalangeal			
	D004	- closed reduction		57.50	6
	E577	- each additional add		10.25	
#	D006	- open reduction	6	282.70	7
		Carpal			
	D007	- closed reduction		128.05	6
#	D008	- open reduction	6	241.30	7

[Commentary:
For open reduction of the distal radio-ulnar joint associated with open reduction of the distal radius, see E064 in the Elbow/Forearm section of the *Schedule*.]

ELBOW AND FOREARM

		Asst	Surg	Anae
	AMPUTATION			
# R613	Through radius and ulna	6	351.05	7
# R614	Elbow disarticulation	6	289.50	6
	ARTHRODESIS			
# R466	Elbow	6	833.45	6
	ARTHROPLASTY			
# E564	revision of elbow arthroplasty	add 35%		
# R281	Ulna replacement (lower end)	6	296.90	6
# R288	Implant radial head	6	452.00	6
# R499	Removal of total replacement	6	402.75	7
# R438	Humeral Prosthesis	6	449.20	10
# R486	Complete arthroplasty replacement	6	1205.95	8
# R510	Interposition arthroplasty	6	435.20	7
	ARTHROSCOPY			
# R683	Elbow arthroscopy setup, includes when rendered debridement, synovectomy, synovial biopsy, removal of loose body(ies) and/or screw, drilling of defect or microfracture, and/or arthroscopic epicondylar release	6	400.00	7

Note:

1. An elbow procedure listed in the Elbow section of the *Schedule* performed arthroscopically is eligible for payment in addition to R683 if that procedure is not described as a component of R683 or described by an E-add-on code to R683.

2. Arthroscopic E-add-on codes listed below are *not eligible for payment* in addition to R683 when the service described by the E-code is a generally accepted component of a procedure described in Note #1.

# E478	Pinning of osteochondral fragment, to R683	add	251.55

Note:

F-prefix fracture procedures are *not eligible for payment* with E478 for the same fracture.

# E481	Osteochondroplasty (extensive bone and arthrofibrotic tissue removal requiring a minimum of 2 hours to resect), to R683	add	500.00
# E482	Soft tissue capsular release for contractures without bone procedure, to R683	add	251.55
# E483	Synovectomy for inflammatory arthritis requiring a minimum of 90 minutes to resect, to R683	add	326.55

Payment rules:

1. Only one of E481, E482 or E483 is eligible for payment same patient same day.

2. Synovectomy less then 90 minutes in duration is included in R683.

3. Osteochondroplasty less than 2 hours in duration is included in R683.

ELBOW AND FOREARM

		Asst	Surg	Anae
	ARTHROTOMY			
# R445	Elbow, loose body, etc.	6	199.55	7
	ASPIRATION/INJECTION			
	See Diagnostic and Therapeutic Procedures - Injections and Infusions.			
	BIOPSY			
	Bone			
Z225	- needle		72.35	6
# Z214	- open	6	144.80	6
	Joint			
# R432	- open	6	171.45	6
# Z228	- Muscle/soft tissue		97.35	6
Z219	- Muscle needle biopsy, soft tissue, per site		34.05	
	DECOMPRESSION/DENERVATION			
# R495	Fasciotomy for compartment syndrome (not including secondary closure wound)	6	397.90	7
# Z783	- Secondary closure		97.35	7
	Catheter			
# Z251	- insertion		49.20	
UVC	- monitoring		visit.fee	
# N190	Exploration and/or decompression and/or neurolysis of ulnar nerve (elbow)	7	286.20	7
# N189	Ulnar nerve transposition at elbow - may include exploration, decompression and/or neurolysis	7	368.55	7
# R426	Denervation - elbow	6	258.00	7
	INCISION AND DRAINAGE			
# R228	Acute	6	302.55	7
# Z226	Soft tissue or bursa, incision and drainage		97.35	7
# R445	Elbow	6	199.55	7
# R231	Sequestrectomy	6	440.15	7
# R229	Saucerization and bone grafting	6	452.90	7
	EXAMINATION/MANIPULATION			
Z222	Manipulation - under general anaesthetic - sole procedure (see Surgical Preamble SP5).		134.10	6

ELBOW AND FOREARM

		Asst	Surg	Anae
	EXCISION			
	Bone			
# R287	Radial head	6	217.95	7
# R286	Radial styloid	6	234.75	7
# R643	Ulna lower end	6	193.00	7
# R290	Olecranon	6	208.85	6
# R291	Olecranon with fascial repair	6	376.85	7
	Bursae			
# R595	Olecranon	6	301.40	6
	Joint Contents			
# R421	Synovectomy/capsulectomy/debridement, etc.	6	490.10	7
	Muscles			
# R524	Myositis ossificans	6	378.10	7
# R517	Foreign body removal		107.70	6
	Tumours			
	Soft tissues			
# R591	- superficial	6	196.05	6
# R592	- deep	6	484.35	7
	Bone tumours			
# R294	- exostosis	6	165.80	7
# R295	- simple excision	6	289.50	7
# R293	- extensive with replacement	6	677.50	6
	RECONSTRUCTION			
	Bone - Pseudoarthrosis			
# R323	Radius or ulna	6	760.45	7
# R473	Radius and ulna	6	786.65	6
# R950	Radius and ulna - circular external fixation.	6	291.40	7
	Bone - Deformity			
	Osteotomy			
# R259	- ulna	6	433.80	7
# R261	- radius with or without ulna	6	841.40	6
# R324	- radius and/or ulna with reconstruction congenital abnormality, synostosis etc.	6	398.10	6
# R951	Single level correction - circular external fixation	6	638.40	7
# R952	Double level correction - circular external fixation	6	798.10	6
	Bone transport			
# R953	- circular external fixation (less than or equal to 6 cm)	6	655.15	6
# R954	- circular external fixation (greater than 6 cm)	6	763.80	7

ELBOW AND FOREARM

		Asst	Surg	Anae
	RECONSTRUCTION			
	Fascia			
	Repair fascial defects			
# R476	- small	6	144.80	7
# R478	- large with or without synthetic graft or rotation flap	6	290.55	7
	Ligaments			
# R597	Simple/single repair	6	325.45	7
# R548	Extensive/multiple repair	6	511.45	7
	Tendons			
	Suture flexor tendon excluding distal biceps tendon repair and/or reconstruction			
# R585	- single	6	433.10	7
# E581	- each additional	add	181.55	
# R183	Distal biceps tendon repair	6	700.00	7
# R184	Distal triceps tendon repair	6	500.00	7
# E061	- Delayed repair requiring use of tendon graft, to R183 or R184	add 50%		

Payment rules:

1. R183 and R184 includes mobilization of muscle, tenolysis, tendon repair as well as reduction and fixation of bony injury if required.
2. E061 is *only eligible for payment* for surgical repair performed more than 6 weeks from the date of injury.
3. E061 is *only eligible for payment* for irreparable tears requiring the use of tendon graft.
4. E061 includes extensive muscle and tendon mobilization, tendon lengthening or other tenoplasty and the use and/or harvest of allograft or autograft tendon.
5. E061 is *not eligible for payment* for chronic biceps or triceps tears that are directly repairable without the use of a tendon graft.

[Commentary:
Suture of extensor tendons of forearm may be claimed using fee codes from hand/wrist section.]

	Tenoplasty			
# R557	- single	6	223.65	7
# E050	- each additional	add	77.05	
	Tenolysis			
# R556	- single	6	202.25	6
# E599	- each additional	add	87.20	
	Transposition/transplantation/transfer			
# R563	- single	6	376.05	7
# E056	- each additional	add	91.90	
# R583	Steindler flexoplasty	6	344.85	7

ELBOW AND FOREARM

		Asst	Surg	Anae
	RELEASE			
	Muscles and tendons			
# R519	- simple, e.g. tennis elbow	6	136.35	6
# R521	- radical, e.g. muscle slide	6	314.60	7
	REDUCTION			
	Dislocations			
	Elbow joint			
# D009	- closed reduction		84.45	6
# D010	- open reduction - acute	6	252.45	7
# R400	- repair chronic, recurrent	6	379.50	6
	Radial head			
# D012	- closed reduction, pulled elbow		39.00	6
# D011	- open reduction - acute	6	193.00	7
# R540	- open reduction - recurrent	6	227.40	7
# R558	- open reduction - late	6	357.20	7

ELBOW AND FOREARM

			Asst	Surg	Anae
	REDUCTION				
	Fractures				
	Epicondyle				
#	F029	- no reduction		67.75	
#	F037	- closed reduction	6	126.25	6
#	F038	- open reduction	6	214.45	7
	Transcondylar/condylar				
#	F039	- no reduction		67.75	
#	F040	- closed reduction	6	298.35	6
#	F045	- closed reduction with traction	6	312.70	6
#	F041	- open reduction	6	983.45	7
	Olecranon				
#	F034	- no reduction, rigid immobilization		126.25	6
#	F035	- closed reduction	6	129.00	6
#	F036	- open reduction	6	705.35	7
	Radius and ulnar shaft				
#	F024	- no reduction, rigid immobilization		67.75	
#	F025	- closed reduction	6	148.50	6
#	F026	- open reduction	6	854.65	7
	Radius and ulna - Monteggia				
#	F014	- no reduction, rigid immobilization		67.75	
#	F022	- closed reduction		144.80	6
	[Commentary: Treatment of a Monteggia fracture-dislocation by open reduction of the ulnar fracture and closed reduction of the radial head dislocation may be claimed as D009 and F033 or F036 depending on the anatomic area of the ulna that is repaired.]				
	Radius or ulna				
	F031	- no reduction, rigid immobilization		81.30	
#	F032	- closed reduction	6	117.85	6
#	F033	- open reduction	6	660.10	7
	Radius - distal				
	F027	- no reduction, rigid immobilization		67.75	
#	F028	- closed reduction, under local anaesthetic		109.45	
#	F046	- closed reduction, under general anaesthetic	6	149.35	6
#	F030	- open reduction, other than isolated radial styloid fracture	6	682.00	7
#	E063	- open reduction of AO/OTA Group C complete intra-articular distal radial fracture requiring dorsal and volar internal fixation, to F030		add 50%	
#	E064	- Open reduction of distal 1/3 ulnar fracture and/or repair of DRUJ dislocation, to F030		add	350.00
	Osteochondral radial or ulnar fracture and/or isolated radial styloid fracture				
#	F021	- open reduction	6	392.40	7

ELBOW AND FOREARM

Asst	Surg	Anae

Payment rules:

1. F021 is *not eligible for payment* with F030 for fracture(s) of the same wrist.

2. E063 is *not eligible for payment* unless both dorsal and volar internal fixation are described for treatment of an AO/OTA Group C distal radial fracture.

3. F030 includes denervation of wrist, if performed.

[Commentary:

The AO/OTA classification of distal radial fractures is as follows:

A – extra-articular fracture

B – partial articular fracture (involving radial styloid, dorsal rim or volar rim)

C – complete articular fracture]

SHOULDER, ARM AND CHEST

		Asst	Surg	Anae
	AMPUTATION			
# R617	Forequarter	10	490.95	15
# R616	Shoulder disarticulation	9	373.10	9
# R615	High humerus	6	423.30	6
	ARTHRODESIS			
# R467	Shoulder	6	468.65	6
	ARTHROPLASTY			
# E564	- revision of prosthesis	add 35%		
# R438	Humeral prosthesis	6	676.90	10
# R487	Total prosthesis	8	905.80	10
# R240	Revision total arthroplasty shoulder	9	942.95	15
# R498	Removal prosthesis/no replacement	6	397.20	8
	ARTHROSCOPY			
# R684	Shoulder arthroscopy setup, includes when rendered debridement, synovectomy, removal of loose body(ies) and/or screw, drilling of defect or microfracture, and/or synovial biopsy	6	400.00	10

Note:

1. A shoulder procedure listed in the Shoulder section of the *Schedule* performed arthroscopically is eligible for payment in addition to R684 if that procedure is not described as a component of R684 or described by an E-add-on code to R684.

2. Arthroscopic E-add-on codes listed below are *not eligible for payment* in addition to R684 when the service described by the E-code is a generally accepted component of a procedure described in Note #1.

# E478	Pinning of osteochondral fragment, to R684	add	251.55	

Note:

F-prefix fracture procedures are *not eligible for payment* with E478 for the same fracture.

# E484	Superior labral anterior posterior (SLAP) repair, to R684	add	336.65	
# E485	Arthroscopic capsular release for frozen shoulder, to R684	add	240.50	

Payment rules:

E484 is *not eligible for payment* in addition to R401.

	ARTHROTOMY			
# R411	Shoulder	6	223.65	7
	ASPIRATION/INJECTION			

See Diagnostic and Therapeutic Procedures - Injections and Infusions.

SHOULDER, ARM AND CHEST

		Asst	Surg	Anae
	BIOPSY			
	Bone			
Z220	- needle/punch, x-ray control		89.70	6
# Z214	- open	6	144.80	6
	Joint			
# R411	- open	6	223.65	7
# Z228	Soft tissue - open		97.35	6
Z219	Muscle needle biopsy, soft tissue, per site		34.05	
	Incision and Drainage			
# R222	Humerus/clavicle/scapula	6	342.95	7
# Z226	Bursae/soft tissue		97.35	7
# R411	Joint	6	223.65	7
# R225	Sequestrectomy	6	437.85	7
# R223	Saucerization with bone graft	6	387.90	7
	EXAMINATION AND MANIPULATION			
Z223	Manipulation under general anaesthetic - sole procedure (see Surgical Preamble SP5)		173.00	6
	EXCISION			
	Clavicle or Acromion			
# R298	Simple (includes ligament)	6	250.25	7

Note:
When R298 is rendered in association with R416, R298 is payable at 100% and R416 is payable at 85%.

# R641	Major tumour	6	290.55	7
# R214	Malignant tumour with reconstruction	6	484.35	6
	Humerus			
# R292	Head	6	299.75	6
# R294	Exostosis	6	165.80	7
# R295	Benign tumour	6	289.50	7
# R297	Malignant tumour with reconstruction	6	681.10	6
	EXCISION			
	Joint			
# R422	Synovectomy and debridement	6	490.25	10
# R512	Excision of subacromial bursa (not to be claimed with R416, R593 or R594)	6	211.60	7
	Muscle/fascia			
# R522	- simple	6	193.00	6

		Asst	Surg	Anae
# R523	- complex	6	484.35	7
# R416	Rotator cuff exploration - includes acromioplasty, excision of coraco-acromial ligament and subacromial bursa but excludes simple excision of clavicle	6	206.90	10

Note:
When R416 is rendered in association with R298, R416 is payable at 85% and R298 is payable at 100%.

RECONSTRUCTION

Pseudoarthrosis

# R329	Clavicle	6	672.30	6
# R325	Humerus	6	952.45	6
# R956	Humerus - circular external fixation	6	291.40	7

DEFORMITY

Osteotomy

# R260	- humerus	6	559.25	7
# R298	- clavicle	6	250.25	7
# R235	- glenoid	6	279.35	6
# R957	Single level correction - circular external fixation	6	510.35	6
# R958	Double level correction - circular external fixation.	6	638.40	6
	Bone transport			
# R959	- circular external fixation (less than or equal to 6 cm)	6	655.15	6
# R960	- circular external fixation (greater than 6 cm)	6	763.80	6
	Humeral lengthening			
# R961	- circular external fixation (less than or equal to 6 cm)	6	438.00	6
# R962	- circular external fixation (greater than 6 cm)	6	655.15	6

Note:
Reconstruction - Nerves - see Operations on the Nervous System.

RECONSTRUCTION

Muscles/soft tissues

# R527	Muscle transplant - pectoralis major	6	626.90	6
# R353	Scapulopexy congenital elevation	6	385.15	6
# R568	Trapezius/sternomastoid transplant	6	338.65	7
# R589	Tendon repair or release - biceps	6	227.40	7
# R685	Tendon release with tenodesis - biceps	6	314.60	7
	Rotator cuff repair			
# R593	- simple, end-to-end or side-to-side (includes acromioplasty, excision of coraco-acromial ligament and subacromial bursa)	6	345.35	10

		Asst	Surg	Anae
# R594	- complex (includes implantation into bone, and as required, acromioplasty, excision of coraco-acromial ligament, subacromial bursa and excision of distal clavicle).....	6	498.30	10
# E057	- revision/repair following previous rotator cuff surgery, to R594 ..... add 30%			
	RELEASE			
# R521	Muscle/tendon (other than biceps)	6	314.60	7
# R526	Sternomastoid	6	296.05	7
	REDUCTION			
	Fractures			
	Tuberosity			
# F047	- no reduction.....		67.80	
# F048	- closed reduction	6	117.85	6
# F049	- open reduction (without cuff tear).....	6	290.55	6
	Neck without dislocation of head			
# F053	- no reduction.....		67.80	
# F054	- closed reduction		133.60	6
# F055	- open reduction.....	6	775.95	6
	Neck with dislocation of head			
# F050	- no reduction.....		67.80	
# F051	- closed reduction	6	183.80	6
# F052	- open reduction.....	6	843.65	6
	Shaft			
# F042	- no reduction.....		67.80	
# F043	- closed reduction	6	147.60	6
# F044	- open reduction.....	6	904.15	6
	Clavicle			
UVC	- no reduction.....		visit.fee	
# F110	- closed reduction with anaesthetic	6	62.20	7
# F118	- open reduction.....	6	691.30	7
	Scapula			
# F119	- no reduction.....		67.80	
# F121	- open reduction.....	6	908.90	6
	Sternum			
# F123	- closed reduction		115.95	
# F124	- open reduction - pleura open (see General Preamble GP12)	9	I.C	13
# F125	- pleura closed (see General Preamble GP12)	6	I.C	6
	Ribs			
UVC	- no reduction.....		visit.fee	
# F131	- pleura closed (see General Preamble GP12)	6	I.C	6

		Asst	Surg	Anae
	Dislocations			
	Acromio-clavicular/sterno-clavicular			
# D014	- no reduction		67.80	
# D025	- closed with anaesthetic	6	134.55	6
# D023	- open reduction	6	326.40	7
# R596	- late	6	350.50	6
	Glenohumeral joint			
# D015	- closed reduction without anaesthetic		49.20	
# D016	- closed reduction with anaesthetic		111.40	6
# D017	- open reduction, early	6	323.85	6
# R472	- open reduction, late	6	580.90	10
# R401	- open reduction, recurrent	6	524.55	10
# E062	- coracoid transfer (Laterjet) or bone block graft to glenoid, to R401 ... add		350.00	
# E058	- revision/repair following previous glenohumeral joint surgery, to R401 ... add 30%			

Payment rules:

1. E551A, E552A, E553A are *not eligible for payment* with E062.

2. R472 is *not eligible for payment* for open reduction and repair of recurrent glenohumeral instability.

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

SKULL AND MANDIBLE

		Asst	Surg	Anae
	ARTHROPLASTY			
# R433	Temporomandibular joint - unilateral	6	349.30	10
	BIOPSY			
	Bone			
# Z869	- punch, simple		48.50	7
# Z870	- punch, x-ray control		120.70	6
# Z242	- open	6	193.00	7
	INCISION AND DRAINAGE			
# Z234	Mandibular sequestrectomy	7	281.25	7
	EXCISION			
# R272	Bone - tumour (see General Preamble GP12)	I.C	I.C	I.C
# R278	Maxilla, with exenteration of orbit and skin graft	6	532.95	7
# R279	Maxilla advancement	6	440.15	8
# R280	Mandible	6	353.10	7
# R284	Mandibular condyle	6	276.55	7
# R428	Temporomandibular meniscectomy	6	249.75	7
	RECONSTRUCTION			
	Facial paralysis			
# R531	- static slings	6	307.15	6
# R532	- dynamic slings	6	399.00	6
# R533	Composite repair for facial paralysis, plication of paralyzed muscles, and resection for paralysis of over active muscles	6	511.90	7
# E597	- with meloplasty ..... add		87.05	

Note:
Claims for R533 will be assessed by the *Medical Consultant*.

SKULL AND MANDIBLE

		Asst	Surg	Anae
	ORTHOGNATHIC SURGERY			
	Anterior dento-alveolar osteotomy, maxilla or mandible			
# R382	- one segment	6	803.80	15
# R383	- two segments	6	932.10	15
	Posterior dento-alveolar osteotomy, maxilla			
# R349	- one side	6	803.80	15
# R351	- both sides, single segment	6	932.10	15
# R385	- both sides, separate segments	6	1187.50	15
	Posterior dento-alveolar osteotomy, mandible			
# R462	- one side	6	803.80	15
# R463	- both sides	6	1187.50	15
	Total U dento-alveolar osteotomy			
# R502	- mandible	6	1228.70	15
# R507	- maxilla	6	1315.70	15
# R511	Mandibular or maxillary visor osteotomy for alveolar hypoplasia	6	1146.40	15
	Genioplasty			
# R386	- one segment	6	384.60	10
# R387	- two segments, or for laterognathia	6	575.45	10
# R388	- three segments	6	767.85	10
	Mandibular osteotomies for prognathism			
# R480	- subcondylar	6	420.10	7
# R384	- vertical ramus	6	932.10	15
# R518	- sagittal split	6	932.10	15
	Mandibular osteotomies for retrognathia, any technique			
# R520	- advancement - up to 10 mm	6	932.10	15
# R529	- advancement - 10 to 20 mm, inclusive	6	1058.40	15
# R535	- advancement - greater than 20 mm	6	1356.90	15
# E588	- for apertognathia or laterognathia	add	256.40	

SKULL AND MANDIBLE

		Asst	Surg	Anae
	ORTHOGNATHIC SURGERY			
	LeFort I advancement			
# R379	- in one segment	10	803.80	20
# E961	- in two segments	add	296.60	
# E962	- in three segments	add	594.20	
	LeFort I intrusion			
# R538	- in one segment	10	1059.35	20
# E963	- in two segments	add	296.60	
# E964	- in three segment	add	594.20	
	LeFort I extrusion			
# R567	- in one segment*	10	1315.70	20
# E965	- in two segments	add	296.60	
# E966	- in three segments	add	594.20	
	LeFort I cleft palate			
# R580	- in one segment*	10	1525.30	20
# E967	- in two segments	add	256.40	
# E968	- in three segments	add	511.90	
# E969	- with SMR	add	204.80	
# E970	- with pharyngoplasty	add	307.15	
# E971	- with closure alveolar fistula with or without bone graft	add	383.65	
# E972	- with closure hard palate fistula with or without bone graft	add	511.90	
# R588	Naso-maxillary osteotomy without LeFort I*	6	803.80	15
# R389	LeFort II maxillary osteotomy and advancement*	10	1443.95	20
# R395	Construction glenoid fossa and zygomatic arch* (Obwegeser technique)	10	1402.75	20
# R396	Construction absent condyle and ascending ramus*	6	803.80	10
# R609	Combined LeFort I and LeFort III osteotomy in hemifacial microsomia	10	1586.20	20
# R145	Mandibular condylotomy	6	204.80	7
# R618	Coronoidotomy	6	204.80	7
# R644	Coronoidectomy	6	307.15	6

Note:

* Includes harvesting and grafting of bone or cartilage grafts.

SKULL AND MANDIBLE

		Asst	Surg	Anae
	ORTHOGNATHIC SURGERY			
	Reconstruction mandible with bone grafts* and/or plate or prosthesis.			
	Unilateral			
# R334	- partial	6	409.55	15
# R335	- complete	6	819.15	15
	Bilateral			
# R645	- partial	6	819.15	15
# R646	- complete	6	1023.95	15
	Oral vestibuloplasty			
# R647	- with secondary epithelization	6	204.80	6
# R648	- with skin graft	6	307.15	6
	Temporomandibular ankylosis			
# R649	- excision bone or fibrous block	6	461.30	7
# R650	- with insertion of prosthetic device or muscle flap	6	511.90	13
# R651	- with construction of condyle and ascending ramus*	6	666.00	15
	Onlay bone grafts or alloplastic reconstruction to face when not part of standard osteotomy for reconstruction			
	Mandible			
# Z253	- unilateral		394.80	
# Z254	- bilateral		507.45	
	Maxilla			
# Z255	- unilateral		394.80	
# Z256	- bilateral		507.45	
	Zygoma			
# Z257	- unilateral		337.85	
# Z258	- bilateral		450.50	
	Temporal			
# Z259	- unilateral		450.50	
# Z260	- bilateral		563.10	
	Frontal			
# Z261	- unilateral		450.50	
# Z262	- bilateral		563.10	

Note:
For Z253 to Z262, services described as harvesting and/or use of homogenous bone grafts may be claimed in addition. See page N3 for the appropriate listing(s).

[Commentary:
Alloplastic materials include high density polyethylene, titanium mesh, resorbable mesh plus composites, calcium phosphate bone cements and other materials.]

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

SKULL AND MANDIBLE

		Asst	Surg	Anae
	Application of dental arch bars, or splint, for facial osteotomy			
# Z239	- one arch bar	6	133.00	6
# Z240	- two arch bars	6	204.80	7
# R354	Interdental wiring for temporomandibular joint disorder	6	154.00	7
# R652	- Removal intermaxillary fixation devices under general anaesthesia - as sole procedure		102.35	6

Note:
* Includes harvesting and grafting of bone or cartilage grafts.

ORBITO-CRANIAL SURGERY

	Bilateral periorbital correction Treacher-Collins Syndrome			
# R390	- with or without bone grafts* (extra-cranial)	10	1699.45	20
# R653	- with skull and muscle transpositions* (includes skull reconstruction) (intracranial)	10	2196.35	25
	Pericranial flap to orbit or face			
# R654	- unilateral		307.15	6
E973	- when in conjunction with coronal approach for main operation	add	178.90	
# R655	- bilateral		409.55	7
# E974	- when in conjunction with coronal approach for main operation	add	297.55	
# R378	LeFort III total maxillary advancement*	12	2037.35	25
# R656	LeFort III and subcranial hypertelorism correction*	12	2590.35	25
# R657	LeFort III and LeFort I maxillary advancement*	12	2334.85	25
# R658	LeFort II, subcranial hypertelorism correction Le Fort I maxillary advancement*	12	2928.10	25
	Upper LeFort III advancement without occlusal change*			
# R659	- unilateral	6	932.10	10
# R675	- bilateral	12	1443.95	25
	Forehead advancement (bone grafts not included)			
# R676	- unilateral	12	1187.50	25
# R393	- bilateral	12	1443.95	25
# R394	Cranial vault reshaping* - anterior or posterior half	10	1525.30	20
# R677	Total cranial vault reshaping*	12	2078.35	25
	Medial transnasal canthopexy			
# R398	- unilateral	6	414.30	6
# E557	- when done in conjunction with another procedure	add	154.00	

Note:
* Includes harvesting and grafting of bone or cartilage grafts.

SKULL AND MANDIBLE

		Asst	Surg	Anae
	ORBITO-CRANIAL SURGERY			
	Lateral canthoplasty			
# R399	unilateral	6	204.80	6
# E930	- when done in conjunction with another procedure..... add		102.35	
	Hypertelorism correction			
# R376	- intracranial approach*	12	2334.85	25
# R377	- subcranial U osteotomies*	12	1950.15	25
# R678	- medial orbital wall osteotomies*	10	1228.70	20
# R679	- medial and lateral orbital wall osteotomies*	10	1612.30	20
	Orbital dystopia*			
# R391	- intracranial approach	12	1950.15	25
# R392	- extracranial approach	10	1485.10	20
	Orbital cranial osteotomy*			
# R380	- intracranial approach	12	1495.50	25

Note:
Claims for R380 with N153 rendered for the same patient should be submitted using the manual review indicator and accompanied by supporting documentation.

# R381	- extracranial approach	10	1121.50	20
	Late correction traumatic enophthalmos			
	Tessier Technique - total periorbital stripping and bone grafts.			
# R680	- intracranial	12	1997.05	25
# R681	- extracranial	10	1443.95	20
	Harvesting of bone graft when not included			
# Z263	Iliac bone graft		102.35	
	Rib graft			
# Z264	- one rib		154.00	
# E975	- each subsequent rib..... add		76.50	
	Costochondral or chondral graft			
# Z265	- one rib		230.65	
# E976	- each subsequent rib..... add		154.00	
# Z266	- split cranial graft		204.80	

Note:
* Includes harvesting and grafting of bone or cartilage grafts.

		Asst	Surg	Anae

SURGERY FOR CORRECTION OF DOWN'S SYNDROME FACIAL STIGMATA

Augmentation of zygoma (bilateral)

# Z267	- with prosthetic implant		184.60	
# Z268	- with autogenous bone or cartilage*		230.65	

Augmentation of chin

# Z269	- with prosthetic implant		154.00	
# Z270	- with autogenous bone or cartilage*		189.45	
# Z271	Horizontal resection, red lower lip		184.60	

Note:
* Includes harvesting and grafting of bone or cartilage grafts.

Bicoronal flaps

R347	Bicoronal flaps		200.00	

Note:
R347 requires elevation of bicoronal flaps with exposure of the upper half facial skeleton and subsequent closure and re-suspension of soft tissues.

REDUCTION

Fractures

Orbit - open reduction rim/wall fracture

# E173	Zygomatic fracture dislocation	6	594.70	7
# E933	- with mini-plate(s)**, per major fracture line ..... add		99.85	
# E934	- with primary bone graft (separate site) ..... add		204.80	

Orbit

# E174	- blowout fracture of floor	6	767.70	7
# E934	- with primary bone graft (separate site) ..... add		204.80	

Nasal bones - to include manipulation of nasal septum

# F136	- closed reduction		102.35	6
# F137	- open reduction		316.35	10
# E825	- with mini-plate(s)**, per major fracture line ..... add		63.95	

Orbit with maxilla

# F150	- closed reduction and dental wiring		256.40	7
# F142	- with wiring and local fixation	6	685.20	7
# E830	- with mini-plate(s)**, per major fracture line ..... add		107.20	
# E932	- primary bone graft reconstruction (separate site) in addition to local repair, unilateral ..... add		205.00	
# E935	- primary bone graft reconstruction (separate site) in addition to local repair, bilateral ..... add		307.70	

Note:
E932, E934, and E935 are not to be billed with Z263, Z264, Z265, Z266, E975, or E976.

Midface fractures

		Asst	Surg	Anae
	Application of craniofacial suspension wires and external fixation devices (not to be billed in addition to maxillary repair).			
# F143	- middle ¼ facial	6	577.65	8
# E830	- with mini-plate(s)**, per major fracture line	add	107.20	
# F144	- cranial-facial separation	6	1594.90	10
# E830	- with mini-plate(s)**, per major fracture line	add	107.20	

Note:
** Where mini-plate(s) are used, one mini-plate fee per each major fracture line (e.g. infraorbital, malar-zygomatic, nasal-frontal, LeFort I, LeFort II and III) (per major fracture line per side) should be billed.

	Mandible			
UVC	- no reduction		visit fee	
# F138	- closed reduction, includes maxillary-mandibular fixation	6	350.00	7

Note:
Maxillary-mandibular fixation includes any external fixation technique.

# F139	- open reduction, per fracture, to include intermaxillary fixation	6	761.50	6
# E828	- rigid internal fixation, any method, to F139	add	193.50	

Note:
Rigid internal fixation *may include* the use of a mini-plate(s), or other internal fixation device(s).

Payment rules:
1. E828 is limited to one service for each major fracture line (e.g. infraorbital, malar zygomatic, nasal-frontal, LeFort I, LeFort II and III) when a mini-plate is used.

2. Z239, Z240, R652 or D062 are *not eligible for payment* in addition to F138 or F139.

# F140	- removal of intermaxillary fixation device(s)		100.00	

Payment rules:
1. A maximum of one F140 is eligible for payment per patient per day.

2. F140 is *not eligible for payment* in addition to F138 or F139.

[Commentary:
For removal of intermaxillary fixation devices under *general anaesthesia*, see R652.]

# F146	- complicated (see General Preamble GP12)	I.C	I.C	I.C

Dislocations

	Temporomandibular joint			
# D062	- closed reduction		51.65	6
# D063	- open reduction	6	256.40	7

PELVIS AND HIP

		Asst	Surg	Anae
	AMPUTATION			
# R631	Hemipelvectomy - hindquarter	10	796.20	15
# R630	Hip disarticulation	10	753.50	10
	ARTHRODESIS			
# R469	Sacro-iliac joint	6	395.25	7
# R514	Symphysis pubis	6	387.00	7
# R470	Hip	6	703.45	8
	ARTHROPLASTY			
# R439	Unipolar	6	641.15	10
# R440	Total hip replacement - acetabulum and femur	8	708.70	10
# R553	Total hip replacement with take down of fusion	8	972.90	15
	Revision total arthroplasty hip - one or both components			
# R241	- acetabular or femoral	9	1304.80	15
# E589	- bone graft to acetabulum	add	101.25	
# E593	- acetabular reconstruction (extensive, including bone grafts)	add	194.00	
# R481	Reattachment of greater trochanter (late)	6	290.55	8
	Removal only			
# R443	- non-cemented	6	447.30	8
# R488	- cemented	6	557.75	8
# R491	Replacement acetabular liner and/or femoral head	8	532.30	10
	ARTHROSCOPY			
# R686	Hip arthroscopy set up, includes when rendered debridement, synovectomy, removal of loose body(ies) and/or screw, drilling of defect, microfracture, abrasion arthroplasty, and/or synovial biopsy	6	669.80	10
# E487	Resection of labrum, to R686	add	240.00	
# E488	Repair of labrum, to R686	add	350.00	
# E482	Soft tissue capsular release without bone procedure, to R686	add	251.55	
# E490	Osteochondroplasty (extensive bone and arthrofibrotic tissue removal requiring a minimum of 2 hours to resect), to R686	add	500.00	

Payment rules:

1. E487 is *not eligible for payment* in addition to E488.

2. Only one of E482 or E490 is eligible for payment same patient same day.

3. Osteochondroplasty requiring less than 2 hours is included in R686.

PELVIS AND HIP

		Asst	Surg	Anae
	ARTHROTOMY			
# R547	Sacro-iliac joint	6	290.55	7
# R415	Hip - with removal of loose body	6	301.60	7
	ASPIRATION/INJECTION			
	See Diagnostic and Therapeutic Procedures - Injections and Infusions.			
# Z290	Hip - infant or child, under general anaesthesia	6	63.95	6
	BIOPSY			
	Bone			
Z212	- punch needle		97.90	
# Z217	- under general anaesthetic		72.35	7
# Z214	- open	6	144.80	6
	Joint			
# R415	- open	6	301.60	7
	Soft tissue			
# Z228	- open		97.35	6
Z219	Muscle needle biopsy, soft tissue, per site		34.05	
	DENERVATION/DECOMPRESSION			
	Exploration, decompression, division, excision, biopsy, neurolysis and/or transposition			
# N188	- minor nerve - including digital, cutaneous or lateral femoral cutaneous nerve	6	153.70	7
# N285	- major nerve - excluding carpal tunnel or ulnar nerve at elbow	7	283.50	7
# N177	Sciatic nerve in buttock	7	430.75	7
R427	Denervation of hip	6	387.00	6

Note:
N188 or N285 when performed through the same incision as flexor tendon repairs R585 or E581 is an insured service payable at nil.

	INCISION AND DRAINAGE			
# R269	Bone	6	290.55	7
# Z226	Bursae/soft tissue		97.35	7
# R415	Joint	6	301.60	7
# R249	Sequestrectomy and/or saucerization	6	379.50	7
	EXAMINATION/MANIPULATION			
Z252	Manipulation - under general anaesthetic (see Surgical Preamble SP5) - sole procedure		39.00	6

PELVIS AND HIP

		Asst	Surg	Anae
	EXCISION			
	Bone			
# R639	Simple cyst, etc.	6	338.75	7
# R330	Major resection tumour	6	629.65	7
# R216	Radical resection tumour	8	1007.35	8
# F115	Coccyx	6	208.80	6
# R315	Head and neck, femur	6	452.90	6
	Muscle			
# R522	- simple	6	193.00	6
# R523	- complex	6	484.35	7
# R524	- myositis	6	378.10	7
	Joint			
# R423	Synovectomy/debridement	6	470.50	7
	Bursae			
# R590	GT trochanteric/ischial	6	201.40	7
	RECONSTRUCTION			
	Pseudoarthrosis			
# R364	Pelvis	8	873.00	10
	[Commentary: For pseudoarthrosis of any part of the femur, see R328.]			
	Osteotomy			
	Pelvis			
# R265	- infant	8	399.00	8
# R273	- other	8	623.35	8
# R263	Hip	6	578.55	7
	Muscle/tendon			
# R521	Muscle release	6	314.60	7
	Tenotomy			
# Z232	- closed adductors		49.20	6
# Z233	- open adductors		97.35	7
# R545	- iliopsoas	6	266.35	6
	Tendon transfer			
# R570	Iliopsoas	6	520.60	7
# R569	Abductor	6	339.65	6

			Asst	Surg	Anae
		REDUCTION			
		Fractures - dislocation(s)			
		No Reduction			
	UVC	- Coccyx		visit.fee	
	UVC	- Pelvic Ring		visit.fee	
	UVC	- Sacrum		visit.fee	
	UVC	- Femoral neck, pertrochanteric, intertrochanteric, trochanteric, subtrochanteric		visit.fee	
	UVC	- Acetabulum		visit.fee	
		[Commentary: Application of femoral fracture transport splint, skin traction or pelvic sling constitute emergency splinting rather than closed reductions. These are included in visit fee, if performed.]			
		Closed Reduction			
		Pelvic ring			
#	F134	- Closed reduction of anterior and/or posterior pelvic ring fracture(s) and/or dislocation(s) including rigid external fixation of anterior/posterior pelvic ring and/or percutaneous fixation of anterior pelvic ring.	6	750.00	6
#	D059	- Closed reduction of sacrum and/or unilateral SI joint dislocation, with or without closed reduction of anterior pelvic ring fracture(s), including percutaneous fixation of sacrum and/or SI joint		800.00	6
	E555	- rigid external fixation to D059		add 50%	
	E569	- percutaneous fixation of anterior pelvic ring only, to D059		add 50%	
#	D042	- Hip dislocation		268.25	6
		Open reduction			
#	F135	Anterior pelvic ring fracture excluding sacrum, sacro-iliac joint(s) or acetabulum	6	950.00	8
#	D060	Sacrum and/or unilateral sacroiliac joint	6	950.00	6
#	D052	Lips	7	922.90	8
#	D046	One pillar	6	1458.50	10
#	D047	Two pillars	8	2187.15	12
#	D043	Hip dislocation	7	406.45	7
#	R628	Hip dislocation, late, after four weeks	7	774.90	10
#	F100	Femoral neck, pertrochanteric, intertrochanteric, trochanteric – cannulated screws, pin/plate and screws or intramedullary fixation with proximal and distal locking screws	6	771.75	10
#	F101	Primary prosthesis, femur only (includes Moore, Thompson, Unipolar, Bipolar)	6	672.65	10
		Slipped epiphysis			
#	R607	- closed reduction/traction	6	387.00	8

PELVIS AND HIP

		Asst	Surg	Anae
# R642	- closed reduction/internal fixation	6	502.30	8
# R627	- open reduction/fixation	6	758.65	8

Payment rules:

1. F134 is *not eligible for payment* if percutaneous fixation of the sacrum or sacroiliac joint(s) is performed.
2. F134 is *not eligible for payment* for application of a pelvic sling or MAST trousers to a pelvic fracture.
3. E555 and E569 are *not eligible for payment* with F134 as this fee code includes rigid external fixation of anterior/posterior pelvic ring and/or percutaneous fixation of anterior pelvis.
4. E569 is *not eligible for payment* with D059 for percutaneous fixation of the sacrum and/or unilateral SI joint as this is included in D059
5. Open reduction of acetabular or femoral head or hip fracture or dislocations include arthrotomy and/or removal of loose body(ies) if performed.
6. F101 includes reduction and fixation of trochanteric fracture if performed.
7. R628 is *not eligible for payment* with D042

[Commentary:
Open reduction codes for pelvic fractures should only be claimed when the operative procedure includes exposure of the fracture with reduction and internal fixation. Minimally invasive, image-guided reduction without fracture exposure and with percutaneous fixation does not constitute open reduction.]

Sacro-coccygeal

UVC	- closed reduction		visit.fee	
# D061	- open, removal of coccyx	6	193.00	6

Congenital/developmental dislocation of the hip

# R404	- closed reduction (includes tenotomy and cast)		190.20	7
# R405	- repeat (includes cast)		131.80	6
# R406	- open reduction (includes tenotomy and arthrotomy)	7	472.35	7

FEMUR

		Asst	Surg	Anae
	AMPUTATION			
# R625	Gritti-Stokes or Callander	6	602.75	7
# R626	Through femur	6	602.80	7
	BIOPSY			
	Bone			
# Z869	- core, punch		48.50	7
# Z870	- x-ray control/general anaesthetic		120.70	6
# Z242	- open	6	193.00	7
	Soft tissue			
# Z228	- open		97.35	6
Z219	Muscle needle biopsy, soft tissue, per site		34.05	
# R256	Injection into bone cysts		117.00	
	INCISION AND DRAINAGE			
# R242	Bone	6	425.40	7
# R245	Sequestrectomy	6	516.20	7
# R243	Saucerization and graft	6	619.90	6
# Z226	Soft tissue		97.35	7
	EXCISION			
	Bone			
# R314	Simple cyst/exostosis	6	330.30	6
	Bone tumour			
# R330	- simple	6	629.65	7
# R216	- with reconstruction/graft	8	1007.35	8
	Muscle			
# R522	- simple	6	193.00	6
# R523	- complex	6	484.35	7
	RECONSTRUCTION			
	Fascial			
# R632	- simple	6	193.00	7
# R633	- complex with or without synthetic graft or rotation flap	6	402.75	7
	Pseudoarthrosis			
# E048	- intramedullary nail with distal and proximal locking screws - femur ... add		108.75	
# R328	Bone graft with or without external fixation	6	1139.65	6
# R967	Circular external fixation	6	291.40	6

FEMUR

		Asst	Surg	Anae
	RECONSTRUCTION			
	Deformity			
# R262	Osteotomy femoral shaft	6	996.40	6
# R215	Osteotomy supracondylar	6	387.00	6
# R963	Single level correction - circular external fixation	6	638.40	7
# R964	Double level correction - circular external fixation	6	798.10	6
# R965	Bone transport - circular external fixation (less than or equal to 6 cm)	6	655.15	6
# R966	Bone transport - circular external fixation (greater than 6 cm)	6	763.80	6
	Leg length discrepancy			
# R333	Femoral shortening	6	480.70	6
# R332	Femoral lengthening	6	541.95	6
# R968	Lengthening with circular external fixation (less than or equal to 6 cm)	6	546.55	6
# R969	Lengthening with circular external fixation (greater than 6 cm)	6	763.80	6
# R340	Femoral epiphysiodesis	6	301.60	7
# R341	Tibial and femoral epiphysiodesis	6	426.90	7
# R343	Femoral stapling	6	313.65	7
# R344	Tibial and femoral stapling	6	387.00	6
	Muscles/tendons			
	Quadriceps repair			
# R589	- simple	6	227.40	7
# R587	- reconstructive	6	387.00	7
# R530	Quadricepsplasty - all types	6	381.40	7
# R561	Ilio-tibial band	6	190.10	6
# Z197	Closed release of ilio-tibial band		49.20	6
	Tenotomy of hamstrings			
# R543	- single	6	168.85	7
# R562	- multiple	6	193.00	6
	Lengthening of hamstrings			
# R557	- single	6	223.65	7
# E050	- each additional	add	77.05	
# R571	Tendon or muscle transfer	6	461.00	7
# E049	- each additional	add	87.20	
# R524	Excision of myositis	6	378.10	7
	Fractures			
	No reduction			
UVC	- cast and bed rest		visit.fee	
F094	- Closed reduction with application of skin traction or Pavlik harness - infant	6	258.00	6

FEMUR

		Asst	Surg	Anae
# F095	Closed reduction of femoral fracture including one of: - application of external fixation, or - skeletal traction, or - closed reduction with application of unilateral or bilateral hip spica cast in infant or child	6	407.35	6
	Open reduction			
# F096	Femur	6	774.05	8
# F093	Diaphyseal or metaphyseal distal femur fracture with intra-articular extension – with or without intramedullary fixation	6	1285.00	8

Payment rules:

1. F096 includes intramedullary nail with proximal and distal locking screws if performed.
2. F093 is *not eligible for payment* for repair of an isolated distal femoral osteochondral fracture.
3. F021 and F096 are *not eligible for payment* with F093 for treatment of fractures below the intertrochanteric region on the same femur.
4. E555 is *not eligible for payment* with F094 or F095.
5. Z207 and Z209 are *not eligible for payment* with F095.

KNEE

		Asst	Surg	Anae
	AMPUTATION			
# R625	Through knee - disarticulation	6	602.75	7
	ARTHRODESIS			
# R468	Knee	6	402.75	6
	ARTHROPLASTY			
# E564	- revision of arthroplasty	add 35%		
# R509	Patellar arthroplasty	6	241.60	7
	Hemiarthroplasty			
# R482	- single component (e.g. MacIntosh)	6	351.70	6
# R483	- double component (e.g. Marmar)	8	619.90	7
# R441	Total replacement/both compartments	8	681.15	8
# R248	Total knee replacement with take down of fusion	8	838.00	8
# R244	Revision total arthroplasty knee	8	1174.30	8
# E598	- with associated patellar replacement or patelloplasty, to R482, R483, R441, R248 or R244	add	94.60	
# R442	Replacement Liner	8	451.05	8

Claims submission instructions:
When a unicondylar knee arthroplasty is revised to a total knee replacement without use of stems and/or augments, submit claim using R441 total replacement/both compartments.

# R496	Removal of hemiarthroplasty - without replacement	6	242.25	7
# R497	Removal of total arthroplasty - without replacement	6	368.40	6

KNEE

		Asst	Surg	Anae
	ARTHROSCOPY			
	Degenerative Diseases of the Knee			
# R687	Knee arthroscopy set-up, degenerative disease of the knee. Includes when rendered for synovial biopsy and/or resection or trimming of plica	6	97.35	7
	Non-Degenerative Disorders of the Knee or Acutely Locked Knee			
# R699	Knee arthroscopy set-up, non-degenerative disorders of the knee or acutely locked knee. Includes when rendered for synovial biopsy and/or resection or trimming of plica	6	97.35	7

Payment rules:

1. A knee procedure listed in the Knee section of the *Schedule* performed arthroscopically is eligible for payment in addition to R687 or R699 if that procedure is not described as a component of R699 or described by an E-add-on code to R699.

2. Arthroscopic E-add-on codes listed below are *not eligible for payment* in addition to R687 or R699 when the service described by the E-code is a generally accepted component of a procedure described in Payment Rule #1.

3. E476 is *not eligible for payment* with R687 or R699 unless there is:

- **a.** evidence of an intra-articular loose body causing mechanical symptoms; or
- **b.** a symptomatic loose screw.

4. E-codes from the arthroscopy section other than E494, E495 and E476 are *not eligible for payment* with R687.

5. Except where prior approval has been given by a *MOH medical consultant*, E494 and E495 are *not eligible for payment* with R687 unless all of the following criteria are met:

- **a.** Kellgren-Lawrence knee osteoarthritis grade less than 3 as documented on standing knee x-rays performed within the last 12 *month*s; and
- **b.** Unstable chondral pathology or meniscal tear causing mechanical symptoms which have not responded to a minimum of six *month*s active non-surgical treatment.

6. R687 is eligible for payment in all patients with degenerative disease when a diagnostic arthroscopy is required prior to or in conjunction with reconstructive proximal tibial or distal femoral osteotomy.

[Commentary:

1. R687 is an *uninsured service* for any of the following:

- **a.** arthroscopic lavage of the knee alone (without debridement) for osteoarthritis;
- **b.** when the criteria in payment rule 5 are not met and no other arthroscopic E-add-on codes are medically necessary; or
- **c.** when prior approval of R687 and E494 or E495 is denied by the ministry.

2. Arthroscopic lavage of the knee alone (without debridement) is not recommended for any stage of osteoarthritis.

3. The routine use of debridement for treatment of osteoarthritis of the knee is not recommended by the Ontario Health Technology Advisory Committee (OHTAC). See https://www.hqontario.ca/Portals/0/Documents/evidence/reports/recommendation-update-arthroscopic-debridement-1411-en.pdf

KNEE

	Asst	Surg	Anae

4. Prior approval may be granted for E494 or E495 in patients with Kellgren-Lawrence grade 3 or 4 osteoarthritis (see Kohn MD, Sassoon AA, Fernando ND. Classifications in brief: Kellgren-Lawrence classification of osteoarthritis. Clin Orthop Relat Res. 2016 Aug; 474(8):1886-93) if the clinical record supports:

a. Significant functional impairment caused by an unstable articular chondral flap or degenerative meniscal tear which has not responded to a minimum of six *month*s active non-surgical treatment; and

b. the patient is not a current candidate for knee realignment or arthroplasty.]

E476 Removal of symptomatic loose body(ies) and/or screw ... add 192.00

Note:
Removal of iatrogenic loose body(ies) is *not eligible for payment*.

E491 Lateral release ..... add 161.45

E492 Synovectomy - for diseased synovium, anterior, posterior or complete ..... add 231.30

E493 Drilling of defect (includes removal of loose body(ies) ..... add 251.55

E478 Pinning of osteochondral fragment ..... add 251.55

Note:
F-prefix fracture procedures are *not eligible for payment* with E478 for the same fracture.

E494 Debridement (degenerative cartilage) – substantial debridement of 1 or more focal flaps of unstable degenerative articular cartilage causing mechanical symptoms, includes, when rendered, synovectomy, meniscal trimming and/or chondroplasty ..... add 299.00

E498 Debridement (trauma) - substantial debridement of 1 or more focal flaps of unstable post-traumatic articular cartilage causing mechanical symptoms, includes, when rendered, synovectomy, meniscal trimming and/or chondroplasty add 299.00

Payment rules:

1. E492 is *not eligible for payment* in addition to E494 or E498.

2. E498 is *not eligible for payment* with R687 or E494.

3. E494 or E498 are *not eligible for payment* for the debridement of cartilage flaps for the purpose of surgical visualization alone.

[Commentary:
When E494 or E495 are claimed with R687, or E498 is claimed with R699 it is recommended that the intra-articular pathology be documented with pre- and post-procedural photographic images taken during arthroscopy which are archived in the permanent medical record where possible.]

E489 Microfracture and/or abrasion arthroplasty, for cartilage deficiency (includes removal of loose body(ies)) ..... add 250.00

E495 Meniscectomy, partial or total, for symptomatic meniscal tear ..... add 240.45

KNEE

		Asst	Surg	Anae
# E496	Repair medial or lateral meniscus, includes when rendered debridement of attachment site ..... add		336.65	

Note:

1. E495 is *not eligible for payment* in addition to E496 for the same meniscus.

2. Trimming of a meniscus does not constitute E495 or E496.

3. E489 and/or E494 and/or E498 are *not eligible for payment* in addition to E496 for debridement of attachment site.

ARTHROTOMY

# R412	Knee - with or without removal of loose body	6	207.90	7
# R413	Osteochondritis dissecans with drilling and/or internal fixation	6	267.25	7

ASPIRATION

See Diagnostic and Therapeutic Procedures - Injections or Infusions.

BIOPSY

Bone/joint

Z870	- needle.....		120.70	6
# Z242	- open	6	193.00	7

Soft tissue

# Z228	- open		97.35	6
Z219	Muscle needle biopsy, soft tissue, per site		34.05	

DENERVATION/DECOMPRESSION

# R426	Denervation of knee.....	6	258.00	7
# N285	Denervation of gastrocnemius	7	283.50	7

INCISION AND DRAINAGE

# Z226	Soft tissue		97.35	7
# R444	Joint	6	256.30	7

EXAMINATION/MANIPULATION

Z222	Manipulation - under general anaesthetic (see Surgical Preamble SP5) - sole procedure.		134.10	6

Excision

Baker's cyst

# R431	- simple	6	148.50	6
# R434	- extensive	6	264.50	7
# R501	Cysts of meniscus.....	6	126.25	6
# R429	Meniscectomy.....	6	241.30	6
# R417	Debridement of joint without synovectomy	6	290.55	7
# R424	Synovectomy	6	430.65	7
# R506	Prepatellar bursae	6	149.45	6
# R312	Patella - to include fascial repair.....	6	276.55	7
# R318	Excision exostosis/cyst patella	6	126.25	6

KNEE

		Asst	Surg	Anae
	RECONSTRUCTION			
	Meniscus			
# R508	Suturing of medial or lateral meniscus	6	242.25	7
	Muscles/Tendons			
	Tenoplasty			
# R584	- one	6	144.80	7
# E050	- each additional ... add		77.05	
	Suture of patellar or quadriceps tendon			
# R589	- early	6	227.40	7
# R587	- late	6	387.00	7
	Transplant of tendon			
# R571	- single	6	461.00	7
# E049	- each additional ... add		87.20	
	Tenotomy			
	- closed			
# Z237	- one		49.20	6
# Z238	- multiple		72.35	7
	- open			
# R564	- one	6	232.00	7
# R566	- multiple	6	253.30	6
# R516	Release patellar retinaculum	6	161.45	7
	Ligaments			
# R599	- simple - one	6	361.95	6
# R542	- extensive ligament reconstruction (including synthetics) includes when rendered preparation of intracondyar notch	6	517.85	7
# E059	- revision/repair following previous reconstruction of knee ligaments, to R542 ... add 30%			
# R539	- removal of synthetics	6	213.45	7
	REDUCTION			
	Fractures			
	Patella			
# F085	- no reduction		67.75	
# F087	- open reduction or excision with or without repair	6	504.45	7
# F021	Osteochondral fracture - open reduction	6	392.40	7
	Dislocations			
	Knee			
# D038	- closed reduction		207.90	6
# D039	- open reduction	6	309.00	7

KNEE

		Asst	Surg	Anae
	Patella			
	- closed reduction			
# D040	- without anaesthetic		62.20	
# D031	- with anaesthetic		97.35	6
	- open reduction			
# D041	- early		335.65	7
# R255	- late	6	559.55	7
# R403	- repair of recurrent dislocation, with or without osteotomy (includes inspection of the joint)	6	487.70	7
# R515	Congenital dislocation - knee (open)	6	559.55	7

FIBULA AND TIBIA

		Asst	Surg	Anae
	AMPUTATION			
# R624	Tibia/fibula	6	552.70	7
	BIOPSY			
	Bone			
# Z870	- simple - punch		120.70	6
# Z242	- open	6	193.00	7
	Soft tissue			
# Z228	- open		97.35	6
Z219	Muscle needle biopsy, soft tissue, per site		34.05	
# R256	Injection into bone cysts		117.00	
	DECOMPRESSION/DENERVATION			
# R495	Decompression of fascial compartments	6	397.90	7
# Z783	Secondary closure		97.35	7
# Z251	Catheter insertion		49.20	
UVC	Monitoring of pressure monitoring device		visit.fee	
# N184	Decompression of posterior tibial or common peroneal nerve	6	165.20	7
	INCISION AND DRAINAGE			
# R237	Bone	6	355.95	7
# R239	Sequestrectomy	6	329.40	7
# R238	Saucerization and bone grafting	6	411.20	7
# Z226	Soft tissue		97.35	7
	EXCISION			
# R311	Exostosis/cyst	6	303.50	6
# R210	Fibular head	6	193.00	7
	Tumour			
# R295	- simple	6	289.50	7
# R253	- extensive with repair	6	648.20	6
# R246	Excision bony ridge to include interpositional materials	6	385.15	7
	Muscle/soft tissue			
# R522	- simple	6	193.00	6
# R523	- complex	6	484.35	7
	RECONSTRUCTION			
	Pseudoarthrosis			
# E041	- intramedullary nail with distal and proximal locking screws - tibia ... add		81.55	
# R326	Tibia/fibula	6	908.95	6
# R327	By-pass fibular graft	6	341.45	6
# R372	Congenital pseudoarthrosis	6	484.35	6

FIBULA AND TIBIA

		Asst	Surg	Anae
# R970	Circumferential external fixation	6	291.40	6
	Deformity			
# R289	Osteotomy tibia and fibula - adult or child	6	376.80	6
# R971	Single level correction - circular external fixation	6	510.35	6
# R972	Double level correction - circular external fixation	6	638.40	6
	Bone transport			
# R973	- circular external fixation (less than or equal to 6 cm)	6	634.70	6
# R974	- circular external fixation (greater than 6 cm)	6	763.80	6
# R403	- repair of recurrent dislocation, with or without osteotomy (includes inspection of the joint)	6	487.70	7
	Leg length discrepancy			
# R331	Tibial lengthening	6	470.50	6
# R458	Tibial shortening	6	387.00	6
# R341	Tibial and femoral epiphysiodesis	6	426.90	7
# R339	Tibial epiphysiodesis	6	322.05	7
	Tibial stapling			
# R342	- one side	6	193.00	7
# R460	- both sides	6	242.25	6
# R344	Tibial and femoral stapling	6	387.00	6
# R975	Lengthening with circular external fixation (less than or equal to 6 cm)	6	438.00	6
# R976	Lengthening with circular external fixation (greater than 6 cm)	6	655.15	6
	REDUCTION			
	Fractures			
	Tibia *with or without* fibula			
# F078	- no reduction, rigid immobilization		115.95	
# F079	- closed reduction	6	180.05	6
# F080	- open reduction - shaft	6	789.00	6
	Intramedullary nail with distal and proximal locking screws			
# E041	- tibia ... add		81.55	
# F081	- medial or lateral tibial plateau	6	813.55	6
# E532	- both tibial plateaus, same knee ... add 50%			
	Fibula			
# F082	- no reduction, rigid immobilization		67.75	
# F083	- closed reduction		101.25	6
# F084	- open reduction	6	653.05	7

FOOT AND ANKLE

		Asst	Surg	Anae
	AMPUTATION			
# R620	Metatarsal/phalanx disarticulation	6	226.00	6
# E585	- each additional (add)		47.30	
# R621	Ray (single)	6	286.00	6
# R623	Symes	6	285.80	7
# R622	Transmetatarsal/transtarsal	6	326.60	7
# R619	Terminal Symes	6	144.80	6
	ARTHRODESIS			
# R719	Ankle	6	833.45	6
# R552	- revision of arthrodesis	6	506.65	7
# R471	Interphalangeal	6	216.15	6
# E575	- each additional (add)		80.35	
# R477	Metatarsophalangeal	6	468.35	7
# R695	Subtalar	6	761.95	6
# E511	- additional midtarsal(s), to R695 (add)		175.80	
# R696	Midtarsal, single joint	6	500.00	6
# E512	- additional midtarsal(s), to R696 (add)		175.80	
# R697	Metatarsal-tarsal (fusion of one or more joints)	6	452.05	6
# R475	Ankle and subtalar fusion with or without additional midtarsal(s), one stage	6	1250.20	6

Payment rules:

1. R719, R695, R696, and R697 include any neurovascular exploration and/or protection and tenolysis, when rendered.
2. R696 is not payable in addition to R695 same patient, same side, same day.
3. R719 or R695 are not payable in addition to R475 same patient, same side, same day
4. R719 is *not eligible for payment* with R695 same patient, same side, same day.
5. R475 is *not eligible for payment* for treatment of acute (< 6 weeks from injury) ankle and/or subtalar fractures.

[Commentary:
Treatment of acute ankle and/or subtalar fractures by one-stage ankle and subtalar fusion is *not eligible for payment* as R719, R695 or R475 and should be claimed using fee code(s) that describe the fracture(s) being treated.]

	ARTHROPLASTY			
# E564	- revision of arthroplasty (add 35%)			
# R493	Ankle - total replacement	8	1204.50	10
# R694	Ankle - liner replacement	8	353.25	10

Note:
E564 is *not eligible for payment* with R694.

# R479	Removal of prosthesis without replacement	6	193.00	6
	Metatarsophalyngeal interposition			
# R456	- single	6	144.80	6

FOOT AND ANKLE

		Asst	Surg	Anae
# E538	- each additional ..... add		38.00	
# R453	Metatarsophalyngeal (Swansons, etc.)	6	376.60	7
# R454	- multiple	6	387.00	7
# R500	Removal - prosthesis without replacement	6	144.80	6

ARTHROSCOPY

# R688	Ankle arthroscopy setup, includes when rendered debridement, synovectomy, removal of loose body(ies) and/ or screw, drilling of defect or microfracture and/or synovial biopsy	6	400.00	7

Note:

1. An ankle procedure listed in the Foot and Ankle section of the *Schedule* performed arthroscopically is eligible for payment in addition to R688 if that procedure is not described as a component of R688 or described by an E-add-on code to R688.

2. Arthroscopic E-add-on codes listed below are *not eligible for payment* in addition to R688 when the service described by the E-code is a generally accepted component of a procedure described in Note #1.

# E477	Arthroscopy of subtalar and/or intratarsal joint(s), through separate portals, to R688 ..... add		192.00	
# E478	Pinning of osteochondral fragment, to R688 ..... add		251.55	

Note:

F-prefix fracture procedures are *not eligible for payment* with E478 for the same fracture.

# E481	Osteochondroplasty (extensive bone and arthrofibrotic tissue removal requiring a minimum of 2 hours to resect), to R688 ..... add		500.00	
# E483	Synovectomy for inflammatory arthritis requiring a minimum of 90 minutes to resect, to R688 ..... add		326.55	
# R689	Excision of Os Trigonum (sole procedure)	6	230.00	7

Payment rules:

1. Only one of E481 or E483 is eligible for payment same patient same day.

2. R688 is *not eligible for payment* in addition to R689.

ARTHROTOMY

Ankle

# R503	- removal of loose body, etc.	6	167.10	6
# E539	- with osteotomy of malleolus ..... add		117.85	
# R504	Midtarsals	6	144.80	7
# R505	Metatarsal/phalangeal	6	218.20	6

ASPIRATION

See Diagnostic and Therapeutic Procedure - Injections or Infusions.

FOOT AND ANKLE

			Asst	Surg	Anae
		BIOPSY			
		Bone			
		Needle			
	Z869	- punch		48.50	7
#	Z870	- under general anaesthetic		120.70	6
#	Z242	- open	6	193.00	7
		Joint			
#	R409	- open		168.00	6
		Soft tissue			
#	Z228	- open		97.35	6
	Z219	Muscle needle biopsy, soft tissue, per site		34.05	
		INCISION AND DRAINAGE			
#	R220	Bone	6	262.70	7
#	Z226	Bursae		97.35	7
#	R503	Joints	6	167.10	6
#	Z228	Soft tissue - open		97.35	6
#	R201	Sequestrectomy	6	290.85	7
#	R202	Saucerization and bone graft	6	387.00	7
		EXAMINATION/MANIPULATION			
	Z222	Manipulation - under general anaesthetic (see Surgical Preamble SP5) - sole procedure		134.10	6
		Club foot, etc. - manipulation and cast/strapping			
	Z235	- without anaesthetic		19.45	
#	Z224	- with anaesthetic		39.00	6
		EXCISION			
		Bone			
#	R299	Phalanx	6	127.15	6
#	R309	Metatarsal head	6	222.95	6
#	E587	- each additional	add	80.35	
#	R305	Accessory navicular (scaphoid)	6	155.90	6
#	R302	Bunion/bunionette	6	150.30	6
#	R307	Calcaneal spur	6	139.25	6
#	R282	Exostosis (dorsal, subungual)	6	120.55	6
#	R308	Os calcis, talus	6	283.95	7
#	R301	Sesamoid, one or both	6	142.00	6
#	R306	Tarsal bar	6	438.00	7
#	R266	Tumour (foot)	6	241.30	6
		Joint			
#	R420	Ankle synovectomy	6	316.25	7

FOOT AND ANKLE

		Asst	Surg	Anae
	Metatarsophalangeal synovectomy/capsulectomy/debridement			
# R425	- one	6	261.55	6
# R414	- two or more	6	339.65	7
	Soft Tissue			
# R506	Bursa	6	149.45	6
# R549	Ganglion - simple or complex	6	221.80	6
# R576	Excision of fascia for Dupuytrens (planter fibromatosis), one or more rays	6	322.15	6
# E831	- use of skin grafts, or revision surgery (*with or without* skin grafts), to R549 or R576 ..... add 30%			

Payment rules:

1. R576 is not payable for treatment of Dupuytren's by aponeurotomy.

2. A maximum of one R576 is eligible for payment per limb, per day.

Note:

1. Services listed under "Skin Flaps and Grafts" are *not eligible for payment* with R549 or R576.

2. R576 and E831 include the plantar and digital components of the Dupuytrens procedure, when rendered.

	Muscle			
# R522	- simple	6	193.00	6
# R523	- complex	6	484.35	7
	RECONSTRUCTION			
	Pseudoarthrosis			
# R363	Malleoli	6	404.50	7
# R321	Tarsals/metatarsals/phalanx	6	392.90	7
	Deformity			
	Osteotomy			
# R259	- os calcis	6	433.80	7
# R276	- metatarsals and phalanx	6	144.80	7
# E596	- each additional ..... add		41.70	
# R277	- midtarsal/tarsal	6	365.05	7
	Shortening metatarsal			
# R337	- one	6	225.50	6
# R338	- two or more	6	356.25	7
# R977	Circular external fixation without osteotomy*	6	583.75	6
# R978	Circular external fixation with osteotomy*	6	729.45	6
# R979	Circular external fixation with multiple osteotomies*	6	911.30	6

Note:

* This requires the application of tibial apparatus.

	Forefoot			
# R430	Claw or hammer or overlapping 5th toe	6	287.70	6
# E594	- each additional hammer toe ..... add		56.55	

FOOT AND ANKLE

		Asst	Surg	Anae
# R355	Hallux valgus reconstruction	6	446.40	7
# R360	Major forefoot reconstruction, must include the first MP joint and a minimum of 2 other MP joints	6	711.15	7

Payment rules:

1. R355 includes first metatarsal bunionectomy, tenotomy(ies),soft tissue releases and plications, and may include metatarsophalangeal synovectomy/debridement if performed.

2. Excisional arthroplasty for treatment of hallux valgus should be claimed as R309 or E587 and is *not eligible for payment* as R355.

Club Foot

# R408	Posterior or medial release	6	312.70	7
# R448	Posteromedial release, lateral shortening, tendon transfers and fusion	6	371.20	7
# R313	Complex reconstruction or revision of previous club foot repair (not to include simple tendon releases)	6	468.65	6
# R546	Plantar fascia release (Steindler)	6	248.95	6

Ligaments

Ankle

# R185	- one	6	346.85	7
# R744	- extensive/multiple	6	588.20	7

Tendons

# R640	Exploration - tendon sheath	6	200.90	7

Tenolysis - extensive release

# R556	- one	6	202.25	6
# E599	- each additional digit ... add		87.20	

Tendon transfer foot and ankle

# R565	- single	6	253.30	7
# E055	- each additional ... add		94.60	
# R572	Tenodesis	6	338.10	7
# R560	Graft	6	253.30	6
# E053	- each additional ... add		94.60	

Lengthening or shortening

# R557	- one	6	223.65	7
# E050	- each additional ... add		77.05	

Suture extensor tendon

# R578	- one	6	276.10	7
# E580	- each additional ... add		119.40	

Suture flexor tendon

# R585	- one	6	433.10	7
# E581	- each additional ... add		181.55	

Achilles tendon repair

FOOT AND ANKLE

		Asst	Surg	Anae
# R589	- early	6	227.40	7
# R587	- late	6	387.00	7
	Tenotomy - open			
# R579	- one toe		87.20	6
# R581	- more than one toe		226.05	7
	Tenotomy - closed			
# Z229	- one toe		49.20	7
# Z243	- more than one toe		97.35	7
	Achilles or tibialis anterior/posterior tenotomy			
# R544	- open	6	252.00	7
# R555	- closed		132.70	6

REDUCTION

Fractures

Ankle

# F074	- no reduction - rigid immobilization		67.75	
# F075	- closed reduction	6	144.80	6
	- open reduction			
# F076	- one malleolus	6	466.70	7
# F077	- multiple malleoli or ligaments	6	746.10	7
	Ankle fracture with tibial Plafond burst			
# F104	- closed reduction and external fixation	6	363.40	6
# F108	- open reduction	6	954.35	6

Payment rules:

1. F108 is *only eligible for payment* for AO/OTA ankle plafond fractures classified as partial articular (43-B) or complete articular (43-C).
2. F108 includes repair of medial or lateral or syndesmotic ligaments of the same ankle if performed.
3. F108 is *not eligible for payment* with, F076, F077, R185 and/or R744 for repair/ reconstruction of the same ankle.
4. F104 is *not eligible for payment* for closed reduction of an ankle tibial plafond burst fracture without external fixation.
5. E555 is *not eligible for payment* with F104.

Metatarsus

F061	- one or more		49.20	
F062	- with rigid immobilization		67.75	
	- closed reduction			
F063	- one or more	6	98.35	6
	- open reduction			
# F064	- one	6	358.05	7
# F065	- two or more	6	501.60	7

FOOT AND ANKLE

			Asst	Surg	Anae
		Os calcis or talar neck or body, excluding osteochondral and/or avulsion fractures of the talus/os calcis			
	F070	- no reduction os calcis or talar neck/body - rigid immobilization		97.35	
	F071	- closed reduction, os calcis fracture or Hawkins type 2 talar neck fractures		161.45	7
		- open reduction			
#	F072	- os calcis fracture with repair of both the subtalar and calcaneocuboid joints or talus fracture with repair of the talar neck or body	6	746.10	6

Payment rules:
F072 is *not eligible for payment* for repair of an isolated talar or os calcis osteochondral or avulsion fracture.

Phalanx

	F056	- no reduction - rigid immobilization		49.20	
	E560	- each additional add		12.05	
	F058	- closed reduction - one		72.35	6
	E561	- each additional add		14.90	
#	F060	- open reduction	6	276.25	7

Tarsus including osteochondral and/or avulsion fractures of the talus/os calcis excluding other os calcis and talus neck/body fractures

	F066	- no reduction - rigid immobilization		98.10	
	F067	- closed reduction	6	165.20	6
#	F068	- open reduction	6	456.45	7

Intra-articular fracture - I.P. Joint

	F057	- closed reduction		77.95	
#	F059	- open reduction	6	144.80	7

REDUCTION

Dislocations

Ankle

#	D035	- closed reduction	6	111.35	6
#	D036	- open reduction	6	252.45	7

[Commentary:
Repair of recurrent ankle dislocation and/or subluxation should be claimed using ligament repair fee codes rather than D035 or D036.]

Interphalangeal

	D027	- closed reduction		57.50	6
	E578	- each additional add		10.25	
#	D029	- open reduction	6	151.25	6

Metatarsophalangeal

	D030	- closed reduction		57.50	6
	E579	- each additional add		10.25	

FOOT AND ANKLE

			Asst	Surg	Anae
#	D032	- open reduction	6	163.35	7
		Tarsus			
	D033	- closed reduction		147.60	6
#	D034	- open reduction	6	298.55	7
		Tarso-metatarsal			
	D026	- closed reduction, one or more joints		147.60	6
	D028	- open reduction, one joint	6	545.70	6
	E508	- each additional joint, to D028	add	85.00	

[Commentary:
The applicable fracture service (i.e. F063, F065) may be eligible for payment when rendered in addition to D026 or D028.]

MUSCULOSKELETAL SYSTEM SURGICAL PROCEDURES

NOT ALLOCATED

RESPIRATORY SURGICAL PROCEDURES

NOSE

		Asst	Surg	Anae
Z298	Nasopharynx (including oropharynx, oral cavity and hypopharynx) Examination Under General Anesthetic (EUGA) of nasopharynx for malignant disease including biopsies (*not eligible for payment* if rendered in conjunction with tonsillectomy and adenoidectomy or quadroscopy)....		41.25	6
	Excision of nasopharyngeal or oropharyngeal lesion			
# R181	- with palatal split.....	6	508.20	7
R182	- with mandibulotomy, glossotomy and/or palatal split	7	1216.80	10
Z297	Insertion of prosthesis for nasal septal perforation.....		18.30	
	ENDOSCOPY			
	Fiberoptic endoscopy of upper airway (nose) (*IOP*)			
Z296	- with flexible endoscope - if only operative procedure performed.....		33.25	
Z299	- with rigid endoscope, for diagnostic evaluation, or to facilitate biopsy or surgical treatment of pathology in the posterior nasal cavity, hypopharynx or larynx		8.55	

Note:
Z296 is *not eligible for payment* in addition to Z292 on the same patient on the same date of service.

# Z317	Examination under anaesthesia (EUA) of nose including suction cautery for posterior epistaxis - unilateral or bilateral		112.05	6
# Z306	Excision of middle turbinate concha bullosa - unilateral.....		55.60	7
	INCISION			
# Z301	Drainage of abscess or haematoma.....		55.60	6
# Z302	Turbinate reduction - unilateral or bilateral (by any method) ..		55.60	6
	EXCISION			
	Nasal polyp			
Z304	- single.....		21.00	
E839	- with flexible endoscope, to Z304..... add		35.25	
# Z305	- multiple or involving general anaesthetic - unilateral.....		55.60	7
	Choanal polypectomy			
# Z308	- unilateral.....		55.60	7
	Biopsy			
Z309	- single.....		18.30	
E839	- with flexible endoscope, to Z309..... add		35.25	
# Z310	- multiple or involving general anaesthetic		50.90	6
	Removal of foreign body			
# Z311	- local anaesthetic.....		10.55	
E839	- with flexible endoscope, to Z311..... add		35.25	
# Z312	- general anaesthetic.....		50.90	6

RESPIRATORY SURGICAL PROCEDURES

NOSE

		Asst	Surg	Anae
# M010	Excision of intranasal lesions by lateral rhinotomy approach	6	493.90	7
# M011	Excision of other intranasal lesions (see General Preamble GP12)	I.C	I.C	I.C

RESPIRATORY SURGICAL PROCEDURES

NOSE

		Asst	Surg	Anae
	RECONSTRUCTION			
# M012	Septoplasty		293.95	10
# M013	Partial septorhinoplasty (excluding osteotomies)		526.00	10
# M014	Septorhinoplasty	6	541.65	10
# E841	- with autologous bone or cartilage graft - from site(s) other than nose, to a maximum of two, to M014 ... add		226.80	
# E842	- with non-autologous graft or implant, to M014 ... add		58.60	
# E642	- if performed by external approach using transverse columellar and rim incisions with elevation of nasal tip skin flap, to M012, M013 or M014 ... add		119.20	
# E840	- with repair of septal perforation, to M012, M013 or M014 ... add		119.20	
# R319	Graft to nose - autologous, bone or cartilage (without septorhinoplasty)	6	360.45	7
# R320	non-autologous or prosthetic implant (without septorhinoplasty)	6	232.00	7

Note:
M013, M014, R319, R320 - These procedures require written prior authorization by a Ministry of Health *medical consultant*. (see Surgical Preamble, paragraph 17).

# M015	Septodermoplasty (to include fascial and other grafts)		306.85	7
# M016	Repair of septal perforation		358.70	7
# E642	- if performed by external approach using transverse columellar and rim incisions with elevation of nasal tip skin flap, to M015 or M016 ... add		119.20	
# M017	Packing for localization of cerebrospinal rhinorrhea		39.60	6
# E603	- with fluorescein injection, to M017 ... add		50.90	
# M033	Closure or opening of nostril for atrophic rhinitis		254.15	7
# M018	Endonasal augmentation for atrophic rhinitis - unilateral (including obtaining graft or preparing implant)		306.85	7
# M020	Repair of choanal atresia - unilateral or bilateral	6	360.45	6
# M021	Puncture and insertion of tube for choanal atresia - unilateral or bilateral		123.70	6
# M028	Dilation of choanal atresia - unilateral or bilateral		73.80	6
	RECONSTRUCTION			
	Rhinoplasty for reconstruction of cleft lip - nasal deformity			
# M030	- complex, to include necessary grafts and septoplasty	6	1082.30	7
# M032	- tip and septum to include total take down of cleft lip		432.45	6
# M031	- tip and septum reconstruction to include minor lip repair (Minor revision, Z-plasty)		254.15	7
# E642	- if performed by external approach using transverse columellar and rim incisions with elevation of nasal tip skin flap, to M030, M032 or M031 ... add		119.20	

RESPIRATORY SURGICAL PROCEDURES

NOSE

		Asst	Surg	Anae

Note:
Cleft lip reconstruction (S013, S014, S015) is *not eligible for payment* with M030, M031 or M032.

TREATMENT OF EPISTAXIS (NASAL HAEMORRHAGE)

Z314	Cauterization - unilateral		11.50	6
Z315	Anterior packing - unilateral		15.35	6
Z316	Posterior packing - unilateral or bilateral		35.50	6
E839	- with flexible endoscope, to Z314, Z315 or Z316 ..... add		35.25	
# M027	Ligation of external carotid artery - unilateral	6	297.25	6
# R788	Ligation of internal maxillary artery - unilateral	7	408.10	10
# R789	Ligation of anterior ethmoidal artery - unilateral	6	299.85	7
# Z313	Endoscopic transnasal ligation of the sphenopalatine artery for posterior epistaxis - unilateral		123.70	

RESPIRATORY SURGICAL PROCEDURES

ACCESSORY NASAL SINUSES

		Asst	Surg	Anae
	ACCESSORY NASAL SINUSES - EXTERNAL OR ENDONASAL APPROACH			
	Antrum or sinus lavage			
# Z319	Antral puncture and/or lavage - unilateral or bilateral		43.15	6
	Note: Z319 is *not eligible for payment* when rendered with any other surgical procedure by the same physician on the same patient, on the same *day*.			
	Maxillary			
# M055	- Caldwell-Luc (includes intranasal antrostomy) - unilateral	6	247.35	10
	[Commentary: For antrostomy by endonasal or endoscopic approach see M054.]			
	Maxillectomy			
# M056	- partial or complete	7	971.75	10
# E947	- with orbital exenteration, to M056	add	306.85	
# M058	Radical frontal sinusectomy for tumour, radical exenteration of disease with drill out for access, or ostium revision		460.20	10
# M063	Coronal and/or osteoplastic procedure for frontal sinusectomy, reconstruction or obliteration - unilateral or bilateral	7	716.25	10
	[Commentary: For frontal trephine see Z318.]			
	External frontal-ethmoidal sinusectomy and/or reconstruction			
# M059	- unilateral	6	460.20	10
	External or transantral ethmoidectomy			
# M023	- unilateral (to include Caldwell-Luc with transantral approach)	6	360.45	10
	Sphenoid			
# M061	Trans-septal sphenoidectomy for tumour or radical exenteration of disease		355.65	10
	Note: M061 is *not eligible for payment* when rendered for performing the approach to the pituitary fossa as part of N111, N112, N114 or N116.			
# M064	External transethmoidal sphenoid sinusectomy	7	612.65	10
	Closure of antral fistula			
# M067	- under general anaesthetic (to include Caldwell-Luc if necessary)		345.15	7

RESPIRATORY SURGICAL PROCEDURES

ACCESSORY NASAL SINUSES

		Asst	Surg	Anae
	ACCESSORY NASAL SINUSES – ENDOSCOPIC APPROACH			
# Z318	Trephine or endoscopic frontal sinusotomy, including Draf I, if performed		133.30	7
# M054	Intranasal maxillary antrostomy – unilateral – by endoscopic or endonasal approach	6	123.70	10
# M050	Frontal sinusotomy, extended, Draf II, unilateral		350.00	10
# E865	- bilateral procedure, to M050	add	200.00	
# M052	Median frontal sinusotomy (Draf III / Modified Lothrop)		660.20	10
	Ethmoidectomy/Antrostomy			
# M083	Intranasal ethmoidectomy, may include maxillary antrostomy, with endoscope – unilateral (*not eligible for payment* with M061 or M054)		350.00	10
# E844	- bilateral procedure, to M083	add	200.00	

Payment rules:

1. M083 is *only eligible for payment* in addition to M050 or M052 when endoscopic intranasal ethmoidectomy is medically necessary to treat ethmoid sinus pathology. Ethmoidectomy performed for surgical access is not eligible for separate payment.

# Z350	Endoscopic sphenoidotomy - unilateral		123.70	10
# E843	- bilateral procedure, to Z350	add	103.05	
# E845	- when performed using a 3D CT/MRI image guided system, to M050, M052, M083 or Z350	add	140.00	

Note:

E845 is *only eligible for payment* under the following circumstances:

1. Identification of the anatomy of the paranasal sinuses distorted by previous surgery, trauma, abnormalities of development or benign or malignant tumours; or

2. A pathological lesion abuts the base of the skull, orbit, optic nerve or carotid artery.

# Z351	Endoscopic Septoplasty		122.40	10
# M086	Trans-nasal endoscopic repair of CSF rhinorrhea (includes harvesting of graft material) with or without 3D CT/MRI image guided system		822.45	15

RESPIRATORY SURGICAL PROCEDURES

LARYNX

		Asst	Surg	Anae
	ENDOSCOPY			
	Laryngoscopy			
# E600	- using operating microscope - to charges for laryngoscopy ..... add		33.60	
	Direct			
# Z292	- without biopsy.....		61.30	6
# Z293	- with biopsy.....		61.30	6
# Z322	- with removal of foreign body		106.45	6
# Z323	- with removal of lesion(s).....		226.35	6
# E643	- when using laser with microlaryngoscopy for benign disease, to Z323 ..... add		121.65	

Note:

1. E600 is *not eligible for payment* in addition to E643.

2. Z292 rendered in association with gastroscopy, oesophagoscopy, oesophagoscopy-gastroscopy, duodenoscopy, and small bowel push enteroscopy services is *not eligible for payment* unless the laryngoscopy service is rendered for suspicion of disease of the larynx. Claims for Z292 in these circumstances are assessed by a *medical consultant* on a manual review basis and require the submission of a written explanation.

3. Z296 is *not eligible for payment* in addition to Z292 on the same patient on the same date of service

[Commentary:
Manual review is not required for Z293, Z322 and Z323 rendered in association with gastroscopy, oesophagoscopy, oesophagoscopy-gastroscopy, duodenoscopy, and small bowel push enteroscopy services.]

# Z343	- with dilatation of larynx, to include bronchoscopy if necessary		202.35	7
	Indirect			
# Z324	- with biopsy or removal of foreign body.....		44.70	6
	INTRODUCTION			
# M080	Teflon augmentation larynx.....	6	182.10	7
	EXCISION			
	Laryngectomy			
# M081	- total.....	6	838.90	13
# E882	- with thyroid lobectomy, to M081..... add		177.40	
# E883	- with thyroid lobectomy, must include excision of isthmus and pyramidal tract, to M081 ..... add		266.60	
# E884	- with total thyroidectomy, to M081..... add		374.00	
# M082	Laryngofissure	6	444.80	8

Note:
Excision to include laryngoscopy.

Laryngectomy

RESPIRATORY SURGICAL PROCEDURES

LARYNX

		Asst	Surg	Anae
# M084	- segmental, including reconstruction	6	888.85	9
# M085	Arytenoidectomy or arytenoidopexy or lateralization procedure	6	395.05	8
	REPAIR (TO INCLUDE LARYNGOSCOPY)			
# M090	Laryngoplasty - e.g. repair of stenosis and fractures, transections - not to be billed with M084	6	642.45	7
# M089	Creation of tracheo-oesophageal fistula	6	234.60	6
# Z320	Insertion of voice prosthesis		25.85	
# Z303	Removal of laryngeal stent or keel		240.20	6

RESPIRATORY SURGICAL PROCEDURES

TRACHEA AND BRONCHI

	Asst	Surg	Anae

PREAMBLE

1. When bronchoscopy, flexible or rigid, is rendered in conjunction with laryngoscopy or oesophagoscopy, only the bronchoscopy is eligible for payment.
2. Bronchoscopy rendered by the same surgeon immediately following thoracic surgery under the same anaesthetic is *not eligible for payment*.
3. Bronchoscopy (including intraoperative bronchoscopy) rendered the same *day* as a major lung resection is *not eligible for payment* if a bronchoscopy has been rendered by the same physician to the same patient in the 3-*week* period preceding the major lung resection.

ENDOSCOPY

Bronchoscopy

# Z360	Emergency rigid bronchoscopy for obstructed airway			474.65	

Note:

1. Z360 is eligible for payment only for life-threatening emergency situations where the patient is not intubated.
2. No other bronchoscopy service is eligible for payment with Z360.
3. Life Threatening Critical Care and Other Critical Care services are not payable in addition to Z360 to the same physician for the same patient, same *day*.

# Z327	- flexible or rigid, with or without bronchial biopsy, suction or injection of contrast material.....	nil		124.90	6
# E846	- rigid bronchoscopy rendered immediately after flexible bronchoscopy, to Z327	add		95.70	

Note:
E846 is *only eligible for payment* when rendered for the treatment of a condition identified by the preceding flexible bronchoscopy.

# E632	- with removal of foreign body, to Z327	add		68.40
# E633	- with dilatation of stricture, to Z327	add		44.55
# E634	- with selective endobronchial blocker or catheter insertion, to Z327	add		52.00
# E635	- with palliative endobronchial tumour resection including laser or cryotherapy, to Z327	add		67.20
# E636	- with broncho-alveolar lavage for diagnosis of malignancy or diagnosis and/or treatment of infection and includes obtaining specimens suitable for differential cellular analysis, to Z327	add		50.00
# E637	- with selective brushings of all 18 segmental bronchi for occult carcinoma in situ; specimens labeled as to site, to Z327	add		76.45
# E638	- with transbronchial lung biopsy with or without image intensification, to Z327	add		81.90
# E622	- any bronchoscopic procedure for patients under 3 years of age, to Z327	add		79.40
# E677	- transbronchial needle aspiration (TBNA) of mediastinal and/or hilar lymph nodes, to Z327	add		104.00

RESPIRATORY SURGICAL PROCEDURES

TRACHEA AND BRONCHI

		Asst	Surg	Anae
# E678	- TBNA of lung mass, to Z327 ..... add		104.00	
# E838	- bronchoscopy in a high risk patient with respiratory failure (i.e. severe hypoxemia or hypercapnia), to Z327..... add		79.40	

Note:
E838 is *not eligible for payment* unless the physician remains with the patient after the procedure is completed and until oxygen levels have returned to their pre-intervention level and it is apparent the patient will not require assisted ventilation.

# Z342	Limited bronchoscopy with placement of endobronchial blocker and/or double lumen tube		112.55	
# Z359	Repeat bronchoscopy for tracheobronchial toilet when performed within one week of another bronchoscopic procedure		56.65	6
# G050	Endobronchial ultrasound (EBUS), for guided biopsy of hilar and/or mediastinal lymph nodes.....		203.05	
# E837	- additional biopsy(s) performed by EBUS, to a maximum of 3, to G050 ..... add		50.75	

RESPIRATORY SURGICAL PROCEDURES

TRACHEA AND BRONCHI

		Asst	Surg	Anae
	Quadroscopy or panendoscopy			
# Z355	- with or without biopsy (nasopharyngoscopy, laryngoscopy, bronchoscopy, oesophagoscopy with or without gastro-duodenoscopy) using separate instruments in search of malignant disease		321.45	6
	TRACHEO-BRONCHIAL ASPIRATION			
# Z344	First procedure		45.95	
# Z345	Subsequent procedures performed by same physician		18.60	
	Note: Not to apply to: **1.** operating surgeons, **2.** when respiratory unit fees apply; or **3.** within the first two hours post-operatively.			
# Z326	Change of tracheostomy tube		12.50	
# Z346	Transtracheal aspiration		22.35	
# Z356	Closure of persistent tracheostoma		133.95	6
	INCISION			
# Z741	Tracheotomy	6	273.15	6
# E639	- with anterior cricoid split	add	78.50	
# Z738	Insertion of Montgomery “T” Tube or similar laryngeal or tracheal stent	6	216.10	8
# Z325	Emergency tracheotomy	10	474.65	10
	Note: **1.** Z325 is eligible for payment only for life-threatening emergency situations where the patient is not intubated. **2.** Percutaneous tracheostomy, cricothyroidotomy or other emergency airway punctures do not constitute Z325.			
	EXCISION			
E623	- repeat operation after 30 days	add	415.15	
# M099	Segmental resection of cervical trachea	9	918.60	10
# E631	- with resection of cricoid	add	314.20	
# M103	Segmental resection of trachea with either sternotomy or thoracotomy	9	1294.20	13
# M104	Carinal resection (without pulmonary resection)	11	825.40	15
	REPAIR			
# M100	Tracheal rupture, transcervical	9	654.30	10
# M101	Tracheal-bronchial rupture, transthoracic	9	868.15	13

RESPIRATORY SURGICAL PROCEDURES

CHEST WALL AND MEDIASTINUM

		Asst	Surg	Anae
	EXCISION			
# M105	Chest wall tumour, resection of 2 or more ribs, with or without costal cartilage, or, wide resection of one rib, with or without costal cartilage for malignant or suspected malignant chest wall tumour	9	1040.00	13
# E847	- with reconstruction of diaphragm requiring repair with mesh or equivalent synthetic material to M105 ... add		75.00	

Payment rules:

1. M105 is *not eligible for payment* when rib resection is required as part of surgical exposure for another procedure.

2. M105 is *not eligible for payment* for incisional biopsy of chest wall tumour or excisional rib biopsy.

3. Z353 or Z354 are not eligible for payment same day as M105.

[Commentary:
See Z353 for incisional biopsy of chest wall tumour and Z354 for excisional biopsy of rib for tumour.]

	Chest wall reconstruction			
# E640	- after chest wall resection where a significant defect (minimum 5 cm in diameter) remains requiring repair with synthetic material ... add		179.55	
# E601	- for each additional rib (more than 3) to a maximum of 3 additional ... add		57.50	
# E602	- with sternal resection ... add		177.95	
# M107	Total sternectomy	9	812.25	13
# N284	Excision of first rib and/or cervical rib to include scalenotomy, fibrolysis, and/or neurolysis when required	6	714.00	6
# M106	Mediastinal tumour	9	1255.00	13
# E847	- with reconstruction of diaphragm requiring repair with mesh or equivalent synthetic material to M106 ... add		75.00	
# M108	Ligation of thoracic duct - as sole procedure	6	410.45	6
# E683	- when performed thorascopically, by video-assisted thoracic surgery (VATS), by robotic-assisted surgery, or by uniportal approach, to M106 or M108 ... add		35%	
	REPAIR			
	Chest wall - pleura			
# M109	- closed (see General Preamble GP12)		IC	6
# M110	- open (see General Preamble GP12)		IC	13
# M112	- Sternal debridement and rewiring with or without special mechanical instrumentation – as sole procedure	6	500.00	7
# M116	- fixation for trauma	6	550.00	7
# E604	- for fixation of each additional rib exceeding four ribs. add		55.60	2

RESPIRATORY SURGICAL PROCEDURES

CHEST WALL AND MEDIASTINUM

		Asst	Surg	Anae
# E683	- when performed thorascopically, by video-assisted thoracic surgery (VATS), by robotic-assisted surgery, or by uniportal approach, to M116 ..... add 35%			
# M117	Sternal fixation for trauma.....	6	251.45	6
# R352	Pectus excavatum or carinatum repair (by reconstruction, not implant).....	6	1331.70	11
# Z742	Phrenicotomy.....	6	106.45	6
	INCISION			
# Z353	Incisional biopsy of chest wall tumour	6	110.90	7
# Z354	Excisional biopsy of rib, or rib resection for drainage	6	142.20	7
# Z357	Thoracic window creation	6	228.25	7
# Z358	Thoracic window closure	6	111.20	6
	ENDOSCOPY			
# Z329	Mediastinoscopy	6	380.00	7
# Z330	- with bronchoscopy.....	6	490.00	7
# Z328	- with mediastinotomy.....	6	475.80	7
# Z348	- with bronchoscopy and mediastinotomy	6	605.85	7
	Anterior mediastinotomy			
# Z347	- when sole procedure performed.....	6	300.00	6

RESPIRATORY SURGICAL PROCEDURES

LUNGS AND PLEURA

		Asst	Surg	Anae
	INTRODUCTION - THORACENTESIS			
Z332	Aspiration for diagnosis or therapeutic drainage		104.40	6
E542	- when performed outside hospital ... add		12.65	
Z349	Intrapleural administration of chemotherapy or sclerosing agent - by any method		23.25	
# Z334	Total unilateral lung lavage with or without bronchoscopy using Double Lumen Tube and single lung anaesthesia		304.60	13
	ENDOSCOPY			
# Z335	Thoracoscopy (pleuroscopy) with or without pleural biopsy, suction, etc.		242.35	7
	INCISION			
# Z340	Biopsy of lung, needle		243.30	7
# Z336	Biopsy of pleura, needle - including diagnostic aspiration		59.15	6
# Z341	Tube thoracostomy for closed drainage (chest tube)		76.80	6
# Z352	Intrapleural administration of thrombolytic or fibrinolytic agent via thoracostomy tube (chest tube)		50.00	
# Z363	Removal of thoracostomy tube (chest tube)		20.00	

Payment rules:
Z363 is *not eligible for payment* for the same patient on the same day as Z341.

# Z349	Intrapleural administration of chemotherapy or sclerosing agent - by any method		23.25	
# M133	Thoracotomy for removal of foreign body	9	390.65	13
# M137	Thoracotomy with or without biopsy	9	390.65	13
# M134	Thoracotomy for post-operative haemorrhage or empyema	9	390.65	13
# M132	Repair of ruptured diaphragm or plication of diaphragm by thoracic approach	9	900.00	13
# M130	Closure of broncho-pleural fistula (transthoracic or trans-sternal)	9	584.75	13
# E609	- with intercostal muscle bundle, pericardium, Azygos vein, or pericardial fat pad, to M130 ... add		121.70	
# E610	- with myovascular flap (pectoralis major, latissimus dorsi, rectus abdominus) ... add		263.80	
# M135	Major decortication of lung for empyema or tumour	11	848.80	15
# Z339	Intercostal drainage with insufflation of sclerosing agent under general anaesthesia	6	182.90	6

LUNGS AND PLEURA

		Asst	Surg	Anae
Chronic indwelling pleural catheter for palliative management of malignant pleural effusion				
Z361	Insertion of indwelling catheter			200.00
Z362	Removal of indwelling catheter			200.00

Note:

1. Z361 and Z362 include any image guidance and interpretation.

2. Z361 and Z362 are not payable for adjustment of a previously inserted indwelling pleural catheter. The applicable visit fee may be claimed.

RESPIRATORY SURGICAL PROCEDURES

LUNGS AND PLEURA

		Asst	Surg	Anae
	EXCISION			
# M138	Hilar lymph node or lung biopsy with full thoracotomy.....	9	534.10	13
# M142	Pneumonectomy, may include radical mediastinal node dissection, sampling or pericardial resection requiring repair	10	2125.00	14
# E609	- with intercostal muscle bundle, pericardium, Azygos vein or pericardial fat pad, to M142 ..... add		121.70	
# M143	Lobectomy, may include radical mediastinal node dissection or sampling	10	1753.25	13
# E644	- radical mediastinal node dissection following preoperative chemotherapy and/or radiotherapy, to M142, M143, S089 or S090 ..... add		400.00	
# E683	- when performed thoracoscopically, by video-assisted thoracic surgery (VATS), by robotic-assisted surgery, or by uniportal approach, to M142 or M143 ..... add 35%			
# M144	Segmental resection, including segmental bronchus and artery	10	1802.20	13
# E683	- when performed thoracoscopically, by video-assisted thoracic surgery (VATS), by robotic-assisted surgery, or by uniportal approach, to M144 ..... add 35%			
# M145	Wedge resection of lung	10	1054.25	13
# M151	Bullectomy for major bullous disease	10	725.00	13
# M149	Pleurectomy, and/or apical bullectomy for pneumothorax	10	525.00	13
E683	- when performed thoracoscopically, by video-assisted thoracic surgery (VATS), by robotic-assisted surgery, or by uniportal approach, to M145, M149 or M151 ..... add 35%			

RESPIRATORY SURGICAL PROCEDURES

LUNGS AND PLEURA

			Asst	Surg	Anae
	The following E codes may apply to the preceding M prefix excision codes:				
# E612	- total extra-pleural pneumonectomy	add		338.35	
# E613	- sleeve pneumonectomy	add		500.00	
# E614	- omental graft	add		162.45	
# E615	- intra-pericardial dissection	add		250.00	
# E611	- with resection of diaphragm and direct suture closure	add		145.00	
# E849	- with resection of diaphragm and reconstruction requiring repair with mesh or equivalent synthetic material	add		220.00	
# E848	- with reconstruction of pericardium requiring repair with synthetic graft material	add		80.00	
# E616	- bi-lobectomy on right side, or segmentectomy plus lobectomy (same side)	add		305.50	
# E617	- with pleural tent	add		78.80	
# E618	- with decortication of remaining lobe(s) or major thoracic lysis of adhesions (requiring at least 60 minutes of additional dedicated operative time)	add		426.50	
# E619	- sleeve lobectomy	add		162.45	

Payment rules:
E618 is *only eligible for payment* when a minimum of 60 minutes is dedicated to decortication of remaining lobes and/or major thoracic lysis of adhesions, exclusive of time spent rendering any other service or procedure to the patient.

Medical record requirements:
The physician must record on the patient's permanent medical record the time when the decortication or lysis of adhesions started and ended. If the patient's permanent medical record does not include this required information, the service is *not eligible for payment*.

			Asst	Surg	Anae
# E620	- with wedge bronchoplasty	add		78.80	
# E621	- with diagnostic wedge resection	add		45.85	
# E624	- with completion pneumonectomy for positive resection margin	add		111.20	
# E625	- with sleeve resection of pulmonary artery	add		142.20	
# E608	- each additional wedge resection of lung (to a maximum of 3)	add		84.15	
# E607	- re-operation more than 30 days subsequent to previous excision, to appropriate excision fee	add		152.30	
# M155	Lung transplant (one lung)		18	2773.25	40
M156	Repeat lung transplant (one lung)		24	2670.55	40
M157	Donor Heart - Lung removal		8	906.45	8

RESPIRATORY SURGICAL PROCEDURES

NOT ALLOCATED

CARDIOVASCULAR SURGICAL PROCEDURES

PREAMBLE

1. Unless otherwise stated, excision or repair procedures for arteries and veins include endartectomy, thrombectomy and/or bypass graft.
2. Excision or repair procedures for arteries and veins include harvest of graft tissue, except where harvest of graft tissue is explicitly excluded from the procedure. Where harvest of graft tissue is included as a specific element of the procedure, the harvest is an insured service payable at nil.
3. E516 is eligible for payment once per physician per surgical event when any of the following cardiovascular surgical procedures is complicated by active infective endocarditis (IE):

   R724, R725, R772, R726, R727, R731, R728, R729, R730, R734, R735, R733, R773, R774, R930, R732, R736, R737, R732, R863, R876

   E516 is eligible for payment when the surgical procedure is performed in the setting of active IE confirmed by preoperative diagnostics and operative findings that directly impact the procedure.

   E516 is *not eligible for payment* if IE is incidental, resolved, or does not complicate the procedure.

E516 - Endocarditis complexity premium, to procedural fee(s) ..... add 25%

CARDIOVASCULAR SURGICAL PROCEDURES

HEART AND PERICARDIUM

		Asst	Surg	Anae

Note:
Preliminary diagnostic catheterization - extra to operative fees (see Diagnostic and Therapeutic Procedures). The basic anaesthetic fee of 28 units or more for major cardiovascular surgery includes such procedures as insertion of C.V.P. line (G269), arterial line (G268), blood sampling, blood analysis and interpretations.

# R700	With hypothermia and without bypass - basic fee for cardiovascular procedures		-	25

Note:
R700 replaces procedural basic code when hypothermia is used where basic is less than 25 units.

# Z759	Removal of failed vascular graft without arterial reconstruction - when sole procedure.....		189.55	6
# E655	- re-operation for failed vascular grafts - for repair or replacement of existing prosthesis (more than one month after original operation).....	add	348.70	

Pump bypass

# E650	- includes cannulating and decannulating heart or major vein, major artery, supervision of pump and pump run	add	400.00	28
# E682	- graft of major vessel other than ascending aorta for the purpose of cardiopulmonary bypass or ventricular assist device, to E650, R701, R702, R703, R704 and Z743	add	423.85	

Note:
For the anaesthesiologist, when a pump (with or without an oxygenator and with or without Hypothermia) is used in conjunction with an anaesthetic for cardiovascular procedures, submit claim using E650C with 28 basic units plus time units, instead of the basic units for the cardiovascular procedure.

Extracorporeal Membrane Oxygenator (ECMO)

# Z788	- includes cannulating and decannulating, by any method, heart, vein and/or artery and repair of vessels if rendered.		400.00	6

Circulatory assist device e.g. intra-aortic balloon

# Z743	- open		307.80	7
# Z780	- percutaneous.....		219.80	7

Note:
Includes cannulation, repair of artery, daily care and supervision.

CARDIOVASCULAR SURGICAL PROCEDURES

HEART AND PERICARDIUM

		Asst	Surg	Anae
	Decannulation of circulatory assist device			
# Z744	- open		123.05	6
# Z781	- percutaneous		39.00	

Note:
1. Includes repair of artery.
2. R815 not to be claimed in addition to Z744.

	Repositioning of intra-aortic balloon pump			
# Z751	- open		127.95	6
# Z782	- percutaneous		82.55	

Note:
No claim to be made for repositioning within 24 hrs of original insertion.

	Re-operation involving open heart procedures			
# E670	- following previous thoracotomy	add	224.70	
# E671	- following previous sternotomy	add	543.60	

Note:
More than one *month* after original operation.

	Cardiac massage			
# R765	- open	13	231.30	13

Note:
For closed massage - see Critical Care - Diagnostic and Therapeutic Procedures.

# Z433	Replacement of pacemaker pack (single or multiple leads)		146.45	6
# Z444	Insertion of permanent endocardial electrode and implantation of pack, includes insertion of temporary transvenous lead at same surgical procedure by same surgeon	6	323.75	6
# Z445	Repositioning of permanent endocardial electrode (as separate procedure)		323.75	6
# Z435	Insertion of permanent endocardial electrode(s)		154.10	
# Z436	Exposure of vein and implantation of pack		166.55	6
# R752	Atrio-ventricular sequential pacemaker with permanent atrial and ventricular endocardial electrodes	6	454.55	6
# R751	Implantation of epicardial electrode(s) plus implantation of pack	6	465.00	20
# Z429	Implantation of coronary sinus lead for biventricular pacing	6	299.25	8

CARDIOVASCULAR SURGICAL PROCEDURES

HEART AND PERICARDIUM

		Asst	Surg	Anae
	Ventricular assist devices			
# R701	- uni-ventricular	18	721.60	28
# R702	- bi-ventricular	18	1334.80	28
# R703	- paracorporeal	18	1443.05	28
# R704	- implantable	18	2163.35	28
# R705	- removal of ventricular assist device	18	508.55	20

Payment rules:

1. R701 or R702 are eligible for payment only for paracorporeal devices inserted for less than 14 days.

2. Despite payment rule #1, R701 is also eligible for payment in addition to R703 or R704 when a right ventricular assist device is inserted to support a left ventricular assist device, regardless of the duration of insertion of the right ventricular assist device.

3. R703 is eligible for payment only for paracorporeal devices inserted for 14 or more *day*s.

4. R705 is *only eligible for payment* for removal of paracorporeal or implantable ventricular assist devices inserted for 14 or more days.

5. R705 includes repair of vessels when rendered.

6. Z744 (decannulation of circulatory assist device) is eligible for payment for removal of paracorporeal or implantable ventricular assist devices inserted for less than 14 days.

7. Only one of Z744 or R705 is eligible for payment per patient per *day* for removal of ventricular assist devices.

8. Extracorporeal membrane oxygenator procedures do not constitute R701, R702, R703 or R704.

[Commentary:

1. Extracorporeal membrane oxygenator procedures are eligible for payment as Z788.

2. Z744 or R705 are eligible for payment when rendered with cardiac transplantation.

3. If a ventricular assist device is replaced, both the appropriate removal and insertion fee codes are eligible for payment.]

Claims submission instructions:

Submit claims for R703 and R705 only after the device has been inserted for 14 or more days.

# Z412	Replacement or repair of pacemaker lead	6	110.75	7
# Z428	Pacemaker lead extraction, including the use of extraction sheathes, with or without laser or similar technology.	10	598.50	7
# E628	- each additional lead extraction	add	194.50	
	Implantation of cardioverter (CD) defibrillator			
# R753	- by thoracotomy	6	720.30	20
# R761	- by transvenous approach	6	587.35	8

Note:

Induction of ventricular arrhythmia at time of CD implant payable at 85%. See note re: G259 in Diagnostic and Therapeutic Procedures.

# Z415	Removal and/or replacement of implantable cardioverter defibrillator	6	339.45	7

CARDIOVASCULAR SURGICAL PROCEDURES

HEART AND PERICARDIUM

		Asst	Surg	Anae
	Thoracotomy			
# M137	- with or without biopsy	9	390.65	13
# M134	- for post-operative haemorrhage	9	390.65	13
# Z401	Aspiration of pericardium		131.70	
# Z414	Injection of pericardial sclerosing agents		23.10	
# R750	Open biopsy of pericardium and drainage (transthoracic or epigastric)	13	317.85	13
	Pericardiectomy			
# R748	- one side open	13	635.45	20
# R749	- both sides open or sternal split	13	1097.90	20
	Pericardiotomy for Drainage			
# R707	Surgical drainage of pericardial effusion for cardiac tamponade, by open or video-assisted thoracic surgery (VATS) approach	13	600.00	13

Note:

1. R707 is *not eligible for payment* in the setting of pericardial effusion with no evidence of tamponade and clinical instability

2. R707 is *not eligible for payment* in addition to pericardiocentesis or pericardiectomy

	Cardiotomy			
# R712	- with exploration	18	525.75	20
# R713	- with removal of foreign body	18	635.45	20
# R714	- with removal of tumour	18	576.40	20
# E660	- epicardial E.P.S. mapping ....add		185.15	
# E661	- endocardial E.P.S. mapping ....add		185.15	
# E658	- HIS Bundle ablation ....add		278.10	
# R711	Division of accessory conduction pathway (to include cardiotomy, mapping with or without HIS bundle)	nil	741.55	20
# R709	Left atrial ablative procedure for surgical treatment of atrial arrhythmia (either Cox-Maze procedure or performed using an energy source)	18	778.65	20

Note:

R709 includes all left atrial ablation sites, internal exclusion or external excision of the left atrial appendage, and the ablation procedure involving the pulmonary veins.

# R706	Right and left atrial ablative procedure for treatment of atrial arrhythmia - surgical procedure or performed with an energy source	18	1245.85	20

Note:

R706 includes all the required elements of R709 and also includes the ablation procedure involving any endocardial and epicardial right atrial ablation lines.

[Commentary:

Examples of energy sources used for ablation *may include* cryoablation, microwave, or radiofrequency (unipolar or bipolar) ablation.]

CARDIOVASCULAR SURGICAL PROCEDURES

HEART AND PERICARDIUM

		Asst	Surg	Anae
# R710	Resection/ablation for ventricular tachycardia (to include cardiotomy, mapping with or without HIS bundle)		1112.15	20
	Excision			
# R920	Ventricular tumour	18	780.80	28
# R746	Ventricular aneurysm	18	947.80	28
# R747	Aneurysm of sinus of Valsalva	18	783.55	28
# E648	- excision of extensive endocardial scar, to ventriculotomy or aneurysm repair ....add		135.80	
# R741	Coronary artery endarterectomy and/or gas endarterectomy	18	730.70	20
# R740	Left atrial appendage occlusion/excision by suture or device, Sole procedure	6	400.00	7
# E521	- when done in conjunction with another procedure .....add		200.00	

Payment rules:
E521 is *not eligible for payment* for the same patient on the same day as R709.

CARDIOVASCULAR SURGICAL PROCEDURES

HEART AND PERICARDIUM

		Asst	Surg	Anae
	Coronary artery repair			
# R742	- one	18	981.85	20
# R743	- two	18	1401.25	20
# E654	- each additional ... add		188.85	
# E645	- off pump coronary artery bypass grafting, to R742 or R743 ... add	24	371.00	40
# E651	- with coronary endarterectomy and/or gas endarterectomy, to R742 or R743 ... add		202.05	

Note:

1. For the anaesthesiologist, when off-pump coronary artery bypass grafting is rendered, submit claim using E645C with 40 basic units plus time units, instead of R742C or R743C.

2. For the surgical assistant, when off-pump coronary artery bypass grafting is rendered, submit claim using E645B with 24 basic units plus time units, instead of R742B or R743B.

# E652	- use of internal mammary or epigastric or radial artery for construction of bypass graft, to R742 or R743 ... add		187.85	
# E646	- vein patch angioplasty of coronary artery ... add		187.80	
	Interruption of bronchial collateral arteries (one or more arteries)			
# R857	- as sole procedure	13	730.70	20
# E663	- when done in conjunction with other cardiac surgery add		183.00	
	Ligation or division patent ductus			
# R754	- infant or child	13	525.75	20
# R755	- adolescent or adult	13	801.10	20
	Resection coarctation			
# R757	- infant	13	785.90	20
# R756	- child	13	755.80	20
# R758	- adolescent or adult	13	1079.80	20
# R759	Congenital heart procedures - e.g. Blalock, Glenn, Potts, Waterston or Central	13	774.35	20
	Creation of ASD			
# R763	- by balloon septostomy	9	317.85	9
# R762	- by thoracotomy or Sterling Edwards	18	755.80	20
	Closure of atrial septal defect			
# R715	- secundum	18	828.65	20
# R716	- endocardial cushion and valve defect	18	1233.10	20
# R717	- with anamalous pulmonary venous drainage	18	948.75	28
# R718	Closure of ventricular septal defect	18	948.75	28

Note:

R718 should be claimed only once regardless of the number of defects repaired by one patch.

CARDIOVASCULAR SURGICAL PROCEDURES

HEART AND PERICARDIUM

		Asst	Surg	Anae
Percutaneous transluminal catheter assisted closure for Secundum atrial septal defect				
Z465	- device closure of a single defect		198.55	
Z466	- device closure of two or more defects		347.45	

Note:
A maximum of 2 services of either Z465 or Z466 are *eligible for payment* if the services are rendered by 2 different physicians, same patient same *day*.

# R870	Orthotopic cardiac transplantation	18	1659.50	28
# R872	Donor cardiectomy	7	527.80	8
# R874	Cardiopulmonary transplantation	18	2565.30	28
# M157	Donor Heart - Lung removal	8	906.45	8

CARDIOVASCULAR SURGICAL PROCEDURES

HEART AND PERICARDIUM

REPAIR

		Asst	Surg	Anae
# R720	Total repair Tetralogy of Fallot - with or without previous arterial shunt	18	1408.85	28
# R722	Total anomalous pulmonary venous drainage	18	1263.35	28
# R723	Total correction transposition of great vessels	18	1263.35	28
# R721	Arterial repair of transposition	18	1739.20	28
# R921	Complete A-V canal	18	1480.40	28
# R922	Single ventricle	18	1687.50	28
# R923	Double outlet - right/left ventricle	18	1516.70	28
# R924	Double outlet ventricle with transposition	18	1728.90	28
# R925	Truncus arteriosus	18	1718.55	28
# R926	Interrupted aortic arch	18	1516.70	28
# R927	Aorto-pulmonary window	18	960.40	28
# R928	R-V outflow tract with valve and tubular graft	18	1064.55	28
# R929	Debanding arterioplasty of pulmonary artery	18	1034.35	28
# R768	Pulmonary artery banding	13	628.95	20
# R769	- with pressure studies by anaesthesiologist, extra/hour		-	6
# R770	Correction of cor triatriatum	18	970.95	20
# R771	Vascular ring	18	828.65	20

CARDIOVASCULAR SURGICAL PROCEDURES

VALVES

		Asst	Surg	Anae
# R724	Pulmonary valvotomy	18	727.00	28
# R725	Pulmonary valvotomy and infundibular resection	18	758.80	28
# R772	Pulmonary valve replacement	18	758.80	28
# R726	Tricuspid valvotomy	18	853.25	20
# R727	Tricuspid annuloplasty	18	678.80	20
# R731	Tricuspid valvuloplasty	18	770.55	28
# R728	Tricuspid valve replacement	18	777.40	28
# R729	Mitral valvotomy	18	717.25	20
# R730	Mitral valvotomy - restenosis	18	798.80	20
# R734	Mitral annuloplasty	18	837.00	20
# R735	Mitral replacement	18	1315.65	28
# R733	Mitral valvuloplasty	18	963.40	28
	Mitral valve reconstruction			
# R773	- simple (includes annuloplasty)	18	1648.25	28
# R774	- complex (includes annuloplasty and repair of both the anterior and posterior leaflets)	18	2058.20	28
# R930	Aortic valvoloplasty	18	837.70	28
# R736	Aortic valvotomy	18	776.05	20
# R737	Aortic infundibular resection (ventriculomyotomy)	18	913.20	28
# R732	Aortic valve replacement by open surgical approach	18	1548.25	28
# E647	- patch aortoplasty with pericardium or graft, to R732 and/or aortic annuloplasty ..... add		264.70	
# E656	- aortic annuloplasty (reconstruction and enlargement of aortic annulus), to R732 and/or patch aortoplasty ..... add		288.85	
# R739	- Aortic valve replacement by percutaneous approach	18	949.20	28

Payment rules:

1. R739 includes all aspects of the service including vascular access, intraprocedural imaging guidance, ballon valvuloplasty as required, and valve deployment
2. Intraoperative images obtained and/or interpreted in conjunction with R739 are not eligible for separate payment
3. E650 is *only eligible for payment* with R739 when cardiopulmonary bypass is medically necessary due to hybrid procedures, intraoperative complications, or patient indication (as confirmed by operative documentation).

# R863	Replacement of aortic valve, replacement of ascending aorta, and reimplantation of coronary arteries (Modified Bentall)	18	2153.40	28
# R876	Valve sparing aortic root replacement or remodelling	18	2230.75	28

Note:
Multivalvular replacement - the fee will be that for the major valve replaced plus 85% of the fee for the additional valve or valves.

CARDIOVASCULAR SURGICAL PROCEDURES

ARTERIES

		Asst	Surg	Anae
	Cannulation for infusion chemotherapy			
# R775	- superficial temporal artery	6	109.10	6
# R776	- hepatic artery	6	287.05	7
# R778	- carotid artery	6	148.50	6
# R760	Regional isolation perfusion e.g. iliac	10	410.45	10
# R764	Exploration of major artery	6	271.60	10
	INCISION			
# Z402	Arteriotomy		117.30	6

Note:
Z402 not allowed in addition to other major cardiovascular surgery.

REPAIR

Traumatic

# R790	Suture of lacerated major artery	6	316.85	10
# R795	Repair of lacerated major artery or microscopic repair of digital artery (including patch angioplasty)	10	598.40	10
# R862	- by bypass or interposition graft	10	834.30	10
	LIGATION			
# R781	Ligation of artery - as sole procedure	6	170.10	8
# R788	Internal maxillary artery - Caldwell Luc approach	7	408.10	10
# R789	Anterior ethmoid artery	6	299.85	7
# R708	Internal iliac artery (unilateral or bilateral)	7	409.55	10

EXCISION AND/OR REPAIR

1. Common femoral artery repair includes repair to the profunda femoris artery as far as the first major branch.
2. If the repair extends beyond the first major branch of the profunda femoris artery, R815 may be claimed in addition.
3. If the repair extends beyond the second major branch of the profunda femoris artery, R856 instead of R815 may be claimed in addition.
4. For procedures involving the application of a complete aortic cross clamp, the anaesthetic basic fee will depend on:
   a. the level of application of the cross clamp; and
   b. the surgical exposure and extent of the aortic repair

# E679	- with vein graft harvest remote from site of by-pass and only when saphenous vein is unavailable	add	124.10
# E649	- embolectomy and/or thrombectomy when done in conjunction with other vascular procedures	add	112.45

ARTERIES

Asst | Surg | Anae

Note:
E649 is *only eligible for payment* under the following circumstances:

a. when embolectomy and/or thrombectomy is rendered at a site other than the main operative site; or

b. when embolectomy and/or thrombectomy is rendered at the main operative site and thrombus and/or embolus was present prior to surgery.

[Commentary:
E649 is *not eligible for payment* when rendered at the main operative site in any other circumstance other than paragraph b above.]

CARDIOVASCULAR SURGICAL PROCEDURES

ARTERIES

		Asst	Surg	Anae
# R875	Endovascular aneurysm repair using stent grafting	10	1563.05	17
	Two Surgeon			
# R888	- Endovascular aneurysm repair using stent grafting – first surgeon	10	1172.30	17
# R889	- Endovascular aneurysm repair using stent grafting – second surgeon	nil	1172.30	nil
# E627	- ruptured aneurysm, to R875 or R888 .....add		619.25	
# E510	- for branched or fenestrated devices, to R875 or R888 .....add		926.85	
# E509	- conduit to aorta or common iliac artery, to R875 or R888 .....add		805.65	

Note:

1. These services include insertion of all catheters including access catheters, interpretation of any images which may be taken at the time of the procedures.

2. E510 is *not eligible for payment* for branched or fenestrated devices to the common iliac artery(s).

3. E510 is *not eligible for payment* with E627.

[Commentary:

1. Endovascular repair for abdominal aortic aneurysms is only recommended for patients who are at high-risk of per*iop*erative morbidity or death from open surgical repair.

2. For open repair of abdominal aorta aneurysms, see page Q14.]

Abdominal surgical exposure

# R880	- supraceliac aortic cross clamp		-	20
# R881	- infraceliac aortic cross clamp		-	17
# R882	Thoracic surgical exposure.....		-	25
# R883	Thoraco-abdominal surgical exposure		-	30
# R815	Arterioplasty with or without patch graft including microvascular anastomosis, arterial or venous (other than listed below)...	10	581.85	10

Carotid

# R792	- endarterectomy, with or without bypass graft	10	982.95	10
# E665	- with patch graft, to R792.....add		419.00	

Note:

R815 is *not eligible for payment* with R792.

# R796	- carotid - carotid body tumor / aneurysm repair.....	10	950.80	10

Aortic arch reconstruction

# R830	- innominate.....	10	910.70	10
# R831	- subclavian	10	910.70	10
# R832	- vertebral	10	867.35	10
# E659	- with thoracotomy.....add	6	169.00	
# E667	- ruptured .....add		266.60	

CARDIOVASCULAR SURGICAL PROCEDURES

ARTERIES

		Asst	Surg	Anae
	Thoracic aorta aneurysm - repair or excision with graft			
# R799	- ascending aorta	18	1473.15	20
	Two Surgeon			
# R890	- ascending aorta – first surgeon	18	1104.85	20
# R891	- ascending aorta – second surgeon	nil	1104.85	nil
# R800	- aortic arch	18	1840.35	20
	Two Surgeon			
# R892	- aortic arch – first surgeon	18	1380.25	20
# R893	- aortic arch – second surgeon	nil	1380.25	nil
# R801	- descending aorta with or without temporary shunt	10	1260.30	20
	Two Surgeon			
# R894	- descending aorta with or without temporary shunt – first surgeon	10	945.25	20
# R895	- descending aorta with or without temporary shunt – second surgeon	nil	945.25	nil
# E667	- ruptured	add	266.60	
	Thoraco-abdominal aneurysm - repair or excision with graft			
# R803	Thoraco-abdominal aneurysm	18	3261.85	30
	Two Surgeon			
# R898	Thoraco-abdominal aneurysm – first surgeon	18	2446.40	30
# R899	Thoraco-abdominal aneurysm – second surgeon	nil	2446.40	nil

Note:
If the services of a second anaesthesiologist are required, the second anaesthesiologist is also permitted to claim R803C.

	Abdominal aorta (aneurysm and or peripheral arterial disease) - repair or excision with graft			
# R802	- open abdominal aortic repair (tube graft or endarterectomy)	10	2031.95	17
	Two Surgeon			
# R896	- open abdominal aortic repair (tube graft or endarterectomy)– first surgeon	10	1523.95	17
# R897	- open abdominal aortic repair (tube graft or endarterectomy) – second surgeon	nil	1523.95	nil
# R817	- open abdominal aortic repair including iliac and/or femoral arteries (unilateral or bilateral)	10	2655.20	17
	Two Surgeon			
# R886	- open abdominal aortic repair including iliac and/or femoral arteries (unilateral or bilateral) – first surgeon	10	1991.40	17

CARDIOVASCULAR SURGICAL PROCEDURES

ARTERIES

		Asst	Surg	Anae
# R887	- open abdominal aortic repair including iliac and/or femoral arteries (unilateral or bilateral) – second surgeon	nil	1991.40	nil
# E626	- with implantation of inferior mesenteric artery, to R802, R896, R817, or R886 ..... add		174.35	
# E627	- ruptured aneurysm to R802, R896, R803, R898, R817, or R886add		619.25	
# E986	- suprarenal or supraceliac aortic cross clamp, to R802, R896, R817, R886 ..... add		250.00	

[Commentary:
For endovascular aneurysm repair, see page Q13.]

CARDIOVASCULAR SURGICAL PROCEDURES

ARTERIES

		Asst	Surg	Anae
	Mesenteric or celiac artery repair			
# R811	- aneurysm	10	410.85	10
# R935	- removal of band only	10	410.85	10
# R936	- endarterectomy or graft	10	1404.45	10
	Note: Use R935 for excision of celiac ganglion.			
# R940	Pulmonary thromboendarterectomy (PTE) - includes circulatory arrest with hypothermia	18	2728.40	28
	Aorto-Iliac repair			
# R814	- embolectomy or thrombectomy of bifurcation (aorta or graft)	10	461.50	10
# R858	Removal of infected aortic graft (stem and/or limbs, unilateral or bilateral)*	10	1082.60	17
# E664	- closure of duodenum	add	127.05	
# E986	- suprarenal or supraceliac aortic cross clamp, to R858	add	250.00	
	Note: * Arterial reconstruction extra.			
# R805	Renal artery - aneurysm - reconstruction or excision with graft	10	867.35	10
# R806	Renal artery repair	10	867.35	10
# R807	Splenic artery aneurysm - reconstruction or excision with graft	10	411.05	10
# R786	Iliac repair to include internal iliac aneurysm	10	805.65	10
# R937	Ilio-femoral bypass graft	10	805.65	10
	Per-obturator ilio-femoral graft			
# R860	- with saphenous vein	10	898.55	10
# R861	- with prosthetic graft	10	876.85	10
	Profundoplasty			
# R855	Common femoral/profunda femoris repair - as sole procedure	10	559.20	10
# R856	Extended profundoplasty	10	818.80	10
# R933	Axillo-femoral, femoro-femoral or axillo-axillary graft	10	656.55	10
# R932	Axillo-bilfemoral graft	10	1200.00	10
# R934	Aorto-femoral unilateral graft	10	867.35	17
# R808	Femoral aneurysm - reconstruction or excision with graft	10	600.30	10
# R873	Thrombin injection of femoral artery pseudoaneurysm		68.20	6
	Note: J202 is payable when rendered in conjunction with R873.			
# R864	Repair of false aneurysm at groin anastomosis	10	893.20	10

CARDIOVASCULAR SURGICAL PROCEDURES

ARTERIES

		Asst	Surg	Anae
# R809	Femoral-popliteal endarterectomy	10	759.60	10
# R878	Subintimal dissection for recanalization of femoral/popiteal/ tibial arterial occlusive disease	10	759.60	10
# R879	Subintimal dissection for recanalization of iliac/aorta arterial occlusive disease	10	759.60	10
# E815	- angioplasty remote from subintimal dissection site, to R878 and R879 ....add		398.15	

Note:
E815 includes placement of stent(s) or any other device(s), when rendered.

Payment rules:

1. R878 is *not eligible for payment* same patient same *day* as R809, R791, R794, R787, R780 or R797.

2. R879 is *not eligible for payment* same patient same *day* as R860 or R861.

3. R878 and R879 include catheter placement, angiography and any image guidance. Obtaining and interpreting any images in conjunction with R878 and R879 are *not eligible for payment* to any physician.

4. Bilateral procedures for R878 or R879 are payable only as separate services when subintimal dissection is performed using separate bilateral incisions.

Femoro-popliteal

# R791	- with saphenous vein	10	1077.25	10
# E672	- composite femoral popliteal/tibial bypass (vein PFPE, dacron) ....add		133.40	
# R794	- with prosthetic graft	10	733.15	10

Femoro-anterior/posterial tibial/peroneal bypass graft

# R787	- with saphenous or arm vein, with or without splicing	10	1265.00	10
# E672	- composite femoral popliteal/tibial bypass (vein PFPE, dacron) ....add		133.40	
# R780	- with prosthetic graft	10	878.00	10

Note:
R791, E672, R794, R787, E672, R780 *with or without* endarterectomy.

# R810	Popliteal aneurysm	7	805.65	10
# R812	Peripheral arteries other than listed - aneurysm	7	410.45	10
# R813	Embolectomy - artery or graft - as sole procedure	7	769.55	10
# R867	Thrombectomy - artery or graft - as sole procedure	7	490.00	10
# R866	Gastric devascularization - as sole procedure	10	549.65	10

In-situ saphenous vein arterial bypass

CARDIOVASCULAR SURGICAL PROCEDURES

ARTERIES

		Asst	Surg	Anae
# R797	- popliteal	10	1414.15	17
	One Vascular Surgeon			
# R804	- tibial	10	1643.00	17
	Two Vascular Surgeons			
# R766	- tibial - first surgeon	10	1303.00	17
# R767	- tibial - second surgeon	nil	1303.00	nil

Payment rules:

1. R766 and R767 are *only eligible for payment* to a physician that is a vascular surgeon with a specialty designation in General Surgery (03) or Vascular Surgery (17).

2. R766 and R767 are *not eligible for payment* with R804.

[Commentary:
Surgical assistant units associated with R766 are *only eligible for payment* to one physician.]

VEINS

Varicose veins involving the long and/or short saphenous vein(s)

Surgical services (ligation/stripping) for the treatment of varicose veins involving the long saphenous and/or short saphenous vein(s) are only insured when all of the following conditions are met:

1. There is incompetence (i.e. reflux) at the saphenofemoral junction or saphenopopliteal junction that is documented by Doppler or duplex ultrasound scanning;

2. The patient has failed a trial of conservative management of at least three *month*s duration; and

3. The patient has at least one of the conditions described in either a. or b. below:

a. One or more of the following signs of chronic venous insufficiency:

i. Eczema;

ii. Pigmentation;

iii. Lipodermatosclerosis;

iv. Ulceration

b. Varicosities that result in one or more of the following:

i. Ulceration secondary to venous stasis;

ii. One or more significant hemorrhages from a ruptured superficial varicosity;

iii. Two or more episodes of minor hemorrhage from a ruptured superficial varicosity;

iv. Recurrent superficial thrombophlebitis;

v. Stasis dermatitis;

vi. Varicose eczema;

vii. Lipodermosclerosis;

viii. Unremitting edema or intractable pain interfering with activities of daily living and requiring chronic analgesic medication.

1. Conservative management includes analgesics and prescription gradient support compression stockings.

2. Significant hemorrhage refers to a hemorrhage related to varicose veins that requires iron therapy or transfusion.]

LIGATION/STRIPPING

		Asst	Surg	Anae
# Z745	Saphenous		53.20	6
# R868	High ligation and stripping of long saphenous vein with groin dissection	6	200.00	7
# R869	Stripping of short saphenous vein with popliteal dissection	6	107.50	7
# R837	Multiple ligation and avulsion	6	200.00	7
# R844	Recurrent varicose veins - multiple ligation and/or stripping	6	353.80	7
# R842	Extra fascial and sub-fascial incompetent perforators by full fascial technique	6	384.75	7
# E653	- plus stripping	add	127.15	
# Z746	Femoral	6	74.25	7
# Z747	Popliteal	6	74.25	7
# Z748	Internal jugular	6	148.60	7
# R839	Internal iliac	6	394.85	10
# R834	I.V.C. - transabdominal	6	446.50	10

CARDIOVASCULAR SURGICAL PROCEDURES

VEINS

	Asst	Surg	Anae
# R838 I.V.C. - transvenous (umbrella)	6	330.65	10

VEINS

		Asst	Surg	Anae
	EXCISION			
	Resection of AV aneurysm or fistula with or without major graft			
# R825	- major aneurysm	10	975.50	17
# R826	- minor aneurysm	10	497.25	10

Payment rules:
R825 and R826 are *not eligible for payment* for revision or repair of an AV fistula or graft required for haemodialysis.

[Commentary:
See listings for revision or repair of arterio-venous (AV) fistula or graft for haemodialysis on page J38 of the Diagnostic and Therapeutic Procedures section of this *Schedule*.]

	REPAIR			
# R820	Lacerated major vein e.g. femoral, popliteal, vena cava, axillary, sub-clavian, brachial or microscopic repair of digital vein	6	396.95	7
# R818	- including patch	10	596.70	10
# R819	- by vein graft	10	793.55	10
# R835	S.V.C. bypass graft	7	758.40	17
# R836	Pulmonary embolectomy	18	866.55	20
# R828	Ilio-femoral thrombectomy *with or without* femoral vein ligation	10	446.50	10
# E657	- plus I.V.C. ligation ....add		487.25	
# R829	Thrombectomy, other than above	7	302.80	10
# R865	Distal spleno-renal shunt	10	1259.55	10
	ANASTOMOSIS			
# R822	Porto-caval	10	1046.55	10
	Spleno-renal			
# R823	- abdominal approach	10	1117.90	10
# R821	- transthoracic approach	10	1117.90	13
# R824	Meso-caval	10	866.55	10
# R827	Creation of A.V. fistula	6	490.15	7
# R841	Obliteration of A.V. fistula		82.55	7
# R833	Ligation or removal of by-pass graft		82.55	6

CARDIOVASCULAR SURGICAL PROCEDURES

NOT ALLOCATED

HAEMATIC AND LYMPHATIC SURGICAL PROCEDURES

SPLEEN AND MARROW

		Asst	Surg	Anae
	INCISION			
# Z404	Splenic puncture and aspiration		100.45	6
# Z403	Bone marrow aspiration and/or core biopsy		133.55	6

Payment rules:
If Z404 or Z403 does not result in any material for examination, the service is *not eligible for payment*.

Bone marrow transplantation - team fee

# Z425	- aspiration from donor		506.75	8
# Z426	- infusion into recipient.....		62.55	6

[Commentary:
Please refer to Cancer Care Ontario's Guidelines at https://www.cancercareontario.ca/en/cancer-care-ontario/programs/clinical-services/specialized-services-oversight/stem-cell-transplant-program.

EXCISION

# R905	Splenectomy - partial or complete	7	493.90	7
# E793	- laparoscopic or laparoscopic assisted, to R905. add 25%			

HAEMATIC AND LYMPHATIC SURGICAL PROCEDURES

LYMPH CHANNELS

		Asst	Surg	Anae
	ANASTOMOSIS			
# R846	Micro lympho - lympho or lymphovenous	7	691.40	7
	INCISION			
# Z410	Drainage of sub-fascial abscess		92.40	6
# Z413	Scalene node fine needle aspiration		31.25	
	EXCISION			
	Cystic hygroma			
# R907	- unilateral	6	408.65	7
	Neck lymph nodes			
# R910	- limited dissection, must include 2 levels (unilateral) or central compartment	10	568.70	7
# R915	- comprehensive dissection, must include 3 or more levels, unilateral	10	1120.80	8
# R912	Ileoinguinal, radical resection	6	733.95	8
	Axillary or inguinal lymph nodes			
# R913	- radical resection, unilateral	6	551.90	7
# R914	- limited resection, unilateral	6	310.95	6
	BIOPSY			
# Z405	Anterior cervical lymph node(s), unilateral	6	186.90	6
# Z411	Axillary or inguinal lymph node(s), unilateral	6	68.70	6
# Z406	Scalene, posterior cervical lymph node(s), unilateral	6	247.75	6
# Z578	Multiple para-aortic lymph nodes		93.00	
# Z427	Sentinel node biopsy, per draining basin	6	330.45	8
	Percutaneous retroperitoneal			
# Z407	- one group	6	117.90	6
# Z409	- two or more groups	6	162.20	6
# R916	Re-exploration of vascular graft and closure of lymph fistula in groin	6	207.30	6

DIGESTIVE SYSTEM SURGICAL PROCEDURES

ORAL CAVITY AND PHARYNX

			Asst	Surg	Anae

Note:
To include nasopharynx, oropharynx, hypopharynx except where otherwise specified.

INCISION

#	Z506	Drainage of oral abscess or haematoma		50.90	6
#	Z510	Drainage of pharyngeal abscess or haematoma		91.10	6
#	Z524	Drainage of haematoma or deep neck abscess (external approach)	6	271.05	7
	Z501	Biopsy		35.50	
	E542	- when performed outside of hospital ... add		12.65	
#	Z537	- requiring general anaesthetic		97.05	6
	Z111	Frenotomy - not requiring general anaesthetic		20.00	
	E542	- when performed outside of hospital ... add		12.65	
#	Z112	Frenotomy requiring general anaesthetic or frenectomy		50.90	6
#	S031	Palatal fenestration		197.55	6

EXCISION

Lesion

	Z502	- less than 2 cms	6	71.00	6
	S003	- 2 to 4 cms, inclusive	6	354.50	6
	S006	- over 4 cms	6	431.15	7
	E542	- when performed outside of hospital ... add		12.65	
	S004	Ranula	6	165.80	6
	S005	Composite resection of lesion of oral cavity and/or oropharynx with partial resection of mandible	10	1030.70	12
	S007	Extended composite resection of lesion of oral cavity and oropharynx with partial resection of mandible and resection of maxilla	10	1059.45	12
#	S050	Cryotherapy for treatment of pre-malignant or malignant lesions of oral cavity or sinuses		148.60	6

Glossectomy

#	S018	- partial	6	197.45	8
#	S020	Glossoplasty	6	197.45	6

Extraction of tooth (complete care)

	S023	- single		24.90	6
	E700	- each additional tooth ... add		13.40	
#	S028	Dentigerous cyst	6	98.80	6
#	S900	Basic units for anaesthesia with any unlisted dental surgical procedure performed by dental or oral surgeon (see General Preamble GP92)			8

DIGESTIVE SYSTEM SURGICAL PROCEDURES

ORAL CAVITY AND PHARYNX

		Asst	Surg	Anae
# S021	Repair of extensive laceration (see General Preamble GP12)	6	I.C	I.C

Note:
For minor lacerations - see Skin.

# S034	Cleft palate repair	6	369.25	8
# S035	Removal of sutures under general anaesthesia		41.25	6
# S032	Bone graft to palate	6	335.65	8

Closure of fistula

# S030	- anterior alveolar	6	197.45	6
# S033	- palate	6	281.95	8
# S036	Uvulopalatopharyngoplasty (includes tonsillectomy)		239.75	6

Note:
S036 Uvulopalatopharyngoplasty is an insured service only under the following conditions:

a. For the treatment of obstructive sleep apnea that is unresponsive to continuous positive airway pressure (CPAP) or intolerant of continuous positive airway pressure (CPAP) and;

b. the procedure is rendered to correct an identified site of airway obstruction causing the obstructive sleep apnea.

[Commentary:
Uvulopalatopharyngoplasty is not an insured service when rendered solely for the treatment of snoring.]

# S069	Pharyngoplasty	8	360.45	8
# S002	Excision of parapharyngeal space lesions (with mobilization of parotid gland)	6	907.05	8
# S067	Partial pharyngectomy - transthyroid, lateral or robotic transoral approach	8	1017.20	11
# S068	Pharyngo-laryngectomy	8	1155.45	14
# E882	- with hemithyroidectomy	add	177.40	
# E883	- with subtotal thyroidectomy	add	266.60	
# E884	- with total thyroidectomy	add	374.00	

[Commentary:
Mucosal or buccal fat flap closure of significant defect not amenable to primary closure at the time of partial pharyngectomy may be claimed as pharyngoplasty, S069.]

Branchial

# S058	- cleft lesion	6	306.85	7
# S059	- repeat procedure	6	435.30	6
# S061	Thyroglossal duct remnant	6	340.15	7
# S062	- repeat procedure	6	410.40	6
# S063	Tonsillectomy and may include adenoidectomy		214.50	6
# S065	Adenoidectomy		101.25	6
E839	- with flexible endoscope, to S063 or S065	add	35.25	

DIGESTIVE SYSTEM SURGICAL PROCEDURES

ORAL CAVITY AND PHARYNX

		Asst	Surg	Anae
	Secondary suture or cauterization following tonsillectomy and/or adenoidectomy			
# S066	- when haemorrhage occurs after initial procedure		121.05	6
# S024	Excision of torus palatinus	6	197.45	6

DIGESTIVE SYSTEM SURGICAL PROCEDURES

SALIVARY GLANDS AND DUCTS

		Asst	Surg	Anae
	INCISION			
# Z500	Sialolithotomy		30.65	
# Z521	- requiring general anaesthesia	6	103.60	6
	EXCISION			
# S042	Submandibular gland or sublingual gland	6	391.05	7
	Parotid gland			
# S043	- total (with preservation of facial nerve)	6	885.75	10
# S044	- total (without preservation of facial nerve)	6	593.00	10
# S045	- subtotal (with preservation of facial nerve)	6	752.10	10
# S047	- repeat subtotal (with preservation of facial nerve)	6	774.50	10
# Z522	Excision small tumour	6	51.25	7
	RECONSTRUCTION			
# S049	Plastic repair of duct	6	202.25	7
Z511	Dilation and/or probing of duct		43.15	6
# S057	Submandibular duct relocation	6	360.75	7

LIPS

			Asst	Surg	Anae
	INCISION				
# Z503	Biopsy			35.40	6
E542	- when performed outside of hospital	add		12.65	
	EXCISION				
	Wedge resection of lip				
# S011	- vermilion		6	98.45	6
# S010	- with plastic repair			275.00	6
Z504	Excision of lesion		6	61.15	6
E542	- when performed outside of hospital	add		12.65	
# S012	Lip shave vermilionectomy		6	225.00	6
	RECONSTRUCTION				
	Cleft lip				
# S013	- unilateral		6	363.30	8
# E501	- with nasal cartilage realignment	add		304.30	
# S014	Reconstruction with lip switch flap		6	444.40	8
# S015	Complex reconstruction or revision of previous repair and excision (see General Preamble GP12)			I.C	I.C

Note:
Cleft lip reconstruction (S013, S014, S015) is *not eligible for payment* with M030, M031 or M032.

ENDOSCOPIC ULTRASOUND

			Asst	Surg	Anae
	Radial or linear probe through endoscope				
# E800	- to endoscopy fee	add		101.50	
# E801	- including biliary and/or pancreatic examination, to endoscopy fee	add		152.30	

Note:
The amount payable for E800 when rendered in conjunction with E801 is zero.

			Asst	Surg	Anae
	Linear or radial echo-endoscope				
# S236	- excluding biliary or pancreatic examination (scope also used for therapeutic procedures)		nil	203.05	6
# S237	- including biliary and/or pancreatic examination (scope also used for therapeutic procedures)		nil	253.80	6
# E802	- biopsy or fine needle aspiration, to a maximum of 3, per lesion	add		50.75	
# E803	- dilation of stricture	add		30.65	
# E804	- injection of one or more of any of the following - metastases, nodes, masses, or celiac plexus	add		145.05	
# E805	- drainage of pseudocyst (including stent insertion if performed)	add		203.05	

Note:

1. The amount payable for S236 when rendered in conjunction with S237 is zero.

2. The amount payable for upper and/or lower GI endoscopy rendered in conjunction with S236 or S237 is zero unless the upper and/or lower GI endoscopy is required due to the limited visualization with the linear or radial echo-endoscope.

DIGESTIVE SYSTEM SURGICAL PROCEDURES

OESOPHAGUS

		Asst	Surg	Anae
	For procedures on the oesophagus, the following basic units for assistants and anaesthesiologists will apply except if a basic fee is listed.			
# S073	Cervical approach	6	-	7
# S074	Thoracic approach	10	-	13
# S075	Abdominal approach	7	-	8
	ENDOSCOPY			
# Z515	Oesophagoscopy, with or without biopsy(ies)		68.25	4
	Oesophagoscopy-gastroscopy, *with or without* duodenoscopy			
# Z399	- elective	nil	92.50	4
# Z400	- for active bleeding	nil	125.10	4
# E836	- endoscopic mucosal resection (EMR) of very large sessile polyp (> 3cm) or lesion (>3 cm) of the upper gastrointestinal tract, total excision, to Z399, Z515, or Z527 add		227.65	
# E696	- with dilatation of oesophagus add		30.65	
# E702	- with multiple (3 or more) biopsies of specific lesion add		15.10	
# E690	- with removal of foreign body(ies) add		43.85	
# E795	- with brushing of oesophagus, stomach, and/or duodenum add		46.30	
# E770	- with duodenoscopy and drainage of bile after I.V. CCK stimulation add		23.10	
# E692	- with laser debulking add		69.70	
# E698	- with pneumatic or balloon dilation add		69.70	
# E703	- with snare polypectomy first polyp (> 1 cm) add		50.50	
# E799	- each additional polyp, by snare polypectomy (> 1 cm) (to a maximum of 2) add		25.25	
# E695	- laser palliation of oesophageal tumour, extensive, complete obstruction (see General Preamble GP12) add		I.C	
# E797	- management of uncomplicated upper or lower gastrointestinal bleeding, by any technique (e.g. laser, injection, diathermy, banding etc.) add		46.30	
# E798	- management of complicated upper gastrointestinal bleeding by any technique in haemodynamically unstable patients with active bleeding during endoscopy add		69.70	
# E629	- endoscopic placement of stent in duodenum add		137.05	
# E813	- radiofrequency ablation of dysplastic Barrett's esophagus, to Z399, Z515, or Z527 add		215.00	

[Commentary:
E690 is payable for removal of a foreign body including a stent by oesophagoscopy-gastroscopy-duodenoscopy.]

DIGESTIVE SYSTEM SURGICAL PROCEDURES

OESOPHAGUS

		Asst	Surg	Anae

Note:

1. Z292 rendered in association with oesophagoscopy and oesophagoscopy-gastroscopy services is *not eligible for payment* unless the laryngoscopy service is rendered for suspicion of disease of the larynx. Claims for Z292 in these circumstances are assessed by a *medical consultant* on a manual review basis and require the submission of a written explanation.

2. E836 is *only eligible for payment* when resection requires submucosal injection and piecemeal resection

3. E836 includes any hemostatic techniques performed at the time of polypectomy

4. E836 is limited to a maximum of 2 services per patient per day

[Commentary:
Manual review is not required for Z293, Z322 and Z323 rendered in association with oesophagoscopy and oesophagoscopy-gastroscopy services.]

INCISION

Oesophagostomy

Cervical

# S084	- other than neonatal		212.35	
# S085	- neonatal		304.20	

Intrathoracic oesophageal stent

# S082	- via laparotomy		410.55	7
# S083	- via oesophagoscope (includes Z515)		304.20	6
# S081	Trans-oesophageal division of oesophageal varices		558.05	
# S080	Oesophageal-gastric devascularization (including splenectomy and oesophageal division/anastomosis)		898.15	

EXCISION

# S087	Intrathoracic diverticulum		507.00	
# S086	Cricopharyngeal myotomy, open approach		300.00	
# Z505	Cricopharyngeal myotomy, when rendered by endoscopy, or in association with a surgical procedure during the same anaesthetic	6	37.20	6
# S088	Cricopharyngeal diverticulum		390.05	
# S089	Partial oesophageal resection and reconstruction (including intestinal transposition)		1180.50	17
# S090	Total thoracic oesophageal resection	10	1912.30	13
# E730	- with reconstruction ....add		740.95	
# E847	- with reconstruction of diaphragm requiring repair with mesh or equivalent synthetic material, to S089 or S090 ....add		75.00	
# E644	- radical mediastinal node dissection following preoperative chemotherapy and/or radiotherapy, to S089 or S090 .add		400.00	

Note:

1. S086 is *not eligible for payment* with S088.

2. Z505 is *not eligible for payment* with S086.

# S093	Enucleation of benign oesophageal tumour		584.15	

OESOPHAGUS

		Asst	Surg	Anae
# E683	- when performed thorascopically, by video-assisted thoracic surgery (VATS), by robotic-assisted surgery, or by uniportal approach, to S087, S089, S090, S093 ..... add 35%.			

REPAIR

# S161	Oesophageal myotomy, partial (below aortic arch).....			584.15
# E758	- with oesophageal hiatus hernia repair .....add			217.35
# S100	Total thoracic oesophageal myotomy (as sole procedure)			841.35
# E758	- with oesophageal hiatus hernia repair .....add			217.35
# E683	- when performed thorascopically, by video-assisted thoracic surgery (VATS), by robotic-assisted surgery, or by uniportal approach, to S100, S161 ..... add 35%.			

REPAIR

Oesophageal hiatus hernia

# S091	- abdominal or transthoracic approach with fundal plication..		10	750.00
# S092	- recurrent		10	1100.00
# S079	- massive paraesophageal		10	1200.00

Payment rules:

S079 is *only eligible for payment* for surgical repair of

a. a paraesophageal hernia with >50% intrathoracic herniation of the stomach with the fundus lying above the gastroesophageal junction, or

b. a paraesophageal hernia with herniation of the stomach and any other abdominal organ(s) through the crus.

# E793	- laparoscopic, thoracoscopic, or laparoscopic/ thoracoscopic assisted, to S091, S092, or S079 ..... add 25%			
# E744	- with gastroplasty, to either S091, S092, or S079 .....add			115.80
# E847	- with reconstruction of diaphragm requiring repair with mesh or equivalent synthetic material, to S091, S092, or S079 .....add			75.00
# E742	- when S091, S092, or S079, with or without gastroplasty, is done in conjunction with cholecystectomy, and/or vagotomy with or without drainage procedures, add E742 to S091, S092, or S079 (with or without E744) for each additional procedure performed. For any other combination of surgical procedures with oesophageal hiatus hernia repair (with the exception of S161 and S100), see Surgical Preamble SP2 .....add			217.35
# S095	Oesophageal stricture (Thal) - may include oesophageal hiatus hernia repair with or without gastroplasty.....			676.05
# S096	Ruptured oesophagus, suture and drainage		10	1200.00
# S097	Oesophago-gastrostomy for bypass (as sole procedure).....			692.65

OESOPHAGUS

		Asst	Surg	Anae
# E683	- when performed thorascopically, by video-assisted thoracic surgery (VATS), by robotic-assisted surgery, or by uniportal approach, to S095, S096, S097 ..... add 35%			
	Oesophageal bypass, abdomen to neck			
# S098	- with stomach	10	912.60	
# S099	- with colon or jejunum.....	10	1264.05	
# E683	- when performed thorascopically, by video-assisted thoracic surgery (VATS), by robotic-assisted surgery, or by uniportal approach, to S098 or S099 ..... add 35%			
	SUTURE			
# S103	Closure of H-type tracheo-oesophageal fistula by cervical or thoracic approach.....		923.05	
# S104	Repair of oesophageal atresia with or without tracheal fistula.		2508.75	
	DILATION OF OESOPHAGUS			
	Passive (bougie)			
# Z529	- initial session		40.55	
# Z530	- repeat session (within three months following previous dilation).....		27.35	
	Pneumatic			
# Z525	- as sole procedure.....		110.85	
# Z523	- with rigid dilators guided over a string or wire		52.90	
# Z531	Repeat dilations during the same admission		26.40	

DIGESTIVE SYSTEM SURGICAL PROCEDURES

STOMACH

		Asst	Surg	Anae
	ENDOSCOPY			
	Gastroscopy			
# Z527	- may include biopsies, photography and removal of polyps less than or equal to 1 cm		82.90	4
# Z547	- with removal of foreign body		99.75	4
# Z528	- subsequent (within three months following previous gastroscopy)		67.85	4

Note:
Z292 rendered in association with gastroscopy services is *not eligible for payment* unless the laryngoscopy service is rendered for suspicion of disease of the larynx. Claims for Z292 in these circumstances are assessed by a *medical consultant* on a manual review basis and require the submission of a written explanation.

[Commentary:
Manual review is not required for Z293, Z322 and Z323 rendered in association with gastroscopy services.]

# E674	- with snare polypectomy - 1st polyp > 1 cm (maximum 1) add		142.40	
# E675	- with snare polypectomy each - additional polyp > 1 cm (maximum 2) add		73.50	

Note:
E674, E675 are payable with Z527, Z547 or Z528.

	INCISION			
	Gastrotomy			
# S116	- with removal of tumour or foreign body	6	406.85	7
# E731	- with suture of bleeding peptic ulcer add		247.05	
# S117	Pyloromyotomy (Ramstedt's)	6	611.35	10

Payment rules:
1. S117 is *only eligible for payment* for *newborns* and *infants*.

	Gastrostomy			
# S118	Gastrostomy	6	467.85	7
# E697	- with repair of Mallory-Weiss laceration add		142.40	
# E707	- when done with another intra-abdominal procedure		70.80	
# Z532	Percutaneous endoscopic gastrostomy	6	172.95	7
Z520	Change of gastrostomy tube		10.65	
	EXCISION			
	Biopsy - incisional			
# Z526	- by gastrostomy		73.60	
# Z533	- by intubation		36.80	

DIGESTIVE SYSTEM SURGICAL PROCEDURES

STOMACH

		Asst	Surg	Anae
	GASTRECTOMY			
# S122	Wedge resection for ulcer	7	520.00	7
# E708	- with vagotomy	add	122.05	
# E713	- after previous partial gastrectomy	add	137.55	
# E793	- laparoscopic or laparoscopic assisted, to S122	add 25%		
	Partial or subtotal			
# S123	- distal	7	840.00	8
# S125	- proximal	7	900.00	8
# E731	- with suture of bleeding peptic ulcer	add	247.05	
# E708	- with vagotomy	add	122.05	
# E709	- with cholecystectomy	add	139.00	
# E711	- after previous gastro-enterostomy	add	121.35	
# E706	- with choledochotomy	add	139.00	
# E712	- after previous vagotomy and pyloroplasty	add	126.50	
# E713	- after previous partial gastrectomy	add	137.55	
# E644	- radical mediastinal node dissection following preoperative chemotherapy and/or radiotherapy, to S125	add	400.00	
# E847	- with reconstruction of diaphragm requiring repair with mesh or equivalent synthetic material, to S125	add	75.00	
# E793	- laparoscopic or laparoscopic assisted, to S123 or S125	add 25%		
	Total gastrectomy			
# S128	- with or without splenectomy	7	1235.00	9
# E709	- with cholecystectomy	add	139.00	
# E706	- with choledochotomy	add	139.00	
# E713	- after previous partial gastrectomy	add	137.55	
# E847	- with reconstruction of diaphragm requiring repair with mesh or equivalent synthetic material, to S128	add	75.00	
# E793	- laparoscopic or laparoscopic assisted, to S128	add 25%		
# E644	- radical mediastinal node dissection following preoperative chemotherapy and/or radiotherapy, to S128	add	400.00	
# S129	Conversion of previous gastrectomy to Roux-en-y	7	910.00	9

DIGESTIVE SYSTEM SURGICAL PROCEDURES

STOMACH

		Asst	Surg	Anae
	Vagotomy			
# S131	- truncal or selective	7	375.80	7
# S124	- highly selective (as sole procedure without pyloroplasty or gastroenterostomy)	7	572.85	7
# S121	Transabdominal vagotomy after previous vagotomy	7	416.50	8

Note:
For suture of duodenal ulcer, refer to S139 on next page.

# S120	Gastric bypass with Roux-en-Y anastomosis, for morbid obesity	7	1350.00	10
# S115	Reversal of previous vertical banded gastroplasty	7	820.00	10
# S114	Sleeve gastrectomy	7	820.00	10

Note:

1. S114 Sleeve gastrectomy is *only eligible for payment* when:

a. a Roux-en-Y gastric bypass is not possible due to small bowel disease/adhesions or previous surgery; or

b. performed as a planned staged surgery in patients with a BMI > 60 to enable the patient to lose weight.

2. S120 is an insured service only when all of the conditions set out in the Surgical Preamble are satisfied.

3. S189 is *not eligible for payment* in conjunction with S120.

4. S160 is *not eligible for payment* in conjunction with S120.

5. Mini-gastric bypass (loop gastric bypass) does not constitute gastric bypass or partition for the purpose of S120.

[Commentary:
The second stage would be a gastric bypass with Roux-en-Y.]

# S113	Removal of gastric band	7	341.60	10

Note:
S113 is *only eligible for payment* when the gastric band requires removal due to:

1. Complications related to the gastric band; or

2. Conversion to gastric bypass.

# E793	- laparoscopic or laparoscopic assisted, to S113, S114, S115 or S120	add 25%

[Commentary:

1. S120 does not include the service described as adjustable gastric banding by laparoscopic or open surgical method. See section 37.1 of Regulation 552 under the *Health Insurance Act*.

2. Morbid obesity refers to patients with a *Body Mass Index (BMI)* > 40.]

DIGESTIVE SYSTEM SURGICAL PROCEDURES

STOMACH

		Asst	Surg	Anae
	REPAIR			
# S132	Pyloroplasty	7	406.85	7
# S133	Pyloroplasty and vagotomy	7	528.85	7
# E731	- with suture of bleeding peptic ulcer ... add		247.05	
# S137	Pyloroplasty or gastroenterostomy plus vagotomy and cholecystectomy	7	678.90	8
# E731	- with suture of bleeding peptic ulcer ... add		247.05	
# E721	- with choledochotomy ... add		139.00	
# S134	Gastroduodenostomy or gastrojejunostomy	7	406.85	7
# E716	- either of above plus vagotomy ... add		167.75	
# E711	- after previous gastroenterostomy ... add		121.35	
# E721	- with choledochotomy ... add		139.00	
# E793	- laparoscopic or laparoscopic assisted, to S134 add 25%			
	SUTURE			
# S138	Closure of gastrostomy or other external fistula of stomach	6	345.85	7
# S139	Gastrorrhaphy (for perforated gastric or duodenal ulcer or wound)	6	769.60	7
# S140	Closure of gastrocolic fistula	7	654.05	7

Note:
For suture of duodenal ulcer, refer to S139 above.

DIGESTIVE SYSTEM SURGICAL PROCEDURES

INTESTINES (EXCEPT RECTUM)

			Asst	Surg	Anae
	ENDOSCOPY				
# Z560	Duodenoscopy (not to be claimed if Z399 and/or Z400 performed on same patient within 3 months)			92.10	4
# Z749	Subsequent procedure (within three months following previous endoscopic procedure)			72.55	4
# E629	- endoscopic placement of stent in duodenum	add		137.05	
# Z584	Small bowel push enteroscopy			185.15	
# E797	- management of uncomplicated upper or lower gastrointestinal bleeding, by any technique (e.g. laser, injection, diathermy, banding etc.) to Z584	add		46.30	
# E798	- management of complicated upper gastrointestinal bleeding by any technique in haemodynamically unstable patients with active bleeding during endoscopy, to Z584	add		69.70	
# Z588	Double Balloon enteroscopy			50.00	
# E250	- surgical time, to Z588	per 15 minutes or major part thereof		100.00	

Note:

1. Z292 rendered in association with duodenoscopy and small bowel push enteroscopy services is *not eligible for payment* unless the laryngoscopy service is rendered for suspicion of disease of the larynx. Claims for Z292 in these circumstances are assessed by a *medical consultant* on a manual review basis and require the submission of a written explanation.

2. Z588 is an all-inclusive fee code. With the exception of E250, no other surgical or procedural services are eligible for payment when Z588 is eligible for payment.

3. Time units are calculated based on the time spent by the physician in direct contact with the patient for the purpose of the procedure. Time commences when the physician is first in attendance with the patient in the operating/procedure room and ends when the physician is no longer in attendance with that patient in the operating/procedure room.

[Commentary:
Manual review is not required for Z293, Z322 and Z323 rendered in association with duodenoscopy and small bowel push enteroscopy services.]

# Z512	Endoscopy of ileostomy or colostomy, or reduction of obstructed Koch ileostomy			36.80	4
# E747	- to cecum	add		31.15	
# Z514	- with biopsy			44.55	4
	SIGMOIDOSCOPY				
# Z580	Sigmoidoscopy (using 60 cm. flexible endoscope)		nil	57.70	5

Note:

1. Z580 is *not eligible for payment* with Z491, Z492, Z493, Z494, Z495, Z496, Z497, Z498, Z499 or Z555 same patient same day.

2. For sigmoidoscopy with rigid scope, see Z535 (Rectum).

3. Time units and anaesthesia extra units listed on GP97 are *not eligible for payment* with anaesthesia services for Z580C.

4. E003C is not payable for anaesthesia services rendered for Z580.

INTESTINES (EXCEPT RECTUM)

		Asst	Surg	Anae

COLONOSCOPY

Colonoscopy for Risk Evaluation

# Z497	Confirmatory colonoscopy - sigmoid to descending colon.....	nil	51.95	5

Payment rules:
Z497 is eligible for payment for a colonoscopy rendered for a patient with a positive:

1. faecal occult blood test(s) or faecal immunochemical test(s) (FIT);
2. sigmoidoscopy;
3. barium enema; or
4. CT abdomen/pelvis or CT colonography examination(s).

# Z499	Absence of signs or symptoms, family history associated with an increased risk of malignancy, in accordance with current Ontario generally accepted clinical practice guidelines– sigmoid to descending colon	nil	51.95	5

Payment rules:
Z499 is only insured when rendered for a patient aged in accordance with current Ontario generally accepted clinical practice guidelines

# Z492	Follow up of normal colonoscopy (Z499), absence of intervening signs or symptoms - sigmoid to descending....	nil	51.95	5
# Z493	Follow up of normal colonoscopy (Z497, Z555), absence of intervening signs or symptoms - sigmoid to descending....	nil	51.95	5

Payment rules:

Z492 and Z493 are insured services when rendered at the frequency of follow up in accordance with current Ontario generally accepted clinical practice guidelines.

[Commentary:

1. Z492 and Z493 are eligible for payment for a colonoscopy rendered to a patient following a prior normal colonoscopy who has remained asymptomatic.
2. A colonoscopy is considered normal if there were either no polyps or only small (<1 cm) hyperplastic polyps present.
3. An exception to #1 above is a patient with serrated polyposis syndrome who are at risk for colorectal cancer and need to be identified for more intensive follow-up evaluation. See Z494.
4. A patient with sessile serrated lesions that may have only been partially removed or adenomatous polyps that are removed piecemeal should be considered for follow-up evaluation at short intervals (2–6 *month*s) to verify complete removal. See Z491.]
5. Current Ontario colorectal cancer screening guidelines may be found at the following link: https://www.cancercareontario.ca/en/guidelines-advice/cancer-continuum/screening/resources-healthcare-providers/colorectal-cancer-screening-summary]

INTESTINES (EXCEPT RECTUM)

		Asst	Surg	Anae
	Colonoscopy - For diagnosis or ongoing management			
# Z496	Presence of signs or symptoms - sigmoid to descending colon	nil	51.95	5
# Z494	Hereditary (e.g. Familial adenomatous Polyposis or Hereditary Non-Polyposis Colorectal Cancer) or other bowel disorders (e.g. inflammatory bowel disease) associated with increased risk of malignancy	nil	51.95	5

Payment rules:
Z494 is eligible for payment when rendered at the age and frequency of follow up in accordance with generally accepted clinical practice guidelines.

# Z498	Follow up of abnormal colonoscopy - sigmoid to descending colon	nil	51.95	5

Payment rules:

1. Z498 is eligible for payment for a colonoscopy rendered for the follow-up of a patient with a previous malignancy(ies) in accordance with current Ontario generally accepted post-polypectomy surveillance clinical practice guidelines.

2. Z498 is eligible for payment when rendered for follow up of polyps in accordance with current Ontario generally accepted post-polypectomy surveillance clinical practice guidelines.

[Commentary:
Current Ontario colorectal cancer screening and post-polypectomy surveillance guidelines may be found at the following links: https://www.cancercareontario.ca/en/guidelines-advice/cancer-continuum/screening/resources-healthcare-providers/colorectal-cancer-screening-summary and https://www.cancercareontario.ca/en/guidelines-advice/cancer-continuum/screening/resources-healthcare-providers/post-polypectomy-surveillance-recommendations-summary]

# Z495	Follow up of unsatisfactory colonoscopy	nil	51.95	5

Payment rules:
Z495 is *only eligible for payment* for a technically unsatisfactory colonoscopy due to poor preparation, failure to intubate the cecum or inability to complete the examination

# Z491	Follow up of incomplete polyp resection	nil	51.95	5

Payment rules:

1. Z491 is *only eligible for payment* for:

a. Sessile polyps that were only partially removed; or

b. Adenomatous polyps that were removed piecemeal or contained high grade dysplasia.

2. Z491 is *not eligible for payment* if performed more than six *month*s following the initial colonoscopy.

# Z555	Absence of signs or symptoms or risk factors, 50 years of age or older - sigmoid to descending colon	nil	51.95	5

Payment rules:
Z555 is an *uninsured service* for the same patient in the 10 year period following the previous Z555.

Note:

1. Only one of Z491, Z492, Z493, Z494, Z495, Z496, Z497, Z498, Z499 or Z555 is eligible for payment per patient per day.

INTESTINES (EXCEPT RECTUM)

		Asst	Surg	Anae

2. Time units and anaesthesia extra units listed on GP97 are *not eligible for payment* with anaesthesia services for Z491C, Z492C, Z493C, Z494C, Z495C, Z496C, Z497C, Z498C, Z499C or Z555C.

3. E003C is not payable for anaesthesia services rendered for Z491, Z492, Z493, Z494, Z495, Z496, Z497, Z498, Z499 or Z555.

4. Colonoscopy to investigate chronic constipation is only insured when:

a. patients are aged 50 years or older;

b. patients have family history associated with an increased risk of malignancy, in accordance with current Ontario generally accepted clinical practice guidelines; or

c. it is necessary to exclude organic disease for patients with alarm features, such as bleeding, abdominal pain and new onset symptoms.

[Commentary:
The Choosing Wisely Canada Recommendation to avoid performing colonoscopy for constipation in those under the age of 50 years without family history of colon cancer or alarm features may be found at the following link: https://choosingwiselycanada.org/gastroenterology/ .]

# E740	- to splenic flexure, to Z491, Z492, Z493, Z494, Z495, Z496, Z497, Z498, Z499 or Z555	add	nil	51.75
# E741	- to hepatic flexure, to Z491, Z492, Z493, Z494, Z495, Z496, Z497, Z498, Z499 or Z555	add	nil	31.15
# E747	- to cecum, to Z491, Z492, Z493, Z494, Z495, Z496, Z497, Z498, Z499 or Z555	add	nil	31.15
# E705	- into terminal ileum, to Z491, Z492, Z493, Z494, Z495, Z496, Z497, Z498, Z499 or Z555	add		30.30
# E630	- endoscopic placement of stent in colon, to Z491, Z492, Z493, Z494, Z495, Z496, Z497, Z498, Z499 or Z555	add		137.05
# E717	- if biopsy and/or coagulation of angiodysplastic lesion(s) (one or more), to Z491, Z492, Z493, Z494, Z495, Z496, Z497, Z498, Z499, Z555 or Z580	add		27.05
# E785	- multiple biopsies for surveillance of inflammatory bowel disease-associated colorectal cancer or dysplasia, to Z491, Z492, Z493, Z494, Z495, Z496, Z497, Z498, Z499 or Z555	add		54.25
# E797	- management of uncomplicated upper or lower gastrointestinal bleeding, by any technique (e.g. laser, injection, diathermy, banding etc.) to Z496 or Z497	add		46.30
E749	- when Z491, Z492, Z493, Z494, Z495, Z496, Z497, Z498, Z499, Z512, Z555 or Z580 rendered in private office	add		22.35

Note:

1. E717 rendered in conjunction with E785 is *not eligible for payment*.

2. For sigmoidoscopy with rigid scope, see Z535 (Rectum).

3. E785 is *only eligible for payment* when:

a. billed with diagnostic code 555 for Crohn's disease, 556 for ulcerative colitis, or 576 for primary sclerosing cholangitis; and

		Asst	Surg	Anae

b. multiple random screening biopsies (>34 sites) for malignant changes in inflammatory bowel disease, or targeted biopsies have been collected using 1) Dye-chromoendoscopy (DCE), 2) virtual chromoendoscopy (VCE) with narrow band imaging (NBI), or 3) high-definition white-light-endoscopy (HD-WLE) with HD-iScan, or equivalent.

[Commentary:

1. E749 is *not eligible for payment* in a hospital

2. For assessments claimed same day as colonoscopy by Internal Medicine (13) or Gastroenterology (41) see A120.

3. E785 is *not eligible for payment* in the context of standard definition white light endoscopy (SD-WLE).

# Z513	Hydrostatic - Pneumatic dilatation of colon stricture(s) through colonoscope		107.50	
# Z571	Excision of first polyp (3 mm to 5mm)	nil	150.15	4
# E720	- each additional polyp (3 mm to 5 mm)	add	77.50	
# Z518	Excision of first polyp (6 mm to 9 mm)	nil	150.15	4
# E520	- each additional polyp (6 mm to 9 mm)	add	77.50	
# Z517	Excision of first polyp (10 mm to 19 mm)	nil	150.15	4
# E519	- each additional polyp (10 mm to 19 mm	add	77.50	
# Z516	Excision of first polyp (20 mm to 29 mm)	nil	150.15	4
# E518	- each additional polyp (20 mm to 29 mm)	add	77.50	

Payment rules:

1. Only one of Z571, Z518, Z517 or Z516 is eligible for payment per patient per day.

2. A maximum of 2 services of any combination of E720, E520, E519, or E518 are eligible for payment per patient per day.

3. Excision of polyps <3mm is *not eligible for payment*.

Claims submission instructions:

The largest polyp excised should be used to determine the appropriate fee code to claim for the first polyp (Z571, Z518, Z517 or Z516).

Note:

Z497, Z499, Z492, Z493, Z496, Z494, Z498, Z495, Z491, and Z555 include fulguration, if performed.

# E685	Total excision of very large sessile polyp (> 3 cm) through colonoscope, and may include fulguration, each		227.65
	Excision of obstructive tumour or stricture through colonoscope		
# Z764	- less than 2 cm.		69.80
# Z765	- 2 cm or greater		131.75
# E687	- with laser debulking	add	69.80

INCISION

Enterotomy

# S149	Ileostomy	6	535.90	7

INTESTINES (EXCEPT RECTUM)

		Asst	Surg	Anae
# S150	Small intestine - including excision of polyps or biopsy	6	463.25	7
# S151	Insertion of feeding enterostomy	6	356.50	7
# E737	- when done with another intra-abdominal procedure.. add		82.35	
# S154	Large intestine - including excision of polyps	6	463.25	7
# S155	Colonoscopy with laparotomy	6	387.40	7
# S156	Exteriorization of intestine (Mickulicz)	6	406.85	6
# S157	Colostomy	6	535.90	7
# S158	Cecostomy	6	387.40	7
# S160	Entero-enterostomy	6	470.65	7
# E793	- laparoscopic or laparoscopic assisted, to S149 or S157…… .add 25%			

EXCISION

# E714	- repair of entero-cutaneous fistula in conjunction with bowel resection add		82.35	
# S162	Local excision of lesion of intestine	6	528.85	7
# Z750	Resection of exteriorized intestine	6	82.35	7

Resection with anastomosis

Small intestine

# S164	- duodenum	6	1155.95	7
# S165	- other	6	844.25	7
# S166	Small and large intestine terminal ileum, cecum and ascending colon (right hemicolectomy)	7	1029.45	7
# S167	Large intestine - any portion	7	1004.40	7
# E796	- with mobilization of splenic flexure, to S167 add		117.15	
# S169	Total colectomy with ileo-rectal anastomosis	9	1502.80	9
# S172	Total colectomy with mucosal proctectomy with ileal pouch, ileoanal anastomosis and loop ileostomy	9	2247.70	10
# S171	Left hemicolectomy with anterior resection or proctosigmoidectomy (anastomosis below peritoneal reflection & mobilization of splenic flexure)	7	1290.55	8
# E808	- neo-rectal pouch formation, to S169 or S171 add		170.80	
# E793	- laparoscopic or laparoscopic assisted, to S165, S166, S167, S169, S171 or S172 add 25%			

Ileostomy

# S168	- subtotal colectomy	7	1435.20	7
# S170	- plus total colectomy plus abdomino-perineal resection	9	2486.50	10
# E793	- laparoscopic or laparoscopic assisted, to S168 or S170 add 25%			

Two-surgeon team

INTESTINES (EXCEPT RECTUM)

		Asst	Surg	Anae
# S173	- abdominal	9	1812.00	10
# S174	- perineal		533.80	
# E738	- with continent ileostomy, to either S168, S169, S170, S173 or S174 ... add		441.10	
E718	- bowel resection following previous resection with anastomosis, or following S217, S213, S214 or S215 ... add		162.15	

Note:
E718 is not to be added to S181, S182, S185, S191, S192 or S193.

# S188	Bowel resection without anastomosis (colostomy and mucous fistula)	6	877.40	6
# S189	Intestinal bypass for morbid obesity	7	951.20	10
# E793	- laparoscopic or laparoscopic assisted, to S189 add 25%			

Note:
1. S189 is an insured service only when all of the conditions set out in the Surgical Preamble are satisfied.

2. Mini-gastric bypass (loop gastric bypass) does not constitute intestinal bypass for the purpose of S189.

Intestinal obstruction (mechanical)

One stage

# S175	- without resection	6	814.95	7
# S176	- with entero-enterostomy	6	1023.75	7
# S177	- with resection	6	1207.25	7
# S180	- with enterotomy	6	943.60	7

Note:
If staged procedure, refer to Surgical Preamble SP2.

# S178	Intestinal atresia (newborn)	6	1722.55	7
# S179	Meconium ileus	6	1722.55	7

REPAIR

Revision of ileostomy or colostomy

# S181	- skin level	6	131.75	7
# S182	- full thickness	6	467.90	7
# S192	Simple revision of continent ileostomy pouch	6	387.40	7
# S191	Complete reconstruction of continent ileostomy to include valve repair	6	1083.10	7
# S193	Revision of standard ileostomy into continent ileostomy pouch	6	903.55	7
# S183	Cecopexy or sigmoidopexy (as sole procedure)	6	314.80	6

SUTURE

# S184	Suture of intestine	6	314.80	7
# E721	- with choledochotomy ... add		139.00	

INTESTINES (EXCEPT RECTUM)

		Asst	Surg	Anae
# S185	Closure of colostomy or enterostomy - with or without resection and/or anastomosis	6	574.70	7
# S187	Plication of small intestine for adhesions	6	602.20	7

Note:
For division or removal of adhesions only, use S312.

MANIPULATION

# Z538	Reduction of prolapse		25.25	6
# Z539	Dilation of gastrostomy, enterostomy, colostomy, etc.		25.25	6

Intubation of small intestine (therapeutic or diagnostic)

# Z540	- with or without fluoroscopy		79.80	
# E732	- with biopsy	add	29.10	

DIGESTIVE SYSTEM SURGICAL PROCEDURES

MISCELLANEOUS

		Asst	Surg	Anae
	MECKEL'S DIVERTICULUM			
# S194	Meckel's diverticulum excision	6	356.50	7
# S159	- with small bowel resection	6	406.85	7
	MESENTERY			
# S195	Local excision of lesion	6	305.05	7
# S199	Resection of mesentery	6	325.40	6
	APPENDIX			
# S204	Incision and drainage of abscess	6	273.60	7
# S207	Appendectomy with or without perforation	6	524.60	7

Payment rules:

1. S204, S313, S314, Z594 and E686 are *not eligible for payment* with S207.

[Commentary:
S207 is to be claimed for an appendectomy regardless of whether the appendix is intact or ruptured.]

	SMALL INTESTINE			
# S152	Bowel lengthening procedure in a paediatric patient	9	1700.00	10

[Commentary:
Examples of a bowel lengthening procedure include serial transverse enteroplasty (STEP) or longitudinal intestinal lengthening and tailoring (LILT).]

Payment rules:

1. S152 is *not eligible for payment* with any other services described in the Digestive System Surgical Procedures/Intestines (Except Rectum) section of the *Schedule*, for the same patient, same day.

2. S152 is limited to one per patient per day.

	TRANSPLANT			
	Small bowel transplant			
# S201	- donor	6	964.50	8
# S202	- recipient	20	3129.95	30
	Multivisceral transplant			
# S196	- donor	6	3129.95	8
# S197	- recipient, without evisceration	25	9034.70	35
# E807	- recipient, with evisceration, to S197	add	3011.50	

Payment rules:

1. S197 must include transplant of the small bowel and liver, *with or without* transplant of the duodenum, stomach, pancreas and large bowel.

2. S196 must include removal of the small bowel and liver, *with or without* removal of the duodenum, stomach, pancreas and large bowel.

MISCELLANEOUS

Asst | Surg | Anae

3. Surgical fees for transplant procedures represent payment in full for the surgical services required to perform the described procedure. In the event the transplant procedure described by S201/S202/S196/S197 is performed by more than one surgeon, only one surgical service is eligible for payment; the components of the surgical service are not divisible among the physicians for claims purposes.

[Commentary:
Where the surgical service is performed by more than one surgeon, the physicians are responsible for apportioning payment amongst themselves.]

RECTUM

		Asst	Surg	Anae
	ENDOSCOPY			
	Sigmoidoscopy with or without anoscopy			
Z535	- with rigid scope		36.80	4
Z536	- with biopsy(ies)		44.55	4
Z592	- with decompression of volvulus		49.40	4
E746	- when Z535, Z536 or Z592 performed outside hospitaladd		5.85	
# E641	- endoscopic placement of stent in rectum ... add		137.05	
# E797	- management of uncomplicated upper or lower gastrointestinal bleeding, by any technique (e.g. laser, injection, diathermy, banding etc.) ... add		46.30	
	Note: Z535 not to be billed with Z555 or Z580.			
	EXCISION			
	Proctectomy and Anterior Resection			
# S213	Anterior resection or proctosigmoidectomy (anastomosis below peritoneal reflection)	8	1377.95	8
# E808	- neo-rectal pouch formation, to S213 ... add		170.80	
# E810	- with coloanal anastomosis, to S213 ... add 25%			
# S214	Abdomino-perineal resection or pull through	8	1743.15	10
# E793	- laparoscopic or laparoscopic assisted, to S213 or S214 ... add 25%			
	Two surgeon team (for abdomino-perineal resection or pull through)			
# S215	- abdominal surgeon	8	1426.45	10
# S216	- perineal surgeon		591.25	
	Hartmann Procedure and Reconstruction			
# S217	Hartmann procedure	8	1211.10	9
# S218	Colon reconstruction following Hartmann procedure	8	1237.45	8
# E796	- with mobilization of splenic flexure, to S218 ... add		117.15	
	Transanal Total Mesorectal Excision (TaTME)			
# S210	TaTME with proctosigmoidectomy and anastomosis below peritoneal reflection.- one surgeon technique	8	2448.75	10
	Two-surgeon team (for TaTME)			
# S211	TaTME with proctosigmoidectomy and anastomosis below peritoneal reflection - abdominal surgeon	8	950.00	10
# S212	TaTME with proctosigmoidectomy and anastomosis below peritoneal reflection - perineal surgeon	nil	1498.75	nil
	Biopsies and Minor Excisions			
# E793	- laparoscopic or laparoscopic assisted, to S215, S217 or S218 ... add 25%			
# Z752	Biopsy of rectosigmoid or above for Hirschsprung's disease	6	82.35	6

RECTUM

		Asst	Surg	Anae
# E710	- each additional biopsy ..... add		45.55	
# S222	Presacral or trans-sacral proctotomy and excision of lesion ..	6	540.15	7
	Polyps or tumours of rectum or sigmoid *			
# Z753	- electrocoagulation - base under 2 cm		24.25	7
# Z754	- excision - base under 2 cm	6	82.35	6
# Z784	- excision and suture - base 2 to 5 cm, inclusive.....	6	213.50	6
# Z785	- excision and suture - base over 5 cm.....	6	582.95	7
# Z755	- electrocoagulation - base 2 to 5 cm, inclusive.....	6	142.40	6
# Z761	- electrocoagulation - base over 5 cm	6	219.90	7
# E688	- with laser debulking ..... add		69.80	

Note:

1. To a maximum of 2, any size or technique.

2. For fulguration or excision of tumours through the colonoscope, refer to page S19.

DIGESTIVE SYSTEM SURGICAL PROCEDURES

RECTUM

		Asst	Surg	Anae
	REPAIR			
# S223	Anastomosis of rectum	6	555.90	6
	Rectal prolapse			
# S225	- excision of mucous membrane	6	272.35	7
# S226	- perineal repair - major	6	536.20	6
# S227	- abdominal approach	6	1035.85	8
# S228	- insertion of Thiersh wire	6	217.30	6
	SUTURE			
# S229	Suture of rectum, trauma-external approach	6	404.75	7
	Closure of fistula			
# S231	- rectovaginal (any repair)	6	338.55	7
# S525	- rectovesical	6	479.10	7
	MANIPULATION			
# Z541	Dilation and/or disimpaction or removal of foreign body under general anaesthetic (as sole procedure)		66.50	6
# Z756	Fecal disimpaction - no anaesthetic		46.00	

Note:

1. The fees for excision, ligation, injection of haemorrhoids and treatment of intra or perianal condylomata acuminata include anoscopy.

2. Z756 is *only eligible for payment* when personally rendered by the physician for documented severe fecal impaction refractory to conservative management as confirmed by clinical examination (e.g., abdominal x-ray or rectal exam) and symptoms.

	ENDOSCOPY			
Z543	Anoscopy (proctoscopy)		8.70	
	INCISION			
# Z544	Biopsy		34.90	6
Z545	Thrombosed haemorrhoid(s)		25.25	6
E542	- when performed outside hospital ..... add		12.65	
# S241	Sphincterotomy(ies) under local anaesthesia	6	100.45	
# S243	Sphincterotomy(ies) under general anaesthesia	6	227.75	6

RECTUM

		Asst	Surg	Anae
	EXCISION			
# S247	Haemorrhoidectomy, with or without sigmoidoscopy or repair of fissure(s) and/or sphincterotomy and/or anal dilation	6	260.15	6
# Z565	Complete haemorrhoidectomy using cryotherapy and/or Barron ligation(s) including rectal dilation		99.60	6
# Z546	Barron ligation(s) (not to exceed 6 in any one year)	nil	39.40	
# Z566	Barron ligation(s) plus cryotherapy (not to exceed 6 in any one year)	nil	39.10	
# S249	Local excision for malignancy	6	331.40	7
Z757	Excision of benign anal lesion(s)	6	47.15	6
E542	- when performed outside hospital ..... add		12.65	
# S251	Fistula-in-ano - exploration of fistula tract and insertion of Seton drain and/or fistulotomy	6	234.45	6
# S250	Ligation of intersphincteric fistula tract (LIFT) and/or endorectal advancement flap (ERAF) for definitive repair	6	339.50	6
E811	- for recurrent fistulae, to S250 or S251 ..... add 25%			

Payment rules:
S247 and Z565 are only insured when the patient has:

a. failed a trial of non-surgical therapy;
b. Grade III or IV haemorrhoids; or
c. haemorrhoids with substantial concomitant skin tags.

	INJECTION			
Z575	Haemorrhoid injections (to a maximum of 6 per year)		27.05	
Z576	Injections for anal fissure		35.90	6
	REPAIR			
# S253	Low imperforate anus repair	7	1224.00	7
# S260	High imperforate anus repair (supra-levator)	7	2050.75	7
# S256	Excision of scar, for stenosis	6	162.15	6
# S257	Anoplasty, for stenosis	6	313.20	6
# S258	Repair of anal sphincter	6	275.05	7
# S259	Repair of anal sphincter and ano-rectal ring	6	405.95	6
	DESTRUCTION			
Z548	Cauterization of fissure		34.90	6
	Fulguration of condylomata			
Z549	- local anaesthetic		30.95	
# Z758	- general anaesthetic	6	97.65	6
	MANIPULATION			
Z550	Dilation of anal sphincter		13.70	6
# S248	Peter Lord procedure		49.65	6

DIGESTIVE SYSTEM SURGICAL PROCEDURES

LIVER

		Asst	Surg	Anae
	INCISION			
	Biopsy			
# Z554	- incisional		102.10	
# Z551	- needle		95.80	7
# S268	Insertion of implantable pump for continuous liver perfusion	7	604.95	7
	EXCISION			
	Hepatectomy			
# S269	- local excision of lesion (less than 5 cm)	7	350.65	7
# S275	- partial lobectomy (excision greater than 5 cm)	8	585.05	8
# S270	- Hepatectomy, one or two liver segments	12	1426.05	12
# S267	- Hepatectomy, three or four liver segments	12	1885.55	12
# S271	- Hepatectomy, five or more liver segments	12	2135.35	12
# E812	- for repeat resection procedures, to S267, S270, S271	add 25%		
# E814	- with portal lymphadenectomy, to S267, S269, S270, S271, S275, S291	add	287.65	

Note:
E814 is *only eligible for payment* when a formal portal lymphadenectomy has been performed and the operative record describes removal of all lymphatic tissue surrounding the common bile duct/ hepatic artery and portal vein.

# S272	Laparotomy, cholangiogram and biopsy (neonatal jaundice)	6	387.40	7
# E793	- laparoscopic or laparoscopic assisted, to S267, S269, S270, S271, S272 or S275	add 25%		
	Liver transplant			
# E765	- with reconstruction or repair of the hepatic artery (i.e. re-anastomosis or conduit), to liver transplant fee	add	342.10	
# S274	Deceased donor, liver removal	6	1098.25	8
# S294	Deceased donor, liver transplant	20	3129.95	30
# S295	Repeat liver transplant	30	4299.90	40
# S265	Living donor, hepatectomy	20	4760.60	35
# S266	Living donor, orthotopic liver transplant	25	6023.10	35

Note:
Cholecystectomy is *not eligible for payment* in conjunction with liver lobectomy involving liver segments #4 and/or #5, or formal anatomic resection involving liver segments #4 and/or #5.

	REPAIR			
# S273	Marsupialization and/or decompression of cyst(s) or abscess(es)	7	434.80	7
# E715	- more than three cysts or abscess(es)	add	74.90	

DIGESTIVE SYSTEM SURGICAL PROCEDURES

BILIARY TRACT

		Asst	Surg	Anae

Note:
Unless otherwise specified, there is no additional fee payable for cholangiogram during abdominal surgery.

ENDOSCOPY

Endoscopic retrograde cholangiopancreatography (ERCP)

# Z561	- with cannulation of common bile duct and/or pancreatic duct		213.15	6
# Z558	- including sphincterotomy and may include removal of one or more bile duct stones		300.25	6
# Z760	- through gastrojejunostomy following previous Billroth II		251.85	6
# E702	- with multiple (3 or more) biopsies of a specific lesion	add	15.10	
# E666	- with biliary tract manometry	add	52.30	
# E662	- with intraductal cytology brushing or intraductal biopsy	add	49.75	
# E668	- with cannulation of minor papilla	add	93.80	
# E680	- with insertion of first endobiliary prosthesis and/or pancreatic stent (maximum 1)	add	82.35	
# E681	- with insertion of each additional endobiliary prosthesis and/or pancreatic stent (maximum 3)	add	43.60	
# E669	- with oesophagoscopy-gastroscopy and may include duodenoscopy	add	102.75	
# E816	- with electrohydraulic lithotripsy for choledocholithiasis	add	50.00	

Note:

1. E662, E666, E668, E702, E680, E681, E669, and E816 are payable with Z561, Z558 or Z760.

2. E816 is *only eligible for payment* for confirmed choledocholithiasis that is refractory to standard extraction methods

# Z593	Nasobiliary catheter insertion		55.25

INCISION

# S233	Percutaneous trans-hepatic catheter drainage of obstructed bile ducts including daily supervision and including percutaneous cholangiogram and catheterization to duodenum if achieved		394.25
# S234	Replacement of catheter in above		64.85

Biliary duct calculus manipulation and/or removal via T-tube tract

# Z562	- as sole procedure		116.20	7
# Z542	Intubation of bile duct for obstruction		85.25	

DIGESTIVE SYSTEM SURGICAL PROCEDURES

BILIARY TRACT

		Asst	Surg	Anae
	INCISION			
# S278	Cholecystostomy	7	408.05	7
# S276	Choledochotomy (previous cholecystectomy)	7	694.80	8
# S280	Transduodenal sphincterotomy and choledochotomy (previous cholecystectomy)	7	961.80	9
# S281	Choledochoduodenostomy or choledochoenterostomy or choledochocholechostomy	7	821.80	9
# E704	- with choledochoscopy, to S276, S280, S281 or S287 plus E721 add		46.50	
	Note: S281 cannot be claimed with S276.			
# S282	Cholecystogastrostomy	7	447.45	7
# S283	Cholecystoenterostomy	7	509.50	7
# E743	- with entero-enterostomy, to S281 or S283 add		174.25	
# S285	Intrahepatic choledochoenterostomy (anastomosis above the common hepatic duct bifurcation)	9	915.30	12
	EXCISION			
# S287	Cholecystectomy	7	544.30	7
# S286	Completion cholecystectomy (removal of gallbladder remnant following prior incomplete or subtotal cholecystectomy)		800.00	
# E721	- with choledochotomy add		139.00	
# E722	- with transduodenal sphincterotomy add		185.25	1
# E728	- with truncal or selective vagotomy add		167.65	
# E729	- with highly selective vagotomy add		324.25	
# E794	- with intra-operative cholangiogram add		40.80	
# S291	Choledochectomy for tumour*	8	463.25	8
	REPAIR			
# S292	Common duct stricture, dissection and/or resection*	7	203.40	10
# S293	Biliary duct atresia, infant (see General Preamble GP12)	8	I.C	12
# Z596	Extracorporeal shock wave lithotripsy for bile duct calculi		314.20	6

Note:
* For reconstruction, refer to S281.

PANCREAS

		Asst	Surg	Anae
	INCISION			
	Biopsy			
# Z762	- needle		102.10	
# Z577	- incisional		139.00	7
# S297	Drainage of acute pancreatitis or abscess or marsupialization of cyst	7	406.85	7
	EXCISION			
	Pancreatectomy			
# S298	Complete with splenectomy	9	1883.90	13
# S300	"Whipple type" procedure	9	2746.70	13
# S301	Local complete excision of tumour or lesion	8	579.10	8
# S309	Distal / left-sided or central (body, tail or neck, including any portion with splenectomy with or without anastomosis	9	1611.65	11
# S299	Distal - body, tail with preservation of spleen, with or without anastomosis	9	1305.70	11
# E793	- laparoscopic or laparoscopic assisted, to S298, S299, S300, S301 or S309	add 25%		
# E709	- with cholecystectomy, to S299, S300 or S309	add	139.00	
	REPAIR			
	Pancreatic cyst			
# S305	- gastrostomy	7	589.95	8
# S306	- duodenostomy	8	589.95	8
# S307	- jejunostomy	8	589.95	8
# S304	Lateral pancreatoduodenostomy or anastomosis of filleted pancreatic duct to intestine (Puestow)	9	926.45	10
	TRANSPLANT			
# S302	Donor pancreas removal	6	773.75	8
# S303	Back-bench pancreas graft preparation		339.75	
# S308	Pancreas transplant	20	2378.30	30

DIGESTIVE SYSTEM SURGICAL PROCEDURES

ABDOMEN, PERITONEUM AND OMENTUM

PREAMBLE

1. Unless otherwise specified, when the laparoscope is used as a means of entrance to perform an intra-abdominal procedure, the laparoscopy is *not eligible for payment*.
2. When a diagnostic laparoscopy is performed prior to laparotomy, the initial procedure should be claimed as E860.
3. When an exploratory laparotomy is performed followed by a colostomy through another incision in the abdomen, the colostomy fee should be claimed at 100% and the laparotomy at 85% of the listed fee.

ABDOMEN, PERITONEUM AND OMENTUM

			Asst	Surg	Anae
	PARACENTESIS				
	Aspiration				
Z590	- for diagnostic sample			31.30	
Z591	- with therapeutic drainage with or without diagnostic sample			57.65	6
E724	- administration of chemotherapy or sclerosing agent	add		23.25	
Z763	Paracentesis with lavage for diagnosis			38.70	6
E542	- when performed outside hospital, to Z590, Z591 or Z763	add		12.65	
	INCISION				
# Z563	Needle biopsy of peritoneum			52.40	
# Z564	Open lavage of peritoneal cavity for diagnosis without manual exploration of peritoneal cavity			73.60	7
# S312	Laparotomy, with or without biopsy or for Hirschsprung's disease (except biopsies of stomach, liver, pancreas and multiple para-aortic lymph nodes)		6	485.25	7
# S324	Temporary abdominal closure with or without peritoneal washout		6	376.25	7

Note:

1. S312 - use for division or removal of adhesions, if no other abdominal surgery performed - may not be claimed with other intra-abdominal procedures (except for *IOP*).

2. S324 is *only eligible for payment* when rendered as a standalone procedure

3. S324 is *not eligible for payment*:

a. When definitive fascial closure is achieved at the same operative episode

b. For superficial wound management or application of negative pressure therapy only

# E745	- insertion of tubes and post-operative continuous peritoneal lavage when combined with any other abdominal procedure	add		94.85	
	Laparotomy				
# S321	- for acute trauma		6	671.65	6
# E733	- with repair of intestine - single	add		162.90	
# E734	- multiple and/or with resection	add		241.55	
# E735	- with splenectomy (partial or complete)	add	4	325.80	
# E736	- with repair of lacerated liver	add	4	214.95	
# E739	- with repair of diaphragm	add	4	139.60	
# E723	- with repair of lacerated spleen	add	4	325.85	
# E693	- with repair of ruptured bladder	add	4	-	
# E694	- with nephrectomy	add	4	-	

ABDOMEN, PERITONEUM AND OMENTUM

		Asst	Surg	Anae
	INCISION			
	Peritoneal abscess			
# S313	- subphrenic	7	370.95	7
# S314	- abdominal	6	301.10	7
# Z569	Pelvic abscess, incision and drainage - rectal or vaginal approach		122.05	7
# Z594	Percutaneous abdominal abscess drainage including daily supervision, for one or more abscesses within the same abdominal quadrant or the pelvis		508.80	
# E686	- within each other abdominal quadrant, or the pelvis (if the initial abscess was not in the pelvis) ... add		144.10	
Z595	Replacement of drainage catheter in abdominal abscess		54.05	
# Z574	Removal of infected sutures from abdominal wall or re-exploration of wound for bleeding - general anaesthetic	6	94.85	7
# S311	Umbilical vein intra-abdominal dissection and catheterization	6	232.50	6

Note:
For vascular *newborn* - see Diagnostic & Therapeutic Procedures - Vascular Cannulation.

# S320	Insertion of antabuse into abdominal wall		58.15	
	Insertion of peritoneo-jugular shunt for ascites			
# S203	- primary	7	281.85	7
# S209	- revision	7	237.00	7
# S310	Insertion of intraperitoneal chemotherapy port by laparotomy or laparoscopy	6	215.10	6
# S315	Removal of intraperitoneal chemotherapy port by laparotomy or laparoscopy	6	215.10	6

Payment rules:
S310 or S315 are *not eligible for payment* in addition to any open or laparoscopic abdominal procedure.

	EXCISION			
# S316	Excision of full thickness abdominal wall tumour and primary closure (see General Preamble GP12)		I.C	7
# S317	Umbilectomy - plastic	6	111.45	7

		Asst	Surg	Anae
	Panniculectomy			
# S318	Panniculectomy, including any necessary diastasis repair	6	500.00	6
# E748	- with repair of umbilical hernia, to S318 ..... add		122.05	
# E809	- excision of panniculus that extends beyond the mid thigh, to S318 ..... add		250.00	

Note:

1. Panniculectomy is only insured in those circumstances described in Appendix D of this *Schedule*. Prior authorization of payment from the *MOH* is required.

2. S318 is *not eligible for payment* when performed in conjunction with abdominal or pelvic procedures unless the payment requirements for panniculectomy are separately fulfilled.

[Commentary:

1. In circumstances where the proposed panniculectomy surgery *may include* excision of a panniculus that extends below the mid thigh, the requesting physician must provide sufficient information with the request for prior authorization of payment.

2. Abdominoplasty is not an insured service.]

# S319	Mesenteric cyst	6	381.65	6

ABDOMEN, PERITONEUM AND OMENTUM

		Asst	Surg	Anae
	ENDOSCOPY			
	Peritoneoscopy, culdoscopy or laparoscopy			
# Z552	- without biopsy	6	160.50	6
# Z553	- with biopsy and/or lysis of adhesions and/or removal of foreign body and/or cautery of endometrial implants	6	196.65	6
	REPAIR			
# S325	Omentopexy - as sole operative procedure	6	305.05	7
	HERNIOTOMY			
# E725	- recurrent - all types of hernia, except oesophageal ... add	4	130.00	
	Inguinal and/or femoral			
# S322	- infants	6	522.60	7
# S326	- children	6	442.20	6
# S323	- adolescents and adults	6	357.80	7
	Unilateral with exploration of other side			
# S328	- infants and children	6	458.40	7
	Strangulated or incarcerated			
# S329	- without resection of bowel	6	425.00	7
# S330	- with resection of bowel	6	660.50	7
# S345	Massive sliding inguinal hernia	6	491.15	7
E726	- repeat recurrent inguinal hernia (more than 2 repairs), to S322, S323, S326, S329 or S330 ... add	4	257.35	
	Umbilical			
# S332	- adolescent or adult, with or without resection of incarcerated/strangulated contents	6	324.20	6
# S333	- child (operative), with or without resection of incarcerated/ strangulated contents	6	240.75	6
# E764	- umbilical hernia repair when done in conjunction with other abdominal surgery, to other surgery ... add		27.55	

Payment rules:

1. E764 is *only eligible for payment* for services related to a pre-existing umbilical hernia that is documented in the patient's permanent medical record prior to the service being provided.

	Ventral or Incisional hernia			
# S340	Hernia fascial defect (diameter < 5 cm) OR any size repaired with primary closure	6	370.95	7
# S344	Hernia fascial defect (diameter 5 cm or greater) repaired with mesh closure	6	569.35	7
# E829	- repair of defect (5-10 cm) with component separation, to S344 ... add		341.60	
# E827	- repair of defect (> 10 cm) with component separation, to S344 ... add		683.20	

ABDOMEN, PERITONEUM AND OMENTUM

		Asst	Surg	Anae
	Omphalocele and gastroschisis			
# S348	Primary or first stage repair	7	1266.60	7
# E691	- requiring mobilization of abdominal wall musculature, to S348 ... add		178.40	
# S349	Second or subsequent stage repair	7	1603.65	7
	Congenital diaphragmatic hernia			
# S346	Primary or first stage repair	9	1300.55	13
# S347	Second or subsequent stage repair	9	537.65	13
# E793	- laparoscopic or laparoscopic assisted, to S344. add 25%			
# E726	- repeat recurrent inguinal hernia (more than 2 repairs), to S322, S323, S326, S329 or S330 ... add	4	257.35	
# S342	Epigastric	6	239.20	6
# E727	- hydrocele - extra - applicable to adults only ... add		75.05	
	SUTURE			
# S343	Secondary closure for evisceration - sole operative procedure in abdomen	6	350.00	7

UROGENITAL AND URINARY SURGICAL PROCEDURES

PREAMBLE - KIDNEY AND UPPER URINARY TRACT

1. No additional claim should be made for nephroscopy when done at the time of pyelolithotomy or nephrolithotomy. This does not apply to nephroscopy done in conjunction with codes listed under "Percutaneous - Procedures."
2. In a routine surgical approach to the kidney and related procedures, no additional claim should be made for rib resection carried out for access purposes.
3. When an adrenalectomy is performed in conjunction with a nephrectomy, and is incidental to the removal of the kidney, there should be no additional claim for the adrenalectomy.

UROGENITAL AND URINARY SURGICAL PROCEDURES

KIDNEY AND UPPER URINARY TRACT

		Asst	Surg	Anae
# E752	- with repeat surgery on kidney at least 30 days after previous kidney surgery ..... add		83.25	
	INCISION			
# Z601	Renal biopsy, needle		153.85	6
# S401	Drainage of renal or perirenal abscess	7	440.95	7
# S400	Laparoscopic placement of probe(s) for ablation of renal tumour	7	434.15	7
	Payment rules: This service is *not eligible for payment* in addition to J069.			
# S405	Nephrolithotomy or pyelolithotomy - open or laparoscopic.....	7	603.45	7
	EXCISION			
# S411	Partial or heminephrectomy	7	972.35	7
# E792	- when performed laparoscopically, to S411 ..... add 25%			
# S416	- Nephrectomy	9	972.35	13
# E766	- with gland dissection ..... add		29.70	
# E767	- with repair of vena cava for thrombus - below the hepatic vein ..... add		280.35	
# E768	- with repair of vena cava for thrombus - above the hepatic vein ..... add		480.30	
# E792	- when performed laparoscopically, to S416 ..... add 25%			
# S424	Extrophy - plastic closure of bladder with closure of abdominal wall and urethral lengthening with closure of pelvic floor with or without reimplantation of ureters	7	1324.00	10
# S420	Nephroureterectomy, total, with resection of ureterovesical junction	7	1336.35	10
# E792	- when performed laparoscopically, to S420 .....add 25%			
	REPAIR			
# S422	Pyeloplasty (with or without nephropexy)	7	972.35	7
# E792	- when performed laparoscopically, to S422 ..... add 25%			
# E754	- with removal of calculus ..... add		61.65	
	SUTURE			
# S429	Ruptured or lacerated kidney - repair or removal	7	437.20	7
	EXTRA RENAL PROCEDURES			
# S431	Excision of retroperitoneal tumour	7	381.60	7
# S432	Exploration of retroperitoneal tumour	7	260.85	7
# S433	Sacrococcygeal teratoma	6	437.20	6
# Z630	Extracorporeal shock wave lithotripsy		320.65	6

UROGENITAL AND URINARY SURGICAL PROCEDURES

KIDNEY AND UPPER URINARY TRACT

		Asst	Surg	Anae
	PERCUTANEOUS PROCEDURES			
# Z629	Percutaneous nephrostomy		164.40	6
# Z623	Insertion of stent		101.95	
# Z624	Dilatation of tract		105.25	
# Z625	Selective catheterization of calyces (one or more)		55.35	
# Z626	Nephroscopy, percutaneous or retrograde		102.85	6
# Z627	Removal of renal calculi	6	180.35	7
# E759	- if disintegrated by any method, to Z627 add		102.85	
# E772	- percutaneous removal of staghorn calculus filling renal pelvis and extending into calyces add		188.15	
# Z636	Endoscopic ureterotomy or pyelotomy		293.00	7

[Commentary:
Z636 is eligible for payment when rendered by percutaneous or retrograde route.]

# Z637	Percutaneous ablation of calyceal diverticulum to include dilation of communication with calyx and fulguration		262.75	6
# Z600	Change of nephrostomy tube		44.00	
	RENAL TRANSPLANTATION PROCEDURES			

Note:
Submit on recipient's claim. These fees do not include immunosuppressive therapy which is on a fee-for-service basis.

# E762	- reconstruction or repair of renal artery done in addition torenal transplantation procedures add		307.20	
# S435	Kidney transplant	9	1585.10	13
# E769	- team fee (not to be billed when assistant fees are billed) add		260.05	
# S434	Kidney re-transplant	9	1896.35	13
# E771	- team fee (not to be billed when assistant fees are billed) add		350.45	
# S436	Donor nephrectomy - unilateral or bilateral (to include renal perfusion with hypothermia when rendered by surgeon)	7	700.30	8
# E753	- live donor add		430.35	
# E792	- when performed laparoscopically, to S436 add 25%			

Note:
For nephrological components - see Diagnostic and Therapeutic Procedures.

# Z631	Fine needle aspiration of renal transplant		45.15	
	ENDOSCOPIC PROCEDURES			
# S470	Cystoscopy with manipulation and/or removal of calculus and retrograde pyelogram if required		240.65	6
# Z638	Endoscopic treatment of vesicoureteral reflux by subureteral injection of agent, unilateral or bilateral	6	450.00	6

Note:
Z606, Z607, Z611, Z617 and Z628 are *not eligible for payment* with Z638.

		Asst	Surg	Anae
	Cystoscopy and diagnostic Ureteroscopy			
# Z628	- above intramural		125.70	6
# E819	- diagnostic ureteroscopy of second ureter, to Z628 .... add		54.65	
# E822	- ureteroscopy to upper third of ureter or renal pelvis, to Z628 .... add		39.60	
# E760	- with removal of calculus .... add		174.55	
# E761	- intracorporeal lithotripsy by any method .... add		100.75	
# E820	- with biopsy of one or more sites in ureter and/or pelvis using ureteroscope .... add		53.35	
# E823	- resection and fulgarization of one or more ureteral or renal pelvic tumours, to Z628 .... add		250.50	
	INCISION			
	Ureterotomy, abdominal or vaginal exploratory or for drainage			
	With removal of calculus			
# S445	- upper 2/3	6	376.80	7
# S446	- lower 1/3	6	482.40	7
	Where ureter has been previously opened			
# S447	- upper 2/3	6	437.20	6
# S448	- lower 1/3	6	522.50	7
	EXCISION			
	Ureterectomy			
# S449	- including ureterovesical junction	6	477.50	7
# S450	- other e.g. partial	6	355.60	7
	REPAIR			
# S452	Ureteroileal conduit	6	844.95	9
# S454	- with ureterectomy and ileal replacement	6	957.85	9
# S457	Ureteroureterostomy	6	592.05	8
# E792	- when performed laparoscopically, to S457 ..... add 25%			
	Re-implantation			
# S451	Ureterovesical anastomosis or re-implantation unilateral	6	525.55	8
	Note: Not to be billed in addition to S482.			
# S561	Re-implantation of ureter with extensive tapering with or without ureterolysis	6	743.45	8
# S562	Re-implantation of bifid ureter	6	747.90	8
# E792	- when performed laparoscopically, to S451, S561 or S562 ..... add 25%			
# Z638	Endoscopic treatment of vesicoureteral reflux by subureteral injection of agent, unilateral or bilateral	6	450.00	6

Note:
Z606, Z607, Z611, Z617 and Z628 are *not eligible for payment* with Z638.

UROGENITAL AND URINARY SURGICAL PROCEDURES

KIDNEY AND UPPER URINARY TRACT

		Asst	Surg	Anae
	Ureterointestinal anastomosis			
# S455	- unilateral	6	355.60	7
# S462	- bilateral	6	469.10	6
	Ureterostomy			
	Cutaneous			
# S458	- unilateral	6	530.55	6
# S463	- with lower third ureterotomy	6	409.10	6
# S459	Ureterovaginal fistula	6	596.95	6
	Ureterolysis for periureteral fibrosis			
# S460	- unilateral	6	480.25	6
# E792	- when performed laparoscopically, to S460 ..... add 25%			

Note:
When a physician submits a claim for performing any insured surgical procedure on the same patient on the same *day* as the physician submits a claim for rendering S460, the S460 service is included (in addition to the *common elements*) as a specific element of that other insured service.

	Ureteroplasty (Hutch)			
# S461	- unilateral	6	355.60	6
	Bladder flap (Boari)			
# S427	- to include re-implantation of ureter	6	705.80	6
# E792	- when performed laparoscopically, to S427 ..... add 25%			
	SUTURE			
	Traumatic rupture, or transection (partial or complete)			
	Immediate			
# S465	- upper 2/3	6	409.10	6
# S466	- lower 1/3	6	468.70	6
	Late repair			
# S467	- upper 2/3	6	467.85	6
# S468	- lower 1/3	6	517.15	7

UROGENITAL AND URINARY SURGICAL PROCEDURES

PREAMBLE - BLADDER AND URETHRA

1. No extra claim should be made for EUA when done at the time of cystoscopy.
2. Visit fees, as applicable, to be claimed for changing a suprapubic tube.
3. No claim should be made for pre-cystoscopy dilatation of the male urethra unless urethral stricture is the primary diagnosis. No claim should be made for dilatation of the female urethra when done at the same time as cystoscopy.
4. “E” prefixed codes are payable in addition to any “S” or “Z” code listed under the “Bladder” subheading or to Z626 or Z628, unless separately noted.

UROGENITAL AND URINARY SURGICAL PROCEDURES

BLADDER

			Asst	Surg	Anae
	ENDOSCOPY - CYSTOSCOPY				
	Diagnostic and Therapeutic Procedures				
# Z606	Diagnostic with or without urethroscopy			77.00	5
# Z607	Repeat within 30 days			38.05	5
# E775	- with catheterization of the ureter and collection of the ureteral specimen, unilateral	add		16.45	
# E817	- with catheterization of the ureter and retrograde injection of opaque media, unilateral	add		16.45	
# E776	- with unilateral brush biopsy of renal pelvis and/or ureter, and/or transurethral biopsy of bladder	add		26.70	
# E818	- with insertion of ureteric stent, unilateral	add		26.70	
# E777	- with cystometrogram (to include urethral pressure profile if necessary)	add		12.35	
# E783	- with secondary surgical evacuation of bladder clots and control of haemorrhage	add		106.80	
# E784	- with hydrodistention of bladder - general anaesthetic	add		53.45	
# E824	- with bladder biopsy - general anaesthetic	add		53.45	
# E773	- with placement of ureteric stent past obstructing lesion (unilateral)	add		53.50	

Note:

1. Only one of E773 or E818 is eligible for payment for the same ureteric obstruction.

2. Time units and anaesthesia extra units listed on GP97 are *not eligible for payment* with anaesthesia services for Z606C or Z607C.

3. E003C is not payable for anaesthesia services rendered for Z606 or Z607.

# E791	- with periurethral injection of bulking agents	add		50.70	

Payment rules:

1. E791 is *not eligible for payment* with any procedural fee code other than Z606

2. E791 is *only eligible for payment* for one treatment per patient every 16 weeks

# E781	- with electrocoagulation - tumour(s)	add		53.50	
# E782	- with electrocoagulation - Hunner ulcer	add		53.50	
# E786	- with resection or incision bladder neck, female	add		106.85	
# E787	- with resection or incision bladder neck, male	add		279.20	
# E788	- with ureteral meatotomy, by any means	add		99.70	
# E789	- with removal foreign body or calculus	add		106.85	
# E790	- with removal of ureteric catheter	add		9.45	
# E751	- with insertion of chemotherapeutic agent(s)	add		58.65	

Note:

E751 is *not eligible for payment* with Z603 or Z611.

Excision of tumour or tumours including base and adjacent muscles and electrocoagulation, if necessary

# Z632	- single tumour 1 to 2 cm diameter			290.90	6
# Z633	- single tumour over 2 cm diameter			468.70	6
# Z634	- multiple tumours			468.70	6

UROGENITAL AND URINARY SURGICAL PROCEDURES

BLADDER

		Asst	Surg	Anae

Note:
No additional claim for cystoscopy when done at the same time as excision of tumour(s).

Catheterization

Z603	- home	16.25
# Z611	- hospital or office	9.15

Note:
1. Catheterization is *only eligible for payment* for acute retention, change of Foley catheter or suprapubic tube or instillation of medication.

2. Z603 or Z611 is *only eligible for payment* when *rendered personally by the physician*.

3. Z611 is *not eligible for payment* in conjunction with any surgical procedure.

Z608	Manual catheter declotting and irrigation of bladder	58.65
Z610	Intravesical instillation of BCG or immunotherapeutic agent or chemotherapeutic agent for the treatment of bladder cancer	25.65

Payment rules:
1. This service is *only eligible for payment* when the service, including the catheterization and preparation and disposal of the agents, is *rendered personally by the physician*.

2. Z603 or Z611 is *not eligible for payment* in addition to Z610.

[Commentary:
Z610 is not payable for indications other than bladder cancer.]

INCISION

# S478	Cystotomy or cystostomy	6	215.80	6
# Z480	Cystotomy with trochar and cannula and insertion of tube		91.45	6
# E750	- when done in conjunction with another procedure ..... add		27.90	
# S481	Cystolithotomy - when sole operative procedure	6	279.45	7
# E792	- when performed laparoscopically, to S481 ..... add 25%			
# S476	Cutaneous vesicostomy	6	468.70	6

EXCISION

Cystectomy - Partial

# S482	- partial for tumour or diverticulum (single or multiple)	6	409.10	6
# S483	- with reimplantation of ureter	6	592.05	7
# S490	- with reimplantation of ureters	6	786.35	7
# E792	- when performed laparoscopically, to S482, S483 or S490 ..... add 25%			

Note:
S482 not to be billed in addition to S451.

UROGENITAL AND URINARY SURGICAL PROCEDURES

BLADDER

		Asst	Surg	Anae
	Cystectomy - Complete			
# S484	- complete cystectomy, without transplant	6	848.90	10
# S485	- with ureterointestinal transplant	8	1053.70	13
# S453	- with ureteroileal conduit	9	1340.40	15
# S440	- with continent urinary diversion	9	1582.00	15
# E792	- when performed laparoscopically, to S484, S485, S453 or S440	add 25%		
# S438	Retroperitoneal lymph node dissection for bladder cancer, specimen must include obturator, internal iliac and external iliac nodes as a minimum to the level of the iliac bifurcation, bilateral	7	675.35	7
# S441	Creation of continent urinary diversion	9	1086.45	15
# S471	Excision of urachal cyst or sinus with or without umbilical hernia repair	6	317.65	6
# E792	- when performed laparoscopically, to S471	add 25%		
	Extrophy - excision of bladder and repair of abdominal wall			
# S488	- inclusive of graft	6	230.95	6
# S491	Plastic repair of extrophy using bladder and including skin flaps	6	703.85	6
	REPAIR			
# S512	Repair of ruptured bladder	6	371.40	6
# S513	Cystoplasty, using intestine	8	742.80	9
	Plastic repair of bladder neck			
# S518	- child	6	529.60	6
# S519	- adolescent or adult	6	468.70	7
	DESTRUCTION			
# S521	Litholapaxy and removal of fragments		231.35	6
# E792	- when performed laparoscopically, to S521	add 25%		
	SUTURE			
	Closure of fistula			
# S522	External, suprapubic	6	279.65	7
	Vesicovaginal			
# S523	- vaginal approach	6	848.90	6
# S524	- transvesical approach (with or without omental flap)	6	583.60	6
# S525	Vesicorectal or vesicosigmoid	6	479.10	7
# E792	- when performed laparoscopically, to S522, S524 or S525	add 25%		

Note:
Closure of fistula - see also Operations on the Female Genital System, page V4.

UROGENITAL AND URINARY SURGICAL PROCEDURES

URETHRA

		Asst	Surg	Anae
	ENDOSCOPY			
	Urethroscopy			
# Z617	- diagnostic		38.05	6
# Z618	- with biopsy		83.30	6
# S547	Removal of foreign body or calculus		182.90	7
	INCISION			
# Z616	Biopsy of urethra (without endoscopy)		25.25	6
	Urethrotomy			
# S530	- external	6	231.35	6
# S532	- transurethral (visual)	6	178.00	6
# S538	- repeat procedure within 6 months by same surgeon	6	102.65	6
# S531	Urethrostomy	6	231.35	6
# Z604	Meatotomy and plastic repair		42.45	6
# Z609	Periurethral abscess		33.85	6
	EXCISION			
# S536	Caruncle	6	127.35	6
# S537	Urethral papilloma, single or multiple		127.35	6
# S541	Diverticulectomy - male or female	6	279.65	7
# S542	Posterior urethral valve	6	355.60	6
# S543	Prolapse urethra	6	127.35	7
# S544	Urethrectomy - radical	6	318.35	6
	REPAIR			
# S548	Urethral sling	6	409.10	6
# S815	Tension free vaginal tape mid-urethral sling, by any method/ approach	6	421.65	6

Payment rules:
Cystoscopy (Z606) is *not eligible for payment* with S815 or S548 unless the cystoscopy is rendered for suspicion of disease.

	Retropubic urethropexy for stress incontinence			
# S549	- primary procedure	6	419.75	6
# S546	- repeat procedure for failed retropubic or vaginal surgery for stress incontinence	6	532.00	7
# E862	- when performed laparoscopically, to S549 or S546 ..... add 25%			

Note:
See also procedures for stress incontinence in Female Genital Surgical Procedures.

# S539	Insertion of artificial urinary sphincter	6	832.65	6
# S540	Revision or removal of artificial urinary sphincter	6	257.05	7

UROGENITAL AND URINARY SURGICAL PROCEDURES

URETHRA

		Asst	Surg	Anae
	Urethroplasty			
	First stage			
# S545	- posterior	6	381.60	6
# S550	- anterior	6	293.35	6
# S558	Second stage	6	235.35	6
# S535	One stage repair and may include skin grafting	6	959.65	6
	SUTURE			
# Z612	Endoscopic urethral realignment for urethral trauma	6	250.00	6

Payment rules:
Cystoscopy, urethroscopy, retrograde urethrogram or insertion of guidewire/catheter is *not eligible for payment* with Z612.

	Posterior urethra			
# S553	- late repair	6	1139.05	7
	Fistula			
# S554	- penile urethra (diversion of urine extra)		98.70	6
# S555	- perineal urethra	6	349.45	6
# S556	Rectourethral with diversion, colostomy and closure of colostomy	6	592.05	7
	DESTRUCTION			
# S557	Urethrovesicolysis - when sole operative procedure	6	231.35	6
# S564	Transurethral incision or resection of external sphincter - when sole operative procedure		348.80	6
	MANIPULATION			
	Dilatation of stricture			
Z621	- male, local anaesthetic		20.60	
# Z619	- male, general anaesthetic		56.50	6
	Dilatation of urethra			
Z622	- female		10.60	
# Z620	- female, general anaesthetic		44.65	6
# Z615	Filiform and follower urethral dilation and may include bladder catheterization		64.05	6

Note:
Z619, Z620, Z621, Z622 payable at nil if claimed with Z615.

NOT ALLOCATED

MALE GENITAL SURGICAL PROCEDURES

PENIS

		Asst	Surg	Anae
	INCISION			
	Slit of prepuce			
# S567	- newborn		61.35	
# S568	- infant		62.45	6
# S569	- adult or child		65.30	6
	Emergency Management of Priapism			
# Z786	Aspiration and irrigation of corpora cavernosa with intracavernosal vasoactive injection for priapism, with or without distal corporoglanular shunt		250.00	

Payment rules:
Z786 is not payable if followed by S565 or another penile surgery during the same priapismic episode

	EXCISION			
	Circumcision - for physical symptomatology only			
# S573	- for patients aged one year or older	6	225.95	6
# S577	- for infants less than one year of age	6	201.60	6

Note:
1. Circumcision is an insured service only when medically necessary. As such, circumcision performed for ritual, cultural, religious or cosmetic reasons at any age is not an insured service.
2. Circumcision for neonatal phimosis is not an insured service.

Z702	Biopsy		42.45	6
E542	- when performed outside of hospital	add	12.65	
	Amputation			
# S574	- partial	6	304.65	7
# S575	- partial with inguinal glands 1 or 2 stages	6	468.70	7
# S576	- radical with inguinal and femoral glands 1 or 2 stages	6	771.15	7
	Condylomata			
Z701	- local anaesthetic		34.95	
# Z767	- general anaesthetic		84.25	6
# S599	Excision plaque for Peyronies disease	6	306.85	7

Note:
Where grafting is necessary, appropriate skin graft fee is payable with S599.

	REPAIR			
	Hypospadias or Epispadia			
	One stage repair			
# S578	- with meatus to but not into glans	6	636.55	7
# S571	- with advancement of meatus into glans	6	658.65	6
# S572	- into glans using island flap pedicle (penoscrotal)	6	935.30	6
# S579	Chordee repair	6	231.35	6

MALE GENITAL SURGICAL PROCEDURES

PENIS

			Asst	Surg	Anae
#	S580	Plastic reconstruction, urethra	6	355.60	7
#	S581	Closure urethro-cutaneous fistula		318.35	7
#	S565	Proximal cavernoso-spongiosal or other venous shunt for the management of priapism	6	500.00	6
#	S582	Repair of penile fracture or traumatic laceration of corpus cavernosum	6	650.00	6

Payment rules:
S582 includes degloving of penis, repair of tunica albuginea, evacuation of hematoma, and urethral repair, if required

#	S597	Penile prosthesis for impotence	6	424.45	7
#	E755	- with inflatable prosthesis	add	74.30	
#	S588	Surgical removal of prosthesis	6	148.45	7
#	S566	Revision including removal of prosthesis	6	239.75	7
	Z700	Intracorporeal injection for impotence		27.80	

MALE GENITAL SURGICAL PROCEDURES

TESTIS

		Asst	Surg	Anae
	INCISION			
# Z703	Abscess		59.10	6
	BIOPSY			
# Z704	Single		59.10	7
# Z705	Bilateral		89.35	7
# Z706	- with vasography		129.50	6
	Note: See also Diagnostic Radiology - GU Tract.			
	Orchidectomy			
# S589	unilateral	6	182.90	7
# S598	unilateral, radical for malignancy	6	361.45	7
# E834	- with insertion of testicular prosthesis, to S589 or S598 (maximum 2) ... add		50.00	
# S590	Retroperitoneal lymph node dissecton (RPLND) for testicular tumour	6	894.35	8
# E792	- when performed laparoscopically, to S590 ... add 25%			
	REPAIR			
	Orchidopexy			
# S591	- for undescended testis, any type, one or two stages to include hernia repair where required	6	465.20	7
# S593	Exploration for undescended testicle, without orchidopexy	6	465.20	7
# E792	- when performed laparoscopically, to S591 or S593 ... add 25%			
# S600	Reduction of torsion of testis or appendix testis and orchidopexy (one or both sides) if required	6	456.95	6
# S595	Ruptured testicle	6	448.70	7
# S596	Insertion of testicular prosthesis	6	212.20	6

[Commentary:
See Appendix D - Sub-Surface Pathology under Congenital Deformities and Post-Traumatic Deformities.]

MALE GENITAL SURGICAL PROCEDURES

EPIDIDYMIS AND TUNICA VAGINALIS

		Asst	Surg	Anae
	EPIDIDYMIS			
# Z707	Incision of abscess		59.10	6
# S601	Spermatocele or spermatic granuloma excision	6	222.80	6
	Epididymectomy			
# S602	- unilateral	6	182.90	6
	TUNICA VAGINALIS			
Z708	Hydrocele aspiration		21.20	
# S611	Hydrocele excision - unilateral	6	222.80	6

Note:
Hydrocele excision rendered with hernia repair is claimed as E727.

MALE GENITAL SURGICAL PROCEDURES

SCROTUM

			Asst	Surg	Anae
		INCISION			
		Abscess or haematocele			
	Z709	- local anaesthetic		42.45	
#	Z768	- general anaesthetic		106.10	6
#	S616	- and exploration - unilateral	6	106.10	7
		EXCISION			
#	S618	Resection of scrotum	6	231.35	7

SUTURE

Note:
For suture of lacerations, refer to the general listings under Integumentary System Surgical Procedures - Skin and Subcutaneous Tissue - Suture of Lacerations. Where suture of lacerations is the sole procedure and is done under *general anaesthesia*, refer to code E530.

VAS DEFERENS

		Asst	Surg	Anae
	INCISION			
# Z710	Vasography		55.15	6
	REPAIR			
	Vasovasostomy and/or vasoepididymostomy			
# S623	- unilateral	6	215.80	6
S625	- including biopsy and vasography	6	260.85	6

Note:
To include microscopic control if required.

	SUTURE			
	Vasectomy			
S626	- uni - or bilateral - by any technique	nil	115.10	6
E545	- when performed outside hospital	add	13.75	

Note:
Vasectomy reversal is an insured benefit only for treatment of significant symptomatology, and requires prior approval. Re-establishing fertility does not constitute significant symptomatology.

MALE GENITAL SURGICAL PROCEDURES

SPERMATIC CORD AND SEMINAL VESICLES

		Asst	Surg	Anae
	SPERMATIC CORD			
	Hydrocele excision			
# S630	- single	6	220.10	6
	Varicocele excision			
# S631	- single	6	220.10	7

Note:
S630 when done with hernia repair use E727.

	SEMINAL VESICLES			
# Z711	Incision of abscess		120.80	6
# S636	Vesiculectomy	6	552.30	6

MALE GENITAL SURGICAL PROCEDURES

PROSTATE

		Asst	Surg	Anae

PREAMBLE

A transurethral resection followed within 10 days by a bilateral orchidectomy because of carcinoma of the prostate should be claimed in accordance with paragraph (3) of the Surgical Preamble (SP2.).

INCISION

# Z712	Biopsy, needle		91.60	6
# E821	- when performed by transperineal method, to Z712		20.00	
# Z713	Biopsy, needle with drainage abscess.....	6	98.70	6

EXCISION

Prostatectomy

# S650	- simple, by retropubic or suprapubic approach, with or without removal of bladder stones.....	6	689.75	6
# S651	- radical, with or without removal of bladder stones	6	1174.70	10
# E792	- when performed laparoscopically, to S650 or S651 ..... add 25%			

Note:

1. Prostatectomy (S650, S651) does not include investigative cystoscopy but includes vasectomy when rendered.
2. S651 includes S519 - plastic repair of bladder neck when rendered and/or S636 - vesiculectomy when rendered.

# S652	Staging pelvic lymphadenectomy for prostatic cancer (laparoscopic or open) must include at a minimum bilateral obturator nodes	7	431.20	10
# E792	- when performed laparoscopically, to S652 .....add 25%			

[Commentary:
A sampling of nodes does not constitute a complete staging lymphadenectomy. When only a sampling of nodes is performed, either S312 - laparotomy or Z553 - laparoscopic biopsy, may be eligible for payment depending on procedure performed.]

ENDOSCOPY

# S655	Endoscopic removal or destruction of prostatic tissue.....		483.05	7
# S639	Laser enucleation of the prostate including morcellation of prostatic tissue		550.00	7
# S654	- for residual or regrowth of tissue within one year of previous prostatectomy by same surgeon		440.85	6
# S656	- Transurethral drainage of abscess.....		91.45	6

FEMALE GENITAL SURGICAL PROCEDURES

PREAMBLE

Asst	Surg	Anae

1. In composite operations such as anterior and posterior repair and D&C or anterior and posterior repair and cauterization of cervix and b*iop*sy, the amount payable is equal to the fee for the major procedure(s).

2. A D&C is *not eligible for payment* if rendered with hysterectomy or management of ectopic pregnancy (S784) or if rendered routinely with tubal occlusion.

# E857	-	if a D&C is required for abnormal uterine bleeding and rendered with tubal occlusion or with diagnostic laparoscopy, to other procedure	add 78.45

3. The amount payable for a D&C for pregnancy termination (S752, S756 or S785) is reduced to 85% of the full fee when rendered with tubal occlusion (S741).

4. Unless otherwise specified, when the laparoscope is used as a means of entrance to perform an intra-abdominal procedure, the laparoscopy is not eligible for additional payment.

5. A diagnostic laparoscopy is eligible for payment as E860 when rendered prior to laparotomy.

# E854	-	ureterolysis - unilateral - payable in conjunction with major gynaecological operative procedure except S743 and must include surgical definition of pararectal and paravesical spaces, identification of uterine artery and vein, and mobilization of the pelvic ureter from common iliac vessels to ureterovesical junction	add 170.00

FEMALE GENITAL SURGICAL PROCEDURES

VULVA AND INTROITUS

		Asst	Surg	Anae
	Abscess of vulva, Bartholin or Skene's gland - incision and drainage			
	Z714 - local anaesthetic		25.40	
	E542 - when performed outside hospital add		12.65	
#	Z715 - general anaesthetic	6	102.05	6
#	Z716 Marsupialization of Bartholin's cyst or abscess	6	110.95	6
	EXCISION			
	Z477 - Biopsy(ies) - sole procedure, local anaesthetic		39.60	
	E542 - when performed outside hospital add		12.65	
#	Z475 - Biopsy(ies) - sole procedure, general anaesthetic	6	102.05	6
#	S707 Hymenectomy (with or without perineotomy) or hymenotomy		121.05	6
#	S706 Cyst of Bartholin's gland	6	161.40	6
	Condylomata - single or multiple			
	Chemical and/or cryosurgery			
	Z733 - one or more		12.00	
	Surgical excision or electrodesiccation or CO_2 laser			
	Z736 - local anaesthetic		32.60	
#	Z769 - general anaesthetic		124.60	6
	Vulvectomy			
#	S703 - simple	8	257.05	8
#	S704 - radical - without gland dissection	8	431.45	8
	REPAIR			
#	S708 Non-obstetrical injury to vulva and/or vagina, and/or perineum (see General Preamble GP12)		I.C	I.C
#	S701 Repair of infibulation - resulting from female genital mutilation		115.00	6

FEMALE GENITAL SURGICAL PROCEDURES

VAGINA

		Asst	Surg	Anae
	ENDOSCOPY			
Z478	Vaginoscopy (premenarchal) with or without medication		56.70	6
	Note: Culdoscopy - see Z552 - Abdomen, Peritoneum and Omentum - Digestive System.			
	INCISION			
# S712	Culdotomy, drainage or needle puncture		115.00	6
Z728	Incision and drainage of cyst, abscess or haematoma		97.20	6
	EXCISION			
	Biopsy(ies) - when sole procedure			
Z722	- local anaesthetic		39.60	
E542	- when performed outside of hospital, to Z722 ..... add		12.65	
# Z723	- general anaesthetic		97.20	6
# S715	Excision of cyst(s), or benign tumour(s)	6	140.45	6
# S742	Colpectomy - e.g. for carcinoma	6	365.55	6
# S702	Excision of congenital vaginal septum	6	159.55	6
	REPAIR			
# S716	Anterior or posterior repair	8	250.65	8
	Anterior and posterior			
# S717	- repair	8	396.80	8
# S718	- repair of enterocoele and/or vault prolapse	8	432.45	8
	Posterior repair and repair of			
# S719	- enterocoele and/or vault prolapse	8	366.55	8
# S723	- anal sphincter	8	305.90	8
	Anterior repair			
# S720	- with or without posterior repair and repair of uterine prolapse (Fothergill or Watkin's interposition)	8	432.45	8
# S721	Anterior, posterior repair with excision of cervical stump	8	432.45	8
	Post hysterectomy vault prolapse			
# S722	- repair by vaginal approach, may include enterocoele and/or anterior and posterior repair	8	432.45	8
# S812	- repeat - repair by vaginal approach, may include enterocoele and/or anterior and posterior repair	8	515.05	8
	Abdominal approach to vaginal vault prolapse			
# S760	- vaginal sacropexy	8	432.45	8
# S813	- repeat - vaginal sacropexy	8	515.05	8
# S761	Combined abdominal/vaginal approach for vaginal vault prolapse	8	431.45	8

FEMALE GENITAL SURGICAL PROCEDURES

VAGINA

		Asst	Surg	Anae
# E862	- when performed laparoscopically, to S760, S813 or S761 ..... add 25%			
# S724	Perineorrhaphy (*not eligible for payment* with delivery or other vaginal surgery procedures).....	8	127.35	8
# S725	Colpocleisis (LeFort or modification)	8	300.35	8
# S726	Construction of artificial vagina (see General Preamble GP12)	6	I.C	6
	Closure of fistula			
# S523	Vesicovaginal.....	6	848.90	6
# S231	Rectovaginal (any repair).....	6	338.55	6
# S729	Ureterovaginal	6	560.95	6
# S709	Urethrovaginal	6	374.85	6
	Retropubic Urethropexy			
# S549	Primary procedure	6	419.75	6
# S546	Repeat procedure for failed retropubic or vaginal surgery for stress incontinence.....	6	532.00	7
# E862	- when performed laparoscopically, to S549 or S546 ..... add 25%			
# S815	Tension free vaginal tape mid-urethral sling by any method/ approach	6	421.65	6

Payment rules:
Cystoscopy (Z606) is *not eligible for payment* with S815 unless the cystoscopy is rendered for suspicion of disease.

Combined Abdominal-Vaginal Procedure for Stress Incontinence (Sling Procedure)

[Commentary:
Combined abdominal vaginal sling procedures are indicated for the management of stress incontinence or genital prolapse, particularly following previous failed anti-incontinence procedures of any kind, or a very large cystocoele. The procedure usually entails entry into the space of Retzius through an abdominal approach (open or laparoscopic) in conjunction with an anterior vaginal dissection (*with or without* cystoscopy) following which the sling material (autologous, synthetic or xenograft) is passed through the perineal membrane, placed under appropriate tension at the bladder neck, and sutured to Cooper's ligament bilaterally.]

Payment rules:

1. Anti-prolapse procedures or other anti-incontinence procedures are *not eligible for payment* when rendered with combined abdominal-vaginal procedures for stress incontinence (sling procedures).

2. Cystoscopy (Z606) is *not eligible for payment* with combined abdominal-vaginal procedures for stress incontinence (sling procedures) unless the cystoscopy is rendered for suspicion of disease.

[Commentary:
Those procedures listed under the titles "Following one previous failed procedure" or "Following two or more previously failed procedures" are eligible for payment following failure of the appropriate number of any listed procedure.]

FEMALE GENITAL SURGICAL PROCEDURES

VAGINA

		Asst	Surg	Anae
	Primary approach			
# S728	One surgeon	7	429.10	7
# E862	- when performed laparoscopically, to S728 ..... add 25%			
	Two surgeons			
# S730	- vaginal surgeon	7	330.50	7
# E863	- when performed laparoscopically, to S730 ..... add 25%			
S740	- abdominal surgeon	7	330.50	
# E862	- when performed laparoscopically, to S740 ..... add 25%			
	Following previous failed procedure			
# S731	One surgeon	7	557.95	7
# E862	- when performed laparoscopically, to S731 ..... add 25%			
	Two surgeons			
# S732	- vaginal surgeon	7	429.65	7
# E863	- when performed laparoscopically, to S732 ..... add 25%			
# S733	- abdominal surgeon	7	429.65	
# E862	- when performed laparoscopically, to S733 ..... add 25%			
	Following two or more failed procedures			
# S748	One surgeon	7	686.70	7
# E862	- when performed laparoscopically, to S748 ..... add 25%			
	Two surgeons			
# S749	- vaginal surgeon	7	528.75	7
# E863	- when performed laparoscopically, to S749 ..... add 25%			
S751	- abdominal surgeon	7	528.75	
# E862	- when performed laparoscopically, to S751 ..... add 25%			
# S811	Rectus abdominus myocutaneous neovaginostomy - includes harvest of longitudinal, vertical or transverse rectus abdominus flap(s), formation of vaginal pouch and insertion of vaginal mold	8	829.40	8
	MANIPULATION			
	Examination and/or dilatation (may include insertion and/or removal of IUD)			
# Z735	- general anaesthetic - as sole procedure		56.70	6
G552	Removal of IUD without GA		23.80	

FEMALE GENITAL SURGICAL PROCEDURES

CERVIX UTERI

			Asst	Surg	Anae
	ENDOSCOPY				
Z731	Initial investigation of abnormal cervical cancer screening test or lesion of the lower genital tract, including vulva under colposcopic technique with or without biopsy(ies)			53.50	
Z787	Follow-up colposcopy with biopsy(ies)			53.50	
Z730	Follow up colposcopy without biopsy			28.35	

Payment rules:

1. Z731, Z787 and Z730 include collection of cervical cancer screening specimen(s) for cytology and/or endocervical curetting if performed.

2. Z731, Z787 and Z730 include collection of cervical cancer screening specimen(s) for HPV testing if performed for cervical cancer screening related indications.

3. G394 or G365 are *not eligible for payment* with Z731, Z787 and Z730.

4. Z720 is *not eligible for payment* with Z731, Z787 or Z730.

5. A screening colposcopy is included in the assessment.

[Commentary:
Colposcopy recommendations for people with abnormal cervical cancer screening results are available at https://www.cancercare.on.ca/.]

			Asst	Surg	Anae
	CAUTERIZATION				
UVC	Chemical			visit.fee	
Z732	Cryotherapy			17.30	
Z724	Electro			8.55	
# Z725	Dilatation and cauterization under general anaesthesia			50.90	6
	CONIZATION				
# Z766	Loop Electrosurgical Excision Procedure (LEEP)			85.65	
# S744	Cervix - cone biopsy - any technique, with or without D&C		6	190.25	6
Z729	Cryoconization, electroconization or CO_2 laser therapy with or without curettage for premalignant lesion (dysplasia or carcinoma in situ), out-patient procedure			38.35	
	EXCISION				
Z720	Biopsy - with or without fulguration			20.00	6
# S765	Amputation of cervix		6	206.30	6
	Cervical stump				
# S766	- abdominal		6	339.80	6
# S767	- vaginal		6	339.80	7

Note:
Excision of cervical polyp(s) under *general anaesthesia*, submit using Z720.

FEMALE GENITAL SURGICAL PROCEDURES

CORPUS UTERI

		Asst	Surg	Anae
	REPAIR			
# S774	Repair of incompetent cervix - not associated with pregnancy	6	142.50	6
	ENDOSCOPY			
	Hysteroscopy			
# Z582	- diagnostic		111.50	6
# Z583	- with uterine biopsy and/or D&C		133.70	6
# Z585	- with cannulization of tube(s), lysis of intrauterine adhesions		149.60	6
# Z587	- with resection of one or more endometrial polyps or fibroids, with or without D&C		206.35	6
# Z586	- with lysis of intrauterine adhesions/synechiae requiring a minimum of 60 minutes of surgical time		368.75	7

[Commentary:
Lysis of intrauterine adhesions/synechiae requiring less than 60 minutes constitutes the service described by Z585.]

Note:
Only one of Z582, Z583, Z585, Z587 or Z586 is eligible for payment for the same patient on the same *day*.

	INCISION OR EXCISION			
# E861	- paracervical block - payable in addition to endometrial sampling, ablation or curettage by same physician in an office - unilateral or bilateral	add	9.00	
Z770	Endometrial sampling		38.85	
E542	- when performed outside hospital	add	12.65	
# S772	Endometrial ablation by any method		225.90	6

Note:
Hysteroscopy (Z582, Z583, Z587) is *not eligible for payment* when rendered with endometrial ablation (S772).

	Abortion			
UVC	- spontaneous, complete		visit.fee	
# S768	- spontaneous, incomplete - including D&C		113.40	6
# S752	- induced - by any surgical technique up to and including 14 weeks gestation		112.40	6
# S785	- induced - by any surgical technique after 14 weeks of gestation		189.85	6

Payment rules:
S785 is *only eligible for payment* if the length of gestation is confirmed by ultrasound.

# S756	- missed abortion, or evacuation of molar pregnancy, by any surgical technique		120.45	6
# S770	- hysterotomy	6	245.40	7

CORPUS UTERI

		Asst	Surg	Anae
# S783	- hysterotomy with tubal interruption	6	257.05	6
# S754	Diagnostic curettage (with or without cauterization, biopsy of cervix removal of polyps, or hysterosalpingography)		97.20	6
# S764	Myomectomy by any technique except hysteroscopic	8	406.90	8
	INCISION OR EXCISION			
	Hysterectomy - with or without adnexa (unless otherwise specified)			
# S757	- abdominal - total or subtotal	8	643.35	8
# S816	- vaginal	8	643.35	8
# S758	- with anterior and posterior vaginal repair and including enterocoele and/or vault prolapse repair when rendered	8	733.45	8
# S759	- with anterior or posterior vaginal repair and including enterocoele and/or vault prolapse repair when rendered	8	655.05	8
# E090	- removal of one or both ovaries with moderate or severe endometrosis, to S757, S758 or S759	add	260.80	
# E862	- when hysterectomy is performed laparoscopically, or with laparoscopic assistance, abdominal or vaginal, to S757, S758, S759 or S816	add 25%		
# S710	- with omentectomy for malignancy	8	820.40	8
# S763	- radical (Wertheim or Schauta) - includes node dissection	8	1081.80	8
# S762	- radical trachelectomy - excluding node dissection	8	801.10	8
# E862	- when performed laparoscopically, to S710, S763, S762	add 25%		

Note:
S722, S760, S812, S813, S738, S741, S745, S747, S780, S781 and S782 are *not eligible for payment* when rendered with S757, S816, S758, S759, S710, S763 or S762.

[Commentary:
Hysterectomy (S757, S816) for benign conditions should only be performed when less invasive treatments have been found to be unsuccessful or are declined by the patient.]

# S776	Staging pelvic lymphadenectomy for carcinoma (laparoscopic or open)	8	462.30	8
# S781	Staging Para-aortic lymphadenectomy for carcinoma (laparoscopic or open) (not eligible for payment when rendered with Z578 and/or S776)	8	431.20	8
	REPAIR			
	Hysteroplasty			
# S779	- excision of septum	6	349.00	6
# S775	- unification of double uterus (Strassman)	6	431.45	7
# S777	- uterine inversion, operative	6	349.00	6
# S778	Presacral neurectomy (with or without ovarian neurectomy)	6	349.00	6

FEMALE GENITAL SURGICAL PROCEDURES

FALLOPIAN TUBE

		Asst	Surg	Anae
	EXCISION, SUTURE OR REPAIR			
	Ectopic pregnancy			
# S784	- management by any surgical technique	6	462.20	7
# E852	- with tuboplasty ... add		49.25	
# E860	- diagnostic laparoscopy prior to laparotomy ... add		131.45	
# S738	Salpingectomy or salpingo-oophorectomy (uni- or bilateral) ..	8	366.20	8
# S741	Tubal occlusion or interruption for the purpose of sterilization, by any method or approach	8	155.70	8
	Tubal plastic operation with/without operating microscope (unilateral or bilateral)			
# S735	- fimbriolysis	6	334.35	6
# S736	- salpingostomy	6	359.55	7
# S739	- fimbriolysis and salpingostomy	6	434.55	7
# E862	- when performed laparoscopically, to S735, S736 or S739 ... add 25%			
	Repair of extensive unilateral or bilateral tubal and peritubal disease			
	For infertility, pelvic inflammatory disease or endometriosis *with or without* laser treatment and ureterolysis			
# S743	- laparotomy	8	657.00	8
# E862	- when performed laparoscopically, to S743 ... add 25%			

Note:

1. Z737 or E854 are *not eligible for payment* when rendered same patient same *day* as S743 by any surgeon.

2. Reconstruction or repair for infertility following previous sterilization is not an insured service.

3. S162 is *only eligible for payment* in addition to S743 when records document that a transmural intestinal resection was rendered.

	Laparoscopy			
# Z552	- without biopsy	6	160.50	6
# Z553	- with biopsy and/or lysis of adhesions and/or removal of foreign body and/or cautery of endometrial implants	8	196.65	8
# E855	- with dye injection ... add		25.85	
# E857	- with D&C ... add		78.45	
# Z737	Laser treatment of extensive pelvic disease	8	215.80	8

FEMALE GENITAL SURGICAL PROCEDURES

OVARY

		Asst	Surg	Anae
	EXCISION (UNILATERAL OR BILATERAL)			
# S780	Biopsy of ovaries by laparotomy	8	257.05	8
	Oophorectomy			
# S745	- and/or oophorocystectomy	8	366.20	8
# E090	- removal of contralateral ovary with moderate or severe endometriosis, to S745 ... add		260.80	
# S782	- with total omentectomy	8	410.40	8
# S747	Para ovarian cystectomy	8	306.85	8
# S714	Second look exploratory laparotomy including biopsies, when done as part of chemotherapy protocol for ovarian carcinoma with or without total omentectomy	8	431.45	8
# S727	Ovarian debulking, for ovarian carcinoma of stage 2C, 3B, 3C, or 4 and may include hysterectomy, omentectomy, bowel resection, one or more biopsies and/or resection of pelvic peritoneum	8	1081.80	8
# E853	- with resection of diaphragm including reconstruction, to S727 ... add		145.00	
# S750	Radical resection pelvic and para-aortic nodes for cancer	8	797.45	8

Note:

1. Z758, S776 or S781 are *not eligible for payment* when rendered to the same patient same *day* as S750.

2. The ovarian excision codes include payment for unilateral or bilateral services except for S745 when the contralateral ovary has moderate or severe endometriosis and E090 can be billed.

3. For Diagnostic and Therapeutic procedures - see gynaecology.

ENDOCRINE SURGICAL PROCEDURES

THYROID GLAND

			Asst	Surg	Anae
		INCISION			
	Z726	Aspiration, thyroid cyst		38.00	
#	Z727	Percutaneous silicone core needle biopsy		71.30	7
	Z771	Aspiration biopsy, thyroid gland or nodule fine needle method		38.00	
#	S786	Abscess		82.25	6
		EXCISION			
		Biopsy			
#	S787	- surgical	6	213.15	7
		Thyroidectomy			
#	S788	- total	6	777.30	10
#	S793	- completion following previous subtotal or hemi-thyroidectomy	6	650.00	10
#	E880	- parathyroid(s) re-implantation, to S788 or S793 ..... add		184.60	
#	S789	- subtotal	6	656.25	10
#	S790	- hemi	6	525.15	10

ENDOCRINE SURGICAL PROCEDURES

PARATHYROID, THYMUS AND ADRENAL GLANDS

		Asst	Surg	Anae
	EXCISION			
# S795	Exploration and/or removal, parathyroids or parathyroid tumour	6	605.45	10
# S796	- if requiring splitting of sternum	10	687.60	13
# E880	- parathyroid(s) re-implantation ... add		184.60	
# E885	- transcervical thymectomy performed in association with parathyroidectomy ... add		106.00	
# S792	Re-exploration of neck for hyperparathyroidism	6	685.00	8
# E882	- with hemi thyroidectomy ... add		177.40	
# E883	- with subtotal thyroidectomy ... add		266.60	
# E884	- with total thyroidectomy ... add		374.00	
# S797	Thymectomy	10	615.10	13
# E683	- when performed thorascopically, by video-assisted thoracic surgery (VATS), by robotic-assisted surgery, or by uniportal approach, to S797 ... add 35%			
	Adrenalectomy or exploration			
# S798	- unilateral	10	692.90	10
# S799	- bilateral, with or without oophorectomy	10	1107.10	11
	Adrenalectomy			
# S800	- unilateral for pheochromocytoma	10	934.60	13
# E793	- laparoscopic or laparoscopic assisted, to S798, S799 or S800 ... add 25%			

Note:
When an adrenalectomy is performed in conjunction with a nephrectomy, and is incidental to the removal of the kidney, there should be no additional claim for the adrenalectomy.

# Z772	Thymus transplant		81.45	6

NEUROLOGICAL SURGICAL PROCEDURES

CRANIAL

			Asst	Surg	Anae
	Z811	Intravenous drug test for pain		54.10	6
#	E919	- intracranial duroplasty (greater than 2 cm diameter) to any intracranial procedure ... add		254.45	
#	E921	- repeat cranial procedure - payable in addition to any open intracranial procedure and N111, N114 and N116 but excluding N127 ... add		262.15	

BRAIN

Craniotomy plus excision

Astrocytoma, oligodendroglioma, glioblastoma or metastatic tumour

#	N103	- supratentorial	15	1877.70	15
#	N151	- infratentorial	15	2004.00	15
#	N152	Craniotomy plus lobectomy	15	1754.90	15
#	E901	- with operating microscope ... add		252.40	

Meningioma and other tumourous lesions, including pituitary tumours

#	N102	- supratentorial	15	2004.00	15
#	N153	- infratentorial or basal	15	2817.30	15
#	E901	- with operating microscope ... add		252.40	
#	E902	- lesion greater than 2 cm diameter, to N102 or N153 . add		454.15	
#	E903	- team fee for acoustic neuroma, same approach ... add		614.70	

Note:
Claims for N200 or R380 with N153 rendered for the same patient should be submitted using the manual review indicator and accompanied by supporting documentation.

NEUROSURGERY - OPEN SURGICAL APPROACH

Intracranial aneurysm repair

Craniotomy approaches

#	N105	Carotid circulation - per vessel	15	2665.20	20
#	N154	Vertebrobasilar circulation, including aneurysm of vein of Galen	15	2759.00	20
#	E901	- with operating microscope, to N105 or N154 ... add		252.40	
#	E898	- lesion greater than 2.5 cm, to N105 or N154 ... add		283.80	
#	E979	- clinoidal drilling for complex aneurysms, to N105 or N154 ... add		396.70	
#	E908	- removal of intracerebral and/or subdural haematoma in conjunction with a ruptured intracranial aneurysm or arteriovenous malformation, to N105 or N154 ... add		304.30	

Cerebral vascular malformation

Craniotomy

#	N106	- supratentorial	15	2310.05	20
#	N155	- infratentorial	15	2244.00	20
#	E895	- of cerebral arteriovenous malformation greater than 4 cm, to N106 or N155 ... add		373.80	
#	E901	- with operating microscope, to N106 or N155 ... add		252.40	

NEUROLOGICAL SURGICAL PROCEDURES

CRANIAL

		Asst	Surg	Anae
# E908	- removal of intracerebral and/or subdural haematoma in conjunction with a ruptured intracranial aneurysm or arteriovenous malformation, to N106 or N155 ..... add		304.30	
# N218	Extracranial-intracranial microvascular anastomosis superficial temporal artery	15	1364.05	15
# N156	Occipital artery	15	1229.55	15
# E904	- posterior fossa ..... add		241.00	
# N121	Extracranial-intracranial long venous bypass (from internal carotid in the neck or any of the trunk vessels in the neck or chest to a major intracerebral vessel, i.e. vertebral, internal carotid, middle cerebral)	15	1711.40	15

Carotid-cavernous fistula

# N108	Obliteration of intracranial dural arteriovenous fistula (including carotid cavernous fistula) to include craniotomy and combined cervical and intracranial procedure	15	1229.55	15

INTRACRANIAL ENDOVASCULAR SURGERY

Intracranial aneurysm repair

Endovascular approaches

# N122	Anterior circulation	15	2302.30	20
# N125	Posterior circulation, including vein of Galen	15	2302.30	20
# E894	- aneurysm greater than 2.5 cm, to N122 or N125..... add		229.55	
# E989	- balloon assistance or balloon standby, to N122 or N125 ..... add		300.00	
# E990	- stent assistance, to N122 or N125 ..... add		400.00	
# E991	- flow-diverter or intra-saccular device deployment, to N122 or N125 ..... add		700.00	

Payment rules:

1. N122 and N125 are comprehensive intracranial endovascular management services including endovascular treatment of all intracranial aneurysm pathology in the anatomic area described.
2. N122 and N125 include catheter placement, angiography and any image guidance. Obtaining and interpreting any images in conjunction with N122 and N125 are *not eligible for payment* to any physician.
3. No 'N'-prefix services other than N122 and N125 are eligible for payment during the same operative session.
4. E989, E990, and E991 are payable once per eligible fee code per operative session. These fee codes are not payable per vessel or per device (even if multiple devices are used in the same category)
5. E991 is *not eligible for payment* for liquid embolic agents, coil embolization or stent-assisted coiling

[Commentary:

1. "Intra-saccular devices" refer to endovascular implants designed to be deployed within the aneurysm sac to achieve in-saccular flow disruption or occlusion (e.g., WEB, Artisse).

NEUROLOGICAL SURGICAL PROCEDURES

CRANIAL

		Asst	Surg	Anae
2.	"Flow-diverter devices" refer to endovascular implants designed to be deployed within the parent artery across the neck of an aneurysm to redirect blood flow away from the aneurysm sac.			
	Cerebral arteriovenous malformation			
	Endovascular approach for obliteration			
# N107	Endovascular approach to include balloon catheter or embolization techniques for arteriovenous malformation ...	15	1456.95	15
	Carotid-cavernous fistula			
# N118	Endovascular approach to include balloon catheter or embolization techniques for dural arteriovenous fistula including carotid cavernous fistula	15	952.05	15
	Endovascular thrombectomy (EVT)			
# N131	Endovascular thrombectomy for acute ischemic stroke secondary to large vessel occlusion.....	15	1456.95	15
# E987	- with intracranial stent, to N131.....	add	600.00	
# E988	- with extracranial stent, to N131.....	add	450.00	
	Payment rules:			
1.	N131 includes all components of the EVT including vascular access, catheter placement, angiography, any image guidance, mechanical thrombectomy and revascularization assessment.			
2.	Obtaining and interpreting any images in conjunction with N131 are *not eligible for payment* to any physician. No other 'X' or 'J'-prefix services are eligible for payment during the same operative session.			
3.	E987 and E988 are payable once per eligible fee code per EVT session regardless of the number of stents deployed			
	SPONTANEOUS INTRACEREBRAL HAEMORRHAGE			
	Craniotomy plus removal			
# N104	- supratentorial.....	15	1416.40	15
# N157	- infratentorial.....	15	1704.00	15
# N120	Burr hole plus drainage.....	15	481.90	15
	INTRACRANIAL CYST			
	Craniotomy plus evacuation			
# N158	- supratentorial.....	15	968.50	15
# N159	- infratentorial.....	15	1065.05	15
	Note: N158, N159 to include interventriculostomy.			
# N160	Burr hole plus aspiration	15	426.95	15

NEUROLOGICAL SURGICAL PROCEDURES

CRANIAL

		Asst	Surg	Anae
	INTRACRANIAL ABSCESS			
# N117	Craniotomy	15	1631.15	15
	Burr hole			
# N115	- aspiration	7	578.85	7
# Z818	- subsequent aspiration through existing burr hole within 30 days		215.35	
# Z813	- plus needling of brain for biopsy	7	560.85	7
# N127	Re-opening of craniotomy for post-operative haematoma or for removal of bone flap	11	518.85	11
# N113	Craniotomy for brain biopsy (other than for tumour)	11	1019.15	11
# N130	Craniotomy plus midline commissurotomy	15	1014.85	15
# N109	Hemispherectomy	15	1878.35	15
# N110	Lobectomy and/or excision of cortical scar for epilepsy	15	2432.45	15
# N128	Repair of encephalocoele	15	924.70	15
# N129	Posterior fossa decompression for Arnold Chiari malformation	15	1577.05	15
# E901	- with operating microscope, to N129	add	252.40	
# N126	Intra-oral approach to lesions of the skull base and upper cervical spine	15	1442.95	15
# N123	Stereotaxis - intracranial (to include ventriculography)	11	623.20	11
# E931	- with implantation (and removal) of radioactive sources into brain tumour	add	222.85	
# E896	- sophisticated micro-electrode recording during stereotaxis, to N123	add	400.40	

Functional stereotaxy

Payable for neuroablative and implantation therapy for treatment of movement disorders of basal ganglia and connections (e.g. Parkinson's disease). Must include pre-operative planning, application of stereotactic frame, intra-operative imaging, micro-electrode placement and recording, ablation of lesion and/or electrode implantation.

# N124	Functional stereotaxy	9	2194.70	11

Note:
N123 performed in conjunction with N124 is an insured service payable at nil.

# N119	Intracranial implantation of chronic surface electrodes	11	1364.90	11
# Z823	Implantation or revision of stimulation pack or leads (peripheral nerve, brain)	8	434.95	8
# Z824	Removal of chronic surface or depth electrodes		266.60	
# Z802	Ventricular puncture through previous burr hole or fontanelle or puncture and/or aspiration of cisterna		81.65	7

NEUROLOGICAL SURGICAL PROCEDURES

CRANIAL

			Asst	Surg	Anae
	Ventriculoscopy				
# Z825	- to include burr hole			731.20	7
# E916	- with biopsy	add		233.30	
# E917	- with interventriculostomy	add		301.70	
# E918	- with removal of foreign body	add		132.80	
# Z820	Insertion of intracranial pressure monitor and/or external ventricular drainage		nil	395.85	7
# Z812	Subsequent revisions or replacements within 30 days	each	6	279.55	7

Payment rules:

1. Z820 is limited to one per patient per day.

NEUROLOGICAL SURGICAL PROCEDURES

CRANIAL

		Asst	Surg	Anae
	CRANIO-CEREBRAL INJURIES			
UVC	Non-operative care		visit. fee	
	Reduction of skull fracture			
# N139	- simple, depressed	7	634.90	7
# N140	- compound	11	1098.45	11
# E912	- with repair of dural laceration ... add		233.30	
	Extracerebral haematoma and/or hygroma			
# N143	Drainage by burr hole(s) - unilateral	7	647.80	7
# N144	Drainage and/or removal by craniotomy	11	999.30	11
	CEREBRAL INJURY			
# N148	Removal of intracerebral haematoma and/or debridement of traumatized brain (includes management of any skull fracture)	15	1341.55	15

Note:
N143 is *not eligible for payment* in addition to N144 or N148 for the same craniotomy procedure.

# N149	Removal of foreign body from brain	15	968.50	15
# N150	C.S.F. leak - intracranial repair (to include trans-sphenoidal approach)	15	1065.45	15
# N200	Decompressive craniectomy (frontal, sub-temporal)	11	1018.45	11

Note:
Claims for N200 with N153 rendered for the same patient should be submitted using the manual review indicator and accompanied by supporting documentation.

	Subdural tap(s)			
# Z803	- unilateral		53.10	
	CRANIAL NERVES			
# N258	Percutaneous coagulation or glyceral injection of gasserian (trigeminal) ganglion or root - unilateral	nil	504.95	11
# N259	V - Decompression or rhizotomy (partial or complete) trigeminal nerve	11	671.75	11
# N265	VII - Differential section facial nerve for hemi-facial spasm (extracranial approach)	6	348.30	6
# N266	Anastomosis hypoglossal or accessory to facial nerve	6	727.80	6
# N267	Occipital and/or suboccipital craniectomy for compression, decompression or section of cranial nerves	11	1280.90	11
# E901	- with operating microscope, to N266 or N267 ... add		252.40	
# N269	XI - Division of nerves to sternomastoid in neck	6	292.25	7
# Z826	Inferior dental neurectomy	6	184.00	6
# Z827	Infraorbital or supraorbital neurectomy	6	158.45	7

NEUROLOGICAL SURGICAL PROCEDURES

CRANIAL

		Asst	Surg	Anae
CAROTID AND VERTEBRAL ARTERIES				
# N223	Vertebral endarterectomy	10	798.80	10
# Z815	Temporal artery - biopsy, ligation or cryosurgery		200.00	6
# Z808	Progressive carotid occlusion by Selverstone clamp	10	317.85	10
# Z807	Removal of Selverstone clamp	10	266.60	10

[Commentary:
For carotid endarterectomy, refer to R792 on page Q13 of the Cardiovascular Surgical Procedures section.]

EXTRACRANIAL ENDOVASCULAR SURGERY

# N132	Carotid and vertebrobasilar artery stenting, with or without embolic protection device	15	1456.95	15

Payment rules:
N132 includes all components of the service including vascular access, intraoperative imaging/ fluoroscopy, selective catheterization, pre/post-dilatation angioplasty as required, stent deployment, and embolic protection device placement, if used.

NEUROLOGICAL SURGICAL PROCEDURES

CRANIAL

		Asst	Surg	Anae
	CSF SHUNTING PROCEDURES			
# N230	CSF shunting procedures - all types	11	1105.25	11
	Revision of CSF shunt			
# N245	- operative - all types	7	674.70	7
# Z801	- non-operative		51.50	
	Conversion of shunt (e.g. ventriculoperitoneal to ventriculoatrial)			
# N174	- includes removal of existing shunt	7	585.90	7
# N246	Removal of shunt - any type	7	289.70	7
# Z809	Insertion of CSF reservoir (Ommaya) including burr holes	11	428.90	11
# N249	Third ventriculostomy	11	1084.25	11
# Z821	Injection of diagnostic or therapeutic agent into shunt apparatus		53.10	
	SKULL			
	Repair of skull defect			
# N161	Cranioplasty, any non-autologous material	11	669.15	11
# N201	Rib graft cranioplasty (defect less than 7.5 cm)	15	855.80	15
# N202	Replacement of bone flap	11	540.95	11
# N203	Skull tumour, excision	11	408.30	11
	Craniosynostosis, linear craniectomy			
# N206	- one suture	11	430.75	11
# N207	- multiple sutures	15	563.50	15
	Morcellation procedure			
# N162	- one suture	11	430.75	11
# N163	- multiple sutures	15	614.70	15
	Lateral canthal advancement			
	Unilateral			
# N164	- one surgeon	15	696.35	15
# N165	- two surgeons, major portion	15	430.75	15
# N166	- two surgeons, lesser portion		345.35	
	Bilateral			
# N167	- one surgeon	15	952.55	15
# N168	- two surgeons, major portion	15	614.70	15
# N169	- two surgeons, lesser portion		461.10	
	Craniotomy			
# N208	- for craniofacial repair	15	918.15	15
# E922	- with repair of frontonasal encephalocele ..... add		215.35	

CRANIAL

		Asst	Surg	Anae
	ORBIT			
	Craniotomy			
# N211	- plus removal of orbital tumour	15	1116.60	15
# N212	- plus orbital decompression (roof of orbit with or without lateral wall)	15	1045.45	15
# N213	- for decompression of optic nerve(s)	15	1116.60	15
# E901	- with operating microscope, to N211 or N213 ..... add		252.40	

CRANIAL

		Asst	Surg	Anae

BRAIN

SKULL BASE SURGERY – SURGICAL ACCESS - ENDONASAL APPROACH

Surgeon not rendering resection of lesion(s)

# N112	Endonasal endoscopic or microscopic approach for surgical access to sella turcica - includes when rendered middle turbinate reductions, maxillary antrostomies, ethmoidotomies, ethmoidectomies, sphenoidotomies, septotomy, septoplasty and septal mucosal flap(s) harvest associated with septotomy or sphenoidal mucosal flap(s) .	nil	1360.00	nil

Surgeon rendering resection of lesion(s)

E905	- endonasal endoscopic or microscopic approach for surgical access to sella turcica - includes when rendered middle turbinate reductions, maxillary antrostomies, ethmoidotomies, ethmoidectomies, sphenoidotomies, septotomy, septoplasty and septal mucosal flap(s) harvest associated with septotomy or sphenoidal mucosal flap(s), to N111, N114 or N116 ..... add		750.00	
E886	- extended endonasal endoscopic approach, for access to each anatomical area, anterior skull base, clivus/posterior fossa, C1 - C2, occipital condyle(s) when rendered, to N111, N112, N114 or N116..... add		800.00	

Payment rules:
No services from the Respiratory Surgical Procedures or Integumentary System Surgical Procedures sections of this *Schedule* are eligible for payment with N111, N112, N114 or N116.

SKULL BASE SURGERY – RESECTION OF LESION(S) - ENDONASAL APPROACH

Pituitary lesion(s)

# N111	Transsphenoidal microscopic resection of lesion(s) originating in the sella turcica requiring simple closure, repair and/or reconstruction of surgical defect(s)		2021.40	20
# N114	Transsphenoidal endonasal endoscopic resection of lesion(s) originating in the sella turcica requiring simple closure, repair and/or reconstruction of surgical defect(s)		1742.45	20
E887	- resection of pituitary lesion(s) extending beyond the sella turcica to the optic nerve(s), optic chiasm or hypothalamus, to N111 or N114 ..... add		500.00	

Non-pituitary lesion(s)

# N116	Endonasal endoscopic resection of non-pituitary lesion(s) not originating from pituitary tissue requiring simple closure, repair and/or reconstruction of surgical defect(s)		2243.45	20
E888	Resection of non-pituitary lesion(s) involving the sellar region that extends to the optic nerve(s), optic chiasm or hypothalamus, to N116..... .add		500.00	

CRANIAL

		Asst	Surg	Anae

Complex endonasal endoscopic resection of pituitary and non-pituitary lesion(s)

E889	- complex endonasal endoscopic resection from cranial nerves, to N114 or N116	add	520.00
E890	- complex endonasal endoscopic resection from cavernous sinuses, to N114 or N116.....	add	520.00
E891	- complex endonasal endoscopic resection from frontal or temporal lobe or brainstem, to N114 or N116	add	520.00

Payment rules:

1. E889, E890 and E891 are *only eligible for payment* to a physician who has completed a fellowship in skull base surgery or who has equivalent experience.

2. E889, E890 and E891 are *only eligible for payment* when rendered with E887 or E888.

3. Harvesting and/or use of any autologous materials (e.g. bone, fascia, dermis, muscle) is *not eligible for payment* with N111, N112, N114 or N116.

[Commentary:
Examples of non-pituitary lesions include meningioma, craniopharyngioma, chordoma.]

SKULL BASE SURGERY – COMPLEX CLOSURE, REPAIR AND/OR RECONSTRUCTION OF DEFECT(S)

E892	- harvesting of pedicled vascular flap(s) greater than 3cm in size for use in complex endoscopic closure, repair and/or reconstruction of surgical defect(s) to N111, N112, N114 or N116.....	add	500.00
E893	- complex closure, repair and/or reconstruction of surgical defect(s) - includes duroplasty when rendered to N111, N112, N114 or N116.....	add	555.00

Note:
A complex closure, repair and/or reconstruction is defined as surgical closure, repair and/or reconstruction:

a. for a lesion extending beyond the sella turcica; and

b. is necessary for repair of CSF leak(s); and

c. requires the use of pedicled vascular flap(s) greater than 3 cm in size.

Payment rules:

1. N111, N114 and N116 requires simple closure, reconstruction and/or repair of surgical defect(s) and includes the harvesting and use of any autogenous materials and/or pedicled flap(s) less than 3 cm in size. E892 and E893 are *not eligible for payment* for simple closure, reconstruction and/or repair.

2. E919 is eligible for payment, if rendered, when performed as part of a simple closure, reconstruction and/or repair. E919 is *not eligible for payment* with E893.

[Commentary:
E892 and E893 may only be claimed when a complex closure, repair and/or reconstruction is required, as defined in the note above.]

PERIPHERAL NERVES

		Asst	Surg	Anae
# E906	- to basic fee for neurolysis, nerve tumour excision, nerve suture, nerve transfer, or nerve graft when using operating microscope..... add 40%			
# E925	- to basic fee for a repeat peripheral nerve procedure, (i.e., any N-prefix surgical fee code in the Peripheral Nerves section), or when acute nerve injury repair by suture, transfer or graft is delayed for more than 4 weeks..... ..... add 30%			
	Exploration, decompression, division, excision, biopsy, neurolysis and/or transposition by open surgical exposure			
# N188	- minor nerve - including digital, cutaneous or lateral femoral cutaneous nerve.....	6	153.70	7
# N285	- major nerve - excluding carpal tunnel or ulnar nerve at elbow.....	7	283.50	7
# N283	Decompression, for thoracic outlet syndrome including excision of cervical and/or first rib and scalenotomy.....	7	389.05	7
# N282	Brachial plexus (excluding excision of cervical and/or first rib and scalenotomy).....	6	1466.25	6
	Payment rules: **1.** N282 is eligible for payment with N283 when a complete brachial plexus neurolysis is performed in addition to excision of cervical and/or first rib, and scalenectomy.			
# N290	Carpal tunnel release.....	6	197.15	6
# N190	Exploration and/or decompression and/or neurolysis of ulnar nerve (elbow).....	7	286.20	7
# N189	Ulnar nerve transposition at elbow - may include exploration, decompression and/or neurolysis.....	7	368.55	7
# N177	Sciatic nerve in buttock.....	7	430.75	7
# N184	Decompression of posterior tibial or common peroneal nerve	6	165.20	7
# N286	Tumour or neuroma - major nerve.....	7	317.85	7
# N295	Excision of Morton's or subcutaneous neuroma, glomus or small cutaneous nerve tumour	6	109.95	6
# E911	- implantation of neuroma into bone or muscle, to N286 or N295 ..... add 40%			
	Nerve suture			
# N289	- minor - (sensory/cutaneous nerve).....	7	296.65	7
# N287	- major - (mixed sensory and motor nerve, or pure motor nerve)	7	593.25	7
	Nerve transfer			
# N293	- minor – (sensory/cutaneous nerve).....	6	363.90	6
# N291	- major – (mixed sensory and motor nerve, or pure motor nerve)	6	841.75	6

[Commentary:
See Ocular and Aural Surgical Procedures for Facial nerve decompression, grafting fee codes and Neurological Surgical Procedures – Cranial for Facial nerve transfer fee codes]

PERIPHERAL NERVES

		Asst	Surg	Anae
	Nerve graft			
# N183	- minor - (sensory/cutaneous nerve).....	6	471.05	6
# N288	- major - (mixed sensory and motor nerve, or pure motor nerve)	6	927.55	6
# E899	- for each additional cable, to N288 ..... add		102.45	

Payment rules:

1. N188 or N285 when performed through the same incision as flexor tendon repairs R585 or E581 is an insured service payable at nil.

2. N289, N287, N293, N291, N183 and/or N288 include exploration, decompression, division, excision, and/or neurolysis of the nerve(s) involved, if performed.

3. N293 or N291 are *only eligible for payment* for coaptation of one or more donor nerve fascicles to a recipient nerve.

4. Nerve graft fees include harvesting of the nerve(s) required for grafting.

5. Peripheral nerve fees codes include any guidance, nerve stimulation, or nerve mapping if performed.

		Asst	Surg	Anae
	Implantable peripheral nerve stimulators			
# Z816	Implantation of electrode for peripheral nerve stimulation.....	6	241.00	6
# Z823	Implantation or revision of stimulation pack or leads, (peripheral nerve, brain)	8	434.95	8

NEUROLOGICAL SURGICAL PROCEDURES

NOT ALLOCATED

OCULAR SURGICAL PROCEDURES

EYEBALL

		Asst	Surg	Anae
	EXAMINATION			
# Z850	- when sole procedure or with unlisted minor procedures with general anaesthesia		200.00	6
E982	- when service is rendered to newborn, infant or child (ages 0 to 15 inclusive), to Z850 ..... add 30%			
	EXCISION			
# E108	Enucleation, donor eye, post-mortem (one or both)		131.25	
	REPAIR			
# E104	Removal of intraocular foreign body	6	542.00	6
# E105	Non-magnetic - posterior segment	6	424.35	6

Payment rules:

1. E105 is eligible for payment for removal of silicone oil where that is the sole procedure performed.
2. E105 is eligible for payment in addition to another procedure where the second procedure is independent or unrelated to the retinal detachment and removal of the silicone oil would not be considered a preparatory component required to facilitate the additional procedures.

	Penetrating wound			
# E106	- with prolapse of intraocular tissue	6	640.00	7
# E107	- without prolapse of intraocular tissue	6	496.00	7

OCULAR SURGICAL PROCEDURES

CORNEA

		Asst	Surg	Anae
	INCISION			
# Z851	Therapeutic paracentesis		70.00	6
# E175	- therapeutic paracentesis done in conjunction with E186, E187 or E149 ... add		20.00	
# Z844	Diagnostic Paracentesis for: 1) suspected intraocular infection; 2) intraocular inflammation / uveitis; or 3) suspected cancer involving the intraocular structures or fluids		100.00	6

Payment rules:

1. Z851 is *not eligible for payment* for same patient same day as E175 or Z844.

2. Z851 and Z844 are *not eligible for payment* for same patient same day as E186, E187, or E149.

3. Z844 is *only eligible for payment* if the sample obtained through paracentesis is sent for one or more of the following:

a. culture

b. cellular analysis

c. molecular analysis

CORNEAL CROSS-LINKING

Corneal Cross Linking (CXL) is eligible for payment if the patient has one of the following medical indications:

a. Mild to moderate progressive keratoconus;

b. Corneal thinning or ectasia following laser photorefractive or phototherapeutic surgery;

c. Pellucid marginal corneal degeneration; and

d. Recurrent keratoconus after corneal transplantation.

E202	Corneal cross-linking		200.00	

Payment rules:

E202 is *not eligible for payment* for the same patient and performed on the same day as E117.

Removal embedded foreign body

- local anaesthetic

Z847	- one foreign body		33.00	
Z848	- two foreign bodies		45.00	
Z845	- three or more foreign bodies (see General Preamble GP12)		I.C	
# Z852	- general anaesthetic		74.20	6

Chelation of band keratopathy with EDTA

Z849	- local anaesthetic		153.80	
# Z863	- general anaesthetic		150.00	6
# E128	Anterior chamber - open evacuation of clot	6	496.00	6

OCULAR SURGICAL PROCEDURES

CORNEA

		Asst	Surg	Anae
	EXCISION			
	Pterygium			
# E206	- simple (unilateral)		175.00	6
# E205	- with partial keratectomy	6	355.00	6
# E207	- with lamellar graft	6	453.00	6
# E937	- with autogenous conjunctival transplant ... add		191.05	
# E948	- with mucous membrane graft ... add		165.35	
# E117	Keratectomy or relaxing incisions post penetrating keratoplasty or post traumatic corneal scar (non cosmetic)	6	308.30	6
	Excision of dermoid			
# E118	- with partial keratectomy		308.30	6
# E119	- with lamellar graft	6	542.00	6
	Ulcer cautery			
	Including laser and/or electrocautery, epithelial debridement, cryotherapy, corneal b*iop*sy and/or corneal puncture			
Z871	- local anaesthetic		26.60	
# Z853	- general anaesthetic		74.20	6
	REPLACEMENT			
	Corneal transplant			
# E121	- penetrating	6	740.00	7
# E951	- with artificial prosthesis ... add		52.40	
# E122	- lamellar	6	590.00	7
# E124	Limbal stem cell transplant	6	740.00	8
# E123	Division of iris to cornea and/or angle		161.75	6

Payment rules:

1. E117 is *not eligible for payment* with E124.

2. E123 is *not eligible for payment* with E133, E132, E114, E115, E156 or E157

3. E121 is eligible for payment for performing DSEK (Descemet's Stripping Endothelial Keratoplasty), DMEK (Descemet's Membrane Endothelial Keratoplasty) and DALK (Deep Anterior Lamellar Keratoplasty)

4. E123 is *only eligible for payment* in addition to E121 under one of the following circumstances:

- **a.** Previous corneal transplantation,
- **b.** Post-operative corneal melt,
- **c.** Corneal perforation from trauma or infection, or
- **d.** Congenital conditions with iris corneal adhesions only when the iris adhesion is documented preoperatively and documented in the operative record.

5. E117 is *not eligible for payment* with E121.

OCULAR SURGICAL PROCEDURES

SCLERA, IRIS AND CILIARY BODY

		Asst	Surg	Anae
	SCLERA			
# E127	Sclerotomy, posterior		166.45	4
	Payment rules: E127 is *not eligible for payment* with E152 or E153.			
	GLAUCOMA FILTERING PROCEDURES			
# E132	Glaucoma filtering procedures ab externo (e.g. trabeculectomy, trabeculotomy, deep sclerectomy, viscocanalostomy)	6	550.00	6
# E114	Plate and tube glaucoma drainage procedure	6	840.00	6
# E115	Minimally invasive glaucoma surgery or minimally invasive bleb surgery, ab interno or ab externo (e.g. Hydrus stent, iStent, Trabectome, Kahook dual blade, canaloplasty, XEN Gel Stent, PreserFlo MicroShunt)	6	350.00	6
# E110	- with cataract extraction, all types of, by any procedure, includes extraction of native lens and insertion of artificial intraocular lens (same eye), to E132, E114, E115 ..... add		271.50	
# E984	- following previous glaucoma filtering procedure, to E132, E114, E115 ..... add		137.50	
	Payment rules: E132 is *not eligible for payment* for primary lensectomy or bleb repair.			
	IRIS AND CILIARY BODY			
# E131	Laser iridotomy	6	161.75	6
# E134	Laser angle surgery or trans-scleral or endoscopic cyclo-photocoagulation of the ciliary body		205.55	7
# E130	Iridectomy - surgical - when sole procedure	6	308.30	6
# E212	Bleb repair with conjunctival pull-down	6	210.00	6
# E213	Bleb repair with conjunctival, scleral or mucous membrane graft	6	262.50	6
# E133	Extraocular glaucoma procedures	6	182.75	6
# E135	Ciliary body re-attachment	6	505.45	7
# E156	Intraocular suturing of iris/pupillary defect	6	350.00	7
# E157	Placement and/or suturing of iris prosthetic device with or without suturing of iris/pupillary defect	6	550.00	7

Payment rules:

1. E950 is *not eligible for payment* in conjunction with E156 or E157.

2. E156 is *not eligible for payment* for repair of iris tears resulting from cataract extraction.

OCULAR SURGICAL PROCEDURES

CRYSTALLINE LENS

		Asst	Surg	Anae
	INCISION			
# E139	Capsulotomy or primary or subsequent needling	6	161.75	5

Payment rules:
E139 is *not eligible for payment* when rendered to facilitate the main operative procedure (e.g. as part of a vitrectomy to improve visualization or for lens extraction).

EXCISION

Cataract

To include retrobulbar injection when administered by surgeon

# E140	- all types of, by any procedure, includes extraction of native lens insertion of artificial intraocular lens.....		397.75	5
# E141	- dislocated lens extraction	6	505.45	5
# E950	- insertion of artificial intraocular lens, to E141 ..... add		92.50	
# E138	Scleral fixation of artificial intraocular lens and/or sutured capsular tension device.....	6	450.00	5
# E144	Removal of artificial intraocular lens	6	450.00	5
# E950	- insertion of artificial intraocular lens, to E144 ..... add		92.50	
# E145	Repositioning surgical of dislocated intraocular lens		350.00	5
# E146	Insertion of artificial intraocular lens for aphakic eye	6	400.00	5

Payment rules:

1. Time units and anaesthesia extra units listed on GP97 are *not eligible for payment* with anaesthesia services for E138C, E139C, E140C, E141C, E144C, E145C or E146C.

2. E003C is not payable for anaesthesia services rendered for E138, E139, E140, E141, E144, E145 or E146.

3. E145 and E146 are *only eligible for payment* for revisions to previously implanted artificial intraocular lens.

4. E950 is *only eligible for payment* with E144 when dislocated implanted artificial intraocular lens is removed and replaced during same surgery.

5. E146 is *not eligible for payment* with E140, E141 or E144.

[Commentary:

1. Refer to E023C on GP100 for anaesthesia services other than procedural sedation rendered in support of E138, E139, E140, E141, E144, E145 and E146.

2. Local infiltration or topical anaesthesia used as an anaesthetic for any procedure is *not eligible for payment*.]

OCULAR SURGICAL PROCEDURES

VITREOUS

		Asst	Surg	Anae
	Vitrectomy			
# E940	- Anterior vitrectomy by corneal or pars plana approach, when done in conjunction with another intraocular procedure.....add		105.00	
# E148	Vitrectomy, complete and by posterior approach, with vitreous exchange (air, gas, or artificial vitreous substance)	6	810.00	7
# E938	- with transscleral retinal suturing, to E148 .....add		213.20	
	Injections and/or paracentesis			
# E186	Intravitreal injection of medication for the treatment of wet macular degeneration, left eye	nil	90.00	5
# E187	Intravitreal injection of medication for the treatment of wet macular degeneration, right eye.....	nil	90.00	5
# E149	Vitreous injection or aspiration, posterior with needle for culture and/or injection of medication, other than for macular degeneration	nil	90.00	5
# E175	- therapeutic paracentesis, to E186, E187, or E149 .....add		20.00	
# E142	Preretinal membrane peeling or segmentation to include vitrectomy, complete and by posterior approach, with vitreous exchange (air, gas, or artificial vitreous substance)	6	920.00	6

Payment rules:

1. E186 and E187 are each limited to 12 per patient per 12-month period. Services in excess of this limit are *only eligible for payment* in exceptional circumstances where warranted by clinical conditions. Physicians must document the appropriate clinical indications for services in excess of the limit on the patient's permanent medical record.
2. Time units and anaesthesia extra units listed on GP97 are *not eligible for payment* with anaesthesia services for E186C, E187C, or E149C.
3. E003C is not payable for anaesthesia services rendered for E186, E187, or E149.
4. If paracentesis is performed through the same site as E186, E187, or E149, E175 is *not eligible for payment.*
5. E148, E142, E149, E186, E187, E175, Z851 are *not eligible for payment* with E112
6. E940 is *not eligible for payment* with E142 or E148.
7. E154 is *not eligible for payment* with E142 except when extensive pan-retinal laser coagulation is required to treat underlying pathology resulting in two separate procedures being performed and each are documented in the medical record.
8. E151 is *only eligible for payment* with E142 or E148 when laser is performed to treat a retinal detachment with presence of subretinal fluid, in association with the vitrectomy.
9. E141 is *only eligible for payment* with E142 or E148 when removal of the lens fragments in the posterior vitreous substance requires the use of a separate instrument (fragmatome unit).
10. E148 and E142 include the removal of silicone oil along with residual vitreous, if performed.

VITREOUS

Asst	Surg	Anae

11. E149 is *not eligible for payment* at the time of surgery when the agent administered (e.g. antibiotics or steroids) is in relation to the condition being addressed by the primary operative procedure. E149 is *only eligible for payment* in addition to the primary operative procedure where there is a clearly separate unrelated diagnosis and E149 is the primary treatment for the separate unrelated condition.

[Commentary:

1. Current research supports “treat and extend” injection protocols with most studies supporting that an average of approximately 8 injections per year will control disease. Patients should only receive more than 8 injections per year in the presence of clinical and diagnostic evidence of disease instability.

2. Refer to E023C on GP100 for anaesthesia services other than procedural sedation rendered in support of E186, E187, or E149.

3. Local infiltration or topical anaesthesia used as an anaesthetic for any procedure is *not eligible for payment*.]

OCULAR SURGICAL PROCEDURES

RETINA AND EXTRA OCULAR MUSCLES

		Asst	Surg	Anae
	RETINA			
# E151	Re-attachment of retina and choroid by diathermy, photocoagulation or cryopexy as an initial procedure	6	282.65	6
# E152	Scleral resection or buckling procedure - with or without diathermy, photo-coagulation or cryopexy, primary or subsequent procedure.....	6	700.00	7
# E153	Revision for retinal detachment following unsuccessful operation or fresh detachment in the same eye with or without diathermy, photocoagulation or cryopexy.....	6	840.00	7
# E161	Removal of scleral implant.....		250.00	6
# E154	Photocoagulation (xenon, argon laser, etc.) - one eye		182.75	6
# E125	Laser retinopexy for Retinopathy of Prematurity or retinoblastoma – one eye		750.00	6
# E126	Laser retinopexy for Retinopathy of Prematurity or retinoblastoma – both eyes		1245.00	6
# E155	Cryopexy - extraocular or sub-conjunctival - one eye.....		205.00	6
# E112	Pneumatic Retinopexy.....		160.00	6

Payment rules:

1. E148, E142, E149, E186, E187, E175 and Z851 are *not eligible for payment* with E112 on the same day.

2. A maximum of one E112 is eligible for payment per eye per day.

	REPAIR			
	Strabismus procedures			
# E185	- horizontal or vertical rectus muscle (per muscle)	6	525.15	6
# E184	- inferior oblique muscle (per muscle)	6	543.65	6
# E183	- superior oblique muscle (per muscle)	6	600.00	6
# E182	- Transposition of extraocular muscle to treat paretic or lost, damaged eye muscle	6	600.00	6
# E949	- for adjustable suture ..... add		180.00	
# E877	- repeat strabismus procedure(s), to E185, E184, E183, or E182..... add 30%			

Payment rules:

A maximum of 4 of any combination of E182, E183, E184, E185 are eligible for payment per patient per day.

OCULAR SURGICAL PROCEDURES

ORBIT

		Asst	Surg	Anae
	INCISION			
# E164	Drainage of abscess		620.70	7
	EXCISION			
# E102	Enucleation, with or without primary implant	6	695.85	7
# E103	Evisceration, with or without primary implant	6	695.85	7
# E109	Enucleation/evisceration with insertion of implant and reattachment of extraocular muscles	6	809.50	7
	Note: E102 or E103 are *not eligible for payment* with E109.			
# E171	Exenteration	6	1005.00	6
# E941	- with major plastic repair	add	296.90	
# E181	Secondary orbital implant	6	640.00	6
	Tumour or foreign body			
# E166	- anterior route	6	780.70	6
# E167	- posterior exposure	6	1114.05	7
# E172	Biopsy (anterior)		200.00	6
# E168	Biopsy (posterior exposure)		308.30	6
# E165	Lateral orbitotomy (Kronlein)	6	1258.60	7
	Decompression			
# E169	- two or more walls	6	1267.55	6
	RECONSTRUCTION			
	Dermis fat graft			
# E160	- immediately following enucleation		190.30	
# E163	- delayed	6	514.80	7
# E176	Fornix reconstruction		325.00	7
# E177	- with mucous membrane graft		321.60	6
# E937	- with autogenous conjunctival transplant	add	191.05	
	Free mucous membrane graft			
# E178	- full thickness		222.65	7
# E179	- split thickness		296.90	6
# E180	Alloplastic volume replacement		411.20	7

Note:
Repair - for E173 and E174 see Skull and Mandible - Musculoskeletal System.

OCULAR SURGICAL PROCEDURES

EYELIDS

			Asst	Surg	Anae
	INCISION				
	Drainage of abscess				
Z854	- local anaesthetic			60.00	
# Z855	- general anaesthetic			225.00	6
	EXCISION				
	Chalazion				
	Single or multiple				
Z874	- local anaesthetic			70.00	
E542	- when performed outside hospital	add		12.65	
# Z856	- general anaesthetic			150.00	6
	Note:				
	See Appendix D Surface Pathology.				
	Epilation				
Z857	- by hyfrecator, electrolysis or cryopexy			115.80	6
	Note:				
	Verruca, keratosis, etc. - see Skin and Subcutaneous Tissue - Integumentary System also Lid Tumours or Unlisted Plastic Procedures.				
	SUTURE				
# E190	Tarsorrhaphy			241.05	6
# E191	Double adhesion			306.35	7
	REPAIR				
# E192	Ptosis		6	578.30	6
# E193	- repeat or second repair		6	670.40	6
# E194	Distichiasis repair or trichiasis repair by tarsal transplantation - unilateral		6	521.00	6
# E196	Entropion, other than Zeigler puncture		6	416.20	6
# E945	- repeat	add		81.00	
# E948	- with mucous membrane graft	add		165.35	
# E197	Ectropion, other than Zeigler puncture		6	424.20	6
# E945	- repeat by second surgeon	add		81.00	
Z860	Zeigler punctures (for entropion/ectropion)			26.60	6
	Note:				
	With skin graft - see Plastic Surgery Procedures - Integumentary System.				
# E199	Laceration, full thickness			452.65	6
# E198	- including lid margin			573.15	7
# E221	Laceration of eyelid including levator palpebrae superioris with ptosis		6	645.35	7

OCULAR SURGICAL PROCEDURES

EYELIDS

		Asst	Surg	Anae
	Blepharoplasty			
# E200	- excision of skin, with or without partial excision of the orbicularis oculi muscle - one lid		82.80	6
# E201	- same as E200 plus removal of orbital fat and/or major lid fold reconstruction - one lid	6	205.55	7
	Note: Blepharoplasty is only insured in those circumstances described in the Appendix D - prior approval of the Ministry of Health is required.			
# E211	Lid lengthening procedure	6	288.35	6
# E953	- with scleral graft ... add		80.90	
# E222	Primary closure of full thickness lid defect	6	290.00	6
# E942	- with cantholysis ... add		53.20	
# E943	- with releasing rotation flap including cantholysis ... add		89.45	
# E223	Tarsoconjunctival flap and skin graft (Hughes)	6	484.35	7
# E224	- second stage		108.45	7
# E225	Lower or upper eyelid bridge flap	6	484.35	6
# E226	- second stage		108.45	6
# E227	Temporal rotation flap	6	514.80	6
# E944	- with free posterior lamellar graft ... add		175.15	
# E228	Free tarsal, scleral or cartilage graft with local skin mobilization	6	535.80	7
# E229	Free composite eyelid graft	6	535.80	7
# E230	Medial canthoplasty (skin and muscle)	6	257.90	6
	Medial canthal tendon			
# E231	- tendon repair only	6	267.35	7
# E232	- fixation to bone	6	412.05	6
# E233	- when done in conjunction with another procedure ... add		153.25	
	Lateral canthal surgery			
# E234	Canthotomy		51.45	
	Note: Not to be claimed with E140 or E141.			
# E977	- if excision is performed in hospital for tumour free margin with frozen section, to excision or repair fees ... add 25%			
	Note: E977 is payable only in addition to codes E222, E223, E225, E226, E227, E228, E229 or E300.			
# E235	Cantholysis - when primary procedure		107.50	6
# E236	Lateral canthopexy		255.00	6
# E930	- when done in conjunction with another procedure ... add		102.35	
UVC	Removal of foreign body		visit.fee	

OCULAR SURGICAL PROCEDURES

CONJUNCTIVA

			Asst	Surg	Anae
		EXCISION			
#	E208	Peritomy (Gunderson conjunctival flap)		225.00	6
	Z861	Biopsy		26.60	6
		REPAIR			
#	E210	Excision of conjunctival lesion		490.65	6
#	E948	- with mucous membrane graft	add	165.35	
	E937	- with autogenous conjunctival transplant	add	191.05	

OCULAR SURGICAL PROCEDURES

LACRIMAL TRACT

		Asst	Surg	Anae
	INCISION			
# Z862	Dacryocystotomy - general anaesthetic		52.40	6
# Z917	Three “Snip” punctum procedure - per punctum - maximum 4 per patient ....each		65.70	6
	EXCISION			
# E215	Dacryocystectomy	6	496.00	6
	REPAIR			
	Lacerated canaliculus			
# E216	- immediate repair	6	501.75	6
# E217	- delayed repair	6	616.85	6
# E218	Dacryocystorhinostomy	6	815.75	6
# E939	- repeat procedure by second surgeon ..... add		150.00	
# E954	- with lacrimal bypass procedure (e.g. Lester Jones) or canalicular reconstruction ..... add		183.55	
	Lacrimal bypass procedure (e.g. Lester Jones)			
# E219	- when sole procedure (both stages)		250.00	6
	MANIPULATION			
Z901	Irrigation of nasolacrimal system - per eye		27.00	
	Probing and dilation of duct, initial or repeat			
	Local anaesthetic			
Z902	- unilateral		27.00	
	General anaesthetic			
# Z864	- unilateral or bilateral		200.00	6
# Z865	- with insertion of inlying tube or filament		250.00	6
Z918	Re-insertion of Lester Jones tube		52.40	

AURAL SURGICAL PROCEDURES

EXTERNAL EAR

			Asst	Surg	Anae

PREAMBLE

When debridement of ears under microscopy is carried out for access purposes only, no claim should be made for the debridement.

ENDOSCOPY

Removal of foreign body

	Z915	- simple	10.55	
	Z866	- complicated, general anaesthetic	50.90	6
#	E302	- requiring post auricular or endaural incisions	202.35	6
#	E303	- from middle ear space	202.35	6

Note:
Z915 claimed solely for removal of cerumen is payable at nil.

Removal of drainage tube(s)

#	Z906	- under general anaesthetic, unilateral	66.50	6

Note:
For contralateral procedure, Z906 is payable at 85% of the listed fee.

INCISION

	Z909	Biopsy, ear canal	25.85	
#	Z846	- general anaesthetic (if sole procedure performed)	50.90	6

Incision and drainage of extensive haematoma of pinna with packing of ear and external compression dressing

#	E317	- general anaesthetic	139.95	6
#	E318	- local anaesthetic	92.40	
#	E305	- Limited incision for perichondritis, removal of cartilage and drainage	155.30	6
#	E306	Radical surgery for perichondritis	291.50	7

AURAL SURGICAL PROCEDURES

EXTERNAL EAR

		Asst	Surg	Anae
	EXCISION			
	Local excision, polyp			
Z904	- office		25.85	
# Z905	- hospital		50.90	6
	Resection of pinna			
# E300	- with primary closure		248.05	6
# E977	- if excision is performed in hospital for tumour free margin with frozen section, to excision or repair fees, to E300 add 25%			
# E301	- with local flap		355.35	6
	Exostosis			
# E311	- endomeatal surgery and removal and drilling out of exostosis		243.35	7
# E312	- with multiple removal with necessary grafting		355.40	7
# E313	- post auricular approach		362.55	6
# Z903	Pre-auricular sinus		62.95	
# E309	- general anaesthetic		208.05	6
	REPAIR			
	Congenital defects			
	External			
# E307	- minor	6	219.60	6
# E308	- major	6	345.15	7
# E310	Otoplasty for correction of outstanding ears - unilateral	6	247.35	7
# E304	Reconstruction of total ear with cartilage graft (e.g. Brent Technique), first stage	6	619.35	6

Note:

1. E304, E307, E308 - Descriptive details of procedure (e.g. operative report) should be submitted with claims for professional assessment (see Surgical Preamble, paragraph 17).

2. E310 - for patients 18 years of age or older, please see Appendix D, Sub-Surface Pathology.

# E314	Meatoplasty or canalplasty for congenital malformation	6	297.25	7
# E955	- with grafting of canal add		202.35	
# E956	- with tympanoplasty and/or ossiculoplasty, and/or mastoidectomy add		399.90	2

AURAL SURGICAL PROCEDURES

MIDDLE EAR

		Asst	Surg	Anae

DEBRIDEMENT

Under microscopy, debridement of mastoid cavities, and/or ears with significant external or middle ear pathology but not for removal of cerumen.

Z907	- unilateral		27.40	
# Z908	- under general anaesthetic, with or without repair of small perforation - when sole ear procedure(s) performed - unilateral		50.90	6

Note:

1. Debridement not performed under microscopy (e.g. if performed using loupes or magnifying headlights) or in the absence of significant external or middle ear pathology, or for removal of cerumen does not constitute Z907 or Z908.

2. G420 is *not eligible for payment* in conjunction with Z906, Z907, Z908 or Z913.

3. For contralateral procedures, Z907 and Z908 are payable at 85% of the listed fee.

INCISION

# Z912	Myringotomy, to include aspiration when indicated - unilateral		42.15	6
# Z914	- with insertion of ventilation tube using operating microscope - unilateral		78.60	6
# Z916	Intratympanic injection, with or without myringotomy - unilateral		75.90	6

[Commentary:

Z912 is *not eligible for payment* when rendered in conjunction with the service described by Z916.]

Note:

Z912 or Z914 performed on an otherwise healthy *child* is *only eligible for payment* for the treatment of symptomatic chronic otitis media with effusion that has persisted beyond 3 months or recurrent episodes of acute otitis media with effusion.

EXCISION

Mastoidectomy

# E320	Cortical mastoidectomy	6	345.15	10
# E322	Modified or radical mastoidectomy	6	627.10	10
# E315	Revision mastoidectomy with revision of middle ear	6	674.00	10
# E946	- with mastoid cavity obliteration E315, E320 or E322	add	106.45	
# E959	- with meatoplasty and/or canalplasty	add	106.45	
# E960	- with ossiculoplasty E315, E320 or E322	add	103.80	
# E985	- with tympanoplasty, to E315, E320 or E322	add	106.45	
# E319	Atticotomy	6	345.30	6

REPAIR

# E323	Myringoplasty		209.05	6
Z913	Repair of small perforation under local anaesthesia, with or without debridement, unilateral		39.00	

AURAL SURGICAL PROCEDURES

MIDDLE EAR

Note:

1. Z913 is *not eligible for payment* with Z908 or E323.

2. For contralateral procedure, Z913 is payable at 85% of the listed fee.

Tympanoplasty

			Asst	Surg	Anae
# E336	Type 1 (myringoplasty with exploration of middle ear)			345.15	7
# E337	- with ossiculoplasty			468.85	10
# E957	- with mastoidectomy	add		138.05	
# E959	- with meatoplasty and/or canalplasty	add		106.45	
# E333	Ossiculoplasty		6	406.55	10
# E325	Facial nerve decompression		6	642.45	10
# E326	Facial nerve grafting (to include decompression)		6	987.65	10
# E327	Closure of mastoid fistula		6	252.15	10
# E328	Tympanotomy			288.50	10
# E981	- with removal of middle ear tumour	add		132.35	
# E329	Tympanic neurectomy			370.10	10
# E316	Tympanotomy with fistula repair			395.05	10

AURAL SURGICAL PROCEDURES

INNER EAR

		Asst	Surg	Anae
	INCISION			
# E332	Labyrinthotomy or labyrinthectomy (including Fick procedure)		548.45	10
	REPAIR			
# E335	Stapedectomy with prosthesis		637.15	10
# E331	Revision stapedectomy		673.65	6
# E321	Posterior/superior canal occlusion	6	612.70	8
# E339	Endolymphatic shunt or sac decompression	6	661.55	10
# E345	Temporal bone resection	10	1379.10	15
	Permanent Cochlear Prosthesis Insertion			
# E341	Intra-cochlear	7	737.30	9
	Bone Conduction Hearing Aid Insertion			
# E346	- implantable, including necessary mastoidectomy	6	345.15	7

SPINAL SURGICAL PROCEDURES

PREAMBLE

[Commentary:
The structure of this section uses “N” prefix codes to describe the basic elements of spine surgery: decompression and arthrodesis (fusion), both anterior and posterior. Specific “E” prefix codes can be added where indicated to determine the amount payable for a particular operation. In accordance with the surgical preamble, the full fee applies to the major procedure and additional “N” prefix procedures are payable in addition to the major procedure at 85% of the fee unless otherwise stated.]

OTHER TERMS AND DEFINITIONS

1. The preamble to the Musculoskeletal System Surgical Procedures section also applies to this section as applicable (e.g. fractures).
2. Fusion of one disc level (one motion segment) includes two levels of instrumentation.
3. Obtaining bone for grafting is included as a component of all fusion procedures and is *not eligible for payment* when performed with any fusion procedure.
4. Thoracotomy performed in conjunction with spinal procedures by a surgeon not performing the spinal surgery constitutes M137 (P14).
5. Laparotomy performed in conjunction with spinal procedures by a surgeon not performing the spinal surgery constitutes S312 (S34).
6. Three-dimensional (3D) computer-assisted stereotactic navigation (E378) must include the pre-operative or intra-operative generation of axial, sagittal and coronal reformatted images that are processed and virtually represented in 3D by a surgical navigational system. In addition, the surgical navigational system must be used to reflect the position of an image-guided (tracked) surgical tool(s) relative to the patient's anatomy. This may be performed by either frame or frameless technique and applies to any spinal level.
7. Two-dimensional (2D) computer-assisted stereotactic navigation (E379) must include the intra-operative generation of antero-posterior, lateral or multiple oblique 2D views that are processed and virtually represented in 2D by a surgical navigational system. In addition, the surgical navigational system must be used to reflect the position of an image-guided (tracked) surgical tool(s) relative to the patient's anatomy. This may be performed by either frame or frameless technique and applies to any spinal level.

   Note:
   The use of an intra-operative imaging tool such as a portable x-ray, fluoroscope (2D or 3D), CT, MRI or ultrasound for "live" localization without a surgical navigational system as defined above does not constitute E378 or E379 and is *not eligible for payment*.
8. Acute spinal cord injury premium (E383) is *only eligible for payment* when rendered to patients who are described under ASIA impairment scale ratings A to C and have acute conditions which have been present for 6 *week*s or less.

ASIA IMPAIRMENT SCALE

A. Complete - No motor or sensory function is preserved in the sacral segments S4-S5.

B. Incomplete - Sensory but not motor function is preserved below the neurological level and extends though the sacral segments S4-S5.

PREAMBLE

C. Incomplete - Motor function is preserved below the neurological level, and the majority of key muscles below the neurological level have a muscle grade less than 3.

9. Use of the operating microscope, both intra and extradural, when required, is included as a component of all spinal fee schedule codes and is *not eligible for payment* when rendered with any procedure in this section.

SPINAL SURGICAL PROCEDURES

ANTERIOR SPINAL DECOMPRESSION

		Asst	Surg	Anae
	All levels			
# E383	- acute spinal cord injury premium ..... add		255.00	
# E382	- spinal duroplasty using autologous/allogenic/synthetic tissue..... add		244.80	
	Cervical			
# N500	Disc excision (one level).....	10	1097.90	10
# N501	Vertebrectomy (removal of vertebral body and excision of adjacent discs)	11	1267.15	11
# E360	- each additional level decompression, to N500 or N501 ..... add		306.00	
# N569	Anterior cervical decompression by intra-oral approach.....	15	1442.95	15

Note:
No other anterior cervical decompression codes (i.e. N500, N501, E360) are *eligible for payment* when rendered with anterior cervical decompression by intra-oral approach (N569).

	Thoracic - includes thoracotomy			
# N502	Disc excision (one level).....	11	1530.00	15
# N503	Vertebrectomy (removal of vertebral body and excision of adjacent discs)	12	1836.00	17
# E360	each additional level decompressed, to N502 or N503 .... add		306.00	
# E362	- combined thoracotomy/laparotomy, to N502 or N503 add		153.00	
	Thoracic - thoracotomy by separate surgeon			
# N504	Disc excision (one level).....	11	1122.00	15
# N505	Vertebrectomy (removal of vertebral body and excision of adjacent discs)	12	1428.00	17
# E360	- each additional decompressed, to N504 or N505..... add		306.00	
	Lumbar - includes laparotomy/retroperitoneal approach			
# N506	Disc excision (one level).....	9	1224.00	13
# N507	Vertebrectomy (removal of vertebral body and excision of adjacent discs)	10	1734.00	15
# E360	- each additional level decompressed, to N506 or N507 ..... add		306.00	
# E362	- combined thoracotomy/laparotomy, to N506 or N507 add		153.00	
	Lumbar - laparotomy/retroperitoneal approach by separate surgeon			
# N508	Disc excision (one level).....	9	918.00	13
# N579	Vertebrectomy (removal of vertebral body and excision of adjacent discs)	10	1428.00	15
# E360	- each additional level decompressed, to N508 or N579 ..... add		306.00	

SPINAL SURGICAL PROCEDURES

ANTERIOR SPINAL ARTHRODESIS FOLLOWING DECOMPRESSION

			Asst	Surg	Anae
	Cervical - without instrumentation				
# E363	- one disc level, to N500 or N501	add		357.00	
# E364	- each additional disc level fused, to E363	add		102.00	
	Cervical - with instrumentation including cages				
# E365	- one disc level, to N500, N501, N572, N560 or N561	add		862.00	
# E366	- each additional disc level fused, to E365	add		153.00	
	Thoracic/Lumbar - without instrumentation				
# E367	- one disc level, to N502, N503, N504, N505, N506, N507, N508 or N579	add		255.00	
# E364	- each additional disc level fused, to E367	add		102.00	
	Thoracic/Lumbar - with instrumentation including cages				
# E365	- one disc level, to N502, N503, N504, N505, N506, N507, N508, N579, N560 or N561	add		862.00	
# E366	- each additional disc level fused, to E365	add		153.00	
	Artificial Disc Insertion				
# N526	Artificial disc insertion (includes approach)		11	2040.00	17
# N525	Artificial disc insertion (approach by separate surgeon)		10	1734.00	15
# E394	- each additional level replaced, to N526 or N525	add		765.00	

Note:
No other services in the Spinal Surgical Procedures section are *eligible for payment* when rendered with insertion of an artificial disc (N525, N526) except E394.

SPINAL SURGICAL PROCEDURES

ANTERIOR SPINAL ARTHRODESIS WITH INSTRUMENTATION WITHOUT DECOMPRESSION

		Asst	Surg	Anae
	Cervical			
# N516	One disc level	7	510.00	10
# E366	- each additional disc level fused, to N516 add		153.00	
	Thoracic - includes thoracotomy			
# N517	One disc level	9	1224.00	13
# E366	- each additional disc level fused, to N517 add		153.00	
	Thoracic - thoracotomy by separate surgeon			
# N518	One disc level	9	765.00	13
# E366	- each additional disc level fused, to N518 add		153.00	
	Lumbar - includes laparotomy/retroperitioneal approach			
# N559	One disc level	7	1122.00	13
# E366	- each additional disc level fused, to N559 add		153.00	
# E362	- combined thoracotomy/laparotomy, to N559 add		153.00	
	Lumbar - laparotomy/retroperitoneal approach by separate surgeon			
# N580	One disc level	7	765.00	10
# E366	- each additional disc level fused, to N580 add		153.00	

SPINAL SURGICAL PROCEDURES

POSTERIOR SPINAL DECOMPRESSION

		Asst	Surg	Anae
	Note: Includes hemi and total laminectomy, foraminotomy and facetectomy.			
	All levels			
# E383	- acute spinal cord injury premium ..... add		255.00	
# E382	- spinal duroplasty using autologous/allogenic/synthetic tissue..... add		244.80	
# N521	Re-opening of laminectomy for post-op haematoma/infection	7	357.00	8
# N522	Re-opening of laminectomy for repair of CSF leak.....	7	535.50	8
	Note: **1.** N521 and N522 are *not eligible for payment* when rendered with any service in the Spinal Surgical Procedures section except duroplasty (E382) if required. **2.** N521 is *not eligible for payment* if rendered with N522.			
	Cervical / Thoracic			
# N509	One level - unilateral.....	9	1004.70	12
# N510	One level - bilateral.....	9	1346.05	17
# E374	- foramen magnum decompression < 3cm as part of cervical decompression, to N510..... add		357.00	
# E361	- each additional level decompressed including disc excision - unilateral or bilateral, to N509 or N510..... add		260.80	
# N520	One level - laminoplasty (includes fixation of lamina)	9	1514.70	14
# E380	- each additional level - laminoplasty (includes fixation of lamina), to N520..... add		357.00	
# E368	- first disc excision, to N509, N510 or N520..... add		306.00	
	Lumbar			
# N511	One level - unilateral.....	8	800.70	15
# N512	One level - bilateral.....	8	1118.90	15
# E368	- first disc excision, to N511 or N512..... add		306.00	
# N524	One level - bilateral canal enlargement - unilateral approach	9	1300.25	15
# E361	- each additional level decompressed including disc excision - unilateral or bilateral, to N511, N512 or N524 ..... add		260.80	
# N571	Percutaneous discotomy	6	255.00	8
# E385	- each additional level of percutaneous discotomy, to N571 ..... add		71.40	
	Removal of Vertebral Body including Pedicles for Osteotomy			
# N574	Above cord and conus (includes partial rib resection) - each level	9	1020.00	13
# N575	Below conus - each level.....	9	765.00	9
# N576	Smith Peterson Osteotomy - each level	9	255.00	9

SPINAL SURGICAL PROCEDURES

POSTERIOR SPINAL ARTHRODESIS FOLLOWING DECOMPRESSION OR OSTEOTOMY

		Asst	Surg	Anae
	All levels			
# E378	- 3D stereotactic spinal procedure ..... add		510.00	
# E379	- 2D stereotactic spinal procedure ..... add		510.00	
	Cervical, Thoracic & Lumbar … without instrumentation			
# E369	- one disc level, to N509, N510, N520, N511 or N512 . add		255.00	
# E364	- each additional disc level fused, to E369..... add		102.00	
	Cervical … with instrumentation - by same surgeon			
# E384	- C1/C2 screw fixation (transarticular, pedicle, lateral mass), to N509, N510, N560, N561or N572 ..... add		1020.00	
# E370	- one disc level - below C2, to N509, N510, N572, N574, N575, N576, N560 or N561 ..... add		880.15	
# E371	- fusion to occiput, to E384..... add		816.00	
# E366	- each additional disc level fused except fusion to occiput or fusion of cervico-thoracic junction, to E384 or E370.. add		153.00	
# E377	- cervico-thoracic junction, to N509, N510, E370, N572, N574, N560 or N561 ..... add		255.00	

Note:
Submit claims for levels fused in addition to E384 or E370 using one of E366, E371 or E377 as appropriate.

[Commentary:
E370 will be reduced to E366 if claimed with E384.]

	Cervical … with instrumentation - by separate surgeon			
# N528	C1/C2 screw fixation (transarticular, pedicle, lateral mass)....		1020.00	
# E371	fusion to occiput, to N528 ..... add		816.00	
# N513	One disc level - below C2.....		867.00	
# E366	- each additional disc level fused except fusion to occiput or fusion of cervico-thoracic junction, to N528 or N513 . add		153.00	
# E377	- cervico-thoracic junction, to N513, N572, N574, N560 or N561 ..... add		255.00	

Note:
Submit claims for levels fused in addition to N528 or N513 using one of E366, E371, or E377 as appropriate.

[Commentary:
N513 will be reduced to E366 if claimed with N528.]

	Thoracic & Lumbar … with instrumentation - by same surgeon			
# E370	- one disc level, to N509, N510, N511, N512, N572, N574, N575, N576, N560 or N561 ..... add		880.15	
# E366	- each additional disc level fused, to E370..... add		153.00	
# E387	- spinopelvic fixation with iliac or S2 alar-iliac screws, to N511, N512, N575, N576, N560 or N561 ..... add		300.00	

POSTERIOR SPINAL ARTHRODESIS FOLLOWING DECOMPRESSION OR OSTEOTOMY

		Asst	Surg	Anae

Thoracic & Lumbar … with instrumentation - by separate surgeon

# N513	One disc level		867.00
# E366	- each additional disc level fused, to N513.....	add	153.00
# E387	- spinopelvic fixation with iliac or S2 alar-iliac screws, to N513	add	300.00

Posterior Interbody Arthrodesis or Nuclear Replacement

# E372	- one disc level, to N509, N510, N511, N512 or N513 .	add	510.00
# E376	- each additional disc level stabilized, to E372.....	add	255.00

Payment rules:

1. E372 includes discectomy.

2. Posterior interbody arthrodesis includes insertion of cage or structural bone graft.

3. Insertion of morselized bone graft alone following discectomy is *not eligible for payment* as E372 or E376.

4. E372 and E376 are *not eligible for payment* with N540 or E389 at the same spinal level.

[Commentary:
L5-S1 fusion does not constitute spinopelvic fixation.]

SPINAL SURGICAL PROCEDURES

POSTERIOR SPINAL ARTHRODESIS AS SOLE PROCEDURE

			Asst	Surg	Anae
	All levels				
# E378	- 3D stereotactic spinal procedure	add		510.00	
# E379	- 2D stereotactic spinal procedure	add		510.00	

[Commentary:
See Spinal Surgical Procedures Preamble for definition of eligible 2D and 3D stereotactic navigation systems.]

	Cervical & Thoracic … without instrumentation				
# N519	C1/C2 fusion using graft/posterior wires		8	612.00	10
# N514	One disc level - below C2		7	408.00	10
# E364	- each additional disc level fused, to N514 or N519	add		102.00	

Note:

1. N519 is *not eligible for payment* when rendered with any other fusion procedure at the same level.

2. Submit claims for levels fused in addition to N519 using E364.

[Commentary:
N514 will be reduced to E364 if claimed with N519.]

	Lumbar … without instrumentation				
# N581	One disc level		7	408.00	10
# E364	- each additional disc level fused, to N581	add		102.00	
	Cervical & Thoracic … with instrumentation				
# N532	C1/C2 screw fixation (transarticular, pedicle, lateral mass)		9	1224.00	11
# N515	One disc level - below C2		9	1020.00	11
# E366	- each additional level fused except fusion to occiput or fusion of cervico-thoracic junction, to N532 or N515	add		153.00	
# E371	- fusion to occiput, to N532	add		816.00	
# E377	- cervico-thoracic junction, to N515 or N572	add		255.00	

Note:
Submit claims for levels fused in addition to N532 or N515 using one of E366, E371, or E377 as appropriate.

[Commentary:
N515 will be reduced to E366 if claimed with N532.]

	Lumbar … with instrumentation				
# N582	One disc level		9	1020.00	15
# E366	- each additional disc level fused, to N582	add		153.00	
# E387	- spinopelvic fixation with iliac or S2 alar-iliac screws, to N582	add		300.00	
# N533	Pars reconstruction for spondylolysis		9	1020.00	11

Note:
No other services in the Spinal Surgical Procedures section are *eligible for payment* when rendered with N533.

[Commentary:
L5-S1 fusion does not constitute spinopelvic fixation.]

SPINAL SURGICAL PROCEDURES

FRACTURES OF THE SPINE

		Asst	Surg	Anae
# F200	No reduction, brace (includes Halo orthosis), total care by operating surgeon		178.50	
# F201	Closed reduction, fracture/dislocation (Halo or caliper traction)	6	280.50	6
# E383	- acute spinal cord injury premium, to F201 ... add		255.00	
# N572	Open reduction, any single level, spine fracture/dislocation, anterior/posterior	8	1097.30	11
# E395	- open reduction, additional level, spine fracture/dislocation, anterior/posterior, to N572 ... add		306.00	

[Commentary:
For closed and open reduction of sacral or sacro-iliac fractures and/or dislocations, see listings in the Pelvis and Hip section of the *Schedule*.]

# E383	- acute spinal cord injury premium, to N572 ... add		255.00	
# E362	- combined thoracotomy/laparotomy, to N572 ... add		153.00	
# E378	- 3D stereotactic spinal procedure, to N572 ... add		510.00	
# E379	- 2D stereotactic spinal procedure, to N572 ... add		510.00	

[Commentary:
See Spinal Surgical Procedures Preamble for definition of eligible 2D and 3D stereotactic navigation systems.]

# N573	Anterior odontoid screw fixation	8	1020.00	11
# E378	- 3D stereotactic spinal procedure, to N573 ... add		510.00	
# E379	- 2D stereotactic spinal procedure, to N573 ... add		510.00	
# N570	Vertebroplasty (injection of bone cement) as sole procedure, first level	7	1004.50	9
# E388	- vertebroplasty combined with any other procedure, first level, to other procedure ... add		204.00	
# E391	- vertebroplasty, each additional level, to N570 or E388 ... add		252.95	
# N583	Kyphoplasty (balloon tamp and injection of bone cement) as sole procedure, first level	8	1201.55	11
# E392	- kyphoplasty combined with any other procedure, first level, to other procedure ... add		510.00	
# E393	- kyphoplasty, each additional level, to N583 or E392 ... add		510.00	

Note:

1. Decompressive services at the level of the fracture are *not eligible for payment* when rendered with N572 as they are included in the open reduction.
2. No other services in the Spinal Surgical Procedures section are *eligible for payment* when rendered with N573 except E378 or E379.
3. No other services in the Spinal Surgical Procedures section are *eligible for payment* when rendered with N570 except E391.
4. No other services in the Spinal Surgical Procedures section are *eligible for payment* when rendered with N583 except E393.

[Commentary:
Fusion procedures are *eligible for payment* when performed in addition to N572.]

SPINAL SURGICAL PROCEDURES

TUMOURS/INFECTIONS OF THE SPINE

		Asst	Surg	Anae
# E386	- extradural decompression - spinal cord or cauda equina - tumour or infection ..... add 42%			

Note:
E386 only applies to the major decompressive procedure.

# N553	Simple soft tissue tumour excision under 5cm	6	204.00	8
# N554	Radical soft tissue tumour excision 5cm and greater	9	484.50	13

Spinal osteomyelitis

# N549	- incision and drainage including sequestrectomy, anterior approach	7	632.40	10
# N548	- incision and drainage only, posterior approach	6	102.00	7
# N550	- sequestrectomy, posterior approach	6	357.00	6

Note:
N548 is *not eligible for payment* when rendered with N550 as it is included in the N550 service.

# N560	Intradural extramedullary spinal tumour(s) - partial or total removal.....	8	2536.80	10
# N561	Intradural intramedullary spinal tumour(s) - partial or total removal.....	9	2927.70	12
# E382	- spinal duroplasty using autologous/allogenic/synthetic tissue, to N560 or N561 ..... add		244.80	
# E383	- acute spinal cord injury premium, to N560 or N561... add		255.00	

Note:
1. No other decompressive codes are *eligible for payment* when rendered with N560 or N561.

2. N560 is *not eligible for payment* when rendered with N561.

SPINAL SURGICAL PROCEDURES

DEFORMITIES OF THE SPINE

		Asst	Surg	Anae
# N539	Anterior scoliosis correction - any number of levels (includes approach, disc excision and instrumentation)	12	3060.00	20
# N540	Posterior scoliosis correction - up to six levels (includes approach, disc excision and instrumentation)	11	3230.10	20
# E389	- each additional level of scoliosis correction over six levels, to N540 ..... add		102.00	
# E390	- halo fixation/traction - pre- or peri-operative, to N539 or N540 ..... add		255.00	
# E387	- spinopelvic fixation with iliac or S2 alar-iliac screws, to N539 or N540..... add		300.00	
# E378	- 3D stereotactic spinal procedure, to N539 or N540... add		510.00	
# E379	- 2D stereotactic spinal procedure, to N539 or N540... add		510.00	

[Commentary:
See Spinal Surgical Procedures Preamble for definition of eligible 2D and 3D stereotactic navigation systems.]

# E383	- acute spinal cord injury premium, to N539 or N540... add		255.00	

[Commentary:
L5-S1 fusion does not constitute spinopelvic fixation.]

SPINAL SURGICAL PROCEDURES

REVISION PROCEDURES FOR SPINAL SURGERY

		Asst	Surg	Anae
# N568	Removal of anterior instrumentation	8	306.00	8
# N541	Removal of posterior instrumentation	8	255.00	8
# E373	- for repeat decompression ... add 30%			
# E375	- for repeat fusion ... add 30%			

Note:

1. The repeat decompression premium (E373) only applies to the major “N” prefix decompressive procedure (N500, N501, N502, N503, N504, N505, N506, N507, N508, N579, N509, N510, N511, N512).
2. The repeat fusion premium (E375) only applies to the major fusion “E” or “N” prefix codes (E363, E365, E367, N516, N517, N518, N559, N580, E369, E384, E370, N528, N513, N519, N514, N581, N532, N515, N582).

SPINAL SURGICAL PROCEDURES

PROCEDURES ON MUSCULOSKELETAL ELEMENTS

		Asst	Surg	Anae
# Z940	Vertebral needle biopsy	6	177.05	
	Open vertebral biopsy			
# N546	- posterior approach - sole procedure	6	244.80	7
# N547	- anterior approach - sole procedure	6	306.00	8
# N551	Excision spinous process - sole procedure	6	229.50	6
# N552	Excision transverse process - sole procedure	6	382.50	8

Note:
N546, N547, N551 or N552 are *not eligible for payment* when rendered with any other service in the Spinal Surgical Procedures section.

SPINAL SURGICAL PROCEDURES

PROCEDURES INVOLVING NEURAL ELEMENTS

		Asst	Surg	Anae
# Z941	Percutaneous diagnostic stimulation of spinal cord, trigeminal nerve root and / or ganglion	6	331.50	8
# Z942	Implantation or revision of stimulation pack or leads	6	306.00	8
# Z943	Programming infusion pump or dorsal column stimulator		142.20	
# Z944	Lumbar sub-arachnoid drainage of CSF		89.75	
# N527	Percutaneous cordotomy or tractotomy	6	469.20	8
# N529	Medullary spinal trigeminal tractotomy	10	1020.00	15
# E383	- acute spinal cord injury premium, to N529 ... add		255.00	
# N564	Open myelotomy for lesion - unilateral or bilateral	8	1020.00	10

Note:
No decompressive codes are *eligible for payment* when rendered with N529 or N564.

# N523	AV malformation of cord - excision/obliteration	10	1891.70	13
# E383	- acute spinal cord injury premium, to N523 ... add		255.00	

Note:
No other decompressive codes are *eligible for payment* when rendered with N523.

# N555	Insertion / revision / removal of implantable infusion pump		590.40	8
# N530	Implantation of spinal cord stimulating electrode by laminectomy	8	1008.90	10

Note:
N530 is *not eligible for payment* when rendered with any decompressive codes.

# N563	Implantation of permanent subcutaneous reservoir including laminectomy	11	510.00	11

Note:
N563 is *not eligible for payment* when rendered with any decompressive codes.

# N531	Removal of any stimulation pack or electrode	6	306.00	7

Note:
N531 is *not eligible for payment* when rendered with any other services in the Spinal Surgical Procedures section

Percutaneous vertebral facet medial branch or sacral lateral branch neurotomy

# N556	First site		142.80	6
# E396	- each additional site to N556 ... add		71.40	
# N534	Percutaneous radio frequency posterior dorsal root rhizotomy - any number of levels		379.45	8

PROCEDURES INVOLVING NEURAL ELEMENTS

		Asst	Surg	Anae
	Sympathectomy - unilateral			
# N542	- cervical	6	357.00	6
# N543	- cervico-dorsal	10	586.50	10
# N544	- thoracic approach	9	433.50	13
# N545	- lumbar	6	295.80	6
# N557	Syringo-subarachnoid shunt	8	1224.00	12
# N558	Syringopleural/syringoperitoneal shunt	9	1428.00	13
# E383	- acute spinal cord injury premium, to N557 or N558 ... add		255.00	

Note:
N557, N558 are *not eligible for payment* when rendered with any decompressive service.

# N562	Intradural neurolysis of unusual lesions e.g. diastematomyelia, tethered conus, intramedullary haematoma, etc. including laminectomy	8	1224.00	12
# E361	- each additional level decompressed including disc excision - unilateral or bilateral, to N562 ... add		260.80	
# E383	- acute spinal cord injury premium, to N562 ... add		255.00	
# E382	- spinal duroplasty using autologous/allogenic/synthetic tissue, to N562 ... add		244.80	

Note:
N562 is *not eligible for payment* when rendered with any other decompressive codes except additional levels (E361).

# N577	Intradural rhizotomy anterior/posterior (uni/bilateral) - any number of roots	8	1276.65	10
# N578	Dorsal root entry zone lesions for pain relief – any number of levels	8	1020.00	10

Note:
N577, N578 are *not eligible for payment* when rendered with any service in the Spinal Surgical Procedures section.

MENINGOCOELE AND MYELOMENINGOCOELE

		Asst	Surg	Anae
# E382	- spinal duroplasty using autologous/allogenic/synthetic tissue..... add		244.80	
# N535	Repair of meningocoele.....	7	510.00	9
# N536	Repair of myelomeningocoele (one surgeon).....	7	1217.10	9
	Repair of myelomeningocoele (two surgeons)			
# N537	- neurosurgeon		510.00	9
# N538	- reconstructive surgeon		881.55	
# N565	Repair of lipomeningocoele including release of tethered cord	8	1622.80	10
# N566	Repair of anterior sacral meningocoele including release of tethered cord	8	1020.00	10
# N567	Repair of intraspinal meningocoele	8	1020.00	10

Note:
No decompressive codes are *eligible for payment* rendered with N535, N536, N537, N538, N565, N566 or N567.

[Commentary:
Fusion procedures are *eligible for payment* with these procedures when performed.]

SPINAL SURGICAL PROCEDURES

NOT ALLOCATED

APPENDIX A

Appendix A does not form part of the *Schedule* of Benefits: Physician Services under the *Health Insurance Act* and is for your information only.

UNINSURED SERVICES:

Please refer to Section 24, Regulation 552 Revised Regulation of Ontario, 1990, under the *Health Insurance Act*.

For a complete text version of Section 24, please refer to:
https://www.ontario.ca/laws/regulation/940114

APPENDIX A

NOT ALLOCATED

APPENDIX B

Appendix B does not form part of the *Schedule* of Benefits: Physician Services under the *Health Insurance Act* and is reproduced for your information only.

CONFLICT OF INTEREST:

Please refer to Sections 15, 16 and 17 of Regulation 114/94 made under the *Medicine Act*, 1991.

For a complete text version of Section 15, 16, and 17, please refer to:

https://www.ontario.ca/laws/regulation/940114

RECORDS:

Please refer to Sections 18 and 19 of Regulation114/94 made under the *Medicine Act*, 1991.

For a complete text version of Section 18 and 19 please refer to:

https://www.ontario.ca/laws/regulation/940114

APPENDIX B

NOT ALLOCATED

APPENDIX C

Appendix C does not form part of the *Schedule* of Benefits: Physicians' Services under the *Health Insurance Act* and is reproduced for your information only.

BENEFITS OUTSIDE ONTARIO

See Sections 28 and 29 of Regulation 552 of Revised Regulations of Ontario, 1990 made under the *Health Insurance Act* for payment of physicians services outside the country.

INTERPROVINCIAL RECIPROCAL BILLING OF MEDICAL CLAIMS

On April 1, 1988, a reciprocal billing arrangement for insured medical claims came into effect between Ontario and all provinces and territories except Quebec.

The arrangement allows Ontario physicians who voluntarily participate to bill the Ministry of Health directly for services rendered to eligible Canadian residents other than residents covered by the Quebec Plan.

Participating physicians will receive payment at the Ministry of Health *Schedule* of Benefits rates and must accept the payment as payment in full. The agreement includes services rendered by private medical laboratories and private diagnostic facilities but does not include diagnostic services rendered in a hospital setting. (See Bulletin #4210).

Physicians who do not wish to participate, or who are unable to obtain proof of provincial health coverage, must deal with the patient directly issuing an itemized letterhead account or using the standard Out-of-Province/Country Claims Submission Form.

A distinct claim form is available from Ministry of Health Offices for participants in the inter-provincial reciprocal medical billing system. The Ministry of Health also accepts billings for these services on various magnetic media types. Further details can be obtained from any Ministry of Health office.

BENEFITS OUTSIDE CANADA

Prior approval from the Ministry of Health is required for payment for services rendered outside of Canada in connection with an illness, disease, condition or injury that:

a. is not acute and unexpected, requiring immediate treatment; or

b. does not arise outside of Canada.

APPENDIX C

NOT ALLOCATED

APPENDIX D

PREAMBLE

1. Within the context of this policy, the word “function” means physical function.
2. Surgery to alleviate significant physical symptoms, which have not responded to a minimum of six *month*s active treatment, or to restore or improve function to any area altered by disease, trauma or congenital deformity normally is an insured service.
3. Services rendered by physicians that are solely for the purpose of alteration or restoration of appearance are not an insured service except under circumstances as listed in the following policy:
   a. Emotional, psychological or psychiatric grounds are not considered sufficient reason for the coverage of surgery for alteration of appearance except under exceptional circumstances.
   b. Surgery to alter a non-symptomatic significant defect in appearance caused by disease, trauma, or congenital deformity may be allowed on an Independent Consideration basis, on request of the operating physician provided that it is
      i. Recommended by a psychiatric facility (as designated by The *Mental Health Act*) or equivalent, or
      ii. Performed on a patient who is less than 18 years of age and the defect is in the area of the body which normally and usually would not be clothed.
4. In establishing this policy, it has been recognized that
   a. Peer acceptance in our society often is influenced disproportionately by facial appearance.
   b. *Child*ren are especially susceptible to emotional trauma caused by physical appearances.
5. Surgery to revise or remove features of physical appearance which are familial in nature and do not interfere with function is not an insured service.
6. Within the context of this policy, the word “disease” does not include the normal sequelae of aging. Surgery to alter changes in appearances caused by aging is not an insured service.
7. Within the context of this policy, the word “trauma” includes trauma due to treatment such as surgery, radiation, etc.
8. The phrase “reasonable period of convalescence” should be considered as two years. Independent consideration will be given to the questionable cases.
9. Prior authorization from the Ministry of Health is not required for all surgery to alter appearance. It is required only for those categories of procedures in which some cases may not be an insured service.
10. Suitable documentation, with the exception of photographs, may be requested in some cases before prior authorization can be considered.
11. The treatment of acute medical or surgical complications resulting from surgery for alteration of appearance and/or function is an insured service whether or not the original surgery was covered by the Ministry of Health. No prior authorization is required.
12. Revision, because of undesirable results, of a surgery, which was originally performed for alteration of appearance, is an insured service only if the original surgery was an insured service and if the revision either is part of a pre-planned staged process or occurs within a reasonable period of convalescence. Prior authorization is required only when the original surgical procedure, if it had been carried out at the time of the proposed revision, would have required such authorization.

APPENDIX D

SURFACE PATHOLOGY

1. **Trauma Scars**
   - **a.** Neck or Face:
     - **i.** Includes ears and non-hair bearing areas of the scalp.
     - **ii.** Repair of all such scars is an insured service, except for scars resulting from previous surgery to alter appearance that was not originally an insured service.
     - **iii.** Repair procedures will depend upon the lesion but *may include* excision, revision, dermabrasion, etc.
     - **iv.** Rhytidectomy procedures for cosmetic reasons, however, are not insured services.
     - **v.** Prior authorization from the Ministry of Health for repair of trauma scars to the face or neck is not required.
   - **b.** Scars in other Anatomical Areas
     - **i.** Repair of scars which interfere with function or which are significantly symptomatic (pain, ulceration, etc.) is an insured service.
     - **ii.** Scars with no significant symptoms or functional interference
       - Repair is an insured service if such a repair is part of a pre-planned post-traumatic (including post-surgical) staged process. Notification to the Ministry of Health must be included as part of the planning process.
       - Other post-traumatic scar revision is not an insured service.
       - Scar revision should not be claimed when excision of a scar is the method of gaining access to the surgical site of the major procedure.
         - Prior authorization from the Ministry of Health is required for all scar repair procedures in areas other than the face or neck. Scar revision codes should be used (e.g. R026-R029).
2. **Keloids**
   - **a.** Head or Neck
     - **i.** The repair of all such keloids is an insured service.
     - **ii.** Repair procedures *may include* excision, injection, dermabrasion or planning.
     - **iii.** Prior authorization is not required.
   - **b.** Excision of keloids in other areas
     - **i.** Not an insured service unless significantly symptomatic (pain, ulceration, etc.) or there is functional impairment.
     - **ii.** Prior authorization from the Ministry of Health is required.
3. **Tattoos**

   Excision or destruction of tattoos resulting from sexual or ritual abuse, concentration camp or prisoner of war experience is an insured service. Excision or destruction of any other tattoos, irrespective of the anatomical area, is not an insured service.

APPENDIX D

SURFACE PATHOLOGY

4. Benign Lesions such as nevi, haemangioma, keratoses, neurofibromata

Note:

1. Any lesions (e.g. keratosis, nevi) removed for cosmetic purposes and not for any clinical suspicion of disease or malignancy must be billed to the patient.

2. Incision of comedones, acne pustules and milia are not insured services.

a. Face or Neck

i. Excision or destruction of these lesions is an insured service, where there is any suspicion of disease or malignancy.

ii. Destruction of any Port Wine Stain on the face or neck is an insured service.

iii. Prior authorization is not required.

b. Other Anatomical Areas

i. Normally not an insured service if removed for alteration of appearance only, rather than for medical necessity or because of clinical suspicion or evidence of malignancy.

ii. Removal of very large lesions that would be considered disfiguring in patients of any age may be an insured service. Prior authorization from the Ministry of Health is required.

iii. Prior authorization from the Ministry of Health is required.

5. Hair Loss

a. Head or Neck

i. Patients aged 17 and below

- Repair is an insured service for non-hereditary etiologies. Prior authorization is not required.
- If it is possible that a planned staged procedure will extend beyond the age of 17, prior authorization from the Ministry of Health is required for those services rendered beyond the age of 17.

ii. Post-traumatic

- Repair to the area of traumatic hair loss is an insured service only if carried out within a reasonable period of convalescence. (see Paragraph 7 of this Appendix).
- Prior authorization from the Ministry of Health is required.
- Usual repair procedures *may include* skin shifts or flaps, skin grafts, or hair plugs.

iii. Other Etiology - not an insured service.

b. Other Anatomical Areas - not an insured service.

6. Epilation of Hair - not an insured service.

7. Redundant Skin

a. Excision of redundant skin for elimination of wrinkles, etc. is not an insured service.

b. Blepharoplasty is an insured service only if a vertical visual field defect crosses the fixation point and is caused by redundant eyelid. Prior authorization from the Ministry of Health is required. A computer-generated visual field report and interpretative report must accompany the request for prior authorization.

APPENDIX D

SURFACE PATHOLOGY

8. Warts

a. Removal or treatment of warts is not an insured service subject to (b) and (c) below.

b. Removal or treatment of the following is an insured service. Prior authorization is not required.

i. plantar warts by any listed procedure except excision or removal by electrocoagulation and/or curetting;

ii. perianal warts by any listed procedure;

iii. genital warts by any listed procedure;

iv. all other warts by any listed procedure in the case of immunocompromised patients

c. Removal or treatment of warts by any listed procedure is an insured service in the case of warts on the head or neck of an *infant* or *child*. Prior authorization is not required.

9. Chalazions

Excision of chalazions is insured only for acute eyelid inflammation, induction of astigmatism, visual field defects or suspicion of malignancy.

10. Acne Lesions and Scars

Assessment of patients with acne, including the provision of prescriptions for oral and topical medications, is an insured service. Destruction or repair of acute acne lesions or chronic acne scars by any surgical or physical procedure (e.g. incision, excision, injections, dermabrasion, grafting, chemical peel, cryotherapy, laser, etc.) is not an insured service.

11. Congenital Deformities

a. Head or Neck

i. Repair of a congenital deformity, which interferes with function, is an insured service. Prior authorization from the Ministry of Health is required.

ii. Surgery to correct “Outstanding Ears” is only an insured service in patients who are under eighteen years of age. Prior authorization is not required.

b. Other Anatomical Areas

i. Repair of a congenital deformity, which interferes with function, is an insured service.

ii. Insertion of testicular prosthesis for congenital absence of one or both testes is an insured service. Prior authorization is not required.

12. Post-Traumatic Deformities

a. Reconstructive procedures are insured services at the acute stage; within two years, or if part of a pre-planned staged process of repair.

b. Reconstructive procedures *may include* bone revision, tissue shifts and grafts, prosthesis implantation etc.

c. Prior authorization from the Ministry of Health is required for repairs beyond the acute stage.

d. Insertion of testicular prosthesis is an insured service when performed at any time subsequent to an orchidectomy procedure. Prior authorization is not required.

APPENDIX D

SURFACE PATHOLOGY

13. Deformities resulting from local disease (such as loss or distortion of bone, muscle, connective tissue, adipose tissue, etc.)

a. Head or Neck

i. Reconstructive procedures for significant abnormalities are an insured service at the acute stage, during a chronic disease process: within a reasonable period of convalescence (see Paragraph 7 of this Appendix) or if part of a planned staged process of repair initiated during one of these periods.

ii. Repair procedures normally *may include* tissue grafts, flaps or shifts, bone revision, prosthesis insertion, etc.

iii. Face lifts, modified face lifts, brow lifts, etc., are not insured services if skin only is involved in the procedure. However, a repair such as ptosis repair or face-lift with underlying slings is an insured service if the procedure is to correct significant deformity following stroke, cancer, seventh nerve palsy etc.

iv. Prior authorization from the Ministry of Health is required.

b. Other Anatomical Areas

i. Not an insured service if the correction is for appearance only.

ii. Correction of severe deformity resulting from polio or neurological disease will be considered for payment.

iii. Insertion of testicular prosthesis is an insured service. Prior authorization is not required.

14. Breast Surgery

a. Post-mastectomy breast reconstruction

See listed services for payment requirements related to post-mastectomy breast reconstruction.

[Commentary:

1. Unilateral augmentation mammoplasty in association with post-mastectomy reconstruction of the contralateral breast is an insured service.

2. Unilateral reduction mammoplasty in association with post-mastectomy reconstruction of the contralateral breast is an insured service.

3. Prior authorization of payment is not required for balancing unilateral augmentation mammoplasty or balancing reduction mammoplasty in association with post-mastectomy breast reconstruction.]

b. Augmentation mammoplasty (other than post-mastectomy breast reconstruction)

i. Augmentation mammoplasty when performed for reasons other than post-mastectomy breast reconstruction of the contralateral breast is only insured for the following conditions and when prior authorization of payment is obtained from the Ministry of Health:

a. breast aplasia;

b. severe unilateral hypoplasia of the breast; or

c. gross disproportion.

ii. Only a unilateral procedure (i.e. augmentation or reduction mammoplasty) is insured when performed solely for gross disproportion.

[Commentary:
Augmentation mammoplasty services are subject to Paragraph (b) of Section 17 of Appendix D of this *Schedule*.]

c. Reduction Mammoplasty (other than post-mastectomy breast reconstruction)

i. Reduction mammoplasty when performed for reasons other than post-mastectomy breast reconstruction of the contralateral breast is only insured for the following conditions and when prior authorization of payment is obtained from the Ministry of Health:

a. significant associated symptomatology; or

b. gross disproportion.

ii. Only a unilateral procedure (i.e. augmentation or reduction mammoplasty) is insured when performed solely for gross disproportion.

[Commentary:
Ptosis and/or size alone are not sufficient grounds for coverage of reduction mammoplasty.]

d. Accessory breasts or accessory nipples

i. Excision of accessory breast and nipple tissue is an insured service.

[Commentary:
The listed service under Skin and Subcutaneous Tissue of the Integumentary System Surgical Procedures section of this *Schedule* that best describes the procedure performed should be used for excision of accessory breast tissue and/or accessory nipples.

ii. Prior authorization of payment is not required.

15. Septorhinoplasty

This is an insured service when the rhinoplasty component is necessary to obtain an adequate airway or; for persons aged 16 years and under, at the time of trauma and for whom the rhinoplasty is completed, or is part of a preplanned staged repair which is commenced, at any time following trauma and prior to the age of 19 years; or, for persons aged 17 years and older at the time of trauma and for whom the rhinoplasty is completed, or is part of a preplanned staged repair which is commenced, within 2 years following trauma. (see Paragraph 6 of this Appendix).

In cases where a septoplasty is necessary to improve function and a rhinoplasty is done for cosmetic purposes, the Ministry of Health will pay the part of the operation that was medically necessary (e.g. if a septorhinoplasty is performed and a septoplasty was necessary to improve the airway, the Ministry of Health will pay M012 and the surgeon is entitled to claim the difference from the patient). However, if a septorhinoplasty is approved by the Ministry, no extra charge may be made to the patient.

Prior authorization from the Ministry of Health is required. A description of the external deformity should be provided.

16. Excision of excess fatty tissue and/or skin

a. Panniculectomy is only insured in the following circumstances and when prior authorization of payment is obtained from the *MOH*:

i. where there is significant associated symptomatology related to the panniculus;

ii. where the panniculus extends to a level below the pubis symphysis when the patient is standing; and

iii. where the patient's weight has been stable for a minimum of 6 *month*s when panniculectomy is requested in relation to weight loss.

b. Excision of excess fatty tissue and/or skin other than for panniculectomy is not an insured service.

[Commentary:
Examples of significant clinical symptomatology include significant low back pain, chronic skin breakdown, recalcitrant skin rashes or infections beneath the panniculus, including recurring candidiasis, recurrent cellulitis, recurrent ulceration, or tissue necrosis.]

17. Sex-Reassignment Surgery

Sex-reassignment surgical procedures listed in this section are insured services when prior authorization has been obtained from the *MOH*.

A request for prior authorization must be completed by a physician or nurse practitioner.

PART A – SUPPORTING DOCUMENTATION NECESSARY FOR A REQUEST FOR PRIOR AUTHORIZATION FOR SURGERY:

A prior authorization request must include supporting assessment(s) that recommend surgery; the assessment must be completed by a provider trained in the assessment, diagnosis, and treatment of gender dysphoria in accordance with the World Professional Association for Transgendered Health (WPATH) Standards of Care that are in place at the time of the recommendation ("appropriately trained provider").

Supporting assessments recommending surgery may be provided by an appropriately trained:

1. Physician;
2. Nurse Practitioner;
3. Registered Nurse;
4. Psychologist; or
5. Registered social worker

in accordance with the requirements of Part B below.

[Commentary:
1. A provider must be able to provide documentation of their training in the assessment, diagnosis and treatment of gender dysphoria on request by the MOH.
2. The physician or nurse practitioner submitting a request for prior authorization may also be one of the providers who provides a supporting assessment.]

Note:
"Registered social worker" refers to a social worker who has a master's degree in social work and who holds a current certificate of registration from the Ontario College of Social Workers and Social Service Workers.

APPENDIX D

SURFACE PATHOLOGY

PART B – SPECIFIC REQUIREMENTS FOR APPROVAL:

Prior authorization for sex-reassignment surgery will only be provided when the following requirements have been met and only for the specific services listed:

1. External Genital Surgery (clitoral release, glansplasty, metoid*iop*lasty, penile implant, phalloplasty, scrotoplasty, testicular implants, urethroplasty, vaginectomy, penectomy, vaginoplasty)

a. Two supporting assessments from appropriately trained providers confirming that the patient is an appropriate candidate for surgery as follows:

i. One assessment from a physician or nurse practitioner; and

ii. One assessment from a different physician, different nurse practitioner, registered nurse, psychologist, or regulated social worker; and

b. The supporting assessments confirm that the insured person meets all of the following criteria:

i. Has a diagnosis of persistent gender dysphoria;

ii. Has completed twelve (12) continuous *month*s of hormone therapy (unless hormones are contraindicated);

iii. Has completed twelve (12) continuous *month*s of living in a gender role that is congruent with their gender identity; and

iv. Is recommended for surgery.

2. Hysterectomy, Salpingo-oophorectomy, Orchidectomy

a. Two supporting assessments from appropriately trained providers confirming the patient is an appropriate candidate for surgery as follows:

i. One assessment from a physician or nurse practitioner; and

ii. One assessment from a different physician, a different nurse practitioner, registered nurse, psychologist or regulated social worker; and

b. The supporting assessments confirm that the insured person has:

i. a diagnosis of persistent gender dysphoria; and

ii. has completed twelve (12) continuous *month*s of hormone therapy (unless hormones are contraindicated).

3. Mastectomy

a. One supporting assessment from an appropriately trained provider who is a physician or nurse practitioner confirming the patient is an appropriate candidate for surgery; and

b. The assessment confirms that the insured person has diagnosis of persistent gender dysphoria.

4. Augmentation Mammoplasty

a. One supporting assessment from an appropriately trained provider who is a physician or nurse practitioner confirming the patient is an appropriate candidate for surgery; and

b. The assessment confirms that the insured person has:

i. a diagnosis of persistent gender dysphoria; and

ii. has completed twelve (12) continuous *month*s of hormone therapy with no breast enlargement (unless hormones are contraindicated).

SURFACE PATHOLOGY

PART C – POST-SURGICAL COMPLICATIONS:

Additional surgery that is required because of complications causing significant physical symptoms or functional impairment is insured when prior authorization has been obtained from the *MOH*.

The prior authorization request must be made by the surgeon proposing the surgery.

[Commentary:
There are additional requirements for surgical services to be received at a hospital or health facility outside Canada and a separate prior approval of the General Manager of *OHIP* is required. See
https://www.ontario.ca/page/ohip-coverage-while-outside-canada
for application process and requirements.]

18. Sex-Assignment Surgery

Sex-assignment surgery for persons with congenitally ambiguous genitalia is an insured service. Prior authorization from the Ministry of Health is not required.

APPENDIX D

NOT ALLOCATED

APPENDIX F

Appendix F does not form part of the *Schedule* of Benefits: Physician Services under the *Health Insurance Act* and is reproduced for your information only.

This attachment is included in the publication for information purposes only.

The services set out below are not "insured services" within the meaning of the *Health Insurance Act* but are paid by the Ministry of Health, acting as paying agent on behalf of the Ministry of Children, Community and Social Services (MCCSS), the Ministry of the Attorney General, the Ministry of the Solicitor General, and the Workplace Safety and Insurance Board (WSIB).

MCSS ONTARIO DISABILITY SUPPORT PROGRAM (ODSP)

K050	Health Status Report and *Act*ivities of Daily Living Index (completion of amalgamated forms for initial ODSP application)	116.15
K051	Health Status Report (completed separately) for initial ODSP application	92.90
K052	*Act*ivities of Daily Living Index (completed separately) for initial ODSP application	23.20
K057	Medical Form Part A for Medical Review process	40.70
K058	Medical Form Part B including both Health Status Report and Activities of Daily Living Index for Medical Review process	145.15
K059	Health Status Report of Part B (completed separately) for Medical Review process	116.15
K060	Activities of Daily Living Index of Part B (completed separately) for Medical Review process	29.05
K054	Mandatory Special Necessities Benefit Request Form	29.05
K055	Application for Special Diet Allowance	23.20
K056	Application for Pregnancy/Breast-feeding Nutritional Allowance	23.20

PERIODIC OCULO-VISUAL ASSESSMENT

K065	Eye examination rendered to patients between the ages 20 and 64 who are recipients of income support under the *Ontario Disability Support Program Act*, 1997	56.80
K066	Eye examination rendered to patients between the ages 20 and 64 who are recipients of income assistance or benefits under the *Ontario Works Act*, 1997	56.80

These assessments are rendered primarily to determine if a patient has a simple refractive error (defined as myopia, hypermetropia, presbyopia, anisometropia or astigmatism) and include all services necessary to perform the assessment (ordinarily relevant ocular medical history, relevant past medical history, relevant family history, visual acuity examination, ocular mobility examination, refraction, slit lamp examination of the anterior segment, ophthalmoscopy, tonometry), advice and/or instruction to the patient and provision of a written refractive prescription if required.

Note:

1. These services are limited to a maximum of one per patient every 24-*month* period regardless of whether a periodic oculo-visual assessment or a major eye examination is rendered by the same physician, a different physician, or when the service is rendered by an optometrist described as a “major oculo-visual examination” in the *Schedule* of Benefits for Optometry Services

APPENDIX F

Appendix F does not form part of the *Schedule* of Benefits: Physician Services under the *Health Insurance Act* and is reproduced for your information only.

2. For physicians other than ophthalmologists, claims submitted for any other service by the same physician the same day as either of these services are *not eligible for payment*.

3. This payment represents full payment for the service. No additional charge to either *OHIP* or the patient for this service is permitted.

MCCSS ONTARIO WORKS PROGRAM (OW)

K053 A Limitation to Participation Form 17.45

Note:
The MCCSS forms identified above are provided to patients only by social services staff. The fee codes are specific to the applicable form and are not to be claimed for completion of any other government document. Inquiries regarding MCCSS forms may be directed to the local MCCSS office.

K061 Taking of blood samples in a hospital setting at the request of a police officer 34.80

Cortical evoked audiometry, multiple frequency (minimum of 4 frequencies in each ear) as required by WSIB:

G153 - technical component 11.35

G154 - professional component 45.85

Note:
The technical component of the cortical evoked audiometry service rendered in a hospital is payable at 86.10% of the listed fee.

APPENDIX G

Appendix G does not form part of the *Schedule* of Benefits: Physician Services under the *Health Insurance Act* and is reproduced for your information only.

MEDICAL RECORDS

Please refer to Section 18 of Regulation 114/94 made under the *Medicine Act*, 1991, and Section 37.1 of the *Health Insurance Act*.

For a complete text version of Section 18 of Regulation 114/94 under the *Medicine Act*, please refer to:

https://www.ontario.ca/laws/regulation/940114

For a complete text version of Section 17.4, of the *Health Insurance Act*, please refer to:

https://www.ontario.ca/laws/statute/90h06#BK27

APPENDIX G

NOT ALLOCATED

APPENDIX H

Appendix H does not form part of the Schedule of Benefits: Physician Services under the Health Insurance Act and is reproduced for your information only.

ASSISTING AT SURGERY AND ANAESTHESIA TIME UNITS TABLE

Time in Minutes [Hours]		Assistant Time Units for Billing	Anaesthesia Time Units for Billing
0-15		1	1
>15-30		2	2
>30-45		3	3
>45-60		4	4
>60-75	[>1h – 1h 15m]	6	6
>75-90	[>1h 15m – 1h 30m]	8	8
>90-105	[>1h 30m – 1h 45m]	10	11
>105-120	[>1h 45m – 2h]	13	14
>120-135	[>2h – 2h 15m]	16	17
>135-150	[>2h 15m – 2h 30m]	19	20
>150-165	[>2h 30m – 2h 45m]	22	23
>165-180	[>2h 45m – 3h]	25	26
>180-195	[>3h – 3h 15m]	28	29
>195-210	[>3h 15m – 3h 30m]	31	32
>210-225	[>3h 30m – 3h 45m]	34	35
>225-240	[>3h 45m – 4h]	37	38
>240-255	[>4h – 4h 15m]	40	41
>255-270	[>4h 15m – 4h 30m]	43	44
>270-285	[>4h 30m – 4h 45m]	46	47
>285-300	[>4h 45m – 5h]	49	50
>300-315	[>5h – 5h 15m]	52	53
>315-330	[>5h 15m – 5h 30m]	55	56
>330-345	[>5h 30m – 5h 45m]	58	59
>345-360	[>5h 45m – 6h]	61	62
>360-375	[>6h – 6h 15m]	64	65
>375-390	[>6h 15m – 6h 30m]	67	68
>390-405	[>6h 30m – 6h 45m]	70	71
>405-420	[>6h 45m – 7h]	73	74
>420-435	[>7h – 7h 15m]	76	77
>435-450	[>7h 15m – 7h 30m]	79	80
>450-465	[>7h 30m – 7h 45m]	82	83

APPENDIX H

Time in Minutes [Hours]	Assistant Time Units for Billing	Anaesthesia Time Units for Billing
>465-480 [>7h 45m – 8h]	85	86
>480-495 [>8h – 8h 15m]	88	89
>495-510 [>8h 15m – 8h 30m]	91	92

APPENDIX J

Section 1 – Eligible Comprehensive Virtual Care Services

VIDEO OR TELEPHONE

A001A, A007A, A008A, A013A, A014A, A020A, A023A, A024A, A033A, A034A, A043A, A044A, A051A, A053A, A054A, A058A, A063A, A064A, A071A, A073A, A074A, A078A, A083A, A084A, A093A, A094A, A111A, A113A, A114A, A118A, A131A, A133A, A134A, A138A, A151A, A153A, A154A, A158A, A161A, A163A, A164A, A168A, A173A, A174A, A181A, A183A, A184A, A188A, A193A, A194A, A203A, A204A, A221A, A233A, A234A, A243A, A244A, A261A, A262A, A263A, A264A, A270A, A283A, A284A, A310A, A311A, A313A, A318A, A338A, A340A, A341A, A343A, A348A, A353A, A354A, A411A, A413A, A414A, A418A, A441A, A443A, A444A, A448A, A461A, A463A, A464A, A468A, A471A, A473A, A474A, A478A, A480A, A481A, A483A, A484A, A488A, A510A, A511A, A570A, A601A, A603A, A604A, A608A, A611A, A613A, A614A, A618A, A621A, A623A, A624A, A628A, A632A, A633A, A638A, A643A, A644A, A661A, A713A, A721A, A723A, A724A, A728A, A760A, A917A, A920A, A927A, A937A, A947A, A957A, A967A, A921A, E424A, H313A, K002A, K003A, K004A, K005A, K007A, K008A, K010A, K012A, K013A, K014A, K015A, K019A, K020A, K022A, K023A, K024A, K025A, K028A, K029A, K030A, K033A, K037A, K039A, K040A, K041A, K044A, K122A, K123A, K125A, K140A, K141A, K142A, K143A, K144A, K195A, K196A, K197A, K198A, K203A, K204A, K205A, K206A, K208A, K209A, K222A, K321A, K623A, K680A, K887A, K888A, K889A, P005A

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VIDEO ONLY

A010A, A011A, A015A, A016A, A021A, A025A, A026A, A035A, A036A, A045A, A046A, A050A, A055A, A056A, A065A, A066A, A075A, A076A, A085A, A086A, A095A, A096A, A116A, A130A, A135A, A136A, A150A, A155A, A156A, A160A, A165A, A166A, A175A, A176A, A180A, A185A, A186A, A190A, A191A, A192A, A195A, A196A, A197A, A198A, A205A, A206A, A210A, A220A, A223A, A225A, A226A, A235A, A236A, A245A, A246A, A253A, A255A, A256A, A260A, A265A, A266A, A275A, A285A, A286A, A315A, A316A, A320A, A325A, A335A, A345A, A346A, A355A, A356A, A365A, A375A, A385A, A395A, A400A, A405A, A415A, A416A, A425A, A435A, A445A, A446A, A460A, A465A, A466A, A470A, A475A, A476A, A485A, A486A, A515A, A525A, A545A, A565A, A575A, A580A, A586A, A590A, A595A, A600A, A605A, A606A, A615A, A616A, A625A, A626A, A635A, A636A, A645A, A646A, A655A, A662A, A665A, A667A, A675A, A680A, A682A, A695A, A710A, A715A, A720A, A725A, A726A, A735A, A745A, A770A, A775A, A795A, A800A, A801A, A802A, A814A, A817A, A818A, A835A, A845A, A865A, A906A, A913A, A914A, A915A, A925A, A935A, A945A, C010A, C013A, C014A, C015A, C016A, C020A, C023A, C024A, C025A, C026A, C033A, C034A, C035A, C036A, C043A, C044A, C045A, C046A, C051A, C053A, C054A, C055A, C063A, C064A, C065A, C066A, C071A, C073A, C074A, C075A, C076A, C083A, C084A, C085A, C086A, C093A, C094A, C095A, C096A, C111A, C113A, C114A, C116A, C130A, C131A, C133A, C134A, C135A, C136A, C150A, C151A, C153A, C154A, C155A, C156A, C160A, C161A, C163A, C164A, C165A, C166A, C173A, C174A, C175A, C176A, C180A, C181A, C183A, C184A, C185A, C186A, C190A, C193A, C194A, C196A, C203A, C204A, C205A, C206A, C210A, C220A, C223A, C225A, C226A, C233A, C234A, C235A, C236A, C243A, C244A, C245A, C246A, C255A, C260A, C263A, C264A, C265A, C266A, C270A, C275A, C283A, C285A, C286A, C311A, C313A, C314A, C315A, C316A, C320A, C325A, C335A, C341A, C343A, C344A, C345A, C346A, C353A, C354A, C355A, C356A, C365A, C375A, C385A, C395A, C411A, C413A, C414A, C415A, C416A, C425A, C435A, C441A, C443A, C444A, C445A, C446A, C460A, C461A, C463A, C464A, C465A, C466A, C470A, C471A, C473A, C474A, C475A, C476A, C480A, C481A, C483A, C484A, C485A, C486A, C510A, C511A, C515A, C545A, C565A, C570A, C575A, C580A, C585A, C586A, C590A, C595A, C600A, C601A, C603A, C604A, C605A, C606A, C611A, C613A, C614A, C615A, C616A, C623A, C624A, C625A, C626A, C635A, C643A, C644A, C645A, C646A, C655A, C661A, C662A, C665A, C667A, C675A, C680A, C682A, C695A, C720A, C721A, C723A, C724A, C725A, C726A, C710A, C713A, C715A, C735A, C745A, C760A, C770A, C775A, C795A, C845A, C865A, C895A, C915A, C925A, C935A, C945A, K630A, W025A, W026A, W075A, W076A, W130A, W150A, W155A, W156A, W165A, W185A, W190A, W196A, W235A, W236A, W275A, W310A, W355A, W356A, W375A, W395A, W425A, W435A, W465A, W466A, W510A, W511A, W515A, W516A, W535A, W720A, W725A, W726A, W770A, W775A, W795A, W895A, W925A

APPENDIX J

Section 2 – Eligible Limited Virtual Care Services

Code	Description
A101A	Video
A102A	Telephone

APPENDIX J

NOT ALLOCATED

APPENDIX Q

Appendix Q does not form part of the *Schedule* of Benefits: Physician Services under the *Health Insurance Act* and is for your information only.

Please Refer to the Primary Health Care Fact Sheets for complete billing information.

Summary of Acronyms	
CCM	Comprehensive Care Model
FHG	Family Health Group
FHN	Family Health Network
FHO	Family Health Organization
RNPGA	Rural and Northern Physician Group Agreement
BSM	Community Sponsored Agreement Blended Salary Model
GHC	Group Health Centre
SJHC	St Joseph's Health Centre
SEAMO	South Eastern Academic Medical Organization
TPCA	Toronto *Palliative Care* Agreement
WHA	Weeneebayko Health Ahtuskaywin

Code	Description	Fee	Eligible Models
New Patient Fees			
Q023A	Unattached Patient Fee	150.00	CCM, FHG, FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA
Q043A	New Patient Fee Abnormal Colorectal Cancer (CRC)/ Increased Risk Payment Based on age of patient	150.00 (up to 64 years) 170.00 (65 to 74 years) 230.00 (75 Years +)	CCM, FHG, FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA For minimum requirements to claim Q043A please see INFOBulletin 4723

APPENDIX Q

Code	Description	Fee	Eligible Models
New Patient Fees			
Q053A	HCC Complex-Vulnerable Patient Fee	350.00	CCM, FHG, FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA

Code	Description	Fee	Eligible Models
After Hours Fees			
Q012A	After Hours Fee	30%	FHG, FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA
Q016A	After Hours Fee	30%	CCM
Q017A	HIV After Hours Fees	30%	HIV

Code	Description	Fee	Eligible Models
Weekend & Holiday Access for FHO Patient			
Q888A	Weekend Access for FHO Patients	44.55	FHO

Code	Description	Fee	Eligible Models
Chronic Disease Management			
Q042A	Smoking Cessation Counselling Fee (2 / year)	7.70	CCM, FHG, FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA
Q050A	Heart Failure Management Incentive (Annual)	125.00	CCM, FHG, FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA

APPENDIX Q

Code	Description	Fee	Eligible Models
Newborn Care Fees			
Q014A	Newborn Care Episodic Fee	15.05	FHN, SEAMO
Q015A	Newborn Care Episodic Fee	13.99	FHO

Code	Description	Fee	Eligible Models
Rostering Fees			
Q200A	Per Patient Rostering Fee	0.00	CCM, FHG, FHN, FHO, RNPGA, BSM, SJHC, SEAMO, WHA
Q201A	Per Patient Rostering Fee	0.00	GHC, FHN, FHO
Q202A	Per Patient Rostering Fee	0.00	GHC, FHN, FHO

Code	Description	Fee	Eligible Models
Q590A	Basic Flu Shot - fee for visit premium	8.80	FHN, FHO
Q593A	Sole Visit Premium COVID-19 vaccine PEM	8.80	FHO, FHN, GHC, RNPGA, WHA, SJHC, TPCA, BSM, GP Focus Care of the Elderly, GP Focus HIV, Homeless Shelter Agreements, Sioux Lookout Agreements

APPENDIX Q

Code	Description	Fee	Eligible Models
Preventive Care Fees and Bonuses			
Q150A	Colorectal Cancer Screening Fee (Once per patient every two years unless a patient has a negative colonoscopy (i.e., revealing either no polyps or only hyperplastic polyps in the sigmoid or rectum), then only after a period of 10 years, unless earlier screening is clinically indicated based on findings, advice and/or recommendations of the specialist who rendered the colonoscopy)	7.00	All primary care physicians in Ontario including physicians participating in Patient Enrolment Models For minimum requirements to claim Q150A please see INFOBulletin 4723
Q152A	Colorectal Cancer Screening Test Completion Fee (Once per patient every two years unless a patient has a negative colonoscopy (i.e., revealing either no polyps or only hyperplastic polyps in the sigmoid or rectum), then only after a period of 10 years, unless earlier screening is clinically indicated based on findings, advice and/or recommendations of the specialist who rendered the colonoscopy)	5.00	All primary care physicians in Ontario including FHG and CCM physicians who do not meet the minimum roster size. Physicians participating in Patient Enrolment Models who are eligible for Preventive Care Bonus Payment are **not** eligible to bill this fee code. For minimum requirements to claim Q152A please see INFOBulletin 4723

APPENDIX Q

Code	Description	Fee	Eligible Models
Preventive Care Fees and Bonuses (continued)			
Q100A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Influenza Vaccine - 60% ($220)	Bill at $0.00	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q101A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Influenza Vaccine - 65% ($440)	Bill at $0.00	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q102A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Influenza Vaccine - 70% ($770)	Bill at $0.00	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q103A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Influenza Vaccine - 75% ($1100)	Bill at $0.00	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q104A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Influenza Vaccine - 80% ($2200)	Bill at $0.00	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size

APPENDIX Q

Code	Description	Fee	Eligible Models
Preventive Care Fees and Bonuses (continued)			
Q105A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Cervical Cancer Screening - 60% ($220)	Bill at $0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size

Code	Description	Fee	Eligible Models
Preventive Care Fees and Bonuses (continued)			
Q106A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Cervical Cancer Screening - 65% ($440)	Bill at $0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q107A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Cervical Cancer Screening - 70% ($660)	Bill at $0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q108A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Cervical Cancer Screening - 75% ($1320)	Bill at $0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q109A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Cervical Cancer Screening - 80% ($2200)	Bill at $0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size

APPENDIX Q

Code	Description	Fee	Eligible Models
Preventive Care Fees and Bonuses (continued)			
Q110A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Mammography - 55% ($220)	Bill at $0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q111A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Mammography - 60% ($440)	Bill at $0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size

APPENDIX Q

Code	Description	Fee	Eligible Models
Preventive Care Fees and Bonuses (continued)			
Q112A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Mammography - 65% ($770)	Bill at $0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q113A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Mammography - 70% ($1320)	Bill at $0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q114A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Mammography - 75% ($2200)	Bill at $0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q115A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Childhood Immunizations - 85% ($440)	Bill at $0.00	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q116A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Childhood Immunizations - 90% ($1100)	Bill at $0.00	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size

APPENDIX Q

Code	Description	Fee	Eligible Models
Preventive Care Fees and Bonuses (continued)			
Q117A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Childhood Immunizations - 95% ($2200)	Bill at $0.00	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size

APPENDIX Q

Code	Description	Fee	Eligible Models
Preventive Care Fees and Bonuses (continued)			
Q118A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Colorectal Cancer Screening - 15% ($220)	Bill at $0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q119A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Colorectal Cancer Screening - 20% ($440)	Bill at $0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q120A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Colorectal Cancer Screening - 40% ($1100)	Bill at $0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q121A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Colorectal Cancer Screening - 50% ($2200)	Bill at $0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size
Q122A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Colorectal Cancer Screening - 60% ($3300)	Bill at $0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size

APPENDIX Q

Code	Description	Fee	Eligible Models
Preventive Care Fees and Bonuses (continued)			
Q123A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Colorectal Cancer Screening - 70% ($4000)	Bill at $0.00	RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size

Code	Description	Fee	Eligible Models
Premiums Payable to Physicians When Providing Eligible Comprehensive Virtual Care Services			
Q012A	Primary care after-hours fee	30% of virtual fee paid	FHO, FHN, FHG, GHC, BSM, RNPGA, SJHC, WAHA
Q016A	CCM after-hours fee	30% of virtual fee paid	CCM
Q017A	HIV after-hours fee	30% of virtual fee paid	GP Focused HIV
Q018A	GP focus – COE1 after-hours fee	30% of virtual fee paid	GP Focused COE
Q020A	Serious mental illness premium: special payment for mental health services	$1,200 - $2,400	FHN, FHO, FHG, BSM, GHC, RNPGA, WAHA, SJHC, GP Focused HIV, Sioux Lookout Agreement
Q021A	Serious mental illness premium: special payment for mental health services	$1,200 - $2,400	FHN, FHO, FHG, BSM, GHC, RNPGA, WAHA, SJHC, GP Focused HIV, Sioux Lookout Agreement
Q042A	Smoking cessation counselling fee	7.70	BSM, CCM, FHG, FHN, FHO, GHC, GP Focused HIV, RNGPA, SJHC, WAHA
Q091	Primary care after-hours fee	10% of virtual fee paid	TPCA, GP Focused Palliative Care
Q150A	Colorectal cancer screening fee	7.00	All GP physicians
Q152A	Colorectal cancer screening test completion fee	5.00	All GP physicians

APPENDIX Q

Code	Description	Fee	Eligible Models
Premiums Payable to Physicians When Providing Eligible Comprehensive Virtual Care Services			
-	Palliative care special premium	$3,600 - $6,000	All GP physicians

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A007	44.55			A4
A008	13.40			A4
A010	95.60			A73
A011	47.10			A73
A013	64.65			A78
A014	31.45			A78
A015	109.70			A77
A016	52.15			A77
A020	60.00			A94
A021	164.90			A92
A023	46.15			A91
A024	23.50			A91
A025	77.50			A91
A026	47.75			A91
A027	158.15			A91
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A341	83.40			A195
A343	95.95			A195
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G119	190.00			J76
G120			7.00	J19
G121		14.55		J19
G123	17.10			J81
G125	100.00			J71
G126			7.00	J19
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G201	1.60			J4
G202	7.15			J4
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G219	34.20			J81
G220	34.20			J81
G221	16.95			J81
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G224	15.55			J72
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G228	34.10			J81
G229	54.65			J81
G230	54.65			J81
G231	34.10			J81
G232	150.00			J78
G233	200.00			J78
G234	55.10			J78
G235	34.10			J82
G236	150.00			J78
G238	34.10			J82
G239	127.60			J76
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G370	20.25			J53
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G802	83.80			J34
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J011	101.90			E5
J012				E5
J013	185.90			E6
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J018	80.10			E6
J020	26.05			E5
J021	186.05			E2
J022	92.15			E2
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J128		32.10	17.55	G4
J135		48.75	28.85	G4
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J164		24.40	12.30	G6
J165		99.95	33.15	G6
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J199		6.85	7.80	G9
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J319		11.25		H5
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J323		4.20		H6
J324		3.25	4.20	H4
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X010		28.65	15.55	D5
X011		21.70	11.30	D5
X012		29.90	14.45	D5
X016		14.85	9.90	D5
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X018		16.85	9.90	D5
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X020		13.75	8.70	D5
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X028		25.90	8.70	D6
X031		29.70	14.55	D6
X032		53.55	22.65	D6
X033		21.70	11.10	D6
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X035		21.70	11.30	D6
X036		14.90	7.00	D6
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X040		17.95	8.55	D10
X045		14.90	7.00	D7
X046		21.70	11.30	D7
X047		17.95	8.70	D7
X048		17.95	8.70	D7
X049		17.95	8.70	D7
X050		14.90	7.00	D7
X051		14.90	7.00	D7
X052		14.90	7.00	D7
X053		14.90	7.00	D7
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X090		14.90	6.95	D10
X091		21.90	11.70	D10
X092		28.15	13.55	D10
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X101		22.80	10.05	D10
X103		60.95	63.75	D11
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X135		27.50	13.80	D12
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X148		55.20	48.00	D16
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X154		15.95	5.15	D24
X155		55.20	48.00	D16
X156		26.25	30.00	D15
X158		28.95	25.10	D15
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X160		48.90	34.00	D15
X161		78.60	69.65	D15
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X177		15.60	10.05	D24
X178		37.15	33.85	D24
X179		29.60	15.85	D15
X180		38.95	31.35	D15
X181		59.65	47.35	D15
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X183		48.40	37.85	D24
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X191		21.70	9.80	D12
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X196		9.25	21.75	D14
X197		9.25	21.75	D14
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X204		29.90	11.60	D6
X205		33.40	11.75	D6
X206		40.35	14.55	D6
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X215		22.90	9.90	D7
X216		30.85	12.70	D7
X217		22.90	9.90	D7
X218		22.90	9.90	D7
X219		22.90	9.90	D7
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X224		22.90	9.90	D8
X225		30.85	12.70	D8
X226		22.90	9.90	D8
X227		22.90	9.90	D8
X228		22.90	9.90	D8
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X330	100.00			C6
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X335	80.00			C6
X336	100.00			C6
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Z095	37.70			M24
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Z101	28.20			M1
Z102	48.60			M1
Z103	48.60			M1
Z104	33.25			M1
Z105	72.30			M1
Z106	48.60			M1
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Z108	78.90			M1
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